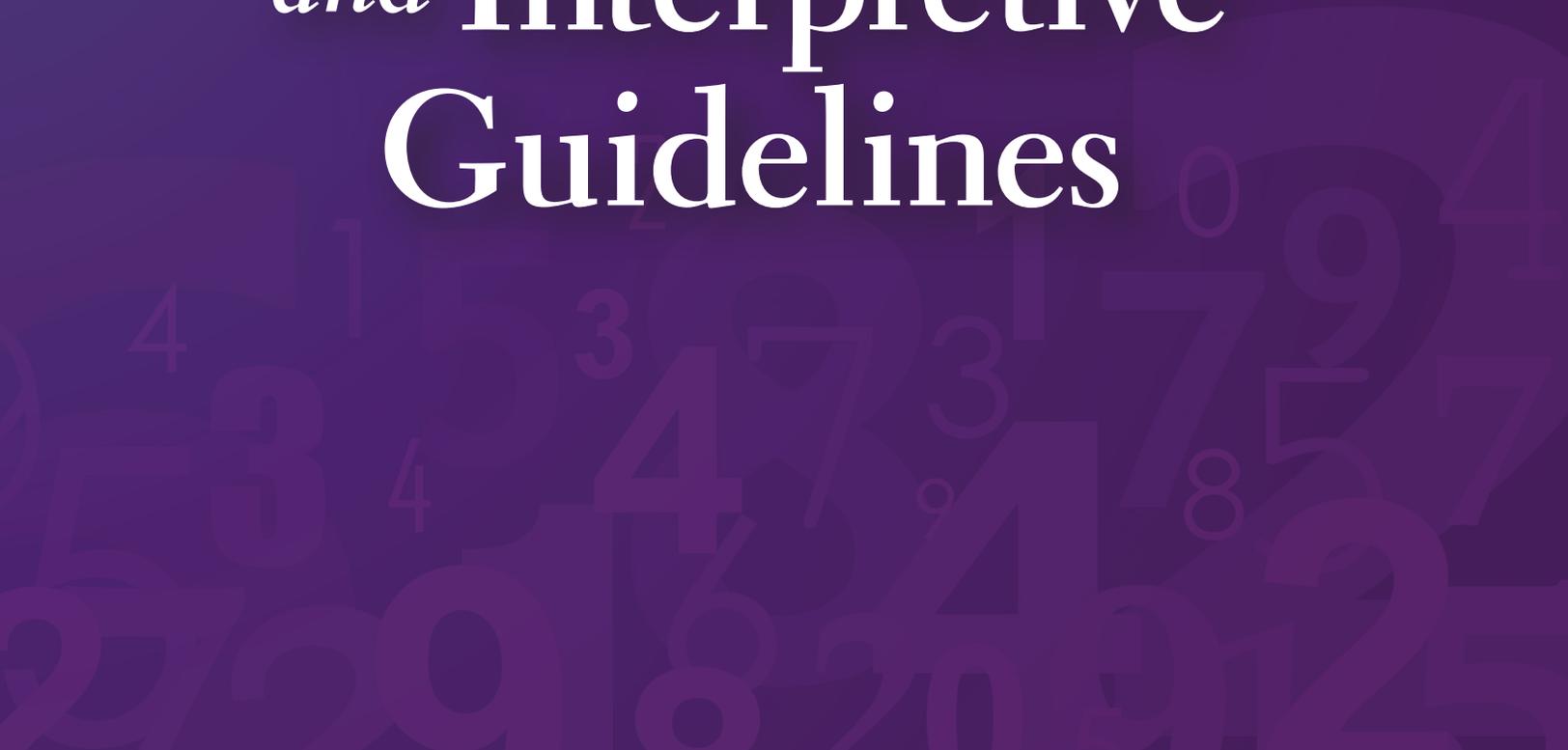


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# Introduction

Every hospital should have a copy of up-to-date Centers for Medicare & Medicaid Services' (CMS) *Conditions of Participation* (CoP) and *Interpretive Guidelines* (IG) because surveyors use them to guide inspections, and following such guidelines helps to ensure full reimbursement. This document is also referred to as the *State Operations Manual*.

This book reproduces the most current version of the CMS hospital CoPs and IGs verbatim. It includes CMS' survey protocol guidelines, which includes a list of questions surveyors will ask and the policies they will look for during an on-site visit.

This book also reproduces the Emergency Medical Treatment and Labor Act (EMTALA) regulations, also reprinted verbatim. Medicare participating hospitals must meet these regulations, which require hospitals (including critical access hospitals) with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination.

Our goal is to make it easier for you to understand the CoP requirements and have a successfully survey and receive full reimbursement. We hope you will find this book to be an essential resource to help you comply with CMS regulations.

