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Overview

This chapter outlines the enrollment requirements that you must meet in order to receive payment in the Medicare program as a DMEPOS supplier.

All DMEPOS suppliers who serve Medicare beneficiaries and meet the supplier standards listed in this chapter must enroll and obtain a supplier number, which is also known as a Provider Transaction Access Number (PTAN), with the National Supplier Clearinghouse (NSC). The Centers for Medicare & Medicaid Services (CMS) has contracted with the NSC to distribute applications, verify data, and maintain a national DMEPOS supplier file. The NSC does not process or maintain information on claims.

Before enrolling with the NSC, you must obtain a National Provider Identifier (NPI). Applying for an NPI is a separate process from enrollment with the NSC.

All claims filed to Medicare must include your NPI. Legacy supplier numbers (PTANs) issued by the NSC are no longer permitted in the claim filing process.

1. National Provider Identifier (NPI)

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* mandated the adoption of standard unique identifiers for health care providers, as well as the adoption of standard unique identifiers for health plans. For health care providers, the National Provider Identifier (NPI) is the standard unique identifier. The CMS has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. For more information about NPI enumeration, visit https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/.

Please note that each enrolled supplier of DMEPOS that is a covered entity under HIPAA must designate each practice location (if it has more than one) as a subpart and ensure that each subpart obtains its own unique NPI. Federal regulations require that each location of a Medicare DMEPOS supplier have its own unique billing number. In order to comply with that regulation, each location must have its own unique NPI.

The CMS requires that suppliers obtain their NPI prior to enrolling or updating their enrollment record with the NSC. The NSC will not process an enrollment application without the NPI and a copy of the NPI notification letter received from the NPPES or the organization requesting an NPI.

You can apply for an NPI online at https://NPPES.cms.hhs.gov. If you prefer to apply through a paper application, you may obtain the NPI Application/Update Form (CMS-10114) from the CMS website at http://www.cms.gov/cmsforms/downloads/CMS10114.pdf or by request from the NPI Enumerator at the following contact information:

NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059

Phone: 1.800.465.3203
TTY: 1.800.692.2326
Email: customerservice@npienumerator.com

2. National Supplier Clearinghouse (NSC)

After obtaining an NPI, you must enroll with the NSC by completing the CMS-855S enrollment application. This must be done in order to obtain a supplier number, also known as a Provider Transaction Access Number (PTAN). You must have both an NPI and a PTAN in order to be eligible to receive Medicare payment for covered DMEPOS services.

The NSC enrollment process:

1. Complete and submit the Medicare enrollment application form (CMS-855S) and any necessary supporting documentation (including the NPI notification letter) or complete the online version of the CMS-855S through the Provider Enrollment Chain Ownership System (PECOS) at https://pecos.cms.hhs.gov/.

2. The NSC will review the application and conduct a site visit to verify compliance with the supplier standards (see below).

3. After completing its review, the NSC will notify you of its enrollment decision in writing.

The CMS 855S Form

All DMEPOS suppliers initially enrolling with the NSC must complete the CMS-855S form. You may also need to complete the CMS-855S form and submit it to the NSC in other situations, such as if you are:

- Currently enrolled in Medicare as a DMEPOS supplier and need to report changes to your business, other than enrolling a new business location (e.g., you are adding, deleting, or changing existing information under this Medicare supplier billing number). Changes must be reported within 30 days of the effective date of the change.

- Currently enrolled in Medicare as a DMEPOS supplier but need to enroll a new business location. This is to add a new location to an organization with a tax identification number already listed with the NSC. (This differs from changing information on an already existing location.)

  Note: 42 C.F.R. 424.57(b)(1) requires suppliers to enroll separate physical locations, other than warehouses or repair facilities.

- Currently enrolled in Medicare as a DMEPOS supplier and have been asked to reenroll in order to verify or update your information. This includes situations where you have been asked to attest your organization is still eligible to receive Medicare payments.

- Reactivating your Medicare DMEPOS supplier billing number (e.g., your Medicare supplier billing number was deactivated because of non-billing, and you wish to receive payment from Medicare for future claims).

- Voluntarily terminating your Medicare DMEPOS supplier billing number.

Instructions on how to obtain and complete the CMS 855S may be found under the "Supplier Enrollment" section of the NSC website (http://www.PalmettoGBA.com/NSC). If you wish to enroll or update your enrollment information online, visit the CMS PECOS website (https://pecos.cms.hhs.gov/).

You are accountable for the accuracy of the information on the CMS 855S form. Any deliberate misrepresentation or concealment of material information may subject your company to liability under civil and criminal laws.

