CMS HOSPITAL CONDITIONS OF PARTICIPATION (COPS) 2022
Part 4 of 5

QAPI, Medical Staff, Radiology, Lab, Dietary, UR, Emergency Preparedness and Facility Services

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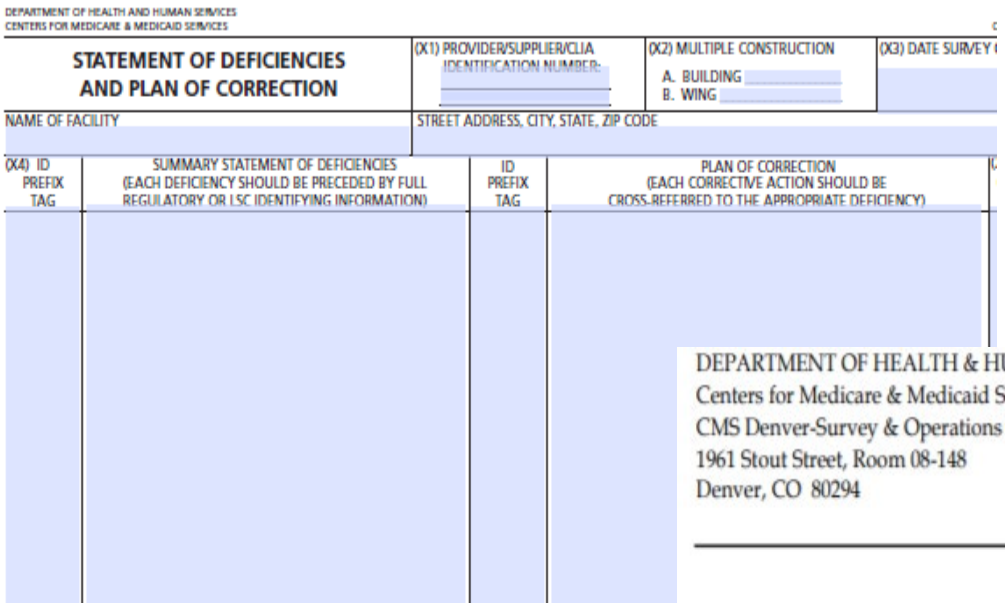
Why We are Here Today



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(X3) DATE SURVEY

NAME OF FACILITY

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS Denver-Survey & Operations Group
1961 Stout Street, Room 08-148
Denver, CO 80294

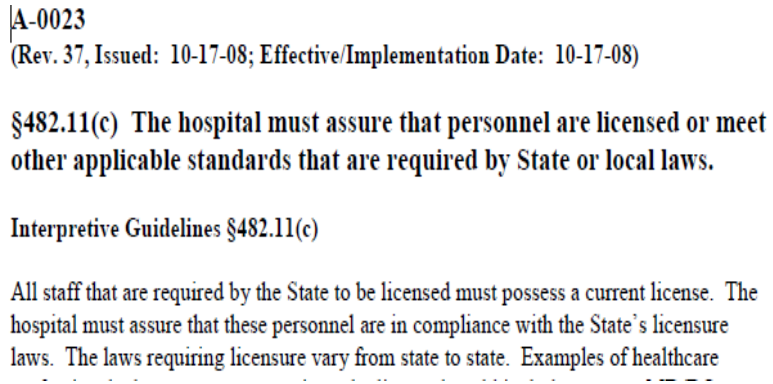
PUBLIC NOTICE FOR INVOLUNTARY TERMINATION OF MEDICARE/MEDICAID PROVIDER AGREEMENT

Notice is hereby given that the agreement between Clear View Behavioral Health, 4770 Larimer Parkway, Johnstown, Colorado 80534, and the Secretary of Health and Human Services, as a provider o services in the Health Insurance for the Aged and Disable Program (Medicare) is to be terminated at the close of October 28, 2020.

The Medicare program will not make payment for inpatient hospital services furnished to patients who are admitted after the close of October 28, 2020. For patients admitted on October 28, 2020, or earlier, payment may continue for up to 30 calendar days of inpatient hospital services furnished after October 28, 2020.

The Conditions of Participation (CoPs)

- Manual first out 1986
  - Multiple updates
- Section numbers – "Tag" numbers
- Start in the Federal Register
  - Interpretive Guidelines
  - Survey procedures



A-0023
(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§482.11(c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.

Interpretive Guidelines §482.11(c)

All staff that are required by the State to be licensed must possess a current license. The hospital must assure that these personnel are in compliance with the State's licensure laws. The laws requiring licensure vary from state to state. Examples of healthcare

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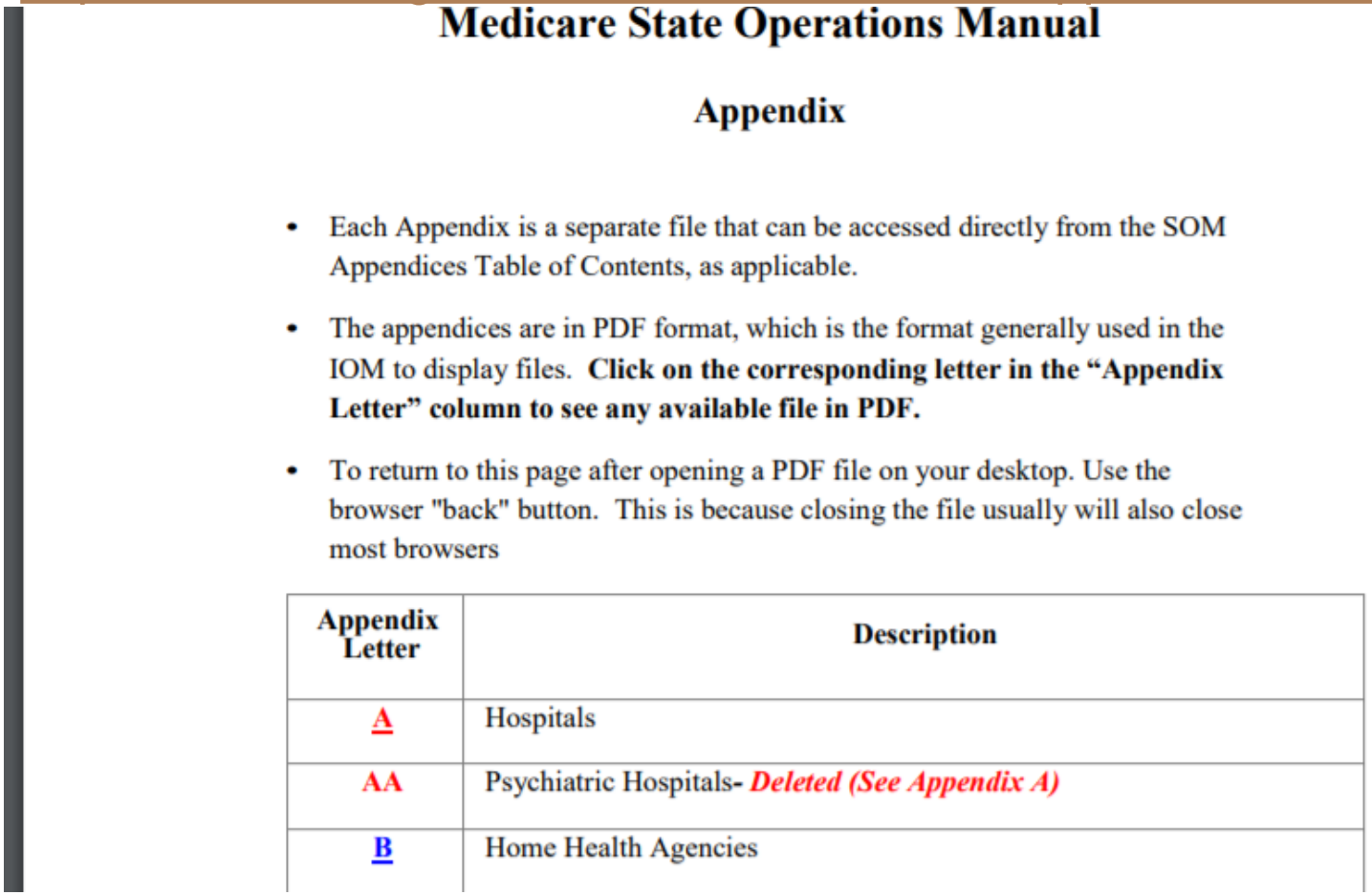
How to Keep Up with Changes

- Confirm current CoP [1].
- Check the survey and certification website monthly [2].
- If new manual – check CMS transmittal page [3].
- Have one person in your facility who has this responsibility

- [1] http://www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf
- 2 http://www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage
- 3 http://www.cms.gov/Transmittals

CMS Hospital CoP Manual

- https://www.cms.gov/files/document/som107appendicestoc.pdf.



Medicare State Operations Manual

Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. **Click on the corresponding letter in the "Appendix Letter" column to see any available file in PDF.**
- To return to this page after opening a PDF file on your desktop. Use the browser "back" button. This is because closing the file usually will also close most browsers

Appendix Letter	Description
A	Hospitals
AA	Psychiatric Hospitals- *Deleted (See Appendix A)*
B	Home Health Agencies

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CMS CoP Manual

Appendix Letter	Description
	Guidance
P	Survey Protocol for Long-Term Care Facilities
PP	Interpretive Guidelines for Long-Term Care Facilities
Q	Determining Immediate Jeopardy
R	Resident Assessment Instrument for Long-Term Care Facilities
S	Mammography Suppliers - **Deleted**
T	Swing-Beds – **Deleted (See Appendix A and Appendix W)**
U	Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions
V	Responsibilities of Medicare Participating Hospitals In Emergency Cases
W	Critical Access Hospitals (CAHs)
Y	Organ Procurement Organization (OPO)
Z	Emergency Preparedness for All Provider and Certified Supplier Types

State Operation Manual – Acute/PPS

State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

Table of Contents

(Rev. 200, 02-21-20)

State Operation Manual – Critical Access

State Operations Manual

Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev. 200, 02-21-20)

Transmittals for Appendix W

INDEX

Survey Protocol

CMS Survey Memos

Policy & Memos to States and Regions

CMS Quality Safety & Oversight memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices. www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions

Show entries: 5 per page | Filter On | Apply

Showing 1-10 of 521 entries

Title	Memo #	Posting Date	Fiscal Year
Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes	QSO-20-14-NH	2020-03-04	2020
Suspension of Survey Activities	QSO-20-12-All	2020-03-04	2020
Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge	QSO-20-13-Hospitals	2020-03-04	2020
Release of Additional Toolkits to Ensure Safety and Quality in Nursing Homes	20-11-NH	2020-02-14	2020
Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2019-nCoV)	20-09-ALL	2020-02-06	2020
Notification to Surveyors of the Authorization for Emergency Use of the CDC		2020-02-	

Report Adverse Events to PI

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality /Survey & Certification Group

Ref: S&C: 13-19-HOSPITALS

DATE: **March 15, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: AHRQ Common Formats - Information for Hospitals and State Survey Agencies (SAs) - Comprehensive Patient Safety Reporting Using AHRQ Common Formats

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html

Memorandum Summary

Hospitals are Required to Track Adverse Events: The Condition of Participation (CoP) for Quality Assessment and Performance Improvement (QAPI) at 42 CFR 482.21(a)(2) requires hospitals to track adverse patient events. However, several recent reports completed by the Department of Health and Human Services Office of the Inspector General (OIG) indicated that hospitals fail to identify most adverse events.

Use of the Common Formats May Help Hospitals Improve Tracking. The OIG suggested staff failure to understand what events need to be reported to the hospital's QAPI program contributes to the problems with internal tracking systems. The OIG recommended that the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) could help hospitals improve their ability to track adverse patient safety events by disseminating information on AHRQ's Common Formats. The Common Formats define a systematic process for reporting adverse events, near misses, and unsafe conditions, and allow a hospital to report harm from all causes. Hospital use of the AHRQ Common Formats is voluntary, but a hospital that uses them and is adept at the analysis that they permit will be in a better position

CMS Changes to QAPI: Hospital Improvement Rule

QAPI

- Hospitals required to examine the quality of its services
  - Implement specific improvement projects on an ongoing basis
  - Result – hospitals have made progress in delivering safer, high-quality care

QAPI Program

- Hospital QAPI program must
  - Incorporate quality indicator data
    - Include patient care data
  - Submitted to or received from Medicare quality reporting and quality performance programs
    - Includes data on readmissions and hospital acquired conditions (HACs)

Data Collected

- Hospitals already collecting/reporting such data
  - Efficient to include some of this data in the QAPI program
  - Examples:
    - HAC Reduction Program
    - Hospital VBP Program
    - Inpatient and Outpatient Quality Reporting Program

Hospitals in Systems

- Can have system wide QAPI – optional
  - Except for CAHs
  - Called “unified and integrated QAPI for multi-hospital systems”
  - Must be part of a hospital system
- Under a Board responsible for 2 or more hospitals
- Board - responsible for making sure that each of the hospitals meet all the QAPI requirements
- Must be consistent with your state law

Requirements for Hospitals in Systems

- Each hospital must show:
  - Program is established in a manner
  - Considers each hospital's unique circumstances
  - Any significant differences in patient population or services offered
    - Examples
      - Pediatric hospital verses a psychiatric hospital or an acute care hospital
      - Hospital has a burn unit or a cardiovascular unit and does multiple open hearts or cardiac procedures

Requirements – continued

- Each must have P&Ps to
  - Ensure the needs and concerns of each hospital is addressed
  - Regardless of practice or location
  - Ensures issues localized to a particular hospital are considered
- Such a model would incorporate each individual hospital's QAPI program
  - Promotes increased efficiencies, innovations, and flexibility and allow for dissemination of best practices

QAPI Survey Memo

Hospital CoPs for QAPI

- 2014: CoPs for QA and Performance Improvement
- 2013: Memo on AHRQ Common Formats
  - Hospitals are required to track adverse events for PI
- Short section
  - Hospital Compare program* is not part of the CMS CoP
  - Hospital Compare – the indicators that must be sent to CMS to receive full reimbursement rates

Adverse Event Reporting

- Hospitals required to track adverse events
- Several reports show nurses and others not reporting adverse events
  - Events not getting into the PI system 86% of the time
- OIG recommends using AHRQ common formats to help with the tracking*
- Could help hospitals improve the reporting process

Hospital CoPs for QAPI

- Must have an ongoing PI program
- Shows measurable improvements
- Identifies and reduces medical errors
  - Diagnostic errors
  - Equipment failures
  - Blood transfusion
  - Medication errors

Hospital CoPs for QAPI – cont'd

- Medical errors may be difficult to detect in hospitals and are under reported
- Ensure incident reports are completed for errors and near misses
- QAPI Worksheet is an excellent resource to understanding the QAPI requirements*

CMS Hospital CoPs

- Triggers can help hospitals find errors
  - Trigger tools available on IHI website[1]
- Program must incorporate quality indicator data including patient data (274)
- CMS will look at information submitted to or from QIO (Quality Improvement Organizations)

[1]www.ihi.org

QAPI Standards

Program Improvement Program

- Starts at Tag 263
- Standard: Must have PI program
  - Ongoing
  - Data driven
  - Effective
- Board must make sure that PI program reflects the complexity of the hospital's organization and services
  - Must involve all departments including contracted services
  - Focus on indicators to improve health outcomes

Program Scope 273 2020

- Standard: PI program needs to be ongoing and show measurable improvements to improve health outcomes
  - Must measure, analyze and track the quality indicators
- Must include quality data including patient care data
  - Such as dated submitted to or received from Medicare
  - Quality reporting and quality performance programs
- Frequency of collection must be specified by the board

Triggers and Data Use

- Triggers can help hospitals find errors
- Consider information submitted to or from QIO
- Use data to identify opportunities for improvement (283)
  - Focus on high risk, high volume, or problem prone areas
  - Consider the incidence and severity of problems in those areas
  - Take action to improve and track the improvements made

Patient Safety, Medical Errors, AE 286

- Standard: PI program must include indicators to identify and reduce medical errors
  - Track medical errors and ADE
  - Analyze their causes and implement preventive actions
  - EX: root cause analysis (RCA), FMEA, or QAPI review
- Board is responsible for the operations of the hospital
- Medical and administrative staff are accountable to make sure clear expectations for safety

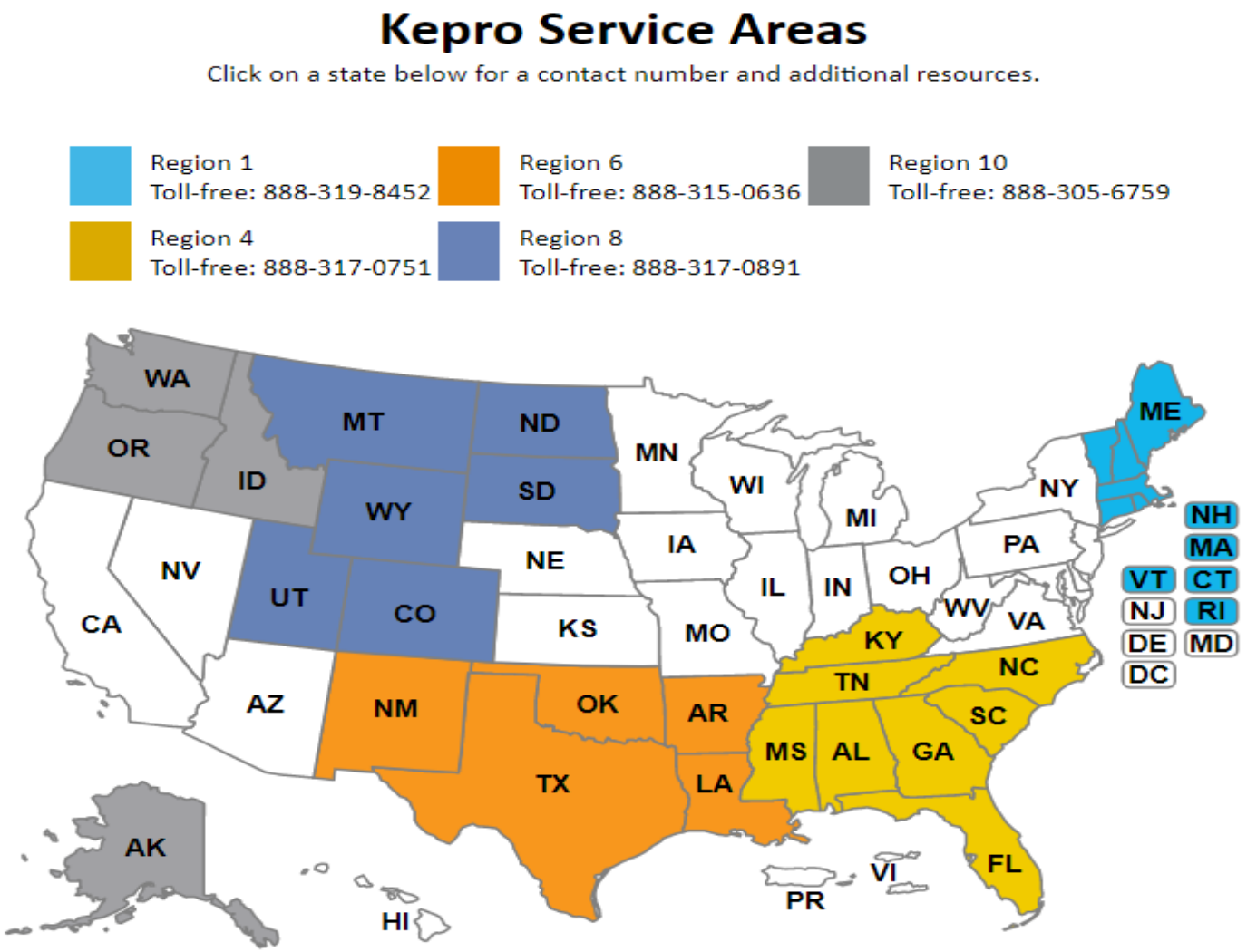
PI Projects 297

- Standard: Hospital must conduct PI projects
  - Number projects depends on size of the hospital and type(s) of services provided
  - May develop an information technology system to improve patient safety and quality
  - Document the projects and reasons for doing
  - Can participate in a QIO project or do one that is of comparable effort

QIOs and QAPI

- QIOs advance the quality of care for Medicare patients
- Every state has a QIO (Quality Improvement Organization) under contract by CMS
- CMS has a website on information about QIOs

