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CONTENTS

About the Authors .... **v**

Introduction .... **vii**

Crosswalk **1**

§482.11 *CoP:* Compliance with Federal, State, and Local Laws 1
§482.12 *CoP:* Governing Body 3
§482.13 *CoP:* Patient Rights 19
§482.21 *CoP:* Quality Assessment and Performance Improvement Program 39
§482.22 *CoP:* Medical Staff 46
§482.23 *CoP:* Nursing Services 57
§482.24 *CoP:* Medical Record Services 68
§482.25 *CoP:* Pharmaceutical Services 75
§482.26 *CoP:* Radiologic Services 83
§482.27 *CoP:* Laboratory Services 89
§482.28 *CoP:* Food and Dietetic Services 99
§482.30 *CoP:* Utilization Review 102
§482.41 *CoP:* Physical Environment 110
§482.42 *CoP:* Infection Control 116
§482.43 *CoP:* Discharge Planning 120
§482.45 *CoP:* Organ, Tissue, and Eye Procurement 128
§482.51 *CoP:* Surgical Services 132
§482.52 *CoP:* Anesthesia Services 138
§482.53 *CoP:* Nuclear Medicine Services 144
§482.54 *CoP:* Outpatient Services 149
§482.55 *CoP:* Emergency Services 151
§482.56 *CoP:* Rehabilitation Services 154
§482.57 *CoP:* Respiratory Services 157

Appendix A **161**

Appendix B **173**

Appendix C **177**

Appendix D **181**

Appendix E **183**

Appendix F **209**

Clinic/Physician Office Tracer 210
CMS Survey Tips/Documents 215
CMS/OSHA Regulatory Training Requirements 217
ED Tracer 219
ICU Tracer 225
Medical Staff File Review 231
OR/Procedural Area Tracer 234
Restraint Documentation Audit 240

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About the Authors

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She is based at Centura Health's corporate office in Englewood, Colorado. Prior to her current responsibilities, she was the statewide vice president of quality/process improvement & corporate responsibility officer for Centura Health at Home, was a member of the Executive Team, led the organization successfully through both Joint Commission and state/CMS surveys, has a Black Belt designation in Six Sigma, and recently became certified in healthcare compliance. She also held administrative and quality director positions in both patient care and operational departments within acute care hospital settings, where she was the lead person for validation and other unannounced survey visits. She received both her Bachelor of Arts and Masters in Business Administration degrees from the University of Colorado at Denver.

Beth A. Hepola, RN, BSN, MBA, is director of regulatory readiness for Centura Health, a statewide integrated healthcare delivery system consisting of 16 hospitals, six home health and hospice agencies, seven senior living communities, eight emergency or urgent care centers, and more than 250 physician practices. She is located at Centura Health's corporate office in Englewood, Colorado.

Having 30 years' leadership experience in healthcare and over 18 years' experience in directing quality management and performance improvement programs, she has significant experience leading successful Joint Commission accreditation, CMS and state licensure, certification, and validation surveys. In her current role, Hepola specializes in accreditation and regulatory compliance through education, evaluation, preparation, and post-survey response. In this role, she also drives the system's regulatory plan, leading practices for regulatory preparation and response, and system performance improvement. She received her Bachelor of Science in Nursing from the University of Wisconsin, Madison, and her Masters in Business Administration from the University of Colorado at Denver.

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Introduction

In today's world, there are many choices to choose from. Walk down any grocery aisle, shop at any hardware store, or Google any topic—consumers have a choice of what brand to buy, what light bulb to obtain, or which website to access. The same is now true for hospitals in choosing an accreditation agency for deemed status; there are more choices than in the past.

In 2010, the Centers for Medicare & Medicaid Services (CMS) mandated that states ensure that all nonaccredited, non-deemed hospitals and critical access hospitals are surveyed at least every three years and that targeted surveys occur for not less than 5% of all hospitals and critical access hospitals in the state. Given the differences in survey process (state inspections versus accreditation survey/consultation), there is good reason for hospitals to consider accreditation by a deemed status accreditor.

