CHAMPION CHAT

Healthcare QUALITY ASSOCIATION ON ACCREDITATION

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

Vol. 4 Qtr. 2
MAY 2013

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

The 2013 OIG Work Plan

Wayne H. van Halem

Each year, the Office of Inspector General drafts a "Work Plan" report which provides brief descriptions of the activities that they plan to initiate or continue throughout the fiscal year. This information is important because, in many instances, these activities will be the focus of audits by OIG, CMS, and/or its contractors. Suppliers should be aware of the specific items in the plan so that they determine where to focus their own internal controls in order to better prepare themselves for a potential audit of these areas.

Quality Standards—Accreditation of Medical Equipment Suppliers

This review will examine accreditation organizations' (AO) requirements and processes for granting accreditation to ensure that medical equipment suppliers meet each of Medicare's quality standards. Failure to meet quality standards could pose a threat to beneficiary safety and quality of care as well as place Medicare resources at risk. Medical equipment suppliers must become accredited by a CMS-approved AO and must comply with quality standards to maintain their billing privileges. CMS oversees AOs through validation surveys. This review will also evaluate CMS's procedures for conducting validation surveys. Such surveys help CMS determine whether an AO's accreditation procedures are adequately ensuring that suppliers are complying with Medicare's quality standards.

Program Integrity—Reliability of Service Code Modifiers on Medical Equipment Claims

OIG will determine the appropriateness of Part B payments that Medicare made on the basis of specific service code modifiers that suppliers entered on the claims. Such modifiers indicate that suppliers have required supporting documentation on file. Suppliers must provide, upon request, the documentation to support the claims for payment. Payments to service providers are precluded unless the provider maintains and furnishes, upon request, the information necessary to determine the amounts due. Reviews of suppliers conducted by Medicare claims processing contractors found that suppliers had little or no documentation to support their claims, suggesting that many of the claims submitted may have been improper and should not have been paid by Medicare. ***Note: This review will likely focus on the proper use of the KX modifier when submitting claims. This is an area suppliers should take extra caution when using code modifiers.***

Program Integrity—Use of Surety Bonds To Recover Medical Equipment Supplier Overpayments

OIG will review CMS's use of surety bonds to recover overpayments made to medical equipment suppliers. OIG will determine the extent to which CMS maintains complete and accurate surety bond information for medical equipment suppliers. OIG will also determine the number of medical equipment suppliers with overpayment debt, the extent to which these suppliers had surety bond coverage, and the amount of overpayment debt that could have been recovered through surety bonds since October 2009.

Lower Limb Prostheses—Supplier Compliance With Payment Requirements (New)

OIG will review Medicare Part B payments for claims submitted by medical equipment suppliers for lower limb prosthetics to determine whether the requirements of CMS's *Benefits Policy Manual*, Pub. 100-02, ch. 15, § 120, were met. Payments to service providers are precluded unless the provider has and furnishes upon request the information necessary to determine the amounts due.

Power Mobility Devices—Supplier Compliance With Payment Requirements (New)

OIG will conduct a series of reviews related to power mobility devices (PMD). The reviews will focus on whether Medicare payments for PMD claims submitted by medical equipment suppliers were made in accordance with requirements at 42 CFR § 410.38(c)(2). Medicare does not pay for items or services that are "not reasonable and necessary." OIG will also determine whether savings can be achieved by Medicare for PMDs that are not affected by the Affordable Care Act, § 3136, which eliminated the option of a lump-sum purchase for certain PMDs.

Vacuum Erection Systems—Reasonableness of Medicare's Fee Schedule Amounts Compared to Amounts Paid by Other Payers

Our review will determine the reasonableness of the Medicare fee schedule amount for Vacuum Erection Systems (VES). OIG will compare Medicare

(Continued on page 2)

Wayne van Halem is an author, consultant, and President of The van Halem Group, LLC in Atlanta, GA. Since 2006, his company has helped countless providers navigate complex issues related to Medicare and Medicaid audits, appeals, and compliance. A former auditor and national Appeals Director with Medicare, Wayne's proven experience and sound counsel, captured in books, lectures and publications, have uniquely positioned him as a resource to all types of healthcare providers.

