We Have to Comply with Medicare CoPs??

But We Are a Pediatric Agency!

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Objectives:

- Identify challenges a pediatric agency may face when seeking accreditation and initial Medicare Certification
- Describe the preparation required prior to notification of readiness for survey
- Discuss how to achieve and maintain the required census without significant loss of revenue
- Identify tools to use in preparing your staff for a successful survey
Where Do We Begin?

- Secure a location (physical building or office)
- Identify an Administrator
- Telephone and fax service established
- State Approval/Licensing
- Licensing Entities (varies by state)
- CMS
- Medicaid Certification

State Approval/Licensing

Request for approval

- Initial letter of intent
- Description of tentative service area
- Services that will be provided (minimum of two)
If licensure required the following may be requested (Contact the State Department of Health to determine licensing requirements in your state)

- Application fee
- Criminal background checks (owners and administrator)
- May request policies and procedures

State requirements:
- Detailed letter of intent
- Name of perspective Agency
- Name of owners
- Physical Address with phone and fax numbers established
- Name, title, and address for Administrator
- Agency organizational chart
- Agency Administrator's name and qualifications (resume)
- State Approval Granted
Medicare Approval

Complete 855A:

- Submit to Medicare Administrative Contractor (MAC)
- MAC will review and approve or deny
- Agency cannot be surveyed until the MAC has completed its initial review of the 855A and made recommendation for approval to CMS

Medicare Approval, cont.

- Letter indicating the accrediting organization that will be used for initial survey
- Propose Geographical Service Area for Agency
- Form CMS 1572 A and 1572 B (attached to letter)
- Form CMS 1561
- Background Checks
- Medicare Administrative Contractor (MAC) will review and make recommendation for approval or denial
OCR Packet (Office of Civil Rights)

OCR

- Civil Rights Information Request for Medicare Certification – Health Provider Information
- Assurance Compliance Form HHS 690
- Non-Discrimination Policy
- Descriptions of Non-Discrimination Notices and dissemination methods
- Admission Requirements/Eligibility
- Description of any policies or practices limiting admissions/services on the basis of age
OCR, cont.

• If greater than 15 employees – procedures used for handling disability discrimination grievances along with name of Section 504 coordinator

• Procedures to effectively communicate with individuals or are limited English Proficient (LEP)

• Procedures used to effectively communicate with individuals who are hard of hearing, deaf, blind, have low vision, or other sensory, manual or speaking skills

OCR, cont.

• Notice of Program Accessibility and methods used to disseminate information to patients about the existence and location of services and facilities that are available to persons with disabilities
Medicare Approval

Send Fully Operational Letter

- Once the agency is operational
- Has served at least ten (10) patients
- At least 7 skilled nursing patients remain active
- Serviced at least 1 patient of second service
- The CMS 855 enrollment application has been completed and approved
- Capitalization requirements have been completed

Accrediting Organizations Approved by CMS

Three Agencies Approved to Survey for Medicare Certification through Deemed Status

- CHAP – Community Health Accreditation Program (Established 1965)
- Joint Commission (Established 1951)
- ACHC – Accreditation Commission for Health Care (Established 1986)
What is Deemed Status?

- CMS may grant an organization "deeming" authority to conduct these types of surveys and "deem" each subsequently accredited health care organization as meeting the Medicare and Medicaid certification requirements.

- The health care organization would have "deemed status" and would not be subject to a separate Medicare survey and certification process conducted by the state.

Choosing an Accreditation Organization

Areas to consider:

- Cost
- Waiting Time
- Application Requirements
- Check with other Agencies on their experiences
ACHC

Cost

- $1500 nonrefundable deposit
- Total fees based upon statistics from organization’s last completed fiscal year prior to application
- If agency has not completed at least one fiscal year prior to application, applicant will submit year to date statistics

Waiting Time

Step 1:
- Register for ACHC Standards for Accreditation
- You will be assigned an Accreditation Advisor
- Logon and Password assigned

Step 2:
- Prepare your Preliminary Evidence Report (PER)
- Documents, policies and procedures that show compliance with ACHC Standards
- Time required: depends on resources allotted to project
ACHC, cont.

Step 3
Submit electronically:
- Application
- PER
- $1500 deposit
- CMS 855A approval letter
- TEST OASIS Transmission
- Medicare Certification checklist
- ACHC will review documents for completeness
- Process takes 2–3 Business Days

ACHC, cont.

Step 4
- Agreement for accreditation services sent to Agency
- Fee estimate based on demographics from Agency’s application will be sent
- Agency signs and returns within 14 days

Step 5:
- Accreditation Advisor will assign a surveyor and schedule the survey
- ACHC Surveyor will receive documents within 5–7 days for review
**ACHC, cont.**

Step 6:
- Desk Review
- Agency will be notified by ACHC of any changes needed a minimum of 30 days prior to survey
- Agency has up to 21 days to submit changes

Step 7:
- Unannounced On–Site Survey will occur approximately 60–120 days after surveyor is assigned to the Agency

**ACHC, cont.**

Step 8: Post survey
- Scoring
- Summary of Findings prepared. Surveyor has 5 business days to submit findings to Accreditation Advisor
- Review Committee with ACHC will review survey findings and decision sent to Agency (approximately 10–15 days of receipt from surveyor)
ACHC, cont.