Any hospital that receives Medicare or Medicaid reimbursement for services must meet the federal requirements outlined by CMS called *Conditions of Participation* (*CoP*). In addition, most hospitals and healthcare systems participate in a voluntary survey process through an accreditation agency, such as The Joint Commission. However, in recent years, other accrediting bodies have been formed and received deeming authority from CMS.

One thing that has not changed is that CMS and other accrediting agencies all regulate the administration of care—that is, they regulate the same aspect of healthcare. And most facilities can't or don't choose to follow one or the other. Both the hospital and the regulatory/accrediting agency surveying the facility want to demonstrate that the organization meets the necessary requirements for compliance. This is done primarily through document review, interviews with leaders and staff, observations, and tracer methodology.

Organizations must maintain a constant state of readiness and ongoing compliance in order to have successful outcomes. Doing so can seem overwhelming when you have multiple surveys for which to be ready, but healthcare facilities do not necessarily need to prepare different documents or different processes to meet the regulatory standards.

To help healthcare organizations maintain preparations for surveys, this book outlines and provides tools to assist in assessing compliance and survey readiness. It helps hospitals understand the requirements and related standards, see the similarities as well as differences between the requirements, and identify documents or processes that are already in place so survey preparation can be done without duplicating efforts.

The main building blocks for survey readiness included throughout this publication are:

- The CMS *CoP*, which were taken from the *State Operations Manual, Appendix A—Survey Protocol, Regulations, and Interpretive Guidelines for Hospitals* (revised August 2013)

- Related standards from multiple accrediting agencies, including the Center for Improvement of Healthcare Quality (CIHQ), National Integrated Accreditation for Healthcare Organizations (NIAHO [also known as Det Norske Veritas—DNV]), and The Joint Commission
- A summary and analysis section outlining the similarities and differences between CMS and these accrediting agencies' standards
- Other survey tips and recommendations for helpful documents to have available where applicable
- A variety of tools and resources to assist with survey preparation and readiness (located in the attachments)

Following is a general table of contents comparison between CMS, The Joint Commission, NIAHO/DNV, and CIHQ to show some of the similarities.

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CMS	The Joint Commission	NIAHO/DNV	CIHQ
Compliance With Federal, State and Local Law	Accreditation Participation Requirements and Leadership	Governing Body	Governance & Leadership
Governing Body	Leadership	Governing Body Chief Executive Officer	Governance & Leadership
Patient Rights	Patient Rights	Patient Rights	Patient Rights
Quality Assessment and Performance Improvement Program	Performance Improvement	Quality Management System	Quality Assessment & Performance Improvement, plus Targeted Patient Quality & Safety Practices
Medical Staff	Medical Staff	Medical Staff	Medical Staff
Nursing Services	Nursing and Medication Management	Nursing Services and Medication Management	Nursing Services
Medical Record Services	Information Management and Record of Care	Medical Record Services	Management of the Medical Record
Pharmaceutical Services	Medication Management	Medication Management	Medication Management
Radiological Services	Provision of Care, Treatment and Services, Medical Staff, Performance Improvement, Medical Records and Human Resources	Medical Imaging	Radiology Services
Laboratory Services	Waived Testing	Laboratory Services	Laboratory Services
Food and Dietetic Services	Provision of Care, Treatment and Services, Medical Staff, Performance Improvement, Medical Records and Human Resources	Dietary Services	Dietary (Nutrition) Services
Utilization Review		Utilization Review	Utilization Review
Physical Environment	Environment of Care and Life Safety	Physical Environment	Managing the Care Environment
Infection Control	Infection Prevention and Control	Infection Prevention and Control	Infection Prevention & Control

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CMS	The Joint Commission	NIAHO/DNV	CIHQ
Discharge Planning	Provision of Care, Treatment and Services, Medical Staff, Performance Improvement, Medical Records and Human Resources	Discharge Planning	Discharge Planning Services
Organ, Tissue and Eye Procurement	Transplant Safety	Organ, Eye and Tissue Procurement	Organ, Tissue & Eye Procurement
Surgical Services	Provision of Care, Treatment and Services, Medical Staff, Performance Improvement, Medical Records and Human Resources	Surgical Services	Operative & Invasive Services
Anesthesia Services		Anesthesia Services	Anesthesia Services
Nuclear Medicine Services		Nuclear Medicine Services	Nuclear Medicine Services
Outpatient Services		Outpatient Services	Outpatient Services
Emergency Services		Emergency Department	Emergency Services
Rehabilitation Services		Rehabilitation Services	Rehabilitation Services
Respiratory Services		Respiratory Care Services	Respiratory Services
Note: CMS proposed significant new rules	Emergency Management	Physical Environment	Emergency Preparedness
addressed throughout *CoP*	Human Resources	Staffing Management	Human Resources
	National Patient Safety Goals		Note: Includes separate section on Use of Restraint & Seclusion

