CHAMPION CHAT

Healthcare QUALITY ASSOCIATION ON ACCREDITATION ®

HQAA's Quarterly Newsletter to our peers, colleagues & Quality Champions

Vol. 3 Qtr. 4
NOVEMBER 2012

Full DMEPOS | Home Infusion / IV Compounding | Retail Pharmacy with DME | Physician Practice with DMEPOS | 3rd Party Billing | Vent Units

It's Time to Start Thinking Outside the Box (Part 2)

Mary Ellen Conway, President
Capital Healthcare Group

In my article in the last issue, I wrote that there are new programs that are now available to provide DMEPOS items to Medicare beneficiaries without billing Medicare and without winning Competitive Bidding Contracts. I know you think that this can't be true, but it is!

The Affordable Care Act has provisions that require some "outside the box" thinking in terms of new ways to manage Medicare beneficiaries. The two programs we will review are Accountable Care Organizations (ACOs) and Transitional Care/Community Care Transitions Programs. ACOs were created to manage beneficiaries with chronic conditions and Transitional Care/Community Care Transitions Programs were created to reduce 30-day rehospitalizations.

Accountable Care Organization (ACO)

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. Think of them as functioning like an insurance company, such as a Medicare HMO, but they are not insurance companies.

Instead of fee-for-service, ACOs receive a lump sum payment from CMS per beneficiary per year to manage the beneficiary's care and all costs involved, like a Medicare HMO. The goal of the ACO is to provide coordinated care to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors as they:

- Manage chronic diseases
- Meet certain quality measures
- Reduce hospitalizations
- Reduce Emergency Room visits

The ACO is responsible for managing the care of all of the beneficiaries enrolled in their program. All invoices for services and products for these Medicare beneficiaries are submitted to the ACO for payment, not Medicare. Like a Medicare HMO, these beneficiaries must use the services and products that the ACO has in their program. Like a Medicare HMO, a DME Supplier would only receive a referral for equipment for a member of an ACO if the supplier were a contracted supplier with the ACO, as the claim for the item(s) is being paid by the ACO, not Medicare.

And what is so exciting about this? This program functions outside of the regular Medicare system and is NOT involved in Competitive Bidding whatsoever. A supplier needs to be a provider member of the ACO, but would not have to be a bid winner to service these beneficiaries. This is only one of the new opportunities to service Medicare beneficiaries without billing Medicare.

Transitional Care/Community Care Transitions Programs

Nearly one in five Medicare patients discharged from the hospital—approximately 2.6 million seniors– is readmitted within 30 days at a cost of over $26 billion every year. Data has shown that up to 76% of these hospital readmissions are preventable.

Beginning on October 1 of this year, the Affordable Care Act has provisions that prevent hospitals from being paid for re-admissions for Medicare beneficiaries within 30 days of discharge for same/similar conditions. Starting on January 1, 2013, financial penalties will be also imposed upon the hospital for these readmissions. Up until now, hospitals have been focused on discharge and, other than referrals to post-acute providers, were not concerned with those in the community who did not qualify for some level of care or products. But now the tide has turned! Rather than being "discharged", we now refer to these beneficiaries being "transitioned" into the community. Hospitals are creating Transitional Care/Community Care Transitions Programs (the names are used interchangeably), generally with home health agency partners, to manage these beneficiaries in the community and reduce the opportunities for re-admission. And who pays for the items and services? The hospital!

As of October, there are no longer payments for re-hospitalizations within 30 days of discharge—unless there are extenuating circumstances-- and the plan is to extend this to 60 days in the future. The average hospitalization cost for a 2-3 day stay is $7600. Since the hospital is not going to be able to collect their charges from Medicare for these beneficiaries, the hospitals are VERY willing to pay for equipment and home visits whether or not a beneficiary meets Medicare requirements for home visits or DME to help keep the beneficiary safe in the community for 30 days. If a hospital bed or the rental of a portable oxygen concentrator would maintain a beneficiary in his/her home and reduce the chances of a re-admission within 30 days, the hospital will be jumping at the chance to provide it. These fees are much less than the average $7600 the hospital will be losing and does not even take into account the additional financial penalties that will be imposed in only 2 months. This too is another opportunity to service Medicare beneficiaries

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Mary Ellen Conway, RN, BSN, is a nurse health care consultant with over 25 years expertise in management throughout the health care continuum. As the President of Capital Healthcare Group, she is known for her special expertise in operations and regulatory compliance issues in the acute care setting as well as in the post acute arena, from physician practice, home health, hospice, medical equipment, to supplemental staffing and accreditation.

