



Skilled Nursing Facility (SNF) Beneficiary Notices

What SNFs Need to Know

POE0432 (0309)



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Acronyms

| | |
|-------|---|
| ABN | Advance Beneficiary Notice |
| BNI | Beneficiary Notification Initiative |
| CMS | Centers for Medicare & Medicaid Services |
| DOS | Date of Service |
| ED | Expedited Determination |
| FFS | Fee For Service |
| HIC | Health Insurance Claim |
| HCPCS | Healthcare Common Procedure Coding System |



Acronyms (cont.)

| | |
|--------|---|
| HIPAA | Health Insurance Portability and Accountability Act |
| NONC | Notice of Noncoverage |
| PSA | Prostate Specific Antigen |
| PT | Physical Therapy |
| SNF | Skilled Nursing Facility |
| SNFABN | SNF Advance Beneficiary Notice |
| SSA | Social Security Act |
| QIO | Quality Improvement Organization |



Objective

Provide guidance to SNFs regarding when and how to issue proper notices to Medicare beneficiaries and the triggering events for when to issue different types of notices

Agenda

- Review SNFABN for Part A services
- Review Outpatient ABN for Part B services
- Overview of ED for Medicare Part A and Medicare Part B services

What is a SNFABN?

- CMS-approved model notice
 - Form CMS-10055
 - Replaces NONC previously used for notification purposes
- Must provide SNFABN or Denial Letters to beneficiaries
 - Prior to furnishing noncovered extended care services, reducing, or terminating ongoing covered extended care services



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Purpose of SNFABN

- Used for SNF PPS services
 - Does not apply to swing-bed determinations
- Satisfies requirements under LOL for ABN and beneficiary's agreement to pay
- Use of any other notices or of modified SNFABNs may be ineffective in protecting users from liability



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Triggering Events

- Defined as one of three changes to services
 - Initiation
 - Reduction
 - Termination
- SNFs must give SNFABN before reducing, or terminating services

Initiation of Services

- Situation where beneficiary is advised that SNF will not accept beneficiary as patient
 - Because it expects Medicare will not pay for extended care items or services that physician has ordered

Reduction of Services

- Situation where a SNF is proposing to reduce items or services that physician has ordered
 - Because it expects Medicare will not pay
 - For a subset of extended care items or services; or
 - For any items or services at current level and/or frequency of care.

Termination of Services

- Situation where SNF proposes to stop furnishing all extended care items or services
 - Because it expects Medicare will not continue to pay for items or services

When to Issue SNFABN

- Provider believes that Medicare will not pay for, or will not continue to pay for
 - Extended care services that SNF furnishes and that physician ordered
 - Based on Section 1862(a)(1) and 1862(a)(9)
 - Not reasonable and necessary for diagnosis or treatment of illness, injury, or to improve malformed body member
 - Custodial care

Situations in Which a SNFABN Should Not be Given

- Depends on SNFs expectation of Medicare's payment or denial for extended care services
 - SNFABN should not be given if:
 - Expects Medicare to pay
 - Never knows whether or not Medicare will pay
 - Extended care service or item is not a Medicare benefit
 - e.g., personal comfort items

Question #1

- SNFABN is given before extended care services are furnished, reduced, or terminated.

1. True
2. False

Question #2

- SNFABN does not replace NONC previously used for notification purposes.

1. True
2. False

Who Should Receive a SNFABN?

- SNFABN is given to beneficiary or authorized representative
- Authorized representatives include:
 - Spouse, unless legally separated
 - An adult child
 - A parent
 - An adult sibling
 - A close friend
 - Legally appointed representative

ABN Standards

- SNFABNs must include explanation written in lay language of SNFs reason for believing services will be denied payment
- CMS IOM Publication 100-04 *Medicare Claims Processing Manual*
 - Chapter 30, Section 70.4.5
 - Denial paragraphs that cover common reasons why extended care services are noncovered

Delivery of SNFABN

- SNFs shall notify beneficiary by means of timely and effective delivery of proper notice to qualified recipient
 - Beneficiary or authorized representative
- Delivery of SNFABN occurs when beneficiary or authorized representative has received notice and can comprehend its contents

