Medicare-deemed Status: What Does It Mean?

Although 3 organizations have achieved “deemed status” with respect to accreditation of ambulatory surgical facilities, only Medicare may grant certification. An initial accreditation review also may be combined with a Medicare certification review. However, Medicare requirements can be quite rigorous, especially with regard to the physical plant layout. (Aesthetic Surg J 2001; 21:375-376.)

In the course of presenting accreditation workshops at major plastic surgery meetings, I have noticed that some confusion exists about the meaning of “Medicare-deemed status.” Presently, the 3 main accrediting bodies that have achieved deemed status are the American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF), the Accreditation Association for Ambulatory Health Care (AAAHC), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

These accrediting bodies underwent rigorous evaluation of their accreditation requirements and standards, survey procedures, and available resources by the Health Care Financing Agency (HCFA). In addition, facilities recently accredited by these organizations may be subject to unannounced HCFA “validation surveys,” which are performed to determine compliance with Medicare conditions of participation. Noncompliance could lead to loss of “deemed status” by the accrediting organization. It is important to clarify that deemed status refers to the accrediting organization that performs a facility survey; it does not indicate Medicare approval of the inspected facility.

When a facility has passed a Medicare survey, it is granted “certification,” whereas a survey without Medicare involvement confers “accreditation.” There are many options open to surgical facilities. If the facility has never been accredited and desires accreditation by any of the 3 agencies noted previously, it may request that the initial survey be combined with a Medicare certification review. In this case, if all standards are met, the facility then becomes both accredited by the agency and certified by Medicare. A facility that is already accredited by one of the 3 major organizations does not automatically receive Medicare certification simply because the surveying body itself has achieved deemed status. A specific Medicare survey must be requested.

All Medicare surveys are unannounced. In the past, a facility was given a 2-week “window” during which it could expect the survey team. Currently Medicare is trying to expand this period to as much as a month, but a final decision has not yet been made.

A facility does not need to wait until its current term of accreditation has expired before it requests a combined Medicare/accreditation review. This may be performed at any time during the 3-year cycle that the organizations generally use. It is important to understand that if the facility has received its Medicare certification through a state agency, it may continue to obtain it that way, without undergoing a combined Medicare accreditation survey by the accrediting body. This option is also open to those seeking Medicare certification for the first time.

Finally, neither an accreditation approval nor Medicare certification eliminates licensure requirements in states that require this. However, state law may require a separate license for the facility while granting that license on the basis of accreditation by one of the 3 organizations mentioned above.

Once there have been successful Medicare and accreditation surveys, the surveyed facility must apply to the state Medicare agency for forms that grant permission to act as a certified surgical facility under Medicare. These forms are sent to the regional HCFA office, and a supplier number is assigned to the approved facility.

The decision of whether it is economically feasible to seek Medicare certification is one that each practice or
facility director needs to consider on the basis of the type of procedures performed and the regional reimbursement rate provided by HCFA.

At times it may seem that the HCFA requirements are not only contradictory but also more stringent than those of the accrediting bodies. This is primarily because Medicare has not adequately made distinctions among hospital outpatient surgical settings, multiroom ambulatory surgical centers, and single-practitioner office-based surgical facilities.

Medicare is quite specific about the physical layout of the facility. For example, Medicare requires that medical records of Medicare patients are handled separately and are easily identifiable. Other physical requirements for the facility include a separate waiting room; humidity levels in the operating room that are maintained between 50% and 60% and intrinsically controlled; smoke detectors; specific measurements for hallway widths as well as door openings and sizes (considered by many to be excessive); and a type of emergency generator that requires a ground-level or roof location. There is confusion about whether the 1985 National Fire Protection Act codes will continue to be followed or whether Medicare will adopt the 1997 version.

I strongly urge any facility seeking Medicare certification to send representatives to one of the AAAASF workshop sessions that provides an overview of HCFA requirements. These sessions, offered during our national plastic surgery meetings, provide an opportunity to become fully informed about the process of Medicare certification.

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1084-0761/2001/$35.00 + 0 70/1/116719