ACCREDITATION
POLICIES & PROCEDURES
Accreditation Policies & Procedures

I. Introduction

The Accreditation Commission for Health Care, Inc. (ACHC) is an independent, 501(c)3 non-profit accrediting organization, which is certified to ISO 9001:2008 standards. ACHC is governed by a voluntary Board of Commissioners (Board), which is composed of health care professionals and consumers. The Board is responsible for leadership, governance and oversight of the quality of all services provided by the organization. The Board focuses on the development and maintenance of services that promote excellent outcomes through national health care standards. The Board accepts the ongoing duty to monitor the mission and philosophy of the organization and establish the future direction of ACHC in keeping with its mission. In addition to the expert Board members, the organization solicits the support and input from leadership committees such as the Standards and Review Committee, as well as clinical advisors.

The policies and procedures contained in this section pertain to all applicant organizations, whether they are applying for the first time, renewing, or adding or eliminating branches or services. All applicant organizations must follow these accreditation policies and procedures to achieve ACHC accreditation and maintain compliance. Submission of a signed application and contract for survey by an applicant organization constitutes intent to adhere to the policies and procedures in effect on the date on which the application is received by ACHC.

II. Eligibility

Applicant organizations which provide health care services and/or products may apply for accreditation if all of the following eligibility criteria are met:

A. Must be currently operating within the United States and/or its territories;
B. Must have served a minimum of ten (10) clients/patients and have (7) active clients/patients at the time of the survey;
C. Is licensed according to applicable state and federal laws and regulations and maintains all current legal authorization to operate;
D. The building in which services are provided/coordinated is identified, constructed, and equipped to support such services;
E. Clearly defines the services it provides under contract or directly;
F. Must be willing to complete and sign attestation to never falsify or misrepresent accredited programs;
G. Must submit all required documents and fees to ACHC within specified time frames;
H. Medicare providers must meet all criteria for participation with Medicare.

Deemed Status Eligibility

Currently, deemed status accreditation is available to home health and DMEPOS applicant organizations. In addition to the above eligibility criteria, applicant organizations applying for deemed status must meet the following requirements:

A. Meet the intent of the definition set forth by Medicare.
B. Meet the intent of the regulations set forth by state and/or federal regulations for certification;
C. Application must clearly denote and/or include:
   - the intent to seek deemed status
   - copy of CMS-855 approval letter (new providers/organizations only)
   - evidence of successfully completed OASIS transmission (Home Health only)
ACHC Programs

ACHC provides programs with designated services for accreditation. The applicant is required to accredit all services provided within that corporate structure. If the applicant organization offers services under another corporate name/structure and the services are covered under an additional ACHC program, the organization has the option to add additional services for accreditation.

1. **Private Duty Aide**: Aide services encompass all levels of care provided by a nursing assistant or sitter including Personal Care Services, chore, companion sitters and homemakers.

2. **Private Duty Nursing**: PDN services are usually provided either hourly or by shift and are covered by various payers, but not Medicare. Services can be provided by an RN or LPN.

3. **Home Health**: Home Health services are skilled services that are usually provided on a visit basis, as opposed to hourly, for a short duration of time. These services are usually provided by a licensed and/or Medicare certified agency. Home Health services are provided by skilled professionals including nursing; physical, occupational and speech therapy; medical social work and home health aide.

4. **Home/Durable Medical Equipment**: HME/DME services are the selection, delivery, set-up and maintenance of medical equipment and/or oxygen as well as patient education regarding the use of this equipment. Assessment and hands-on care of patients, including performance of any tests, is considered clinical services and will be accredited using the Clinical Respiratory Standards. This includes pulse oximetry measurements.

5. **Clinical Respiratory Care**: This service is provided by a licensed respiratory care practitioner or respiratory therapist. The care includes the skilled assessment, treatment and education of patients.

6. **Hospice**: Hospice is the care of patients with life limiting illnesses in the home or hospice inpatient facility. End of life care involves a multidisciplinary approach to medical care, pain management and emotional/spiritual care. This team approach will be used in the survey process. ACHC surveys are conducted by a hospice nurse surveyor as well as a clinical support surveyor, such as a medical social worker. An agency that provides inpatient services must adhere to the inpatient standards as well as the primary hospice standards.

7. **Infusion Nursing**: This service is the administration of parenteral medications via various accesses and ports by an RN specifically trained in these specialized services. This service can be provided in a variety of settings.

8. **Medical Supply Provider**: The storage and delivery of medical supplies designed to meet the needs of a client/patient requiring the product for their medical management in the home care setting. A physician generally prescribes these services. The items sold are usually disposable or semi-durable in nature. The supplies are normally delivered by mail.

9. **Pharmacy Services**: The infusion therapy continuum of care includes IV drug mixture preparation, IV administration, therapy monitoring, client/patient counseling and education. It is the administration of medications using intravenous, subcutaneous and epidural routes. The IV therapies include IV antibiotics, prescribed primarily for diagnoses such as sepsis, cellulites, total parenteral nutrition, pneumonia, sexually transmitted diseases and others. ACHC scope of service includes: home infusion pharmacy, specialty pharmacy, first
dose services, ambulatory infusion centers and respiratory nebulizer medications.