Question #3

- Miss Jones no longer requires daily skilled nursing services because her condition has stabilized. Should a SNFABN be issued before the patient reaches her last covered day?
 1. Yes
 2. No

Question #4

- Mr. Smith wants to be admitted to the SNF after a two-day hospital admission. He feels that he is entitled to 100 days under his SNF Part A benefit. Should a SNFABN be given to Mr. Smith upon admission?
 1. Yes
 2. No

Telephone Notice

- Telephone notice is not sufficient evidence of proper notice for limiting any potential liability
 - Unless content of telephone contact can be verified and is not disputed by beneficiary
 - Follow up immediately with mailed notice or personal visit to obtain signature

Signature Requirements

- On signature of patient line of SNFABN
 - Beneficiary or authorized representative should sign
- If beneficiary is incapable or incompetent
 - Authorized representative may sign
- SNF must obtain signed and dated SNFABN with Option 1 or 2 selected

Signature Requirements (cont.)

- Obtained either in person, or where this is not possible, via return mail as soon as possible
- Beneficiary refuses to sign and/or refuses to choose any option
 - Annotate ABN indicating circumstances and persons involved

SNFABN Scenario #1

- Mrs. Blake's last skilled covered day is June 14. She no longer requires daily skilled nursing services. She is not capable of receiving the SNFABN.
- SNF does the following:
 - SNFABN is prepared on June 12
 - SNF calls daughter (authorized representative) on June 12 and explains SNFABN details. Daughter states she understands last skilled covered day is June 14

Scenario #1 (cont.)

- SNF documents telephone contact
- Even though daughter said she would be in to see her mother on June 13, SNF mails SNFABN to daughter on June 12. Daughter signs and dates it on June 13.
- Did SNF do this process correctly?
 1. Yes
 2. No

Let's Talk About the Outpatient ABN

What SNFs Need to Know



What is an ABN?

“... written notice given to beneficiary before services are furnished when physician, supplier, or provider believes that Medicare probably or certainly will not pay for some or all of the items or services...”

Did You Know...

- Revised ABN - CMS-approved written notice issued by providers for items and services not covered and given to beneficiaries enrolled in Medicare fee-for-service program
- Revised ABN will now be used to fulfill both mandatory and voluntary notices
- Revised ABN replaces:
 - ABN – G (CMS R-131-G)
 - ABN – L (CMS R-131-L)
 - NEMB (CMS – 20007)

Importance of Issuing Proper ABNs

- Providers that issue proper ABNs
 - Protected from financial liability
- Providers that issue ABNs that fail to meet regulations
 - Not protected from financial liability
 - No beneficiary liability

Financial Liability Protections (FLP) Provisions

- Protect beneficiaries, providers under certain circumstances from unexpected liability for claims that Medicare does not pay
- FLP provisions include:
 - LOL: Section 1879(a)-(g)
 - RR for nonassigned claims for physician services: Section 1842(1)
 - RR for assigned and nonassigned claims for medical equipment and supplies: Section 1834(a)(18), 1834(j)(4), 1879(h)

Purpose of an ABN

- Informs beneficiary that services may be denied by Medicare
 - Before services are rendered
- Allows beneficiary to make informed consumer decision
 - Whether or not to receive items or services

Did You Know...

Limitation of liability protections of Section 1879 applies only when a provider believes that an otherwise covered item or service may be denied either as not reasonable and necessary under Section 1862(a)(1) or because the item or service constitutes custodial care under Section 1862(a)(9)

When Should an ABN Be Issued?

- Expectation of Medicare denial
 - On basis of Social Security Act: Section 1862(a)(1) & (9) & 1879(g)(2)
 - Not reasonable and necessary
 - Custodial care
 - Hospice patient who is not terminally ill

Voluntary ABN

- ABNs are not required for care that is statutorily excluded or fails to meet technical benefit
- Can issue ABN in place of NEMB:
 - Personal comfort items
 - Routine physicals, foot care, and eye care
 - Dental care

Issuers of ABN (Notifiers)

- Entities who issue ABNs are known as notifiers
- Entities can include physicians, providers Medicare contractors or UR committees
- Notifier may direct an employee to deliver an ABN
 - However, notifier is ultimately responsible for effective delivery of ABN
- When multiple entities are involved in rendering care
 - Do not have to issue separate ABN

Who Should Receive an ABN?

