

Important news  
about insurance and  
risk management for  
hospices and home  
health care agencies.

## Maintaining Service Quality During Organizational Reengineering

Barbara Stover Gingerich RN MS FACHE CHCE

This topic is not new to the industry; it was a key strategy used by providers during the home care reimbursement system revisions from retrospective to prospective payment. It is once again a priority strategy, which is driven by the current economic situation and the proposed recommendations and revisions to home health and hospice reimbursement. Given the current global economics, there is a universal need to decrease expenses and increase revenues, not only in the health care sector, but also in all service sectors. In 2005 a collaborative effort between the National Academy of Engineering and the Institute of Medicine, *Building a Better Delivery System: A New Engineering/Health Care Partnership*, found that

**“an estimated thirty to forty cents of every dollar spent on health care ... a half-trillion dollars a year ... is spent on costs associated with: overuse, underuse, misuse, duplication, system failures ... and inefficiency.” [Hostetter, 2008]**

It also verified that only slightly more than fifty percent of patients were receiving evidence-based care, and that 98,000 patients die and one million are injured as the result of medical errors each year [Hostetter, 2008].

The challenge is to redesign and reengineer operations while complying with regulations, meeting licensure and accreditation expectations and maintaining quality. While focusing on meeting the needs present in the communities served by providers, there has been an ongoing outward service growth pattern. This growth expanded traditional hospice and home care services beyond the initial catchment area, mission and focus of the organization. Because the urgency of the need outweighed the strategic planning and operational designing process, this type of expansion is sometimes not well thought out and well designed. In the reengineering/redesigning process, while all service delivery lines must be critically and objectively examined, non-core service lines are often a good starting point.

### Basic Principles and Concepts

Some of the basic reengineering principles and concepts are visioning and creative thinking. These are key strategies to use during the analysis and investigation process. There are also two other very important principles to be constantly in the forefront during the reengineering process. These are amnesty and empowerment [Gingerich, 1996].

Continued on page 2

#### INSIDE THIS ISSUE

**Keep Your Website Up-to-Date:  
Institute a Web Content  
Management Policy**

**GoGlatfelters.com  
Employment Practices Resources  
for HCCIS Customers**

**Record Retention and Loss Control**

**Compliance Concerns:  
Assuring Quality of Medical  
Equipment and Supply Providers**

**Who To Contact**

INSERTS

**Job Descriptions:  
Develop, Integrate, and Update**

**HCCIS Update Reader Survey**

We welcome your comments and questions.

Bruce Williams  
Update  
P.O. Box 2726, York, PA 17405  
1-800-233-1957

**www.hccis.com**



## Maintaining Service Quality During Organizational Reengineering

*Continued from page 1*

By providing amnesty and involving staff in the process, organization leaders will learn more about the day-to-day operations from the 'inside' and have more truthful responses and participation. These principles are also important when leaders educate staff about the need for the changes and can enhance staff commitment to the end product. Staff have a deep concern for patients and the quality of care they provide. It is through the individual staff member's honest contribution that changes can be made that will not adversely affect care and service quality.

### Reengineering Steps

An essential step in revenue analysis is the identification and evaluation of reimbursement trends for all service lines. With the projected Total Calendar Year [CY] 2009 Home Health National Standardized 60-Day Episode Payment Rate increase of only \$1.60 per episode of care and the Medicare Payment Advisory Commission (MedPAC) commissioners focusing on reforming Medicare's hospice benefit, it becomes an even more crucial step in order to maintain organizational viability. In completing this step, it is important to not only evaluate the Medicare reimbursement impact, but also all revenue stream reimbursement trends, such as managed care, traditional health insurance and contractual reimbursement agreements. This baseline information provides a foundation for future decision making.

The next step in reengineering is to critically examine work and work flow that contributes to the cost of service delivery. This usually involves process identification, task analysis and time studies. Each task within specific processes, such as the patient admission process, is identified, listed and examined relative to the task's value and relevance. Tasks/time periods are categorized as value added, necessary, rework, unnecessary work and not working. Categorizing the reasons that unnecessary, rework and not working occurs, such as interruptions, procrastinations, or forces that can clog up or drain down the workflow is the second classification tier used to evaluate work and operational processes. Process mapping identifies all steps in a process, and all steps should be classified and assigned a category [value added, necessary, rework,

not working]. Steps that are necessary and add value are highlighted and retained and where possible the steps that are rework, or not working time, or that add time or use unnecessary resources without improving care, are reduced or eliminated.

