Title 42
Public Health

Part 482 to End

Revised as of October 1, 2016

Containing a codification of documents
of general applicability and future effect

As of October 1, 2016

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# Table of Contents

<table>
<thead>
<tr>
<th>Explanation</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>v</td>
</tr>
</tbody>
</table>

## Title 42:

| Chapter IV—Centers for Medicare & Medicaid Services, Department of Health and Human Services (Continued) | 3 |

| Chapter V—Office of Inspector General-Health Care, Department of Health and Human Services | 867 |

## Finding Aids:

<table>
<thead>
<tr>
<th>Table of CFR Titles and Chapters</th>
<th>975</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alphabetical List of Agencies Appearing in the CFR</td>
<td>995</td>
</tr>
<tr>
<td>List of CFR Sections Affected</td>
<td>1005</td>
</tr>
</tbody>
</table>
Cite this Code: CFR

To cite the regulations in this volume use title, part and section number. Thus, 42 CFR 482.1 refers to title 42, part 482, section 1.
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The Code of Federal Regulations is a codification of the general and permanent rules published in the Federal Register by the Executive departments and agencies of the Federal Government. The Code is divided into 50 titles which represent broad areas subject to Federal regulation. Each title is divided into chapters which usually bear the name of the issuing agency. Each chapter is further subdivided into parts covering specific regulatory areas.

Each volume of the Code is revised at least once each calendar year and issued on a quarterly basis approximately as follows:

- Title 1 through Title 16..............................................................as of January 1
- Title 17 through Title 27 .................................................................as of April 1
- Title 28 through Title 41..............................................................as of July 1
- Title 42 through Title 50.............................................................as of October 1

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(c) The incorporating document is drafted and submitted for publication in accordance with 1 CFR part 51.

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OLIVER A. POTTS,
Director,
Office of the Federal Register.
October 1, 2016.
Title 42—PUBLIC HEALTH is composed of five volumes. The parts in these volumes are arranged in the following order: Parts 1–399, parts 400–413, parts 414–429, parts 430 to 481, and part 482 to end. The first volume (parts 1–399) contains current regulations issued under chapter I—Public Health Service (HHS). The second, third, and fourth volumes (parts 400–413, parts 414–429, and parts 430 to 481) include regulations issued under chapter IV—Centers for Medicare & Medicaid Services (HHS) and the fifth volume (part 482 to end) contains the remaining regulations in chapter IV and the regulations issued under chapter V by the Office of Inspector General—Health Care (HHS). The contents of these volumes represent all current regulations codified under this title of the CFR as of October 1, 2016.

For this volume, Ann Worley was Chief Editor. The Code of Federal Regulations publication program is under the direction of John Hyrum Martinez, assisted by Stephen J. Frattini.
Title 42—Public Health

(This book contains part 482 to End)

CHAPTER IV—Centers for Medicare & Medicaid Services, Department of Health and Human Services (Continued) ....... 482

CHAPTER V—Office of Inspector General-Health Care, Department of Health and Human Services ......................... 1000
CHAPTER IV—CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)


SUBCHAPTER G—STANDARDS AND CERTIFICATION

<table>
<thead>
<tr>
<th>Part</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>482</td>
<td>Conditions of participation for hospitals</td>
</tr>
<tr>
<td>483</td>
<td>Requirements for States and long term care facilities</td>
</tr>
<tr>
<td>484</td>
<td>Home health services</td>
</tr>
<tr>
<td>485</td>
<td>Conditions of participation: Specialized providers</td>
</tr>
<tr>
<td>486</td>
<td>Conditions for coverage of specialized services furnished by suppliers</td>
</tr>
<tr>
<td>488</td>
<td>Survey, certification, and enforcement procedures</td>
</tr>
<tr>
<td>489</td>
<td>Provider agreements and supplier approval</td>
</tr>
<tr>
<td>491</td>
<td>Certification of certain health facilities</td>
</tr>
<tr>
<td>493</td>
<td>Laboratory requirements</td>
</tr>
<tr>
<td>494</td>
<td>Conditions for coverage for end-stage renal disease facilities</td>
</tr>
<tr>
<td>495</td>
<td>Standards for the Electronic Health Record Technology Incentive Program</td>
</tr>
<tr>
<td>498</td>
<td>Appeals procedures for determinations that affect participation in the Medicare program and for determinations that affect the participation of ICFs/IID and certain NFs in the Medicaid program</td>
</tr>
</tbody>
</table>

SUBCHAPTER H—HEALTH CARE INFRASTRUCTURE AND MODEL PROGRAMS

<table>
<thead>
<tr>
<th>Part</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>505</td>
<td>Establishment of the health care infrastructure improvement program</td>
</tr>
<tr>
<td>Part</td>
<td>Page</td>
</tr>
<tr>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>510</td>
<td>820</td>
</tr>
<tr>
<td>600</td>
<td>847</td>
</tr>
<tr>
<td>601-699</td>
<td>847</td>
</tr>
</tbody>
</table>
SUBCHAPTER G—STANDARDS AND CERTIFICATION

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

Subpart A—General Provisions
Sec. 482.1 Basis and scope.
482.2 Provision of emergency services by nonparticipating hospitals.

Subpart B—Administration
482.11 Condition of participation: Compliance with Federal, State and local laws.
482.12 Condition of participation: Governing body.
482.13 Condition of participation: Patient’s rights.
482.15 Condition of participation: Emergency preparedness.

Subpart C—Basic Hospital Functions
482.21 Condition of participation: Quality assessment and performance improvement program.
482.22 Condition of participation: Medical staff.
482.23 Condition of participation: Nursing services.
482.24 Condition of participation: Medical record services.
482.25 Condition of participation: Pharmaceutical services.
482.26 Condition of participation: Radiologic services.
482.27 Condition of participation: Laboratory services.
482.28 Condition of participation: Food and dietetic services.
482.30 Condition of participation: Utilization review.
482.41 Condition of participation: Physical environment.
482.42 Condition of participation: Infection control.
482.43 Condition of participation: Discharge planning.
482.45 Condition of participation: Organ, tissue, and eye procurement.

Subpart D—Optional Hospital Services
482.51 Condition of participation: Surgical services.
482.52 Condition of participation: Anesthesia services.
482.53 Condition of participation: Nuclear medicine services.
482.54 Condition of participation: Outpatient services.
482.55 Condition of participation: Emergency services.
482.56 Condition of participation: Rehabilitation services.
482.57 Condition of participation: Respiratory care services.
482.58 Special requirements for hospital providers of long-term care services (“swing-beds”).

Subpart E—Requirements for Specialty Hospitals
482.60 Special provisions applying to psychiatric hospitals.
482.61 Condition of participation: Special medical record requirements for psychiatric hospitals.
482.62 Condition of participation: Special staff requirements for psychiatric hospitals.
482.68 Special requirements for transplant centers.
482.70 Definitions.

GENERAL REQUIREMENTS FOR TRANSPLANT CENTERS
482.72 Condition of participation: OPTN Membership.
482.74 Condition of participation: Notification to CMS.
482.76 Condition of participation: Pediatric Transplants.
482.78 Condition of participation: Emergency preparedness for transplant centers.

TRANSPLANT CENTER DATA SUBMISSION, CLINICAL EXPERIENCE, AND OUTCOME REQUIREMENTS
482.80 Condition of participation: Data submission, clinical experience, and outcome requirements for initial approval of transplant centers.
482.82 Condition of participation: Data submission, clinical experience, and outcome requirements for re-approval of transplant centers.

TRANSPLANT CENTER PROCESS REQUIREMENTS
482.90 Condition of participation: Patient and living donor selection.
482.92 Condition of participation: Organ recovery and receipt.
482.94 Condition of participation: Patient and living donor management.
482.96 Condition of participation: Quality assessment and performance improvement (QAPI).
482.98 Condition of participation: Human resources.
482.100 Condition of participation: Organ procurement.
482.102 Condition of participation: Patient and living donor rights.
§ 482.104 Condition of participation: Additional requirements for kidney transplant centers.

AUTHORITY: Secs. 1102, 1711 and 1881 of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr), unless otherwise noted.

SOURCE: 51 FR 22042, June 17, 1986, unless otherwise noted.

Subpart A—General Provisions

§ 482.1 Basis and scope.

(a) Statutory basis. (1) Section 1861(e) of the Act provides that—
(i) Hospitals participating in Medicare must meet certain specified requirements; and
(ii) The Secretary may impose additional requirements if they are found necessary in the interest of the health and safety of the individuals who are furnished services in hospitals.

(2) Section 1861(f) of the Act provides that an institution participating in Medicare as a psychiatric hospital must meet certain specified requirements imposed on hospitals under section 1861(e), must be primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons, must maintain clinical records and other records that the Secretary finds necessary, and must meet staffing requirements that the Secretary finds necessary to carry out an active program of treatment for individuals who are furnished services in the hospital. A distinct part of an institution can participate as a psychiatric hospital if the institution meets the specified 1861(e) requirements and is primarily engaged in providing psychiatric services, and if the distinct part meets the records and staffing requirements that the Secretary finds necessary.

(3) Sections 1861(k) and 1902(a)(30) of the Act provide that hospitals participating in Medicare and Medicaid must have a utilization review plan that meets specified requirements.

(4) Section 1883 of the Act sets forth the requirements for hospitals that provide long term care under an agreement with the Secretary.

(5) Section 1905(a) of the Act provides that “medical assistance” (Medicaid) payments may be applied to various hospital services. Regulations interpreting those provisions specify that hospitals receiving payment under Medicaid must meet the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services. See §§ 440.10 and 440.165 of this chapter.).

(b) Scope. Except as provided in subpart A of part 488 of this chapter, the provisions of this part serve as the basis of survey activities for the purpose of determining whether a hospital qualifies for a provider agreement under Medicare and Medicaid.

[51 FR 22042, June 17, 1986, as amended at 60 FR 50442, Sept. 29, 1995]

§ 482.2 Provision of emergency services by nonparticipating hospitals.

(a) The services of an institution that does not have an agreement to participate in the Medicare program may, nevertheless, be reimbursed under the program if—

(1) The services are emergency services; and

(2) The institution meets the requirements of section 1861(e) (1) through (5) and (7) of the Act. Rules applicable to emergency services furnished by nonparticipating hospitals are set forth in subpart G of part 424 of this chapter.

(b) Section 440.170(e) of this chapter defines emergency hospital services for purposes of Medicaid reimbursement.


Subpart B—Administration

§ 482.11 Condition of participation: Compliance with Federal, State and local laws.

(a) The hospital must be in compliance with applicable Federal laws related to the health and safety of patients.

(b) The hospital must be—

(1) Licensed; or

(2) Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals.

(c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.
§ 482.12 Condition of participation: Governing body.

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.

(a) Standard: Medical staff. The governing body must:

(1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;

(2) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff;

(3) Assure that the medical staff has bylaws;

(4) Approve medical staff bylaws and other medical staff rules and regulations;

(5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;

(6) Ensure the criteria for selection are individual character, competence, training, experience, and judgment; and

(7) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society.

(8) Ensure that, when telemedicine services are furnished to the hospital’s patients through an agreement with a distant-site telemedicine entity, the written agreement specifies that the distant-site telemedicine entity is a contractor of services to the hospital and as such, in accordance with § 482.12(e), furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant-site telemedicine entity’s physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with § 482.22(a)(4) of this part, grant privileges to physicians and practitioners employed by the distant-site telemedicine entity based on such hospital’s medical staff recommendations; such staff recommendations may rely on information provided by the distant-site telemedicine entity.

(9) Consult directly with the individual assigned the responsibility for the organization and conduct of the hospital’s medical staff, or his or her designee. At a minimum, this direct consultation must occur periodically throughout the fiscal or calendar year and include discussion of matters related to the quality of medical care provided to patients of the hospital. For a multi-hospital system using a single governing body, the single multi-hospital system governing body must consult directly with the individual responsible for the organized medical staff (or his or her designee) of each hospital within its system in addition to the other requirements of this paragraph (a).

(b) Standard: Chief executive officer. The governing body must appoint a chief executive officer who is responsible for managing the hospital.

(c) Standard: Care of patients. In accordance with hospital policy, the governing body must ensure that the following requirements are met:

(1) Every Medicare patient is under the care of:
(i) A doctor of medicine or osteopathy (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under State law or a State’s regulatory mechanism);

(ii) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license;

(iii) A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform;

(iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices;

(v) A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist; and

(vi) A clinical psychologist as defined in §410.71 of this chapter, but only with respect to clinical psychologist services as defined in §410.71 of this chapter and only to the extent permitted by State law.

(2) Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital. If a Medicare patient is admitted by a practitioner not specified in paragraph (c)(1) of this section, that patient is under the care of a doctor of medicine or osteopathy.

(3) A doctor of medicine or osteopathy is on duty or on call at all times.

(4) A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that—

(i) is present on admission or develops during hospitalization; and

(ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or a clinical psychologist, as that scope is—

(A) Defined by the medical staff; 
(B) Permitted by State law; and

(C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors.

(d) Standard: Institutional plan and budget. The institution must have an overall institutional plan that meets the following conditions:

(1) The plan must include an annual operating budget that is prepared according to generally accepted accounting principles.

(2) The budget must include all anticipated income and expenses. This provision does not require that the budget identify item by item the components of each anticipated income or expense.

(3) The plan must provide for capital expenditures for at least a 3-year period, including the year in which the operating budget specified in paragraph (d)(2) of this section is applicable.

(4) The plan must include and identify in detail the objective of, and the anticipated sources of financing for, each anticipated capital expenditure in excess of $600,000 (or a lesser amount that is established, in accordance with section 1122(g)(1) of the Act, by the State in which the hospital is located) that relates to any of the following:

(i) Acquisition of land;

(ii) Improvement of land, buildings, and equipment; or

(iii) The replacement, modernization, and expansion of buildings and equipment.

(5) The plan must be submitted for review to the planning agency designated in accordance with section 1122(b) of the Act, or if an agency is not designated, to the appropriate health planning agency in the State. (See part 100 of this title.) A capital expenditure is not subject to section 1122 review if 75 percent of the health care facility’s patients who are expected to use the service for which the capital expenditure is made are individuals enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP) that meets the requirements of section 1876(b) of the Act, and if the Department determines that the capital expenditure is for services and facilities that are needed by the HMO or CMP in order to operate efficiently and
§ 482.13 Condition of participation: Patient's rights.

A hospital must protect and promote each patient’s rights.

(a) Standard: Notice of rights—(1) A hospital must inform each patient, or when appropriate, the patient’s representative (as allowed under State law), of the patient’s rights, in advance of furnishing or discontinuing patient care whenever possible.

(2) The hospital must maintain a list of all contracted services, including the scope and nature of the services provided.

(f) Standard: Emergency services. (1) If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55.

(2) If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures in effect with respect to the off-campuse department(s) for appraisal of emergencies and referral when appropriate.

(3) If emergency services are provided at the hospital but are not provided at one or more off-campus departments of the hospital, the governing body of the hospital must assure that the medical staff has written policies and procedures in effect with respect to the off-campus department(s) for appraisal of emergencies and referral when appropriate.

(b) Standard: Exercise of rights. (1) The patient has the right to participate in the development and implementation of his or her plan of care.

(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient’s rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), § 489.102 of this part (Requirements for providers), and §489.104 of this part (Effective dates).

(4) The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.

(c) Standard: Privacy and safety. (1) The patient has the right to personal privacy.

(2) The patient has the right to receive care in a safe setting.

(3) The patient has the right to be free from all forms of abuse or harassment.

(d) Standard: Confidentiality of patient records. (1) The patient has the right to the confidentiality of his or her clinical records.

(2) The patient has the right to access information contained in his or her clinical records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.

(e) Standard: Restraint or seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

(1) Definitions. (i) A restraint is—

(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or

(B) A drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.

(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

(ii) Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

(2) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient a staff member or others from harm.

(3) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

(4) The use of restraint or seclusion must be—

(i) In accordance with a written modification to the patient’s plan of care; and

(ii) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.

(5) The use of restraint or seclusion must be in accordance with the order
of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.

(6) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

(7) The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

(8) Unless superseded by State law that is more restrictive—

(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:

(A) 4 hours for adults 18 years of age or older;

(B) 2 hours for children and adolescents 9 to 17 years of age; or

(C) 1 hour for children under 9 years of age; and

(ii) After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) of this part and authorized to order restraint or seclusion by hospital policy in accordance with State law must see and assess the patient.

(iii) Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospital policy.

(9) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

(10) The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy.

(11) Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.

(12) When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention—

(i) By a—

(A) Physician or other licensed independent practitioner; or

(B) Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section.

(ii) To evaluate—

(A) The patient's immediate situation;

(B) The patient's reaction to the intervention;

(C) The patient's medical and behavioral condition; and

(D) The need to continue or terminate the restraint or seclusion.

(13) States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (e)(12)(i) of this section.

(14) If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) as soon as possible after the completion of the 1-hour face-to-face evaluation.

(15) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored—

(i) Face-to-face by an assigned, trained staff member; or
(ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

(16) When restraint or seclusion is used, there must be documentation in the patient’s medical record of the following:

(i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;

(ii) A description of the patient’s behavior and the intervention used;

(iii) Alternatives or other less restrictive interventions attempted (as applicable);

(iv) The patient’s condition or symptom(s) that warranted the use of the restraint or seclusion; and

(v) The patient’s response to the intervention(s) used, including the rationale for continued use of the intervention.

(f) Standard: Restraint or seclusion: Staff training requirements. The patient has the right to safe implementation of restraint or seclusion by trained staff.

(1) Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion—

(i) Before performing any of the actions specified in this paragraph;

(ii) As part of orientation; and

(iii) Subsequently on a periodic basis consistent with hospital policy.

(2) Training content. The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

(i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.

(ii) The use of nonphysical intervention skills.

(iii) Choosing the least restrictive intervention based on an individualized assessment of the patient’s medical, or behavioral status or condition.

(iv) The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);

(v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.

(vi) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation.

(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

(3) Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients’ behaviors.

(4) Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.

(g) Standard: Death reporting requirements: Hospitals must report deaths associated with the use of seclusion or restraint.

(1) With the exception of deaths described under paragraph (g)(2) of this section, the hospital must report the following information to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient’s death:

(i) Each death that occurs while a patient is in restraint or seclusion.

(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient’s death, regardless of the type(s) of restraint used on the patient during this time. “Reasonable to assume” in this context includes, but is not limited to,
(1) Any death that occurs while a patient is in such restraints.

(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints.

(2) The staff must document in the patient’s medical record the date and time the death was:

(i) Reported to CMS for deaths described in paragraph (g)(1) of this section;

(ii) Recorded in the internal log or other system for deaths described in paragraph (g)(2) of this section.

(4) For deaths described in paragraph (g)(2) of this section, entries into the internal log or other system must be documented as follows:

(i) Each entry must be made not later than seven days after the date of death of the patient.

(ii) Each entry must document the patient’s name, date of birth, date of death, name of attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c), medical record number, and primary diagnosis(es).

(iii) The information must be made available in either written or electronic form to CMS immediately upon request.

(h) Standard: Patient visitation rights. A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. A hospital must meet the following requirements:

(1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, when he or she is informed of his or her other rights under this section.

(2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

(3) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

(4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.

§482.15 42 CFR Ch. IV (10–1–16 Edition)

(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the hospital’s efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts.

(b) Policies and procedures. The hospital must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
   (i) Food, water, medical, and pharmaceutical supplies.
   (ii) Alternate sources of energy to maintain the following:
      (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
      (B) Emergency lighting.
      (C) Fire detection, extinguishing, and alarm systems.
      (D) Sewage and waste disposal.

(2) A system to track the location of on-duty staff and sheltered patients in the hospital’s care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the hospital must document the specific name and location of the receiving facility or other location.

(3) Safe evacuation from the hospital, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

(4) A means to shelter in place for patients, staff, and volunteers who remain in the facility.

(5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

(6) The use of volunteers in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

(7) The development of arrangements with other hospitals and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to hospital patients.

(8) The role of the hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

(c) Communication plan. The hospital must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

(1) Names and contact information for the following:
   (i) Staff.
   (ii) Entities providing services under arrangement.
   (iii) Patients’ physicians.
   (iv) Other hospitals and CAHs
   (v) Volunteers.

(2) Contact information for the following:
   (i) Federal, State, tribal, regional, and local emergency management agencies.
   (ii) Other sources of assistance.

(3) Primary and alternate means for communicating with the following:
   (i) Hospital’s staff.
   (ii) Federal, State, tribal, regional, and local emergency management agencies.

(4) A method for sharing information and medical documentation for patients under the hospital’s care, as necessary, with other health care providers to maintain the continuity of care.
Centers for Medicare & Medicaid Services, HHS § 482.15

(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).

(6) A means of providing information about the general condition and location of patients under the facility’s care as permitted under 45 CFR 164.510(b)(4).

(7) A means of providing information about the hospital’s occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

d Training and testing. The hospital must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

(1) Training program. The hospital must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

(2) Testing. The hospital must conduct exercises to test the emergency plan at least annually. The hospital must do all of the following:

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the hospital experiences an actual natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

(ii) Conduct an additional exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based.

(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the hospital’s response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the hospital’s emergency plan, as needed.

(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.

(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, and TIA 12–6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

(2) Emergency generator inspection and testing. The hospital must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

(3) Emergency generator fuel. Hospitals that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

(f) Integrated healthcare systems. If a hospital is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the hospital may choose to participate in the healthcare system’s coordinated emergency preparedness program. If elected,
the unified and integrated emergency preparedness program must—

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

(2) Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered.

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:

(i) A documented community-based risk assessment, utilizing an all-hazards approach.

(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

(g) Transplant hospitals. If a hospital has one or more transplant centers (as defined in §482.70)—

(1) A representative from each transplant center must be included in the development and maintenance of the hospital’s emergency preparedness program; and

(2) The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant center, and the OPO for the DSA where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency.

(h) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the FEDERAL REGISTER to announce the changes.


(ii) TIA 12–2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12–3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12–4 to NFPA 99, issued March 7, 2013.

(v) TIA 12–5 to NFPA 99, issued August 1, 2013.


(viii) TIA 12–1 to NFPA 101, issued August 11, 2011.


(x) TIA 12–3 to NFPA 101, issued October 22, 2013.

(xi) TIA 12–4 to NFPA 101, issued October 22, 2013.

(xii) [Reserved]


(2) [Reserved]

EFFECTIVE DATE NOTE: At 81 FR 64028, Sept. 16, 2016, §482.15 was added, effective Nov. 15, 2016.
Subpart C—Basic Hospital Functions

§ 482.21 Condition of participation: Quality assessment and performance improvement program.

The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital’s governing body must ensure that the program reflects the complexity of the hospital’s organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

(a) Standard: Program scope. (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and identify and reduce medical errors.

(2) The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations.

(b) Standard: Program data. (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital’s Quality Improvement Organization.

(2) The hospital must use the data collected to—

(i) Monitor the effectiveness and safety of services and quality of care; and

(ii) Identify opportunities for improvement and changes that will lead to improvement.

(3) The frequency and detail of data collection must be specified by the hospital’s governing body.

(c) Standard: Program activities. (1) The hospital must set priorities for its performance improvement activities that—

(i) Focus on high-risk, high-volume, or problem-prone areas;

(ii) Consider the incidence, prevalence, and severity of problems in those areas; and

(iii) Affect health outcomes, patient safety, and quality of care.

(2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.

(3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.

(d) Standard: Performance improvement projects. As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects.

(1) The number and scope of distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital’s services and operations.

(2) A hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not need to demonstrate measurable improvement in indicators related to health outcomes.

(3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.

(4) A hospital is not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort.

(e) Standard: Executive responsibilities. The hospital’s governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following:

(1) That an ongoing program for quality improvement and patient safety,
including the reduction of medical errors, is defined, implemented, and maintained.

(2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated.

(3) That clear expectations for safety are established.

(4) That adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital’s performance and reducing risk to patients.

(5) That the determination of the number of distinct improvement projects is conducted annually.

[68 FR 3454, Jan. 24, 2003]

§ 482.22 Condition of participation: Medical staff.

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.

(a) Standard: Eligibility and process for appointment to medical staff. The medical staff must be composed of doctors of medicine or osteopathy. In accordance with State law, including scope-of-practice laws, the medical staff may also include other categories of physicians (as listed at § 482.12(c)(1)) and non-physician practitioners who are determined to be eligible for appointment by the governing body.

(1) The medical staff must periodically conduct appraisals of its members.

(2) The medical staff must examine the credentials of all eligible candidates for medical staff membership and make recommendations to the governing body on the appointment of these candidates in accordance with State law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations, in addition to the requirements contained in this section.

(3) When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital, the governing body of the hospital whose patients are receiving the telemedicine services may choose, in lieu of the requirements in paragraphs (a)(1) and (a)(2) of this section, to have its medical staff rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the hospital’s governing body ensures, through its written agreement with the distant-site hospital, that all of the following provisions are met:

(i) The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.

(ii) The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician’s or practitioner’s privileges at the distant-site hospital.

(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving the telemedicine services is located.

(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services, the hospital has evidence of an internal review of the distant-site physician’s or practitioner’s performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital’s patients and all complaints the hospital has received about the distant-site physician or practitioner.

(4) When telemedicine services are furnished to the hospital’s patients through an agreement with a distant-site telemedicine entity, the governing body of the hospital whose patients are receiving the telemedicine services
may choose, in lieu of the requirements in paragraphs (a)(1) and (a)(2) of this section, to have its medical staff rely upon the credentialing and privileging decisions made by the distant-site telemedicine entity when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the hospital’s governing body ensures, through its written agreement with the distant-site telemedicine entity, that the distant-site telemedicine entity furnishes services that, in accordance with §482.12(e), permit the hospital to comply with all applicable conditions of participation for the contracted services. The hospital’s governing body must also ensure, through its written agreement with the distant-site telemedicine entity, that all of the following provisions are met:

(i) The distant-site telemedicine entity’s medical staff credentialing and privileging process and standards at least meet the standards at §482.12(a)(1) through (a)(7) and §482.22(a)(1) through (a)(2).

(ii) The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services, which provides the hospital with a current list of the distant-site physician’s or practitioner’s privileges at the distant-site telemedicine entity.

(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving such telemedicine services is located.

(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services, the hospital has evidence of an internal review of the distant-site physician’s or practitioner’s performance of these privileges and sends the distant-site telemedicine entity such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital’s patients, and all complaints the hospital has received about the distant-site physician or practitioner.

(b) Standard: Medical staff organization and accountability. The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to patients.

(1) The medical staff must be organized in a manner approved by the governing body.

(2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.

(3) The responsibility for organization and conduct of the medical staff must be assigned only to one of the following:

(i) An individual doctor of medicine or osteopathy.

(ii) A doctor of dental surgery or dental medicine, when permitted by State law of the State in which the hospital is located.

(iii) A doctor of podiatric medicine, when permitted by State law of the State in which the hospital is located.

(4) If a hospital is part of a hospital system consisting of multiple separately certified hospitals and the system elects to have a unified and integrated medical staff for its member hospitals, after determining that such a decision is in accordance with all applicable State and local laws, each separately certified hospital must demonstrate that:

(i) The medical staff members of each separately certified hospital in the system (that is, all medical staff members who hold specific privileges to practice at that hospital) have voted by majority, in accordance with medical staff bylaws, either to accept a unified and integrated medical staff structure or to opt out of such a structure and to maintain a separate and distinct medical staff for their respective hospital.

(ii) The unified and integrated medical staff has bylaws, rules, and requirements that describe its processes for self-governance, appointment, credentialing, privileging, and oversight, as well as its peer review policies and due process rights guarantees, and
which include a process for the members of the medical staff of each separately certified hospital (that is, all medical staff members who hold specific privileges to practice at that hospital) to be advised of their rights to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their hospital;

(iii) The unified and integrated medical staff is established in a manner that takes into account each member hospital’s unique circumstances and any significant differences in patient populations and services offered in each hospital; and

(iv) The unified and integrated medical staff establishes and implements policies and procedures to ensure that the needs and concerns expressed by members of the medical staff, at each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated medical staff has mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed.

(c) Standard: Medical staff bylaws. The medical staff must adopt and enforce bylaws to carry out its responsibilities. The bylaws must:

(1) Be approved by the governing body.

(2) Include a statement of the duties and privileges of each category of medical staff (e.g., active, courtesy, etc.).

(3) Describe the organization of the medical staff.

(4) Describe the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body.

(5) Include a requirement that—

(i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

(ii) An updated examination of the patient, including any changes in the patient’s condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

(6) Include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges. For distant-site physicians and practitioners requesting privileges to furnish telemedicine services under an agreement with the hospital, the criteria for determining privileges and the procedure for applying the criteria are also subject to the requirements in §482.12(a)(8) and (a)(9), and §482.22(a)(3) and (a)(4).

(d) Standard: Autopsies. The medical staff should attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest. The mechanism for documenting permission to perform an autopsy must be defined. There must be a system for notifying the medical staff, and specifically the attending practitioner, when an autopsy is being performed.


§482.23 Condition of participation: Nursing services.

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.
(a) **Standard: Organization.** The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital.

(b) **Standard: Staffing and delivery of care.** The nursing service must have adequate numbers of licensed registered nurses, licensed practical vocational nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.

1. The hospital must provide 24-hour nursing services furnished or supervised by a registered nurse, and have a licensed practical nurse or registered nurse on duty at all times, except for rural hospitals that have in effect a 24-hour nursing waiver granted under §488.54(c) of this chapter.

2. The nursing service must have a procedure to ensure that hospital nursing personnel for whom licensure is required have valid and current licensure.

3. A registered nurse must supervise and evaluate the nursing care for each patient.

4. The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.

5. A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient’s needs and the specialized qualifications and competence of the nursing staff available.

6. Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing service.

(c) **Standard: Preparation and administration of drugs.**

1. Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient’s care as specified under §482.12(c), and accepted standards of practice.

2. Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

3. Drugs and biologicals may be prepared and administered on the orders contained within pre-printed and electronic standing orders, order sets, and protocols for patient orders only if such orders meet the requirements of §482.24(c)(3).

4. All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.

5. With the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders in accordance with State law and hospital policy, and who is responsible for the care of the patient as specified under §482.12(c).

6. If verbal orders are used, they are to be used infrequently.

7. When verbal orders are used, they must only be accepted by persons who are authorized to do so by hospital policy and procedures consistent with Federal and State law.

8. Orders for drugs and biologicals may be documented and signed by other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law.
including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

(4) Blood transfusions and intravenous medications must be administered in accordance with State law and approved medical staff policies and procedures.

(5) There must be a hospital procedure for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs.

(6) The hospital may allow a patient (or his or her caregiver/support person where appropriate) to self-administer both hospital-issued medications and the patient’s own medications brought into the hospital, as defined and specified in the hospital’s policies and procedures.

(i) If the hospital allows a patient to self-administer specific hospital-issued medications, then the hospital must have policies and procedures in place to:

(A) Ensure that a practitioner responsible for the care of the patient has issued an order, consistent with hospital policy, permitting self-administration.

(B) Assess the capacity of the patient (or the patient’s caregiver/support person where appropriate) to self-administer the specified medication(s).

(C) Instruct the patient (or the patient’s caregiver/support person where appropriate) in the safe and accurate administration of the specified medication(s).

(D) Address the security of the medication(s) for each patient.

(E) Document the administration of each medication, as reported by the patient (or the patient’s caregiver/support person where appropriate), in the patient’s medical record.

(ii) If the hospital allows a patient to self-administer specific hospital-issued medications, then the hospital must have policies and procedures in place to:

(A) Ensure that a practitioner responsible for the care of the patient has issued an order, consistent with hospital policy, permitting self-administration of the specified medication(s), and also determine if the patient (or the patient’s caregiver/support person where appropriate) needs instruction in the safe and accurate administration of the specified medication(s).

(B) Assess the capacity of the patient (or the patient’s caregiver/support person where appropriate) to self-administer the specified medication(s), and also determine if the patient (or the patient’s caregiver/support person where appropriate) needs instruction in the safe and accurate administration of the specified medication(s).

(C) Identify the specified medication(s) and visually evaluate the medication(s) for integrity.

(D) Address the security of the medication(s) for each patient.

(E) Document the administration of each medication, as reported by the patient (or the patient’s caregiver/support person where appropriate), in the patient’s medical record.

§ 482.24 Condition of participation: Medical record services.

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

(a) Standard: Organization and staffing. The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records.

(b) Standard: Form and retention of record. The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

(i) Medical records must be retained in their original or legally reproduced form for a period of at least 5 years.

(ii) The hospital must have a system of coding and indexing medical records. The system must allow for timely retrieval by diagnosis and procedure, in order to support medical care evaluation studies.
(3) The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released by the hospital only in accordance with Federal or State laws, court orders, or subpoenas.

(c) Standard: Content of record. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services.

(1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

(2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

(3) Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders only if the hospital:

(i) Establishes that such orders and protocols have been reviewed and approved by the medical staff and the hospital’s nursing and pharmacy leadership;

(ii) Demonstrates that such orders and protocols are consistent with nationally recognized and evidence-based guidelines;

(iii) Ensures that the periodic and regular review of such orders and protocols is conducted by the medical staff and the hospital’s nursing and pharmacy leadership to determine the continuing usefulness and safety of the orders and protocols; and

(iv) Ensures that such orders and protocols are dated, timed, and authenticated promptly in the patient’s medical record by the ordering practitioner or by another practitioner responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

(4) All records must document the following, as appropriate:

(i) Evidence of—

(A) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient’s medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

(B) An updated examination of the patient, including any changes in the patient’s condition, when the medical history and physical examination are completed within 30 days before admission or registration. Documentation of the updated examination must be placed in the patient’s medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

(ii) Admitting diagnosis.

(iii) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.

(iv) Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.

(v) Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.

(vi) All practitioners’ orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient’s condition.

(vii) Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.
§ 482.25 Condition of participation: Pharmaceutical services.

The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

(a) Standard: Pharmacy management and administration. The pharmacy or drug storage area must be administered in accordance with accepted professional principles.

(1) A full-time, part-time, or consulting pharmacist must be responsible for developing, supervising, and coordinating all the activities of the pharmacy services.

(2) The pharmaceutical service must have an adequate number of personnel to ensure quality pharmaceutical services, including emergency services.

(3) Current and accurate records must be kept of the receipt and disposition of all scheduled drugs.

(b) Standard: Delivery of services. In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with State and Federal law.

(1) All compounding, packaging, and dispensing of drugs and biologicals must be under the supervision of a pharmacist and performed consistent with State and Federal laws.

(2) All drugs and biologicals must be kept in a secure area, and locked when appropriate.

(ii) Drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 must be kept locked within a secure area.

(iii) Only authorized personnel may have access to locked areas.

(3) Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use.

(4) When a pharmacist is not available, drugs and biologicals must be removed from the pharmacy or storage area only by personnel designated in the policies of the medical staff and pharmaceutical service, in accordance with Federal and State law.

(5) Drugs and biologicals not specifically prescribed as to time or number of doses must automatically be stopped after a reasonable time that is predetermined by the medical staff.

(6) Drug administration errors, adverse drug reactions, and incompatibilities must be immediately reported to the attending physician and, if appropriate, to the hospital's quality assessment and performance improvement program.

(7) Abuses and losses of controlled substances must be reported, in accordance with applicable Federal and State laws, to the individual responsible for the pharmaceutical service, and to the chief executive officer, as appropriate.

(8) Information relating to drug interactions and information of drug therapy, side effects, toxicology, dosage, indications for use, and routes of administration must be available to the professional staff.

(9) A formulary system must be established by the medical staff to assure quality pharmaceuticals at reasonable costs.

§ 482.26 Condition of participation: Radiologic services.

The hospital must maintain, or have available, diagnostic radiologic services. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications.

(a) Standard: Radiologic services. The hospital must maintain, or have available, radiologic services according to needs of the patients.
Centers for Medicare & Medicaid Services, HHS
§ 482.27

(b) Standard: Safety for patients and personnel. The radiologic services, particularly ionizing radiology procedures, must be free from hazards for patients and personnel.

(1) Proper safety precautions must be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as appropriate storage, use, and disposal of radioactive materials.

(2) Periodic inspection of equipment must be made and hazards identified must be promptly corrected.

(3) Radiation workers must be checked periodically, by the use of exposure meters or badge tests, for amount of radiation exposure.

(4) Radiologic services must be provided only on the order of practitioners with clinical privileges or, consistent with State law, of other practitioners authorized by the medical staff and the governing body to order the services.

(c) Standard: Personnel. (1) A qualified full-time, part-time, or consulting radiologist must supervise the ionizing radiology services and must interpret only those radiologic tests that are determined by the medical staff to require a radiologist’s specialized knowledge. For purposes of this section, a radiologist is a doctor of medicine or osteopathy who is qualified by education and experience in radiology.

(2) Only personnel designated as qualified by the medical staff may use the radiologic equipment and administer procedures.

(d) Standard: Records. Records of radiologic services must be maintained.

(1) The radiologist or other practitioner who performs radiology services must sign reports of his or her interpretations.

(2) The hospital must maintain the following for at least 5 years:

(i) Copies of reports and printouts.

(ii) Films, scans, and other image records, as appropriate.

[51 FR 22042, June 17, 1986; 51 FR 27848, Aug. 4, 1986]

§ 482.27 Condition of participation: Laboratory services.

The hospital must maintain, or have available, adequate laboratory services to meet the needs of its patients. The hospital must ensure that all laboratory services provided to its patients are performed in a facility certified in accordance with part 493 of this chapter.

(a) Standard: Adequacy of laboratory services. The hospital must have laboratory services available, either directly or through a contractual agreement with a certified laboratory that meets requirements of part 493 of this chapter.

(1) Emergency laboratory services must be available 24 hours a day.

(2) A written description of services provided must be available to the medical staff.

(3) The laboratory must make provision for proper receipt and reporting of tissue specimens.

(4) The medical staff and a pathologist must determine which tissue specimens require a macroscopic (gross) examination and which require both macroscopic and microscopic examinations.

(b) Standard: Potentially infectious blood and blood components—(1) Potentially human immunodeficiency virus (HIV) infectious blood and blood components. Potentially HIV infectious blood and blood components are prior collections from a donor—

(i) Who tested negative at the time of donation but tests reactive for evidence of HIV infection on a later donation;

(ii) Who tests positive on the supplemental (additional, more specific) test or other follow-up testing required by FDA; and

(iii) For whom the timing of seroconversion cannot be precisely estimated.

(2) Potentially hepatitis C virus (HCV) infectious blood and blood components. Potentially HCV infectious blood and blood components are the blood and blood components identified in 21 CFR 610.47.

(3) Services furnished by an outside blood collecting establishment. If a hospital regularly uses the services of an outside blood collecting establishment, it must have an agreement with the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components. The agreement must require
§482.27

that the blood collecting establishment notify the hospital—
(i) Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of HIV or HCV infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection;
(ii) Within 45 days of the test, of the results of the supplemental (additional, more specific) test for HIV or HCV, as relevant, or other follow-up testing required by FDA; and
(iii) Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available, as set forth at 21 CFR 610.48(b)(3).

(4) Quarantine and disposition of blood and blood components pending completion of testing. If the blood collecting establishment (either internal or under an agreement) notifies the hospital of the reactive HIV or HCV screening test results, the hospital must determine the disposition of the blood or blood product and quarantine all blood and blood components from previous donations in inventory.

(i) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is negative, absent other informative test results, the hospital may release the blood and blood components from quarantine.

(ii) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is positive, the hospital must—
(A) Dispose of the blood and blood components; and
(B) Notify the transfusion beneficiaries as set forth in paragraph (b)(6) of this section.

(iii) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is indeterminate, the hospital must destroy or label prior collections of blood or blood components held in quarantine as set forth at 21 CFR 610.46(b)(2), 610.47(b)(2), and 610.48(c)(2).

(5) Recordkeeping by the hospital. The hospital must maintain—
(i) Records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval; and
(ii) A fully funded plan to transfer these records to another hospital or other entity if such hospital ceases operation for any reason.

(6) Patient notification. If the hospital has administered potentially HIV or HCV infectious blood or blood components (either directly through its own blood collecting establishment or under an agreement) or released such blood or blood components to another entity or individual, the hospital must take the following actions:

(i) Make reasonable attempts to notify the patient, or to notify the attending physician or the physician who ordered the blood or blood component and ask the physician to notify the patient, or other individual as permitted under paragraph (b)(10) of this section, that potentially HIV or HCV infectious blood or blood components were transfused to the patient and that there may be a need for HIV or HCV testing and counseling.

(ii) If the physician is unavailable or declines to make the notification, make reasonable attempts to give this notification to the patient, legal guardian, or relative.

(iii) Document in the patient’s medical record the notification or attempts to give the required notification.

(7) Timeframe for notification—(i) For donors tested on or after February 20, 2008. For notifications resulting from donors tested on or after February 20, 2008 as set forth at 21 CFR 610.46 and 21 CFR 610.47 the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HIV or HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification over a period of 12 weeks unless—
(A) The patient is located and notified; or
(B) The hospital is unable to locate the patient and documents in the patient’s medical record the extenuating circumstances beyond the hospital’s control that caused the notification timeframe to exceed 12 weeks.

(ii) For donors tested before February 20, 2008. For notifications resulting from donors tested before February 20, 2008 as set forth at 21 CFR 610.48(b) and (c), the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification and must complete the actions within 1 year of the date on which the hospital received notification from the outside blood collecting establishment.

(8) **Content of notification.** The notification must include the following information:

(i) A basic explanation of the need for HIV or HCV testing and counseling;

(ii) Enough oral or written information so that an informed decision can be made about whether to obtain HIV or HCV testing and counseling; and

(iii) A list of programs or places where the person can obtain HIV or HCV testing and counseling, including any requirements or restrictions the program may impose.

(9) **Policies and procedures.** The hospital must establish policies and procedures for notification and documentation that conform to Federal, State, and local laws, including requirements for the confidentiality of medical records and other patient information.

(10) **Notification to legal representative or relative.** If the patient has been adjudged incompetent by a State court, the physician or hospital must notify a legal representative designated in accordance with State law. If the patient is competent, but State law permits a legal representative or relative to receive the information on the patient’s behalf, the physician or hospital must notify the patient or his or her legal representative or relative. For possible HIV infectious transfusion beneficiaries that are deceased, the physician or hospital must inform the deceased patient’s legal representative or relative. If the patient is a minor, the parents or legal guardian must be notified.

(11) **Applicability.** HCV notification requirements resulting from donors tested before February 20, 2008 as set forth at 21 CFR 610.48 will expire on August 24, 2015.

(c) **General blood safety issues.** For lookback activities only related to new blood safety issues that are identified after August 24, 2007, hospitals must comply with FDA regulations as they pertain to blood safety issues in the following areas:

(1) Appropriate testing and quarantining of infectious blood and blood components.

(2) Notification and counseling of beneficiaries that may have received infectious blood and blood components.

§ 482.28 **Condition of participation: Food and dietetic services.**

The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of participation if the company has a dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment.

(a) **Standard: Organization.** (1) The hospital must have a full-time employee who—

(i) Serves as director of the food and dietetic service;

(ii) Is responsible for the daily management of the dietary services; and

(iii) Is qualified by experience or training.

(2) There must be a qualified dietitian, full-time, part-time, or on a consultant basis.

(3) There must be administrative and technical personnel competent in their respective duties.

(b) **Standard: Diets.** Menus must meet the needs of the patients.
§482.30 Condition of participation: Utilization review.

The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

(a) Applicability. The provisions of this section apply except in either of the following circumstances:

(1) A Utilization and Quality Control Quality Improvement Organization (QIO) has assumed binding review for the hospital.

(2) CMS has determined that the UR procedures established by the State under title XIX of the Act are superior to the procedures required in this section, and has required hospitals in that State to meet the UR plan requirements under §§456.50 through 456.245 of this chapter.

(b) Standard: Composition of utilization review committee. A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in §482.12(c)(1).

(1) Except as specified in paragraphs (b)(2) and (3) of this section, the UR committee must be one of the following:

(i) A staff committee of the institution;

(ii) A group outside the institution—

(A) Established by the local medical society and some or all of the hospitals in the locality; or

(B) Established in a manner approved by CMS.

(2) If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section.

(3) The committee’s or group’s reviews may not be conducted by any individual who—

(i) Has a direct financial interest (for example, an ownership interest) in that hospital; or

(ii) Was professionally involved in the care of the patient whose case is being reviewed.

(c) Standard:Scope and frequency of review. (1) The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of—

(i) Admissions to the institution;

(ii) The duration of stays; and

(iii) Professional services furnished, including drugs and biologicals.

(2) Review of admissions may be performed before, at, or after hospital admission.

(3) Except as specified in paragraph (e) of this section, reviews may be conducted on a sample basis.

(4) Hospitals that are paid for inpatient hospital services under the prospective payment system set forth in part 412 of this chapter must conduct review of duration of stays and review of professional services as follows:

(i) For duration of stays, these hospitals need review only cases that they reasonably assume to be outlier cases based on extended length of stay, as described in §412.80(a)(1)(i) of this chapter; and

(ii) For professional services, these hospitals need review only cases that they reasonably assume to be outlier cases based on extraordinarily high costs, as described in §412.80(a)(1)(ii) of this chapter.

(d) Standard: Determination regarding admissions or continued stays. (1) The determination that an admission or continued stay is not medically necessary—
(i) May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified of §482.12(c), concur with the determination or fail to present their views when afforded the opportunity; and
(ii) Must be made by at least two members of the UR committee in all other cases.

(2) Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in §482.12(c), and afford the practitioner or practitioners the opportunity to present their views.

(3) If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in §482.12(c);

(e) Standard: Extended stay review. (1) In hospitals that are not paid under the prospective payment system, the UR committee must make a periodic review, as specified in the UR plan, of each current inpatient receiving hospital services during a continuous period of extended duration. The scheduling of the periodic reviews may—
(i) Be the same for all cases; or
(ii) Differ for different classes of cases.

(2) In hospitals paid under the prospective payment system, the UR committee must review all cases reasonably assumed by the hospital to be outlier cases because the extended length of stay exceeds the threshold criteria for the diagnosis, as described in §412.80(a)(1)(i). The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis.

(3) The UR committee must make the periodic review no later than 7 days after the day required in the UR plan.

(f) Standard: Review of professional services. The committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.

§482.41 Condition of participation: Physical environment.

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

(a) Standard: Buildings. The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

(1) There must be emergency power and lighting in at least the operating, recovery, intensive care, and emergency rooms, and stairwells. In all other areas not serviced by the emergency supply source, battery lamps and flashlights must be available.

(2) There must be facilities for emergency gas and water supply.

(b) Standard: Life safety from fire. (1) Except as otherwise provided in this section—

(i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.

(ii) Notwithstanding paragraph (b)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.

(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients.

(3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code
imposed by State law adequately protects patients in hospitals.

(4) The hospital must have procedures for the proper routine storage and prompt disposal of trash.

(5) The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire fighting authorities.

(6) The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies.

(7) A hospital may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access;

(8) When a sprinkler system is shut down for more than 10 hours, the hospital must:

(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or

(ii) Establish a fire watch until the system is back in service.

(9) Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016 the sill height must not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement.

(i) The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours.

(ii) The sill height in special nursing care areas of new occupancies must not exceed 60 inches.

(c) Standard: Building safety. Except as otherwise provided in this section, the hospital must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99) and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6.

(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a hospital.

(2) If application of the Health Care Facilities Code required under paragraph (c) of this section would result in unreasonable hardship for the hospital, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.

(d) Standard: Facilities. The hospital must maintain adequate facilities for its services.

(1) Diagnostic and therapeutic facilities must be located for the safety of patients.

(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

(3) The extent and complexity of facilities must be determined by the services offered.

(4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.

(e) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the FEDERAL REGISTER to announce the changes.


(ii) TIA 12-2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.

(v) TIA 12-5 to NFPA 99, issued August 1, 2013.

(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.
§ 482.42 Condition of participation: Infection control.

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

(a) Standard: Organization and policies. A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.

(b) Standard: Responsibilities of chief executive officer, medical staff, and director of nursing services. The chief executive officer, the medical staff, and the director of nursing services must—

(1) Ensure that the hospital-wide quality assessment and performance improvement (QAPI) program and training programs address problems identified by the infection control officer or officers; and

(2) Be responsible for the implementation of successful corrective action plans in affected problem areas.

§ 482.43 Condition of participation: Discharge planning.

The hospital must have in effect a discharge planning process that applies to all patients. The hospital’s policies and procedures must be specified in writing.

(a) Standard: Identification of patients in need of discharge planning. The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

(b) Standard: Discharge planning evaluation. (1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient’s request, the request of a person acting on the patient’s behalf, or the request of the physician.

(2) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.

(3) The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.

(4) The discharge planning evaluation must include an evaluation of the likelihood of a patient’s capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

(5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

(6) The hospital must include the discharge planning evaluation in the patient’s medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.

(c) Standard: Discharge plan. (1) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.

(2) In the absence of a finding by the hospital that a patient needs a discharge plan, the patient’s physician may request a discharge plan. In such a
case, the hospital must develop a discharge plan for the patient.

(3) The hospital must arrange for the initial implementation of the patient’s discharge plan.

(4) The hospital must reassess the patient’s discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

(5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

(6) The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

(i) This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.

(ii) For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and posthospital extended care services through individuals and entities that have a contract with the managed care organizations.

(iii) The hospital must document in the patient’s medical record that the list was presented to the patient or to the individual acting on the patient’s behalf.

(7) The hospital, as part of the discharge planning process, must inform the patient or the patient’s family of their freedom to choose among participating Medicare providers of posthospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.

(8) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of part 420, subpart C, of this chapter.

(d) Standard: Transfer or referral. The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for followup or ancillary care.

(e) Standard: Reassessment. The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.


§ 482.45 Condition of participation: Organ, tissue, and eye procurement.

(a) Standard: Organ procurement responsibilities. The hospital must have and implement written protocols that:

(1) Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the hospital, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the hospital for this purpose;

(2) Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;

(3) Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its options to donate organs, tissues, or eyes or to decline to donate. The individual designated by the hospital to initiate the request to the family must
be an organ procurement representative or a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;

(4) Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the families of potential donors;

(5) Ensure that the hospital works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes take place.

(b) Standard: Organ transplantation responsibilities. (1) A hospital in which organ transplants are performed must be a member of the Organ Procurement and Transplantation Network (OPTN) established and operated in accordance with section 372 of the Public Health Service (PHS) Act (42 U.S.C. 274) and abide by its rules. The term “rules of the OPTN” means those rules provided for in regulations issued by the Secretary in accordance with section 372 of the PHS Act which are enforceable under 42 CFR 121.10. No hospital is considered to be out of compliance with section 1138(a)(1)(B) of the Act, or with the requirements of this paragraph, unless the Secretary has given the OPTN formal notice that he or she approves the decision to exclude the hospital from the OPTN and has notified the hospital in writing.

(2) For purposes of these standards, the term “organ” means a human kidney, liver, heart, lung, or pancreas.

(3) If a hospital performs any type of transplants, it must provide organ-transplant-related data, as requested by the OPTN, the Scientific Registry, and the OPOs. The hospital must also provide such data directly to the Department when requested by the Secretary.

[63 FR 33875, June 22, 1998]
(ii) An updated examination of the patient, including any changes in the patient’s condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration.

(2) A properly executed informed consent form for the operation must be in the patient’s chart before surgery, except in emergencies.

(3) The following equipment must be available to the operating room suites: call-in-system, cardiac monitor, resuscitator, defibrillator, aspirator, and tracheotomy set.

(4) There must be adequate provisions for immediate post-operative care.

(5) The operating room register must be complete and up-to-date.

(6) An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon.

[51 FR 22042, June 17, 1986, as amended at 72 FR 66933, Nov. 27, 2007]

§ 482.52 Condition of participation: Anesthesia services.

If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

(a) Standard: Organization and staffing. The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by—

(1) A qualified anesthesiologist;

(2) A doctor of medicine or osteopathy (other than an anesthesiologist);

(3) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;

(4) A certified registered nurse anesthetist (CRNA), as defined in §410.69(b) of this chapter, who, unless exempted in accordance with paragraph (c)(2) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or

(5) An anesthesiologist’s assistant, as defined in §410.69(b) of this chapter, who is under the supervision of an anesthesiologist who is immediately available if needed.

(b) Standard: Delivery of services. Anesthesia services must be consistent with needs and resources. Policies on anesthesia procedures must include the delineation of preanesthesia and post anesthesia responsibilities. The policies must ensure that the following are provided for each patient:

(1) A preanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, performed within 48 hours prior to surgery or a procedure requiring anesthesia services.

(2) An intraoperative anesthesia record.

(3) A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, no later than 48 hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care.

(c) Standard: State exemption. (1) A hospital may be exempted from the requirement for physician supervision of CRNAs as described in paragraph (a)(4) of this section, if the State in which the hospital is located submits a letter to CMS signed by the Governor, following consultation with the State’s Boards of Medicine and Nursing, requesting exemption from physician supervision of CRNAs. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State’s citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with State law.

(2) The request for exemption and recognition of State laws, and the
withdrawal of the request may be submitted at any time, and are effective upon submission.


§ 482.53 Condition of participation: Nuclear medicine services.

If the hospital provides nuclear medicine services, those services must meet the needs of the patients in accordance with acceptable standards of practice.

(a) Standard: Organization and staffing. The organization of the nuclear medicine service must be appropriate to the scope and complexity of the services offered.

(1) There must be a director who is a doctor of medicine or osteopathy qualified in nuclear medicine.

(2) The qualifications, training, functions, and responsibilities of nuclear medicine personnel must be specified by the service director and approved by the medical staff.

(b) Standard: Delivery of service. Radioactive materials must be prepared, labeled, used, transported, stored, and disposed of in accordance with acceptable standards of practice.

(1) In-house preparation of radiopharmaceuticals is by, or under the supervision of, an appropriately trained registered pharmacist or a doctor of medicine or osteopathy.

(2) There is proper storage and disposal of radioactive material.

(3) If laboratory tests are performed in the nuclear medicine service, the service must meet the applicable requirement for laboratory services specified in §482.27.

(c) Standard: Facilities. Equipment and supplies must be appropriate for the types of nuclear medicine services offered and must be maintained for safe and efficient performance. The equipment must be—

(1) Maintained in safe operating condition; and

(2) Inspected, tested, and calibrated at least annually by qualified personnel.

(d) Standard: Records. The hospital must maintain signed and dated reports of nuclear medicine interpretations, consultations, and procedures.

(1) The hospital must maintain copies of nuclear medicine reports for at least 5 years.

(2) The practitioner approved by the medical staff to interpret diagnostic procedures must sign and date the interpretation of these tests.

(3) The hospital must maintain records of the receipt and disposition of radiopharmaceuticals.

(4) Nuclear medicine services must be ordered only by practitioner whose scope of Federal or State licensure and whose defined staff privileges allow such referrals.


§ 482.54 Condition of participation: Outpatient services.

If the hospital provides outpatient services, the services must meet the needs of the patients in accordance with acceptable standards of practice.

(a) Standard: Organization. Outpatient services must be appropriately organized and integrated with inpatient services.

(b) Standard: Personnel. The hospital must—

(1) Assign one or more individuals to be responsible for outpatient services.

(2) Have appropriate professional and nonprofessional personnel available at each location where outpatient services are offered, based on the scope and complexity of outpatient services.

(c) Standard: Orders for outpatient services. Outpatient services must be ordered by a practitioner who meets the following conditions:

(1) Is responsible for the care of the patient.

(2) Is licensed in the State where he or she provides care to the patient.

(3) Is acting within his or her scope of practice under State law.

(4) Is authorized in accordance with State law and policies adopted by the medical staff, and approved by the governing body, to order the applicable outpatient services. This applies to the following:

(i) All practitioners who are appointed to the hospital’s medical staff and who have been granted privileges to order the applicable outpatient services.
§ 482.55 Condition of participation: Emergency services.

The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice.

(a) Standard: Organization and direction. If emergency services are provided at the hospital—

(1) The services must be organized under the direction of a qualified member of the medical staff;
(2) The services must be integrated with other departments of the hospital;
(3) The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff.

(b) Standard: Personnel. (1) The emergency services must be supervised by a qualified member of the medical staff.
(2) There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.

§ 482.56 Condition of participation: Rehabilitation services.

If the hospital provides rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services, the services must be organized and staffed to ensure the health and safety of patients.

(a) Standard: Organization and staffing. The organization of the service must be appropriate to the scope of the services offered.

(1) The director of the services must have the necessary knowledge, experience, and capabilities to properly supervise and administer the services.
(2) Physical therapy, occupational therapy, speech-language pathology or audiology services, if provided, must be provided by qualified physical therapists, occupational therapists, speech-language pathologists, or audiologists as defined in part 484 of this chapter.

(b) Standard: Delivery of services. Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital’s medical staff to order the services in accordance with hospital policies and procedures and State laws.

(1) All rehabilitation services orders must be documented in the patient’s medical record in accordance with the requirements at §482.24.

(2) The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice and must also meet the requirements of §409.17 of this chapter.

§ 482.57 Condition of participation: Respiratory care services.

The hospital must meet the needs of the patients in accordance with acceptable standards of practice. The following requirements apply if the hospital provides respiratory care service.

(a) Standard: Organization and staffing. The organization of the respiratory care services must be appropriate to the scope and complexity of the services offered.

(1) There must be a director of respiratory care services who is a doctor of medicine or osteopathy with the knowledge experience, and capabilities to supervise and administer the service properly. The director may serve on either a full-time or part-time basis.

(2) There must be adequate numbers of respiratory therapists, respiratory therapy technicians, and other personnel who meet the qualifications specified by the medical staff, consistent with State law.

(b) Standard: Delivery of Services. Services must be delivered in accordance with medical staff directives.

(1) Personnel qualified to perform specific procedures and the amount of supervision required for personnel to
Centers for Medicare & Medicaid Services, HHS § 482.61

carry out specific procedures must be designated in writing.
(2) If blood gases or other laboratory tests are performed in the respiratory care unit, the unit must meet the applicable requirements for laboratory services specified in §482.27.
(3) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.
(4) All respiratory care services orders must be documented in the patient's medical record in accordance with the requirements at §482.24.

§ 482.58 Special requirements for hospital providers of long-term care services ("swing-beds").

A hospital that has a Medicare provider agreement must meet the following requirements in order to be granted an approval from CMS to provide post-hospital extended care services, as specified in §482.61 of this chapter;
(a) Eligibility. A hospital must meet the following eligibility requirements:
(1) The facility has fewer than 100 hospital beds, excluding beds for newborns and beds in intensive care type inpatient units (for eligibility of hospitals with distinct parts electing the optional reimbursement method, see §482.24(d)(5) of this chapter).
(2) The hospital is located in a rural area. This includes all areas not delineated as "urbanized" areas by the Census Bureau, based on the most recent census.
(3) The hospital does not have in effect a 24-hour nursing waiver granted under §488.54(c) of this chapter.
(4) The hospital has not had a swing-bed approval terminated within the two years previous to application.
(b) Skilled nursing facility services. The facility is substantially in compliance with the following skilled nursing facility requirements contained in subpart B of part 483 of this chapter.
(1) Resident rights (§483.10 (b)(3), (b)(4), (b)(5), (b)(6), (d), (e), (h), (i), (j)(1)(vii), (j)(1)(viii), (l), and (m)).
(2) Admission, transfer, and discharge rights (§483.12 (a)(1), (a)(2), (a)(3), (a)(4), (a)(5), (a)(6), and (a)(7)).
(3) Resident behavior and facility practices (§483.13).
(4) Patient activities (§483.15(f)).
(5) Social services (§483.15(g)).
(6) Discharge planning (§483.20(e)).
(7) Specialized rehabilitative services (§483.45).
(8) Dental services (§483.55).

Subpart E—Requirements for Specialty Hospitals

§ 482.60 Special provisions applying to psychiatric hospitals.

Psychiatric hospital must—
(a) Be primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons;
(b) Meet the conditions of participation specified in §§482.1 through 482.23 and §§482.25 through 482.57;
(c) Maintain clinical records on all patients, including records sufficient to permit CMS to determine the degree and intensity of treatment furnished to Medicare beneficiaries, as specified in §482.61; and
(d) Meet the staffing requirements specified in §482.62.

§ 482.61 Condition of participation: Special medical record requirements for psychiatric hospitals.

The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.
(a) Standard: Development of assessment/diagnostic data. Medical records
must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.

(1) The identification data must include the patient’s legal status.

(2) A provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission must be clearly documented as stated by the patient and/or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.

(5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

(b) Standard: Psychiatric evaluation. Each patient must receive a psychiatric evaluation that must—

(1) Be completed within 60 hours of admission;

(2) Include a medical history;

(3) Contain a record of mental status;

(4) Note the onset of illness and the circumstances leading to admission;

(5) Describe attitudes and behavior;

(6) Estimate intellectual functioning, memory functioning, and orientation; and

(7) Include an inventory of the patient’s assets in descriptive, not interpretative, fashion.

(c) Standard: Treatment plan. (1) Each patient must have an individual comprehensive treatment plan that must be based on an inventory of the patient’s strengths and disabilities. The written plan must include—

(i) A substantiated diagnosis;

(ii) Short-term and long-range goals;

(iii) The specific treatment modalities utilized;

(iv) The responsibilities of each member of the treatment team; and

(v) Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included.

(d) Standard: Recording progress. Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the patient as specified in §482.12(c), nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first 2 months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient’s progress in accordance with the original or revised treatment plan.

(e) Standard: Discharge planning and discharge summary. The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient’s hospitalization and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient’s condition on discharge.

[72 FR 60788, Oct. 26, 2007]
Centers for Medicare & Medicaid Services, HHS

§ 482.62

Psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.

(1) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(2) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.

(c) Standard: Availability of medical personnel. Doctors of medicine or osteopathy and other appropriate professional personnel must be available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available within the institution, the institution must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a general hospital that participates in the Medicare program.

(d) Standard: Nursing services. The hospital must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each patient’s active treatment program and to maintain progress notes on each patient.

(1) The director of psychiatric nursing services must be a registered nurse who has a master’s degree in psychiatric or mental health nursing, or its equivalent from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill. The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.

(2) The staffing pattern must insure the availability of a registered professional nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient’s active treatment program.

(e) Standard: Psychological services. The hospital must provide or have available psychological services to meet the needs of the patients.

(f) Standard: Social services. There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures.

(1) The director of the social work department or service must have a master’s degree from an accredited school of social work or must be qualified by education and experience in the social services needs of the mentally ill. If the director does not hold a masters degree in social work, at least one staff member must have this qualification.

(2) Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate, information with sources outside the hospital.

(g) Standard: Therapeutic activities. The hospital must provide a therapeutic activities program.

(1) The program must be appropriate to the needs and interests of patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

(2) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient’s active treatment program.
§ 482.68 Special requirements for transplant centers.

A transplant center located within a hospital that has a Medicare provider agreement must meet the conditions of participation specified in §§ 482.72 through 482.104 in order to be granted approval from CMS to provide transplant services.

(a) Unless specified otherwise, the conditions of participation at §§ 482.72 through 482.104 apply to heart, heart-lung, intestine, kidney, liver, lung, and pancreas centers.

(b) In addition to meeting the conditions of participation specified in §§ 482.72 through 482.104, a transplant center must also meet the conditions of participation specified in §§ 482.1 through 482.57.

EFFECTIVE DATE NOTE: At 81 FR 64030, Sept. 16, 2016, § 482.68 was revised, effective Nov. 15, 2016. For the convenience of the user, the revised text is set forth as follows:

§ 482.68 Special requirement for transplant centers.

A transplant center located within a hospital that has a Medicare provider agreement must meet the conditions of participation specified in §§ 482.72 through 482.104 in order to be granted approval from CMS to provide transplant services.

(a) Unless specified otherwise, the conditions of participation at §§ 482.72 through 482.104 apply to heart, heart-lung, intestine, kidney, liver, lung, and pancreas centers.

(b) In addition to meeting the conditions of participation specified in §§ 482.72 through 482.104, a transplant center must also meet the conditions of participation specified in §§ 482.1 through 482.57.

§ 482.70 Definitions.

As used in this subpart, the following definitions apply:

Adverse event means an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. As applied to transplant centers, examples of adverse events include (but are not limited to) serious medical complications or death caused by living donation; unintentional transplantation of organs of mismatched blood types; transplantation of organs to unintended beneficiaries; and unintended transmission of infectious disease to a beneficiary.

End-Stage Renal Disease (ESRD) means that stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

ESRD Network means all Medicare-approved ESRD facilities in a designated geographic area specified by CMS.

Heart-Lung transplant center means a transplant center that is located in a hospital with an existing Medicare-approved heart transplant center and an existing Medicare-approved lung center that performs combined heart-lung transplants.

Intestine transplant center means a Medicare-approved liver transplant center that performs intestine transplants, combined liver-intestine transplants, or multivisceral transplants.

Network organization means the administrative governing body to the network and liaison to the Federal government.

Pancreas transplant center means a Medicare-approved kidney transplant center that performs pancreas transplants alone or subsequent to a kidney transplant as well as kidney-pancreas transplants.

Transplant center means an organ-specific transplant program (as defined in this rule) within a transplant hospital (for example, a hospital’s lung transplant program may also be referred to as the hospital’s lung transplant center).

Transplant hospital means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients.

Transplant program means a component within a transplant hospital (as defined in this rule) that provides transplantation of a particular type of organ.

GENERAL REQUIREMENTS FOR TRANSPLANT CENTERS

§ 482.72 Condition of participation: OPTN membership.

A transplant center must be located in a transplant hospital that is a member of and abides by the rules and requirements of the Organ Procurement and Transplantation Network (OPTN) established and operated in accordance
with section 372 of the Public Health Service (PHS) Act (42 U.S.C. 274). The term “rules and requirements of the OPTN” means those rules and requirements approved by the Secretary pursuant to §121.4 of this title. No hospital that provides transplantation services shall be deemed to be out of compliance with section 1138(a)(1)(B) of the Act or this section unless the Secretary has given the OPTN formal notice that he or she approves the decision to exclude the transplant hospital from the OPTN and also has notified the transplant hospital in writing.

§ 482.74 Condition of participation: Notification to CMS.

(a) A transplant center must notify CMS immediately of any significant changes related to the center's transplant program or changes that could affect its compliance with the conditions of participation. Instances in which CMS should receive information for follow up, as appropriate, include, but are not limited to:

1. Change in key staff members of the transplant team, such as a change in the individual the transplant center designated to the OPTN as the center’s “primary transplant surgeon” or “primary transplant physician.”
2. Termination of an agreement between the hospital in which the transplant center is located and an OPO for the recovery and receipt of organs as required by section 482.100; and
3. Inactivation of the transplant center.

