



Legal Issues in Home Health & Hospice Survey and Certification

Presented by
Mary St.Pierre, BSN, RN, MGA
William A. Dombi, Esquire
National Association for Home Care

Certification

- Certification is when the State Agency
 - Officially recommends its findings regarding when a health care entity
 - Meets the Acts provider or supplier definition
 - Complies with standards required by Federal regulation

Types of Surveys

- Initial (CMS State Agency moratorium)
- Resurveys
 - Standard
 - Partial Extended
 - Extended
- Complaint
- Immediate Jeopardy
- Look Behind
- Validation

SURVEY FREQUENCY

- Hospice:
 - Every 8 years
- Home Health
 - Resurvey of HHAs: No later than 36 months from prior survey
 - 36 months: no conditions, no deficiencies at 484.18, 484.55, no complaints with deficiencies
 - 12-36 months: no conditions or complaint deficiencies, deficiencies with accepted POC 484.18, 484.55
 - 12 months: Medicare approved less than 3 years, CHOW, condition level deficiencies, fraud and abuse
 - 4-6 months: CoP(s) out and resolved

Note: Random surveys of 5% of 36 month pool at 16-20 months

Completing the Survey

- Conduct of exit conference
- Presentation of findings
- Identification of deficiencies
 - If requirement not in compliance
 - Significant if affects ability to provide adequate care or adversely affects health and safety
- Issuance of statement of deficiencies

Deficiency Levels

- Surveyor considerations
 - Effect on patient outcomes (severity)
 - Number of patients affected (potential or actual)
- Condition level:
 - Very serious
 - Systemic noncompliance
 - Usually associated with identified pattern rather than isolated instance
 - Could be one instance if very serious

Provider Participation

- Preparing for surveys
 - Maintain copies of regulations and surveyor guidance
 - Train staff on regulations and policies
 - Review internal policies
 - Conduct internal surveys
 - Correct identified problems

Provider Participation

- Participating in Survey
 - Check surveyor identify
 - Provide work place
 - Work with staff in identification of patients and records
 - Determine and provide information needed
 - Keep list of records and visits
 - Plan with surveyor for exit conference

Provider Participation

- Exit Conference
 - Audiotape the exit conference (copy for surveyor required)
 - Have appropriate staff participate/available
 - Have surveyed clinical records, regulations, other pertinent information available
 - Maintain professional atmosphere
 - Avoid comments that could be interpreted as admission of error
 - Avoid arguments
- Note: Provider counsel, if present, may not turn exit conference into evidentiary hearing

Provider Participation

- Exit conference (continued)
 - Insist on specifics about citations
 - Use patient records to correct (refute) erroneous interpretations/misperceptions
 - Request specific regulatory references
 - Request specific standard or State references
 - Use CMS manuals, letters to support compliance
 - Request clarification if cited for single incidence

Provider Participation

- Post exit conference
 - Determine validity of stated deficiencies
 - Are surveyor's interpretations of regulations and policies correct?
 - Is citation for failure to comply with own policy
 - Correct valid problems
 - Initiate actions for invalid problems
 - Request surveyor clarification
 - Assemble evidence/supporting documentation
 - Dispute disagreements

Provider Participation

- Disputing Deficiencies
 - Ascending order
 - Surveyor
 - Surveyor supervisor
 - State agency director
 - CMS Region Office
 - CMS Central Office

Responding to Statement of Deficiencies

- Plan of correction
 - Required for ALL deficiencies regardless of dispute
- Respond within required timeframe
- Report survey irregularities
- Valid deficiencies
 - Write corrective action plan
- Disputed deficiencies
 - Accept and write a corrective plan, or
 - Write corrective action plan
 - Cite disagreement
 - Reasons, regulatory citations, CMS letters, other sources

Responding to Statement of Deficiencies

- Follow-up Statement of Deficiencies
 - Check status of corrective plan
 - Check status of comments challenging deficiencies
- Follow-up on unresolved issues: ascending order chain of command
 - Phone, letters, meetings
- Failure to resolve deficiencies: termination

90 Day Termination

- Day 15-notify agency of 90 day termination
- Day 45-revisit if credible allegation
- 2nd Revisit between 45-90
- Day 55-certify noncompliance, notify RO,
- Day 65-RO confirms support
- Day 70-RO sends official termination letter
- Day 90 termination effective

Immediate Jeopardy Termination

- Complete termination by day 23
- 2nd work day-notify RO, provider
 - Deficiencies leading to immediate jeopardy
 - Termination timeline
 - Due process and rights
 - Halt termination if immediate jeopardy corrected and validated by State

