Enrollment Quick Takes

Observational Site Visits vs Full Site Visits

As a durable medical equipment (DME) supplier you are subject to unannounced site visits at any time during your enrollment period with Medicare to verify and validate compliance with the Medicare supplier standards. There are two types of site visits that a supplier may receive: regular site visit and the shorter observational site visit. In both instances, the inspector will be a National Supplier Clearinghouse employee or authorized contractor. The inspector will have a photo identification card and a signed laminated letter signed by the Supplier and Compliance Unit manager on CMS letterhead authorizing the individual to conduct the visit. Before the site visit begins, you may request to view the identification of the inspector. If a supplier is not comfortable with the inspector or feel the inspector is not there under Medicare authority please contact the customer service line at (866) 238-9652 for immediate direction.

Note: Copies of the investigator’s identification or letter is not allowed.

You should be prepared for either type of site visit whenever an authorized inspector arrives at your facility. You cannot request a particular type of visit. During the site visit, you may be asked to comply with the inspector’s requests to view patient files, answer questions, take pictures of inventory present and the interior and exterior of the building, and view and copy documents as requested.

Here are some things you should expect from each type of visit:

Regular site visit

- Formal interview of a designated employee
- Request to view patient files
- Request copies of documents
- Pictures taken of inventory, interior and exterior of the building
- Sign site visit acknowledgement form

Observational site visit

- Pictures taken of inventory, interior and exterior of the building
**Revalidation Reminders**

- Medicare Enrollment Fees are required for all submissions of revalidation applications.
- List the Provider Transaction Access Number (PTAN) for which you are revalidating in section 1B. Can you identify where that is in PECOS?
- Be certain that the revalidation letter you received pertains to your DMEPOSPTAN.
- List all authorized and delegated officials for the organization, as well as the managing employee for the location.
- Complete all sections of the application.

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**Supplier Standard Reminder**

**Standard #15:** 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.

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**“Accreditation and the HCPCS codes you bill for”**

To satisfy supplier standards 22, 23, 24, and 25 suppliers are required to have an accreditation for the products and services they will bill to Medicare. The accreditation for your products and services are given specific accreditation codes. Each code has a corresponding list of HCPCS that are associated with it. It is vital to know which HCPCS codes are associated with your accreditation codes. Knowing this information can prevent billing for HCPCS codes that do not fall under the associated accreditation code. Billing under the improper accreditation codes may lead to inappropriate payments and recoupment of paid money.

The NSC receives approved accreditation information directly from the Accrediting Organizations. This data is housed in PECOS and is the information used by the DME MACs. You can determine what information the NSC has on file by reviewing your PECOS enrollment record. If the accreditation on file is not correct, you should contact your accreditation organization to ensure your records are up to date. Billing for items for which you are not accredited may result in denial of payment.

Once you have verified your accreditation on file is accurate and updated, you should verify which HCPCS you are able to bill under your accreditation code(s). The Medicare contractor, Medicare Pricing, Data Analysis and Coding (PDAC) has published a HCPCS to 855s Crosswalk. This quarterly report provides a mapping of HCPCS to product and service (accreditation) codes as well as a field indicating if the procedure code requires accreditation. To access, go to [www.dmepdac.com](http://www.dmepdac.com) — select reports from the left hand column - choose HCPCS to Product and Service Code Crosswalk link – select the most current version of the report. Your report will appear in the form of an excel spreadsheet.

If you have any additional questions about the crosswalk codes or issues with accessing it, please contact the PDAC at 1-877-735-1326, 8:30 am – 4 pm Central Time.
**Appeals Process**

According to the IOM 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 was not overturned and all appeal options are exhausted, the supplier must wait until the enrollment bar, as specified in the revocation letter, has expired.

When billing privileges have been denied or revoked, the applicant/supplier has two options available to contest the determination. The applicant/supplier 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
- Request for either reconsideration or a CAP must clearly specify the nature of the request.

**CAPs**

The CAP is to ensure the business, at the location in question, is in compliance with the current supplier standards (42 CFR 424.57). Submission of a CAP shall contain, at a minimum, verifiable evidence of compliance and the sufficient assurance of the intent to comply fully with the supplier standards in the future.

The CAP and the acceptability of the plan is negotiated between the NSC/CMS and the applicant/supplier (42 CFR 422.57(d)). However, it is important to note that denials and revocations are generally based on noncompliance with the Supplier Standards. Being in compliance is non-negotiable.

If the NSC/CMS is satisfied the issues of noncompliance have been resolved, billing privileges may be issued or reinstated. If the applicant has been denied, the effective date of the billing privileges will be the day the NSC issues the billing number (1834J of the Social Security Act and 42 CFR 422.57). If revoked, reinstatement will be effective the date CMS approves the CAP and the supplier has been determined to be in compliance with the supplier standards.

If the NSC/CMS upholds either a denial or a revocation, the applicant/supplier may request reconsideration. Please note this request must be made within 60 days from the postmark of the letter issuing the initial determination, and not 60 days from the letter upholding the denial or revocation.
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.

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).

