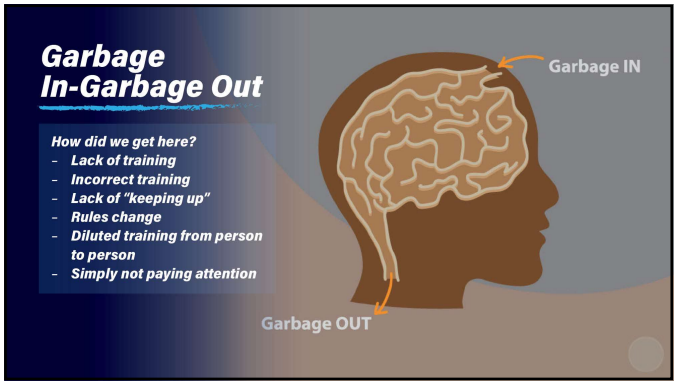

KMC
U
UNIVERSITY
Medicare Mastery
From Fundamentals
to Complicated Compliance
Presented by:
Kathy Weidner, MCS-P, CPCO, CCPC, CCCA
April Lee, DC, CPCO

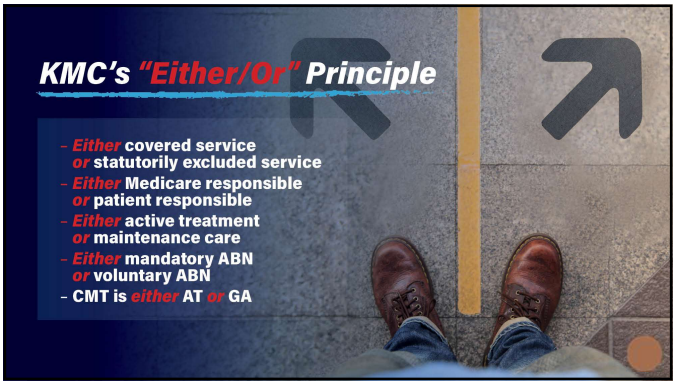
1


It's simple until you make it complicated
Medicare Can Seem Complicated

2


Garbage In-Garbage Out
How did we get here?
- Lack of training
- Incorrect training
- Lack of "keeping up"
- Rules change
- Diluted training from person to person
- Simply not paying attention
Garbage IN
Garbage OUT

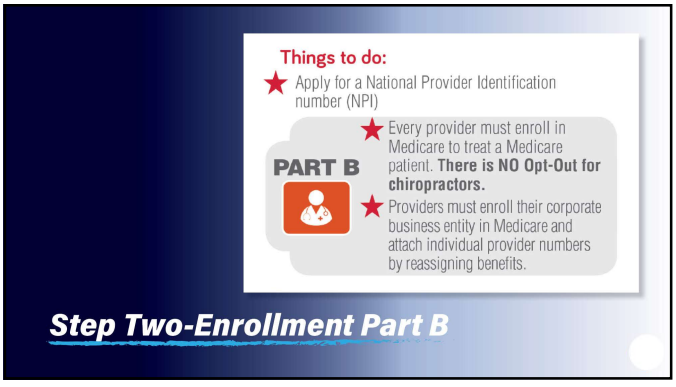
3


KMC's "Either/Or" Principle
- Either covered service or statutorily excluded service
- Either Medicare responsible or patient responsible
- Either active treatment or maintenance care
- Either mandatory ABN or voluntary ABN
- CMT is either AT or GA

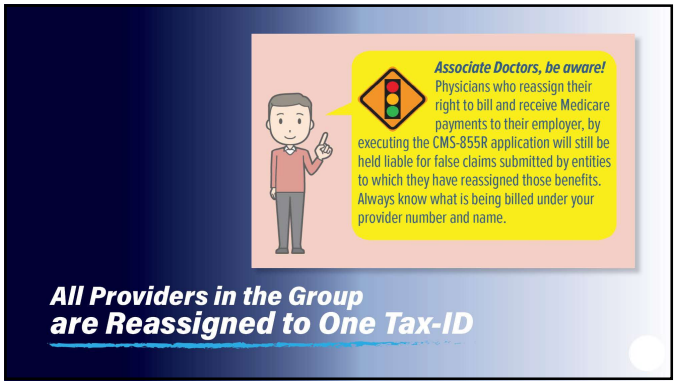
4


CHIROPRACTIC MEDICARE BENEFITS AND LIMITATIONS
Recognize the Fundamentals of Medicare Coverage for Chiropractic Services
Covered and Payable
Active Treatment (AT) Spinal Chiropractic Manipulative TX (CMT)
CPT Codes 98940, 98941, 98942
Covered but Not Payable
*ABN form must be provided to the patient prior to rendering Covered but Not Payable services.
Spinal CMT codes are deemed Covered but Not Payable when performed for:
• Chiropractic maintenance treatment
• More than one spinal manipulation per day
Statutorily Excluded from Medicare Chiropractic Benefit
*ABN is not required for these services. Office Financial Policy is recommended to communicate these limitations of Medicare coverage.
All services/supplies ordered or provided by a chiropractor, other than those defined above, are excluded from the Medicare benefit, and therefore the patient is responsible for payment. This includes but is not limited to:
• Extremity CMT 98943
• X-rays
• Products/supplies
• Therapies
• Exams
• Alternative treatment protocols
Step One:
Must Know The Difference
Chiropractic is Different In Medicare

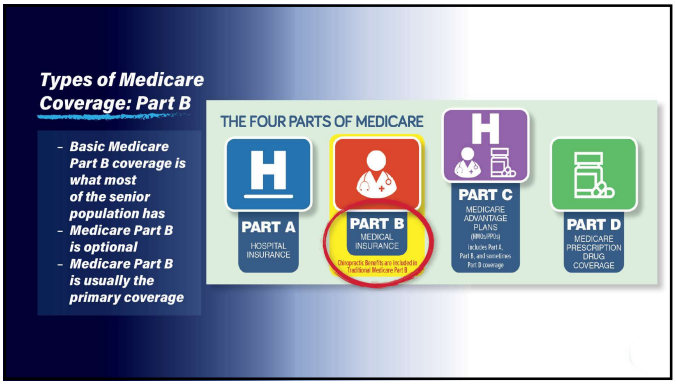
5


Things to do:
Apply for a National Provider Identification number (NPI)
PART B
Every provider must enroll in Medicare to treat a Medicare patient. There is NO Opt-Out for chiropractors.
Providers must enroll their corporate business entity in Medicare and attach individual provider numbers by reassigning benefits.
Step Two-Enrollment Part B

6


Associate Doctors, be aware!
Physicians who reassign their right to bill and receive Medicare payments to their employer, by executing the CMS-855R application will still be held liable for false claims submitted by entities to which they have reassigned those benefits. Always know what is being billed under your provider number and name.
All Providers in the Group
are Reassigned to One Tax-ID

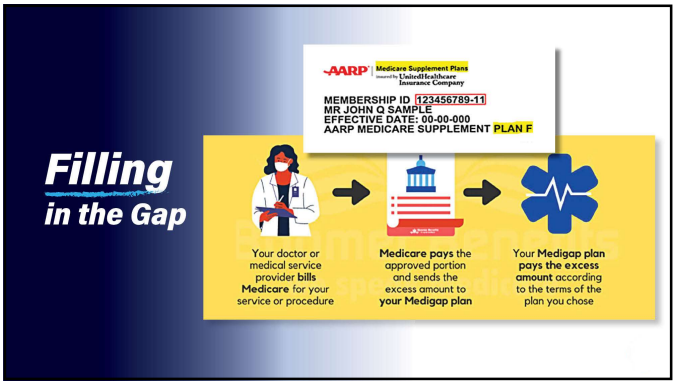
7


Types of Medicare Coverage: Part B
- Basic Medicare Part B coverage is what most of the senior population has
- Medicare Part B is optional
- Medicare Part B is usually the primary coverage
THE FOUR PARTS OF MEDICARE
PART A
HOSPITAL INSURANCE
PART B
MEDICAL INSURANCE
PART C
MEDICARE ADVANTAGE PLANS
PART D
MEDICARE PRESCRIPTION DRUG COVERAGE

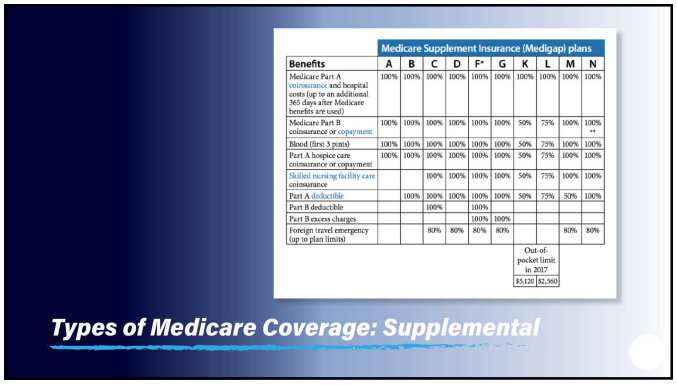
8


Covers 80%
Patient Responsible
20% plus deductible
MEDICARE HEALTH INSURANCE
JOHN L SMITH
1EG4-TE5-MK72
PART A
PART B
03-03-2016
03-03-2016
The Traditional Medicare Card
Beneficiary Name
Medicare ID Number
Medicare Coverage Start Date
Type of Medicare Coverage

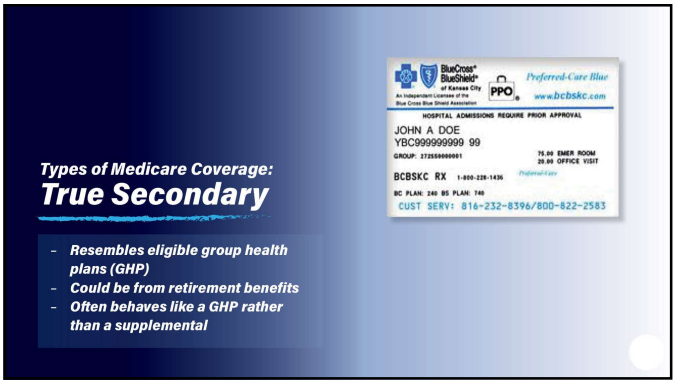
9


Filling
in the Gap
AARP Medicare Supplement Plans
MEMBERSHIP ID 123456789-11
MR JOHN Q SAMPLE
EFFECTIVE DATE: 00-00-000
AARP MEDICARE SUPPLEMENT PLAN F
Your doctor or medical service provider bills Medicare for your service or procedure
Medicare pays the approved portion and sends the excess amount to your Medigap plan
Your Medigap plan pays the excess amount according to the terms of the plan you chose

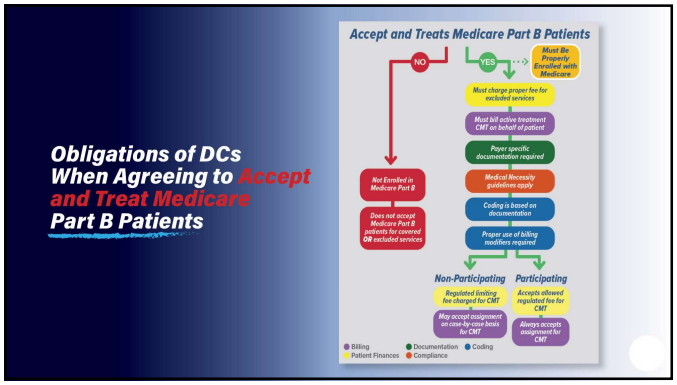
10


Medicare Supplement Insurance (Medigap) plans
Benefits
A B C D F* G K L M N
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)
Medicare Part B coinsurance or copayment
Blood (first 3 pints)
Part A hospice care coinsurance or copayment
Skilled nursing facility care coinsurance
Part A deductible
Part B deductible
Part B excess charges
Foreign travel emergency (up to plan limits)
Out-of-pocket limit in 2017
$5,120 $2,560
Types of Medicare Coverage: Supplemental