From Mary's Desk

Mary Nicholas, MHA
President, CEO

One Little Word….So Much Action

In the August edition of "The Champion Chat", my editorial commentary centered/focused on my time-tested methodology of process improvement using the Plan-Do-Study-Act strategy. We primarily reviewed the "Plan" portion and what that can mean within an organization. My hope is that at least one or two of my readers put it in to a test run or tried it out at a staff meeting. Probably 90% of all staff meetings have a portion where a "Plan" of some kind is discussed or talked about, but to "Plan" with quality and improvement in mind is the goal of this column.

This time around, we'll review the "Do" portion of the method. Seems simple enough, but thought and planning behind the action is what really counts. In the first phase, you planned what to do. Now in this phase you do what you planned. Executing your plan occurs when the following (at a minimum) are focal points of this phase:

- ✓ Communicate: All persons in all areas with whom your plan affects, needs to have a clear and concise explanation of what you want to accomplish with the new plan. (Remember, the planning centers around an area that has demonstrated needs for improvement). Meet with the folks that the new plan will affect, write out the plan and what the end result should look like, post the high points in areas where folks see it, create a poster, send out the specifics electronically. In other words, use any and all best methods to share with those folks that have to implement (Do) this plan. Be clear about the purpose. Point out the changes in the process and highlight the similarities. Clearly identify why the process is changing and what it is changing to.
- ✓ Execute: Ensure that everyone implements as the plan describes. It is important to be able to note what is and isn't working in the next phase. If something goes terribly wrong in the plan, like an unforeseen result that is a hindrance to your business, then allow the cessation of the plan until a "fix" is put in place. Identify ahead of time how long this new process will be in place in this phase of the strategy, i.e. "We will run this new intake form for a 60 day period to see if we are able to gather more complete information".
- ✓ Evaluate: All persons that are a part of implementing (Doing) the new plan should be allowed an opportunity to offer feedback as to the successes, failures, areas of strength and/or weakness. Place the expectation of evaluation out there, so that it is known that feedback will be requested at the end of the trial period. The feedback and information gained will be the crux of the next phase, which is to "Study" what occurred. Be sure to continuously bring feedback to your QI meetings (and document it, of course!).

Next quarter we will look at the "Study" phase to ensure that the explanation of this methodology continues. If you are continuously curious and want more information (a person after my own heart), I did take the August article and turn it in to a blog on our website. I even added a Plan-Do-Study-Act Worksheet that can be used within your organization. It can be found at: Four Ways to Improve your Business
Until then….Keep Quality Continuous!

HQAA Appoints New Infusion Specialist

HQAA is pleased to announce that Willis C. Triplett, PharmD, has accepted the position as the pharmacy specialist to oversee HQAA's infusion home IV compounding and pharmacy accreditation programs.

"I look forward to sharing the value of the HQAA accreditation product with the infusion industry and counterparts," said Triplett. "The method that HQAA uses to support accreditation within an organization is unlike any other. It can benefit both the infusion pharmacy owner and organization."

Triplett has extensive experience in all aspects of home infusion therapy as an owner, senior leader and consultant. "Willis' knowledge in home infusion therapy-related areas blends fully with the philosophy and methodology of the HQAA process and practice," said Mary Nicholas, President/CEO, HQAA. That knowledge includes accreditation, USP Standard 797, healthcare process improvement with CQI techniques, policy and procedure development, business intelligence and dash boarding.

For more information on HQAA infusion accreditation, contact Willis at 866-909-4722.

Get Connected

Find us:

HQAA On the Road
Come visit us at:

NHIA
4/8-11
(Dallas, TX)

HQAA Holiday Hours

*HQAA will be closed on the following:
Thanksgiving - 11/22/12-11/23/12
Christmas - 12/25/12
New Year's Day - 1/1/2013

ACT Topics

NOVEMBER
Emergency-Disaster Preparedness

DECEMBER
Infection Control & Safety

JANUARY 2013
Compliance

FEBRUARY
Managing Your Retail Area

MARCH
Client Medical Records

APRIL
Staff Education, Training and Competency

MAY
Quality Improvement Program

JUNE
Leadership Review

JULY
Forms Review

AUGUST
Disaster & Emergency Preparedness Plan

SEPTEMBER
Grievances/Adverse Management

OCTOBER
Patient Intake Process

This Month in ACT

www.acttoolkit.com

ACT (Accreditation Continuation Toolkit) is the program offered to HQAA accredited providers after their successful accreditation to assist them in maintaining and updating their high quality standards and accreditation requirements on an ongoing, on-line basis so that accreditation renewal is smooth and seamless.