Step 9: Accreditation Decision
- ** Accredited**: no deficiencies
- **Deferred**: Deficient in one or more standards, need to submit a Plan of Correction
- **Dependent**: Deficient in a number of standards and/or at least one Medicare Condition of Participation. Submit a Plan of Correction – a Dependent Survey will be scheduled at Agency’s expense
- **Denied**: Severity of deficiencies – Agency may reapply at a later time when prepared

Step 10: Accreditation Status

ACHC submits recommendation to CMS and the state in which the agency is located.

The state agency will review ACHC recommendations and findings and approve or reject recommendation.
CHAP

Strong Emphasis on organizational management and patient outcomes

CHAP—Responsibilities

- Review application and eligibility for accreditation
- Determine 3 year fees
- Estimate the number of site visit days
- Return 2 Accreditation Service Agreements to applicant for signature
- Upon receipt of fully executed contract Core Standards will be sent to applicant
- Average Time to Complete: 10–14 business days for Applicant to receive contracts for signature once application and fee are received. Within 5–7 business days you should receive the executed contract and the standards.
6 Step Process for Accreditation

Step 1
• Application – can be done online
• Must be licensed in the state if applicable
• Submit $500.00 non-refundable fee
• Submit any required Documents
• Return signed CHAP Accreditation Agreement
• along with first installment of 3 yearly payment
• towards accreditation fees
• Completed Self Study
• Required Patient Census
• Required additional documents

CHAP, cont.

Step 2
• Perform Self-Study Online – (Core and Service Specific)
• Must be completed within 3 months of the contract effective date
• CHAP will review the Self-Study and schedule the site visit
CHAP, cont.

Step 3 – Unannounced Site Visit
• Site visit will last 2–5 business days
• Survey report will be received within 10 business days from the last day of the site visit

Step 4 – Plan of Correction (if indicated)
• Applicant has 10 calendar days to submit
• If not accepted the applicant has 5 calendar days to correct
• Estimated time for Step 4 is 3–4 weeks

CHAP, cont.

Step 5 – Board of Review
• CHAP Board of Review will review Plan of Correction and make accreditation recommendation
• Average time to complete – 6–8 weeks

Step 6 – Board of Review determines accreditation
• Process must be repeated every 3 years
Joint Commission

Patient Safety Focus–9 Step Process

Step 1
• Fulfill your state’s licensure requirements (if applicable)

Step 2
• Complete and Submit the CMS 855a application (must be accepted before Joint Commission Site Visit)

Joint Commission, cont.

Step 3: Begin serving patients
• 10 patients served
• 7 active skilled
• 5 home visits available

Step 4: Request an application online

Step 5
• Complete application and submit $1700 non refundable fee – you will receive a standards manual (*most agencies take 3–4 months to prepare*)
Joint Commission, cont.

Step 6
• Notify your state in writing that you intend to utilize Joint Commission to satisfy Medicare Survey Requirements *(One copy to state and one to Joint Commission Account Executive)*

Step 7
• Complete an OASIS test transmission *(Have verification ready to share with Joint Commission account executive)*

Joint Commission, cont.

Step 8
• Verify your application information with Joint Commission account executive

Step 9: Prepare!
Submitting Request for Accreditation Survey

- Review and compare Medicare CoPs, State regulations, and accreditation organization standards
- Must comply with all standards/regulations
- Notify Medicare Administrative Contractor (MAC) which AO you will be using (if not already notified)

Listing of Medicare Administrative Contractors for Home Health and Hospice

- NHIC, Corp (Region A)
- CGS Administrators, LLC (Region B)
- Palmetto GBA, LLC (Region C)
- National Government Services, Inc (Region D)
Home Health and Hospice Jurisdictions (Administered by A/B MACs)

- Use a team approach
- Develop a realistic project plan and timeline
- Review current Policies and Procedures
  - Policy: statement of intent
  - Procedure: guiding principal
  - Sample Policies may be purchased and edited to save on time
- Educate Staff on changes and Implement new policies

Submitting Request for Accreditation Survey
Submitting Request for Accreditation Survey, cont.

- Meet frequently to assess progress
- Develop a crosswalk to ensure compliance

PER (Preliminary Evidence Report), Self-Study, Application

List:
- CoP/Regulation/Standard (type out the standard number)
- Evidence (how is the standard met)
- Comment (Policy # or copy attached)

Submitting Request for Accreditation Survey, cont.