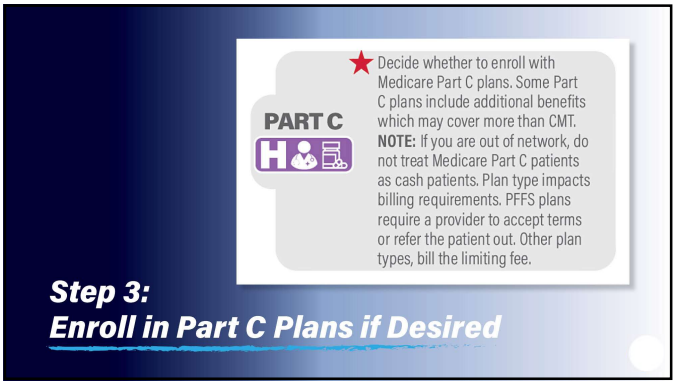
11


Types of Medicare Coverage:
True Secondary
- Resembles eligible group health plans (GHP)
- Could be from retirement benefits
- Often behaves like a GHP rather than a supplemental
BlueCross BlueShield of Kansas City
PPO
Preferred-Care Blue
www.bcbskc.com
HOSPITAL ADMISSIONS REQUIRE PRIOR APPROVAL
JOHN A DOE
YBC999999999 99
BCBSKC RX
CUST SERV: 816-232-8396/800-822-2583

