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DMEPOS

Provider Enrollment – Current State of Affairs

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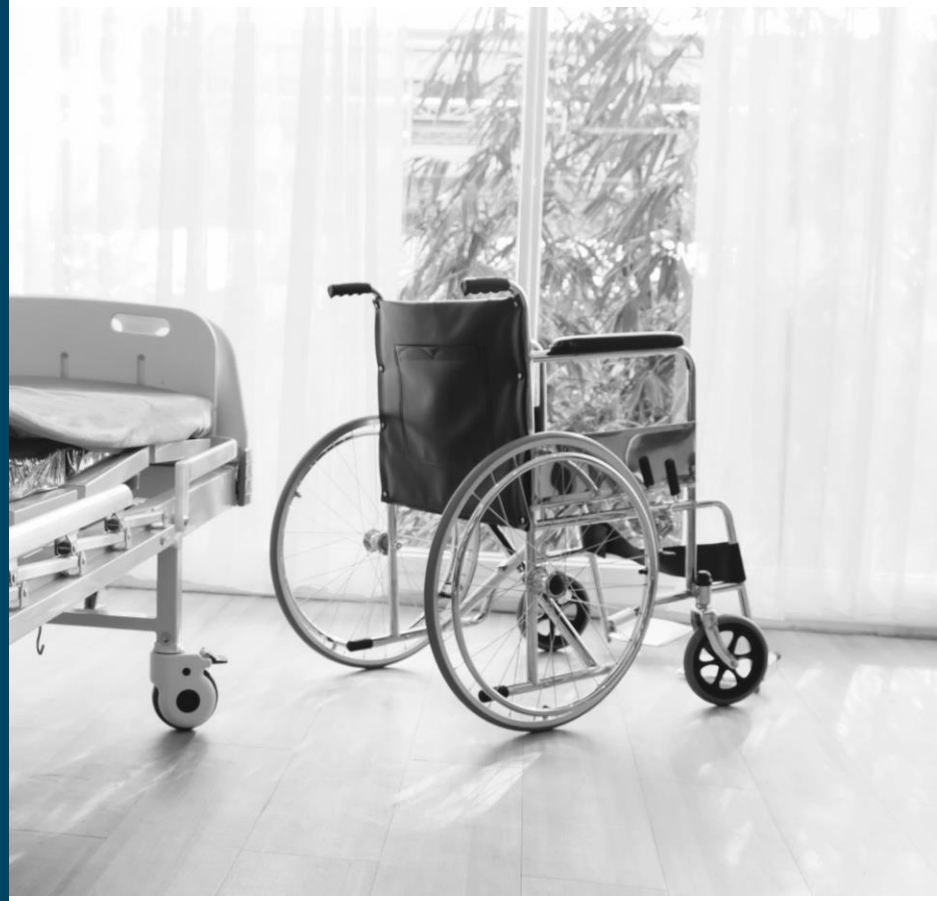

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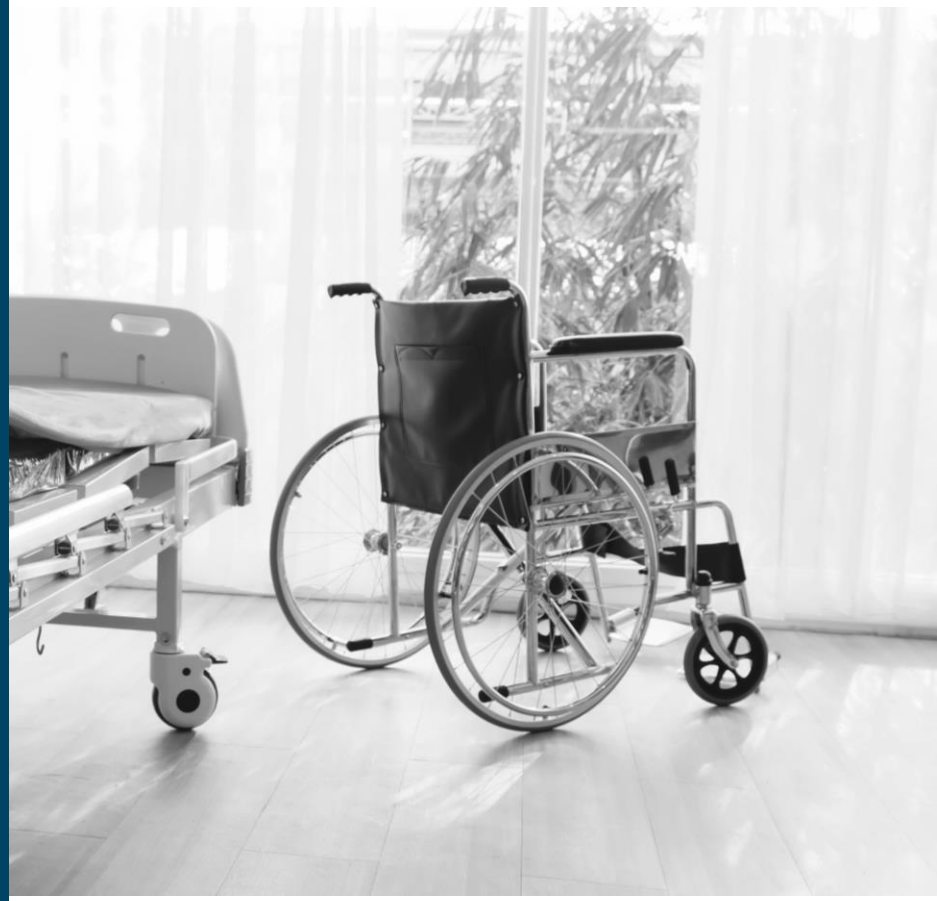
Learn the Lingo



Provider Enrollment Terms

- Corrective Action Plan (CAP): An opportunity for the provider/supplier to **correct the deficiencies** (if possible) that resulted in the denial or revocation of billing privileges
- Deactivation: Billing privileges were stopped but can be restored upon the submission of updated information
- Denial: The enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges for Medicare-covered items or services provided to Medicare beneficiaries
- Rebuttal: An opportunity for the provider or supplier to demonstrate that it meets all applicable enrollment requirements and that Medicare billing privileges should not have been **deactivated**

