

COVID-19 FAQs



Accreditation Commission for Health Care (ACHC) is providing responses to your most frequently asked questions about COVID-19. The Centers for Medicare and Medicaid Services (CMS) continues to update its guidance for providers during the national public health emergency. We have updated our FAQ information to include program-specific guidelines from CMS and the Centers for Disease Control and Prevention (CDC). The impact of the virus is ever-changing, and to best meet your needs, we will continue to adjust our responses to these FAQs as necessary to remain accurate and current.

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ACCREDITATION

Q: Is the public health emergency (PHE) still in effect?

A: U.S. Secretary of Health and Human Services Alex Azar extended the PHE until October 21. Extending the emergency declaration allows providers to continue to use waivers and flexibilities issued to assist in responding to the COVID-19 pandemic.

Q: Is ACHC conducting initial surveys for new organizations?

A: ACHC considers conducting surveys part of our responsibility to support community-based providers, ensuring they are fully operational and prepared to participate as a provider in the healthcare continuum. Therefore, at this time, ACHC is conducting initial surveys, depending upon the program, in areas not severely affected by the outbreak. There is a critical need for new community-based providers to initiate services as hospitals look to discharge patients to alternate sites.

Q: Are any surveys being postponed because of their location?

A: The decision to postpone a survey is based both on the state's reopening criteria and counties identified by the Centers for Disease Control and Prevention (CDC) as experiencing a surge of COVID-19 cases. Limited surveys in these areas still may be conducted for certain cases, such as Immediate Jeopardy or other high-risk situations.

Q: How do I access the CDC website to know what is current?

A: Below is the link to the CDC map showing reported cases by county. Scroll halfway down the page to the section labeled "Cases and Deaths by County." Select the desired state to see the county data.
cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html

Q: Will postponed surveys be rescheduled?

A: Postponed surveys are currently being rescheduled, depending on their location. The remainder of the surveys will be rescheduled when it is considered safe by authorities to do so and organizations are ready to be surveyed. Your accreditation certification date will be extended accordingly.

Information as of 9/9/2020. **Gray shading indicates new information.**

Q: Will there be a fee if I postpone my survey?

A: There is not a fee for postponing your survey prior to the Surveyor traveling to your site. During the pre-survey call, let your Account Advisor know about your decision to postpone. We understand that you may need to put your resources toward caring for patients versus preparing for a survey. It is important that you make the decision to postpone prior to the ACHC Surveyor traveling to your site. Failure to do so could result in additional fees.

Q: Is ACHC conducting renewal surveys?

A: Yes. We will work individually with every organization to understand your specific circumstances and will work to meet the needs of your organization, staff, and patients. We will take into consideration if the organization is in an area listed on the CDC map as severely affected by the outbreak. In addition, many organizations qualify to have a virtual survey conducted, depending on the program to be surveyed.

Q: Are your Surveyors taking safety precautions?

A: Our Surveyors are self-monitoring their health and will provide a form certifying that on the morning of each day of the survey they are symptom-free and following CDC measures to prevent the spread of infectious disease.

Q: Can virtual surveys be conducted that provide full accreditation for non-deemed organizations?

A: Yes. ACHC has a process to conduct virtual surveys for non-deemed organizations. ACHC will schedule a pre-survey meeting and provide a checklist outlining what to expect during the virtual survey, virtual meeting etiquette, technology testing, and readiness to ensure a successful survey.

Q: We are running low on PPE, substituting products, and modifying our infection control procedures. Is this acceptable?

A: Yes. At this time, it is most important to meet the needs of your patients using the best methods you can. We recommend that you document the effective date of this decision and the rationale. Retain this documentation with your performance improvement materials.

Q: Has CMS announced resumption of home health surveys by State Agencies (SAs) and accrediting organizations (AOs)?

A: Yes. As described in CMS QSO 20-35¹⁰, State Agencies and AOs are encouraged to resume normal survey activities, while also addressing the backlog of surveys that were postponed during the public health emergency. To date, ACHC has postponed a minimal number of surveys. We will work individually with each organization to schedule these surveys based on location considerations and specific circumstances related to meeting the needs of your organization, staff, and patients.

Q: I am a Home Health Agency (HHA) located in a state where ACHC conducts surveys for licensure in addition to Medicare certification. Are you working with my state?

A: ACHC is working in tandem with states where we do licensure surveys. Additional information that is state-specific is posted on our website as the states finalize their decisions and processes. Your Account Advisor also can give you up-to-date information.

Q: My state has a shelter-in-place order, yet we know that it is critical to get new HHAs licensed to absorb the hospital overflow. Can you survey me?