(Continued from page 1)

payments made for VES to the amounts paid by non-Medicare payers, such as private insurance companies and the Department of Veterans Affairs (VA), to identify potentially wasteful spending. OIG will estimate the financial impact on the Medicare program and on beneficiaries of aligning the fee schedule payments for VESs with those of non-Medicare payers. ***Note: Often times, reviews that compare acquisition costs or amounts paid by other payers or sources are because Medicare feels the fee schedule may be too high and it could result in a lower reimbursement.***

Back Orthoses—Reasonableness of Medicare Payments Compared to Supplier Acquisition Costs

OIG will compare Medicare reimbursement amounts for the back orthosis procedure code L0631 to supplier acquisition costs to evaluate the reasonableness of Medicare's spending. Back orthoses, which are covered by Social Security Act, § 1832(a)(2), are supplied by Medicare medical equipment suppliers who purchase them from wholesalers or directly from orthotics manufacturers. For 2011, the median Medicare reimbursement amount for an L0631 back brace was $929. OIG has encountered suppliers who can purchase these back orthoses for prices significantly lower than Medicare reimbursement rates. Internet retail prices for back orthoses are also significantly lower than Medicare pays.

Parenteral Nutrition—Reasonableness of Medicare Payments Compared to Payments by Other Payers

OIG will compare Medicare's fee schedule for parenteral nutrition with fees paid by other sources of reimbursement to evaluate the reasonableness of Medicare's spending. OIG will identify reimbursement amounts paid by public and private payers for parenteral nutrition services. In 2009, Medicare paid more than $137 million for parenteral nutrition supplies. Previous OIG work found that Medicare allowances for major parenteral nutrition codes averaged 45 percent higher than Medicaid prices, 78 percent higher than prices available to Medicare risk-contract health maintenance organizations (HMO), and 11 times higher than some manufacturers' contract prices.

To sign up to receive **Champion Chat** or to have copies sent directly to additional staff members, contact us at 866-909-HQAA and tell us who to add to our mailing list

Frequently Replaced Supplies—Supplier Compliance With Medical Necessity, Frequency, and Other Requirements

OIG will review claims for frequently replaced medical equipment supplies to determine whether medical necessity, frequency, and other Medicare requirements are met. For supplies and accessories used periodically, orders or certificates of medical necessity must specify the type of supplies needed and the frequency with which they must be replaced, used, or consumed. (CMS's *Medicare Program Integrity Manual*, Pub. 100-08, ch. 5, §§ 2.3 and 5.9.) Beneficiaries or their caregivers must specifically request refills of repetitive services and/or supplies before suppliers dispense them. (CMS's *Medicare Claims Processing Manual*, Pub. 100-04, ch. 20, § 200.) Suppliers may not initiate refills of orders, and suppliers must not automatically dispense a quantity of supplies on a predetermined regular basis. Medicare does not pay for items or services that are "not reasonable and necessary." (Social Security Act, § 1862(a)(1)(A).) Prior OIG work found that suppliers automatically shipped continuous positive airway pressure system and respiratory-assist device supplies when no physician orders for refills were in effect. Such claims are improper and should not be submitted to Medicare for payment.

HQAA On the Road
Come visit us at:

Heartland Conference
6/10 - 6/13
(Waterloo, IA)

Continuous Positive Airway Pressure Supplies—Reasonableness of Medicare's Replacement of Supplies Compared to That of Other Federal Programs

OIG will determine the extent to which Medicare's supply replacement schedules for supplies related to continuous positive airway pressure (CPAP) machines (equipment used to treat obstructive sleep apnea) vary from those of Medicaid, VA, and Federal Employees Health Benefits programs. OIG will also identify savings that might be achieved by adopting alternative schedules to avoid wasteful spending. Separate charges for replacement supplies, such as masks, tubing, and filters, are covered if a beneficiary either rents or owns a CPAP machine. There are no national coverage determinations for the frequency of replacement of CPAP supplies; rather, this is at the discretion of designated Medicare payment contractors.

Diabetes Testing Supplies—Supplier Compliance With Payment Requirements for Blood Glucose Test Strips and Lancets

OIG will review Medicare Part B payments for home blood glucose test strips and lancet supplies to determine their appropriateness. The local coverage determinations (LCD) issued by the four Medicare contactors that process medical equipment and supply claims requires that the physician's order for each item billed to Medicare include certain elements and be retained by the supplier to support billing for those services. Further, the LCDs require that the supplier add a modifier code to identify when a patient is treated with insulin or not treated with insulin. The amount of supplies allowable for Medicare reimbursement differs depending on the applicable service code modifier.