## **The CMS emergency preparedness rule: What you should already be doing**

Since the start of the 21<sup>st</sup> century, the U.S. has suffered several major disasters: hurricanes, floods, wildfires, blizzards, tornados, and terrorist attacks to name a few. In times of crisis, hospitals and healthcare centers are particularly susceptible to the chaos and failing infrastructure. Events like

hospital power outages, loss of communication, lack of supplies, and emergency response breakdowns can cost patients their lives.

In response, CMS announced in early September that it had finalized new emergency response requirements for healthcare providers participating in the Medicare or Medicaid system. Under the new regulations, hospitals are compelled to communicate and coordinate their emergency plans with other hospitals and government agencies at the tribal, local, regional, state, and federal levels. They are also required to conduct regular emergency preparedness training.

“As people with medical needs are cared for in increasingly diverse settings, disaster preparedness is not only a responsibility of hospitals, but of many other providers and suppliers of healthcare services,” said Nicole Lurie, MD, MPH, Health and Human Services assistant secretary for preparedness and response, in the press release. “Whether it’s trauma care or long-term nursing care or a home health service, patients’ needs for healthcare don’t stop when disasters strike; in fact, their needs often increase in the immediate aftermath of a disaster. All parts of the healthcare system must be able to keep providing care through a disaster, both to save lives and to ensure that people can continue to function in their usual setting. Disasters tend to stress the entire healthcare system, and that’s not good for anyone.”

The requirements close gaps in CMS’ previous regulations, such as requiring facilities coordinate with each other during an emergency, have contingency planning in place, and have emergency response training for staff. The new rules go into effect on November 8, 2016, and must be implemented by November 15, 2017. Work on these new regulations have been ongoing for several years, with the comment period ending back in 2014.

“Situations like the recent flooding in Baton Rouge, Louisiana, remind us that in the event of an emergency, the first priority of healthcare providers and suppliers is to protect the health and safety of their patients,” said CMS Chief Medical Officer Patrick Conway, MD, MSc, in a release. “Preparation, planning, and one comprehensive approach for emergency preparedness is key. One life lost is one too many.”

### **Where this is coming from?**

**Steve MacArthur**, a safety consultant at The Greeley Company in Danvers, Massachusetts, says the rules change has been anticipated ever since Hurricane Sandy hit the East Coast in 2012. Though the update can also be traced back to 2001, when several hospitals with emergency generators located at or below sea level were flooded out during Tropical Storm Allison.

“I think we can safely say that CMS isn’t nearly nimble enough for the recent Louisiana flooding to have had much, if any, bearing whatsoever, beyond perhaps expediting the release of the rule,” he says.

Despite the new rules, MacArthur says that a lot of the new requirements are things that hospitals should have already been doing.

“I suppose I should stop and say that while this rule is new to the ‘marketplace,’ there are really no new concepts contained therein,” he says. “This may provide some guidance for CMS surveyors as they drill down on organizational preparedness activities. But none of this is groundbreaking or in any way representative of a change in how hospitals have done, and will continue to do, business. [It’s] just another set of official ‘eyes’ looking through the compliance microscope.”

### **Risk assessment and emergency planning**

In response to the new rules and the old expectations, MacArthur says the best thing to do is conduct a hazard vulnerability analysis (HVA.) The HVA will identify what kind of crises a facility is most likely to face. It also shows what resources are available or would need to be available in order to provide appropriate response.

“[For example] not everyone is in an environment where an active shooter or terrorist attack is likely,” he says. “So to devote resources to an event that is not likely to occur is irresponsible at best. As a further example, a hospital in Omaha, Nebraska, is not going to spend time developing a response capability for a tidal wave.”

**Lisa Pryse Terry, CHPA, CPP**, senior healthcare advisor at ODS Security Solutions. While unsure how long these rule changes have been anticipated, she says that the recent flooding absolutely played a role in CMS releasing their new rules.

“Many gaps were identified and addressed in Louisiana after Hurricane Katrina. However, after the recent flooding, it became apparent that those actions did not go far enough,” she said. “My advice [to accreditation specialists] would be to ensure that their plans contain specific direction—oversight and accountability—for the three areas mentioned in the rule: communication to coordinate with other systems of care within cities or states; contingency planning; and training of all personnel.”

A preparedness technique she recommends is developing quick reference guides (QRG) for each responding area of a facility. Similar to the Job Action Sheets in the Hospital Emergency Incident Command System (HEICS), an QRG:

- Breaks down each individual’s or area’s responsibilities during an emergency,
- Identifies the chain of command, along with contact information
- Lists document and policies relevant to the situation
- Sorts tasks and duties between those that require “immediate” response vs. “intermediate,” “extended” and “demobilization/system recovery” tasks.