The NSC will contact you if a CMS 855S form is incomplete or has inconsistent information. Furthermore, all suppliers are subject to a site visit in order to determine compliance with the supplier standards, which can be found in this chapter. Suppliers found in noncompliance with the supplier standards are subject to denial or revocation of their NSC issued supplier number. The denial/revocation notification outlines the appeals process available to suppliers, including instructions on requesting an appeal.

NOTE: According to Pub 100-8, Chapter 15, Section 15.8.4, a supplier that is denied enrollment in the Medicare program 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 received notification the determination was upheld.

Furthermore, 42 C.F.R 424.530 (published in April 2006) requires the NSC to return any application received 30 days prior to the date the business was established (Section 4A of the CMS 855S) and to deny any application where the supplier is not operational. 42 C.F.R. 424.502 defines *operational* as follows:

"Operational means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped and stocked to furnish these items or services."

Each DMEPOS supplier applying for a Medicare supplier number must disclose ownership on the CMS 855S form in accordance with Section 1124A of the Social Security Act and Section 4313 of the Balanced Budget Act of 1997, by including:

- The names and social security numbers of the owners, managing employees, those with controlling interest of 5% or more, and/or authorized representatives/members of the board of directors (including non-profit corporations) as well as any partnership regardless of the percentage of ownership.

- The names of all owners, managing employees and/or authorized representatives/members of the board of directors who have received penalties, been sanctioned, or excluded by the Medicare, Medicaid and/or other federal and state authorities or programs.

The term *managing employee* is defined as any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the DMEPOS supplier, or who conducts the day-to-day operations of the DMEPOS supplier. For Medicare enrollment purposes, “managing employee” also includes individuals who are not actual employees of the DMEPOS supplier but, either under contract or through some other arrangement, manage the day-to-day operations of the DMEPOS supplier.

An *authorized official* must be an owner, general partner, chairman of the board, chief financial officer, chief executive officer, or president, OR must hold a position of similar status and authority within the supplier's organization. This individual must have the authorization to legally bind the organization to a contract. The authorized official has the authority to sign the initial CMS 855S application on behalf of the supplier and to notify the NSC of any change or that the supplier number is no longer valid due to sale of the entity. Only the authorized official can add, change, or delete delegated officials or sign off on the change of the authorized official.

Adding delegated officials is an option and is not required. *Delegated officials* may be either a managing employee of the supplier, or hold a 5% direct ownership interest or partnership interest in the supplier. Managing employees include general managers, business managers, or administrators—individuals who exercise operational or managerial control over the supplier, or who conduct the day-to-day operations of the supplier. A delegated official must be an employee of the supplier, and proof, such as a W-2 form, may be requested.

Delegated officials may not delegate their authority to any other individual. Once a delegated official has been designated, he/she may make any changes and/or updates to the provider status including enrolling additional locations, re- enrolling the supplier, reactivating the supplier, or adding new part-owners.

Suppliers may have as many authorized and delegated officials as desired as long as the individual meets the respective definition. These officials are not location specific, but rather are supplier specific. For example, if a supplier has multiple locations under one tax ID number, the authorized and delegated officials appointed will be the authorized signers for all locations.

Additional Forms and Documentation Requirements

When submitting your CMS-855S form to the NSC, you must also include additional documentation such as your NPI notification provided by NPPES and the CMS-588 Electronic Funds Transfer (EFT) Form. These two requirements are documented below. The NSC may also require additional documentation with your application. Please visit the NSC website (http://www.PalmettoGBA.com/NSC) for the most current information about enrollment documentation.

NPI Notification

You must include the submission of your National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System (NPPES). You should

provide your NPI where requested and submit a copy of the notification verifying the NPI. If you are unable to locate your NPI notification you may contact the NPPES at 1.800.465.3203 or send an email to customerservice@npienumerator.com.

Applying for an NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at https://NPPES.cms.hhs.gov. For more information about NPI enumeration, visit https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/.

Note: Each enrolled supplier of DMEPOS that is a covered entity under HIPAA must designate each practice location (if it has more than one) as a subpart and ensure that each subpart obtains its own unique NPI. Federal regulations require that each location of a Medicare DMEPOS supplier have its own unique billing number. In order to comply with that regulation, each location must have its own unique NPI.

In addition, the address listed on the NPI notification must match the address listed on the CMS-855S. The CMS requires a copy of the notification to be submitted with all enrollment documentation, which includes initial applications, changes of information, reenrollments and reactivations.