Provider Enrollment Terms

- Reconsideration: An opportunity for a provider/supplier to furnish evidence that demonstrates that there was **an error made at the time of the initial determination** affecting participation in the Medicare Program
- Re-Enrollment Bar: The length of time that a revoked provider or supplier must wait before they can re-enroll in Medicare
- Revocation: Termination of a provider's or supplier's billing privileges
- Stay of Enrollment: A preliminary, interim status representing a pause in enrollment
- Supplier Standards: Effective December 11, 2000, a list of requirements that DMEPOS suppliers must follow to obtain and retain billing privileges

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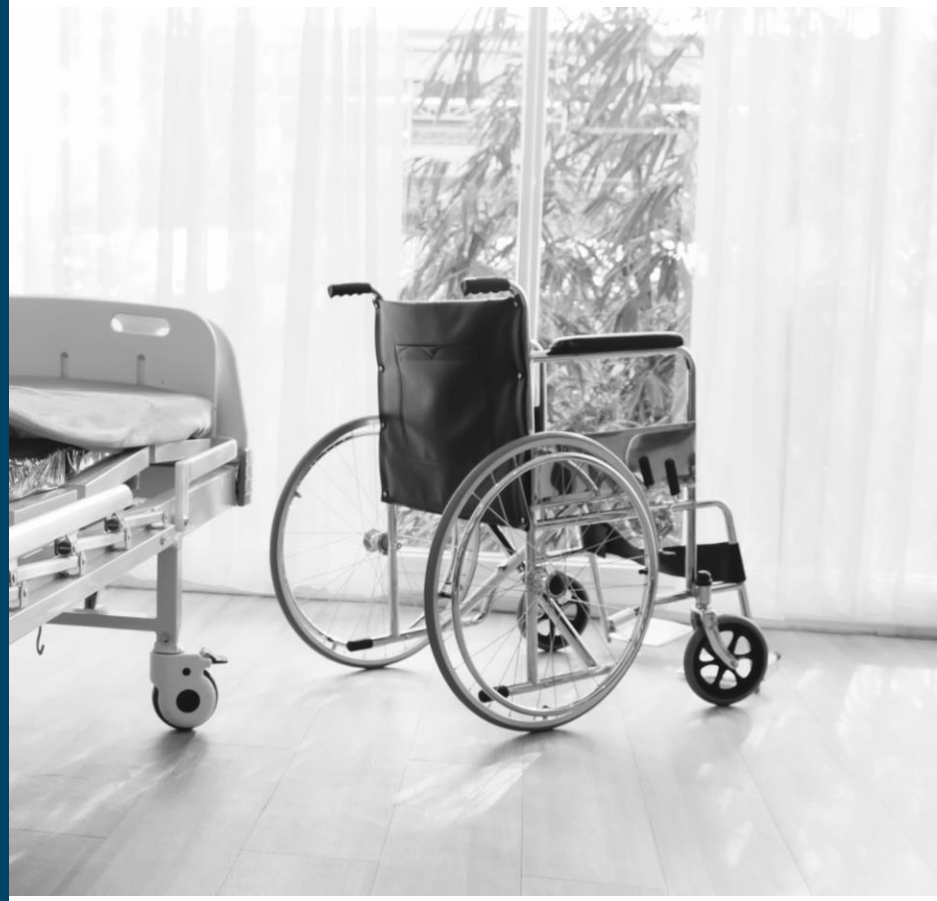
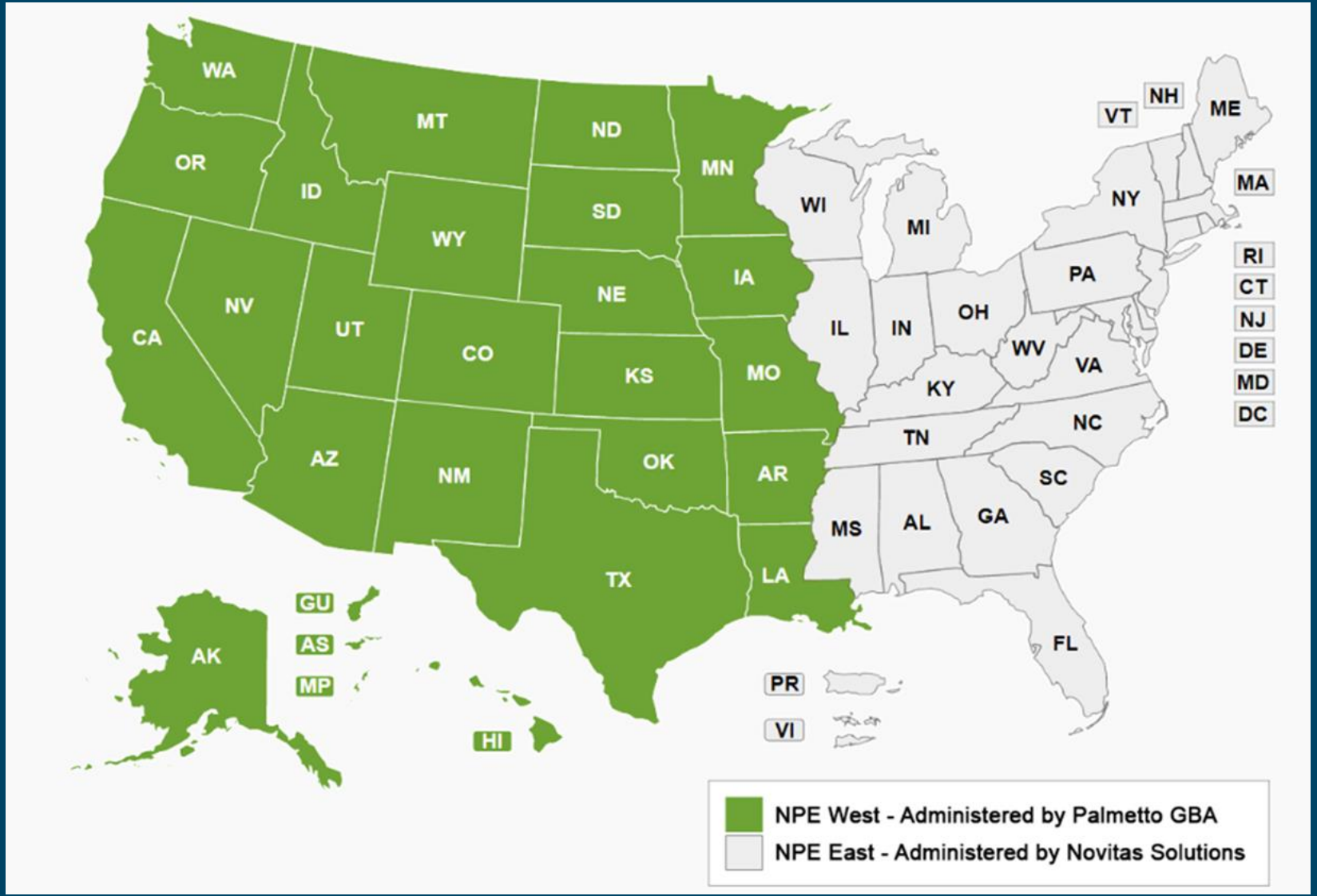