A: ACHC is working with each state where we conduct licensure surveys. Many of these states are permitting on-site surveys because the need is so great for new HHAs to get licensed. ACHC has offered a virtual survey option to these states as well. Account Advisors have the most current information on the directives from each state.

Q: Can my Home Health Agency conduct telehealth visits instead of home visits?

A: HHAs can provide more services to beneficiaries using telehealth within the 30-day episode of care, so long as it's part of the patient's plan of care and does not replace needed in-person visits as ordered on the plan of care. The use of such technology may result in changes to the frequency or types of in-persons visits outlined on existing or new plans of care.¹

Q: Is it true that initial home health assessments can be conducted remotely?

A: By waiving 42 CFR § 484.55(a), HHAs can perform initial assessments and determine patients' homebound status remotely or by record review. This will allow patients to be cared for in the best environment for them while supporting infection control and reducing impact on acute-care and long-term care facilities. This will allow for maximizing coverage if there are limited physician and advanced practice clinicians and will allow those clinicians to focus on caring for patients with the greatest acuity.¹ The plan of care should be modified to reflect which visits will be made in person and which visits will be conducted via telehealth.

Q: Can the PT, OT, and SLP perform an initial and comprehensive assessment for all patients?

A: Yes. CMS is waiving the requirements in 42 CFR § 484.55(a)(2) and § 484.55(b)(3) that rehabilitation skilled professionals may only perform the initial and comprehensive assessments when only therapy services are ordered. This temporary blanket modification allows any rehabilitation professional (OT, PT, or SLP) to perform the initial and comprehensive assessments for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether or not the service establishes eligibility for the patient to be receiving home care. Rehabilitation skilled professionals would not be permitted to perform assessments in nursing-only cases. CMS expects HHAs to match the appropriate discipline that performs the assessments to the needs of the patient, to the greatest extent possible. Therapists must act within their state scope of practice laws when performing initial and comprehensive assessments and access a Registered Nurse or other professional to complete sections of the assessment that are beyond their scope of practice. 4that performs the assessments to the needs of the patient, to the greatest extent possible. Therapists must act within their state scope of practice.⁴

Q: Does the nurse practitioner/physician assistant (NP/PA) have to be enrolled in PECOS in order to sign the plan of care orders/certify the patient for home health services?

A: The NP/PA needs to be enrolled in the Provider Enrollment, Chain and Ownership System (PECOS). CMS has a process in place to try to expedite processing of enrollment.⁹

Q: What if the patient refuses all home visits?

A: While there are some aspects of care that can be done via telehealth, not everything can be accomplished by telehealth when skilled care is required. The HHA will have to work closely with the patient to determine what would help to reassure them that visits from home care staff are safe. If the patient continues to refuse any in-person visits as per the plan of care, including assessment or other patient care visits, the HHA will have to determine if the HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence (§484.60).

Q: Has the homebound definition for home health patients been affected during the national emergency?

A: Yes. CMS is altering the definition during the emergency. Homebound Definition: A beneficiary is considered homebound when their physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes them more susceptible to contract COVID-19. As a result, if a beneficiary is homebound due to COVID-19 and needs skilled services, an HHA can provide those services under the Medicare Home Health benefit.¹

Q: Do I need to supervise a home health aide on site every 14 days?

A: CMS is waiving the requirements at 484.80(h), which require a nurse to conduct an on-site visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an on-site visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time. This waiver is also temporarily suspending the two-week aide supervision requirement at 42 CFR §484.80(h)(1) by a Registered Nurse for home health agencies, but virtual supervision is encouraged during the period of the waiver.¹

Q: For purposes of the statutory requirement that a patient have a face-to-face encounter with a physician or an allowed non-physician practitioner in order to qualify for Medicare home health care, can this encounter occur via telehealth during the pandemic?

A: The face-to-face encounter, as described at 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act, can be performed via telehealth in accordance with the requirements under 1834(m)(4)(C) of the Social Security Act. Under the expansion of telehealth under the 1135 waiver, beneficiaries are able to use telehealth technologies with their doctors and practitioners from home (or other originating site) for the face-to-face encounter to qualify for Medicare home health care.⁸

Q: Has CMS announced resumption of hospice surveys by State agencies and accreditation organizations (AOs)?

A: Yes. As described in CMS QSO 20-35¹⁰, States and AOs are encouraged to resume normal survey activities while also addressing the backlog of surveys that were postponed during the public health emergency. To date, ACHC has postponed a minimal number of surveys. We will work individually with each organization to schedule these surveys based on location considerations and specific circumstances related to meeting the needs of your organization, staff, and patients.