CMS also recommends facilities use the information provided on the “Threat and Hazard Identification and Risk Assessment” page of the Federal Emergency Management Agency (FEMA) webpage ([www.fema.gov/threat-and-hazard-identification-and-risk-assessment](http://www.fema.gov/threat-and-hazard-identification-and-risk-assessment)).

## **Communication and coordination**

The new requirements also say that facilities must coordinate their emergency responses plans with each other. However, different emergencies will require different levels of coordination. For example, some emergencies (local flooding) may only require coordinating with facilities in the local area and while others (earthquakes) may require statewide cooperation. Knowing how wide a net you need to cast geographically requires a knowledge of the crises you're likely to face and the resources you'll need to face them. MacArthur says determining the answer for both these questions, again lies in a properly run HVA.

“Each organization is charged with determining the likely emergencies to which they would need to have response capabilities,” he says. “And some of those emergencies might be sufficiently unique or complicated to drive having a specific response plan. But, if you can provide for an appropriate response with a plan based on the basic all-hazards approach, then that is what they should do. Hospitals need to know what they are doing and understand for what emergencies they and their community are vulnerable; that's pretty much the long and short of it.”

MacArthur notes that every level of government has agencies and resources devoted to emergency planning and response. Healthcare facilities should have already have been in contact with the necessary government agencies, he says, and there's no acceptable excuse for not having done so.

“If there is a shortfall in this area [hospital to government communication] it's because the governmental agencies don't necessarily embrace hospitals as equal participants in this process,” he says. “I've certainly seen hospitals that have tried to reach out to their municipalities only to find that their input is not as willingly received as they might otherwise have wished. As with anything involving the government, there is a hierarchy in place that is not always conducive to collaboration with those a little further down the food chain. That was really one of the recommendations that CMS made when reviewing the response to Superstorm Sandy; the government needs to do a better job of supporting the folks who actually have to respond in the initial onset of the event.”

## **Training**

The CMS requirements also include stricter language on emergency preparedness training and testing. The rules say that testing be done annually, and training on emergency preparedness policies and procedures be given to new hires. The regulation cited the Training and Exercise Planning Workshop section of the Homeland Security Exercise and Evaluation Program as a good resource on conducting annual tests.

Terry suggests that in addition to annual training, facilities should also conduct five- to 10-minute drills These mini-drills should be done on a regular basis during various daily or weekly huddles leading up to the main drill.

MacArthur recommends that facilities conduct a review after every response plan activation; whether it be a training exercise or a real emergency.

There are three things that facilities need to remember when conducting emergency drills, he says:

- Drills also must be deeply rooted in the information from a facility's HVA.
- The scenarios must include participation throughout the organization (i.e., they can't "end" in the emergency department).
- Each drill must be as strenuous as possible to the system to actually identify weaknesses or opportunities.

On the last point, a planned exercise that does not result in the identification of improvement opportunities is basically a waste of time, says MacArthur. "I suppose you could make the case that if you learned something good about your current capabilities or capacity to handle an emergency, it was worth it," he adds. "But I can't help but think the 'drill to failure' makes the most sense for a planned exercise."

So how can you tell if your emergency and communications systems work if you only test them until they break down? MacArthur says the thing to remember that in a real crisis, there's no way to predict how events will play out. The most important thing is to have plans that can flex to meet the unforeseen.

"For all intents and purposes, if an event goes long enough, the communications plan will fail on some level, so you need to have as much redundancy built in to the plan as possible," he says. "Including the use of 'manual' communications; using humans to carry verbal or written information."

"A good emergency response plan is based on scalability—the implementation of the plan can be customized to the size, nature, length, etc., of the emergency—and flexibility. A true catastrophic event rarely occurs in a neat, linear unfolding; multiple systems failures, etc. are always possible. The response plan has to be sufficiently nimble to adapt to constantly changing conditions."

*Originally published in the November 2016 **Briefings on Accreditation and Quality**.*

### **The rule's four standards**

The rule requires that healthcare providers meet the following four standards:

- 1. Emergency plan:** Based on a risk assessment, develop an emergency plan using an all-hazards approach focusing on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the location of a provider or supplier.
- 2. Policies and procedures:** Develop and implement policies and procedures based on the plan and risk assessment.
- 3. Communication plan:** Develop and maintain a communication plan that complies with both federal and state law. Patient care must be well-coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency systems.
- 4. Training and testing program:** Develop and maintain training and testing programs, including initial and annual trainings, and conduct drills and exercises or participate in an actual incident that tests the plan.

### **Emergency response plan components:**

- An all-hazards incident command structure
- Management of communications
- Management of resources and assets
- Management of safety and security
- Management of utility systems
- Management of staff roles and responsibilities
- Management of patient care activities

## **CMS, Joint Commission adopt 2012 edition of *Life Safety Code*®**

In a highly-anticipated move expected to significantly affect the regulatory rules that hospitals and other healthcare facilities are held to, CMS has officially adopted the 2012 edition of the *Life Safety Code*® (*LSC*).