It is during this categorization and classification step that the importance of amnesty and staff involvement becomes clear. A core process redesign concept is the belief that staff closest to the work knows the work best and can make improvements that benefit patients. It is also believed that staff are more open and honest in their communication and evaluation when the reengineering principle of amnesty is present. Using this approach, an organization is better able to measure the impact of proposed redesigned processes from both the quantitative and qualitative perspectives. Examples of individual and small group exercises that can be utilized in initiating this step within the organization are available at the Hospice and Community Care Insurance Services website, [www.hccis.com](http://www.hccis.com), under Resources - Other, titled "Work Categorization Exercise."

**98,000 patients die and one million are injured as the result of medical errors each year.**

### Maintaining Quality

There are several national programs that encourage the process redesign/reengineering approach be used in conjunction with quality improvement activities, for example, the Aldridge National Quality Program and Six Sigma. These programs have assisted health care organizations to expand access to care (by reducing waiting times and increasing transition through the care continuum), improve the quality and safety of care (by reducing variation and ensuring the delivery of evidence-based care) and reduce costs (by eliminating waste and increasing productivity) [Hostetter, 2008]. These are the outcomes that organizations must focus on when making cost reduction/reengineering decisions.

### Current and Future Trends

During this process, consideration must also be given to future trends and availability of new technology that can assist

in the reduction of costs and enhancement of quality. Robotics is one innovative approach to improving clinical services. Robotics is being used in acute care, pharmaceutical and other health care settings. Community-based providers need to explore how robotics can positively impact their services and profitability. For example, robots are being explored as an adjunct to physical and occupational therapy [Noor, 2007]. In the future it might be possible for robots to be programmed to provide the active and passive exercise programs established by therapists, with transmission of joint range of motion and strength measurements directly back to the provider's offices.

Another trend is the provision of education via a computer model or simulation. This allows an individual staff member to improve and maintain skills as well as practice tasks until competency and proficiency are achieved. The result can lead to decreased risk exposure by improved skill and improved costs due to more efficient care delivery.

Electronic records are another trend that can serve to improve efficiency and care quality. By having the electronic visit documentation available to different staff providing care to an individual, there is enhanced communication between staff and increased care consistency. Electronic physician order entry can also decrease medication errors and risk to patients. The benefits and values of electronic records are just beginning to be realized within the home health and hospice care settings.

### Summary

Positive results from process reengineering efforts have been reported from health care systems across the country. The Virginia Mason Medical Center in Seattle reports that their use of process reengineering resulted in a Patient Safety Alert system. This system requires staff encountering a situation likely to harm a patient to "stop the line" and cease any activity that could result in further harm. This alert is then investigated and followed up in accordance with the protocol established. This system has significantly improved patient safety and reduced claims. The primary reason for the need to activate the Patient Safety Alert system was discovered to be a failure to completely communicate across the care setting.

It is important that those processes that reoccur frequently be standardized in order that long-term efficiency and quality be achieved and sustained. When new

staff joins an organization, the new staff member can use the established processes in developing their care approaches. Tools such as checklists, information handouts and printed care paths assist in the ongoing consistency and efficiency in care. Through process improvement, the organization can bring about significant savings, reduce labor costs, increase productivity and enhance staff morale and satisfaction, while concurrently improving care processes and delivery. ♥

#### References:

Gingerich, BS. & Ondeck, DA. 1996. *Home Health Redesign: A Proactive Approach to Managed Care*. Aspen Publishers: Gaithersburg MD.

Hostetter Martha, 2008. *Quality Matters: Health Care Process Improvement*. September 18, 2008. Volume 31. [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=705963](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=705963)

Noor, Ahmed. 2007. FEATURE FOCUS: Engineering Tomorrow. Re-engineering healthcare. *Mechanical Engineering*. <http://www.memagazine.org/backissues/membersonly/nov07/features/reenghc/reenghc.html>



## GoGlatfelters.com Employment Practices Resource for HCCIS Customers

Since the year 2000, the number of employees alleging discrimination, wrongful termination, sexual harassment and retaliation has increased steadily. According to the EEOC (U.S. Equal Employment Opportunity Commission), settlements and judgments in these suits are also on the rise. Employment Practice liability suits are time consuming and costly to defend. What can your organization do to protect itself against this significant exposure?