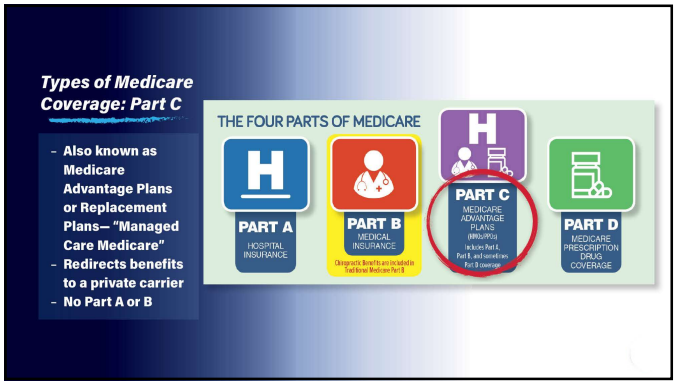
12



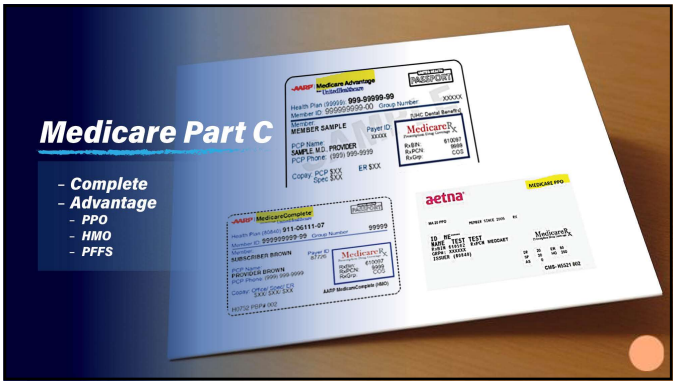
13



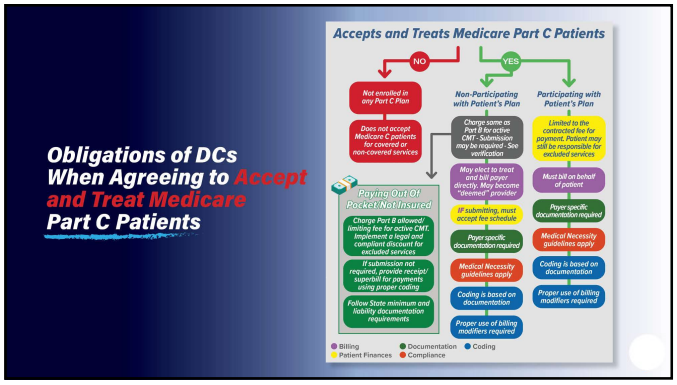
14



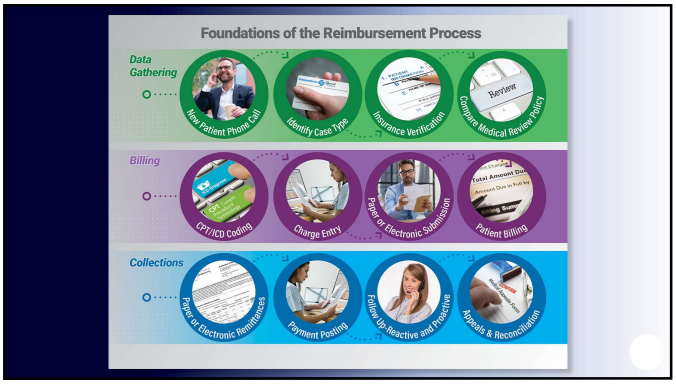
15



16

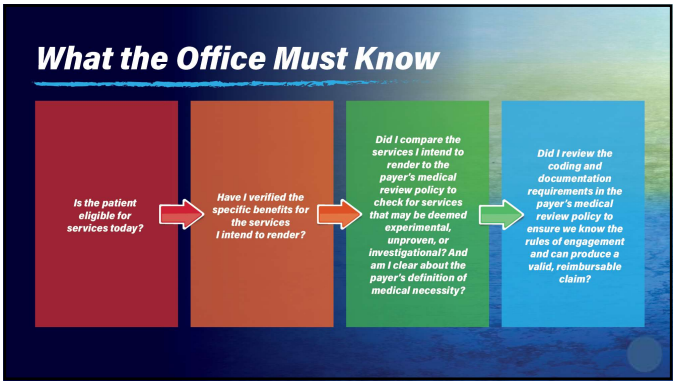


17

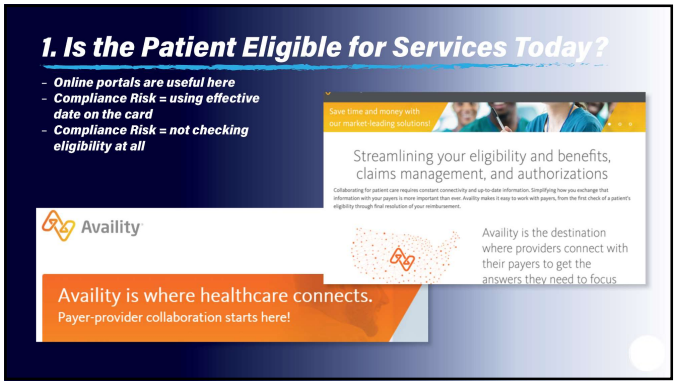


18

19



20



21

22

23

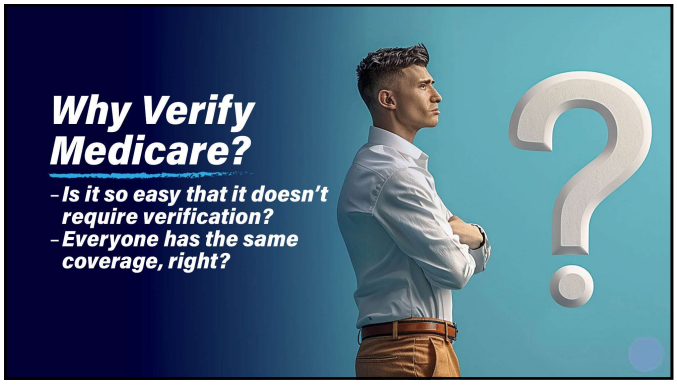
24

25

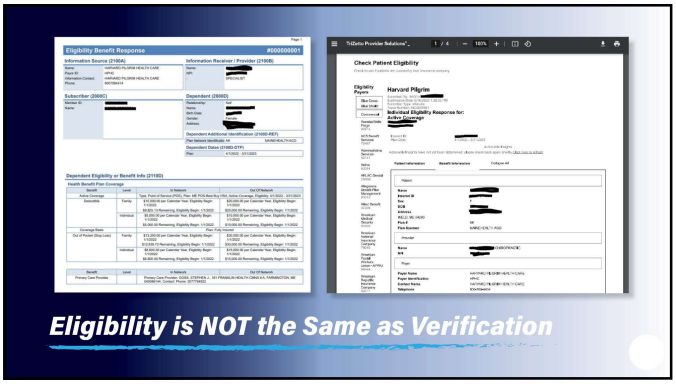
26

27

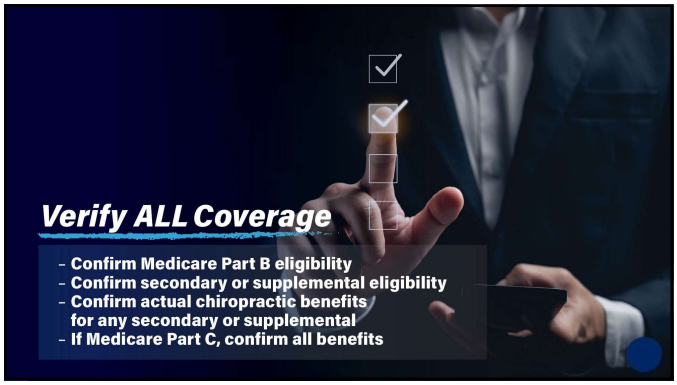
28



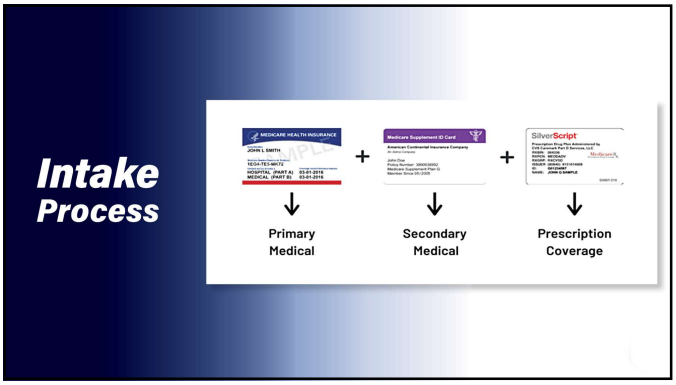
29



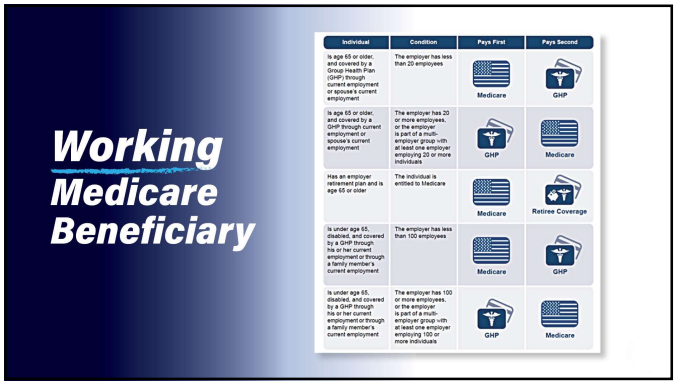
30



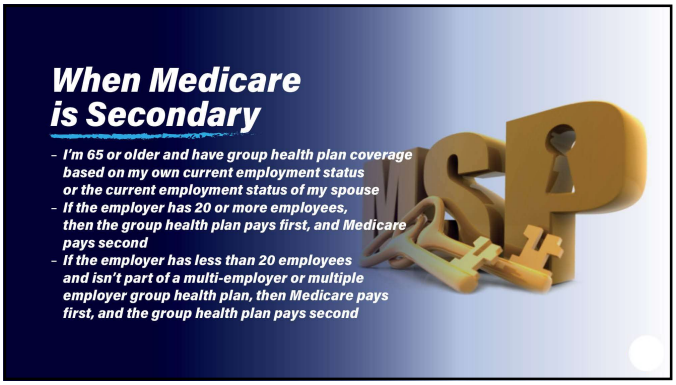
31



32

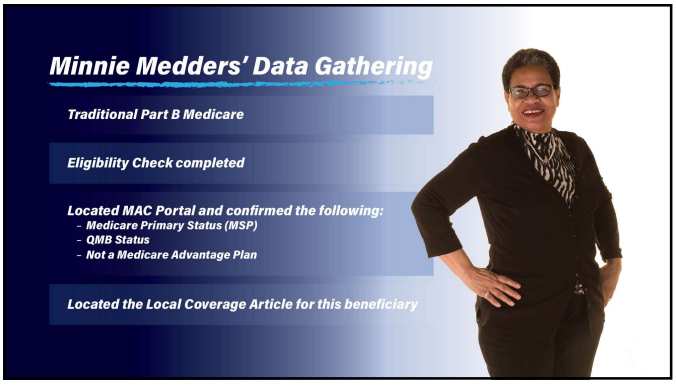


33

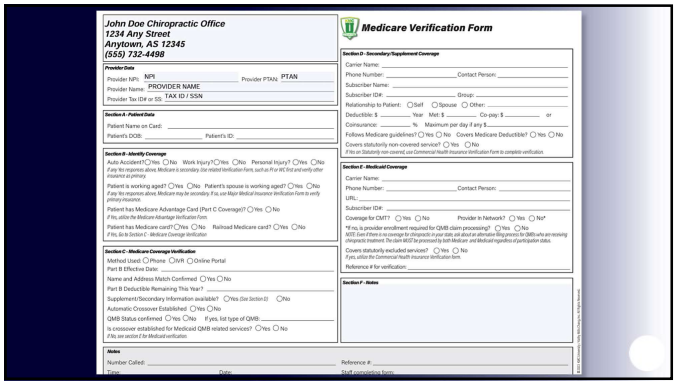


34

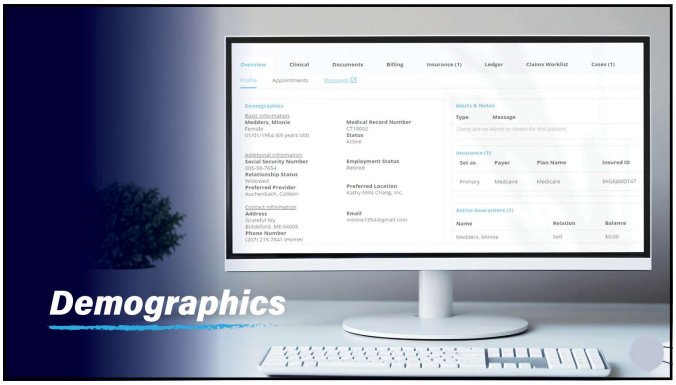
35



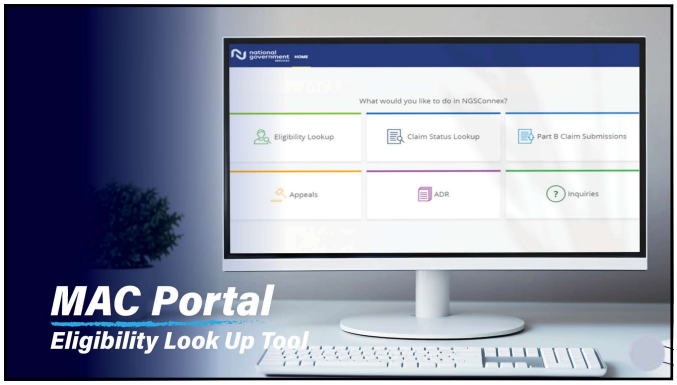
36



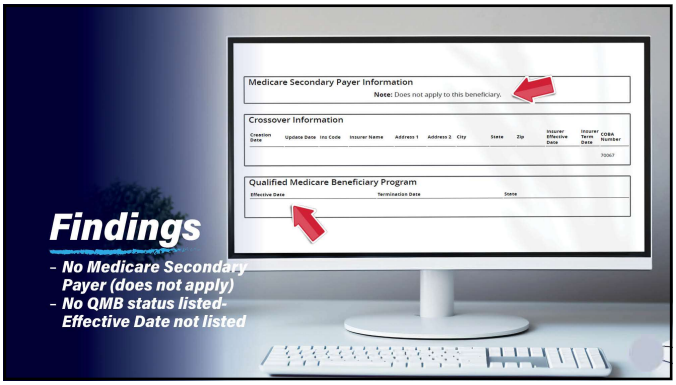
37



38

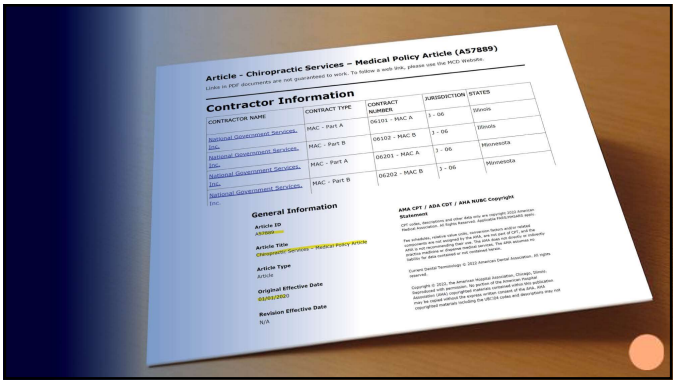


39

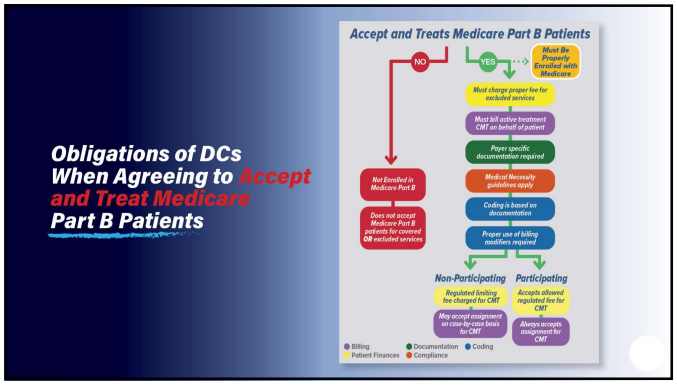


40

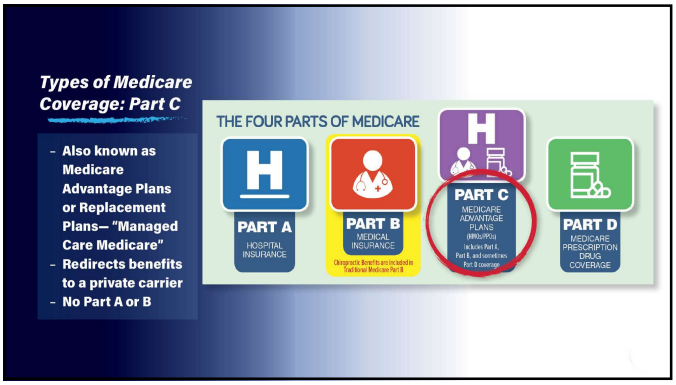
41



42

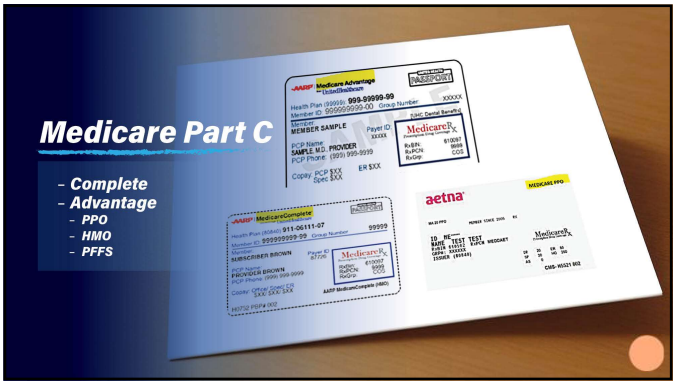


43

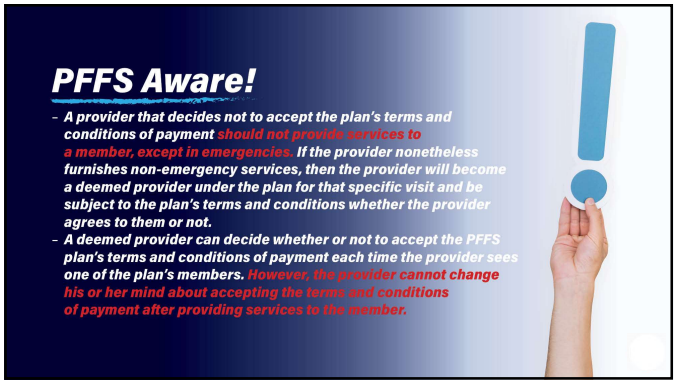


44

45

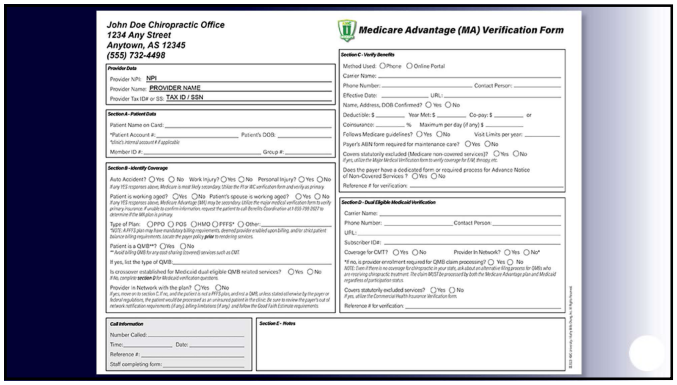


46

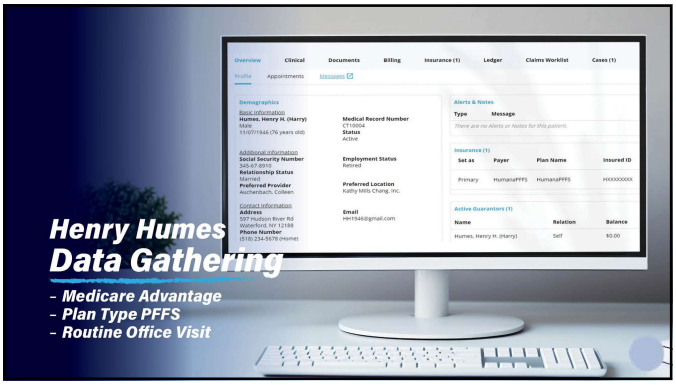


47

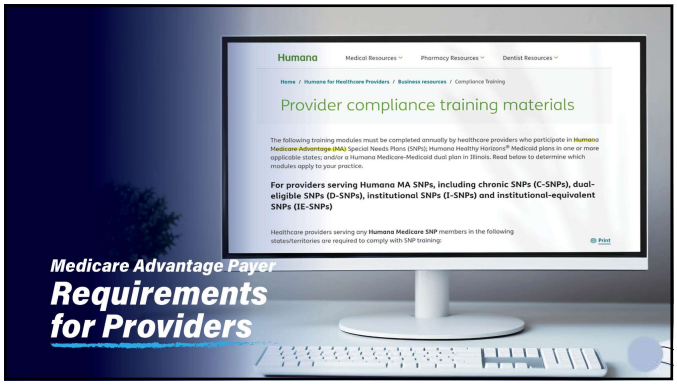
48



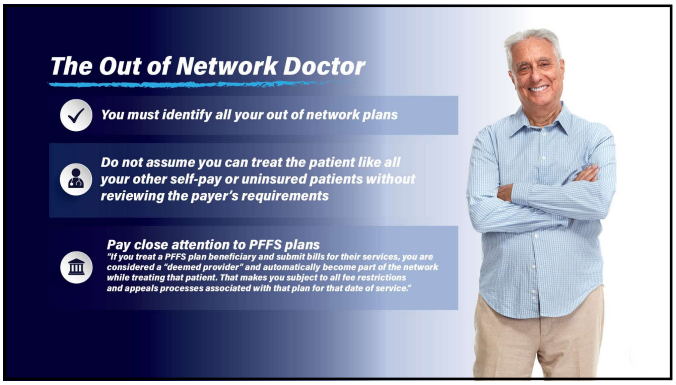
49



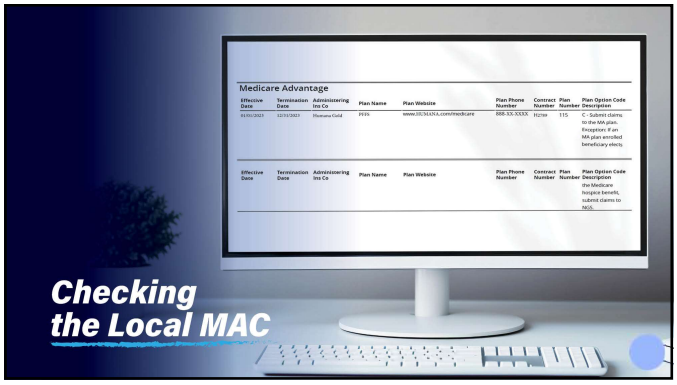
50



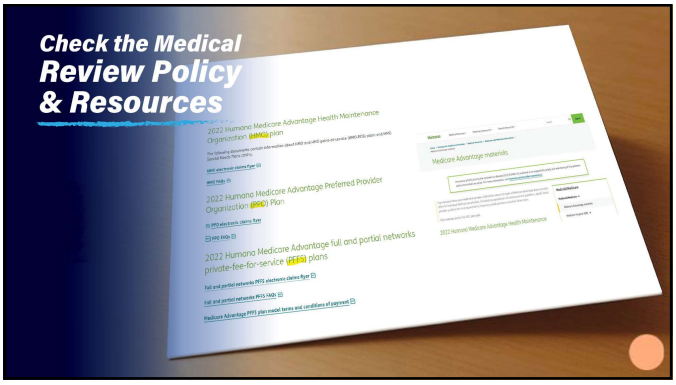
51



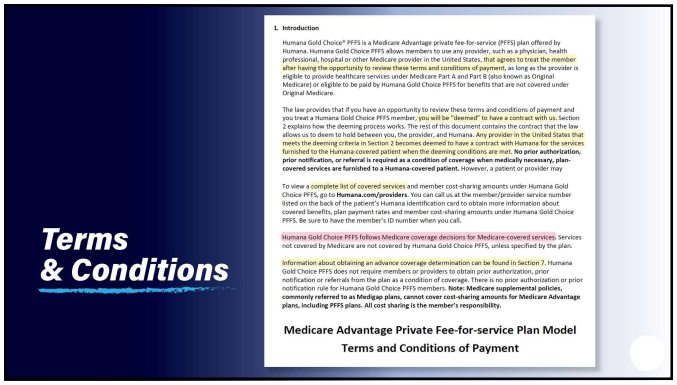
52



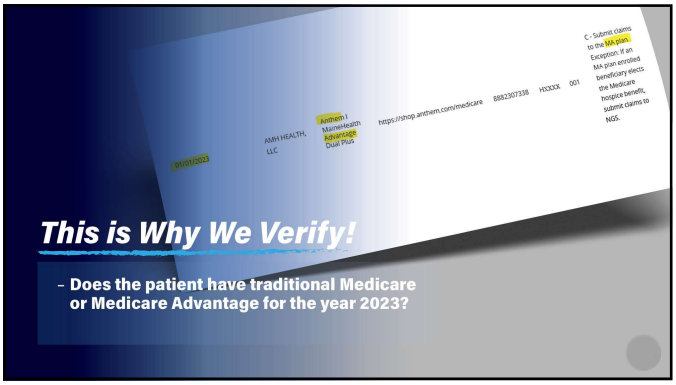
53



54

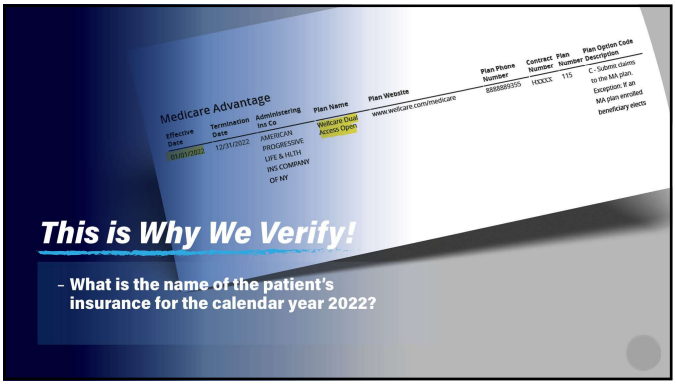


55

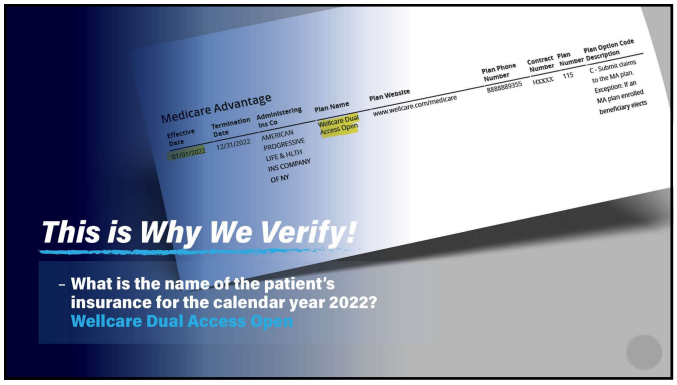


56

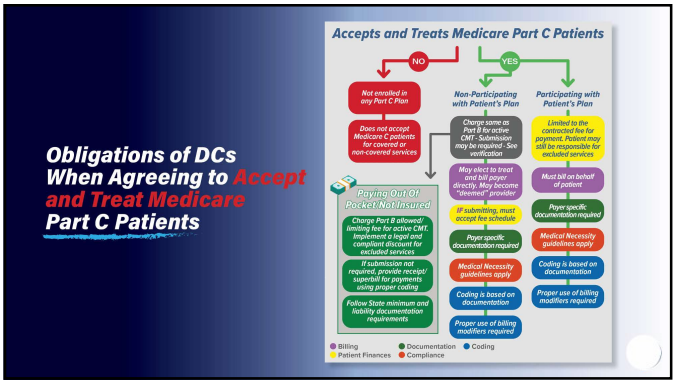
57



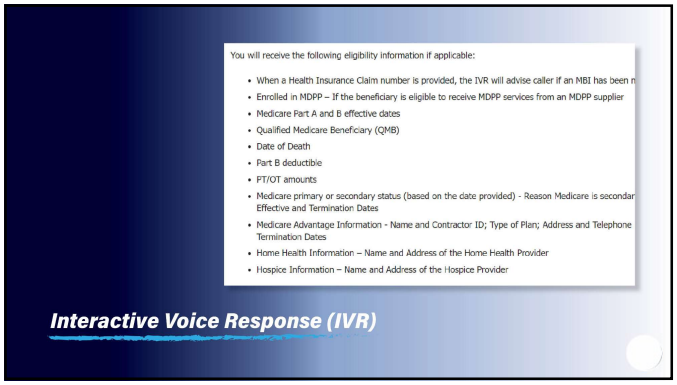
58



59

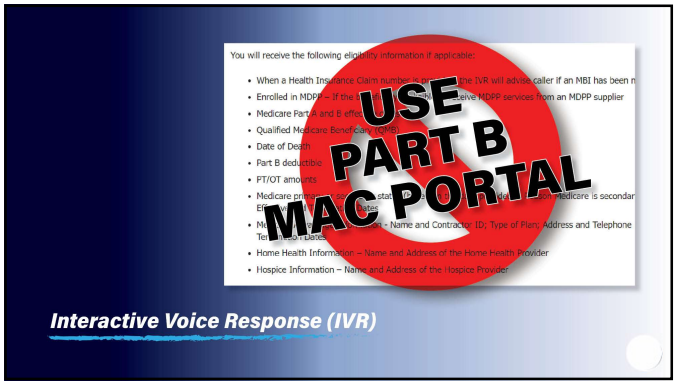


60



61

62

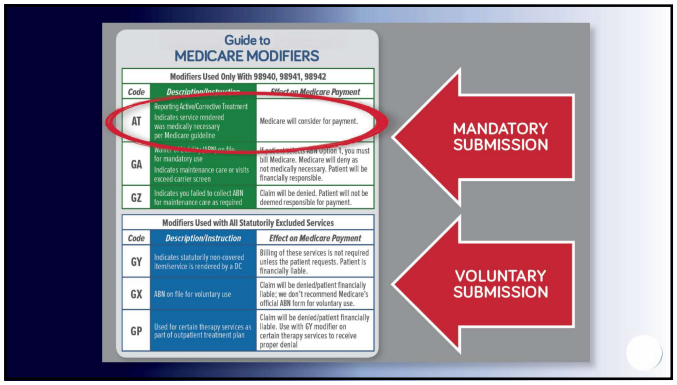


63

64

65

66



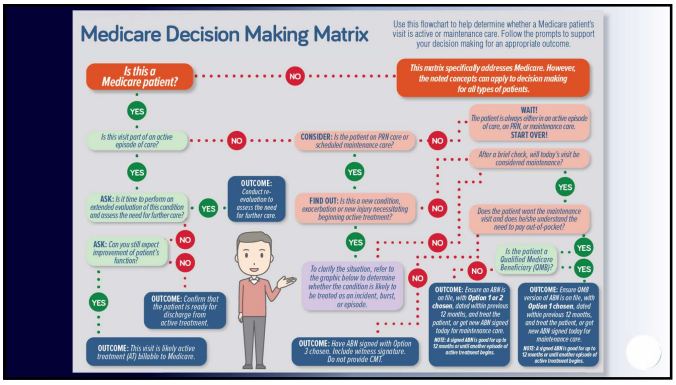
67

68

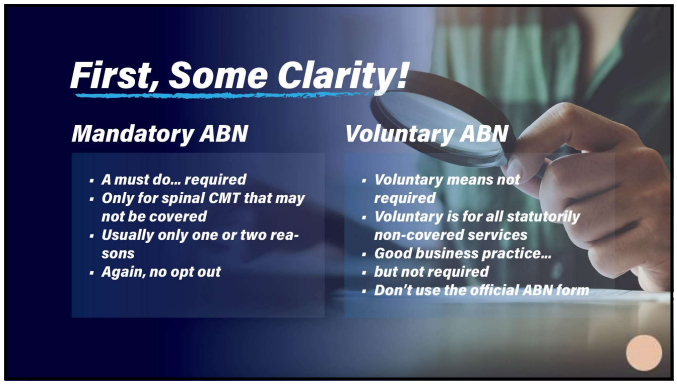
69

70

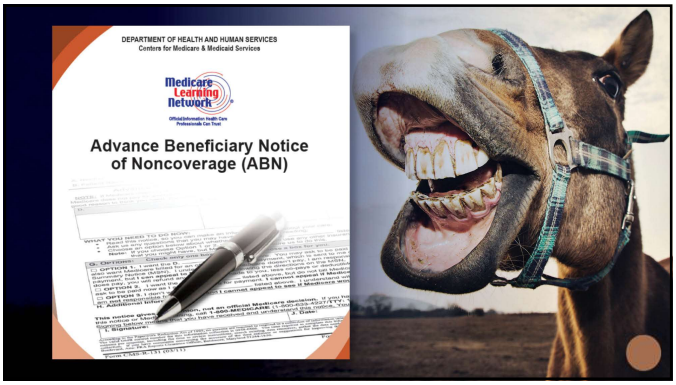