Q: Can a hospice conduct telehealth visits instead of home visits?

A: Hospice providers can provide services to a Medicare patient receiving routine home care through telehealth, if it is feasible and appropriate to do so.²

Q: Can hospice physicians/hospice nurse practitioners conduct the required face-to-face encounter for recertifications using telecommunications technology?

A: Hospices are allowed to use two-way audiovisual telecommunications technology that allows for real-time interaction between the patient and the clinician (e.g., FaceTime, Skype) to satisfy the face-to-face encounter requirement, which is required for the third benefit period (after the patient has typically been receiving hospice for six months) and each subsequent 60-day benefit period thereafter. An explanation of why the clinical findings from the hospice face-to-face encounter support that the patient still has a life expectancy of six months or less is required as part of the recertification narrative. CMS does not believe that telephone calls (audio only or TTY) would provide the necessary clinical information for a hospice physician to determine whether the patient continues to have a life expectancy of six months or less. As such, telephone calls (audio only or TTY) cannot be used to satisfy the hospice face-to-face encounter requirement.⁸

Q: Can hospices complete the initial and comprehensive assessments virtually or over the phone during the COVID-19 national emergency?

A: Assuming that the patient is receiving routine home care during the initial and comprehensive assessment time frame, furnishing services using telecommunications technology (e.g., using two-way audio video telecommunications technology that allows for real-time interaction between the clinician and the patient, like FaceTime or Skype, or using audio-only or TTY telephone calls) would be compliant if such technology can be used to the extent that it is capable of resulting in a full assessment of the patient and caregiver's needs to inform an individualized plan of care. The initial and comprehensive assessments are the foundations of the plan of care, laying out the patient and family needs/goals and outlining the plan for the delivery of these services. An in-person initial and comprehensive assessment is standard practice and crucial to establishing the patient-hospice relationship. During this public health emergency, CMS expects in most, but not all, situations that the initial and comprehensive assessment visits would be done in person.⁸

Q: What if I can't find volunteers to work at my hospice during the national emergency?

A: CMS is waiving the requirement at 42 CFR §418.78(e) that hospices are required to use volunteers, including at least 5% of patient care hours, during the emergency. It is anticipated that hospice volunteer availability and use will be reduced related to COVID-19 surge and anticipated quarantine.²

Q: Do I need to supervise a hospice aide on site every two weeks?

A: CMS is waiving the requirements at 42 CFR 418.76(h), which require a nurse to conduct an on-site visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an on-site visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time.²

Q: Does a hospice still need to complete a comprehensive assessment?

A: Hospices must continue to complete the required assessments and updates; however, the time frames for updating an assessment may be extended from 15 to 21 days.²

Q: Which non-core services are being waived for hospices?

A: CMS is waiving the requirement for hospices to provide certain non-core hospice services during the national emergency, including the requirements at 42 CFR §418.72 for physical therapy, occupational therapy, and speech-language pathology.²

Q: What is the guidance for hospice workers caring for patients in nursing homes?

A: CMS issued a memo that provides guidance to nursing homes on improving their infection control and prevention practices to prevent the transmission of COVID-19. The memo includes temporary revised guidelines for visitation from healthcare professionals, like hospice workers, during the coronavirus national public health emergency.

Q: Is ACHC offering accreditation through virtual surveys for DMEPOS?

A: DMEPOS providers seeking either initial Medicare certification or a renewal accreditation are eligible for an off-site virtual survey that covers the same scope, quality, and review of standards, observations, and interviews as on-site surveys. An on-site validation survey will follow, when feasibly possible, to review implementation of your Plan of Correction (POC) and award full accreditation. To learn more about our virtual process, please join us for a free virtual town hall meeting at 2 p.m. EDT September 18. Register to attend at <https://attendee.gotowebinar.com/register/4890334559815692812>.

Q: Will I know when the virtual survey will occur so that I can have adequate staffing?

A: Yes. ACHC will notify you approximately 48 hours in advance to ensure you have adequate resources to conduct the virtual survey. ACHC will schedule a pre-survey meeting and provide a checklist outlining what to expect during the virtual survey, virtual meeting etiquette, technology testing, and readiness to ensure a successful survey.

Q: Have all payors and stakeholders followed the CMS decision to suspend the need for accreditation?

A: No. Accreditation requirements have been determined based on the decisions of individual entities for state licensure certification, third-party payors, workman's comp, Medicaid, and Medicare Advantage Plans.

Q: I am a DME provider and I don't have enough hand sanitizer for customers to come into my store. Can I offer only curbside service?

