What You Need to Know About the DMEPOS Enrollment Updates and Appeals

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Introduction
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- The NSC was established in 1993 and is CMS’s contractor for enrolling DMEPOS suppliers in the Medicare program.

- The NSC is responsible for processing applications for supplier numbers, processing change of information forms, processing re-enrollments, maintaining supplier information, and enforcing compliance with the supplier standards.

- Changes to the CMS contract for provider enrollment are on the horizon.
  - National Provider Enrollment East – Novitas
  - National Provider Enrollment West – Palmetto
Introduction

- Novitas Solutions

- Palmetto GBA
  - Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, American Samoa, Guam, and Northern Mariana Islands

- Awaiting more details from CMS and the contractors.
Change of Information
Change of Information

- Must be completed within 30 days of the change.
- Complete appropriate sections of CMS-855S.
- Can do via PECOS or paper application.
- Common types of updates:
  - Change of Ownership
  - Change of Address
  - Change in Authorized Official
  - Change in Product and Services
Revocation
Revocation

- General reasons for revocation can be found at 42 CFR 424.535 and include
  - **Noncompliance**
    - If a provider or supplier is determined to not be in noncompliance with CMS enrollment requirements:
      - CMS may request additional documentation from the provider or supplier to determine compliance if adverse information is received or otherwise found concerning the provider or supplier.
      - Information should be provided promptly and clearly show compliance with the supplier.
Revocation

- Noncompliance (cont’d)
  - CMS may outright revoke number retroactive to date found to be in noncompliance.
  - 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 or administrative or management services personnel furnishing services payable by a Federal health care program, of the provider or supplier is:
      - Excluded from the Medicare, Medicaid, and any other Federal health care program.
      - Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services non-procurement common rule at 45 CFR part 76.
Revocation

- **Felonies**
  - The provider, supplier, or any owner or managing employee of the provider or supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR 1001.2) of a Federal or State felony offense that CMS determines is detrimental to the best interests of the Medicare program and its beneficiaries.
Revocation

- **Felonies (cont’d)**
  - Offenses include, but are not limited in scope or severity to:
    - Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
    - Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
    - Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
    - Any felonies that would result in mandatory exclusion.
Revocation

• **Felonies** (cont’d)
  • Revocations based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.
Revocation

- **False or misleading information**
  - The provider or supplier certified as “true” misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.)
- **On-site review**
  - Upon on-site review or other reliable evidence, it is determined that the supplier:
    - Is no longer operational to furnish Medicare-covered items or services.
    - Otherwise fails to satisfy any Medicare enrollment requirement.
Revocation

- **Misuse of billing number**
  - The provider or supplier knowingly sells to or allows another individual or entity to use its billing number.

- **Abuse of billing privileges**
  - Abuse of billing privileges includes either of the following:
    - Submitting a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:
      - Where the beneficiary is deceased.
Revocation

• Abuse of billing privileges (cont’d)
  • CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following:
    • The percentage of submitted claims that were denied during the period under consideration.
    • Whether the provider or supplier has any history of final adverse actions and the nature of any such actions.
    • The type of billing non-compliance and the specific facts surrounding said non-compliance (to the extent this can be determined).
    • Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination.
Revocation

• **Failure to report**
  • The provider or supplier did not comply with the reporting requirements. In determining whether a revocation is appropriate, CMS considers the following factors:
    • Whether the data in question was reported.
    • If the data was reported, how belatedly.
    • The materiality of the data in question.
    • Any other information that CMS deems relevant to its determination.
Revocation

- Failure to document or provide CMS access to documentation
  - The provider or supplier did not comply with the documentation or CMS access requirements.
  - Revocation on these grounds will result in a revocation for a period of not more than 1 year for each act of noncompliance.
Revocation

- Other program termination
  - The supplier is terminated, revoked, or otherwise barred from participation in a State Medicaid program or any other federal health care program. CMS considers the following factors:
    - The reason(s) for the termination or revocation.
    - Whether the provider or supplier is currently terminated, revoked or otherwise barred from more than one program (for example, more than one State's Medicaid program) or has been subject to any other sanctions during its participation in other programs.
    - Any other information that CMS deems relevant to its determination.
  - Medicare may not revoke unless and until a provider or supplier has exhausted all applicable appeal rights.
Revocation