71



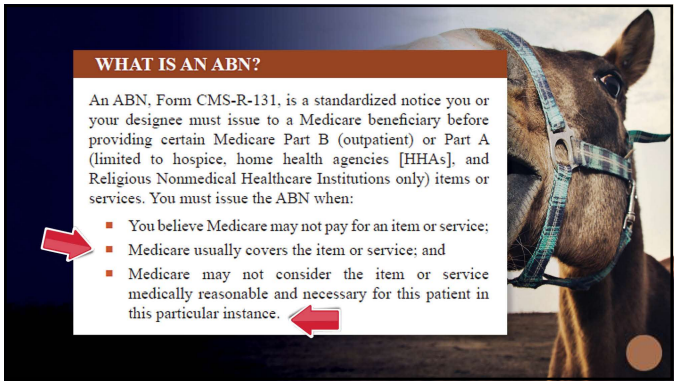
72



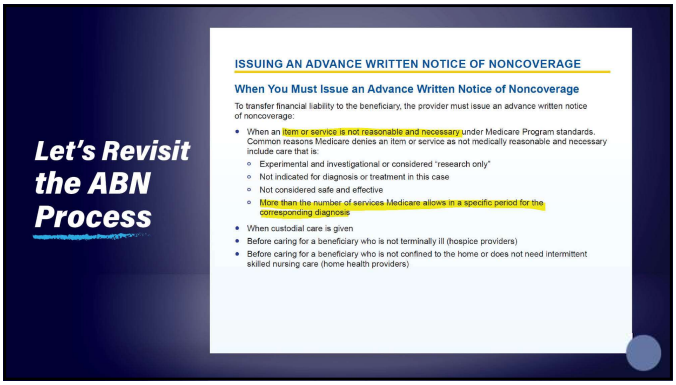
73



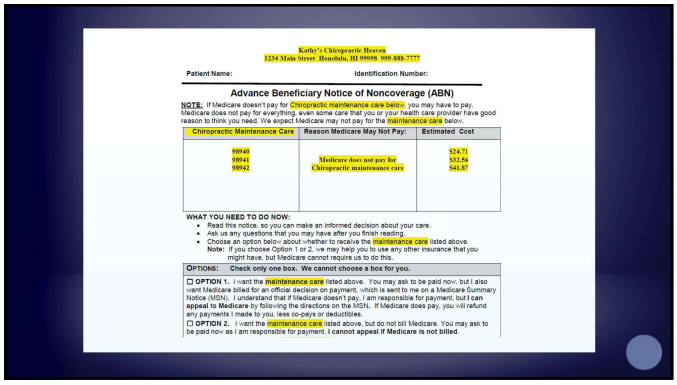
74



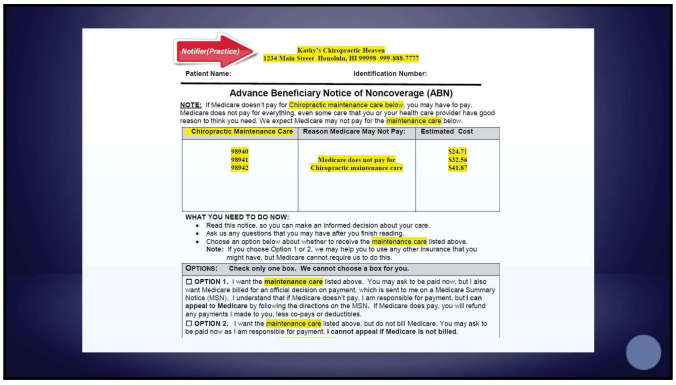
75



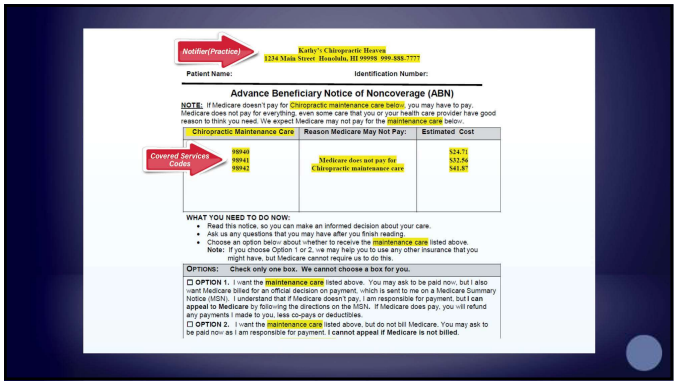
76



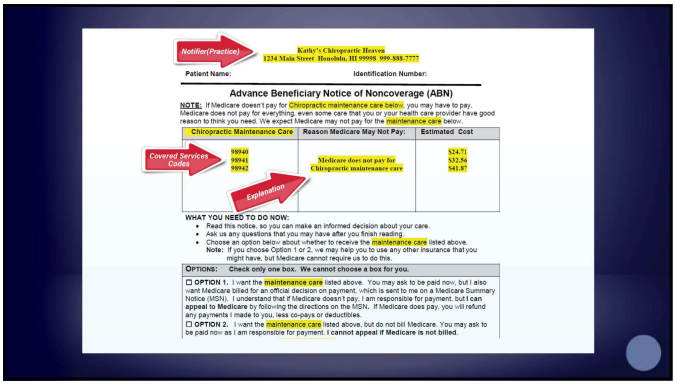
77



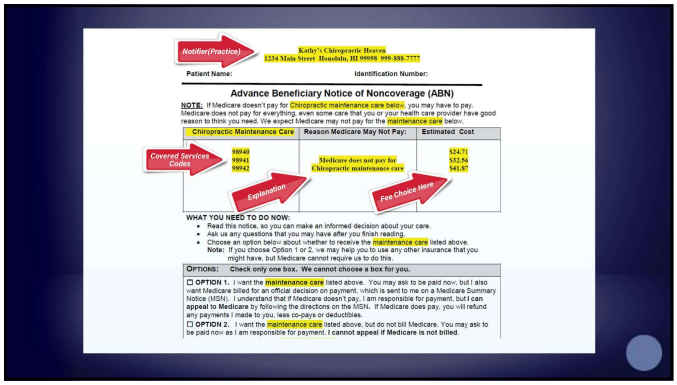
78



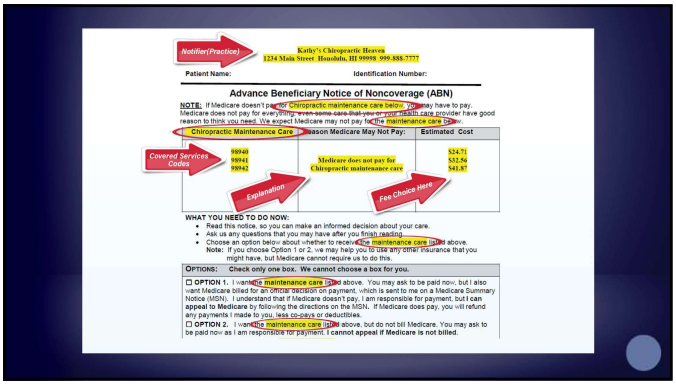
79



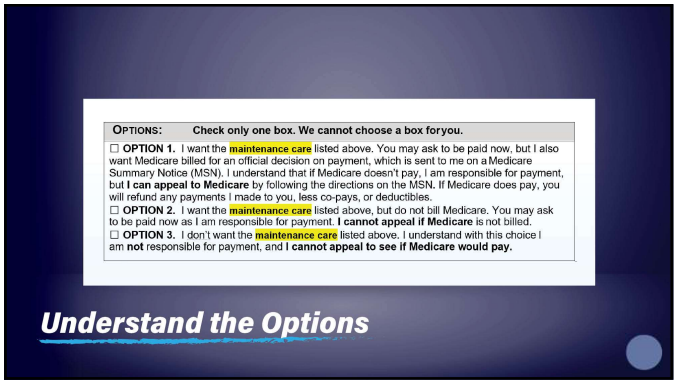
80



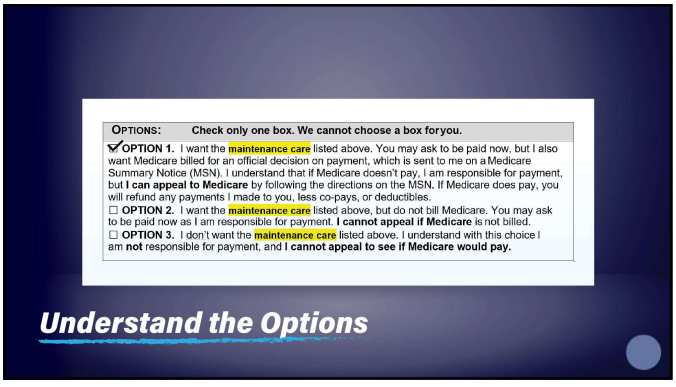
81



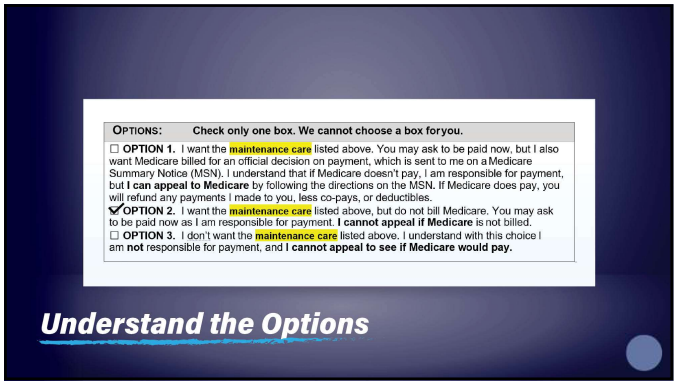
82



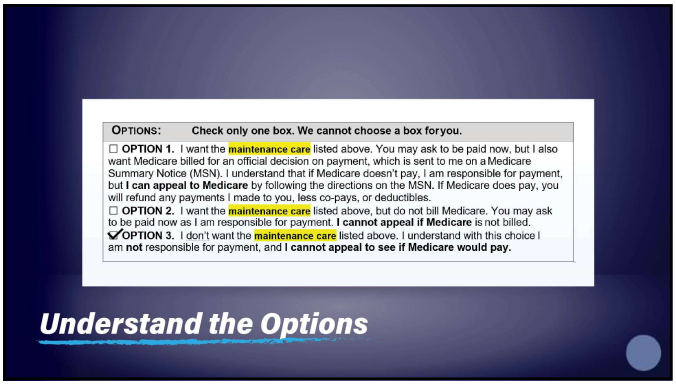
83



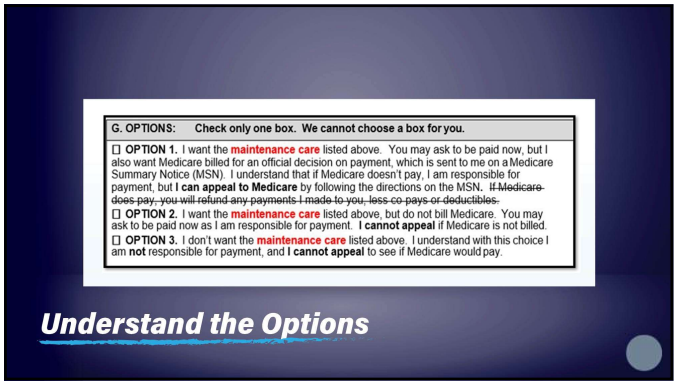
84



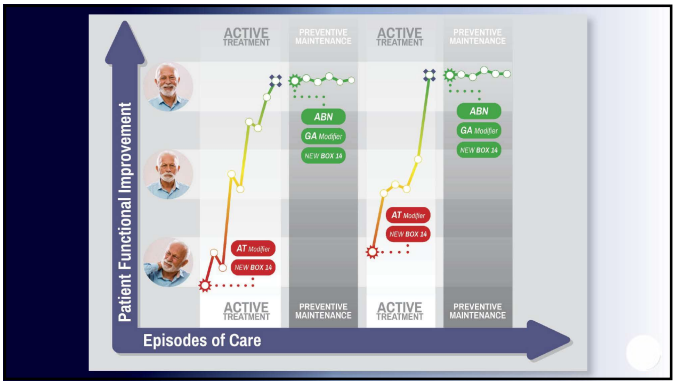
85



86

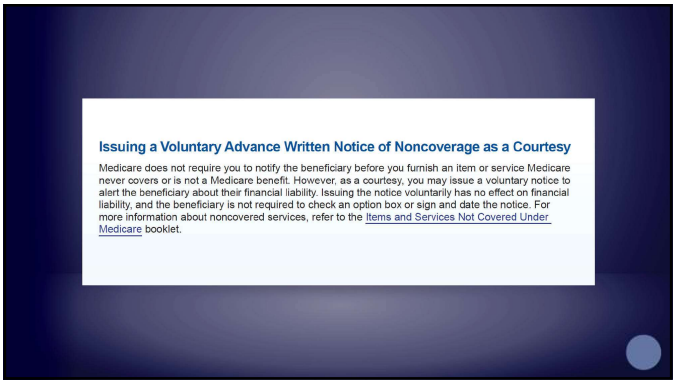


87

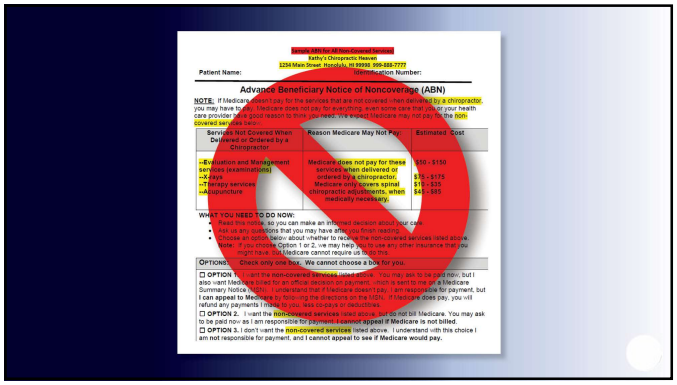


88

89



90


Sample ABN for All Non-Covered Services

Kathy's Chiropractic Heaven

1234 Main Street Honolulu, HI 99745 999-888-7777

Patient Name: Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the services that are not covered when delivered by a chiropractor, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the non-covered services listed below.

Services Not Covered When Delivered or Ordered by a Chiropractor	Reason Medicare May Not Pay:	Estimated Cost
□Evaluation and Management services (examinations) □X-rays □Therapy services □Acupuncture	Medicare does not pay for these services when delivered or ordered by a chiropractor. Medicare only covers spinal chiropractic adjustments, when medically necessary.	$50 - $150 $75 - $175 $10 - $35 $45 - $85

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the non-covered services listed above.
- Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

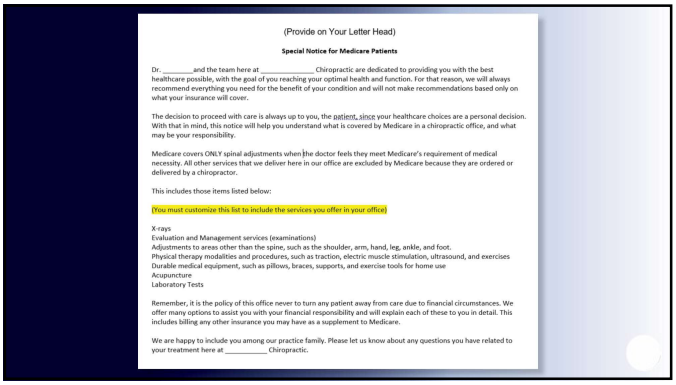
OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the non-covered services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I make to you, less copays or deductibles.

