CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11427	**Date: May 20, 2022**
	Change Request 12734

Transmittal 11414, dated May 12, 2022, is being rescinded and replaced by Transmittal 11427, dated, May 20, 2022, to correct the implementation and effective date. All other information remains the same.

SUBJECT: Claims Processing Manual Update - Pub. 100.04 for Elimination of Certificates of Medical Necessity (CMNs) and Durable Medical Equipment Forms (DIFs)

I. SUMMARY OF CHANGES: CMS is eliminating all remaining CMNs and DIFs effective for claims with dates of service on or after January 1, 2023. This is an update to the Pub. 100-04: Claims Processing manual explaining the planned change. Other Internet Only Manuals that include instructions on CMNs and DIFs will be updated independently.

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	17/70 - Claims Processing Requirements - General
R	19/90 - DME General Information
R	20/10 - Where to Bill DMEPOS and PEN Items and Services
R	20/30 - General Payment Rules
R	20/50 - Payment for Replacement of Equipment
R	20/100 - General Documentation Requirements
R	22/60 - Remittance Advice Codes
R	24/50 - Technical Requirements
R	27/20 - Common Working File (CWF) Operations
R	36/50 - Special Billing Instructions for the DMEPOS Competitive Bidding Program
R	37/1.1.2 – Requirements for Processing VA Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) Claims

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 11427	Date: May 20, 2022	Change Request: 12734

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EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

I. GENERAL INFORMATION

A. Background: CMS is eliminating all remaining CMNs and DIFs effective for claims with dates of service on or after January 1, 2023. This is an update to the Medicare Claims Processing and Benefit Policy Manuals explaining the planned change. Other Internet Only Manuals that include instructions on CMNs and DIFs will also be updated.

The current forms that shall be eliminated are as follows:

CMN

- 484 Oxygen
- 846 Pneumatic Compression Devices
- 847 Osteogenesis Stimulators
- 848 Transcutaneous Electrical Nerve Stimulators
- 849 Seat Lift Mechanisms
- 854 Section C Continuation Form

DIF

- 10125 External Infusion Pumps
- 10126 Enteral and Parenteral Nutrition

B. Policy: Durable Medical Equipment (DME) MACs shall make providers and suppliers aware that CMNs/DIFs are still required until they are eliminated for claims with dates of service on/after Jan 1, 2023.

- For claims with dates of service on or after January 1, 2023 – providers and suppliers no longer need to submit CMNs or DIFs with claims. Due to electronic filing requirements, claims received with these forms attached will be rejected and returned to the provider or supplier.

- For claims with dates of service prior to January 1, 2023 – processes will not change and if the CMN or DIF is required, it will still need to be submitted with the claim, or be on file with a previous claim.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12734.1	Contractors shall make providers and suppliers in their jurisdiction aware that for claims with dates of service on or after January 1, 2023 – providers and suppliers shall no longer submit CMNs or DIFs with claims. Due to electronic filing requirements, claims received with CMN data shall be rejected and returned to the provider or supplier.				X					CEDI
12734.2	Contractors shall make providers and suppliers in their jurisdiction aware that for claims with dates of service prior to January 1, 2023 – processes will not change and if the CMN or DIF is required, it will still need to be submitted with the claim, or be on file with a previous claim.				X					CEDI

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12734.3	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.				X	X

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Paula Smith, Paula.Smith@cms.hhs.gov , Diana Motsiopoulos, diana.motsiopoulos@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

70 - Claims Processing Requirements - General

(Rev. 11427; Issued: 05-20-22; Effective: 01-01-23; Implementation: 01-03-23)

NOTE: *CMS seeks to reduce burden and modernize processes to ensure a reduction in improper payments and an increase in customer satisfaction. The Certificate of Medical Necessity (CMN) form and DME Information Form (DIF) were originally required to help document the medical necessity and other coverage criteria for selected Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items. In the past, a supplier received a signed CMN from the treating physician or created and signed a DIF to submit with the claim. Due to improvements in claims processing and medical records management, the information found on CMNs or DIFs is available either on the claim or in the medical record and is redundant. Therefore, to reduce burden and increase customer satisfaction, providers and suppliers no longer need to submit these forms for services rendered after January 1, 2023.*

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This statement applies throughout the Program Integrity Manual wherever CMNs and DIFs are mentioned.

