MEDICARE COMPLIANCE PROGRAM

Version 1.0 Effective January 1, 2001

Table of Contents

NOTE: In the event of a conflict between the terms of this compliance program and any other NSM manuals, policies, procedures or internal documents, the terms of this compliance program shall control.

NATIONAL SEATING & MOBILITY, INC.
MEDICARE COMPLIANCE PROGRAM

1. Policy Statement

1.1. National Seating & Mobility, Inc., NSM, understands the importance of an effective Medicare compliance program. This program is intended ensure that it's employees adhere to the highest standards of conduct and ethics, and to prevent, detect and resolve violations of law by providing regulatory guidelines, audit procedures, non-retaliatory reporting systems, and disciplinary steps. The Office of the Inspector General (OIG) and the Department of Health and Human Services (HHS) and other federal agencies charged with responsibilities for enforcement of federal law have emphasized the importance of voluntarily developing and implementing compliance plans. This Compliance Program is a dynamic document that will be reviewed at least annually and modified or expanded as required.

1.2. NSM does not tolerate illegal or unethical conduct and will take prompt action whenever the same is detected. This Compliance Program is intended as a complement to, rather than a substitute for legal advice. In order to assure maximum effectiveness of this Compliance Program, it is anticipated that NSM personnel and the compliance officer will consult with legal counsel when suspected legal or ethical violations are detected.

1.3. Questions concerning interpretation of any portion of this plan, including policies, procedures, regulations and statutes, shall be directed to the compliance officer. Outside advice from counsel, government agencies, intermediaries or consultants regarding this plan must be authorized by the compliance officer.

1.4. All employees involved, or who have the potential to be involved, in the provision of products and services to Medicare beneficiaries are required to sign the 'Employee Acknowledgment and Agreement to Comply with National Seating & Mobility, Inc.'s Medicare Compliance Program'.

2. Compliance Officer and Representatives

2.1. A compliance officer, appointed by the management team, will oversee the implementation and monitoring the Compliance Program. The Compliance Officer shall be a person in high executive management having sufficient experience with the healthcare industry, specifically in reimbursement, regulatory, legal and accounting to perform objectively the responsibilities of the position. The compliance officer reports to the President and may not be removed from the position without authorization of the Board of Directors.

2.2. Compliance representatives for each region shall be appointed by the regional vice presidents and shall report to the compliance officer on matters regarding Medicare compliance. The compliance representatives may not be removed from the position unless approved by the compliance officer.

2.3. Responsibilities of the compliance officer:

2.3.1. Overseeing and monitoring implementation of program.

2.3.2. Reporting on a regular basis to the management team.

2.3.3. Periodically revising the program in light of changes in the company, and government regulations.

2.3.4. Coordinating on-going training and education of employees on elements of the Compliance Program.

2.3.5. Overseeing periodic audits of branches and departments with regards to the Compliance Program.

2.3.6. Overseeing the reporting system and ensuring that it is non-retaliatory in nature.

2.3.7. Independently investigating and resolving matters related to compliance violations.

2.4. Responsibilities of the compliance representatives:

2.4.1. Assist the compliance officer, on the branch level, as needed in the duties listed above to assure the Compliance Program is adhered to in the branch offices.

3. Training and Education

3.1. Compliance training and education is required for all employees involved, or who have the potential to be involved, in the provision of products and services to Medicare beneficiaries. Regional vice presidents are responsible for assuring that the appropriate employees in their regions are properly trained. Compliance training will be developed centrally and implemented regionally and at the Branch level. The compliance officer is responsible for development and overseeing the training and education program. Moreover, the compliance officer is responsible for coordinating training for employees when there have been changes in regulations or company policy that relate to the Compliance Program.

3.2. Frequency:

3.2.1. Within 30 days of implementation of program.

3.2.2. Within 30 days hire or change of position within the company.

3.2.3. Within 30 days of regulatory changes and changes in company policy.

3.3. Training and education wi!1 include:

3.3.1. Standards of conduct.

3.3.2. Regulations

3.3.3. Audit procedures

3.3.4. Reporting mechanisms

3.3.5. Disciplinary actions

3.3.6. Testing for understanding of the program

3.3.7. Testing will be primarily intranet based

3.4. Training and education may be in the form of:

3.4.1. Computer based training via the intranet

3.4.2. Seminars and branch office meetings

3.4.3. Videos

3.4.4. Written material

3.4.5. Available via company intranet for continuous reference

4. Audits and Reviews

4.1. NSM is committed to ensuring its Compliance Program is effective and followed by all employees. To that end, NSM is committed to conducting its own audits and reviews to assure compliance.

4.1.1. Semi-Annual Branch Audits/Review

4.1.1.1. Branch office audits to be performed by regional compliance representatives

4.1.1.2. Review of patient files include, but is not limited to, inspection and review of AOB, CMN, cover letters, billing documents, required letters and notifications. A representative sample of Medicare patient files will be randomly selected for review.

4.1.1.3. On-site visits to branch offices to review policies and procedures as they relate to the compliance program.

4.2. Annual Compliance Program Review:

4.2.1. Home office review will be conducted by the compliance officer or designee.

4.2.2. Review a representative sample of Medicare billing files.

4.2.3. Review and update policy and procedure manuals as they relate to the Compliance Program.

4.3. Reporting of audits and reviews:

4.3.1. Written reports of semi-annual audits will be submitted be submitted to the compliance officer for presentation to the management team and branch manager.