☐ OPTION 2. I want the non-covered services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don't want the non-covered services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

91


(Provide on Your Letter Head)

Special Notice for Medicare Patients

Dr. _____ and the team here at _____ Chiropractic are dedicated to providing you with the best healthcare possible, with the goal of you reaching your optimal health and function. For that reason, we will always recommend everything you need for the benefit of your condition and will not make recommendations based only on what your insurance will cover.

The decision to proceed with care is always up to you, the patient, since your healthcare choices are a personal decision. With that in mind, this notice will help you understand what is covered by Medicare in a chiropractic office, and what may be your responsibility.

Medicare covers ONLY spinal adjustments when the doctor feels they meet Medicare's requirement of medical necessity. All other services that we deliver here in our office are excluded by Medicare because they are ordered or delivered by a chiropractor.

This includes those items listed below:

(You must customize this list to include the services you offer in your office)

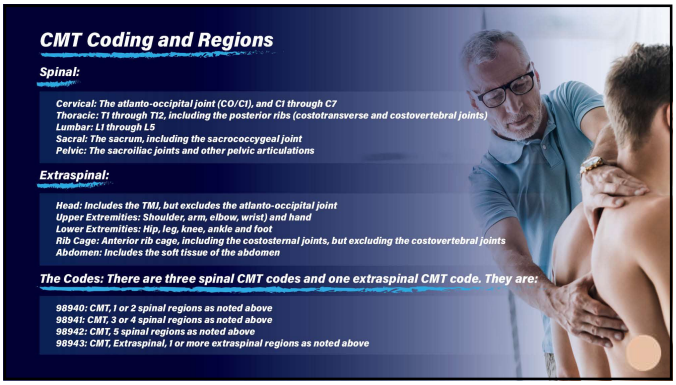
X-rays
Evaluation and Management services (examinations)
Adjustments to areas other than the spine, such as the shoulder, arm, hand, leg, ankle, and foot.
Physical therapy modalities and procedures, such as traction, electric muscle stimulation, ultrasound, and exercises
Durable medical equipment, such as pillows, braces, supports, and exercise tools for home use
Acupuncture
Laboratory Tests

Remember, it is the policy of this office never to turn any patient away from care due to financial circumstances. We offer many options to assist you with your financial responsibility and will explain each of these to you in detail. This includes billing any other insurance you may have as a supplement to Medicare.