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Diabetes Testing Supplies —Effectiveness of System Edits To Prevent Inappropriate Payments for Blood-Glucose Test Strips and Lancets to Multiple Suppliers

OIG will review Medicare's claims processing edits (special system controls) designed to prevent payments to multiple suppliers of home blood-glucose test strips and lancets and determine whether they are effective in preventing inappropriate payments. Suppliers may not dispense test strips and lancets until beneficiaries have nearly exhausted the previously dispensed supplies. The LCDs also require that beneficiaries or their caregivers must specifically request the refills before the suppliers dispense them. Prior OIG work found that inappropriate payments were made to multiple medical equipment suppliers for test strips and lancets dispensed to the same beneficiary with overlapping service dates.

Diabetes Testing Supplies—Potential Questionable Billing for Test Strips in 2011

OIG will review Medicare claims data from 2011 to identify suppliers with inappropriate payments and/or questionable billing for diabetes test strips. OIG will also analyze the geographic location of suppliers that had questionable billing and the extent to which the suppliers were associated with claims for beneficiaries residing in competitive bidding areas in 2011.

Diabetes Testing Supplies—Improper Supplier Billing for Test Strips in Competitive Bidding Areas

OIG will determine the extent to which suppliers improperly billed Medicare non-mail-order diabetes test strips in Competitive Bidding Areas (CBA) in 2011. OIG will also describe billing trends for test strips in CBAs between 2010 and 2011 and the extent to which suppliers conducted activities that OIG determined to be inappropriate (i.e., waiving copayments, contacting beneficiaries, sending unsolicited test strips in 2010 or 2011. There is concern that suppliers may be undermining the Competitive Bidding Program by billing for non-mail order test strips that are actually provided via mail order to receive a higher reimbursement amount and/or may be providing incentives to beneficiaries to receive test strips via non-mail order rather than via mail order, such as by waiving Medicare Part B copayments for beneficiaries.

Diabetes Testing Supplies—Supplier Compliance With Requirements for Non-Mail-Order Claims

OIG will determine whether Part B payments for non-mail-order diabetes testing supplies (e.g., supplies purchased from suppliers that have physical locations) were made in accordance with Medicare requirements. Federal law required a 9.5-percent reduction in fee schedule payments for certain items included in Round 1 of the Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program, including diabetic testing supplies delivered by mail. (Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), § 154(a)(2).) The reduction applied to items provided on or after January 1, 2009, in any geographical area. Suppliers are required to use the service code "KL" modifier on claims for such supplies delivered to Medicare beneficiaries by mail (e.g., common carrier). Claims with the KL modifier are paid at the lower rate. OIG will review claims billed without KL modifiers to confirm whether the resulting higher payments were proper. (CMS's *Medicare Claims Processing Manual*, Pub. 100-04, ch. 36, § 20.5.4.1.)

Competitive Bidding—Mandatory Review

OIG will review the process CMS used to conduct competitive bidding and to make subsequent pricing determinations for certain medical equipment items and services in selected competitive bidding areas under Rounds 1 and 2 of the competitive bidding program. Federal law requires OIG to conduct post-award audits to assess this process.

For more specific details, review the entire report at https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf

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From Mary's Desk

Mary Nicholas, MHA
President, CEO

Proceed with Confidence

This edition's article is the final in a series of four articles that have concentrated on the Plan-Do-Study-Act cycle of quality improvement. As we have reviewed, this cycle is the foundation of how we organize our strategies and methods for improving the quality of our work, our service, and our responsibilities to our customers. Applying these principles is not as burdensome as one might think, as they do have 'roots' in common sense thinking.

The previous articles focused on the "Plan", "Do", and "Study" components of the cycle. An organization decides what needs to be improved, defines how the improvement might occur, and studies the implementation of the defined steps. These are the first three concepts that set the wheels in motion for improvement.

One could (and I dare say it happens more often than not) simply decide on changing something and just give the directive to make the changes. Business moves fast, needs arise quickly, and often we are put in a position to have to make quick, educated decisions on how to move forward. These types of decisions are not necessarily where the P-D-S-A process is needed; after all, that's why experienced, skilled employees are put in positions to make the decisions they make.

The P-D-S-A cycle is for the more complex processes that present errors, concerns, or inconsistencies that impact on business or customer satisfaction and need to be improved.