In addition, there are similarities and differences in how the various agencies survey, as outlined in the following.

CMS

CMS is part of the Department of Health and Human Services and is responsible for issuing the *CoP* as standards of care. Surveys are at no cost and occur annually, unless an organization has deemed status. CMS surveys are typically conducted by surveyors from the state health department agency and focus much more closely on patient care documentation and the corresponding policies and procedures that drive care implementation. Surveyors tend to be less interactive with staff and physicians; they look at patient records for absence of compliance with relevant *CoP* and will turn to staff to ask why something was not documented or why a process deviated from stated policy. Typically, they spend less time on the patient care units than Joint Commission surveyors do.

The Joint Commission

Established in 1951, The Joint Commission is the oldest of the accrediting agencies. Standards were developed back to the early 1900s when the American College of Surgeons created its hospital standardization program, the precursor to today's survey process. The Joint Commission is also the most well known of the accrediting

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bodies. In addition, it fulfills regulatory and payer requirements and provides education and guidance. Survey cost can be expensive. The Joint Commission has proprietary standards (e.g., National Patient Safety Goals) as well as prescriptive standards, along with complex scoring methods. Over the years, The Joint Commission has become more aligned with CMS *CoP*, but there are still differences. Using hospital staff's responses to questions to guide further queries, Joint Commission surveyors are more interactive than CMS. Documentation is examined within the context of elements of performance validation. The response of clinical staff and physicians can keep Joint Commission surveyors from dwelling too deeply in patient records. Policies/procedures, medical staff bylaws, and other documents are reviewed against actual practice. Additionally, surveyors utilize tracer methodology to identify areas of noncompliance

NIAHO/DNVHC

DNV started in 1864 as a global entity in Norway. DNV Healthcare (DNVHC) is an international accrediting body that incorporates ISO 9000 into its standards. It was approved by CMS as a deeming authority in 2008. Surveys are conducted annually. Like The Joint Commission, NIAHO/DNVHC fulfills regulatory and payer requirements and provides education and guidance. With a focus on quality outcomes, NIAHO/DNVHC standards are closely aligned with CMS *CoP*. The company recently added some proprietary standards, and survey cost can be somewhat expensive.

CIHQ

CIHQ is the newest accrediting body and was granted deeming authority in July 2013. A former consulting company for accreditation and regulatory compliance support, CIHQ can accredit acute and critical access hospitals. Almost 90% of their standards align with CMS *CoP*.

State Health Department Agency

State agencies survey according to CMS *CoP* to determine certification to participate in Medicare and Medicaid programs. There is no requirement to be surveyed by one of the other agencies listed earlier outside of the hospital's respective state. The agencies use the *Medicare State Operations Manual* to determine compliance with minimal standards.

The bottom line is that all healthcare organizations will undergo some kind of survey at some point in time. The key is to understand and educate staff about the changes and at the same time remain flexible to manage the changes and processes. Many similarities between CMS and the various accrediting agencies exist. Hopefully, by understanding these similarities as well as the nuances, ongoing survey preparation can be efficient and can help your organization achieve excellent results. After all, the goal of all participants—the hospital, the regulatory agency, and the patient—is high-quality care and service that meets and exceeds standards and expectations. The choice is yours!

Happy reading and good luck in whichever accreditation program your organization pursues. Contact information for the accrediting bodies discussed in this publication is listed next.