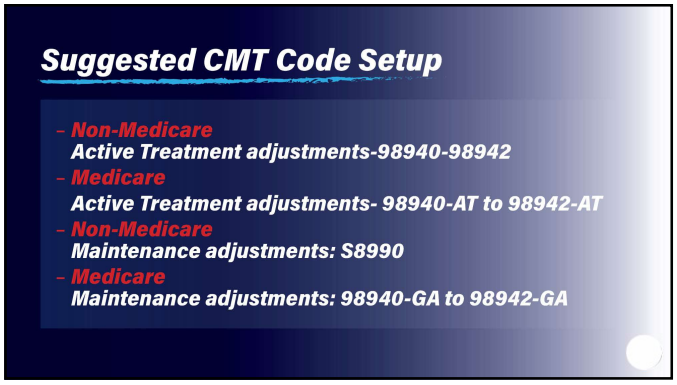
We are happy to include you among our practice family. Please let us know about any questions you have related to your treatment here at _____ Chiropractic.

92

93



94



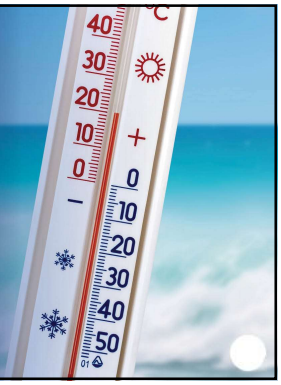
95

96

Never Charge 97010

HOT PACKS
- For chronic pain relating to muscle aches & joint stiffness
- Increases blood flow by dilating blood vessels
- Promotes muscle relaxation & tissue healing

COLD PACKS
- For injuries and acute pain relating to inflammations
- Reduces blood flow by constricting blood vessels
- Numbs pain & reduces the effects of inflammations (swelling & redness) & bruising



97

Diagnosis Hierarchy

Position 1:
Neurological/Injury: Examples of neurological diagnoses include Radiculitis and Sciatic Neuritis.

Position 2:
Structural/Subluxation: Examples of structural diagnoses for the spine include Degenerative Joint Disease, Spondylolisthesis, Scoliosis, etc.

Position 3:
Functional: Examples include Restricted Range of Motion, Deconditioning Syndrome, and muscle wasting.

Position 4:
Soft Tissue/Extraspinal/Other: Fibromyalgia, myofascitis, and myalgia are excellent diagnoses to support manual therapy. Examples of extraspinal diagnoses include Frozen Shoulder, Carpal Tunnel Syndrome, Headache or Pain Syndromes.

Position 5:
Complicating Factors: Examples include obesity, high blood pressure, diabetes, cancer, and other forms of co-morbidities.

Position 6:
External cause, Activity, and Location Codes: Examples are related to mechanisms of injury, like slips, trips, falls and accidents, and activity codes show what the patient was doing when injured. These are not required, but helpful, and if reported are only reported on the first claim.