- Qualified recipients
 - Beneficiary
 - Authorized representative

Authorized Representatives

- Notifiers are responsible for determining who may act as a representative under applicable state law
- A representative is an individual who may make health care and financial decisions
 - Legal guardian
 - Individual with explicit legal authority
 - Durable medical power of attorney

Question #5

- What is the purpose of an ABN?
 1. To be issued for all services rendered to a beneficiary
 2. Informs beneficiary that Medicare is expected to deny the claim, prior to the services being rendered
 3. To be issued for technical denials only

Did You Know...

- Notifiers are required to issue ABNs whenever limitation on liability applies. This typically occurs at three points during a course of treatment known as “triggering events” which are:
 1. Initiations
 2. Reduction
 3. Termination

Triggering Event #1 Initiations

- An initiation is the beginning of a new patient encounter, start of plan of care or beginning of treatment
- If notifiers believes that covered items or services will be noncovered at initiation
 - An ABN must be issued prior to noncovered care

Triggering Event # 2 Reductions

- A reduction will occur when there is a decrease in a component of care
 - Frequency, duration, etc.
 - For example beneficiary receiving outpatient PT five days a week and provider believes goals can be met in three days
 - Reduction in treatment will require an ABN to be issued

Triggering Event # 3 Terminations

- Termination is the discontinuation of certain items or services
 - For example a physical therapist no longer considers outpatient SLP reasonable and necessary
 - An ABN would be issued prior to the termination of the SLP

Delivery Requirements

- ABN delivery is considered effective when:
 1. Delivered by a suitable notifier to a capable recipient and comprehended by recipient
 2. Use correct notice with all required blanks completed
 3. Delivered to beneficiary in person if possible
 4. Provided far enough in advance to allow time to consider all available options
 5. Explained in its entirety and all related questions are answered timely, accurately and completely
 6. Signed by beneficiary/representative

Options for Delivery

- ABNs should be delivered in person and prior to noncovered services
- When in-person delivery is not possible, providers may deliver ABN through one of these means:
 - Telephone
 - Mail
 - Secure fax machine
 - Internet e-mail

Beneficiary Changes Mind on ABN

- After completing and signing ABN beneficiary changes his/her mind provider should:
 - Present previously completed ABN
 - Request beneficiary annotate original ABN
 - Annotation must include clear indication of his/her new option and beneficiary's signature/date
 - If unable to present ABN in person
 - Provider may annotate ABN reflecting new choice and immediately send a copy for beneficiary's signature and date

Beneficiary Refuses to Sign

- If beneficiary refuses to choose an option and/or refuses to sign ABN
 - Provider should annotate ABN indicating refusal to sign and may list witnesses
 - Not a requirement
 - Provide a copy of annotated ABN and keep original in patient's file

Question # 6

- An authorized representative should not be a legal guardian of the beneficiary.
 1. True
 2. False

Beneficiary Liability

- **A beneficiary who has been given a properly written and delivered ABN and agrees to pay may be held liable**
 - **Beneficiary is relieved from liability if he or she does not receive proper notice when required**

Provider Liability

- **A notifier will likely have financial liability for items or services if he or she knew or should have known that Medicare would not pay and fails to issue an ABN when required**
 - **Or issues a defective ABN**

Did You Know...

An ABN can remain effective for up to one year. ABNs may describe treatment of up to a year's duration, as long as no other triggering event occurs. If a new triggering event occurs within the one-year period, a new ABN must be given

General Notice Requirements

- Number of copies – minimum of two copies
 - Including the original
- Reproduction – Providers may reproduce ABN by using
 - Self-carbonizing paper, photocopying, digitized technology or another appropriate method
- Length and size of paper – ABN must not exceed one page in length
 - Attachments are permitted

General Notice Requirements (cont.)