Introduction

From One to Five

- ONE
  - National Supplier Clearinghouse (NSC)
- FIVE
  - NPE East
  - NPE West
  - Palmetto GBA
  - Deloitte Consulting
  - C-HIT

NPE Contractors



Provider Enrollment Appeals & Rebuttals Contractor (PEARC)

- Effective October 9, 2023
- PEARC
  - Chags Health Information Technology, LLC (C-HIT)
- Responsible for processing all provider enrollment related appeals, including:
  - Corrective Action Plan
  - Reconsideration
  - Rebuttals

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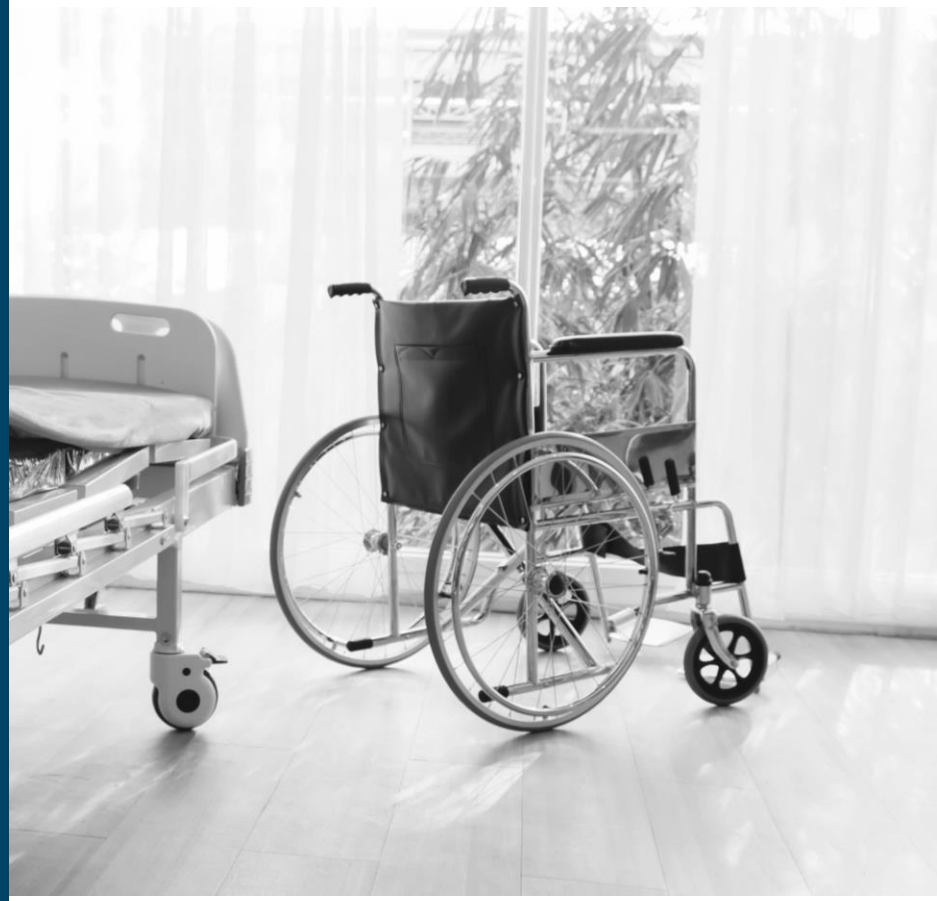
DMEPOS Supplier Standards



Medicare DMEPOS Supplier Standards

- Every Medicare DMEPOS supplier must meet Supplier Standards in order to obtain and retain billing privileges
- Site visits are conducted to ensure compliance with Standards
- Supplier Standards may be found at 42 CFR 424.57c
- Non-compliance can result in revocation
  - Delayed re-enrollment for a minimum of two years

Changes in Information

- A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days. (Standard 2)
  - Can be completed on CMS-855S and submitted with original signatures (stamped, faxed, or copied signatures not accepted) OR
  - Complete changes in PECOS (Provider Enrollment, Chain and Ownership System)

Examples of Changes in Information

- Changes in business location
- Adding/subtracting product lines
- Authorized/delegated official, contact persons
- Insurance or surety bond Information
- Address information
  - Remittance/special payments
  - Correspondence address

Authorized Official vs. Delegated Official

- Authorized Official
  - An appointed official (i.e. CEO, CFO, general partner, chairman of the board, or 5% or greater direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's enrollment information in the Medicare program, and commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

Authorized Official vs. Delegated Official

- What Can an Authorized Official Do?
  - Is the only individual that has the authority to sign the initial CMS-855S application
  - Agrees to notify the Medicare program contractor if any of the information on the application is incorrect or untrue
  - Agrees to notify the NPEast/NPWest of any changes within 30 days of the change
  - Is the only individual that can add and remove delegated officials

Authorized Official vs. Delegated Official

- Delegated Official
  - Delegated officials are persons who are delegated the legal authority by the authorized official to make changes to the supplier file. A delegated official must be a W-2 employee of the supplier or an individual with 5 percent or greater direct ownership interest in, or an individual with partnership interest in, the enrolling supplier. If the delegated official is the managing employee, this individual must be a W-2 employee; and the NSC may request proof this individual is a W-2 employee.

