



## Provider Inquiry Assistance

### Incorporation of Recent Regulatory Revisions Pertinent to Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) – JA6282

**Note:** JA6282 was revised to add a reference to MM7073 at <http://www.cms.gov/MLN MattersArticles/downloads/MM7073.pdf>, which offers further guidance to DMEPOS suppliers regarding licensing, accreditation, and other mandatory quality requirements that may apply.

Related CR Release Date: December 31, 2008 **Revised**

Date Job Aid Revised: December 14, 2010

Effective Date: February 2, 2009

Implementation Date: February 2, 2009

<b>Key Words</b>	MM6282, CR6282, R280PI, DMEPOS, DME
<b>Contractors Affected</b>	DME Medicare Administrative Contractors (DME MACs)
<b>Provider Types Affected</b>	Suppliers submitting claims to DME MACs for services provided to Medicare beneficiaries



Change Request (CR) 6282 is informational and incorporates recent regulatory changes and applicable instructions for the National Supplier Clearinghouse – MAC (NSC-MAC) into the *Medicare Program Integrity Manual* (Chapter 10 (Healthcare Provider/Supplier Enrollment), Section 21 (Special Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Instructions).

#### Provider Needs to Know...

- 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 CR6282. What follows is a summary of these topics.

#### **Timeframe 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. It keeps running from the date the pre-screening letter was sent.**

**Example:** 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.

#### **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.
- A revocation based on a federal exclusion or debarment is effective with the date of the exclusion or debarment.
- 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.**

#### **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.

#### **Accreditation**

##### Medical Practitioners

- The NSC-MAC will follow the accreditation requirements in the Medicare Improvements for Patients and Providers Act of 2008.
  - 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.
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- 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**

- Suppliers that fall in this subset who provide other DME **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.

**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.

**Background**

Chapter 10 of the *Medicare Program Integrity Manual* specifies the procedures Medicare fee-for-service contractors must use to establish and maintain provider and supplier enrollment in the Medicare program.

**Operational  
Impact**

N/A

**Reference  
Materials**

The related MLN Matters® article can be found at <http://www.cms.gov/MLN MattersArticles/downloads/MM6282.pdf> on the CMS website.  
The official instruction (CR6282) issued regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R280PI.pdf> on the CMS website.