To "Act" in this cycle is to accomplish. You took your original strategy and redefined, refined, and reworked it in the areas where things might have failed. You have put in the time, effort and strategic planning to determine where things have been going in the wrong direction. You've plotted out how things can improve and have implemented a trial run of that new strategy. You then studied the effects on the changes you have made. Are the changes positive? Are they the changes you anticipated would happen, or have additional changes come about? Were there any negative consequences of the changes; if so, what were they?

In the actual implementation phase of the final result, you are in the "Act" phase of the cycle. Accomplish your intended goal. Achieve the intended results of your efforts. Measure the improved aspects of your projections. These are all a part of the "Act" phase. You are now able to proceed with confidence in your improvement efforts due to putting in the time and energy needed to ensure that your work flow is the best it can be, with as little disruption to the process as possible.

There have been volumes and volumes of books written on this cycle. As you might imagine, it can be dissected in to a million sub-parts. However, by using these basic principles and the focus behind each, the quality geek in all of us can emerge and develop confidence in making changes that are positive. I'd love to hear from you about how you have made improvements in your organization through the use of the P-D-S-A cycle and what strategies worked the best. Sharing key areas can assist all of us in improving, which certainly is the goal!

The Pharmacist's Dose

Managing Risk Through Quality Improvement

Willis C. Triplett, PharmD., Infusion Specialist

Willis oversees HQAA's infusion home IV compounding and pharmacy programs. He has extensive experience in all aspects of home infusion therapy as an owner, senior leader, and consultant.

Our business operations can be a risky business. We do not create widgets. We work with healthcare and life and death issues daily. In our daily business operations, we must employ measures to ensure the safety of both our staff and our patients.

Business risk can never be eliminated, but it can be mitigated. Quality improvement is the key to reducing our risk over time. Quality improvement means "we" (all of our staff; executives, managers and workers) understand the purpose of our processes and the importance of every detail and every step of our responsibilities in them. Having a quality improvement program requires that we work together when process failures happen to immediately study what went wrong and to adjust our process when needed. We may need to reeducate our staff to reduce the likelihood of making the same mistake a second time.

No matter what business we're in, risk of injuring, angering, or disappointing our customer is reduced by quality improvement measures. If we're going to stay in business, we must create a culture in our organization that requires all of us - management and staff - to identify and analyze failed outcomes and make the appropriate process changes.

If we fail to maintain such a culture, we will be seen to be callously indifferent by our customers, by the media, by society, or even by a jury of our peers. That can mean that we knew we were putting our customer at risk with our product /service and that we acted as though we didn't care.

Most managers are familiar with Toyota's policy of jikoda or Autonomation. When something starts going wrong with the process, it is the duty of every worker to stop the production line. The steps (deeply ingrained in every Toyota manager and employee) are:

1. Detect the abnormality
2. Stop
3. Fix or correct the immediate condition, and
4. Investigate the root cause and install a countermeasure.

Jikoda is the antithesis to callous indifference. Quality improvement cannot take root in a culture in which meaningful errors are ignored or the response to them is delayed by financial or business efficiency considerations. Conversely, meaningful errors will not be allowed to re-occur in a culture of quality improvement.

If our employee reports to us that contamination has been detected in our clean room, or that a pump is delivering at the wrong rate, the correct answer is not a shrug. The correct answer is immediate attention, focus and action. A shrug is callous indifference and society will always bring sanctions for such behavior. If we shrug, we'll learn what risk really means.

HQAA Recently Accredited Quality Champions

Please join us in congratulating these recently accredited providers.