Each month, providers enrolled in ACT work with a "bite-sized" component of standards to ensure that they are reviewing and updating their processes as needed. By addressing accreditation compliance requirements in small, "bite-sized" components, last-minute renewal work is eliminated, and what can be extensive work is accomplished in efficient, incremental steps. Featured monthly topics assist providers in conducting audits and updating information. Providers who subscribe to ACT receive the plans, tools and access to experts in one easy-to-use website, saving both time and money.

In this issue we are highlighting the ACT topics for November, December and January and listing some of the questions posed for subscribers to review to ensure that they are meeting their accreditation standard requirements.

November - ***Emergency-Disaster Preparedness***
What is your organization's definition of an emergency or a disaster? What alternative arrangements have been made with alternate providers in the event that you can't service your customers? What information do you provide to your clients regarding disaster and emergency preparedness?

December - ***Infection Control & Safety***
Are your new staff members always oriented to infection control and safety issues? What is your process for separating clean items from dirty or contaminated items? Are your vehicles up-to-date regarding safety equipment and cleanliness?

January - ***Compliance***
Your compliance program must be much more comprehensive than when you were first accredited. Ensure that your program is complete and effective. Are you auditing your claims to ensure that you are billing correctly? Using the appropriate modifiers when necessary? Are you collecting co-payments appropriately? If you identify an overpayment, is it refunded promptly?

Only HQAA offers on-going service to maintain the accreditation you've worked so hard to achieve. For more information about ACT contact Gabriel Nicholas:
gabe.nicholas@hqaa.org
866.490.7980

Here's what a current customer has to say about HQAA:

"We chose HQAA because we liked the format. We've attended Medtrade for the last 20 years, and when accreditation became an issue we wanted a firm we could work effectively with. HQAA's format was very easy to understand with a helpful process and the feedback was great. There was someone to help each step along the way and made it easier to understand. HQAA was a logical choice for our company."

Tom Tuttle, Manager
Family Medical Supply

HQAA Recently Accredited Quality Champions

Please join us in congratulating these recently accredited providers. We look forward to listing your company as one of our Quality Champions! Come join our family!

