

National Board of Accreditation for Orthotic Suppliers

NBAOS

The Hallmark of Quality Standards for Orthotic Suppliers

FACILITY ON-SITE ACCREDITATION APPLICATION FOR ORTHOTIC SUPPLIERS

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INTRODUCTION

The National Board of Accreditation for Orthotic Suppliers (NBAOS) is recognized by the Centers for Medicare and Medicaid Services (CMS) as a deeming authority to accredit facilities serving as suppliers of durable medical equipment, prosthetics and orthotics (DMEPOS). NBAOS is committed to the high standards established by CMS and is committed to providing an efficient process for suppliers seeking accreditation.

SCOPE OF SERVICES ACCREDITED BY NBAOS

- Orthotics
- Canes
- Crutches
- Walkers
- Hot/Cold Applications
- Dressings

ACCREDITATION REQUIREMENTS

NBAOS accredits facilities that meet the following minimum standards:

- Comply with the Quality Standards established by CMS on August 14, 2006
 - This includes the business quality standards and those specific to orthotics and prosthetics found on the www.cms.gov website.
- Have a federal tax ID number
- Comply with federal, state, and local laws/regulations
- Dispense orthoses by qualified suppliers - registered, certified, or licensed practioners/providers in good standing
- Located in the United States or its territories
- Currently operating as a business entity
- Meet the application requirements and on-site survey requirements established through NBAOS in compliance with CMS standards.

STEPS TO ACCREDITATION

The steps to accreditation through NBAOS are as follows:

- Step 1:** Complete the application form and submit to NBAOS
- Step 2:** Once the application is received by NBAOS, the facility will be provided with the complete survey information required at the time of the on-site survey.
- Step 3:** Once the facility has determined it meets each of the requirements and has all the required information in place, the facility will contact NBAOS indicating the facility is prepared for the on-site survey.
- Step 4:** The on-site survey will be conducted. This is an **UNANNOUNCED** survey. It will be conducted during the business hours reported in the application. Each office location is subject to an unannounced survey.
- Step 5:** The facility will be notified of their accreditation status within five business days following the survey. Facilities will be accredited, placed on probation or notified that the facility does not meet the required standards established by CMS.

Mission Statement

The mission of the National Board of Accreditation for Orthotic Suppliers is to ensure high quality patient care through standards of excellence for orthotic providers.

ORGANIZATION APPLYING FOR ACCREDITATION

Corporate Name _____

DBA _____ Federal Tax ID # _____
[During business as (DBA) if applicable]

PRIMARY CONTACT PERSON(S)

Name _____ Phone _____ Fax _____

Name _____ Phone _____ Fax _____

Note: Indicate below any dates the primary contact individual(s) will not be in the office (e.g. business travel/vacation) for the onsite, unannounced survey. If a survey must be rescheduled due to the contact person not being available the facility will incur a new survey fee.

DMEPOS CATEGORIES WHICH THE SUPPLIER IS SEEKING ACCREDITATION

Mark all that apply

- Orthoses: Custom Fabricated OR01
- Orthoses: Prefabricated (non-custom fabricated) OR02
- Orthoses: Off-The-Shelf OR03
- Contracture Treatment Devices: Dynamic Splint DM04
- Heat & Cold Applications DM08
- Surgical Dressings S01
- Canes and Crutches M01
- Walkers M05

OFFICE LOCATIONS

Primary Facility Location:

Name of Facility _____

Street Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Web site _____ E-mail _____

Clinical Supervisor _____

Office Manager _____

Days/Hours of Operation _____

Medicare number _____ Medicaid number _____

NSC DMERC # _____ Location NPI number _____

Second Facility Location:

Name of Facility _____

Street Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Web site _____ E-mail _____

Clinical Supervisor _____

Office Manager _____

Days/Hours of Operation _____

Medicare number _____ Medicaid number _____

NSC DMERC # _____ Location NPI number _____

Third Facility Location:

Name of Facility _____

Street Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Web site _____ E-mail _____

Clinical Supervisor _____

Office Manager _____

Days/Hours of Operation _____

Medicare number _____ Medicaid number _____

NSC DMERC # _____ Location NPI number _____

Fourth Facility Location:

Name of Facility _____

Street Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Web site _____ E-mail _____

Clinical Supervisor _____

Office Manager _____

Days/Hours of Operation _____

Medicare number _____ Medicaid number _____

NSC DMERC # _____ Location NPI number _____

***If there are additional locations, please attach the information outlined above to this application.

DISCLOSURE OF OWNERSHIP & CONTROL:

Owner's information:

Name/Title: _____

Address _____

City _____ State _____ ZIP _____

Office Phone _____ Fax _____ E-mail _____

Additional owner's information:

Name/Title: _____

Address _____

City _____ State _____ ZIP _____

Office Phone _____ Fax _____ E-mail _____

Name/Title: _____

Address _____

City _____ State _____ ZIP _____

Office Phone _____ Fax _____ E-mail _____

***For additional owners, please attach the information outlined above to this application.

PRACTITIONER INFORMATION

All practitioners listed below are patient care providers of this organization:

1. Name _____ NPI number _____

Type of Practioner: _____ Occupational therapist _____ Physical therapist

_____ Physician _____ Orthotist _____ Other: _____

State License/Registration/Certification Number(s) Indicate # and state:

Number: _____ State: _____

Number: _____ State: _____

Identify which location(s) (based on the location #s identified in this application) the practitioner works: # _____

2. Name _____ NPI number _____

Type of Practioner: _____ Occupational therapist _____ Physical therapist

_____ Physician _____ Orthotist _____ Other: _____

State License/Registration/Certification Number(s) Indicate # and state:

Number: _____ State: _____

Number: _____ State: _____

Identify which location(s) (based on the location #s identified in this application) the practitioner works: # _____

3. Name _____ NPI number _____

Type of Practioner: _____ Occupational therapist _____ Physical therapist

_____ Physician _____ Orthotist _____ Other: _____

State License/Registration/Certification Number(s) Indicate # and state:

Number: _____ State: _____

Number: _____ State: _____

Identify which location(s) (based on the location #s identified in this application) the practitioner works: # _____

4. Name _____ NPI number _____

Type of Practitioner: _____ Occupational therapist _____ Physical therapist

_____ Physician _____ Orthotist _____ Other: _____

State License/Registration/Certification Number(s) Indicate # and state:

Number: _____ State: _____

Number: _____ State: _____

Identify which location(s) (based on the location #s identified in this application) the practitioner works: # _____

5. Name _____ NPI number _____

Type of Practitioner: _____ Occupational therapist _____ Physical therapist

_____ Physician _____ Orthotist _____ Other: _____

State License/Registration/Certification Number(s) Indicate # and state:

Number: _____ State: _____

Number: _____ State: _____

Identify which location(s) (based on the location #s identified in this application) the practitioner works: # _____

6. Name _____ NPI number _____

Type of Practitioner: _____ Occupational therapist _____ Physical therapist

_____ Physician _____ Orthotist _____ Other: _____

State License/Registration/Certification Number(s) Indicate # and state:

Number: _____ State: _____

Number: _____ State: _____

Identify which location(s) (based on the location #s identified in this application) the practitioner works: # _____

7. Name _____ NPI number _____

Type of Practioner: _____ Occupational therapist _____ Physical therapist

_____ Physician _____ Orthotist _____ Other: _____

State License/Registration/Certification Number(s) Indicate # and state:

Number: _____ State: _____

Number: _____ State: _____

Identify which location(s) (based on the location #s identified in this application) the practitioner works: # _____

8. Name _____ NPI number _____

Type of Practioner: _____ Occupational therapist _____ Physical therapist

_____ Physician _____ Orthotist _____ Other: _____

State License/Registration/Certification Number(s) Indicate # and state:

Number: _____ State: _____

Number: _____ State: _____

Identify which location(s) (based on the location #s identified in this application) the practitioner works: # _____

9. Name _____ NPI number _____

Type of Practioner: _____ Occupational therapist _____ Physical therapist

_____ Physician _____ Orthotist _____ Other: _____

State License/Registration/Certification Number(s) Indicate # and state:

Number: _____ State: _____

Number: _____ State: _____

Identify which location(s) (based on the location #s identified in this application) the practitioner works: # _____

10. Name _____ NPI number _____

Type of Practioner: _____ Occupational therapist _____ Physical therapist

_____ Physician _____ Orthotist _____ Other: _____

State License/Registration/Certification Number(s) Indicate # and state:

Number: _____ State: _____

Number: _____ State: _____

Identify which location(s) (based on the location #s identified in this application) the practitioner works: # _____

11. Name _____ NPI number _____

Type of Practioner: _____ Occupational therapist _____ Physical therapist

_____ Physician _____ Orthotist _____ Other: _____

State License/Registration/Certification Number(s) Indicate # and state:

Number: _____ State: _____

Number: _____ State: _____

Identify which location(s) (based on the location #s identified in this application) the practitioner works: # _____

12. Name _____ NPI number _____

Type of Practioner: _____ Occupational therapist _____ Physical therapist

_____ Physician _____ Orthotist _____ Other: _____

State License/Registration/Certification Number(s) Indicate # and state:

Number: _____ State: _____

Number: _____ State: _____

Identify which location(s) (based on the location #s identified in this application) the practitioner works: # _____

***For additional practitioners, please attach the information listed above with this application.
NOTE: Be sure to include all PRN and contract practioners in addition to those employed at the facility.