- Contrast of paper and print – dark ink on a pale background
 - Do not use white print on black paper or highlight the text
- Font – when possible use the fonts as they appear in ABN
 - Alternate fonts

General Notice Requirements (cont.)

- Customization – can pre-print information in certain blanks on ABN
 - May pre-print a menu of items and services and include a cost estimate
- Modification – ABN may not be modified
 - Except as specifically allowed and approved by CMS

Question #7

- An ABN should be given when provider knows at initiation of treatment that the services are not going to be covered.

1. True
2. False

Completing the ABN

- ABN is composed of five sections and ten blanks which must appear in the following order:
 - Header (Blanks A-C)
 - Body (Blanks D-F)
 - Option box (Blank G)
 - Additional information (Blank F)
 - Signature box (Blanks I-J)

Header – Blanks A - C

- Blank A Notifier(s) – Name, address and telephone number including TTY when needed
- Blank B patient name – First and last name of beneficiary receiving the notice
- Blank C Identification number – optional field
 - Can be medical record number
 - Do not use HICN or Social Security number



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Body – Blank D

- The following descriptors may be used in the header of blank D:
 - Item
 - Service
 - Laboratory test
 - Procedure
 - Care
 - Equipment
- Must list specific items or services believed to be non - covered



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Reason Medicare May Not Pay – Blank E

- Explain in beneficiary friendly language why the item or service may not be covered
- Three commonly used reasons for non-coverage:
 - **Medicare does not pay for this test for your condition**
 - **Medicare does not pay for this test as often as this**
 - Denied as too frequent
 - **Medicare does not pay for experimental or research use tests**



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Estimated Cost – Blank F

- Complete Blank F to ensure beneficiary has information to make an informed decision
- Limited examples of acceptable estimates are:
 - Service cost \$250
 - Any dollar estimate equal to or greater than \$150
 - Between \$150-\$300
 - No more than \$500
 - Service cost \$500
 - Any dollar estimate equal to or greater than \$375
 - Between \$400-\$600
 - No more than \$700



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Options – Blank G

- Contains the following three options:
 - Option 1 – I want the item or service listed above, you may be asked to pay now
 - Option 2 – I want the item or service listed above, but do not bill Medicare
 - Option 3 – I don't want the item or service listed above, I am not responsible for payment

Additional Information – Blank H

- Used to provide additional clarification
- For example:
 - **A statement advising beneficiary to notify his or her provider about certain tests that were ordered, but not received**
 - **Information on other insurance coverage for beneficiaries, such as a Medigap policy, if applicable**
 - **An additional dated witness signature; or**
 - **Other necessary annotations**

Signature Box – Blanks I and J

- After beneficiary reviews and understands ABN, signature box must be completed
- Blank I signature – beneficiary/representative must sign
 - Indicates received and understands the notice
- Blank J Date – beneficiary/representative must write the date he or she signed ABN
- Disclosure statement – required in the footer of ABN

Emergencies or Urgent Situations

- Do not issue an ABN in a medical emergency or under duress
 - May be considered coercive
- ABNs issued in the ER may be appropriate
 - Beneficiary is medically stable with no emergent health issues

Repetitive or Continuous Non - Covered Care

- **May give a single ABN describing an extended or repetitive course of noncovered treatment**
 - **Provided that ABN lists all items and services that notifier believes Medicare will not cover**
 - **Limit for use of a single ABN for extended course of treatment is one year**
 - New ABN is required when specified treatment extends beyond one year



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Submitting Claim

- Covered claim
- Occurrence code 32, date of ABN
- Appropriate modifier
 - Only needed when billing covered and noncovered services on single claim
 - Appended to HCPCS
- Normal billing regulations apply



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Occurrence Code 32

- Date beneficiary notified of intent to bill Medicare
 - Items or services may not be paid by Medicare

Modifiers

- Used only when noncovered and covered services cannot be split
- Cannot use modifiers indicating provider liability on entirely no-payment claim(s)
 - Beneficiary liable

Modifier GA

- Item or service is not reasonable and necessary
- Expect Medicare to deny line
- Providers have ABN signed by beneficiary/representative
- Claim submission
 - Submit covered line-item
 - Beneficiary liable