(10) **Complex Rehab and Assistive Technology Supplier:** Rehabilitation Technology Supplier Services are defined as the application of enabling technology systems designed to meet the needs of a specific person experiencing any permanent or long-term loss or abnormality of physical or anatomical structure or function. These services, prescribed by a physician, primarily address wheeled mobility, seating and alternative positioning, ambulation support and equipment, environmental control, augmented communication and other equipment and services that assist the person in performing their activities of daily living.

(11) **Fitter Services:** These services include prosthetic fitting of a variety of products such as diabetic shoes and post-mastectomy breast prosthesis.

(12) **Sleep Lab:** A Sleep Lab is a facility that provides testing for sleeping disorders either in an Independent Diagnostic Testing Facility (IDTF), as defined by CMS, or in hospital based testing facilities. Sleep testing can also be conducted in the home.

III. **Purpose or Principles Governing the Accreditation Survey**

A. **Compliance**

Throughout the survey process, ACHC determines whether the organization is meeting the intent of the accreditation standards. Proof of compliance is based upon such things as review of client records, personnel records, policies and procedures, as well as onsite observations and interviews and other activities as necessary.

**Standard Revision Compliance**

It is the organization’s responsibility to ensure compliance with ACHC standards at all times during the accreditation period. Upon revision of standards, ACHC will establish timeframes for the organization to come into compliance. Timeframes for compliance are determined in part by mandatory timeframes required by state/federal regulations, HIPAA, etc. Compliance with revised standards will be 120 days after notification of the revision by ACHC.

B. **Education**

While the organization is preparing for its onsite survey, ACHC is available to provide assistance in interpretation of standards. A list of independent consultants is available for organizations that need more extensive assistance with preparation for accreditation. These consultants are not employees of ACHC and use of any consultant does not guarantee successfully becoming accredited. ACHC does not endorse any consultant(s). During the onsite survey, surveyors will provide education in areas where standards are not fully met, in addition to “best practice” suggestions to help the organization achieve optimum performance.

C. **Frequency of Surveys**

Accreditation surveys are conducted upon receipt of a new accreditation application and, after receipt of accreditation status, on a triennial basis (upon receipt of a renewal application). All surveys are unannounced. Organizations are allowed to choose up to 10 black out days on which ACHC will not schedule a survey. ACHC does not conduct surveys on major holidays including New Years Day, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving, Christmas Eve, and Christmas Day.
Intermittent unannounced surveys are conducted based upon original survey results, random selection of a percentage of accredited organizations, number of branch additions during an accreditation period, or if a grievance/complaint has been received against an accredited organization.

D. Types of Surveys

1. **Initial Survey**: Organizations which apply for ACHC accreditation for the first time will have an initial survey. Applicant organizations must have served at least ten (10) active clients/patients prior to application submission and have seven (7) clients/patients on service at the time of survey.

2. **Renewal Survey**: Organizations that are accredited by ACHC will receive notification regarding renewal of their accreditation 12 to 15 months prior to their expiration date. Renewal surveys are processed in the same format as an initial survey; however, during the site survey the surveyor also reviews previous deficiencies for compliance.

3. **Deferral Focus Survey**: Organizations that receive a deferral decision may require a focus survey at the applicant organization’s expense. A deferral decision requires a plan of correction and evidence demonstrating compliance with the standard(s) in question. A focus survey will be scheduled if a review of personnel or client/patient files, or site observations are required to verify results of the plan of correction.

4. **Interim Survey**: ACHC reserves the right to randomly visit any ACHC accredited organization during the three-year cycle to determine ongoing and continuing compliance with standards. These interim surveys are random and unannounced. If significant non-compliance with standards is found that requires further action from ACHC, the costs of the survey will be billed to the organization.

5. **Service Addition Survey**: Organizations adding a service(s) within their accredited program during their three-year accreditation period must notify ACHC of the addition within 30 days and complete a Service Addition Application. Service addition applications follow the same process and survey procedures as Initial and Renewal applications. All service additions require an onsite survey to ensure compliance of added service scope standards. Organizations requesting a deemed status survey must have all documentation regarding licensure and certification from CMS/State Agency before ACHC can conduct a survey. (See Section VI. D. Service Addition and Section VII. A. Advertising)

6. **Branch Addition Survey**: Organizations adding branches that meet ACHC’s branch definition must notify ACHC within 30 days after to the opening of that branch, complete a Branch Addition Application for each branch added, and submit required information and applicable branch fees. To qualify as a branch addition, the branch must provide the same services under the organization’s current accreditation. Branch additions may require an onsite survey based on the number of sites seen during the initial accreditation survey. Organizations requesting deemed status must have all documentation regarding licensure/certification from CMS/State Agency before ACHC can conduct an onsite survey. ACHC branch surveys consist of a desk review of submitted documentation and photos, and, when necessary, onsite surveys. (See Section VI. C. Branch Office Addition and Section VII. A Advertising)
IV. Accreditation/Survey Process