4.3.2. Written reports of annual reviews are to be submitted to the management team and compliance officer.

4.4. Corrective Action

4.4.1. It is the responsibility of the compliance officer to coordinate any needed corrective action and report such action and results to the management team in a timely manner.

5. Disciplinary Process for Compliance Program Violations

5.1. An effective compliance program must include procedures to ensure the discipline of employees responsible for failure to detect wrongdoing as well as for those who commit an offense or crime.

5.2. Therefore, all employees will be trained on the importance of adherence to the program and will be required to acknowledge that adherence to the program is a material condition of employment. Employees will be informed that failure to comply with the requirements of the program will result in reprimand, discipline up to and including immediate discharge.

5.3. The company has a policy of progressive discipline for infractions committed by an employee except where immediate termination is identified as the punishment. Whether the prohibited conduct constituted simple negligence, gross negligence or willful wrong-doing will be considered in determining and administering punishment.

5.4. The following list sets forth the recommended disciplinary policy for violations relating to the compliance program. Adherence to the compliance program is an integral part of all NSM employee's duties. NSM considers the normally appropriate punishment for the listed infractions to be set forth below. However, whether the company eventually imposes a punishment less severe than set forth depends upon a number of factors including, but not limited to:

5.4.1. Whether the employee properly reported the violation

5.4.2. Whether the report indicates an awareness of the violation and the employee's involvement; and

5.4.3. Whether the employee cooperates fully in investigating and/or correcting the violation.

5.5. Whether the company eventually imposes a punishment less stringent than termination is left to the sole discretion of the company.

5.6. All employees will be advised that disciplinary action will be taken for violations of the Compliance Program.

5.7. The following steps may be imposed for violations of the Compliance Program and law upon verification:

5.7.1. Violation of criminal law - First offense: Termination

5.7.2. Failure to report conduct by an employee of the company which a reasonable person should know is criminal - First offense. Termination

5.7.3. Willfully and knowingly providing false information to the company or a government agency, customer, insurer or the like - First offense: Termination

5.7.4. Intentional violation of Compliance Program, not amounting to violation of law First offense: Thirty-day suspension up to termination. Second offense: Termination

5.7.5. Negligent violation of Compliance Program, not amounting to violation of law: First offense: Reprimand to 10 day suspension. Second offense: Ten-day suspension to termination. Third offense: Termination

6. Changes Which Must be Submitted to the National Supplier Clearinghouse

6.1. Certain changes that occur during the life of a company are required to be submitted to the National Supplier Clearinghouse in order to update Medicare provider records. These changes are as follows:

6.1.1. Adoption or change in billing service

6.1.2. Management employee change (For example: General Manager or Branch Manager)

6.1.3. Partnership or percentage of ownership change

6.1.4. Change of physical address or phone numbers

6.1.5. Sale of business

6.2. Individual Medicare provider number must be renewed every three years. It is the responsibility of the Branch Manager, General Manager, and Office Administrator to assure that this renewal process is completed in a timely manner.

7. Standards of Conduct

7.1. NSM does not tolerate fraud, abuse or any other violations of law. These Standards of Conduct are a reminder to each employee of our commitment to compliance with all laws and regulations. NSM will conduct its business and operations in accordance with both the law and the highest standards of business, professional and clinical ethics. All NSM employees are expected to adhere to the Standards of Conduct, Codes of Ethics and Standards of Practice listed below.

7.1.1. **Knowledge of Medicare Regulations:** It is NSM's responsibility to outline to employees all applicable Medicare regulations. It is each employee's responsibility to acquire and maintain knowledge of and to assure compliance with these regulations as required by their responsibilities in the Medicare process.

7.1.2. **Reporting Violations:** It is each employee's responsibility to report suspected violations of regulations and Standards of Conduct to the compliance officer.

7.1.3. **Prohibition of Medicare/Medicaid Anti-Fraud and Abuse:** Under federal law it is unlawful to submit false or fraudulent claims for payments related to the provision of health care equipment to any payer or entity.

7.1.4. **Improper Payment, Bribes and Kick-backs:** Under federal law it is unlawful for any person to solicit, offer, pay or receive any remuneration or anything of value to or from any other person to induce or in return for a referral or purchase of a service or item for which payment may be made by any federally funded program.

7.1.5. **Proprietary Information and Confidentiality:** All information concerning the company's business and patient information is the proprietary property of the company. All employees shall assure that confidentiality of this information is strictly maintained. (Refer to NSM's Human Resource Manual, which is incorporated by reference as part of this document)

7.1.6. **Discrimination:** NSM does not tolerate any discrimination based upon race, color, creed, gender, sexual preference, religion, national origin, age or against any qualified individual with a disability in any employment decisions or provision of patient care. All employees must adhere to this non-discriminatory policy. (Refer to NSM's Human Resource Manual, which is incorporated by reference as part of this document)

7.1.7. **Patient Abuse**: NSM will not tolerate any instances of patient abuse. All patients are to be treated with respect and courtesy at all times. Any suspected instances of patient abuse are to be reported to the compliance officer immediately.

7.1.8. **Conflicts of Interest:** All NSM employees shall avoid the potential for conflict of interest and the appearance of impropriety. Employees shall disclose any situation that presents a possible conflict of interest with any interests of an employee or any employee's family members in all transactions, employee agreements and other transactions.