(b) Upon receiving notification of significant changes, CMS will follow up with the transplant center as appropriate, including but not limited to:

1. Requesting additional information;
2. Analyzing the information; or
3. Conducting an on-site review.


§ 482.76 Condition of participation: Pediatric Transplants.

A transplant center that seeks Medicare approval to provide transplantation services to pediatric patients must submit to CMS a request specifically for Medicare approval to perform pediatric transplants using the procedures described at §488.61 of this chapter.

(a) Except as specified in paragraph (d) of this section, a center requesting Medicare approval to perform pediatric transplants must meet all the conditions of participation at §§482.72 through 482.74 and §§482.80 through 482.104 with respect to its pediatric patients.

(b) A center that performs 50 percent or more of its transplants in a 12-month period on adult patients must be approved to perform adult transplants in order to be approved to perform pediatric transplants.

(1) Loss of Medicare approval to perform adult transplants, whether voluntary or involuntary, will result in loss of the center’s approval to perform pediatric transplants.

(2) Loss of Medicare approval to perform pediatric transplants, whether voluntary or involuntary, may trigger a review of the center’s Medicare approval to perform adult transplants.

(c) A center that performs 50 percent or more of its transplants in a 12-month period on pediatric patients must be approved to perform pediatric transplants.

(1) Loss of Medicare approval to perform pediatric transplants, whether voluntary or involuntary, will result in loss of the center’s approval to perform adult transplants.

(2) Loss of Medicare approval to perform adult transplants, whether voluntary or involuntary, may trigger a review of the center’s Medicare approval to perform pediatric transplants.

(3) A center that performs 50 percent or more of its transplants on pediatric patients in a 12-month period is not required to meet the clinical experience requirements prior to its request for approval as a pediatric transplant center.

(d) Instead of meeting all conditions of participation at §§482.72 through 482.74 and §§482.80 through 482.104, a heart transplant center that wishes to provide transplantation services to pediatric heart patients may be approved to perform pediatric heart transplants.
by meeting the Omnibus Budget Reconciliation Act of 1987 criteria in section 4009(b) (Pub. L. 100–203), as follows:

(1) The center’s pediatric transplant program must be operated jointly by the hospital and another facility that is Medicare-approved;

(2) The unified program shares the same transplant surgeons and quality improvement program (including oversight committee, patient protocol, and patient selection criteria); and

(3) The center demonstrates to the satisfaction of the Secretary that it is able to provide the specialized facilities, services, and personnel that are required by pediatric heart transplant patients.

§ 482.78 Condition of participation: Emergency preparedness for transplant centers.

A transplant center must be included in the emergency preparedness planning and the emergency preparedness program as set forth in §482.15 for the hospital in which it is located. However, a transplant center is not individually responsible for the emergency preparedness requirements set forth in §482.15.

(a) Standard: Policies and procedures. A transplant center must have policies and procedures that address emergency preparedness. These policies and procedures must be included in the hospital’s emergency preparedness program.

(b) Standard: Protocols with hospital and OPO. A transplant center must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the transplant center, the hospital in which the transplant center is operated, and the OPO designated by the Secretary, unless the hospital has an approved waiver to work with another OPO, during an emergency.

EFFECTIVE DATE NOTE: At 81 FR 64030, Sept. 16, 2016, §482.78 was added, effective Nov. 15, 2016.

§ 482.80 Condition of participation: Data submission, clinical experience, and outcome requirements for initial approval of transplant centers.

Except as specified in paragraph (d) of this section, and §488.61 of this chapter, transplant centers must meet all data submission, clinical experience, and outcome requirements to be granted initial approval by CMS.

(a) Standard: Data submission. No later than 90 days after the due date established by the OPTN, a transplant center must submit to the OPTN at least 95 percent of required data on all transplants (deceased and living donor) it has performed. Required data submissions include, but are not limited to, submission of the appropriate OPTN forms for transplant candidate registration, transplant beneficiary registration and follow-up, and living donor registration and follow-up.

(b) Standard: Clinical experience. To be considered for initial approval, an organ-specific transplant center must generally perform 10 transplants over a 12-month period.

(c) Standard: Outcome requirements. CMS will review outcomes for all transplants performed at a center, including outcomes for living donor transplants, if applicable. CMS will review adult and pediatric outcomes separately when a center requests Medicare approval to perform both adult and pediatric transplants.

(1) CMS will compare each transplant center’s observed number of patient deaths and graft failures 1-year post-transplant to the center’s expected number of patient deaths and graft failures 1-year post-transplant using the data contained in the most recent Scientific Registry of Transplant Beneficiaries (SRTR) center-specific report.

(2) CMS will not consider a center’s patient and graft survival rates to be acceptable if:

(i) A center’s observed patient survival rate or observed graft survival rate is lower than its expected patient survival rate or expected graft survival rate; and
Centers for Medicare & Medicaid Services, HHS

§ 482.82 Condition of participation: Data submission, clinical experience, and outcome requirements for re-approval of transplant centers.

Except as specified in paragraph (d) of this section, and § 488.61 of this chapter, transplant centers must meet all data submission, clinical experience, and outcome requirements in order to be re-approved.

(a) Standard: Data submission. No later than 90 days after the due date established by the OPTN, a transplant center must submit to the OPTN at least 95 percent of the required data submissions on all transplants (deceased and living donors) performed during the prior 3 years. Required data submissions include, but are not limited to, submission of the appropriate OPTN forms for transplant candidate registration, transplant recipient registration and follow-up, and living donor registration and follow-up.

(b) Standard: Clinical experience. To be considered for re-approval, an organ-specific transplant center must generally perform an average of 10 transplants per year during the prior 3 years.

(c) Standard: Outcome requirements. CMS will review outcomes for all transplants performed at a center, including outcomes for living donor transplants, if applicable. CMS will review adult and pediatric outcomes separately when a center requests Medicare approval to perform both adult and pediatric transplants.

(1) CMS will compare each transplant center’s observed number of patient deaths and graft failures 1-year post-transplant to the center’s expected number of patient deaths and graft failures 1-year post-transplant using data contained in the most recent SRTR center-specific report.

(2) CMS will not consider a center’s patient and graft survival rates to be acceptable if:

(i) A center’s observed patient survival rate or observed graft survival rate is lower than its expected patient survival rate and graft survival rate; and

(ii) All three of the following thresholds are crossed over:

(A) The one-sided p-value is less than 0.05,

(B) The number of observed events (patient deaths or graft failures) minus the number of expected events is greater than 3, and

(C) The number of observed events divided by the number of expected events is greater than 1.5.

(d) Exceptions. (1) A heart-lung transplant center is not required to comply with the clinical experience requirements in paragraph (b) of this section or the outcome requirements in paragraph (c) of this section for heart-lung transplants performed at the center.

(2) An intestine transplant center is not required to comply with the outcome performance requirements in paragraph (c) of this section for intestine, combined liver-intestine or multi-visceral transplants performed at the center.

(3) A pancreas transplant center is not required to comply with the clinical experience requirements in paragraph (b) of this section or the outcome requirements in paragraph (c) of this section for pancreas transplants performed at the center.

(4) A center that is requesting initial Medicare approval to perform pediatric transplants is not required to comply with the clinical experience requirements in paragraph (b) of this section prior to its request for approval as a pediatric transplant center.

(5) A kidney transplant center that is not Medicare-approved on the effective date of this rule is required to perform at least 3 transplants over a 12-month period prior to its request for initial approval.

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with the clinical experience requirements in paragraph (b) of this section or the outcome requirements in paragraph (c) of this section for heart-lung transplants performed at the center.

(2) An intestine transplant center is not required to comply with the outcome requirements in paragraph (c) of this section for intestine, combined liver-intestine, and multivisceral transplants performed at the center.

(3) A pancreas transplant center is not required to comply with the clinical experience requirements in paragraph (b) of this section or the outcome requirements in paragraph (c) of this section for pancreas transplants performed at the center.

(4) A center that is approved to perform pediatric transplants is not required to comply with the clinical experience requirements in paragraph (b) of this section to be re-approved.


TRANSPLANT CENTER PROCESS REQUIREMENTS

§ 482.90 Condition of participation: Patient and living donor selection.

The transplant center must use written patient selection criteria in determining a patient’s suitability for placement on the waiting list or a patient’s suitability for transplantation. If a center performs living donor transplants, the center also must use written donor selection criteria in determining the suitability of candidates for donation.

(a) Standard: Patient selection. Patient selection criteria must ensure fair and non-discriminatory distribution of organs.

(1) Prior to placement on the center’s waiting list, a prospective transplant candidate must receive a psychosocial evaluation, if possible.

(2) Before a transplant center places a transplant candidate on its waiting list, the candidate's medical record must contain documentation that the candidate’s blood type has been determined.

(3) When a patient is placed on a center’s waiting list or is selected to receive a transplant, the center must document in the patient’s medical record the patient selection criteria used.

(4) A transplant center must provide a copy of its patient selection criteria to a transplant patient, or a dialysis facility, as requested by a patient or a dialysis facility.

(b) Standard: Living donor selection. The living donor selection criteria must be consistent with the general principles of medical ethics. Transplant centers must:

(1) Ensure that a prospective living donor receives a medical and psychosocial evaluation prior to donation.

(2) Document in the living donor’s medical record the living donor’s suitability for donation, and

(3) Document that the living donor has given informed consent, as required under § 482.102.

§ 482.92 Condition of participation: Organ recovery and receipt.

Transplant centers must have written protocols for validation of donor-beneficiary blood type and other vital data for the deceased organ recovery, organ receipt, and living donor organ transplantation processes. The transplanting surgeon at the transplant center is responsible for ensuring the medical suitability of donor organs for transplantation into the intended beneficiary.

(a) Standard: Organ receipt. After an organ arrives at a transplant center, prior to transplantation, the transplanting surgeon and another licensed health care professional must verify that the donor’s blood type and other vital data are compatible with transplantation of the intended beneficiary.

(b) Standard: Living donor transplantation. If a center performs living donor transplants, the transplanting surgeon and another licensed health care professional at the center must verify that the living donor’s blood type and other vital data are compatible with transplantation of the intended beneficiary immediately before the removal of the donor organ(s) and, if applicable, prior to the removal of the beneficiary’s organ(s).

[51 FR 22042, June 17, 1986, as amended at 77 FR 20076, May 16, 2012]
§ 482.94 Condition of participation: Patient and living donor management.

Transplant centers must have written patient management policies for the transplant and discharge phases of transplantation. If a transplant center performs living donor transplants, the center also must have written donor management policies for the donor evaluation, donation, and discharge phases of living organ donation.

(a) Standard: Patient and living donor care. The transplant center’s patient and donor management policies must ensure that:

(1) Each transplant patient is under the care of a multidisciplinary patient care team coordinated by a physician throughout the transplant and discharge phases of transplantation; and

(2) If a center performs living donor transplants, each living donor is under the care of a multidisciplinary patient care team coordinated by a physician throughout the donor evaluation, donation, and discharge phases of donation.

(b) Standard: Waiting list management. Transplant centers must keep their waiting lists up to date on an ongoing basis, including:

(1) Updating of waiting list patients’ clinical information;

(2) Removing patients from the center’s waiting list if a patient receives a transplant or dies, or if there is any other reason the patient should no longer be on a center’s waiting list; and

(3) Notifying the OPTN no later than 24 hours after a patient’s removal from the center’s waiting list.

(c) Standard: Patient records. Transplant centers must maintain up-to-date and accurate patient management records for each patient who receives an evaluation for placement on a center’s waiting list and who is admitted for organ transplantation.

(1) For each patient who receives an evaluation for placement on a center’s waiting list, the center must document in the patient’s record that the patient (and in the case of a kidney patient, the patient’s usual dialysis facility) has been informed of his or her transplant status, including notification of:

(i) The patient’s placement on the center’s waiting list;

(ii) The center’s decision not to place the patient on its waiting list; or

(iii) The center’s inability to make a determination regarding the patient’s placement on its waiting list because further clinical testing or documentation is needed.

(2) If a patient on the waiting list is removed from the waiting list for any reason other than death or transplantation, the transplant center must document in the patient’s record that the patient (and in the case of a kidney patient, the patient’s usual dialysis facility) was notified no later than 10 days after the date the patient was removed from the waiting list.

(3) In the case of patients admitted for organ transplants, transplant centers must maintain written records of:

(i) Multidisciplinary patient care planning during the transplant period; and

(ii) Multidisciplinary discharge planning for post-transplant care.

(d) Standard: Social services. The transplant center must make social services available, furnished by qualified social workers, to transplant patients, living donors, and their families. A qualified social worker is an individual who meets licensing requirements in the State in which he or she practices; and

(1) Completed a course of study with specialization in clinical practice and holds a master’s degree from a graduate school of social work accredited by the Council on Social Work Education;

(2) Is working as a social worker in a transplant center as of the effective date of this final rule and has served for at least 2 years as a social worker, 1 year of which was in a transplantation program, and has established a consultative relationship with a social worker who is qualified under (d)(1) of this paragraph.

(e) Standard: Nutritional services. Transplant centers must make nutritional assessments and diet counseling services, furnished by a qualified dietitian, available to all transplant patients and living donors. A qualified dietitian is an individual who meets practice requirements in the State in which he or she practices and is a registered dietitian with the Commission on Dietetic Registration.
§ 482.96 Condition of participation: Quality assessment and performance improvement (QAPI).

Transplant centers must develop, implement, and maintain a written, comprehensive, data-driven QAPI program designed to monitor and evaluate performance of all transplantation services, including services provided under contract or arrangement.

(a) Standard: Components of a QAPI program. The transplant center’s QAPI program must use objective measures to evaluate the center’s performance with regard to transplantation activities and outcomes. Outcome measures may include, but are not limited to, patient and donor selection criteria, accuracy of the waiting list in accordance with the OPTN waiting list requirements, accuracy of donor and beneficiary matching, patient and donor management, techniques for organ recovery, consent practices, patient education, patient satisfaction, and patient rights. The transplant center must take actions that result in performance improvements and track performance to ensure that improvements are sustained.

(b) Standard: Adverse events. A transplant center must establish and implement written policies to address and document adverse events that occur during any phase of an organ transplantation case.

(1) The policies must address, at a minimum, the process for the identification, reporting, analysis, and prevention of adverse events.

(2) The transplant center must conduct a thorough analysis of and document any adverse event and must utilize the analysis to effect changes in the transplant center’s policies and practices to prevent repeat incidents.

§ 482.98 Condition of participation: Human resources.

The transplant center must ensure that all individuals who provide services and/or supervise services at the center, including individuals furnishing services under contract or arrangement, are qualified to provide or supervise such services.

(a) Standard: Director of a transplant center. The transplant center must be under the general supervision of a qualified transplant surgeon or a qualified physician-director. The director of a transplant center need not serve full-time and may also serve as a center’s primary transplant surgeon or transplant physician in accordance with §482.98(b). The director is responsible for planning, organizing, conducting, and directing the transplant center and must devote sufficient time to carry out these responsibilities, which include but are not limited to the following:

(1) Coordinating with the hospital in which the transplant center is located to ensure adequate training of nursing staff and clinical transplant coordinators in the care of transplant patients and living donors.

(2) Ensuring that tissue typing and organ procurement services are available.

(3) Ensuring that transplantation surgery is performed by, or under the direct supervision of, a qualified transplant surgeon in accordance with §482.98(b).

(b) Standard: Transplant surgeon and physician. The transplant center must identify to the OPTN a primary transplant surgeon and a transplant physician with the appropriate training and experience to provide transplantation services, who are immediately available to provide transplantation services when an organ is offered for transplantation.

(1) The transplant surgeon is responsible for providing surgical services related to transplantation.

(2) The transplant physician is responsible for providing and coordinating transplantation care.

(c) Standard: Clinical transplant coordinator. The transplant center must have a clinical transplant coordinator to ensure the continuity of care of patients and living donors during the pre-transplant, transplant, and discharge phases of transplantation and the donor evaluation, donation, and discharge phases of donation. The clinical transplant coordinator must be a registered nurse or clinician licensed by the State in which the clinical transplant coordinator practices, who has experience and knowledge of transplantation and living donation issues. The
clinical transplant coordinator’s responsibilities must include, but are not limited to, the following:
(1) Ensuring the coordination of the clinical aspects of transplant patient and living donor care; and
(2) Acting as a liaison between a kidney transplant center and dialysis facilities, as applicable.
(d) Standard: Independent living donor advocate or living donor advocate team. The transplant center that performs living donor transplantation must identify either an independent living donor advocate or an independent living donor advocate team to ensure protection of the rights of living donors and prospective living donors.
(1) The living donor advocate or living donor advocate team must not be involved in transplantation activities on a routine basis.
(2) The independent living donor advocate or living donor advocate team must demonstrate:
   (i) Knowledge of living organ donation, transplantation, medical ethics, and informed consent; and
   (ii) Understanding of the potential impact of family and other external pressures on the prospective living donor’s decision whether to donate and the ability to discuss these issues with the donor.
(3) The independent living donor advocate or living donor advocate team is responsible for:
   (i) Representing and advising the donor;
   (ii) Protecting and promoting the interests of the donor; and
   (iii) Respecting the donor’s decision and ensuring that the donor’s decision is informed and free from coercion.
(e) Standard: Transplant team. The transplant center must identify a multidisciplinary transplant team and describe the responsibilities of each member of the team. The team must be composed of individuals with the appropriate qualifications, training, and experience in the relevant areas of medicine, nursing, nutrition, social services, transplant coordination, and pharmacology.
(f) Standard: Resource commitment. The transplant center must demonstrate availability of expertise in internal medicine, surgery, anesthesiology, immunology, infectious disease control, pathology, radiology, blood banking, and patient education as related to the provision of transplantation services.
§ 482.100 Condition of participation: Organ procurement.
The transplant center must ensure that the hospital in which it operates has a written agreement for the receipt of organs with an OPO designated by the Secretary that identifies specific responsibilities for the hospital and for the OPO with respect to organ recovery and organ allocation.
§ 482.102 Condition of participation: Patient and living donor rights.
In addition to meeting the condition of participation “Patients rights” requirements at §482.13, the transplant center must protect and promote each transplant patient’s and living donor’s rights.
(a) Standard: Informed consent for transplant patients. Transplant centers must implement written transplant patient informed consent policies that inform each patient of:
   (1) The evaluation process;
   (2) The surgical procedure;
   (3) Alternative treatments;
   (4) Potential medical or psychosocial risks;
   (5) National and transplant center-specific outcomes, from the most recent SRTR center-specific report, including (but not limited to) the transplant center’s observed and expected 1-year patient and graft survival, national 1-year patient and graft survival, and notification about all Medicare outcome requirements not being met by the transplant center;
   (6) Organ donor risk factors that could affect the success of the graft or the health of the patient, including, but not limited to, the donor’s history, condition or age of the organs used, or the patient’s potential risk of contracting the human immunodeficiency virus and other infectious diseases if the disease cannot be detected in an infected donor;
   (7) His or her right to refuse transplantation; and
§ 482.104 Condition of participation: Additional requirements for kidney transplant centers.

(a) Standard: End stage renal disease (ESRD) services. Kidney transplant centers must directly furnish transplantation and other medical and surgical specialty services required for the care of ESRD patients. A kidney transplant center must have written policies and procedures for ongoing communications with dialysis patients’ local dialysis facilities.

(b) Standard: Dialysis services. Kidney transplant centers must furnish inpatient dialysis services directly or under arrangement.

(c) Standard: Participation in network activities. Kidney transplant centers must cooperate with the ESRD Network designated for their geographic area.
Centers for Medicare & Medicaid Services, HHS

area, in fulfilling the terms of the Network's current statement of work.

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

Subpart A [Reserved]

Subpart B—Requirements for Long Term Care Facilities

Sec.
483.1 Basis and scope.
483.5 Definitions.
483.10 Resident rights.
483.12 Admission, transfer and discharge rights.
483.13 Resident behavior and facility practices.
483.15 Quality of life.
483.20 Resident assessment.
483.25 Quality of care.
483.30 Nursing services.
483.35 Dietary services.
483.40 Physician services.
483.45 Specialized rehabilitative services.
483.50 Dental services.
483.60 Pharmacy services.
483.65 Infection control.
483.70 Physical environment.
483.73 Emergency preparedness.
483.75 Administration.

Subpart C—Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals

483.100 Basis.
483.102 Applicability and definitions.
483.104 State plan requirement.
483.106 Basic rule.
483.108 Relationship of PASARR to other Medicaid processes.
483.110 Out-of-State arrangements.
483.112 Preadmission screening of applicants for admission to NFs.
483.114 Annual review of NF residents.
483.116 Residents and applicants determined to require NF level of services.
483.118 Residents and applicants determined not to require NF level of services.
483.120 Specialized services.
483.122 FFP for NF services.
483.124 FFP for specialized services.
483.126 Appropriate placement.
483.128 PASARR evaluation criteria.
483.130 PASARR determination criteria.
483.132 Evaluating the need for NF services and NF level of care (PASARR/NF).
483.134 Evaluating whether an individual with mental illness requires specialized services (PASARR/MI).
483.136 Evaluating whether an individual with intellectual disability requires specialized services (PASARR/ID).

483.138 Maintenance of services and availability of FFP.

Subpart D—Requirements That Must Be Met by States and State Agencies: Nurse Aide Training and Competency Evaluation; and Paid Feeding Assistants

483.150 Statutory basis; Deemed meeting or waiver of requirements.
483.151 State review and approval of nurse aide training and competency evaluation programs.
483.152 Requirements for approval of a nurse aide training and competency evaluation program.
483.154 Nurse aide competency evaluation.
483.156 Registry of nurse aides.
483.158 FFP for nurse aide training and competency evaluation.
483.160 Requirements for training of paid feeding assistants.

Subpart E—Appeals of Discharges, Transfers, and Preadmission Screening and Annual Resident Review (PASARR) Determinations

483.200 Statutory basis.
483.202 Definitions.
483.204 Provision of a hearing and appeal system.
483.206 Transfers, discharges and relocations subject to appeal.

Subpart F—Requirements That Must Be Met by States and State Agencies, Resident Assessment

483.315 Specification of resident assessment instrument.

Subpart G—Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21

483.350 Basis and scope.
483.352 Definitions.
483.354 General requirements for psychiatric residential treatment facilities.
483.356 Protection of residents.
483.358 Orders for the use of restraint or seclusion.
483.360 Consultation with treatment team physician.
483.362 Monitoring of the resident in and immediately after restraint.
483.364 Monitoring of the resident in and immediately after seclusion.
483.366 Notification of parent(s) or legal guardian(s).
483.368 Application of time out.
483.370 Postintervention debriefings.
§ 483.1

(a) Statutory basis. (1) Sections 1819 (a), (b), (c), and (d) of the Act provide that—

(i) Skilled nursing facilities participating in Medicare must meet certain specified requirements; and

(ii) The Secretary may impose additional requirements (see section 1819(d)(4)(B)) if they are necessary for the health and safety of individuals to whom services are furnished in the facilities.

(2) Section 1861(l) of the Act requires the facility to have in effect a transfer agreement with a hospital.

(b) Definition. A distinct part SNF or NF may be comprised of one or more institutions, but does not include an institution for mental diseases as defined in §435.1010 of this chapter.

(3) Sections 1919 (a), (b), (c), and (d) of the Act provide that nursing facilities participating in Medicaid must meet certain specific requirements.

Subpart A—Reserved

Subpart B—Requirements for Long Term Care Facilities

SOURCE: 54 FR 3359, Feb. 2, 1989, unless otherwise noted.

§ 483.5 Definitions.

(a) Facility defined. For purposes of this subpart, facility means a skilled nursing facility (SNF) that meets the requirements of sections 1819(a), (b), (c), and (d) of the Act, or a nursing facility (NF) that meets the requirements of sections 1919(a), (b), (c), and (d) of the Act. “Facility” may include a distinct part of an institution (as defined in paragraph (b) of this section and specified in §440.40 and §440.155 of this chapter), but does not include an institution for individuals with intellectual disabilities or persons with related conditions described in §440.150 of this chapter. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the “facility” is always the entity that participates in the program, whether that entity is comprised of all of, or a distinct part of, a larger institution. For Medicare, an SNF (see section 1819(a)(1) of the Act), and for Medicaid, an NF (see section 1919(a)(1) of the Act) may not be an institution for mental diseases as defined in §435.1010 of this chapter.

(b) Distinct part—(1) Definition. A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it, meets the requirements of this paragraph and of paragraph (b)(2) of this section, and meets the applicable statutory requirements for SNFs or NFs in sections 1819 or 1919 of the Act, respectively. A distinct part SNF or NF may be comprised of one or more
buildings or designated parts of buildings (that is, wings, wards, or floors) that are: In the same physical area immediately adjacent to the institution's main buildings; other areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution’s campus. A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant. The term “distinct part” also includes a composite distinct part that meets the additional requirements of paragraph (c) of this section.

(2) Requirements. In addition to meeting the participation requirements for long-term care facilities set forth elsewhere in this subpart, a distinct part SNF or NF must meet all of the following requirements:

(i) The SNF or NF must be operated under common ownership and control (that is, common governance) by the institution of which it is a distinct part, as evidenced by the following:

(A) The SNF or NF is wholly owned by the institution of which it is a distinct part.

(B) The SNF or NF is subject to the by-laws and operating decisions of a common governing body.

(C) The institution of which the SNF or NF is a distinct part has final responsibility for the distinct part’s administrative decisions and personnel policies, and final approval for the distinct part’s personnel actions.

(D) The SNF or NF functions as an integral and subordinate part of the institution of which it is a distinct part, with significant common resource usage of buildings, equipment, personnel, and services.

(ii) The administrator of the SNF or NF reports to and is directly accountable to the management of the institution of which it is a distinct part.

(iii) The SNF or NF must have a designated medical director who is responsible for implementing care policies and coordinating medical care, and who is directly accountable to the management of the institution of which it is a distinct part.

(iv) The SNF or NF is financially integrated with the institution of which it is a distinct part, as evidenced by the sharing of income and expenses with that institution, and the reporting of its costs on that institution’s cost report.

(v) A single institution can have a maximum of only one distinct part SNF and one distinct part NF.

(vi) (A) An institution cannot designate a distinct part SNF or NF, but instead must submit a written request with documentation that demonstrates it meets the criteria set forth above to CMS to determine if it may be considered a distinct part.

(B) The effective date of approval of a distinct part is the date that CMS determines all requirements (including enrollment with the fiscal intermediary (FI)) are met for approval, and cannot be made retroactive.

(C) The institution must request approval from CMS for all proposed changes in the number of beds in the approved distinct part.

(c) Composite distinct part—(1) Definition. A composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in §413.65(a)(2) of this chapter.

(2) Requirements. In addition to meeting the requirements of paragraph (b) of this section, a composite distinct part must meet all of the following requirements:

(i) A SNF or NF that is a composite of more than one location will be treated as a single distinct part of the institution of which it is a distinct part. As such, the composite distinct part will have only one provider agreement and only one provider number.

(ii) If two or more institutions (each with a distinct part SNF or NF) undergo a change of ownership, CMS must approve the existing SNFs or NFs as meeting the requirements before they are considered a composite distinct part of a single institution. In making such a determination, CMS considers whether its approval or disapproval of a composite distinct part promotes the effective and efficient use of public resources.
monies without sacrificing the quality of care.

(iii) If there is a change of ownership of a composite distinct part SNF or NF, the assignment of the provider agreement to the new owner will apply to all of the approved locations that comprise the composite distinct part SNF or NF.

(iv) To ensure quality of care and quality of life for all residents, the various components of a composite distinct part must meet all of the requirements for participation independently in each location.

(d) **Common area.** Common areas are dining rooms, activity rooms, meeting rooms where residents are located on a regular basis, and other areas in the facility where residents may gather together with other residents, visitors, and staff.

(e) **Fully sprinklered.** A fully sprinklered long term care facility is one that has all areas sprinklered in accordance with National Fire Protection Association 13 “Standard for the Installation of Sprinkler Systems” without the use of waivers or the Fire Safety Evaluation System.

(f) **Major modification** means the modification of more than 50 percent, or more than 4,500 square feet, of the smoke compartment.


§ 483.10 **Resident rights.**

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:

(a) **Exercise of rights.** (1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

(3) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident’s behalf.

(4) In the case of a resident who has not been adjudged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident’s rights to the extent provided by State law.

(b) **Notice of rights and services.** (1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident’s stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;

(2) The resident or his or her legal representative has the right—

(i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and

(ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.

(3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition;

(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and

(5) The facility must—

(i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of—

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each resident when changes are made to the items and services specified in paragraphs (6)(i) (A) and (B) of this section.

(6) The facility must inform each resident before, or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility’s per diem rate.

(7) The facility must furnish a written description of legal rights which includes—

(i) A description of the manner of protecting personal funds, under paragraph (c) of this section;

(ii) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple’s non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse’s medical care in his or her process of spending down to Medicaid eligibility levels;

(iii) A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and

(iv) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

(8) The facility must provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual’s option, formulate an advance directive. This includes a written description of the facility’s policies to implement advance directives and applicable State law. Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. If an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the facility may advance directive information to the individual’s family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

(9) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

(10) The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(11) Notification of changes. (i) A facility must immediately inform the resident; consult with the resident’s physician; and if known, notify the resident’s legal representative or an interested family member when there is—

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident’s physical, mental, or psychosocial status (i.e., a deterioration in
health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a).

(ii) The facility must also promptly notify the resident and, if known, the resident’s legal representative or interested family member when there is—

(A) A change in room or roommate assignment as specified in §483.15(e)(2); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

(iii) The facility must record and periodically update the address and phone number of the resident’s legal representative or interested family member.

(12) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5(c) of this subpart) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.12(a)(8).

(c) Protection of resident funds. (1) The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

(2) Management of personal funds. Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)–(8) of this section.

(3) Deposit of funds. (i) Funds in excess of $50. The facility must maintain a resident’s personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

(ii) Funds less than $50. The facility must maintain a resident’s personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

(4) Accounting and records. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident’s personal funds entrusted to the facility on the resident’s behalf.

(i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(ii) The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

(5) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits—

(i) When the amount in the resident’s account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and

(ii) That, if the amount in the account, in addition to the value of the resident’s other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident’s funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident’s estate.

(7) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(8) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of
this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)

(i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services:

(A) Nursing services as required at §483.30 of this subpart.

(B) Dietary services as required at §483.35 of this subpart.

(C) An activities program as required at §483.15(f) of this subpart.

(D) Room/bed maintenance services.

(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry.

(F) Medically-related social services as required at §483.15(g) of this subpart.

(ii) Items and services that may be charged to residents’ funds. Listed below are general categories and examples of items and services that the facility may charge to residents’ funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:

(A) Telephone.

(B) Television/radio for personal use.

(C) Personal comfort items, including smoking materials, notions and novelties, and confections.

(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.

(E) Personal clothing.

(F) Personal reading matter.

(G) Gifts purchased on behalf of a resident.

(H) Flowers and plants.

(i) Social events and entertainment offered outside the scope of the activities program, provided under §483.15(f) of this subpart.

(J) Noncovered special care services such as privately hired nurses or aides.

(K) Private room, except when therapeutically required (for example, isolation for infection control).

(L) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart.

(iii) Requests for items and services. (A) The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident.

(B) The facility must not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay.

(C) The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.

(d) Free choice. The resident has the right to—

(1) Choose a personal attending physician;

(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident’s well-being;

(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

(e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does...
§ 483.10

not require the facility to provide a private room for each resident;

(2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;

(3) The resident’s right to refuse release of personal and clinical records does not apply when—
   (i) The resident is transferred to another health care institution; or
   (ii) Record release is required by law.

(f) Grievances. A resident has the right to—

(1) Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(g) Examination of survey results. A resident has the right to—

(1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and

(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

(h) Work. The resident has the right to—

(1) Refuse to perform services for the facility;

(2) Perform services for the facility, if he or she chooses, when—
   (i) The facility has documented the need or desire for work in the plan of care;
   (ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;
   (iii) Compensation for paid services is at or above prevailing rates; and
   (iv) The resident agrees to the work arrangement described in the plan of care.

(i) Mail. The resident has the right to privacy in written communications, including the right to—

(1) Send and promptly receive mail that is unopened; and

(2) Have access to stationery, postage, and writing implements at the resident’s own expense.

(j) Access and visitation rights. (1) The resident has the right and the facility must provide immediate access to any resident by the following:

   (i) Any representative of the Secretary;
   (ii) Any representative of the State;
   (iii) The resident’s individual physician;
   (iv) The State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965);
   (v) The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);
   (vi) The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);
   (vii) Subject to the resident’s right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and
   (viii) Subject to reasonable restrictions and the resident’s right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

(2) The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident’s right to deny or withdraw consent at any time.

(3) The facility must allow representatives of the State Ombudsman, described in paragraph (j)(1)(iv) of this section, to examine a resident’s clinical records with the permission of the resident or the resident’s legal representative, and consistent with State law.

(k) Telephone. The resident has the right to have reasonable access to the
use of a telephone where calls can be made without being overheard.

(1) **Personal property.** The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

(m) **Married couples.** The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

(n) **Self-Administration of Drugs.** An individual resident may self-administer drugs if the interdisciplinary team, as defined by § 483.20(k)(2)(ii), has determined that this practice is safe.

(o) **Refusal of certain transfers.** (1) An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate—

(i) A resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or

(ii) A resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.

(2) A resident’s exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual’s eligibility or entitlement to Medicare or Medicaid benefits.

(2) **Definition:** Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(3) **Transfer and discharge requirements.** The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(i) The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the resident’s health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.

(3) **Documentation.** When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident’s clinical record must be documented. The documentation must be made by—

(i) The resident’s physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

(4) **Notice before transfer.** Before a facility transfers or discharges a resident, the facility must—

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident’s clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) **Timing of the notice.** (i) Except as specified in paragraphs (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice may be made as soon as practicable before transfer or discharge when—
(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;
(C) The resident’s health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;
(D) An immediate transfer or discharge is required by the resident’s urgent medical needs, under paragraph (a)(2)(i) of this section; or
(E) A resident has not resided in the facility for 30 days.

(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement that the resident has the right to appeal the action to the State;
(v) The name, address and telephone number of the State long term care ombudsman;
(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and
(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the State LTC ombudsman, the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).

(9) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in §483.5(c)) must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part’s locations.

(b) Notice of bed-hold policy and readmission—(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies—
(i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and
(ii) The nursing facility’s policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

(3) Permitted resident to return to facility. A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident—
(i) Requires the services provided by the facility; and
(ii) Is eligible for Medicaid nursing facility services.
(4) Readmission to a composite distinct part. When the nursing facility to which a resident is readmitted is a composite distinct part (as defined in §483.5(c) of this subpart), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of readmission, the resident must be given the option to return to that location upon the first availability of a bed there.

(c) Equal access to quality care. (1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment;

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §483.10(b)(5)(i) and (b)(6) describing the charges; and

(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.

(d) Admissions policy. (1) The facility must—

(i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and

(ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission, expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident’s income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident’s income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,—

(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term “nursing facility services” so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident’s admission or continued stay on the request for and receipt of such additional services; and

(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

(4) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.


§483.13 Resident behavior and facility practices.

(a) Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.

(b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

(c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(1) The facility must—

(i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
(ii) Not employ individuals who have been—
(A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or
(B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and
(iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.


§ 483.15 Quality of life.

A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident’s quality of life.

(a) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect in full recognition of his or her individuality.

(b) Self-determination and participation. The resident has the right to—

(1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;

(2) Interact with members of the community both inside and outside the facility; and

(3) Make choices about aspects of his or her life in the facility that are significant to the resident.

(c) Participation in resident and family groups. (1) A resident has the right to organize and participate in resident groups in the facility;

(2) A resident’s family has the right to meet in the facility with the families of other residents in the facility;

(3) The facility must provide a resident or family group, if one exists, with private space;

(4) Staff or visitors may attend meetings at the group’s invitation;

(5) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings;

(6) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

(d) Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(e) Accommodation of needs. A resident has the right to—

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

(2) Receive notice before the resident’s room or roommate in the facility is changed.

(f) Activities. (1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.
(2) The activities program must be directed by a qualified professional who—
   (i) Is a qualified therapeutic recreation specialist or an activities professional who—
      (A) Is licensed or registered, if applicable, by the State in which practicing; and
      (B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or
   (ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or
   (iii) Is a qualified occupational therapist or occupational therapy assistant; or
   (iv) Has completed a training course approved by the State.

(g) Social Services. (1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
   (2) A facility with more than 120 beds must employ a qualified social worker on a full-time basis.
   (3) Qualifications of social worker. A qualified social worker is an individual with—
      (i) A bachelor’s degree in social work or a bachelor’s degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and
      (ii) One year of supervised social work experience in a health care setting working directly with individuals.
   (h) Environment. The facility must provide—
      (1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;
      (2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
      (3) Clean bed and bath linens that are in good condition;
      (4) Private closet space in each resident room, as specified in §483.70(e)(2)(iv);
      (5) Adequate and comfortable lighting levels in all areas;
      (6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71–81 °F; and
      (7) For the maintenance of comfortable sound levels.

§ 483.20 Resident assessment.

The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity.

(a) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident’s immediate care.

(b) Comprehensive assessments—(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident’s needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
   (i) Identification and demographic information.
   (ii) Customary routine.
   (iii) Cognitive patterns.
   (iv) Communication.
   (v) Vision.
   (vi) Mood and behavior patterns.
   (vii) Psychosocial well-being.
   (viii) Physical functioning and structural problems.
   (ix) Continence.
   (x) Disease diagnoses and health conditions.
   (xi) Dental and nutritional status.
   (xii) Skin condition.
   (xiii) Activity pursuit.
   (xiv) Medications.
   (xv) Special treatments and procedures.
   (xvi) Discharge potential.
   (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
   (xviii) Documentation of participation in assessment.

The assessment process must include direct observation and communication
with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.

(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident’s physical or mental condition. (For purposes of this section, “readmission” means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)

(ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident’s physical or mental condition. (For purposes of this section, a “significant change” means a major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident’s health status, and requires interdisciplinary review or revision of the care plan, or both.)

(iii) Not less often than once every 12 months.

(c) Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review, and revise the resident’s comprehensive plan of care.

(e) Coordination. A facility must coordinate assessments with the preadmission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.

(f) Automated data processing requirement—(1) Encoding data. Within 7 days after a facility completes a resident’s assessment, a facility must encode the following information for each resident in the facility:

(i) Admission assessment.

(ii) Annual assessment updates.

(iii) Significant change in status assessments.

(iv) Quarterly review assessments.

(v) A subset of items upon a resident’s transfer, reentry, discharge, and death.

(vi) Background (face-sheet) information, if there is no admission assessment.

(2) Transmitting data. Within 7 days after a facility completes a resident’s assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

(i) Admission assessment.

(ii) Annual assessment.

(iii) Significant change in status assessment.

(iv) Significant correction of prior full assessment.

(v) Significant correction of prior quarterly assessment.

(vi) Quarterly review.

(vii) A subset of items upon a resident’s transfer, reentry, discharge, and death.

(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.

(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

(g) Accuracy of assessments. The assessment must accurately reflect the resident’s status.

(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(i) Certification. (1) A registered nurse must sign and certify that the assessment is completed.

(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(j) Penalty for falsification. (1) Under Medicare and Medicaid, an individual who willfully and knowingly—

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 as adjusted annually under 45 CFR part 102 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 as adjusted annually under 45 CFR part 102 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

(k) Comprehensive care plans. (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following—

(i) The services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being as required under §483.25; and

(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

(2) A comprehensive care plan must be—

(i) Developed within 7 days after completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident’s needs, and, to the extent practicable, the participation of the resident, the resident’s family or the resident’s legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

(3) The services provided or arranged by the facility must—

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each resident’s written plan of care.

(l) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes—

(1) A recapitulation of the resident’s stay;

(2) A final summary of the resident’s status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

(m) Preadmission screening for mentally ill individuals and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new resident with—

(i) Mental illness as defined in paragraph (f)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission.

(A) That, because of the physical and mental condition of the individual, the
§ 483.25 Quality of care.

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) Activities of daily living. Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident’s abilities in activities of daily living do not diminish unless circumstances of the individual’s clinical condition demonstrate that diminution was unavoidable. This includes the resident’s ability to—

(i) Bathe, dress, and groom;
(ii) Transfer and ambulate;
(iii) Toilet;
(iv) Eat; and

(v) Use speech, language, or other functional communication systems.

(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

(b) Vision and hearing. To ensure that residents receive proper treatment and services to maintain vision and hearing abilities, the facility must, if necessary, assist the resident—

(1) In making appointments, and
(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

(c) Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual’s clinical condition demonstrates that they were unavoidable; and
(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

(d) Urinary Incontinence. Based on the resident’s comprehensive assessment, the facility must ensure that—

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident’s clinical condition demonstrates that catheterization was necessary; and
(2) A resident with urinary incontinence receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

(e) Range of motion. Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident’s clinical...
Centers for Medicare & Medicaid Services, HHS § 483.25

condition demonstrates that a reduction in range of motion is unavoidable; and

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

(f) Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident’s clinical condition demonstrates that such a pattern was unavoidable.

(g) Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident’s clinical condition demonstrates that use of a naso-gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

(h) Accidents. The facility must ensure that—

(1) The resident environment remains as free of accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(i) Nutrition. Based on a resident’s comprehensive assessment, the facility must ensure that a resident—

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident’s clinical condition demonstrates that this is not possible; and

(2) Receives a therapeutic diet when there is a nutritional problem.

(j) Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

(k) Special needs. The facility must ensure that residents receive proper treatment and care for the following special services:

(1) Injections;

(2) Parenteral and enteral fluids;

(3) Colostomy, ureterostomy, or ileostomy care;

(4) Tracheostomy care;

(5) Tracheal suctioning;

(6) Respiratory care;

(7) Foot care; and

(8) Prostheses.

(l) Unnecessary drugs—(1) General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

(i) In excessive dose (including duplicate drug therapy); or

(ii) For excessive duration; or

(iii) Without adequate monitoring; or

(iv) Without adequate indications for its use; or

(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(vi) Any combinations of the reasons above.

(2) Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that—

(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and

(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

(m) Medication Errors. The facility must ensure that—

(1) It is free of medication error rates of five percent or greater; and

(2) Residents are free of any significant medication errors.

(n) Influenza and pneumococcal immunizations—(1) Influenza. The facility must develop policies and procedures that ensure that—
§ 483.30 Nursing services.

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

(a) Sufficient staff. (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (c) of this section, licensed nurses; and

(ii) Other nursing personnel.

(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(b) Registered nurse. (1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

(ii) The facility must designate a registered nurse to serve as the director of nursing on a full time basis.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

(c) Nursing facilities: Waiver of requirement to provide licensed nurses on a 24-hour basis. To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if—

(i) Before offering the influenza immunization, each resident or the resident’s legal representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

(iii) The resident or the resident’s legal representative has the opportunity to refuse immunization; and

(iv) The resident’s medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident’s legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(v) Exception. As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident’s legal representative refuses the second immunization.

(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;

(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;

(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;

(4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review;

(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;

(6) The State agency granting a waiver of such requirements provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and

(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

(d) SNFs: Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week. (1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that—

(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;

(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and

(iii) The facility either—

(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period, or

(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;

(iv) The Secretary provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and

(v) The facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

(2) A waiver of the registered nurse requirement under paragraph (d)(1) of this section is subject to annual renewal by the Secretary.

(e) Nurse staffing information—(1) Data requirements. The facility must post the following information on a daily basis:

(i) Facility name.

(ii) The current date.

(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

(A) Registered nurses.

(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).

(C) Certified nurse aides.

(iv) Resident census.

(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (e)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review
§ 483.35 Dietary services.

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

(a) Staffing. The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis.

(1) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.

(2) A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.

(b) Sufficient staff. The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.

(c) Menus and nutritional adequacy. Menus must—

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;

(2) Be prepared in advance; and

(3) Be followed.

(d) Food. Each resident receives and the facility provides—

(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

(2) Food that is palatable, attractive, and at the proper temperature;

(3) Food prepared in a form designed to meet individual needs; and

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

(e) Therapeutic diets. Therapeutic diets must be prescribed by the attending physician.

(f) Frequency of meals. (1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below.

(3) The facility must offer snacks at bedtime daily.

(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

(g) Assistive devices. The facility must provide special eating equipment and utensils for residents who need them.

(h) Paid feeding assistants—(1) State-approved training course. A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if—

(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and

(ii) The use of feeding assistants is consistent with State law.

(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).

(ii) In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.

(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems.

(ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

(iii) The facility must base resident selection on the charge nurse’s assessment and the resident’s latest assessment and plan of care.

(i) Sanitary conditions. The facility must—
Centers for Medicare & Medicaid Services, HHS

§ 483.45 Specialized rehabilitative services.

(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and intellectual disability, are required in the resident’s comprehensive plan of care, the facility must—

(1) Provide the required services; or

(2) Obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.

(b) Qualifications. Specialized rehabilitative services must be provided...
under the written order of a physician by qualified personnel.


§ 483.55 Dental services.

The facility must assist residents in obtaining routine and 24-hour emergency dental care.

(a) Skilled nursing facilities. A facility (1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident;

(2) May charge a Medicare resident an additional amount for routine and emergency dental services;

(3) Must if necessary, assist the resident—

(i) In making appointments; and

(ii) By arranging for transportation to and from the dentist’s office; and

(4) Promptly refer residents with lost or damaged dentures to a dentist.

(b) Nursing facilities. The facility (1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, the following dental services to meet the needs of each resident:

(i) Routine dental services (to the extent covered under the State plan); and

(ii) Emergency dental services;

(2) Must, if necessary, assist the resident—

(i) In making appointments; and

(ii) By arranging for transportation to and from the dentist’s office; and

(3) Must promptly refer residents with lost or damaged dentures to a dentist.

[56 FR 48875, Sept. 26, 1991]

§ 483.60 Pharmacy services.

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service consultation. The facility must employ or obtain the services of a licensed pharmacist who—

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(c) Drug regimen review. (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

(2) The pharmacist must report any irregularities to the attending physician and the director of nursing, and these reports must be acted upon.

(d) Labeling of drugs and biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(e) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.


§ 483.65 Infection control.

The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help
prevent the development and transmission of disease and infection.

(a) Infection control program. The facility must establish an infection control program under which it—

(1) Investigates, controls, and prevents infections in the facility;

(2) Decides what procedures, such as isolation, should be applied to an individual resident; and

(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing spread of infection. (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

(c) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.


§ 483.70 Physical environment.

The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

(a) Life safety from fire. (1) Except as otherwise provided in this section—

(i) The LTC facility must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4.)

(ii) Notwithstanding paragraph (a)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.

(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a long-term care facility, but only if the waiver will not adversely affect the health and safety of the patients.

(3) The provisions of the Life safety Code do not apply in a State where CMS finds, in accordance with applicable provisions of sections 1819(d)(2)(B)(ii) and 1919(d)(2)(B)(ii) of the Act, that a fire and safety code imposed by State law adequately protects patients, residents and personnel in long term care facilities.

(4) A long-term care facility may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.

(5) A long term care facility must:

(i) Install, at least, battery-operated single station smoke alarms in accordance with the manufacturer's recommendations in resident sleeping rooms and common areas.

(ii) Have a program for inspection, testing, maintenance, and battery replacement that conforms to the manufacturer's recommendations and that verifies correct operation of the smoke alarms.

(iii) Exception:

(A) The facility has system-based smoke detectors in patient rooms and common areas that are installed, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code, for system-based smoke detectors; or

(B) The facility is fully sprinklered in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.

(6) A long term care facility must:

§ 483.70 42 CFR Ch. IV (10–1–16 Edition)

Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.


(iii) Subject to approval by CMS, a long term care facility may be granted an extension of the sprinkler installation deadline for a time period not to exceed 2 years from August 13, 2013, if the facility meets all of the following conditions:

(A) It is in the process of replacing its current building, or undergoing major modifications to improve the living conditions for residents in all unsprinklered living areas that requires the movement of corridor, room, partition, or structural walls or supports, in addition to the installation of a sprinkler system; or, has had its planned sprinkler installation so impaired by a disaster or emergency, as indicated by a declaration under section 319 of the Public Health Service Act, that CMS finds it would be impractical to meet the sprinkler installation due date.

(B) It demonstrates that it has made the necessary financial commitments to complete the building replacement or modification; or pursuant to a declared disaster or emergency, CMS finds it impractical to make reasonable and necessary financial commitments.

(C) Before applying for the deadline extension, it has submitted plans to State and local authorities that are necessary for approval of the replacement building or major modification that includes the required sprinkler installation, and has received approval of the plans from State and local authorities.

(D) It agrees to complete interim steps to improve fire safety, as determined by CMS.

(iv) An extension granted under paragraph (a)(8)(iii) of this section may be renewed once, for an additional period not to exceed 1 year, if the following conditions are met:

(A) CMS finds that extenuating circumstances beyond the control of the facility will prevent full compliance with the provisions in paragraph (a)(8)(i) of this section by the end of the first waiver period.

(B) All other conditions of paragraph (a)(8)(iii) of this section are met.

(7) Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016 the sill height must not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement.

(8) When a sprinkler system is shut down for more than 10 hours, the LTC facility must:

(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or

(ii) Establish a fire watch until the system is back in service.

(b) Standard: Building safety. Except as otherwise provided in this section, the LTC facility must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative
(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a LTC facility.

(2) If application of the Health Care Facilities Code required under paragraph (b) of this section would result in unreasonable hardship for the LTC facility, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of residents.

(c) Emergency power. (1) An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted.

(2) When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises.

(d) Space and equipment. The facility must—

(1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident’s plan of care; and

(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

(e) Resident rooms. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents.

(1) Bedrooms must—

(i) Accommodate no more than four residents;

(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms;

(iii) Have direct access to an exit corridor;

(iv) Be designed or equipped to assure full visual privacy for each resident;

(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains;

(vi) Have at least one window to the outside; and

(vii) Have a floor at or above grade level.

(2) The facility must provide each resident with—

(i) A separate bed of proper size and height for the convenience of the resident;

(ii) A clean, comfortable mattress;

(iii) Bedding appropriate to the weather and climate; and

(iv) Functional furniture appropriate to the resident’s needs, and individual closet space in the resident’s bedroom with clothes racks and shelves accessible to the resident.

(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations—

(i) Are in accordance with the special needs of the residents; and

(ii) Will not adversely affect residents’ health and safety.

(f) Toilet facilities. Each resident room must be equipped with or located near toilet and bathing facilities.

(g) Resident call system. The nurse’s station must be equipped to receive resident calls through a communication system from—

(1) Resident rooms; and

(2) Toilet and bathing facilities.

(h) Dining and resident activities. The facility must provide one or more rooms designated for resident dining and activities. These rooms must—

(1) Be well lighted;

(2) Be well ventilated, with non-smoking areas identified;

(3) Be adequately furnished; and

(4) Have sufficient space to accommodate all activities.

(i) Other environmental conditions. The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must—

(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;
(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;
(3) Equip corridors with firmly secured handrails on each side; and
(4) Maintain an effective pest control program so that the facility is free of pests and rodents.

The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the FEDERAL REGISTER to announce the changes.

(2) [Reserved]

§ 483.73 Emergency preparedness.

The LTC facility must comply with all applicable Federal, State and local emergency preparedness requirements. The LTC facility must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

(a) Emergency plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.

(2) Include strategies for addressing emergency events identified by the risk assessment.

(3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

(4) Include a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility’s efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

(b) Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph...
(a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following:

(i) Food, water, medical, and pharmaceutical supplies.

(ii) Alternate sources of energy to maintain—

(A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions;

(B) Emergency lighting;

(C) Fire detection, extinguishing, and alarm systems; and

(D) Sewage and waste disposal.

(2) A system to track the location of on-duty staff and sheltered residents in the LTC facility’s care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location.

(3) Safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

(4) A means to shelter in place for residents, staff, and volunteers who remain in the LTC facility.

(5) A system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records.

(6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.

(7) The development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents.

(8) The role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

(c) Communication plan. The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Residents’ physicians.

(iv) Other LTC facilities.

(v) Volunteers.

(2) Contact information for the following:

(i) Federal, State, tribal, regional, or local emergency preparedness staff.

(ii) The State Licensing and Certification Agency.

(iii) The Office of the State Long-Term Care Ombudsman.

(iv) Other sources of assistance.

(3) Primary and alternate means for communicating with the following:

(i) LTC facility’s staff.

(ii) Federal, State, tribal, regional, or local emergency management agencies.

(4) A method for sharing information and medical documentation for residents under the LTC facility’s care, as necessary, with other health care providers to maintain the continuity of care.

(5) A means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii).

(6) A means of providing information about the general condition and location of residents under the facility’s care as permitted under 45 CFR 164.510(b)(4).

(7) A means of providing information about the LTC facility’s occupancy,
needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.

(8) A method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives.

(d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

(1) Training program. The LTC facility must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

(2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do the following:

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

(ii) Conduct an additional exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based.

(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the LTC facility’s response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility’s emergency plan, as needed.

(e) Emergency and standby power systems. The LTC facility must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.

(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, and TIA 12–6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

(2) Emergency generator inspection and testing. The LTC facility must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

(3) Emergency generator fuel. LTC facilities that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

(f) Integrated healthcare systems. If a LTC facility is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the LTC facility may choose to participate in the healthcare system’s coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:
§ 483.75 Administration.

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(a) Licensure. A facility must be licensed under applicable State and local law.

(b) Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

(c) Relationship to other HHS regulations. In addition to compliance with


(ii) Technical interim amendment (TIA) 12–2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12–3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12–4 to NFPA 99, issued March 7, 2013.

(v) TIA 12–5 to NFPA 99, issued August 1, 2013.


(viii) TIA 12–1 to NFPA 101, issued August 11, 2011.


(x) TIA 12–3 to NFPA 101, issued October 22, 2013.

(xi) TIA 12–4 to NFPA 101, issued October 22, 2013.

(xii) [Reserved]


(2) [Reserved]
the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of handicap (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455). Although these regulations are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.

(d) Governing body. (1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and

(2) The governing body appoints the administrator who is—

(i) Licensed by the State where licensing is required; and

(ii) Responsible for management of the facility.

(e) Required training of nursing aides. (1) Definitions.

Licensed health professional means a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

Nurse aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §483.301 of this chapter.

(2) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless:

(i) That individual is competent to provide nursing and nursing related services; and

(ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§ 483.151–483.154 of this part; or

(B) That individual has been deemed or determined competent as provided in §483.150 (a) and (b).

(3) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2) (i) and (ii) of this section.

(4) Competency. A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual—

(i) Is a full-time employee in a State-approved training and competency evaluation program;

(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or

(iii) Has been deemed or determined competent as provided in §483.150 (a) and (b).

(5) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless—

(1) The individual is a full-time employee in a training and competency evaluation program approved by the State; or

(ii) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

(6) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.
(7) **Required retraining.** If, since an individual’s most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

(8) **Regular in-service education.** The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must—

(i) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year;

(ii) Address areas of weakness as determined in nurse aides’ performance reviews and may address the special needs of residents as determined by the facility staff; and

(iii) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

(f) **Proficiency of Nurse aides.** The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care.

(g) **Staff qualifications.** (1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.

(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.

(h) **Use of outside resources.** (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for—

(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and

(ii) The timeliness of the services.

(i) **Medical director.** (1) The facility must designate a physician to serve as medical director.

(2) The medical director is responsible for—

(i) Implementation of resident care policies; and

(ii) The coordination of medical care in the facility.

(j) **Laboratory services.** (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.

(ii) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in part 493 of this chapter.

(iii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must meet the applicable requirements for laboratories in accordance with the requirements of part 493 of this chapter.

(iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.

(2) The facility must—

(i) Provide or obtain laboratory services only when ordered by the attending physician;

(ii) Promptly notify the attending physician of the findings;

(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and
(iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.

(k) Radiology and other diagnostic services. (1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(i) If the facility provides its own diagnostic services, the services must meet applicable conditions of participation for hospitals contained in §482.26 of this subchapter.

(ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

(2) The facility must—

(i) Provide or obtain radiology and other diagnostic services only when ordered by the attending physician;

(ii) Promptly notify the attending physician of the findings;

(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and

(iv) File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.

(l) Clinical records. (1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are—

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized.

(ii) Clinical records must be retained for—

(i) The period of time required by State law; or

(ii) Five years from the date of discharge when there is no requirement in State law; or

(iii) For a minor, three years after a resident reaches legal age under State law.

(3) The facility must safeguard clinical record information against loss, destruction, or unauthorized use;

(4) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by—

(i) Transfer to another health care institution;

(ii) Law;

(iii) Third party payment contract; or

(iv) The resident.

(5) The clinical record must contain—

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The plan of care and services provided;

(iv) The results of any preadmission screening conducted by the State; and

(v) Progress notes.

(m) Disaster and emergency preparedness. (1) The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

(2) The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.

(n) Transfer agreement. (1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that—

(i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician; and

(ii) Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.

(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to
enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

(o) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting of—

(i) The director of nursing services;
(ii) A physician designated by the facility; and
(iii) At least 3 other members of the facility’s staff.

(2) The quality assessment and assurance committee—

(i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and
(ii) Develops and implements appropriate plans of action to correct identified quality deficiencies.

(3) A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

(4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

(p) Disclosure of ownership. (1) The facility must comply with the disclosure requirements of §§ 420.206 and 455.104 of this chapter.

(2) The facility must provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in—

(i) Persons with an ownership or control interest, as defined in §§ 420.201 and 455.101 of this chapter;
(ii) The officers, directors, agents, or managing employees;
(iii) The corporation, association, or other company responsible for the management of the facility; or
(iv) The facility’s administrator or director of nursing.

(3) The notice specified in paragraph (p)(2) of this section must include the identity of each new individual or company.

(q) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160 of this part.

(r) Facility closure-Administrator. Any individual who is the administrator of the facility must:

(1) Submit to the State Survey Agency, the State LTC ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure:

(i) At least 60 days prior to the date of closure; or
(ii) In the case of a facility where the Secretary or a State terminates the facility’s participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate;

(2) Ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

(3) Include in the notice the plan, that has been approved by the State, for the transfer and adequate relocation of the residents of the facility by a date that would be specified by the State prior to closure, including assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

(s) Facility closure. The facility must have in place policies and procedures to ensure that the administrator’s duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (r) of this section.

(t) Hospice services. (1) A long-term care (LTC) facility may do either of the following:

(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.
(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

(2) If hospice care is furnished in an LTC facility through an agreement as
specified in paragraph (t)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:

(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.

(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:

(A) The services the hospice will provide.

(B) The hospice’s responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.

(C) The services the LTC facility will continue to provide, based on each resident’s plan of care.

(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.

(E) A provision that the LTC facility immediately notifies the hospice about the following:

(1) A significant change in the resident’s physical, mental, social, or emotional status.

(2) Clinical complications that suggest a need to alter the plan of care.

(3) A need to transfer the resident from the facility for any condition.

(4) The resident’s death.

(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

(G) An agreement that it is the LTC facility’s responsibility to furnish 24-hour room and board care, meet the resident’s personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident’s needs.

(H) A delineation of the hospice’s responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident’s terminal illness and related conditions.

(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.

(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility’s interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following:

(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
Centers for Medicare & Medicaid Services, HHS  § 483.75

(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.

(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient’s attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.

(iv) Obtaining the following information from the hospice:

(A) The most recent hospice plan of care specific to each patient.

(B) Physician certification and re-certification of the terminal illness specific to each patient.

(C) Names and contact information for hospice personnel involved in hospice care of each patient.

(D) Instructions on how to access the hospice’s 24-hour on-call system.

(E) Hospice medication information specific to each patient.

(F) Physician and attending physician (if any) orders specific to each patient.

(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident’s written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being, as required at § 483.25.

(a) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:

(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);

(ii) Resident census data; and

(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS.

(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.

§ 483.100 Basis.

The requirements of §§ 483.100 through 483.138 governing the State’s responsibility for preadmission screening and annual resident review (PASARR) of individuals with mental illness and intellectual disability are based on section 1919(e)(7) of the Act.

§ 483.102 Applicability and definitions.

(a) This subpart applies to the screening or reviewing of all individuals with mental illness or intellectual disability who apply to or reside in Medicaid certified NFs regardless of the source of payment for the NF services, and regardless of the individual’s or resident’s known diagnoses.

(b) Definitions. As used in this subpart—

(1) An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements on diagnosis, level of impairment and duration of illness:  

(i) Diagnosis. The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised in 1987.

This mental disorder is—

(A) A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability; but

(B) Not a primary diagnosis of dementia, including Alzheimer’s disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in paragraph (b)(1)(A) of this section.

(ii) Level of impairment. The disorder results in functional limitations in major life activities within the past 3 to 6 months that would be appropriate for the individual’s developmental stage. An individual typically has at least one of the following characteristics on a continuing or intermittent basis:

(A) Interpersonal functioning. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation;

(B) Concentration, persistence, and pace. The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks; and

(C) Adaptation to change. The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation.

1The Diagnostic and Statistical Manual of Mental Disorders is available for inspection at the Centers for Medicare & Medicaid Services, room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland, or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the American Psychiatric Association, Division of Publications and Marketing, 1600 K Street, NW., Washington, DC 20006.
Centers for Medicare & Medicaid Services, HHS § 483.106

or requires intervention by the mental health or judicial system.

(iii) Recent treatment. The treatment history indicates that the individual has experienced at least one of the following:

(A) Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization); or

(B) Within the last 2 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

(2) An individual is considered to have dementia if he or she has a primary diagnosis of dementia, as described in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised in 1987, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in paragraph (b)(1)(i)(A) of this section.

(3) An individual is considered to have intellectual disability (IID) if he or she has—

(i) A level of retardation (mild, moderate, severe or profound) described in the American Association on Intellectual Disability’s Manual on Classification in Intellectual Disability (1983). Incorporation by reference of the 1983 edition of the American Association on Intellectual Disability’s Manual on Classification in Intellectual Disability was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51 that govern the use of incorporations by reference; or

(ii) A related condition as defined by §435.1010 of this chapter.

§ 483.104 State plan requirement.

As a condition of approval of the State plan, the State must operate a preadmission screening and annual resident review program that meets the requirements of §§483.100 through 428.138.

§ 483.106 Basic rule.

(a) Requirement. The State PASARR program must require—

(1) Preadmission screening of all individuals with mental illness or intellectual disability who apply as new admissions to Medicaid NFs on or after January 1, 1989;

(2) Initial review, by April 1, 1990, of all current residents with intellectual disability or mental illness who entered Medicaid NFs prior to January 1, 1989; and

(3) At least annual review, as of April 1, 1990, of all residents with mental illness or intellectual disability, regardless of whether they were first screened under the preadmission screening or annual resident review requirements.

(b) Admissions, readmissions and interfacility transfers—

(1) New admission. An individual is a new admission if he or she is admitted to any NF for the first time or does not qualify as a readmission. With the exception of certain hospital discharges described in paragraph (b)(2) of this section, new admissions are subject to preadmission screening.

(2) Exempted hospital discharge. (i) An exempted hospital discharge means an individual—

(A) Who is admitted to any NF directly from a hospital after receiving acute inpatient care at the hospital;

(B) Who requires NF services for the condition for which he or she received care in the hospital; and

The American Association on Intellectual Disability’s Manual on Classification in Intellectual Disability is available for inspection at the Centers for Medicare & Medicaid Services, Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland, or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the American Association on Intellectual Disability, 1719 Kalorama Rd., NW., Washington, DC 20009.
§ 483.108 Relationship of PASARR to other Medicaid processes.

(a) PASARR determinations made by the State mental health or intellectual disability authorities cannot be overturned by the State Medicaid agency, either in the claims process or through other utilization control/review processes or by the State survey and certification agency. Only appeals determinations made through the system specified in subpart E of this part may overturn a PASARR determination made by the State mental health or intellectual disability authorities.
(b) In making their determinations, however, the State mental health and intellectual disability authorities must not use criteria relating to the need for NF care or specialized services that are inconsistent with this regulation and any supplementary criteria adopted by the State Medicaid agency under its approved State plan.

(c) To the maximum extent practicable, in order to avoid duplicative testing and effort, the PASARR must be coordinated with the routine resident assessments required by §483.20(b).

§ 483.110 Out-of-State arrangements.

(a) Basic rule. The State in which the individual is a State resident (or would be a State resident at the time he or she becomes eligible for Medicaid), as defined in §435.403 of this chapter, must pay for the PASARR and make the required determinations, in accordance with §483.52(b).

(b) Agreements. A State may include arrangements for PASARR in its provider agreements with out-of-State facilities or reciprocal interstate agreements.  

[57 FR 56506, Nov. 30, 1992; 58 FR 25784, Apr. 28, 1993]

§ 483.112 Preadmission screening of applicants for admission to NFs.

(a) Determination of need for NF services. For each NF applicant with MI or IID, the State mental health or intellectual disability authority (as appropriate) must determine, in accordance with §483.130, whether, because of the resident’s physical and mental condition, the individual requires the level of services provided by a NF.

(b) Determination of need for specialized services. If the individual with mental illness or intellectual disability is determined to require a NF level of care, the State mental health or intellectual disability authority (as appropriate) must also determine, in accordance with §483.130, whether the individual requires specialized services for the mental illness or intellectual disability, as defined in §483.120.

(c) Timeliness—(1) Except as specified in paragraph (c)(4) of this section, a preadmission screening determination must be made in writing within an annual average of 7 to 9 working days of referral of the individual with MI or IID by whatever agent performs the Level I identification, under §483.128(a) of this part, to the State mental health or intellectual disability authority for screening. (See §483.128(a) for discussion of Level I evaluation.)

(2) The State may convey determinations verbally to nursing facilities and the individual and confirm them in writing.

(3) The State may compute separate annual averages for the mentally ill and individuals with intellectual disabilities/developmentally disabled populations.

(4) The Secretary may grant an exception to the timeliness standard in paragraph (c)(1) of this section when the State—

(i) Exceeds the annual average; and

(ii) Provides justification satisfactory to the Secretary that a longer time period was necessary.

§ 483.114 Annual review of NF residents.

(a) Individuals with mental illness. For each resident of a NF who has mental illness, the State mental health authority must determine in accordance with §483.130 whether, because of the resident’s physical and mental condition, the resident requires—

(1) The level of services provided by—

(i) A NF;

(ii) An inpatient psychiatric hospital for individuals under age 21, as described in section 1905(h) of the Act; or

(iii) An institution for mental diseases providing medical assistance to individuals age 65 or older; and

(2) Specialized services for mental illness, as defined in §483.120.