EFT Form (CMS-588)

You must complete and submit the most current version of the Authorization Agreement for Electronic Funds Transfer (CMS-588). With regards to DMEPOS enrollment, you should submit the EFT when initially enrolling or submitting an application for an additional location. Suppliers must list the proper Medicare contractor and ensure the form has the original signature of the authorized or delegated official. Also, suppliers should submit a separate form for each Medicare contractor where it submits claims.

Along with each completed CMS-855S form, you must include one of the following verifying the account information:

- Voided check
- Deposit slip
- Notification on bank letterhead verifying the account information

The NSC's role is to simply verify the form is complete and to ensure the agreement is signed properly. Once verified, the NSC will send the agreements to the appropriate DME MAC for processing. After receiving and verifying that your EFT application is complete, the DME MAC has 30 days from the date of receipt to process the application.

Again, you should only submit the CMS-588 to the NSC when submitting the CMS 855S for initial enrollment or when enrolling an additional location. The NSC does not enroll suppliers into the EFT program. Any changes to existing EFT information should be submitted to the following address:

CGS
Attn: EFT-DME
PO Box 20010
Nashville, TN 37202

Note: If you are a re-enrolling supplier and not already enrolled to receive payments through electronic fund transfer, you must submit the CMS-588 form.

3. Supplier Standards

Medicare regulations have defined standards that a supplier must meet to receive and maintain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c) and can be found on the NSC website at http://www.PalmettoGBA.com/NSC. An abbreviated version is listed below. **You must disclose these standards to all customers who are Medicare beneficiaries (see standard #16).**

1. A supplier must be in compliance with all applicable federal and state licensure and regulatory requirements.

2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.

3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.

4. A supplier must fill orders from its own inventory or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs or from any other federal procurement or non-procurement programs.

5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment and of the purchase option for capped rental equipment.*

6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable state law and repair or replace free of charge Medicare covered items that are under warranty.

7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.

8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.

9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.

10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.

11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR 424.57 (c) (11).

12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items and maintain proof of delivery and beneficiary instruction.

13. A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts.

14. A supplier must maintain and replace at no charge or repair directly or through a service contract with another company Medicare-covered items it has rented to beneficiaries.

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.

16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.

17. A supplier must disclose any person having ownership, financial or control interest in the supplier.

18. A supplier must not convey or reassign a supplier number (i.e., the supplier may not sell or allow another entity to use its Medicare billing number).

19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.

20. Complaint records must include the name, address, telephone number and health insurance claim number of the beneficiary; a summary of the complaint; and any actions taken to resolve it.

21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.

22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).

23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.

24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.

25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.

26. A supplier must meet the surety bond requirements specified in 42 C.F.R. 424.57(c).

27. A supplier must obtain oxygen from a state-licensed oxygen provider.

28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).

29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.

30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848 (j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

*Although CMS has revised payment rules for capped rental items, supplier standard 5 still applies for inexpensive and routinely purchased items that do not fall into the capped rental category and applicable capped rental items (i.e. complex rehabilitative power wheelchairs and parental/enteral pumps, etc.).

4. Reenrollment

42 C.F.R. section 424.57(e) requires the National Supplier Clearinghouse (NSC) to reenroll suppliers every three years. The NSC is the central entity responsible for maintaining supplier identification and ownership data, as well as other business data. Part of that responsibility requires the NSC to share this information with the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for provider relations and claims processing.

Therefore, it is imperative that the NSC has the most accurate information on file. The reenrollment process also allows the NSC to determine if you are in compliance with the supplier standards.

The reenrollment process takes approximately 60 days, which includes a site visit, if required. Also, workload and the time spent requesting any additional information required to complete the reenrollment package play a part in determining the processing time. Be sure to respond to requests for information from the NSC timely to avoid having your supplier number inactivated and having to begin the process again.

Please contact the NSC for additional information regarding reenrollment.

5. Change of Information

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 10, §7.1

Any changes or updates to information provided on the CMS 855S form must be reported to the NSC within 30 days after such changes have taken place.

Updated information should be submitted on the CMS 855S form. Failure to provide the updated information is grounds for denial or revocation of the Medicare supplier number.

In order to timely receive information from the DME MACs, the NSC must have your correct address. The NSC maintains your correspondence address information and transmits this information to the DME MACs.

Be sure to attach all location specific licenses to any Change of Information form that includes a change of physical location. This will be required before any changes can be made to your supplier file. This will serve as notice you should apply for any new location specific licenses from the specific licensing board (such as Board of Pharmacy, business license offices, etc.) as quickly as possible to ensure compliance with supplier standard #1.