7.1.9. **Disclosure and Anonymity:** All employees are required to report any and all suspected violations of these Standards. NSM agrees, to the greatest extent possible, to maintain confidentiality and respect the anonymity of any employee who reports suspected violations of this code of conduct.

7.1.10. **Cooperation with Investigations:** All employees are required to cooperate

with any investigations regarding violations of these Standards of Conduct.

7.2. These Standards of Conducts also incorporate the standards of practice and protocols of the American Association for Homecare Re/hab Committee (formerly known as the NAMES Re/hab Section) listed below:

7.2.1. Rehabilitation technology companies should provide cost effective options and choices to meet the goals and objectives set by and for, the consumer. Recommendations for specific commercially available products or fabricated components are based on consumer goals, objectives, and desires, as well as input from other professionals as appropriate.

7.2.2. Rehabilitation technology companies should inform the consumer or family of their financial obligations and the requirements for reimbursement through third party funding. When appropriate, the rehabilitation technology companies inform the consumer and family of alternative funding sources that may exist.

7.2.3. Rehabilitation technology companies should educate third party payers and other health care professionals on the cost effectiveness of rehabilitation technology products and services.

7.2.4. Rehabilitation technology companies should assure long term service and support for products and services they provide through knowledgeable, skilled, and trained service personnel. Rehabilitation technology companies should maintain an adequate inventory of replacement parts to provide timely service and repair of all products supplied.

7.2.5. Rehabilitation technology companies should maintain adequate levels of general liability insurance for products and services provided.

7.2.6. Rehabilitation technology companies should pass along all written statements of warranty on commercial products. Rehabilitation technology companies should provide written warranties for adapted or fabricated items.

7.2.7. Rehabilitation technology companies should employ qualified rehabilitation technology suppliers (RTSs) who work directly with customers in the service delivery process.

7.2.8. Rehabilitation technology companies require the RTS to have sufficient education and basic working knowledge of disabilities as they relate to the need for, and application of enabling technology;

7.2.9. Rehabilitation technology companies require the RTS to understand consumer goals and objectives and offer product choices, including custom and commercially available options, with discussion about availability, and cost effectiveness;

7.2.10. Rehabilitation technology companies require the RTSs in their employ to adhere to the NRRTS Code of Ethics and Standards of Practice.

7.2.11. The Rehabilitation Technology Company should provide products for simulation and trial.

7.2.12. The Rehabilitation Technology Company should provide product support and service on site, in the consumer's home and work environment.

7.2.13. Rehabilitation technology companies should maintain complete consumer records, including documentation of the decision making process, tracking of

the process to secure funding, order and provision of equipment. Rehabilitation technology companies should maintain these records in accordance with federal, state and local regulations and in compliance with recognized accreditation programs.

7.2.14. Rehabilitation technology companies should recognize the specialized nature of the technologies they provide and support the provision of this equipment and services with a written Continuous Quality Improvement procedure. This procedure should include ongoing monitoring of company performance in meeting consumer needs, outcome measurement and consumer satisfaction studies.

8. Medicare Suppliers Standards

8.1. Medicare regulations have defined standards which a supplier must meet to receive and maintain a supplier number. These standards can be found on the Medicare Supplier Number Application (HCF A-192).

Effective December 11, 2000 a qualified HME supplier in the Medicare program is one who:

8.1.1. Operates its business and furnished Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements;

8.1.2. Has not made, or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges;

8.1.3. Has the application for billing privileges signed by an individual whose signature binds a supplier;

8.1.4. Fills order, fabricates, or fits items from its own inventory or by contracting with other companies for the purchase of items necessary to fill the order;

8.1.5. Advises beneficiaries that they may either rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental durable medical equipment;

8.1.6. Honors all warranties expressed and implied under applicable State law. A supplier must not charge the beneficiary or the Medicare program for the repair or replacement of Medicare covered items or for services covered under warranty;

8.1.7. Maintains a physical facility on an appropriate site. The physical facility must contain space for storing business records including the supplier's delivery, maintenance, and beneficiary communication records. For purposes of this standard, a post office box or commercial mailbox is not considered a physical facility;

8.1.8. Permits HCFA, or its agents to conduct on-site inspections to as certain supplier compliance with the requirements of this section. The supplier location must be accessible during reasonable business hours to beneficiaries and to HCFA, and must maintain a visible sign and posted hours of operation;

8.1.9. Maintains a primary business telephone listed under the name of the business locally or toll-free for beneficiaries;

8.1.10. Has a comprehensive liability insurance policy in the amount of at least ,000

that covers both the supplier's place of business and all customers and employees of the supplier;

8.1.11. Agrees to not contact a beneficiary by telephone when supplying a Medicare-covered item unless one of the following applies:

8.1.11.1. The individual has given written permission to the supplier to contact them by telephone;

8.1.11.2. The supplier has furnished a Medicare-covered item to the individual and the supplier is contacting the individual to coordinate the delivery of the item;

8.1.11.3. If the contact concerns the furnishing of a Medicare-covered item other than a covered item already furnished to the individual, the supplier has furnished at least one covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact.