A/B MACs (B) are billed with the ASC X12 837 professional claim format or, if approved, with the paper form CMS-1500. A/B MACs (A) are billed with the ASC X12 837 institutional claim format or, if approved, with the paper Form CMS-1450.

See Chapters 24, 25 and 26 for detailed claims processing requirements, including forms, data elements, and formats. See Chapters 21 and 22 for MSN and remittance record requirements. See the official Washington Publishing Company web site for information about ASC X12 formats and related training material.

In addition to requirements applicable to all claims the following apply to drug claims.

- On claims to A/B MACs (A) the drug is identified by the appropriate HCPCS code for the drug administered and billed under revenue code 0636 unless specific instruction states otherwise;
- On claims to A/B MACs (B) the drug is identified by HCPCS code;
- All drugs, including Prodrugs, are reported to DME MACs by National Drug Code (see §80.1.2);
- Where HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4; See examples below.
- Where the NDC is required units are entered in multiples of the units shown in the NDC label description. For example, if the description for the code is 50 mg., and 200 mg are provided, units are shown as 4;
- If the units provided exceed the size of the units field, or require more characters to report than spaces available in the format, repeat the HCPCS or NDC code on multiple lines until all units can be reported;
- Covered administration codes for injections may be billed to the A/B MAC (B) and A/B MAC (A) in addition to billing for the drug. The drug maximum payment allowance is for the drug alone. However, if payment is under a PPS, such as OPPS, the injection would be included in the APC rate.

The examples below include the HCPCS code and indicate the dosage amount specified in the descriptor of that code. Facilities use the units field as a multiplier to arrive at the total dosage amount.

EXAMPLE 1

HCPCS	J7189
Drug	Factor VIIa
Dosage	1 mcg

Actual dosage: 13,365 mcg

On the bill, the facility shows J7189 and 13,365 in the units field (13,365 mcg divided by 1 mcg = 13,365 units).

NOTE: The process for dealing with one international unit (IU) is the same as the process of dealing with one microgram.

EXAMPLE 2

HCPCS	J9355
Drug	Trastuzumab
Dosage	10 mg

Actual dosage: 140 mg

On the bill, the facility shows J9355 and 14 in the units field (140 mg divided by 10mg = 14 units).

When the dosage amount is greater than the amount indicated for the HCPCS code, the facility rounds up to determine units. When the dosage amount is less than the amount indicated for the HCPCS code, use 1 as the unit of measure.

EXAMPLE 3

HCPCS	J3100
Drug	Tenecteplase
Dosage	50 mg

Actual Dosage: 40 mg

The provider would bill for 1 unit, even though less than 1 full unit was furnished.

See §10 for a description of drug payment rules.

90 - DME General Information

(Rev. 11427; Issued: 05-20-22; Effective: 01-01-23; Implementation: 01-03-23)

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This statement applies throughout the Program Integrity Manual wherever CMNs and DIFs are mentioned.

The DME MACs process claims for items of DMEPOS for use **in the beneficiary's home**. Beginning January 1, 2005, Medicare Part B makes payment for medically necessary items of DME, prosthetics, orthotics, and supplies to IHS suppliers that furnish DME for use in the **beneficiary's home**. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §110 for more information on this benefit.

Note that the DME MACs make payment for DMEPOS only in cases where the beneficiary medically needs the equipment in his or her home. Items provided during an inpatient hospital or SNF stay are included in the payment made to the hospital or SNF, with certain exceptions. (See Chapter 6, §20.3 of Pub. 100-04, Medicare Claims Processing Manual for exceptions to SNF consolidated billing, and Chapter 20, §110.3 for exceptions to DMEPOS provided for fitting and training prior to an inpatient discharge.) More information regarding when items of DMEPOS are billed to a DME MAC or to an A/B MAC (A) is outlined below.

