TWO ESSENTIAL RESOURCES
COMBINED INTO ONE PUBLICATION

The CMS Hospital Conditions *of* Participation *and* Interpretive Guidelines

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HCPro
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Tyson Davis, Cover Designer

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HCPro
100 Winners Circle Suite 300
Brentwood, TN 37027
Telephone: 800-650-6787 or 781-639-1872
Fax: 800-785-9212
Email: *customerservice@hcpro.com*

Visit HCPro online at *www.hcpro.com* and *www.hcmarketplace.com.*

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Introduction

Every hospital should have a copy of Centers for Medicare & Medicaid Services' (CMS) up-to-date *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* (SOM).

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 Active 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, have a successful survey, and receive full reimbursement. We this book will help you comply with CMS regulations.

CMS Updates Hospital and CAH Guidelines

The CMS earlier this year published revised guidelines for both Appendix A Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, and Appendix W Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAH) and Swing-Beds in CAHs. The hospital revisions went into effect April 1, 2015, and the CAH revisions went into effect April 7.

The revisions to the hospital manual under Appendix A addressed only a few changes such as outpatient orders, radiopharmaceuticals for nuclear medicine, and dietary. However, one-third of the CAH manual has been completely revised. Revised sections include pharmacology, nursing, rehabilitation, and drugs and biologicals. New sections to the CAH include IV medications and blood and blood products. Many of these standards also exist in the hospital manual.

What do these changes mean for healthcare providers and surveyors? "It's a good thing; most of the changes made are the same standards they have for hospitals, or they're a shortened version of those standards," says **Sue Dill Calloway, RN, MSN, JD, CPHRM, CCMSCP,** president of Patient Safety and Healthcare Consulting, Inc. "I think that's good because a lot of hospitals are in systems now. I think it's going to be easier for the surveyors. It never made sense that the two hospital manuals have so many differences."

Radiology

CMS has changed the wording in the radiology section of Appendix A so that a doctor or pharmacist does not need to be present for a trained nuclear medicine technologist to push the contrast during the nuclear medicine test.

"This makes a lot of sense, especially on evenings and weekends when physicians or pharmacists may not be available," says Dill Calloway. "They removed the term 'direct' from supervision, so the technicians will still be under supervision, but the pharmacist doesn't have to be in the department at the time of administration." Also, hospitals should be aware that CMS issued a memo dated May 15, 2015, that rewrote most of the radiology and nuclear medicine sections in the hospital *CoP* manual under Appendix A.

Dietary

This section was updated in both manuals, with slightly shortened standards in the CAH manual. Medical staff can now credential and grant privileges to qualified dietitians or nutrition professionals if permitted by state law. Some states refer to this person as a registered dietitian (RD) or licensed dietitian (LD).

The qualified dietitian will be able to write diets (e.g., supplemental, therapeutic, total parenteral nutrition, etc.) for patients as well as order lab tests as they relate to dietary needs without the supervision of a physician or another healthcare practitioner.

CMS added two new provisions to this standard. The first states that all hospital patients must have their nutritional needs met in a manner consistent with recognized dietary practices. The second requires that all patient diets must be ordered either by a practitioner caring for the patient or by a qualified dietitian as authorized by the medical staff.

Outpatient services

In Appendix A, CMS has revised the orders for outpatient services standards so that the healthcare practitioner must be licensed in the state where he or she provides patient care, even if the patient is in another state for a short period of time. For example, if a patient lives in one state and receives a prescription for a medication and needs a blood test to monitor the effects, then the patient goes on vacation, the local hospital could decide to run the test.

Drugs and biologicals

This section is new to the CAH manual, and the content varies slightly from the hospital manual. A CAH must have written policies for the administration of all drugs and biologicals based on widely accepted standards of practice and both federal and state law.

Drugs and biologicals can be administered either by or under the supervision of the MD, DO, registered nurse (RN), or, if permitted by state law, the physician's assistant (PA). Although medication administration should be based on a written order, CMS does not prevent CAHs from using either verbal orders or standing orders. In both cases, the practitioner responsible for the patient must put the order in writing as soon as possible.