Kepro QIO: https://www.keproqio.com/



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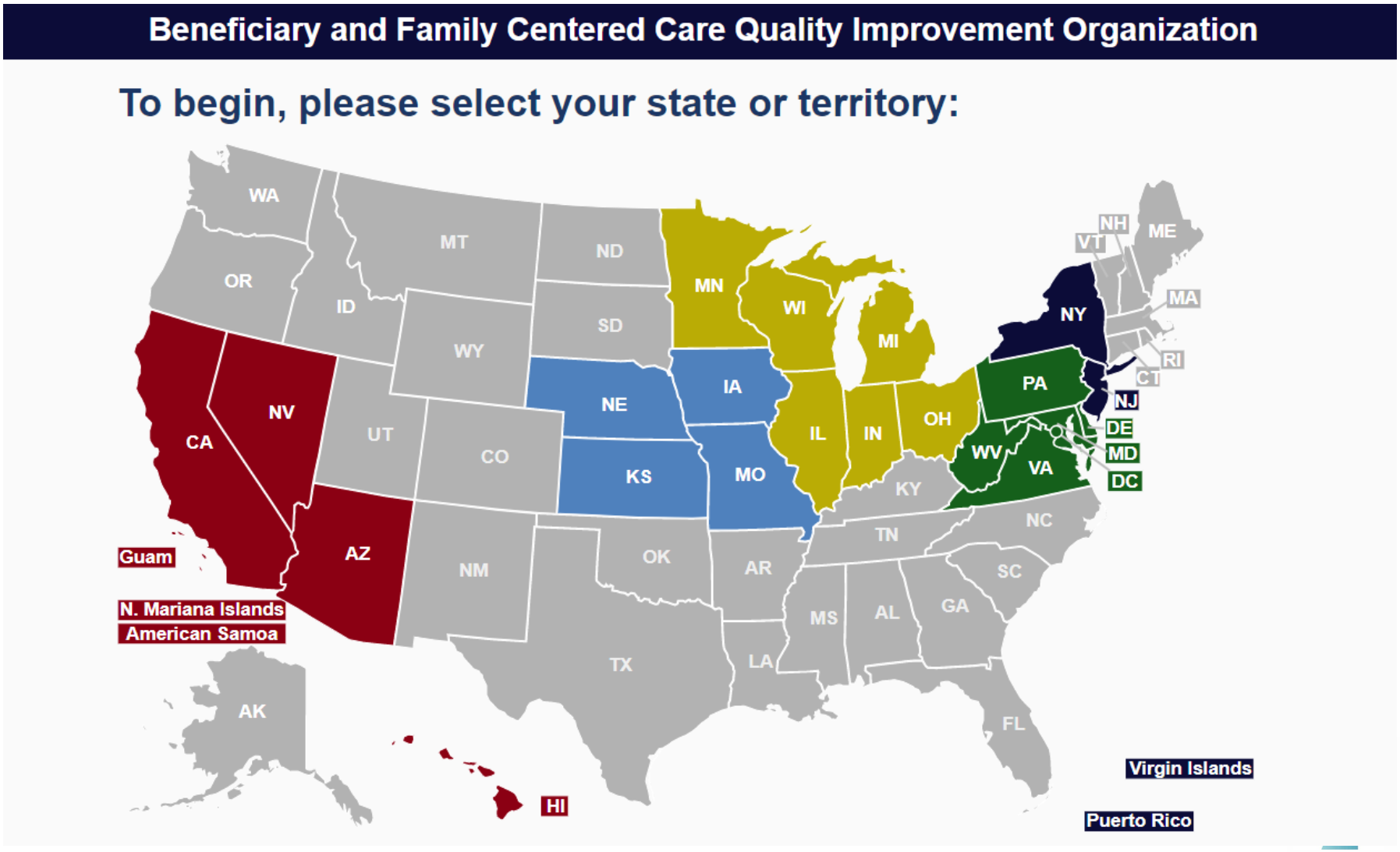
Livanta QIO: https://www.livantaqio.com/en



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Executive Responsibilities 309

- Standard: Board or organized group or individual assumes full legal authority and responsibility for the operations of the hospital
- Plus – the Medical Staff and Administrative officials are responsible and accountable for:
  - Ongoing PI program that
    - Includes patient safety
    - Reducing medical errors
  - Hospital wide PI and patient safety program
  - A determination of the number of PI projects that is conducted annually

Adequate Resources 315

- Standard: Board, Medical Staff, and Administrative Officials are accountable for assuring adequate resources are allocated for
  - Measuring
  - Assessing
  - Improving
  - Sustaining performance
  - And reducing risk to patients
- Process to make sure the improvements continue

Examples of Process Improvement

- Hospitals created a process to ensure
  - MI patients got their thrombolytics timely
  - PCI was done before 90 minutes
  - Pneumonia patients got their antibiotics timely
  - Blood cultures drawn timely

Adequate Resources

- People can attend meetings
- Obtain data
- Conduct analysis
- New processes for neuromuscular blocker agents
- Implement policy on Phenergan administration and Fentanyl patches
- Safer IV pumps
- New anticoagulant program
- Implement central line bundle
- Sepsis and VAP bundle
- Preventing inpatient suicides
- Preventing wrong site surgery & retained FB

Unified and Integrated QAPI 320 New

- If hospital is part of a system and more than two or more hospitals are under one board
  - Can elect to have unified and integrated QAPI
  - The board can elect to do so but it is optional
- Must be consistent with your state law
- Board is responsible and accountable for ensuring that each individual hospital meets all the QAPI requirements
- Interpretive guidelines yet to be issued

Consider Unique Circumstances 321 New

- A shared QAPI program must consider each hospital's unique circumstances
- Must also consider difference in patient populations and services offered
  - For example, one is a pediatric hospital
  - Another hospital system of 4 hospitals has a free-standing psych hospital

Policies and Procedures 322 New

- If decide to have a unified and integrated QAPI must implement policies and procedures
- The policies must ensure that the needs of each individual hospital are met
  - This is regardless of practice or location
- Each must be given due consideration
- Must make sure that issues localized to particular hospitals are considered and addressed

CMS Medical Staff Section

Medical Staff 338

- **Standard:** Hospital must have an organized MS that operates under bylaws approved by Board
  - Must have MS bylaws that apply equally to all
- Each hospital can have
  - Separate medical staff
  - Or a unified integrated (shared) medical staff
    - If requirements are met

Eligibility and Appointment to the MS 339

- Standard: MS may include doctors and other categories of physicians and eligible non-physicians for appointment
- All practitioners who require privileges
  - Evaluated under staff privileging system
  - Must function under the bylaws, R&Rs
  - Must be consistent with state law and the state scope of practice
  - Must examine their credentials

Medical Staff Appraisals 340

- Appraisal procedures must evaluate each member
  - To determine if should be continued, revised, terminated or changed
  - Frequency – CMS recommends at least every 24 months each practitioner

Evaluations and Privileges

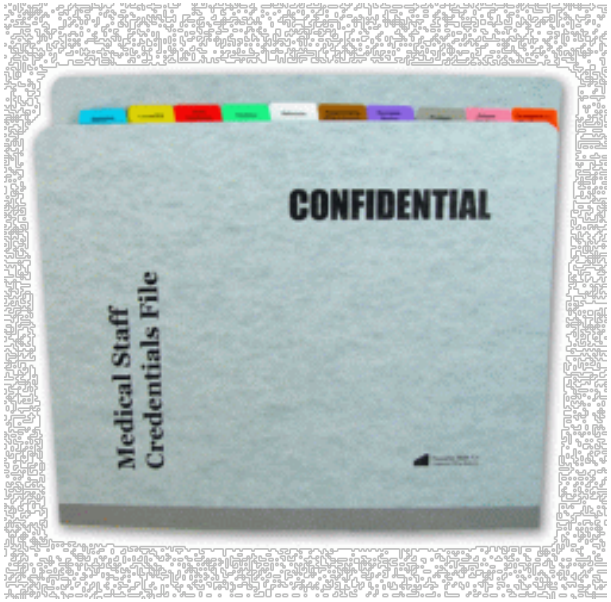
- Must evaluate qualifications and demonstrated competencies to perform each task or activity within scope of practice or privileges
- If requests for privileges goes beyond the specified list for that category of practitioners
  - Need appraisal by MS and approval by the board

Question 1

- Our facility conducts thorough credentialing and peer review for all providers, including NP, PA, CNS
  - Yes
  - No
  - Prefer not to answer

Credential Files

- Must keep separate credentials file for each MS member
  - If limit privileges must follow laws such as reporting to NPDB
    - MS bylaws need to identify process for periodic appraisals



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Credentialing 341

- **Standard:** MS must
  - Examine credentials
  - Make recommendations to the board
  - On appointment of the candidates
  - In accordance with State law
  - Scope of practice laws
  - Medical staff bylaws, rules and regulations
- Recommended candidate subject to bylaws, R&R

Medical Staff Must Examine

- Credentials examined:
  - Request for privileges
  - Evidence of current licensure
  - Training and professional education
  - Documented experience
  - Supporting references of competence

Enforcement

- Cannot make a recommendation based solely on presence/absence of board certification
  - Can require board certification
- Medical staff and Board enforce requirements
- Take action when practitioners do not adhere to bylaws, R&R

Telemedicine – Hospital 342

- **Standard:** When telemedicine services furnished via agreement with distant-site hospital governing board may choose
  - Have medical staff rely on credentialing and privileging decisions of distant site hospital when making recommendations for privileges
  - Hospital must be Medicare-participating
  - Distant-site practitioner privileged at own hospital
  - Practitioner licensed in state where patients located
  - Adverse events/complaints communicated back to distant-site hospital

Telemedicine – Entity 343

- **Standard:** When telemedicine services furnished via agreement with distant-site *entity* governing board may choose
  - Have medical staff rely on credentialing and privileging decisions of distant site entity when making recommendations for privileges
  - Entity must ensure services permit hospital to comply with CoPs
  - Entity's P&C process and standards meet CoPs
  - Practitioner licensed in state where patients located
  - Adverse events/complaints communicated back to distant-site entity

Medical Staff Organization 347

- **Standard:** MS (Medical Staff) is accountable to Board for the quality of medical care
  - Medical staff must be organized in a manner approved by the board
  - If MS has executive committee – majority of members must be MD/DO
  - Responsibility for the MS is assigned to MD, DO, dentist or podiatrist

Interpretive Guidelines

- CoPs create system of checks and balances with overall framework between board and MS
  - Each has its own areas of authority
  - MS provide oversight through peer review and
- Governing body establishes the categories of healthcare professionals eligible for privileges and appointment
- Medical staff applies the criteria for privileges and appointment
  - Makes recommendations on appointment

Survey Procedures

- Will verify
  - Medical staff has a well organized-formalized organizational structure
  - Have lines delineated between the MS and the Board
  - If an MEC – majority of members are MD/DO
  - An individual MD/DO or other is responsible for conduct and organization of medical staff
- Will interview CEO and MS leadership – mechanisms to fulfill duties

Unified and Integrated Medical Staff 348

- Can have a separate and distinct medical staff (MS) for each hospital in a system or
  - A unified and integrated medical staff
  - Must be allowed by state law and establish P&P
  - Must be consistent with MS bylaws
  - MS must have voted and passed by a majority vote
- The medical staff remains responsible for the quality of care provided to patients

Hospital Part of a System 348

- **Standard:** If hospital is part of a system of multiple separately certified hospitals
  - Can elect to have unified and integrated medical staff
  - Must comply with State and local law
- May use one medical staff organization and structure for multiple hospitals
- Must meet all the requirements of the section
  - Must meet all the requirements of the section
- Must share a governing body

Advantages

- Not necessary for each of the hospitals to have:
  - Own distinct medical staff organization and structure
  - Medical staff bylaws
  - Rules & requirements
  - Credentialing and peer review
  - Leadership
  - Etc.

How it Works

- A hospital system consisting of separately certified hospitals
  - Must describe the process for self governance, peer review, appointment, C&P, oversight, due process etc.
- Medical staff would have to pass a vote by the majority to have a unified integrated medical staff
- Hospitals must be part of the system
  - Not simply multi-campus hospitals

Medical Staff

- The unified medical staff
  - Organized and integrated as one body
  - Operates under one set of bylaws approved by governing body
  - Bylaws must apply equally to all practitioners within each category
  - And at all locations
  - To care provided at all locations

Some Specifics

- If had a shared MS before July 11, 2014
  - Must have evidence of the board's election to do this
  - Must still be consistent with state law & document
- MS must still be informed of the right to change their minds and opt out of the shared MS
- 348 and 349 – extensive guidelines
  - Best to read closely

Hospital Part of a System 349

- If hospital is part of a hospital system – can decide to have shared MS if consistent with state law
- MS who hold privileges must have voted by a **majority**
  - To be a shared MS
  - Or to opt out and have a single MS
  - Physicians who only hold telemedicine privileges are not eligible to vote
- Board must also approve
- Must amend bylaws and R/R

Requirements for Shared MS 350

- **Standard**: Hospital systems that elects to have a shared MS must demonstrate
  - There are revised MS bylaws and R/R
  - Describe the process for self governance, appointment, C&P, and oversight
  - Describe process for peer review P&P and due process rights
  - Include process to opt out later of the shared MS
- Will look for documentation of the above things

Unique Circumstances 351

- **Standard:** If hospital is part of a system and decides to have a shared MS then must consider each member hospital's unique circumstances
- Must consider any difference in patient populations
  - EX: rehab hospital, children's hospital, acute care, LTC, or behavioral health hospital
- Leadership and MS must be able to explain decision

Policies and Procedures 352

- Unified and integrated medical staff must establish and implement policies and procedures
  - Ensure needs and concerns
  - Expressed by member
  - Of medical staff
  - At each separately certified hospital
  - Given consideration

Survey Procedure

- Surveyor may ask:
  - Are standing orders approved in each certified hospital and by nursing and pharmacy leadership
  - Are there P&P to minimize drug errors
  - Does the formulary system by the MS or consent requirements take into account any unique circumstances
  - Does this include ensuring infection control problems are identified

Medical Staff Bylaws 353, 354, 355

- **Standard**: MS must adopt and enforce bylaws
- **Standard:** Board must approve bylaws and any changes also
  - TJC has MS.01.01.01: when to put things in the by-laws, rules or responsibilities or policies
  - TJC does C&P tracer since such an important area
- **Standard**: MS bylaws must include statement of duties and privileges in each category
  - Participate in PI, evaluate practitioner on objective criteria, promote appropriate use of health care resources

Privileges

- Privileges for each category
  - Active – courtesy – consulting – referring
- Cannot assume every practitioner can perform every task/activity/privilege specified for that category
- Individual ability to perform each must be individually assessed
  - Core privileging (355)

Organization of Medical Staff 356

- **Standard:** MS bylaws must describe organizational structure of the MS
  - Must lay out the rules/regulation
  - To make clear what are acceptable standards of patient care for diagnosis, medical, surgical care, and rehab
- Survey procedure
  - Describe formation of MS leadership
  - Verify bylaws to describe who is responsible for review and evaluation of the clinical work of MS

Qualifications for Appointment 357

- **Standard**: MS bylaws must describe the qualifications to be met for membership on the MS
  - Individual character
  - Individual competence
  - Individual training
  - Individual experience
  - Individual judgement
- Board certification or society membership alone insufficient

Qualifications for Appointment

- Other qualifications to consider
  - Provide level of acceptable care
  - Complete medical records timely
  - Participate in QI
  - Currently licensed, etc.
- Survey procedure
  - Bylaws describe qualifications
  - Criteria in writing

History and Physical 358 2020

- **Standard**: bylaws must include a requirement that a history and physical (H&P) be completed
  - No more than 30 days before
  - Or 24 hours after admission on each patient
  - Prior to surgery/procedure requiring anesthesia
- Exception: the healthy outpatients having surgery or an outpatient procedure
- Must be completed and documented
  - MD/DO
  - Oral and maxillofacial surgeon or other qualified provider

Exception to H&P

- MS must have P&P identifies appropriate patients and any updates
  - Must be on chart before surgery
  - Would need a pre-procedure assessment or pre-surgery assessment documented in the chart
    - Must include medications and allergies
  - H&P not required for healthy outpatients

Updated Exam Interpretive Guidelines 359

- If no changes in patient's condition found upon examination
- Provider may indicate in the medical record
  - H&P reviewed
  - Patient examined
  - And "no change" has occurred since H&P completed
- Any changes are documented
- If H&P incomplete, inaccurate otherwise unacceptable – may disregard and do another one

When H&P Not Needed 360 New

- The bylaw must require an assessment be done when an H&P is not required
  - Documented in the medical record after registration
  - Must be done before surgery or a procedure requiring anesthesia
- Assessment can be done by a physician, oral and maxillofacial surgeon or other qualified person in accordance with state law and hospital P&P
- Must be done and documented prior to the surgery/procedure

Policy Identifies the Patient Type 361 New

- Medical staff must develop and maintain a policy
- Identifies patient for whom assessment would apply
- Not required – but an option
- Medical staff may choose to require full H&P

Policy Must Include 362 New

- Patient age
- Diagnoses
- Type and number of surgeries
- Procedures to be performed
- Comorbidities
- Level of anesthesia required
- Nationally recognized guidelines and standards of practice
  - For assessment of specific types of patients
  - prior to specific outpatient surgeries and procedures
- Consistent with any state laws

Radiology

TJC Radiation Risks of Diagnostic Imaging

- TJC sentinel event alert and updates Feb 2019*
- The higher the dose of radiation delivered – the greater the risk for long-term damage
  - With repeated doses – harm can occur
- Risk of ionizing radiation: cancer, burns, and other injuries
- X-rays are classified as a carcinogen by WHO

TJC Radiation Information

- Exposure to ionizing radiation has doubled in past 2 decades
- 74 million CTs in 2017 and estimated 29,000 future cancers and 14,500 deaths due to radiation
- 2019 TJC had fluoroscopy changes

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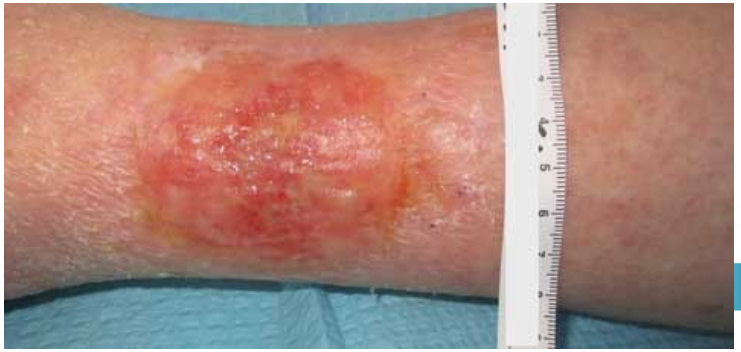
Factors to Eliminate Avoidable Radiation Exposure

- Have a patient safety program and effective P&Ps
- Provide education
  - On managing radiation exposures and optimizing radiation doses
  - On potential dangers of excessive radiation exposure and have a radiation safety officer
  - On typical radiation doses and dose ranges

Factors to Eliminate – continued

- Have clear protocols that identify the maximum dose for each type of study
- Consult with a medical physicist when designing or altering scan protocols
- Train on how to use complex new technology
- Communicate among clinicians, medical physicists, technologists and staff and total 20 recommendations



Radiology – Generally

- Patient exposure to ionizing radiation has doubled in 20 years
  - Due to diagnostic imaging, CT, fluoroscopy, and nuclear medicine (NM) studies
  - Amount of ionizing radiation from CT scan is significantly greater and patient may receive several over their lifetime
  - 80 million studies done every year
- FDA has taken initiatives to reduce unnecessary radiation exposure*
  - Want to make sure it **justified** to use it and dose optimization so **lowest dose** is used (as low as reasonably achievable)

FDA Changes

- Changes discuss safety precautions a hospital should do to decrease radiation exposure such as:
  - Need to identify high risk patient for whom a diagnostic study might be contraindicated
  - Use appropriate shielding of patients and staff that is specific to the type of imaging device
  - Periodically inspect and calibrate the equipment
  - Make sure staff are appropriately trained

Radiology 528

- **Standard:** Must have diagnostic radiology services which must meet professional standards for safety and staff qualifications
  - Diagnose a fracture or presence of a tumor
- If provide therapeutic services – must also meet these standards
  - Stenting an artery or lithotripsy of a kidney stone

Interpretive Guidelines

- Must have P&P for radiology safety
  - Make sure all staff are qualified
- Consider one unified radiology services
  - Regardless where performed through out the hospital
  - Under the direction of a radiologist
- Interpretive guideline explains different tests
  - CT scans – DEXA scans – x-rays – fluoroscopy – radiation therapy – ultrasound – MRI, etc.