Authorized Official vs. Delegated Official

- What Can a Delegated Official Do?
  - Make changes or updates to the supplier file, such as address changes or the addition of a part owner
  - May also sign and submit the CMS-855S to enroll additional locations, revalidate or reactivate an existing supplier
- What a Delegated Official Cannot Do
  - May not delegate its authority to another individual
  - Only the authorized official may appoint someone as a delegated official
  - May not sign the initial CMS-855S application for the initial location

Insurance

- 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, this insurance must also cover product liability and completed operations. (Standard 10)
  - Must be kept up to date
  - Lapses in coverage can result in revocation retroactive to date the coverage lapsed

Common Errors with Insurance

- Policy on file with Provider Enrollment Contractor is expired
  - NPE East/NPE West is listed as the certificate holder and is notified if policy is canceled
- Certificate holder is listed incorrectly

NPE EAST	NPE West
Novitas Solutions, Inc. PO Box 3704 Mechanicsburg, PA 17055-1863	Palmetto GBA AG-495 P.O. Box 100142 Columbia, SC 29202-3142

Licenses

- A supplier must be in compliance with all applicable federal and state licensure and regulatory requirements (Standard 1)
  - DMEPOS State License Directory
  - Pay attention to expiration dates
  - Keep receipts of fees paid
  - Maintain system for tracking
    - Contact persons
    - Logins

Telephone

- 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. (Standard 9)
  - Use of cell phones, beepers, and pagers as the primary business telephone is prohibited
  - Exclusive use of answering machines and answering services as the primary telephone number during posted business hours is prohibited
  - Calls cannot be exclusively forward from the primary business telephone to cell phone or pager

Physical Location

- 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. (Standard 7)
  - Must have valid USPS address (i.e. Suite #)
  - Visible, in-plain-sight signage
  - All interested parties should be able to find your facility and your hours of operation through the use of these permanent signs without any assistance from you or other parties

Hours of Operation

- 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. (Standard 30)
  - The hours of operation indicate when a supplier is open and available
  - During these hours, a beneficiary, CMS or its agents should be able to visit the facility
  - Lunch hours should be posted along with the hours of operation – Recommend making updates on supplier file

Site Inspections

- A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. (Standard 8)
  - $2B Provider Enrollment and Oversight contract provides enrollment and screening support to help CMS detect and prevent fraud, abuse, and waste in Medicare and Medicaid programs
  - Inspection services under the task orders include visits to provider locations, internal site visits, and documentation of findings according to the statement of work
  - Site Visit Contractors
    - Deloitte Consulting (Western region)
    - Palmetto GBA (Eastern region)

Site Inspections – What to Expect

- Site visits are unannounced
- Take place during your posted hours of operation
- Suppliers in Alaska and Hawaii may have a virtual site inspection
- Inspector will have a camera to take various pictures of the facility, sign, inventory, etc.
- Questionnaire to be completed based on the Supplier Standards

Site Inspections – What to Expect

- Two attempts are made to complete a site visit
  - If the facility is still under construction, finds other obvious indications the facility is not a true operating location, or finds that there is no visible sign or office hours posted on first visit, a second attempt will not be made
  - NSC will be notified the site visit could not be completed
- If a site visit is refused or cannot be completed, the supplier is subject to the denial/revocation of Medicare billing privileges

Site Inspections – What to Expect

- Documentation
  - Any licensure required to operate the business
  - Insurance policy showing compliance with Supplier Standard 10
  - An acceptable IRS document
  - Copies of any contracts the supplier may have for inventory, instruction, or repair services
  - Complaint log and resolution protocol
  - Rent/purchase option notification
  - Proof of warranty coverage
  - Can request proof/documentation from any of the 30 Supplier Standards

Site Inspections
What Suppliers Are Saying

- Inspectors have not presented photo identification and/or a signed letter on CMS letterhead authorizing the individual to conduct the visit with them
  - If you are skeptical, call the NPE East/West for verification
- Contractors are not required to provide site inspection acknowledgement letters
  - May request via Freedom of Information Act

Solicitation

- A supplier is prohibited from direct solicitation to Medicare beneficiaries (Standard 11)
  - Prohibited from calling beneficiaries to solicit new business, and you may only contact your patients if one of these three criteria have been met
    - The beneficiary has given written permission to the supplier to make contact by telephone
    - The phone call is related to a covered item that is to be delivered and you are contacting the patient to coordinate the delivery
    - You have furnished at least one covered item to the beneficiary during the preceding 15 months

Solicitation

- Standard only restricts telephone contact as means of direct solicitation; it does not prohibit marketing via other methods
- Advertising by methods such as online, yellow pages, direct mail, and other electronic means of communication is permitted and not considered direct solicitation under this standard

Surety Bond – Reminders

- Must meet the surety bond requirements specified in 42 CFR 424.57(c). Implementation date – May 4, 2009 - Standard 26
  - Guarantees that a DMEPOS supplier will fulfill an obligation or series of obligations to a third party (Medicare program)
  - If obligation not met, third party will recover its losses via the bond
  - Must maintain a valid bond that is no less than $50,000
  - **Set a reminder to review bond coverage annually**
    - Keep in mind that surety bond companies notify the NSC when bonds cancel
    - This includes cancellations due to non-payment of premiums—sometimes up to 45 days before the payment is due
    - Avoid extra scrutiny and keep your bond up to date