A. Interpretive Guide

Prospective applicant organizations can receive an ACHC Interpretive Guide by registering the organization on the ACHC website and downloading a free copy of the Interpretive Guide. ACHC, working with the applicant organization, determines which accreditation manual is most appropriate for services provided. (See Section II. ACHC Programs for guidelines regarding selection of programs and services). Once the manual is ordered, the company will be assigned an Account Manager that will be available to assist them with any questions. Also a username and password will be assigned and the customer will have access to our customer central website. Customer central is a private website that will contain all the information to get started on your accreditation. It will have the application, interpretive guide (standards) and PER specific to the services the customer provides.

B. Organizational Structure and Governance

Based on governance, complexity of corporate structure, tax reporting, and other factors, ACHC will determine the number of applications and number of surveys required. Organizations are required to submit statistical data forms for all locations and an organizational chart with the application to assist in the determination of corporate structure.

C. What is Required to Submit to ACHC to Start the Accreditation Process

Application:

Applications are located on customer central which is an aspect of the ACHC accreditation manual. All information submitted and/or reviewed by ACHC is regarded as confidential and in compliance with HIPAA regulations.

Applications must be filled our correctly and completely in order to proceed with the accreditation process. Statistical data forms are located in the application and must be filled out for the corporate location and all branches (if necessary). Please direct any questions about filling out your application with your account manager. All tax ID; NPI, MCR provider #’s and/or NSC #’s must be included on the application.

Upon receipt of an application, ACHC will assign an application number.

Once application process is complete and validated by ACHC, the onsite survey will be completed within 9 months. If an onsite survey is not completed within 9 months of the application receipt date, by fault of the applicant organization, the application expires and ACHC will require a new application and accreditation fees if the applicant organization wishes to continue the accreditation process.

Deposit:

A deposit of $1500.00 is required to be sent in with your application and PER. Deposits are non-refundable and are applied to your accreditation fees.
D. Preliminary Evidence Report (PER)

The PER is included on customer central as part of the accreditation manual and must be returned with the completed application and deposit. ACHC staff will be available to answer questions during the PER completion process. PER’s can be completed electronically or by paper (Electronically is preferred). Organizations with 10 or more locations must submit their PER in electronic format. After ACHC receives the customer’s PER(s), accreditation staff prepares and mails a complete PER package to each member of the survey team.

***Note: If one of the three items (application, deposit, PER) is not submitted to your account manager, a contract for survey will not be generated until we have everything in its entirety. Once all three items are submitted to ACHC, this is indication that your organization is ready for an ACHC survey.

E. Accreditation Fees

As part of the application review process, a quote for accreditation fees is prepared. Fees, number of surveyors/type of surveyors and number of survey days are based upon statistics from the organization’s last completed fiscal year prior to application for those program(s)/service(s) indicated on the Application and Statistical Data Form. Relevant statistics include but may not be limited to: (a) number and type of services; (b) number of employees; (c) volume of clients/patients served; and (d) number of branches. Applicant organizations which have not completed at least one fiscal year prior to application must submit year to date statistics.

Full accreditation fees are not refundable. Requests for partial refunds must be made in writing, detailing the reason for the request. The partial refund amount is determined on an individual basis and is dependent on the stage in the accreditation process where the organization has withdrawn it’s application.

The applicant organization is held accountable for accurate and timely information. ACHC reserves the right to review and/or adjust accreditation fees based on new or validated information obtained during the survey process which may affect the number of survey days or surveyors required. Continuation of the survey process is contingent upon receipt of total fees prior to the survey. If a surveyor arrives at an organization for survey and discovers the organization is providing services that were not indicated on its’ application, the surveyor will notify ACHC and the organization will be responsible for any additional survey fees.

Accreditation fee structures are reviewed periodically. ACHC reserves the right to adjust accreditation fees and establish the effective date of change based upon the review.

F. Contract for Survey

Once fees and payment schedules are confirmed with the applicant organization, a Contract for Survey is issued. The Contract for Accreditation Survey identifies, but is not limited to: (1) payment schedule for accreditation fees; (2) rescheduling provisions; (3) contract execution timeframe; and (4) notification time frames for organizational changes in ownership/governance, facilities, services, etc.
The organization must review the contract in its entirety and sign and return the entire contract to ACHC within seven (7) calendar days to ensure continuation of the accreditation process. Failure to meet any of the contract terms may result in cancellation of the survey with rescheduling/cancellation fees assessed.

G. Scheduling

Upon execution of the contract, the survey is scheduled. Surveyors are chosen based on their qualifications in a specific area. The number of surveyors for a survey is determined by the size of the organization and the number of services provided. A minimum of one surveyor will be scheduled for all programs. A minimum of two surveyors, one nursing and one non-nursing surveyor (MSW or Clergy) will be scheduled for hospice program surveys. Additional surveyors are assigned based on the service(s) provided that is indicated on the application. Surveyors assigned will be discipline specific to the service(s) provided, which may result in a team of surveyors.