222 Jamaica Economy Drug, Inc.	California Medical Pharmacy, Inc.	Foer Pharmacy
A2z Medical Supplies, Co.	Cardi's Department Store, Inc.	Foods, Inc
Acadian Medical Supply, LLC	Care Initiatives, Inc.	Foot Work
Accord Medical Inc.	Central Heights Pharmacy, Inc	Foundation Care LLC
Ace Medical Equipment & Supplies, Inc.	CFK, Inc	Frees Medical Inc
Activa Medical Supplies, Inc.	Cherubini Enterprises, Inc	Gary Sohn
Advanced Medical Supply Inc	ChildServe Medical Equipment and Supply	Genesis DME Inc.
Advanced Medical Systems, Inc.	CN Enterprises, Inc.	George`s Family Pharmacy
Adventura Sickroom Supply, Inc.	Columbia Sleep Services. LLC	Georgia Medical Equipment and Respiratory Services Inc.
Affinity Home Medical Equipment Inc	Comfort Care Medical Equipment & Uniforms, Inc.	Global Pharmaceutical Corporation
Aids For Recovery, Inc	Community Health, Inc.	Go Pharmacy Inc.
AirVida LLC	Community Memorial Hospital Association	Grider Drug LLC
Airway Respiratory Solutions, LLC	Cook`S Medical Care Co Inc	Guardian Home Healthcare, LLC
Allcare Medical Equipment, Inc.	Country Manor Campus LLC	HealthCare Medical Supply Inc
Allen Medical Inc	County Medical Equipment, LLC	HealthPro Medical Equipment, LLC
Allen Medical Supply, Inc.	Courtland Discount Pharmacy, Inc.	Healthy Pharmacy Inc.
Allen Pharmacy Services	Cpap Care Club, Llc	Help, Inc.
Allenmed, Inc.	CPAP Supplies & Services LLC	Highland Hospital of Rochester
Aloha Medical Supply of the Pacific Inc.	Curtis Saxton	HKA Corp
Alpha Home Medical LLC	Cybercare Enterprises	Holy Cross Apothecary Inc
AM Medical, LLC	Denson Shops Inc.	Home Care Medical Supplies, Inc.
American DME And Medical Supply Inc	Dependable Oxygen Company, Inc	Home Health Solutions Inc
American Home Medical	Diabetic Footwear & Supplies, Inc.	Home Technologies Inc
Anodyne, Inc.	Diabetic Headquarters Inc.	HomeCare Resources, LLC
Apex Family Pharmacy, Inc	Direct DME, Inc.	Homedical Inc.
Arizona Medical Supply, LLC	DME Systems Consulting, Inc.	Homeland LP
Ashland Home Towne Pharmacy Inc	Dodson Home Care, Inc.	Hometown Medical Supply
Assured Home Medical Rental & Sales, Inc	Don B Louie	Houchens Express Pharmacy
Atlantic Medical, LLC	Double D Enterprises of Wilkes, Inc.	Infinite Medical Supply CO.
Atos Medical Inc.	Dowel LLC	Jamison's Pharmacy, Inc
Avera Home Medical Equipment	Duncan Chiropractic Group, PC	Jebix Corporation
Bess & Company Inc.	E & M Lindy Pharmacy, Inc	John F. Lernihan
Bioventus LLC	Eastern Arkansas Diabetic & Medical Supply	Julia Butac Dureg
Bishop's Scant City Pharmacy and Gifts Inc.	Eldercare Home Health and Hospice	Kelly`s Home Medical
Blue Front Drugs Inc.	Elite Respiratory Services & DME, Inc.	Kenton W Randolph
Boulevard Pharmacy Inc.	Eliyahu's Pharmacy Inc.	Kern Infusion Services Inc
Breath of Life Home Medical Equipment and Respiratory Services Inc.	ENTAG Inc	KFM, Inc.
Breckenridge Drug PA	Eppy's IV, Inc	Kimzey-Eilert Medical Supplies, Inc.
Bruce W. Rogers	Family Pharmacy	King Kullen Pharmacies Corp.
C.G.Medical Inc.		
Cache Valley Oxygen, Inc		

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HQAA Recently Accredited Quality Champions