One resource that HCCIS customers can take advantage of is the "My Community Workplace" website, which you can register for under the Education and Training tab of the HCCIS website ([www.hccis.com](http://www.hccis.com)). This resource offers useful tools such as analysis of EEOC data, employment practice training programs and model policies, along with an extensive database of employment practice topics.

My Community Workplace can help you create a safer and more productive workplace. It also covers timely issues such as third party harassment and catastrophic violence. When a new issue arises, you'll know about it. All you need is a user name and password, and you'll have access to one of the most powerful employment liability tools available. We encourage you to identify the right person within your organization to register and sign up now at [www.hccis.com](http://www.hccis.com)!

#### New Feature

If you have previously checked out this website, but have not been back recently, you might want to check out the resources under the "knowledge vault" page. There are numerous sample policies including:

- Computer, Internet and Network Usage
- Progressive Discipline
- Reporting Wrongdoing
- Sexual Harassment Free Workplace

One of the newest features is a comprehensive **model employee handbook**. This can be a very helpful tool to Human Resources professionals who are in the process of updating their own internal resources. So register now and check it out! We think you will be glad you did. ♥



## Keep Your Website Up-to-Date

# Institute a Web Content Management Policy

John M. Belanger II, AIM, AIT, PCLP, CLS  
Director of Applications, Glatfelter Insurance Group

What is fairly obvious to many, is that younger generations have been more immersed in the use of the internet than any previous generation. What is not always immediately apparent is this group's change in expectations as it relates to organizations' use of websites, blogs and other internet-related technologies. A quality website is no longer a "nice to have" but a minimum expectation on the part of the Generation X and Y demographics. Generation Y or "Millennials" (generally accepted as those born from 1979 to 1994) in particular have been "marinated in digital technology" advises Rob Salkowitz, author of *Generation Blend: Managing Across the Technology Age Gap*. "Organizations that are socially or technologically ill-equipped to harness the talent of the Millennials will have difficulty attracting and retaining the skilled workers they need." With such expectations and high visibility, it has become imperative for organizations to ensure their website

is fresh and relevant to prospective customers and partners.

### Introducing a Web Content Management Policy

With such a strong need to have a website or "web presence," how can an organization ensure its content remains timely and of value? Instituting a content management process or policy in your organization can help foster and manage the addition of new content while helping to sidestep common liability pitfalls.

The objective of a web content management or review policy is to structure the website update or review policy just enough to ensure the right people and oversight are involved, but not so much as to introduce an overly burdensome process for your organization. Documenting the process once it is defined helps ensure all involved understand the policy. It is fair to expect that

*Continued on page 4*

## Institute a Web Content Management Policy

*Continued from page 3*

web content management policies will vary in detail from organization to organization. Nevertheless, some fundamentals are needed regardless of the organization's specific mission in order to ensure a sound process. The Web Content Managers Advisory Council, an interagency council sanctioned under the federal General Services Administration (GSA), developed a best practices framework on which an organization can "build" their specific web content management policy. Here is an adaption of this best practices framework you may find beneficial in formalizing a web content management policy and process:

### STEP 1: Lay the foundation

Since one or more individuals at your organization will be devoting a portion of their time to regular website updates and review, speak to your organization's management so they understand the importance of the policy and support it. Management should designate a website coordinator to facilitate and oversee the process. This individual may or may not be the individual updating the site content depending on the website's size.

Management may also be a part of the periodic review and approval process. Best practice, even for small sites, is to have at least one individual in addition to the coordinator to review and approve changes. Since the website is an extension of the organization, it is often beneficial for the owner or another member of senior management to be the designated approval manager for changes.

### STEP 2: Designate content "owners"

All areas of the site should have an "owner" designated to keep the content up to date. That can be the designated web coordinator for small websites, but it is often helpful to designate "subject matter experts" responsibility over portions of the website that include content about their area of expertise. SME's are individuals in the organization with expertise in a particular area. So for example, an insurance company may designate an underwriting manager responsibility over the portion of their website that includes content about their underwriting policies and practices.

### STEP 3: Set expectations for the site reviews

A review of the site by the approval

manager or other individual involved should include attention to both functionality and the quality of the content itself. Do all links work, and go to the expected page? Can visitors successfully navigate their task from start to finish? Is the page written in plain language? Are there errors in spelling or grammar?

