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) issued blanket waivers and new rules on March 30, 2020, that provide temporary regulatory flexibilities and ease administrative burdens for providers during the coronavirus public health emergency declaration. We have updated our FAQ information to include program-specific guidelines from CMS. 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 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 some 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: Is ACHC following CMS guidelines to suspend deemed recertification surveys?

A: Yes. In accordance with the latest guidelines from the Centers for Medicare and Medicaid Services (CMS), ACHC is suspending all deemed recertification surveys for home health, hospice, renal dialysis, and DMEPOS providers. ACHC has been participating in daily conference calls with CMS, ensuring that we are working in unison with the agency.

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

A: ACHC is postponing surveys in states identified by the Centers for Disease Control and Prevention (CDC) as having more than 500 reported cases of COVID-19, as well as areas where residents were ordered to shelter in place by authorities. 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 state. You need to scroll halfway down the page to see the map.
cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html

Q: Will postponed surveys be rescheduled?

A: Postponed 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.

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Q: I really want to have a survey – will ACHC conduct it?

A: We will work individually with every organization to understand specific circumstances surrounding how to meet the needs of your organization, staff, and patients. We will take into consideration if the organization is affected by a CMS directive or is located in an area listed above as severely affected by the outbreak or an order exists to shelter in place.

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: Will you extend my accreditation date?

A: ACHC will extend your accreditation date. Here are the specifics, by provider types:

DMEPOS: ACHC will extend accreditation dates. CMS has approved a 90-day extension.

Specialty Pharmacies and PCAB: ACHC will extend accreditation dates. Pharmacies that do not require DME accreditation are eligible for a virtual survey from ACHC.

Home Health, Hospice, and Renal Dialysis deemed providers: CMS and ACHC will extend the accreditation date.

Home Health, Hospice, and Renal Dialysis non-deemed providers: ACHC will extend the accreditation date.

Private Duty: ACHC will extend the accreditation date.

Sleep Labs: ACHC will extend the accreditation date. In addition, we are finalizing our process to be able to conduct surveys virtually.

Q: How long will my accreditation be extended?

A: For DMEPOS providers, CMS has indicated that the accreditation date can be extended for 90 days. For other deemed programs, there is not a determination on how long CMS will extend accreditation dates. ACHC is in communication daily with CMS and will provide updates as soon as we receive them. Because we do not know the length of the accreditation expiration extensions, ACHC is not updating individual accounts on our website.

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 surveys be conducted remotely?

A: ACHC has a process to conduct virtual surveys for non-deemed organizations that are not providing direct patient care. If CMS permits use of this format in the future, we are ready to expand to deemed programs.

Q: My organization is located in a state that has a shelter-in-place order. Will ACHC be able to survey me as soon as the restrictions are lifted?

A: Yes. As soon as restrictions are lifted, ACHC is ready to resume conducting surveys immediately.

Q: We are running low on personal protective equipment (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.

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HOME HEALTH

Q: I am a home health agency 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: Can my home health agency conduct telehealth visits instead of home visits?

A: Home Health Agencies (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), home health agencies 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]

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]

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

HOSPICE

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 a hospice use telehealth to meet recert face-to-face requirements?

A: Face-to-face encounters for purposes of patient recertification for the Medicare hospice benefit can now be conducted via telehealth. [2]

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]

[2] https://www.cms.gov/files/document/covid-hospices.pdf

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DMEPOS

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: I am a DME provider. Can I operate with reduced store hours as long as I provide on-call services and post reduced hours on my door and answering service?

A: The National Supplier Clearinghouse (NSC) has not provided written guidance, but has verbalized the following:

"We (NSC) are awaiting official guidance from CMS. Until then, if a supplier determines that they must reduce their hours or close the physical office they should post a sign and indicate a phone number where someone can be contacted if beneficiaries need assistance."

Q: Has CMS suspended DME accreditation?

A: CMS is not requiring accreditation for newly enrolling DMEPOS providers and extending any expiring supplier accreditation for a 90-day time period. [3]

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 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]

[3] https://www.cms.gov/files/document/covid-dme.pdf

RENAL DIALYSIS

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]

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