ACHC reserves the right to send a surveyor trainee as part of the survey team. Trainees are sent at no charge to the organization.

All ACHC surveyors/trainee’s must disclose any potential conflict of interest with the applicant organization to ACHC before the surveyor is assigned to conduct the survey. Surveyors/trainee’s with a confirmed conflict are not utilized for the survey being scheduled. Surveys are usually conducted 3 to 7 months after the application process has been completed and validated.

H. PER Review

After the survey is scheduled, the surveyor that has been selected to complete your survey will receive the application and PER that you submitted to your account manager. They will review your polices and all the information about your company. They will complete a desk review, which is a summary of any standards that may need to be corrected before he/she comes on site. This gives you as the provider a chance to make any changes up front to be compliant with ACHC’s standards. You will receive the desk review at least 30 days prior the survey and you will be required to submit those changes back to your account manager. If your surveyor does not find any deficiencies in your PER review, you will be notified by your account manager and a survey can take place at anytime beyond that point.

I. Survey

Surveys are conducted by a single surveyor or a team of surveyors. Surveyors are selected based on the services being surveyed.

Entrance Conference

The surveyor(s) will conduct an entrance and exit conference with representatives of the organization. At the entrance conference, the lead surveyor will briefly introduce himself/herself, along with other members of the survey team (if applicable), discuss PER issues and tentative schedule, and answer questions regarding the survey.

Data Collection

The survey focuses on personnel files, client/patient records, financial management, service contracts, risk management, quality improvement activities, policies and procedures, onsite observations, operational and service delivery outcomes, and staff and client/patient interviews. All applicants will be given explanation of findings/deficiencies throughout the survey process and again during the exit conference.
The applicant organization authorizes ACHC and/or its designated agents to access all records (including client/patient, personnel, financial management, risk management, utilization review, quality assurance and quality improvement) that are necessary to ascertain the degree of compliance with ACHC Standards. ACHC complies with all HIPAA, privacy and security regulations.

Exit Conference

During the exit conference, the surveyor(s) will discuss survey findings. While organization personnel are given the opportunity throughout the survey to provide information that does not appear readily available to the surveyor, the exit conference provides representatives of the organization a final opportunity to clarify information or present data that may not have been available to the surveyor during the survey. A final Summary of Findings will be sent to the organization that will include all details from the survey.

The surveyor does not render judgment as to whether the organization will be granted accreditation; rather, he/she may make a recommendation, based on observation, as to the organization’s accreditation status. Her/his role is to review information presented and to clarify, observe, and verify data that supports compliance with applicable standards.

V. Accreditation Decision

A. Scoring

The lead surveyor ensures that all data collection tools and documentation are completed and submitted to ACHC for the scoring and document review process. Upon receipt of survey documentation ACHC staff reviews documentation for completeness and data is entered into the appropriate scoring tool for computation of survey scores.

B. Document Review

Accreditation staff reviews documentation and scoring and prepares a draft of the applicant organization’s final written report (Summary of Findings) for review and final determination of status. The Summary of Findings indicates a finding of Met, Partially Met, Not Met or Not Applicable, to indicate the results of the data collected for each standard surveyed. Standards with findings of Not Met, Partially Met include a comment and recommendation to assist the organization in taking corrective action to meet the standard. A plan of correction (POC) is required for all standards that are not fully met.

The Senior Vice President of Clinical Compliance and Accreditation is responsible for review of accreditation results. The Standards and Review Committee (SRC) is responsible for oversight of the accreditation approval process. The SRC establishes guidelines for processing, scoring, reviewing, status determination and reporting results of accreditation applications. The Board of Commissioners reserves the right to make the final decision on all applications.

C. Accreditation Status Criteria

Approval of Accreditation

Full accreditation is awarded to an organization when the overall score and each section score are within a range of 90% or above. Submission of a plan of correction will be required for any standard
not fully met. Accreditation is good for 3 years. Effective accreditation dates for new and renewal organizations are determined as follows:

New organization:

1. First day following the survey, if the organization passes survey on the first review.
2. First day after receipt of plan of correction once the plan of correction is approved from deferral status.
3. First day after the focus survey, if the deferral is cleared upon review.

Renewal organization:

1. First day following current accreditation expiration date if the organization passes survey on the first review.
2. First day following current accreditation expiration once the plan of correction is approved from deferral status.

Deferral of Accreditation

Deferral accreditation is given to an organization when the overall score is within the deferral range (80% up to 89.99%). Any individual section that scores below 90% or failure to meet any one Medicare Condition of Participation will also put the organization in deferral status. Home Health and Hospice organizations will be advised of the decision via email and in writing and accreditation will be deferred pending submission of a plan of correction within 10 days and corrective documentation within 70 days of the date of ACHC’s notification letter. Organizations that do not offer Home Health or Hospice services will be advised of the decision in writing and accreditation will be deferred pending submission of a plan of correction within 30 days and corrective documentation within 90 days of the date of ACHC’s notification letter. Once all documentation has been received and reviewed, a determination of the need for an onsite survey will be made.