It's important to note that if a CAH has a psychiatric and/or rehabilitation unit, the CAH must follow the CMS hospital *CoPs* for all services in those units, including verbal and standing orders.

Nursing

CMS significantly revised the nursing section with seemingly commonsense updates, Dill Calloway says. Revisions include mandating that CAHs identify an individual, an RN such as the chief nursing officer, who is responsible for nursing services, including the development of nursing service policies and procedures.

The CAH should have a sufficient number of supervisory and non-supervisory nursing personnel for both inpatient and outpatient services. Staffing schedules will need to be monitored to ensure patient needs are met.

CAHs should also have procedures for assigning and coordinating nursing care for every patient, says Dill Calloway. The RN should consider the capabilities of the nursing staff and assign appropriate tasks while creating assignments. CMS does not want to interfere in staffing assignments, provided the employee meets all educational, training, and experience criteria, and the assignment is in compliance with state law.

Every CAH will have its care supervised by either an RN or a PA where permitted by state law.

A nursing care plan is required for every patient as soon as they are admitted. The care plan will include everything from planning care while in the CAH to planning for transfer to a hospital or for discharge.

CAHs can develop the nursing care plan as part of a larger coordinated interdisciplinary plan of care if they choose. The thought is this will encourage communication and collaboration throughout the patient's team and ultimately result in better patient outcomes, Dill Calloway says. However, everything nursing needs must be included in the interdisciplinary plan of care.

Rehabilitation therapy services

CMS issued IGs for patients undergoing rehabilitation therapy services such as physical therapy, occupational therapy, and speech-language therapy pathology services at a CAH.

The services are optional, but if provided, the services must be provided by staff qualified under state law. It is important to note that rehabilitation services can only be ordered by the patient's physician, NP, or PA, if allowed by state law. Additionally, the provided services must be in compliance with national standards set forth by professional organizations such as the American Physical Therapy Association, the American Occupational Therapy Association, etc. CMS also revised the survey procedures to require the following:

- Review clinical records and determine whether the required care plan was created and applied
- Review employee files to verify the rehabilitation service providers are compliant with education, experience and training, and documented competencies
- Ask the CAH what national standards are being followed and ask for the supporting documentation

Staffing

Another big change in the CAH manual is that CMS has given CAHs the flexibility to develop staffing policies appropriate for the facility. The previous requirement was that a physician needed to be on premises every two weeks.

Now, if a small CAH is in a rural area that does not have any inpatients, having a physician on premises every two weeks may be unnecessary, unlike a larger CAH that has a 10-bed behavioral health center that offers complex services and may need one or more physicians on premises every day. The CAH should evaluate its services and make the necessary adjustments to the physician on-site schedule.

Editor's note: This article originally ran in the July 2015 issue of ***Briefings on The Joint Commission.***

CMS Annual Report

LSC tops disparity rate number for last fiscal year

Every year, CMS releases an annual financial report. Within that report, the agency provides a review of Medicare's oversight of accrediting organizations (AO). It has become an HCPro tradition to take a look at what CMS finds, as well as how The Joint Commission and other AOs fare.

As those of us in the accreditation field know, to be eligible for CMS reimbursement, certain types of healthcare facilities (including hospitals) need to demonstrate compliance with the CMS *CoPs*. For the purposes of this discussion, we will focus primarily on hospital accreditation. CMS has currently approved Medicare accreditation programs for The Joint Commission, DNV Healthcare, the Center for Improvement in Healthcare Quality (CIHQ), and the Healthcare Facilities Accreditation Program (HFAP).

The number of Medicare-certified hospitals was largely unchanged between fiscal year (FY) 2008 and FY 2013. Hospital and psychiatric hospital programs are the only categories in which the majority of facilities participate in Medicare by virtue of accreditation under an approved Medicare program. On paper, the number of deemed hospitals actually decreased between those years, from 4,381 to 3,793; however, the approval of a separate Medicare psychiatric hospital accreditation program in 2011 resulted in 435 deemed psychiatric hospitals moving out of the hospital category. The proportion of Medicare-certified hospitals that were deemed has decreased from 89% to 83% during that time frame.