CMS has confirmed that the final rule adopts updated provisions of the National Fire Protection Association's (NFPA) 2012 edition of the *LSC* as well as provisions of the NFPA's 2012 edition of the Health Care Facilities Code.

The new requirements apply to Medicare- and Medicaid-participating hospitals, long-term care (LTC) facilities, critical access hospitals, inpatient hospice facilities, programs for all-inclusive care for the elderly, religious non-medical healthcare institutions, ambulatory surgical centers (ASC) and

intermediate care facilities for individuals with intellectual disabilities (ICF-IID). Healthcare providers affected by this rule must comply with all regulations by July 4—60 days from the publication date of the rule in the *Federal Register*.

The Joint Commission will also begin surveying facilities to the 2012 *LSC* as of July 5, the accreditor announced in early June. The Joint Commission plans to update the Life Safety chapter for its affected accreditation programs in the “near future.”

The adoption of the rule has long been anticipated, as the *LSC*, which governs fire safety regulations in U.S. hospitals, is updated every three years, and CMS has not formally adopted a new update since 2003, when it adopted the 2000 edition. As a result, CMS surveyors have been holding health-care facilities to different standards to other regulatory agencies that have gradually adopted provisions of the new *LSC* in their survey requirements.

CMS Director of Clinical Standards and Quality Kate Goodrich said the rule will allow facilities to modernize while ensuring that patients and staff have an appropriate level of fire safety. The final rule was published in *Federal Register* (81 Fed. Reg. 26872) and will take effect July 5, unless a particular requirement states otherwise.

The final rule includes several changes over what CMS initially proposed. For example, CMS dropped a proposed holdover requirement for a dedicated air supply and exhaust system in windowless anesthetizing locations (79 Fed. Reg. 21552; April 16, 2014).

Some of the main changes required under the final rule include:

- Healthcare facilities located in buildings that are taller than 75 feet are required to install automatic sprinkler systems within 12 years after the rule’s effective date.
- Healthcare facilities are required to have a fire watch or building evacuation if their sprinkler systems is out of service for more than 10 hours.
- The provisions offer long-term care facilities greater flexibility in what they can place in corridors. Currently, they cannot include benches or other seating areas because of fire code requirements limiting potential barriers to firefighters. Moving forward, LTC facilities will be able to include more home-like items such as fixed seating in the corridor for resting and certain decorations in patient rooms, provided that the décor must be flame-retardant or treated with approved fire-retardant coating.
- Fireplaces will be permitted in smoke compartments without a one-hour fire wall rating, which makes a facility more home-like for residents.

- Cooking facilities may have an opening to the hallway corridor that permits residents of inpatient facilities such as nursing homes to make food for themselves or others if they choose to and facility staff are able to provide supervision.
- For ASCs, alcohol-based hand rub dispensers now may be placed in corridors to allow for easier access.

Visit <https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10043.pdf> to read the full final rule.

Originally published in the July 2016 *Briefings on Accreditation and Quality*.

## **CMS paints accreditation picture in annual report to Congress**

### **Accreditation by the numbers**

*Editor's note: This article was written by **Elizabeth Di Giacomo-Geffers, RN, MPH, CSHA**, a health-care consultant in Trabuco Canyon, California, and a former Joint Commission surveyor, and contributing editor **Matt Phillion, CSHA**.*

CMS has released its *2015 Report to Congress*, which takes a look at the review, validation, and oversight of the activities of approved accreditation organizations (AO), both Medicare accreditation programs and CLIA accreditation programs.

There are currently nine CMS-approved Medicare accrediting organizations serving the following types of facilities: hospitals, psychiatric hospitals, critical access hospitals (CAH), home health agencies (HHA), hospices, ambulatory surgery centers (ASC), outpatient physical therapy and speech-language pathology services (OPT), and rural health clinics (RHC) (see chart on p. X for complete list and acronyms).

Add to this another seven AOs under CLIA:

- The American Association of Blood Banks (AABB)
- American Association for Laboratory Accreditation (A2LA)
- American Osteopathic Association (AOA)
- American Society for Histocompatibility and Immunogenics (ASHI)
- COLA
- College of American Pathologists (CAP)
- The Joint Commission

So what did CMS report to Congress this year? The report weighs in at nearly 100 pages, but let's focus in on Section 4: State Survey Validation of AO Surveys, which summarizes data gathered during two types of validation surveys: substantial allegation surveys (also known as complaint surveys) and representative sample validation surveys, which are routinely conducted to verify AO compliance.