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Website: *www.cms.gov*

National Integrated Accreditation for Healthcare Organizations (NIAHO)
(also referred to as Det Norske Veritas [DNV])
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The Joint Commission
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Website: *www.jointcommission.org*

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Crosswalk

§482.11 *CoP*: Compliance with Federal, State, and Local Laws		
Tag #	CMS *CoP* (2014)	CMS Interpretive Guidelines and Survey Procedures
A-0020	The hospital must ensure that all applicable Federal, State, and local law requirements are met.	
A-0021	a. The hospital must be in compliance with applicable Federal laws related to the health and safety of patients.	*Link to Survey Procedures for §482.11(a)*
A-0022	b. The hospital must be (1) licensed or (2) approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals.	*Link to Survey Procedures for §482.11(b)*
A-0023	c. The hospital must ensure that personnel are licensed or meet other applicable standards that are required by State or local laws.	*Link to Interpretive Guidelines for §482.11(c)* *Link to Survey Procedures for §482.11(c)*
Related Center for Improvement in Healthcare Quality (CIHQ) standards • Governance and Leadership: GL-2 • Human Resources: HR-1		
Related Joint Commission standards • Emergency Management: EM.02.02.11, EP1–9; EM.02.02.15, EP 1–15 • Leadership: LD.04.01.01, EP1–3, 16–18 • Management of Human Resources: HR.01.02.05, EP1–7, 10–15, 16, and 18 • Medical Staff: MS.06.01.03, EP1–7 and 9; MS.06.01.05, EP1–12		

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Related National Integrated Accreditation for Healthcare Organizations/Det Norske Veritas Healthcare, Inc., (NIAHO/DNVHC) standards

- Governing Body: GB.1-SR.1a and b and SR.1d
- Staffing Management: SM.1
- Medical Staff: MS.8, SR.1a–e, SR.2a–e

§482.11 (a–c) *CoP* Analysis/Guidelines

All accreditors are similar when it comes to compliance with federal, state, and local laws. All are looking to see that the hospital has a current license and certification and meets the licensure standards for the state in which the hospital resides. Both are looking to see that hospital personnel required to be licensed have a current license to practice; these licensure laws vary state to state. Positions needing a license could include medical doctors (MD), doctors of osteopathy (DO), RN, physician assistants (PA), occupational therapists (OT), and respiratory therapists. This includes nonemployees providing direct care. Not all states license all types of care provider; there are several national registrations (i.e., registered dietitians and registered cardiovascular invasive specialists) that may not be licensed in their states so it is important to understand and distinguish when differences exist. All regulators require primary source verification of licensure. NIAHO/DNVHC requires that a process is in place to verify licensure and expirations and that the data is shared with the quality assessment and performance improvement (QAPI) structure or human resources (HR) team when such activity is completed at the departmental level. Verification of qualifications, training/ education, and permits should be checked.

Survey Tips:

- Create a listing of all licenses (required and voluntary) and ensure responsibility for timely renewal.
- Have HR and managers keep updated records of current licensure and training/education for staff (including employees, nonemployees, and licensed independent practitioners [LIP])
- Ensure nonemployee contracts for workers who enter patient care areas have similar requirements for occupational health screening and background checks as employees and that primary source verification of licensure is performed for all direct care providers.
- Review medical staff files to verify that credentials information is current.

Suggested Documents:

- Hospital's state license and federal certification certificate and accreditation certificate; Hospital Drug Enforcement Administration (DEA) license, Clinical Laboratory Improvement Amendments (CLIA) license, and radio therapeutic and nuclear medicine licensure/certifications in related departments; other voluntary licensure (i.e., trauma designation, psych designation, neonatal intensive care unit [NICU] designation)
- Personnel files/credentials information with proof of primary source verification
- Bylaws regarding credentialing and privileging
- P&Ps regarding volunteer LIPs and non-LIPs during disaster