Surety Bond

- If enrolling a new practice location, must submit to NPE a new surety bond or amendment or rider to existing bond showing the new location is covered by additional base surety bond of $50,000
- Some companies or organizations that supply DMEPOS are exempt from the surety bond requirements. Such exemptions include
  - Certain physician and non-physician practitioners
  - Physical therapists
  - Occupational therapists
  - State-licensed orthotic and prosthetic personnel
  - Government-owned suppliers
- Please note that all pharmacies are required to submit a surety bond. Pharmacies are not exempt from the surety bond requirement

Revalidation

- Resumed Oct/Nov 2021
  - Was on hold for part of PHE
  - CMS/NSC phasing in revalidation letters for suppliers that missed revalidation due to date falling within the PHE waiver
- Suppliers are required to revalidate every three years
- CMS selects and establishes due dates by which providers and suppliers are required to revalidate
- Lookup tool (https://data.cms.gov/revalidation) for due dates
- The supplier will receive a revalidation letter prompting them to update information in PECOS

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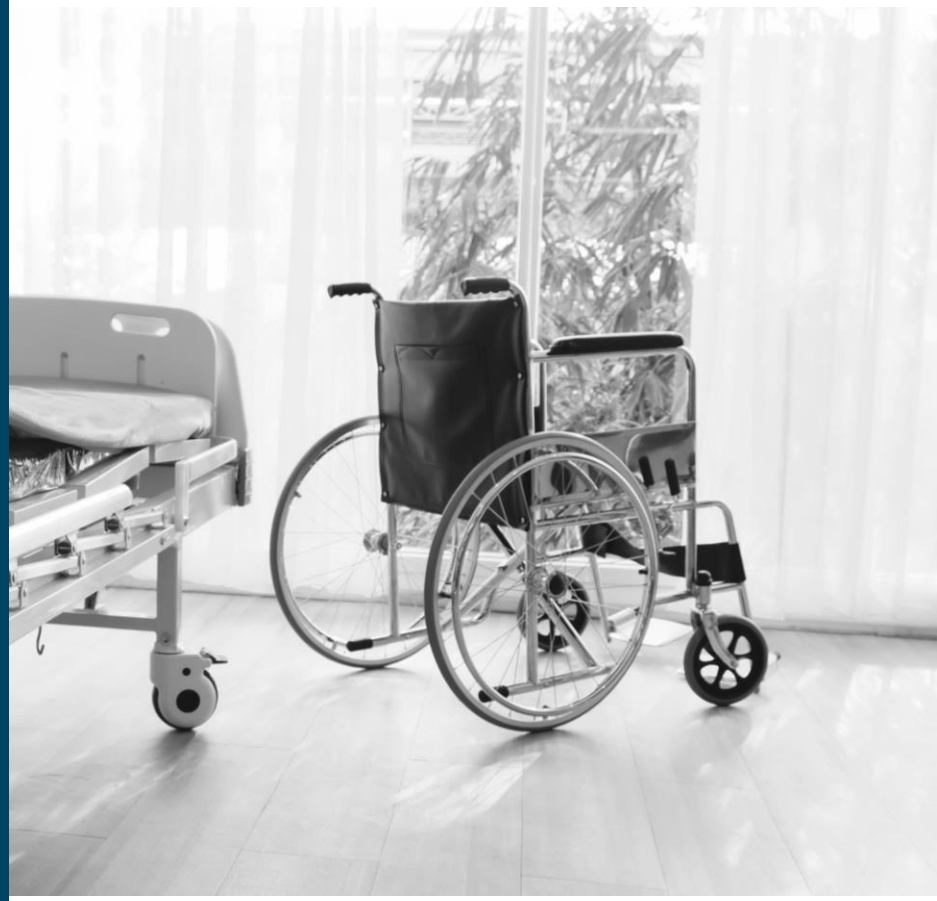
What's New?



Revocation Authority

- 42 C.F.R. § 424.535(a) – Revocation of enrollment in the Medicare program
- CMS may revoke a currently enrolled provider or supplier's Medicare enrollment and any corresponding provider agreement or supplier agreement for the reasons provided under § 424.535(a)(1) – (23)

Updated Provider Enrollment Requirements

- Effective January 1, 2024
- CMS made updates/changes to several regulatory provisions regarding Medicare and Medicaid provider enrollment. These include, but are not limited to, the following:
  - Established several new and revised Medicare denial and revocation authorities
  - Creation of a new Medicare provider enrollment action labeled a “stay of enrollment”

Noncompliance

- 42 C.F.R. §424.535(a)(1)
- The provider or supplier has violated an enrollment requirement listed on the application it/he/she uses for enrollment purposes (e.g., CMS-855S)

CMS Clarifies Intent

- Revocation under §424.535(a)(23) reserved for issues not remedied with update to enrollment record. Examples include:
  - Solicitation to beneficiaries (Supplier Standard 11)
  - Violation of DMEPOS Quality Standards (i.e. accreditation revoked)

Stay of Enrollment

- A stay of enrollment (or “stay”) is a preliminary, interim status representing a pause in enrollment
- A CMS action that’s less burdensome on providers and suppliers than a deactivation or revocation of your Medicare enrollment
- Two-step process in which
  - the provider is non-compliant with at least one Medicare enrollment requirement that
  - could be remedied by submitting the appropriate CMS form, to include the CMS-855S enrollment application or CMS-588 EFT authorization agreement
- Likely used for non-response to revalidation requests

Stay of Enrollment

- You remain enrolled in Medicare during the stay
- Your MAC will reject claims you submit with dates of service within the stay period
- Your stay of enrollment lasts no longer than 60 days
- CMS can impose a stay of less than 60 days
- A stay ends on the earlier of the following dates:
  - The date on which we or your contractor decides you resume compliance with all Medicare enrollment requirements
  - The day after the imposed stay period expires