8.1.11.4. NSM note: NSM employees will only contact Medicare beneficiaries by telephone to: schedule appointments; gather additional medical, demographic or billing information as needed; and in response to telephone calls initiated by the Medicare beneficiary or his/her care providers,

8.1.12. Is responsible for the delivery of Medicare covered items to beneficiaries and maintains proof of delivery (NSM note: in general the drop shipment of Re/hab Technology equipment is not allowed);

8.1.13. Answers questions and respond to complaints a beneficiary has about the Medicare-covered item that was sold or rented;

8.1.14. Maintains and replaces at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries;

8.1.15. Accepts returns from beneficiaries of substandard items;

8.1.16. Discloses these supplier standards to each beneficiary to whom it supplies a Medicare-covered item;

8.1.17. Complies with the disclosure provisions in § 420.206 of this subchapter;

8.1.18. Will not convey or reassign a supplier number;

8.1.19. Has a complaint resolution protocol to address beneficiary complaints that relate to supplier standards;

8.1.20. Maintains the following information on all written and oral beneficiary complaints, including telephone complaints, it receives:

8.1.20.1. The name, address, telephone number, and health insurance claim number of the beneficiary;

8.1.20.2. A summary of the complaint;

8.1.20.3. If an investigation was not conducted, the name of the person making the decision and the reason for the decision.

8.1.21. Provides to HCFA, upon request, any information required by the Medicare statute and implementing regulations.

8.2. Suppliers must comply with all twenty-one (21) provider standards to be eligible to bill Medicare for covered items. Failure to comply may be grounds for denial of all pending

claims and recoupment of moneys paid by Medicare or its agents, the DMERC.

9. Violations Reporting

9.1. NSM encourages employees to report known or suspected violations of regulations or this Compliance Program. This includes any activity that a reasonable person would believe to be a crime or a violation of the Compliance Program.

9.2. NSM does not tolerate any retaliatory action being taken against an employee for reporting violations or suspected violations. It is the policy of the company that no employee shall be punished solely on the basis that he or she reported what was reasonably believed to be an act of wrongdoing or a violation of this program.

9.3. An employee will be subject to disciplinary action if the company reasonably concludes that the report of wrongdoing was knowingly fabricated by the employee, or was knowingly distorted, exaggerated or minimized to either injure someone else or to protect the reporting party or others.

9.4. An employee, whose report of misconduct contains admissions of personal wrongdoing, will not be guaranteed protection from disciplinary action. The weight to be given the self-confession will depend on all the facts known to the company at the time it makes its disciplinary decisions.

9.5. In determining what, if any, disciplinary action may be taken against an employee, the company may take into account an employee's own admissions of wrongdoing; provided, however, that the reporting employee's conduct was not previously known to the company, or its discovery was not imminent, and that the admission was complete and truthful.

9.6. The compliance officer shall establish a voice mailbox and an e-mail address to receive complaints from employees who do not wish to consult with the compliance officer in person. This voice mailbox number will be posted in a highly visible location at the home office and at each branch office.

9.6.1. Reporting via the voice mailbox, via e-mail or in person has been established as the method of communication so that adequate information for investigation can be obtained.

9.7. Confidentiality cannot be guaranteed, since reports must be acted upon, however, privacy will be protected whenever possible. The reporting employee may leave a voice mail in the compliance voice mailbox or through the compliance e-mail address for the compliance officer to contact them at a given number and time if privacy is desired.

10. Steps for handling reports:

10.1. Initial interview information should include:

10.1.1. The followings statement to be read to the employee prior to taking the report:

10.1.1.1. "Any information you provide to me will be carefully reviewed and if warranted may result in an investigation by our employees or outside counsel, such as an attorney. You will not be punished by NSM if you provide information in good faith that later proves to be unfounded. However, if you intentionally provide information that you know to be false, misleading or incomplete, you may be subject to discipline under our Compliance Program. NSM will make every reasonable effort to keep your

information confidential. However, it is not possible to guarantee complete anonymity. Furthermore, it may become necessary for NSM or our lawyers to provide information in the future to the government, including information you are giving me today. Do you understand what I've just read to you?"

10.1.2. Source of employee's information

10.1.3. Description of activity

10.1.4. Names of those involved

10.1.5. Date(s) of suspected violations

10.2. Upon notification of potential violations, the compliance officer will conduct an investigation to determine if a violation has in fact occurred. The compliance officer is responsible for the investigation, but may delegate investigative tasks to other management officials.

10.3. The compliance officer shall interview all persons as deemed necessary to substantiate and corroborate the information provided

10.4. The compliance officer shall have immediate access to all records pertaining to the alleged misconduct. All supervisory personnel will cooperate with the compliance officer to furnish such records and other additional information as required.

10.5. After all documents are reviewed and parties interviewed, the compliance officer shall approach the suspected violator and allow the suspected violator to explain the conduct.

10.6. The compliance officer shall make a report of the investigation stating whether or not it is believed a violation of regulation or the Compliance Program has occurred. If so, the compliance officer will propose corrective and/or disciplinary action.

10.7. The compliance officer shall review the report and recommendations with the management team and legal counsel, as needed, prior to determining appropriate action.

10.8. Upon concurrence of counsel, if deemed appropriate, the compliance officer will report the violation to the appropriate government agency, implement, through the management team, corrective measures and any required disciplinary action.

10.9. The report and accompanying documentation will be kept in a secure file and retained for the appropriate period of time as defined by regulation.

11. Coverage Guidelines

11.1. All NSM employees are required to adhere to Medicare guidelines as outlined in the DMERC Supplier Manual provided for their region. The DMERC Supplier Manuals for each region are incorporated into this document by reference.