For more information on jurisdiction, payment policy, and claims processing rules for DMEPOS, see Chapters 1 (for general information of submitting Medicare claims), 17 (for information specific to drugs paid by the DME MACs), and 20 (for information specific to DMEPOS items and services) of Pub. 100-04, Medicare Claims Processing Manual.

10 - Where to Bill DMEPOS and PEN Items and Services

(Rev. 11427; Issued: 05-20-22; Effective: 01-01-23; Implementation: 01-03-23)

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This statement applies throughout the Program Integrity Manual wherever CMNs and DIFs are mentioned.

Skilled Nursing Facilities, CORFs, OPTs, and hospitals bill the A/B MAC Part A for prosthetic/orthotic devices, supplies, and covered outpatient DME and oxygen (refer to §40). The HHAs should bill Durable Medical Equipment (DME) to the A/B MAC (HHH), or should meet the requirements of a DME supplier and bill the DME MAC. This is the HHA's decision. A/B MACs Part A other than A/B MACs (HHH) will receive claims only for the class "Prosthetic and Orthotic Devices."

Unless billing to the A/B MAC Part A is required as outlined in the preceding paragraph, claims for implanted DME, implanted prosthetic devices, replacement parts, accessories and supplies for the implanted DME shall be billed to the A/B MACs Part B and not the DME MAC.

Suppliers enrolled with the NSC as a DMEPOS supplier should enroll with and bill to the A/B MAC Part B for replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME items that are not required to be billed to the A/B MAC Part A as stated above. Such suppliers should bill the A/B MAC Part B for these items only, unless the entity separately qualified as a supplier for items and/or services in another benefit category.

Suppliers that enroll with the NSC as a DMEPOS supplier shall bill the A/B MAC Part B using their NPI and shall not include their NSC number on the claim.

Under no circumstances should any entity that is enrolled as a DMEPOS supplier with the NSC, that is not the physician or provider that implants the device, bill the A/B MAC Part B for an implanted device. However, DMEPOS suppliers should bill for any of the replacement parts, accessories or supplies for prosthetic implants and surgically implanted DME.

The claims filing jurisdiction for these items is determined by the supplier's location, in accordance with Pub. 100-04, Medicare Claims Processing Manual, chapter 1, section 10. With respect to payment for these items, contractors are reminded of the longstanding policy for payment of DMEPOS items, which specifies that payment for DMEPOS is based on the fee schedule amount for the State where the beneficiary maintains his/her permanent residence.

The Healthcare Common Procedure Coding System (HCPCS) codes that describe these categories of service are updated quarterly. All other DMEPOS items are billed to the DME MAC. See the Medicare

Claims Processing Manual, Chapter 23, §20.3 for additional information. A spreadsheet containing an updated list of HCPCS for which DME MACs have jurisdiction is updated as needed (typically quarterly) to reflect codes that have been added or discontinued (deleted). Any new HCPCS not included in this updated list are A/B MAC jurisdiction only, and not DME MAC jurisdiction. The spreadsheet is posted at the following website: https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html under the heading of Coding.

Parenteral and enteral nutrition, and related accessories and supplies, are covered under the Medicare program as a prosthetic device. See the Medicare Benefit Policy Manual, Chapter 15, for a description of the policy. All Parenteral and Enteral (PEN) services furnished under Part B are billed to the DME MAC. If a provider (see §01) provides PEN items under Part B it shall qualify for and receive a supplier number and bill as a supplier. Note that some PEN items furnished to hospital and SNF inpatients are included in the Part A PPS rate and are not separately billable. (If a service is paid under Part A it should not also be paid under Part B.)