CMS conducted 287 representative sample validation surveys in 2014 (the year discussed in the 2015 report)—115 hospital surveys and 172 non-hospital surveys. The total is slightly lower than 2013 (298 total surveys) with more hospitals and fewer non-hospitals surveyed. The decreased number in validation surveys in 2014 (2013 was also down from 2012) was due to a decrease in federal funding for validation surveys.

### **Disparity rates by facility type**

The goal of validation surveys is to determine whether the AOs are accurately identifying serious problems in a facility—the basic math is the number of AO surveys with missed condition-level deficiency findings divided by the number of 60-day validation surveys equals the disparity rate.

We've talked about this disparity rate in the past and its impact on hospital surveys. How did various facilities do according to CMS' report this year? Let's take a look at hospitals, CAHs, and also psychiatric hospitals, which deserve some additional attention this year as they only began receiving validation surveys in 2012.

Hospital disparity rates in 2014 were down noticeably from 2013, though the disparity rate, at 38%, is still significant. The sample size is relatively small—103 validation surveys in 2014, 96 the year prior—but saw a dropoff from 46% the year prior. This is the lowest the disparity rate has been since 2010.

CAHs, however, saw a significant increase in disparity rates from 40% in 2013 to 52% in 2014. Again, however, small sample sizes hurt the overall analysis a bit—2014 included only 27 validation surveys for CAH, a 20% drop in surveys from 2013 (35).

Psychiatric facilities had what at first blush appears to be a dishearteningly high disparity rate of 75% until you look at the sample sizes—only 12 surveys in 2014. Disparity rates have been high in psych facilities in all three years in which these numbers have been included in the report (75% in 2012 and 60% in 2013) but the sample sizes have been very small (eight and 10 surveys, respectively) every year.

### **Disparity rates by AO**

For our purposes, we can focus on some of the more common AOs for a look at how their disparity rates compared to previous years. The Joint Commission, naturally, had the lion's share of validation surveys in hospitals this year (76 surveys) with a disparity rate of 42%. By comparison, DNV, Inc., had 20 surveys (15% disparity rate) and HFAP had only seven surveys, with a disparity rate of 57%.

CAH disparity rates saw similar imbalance, with Joint Commission receiving 22 out of 27 surveys with a disparity rate of 55%. DNV and HFAP both received “N/A” ratings for their disparity rates due to the sample sizes for both organizations totaling less than five surveys.

Certainly worth noting: All 12 validation surveys for psychiatric hospitals fell under the Joint Commission’s purview in 2014.

Something we’ve discussed in the past that bears repeating: while getting a good look at what the AOs missed is very helpful, it would be beneficial, in the future, to know where the validation surveys missed findings the AOs themselves caught—such a compare-and-contrast list would benefit hospitals in an educational capacity and help all parties improve in the long run.

### **Where were the findings?**

The CMS report details the number and types of deficiencies cited by the validation surveyors as well. It should come as no surprise for anyone dealing with accreditation and survey prep that 2014’s hospital validation survey numbers showed physical environment (dealing with a number of physical environment *Conditions of Participation* [CoP], including *Life Safety Code*® requirements) was far and away the most challenging area, with 30 deficiencies cited by the validation survey and missed by the AO.

For hospitals, nothing else even came close—some nine findings were cited under Governing Body CoPs, seven in Infection Control, but only Physical Environment reached double digits.

Physical Plant and Environment also took the top spot in cited standards for CAH facilities with ten findings, all of which were missed by the AO.

For both types of facilities, the findings were very much in line with previous years’ numbers.

Worthy of note: in psychiatric hospitals, the most-cited deficiency was not Physical Environment (though this it was a close second) but rather Special Medical Records Requirements for Psychiatric Hospitals, with seven findings (four of which were missed by the AO).

### **Self-reported program improvements**

The CMS Report to Congress also provides space where the AOs can discuss their own program improvements in the last year. Given the numbers related to physical environment in the 2014 validation survey data, one program of particular note from The Joint Commission is the AO’s new Emergency Management Portal.

The Joint Commission developed the portal (which can be found online at [www.jointcommission.org/emergency\\_management.aspx](http://www.jointcommission.org/emergency_management.aspx)) to provide timely, relevant, and helpful information to healthcare organizations and to the communities they serve.

The portal provides access to The Joint Commission’s requirements for emergency management and preparedness, but also additional resources such as information about:

- Codes and alerts
- Exercises and drills
- Public health readiness
- Lessons from recent disasters and emergencies

### **The new kid on the block**

Something worthy of mention in this year’s report: The Compliance Team (TCT). The TCT RHC (Rural Health Clinic) accreditation program received initial approval July 18, 2014—because it was approved in mid-2014, TCT does not have any self-initiatives to report in this year’s document.

TCT RHC has been approved for a four-year term.