Kittitas Valley Community Hospital	Mila Valbe	Ruth Maldonado
KYTO Inc.	Mobility Excellence Inc.	RxHealth LLC
Lacey Drug Company, Inc.	Mobility Masters Northern California, Inc.	Safar Mansoor
Laramie Respiratory Service, LLC	Modern Drug Inc	Saint Michael Pharmaceuticals, LLC
Lawrence S Elliott	Modern Medical Mobility, Inc.	Scarboro Oxygen Services, Inc.
Lear Enterprises, Inc.	National Health Care Pharmacy, Inc.	School Bus Sales Co.
Legend Medquipment LLC	New Horizons Durable Medical Equipment LLC	Sequoyah County City of Sallisaw Hospital Authority
Lenox Medical Supply Services	New Iberia RX, Inc.	Shenk Enterprises, LLC
Lestini Inc	New-1 Pharmacy Inc	SHERIAN L. PRINCE
Lexar Corporation	Northwest Medical Supply LLC	Simpson Medical Equipment, Inc.
Liberty Medical Orthopedic Supplies, Inc.	Old World DME Inc.	Slate Belt Medical Equipment & Supplies, Inc
Liberty Medical, Inc.	Oxy-Care Equipment Company	South East Alaska Medical Suppliers Inc
Library Pharmacy Inc.	Oxygen Plus, Inc	Stellar Scripts, Inc.
Lifeline Diabetic	P R Horton RPh, Inc	Sungate Medical, LLC
Lower Valley Elite Businesses, Inc.	Park and King Pharmacy, Inc.	Superior Oxygen Services, Inc.
M.G.R. Homecare, Inc.	Patients Choice, Inc.	Supply Unlimited, Inc.
Madison County Medical Equipment, Inc	Patrick V.Lippa	Sweet Strips
Magic Rest Medical	Pay and Save Inc.	Tabor's Drug
Manna Freight Systems, Inc	Pharmacy Services Inc.	Tara`s Thrifty White, LLC
Mansmith Pharmacy, Inc.	Phoenix Medical Products, Ltd.	TDCS, LLC
Maximum Choice Medical Supply, LLC	Professional Pharmacy Inc.	Texas OxyCare, Inc.
Med Choice, Inc.	Progressive Mobility Consultants, LLC	Tex-Star DME, Inc
Med Health Equipment, LLC	Progressive Motion, Inc	The Custom Prescription Shoppe LLC
Med Life & Orthopedic Shoes Inc.	PulseAir Medical Equipment Inc.	The Home Medical Equipment & Supply Store
MED RX SYSTEMS PLLC	Quality DME, Inc.	The Reliable Medical Supply Services, Inc.
Med-Care of Ascension LLC	Qual-Med Serv, Inc.	The Wheelchair Guy, LLC
MEDIC-AIR, LLC	R and R in Belhaven, LLC	Thomas C Ryan
Medic-Aire Inc.	Rankos` Stadium Pharmacy, Inc.	Todays Respiratory
Medical Specialties Inc.	RAYS INVESTMENT INC	Total Care Dme & Supplies, LLC
Medical Supply Superstore, LLC	Respacare of Louisiana LLC	Towncrest Pharmacy
Medi-Fare Drug & Home Health Center Inc	Respiratory Care Partners,Inc	Treasure Island Pharmacy Care Inc
Medox Corporation	Respitech Medical, Inc.	Tri-State Respiratory
Med-Pro	Rice, PA	Turnbull Enterprises
Mega Nursing Services, Inc	Ritzman Pharmacies Inc.	University of Rochester
Mendota Community Hospital	Robert John & Associates, INC.	V V and M Incorporated
Mercy Diabetic Supply Inc.	Ronald J. Messick	Valley Patient Care
Meridian Medical Supply LLC	Ross Medical Supply Co Inc	VSR Healthcare,Inc.
Mesaba Drug Inc	Rothall, Inc.	VZ LTD
MetroCare Home Medical Equipment, Inc	Rushmore Dental Products, Inc	Ward Medical Services

Compliance Corner

Curtis McLees
Director of Compliance

Not Keeping Up with the Accreditation Standards?

Running on the treadmill and staying in the same place fast?

Reimbursements have dropped, goods cost more, employees would like a raise and as the business owner, you are barely staying in the black. You constantly make cuts to your expenses when you can, but the situation still is less than desirable. Remember the good old days when you were paid enough to make a decent living for yourself and your employees AND provide quality products and services to you customers? Some who have been in our business for many years refer to these as the "Golden Commode Days". As we know, those days are long gone, and today's mantra is certainly to do things with a more efficient, effective and meaningful process.

HQAA understands how difficult it is to stay on top in this business. The extra work involved with the accreditation process for you and your staff can divert resources from other areas of the business that need attention. But there is a way to make things a little easier and take some of the stress out of your next survey by thinking about your accreditation requirements in a way that makes the process more palatable.

Start by looking at your previous survey results report and review the deficiencies the surveyor found. If the surveyor were to walk through the door today, would you be cited for the same deficiencies? What about those areas that you worked on so there would be no deficiencies for survey – are you still in compliance, or did you let things slip because there were other more important fires to put out?

Take a few minutes and look at the accreditation standards. Prioritize them and place them on your calendar to address at manageable intervals. Space them out so you have a couple per week to review. When you do review them, ask yourself if you are still in compliance and if not, what needs to be fixed to be compliant? The key is to space the tasks out and not let them become "all-consuming" at any one time. Remember to prioritize and to delegate if possible so you and your employees won't have to work so hard in the couple of months leading up to your next survey. CMS expects you to be survey ready every day, not to "gear up" to accreditation compliance every 2 ½ years. You can use simple tools that you already may have, such as Outlook. If you can't get to the standards when you have a review scheduled, there is always the "snooze" button on Outlook where you can reset the reminder for a future time. Never delete a task until completed – this keeps the issue in front of you until you know you are in compliance.

Another often overlooked benefit of accreditation is that surveyors can find deficiencies and concerns, that if found by another regulatory agency such as CMS, FDA, or the OIG, may put your business is serious jeopardy, resulting it actions that are much more costly and time consuming than an accreditation survey. Our surveyors are trained to help identify risk areas in your business and, in fact, the accreditation standards have roots in the risk management issues of DME. If you think of these standards as mitigating your risk, they may take on more value to you and your operation.