Radiology 529

- **Standard:** Hospital must have radiology services to meet needs of patients
- Need to have diagnostic radiology services on site
  - Meet the patient's needs
  - Based on volume and types of patients served
- Must be available at all times on campus or nearby
- Can be performed by hospital and hospital staff
  - Via contracted services

Scope and Complexity

- Scope and complexity of diagnostic services must be in writing
  - Therapeutic radiology services are optional
- Interpretation can be via teleradiology
  - Practitioner must be privileged
- ED: make sure services are available at all times
- Surveyor will ask
  - How the hospital has determined the needs of its patients
  - How ensure diagnostic radiology service provided promptly when needed

Question 2

- Our radiology service can provide the entire facility with adequate results in a timely manner, regardless of the time of day.
  - Yes
  - No
  - Prefer not to answer

Therapeutic Radiology 535

- If therapeutic services are provided must meet approved standards for safety
- Radiology services, especially ionizing radiology procedures, must be free from hazards to both patients and staff
- Need P&P to ensure safety and that acceptable standards are met
  - X-rays can cause cataracts, skin damage, & cancer
- MRIs can cause burns, adverse events, risk of flying magnetic items

Standards of Practice

- All radiology services must be provided in accordance with the acceptable standard of practice
  - Example: ACR standards on MRI safety
  - CMS mentions many others
    - Includes FDA, AMA
- Must comply with all state and federal laws

Policies & Procedures

- P&P must include:
  - Principle of as low as reasonably achievable (ALARA)
    - Defined by the EPA
  - Written protocols used or approved by radiologist
    - Ensure studies performed safely and according to specifications
  - Must identify patients at high risk of an adverse event
    - Pregnant – allergy to contrast – implanted devices
  - Requirements to mitigate radiation hazards

Policies & Procedures – cont'd

- P&P must include (continued):
  - Procedures to address risks associated with MRI
  - Training required by staff to enter area where services are provided
  - Staff are trained and competent including training on P&P and how to operate the equipment
  - How to respond to an emergency and must have emergency equipment such as crash cart

Survey Procedures

- Will verify there are written P&Ps for services
  - Is staff familiar with P&P?
  - Are P&P followed
- Hospital must monitor the quality and safety of radiology services
  - Proper patient preparation such as IV access
  - Repeat studies of same patient may be indicator of poor image quality
- Are several blue boxes – advisories or recommendations

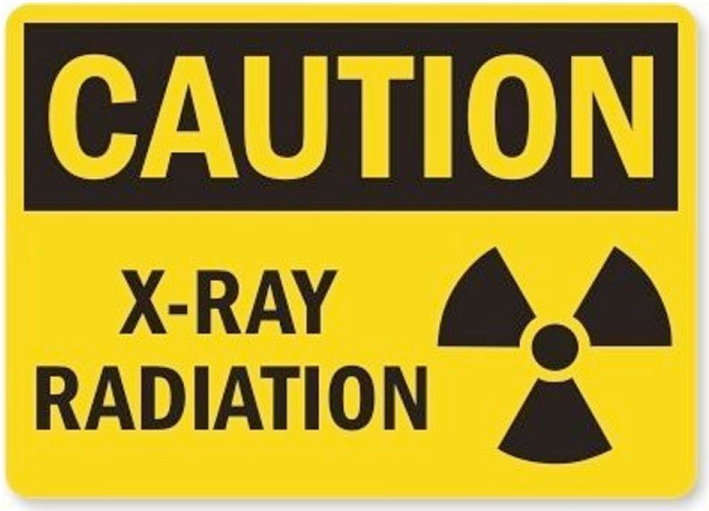
Follow EPA's Guidance on Radiation Doses

For Information Only – Not Required/Not to be Cited

Hospitals are encouraged to follow the recommendation in the EPA's Guidance Report No. 14 concerning patient radiation dosage. The report says "As the ICRP [International Commission on Radiological Protection] has stated, 'Provided that the medical exposures of patients have been properly justified and that the associated doses are commensurate with the medical purpose, it is not appropriate to apply dose limits or dose constraints to the medical exposure of patients, because such limits or constraints would often do more harm than good' (ICRP 2007b). While dose limits do not apply to medical exposures, radiation doses to patients should always be optimized. All responsible parties should always strive to minimize patient irradiation to the dose that is necessary to perform the procedure with adequate image quality. ***The recommendation against establishing absolute dose limits should not discourage a facility from implementing diagnostic reference levels for imaging and interventional procedures. Exceeding these levels should prompt a review of practice at the facility as a quality assurance measure. Dose notification and alert values for CT, notification levels for use during interventional procedures, and trigger levels for follow-up after interventional procedures are also appropriate QA measures [emphasis added]****...(EPA Guidance Report No. 14, p.6)*

Safety Precautions 536

- Need proper safety precautions against radiation hazards
  - Clear and easily recognizable signage – radiation area
  - Such as adequate shielding for patients and staff
  - Appropriate labeling, storage and disposal of radioactive materials



Inspection of Equipment 537

- Must perform periodic inspection of equipment
  - Ensure hazards identified and corrected
  - Need P&P to make sure equipment is periodically inspected and calibrated
  - Follow manufacturers instructions
  - Have a system to track all modifications
    - May affect accuracy of dosage delivered
  - Adverse events re: over-or under-dosing identified and addressed

Worker Safety 538

- Radiation workers must be checked periodically for amount of radiation exposure (538)
  - I.e. – dosimeter badges
  - Identify in policy who required to wear
  - Identify types and location of staff exposed to radiation and could include nursing
  - Staff must be trained in proper use of badges
  - Policies must be approved by the radiologist
- Surveyor may ask what you do when staff exposure exceeds parameters

Additional Radiology Provision

- Need an order for radiology service (539)
  - Medical Staff and Board decide who can order
  - May include practitioners who do not have privileges
- Must have a qualified radiologist to supervise the ionizing radiology services (546)
  - If a consultant – must be privileged
  - Same for teleradiologist
- Must only interpret those tests determined to require a radiologist's specialized knowledge

Additional Provisions – continued

- Only qualified personnel may use radiology equipment (547)
  - Such as radiologist or radiology tech
  - Must know how to respond to adverse events
- Ensure reports are signed by the practitioner who interpreted them (553)
- Records must be maintained for at least 5 years
  - Copies of reports, films, scans, digital files, and printouts

Radiology Records 553

- Radiologist must sign reports they interpreted
- Records must be maintained for at least 5 years
  - Copies of reports, films, scans, digital files, and printouts
  - Check to see if State law requires longer period
- Records must be maintained for all procedures performed
- Surveyor to determine which staff are using which piece of equipment and if qualified

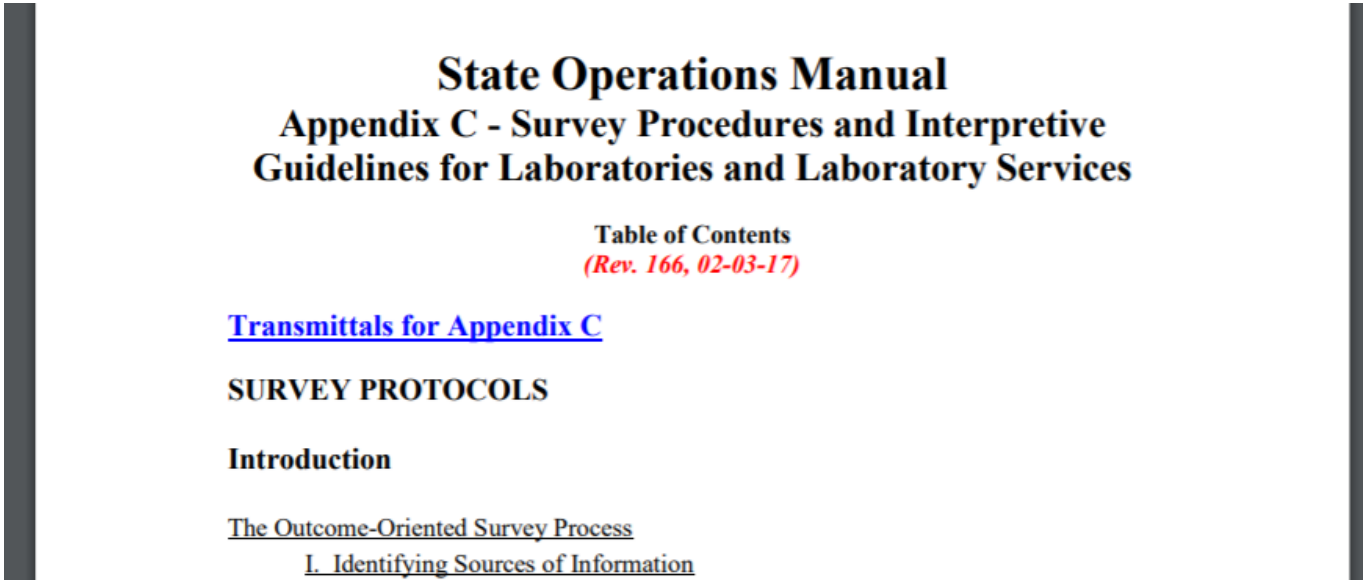
Laboratory Services and Look Back Program

Laboratory Services 576

- Must have adequate lab services to meet the needs of patients
  - Services must be performed in a CLIA certified facility
    - Have a current certificate
  - Services in any department must meet these guidelines
  - At any and all locations
- Can be provided directly or as contracted service
  - Must be incorporated into hospital-wide QAPI

Lab Services – continued

- Lab results are considered medical records and must meet all MR CoPs
- Laboratory Conditions of Participation are in Appendix C



State Operations Manual

Appendix C - Survey Procedures and Interpretive Guidelines for Laboratories and Laboratory Services

Table of Contents

(Rev. 166, 02-03-17)

NASH HEALTHCARE CONSULTING

Adequacy of Lab Services 582

- Must have lab services available
  - Direct or via contract
  - With CLIA certified lab
- Survey Procedures
  - Will determine which services direct and which via a contract
  - Will verify if referral lab is CLIA certified for appropriate test specialty

Joint Commission Standards

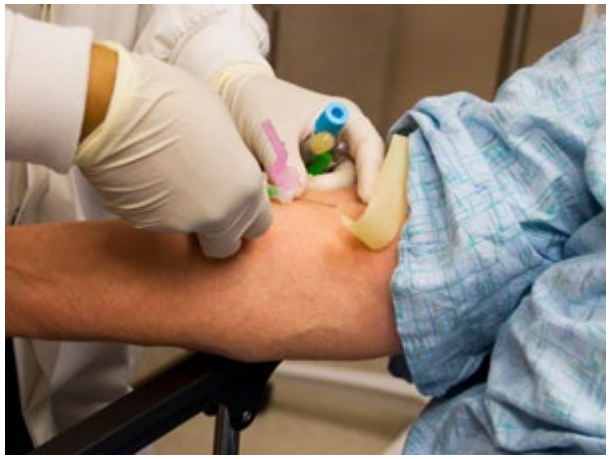
- Environment of Care – maintenance of equipment, emergency preparedness
- Human Resources – qualifications of staff
- Infection Prevention
- Leadership ensures
  - Testing and CLIA certificate
  - Lab services provided
- Waived Testing
  - Policies and procedures
  - Person responsible for performing and supervision
  - Staff and LIPs performing testing competent
  - Quality Control checks on each procedure
  - Records maintained for testing

Emergency Lab-Services Available 583

- Must provide emergency lab services 24/7
  - Directly or indirectly (contracted)
- Multiple campuses –available 24/7 each campus
- Medical staff must determine what lab tests will be immediately available
- Should reflect the scope and complexity of the hospital's operations
  - Written description of emergency lab services available
  - Written description of test available are provided to MS on routine and stat basis

Written Description of Services 584

- Written description of services provided must be available to medical staff
- Surveyor will verify written description exists
  - Plus – the description is accurate and current



NASH HEALTHCARE CONSULTING

Tissue Specimens 585 & 586

- Lab must make provisions for proper receipt and reporting tissue samples (585)
  - Have written instructions for the collection, preservation, transportation, receipts, and reporting of tissue specimen results
- Medical Staff and pathologist must determine when tissue specimens need macroscopic (gross) and microscopic examination (586)
  - Must have written policy on this

Potentially Infectious Blood 592 2020

- Potentially HIV and Hep C infectious blood/products are prior collections from donor who:
  - Tested negative at time of donation but later tests reactive for HIV infection at later donation
  - Tests positive on supplemental test/other follow-up testing required by FDA
  - For whom timing of seroconversion cannot be precisely estimated

Blood and Blood Components

- If regularly use services provided by outside blood collecting establishment (blood bank)
  - Need agreement to govern procurement, transfer and availability of blood and blood products
  - Agreement must require blood bank to notify hospital promptly of HIV and HCV infections

Blood Banks – Time Frames

- If tested negative at time of donation but later tested positive or determined to be at increased risk for transmitting
  - Within 3 calendar days
  - Within 45 days of test – results of additional more specific test for HIV/HCV or other follow-up testing required by FDA
  - Within 3 calendar days after blood bank supplied blood or components from infectious donor
    - Whenever record available

Quarantine of Blood or Components

- If blood bank notifies hospital of positive results
  - Hospital must determine disposition of blood and quarantine from previous donations in inventory
- If blood bank notifies hospital results of additional testing is negative and no other test results
  - Hospital may release the blood

Positive or Indeterminate Results

- If notifies hospital results of additional testing required by FDA are positive must
  - Dispose of blood
  - Notify transfusion recipients
- If blood bank notifies hospital results of additional testing required by FDA are indeterminate must
  - Destroy or label prior collections held in quarantine

Record Keeping and Patient Notification

- Must document source and disposition of all units and keep records for 10 years
- Notification – make reasonable attempts to notify patient and document in record
  - Or attending who ordered the blood and have them notify patient

Patient Notification

- Must have 3 things in the notice:
  - Explanation of need for HIV and HCV testing and counseling
  - Enough oral/written information so patient can make informed decision re: testing/counseling
  - List of programs where can get counseled and tested
- Must make and document 3 attempts in 12 weeks to notify patient unless unable to locate
  - Then document in medical record extenuating circumstances beyond hospital's control resulting in notice exceeding 12 weeks

Notice to Representative or Relative

- If adjudged incompetent – legal representative
- If competent but State law permits representative or relative to receive information on patient's behalf – patient or representative or relative
- If deceased – legal representative or relative
- If minor – parents or legal guardian
- Have policies and procedures for notification and documentation
  - Including requirements for confidentiality and other patient information

Policies and Procedures

- Must have policies and procedures for
  - Notification and documentation
  - Conforms to Federal, State and local laws
- Must include requirements for ensuring confidentiality of records and information

NASH HEALTHCARE CONSULTING

Look Back Activities 593

- For lookback activities only related to new blood safety issues identified after August 24, 2007
- Must comply with FDA regulations pertaining to blood safety issues in:
  - Appropriate testing and quarantining of infectious blood and components
  - Notification and counseling of recipients that may have received infectious blood and components

Food and Dietetic Services

Need for Change

- CMS recognized CoPs too restrictive and lacked flexibility to allow hospitals to extend privileges to RD (Registered Dietician) in accordance with state law
- Believe best qualified to assess patient's nutritional treatment plan, design and implement a nutritional treatment plan
- Used the term RD
- Note – not all states call them RD
  - Licensed dieticians (LD)
  - Qualified nutrition specialists

CMS Changes

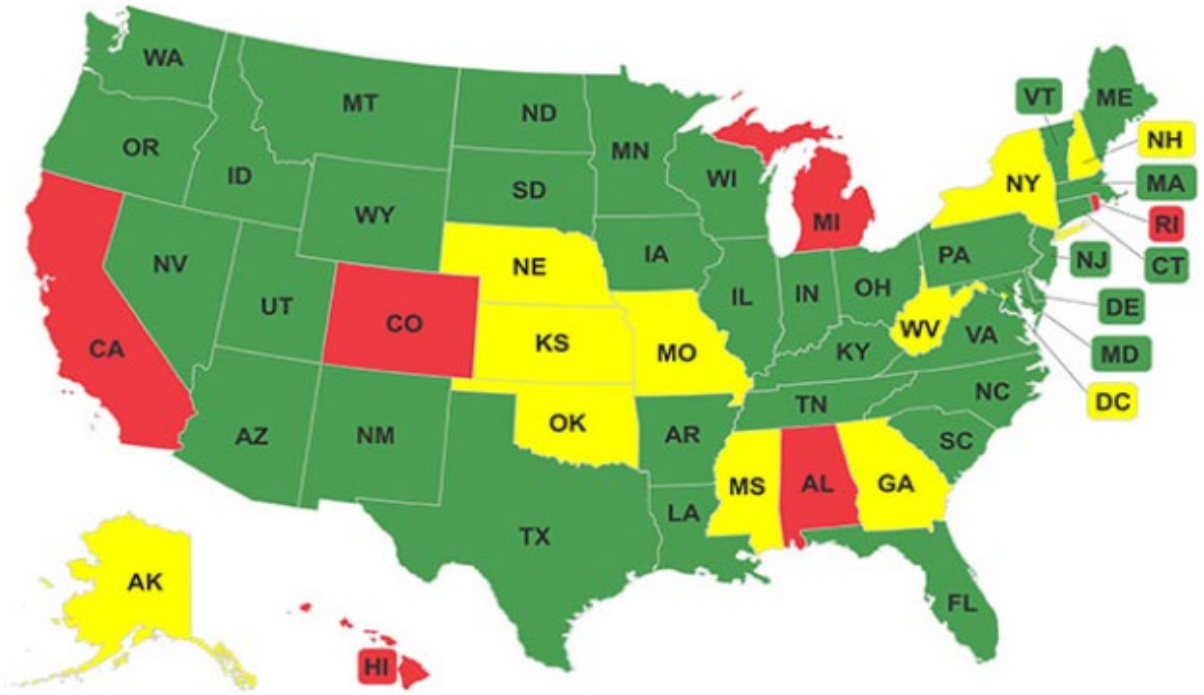
- Included qualified dieticians (such as a RD) as a practitioner who
  - May be privileged to order patient diets (Enteral and parenteral nutrition, supplemental feedings and therapeutic diets) or
  - Order related lab tests
- Dietician or nutritional specialist can be granted nutrition ordering privileges by the Medical Staff (MS) and board
- This can be with or without appointment to the MS

CMS Changes – continued

- Would permit registered dietitians or nutritional specialist to order patient diets independently
  - Without requiring the supervision or approval of a physician or other practitioner
  - When credentialed and privileged
  - Includes swing bed patients

https://www.eatrightpro.org/advocacy/licensure/therapeutic-diet-orders-state-status-and-regulation

Therapeutic Diet Orders: State Status and Regulation



Updated July 2020

The information below is a resource for Academy members considering seeking privileges to order therapeutic diets in the hospital setting. We have sought to identify all relevant statutes and regulations related to therapeutic diet ordering in each state and provide a brief analysis of each state's relevant law.