Further instructions on how to complete a change of information for various reasons may be found in the “Supplier Enrollment/Change of Information” section of the NSC website (http://www.PalmettoGBA.com/NSC).

All CMS 855S forms and changes to previously submitted information must be sent to:

Regular Mail Address

National Supplier Clearinghouse
AG-495
PO Box 100142
Columbia, SC 29202-3142

Overnight Mail Address

National Supplier Clearinghouse
AG-495
2300 Springdale Dr., Bldg 1
Camden, SC 29020

6. Participating/Nonparticipating

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, §30

A Medicare participating supplier is one who voluntarily enters into an agreement to accept assignment for all services furnished to Medicare beneficiaries during a 12-month period, beginning January 1 of each year. Suppliers who choose not to sign the participation contract are referred to as nonparticipating suppliers. Nonparticipating suppliers may choose to accept assignment on a claim-by-claim basis except where CMS regulations require mandatory assignment (i.e., Medicare covered drugs, Indian Health Services). Accepting assignment means accepting the Medicare approved amount as payment in full. Participation status is part of the enrollment process through the National Supplier Clearinghouse.

Open enrollment forms (CMS-460, Medicare Participating DMEPOS Supplier Agreement) are mailed to all suppliers every November. If you are an existing nonparticipating supplier and want to become participating, then you must send the agreement form to the NSC during open enrollment. The form must be postmarked before December 31st of that year.

If you are a participating supplier want to become nonparticipating, you may request to become nonparticipating by sending the request to the NSC on your company letterhead. The request must be postmarked and received before December 31st of the year to become nonparticipating effective January 1st of the next year.

New legislation each year provides incentives for you to become a participating supplier. These incentives are outlined in the participation enrollment letter sent to all suppliers each year, along with other valuable information.

7. Site Visits

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 10, §22

Site Visits:

- Are a tool used by the NSC to assist in making a determination as to whether or not a supplier is in compliance with the supplier standards
- Are conducted in all fifty states and territories

- Are completed for initial applications, reenrollments, and reactivations
- Can and will be conducted at anytime if deemed necessary

The site visit along with the application and supporting documentation are considered in making a determination to issue, deny, or revoke a supplier's billing privileges. Refer to the NSC website for additional information regarding site visits.

8. Do Not Forward

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, §80.5

If you are changing your correspondence or special payment address, you should be aware that any mail returned as undeliverable might result in a "Do Not Forward" (DNF) flag being placed on your account.

The DME MAC uses "return service requested" envelopes for all hardcopy checks and Medicare Remittance Advice (RA), allowing the U.S. Postal Service to return undeliverable mail. When the post office returns checks or RAs, the DME MAC will notify the NSC and cease generating payments (whether you are enrolled for Electronic Funds Transfer or receive hardcopy checks) until you furnish a new address and that address is verified by the NSC. The NSC will also notify the other DME MACs of the DNF issue and these contractors will also stop payments until the issue has been resolved with the NSC.

Also note that a DNF flag will be placed on your account in the event that the DME MAC is notified by your bank of a change in your Electronic Funds Transfer (EFT) banking information. The flag will be removed once the DME MAC receives updated EFT banking information on a valid CMS 588 form. You can avoid this situation by immediately notifying the DME MAC of any changes to your bank account.

Any changes to your EFT banking information should be submitted on the CMS 588 EFT form to the address below. The CMS 588 form is available on the DME MAC Jurisdiction C website at http://www.cgsmedicare.com/jc/forms.

CGS
Attn: EFT-DME
PO Box 20010
Nashville, TN 37202

9. Directory of Medicare Suppliers

The CMS is responsible for producing a directory of all Medicare Suppliers. Please note, this directory will not include any physicians or ambulatory surgical centers, but does include optometrists. The directory of Medicare suppliers can be found online at http://www.medicare.gov/Supplier/Home.asp.

10. Change of Ownership

When there is a change of ownership, a new supplier number must be issued unless the new owners assume all liabilities and the tax identification number of the existing supplier. Otherwise, the

new owner may not use the existing supplier number. The new owner must submit form CMS 855S to the NSC within thirty (30) days of the change of ownership, along with a bill of sale, articles of incorporation filed with the state, and any other documents that show the exact nature of the transaction.

If there is a change in the tax identification number, the outgoing owner must notify the NSC by completing the CMS 855S as a "Voluntary Termination of Billing Number." The request to voluntarily terminate the supplier number must be submitted on the CMS 855S. Pub 100-08, Chapter 10, Section 7 states all changes must be reported on the CMS 855S.

