Accreditation Commission for Health Care (ACHC) is providing responses to your most frequently asked questions during the COVID-19 pandemic. The Centers for Medicare & Medicaid Services (CMS) continues to update its guidance for providers during the national public health emergency. We have updated our FAQ information with program-specific guidelines from CMS and the Centers for Disease Control and Prevention (CDC). To best meet your needs, we will continue adjusting our responses to remain accurate and current.

**ACCREDITATION**

**Q:** Is the public health emergency still in effect?  
**A:** The COVID-19 public health emergency (PHE) is still in effect and has been extended through the middle of January 2022. The extension allows providers to continue using waivers and flexibilities issued in response to the COVID-19 pandemic. This action marks the seventh extension of the PHE since January 31, 2020, when the U.S. Health and Human Services agency introduced waivers that suspended several federal oversight and reporting requirements.

**Q:** Are your Surveyors taking safety precautions?  
**A:** To protect your staff and patients, ACHC has joined other leading healthcare organizations in mandating COVID-19 vaccinations for our Surveyors. As your partner in risk management, it is the right and prudent thing to do.

In addition, our Surveyors are self-monitoring their health, ensuring they are symptom-free, and following CDC measures to prevent the spread of infectious disease.

**Q:** Is ACHC conducting surveys during the PHE?  
**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. ACHC has resumed normal accreditation survey activities for all providers. Initial and renewal on-site surveys for healthcare providers are being conducted in areas where it is safe to do so. For Medicare providers, ACHC is following CMS guidelines.

Information as of 11/03/2021.
Q: Can virtual surveys be conducted that provide full accreditation?

A: ACHC has a process to conduct virtual accreditation surveys for many healthcare providers. Overall, we have resumed conducting on-site surveys in most areas for initial and renewal accreditation, in accordance with updated guidance from CMS and the CDC.

In locations where virus prevalence rates or restrictions do not accommodate an on-site survey, certain providers may be eligible for virtual surveys. Please contact ACHC to discuss the best solutions for your organization. Email customerservice@achc.org or call (855) 937-2242.

To assist providers eligible for a virtual survey, ACHC will schedule a pre-survey meeting and provide information outlining what to expect during the survey, virtual survey etiquette, technology testing, and readiness for a successful survey. An additional on-site survey may be required later for certain organizations.
Q: Has CMS announced resumption of home health surveys by state agencies and accrediting organizations?
A: Yes. As described in CMS QSO 20-35, state agencies and accreditation organizations are encouraged to resume normal survey activities, while also addressing the backlog of postponed surveys. To date, ACHC has postponed a minimal number of surveys.

Q: Can my home health agency conduct telehealth visits instead of home visits?
A: Under CMS waivers during the COVID-19 public health emergency, home health agencies (HHAs) can use telehealth to provide more services to beneficiaries within the 30-day episode of care, if the services are part of the patient’s plan of care and do 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-person visits outlined in existing or new plans of care.

Q: Is it true that initial home health assessments can be conducted remotely?
A: With the CMS waiver of 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. 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 has waived 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 (occupational therapist [OT], physical therapist [PT], or speech-language pathologist [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 the service establishes eligibility for the patient to be receiving home care. Rehabilitation skilled professionals are not 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.

Q: Does the nurse practitioner/physician assistant have to be enrolled in PECOS in order to sign the plan of care orders/certify the patient for home health services?
A: The nurse practitioner/physician assistant (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.
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 has altered 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.

Q: Do I need to supervise a home health aide on site every 14 days?
A: CMS has waived the requirements at 484.80(h), which require a nurse to conduct an on-site visit every two weeks. This includes waiving 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 that may not be physically possible for a period of time. This waiver also temporarily suspended 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.

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 CMS 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.
Q: Has CMS announced resumption of hospice surveys by state agencies and accreditation organizations?
A: Yes. As described in CMS QSO 20-35, states and accreditation organizations are encouraged to resume normal survey activities while also addressing the backlog of postponed surveys. To date, ACHC has postponed a minimal number of surveys.

Q: Can a hospice conduct telehealth visits instead of home visits?
A: Under the CMS waivers, hospice providers can provide services to a Medicare patient receiving routine home care through telehealth, if it is feasible and appropriate to do so.

Q: During the PHE, 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 audio-video 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.

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’s 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 the public health emergency, CMS expects in most, but not all, situations that the initial and comprehensive assessment visits will be done in person.

Q: What if I can’t find volunteers to work at my hospice during the national emergency?
A: CMS has waived the requirement at 42 CFR §418.78(e) that hospices are required to use volunteers, including at least 5 percent of patient care hours, during the emergency. Hospice volunteer availability and use could be reduced due to a surge in COVID-19 cases and quarantine measures.
Q: Do I need to supervise a hospice aide on site every two weeks?
A: CMS has waived the requirements at 42 CFR 418.76(h), which require a nurse to conduct an on-site visit every two weeks. This includes 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.