11.2. The most current Supplier Manuals, as they become available, are posted on the NSM Intranet..

11.3. It is the responsibility of the RTS and other branch office staff to be aware of all coverage criteria issues that impact the provision of Re/habilitation Technology products to Medicare beneficiaries.

12. Waivers of Co-pays or Deductibles

12.1. Routine waiver of Medicare co-pays and deductibles is prohibited by regulation.

12.2. NSM's policy/procedure for collecting outstanding patient balances apply to outstanding Medicare co-pays and deductibles.

12.3. The Assignment of Benefits, AOB, signed by the patient or other responsible party will indicate that, if a co-pay or deductible is due, the patient will be responsible.

12.4. Exceptions should be made only due to a particular patient's significant financial hardship. Financial statements and other documentation are required. The exceptions must be documented and approved by the regional vice president and branch manager, regardless of the amount due.

13. Capped Rental Equipment

13.1. At the beginning of the tenth month of rental of all Capped Rental Items (see your Medicare Supplier Manual for details) the following letter must be sent to the beneficiary. The beneficiary has 30 days to respond.

13.1.1. Tenth Month Purchase Option Letter for All Capped Rental Items

You have been renting your _____ for 10 continuous months. Medicare requires National Seating and Mobility, Inc. to give you the option of converting your rental agreement to a purchase agreement. This means that if you accept this option, you would own the medical equipment. If you accept the purchase option, Medicare continues making rental payments for your equipment for 3 additional rental months. You are responsible for the 20 percent coinsurance amounts or, for unassigned claims, the supplier's entire charge. After these additional rental payments are made, title to the equipment is transferred to you. You have until _____ to elect the purchase option. If you decide not to elect the purchase option, Medicare continues making rental payments for an additional 5 rental months, or a total of 15 months. After a total of 15 rental months have been paid, title to the equipment remains with the medical equipment supplier, however, the supplier may not charge you any additional rental amounts. In making your decision to rent or purchase the equipment, you should know that for purchase equipment, you are responsible for 20 percent of the service charge each time your equipment is actually serviced or, for unassigned claims, the supplier's entire charge. However, for equipment that is rented for 15 months, your responsibility for such service is limited to 20 percent coinsurance on a maintenance and servicing fee payable twice per year when whether or not the equipment is actually serviced.

Supplier's Name _____

Option Chosen: Purchase [ ] Rental [ ]

Beneficiary's Signature _____ Date _____

14. Electric Wheelchairs

14.1. Prior to delivery of an electric wheelchair to a Medicare beneficiary, he/she must be presented with the option of purchasing or renting the equipment. If he/she chooses to rent the equipment, he/she must be sent the Tenth Month Purchase Option Letter as outlined in 13.1.1. The following must be included in the document presented to the beneficiary prior to delivery.

14.1.1. First Month Purchase Option Letter for Electric Wheelchairs

If you need an electric wheelchair prescribed by your doctor, you may already know that Medicare can help pay for it. Medicare requires National Seating and Mobility, Inc. to give you the option of either renting or purchasing it. If you decide the purchase

is more economical, for example, because you will need the electric wheelchair for a long time, Medicare pays 80 percent of the allowed purchase price in a lump sum amount. You are responsible for the 20 percent co-insurance amounts or, for unassigned claims, the suppliers entire charge. However, you must elect to purchase the electric wheelchair at the time your medical equipment supplier furnishes you with the item. If you elect to rent the electric wheelchair, you are again given the option of purchasing it during your 10th rental month. The option will not be extended at any other time.

If you continue to rent the electric wheelchair for 10 months, Medicare requires National Seating and Mobility, Inc. to give you the option of converting your rental agreement to a purchase agreement. This means that if you accept this option, you would own the medical equipment. If you accept the purchase option, Medicare continues making rental payments for your equipment for 3 additional rental months. You are responsible for the 20 percent coinsurance amounts or, for unassigned claims, the suppliers entire charge. After these additional rental payments are made, title to the equipment is transferred to you. You have until _____ to elect the purchase option. If you decide not to elect the purchase option, Medicare continues making rental payments for an additional 5 rental months, or a total of 15 months. After a total of 15 rental months have been paid, title to the equipment remains with the medical equipment supplier, however, the supplier may not charge you any additional rental amounts.

In making your decision to rent or purchase the equipment, you should know that for purchased equipment, you are responsible for 20 percent of the service charge each time your equipment is actually serviced or, for unassigned claims, the supplier's entire charge. However, for equipment that is rented for 15 months, your responsibility for such service is limited to 20 percent coinsurance on a maintenance and servicing fee payable twice per year whether or not the equipment is actually serviced.
Supplier's Name: National Seating and Mobility, Inc.
Option Chosen: Purchase [ ] Rental [ ]

15. Advanced Beneficiary Notification of Medicare Non-payment – Waiver of Liability

15.1. The Waiver of Liability provision was established to protect Medicare beneficiaries and suppliers from unknowingly being liable for services which Medicare denies as medically unnecessary. This limitation of liability applies only to assigned claims for non-physician services which Medicare determined were not "reasonable or necessary." It does not apply to services which are denied because of Medicare exclusions (services which are never covered under the Medicare program), such as bathroom safety equipment. The patient is responsible for payment of items and services not covered under the Medicare program.

15.2. The Advanced Beneficiary Notification of Medicare Non-payment – Waiver of Liability form, must include the following:

15.2.1. 'Supplier's Notice:
Medicare will only pay for services it determines to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. National Seating and Mobility, Inc. believes that, in your case, Medicare is likely to deny payment for _____for the following reasons _____.

