

In This Issue

Page 2

- Reactivation After Deactivation
- The Competitive Bidding Corner
- Oxygen Suppliers Exiting the Medicare Program

Page 3

- The Appeals Process

Page 4

- The Revised EFT Agreement
- Preparing for Site Inspections
- Your Opinion Matters

Page 5

- Billing News You Can Use From the DME MACs

Page 6

- Ask Wendell
- Online Application Status Tool

Page 7

- Who's Exempt from Accreditation
- Tips for Quality Customer Care

Page 8

- Contact Information
- Listserv QR Code



From the Desk of the Director: Nancy C. Parker

The Ball has dropped, corks have popped, and we've all probably joined in for a rousing rendition of Auld Lang Syne or some semblance of it. Twenty-fourteen has arrived and much

like last year, we offer a commitment of excellence by responding to the growing needs of the DMEPOS supplier community with strengthened relationships, better customer care, and enhanced methods of communication. It is our goal to provide you with a seamless enrollment process while adhering to the rules, procedures and policies as outlined by CMS and federal regulations. With this in mind, we encourage you to stay abreast of the current enrollment standards and make every effort to remain in compliance with them at all times. There are a number of tools readily available for your use. You can register for the NSC Listserv to get timely, accurate information. Maintain required licensure by routinely reviewing the database housed on the NSC Website. There's on-line web chat, the application status tool and let's not forget to listen for automated development reminder calls when there is outstanding information owed to the NSC for pending in-house documents. Take a moment to read *NSC News* for a broad array of comprehensive enrollment information. Review the opinion poll and give us your feedback. It's a new and exciting year. Let's all resolve to be better about our business!

2014 Medicare Enrollment Fees Announced

Section 6401(a) of the Affordable Care Act (ACA) requires the secretary to impose a fee on certain Medicare suppliers. The fee is to be used by the secretary to cover the cost of program integrity efforts including the cost of screening associated with provider enrollment processes, including those under section 1866(j) and section 1128J of the Social Security Act. The application fee is \$542 for CY2014 and can be submitted by debit card, credit card or electronic check through the Internet-based PECOS system. All suppliers completing the CMS-855S enrollment application or presenting enrollment information via Internet-based PECOS are subject to the fee for the following:

- New locations
- Additional locations
- Revalidations
- Reactivations

Applications will not be processed until funds are cleared. For additional information, read the MLN Matters Article that can be found on the CMS Website outlining specific details of the rule.

Reactivation After Deactivation

There are a number of reasons why a supplier's billing privileges may be deactivated:

- Not billing for reimbursement within four consecutive quarters;
- Do Not Forward (DNF) alert initiated by one of the DME MAC billing jurisdictions
- Non- response to a revalidation request
- Non- response to a development request

Typically, the onset of a deactivation will prompt an excess of calls to NSC customer service seeking the most expeditious manner of reactivation. The NSC processes all applications and reactivations in the order in which they are received. Of all applications submitted, we see upwards of **75%** that require some level of development. Often, suppliers are over-anxious to get their reactivation in the queue and inadvertently overlook key sections or fail to send in pertinent documents, thus negating swift submission. Suppliers are reminded to employ the basic practice of looking before you leap when submitting information to the NSC. Ultimately, once processed, billing privileges are reinstated with a retroactive effective date if compliant. If deactivated for non-billing or if billing privileges were voluntarily terminated, the effective date will be based on the completion of the reactivation process.

The Competitive Bidding Corner

Contract Supplier Reminders- From the CBIC

If you wish to change your Authorized Official (AO) or add/remove your Backup Authorized Official (BAO) to another AO, update contact information for your AO or BAO (e-mail or telephone number), or add/update a toll-free number for the www.Medicare.gov/SupplierDirectory website -- please complete and submit The Contract Supplier Change of Information Form to the CBIC

(<https://www.dmecompetitivebid.com/secure/cbicsecure.nsf/COIContact>). It is not necessary to notify the CBIC of a change of address or non-toll-free telephone number. This information is obtained from PECOS.

If you wish to add or remove a location(s) from your contract, please complete and submit the Contract Supplier Location Update Form to the CBIC (<https://www.dmecompetitivebid.com/secure/cbicsecure.nsf/COI>).

If you enter into a subcontracting agreement, you must notify the CMS within 10 business days after the date you enter into a subcontracting arrangement. Please complete and submit the Subcontractor Disclosure Form to the CBIC (<https://www.dmecompetitivebid.com/secure/cbicsecure.nsf/SubConDisc>). As a reminder, a subcontractor may only perform the following functions on behalf of a contract supplier: purchase of inventory, delivery and instruction, and repair of rented equipment. No other services may be provided by the subcontractor.