30 - General Payment Rules

(Rev. 11427; Issued: 05-20-22; Effective: 01-01-23; Implementation: 01-03-23)

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This statement applies throughout the Program Integrity Manual wherever CMNs and DIFs are mentioned.

B3-5102

DMEPOS are categorized into one of the following payment classes:

- Inexpensive or other routinely purchased DME;
- Items requiring frequent and substantial servicing;
- Certain customized items;
- Other prosthetic and orthotic devices;
- Capped rental items; or
- Oxygen and oxygen equipment.

The CMS determines the category that applies to each HCPSC code and issues instructions when changes are appropriate. See §§130 for billing information for each payment class.

DME, including DME furnished under the home health benefit and Part B DME benefit, is paid on the basis of the fee schedule.

Oxygen and oxygen equipment are paid on the basis of a fee schedule.

Any DME or oxygen furnished to inpatients under a Part A covered stay is included in the SNF or hospital PPS rate. When an inpatient in a hospital or SNF is not entitled to Part A inpatient benefits, payment may not be made under Part B for DME or oxygen provided in the hospital or SNF because such facilities do not qualify as a patient's home. The definition of DME in §1861(n) of the Act provides that DME is covered by Part B only when intended for use in the home, which explicitly does not include a SNF or hospital. (See the Medicare Benefit Policy Manual, Chapter 15). This does not preclude separate billing for DME furnished after discharge.

Payment to providers and suppliers other than Home Health Agencies (HHAs) for supplies that are necessary for the effective use of DME is made on the basis of a fee schedule, except that payment for drugs is made under the drug payment methodology rules (See Chapter 17 for drug payment information.)

Payment for prosthetics and orthotics is made on the basis of a fee schedule whether it is billed to the A/B MAC (A), (B), or (HHH), or DME MAC.

Payment under Part B for surgical dressings is made on the basis of the fee schedule except:

- Those applied incident to a physician's professional services;
- Those furnished by an HHA; and
- Those applied while a patient is being treated in an outpatient hospital department.

50 - Payment for Replacement of Equipment

(Rev. 11427; Issued: 05-20-22; Effective: 01-01-23; Implementation: 01-03-23)

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This statement applies throughout the Program Integrity Manual wherever CMNs and DIFs are mentioned.

B3-5102.2.B

Replacement of equipment which the beneficiary owns or is purchasing or is a capped rental item is covered in cases of loss, or irreparable damage or wear, and when required because of a change in the patient's condition subject to the following provisions. Expenses for replacement required because of loss or irreparable damage may be reimbursed without a physician's order when, in the DME MAC's judgment, the equipment as originally ordered, considering the age of the order, still fills the patient's medical needs. However, claims involving replacement equipment necessitated because of wear or a change in the patient's condition must be supported by a current physician's order. (See the Medicare Benefit Policy Manual, Chapter 16, for payment for equipment replaced under a warranty.)

DME MACs investigate and deny cases suggesting malicious damage, culpable neglect or wrongful disposition of equipment as discussed in the Benefit Policy Manual, Chapter 15, where it is determined that it is unreasonable to make program payment under the circumstances. They refer such cases to the program integrity specialist in the RO.

DME MACs do not pay for replacement of rented equipment except capped rental items. (See §50.1) However, they pay for replacement of purchased equipment in the following classes: inexpensive or routinely purchased, customized items, capped rental (where the beneficiary has elected to purchase the item), and other prosthetic and orthotic devices. They do not pay for purchase or replacement of items that require frequent and substantial servicing or oxygen equipment.

100 - General Documentation Requirements

(Rev. 11427; Issued: 05-20-22; Effective: 01-01-23; Implementation: 01-03-23)

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This statement applies throughout the Program Integrity Manual wherever CMNs and DIFs are mentioned.

B3-4107.1, B3-4107.8, HHA-463, Medicare Handbook for New Suppliers: Getting Started, B-02-31

Benefit policies are set forth in the Medicare Benefit Policy Manual, Chapter 15, §§110-130.