### **References:**

FY 2015 Report to Congress (RTC): Review of Medicare’s Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program, [www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-16-07.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-16-07.html)

Hospitals—Centers for Medicare & Medicaid Services,

Full Text Statements of Deficiencies Hospital Surveys - Updated 01/28/2016 [ZIP, 18MB]

*Originally published in the April 2016 **Briefings on Accreditation and Quality**.*

## **How to Track Updates**

CMS provides the following instructions for tracking updates on the CMS website under Regulations and Guidance ([www.cms.hhs.gov](http://www.cms.hhs.gov)):

- Each appendix is a separate file that can be accessed directly from the SOM Appendix Table of Contents, as applicable.
- The appendixes are in PDF format, which is the format generally used in the SOM to display files. Click on the red button in the Download column to download a copy of any available file in PDF format.
- To return to this page after opening a PDF file on your desktop, use your browser’s “back” button, because closing the file will also close most browsers.

The following is a list of several CMS Web pages and instructions on how they are of use:

- For tracking updates, refer to the CMS State Survey and Certification page, located at [www.cms.hhs.gov/SurveyCertificationGenInfo](http://www.cms.hhs.gov/SurveyCertificationGenInfo). Everyone should check this page monthly for updates—appoint someone to do so. This page contains CMS survey and certification memoranda, guidance, clarifications, and instructions to state survey agencies and CMS regional offices. It is searchable by date and keyword.
- The CMS Transmittals page also provides information on important issues ([www.cms.hhs.gov/transmittals](http://www.cms.hhs.gov/transmittals)). According to the CMS website, program transmittals are used to communicate new or changed policies and/or procedures that are being incorporated into a specific CMS program manual. The cover page (or transmittal page) summarizes the new and changed material, specifying what has been changed.
- If you are working in a hospital setting, another good place to check for updates includes CMS' Hospital Center page, which can be found at [www.cms.hhs.gov/center/hospital.asp](http://www.cms.hhs.gov/center/hospital.asp). Most of the announcements this year have been related to payment systems, but accreditation-related changes are also announced here.
- The EMTALA page ([www.cms.hhs.gov/EMTALA](http://www.cms.hhs.gov/EMTALA)) should also be checked. On this page, you will find updates to regulations, manuals, and appendixes, and links back to transmittals related to EMTALA and EMTALA survey and certification letters. There is also a series of links to additional material.

# State Operations Manual

## Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

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*(Rev. 151, 11-20-15)*

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## Survey Protocol

### ***Introduction***

**(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)**

Hospitals are required to be in compliance with the Federal requirements set forth in the Medicare Conditions of Participation (CoP) in order to receive Medicare/Medicaid payment. The goal of a hospital survey is to determine if the hospital is in compliance with the CoP set forth at 42 CFR Part 482. Also, where appropriate, the hospital must be in compliance with the PPS exclusionary criteria at 42 CFR 412.20 Subpart B and the swing-bed requirements at 42 CFR 482.66

Certification of hospital compliance with the CoP is accomplished through observations, interviews, and document/record reviews. The survey process focuses on a hospital's performance of patient-focused and organizational functions and processes. The hospital survey is the means used to assess compliance with Federal health, safety, and quality standards that will assure that the beneficiary receives safe, quality care and services.

### **Regulatory and Policy Reference**

- The Medicare Conditions of Participation for hospitals are found at 42CFR Part 482.
- Survey authority and compliance regulations can be found at 42 CFR Part 488 Subpart A.
- Should an individual or entity (hospital) refuse to allow immediate access upon reasonable request to either a State Agency or CMS surveyor, the Office of the Inspector General (OIG) may exclude the hospital from participation in all Federal healthcare programs in accordance with 42 CFR 1001.1301.
- The regulatory authority for the photocopying of records and information during the survey is found at 42 CFR 489.53(a)(13).
- The CMS State Operations Manual (SOM) provides CMS policy regarding survey and certification activities.

Surveyors assess the hospital's compliance with the CoP for all services, areas and locations in which the provider receives reimbursement for patient care services billed under its provider number.

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct the survey at other times. This may include weekends and times outside of normal daytime (Monday through Friday) working hours. When the survey begins at times outside of normal work times, the survey team modifies the

survey, if needed, in recognition of patients' activities and the staff available.

All hospital surveys are unannounced. Do not provide hospitals with advance notice of the survey.

### **Tasks in the Survey Protocol**

Listed below, and discussed in this document, are the tasks that comprise the survey protocol for hospital.