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§482.12 *CoP*: Governing Body		
Tag #	CMS *CoP* (2014)	CMS Interpretive Guidelines and Survey Procedures
A-0043	There must be an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.	*Link to Interpretive Guidelines for §482.12* *Link to Survey Procedures for §482.12*
A-0044	(a) Standard: Medical staff—The governing body must:	*Link to Interpretive Guidelines for §482.12(a)*
A-0045	(1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;	*Link to Interpretive Guidelines for §482.12(a)(1)* *Link to Survey Procedures for §482.12(a)(1)*
A-0046	(2) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff;	*Link to Interpretive Guidelines for §482.12(a)(2)* *Link to Survey Procedures for §482.12(a)(2)*
A-0047	(3) Ensure that the medical staff has bylaws;	*Link to Interpretive Guidelines for §482.12(a)(3)* *Link to Survey Procedures for §482.12(a)(3)*
A-0048	(4) Approve medical staff bylaws and other medical staff rules and regulations;	*Link to Interpretive Guidelines for §82.12(a)(4)* *Link to Survey Procedures for §482.12(a)(4)*
A-0049	(5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;	*Link to Interpretive Guidelines for §482.12(a)(5)* *Link to Survey Procedures for §482.12(a)(5)*
A-0050	(6) Ensure the criteria for selection are individual character, competence, training, experience, and judgment; and	*Link to Interpretive Guidelines for §482.12(a)(6)* *Link to Survey Procedures for §482.12(a)(6)*

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A-0051	(7) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society.	*Link to Interpretive Guidelines for §482.12(a)(7)* *Link to Survey Procedures for §482.12(a)(7)*
A-0052	(8) Ensure that, when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital, the agreement is written and that it specifies that it is the responsibility of the governing body of the distant-site hospital to meet the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant-site hospital's physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(3) of this part, grant privileges based on its medical staff recommendations that rely on information provided by the distant-site hospital.	*Link to Interpretive Guidelines for §482.12(a)(8) & (a)(9)* *Link to Survey Procedures for §482.12(a)(8) & (a)(9)*

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A-0052	(9) Ensure that when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, the written agreement specifies that the distant-site telemedicine entity is a contractor of services to the hospital and as such, in accordance with §482.12(e), furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including, but not limiited to, the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant-site telemedicine entity's physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(4) of this part, grant privileges to physicians and practitioners employed by the distant-site telemedicine entity based on such hospital's medical staff recommendations; such staff recommendations may rely on information provided by the distant-site telemedicine entity.	*Link to Interpretive Guidelines for §482.12(a)(8) & (a)(9)* *Link to Survey Procedures for §482.12(a)(8) & (a)(9)*
A-0053	(10) Consult directly with the individual assigned the responsibility for the organization and conduct of the hospital's medical staff, or his or her designee. At a minimum, this direct consultation must occur periodically throughout the fiscal or calendar year and include discussion of matters related to the quality of medical care provided to patients of the hospital. For a multi-hospital system using a single governing body, the single multi-hospital governing body must consult directly with the individual responsible for the organized medical staff (or his or her designee) of each hospital within its system in addition to the other requirements of this paragraph (a).	

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Related CIHQ standards

- Governance and Leadership: GL-3, GL-4

Related Joint Commission standards by chapter

- Leadership: LD.01.01.01, EP1–3; LD.01.03.01, EP1–2; LD.01.05.01, EP1–7; LD.04.03.09, EP1–9
- Medical Staff: MS.01.01.01, EP1–37; MS.02.01.01, EP1–12; MS.03.01.01, EP1–11, 13–14, 16–17; MS.06.01.03, EP1–7 and 9; MS.06.01.05, EP1–12; MS.06.01.07, EP1–8; MS.07.01.01, EP1–4; MS.1.01.01, EP1

Related NIAHO/DNVHC standards

- Governing Body: GB.1, SR.1c; GB.3 SR.4, SR.5
- Medical Staff: MS.2; MS.3; MS.7 SR.1, SR.2; MS.11-SR.1, SR.3; MS.20-SR.1a–d; SR.2a–d; SR.3

§482.12 (a) *CoP* Analysis/Guidelines

All hospitals must have a governing body. Since May 2012, the Centers for Medicare and Medicaid Services (CMS) allows a multihospital system to operate with a single governing board. CMS has also clarified the discussion of the use of a unified hospital system governing body, for example, by noting that a factor to consider when deciding whether to use a system governing body would be the impact on the Medicare payment status of hospitals-within-hospitals and hospital satellites. CMS also clarified that, although a hospital system's governing board may institute uniform quality assessment and performance improvement (QAPI) requirements, each individual hospital within a CCN must maintain evidence of its own QAPI program.