- Debt referred to the United States Department of Treasury
  - The supplier has an existing debt that CMS appropriately refers to the United States Department of Treasury. CMS considers the following factors:
    - The reason(s) for the failure to fully repay the debt (to the extent this can be determined).
    - Whether the provider or supplier has attempted to repay the debt (to the extent this can be determined).
    - Whether the provider or supplier has responded to CMS' requests for payment (to the extent this can be determined).
    - Whether the provider or supplier has any history of final adverse actions or Medicare or Medicaid payment suspensions.
    - The amount of the debt.
    - Any other evidence that CMS deems relevant to its determination.
Revocation

- Revoked under different name, numerical identifier or business identity
  - The provider or supplier is currently revoked under a different name, numerical identifier, or business identity, and the applicable reenrollment bar period has not expired.
  - In determining whether a provider or supplier is a currently revoked provider or supplier under a different name, numerical identifier, or business identity, CMS investigates the degree of commonality by considering the following factors:
    - Owning and managing employees and organizations (regardless of whether they have been disclosed on the Form CMS-855 application).
    - Geographic location.
    - Provider or supplier type.
    - Business structure.
    - Any evidence indicating that the two parties are similar or that the provider or supplier was created to circumvent the revocation or reenrollment bar.
Revocation

• Revoked under different name, numerical identifier or business identity (cont’d)
  • Affiliation that poses an undue risk
    • CMS determines that the provider or supplier has or has had an affiliation under § 424.519 that poses an undue risk of fraud, waste, or abuse to the Medicare program.
Reenrollment Bar
Reenrollment Bar

- A supplier is barred from participating in the Medicare program from the effective date of the revocation until the end of the reenrollment bar. The reenrollment bar:
  - Begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 10 years depending on the severity of the basis for revocation.
  - Does not apply in the event a revocation of Medicare enrollment is based upon a supplier's failure to respond timely to a revalidation request or other request for information.
Reenrollment Bar

- CMS may add up to 3 more years to the provider's or supplier's reenrollment bar (even if such period exceeds the 10-year if it determines that the provider or supplier is attempting to circumvent its existing reenrollment bar by enrolling in Medicare under a different name, numerical identifier or business identity.
Reenrollment Bar

- CMS may impose a reenrollment bar of up to 20 years on a supplier if the supplier is being revoked from Medicare for the second time. CMS considers the following factors:
  - The reasons for the revocations.
  - The length of time between the revocations.
  - Whether the provider or supplier has any history of final adverse actions (other than Medicare revocations) or Medicare or Medicaid payment suspensions.
  - Any other information that CMS deems relevant to its determination.

- A reenrollment bar applies to a provider or supplier under any of its current, former or future names, numerical identifiers or business identities.
Appeals Process
Appeals Process

- CAP
  - Must be submitted within 35 days of revocation.
  - Purpose of the CAP is to ensure the business, at the location in question, is in compliance with the current supplier standards.
  - 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.
Appeals Process

- CAP (cont’d)
  - 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 releases the number.
    - 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.
Appeals Process

- When a CAP is Not Available
  - If CMS determines, upon on-site review, 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.
  - The 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
    - Excluded from the Medicare, Medicaid, and any other federal health care program.
    - Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement program or activity.
Appeals Process

- When a CAP is Not Available (cont’d)
  - The 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.
Reconsideration
Reconsideration

- Please note this request must be made within 65 days from the postmark of the letter issuing the initial determination, and not 65 days from the letter upholding the denial or revocation.
- In other words, filing a CAP won’t toll the time for filing a reconsideration.
- 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.
- The request must have the signature of the authorized official, owner or partner on file.
Enrollment Denials
Enrollment Denials

- A 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.
Administrative Law Judge
Administrative Law Judge

- Must be filed within 60 days of the reconsideration decision.
- Much more like a formal process.
- CMS will assign an attorney to handle the matter.
Questions?
Thank you

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