98

Group 1 Codes:

ICD-10 Codes	Description
M99.00	Segmental and somatic dysfunction of head region
M99.01	Segmental and somatic dysfunction of cervical region
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region

Primary DX Must

Be Subluxation/ Segmental Dysfunction

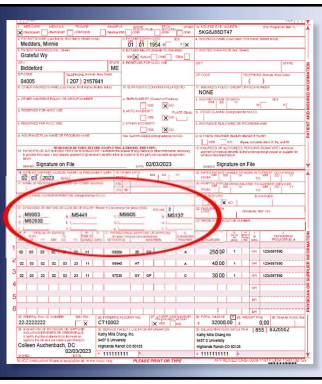
99

Medicare DX Coding

- The preferred order is the same but use the required coupling of the primary segmental dysfunction diagnosis first, and the secondary neuromusculoskeletal diagnosis listed second in the pair. Then move on to the next condition and repeat that coupling for the next condition.

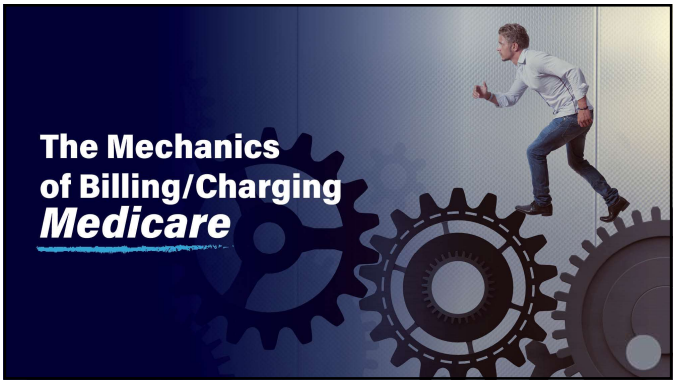
100

Clean Claim

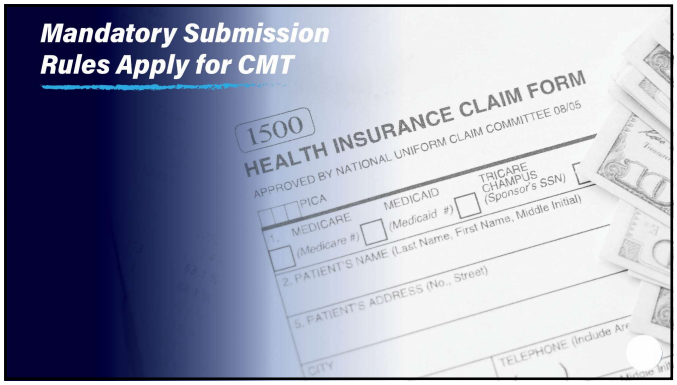


101

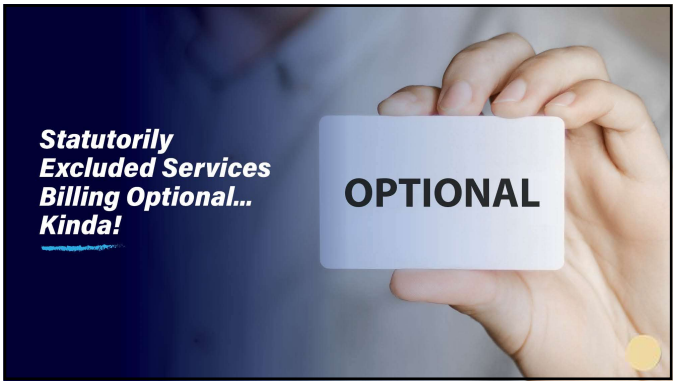
The Mechanics of Billing/Charging Medicare



102



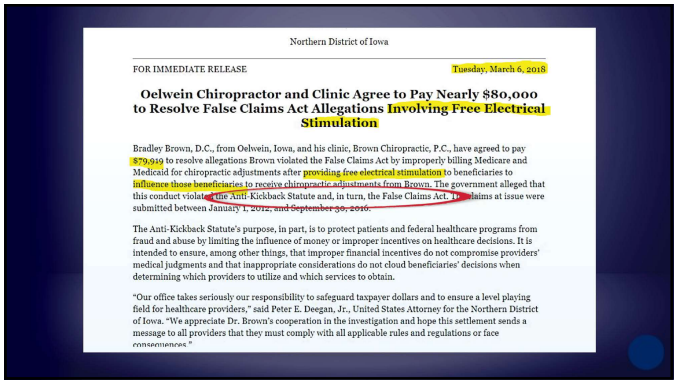
103



104

105

106



Northern District of Iowa

FOR IMMEDIATE RELEASE — Tuesday, March 6, 2018

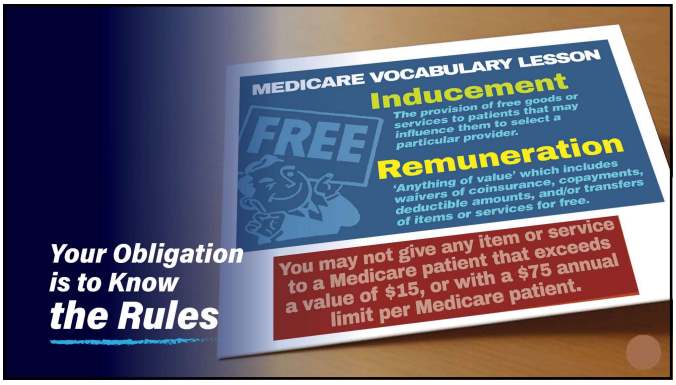
Oelwein Chiropractor and Clinic Agree to Pay Nearly $80,000 to Resolve False Claims Act Allegations Involving Free Electrical Stimulation

Bradley Brown, D.C., from Oelwein, Iowa, and his clinic, Brown Chiropractic, P.C., have agreed to pay $79,919 to resolve allegations Brown violated the False Claims Act by improperly billing Medicare and Medicaid for chiropractic adjustments after providing free electrical stimulation to beneficiaries to influence those beneficiaries to receive chiropractic adjustments from Brown. The government alleged that this conduct violated the Anti-Kickback Statute and, in turn, the False Claims Act. The claims at issue were submitted between January 1, 2012, and September 30, 2016.

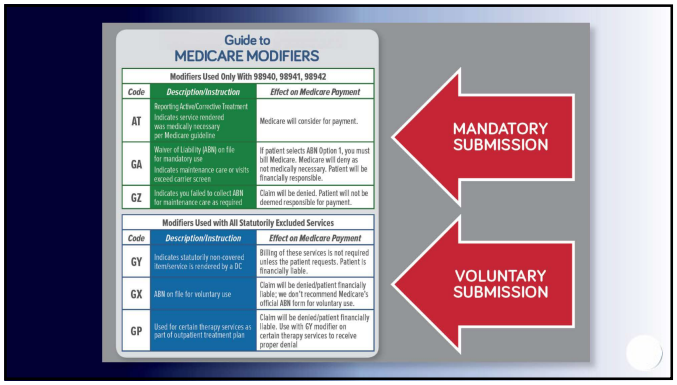
The Anti-Kickback Statute's purpose, in part, is to protect patients and federal healthcare programs from fraud and abuse by limiting the influence of money or improper incentives on healthcare decisions. It is intended to ensure, among other things, that improper financial incentives do not compromise providers' medical judgments and that inappropriate considerations do not cloud beneficiaries' decisions when determining which providers to utilize and which services to obtain.

"Our office takes seriously our responsibility to safeguard taxpayer dollars and to ensure a level playing field for healthcare providers," said Peter E. Deegan, Jr., United States Attorney for the Northern District of Iowa. "We appreciate Dr. Brown's cooperation in the investigation and hope this settlement sends a message to all providers that they must comply with all applicable rules and regulations or face consequences."

107

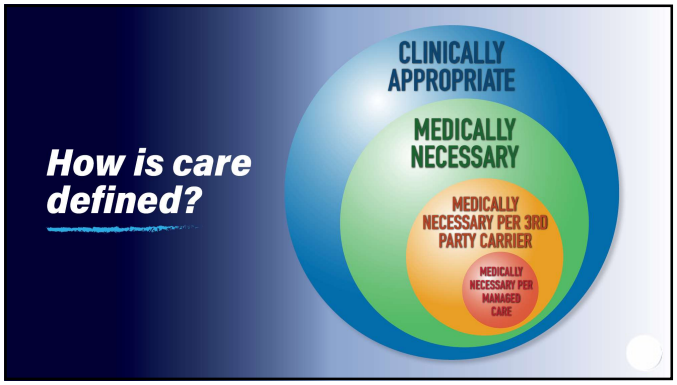


108



109

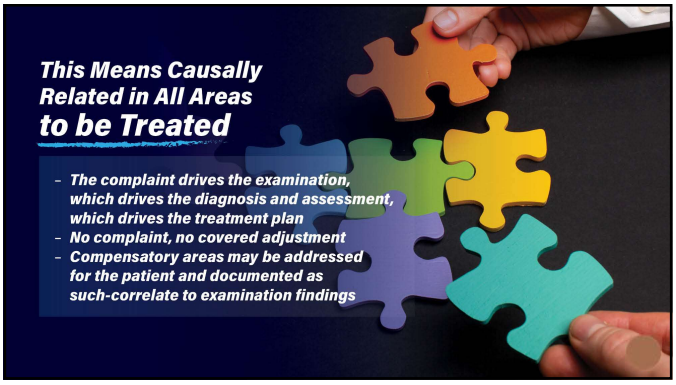
110



111

112

113



114

In Conclusion

Steps to Compliant Coding and Documentation of Full Spine Adjustments

1. Using the complete history, examination, and required clinical decision-making, determine a diagnosis and treatment plan for any patient being treated for an active condition. In the course of this process, define/identify the primary areas of subluxation clearly in your treatment plan.
2. Document all treatment rendered and every segment adjusted in your patient's health record and/or daily notes. **Define** how you differentiated between areas of primary (medically necessary) subluxations in your notes or areas of secondary (clinically appropriate) compensation that were addressed.
3. Match the levels of primary subluxation treated with the appropriate Chiropractic Manipulative Treatment (CMT) code. **Do not count the areas of compensatory subluxations** addressed when selecting the appropriate CMT code level to be billed.
4. Write an office policy about your intention to seek third-party reimbursement ONLY for those areas that are deemed medically necessary. Further, state that you will NEVER upcharge a patient or carrier when you address other areas (compensatory subluxation) in an effort to stabilize the primary subluxation(s).

115

Is the condition likely to be treated as an INCIDENT, BURST or EPISODE?

KMC University's classification of treatment lengths for active treatment are described as incidents, bursts, and episodes. Follow these cues to verify that your documentation is sufficient to warrant the level of recommended care.

Is there a subluxation present, capable of causing a significant neuromusculoskeletal (NMS) condition, and does the patient have a documented loss of function that can be improved? → NO → In this circumstance, per Medicare coverage requirements, medical necessity cannot be established and therefore the condition is likely maintenance care.

YES

CONSIDER: Will the condition likely be resolved within 1–3 visits? → NO

CONSIDER: Will the condition likely be resolved within about a month? → NO

CONSIDER: Will the condition likely require treatment beyond a month?