The stress involved with a survey is high enough – you shouldn't add to it by being unprepared and thus experience the consequences of a survey with poor results and multiple deficiencies. Remove some of the stress by preparing for the process of re-accreditation a little at a time and ahead of time. HQAA's ACT service helps to minimize the amount of stress leading up to survey, as it helps keep you organized so that items aren't ignored or let go. The ACT Service takes the focus areas of accreditation, breaks them up in to small tasks and then offers opportunities to share the responsibilities. If you need a better way to organize your time and manage your requirements ongoing, the ACT service just might be for you. For more info about ACT, please contact Gabriel Nicholas at gabe.nicholas@hqaa.org or 866.490.7980.

It's Time to Start Thinking Outside the Box (Part 2)

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without billing Medicare or winning a Competitive Bidding contract!

Are these programs going to be a windfall of business for you? Probably not right away, but don't you want to be a part of these networks and care delivery teams as they are getting formed? I promise your competitor does! Bring these programs to your referral sources now, before your competition does, or you will be left out in the dark. Offer them to your managed care providers as well since they have the same concerns with managing costs.

These two programs in particular provide innovative solutions and decrease your reliance on payment directly from Medicare. They offer "outside the box" solutions without worrying about the current payment requirements for these newly addressed issues while providing you with significantly reduced administrative collection expenses and, in particular, significantly reduced (or no) audit process! Please contact our office if we can be of any assistance to you in working with your referral sources to get these programs up and running.

Regulatory Update

Mary Ellen Conway, President
Capital Healthcare Group

MPP: It's Now or Never

The time has come to speak up and save your industry, and that critical time is very limited.

Round Two of Competitive Bidding is in the final stages for implementation in 8 months and the Re-bid of Round 1 is underway. Your industry is going to implode under the current unsustainable bidding program and we suddenly have one last opportunity to make a change—the Market Pricing Program bill, HR 6490, known as the MPP.

MPP is an alternative to the current CMS bidding program. While still based around an auction structure, the MPP framework addresses many of the critical shortcomings in the current bidding program such as imposition of the median prices, non-binding bids and population-based auction areas that fail to reflect actual markets.

After months of discussion with Congressman Tom Price (R-GA), involving both the American Association for Homecare and the Georgia Association for Medical Equipment Suppliers (GAMES), Mr. Price agreed to support the MPP and to introduce legislation in the House of Representatives.

Kudos to Todd Tyson, president of Hi-Tech Healthcare, Inc., Norcross, Ga., and the other activists at GAMES who have demonstrated how a national trade organization (AAHomecare), in conjunction with a network of state advocates, can highlight a critical problem (in this case the flawed Competitive Bidding program) and generate the interest and support within Congress for legislation to address the issue. With competitive bidding posing a threat to Medicare beneficiaries and the companies that provide their care, AAHomecare and organizations like GAMES have led the charge in making sure Congress understands the magnitude of the problem.

Now is the Time
What do we need to do? Circle the wagons and mount a last stand!

We need to lobby our legislators, those who are still in office until the end of the year and those who will serve in the next Congress, and be VERY vocal with our concerns. We need to express our concerns and request their participation in HR 6490 in the final "Lame Duck" session of Congress for this year. We have the rare opportunity to get our bill without the need for a Senate companion bill into the end-of-year reconciliation package that will need to be passed before Congress can recess for the holidays.

All HME providers and other stakeholders should take steps to educate lawmakers about the perils of the bidding program and **explain why MPP is the right solution**.

Briefly, the MPP bill creates a more realistic bidding program. The highlights of the bill include:

- Limiting the size of each MSA—possibility by limiting the MSA to one county
- The maximum capacity for any provider would be 20%--thus allowing more room for bid winners
- Limiting the bidding to 2 product categories per MSA
- The beneficiary having an option to "opt-out"
- Expanding the "grandfathering" for providers who do not win contracts
- Much more realistic time frame for the process, including the roll out of the program.