### STEP 4: Develop a schedule and conduct regular site reviews

The Web Content Managers Advisory Council suggests that a complete review of all content be done at least once a year at a minimum. A quarterly or even monthly review of the "home page," "what's new" pages and other content may make sense for those areas of the website if those areas change more frequently.

Regardless of the schedule for your organization, website reviews should be conducted on a regular schedule. Those involved in the process should know exactly the areas of the website for which they are responsible.

### STEP 5: Update the site

The proposed changes to the website should only be made once the proposed changes are reviewed and approved by the designated approval manager or web coordinator.

### STEP 6: Monitor and follow-up

The website coordinator and/or management should be apprised when updates are completed.

### Summary

Websites and use of the internet are woven into the fabric of our modern culture. No more is an organization's website a mere novelty; it is a necessity as up and coming generations reshape societal expectations. Organizations that understand this and make their website a priority in the presentation of their brand or mission better position themselves to attract new employees, partners and customers. Instituting a web content management policy assists organizations in this process so their site stays up to date and relevant to potential customers, business partners and volunteers. ♥

#### Sources:

Salkowitz, Rob. *Generation Blend: Managing Across the Technology Age Gap*. Hoboken, New Jersey: John Wiley & Sons, Inc., 2008.

Webcontent.gov. 5 Mar. 2008. Web Content Managers Advisory Council. 18 Feb. 2009. <http://www.usa.gov/webcontent/index.shtml>.

# Record Retention and Loss Control



Betty Norman, BSN, MBA, CPHRM

**A**bsent any specific laws or regulations mandating a retention period, organizations are not required to retain all records and information forever. It is important, however, that healthcare entities have specific written guidelines for retention of patient care and other business related records so that practices are uniform and consistent across the organization.

The majority of states have retention requirements that can be used to develop the organization's retention policy, particularly for patient records. In the absence of specific state requirements, the organization should keep these records for at least the period of time specified by the state's statute of limitations or for a sufficient period of time to prove compliance with laws and regulations.

If the patient was a minor, the organization should retain the record until the patient reaches the age of majority (as defined by state law) plus the period of the statute of limitations.

### Conditions of Participation

The new Hospice Conditions of Participation standard related to patient record retention (Standard 418.104 (d)) states: "Patient clinical records must be retained for 6 years after the death or discharge of the patient, unless State law stipulates a

longer period of time. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform its State agency and its CMS Regional office where such clinical records will be stored and how they can be accessed.”

The Home Care Conditions of Participation are very similar. Standard 484.48 (a) states: “Clinical records are retained for 5 years after the month the cost report to which the records apply is filed with the intermediary, unless State law stipulates a longer period of time. Policies provide for retention even if the HHA discontinues operations. If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient.”

### Unique Issues Related to Electronic Records

An electronic record includes information that is:

- Recorded on any electronic medium (e.g., magnetic medium)
- Intended to provide documentation for long-term retention that has legal or business evidentiary value

For organizations utilizing a combination of paper and electronic records consideration should be given to conversion of paper documents into electronic records using copiers and scanners. Information systems should be backed up periodically and the backup data maintained off site in a secure location. The frequency of the backup procedure is determined by the organization’s needs. Policy should also indicate at what point electronic documents are locked and available as read-only. Any subsequent additions, changes, or deletions would be handled as addendums to the record.

### Compliance Record Retention

Compliance programs should establish specific written policies to address the retention of all types of documentation. This would include clinical and medical records, health records, claims documentation and compliance documentation. Compliance documentation includes all records that would be necessary to protect the integrity of the compliance process and confirm the effectiveness of the program, including employee training documentation, reports from hot lines, results of internal investigations, results of auditing and monitoring activities, modifications to the program and self-disclosures.

### Records in Litigation

Additional measures should be taken to secure and retain records that are in litigation. The original, complete patient record related to an incident or case in litigation should be removed from general access and circulation and kept in a locked file in a secure location. Any requests to access or view the record should be handled by the designated risk manager or administrator, who should remain present during the time the record is being reviewed. This will serve to maintain the integrity of the information and prevent any loss of information or alterations to the record.