Request for Copies of ABNs

- National Government Services request for copies of ABNs not limited to following situations:
 - Need from hearing and appeals processes
 - Practical need to identify an item/service
 - DOS
 - Reasons for predicting Medicare denial
 - Other pertinent facts about notification
 - Plausible allegation or dispute on ABN
 - Data analysis, utilization, or other investigational study

Do's & Don'ts of Issuing an ABN

- Do issue an ABN prior to services being rendered when services are not reasonable and necessary
- Do explain to beneficiary why services are going to be noncovered
- Don't issue an ABN for all of the services that a beneficiary receives
- Don't issue an ABN after services have been rendered



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Expedited Determination Process

What SNFs Need to Know



Expedited Determination Process Definition

Effective July 1, 2005, beneficiaries in traditional Medicare were given access to a new fast-track expedited review process of the determination of the ending of specific Medicare services.

Facilities Affected

- Swing-Bed Units
- SNFs
- Hospices
- HHAs
- CORFs

Provider Responsibility

- Providers are required to notify beneficiaries of their right to an expedited review of discontinuation of Medicare services
 - Two notices have been provided for notification

Expedited Determination Notices

- Generic Notice: CMS Notice – 10123
- Detailed Notice: CMS Notice – 10124

Generic Notice CMS-10123

- Completed copy of notice must be given to beneficiary no later than two days before termination of services
- Valid delivery
 - Beneficiary must be able to understand purpose and contents of notice in order to sign for receipt
 - Beneficiary must understand that they may appeal termination decision
- If beneficiary is not able to comprehend contents of notice
 - Notice must be delivered to and signed by an authorized representative

Generic Notice Delivery

- Telephone notice should include:
 - when services are no longer covered
 - appeal rights and the telephone number of the appropriate quality improvement organization
 - date of the conversation is considered date of notice
 - confirm by written notice mailed on the same date
- Document the telephone contact to include:
 - Name of person initiating the contact,
 - Name of the representative contacted,
 - Date and time of the contact
 - Telephone number called.

Generic Notice (cont.)

- Refusal to sign does not make the notice invalid as long as you document the notice was given and refusal by the beneficiary to sign
- Retain a dated copy of the notice in the beneficiary's medical file
- If face-to-face or direct phone contact can not be made, use certified mail (date of signature is date of receipt)
- If returned by post office with no indication of a refusal date, beneficiary liability starts on the second working day after the provider's mailing date

Question #8

The Generic Notice CMS-10123 should be given no later than two days before termination of services?

1. True
2. False

Question #9

If the beneficiary is unable to comprehend the notice, it is appropriate to give notice to a representative in person, by telephone, or as a last resort, by certified mail?

1. True
2. False



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Detailed Notice CMS-10124

- Completed copy of notice must be given to beneficiary upon notice from QIO that beneficiary has appealed termination of services
 - No later than close of business of the day of QIO's notification



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Quality Improvement Organization

- Assigned to cover specific States
 - Contact providers when actual expedited determination request is received
 - Maybe by telephone
 - Required to notify provider of request for an expedited review without delay
 - CMS directory of State QIOs
 - <http://www.cms.hhs.gov/qio>



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Points of Interest Regarding Delivery of Both Notices

- Provider may deliver detailed notice to QIO
 - Via personal delivery, courier service as same day delivery
 - FAX or phone contact as long as followed up with mailed notice
- E-mail notice is not permitted
 - Violates HIPAA regulations
 - Medicare HIC number on Generic Notice
- Beneficiaries must file timely review with QIO
 - By noon of calendar day after generic notice was received or day before coverage ends



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Points of Interest Regarding Delivery of Both Notices (cont.)

- CMS clarified that requests should also be considered up to 24 hours after coverage ends
 - Cases where there is an abrupt end
- Regulations require QIOs to honor untimely requests for expedited reviews
 - 60 calendar days from coverage ends date on generic notice

Question #10

Delivery of either notice to the Quality Improvement Organization by e-mail is prohibited?