A Hug Away Medical Supplies, Inc	Front Range Medical Center Inc.	MJRRX.INC
A&A Medical Equipment	Future Pharmacy Inc.	MMS Equipment of Fort Worth, Inc.
AAA HEALTHCARE PRODUCTS, INC.	Generations Mobility	Momba Pharmacy Services LLC
Accel Custom Rehab LLC	Gillette Wheelchair Engineers Inc	NORTH BERKSHIRE PHARMACY INC
ACG Medical Supply Inc.	Glendale Pharmacy	North Rialto Shopping Center Drug
ADVANCED PAIN SOLUTIONS LLC	GNL PHARMACY CORP.	OLD MAIN PHARMACY INC
Air Systems of Illinois, Inc.	Great Lakes DME, LLC	OSS Orthopaedic Hospital, LLC
All Star Partners, LP	H.R. Pharmacy	OxyLife Respiratory Services, LLC
American Preferred Home Medical	HCA of PALM BEACH, INC.	Palmer Pharmacy Plus, Inc.
Athens Limestone Health Services, LLC	Healthline Medical Equipment Inc	Palmetto Medical Services, Inc.
B&B PHARMACY, PLLC	HealthMed Solutions,Inc.	Pediatric Therapy of Aiken, LLC
Boston Orthopedic & Respiratory Equipment LLC	HGA Home Medical Equipment	PHS LLC
Breathe Easy Medical Inc.	High Tech Medical Supplies LLC	Pine Pharmacy of Niagara Falls, LLC
Brite Pharmacy Inc	HILLS PHARMACY LLC	Preferred Pharmacy Tellico Greens, LLC
C&D Medical Equipment, LLC	Home-Ox of Kansas Inc.	Priority Healthcare Equipment Inc.
Cal City Medical Supply, Inc.	Hometown Pharmacy LLC	PRITI PATEL INC.
California Pharmaceutical Supply, Inc.	Houston Stat Medical Supply & Equipment, Inc.	Progressive Health and Rehabilitation, Ltd.
Canestraros Inc	Huey`s Home Medical, Inc.	Respiratory Quality Services, LLC
CANTERS PHARMACY	Hypnos Medical Equipments	RML Pharmacy, P.C.
Canyon Healthcare LLC	Integrated Health And Performance Systems, PA	Salem Village Nursing and Rehabilitation Center, LLC
Ciscura, Inc	Jordan Medical, LLC	Skyline Medical LLC
CMSRX INC	JOSEPH B TARPY	South Florida Mobility, Inc.
COMFORT MEDICAL	Kinetix Medical Equipment, LLC	Southern Pharmacy Services
Community Health & Rehabilitation SC	Lincoln Medical Supply, Inc.	Special Needs Network, Inc.
Complete Home Care, Inc.	Med World HME, Inc.	Springfield Surgical Supply
Cristal Medical Supply Inc	Medco Rentals Inc	SUNSHINE PHARMACY OF NY INC
Daniele Medical Equipment, LLC	Medical Compression Systems, Inc.	Tanglewood Medical Supplies, Inc
David Petsch Enterprises, Inc.	Medical Sales Inc.	Thomas Pawlowski
Diabetes Care Club, LLC	Medical Supply Depot, Inc	Three B Financial Service Inc.
Doris Antos, D.C., P. L.	MEDLINX, LLC	TRINITY CARE PHARMA INC
Edward E Sixta	MedServ Equipment Corp	Unity Pharmacy, LLC
Eldon Drug Co.	Medtrex, Inc.	Universal Medical Rentals and Equipment Sales, Inc
ENT Medical Services Sleep Supply, LLC	MetroCare Home Medical Equipment, Inc.	VALLEY MEDICAL LLC
Fannon Drug Company	Michael`s Pharmacy Inc.	WASEM`S INC
Forward Bound Mobility, LLC	Mississippi Valley Sleep Supplies, LLC	Washington Wellness, PLLC
Freedom Medical Supplies Llc.	Mitchell Oxygen LLC	

We look forward to listing your company as one of our Quality Champions!
Come join our family!

This Month in AMPT / ACT

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. It is the only such product offered to assist with accreditation renewal in the industry. AMPT (Accreditation Maintenance Program Toolkit) is its counterpart for all accredited providers.

Each month, providers enrolled in ACT or AMPT 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 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/AMPT topics for May, June, and July, and listing some of the questions posed for subscribers to review to ensure that they are meeting their accreditation standard requirements.

Upcoming Topics

☑ MAY
Quality Improvement Program

☑ JUNE
Leadership Review

☑ JULY
Forms Review

May - ***Quality Improvement Program***
Are you polling your customer groups to gather information that will help you improve the quality of your services? What do your results tell you? Do your QI reports include all required components?

June - ***Leadership Review***
Are your Board of Directors and Advisory Committee policies accurate and up to date and in compliance? Is your Compliance Program up to date? You may need to have more in your program currently than you did when you were first accredited.

July - ***Forms Review***
Is your patient packet current and up to date with all of the forms you need to provide to your customers? What about the forms you use for HR documentation: orientation checklist, competency forms and more? Do they need to be reviewed and updated? How about the Employee Manual?