(b) Individuals with intellectual disability. For each resident of a NF who has intellectual disability, the State intellectual disability or developmental disability authority must determine in accordance with §483.130 whether, because of his or her physical or mental condition, the resident requires—

(1) The level of services provided by a NF or an intermediate care facility for individuals with intellectual disabilities; and

(2) Specialized services for intellectual disability as defined in §483.120.
§ 483.116 Residents and applicants determined to require NF level of services.

(a) Individuals needing NF services. If the State mental health or intellectual disability authority determines that a resident or applicant for admission to a NF requires a NF level of services, the NF may admit or retain the individual.

(b) Individuals needing NF services and specialized services. If the State mental health or intellectual disability authority determines that a resident or applicant for admission requires both a NF level of services and specialized services for the mental illness or intellectual disability—
   (1) The NF may admit or retain the individual; and
   (2) The State must provide or arrange for the provision of the specialized services needed by the individual while he or she resides in the NF.

§ 483.118 Residents and applicants determined not to require NF level of services.

(a) Applicants who do not require NF services. If the State mental health or intellectual disability authority determines that an applicant for admission to a NF does not require NF services, the applicant cannot be admitted. NF services are not a covered Medicaid service for that individual, and further screening is not required.

(b) Residents who require neither NF services nor specialized services for MI or IID. If the State mental health or intellectual disability authority determines that a resident requires neither the level of services provided by a NF nor specialized services for MI or IID, regardless of the length of stay in the facility, the State must—
   (1) Arrange for the safe and orderly discharge of the resident from the facility in accordance with §483.12(a); and
   (2) Prepare and orient the resident for discharge.

(c) Residents who do not require NF services but require specialized services for MI or IID—
   (1) Long term residents. Except as otherwise may be provided in an alternative disposition plan adopted under section 1919(e)(7)(E) of the Act, for any resident who has continuously resided in a NF for at least 30 months before the date of the determination, and who requires only specialized services as defined in §483.120, the State must, in consultation with the resident’s family or legal representative and caregivers—
      (i) Offer the resident the choice of remaining in the facility or of receiving services in an alternative appropriate setting;
      (ii) Inform the resident of the institutional and noninstitutional alternatives covered under the State Medicaid plan for the resident;
      (iii) Clarify the effect on eligibility for Medicaid services under the State plan if the resident chooses to leave the facility, including its effect on re-admission to the facility; and
      (iv) Regardless of the resident’s choice, provide for, or arrange for the provision of specialized services for the mental illness or intellectual disability.
   (2) Short term residents. Except as otherwise may be provided in an alternative disposition plan adopted under section 1919(e)(7)(E) of the Act, for any resident who requires only specialized services, as defined in §483.120, and who has not continuously resided in a NF for at least 30 months before the date of the determination, the State must, in consultation with the resident’s family or legal representative and caregivers—
      (i) Arrange for the safe and orderly discharge of the resident from the facility in accordance with §483.12(a);
      (ii) Prepare and orient the resident for discharge; and
      (iii) Provide for, or arrange for the provision of, specialized services for
§ 483.120 Specialized services.

(a) Definition—(1) For mental illness, specialized services means the services specified by the State which, combined with services provided by the NF, results in the continuous and aggressive implementation of an individualized plan of care that—
   (i) Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals and, as appropriate, other professionals.
   (ii) Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and
   (iii) Is directed toward diagnosing and reducing the resident’s behavioral symptoms that necessitated institutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

(2) For intellectual disability, specialized services means the services specified by the State which, combined with services provided by the NF or other service providers, results in treatment which meets the requirements of § 483.440(a)(1).

(b) Who must receive specialized services. The State must provide or arrange for the provision of specialized services, in accordance with this subpart, to all NF residents with MI or IID whose needs are such that continuous supervision, treatment and training by qualified mental health or intellectual disability personnel is necessary, as identified by the screening provided in § 483.130 or §§ 483.134 and 483.136.

(c) Services of lesser intensity than specialized services. The NF must provide mental health or intellectual disability services which are of a lesser intensity than specialized services to all residents who need such services.

§ 483.122 FFP for NF services.

(a) Basic rule. Except as otherwise may be provided in an alternative disposition plan adopted under section 1919(e)(7)(E) of the Act, FFP is available in State expenditures for NF services provided to a Medicaid eligible individual subject to the requirements of this part only if the individual has been determined—

(1) To need NF care under § 483.116(a) or

(2) Not to need NF services but to need specialized services, meets the requirements of § 483.118(c)(1), and elects to stay in the NF.

(b) FFP for late reviews. When a preadmission screening has not been performed prior to admission or an annual review is not performed timely, in accordance with § 483.114(c), but either is performed at a later date, FFP is available only for services furnished after the screening or review has been performed, subject to the provisions of paragraph (a) of this section.

§ 483.124 FFP for specialized services.

FFP is not available for specialized services furnished to NF residents as NF services.

§ 483.126 Appropriate placement.

Placement of an individual with MI or IID in a NF may be considered appropriate only when the individual’s needs are such that he or she meets the minimum standards for admission and the individual’s needs for treatment do not exceed the level of services which can be delivered in the NF to which the individual is admitted either through NF services alone or, where necessary, through NF services supplemented by special services provided by or arranged for by the State.
§ 483.128 PASARR evaluation criteria.

(a) Level I: Identification of individuals with MI or IID. The State’s PASARR program must identify all individuals who are suspected of having MI or IID as defined in §483.102. This identification function is termed Level I. Level II is the function of evaluating and determining whether NF services and specialized services are needed. The State’s performance of the Level I identification function must provide at least, in the case of first time identifications, for the issuance of written notice to the individual or resident and his or her legal representative that the individual or resident is suspected of having MI or IID and is being referred to the State mental health or intellectual disability authority for Level II screening.

(b) Adaptation to culture, language, ethnic origin. Evaluations performed under PASARR and PASARR notices must be adapted to the cultural background, language, ethnic origin and means of communication used by the individual being evaluated.

(c) Participation by individual and family. PASARR evaluations must involve—

(1) The individual being evaluated;
(2) The individual’s legal representative, if one has been designated under State law; and
(3) The individual’s family if—

(i) Available; and
(ii) The individual or the legal representative agrees to family participation.

(d) Interdisciplinary coordination. When parts of a PASARR evaluation are performed by more than one evaluator, the State must ensure that there is interdisciplinary coordination among the evaluators.

(e) The State’s PASARR program must use at least the evaluative criteria of §483.130 (if one or both determinations can easily be made categorically as described in §483.130) or of §§483.132 and 483.134 or §483.136 (or, in the case of individuals with both MI and IID, §§483.132, 483.134 and 483.136 if a more extensive individualized evaluation is required).

(f) Data. In the case of individualized evaluations, information that is necessary for determining whether it is appropriate for the individual with MI or IID to be placed in an NF or in another appropriate setting should be gathered throughout all applicable portions of the PASARR evaluation (§§483.132 and 483.134 and/or §483.136). The two determinations relating to the need for NF level of care and specialized services are interrelated and must be based upon a comprehensive analysis of all data concerning the individual.

(g) Preexisting data. Evaluators may use relevant evaluative data, obtained prior to initiation of predreadmission screening or annual resident review, if the data are considered valid and accurate and reflect the current functional status of the individual. However, in the case of individualized evaluations, to supplement and verify the currency and accuracy of existing data, the State’s PASARR program may need to gather additional information necessary to assess proper placement and treatment.

(h) Findings. For both categorical and individualized determinations, findings of the evaluation must correspond to the person’s current functional status as documented in medical and social history records.

(i) Evaluation report: Individualized determinations. For individualized PASARR determinations, findings must be issued in the form of a written evaluative report which—

(1) Identifies the name and professional title of person(s) who performed the evaluation(s) and the date on which each portion of the evaluation was administered;
(2) Provides a summary of the medical and social history, including the positive traits or developmental strengths and weaknesses or developmental needs of the evaluated individual;
(3) If NF services are recommended, identifies the specific services which are required to meet the evaluated individual’s needs, including services required in paragraph (i)(5) of this section;
(4) If specialized services are not recommended, identifies any specific intellectual disability or mental health services which are of a lesser intensity.
than specialized services that are required to meet the evaluated individual's needs;

(5) If specialized services are recommended, identifies the specific intellectual disability or mental health services required to meet the evaluated individual's needs; and

(6) Includes the bases for the report's conclusions.

(j) Evaluation report: Categorical determinations. For categorical PASARR determinations, findings must be issued in the form of an abbreviated written evaluative report which—

(1) Identifies the name and professional title of the person applying the categorical determination and the data on which the application was made;

(2) Explains the categorical determination(s) that has (have) been made and, if only one of the two required determinations can be made categorically, describes the nature of any further screening which is required;

(3) Identifies, to the extent possible, based on the available data, NF services, including any mental health or specialized psychiatric rehabilitative services, that may be needed; and

(4) Includes the bases for the report's conclusions.

(k) Interpretation of findings to individual. For both categorical and individualized determinations, findings of the evaluation must be interpreted and explained to the individual and, where applicable, to a legal representative designated under State law.

(l) Evaluation report. The evaluator must send a copy of the evaluation report to the—

(1) Individual or resident and his or her legal representative;

(2) Appropriate State authority in sufficient time for the State authorities to meet the times identified in §483.112(c) for PASs and §483.114(c) for ARRs;

(3) Admitting or retaining NF;

(4) Individual's attending physician; and

(5) The discharging hospital if the individual is seeking NF admission from a hospital.

(m) The evaluation may be terminated if the evaluator finds at any time during the evaluation that the individual being evaluated—

(1) Does not have MI or IID; or

(2) Has—

(i) A primary diagnosis of dementia (including Alzheimer's Disease or a related disorder); or

(ii) A non-primary diagnosis of dementia without a primary diagnosis that is a serious mental illness, and does not have a diagnosis of IID or a related condition.

[57 FR 56506, Nov. 30, 1992; 58 FR 25784, Apr. 28, 1993]

§483.130 PASARR determination criteria.

(a) Basis for determinations. Determinations made by the State mental health or intellectual disability authority as to whether NF level of services and specialized services are needed must be based on an evaluation of data concerning the individual, as specified in paragraph (b) of this section.

(b) Types of determinations. Determinations may be—

(1) Advance group determinations, in accordance with this section, by category that take into account that certain diagnoses, levels of severity of illness, or need for a particular service clearly indicate that admission to or residence in a NF is normally needed, or that the provision of specialized services is not normally needed; or

(2) Individualized determinations based on more extensive individualized evaluations as required in §483.132, §483.134, or §483.136 (or, in the case of an individual having both IID and MI, §§483.134 and 483.136).

(c) Group determinations by category. Advance group determinations by category developed by the State mental health or intellectual disability authorities may be made applicable to individuals by the NF or other evaluator following Level I review only if existing data on the individual appear to be current and accurate and are sufficient to allow the evaluator readily to determine that the individual fits into the category established by the State authorities (see §483.132(c)). Sources of existing data on the individual that could form the basis for applying a categorical determination by the State authorities would be hospital records, physician's evaluations, election of hospice status, records of community
mental health centers or community intellectual disability or developmental disability providers.

(d) Examples of categories. Examples of categories for which the State mental health or intellectual disability authority may make an advance group determination that NF services are needed are—

(1) Convalescent care from an acute physical illness which—

(i) Required hospitalization; and

(ii) Does not meet all the criteria for an exempt hospital discharge, which is not subject to preadmission screening, as specified in §483.106(b)(2).

(2) Terminal illness, as defined for hospice purposes in §418.3 of this chapter;

(3) Severe physical illnesses such as coma, ventilator dependence, functioning at a brain stem level, or diagnoses such as chronic obstructive pulmonary disease, Parkinson’s disease, Huntington’s disease, amyotrophic lateral sclerosis, and congestive heart failure which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services;

(4) Provisional admissions pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears;

(5) Provisional admissions pending further assessment in emergency situations requiring protective services, with placement in a nursing facility not to exceed 7 days; and

(6) Very brief and finite stays of up to a fixed number of days to provide respite to in-home caregivers to whom the individual with MI or IID is expected to return following the brief NF stay.

(e) Time limits. The State may specify time limits for categorical determinations that NF services are needed and in the case of paragraphs (d)(4), (5) and (6) of this section, must specify a time limit which is appropriate for provisional admissions pending further assessment and for emergency situations and respite care. If an individual is later determined to need a longer stay than the State’s limit allows, the individual must be subjected to an annual resident review before continuation of the stay may be permitted and payment made for days of NF care beyond the State’s time limit.

(f) The State mental health and intellectual disability authorities may make categorical determinations that specialized services are not needed in the provisional, emergency and respite admission situations identified in §483.130(d)(4)–(6). In all other cases, except for §483.130(h), a determination that specialized services are not needed must be based on a more extensive individualized evaluation under §483.134 or §483.136.

(g) Categorical determinations: No positive specialized treatment determinations. The State mental health and intellectual disability authorities must not make categorical determinations that specialized services are needed. Such a determination must be based on a more extensive individualized evaluation under §483.134 or §483.136 to determine the exact nature of the specialized services that are needed.

(h) Categorical determinations: Dementia and IID. The State intellectual disability authority may make categorical determinations that individuals with dementia, which exists in combination with intellectual disability or a related condition, do not need specialized services.

(i) If a State mental health or intellectual disability authority determines NF needs by category, it may not waive the specialized services determination. The appropriate State authority must also determine whether specialized services are needed either by category (if permitted) or by individualized evaluations, as specified in §483.134 or §483.136.

(j) Recording determinations. All determinations made by the State mental health and intellectual disability authority, regardless of how they are arrived at, must be recorded in the individual’s record.

(k) Notice of determination. The State mental health or intellectual disability authority must notify in writing the following entities of a determination made under this subpart:

(1) The evaluated individual and his or her legal representative;

(2) The admitting or retaining NF;

(3) The individual or resident’s attending physician; and
(4) The discharging hospital, unless the individual is exempt from preadmission screening as provided for at §483.106(b)(2).

(1) Contents of notice. Each notice of the determination made by the State mental health or intellectual disability authority must include—
(1) Whether a NF level of services is needed;
(2) Whether specialized services are needed;
(3) The placement options that are available to the individual consistent with these determinations; and
(4) The rights of the individual to appeal the determination under subpart E of this part.

(m) Placement options. Except as otherwise may be provided in an alternative disposition plan adopted under section 1919(e)(7)(E) of the Act, the placement options and the required State actions are as follows:
(1) Can be admitted to a NF. Any applicant for admission to a NF who has MI or IID and who requires the level of services provided by a NF, regardless of whether specialized services are also needed, may be admitted to a NF, if the placement is appropriate, as determined in §483.126. If specialized services are also needed, the State is responsible for providing or arranging for the provision of the specialized services.
(2) Cannot be admitted to a NF. Any applicant for admission to a NF who has MI or IID and who does not require the level of services provided by a NF, regardless of whether specialized services are also needed, is inappropriate for NF placement and must not be admitted.
(3) Can be considered appropriate for continued placement in a NF. Any NF resident with MI or IID who requires the level of services provided by a NF, regardless of the length of his or her stay or the need for specialized services, can continue to reside in the NF, if the placement is appropriate, as determined in §483.126.
(4) May choose to remain in the NF even though the placement would otherwise be inappropriate. Any NF resident with MI or IID who does not require the level of services provided by a NF but does require specialized services and who has continuously resided in a NF for at least 30 consecutive months before the date of determination may choose to continue to reside in the facility or to receive covered services in an alternative appropriate institutional or noninstitutional setting. Wherever the resident chooses to reside, the State must meet his or her specialized services needs. The determination notice must provide information concerning how, when, and by whom the various placement options available to the resident will be fully explained to the resident.
(5) Cannot be considered appropriate for continued placement in a NF and must be discharged (short-term residents). Any NF resident with MI or IID who does not require the level of services provided by a NF but does require specialized services and who has resided in a NF for less than 30 consecutive months must be discharged in accordance with §483.12(a) to an appropriate setting where the State must provide specialized services. The determination notice must provide information on how, when, and by whom the resident will be advised of discharge arrangements and of his/her appeal rights under both PASARR and discharge provisions.
(6) Cannot be considered appropriate for continued placement in a NF and must be discharged (short or long-term residents). Any NF resident with MI or IID who does not require the level of services provided by a NF and does not require specialized services regardless of his or her length of stay, must be discharged in accordance with §483.12(a). The determination notice must provide information on how, when, and by whom the resident will be advised of discharge arrangements and of his/her appeal rights under both PASARR and discharge provisions.

(n) Specialized services needed in a NF. If a determination is made to admit or allow to remain in a NF any individual who requires specialized services, the determination must be supported by assurances that the specialized services that are needed can and will be provided or arranged for by the State while the individual resides in the NF.
(o) Record retention. The State PASARR system must maintain
§ 483.132 Evaluating the need for NF services and NF level of care (PASARR/NF).

(a) Basic rule. For each applicant for admission to a NF and each NF resident who has MI or IID, the evaluator must assess whether—

(1) The individual’s total needs are such that his or her needs can be met in an appropriate community setting;

(2) The individual’s total needs are such that they can be met only on an inpatient basis, which may include the option of placement in a home and community-based services waiver program, but for which the inpatient care would be required;

(3) If inpatient care is appropriate and desired, the NF is an appropriate institutional setting for meeting those needs in accordance with § 483.126; or

(4) If the inpatient care is appropriate and desired but the NF is not the appropriate setting for meeting the individual’s needs in accordance with § 483.126, another setting such as an ICF/IID, an IMD providing services to individuals aged 65 or older, or a psychiatric hospital is an appropriate institutional setting for meeting those needs.

(b) Determining appropriate placement. In determining appropriate placement, the evaluator must prioritize the physical and mental needs of the individual being evaluated, taking into account the severity of each condition.

(c) Data. At a minimum, the data relied on to make a determination must include:

(1) Evaluation of physical status (for example, diagnoses, date of onset, medical history, and prognosis);

(2) Evaluation of mental status (for example, diagnoses, date of onset, medical history, likelihood that the individual may be a danger to himself/herself or others); and

(3) Functional assessment (activities of daily living).

§ 483.134 Evaluating whether an individual with mental illness requires specialized services (PASARR/MI).

(a) Purpose. The purpose of this section is to identify the minimum data needs and process requirements for the State mental health authority, which is responsible for determining whether or not the applicant or resident with MI, as defined in § 483.102(b)(1) of this part, needs a specialized services program for mental illness as defined in § 483.120.

(b) Data. Minimum data collected must include—

(1) A comprehensive history and physical examination of the person. The following areas must be included (if not previously addressed):

(i) Complete medical history;

(ii) Review of all body systems;

(iii) Specific evaluation of the person’s neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes; and

(iv) In case of abnormal findings which are the basis for an NF placement, additional evaluations conducted by appropriate specialists.

(2) A comprehensive drug history including current or immediate past use of medications that could mask symptoms or mimic mental illness.

(3) A psychosocial evaluation of the person, including current living arrangements and medical and support systems.

(4) A comprehensive psychiatric evaluation including a complete psychiatric history, evaluation of intellectual functioning, memory functioning, and orientation, description of current
attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia, and degree of reality testing (presence and content of delusions) and hallucinations.

(5) A functional assessment of the individual’s ability to engage in activities of daily living and the level of support that would be needed to assist the individual to perform these activities while living in the community. The assessment must determine whether this level of support can be provided to the individual in an alternative community setting or whether the level of support needed is such that NF placement is required.

(6) The functional assessment must address the following areas: Self-monitoring of health status, self-administering and scheduling of medical treatment, including medication compliance, or both, self-monitoring of nutritional status, handling money, dressing appropriately, and grooming.

(c) Personnel requirements. (1) If the history and physical examination are not performed by a physician, then a physician must review and concur with the conclusions.

(2) The State may designate the mental health professionals who are qualified—

(i) To perform the evaluations required under paragraph (b) (2)–(6) of this section including the—
(A) Comprehensive drug history;
(B) Psychosocial evaluation;
(C) Comprehensive psychiatric evaluation;
(D) Functional assessment; and
(ii) To make the determination required in paragraph (d) of this section.

(d) Data interpretation. Based on the data compiled, a qualified mental health professional, as designated by the State, must validate the diagnosis of mental illness and determine whether a program of psychiatric specialized services is needed.

§ 483.136 Evaluating whether an individual with intellectual disability requires specialized services (PASARR/IID).

(a) Purpose. The purpose of this section is to identify the minimum data needs and process requirements for the State intellectual disability authority to determine whether or not the applicant or resident with intellectual disability, as defined in §483.102(b)(3) of this part, needs a continuous specialized services program, which is analogous to active treatment, as defined in §435.1010 of this chapter and §483.440.

(b) Data. Minimum data collected must include the individual’s comprehensive history and physical examination results to identify the following information or, in the absence of data, must include information that permits a reviewer specifically to assess:

(1) The individual’s medical problems;
(2) The level of impact these problems have on the individual’s independent functioning;
(3) All current medications used by the individual and the current response of the individual to any prescribed medications in the following drug groups:
   (i) Hypnotics,
   (ii) Antipsychotics (neuroleptics),
   (iii) Mood stabilizers and antidepressants,
   (iv) Anti-anxiety-sedative agents, and
   (v) Anti-Parkinson agents.
(4) Self-monitoring of health status;
(5) Self-administering and scheduling of medical treatments;
(6) Self-monitoring of nutritional status;
(7) Self-help development such as toileting, dressing, grooming, and eating;
(8) Sensorimotor development, such as ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination, and extent to which prosthetic, orthotic, corrective or mechanical supportive devices can improve the individual’s functional capacity;
(9) Speech and language (communication) development, such as expressive language (verbal and nonverbal), receptive language (verbal and nonverbal), extent to which non-oral communication systems can improve the individual’s function capacity, auditory functioning, and extent to which amplification devices (for example, hearing aid) or a program of amplification can improve the individual’s functional capacity;
(10) Social development, such as interpersonal skills, recreation-leisure skills, and relationships with others;
(11) Academic/educational development, including functional learning skills;
(12) Independent living development such as meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to the neighborhood, town, city), laundry, housekeeping, shopping, bedmaking, care of clothing, and orientation skills (for individuals with visual impairments);
(13) Vocational development, including present vocational skills;
(14) Affective development such as interests, and skills involved with expressing emotions, making judgments, and making independent decisions; and
(15) The presence of identifiable maladaptive or inappropriate behaviors of the individual based on systematic observation (including, but not limited to, the frequency and intensity of identified maladaptive or inappropriate behaviors).

(c) Data interpretation—(1) The State must ensure that a licensed psychologist identifies the intellectual functioning measurement of individuals with IID or a related condition.
(2) Based on the data compiled in paragraph (b) of this section, the State intellectual disability authority, using appropriate personnel, as designated by the State, must validate that the individual has IID or is a person with a related condition and must determine whether specialized services for intellectual disability are needed. In making this determination, the State intellectual disability authority must make a qualitative judgment on the extent to which the person’s status reflects, singly and collectively, the characteristics commonly associated with the need for specialized services, including—
   (i) Inability to—
   (A) Take care of the most personal care needs;
   (B) Understand simple commands;
   (C) Communicate basic needs and wants;
   (D) Be employed at a productive wage level without systematic long term supervision or support;
   (E) Learn new skills without aggressive and consistent training;
   (F) Apply skills learned in a training situation to other environments or settings without aggressive and consistent training;
   (G) Demonstrate behavior appropriate to the time, situation or place without direct supervision; and
   (H) Make decisions requiring informed consent without extreme difficulty;
   (ii) Demonstration of severe maladaptive behavior(s) that place the person or others in jeopardy to health and safety; and
   (iii) Presence of other skill deficits or specialized training needs that necessitate the availability of trained IID personnel, 24 hours per day, to teach the person functional skills.


§ 483.138 Maintenance of services and availability of FFP.

(a) Maintenance of services. If a NF mails a 30 day notice of its intent to transfer or discharge a resident, under §483.12(a) of this chapter, the agency may not terminate or reduce services until—
   (1) The expiration of the notice period; or
   (2) A subpart E appeal, if one has been filed, has been resolved.

(b) Availability of FFP. FFP is available for expenditures for services provided to Medicaid beneficiaries during—
   (1) The 30 day notice period specified in §483.12(a) of this chapter; or
   (2) During the period an appeal is in progress.

Subpart D—Requirements That Must Be Met by States and State Agencies: Nurse Aide Training and Competency Evaluation, and Paid Feeding Assistants

SOURCE: 56 FR 48919, Sept. 26, 1991, unless otherwise noted.
§ 483.150 Statutory basis; Deemed meeting or waiver of requirements.

(a) Statutory basis. This subpart is based on sections 1819(b)(5), 1819(f)(2), 1919(b)(5), and 1919(f)(2) of the Act, which establish standards for training nurse-aides and for evaluating their competency.

(b) Deemed meeting of requirements. A nurse aide is deemed to satisfy the requirement of completing a training and competency evaluation approved by the State if he or she successfully completed a training and competency evaluation program before July 1, 1989 if—

(1) The aide would have satisfied this requirement if—

(i) At least 60 hours were substituted for 75 hours in sections 1819(f)(2) and 1919(f)(2) of the Act, and

(ii) The individual has made up at least the difference in the number of hours in the program he or she completed and 75 hours in supervised practical nurse aide training or in regular in-service nurse aide education;

or

(2) The individual was found to be competent (whether or not by the State) after the completion of nurse aide training of at least 100 hours duration.

(c) Waiver of requirements. A State may—

(1) Waive the requirement for an individual to complete a competency evaluation program approved by the State for any individual who can demonstrate to the satisfaction of the State that he or she has served as a nurse aide at one or more facilities of the same employer in the state for at least 24 consecutive months before December 19, 1989; or

(2) Deem an individual to have completed a nurse aide training and competency evaluation program approved by the State if the individual completed, before July 1, 1989, such a program that the State determines would have met the requirements for approval at the time it was offered.

§ 483.151 State review and approval of nurse aide training and competency evaluation programs.

(a) State review and administration. (1) The State—

(i) Must specify any nurse aide training and competency evaluation programs that the State approves as meeting the requirements of §483.152 and/or competency evaluations programs that the State approves as meeting the requirements of §483.154; and

(ii) May choose to offer a nurse aide training and competency evaluation program that meets the requirements of §483.152 and/or a competency evaluation program that meets the requirements of §483.154.

(2) If the State does not choose to offer a nurse aide training and competency evaluation program or competency evaluation program, the State must review and approve or disapprove nurse aide training and competency evaluation programs and nurse aide competency evaluation programs upon request.

(b) Requirements for approval of programs. (1) Before the State approves a nurse aide training and competency evaluation program or competency evaluation program, the State must—

(i) Determine whether the nurse aide training and competency evaluation program meets the course requirements of §483.152;

(ii) Determine whether the nurse aide competency evaluation program meets the requirements of §483.154; and

(iii) In all reviews other than the initial review, visit the entity providing the program.

(2) The State may not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility which, in the previous two years—

(i) In the case of a skilled nursing facility, has operated under a waiver under section 1819(b)(4)(C)(i)(II) of the Act;
(ii) In the case of a nursing facility, has operated under a waiver under section 1919(b)(4)(C)(ii) of the Act that was granted on the basis of a demonstration that the facility is unable to provide nursing care required under section 1919(b)(4)(C)(i) of the Act for a period in excess of 48 hours per week;

(iii) Has been subject to an extended (or partial extended) survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act;

(iv) Has been assessed a civil money penalty described in section 1819(h)(2)(A)(ii) of the Act of not less than $5,000 as adjusted annually under 45 CFR part 102; or

(v) Has been subject to a remedy described in sections 1819(h)(2)(B)(i) or (iii), 1819(h)(4), 1919(h)(2)(A)(i), (iii) or (iv) of the Act.

(3) A State may not, until two years since the assessment of the penalty (or penalties) has elapsed, approve a nurse aide training and competency evaluation program offered by or in a facility that, within the two-year period beginning October 1, 1988—

(i) Had its participation terminated under title XVIII of the Act or under the State plan under title XIX of the Act;

(ii) Was subject to a denial of payment under title XVIII or title XIX;

(iii) Was assessed a civil money penalty of not less than $5,000 as adjusted annually under 45 CFR part 102 for deficiencies in nursing facility standards;

(iv) Operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of its residents; or

(v) Pursuant to State action, was closed or had its residents transferred.

(c) Waiver of disapproval of nurse aide training programs. (1) A facility may request that CMS waive the disapproval of its nurse aide training program when the facility has been assessed a civil money penalty of not less than $5,000 as adjusted annually under 45 CFR part 102 if the civil money penalty was not related to the quality of care furnished to residents in the facility.

(2) For purposes of this provision, “quality of care furnished to residents” means the direct hands-on care and treatment that a health care professional or direct care staff furnished to a resident.

(3) Any waiver of disapproval of a nurse aide training program does not waive any requirement upon the facility to pay any civil money penalty.

(d) Time frame for acting on a request for approval. The State must, within 90 days of the date of a request under paragraph (a)(3) of this section or receipt of additional information from the requester—

(1) Advise the requester whether or not the program has been approved; or

(2) Request additional information from the requesting entity.

(e) Duration of approval. The State may not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years. A program must notify the State and the State must review that program when there are substantive changes made to that program within the 2-year period.

(f) Withdrawal of approval. (1) The State must withdraw approval of a nurse aide training and competency evaluation program if any of the applicable requirements of §483.152 or §483.154 are not met by the program.

(2) The State may withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program if the State determines that any of the applicable requirements of §483.152 or §483.154 are not met by the program.

(3) The State must withdraw approval of a nurse aide training and competency evaluation program or a nurse aide competency evaluation program—

(i) If the entity providing the program refuses to permit unannounced visits by the State.

(4) If a State withdraws approval of a nurse aide training and competency evaluation program or competency evaluation program—

(i) The State must notify the program in writing, indicating the reason(s) for withdrawal of approval of the program.

(ii) Students who have started a training and competency evaluation program from which approval has been
withdrawn must be allowed to complete the course.


§ 483.152 Requirements for approval of a nurse aide training and competency evaluation program.

(a) For a nurse aide training and competency evaluation program to be approved by the State, it must, at a minimum—

(1) Consist of no less than 75 clock hours of training;

(2) Include at least the subjects specified in paragraph (b) of this section;

(3) Include at least 16 hours of supervised practical training. Supervised practical training means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or a licensed practical nurse;

(4) Ensure that—

(i) Students do not perform any services for which they have not trained and been found proficient by the instructor; and

(ii) Students who are providing services to residents are under the general supervision of a licensed nurse or a registered nurse;

(5) Meet the following requirements for instructors who train nurse aides;

(i) The training of nurse aides must be performed by or under the general supervision of a registered nurse who possesses a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of long term care facility services;

(ii) Instructors must have completed a course in teaching adults or have experience in teaching adults or supervising nurse aides;

(iii) In a facility-based program, the training of nurse aides may be performed under the general supervision of the director of nursing for the facility who is prohibited from performing the actual training; and

(iv) Other personnel from the health professions may supplement the instructor, including, but not limited to, registered nurses, licensed practical/vocational nurses, pharmacists, dietitians, social workers, sanitarians, fire safety experts, nursing home administrators, gerontologists, psychologists, physical and occupational therapists, activities specialists, speech/language/hearing therapists, and resident rights experts. Supplemental personnel must have at least 1 year of experience in their fields;

(6) Contain competency evaluation procedures specified in §483.154.

(b) The curriculum of the nurse aide training program must include—

(1) At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:

(i) Communication and interpersonal skills;

(ii) Infection control;

(iii) Safety/emergency procedures, including the Heimlich maneuver;

(iv) Promoting residents’ independence; and

(v) Respecting residents’ rights.

(2) Basic nursing skills;

(i) Taking and recording vital signs;

(ii) Measuring and recording height and weight;

(iii) Caring for the residents’ environment;

(iv) Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor; and

(v) Caring for residents when death is imminent.

(3) Personal care skills, including, but not limited to—

(i) Bathing;

(ii) Grooming, including mouth care;

(iii) Dressing;

(iv) Toileting;

(v) Assisting with eating and hydration;

(vi) Proper feeding techniques;

(vii) Skin care; and

(viii) Transfers, positioning, and turning.

(4) Mental health and social service needs:

(i) Modifying aide’s behavior in response to residents’ behavior;

(ii) Awareness of developmental tasks associated with the aging process;

(iii) How to respond to resident behavior;
(iv) Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident’s dignity; and
(v) Using the resident’s family as a source of emotional support.

(5) Care of cognitively impaired residents:
(i) Techniques for addressing the unique needs and behaviors of individual with dementia (Alzheimer’s and others);
(ii) Communicating with cognitively impaired residents;
(iii) Understanding the behavior of cognitively impaired residents;
(iv) Appropriate responses to the behavior of cognitively impaired residents; and
(v) Methods of reducing the effects of cognitive impairments.

(6) Basic restorative services:
(i) Training the resident in self care according to the resident’s abilities;
(ii) Use of assistive devices in transferring, ambulation, eating, and dressing;
(iii) Maintenance of range of motion;
(iv) Proper turning and positioning in bed and chair;
(v) Bowel and bladder training; and
(vi) Care and use of prosthetic and orthotic devices.

(7) Residents’ Rights.
(i) Providing privacy and maintenance of confidentiality;
(ii) Promoting the resident’s right to make personal choices to accommodate their needs;
(iii) Giving assistance in resolving grievances and disputes;
(iv) Providing needed assistance in getting to and participating in resident and family groups and other activities;
(v) Maintaining care and security of residents’ personal possessions;
(vi) Promoting the resident’s right to be free from abuse, mistreatment, and neglect and the need to report any instances of such treatment to appropriate facility staff;
(vii) Avoiding the need for restraints in accordance with current professional standards.

(c) Prohibition of charges. (1) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program may be charged for any portion of the program (including any fees for textbooks or other required course materials).

(2) If an individual who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide training and competency evaluation program, the State must provide for the reimbursement of costs incurred in completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide.

§ 483.154 Nurse aide competency evaluation.

(a) Notification to individual. The State must advise in advance any individual who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the State’s nurse aide registry.

(b) Content of the competency evaluation program—(1) Written or oral examinations. The competency evaluation must—
(i) Allow an aide to choose between a written and an oral examination;
(ii) Address each course requirement specified in § 483.152(b);
(iii) Be developed from a pool of test questions, only a portion of which is used in any one examination;
(iv) Be developed from a pool of test questions, only a portion of which is used in any one examination;
(v) If oral, must be read from a prepared text in a neutral manner.

(2) Demonstration of skills. The skills demonstration must consist of a demonstration of randomly selected items drawn from a pool consisting of the tasks generally performed by nurse aides. This pool of skills must include all of the personal care skills listed in § 483.152(b)(3).

(c) Administration of the competency evaluation. (1) The competency examination must be administered and evaluated only by—
(i) The State directly; or
(ii) A State approved entity which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid.

(2) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide competency evaluation program may be charged for any portion of the program.

(3) If an individual who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide competency evaluation program, the State must provide for the reimbursement of costs incurred in completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide.

(4) The skills demonstration part of the evaluation must be—

(i) Performed in a facility or laboratory setting comparable to the setting in which the individual will function as a nurse aide; and

(ii) Administered and evaluated by a registered nurse with at least one year’s experience in providing care for the elderly or the chronically ill of any age.

(d) Facility proctoring of the competency evaluation. (1) The competency evaluation may, at the nurse aide’s option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is described in §483.151(b)(2).

(2) The State may permit the competency evaluation to be proctored by facility personnel if the State finds that the procedure adopted by the facility assures that the competency evaluation program—

(i) Is secure from tampering;

(ii) Is standardized and scored by a testing, educational, or other organization approved by the State; and

(iii) Requires no scoring by facility personnel.

(3) The State must retract the right to proctor nurse aide competency evaluations from facilities in which the State finds any evidence of impropriety, including evidence of tampering by facility staff.

(e) Successful completion of the competency evaluation program. (1) The State must establish a standard for satisfactory completion of the competency evaluation. To complete the competency evaluation successfully an individual must pass both the written or oral examination and the skills demonstration.

(2) A record of successful completion of the competency evaluation must be included in the nurse aide registry provided in §483.156 within 30 days of the date if the individual is found to be competent.

(f) Unsuccessful completion of the competency evaluation program. (1) If the individual does not complete the evaluation satisfactorily, the individual must be advised—

(i) Of the areas which he or she did not pass; and

(ii) That he or she has at least three opportunities to take the evaluation.

(2) The State may impose a maximum upon the number of times an individual upon the number of times an individual may attempt to complete the competency evaluation successfully, but the maximum may be no less than three.

§ 483.156 Registry of nurse aides.

(a) Establishment of registry. The State must establish and maintain a registry of nurse aides that meets the requirements of this section. The registry—

(1) Must include as a minimum the information contained in paragraph (c) of this section:

(2) Must be sufficiently accessible to meet the needs of the public and health care providers promptly;

(3) May include home health aides who have successfully completed a home health aide competency evaluation program approved by the State if home health aides are differentiated from nurse aides; and

(4) Must provide that any response to an inquiry that includes a finding of abuse, neglect, or misappropriation of property also include any statement disputing the finding made by the nurse aide, as provided under paragraph (c)(1)(ix) of this section.

(b) Registry operation. (1) The State may contract the daily operation and maintenance of the registry to a non-
§ 483.158 FFP for nurse aide training and competency evaluation.

(a) State expenditures for nurse aide training and competency evaluation programs and competency evaluation programs are administrative costs. They are matched as indicated in § 433.15(b)(8) of this chapter.

(b) FFP is available for State expenditures associated with nurse aide training and competency evaluation programs and competency evaluation programs only for—

(1) Nurse aides employed by a facility;

(2) Nurse aides who have an offer of employment from a facility;

(3) Nurse aides who become employed by a facility not later than 12 months after completing a nurse aide training
and competency evaluation program or competency evaluation program; or
(4) Nurse aides who receive an offer of employment from a facility not later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program.

§ 483.160 Requirements for training of paid feeding assistants.
(a) Minimum training course contents. A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following:
(1) Feeding techniques.
(2) Assistance with feeding and hydration.
(3) Communication and interpersonal skills.
(4) Appropriate responses to resident behavior.
(5) Safety and emergency procedures, including the Heimlich maneuver.
(6) Infection control.
(7) Resident rights.
(8) Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.
(b) Maintenance of records. A facility must maintain a record of all individuals, used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.

[68 FR 55539, Sept. 26, 2003]

Subpart E—Appeals of Discharges, Transfers, and Preadmission Screening and Annual Resident Review (PASARR) Determinations

SOURCE: 57 FR 56514, Nov. 30, 1992, unless otherwise noted.

§ 483.200 Statutory basis.
This subpart is based on sections 1919(e)(3) and (f)(3) and 1919(e)(3) and (f)(3) of the Act, which require States to make available, to individuals who are discharged or transferred from SNFs or NFs, an appeals process that complies with guidelines issued by the Secretary.

[68 FR 50443, Sept. 29, 1995]

§ 483.202 Definitions.
For purposes of this subpart and subparts B and C—
Discharge means movement from an entity that participates in Medicare as a skilled nursing facility, a Medicare certified distinct part, an entity that participates in Medicaid as a nursing facility, or a Medicaid certified distinct part to a noninstitutional setting when the discharging facility ceases to be legally responsible for the care of the resident.
Individual means an individual or any legal representative of the individual.
Resident means a resident of a SNF or NF or any legal representative of the resident.
Transfer means movement from an entity that participates in Medicare as a skilled nursing facility, a Medicare certified distinct part, an entity that participates in Medicaid as a nursing facility or a Medicaid certified distinct part to another institutional setting when the legal responsibility for the care of the resident changes from the transferring facility to the receiving facility.

§ 483.204 Provision of a hearing and appeal system.
(a) Each State must provide a system for:
(1) A resident of a SNF or a NF to appeal a notice from the SNF or NF of intent to discharge or transfer the resident; and
(2) An individual who has been adversely affected by any PASARR determination made by the State in the context of either a preadmission screening or an annual resident review under subpart C of part 483 to appeal that determination.
(b) The State must provide an appeals system that meets the requirements of this subpart, § 483.12 of this part, and part 431 subpart E of this chapter.

[57 FR 56506, Nov. 30, 1992; 58 FR 25784, Apr. 28, 1993]
§ 483.206 Transfers, discharges and relocations subject to appeal.

(a) “Facility” means a certified entity, either a Medicare SNF or a Medicaid NF (see §§ 483.5 and 483.12(a)(1)).

(b) A resident has appeal rights when he or she is transferred from—

(1) A certified bed into a noncertified bed; and

(2) A bed in a certified entity to a bed in an entity which is certified as a different provider.

(c) A resident has no appeal rights when he or she is moved from one bed in the certified entity to another bed in the same certified entity.

Subpart F—Requirements That Must be Met by States and State Agencies, Resident Assessment

§ 483.315 Specification of resident assessment instrument.

(a) Statutory basis. Sections 1819(e)(5) and 1919(e)(5) of the Act require that a State specify the resident assessment instrument (RAI) to be used by long term care facilities in the State when conducting initial and periodic assessments of each resident’s functional capacity, in accordance with § 483.20.

(b) State options in specifying an RAI. The RAI that the State specifies must be one of the following:

(1) The instrument designated by CMS.

(2) An alternate instrument specified by the State and approved by CMS, using the criteria specified in the State Operations Manual issued by CMS (CMS Pub. 7) which is available for purchase through the National Technical Information Service, 5285 Port Royal Rd., Springfield, VA 22151.

(c) State requirements in specifying an RAI. (1) Within 30 days after CMS notifies the State of the CMS-designated RAI or changes to it, the State must do one of the following:

(i) Specify the CMS-designated RAI.

(ii) Notify CMS of its intent to specify an alternate instrument.

(2) Within 60 days after receiving CMS approval of an alternate RAI, the State must specify the RAI for use by all long term care facilities participating in the Medicare and Medicaid programs.

(3) After specifying an instrument, the State must provide periodic educational programs for facility staff to assist with implementation of the RAI.

(4) A State must audit implementation of the RAI through the survey process.

(5) A State must obtain approval from CMS before making any modifications to its RAI.

(6) A State must adopt revisions to the RAI that are specified by CMS.

(d) CMS-designated RAI. The CMS-designated RAI is published in the State Operations Manual issued by CMS (CMS Pub. 7), as updated periodically, and consists of the following:

(1) The minimum data set (MDS) and common definitions.

(2) Care area assessment (CAA) guidelines and care area triggers (CATs) that are necessary to accurately assess residents, established by CMS.

(3) The quarterly review, based on a subset of the MDS specified by CMS.

(4) The requirements for use of the RAI that appear at § 483.20.

(e) Minimum data set (MDS). The MDS includes assessment in the areas specified in § 483.20(b)(1) through (xviii) of this chapter, and as defined in the RAI manual published in the State Operations Manual issued by CMS (CMS Pub. 100-07).

(f) [Reserved]

(g) Criteria for CMS approval of alternate instrument. To receive CMS approval, a State’s alternate instrument must use the standardized format, organization, item labels and definitions, and instructions specified by CMS in the latest issuance of the State Operations Manual issued by CMS (CMS Pub. 7).

(h) State MDS system and database requirements. As part of facility agency responsibilities, the State Survey Agency must:

(1) Support and maintain the CMS State system and database.

(2) Specify to a facility the method of transmission of data, and instruct the facility on this method.

(3) Upon receipt of facility data from CMS, ensure that a facility resolves errors.
Centers for Medicare & Medicaid Services, HHS  § 483.352

(4) Analyze data and generate reports, as specified by CMS.
   (i) State identification of agency that receives RAI data. The State must identify the component agency that receives RAI data, and ensure that this agency restricts access to the data except for the following:
   (1) Reports that contain no resident-identifiable data.
   (2) Transmission of reports to CMS.
   (3) Transmission of data and reports to the State agency that conducts surveys to ensure compliance with Medicare and Medicaid participation requirements, for purposes related to this function.
   (4) Transmission of data and reports to the State Medicaid agency for purposes directly related to the administration of the State Medicaid plan.
   (5) Transmission of data and reports to other entities only when authorized as a routine use by CMS.
   (j) Resident-identifiable data. (1) The State may not release information that is resident-identifiable to the public.
   (2) The State may not release RAI data that is resident-identifiable except in accordance with a written agreement under which the beneficiary agrees to be bound by the restrictions described in paragraph (i) of this section.


Subpart G—Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21

SOURCE: 66 FR 7161, Jan. 22, 2001, unless otherwise noted.

§ 483.350 Basis and scope.

(a) Statutory basis. Sections 1905(a)(16) and (h) of the Act provide that inpatient psychiatric services for individuals under age 21 include only inpatient services that are provided in an institution (or distinct part thereof) that is a psychiatric hospital as defined in section 1861(f) of the Act or in another inpatient setting that the Secretary has specified in regulations. Additionally, the Children’s Health Act of 2000 (Pub. L. 106–310) imposes procedural reporting and training requirements regarding the use of restraints and involuntary seclusion in facilities, specifically including facilities that provide inpatient psychiatric services for children under the age of 21 as defined by sections 1905(a)(16) and (h) of the Act.

(b) Scope. This subpart imposes requirements regarding the use of restraint or seclusion in psychiatric residential treatment facilities, that are not hospitals, providing inpatient psychiatric services to individuals under age 21.

§ 483.352 Definitions.

For purposes of this subpart, the following definitions apply:

Drug used as a restraint means any drug that—
   (1) Is administered to manage a resident’s behavior in a way that reduces the safety risk to the resident or others;
   (2) Has the temporary effect of restricting the resident’s freedom of movement; and
   (3) Is not a standard treatment for the resident’s medical or psychiatric condition.

Emergency safety intervention means the use of restraint or seclusion as an immediate response to an emergency safety situation.

Emergency safety situation means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

Mechanical restraint means any device attached or adjacent to the resident’s body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

Minor means a minor as defined under State law and, for the purpose of this subpart, includes a resident who has been declared legally incompetent by the applicable State court.

Personal restraint means the application of physical force without the use
§ 483.354 General requirements for psychiatric residential treatment facilities.

A psychiatric residential treatment facility must meet the requirements in §441.151 through §441.182 of this chapter.

§ 483.356 Protection of residents.

(a) Restraint and seclusion policy for the protection of residents. (1) Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

(2) An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.

(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only—

(i) To ensure the safety of the resident or others during an emergency safety situation; and

(ii) Until the emergency safety situation has ceased and the resident’s safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.

(4) Restraint and seclusion must not be used simultaneously.

(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident’s chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).

(c) Notification of facility policy. At admission, the facility must—

(1) Inform both the incoming resident and, in the case of a minor, the resident’s parent(s) or legal guardian(s) of the facility’s policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program;

(2) Communicate its restraint and seclusion policy in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators;

(3) Obtain an acknowledgment, in writing, from the resident, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility’s policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the resident’s record; and

(4) Provide a copy of the facility policy to the resident and in the case of a
§ 483.358 Orders for the use of restraint or seclusion.

(a) Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 be provided under the direction of a physician.

(b) If the resident’s treatment team physician is available, only he or she can order restraint or seclusion.

(c) A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

(d) If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident’s record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use.

(h) Staff must document the intervention in the resident’s record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

(1) Each order for restraint or seclusion as required in paragraph (g) of this section.

(2) The time the emergency safety intervention actually began and ended.

(3) The time and results of the 1-hour assessment required in paragraph (f) of this section.

(4) The emergency safety situation that required the resident to be restrained or put in seclusion.

(5) The name of staff involved in the emergency safety intervention.

§ 483.358 Orders for the use of restraint or seclusion.

(d) Contact information. The facility’s policy must provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization.

§ 483.358 Orders for the use of restraint or seclusion.

(a) Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 be provided under the direction of a physician.

(b) If the resident’s treatment team physician is available, only he or she can order restraint or seclusion.

(c) A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

(d) If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident’s record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use.

(h) Staff must document the intervention in the resident’s record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

(1) Each order for restraint or seclusion as required in paragraph (g) of this section.

(2) The time the emergency safety intervention actually began and ended.

(3) The time and results of the 1-hour assessment required in paragraph (f) of this section.

(4) The emergency safety situation that required the resident to be restrained or put in seclusion.

(5) The name of staff involved in the emergency safety intervention.
§ 483.360 Consultation with treatment team physician.

If a physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion orders the use of restraint or seclusion, that person must consult the resident’s treatment team physician, unless the ordering physician is in fact the resident’s treatment team physician. The person ordering the use of restraint or seclusion must—

(a) Consult with the resident’s treatment team physician as soon as possible and inform the team physician of the emergency safety situation that required the resident to be restrained or placed in seclusion; and

(b) Document in the resident’s record the date and time the team physician was consulted.


§ 483.362 Monitoring of the resident in and immediately after restraint.

(a) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention.

(b) If the emergency safety situation continues beyond the time limit of the order for the use of restraint, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions.

(c) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident’s well-being and trained in the use of emergency safety interventions, must evaluate the resident’s well-being immediately after the restraint is removed.


§ 483.364 Monitoring of the resident in and immediately after seclusion.

(a) Clinical staff, trained in the use of emergency safety interventions, must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Video monitoring does not meet this requirement.

(b) A room used for seclusion must—

(1) Allow staff full view of the resident in all areas of the room; and

(2) Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

(c) If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions.

(d) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident’s well-being and trained in the use of emergency safety interventions, must evaluate the resident’s well-being immediately after the resident is removed from seclusion.


§ 483.366 Notification of parent(s) or legal guardian(s).

If the resident is a minor as defined in this subpart:

(a) The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

(b) The facility must document in the resident’s record that the parent(s) or
Centers for Medicare & Medicaid Services, HHS § 483.372

legal guardian(s) has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.

§ 483.368 Application of time out.
(a) A resident in time out must never be physically prevented from leaving the time out area.
(b) Time out may take place away from the area of activity or from other residents, such as in the resident’s room (exclusionary), or in the area of activity or other residents (inclusionary).
(c) Staff must monitor the resident while he or she is in time out.

§ 483.370 Postintervention debriefings.
(a) Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the resident. Other staff and the resident’s parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident’s parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion.
(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of—
(1) The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;
(2) Alternative techniques that might have prevented the use of the restraint or seclusion;
(3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and
(4) The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.
(c) Staff must document in the resident’s record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the resident’s treatment plan that result from the debriefings.

§ 483.372 Medical treatment for injuries resulting from an emergency safety intervention.
(a) Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention.
(b) The psychiatric residential treatment facility must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that—
(1) A resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;
(2) Medical and other information needed for care of the resident in light of such a transfer, will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and
(3) Services are available to each resident 24 hours a day, 7 days a week.
(c) Staff must document in the resident’s record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.
(d) Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.
§ 483.374 Facility reporting.

(a) Attestation of facility compliance. Each psychiatric residential treatment facility that provides inpatient psychiatric services to individuals under age 21 must attest, in writing, that the facility is in compliance with CMS’s standards governing the use of restraint and seclusion. This attestation must be signed by the facility director.

(1) A facility with a current provider agreement with the Medicaid agency must provide its attestation to the State Medicaid agency by July 21, 2001.

(2) A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency.

(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State-designated Protection and Advocacy system. Serious occurrences that must be reported include a resident’s death, a serious injury to a resident as defined in § 483.352 of this part, and a resident’s suicide attempt.

(1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State-designated Protection and Advocacy system by no later than close of business the next business day after the serious occurrence. The report must include the name of the resident involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the facility.

(2) In the case of a minor, the facility must notify the resident’s parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.

(3) Staff must document in the resident’s record that the serious occurrence was reported to both the State Medicaid agency and the State-designated Protection and Advocacy system, including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident’s record, as well as in the incident and accident report logs kept by the facility.

(c) Reporting of deaths. In addition to the reporting requirements contained in paragraph (b) of this section, facilities must report the death of any resident to the Centers for Medicare & Medicaid Services (CMS) regional office.

(1) Staff must report the death of any resident to the CMS regional office by no later than close of business the next business day after the resident’s death.

(2) Staff must document in the resident’s record that the death was reported to the CMS regional office.


§ 483.376 Education and training.

(a) The facility must require staff to have ongoing education, training, and demonstrated knowledge of—

(1) Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;

(2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and

(3) The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.

(b) Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.

(c) Individuals who are qualified by education, training, and experience must provide staff training.

(d) Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

(e) Staff must be trained and demonstrate competency before participating in an emergency safety intervention.

(f) Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis.

(g) The facility must document in the staff personnel records that the training and demonstration of competency
were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.

(h) All training programs and materials used by the facility must be available for review by CMS, the State Medicaid agency, and the State survey agency.

Subpart H (Reserved)

Subpart I—Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities


§483.400 Basis and purpose.

This subpart implements section 1905 (c) and (d) of the Act which gives the Secretary authority to prescribe regulations for intermediate care facility services in facilities for individuals with intellectual disabilities or persons with related conditions.

§483.405 Relationship to other HHS regulations.

In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80), nondiscrimination on the basis of handicap (45 CFR part 84), nondiscrimination on the basis of age (45 CFR part 91), protection of human subjects of research (45 CFR part 46), and fraud and abuse (42 CFR part 455). Although those regulations are not in themselves considered conditions of participation under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue, Federal financial assistance.

§483.410 Condition of participation: Governing body and management.

(a) Standard: Governing body. The facility must identify an individual or individuals to constitute the governing body of the facility. The governing body must—

(1) Exercise general policy, budget, and operating direction over the facility;

(2) Set the qualifications (in addition to those already set by State law, if any) for the administrator of the facility; and

(3) Appoint the administrator of the facility.

(b) Standard: Compliance with Federal, State, and local laws. The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to health, safety, and sanitation.

(c) Standard: Client records. (1) The facility must develop and maintain a recordkeeping system that includes a separate record for each client and that documents the client’s health care, active treatment, social information, and protection of the client’s rights.

(2) The facility must keep confidential all information contained in the clients’ records, regardless of the form or storage method of the records.

(3) The facility must develop and implement policies and procedures governing the release of any client information, including consents necessary from the client, or parents (if the client is a minor) or legal guardian.

(4) Any individual who makes an entry in a client’s record must make it legibly, date it, and sign it.

(5) The facility must provide a legend to explain any symbol or abbreviation used in a client’s record.

(6) The facility must provide each identified residential living unit with appropriate aspects of each client’s record.

(d) Standard: Services provided under agreements with outside sources. (1) If a service required under this subpart is not provided directly, the facility must have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.

(2) The agreement must—

(i) Contain the responsibilities, functions, objectives, and other terms agreed to by both parties; and

(ii) Provide that the facility is responsible for assuring that the outside
services meet the standards for quality of services contained in this subpart.

(3) The facility must assure that outside services meet the needs of each client.

(4) If living quarters are not provided in a facility owned by the ICF/IID, the ICF/IID remains directly responsible for the standards relating to physical environment that are specified in §483.470 (a) through (g), (j) and (k).

(e) Standard: Licensure. The facility must be licensed under applicable State and local law.


§ 483.420 Condition of participation: Client protections.

(a) Standard: Protection of clients’ rights. The facility must ensure the rights of all clients. Therefore, the facility must—

(1) Inform each client, parent (if the client is a minor), or legal guardian, of the client’s rights and the rules of the facility;

(2) Inform each client, parent (if the client is a minor), or legal guardian, of the client’s medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment;

(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process;

(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities;

(5) Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment;

(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints;

(7) Provide each client with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs;

(8) Ensure that clients are not compelled to perform services for the facility and ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities;

(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail;

(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans;

(11) Ensure clients the opportunity to participate in social, religious, and community group activities;

(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and ensure that each client is dressed in his or her own clothing each day; and

(13) Permit a husband and wife who both reside in the facility to share a room.

(b) Standard: Client finances. (1) The facility must establish and maintain a system that—

(i) Assures a full and complete accounting of clients’ personal funds entrusted to the facility on behalf of clients; and

(ii) Precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

(2) The client’s financial record must be available on request to the client, parents (if the client is a minor) or legal guardian.

(c) Standard: Communication with clients, parents, and guardians. The facility must—

(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate;

(2) Answer communications from clients’ families and friends promptly and appropriately;

(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with
the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate;

(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy;

(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations; and

(6) Notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

(d) Standard: Staff treatment of clients.

(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

(i) Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment.

(ii) Staff must not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

(iii) The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

(3) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident and, if the alleged violation is verified, appropriate corrective action must be taken.

§ 483.430 Condition of participation: Facility staffing.

(a) Standard: Qualified intellectual disability professional. Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who—

(1) Has at least one year of experience working directly with persons with intellectual disability or other developmental disabilities; and

(2) Is one of the following:

(i) A doctor of medicine or osteopathy.

(ii) A registered nurse.

(iii) An individual who holds at least a bachelor's degree in a professional category specified in paragraph (b)(5) of this section.

(b) Standard: Professional program services. (1) Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Professional program staff must work directly with clients and with paraprofessional, nonprofessional and other professional program staff who work with clients.

(2) The facility must have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

(3) Professional program staff must participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

(4) Professional program staff must participate in on-going staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

(5) Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. Those professional program staff who do not fall under the jurisdiction of State licensure, certification, or registration requirements, specified in § 483.410(b), must meet the following qualifications:

(i) To be designated as an occupational therapist, an individual must be
eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

(ii) To be designated as an occupational therapy assistant, an individual must be eligible for certification as a certified occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

(iii) To be designated as a physical therapist, an individual must be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

(iv) To be designated as a physical therapy assistant, an individual must be eligible for registration by the American Physical Therapy Association or another comparable body.

(v) To be designated as a psychologist, an individual must have at least a master’s degree in psychology from an accredited school.

(vi) To be designated as a social worker, an individual must—
(A) Hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or
(B) Hold a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

(vii) To be designated as a speech-language pathologist or audiologist, an individual must—
(A) Be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language-Hearing Association or another comparable body; or
(B) Meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

(viii) To be designated as a professional recreation staff member, an individual must have a bachelor’s degree in recreation or in a specialty area such as art, dance, music or physical education.

(ix) To be designated as a professional dietitian, an individual must be eligible for registration by the American Dietetics Association.

(x) To be designated as a human services professional an individual must have at least a bachelor’s degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

(xi) If the client’s individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of paragraph (b)(5) (i) through (x) of this section are not required—
(A) Except for qualified intellectual disability professionals; 
(B) Except for the requirements of paragraph (b)(2) of this section concerning the facility’s provision of enough qualified professional program staff; and
(C) Unless otherwise specified by State licensure and certification requirements.

(c) Standard: Facility staffing. (1) The facility must not depend upon clients or volunteers to perform direct care services for the facility.

(2) There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing—

(i) Clients for whom a physician has ordered a medical care plan;

(ii) Clients who are aggressive, assaultive or security risks;

(iii) More than 16 clients; or

(iv) Fewer than 16 clients within a multi-unit building.

(3) There must be a responsible direct care staff person on duty on a 24 hour basis (when clients are present) to respond to injuries and symptoms of illness, and to handle emergencies, in each defined residential living unit housing—

(i) Clients for whom a physician has not ordered a medical care plan;

(ii) Clients who are not aggressive, assaultive or security risks; and

(iii) Sixteen or fewer clients,
(4) The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.

(d) Standard: Direct care (residential living unit) staff. (1) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

(2) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

(3) Direct care staff must be provided by the facility in the following minimum ratios of direct care staff to clients:

(i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 3.2.

(ii) For each defined residential living unit serving moderately retarded clients, the staff to client ratio is 1 to 4.

(iii) For each defined residential living unit serving clients who function within the range of mild retardation, the staff to client ratio is 1 to 6.4.

(4) When there are no clients present in the living unit, a responsible staff member must be available by telephone.

(e) Standard: Staff training program. (1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' developmental, behavioral, and health needs.

(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

(4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

§ 483.440 Condition of participation: Active treatment services.

(a) Standard: Active treatment. (1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward—

(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and

(ii) The prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

(b) Standard: Admissions, transfers, and discharge. (1) Clients who are admitted by the facility must be in need of and receiving active treatment services.

(2) Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

(3) A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

(4) If a client is to be either transferred or discharged, the facility must—

(i) Have documentation in the client's record that the client was transferred or discharged for good cause; and

(ii) Provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility must—
§ 483.440

(i) Develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies; and

(ii) Provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

(c) Standard: Individual program plan.

(1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to—

(i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and

(ii) Designing programs that meet the client's needs.

(2) Appropriate facility staff must participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment must take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and must—

(i) Identify the presenting problems and disabilities and where possible, their causes;

(ii) Identify the client's specific developmental strengths;

(iii) Identify the client's specific developmental and behavioral management needs;

(iv) Identify the client's need for services without regard to the actual availability of the services needed; and

(v) Include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the community, and as applicable, vocational skills.

(4) Within 30 days after admission, the interdisciplinary team must prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section, and the planned sequence for dealing with those objectives. These objectives must—

(i) Be stated separately, in terms of a single behavioral outcome;

(ii) Be assigned projected completion dates;

(iii) Be expressed in behavioral terms that provide measurable indices of performance;

(iv) Be organized to reflect a developmental progression appropriate to the individual; and

(v) Be assigned priorities.

(5) Each written training program designed to implement the objectives in the individual program plan must specify:

(i) The methods to be used;

(ii) The schedule for use of the method;

(iii) The person responsible for the program;

(iv) The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;

(v) The inappropriate client behavior(s), if applicable; and

(vi) Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

(6) The individual program plan must also:

(i) Describe relevant interventions to support the individual toward independence;

(ii) Identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found;

(iii) Include, for those clients who lack them, training in personal skills...
essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

(iv) Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support.

(v) Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

(vi) Include opportunities for client choice and self-management.

(7) A copy of each client’s individual program plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

(d) Standard: Program implementation. 
(1) As soon as the interdisciplinary team has formulated a client’s individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client’s individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

(e) Standard: Program documentation. 
(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

(2) The facility must document significant events that are related to the client’s individual program plan and assessments and that contribute to an overall understanding of the client’s ongoing level and quality of functioning.

(f) Standard: Program monitoring and change. (1) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client—

(i) Has successfully completed an objective or objectives identified in the individual program plan;

(ii) Is regressing or losing skills already gained;

(iii) Is failing to progress toward identified objectives after reasonable efforts have been made; or

(iv) Is being considered for training towards new objectives.

(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.

(3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to—

(i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights;

(ii) Insure that these programs are conducted only with the written informed consent of the client, parent (if the client is a minor), or legal guardian; and

(iii) Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other area
that the committee believes need to be addressed.
(4) The provisions of paragraph (f)(3) of this section may be modified only if, in the judgment of the State survey agency, Court decrees, State law or regulations provide for equivalent client protection and consultation.

§ 483.450 Condition of participation: Client behavior and facility practices.
(a) Standard: Facility practices—Conduct toward clients. (1) The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. These policies and procedures must—
(i) Promote the growth, development and independence of the client;
(ii) Address the extent to which client choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible;
(iii) Specify client conduct to be allowed or not allowed; and
(iv) Be available to all staff, clients, parents of minor children, and legal guardians.
(2) To the extent possible, clients must participate in the formulation of these policies and procedures.
(3) Clients must not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.
(b) Standard: Management of inappropriate client behavior. (1) The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior. These policies and procedures must be consistent with the provisions of paragraph (a) of this section. These procedures must—
(i) Specify all facility approved interventions to manage inappropriate client behavior;
(ii) Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive;
(iii) Insure, prior to the use of more restrictive techniques, that the client’s record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective; and
(iv) Address the following:
(A) The use of time-out rooms.
(B) The use of physical restraints.
(C) The use of drugs to manage inappropriate behavior.
(D) The application of painful or noxious stimuli.
(E) The staff members who may authorize the use of specified interventions.
(F) A mechanism for monitoring and controlling the use of such interventions.
(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.
(3) Techniques to manage inappropriate client behavior must never be used for disciplinary purposes, for the convenience of staff or as a substitute for an active treatment program.
(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client’s individual program plan, in accordance with § 483.440(c) (4) and (5) of this subpart.
(5) Standing or as needed programs to control inappropriate behavior are not permitted.
(c) Standard: Time-out rooms. (1) A client may be placed in a room from which egress is prevented only if the following conditions are met:
(i) The placement is a part of an approved systematic time-out program as required by paragraph (b) of this section. (Thus, emergency placement of a client into a time-out room is not allowed.)
(ii) The client is under the direct constant visual supervision of designated staff.
(iii) The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.
(2) Placement of a client in a time-out room must not exceed one hour.
(3) Clients placed in time-out rooms must be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects,
uncovered light fixtures, unprotected electrical outlets.
(4) A record of time-out activities must be kept.
(d) Standard: Physical restraints. (1) The facility may employ physical restraint only—
(i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;
(ii) As an emergency measure, but only if absolutely necessary to protect the client or others from injury; or
(iii) As a health-related protection prescribed by a physician, but only if absolutely necessary for client protection during the time that a medical condition exists.
(2) Authorizations to use or extend restraints as an emergency must be:
(i) In effect no longer than 12 consecutive hours; and
(ii) Obtained as soon as the client is restrained or stable.
(3) The facility must not issue orders for restraint on a standing or as needed basis.
(4) A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints, released from the restraint as quickly as possible, and a record of these checks and usage must be kept.
(5) Restraints must be designed and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.
(6) Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two hour period in which restraint is employed, and a record of such activity must be kept.
(7) Barred enclosures must not be more than three feet in height and must not have tops.
(e) Standard: Drug usage. (1) The facility must not use drugs in doses that interfere with the individual client’s daily living activities.
(2) Drugs used for control of inappropriate behavior must be approved by the interdisciplinary team and be used only as an integral part of the client’s individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.
(3) Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.
(4) Drugs used for control of inappropriate behavior must be—
(i) Monitored closely, in conjunction with the physician and the drug regimen review requirement at §483.460(j), for desired responses and adverse consequences by facility staff; and
(ii) Gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.
§ 483.460 Condition of participation: Health care services.
(a) Standard: Physician services. (1) The facility must ensure the availability of physician services 24 hours a day.
(2) The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care. This plan must be integrated in the individual program plan.
(3) The facility must provide or obtain preventive and general medical care as well as annual physical examinations of each client that at a minimum include the following:
(i) Evaluation of vision and hearing.
(ii) Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.
(iii) Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed.
(iv) Tuberculosis control, appropriate to the facility’s population, and in accordance with the recommendations of
the American College of Chest Physicians or the section of diseases of the chest of the American Academy of Pediatrics, or both. 

(4) To the extent permitted by State law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this section.

(b) **Standard: Physician participation in the individual program plan.** A physician must participate in—

(1) The establishment of each newly admitted client’s initial individual program plan as required by § 456.380 of this chapter that specified plan of care requirements for ICFs; and

(2) If appropriate, physicians must participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.