As we all know, AOs are responsible for surveying facilities on-site during the site visits we work so hard to prepare for. In FY 2013, according to CMS reports, AOs performed 1,770 initial surveys and 3,324 follow-up surveys. So how did this break down by individual AOs? Again, focusing on hospitals, FY 2013 saw the following:

- The Joint Commission: 3,372 deemed hospitals, 48 initial surveys, 1,165 renewal surveys
- HFAP: 168 deemed hospitals, six initial surveys, 52 renewal surveys
- DNV: 253 deemed hospitals, 41 initial surveys, 62 renewal surveys

Among those surveys, how did hospitals fare? DNV awarded full accreditation to 100% of hospitals surveyed (with two pending approval). HFAP also awarded 100% of hospitals surveyed full accreditation (though it denied one ambulatory surgical center accreditation). The Joint Commission awarded full accreditation to 98% of its hospitals, with three hospitals receiving denial of full accreditation (19 were pending approval at the time the CMS report was released).

State surveys

Meanwhile, the number of state surveys continues to grow, as does the impact of those surveys.

Since 2007, CMS has worked to strengthen its oversight of AOs. In FY 2013, there was a slight decrease in the number of representative sample validation surveys due to less funding available for such surveys.

In 2007, 55 hospitals and 35 nonhospitals were surveyed. This number jumped to 92 and 76, respectively, the following year. Those numbers climbed significantly each year, most significantly in 2012 with 102 hospital and 230 nonhospital surveys, although the totals were slightly lower in 2013 with 106 hospitals and 192 nonhospital surveys.

The overall result? An increase of 231% for overall validation surveys conducted.

But what about the 60-day validation survey? This survey is meant to assess the AO's ability to identify noncompliance with the *CoPs*.

CMS determines the number of validation surveys to perform on each AO based on the number of facilities that AO surveys each month, as well as factoring in the overall budgeted targets by state and facility type for validation surveys. CMS tries to create a relatively representative national sample for each program. In FY 2013, 3% of hospitals received a validation survey.

Here's where the rubber meets the road: Following a validation survey, CMS looks at the number of condition-level deficiencies cited by the state agencies performing the survey versus those cited by the AO. CMS is looking for how accurately the AO is surveying the hospital or other program for serious deficiencies.

If the state agency cites a condition-level deficiency for which the AO has not cited a comparable deficiency, CMS considers that area of noncompliance "missed." This miss factors into the AO's "disparity rate," which is the number of AO surveys with missed condition-level deficiency findings divided by the number of 60-day validation surveys.

How did hospital accreditors perform in FY 2013? On the whole, according to CMS, not well—out of 96 60-day validation surveys, state agencies found 52 condition-level deficiencies, 44 of which were missed by the AO, for a disparity rate of 46%. This number has climbed over the years as validation surveys have increased: from 33% in 2008 to 36% in 2009, 38% in 2010, and 44% in both 2011 and 2012.

Let's break down how each individual AO did. Obviously, the numbers will be somewhat skewed given the larger market share and number of surveys The Joint Commission is involved in—namely, The Joint Commission had more than seven times the number of validation surveys than either of the other organizations. That said, The Joint Commission had a disparity rate of 41% in 2013, compared to a rate of 67% for HFAP and 64% for DNV Healthcare.

Physical environment versus other conditions

When looking at noncompliance it is telling to see how facilities and physical environment requirements impact totals for findings. CMS writes:

Examining the specific condition-level deficiencies cited by the SAs across all 60-day validation surveys provides an indication of the types of quality problems that exist in these facility types as well as the relationship between SA and AO citations for specific conditions.

CMS uses two approaches to analyze the results: a review of types of condition-level citations and a comparison of the number of surveys where the state agencies found physical environment condition-level deficiencies and the number of other types of deficiencies cited.

"Both approaches highlight the same conclusion," CMS writes. "SAs identify more serious physical environment deficiencies than any other type of serious deficiency on validation surveys, and the AOs miss a significant number of these environmental deficiencies."

