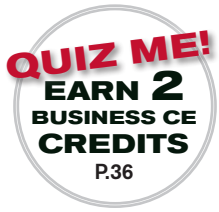
By **JIM LAWSON**

Compliance Issues and Facility Accreditation

ABC representative offers advice for avoiding common mistakes



New this year, *O&P Almanac* is inviting guest authors to write for the quarterly *Compliance Corner* column. This month's column is written by Jim Lawson, outreach development manager at the American Board for Certification in Orthotics, Prosthetics, and Pedorthics.

CE CREDITS ***Editor's Note:*** Readers of *Compliance Corner* are now eligible to earn two CE credits. After reading this column, simply scan the QR code or use the link on page 36 to take the *Compliance Corner* quiz. Receive a score of at least 80 percent, and AOPA will transmit the information to the certifying boards.

OVER THE PAST FIVE YEARS, O&P professionals have gleaned a great deal of valuable information from those that live and breathe accreditation compliance—surveyors, compliance experts from AOPA and the American Board for Certification in Orthotics, Prosthetics, and Pedorthics (ABC), Medicare representatives, and the many facility owners and compliance officers that attend ABC's accreditation sessions across the country. Regardless of the perspective, each one of these individuals has shared his or her own examples, suggestions, and pitfalls when it comes to compliance. And while many of you are tired of hearing about the big "C," we must remember that it's necessary both for reimbursement and, most importantly, quality patient care.

As you know, compliance starts with standards—those required by Medicare and your accrediting organization. As one of the nine deemed accrediting authorities by Medicare, ABC has a total of 142 patient-care facility standards, which include those also required by Medicare. It has been our experience that the most commonly missed or misunderstood standards tend to be the same year after year. These standards fall into three main areas of compliance: patient chart documentation, performance management review, and privileging.

Patient Chart Documentation

Patient chart documentation can be a saving grace or a major thorn in your side. Everything, from the diagnostic-specific clinical evaluation, to the final outcome measures, to the treatment plan, must be sufficiently documented in the patient's record. This includes any interactions with or about the patient. Be it your direct care, that of a privileged caregiver, or communications from the prescriber or other health-care team member, all touch points must be documented.

So, where should you start? At the end. This may seem odd, but keep in mind that it's difficult to begin any journey or endeavor without knowing where you want to go—or, in this case, where your patient wants to go. Listen carefully to the patient's goals for both the short and long term, and document these established patient goals and expected outcomes in your patient's chart. It's a good idea to also measure and document patient progress along the way using tools such as surveys, evaluations, and outcome measures. Think of documentation and patient feedback as necessary pit stops along the road to success. Just as photos serve as evidence of your travels for family and friends, documentation serves as evidence of patient interactions for those that weren't present: surveyors, auditors, and payors.

Beyond getting everything documented in the patient chart, can you say that what is documented is clear and detailed? One area where documentation clarity can get particularly rocky is with the delivery of an item—specifically,

the documentation of that delivery or lack thereof. This lack of documentation in the past has resulted in far too many recovery audit contractor (RAC) audits. Ask yourself this question: Is your documentation detailed enough to allow a Medicare contractor or a third-party payor's staff to understand exactly what is being delivered? The brands and serial numbers are no longer required but can certainly be helpful. So why not continue including them? The Health-Care Common Procedure Coding System (HCPCS) codes also are acceptable documentation, but remember you must list the entire HCPCS descriptor. Even the smallest details can cause major trouble. For instance, does the delivery receipt address match the location where the beneficiary took possession of the device? Are all signatures legible, and do any designee signatures also include their relationship to the patient? These seemingly minor details can quickly snowball into red flags for surveyors.

You've determined the goals, developed a treatment plan, and delivered the item, but does your patient and/or his or her caregiver know how to use and care for the item? Instructions, both verbal and written, are extremely important regardless of how simple the device may be. You must document that you have provided and reviewed all instructions for the use of the device and explained what, if any, supplies are necessary to maintain and clean it. Has your patient been taught how to adjust (if appropriate) the device, inspect his or her skin, and report problems if and when they occur? If you are following the standards for compliance, then the answer should be a resounding, "Yes!"

The patient chart documentation missteps don't stop there. Surveyors

find that some of the items most often missing from the patient's record involve patient feedback on the effectiveness of the device or services received. Most of you are already getting this input when you see your patients; just remember to document it in the patient's record.

Making sure that your patient charts have clear and detailed documentation not only serves as evidence of the care and items you provide, but it also helps you remember crucial events and treatment. By recording all patient encounters, you can identify trends that will help guide you in developing the most effective and successful treatment plan.

Performance Management Review

Performance management standards regularly make our "Top 10 Most Overlooked Standards" list, accounting for four of the 10. Most facilities meet ABC's requirement to implement an effective, company-wide, and documented performance management and improvement program, but some fall short when it comes to the review and follow-up process. The goal is for you to design processes that effectively measure, assess, and improve your facility's organizational performance as well as related patient outcomes that affect the level and quality of patient care.