### Loss of Medical Records

If all of the medical record is lost or destroyed—whether through inadvertent carelessness or a deliberate act to cover up negligence—the organization may find itself in an untenable legal position. Health care providers should prepare for medical record damage that may result from disasters such as hurricanes, tornados, floods, sewage backup, or other types of water-related disasters, fires, power failures (when using electronic medical records), or evacuations. Facilities must have backup systems in place to access medical records during emergencies as well as

methods to recover medical records damaged by disasters. For example, fire/water/storm damage restoration companies may provide assistance for recovering records; however, when contracting with such companies, facilities should ensure that safeguards are in place to protect the privacy and confidentiality of resident information.

### Destruction of Medical Records

When a decision is made to destroy medical records, either because the retention period has expired or the record has been transferred onto some other medium, the method of destruction needs to be complete, (i.e., shredding, pulverization, incineration) to protect against confidentiality breeches. Some organizations use a commercial vendor to handle medical record destruction. A written business agreement between the two parties should be established in order to comply with HIPAA (Health Insurance Portability and Accountability Act) requirements. This will help to establish safeguards to protect confidentiality and indemnify the organization.

A destruction log must be maintained to identify the destroyed records. At minimum, the destruction log must

*Continued on page 8*

## CHECKLIST

### for Review of Internal Policies/Procedures Related to Retention:

#### Step 1: Identify which records are relevant.

The first step in drafting a record retention policy is to identify which records are relevant. To do this, make a list of all of the kinds of records that have regulatory retention requirements or could help prove a disputed issue in the future. Management staff can assist in this process by identifying those documents they routinely retain in their departments. For example:

- Patient records (e.g., medical and contact information);
- Employee records (e.g., employment applications, performance evaluations, wage and benefits information, schedules and training documentation);
- Accounting records (e.g., accounting journals and ledgers, budgets, bank deposit slips and statements, cancelled checks, expense reports, inventories and invoices);
- Corporate records (e.g., annual and quarterly reports, financial statements, articles of incorporation and bylaws and board and staff meeting minutes);
- Tax records (e.g., federal and state income tax returns, payroll tax returns, property tax returns and supporting forms and documentation);
- Legal/Insurance records (e.g., vendor contracts, commercial real estate leases, business insurance policies and Medicare/Medicaid regulatory documents).

#### Step 2: Develop a retention schedule.

The most important factors to consider when determining the retention periods for the kinds of records listed in Step 1 are any applicable state and federal laws, including the “statute of limitations” for filing different kinds of lawsuits. The statute of limitations (SOL) is the maximum time allowed by a state or federal law for filing a lawsuit.

#### Step 3: Monitor Compliance and Enforce Policy.

Begin enforcement by disseminating the policy to all employees, particularly management staff, and ensuring that they read and understand it. Compliance with retention policies can be monitored as part of the corporate compliance and/or performance improvement function.



## COMPLIANCE CONCERNS:

# Assuring Quality of Medical Equipment and Supply Providers

Barbara Stover Gingerich RN MS FACHE CHCE

The September 30, 2009 date is set for all Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies [DMEPOS] providers to achieve accreditation if they desire to retain their Centers for Medicare and Medicaid Services [CMS] provider status. This must be achieved in order to continue billing with their National Provider Identification [NPI] number after this date. As DMEPOS providers prepare to meet this deadline their resources will be focused on this mandatory date. As a consumer of DMEPOS services it will be important to you that ongoing service quality and customer service are provided to your patients throughout this process. Having had experience with the accreditation process for your organization, you might also be of assistance while the DMEPOS provider undergoes this process.

### Accreditation Provider Selection

Unlike home care and hospice organizations, DMEPOSs have a long list of accreditation organizations from which to choose. CMS approved many accrediting organizations as deeming authorities for the DMEPOS providers, but not all approved accrediting organizations are approved for all service lines. The specific approved service lines are: Durable Medical Equipment, Respiratory, Orthotics and Prosthetics, Rehab Technology and Supplies.