Beneficiary 's Acknowledgment and Agreement to Pay:
I have been notified by my supplier that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reason stated. If

Medicare denies the payment, I agree to be personally and fully responsible for payment."

16. Assignment of Benefits – AOB

16.1. The AOB must be specific to the particular products that the patient is currently being provided. For example the AOB must list "power chair" or "manual chair", etc.. Blanket AOBs on file are no longer acceptable.

16.2. The AOB should be signed by the patient. If the patient is unable to sign, then the signature of a family member, preferably one who holds power of attorney, is required. If signed by anyone other than the patient, the relationship of the signee and the reason why the patent cannot sign must be listed on the AOB.

16.3. The signature of a therapist, nurse or other allied health professional, who does not hold power of attorney for the patient, on an AOB, does not authorize NSM to file a claim on behalf of the patient.

16.4. The Assignment of Benefit document must include the following:

16.4.1. "**Assignment of benefits** – (1) I hereby authorize that payment of my Medicare, Medicaid or other insurance benefits to cover the following products and services be made, on my behalf, to National Seating and Mobility, Inc. _____, date: _____. (2) I authorize any holder of medical or other information about me to release to National Seating and Mobility, Inc.; my insurance carrier; State agency and the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services. **Financial responsibility** - (3) I understand that I will be responsible for any deductible co-insurance or payment in the event my insurance carrier denies payment. (4) I further understand that I will be responsible for any interest charges, collection or attorney's fees in the event my balance owed to National Seating and Mobility, Inc. becomes 60 days past due. (5) If the equipment provided is covered by Medicare, I will be responsible for the co-payment only unless I sign an Advanced Beneficiary Notification of Medicare Non-payment also known as a "Waiver of Liability". (6) **Medicaid Coverage** - I further understand that if, at the time of delivery and billing for the equipment, I am covered, eligible and participating in a Medicaid program and this has been disclosed to National Seating and Mobility, Inc., I will not be responsible for any payment."

17. Delivery Ticket

17.1. All Medicare transactions require a delivery ticket signed and dated by the patient or responsible party as outlined in 13.2 and 13.3 above.

17.2. At the time of delivery, a copy of the current "Medicare Supplier's Standards" must be given to the patient. The supplier's standards effective 12/11/00 state that a Medicare Supplier:

17.2.1. Operates its business and furnished Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements;

17.2.2. Has not made, or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges;

17.2.3. Has the application for billing privileges signed by an individual whose signature binds a supplier;

17.2.4. Fills order, fabricates, or fits items from its own inventory or by contracting with other companies for the purchase of items necessary to fill the order;

17.2.5. Advises beneficiaries that they may either rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental durable medical equipment;

17.2.6. Honors all warranties expressed and implied under applicable State law. A supplier must not charge the beneficiary or the Medicare program for the repair or replacement of Medicare covered items or for services covered under warranty;

17.2.7. Maintains a physical facility on an appropriate site. The physical facility must contain space for storing business records including the supplier's delivery, maintenance, and beneficiary communication records. For purposes of this standard, a post office box or commercial mailbox is not considered a physical facility;

17.2.8. Permits HCFA, or its agents to conduct on-site inspections to as certain supplier compliance with the requirements of this section. The supplier location must be accessible during reasonable business hours to beneficiaries and to HCFA, and must maintain a visible sign and posted hours of operation;

17.2.9. Maintains a primary business telephone listed under the name of the business locally or toll-free for beneficiaries;

17.2.10. Has a comprehensive liability insurance policy in the amount of at least ,000 that covers both the supplier's place of business and all customers and employees of the supplier;

17.2.11. Agrees to not contact a beneficiary by telephone when supplying a Medicare-covered item unless one of the following applies:

17.2.11.1. The individual has given written permission to the supplier to contact them by telephone;

17.2.11.2. The supplier has furnished a Medicare-covered item to the individual and the supplier is contacting the individual to coordinate the delivery of the item;

17.2.11.3. If the contact concerns the furnishing of a Medicare-covered item other than a covered item already furnished to the individual, the supplier has furnished at least one covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact.

17.2.12. Is responsible for the delivery of Medicare covered items to beneficiaries and maintains proof of delivery (NSM note: in general the drop shipment of Re/hab Technology equipment is not allowed);

17.2.13. Answers questions and respond to complaints a beneficiary has about the Medicare-covered item that was sold or rented;

17.2.14. Maintains and replaces at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries;

17.2.15. Accepts returns from beneficiaries of substandard items;

17.2.16. Discloses these supplier standards to each beneficiary to whom it supplies a Medicare-covered item;

17.2.17. Complies with the disclosure provisions in 42 C.F.R. §420.206;

17.2.18. Will not convey or reassign a supplier number;

17.2.19. Has a complaint resolution protocol to address beneficiary complaints that relate to supplier standards;

17.2.20. Maintains the following information on all written and oral beneficiary complaints, including telephone complaints, it receives:

17.2.20.1. The name, address, telephone number, and health insurance claim number of the beneficiary;

17.2.20.2. A summary of the complaint;

17.2.20.3. If an investigation was not conducted, the name of the person making the decision and the reason for the decision.

17.2.21. Provides to HCFA, upon request, any information required by the Medicare statute and implementing regulations.

17.3. Suppliers must comply with all twenty-one (21) provider standards to be eligible to bill Medicare for covered items. Failure to comply may be grounds for denial of all pending claims and recoupment of moneys paid by Medicare or its agents, the DMERC.