(c) **Standard: Nursing services.** The facility must provide clients with nursing services in accordance with their needs. These services must include—

(1) Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process; 

(2) The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan; 

(3) For those clients certified as not needing a medical care plan, a review of their health status which must—

(i) Be by a direct physical examination; 

(ii) Be by a licensed nurse;  

(iii) Be on a quarterly or more frequent basis depending on client need;  

(iv) Be recorded in the client’s record; and 

(v) Result in any necessary action (including referral to a physician to address client health problems). 

(4) Other nursing care as prescribed by the physician or as identified by client needs; and 

(5) Implementing, with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to—

(i) Training clients and staff as needed in appropriate health and hygiene methods;  

(ii) Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control; and 

(iii) Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. 

(d) **Standard: Nursing staff.** (1) Nurses providing services in the facility must have a current license to practice in the State. 

(2) The facility must employ or arrange for licensed nursing services sufficient to care for clients health needs including those clients with medical care plans. 

(3) The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section. 

(4) If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or on-site consultation to the licensed practical or vocational nurse. 

(5) Non-licensed nursing personnel who work with clients under a medical care plan must do so under the supervision of licensed persons. 

(e) **Standard: Dental services.** (1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement. 

(2) If appropriate, dental professionals must participate, in the development, review and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team. 

(3) The facility must provide education and training in the maintenance of oral health. 

(f) **Standard: Comprehensive dental diagnostic services.** Comprehensive dental diagnostic services include—
(1) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client’s oral condition, not later than one month after admission to the facility (unless the examination was completed within twelve months before admission);

(2) Periodic examination and diagnosis performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease; and

(3) A review of the results of examination and entry of the results in the client’s dental record.

(g) Standard: Comprehensive dental treatment. The facility must ensure comprehensive dental treatment services that include—

(1) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist; and

(2) Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.

(h) Standard: Documentation of dental services. (1) If the facility maintains an in-house dental service, the facility must keep a permanent dental record for each client, with a dental summary maintained in the client’s living unit.

(2) If the facility does not maintain an in-house dental service, the facility must obtain a dental summary of the results of dental visits and maintain the summary in the client’s living unit.

(i) Standard: Pharmacy services. The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

(j) Standard: Drug regimen review. (1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.

(2) The pharmacist must report any irregularities in clients’ drug regimens to the prescribing physician and interdisciplinary team.

(3) The pharmacist must prepare a record of each client’s drug regimen reviews and the facility must maintain that record.

(4) An individual medication administration record must be maintained for each client.

(5) As appropriate the pharmacist must participate in the development, implementation, and review of each client’s individual program plan either in person or through written report to the interdisciplinary team.

(k) Standard: Drug administration. The facility must have an organized system for drug administration that identifies each drug up to the point of administration. The system must assure that—

(1) All drugs are administered in compliance with the physician’s orders;

(2) All drugs, including those that are self-administered, are administered without error;

(3) Unlicensed personnel are allowed to administer drugs only if State law permits;

(4) Clients are taught how to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise;

(5) The client’s physician is informed of the interdisciplinary team’s decision that self-administration of medications is an objective for the client;

(6) No client self-administers medications until he or she demonstrates the competency to do so;

(7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law; and

(8) Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician.

(l) Standard: Drug storage and record-keeping. (1) The facility must store drugs under proper conditions of sanitation, temperature, light, humidity, and security.

(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Clients who have been trained to self administer drugs in accordance with §483.460(k)(4) may have access to keys to their individual drug supply.
(3) The facility must maintain records of the receipt and disposition of all controlled drugs.

(4) The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR part 308).

(5) If the facility maintains a licensed pharmacy, the facility must comply with the regulations for controlled drugs.

(m) Standard: Drug labeling. (1) Labeling of drugs and biologicals must—
(i) Be based on currently accepted professional principles and practices; and
(ii) Include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.

(2) The facility must remove from use—
(i) Outdated drugs; and
(ii) Drug containers with worn, illegible, or missing labels.

(3) Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client’s current medication supply if discontinued by the physician.

(n) Standard: Laboratory services. (1) If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter.

(2) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 493 of this chapter.

[53 FR 20496, June 3, 1988, as amended at 57 FR 7136, Feb. 28, 1992]

§ 483.470 Condition of participation: Physical environment.

(a) Standard: Client living environment.

(1) The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

(2) The facility must not segregate clients solely on the basis of their physical disabilities. It must integrate clients who have ambulation deficits or who are deaf, blind, or have seizure disorders, etc., with others of comparable social and intellectual development.

(b) Standard: Client bedrooms. (1) Bedrooms must—

(i) Be rooms that have at least one outside wall;

(ii) Be equipped with or located near toilet and bathing facilities;

(iii) Accommodate no more than four clients unless granted a variance under paragraph (b)(3) of this section;

(iv) Measure at least 60 square feet per client in multiple client bedrooms and at least 80 square feet in single client bedrooms; and

(v) In all facilities initially certified, or in buildings constructed or with major renovations or conversions on or after October 3, 1988, have walls that extend from floor to ceiling.

(2) If a bedroom is below grade level, it must have a window that—

(i) Is usable as a second means of escape by the client(s) occupying the room; and

(ii) Is no more than 44 inches (measured to the window sill) above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches (measured to the window sill) above the floor.

(3) The survey agency may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified intellectual disability professional—

(i) Certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours; and

(ii) Documents the reasons why housing in a room of only four or fewer persons would not be medically feasible.

(4) The facility must provide each client with—

(i) A separate bed of proper size and height for the convenience of the client;

(ii) A clean, comfortable, mattress;
(iii) Bedding appropriate to the weather and climate; and
(iv) Functional furniture appropriate to the client’s needs, and individual closet space in the client’s bedroom with clothes racks and shelves accessible to the client.

(c) Standard: Storage space in bedroom. The facility must provide—

(1) Space and equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety; and
(2) Suitable storage space, accessible to clients, for personal possessions, such as TVs, radios, prosthetic equipment and clothing.

(d) Standard: Client bathrooms. The facility must—

(1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients;
(2) Provide for individual privacy in toilets, bathtubs, and showers; and
(3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 °Fahrenheit.

(e) Standard: Heating and ventilation. (1) Each client bedroom in the facility must have—

(i) At least one window to the outside; and
(ii) Direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.

(2) The facility must—

(i) Maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means; and
(ii) Ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.

(f) Standard: Floors. The facility must have—

(1) Floors that have a resilient, non-abrasive, and slip-resistant surface;
(2) Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor; and
(3) Exposed floor surfaces and floor coverings that promote mobility in areas used by clients, and promote maintenance of sanitary conditions.

(g) Standard: Space and equipment. The facility must—

(1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this subpart and as identified in each client’s individual program plan.
(2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

(3) Provide adequate clean linen and dirty linen storage areas.

(h) Standard: Emergency plan and procedures. (1) The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

(2) The facility must communicate, periodically review, make the plan available, and provide training to the staff.

(i) Standard: Evacuation drills. (1) The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to—

(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;
(ii) Ensure that all personnel on all shifts are familiar with the use of the facility’s fire protection features; and
(iii) Evaluate the effectiveness of emergency and disaster plans and procedures.

(2) The facility must—

(i) Actually evacuate clients during at least one drill each year on each shift;
(ii) Make special provisions for the evacuation of clients with physical disabilities;
(iii) File a report and evaluation on each evacuation drill;
(iv) Investigate all problems with evacuation drills, including accidents, and take corrective action; and
(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

(3) Facilities must meet the requirements of paragraphs (i)(1) and (2) of this subsection for any live-in and relief staff they utilize.

(j) Standard: Fire protection—(1) General. Except as otherwise provided in this section—

(i) The facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4).

(ii) Notwithstanding paragraph (j)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.

(iii) Chapters 32.3.2.11.2 and 33.3.2.11.2 of the adopted 2012 Life Safety Code do not apply to a facility.

(iv) Beginning July 5, 2019, an ICF–IID must be in compliance with Chapter 33.2.3.5.7.1, Sprinklers in attics, or Chapter 33.2.3.5.7.2, heat detection systems in attics of the Life Safety Code.

(2) The State survey agency may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

(3) A facility that meets the LSC definition of a residential board and care occupancy must have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the Fire Safety Evaluation System for Board and Care facilities (FSES/BC).

(4) If CMS finds that the State has a fire and safety code imposed by State law that adequately protects a facility’s clients, CMS may allow the State survey agency to apply the State’s fire and safety code instead of the LSC.

(5) Facilities that meet the Life Safety Code definition of a health care occupancy. (i) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a residential board and care facility, but only if the waiver will not adversely affect the health and safety of the patients.

(ii) A facility may install alcohol-based hand rub dispensers if the dispensers are installed in a manner that adequately protects against inappropriate access.

(iii) When a sprinkler system is shut down for more than 10 hours, the ICF–IID must:

(A) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or

(B) Establish a fire watch until the system is back in service.

(iv) Beginning July 5, 2019, an ICF–IID must be in compliance with Chapter 33.2.3.5.7.1, Sprinklers in attics, or Chapter 33.2.3.5.7.2, heat detection systems in attics of the Life Safety Code.

(v) Except as otherwise provided in this section, ICF–IIDs must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5 and TIA 12–6).

(A) Chapter 7,8,12 and 13 of the adopted Health Care Facilities Code does not apply to an ICF–IID.

(B) If application of the Health Care Facilities Code required under paragraph (j)(5)(iv) of this section would result in unreasonable hardship for the ICF–IID, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of clients.

(k) Standard: Paint. The facility must—

(1) Use lead-free paint inside the facility; and

(2) Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.

(l) Standard: Infection control. (1) The facility must provide a sanitary environment to avoid sources and transmission of infections. There must be an
active program for the prevention, control, and investigation of infection and communicable diseases.

(2) The facility must implement successful corrective action in affected problem areas.

(3) The facility must maintain a record of incidents and corrective actions related to infections.

(4) The facility must prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.

(m) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the FEDERAL REGISTER to announce the changes.


(ii) TIA 12-2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.

(v) TIA 12-5 to NFPA 99, issued August 1, 2013.

(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.


(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.


(x) TIA 12-3 to NFPA 101, issued October 22, 2013.

(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.

(2) [Reserved]
(b) Policies and procedures. The ICF/IID must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

1. The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following:
   (i) Food, water, medical, and pharmaceutical supplies.
   (ii) Alternate sources of energy to maintain the following:
       (A) Temperatures to protect client health and safety and for the safe and sanitary storage of provisions.
       (B) Emergency lighting.
       (C) Fire detection, extinguishing, and alarm systems.
       (D) Sewage and waste disposal.
2. A system to track the location of on-duty staff and sheltered clients in the ICF/IID’s care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID must document the specific name and location of the receiving facility or other location.
3. Safe evacuation from the ICF/IID, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.
4. A means to shelter in place for clients, staff, and volunteers who remain in the facility.
5. A system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records.
6. The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.

(c) Communication plan. The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include the following:

1. Names and contact information for the following:
   (i) Staff.
   (ii) Entities providing services under arrangement.
   (iii) Clients’ physicians.
   (iv) Other ICF/IIDs.
   (v) Volunteers.
2. Contact information for the following:
   (i) Federal, State, tribal, regional, and local emergency preparedness staff.
   (ii) Other sources of assistance.
   (iii) The State Licensing and Certification Agency.
   (iv) The State Protection and Advocacy Agency.
3. Primary and alternate means for communicating with the ICF/IID’s staff, Federal, State, tribal, regional, and local emergency management agencies.
4. A method for sharing information and medical documentation for clients under the ICF/IID’s care, as necessary, with other health care providers to maintain the continuity of care.
5. A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii).
6. A means of providing information about the general condition and location of clients under the facility’s care as permitted under 45 CFR 164.510(b)(4).
7. A means of providing information about the ICF/IID’s occupancy, needs, and its ability to provide assistance, to
the authority having jurisdiction, the
Incident Command Center, or designee.
(8) A method for sharing information
from the emergency plan that the fa-
cility has determined is appropriate
with clients and their families or rep-
resentatives.
(d) Training and testing. The ICF/IID
must develop and maintain an emer-
gency preparedness training and test-
ing program that is based on the emer-
gency plan set forth in paragraph (a) of
this section, risk assessment at para-
graph (a)(1) of this section, policies and
procedures at paragraph (b) of this sec-
tion, and the communication plan at
paragraph (c) of this section. The train-
ing and testing program must be re-
viewed and updated at least annually.
The ICF/IID must meet the require-
ments for evacuation drills and train-
ing at §483.470(h).
(1) Training program. The ICF/IID
must do all the following:
(i) Initial training in emergency pre-
paredness policies and procedures to all
new and existing staff, individuals pro-
viding services under arrangement, and
volunteers, consistent with their ex-
pected roles.
(ii) Provide emergency preparedness
training at least annually.
(iii) Maintain documentation of the
training.
(iv) Demonstrate staff knowledge of
emergency procedures.
(2) Testing. The ICF/IID must conduct
exercises to test the emergency plan at
least annually. The ICF/IID must do
the following:
(i) Participate in a full-scale exercise
that is community-based or when a
community-based exercise is not acces-
sible, an individual, facility-based. If
the ICF/IID experiences an actual nat-
ural or man-made emergency that re-
quires activation of the emergency
plan, the ICF/IID is exempt from en-
gaging in a community-based or indi-
vidual, facility-based full-scale exer-
cise for 1 year following the onset of
the actual event.
(ii) Conduct an additional exercise
that may include, but is not limited to
the following:
(A) A second full-scale exercise that
is community-based or individual, fa-
cility-based.
(B) A tabletop exercise that includes
a group discussion led by a facilitator,
using a narrated, clinically-relevant
emergency scenario, and a set of prob-
lem statements, directed messages, or
prepared questions designed to chal-
genue an emergency plan.
(e) Integrated healthcare systems. If an
ICF/IID is part of a healthcare system
consisting of multiple separately cer-
tified healthcare facilities that elects
to have a unified and integrated emer-
gency preparedness program, the ICF/
IID may choose to participate in the
healthcare system’s coordinated emer-
gency preparedness program. If elected,
the unified and integrated emergency
preparedness program must do all of
the following:
(1) Demonstrate that each separately
certified facility within the system ac-
tively participated in the develop-
ment of the unified and integrated emer-
gency preparedness program.
(2) Be developed and maintained in a
manner that takes into account each
separately certified facility’s unique
circumstances, patient populations,
and services offered.
(3) Demonstrate that each separately
certified facility is capable of actively
using the unified and integrated emer-
gency preparedness program and is in
compliance with the program.
(4) Include a unified and integrated
emergency plan that meets the require-
ments of paragraphs (a)(2), (3), and (4)
of this section. The unified and inte-
grated emergency plan must also be
based on and include all of the fol-
lowing:
(i) A documented community-based
risk assessment, utilizing an all-haz-
ards approach.
(ii) A documented individual facility-
based risk assessment for each sepa-
rately certified facility within the
health system, utilizing an all-hazards
approach.
(5) Include integrated policies and
procedures that meet the requirements
set forth in paragraph (b) of this sec-
tion, a coordinated communication
plan and training and testing programs
§ 483.480 Condition of participation: Dietetic services.

(a) Standard: Food and nutrition services. (1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.

(2) A qualified dietitian must be employed either full-time, part-time, or on a consultant basis at the facility’s discretion.

(3) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food services.

(4) The client’s interdisciplinary team, including a qualified dietitian and physician, must prescribe all modified and special diets including those used as a part of a program to manage inappropriate client behavior.

(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client’s nutritional status and needs.

(b) Standard: Meal services. (1) Each client must receive at least three meals daily, at regular times comparable to normal mealtimes in the community with—

(i) Not more than 14 hours between a substantial evening meal and breakfast of the following day, except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast; and

(ii) Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under paragraph (b)(1)(i) of this section.

(2) Food must be served—

(i) In appropriate quantity;

(ii) At appropriate temperature;

(iii) In a form consistent with the developmental level of the client; and

(iv) With appropriate utensils.

(3) Food served to clients individually and uneaten must be discarded.

(c) Standard: Menus. (1) Menus must—

(i) Be prepared in advance;

(ii) Provide a variety of foods at each meal;

(iii) Be different for the same days of each week and adjusted for seasonal changes; and

(iv) Include the average portion sizes for menu items.

(2) Menus for food actually served must be kept on file for 30 days.

(d) Standard: Dining areas and service. The facility must—

(1) Serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician;

(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs;

(3) Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client;

(4) Supervise and staff dining rooms adequately to direct self-help dining procedure, to assure that each client receives enough food and to assure that each client eats in a manner consistent with his or her developmental level; and

(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician.
and accepted professional standards and principles.

484.14 Condition of participation: Organization, services, and administration.

484.16 Condition of participation: Group of professional personnel.

484.18 Condition of participation: Acceptance of patients, plan of care, and medical supervision.

484.20 Condition of participation: Reporting OASIS information.

484.22 Condition of participation: Emergency preparedness.

Subpart C—Furnishing of Services

484.30 Condition of participation: Skilled nursing services.

484.32 Condition of participation: Therapy services.

484.34 Condition of participation: Medical social services.

484.36 Condition of participation: Home health aide services.

484.38 Condition of participation: Qualifying to furnish outpatient physical therapy or speech pathology services.

484.40 Condition of participation: Clinical records.

484.42 Condition of participation: Evaluation of the agency’s program.

484.45 Condition of participation: Comprehensive assessment of patients.

Subpart D [Reserved]

Subpart E—Prospective Payment System for Home Health Agencies

484.200 Basis and scope.

484.202 Definitions.

484.205 Basis of payment.

484.210 Data used for the calculation of the national prospective 60-day episode payment.

484.215 Initial establishment of the calculation of the national 60-day episode payment.

484.220 Calculation of the national adjusted prospective 60-day episode payment rate for case-mix and area wage levels.

484.225 Annual update of the unadjusted national prospective 60-day episode payment rate.

484.230 Methodology used for the calculation of the low-utilization payment adjustment.

484.235 Methodology used for the calculation of the partial episode payment adjustment.

484.240 Methodology used for the calculation of the outlier payment.

484.295 Patient assessment data.

484.296 Limitation on review.

484.265 Additional payment.

Subpart F—Home Health Value-Based Purchasing (HHVBP) Model Components for Compelling Home Health Agencies Within State Boundaries

484.300 Basis and scope of subpart.

484.305 Definitions.

484.310 Applicability of the Home Health Value-Based Purchasing (HHVBP) Model.

484.315 Data reporting for measures and evaluation under the Home Health Value-Based Purchasing (HHVBP) Model.

484.320 Calculation of the Total Performance Score.

484.325 Payments for home health services under Home Health Value-Based Purchasing (HHVBP) Model.

484.330 Process for determining and applying the value-based payment adjustment under the Home Health Value-Based Purchasing (HHVBP) Model.

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1395hh) unless otherwise indicated.

SOURCE: 54 FR 33367, Aug. 14, 1989, unless otherwise noted.

Subpart A—General Provisions

§ 484.1 Basis and scope.

(a) Basis and scope. This part is based on the indicated provisions of the following sections of the Act:

(1) Sections 1861(o) and 1891 establish the conditions that an HHA must meet in order to participate in Medicare.

(2) Section 1861(z) specifies the Institutional planning standards that HHAs must meet.

(3) Section 1895 provides for the establishment of a prospective payment system for home health services covered under Medicare.

(b) This part also sets forth additional requirements that are considered necessary to ensure the health and safety of patients.

[60 FR 50443, Sept. 29, 1995, as amended at 65 FR 41211, July 3, 2000]

§ 484.2 Definitions.

As used in this part, unless the context indicates otherwise—Bylaws or equivalent means a set of rules adopted by an HHA for governing the agency’s operation.

Branch office means a location or site from which a home health agency provides services within a portion of the
total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the branch independently to meet the conditions of participation as a home health agency.

Clinical note means a notation of a contact with a patient that is written and dated by a member of the health team, and that describes signs and symptoms, treatment and drugs administered and the patient’s reaction, and any changes in physical or emotional condition.

HHA stands for home health agency.


Parent home health agency means the agency that develops and maintains administrative controls of subunits and/or branch offices.

Primary home health agency means the agency that is responsible for the services furnished to patients and for implementation of the plan of care.

Progress note means a written notation, dated and signed by a member of the health team, that summarizes facts about care furnished and the patient’s response during a given period of time.

Proprietary agency means a private profit-making agency licensed by the State.

Public agency means an agency operated by a State or local government.

Subdivision means a component of a multi-function health agency, such as the home care department of a hospital or the nursing division of a health department, which independently meets the conditions of participation for HHAs. A subdivision that has subunits or branch offices is considered a parent agency.

Subunit means a semi-autonomous organization that—

(1) Serves patients in a geographic area different from that of the parent agency; and

(2) Must independently meet the conditions of participation for HHAs because it is too far from the parent agency to share administration, supervision, and services on a daily basis.

Summary report means the compilation of the pertinent factors of a patient’s clinical notes and progress notes that is submitted to the patient’s physician.

Supervision means authoritative procedural guidance by a qualified person for the accomplishment of a function or activity. Unless otherwise specified in this part, the supervisor must be on the premises to supervise an individual who does not meet the qualifications specified in §484.4.

§ 484.4 Personnel qualifications.

Staff required to meet the conditions set forth in this part are staff who meet the qualifications specified in this section.

Administrator, home health agency. A person who:

(a) Is a licensed physician; or

(b) Is a registered nurse; or

(c) Has training and experience in health service administration and at least 1 year of supervisory or administrative experience in home health care or related health programs.

Audiologist. A person who:

(a) Meets the education and experience requirements for a Certificate of Clinical Competence in audiology granted by the American Speech-Language-Hearing Association; or

(b) Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

Home health aide. Effective for services furnished after August 14, 1990, a person who has successfully completed a State-established or other training program that meets the requirements of §484.36(a) and a competency evaluation program or State licensure program that meets the requirements of §484.36 (b) or (e), or a competency evaluation program or State licensure program that meets the requirements of §484.36 (b) or (e). An individual is not considered to have completed a training and competency evaluation program, or a competency evaluation program if, since the individual’s most recent completion of this program(s), there has been a continuous period of 24 consecutive months during none of which the individual furnished services
Occupational therapist. A person who—

(a)(1) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing, unless licensure does not apply;

(2) Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA), or successor organizations of ACOTE; and

(3) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

(b) On or before December 31, 2009—

(1) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing; or

(2) When licensure or other regulation does not apply—

(i) Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or successor organizations of ACOTE; and

(ii) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

(c) On or before January 1, 2008—

(1) Graduated after successful completion of an occupational therapy program accredited jointly by the committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association; or

(2) Is eligible for the National Registration Examination of the American Occupational Therapy Association or the National Board for Certification in Occupational Therapy.

(d) On or before December 31, 1977—

(1) Had 2 years of appropriate experience as an occupational therapist; and

(2) Had achieved a satisfactory grade on an occupational therapist proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

(e) If educated outside the United States, must meet all of the following:

(1) Graduated after successful completion of an occupational therapist education program accredited as substantially equivalent to occupational therapist entry level education in the United States by one of the following:

(i) The Accreditation Council for Occupational Therapy Education (ACOTE).

(ii) Successor organizations of ACOTE.

(iii) The World Federation of Occupational Therapists.

(iv) A credentialing body approved by the American Occupational Therapy Association.

(2) Successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

(3) On or before December 31, 2009, is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing.

Occupational therapy assistant. A person who—

(a) Meets all of the following:

(1) Is licensed, unless licensure does not apply, or otherwise regulated, if applicable, as an occupational therapy assistant by the State in which practicing.

(2) Graduated after successful completion of an occupational therapy assistant education program accredited by the Accreditation Council for Occupational Therapy Education, (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or its successor organizations.

(3) Is eligible to take or successfully completed the entry-level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

(b) On or before December 31, 2009—

(c) On or before January 1, 2008—

(1) Graduated after successful completion of an occupational therapy program accredited jointly by the committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association; or

(2) Is eligible for the National Registration Examination of the American Occupational Therapy Association or the National Board for Certification in Occupational Therapy.

(d) On or before December 31, 1977—

(1) Had 2 years of appropriate experience as an occupational therapist; and

(2) Had achieved a satisfactory grade on an occupational therapist proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.
(1) Is licensed or otherwise regulated as an occupational therapy assistant, if applicable, by the State in which practicing; or any qualifications defined by the State in which practicing, unless licensure does not apply; or
(2) Must meet both of the following:
   (i) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy Association.
   (ii) After January 1, 2010, meets the requirements in paragraph (a) of this section.
(c) After December 31, 1977 and on or before December 31, 2007—
   (1) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy Association; or
   (2) Completed the requirements to practice as an occupational therapy assistant applicable in the State in which practicing.
(d) On or before December 31, 1977—
   (1) Had 2 years of appropriate experience as an occupational therapy assistant; and
   (2) Had achieved a satisfactory grade on an occupational therapy assistant proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.
(e) If educated outside the United States, on or after January 1, 2008—
   (1) Graduated after successful completion of an occupational therapy assistant education program that is accredited as substantially equivalent to occupational therapist assistant entry level education in the United States by—
      (i) The Accreditation Council for Occupational Therapy Education (ACOTE).
      (ii) Its successor organizations.
      (iii) The World Federation of Occupational Therapists.
      (iv) By a credentialing body approved by the American Occupational Therapy Association; and
   (2) Successfully completed the entry-level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).
Physical therapist. A person who is licensed, if applicable, by the State in which practicing, unless licensure does not apply and meets one of the following requirements:
(a)(1) Graduated after successful completion of a physical therapist education program approved by one of the following:
      (i) The Commission on Accreditation in Physical Therapy Education (CAPTE).
      (ii) Successor organizations of CAPTE.
      (iii) An education program outside the United States determined to be substantially equivalent to physical therapist entry-level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or an organization identified in 8 CFR 212.15(e) as it relates to physical therapists; and
   (2) Passed an examination for physical therapists approved by the State in which physical therapy services are provided.
(b) On or before December 31, 2009—
   (1) Graduated after successful completion of a physical therapy curriculum approved by the Commission on Accreditation in Physical Therapy Education (CAPTE); or
   (2) Meets both of the following:
      (i) Graduated after successful completion of an education program determined to be substantially equivalent to physical therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified in 8 CFR 212.15(e) as it relates to physical therapists.
      (ii) Passed an examination for physical therapists approved by the State in which physical therapy services are provided.
(c) Before January 1, 2008—
   (1) Graduated from a physical therapy curriculum approved by one of the following:
(ii) The Committee on Allied Health Education and Accreditation of the American Medical Association.


(d) On or before December 31, 1977 was licensed or qualified as a physical therapist and meets both of the following:

(1) Has 2 years of appropriate experience as a physical therapist.

(2) Has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

(e) Before January 1, 1966—

(1) Was admitted to membership by the American Physical Therapy Association; or

(2) Was admitted to registration by the American Registry of Physical Therapists; or

(3) Has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education.

(f) Before January 1, 1966 was licensed or registered, and before January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy.

(g) If trained outside the United States before January 1, 2008, meets the following requirements:

(1) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy.

(2) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

Physical therapist assistant. A person who is licensed, unless licensure does not apply, registered, or certified as a physical therapist assistant, if applicable, by the State in which practicing, and meets one of the following requirements:

(a)(1) Graduated from a physical therapist assistant curriculum approved by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association; or if educated outside the United States or trained in the United States military, graduated from an education program determined to be substantially equivalent to physical therapist assistant entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified at 8 CFR 212.15(e); and

(2) Passed a national examination for physical therapist assistants.

(b) On or before December 31, 2009, meets one of the following:

(1) Is licensed, or otherwise regulated in the State in which practicing.

(2) In States where licensure or other regulations do not apply, graduated on or before December 31, 2009, from a 2-year college-level program approved by the American Physical Therapy Association and, effective January 1, 2010 meets the requirements of paragraph (a) of this definition.

(c) Before January 1, 2008, where licensure or other regulation does not apply, graduated from a 2-year college-level program approved by the American Physical Therapy Association.

(d) On or before December 31, 1977, was licensed or qualified as a physical therapist assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

Physician. A doctor of medicine, osteopathy or podiatry legally authorized to practice medicine and surgery by the State in which such function or action is performed.

Practical (vocational) nurse. A person who is licensed as a practical (vocational) nurse by the State in which practicing.

Public health nurse. A registered nurse who has completed a baccalaureate degree program approved by the National League for Nursing for public health nursing preparation or postregistered nurse study that includes content approved by the National League for Nursing for public health nursing preparation.
Registered nurse (RN). A graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which practicing.

Social work assistant. A person who:

(1) Has a baccalaureate degree in social work, psychology, sociology, or other field related to social work, and has had at least 1 year of social work experience in a health care setting; or

(2) Has 2 years of appropriate experience as a social work assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a social work assistant after December 31, 1977.

Social worker. A person who has a master’s degree from a school of social work accredited by the Council on Social Work Education, and has 1 year of social work experience in a health care setting.

Speech-language pathologist. A person who has a master’s or doctoral degree in speech-language pathology, and who meets either of the following requirements:

(a) Is licensed as a speech-language pathologist by the State in which the individual furnishes such services; or

(b) In the case of an individual who furnishes services in a State which does not license speech-language pathologists:

(1) Has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience);

(2) Performed not less than 9 months of supervised full-time speech-language pathology services after obtaining a master’s or doctoral degree in speech-language pathology or a related field; and

(3) Successfully completed a national examination in speech-language pathology approved by the Secretary.

(i) The HHA must advise the patient in advance of any change in the plan of care before the change is made.

(2) The patient has the right to participate in the planning of the care.

(i) The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.

(ii) The HHA complies with the requirements of subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.

(d) Standard: Confidentiality of medical records. The patient has the right to confidentiality of the clinical records maintained by the HHA. The HHA must advise the patient of the agency’s policies and procedures regarding disclosure of clinical records.

(e) Standard: Patient liability for payment. (1) The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient. Before the care is initiated, the HHA must inform the patient, orally and in writing, of—

(i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA;

(ii) The charges for services that will not be covered by Medicare; and

(iii) The charges that the individual may have to pay.

(2) The patient has the right to be advised orally and in writing of any changes in the information provided in accordance with paragraph (e)(1) of this section when they occur. The HHA must advise the patient of these changes orally and in writing as soon as possible, but no later than 30 calendar days from the date that the HHA becomes aware of a change.

(f) Standard: Home health hotline. The patient has the right to be advised of the availability of the toll-free HHA hotline in the State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advance directives requirements.


§ 484.11 Condition of participation: Release of patient identifiable OASIS information.

The HHA and agent acting on behalf of the HHA in accordance with a written contract must ensure the confidentiality of all patient identifiable information contained in the clinical record, including OASIS data, and may not release patient identifiable OASIS information to the public.

[64 FR 3763, Jan. 25, 1999]

§ 484.12 Condition of participation: Compliance with Federal, State, and local laws, disclosure and ownership information, and accepted professional standards and principles.

(a) Standard: Compliance with Federal, State, and local laws and regulations. The HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations. If State or applicable local law provides for the licensure of HHAs, an agency not subject to licensure is approved by the licensing authority as meeting the standards established for licensure.

(b) Standard: Disclosure of ownership and management information. The HHA must comply with the requirements of part 420, Subpart C of this chapter. The HHA also must disclose the following information to the State survey agency at the time of the HHA’s initial request for certification, for each survey, and
§ 484.14  Condition of participation: Organization, services, and administration.

Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable. Administrative and supervisory functions are not delegated to another agency or organization and all services not furnished directly, including services provided through subunits are monitored and controlled by the parent agency. If an agency has subunits, appropriate administrative records are maintained for each subunit.

(a) Standard: Services furnished. Part-time or intermittent skilled nursing services and at least one other therapeutic service (physical, speech, or occupational therapy; medical social services; or home health aide services) are made available on a visiting basis, in a place of residence used as a patient’s home. An HHA must provide at least one of the qualifying services directly through agency employees, but may provide the second qualifying service and additional services under arrangements with another agency or organization.

(b) Standard: Governing body. A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency. The governing body appoints a qualified administrator, arranges for professional advice as required under §484.16, adopts and periodically reviews written bylaws or an acceptable equivalent, and oversees the management and fiscal affairs of the agency.

(c) Standard: Administrator. The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency’s ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff; employs qualified personnel and ensures adequate staff education and evaluations; ensures the accuracy of public information materials and activities; and implements an effective budgeting and accounting system. A qualified person is authorized in writing to act in the absence of the administrator.

(d) Standard: Supervising physician or registered nurse. The skilled nursing and other therapeutic services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least 1 year of nursing experience and is a public health nurse). This person, or similarly qualified alternate, is available at all times during operating hours and participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.

(e) Standard: Personnel policies. Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current.

(f) Standard: Personnel under hourly or per visit contracts. If personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following:

(1) Patients are accepted for care only by the primary HHA.
(2) The services to be furnished.
(3) The necessity to conform to all applicable agency policies, including personnel qualifications.
(4) The responsibility for participating in developing plans of care.
(5) The manner in which services will be controlled, coordinated, and evaluated by the primary HHA.
(6) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation.
(7) The procedures for payment for services furnished under the contract.

(g) Standard: Coordination of patient services. All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. A written summary report for each patient is sent to the attending physician at least every 60 days.

(h) Standard: Services under arrangements. Services furnished under arrangements are subject to a written contract conforming with the requirements specified in paragraph (f) of this section and with the requirements of section 1861(w) of the Act (42 U.S.C. 1495x(w)).

(i) Standard: Institutional planning. The HHA, under the direction of the governing body, prepares an overall plan and a budget that includes an annual operating budget and capital expenditure plan.

(1) Annual operating budget. There is an annual operating budget that includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items. However, it is not required that there be prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense.

(2) Capital expenditure plan. (i) There is a capital expenditure plan for at least a 3-year period, including the operating budget year. The plan includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure of more than $600,000 for items that would under generally accepted accounting principles, be considered capital items. In determining if a single capital expenditure exceeds $600,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant, building, and equipment are included. Expenditures directly or indirectly related to capital expenditures, such as grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land are also included. Transactions that are separated in time, but are components of an overall plan or patient care objective, are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, notes and other costs incurred for borrowing funds.

(ii) If the anticipated source of financing is, in any part, the anticipated payment from title V (Maternal and Child Health and Crippled Children’s Services) or title XVIII (Medicare) or title XIX (Medicaid) of the Social Security Act, the plan specifies the following:

(A) Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed in accordance with the Public Health Service Act or the Intellectual Disability Facilities and Community Mental Health Centers Construction Act of 1963.

(B) Whether a capital expenditure proposal has been submitted to the designated planning agency for approval in accordance with section 1122 of the Act (42 U.S.C. 1320a–1) and implementing regulations.

(C) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it was presented to that agency.

(3) Preparation of plan and budget. The overall plan and budget is prepared
under the direction of the governing body of the HHA by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the HHA.

(4) **Annual review of plan and budget.**

The overall plan and budget is reviewed and updated at least annually by the committee referred to in paragraph (i)(3) of this section under the direction of the governing body of the HHA.

(j) **Standard: Laboratory services.**

(1) If the HHA engages in laboratory testing outside of the context of assisting an individual in self-administering a test with an appliance that has been cleared for that purpose by the FDA, such testing must be in compliance with all applicable requirements of part 493 of this chapter.

(2) If the HHA chooses to refer specimens for laboratory testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the applicable requirements of part 493 of this chapter.

§ 484.18 **Condition of participation: Acceptance of patients, plan of care, and medical supervision.**

Patients are accepted for treatment on the basis of a reasonable expectation that the patient’s medical, nursing, and social needs can be met adequately by the agency in the patient’s place of residence. Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

(a) **Standard: Plan of care.** The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. The therapist and other agency personnel participate in developing the plan of care.

(b) **Standard: Periodic review of plan of care.** The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient’s condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60-day episode. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.
(c) **Standard: Conformance with physician orders.** Drugs and treatments are administered by agency staff only as ordered by the physician with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per agency policy developed in consultation with a physician, and after an assessment for contraindications. Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in §484.4 of this chapter) responsible for furnishing or supervising the ordered services. Verbal orders are only accepted by personnel authorized to do so by applicable State and Federal laws and regulations as well as by the HHA’s internal policies.


§ 484.22 Condition of participation: Emergency preparedness.

The Home Health Agency (HHA) must comply with all applicable Federal, State, and local emergency preparedness requirements. The HHA must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

(a) **Emergency plan.** The HHA must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following:

1. Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
2. Include strategies for addressing emergency events identified by the risk assessment.
3. Address patient population, including, but not limited to, the type of services the HHA has the ability to provide in an emergency, and continuity of operations, including delegations of authority and succession plans.
4. Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the HHA’s efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

(b) **Policies and procedures.** The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set...
§ 484.22

42 CFR Ch. IV (10–1–16 Edition)

forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

(1) The plans for the HHA’s patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at § 484.55.

(2) The procedures to inform State and local emergency preparedness officials about HHA patients in need of evacuation from their residences at any time due to an emergency situation based on the patient’s medical and psychiatric condition and home environment.

(3) The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact.

(4) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

(5) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.

(c) Communication plan. The HHA must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Patients’ physicians.

(iv) Volunteers.

(2) Contact information for the following:

(i) Federal, State, tribal, regional, or local emergency preparedness staff.

(ii) Other sources of assistance.

(3) Primary and alternate means for communicating with the HHA’s staff, Federal, State, tribal, regional, and local emergency management agencies.

(4) A method for sharing information and medical documentation for patients under the HHA’s care, as necessary, with other health care providers to maintain the continuity of care.

(5) A means of providing information about the general condition and location of patients under the facility’s care as permitted under 45 CFR 164.510(b)(4).

(6) A means of providing information about the HHA’s needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

(d) Training and testing. The HHA must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

(1) Training program. The HHA must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Demonstrate staff knowledge of emergency procedures.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If
the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA’s response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA’s emergency plan, as needed. (e) Integrated healthcare systems. If a HHA is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the HHA may choose to participate in the healthcare system’s coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following: (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered. (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include all of the following: (i) A documented community-based risk assessment, utilizing an all-hazards approach. (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach. (5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively. EFFECTIVE DATE NOTE: At 81 FR 64033, Sept. 16, 2016, §484.22 was added, effective Nov. 15, 2016. Subpart C—Furnishing of Services §484.30 Condition of participation: Skilled nursing services. The HHA furnishes skilled nursing services by or under the supervision of a registered nurse and in accordance with the plan of care.
and assists the patient in learning appropriate self-care techniques.

§ 484.32 Condition of participation: Therapy services.

Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of care. The qualified therapist assists the physician in evaluating level of function, helps develop the plan of care (revising it as necessary), prepares clinical and progress notes, advises and consults with the family and other agency personnel, and participates in in-service programs.

(a) Standard: Supervision of physical therapy assistant and occupational therapy assistant. Services furnished by a qualified physical therapy assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapy assistant or occupational therapy assistant performs services planned, delegated, and supervised by the therapist, assists in preparing clinical notes and progress reports, and participates in educating the patient and family, and in in-service programs.

(b) Standard: Supervision of speech therapy services. Speech therapy services are furnished only by or under supervision of a qualified speech pathologist or audiologist.

§ 484.34 Condition of participation: Medical social services.

If the agency furnishes medical social services, those services are given by a qualified social worker or by a qualified social work assistant under the supervision of a qualified social worker and in accordance with the plan of care. The social worker assists the physician and other team members in understanding the significant social and emotional factors related to the health problems, participates in the development of the plan of care, prepares clinical and progress notes, works with the family, uses appropriate community resources, participates in discharge planning and in-service programs, and acts as a consultant to other agency personnel.

§ 484.36 Condition of participation: Home health aide services.

Home health aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. They are closely supervised to ensure their competence in providing care. For home health services furnished (either directly or through arrangements with other organizations) after August 14, 1990, the HHA must use individuals who meet the personnel qualifications specified in § 484.4 for “home health aide”.

(a) Standard: Home health aide training—(1) Content and duration of training. The aide training program must address each of the following subject areas through classroom and supervised practical training totalling at least 75 hours, with at least 16 hours devoted to supervised practical training. The individual being trained must complete at least 16 hours of classroom training before beginning the supervised practical training.

(i) Communications skills.

(ii) Observation, reporting and documentation of patient status and the care or service furnished.

(iii) Reading and recording temperature, pulse, and respiration.

(iv) Basic infection control procedures.

(v) Basic elements of body functioning and changes in body function that must be reported to an aide’s supervisor.

(vi) Maintenance of a clean, safe, and healthy environment.

(vii) Recognizing emergencies and knowledge of emergency procedures.

(viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the HHAs, including the need for respect for the patient, his or her privacy and his or her property.
(ix) Appropriate and safe techniques in personal hygiene and grooming that include—
(A) Bed bath.
(B) Sponge, tub, or shower bath.
(C) Shampoo, sink, tub, or bed.
(D) Nail and skin care.
(E) Oral hygiene.
(F) Toileting and elimination.
(x) Safe transfer techniques and ambulation.
(xi) Normal range of motion and positioning.
(xii) Adequate nutrition and fluid intake.
(xiii) Any other task that the HHA may choose to have the home health aide perform.

“Supervised practical training” means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or licensed practical nurse.

(2) Conduct of training—(i) Organizations. A home health aide training program may be offered by any organization except an HHA that, within the previous 2 years has been found—
(A) Out of compliance with requirements of this paragraph (a) or paragraph (b) of this section;
(B) To permit an individual that does not meet the definition of “home health aide” as specified in §484.4 to furnish home health aide services (with the exception of licensed health professionals and volunteers);
(C) Has been subject to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of the CMS or the State);
(D) Has been assessed a civil monetary penalty of not less than $5,000 as an intermediate sanction;
(E) Has been found to have compliance deficiencies that endanger the health and safety of the HHA’s patients and has had a temporary management appointed to oversee the management of the HHA;
(F) Has had all or part of its Medicare payments suspended; or
(G) Under any Federal or State law within the 2-year period beginning on October 1, 1988—
(1) Has had its participation in the Medicare program terminated;
(2) Has been assessed a penalty of not less than $5,000 for deficiencies in Federal or State standards for HHAs;
(3) Was subject to a suspension of Medicare payments to which it otherwise would have been entitled;
(4) Had operated under a temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA’s patients; or
(5) Was closed or had it’s residents transferred by the State.
(ii) Qualifications for instructors. The training of home health aides and the supervision of home health aides during the supervised practical portion of the training must be performed by or under the general supervision of a registered nurse who possesses a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of home health care. Other individuals may be used to provide instruction under the supervision of a qualified registered nurse.

(3) Documentation of training. The HHA must maintain sufficient documentation to demonstrate that the requirements of this standard are met.

(b) Standard: Competency evaluation and in-service training—(1) Applicability. An individual may furnish home health aide services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this paragraph. The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.

(2) Content and frequency of evaluations and amount of in-service training.
(i) The competency evaluation must address each of the subjects listed in paragraph (a)(1)(ii) through (xiii) of this section.
(ii) The HHA must complete a performance review of each home health aide no less frequently than every 12 months.
(iii) The home health aide must receive at least 12 hours of in-service training during each 12-month period.
§ 484.36  Conduct of evaluation and training—(i) Organizations. A home health aide competency evaluation program may be offered by any organization except as specified in paragraph (a)(2)(i) of this section.

The in-service training may be offered by any organization.

(ii) Evaluators and instructors. The competency evaluation must be performed by a registered nurse. The in-service training generally must be supervised by a registered nurse who possesses a minimum of 2 years of nursing experience at least 1 year of which must be in the provision of home health care.

(iii) Subject areas. The subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section must be evaluated after observation of the aide’s performance of the tasks with a patient. The other subject areas in paragraph (a)(1) of this section may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient.

(4) Competency determination. (i) A home health aide is not considered competent in any task for which he or she is evaluated as “unsatisfactory”. The aide must not perform that task without direct supervision by a licensed nurse until after he or she receives training in the task for which he or she was evaluated as “unsatisfactory” and passes a subsequent evaluation with “satisfactory”.

(ii) A home health aide is not considered to have successfully passed a competency evaluation if the aide has an “unsatisfactory” rating in more than one of the required areas.

(5) Documentation of competency evaluation. The HHA must maintain documentation which demonstrates that the requirements of this standard are met.

(6) Effective date. The HHA must implement a competency evaluation program that meets the requirements of this paragraph before February 14, 1990. The HHA must provide the preparation necessary for the individual to successfully complete the competency evaluation program. After August 14, 1990, the HHA may use only those aides that have been found to be competent in accordance with § 484.36(b).

(c) Standard: Assignment and duties of the home health aide—(1) Assignment. The home health aide is assigned to a specific patient by the registered nurse. Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.

(2) Duties. The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under State law. The duties of a home health aide include the provision of hands-on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self-administered. Any home health aide services offered by an HHA must be provided by a qualified home health aide.

(d) Standard: Supervision. (1) If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d)(2) of this section. If the patient is not receiving skilled nursing care, but is receiving another skilled service (that is, physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist.

(2) The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an onsite visit to the patient’s home no less frequently than every 2 weeks.

(3) If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient’s home no less frequently than every 60 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.

(4) If home health aide services are provided by an individual who is not
employed directly by the HHA (or hospice), the services of the home health aide must be provided under arrangements, as defined in section 1861(w)(1) of the Act. If the HHA (or hospice) chooses to provide home health aide services under arrangements with another organization, the HHA’s (or hospice’s) responsibilities include, but are not limited to—

(i) Ensuring the overall quality of the care provided by the aide;

(ii) Supervision of the aide’s services as described in paragraphs (d)(1) and (d)(2) of this section; and

(iii) Ensuring that home health aides providing services under arrangements have met the training requirements of paragraphs (a) and (b) of this section.

§ 484.38 Condition of participation: Qualifying to furnish outpatient physical therapy or speech pathology services.

An HHA that wishes to furnish outpatient physical therapy or speech pathology services must meet all the pertinent conditions of this part and also meet the additional health and safety requirements set forth in §§485.711, 485.713, 485.715, 485.719, 485.723, and 485.727 of this chapter to implement section 1861(p) of the Act.

§ 484.48 Condition of participation: Clinical records.

A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient’s medical and health status at discharge.

(a) Standards: Retention of records. Clinical records are retained for 5 years after the month the cost report to which the records apply is filed with the intermediary, unless State law stipulates a longer period of time. Policies provide for retention even if the HHA discontinues operations. If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient.

(b) Standards: Protection of records. Clinical record information is safeguarded against loss or unauthorized use. Written procedures govern use and removal of records and the conditions for release of information. Patient’s written consent is required for release of information not authorized by law.

§ 484.52 Condition of participation: Evaluation of the agency’s program.

The HHA has written policies requiring an overall evaluation of the agency’s total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation assesses
§ 484.55 Condition of participation: Comprehensive assessment of patients.

Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient’s current health status and includes information that may be used to demonstrate the patient’s progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient’s continuing need for home care and meet the patient’s medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient’s eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary.

(a) Standard: Initial assessment visit.

(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient’s return home, or on the physician-ordered start of care date.

(2) When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional.

(b) Standard: Completion of the comprehensive assessment. (1) The comprehensive assessment must be completed in a timely manner, consistent with the patient’s immediate needs, but no later than 5 calendar days after the start of care.

(2) Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status.

(3) When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician, a physical therapist, speech-language pathologist or occupational therapist may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status.

The occupational therapist may complete the comprehensive assessment if the need for occupational therapy establishes program eligibility.

(c) Standard: Drug regimen review. The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects...
Centers for Medicare & Medicaid Services, HHS

§484.205

and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient’s condition warrants due to a major decline or improvement in the patient’s health status, but not less frequently than—

(1) The last five days of every 60 days beginning with the start-of-care date, unless there is a—

(i) Beneficiary elected transfer;

(ii) Significant change in condition;

or

(iii) Discharge and return to the same HHA during the 60-day episode.

(2) Within 48 hours of the patient’s return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests;

(3) At discharge.

(e) Standard: Incorporation of OASIS data items. The OASIS data items determined by the Secretary must be incorporated into the HHA’s own assessment and must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.

§484.202 Definitions.

As used in this subpart—

Case-mix index means a scale that measures the relative difference in resource intensity among different groups in the clinical model.

Discipline means one of the six home health disciplines covered under the Medicare home health benefit (skilled nursing services, home health aide services, physical therapy services, occupational therapy services, speech-language pathology services, and medical social services).

Home health market basket index means an index that reflects changes over time in the prices of an appropriate mix of goods and services included in home health services.

Rural area means, with respect to home health episodes ending on or after January 1, 2006, an area defined in §412.64(b)(1)(ii)(C) of this chapter.

Urban area means, with respect to home health episodes ending on or after January 1, 2006, an area defined in §412.64(b)(1)(ii)(A) and (B) of this chapter.

§484.205 Basis of payment.

(a) Method of payment. An HHA receives a national prospective 60-day episode payment of a predetermined rate for a home health service previously paid on a reasonable cost basis (except the osteoporosis drug defined in section 1861(kk) of the Act) as of August 5, 1997. The national 60-day episode payment is determined in accordance with §484.215. The national prospective 60-day episode payment is subject to the following adjustments and additional payments:

(1) A low-utilization payment adjustment (LUPA) of a predetermined per-visit rate as specified in §484.230.

(2) A partial episode payment (PEP) adjustment due to an intervening event...
defined as a beneficiary elected transfer or a discharge and return to the same HHA during the 60-day episode, that warrants a new 60-day episode payment during an existing 60-day episode, that initiates the start of a new 60-day episode payment and a new physician certification of the new plan of care. The PEP adjustment is determined in accordance with §484.235.

(3) An outlier payment is determined in accordance with §484.240.

(b) Episode payment. The national prospective 60-day episode payment represents payment in full for all costs associated with furnishing home health services previously paid on a reasonable cost basis (except the osteoporosis drug listed in section 1861(m) of the Act as defined in section 1861(kk) of the Act) as of August 5, 1997 unless the national 60-day episode payment is subject to a low-utilization payment adjustment set forth in §484.230, a partial episode payment adjustment set forth at §484.235, or an additional outlier payment set forth in §484.240. All payments under this system may be subject to a medical review adjustment reflecting beneficiary eligibility, medical necessity determinations, and HHRG assignment. DME provided as a home health service as defined in section 1861(m) of the Act continues to be paid the fee schedule amount.

(1) Split percentage payment for initial episodes. The initial percentage payment for initial episodes is paid to an HHA at 60 percent of the case-mix and wage adjusted 60-day episode rate. The residual final payment for initial episodes is paid at 40 percent of the case-mix and wage adjusted 60-day episode rate. Split percentage payments are made in accordance with requirements at §409.43(c) of this chapter.

(2) Split percentage payment for subsequent episodes. The initial percentage payment for subsequent episodes is paid to an HHA at 50 percent of the case-mix and wage adjusted 60-day episode rate. The residual final payment for subsequent episodes is paid at 50 percent of the case-mix and wage adjusted 60-day episode rate. Split percentage payments are made in accordance with requirements at §409.43(c) of this chapter.

(c) Low-utilization payment. An HHA receives a national 60-day episode payment of a predetermined rate for home health services previously paid on a reasonable cost basis as of August 5, 1997, unless CMS determines at the end of the 60-day episode that the HHA furnished minimal services to a patient during the 60-day episode. A low-utilization payment adjustment is determined in accordance with §484.230.

(d) Partial episode payment adjustment. (1) An HHA receives a national 60-day episode payment of a predetermined rate for home health services unless CMS determines an intervening event, defined as a beneficiary elected transfer or discharge with goals met or no expectation of return to home health and the beneficiary returned to home health during the 60-day episode, warrants a new 60-day episode for purposes of payment. A start of care OASIS assessment and physician certification of the new plan of care are required.

(2) The PEP adjustment will not apply in situations of transfers among HHAs of common ownership. Those situations will be considered services provided under arrangement on behalf of the originating HHA by the receiving HHA with the common ownership interest for the balance of the 60-day episode. The common ownership exception to the transfer PEP adjustment does not apply if the beneficiary moves to a different MSA or Non-MSA during the 60-day episode before the transfer to the receiving HHA. The transferring HHA in situations of common ownership not only serves as a billing agent, but must also exercise professional responsibility over the arranged-for services in order for services provided under arrangements to be paid.

(3) If the intervening event warrants a new 60-day episode payment and a new physician certification and a new plan of care, the initial HHA receives a partial episode payment adjustment reflecting the length of time the patient remained under its care. A partial episode payment adjustment is determined in accordance with §484.235.

(e) Outlier payment. An HHA receives a national 60-day episode payment of a predetermined rate for a home health service, unless the imputed cost of the 60-day episode exceeds a threshold
amount. The outlier payment is defined to be a proportion of the imputed costs beyond the threshold. An outlier payment is a payment in addition to the national 60-day episode payment. The total of all outlier payments is limited to no more than 2.5 percent of total outlays under the HHA PPS. An outlier payment is determined in accordance with §484.240.

§484.210 Data used for the calculation of the national prospective 60-day episode payment.

To calculate the national prospective 60-day episode payment, CMS uses the following:

(a) Medicare cost data on the most recent audited cost report data available.

(b) Utilization data based on Medicare claims.

(c) An appropriate wage index to adjust for area wage differences.

(d) The most recent projections of increases in costs from the HHA market basket index.

(e) OASIS assessment data and other data that account for the relative resource utilization for different HHA Medicare patient case-mix. An HHA must submit to CMS the OASIS data described at §484.55(b)(1) and (d)(1) in order for CMS to administer the payment rate methodologies described in §§484.215, 484.230 and 484.235.

§484.215 Initial establishment of the calculation of the national 60-day episode payment.

(a) Determining an HHA’s costs. In calculating the initial unadjusted national 60-day episode payment applicable for a service furnished by an HHA using data on the most recent available audited cost reports, CMS determines each HHA’s costs by summing its allowable costs for the period. CMS determines the national mean cost per visit.

(b) Determining HHA utilization. In calculating the initial unadjusted national 60-day episode payment, CMS determines the national mean utilization for each of the six disciplines using home health claims data.

(c) Use of the market basket index. CMS uses the HHA market basket index to adjust the HHA cost data to reflect cost increases occurring between October 1, 1996 through September 30, 2001.

(d) Calculation of the unadjusted national average prospective payment amount for the 60-day episode. CMS calculates the unadjusted national 60-day episode payment in the following manner:

(1) By computing the mean national cost per visit.

(2) By computing the national mean utilization for each discipline.

(3) By multiplying the mean national cost per visit by the national mean utilization summed in the aggregate for the six disciplines.

(4) By adding to the amount derived in paragraph (d)(3) of this section, amounts for nonroutine medical supplies, an OASIS adjustment for estimated ongoing reporting costs, an OASIS adjustment for the one time implementation costs associated with assessment scheduling form changes and amounts for Part B therapies that could have been unbundled to Part B prior to October 1, 2000. The resulting amount is the unadjusted national 60-day episode rate.

(e) Standardization of the data for variation in area wage levels and case-mix. CMS standardizes—

(1) The cost data described in paragraph (a) of this section to remove the effects of geographic variation in wage levels and variation in case-mix;

(2) The cost data for geographic variation in wage levels using the hospital wage index; and

(3) The cost data for HHA variation in case-mix using the case-mix indices and other data that indicate HHA case-mix.

§484.220 Calculation of the adjusted national prospective 60-day episode payment rate for case-mix and area wage levels.

CMS adjusts the national prospective 60-day episode payment rate to account for the following:

(a) HHA case-mix using a case-mix index to explain the relative resource utilization of different patients. To address changes to the case-mix that are
§ 484.225 Annual update of the unadjusted national prospective 60-day episode payment rate.

(a) CMS updates the unadjusted national 60-day episode payment rate on a fiscal year basis (as defined in section 1895(b)(1)(B) of the Act).

(b) For 2007 and subsequent calendar years, in accordance with section 1895(b)(3)(B)(v) of the Act, in the case of a home health agency that submits home health quality data, as specified by the Secretary, the unadjusted national prospective 60-day episode rate is equal to the rate for the previous calendar year increased by the applicable home health market basket index amount.

(c) For 2007 and subsequent calendar years, in accordance with section 1895(b)(3)(B)(v) of the Act, in the case of a home health agency that does not submit home health quality data, as specified by the Secretary, the unadjusted national prospective 60-day episode rate is equal to the rate for the previous calendar year increased by the applicable home health market basket index amount minus 2 percentage points. Any reduction of the percentage change will apply only to the calendar year involved and will not be taken into account in computing the prospective payment amount for a subsequent calendar year.

[72 FR 49879, Aug. 29, 2007, as amended at 80 FR 68717, Nov. 5, 2015]

§ 484.230 Methodology used for the calculation of the low-utilization payment adjustment.

An episode with four or fewer visits is paid the national per-visit amount by discipline updated annually by the applicable market basket for each visit type. The national per-visit amount is determined by using cost data set forth in §484.210(a) and adjusting by the appropriate wage index based on the site of service for the beneficiary. For 2008 and subsequent calendar years, an amount will be added to low-utilization payment adjustments for low-utilization episodes that occur as the beneficiary’s only episode or initial episode in a sequence of adjacent episodes. For purposes of the home health PPS, a sequence of adjacent episodes for a beneficiary is a series of claims with no more than 60 days without home care between the end of one episode, which is the 60th day (except for episodes that have been PEP-adjusted), and the beginning of the next episode.


§ 484.235 Methodology used for the calculation of the partial episode payment adjustment.

(a) CMS makes a PEP adjustment to the original 60-day episode payment that is interrupted by an intervening event described in §484.205(d).

(b) The original 60-day episode payment is adjusted to reflect the length of time the beneficiary remained under the care of the original HHA based on the first billable visit date through and including the last billable visit date.

(c) The partial episode payment is calculated by determining the actual days served by the original HHA as a proportion of 60 multiplied by the initial 60-day episode payment.

§ 484.240 Methodology used for the calculation of the outlier payment.

(a) CMS makes an outlier payment for an episode whose estimated cost exceeds a threshold amount for each case-mix group.
Centers for Medicare & Medicaid Services, HHS

§ 484.265

(b) The outlier threshold for each case-mix group is the episode payment amount for that group, or the PEP adjustment amount for the episode, plus a fixed dollar loss amount that is the same for all case-mix groups.

(c) The outlier payment is a proportion of the amount of estimated cost beyond the threshold.

(d) CMS imputes the cost for each episode by multiplying the national per-visit amount of each discipline by the number of visits in the discipline and computing the total imputed cost for all disciplines.

(e) The fixed dollar loss amount and the loss sharing proportion are chosen so that the estimated total outlier payment is no more than 2.5 percent of total payment under home health PPS.

(i) The total amount of outlier payments to a specific home health agency for a year may not exceed an amount equal to 10 percent of the total payments to the specific agency under home health PPS for the year.

§ 484.245 [Reserved]

§ 484.250 Patient assessment data.

(a) Data submission. An HHA must submit the following data to CMS:

(1) The OASIS data described at § 484.55(b)(1) and (d)(1) for CMS to administer the payment rate methodologies described in §§ 484.215, 484.230, and 484.235, and to meet the quality reporting requirements of section 1895(b)(3)(B)(v) of the Act.

(2) The Home Health Care CAHPS survey data for CMS to administer the payment rate methodologies described in § 484.225(c), and to meet the quality reporting requirements of section 1895(b)(3)(B)(v) of the Act.

(b) Patient count. An HHA that has less than 60 eligible unique HHCAHPS patients annually must annually submit to CMS their total HHCAHPS patient count to CMS to be exempt from the HHCAHPS reporting requirements for a calendar year period.

(c) Survey requirements. An HHA must contract with an approved, independent HHCAHPS survey vendor to administer the HHCAHPS Survey on its behalf.

(1) CMS approves an HHCAHPS survey vendor if such applicant has been in business for a minimum of 3 years and has conducted surveys of individuals and samples for at least 2 years.

(i) For HHCAHPS, a “survey of individuals” is defined as the collection of data from at least 600 individuals selected by statistical sampling methods and the data collected are used for statistical purposes.

(ii) All applicants that meet these requirements will be approved by CMS.

(2) No organization, firm, or business that owns, operates, or provides staffing for a HHA is permitted to administer its own Home Health Care CAHPS (HHCAHPS) Survey or administer the survey on behalf of any other HHA in the capacity as an HHCAHPS survey vendor. Such organizations will not be approved by CMS as HHCAHPS survey vendors.

(3) Approved HHCAHPS survey vendors must fully comply with all HHCAHPS oversight activities, including allowing CMS and its HHCAHPS program team to perform site visits at the vendors’ company locations.

§ 484.260 Limitation on review.

An HHA is not entitled to judicial or administrative review under sections 1869 or 1878 of the Act, or otherwise, with regard to the establishment of the payment unit, including the national 60-day prospective episode payment rate, adjustments and outlier payments. An HHA is not entitled to the review regarding the establishment of the transition period, definition and application of the unit of payments, the computation of initial standard prospective payment amounts, the establishment of the adjustment for outliers, and the establishment of case-mix and area wage adjustment factors.

§ 484.265 Additional payment.

QIO photocopy and mailing costs. An additional payment is made to a home health agency in accordance with § 476.78 of this chapter for the costs of
§ 484.300 Photocopying and mailing medical records requested by a QIO.

[68 FR 67960, Dec. 5, 2003]

Subpart F—Home Health Value-Based Purchasing (HHVBP) Model Components for Competing Home Health Agencies Within State Boundaries

SOURCE: 80 FR 68718, Nov. 5, 2015, unless otherwise noted.

§ 484.305 Definitions.

As used in this subpart—

Applicable measure means a measure for which the competing HHA has provided 20 home health episodes of care per year.

Applicable percent means a maximum upward or downward adjustment for a given performance year, not to exceed the following:

(1) For CY 2018, 3-percent.

(2) For CY 2019, 5-percent.

(3) For CY 2020, 6-percent.

(4) For CY 2021, 7-percent.

(5) For CY 2022, 8-percent.

Benchmark refers to the mean of the top decile of Medicare-certified HHA performance on the specified quality measure during the baseline period, calculated separately for the larger-volume and smaller-volume cohorts within each state.

Competing home health agency or agencies means an agency or agencies:

(1) That has or have a current Medicare certification; and,

(2) Is or are being paid by CMS for home health care delivered within any of the states specified in § 484.310.

Home health prospective payment system (HH PPS) refers to the basis of payment for home health agencies as set forth in §§ 484.200 through 484.245.

Larger-volume cohort means the group of competing home health agencies within the boundaries of selected states that are participating in HHCAHPs in accordance with § 484.250.

Linear exchange function is the means to translate a competing HHA’s Total Performance Score into a value-based payment adjustment percentage.

New measures means those measures to be reported by competing HHAs under the HHVBP Model that are not otherwise reported by Medicare-certified HHAs to CMS and were identified to fill gaps to cover National Quality Strategy Domains not completely covered by existing measures in the home health setting.

Payment adjustment means the amount by which a competing HHA’s final claim payment amount under the HH PPS is changed in accordance with the methodology described in § 484.325.

Performance period means the time period during which data are collected for the purpose of calculating a competing HHA’s performance on measures.

Selected state(s) means those nine states that were randomly selected to compete/participate in the HHVBP Model via a computer algorithm designed for random selection and identified at § 484.310(b).

Smaller-volume cohort means the group of competing home health agencies within the boundaries of selected states that are exempt from participation in HHCAHPs in accordance with § 484.250.

Starter set means the quality measures selected for the first year of this model.

Total Performance Score means the numeric score ranging from 0 to 100 awarded to each competing HHA based on its performance under the HHVBP Model.

Value-based purchasing means measuring, reporting, and rewarding excellence in health care delivery that takes into consideration quality, efficiency, and alignment of incentives. Effective health care services and high performing health care providers may be rewarded with improved reputations through public reporting, enhanced payments through differential reimbursements, and increased market.
§ 484.310 Applicability of the Home Health Value-Based Purchasing (HHVBP) Model.

(a) General rule. The HHVBP Model applies to all Medicare-certified home health agencies (HHAs) in selected states.

(b) Selected states. Nine states have been selected in accordance with CMS’s selection methodology. All Medicare-certified HHAs that provide services in Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee will be required to compete in this model.

§ 484.315 Data reporting for measures and evaluation under the Home Health Value-Based Purchasing (HHVBP) Model.

(a) Competing home health agencies will be evaluated using a starter set of quality measures.

(b) Competing home health agencies in selected states will be required to report information on New Measures, as determined appropriate by the Secretary, to CMS in the form, manner, and at a time specified by the Secretary.

(c) Competing home health agencies in selected states will be required to collect and report such information as the Secretary determines is necessary for purposes of monitoring and evaluating the HHVBP Model under section 1115A(b)(4) of the Act (42 U.S.C. 1315a).

§ 484.320 Calculation of the Total Performance Score.

A competing home health agency’s Total Performance Score for a model year is calculated as follows:

(a) CMS will award points to the competing home health agency for performance on each of the applicable measures in the starter set, excluding the New Measures.

(b) CMS will award points to the competing home health agency for reporting on each of the New Measures in the starter set, worth up to ten percent of the Total Performance Score.

(c) CMS will sum all points awarded for each applicable measure excluding the New Measures in the starter set, weighted equally at the individual measure level, to calculate a value worth 90-percent of the Total Performance Score.

(d) The sum of the points awarded to a competing HHA for each applicable measure in the starter set and the points awarded to a competing HHA for reporting data on each New Measure is the competing HHA’s Total Performance Score for the calendar year.

§ 484.325 Payments for home health services under Home Health Value-Based Purchasing (HHVBP) Model.

CMS will determine a payment adjustment up to the maximum applicable percentage, upward or downward, under the HHVBP Model for each competing home health agency based on the agency’s Total Performance Score using a linear exchange function. Payment adjustments made under the HHVBP Model will be calculated as a percentage of otherwise-applicable payments for home health services provided under section 1895 of the Act (42 U.S.C. 1395ff).

§ 484.330 Process for determining and applying the value-based payment adjustment under the Home Health Value-Based Purchasing (HHVBP) Model.

(a) General. Competing home health agencies will be ranked within the larger-volume and smaller-volume cohorts in selected states based on the performance standards that apply to the HHVBP Model for the baseline year, and CMS will make value-based payment adjustments to the competing HHAs as specified in this section.

(b) Calculation of the value-based payment adjustment amount. The value-based payment adjustment amount is calculated by multiplying the Home Health Prospective Payment final claim payment amount as calculated in accordance with §484.205 by the payment adjustment percentage.

