



EDUCATIONAL RESOURCES

# HOW TO RESPOND TO PTAN REVOCAATION, PAYMENT SUSPENSION, AND OTHER ADVERSE ACTIONS

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# INTRODUCTION

# INTRODUCTION

- There is an increase in utilization of DME.
- Generally speaking, HME is expensive.
- There have been some bad actors who make things tough on those trying to do the right thing.
- CMS contractors are becoming more aggressive in their oversight of DME Suppliers.
- It is a priority of CMS to uncover and prevent fraud in the Medicare fee-for-service program.
- Health care providers (not just DME providers) have become the new bogey man to the government.

# OVERVIEW

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- Not too many years ago, an HME provider was not vulnerable to scrutiny from many people/agencies.
- The DME MAC would conduct post-payment claim reviews.
- An NSC inspector would show up every couple of years to make sure that hours were posted and the provider had insurance.
- And in a worse-case scenario, which did not happen often, the Department of Justice (“DOJ”) or Office of Inspector General (“OIG”) would investigate the provider. That was about it.

# OVERVIEW

- My, how things have changed...
- Now, the DME provider is under constant scrutiny.
- DME MACs, RACs, CERTs, and UPICs are routinely looking at post-payment claims.
- TPE audits are the new norm.
- UPICs are aggressively conducting prepayment reviews.
- CMS awarded a national contract to Performant to act as the RAC contractor and to focus on DME, home health, and hospice.
- The accrediting organizations (“AOs”) are being required by CMS to ask probing questions and report to CMS and the NSC any activities that the AOs believe are improper.

# OVERVIEW

- The UPICs are directing DME MACs to suspend payments when the ZPICs conclude that improper activities are occurring.
- In response to reports from the UPICs, the NSC is suspending/revoking supplier numbers.
- When conducting post-payment audits, the DME MACs and UPICs are asking questions that go far beyond whether the provider has complete and accurate documentation.
- The NSC is aggressively conducting unannounced on-site inspections; in so doing, the NSC inspectors are asking questions that go beyond the rudimentary questions that have been posed in the past.



# COVID-19 AND SUPPLIER ENROLLMENT

- All other providers and suppliers (including DMEPOS) eligible to enroll in Medicare.
- Expedite any pending or new applications.
- All clean web applications will be processed within 7 business days and all clean paper applications in 14 business days.
- Waive the following screening requirements for all enrollment applications received on or after March 1, 2020:
  - Application Fee – 42 C.F.R. 424.514
  - Criminal background checks associated with fingerprint-based criminal background checks (FCBC) 42 C.F.R. 424.518 (to the extent applicable)
  - Site-visits – 42 C.F.R. 424.517
- Postpone all revalidation actions.



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# NSC RISK



# NSC COMPLIANCE

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- Quickest way to kick a supplier out of the Medicare program is to revoke its supplier number.
- NSC is looking at compliance with the Supplier Standards.

# SUPPLIER STANDARDS

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- A supplier must be in compliance with all applicable federal and state licensure and regulatory requirements.
  - State Licensure website - [https://www.palmettogba.com/licensure/licdirec.nsf/NSCLicensureMap\\_N](https://www.palmettogba.com/licensure/licdirec.nsf/NSCLicensureMap_N)
- A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the NDC within 30 days.

# SUPPLIER STANDARDS

- An authorized individual (one whose signature is binding) must sign the enrollment application for billing privileges.
- A supplier must fill orders from its own inventory or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any state health care programs, or from any other federal procurement or non-procurement programs.
- A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased DME and of the purchase option for capped rental equipment.

# SUPPLIER STANDARDS

- A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable state law and repair or replace free of charge Medicare-covered items that are under warranty.
- A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
- A supplier must permit CMS or its agents to conduct onsite inspections to ascertain the supplier's compliance with these standards.

# SUPPLIER STANDARDS

- A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll-free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service, or cell phone during posted business hours is prohibited.
- A supplier must have comprehensive liability insurance in the amount of at least \$300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, the insurance must also cover product liability and completed operations.
- A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR 424.57 (c) (11).



# SUPPLIER STANDARDS

- A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare-covered items and maintain proof of delivery and beneficiary instruction.
- A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts.
- A supplier must maintain and replace at no charge or repair, directly or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.
- A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.

# SUPPLIER STANDARDS

- A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
- A supplier must disclose any person having ownership, financial, or control interest in the supplier.
- A supplier must not convey or reassign a supplier number (i.e., the supplier may not sell or allow another entity to use its Medicare billing number).
- A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.

# SUPPLIER STANDARDS

- Complaint records must include the name, address, telephone number, and health insurance claim number of the beneficiary; a summary of the complaint; and any actions taken to resolve it.
- A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
- All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).