1. True
2. False

Notification Requirements by Provider Type

| Provider 1: Discharging Beneficiary | Provider 2: Receiving Beneficiary | Provider 1: Issue Generic Notice? | Rationale |
|---|---|---|--|
| SNF Part A, SNF Part B, Swing-Bed | (Another) SNF | No | Transfer among same type providers does not require expedited notice. |
| SNF Part A, SNF Part B, Swing Bed | NF, non- skilled DPU or non-swing bed | Yes | The beneficiary has the right to review of the change in the level of service to noncovered. |



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Notification Requirements by Provider Type (cont.)

| Provider 1: Discharging Beneficiary | Provider 2: Receiving Beneficiary | Provider 1: Issue Generic Notice? | Rationale |
|--|---|---|---|
| Any FFS provider required to give expedited notice | Acute Hospital | No | Notice is not covered when beneficiary requires a higher level of service |
| Any FFS provider required to give expedited notice | Not to a Medicare provider type, home settings including AL | Yes | Basic right to review of discharge/ termination of coverage |



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Let's Look at a Part A Scenario

- Mrs. Thomas will be coming off of all skilled Part A services in two days and has benefit days remaining. She will then receive custodial care services.
- Which one of these notices should be give to the beneficiary or authorized representative?
 1. ABN and Generic ED notice
 2. Generic ED notice and SNFABN

Let's Look at a Part B Scenario

- A beneficiary meets his treatment goals for PT earlier than anticipated. PT is planning to discharge the beneficiary in two days. The beneficiary wants to continue PT services even though he's been told that they are not reasonable and medically necessary.
- Which one of these notices should the SNF give to the beneficiary or authorized representative?
 1. Generic ED notice
 2. ABN
 3. Generic ED notice and ABN

References

- Form CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)
 - <http://www.cms.hhs.gov/medicare/bni>
- CMS Web site at:
 - <http://www.cms.hhs.gov/manuals>
 - CMS Publication IOM 100-4, Chapter 30
 - Section 70 - 70.6.9.4
 - Sections 1862(a)(1) and 1862(a)(9)

References

- <http://www.cms.hhs.gov/manuals>
 - ABN regulations
 - Publication 100-04, Chapter 30
 - ABN forms
 - http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp
 - Revised ABN CMS-R-131 form
- Social Security Act
 - http://www.ssa.gov/OP_Home/ssact/comp-ssa.htm

References (cont.)

- Revised Expedited Determination Questions and Answers March 2006
 - CMS Web site Beneficiary Notice Initiative Files:
<http://www.cms.hhs.gov/>
 - Search: BNI

Submission of Questions

- Questions regarding this educational session may be submitted by fax along with the session assessments to 1(513) 852-4207.
- A summary of the information in this session as well as questions and answers will be posted to the National Government Service Web site in the month following the session
- Listserv notice of the posting of the summary will be sent

Medicare University Training Event Number: 09090TALJL1

- Topic =Skilled Nursing Facility Notices
- Medicare University Credits (MUCs) = 2
- # of Sessions = 1



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Medicare University Credit Self-Reporting Instructions

- To earn MUCs, you must self-report your attendance after this training event has ended:
 - Go to <http://www.NGS Medicare.com>, select your business type and region, then select “Go”
 - On the lower-right side of the page, select the Medicare Learning Management System logo
 - **Note:** This icon will soon be replaced with the Medicare University logo



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Medicare University Credit Self-Reporting Instructions

- Log on to the National Government Services Medicare University site
 - **Note:** You will be prompted to enter your Medicare University log on ID and password. If you don't already have one, you may obtain one at this point
- Select “Course Catalog” from the left side menu
- Select the “Details” button for the appropriate course “Self-Reporting of Attendance at the Introduction to the Medicare Part B IVR”



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Medicare University Credit Self-Reporting Instructions

- A new window will open providing the event description and information; select the “Enroll” button (the screen will then refresh)
- Next, select “Curriculum List” from the left side menu; locate the self-reporting course you just enrolled in and select the “Go” button next to it
- A new page will open; select the “Launch” button on the new page and the course will load in a new window
- Enter the training event number (provided on slide #53) and select the “Submit” button



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Thank You!