That means that the DMEPOS provider needs to evaluate the accrediting organization to assure that its approval covers all of their service lines and needs. They also need to be certain that the selected accrediting organization is able to provide a timely survey this year as well as availability of ongoing accreditation triennially. The list, approved by CMS to provide DMEPOS deemed accreditation includes the following:

1. Accreditation Commission for Healthcare, Inc. (ACHC) - [www.achc.org](http://www.achc.org)
2. American Board for Certification in Orthotics and Prosthetics, Inc. (ABC) - [www.abcop.com](http://www.abcop.com)
3. Board for Orthotist/Prosthetist Certification (BOC) - [www.bocusa.org](http://www.bocusa.org)
4. Commission on Accreditation of Rehabilitation Facilities (CARF) - [www.carf.org](http://www.carf.org)
5. Community Health Accreditation Program (CHAP) - [www.chapinc.org](http://www.chapinc.org)
6. Healthcare Quality Association on Accreditation (HQAA) - [www.hqaa.org](http://www.hqaa.org)
7. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) - [www.jointcommission.org](http://www.jointcommission.org)
8. National Association of Boards of Pharmacy (NABP) - [www.nabp.net](http://www.nabp.net)
9. National Board of Accreditation for Orthotic Suppliers (NBAOS) - [www.nbaos.org](http://www.nbaos.org)
10. The Compliance Team, Inc. - [www.exemplaryprovider.com](http://www.exemplaryprovider.com) [CMS.DeemedAccreditationOrganizations]

For specific coverages and services approved by CMS for these accreditation organizations, please access: <http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizations.pdf>

### Quality Standards

In addition to meeting the selected accreditation organization's standards, DMEPOS must also meet the quality standards released by CMS in October 2008. This 19-page document identifies key quality initiatives that the DMEPOS must implement and maintain as part of its ongoing operations. Leaders of home health and hospice organizations will find it useful to understand CMS's expectations of DMEPOS. For example, these quality standards address delivery and set up, as well as patients' and/or caregivers' training/instructions [education] follow-up, product safety, intake and assessment, infection control and the consumer complaint process. The first section [i.e., business standard section] of this quality manual applies to all DMEPOS providers and includes chapters focused on administration, financial management, human resource management, consumer services, performance management, product safety, and information management.

The second section of the quality standards manual focuses on service standards, and it is these standards that are of the most interest to home health and hospice leaders. These standards establish expectations that relate directly to patient care needs and patient education. These standards provide home health and hospice leaders with specific information about what is required of DMEPOS. This includes specific expectations that directly integrate with the home health or hospice organization's own quality improvement measures.

There are three Appendices to this manual, with each appendix addressing different service lines. Home health and hospice providers can print out the CMS DMEPOS Quality Standards Manual to

have as a resource by accessing:  
<http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DMEPOSAccreditationStandards.pdf>

### Evaluating Your DMEPOS Providers

Home health and hospice leaders expect the DMEPOS providers with which they contract or use for patient and agency equipment and supplies to provide quality services and equipment and to adhere to specific standards. These quality standards, released by CMS, are of assistance when evaluating the services of DMEPOS providers. Specific functions that home health and hospice leaders can expect from DMEPOS is that they are timely in responding to requests for services and communicate about the expected time the items [supplies, equipment, etc] will be delivered. The DMEPOS provider should also provide verification that the equipment, supplies, etc were delivered to the patient/caregiver. If there is an inability to deliver the requested items, for example, should a patient refuse the delivery of equipment or supplies, the DMEPOS provider is also expected to communicate this to the requesting source.

Another expectation of DMEPOS providers is that they will supply written and verbal education to patients and/or caregivers regarding how to use the equipment and any maintenance needed to keep the equipment in working order.

Additional education is to include any known potential hazards from the use of the equipment, need for emergency or battery back-up and what infection control activities should be undertaken to prevent infections from occurring and/or spreading.

Record keeping is also an important quality expectation and DMEPOS providers are expected to record identifying information about the items delivered. In the case of equipment, this includes the model and make of the equipment and any additional identifier/tracking numbers, or any other identifier of non-custom equipment and/or item(s) provided. This tracking is essential should a recall of equipment or supplies be issued. With this record keeping, recalled items can be quickly located within the patient setting and removed and replaced with another piece of equipment or other supplies.

The DMEPOS provider must also provide the patient/caregiver with information on how to contact them, including

customer service telephone number(s), regular business hours and after-hours access and emergency coverage. When appropriate, rent versus purchase options are to be discussed with the patient/caregiver and documented. Should patients have complaints about the DMEPOS provider, the expectation is that the provider notifies the patient within five calendar days that the complaint has been received and is being investigated. It is also expected that within 14 calendar days, the DMEPOS provider will provide written notification regarding investigation results to the patient/caregiver.