YES

DOCUMENT:
- History/Chief Complaint
- Mechanism of injury
- OATS if last score was > 30 days old
- Exam/Physical findings/PART
- DX: Sig. Dys. + 2ndary condition per region treated
- Measurable functional deficits
- TX Plan including goals, and estimated discharge

Formal E/M service **may not be necessary.** Documentation within CMT may be possible.

Incident

DOCUMENT:
- History/Chief Complaint
- Mechanism of injury
- OATS result and score
- Exam/Physical findings/PART
- DX: Sig. Dys. + 2ndary condition per region treated
- Measurable functional deficits
- TX plan, including STG&LTG
- Estimated discharge or re-evaluation date

Formal E/M service **necessary** to establish medical necessity for this much care.

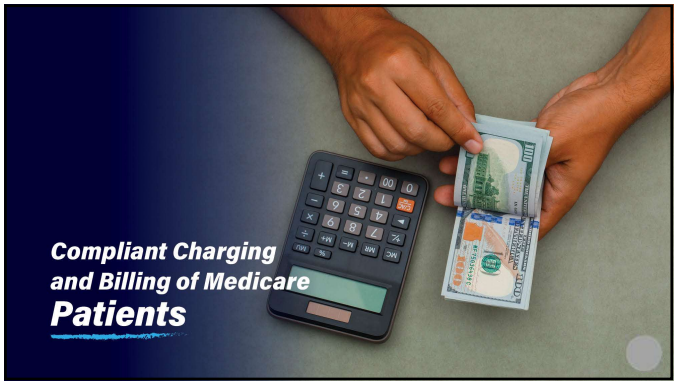
Burst

DOCUMENT:
- History/Chief Complaint
- Mechanism of injury
- OATS result and score
- Exam/Physical findings/PART
- DX: Sig. Dys. + 2ndary condition per region treated
- Measurable functional deficits
- TX Plan including goals
- Date of next re-evaluation (re-evals at least every 30 days)

Formal E/M service **necessary** to establish medical necessity for this much care.

Episode

116



117

Billing and Collecting from Medicare Patients

The more you know:

- Patients are responsible for the full charge for statutorily non-covered services, unless other insurance is available
- Patient financial responsibility for CMT depends on the provider's enrollment status (Par or Non-Par) and whether the service is active (AT) or maintenance (GA)

The provider collects:

SERVICE	PARTICIPATING (PAR)	NON-PARTICIPATING (NON-PAR)
Spinal CMT (AT)	Only 20% of Medicare allowed fee*. Patient may have secondary insurance that will pay this amount.	Up to 100% of the Limiting Fee for non-assigned claims. 20% of non-par allowable fee for selectively assigned claims*.
Spinal CMT (GA)**	1 of 3 choices: Medicare's **par allowable** fee; the provider's actual fee; a published maintenance fee through a DMPO***.	1 of 3 choices: Medicare's **Limiting Fee**; the provider's actual fee; a published maintenance fee through a DMPO***.

118

Things to do:

Follow the examples given in this table as a guide to estimate Medicare collections. All figures are examples only.

PROCEDURE CODE	MEDICARE REIMBURSES 80% OF THIS FEE*		DIFFERENCE BETWEEN LIMITING FEE AND NON-PAR ALLOWABLE IS NOT RECOVERED BY THE PATIENT			
	PAR ALLOWABLE	NON-PAR ALLOWABLE	NON-PAR LIMITING FEE (LF)	REDUCED LF (EHR)**	REDUCED LF (MIPS)**	REDUCED LF (EHR+MIPS)**
98940	$28.93	$27.48	$31.60	$30.66	$30.97	$30.05
98941	$41.55	$39.47	$45.39	$44.03	$44.48	$43.15
98942	$54.18	$41.47	$49.19	$47.42	$48.01	$56.27

The Method to the Madness-CMT Codes

119

Treating and Billing Family Members

The following is taken directly from CMS Policy Manual 100-02 Medicare Benefit Policy Manual:

Members of the Patient's Household (Rev. 1, 10-01-03) A3-3161, HO-260.12, B3-2332

B. Immediate Relative

The following degrees of relationship are included within the definition of immediate relative.

- *Husband and wife;*
- *Natural or adoptive parent, child, and sibling;*
- *Stepparent, stepchild, stepbrother, and stepsister;*
- *Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; Grandparent and grandchild; and*
- *Spouse of grandparent and grandchild*

NOTE 1: A brother-in-law or sister-in-law relationship does not exist between the physician, supplier or owner of a provider (or supplier) and the spouse of his wife's or her husband's brother or sister.

NOTE 2: A father-in-law or mother-in-law relationship does not exist between a physician or the owner of a provider and his or her spouse's stepfather or stepmother. A step-relationship and an in-law relationship continues to exist even if the marriage upon which the relationship is based is terminated through divorce or through the death of one of the parties. For example, if a provider treats the stepfather of the owner after the death of the owner's natural mother or after the owner's stepfather and natural mother are divorced, or if the provider treats the owner's father-in-law or mother-in-law after the death of their spouse, the services are considered to have been furnished to an immediate relative, and therefore, are excluded from coverage.

C. Members of Patient's Household

These are persons sharing a common abode with the patient as a part of a single family unit, including those related by blood, marriage or adoption, domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included.

120

Three Choices for Fees During Maintenance Care

1. Charge allowable fee or limiting fee
2. Charge your actual fee
3. Charge a discounted fee for maintenance if the patient qualifies and you offer this to ALL types of patients
4. Codify this in your compliance policy

121

Option One: Payer's Allowable or Limiting Fee

Continue	Charge	Set
– Continue to charge the allowable or limiting fee in maintenance care	– Charge that fee when billing for active treatment	– Set policy that says THIS is your fee for all phases of care: acute, chronic, or maintenance

122

Option Two: Charge Provider's Actual Fee for Maintenance Care

50.7.3 - Effects of Lack of Notification, Medicare Review and Claim Adjudication

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Beneficiary Liability

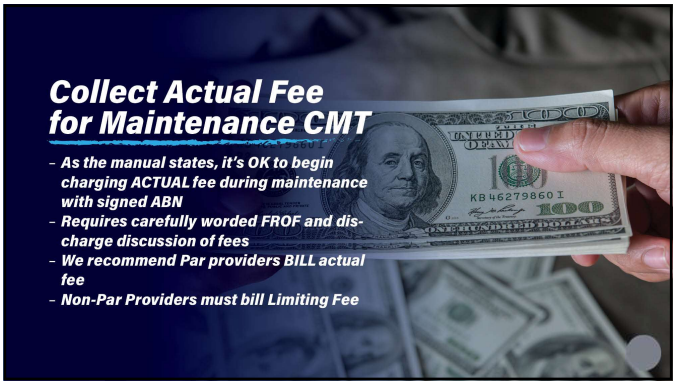
A beneficiary who has been given a properly written and delivered ABN and agrees to pay may be held liable. The charge may be the supplier/provider's usual and customary fee for that item or service and is not limited to the Medicare fee schedule. If the beneficiary does not receive proper notice when required, s/he is relieved from liability.

Notifiers may not issue ABNs to shift financial liability to a beneficiary when full payment is made through bundled payments. In general, ABNs cannot be used where the beneficiary would otherwise not be financially liable for payment for the service because Medicare made full payment. See 50.13 for information on collection of funds.

123

Collect Actual Fee for Maintenance CMT

- As the manual states, it's OK to begin charging ACTUAL fee during maintenance with signed ABN
- Requires carefully worded FROF and discharge discussion of fees
- We recommend Par providers BILL actual fee
- Non-Par Providers must bill Limiting Fee



124

Option Three: Publish a Maintenance Fee Schedule Anyone Can Access

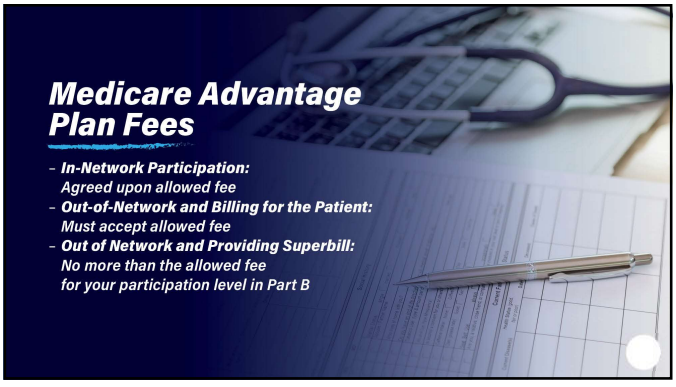
- The safest, and cleanest way to do this is to join a DMPO network like ChiroHealthUSA
- Within that fee schedule, post a fee for maintenance CMT, regardless of levels
- Anyone that is a member can access that fee schedule

ChiroHealthUSA®
The Network That Works for Chiropractic

125

Medicare Advantage Plan Fees

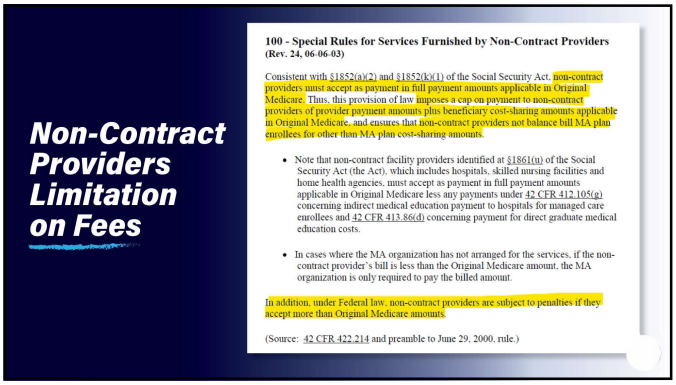
- In-Network Participation: Agreed upon allowed fee
- Out-of-Network and Billing for the Patient: Must accept allowed fee
- Out of Network and Providing Superbill: No more than the allowed fee for your participation level in Part B



126


Non-Contract Providers Limitation on Fees
- In-Network Participation:
Agreed upon allowed fee
- Out-of-Network and Billing for the Patient:
Must accept allowed fee
- Out of Network and Providing Superbill:
No more than the allowed fee
for your participation level in Part B

127


Non-Contract Providers Limitation on Fees
100 - Special Rules for Services Furnished by Non-Contract Providers
(Rev. 24, 06-06-03)
Consistent with §1852(a)(2) and §1852(k)(1) of the Social Security Act, non-contract providers must accept as payment in full payment amounts applicable in Original Medicare. Thus, this provision of law imposes a cap on payment to non-contract providers of provider payment amounts plus beneficiary cost-sharing amounts applicable in Original Medicare, and ensures that non-contract providers not balance bill MA plan enrollees for other than MA plan cost-sharing amounts.
• Note that non-contract facility providers identified at §1861(u) of the Social Security Act (the Act), which includes hospitals, skilled nursing facilities and home health agencies, must accept as payment in full payment amounts applicable in Original Medicare less any payments under 42 CFR 412.105(g) concerning indirect medical education payment to hospitals for managed care enrollees and 42 CFR 413.86(d) concerning payment for direct graduate medical education costs.
• In cases where the MA organization has not arranged for the services, if the non-contract provider's bill is less than the Original Medicare amount, the MA organization is only required to pay the billed amount.
In addition, under Federal law, non-contract providers are subject to penalties if they accept more than Original Medicare amounts.
(Source: 42 CFR 422.214 and preamble to June 29, 2000, rule.)

128


Let's Discuss and Q/A

129