Medicare Learning Network
MLN Matters
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – The Medicare Patients and Providers Act (MIPPA) of 2008 section 154(b) provides that eligible professionals and other persons are exempt from meeting the *September 30, 2009* accreditation deadline that generally applies to other DMEPOS suppliers unless the Centers for Medicare & Medicaid Services (CMS) determines that the quality standards are specifically designed to apply to such professionals and persons. The eligible professionals to whom this exemption applies includes Physicians, Physical Therapists, Occupational Therapists, Qualified Speech-Language Pathologists, Physician Assistants, and Nurse Practitioners. Additionally, section 154(b) of MIPPA allows the Secretary to specify "other persons" that, like the eligible professionals described above, are exempt from meeting the accreditation requirements unless CMS determines that the quality standards are specifically designed to apply to such other persons. At this time, Medicare is defining "such other persons" as Orthotists, Prosthetists, Opticians, and Audiologists.

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Related CR Transmittal #: R280PI
Implementation Date: February 2, 2009

Incorporation of Recent Regulatory Revisions Pertinent to Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Provider Types Affected

Suppliers submitting claims to Medicare contractors (DME Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is informational in nature and based on Change Request (CR) 6282 which incorporates recent regulatory changes and applicable instructions for the National Supplier Clearinghouse – Medicare Administrative Contractor (NSC-MAC) into the Medicare Program Integrity Manual (Chapter 10 (Healthcare Provider/Supplier Enrollment)).

Background

The Medicare Program Integrity Manual (Chapter 10) specifies the procedures Medicare fee-for-service contractors must use to establish and maintain provider and supplier enrollment in the Medicare program. Change Request (CR) 6282 incorporates National Supplier Clearinghouse – Medicare Administrative Contractor (NSC-MAC) instructions into the Medicare Program Integrity Manual, Chapter 10 (Healthcare Provider/Supplier Enrollment), Section 21 (Special Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Instructions).

These NSC-MAC instructions evolved from recent regulatory revisions regarding the following topics:

- The timeframe in which providers and suppliers must furnish developmental information to the NSC-MAC;
- Effective dates of certain types of revocations;
- Alert codes; and
- Accreditation.

A complete description of these NSC-MAC instructions/topics is included as an attachment to CR 6282, and the following provides a summary:

1) The timeframe in which providers and suppliers must furnish developmental information to the contractor

A Medicare contractor (including the NSC-MAC) may reject a provider/supplier's application if the provider/supplier fails to furnish complete information on the enrollment application, including all supporting documentation, within 30 calendar days from the date of the contractor's request for the missing information or documentation.

The 30-day clock starts on the date the pre-screening letter was sent to the provider/supplier. If the contractor makes a follow-up request for information, the 30-day clock does not start anew; rather, it keeps running from the date the pre-screening letter was sent. To illustrate, suppose that the contractor sent out a pre-screening letter on March 1 (thus triggering the 30-day clock) that asked for clarifying information in Sections 4 and 5 of the CMS-855B. (All supporting documentation was provided.) The provider sent in most, but not all of the requested data. Though not required to make an additional contact beyond the pre-screening letter, the contractor telephoned the provider on March 20 to request the remaining missing data. The provider failed to respond. The contractor can reject the application on March 31, which is 30 days after the initial request.

2) Effective dates of certain types of revocations

A revocation is effective 30 days after the Centers for Medicare & Medicaid Services (CMS) or the Medicare contractor (including the NSC-MAC) mails the notice of its determination to the provider or supplier. However, a revocation based on a Federal exclusion or debarment is effective with the date of the exclusion or debarment. In addition, if the revocation was due to the revocation or suspension of the provider/supplier's license or certification to perform Medicare services, said revocation can be made retroactive to the date of the license suspension/revocation.

3) Alert codes

The NSC-MAC will receive and maintain "alert indicators" based on findings from the DME-MACs as well as on information received from Medicare's Program Integrity contractors.

4) Accreditation

The NSC-MAC will follow the accreditation requirements in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Individual medical practitioners, inclusive of group practices of same, will not currently require accreditation for enrollment. The practitioner types are those specifically stated in Sections 1848(K)(3)(B) and 1842(b)(18)(C) of the Social Security Act as Amended. In addition, the practitioner categories of physicians, orthotists, prosthetists, optometrists, opticians, audiologists, occupational therapists, physical therapists and suppliers who provide drugs and pharmaceuticals (only) will not currently require accreditation for enrollment.

Suppliers that fall in this subset who provide other durable medical equipment outside of their specialty are required to be accredited to bill Medicare as a DMEPOS supplier. DMEPOS companies that are owned by any exempted individuals are NOT exempt from accreditation. For example, physicians are exempt from accreditation requirements for supplies they provide to their physician practice patients; however, if a physician owns a DMEPOS company, that company is NOT exempt from accreditation. Similarly, suppliers that provide only drugs and pharmaceuticals are exempt from the accreditation requirement; however, if the supplier provides equipment to administer drugs or pharmaceuticals, the supplier must be accredited.

If a previously exempted supplier enrollment application was returned for non-accreditation, the supplier must resubmit its CMS 855S Medicare enrollment application to the NSC to obtain/maintain Medicare billing privileges.

Additional Information

The official instruction, CR 6282, issued to your DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R280PI.pdf* on the CMS website.

If you have any questions, please contact DME MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.