This information has been consistent over the past several years of data collection. Interestingly, despite CMS finding more missed environmental deficiencies than any other type, facilities- and environmental-related citations have dominated the top 20 most-cited standards for The Joint Commission every year for the past several years as well.

According to CMS, the most missed deficiencies other than physical environment (for which CMS says AOs missed 31 out of 33 findings) were:

- Infection control, cited 15 times by state agencies and missed seven times by AOs
- Governing body, cited 12 times by state agencies and missed eight times by AOs

There were missed findings in nine other categories as well, but all were single-digit numbers in terms of both findings and missed deficiencies.

How much do aging buildings and increasing regulatory requirements play into these findings? It would be interesting in future analyses to see exactly how such factors have impeded facilities' improvement. It would also be worthwhile to find out, should CMS release the information, which deficiencies the AOs uncovered that CMS surveyors did not as a comparison of effectiveness.

Life Safety Code® misses

According to the CMS report, "physical environment condition is still the single largest driver of disparity rates for hospitals" and CAHs.

The disparity rate for physical environment ranges between 13 and 22 percentage points higher than the disparity rates calculated for other health and safety issues.

CMS also writes: "The majority of the physical environment disparity consists of *LSC* [*Life Safety Code*®] deficiencies."

CMS engineers have generated a report that identifies the top *LSC* deficiencies cited by state agencies for FY 2013, which are consistent with the previous two years as well. The report is intended, CMS notes, to provide AOs with "an understanding of the emphasis of CMS *LSC* surveys, which should allow the AOs to ensure their programs are focusing on the same *LSC* provisions. Should AOs choose to focus on the top *LSC* deficiencies cited by the SAs, we would expect this would result in a reduced *LSC* disparity."

CMS reports that AOs have particular difficulty identifying deficiencies related to the *LSC* 2000 edition requirements CMS has adopted. This might catch followers of the progress of the 2012 *LSC* by surprise—CMS notes that it has issued a number of categorical waivers to the *LSC* 2000 edition that aligns its requirements more closely with the *LSC* 2012 edition, but AOs are required to use standards that are "consistent with Medicare standards, and may not unilaterally impose a different *LSC* edition than CMS has adopted."

The CMS report states that the agency does not believe a difference in *LSC* editions accounts for the extent and persistence of AOs' problems with *LSC* deficiencies.

CMS improvements

CMS has also made several moves to improve its oversight and collaboration with AOs. Let's review some of the most significant updates:

- **Communication**. CMS meets periodically with national AOs to foster communication between the AOs and CMS. These meetings also serve as a forum to discuss operational and program-specific issues, to "better assure ongoing deemed facility compliance with Medicare conditions," and to provide information and education to those organizations.
- **Consultation**. CMS is also working to increase opportunities for AOs and other stakeholders to provide input into the development of "sub-regulatory guidance concerning Medicare standards and survey processes."
- **AO education**. CMS also works to provide formal written and oral feedback to AOs as part of both the deeming process and the data review process. In addition, CMS invites AOs to send representatives to state agency surveyor training courses.
- **ASSURE upgrade**. In the previous fiscal year, CMS upgraded the desktop version of its ASSURE database with a Web-based application.

Readiness and sustained compliance or proactive preparation for sustained compliance

1. Identify top compliance issues with CMS and the AO, as applicable to your organization
2. Drill down to the root cause of noncompliance and embrace this as an improvement opportunity for the patient population(s) served
3. Develop a sustained compliance model (plan, implement, and evaluate)
4. Hold process owners accountable
5. Educate leadership and the respective process owners and team members
6. Present and review results with leadership and staff, at least quarterly
7. Coordinate, communicate, and collaborate with leaders and staff on progress
8. Share your excellence by publishing, presenting poster session(s), and/or public speaking
9. Celebrate your success

Reference: CMS Financial Report *(www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/CMS-Financial-Report-for-Fiscal-Year-2014.pdf).*

Editor's note: This article was written by ***Elizabeth Di Giacomo-Geffers, RN, MPH, CSHA,*** *and originally ran in the April 2015 issue of* ***Briefings on The Joint Commission.***

CMS Issues Guidelines Update

CMS issued a recent memo with updates to the IGs impacting hospitals across several areas. The memo updated portions of existing guidelines. In addition, the guidelines addressed areas in the requirements for ambulatory surgical centers, rural health clinics, and federally qualified health centers.