(c) Calculation of the payment adjustment percentage. The payment adjustment percentage is calculated as the product of: The applicable percent as defined in §484.320, the competing HHA’s Total Performance Score divided by 100, and the linear exchange function slope.
PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

Subpart A [Reserved]

Subpart B—Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities

Sec.
485.50 Basis and scope.
485.51 Definition.
485.54 Condition of participation: Compliance with State and local laws.
485.56 Condition of participation: Governing body and administration.
485.58 Condition of participation: Comprehensive rehabilitation program.
485.60 Condition of participation: Clinical records.
485.62 Condition of participation: Physical environment.
485.64 Condition of participation: Disaster procedures.
485.66 Condition of participation: Utilization review plan.
485.68 Condition of participation: Emergency preparedness.
485.70 Personnel qualifications.
485.74 Appeal rights.

Subparts C–E [Reserved]

Subpart F—Conditions of Participation: Critical Access Hospitals (CAHs)

485.601 Basis and scope.
485.603 Rural health network.
485.604 Personnel qualifications.
485.606 Designation and certification of CAHs.
485.608 Condition of participation: Compliance with Federal, State, and local laws and regulations.
485.610 Condition of participation: Status and location.
485.612 Condition of participation: Compliance with hospital requirements at the time of application.
485.616 Condition of participation: Agreements.
485.618 Condition of participation: Emergency services.
485.620 Condition of participation: Number of beds and length of stay.
485.623 Condition of participation: Physical plant and environment.
485.625 Condition of participation: Emergency preparedness.
485.627 Condition of participation: Organizational structure.
485.631 Condition of participation: Staffing and staff responsibilities.
485.635 Condition of participation: Provision of services.

485.638 Condition of participation: Clinical records.
485.639 Condition of participation: Surgical services.
485.641 Condition of participation: Periodic evaluation and quality assurance review.
485.643 Condition of participation: Organ, tissue, and eye procurement.
485.645 Special requirements for CAH providers of long-term care services ("swing-beds").
485.647 Condition of participation: psychiatric and rehabilitation distinct part units.

Subpart G [Reserved]

Subpart H—Conditions of Participation for Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services

485.701 Basis and scope.
485.703 Definitions.
485.705 Personnel qualifications.
485.707 Condition of participation: Compliance with Federal, State, and local laws.
485.709 Condition of participation: Administrative management.
485.711 Condition of participation: Plan of care and physician involvement.
485.713 Condition of participation: Physical therapy services.
485.715 Condition of participation: Speech pathology services.
485.717 Condition of participation: Rehabilitation program.
485.719 Condition of participation: Arrangements for physical therapy and speech pathology services to be performed by other than salaried organization personnel.
485.721 Condition of participation: Clinical records.
485.723 Condition of participation: Physical environment.
485.725 Condition of participation: Infection control.
485.727 Condition of participation: Disaster preparedness.
485.729 Condition of participation: Program evaluation.

Subpart I [Reserved]

Subpart J—Conditions of Participation: Community Mental Health Centers (CMHCs)

485.900 Basis and scope.
485.902 Definitions.
485.904 Condition of participation: Personnel qualifications.
485.910 Condition of participation: Client rights.
Subpart A—Reserved

Subpart B—Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities

$485.50 Basis and scope.

This subpart sets forth the conditions that facilities must meet to be certified as comprehensive outpatient rehabilitation facilities (CORFs) under section 1861(cc)(2) of the Social Security Act and be accepted for participation in Medicare in accordance with part 489 of this chapter.

$485.51 Definition.

As used in this subpart, unless the context indicates otherwise, "comprehensive outpatient rehabilitation facility", "CORF", or "facility" means a nonresidential facility that—

(a) Is established and operated exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons, at a single fixed location, by or under the supervision of a physician except as provided in paragraph (c) of this section;

(b) Meets all the requirements of this subpart.

(c) Exception. May provide influenza, pneumococcal and Hepatitis B vaccines provided the applicable conditions of coverage under §410.58 and §410.63 of this chapter are met.

$485.54 Condition of participation: Compliance with State and local laws.

The facility and all personnel who provide services must be in compliance with applicable State and local laws and regulations.

(a) Standard: Licensure of facility. If State or local law provides for licensing, the facility must be currently licensed or approved as meeting the standards established for licensure.

(b) Standard: Licensure of personnel. Personnel that provide service must be licensed, certified, or registered in accordance with applicable State and local laws.

$485.56 Condition of participation: Governing body and administration.

The facility must have a governing body that assumes full legal responsibility for establishing and implementing policies regarding the management and operation of the facility.

(a) Standard: Disclosure of ownership. The facility must comply with the provisions of part 420, subpart C of this chapter that require health care providers and fiscal agents to disclose certain information about ownership and control.

(b) Standard: Administrator. The governing body must appoint an administrator who—

(1) Is responsible for the overall management of the facility under the authority delegated by the governing body;

(2) Implements and enforces the facility’s policies and procedures;

(3) Designates, in writing, an individual who, in the absence of the administrator, acts on behalf of the administrator; and

(4) Retains professional and administrative responsibility for all personnel providing facility services.

(c) Standard: Group of professional personnel. The facility must have a group of professional personnel associated with the facility that—
§ 485.56  

(1) Develops and periodically reviews policies to govern the services provided by the facility; and

(2) Consists of at least one physician and one professional representing each of the services provided by the facility.

(d) **Standard: Institutional budget plan.** The facility must have an institutional budget plan that meets the following conditions:

(1) It is prepared, under the direction of the governing body, by a committee consisting of representatives of the governing body and the administrative staff.

(2) It provides for—

   (i) An annual operating budget prepared according to generally accepted accounting principles;

   (ii) A 3-year capital expenditure plan if expenditures in excess of $100,000 are anticipated, for that period, for the acquisition of land; the improvement of land, buildings, and equipment; and the replacement, modernization, and expansion of buildings and equipment; and

   (iii) Annual review and updating by the governing body.

(e) **Standard: Patient care policies.** The facility must have written patient care policies that govern the services it furnishes. The patient care policies must include the following:

(1) A description of the services the facility furnishes through employees and those furnished under arrangements.

(2) Rules for and personnel responsibilities in handling medical emergencies.

(3) Rules for the storage, handling, and administration of drugs and biologicals.

(4) Criteria for patient admission, continuing care, and discharge.

(5) Procedures for preparing and maintaining clinical records on all patients.

(6) A procedure for explaining to the patient and the patient’s family the extent and purpose of the services to be provided.

(7) A procedure to assist the referring physician in locating another level of care for—patients whose treatment has terminated and who are discharged.

(8) A requirement that patients accepted by the facility must be under the care of a physician.

(9) A requirement that there be a plan of treatment established by a physician for each patient.

(10) A procedure to ensure that the group of professional personnel reviews and takes appropriate action on recommendations from the utilization review committee regarding patient care policies.

(f) **Standard: Delegation of authority.** The responsibility for overall administration, management, and operation must be retained by the facility itself and not delegated to others.

(1) The facility may enter into a contract for purposes of assistance in financial management and may delegate to others the following and similar services:

   (i) Bookkeeping.

   (ii) Assistance in the development of procedures for billing and accounting systems.

   (iii) Assistance in the development of an operating budget.

   (iv) Purchase of supplies in bulk form.

   (v) The preparation of financial statements.

(2) When the services listed in paragraph (f)(1) of this section are delegated, a contract must be in effect and:

   (i) May not be for a term of more than 5 years;

   (ii) Must be subject to termination within 60 days of written notice by either party;

   (iii) Must contain a clause requiring renegotiation of any provision that CMS finds to be in contravention to any new, revised or amended Federal regulation or law;

   (iv) Must state that only the facility may bill the Medicare program; and

   (v) May not include clauses that state or imply that the contractor has power and authority to act on behalf of the facility, or clauses that give the contractor rights, duties, discretions, or responsibilities that enable it to dictate the administration, management, or operations of the facility.
§ 485.58 Condition of participation: Comprehensive rehabilitation program.

The facility must provide a coordinated rehabilitation program that includes, at a minimum, physicians' services, physical therapy services, and social or psychological services. These services must be furnished by personnel that meet the qualifications set forth in §§485.70 and 484.4 of this chapter and must be consistent with the plan of treatment and the results of comprehensive patient assessments.

(a) Standard: Physician services. (1) A facility physician must be present in the facility for a sufficient time to—

(i) Provide, in accordance with accepted principles of medical practice, medical direction, medical care services, consultation, and medical supervision of nonphysician staff;

(ii) Establish the plan of treatment in cases where a plan has not been established by the referring physician;

(iii) Assist in establishing and implementing the facility's patient care policies; and

(iv) Participate in plan of treatment reviews, patient case review conferences, comprehensive patient assessment and reassessments, and utilization review.

(2) The facility must provide for emergency physician services during the facility operating hours.

(b) Standard: Plan of treatment. For each patient, a physician must establish a plan of treatment before the facility initiates treatment. The plan of treatment must meet the following requirements:

(1) It must delineate anticipated goals and specify the type, amount, frequency and duration of services to be provided.

(2) It must be promptly evaluated after changes in the patient's condition and revised when necessary.

(3) It must, if appropriate, be developed in consultation with the facility physician and the appropriate facility professional personnel.

(4) It must be reviewed at least every 60 days by a facility physician who, when appropriate, consults with the professional personnel providing services. The results of this review must be communicated to the patient's referring physician for concurrence before treatment is continued or discontinued.

(5) It must be revised if the comprehensive reassessment of the patient's status or the results of the patient case review conference indicate the need for revision.

(c) Standard: Coordination of services. The facility must designate, in writing, a qualified professional to ensure that professional personnel coordinate their related activities and exchange information about each patient under their care. Mechanisms to assist in the coordination of services must include—

(1) Providing to all personnel associated with the facility, a schedule indicating the frequency and type of services provided at the facility;

(2) A procedure for communicating to all patient care personnel pertinent information concerning significant changes in the patient's status;

(3) Periodic clinical record entries, noting at least the patient's status in relationship to goal attainment; and

(4) Scheduling patient case review conferences for purposes of determining appropriateness of treatment, when indicated by the results of the initial comprehensive patient assessment, reassessment(s), the recommendation of the facility physician (or other physician who established the plan of treatment), or upon the recommendation of one of the professionals providing services.

(d) Standard: Provision of services. (1) All patients must be referred to the facility by a physician who provides the following information to the facility before treatment is initiated:

(i) The patient's significant medical history.

(ii) Current medical findings.

(iii) Diagnosis(es) and contraindications to any treatment modality.

(iv) Rehabilitation goals, if determined.

(2) Services may be provided by facility employees or by others under arrangements made by the facility.

(3) The facility must have on its premises the necessary equipment to implement the plan of treatment and sufficient space to allow adequate care.

(4) The services must be furnished by personnel that meet the qualifications
of § 485.70 and the number of qualified personnel must be adequate for the volume and diversity of services offered. Personnel that do not meet the qualifications specified in § 485.70 may be used by the facility in assisting qualified staff. When a qualified individual is assisted by these personnel, the qualified individual must be on the premises, and must instruct these personnel in appropriate patient care service techniques and retain responsibility for their activities.

(5) A qualified professional must initiate and coordinate the appropriate portions of the plan of treatment, monitor the patient’s progress, and recommend changes, in the plan, if necessary.

(6) A qualified professional representing each service made available at the facility must be either on the premises of the facility or must be available through direct telecommunication for consultation and assistance during the facility’s operating hours. At least one qualified professional must be on the premises during the facility’s operating hours.

(7) All services must be provided consistent with accepted professional standards and practice.

(e) Standard: Scope and site of services—(1) Basic requirements. The facility must provide all the CORF services required in the plan of treatment and, except as provided in paragraph (e)(2) of this section, must provide the services on its premises.

(2) Exceptions. Physical therapy, occupational therapy, and speech-language pathology services may be furnished away from the premises of the CORF including the individual’s home when payment is not otherwise made under Title XVIII of the Act. In addition, a single home environment evaluation is covered if there is a need to evaluate the potential impact of the home environment on the rehabilitation goals. The single home environment evaluation requires the presence of the patient and the physical therapist, occupational therapist, or speech-language pathologist, as appropriate.

(f) Standard: Patient assessment. Each qualified professional involved in the patient’s care, as specified in the plan of treatment, must—

(1) Carry out an initial patient assessment; and

(2) In order to identify whether or not the current plan of treatment is appropriate, perform a patient reassessment after significant changes in the patient’s status.

(g) Standard: Laboratory services. (1) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.

(2) If the facility chooses to refer specimens for laboratory testing, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter.

§ 485.60 Condition of participation: Clinical records.

The facility must maintain clinical records on all patients in accordance with accepted professional standards and practice. The clinical records must be completely, promptly, and accurately documented, readily accessible, and systematically organized to facilitate retrieval and compilation of information.

(a) Standard: Content. Each clinical record must contain sufficient information to identify the patient clearly and to justify the diagnosis and treatment. Entries in the clinical record must be made as frequently as is necessary to insure effective treatment and must be signed by personnel providing services. All entries made by assistant level personnel must be countersigned by the corresponding professional. Documentation on each patient must be consolidated into one clinical record that must contain—

(1) The initial assessment and subsequent reassessments of the patient’s needs;

(2) Current plan of treatment;

(3) Identification data and consent or authorization forms;

(4) Pertinent medical history, past and present;

(5) A report of pertinent physical examinations if any;
(6) Progress notes or other documentation that reflect patient reaction to treatment, tests, or injury, or the need to change the established plan of treatment; and

(7) Upon discharge, a discharge summary including patient status relative to goal achievement, prognosis, and future treatment considerations.

(b) Standard: Protection of clinical record information. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. The facility must have procedures that govern the use and removal of records and the conditions for release of information. The facility must obtain the patient’s written consent before releasing information not required to be released by law.

(c) Standard: Retention and preservation. The facility must retain clinical record information for 5 years after patient discharge and must make provision for the maintenance of such records in the event that it is no longer able to treat patients.

§ 485.62 Condition of participation: Physical environment.

The facility must provide a physical environment that protects the health and safety of patients, personnel, and the public.

(a) Standard: Safety and comfort of patients. The physical premises of the facility and those areas of its surrounding physical structure that are used by the patients (including at least all stairwells, corridors and passageways) must meet the following requirements:

(1) Applicable Federal, State, and local building, fire, and safety codes must be met.

(2) Fire extinguishers must be easily accessible and fire regulations must be prominently posted.

(3) A fire alarm system with local (in-house) capability must be functional, and where power is generated by electricity, an alternate power source with automatic triggering must be present.

(4) Lights, supported by an emergency power source, must be placed at exits.

(5) A sufficient number of staff to evacuate patients during a disaster must be on the premises of the facility whenever patients are being treated.

(6) Lighting must be sufficient to carry out services safely; room temperature must be maintained at comfortable levels; and ventilation through windows, mechanical means, or a combination of both must be provided.

(7) Safe and sufficient space must be available for the scope of services offered.

(b) Standard: Sanitary environment. The facility must maintain a sanitary environment and establish a program to identify, investigate, prevent, and control the cause of patient infections.

(1) The facility must establish written policies and procedures designed to control and prevent infection in the facility and to investigate and identify possible causes of infection.

(2) The facility must monitor the infection control program to ensure that the staff implement the policies and procedures and that the policies and procedures are consistent with current practices in the field.

(3) The facility must make available at all times a quantity of laundered linen adequate for proper care and comfort of patients. Linens must be handled, stored, and processed in a manner that prevents the spread of infection.

(4) Provisions must be in effect to ensure that the facility’s premises are maintained free of rodent and insect infestation.

(c) Standard: Maintenance of equipment, physical location, and grounds.

The facility must establish a written preventive maintenance program to ensure that—

(1) All equipment is properly maintained and equipment needing periodic calibration is calibrated consistent with the manufacturer’s recommendations; and

(2) The interior of the facility, the exterior of the physical structure housing the facility, and the exterior walkways and parking areas are clean and orderly and maintained free of any defects that are a hazard to patients, personnel, and the public.

(d) Standard: Access for the physically impaired. The facility must ensure the following:
§ 485.64 Condition of participation: Disaster procedures.

The facility must have written policies and procedures that specifically define the handling of patients, personnel, records, and the public during disasters. All personnel associated with the facility must be knowledgeable with respect to these procedures, be trained in their application, and be assigned specific responsibilities.

(a) Standard: Disaster plan. The facility’s written disaster plan must be developed and maintained with assistance of qualified fire, safety, and other appropriate experts. The plan must include—

(1) Procedures for prompt transfer of casualties and records;

(2) Procedures for notifying community emergency personnel (for example, fire department, ambulance, etc.);

(3) Instructions regarding the location and use of alarm systems and signals and fire fighting equipment; and

(4) Specification of evacuation routes and procedures for leaving the facility.

(b) Standard: Drills and staff training.

(1) The facility must provide ongoing training and drills for all personnel associated with the facility in all aspects of disaster preparedness.

(2) All new personnel must be oriented and assigned specific responsibilities regarding the facility’s disaster plan within two weeks of their first workday.

Effective Date Note: At 81 FR 64035, Sept. 16, 2016, §485.64 was removed and reserved, effective Nov. 15, 2016.

§ 485.66 Condition of participation: Utilization review plan.

The facility must have in effect a written utilization review plan that is implemented at least each quarter, to assess the necessity of services and promotes the most efficient use of services provided by the facility.

(a) Standard: Utilization review committee. The utilization review committee, consisting of the group of professional personnel specified in §485.56(c), a committee of this group, or a group of similar composition, comprised by professional personnel not associated with the facility, must carry out the utilization review plan.

(b) Standard: Utilization review plan. The utilization review plan must contain written procedures for evaluating—

(1) Admissions, continued care, and discharges using, at a minimum, the criteria established in the patient care policies;

(2) The applicability of the plan of treatment to established goals; and

(3) The adequacy of clinical records with regard to—

(i) Assessing the quality of services provided; and

(ii) Determining whether the facility’s policies and clinical practices are compatible and promote appropriate and efficient utilization of services.

§ 485.68 Condition of participation: Emergency preparedness.

The Comprehensive Outpatient Rehabilitation Facility (CORF) must comply with all applicable Federal, State, and local emergency preparedness requirements. The CORF must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:
(a) **Emergency plan.** The CORF must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The plan must do all of the following:

1. Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.

2. Include strategies for addressing emergency events identified by the risk assessment.

3. Address patient population, including, but not limited to, the type of services the CORF has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

4. Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the CORF’s efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts;

5. Be developed and maintained with assistance from fire, safety, and other appropriate experts.

(b) **Policies and procedures.** The CORF must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

1. Safe evacuation from the CORF, which includes staff responsibilities, and needs of the patients.

2. A means to shelter in place for patients, staff, and volunteers who remain in the facility.

3. A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

4. The use of volunteers in an emergency and other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.

(c) **Communication plan.** The CORF must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

1. Names and contact information for the following:
   - Staff.
   - Entities providing services under arrangement.
   - Patients’ physicians.
   - Other CORFs.
   - Volunteers.

2. Contact information for the following:
   - Federal, State, tribal, regional, and local emergency management agencies.
   - Other sources of assistance.

3. Primary and alternate means for communicating with the CORF’s staff, Federal, State, tribal, regional, and local emergency management agencies.

4. A method for sharing information and medical documentation for patients under the CORF’s care, as necessary, with other health care providers to maintain the continuity of care.

5. A means of providing information about the CORF’s needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.

(d) **Training and testing.** The CORF must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

1. **Training program.** The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF’s emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and firefighting equipment.

(2) Testing. The CORF must conduct exercises to test the emergency plan at least annually. The CORF must do the following:

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the CORF experiences an actual natural or man-made emergency that requires activation of the emergency plan, the CORF is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

(ii) Conduct an additional exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based.

(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the CORF’s response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the CORF’s emergency plan, as needed.

(e) Integrated healthcare systems. If a CORF is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the CORF may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

(2) Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered.

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:

(i) A documented community–based risk assessment, utilizing an all-hazards approach.

(ii) A documented individual facility–based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

EFFECTIVE DATE NOTE: At 81 FR 64035, Sept. 16, 2016, §485.68 was added, effective Nov. 15, 2016.

§ 485.70 Personnel qualifications.

This section sets forth the qualifications that must be met, as a condition of participation, under §485.58, and as a condition of coverage of services under §410.100 of this chapter.

(a) A facility physician must be a doctor of medicine or osteopathy who—

(1) Is licensed under State law to practice medicine or surgery; and

(2) Has had, subsequent to completing a 1-year hospital internship, at
Centers for Medicare & Medicaid Services, HHS § 485.70

least 1 year of training in the medical management of patients requiring rehabilitation services; or
(3) Has had at least 1 year of full-time or part-time experience in a rehabilitation setting providing physicians’ services similar to those required in this subpart.

(b) A licensed practical nurse must be licensed as a practical or vocational nurse by the State in which practicing, if applicable.

(c) An occupational therapist and an occupational therapy assistant must meet the qualifications in § 484.4 of this chapter.

(d) An orthotist must—
(1) Be licensed by the State in which practicing, if applicable;
(2) Have successfully completed a training program in orthotics that is jointly recognized by the American Council on Education and the American Board for Certification in Orthotics and Prosthetics; and
(3) Be eligible to take that Board’s certification examination in orthotics.

(e) A physical therapist and a physical therapist assistant must meet the qualifications in § 484.4 of this chapter.

(f) A prosthetist must—
(1) Be licensed by the State in which practicing, if applicable;
(2) Have successfully completed a training program in prosthetics that is jointly recognized by the American Council on Education and the American Board for Certification in Orthotics and Prosthetics; and
(3) Be eligible to take that Board’s certification examination in prosthetics.

(g) A psychologist must be certified or licensed by the State in which he or she is practicing, if that State requires certification or licensing, and must hold a masters degree in psychology from and educational institution approved by the State in which the institution is located.

(h) A registered nurse must be a graduate of an approved school of nursing and be licensed as a registered nurse by the State in which practicing, if applicable.

(i) A rehabilitation counselor must—
(1) Be licensed by the State in which practicing, if applicable;
(2) Hold at least a bachelor’s degree; and
(3) Be eligible to take the certification examination administered by the Commission on Rehabilitation Counselor Certification.

(j) A respiratory therapist must complete one of the following criteria:
(1) Criterion 1. All of the following must be completed:
(i) Be licensed by the State in which practicing, if applicable.
(ii) Have successfully completed a nationally-accredited educational program for respiratory therapists.
(iii)(A) Be eligible to take the registry examination administered by the National Board for Respiratory Care for respiratory therapists; or
(B) Have passed the registry examination administered by the National Board for Respiratory Care for respiratory therapists.
(2) Criterion 2: All of the following must be completed:
(i) Be licensed by the State in which practicing, if applicable.
(ii) Have equivalent training and experience as determined by the National Board for Respiratory Care.

(k) A respiratory therapy technician must—
(1) Be licensed by the State in which practicing, if applicable;
(2) Have successfully completed a training program accredited by the Committees on Allied Health Education and Accreditation (CAHEA) in collaboration with the Joint Review Committee for Respiratory Therapy Education; and
(3) Either—
(i) Be eligible to take the certification examination for respiratory therapy technicians administered by the National Board for Respiratory Therapy, Inc.; or
(ii) Have equivalent training and experience as determined by the National Board for Respiratory Therapy, Inc.

(l) A social worker must—
(1) Be licensed by the State in which practicing, if applicable;
(2) Hold at least a bachelor’s degree from a school accredited or approved by the Council on Social Work Education; and
(3) Have 1 year of social work experience in a health care setting.
(m) A speech-language pathologist must meet the qualifications set forth in part 484 of this chapter.

§ 485.74 Appeal rights.

The appeal provisions set forth in part 498 of this chapter, for providers, are applicable to any entity that is participating or seeks to participate in the Medicare program as a CORF.

Subparts C–E [Reserved]

Subpart F—Conditions of Participation: Critical Access Hospitals (CAHs)

SOURCE: 58 FR 30671, May 26, 1993, unless otherwise noted.

§ 485.601 Basis and scope.

(a) Statutory basis. This subpart is based on section 1820 of the Act which sets forth the conditions for designating certain hospitals as CAHs.

(b) Scope. This subpart sets forth the conditions that a hospital must meet to be designated as a CAH.

§ 485.603 Rural health network.

A rural health network is an organization that meets the following specifications:

(a) It includes—

(1) At least one hospital that the State has designated or plans to designate as a CAH; and

(2) At least one hospital that furnishes acute care services.

(b) The members of the organization have entered into agreements regarding—

(1) Patient referral and transfer;

(2) The development and use of communications systems, including, where feasible, telemetry systems and systems for electronic sharing of patient data; and

(3) The provision of emergency and nonemergency transportation among members.

(c) Each CAH has an agreement with respect to credentialing and quality assurance with at least—

(1) One hospital that is a member of the network when applicable;

(2) One QIO or equivalent entity; or

(3) One other appropriate and qualified entity identified in the State rural health care plan.

§ 485.604 Personnel qualifications.

Staff that furnish services in a CAH must meet the applicable requirements of this section.

(a) Clinical nurse specialist. A clinical nurse specialist must be a person who—

(1) Is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed in accordance with State nurse licensing laws and regulations; and

(2) Holds a master’s or doctoral level degree in a defined clinical area of nursing from an accredited educational institution.

(b) Nurse practitioner. A nurse practitioner must be a registered professional nurse who is currently licensed to practice in the State in which the clinical nurse specialist services are performed in accordance with State nurse licensing laws and regulations; and

(2) Holds a master’s or doctoral level degree in a defined clinical area of nursing from an accredited educational institution.

(b) Nurse practitioner. A nurse practitioner must be a registered professional nurse who is currently licensed to practice in the State, who meets the State’s requirements governing the qualification of nurse practitioners, and who meets one of the following conditions:

(1) Is currently certified as a primary care nurse practitioner by the American Nurses’ Association or by the National Board of Pediatric Nurse Practitioners and Associates.

(2) Has successfully completed a 1 academic year program that—

(i) Prepares registered nurses to perform an expanded role in the delivery of primary care;

(ii) Includes at least 4 months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and

(iii) Awards a degree, diploma, or certificate to persons who successfully complete the program.
(3) Has successfully completed a formal educational program (for preparing registered nurses to perform an expanded role in the delivery of primary care) that does not meet the requirements of paragraph (a)(2) of this section, and has been performing an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately preceding June 25, 1993.

(c) Physician assistant. A physician assistant must be a person who meets the applicable State requirements governing the qualifications for assistants to primary care physicians, and who meets at least one of the following conditions:

(1) Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians.

(2) Has satisfactorily completed a program for preparing physician assistants that—

(i) Was at least one academic year in length;

(ii) Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

(iii) Was accredited by the American Medical Association’s Committee on Allied Health Education and Accreditation.

(3) Has satisfactorily completed a formal educational program (for preparing physician assistants) that does not meet the requirements of paragraph (c)(2) of this section and has been assisting primary care physicians for a total of 12 months during the 18-month period immediately preceding June 25, 1993.

§ 485.608 Condition of participation: Compliance with Federal, State, and local laws and regulations.

The CAH and its staff are in compliance with applicable Federal, State and local laws and regulations.

(a) Standard: Compliance with Federal laws and regulations. The CAH is in compliance with applicable Federal laws and regulations related to the health and safety of patients.

(b) Standard: Compliance with State and local laws and regulations. All patient care services are furnished in accordance with applicable State and local laws and regulations.

(c) Standard: Licensure of CAH. The CAH is licensed in accordance with applicable Federal, State and local laws and regulations.

(d) Standard: Licensure, certification or registration of personnel. Staff of the CAH are licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations.

§ 485.606 Designation and certification of CAHs.

(a) Criteria for State designation. (1) A State that has established a Medicare rural hospital flexibility program described in section 1820(c) of the Act may designate one or more facilities as CAHs if each facility meets the CAH conditions of participation in this subpart F.

(2) The State must not deny any hospital that is otherwise eligible for designation as a CAH under this paragraph (a) solely because the hospital has entered into an agreement under which the hospital may provide posthospital SNF care as described in § 482.58 of this chapter.

(b) Criteria for CMS certification. CMS certifies a facility as a CAH if—

(1) The facility is designated as a CAH by the State in which it is located and has been surveyed by the State survey agency or by CMS and found to meet all conditions of participation in this part and all other applicable requirements for participation in part 489 of this chapter.

(2) The facility is a medical assistance facility operating in Montana or a rural primary care hospital designated by CMS before August 5, 1997, and is otherwise eligible to be designated as a CAH by the State under the rules in this subpart.
§ 485.610 Condition of participation: Status and location.

(a) Standard: Status. The facility is—

(1) A currently participating hospital that meets all conditions of participation set forth in this subpart;

(2) A recently closed facility, provided that the facility—

(i) Was a hospital that ceased operations on or after the date that is 10 years before November 29, 1999; and

(ii) Meets the criteria for designation under this subpart as of the effective date of its designation; or

(3) A health clinic or a health center (as defined by the State) that—

(i) Is licensed by the State as a health clinic or a health center;

(ii) Was a hospital that was downsized to a health clinic or a health center; and

(iii) As of the effective date of its designation, meets the criteria for designation set forth in this subpart.

(b) Standard: Location in a rural area or treatment as rural. The CAH meets the requirements of either paragraph (b)(1) or (b)(2) of this section or the requirements of paragraph (b)(3), (b)(4), or (b)(5) of this section.

(1) The CAH meets the following requirements:

(i) The CAH is located outside any area that is a Metropolitan Statistical Area, as defined by the Office of Management and Budget, or that has been recognized as urban under §412.64(b), excluding paragraph (b)(3) of this chapter;

(ii) The CAH has not been classified as an urban hospital for purposes of the standardized payment amount by CMS or the Medicare Geographic Classification Review Board under §412.230(e) of this chapter, and is not among a group of hospitals that have been redesignated to an adjacent urban area under §412.232 of this chapter.

(2) The CAH is located within a Metropolitan Statistical Area, as defined by the Office of Management and Budget, but is being treated as being located in a rural area in accordance with §412.103 of this chapter.

(3) Effective for October 1, 2004 through September 30, 2006, the CAH does not meet the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, in FY 2004, was not part of a Metropolitan Statistical Area as defined by the Office of Management and Budget, but as of FY 2005 was included as part of such a Metropolitan Statistical Area as a result of the most recent census data and implementation of the new Metropolitan Statistical Area definitions announced by the Office of Management and Budget on June 3, 2003.

(4) Effective for October 1, 2009 through September 30, 2011, the CAH does not meet the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, in FY 2009, was not part of a Metropolitan Statistical Area as defined by the Office of Management and Budget, but, as of FY 2010, was included as part of such a Metropolitan Statistical Area as a result of the most recent census data and implementation of the new Metropolitan Statistical Area definitions announced by the Office of Management and Budget on November 20, 2008.

(5) Effective on or after October 1, 2014, for a period of 2 years beginning with the effective date of the most recent Office of Management and Budget (OMB) standards for delineating statistical areas adopted by CMS, the CAH no longer meets the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, prior to the most recent OMB standards for delineating statistical areas adopted by CMS and the most recent Census Bureau data, was located in a rural area as defined by OMB, but under the most recent OMB standards for delineating statistical areas adopted by CMS and the most recent Census Bureau data, is located in an urban area.

(c) Standard: Location relative to other facilities or necessary provider certification. The CAH is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or before January 1, 2006, the CAH is certified by the State as being a necessary provider of health care services to residents in the area. A CAH that is designated as a necessary provider on
or before December 31, 2005, will maintain its necessary provider designation after January 1, 2006.

(d) **Standard: Relocation of CAHs with a necessary provider designation.** A CAH that has a necessary provider designation from the State that was in effect prior to January 1, 2006, and relocates its facility after January 1, 2006, can continue to meet the location requirement of paragraph (c) of this section based on the necessary provider designation only if the relocated facility meets the requirements as specified in paragraph (d)(1) of this section.

(1) If a necessary provider CAH relocates its facility and begins providing services in a new location, the CAH can continue to meet the location requirement of paragraph (c) of this section based on the necessary provider designation only if the relocated facility—

(i) Serves at least 75 percent of the same service area that it served prior to its relocation;

(ii) Provides at least 75 percent of the same services that it provided prior to the relocation; and

(iii) Is staffed by 75 percent of the same staff (including medical staff, contracted staff, and employees) that were on staff at the original location.

(2) If a CAH that has been designated as a necessary provider by the State begins providing services at another location after January 1, 2006, and does not meet the requirements in paragraph (d)(1) of this section, the action will be considered a cessation of business as described in §489.52(b)(3).

(e) **Standard: Off-campus and co-location requirements for CAHs.** A CAH may continue to meet the location requirements of paragraph (c) of this section only if the CAH meets the following:

(1) If a CAH with a necessary provider designation is co-located (that is, it shares a campus, as defined in §413.65(a)(2) of this chapter, with another hospital or CAH), the necessary provider CAH can continue to meet the location requirement of paragraph (c) of this section only if the co-location arrangement was in effect before January 1, 2008, and the type and scope of services offered by the facility co-located with the necessary provider CAH do not change. A change of ownership of any of the facilities with a co-location arrangement that was in effect before January 1, 2008, will not be considered to be a new co-location arrangement.

(2) If a CAH or a necessary provider CAH operates an off-campus provider-based location, excluding an RHC as defined in §405.2401(b) of this chapter, but including a department or remote location, as defined in §413.65(a)(2) of this chapter, or an off-campus distinct part psychiatric or rehabilitation unit, as defined in §485.647, that was created or acquired by the CAH on or after January 1, 2008, the CAH can continue to meet the location requirement of paragraph (c) of this section only if the off-campus provider-based location or off-campus distinct part unit is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH.

(3) If either a CAH or a CAH that has been designated as a necessary provider by the State does not meet the requirements in paragraph (e)(1) of this section, by co-locating with another hospital or CAH on or after January 1, 2008, or creates or acquires an off-campus provider-based location or off-campus distinct part unit on or after January 1, 2008, that does not meet the requirements in paragraph (e)(2) of this section, the CAH’s provider agreement will be subject to termination in accordance with the provisions of §489.53(a)(3) of this subchapter, unless the CAH terminates the off-campus arrangement or the co-location arrangement, or both.

§ 485.616 Condition of participation: Agreements.

(a) Standard: Agreements with network hospitals. In the case of a CAH that is a member of a rural health network as defined in § 485.603 of this chapter, the CAH has in effect an agreement with at least one hospital that is a member of the network for—

(1) Patient referral and transfer;

(2) The development and use of communications systems of the network, including the network’s system for the electronic sharing of patient data, and telemetry and medical records, if the network has in operation such a system; and

(3) The provision of emergency and nonemergency transportation between the facility and the hospital.

(b) Standard: Agreements for credentialing and quality assurance. Each CAH that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least—

(1) One hospital that is a member of the network;

(2) One QIO or equivalent entity; or

(3) One other appropriate and qualified entity identified in the State rural health care plan.

(c) Standard: Agreements for credentialing and privileging of telemedicine physicians and practitioners. (1) The governing body of the CAH must ensure that, when telemedicine services are furnished to the CAH’s patients through an agreement with a distant-site hospital, the agreement is written and specifies that it is the responsibility of the governing body of the distant-site hospital to meet the following requirements with regard to its physicians or practitioners providing telemedicine services:

(i) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.

(ii) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff.

(iii) Assure that the medical staff has bylaws.

(iv) Approve medical staff bylaws and other medical staff rules and regulations.

(v) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.

(vi) Ensure the criteria for selection are individual character, competence, training, experience, and judgment.

(vii) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society.

(2) When telemedicine services are furnished to the CAH’s patients through an agreement with a distant-site hospital, the CAH’s governing body or responsible individual may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site hospital regarding individual distant-site physicians or practitioners. The CAH’s governing body or responsible individual must ensure, through its written agreement with the distant-site hospital, that the following provisions are met:

(i) The distant-site hospital providing telemedicine services is a Medicare-participating hospital.

(ii) The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician’s or practitioner’s privileges at the distant-site hospital;

(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the CAH is located; and

(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician’s or practitioner’s performance of these privileges and sends the distant-site hospital such information for
Centers for Medicare & Medicaid Services, HHS

§ 485.618 Condition of participation: Emergency services.

The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.

(a) Standard: Availability. Emergency services are available on a 24-hours a day basis.

(b) Standard: Equipment, supplies, and medication. Equipment, supplies, and medication used in treating emergency cases are kept at the CAH and are readily available for treating emergency cases. The items available must include the following:

(1) Drugs and biologicals commonly used in life-saving procedures, including analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.

(2) Equipment and supplies commonly used in life-saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac
(c) Standard: Blood and blood products. The facility provides, either directly or under arrangements, the following:

(1) Services for the procurement, safekeeping, and transfusion of blood, including the availability of blood products needed for emergencies on a 24-hours a day basis.

(2) Blood storage facilities that meet the requirements of 42 CFR part 493, subpart K, and are under the control and supervision of a pathologist or other qualified doctor of medicine or osteopathy. If blood banking services are provided under an arrangement, the arrangement is approved by the facility’s medical staff and by the persons directly responsible for the operation of the facility.

(d) Standard: Personnel. (1) Except as specified in paragraph (d)(3) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care, on call and immediately available by telephone or radio contact, and available on site within the following timeframes:

(i) Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in paragraph (d)(1)(ii) of this section; or

(ii) Within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met:

(A) The CAH is located in an area designated as a frontier area (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets the criteria for a remote location adopted by the State in its rural health care plan, and approved by CMS, under section 1820(b) of the Act.

(B) The State has determined, under criteria in its rural health care plan, that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH.

(C) The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.

(2) A registered nurse with training and experience in emergency care can be utilized to conduct specific medical screening examinations only if—

(i) The registered nurse is on site and immediately available at the CAH when a patient requests medical care; and

(ii) The nature of the patient’s request for medical care is within the scope of practice of a registered nurse and consistent with applicable State laws and the CAH’s bylaws or rules and regulations.

(3) A registered nurse satisfies the personnel requirement specified in paragraph (d)(1) of this section for a temporary period if—

(i) The CAH has no greater than 10 beds;

(ii) The CAH is located in an area designated as a frontier area or remote location as described in paragraph (d)(1)(ii)(A) of this section;

(iii) The State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation on the issue of using RNs on a temporary basis as part of their State rural healthcare plan with the State Boards of Medicine and Nursing, and in accordance with State law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in paragraph (d)(1) of this section;

(iv) Once a Governor submits a letter, as specified in paragraph (d)(3)(iii) of this section, a CAH must submit documentation to the State survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate
Centers for Medicare & Medicaid Services, HHS

§ 485.620 Condition of participation: Number of beds and length of stay.

(a) Standard: Number of beds. Except as permitted for CAHs having distinct part units under § 485.647, the CAH maintains no more than 25 inpatient beds. Inpatient beds may be used for either inpatient or swing-bed services.

(b) Standard: Length of stay. The CAH provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.

§ 485.623 Condition of participation: Physical plant and environment.

(a) Standard: Construction. The CAH is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provision of services.

(b) Standard: Maintenance. The CAH has housekeeping and preventive maintenance programs to ensure that—

(1) All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition;

(2) There is proper routine storage and prompt disposal of trash;

(3) Drugs and biologicals are appropriately stored;

(4) The premises are clean and orderly; and

(5) There is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.

(c) Standard: Coordination with emergency response systems. The CAH must, in coordination with emergency response systems in the area, establish procedures under which a doctor of medicine or osteopathy is immediately available by telephone or radio contact on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the CAH or other appropriate locations for treatment.

(d) Standard: Life safety from fire. (1) Except as otherwise provided in this section—

(i) The CAH must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.)

(ii) Notwithstanding paragraph (d)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.

(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a CAH, but only if the waiver will not adversely affect the health and safety of the patients.

(3) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the CAH, but only if the waiver does not

adversely affect the health and safety of patients.

(4) The CAH maintains written evidence of regular inspection and approval by State or local fire control agencies.

(5) A CAH may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.

(6) When a sprinkler system is shut down for more than 10 hours, the CAH must:
   (i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or
   (ii) Establish a fire watch until the system is back in service.

(7) Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016 the sill height must not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement.

   (i) The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours.

   (ii) Special nursing care areas of new occupancies shall not exceed 60 inches.

(e) Standard: Building safety. Except as otherwise provided in this section, the CAH must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5 and TIA 12–6).

(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a CAH.

(2) If application of the Health Care Facilities Code required under paragraph (e) of this section would result in unreasonable hardship for the CAH, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.

(f) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.


   (ii) TIA 12–2 to NFPA 99, issued August 11, 2011.

   (iii) TIA 12–3 to NFPA 99, issued August 9, 2012.

   (iv) TIA 12–4 to NFPA 99, issued March 7, 2013.

   (v) TIA 12–5 to NFPA 99, issued August 1, 2013.


   (viii) TIA 12–1 to NFPA 101, issued August 11, 2011.


   (x) TIA 12–3 to NFPA 101, issued October 22, 2013.

   (xi) TIA 12–4 to NFPA 101, issued October 22, 2013.

(2) [Reserved]

§485.625 Condition of participation: Emergency preparedness.

The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The
Centers for Medicare & Medicaid Services, HHS § 485.625

CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness plan must include, but not be limited to, the following elements:

(a) **Emergency plan.** The CAH must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The plan must do all of the following:

1. Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
2. Include strategies for addressing emergency events identified by the risk assessment.
3. Address patient population, including, but not limited to, persons at risk; the type of services the CAH has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
4. Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the CAH's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

(b) **Policies and procedures.** The CAH must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

1. The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place, include, but are not limited to—
   i. Food, water, medical, and pharmaceutical supplies;
   ii. Alternate sources of energy to maintain:
      A. Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions;

(B) Emergency lighting;
(C) Fire detection, extinguishing, and alarm systems; and
(D) Sewage and waste disposal.
2. A system to track the location of on-duty staff and sheltered patients in the CAH’s care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the CAH must document the specific name and location of the receiving facility or other location.
3. Safe evacuation from the CAH, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.
4. A means to shelter in place for patients, staff, and volunteers who remain in the facility.
5. A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.
6. The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.
7. The development of arrangements with other CAHs or other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to CAH patients.
8. The role of the CAH under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

(c) **Communication plan.** The CAH must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

1. Names and contact information for the following:
   i. Staff.
§ 485.625

(ii) Entities providing services under arrangement.
(iii) Patients' physicians.
(iv) Other CAHs and hospitals.
(v) Volunteers.

(2) Contact information for the following:
(i) Federal, State, tribal, regional, and local emergency preparedness staff.
(ii) Other sources of assistance.

(3) Primary and alternate means for communicating with the following:
(i) CAH's staff.
(ii) Federal, State, tribal, regional, and local emergency management agencies.

(4) A method for sharing information and medical documentation for patients under the CAH's care, as necessary, with other health care providers to maintain the continuity of care.

(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).

(6) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).

(7) A means of providing information about the CAH's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.

(d) Training and testing. The CAH must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

(1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

(2) Testing. The CAH must conduct exercises to test the emergency plan at least annually. The CAH must do the following:
(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based exercise. If the CAH experiences an actual natural or man-made emergency that requires activation of the emergency plan, the CAH is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.
(ii) Conduct an additional exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based.
(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the CAH's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the CAH's emergency plan, as needed.

(e) Emergency and standby power systems. The CAH must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.

(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, and TIA 12–6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when
an existing structure or building is renovated.

(2) Emergency generator inspection and testing. The CAH must implement emergency power system inspection and testing requirements found in the Health Care Facilities Code, NFPA 110, and the Life Safety Code.

(3) Emergency generator fuel. CAHs that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

(f) Integrated healthcare systems. If a CAH is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the CAH may choose to participate in the healthcare system’s coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

(2) Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered.

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include—

(i) A documented community-based risk assessment, utilizing an all-hazards approach.

(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

(g) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the FEDERAL REGISTER to announce the changes.


(ii) Technical interim amendment (TIA) 12–2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12–3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12–4 to NFPA 99, issued March 7, 2013.

(v) TIA 12–5 to NFPA 99, issued August 1, 2013.


(viii) TIA 12–1 to NFPA 101, issued August 11, 2011.


(x) TIA 12–3 to NFPA 101, issued October 22, 2013.

(xi) TIA 12–4 to NFPA 101, issued October 22, 2013.

(xii) [Reserved]

§ 485.627 Condition of participation: Organizational structure.

(a) Standard: Governing body or responsible individual. The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH’s total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.

(b) Standard: Disclosure. The CAH discloses the names and addresses of—

(1) Its owners, or those with a controlling interest in the CAH or in any subcontractor in which the CAH directly or indirectly has a 5 percent or more ownership interest, in accordance with subpart C of part 420 of this chapter;

(2) The person principally responsible for the operation of the CAH; and

(3) The person responsible for medical direction.

§ 485.631 Condition of participation: Staffing and staff responsibilities.

(a) Standard: Staffing—(1) The CAH has a professional health care staff that includes one or more doctors of medicine or osteopathy, and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists.

(2) Any ancillary personnel are supervised by the professional staff.

(3) The staff is sufficient to provide the services essential to the operation of the CAH.

(4) A doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish patient care services at all times the CAH operates.

(5) A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the CAH has one or more inpatients.

(b) Standard: Responsibilities of the doctor of medicine or osteopathy. (1) The doctor of medicine or osteopathy—

(i) Provides medical direction for the CAH’s health care activities and consultation for, and medical supervision of, the health care staff;

(ii) In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the CAH’s written policies governing the services it furnishes.

(iii) In conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the CAH’s patient records, provides medical orders, and provides medical care services to the patients of the CAH; and

(iv) Periodically reviews and signs the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants.

(v) Periodically reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants only to the extent required under State law where State law requires record reviews or co-signatures, or both, by a collaborating physician.

(2) A doctor of medicine or osteopathy is present for sufficient periods of time to provide medical direction, consultation, and supervision for the services provided in the CAH, and is available through direct radio or telephone communication or electronic communication for consultation, assistance with medical emergencies, or patient referral.

(c) Standard: Physician assistant, nurse practitioner, and clinical nurse specialist responsibilities. (1) The physician assistant, the nurse practitioner, or clinical nurse specialist members of the CAH’s staff—

(i) Participate in the development, execution and periodic review of the written policies governing the services the CAH furnishes; and

(ii) Participate with a doctor of medicine or osteopathy in a periodic review of the patients’ health records.

(2) The physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions to the extent they are not being...
performed by a doctor of medicine or osteopathy:
(i) Provides services in accordance with the CAH’s policies.
(ii) Arranges for, or refers patients to, needed services that cannot be furnished at the CAH, and assures that adequate patient health records are maintained and transferred as required when patients are referred.
(3) Whenever a patient is admitted to the CAH by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff of the CAH is notified of the admission.


§ 485.635 Condition of participation: Provision of services.

(a) Standard: Patient care policies. (1) The CAH’s health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.
(2) The policies are developed with the advice of members of the CAH’s professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of § 485.631(a)(1).
(3) The policies include the following:
(i) A description of the services the CAH furnishes, including those furnished through agreement or arrangement.
(ii) Policies and procedures for emergency medical services.
(iii) Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH.
(iv) Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.
(v) Procedures for reporting adverse drug reactions and errors in the administration of drugs.
(vi) A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.
(vii) Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of § 483.25(i) of this chapter is met with respect to inpatients receiving posthospital SNF care.
(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH.

(b) Standard: Patient services—(1) General: (i) The CAH provides those diagnostic and therapeutic services and supplies that are commonly furnished in a physician’s office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or emergency department. These CAH services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.
(ii) The CAH furnishes acute care inpatient services.
(2) Laboratory services. The CAH provides basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 236a). (See the laboratory requirements specified in part 493 of this chapter.) The services provided include the following:
(i) Chemical examination of urine by stick or tablet method or both (including urine ketones).
(ii) Hemoglobin or hematocrit.
(iii) Blood glucose.
(iv) Examination of stool specimens for occult blood.
(v) Pregnancy tests.
(vi) Primary culturing for transmittal to a certified laboratory.

(3) Radiology services. Radiology services furnished by the CAH are provided by personnel qualified under State law, and do not expose CAH patients or personnel to radiation hazards.

(4) Emergency procedures. In accordance with requirements of § 485.618, the CAH provides medical services as a first response to common life-threatening injuries and acute illness.

(c) Standard: Services provided through agreements or arrangements. (1) The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including—
   (i) Services of doctors of medicine or osteopathy;
   (ii) Additional or specialized diagnostic and clinical laboratory services that are not available at the CAH; and
   (iii) Food and other services to meet inpatients' nutritional needs to the extent these services are not provided directly by the CAH.

(2) If the agreements or arrangements are not in writing, the CAH is able to present evidence that patients referred by the CAH are being accepted and treated.

(3) The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided.

(4) The person principally responsible for the operation of the CAH under § 485.627(b)(2) of this chapter is also responsible for the following:
   (i) Services furnished in the CAH whether or not they are furnished under arrangements or agreements.
   (ii) Ensuring that a contractor of services (including one for shared services and joint ventures) furnishes services that enable the CAH to comply with all applicable conditions of participation and standards for the contracted services.

(5) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier.

(d) Standard: Nursing services. Nursing services must meet the needs of patients.

(1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available.

(2) A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.

(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.

(4) A nursing care plan must be developed and kept current for each inpatient.

(e) Standard: Rehabilitation Therapy Services. Physical therapy, occupational therapy, and speech-language pathology services furnished at the CAH, if provided, are provided by staff qualified under State law, and consistent with the requirements for therapy services in § 409.17 of this subpart.

(f) Standard: Patient visitation rights. A CAH must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the CAH may need to place on such rights and the reasons for the clinical restriction or limitation. A CAH must meet the following requirements:

(1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, in advance of furnishing patient care whenever possible.

(2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive
§ 485.639 Conditions of participation: Surgical services.

If a CAH provides surgical services, surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body, or responsible individual, of the CAH in accordance with the designation requirements under paragraph (a) of this section.

(a) Designation of qualified practitioners. The CAH designates the practitioners who are allowed to perform surgery for CAH patients, in accordance with its approved policies and procedures, and with State scope of practice laws. Surgery is performed only by—

(1) A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act; and

(2) A doctor of dental surgery or dental medicine; or

(3) A doctor of podiatric medicine.

(b) Anesthetic risk and evaluation. (1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.
(2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia.

(3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.

(c) Administration of anesthesia. The CAH designates the person who is allowed to administer anesthesia to CAH patients in accordance with its approved policies and procedures and with State scope-of-practice laws.

(1) Anesthesia must be administered by only—

(i) A qualified anesthesiologist;

(ii) A doctor of medicine or osteopathy other than an anesthesiologist; including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;

(iii) A doctor of dental surgery or dental medicine;

(iv) A certified registered nurse anesthetist (CRNA), as defined in §410.69(b) of this chapter;

(v) An anesthesiologist’s assistant, as defined in §410.69(b) of this chapter; or

(vi) A supervised trainee in an approved educational program, as described in §413.85 or §413.86 of this chapter.

(2) In those cases in which a CRNA administers the anesthesia, the anesthesiologist must be under the supervision of the operating practitioner except as provided in paragraph (e) of this section. An anesthesiologist’s assistant who administers anesthesia must be under the supervision of an anesthesiologist.

(d) Discharge. All patients are discharged in the company of a responsible adult, except those exempted by the practitioner who performed the surgical procedure.

(e) Standard: State exemption. (1) A CAH may be exempted from the requirement for physician supervision of CRNAs as described in paragraph (c)(2) of this section, if the State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation with the State’s Boards of Medicine and Nursing, requesting exemption from physician supervision for CRNAs. The letter from the Governor must attest that he or she has consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State’s citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with State law.

(2) The request for exemption and recognition of State laws and the withdrawal of the request may be submitted at any time, and are effective upon submission.

§ 485.641 Condition of participation: Periodic evaluation and quality assurance review.

(a) Standard: Periodic evaluation—(1) The CAH carries out or arranges for a periodic evaluation of its total program. The evaluation is done at least once a year and includes review of—

(i) The utilization of CAH services, including at least the number of patients served and the volume of services;

(ii) A representative sample of both active and closed clinical records; and

(iii) The CAH’s health care policies.

(2) The purpose of the evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed.

(b) Standard: Quality assurance. The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that—

(1) All patient care services and other services affecting patient health and safety, are evaluated;

(2) Nosocomial infections and medication therapy are evaluated;

(3) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialists, and physician assistants at the CAH are evaluated by a
member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH;

(i) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by—

(ii) One hospital that is a member of the network, when applicable;

(iii) One QIO or equivalent entity;

(iv) One other appropriate and qualified entity identified in the State rural health care plan;

(v) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH’s patients under a written agreement between the CAH and a distant-site hospital, the distant-site hospital; or

(vi) The CAH staff considers the findings of the evaluations, including any findings or recommendations of the QIO, and takes corrective action if necessary.

(ii) The CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.

(iii) The CAH documents the outcome of all remedial action.


§ 485.643 Condition of participation: Organ, tissue, and eye procurement.

The CAH must have and implement written protocols that:

(a) Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the CAH. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose;

(b) Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;

(c) Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;

(d) Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the families of potential donors;

(e) Ensure that the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes take place.

(f) For purposes of these standards, the term “organ” means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).


§ 485.645 Special requirements for CAH providers of long-term care services (“swing-beds”)

A CAH must meet the following requirements in order to be granted an approval from CMS to provided post-hospital ‘SNF’ care, as specified in §409.30 of this chapter, and to be paid
for SNF-level services, in accordance with paragraph (c) of this section.

(a) Eligibility. A CAH must meet the following eligibility requirements:

1. The facility has been certified as a CAH by CMS under § 485.606(b) of this subpart; and

2. The facility provides not more than 25 inpatient beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section.

(b) Facilities participating as rural primary care hospitals (RPCHs) on September 30, 1997. These facilities must meet the following requirements:

1. Notwithstanding paragraph (a) of this section, a CAH that participated in Medicare as a RPCH on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care may continue in that status under the same terms, conditions and limitations that were applicable at the time those approvals were granted.

2. A CAH that was granted swing-bed approval under paragraph (b)(1) of this section may request that its application to be a CAH and swing-bed provider be reevaluated under paragraph (a) of this section. If this request is approved, the approval is effective not earlier than October 1, 1997. As of the date of approval, the CAH no longer has any status under paragraph (b)(1) of this section and may not request reinstatement under paragraph (b)(1) of this section.

(c) Payment. Payment for inpatient RPCH services to a CAH that has qualified as a CAH under the provisions in paragraph (a) of this section is made in accordance with § 413.70 of this chapter.

Payment for post-hospital SNF-level of care services is made in accordance with the payment provisions in § 413.114 of this chapter.

(d) SNF services. The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:

1. Residents rights (§ 483.10(b)(3) through (b)(6), (d), (e), (f), (i), (j)(1)(vii) and (viii), (l), and (m) of this chapter).

2. Admission, transfer, and discharge rights (§ 483.12(a) of this chapter).

3. Resident behavior and facility practices (§ 483.13 of this chapter).

4. Patient activities (§ 483.15(f) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of § 483.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy.

5. Social services (§ 483.15(g) of this chapter).

6. Comprehensive assessment, comprehensive care plan, and discharge planning (§ 483.20(b), (k), and (l) of this chapter, except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under § 483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in § 413.343(b) of this chapter).

7. Specialized rehabilitative services (§ 483.45 of this chapter).

8. Dental services (§ 483.55 of this chapter).

9. Nutrition (§ 483.25(i) of this chapter).


(a) Conditions. (1) If a CAH provides inpatient psychiatric services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in subparts A, B, C, and D of part 482 of this subchapter, the common requirements of § 412.25(a)(2) through (f) of part 412 of this chapter for hospital units excluded from the prospective payment systems, and the additional requirements of § 412.27 of part 412 of this chapter for excluded psychiatric units.

2. If a CAH provides inpatient rehabilitation services in a distinct part unit, the services furnished by the distinct part unit must comply with the
Centers for Medicare & Medicaid Services, HHS  § 485.703

§ 485.703 Definitions.

Clinic. A facility that is established primarily to furnish outpatient physician services and that meets the following tests of physician involvement:

(1) The medical services are furnished by a group of three or more physicians practicing medicine together.

(2) A physician is present during all hours of operation of the clinic to furnish medical services, as distinguished from purely administrative services.

Extension location. A location or site from which a rehabilitation agency provides services within a portion of the total geographic area served by the primary site. The extension location is part of the rehabilitation agency. The extension location should be located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the extension location to independently meet the conditions of participation as a rehabilitation agency.

Organization. A clinic, rehabilitation agency, or public health agency.

Public health agency. An official agency established by a State or local government, the primary function of which is to maintain the health of the population served by performing environmental health services, preventive medical services, and in certain cases, therapeutic services.

Rehabilitation agency. An agency that—

(1) Provides an integrated interdisciplinary rehabilitation program designed to upgrade the physical functioning of handicapped disabled individuals by bringing specialized rehabilitation staff together to perform as a team; and

(2) Provides at least physical therapy or speech-language pathology services.

Supervision. Authoritative procedural guidance that is for the accomplishment of a function or activity and that—

(1) Includes initial direction and periodic observation of the actual performance of the function or activity; and

(2) Is furnished by a qualified person—

(i) Whose sphere of competence encompasses the particular function or activity; and

...
§ 485.705 Personnel qualifications.

(a) General qualification requirements. Except as specified in paragraphs (b) and (c) of this section, all personnel who are involved in the furnishing of outpatient physical therapy, occupational therapy, and speech-language pathology services directly by or under arrangements with an organization must be legally authorized (licensed or, if applicable, certified or registered) to practice by the State in which they perform the functions or actions, and must act only within the scope of their State license or State certification or registration.

(b) Exception for Federally defined qualifications. The following Federally defined qualifications must be met:

(1) For a physician, the qualifications and conditions as defined in section 1861(r) of the Act and the requirements in part 484 of this chapter.

(2) For a speech-language pathologist, the qualifications specified in section 1861(11)(1) of the Act and the requirements in part 484 of this chapter.

(c) Exceptions when no State Licensing laws or State certification or registration requirements exist. If no State licensing laws or State certification or registration requirements exist for the profession, the following requirements must be met—

(1) An administrator is a person who has a bachelor’s degree and:

(i) Has experience or specialized training in the administration of health institutions or agencies; or

(ii) Is qualified and has experience in one of the professional health disciplines.

(2) An occupational therapist must meet the requirements in part 484 of this chapter.

(3) An occupational therapy assistant must meet the requirements in part 484 of this chapter.

(4) A physical therapist must meet the requirements in part 484 of this chapter.

(5) A physical therapist assistant must meet the requirements in part 484 of this chapter.

(6) A social worker must meet the requirements in part 484 of this chapter.

(7) A vocational specialist is a person who has a baccalaureate degree and—

(i) Two years experience in vocational counseling in a rehabilitation setting such as a sheltered workshop, State employment service agency, etc.; or

(ii) At least 18 semester hours in vocational rehabilitation, educational or vocational guidance, psychology, social work, special education or personnel administration, and 1 year of experience in vocational counseling in a rehabilitation setting; or

(iii) A master’s degree in vocational counseling.

(8) A nurse practitioner is a person who must:

(i) Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and

(ii) Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; or

(iii) Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law and have been granted a Medicare billing number as a nurse practitioner by December 31, 2000; or

(iv) Be a nurse practitioner who on or after January 1, 2001, applies for a Medicare billing number for the first time and meets the standards for nurse practitioners in paragraphs (c)(8)(i) and (c)(8)(ii) of this section; or

(v) Be a nurse practitioner who on or after January 1, 2003, applies for a Medicare billing number for the first time and possesses a master’s degree in nursing and meets the standards for nurse practitioners in paragraphs (b)(1)(i) and (b)(1)(ii) of this section.
§ 485.709 Condition of participation: Administrative management.

The clinic or rehabilitation agency has an effective governing body that is legally responsible for the conduct of the clinic or rehabilitation agency. The governing body designates an administrator, and establishes administrative policies.

(a) Standard: Governing body. There is a governing body (or designated person(s) so functioning) which assumes full legal responsibility for the overall conduct of the clinic or rehabilitation agency and for compliance with applicable laws and regulations. The name of the owner(s) of the clinic or rehabilitation agency is fully disclosed to the State agency. In the case of corporations, the names of the corporate officers are made known.

(b) Standard: Administrator. The governing body—

(1) Appoints a qualified full-time administrator;

(2) Delegates to the administrator the internal operation of the clinic or rehabilitation agency in accordance with written policies;

(3) Defines clearly the administrator’s responsibilities for procurement and direction of personnel; and

(4) Designates a competent individual to act during temporary absence of the administrator.

(c) Standard: Personnel policies. Personnel practices are supported by appropriate written personnel policies that are kept current. Personnel records include the qualifications of all professional and assistant level personnel, as well as evidence of State licensure if applicable.

(d) Standard: Patient care policies. Patient care practices and procedures are supported by written policies established by a group of professional personnel including one or more physicians associated with the clinic or rehabilitation agency, one or more qualified physical therapists (if physical therapy services are provided), and one or more qualified speech pathologists (if speech pathology services are provided). The policies govern the outpatient physical therapy and/or speech pathology services and related services that are provided. These policies are evaluated at least annually by the
§ 485.711 Condition of participation: Plan of care and physician involvement.

For each patient in need of outpatient physical therapy or speech pathology services, there is a written plan of care established and periodically reviewed by a physician, or by a physical therapist or speech pathologist respectively.

(a) Standard: Medical history and prior treatment. The following are obtained by the organization before or at the time of initiation of treatment:

(1) The patient’s significant past history.
(2) Current medical findings, if any.
(3) Diagnosis(es), if established.
(4) Physician’s orders, if any.
(5) Rehabilitation goals, if determined.
(6) Contraindications, if any.
(7) The extent to which the patient is aware of the diagnosis(es) and prognosis.
(8) If appropriate, the summary of treatment furnished and results achieved during previous periods of rehabilitation services or institutionalization.

(b) Standard: Plan of care. (1) For each patient there is a written plan of care established by the physician or by the physical therapist or speech-language pathologist who furnishes the services.

(2) The plan of care for physical therapy or speech pathology services indicates anticipated goals and specifies for those services the—

(i) Type;
(ii) Amount;
(iii) Frequency; and
(iv) Duration.

(3) The plan of care and results of treatment are reviewed by the physician or by the individual who established the plan at least as often as the patient’s condition requires, and the indicated action is taken.

(4) Changes in the plan of care are noted in the clinical record. If the patient has an attending physician, the therapist or speech-language pathologist who furnishes the services promptly notifies him or her of any change in the patient’s condition or in the plan of care.

(c) Standard: Emergency care. The rehabilitation agency must establish procedures to be followed by personnel in an emergency, which cover immediate care of the patient, persons to be notified, and reports to be prepared.


§ 485.713 Condition of participation: Physical therapy services.

If the organization offers physical therapy services, it provides an adequate program of physical therapy and has an adequate number of qualified personnel and the equipment necessary to carry out its program and to fulfill its objectives.

(a) Standard: Adequate program. (1) The organization is considered to have an adequate outpatient physical therapy program if it can:

(i) Provide services using therapeutic exercise and the modalities of heat, cold, water, and electricity;
(ii) Conduct patient evaluations; and
(iii) Administer tests and measurements of strength, balance, endurance, range of motion, and activities of daily living.

(2) A qualified physical therapist is present or readily available to offer supervision when a physical therapist assistant furnishes services.

(i) If a qualified physical therapist is not on the premises during all hours of operation, patients are scheduled so as to ensure that the therapist is present when special skills are needed, for example, for evaluation and reevaluation.

(ii) When a physical therapist assistant furnishes services off the organization’s premises, those services are supervised by a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days.

(b) Standard: Facilities and equipment. The organization has the equipment and facilities required to provide the
range of services necessary in the treatment of the types of disabilities it accepts for service.

(c) Standard: Personnel qualified to provide physical therapy services. Physical therapy services are provided by, or under the supervision of, a qualified physical therapist. The number of qualified physical therapists and qualified physical therapist assistants is adequate for the volume and diversity of physical therapy services offered. A qualified physical therapist is on the premises or readily available during the operating hours of the organization.

(d) Standard: Supportive personnel. If personnel are available to assist qualified physical therapists by performing services incident to physical therapy that do not require professional knowledge and skill, these personnel are instructed in appropriate patient care services by qualified physical therapists who retain responsibility for the treatment prescribed by the attending physician.

§ 485.717 Condition of participation: Rehabilitation program.

This condition and standards apply only to a rehabilitation agency’s own patients, not to patients of hospitals, skilled nursing facilities (SNFs), or Medicaid nursing facilities (NFs) to which the agency furnishes services. The hospital, SNF, or NF is responsible for ensuring that qualified staff furnish services for which they arrange or contract for their patients. The rehabilitation agency provides physical therapy and speech-language pathology services to all of its patients who need them.

(a) Standard: Qualification of staff. The agency’s therapy services are furnished by qualified individuals as direct services and/or services provided under contract.

(b) Standard: Arrangements for services. If services are provided under contract, the contract must specify the term of the contract, the manner of termination or renewal and provide that the agency retains responsibility for the control and supervision of the services.

§ 485.719 Condition of participation: Arrangements for physical therapy and speech pathology services to be performed by other than salaried organization personnel.

(a) Conditions. If an organization provides outpatient physical therapy or speech pathology services under an arrangement with others, the services are to be furnished in accordance with the terms of a written contract, which provides that the organization retains of professional and administrative responsibility for, and control and supervision of, the services.

(b) Standard: Contract provisions. The contract—

(1) Specifies the term of the contract and the manner of termination or renewal;
§ 485.721 Condition of participation: Clinical records.

The organization maintains clinical records on all patients in accordance with accepted professional standards, and practices. The clinical records are completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.

(a) Standard: Protection of clinical record information. The organization recognizes the confidentiality of clinical record information and provides safeguards against loss, destruction, or unauthorized use. Written procedures govern the use and removal of records and the conditions for release of information. The patient’s written consent is required for release of information not authorized by law.

(b) Standard: Content. The clinical record contains sufficient information to identify the patient clearly, to justify the diagnosis(es) and treatment, and to document the results accurately. All clinical records contain the following general categories of data:

(1) Documented evidence of the assessment of the needs of the patient, of an appropriate plan of care, and of the care and services furnished.

(2) Identification data and consent forms.

(3) Medical history.

(4) Report of physical examinations, if any.

(5) Observations and progress notes.

(6) Reports of treatments and clinical findings.

(7) Discharge summary including final diagnosis(es) and prognosis.

(c) Standard: Completion of records and centralization of reports. Current clinical records and those of discharged patients are completed promptly. All clinical information pertaining to a patient is centralized in the patient’s clinical record. Each physician signs the entries that he or she makes in the clinical record.

(d) Standard: Retention and preservation. Clinical records are retained for at least:

(1) The period determined by the respective State statute, or the statute of limitations in the State; or

(2) In the absence of a State statute—

(i) Five years after the date of discharge; or

(ii) In the case of a minor, 3 years after the patient becomes of age under State law or 5 years after the date of discharge, whichever is longer.