Oxygen Suppliers Exiting the Medicare Program

A supplier exiting the Medicare oxygen business with oxygen patients who they are unable to transfer to new suppliers are in violation of their regulatory and statutory obligations. Section 1834(a)(5)(F)(ii)(I) of the Social Security Act as amended requires that an oxygen supplier that received the 36th month rental payment continue furnishing the oxygen equipment during any period of medical need for the remainder of the equipment's reasonable useful lifetime. Further, the regulation at 42 Code of Federal Regulations Section 414.226(g)(1) requires, barring a few exceptions, that the supplier that furnishes oxygen equipment in the first month during which payment is made must continue to furnish the equipment for the entire 36-month period of continuous use, unless medical necessity ends.

Appeals Process

When billing privileges have been denied or revoked, the applicant/supplier has two options available to contest the determination. The applicant/supplier in most instances may submit a Corrective Action Plan (CAP) or submit a request for reconsideration. When submitting your request, please keep in mind the following:

- The applicant/supplier must submit a CAP within 30 days from the postmark of the denial or revocation letter
- The request for reconsideration must be made within 60 days from the postmark of the denial or revocation letter
- The request must have the original signature of the authorized official, owner or partner on file

Note: According to Pub 100-8, Chapter 15, Section 25, a provider or supplier that is denied enrollment in the Medicare program or whose billing privileges have been revoked cannot submit a new enrollment application until the following has occurred:

- If the denial was not appealed, the provider or supplier may reapply after its appeal rights have lapsed
- If the denial was appealed, the provider or supplier may reapply after it has received notification the determination was upheld
- If the revocation is not overturned and all appeal options are exhausted, the supplier must wait the enrollment bar as specified in the revocation letter.

When a CAP Won't Fit

Pursuant to 424.535(a)(5), if CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients. Upon on-site review, CMS determines that—

Provider or supplier conduct. The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is—

(i) Excluded from the Medicare, Medicaid, and any other Federal health care program (ii) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement program or activity;

Felonies. The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries;

On-site review. CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients. Upon on-site review, CMS determines that the supplier is non-operational.

When revoked for the aforementioned reasons, the supplier's only recourse is to submit a reconsideration request. More specific detail can be found at 424.535(a) (1), (a) (2), (a) (3), and (a) (5).

The REVISED 588 EFT Form

The Office of Management and Budget recently approved changes to the CMS 588 - Electronic Funds Transfer (EFT) Authorization Agreement. The Centers for Medicare & Medicaid Services (CMS) has placed the revised agreement on the CMS' form search page. Any newly submitted CMS 588 applications should be submitted on the current version of the CMS 588 (09/13).

**EFTs for new locations may be submitted to the NSC along with the 855S application or via Internet-based PECOS. All other EFTs should be sent to the DME MAC billing jurisdictions.*



You've done your research, gathered your licenses and other key forms, become accredited, remitted your enrollment fee, submitted your application to the National Supplier Clearinghouse and now anxiously awaiting the issuance of your Medicare DMEPOS PTAN. Just when you're starting to feel a moment of relief, you realize that there is yet another step in the process—receiving an onsite inspection and review. Normally, investigators conduct either full or observational assessments on DMEPOS suppliers' facilities with the results guiding the determination of an applications' approval or denial, reactivation or revocation. Suppliers adhering to regulations as prescribed in the current supplier standards should not be alarmed upon receipt of an arbitrary site inspection as this is well within the normal scope of the NSC. Generally, the inspector enters the facility, snaps photos of inventory and space, reviews file maintenance and record keeping, and looks over licensure and other required documents. It is important a knowledgeable staff member be made available to answer any questions or direct the reviewer to designated areas where Medicare related information is kept. A site visit acknowledgement form must be signed verifying the inspection was completed. Then your application is processed and barring any infractions, your PTAN will be assigned--Mission Accomplished!

Your Opinion Matters: Did you know there have been significant enhancements made to Internet-based PECOS since its initial implementation? The process is now 100% electronic comprised with an electronic signature feature and the digital upload of key documents. Have you had an opportunity to submit enrollment information via PECOS? Tell us what **you** think. Do you favor electronic or hard copy submission? Send your comments to Medicare.NSC@PalmettoGBA.com with a subject line: **My Opinion Matters**. Comments will be accented until February 28, 2014.