Food and dietetic services

Requirements for food and dietetic services were revised to permit a qualified dietitian or nutrition professional to order diets if authorized by the medical staff and in accordance with state law governing dietitians and nutrition professionals. This includes diet ordering, which is no longer restricted to physicians and nonphysician practitioners such as NPs or PAs.

“This was pretty interesting,” says Dill Calloway. “Who knows more about dietetics than dietitians?”

These changes include therapeutic diet and supplemental feeding orders and allow nonphysicians with the proper training and expertise to order diets for patients. Organizations, however, must remain consistent with their own state laws, Dill Calloway notes.

Nuclear medicine services

These regulations were revised to remove the requirement for “direct” supervision of in-house preparation of radiopharmaceuticals, to be provided by an appropriately trained registered pharmacist or MD/DO. This means a supervising physician or pharmacist need not always be present when radiopharmaceuticals are being prepared.

The final rule itself addresses this, stating that CMS expects most hospitals will follow the guidelines of the Society of Nuclear Medicine and Molecular Imaging with respect to the use of nuclear medicine technologists.

“The nuclear medicine part of the memo is pretty straightforward. No surprises there,” says Dill Calloway.

Outpatient services

A new standard was added to the hospital outpatient services *CoPs* reflecting current IGs on the ordering of outpatient services. These services, CMS notes, may be ordered by any practitioner:

- Responsible for the care of the patient
- Who is licensed and acting within his or her scope of practice in the state where he or she provides care to the patient
- Who has been authorized in accordance with state law and by the medical staff and approved by the governing body to order specific outpatient services

This new standard applies to members of the medical staff who have been granted privileges to order outpatient services; it also applies to practitioners not on the medical staff but who meet the criteria for authorization to order outpatient services.

“They’re really adamant about orders,” says Dill Calloway. “The whole idea was where they got this wrong previously.”

CMS has handled this section incorrectly and has made several attempts to make it right.

“The *CoPs* [previously] said that only a physician, an MD or DO, can order rehab or respiratory therapy,” says Dill Calloway. “But PAs, NPs, they would order respiratory therapy treatments or oxygen. They have those roles.”

CMS tried to change this in the regulations. "They said if you are credentialed and privileged you can" order those services, says Dill Calloway.

However, this also impacted outpatient orders. "There was a big issue because you had to have a physician order, so if you have open heart surgery in the next county and they send you back to your own county to have cardiac rehab, [the ordering physician] isn't credentialed and privileged there," says Dill Calloway. "That started this whole issue on who can order outpatient tests." The more mobile people became, the more problematic this requirement grew.

Swing-bed services

Although not the most headline-catching change in the memo, this update is of specific interest to AOs.

According to the CMS memo, this regulation was moved from Subpart E, concerning specialty hospitals, to Subpart D, concerning optional hospital services. This means that CMS-approved Medicare hospital accreditation programs are required to develop and implement standards for swing-bed services, and that separate state surveys of swing-bed services will not be required in deemed status hospitals once CMS has approved the revised AO standards.

Utilization review

Rather than outright changing this regulation, CMS "took this opportunity to correct our guidance to reflect statutory changes to section 1865 of the Social Security Act, enacting part of the Medicare Improvements for Patients and Providers Act," the memo states.

Based on these changes, any AO seeking CMS approval of its hospital accreditation program must demonstrate that it has standards for utilization review and that its standards meet or exceed Medicare standards.

"Thus," CMS writes, "we are removing language in our guidance indicating that utilization review *CoP* compliance must always be assessed by State Survey Agencies (SA), since this is no longer the case for deemed status hospitals."

"There were no regulatory changes, but they took this opportunity to reflect changes for accrediting organizations seeking CMS deemed status," says Dill Calloway. "Those organizations have to demonstrate that their utilization review standards have met or exceeded existing standards."