Deferral focus surveys are invoiced at a per-surveyor per-day fee. After the focus survey takes place, if the organization is subsequently found to be in compliance and has a passing score in accordance with approval criteria, full accreditation is awarded and a Certificate of Accreditation will be issued.

If a focus survey is not required, based on the review of the plan of correction and corrective documentation, ACHC will determine which deficiencies are cleared and make a final decision regarding accreditation status.

Denial of Accreditation

Denial of accreditation is given to an organization when the total overall score is below 80%. If a determination is made to deny accreditation, the organization is advised in writing.

When accreditation is denied, new applicant organization has the option of reapplying for accreditation at any time they feel they are ready for survey. At the time of re-application, a new application must be submitted with appropriate application fee. Reapplications are processed and accreditation fees charged in accordance with the application process. Organizations that are denied as a result of a reaccreditation survey will be handled on a case by case basis. The organization will be responsible for full payment of the reaccreditation survey before that survey is scheduled.
D. Accreditation Documentation

All documentation regarding the providers accreditation is described in the approval letter which is sent with the Certificate(s) of Accreditation and signed by the Senior Vice President of Clinical Compliance and Accreditation. Certificates of Accreditation are provided for all locations listed in the Application for Accreditation and included in the survey process.

Organizations will be notified in writing of the accreditation decision within four weeks of the last day of the survey. Accreditation survey scores are not sent with the decision letter.

When applicable, the accredited organization should send a copy of the Letter of Accreditation, Summary of Findings and Accreditation Certificate for all locations to the state governing body within 30 days of receipt.

E. Continued Compliance

Accreditation is contingent upon continued compliance with the standards and these accreditation policies and procedures.

Accreditation is not automatically renewable. Approximately 15 months prior to the organization’s expiration of accreditation, ACHC will notify the organization in writing and include a renewal application and PER. If renewal applications are not submitted when specified in the renewal letter, sufficient time may not exist to schedule and complete a survey prior to the organization’s expiration date. In this event, ACHC will automatically withdraw accreditation at the expiration of the current accreditation period. CMS and all appropriate regulatory agencies will be notified if an organization with deemed status loses its accreditation status. Renewal applications are processed through the accreditation process as stated in Section IV Accreditation/Survey Process.

After the organization is officially granted accreditation, ACHC reserves the right to make unannounced onsite visits at any time during a three-year accreditation cycle to determine continuing compliance with standards. If an interim visit reveals noncompliance with ACHC standards or Medicare COPs, a Plan of Correction and supportive documentation is required and full survey fees/expenses will be billed to the organization. ACHC conducts interim surveys based on a percentage of currently accredited organizations and/or patient complaints received by ACHC.

ACHC sends accredited organizations new/revised standards upon release, along with timeframes for organizations to come into compliance.

F. Appeals

Applicant organizations, whether applying for the first time or renewing their accreditation, may formally request to appeal a denial decision. The procedure to appeal a denial of accreditation is as follows:
1. The applicant organization or accredited organization must submit a written request for appeal to its ACHC Account Manager no later than 30 calendar days from the date on ACHC’s denial letter. Requests received after this 30 calendar day time frame will not be granted.

2. The written request must outline the standard(s) noted in the Summary of Findings where the organization believes ACHC incorrectly determined a standards violation. The organization must also provide evidence to support that, at the time of the site survey, the organization was in compliance with the standard(s). Any evidence the organization submits must have been presented to and reviewed by the surveyor(s) at the time of the survey. Evidence provided with the request letter will not be returned to the organization.

3. Upon receipt of the request for appeal, ACHC will send an acknowledgement letter to the organization, stating that results from the appeal will be sent to the organization in writing within 30 calendar days of ACHC’s receipt of the request.

4. The ACHC appeal panel is composed of a minimum of three individuals, who have clinical and/or program expertise to evaluate and determine whether ACHC followed its stated policies and procedures in conducting the organization’s accreditation survey.

   Any ACHC appeal panel member who participated in the original denial decision, or is affiliated with the organization, or who has a conflict of interest with the organization under review, will recuse himself/herself from voting on the appeal under consideration.

5. Upon completion, ACHC will notify the organization in writing of the ACHC appeal panel’s decision to either uphold or reverse the original denial decision.

6. All decisions made by the ACHC appeal panel are final.

VI. Notification of Changes

Post-Accreditation Changes

Accreditation is not automatically transferable when there is a merger or change in ownership. ACHC requires the organization to provide written notification thirty (30) days prior to a branch office addition or deletion, service addition or deletion, or change in the name, location, ownership or control of the organization.

Upon receipt of the appropriate documentation, including licensure and certification documentation from CMS/State Agency, ACHC will review for completeness and determine whether the organization’s accreditation certificate is still accurate. If an updated certificate(s) is required, a processing fee may be charged prior to issuance of a new certificate(s). Change in ownership or control of the organization may result in ACHC conducting onsite survey(s), with applicable survey fees.