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

It's Blogtastic!

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 help keep your business organized. Click "BLOG" on the blue bar on our home page!

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

"ACT is a very good tool. It literally walks you through every policy throughout the course of a three-year period. So your staff is continually being trained and educated."

Chris Pund, Operations Manager
HLS Pharmacies; multi-state chain

See more from Chris on the HQAA YouTube page by clicking here.

Regulatory Update

Mary Ellen Conway, President
Capital Healthcare Group

May 1 = PECOS

After a brief announcement and retraction, CMS settled on May 1, 2013, as the day that Phase Two of the Internet-based Provider Enrollment, Chain, and Ownership System (**PECOS**) will go into effect. PECOS is the new system created by CMS to ensure that only vetted and acknowledged (enrolled) prescribers can prescribe certain community services and products. After May 1st, CMS will deny all HME, Part B, and Part A home health agency claims that are submitted by providers with products/services ordered by health care professionals who are not enrolled in the PECOS system.

You might remember that PECOS was ready to be implemented a few years ago, but at the last minute, CMS put the start date on hold. At the time, there was only a very small percentage of prescribers actually enrolled in PECOS (as suppliers were reporting to CMS) and the new on-line system was very complicated and lengthy. Due to the extremely high number of warnings that HME providers were receiving, AAHomecare immediately asked CMS to take a much more measured approach and delay the start of Phase Two until data showed that the vast majority of ordering clinicians were enrolled in the system.

Since October 9th of last year (Phase One), suppliers have been receiving warning notices on their submitted claims with clinicians who are not enrolled in PECOS. Hopefully, you and your staff have not been ignoring these edits for the last few months and have spoken to your non-enrolled prescribers. "CMS indicates that they have taken proactive steps to enroll ordering and referring providers," say AAHomecare officials in a message to members, and are ready to launch the program. CMS estimates that less than one percent of ordering clinicians have not enrolled in PECOS. Do you think that less than 1% of YOUR prescribers are not enrolled? Most of my clients say no, it is much higher.

This presents a challenge for you. Are you going to take referrals from prescribers who are not enrolled as of May 1st? The answer is **NO**. These prescribers have been receiving edits on their own claims for Part B services for months, warning them that they must be enrolled. You and your peers in HME and home care who receive referrals from them have been (or should have been) warning the prescribers as well. There is no retroactive process to pay claims if the prescriber does not enroll in PECOS until after May 1. Your claims will be unpaid and not paid on resubmission. So **you must stop taking referrals from those prescribers right away**. Realize that no provider will be accepting them, as no one is going to get paid.

There are two things you can do if you are in this situation.

1. Print the PECOS application and enrollment materials, with the instructions, and bring them to your prescribers. Hand them the copies and explain that you, and the other post-acute providers, are no longer able to bill Medicare for their patients and that you can no longer accept referrals as of today.
2. Avoid unnecessary denials by ensuring that you submit claims using an individual clinician's NPI rather than an organization NPI. Many practices have been accustomed to providing an organizational NPI with referrals. While CMS has tried to discourage this over the past years, some are late to implement the change and get updated NPI numbers for each practitioner, but they have had a few years to get this done.

Mary Ellen Conway, RN, BSN, is a nurse health care consultant with over 25 years expertise in management throughout the health care continuum, and the President of Capital Healthcare Group.

For a detailed description of PECOS-related issues and activities, including an FAQ, read the recent MLN Matters article.

Editor's Note: At press time, CMS announced that the PECOS implementation has been delayed. Watch for a new announcement of the start date in the next few months.

* * * * *

Ask the Coaches

Q: Our organization is considering subcontracting delivery services. Would the delivery company require accreditation?

A: Yes, a delivery company would need to be accredited if they deliver the item, set it up, and instruct the patient/caregiver on the use of the item and the completion of the required paperwork (AOB, Rights and Responsibilities, etc.) A delivery service, such as UPS, DHL or Fed Ex, that merely delivers a mail-ordered item or refill supply, does not need to be accredited. The supplier is required to provide instruction and set-up for all ordered DME. The supplier should not be relying on delivery services (Fed Ex, DHL, UPS) to deliver items that need to be set up and instructed in use. If you have a question about your specific situation and the accreditation process for subcontractors, please contact us at 866-909-4722.

Q: While attending Medtrade I noticed that HQAA was advertising a new product called the AMPT Service. What is this product and should I sign up for it?