NASH HEALTHCARE CONSULTING

Food and Dietetic Services 618

- Hospital must have organized dietary services
  - Directed and staffed by adequate qualified personnel
- If contract with outside company:
  - Company must have a dietician
  - Serves hospital on full- part time or consultant basis
  - Maintain minimum standards of the CoPs
  - Provide for liaison with MS on recommendations on dietary policies

Organization

- Dietary services must be organized, directed and staffed
  - Ensure nutritional needs of the patient are
  - Met in accordance with physician orders
  - Plus – acceptable standard of practice

7 Dietary Policies Required

- 1. Availability of diet manual and therapeutic diet menus
  - Sometimes called Nutrition Care Manual (NCM) or Pediatric Nutrition Care Manual (PNCM)
- 2. Frequency of meals served
- 3. System for diet ordering and patient tray delivery
- 4. Accommodation of non-routine occurrences
  - Parenteral nutrition – including TPN and peripheral parenteral nutrition, supplements
  - Changes in diet orders, early/late trays

7 Policies Required cont'd

- 5. Integration of food and dietetic services into hospital wide QAPI and infection control programs
- 6. Guidelines on acceptable hygiene practices of personnel
- 7. Guidelines for kitchen sanitation
  - Important to protect against germs and bacteria that cause illness

Organization 620

- Must have full time employee
  - Serves as director
  - Responsible for daily management of dietary services
  - Must be granted authority and delegation by the Board and MS for the operation of dietary services
- Job description should be
  - Position specific
  - Clearly delineate authority for direction of food and dietary services
  - Includes training programs for dietary staff, ensuring P&Ps are followed and scope/complexity of operations

5 Policies Director Must Develop

- Safety practices for food handling
- Emergency food supplies
- Orientation, work assignment, supervision of work and personnel performance
- Menu planning including:
  - Purchase of foods and supplies
  - Retention of essential records (cost, menus, training records, QAPI reports)
- Service QAPI program

Dietitian 621

- Must have qualified dietitian
  - Full/part time or consultant
- Must supervise nutritional aspects of patient care
  - Approve patient menus and nutritional supplements
- Provide patient/family dietary counseling
- Perform and document nutritional assessments

Dietitian Responsibilities – continued

- Evaluate patient tolerance to therapeutic diets when appropriate
- Collaborate with other services (MS, nursing, pharmacy, social work)
- Maintain data to recommend, prescribe therapeutic diets
- If not full time – hospital must make provisions for when consultation is needed

Additional Requirements

- Must have administrative and technical personnel competent in their duties (622)
- Menus must be nutritional, balanced, and meet special needs of patients (629)
- Affected patients include
  - All inpatients
  - Outpatients who stay is long enough that they must be fed

Additional Requirements – continued

- Patients must be assessed for risk of
  - Nutritional deficiencies
  - Need for therapeutic diets
  - Need for supplements

- TJC – PC.01.02.91 – nutritional assessment should be done

Question 3

- Our dietary services are provided: (check all that apply)
  - In-house
  - By contract
  - Include requirements for providing healthy meals for staff/visitors
  - Need work

Dietary Services

- The IOM's Food and Nutrition Board's Dietary Reference Intake (DRI)* 4 reference values includes:
  - 1. RDA or the recommended dietary allowance is average dietary intake of a nutrition sufficient of healthy people
  - 2. Adequate Intake (AI) for a nutrient is similar to the ESADDI and is only determine when an RDA can be determined
    - Estimated Safe and Adequate Daily Intake (ESADDI)
    - AI is based on observed intakes of the nutrient by a group of healthy persons

IOM's DRI – cont'd

- DRI reference values (continued)
  - 3. Tolerable Upper Intake Level (UL) – highest daily intake of a nutrient that is likely to pose no risks of toxicity for most people
    - As the UL increase, risk increases
  - 4. Estimated Average Requirement (EAR) is the amount of the nutrient that is estimated to meet the requirement of half of the health people

USDA provides access to an interactive DRI tool and DRI tables at http://fnic.nal.usda.gov/dietary-guidance/dietary-reference-intakes

Dietary Reference Intakes (DRIs): Estimated Average Requirements

Food and Nutrition Board, Institute of Medicine, National Academies

Life Stage Group	Calcium (mg/d)	CHO (g/kg/d)	Protein (g/d)	Vit A (μg/d)[a]	Vit C (mg/d)	Vit D (μg/d)	Vit E (mg/d)[b]	Thiamin (mg/d)	Ribo-flavin (mg/d)	Niacin (mg/d)[c]	Vit B_6 (mg/d)	Folate (μg/d)[d]	Vit B_{12} (μg/d)	Copper (μg/d)	Iodine (μg/d)	Iron (mg/d)	Magnes-ium (mg/d)	Molyb-denum (μg/d)	Phos-phorus (mg/d)	Sele-nium (μg/d)	Zinc (mg/
Infants																					
0 to 6 mo																					
6 to 12 mo			1.0													6.9					2.5
Children																					
1–3 y	500	100	0.87	210	13	10	5	0.4	0.4	5	0.4	120	0.7	260	65	3.0	65	13	380	17	2.5
4–8 y	800	100	0.76	275	22	10	6	0.5	0.5	6	0.5	160	1.0	340	65	4.1	110	17	405	23	4.0
Males																					
9–13 y	1,100	100	0.76	445	39	10	9	0.7	0.8	9	0.8	250	1.5	540	73	5.9	200	26	1,055	35	7.0
14–18 y	1,100	100	0.73	630	63	10	12	1.0	1.1	12	1.1	330	2.0	685	95	7.7	340	33	1,055	45	8.5
19–30 y	800	100	0.66	625	75	10	12	1.0	1.1	12	1.1	320	2.0	700	95	6	330	34	580	45	9.4
31–50 y	800	100	0.66	625	75	10	12	1.0	1.1	12	1.1	320	2.0	700	95	6	350	34	580	45	9.4
51–70 y	800	100	0.66	625	75	10	12	1.0	1.1	12	1.4	320	2.0	700	95	6	350	34	580	45	9.4
> 70 y	1,000	100	0.66	625	75	10	12	1.0	1.1	12	1.4	320	2.0	700	95	6	350	34	580	45	9.4
Females																					
9–13 y	1,100	100	0.76	420	39	10	9	0.7	0.8	9	0.8	250	1.5	540	73	5.7	200	26	1,055	35	7.0
14–18 y	1,100	100	0.71	485	56	10	12	0.9	0.9	11	1.0	330	2.0	685	95	7.9	300	33	1,055	45	7.3
19–30 y	800	100	0.66	500	60	10	12	0.9	0.9	11	1.1	320	2.0	700	95	8.1	255	34	580	45	6.8
31–50 y	800	100	0.66	500	60	10	12	0.9	0.9	11	1.1	320	2.0	700	95	8.1	265	34	580	45	6.8
51–70 y	1,000	100	0.66	500	60	10	12	0.9	0.9	11	1.3	320	2.0	700	95	5	265	34	580	45	6.8
> 70 y	1,000	100	0.66	500	60	10	12	0.9	0.9	11	1.3	320	2.0	700	95	5	265	34	580	45	6.8
Pregnancy																					
14–18 y	1,000	135	0.88	530	66	10	12	1.2	1.2	14	1.6	520	2.2	785	160	23	335	40	1,055	49	10.5
19–30 y	800	135	0.88	550	70	10	12	1.2	1.2	14	1.6	520	2.2	800	160	22	290	40	580	49	9.5
31–50 y	800	135	0.88	550	70	10	12	1.2	1.2	14	1.6	520	2.2	800	160	22	300	40	580	49	9.5
Lactation																					
14–18 y	1,000	160	1.05	885	96	10	16	1.2	1.3	13	1.7	450	2.4	985	209	7	300	35	1,055	59	10.9
19–30 y	800	160	1.05	900	100	10	16	1.2	1.3	13	1.7	450	2.4	1,000	209	6.5	255	36	580	59	10.4
31–50 y	800	160	1.05	900	100	10	16	1.2	1.3	13	1.7	450	2.4	1,000	209	6.5	265	36	580	59	10.4

NOTE: An Estimated Average Requirement (EAR) is the average daily nutrient intake level estimated to meet the requirements of half of the healthy individuals in a group. EARs have not been established for vitamin K, pantothenic acid, biotin, choline, chromium, fluoride, manganese, or other nutrients not yet evaluated via the DRI process.

Therapeutic Diet

- May help meet the patient's nutritional needs
  - Assess patients for risk of nutritional deficiencies
- Refer to a diet ordered as part of the patient's treatment
  - For a disease or clinical condition
  - Or to eliminate, decrease, or increase certain substances in the diet(e.g., sodium or potassium),
  - To provide mechanically altered food when indicated

Patient Assessment

- Patients must be assessed to determine if they need a therapeutic diet for other nutritional deficiencies
  - Include in patient's care plan
  - Include the need to monitor intake
  - Include if need daily weights, I&O, or lab values
- Nursing does an admission assessment which includes a nutritional screen
  - Helps determine the patient's risk
  - If a dietary consult is needed

Nutritional Assessment Includes

- Patient may need comprehensive assessment if:
  - Medical or surgical conditions or physical status interferes with their ability to digest or absorb nutrients
  - Patient has S&S indicating risk for malnutrition
    - Anorexia, bulimia, electrolyte imbalance, dysphagia, ESRD or certain medications
  - Patient medical condition adversely affected by intake and so need a special diet
    - CHF, renal disease, diabetes, etc.
  - Patient receiving artificial nutrition
    - Tube feeding, TPN, or peripheral parenteral nutrition

Substitutes

- Patients who refuse food should be offered substitutes of equal nutritional value – to meet basic nutritional needs
  - Care plan must address
  - Including monitoring of status
    - Weight
    - I&O
    - Labs

Survey Procedure

- Surveyor will ask dietician
  - How the menus and nutritional needs of patient are being met
  - EX – rely on DRIs, including RDA
  - Will ask how patients identified as having specialized needs are monitored
  - Will look for order for therapeutic diet
  - Will look at sample of patient records of patients identified with special nutritional needs

Diet Order Needed 630

- Standard: Need an order for all patient diets including therapeutic diets
  - Must be by practitioner responsible for care (doctor, PA, NP)
  - Qualified dietician or qualified nutritional professional
  - Authorized in the medical staff bylaws
  - Consistent with state law
- A few states prohibit a dietician to prescribe a therapeutic diet – against state law

Diets

- Must be based on an assessment of the patient's nutritional and therapeutic needs
  - Must be documented in the medical record
  - Including patient's tolerance to the therapeutic diet
    - Patient has a new diagnosis of CHF and put on a 2-gram low sodium diet and losses weight because she does not like the taste of the food without salt
- Board may permit the medical staff to grant privileges to dieticians or nutritional professionals

Qualified Dietician/Nutrition Professional

- Many states have a specific statute that determines
- Registered dietician may be defined to include one who is registered with Commission on Dietetic Registration or state law
- Hospital must ensure person qualified before appointing them to the medical staff or C&P
- Other terms used to refer to persons not dieticians but may qualify per State law to order diets:
  - Nutritionists – nutrition professionals – certified clinical nutritionists – certified nutrition specialists

If Not Privileged/Credentialed

- If the hospital decides **not** to privilege and credential, even if that state's law allows
  - Patient must have a diet ordered by the practitioner responsible for the patient's care
- If not C&P – person can still do a nutritional assessment and make recommendations

Survey Procedure 630

- Surveyor
  - Will ensure diet is ordered and if dietician writes orders – confirm person C&P by medical staff
  - Will ask hospital to show them what national standard they are using
  - Review medical records to verify diet orders are provided as prescribed by the practitioner
  - Is to determine if patient's nutritional needs have been met
  - Will determine if dietary intake and nutritional status is being monitored

Therapeutic Diet Manual 631

- Current therapeutic diet manual
  - Approved by qualified dietitian and medical staff
  - Must be readily available to all medical/nursing/food service personnel
  - In accordance with current national standards
  - Includes various types diets routinely ordered
  - Used consistently as a guide for ordering/preparing diets
  - Must not be more than 5 years old

Utilization Review

Utilization Review – Generally

- Section only 8 pages
- Addresses services provided to Medicare and Medicaid patients
- TJC amended the leadership chapter (LD.04.01.01)
  - Requires a **UR plan** and **UR committee** with at least two physician members

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Utilization Review 652

- Hospital must have a UR plan that provides for
  - Review of services
  - Furnished by the institution
  - Furnished by members of the MS
  - To Medicare and Medicaid beneficiaries
- Plan should state responsibility and authority of those involved in the UR process

Exceptions – When UR Plan Not Needed 653

- Two exceptions to the UR plan requirement:
  - 1. The Utilization and Quality Control QIO has assumed binding review for the hospital
    - Must have an agreement with the QIO under contract by CMS to assume binding review
  - 2. CMS has determined the UR procedures established by the state under Medicaid are superior to the UR requirements for the Medicare program
  - Plus – has required the hospital to meet the UR requirements under section 456.50 to 456.245 (Utilization Control for Hospitals-Medicaid or Medical Assistance Programs)
    - None are currently approved by CMS

Survey Procedures

- Surveyor to verify
  - Hospital has a UR plan
  - UR plan meets the requirements
- If hospital has an agreement with a QIO
  - Surveyor do not need to assess the remaining UR standards
- If no contract with the QIO and not following the UR standards – can be cited at the condition level

Composition of UR Committee 654

- 2 or more practitioners must carry out UR function
  - At least 2 members must be doctors – MD/DO
- Committee must be either
  - Staff committee of the hospital or
  - An outside group established by the local medical society for hospitals in that locale
    - And established in a manner approved by CMS
- If facility small and impracticable to have properly functioning committee –
  - Establish as a outside group approved by CMS (above)

UR Committee – Limitation

- A committee may not be conducted
  - By an individual who has a direct financial or ownership interest (5% or more in Survey procedures)
  - Who was professionally involved in the care of the patient whose case is being reviewed
- Survey procedure
  - Determine UR committee composition
  - Will look to see if the governing board has delegated UR function to a outside group if impracticable to have a staff committee

Scope & Frequency of Reviews 655

- Completed for M/M patients re: medical necessity of admission, duration of stay and services provided
- Review of admissions – done before, at or after admission
- May be on a sample basis
  - Except for reviews of cases assumed to outlier cases
    - Extended stay
    - High costs

Scope & Frequency of Reviews

- Surveyor will examine UR plan to determine
  - Medical necessity is reviewed for admission, duration of stay and services provided
- IPPS (inpatient prospective payment system) hospital must conduct review of duration of stays and professional services
  - Duration – those cases reasonably assumed to be outliers based on length of stay
  - Professional services – outliers based on extraordinarily high costs

Admissions or Continued Stay 656

- Decision admission/continued stay not medically necessary determined by
  - One UR committee member if practitioner(s) concur
  - OR – fails to present views when given opportunity
  - Otherwise – must be made by at least 2 members
- Before determining admission/continued stay was not medically necessary
  - UR committee must consult the MD responsible for the care
  - Afford opportunity to present their views

Admissions/Continued Stay – continued

- If decide admission/continued stay not medically necessary must
  - Provide written notification
  - No later than two days after determination
  - To the hospital, patient and practitioner
- Key – document medical necessity that a second midnight hospitalization is medically necessary – the “2-midnight rule”

Review of Medical Necessity

- Review medical necessity for:
  - Appropriateness of the setting
  - Extended stays
  - Professional services rendered such as cardiac cath, ED, and radiology services
- Important given Recovery Audit Contractors or RACs
  - American Hospital Association, AHIMA, and CMS has website of resources for the RACs
  - RAC program to identify improper Medicare payments including overpayment and underpayments

Extended Stay Review 657

- If hospital not paid under IPPS – UR committee must conduct periodic review
  - Of each current inpatient receiving hospitals services
  - During continuous period of extended stay
- If paid under IPPS – must review ***all*** cases
  - Reasonably assumed to be outliers
  - Due to extended LOS exceed threshold criteria for diagnosis
- Must conduct no later than 7 days after day in set out in the plan

Review Professional Services 658

- UR committee must professional services provided
  - To determine medical necessity
  - Promote most efficient use of available health facilities and services
- Review includes:
  - Availability and use of necessary services
    - Underused, overuse, appropriate use
  - Timeliness of scheduling services
    - OR, diagnostic
  - Therapeutic procedures

Notice Act Law
MOON Form

Notice Act Law "MOON"

- "Medicare Outpatient Observation Notice"
- Requirements:
  - Give written notice to the outpatient observation patients
    - Plus – an oral explanation of the notification
  - Patients in an outpatient observation bed for more than **24 hours**
  - Need not wait 24 hours
  - Use revised forms after April 1, 2020 – only change was expiration date
  - Must be given before discharge and no later than **36 hours** after observation begins

MOON Notice

- Tells patient they are an outpatient receiving observation services
  - Not an inpatient
- Must explain the implications
  - Including cost sharing and post-hospitalization eligibility for SNF

MOON Notice – continued

- If patient refuses to sign:
  - Staff member can sign a certification statement that it was given
  - Date and time
- Use plain language
- Use form determined by the secretary

Notice Act Law

- Are several documents*
  - Includes the form in English and Spanish
  - Is in pdf and Word version
- Instructions on completing the form
- Rationale for the law
  - Medicare patient who was in observation for one day and then changed to inpatient status for two
  - The patient then transferred to the SNF only to learn $46,000 bill not covered
    - Did not have qualifying 3-day stay

Physical Environment and Maintenance

Physical Environment 700

- Hospital must be constructed, arranged, and maintained to ensure the safety of patient
  - And to provide diagnosis and treatment and for services appropriate for the community
- CoP applies to
  - All locations of the hospital
  - All campuses
  - All satellites

Facility Maintenance 701

- Maintenance and hospital departments responsible for the buildings and equipment must be incorporated into the QAPI program
  - Must also comply with the QAPI requirements
- Survey of physical environment should be conducted by one surveyor
- Life Safety Code survey may be conducted by specially trained surveyor
  - LSC very important and being hit hard in the surveys

Buildings

- Condition of physical plant and overall hospital environment must be developed and maintained for the safety and well being of patients
  - Make sure routine and preventive maintenance activities are done,
  - As manufacturer requires
  - By state and federal law
- Conduct ongoing maintenance inspections
  - Routine and PM and testing activities should be incorporated into hospital QAPI plan

Buildings Accessibility

- The hospital must be constructed and maintained to minimize risk for
  - Patients
  - Employees
  - Visitors
- Safety features must be addressed in accordance with nationally recognized standards
- Must ensure hospital meets State and Federal accessibility standards
  - OCR requirements

Age Related Features

- Hospital must address safety hazards and risks related to age
  - Includes neonatal, pediatric, and geriatric patients
  - Must be consistent with nationally recognized standards
- Age related risks include:
  - Access to medications cleaning supplies and other hazardous materials
  - Furniture
  - Medical equipment
  - Security and increased chance of falls

Security

- Hospital must have adequate security
  - To prevent elopement or patients from leaving
  - To also prevent unauthorized access to the unit
- Must meet nationally recognized standard
  - International Association for Healthcare Security has Security Guidelines

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Question 4

- Our security processes are:
  - Contracted
  - Employed
  - Not sure

Areas to Consider

- Patient Care
  - Prevention of newborns/infant abduction,
  - Pediatric patients
  - Behavioral health patients – elopement, self-harm
  - Patients with diminished capacity – dementia
- Prevent access to non-clinical rooms
  - Electrical rooms
  - Ventilation
  - HVAC rooms
  - Gas storage

Ligature Risk – Briefly

- Preventing inpatient suicide and creating a safe care setting is important to both TJC and CMS
- CMS wants a safe environment to prevent suicidal patients from hanging themselves or strangulation
  - Focuses on the care and safety of behavioral health patient and staff

Ligature Risks

- Presence of unmitigated ligature risks in psych hospital or dedicated psych unit is considered “Immediate Jeopardy”
  - Includes risks located where patients at risk for suicide are identified
- Ligature risk findings must be referred to the health and safety surveyors
- They will evaluate further and determine if hospital needs to be cited under tag 144 in patient rights

Weather-Related Issues & Power Strips

- Hospital must address weather related issues
  - Interior and exterior locations
  - Driveways, entry points, garages, and walkways
- Any power strips deficiencies must be reported to LSC surveyors for citation
  - Tag 701 has detailed discussion of power strips*
- Discusses when they can be used both outside and inside the patient care area

Emergency Systems 702 and 703

- Power and lighting required in OR, PACU, ICU, ER and stairwells (702)
  - Other areas – battery lamps and flashlights must be available
- Must be facilities for emergency gas and water supply (703)

Life Safety Code 710 2020

- Need positive latching hardware where flammable/combustible materials
  - No roller latches
- Hospital needs to meet the Life Safety Code
  - NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4
  - CMS may waive LSC if results in unreasonable hardship and will affect the health or safety of patients
- Outpatient surgery departments must meet the provisions applicable to ambulatory health care occupancies

Trash 713 2020

- Need a procedure for the proper routine storage and disposal of trash
  - Trash includes bio-hazardous waste
  - Storage of trash must be in accordance with state and federal law (EPA, CDC, OSHA, state environmental health and safety regulations)
  - Interpretive guidelines are pending
- Need policies for storage and disposal of trash

Additional Life Safety Requirements

- Written fire control plan (714)
  - Reporting
  - Extinguishing
  - Protection of patients, personnel and guest
  - Evacuation
  - Cooperation with authorities
- Written evidence of regular inspections & approval by state/local fire control agencies (715)

Alcohol Based Hand Rub Dispensers 716 2020

- The hospital may install alcohol-based hand rub dispensers
  - Must be installed in a manner that protects against inappropriate access
    - For example, on the psych unit do not to have in manner patient can drink it
- Amended for alcohol-based hand dispensers
- Interpretive guidelines are pending

Sprinkler System 717 2020

- If the sprinkler system is shut down for more than 10 hours the hospital must:
  - Evacuate the part of the building without the sprinkler until it is back in service
  - Establish a fire watch until it is back in service
- Interpretive guidelines are pending

