



HOME HEALTH SITE SURVEY SURVIVAL GUIDE

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INTRODUCTION

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Home health agencies (HHAs) are required to meet the definition of an HHA in section 1861(o) of the Social Security Act (the Act) as well as be in compliance with the Federal requirements set forth in the Medicare Conditions of Participation (CoPs) in order to receive Medicare/Medicaid payment. The goal of the HHA survey is to determine if the agency is in compliance with the CoPs set forth at 42 CFR Part 484.

The HHA survey process incorporates an approach that is patient-focused, outcome-oriented, and data-driven, making it more effective and efficient in assessing, monitoring, and evaluating the quality of care delivered by an HHA. Through the survey process, surveyors determine if the HHA has the ability to meet minimum health and safety standards, deliver needed patient services and, most importantly, if the delivery of those services impacts the quality of care and results in positive patient outcomes.

Longstanding surveyor guidance was updated in a [Survey, Certification and Enforcement Procedures letter](#) issued by CMS on March 14, 2014 to enact changes prompted by the introduction of sanctions in home health. In its revised guidance to surveyors, CMS expressed the overall goal of ensuring the provision of care necessary to attain and maintain the “highest practicable functional capacity” through sustained (not cyclical), substantial, compliance with Medicare requirements and state law. In this letter, CMS provided State Agencies with revised guidance to surveyors.

The purpose of this guide is to direct HHAs to the survey protocols and guidance surveyors use to prepare for the survey, conduct the survey, and evaluate the survey findings. Survey survival and avoidance of deficiencies depends on a HHA’s ability to remain in continuous compliance with the CoPs, understand the survey process, and know their rights during and after a survey. Sanctions, which went into effect in 2013, can be imposed when survey deficiencies indicate substandard care. Sanctions include: 1) civil money penalties, 2) suspension of payment for all new admissions, 3) temporary management of the HHA, 4) directed plan of correction, and 5) directed in-service training. Continuous, substantial compliance with the CoPs is essential to avoid sanctions, which can result in disruption of HHA operations and cash flow.

THE SURVEY PROCESS

THE SURVEY PROCESS

Surveys must be unannounced, whether Routine (initial or 36-month resurvey), Complaint, Change of Ownership (CHOW), Reactivation of Billing, Significant Change in Services, Addition of a Branch, Look-Behind, or Validation. HHAs must always be prepared for a surveyor visit since surveys may occur at any time, not just within the 36-month resurvey timeline.

Each Condition of Participation consists of multiple standards, which are assigned “G” tags. G tags are assigned to one of three levels, based on their impact on patient care:

- Level 1: Most related to patient care
- Level 2: Moderately related to patient care
- Level 3: Least related to patient care (all others)

STANDARD AND PARTIAL EXTENDED SURVEYS

The survey process begins as a Standard Survey with evaluation of compliance with the Level 1 standards. If compliance with all Level 1 standards is found, the survey ends. However, if noncompliance is found, or noncompliance with additional conditions is suspected, the surveyor must proceed to a Partial Extended Survey. A Partial Extended Survey includes addition of evaluation of Level 2 standards, which are those moderately related to patient care, and may be extended to other related conditions at the surveyors discretion.

Deficiencies are defined as either standard level or condition level as follows:

- Standard level deficiency: Noncompliance with one or more of the standards that make up each condition of participation for HHAs.
- Condition-level deficiency: Any deficiency that substantially limits the provider’s or supplier’s capacity to furnish adequate care or which adversely affects the health or safety of patients

According to §488.24, the State Agency surveyor will certify that a provider is not in compliance with the CoPs where the deficiencies are of such character as to *substantially limit the provider’s capacity to furnish adequate care, or which adversely affect the health and safety of patients.*

THE SURVEY PROCESS

EXTENDED SURVEYS

When substandard care is identified during a standard survey, defined as noncompliance with one or more conditions of participation at the condition-level, an Extended Survey ensues. The Extended Survey reviews and identifies the HHA's policies, procedures, and practices that produced the substandard care and may also review additional CoPs depending on the nature and extent of serious risk to patients that is identified in the standard survey. If the surveyor identifies or suspects an immediate jeopardy situation, (has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident), the surveyor must follow guidance which could lead to immediate termination of an HHA.

