Be prepared for when surveyors come knocking

Nobody wants to come to work some morning and find a team of inspectors waiting. There is nothing like a surprise exam to make one nervous. Yet inspections are necessary—and not necessarily evil.

Ambulatory surgery center (ASC) inspections are required for Medicare certification by the Centers for Medicare & Medicaid Services (CMS), by many states for state certification or licensing, and in response to complaints and serious incidents.

According to ASC managers, routine CMS inspections or surveys are becoming more frequent and more detailed. Where they used to occur at 5- to 10-year intervals, now the trend is 3 to 5 years.

“If you haven’t had a survey in the past 4 years, you can expect one soon,” cautions Jan Allison, RN, director of accreditation and survey readiness for Surgical Care Affiliates (SCA) in Deerfield, Illinois.

Surveyors will not only return sooner than usual; they also may be more experienced than previously and have an eye out for details they might have ignored before.

The why and the how

For those who are new to ASC management or who have not experienced a survey in quite a while, the CMS instructions to surveyors provide reminders of what to expect.

To receive Medicare payment, ASCs must meet Conditions for Coverage (CfC) established by CMS, which generally are followed by insurance companies. Surveys are the means to determine if an ASC meets the CfC.

Survey authority and compliance regulations are covered in 42 CFR 416 Subpart B and 42 CFR Part 488 Subpart A. Because CMS delegates certification authority to states, the survey instructions are part of the CMS State Operations Manual. Among organizations authorized to conduct Medicare surveys are the Joint Commission and the Accreditation Association for Ambulatory Health Care (AAAHC).

One quick way to fail a survey is to deny access to the surveyors. “Should an individual or entity refuse to allow immediate access upon reasonable request to either a state agency or CMS surveyor, the Department of Health and Human Services Office of Inspector General may exclude the ASC from participation in all federal healthcare programs in accordance with 42 CFR 1001.1301,” the manual states. It also stipulates that “all surveys are unannounced.”

The year 2008 was something of a turning point in ASC survey history. That year, CMS proposed revised CfCs, which took effect in January 2009 (the first revision since 1982), and ordered an increase in the frequency of surveys, with a goal of maximum 3-year intervals. Also in 2008, the public was alarmed by news of an outbreak of hepatitis C at a Nevada endoscopy clinic in late 2007. The infection was traced to misuse of needles and reuse of single-use medication vials. The outbreak prompted an investigation by the Centers for Disease Control and Prevention (CDC) as well as a recommendation for clinician education and stricter surveillance.
Meanwhile, CMS and state health departments were able to act on the decision to step up surveys by using federal stimulus funds that became available in 2009. They hired new, less experienced surveyors to expand the staff.

That was 5 years ago. By now, those surveyors are more familiar with the new CfCs and better at sizing up an ASC’s operation and deciding which of the 100s of regulations to focus on.

“Surveyors are learning what to look for,” Allison says. “They have a more critical eye than ever before.”

For example, to assess infection control and hand hygiene, they may look beyond hand washing between patients to notice whether a nurse has performed hand hygiene after touching a privacy curtain.

In the OR, they notice when items are left on the anesthesia cart after being removed from their packaging but not used during the procedure. They check to see that those items are not used on future patients.

Surveyors now often look under equipment and furniture for rust, tape residue, or other possible sources of contamination.

Nurses have remarked on the level of detail. They ask Allison why “what was okay in the past is suddenly not okay.” She responds, “Either a code or regulation has changed, or it was never in compliance and was overlooked in the past.”

**Shifting priorities**

One area where surveyors have been easing up is radiology. Until 2013, ASCs were expected to have a staff radiologist even if none of their specialties required one.

In a proposed rule, CMS modified CfC Sec 416.49(b)(1) to require that ASCs limit radiology services to those integral to the procedures it performs and changed Sec 416.49(b)(2) to permit a qualified physician to supervise radiology services. The agency has not yet followed up with a final rule, but surveyors have not been citing ASCs under the previous rule, according to Allison.

Instead, surveyors have renewed their interest in quality improvement, infection control, medication administration, and the responsibilities of governing boards.

“Surveyors focus on areas they can see easily,” explains consultant John Goehle, MBA, CASC, CPA, chief operating officer (COO) of Ambulatory Healthcare Strategies, Spencerport, New York. He previously was COO of Brighton Surgery Center in Rochester, New York, and now helps ASCs manage compliance—including accreditation surveys.

Surveyors spend as much time observing clinical activities as they do inspecting documentation, and both are critical, he says. “You have to provide proof of every step in response to an incident. If you didn’t document it, it didn’t happen.”

Based on various reports, the following are some of the most common potential discrepancies surveyors will be looking for in upcoming reviews:

- Governing board oversight. The board should meet at least quarterly and record its proceedings.
- Peer review. Physicians must review each other’s work, both routine cases and adverse events. The ASC must maintain review summaries for each physician. Larger ASCs may have peer review committees to oversee reviews, whereas smaller ASCs will give that responsibility to the quality improvement committee.
- Infection control program. An ASC should have its own infection control manual. The manual may be based on model documents from AORN, the CDC, or other sources, but it should be tailored to the individual facility. The ASC must show that it follows the manual. An infection control coordinator must be appointed and trained. Sterilization of instruments and devices must be done in accordance with the manufacturers’ instructions, which should be available to the surveyor. Patient
care equipment should be cleaned after each use. Surveyors also will look at hand hygiene, air quality, and humidity.

• Quality improvement program. ASCs must have quality assurance and performance improvement (QAPI) programs supervised by their governing boards, as documented in the minutes. To demonstrate an active QAPI program, the quality council should meet at least quarterly to review and analyze quality data. Surveyors will be looking for trends such as a series of incidents.

• Pharmaceutical services. Staff must use proper technique for safe injections. They must label syringes and multidose vials with expiration dates, and control narcotics with double-locked cabinets and restricted key access. The consulting pharmacist can help with preparation by reviewing with staff the laws regarding controlled drugs and good management practices.

• Quality reporting. As ASC quality reporting rules are implemented, surveyors will be paying more attention to use of the new quality codes on Medicare claim forms, as well as Internet reporting for the newer codes.

Dealing with discrepancies
The survey ends with an exit conference to review findings, but the survey results are not official until the survey organization sends a letter to the ASC.

Expect the surveyor to find a few discrepancies. “There will always be something,” Goehle says. “Nobody is going to come out of a survey totally clean. You will always get comments.” He recalls that a surveyor told an ASC manager, “You’re lying if you say nothing has gone wrong in 3 years.”

Most citations are at the level of noncompliance with 1 or more standards. If surveyors find a serious threat to patient safety or a repeated failure to meet a particular standard, they issue a condition-level citation, which triggers a repeat inspection and possibly more serious sanctions, including closure. One type of serious discrepancy is improper response to an incident such as a patient fall or hospital transfer.

For every deficiency, the surveyor requires a plan of correction, which must contain the following components:

• what you will do to correct it
• who will be responsible
• when the problem will be corrected (for Medicare surveys, the deadline is 30 days)
• what process you will use to ensure it will not happen again.

Goethe calls this “closing the loop.” The next time a survey is done, the surveyor will check to verify that the problem that was cited has been corrected.

Despite the discomfort it may cause, any citation can provide a learning experience and path to improvement in patient outcomes. But surveyors can make mistakes. It is possible to successfully challenge a citation. Goehle recalls a case in which the surveyor was in a hurry and refused to examine an ASC’s disaster response manual. Later, he cited the ASC for not having a manual. ✤

—Paula DeJohn

Reference