Failure of the organization to notify ACHC of post-accreditation changes or provide additional requested information may result in assessment of penalties up to and including revocation of accreditation.
A. Name/Location Changes

The organization’s notification letter to ACHC must include the following:

1. Effective date of the change
2. Former name, as well as new legal name, if applicable
3. Former location as well as new location, if applicable
4. Any change of services, if applicable
5. Include original certificate of accreditation with the letter only for Name change or relocation to a different city.
6. Include copies of Articles of Incorporation, if applicable
7. Include copies of business license, if applicable

Upon written notification of a change in the organization's name, ACHC will review copies of the Articles of Incorporation and business license, if applicable. A new Certificate of Accreditation with the new name will be issued once ACHC receives the appropriate certificate re-issuance fee.

If the organization is relocated to a new city, ACHC will issue a new Certificate of Accreditation with the new location upon receipt of appropriate certificate re-issuance fees.

B. Merger/Ownership Changes

The organization’s notification letter to ACHC must include the following:

1. Effective date of the change
2. Former name, as well as new legal name, if applicable
3. Former location as well as new location, if applicable
4. Any change of services, if applicable
5. Include original certificate of accreditation with the letter, if new certificate is required
6. Include copies of Articles of Incorporation, if applicable
7. Include copies of business license, if applicable

Upon execution of the state required filings of ownership change/merger, a letter documenting the transaction shall be submitted to ACHC, postmarked within 2 weeks of the effective date of filing.

Based on a review of documentation submitted, ACHC will make a determination whether an onsite survey, preparation of new Certificate of Accreditation, assessment of fees, and/or other action is required.

C. Branch Office Addition

ACHC defines a branch as a location serving clients/patients, maintaining client/patient and/or personnel records and accepting referrals and inquiries directly from potential clients/patients. A branch office that opens after accreditation is granted will not advertise or otherwise consider itself an accredited entity until official notification from ACHC.
If an organization adds a branch after its corporate accreditation takes place, ACHC requires the organization to provide written notification within thirty (30) days after the opening/acquisition/merger which resulted in the new location. **Failure to notify ACHC of this branch addition in the 30 day timeframe could result in disciplinary action.** This letter should include the service(s) to be offered at each branch. Agencies that have deemed status will be surveyed after the CMS regional office approves the branch addition and authorizes ACHC to perform the survey, if applicable. Questions regarding this process should be directed to ACHC’s Accreditation Department.

Upon receipt of the organization’s written notification, ACHC will send the organization a Branch Addition Application, and Branch Addition Requirements List specific to the organization’s services provided. The Branch Addition Requirements List outlines documentation necessary for ACHC to determine/conduct an offsite review or schedule an onsite survey of the new location.

ACHC reserves the right to conduct an onsite survey of any branch addition. If it is determined an onsite review is necessary, the normal unannounced survey scheduling process will apply and additional fees may be assessed.

A review of the documentation is performed and any missing information is requested from the organization in writing via fax/email/mail, along with timeframes for receipt. ACHC will hold the branch addition documentation without further processing until the missing information is received from the organization.

Upon approval, ACHC will mail a letter confirming accreditation of the new location for the duration of the corporate accreditation, and include an accreditation certificate.

**D. Service Addition**

Once ACHC is notified of the service addition, the company will receive the service addition application packet. Upon receipt of the completed application, the accreditation staff follows the application review, scheduling and contract preparation process.

ACHC will require a focused review and an onsite survey to determine if the organization is in compliance with applicable standards for the added service. If the data collected during the onsite survey reflects a passing score for the service(s), a certificate of accreditation for the service is issued for the duration of the current accreditation period.

**E. Service Discontinuation**

An accredited organization must notify ACHC in writing of any service that has been discontinued. A new service addendum may need to be completed for CMS purposes.

**VII. Public Information**

**A. Logo/Advertising Language**

An organization must accurately describe only the program(s), service(s) and branch office(s) currently accredited by ACHC and abide by the Guidelines for Use of ACHC’s Logo when advertising its accreditation status to the general public. False or misleading advertising represents noncompliance with accreditation and will result in penalties up to and including withdrawal of accreditation. The Guidelines for Use of ACHC’s Logo are sent to organizations in their accreditation notification packet. Branches and services accredited during the accreditation cycle can
not be advertised as accredited until appropriate applications are submitted and accreditation certificates are received.

B. Press Releases
ACHC encourages organizations to publicize their accreditation status and provides a sample press release in the accreditation notification packet.

VIII. Nonconformance Policy

ACHC will process complaints, conduct investigations, discuss issues noted during surveys, and issue disciplinary actions according to the policies and procedures approved by the ACHC Board of Commissioners.

