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Shake the Headache

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Ease the pain of accreditation and watch referrals and revenue increase.

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The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandates accreditation for HME suppliers who wish to be Medicare suppliers. While there is no time frame for mandatory accreditation in the legislation, it is a safe bet that it will coincide with the implementation of Medicare's competitive bidding program.

Both competitive bidding and accreditation will require that providers tighten up their processes to operate as efficiently as possible. Providers already overwhelmed with regulations and all-too-frequent reimbursement woes will have more on their plates than ever before. But the fact is that competitive bidding without mandatory accreditation would likely be a worse scenario.

Why? Because accreditation may be the only effective way to level the playing field among potential "bidders" in the competitive bidding program. Let's face it—there is a tangible cost (in terms of dollars) for the HME supplier that commits to providing a level of care consistent with satisfactory patient outcomes. It is certainly true that many HME suppliers pride themselves on the quality of care their company provides; no additional rules or regulations required. But with ever-tightening reimbursement by payors across the board, standards of care are not universally followed—corners get cut every day. By adopting quality standards that all HME companies must meet to qualify for a share of the Medicare DME market, providers can be assured that they are bidding against the same set of deliverables as their competition.

Currently, HME providers seeking accreditation have three accrediting bodies to choose from—the Joint Commission for Accreditation of Healthcare Organizations (JCAHO); the Accreditation Commission for Health Care (ACHC); and Community Health Accreditation Program (CHAP). The differences among these accrediting bodies are minimal in many respects. They share the same basic accreditation standards; they each accredit organizations in 3-year cycles; and all three reserve the right to conduct random unannounced surveys at their option. The costs charged for accreditation survey are fairly similar as well, although JCAHO and ACHC have an arguably more straightforward, less complex method of calculating fees charged to the provider.

How then to choose which organization to accredit your company if it has never been accredited before? Some insurance payors require accreditation as a condition of their contracts with providers. The choice should depend, in large part, on which accrediting organizations are recognized by other payors your company contracts with or hopes to contract with in the future. JCAHO, having had many years' head start on their competitors, is recognized by nearly all insurance payors. However, ACHC and CHAP have also gained wide recognition by more and more insurance payors in the past few years.

If insurance payor preference is not an issue, the choice largely comes down to personal preference. In that instance, your best bet is to take the time to speak with representatives of all three accrediting bodies and briefly review the basics of their individual requirements for accreditation before making a decision.

Once you have settled on an accrediting organization, you should receive a manual that outlines the standards for certification. Generally, your company will need to demonstrate 4 to 6 months of compliance with these standards to successfully complete an accreditation survey. Combine that with the 4 to 6 months' it takes to bring an organization seeking first-time accreditation into compliance with the required standards, and it is easy to see that planning for a survey should start 8 to 12 months before the anticipated need.

The Devil in the Details

Once you are ready to seek accreditation, the best place to start is a comparison between your company's policy and procedures, and the written standards provided to you by the accrediting body that you chose. Check to see that your company has policies and procedures that cover the numerous standards of the accrediting body and make note of areas where further policy and procedure development will be required. If your company does not have formal, written policies and procedures in place, now is the time to write them. That, of course, can be a time-consuming task. Alternatively, you can purchase a set of policies and procedures designed for HME providers seeking accreditation and customize them .

Next, review your procedures to assess whether your company has set up realistic criteria within the individual policies. Although accrediting organizations will insist that you have certain policies in place, they will not mandate the specifics unless those specifics are mandated by state or federal regulations. In essence, the details are up to you.

However, your company will be scored on whether it follows the policies and procedures that have been adopted. For instance, if your company's policy and procedures call for follow-up of oxygen patients by a

respiratory care practitioner within 3 days of setup, the accrediting body will hold you to that standard and will look for documentation in patient records that follow-up calls are made within the proper time frame. The bottom line is that each and every policy you adopt should define realistic, achievable criteria within the framework of acceptable standards.

Once you have fine-tuned the policies and procedures, do an audit or self-survey to determine if your operations reflect compliance with the criteria you have established. To help you identify opportunities for improvement, the audit should mimic an actual accreditation survey as closely as possible.

Review the personnel files of all company employees, including contracted employees who work on an "as needed" basis. Pay particular attention to assessing whether your are in compliance with accreditation standards that require that orientation, training, and competency testing activities are completed and documented; that all state and federal regulations are being followed; and that job descriptions and employee evaluations are accurate and up to date.

Next, audit a random sampling of your patient records to determine if your company is in compliance with documentation standards. This documentation, at a minimum, should include a home assessment and plan of care for patients receiving recurring rental equipment; delivery tickets, signed by the patient or caregiver that discloses patient payment responsibilities; and emergency contact information. Also look for documentation of acknowledgment by the patient or caregiver that they have been instructed on the equipment provided, and informed of your company's contact information as well as their rights and responsibilities as a client (and the privacy policy that your company adheres to in compliance with HIPAA regulations).

Documentation in the patient record should conform to state and federal regulations, particularly those that require recording of serial and lot numbers of equipment and supplies provided to specific patients—so that proper procedures can be instituted in a recall. Last, make sure patient follow-up visits and equipment checks are completed and documented. And remember, it is necessary that your patient care documentation demonstrate that staff members have addressed and resolved any problems identified during follow-up visits.

Accreditation can be time-consuming, but the payoffs are numerous. Not only will your company be able to contract with a wider ranger of payors, but the enhancements to the quality of care your company provides can help drive revenue by increasing referrals.

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