Billing News You Can USE—From the DME MACs

Enforcement of the Detailed Written Order Prior to Delivery and National Provider Identifier Requirements for Dates of Services on or after January 1, 2014

Section 6407 of the Affordable Care Act was implemented on July 1, 2013, established a face-to-face encounter requirement and a detailed written order prior to delivery containing the prescribing practitioner's NPI for certain DME items listed in Medicare Learning Networks Matters Article, "[MM8304 Revised – Detailed Written Orders and Face-to-Face Encounters](#)." While active enforcement of the face-to-face requirements has been postponed until a future date to be announced by the CMS in Calendar Year 2014, the delay **does not impact** provisions related to detailed written orders prior to delivery. The four DME MACs began enforcement of the written order prior to delivery requirement for dates of service on or after January 1, 2014.

Failure to obtain a valid detailed written order prior to delivery (which includes the prescribing practitioner's NPI) will result in the item being denied as excluded by statute.

Suppliers who have questions about detailed written orders prior to delivery and what is required in order for the detailed written order to be considered valid should contact their local DME MAC.

Claim Denials due to PECOS Phase 2 Edits

Effective January 6, 2014, CMS turned on the Phase 2 ordering/referring denial edits. This means that Medicare will deny DMEPOS claims if the ordering/referring physician is not identified, not enrolled in PECOS or not of a specialty type that may order/refer the service/item being billed.

Suppliers should refer to Medicare Learning Networks Matters Article SE1305 "[Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency \(HHA\) Claims \(Change Requests 6417, 6421, 6696, and 6856\)](#)" for complete information.

Join the Medicare Contractors at Upcoming National Events!

The **4th Annual POWER Symposium** will be held from March 6 – March 9, 2014 at the Gaylord Opryland Resort & Convention Center in Nashville, Tennessee. A half-day session will be offered on March 6, 2014 from 12:00pm – 4:00pm.

The **Medtrade Exposition** will be held from March 10-12, 2014 at the Mandalay Bay Convention Center in Las Vegas, Nevada.

Make sure to visit the Medicare Contractors in **booth # 643**.

Join the Medicare Contractors for a CERT Update and open Q & A on Wednesday, October 9th from 10:30am – 11:30am.

The **National Home Infusion Association (NHIA) Annual Conference** will be held from March 31 – April 3, 2014 at the Rosen Shingle Creek Resort in Orlando, Florida. Make sure to visit the Medicare Contractors at **booth #118**.

Join the Medicare Contractors at the round table sessions held April 1, 2014 from 5:00pm – 6:30pm and April 2, 2014 from 4:15pm – 5:45pm.

ASK WENDELL



Q. Can I use the PTAN for my main location to bill all other locations?

A. No. Each location where Medicare beneficiaries are served must be assigned an individual PTAN. All claims can be submitted from one location; however, the PTAN of the location where services were rendered must be reported on the claim form.

Q. Can I file claims to Medicare while my change of ownership is being processed?

A. Suppliers should NOT file claims until the change of ownership has been completely processed and they have been notified by the NSC. There are some instances where a seller/buyer unknowingly enters into an agreement that is not wholly compliant and they are not able to receive reimbursement for dates of service during that timeframe. Normally, with a valid sales agreement and evidence of meeting all supplier standards at the time of the sale, billing privileges will be made retroactive once compliance is shown.

**Remember, submitting an application does not guarantee billing privileges.*

Q. If I initially submitted an application along with the fee in 2013 but it was closed because I did not send all of my information that was requested, when I resubmit my application this year, can I send the 2013 fee?

A. Suppliers must remit the current year's fee when submitting applications to the NSC even if they have previously submitted enrollment fees for an application that was closed.

Q. As a physician is my malpractice or professional insurance acceptable to submit to the NSC?

A. No. In order to meet this requirement comprehensive general liability insurance is required. The NSC must be listed as the certificate holder.

Got a question for Wendell? Email Medicare.NSC@PalmettoGBA.Com with the subject line: Ask Wendell.



Online Application Status Tool

Want to quickly check the status of your application, change of information, reactivation or revalidation? Use your PTAN, Tax ID, or NPI and check the status using the online application status tool housed on the NSC Website. Log onto www.PalmettoGBA.com/NSC and select 'NSC Application Status Tool' from the homepage under Self Service Tool. It's fast, quick and easy and gives you up-to-date information regarding correspondence that you've sent to the NSC via the CMS-855s or Internet-based PECOS.

WHO'S EXEMPT FROM ACCREDITATION?