A: The AMPT(Accreditation Maintenance Program Toolkit) product is similar to the ACT Service but was designed as a service for all DMEPOS suppliers no matter who they are accredited by. It is the only industry-wide program to assist suppliers in maintaining their accreditation between accreditation cycles. If you have business acquaintances who may want to become more familiar with HQAA, the AMPT Service would be an excellent introduction to our process and how they can become HQAA Champions too!

The AMPT Service offers:

- 18 different monthly topics covering all aspects of accreditation compliance

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Ask the Surveyor

your questions answered...

Jim Moyer,
Director of Survey Quality

Quality Improvement from a Surveyor Perspective

One area that generally receives a lot of attention and discussion during surveys is that of Quality Improvement. Much of the discussion centers around techniques to use and ways to organize, since there are stated areas within the standards that have to be monitored.

Many organizations choose their topics in response to the Medicare guidelines / HQAA standards. Others look further and deeper into their organization to determine why certain indicators are important to their company and what they are looking to achieve by reviewing them; the "why" behind the "what".

The concept of continuously monitoring quality is to locate, identify and correct any company weaknesses you look to improve. You can better evaluate the importance of each area if you take the five areas Medicare requires you to review and break them down into smaller bites.

- The satisfaction/complaints of patients/clients regarding products and services and the satisfaction/complaints of referral sources or staff.
- Frequency of billing and coding errors
- Business activities (or other similar functions or services such as staff performance, service issues, or information exchanges) that focus on client/customer access to equipment, items, services, and information.
- Timeliness of response to customers regarding problems/issues/concerns.
- Adverse events to beneficiaries due to inadequate or malfunctioning equipment, items, or services (e.g., injuries, accidents, signs and symptoms of infection, hospitalizations). This may be identified through follow-up with the prescribing physician, other healthcare team members, or the beneficiary or caregiver.

Persons managing each of these areas can review ways to break down each process and then evaluate how effective your actions are in each instance. Asking tough questions gets you to better results. Such questions might be:

- Are you getting a sufficient number of satisfaction surveys returned?
- What are the most frequent complaints?
- How are you managing correction of flaws that customers find with your processes?
- How often are you reviewing financials to ensure you are on target?
- What information is contained within regular billing and collections reports that you can actually use?
- Who is monitoring responses and response times to customers when there are concerns?

Take the answers to the tough questions and make the appropriate changes for your desired outcomes.

For more details and a QI Program management outline, go to the HQAA Blog at: http://www.hqaa.org/blog

Submit your questions by clicking "Ask the Surveyor"

Here's Our Latest News - What's Yours?

We hope you are enjoying your issues of Champion Chat as much as we enjoy providing them to you. Help us stay in touch with what's happening in your world by keeping us up-to-date. We rely on you to suggest stories, submit questions to our team of experts, and give us feedback on the items and articles you are reading. We need you, our industry colleagues and accredited providers, to keep us in your "loop". If you, a co-worker, supervisor, or owner of your company has been recognized in some way, or has done an outstanding job of demonstrating Champion behavior, submit your nominations for HQAA Champions in the News to info@hqaa.org so that we can share your pride in making a difference in your customers lives, your community or in the industry. We appreciate the questions you've sent to Ask the Surveyor and Ask the Coaches and hope the questions and answers we've featured have been helpful. Your involvement helps us stay informed and in touch.

Keep those emails coming!

(Ask the Coaches.. Continued from page 7)

- Weekly, bite-size worksheets highlighting important areas to check, review and share with your team
- Built-in reporting processes to share with company leadership and all employees to keep accreditation components alive

And more!

Those who are already accredited with HQAA can get these benefits through the ACT Service. The cost for either of these services is $75.00/month and a percentage of your total paid subscription will be applied to your HQAA renewal or a new HQAA sign-up (as applicable). As always, please contact us with any questions on this new product.

Q: I am a chiropractor in the state of Florida. Do I have to also obtain licensure for DMEPOS in FL?

A: Yes. According to information received recently, if a chiropractor rents or sells DME (including TENS units), the chiropractor must be an accredited DME supplier. Accreditation is not required for the chiropractor to use any DME device on the patient during an office visit, only for those items and devices that are rented or sold to the patient. Nor is it required for prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner; motorized scooters; personal transfer systems; and specialty beds, for use by a person with a medical need.