(e) Standard: Indexes. Clinical records are indexed at least according to name of patient to facilitate acquisition of statistical medical information and retrieval of records for research or administrative action.

(f) Standard: Location and facilities. The organization maintains adequate facilities and equipment, conveniently located, to provide efficient processing of clinical records (reviewing, indexing, filing, and prompt retrieval).

§ 485.723 Condition of participation: Physical environment.

The building housing the organization is constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public and provides a functional, sanitary, and comfortable environment.

(a) Standard: Safety of patients. The organization satisfies the following requirements:

(1) It complies with all applicable State and local building, fire, and safety codes.

(2) Permanently attached automatic fire-extinguishing systems of adequate capacity are installed in all areas of
the premises considered to have special fire hazards. Fire extinguishers are conveniently located on each floor of the premises. Fire regulations are prominently posted.

(3) Doorways, passageways and stairwells negotiated by patients are:
(i) Of adequate width to allow for easy movement of all patients (including those on stretchers or in wheelchairs), (ii) free from obstruction at all times, and (iii) in the case of stairwells, equipped with firmly attached handrails on at least one side.
(4) Lights are placed at exits and in corridors used by patients and are supported by an emergency power source.
(5) A fire alarm system with local alarm capability and, where applicable, an emergency power source, is functional.
(6) At least two persons are on duty on the premises of the organization whenever a patient is being treated.
(7) No occupancies or activities undesirable or injurious to the health and safety of patients are located in the building.

(b) Standard: Maintenance of equipment, building, and grounds. The organization establishes a written preventive-maintenance program to ensure that—
(1) The equipment is operative, and is properly calibrated; and
(2) The interior and exterior of the building are clean and orderly and maintained free of any defects that are a potential hazard to patients, personnel, and the public.
(c) Standard: Other environmental considerations. The organization provides a functional, sanitary, and comfortable environment for patients, personnel, and the public.
(1) Provision is made for adequate and comfortable lighting levels in all areas; limitation of sounds at comfort levels; a comfortable room temperature; and adequate ventilation through windows, mechanical means, or a combination of both.
(2) Toilet rooms, toilet stalls, and lavatories are accessible and constructed so as to allow use by non-ambulatory and semiambulatory individuals.
(3) Whatever the size of the building, there is an adequate amount of space for the services provided and disabilities treated, including reception area, staff space, examining room, treatment areas, and storage.

§ 485.725 Condition of participation: Infection control.

The organization that provides outpatient physical therapy services establishes an infection-control committee of representative professional staff with responsibility for overall infection control. All necessary housekeeping and maintenance services are provided to maintain a sanitary and comfortable environment and to help prevent the development and transmission of infection.
(a) Standard: Infection-control committee. The infection-control committee establishes policies and procedures for investigating, controlling, and preventing infections in the organization and monitors staff performance to ensure that the policies and procedures are executed.
(b) All personnel follow written procedures for effective aseptic techniques. The procedures are reviewed annually and revised if necessary to improve them.
(c) Standard: Housekeeping. (1) The organization employs sufficient housekeeping personnel and provides all necessary equipment to maintain a safe, clean, and orderly interior. A full-time employee is designated as the one responsible for the housekeeping services and for supervision and training of housekeeping personnel.
(2) An organization that has a contract with an outside resource for housekeeping services may be found to be in compliance with this standard provided the organization or outside resource or both meet the requirements of the standard.
(d) Standard: Linen. The organization has available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection.
(e) Standard: Pest control. The organization's premises are maintained free
§ 485.727 Condition of participation: Disaster preparedness.

The organization has a written plan, periodically rehearsed, with procedures to be followed in the event of an internal or external disaster and for the care of casualties (patients and personnel) arising from a disaster.

(a) Standard: Disaster plan. The organization has a written plan in operation, with procedures to be followed in the event of fire, explosion, or other disaster. The plan is developed and maintained with the assistance of qualified fire, safety, and other appropriate experts, and includes:

1. Transfer of casualties and records;
2. The location and use of alarm systems and signals;
3. Methods of containing fire;
4. Notification of appropriate persons; and
5. Evacuation routes and procedures.

(b) Standard: Staff training and drills. All employees are trained, as part of their employment orientation, in all aspects of preparedness for any disaster. The disaster program includes orientation and ongoing training and drills for all personnel in all procedures so that each employee promptly and correctly carries out his assigned role in case of a disaster.

(c) Communication plan. The organizations must develop and maintain an emergency preparedness communication plan that must be reviewed and updated at least annually. The plan must do all of the following:

1. Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
2. Include strategies for addressing emergency events identified by the risk assessment.
3. Address patient population, including, but not limited to, the type of services the organizations have the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
4. Address the location and use of alarm systems and signals; and other appropriate experts.
5. Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation.
6. Be developed and maintained with assistance from fire, safety, and other appropriate experts.

(b) Policies and procedures. The organizations must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

1. Safe evacuation from the organizations, which includes staff responsibilities, and needs of the patients.
2. A means to shelter in place for patients, staff, and volunteers who remain in the facility.
3. A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.
4. The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated healthcare professionals to address surge needs during an emergency.

(c) Communication plan. The organizations must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

§ 485.727 Condition of participation: Emergency preparedness.

The Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services (“Organizations”) must comply with all applicable Federal, State, and local emergency preparedness requirements. The Organizations must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

(a) Emergency plan. The Organizations must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The plan must do all of the following:

1. Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
2. Include strategies for addressing emergency events identified by the risk assessment.
3. Address patient population, including, but not limited to, the type of services the Organizations have the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
4. Address the location and use of alarm systems and signals; and other appropriate experts.
5. Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation.
6. Be developed and maintained with assistance from fire, safety, and other appropriate experts.

(b) Policies and procedures. The Organizations must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

1. Safe evacuation from the Organizations, which includes staff responsibilities, and needs of the patients.
2. A means to shelter in place for patients, staff, and volunteers who remain in the facility.
3. A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.
4. The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated healthcare professionals to address surge needs during an emergency.

(c) Communication plan. The Organizations must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:
The Organizations must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

Training program. The Organizations must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Conduct an additional exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based.

(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the Organization's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise their emergency plan, as needed.

Integrated healthcare systems. If the Organizations are part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the Organizations may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:

(i) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

(ii) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.

(iii) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance.

(iv) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include all of the following:

(A) A documented community-based risk assessment, utilizing an all-hazards approach.

(B) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

§485.729 Condition of participation: Program evaluation.

The organization has procedures that provide for a systematic evaluation of its total program to ensure appropriate
utilization of services and to determine whether the organization’s policies are followed in providing services to patients through employees or under arrangements with others.

(a) Standard: Clinical-record review. A sample of active and closed clinical records is reviewed quarterly by the appropriate health professionals to ensure that established policies are followed in providing services.

(b) Standard: Annual statistical evaluation. An evaluation is conducted annually of statistical data such as number of different patients treated, number of patient visits, condition on admission and discharge, number of new patients, number of patients by diagnosis(es), sources of referral, number and cost of units of service by treatment given, and total staff days or work hours by discipline.


Subpart I [Reserved]

Subpart J—Conditions of Participation: Community Mental Health Centers (CMHCs)

Source: 78 FR 64630, Oct. 29, 2013, unless otherwise noted.

§ 485.900 Basis and scope.

(a) Basis. This subpart is based on the following sections of the Social Security Act:

(1) Section 1832(a)(2)(J) of the Act specifies that payments may be made under Medicare Part B for partial hospitalization services furnished by a community mental health center (CMHC) as described in section 1861(ff)(3)(B) of the Act.

(2) Section 1861(ff) of the Act describes the items and services that are covered under Medicare Part B as “partial hospitalization services” and the conditions under which the items and services must be provided. In addition, section 1861(ff) of the Act specifies that the entities authorized to provide partial hospitalization services under Medicare Part B include CMHCs and defines that term.

(3) Section 1866(e)(2) of the Act specifies that a provider of services for purposes of provider agreement requirements includes a CMHC as defined in section 1861(ff)(3)(B) of the Act, but only with respect to providing partial hospitalization services.

(b) Scope. The provisions of this subpart serve as the basis of survey activities for the purpose of determining whether a CMHC meets the specified requirements that are considered necessary to ensure the health and safety of clients; and for the purpose of determining whether a CMHC qualifies for a provider agreement under Medicare.

§ 485.902 Definitions.

As used in this subpart, unless the context indicates otherwise—

Active treatment plan means an individualized client plan that focuses on the provision of care and treatment services that address the client’s physical, psychological, psychosocial, emotional, and therapeutic needs and goals as identified in the comprehensive assessment.

Community mental health center (CMHC) means an entity as defined in §410.2 of this chapter.

Comprehensive assessment means a thorough evaluation of the client’s physical, psychological, psychosocial, emotional, and therapeutic needs related to the diagnosis under which care is being furnished by the CMHC.

Employee of a CMHC means an individual—

(1) Who works for the CMHC and for whom the CMHC is required to issue a W–2 form on his or her behalf; or

(2) For whom an agency or organization issues a W–2 form, and who is assigned to such CMHC if the CMHC is a subdivision of an agency or organization.

Initial evaluation means an immediate care and support assessment of the client’s physical, psychosocial (including a screen for harm to self or others), and therapeutic needs related to the psychiatric illness and related conditions for which care is being furnished by the CMHC.

Representative means an individual who has the authority under State law to authorize or terminate medical care on behalf of a client who is mentally or
physically incapacitated. This includes a legal guardian.

Restraint means—

(1) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a client to move his or her arms, legs, body, or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a client for the purpose of conducting routine physical examinations or tests, or to protect the client from falling out of bed, or to permit the client to participate in activities without the risk of physical harm (this does not include a client being physically escorted); or

(2) A drug or medication when it is used as a restriction to manage the client’s behavior or restrict the client’s freedom of movement, and which is not a standard treatment or dosage for the client’s condition.

Seclusion means the involuntary confinement of a client alone in a room or an area from which the client is physically prevented from leaving.

Volunteer means an individual who is an unpaid worker of the CMHC; or if the CMHC is a subdivision of an agency or organization, is an unpaid worker of the agency or organization and is assigned to the CMHC. All volunteers must meet the standard training requirements under §485.918(d).

§ 485.904 Condition of participation: Personnel qualifications.

(a) Standard: General qualification requirements. All professionals who furnish services directly, under an individual contract, or under arrangements with a CMHC, must be legally authorized (licensed, certified or registered) in accordance with applicable Federal, State and local laws, and must act only within the scope of their State licenses, certifications, or registrations. All personnel qualifications must be kept current at all times.

(b) Standard: Personnel qualifications for certain disciplines. The following qualifications must be met:

(1) Administrator of a CMHC. A CMHC employee who meets the education and experience requirements established by

the CMHC’s governing body for that position and who is responsible for the day-to-day operation of the CMHC.

(2) Clinical psychologist. An individual who meets the qualifications at §410.71(d) of this chapter.

(3) Clinical Social worker. An individual who meets the qualifications at §410.73 of this chapter.

(4) Social worker. An individual who—

(i) Has a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education, or a baccalaureate degree in psychology or sociology, and is supervised by a clinical social worker, as described in paragraph (b)(3) of this section; and

(ii) Has 1 year of social work experience in a psychiatric healthcare setting.

(5) Mental health counselor. A professional counselor who is certified and/or licensed by the State in which he or she practices, and has the skills and knowledge to provide a range of behavioral health services to clients. The mental health counselor conducts assessments and provides services in areas such as psychotherapy, substance abuse, crisis management, psychoeducation, and prevention programs.

(6) Occupational therapist. A person who meets the requirements for the definition of “occupational therapist” at §484.4 of this chapter.

(7) Physician. An individual who meets the qualifications and conditions as defined in section 1861(r) of the Act, and provides the services at §410.20 of this chapter, and has experience providing mental health services to clients.

(8) Physician assistant. An individual who meets the qualifications and conditions as defined in section 1861(s)(2)(K)(i) of the Act and provides the services, in accordance with State law, at §410.74 of this chapter.

(9) Advanced practice nurse. An individual who meets the following qualifications:

(i) Is a nurse practitioner who meets the qualifications at §410.75 of this chapter; or

(ii) Is a clinical nurse specialist who meets the qualifications at §410.76 of this chapter.
§ 485.910 Condition of participation: Client rights.

The client has the right to be informed of his or her rights. The CMHC must protect and promote the exercise of these client rights.

(a) Standard: Notice of rights and responsibilities. (1) During the initial evaluation, the CMHC must provide the client, the client's representative (if appropriate) or surrogate with verbal and written notice of the client’s rights and responsibilities. The verbal notice must be in a language and manner that the client or client’s representative or surrogate understands. Written notice must be understandable to persons who have limited English proficiency.

(2) During the initial evaluation, the CMHC must inform and distribute written information to the client concerning its policies on filing a grievance.

(3) The CMHC must obtain the client’s and/or the client representative’s signature confirming that he or she has received a copy of the notice of rights and responsibilities.

(b) Standard: Exercise of rights and respect for property and person. (1) The client has the right to—

(i) Exercise his or her rights as a client of the CMHC.

(ii) Have his or her property and person treated with respect.

(iii) Voice grievances and understand the CMHC grievance process; including but not limited to grievances regarding mistreatment and treatment or care that is (or fails to be) furnished.

(iv) Not be subjected to discrimination or reprisal for exercising his or her rights.

(2) If a client has been adjudged incompetent under State law by a court of proper jurisdiction, the rights of the client are exercised by the person appointed in accordance with State law to act on the client’s behalf.

(3) If a State court has not adjudged a client incompetent, any legal representative designated by the client in accordance with State law may exercise the client’s rights to the extent allowed under State law.

(c) Standard: Rights of the client. The client has a right to—

(1) Be involved in developing his or her active treatment plan.

(2) Refuse care or treatment.

(3) Have a confidential clinical record. Access to or release of client information and the clinical record client information is permitted only in accordance with 45 CFR parts 160 and 164.

(4) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client property.

(5) Receive information about specific limitations on services that he or she will be furnished.

(6) Not be compelled to perform services for the CMHC, and to be compensated by the CMHC for any work performed for the CMHC at prevailing wages and commensurate with the client’s abilities.

(d) Standard: Addressing violations of client rights. The CMHC must adhere to the following requirements:

(1) Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client property by anyone, including those furnishing services on behalf of the CMHC, are reported immediately to the CMHC’s administrator by CMHC employees, volunteers and contracted staff.

(2) Immediately investigate all alleged violations involving anyone furnishing services on behalf of the CMHC and immediately take action to prevent further potential violations while
the alleged violation is being verified. Investigations and documentation of all alleged violations must be conducted in accordance with procedures established by the CMHC.

(3) Take appropriate corrective action in accordance with State law if the alleged violation is investigated by the CMHC’s administration or verified by an outside entity having jurisdiction, such as the State survey and certification agency or the local law enforcement agency; and

(4) Ensure that, within 5 working days of becoming aware of the violation, all violations are reported to the State survey and certification agency, and verified violations are reported to State and local entities having jurisdiction.

(e) Standard: Restraint and seclusion.

(1) All clients have the right to be free from physical or mental abuse, and corporal punishment. All clients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion, defined in § 485.902, may only be imposed to ensure the immediate physical safety of the client, staff, or other individuals.

(2) The use of restraint or seclusion must be in accordance with the written order of a physician or other licensed independent practitioner who is authorized to order restraint or seclusion in accordance with State law and must not exceed one 1-hour duration per order.

(3) The CMHC must obtain a corresponding order for the client’s immediate transfer to a hospital when restraint or seclusion is ordered.

(4) Orders for the use of restraint or seclusion must never be written as a standing order or on an as-needed basis.

(5) When a client becomes an immediate threat to the physical safety of himself or herself, staff or other individuals, the CMHC must adhere to the following requirements:

(i) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the client or other individuals from harm.

(ii) The use of restraint or seclusion must be implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by State law.

(iv) The condition of the client who is restrained or secluded must be continuously monitored by a physician or by trained staff who have completed the training criteria specified in paragraph (f) of this section.

(v) When restraint or seclusion is used, there must be documentation in the client’s clinical record of the following:

(A) A description of the client’s behavior and the intervention used.

(B) Alternatives or other less restrictive interventions attempted (as applicable).

(C) The client’s condition or symptom(s) that warranted the use of the restraint or seclusion.

(D) The client’s response to the intervention(s) used, including the rationale for continued use of the intervention.

(E) The name of the hospital to which the client was transferred.

(f) Standard: Restraint or seclusion: Staff training requirements.

(1) Training intervals. In facilities where restraint and seclusion are permitted, all appropriate client care staff working in the CMHC must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a client in restraint or seclusion and use of alternative methods to restraint and seclusion. In facilities where restraint and seclusion are not permitted, appropriate client care staff working in...
CMHC must be trained in the use of alternative methods to restraint and seclusion. Training will occur as follows:

(i) Before performing any of the actions specified in this paragraph (f).
(ii) As part of orientation.
(iii) Subsequently on a periodic basis, consistent with the CMHC’s policy.

(2) Training content. The CMHC must require all appropriate staff caring for clients to have appropriate education, training, and demonstrated knowledge based on the specific needs of the client population in at least the following:

(i) Techniques to identify staff and client behaviors, events, and environmental factors that may trigger circumstances that could require the use of restraint or seclusion.
(ii) The use of nonphysical intervention skills.
(iii) In facilities where restraint and seclusion are permitted, choosing the least restrictive intervention based on an individualized assessment of the client’s medical and behavioral status or condition.
(iv) The safe application and use of all types of restraint or seclusion that are permitted in the CMHC, including training in how to recognize and respond to signs of physical and psychological distress.
(v) In facilities where restraint and seclusion are permitted, clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
(vi) In facilities where restraint and seclusion are permitted, monitoring the physical and psychological well-being of the client who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by the CMHC’s policy.

(3) Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address clients’ behaviors.

(4) Training documentation. The CMHC must document in the staff personnel records that the training and demonstration of competency were successfully completed.

(5) Standard: Death reporting requirements. The CMHC must report deaths associated with the use of seclusion or restraint.

(1) The CMHC must report to CMS each death that occurs while a client is in restraint or seclusion awaiting transfer to a hospital.

(2) Each death referenced in paragraph (g)(1) of this section must be reported to the CMS Regional Office by telephone no later than the close of business the next business day following knowledge of the client’s death.

(3) Staff must document in the client’s clinical record the date and time the death was reported to CMS.

§ 485.914 Condition of participation: Admission, initial evaluation, comprehensive assessment, and discharge or transfer of the client.

The CMHC must ensure that all clients admitted into its program are appropriate for the services the CMHC furnishes in its facility.

(a) Standard: Admission. (1) The CMHC must determine that each client is appropriate for the services it provides as specified in §410.2 of this chapter.

(2) For clients assessed and admitted to receive partial hospitalization services, the CMHC must also meet separate requirements as specified in §485.918(f).

(b) Standard: Initial evaluation. (1) A licensed mental health professional employed by the CMHC and acting within his or her state scope of practice requirements must complete the initial evaluation within 24 hours of the client’s admission to the CMHC.

(2) The initial evaluation, at a minimum, must include the following:

(i) The admitting diagnosis as well as other diagnoses.
(ii) The source of referral.
(iii) The reason for admission as stated by the client or other individuals who are significantly involved.
(iv) Identification of the client’s immediate clinical care needs related to the psychiatric diagnosis.
(v) A list of current prescriptions and over-the-counter medications, as well as other substances that the client may be taking.
(vi) For partial hospitalization services only, include an explanation as to why the client would be at risk for hospitalization if the partial hospitalization services were not provided.
(3) Based on the findings of the initial evaluation, the CMHC must determine the appropriate members of each client’s interdisciplinary treatment team.

(c) **Standard: Comprehensive assessment.**
   (1) The comprehensive assessment must be completed by licensed mental health professionals who are members of the interdisciplinary treatment team, performing within their State’s scope of practice.
   (2) The comprehensive assessment must be completed in a timely manner, consistent with the client’s immediate needs, but no later than 4 working days after admission to the CMHC.
   (3) The comprehensive assessment must identify the physical, psychological, psychosocial, emotional, therapeutic, and other needs related to the client’s psychiatric illness. The CMHC’s interdisciplinary treatment team must ensure that the active treatment plan is consistent with the findings of the comprehensive assessment.
   (4) The comprehensive assessment, at a minimum, must include the following:
      (i) The reasons for the admission.
      (ii) A psychiatric evaluation, completed by a psychiatrist, non-physician practitioner or psychologist practicing within the scope of State licensure that includes the medical history and severity of symptoms. Information may be gathered from the client’s primary health care provider (if any), contingent upon the client’s consent.
      (iii) Information concerning previous and current mental status, including but not limited to, previous therapeutic interventions and hospitalizations.
      (iv) Information regarding the onset of symptoms of the illness and circumstances leading to the admission.
      (v) A description of attitudes and behaviors, including cultural and environmental factors that may affect the client’s treatment plan.
      (vi) An assessment of intellectual functioning, memory functioning, and orientation.
      (vii) Complications and risk factors that may affect the care planning.
      (viii) Functional status, including the client’s ability to understand and participate in his or her own care, and the client’s strengths and goals.
      (ix) Factors affecting client safety or the safety of others, including behavioral and physical factors, as well as suicide risk factors.
      (x) A drug profile that includes a review of all of the client’s prescription and over-the-counter medications; herbal remedies; and other alternative treatments or substances that could affect drug therapy.
      (xi) The need for referrals and further evaluation by appropriate health care professionals, including the client’s primary health care provider (if any), when warranted.
      (xii) Factors to be considered in discharge planning.
      (xiii) Identification of the client’s current social and health care support systems.
      (xiv) For pediatric clients, the CMHC must assess the social service needs of the client, and make referrals to social services and child welfare agencies as appropriate.

(d) **Standard: Update of the comprehensive assessment.**
   (1) The CMHC must update the comprehensive assessment via the CMHC interdisciplinary treatment team, in consultation with the client’s primary health care provider (if any), when changes in the client’s status, responses to treatment, or goal achievement have occurred.
   (2) The assessment must be updated no less frequently than every 30 days.
   (3) The update must include information on the client’s progress toward desired outcomes, a reassessment of the client’s response to care and therapies, and the client’s goals.

(e) **Standard: Discharge or transfer of the client.**
   (1) If the client is transferred to another entity, the CMHC must, within 2 working days, forward to the entity, a copy of—
      (i) The CMHC discharge summary.
      (ii) The client’s clinical record, if requested.
   (2) If a client refuses the services of a CMHC, or is discharged from a CMHC due to noncompliance with the treatment plan, the CMHC must forward to the primary health care provider (if any) a copy of—
      (i) The CMHC discharge summary.
(ii) The client’s clinical record, if requested.
(3) The CMHC discharge summary must include—
   (i) A summary of the services provided, including the client’s symptoms, treatment and recovery goals and preferences, treatments, and therapies.
   (ii) The client’s current active treatment plan at time of discharge.
   (iii) The client’s most recent physician orders.
   (iv) Any other documentation that will assist in post-discharge continuity of care.
(4) The CMHC must adhere to all Federal and State-related requirements pertaining to the medical privacy and the release of client information.

§ 485.916 Condition of participation: Treatment team, person-centered active treatment plan, and coordination of services.

The CMHC must designate an interdisciplinary treatment team that is responsible, with the client, for directing, coordinating, and managing the care and services furnished for each client. The interdisciplinary treatment team is composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and therapeutic needs of CMHC clients.

(a) Standard: Delivery of services. (1) An interdisciplinary treatment team, led by a physician, NP, PA, CNS, clinical psychologist, or clinical social worker, must provide the care and services offered by the CMHC.
   (2) Based on the findings of the comprehensive assessment, the CMHC must determine the appropriate licensed mental health professional, who is a member of the client’s interdisciplinary treatment team, to coordinate care and treatment decisions with each client, to ensure that each client’s needs are assessed, and to ensure that the active treatment plan is implemented as indicated.
   (3) The interdisciplinary treatment team may include:
      (i) A doctor of medicine, osteopathy or psychiatry (who is an employee of or under contract with the CMHC).
      (ii) A psychiatric registered nurse.
      (iii) A clinical social worker.
      (iv) A clinical psychologist.
      (v) An occupational therapist.
      (vi) Other licensed mental health professionals, as necessary.
      (vii) Other CMHC staff or volunteers, as necessary.
(4) If the CMHC has more than one interdisciplinary team, it must designate the treatment team responsible for establishing policies and procedures governing the coordination of services and the day-to-day provision of CMHC care and services.

   (b) Standard: Person-centered active treatment plan. All CMHC care and services furnished to clients must be consistent with an individualized, written, active treatment plan that is established by the CMHC interdisciplinary treatment team, the client, and the client’s primary caregiver(s), in accordance with the client’s recovery goals and preferences, within 7 working days of admission to the CMHC. The CMHC must ensure that each client and the client’s primary caregiver(s), as applicable, receive education and training provided by the CMHC that are consistent with the client’s and caregiver’s responsibilities as identified in the active treatment plan.

   (c) Standard: Content of the person-centered active treatment plan. The CMHC must develop a person-centered individualized active treatment plan for each client. The active treatment plan must take into consideration client recovery goals and the issues identified in the comprehensive assessment. The active treatment plan must include all services necessary to assist the client in meeting his or her recovery goals, including the following:
      (1) Client diagnoses.
      (2) Treatment goals.
      (3) Interventions.
      (4) A detailed statement of the type, duration, and frequency of services, including social work, psychiatric nursing, counseling, and therapy services, necessary to meet the client’s specific needs.
      (5) Drugs, treatments, and individual and/or group therapies.
      (6) Family psychotherapy with the primary focus on treatment of the client’s conditions.
      (7) The interdisciplinary treatment team’s documentation of the client’s or
(d) Standard: Review of the person-centered active treatment plan. The CMHC interdisciplinary treatment team must review, revise, and document the individualized active treatment plan as frequently as the client’s condition requires, but no less frequently than every 30 calendar days. A revised active treatment plan must include information from the client’s initial evaluation and comprehensive assessments, the client’s progress toward outcomes and goals specified in the active treatment plan, and changes in the client’s goals. The CMHC must also meet partial hospitalization program requirements specified under §424.24(e) of this chapter if such services are included in the active treatment plan.

(e) Standard: Coordination of services. The CMHC must develop and maintain a system of communication that assures the integration of services in accordance with its policies and procedures and, at a minimum, would do the following:

(1) Ensure that the interdisciplinary treatment team maintains responsibility for directing, coordinating, and supervising the care and services provided.
(2) Ensure that care and services are provided in accordance with the active treatment plan.
(3) Ensure that the care and services provided are based on all assessments of the client.
(4) Provide for and ensure the ongoing sharing of information among all disciplines providing care and services, whether the care and services are provided by employees or those under contract with the CMHC.
(5) Provide for ongoing sharing of information with other health care and non-medical providers, including the primary health care provider, furnishing services to a client for conditions unrelated to the psychiatric condition for which the client has been admitted, and non-medical supports addressing environmental factors such as housing and employment.

§485.917 Condition of participation: Quality assessment and performance improvement.

The CMHC must develop, implement, and maintain an effective, ongoing, CMHC-wide data-driven quality assessment and performance improvement program (QAPI). The CMHC’s governing body must ensure that the program reflects the complexity of its organization and services, involves all CMHC services (including those services furnished under contract or arrangement), focuses on indicators related to improved behavioral health or other healthcare outcomes, and takes actions to demonstrate improvement in CMHC performance. The CMHC must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

(a) Standard: Program scope. (1) The CMHC program must be able to demonstrate measurable improvement in indicators related to improving behavioral health outcomes and CMHC services.
(2) The CMHC must measure, analyze, and track quality indicators; adverse client events, including the use of restraint and seclusion; and other aspects of performance that enable the CMHC to assess processes of care, CMHC services, and operations.

(b) Standard: Program data. (1) The program must use quality indicator data, including client care, and other relevant data, in the design of its program.
(2) The CMHC must use the data collected to do the following:
(i) Monitor the effectiveness and safety of services and quality of care.
(ii) Identify opportunities and priorities for improvement.
(3) The frequency and detail of the data collection must be approved by the CMHC’s governing body.

(c) Standard: Program activities. (1) The CMHC’s performance improvement activities must:
(i) Focus on high risk, high volume, or problem-prone areas.
(ii) Consider incidence, prevalence, and severity of problems.
(iii) Give priority to improvements that affect behavioral outcomes, client...
safety, and person-centered quality of care.

(2) Performance improvement activities must track adverse client events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the CMHC.

(3) The CMHC must take actions aimed at performance improvement and, after implementing those actions, the CMHC must measure its success and track performance to ensure that improvements are sustained.

(d) **Standard: Performance improvement projects.** CMHCs must develop, implement and evaluate performance improvement projects.

(1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the CMHC’s population and internal organizational needs, must reflect the scope, complexity, and past performance of the CMHC’s services and operations.

(2) The CMHC must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.

(e) **Standard: Executive responsibilities.** The CMHC’s governing body is responsible for ensuring the following:

(1) That an ongoing QAPI program for quality improvement and client safety is defined, implemented, maintained, and evaluated annually.

(2) That the CMHC-wide quality assessment and performance improvement efforts address priorities for improved quality of care and client safety, and that all improvement actions are evaluated for effectiveness.

(3) That one or more individual(s) who are responsible for operating the QAPI program are designated.

§ 485.918 Condition of participation: Organization, governance, administration of services, and partial hospitalization services.

The CMHC must organize, manage, and administer its resources to provide CMHC services, including specialized services for children, elderly individuals, individuals with serious mental illness, and residents of its mental health service area who have been discharged from an inpatient mental health facility.

(a) **Standard: Governing body and administrator.** (1) A CMHC must have a designated governing body made up of two or more designated persons, one of which may be the administrator, that assumes full legal authority and responsibility for the management of the CMHC, the services it furnishes, its fiscal operations, and continuous quality improvement. One member of the governing body must possess knowledge and experience as a mental health clinician.

(2) The CMHC’s governing body must appoint an administrator who reports to the governing body and is responsible for the day-to-day operation of the CMHC. The administrator must be a CMHC employee and meet the education and experience requirements established by the CMHC’s governing body.

(b) **Standard: Provision of services.** (1) A CMHC must be primarily engaged in providing the following care and services to all clients served by the CMHC regardless of payer type, and must do so in a manner that is consistent with the following accepted standards of practice:

(i) Provides outpatient services, including specialized outpatient services for children, elderly individuals, individuals with serious mental illness, and residents of its mental health service area who have been discharged from inpatient mental health facilities.

(ii) Provides 24-hour-a-day emergency care services.

(iii) Provides day treatment, partial hospitalization services other than in an individual’s home or in an inpatient or residential setting, or psychosocial rehabilitation services.

(iv) Provides screening for clients being considered for admission to State mental health facilities to determine the appropriateness of such services, unless otherwise directed by State law.

(v) Provides at least 40 percent of its items and services to individuals who are not eligible for benefits under title XVIII of the Act, as measured by the total number of CMHC clients treated by the CMHC for whom services are not paid for by Medicare, divided by the
total number of clients treated by the CMHC for each 12-month period of enrollment.

(A) A CMHC is required to submit to CMS a certification statement provided by an independent entity that certifies that the CMHC’s client population meets the 40 percent requirement specified at this paragraph (b)(1)(v).

(B) The certification statement described in paragraph (b)(1)(v)(A) of this section is required upon initial application to enroll in Medicare, and as a part of revalidation, including any off cycle revalidation, thereafter carried out pursuant to §424.530 of this chapter. Medicare enrollment will be denied or revoked in instances where the CMHC fails to provide the certification statement as required. Medicare enrollment will also be denied or revoked if the 40 percent requirement as specified in this paragraph (b)(1)(v) is not met.

(vi) Provides individual and group psychotherapy utilizing a psychiatrist, psychologist, or other licensed mental health counselor, to the extent authorized under State law.

(vii) Provides physician services.

(viii) Provides psychiatric nursing services.

(ix) Provides clinical social work services.

(x) Provides family counseling services, with the primary purpose of treating the individual’s condition.

(xi) Provides occupational therapy services.

(xii) Provides services of other staff trained to work with psychiatric clients.

(xiii) Provides drugs and biologicals furnished for therapeutic purposes that cannot be self-administered.

(xiv) Provides client training and education as related to the individual’s care and active treatment.

(xv) Provides individualized therapeutic activity services that are not primarily recreational or diversionary.

(xvi) Provides diagnostic services.

(2) The CMHC and individuals furnishing services on its behalf must meet applicable State licensing and certification requirements.

(c) Standard: Professional management responsibility. A CMHC that has a written agreement with another entity, individual, or organization to furnish any services under arrangement must retain administrative and financial management and oversight of staff and services for all arranged services. As part of retaining financial management responsibility, the CMHC must retain all payment responsibility for services furnished under arrangement on its behalf. Arranged services must be supported by a written agreement which requires that all services be as follows:

(1) Authorized by the CMHC.

(2) Furnished in a safe and effective manner.

(3) Delivered in accordance with established professional standards, the policies of the CMHC, and the client’s active treatment plan.

(d) Standard: Staff training. (1) A CMHC must provide education about CMHC care and services, and person-centered care to all employees, volunteers, and staff under contract who have contact with clients and their families.

(2) A CMHC must provide an initial orientation for each individual furnishing services that addresses the specific duties of his or her job.

(3) A CMHC must assess the skills and competence of all individuals furnishing care and, as necessary, provide in-service training and education programs where indicated. The CMHC must have written policies and procedures describing its method(s) of assessing competency and must maintain a written description of the in-service training provided during the previous 12 months.

(e) Standard: Physical environment—(1) Environmental conditions. The CMHC must provide a safe, functional, sanitary, and comfortable environment for clients and staff that is conducive to the provision of services that are identified in paragraph (b) of this section.

(2) Building. The CMHC services must be provided in a location that meets Federal, State, and local health and safety standards and State health care occupancy regulations.

(3) Infection control. There must be policies, procedures, and monitoring for the prevention, control, and investigation of infection and communicable
diseases with the goal of avoiding sources and transmission of infection.

(4) Therapy sessions. The CMHC must ensure that individual or group therapy sessions are conducted in a manner that maintains client privacy and ensures client dignity.

(i) Standard: Partial hospitalization services. A CMHC providing partial hospitalization services must—
(1) Provide services as defined in §410.2 of this chapter.
(2) Provide the services and meet the requirements specified in §410.43 of this chapter.
(3) Meet the requirements for coverage as described in §410.110 of this chapter.
(4) Meet the content of certification and plan of treatment requirements as described in §424.24(e) of this chapter.

(g) Standard: Compliance with Federal, State, and local laws and regulations related to the health and safety of clients. The CMHC and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations related to the health and safety of clients. If State or local law provides for licensing of CMHCs, the CMHC must be licensed. The CMHC staff must follow the CMHC’s policies and procedures.

§485.920 Condition of participation: Emergency preparedness.

The Community Mental Health Center (CMHC) must comply with all applicable Federal, State, and local emergency preparedness requirements. The CMHC must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

(a) Emergency plan. The CMHC must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following:
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
(2) Include strategies for addressing emergency events identified by the risk assessment.

(3) Address client population, including, but not limited to, the type of services the CMHC has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the CMHC’s efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

(b) Policies and procedures. The CMHC must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

(1) A system to track the location of on-duty staff and sheltered clients in the CMHC’s care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the CMHC must document the specific name and location of the receiving facility or other location.

(2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

(3) A means to shelter in place for clients, staff, and volunteers who remain in the facility.

(4) A system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records.

(5) The use of volunteers in an emergency or other emergency staffing strategies, including the process and
role for integration of state or Federally designated health care professionals to address surge needs during an emergency.

(6) The development of arrangements with other CMHCs or other providers to receive clients in the event of limitations or cessation of operations to maintain the continuity of services to CMHC clients.

(7) The role of the CMHC under a waiver declared by the Secretary of Health and Human Services, in accordance with section 1135 of the Social Security Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

(c) Communication plan. The CMHC must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

(1) Names and contact information for the following:
   (i) CMHC’s staff.
   (ii) Entities providing services under arrangement.
   (iii) Clients’ physicians.
   (iv) Other CMHCs.
   (v) Volunteers.

(2) Contact information for the following:
   (i) Federal, State, tribal, regional, and local emergency preparedness staff.
   (ii) Other sources of assistance.

(3) Primary and alternate means for communicating with the following:
   (i) CMHC’s staff.
   (ii) Federal, State, tribal, regional, and local emergency management agencies.

(4) A method for sharing information and medical documentation for clients under the CMHC’s care, as necessary, with other health care providers to maintain the continuity of care.

(5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii).

(6) A means of providing information about the general condition and location of clients under the facility’s care as permitted under 45 CFR 164.510(b)(4).

(7) A means of providing information about the CMHC’s needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.

(d) Training and testing. The CMHC must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

(1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

(2) Testing. The CMHC must conduct exercises to test the emergency plan at least annually. The CMHC must:

   (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the CMHC experiences an actual natural or man-made emergency that requires activation of the emergency plan, the CMHC is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

   (ii) Conduct an additional exercise that may include, but is not limited to the following:

      (A) A second full-scale exercise that is community-based or individual, facility-based.

      (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

   (iii) Analyze the CMHC’s response to and maintain documentation of all
drills, tabletop exercises, and emergency events, and revise the CMHC’s emergency plan, as needed.

(e) Integrated healthcare systems. If a CMHC is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the CMHC may choose to participate in the healthcare system’s coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

(2) Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered.

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance.

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include all of the following:

(i) A documented community-based risk assessment, utilizing an all-hazards approach.

(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

*Effective Date Note:* At 81 FR 64039, Sept. 16, 2016, § 485.920 was added, effective Nov. 15, 2016.
ORGAN PROCUREMENT ORGANIZATION PROCESS PERFORMANCE MEASURES

§ 486.320 Condition: Participation in Organ Procurement and Transplantation Network.

§ 486.322 Condition: Relationships with hospitals, critical access hospitals, and tissue banks.

§ 486.324 Condition: Administration and governing body.

§ 486.326 Condition: Human resources.

§ 486.328 Condition: Reporting of data.

§ 486.330 Condition: Information management.

§ 486.342 Condition: Requesting consent.

§ 486.344 Condition: Evaluation and management of potential donors and organ placement and recovery.

§ 486.346 Condition: Organ preparation and transport.

§ 486.348 Condition: Quality assessment and performance improvement (QAPI).

§ 486.360 Condition for Coverage: Emergency preparedness.

AUTHORITY: Secs. 1102, 1138, and 1871 of the Social Security Act (42 U.S.C. 1302, 1320b-8, and 1395hh) and section 371 of the Public Health Service Act (42 U.S.C. 273).

Subpart A—General Provisions

§ 486.1 Basis and scope.

(a) Statutory basis. This part is based on the following sections of the Act:

1102 and 1138(b), 1871 of the Social Security Act, section 371(b) of the Public Health Service Act—for coverage of organ procurement services.

1861(p)—for coverage of outpatient physical therapy services furnished by physical therapists in independent practice.

1861(s) (3), (15), and (17)—for coverage of portable X-ray services.

(b) Scope. (1) This part sets forth the conditions for coverage of certain specialized services that are furnished by suppliers and that are not specified in other portions of this chapter.

(2) The conditions for coverage of other specialized services furnished by suppliers are set forth in the following regulations which, unless otherwise indicated, are part of this chapter:

(i) Ambulatory surgical center (ASC) services—Part 416.

(ii) Ambulance services—Part 410, subpart B.

(iii) ESRD services—Part 405, subpart U.

(iv) Laboratory services—Part 493.

(v) Mammography services—Part 410, subpart B (§ 410.34) and 21 CFR part 900, subpart B, of the Food and Drug Administration regulations.

(vi) Rural health clinic and Federally qualified health center services—Part 491, subpart A.


Subpart B [Reserved]

Subpart C—Conditions for Coverage: Portable X-Ray Services

AUTHORITY: Secs. 1102, 1861(s) (3), (11) and (12), 1864, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(s) (3), (11), and (12), 1395aa and 1395hh).


§ 486.100 Condition for coverage: Compliance with Federal, State, and local laws and regulations.

The supplier of portable X-ray services is in conformity with all applicable Federal, State, and local laws and regulations.

(a) Standard—licensure or registration of supplier. In any State in which State or applicable local law provides for the licensure or registration of suppliers of X-ray services, the supplier is (1) licensed or registered pursuant to such law, or (2) approved by the agency of the State or locality responsible for licensure or registration as meeting the standards established for such licensure or registration.

(b) Standard—licensure or registration of personnel. All personnel engaged in operating portable X-ray equipment are currently licensed or registered in accordance with all applicable State and local laws.

(c) Standard—licensure or registration of equipment. All portable X-ray equipment used in providing portable X-ray services is licensed or registered in accordance with all applicable State and local laws.

(d) Standard—conformity with other Federal, State, and local laws and regulations. The supplier of portable X-ray
§ 486.102 Condition for coverage: Supervision by a qualified physician.

Portable X-ray services are provided under the supervision of a qualified physician.

(a) Standard—physician supervision. The performance of the roentgenologic procedures is subject to the supervision of a physician who meets the requirements of paragraph (b) of this section and one of the following requirements is met:

(1) The supervising physician owns the equipment and it is operated only by his employees, or

(2) The supervising physician certifies annually that he periodically checks the procedural manuals and observes the operators’ performance, that he has verified that equipment and personnel meet applicable Federal, State, and local licensure and registration requirements and that safe operating procedures are used.

(b) Standard—qualifications of the physician supervisor. Portable X-ray services are provided under the supervision of a licensed doctor of medicine or licensed doctor of osteopathy who is qualified by advanced training and experience in the use of X-rays for diagnostic purposes, i.e., he (1) is certified in radiology by the American Board of Radiology or by the American Osteopathic Board of Radiology or possesses qualifications which are equivalent to those required for such certification, and at least 12 full months of pertinent portable X-ray equipment operation experience in the 5 years prior to January 1, 1968.

(3) For those whose training was completed prior to July 1, 1960: Successful completion of 24 full months of training or experience under the direct supervision of a physician who is certified in radiology by the American College of Radiology or who possesses qualifications which are equivalent to those required for such certification, and at least 12 full months of pertinent portable X-ray equipment operation experience in the 5 years prior to January 1, 1968.

(4) For those whose training was completed prior to January 1, 1993, successful completion of a program of formal training in X-ray technology in a school approved by the Council on Education in Radiologic Technology (JRCERT), or have earned a bachelor’s or associate degree in radiologic technology from an accredited college or university.

Portable X-ray services are provided by qualified technologists.

(a) Standard—qualifications of technologists. All operators of the portable X-ray equipment meet the requirements of paragraphs (a)(1), (2), (3), or (4) of this section:

(1) Successful completion of a program of formal training in X-ray technology in a school approved by the Joint Review Committee on Education in Radiologic Technology (JRCERT), or have earned a bachelor’s or associate degree in radiologic technology from an accredited college or university.

(2) For those whose training was completed prior to July 1, 1966, but on or after July 1, 1960: Successful completion of 24 full months of training and/or experience under the direct supervision of a physician who is certified in radiology by the American College of Radiology or who possesses qualifications which are equivalent to those required for such certification, and at least 12 full months of pertinent portable X-ray equipment operation experience in the 5 years prior to January 1, 1968.

(3) For those whose training was completed prior to January 1, 1993, successful completion of a program of formal training in X-ray technology in a school approved by the Council on Education of the American Medical Association, or by the American Osteopathic Association is acceptable.

(b) Standard—personnel orientation. The supplier of portable X-ray services has an orientation program for personnel, based on a procedural manual.
which is: Available to all members of the staff, incorporates relevant portions of professionally recognized documents, and includes instruction in all of the following:

1. Precautions to be followed to protect the patient from unnecessary exposure to radiation.
2. Precautions to be followed to protect an individual supporting the patient during X-ray procedures from unnecessary exposure to radiation.
3. Precautions to be followed to protect other individuals in the surrounding environment from exposure to radiation.
4. Precautions to be followed to protect the operator of portable X-ray equipment from unnecessary exposure to radiation.
5. Considerations in determining the area which will receive the primary beam.
6. Determination of the time interval at which to check personnel radiation monitors.
7. Use of the personnel radiation monitor in providing an additional check on safety of equipment.
8. Proper use and maintenance of equipment.
9. Proper maintenance of records.
10. Technical problems which may arise and methods of solution.
11. Protection against electrical hazards.
12. Hazards of excessive exposure to radiation.

(c) Standard: Employee records. Records are maintained and include evidence that—
1. Each employee is qualified for his or her position by means of training and experience; and
2. Employees receive adequate health supervision.

§ 486.106 Condition for coverage: Referral for service and preservation of records.

All portable X-ray services performed for Medicare beneficiaries are ordered by a physician or a nonphysician practitioner as provided in § 410.32(a)(2) and records are properly preserved.

(a) Standard—referral by a physician or nonphysician practitioners. Portable X-ray examinations are performed only on the order of a physician licensed to practice in the State or by a nonphysician practitioner acting within the scope of State law. Such nonphysician practitioners may be treated the same as physicians treating beneficiaries for the purpose of this paragraph. The supplier’s records show that:
1. The portable X-ray test was ordered by a licensed physician or a nonphysician practitioner acting within the State scope of law; and
2. Such physician or nonphysician practitioner’s written, signed order specifies the reason a portable X-ray test is required, the area of the body to be exposed, the number of radiographs to be obtained, and the views needed; it also includes a statement concerning the condition of the patient which indicates why portable X-ray services are necessary.

(b) Standard—records of examinations performed. The supplier makes for each patient a record of the date of the portable X-ray examination, the name of the patient, a description of the procedures ordered and performed, the referring physician or nonphysician practitioner, the operator(s) of the portable X-ray equipment who performed the examination, the physician to whom the radiograph was sent, and the date it was sent.

(c) Standard—preservation of records. Such reports are maintained for a period of at least 2 years, or for the period of time required by State law for such records (as distinguished from requirements as to the radiograph itself), whichever is longer.

§ 486.108 Condition for coverage: Safety standards.

X-ray examinations are conducted through the use of equipment which is free of unnecessary hazards for patients, personnel, and other persons in the immediate environment, and through operating procedures which
provide minimum radiation exposure to patients, personnel, and other persons in the immediate environment.

(a) Standard—tube housing and devices to restrict the useful beam. The tube housing is of diagnostic type. Diaphragms, cones, or adjustable collimators capable of restricting the useful beam to the area of clinical interest are used and provide the same degree of protection as is required of the housing.

(b) Standard—total filtration. (1) The aluminum equivalent of the total filtration in the primary beam is not less than that shown in the following table except when contraindicated for a particular diagnostic procedure.

<table>
<thead>
<tr>
<th>Operating kVp</th>
<th>Total filtration (inherent plus added)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 50 kVp</td>
<td>0.5 millimeters aluminum.</td>
</tr>
<tr>
<td>50–70 kVp</td>
<td>1.5 millimeters aluminum.</td>
</tr>
<tr>
<td>Above 70 kVp</td>
<td>2.5 millimeters aluminum.</td>
</tr>
</tbody>
</table>

(2) If the filter in the machine is not accessible for examination or the total filtration is unknown, it can be assumed that the requirements are met if the half-value layer is not less than that shown in the following table:

<table>
<thead>
<tr>
<th>Operating kVp</th>
<th>Half-value layer</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 kVp</td>
<td>0.6 millimeters aluminum.</td>
</tr>
<tr>
<td>70 kVp</td>
<td>1.6 millimeters aluminum.</td>
</tr>
<tr>
<td>90 kVp</td>
<td>2.6 millimeters aluminum.</td>
</tr>
<tr>
<td>100 kVp</td>
<td>2.8 millimeters aluminum.</td>
</tr>
<tr>
<td>110 kVp</td>
<td>3.0 millimeters aluminum.</td>
</tr>
<tr>
<td>120 kVp</td>
<td>3.3 millimeters aluminum.</td>
</tr>
</tbody>
</table>

(c) Standard—termination of exposure. A device is provided to terminate the exposure after a preset time or exposure.

(d) Standard—control panel. The control panel provides a device (usually a milliammeter or a means for an audible signal to give positive indication of the production of X-rays whenever the X-ray tube is energized. The control panel includes appropriate indicators (labelled control settings and/or meters) which show the physical factors (such as kVp, mA, exposure time or whether timing is automatic) used for the exposure.

(e) Standard—exposure control switch. The exposure control switch is of the dead-man type and is so arranged that the operator can stand at least 6 feet from the patient and well away from the useful beam.

(f) Standard—protection against electrical hazards. Only shockproof equipment is used. All electrical equipment is grounded.

(g) Standard—mechanical supporting or restraining devices. Mechanical supporting or restraining devices are provided so that such devices can be used when a patient must be held in position for radiography.

(h) Standard—protective gloves and aprons. Protective gloves and aprons are provided so that when the patient must be held by an individual, that individual is protected with these shielding devices.

(i) Standard—restriction of the useful beam. Diaphragms, cones, or adjustable collimators are used to restrict the useful beam to the area of clinical interest.

(j) Standard—personnel monitoring. A device which can be worn to monitor radiation exposure (e.g., a film badge) is provided to each individual who operates portable X-ray equipment. The device is evaluated for radiation exposure to the operator at least monthly and appropriate records are maintained by the supplier of portable X-ray services of radiation exposure measured by such a device for each individual.

(k) Standard—personnel and public protection. No individual occupationally exposed to radiation is permitted to hold patients during exposures except during emergencies, nor is any other individual regularly used for this service. Care is taken to assure that pregnant women do not assist in portable X-ray examinations.


§ 486.110 Condition for coverage: Inspection of equipment.

Inspections of all X-ray equipment and shielding are made by qualified individuals at intervals not greater than every 24 months.

(a) Standard—qualified inspectors. Inspections are made at least every 24 months by a radiation health specialist who is on the staff of or approved by an
appropriate State or local government agency.

(b) **Standard—records of inspection and scope of inspection.** The supplier maintains records of current inspections which include the extent to which equipment and shielding are in compliance with the safety standards outlined in §486.108.


Subparts D–F [Reserved]

Subpart G—Requirements for Certification and Designation and Conditions for Coverage: Organ Procurement Organizations

SOURCE: 71 FR 31046, May 31, 2006, unless otherwise noted.

§486.301 Basis and scope.

(a) **Statutory basis.** (1) Section 1138(b) of the Act sets forth the requirements that an organ procurement organization (OPO) must meet to have its organ procurement services to hospitals covered under Medicare and Medicaid. These include certification as a “qualified” OPO and designation as the OPO for a particular service area.

(2) Section 371(b) of the Public Health Service Act sets forth the requirements for certification and the functions that a qualified OPO is expected to perform.

(3) Section 1102 of the Act authorizes the Secretary of Health and Human Services to make and publish rules and regulations necessary to the efficient administration of the functions that are assigned to the Secretary under the Act.

(4) Section 1871 of the Act authorizes the Secretary to prescribe regulations as may be necessary to carry out the administration of the Medicare program under title XVIII.

(b) **Scope.** This subpart sets forth—

(1) The conditions and requirements that an OPO must meet;

(2) The procedures for certification and designation of OPOs; and

(3) The terms of the agreement with CMS and the basis for and the effect of de-certification.

(4) The requirements for an OPO to be re-certified.

§486.302 Definitions.

As used in this subpart, the following definitions apply:

**Adverse event** means an untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof. As applied to OPOs, adverse events include but are not limited to transmission of disease from a donor to a beneficiary, avoidable loss of a medically suitable potential donor for whom consent for donation has been obtained, or delivery to a transplant center of the wrong organ or an organ whose blood type does not match the blood type of the intended beneficiary.

**Agreement cycle** refers to the time period of at least 4 years when an agreement is in effect between CMS and an OPO.

**Certification** means a CMS determination that an OPO meets the requirements for certification at §486.303.

**Death record review** means an assessment of the medical chart of a deceased patient to evaluate potential for organ donation.

**Decertification** means a CMS determination that an OPO no longer meets the requirements for certification at §486.303.

**Designated requestor or effective requestor** is an individual (generally employed by a hospital), who is trained to handle or participate in the donation consent process. The designated requestor may request consent for donation from the family of a potential donor or from the individual(s) responsible for making the donation decision in circumstances permitted under State law, provide information about donation to the family or decision-maker(s), or provide support to or collaborate with the OPO in the donation consent process.

**Designation** means CMS assignment of a geographic service area to an OPO. Once an OPO is certified and assigned a geographic service area, organ procurement costs of the OPO are eligible for
Medicare and Medicaid payment under section 1138(b)(1)(F) of the Act.

**Donation service area (DSA)** means a geographical area of sufficient size to ensure maximum effectiveness in the procurement and equitable distribution of organs and that either includes an entire metropolitan statistical area or does not include any part of such an area and that meets the standards of this subpart.

**Donor** means a deceased individual from whom at least one vascularized organ (heart, liver, lung, kidney, pancreas, or intestine) is recovered for the purpose of transplantation.

**Donor after cardiac death (DCD)** means an individual who donates after his or her heart has irreversibly stopped beating. A donor after cardiac death may be termed a non-heartbeating or asystolic donor.

**Donor document** means any documented indication of an individual’s choice regarding his or her wishes concerning organ and/or tissue donation that was made by that individual or another authorized individual in accordance with any applicable State law.

**Eligible death for organ donation** means the death of a patient 70 years old or younger, who ultimately is legally declared brain dead according to hospital policy independent of family decision regarding donation or availability of next-of-kin, independent of medical examiner or coroner involvement in the case, and independent of local acceptance criteria or transplant center practice, who exhibits none of the following:

1. **Active infections (specific diagnoses).**
   - **Bacterial:**
     - Tuberculosis.
   - **Viral:**
     - HIV infection by serologic or molecular detection.
   - **Rabies.**
   - **Reactive Hepatitis B Surface Antigen.**
   - **Retroviral infections including HTLV type I.**
   - **Viral Encephalitis or Meningitis.**
   - **Active Herpes simplex, varicella zoster, or cytomegalovirus viremia or pneumonia.**
   - **Acute Epstein Barr Virus (mononucleosis).**
   - **West Nile Virus infection.**
   - **Severe acute respiratory syndrome (SARS).**
   - **Fungal:**
     - Active infection with Cryptococcus, Aspergillus, Histoplasma, Coccidioides.
     - Active candidemia or invasive yeast infection.
   - **Parasites:** active infection with Trypanosoma cruzi (Chagas’), Leishmania, Strongyloides, or Malaria (Plasmodium sp.).
   - **Prion** Creutzfeldt-Jacob Disease.
2. **General:**
   - **Aplastic Anemia.**
   - **Agranulocytosis.**
   - **Extreme Immaturity (<500 grams or gestational age of <32 weeks).**
   - **Current malignant neoplasms except non-melanoma skin cancers such as basal cell and squamous cell cancer and primary CNS tumors without evident metastatic disease.**
   - **Previous malignant neoplasms with current evident metastatic disease.**
   - **A history of melanoma.**
   - **Hematologic malignancies:** Leukemia, Hodgkin’s Disease, Lymphoma, Multiple Myeloma.
   - **Multi-system organ failure (MSOF) due to overwhelming sepsis or MSOF without sepsis defined as 3 or more systems in simultaneous failure for a period of 24 hours or more without response to treatment or resuscitation.**
   - **Active Fungal, Parasitic, viral, or Bacterial Meningitis or encephalitis.**
3. **The number of eligible deaths is the denominator for the donation rate outcome performance measure as described at §486.318(a)(1).**

**Eligible donor** means any donor that meets the eligible death criteria. The number of eligible donors is the numerator of the donation rate outcome performance measure.

**Entire metropolitan statistical area** means a metropolitan statistical area (MSA), a consolidated metropolitan statistical area (CMSA), or a primary metropolitan statistical area (PMSA).
listed in the State and Metropolitan Area Data Book published by the U.S. Bureau of the Census. CMS does not recognize a CMSA as a metropolitan area for the purposes of establishing a geographical area for an OPO.

Expected donation rate means the donation rate expected for an OPO based on the national experience for OPOs serving similar hospitals and donation service areas. This rate is adjusted for the following hospital characteristics: Level I or Level II trauma center, Metropolitan Statistical Area size, MS Case Mix Index, total bed size, number of intensive care unit (ICU) beds, primary service, presence of a neurosurgery unit, and hospital control/ownership.

Observed donation rate is the number of donors meeting the eligibility criteria per 100 deaths.

Open area means an OPO service area for which CMS has notified the public that it is accepting applications for designation.

Organ means a human kidney, liver, heart, lung, pancreas, or intestine (or multivisceral organs when transplanted at the same time as an intestine).

Organ procurement organization (OPO) means an organization that performs or coordinates the procurement, preservation, and transport of organs and maintains a system for locating prospective beneficiaries for available organs.

Re-certification cycle means the 4-year cycle during which an OPO is certified.

Standard criteria donor (SCD) means a donor that meets the eligibility criteria for an eligible donor and does not meet the criteria to be a donor after cardiac death or expanded criteria donor.

Transplant hospital means a hospital that provides organ transplants and other medical and surgical specialty services required for the care of transplant patients. There may be one or more types of organ transplant centers operating within the same transplant hospital.

Urgent need occurs when an OPO’s noncompliance with one or more conditions for coverage has caused, or is likely to cause, serious injury, harm, impairment, or death to a potential or actual donor or an organ beneficiary.


REQUIREMENTS FOR CERTIFICATION AND DESIGNATION

§ 486.303 Requirements for certification.

In order to be certified as a qualified organ procurement organization, an organ procurement organization must:

(a) Have received a grant under 42 U.S.C. 273(a) or have been certified or re-certified by the Secretary within the previous 4 years as being a qualified OPO.

(b) Be a non-profit entity that is exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1986.

(c) Have accounting and other fiscal procedures necessary to assure the fiscal stability of the organization, including procedures to obtain payment for kidneys and non-renal organs provided to transplant hospitals.

(d) Have an agreement with CMS, as the Secretary's designated representative, to be reimbursed under title XVIII for the procurement of kidneys.

(e) Have been re-certified as an OPO under the Medicare program from January 1, 2002 through December 31, 2005.

(f) Have procedures to obtain payment for non-renal organs provided to transplant centers.

(g) Agree to enter into an agreement with any hospital or critical access hospital in the OPO’s service area, including a transplant hospital that requests an agreement.

(h) Meet the conditions for coverage for organ procurement organizations, which include both outcome and process performance measures.

(i) Meet the provisions of titles XI, XVIII, and XIX of the Act, section 371(b) of the Public Health Services Act, and any other applicable Federal regulations.

§ 486.304 Requirements for designation.

(a) Designation is a condition for payment. Payment may be made under the Medicare and Medicaid programs
§ 486.306 OPO service area size designation and documentation requirements.

(a) General documentation requirement. An OPO must make available to CMS documentation verifying that the OPO meets the requirements of paragraphs (b) and (c) of this section at the time of application and throughout the period of its designation.

(b) Service area designation. The defined service area either includes an entire metropolitan statistical area or a New England county metropolitan statistical area as specified by the Director of the Office of Management and Budget or does not include any part of such an area.

(c) Service area location and characteristics. An OPO must define and document a proposed service area's location through the following information:

(1) The names of counties (or parishes in Louisiana) served or, if the service area includes an entire State, the name of the State.

(2) Geographic boundaries of the service area.

(3) The number and the names of all hospitals and critical access hospitals in the service area that have both a ventilator and an operating room.


§ 486.308 Designation of one OPO for each service area.

(a) CMS designates only one OPO per service area. A service area is open for competition when the OPO for the service area is de-certified and all administrative appeals under §486.314 are exhausted.

(b) Designation periods—

(1) General. An OPO is normally designated for a 4-year agreement cycle. The period may be shorter, for example, if an OPO has voluntarily terminated its agreement with CMS and CMS selects a successor OPO for the balance of the 4-year agreement cycle. In rare situations, a designation period may be longer, for example, a designation may be extended if additional time is needed to select a successor OPO to replace an OPO that has been de-certified.

(2) Re-Certification. Re-certification must occur not more frequently than once every 4 years.

(c) Unless CMS has granted a hospital a waiver under paragraphs (d) through (f) of this section, the hospital must enter into an agreement only with the OPO designated to serve the area in which the hospital is located.

(d) If CMS changes the OPO designated for an area, hospitals located in that area must enter into agreements with the newly designated OPO or submit a request for a waiver in accordance with paragraph (e) of this section within 30 days of notice of the change in designation.

(e) A hospital may request and CMS may grant a waiver permitting the hospital to have an agreement with a designated OPO other than the OPO designated for the service area in which the hospital is located. To qualify for a waiver, the hospital must submit data to CMS establishing that—

(1) The waiver is expected to increase organ donations; and

(2) The waiver will ensure equitable treatment of patients listed for transplants within the service area served by the hospital’s designated OPO and within the service area served by the OPO with which the hospital seeks to enter into an agreement.

(f) In making a determination on waiver requests, CMS considers—

(1) Cost effectiveness;

(2) Improvements in quality;

(3) Changes in a hospital’s designated OPO due to changes in the definitions of metropolitan statistical areas, if applicable; and

(4) The length and continuity of a hospital’s relationship with an OPO.
other than the hospital’s designated OPO.

(g) A hospital may continue to operate under its existing agreement with an out-of-area OPO while CMS is processing the waiver request. If a waiver request is denied, a hospital must enter into an agreement with the designated OPO within 30 days of notification of the final determination.


§ 486.309 Re-certification from August 1, 2006 through July 31, 2010.

An OPO will be considered to be re-certified for the period of August 1, 2006 through July 31, 2010 if an OPO met the standards to be a qualified OPO within a 4-year period ending December 31, 2001 and has an agreement with the Secretary that is scheduled to terminate on July 31, 2006. Agreements based on the August 1, 2006 through July 31, 2010 re-certification cycle will end on January 31, 2011.

§ 486.310 Changes in control or ownership or service area.

(a) OPO requirements. (1) A designated OPO considering a change in control (see § 413.17(b)(3)) or ownership or in its service area must notify CMS before putting it into effect. This notification is required to ensure that the OPO, if changed, will continue to satisfy Medicare and Medicaid requirements. The merger of one OPO into another or the consolidation of one OPO with another is considered a change in control or ownership.

(2) A designated OPO considering a change in its service area must obtain prior CMS approval. In the case of a service area change that results from a change of control or ownership due to merger or consolidation, the OPOs must resubmit the information required in an application for designation. The OPO must provide information specific to the board structure of the new organization, as well as operating budgets, financial information, and other written documentation CMS determines to be necessary for designation.

(b) CMS requirements. (1) If CMS finds that the OPO has changed to such an extent that it no longer satisfies the requirements for OPO designation, CMS may de-certify the OPO and declare the OPO’s service area to be an open area. An OPO may appeal such a de-certification as set forth in § 486.314. The OPO’s service area is not opened for competition until the conclusion of the administrative appeals process.

(2) If CMS finds that the changed OPO continues to satisfy the requirements for OPO designation, the period of designation of the changed OPO is the remaining portion of the 4-year term of the OPO that was reorganized. If more than one designated OPO is involved in the reorganization, the remaining designation term is the longest of the remaining periods unless CMS determines that a shorter period is in the best interest of the Medicare and Medicaid programs. The changed OPO must continue to meet the requirements for certification at § 486.303 throughout the remaining period.

§ 486.312 De-certification.

(a) Voluntary termination of agreement. If an OPO wishes to terminate its agreement, the OPO must send CMS written notice of its intention to terminate its agreement and the proposed effective date. CMS may approve the proposed date, set a different date no later than 6 months after the proposed effective date, or set a date less than 6 months after the proposed effective date if it determines that a different date would not disrupt services to the service area. If CMS determines that a designated OPO has ceased to furnish organ procurement services to its service area, the cessation of services is deemed to constitute a voluntary termination by the OPO, effective on a date determined by CMS. CMS will de-certify the OPO as of the effective date of the voluntary termination.

(b) Involuntary termination of agreement. During the term of the agreement, CMS may terminate an agreement with an OPO if the OPO no longer meets the requirements for certification at § 486.303. CMS may also terminate an agreement immediately in cases of urgent need, such as the discovery of unsound medical practices.
CMS will de-certify the OPO as of the effective date of the involuntary termination.

(c) Non-renewal of agreement. CMS will not voluntarily renew its agreement with an OPO if the OPO fails to meet the requirements for certification at § 486.318, based on findings from the most recent re-certification cycle, or the other requirements for certification at § 486.303. CMS will de-certify the OPO as of the ending date of the agreement.

(d) Notice to OPO. Except in cases of urgent need, CMS gives written notice of de-certification to an OPO at least 90 days before the effective date of the de-certification. In cases of urgent need, CMS gives written notice of de-certification to an OPO at least 3 calendar days prior to the effective date of the de-certification. The notice of de-certification states the reasons for de-certification and the effective date.

(e) Public notice. Once CMS approves the date for a voluntary termination, the OPO must provide prompt public notice of the date of de-certification and such other information as CMS may require through publication in local newspapers in the service area. In the case of involuntary termination or non-renewal of an agreement, CMS provides public notice of the date of de-certification through publication in local newspapers in the service area. No payment under titles XVIII or XIX of the Act will be made with respect to organ procurement costs attributable to the OPO on or after the effective date of de-certification.

§ 486.314 Appeals.

If an OPO’s de-certification is due to involuntary termination or non-renewal of its agreement with CMS, the OPO may appeal the de-certification on substantive and procedural grounds.

(a) Notice of initial determination. CMS mails notice to the OPO of an initial de-certification determination. The notice contains the reasons for the determination, the effect of the determination, and the OPO’s right to seek reconsideration.

(b) Reconsideration. (1) Filing request. If the OPO is dissatisfied with the de-certification determination, it has 15 business days from receipt of the notice of de-certification to seek reconsideration from CMS. The request for reconsideration must state the issues or findings of fact with which the OPO disagrees and the reasons for disagreement.

(2) An OPO must seek reconsideration before it is entitled to seek a hearing before a hearing officer. If an OPO does not request reconsideration or its request is not made timely, the OPO has no right to further administrative review.

(3) Reconsideration determination. CMS makes a written reconsidered determination within 10 business days of receipt of the request for reconsideration, affirming, reversing, or modifying the initial determination and the findings on which it was based. CMS augments the administrative record to include any additional materials submitted by the OPO, and a copy of the reconsideration decision and sends the supplemented administrative record to the CMS hearing officer.

(c) Request for hearing. An OPO dissatisfied with the CMS reconsideration decision, must file a request for a hearing before a CMS hearing officer within 40 business days of receipt of the notice of the reconsideration determination. If an OPO does not request a hearing or its request is not received timely, the OPO has no right to further administrative review.

(d) Administrative record. The hearing officer sends the administrative record to both parties within 10 business days of receipt of the request for a hearing.