This rectifies a few issues, she says. "I don't think there's ever been a deficiency in utilization review. It hasn't been updated in many years. People update their utilization review plan based on medical necessity and different tools they're using, but what CMS told me is they come in and ask, 'Do you have a contract or are you participating in a [quality improvement] program with the state?'"

Ambulatory surgical center changes

Some of the changes issued for ambulatory surgical centers (ASC) in the CMS memo may be of interest across the board. Specifically, CMS has revised a technical error for surgical services at ASCs. The regulations now correctly cross-reference the right tag numbers when referencing the regulation permitting ASCs in certain states to be exempt from the requirement for physician supervision of nonphysician practitioners who administer anesthesia.

"We are also introducing a standard-level tag for the regulatory language found in the condition stem statement related to a requirement to perform surgery in a safe manner, to allow citation at either the standard or condition level, as appropriate," according to CMS.

The memo also updates several components of ASC laboratory and radiological services. CMS revised the requirements to explicitly state that radiological services may only be provided at ASCs when it is integral to surgical procedures offered at the center.

"Rewriting this section was important," says Dill Calloway. "They had just adopted the hospital radiology standards, and that hadn't made any sense. They never should have done that, and so this fixes the issue."

CMS now requires ASCs providing radiological services to comply with only certain provisions of the hospital *CoPs* for radiological services.

Lastly, CMS has revised the ASC requirements to require the ASC's governing body to appoint an individual qualified in accordance with state law and the ASC's policies who will be responsible for ensuring that all radiologic services are provided in accordance with the cross-referenced hospital requirements.

Editor's note: This article originally ran in the April 2015 issue of ***Briefings on The Joint Commission.***

CMS Updates PSI Worksheets

In a memo dated October 31, 2014, the CMS Center for Clinical Standard and Quality/Survey and Certification Group targeted patient safety in a number of announcements.

Specifically, the memo addresses the 2015 Hospital Patient Safety Initiative (PSI). First, the organization announced and provided three hospital PSI worksheets, developed as part of the initiative. The worksheets were recently revised for use in all hospital survey activity when assessing compliance with the *CoPs* for quality assessment performance improvement (QAPI), infection control, and discharge planning.

According to the official announcement, "State Survey Agencies (SAs) will be required to complete

hospital PSI surveys using the three worksheets in combination as discussed with the S&C Mission and Priority Document (MPD), contingent upon the availability of supplemental funding for this Tier 2 survey work."

Where did this all come from? Back in 2011, CMS began piloting three worksheets for SA surveyors to use through the PSI to, according to the memo, "better assess compliance with the hospital *CoPs* for QAPI, infection control, and discharge planning." This was part of a larger initiative by the agency to reduce healthcare-acquired conditions such as healthcare-associated infections (HAI) and preventable readmissions, two challenging areas for hospitals across the board. This latest memo comes after the end of the pilot phase. The worksheets have been revised to reflect that pilot period based on feedback received over the course of the process, and CMS now considers them ready for use as part of the general survey process for hospitals according to the memo.

FY 2015

According to the memo, these worksheets will be used for all hospital survey activity by SA surveyors "whenever assessment of compliance with any of the three associated *CoPs* occurs," the memo notes. This includes:

- All complaint surveys involving assessment of compliance with one or more of these *CoPs*
- All full, standard surveys, including:
  - Representative sample validation
  - Recertification surveys
  - Full surveys that the regional office requires after a complaint survey with condition-level noncompliance

Depending on the specifics of the survey activity, the worksheets may be used individually or in combination with each other. Unlike in prior years, however, the worksheets will not be submitted to CMS or any CMS contractor according to the announcement, "although CMS may require completed worksheets to be submitted at a later date or in future years," which is worthy of note. The completed worksheets may afterward be attached in CMS records as part of the survey documentation, but that decision will be left to the state agency's director's discretion.

Citations from previous years

Here is another change very much worth noting: Hospitals surveyed during FY 2013 and 2014 as part of the PSI were not cited for any identified noncompliance. Moving forward, the memo notes, all identified noncompliance must be cited as directed in the instructions for each question on each of these three worksheets. (Surveyors will follow usual citation practices, including documenting noncompliance on Form CMS-2567.)