A: Yes. You need to make decisions that allow you to continue providing services to the best of your ability while decreasing exposure to the public. Document the effective date of this decision and the rationale. Retain this documentation with your performance improvement materials.

Q: Has the National Supplier Clearinghouse (NSC) published a waiver of any DME supplier standards?

A: The NSC has not provided written guidance but has verbalized that it will follow CMS instructions. While the public health emergency is ongoing, CMS has issued instructions to the NSC to waive the following standards:

- Supplier Standard 7: Physical Access: Maintains a physical facility on an appropriate site.
- Supplier Standard 9: Business Phone: Maintains a primary business telephone that is operating at the appropriate site listed under the name of the business locally or toll free for beneficiaries.
- Supplier Standard 30: Minimum hours of operation: Except as specified in paragraph (c)(30)(ii), is open to the public a minimum of 30 hours per week.

Q: What are the replacement requirements for DMEPOS during the national emergency?

A: When Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable, DME Medicare Administrative Contractors have the flexibility to waive replacement requirements under Medicare such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required during the emergency. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise rendered unusable or unavailable as a result of the emergency.³

Q: Are signatures and proof of delivery required for DME and Medicare Part B drugs?

A: CMS is waiving signature and proof of delivery requirements for Part B drugs and Durable Medical Equipment when a signature cannot be obtained because of the inability to collect signatures. Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of COVID-19.³

Q: Can DME items be provided with a verbal order?

A: DMEPOS items, except for Power Mobility Devices (PMDs), can be provided via a verbal order. A signature is required prior to submitting claims for payment but the order can be signed electronically. PMDs require a signed, written order prior to delivery.⁷

Q: Are PTs and OTs allowed to conduct specialty evaluations for patients needing custom-built wheelchairs via telehealth?

A: CMS has authorized additional telehealth waivers expanding the type of healthcare professionals eligible to bill for telehealth services. Physical therapists, occupational therapists, and speech therapists are now able to bill for telehealth services.⁴

Q: I am unable to obtain completed Certificate of Medical Necessity (CMN) forms for oxygen or medical necessity information needed for external infusion pump DME Information Forms (DIFs) from physicians who prescribed them. How can I bill for this equipment without a CMN/DIF?

A: The DME MACs have announced that effective March 1, 2020, CMNs for oxygen and DIFs for external infusion pump claims will not be required during the coronavirus emergency because of the interim final rule published in April waiving clinical indication requirements. The latest announcement also included instructions for submitting claims.

Below is a link from one of the DME MACs that you can reference:

<https://cgsmedicare.com/jc/pubs/news/2020/05/cope17144.html>

Q: I have several patients who reside in a long-term care (LTC) setting. What can I do to help ensure safe and effective care for them and promote awareness of their needs between the LTC staff and the dialysis facility staff?

A: First and foremost, the lines of communication should be open, and information should flow between the two healthcare providers. CMS guidance suggests using a reporting mechanism for communication between the healthcare workers of both organizations to promote situational awareness. Communication with transportation and other contracted providers that transport patients between the facilities should also be provided to ensure infection control precautions are followed.¹¹

Q: Are dialysis access placement and organ transplantation procedures considered essential surgical procedures?

A: Yes. CMS released clarification, in the memorandum dated 8/17/2020 Ref: QSO-20-36-ESRD, that dialysis access placement or repair of AV Fistulas, AV Grafts, and Peritoneal Dialysis catheters are essential in establishing that vascular access is crucial for ESRD patients to receive their life-sustaining dialysis therapy. In addition, CMS clarified that organ transplantation procedures are essential for those suffering from irreversible organ failure. Each transplant procedure or delays should be evaluated on a case-by-case basis.¹²

Q: How can I be sure my dialysis facility's cleaning and disinfecting procedures are appropriate and effective?

A: If you are using the current procedures for cleaning and disinfecting the dialysis station as indicated in the ESRD Conditions for Coverage §494.30: Infection Control, that procedure is acceptable for patients with COVID-19. The facility must ensure, however, that they are using a disinfection product that is effective or active against SARS-CoV-2. In addition, it is essential to ensure staff are strictly following the label instructions for dilution and proper use per the manufacturer's guidelines.¹³

Q: Will ACHC offer temporary accreditation through virtual surveys for renal dialysis providers?

A: Yes. Renal dialysis providers seeking initial Medicare certification and/or a service addition are eligible for an off-site review that covers the same scope, quality, and review of standards, observations, and interviews as on-site surveys. Once compliance is demonstrated, a temporary accreditation is awarded. A subsequent full on-site survey will be conducted to award full accreditation after the public health emergency is lifted.