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 can be extended from 15 to 21 days.

Q: Which noncore services are being waived for hospices?
A: CMS has waived the requirement for hospices to provide certain noncore hospice services during the national emergency, including the requirements at 42 CFR §418.72 for physical therapy, occupational therapy, and speech-language pathology. The waiver allows patients to refuse those services during the PHE to decrease the number of people coming into contact with patients and reduce the risk of possible exposure. It allows a change in the plan of care, but hospices still must be able to provide the services.

Q: What is the guidance for hospice workers caring for patients in nursing homes?
A: CMS, in collaboration with the CDC, issued updated 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: ACHC has a process to conduct virtual accreditation surveys for DMEPOS providers. Generally, ACHC has resumed conducting on-site surveys in most areas for initial and renewal DMEPOS Accreditation, in accordance with updated guidance from CMS and the CDC. In locations where virus prevalence rates or restrictions do not accommodate an on-site survey, DMEPOS providers are eligible for virtual surveys during the COVID-19 public health emergency.

Off-site virtual surveys cover the same scope, quality, and review of standards, observations, and interviews as on-site surveys. An on-site validation visit may follow, when feasibly possible, to review implementation of the Plan of Correction (POC) and anything not reviewed in the virtual survey. Organizations must remain in compliance with standards during the validation visit and throughout their accreditation cycle. Noncompliance could jeopardize accreditation status.

For more information on DMEPOS virtual surveys, please contact ACHC to discuss the best solutions for your organization. You also can listen to a free recording of an ACHC town hall on the DMEPOS virtual survey process.

Q: Will I know when the virtual survey will occur so I can have adequate staffing?
A: Yes. ACHC will notify you approximately 48 hours in advance to make sure you have adequate resources for the virtual survey. ACHC will schedule a pre-survey meeting and provide information outlining what to expect during the virtual survey, virtual meeting etiquette, technology testing, and readiness for a successful survey.

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 issued instructions to the NSC to waive the following standards:

- 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) items are 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 item must be replaced and are reminded to maintain documentation indicating that the DMEPOS item was lost, destroyed, irreparably damaged, or otherwise rendered unusable or unavailable as a result of the emergency.
COVID-19 FAQs

Q: Are signatures and proof of delivery required for DME and Medicare Part B drugs?
A: CMS has waived signature and proof of delivery requirements for Part B drugs and durable medical equipment when a signature cannot be obtained. Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of the pandemic.

Q: Can DMEPOS 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.

Q: Are PTs and OTs allowed to conduct specialty evaluations via telehealth for patients needing custom-built wheelchairs?
A: CMS has authorized additional telehealth waivers that expand 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.

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 announced that CMNs for oxygen and DIFs for external infusion pump claims are not required during the coronavirus emergency because of the interim final rule published in April 2020 that waived clinical indication requirements. Instructions for submitting claims also were provided.
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.

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

A: Yes. CMS released clarification, in the memorandum dated August 17, 2020, Ref: QSO-20-36-ESRD, that dialysis access placement or repair of arteriovenous (AV) fistulas or grafts, and peritoneal dialysis catheters are essential in establishing that vascular access is crucial for end-stage renal dialysis (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.

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.

Q: Are there special considerations for screening home dialysis patients?

A: Dialysis facilities should continue to follow CMS guidelines and facility policies as required regarding monthly monitoring of home dialysis patients while an on-site visit occurs at the facility.

Recommendations for screening that apply to in-center patients and visitors also apply to any home dialysis patient who comes into the facility for care or evaluation. Facilities should remain vigilant in monitoring all patients and staff in accordance with CMS guidelines and facility internal policies and procedures.

Q: Is ACHC offering on-site accreditation surveys for renal dialysis providers?

A: Yes. ACHC has resumed normal accreditation activities and is offering on-site surveys nationwide for renal dialysis organizations.

For more information on survey options, contact your Account Advisor or ACHC customer service.
Q: Which specific patient assessment frequency requirements were waived for renal dialysis?

A: CMS has waived the following requirements at 42 CFR §494.80(b) related to the frequency of assessments for patients admitted to a dialysis facility during the emergency. CMS waived 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, physician treating the patient for ESRD, social worker, and 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 waived:

- §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.

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

A: CMS has modified two requirements related to care planning, specifically:

- §494.90(b)(2): CMS modified 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 also applies 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 modified the requirement that the ESRD dialysis facility 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 waived the requirement for a monthly in-person visit if the patient is considered stable and also recommended using telehealth flexibilities, such as phone calls, to ensure patient safety.

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

A: CMS has waived 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 in skilled nursing facilities receive their scheduled treatments?

A: CMS has waived 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 services to its patients in a 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 residents’ usual Medicare-certified dialysis facility. Further, 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 manufacturers’ instructions for use.