# SUPPLIER STANDARDS

- All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
- All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
- All suppliers must disclose upon enrollment all products and services including the addition of new product lines for which they are seeking accreditation.
- A supplier must meet the surety bond requirements specified in 42 C.F.R. 424.57(c).
- A supplier must obtain oxygen from a state-licensed oxygen provider.

# SUPPLIER STANDARDS

- A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f)
- A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
- A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848 (j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.



# ALWAYS BE PREPARED

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- NSC Site Visits
- Prepare a notebook:
  - Copy of CMS-855S
  - Surety bond
  - Insurance
  - Equipment warranty
  - Rental purchase option
  - Inventory agreements

# NSC REVOCATIONS

- Supplier Audit and Compliance Unit (SACU):
  - 21-day letter
  - Revocation letter
- Corrective Action Plans:
  - 30 days to file
- Appeals:
  - Reconsideration Request:
    - request must be made within 60 days from the postmark of the letter issuing the initial determination
    - an on-the-record hearing before a Hearing Officer not involved in the initial decision to deny or revoke billing privileges.
- Administrative Law Judge Appeal

# MANAGE REVALIDATION RISK

- Check to see if your revalidation is due by using the CMS tool here:  
<https://data.cms.gov/revalidation>
- Failure to revalidate will revoke billing privileges and freeze Medicare payments.
  - The NSC will not accept revalidations received more than 7 months before the CMS posted revalidation date.
  - Pay the \$586 fee <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do#headingLv1>
  - Complete the online application through PECOS  
<https://pecos.cms.hhs.gov/pecos/login.do#headingLv1>
  - Confirm the NSC is processing your (revalidation) application  
[https://www4.palmettogba.com/ecx\\_nscast/](https://www4.palmettogba.com/ecx_nscast/)
  - Check back to ensure they do not need more information to complete processing.
- NSC application Status Tool:
  - [https://www4.palmettogba.com/ecx\\_nscast/](https://www4.palmettogba.com/ecx_nscast/)

# MANAGE LICENSURE RISK

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- The NSC maintains a State Licensure Directory that indicates known licensure requirements by product and state.
- The database includes contact information for the licensing agencies for clarification on detailed requirements and possible exemptions.
- Failure to keep up with state licensure requirements will result in PTAN revocation and will jeopardize competition bids.

# PAYMENT SUSPENSION INITIATIVES

- 42 CFR 405.371:
  - Reliable evidence of an overpayment; or
  - Credible allegation of fraud
  - Duration of 180 days and can be continued for additional 180-day periods.
- Most recent payment suspensions center around orthotic bracing.



# PAYMENT SUSPENSIONS: THE BASICS

- May be used if:
  - Reliable information that an overpayment exists (even if the amount is not determined)
  - Reliable information that the payments to be made may not be correct
  - Reliable information that a request for records or other essential information to determine the amounts due was not furnished
  - In the event of a credible allegation of fraud
- Two Types of Suspensions:
  - Fraud suspensions
  - General suspensions

# FRAUD SUSPENSIONS

- Examples:
  - Forged signatures or pattern of false documentation submitted
  - Law enforcement has subpoenaed records or executed a search warrant
  - Individual indicted by a federal grand jury for fraud or theft
- Process:
  - Inform the assigned Business Function Lead (BFL) of the potential suspension
  - Submit a suspension request via the Fraud Investigation Database (FID) to CMS Center for Program Integrity (CPI) for review and if approved, notice is sent
- Timing:
  - Up to 360 days
  - May go beyond 360 if DOJ or OIG submit a written request for extension

# GENERAL SUSPENSIONS

- Examples:
  - Reliable information an overpayment exists or that payments to be made may not be correct
  - Failure to furnish records or other information
- Process:
  - Similar to fraud suspensions
  - Requests discussed and sent to CPI and if approved, notice is sent
- Timing:
  - Up to 360 days only
  - Can continue beyond if transitions to a fraud suspension

# SUSPENSION EFFECTS ON MULTIPLE JURISDICTIONS

- If the same tax identification is used, suspensions apply to all jurisdictions where its used
- Doesn't matter if it is a general or fraud suspension
- The UPIC that requests is the lead contractor that informs the others, but all contractors can take administrative action in their respective jurisdiction
- Contractors are recommended to hold monthly calls to discuss their efforts and findings

# OPPORTUNITY FOR REBUTTAL

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- You receive a suspension notice. Now what?
  - No appeal rights
  - File a rebuttal:
    - Your opportunity to respond to a suspension decision
    - Rebuttal rights will be stated in the suspension notice
    - Must be submitted within 15 days (able to request an extension for more time to respond with good cause)
    - UPIC will consult with CPI and respond





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# QUESTIONS?

Email us at [auweb@achcu.com](mailto:auweb@achcu.com)



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# THANK YOU

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