Outside Window 718 2020

- Every sleeping room must have an outside window or outside door
  - The sill height must not exceed 36 inches above the floor for buildings constructed after July 5, 2016
  - Sill height in special nursing care areas of new occupancies must not exceed 60 inches
- The interpretive guidelines are pending
- NOTE: does not mention whether the window can be opened

Building Safety 720 2020

- The hospital must follow Health Care Facility Code
  - NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5 and TIA 12–6
  - Chapters 7, 8, 12, and 13 do not apply to hospitals
- CMS can give a waiver for an unreasonable hardship
  - As long as does not affect the health or safety of patients
- Interpretive guidelines are pending

Facilities 722 2020

- Maintain adequate facilities for its service –
  - Designed and maintained
  - Per federal, state, and local laws
  - Reflect scope and complexity of services per accepted standards of practice
- Toilets, sinks, and equipment should be accessible
- Water acceptable for its intended use such
  - Drinking – lab water – irrigation
  - Review water quality monitoring

Legionnaires' Disease (LD)

- The bacterium Legionella grows in parts of hospital water systems that are continuously wet such as
  - Water heaters and filters >Fountains & ice machines
  - Shower heads and hoses >Water storage tanks,
  - Eyewash stations, etc.
- Check your waterborne pathogen compliance
- Conduct a facility risk assessment - determine if it could spread in your facility water system

Diagnostic/Therapeutic Facilities 723 & 724 2020

- Standard: Diagnostic and therapeutic facilities located for the safety of patients (guidelines pending) (723)
- Standard: Facilities, supplies, and equipment must be maintained to ensure an acceptable level of quality and safety (guidelines pending) (724)
  - Must make sure condition of hospital is maintained in a manner to provide for acceptable level of safety for patients, visitors, and staff
  - Need supplies to meet patient needs
  - Ensure against theft or contamination of supplies
  - Need emergency supplies such as when a disaster occurs

Complexity of Building 725 2020

- Standard: The extent and complexity of facilities must be determined by the services offered
  - Needs to be large enough
  - Must be appropriately designed and equipped for the services the hospital provides
  - Must comply with all federal and state laws
- Surveyor to verify that the hospital is
  - Large enough
  - Properly equipped
  - For the number of patients and services provided

Ventilation, Light, Temperature 726

- There must be proper ventilation, light, and temperature controls in pharmacy, food preparation and other appropriate areas
- Guidelines pending
- Consider:
  - Ventilation where oxygen transferred, isolation rooms
  - Lighting – patient, medication and food prep rooms
  - Temperature/humidity/airflow – in OR*

CMS Memo April 2013 Relative Humidity

- AORN: temperature between 68-73 degrees and humidity between 30-60% in OR, PACU, cath lab, endoscopy rooms and instrument processing areas
- ASHE: 20-60%*
- CMS: if no state law can write policy or procedure or process to implement the waiver
  - Waiver allows RH between 20-60%
- In anesthetizing locations- see definition in memo*

Impact of Lowering the Humidity

- Lowering humidity can
  - Impact some equipment and supplies
  - Affect shelf life and product integrity of some sterile supplies – EKG electrodes
  - Some equipment may be affected by electrostatic discharge – especially older equipment
  - Can cause erratic behavior of software and premature failure of the equipment
  - It can affect calibration of the equipment
- Follow the manufacturers instructions for use that explains any RH requirements

Standards Incorporated by Reference 730 2020

- Discusses that the standards incorporated by reference were approved by the Director of the Office of the Federal Register
- Provides information on the National Fire Protection Association (NFPA)
- For information on the availability of this material at NARA, call 202–741–6030, or go to: www.archives.gov/federal_register/code_of_federalregulations/ibr_locations.htm l

Emergency Preparedness

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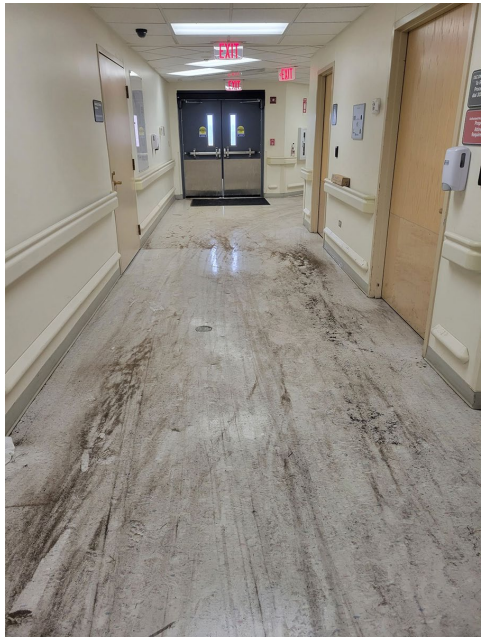

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Emergency Preparedness – Appendix Z

- Must plan for natural and man-made disasters
- Must train staff and conduct testing – annually
- Must coordinate with local, state and federal systems
- Must have adequate supplies
- Must assist providers to meet the needs of patients and others during a disaster

  - Questions: SCGEmergencyPrep@cms.hhs.gov

Emergency Preparedness

- Must perform risk assessment
  - Develop emergency plan based on assessment
  - Plan must be reviewed every 2 years
  - Must do training and testing and conduct full scale exercises
- Consider special needs of patient populations
  - Psyche patients
- Emergency fuel and generator testing
- Must have P&Ps

Other Considerations

- Security of patients and supplies
- Method to obtain
  - Pharmaceuticals
  - Food
  - Other supplies/equipment
- Staff
  - Qualification/training needed by personnel
  - Identification, availability and notification of personnel

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P&P Include

- Process to track location of on-duty staff and sheltered patients and if patients transferred
- Safe evacuation from the hospital
- System of documentation and ensure confidentiality
- Use of volunteers in an emergency
- A communication plan
  - Include name/contact information for staff, physicians, and others
  - Method to share information about the condition of patients

Discussion

- State surveyors arrived at Nations hospital unannounced due to concerns of immediate jeopardy – increase in newborn and pediatric abductions. Two infants and one 3-year-old were taken from the facility and later found unharmed and with a non-custodial parent. The processes or systems CMS will focus on should include:
  - Security systems – alarms
  - Nursing – observation
  - Documentation
  - Other

Speaker

- Lena Browning
- MHA, BSN, RNC-NIC, CSHA
- Consultant, Nash Healthcare Consulting
- 270-499-0843
- LBrowning@Nashhc.com
- Email questions to CMS:
  Critical Access Hospitals: qsog_CAH@cms.hhs.gov.
  Acute hospitals: **qsog_hospital@cms.hhs.gov.**

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APPENDIX and ADDITIONAL RESOURCES

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Worksheet Links

- Infection Control:
- https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/survey-and-cert-letter-15-12-attachment-1.pdf.
- Discharge Planning:
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-3.pdf.
- QAPI:
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-2.pdf.

Title	Memo #	Posting Date ▲	Fiscal Year
Guidance for Processing Attestations from Ambulatory Surgical Centers (ASCs) Temporarily Enrolling as Hospitals during the COVID-19 Public Health Emergency	QSO-20-24-ASC	2020-04-03	2020
Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) and Psychiatric Residential Treatment Facilities (PRTFs)	QSO-20-23-ICF/IID & PRTF	2020-03-30	2020
Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Coronavirus Disease 2019 (COVID-19) (Revised)	QSO-20-15 Hospital/CAH/EMTALA REVISED	2020-03-30	2020
Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Outpatient Settings: FAQs and Considerations	QSO-20-22- ASC, CORF, CMHC, OPT, RHC/FQHCs	2020-03-30	2020
Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in dialysis facilities (Revised)	QSO-20-19-ESRD REVISED	2020-03-30	2020
Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs): FAQs, Considerations for Patient Triage, Placement, Limits to Visitation and Availability of 1135 waivers.	QSO-20-13-Hospitals-CAHs REVISED	2020-03-30	2020
Clinical Laboratory Improvement Amendments (CLIA) Laboratory Guidance During COVID-19 Public Health Emergency	QSO-20-21-CLIA	2020-03-26	2020
Prioritization of Survey Activities	QSO-20-20-All	2020-03-23	2020

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions

QAPI – Quality Assessment Performance Improvement

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Hospital Improvement New Law

This document is scheduled to be published in the Federal Register on 09/30/2019 and available online at **https://federalregister.gov/d/2019-20736**, and on **govinfo.gov**

[Billing Code: 4120-01-P]

https://federalregister.gov/d/2019-20736 and 393 Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 416, 418, 441, 460, 482, 483, 484, 485, 486, 488, 491, and 494

[CMS-3346-F; CMS-3334-F; CMS-3295-F]

RIN 0938-AT23

Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule reforms Medicare regulations that are identified as unnecessary, obsolete, or excessively burdensome on health care providers and suppliers. This final rule also

CMS Website on Hospital-Acquired Conditions

CMS.gov
Centers for Medicare & Medicaid Services

Search

Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Private Insurance | Innovation Center | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach & Education

Home > Medicare > Hospital-Acquired Conditions (Present on Admission Indicator) > Hospital-Acquired Conditions

Hospital-Acquired Conditions (Present on Admission Indicator)

- Statute Regulations Program Instructions
- HAC Regulations and Notices
- Affected Hospitals
- Reporting
- Coding
- Hospital-Acquired Conditions
- ICD-10 HAC List
- Educational Resources

Hospital-Acquired Conditions

Section 5001(c) of Deficit Reduction Act of 2005 requires the Secretary to identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.

On July 31, 2008, in the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2009 Final Rule, CMS included 10 categories of conditions that were selected for the HAC payment provision. Payment implications began October 1, 2008, for these Hospital Acquired Conditions. The IPPS FY 2009 Final Rule is available in the **Statute/Regulations/Program Instructions** section, accessible through the navigation menu at left.

These 14 categories of HACs listed below include the HACs from the IPPS FY 2013 Final Rule which are Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) and Iatrogenic Pneumothorax with Venous Catheterization. For FY 2014 through FY 2020, there are no additional HAC categories added:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
  - Fractures
  - Dislocations
  - Intracranial Injuries
  - Crushing Injuries
  - Burn
  - Other Injuries
- Manifestations of Poor Glycemic Control
  - Diabetic Ketoacidosis

hwww.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions

Hospital Compare Website

Medicare.gov | Hospital Compare

The Official U.S. Government Site for Medicare

Hospital Compare Home | About Hospital Compare | About the data | Resources | Help

Home

Share

You can now view Department of Defense and Veterans Health Administration hospital performance data through the search function. At this time, Medicare won't pay for services at DoD/VA hospitals for non-DoD/VA beneficiaries except in very limited circumstances.

www.medicare.gov/hospitalcompare/search.html

Find a hospital

A field with an asterisk (*) is required.

* Location

Example: 45802 or Lima, OH or Ohio

ZIP code or City, State or State

Hospital name (optional)

Full or Partial Hospital Name

Search

Spotlight

- Compare hospitals based on their overall star rating, which summarizes

Tools and Tips

- Get information on choosing a hospital, filing a complaint, or

Additional Information

- Hospital Compare data last updated on: January 29, 2020. Explore and

Report Shows Readmission Rates

	RIVERSIDE METHODIST HOSPITAL	NATIONAL RATE
Rate of readmission for heart attack patients	No Different Than the National Rate	15.7%
Hospital return days for heart attack patients	Average Days per 100 Discharges	Not Available[5]

Heart failure

For more information, click on the links below:

- Find out why these measures are important.
- Get more information about the data.
- Get the current data collection period.

Show Graphs | View More Details

	RIVERSIDE METHODIST HOSPITAL	NATIONAL RATE
Rate of readmission for heart failure patients	Better Than the National Rate	21.6%
Hospital return days for heart failure patients	Fewer Days Than Average per 100 Discharges	Not Available[5]

Heart failure - details

Get the current data collection periods.

Table 1 of 2: Rate of readmission for heart failure patients

The results show differences in rates of readmission for Medicare beneficiaries. The results account for how sick patients were when they were hospitalized. They do not include people in Medicare Advantage (like an HMO or PPO) plans or people who do not have Medicare.

The national rate of readmission for heart failure patients was 21.6%

Hospital name	Better than the national rate	No different than the national rate	Worse than the national rate
RIVERSIDE METHODIST HOSPITAL	X		

The table below shows the number of hospitals in each rate of readmission category across the nation and the state. VHA data are included in the state and national data shown here.

Out of 4665 hospitals in the United States →	**120** hospitals were better than national rate	**3487** hospitals were no different than national rate	**163** hospitals were worse than national rate
	895 hospitals did not have enough cases to reliably tell how well they are performing		
Out of 155 hospitals in Ohio →	**3** hospitals were better than national rate	**142** hospitals were no different than national rate	**2** hospitals were worse than national rate
	8 hospitals in Ohio did not have enough cases to reliably tell how well they are performing		

For more information:

- Learn more about how the hospital readmission measures are calculated.

More Information on CMS HACs

CMS.gov
Centers for Medicare & Medicaid Services

Search

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs

Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Private Insurance | Innovation Center | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach & Education

Home > Medicare > Hospital-Acquired Conditions (Present on Admission Indicator) > ICD-10 HAC List

Hospital-Acquired Conditions (Present on Admission Indicator)

- Statute Regulations Program Instructions
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ICD-10 HAC List

Effective October 1, 2015, the ICD-10 Version 33 Hospital Acquired Condition (HAC) list replaced the ICD-9-CM Version 32 HAC list. The ICD-10 HAC List using V37 of the ICD-10 MS-DRG Definitions Manual is located in 'Appendix I' of the ICD10_Definitions_Manual_MSDRG_v37.0.TEXT.zip file located at the following link ICD-10 MS-DRG Definitions Manual Files v37 R1 (Updated September 19, 2019) (ZIP) on the MS-DRG Classifications and Software webpage. An HTML version of the ICD-10 Version 37 HAC list is located in Appendix I Hospital Acquired Conditions (HACS) List at the following link ICD-10-CM/PCS MS-DRG v37 R1 Definitions Manual Table of Contents - Full Titles - HTML Versions-UPDATED. .

The FY 2020 v37 ICD-10 Hospital Acquired Condition (HAC) List is also located under the **Downloads** section below.

CMS has also provided a CMS HAC Feedback Mailbox for feedback on the HAC List. The link for this specific mailbox is provided in the **Related Links** section below. All input regarding the HAC List is welcome.

Downloads

- FY 2020 Hospital Acquired Conditions List (Updated 09/19/2019) (ZIP)
- FY2017 DRA HAC Update Summary (PDF)
- FY 2017 HOSPITAL ACQUIRED CONDITIONS LIST (ZIP)
- FY 2016 ICD-10 HAC List (ZIP)
- FY 2019 Hospital Acquired Conditions List (ZIP)
- FY 2018 HOSPITAL ACQUIRED CONDITIONS LIST (UPDATED 11/14/17) (ZIP)

CMS Hospital Acquired Conditions or HACs

Hospital-Acquired Conditions

Section 5001(c) of Deficit Reduction Act of 2005 requires the Secretary to identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.

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- Foreign Object Retained After Surgery
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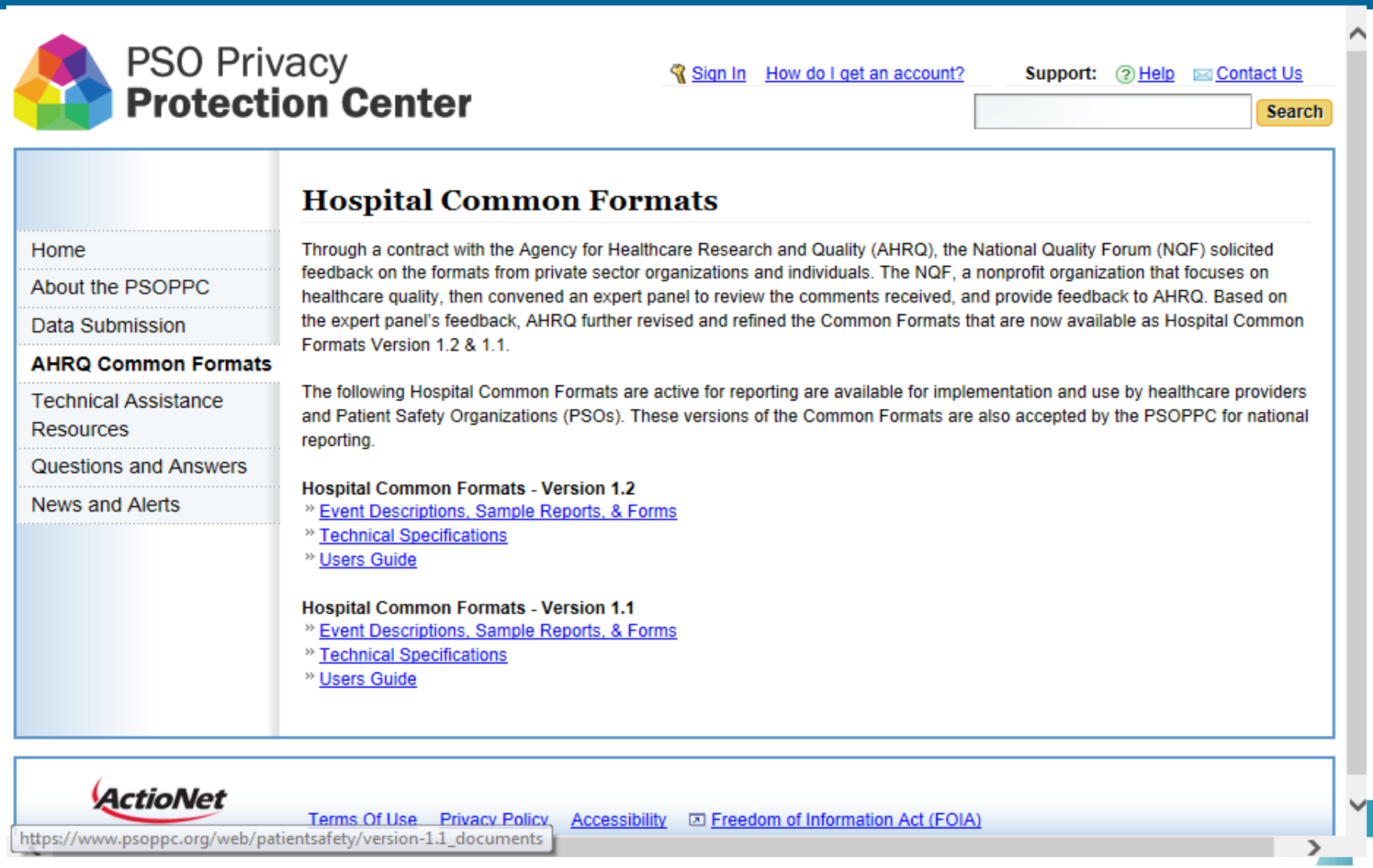
- Falls and Trauma
  - Fractures
  - Dislocations
  - Intracranial Injuries
  - Crushing Injuries
  - Burn
  - Other Injuries
- Manifestations of Poor Glycemic Control
  - Diabetic Ketoacidosis

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html

Hospital Common Formats



CMS QAPI Worksheet

PART 2: DATA COLLECTION AND ANALYSIS - QUALITY INDICATOR TRACERS			
Instructions for Part #2 Questions: **Select 3 distinct quality indicators (not patient safety analyses) and trace them answering the following multipart question. Focus on indicators with related QAPI activities or projects. At least one of the indicators must have been in place long enough for most questions to be applicable.**			
Elements to be Assessed	**Indicator #1**	**Indicator #2**	**Indicator #3**
Write in indicator selected:			
2.1.a Can the hospital provide evidence that each quality indicator selected is related to improved health outcomes? (e.g., based on QIO, guidelines from a nationally recognized organization, hospital specific evidence, peer-reviewed research, etc.)	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
2.1.b Is the scope of data collection appropriate to the indicator, e.g., an indicator related to labor and delivery might be appropriate to all areas of that unit and the ED, but indicators related to hand hygiene would require data from multiple parts of the hospital.	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
2.1.c Is the method (e.g., chart reviews, monthly observations, etc.) and frequency of data collection specified?	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO

CMS Website for Hospital Readmission

Hospital Readmissions Reduction Program (HRRP)

The Hospital Readmissions Reduction Program (HRRP) is a Medicare value-based purchasing program that reduces payments to hospitals with excess readmissions. The program supports the national goal of improving healthcare for Americans by linking payment to the quality of hospital care.