In the event that a surveyor identifies the need for an Extended Survey, the following additional material may be examined in order to determine compliance with Level 2 Standards:

- Personnel records
- Contracts
- Policies and procedures
- Clinical/procedural references
- Documentation of home health aide training and/or competency evaluation
- Documentation of complaint investigation and resolution
- CLIA waiver (if any)

SURVEY PREPARATION

SURVEY PREPARATION

The more familiar HHAs are with the regulations and surveyor policies and protocols, the better the outcome of their survey experience. Surveyors are required to use the following primary investigation methods:

- HHA staff/patient interviews
- Home visits to patients
- Clinical records reviews

Further, since surveyors are required to analyze the following documents prior to initiating a survey, HHA systems for continuously monitoring and updating these documents are essential:

- Licensure (agency and professional)
- Prior survey results and compliance with plans of correction
- Complaint history and resolution
- OASIS Reports: Potentially Avoidable Events Report; OBQI Outcome Report; Patient/Agency Characteristics Report (used to select records/visits); Submission Statistics by Agency Report; Error Summary Report by HHA

STANDARD SURVEY LEVEL 1 G TAGS

Surveyors are instructed to assess for compliance with Level 1 G Tags during a standard survey using the three investigative methods: staff/patient interviews, home visits, and record review. CMS does not prescribe how HHAs are to meet requirements, but will inspect HHAs for “evidence that” they have appropriate protocols and practices in place during day-to-day operations that ensure compliance with regulations.

§484.10 Patient rights

G107 Investigate & document complaints & resolutions

The expected outcome for this Level 1 standard is that all complaints are investigated, resolved and documented by the HHA. Evidence that:

- Patients are informed of their right to express grievances
- Identification, investigation and resolution of complaints policies are followed
- Complaints and their investigations and findings are documented

SURVEY PREPARATION

G109 Participate in planning of care & treatment

The expected outcome for this Level 1 standard is that patients are involved in developing their plan of care. Evidence that:

- Patients are informed about and contribute to planning
- Staff facilitate patient/caregiver's participation on planning care
- Plans of care address the patient identified needs and goals

§484.12 Compliance with Federal, State & local laws, disclosure, ownership information, accepted professional standards & principles

G121 Comply with professional standards & principles

The expected outcome for this Level 1 standard is that all care providers follow parameters defined by State practice acts, Federal and State laws and regulations, HHA policies and other professionally accepted guidelines (e.g., CDC guidelines for infection control). Evidence that:

- All clinical staff members (direct and contractual) follow professional practice standards, laws, HHA policies and procedures (e.g., handwashing and infection control measures, injections and wound care, documentation of wound status, or physical assessment)
- Skills of staff are monitored to determine if their skills are appropriate and adequate for the agency's patients (e.g., competency testing, supervisory visits, skills labs, etc.)

§484.14 Organization, services, and administration

G123 Identifiable lines of authority

The expected outcome for this Level 1 standard is that the lines of authority within the HHA are clearly defined for delegation of responsibility to the patient care level. Evidence that:

- An organizational chart provides descriptions of relations between administrative and clinical staff
- Staff are aware of the organizational structure, lines of authority, delegation of responsibility, and services furnished (both directly and under arrangement) and the HHA's relationship to any corporate structure
- Agency operations at any additional locations, branches are identified and oversight provided

SURVEY PREPARATION

G133 (Administrator) Organizes & directs the agency's functions

The expected outcome for this Level 1 standard is that the HHA has a qualified administrator appointed by the governing body who directs day-to-day agency functions according to regulations, policies and procedures and maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. Evidence that:

- Administrator meets required qualifications
- Appointment/approval of the administrator was by the governing body
- Policies and practices to ensure ongoing liaison with the governing body are followed

G143 Maintain liaison & support plan of care objectives

The expected outcome for this Level 1 standard is that information regarding each patient's health status and plan of care is communicated among all relevant care providers, including, but not limited to, the home health aide and the physician. Evidence that:

- Policies exist and are followed for provider communication about clinical findings and plan of care with patient/caregivers and other providers within and outside the agency (e.g. professional staff, home health aides, physician(s))
- Coordination of care planning among staff and/or contract personnel providing services occurs
- Information about changes in patient's condition, response to interventions (e.g., medication side effects, responses to wound therapy, laboratory values, etc.) and teaching, changes in the plan of care, and discharge planning are discussed with or forwarded to the appropriate care providers and clinical managers
- Discharge planning is coordinated with, and communicated among, the appropriate care providers

G144 Documentation shows effective care coordination

The expected outcome for this Level 1 standard is that communication among care providers is documented. Evidence that:

- Coordination documentation policies and guidelines are present
- Coordination activities to providers within and outside the agency, including case conferences, informal conferences and phone calls are documented in the clinical record (e.g., information about changes in condition, changes in plan of care, medication side effects, responses to wound therapy, laboratory values, teaching, progress toward goals and discharge plan)

SURVEY PREPARATION

§484.18 Acceptance of patients, plan of care & medical supervision

G157 All patients' needs adequately met in residence

The expected outcome for this Level 1 standard is that the HHA will only accept patients for care if the HHA can adequately meet the patient's medical, nursing and social needs in the patient's place of residence. Evidence that:

- Policies exist to ensure that patients are admitted or are denied services according to the intent of this standard
- If the agency has trouble staffing to meet the patient's need, the physician and patient are notified and options discussed (e.g. transfer to another agency, delay in services that would not jeopardize patient safety)

G158 Care follows written plan/reviewed by physician

The expected outcome for this Level 1 standard is that every HHA patient will have a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Evidence that:

- Every patient, regardless of payer, has a physician ordered and signed plan of care
- Plans of care include all required elements and are signed and dated by physicians (diagnoses, services, frequency, medications, functional status, goals, etc.)
- All physician orders, including interim written and verbal orders are in the patient's record
- Timing of physician signatures is in accord with agency policy and State regulations, and prior to submitting a final claim to Medicare
- Policies exist and are followed to resolve any problems securing timely physician signatures

G159 Plan of care covers all pertinent diagnoses

The expected outcomes for this Level 1 standard are that patients receive appropriate services and care based on an assessment of their needs and physician orders and that HHA develops a plan of care specific to each patient's needs and containing all required elements. Evidence that:

- The plan of care addresses all medical, nursing, rehabilitative, social, and discharge planning needs identified in the comprehensive assessment
- Interventions are detailed and implemented for all primary and secondary diagnoses
- For patients with co-morbidities, there is evidence that inter-related factors are addressed in managing the patient's care (e.g., addressing nutrition and skin care in a wound care patient who has diabetes)

SURVEY PREPARATION

G164 Alert physician of changes in condition

The expected outcome for this Level 1 standard is that changes in patient status, including measurements outside of stated parameters or any changes that suggest a need to alter the plan of care, are reported promptly to all ordering physician(s), including notifying all ordering physician(s) and physicians responsible for patients after discharge of discharge plans.

Evidence that:

- Changes in the patient's condition are documented in the patient's clinical record
- Physician(s) are notified of changes in pertinent clinical findings
- Physician(s) are notified of failure of patients to progress toward established goals suggesting need to revise the plan of care
- Physician(s) are notified if the patient progresses to the point where it is no longer reasonable and necessary to continue services

G165 Administer drugs/treatments ordered by doctor

The expected outcome for this Level 1 standard is that HHA staff administer only medications and treatments as ordered by the physician (except influenza and pneumonia vaccines, which may be administered per agency policy after assessment for contraindication. Evidence of:

- Physician orders for all medications administered (including topical medications)
- Patient assessments for contraindication to administration of influenza or pneumococcal vaccines (as appropriate)

G166 Verbal orders put in writing/signed/dated

The expected outcome for this Level 1 standard is that all verbal orders are written, signed and dated by the appropriate RN or qualified skilled therapist. Evidence that:

- Agency has policies and procedures for obtaining physician orders, including initial and interim verbal orders
- Personnel who accept verbal orders do so in accordance with State and Federal law and regulations and HHA policy
- Verbal orders are signed and dated by the registered nurse or qualified therapist who is furnishing or supervising the ordered service
- That the responsible RN or therapist makes necessary revisions to the plan of care based on verbal orders

SURVEY PREPARATION

§484.30 Skilled nursing services and §484.32 Therapy services

G170 In accordance with the plan of care

The expected outcome for this Level 1 standard is that each patient receives nursing care (and therapy services) as ordered on his/her plan of care. Evidence that:

- Clinical managers ensure that physician orders, agency policies, and regulations are being followed in delivering care to each patient (including obtaining interim orders and getting physician signatures)
- Care is provided in accordance with laws, regulations, state practice acts, accepted professional standards or HHA policies/procedures (e.g., wound care procedures, prevention of infection, physical assessment, and medication review)
- Services began as ordered within the ordered time frame, at the frequency ordered
- Plans of care are patient-specific (i.e., contain measurable goals and instructions for care that are specific to the individual patient) with stated parameters for measurements where appropriate
- Care is provided to each patient as ordered on the plan of care
- Patient needs that are not addressed in the plan of care are communicated to the physician
- Licensed practical nurses, physical therapy assistants, occupational therapy assistants are appropriately supervised according to State practice acts and the HHA's policies and procedures

G172 Regularly re-evaluates the patient's nursing (and therapy) needs

The expected outcome for this Level 1 standard is that the patient's status and nursing (and therapy) needs are re-evaluated by the RN (or therapist) at least every 60 days (or more often if the patient's condition or needs change). Evidence that:

- Clinical status, progress are evaluated in relation to the specific care that has been provided
- Any intervening events that impact progress have been recorded appropriately
- Updated and follow-up assessments are completed and transmitted according to OASIS requirements

SURVEY PREPARATION

G173 Initiates the plan of care and necessary revisions

The expected outcome for this Level 1 standard is that the RN (and therapist) initiate the plan of care and any revisions to plan of care when appropriate. Evidence that:

- The plan of care was updated if indicated by a change in patient condition or needs
- All ordering physicians are informed of revisions to the plan of care

G174 Services requiring specialized nursing skill (or therapy skill)

The expected outcome for this Level 1 standard is that patients who have specialized nursing (or therapy) needs receive care from qualified nurses (or therapist) who are capable and competent to provide care as ordered and needed. Evidence that:

- Nurses and therapists have the appropriate training and/or credentials to carry out specialized procedures (e.g., IV care, ostomy care, wound assessment and care)

G175 Preventive/rehabilitative nursing procedures

The expected outcome for this Level 1 standard is that patients receive appropriate preventive and rehabilitative nursing care as ordered on the plan of care. Evidence that:

- Rehabilitative nursing is provided by nurses with adequate knowledge and skills and in coordination with therapists as appropriate

G176 Skilled Nurse: Prepares clinical & progress notes, coordinates services, informs physician of changes, and G187 Therapist: Prepares clinical and progress notes

The expected outcomes for this Level 1 standard are: The clinical and progress nursing (and therapy) notes are complete and provide consistent (i.e., non-conflicting) data regarding patient status and treatments/services provided; and they regularly coordinate and communicate with other staff members and the physician about the patient's condition and needs. Evidence of:

- Documentation of necessary information about patient condition, interventions, teaching, and response to interventions and teaching, changes in the plan of care, and discharge planning
- Documentation of exchange of information to other caregivers within and outside the agency, patient/caregivers and physician(s)

SURVEY PREPARATION

G177 Skilled Nursing: Counsels patient/family in meeting all needs, and G188 Therapy: Advises/ consults with family/personnel

The expected outcome for these Level 1 standards are that the RN (and therapist) counsels the patient and family in meeting nursing and related needs and communicate with patient/family and other agency personnel such as the physician and other disciplines regarding patient's progress towards goals and outcomes. Evidence of:

- Teaching provided to patient/caregivers based on needs identified in the comprehensive assessment and plan of care
- Responses to teaching and necessary amendments to the plan based on those responses

§484.32 Therapy services (In addition to above)

G186 Assists physician in evaluating/developing plan of care

The expected outcome for this Level 1 standard is that the qualified therapist assists the physician in evaluating the patient's level of function (e.g., evaluates the patient when ordered), and assists the physician in developing and revising a plan of care that addresses the patient's needs. Evidence that:

- Therapists communicate their findings to the physician
- Therapists develop a plan with the physician that spells out treatments, modalities, and frequency

§484.36 Home health aide services

G224 Written Instructions by the RN or Therapist

The expected outcome for this Level 1 standard is that the home health aide receives written instructions by the RN or other appropriate professional responsible for supervising the aide for patient care that are clear and complete and address patients' current needs. Evidence that:

- Written aide instructions (plans) are prepared by appropriate skilled professional
- Aide instructions are clear and complete, according to the specific patient's needs, and in accord with physician orders (e.g. frequency of visits)
- Copies of aide instructions are accessible to appropriate parties (e.g. to aide, patient, clinical record)
- Aides are knowledgeable of findings, condition changes, problems to report and to whom

SURVEY PREPARATION

G229 On-site visits every two weeks

The expected outcome for this Level 1 standard is that the aide supervisory visits occur no less frequently than every 14 days. Additional instruction is provided to the aide if needed based on the information obtained from the supervisory visits. Evidence that:

- Aide supervisory visits to patients receiving skilled care occurred every two weeks
- Demonstration of special care procedures was provided to the aide and documented
- Visits requiring direct observation of the aide providing care was carried out as required and documented

§484.48 Condition: Clinical records

G236 Maintain in accordance with professional standard

The expected outcomes for this Level 1 standard are: every patient has a clinical record that contains all required elements in accord with professional standards, agency policies and HIPAA standards. Evidence that:

- Clinical record for every patient contains all required elements and is current, organized, and provides a clear synopsis of the services provided to the patient by staff or contractors
- Filing of documents into the clinical record is current according to agency policy and any applicable State filing timelines
- Electronic signatures are accepted in accord with professional standards and agency policy and meet authentication criteria
- Originals and subsequent copies of corrected comprehensive assessments are maintained
- Documentation details such information as vital signs; insulin injections; blood glucose values; wound appearance, location(s) and treatment; and pain location(s), frequency, severity, interventions, and response to intervention
- Clinical record corrections are made in accord with professional standards and agency policy
- Policies are present and followed for the safety and confidentiality of patient records is ensured within and outside the office
- Monitoring systems are in place to determine compliance with policies regarding documentation, filing, record confidentiality

SURVEY PREPARATION

§484.55 Comprehensive assessment of patients

G331 RN (or therapist when therapy only) conducts an initial assessment visit

The expected outcome for this Level 1 standard is: The RN (or therapist) completes the initial assessment and the comprehensive assessment and the comprehensive assessment is consistently complete and findings are addressed in plan of care. Evidence that:

- Initial assessment policies address how Medicare eligibility and homebound status are determined
- The initial assessment visit is conducted to determine the immediate care and support needs of the patient by a nurse if nursing service is ordered

G332 Initial assessment within 48 hours or upon start-of care date

The expected outcome for this Level 1 standard is that the patient receives an initial assessment within the required timeframes. Evidence that:

- Agency policy for an initial assessment visit complies with federal and state requirements
- Physician specified start of care dates are documented when applicable
- Intervening events that prohibit completion of a start of care in the required timeframe are documented in the record and the physician informed

G334 Standard: Completion of the comprehensive assessment: Assessment must be completed no later than 5 calendar days after the start of care date

The expected outcome for this Level 1 standard is that the comprehensive assessment is completed within required time frames. Evidence that:

- According to OASIS data management reports and records reviewed on site, the start of care comprehensive assessments are completed within the required time frame
- Explanations for start of care comprehensive assessments completed outside of the required time frame are documented (e.g. patient refused visit)