(1) The administrative record consists of, but is not limited to, the following:

(i) Factual findings from the survey(s) on the OPO conditions for coverage.

(ii) Data from the outcome measures.

(iii) Rankings of OPOs based on the outcome data.

(iv) Correspondence between CMS and the affected OPO.

(2) The administrative record will not include any privileged information.

(e) Pre-Hearing conference. At any time before the hearing, the CMS hearing officer may call a pre-hearing conference if he or she believes that a conference would more clearly define the issues. At the pre-hearing conference,
the hearing officer may establish the briefing schedule, sets the hearing date, and addresses other administrative matters. The hearing officer will issue an order reflecting the results of the pre-hearing conference.

(f) Date of hearing. The hearing officer sets a date for the hearing that is no more than 60 calendar days following the receipt of the request for a hearing.

(g) Conduct of hearing. (1) The hearing is open to both parties, CMS and the OPO.

(2) The hearing officer inquires fully into all the matters at issue and receives in evidence the testimony of witnesses and any documents that are relevant and material.

(3) The hearing officer provides the parties with an opportunity to enter an objection to the inclusion of any document. The hearing officer will consider the objection and will rule on the document’s admissibility.

(4) The hearing officer decides the order in which the evidence and the arguments of the parties are presented and the conduct of the hearing.

(5) The hearing officer rules on the admissibility of evidence and may admit evidence that would be inadmissible under rules applicable to court procedures.

(6) The hearing officer rules on motions and other procedural items.

(7) The hearing officer regulates the course of the hearing and conduct of counsel.

(8) The hearing officer may examine witnesses.

(9) The hearing officer takes any action authorized by the rules in this subpart.

(h) Parties’ rights. CMS and the OPO may:

(1) Appear by counsel or other authorized representative, in all hearing proceedings.

(2) Participate in any pre-hearing conference held by the hearing officer.

(3) Agree to stipulations as to facts which will be made a part of the record.

(4) Make opening statements at the hearing.

(5) Present relevant evidence on the issues at the hearing.

(6) Present witnesses, who then must be available for cross-examination, and cross-examine witnesses presented by the other party.

(7) Present oral arguments at the hearing.

(i) Hearing officer’s decision. The hearing officer renders a decision on the appeal of the notice of de-certification within 20 business days of the hearing.

(1) Reversal of de-certification. If the hearing officer reverses CMS’ determination to de-certify an OPO in a case involving the involuntary termination of the OPO’s agreement, CMS will not terminate the OPO’s agreement and will not de-certify the OPO.

(2) De-certification is upheld. If the de-certification determination is upheld by the hearing officer, the OPO is de-certified and it has no further administrative appeal rights.

(j) Extension of agreement. If there is insufficient time prior to expiration of an agreement with CMS to allow for competition of the service area and, if necessary, transition of the service area to a successor OPO, CMS may choose to extend the OPO’s agreement with CMS.

(k) Effects of de-certification. Medicare and Medicaid payments may not be made for organ procurement services the OPO furnishes on or after the effective date of de-certification. CMS will then open the de-certified OPO’s service area for competition as set forth in §486.316(c).

§ 486.316 Re-certification and competition processes.

(a) Re-Certification of OPOs. An OPO is re-certified for an additional 4 years and its service area is not opened for competition when the OPO:

(1) Meets two out of the three outcome measures requirements at §486.318; and

(2) Has been shown by survey to be in compliance with the requirements for certification at §486.303, including the conditions for coverage at §§486.320 through 486.348.

(b) De-certification and competition. If an OPO does not meet two out of the three outcome measures as described in paragraph (a)(1) of this section or the requirements described in paragraph...
§ 486.318  
(a)(2) of this section, the OPO is de-certified. If the OPO does not appeal or the OPO appeals and the reconsideration official and CMS hearing officer uphold the de-certification, the OPO’s service area is opened for competition from other OPOs. The de-certified OPO is not permitted to compete for its open area or any other open area. An OPO competing for an open service area must submit information and data that describe the barriers in its service area, how they affected organ donation, what steps the OPO took to overcome them, and the results.

(c) Criteria to compete. To compete for an open service area, an OPO must meet the criteria in paragraph (a) of this section and the following additional criteria:

(1) The OPO’s performance on the donation rate outcome measure and yield outcome measure is at or above 100 percent of the mean national rate averaged over the 4 years of the re-certification cycle; and

(2) The OPO’s donation rate is at least 15 percentage points higher than the donation rate of the OPO currently designated for the service area.

(3) The OPO must compete for the entire service area.

(d) Criteria for selection. CMS will designate an OPO for an open service area based on the following criteria:

(1) Performance on the outcome measures at § 486.318;

(2) Relative success in meeting the process performance measures and other conditions at §§ 486.320 through 486.348;

(3) Contiguity to the open service area.

(4) Success in identifying and overcoming barriers to donation within its own service area and the relevance of those barriers to barriers in the open area. An OPO competing for an open service area must submit information and data that describe the barriers in its service area, how they affected organ donation, what steps the OPO took to overcome them, and the results.

(e) No OPO applies. If no OPO applies to compete for a de-certified OPO’s open area, CMS may select a single OPO to take over the entire open area or may adjust the service area boundaries of two or more contiguous OPOs to incorporate the open area. CMS will make its decision based on the criteria in paragraph (d) of this section.


ORGAN PROCUREMENT ORGANIZATION
OUTCOME REQUIREMENTS

§ 486.318  Condition: Outcome measures.

(a) With the exception of OPOs operating exclusively in noncontiguous States, Commonwealths, Territories, or possessions, an OPO must meet two out of the three following outcome measures:

(1) The OPO’s donation rate of eligible donors as a percentage of eligible deaths is no more than 1.5 standard deviations below the mean national donation rate of eligible donors as a percentage of eligible deaths, averaged over the 4 years of the re-certification cycle. Both the numerator and denominator of an individual OPO’s donation rate ratio are adjusted by adding a 1 for each donation after cardiac death donor and each donor over the age of 70;

(2) The observed donation rate is not significantly lower than the expected donation rate for 18 or more months of the 36 months of data used for re-certification, as calculated by the SRTR;

(3) At least 2 out of the 3 following yield measures are no more than 1 standard deviation below the national mean, averaged over the 4 years of the re-certification cycle:

(i) The number of organs transplanted per standard criteria donor, including pancreata used for islet cell transplantation;

(ii) The number of organs transplanted per expanded criteria donor, including pancreata used for islet cell transplantation; and

(iii) The number of organs used for research per donor, including pancreata used for islet cell research.

(b) For OPOs operating exclusively in noncontiguous States, Commonwealths, Territories, and possessions, an OPO must meet two out of the three following outcome measures:

(1) The OPO’s donation rate of eligible donors as a percentage of eligible
§ 486.322 Condition: Relationships with hospitals, critical access hospitals, and tissue banks.

(a) Standard: Hospital agreements. An OPO must have a written agreement with 95 percent of the Medicare and Medicaid participating hospitals and critical access hospitals in its service area that have both a ventilator and an operating room and have not been granted a waiver by CMS to work with another OPO. The agreement must describe the responsibilities of both the OPO and hospital or critical access hospital in regard to donation after cardiac death (if the OPO has a protocol for donation after cardiac death) and the requirements for hospitals at § 482.45 or § 485.643. The agreement must specify the meaning of the terms “timely referral” and “imminent death.”

(b) Standard: Designated requestor training for hospital staff. The OPO must offer to provide designated requestor training on at least an annual basis for hospital and critical access hospital staff.

(c) Standard: Cooperation with tissue banks.

(1) The OPO must have arrangements to cooperate with tissue banks that have agreements with hospitals and critical access hospitals with which the OPO has agreements. The OPO must cooperate in the following activities, as may be appropriate, to ensure that all usable tissues are obtained from potential donors:

(i) Screening and referral of potential tissue donors.
(ii) Obtaining informed consent from families of potential tissue donors.

(iii) Retrieval, processing, preservation, storage, and distribution of tissues.

(iv) Providing designated requester training.

(2) An OPO is not required to have an arrangement with a tissue bank that is unwilling to have an arrangement with the OPO.

§ 486.324 Condition: Administration and governing body.

(a) While an OPO may have more than one board, the OPO must have an advisory board that has both the authority described in paragraph (b) of this section and the following membership:

(1) Members who represent hospital administrators, either intensive care or emergency room personnel, tissue banks, and voluntary health associations in the OPO’s service area.

(2) Individuals who represent the public residing in the OPO’s service area.

(3) A physician with knowledge, experience, or skill in the field of human histocompatibility, or an individual with a doctorate degree in a biological science and with knowledge, experience, or skills in the field of human histocompatibility.

(4) A neurosurgeon or other physician with knowledge or skills in the neurosciences.

(5) A transplant surgeon representing each transplant hospital in the service area with which the OPO has arrangements to coordinate its activities. The transplant surgeon must have practicing privileges and perform transplants in the transplant hospital represented.

(6) An organ donor family member.

(b) The OPO board described in paragraph (a) of this section has the authority to recommend policies for the following:

(1) Procurement of organs.

(2) Effective agreements to identify potential organ donors with a substantial majority of hospitals in its service area that have facilities for organ donation.

(3) Systematic efforts, including professional education, to acquire all useable organs from potential donors.

(4) Arrangements for the acquisition and preservation of donated organs and provision of quality standards for the acquisition of organs that are consistent with the standards adopted by the OPTN, including arranging for testing with respect to preventing the acquisition of organs that are infected with the etiologic agent for acquired immunodeficiency syndrome (AIDS).

(5) Appropriate tissue typing of organs.

(6) A system for allocation of organs among transplant patients that is consistent with the rules and requirements of the OPTN, as defined in § 486.320 of this part.

(7) Transportation of organs to transplant hospitals.

(8) Coordination of activities with transplant hospitals.

(9) Participation in the OPTN.

(10) Arrangements to cooperate with tissue banks for the retrieval, processing, preservation, storage, and distribution of tissues as may be appropriate to assure that all useable tissues are obtained from potential donors.

(11) Annual evaluation of the effectiveness of the OPO in acquiring organs.

(12) Assistance to hospitals in establishing and implementing protocols for making routine inquiries about organ donations by potential donors.

(c) The advisory board described in paragraph (a) of this section has no authority over any other activity of the OPO and may not serve as the OPO’s governing body or board of directors. Members of the advisory board described in paragraph (a) of this section are prohibited from serving on any other OPO board.

(d) The OPO must have bylaws for each of its board(s) that address potential conflicts of interest, length of terms, and criteria for selecting and removing members.

(e) A governing body must have full legal authority and responsibility for the management and provision of all OPO services and must develop and oversee implementation of policies and procedures considered necessary for the effective administration of the OPO, including fiscal operations, the OPO’s quality assessment and performance
improvement (QAPI) program, and services furnished under contract or arrangement, including agreements for these services. The governing body must appoint an individual to be responsible for the day-to-day operation of the OPO.

(f) The OPO must have procedures to address potential conflicts of interest for the governing body described in paragraph (d) of this section.

(g) The OPO’s policies must state whether the OPO recovers organs from donors after cardiac death.

§ 486.326 Condition: Human resources.

All OPOs must have a sufficient number of qualified staff, including a director, a medical director, organ procurement coordinators, and hospital development staff to obtain all usable organs from potential donors, and to ensure that required services are provided to families of potential donors, hospitals, tissue banks, and individuals and facilities that use organs for research.

(a) Standard: Qualifications. (1) The OPO must ensure that all individuals who provide services and/or supervise services, including services furnished under contract or arrangement, are qualified to provide or supervise the services.

(2) The OPO must develop and implement a written policy that addresses potential conflicts of interest for the OPO’s director, medical director, senior management, and procurement coordinators.

(3) The OPO must have credentialing records for physicians and other practitioners who routinely recover organs in hospitals under contract or arrangement with the OPO and ensure that all physicians and other practitioners who recover organs in hospitals with which the OPO has agreements are qualified and trained.

(b) Standard: Staffing. (1) The OPO must provide sufficient coverage, either by its own staff or under contract or arrangement, to assure both that hospital referral calls are screened for donor potential and that potential donors are evaluated for medical suitability for organ and/or tissue donation in a timely manner.

(2) The OPO must have a sufficient number of qualified staff to provide information and support to potential organ donor families; request consent for donation; ensure optimal maintenance of the donor, efficient placement of organs, and adequate oversight of organ recovery; and conduct QAPI activities, such as death record reviews and hospital development.

(3) The OPO must provide a sufficient number of recovery personnel, either from its own staff or under contract or arrangement, to ensure that all usable organs are recovered in a manner that, to the extent possible, preserves them for transplantation.

(c) Standard: Education, training, and performance evaluation. The OPO must provide its staff with the education, training, and supervision necessary to furnish required services. Training must include but is not limited to performance expectations for staff, applicable organizational policies and procedures, and QAPI activities. OPOs must evaluate the performance of their staffs and provide training, as needed, to improve individual and overall staff performance and effectiveness.

(d) Standard: Medical director. The OPO’s medical director is a physician licensed in at least one of the States or territories within the OPO’s service area or as required by State or territory law or by the jurisdiction in which the OPO is located. The medical director is responsible for implementation of the OPO’s protocols for donor evaluation and management and organ recovery and placement. The medical director is responsible for oversight of the clinical management of potential donors, including providing assistance in managing a donor case when the surgeon on call is unavailable.

§ 486.328 Condition: Reporting of data.

(a) An OPO must provide individually-identifiable, hospital-specific organ donation and transplantation data and other information to the Organ Procurement and Transplantation Network, the Scientific Registry of Transplant Beneficiaries, and DHHS, as requested by the Secretary. The
data may include, but are not limited to:
(1) Number of hospital deaths;
(2) Results of death record reviews;
(3) Number and timeliness of referral calls from hospitals;
(4) Number of eligible deaths;
(5) Data related to non-recovery of organs;
(6) Data about consents for donation;
(7) Number of eligible donors;
(8) Number of organs recovered, by type of organ; and
(9) Number of organs transplanted, by type of organ.
(b) An OPO must provide hospital-specific organ donation data annually to the transplant hospitals with which it has agreements.
(c) Data to be used for OPO re-certification purposes must be reported to the OPTN and must include data for all deaths in all hospitals and critical access hospitals in the OPO’s donation service area, unless a hospital or critical access hospital has been granted a waiver to work with a different OPO.
(d) Data reported by the OPO to the OPTN must be reported within 30 days after the end of the month in which a death occurred. If an OPO determines through death record review or other means that the data it reported to the OPTN was incorrect, it must report the corrected data to the OPTN within 30 days of the end of the month in which the error is identified.
(e) For the purpose of determining the information to be collected under paragraph (a) of this section, the following definitions apply:
(1) Kidneys procured. Each kidney recovered will be counted individually. En bloc kidneys recovered will count as two kidneys procured.
(2) Kidneys transplanted. Each kidney transplanted will be counted individually. En bloc kidney transplants will be counted as two kidneys transplanted.
(3) Extra-renal organs procured. Each organ recovered is counted individually.
(4) Extra-renal organs transplanted. Each organ or part thereof transplanted will be counted individually. For example, a single liver is counted as one organ procured and each portion that is transplanted will count as one transplant. Further, a heart and double lung transplant will be counted as three organs transplanted. A kidney/pancreas transplant will count as one kidney transplanted and one extra-renal organ transplanted.
§ 486.330 Condition: Information management.
An OPO must establish and use an electronic information management system to maintain the required medical, social and identifying information for every donor and transplant beneficiary and develop and follow procedures to ensure the confidentiality and security of the information.
(a) Donor information. The OPO must maintain a record for every donor. The record must include, at a minimum, information identifying the donor (for example, name, address, date of birth, social security number or other unique identifier, such as Medicare health insurance claim number), organs and (when applicable) tissues recovered, date of the organ recovery, donor management data, all test results, current hospital history, past medical and social history, the pronouncement of death, and consent and next-of-kin information.
(b) Disposition of organs. The OPO must maintain records showing the disposition of each organ recovered for the purpose of transplantation, including information identifying transplant beneficiaries.
(c) Data retention. Donor and transplant beneficiary records must be maintained in a human readable and reproducible paper or electronic format for 7 years.
(d) Format of records. The OPO must maintain data in a format that can readily be transferred to a successor OPO and in the event of a transfer must provide to CMS copies of all records, data, and software necessary to ensure uninterrupted service by a successor OPO. Records and data subject to this requirement include donor and transplant beneficiary records and procedural manuals and other materials used in conducting OPO operations.
§ 486.342 Condition: Requesting consent.

An OPO must encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of potential donor families.

(a) An OPO must have a written protocol to ensure that, in the absence of a donor document, the individual(s) responsible for making the donation decision are informed of their options to donate organs or tissues (when the OPO is making a request for tissues) or to decline to donate. The OPO must provide to the individual(s) responsible for making the donation decision, at a minimum, the following:

1. A list of the organs and/or tissues that may be recovered.
2. The most likely uses for the donated organs or tissues.
3. A description of the screening and recovery processes.
4. Information about the organizations that will recover, process, and distribute the tissue.
5. Information regarding access to and release of the donor's medical records.
6. An explanation of the impact the donation process will have on burial arrangements and the appearance of the donor’s body.
7. Contact information for individual(s) with questions or concerns.
8. A copy of the signed consent form if a donation is made.

(b) If an OPO does not request consent to donation because a potential donor consented to donation before his or her death in a manner that satisfied applicable State law requirements in the potential donor’s State of residence, the OPO must provide information about the donation to the family of the potential donor, as requested.

§ 486.344 Condition: Evaluation and management of potential donors and organ placement and recovery.

The OPO must have written protocols for donor evaluation and management and organ placement and recovery that meet current standards of practice and are designed to maximize organ quality and optimize the number of donors and the number of organs recovered and transplanted per donor.

(a) Potential donor protocol management. (1) The medical director is responsible for ensuring that potential donor evaluation and management protocols are implemented correctly and appropriately to ensure that potential donors are thoroughly assessed for medical suitability for organ donation and clinically managed to optimize organ viability and function.

(2) The OPO must implement a system that ensures that a qualified physician or other qualified individual is available to assist in the medical management of a potential donor when the surgeon on call is unavailable.

(b) Potential donor evaluation. The OPO must do the following:

1. Verify that death has been pronounced according to applicable local, State, and Federal laws.
2. Determine whether there are conditions that may influence donor acceptance.
3. If possible, obtain the potential donor’s medical and social history.
4. Review the potential donor’s medical chart and perform a physical examination of the donor.
5. Obtain the potential donor’s vital signs and perform all pertinent tests.

(c) Testing. The OPO must do the following:

1. Arrange for screening and testing of the potential donor for infectious disease according to current standards of practice, including testing for the human immunodeficiency virus.
2. Ensure that screening and testing of the potential donor (including point-of-care testing and blood typing) are conducted by a laboratory that is certified in the appropriate specialty or subspecialty of service in accordance with part 493 of this chapter.
3. Ensure that the potential donor’s blood is typed using two separate blood samples.
4. Document potential donor’s record with all test results, including blood type, before organ recovery.

(d) Standard: Collaboration with transplant programs. (1) The OPO must establish protocols in collaboration with transplant programs that define the roles and responsibilities of the OPO and the transplant program for all activities associated with the evaluation and management of potential donors,
organ recovery, and organ placement, including donation after cardiac death, if the OPO has implemented a protocol for donation after cardiac death.

(2) The protocol must ensure that:
(i) The OPO is responsible for two separate determinations of the donor’s blood type;
(ii) If the identity of the intended recipient is known, the OPO has a procedure to ensure that prior to organ recovery, an individual from the OPO’s staff compares the blood type of the donor with the blood type of the intended recipient, and the accuracy of the comparison is verified by a different individual;
(iii) Documentation of the donor’s blood type accompanies the organ to the hospital where the transplant will take place.

(3) The established protocols must be reviewed regularly with the transplant programs to incorporate practices that have been shown to maximize organ donation and transplantation.

(e) Documentation of beneficiary information. If the intended beneficiary has been identified prior to recovery of an organ for transplantation, the OPO must have written documentation from the OPTN showing, at a minimum, the intended organ beneficiary’s ranking in relation to other suitable candidates and the recipient’s OPTN identification number and blood type.

(f) Donation after cardiac death. If an OPO recovers organs from donors after cardiac death, the OPO must have protocols that address the following:
(1) Criteria for evaluating patients for donation after cardiac death;
(2) Withdrawal of support, including the relationship between the time of consent to donation and the withdrawal of support;
(3) Use of medications and interventions not related to withdrawal of support;
(4) Involvement of family members prior to organ recovery;
(5) Criteria for declaration of death and the time period that must elapse prior to organ recovery.

(g) Organ allocation. The OPO must have a system to allocate donated organs among transplant patients that is consistent with the rules and requirements of the OPTN, as defined in §486.320 of this part.

(h) Organ placement. The OPO must develop and implement a protocol to maximize placement of organs for transplantation.


§ 486.346 Condition: Organ preparation and transport.

(a) The OPO must arrange for testing of organs for infectious disease and tissue typing of organs according to current standards of practice. The OPO must ensure that testing and tissue typing of organs are conducted by a laboratory that is certified in the appropriate specialty or subspecialty of service in accordance with part 493 of this chapter.

(b) The OPO must send complete documentation of donor information to the transplant center with the organ, including donor evaluation, the complete record of the donor’s management, documentation of consent, documentation of the pronouncement of death, and documentation for determining organ quality. Two individuals, one of whom must be an OPO employee, must verify that the documentation that accompanies an organ to a transplant center is correct.

(c) The OPO must develop and follow a written protocol for packaging, labeling, handling, and shipping organs in a manner that ensures their arrival without compromise to the quality of the organ. The protocol must include procedures to check the accuracy and integrity of labels, packaging, and contents prior to transport, including verification by two individuals, one of whom must be an OPO employee, that information listed on the labels is correct.

(d) All packaging in which an organ is transported must be marked with the identification number, specific contents, and donor’s blood type.

§ 486.348 Condition: Quality assessment and performance improvement (QAPI).

The OPO must develop, implement, and maintain a comprehensive, data-driven QAPI program designed to monitor and evaluate performance of all
Centers for Medicare & Medicaid Services, HHS

§ 486.360 Condition for Coverage: Emergency preparedness.

The Organ Procurement Organization (OPO) must comply with all applicable Federal, State, and local emergency preparedness requirements. The OPO must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

(a) Emergency plan. The OPO must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The plan must do all of the following:
   (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
   (2) Include strategies for addressing emergency events identified by the risk assessment.
   (3) Address the type of hospitals with which the OPO has agreements; the type of services the OPO has the capacity to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
   (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the OPO’s efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

(b) Policies and procedures. The OPO must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and, the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:
   (1) A system to track the location of on-duty staff during and after an emergency. If on-duty staff is relocated during the emergency, the OPO must document the specific name and location of the receiving facility or other location.
   (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

(c) Communication plan. The OPO must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The
§ 486.360  
42 CFR Ch. IV (10–1–16 Edition)

communication plan must include all of the following:

(1) Names and contact information for the following:
   (i) Staff.
   (ii) Entities providing services under arrangement.
   (iii) Volunteers.
   (iv) Other OPOs.
   (v) Transplant and donor hospitals in the OPO’s Donation Service Area (DSA).

(2) Contact information for the following:
   (i) Federal, State, tribal, regional, and local emergency preparedness staff.
   (ii) Other sources of assistance.

(3) Primary and alternate means for communicating with the following:
   (i) OPO’s staff.
   (ii) Federal, State, tribal, regional, and local emergency management agencies.

(d) Training and testing. The OPO must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

(1) Training. The OPO must do all of the following:
   (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
   (ii) Provide emergency preparedness training at least annually.
   (iii) Maintain documentation of the training.
   (iv) Demonstrate staff knowledge of emergency procedures.

(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:
   (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
   (ii) Analyze the OPO’s response to and maintain documentation of all tabletop exercises, and emergency events, and revise the OPO’s emergency plan, as needed.

(e) Continuity of OPO operations during an emergency. Each OPO must have a plan to continue operations during an emergency.

(1) The OPO must develop and maintain in the protocols with transplant programs required under §486.344(d), mutually agreed upon protocols that address the duties and responsibilities of the transplant program, the hospital in which the transplant program is operated, and the OPO during an emergency.

(2) The OPO must have the capability to continue its operation from an alternate location during an emergency. The OPO could either have:
   (i) An agreement with one or more other OPOs to provide essential organ procurement services to all or a portion of its DSA in the event the OPO cannot provide those services during an emergency.
   (ii) If the OPO has more than one location, an alternate location from which the OPO could conduct its operation; or
   (iii) A plan to relocate to another location as part of its emergency plan as required by paragraph (a) of this section.

(f) Integrated healthcare systems. If an OPO is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the OPO may choose to participate in the healthcare system’s coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

(2) Be developed and maintained in a manner that takes into account each separately certified facility’s unique
Centers for Medicare & Medicaid Services, HHS

(c) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance.

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include all of the following:

(i) A documented community-based risk assessment, utilizing an all-hazards approach.

(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

EFFECTIVE DATE NOTE: At 81 FR 64040, Sept. 16, 2016, § 486.360 was added, effective Nov. 15, 2016.

PART 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

Subpart A—General Provisions

Sec.
488.1 Definitions.
488.2 Statutory basis.
488.3 Conditions of participation, conditions for coverage, conditions for certification and long term care requirements.
488.4 General rules for a CMS-approved accreditation program for providers and suppliers.
488.5 Application and re-application procedures for national accrediting organizations.
488.6 Providers or suppliers that participate in the Medicaid program under a CMS-approved accreditation program.
488.7 Release and use of accreditation surveys.
488.8 Ongoing review of accrediting organizations.
488.9 Validation surveys.
Pt. 488

488.314 Survey teams.
488.318 Inadequate survey performance.
488.320 Sanctions for inadequate survey performance.
488.325 Disclosure of results of surveys and activities.
488.330 Certification of compliance or non-compliance.
488.331 Informal dispute resolution.
488.332 Investigation of complaints of violations and monitoring of compliance.
488.334 Educational programs.
488.335 Action on complaints of resident neglect and abuse, and misappropriation of resident property.

Subpart F—Enforcement of Compliance For Long-Term Care Facilities with Deficiencies

488.400 Statutory basis.
488.401 Definitions.
488.402 General provisions.
488.404 Factors to be considered in selecting remedies.
488.406 Available remedies.
488.408 Selection of remedies.
488.410 Action when there is immediate jeopardy.
488.412 Action when there is no immediate jeopardy.
488.414 Action when there is repeated sub-standard quality of care.
488.415 Temporary management.
488.417 Denial of payment for all new admissions.
488.419 Secretarial authority to deny all payments.
488.422 State monitoring.
488.424 Directed plan of correction.
488.426 Directed in-service training.
488.428 Transfer of residents, or closure of the facility and transfer of residents.
488.430 Civil money penalties: Basis for imposing penalty.
488.431 Civil money penalties imposed by CMS and independent informal dispute resolution: for SNFS, dually-participating SNF/NFs, and NF-only facilities.
488.432 Civil money penalties imposed by the State: NF-only.
488.433 Civil money penalties: Uses and approval of civil money penalties imposed by CMS.
488.434 Civil money penalties: Notice of penalty.
488.436 Civil money penalties: Waiver of hearing, reduction of penalty amount.
488.438 Civil money penalties: Amount of penalty.
488.440 Civil money penalties: Effective date and duration of penalty.
488.442 Civil money penalties: Due date for payment of penalty.
488.444 Civil money penalties: Settlement of penalties.

42 CFR Ch. IV (10–1–16 Edition)

488.446 Administrator sanctions: long-term care facility closures.
488.450 Continuation of payments to a facility with deficiencies.
488.452 State and Federal disagreements involving findings not in agreement in non-State operated NFs and dually participating facilities where there is no immediate jeopardy.
488.454 Duration of remedies.
488.456 Termination of provider agreement.

Subpart G [Reserved]

Subpart H—Termination of Medicare Coverage and Alternative Sanctions for End-Stage Renal Disease (ESRD) Facilities

488.604 Termination of Medicare coverage.
488.606 Alternative sanctions.
488.608 Notice of alternative sanction and appeal rights: Termination of coverage.

Subpart I—Survey and Certification of Home Health Agencies

488.700 Basis and scope.
488.705 Definitions.
488.710 Standard surveys.
488.715 Partial extended surveys.
488.720 Extended surveys.
488.725 Unannounced surveys.
488.730 Survey frequency and content.
488.735 Surveyor qualifications.
488.740 Certification of compliance or non-compliance.
488.745 Informal Dispute Resolution (IDR).

Subpart J—Alternative Sanctions for Home Health Agencies With Deficiencies

488.800 Statutory basis.
488.805 Definitions.
488.810 General provisions.
488.815 Factors to be considered in selecting sanctions.
488.820 Available sanctions.
488.825 Action when deficiencies pose immediate jeopardy.
488.830 Action when deficiencies are at the condition-level but do not pose immediate jeopardy.
488.835 Temporary management.
488.840 Suspension of payment for all new patient admissions.
488.845 Civil money penalties.
488.850 Directed plan of correction.
488.855 Directed in-service training.
488.860 Continuation of payments to an HHA with deficiencies.
488.865 Termination of provider agreement.

Authority: Secs. 1102, 1128i, 1864, 1865, 1871 and 1875 of the Social Security Act, unless otherwise noted (42 U.S.C 1395a, 1395bb, 1395h(b) and 1395ll).
Subpart A—General Provisions

§ 488.1 Definitions.

As used in this part—

Act means the Social Security Act.

Certification means a determination made by the state survey agency that providers and suppliers are in compliance with the applicable conditions of participation, conditions for coverage, conditions for certification, or requirements.

Conditions for certification means the health and safety standards RHCs must meet to participate in the Medicare program.

Conditions for coverage means the requirements suppliers must meet to participate in the Medicare program.

Conditions of participation means the requirements providers other than skilled nursing facilities must meet to participate in the Medicare program and includes conditions of certification for rural health clinics.

Deemed status means that CMS has certified a provider or supplier for Medicare participation, based on all of the following criteria having been met: The provider or supplier has voluntarily applied for, and received, accreditation from a CMS-approved national accrediting organization under the applicable Medicare accreditation program; the accrediting organization has recommended the provider or supplier to CMS for Medicare participation; CMS has accepted the accrediting organization’s recommendation; and CMS finds that all other participation requirements have been met.

Full review means a survey of a provider or supplier for compliance with all of the Medicare conditions or requirements applicable to that provider or supplier type.

Immediate jeopardy means a situation in which the provider’s or supplier’s non-compliance with one or more Medicare requirements, conditions of participation, conditions for coverage or certification has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident or patient.

Medicare condition means any condition of participation or for coverage, including any long term care requirements.

National accrediting organization means an organization that accredits provider entities, as that term is defined in section 1865(a)(4) of the Act, under a specific program and whose accredited provider entities under each program are widely located geographically across the United States.

Provider of services or provider refers to a hospital, critical access hospital, skilled nursing facility, nursing facility, home health agency, hospice, comprehensive outpatient rehabilitation facility, or a clinic, rehabilitation agency or public health agency that furnishes outpatient physical therapy or speech pathology services.

Rate of disparity means the percentage of all sample validation surveys for which a State survey agency finds non-compliance with one or more Medicare conditions and no comparable condition level deficiency was cited by the accreditation organization, where it is reasonable to conclude that the deficiencies were present at the time of the accreditation organization’s most recent surveys of providers or suppliers of the same type.

Example: Assume that during a validation review period State survey agencies perform validation surveys at 200 facilities of the same type (for example, ambulatory surgical centers, home health agencies) accredited by the same accreditation organization. The State survey agencies find 60 of the facilities out of compliance with one or more Medicare conditions, and it is reasonable to conclude that these deficiencies were present at the time of the most recent survey by an accreditation organization. The accreditation organization, however, has found deficiencies comparable to the condition level deficiencies at only 22 of the 60 facilities. These validation results would yield ((60-22)/200) a rate of disparity of 19 percent.

Reasonable assurance means that an accrediting organization has demonstrated to CMS’s satisfaction that its accreditation program requirements meet or exceed the Medicare program requirements.

State includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

State survey agency refers to the state health agency or other appropriate agency.
§ 488.2

State or local agency CMS uses to perform survey and review functions provided for in sections 1864, 1819(g), and 1919(g) of the Act.

Substantial allegation of non-compliance means a complaint from any of a variety of sources (such as patient, relative, or third party), including complaints submitted in person, by telephone, through written correspondence, or in newspaper or magazine articles, that would, if found to be present, adversely affect the health and safety of patients or residents and raises doubts as to a provider’s or supplier’s compliance with any Medicare condition of participation, condition for coverage, condition for certification, or requirements.

Supplier means any of the following: Independent laboratory; portable X-ray services; physical therapist in independent practice; ESRD facility; rural health clinic; Federally qualified health center; chiropractor; or ambulatory surgical center.

§ 488.3

Statutory basis.

This part is based on the indicated provisions of the following sections of the Act:

1128—Exclusion of entities from participation in Medicare.
1128A—Civil money penalties.
1128(b)—Requirements for organ procurement organizations and organ procurement agencies.
1814—Conditions for, and limitations on, payment for Part A services.
1819—Requirements for SNFs.
1820—Requirements for CAHs.
1832(a)(2)(C)—Requirements for Organizations that provide outpatient physical therapy and speech language pathology services.
1832(a)(2)(F)—Requirements for ASCs.
1832(a)(2)(J)—Requirements for partial hospitalization services provided by CMHCs.
1834(e)—1861, 1861, 1883, 1891, 1913 or 1919 of the Act.
1861(p)(4)—Requirements for rehabilitation agencies.
1861(z)—Institutional planning standards that hospitals and SNFs must meet.
1861(aa)—Requirements for RHCs and FQHCs.
1861(cc)(2)—Requirements for CORFs.
1861(dd)—Requirements for hospices.
1861(ee)—Discharge planning guidelines for hospitals.
1861(ff)(3)(A)—Requirements for CMHCs.
1861(ss)(2)—Accreditation of religious non-medical health care institutions.
1883—Consultation with state agencies, accrediting bodies, and other organizations to develop conditions of participation, conditions for coverage, conditions for certification, and requirements for providers or suppliers.
1884—Use of State survey agencies.
1885—Effect of accreditation.
1875(b)—Requirements for performance review of CMS-approved accreditation programs.
1880—Requirements for hospitals and SNFs of the Indian Health Service.
1881—Requirements for ESRD facilities.
1883—Requirements for hospitals that furnish extended care services.
1913—Conditions of participation for home health agencies; home health quality.
1912—Requirements for participation in the Medicaid program.
1919—Medicaid requirements for hospitals that provide NF care.
1919—Medicaid requirements for NFs.

§ 488.4

Conditions of participation, conditions for coverage, conditions for certification and long term care requirements.

(a) Basic rules. To be approved for participation in, or coverage under, the Medicare program, a prospective provider or supplier must meet the following:

(1) Meet the applicable statutory definitions in section 1138(b), 1819, 1820, 1832(a)(2)(C), 1832(a)(2)(F), 1832(a)(2)(J), 1834(e), 1861, 1883, 1891, 1913 or 1919 of the Act.

(2) Be in compliance with the applicable conditions, certification requirements, or long term care requirements prescribed in part 405 subparts U or X, part 410 subpart E, part 416, part 418 subpart C, parts 482 through 486, part 491 subpart A, or part 494 of this chapter.

(b) Special conditions. The Secretary shall consult with state agencies and
Centers for Medicare & Medicaid Services, HHS

§ 488.5 Application and re-application procedures for national accrediting organizations.

(a) Information submitted with application. A national accrediting organization applying to CMS for approval or re-approval of an accreditation program under §488.4 must furnish CMS with all of the following information and materials to demonstrate that the program provides reasonable assurance that the entities accredited under the program meet or exceed the applicable Medicare conditions or requirements. This information must include the following:

(1) Documentation that demonstrates the organization meets the definition of a “national accrediting organization” under §488.1 as it relates to the accreditation program.

(2) The type of provider or supplier accreditation program for which the organization is requesting approval or re-approval.

(3) A detailed crosswalk (in table format) that identifies, for each of the applicable Medicare conditions or requirements, the exact language of the organization’s comparable accreditation requirements and standards.

(4) A detailed description of the organization’s survey process to confirm that a provider or supplier meets or exceeds the Medicare program requirements. This description must include all of the following information:

(i) Frequency of surveys performed and an agreement by the organization to re-survey every accredited provider or supplier, through unannounced surveys, no later than 36 months after the prior accreditation effective date, including an explanation of how the accrediting organization will maintain the schedule it proposes. If there is a statutorily-mandated survey interval of less than 36 months, the organization must indicate how it will adhere to the statutory schedule.

(ii) Documentation demonstrating the comparability of the organization’s survey process and surveyor guidance to those required for state survey agencies conducting federal Medicare surveys for the same provider or supplier type, in accordance with the applicable

§ 488.4 General rules for a CMS-approved accreditation program for providers and suppliers.

(a) The following requirements apply when a national accrediting organization has applied for CMS approval of a provider or supplier accreditation program and CMS has found that the program provides reasonable assurance for providers or suppliers accredited under the program:

(1) When a provider or supplier demonstrates full compliance with all of the accreditation program requirements of the accrediting organization’s CMS-approved accreditation program, the accrediting organization may recommend that CMS grant deemed status to the provider or supplier.

(2) CMS may deem the provider or supplier, excluding kidney transplant centers within a hospital and ESRD facilities, to be in compliance with the applicable Medicare conditions or requirements. The deemed status provider or supplier is subject to validation surveys as provided at §488.9.

(b) [Reserved]

[80 FR 29835, May 22, 2015]
requirements or conditions of participation or conditions for coverage or certification.

(iii) Copies of the organization’s survey forms, guidelines, and instructions to surveyors.

(iv) Documentation demonstrating that the organization’s survey reports identify, for each finding of non-compliance with accreditation standards, the comparable Medicare CoPs, CfCs, conditions for certification, or requirements.

(v) Description of the organization’s accreditation survey review process.

(vi) Description of the organization’s procedures and timelines for notifying surveyed facilities of non-compliance with the accreditation program’s standards.

(vii) Description of the organization’s procedures and timelines for monitoring the provider’s or supplier’s correction of identified non-compliance with the accreditation program’s standards.

(viii) A statement acknowledging that, as a condition for CMS approval of a national accrediting organization’s accreditation program, the organization agrees to provide CMS with information extracted from each accreditation survey for a specified provider or supplier as part of its data submissions required under paragraph (a)(11)(ii) of this section, a copy of all survey reports and related information for applicants seeking initial participation in Medicare, and, upon request from CMS, a copy of the most recent accreditation survey for a specified provider or supplier, together with any other information related to the survey as CMS may require (including corrective action plans).

(ix) A statement acknowledging that the accrediting organization will provide timely notification to CMS when an accreditation survey or complaint investigation identifies an immediate jeopardy as that term is defined at §489.3 of this chapter. Using the format specified by CMS, the accrediting organization must notify CMS within two business days from the date the accrediting organization identifies the immediate jeopardy.

(5) The criteria for determining the size and composition of the organization’s survey teams for the type of provider or supplier to be accredited, including variations in team size and composition for individual provider or supplier surveys.

(6) The overall adequacy of the number of the organization’s surveyors, including how the organization will increase the size of the survey staff to match growth in the number of accredited facilities while maintaining re-accreditation intervals for existing accredited facilities.

(7) A description of the education and experience requirements surveyors must meet.

(8) A description of the content and frequency of the organization’s in-service training it provides to survey personnel.

(9) A description of the organization’s evaluation systems used to monitor the performance of individual surveyors and survey teams.

(10) The organization’s policies and procedures to avoid conflicts of interest, including the appearance of conflicts of interest, involving individuals who conduct surveys or participate in accreditation decisions.

(11) A description of the organization’s data management and analysis system for its surveys and accreditation decisions, including all of the following:

(i) A detailed description of how the organization uses its data to assure the compliance of its accreditation program with the Medicare program requirements.

(ii) A statement acknowledging that the organization agrees to submit timely, accurate, and complete data to support CMS’s evaluation of the accrediting organization’s performance. Data to be submitted includes, but is not limited to, accredited provider or supplier identifying information, survey schedules, survey findings, and notices of accreditation decisions. The organization must submit necessary data according to the instructions and timeframes CMS specifies.
(12) The organization’s procedures for responding to, and investigating, complaints against accredited facilities, including policies and procedures regarding referrals when applicable to appropriate licensing bodies and ombudsman programs.

(13) The organization’s accreditation status decision-making process, including its policies and procedures for granting, withholding, or removing accreditation status for facilities that fail to meet the accrediting organization’s standards or requirements, assignment of less than full accreditation status or other actions taken by the organization in response to non-compliance with its standards and requirements. The organization must furnish the following:

(i) A description of all types and categories of accreditation decisions associated with the program for which approval is sought, including the duration of each.

(ii) A statement acknowledging that the organization agrees to notify CMS (in a manner CMS specifies) of any decision to revoke, withdraw, or revise the accreditation status of a specific deemed status provider or supplier, within three business days from the date the organization takes an action.

(14) A list of all facilities currently accredited by the organization under the program for which CMS approval is sought, including the type and category of accreditation currently held by each provider or supplier, and the expiration date of each provider’s or supplier’s current accreditation.

(15) A schedule of all surveys expected to be conducted by the organization for the accreditation program under review during the 6-month period following submission of the application.

(16) The three most recent audited financial statements of the organization that demonstrate that the organization’s staffing, funding, and other resources are adequate to perform the required surveys and related activities.

(17) A statement that it will:

(i) Provide written notification to CMS and to all providers or suppliers accredited under a CMS-approved accreditation program at least 90 calendar days in advance of the effective date of a decision by the organization to voluntarily terminate its CMS-approved accreditation program, including the implications for their deemed status in accordance with §488.8(g)(2); and

(ii) Adhere to the requirements for written notice to its accredited providers or suppliers at §488.8(e) in the case of an involuntary termination.

(18) A statement that it will provide written notification to CMS of any proposed changes in the organization’s CMS-approved accreditation program and that it agrees not to implement the proposed changes without prior written notice of continued program approval from CMS except as provided for at §488.8(b)(2).

(19) A statement that, in response to a written notice from CMS to the organization of a change in the applicable conditions or requirements or in the survey process, the organization will provide CMS with proposed corresponding changes in the organization’s requirements for its CMS-approved accreditation program to ensure continued comparability with the CMS conditions or requirements or survey process. The organization must comply with the following requirements:

(i) The proposed changes must be submitted within 30 calendar days of the date of the written CMS notice to the organization or by a date specified in the notice, whichever is later. CMS will give due consideration to an organization’s request for an extension of the deadline.

(ii) The proposed changes will not be implemented without prior written notice of continued program approval from CMS, except as provided for at §488.8(b)(1)(iv).

(20) A statement acknowledging that, as a condition for CMS’s approval of an accreditation program, the organization will agree to permit its surveyors to serve as witnesses in a legal proceeding if CMS takes an adverse action against a provider or supplier on the basis of the organization’s accreditation survey findings, and will cooperate with CMS to make surveyors and other staff available when needed.
(b) Additional information needed. If CMS determines that additional information is necessary to make a determination for approval or denial of the organization’s initial application or reapplication for CMS’s approval of an accreditation program, CMS will notify the organization and afford it an opportunity to provide the additional information.

(c)(1) Withdrawing an application. An accrediting organization may withdraw its initial application for CMS’s approval of its accreditation program at any time before CMS publishes the final notice described in paragraph (e)(2) of this section.

(2) Voluntary termination of a CMS-approved accreditation program. An accrediting organization may voluntarily terminate its CMS-approved accreditation program at any time. The accrediting organization must notify CMS of its decision to voluntarily terminate its approved accreditation program at least 90 calendar days in advance of the effective date of the termination. In accordance with the requirement at §488.4(a)(17)(i), the accrediting organization must also provide written notice at least 90 days in advance of the effective date of the termination to each of its deemed status providers or suppliers.

(d) Re-submitting a request. (1) Except as provided in paragraph (d)(2) of this section, an organization whose request for CMS’s approval or re-approval of an accreditation program has been denied may resubmit its application if the organization satisfies all of the following requirements:

(i) Revises its accreditation program to address the issues related to the denial of its previous request.

(ii) Demonstrates that it can provide reasonable assurance.

(iii) Resubmits the application in its entirety.

(2) If an accrediting organization has requested, in accordance with subpart D of this part, a reconsideration of CMS’s determination that its request for approval of an accreditation program is denied, it may not submit a new application for approval of an accreditation program for the type of provider or supplier at issue in the reconsideration until the reconsideration is administratively final.

(e) Public notice and comment. CMS publishes a notice in the Federal Register when the following conditions are met:

(1) Proposed notice. When CMS receives a complete application from a national accrediting organization seeking CMS’s approval of an accreditation program, it publishes a proposed notice. The proposed notice identifies the organization and the type of providers or suppliers to be covered by the accreditation program and provides 30 calendar days for the public to submit comments to CMS.

(2) Final notice. When CMS decides to approve or disapprove a national accrediting organization’s application, it publishes a final notice within 210 calendar days from the date CMS determines the AO’s applications was complete, unless the application was for a skilled nursing facility accreditation program. There is no timeframe for publication of a final notice for a national accrediting organization’s application for approval of a skilled nursing facility accreditation program. The final notice specifies the basis for the CMS decision.

(i) Approval or re-approval. If CMS approves or re-approves the accrediting organization’s accreditation program, the final notices describes how the accreditation program provides reasonable assurance. The final notice specifies the effective date and term of the approval (which may not be later than the publication date of the notice and which will not exceed 6 years).

(ii) Disapproval. If CMS does not approve the accrediting organization’s accreditation program, the final notice describes, except in the case of a skilled nursing facility accreditation program, how the organization fails to provide reasonable assurance. In the case of an application for a skilled nursing facility accreditation program, disapproval may be based on the program’s failure to provide reasonable assurance, or on CMS’s decision to exercise its discretion in accordance with section 1865(a)(1)(B) of the Act. The final notice specifies the effective date of the decision.

[80 FR 29835, May 22, 2015]
§ 488.6 Providers or suppliers that participate in the Medicaid program under a CMS-approved accreditation program.

A provider or supplier that has been granted “deemed status” by CMS by virtue of its accreditation from a CMS-approved accreditation program is eligible to participate in the Medicaid program if they are not required under Medicaid regulations to comply with any requirements other than Medicare participation requirements.

[80 FR 29837, May 22, 2015]

§ 488.7 Release and use of accreditation surveys.

A Medicare participating provider or supplier deemed to meet program requirements in accordance with § 488.4 must authorize its accrediting organization to release to CMS a copy of its most current accreditation survey and any information related to the survey that CMS may require (including, but not limited to, corrective action plans).

(a) CMS may determine that a provider or supplier does not meet the applicable Medicare conditions or requirements on the basis of its own investigation of the accreditation survey or any other information related to the survey.

(b) With the exception of home health agency surveys, general disclosure of an accrediting organization’s survey information is prohibited under section 1865(b) of the Act. CMS may publicly disclose an accreditation survey and information related to the survey, upon written request, to the extent that the accreditation survey and survey information are related to an enforcement action taken by CMS.

[80 FR 29837, May 22, 2015]

§ 488.8 Ongoing review of accrediting organizations.

(a) Performance review. In accordance with section 1875(b) of the Act, CMS evaluates the performance of each CMS-approved accreditation program on an ongoing basis. This review includes, but is not limited to the following:

(1) Review of the organization’s survey activity.

(2) Analysis of the results of the validation surveys under §488.9(a)(1), including the rate of disparity between certifications of the accrediting organization and certifications of the SA.

(3) Review of the organization’s continued fulfillment of the requirements in §488.5(a).

(b) Comparability review. CMS assesses the equivalency of an accrediting organization’s CMS-approved program requirements to the comparable Medicare requirements if the following conditions exist:

(1) CMS imposes new Medicare certification requirements or changes its survey process.

(ii) CMS specifies in its written notice a timeframe, not less than 30 calendar days from the date of the notice, for the accrediting organization to submit its proposed equivalent changes, including its implementation timeframe, for CMS review. CMS may extend the deadline after due consideration of a written request for extension by the accrediting organization submitted prior to the original deadline.

(iii) After completing the comparability review CMS provides written notification to the organization whether or not the accreditation program, including the proposed revisions and implementation timeframe, continues to meet or exceed all applicable Medicare requirements.

(iv) If, no later than 60 calendar days after receipt of the organization’s proposed changes, CMS does not provide the written notice to the organization required in paragraph (b)(1)(ii) of this section, then the revised program will be deemed to meet or exceed all applicable Medicare requirements and to have continued CMS approval.

(v) If an organization fails to submit its proposed changes within the required timeframe, or fails to implement the proposed changes that have been determined by CMS or deemed to be comparable, CMS may open an accreditation program review in accordance with paragraph (c) of this section.

(2) An accrediting organization proposes to adopt new requirements or to change its survey process.
(i) An accrediting organization must provide written notice to CMS of any proposed changes in its accreditation requirements or survey process and must not implement any changes before receiving CMS’s approval, except as provided below.

(ii) If, no later than 60 calendar days after receipt of the organization’s proposed changes, CMS does not provide written notice to the organization that the accreditation program, including the proposed revisions, continues or does not continue to meet or exceed all applicable Medicare requirements, then the revised program will be deemed to meet or exceed all applicable Medicare requirements and to have continued CMS approval.

(iii) If an organization implements changes that have neither been determined by CMS nor deemed to be comparable to the applicable Medicare requirements, CMS may open an accreditation program review in accordance with paragraph (c) of this section.

(c) CMS-approved accreditation program review. If a comparability or performance review reveals evidence of substantial non-compliance of an accrediting organization’s CMS-approved accreditation program with the requirements of this subpart, CMS may initiate an accreditation program review.

(1) If an accreditation program review is initiated, CMS provides written notice to the organization indicating that its CMS-approved accreditation program approval may be in jeopardy and that an accreditation program review is being initiated. The notice provides all of the following information:

(i) A statement of the instances, rates or patterns of non-compliance identified, as well as other related information, if applicable.

(ii) A description of the process to be followed during the review, including a description of the opportunities for the accrediting organization to offer factual information related to CMS’s findings.

(iii) A description of the possible actions that may be imposed by CMS based on the findings of the accreditation program review.

(iv) The actions the accrediting organization must take to address the identified deficiencies including a timeline for implementation not to exceed 180 calendar days after receipt of the notice that CMS is initiating an accreditation program review.

(2) CMS reviews the accrediting organization’s plan of correction for acceptability.

(3) If CMS determines as a result of the accreditation program review or a review of an application for renewal of an existing CMS-approved accreditation program that the accrediting organization has failed to meet any of the requirements of this subpart, CMS may place the accrediting organization’s CMS-approved accreditation program on probation for a period up to 180 calendar days to implement corrective actions, not to exceed the accrediting organization’s current term of approval. In the case of a renewal application where CMS has placed the accreditation program on probation, CMS indicates that any approval of the application is conditional while the program is placed on probation.

(i) Within 60 calendar days after the end of any probationary period, CMS issues a written determination to the accrediting organization as to whether or not a CMS-approved accreditation program continues to meet the requirements of this subpart, including the reasons for the determination.

(ii) If CMS has determined that the accrediting organization does not meet the requirements, CMS withdraws approval of the CMS-approved accreditation program. The notice of determination provided to the accrediting organization includes notice of the removal of approval, reason for the removal, including the effective date determined in accordance with paragraph (c)(3)(iii) of this section.

(iii) CMS publishes in the FEDERAL REGISTER a notice of its decision to withdraw approval of a CMS-approved accreditation program, including the reasons for the withdrawal, effective 60 calendar days from the date of publication of the notice.

(d) Immediate jeopardy. If at any time CMS determines that the continued approval of a CMS-approved accreditation program of any accrediting organization poses an immediate jeopardy
§ 488.9 Validation surveys.

(a) Basis for survey. CMS may require a survey of an accredited provider or supplier to validate the accrediting organization’s CMS-approved accreditation process. These surveys are conducted on a representative sample basis, or in response to substantial allegations of non-compliance.

(1) For a representative sample, the survey may be comprehensive and address all Medicare conditions or requirements, or it may be focused on a specific condition(s) as determined by CMS.
(2) For a substantial allegation of noncompliance, the SA surveys for any condition(s) or requirement(s) that CMS determines is related to the allegations.

(b) Selection for survey. (1) A provider or supplier selected for a validation survey must cooperate with the SA that performs the validation survey.

(2) If a provider or supplier selected for a validation survey fails to cooperate with the SA, it will no longer be deemed to meet the Medicare conditions or requirements, but will be subject to a review by the SA in accordance with §488.10(a), and may be subject to termination of its provider agreement under §489.53 of this chapter.

(c) Consequences of a finding of noncompliance. (1) If a CMS validation survey results in a finding that the provider or supplier is out of compliance with one or more Medicare conditions or requirements, the provider or supplier will no longer be deemed to meet the Medicare conditions or requirements and will be subject to ongoing review by the SA in accordance with §488.10(a) until the provider or supplier demonstrates compliance.

(2) CMS may take actions for the deficiencies identified in the state validation survey in accordance with §488.24, or may first direct the SA to conduct another survey of the provider's or supplier's compliance with specified Medicare conditions or requirements before taking the enforcement actions provided for at §488.24.

(3) If CMS determines that a provider or supplier is not in compliance with applicable Medicare conditions or requirements, the provider or supplier may be subject to termination of the provider or supplier agreement under §489.53 of this chapter or of the supplier agreement in accordance with the applicable supplier conditions and any other applicable intermediate sanctions and remedies.

(d) Re-instating deemed status. An accredited provider or supplier will be deemed to meet the applicable Medicare conditions or requirements in accordance with this section if all of the following requirements are met:

(1) It withdraws any prior refusal to authorize its accrediting organization to release a copy of the provider's or supplier's current accreditation survey.

(2) It withdraws any prior refusal to allow a validation survey, if applicable.

(3) CMS finds that the provider or supplier meets all applicable Medicare CoP, CoC, conditions of certification, or requirements.

(e) Impact of adverse actions. The existence of any performance review, comparability review, deemed status review, probationary period, or any other action by CMS, does not affect or limit conducting any validation survey.

§ 488.10 State survey agency review: Statutory provisions.

(a) Section 1864(a) of the Act requires the Secretary to enter into an agreement with any State that is able and willing to do so, under which appropriate State or local survey agencies will determine whether:

(1) Providers or prospective providers meet the Medicare conditions of participation or requirements (for SNFs and NFs);

(2) Suppliers meet the conditions for coverage; and

(3) Rural health clinics meet the conditions of certification.

(b) Section 1865(a) of the Act provides that if an institution is accredited by a national accrediting organization recognized by the Secretary, it may be deemed to have met the applicable conditions or requirements.

(c) Section 1864(c) of the Act authorizes the Secretary to enter into agreements with state survey agencies for the purpose of conducting validation surveys in institutions accredited by an accreditation program recognized by the Secretary.

(d) Section 1865(c) provides that an accredited institution that is found after a validation survey to have significant deficiencies related to health and safety of patients will no longer meet the applicable conditions or requirements.

[80 FR 29839, May 22, 2015]
§ 488.11 State survey agency functions.

State and local agencies that have agreements under section 1864(a) of the Act perform the following functions:

(a) Survey and make recommendations regarding the issues listed in § 488.10.

(b) Conduct validation surveys of deemed status providers and suppliers as provided in § 488.9.

(c) Perform other surveys and carry out other appropriate activities and certify their findings to CMS.

(d) Make recommendations regarding the effective dates of provider agreements and supplier approvals in accordance with § 489.13 of this chapter.


§ 488.12 Effect of survey agency certification.

Certifications by the State survey agency represent recommendations to CMS.

(a) On the basis of these recommendations, CMS will determine whether:

(1) A provider or supplier is eligible to participate in or be covered under the Medicare program; or

(2) A provider or supplier accredited under a CMS-approved accreditation program remains deemed to meet the Medicare conditions or requirements, or will be placed under the jurisdiction of the SA and subject to further enforcement actions in accordance with the provisions at § 489.9.

(b) Notice of CMS’s determination will be sent to the provider or supplier.

[53 FR 22859, June 17, 1988, as amended at 80 FR 29839, May 22, 2015]

§ 488.13 Loss of accreditation.

If an accrediting organization notifies CMS that it is terminating a provider or supplier due to non-compliance with its CMS-approved accreditation requirements, the SA will conduct a full review in a timely manner.

[80 FR 29839, May 22, 2015]

§ 488.14 Effect of QIO review.

When a QIO is conducting review activities under section 1154 of the Act and part 466 of this chapter, its activities are in lieu of the utilization review and evaluation activities required of health care institutions under sections 1861(e)(6), and 1861(k) of the Act.

[59 FR 56237, Nov. 10, 1994]

§ 488.18 Documentation of findings.

(a) The findings of the State agency with respect to each of the conditions of participation, requirements (for SNFs and NFs), or conditions for coverage must be adequately documented. When the State agency certifies to the Secretary that a provider or supplier is not in compliance with the conditions or requirements (for SNFs and NFs), and therefore not eligible to participate in the program, such documentation includes, in addition to the description of the specific deficiencies which resulted in the agency’s recommendation, any provider or supplier response.

(b) If a provider or supplier is certified by the State agency as in compliance with the conditions or participation requirements (for SNFs and NFs) or as meeting the requirements for special certification (see § 488.54), with deficiencies not adversely affecting the health and safety of patients, the following information will be incorporated into the finding:

(1) A statement of the deficiencies that were found.

(2) A description of further action that is required to remove the deficiencies.

(3) A time-phased plan of correction developed by the provider and supplier and concurred with by the State agency.

(4) A scheduled time for a resurvey of the institution or agency to be conducted by the State agency within 90 days following the completion of the survey.

(c) If, on the basis of the State certification, the Secretary determines that the provider or supplier is eligible to participate, the information described in paragraph (b) of this section will be incorporated into a notice of eligibility to the provider or supplier.

(d) If the State agency receives information to the effect that a hospital or a critical access hospital (as defined in section 1861(mm)(1) of the Act) has violated § 489.24 of this chapter, the State
§ 488.20 Periodic review of compliance and approval.

(a) Determinations by CMS to the effect that a provider or supplier is in compliance with the conditions of participation, or requirements (for SNFs and NFs), or the conditions for coverage are made as often as CMS deems necessary and may be more or less than a 12-month period, except for SNFs, NFs and HHAs. (See §488.30 for special rules for SNFs and NFs.)

(b) The responsibilities of State survey agencies in the review and certification of compliance are as follows:

(1) Resurvey providers or suppliers as frequently as necessary to ascertain compliance and confirm the correction of deficiencies;

(2) Review reports prepared by a Professional Standards Review Organization (authorized under Part B Title XI of the Act) or a State inspection of care team (authorized under Title XIX of the Act) regarding the quality of a facility’s care;

(3) Evaluate reports that may pertain to the health and safety of patients; and

(4) Take appropriate actions that may be necessary to achieve compliance or certify noncompliance to CMS.

(c) A State survey agency certification to CMS that a provider or supplier is no longer in compliance with the conditions of participation or requirements (for SNFs and NFs) or conditions for coverage will supersede the State survey agency’s previous certification.


EFFECTIVE DATE NOTE: At 59 FR 32120, June 22, 1994, in §488.18, paragraph (d) was added. The amendment contains information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

§ 488.24 Certification of noncompliance.

(a) Special rules for certification of noncompliance for SNFs and NFs are set forth in §488.330.

(b) The State agency will certify that a provider or supplier is not or is no longer in compliance with the conditions of participation or conditions for coverage where the deficiencies are of such character as to substantially limit the provider’s or supplier’s capacity to furnish adequate care or which adversely affect the health and safety of patients; or

(c) If CMS determines that an institution or agency does not qualify for participation or coverage because it is not in compliance with the conditions of participation or conditions for coverage, or if a provider’s agreement is terminated for that reason, the institution or agency has the right to request that the determination be reviewed.

(Apppeals procedures are set forth in part 498 of this chapter.)

(59 FR 56237, Nov. 10, 1994)

§ 488.26 Determining compliance.

(a) Additional rules for certification of compliance for SNFs and NFs are set forth in §488.330.

(b) The decision as to whether there is compliance with a particular requirement, condition of participation, or condition for coverage depends upon the manner and degree to which the provider or supplier satisfies the various standards within each condition. Evaluation of a provider’s or supplier’s performance against these standards enables the State survey agency to document the nature and extent of deficiencies, if any, with respect to a particular function, and to assess the need for improvement in relation to the prescribed conditions.
§ 488.30 Revisit user fee for revisit surveys.

(a) Definitions. As used in this section, the following definitions apply:

Certification (both initial and recertification) means those activities as defined in §488.1.

Complaint surveys means those surveys conducted on the basis of a substantial allegation of noncompliance, as defined in §488.1.

Provider of services, provider, or supplier has the meaning defined in §488.1, and ambulatory surgical centers, transplant centers, and religious nonmedical health care institutions subject to §§418.2, 482.70, and 403.702 [C8] of this chapter, respectively, will be subject to user fees unless otherwise exempted.

Revisit survey means a survey performed with respect to a provider or supplier cited for deficiencies during an initial certification, recertification, or
§488.30 42 CFR Ch. IV (10–1–16 Edition)

substantiated complaint survey and that is designed to evaluate the extent to which previously-cited deficiencies have been corrected and the provider or supplier is in substantial compliance with applicable conditions of participation, requirements, or conditions for coverage. Revisit surveys include both offsite and onsite review.

Substantiated complaint survey means a complaint survey that results in the proof or finding of noncompliance at the time of the survey, a finding that noncompliance was proven to exist, but was corrected prior to the survey, and includes any deficiency that is cited during a complaint survey, whether or not the cited deficiency was the original subject of the complaint.

(b) Criteria for determining the fee. (1) The provider or supplier will be assessed a revisit user fee based upon one or more of the following:

(i) The average cost per provider or supplier type.

(ii) The type of revisit survey conducted (onsite or offsite).

(iii) The size of the provider or supplier.

(iv) The number of follow-up revisits resulting from uncorrected deficiencies.

(v) The seriousness and number of deficiencies.

(2) CMS may adjust the fees to account for any regional differences in cost.

(c) Fee schedule. CMS must publish in the Federal Register the proposed and final notices of a uniform fee schedule before it assesses revised revisit user fees. The notices must set forth which criteria will be used and how, as well as the amounts of the assessed fees based on the criteria as identified in paragraph (b) of this subpart.

(d) Collection of fees. (1) Fees for revisit surveys under this section may be deducted from amounts otherwise payable to the provider or supplier. As they are collected, fees will be deposited as an offset collection to be used exclusively for survey and certification activities conducted by State survey agencies pursuant to section 1864 of the Act or by CMS, and will be available for CMS until expended. CMS may devise other collection methods as it deems appropriate. In determining these methods, CMS will consider efficiency, effectiveness, and convenience for the providers, suppliers, and CMS. CMS may consider any method allowed by law, including: Credit card; electronic fund transfer; check; money order; and offset collections from claims submitted.

(2) Fees for revisit surveys under this section are not allowable items on a cost report, as identified in part 413, subpart B of this chapter, under title XVIII of the Act.

(3) Fees for revisit surveys will be due for any revisit surveys conducted during the time period for which authority to levy a revisit user fee exists.

(e) Reconsideration process for revisit user fees. (1) CMS will review a request for reconsideration of an assessed revisit user fee—

(i) If a provider or supplier believes an error of fact has been made in the application of the revisit user fee, such as clerical errors, billing for a fee already paid, or assessment of a fee when there was no revisit conducted, and

(ii) If the request for reconsideration is received by CMS within 14 calendar days from the date identified on the revisit user fee assessment notice.

(2) CMS will issue a credit toward any future revisit surveys conducted, if the provider or supplier has remitted an assessed revisit user fee and for which a reconsideration request is found in favor of the provider or supplier. If in the event that CMS judges that a significant amount of time has elapsed before such a credit is used, CMS will refund the assessed revisit user fee amount paid to the provider or supplier.

(3) CMS will not reconsider the assessment of revisit user fees that request reconsideration of the survey findings or deficiency citations that may have given rise to the revisit, the revisit findings, the need for the revisit itself, or other similarly identified basis for the assessment of the revisit user fee.

(f) Enforcement. If the full revisit user fee payment is not received within 30 calendar days from the date identified on the revisit user fee assessment notice, CMS may terminate the facility's provider agreement (pursuant to
Subpart B—Special Requirements

§ 488.52 Temporary waivers applicable to hospitals.

(a) General provisions. If a hospital is found to be out of compliance with one or more conditions of participation for hospitals, as specified in part 482 of this chapter, a temporary waiver may be granted by CMS. CMS may extend a temporary waiver only if such a waiver would not jeopardize or adversely affect the health and safety of patients. The waiver may be issued for any one year period or less under certain circumstances. The waiver may be withdrawn earlier if CMS determines this action is necessary to protect the health and safety of patients. A waiver may be granted only if:

1. The hospital is located in a rural area. This includes all areas not delineated as “urban” by the Bureau of the Census, based on the most recent census;
2. The hospital has 50 or fewer inpatient hospital beds;
3. The character and seriousness of the deficiencies do not adversely affect the health and safety of patients; and
4. The hospital has made and continues to make a good faith effort to comply with personnel requirements consistent with any waiver.

(b) Minimum compliance requirements. Each case will have to be decided on its individual merits, and while the degree and extent of compliance will vary, the institution must, as a minimum, meet all of the statutory conditions in section 1861(e)(1)–(8), in addition to meeting such other requirements as the Secretary finds necessary under section 1861(e)(9). (For further information relating to the exception in section 1861(e)(5) of the Act, see paragraph (c) of this section.)

§ 488.54 Temporary waiver of 24-hour nursing requirement.

CMS may waive the requirement contained in section 1861(e)(5) that a hospital must provide 24-hour nursing service furnished or supervised by a registered nurse. Such a waiver may be granted when the following criteria are met:

1. The hospital’s failure to comply fully with the 24-hour nursing requirement is attributable to a temporary shortage of qualified nursing personnel in the area in which the hospital is located.
2. A registered nurse is present on the premises to furnish or supervise the nursing services during at least the daytime shift, 7 days a week.
3. The hospital has in charge, on all tours of duty not covered by a registered nurse, a licensed practical (vocational) nurse.
4. The hospital complies with all requirements specified in paragraph (a) of this section.

§ 488.56 Temporary waivers applicable to skilled nursing facilities.

(a) Waiver of 7-day registered nurse requirement. To the extent that § 483.30 of this chapter requires any skilled nursing facility to engage the services of a registered nurse more than 40 hours a week, the Secretary may waive such requirement for such periods as he
§ 488.60 Special procedures for approving end stage renal disease facilities.