W C N K A G M S L S I H S D K
 S R U B N K D T T I R O S O G
 D F P W L F E S R P R G N P W
 K F Z A Y P I I E T S I A T J
 L L C P E P G G H A A S I O I
 R O Z M A T A O X B F G C M O
 D Z H R K U T L T Z O X I E A
 Q P E Y K I C O Q D I Y S T G
 W H T F S E G I G W X E Y R L
 T A R T F J F D Q H N R H I I
 C X S M I B F U F J N O P S L
 H O P T I C I A N S B E E T T
 P R O S T H E T I S T S E S P
 O S F A A N K S L D I Z R K O
 S T S I R A L U C O F K B N G



AUDIOLOGISTS
 OCULARISTS
 OPTICIANS
 *THERAPISTS (occupational/physical)
 OPTOMETRISTS

ORTHOTISTS
 PHYSICIANS
 PROSTHETISTS

Tips for Quality Customer Care

1. For accurate responses, be specific and consistent in giving an account of your situation each time you call customer service.
2. Retain all documents submitted/received and have them readily available when inquiring about the file.
3. For exclusive information, be certain that only individuals on the supplier's file are contacting the NSC.
4. Be prepared to provide your PTAN, NPI, and/or Tax ID Number when requested.
5. Utilize tools available such as Web Chat, IVR, and the online applications status tool for general information to keep the lines free for responses that require more research or detail.

Contacting the DME MACs

Jurisdiction A – NHIC, Corp

CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT
Supplier Customer Service: (866) 590-6731
Interactive Voice Response Unit: (866) 419-9458

Jurisdiction B – National Government Services

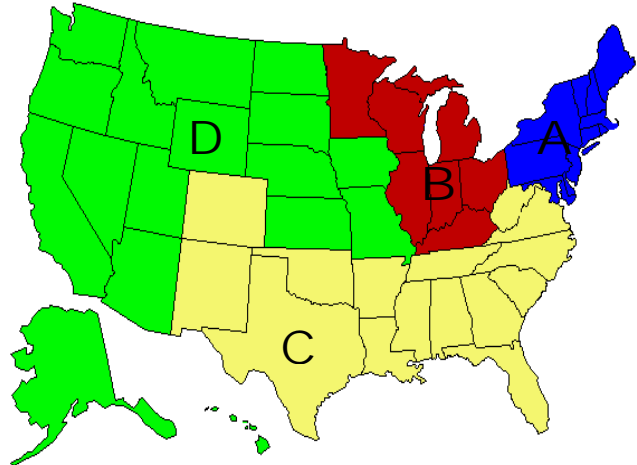
IL, IN, KY, MI, MN, OH, WI
Supplier Customer Service: (866) 590-6727
Interactive Voice Response Unit: (877) 299-7900

Jurisdiction C – CGS Administrators

AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, SC, TN, TX, VI, VA, WV
Supplier Customer Service: (866) 270-4909
Interactive Voice Response Unit: (866) 238-9650

Jurisdiction D – Noridian Healthcare Solutions

AK, AS, AZ, CA, GU, HI, IA, ID, KS, MO, MP, MT, ND, NE, NV, OR, SD, UT, WA, WY
Supplier Customer Service: (877) 320-0390
Interactive Voice Response Unit: (877) 320-0390



Common Electronic Data Interchange (CEDI)
 All Billing Jurisdictions
1-866-311-9184

Who Ya' Gonna Call?

Contact the NSC with questions regarding:	Contact your DME MAC with questions regarding:
<ul style="list-style-type: none"> The CMS 855S application form The application process Site visits Licensure requirements The Medicare DMEPOS supplier standards NSC education opportunities Changes in supplier information 'DNF' (do not forward) issues Reactivation of billing privileges Supplier fraud Appeal process (for denied/revoked billing privileges) Voluntary termination of billing privileges 	<ul style="list-style-type: none"> Claims processing Payment questions and issues EDI / electronic claims processing Electronic funds transfers Documentation requirements Pricing Appeals process of claims payments Fraud and abuse <p style="text-align: center; color: red; margin-top: 10px;">Contact the EUS Helpdesk with questions regarding:</p> <ul style="list-style-type: none"> To report an application navigation or access problem with Internet-based PECOS

ARE YOU REGISTERED?

Log on to www.palmettogba.com/nsc and subscribe to the NSC listserv to receive timely information and updates regarding Medicare enrollment procedures and guidelines. Don't be left behind, register now!



Scan the QR Code
to register for
timely updates
through the NSC
Listserv