### Summary

There are several specific deadlines that existing DMEPOS providers must meet. If they are currently enrolled in the Medicare program, they must obtain and submit proof of accreditation to the National Supplier Clearinghouse (NSC) by September 30, 2009. If the DMEPOS does not submit this proof, the NSC will revoke the DMEPOS provider's billing privileges on October 1, 2009. Home health and hospice leaders should make certain the providers they are using meet this requirement and are able to continue to provide services to Medicare and Medicaid recipients after this date.

If a new DMEPOS provider approaches your organization about using its services, they must have been accredited prior to submitting the enrollment application to the NSC. Home health and hospice leaders should ask for verification of the successful completion of accreditation and documentation that the DMEPOS provider is approved to participate in Medicare and Medicaid via the Centers for Medicare and Medicaid Services [CMS]. By confirming that DMEPOS providers are in compliance with accreditation and quality standards, the home health and hospice organization is better able to assure that their patients are receiving equipment and supplies via a DMEPOS provider that has met CMS's quality standards. ♥

Does your  
 provider  
 meet all  
 requirements?



### References/Resources:

- <http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizations.pdf>
- <http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DMEPOSAccreditationMIPPA-FactSheet.pdf>
- <http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DMEPOSAccreditationStandards.pdf>
- <http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DMEPOSQualityStandardsPresentation.pdf>

## Record Retention and Loss Control

*Continued from page 5*

capture the information listed below:

- a. Date of destruction
- b. Destroyed by [name(s) of the individuals responsible for destroying the records]
- c. Witness [name(s) of the person witnessing the destruction]
- d. Method of destruction
- e. Patient information [full name, medical record number, date of admission, date of discharge]

The organization should also request certification that the records have been destroyed properly.

### Summary

There are numerous reference and resources for information on retention of documents. One of the best resources for information on retention of records for healthcare organizations is the American Health Information Management Association (AHIMA). Their Practice Brief on the topic, "Retention of Health Information," can be accessed at [www.ahima.org](http://www.ahima.org). This Practice Brief includes tables outlining Federal Record Retention Requirements and State Laws or Regulations Pertaining to Retention of Health Information. There is a separate Practice Brief on Retaining Healthcare Business Records. ♥

## Who to Contact

Hospice and Community Care Insurance Services • P.O. Box 2726, York, PA 17405  
 1-800-233-1957 • Fax: 717-747-7021 • [hccis.com](http://hccis.com)

Members who insure directly with us (not through another agent or broker), please request Certificates of Insurance, submit claims, make policy changes, or ask questions about your policies, by contacting the Customer Service Representative responsible for your state.

**Tracy Guinn**, Ext. 7597

*Western States:* AK, AR, AZ, CA, CO, HI, IA, ID, IL, IN, KS, LA, MI, MN, MO, MT, ND, NE, NM, NV, OK, OR, SD, TX, UT, WA, WI, WY

**Sheila Simmons**, Ext. 7595

*Eastern States:* AL, CT, DC, DE, FL, GA, KY, MA, MD, ME, MS, NC, NH, NJ, NY, OH, PA, RI, SC, TN, VA, VT, WV

Insurance Brokers, please contact the Underwriter responsible for your state.

**Mike Hetrick**, Ext. 7535

*West:* AK, AZ, CA, HI, ID, NV, OR, UT, WA

**Greg Lindstrom**, Ext. 7561 – *Southeast:* FL, NC

**Sheree Van Natter**, Ext. 7566

*Northeast:* CT, DC, DE, IN, KY, MA, MD, ME, MI, NH, NJ, NY, OH, PA, RI, VA, VT, WV

**Sheri Eckenrode**, Ext. 7588 – *South Central:* LA, TX

**Sarah Vail**, Ext. 7541

*Midwest:* AL, AR, CO, GA, IA, IL, KS, MO, MN, MS, MT, ND, NE, NM, OK, SC, TN, WI, WY

Administered by Glatfelter Underwriting Services, Inc.  
 and Glatfelter Insurance Services in CA, MN, NY, TX, and UT  
 and Glatfelter Brokerage Services in NY

To print additional  
 copies of the newsletter,  
 visit our web site at  
[www.hccis.com](http://www.hccis.com)

P.O. Box 2726, York, PA 17405

A Division of Glatfelter Insurance Group

INSURANCE SERVICES

CommunityCare

and Hospice



# Update

PRSRST STD.  
 U.S. POSTAGE  
**PAID**  
 YORK PA  
 PERMIT NO. 631