SURVEY PREPARATION

G335 RN must conduct a complete assessment and for Medicare patients determine eligibility & homebound status

The expected outcome for this Level 1 standard is that for Medicare and Medicaid patients receiving skilled nursing services, an RN conducts and completes the comprehensive assessment, and confirms the eligibility of Medicare patients, including homebound verification, for the Medicare home health benefit. Evidence that:

- When nursing and therapy *are both ordered* at the start of care, the registered nurse performs the start of care comprehensive assessment

G336 PT/ST/OT may complete comprehensive assessment if only service ordered. The OT may complete if OT establishes eligibility.

The expected outcome for this Level 1 standard is that for a therapy-only case, the RN (if required by agency policy or State law) or the physical therapist or speech language pathologist conducts and completes the comprehensive assessment at the patient's admission to the HHA. Occupational therapists may conduct and complete the assessment when the need for occupational therapy establishes program eligibility. Evidence that:

- The appropriate clinicians conducted the comprehensive assessments

G337 Comprehensive assessment must include review of all meds the patient is currently taking

The expected outcomes for this Level 1 standard are: The comprehensive assessment consistently includes a thorough review of the patient's medications, including all prescribed and over-the-counter medications the patient is using, to identify any potential adverse effects and drug reactions; the patient's medication list or medications are reviewed and the medication profile/list is updated; and the physician is notified promptly regarding any medication discrepancies, side effects, problems or reactions. Evidence that:

- Policies exist and are followed for medication assessment for all (including therapy only) patients on ALL medications prescribed/used (i.e. oral, injectable, topical, over-the-counter)
- Discrepancies between medications in the home, on the plan of care, medication list and visit notes are addressed with the physician
- Patients are assessed for potential adverse effects and drug reactions
- Physician(s) are notified of adverse effects, patient compliance issues

SURVEY PREPARATION

G338 Comprehensive assessment must be updated & revised

The expected outcomes for this Level 1 standard are: The comprehensive assessment is updated and revised as required and updated patient information is included in care planning; and the comprehensive assessment data are consistent with other patient status data in the clinical record. Evidence that:

- Other Follow-Up assessments are conducted and documented when the patient has a major decline or improvement

G340 Within 48 hours of the patient return home after 24 hours or more hospital stay other than diagnostic tests

The expected outcome for this Level 1 standard is that the patient's needs are assessed and incorporated into the plan of care upon his/her return home from a hospital stay (as described in this requirement). Evidence that:

- Resumption of care assessments are completed within the required timeframe
- Reasons why an assessment was not completed within the required time frame are documented and valid

SURVEY COMPLETION

SURVEY COMPLETION

Upon completion of every survey, the surveyor must analyze findings relative to each requirement to determine the presence of deficiencies, and whether the deficiencies are standard or condition level. A CoP may be considered out of compliance for one or more standard level deficiencies and cited at the condition-level, if, in a surveyor's judgment, the deficiency constitutes a significant or a serious finding that adversely affects, or has the potential to adversely affect, patient outcomes.

A condition is cited based upon:

- The effect or potential effect on the patient care outcomes,
- The degree of severity,
- The frequency of occurrence, and
- The impact on the delivery of services.

SURVEY SANCTIONS

Once a survey is completed, imposition of sanctions depends on the following:

- Extent of jeopardy to patient health and safety
- Nature, manner, degree, duration of noncompliance
- Presence of repeat deficiencies (i.e. failure to correct & sustain compliance)
- Extent deficiencies directly related to poor quality care
- Extent HHA is part of a larger organization with performance problems
- Indication of system-wide failure to provide quality care
- Other factors including history of noncompliance with CoPs

AGENCY RESPONSIBILITIES

AGENCY RESPONSIBILITIES

HHAs must be prepared to provide all of the following during a Standard Survey:

- Access to the HHA once surveyor identification has been verified
- Access to agency administrator (or acting administrator)
- Space for an entrance interview, record review, and exit conference
- Explanation of organizational structure, a copy of the organization chart, lines of authority, delegation of responsibility, identification of services furnished (both directly and under arrangement) and any HHA relationship to a corporate structure.
- Information about additional locations, including branches
- A roster of agency patients and the number of unduplicated patients admitted for skilled services during a recent 12-month period
- A list of all active patients (Medicare/Medicaid/private pay) receiving skilled services that identifies the start of care (SOC) date, primary diagnosis, and services provided
- A list or access to names of patients scheduled for a home visit during the survey, including patients in all branch locations
- A list of current (direct and contracted) employees (including name and title)
- The names of key staff and clinical staff person(s) who will be the primary resource to respond to the surveyor's questions
- On site unrestricted access to the clinical records
- Guidance on clinical record system (paper and electronic)
- Access to staff for needed interviews
- Access to patients for home visits
- Photocopies, if requested, of documents and records
- Participation in exit conference
- Completion of a plan of correction for all deficiencies not reversed in an IDR

AGENCY RIGHTS

AGENCY RIGHTS

During a survey, HHAs have the right to:

- Have agency staff assist with collection of documentation and provide guidance on clinical record system
- Be present in the agency at all times that the surveyor is on-site
- Request clarification of any surveyor comments/statements
- Offer home visit transport/escort to surveyor
- Offer additional evidence to the survey team (e.g. documentation, policies, staff input, CMS information) to clarify or refute negative findings
- Request resolution of conflicts with survey team from State Agency supervisor and CMS Region Office if necessary
- Unlimited agency representation during exit conference (Exception: unless approved by the survey team, attorney presence may lead to termination of conference)
- Exit conference with full review of preliminary findings
- Audio record exit conference (Must provide copy to surveyor)
- Video record exit conference (With surveyor permission only)
- Additional explanation of findings
- Present additional evidence to refute deficiencies during and after the exit conference (but before a statement of deficiencies is issued)
- Contact the surveyor, survey supervisor and/or the CMS Region Office if survey errors are suspected in statement of deficiencies
- Submit an Informal Dispute Resolution (IDR) if disagree with Condition Level deficiency
- Write a plan of correction
- Record disagreements and offer additional supporting documentation along with the plan of correction
- Submit credible allegation and request resurvey once plan of correction is accepted
- Appeal sanctions

PLAN OF CORRECTION

Although HHAs have the right to an IDR process to contest deficiencies, the policies and time clock for response to cited deficiencies remains in place. Therefore, HHA are advised to address all disagreements with surveyor findings before a written statement of deficiency is finalized. Timing is critical since, once a deficiency is cited, a plan of correction is required whether the deficiency citation was correct or incorrect.

YOUR KEY TO SURVEY SUCCESS

ENSURING SURVEY SUCCESS WITH HEALTHCAREFIRST

At HEALTHCARE*first*, we are here to partner with you to make your site surveys as pain-free and easy as possible by delivering a comprehensive EHR system backed by superior support and service.

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- **Patient Care** - With an intuitive point of care solution featuring our innovative CAREpliance™ technology, clinicians can conduct assessments, establish the plan of care, and complete visits with ease while ensuring compliance with CMS documentation requirements.
- **Quality Assurance & Coding** - QA is a breeze with *first*HOMECARE. CAREpliance™ technology produces compliant clinical documentation, but the system doesn't just stop there. *first*HOMECARE further protects agencies with document tracking tools, visit reviews, triggers, and fail safe alerts to raise awareness of potential issues, allowing your team to make corrections prior to coding and submitting OASIS data and claims.
- **Billing & Collections** - Rest assured that your claims are clean and accurate for services provided. Customizable warnings and fatal errors alert you of problematic items that could prevent full reimbursement, allowing for corrections before submission.
- **Analytics & Reporting** - Referrals, clinical performance and productivity, compliance, financial health, and personnel management reports give you more control and confidence in proactively managing your agency.
- **Survey Alert! High Priority Support Protocol** - Surveyors on site? Our world class customer service team are on hand at a moment's notice to answer your questions and provide immediate assistance when surveyors arrive.

CONTACT US at 800.841.6095 or connect@healthcarefirst.com to learn more!