How you can help today:

- E-mail or call your Representative in the House and urge him/her to sign on as a Cosponsor to H.R. 6490. The Capitol switchboard number is (202) 224-3121. Or use the AA Homecare Action Center at http://action.aahomecare.org/ to find your legislator by zip code. You do not have to be a member to use this tool.
- Use the issue brief and summary for H.R. 6490 and the Market Pricing Program found on the AA Homecare website at

http://www.aahomecare.org/associations/3208/files/HR6490_MPP_Issue_Brief_Bill_Summary.pdf

- Describe to your Congressional Representative that H.R. 6490 is a bipartisan bill that will bring market-based pricing to home medical equipment and services in Medicare.

Time is running out. We have a critical window and we must act as soon as possible. It's now or never.

It's Blog-o-licious!

HQAA has updated and is adding to our Blog site regularly. Have you checked it out lately? You can find helpful tips, information and even forms and documents to keep your business organized. Find "BLOG" on the blue bar on our home page!

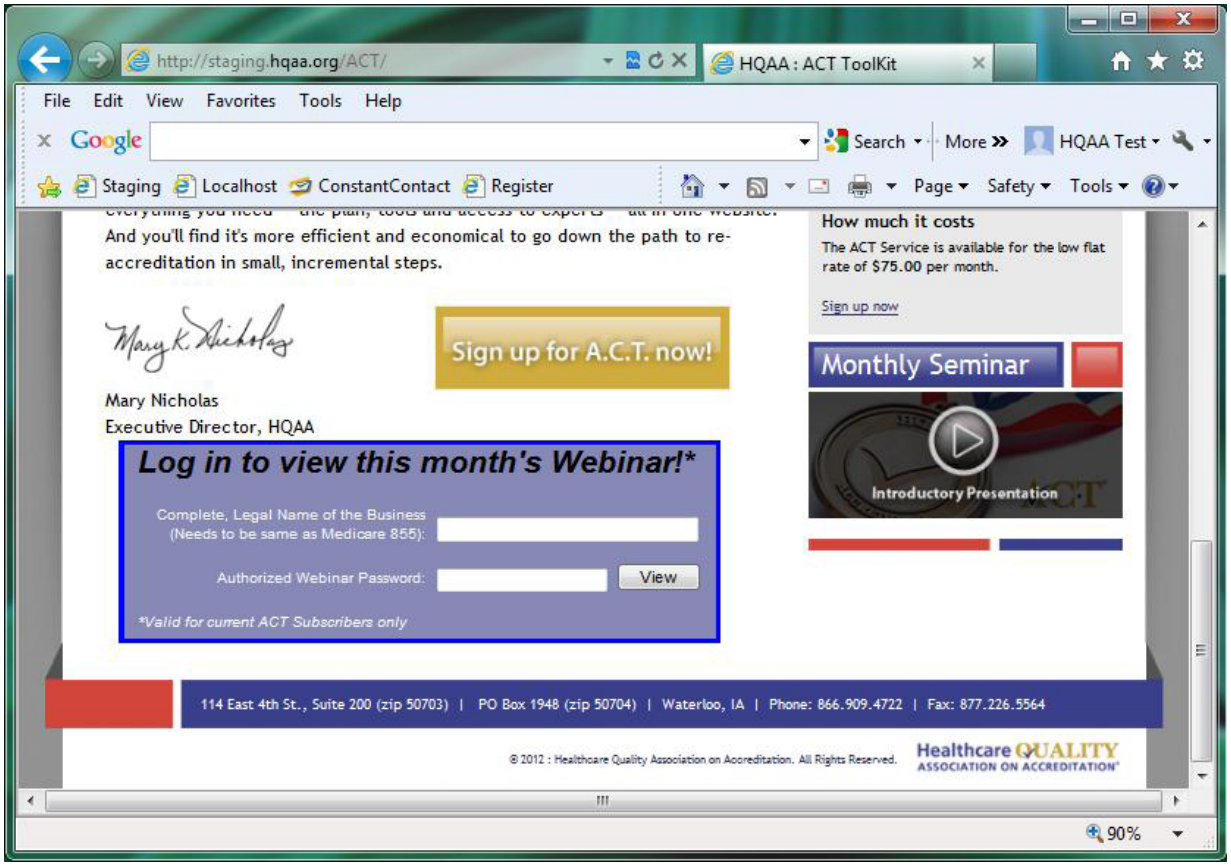
Ask the Coaches

Q: Does HQAA offer any resources that might help me organize my files according to the standards?