Section 3025 of the Affordable Care Act requires the Secretary of the Department of Health and Human Services (HHS) to establish HRRP and reduce payments to Inpatient Prospective Payment System (IPPS) hospitals for excess readmissions beginning October 1, 2012 (i.e., Fiscal Year [FY] 2013). Additionally, the 21st Century Cures Act requires CMS to assess a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid beginning in FY 2019. The legislation requires estimated payments under the non-stratified methodology (i.e., FY 2013 to FY 2018) equal payments under the stratified methodology (i.e., FY 2019 and subsequent years) to maintain budget neutrality.

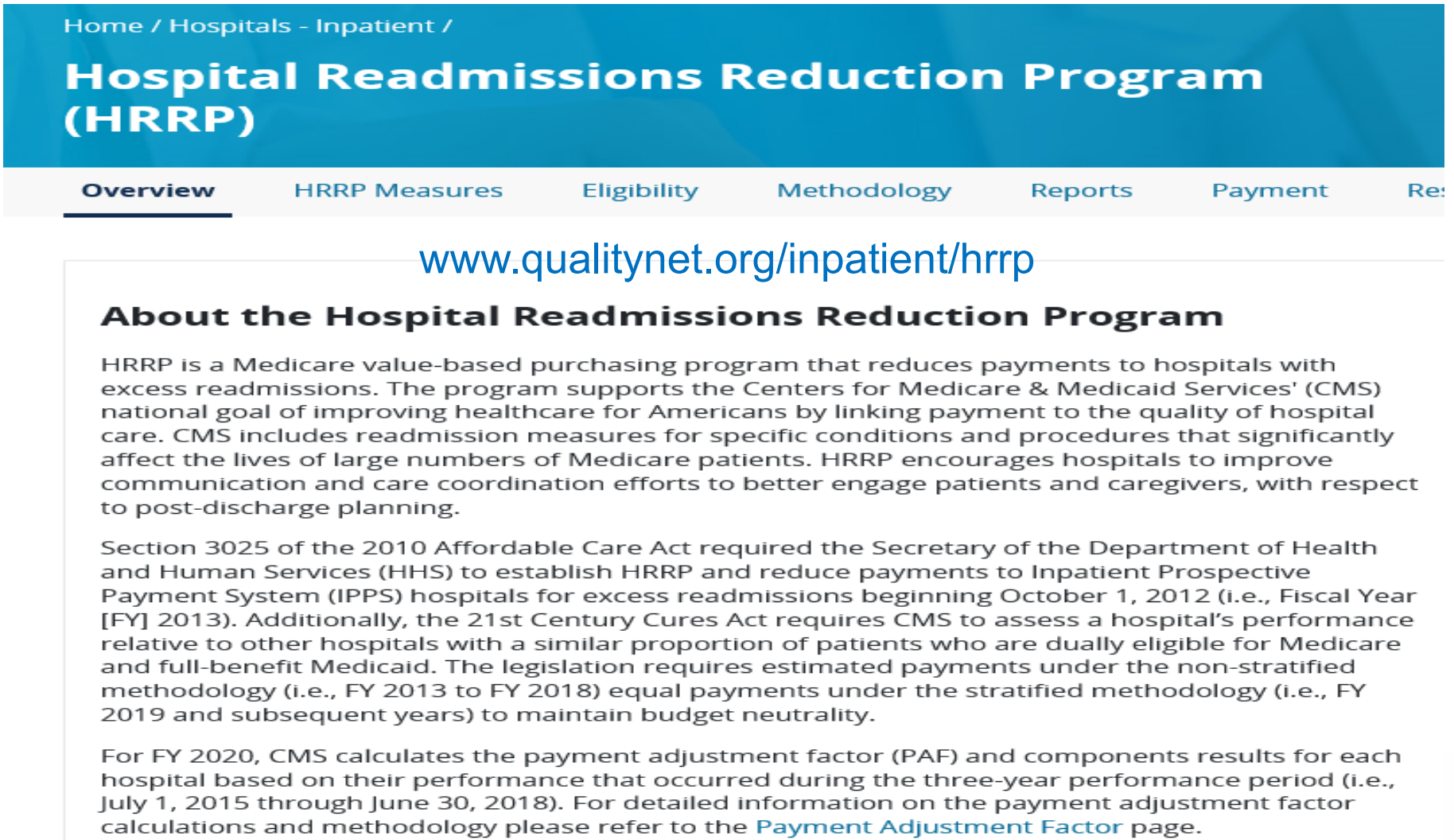
CMS includes the following six condition/procedure-specific 30-day risk-standardized unplanned readmission measures in the program:

- Acute Myocardial Infarction (AMI)
- Chronic Obstructive Pulmonary Disease (COPD)
- Heart Failure (HF)
- Pneumonia
- Coronary Artery Bypass Graft (CABG) Surgery
- Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA/TKA)

https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program/

For FY 2020, CMS calculates the payment adjustment factor and component results for each hospital based on their performance during the three-year performance period of July 1, 2015 through June 30, 2018. Payment reductions are applied to all Medicare fee-for-service (FFS) base operating diagnosis-related group (DRG) payments between October 1, 2019 through September 30, 2020. The payment reduction is capped at 3% (i.e., payment adjustment factor of 0.97)

Quality Net Hospital Readmission Program



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Data on Hospital Compare Website

CMS.gov
Centers for Medicare & Medicaid Services

Search

Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Private Insurance | Innovation Center | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach & Education

Home > Medicare > Hospital Quality Initiative > Hospital Compare

Hospital Quality Initiative

- Highlights
- Hospital Inpatient Quality Reporting Program
- Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
- Hospital Outpatient Quality Reporting Program
- Hospital Compare
- Hospital Compare Ads
- Inpatient Measures
- Process of Care Measures
- Outcome Measures
- HCAHPS: Patients' Perspectives of Care Survey
- Medicare Payment and Volume Information for Consumers
- Premier Hospital Quality Incentive Demonstration
- Premier Hospital Historical Data
- Hospital Archives

Hospital Compare

Hospital Compare is a consumer-oriented website that provides information on how well hospitals provide recommended care to their patients. This information can help consumers make informed decisions about where to go for health care. Hospital Compare allows consumers to select multiple hospitals and directly compare performance measure information related to heart attack, heart failure, pneumonia, surgery and other conditions. These results are organized by:

- General information
- Survey of patients' experiences
- Timely & effective care
- Complications
- Readmissions & deaths
- Use of medical imaging
- Payment & value of care

www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare

Access the Hospital Compare Web site at www.medicare.gov/hospitalcompare

Hospital Compare was created through the efforts of Medicare and the Hospital Quality Alliance (HQA). The HQA: Improving Care Through Information was created in December 2002. The HQA was a public-private collaboration established in December 2002 to promote reporting on hospital quality of care. The HQA consisted of organizations that represented consumers, hospitals, providers, employers, accrediting organizations, and federal agencies. The HQA effort was intended to make it easier for consumers to make informed health care decisions and to support efforts to improve quality in U.S. hospitals. Since it's inception, many new measures and topics have been displayed in the site.

In 2005, the first set of 10 "core" process of care measures were displayed on such topics as heart attack, heart failure, pneumonia and surgical care.

Quality Improvement Organizations

What are QIOs?

CMS contracts with one organization in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands to serve as that state/jurisdiction's Quality Improvement Organization (QIO) contractor. QIOs are private, mostly not-for-profit organizations, which are staffed by professionals, mostly doctors and other health care professionals, who are trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care. QIO contracts are 3 years in length, with each 3-year cycle referenced as an ordinal "SOW."

What do QIOs do?

By law, the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. Based on this statutory charge, and CMS' Program experience, CMS identifies the core functions of the QIO Program as:

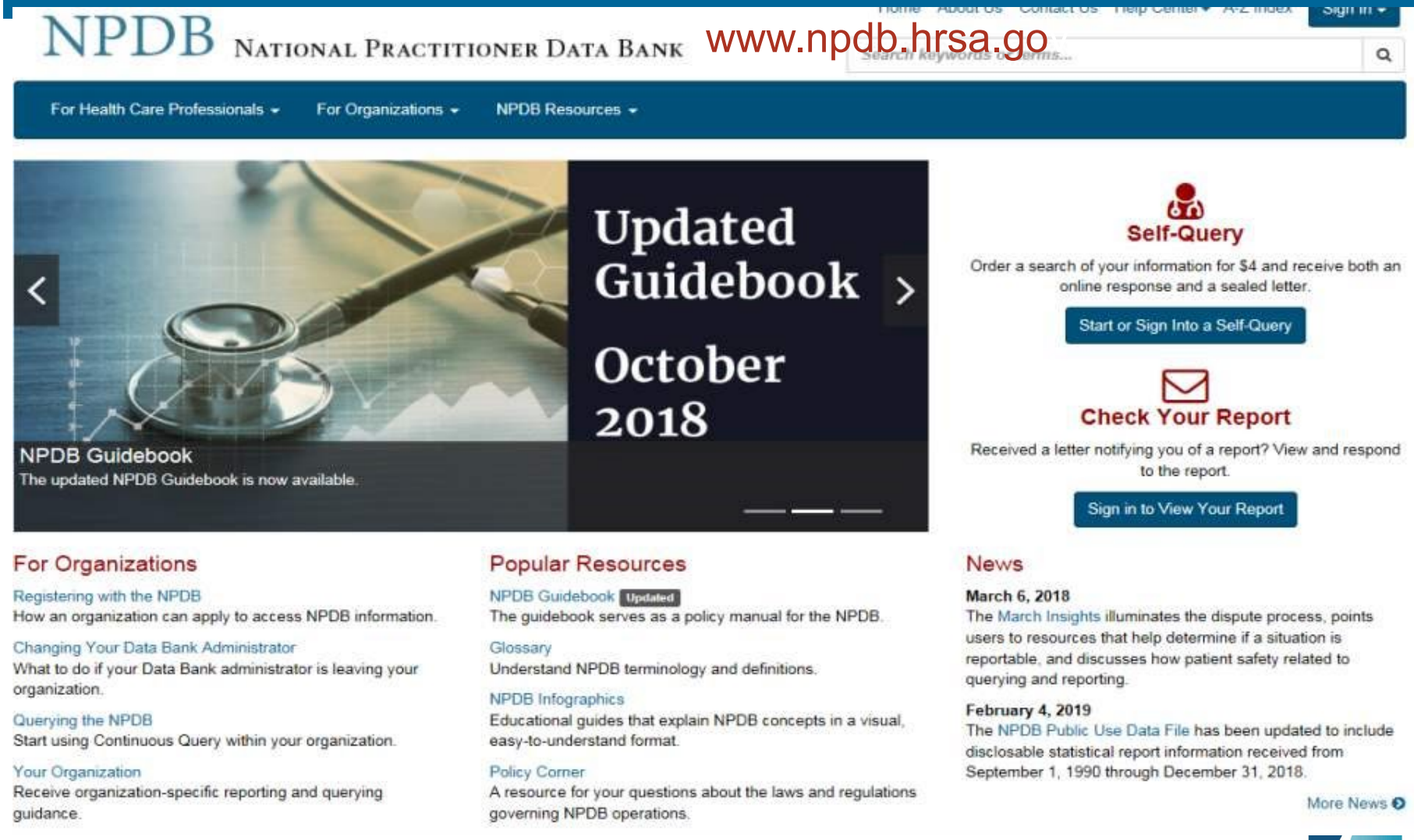
- Improving quality of care for beneficiaries;
- Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
- Protecting beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

Why does CMS have QIOs?

CMS relies on QIOs to improve the quality of health care for all Medicare beneficiaries. Furthermore, QIOs are required under Sections 1152-1154 of the Social Security Act. CMS views the QIO Program as an important resource in its effort

Medical Staff

National Practitioner Data Bank



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Radiology

The Joint Commission
Sentinel Event Alert

www.jointcommission.org/assets/1/18/SEA_47_Radiation_REVISED2_Feb_2018.pdf

A complimentary publication of The Joint Commission

Issue 47, August 24, 2011
Revised: February 2019 (in red)

Radiation risks of diagnostic imaging and fluoroscopy

Published for Joint Commission accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel events, describes their common underlying causes, and suggests steps to prevent occurrences in the future.

Accredited organizations should consider information in an Alert when designing or redesigning relevant processes and consider implementing relevant suggestions contained in the Alert or reasonable alternatives.

Please route this issue to appropriate staff within your organization. *Sentinel Event Alert* may only be reproduced in its entirety and credited to The Joint Commission. To

Diagnostic radiation, which includes fluoroscopy, is an effective tool that can save lives. The higher the dose of radiation delivered at any one time, however, the greater the risk for long-term damage. If a patient receives repeated doses, harm can also occur as the cumulative effect of those multiple doses over time.[1,2,3] Conversely, using insufficient radiation may increase the risk of misdiagnosis, delayed treatment, or, if the initial test is inadequate, repeat testing with the attendant exposure to even more radiation.[4] The risks associated with the use of ionizing radiation in diagnostic imaging include cancer, burns and other injuries.[1,5,6,7] X-rays are officially classified as a carcinogen by the World Health Organization's International Agency for Research on Cancer, the Agency for Toxic Substances and Disease Registry of the Centers for Disease Control and Prevention, and the National Institute of Environmental Health Sciences.[1]

Over the past two decades, the U.S. population's total exposure to ionizing radiation has nearly doubled.[8] Diagnostic imaging and fluoroscopy services can be provided in hospitals, imaging centers, physician and dental offices, and practitioners can order tests and procedures that involve exposure to radiation, with no knowledge of when the patient was last irradiated or how much radiation the patient had previously received. From the 74 million CT (computerized tomography) scans performed in the U.S. during 2017, it has been estimated that 29,000 future cancers and 14,500 future deaths could develop due to radiation (cancer incidence = 0.04 percent).[9] Another study estimates the incidence of cancer related to CT radiation at 0.02 to 0.04 percent.[10] While these studies' conclusions rely upon some currently unverified scientific assumptions – namely, a linear relationship between radiation dose and risk even at very low exposures – they do highlight the

Mentions ACR Radiology Appropriateness Criteria

ACR AMERICAN COLLEGE OF RADIOLOGY

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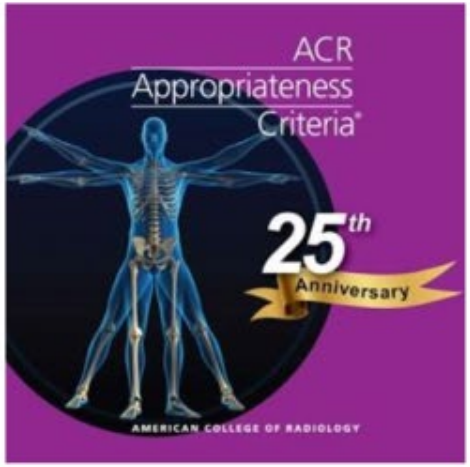
ACR Appropriateness Criteria

The ACR Appropriateness Criteria® (AC) are evidence-based guidelines to assist referring physicians and other providers in making the most appropriate imaging or treatment decision for a specific clinical condition. Employing these guidelines helps providers enhance quality of care and contribute to the most efficacious use of radiology. Learn more »

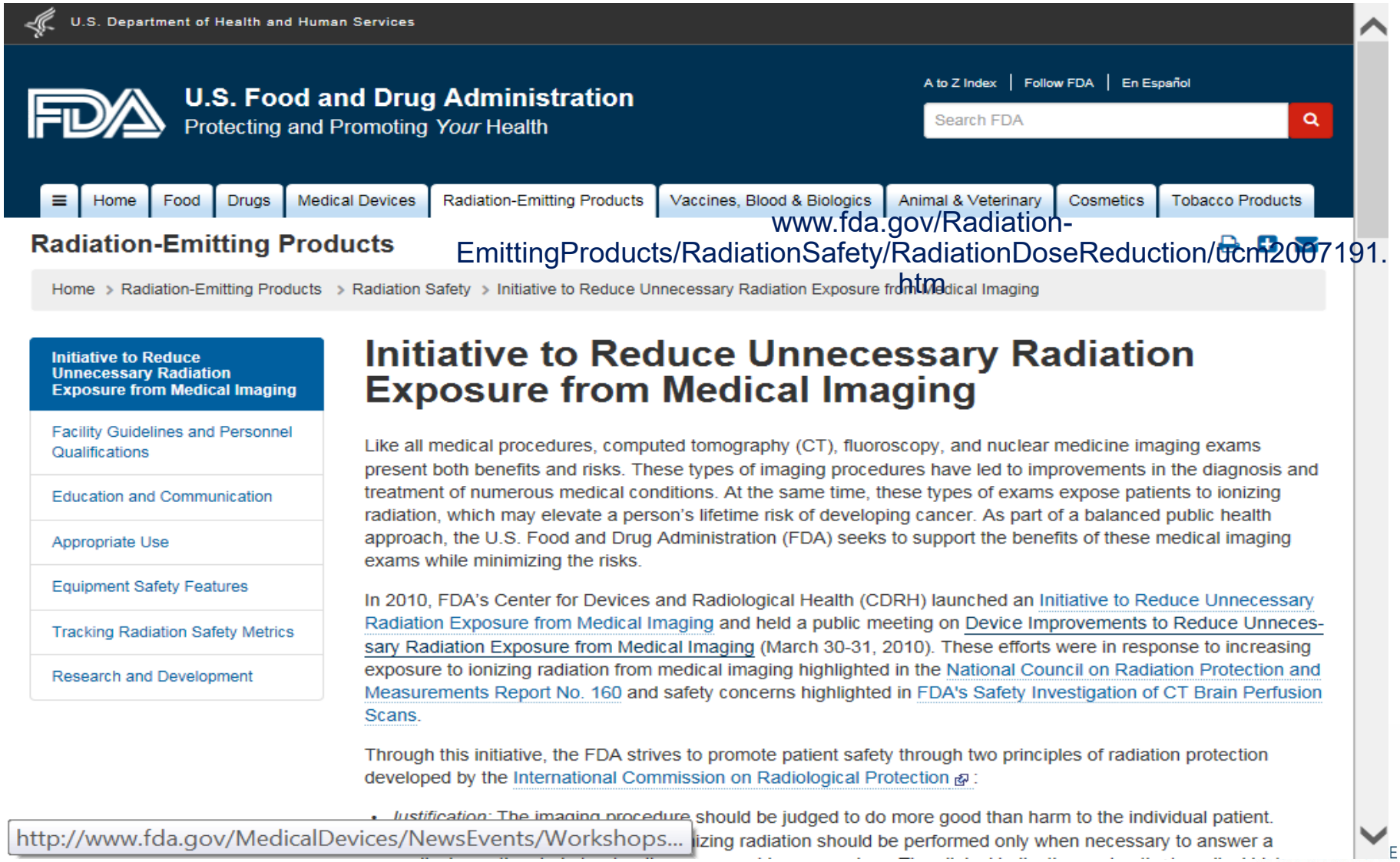


www.acr.org/Clinical-Resources/ACR-Appropriateness-Criteria

See the complete list of ACR AC topics and ratings tables »

Browse Topics

FDA Reduce Unnecessary Radiation Exposure



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U.S. Food and Drug Administration
Protecting and Promoting *Your* Health

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Radiation-Emitting Products

www.fda.gov/RadiationEmittingProducts/RadiationSafety/RadiationDoseReduction/ucm2007191.htm

Home > Radiation-Emitting Products > Radiation Safety > Initiative to Reduce Unnecessary Radiation Exposure from Medical Imaging

Initiative to Reduce Unnecessary Radiation Exposure from Medical Imaging

- Facility Guidelines and Personnel Qualifications
- Education and Communication
- Appropriate Use
- Equipment Safety Features
- Tracking Radiation Safety Metrics
- Research and Development

Initiative to Reduce Unnecessary Radiation Exposure from Medical Imaging

Like all medical procedures, computed tomography (CT), fluoroscopy, and nuclear medicine imaging exams present both benefits and risks. These types of imaging procedures have led to improvements in the diagnosis and treatment of numerous medical conditions. At the same time, these types of exams expose patients to ionizing radiation, which may elevate a person's lifetime risk of developing cancer. As part of a balanced public health approach, the U.S. Food and Drug Administration (FDA) seeks to support the benefits of these medical imaging exams while minimizing the risks.

In 2010, FDA's Center for Devices and Radiological Health (CDRH) launched an Initiative to Reduce Unnecessary Radiation Exposure from Medical Imaging and held a public meeting on Device Improvements to Reduce Unnecessary Radiation Exposure from Medical Imaging (March 30-31, 2010). These efforts were in response to increasing exposure to ionizing radiation from medical imaging highlighted in the National Council on Radiation Protection and Measurements Report No. 160 and safety concerns highlighted in FDA's Safety Investigation of CT Brain Perfusion Scans.