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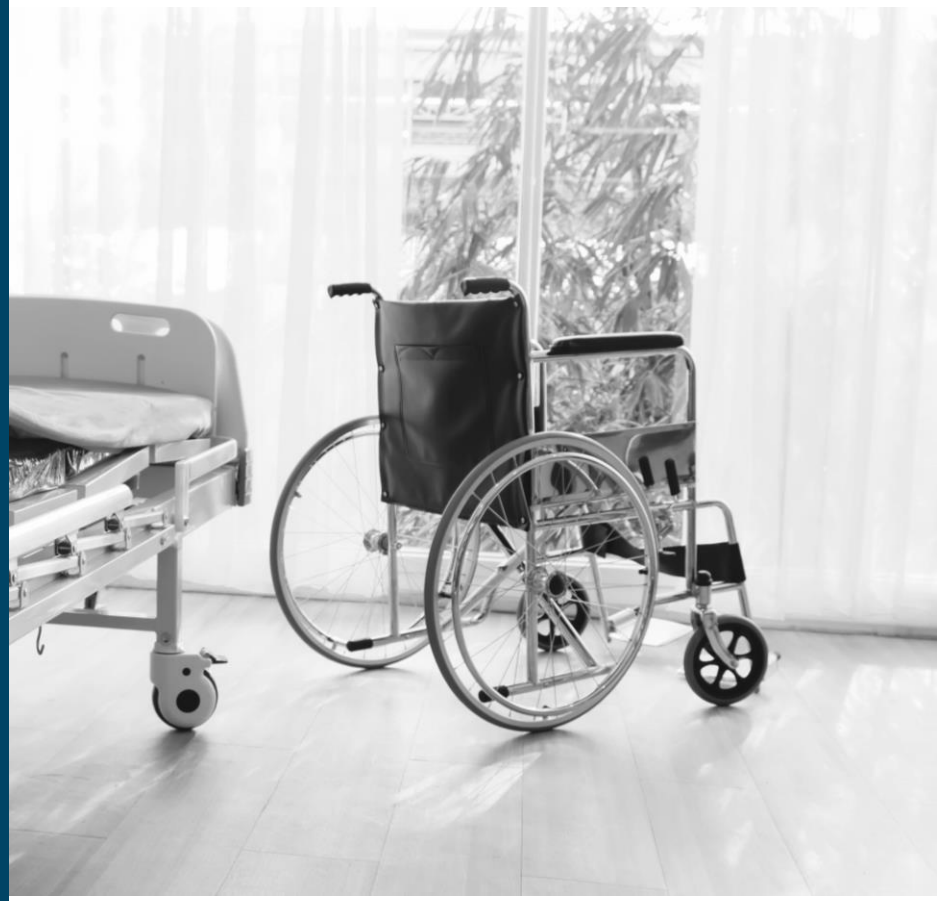
Resolving the Issues



Corrective Action Plan (CAP)

- Must be submitted within 35 days of revocation
- Must contain verifiable evidence that the provider/supplier is in compliance with Medicare requirements
- Must be submitted in the form of a letter that is signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative
- When submitting a CAP, a provider or supplier has only one opportunity to correct all deficiencies that served as the basis of the initial determination

Corrective Action Plan (CAP)

- A decision will be issued within 60 days of receipt of the CAP
- If favorable, PTAN will be reinstated with an effective date retroactive to the date of the license suspension or revocation
- The denial of a CAP is not an initial determination and does not give rise to further appeal rights

Reconsideration

- A reconsideration request is an opportunity for a provider/supplier to furnish evidence that demonstrates that there was an error made at the time of the initial determination affecting participation in the Medicare Program
- Must be submitted within 65 days from the date of the initial determination
  - **IMPORTANT: Not 65 days from the CAP decision!!**
- Request must state the issues or the findings of fact with which you disagree and the reasons for disagreement
- The request must have the signature of the authorized official, owner, or partner on file

Reconsideration

- A reconsideration request is specifically for an on-the-record hearing before a Hearing Officer not involved in the initial decision to deny or revoke billing privileges
- Should include all written evidence and statements that are relevant to the basis for the initial determination. Unless an ALJ allows it, this is the only opportunity to submit new documentary evidence in the administrative appeals process

Reconsideration

- A decision will be issued within 90 days of receipt of the reconsideration request
- If favorable, PTAN will be reinstated with an effective date retroactive to the date of the license suspension or revocation
- If unfavorable, a hearing before an ALJ may be requested

Administrative Law Judge (ALJ) Hearing

- Any provider or supplier that disagrees with a reconsideration decision is entitled to a hearing before an ALJ
- The provider or supplier must file the request in writing within 60 days from receipt of the notice of the reconsideration decision
- The request for an ALJ hearing must
  - Identify the specific issues and the findings of fact and conclusions of law with which the provider or supplier disagrees and
  - Specify the basis for contending that the findings and conclusions are incorrect
- The ALJ must issue a written decision or dismissal order or remand to CMS