A: HQAA's new blog section (www.hqaa.org/blog) does offer articles, tips and often resources to help with organization, audits, or communicating with others. The articles are written by HQAA staff and surveyors and are focused on offering an efficient and effective way to manage some of the standards.

Q: We subscribe to the ACT service and I would like to share the monthly webinars with my staff. Is there a way I can do this without sharing my username and password?

A: Yes! We have programmed a way for your employees to log in and view just the webinar, without your sharing your usernames and passwords. Please give us a call at 877-226-5564 to learn how.



To sign up to receive **Champion Chat** directly, click **here** or contact us at 866-909-HQAA and ask us to add you to our mailing list

Heartfelt Thoughts

HQAA would like to extend our thoughts and prayers to our customers, staff and allies who have been affected by both Hurricane Sandy and the storm that followed. We've seen the devastation that occurred and we know that our suppliers are out servicing their patients and have been working through this disaster day and night. Please know that we support your efforts and hope you will reach out to us to share your stories after the crisis has passed.

Ask the Surveyor

your questions answered...

Jim Moyer
Assistant Director of Survey Services

Grievances and Complaints

Our Surveyors have received numerous questions regarding when to record a complaint, what is the threshold level to make it a recordable complaint and more.

In order to determine if a grievance or complaint needs to be recorded, you must first decide what ***is***, and what ***is not***, a complaint. Your team must determine the threshold that it takes for a concern or question to truly be a complaint/grievance. Not every concern expressed may be a complaint. Let's look at two examples:

Situation A: You have provided a window of time for delivery and your Service Tech/Driver arrives ten minutes after the stated window. The patient calls to complain about the delivery time.

This can only be answered after your organization has determined what is and is not a complaint. Generally, this might not be considered a complaint. However, if the patient or caregiver were to take this issue to the owner, referral source or the payer, this could be elevated to complaint status.

You could also use this opportunity as an example to coach your staff to do a better job of explaining delivery time windows when setting up appointments. If you do not document it as a complaint, there may not be a way to track that it was an expressed concern. Complaints are often opportunities for improvement and should be viewed as such and not "frowned upon" or rarely acknowledged.

Situation B: Your Service Tech/Driver fails to deliver the DME on the day it is scheduled, does not contact the office to explain why this is not happening as expected and does not contact the patient to reschedule the delivery. The customer calls the office. Is this a complaint?

In this case, this should be a complaint. You are obligated to record it, research the circumstances, review the outcome and record the resolution.

Medicare takes complaints seriously. They list information concerning complaints in 2 of the 30 Medicare DMEPOS Supplier Standards (abbr.. Version 1-4-12).

> 19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
>
> 20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.

When you receive a complaint, you must use a uniform process for review and follow-up. Documentation of the following is required to ensure you are meeting both the HQAA standard and the Medicare Quality Standards:

a. Record the date when the complaint was received and by whom:
b. List the name, address, and contact number of individual contacting your organization;
c. List the details of the complaint or grievance;
d. Note what investigation has been performed;
e. Show your response and your resolution to the complaint; and
f. List any additional payer requirements (i.e. Medicare HIC number).

One of the areas which organizations fail to complete properly is the follow-up to a complaint. The requirement in the CMS Final Quality Standard states that within five (5) calendar days of receiving a beneficiary's complaint, the supplier shall notify the beneficiary, using either oral, telephone, e-mail, fax, or letter format, that it has received the complaint and it is being investigated.

The element commonly found deficient on survey is the additional CMS requirement that ***within 14 calendar days*****, the supplier shall provide written notification to the beneficiary of the results of its investigation and response.**

Additionally, the supplier is required to maintain documentation of all complaints received, any copies of the investigations and all responses to beneficiaries. Always maintain a copy of this written notification to demonstrate your follow-up with the complaint.

This requirement is enforced not just by your accreditor but by the NSC (National Supplier Clearinghouse) as well. When you receive a site visit from the NSC, whether it is a random visit or in conjunction with re-validation or a primary enrollment, one of the items that the site visitor will request to review is your complaint log/record. It is essential to be able to show you have met all of the requirements and not just the requirements to have a log. You need to demonstrate at the time of that visit that you acknowledge complaints, contact the patient(s), research the issue(s) and provide the patient with a resolution.

During your on-site accreditation survey, your surveyor will also review your complaint logs/ records to ensure compliance with this standard.

Submit your questions by clicking "Ask the Surveyor"

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