Program integrity policies for DMEPOS are set forth in the Medicare Program Integrity Manual, Chapter 5.

See Chapter 21 for applicable MSN messages.

See Chapter 22 for Remittance Advice coding.

60 - Remittance Advice Codes

(Rev. 11427; Issued: 05-20-22; Effective: 01-01-23; Implementation: 01-03-23)

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The remittance advice provides explanation of any adjustment(s) made to the payment. The difference between the submitted charge and the actual payment must be accounted for in order for the ASC X12 835 to balance. The term “adjustment” may mean any of the following:

- denied
- zero payment
- partial payment
- reduced payment
- penalty applied
- additional payment
- supplemental payment

Group Codes, Claim Adjustment Reason Codes and Remittance Advice Remark Codes are used to explain adjustments at the claim or service line level. Provider Level Adjustment or PLB Reason Codes are used to explain any adjustment at the provider level.

50 - Technical Requirements

(Rev. 11427; Issued: 05-20-22; Effective: 01-01-23; Implementation: 01-03-23)

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20 - Common Working File (CWF) Operations

(Rev. 11427; Issued: 05-20-22; Effective: 01-01-23; Implementation: 01-03-23)

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- ***For claims with dates of service prior to January 1, 2023*** *– processes will not change and if the CMN or DIF is required, it will still need to be submitted with the claim, or be on file with a previous claim.*

This statement applies throughout the Program Integrity Manual wherever CMNs and DIFs are mentioned.

This section is intended only to be a brief profile synopsis of CWF operations. The system and user documentation should be closely examined for further details.

The Common Working File system provides a single data source where the contractors can verify beneficiary eligibility to receive prepayment review and approval of claims.
Each Host site is responsible for processing those claims submitted for beneficiaries on its database. These claims are processed through a shared software system supplied to each Host by the CWF Maintenance Contractor (CWFM). Each change made to the CWF software is released to all Host sites in a uniform manner. This software performs consistency and utilization editing on claims for corrective action by the MAC's.

The CWF system ensures that:

1. The beneficiary is entitled to either Part A or Part B benefits, depending on the type of claim submitted.
2. The co-pay and/or deductible applied, if any, is accurate.
3. Services are allowed.
4. Benefits are available for the services submitted on the claim

The CWF system also ensures that the services on the claim have not been paid on another claim - either the same type or another type of claim. If any of these conditions occur, the CWF system returns a response and identifies the reason for the rejection. The response also includes one or more trailers that identify the correct information necessary for the Medicare contractor to take the necessary action.

Prior to adjudication of claims, the CWF Host will send the claim to Fraud Prevention System (FPS) for review. FPS will make a payment determination which will be sent to the CWF Host. The CWF Host will then process the claims through consistency and utilization to ensure beneficiary is entitled to either Part A or Part B benefits, depending on the type of claim submitted.

Once the claim passes all of the edits, the CWF beneficiary master file is updated to reflect the benefits now available, as well as any changes to the deductible status. The claim is added to the CWF full claim history file.

CWF also provides eligibility and entitlement check via the beneficiary data streamlining (BDS) system which occurs earlier in the claims lifecycle to check for Medicare beneficiary identifier, eligibility and entitlement prior to the submission of the claim.

50 - Special Billing Instructions for the DMEPOS Competitive Bidding Program

(Rev. 11427; Issued: 05-20-22; Effective: 01-01-23; Implementation: 01-03-23)

NOTE: *CMS seeks to reduce burden and modernize processes to ensure a reduction in improper payments and an increase in customer satisfaction. The Certificate of Medical Necessity (CMN) form and DME Information Form (DIF) were originally required to help document the medical necessity and other coverage criteria for selected Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items. In the past, a supplier received a signed CMN from the treating physician or created and signed a DIF to submit with the claim. Due to improvements in claims processing and medical records management, the information found on CMNs or DIFs is available either on the claim or in the medical record and is redundant. Therefore, to reduce burden and increase customer satisfaction, providers and suppliers no longer need to submit these forms for services rendered after January 1, 2023.*

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This statement applies throughout the Program Integrity Manual wherever CMNs and DIFs are mentioned.