Immediate Jeopardy Termination

- 3rd working day-overnight to RO for review
- 5th working day-RO notifies HHA & public
- 10th working day-HHA & RO notified of all deficiencies, state Medicaid agency notified
- 23rd calendar day-termination effective
 - Unless threat removed
 - If condition still out-90 day termination cycle

Immediate Jeopardy Triggers

- Patient injuries
- Physical abuse
- Verbal abuse
- Restraint use
- Failure to ID allergies
- Incorrect medication
- Failure to follow plan of care
- Failure to monitor diabetic blood sugars
- Improper handling blood and body fluids
- Infections
- Incorrect administration of gases

Surveyor Decision Tree

- Did the harm meet the immediate jeopardy definition?
- Is the harm likely to recur?
- Was the provider aware?
- Did the provider investigate the circumstances?
- Did provider implement corrective action?

APPEAL RIGHTS

- Right to Comment
- Formal Appeal Rights

RIGHT TO COMMENT

- SOM section 2728
- Part of the response process to a Statement of Deficiencies
- Three optional approaches

RIGHT to COMMENT: OPTIONS

- Accept all deficiencies and submit a Plan of Correction
- Submit Plan of Correction and record objections to cited deficiencies
- Record objections to cited deficiencies

Recording Objections

- Record on right side of CMS-2567 form
- Refute accuracy of factual findings: must submit evidence to support objection
- SA will not consider objections to level of deficiency citations
- Refute policy standard applied to facts: cite to regulations, SOM, or other CMS/SA written interpretations integrated with facts

ADVOCACY TIPS

- Combining a Plan of Correction with Objections is the safest approach
- Irregularities in the survey process should be reported to SA or RCMS instead of using the Objections process
- Follow up with call to SA regarding Objections
- Include RCMS if no quick response on policy standards
- Secure written confirmation if deficiency withdrawn

ADVOCACY TIPS

- Objections do not slow down termination process
- Plan of Correction must meet “credible allegation” standard
- Negotiate parameters of re-survey
- Involve NAHC in policy related disputes
- Third surveys possible before end of termination cycle

DENIAL and TERMINATION PROCESS

- Initial certification denials
- Involuntary terminations
- Voluntary terminations

CAUSES

- Failure to meet CoPs
- Failure to meet basic definition of a provider
- Medicare patient discrimination
- Refusal to allow record examination
- False statements and false claims
- Failure to furnish ownership and management information

VOLUNTARY TERMINATIONS

- Provider notice of voluntary termination
- No later than 6 months after notice filed
- Cessation of operations
- SoM requires no CMS action where provider temporarily or permanently ceases all business operations
- CMS notice required if Medicare only cessation

ADVOCACY TIPS

- Provider to public notice
- CMS will notify public if non-compliance
- Watch for “Voluntary Termination” by CMS

CMS Initiated Voluntary Terminations

- Generally triggered by extended payment suspensions
- If business suspensions continue through date of CMS notice, provider has problems
- ALJs have accepted CMS voluntary suspensions

Involuntary Terminations

- Standard terminations on 90 day cycle
- Immediate jeopardy terminations on 2 to 15 day cycle
- Cycles continue during Objections and Resurvey processes

Advocacy Tips

- Early intervention is better
- Attempt to shift immediate jeopardy termination to standard termination to gain time for corrective action
- While fixing deficiencies continue compliance in all other areas

Appeal Rights

- “Reconsideration” available only for initial certification denials
- Terminations proceed to ALJ, DAB(MAC), and Federal Court
- No formal pre-termination appeal rights

ALJ Hearings

- De Novo review
- Terminations prioritized over denials
- Adversarial proceedings
- Speed of hearings varies
- Success is known

ADVOCACY TIPS

- Use of counsel is crucial
- Anticipate protracted, expensive contests
- Need extensive expert support on clinical issues
- Policies issues require in-depth, historical review and presentation
- No sympathy factor with ALJ
- ALJ has limited experience

ADVOCACY TIPS

- Expect CMS appeal if ALJ decides in provider's favor
- Anticipate CMS will use alternative approaches to close provider if termination process does not work
- Consider option of reinstatement as settlement

Reinstatement

- Deficiency has been removed
- “Reasonable assurance that it will not recur”
- Two surveys required by CMS
- Second survey follows 90 days after first
- N.B. Do not forget the provider enrollment process when considering the timing

OPTION: Acquisition

- May be cheaper route than appeal or reinstatement
- Discretion of survey action in CHOW
- Likely survey if SA/RCMS notes CHOW involving principal from terminated provider

CONCLUSION

- Get serious about CoP compliance
- Absence of recertification surveys has lead to complacency
- Refocus on recert surveys raises new risks
- Corrective action is most efficient route to survival
- Appeal process inadequate with no pre-termination protections