All disciplinary actions taken by ACHC will be reported on the ACHC Website. The information to be provided in these reports will include but is not limited to:

- organization name and address
- type of accreditation
- final action

A. Handling of Complaints

Complaints about accredited organizations are to be filed with the ACHC office. These complaints should identify facts or circumstances that relate to the complaint. ACHC will receive complaints by phone, mail, fax, email, the ACHC website or in person.

ACHC will investigate and/or review, and follow up on complaints from any source where an ACHC accredited organization appears to be out of compliance with its accreditation standards or Medicare COPs. As required by ACHC standards, accredited organizations must provide ACHC’s telephone number to their clients/patients as part of their client/patient hand-out for purposes of reporting a complaint.

Complaints should document:

- The name, mailing address and phone number of the person filing the complaint;
- The name of the organization involved;
- A detailed description of the incident that is the subject of the complaint, including identification of date, time, and location of each incident, as well as the identity of other individuals with information about the incident.

Anonymous complaints will not be accepted. The complainants’ identity will be kept confidential whenever possible. While under investigation by ACHC, a complaint is a confidential matter. However, ACHC cannot guarantee complainants that their identity will remain confidential if disclosed to ACHC. All substantiated findings become part of the permanent file of the organization involved and are public record.

Processing a Complaint

The ACHC Quality Assurance Manager or designee will inform the Senior Vice President of Clinical Compliance and Accreditation of the receipt of a complaint. Upon receipt of a complaint, a complaint file will be opened and the Quality Assurance Manager and the Senior Vice President of
Clinical Compliance and Accreditation will conduct an initial review of the complaint to determine whether there is sufficient information presented to go forward with an investigation. This initial review consists of determining if the information presented meets the elements necessary to proceed with further inquiry. To determine if an investigation of a complaint is warranted, the information gathered will be analyzed to determine whether, if true, it would constitute a violation of ACHC standards or Medicare Conditions of Participation. If upon initial review there is no evidence that a violation has occurred, the complaint is closed and the complainant will be notified that no breach of standard has occurred.

If the Quality Assurance Manager and Senior Vice President of Clinical Compliance and Accreditation conclude that the information shows that a violation may have occurred, the Quality Assurance Manager shall notify the organization that an investigation has been initiated. The investigation will be performed by the Quality Assurance Manager, as directed by and with the help of the Senior Vice President of Clinical Compliance and Accreditation. The organization or other subjects of the investigation may be interviewed and the organization may be asked for records for review during the investigation. An onsite survey may be required in order to complete the investigation.

If no violation is found following investigation, the Quality Assurance Manager will confer with the Senior Vice President of Clinical Compliance and Accreditation, at which time the complaint file may be closed. If closed, the complainant and the organization will be notified and no further action will be taken.

If sufficient evidence exists that the organization has violated the ACHC standards or Medicare Conditions of Participation, the organization may be penalized. If the organization is penalized at any level above a warning, the penalty will be listed on the ACHC website and CMS and/or other appropriate regulatory agencies will be notified.

If upon review of information it is determined that immediate jeopardy to the client/patient is present and ongoing, ACHC will notify the CMS regional office (RO) and conduct its investigation within two (2) business days of authorization from the RO. If it is determined the situation is non-immediate jeopardy, the complaint will be prioritized within two (2) business days of receipt and ACHC will conduct an investigation of the matter within 30 days to determine the exact nature of the complaint and the action warranted. Depending upon the nature of the complaint, one or both of the following actions may be taken:

1. ACHC will contact the organization, notifying it of the complaint and address the following:
   - provide a description of the complaint(s)
   - request the organization's cooperation in resolving the complaint
   - request the organization respond to the complaint within the identified time frame
   - ask the organization if they were aware of the complaint and if they have taken action

2. ACHC may contact the organization via phone and/or fax or designate personnel to go unannounced to the organization and request immediate access to information and data related to the standards indicated in the complaint.

ACHC will review all the information and data collected relative to the complaint. If necessary, a summary report will be sent to the Standards and Review Committee for a final decision. If an investigation reveals the complaints allegations are substantiated and the patient’s health, safety and
welfare are in jeopardy, the organization may face disciplinary action, including suspension or revocation of accreditation.

If any noncompliance with ACHC standards or Medicare COPs is confirmed during the onsite complaint investigation survey, a plan of correction and supportive documentation is required and survey fees/expenses will be billed to the organization. If ACHC makes the decision to withdraw accreditation, ACHC will notify the appropriate regulatory bodies of its decision.

B. Disciplinary Actions as a Result of Survey Findings

Disciplinary actions can also result from information gathered during a survey. Failure to adhere to certain standards and/or Medicare COPs, failure to follow ACHC policies and procedures or failure to submit and follow an appropriate plan of correction will result in a disciplinary action. Investigations regarding issues found during the survey process may be further investigated by a request for documentation, interviews and/or unannounced on-site surveys. The organization will be billed for surveys conducted as a result of a disciplinary action.