The old supplier number will be inactivated. If the NSC determines the new owners have met all requirements, the new number will be effective from the date of the change of ownership. Claims for items furnished between the date of the change of ownership and the issuance of the new supplier number may be submitted to the DME contractor once the supplier has received the new number.

Instructions and further information regarding the completion of the CMS 855S as a voluntary termination may be found on the NSC website under "Supplier Enrollment/Change of Information/Change of Information Guide".

11. NSC Resources

The NSC Website

Visit the NSC website at http://www.PalmettoGBA.com/NSC for:

- Helpful hints for completing the CMS 855S
- Numerous FAQs regarding the enrollment process
- Information regarding the NSC site visit process
- Licensure information
- A checklist to ensure the CMS 855S was completed properly and that all required documentation has been provided

The NSC Customer Service Line

NSC analysts are available at 1.866.238.9652 Monday through Friday from 9:00am until 5:00pm (ET) to answer questions regarding the enrollment process. If you have questions regarding supplier specific information, please be sure an individual listed on the supplier file contacts the NSC Customer Service Line. NSC analysts will not be able to give supplier specific information to someone who is not listed on the supplier file. The NSC also has a voice mailbox available to Spanish-speaking suppliers.

NSC Email Address

If preferred, you may email your questions to medicare.NSC@PalmettoGBA.com. Questions received will be answered within a reasonable time frame. Do not submit protected healthcare information via email.

Interactive Voice Response (IVR) Unit

The NSC Interactive Voice Response (IVR) Unit allows you to obtain:

- General information regarding the enrollment process
- Information on the appeals process
- Status of a new application, reenrollment, reactivation, or change of information
- Instructions on how to obtain a CMS 855S
- Contact information for the NSC, DME MACs, and CMS

The IVR is available 24 hours a day, seven days a week (except for routine system maintenance) and can be accessed by calling the NSC Customer Service Line at 1.866.238.9652.

12. Supplier Audit and Compliance Unit (SACU)

The Supplier Audit and Compliance Unit (SACU) is tasked to review new applicants and existing suppliers to determine if they are in compliance with current supplier standards. Most suppliers and supplier organizations are interested in fraud and abuse control to protect their industry's image with the public and Congress. This task is, by its nature, a cooperative effort. It involves some beneficiaries, state Medicaid agencies, the DME MACs, and federal agencies such as the Centers for Medicare & Medicaid Services (CMS), the Office of the Inspector General (OIG), the Department of Health and Human Services (DHHS), and the United States Attorney's Office (USAO).

The SACU has the authority to deny new applicants and to recommend revocation to CMS and/or inactivate existing supplier numbers when it is determined that such suppliers are not in compliance with the published standards. In addition, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 created criminal and civil penalties for suppliers who submit fraudulent applications to a government health care organization. Fully developed cases are submitted for prosecution to the U. S. Attorney's Office, Columbia, South Carolina. The U. S. Attorney has jurisdiction nationwide because all the applications are received, and the supplier numbers issued, by the NSC in Columbia, South Carolina.

13. DMEPOS Accreditation

In order to enroll or retain Medicare billing privileges, certain DMEPOS suppliers need to complete the accreditation process and be in compliance with certain quality standards prior to enrolling as a supplier.

Information about the DMEPOS accreditation requirements, along with a list of the accreditation organizations and guidance regarding the DMEPOS Quality Standards for DMEPOS suppliers, is located in the Downloads section of the CMS DMEPOS Accreditation webpage at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/DMEPOSAccreditation.html. You can also find accreditation information on the NSC website at http://www.palmettogba.com/NSC.

14. Surety Bonds

A DMEPOS surety bond is a bond issued by an entity (the surety) guaranteeing that a DMEPOS supplier will fulfill an obligation or series of obligations to a third party (the Medicare Program). If the obligation is not met, the third party will recover its losses via the bond.

Suppliers enrolling in the Medicare Program for the first time, existing suppliers undergoing a change of ownership, or existing suppliers establishing a new practice location are required to submit a surety bond to the NSC with their CMS-855S Medicare Enrollment Application – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers. Absent an exception to the bonding requirement, the NSC will reject a pending supplier's enrollment application if the supplier has not submitted a valid surety bond.

For information about surety bond requirements, refer to the CMS DMEPOS Enrollment webpage at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/DMEPOSEnrollment.html. You can also find surety bond information on the NSC website at http://www.palmettogba.com/NSC.