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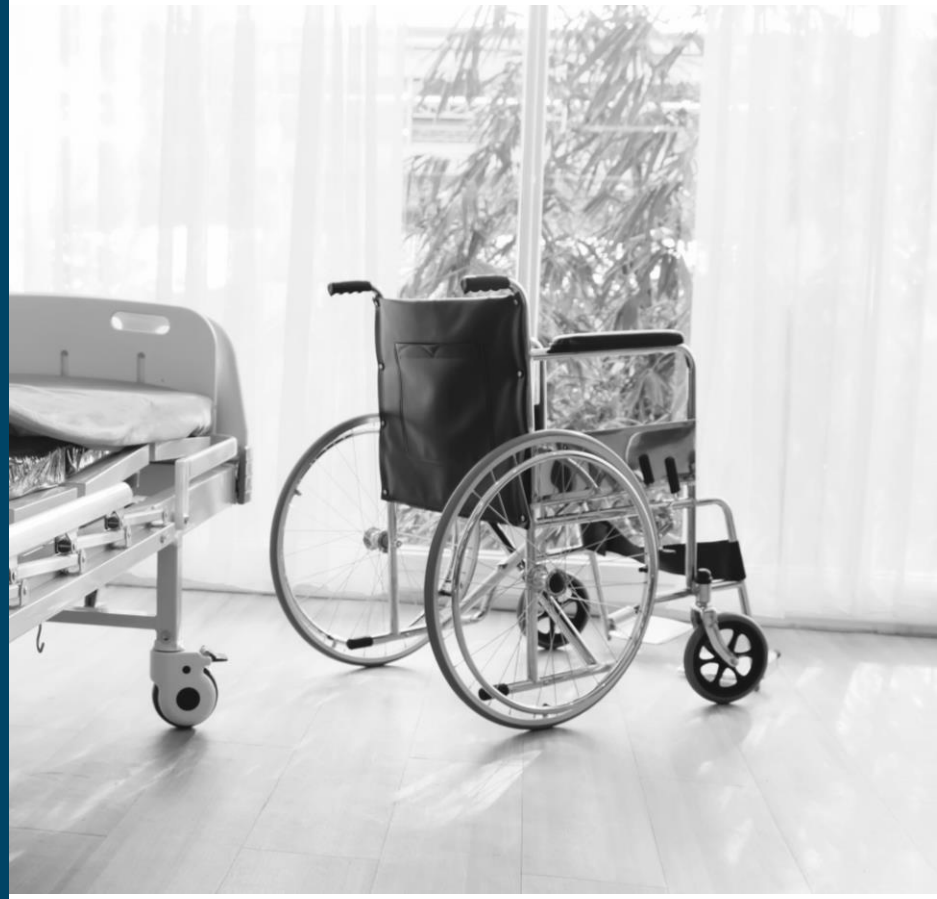
Anything Else?



Rebuttals

- 42 CFR §424.540(a)
- A provider or supplier whose Medicare billing privileges have been deactivated may file a rebuttal
- A rebuttal is an opportunity for the provider or supplier to demonstrate that it meets all applicable enrollment requirements and that Medicare billing privileges should not have been deactivated
- The deactivation letter will list where to submit your rebuttal
- A decision will be rendered within 30 days of receipt of a valid rebuttal

Rebuttals

- Must be submitted within 15 calendar days from the date of the deactivation notice
- May be mailed, emailed, or faxed
- Must specify the facts or issues with which the provider/supplier disagrees, and the reason for the disagreement
- Should include all documentation and information the provider/supplier would like to be considered in reviewing the deactivation
- Must be in the form of a letter that is signed and dated by the provider, authorized/delegated official, or a legal representative
- Rebuttal decisions are final and are not offered further rebuttal rights or appeal rights

EFT Requirement

- CMS is reporting they still have many DME providers that do not have an EFT on file and are being paid by check
- Letters will be sent out in Spring 2024 to force these suppliers to complete the CMS-588 EFT form
- Failure to respond with a completed CMS-588 form within 90 days will result in a deactivation of the PTAN

EFT Precertification Process

- EFT information is subject to a pre-certification process in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made
- This occurs for the jurisdiction(s) in which the EFT information was sent
- During the pre-certification process, all payments will be held in that jurisdiction(s), and no paper checks will be issued
- Pre-certification takes approximately 14 business days (this excludes holidays and weekends) after approval of the application
- If any payments are held, they will begin to release within three to four business days after successful pre-certification occurs. f a supplier's current EFT information is missing from any of the four DME MAC jurisdictions
- Any change to EFT banking information (additions or updates) will result in a precertification

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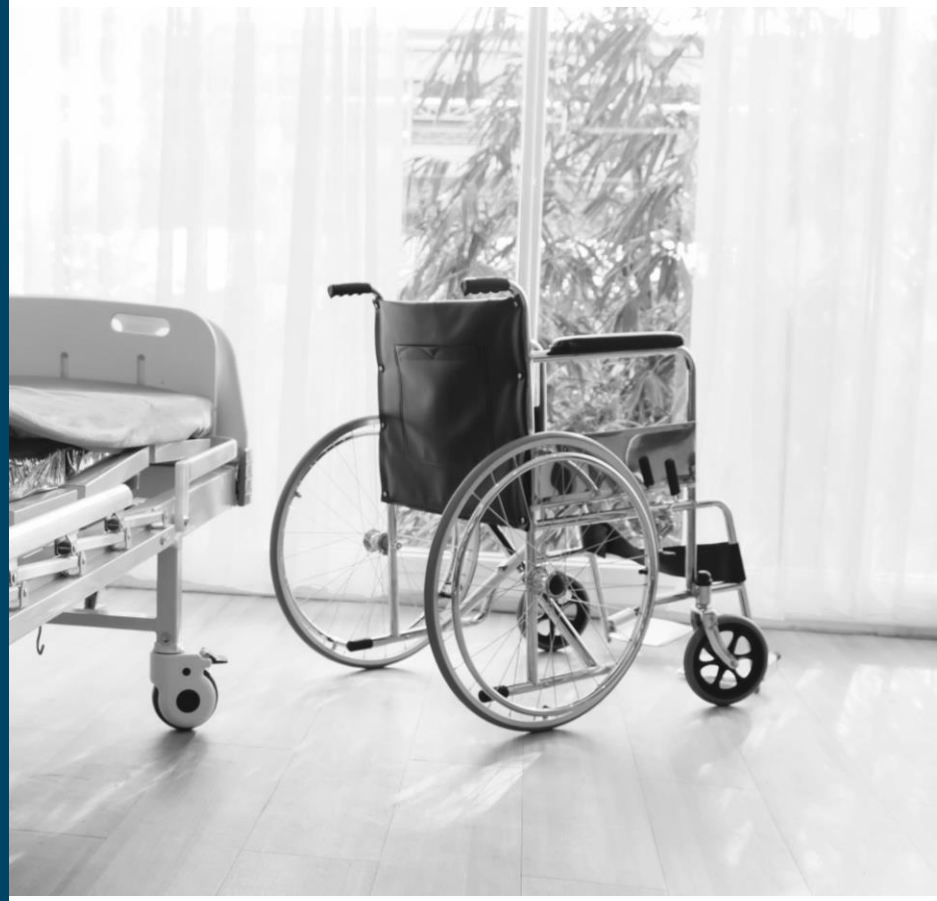
Best Practices



Best Practices

- Managing enrollment and licensure is a component of compliance
- Be proactive
- Develop managing and tracking system for licenses, insurance expiration and other date-driven items
  - Include contact persons and logins
- Don’t navigate issues alone – consider the help of consultants and/or counsel, mistakes can cost you!