You can achieve this not only by having written processes for collecting and analyzing data, but by supporting a culture of continuous improvement through identifying, resolving, and documenting any patient-care-related issues on an ongoing basis. That means you must seek input not only from your patients but also from your employees and referral sources to understand the full scope of your performance. The results from all feedback, including patient satisfaction surveys, must be documented and evaluated. When opportunities to improve are identified, actions must be taken and monitored to assess their effectiveness.

ABC surveyors request a variety of documentation related to performance management during their onsite visit. This can include:

- Any changes you made to policies and procedures as a result of identified issues
- Minutes from meetings outlining improvements to your facility's level of care
- Returned patient satisfaction surveys and the analysis of the results
- Documented feedback from employees and referral sources
- Patient complaint logs and documentation of complaint handling and resolution
- Billing and coding error logs and identification of issues that may require training or retraining
- Documentation of adverse events related to malfunctioning devices and what actions were taken to ensure nonrecurrence.

Keep in mind that ABC also requires you to document your formal review and analysis of your performance management program at least annually. The review can include an overview of accomplishments, success in meeting identified goals, as well as a future outlook to help guide your practice in achieving its vision and mission.

An ongoing review of your performance management and improvement processes will support your practice's commitment to quality patient care.

Privileging

Privileging has been an accepted practice model for many practitioners, allowing them to extend their patient care and overall efficiency. But privileging can be confusing and that's why it is important to get it right to protect both your credential and your patients.

It is particularly important given the upcoming changes to ABC's privileging rules. If you are participating in privileging or plan to do so in the future, please be aware that beginning Jan. 1, 2019, the ABC Scope of Practice eliminates the practice of privileging noncertified individuals to provide patient care. Only certified individuals may continue to be privileged beyond their scope of practice with this change. In addition, changes are being made to the definitions of "Direct Supervision" and "Supervision of a Credentialed Caregiver," and a new category has been added for "Support Personnel." This change by the ABC Board of Directors represents its viewpoint that those delivering patient care should be educated and certified.

Privileging of credentialed individuals to provide services beyond their defined scope must ensure appropriate, effective, ethical, and safe delivery of patient care. The credentialed caregiver may be privileged under Indirect Supervision based on Written Objective Criteria.

The new definition of Direct Supervision still requires the credentialed supervising individual to be available for consultation throughout the patient-care process; however, the supervisor must now be physically on site while the care is being provided.

What is the role of Support Personnel? An ABC credential holder may delegate certain tasks in the provision of any custom-fabricated or custom-fitted orthosis, prosthesis, or pedorthic device to noncredentialed support personnel. Those delegated tasks must be within the ABC credential holder's scope of practice. The tasks *cannot* include patient assessment, formulation of a treatment plan, final fitting and delivery, or any follow-up care that modifies the function of the device as originally prescribed. Any tasks delegated to Support Personnel must be supervised under Direct Supervision.

Beginning Jan. 1, 2019, the ABC Scope of Practice eliminates the practice of privileging noncertified individuals to provide patient care.

In order to privilege an individual outside his or her scope of practice, you must establish Written Objective Criteria. This trips a lot of facility owners up when it comes time to produce the appropriate documentation during the onsite survey. So, what are Written Objective Criteria, and how do you document them?

Written Objective Criteria are defined as the ways in which a caregiver has gained the necessary knowledge and skills to be able to provide a specific patient-care service. These criteria must be clear and related to the diagnosis involved and the device being provided.

Examples of required documentation may take different forms including, but not limited to, proof of completion of continuing education courses related to a specific diagnosis or device, documented in-house training/in-services that are specific to the patient-care service the caregiver is being privileged to provide, and/or documented specific work experiences participating in patient-care activities. A log or checklist is not adequate by itself. Substantiating documentation that supports what is described in the log must be documented.

As always, the credentialed supervisor (whether through Direct or Indirect Supervision) must review the work and notes of the privileged personnel and co-sign and date the record. All of this must happen within 15 days of the date the care was provided.

Be sure that you understand what co-signing implies. As the credentialed supervisor (using your credential as validation), your signature says that you approve the work performed. The responsibility is now yours if any future problems arise. If you don't feel comfortable with the care provided, or if you feel you don't have sufficient documentation for privileging an individual, we advise that you hold off until you are confident you have the appropriate required documentation.

Committing to Compliance

If there's one thing you take away from this article, it should be that compliance, though sometimes challenging, is necessary to protect you, your staff, your business, and, most importantly, your patients. And as we all know, we wouldn't be here if it weren't for our patients.

Just remember that you don't have to tackle the big "C" alone. Make it a team effort. Get your staff involved, and reach out to those ready to share their knowledge and experiences. ABC is here to help. O&P

Jim Lawson *is outreach development manager at the American Board for Certification in Orthotics, Prosthetics, and Pedorthics.*

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