Through this initiative, the FDA strives to promote patient safety through two principles of radiation protection developed by the International Commission on Radiological Protection :

- *Justification:* The imaging procedure should be judged to do more good than harm to the individual patient.
- izing radiation should be performed only when necessary to answer a

http://www.fda.gov/MedicalDevices/NewsEvents/Workshops...

CONSULTING

Image Wisely

Image Wisely is a joint initiative of the American College of Radiology, Radiological Society of North America, American Society of Radiological Technologists and American Association of Physicists in Medicine.

Image Gently Website

Dietary

IOM DRI or Dietary Reference Intake

http://fnic.nal.usda.gov/dietary-guidance/dietary-reference-intakes/dri-nutrient-reports

www.health.gov/dietaryguidelines/2015.asp

Dietary Guidelines for Americans, 2015

HHS's Office of Disease Prevention and Health Promotion (ODPHP) has the administrative leadership for the 2015 edition and is strongly supported by USDA's Center for Nutrition Policy and Promotion in Committee and process management, and evidence analysis functions. The Departments jointly review the Committee's recommendations and develop and publish the revised Dietary Guidelines for Americans policy document.

Recommendations from the Dietary Guidelines for Americans are intended for Americans ages 2 years and over, including those at increased risk of chronic disease, and provide the basis for federal food and nutrition policy and education initiatives. The Dietary Guidelines encourage Americans to focus on eating a healthful diet—one that focuses on foods and beverages that help achieve and maintain a healthy weight, promote health, and prevent disease.

Optimizing the Process for Establishing the Dietary Guidelines for Americans: The Selection Process

DETAILS

130 pages | 6 x 9 | PAPERBACK
ISBN 978-0-309-45360-8 | DOI: 10.17226/24637

AUTHORS

Committee to Review the Process to Update the Dietary Guidelines for Americans; Food and Nutrition Board; Health and Medicine Division; National Academies of Sciences, Engineering, and Medicine

www.nap.edu/download/24883

Redesigning the Process for Establishing the Dietary Guidelines for Americans

DETAILS

260 pages | 6 x 9 | PAPERBACK
ISBN 978-0-309-46482-6 | DOI 10.17226/24883

CONTRIBUTORS

Committee to Review the Process to Update the Dietary Guidelines for Americans; Food and Nutrition Board; Health and Medicine Division; National Academies of Sciences, Engineering, and Medicine

Guiding Principles for Developing Dietary Reference Intakes Based on Chronic Disease

DETAILS

334 pages | 6 x 9 | PAPERBACK
ISBN 978-0-309-46256-3 | DOI 10.17226/24828

CONTRIBUTORS

Shiriki Kumanyika and Maria P. Oria, Editors; Committee on the Development of Guiding Principles for the Inclusion of Chronic Disease Endpoints in Future Dietary Reference Intakes; Food and Nutrition Board; Health and Medicine Division; National Academies of Sciences, Engineering, and Medicine

Academy of Nutrition and Dietetics

eat right. Academy of Nutrition and Dietetics

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www.eatright.org

Food

Nutrition

Making the smart food and nutrition choices is a necessary part of everyone's daily life.

- Dietary Guidelines and MyPlate
- Vegetarian and Special Diets
- Eat Right at School
- Eating as a Family
- Healthy Eating
- Nutrition Facts and Food Labels

Planning and Prep

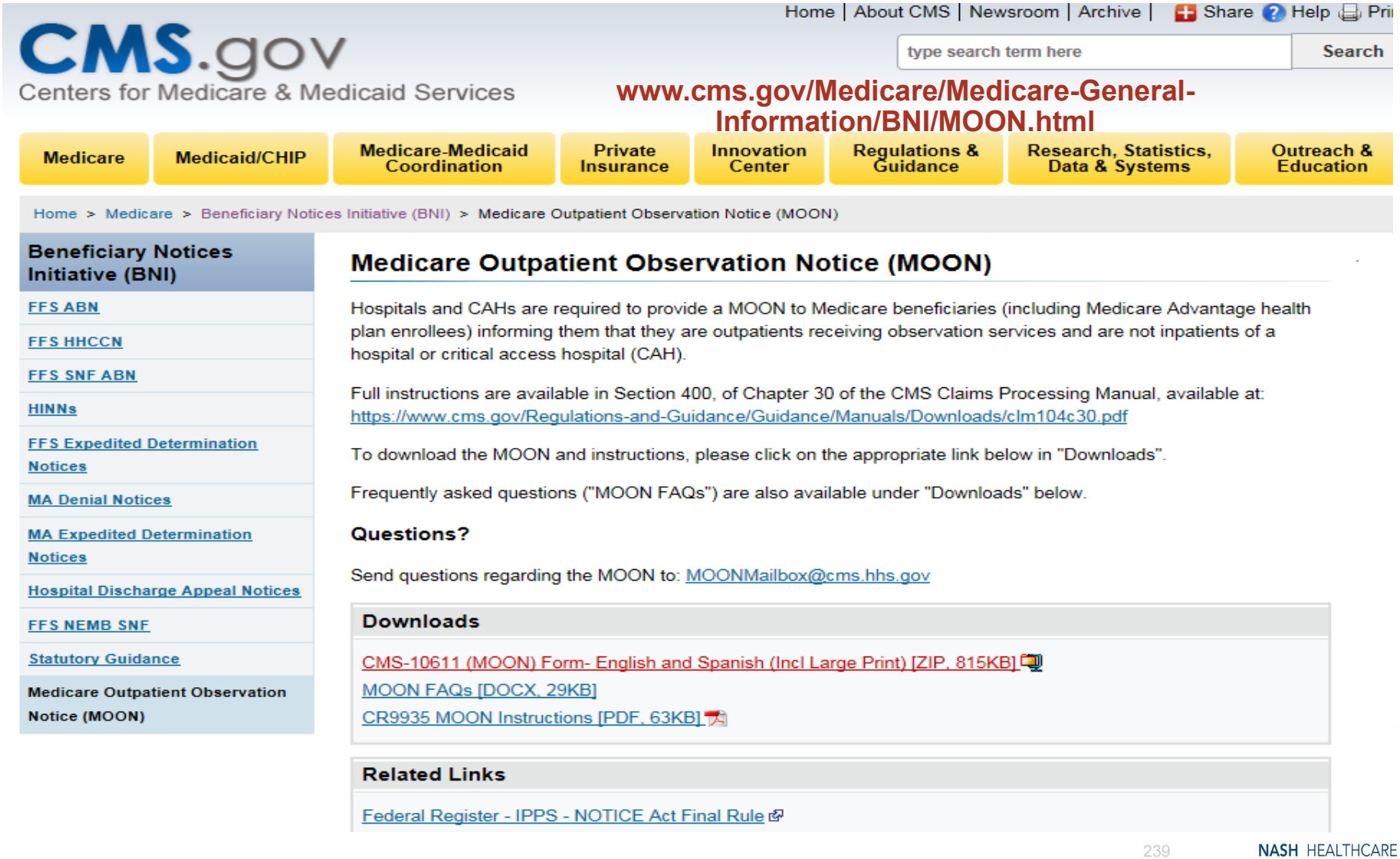
Navigate grocery store aisles, make healthful choices and get nutritious meals to the table.

- Cooking Tips and Trends
- Eat Right on a Budget
- Recipes
- Smart Shopping
- Snack and Meal Ideas

Utilization Review/MOON

NASH HEALTHCARE CONSULTING

CMS MOON Website



New MOON Form Use after April 1, 2020

Medicare Outpatient Observation Notice

Patient name: **Patient number:**

You're a hospital outpatient receiving observation services. You are not an inpatient because:

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

If you have any questions about your observation services, ask the hospital staff member giving you this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Form CMS 10611-MOON Expiration 12/31/2022 OMB approval 0938-1308

Options on the Moon Form

- Your diagnostic testing is not yet complete;
- Further treatments of your condition are needed;
- Consultation needs to be completed;
- Ongoing evaluation and management of your condition is needed;
- You require more care after your surgery but should be able to be discharged within 48 hours;
- Your Medicare Advantage plan has told your doctor to place you in observation;
- Other.

IM Notice Revised Form April 1, 2020

Important Message from Medicare

Patient name: **Patient number:**

Your Rights as a Hospital Inpatient:

- You can receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- You can be involved in any decisions about your hospital stay.
- You can report any concerns you have about the quality of care you receive to your QIO at: {insert QIO name and toll-free number of QIO} The QIO is the independent reviewer authorized by Medicare to review the decision to discharge you.
- You can work with the hospital to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.
- You can speak with your doctor or other hospital staff if you have concerns about being discharged.

Your Right to Appeal Your Hospital Discharge:

- You have the right to an immediate, independent medical review (appeal) of the decision to discharge you from the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the reviewer will each receive a copy of a detailed explanation about why your covered hospital stay should not continue. You will receive this detailed notice only after you request an appeal.
- If the QIO finds that you are not ready to be discharged from the hospital, Medicare will continue to cover your hospital services.
- If the QIO agrees services should no longer be covered after the discharge date, neither Medicare nor your Medicare health plan will pay for your hospital stay after noon of the day after the QIO notifies you of its decision. If you stop services no later than that time, you will avoid financial liability.
- If you do not appeal, you may have to pay for any services you receive after your discharge date.

See page 2 of this notice for more information.

Form CMS 10065-IM (Exp. 12/31/2022) OMB approval 0938-1019

Detailed Notice Use after April 1, 2020

Detailed Notice of Discharge

Date:

Patient name: **Patient number:**

This notice gives a detailed explanation of why your hospital or Medicare health plan has determined Medicare coverage for your hospital stay should end. This notice is not the decision on your appeal. The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your hospital stay should end.

- The facts used to make this decision:

- Detailed explanation of why your hospital stay is no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

- Plan policy, provision, or rationale used in making the decision (health plans only):

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at:

{insert hospital/Medicare health plan name and toll-free telephone number}

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form CMS 10066-DND (Exp. 12/31/2022) OMB approval 0938-1019

Medicare Outpatient Observation Notice (MOON)

The MOON is a standardized notice to inform beneficiaries (including Medicare health plan enrollees) that they are an outpatient receiving observation services and are not an inpatient of the hospital or critical access hospital (CAH).

The MOON is mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), passed on August 6, 2015. The NOTICE Act requires all hospitals and CAHs to provide written and oral notification under specified guidelines.

Medicare Outpatient Observation Notice and accompanying form instructions are available in "Downloads" below. Manual instructions will be made available in the coming weeks. All hospitals and CAHs are required to provide the MOON beginning no later than March 8, 2017.

See "Federal Register - IPPS - NOTICE Act Final Rule" in "Related Links" below to view the final NOTICE Act regulation (Section L and 42 CFR 489.20).

Downloads

CMS-10611 (MOON) [ZIP, 141KB]

www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni

Related Links

Federal Register - IPPS - NOTICE Act Final Rule

Has a Large Print Version

Medicare Outpatient Observation Notice

Patient name: **Patient number:**

You're a hospital outpatient receiving observation services. You are not an inpatient because:

1

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.

2

- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

If you have any questions about your observation services, ask the hospital staff member

(Hospitals may include contact information or logo here)

Your costs for medications:

Generally, prescription and over-the-counter drugs, including "self-administered drugs," you get in a hospital outpatient setting (like an emergency department) aren't covered by Part B. "Self-administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow you to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs. You'll likely need to pay out-of-pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

Instructions on MOON Form

Notice Instructions: Medicare Outpatient Observation Notice

Page 1 of the Medicare Outpatient Observation Notice (MOON)

The following blanks must be completed by the hospital. Information inserted may be typed or legibly hand-written in 12-point font or the equivalent.

Patient Name:

Fill in the patient's full name or attach patient label.

Patient ID number:

Fill in an ID number that identifies this patient, such as a medical record number or the patient's birthdate or attach a patient label. This number should not be the patient's social security number.

"You're a hospital outpatient receiving observation services. You are not an inpatient because:"

MOON FORM FAQs

Medicare Outpatient Observation Notice
Frequently Asked Questions
March 8, 2017

www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect

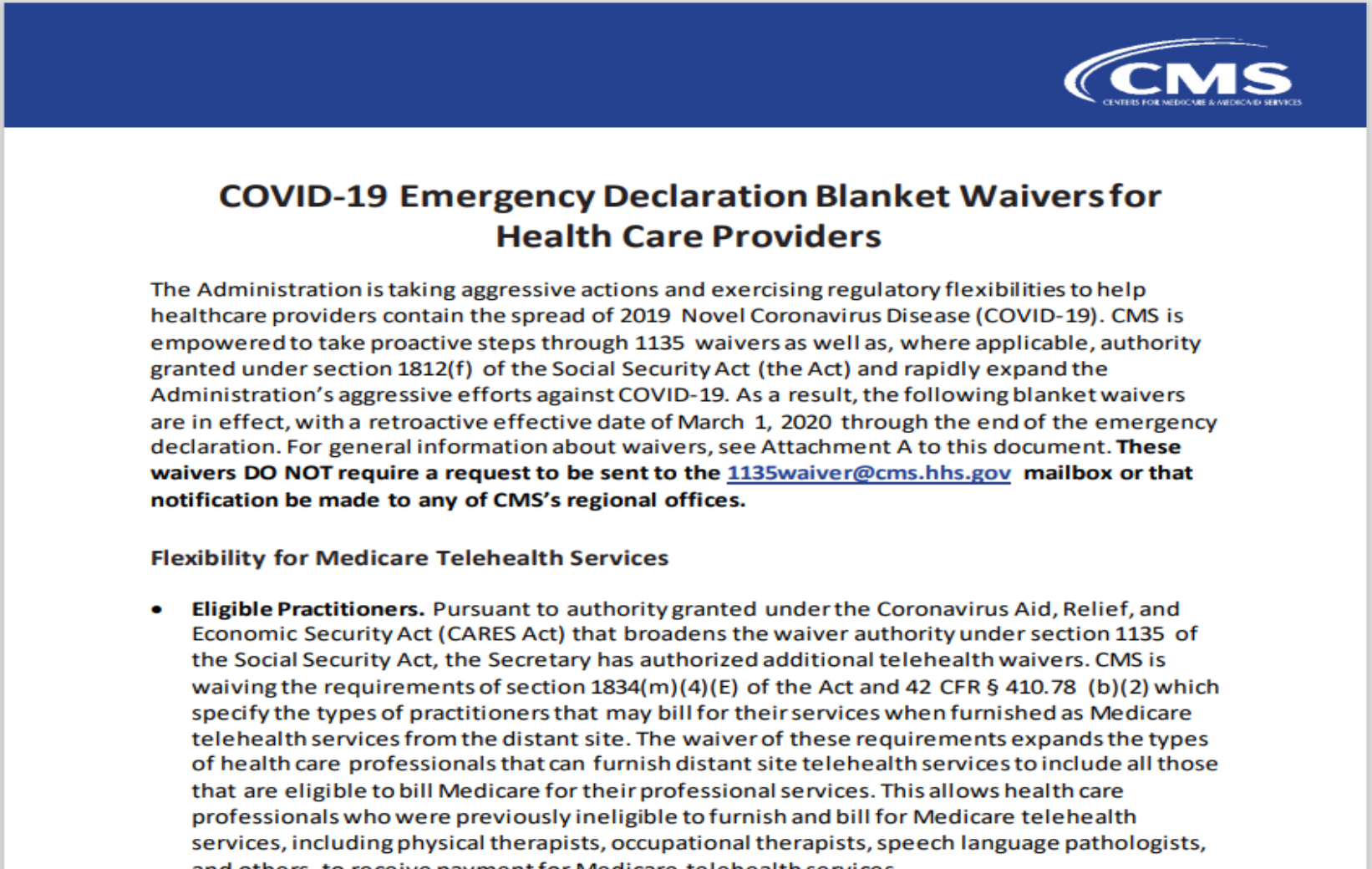
Q1. How should hospitals and critical access hospitals (CAHs) complete the "You're a hospital outpatient receiving observation services. You are not an inpatient because:" free-text field?

A. The purpose of the MOON free-text field is to provide a clinical rationale for why the beneficiary is receiving observation services as an outpatient and is not an inpatient.

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department

COVID 19 Blanket Waivers – See page 16

- https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers



COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

The Administration is taking aggressive actions and exercising regulatory flexibilities to help healthcare providers contain the spread of 2019 Novel Coronavirus Disease (COVID-19). CMS is empowered to take proactive steps through 1135 waivers as well as, where applicable, authority granted under section 1812(f) of the Social Security Act (the Act) and rapidly expand the Administration's aggressive efforts against COVID-19. As a result, the following blanket waivers are in effect, with a retroactive effective date of March 1, 2020 through the end of the emergency declaration. For general information about waivers, see Attachment A to this document. **These waivers DO NOT require a request to be sent to the 1135waiver@cms.hhs.gov mailbox or that notification be made to any of CMS's regional offices.**

Flexibility for Medicare Telehealth Services

- **Eligible Practitioners.** Pursuant to authority granted under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that broadens the waiver authority under section 1135 of the Social Security Act, the Secretary has authorized additional telehealth waivers. CMS is waiving the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2) which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists,

Facility Maintenance/Supplies

NASH HEALTHCARE CONSULTING

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality /Survey & Certification Group

Ref: S&C: 14-07-Hospital

DATE: **December 20, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Hospital Equipment Maintenance Requirements

Memorandum Summary

- ***S&C 12-07-Hospital Superceded:*** We are updating previously provided guidance to clarify:
  - Hospital facilities, supplies and equipment must be maintained to ensure an acceptable level of safety and quality.
  - A hospital may adjust its maintenance, inspection, and testing frequency and activities for facility and medical equipment from what is recommended by the manufacturer, based on a risk-based assessment by qualified personnel, unless:
    - Other Federal or state law; or hospital Conditions of Participation (CoPs) require adherence to manufacturer's recommendations and/or set specific requirements. For example, all imaging/radiologic equipment must be maintained per manufacturer's recommendations; or
    - The equipment is a medical laser device; or
    - New equipment without a sufficient amount of maintenance history has been acquired.
- Hospitals electing to adjust facility or medical equipment maintenance must develop policies and procedures and maintain documentation supporting their Alternate Equipment Management (AEM) program. They must adhere strictly to the AEM activities and/or

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Center for Clinical Standards and Quality/Survey & Certification Group

S&C Memo: 18-06- Hospitals

DATE: December 08, 2017

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Clarification of Ligature Risk Policy

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

Memorandum Summary

- **Ligature Risks Compromise Psychiatric Patients' Right to Receive Care in a Safe Setting:** The care and safety of psychiatric patients and the staff that provide that care are our primary concerns. The Centers for Medicare & Medicaid Services (CMS) is in the process of drafting comprehensive ligature risk interpretive guidance to provide direction and clarity for Regional offices (RO), State Survey Agencies (SAs), and accrediting organizations (AOs).
- **Definition of a Ligature Risk:** A ligature risk (point) is defined as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes, and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures.
- **Focus of Ligature Risks:** The focus for a ligature "resistant" or ligature "free" environment is primarily aimed at Psychiatric units/hospitals.
- **Interim Guidance:** Until CMS' comprehensive ligature risk interpretive guidance is released, the ROs, SAs and AOs may use their judgment as to the identification of

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Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C 17-30-*Hospitals/CAHs/NHs*
REVISED 06.09.2017

DATE: **June 02, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Requirement to Reduce *Legionella* Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD)
******Revised to Clarify Provider Types Affected******

Memorandum Summary

- ***Legionella* Infections**: The bacterium *Legionella* can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least 50 years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as showerheads, cooling towers, hot tubs, and decorative fountains.

Tag 701 on Power Strips
From Hospital CoP, page 375

Life Safety Code surveyors assess the use of power strips in healthcare facilities. However, the following guidance is provided as reference for healthcare surveyors as they survey physical environment along with other CoP requirements. Any observed power strip deficiencies should be conveyed to the LSC surveyors for citation.
If line-operated medical equipment is used in a patient care room/area, inside the patient care vicinity:

• UL power strips would have to be a permanent component of a rack-, table-, pedestal-, or cart-mounted & tested medical equipment assembly

• Power strips providing power to medical equipment in a patient care room/area must be UL 1363A or UL 60601-1

• Power strips cannot be used for non-medical equipment

If line-operated medical equipment is used in a patient care room/area, outside the patient care vicinity:
• UL power strips could be used for medical & non-medical equipment with precautions as described in the memo

• Power strips providing power to medical equipment in a patient care room/area must be UL 1363A or UL 60601-1

• Power strips providing power to non-medical equipment in a patient care room/area must be UL 1363

If line-operated medical equipment is not used in a patient care room/area, inside and outside the patient care vicinity:
• UL power strips could be used with precautions

Power strips providing power to non-medical equipment in a patient care room/area must be UL 1363. In non-patient care areas/rooms, other UL strips could be used with the general precautions.