Task 1	Off-Site Survey Preparation
Task 2	Entrance Activities
Task 3	Information Gathering/ Investigation
Task 4	Preliminary Decision Making and Analysis of Findings
Task 5	Exit Conference
Task 6	Post-Survey Activities

### **Survey Modules for Specialized Hospital Services**

The modules for PPS-exempt units (psychiatric and rehabilitation), psychiatric hospitals, rehabilitation hospitals and swing-bed hospitals are attached to this document. The survey team is expected to use all the modules that apply to the hospital being surveyed. For example, if the hospital has swing-beds, a PPS excluded rehabilitation unit, and a PPS excluded psychiatric unit, the team will use those three modules in addition to this protocol to conduct the survey. If the hospital is a rehabilitation hospital, the team will use the rehabilitation hospital module in addition to this protocol to conduct the survey. If the hospital is a psychiatric hospital and if the survey team will be assessing the hospital's compliance with both the hospital CoPs and psychiatric hospital special conditions, the team will use the psychiatric hospital module in addition to this protocol to conduct the survey.

### **Survey Team**

#### **Size and Composition**

The SA (or the RO for Federal teams) decides the composition and size of the team. In general, a suggested survey team for a full survey of a mid-size hospital would include two-four surveyors who will be at the facility for 3 or more days. Each hospital survey team should include at least one RN with hospital survey experience, as well as other surveyors who have the expertise needed to determine whether the facility is in compliance. Survey team size and composition are normally based on the following factors:

- Size of the facility to be surveyed, based on average daily census;
- Complexity of services offered, including outpatient services;
- Type of survey to be conducted;
- Whether the facility has special care units or off-site clinics or locations;
- Whether the facility has a historical pattern of serious deficiencies or complaints; and

- Whether new surveyors are to accompany a team as part of their training.

### **Training for Hospital Surveyors**

Hospital surveyors should have the necessary training and experience to conduct a hospital survey. Attendance at a Basic Hospital Surveyor Training Course is suggested. New surveyors may accompany the team as part of their training prior to completing the Basic Hospital Surveyor Training Course.

### **Team Coordinator**

The survey is conducted under the leadership of a team coordinator. The SA (or the RO for Federal teams) should designate the team coordinator. The team coordinator is responsible for assuring that all survey preparation and survey activities are completed within the specified time frames and in a manner consistent with this protocol, SOM, and SA procedures. Responsibilities of the team coordinator include:

- Scheduling the date and time of survey activities;
- Acting as the spokesperson for the team;
- Assigning staff to areas of the hospital or tasks for the survey;
- Facilitating time management;
- Encouraging on-going communication among team members;
- Evaluating team progress and coordinating daily team meetings;
- Coordinating any ongoing conferences with hospital leadership (as determined appropriate by the circumstances and SA/RO policy) and providing on-going feedback, as appropriate, to hospital leadership on the status of the survey;
- Coordinating Task 2, Entrance Conference;
- Facilitating Task 4, Preliminary Decision Making;
- Coordinating Task 5, Exit Conference; and
- Coordinating the preparation of the Form CMS-2567.

### ***Task 1 - Off-Site Survey Preparation***

#### **General Objective**

The objective of this task is to analyze information about the provider in order to identify areas of potential concern to be investigated during the survey and to determine if those areas, or any special features of the provider (e.g., provider-based clinics, remote locations, satellites, specialty units, PPS-exempt units, services offered, etc.) require the addition of any specialty surveyors to the team. Information obtained about the provider will also allow the SA (or the RO for Federal teams) to determine survey team size and composition, and to develop a preliminary survey plan. The type of provider information needed includes:

- Information from the provider file (to be updated on the survey using the Hospital/CAH Medicare Database Worksheet), such as the facility's ownership, the type(s) of services offered, any prospective payment system (PPS) exclusion(s), whether the facility is a provider of swing-bed services, and the number, type and location of any off-site locations;
- Previous Federal and state survey results for patterns, number, and nature of deficiencies, as well as the number, frequency, and types of complaint investigations and the findings;
- Information from CMS databases available to the SA and CMS. Note the exit date of the most recent survey;
- Waivers and variances, if they exist. Determine if there are any applicable survey directive(s) from the SA or the CMS Regional Office (RO); and
- Any additional information available about the facility (e.g., the hospital's Web site, any media reports about the hospital, etc).

### **Off-Site Survey Preparation Team Meeting**

The team should prepare for the survey offsite so they are ready to begin the survey immediately upon entering the facility. The team coordinator should arrange an off-site preparation meeting with as many team members as possible, including specialty surveyors. This meeting may be a conference call if necessary.

During the meeting, discuss at least the following:

- Information gathered by the team coordinator;
- Significant information from the CMS databases that are reviewed;
- Update and clarify information from the provider file so a surveyor can update the Medicare database using the "Hospital/CAH Medicare Database Worksheet," [Exhibit 286](#);

- Layout of the facility (if available);
- Preliminary team member assignments;
- Date, location and time team members will meet to enter the facility;
- The time for the daily team meetings; and
- Potential date and time of the exit conference.

