CHAPTER 2: THE SURVEY PROCESS

Surveyors are getting more detailed training on, wound care and coding. In Chapter 10 of the CMS State Operations Manual, there are three specific expectations of the regulations outlined for surveyors. Surveyors are expected to check:

1. **Sustained compliance.** Agencies must remain in substantial compliance with the CoPs and state law. Agencies are expected to make necessary changes in any deficient policies and procedures to ensure any correction made is continuing — not just for purposes of getting past survey issues. Agencies must continuously monitor their own performance to sustain compliance.
2. **Deficiencies promptly addressed.** The state and CMS regional offices are required to demand quick remedies to come under compliance when found deficient. This requirement to expedite compliance is one of the primary reasons for the sanctions currently being enforced within the industry.
3. **Patients expected to attain and maintain highest functional capacity.** Patients admitted to home health must receive the care and services necessary to achieve and maintain the highest level of function.

Who conducts surveys?

The state survey agency or the CMS regional office decides the size of the team. Each home health survey team should include at least one nurse with home health survey experience. Other surveyors who have the expertise to determine whether the agency is in compliance may be used as needed.

Surveyors should have the necessary training and experience to conduct a home health survey. All home health surveyors must attend a CMS-sponsored basic home health surveyor training course. New surveyors may accompany the team and observe what's going on as part of their training prior to completing the CMS basic home health agency trainer course.

Size of the survey team

The state and regional office will decide on the number of surveyors to send to an agency depending on agency census, number of branches and agency history, including whether there has been a pattern of deficient practices in the past or pattern of complaints.

If new surveyors are training during the survey, more members may attend.

Types of surveys

Standard survey

A standard survey must be conducted every 36 months for all agencies.

CMS surveyors also conduct standard surveys in conjunction with a change in ownership or change in agency management. The purpose of this survey would be to determine if the quality of care would not be altered in any way. Expect the survey within two months of the reported change. Of course, agencies are required to notify the state of these changes. The survey department may ask for copies of written policies and procedures, personnel qualifications and agreements. If your agency undergoes a change in ownership, you can save time by submitting this information along with the notification of the changes.

A significant number of complaints about an agency also could trigger a standard survey. During standard surveys, expect your surveyor to follow guidelines for Level 1 highest priority standards unless conditions in the agency trigger an extended survey.

Initial certification

Agency owners wishing to get into Medicare home health must undergo an initial survey that has been requested by the agency in writing.

The agency also must:

- Be operational;
- Meet the capitalization requirements;
- Submit a complete Form CMS-855A to the Medicare Administrative Contractor (MAC);
- Provide nursing and at least one other therapeutic service;
- Demonstrate ability to function in all areas of the home care business including billing, coding and OASIS;
- Have been successful in transmitting OASIS to the state repository; and
- Have cared for at least 10 patients with a minimum of seven active at the time of the survey — though CMS does make some exceptions in medically underserved areas, which are determined by the CMS regional office.

The initial survey is fairly easy to accomplish with the right guidance. There are a minimal number of patients to attend to, minimal staff and no history. Agencies that pay attention to the standards typically are successful with this survey.

For the past few years, CMS has indicated that state survey departments devote more of their efforts on recertification and complaint surveys while accrediting bodies such as The Joint Commission and Community Health Accreditation Program (CHAP) are available to complete the initial surveys when the agency requests it.

Recertification survey

All agencies are subject to a recertification survey at least every 36 months. The recertification is likely to begin with a standard level — in which Level 1 tags are assessed. (See more on Level 1 and Level 2 later in this chapter.) But recertification surveys may go beyond that to a partial-extended or extended survey if noncompliance is indicated.

Post-survey revisit (Follow-up)

The state agency will follow up on all areas of compliance cited during a survey. It is possible that a surveyor will follow up via telephone or mail in lieu of an on-site visit. The surveyor would not use this method of following up if there was a question as to whether the reported corrections were actually completed. Most often, an on-site visit would be necessary to assure corrections were made according to the plan of correction presented.

Condition-level citations are always followed up by an on-site visit for compliance.

This follow-up visit would be documented on the CMS form 2567B. The state agency prefers to have the same team member who found the deficiency conduct the follow-up survey for evidence of correction(s).

Should the surveyor find there are continuing problems, another 2567B form would be completed and the agency may be given the option to present another plan of correction.

Partial-extended survey

This survey would be conducted if one or more deficient practices or a condition-level deficiency were found during a standard survey. It's an effort to determine if there are more deficient practices within the agency. The surveyors would then review other conditions before making a decision on compliance.

Partial-extended surveys also are conducted when the surveyor's offsite preparation determines a concern. For example, the surveyor may have a concern about the agency's transmission of OASIS data and want to review that further during the survey.

The partial-extended survey would involve a review of Level 2 standards under the Level 1 standard found out of compliance. The surveyor also may extend a review of the agency in conditions that are related to the deficient practice. For instance, if during a home visit the surveyor finds deficient infection control practices by the nurse, the agency might be found out of compliance. The surveyor may choose to go back to the agency to review policies related to infection control and/or look at personnel records in an effort to evaluate the infection control competency of the nurse that could lead to additional compliance issues and addition citations.

Extended survey

If a surveyor discovers a reason to open an extended survey, all conditions are ripe for review. An extended survey must be conducted if a condition-level citation is found. At this point, the surveyor will review "policies, procedures and practices that produced the substandard care." Most often, the extended survey will be conducted during the time of the scheduled survey. However, it must be conducted no more than 14 days following the survey in which the agency was found out of compliance.

Validation/look-behind survey

Validation surveys are conducted for deemed status agencies within 60 days of a survey. Or, they may be prompted by complaints or allegations of significant deficiencies that could affect patients' health and safety. During validation surveys, CMS will review all conditions.

Federal law doesn't require CMS to conduct look-behind surveys to assess state agencies' survey performance during home health surveys. But CMS may conduct such surveys if it wishes. In these cases, CMS itself conducts the look-behind survey of a home health agency rather than contracting with another entity to do it. CMS then compares its results for an individual agency with the state agency's results for the same home health agency.