CMS removed the requirement that a hospital's governing body must include a member or members of the medical staff but added a requirement that the governing body must consult directly with the individual responsible for the organization and conduct of the hospital's medical staff, or his/her designee. The consultation is required to be periodic throughout the year (where we expect it to occur at least twice in a fiscal or calendar year) and to include discussion of matters related to the quality of medical care provided to the hospital's patients. For a multi-hospital system using a single, unified governing body, there must be consultation directly with the individual (or designee) responsible for the medical staff in each hospital within its system.

NIAHO/DNVHC specifies that if more than one governing body is identified (e.g., a healthcare system with local and system governing bodies), the reporting structure and responsibility of the respective bodies should be identified and differentiated. NIAHO/DNVHC clarifies in its standards that the medical staff must be organized and integrated as one body that operates under one set of bylaws apprpoved by the governing body and that the medical staff bylaws must apply equally to all practitioners within each category of practitioners.

All accreditors and CMS emphasize the interrelationship between a hospital's governing board and its medical staff. The governing body has overall responsibility for the conduct and care provided by the organization. NIAHO/DNVHC states that the governing body is also responsible for compliance with all of its standards. CMS and accrediting organizations place responsibility to approve appointments, reappointments, and privileging with the governing body. NIAHO/DNVHC allows the board to delegate the authority to render initial appointment, reappointment, and renewal or modification of clinical privileges decisions to a committee of the governing body. The medical staff should provide recommendations on credentials and clinical privileges, and medical staff bylaws/policies and procedures to the governing body. One group cannot work without the other to establish consistent policies, processes, and care guidelines for the institution.

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CMS requires the medical staff to have bylaws, policies, procedures, credentialing and clinical privileging processes, and quality of care oversight, with accountability to the governing board of the hospital.

CMS expanded the list of practitioners who may be given the responsibility for the organization and conduct of the medical staff to doctors of podiatric medicine; doctors of dental surgery or dental medicine have always been acceptable for such positions. Many medical staff organizations still limit this role to that of an MD or DO. Nothing in the *CoPs* prohibits hospitals and their medical staffs from establishing certain practice privileges for other categories of physician practitioners excluded from medical staff membership under state law, or from granting those privileges to individual practitioners in those categories, as long as such privileges are recommended by the medical staff, approved by the governing body, and in accordance with state law. CMS also specified that the medical staff must exercise oversight, such as through credentialing and competency review, of nonphysician practitioners to whom it grants privileges, just as it would for those practitioners appointed to its medical staff. Such practitioners include: Physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, anesthesiologists' assistants, and registered dieticians or nutrition professionals.

Other types of licensed healthcare professionals have a more limited scope of practice and usually are not eligible for medical staff privileges, depending on state law and medical staff bylaws, rules and regulations include, but are not limited to: Physical therapists, occupational therapists, and speech language therapists. Furthermore, some states have established a scope of practice for certain licensed pharmacists who are permitted to provide patient care, services that make them more like the above types of nonphysician practitioners, including the monitoring and assessing of patients and ordering medications and laboratory tests. In such states, a hospital may grant medical staff privileges to such pharmacists and/or appoint them as members of the medical staff. There is no standard term for such pharmacists, although they are sometimes referred to as "clinical pharmacists."

CMS and accrediting organizations are in alignment regarding telemedicine privileges; deemed status organizations can now use distant-site privileging information for telemedicine providers if there is a contract with the distant-site hospital detailing their requirements for complaint privileging processes and that information regarding periodic appraisals is shared so long as the distant-site accreditor is a CMS provider and is compliant with the accreditors' standards.

Survey Tips:

- Review hospital board/governing body bylaws and/or responsibility matrix to ensure aspects critical to their role are outlined (i.e., responsibility for medical staff bylaws and credentialing, Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), grievance process, contract services).
- Review governing body meeting minutes for documentation on approval/denial of medical staff recommendations and actions.
- Review medical staff bylaws/P&Ps and whether changes or revisions were accepted by the medical staff at large with final approval by the governing body.
- Review credentials files to verify information is up to date and complete and that criteria for selection are applicable to the discipline and meet minimum components defined by CMS and accreditor. Ensure that privileges are compliant with scope of practice laws and are in accordance with medical staff bylaws, rules, and regulations.
- Review contract for telemedicine privileges if using distant-site information.
- Review medical staff bylaws if using distant-site information for telemedicine providers.