Also of note: CMS mentions in its official memo that there are worksheet questions that continue, for the time being, to be for information purposes only. No citations will be made for these questions regardless of the response. In fact, instructions on the worksheets explicitly identify the questions for which no citations will be made.

Sample surveys

The memo notes that according to the FY 2015 S&C Mission and Priority Document (MPD), SAs are expected to perform targeted surveys of selected hospitals using all three of these updated worksheets in combination as part of the ongoing PSI. (Interestingly, this will be contingent upon availability of supplemental funding for the surveys.) This is different from prior years, though SAs are required to cite all deficient practices identified through these PSI surveys. (For the curious, CMS provides the number of anticipated surveys expected in 2015 that each state's agency will be required to complete.)

The CMS Central Office will distribute a list of hospitals from which the SAs will select hospitals for survey. The lists will be generated based upon prior citation data from SAs and AOs. CMS will identify hospitals that are at a potentially greater risk of noncompliance. (A similar process occurred with the FY 2014 pilot phase of the PSI.)

SAs will receive the lists in January 2015 (tentatively), at which point they will also receive an updated (FY 2015) PSI Protocol and Frequently Asked Questions document.

When will state agencies act?

According to the memo, SAs "will not undertake any PSI surveys until CMS advises that supplemental funding has been confirmed available for this initiative."

All FY 2015 PSI survey activity must be completed by September 1, 2015.

The SAs are expected to use and complete the worksheets for each PSI survey, but SAs will not be required to submit completed PSI sample survey worksheets to CMS in FY 2015, according to the memo. CMS may require submission of this information in future years.

The state agencies will need to notify CMS of:

- The names of the hospitals surveyed
- City
- State
- CMS certification number
- Survey dates

This information will be used for tracking purposes and for PSI supplemental payments.

HCPro will continue to monitor the progress of both the implementation of these worksheets as well as the PSI program in general to keep readers abreast of the latest developments.

Further reading

APIC: CMS issues revised survey worksheets (*www.apic.org/Advocacy/Advocacy-Updates/Detail?id=c5bceb56-daad-4f15-82cf-3c58c12f0763*)

Hospital Infection Control Worksheet (*http://apic.informz.net/apic/data/images/AdminInfo15-05.02.FY%202015_PSI%20Infection_Control_Worksheet_%20revised%2010.31....pdf*)

Hospital Quality Assessment Performance Improvement (QAPI) Worksheet (*http://apic.informz.net/apic/data/images/AdminInfo15-05.03.FY%202015_PSI_QAPI_Worksheet_%20revised%2010.31.14.pdf*)

Hospital Discharge Planning Worksheet (*http://apic.informz.net/apic/data/images/AdminInfo15-05.04.FY%202015%20PSI_Discharge_Planning_Worksheet_%20revised%2010.3....pdf*)

CDPH L&C Initial Assessment & Gap Analysis Report (*https://www.google.com/?gws_rd=ssl#q=CMS+FY+2015+S%26C+Mission+%26+Priority+Document+(MPD)*)

Hospital Inpatient Value-Based Purchasing Program Fact Sheet (*www.google.com/?gws_rd=ssl#q=Appendix+5+of+the+MPD+lists+the+number+of+FY+2015+PSI+surveys)*

Editor's note: This article was written by ***Elizabeth DiGiacomo-Geffers, RN, MPH, CSHA,*** *and originally ran in the January 2015 issue of* ***Briefings on The Joint Commission.***

How to Track Updates

CMS provides the following instructions for tracking updates on the CMS website under Regulations and Guidance (*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.* 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*). 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*. 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*) 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. 149, 10-09-15)

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 *CoP*s 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 *CoP*s you need.

This is where HCPro comes in! We have taken the most recent version of CMS' *CoP*s 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 *CoP*s and IGs, which are difficult to find online and lengthy and tedious to print
- Highlights changes, including major updates made in the past year
- Includes most recent *CoP* IGs from CMS
- Includes most recent EMTALA IGs
- Includes CMS survey protocol

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HCPro
a division of BLR
100 Winners Circle | Suite 300
Brentwood, TN 37027
www.hcmarketplace.com