17.4. The signed delivery ticket not only indicates receipt of the product by the patient, but that they received the Medicare mandated instruction in the care, maintenance and safe use of the product. The signature of a therapist, nurse or other allied health professional, who does not hold power of attorney for the patient, is not adequate documentation of delivery for Medicare billing purposes.

17.5. All delivery tickets must include the following above the signature area:

17.5.1. "My signature below acknowledges receipt of the above equipment; applicable owner's/instruction manual; instruction on care and maintenance of the equipment and that I have been advised of and understand my rights and responsibilities as they relate to the provision of this equipment."

18. Signature Block

18.1. The following signature block must be included on all documents signed by a Medicare Beneficiary or his/her representative:

18.1.1. "By my signature below, I acknowledge that I have read, understood and agree to the foregoing provisions. If I am not the patient, my signature acknowledges the same and that I am duly authorized by the patient or by law as the patient's agent and/or representative to execute the document on the patient's behalf.
Patient's name: (please print) _____
Patient's signature: _____ Date: _____
Authorized representative's name: (please print) _____
Authorized representative's signature: _____ Date: _____
Relationship to patient: _____
Reason patient cannot sign: _____"

19. Patient Records and Documentation

19.1. Under federal law it is illegal to knowingly and willfully:

19.1.1. falsify, conceal or cover up by any trick, scheme, or device a material fact;

19.1.2. make any false, fictitious, or fraudulent statements or representations;

19.1.3. make or use any false writing or statement or entry as related to health care matters.

19.2. All employees must meet all record keeping obligations.

19.2.1. No record or entry will be falsified, backdated, defaced, destroyed or altered.

19.2.2. All transactions, patient encounters and services must be properly documented and accounted for fully, and recorded in the NSM's records.

19.2.3. The records of the company shall not be altered in any manner and will be maintained with quality and integrity.

19.3. All patient records must be maintained for seven years from the date of remittance.

19.4. All patient information will be considered confidential as outlined in NSM's Human Resource Manual.

19.5. Patient records will be maintained in an orderly file.

19.6. Contents of Patient Files for Medicare Compliance

19.6.1. Delivery ticket must include:

19.6.1.1. Description of items delivered. This must match items billed.

19.6.1.2. Date of delivery.

19.6.1.3. Signature and date showing proof of delivery (see 13.2)

19.6.2. Signed AOB (see 13)

19.6.3. Signed, original CMN (if applicable)

19.6.4. Purchase option letter if applicable.

19.6.4.1. Must be provided after 10 months of rental for capped rental equipment

19.6.4.2. Must be provided at time of delivery for power wheelchairs and again after 10 months if rental option is chosen.

19.6.4.3. Must be signed and dated by patient showing decision to rent or purchase

19.7. Advance Beneficiary Notice of Medicare Non-payment (if applicable)

19.7.1. Commonly called Waiver of Liability

19.7.2. Must include the name and description of equipment provided.

19.7.3. Must include a statement that Medicare is likely to deny payment and an accurate reason why.

19.7.4. Must include the patient's agreement to pay if equipment is denied.

19.7.5. Must be signed and dated by the patient prior to delivery.

19.7.6. "GA" modifier must be used on billing document

20. Certificate of Medical Necessity (CMN) Requirements

20.1. Federal regulations require that an original signed and dated physician's order or CMN signed, dated and completed by physician, be on file for all equipment billed to Medicare.

20.2. Use the Medicare CMN listed for the equipment ordered:

20.2.1. HCFA 843; DMERC 02.03A - Motorized wheelchairs, options and accessories

20.2.2. HCF A 844; DMERC 02.03B - Manual wheelchairs, options and accessories

20.2.3. HCFA 850; DMERC 07.02B - Power operated vehicles.

20.2.4. HCFA 854; DMERC 11.01- Section C Continuation Form (second page to be

used when Section C list does fit on one page – Note: Must be signed and dated by physician)

20.2.5. Refer to your DMERC Supplier Manual for updated and/or additional CMNs

20.3. The CMN sent to the physician for completion must have Section C completed be two-sided with - the instructions on the back.

20.4. The CMN, both front and back, with date and time of transmission automatically imprinted by fax machine, may be faxed from supplier to physician.

20.5. If urgent, the supplier may receive a signed, faxed copy from the physician, but must also receive the signed original for their records.

20.6. CMNs are valid for 90 days.

20.7. Cover letters accompanying CMNs to the physician:

20.7.1. Must not refer to the patient's medical condition.

20.7.2. Must not influence the physician with regards to the medical necessity questions in Section B.

20.7.3. May instruct the physician as to which sections to complete.

20.8. Section A may be completed by supplier or physician.

20.9. Section B **must** be completed by the physician, physician's employee, therapist or other clinical professional not associated with NSM.

20.10. Section C must be completed by the supplier prior to the physician signing and dating the CMN, and meet the following guidelines:

20.10.1. Description of items listed in Section A plus any options and accessories. Only those items included in the physician's order may be listed.

20.10.2. Charges to be submitted on claim must be indicated.

20.10.2.1. The Manufacturer Suggested Retail Price and the Medicare allowable, if known. If a non-coded item, N/A should be listed under Medicare allowable.