- Obtain CLIA Waiver
- OASIS – ability to transmit
  - Agency has to provide proof that they are able to transmit OASIS data
Preparing for Survey

Ongoing Education of staff

• Need to get staff buy-in, emphasize quality
• Involve all staff in the process
• Know and understand reports that will need to be completed
• Know your resources
• Prepare a survey manual – what to do

Preparing for Survey, cont.

Require admission of 10 patients and have 7 active at time of survey

• Need to maintain 7 skilled nursing active patients
• At least one patient receiving second service in the total 10 served

Patients need to meet Medicare admission requirements

• Face-to-Face
• Primary diagnosis
• Require skilled nursing services and/or Home health aide services
Preparing for Survey, cont.

Mock Survey
- Practice survey
- Prepare staff for interview questions
- Is Office well organized and required certificates/references easy to find
- Use checklist provided by AO to make sure all areas are available

Preparing for Survey, cont.

Chart Audits
- Make sure charts are neat and consistently organized
- Make sure all required documents in chart
- Review documentation for appropriateness and thoroughness

Personnel File Audits
- Required education in files
- Consistent organization
Challenges a Pediatric Agency May Face

Require admission of 10 patients and have 7 active at time of survey

- Need to maintain 7 skilled nursing active patients
- At least one patient receiving second service in the total 10 served

Preparing for Survey

- Appoint a Professional Advisory Committee (PAC)
- Convene PAC
- Have PAC minutes available for on-site review by surveyor
Challenges a Pediatric Agency May Face...

- Patients need to meet Medicare admission Requirements
  - Face-to-Face
  - Primary diagnosis
  - Require skilled nursing services and/or Home health aide services
- Cannot bill for these patients
  - Minimize out-side field staff work
- Visits vs. extended hourly
- Minimizing Expenses up to certification

Challenges a Pediatric Agency May Face, cont.

- Educate referral sources
  - Type of service required to obtain accreditation
  - Service may be different than what your Agency completes (pediatric versus geriatric)
- Admitting patients with reasonable expectation to meet discharge
- Educate patients on process
- Inform patients of need to give written approval for survey visits
Maintain Compliance with Patients

- Compliance with documentation
  - Care Coordination
  - Education documented
  - Relationships exists between diagnosis, medications, treatments, and goals

- Reportable Parameters
  - Based off of physician orders/diagnosis/treatment, and medication
  - Documentation appropriate based off of reportable parameters

Maintain Compliance with Patients, cont.

- Show Progress Towards Discharge
- HHABN
- Notice of Medicare of Non-coverage
- Supervisory Visits
  - Accrediting organization required more frequent supervisory visits than COPs
Common Reports a Surveyor Will Ask For...

- Unduplicated Admission Report
- Schedules
- List of current patients, include SOC, payor source, primary diagnosis and services provided
- List of patients discharged and reason for discharge
- Home Health Aide Case
- List of all employees hired (may be a certain time frame)

Unannounced On-Site Survey

- Number of surveyors depends on your census
- Ask for identification from the surveyor
- Opening Conference
- Agency tour – show Surveyor around office
Unannounced On–Site Survey, cont.

- Data Collection:
  - Personnel files
  - Patient record review
  - Financial/billing records
  - Service contracts
  - Risk Management
  - Performance Improvement (PI) Activities
  - Policies and Procedures (P & P)
  - On–site observations (patient visits)
  - Personnel and patient interviews
- Closing Conference

Survey Statement of Deficiency and Plan of Corrections

- Agency will receive a summary of survey
- Plan of Correction will need to be completed by Agency and returned for approval by accrediting organization
  - Non–compliance with a standard or CoP
  - Is this at condition level or deficiency level
  - Actions that Agency will take to correct findings and to monitor that this will not occur again
  - Date Agency will meet compliance with this deficiency and/or condition level
  - Who is responsible for the corrections
  - Process Agency will take to prevent from occurring again
Transitioning Adults Back to Pediatrics

- Current patients – evaluate their progress towards goals. Discharge when goals met.
- Assist with locating other Agencies that may assist with patients’ needs if not consistent with Agency specialty
- Decrease visits as medically needed
- Educate resources on accreditation and focus of pediatric admissions
- Begin admitting pediatric patients

Maintaining Compliance With Pediatric Patients After Obtaining Accreditation

- Documentation
- Education
- Keep updated on any changes with Accrediting Agency – subscribe to email updates
- Keep updated on regulatory changes
- Professional organization list-serves (NAHC)
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Resources

- ACHC  www.achc.org
- CHAP  www.chapinc.org
- Joint Commission  www.jointcommission.org
- Homecare Survey Prep and Survival Guide, Paula Long, RN, CHCE
- The Home Health Conditions of Interpretive Guidelines, Beacon Health
Resources

Websites for MACs

- NHIC, Corp (Region A)  
  www.medicarenhic.com/

- CGS Administrators, LLC (Region B)  
  www.cgsmedicare.com/

- Palmetto GBA, LLC (Region C)  
  www.palmettogba.com/medicare

- National Government Services, Inc (Region D)  
  www.ngsmedicare.com/