Reconsiderations
If you feel the NSC has made a factual mistake or the noncompliance issue has been corrected, the supplier may submit a reconsideration request. A reconsideration request is specifically for an on-the-record hearing before a Hearing Officer (HO) not involved in the initial decision to deny or revoke billing privileges. Upon the receipt of a timely request, the NSC will forward the hearing package to the HO. The HO will then schedule, conduct and render a decision.

If you have any questions regarding this information, please contact the NSC Customer Line at 866-238-9652.

DMEPOS suppliers choosing to appeal a Medicare denial or revocation are encouraged to use the Hearings and Appeals checklist when submitting documentation for review. Suppliers are still required to submit a detailed cover letter specifying the request of reconsideration or a CAP. The checklist should be submitted along with the CAP/reconsideration packet. Your submission can be submitted through the NSC website via the NSC Web Form Submission tool.

Did You Know?

NSC Application Status Tool
Don’t want to pick up the phone and call the NSC to get a status of an application? No problem. You can just pull up the NSC Application Status Tool on-line and check the status of your reactivation, revalidation, and change of information. You can even get the status of new applications and additional locations.

Visit: https://www4.palmettogba.com/ecx_nscast/
**Surety Bond**

If your surety bond with the NSC has lapsed, you are subject to revocation. The surety company sends the NSC notifications of lapses of coverage. They rarely send notifications of reinstatements of coverage. It is your responsibility to ensure we have received any reinstatement correspondence. Please ensure your surety bond is current. If you have a new bond or your bond has been reinstated, please notify the NSC within 30 days of the bond issuance to avoid being revoked. You can easily submit the new bonds or reinstatements using the NSC Web Form Submission tool.

**PECOS**

Increasingly, DMEPOS Suppliers are recognizing the benefits of using Internet-based PECOS (Provider Enrollment, Chain and Ownership System) to submit enrollment information to the National Supplier Clearinghouse. DMEPOS suppliers can use Internet-based PECOS to enroll, revalidate, make a change in their enrollment record, view their Medicare enrollment information on file with Medicare and check on the status of a Medicare enrollment application via the internet.

**Did you know?**

- Since its fall 2010 implementation, Internet-based PECOS has undergone several phases that improved functionality for users
- Revalidations and changes of information are easier to complete because PECOS is pre-populated with the enrollment information already on file
- You can upload your supporting documentation and e-Sign via Internet-based PECOS making your submission completely electronic
- Submission through internet-based PECOS decreases development requests and requests for additional information for incomplete applications ultimately, accelerating the enrollment process
- Submitting information through Internet-based PECOS can significantly reduce the application completion time for you

Give Internet-based PECOS a try!

Log onto the CMS Website or Register to become a new user at: https://pecos.cms.hhs.gov/pecos/login.do

Go to our website for additional information and CMS Resources: http://www.palmettogram.com/nsc or https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Index.html

**Ask Wendell**

**Q. Are suppliers required to have beneficiaries sign a document stating they have received warranty information? Will site inspectors look for this signature?**

**A.** Supplier standard 6 states, ‘The supplier must provide, upon request, documentation that it has provided beneficiaries with information about Medicare covered items covered under warranty, in the form of copies of letters, logs, or signed notices.’ As indicated by the standard, the supplier may choose document how warranty information was provided. The NSC site inspector will review the beneficiary file to see if this information was provided.
Q. How can I be sure the individual present to conduct the site visit is authorized to do so?

A. An authorized site inspector, whether an NSC employee or a contractor, will have a photo identification card and a signed letter on CMS letterhead authorizing the individual to conduct the visit. Please note, the inspector will have a camera to take various pictures of the facility, posted signage, inventory, etc. The inspector will also have a questionnaire to complete based on the supplier standards.

The inspector will ask to review your files to determine if you are in compliance with certain requirements of the supplier standards. However, the site inspector should not take files, make copies or take pictures of the information contained in the files.

Please notify the NSC immediately if the site inspector requests to take the original or make copies of the beneficiary files, fails to present the photo ID or fails to present the signed authorization letter. You should not give any information to an individual that is not properly credentialed. Please call 866-238-9652 to report any concerns.

**NSC Listserv**

Are you reading this Newsletter by means of your email inbox? Or, have you had to pull up the NSC’s website to obtain your copy?

Sign up for the **NSC Listserv** and get these benefits:

- Get notified of important updates for the NSC
- Have NSC newsletters delivered directly to your inbox
- Monthly reminders about NSC revalidations due
- Stay current on policies and procedures to maintain your active supplier status

You can sign up for the **NSC Listserv** at [https://www.palmettogba.com/listserv](https://www.palmettogba.com/listserv)

**EFT Agreements**

- **Required** with initial application or new location application only – all EFT information can be submitted via PECOS with your application
- **Required**: voided check, preprinted deposit slip or confirmation of account information on bank letterhead
- Changes to your EFT information should be submitted directly to your DME MAC using the CMS Form 588
- CMS Form 588 must have original signature of authorized or delegated official on file with the NSC
- CMS Form 588 can be located on [CMS Website](https://www.cms.gov)

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**Disclaimer:** Though all publications are checked for accuracy, information is subject to change based on rules and regulations. ?s call NSC- 866-238-9652.