Gather copies of resources that may be needed. These may include:

- Medicare Hospital CoP and Interpretive Guidelines ([Appendix A](#));
- Survey protocol and modules;
- Immediate Jeopardy ([Appendix Q](#));
- Responsibilities of Medicare Participating Hospitals in Emergency Cases ([Appendix V](#));
- Hospital Swing-Bed Regulations and Interpretive Guidelines ([Appendix T](#));
- Hospital/CAH Medicare Database Worksheet, [Exhibit 286](#);
- [Exhibit 287](#), Authorization by Deemed Provider/Supplier Selected for Accreditation Organization Validation Survey; and
- Worksheets for swing-bed, PPS exclusions, and restraint/seclusion death reporting.

## ***Task 2 - Entrance Activities***

### **General Objectives**

The objectives of this task are to explain the survey process to the hospital and obtain the information needed to conduct the survey.

### **General Procedures**

#### **Arrival**

The entire survey team should enter the hospital together. Upon arrival, surveyors should

present their identification. The team coordinator should announce to the Administrator, or whoever is in charge, that a survey is being conducted. If the Administrator (or person in charge) is not onsite or available (e.g., if the survey begins outside normal daytime Monday-Friday working hours), ask that they be notified that a survey is being conducted. Do not delay the survey because the Administrator or other hospital staff is/are not on site or available.

### **Entrance Conference**

The entrance conference sets the tone for the entire survey. Be prepared and courteous, and make requests, not demands. The entrance conference should be informative, concise, and brief; it should not utilize a significant amount of time. Conduct the entrance conference with hospital administrative staff that is available at the time of entrance. During the entrance conference, the Team Coordinator should address the following:

- Explain the purpose and scope of the survey;
- Briefly explain the survey process;
- Introduce survey team members, including any additional surveyors who may join the team at a later time, the general area that each will be responsible for, and the various documents that they may request;
- Clarify that all hospital areas and locations, departments, and patient care settings under the hospital provider number may be surveyed, including any contracted patient care activities or patient services located on hospital campuses or hospital provider based locations;
- Explain that all interviews will be conducted privately with patients, staff, and visitors, unless requested otherwise by the interviewee;
- Discuss and determine how the facility will ensure that surveyors are able to obtain the photocopies of material, records, and other information as they are needed;
- Obtain the names, locations, and telephone numbers of key staff to whom questions should be addressed;
- Discuss the approximate time, location, and possible attendees of any meetings to be held during the survey. The team coordinator should coordinate any meetings with facility leadership; and
- Propose a preliminary date and time for the exit conference.

During the entrance conference, the Team Coordinator will arrange with the hospital

administrator, or available hospital administrative supervisory staff if he/she is unavailable to obtain the following:

- A location (e.g., conference room) where the team may meet privately during the survey;
- A telephone for team communications, preferably in the team meeting location;
- A list of current inpatients, providing each patient's name, room number, diagnosis(es), admission date, age, attending physician, and other significant information as it applies to that patient. The team coordinator will explain to the hospital that in order to complete the survey within the allotted time it is important the survey team is given this information as soon as possible, and request that it be no later than 3 hours after the request is made. SAs may develop a worksheet to give to the facility for obtaining this information;
- A list of department heads with their locations and telephone numbers;
- A copy of the facility's organizational chart;
- The names and addresses of all off-site locations operating under the same provider number;
- The hospital's infection control plan;
- A list of employees;
- The medical staff bylaws and rules and regulations;
- A list of contracted services; and
- A copy of the facility's floor plan, indicating the location of patient care and treatment areas;

Arrange an interview with a member of the administrative staff to complete the Hospital/CAH Medicare Database Worksheet that will be used to update the provider's file in the Medicare database. The worksheet may not be given to hospital personnel for completion.

### **Hospital Tours**

Guided tours of the hospital are not encouraged and should be avoided. While a tour of a small facility may take place in less than one-man hour, a tour of a large facility could consume several man hours of allocated survey time and resources that are needed to conduct the survey.

# The CMS

## Hospital Conditions of Participation and Interpretive Guidelines

Compliance with the *Conditions of Participation (CoP)* is required to meet Medicare and Medicaid hospital regulations. CMS makes updates to the CoPs on its website, but few have the time to sort through the plethora of information and identify where the updated information is located. CMS also doesn't highlight the changes, making it even more difficult to find the CoPs you need.

This is where HCPro comes in! We have taken the most recent version of CMS' CoPs and the corresponding Interpretive Guidelines (IG) and reprinted them in an easy-to-use format to simplify your job.

### THIS BOOK:

- Provides an easy-to-read hard copy reference of CoPs and IGs, which are difficult to find online and lengthy and tedious to print
- Includes most recent CoP IGs from CMS
- Includes most recent EMTALA IGs
- Includes CMS survey protocol

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