20.11. Section D must be completed by a physician presently treating the patient.

20.11.1. CMNs for POVs (scooters) must be signed by a physician specializing in physical medicine and rehabilitation, orthopedic surgery, neurology or rheumatology. Exception: When such a specialist is not within one day's round-trip of the patient's home. Documentation of this must be submitted with CMN.

20.12. The CMN must be signed and dated by the physician after Section B is completed.

20.13. Any changes made to the CMN after it is signed by the physician must be signed (not initialed) and dated again by the physician. Any errors should be corrected with a single stroke drawn through the error. No "white-out" or erasures are allowed.

20.14. The original, signed CMN must be retained in the supplier's patient file.

20.15. For items not requiring an CMN, an order for the item which has been signed and dated by the ordering physician must be kept in the patient's file. For cushions, support surfaces, TENS units and seat lifts, the physicians order must be in hand and dated before the product is delivered to the patient.

21. Medicare Billing

21.1. The guidelines below provide an overview of the Medicare billing process and are not intended to be all-inclusive. Each branch office should consult their DMERC Supplier Manual for details. Each branch office is responsible for knowing the Medicare guidelines as interpreted by their DMERC and correctly processing Medicare claims.

21.2. For items or services to be billed to Medicare:

21.2.1. The item or service must be medically necessary.

21.2.2. A signed CMN and/or order must be on file for those specific items. (See "CMN Requirements" for details.)

21.2.3. A signed delivery ticket must be on file for those specific items. The items billed must match those delivered.

21.2.4. A purchase option letter signed at the time of delivery must be on file for power wheelchairs.

21.2.5. A signed purchase option letter must be on file for capped rental equipment after ten months of rental.

21.2.6. An Advance Beneficiary Notice of Medicare Non-payment – Waiver of Liability signed at the time of delivery must be on file for items that may not be considered not medically necessary for an individual beneficiary.

21.3. False Claims - Under federal law it is illegal to submit a claim:

21.3.1. For services or items that were not provided

21.3.2. For services or items that were provided in a false or fraudulent manner

21.3.3. For services that were performed by a provider that was excluded from the health care program at issue

21.3.4. For services or items that a person knows or should know are not medically necessary

21.4. Filing a Medicare claim:

21.4.1. Charges must be submitted on a HCFA 1500 or submitted electronically.

21.4.2. Supplier must accept assignment if beneficiary is also a Medicaid recipient.

21.4.3. Medicare HCPCS codes must be used for items provided.

21.4.4. Appropriate modifiers must be used as explained in the DMERC Supplier Manual.

21.4.5. Billed items must be included on the CMN or physician's order.

21.4.6. Procedure codes must match those on the CMN or order.

21.4.7. Diagnosis must match those on the CMN.

21.4.8. Date of signed delivery ticket must be used as the date of service.

21.4.8.1. Equipment may be delivered to a Medicare beneficiary in a hospital no more than 48 hours before discharge. IN this case the date of discharge should be used as the date of service. The supplier is responsible, if required, to deliver the equipment to the beneficiary’s home upon discharge.

21.4.9. Claims for repairs and modifications must include the serial #, make and date of purchase and funding/payment source for the equipment to be repaired.

21.4.10. Include with hard copy claims: CMN, manufacturer's pricing, itemization, evaluation (for seating systems), medical necessity explained for certain accessories as required

21.4.11. All claims must be submitted within one year of date of service.

21.4.12. Beneficiaries may not be billed for the 10% reimbursement reduction on assigned claims filed over one year from the date of service.

21.5. The supplier is responsible for:

21.5.1. Being reasonably certain that the prescribing physician is licensed and/or certified.

21.5.2. Ensuring that Medicare is not charged a higher rate than non-Medicare payers.

21.5.3. Filing claims with primary insurance and billing Medicare with valid denials from primary carrier if Medicare is secondary.

21.5.4. Ensuring Medicare beneficiaries are not billed for balances other than co-insurance, deductibles and non-covered items for which they have signed an Advance Beneficiary Notice of Medicare Non-payment – Waiver of Liability.

21.5.5. Ensuring the collection procedures for Medicare beneficiaries are the same as those for other payer sources.

22. Patient Grievance Process

22.1. NSM encourages patients to voice grievances and recommend changes in policies and services without coercion, discrimination or reprisal. It is NSM's policy to respond to all questions and/or complaints in a timely and professional manner. A record of these questions, complaints and follow up documentation is available at the home office.

22.2. The NSM Complaint Resolution Procedure is incorporated into this document by reference.

23. Kickbacks and Improper Gifts

23.1. The Medicare and Medicaid Anti-Kickback statute makes it a crime:

23.1.1. for a person to knowingly and willfully accept payment or other remuneration for referring a patient to another for the furnishing of any item or service for which payment may be made in the whole or part by the Medicare or Medicaid programs;

23.1.2. for a person to knowingly and willfully make such a payment to induce (any act intended to influence the reason or judgment of another) such a referral.

23.2. NSM prohibits employees from entering into any agreement or arrangement, which calls for a commission, rebate, bribe or kickback in cash or in kind.

23.2.1. If an employee is approached about such an arrangement, the employee will report the incident to the compliance officer immediately.

23.2.2. If an employee suspects that the purpose of a proposed transaction or course of conduct is a direct or indirect cause of improper award, the advice of the compliance officer should be sought immediately.

24. In the event of a conflict between the terms of this compliance program and any other NSM manuals, policies, procedures or internal documents, the terms of this compliance program shall control.