

STAFF NEWSLETTER

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CMS Impacts Your Survey

How are changes at Medicare affecting your accreditation survey?

Accreditation is mandatory for DMEs to participate in the Medicare program; and Medicare verifies that all products billed to Medicare are in the accreditor's data base for your business.



I'm Back!

↳ The newest rules are that every location with a Medicare billing number must be physically visited when the business gets surveyed; and re-surveys must be completed no later than 36 months after the previous survey.

As a result, most companies are now getting their un-announced re-survey several months earlier than they expected, typically about 30-33 months after the prior inspection.

At some point in your accreditation inspection, after performing home visits to patients, and audits of patient and personnel files, review of equipment cleaning, maintenance, and storage, the accreditation visitor will move into the billing department. They may look over the billing person's shoulder to see how your company is able to link equipment and items to the beneficiary as well as verify you are posting payments to the individual patient account.

The accreditation surveyor is essentially an extension of Medicare, directed to audit that your business is following all applicable billing rules. Regardless of who you are accredited by, the surveyor needs to ensure that the company has accurate billing to beneficiaries and the Medicare program. The surveyor is supposed to review financial management practices at your company (like validating you have a budget.

Some of the specific requirements they review are:

- Does the delivery receipt have make, model, and serial number of the equipment provided to the patient?
- Did the patient sign *and date* the delivery form?
- If the caregiver or someone else signed the form for the patient, did that person also write what their relationship is to the patient and why the patient could not sign the form (such as sleeping, unavailable, unable to sign)?
- Do the items *delivered* correspond to the items *billed*?
- Did staff correctly complete the Advance Beneficiary Notice (ABN) and use appropriate claims modifiers?