Q: What specific patient assessment frequency requirements are being waived for renal dialysis?

A: CMS is waiving the following requirements at 42 CFR §494.80(b) related to the frequency of assessments for patients admitted to the dialysis facility during the emergency. CMS is waiving the “on-time” requirements for the initial and follow-up comprehensive assessments within the specified time frames as noted below. This waiver applies to assessments conducted by members of the interdisciplinary team, including: a Registered Nurse, a physician treating the patient for End-Stage Renal Disease (ESRD), a social worker, and a dietitian. These waivers are intended to ensure that dialysis facilities are able to focus on the operations related to the Public Health Emergency.

Specifically, CMS is waiving:

- §494.80(b)(1): An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 outpatient hemodialysis sessions, beginning with the first outpatient dialysis session.
- §494.80(b)(2): A follow-up comprehensive reassessment must occur within three months after the completion of the initial assessment to provide information to adjust the patient’s plan of care specified in §494.90.⁴

Q: Can you describe the time period for initiation of care planning and monthly physician visits?

A: CMS is modifying two requirements related to care planning, specifically:

- §494.90(b)(2): CMS is modifying the requirement that requires the dialysis facility to implement the initial plan of care within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions, beginning with the first outpatient dialysis session. This modification will also apply to the requirement for monthly or annual updates of the plan of care within 15 days of the completion of the additional patient assessments.
- §494.90(b)(4): CMS is modifying the requirement that requires the ESRD dialysis facility to ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician’s assistant providing ESRD care at least monthly, and periodically while the hemodialysis patient is receiving in-facility dialysis. CMS is waiving the requirement for a monthly in-person visit if the patient is considered stable and also recommends exercising telehealth flexibilities, e.g., phone calls, to ensure patient safety.⁴

Q: What are the expectations for home visits to assess adaptation to home dialysis?

A: CMS is waiving the requirement at 42 CFR §494.100(c)(1)(i), which requires the periodic monitoring of the patient’s home adaptation, including visits to the patient’s home by facility personnel. For more information on existing flexibilities for in-center dialysis patients to receive their dialysis treatments in the home, or long-term care facility, reference QSO-20-19-ESRD.

Q: What can I do to ensure my patients who are in Skilled Nursing Facilities receive their scheduled treatments?

A: CMS is waiving the requirement at 42 CFR §494.180(d), which specifically requires a dialysis facility to provide services directly on its main premises or on other premises that are contiguous with the main premises. The waiver allows dialysis facilities to provide service to its patients in the nursing home or skilled nursing facility. CMS continues to require that services provided to these nursing home residents are under the direction of the same governing body and professional staff as the resident's usual Medicare-certified dialysis facility. Further, in order to ensure that care is safe, effective, and provided by trained and qualified personnel, CMS requires that the dialysis facility staff: furnish all dialysis care and services, provide all equipment and supplies necessary, maintain equipment and supplies in the nursing home, and complete all equipment maintenance, cleaning, and disinfection using appropriate infection control procedures and manufacturer's instructions for use.

Q: Does the Federal Drug Administration (FDA) have updated guidelines for compounding pharmacies?

A: As PPE shortages become severe, such shortages have the potential to significantly impact the quality, purity, and even the availability of drugs that are compounded for patients, including those in critical need.⁵ Compounders may consider alternate risk mitigation strategies when standard PPE is unavailable during the COVID-19 public health emergency. Compounders should consider such alternate approaches carefully and on a case-by-case basis to evaluate whether they provide protection to the drug product that is comparable to that provided by the risk mitigation strategies described in the FDA guidance documents.

For the most recent guidance, check the FDA guidance webpage at:

<https://www.fda.gov/regulatory-information/search-fda-guidance-documents>.

¹ <https://www.cms.gov/files/document/covid-home-health-agencies.pdf>

² <https://www.cms.gov/files/document/covid-hospices.pdf>

³ <https://www.cms.gov/files/document/covid-dme.pdf>

⁴ <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>

⁵ <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/temporary-policy-compounding-certain-drugs-hospitalized-patients-outsourcing-facilities-during-covid>

⁶ <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf>

⁷ <https://www.cms.gov/files/document/covid-dme.pdf>

⁸ <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

⁹ <https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf>

¹⁰ <https://www.cms.gov/files/document/qso-20-35-all.pdf>

¹¹ <https://esrdnetworks.org/education/sharing-best-practices-in-the-kidney-community/covid-19-communication-between-snf-pch-dialysis-facilities-communication-06-19-2020>

¹² <https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf>

¹³ <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19>