Claims for competitively bid items shall be submitted under the general DMEPOS claims billing guidelines specified in Chapter 20, §110 of the Medicare Claims Processing Manual, with the following exceptions described in this section.

1.1.2 – Requirements for Processing VA Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) Claims

(Rev. 11427; Issued: 05-20-22; Effective: 01-01-23; Implementation: 01-03-23)

NOTE: *CMS seeks to reduce burden and modernize processes to ensure a reduction in improper payments and an increase in customer satisfaction. The Certificate of Medical Necessity (CMN) form and DME Information Form (DIF) were originally required to help document the medical necessity and other coverage criteria for selected Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items. In the past, a supplier received a signed CMN from the treating physician or created and signed a DIF to submit with the claim. Due to improvements in claims processing and medical records management, the information found on CMNs or DIFs is available either on the claim or in the medical record and is redundant. Therefore, to reduce burden and increase customer satisfaction, providers and suppliers no longer need to submit these forms for services rendered after January 1, 2023.*

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This statement applies throughout the Program Integrity Manual wherever CMNs and DIFs are mentioned.

The process of receiving VA DMEPOS claims for a no-pay Electronic Medicare Remittance Advice (e-MRA) is effective on April 1, 2018. The processing of these claims, as with the Part A and Part B claims, allows for a CMS no-pay e-MRA to be generated for all DMEPOS claims submitted to CMS by the VA. VA DMEPOS claims are processed by a single DME MAC. For VA DMEPOS claims the e-MRA displays the amount that Medicare would have paid for the claim using the same fee schedule payments as DMEPOS Medicare claims would've paid and are based on the beneficiary's state of residence. The same deductible and coinsurance rules applicable to Medicare are applied to the VA claims and are provided on the e-MRA.

The VA submits DMEPOS claims via the ANSI X12 837P electronic format. The VA claims will be processed through the Medicare DME MAC Common Electronic Data Interchange (CEDI) front end system, DMEPOS claims processing system (VMS) and the common working file (CWF). In addition to following the ANSI X12 837P standards for claims submissions the following criteria applies:

- The VA's submitter of record is the approved biller and submits all VA electronic claims to CEDI.
- The VA supplies CMS, the VA DME MAC and CEDI with the VA facility NPI list. Validation of the NPI is done at the CMS front end contractor.
- VA claims are processed as mandatory assigned claims, no beneficiary submitted claims will be processed.
- VA DMEPOS submitted claims must be for beneficiaries that reside in the US and its territories.
- The VA must submit claims for Medicare approved HCPCS provided on the DMEPOS jurisdiction list which can be found at https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html.
- The VA DMEPOS claims are subject to the Medicare timely filing rules. Claims will be accepted for processing with dates of service one year prior to the date of receipt.
- The VA will submit paper CMNs for DMEPOS items that require a CMN per Medicare rules. The CMNs will be faxed (until the time VA has the ability to submit CMNs electronically) to the DME MAC. Claims requiring a CMN may be held for up to 2 weeks to allow for receipt of the CMN. Claims will be denied if a CMN is not received within 2 weeks.

The CWF edits to ensure the same three conditions stated above for A/B claims are applicable and must be present for adjudication on the DMEPOS claims. In addition, MSP claims are accepted from the VA and the CWF will apply MSP editing to VA DMEPOS claims.

Finalized claims will be included in the VA e-MRA and produced in the CMS flat file format. CEDI will translate the VA e-MRA flat file to the ANSI X12 835 format and make the file(s) available for the VA's submitter of record to retrieve.

Adjustments to claims submitted by the VA can be made only for redeterminations or cancels. This applies to all DMEPOS claims submitted by the VA for VA facilities and for independent suppliers.