AFFIRMATION OF COMPLIANCE

The facility has identified an authorized representative to affix a legally binding signature to assume responsibility, on behalf of the facility, for the accuracy and truthfulness of the completed application and survey.

Outlined below are conditions required by CMS to serve as an accredited supplier for durable medical equipment, prosthetics and orthotic supplies (DMEPOS). The facility legally authorized representative must carefully review and sign the Affirmation of Compliance document in order to proceed with the survey and application process. The document includes the following conditions of participation:

- The supplier states full compliance with Medicare regulations and policies and Medicare contractor policies and articles.
- The supplier states full compliance with Medicare coverage, claim processing, and payment policies.
- The supplier shall disclose audits by Medicare (within the past 12 months or since the last accreditation) and provide copies of compliance requirements or repayment requirements.
- The supplier shall comply with 1834 (h) of the Social Security Act addressing "Payment for Prosthetic Devices and Orthotics and Prosthetics".
- The supplier shall complete and provide copies of the Medicare Disclosure of Ownership and Control Information requirements at 42 CFR 420.210 through 420.206.
- The supplier complies with all CMS Quality Standards and those quality standards identified in appendix C (Custom-fabricated, custom-fitted, custom-made orthotics, prosthetic devices, somatic, ocular and facial prosthetics, and therapeutic shoes and inserts).
- The supplier shall conform to necessary revisions in the accreditation requirements, policies and/or procedures as mandated by Medicare or deemed necessary by NBAOS and shall acknowledge receipt of the changes within the stated deadline.
- The supplier shall inform NBAOS of new office locations or changes in office locations (ownership/address/closings/etc.) within 30 days of the change.
- Should the supplier appeal the decision of NBAOS, the supplier shall be responsible for the expenses incurred during the appeal process, up to and including a hearing, where the original decision of NBAOS is upheld.
- The supplier understands the mandatory survey requirements must be complete at the time of the onsite survey or a new survey will be scheduled. When any additional onsite survey is necessary, such as when the mandatory survey requirements are not met, the supplier is on probation, a complaint is received about the supplier resulting in an additional survey or any other necessary reason, the supplier is responsible to pay a second onsite survey fee.
- Once accredited, the supplier shall remain in compliance with each of the requirements of CMS and NBAOS as outlined in the application and survey requirements.
- The supplier affirms that each provider does not have a criminal history or legal action pending against them.

Legally Authorized Signature

Date

Printed Name of Authorized Signature

Witness

Date

ACCREDITATION FEES

- **\$100 Initial Application Fee**
 - Facility may apply at any time
 - Facility will receive detailed listing of survey requirements
- **\$2,750 + fees* On-Site Survey Fee (*plus all surveyor travel expenses)**
 - Facility will submit when prepared for on-site survey
 - Unannounced survey will be conducted
 - Note: Facilities in remote areas (more than 30 miles from a city with a population greater than 100,000) will be responsible for transportation, meals and accommodations necessary to conduct the survey.
 - Facilities that require a second onsite survey due to mandatory information not being available at the time of the initial onsite survey, being placed on probation where a second onsite survey is necessary, having a complaint filed against the facility where an onsite survey becomes necessary, or any other reason where additional onsite surveys are necessary result in an additional onsite survey fee.
- **\$350 – Each Satellite Location Fee**
 - Facility will submit when prepared for on-site survey at primary office location
 - Unannounced survey will be conducted
 - Surveyor travel expenses (transportation/meals/accommodations) are the responsibility of the facility when the surveyor travels more than 30 miles to the survey site from the primary office site.
- **\$1,500 Re-Accreditation (Renewal) Fee**
 - Required each three years
 - Unannounced survey will be conducted
 - Re-accreditation fees are subject to revision as warranted by NBAOS
- **\$350 - Each Satellite Location Renewal Fee**
 - Facility will submit when prepared for on-site survey at primary office location
 - Unannounced survey will be conducted at each office location
- **Appeals & Hearings**
 - Filing for an appeal or a hearing is \$350
 - All expenses are incurred by the facility.

PAYMENT OPTIONS

CHECK

Check #: _____ Amount: _____

Enclose your check with the application

CREDIT CARD

Type: _____ VISA _____ MasterCard

Name on Card: _____

Credit Card Number: _____ Expiration Date: _____

Authorized Signature: _____ Amount Charged: _____

NOTE: Once NBAOS receives this On-site Survey Accreditation Application your survey will be an unannounced survey.

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