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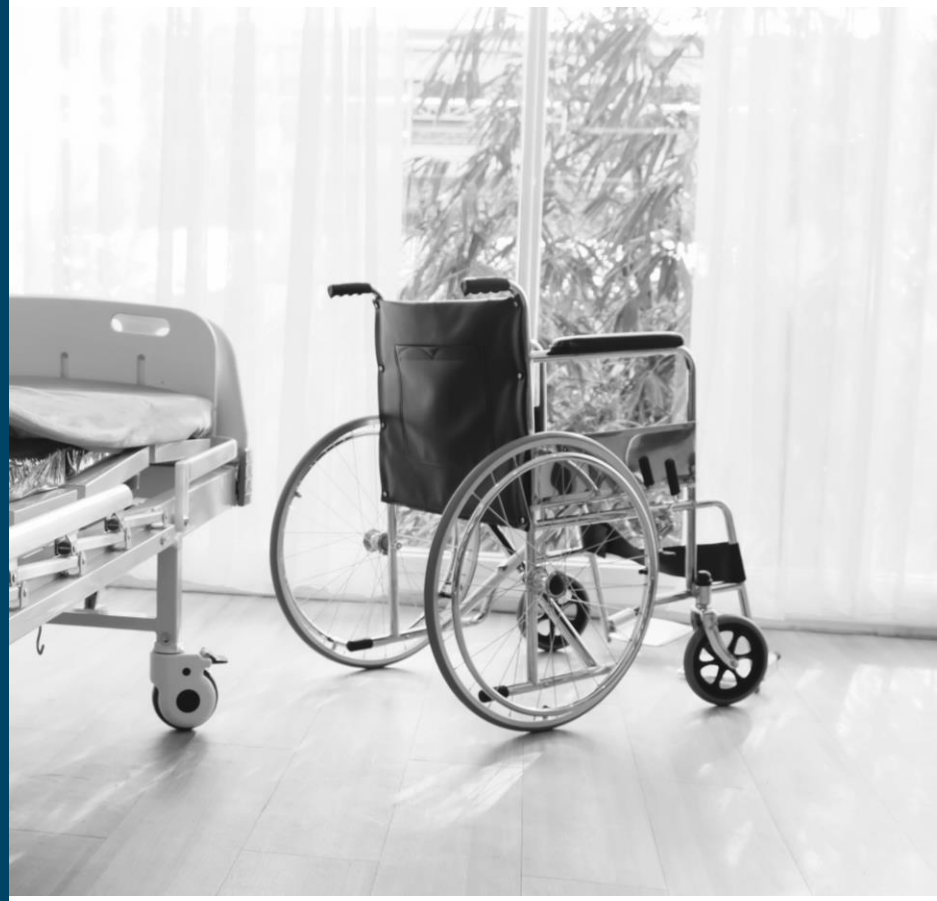
Questions?



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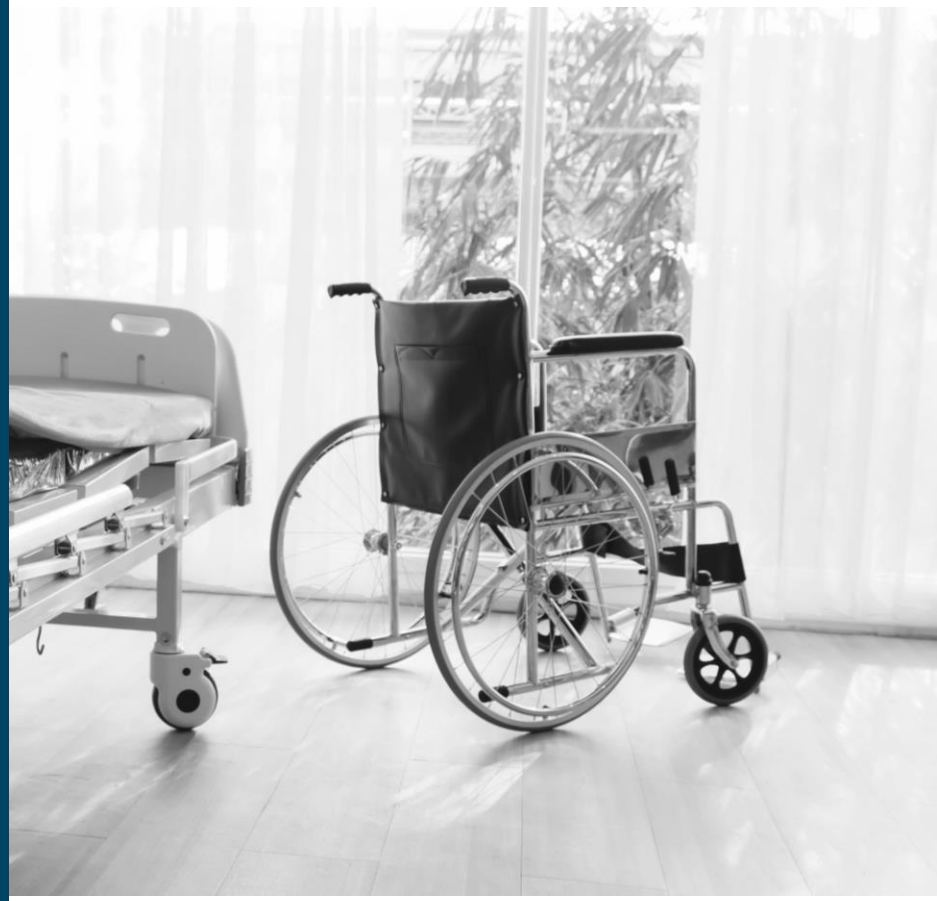

Thank you

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