C. Overview of Disciplinary Actions

The following are Disciplinary Actions authorized by the Accreditation Commission for Health Care to discipline an organization for violations of ACHC standards and Medicare Conditions of Participation:

1. Warning
2. Reprimand
3. Probation
4. Suspension
5. Revocation

Warning

A warning is a written communication between ACHC and the organization that serves as notice that an ACHC standard or Medicare Condition of Participation may have been breached, but the conduct does not rise to the level which warrants public censure. A warning may be issued by the Senior Vice President of Clinical Compliance and Accreditation to an organization. It is a minimal disciplinary action and is not considered public information.

A warning will be issued following an investigation if the Senior Vice President of Clinical Compliance and Accreditation acting on behalf of ACHC, believes that there is insufficient evidence to support a disciplinary action against the organization, but there is sufficient evidence to notify the organization that continuing the activities which led to the complaint being submitted to ACHC may result in action against the organization.

Reprimand

A reprimand is a formal sanction that expresses concern about the actions of an organization but does not restrict accreditation certification. A reprimand is considered public information and will be reported to national and state regulatory agencies. A reprimand may be issued by the Senior Vice President of Clinical Compliance and Accreditation to an organization if there is sufficient evidence that a violation of a statute(s), accreditation standards, and/or rules has occurred, but the violation is not of sufficient seriousness to warrant suspension or revocation of the accreditation.
Probation

ACHC may determine that it is appropriate to allow an organization continued accreditation and not revoke or suspend the organization’s accreditation. In assessing the appropriateness of a probationary penalty, ACHC will consider all the facts and circumstances of the conduct at issue and the organization’s prior performance. In particular, ACHC will review the nature, severity, and scope of the violation, the degree and scope of harm to patients and the nature of the motivations of the organization that led to the conduct in question.

Further, in assessing the overall appropriateness of probation and in defining the appropriate duration of the probation, ACHC also will review the organization’s service performance, prior history of violations of ACHC’s standards or accreditation policies and procedures, especially prior violations of the provisions that relate directly to the conduct then in question, and also whether any probationary condition that might be imposed will provide sufficient safeguards to ensure the safety and welfare of the public as well as the successful remediation of the organization’s conduct. A probationary sanction may be invoked for a period not to exceed three (3) years since situations that would require monitoring for a period longer than that are inappropriate for a probationary sanction.

Probation may be offered to an organization by ACHC as part of the issuance of a new accreditation certification. Failure to comply with the stated conditions is grounds for suspension or revocation of the accreditation.

The Senior Vice President of Clinical Compliance and Accreditation may place an organization on probation after presenting the facts of the investigation to the Standards and Review Committee. Decisions regarding probation will be made by the Standards and Review Committee. Probation is considered public information and will be reported to the appropriate state and national regulatory agencies and listed on the ACHC website.

Suspension

When ACHC determines it is appropriate, it places an organization on suspension of accreditation for a fixed period of time up to six (6) months, with the understanding that at the end of the specified period of time, and with the completion of any additional conditions including, but not limited to, completion of corrective actions or monitoring of particular areas of practice or conduct that successfully demonstrate successful outcomes relative to investigational findings, the accreditation will automatically be reinstated and reissued upon the organization’s payment of the standard cost for the issuance of a replacement accreditation certificate. The Senior Vice President of Clinical Compliance and Accreditation may place an organization on probation after presenting the facts of the investigation to the Standards and Review Committee. Decisions regarding suspension will be made by the Standards and Review Committee. Suspensions are considered public record and will be reported to all appropriate agencies and listed on the ACHC website.

Revocation

Revocation entails loss of accreditation for a specified period of time. Accreditation may be re-issued after the specified period has expired and the organization has petitioned for reinstatement, and provided sufficient evidence of compliance with accreditation standards, Medicare Conditions of Participation and any conditions imposed by ACHC at the time of the revocation. Decisions regarding revocation will be made by the Standards and Review Committee. Revocation decisions are considered public record and will be reported to all appropriate agencies and listed on the ACHC website.
Obtaining Records for Investigation

ACHC may request the organization to produce records to allow ACHC to investigate the organization. ACHC’s Senior Vice President of Clinical Compliance and Accreditation is authorized by ACHC to request all needed records for investigation purposes. Each request will identify the pertinent document or records needed by ACHC. A time shall be specified in the request by which the documents shall be produced.

In issuing requests for documents, ACHC shall make every effort to limit its request to the minimum necessary information required in order to complete its investigation and will also otherwise comply with the Privacy Rule adopted by the United States Department of Health and Human Services and codified at 45 CFR § 164.500 et seq.

Reporting of Disciplinary Actions

All disciplinary actions taken by ACHC will be reported in the Surveyor Newsletter and on ACHC’s website. In addition, as required by federal law, a report of actions will be made to all applicable local, state and federal regulatory agencies. ACHC will report any probation, revocation or suspension of an organization’s accreditation to all appropriate regulatory bodies including Centers for Medicare and Medicaid, National Supplier Clearinghouse and state licensure agencies. The information to be provided includes:

- Facility name and address
- Owner name(s) and address(s) and/or Board of Director(s)
- Type of accreditation (Initial or Renewal)
- Disciplinary action