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Suggested Documents:

- Hospital/governing body bylaws and/or responsibility matrix outlining hospital board responsibilities
- Medical staff bylaws/P&Ps and organizational chart
- List of governing body members
- Governing body meeting minutes
- List of medical staff executive committee members and minutes
- Credentials files/medical staff privileges
- Listing of contract services agreements

§482.12 *CoP*: Governing Body (continued)

Tag #	CMS *CoP* (2014)	CMS Interpretive Guidelines and Survey Procedures
A-0057	(b) Standard: Chief executive officer—The governing body must appoint a chief executive officer who is responsible for managing the hospital.	*Link to Interpretive Guidelines for §482.12(b)* *Link to Survey Procedures for §482.12(b)*

Related CIHQ standards

- Governance and Leadership: GL-5

Related Joint Commission standards by chapter

- Leadership: LD.01.02.01, EP1–2 and 4; LD.01.03.01, EP1–2; LD.01.04.01, EP1–3, 5, 11

Related NIAHO/DNVHC standards

- Chief Executive Officer: CE.1

§482.12 (b) *CoP* Analysis/Guidelines

The governing body must have a formal process for appointing one chief executive officer (CEO) for the hospital who is responsible for managing the entire organization. CMS and The Joint Commission verify that the documented process is followed and the CEO has ultimate responsibility.

Survey Tips:

- Review hospital/governing body bylaws and/or responsibility matrix outlining process for CEO appointment.
- Have updated CEO job description and ensure the CEO meets the qualifications outlined in the job description and was appointed by the hospital/governing body.
- Review chain of command structure if CEO is absent.

Suggested Documents:

- Hospital bylaws
- Governing body meeting minutes showing appointment of CEO
- Job description for CEO
- Hospital/governing body bylaws and/or responsibility matrix outlining hospital board responsibilities

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§482.12 *CoP*: Governing Body (continued)		
Tag #	CMS *CoP* (2014)	CMS Interpretive Guidelines and Survey Procedures
A-0063	(c) Standard: Care of patients—In accordance with hospital policy, the governing body must ensure that the following requirements are met:	
A-0064	(1) Every Medicare patient is under the care of:	*Link to Interpretive Guidelines for §482.12(c)(1)* *Link to Survey Procedures for §482.12(c)(1)*
	(i) A doctor of medicine or osteopathy (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified healthcare personnel to the extent recognized under State law or a State's regulatory mechanism.);	
	(ii) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license;	
	(iii) A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform;	
	(iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices;	
	(v) A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist; and	

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	(vi) A clinical psychologist as defined in §410.71 of this chapter, but only with respect to clinical psychologist services as defined in §410.71 of this chapter and only to the extent permitted by State law.	
A-0065	(2) Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital.	*Link to Survey Procedures for §482.12(c)(2)*
A-0066	If a Medicare patient is admitted by a practitioner not specified in paragraph (c)(1) of this section, that patient is under the care of a doctor of medicine or osteopathy.	*Link to Interpretive Guidelines for §482.12(c)(2)* *Link to Survey Procedures for §482.12(c)(2)*
A-0067	(3) A doctor of medicine or osteopathy is on duty or on call at all times.	*Link to Survey Procedures for §482.12(c)(3)*
A-0068	(4) A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problems that:	*Link to Interpretive Guidelines for §482.12(c)(4)* *Link to Survey Procedures for §482.12(c)(4)*
	(i) Is present on admission or develops during hospitalization; and	
	(ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is (A) defined by the medical staff; (B) permitted by State law; and (C) limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors.	
Related CIHQ standards • Governance and Leadership: GL-6		
Related Joint Commission standards by chapter • Medical Staff: MS.03.01.01, EP1–11, 13–14, 16, 17; MS.03.01.03, EP1–6, 12		
Related NIAHO/DNVHC standards • Medical Staff: MS.15-SR.1a–f and SR.2a and b		

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2015 Edition

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