Relative Humidity

Humidity in Anesthetizing Areas

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Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-25-LSC & ASC

DATE: **April 19, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Relative Humidity (RH): Waiver of Life Safety Code (LSC) Anesthetizing Location Requirements; Discussion of Ambulatory Surgical Center (ASC) Operating Room Requirements

Memorandum Summary

- ***RH of ≥20 Percent Permitted in Anesthetizing Locations:*** The Centers for Medicare & Medicaid Services (CMS) is issuing a categorical LSC waiver permitting new and existing ventilation systems supplying hospital and critical access hospital (CAH) anesthetizing locations to operate with a RH of ≥20 percent, instead of ≥35 percent. We are also recommending that RH not exceed 60 percent in these locations.
- ***This Waiver Does Not Apply:***
  - When more stringent RH control levels are required by State or local laws and regulations; or
  - Where reduction in RH would negatively affect ventilation system performance.
- ***Hospitals & CAHs Must Elect to Use the Categorical Waiver:***
  - Individual waiver applications are not required, but facilities are expected to have written documentation that they have elected to use the waiver.
  - At the entrance conference for any survey assessing LSC compliance, a facility that has elected to use this waiver must notify the survey team.
- ***Ongoing Requirements:***
  - Facilities must monitor RH in anesthetizing locations and take corrective actions when needed to ensure RH remains at or above 20 percent.
- ***ASCs:*** ASCs are not subject to all of the same LSC requirements as hospitals, but are required, consistent with 42 CFR 416.44(a)(1), to maintain RH in operating rooms in accordance with nationally accepted guidelines.
- ***State Operations Manual (SOM) Appendices A, I, L & W are being updated accordingly.***

CMS Memo on Low Relative Humidity

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Ref: S&C: 15-27-Hospital, CAH & ASC

DATE: **February 20, 2015**

TO: State Survey Agency Directors

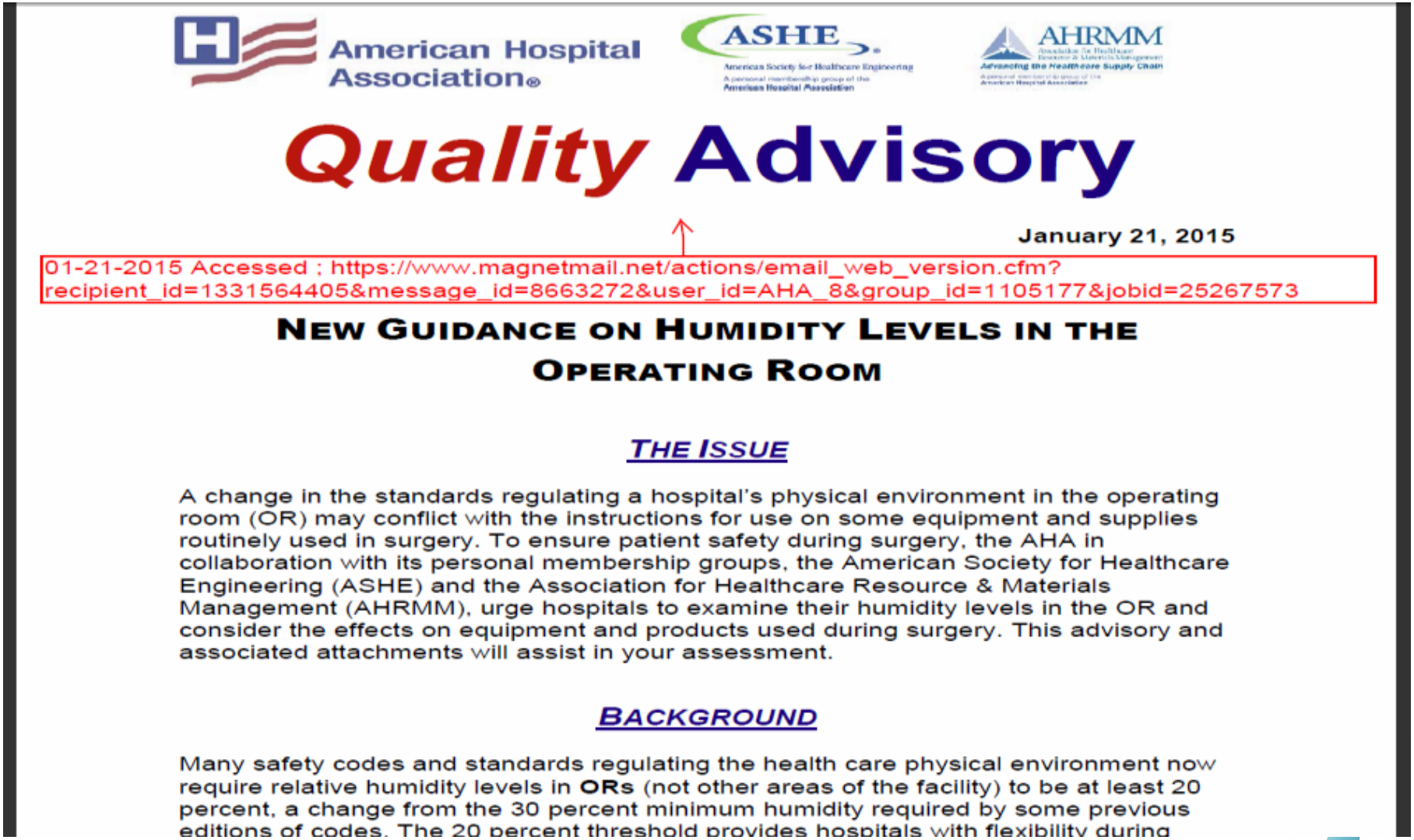
FROM: Director
Survey and Certification Group

SUBJECT: Potential Adverse Impact of Lower Relative Humidity (RH) in Operating Rooms (ORs)

Memorandum Summary

- ***Information on OR RH*** is provided for Ambulatory Surgical Centers (ASCs) & Supplemental Information for Hospitals & Critical Access Hospitals (CAHs) Using the Categorical Waiver of Life Safety Code (LSC) Anesthetizing Location RH Requirements
  - The Association for the Advancement of Medical Instrumentation (AAMI) coordinated the release on January 5, 2015 of a Joint Communication of multiple healthcare-related organizations on how a RH of <30% in ORs may affect the performance of some sterile supplies and electro-medical equipment.
- ***S&C 13-25-LSC & ASC*** permits hospitals and CAHs to use a LSC categorical waiver to establish an RH level <35% in anesthetizing locations. Before electing or continuing to use this categorical waiver, hospitals and CAHs are expected to ensure that the humidity levels in their ORs are compatible with the manufacturers' instructions for use (IFUs) for the supplies and equipment used in that setting.
- ***ASCs do not require a categorical waiver*** in order to use a lower RH level in their ORs but also need to ensure they comply with the IFUs for their OR supplies and equipment.

Impact of Lowering the Humidity



American Hospital Association®

ASHE American Society for Healthcare Engineering

AHRMM Advancing the Healthcare Supply Chain

Quality Advisory

January 21, 2015

01-21-2015 Accessed ; https://www.magnetmail.net/actions/email_web_version.cfm?recipient_id=1331564405&message_id=8663272&user_id=AHA_8&group_id=1105177&jobid=25267573

NEW GUIDANCE ON HUMIDITY LEVELS IN THE OPERATING ROOM

THE ISSUE

A change in the standards regulating a hospital's physical environment in the operating room (OR) may conflict with the instructions for use on some equipment and supplies routinely used in surgery. To ensure patient safety during surgery, the AHA in collaboration with its personal membership groups, the American Society for Healthcare Engineering (ASHE) and the Association for Healthcare Resource & Materials Management (AHRMM), urge hospitals to examine their humidity levels in the OR and consider the effects on equipment and products used during surgery. This advisory and associated attachments will assist in your assessment.

BACKGROUND

Many safety codes and standards regulating the health care physical environment now require relative humidity levels in **ORs** (not other areas of the facility) to be at least 20 percent, a change from the 30 percent minimum humidity required by some previous editions of codes. The 20 percent threshold provides hospitals with flexibility during

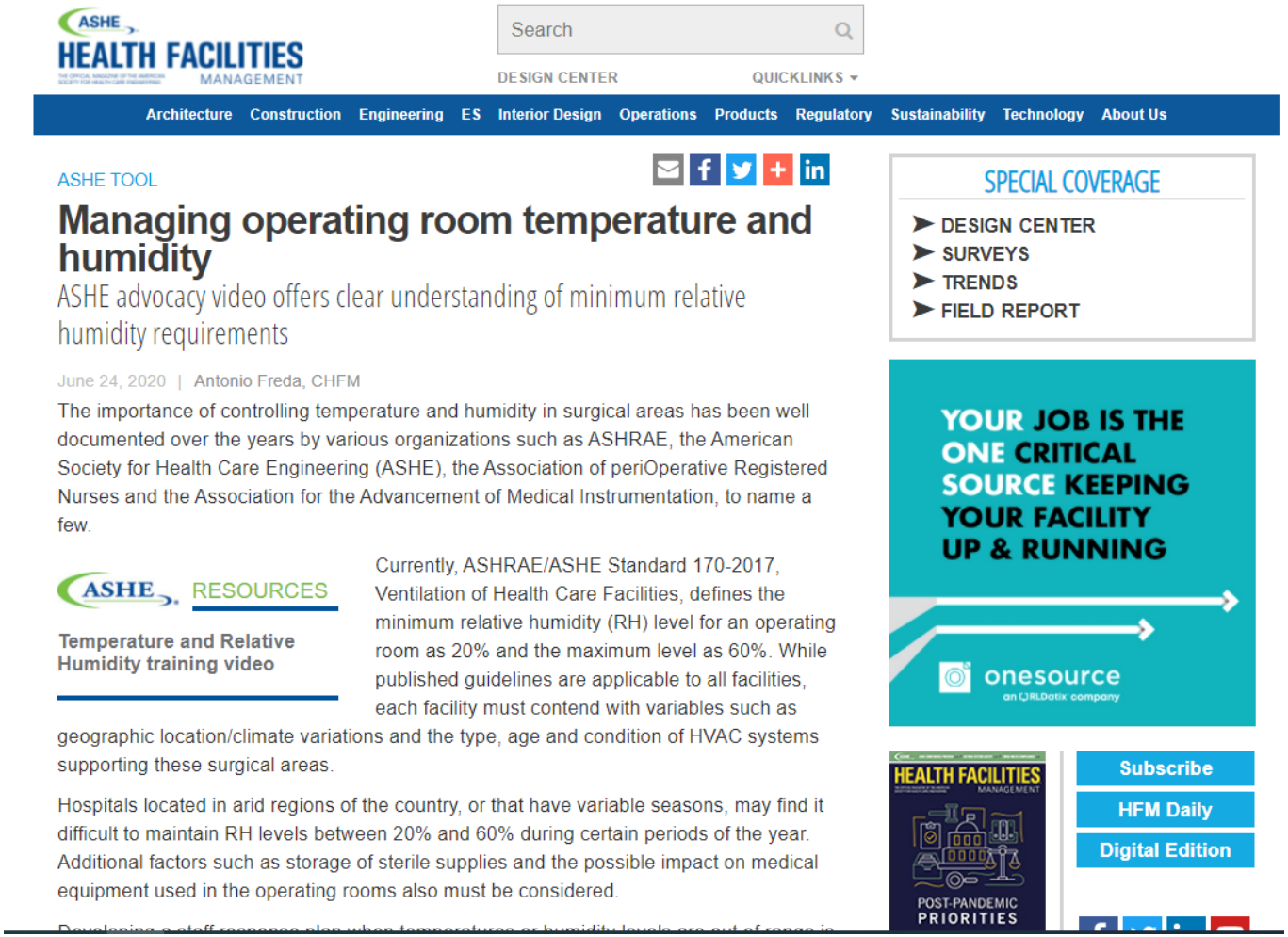
Lowering Humidity Can Have Other Effects

RELATIVE HUMIDITY LEVELS IN THE OPERATING ROOM
JOINT COMMUNICATION TO HEALTHCARE DELIVERY ORGANIZATIONS
January 2015

This is an important communication to the multiple stakeholders in healthcare whose work touches sterile supplies and electro-medical equipment used in delivering care to patients. The subject is about how relative humidity (RH) levels lower than 30% can impact the integrity and functionality of some of these products, with a special emphasis on RH levels in the operating room (OR). The following professional organizations have collaborated in the development of this communication: Ambulatory Surgery Center Association (ASCA), American College of Clinical Engineering (ACCE), American Hospital Association (AHA), American Society for Healthcare Engineering (ASHE), American Society of Anesthesiologists (ASA), American Society of Heating, Refrigeration and Air Conditioning Engineers (ASHRAE), Association for Healthcare Resource & Materials Management (AHRMM), Association for the Advancement of Medical Instrumentation (AAMI), Association of periOperative Registered Nurses (AORN), Association of Surgical Technologists (AST), Health Industry Distributors Association (HIDA), and the International Association of Healthcare Central Service Materials Management (IAHCSMM).[1]

ASHE – OR Temperature and Humidity

- https://www.hfmmagazine.com/articles/3939-managing-operating-room-temperature-and-humidity.



ASHE HEALTH FACILITIES MANAGEMENT

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ASHE TOOL

Managing operating room temperature and humidity

ASHE advocacy video offers clear understanding of minimum relative humidity requirements

June 24, 2020 | Antonio Freda, CHFM

The importance of controlling temperature and humidity in surgical areas has been well documented over the years by various organizations such as ASHRAE, the American Society for Health Care Engineering (ASHE), the Association of periOperative Registered Nurses and the Association for the Advancement of Medical Instrumentation, to name a few.

ASHE RESOURCES

Temperature and Relative Humidity training video

Currently, ASHRAE/ASHE Standard 170-2017, Ventilation of Health Care Facilities, defines the minimum relative humidity (RH) level for an operating room as 20% and the maximum level as 60%. While published guidelines are applicable to all facilities, each facility must contend with variables such as geographic location/climate variations and the type, age and condition of HVAC systems supporting these surgical areas.

Hospitals located in arid regions of the country, or that have variable seasons, may find it difficult to maintain RH levels between 20% and 60% during certain periods of the year. Additional factors such as storage of sterile supplies and the possible impact on medical equipment used in the operating rooms also must be considered.

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Emergency Preparedness

CMS Website and FAQs

Emergency Preparedness is Appendix Z

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Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO19-06-ALL

DATE: **February 1, 2019**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Emergency Preparedness- Updates to Appendix Z of the State Operations Manual (SOM)

www.cms.gov/files/document/appendices-table-content.pdf

Memorandum Summary

- **Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers:** On September 16, 2016, the *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* (Emergency Preparedness Rule) final rule was published in the Federal Register.
- Health care providers and suppliers affected by the rule were required comply and implement all regulations by November 15, 2017.
- We are updating Appendix Z of the SOM to reflect changes to add emerging infectious diseases to the definition of all-hazards approach, new Home Health Agency (HHA) citations and clarifications under alternate source power and emergency standby systems.

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www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html

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- Templates & Checklists

Emergency Preparedness Rule

Survey & Certification- Emergency Preparedness Regulation Guidance

Guidance for Surveyors, Providers and Suppliers Regarding the New Emergency Preparedness (EP) Rule

On September 8, 2016 the Federal Register posted the final rule *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers*. The regulation goes into effect on November 16, 2016. Health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date, on November 16, 2017.

Purpose: To establish national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems. The following information will apply upon publication of the final rule:

- Requirements will apply to all 17 provider and supplier types.
- Each provider and supplier will have its own set of Emergency Preparedness regulations incorporated into its set of conditions or requirements for certification.
- Must be in compliance with Emergency Preparedness regulations to participate in the Medicare or Medicaid program. The below downloadable sections will provide additional information, such as the background and overview of the final rule and related resources.

Additional information has been provided on the left side hyperlinks categorized by information from the EP Rule, such as the Emergency Preparedness Plan, Communication Plan, Policies and Procedures and Testing.

Plan for Emergency Preparedness

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Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C 17-05-ALL

DATE: **October 28, 2016**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-05.pdf

SUBJECT: Information on the Implementation Plans for the Emergency Preparedness Regulation

Memorandum Summary

- **Information for Implementation:** The Centers for Medicare & Medicaid Services (CMS) Survey and Certification Group is providing general information regarding the implementation plans for the new Emergency Preparedness Rule. The information addresses the implementation date for providers and suppliers, the development of Interpretive Guidelines (IGs), surveyor training and resources available to assist in the implementation of this regulation.
- **Affects all 17 providers and suppliers:** The regulation affects all 17 providers and suppliers and must be fully implemented by November 15, 2017.

Training to Staff Memo

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Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C 17-21-ALL

DATE: **March 24, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Information to Assist Providers and Suppliers in Meeting the New Training and Testing Requirements of the Emergency Preparedness Requirements for Medicare & Medicaid Participating Providers and Suppliers Final Rule

Memorandum Summary

Information for Implementation: The Centers for Medicare & Medicaid Services (CMS) is providing information to assist providers and suppliers in meeting the Training and Testing requirements of the new Emergency Preparedness Final Rule that was published on September 16, 2016 (81 FR 63860) and became effective on November 15, 2016.

List of State by State Healthcare Coalitions

Survey & Certification - Emergency Preparedness

- State Survey Agency Guidance
- Health Care Provider Guidance
- Lessons Learned/Archives
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www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html

Emergency Preparedness Rule

Survey & Certification- Emergency Preparedness Regulation Guidance

Guidance for Surveyors, Providers and Suppliers Regarding the New Emergency Preparedness (EP) Rule

On September 8, 2016 the Federal Register posted the final rule *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers*. The regulation goes into effect on November 16, 2016. Health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date, on November 16, 2017.

Purpose: To establish national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems. The following information will apply upon publication of the final rule:

- Requirements will apply to all 17 provider and supplier types.
- Each provider and supplier will have its own set of Emergency Preparedness regulations incorporated into its set of conditions or requirements for certification.
- Must be in compliance with Emergency Preparedness regulations to participate in the Medicare or Medicaid program. The below downloadable sections will provide additional information, such as the background and overview of the final rule and related resources.

Additional information has been provided on the left side hyperlinks categorized by information from the EP Rule, such as the Emergency Preparedness Plan, Communication Plan, Policies and Procedures and Testing.

The below downloadable sections will provide additional information, such as the background and overview of the final rule and related resources.

Downloads

By Name By State Healthcare Coalitions - Updated 1-12-17 [PDF, 361KB]

Facility Transfer Agreement - Example [PDF, 56KB]

17 Facility- Provider Supplier Types Impacted [PDF, 89KB]

Emergency Preparedness Checklist Updated

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Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C-14-12-ALL

DATE: **February 28, 2014**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Survey and Certification Emergency Preparedness Initiative: S&C Emergency Preparedness Checklist Revision

Memorandum Summary

Revised Emergency Preparedness Checklist: The Centers for Medicare & Medicaid Services (CMS) is alerting healthcare facilities that we have revised current emergency preparedness checklist information for health care facility planning. These updates provide more detailed guidance about patient/resident tracking, supplies and collaboration.

Emergency Preparedness Appendix Z

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Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C 17-29-ALL

DATE: **June 02, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Advanced Copy- Appendix Z, Emergency Preparedness Final Rule Interpretive Guidelines and Survey Procedures

Memorandum Summary

- **Advanced Copy of Interpretive Guidelines:** The Centers for Medicare & Medicaid Services (CMS) is releasing a new Appendix Z of the State Operations Manual (SOM) which contains the interpretive guidelines and survey procedures for the Emergency Preparedness Final Rule.
- **Affects all 17 providers and suppliers:** Appendix Z applies to all 17 providers and suppliers included in the Final Rule.

Emergency Preparedness is Appendix Z

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Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO19-06-ALL

DATE: **February 1, 2019**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Emergency Preparedness- Updates to Appendix Z of the State Operations Manual (SOM)

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-06-ALL.pdf

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Final Regulations Published Sept 16, 2016

www.gpo.gov/fdsys/pkg/FR-2016-09-16/pdf/2016-21404.pdf

FEDERAL REGISTER

Vol. 81 Friday,
No. 180 September 16, 2016

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 416, 418, et al.
Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; Final Rule