(a) Consideration for approval. An ESRD facility that wishes to be approved or that wishes an expansion of dialysis services to be approved for coverage, in accordance with part 494 of this chapter, must secure a determination by the Secretary. To secure a determination, the facility must submit the following documents and data for consideration by the Secretary:

(1) Certification by the State agency referred to in §488.12 of this part.

(2) Data furnished by ESRD network organizations and recommendations of the Public Health Service concerning the facility’s contribution to the ESRD services of the network.

(3) Data concerning the facility’s compliance with professional norms and standards.

(4) Data pertaining to the facility’s qualifications for approval or for any expansion of services.

(b) Waiver of medical director requirement. To the extent that §488.75(i) of this chapter requires any skilled nursing facility to engage the services of a medical director either part-time or full-time, the Secretary may waive such requirement for such periods as he deems appropriate if, based upon documented findings of the State agency, he determines that:

(1) Such facility is located in an area where the supply of physicians is not sufficient to permit compliance with this requirement without seriously reducing the availability of physician services within the area, and

(2) Such facility has made and continues to make a good faith effort to comply with §488.75(i) of this chapter, but such compliance is impeded by the unavailability of physicians in the area.

Centers for Medicare & Medicaid Services, HHS § 488.61

granted, and may be renewed on an annual basis, under circumstances where rigid application of minimal utilization rate requirements would adversely affect the achievement of ESRD program objectives.

c) New applicant. A facility which has not previously participated in the ESRD program must submit a plan detailing how it expects to meet the conditional minimal utilization rate status by the end of the second calendar year of its operation under the program and meet the unconditional minimal utilization rate status by the end of the fourth calendar year of its operation under the program.

d) Notification. The Secretary will notify each facility and its network coordinating council of its initial and its subsequent minimal utilization rate classification.

e) Failure to meet minimal utilization rate. A facility failing to meet standards for unconditional status or conditional status, or if applicable, for exception status, will be so notified at the time of such classification.

(f) Interim regulations participant. A facility previously participating under the interim regulations will not be approved under the program established by subpart U until it has demonstrated that it meets all the applicable requirements of this subpart, including the appropriate minimal utilization rate. It may continue under the interim program only for a period not to exceed 1 year from the effective date of these amendments (see § 405.2100(c) of this chapter). During this period it may demonstrate its ability to meet the appropriate minimal utilization rate. Failure to qualify under this subpart will automatically terminate coverage of such facility’s services under the ESRD program at the end of such year.

§ 488.61 Special procedures for approval and re-approval of organ transplant centers.

For the purposes of this subpart, the survey, certification, and enforcement procedures described at 42 CFR part 488, subpart A apply to transplant centers, including the periodic review of compliance and approval described at § 488.20.

(a) Initial approval procedures for transplant centers that are not Medicare-approved as of June 28, 2007. A transplant center, including a kidney transplant center, may submit a request to CMS for Medicare approval at any time.

(1) The request, signed by a person authorized to represent the center (for example, a chief executive officer), must include:

(i) The hospital’s Medicare provider I.D. number;

(ii) Name(s) of the designated primary transplant surgeon and primary transplant physician; and,

(iii) A statement from the OPTN that the center has complied with all data submission requirements.

(2) To determine compliance with the clinical experience and outcome requirements at §§ 482.80(b) and 482.80(c), CMS will review the data contained in the most recent OPTN Data Report and 1-year patient and graft survival data contained in the most recent Scientific Registry of Transplant Beneficiary (SRTR) center-specific report.

(3) If CMS determines that a transplant center has not met the data submission, clinical experience, or outcome requirements, CMS may deny the request for approval or may review the center’s compliance with the conditions of participation at §§ 482.72 through 482.76 and §§ 482.104 of this chapter, using the procedures described at 42 CFR part 488, subpart A, to determine whether the center’s request will be approved. CMS will notify the transplant center in writing whether it is approved and, if approved, of the effective date of its approval.

(4) CMS will consider mitigating factors in accordance with paragraphs (f), (g), and (h) of this section.

(5) If CMS determines that a transplant center has met the data submission, clinical experience, and outcome requirements, CMS will review the center’s compliance with the conditions of participation contained at §§ 482.72 through 482.76 and §§ 482.90 through
488.61 of this chapter using the procedures described at 42 CFR part 488, subpart A. If the transplant center is found to be in compliance with all the conditions of participation at §§ 482.72 through 482.104, except for § 482.82 of this chapter (Re-approval Requirements), CMS will notify the transplant center in writing of the effective date of its Medicare approval. CMS will notify the transplant center in writing if it is not Medicare-approved.

(6) A kidney transplant center may submit a request for initial approval after performing at least 3 transplants over a 12-month period.

(b) Initial approval procedures for transplant centers, including kidney transplant centers, that are Medicare approved as of June 28, 2007. (1) A transplant center that wants to continue to be Medicare approved must be in compliance with the conditions of participation at §§ 482.72 through 482.104 as of June 28, 2007 and submit a request to CMS for Medicare approval under the conditions of participation no later than December 26, 2007, using the process described in paragraph (a)(1) of the section.

(2) CMS will determine whether to approve the transplant center, using the procedures described in paragraphs (a)(2) through (a)(5) of this section. Until CMS makes a determination whether to approve the transplant center under the conditions of participation at §§ 482.72 through 482.104 as of June 28, 2007 and submit a request to CMS for Medicare approval under the conditions of participation no later than December 26, 2007, using the process described in paragraph (a)(1) of the section, the transplant center will continue to be Medicare approved under the end stage renal disease (ESRD) conditions for coverage (CfCs) in part 405, subpart U of this chapter for kidney transplant centers or the pertinent national coverage decisions (NCDs) for extra-renal organ transplant centers, as applicable, and the transplant center will continue to be reimbursed for services provided to Medicare beneficiaries. CMS will notify the transplant center in writing of the effective date of its loss of Medicare approval.

(4) If a transplant center that is Medicare approved as of June 28, 2007 submits a request for approval under the CoPs at §§ 482.72 through 482.104 of this chapter but CMS does not approve the transplant center, or if the transplant center does not submit its request to CMS for Medicare approval under the CoPs by December 26, 2007, CMS will revoke the transplant center’s approval under the conditions for coverage for kidney transplant centers or the national coverage decisions for extra-renal transplant centers, as applicable, and the transplant center will no longer be reimbursed for services provided to Medicare beneficiaries. CMS will notify the transplant center in writing of the effective date of its revocation.

(c) Re-approval procedures. Once Medicare-approved, transplant centers, including kidney transplant centers, must be in continuous compliance with all the conditions of participation for transplant centers at §§ 482.72 through 482.104 of this chapter, except for § 482.80 (initial approval requirements).

(1) CMS will review the transplant center’s data on an on-going basis and in making re-approval determinations.

(i) To determine compliance with the data submission requirements at § 482.82(a) of this chapter, CMS will request data submission data from the OPTN for the previous 3 calendar years.

(ii) To determine compliance with the clinical experience and outcome requirements at § 482.82(b) and (c) of this chapter, CMS will review the data contained in the most recent OPTN Data Report for the previous 3 years and 1-year patient and graft survival data contained in the most recent SRTR center-specific reports.

(2) CMS may choose to review the transplant center for compliance with §§ 482.72 through 482.76 and 482.90 through 482.104 of this chapter, using the procedures described at 42 CFR part 488, subpart A.

(3) CMS will consider mitigating factors in accordance with paragraphs (f), (g), and (h) of this section.

(4) CMS will notify the transplant center in writing if its approval is being revoked and of the effective date of the revocation.
(d) Loss of Medicare Approval. Centers that have lost their Medicare approval may seek re-entry into the Medicare program at any time. A center that has lost its Medicare approval must:

(1) Request initial approval using the procedures described in §488.61(a);

(2) Be in compliance with §§482.72 through 482.104 of this chapter, except for §482.82 (Re-approval Requirements), at the time of the request for Medicare approval; and

(3) Submit a report to CMS documenting any changes or corrective actions taken by the center as a result of the loss of its Medicare approval status.

(e) Transplant Center Inactivity. A transplant center may remain inactive and retain its Medicare approval for a period not to exceed 12 months. A transplant center must notify CMS upon its voluntary inactivation as required by §482.74(a)(3) of this chapter.

(f) Consideration of mitigating factors in initial approval and re-approval survey, certification, and enforcement actions for transplant centers—(1) Factors. Except for situations of immediate jeopardy or deficiencies other than failure to meet requirements of §488.80 or §488.82, CMS will consider such mitigating factors as may be appropriate in light of the nature of the deficiency and circumstances, including (but not limited to) the following, in making a decision of initial and re-approval of a transplant center that does not meet the data submission, clinical experience, or outcome requirements:

(i) The extent to which outcome measures are not met or exceeded;

(ii) Availability of Medicare-approved transplant centers in the area;

(iii) Extenuating circumstances (for example, natural disaster) that have a temporary effect on meeting the conditions of participation;

(iv) Program improvements that substantially address root causes of graft failures or patient deaths, that have been implemented and institutionalized on a sustainable basis, and that are supported by outcomes more recent than the latest available SRTR report, for which there is a sufficient post-transplant patient or graft survival period and a sufficient number of transplants such that CMS finds that the program demonstrates present-day compliance with the requirements at §482.80(c)(2)(i)(C) or §482.82(c)(2)(i)(C) of this chapter;

(v) Whether the program has made extensive use of innovative transplantation practices relative to other transplant programs, such as a high rate of transplantation of individuals who are highly sensitized or children who have undergone a Fontan procedure compared to most other transplant programs, where CMS finds that the innovative practices are supported by evidence-based published research literature or nationally recognized standards or Institution Review Board (IRB) approvals, and the SRTR risk-adjustment methodology does not take the relevant key factors into consideration; and

(vi) Whether the program’s performance, based on the OPTN method of calculating patient and graft survival, is within the OPTN’s thresholds for acceptable performance and does not flag OPTN performance review under the applicable OPTN policy.

(2) Content. A request for consideration of mitigating factors must include sufficient information to permit an adequate review and understanding of the transplant program, the factors that have contributed to outcomes, program improvements or innovations that have been implemented or planned, and in the case of natural disasters, the recovery actions planned. Examples of information to be submitted with each request include (but are not limited to) the following:

(i) The name and contact information for the transplant hospital and the names and roles of key personnel of the transplant program;

(ii) The type of organ transplant program(s) for which approval is requested;

(iii) The conditions of participation for which approval is requested;

(iv) The program’s organizational chart with full-time equivalent levels, roles, and structure for reporting to hospital leadership;

(v) For applications involving substandard patient or graft survival, the rationale and supporting evidence for
CMS' review includes, but is not limited to—

(A) Root Cause Analysis for patient deaths and graft failures, including factors the program has identified as likely causal or contributing factors for patient deaths and graft failures;

(B) Program improvements that have been implemented and improvements that are planned;

(C) Patient and donor/organ selection criteria and evaluation protocols, including methods for pre-transplant patient evaluation by cardiologists, hematologists, nephrologists, and psychiatrists or psychologists to the extent applicable;

(D) Waitlist management protocols and practices relevant to outcomes;

(E) Pre-operative management protocols and practices;

(F) Immunosuppression/infection prophylaxis protocols;

(G) Post-transplant monitoring and management protocols and practices;

(H) Quality Assessment and Performance Improvement (QAPI) Program meeting minutes from the most recent four meetings and attendance rosters from the most recent 12 months;

(I) Quality dashboard and other performance indicators; and

(J) The most recent data regarding transplants that have been made and for outcomes in terms of both patient survival and graft survival;

(vi) For mitigating factors requests based on innovative practice:

(A) A description of the innovations that have been implemented and identification of the specific cases for which the innovative practices are relevant so as to enable the patient and graft survival data for such cases to be compared with all other transplants for at least the period covered by the latest available SRTR report.

(B) The literature, research, or other evidentiary basis that supports consideration of the practice(s) as innovative.

(vii) For requests based on natural disasters or public health emergency:

(A) A description of the disaster or emergency, the specific impact on the program, the time periods of the event(s) and of its immediate recovery aftermath;
approval or re-approval based on mitigating factors. A Systems Improvement Agreement follows the process specified in paragraph (h) of this section.

(2) Limitation. CMS will not approve any program with a condition-level deficiency. However, CMS may approve a program with a standard-level deficiency upon receipt of an acceptable plan of correction.

(h) Transplant Systems Improvement Agreement. A Systems Improvement Agreement is a binding agreement, entered into voluntarily by the hospital and CMS, through which CMS extends a prospective Medicare termination date and offers the program additional time to achieve compliance with the conditions of participation, contingent on the hospital’s agreement to participate in a structured regimen of quality improvement activities, demonstrate improved outcomes, and waive the right to appeal termination based on the identified deficiency or deficiencies (that led to the Agreement) in consideration for more time to demonstrate compliance. In some cases, transplant programs may enter a period of inactivity—voluntarily, or imposed as a condition of the Systems Improvement Agreement.

(1) Content. In exchange for the additional time to initiate or continue activities to achieve compliance with the conditions of participation, the hospital must agree to a regimen of specified activities, including (but not limited to) all of the following:

(i) Patient notification about the degree and type of noncompliance by the program, an explanation of what the program improvement efforts mean for patients, and financial assistance to defray the out-of-pocket costs of co-payments and testing expenses for any wait-listed individual who wishes to be listed with another program;

(ii) An external independent peer review team that conducts an onsite assessment of the program. The peer review must include—

(A) Review of policies, staffing, operations, relationship to hospital services, and factors that contribute to program outcomes;

(B) Suggestions for quality improvements the hospital should consider;

(C) Both verbal and written feedback provided directly to the hospital;

(D) Verbal debriefing provided directly to CMS; neither the hospital nor the peer review team is required to provide a written report to CMS; and

(E) Onsite review by a multidisciplinary team that includes a transplant surgeon with expertise in the relevant organ type(s), a transplant administrator, an individual with expertise in transplant QAPI systems, a social worker or psychologist or psychiatrist, and a specialty physician with expertise in conditions particularly relevant to the applicable organ types(s) such as a cardiologist, nephrologist, or hepatologist. Except for the transplant surgeon, CMS may permit substitution of one type of expertise for another individual who has expertise particularly needed for the type of challenges experienced by the program, such as substitution of an infection control specialist in lieu of, or in addition to, a social worker;

(iii) An action plan that addresses systemic quality improvements and is updated after the onsite peer review;

(iv) An onsite consultant whose qualifications are approved by CMS, and who provides services for 8 days per month on average for the duration of the agreement, except that CMS may permit a portion of the time to be spent offsite and may agree to fewer consultant days each month after the first 3 months of the Systems Improvement Agreement;

(v) A comparative effectiveness analysis that compares policies, procedures, and protocols of the transplant program with those of other programs in areas of endeavor that are relevant to the center’s current quality improvement needs;

(vi) Development of increased proficiency, or demonstration of current proficiency, with patient-level data from the Scientific Registry of Transplant Recipients and the use of registry data to analyze outcomes and inform quality improvement efforts;

(vii) A staffing analysis that examines the level, type, training, and skill of staff in order to inform transplant center efforts to ensure the engagement and appropriate training and credentialing of staff;
(viii) Activities to strengthen performance of the Quality Assessment and Performance Improvement Program to ensure full compliance with the requirements of § 482.96 and § 482.21 of this chapter;

(ix) Monthly (unless otherwise specified) reporting and conference calls with CMS regarding the status of programmatic improvements, results of the deliverables in the Systems Improvement Agreement, and the number of transplants, deaths, and graft failures that occur within 1 year post-transplant; and

(x) Additional or alternative requirements specified by CMS, tailored to the transplant program type and circumstances. CMS may waive the content elements at paragraphs (h)(1)(v), (h)(1)(vi), (h)(1)(vii), or (h)(1)(viii) of this section if it finds that the program has already adequately conducted the activity, the program is already proficient in the function, or the activity is clearly inapplicable to the deficiencies that led to the Agreement.

(2) **Timeframe.** A Systems Improvement Agreement will be established for up to a 12-month period, subject to CMS' discretion to determine if a shorter timeframe may suffice. At the hospital's request, CMS may extend the agreement for up to an additional 6-month period.


§ 488.64 Remote facility variances for utilization review requirements.

(a) As used in this section:

1. An “available” individual is one who:

   (i) Possesses the necessary professional qualifications;

   (ii) Is not precluded from participating by reason of financial interest in any such facility or direct responsibility for the care of the patients being reviewed or, in the case of a skilled nursing facility, employment by the facility; and

   (iii) Is not precluded from effective participation by the distance between the facility and his residence, office, or other place of work. An individual whose residence, office, or other place of work is more than approximately one hour's travel time from the facility shall be considered precluded from effective participation.

   (2) “Adjacent facility” means a health care facility located within a 50-mile radius of the facility which requests a variance.

   (b) The Secretary may grant a requesting facility a variance from the time frames set forth in §§ 405.1137(d) of this chapter and 482.30 as applicable, within which reviews all of cases must be commenced and completed, upon a showing satisfactory to the Secretary that the requesting facility has been unable to meet one or more of the requirements of § 405.1137 of this chapter or § 482.30 of this chapter, as applicable, by reason of insufficient medical and other professional personnel available to conduct the utilization review required by § 405.1137 of this chapter or § 482.30 of this chapter, as applicable.

   (c) The request for variance shall document the requesting facility's inability to meet the requirements for which a variance is requested and the facility's good faith efforts to comply with the requirements contained in § 405.1137 of this chapter or § 482.30 of this chapter, as applicable.

   (d) The request shall include an assurance by the requesting facility that it will continue its good faith efforts to comply with the requirements contained in § 405.1137 of this chapter or § 482.30 of this chapter, as applicable.

   (e) A revised utilization review plan for the requesting facility shall be submitted concurrently with the request for a variance. The revised plan shall specify the methods and procedures which the requesting facility will use, if a variance is granted, to assure:

   (1) That effective and timely control will be maintained over the utilization of services; and

   (2) That reviews will be conducted so as to improve the quality of care provided to patients.

   (f) The request for a variance shall include:

   (1) The name, location, and type (e.g., hospital, skilled nursing facility) of the facility for which the variance is requested;
Centers for Medicare & Medicaid Services, HHS § 488.68

(2) The total number of patient admissions and average daily patient census at the facility within the previous six months;

(3) The total number of title XVIII and title XIX patient admissions and the average daily patient census of title XVIII and title XIX patients in the facility within the previous six months;

(4) As relevant to the request, the names of all physicians on the active staff of the facility and the names of all other professional personnel on the staff of the facility, or both;

(5) The name, location, and type of each adjacent facility (e.g., hospital, skilled nursing facility);

(6) The distance and average travel time between the facility and each adjacent facility;

(7) As relevant to the request, the location of practice of available physicians and the estimated number of other available professional personnel, or both (see paragraph (a)(1)(iii) of this section);

(8) Documentation by the facility of its attempt to obtain the services of available physicians or other professional personnel, or both; and

(9) A statement of whether a QIO exists in the area where the facility is located.

g) The Secretary shall promptly notify the facility of the action taken on the request. Where a variance is in effect, the validation of utilization review pursuant to §405.1137 of this chapter or §482.30 shall be made with reference to the revised utilization review plan submitted with the request for variance.

(h) The Secretary, in granting a variance, will specify the period for which the variance has been granted; such period will not exceed one year. A request for a renewal shall be submitted not later than 30 days prior to the expiration of the variance and shall contain all information required by paragraphs (c), (d), and (f) of this section. Renewal of the variance will be contingent upon the facility’s continuing to meet the provisions of this section.

§ 488.68 State Agency responsibilities for OASIS collection and data base requirements.

As part of State agency survey responsibilities, the State agency or other entity designated by CMS has overall responsibility for fulfilling the following requirements for operating the OASIS system:

(a) Establish and maintain an OASIS database. The State agency or other entity designated by CMS must—

(1) Use a standard system developed or approved by CMS to collect, store, and analyze data;

(2) Conduct basic system management activities including hardware and software maintenance, system back-up, and monitoring the status of the database; and

(3) Obtain CMS approval before modifying any parts of the CMS standard system including, but not limited to, standard CMS-approved—

(i) OASIS data items;

(ii) Record formats and validation edits; and

(iii) Agency encoding and transmission methods.

(b) Analyze and edit OASIS data. The State agency or other entity designated by CMS must—

(1) Upon receipt of data from an HHA, edit the data as specified by CMS and ensure that the HHA resolves errors within the limits specified by CMS;

(2) At least monthly, make available for retrieval by CMS all edited OASIS records received during that period, according to formats specified by CMS, and correct and retransmit previously rejected data as needed; and

(3) Analyze data and generate reports as specified by CMS.

(c) Ensure accuracy of OASIS data. The State agency must audit the accuracy of the OASIS data through the survey process.
§ 488.68

(d) **Restrict access to OASIS data.** The State agency or other entity designated by CMS must do the following:

1. Ensure that access to data is restricted except for the transmission of data and reports to—
   (i) CMS;
   (ii) The State agency component that conducts surveys for purposes related to this function; and
   (iii) Other entities if authorized by CMS.
2. Ensure that patient identifiable OASIS data is released only to the extent that it is permitted under the Privacy Act of 1974.

(e) **Provide training and technical support for HHAs.** The State agency or other entity designated by CMS must—

1. Instruct each HHA on the administration of the data set, privacy/confidentiality of the data set, and integration of the OASIS data set into the facility’s own record keeping system;
2. Instruct each HHA on the use of software to encode and transmit OASIS data to the State;
3. Specify to a facility the method of transmission of data to the State, and instruct the facility on this method.
4. Monitor each HHA’s ability to transmit OASIS data.
5. Provide ongoing technical assistance and general support to HHAs in implementing the OASIS reporting requirements specified in the conditions of participation for home health agencies; and
6. Carry out any other functions as designated by CMS necessary to maintain OASIS data on the standard State system.

[64 FR 3763, Jan. 25, 1999]
§ 488.100 Long term care survey forms, Part A.

**PART A — ADMINISTRATIVE AND PROCEDURAL REQUIREMENTS**

**MEDICARE / MEDICAID SKILLED NURSING FACILITY AND INTERMEDIATE CARE FACILITY SURVEY REPORT**

<table>
<thead>
<tr>
<th>PROVIDER NUMBER</th>
<th>FACILITY NAME AND ADDRESS (City, State, Zip Code)</th>
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Form HCFA-335 (2-96)
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<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
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<td>F500</td>
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<tr>
<td>F501</td>
<td>A. Licensure</td>
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<td>F502</td>
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<td>F504</td>
<td>B. Personnel Licensure</td>
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<td>F505</td>
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<tr>
<td>F506</td>
<td>Staff of the facility are licensed or registered in accordance with applicable State laws.</td>
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<td>F507</td>
<td>C. Compliance with Other Laws</td>
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<td>F510</td>
<td></td>
<td>MET</td>
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<tr>
<td>CODE</td>
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<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
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<td>The facility is in compliance with applicable regulations pertaining to:</td>
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<tr>
<td>F511</td>
<td>Buying, dispensing, safeguarding, administering, and disposing of medications and controlled substances.</td>
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<td></td>
<td>Exception: Not applicable to SNFs.</td>
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<tr>
<td>F512</td>
<td>Construction, maintenance and equipment.</td>
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<td></td>
<td>Exception: Not applicable to SNFs.</td>
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<tr>
<td>F513</td>
<td>Current reports from all responsible governmental agencies are retained at the facility.</td>
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<tr>
<td>F514</td>
<td><strong>Governing Body and Management (Condition of Participation)</strong></td>
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<tr>
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<td>SNF (405.1121)</td>
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<tr>
<td></td>
<td>The facility has a governing body with full legal authority and responsibility for operation of the facility.</td>
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<td></td>
<td><strong>A. Disclosure</strong></td>
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<tr>
<td></td>
<td>SNF (405.1121(a)) (Standard)</td>
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<td>Full disclosure of ownership has been made in accordance with requirements at 42 CFR 420.206.</td>
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<td><strong>B. Administration</strong></td>
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<td></td>
<td>SNF (405.1121(d)) (Standard)</td>
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<tr>
<td>F516</td>
<td>1. Written bylaws address the operation of the facility.</td>
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<tr>
<td>F517</td>
<td>2. Written bylaws and policies address effective resident care.</td>
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<tr>
<td>F518</td>
<td>3. Bylaws are reviewed and revised as necessary.</td>
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<tr>
<td>CODE</td>
<td>GOVERNING BODY AND MANAGEMENT</td>
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<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
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<td>F520</td>
<td>ICF (442.301) (Standard)</td>
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<tr>
<td>F521</td>
<td>SNF (405.1121(d)) (Standard)</td>
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<td>The facility has policies which ensure that the facility cooperates in an effective program for regular independent medical evaluation and audit of residents in the facility to the extent required by the programs in which the facility participates.</td>
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<tr>
<td>F522</td>
<td>SNF (405.1121(e)) (Standard)</td>
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<td>F523</td>
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<tr>
<td>F524</td>
<td>The facility has a licensed administrator who has authority for the overall operation of the facility. (Administrator’s license or registration number).</td>
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<td>F525</td>
<td>ICF (442.304) (Standard)</td>
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<tr>
<td>F526</td>
<td>1. The administrator or another professional staff member is the resident care director (RSD).</td>
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<tr>
<td>F527</td>
<td>2. The RSD coordinates and monitors each resident’s care.</td>
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</tbody>
</table>
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>GOVERNING BODY AND MANAGEMENT</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F. Institutional Planning</td>
<td></td>
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</tr>
<tr>
<td>F528</td>
<td>SNF (405.1121(f)) (Standard)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. The facility has an overall plan and budget prepared by a committee of representatives from the governing body, administrative staff, and the organized medical staff (if any):</td>
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<tr>
<td>F530</td>
<td>2. The overall plan and budget is reviewed and updated at least annually.</td>
<td></td>
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<tr>
<td>F531</td>
<td>3. The plan includes a capital expenditures plan, if necessary.</td>
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<tr>
<td></td>
<td>G. Personnel Policies and Procedures</td>
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<tr>
<td>F532</td>
<td>SNF (405.1121(g)) (Standard)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td></td>
<td>1. The facility has written policies and procedures that support sound resident care and personnel practices and address, at least:</td>
<td></td>
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<tr>
<td>F533</td>
<td>a. Control of communicable disease;</td>
<td></td>
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<tr>
<td>F534</td>
<td>b. The review of employee incidents and accidents to identify health and safety hazards; and</td>
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<tr>
<td>F535</td>
<td>c. The existence of a safe and sanitary environment.</td>
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</tr>
<tr>
<td>F536</td>
<td>2. Personnel records are current, available to each employee, and contain sufficient information to support placement in the position to which assigned.</td>
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</tr>
<tr>
<td>F537</td>
<td>3. Referral or provision for periodic health examinations to ensure freedom from communicable disease.</td>
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<td></td>
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<tr>
<td>CODE</td>
<td>GOVERNING BODY AND MANAGEMENT</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
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<tr>
<td>H. Outside Resources/Consultant Agreements</td>
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<tr>
<td>F538</td>
<td>SNF (405.1121)(j) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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<tr>
<td>F539</td>
<td>ICF (442.317) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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<tr>
<td>F540</td>
<td>The facility has written agreements with qualified persons to render a service (if it does not employ a qualified professional person to do so). The agreements:</td>
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<tr>
<td>F541</td>
<td>1. Address the responsibilities, functions, objectives, and terms (including financial arrangements and charges);</td>
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<tr>
<td>F542</td>
<td>2. Are signed by an authorized representative of the facility and the outside resource; and</td>
<td></td>
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<tr>
<td>F543</td>
<td>3. Specify that the facility retains ultimate responsibility for the services rendered.</td>
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<tr>
<td>I. Notification of Change in Resident Status</td>
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<tr>
<td>F544</td>
<td>SNF (405.1121)(j) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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</tr>
<tr>
<td>F545</td>
<td>The facility has policies and procedures to notify physicians and other responsible persons in the event of an accident involving the resident, or resident's physical, mental or emotional status, or resident charges, billings or related administrative matter.</td>
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</table>
### NAME OF FACILITY

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<tr>
<th>CODE</th>
<th>GOVERNING BODY AND MANAGEMENT</th>
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<th>N/A</th>
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</tr>
</thead>
<tbody>
<tr>
<td>J. Resident Rights</td>
<td>SNF (405.1121(k)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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<td>F546</td>
<td>Indicators 1 thru 12 apply to SNFs.</td>
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<td>F547</td>
<td>ICF (442.311) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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<tr>
<td>F548</td>
<td>1. Information</td>
<td></td>
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<tr>
<td>F549</td>
<td>a. The facility informs each resident, before or at the time of admission, of his rights and responsibilities.</td>
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<td></td>
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<tr>
<td>F550</td>
<td>b. The facility informs each resident, before or at the time of admission, of all rules governing resident conduct.</td>
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<tr>
<td>F551</td>
<td>c. The facility informs each resident of amendments to their policies on residents' rights and responsibilities and rules governing conduct.</td>
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<tr>
<td>F552</td>
<td>d. Each resident acknowledges in writing receipt of residents' rights information and any amendment to it.</td>
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</tr>
<tr>
<td>F553</td>
<td>e. The resident must be informed in writing of all services and charges for services.</td>
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</tr>
<tr>
<td>F554</td>
<td>f. The resident must be informed in writing of all changes in services and charges before or at the time of admission and on a continuing basis.</td>
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<tr>
<td>F555</td>
<td>g. The resident must be informed of services not covered by Medicare or Medicaid in the basic rate.</td>
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</tbody>
</table>
## 2. Medical Condition and Treatment

<table>
<thead>
<tr>
<th>CODE</th>
<th>GOVERNING BODY AND MANAGEMENT</th>
<th>YES</th>
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<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F555</td>
<td>a. Each resident is informed by a physician of his health and medical condition unless the physician decides that informing the resident is medically contraindicated.</td>
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<td></td>
<td>b. Each resident is given an opportunity to participate in planning his total care and medical treatment.</td>
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<td></td>
<td>c. Each resident is given an opportunity to refuse treatment.</td>
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<td></td>
<td>d. Each resident gives informed, written consent before participating in experimental research.</td>
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<tr>
<td></td>
<td>e. If the physician decides that informing the resident of his health and medical condition is medically contraindicated, the physician has documented this decision in the resident's medical record.</td>
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</tbody>
</table>

## 3. Transfer and Discharge

Each resident is transferred or discharged only for:

<table>
<thead>
<tr>
<th>CODE</th>
<th>GOVERNING BODY AND MANAGEMENT</th>
<th>YES</th>
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</tr>
</thead>
<tbody>
<tr>
<td>F560</td>
<td>a. Medical reasons.</td>
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<td></td>
<td>b. His/her welfare or that of other residents.</td>
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<tr>
<td></td>
<td>c. Nonpayment except as prohibited by the Medicare or Medicaid program.</td>
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</tbody>
</table>

## 4. Exercising Rights

Each resident is encouraged and assisted to exercise his/her rights as a resident of the facility and as a citizen.

<table>
<thead>
<tr>
<th>CODE</th>
<th>GOVERNING BODY AND MANAGEMENT</th>
<th>YES</th>
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<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F563</td>
<td>a. Each resident is allowed to submit complaints and recommendations concerning the policies and services of the facility to staff or to outside representatives of the resident's choice or both.</td>
<td></td>
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<tr>
<td></td>
<td>b. Such complaints are submitted free from restraint, coercion, discrimination, or reprisal.</td>
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<tr>
<td>CODE</td>
<td>GOVERNING BODY AND MANAGEMENT</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
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</tr>
<tr>
<td>5. Financial Affairs</td>
<td>a. Residents are allowed to manage their own personal financial affairs.</td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. The facility establishes and maintains a system that assures full and complete accounting of residents' personal funds. An accounting report is made to residents in skilled nursing facilities at least on a quarterly basis.</td>
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<tr>
<td></td>
<td>c. The facility does not commingle resident funds with any other funds other than resident funds.</td>
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<tr>
<td></td>
<td>d. If a resident requests assistance from the facility in managing his personal financial affairs, resident's delegation is in writing.</td>
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<tr>
<td></td>
<td>e. The facility system of accounting includes written receipts for:</td>
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<tr>
<td></td>
<td>1. All personal possessions and funds received by or deposited with the facility.</td>
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<tr>
<td></td>
<td>2. All disbursement made to or for the resident.</td>
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<tr>
<td></td>
<td>f. The financial record must be available to the resident and his/her family.</td>
<td></td>
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</tr>
<tr>
<td>6. Freedom from Abuse and Restraints</td>
<td>a. Each resident is free from mental and physical abuse.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>b. Chemical and physical restraints are only used when authorized by a physician in writing for a specified period of time or in emergencies.</td>
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<td></td>
<td>c. If used in emergencies, they are necessary to protect the resident from injury to himself or others.</td>
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<tr>
<td>CODE</td>
<td>GOVERNING BODY AND MANAGEMENT</td>
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<tr>
<td>F576</td>
<td>d. The use is authorized by a professional staff member identified in the written policies and procedures of the facility.</td>
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<tr>
<td>F577</td>
<td>e. The use is reported promptly to the resident’s physician by the staff member.</td>
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</tbody>
</table>

7. Privacy

| F578 | a. Each resident is treated with respect, consideration and full recognition of his/her dignity and individuality. |
|      | b. Each resident is given privacy during treatment and care of personal needs. |
| F580 | c. Each resident’s records, including information in an automated data bank, are treated confidentially. |
| F581 | d. Each resident must give written consent before the facility releases information from his/her record to someone not otherwise authorized to receive it. |
| F582 | e. Married residents are given privacy during visits by their spouses. |
| F583 | f. Married residents are permitted to share a room. |

8. Work

| F584 | No resident may be required to perform services for the facility. |

9. Freedom of Association and Correspondence

<p>| F585 | a. Each resident is allowed to communicate, associate and meet privately with individuals of his choice unless this intrudes upon the rights of another resident. |
|      | b. Each resident is allowed to send and receive personal mail unopened. |</p>
<table>
<thead>
<tr>
<th>CODE</th>
<th>GOVERNING BODY AND MANAGEMENT</th>
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</tr>
</thead>
<tbody>
<tr>
<td>F587</td>
<td>10. Activities</td>
<td></td>
<td></td>
<td></td>
<td>Each resident is allowed to participate in social, religious, and community group activities.</td>
</tr>
<tr>
<td>F588</td>
<td>11. Personal Possessions</td>
<td></td>
<td></td>
<td></td>
<td>Each resident is allowed to retain and use his personal possessions and clothing as space permits.</td>
</tr>
<tr>
<td>F589</td>
<td>12. Written Policies and Procedures: Delegation of Rights and Responsibilities</td>
<td></td>
<td></td>
<td></td>
<td>ICF (442.312) (Standard) ☐ MET ☐ NOT MET</td>
</tr>
<tr>
<td>F590</td>
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<td></td>
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<td></td>
<td>a. The facility has written policies and procedures that provide that all the rights and responsibilities of a resident pass to the resident’s guardian, next of kin or sponsoring agency or agencies if the resident is adjudicated incompetent under State law or is determined by his physician to be incapable of understanding his rights and responsibilities.</td>
</tr>
<tr>
<td>F591</td>
<td></td>
<td></td>
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<td>b. Physician determinations of incapability and the specific reasons thereof are recorded by the physician in the resident’s record.</td>
</tr>
<tr>
<td>F592</td>
<td>K. Resident Care Policies</td>
<td></td>
<td></td>
<td></td>
<td>SNF (405.1121(b)) (Standard) ☐ MET ☐ NOT MET</td>
</tr>
<tr>
<td>F593</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. The facility has written policies to govern the continuing skilled nursing care and related medical or other services provided.</td>
</tr>
<tr>
<td>F594</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. These policies reflect awareness of and provision for meeting the total medical and psychosocial needs of residents including admission, transfer, discharge planning, and the range of services available to residents; and</td>
</tr>
<tr>
<td>CODE</td>
<td>GOVERNING BODY AND MANAGEMENT</td>
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<tr>
<td>F596</td>
<td>3. The protection of residents' personal and property rights.</td>
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<tr>
<td>F596</td>
<td>4. The policies are developed by a group of professional personnel, including the Medical Director or the organized medical staff, and are periodically reviewed and revised (if necessary).</td>
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<td>F597</td>
<td>5. These policies are available to admitting physicians, sponsoring agencies, residents, and the public.</td>
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<td>F598</td>
<td>6. The Medical Director or a registered nurse is designated as responsible for the execution of the policies.</td>
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<td></td>
<td>L. Public Availability</td>
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<tr>
<td>F599</td>
<td>ICF (442.306) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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<tr>
<td>F600</td>
<td>1. The facility has written policies and procedures governing all the services it provides.</td>
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<tr>
<td>F601</td>
<td>2. The policies and procedures are available to the staff and residents, members of the facility, the public, and legal representatives of residents.</td>
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<tr>
<td></td>
<td>M. Admissions</td>
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<tr>
<td>F602</td>
<td>ICF (442.306) (Standard)</td>
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<td>☐ NOT MET</td>
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<td></td>
<td>The facility has written policies and procedures that ensure that it admits as residents only those residents whose needs can be met by:</td>
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<tr>
<td>F603</td>
<td>1. the facility itself.</td>
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<tr>
<td>F604</td>
<td>2. the facility in cooperation with community resources.</td>
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<tr>
<td>F605</td>
<td>3. the facility in cooperation with other providers of care affiliated with or under contract to the facility.</td>
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<tr>
<td>CODE</td>
<td>GOVERNING BODY AND MANAGEMENT</td>
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<tr>
<td>N. Transfers</td>
<td>ICF (442.307) (Standard)</td>
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<tr>
<td>F606</td>
<td>N. Transfers</td>
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<tr>
<td>F607</td>
<td>N. Transfers</td>
<td>MET</td>
<td></td>
<td></td>
<td>1. The facility has written policies and procedures to ensure that residents are transferred promptly to a hospital, SNF, or other appropriate facility when a change is necessary.</td>
</tr>
<tr>
<td>F608</td>
<td>N. Transfers</td>
<td></td>
<td></td>
<td></td>
<td>2. Except in emergencies, the facility consults the resident, his next of kin, the attending physician, and the responsible agency, if any, at least five days before discharge.</td>
</tr>
<tr>
<td>F609</td>
<td>N. Transfers</td>
<td></td>
<td></td>
<td></td>
<td>3. The facility uses casework services and other means to ensure that adequate arrangements are made to meet resident's needs through other resources.</td>
</tr>
<tr>
<td>O. Restraints</td>
<td>ICF (442.308) (Standard)</td>
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</tr>
<tr>
<td>F610</td>
<td>O. Restraints</td>
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</tr>
<tr>
<td>F611</td>
<td>O. Restraints</td>
<td>MET</td>
<td></td>
<td></td>
<td>1. Define the uses of chemical and physical restraints.</td>
</tr>
<tr>
<td>F612</td>
<td>O. Restraints</td>
<td></td>
<td></td>
<td></td>
<td>2. Identify the professional personnel who may authorize the use of restraints in emergencies under 442.311(f).</td>
</tr>
<tr>
<td>F613</td>
<td>O. Restraints</td>
<td></td>
<td></td>
<td></td>
<td>3. Describe procedures for monitoring and controlling the use of these restraints.</td>
</tr>
<tr>
<td>P. Complaints</td>
<td>ICF (442.309) (Standard)</td>
<td></td>
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</tr>
<tr>
<td>F614</td>
<td>P. Complaints</td>
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<td></td>
</tr>
<tr>
<td>F615</td>
<td>P. Complaints</td>
<td></td>
<td></td>
<td></td>
<td>1. Describe the procedures the facility uses to receive complaints and recommendations from residents.</td>
</tr>
<tr>
<td>F616</td>
<td>P. Complaints</td>
<td></td>
<td></td>
<td></td>
<td>2. Ensure that the facility responds to complaints and recommendations.</td>
</tr>
<tr>
<td>CODE</td>
<td>GOVERNING BODY AND MANAGEMENT</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
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<tr>
<td>F617</td>
<td>SNF (405.1121(h)) (Standard)</td>
<td></td>
<td></td>
<td></td>
<td>1. The facility conducts an orientation program for all new employees that includes a review of all its policies.</td>
</tr>
<tr>
<td>F618</td>
<td>ICF (442.314) (Standard)</td>
<td></td>
<td></td>
<td></td>
<td>2. The facility plans and conducts an in-service staff development program for all personnel to assist them in developing and improving their skills.</td>
</tr>
<tr>
<td>F619</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. The facility maintains a record of the orientation and staff development programs it conducts.</td>
</tr>
<tr>
<td>F620</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4. The record includes the content of the program and the names of participants.</td>
</tr>
<tr>
<td>F621</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5. In-service training includes at least prevention and control of infections, fire prevention and safety, confidentiality of resident information, and preservation of resident dignity including protection of resident’s privacy and personal and property rights.</td>
</tr>
<tr>
<td>CODE</td>
<td>MEDICAL DIRECTION</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
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<tr>
<td>F624</td>
<td>Medical Direction (Condition of Participation)</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
<td>The facility has a written agreement with a licensed physician to serve as Medical Director on a part-time or full-time basis as is appropriate to the needs of the residents and the facility. (See 405.191(b) regarding waiver of this requirement.)</td>
</tr>
<tr>
<td>A. Coordination of Medical Care</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>F625</td>
<td>SNF (405.1122)(a) (Standard)</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>F626</td>
<td>1. Medical direction and coordination of medical care in the facility are provided by a Medical Director.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F627</td>
<td>2. The Medical Director is responsible for development of policies approved by the governing body.</td>
<td></td>
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</tr>
<tr>
<td>F628</td>
<td>3. Coordination of medical care includes liaison with attending physicians to ensure their writing orders promptly upon admission of a resident, and periodic evaluation of the adequacy and appropriateness of health professional and supportive staff and services.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>B. Responsibilities to the Facility</td>
<td></td>
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</tr>
<tr>
<td>F629</td>
<td>SNF (405.1122)(b) (Standard)</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
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</tr>
<tr>
<td>F630</td>
<td>1. The Medical Director is responsible for surveillance of the health status of the facility’s employees.</td>
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</tr>
<tr>
<td>F631</td>
<td>2. Incidents and accidents that occur on the premises are reviewed by the Medical Director to identify hazards to health and safety.</td>
<td></td>
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<tr>
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<td>PHYSICIAN SERVICES</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>F632</td>
<td>SNF (405.1123)</td>
<td></td>
<td></td>
<td></td>
<td>Residents in need of skilled or rehabilitative care are admitted to the facility only upon the recommendation of, and remain under the care of, a physician. To the extent feasible, each resident designates a personal physician.</td>
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<tr>
<td></td>
<td></td>
<td>MET</td>
<td></td>
<td>NOT</td>
<td></td>
</tr>
<tr>
<td>A.</td>
<td>Physician Supervision</td>
<td></td>
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</tr>
<tr>
<td>F633</td>
<td>SNF (405.1123(b))</td>
<td></td>
<td></td>
<td></td>
<td>1. The facility has a policy that the health care of every resident must be under the supervision of a physician.</td>
</tr>
<tr>
<td>F634</td>
<td>ICF (442.346)</td>
<td></td>
<td></td>
<td></td>
<td>2. All attending physicians must make arrangements for the medical care of their residents in their absence.</td>
</tr>
<tr>
<td></td>
<td>(Standard)</td>
<td>MET</td>
<td></td>
<td>NOT</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Emergency Services</td>
<td></td>
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<tr>
<td>F637</td>
<td>SNF (405.1123(c))</td>
<td></td>
<td></td>
<td></td>
<td>The facility has written procedures available at each nurses' station, that provide for having a physician available to furnish necessary medical care in case of emergency.</td>
</tr>
<tr>
<td></td>
<td>(Standard)</td>
<td>MET</td>
<td></td>
<td>NOT</td>
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## Nursing Services (Condition of Participation)

<table>
<thead>
<tr>
<th>CODE</th>
<th>NURSING SERVICES</th>
<th>YES</th>
<th>NO</th>
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</tr>
</thead>
<tbody>
<tr>
<td>F638</td>
<td>SNF (405.1124)</td>
<td>☐ MET ☐ NOT MET</td>
<td></td>
<td></td>
<td>The facility provides 24-hour service by licensed nurses, including the services of a registered nurse at least during the day tour of duty, 7 days a week. There is an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing needs of all residents (See 405.1911(a) regarding waiver of the 7-day registered nurse requirement).</td>
</tr>
<tr>
<td>F639</td>
<td>ICF (442.342)   (Standard)</td>
<td>☐ MET ☐ NOT MET</td>
<td></td>
<td></td>
<td>The facility provides nursing care as needed including restorative nursing care.</td>
</tr>
</tbody>
</table>

### A. Director of Nursing Services

- **F640** SNF (405.1124(a)) (Standard) ☐ MET ☐ NOT MET
  - **F641** 1. The director of nursing services is a qualified registered nurse employed full-time.
  - **F642** 2. The director of nursing services has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing services staff, and serves only one facility in this capacity.
  - **F643** 3. If the director of nursing services has other institutional responsibilities, a qualified registered nurse serves as assistant so that there is the equivalent of a full-time director of nursing services on duty.
NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>NURSING SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
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<tbody>
<tr>
<td>F644</td>
<td>ICF (442.339)</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
<td>Health Services Supervision</td>
</tr>
<tr>
<td>F645</td>
<td></td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>1. The facility has a full-time registered nurse, or a licensed practical or vocational nurse to supervise the health services 7 days a week on the day shift.</td>
</tr>
<tr>
<td>F646</td>
<td></td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>2. The nurse has a current State license.</td>
</tr>
<tr>
<td>F647</td>
<td></td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>3. If the supervisor of health services is a licensed practical or vocational nurse, the facility has a formal contract with a registered nurse to serve as a consultant no less than 4 hours a week.</td>
</tr>
<tr>
<td>F648</td>
<td></td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>4. To qualify to serve as a health services supervisor, a licensed practical or vocational nurse must:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>a. Have graduated from a State-approved school of practical nursing, or</td>
</tr>
<tr>
<td>F649</td>
<td></td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>b. Have education or other training that the State authority responsible for licensing practical nurses considered equal to graduation from a State-approved school of practical nursing, or</td>
</tr>
<tr>
<td>F650</td>
<td></td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>c. Have passed the Public Health Service examination for waivered licensed practical or vocational nurses.</td>
</tr>
<tr>
<td>F651</td>
<td></td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>5. If the nurse in charge is licensed by the State in a category other than registered nurse or licensed practical or vocational nurse:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>a. The individual has completed a training program to get the license that includes at least the same number of classroom and practice hours in all nursing subjects as in the program of a State-approved school of practical or vocational nursing, and</td>
</tr>
</tbody>
</table>
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>NURSING SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>NIA</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F652</td>
<td>b. The State agency responsible for licensing the individual submits a report to the Medicaid agency comparing State-licensed practical nurse or vocational nurse course requirements with those for the program completed by the individual.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>F653</td>
<td>C. Twenty-four Hour Nursing Service</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F654</td>
<td>SNF (405.1124(e)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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<tr>
<td>F654</td>
<td>ICF (442.338) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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</tr>
<tr>
<td>F655</td>
<td>1. 24-Hour Nursing</td>
<td></td>
<td></td>
<td></td>
<td>Nursing policies and procedures address the total nursing needs of the residents.</td>
</tr>
<tr>
<td>F656</td>
<td>The policies are designed to ensure that each resident receives: Treatment.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F657</td>
<td>Medications as prescribed.</td>
<td></td>
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<tr>
<td>F658</td>
<td>Diet as prescribed.</td>
<td></td>
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</tr>
<tr>
<td>F659</td>
<td>Rehabilitative nursing care as needed.</td>
<td></td>
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<tr>
<td>F660</td>
<td>Proper care to prevent decubitus ulcers and deformities.</td>
<td></td>
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</tr>
<tr>
<td>F661</td>
<td>Proper care to ensure that residents are clean, well-groomed and comfortable.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F662</td>
<td>Protection from accident and injury.</td>
<td></td>
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</tr>
<tr>
<td>F663</td>
<td>Protection from infection.</td>
<td></td>
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<tr>
<td>F664</td>
<td>Encouragement, assistance, and training in self-care and group activities.</td>
<td></td>
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NAME OF FACILITY

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<th>CODE</th>
<th>NURSING SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
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<tbody>
<tr>
<td>F665</td>
<td>2. Weekly time schedules are maintained and indicate the number and classifications of nursing personnel including relief personnel, who worked on each unit for each tour of duty.</td>
<td></td>
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<tr>
<td>D.</td>
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<tr>
<td>F666</td>
<td>D. Rehabilitative Nursing Care</td>
<td>☐</td>
<td>☒</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>SNF (405.1124(d)) (Standard)</td>
<td>☐</td>
<td>☒</td>
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</tr>
<tr>
<td>F667</td>
<td>Nursing personnel are trained in rehabilitative nursing.</td>
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<tr>
<td>E.</td>
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<tr>
<td>F668</td>
<td>E. Supervision of Resident Nutrition</td>
<td>☐</td>
<td>☒</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>SNF (405.1124(f)) (Standard)</td>
<td>☐</td>
<td>☒</td>
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<tr>
<td>F669</td>
<td>A procedure is established to inform dietetic service of physicians' diet orders and of residents' dietetic problems.</td>
<td></td>
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<tr>
<td>F.</td>
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<tr>
<td>F670</td>
<td>F. Administration of Drugs</td>
<td>☐</td>
<td>☒</td>
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<tr>
<td></td>
<td>SNF (405.1124(g)) (Standard)</td>
<td>☐</td>
<td>☒</td>
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<tr>
<td>F671</td>
<td>Procedures are established by the Pharmaceutical Services Committee (see 405.1127(d)) to ensure that drugs are checked against physicians' orders.</td>
<td></td>
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<td></td>
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<tr>
<td>G.</td>
<td></td>
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</tr>
<tr>
<td>F672</td>
<td>G. Conformance with Physicians' Drug Orders</td>
<td>☐</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SNF (405.1124(h)) (Standard)</td>
<td>☐</td>
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<tr>
<td></td>
<td>Indicators 1 thru 4 apply to SNFs.</td>
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<tr>
<td>F673</td>
<td>ICF (442.335) (Standard)</td>
<td>☐</td>
<td>☒</td>
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<tr>
<td>F674</td>
<td>1. Drugs not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies.</td>
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### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>NURSING SERVICES</th>
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<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
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<tbody>
<tr>
<td>F675</td>
<td>2. The attending physician is notified of an automatic stop order prior to the last dose so that the physician may decide if the administration of the drug or biological is to be continued or altered.</td>
<td></td>
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<tr>
<td>F676</td>
<td>ICF (442.334) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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<tr>
<td>F677</td>
<td>3. Physicians' verbal orders for drugs are given only to a licensed nurse, pharmacist, or physician and are immediately recorded and signed by the person receiving the order. (Verbal orders for Schedule II drugs are permitted only in the case of a bona fide emergency situation.)</td>
<td></td>
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<tr>
<td>F678</td>
<td>4. Such orders are countersigned by the attending physician within a reasonable time.</td>
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### H. Storage of Drugs and Biologicals

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<th>NO</th>
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<tr>
<td>F679</td>
<td>SNF (405.1124(iii)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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<tr>
<td>F680</td>
<td>1. Procedures for storing and disposing of drugs and biologicals are established by the pharmaceutical services committee.</td>
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</tr>
<tr>
<td>F681</td>
<td>2. In accordance with State and Federal laws, all drugs and biologicals are stored in locked compartments under proper temperature controls.</td>
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<tr>
<td>F682</td>
<td>3. Only authorized personnel have access to the keys.</td>
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<tr>
<td>F683</td>
<td>4. Separately locked, permanently affixed compartments are provided for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention &amp; Control Act of 1970 and other drugs subject to abuse, except under single unit dosage distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</td>
<td></td>
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<tr>
<td>F684</td>
<td>5. An emergency medication kit approved by the pharmaceutical services committee is kept readily available.</td>
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NAME OF FACILITY

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<th>CODE</th>
<th>DIETETIC SERVICES</th>
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<th>N/A</th>
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<td></td>
<td><strong>Dietetic Services (Condition of Participation)</strong></td>
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<tr>
<td>F685</td>
<td>SNF (405.1125)</td>
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<td></td>
<td></td>
<td>The facility provides a hygienic dietetic service that meets the daily nutritional needs of patients, ensures that special dietary needs are met, and provides palatable and attractive meals. A facility that has a contract with an outside food management company may be found to be in compliance with this condition provided the facility and/or company meets the standards listed herein.</td>
</tr>
<tr>
<td>A. Staffing</td>
<td></td>
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</tr>
<tr>
<td>F686</td>
<td>SNF (405.1125(a)) (Standard)</td>
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</tr>
<tr>
<td>F687</td>
<td>1. Overall supervisory responsibility for the dietetic service is assigned to a full-time qualified dietetic service supervisor.</td>
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</tr>
<tr>
<td>F688</td>
<td>2. If the dietetic service supervisor is not a qualified dietitian, the dietetic service supervisor functions with frequent, regularly scheduled consultation from a person so qualified. (§405.1101(e).)</td>
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<tr>
<td>F689</td>
<td>3. In addition, the facility employs sufficient supportive personnel competent to carry out the functions of the dietetic service.</td>
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</tr>
<tr>
<td>F690</td>
<td>4. If consultant dietetic services are used, the consultant’s visits are at appropriate times, and of sufficient duration and frequency to provide continuing liaison with medical and nursing staffs, advice to the administrator, resident counseling, guidance to the supervisor and staff of the dietetic service, approval of all menus, and participation in the development or revisions of dietetic policies and procedures. (See §405.1121(i).)</td>
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</tbody>
</table>
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>DIETETIC SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B. Staffing</td>
<td></td>
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<tr>
<td>F691</td>
<td>ICF (442.332)</td>
<td></td>
<td></td>
<td></td>
<td>(Standard)</td>
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<td></td>
<td></td>
<td>MET</td>
<td></td>
<td>NOT MET</td>
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<tr>
<td>F692</td>
<td>1. The facility has a staff member trained or experienced in</td>
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<tr>
<td></td>
<td>food management or nutrition who is responsible for:</td>
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<tr>
<td></td>
<td>a. Planning meals that meet the nutritional needs of each</td>
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<tr>
<td></td>
<td>resident.</td>
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<tr>
<td>F693</td>
<td>b. Following the orders of the resident's physician.</td>
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<tr>
<td>F694</td>
<td>c. To the extent medically possible, following the</td>
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<td></td>
<td>recommended dietary allowances of the Food and Nutrition</td>
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<tr>
<td></td>
<td>Board of the National Research Council, National</td>
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<tr>
<td></td>
<td>Academy of Sciences (Recommended Dietary</td>
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<tr>
<td>F695</td>
<td>d. Supervising the meal preparation and service to ensure</td>
<td></td>
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<tr>
<td></td>
<td>that the menu plan is followed.</td>
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<tr>
<td>F696</td>
<td>2. For residents who required medically prescribed special</td>
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<tr>
<td></td>
<td>diets, the facility:</td>
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<tr>
<td></td>
<td>a. Has menus for those residents planned by a</td>
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<tr>
<td></td>
<td>professionally qualified dietitian or reviewed and</td>
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<tr>
<td></td>
<td>approved by the attending physician; and</td>
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<tr>
<td>F697</td>
<td>b. Supervises the preparation and serving of meals to</td>
<td></td>
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<tr>
<td></td>
<td>ensure that the resident accepts the special diet.</td>
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<tr>
<td>F698</td>
<td>3. The facility keeps for 30 days a record of each menu as</td>
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<tr>
<td></td>
<td>served.</td>
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</table>
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>DIETETIC SERVICES/ SPECIALIZED REHABILITATION SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
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<tbody>
<tr>
<td>C. Hygiene of Staff</td>
<td></td>
<td></td>
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<tr>
<td>F699</td>
<td>SNF (405.1125(g)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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<tr>
<td>D. Sanitary Conditions</td>
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</tr>
<tr>
<td>F701</td>
<td>SNF (405.1125(g)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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<tr>
<td>F702</td>
<td>Written reports of inspections by State and local health authorities are on file at the facility, with notation made of action taken by the facility to comply with any recommendations.</td>
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<tr>
<td>Specialized Rehabilitation Services (Condition of Participation)</td>
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<tr>
<td>F703</td>
<td>SNF (405.1126)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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<tr>
<td>The facility provides, or arranges for, under written agreement, specialized rehabilitative services by qualified personnel (i.e., physical therapy, speech pathology and audiology, and occupational therapy) as needed by residents to improve and maintain functioning. Safe and adequate space and equipment are available, commensurate with the services offered. If the facility does not offer such services directly, it does not admit nor retain residents in need of this care unless provision is made for such services under arrangement with qualified outside resources under which the facility assumes professional responsibility for the services rendered. (See §405.1121(i).)</td>
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<tr>
<td>CODE</td>
<td>SPECIALIZED REHABILITATION SERVICES</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
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<tr>
<td>F704</td>
<td>A. Staffing and Organization</td>
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<tr>
<td></td>
<td>SNF (405.1125(a)) (Standard)</td>
<td>☑</td>
<td></td>
<td></td>
<td>Indicators 1 thru 3 apply to SNFs</td>
</tr>
<tr>
<td>F705</td>
<td>ICF (442.343) (Standard)</td>
<td>☑</td>
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<tr>
<td>F706</td>
<td>1. Specialized rehabilitative services are provided, in accordance with accepted professional practices, by qualified therapists or by qualified assistants or other supportive personnel under the supervision of qualified therapists.</td>
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<tr>
<td>F707</td>
<td>2. Other rehabilitative services also may be provided, but must be in a facility where all rehabilitative services are provided through an organized rehabilitative service under the supervision of a physician qualified in physical medicine who determines the goals and limitations of these services and assigns duties appropriate to the training and experience of those providing such services.</td>
<td></td>
<td></td>
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<td>Exception: Does not apply to ICFs.</td>
</tr>
</tbody>
</table>
| F708 | 3. Written administrative and resident care policies and procedures are developed for rehabilitative services by appropriate therapists and representatives of the medical, administrative, and nursing staffs. |     |    |     | Exception: Does not apply to ICF's  
See General Requirements 442.305 |
### NAME OF FACILITY

#### SPECIALIZED REHABILITATION SERVICES/ PHARMACEUTICAL SERVICES

<table>
<thead>
<tr>
<th>CODE</th>
<th>SPECIALIZED REHABILITATION SERVICES/ PHARMACEUTICAL SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Documentation of Services &lt;br&gt; F709 &lt;br&gt; SNF (405.1126(d)) (Standard)</td>
<td>☐ MET ☐ NOT MET</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>The physician's order, the plan of rehabilitative care, services rendered, evaluations of progress, and other pertinent information are recorded in the patient's medical record, and are dated and signed by the physician ordering the service and the person who provided the service.</td>
</tr>
<tr>
<td>C. Qualifying to Provide Outpatient Physical Therapy Services &lt;br&gt; F710 &lt;br&gt; SNF (405.1126(d)) (Standard)</td>
<td>☐ MET ☐ NOT MET</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>If the facility provides outpatient physical therapy services, it meets the applicable health and safety regulations pertaining to such services as are included in Subpart Q of this part. (See §405.1719, 405.1720, 405.1722(a) and (b)(1)(2)(3)(4), (5), (6), (7), and (8); and 405.1725.)</td>
</tr>
<tr>
<td>Pharmaceutical Services (Condition of Participation) &lt;br&gt; F711 &lt;br&gt; SNF (405.1127)</td>
<td>☐ MET ☐ NOT MET</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>The facility has appropriate methods and procedures for the dispensing and administering of drugs and biologics. The facility is responsible for providing such drugs and biologics for its residents, insofar as they are covered under the programs, and for ensuring that pharmaceutical services are provided in accordance with accepted professional principles.</td>
</tr>
<tr>
<td>CODE</td>
<td>PHARMACEUTICAL SERVICES</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
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</tr>
<tr>
<td>A. Supervision of Services</td>
<td></td>
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<tr>
<td>F712</td>
<td>SNF (405.1127(a)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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<tr>
<td>F713</td>
<td>1. The pharmaceutical services are under the general supervision of a qualified pharmacist.</td>
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<tr>
<td>F714</td>
<td>2. The pharmacist is responsible to the administrative staff for developing coordinating, and supervising all pharmaceutical services.</td>
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<tr>
<td>F715</td>
<td>3. The pharmacist (if not a full-time employee) devotes a sufficient number of hours, based upon the needs of the facility, during regularly scheduled visits to carry out these responsibilities.</td>
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<tr>
<td>F716</td>
<td>ICF (442.333) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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</tr>
<tr>
<td>F717</td>
<td>1. The facility employs a licensed pharmacist, or</td>
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<tr>
<td>F718</td>
<td>2. The facility has formal arrangements with a licensed pharmacist to advise the facility on ordering, storage, administration, disposal and recordkeeping of drugs and biologicals.</td>
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<tr>
<td>B. Control and Accountability</td>
<td></td>
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<tr>
<td>F719</td>
<td>SNF (405.1127(b)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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<tr>
<td>F720</td>
<td>1. The pharmaceutical service has procedures for control and accountability of all drugs and biologicals throughout the facility.</td>
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<tr>
<td>F721</td>
<td>2. Only approved drugs and biologicals are used in the facility.</td>
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<tr>
<td>F722</td>
<td>3. Records of receipt and disposition of all controlled drugs are maintained in sufficient detail to enable an accurate reconciliation.</td>
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</tbody>
</table>
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>PHARMACEUTICAL SERVICES: LABORATORY AND RADIOLOGIC SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>C. Pharmaceutical Services Committee</td>
<td></td>
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<tr>
<td>F723</td>
<td>SNF (405.1127(d)) (Standard)</td>
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<tr>
<td>F724</td>
<td>1. A pharmaceutical services committee or its equivalent develops written policies and procedures for safe and effective drug therapy, distribution, control and use.</td>
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<tr>
<td>F725</td>
<td>2. The committee is comprised of at least the pharmacist, the director of nursing services, the administrator, and one physician.</td>
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<tr>
<td>F726</td>
<td>3. The committee oversees pharmaceutical services in the facility, makes recommendations for improvement, and monitors the service to ensure its accuracy and adequacy.</td>
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<tr>
<td></td>
<td>Laboratory and Radiologic Services (Condition of Participation)</td>
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<tr>
<td>F727</td>
<td>SNF (405.1128j)</td>
<td></td>
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<tr>
<td></td>
<td>The facility has provision for promptly obtaining required laboratory, X-ray, and other diagnostic services.</td>
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<td></td>
</tr>
<tr>
<td>A. Provision for Services</td>
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<tr>
<td>F728</td>
<td>SNF (405.1128(aa)) (Standard)</td>
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<tr>
<td>F729</td>
<td>1. If the facility provides its own laboratory and X-ray services, these meet the applicable conditions established for certification of hospitals that are contained in 405.1028 and 405.1029, respectively.</td>
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</tr>
<tr>
<td>CODE</td>
<td>LABORATORY AND RADIOLOGIC SERVICES/ DENTAL SERVICES</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
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<tr>
<td>F730</td>
<td>2. If the facility itself does not provide such services, arrangements are made for obtaining these services from a physician's office, a participating hospital or skilled nursing facility, or a portable x-ray supplier or independent laboratory which is approved to provide these services under the program.</td>
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<tr>
<td>F731</td>
<td>3. The facility assists the resident, if necessary, in arranging for transportation to and from the source of service.</td>
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</tbody>
</table>

B. Blood and Blood Products

<table>
<thead>
<tr>
<th>CODE</th>
<th>LABORATORY AND RADIOLOGIC SERVICES/ DENTAL SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F732</td>
<td>SNF (405.1128(b)) (Standard)  ☐ MET ☐ NOT MET</td>
<td></td>
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</tr>
<tr>
<td>F733</td>
<td>1. Blood handling and storage facilities are safe, adequate, and properly supervised.</td>
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<tr>
<td>F734</td>
<td>2. If the facility provides for maintaining and transfusing blood and blood products, it meets the conditions established for certification of hospitals that are contained in §405.1028(j).</td>
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<tr>
<td>F735</td>
<td>3. If the facility does not provide its own facility but does provide transfusion services alone, it meets at least the requirements of §405.1028(j)(1), (3), (4), (6), and (9).</td>
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Dental Services (Condition of Participation)

<table>
<thead>
<tr>
<th>CODE</th>
<th>LABORATORY AND RADIOLOGIC SERVICES/ DENTAL SERVICES</th>
<th>YES</th>
<th>NO</th>
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<th>EXPLANATORY STATEMENT</th>
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<tbody>
<tr>
<td>F736</td>
<td>SNF (405.1129)  ☐ MET ☐ NOT MET</td>
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</tbody>
</table>

The facility has satisfactory arrangements to assist residents to obtain routine and emergency dental care (see §405.1121(i)). (The basic hospital insurance program does not cover the services of a dentist in a skilled nursing facility in connection with the care, treatment, filling, removal, or replacement of teeth or structures supporting the teeth; and only certain oral surgery is included in the supplemental medical insurance program.)
NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>DENTAL SERVICES/SOCIAL SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
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<tbody>
<tr>
<td>A. Advisory Dentist</td>
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<tr>
<td>F737</td>
<td>SNF (405.1129(a)) (Standard)</td>
<td>□ MET</td>
<td>□ NOT MET</td>
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</tr>
<tr>
<td>F738</td>
<td>A dentist recommends oral hygiene policies and practices for the care of residents. (§405.1121(h).)</td>
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<tr>
<td>B. Arrangements of Outside Services</td>
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<tr>
<td>F739</td>
<td>SNF (405.1129(b)) (Standard)</td>
<td>□ MET</td>
<td>□ NOT MET</td>
<td></td>
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</tr>
<tr>
<td>F740</td>
<td>1. The facility has a cooperative agreement with a dentist, and</td>
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</tr>
<tr>
<td>F741</td>
<td>2. Maintains a list of dentists in the community for residents who do not have a private dentist.</td>
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</tr>
<tr>
<td>F742</td>
<td>3. The facility assists the resident, if necessary, in arranging for transportation to and from the dentist’s office.</td>
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</tr>
<tr>
<td>Social Services (Condition of Participation)</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>F743</td>
<td>SNF (405.1130)</td>
<td>□ MET</td>
<td>□ NOT MET</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>The facility has satisfactory arrangements for identifying the medically related social and emotional needs of the resident. It is not mandatory that the skilled nursing facility itself provide social services in order to participate in the program. If the facility does not provide social services, it has written procedures for referring residents in need of social services to appropriate social agencies. If social services are offered by the facility, they are provided under a clearly defined plan, by qualified persons, to assist each resident to adjust to the social and emotional aspects of the resident’s illness, treatment, and stay in the facility.</td>
<td></td>
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</tr>
<tr>
<td>CODE</td>
<td>SOCIAL SERVICES</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
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<td>------</td>
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</tr>
<tr>
<td>F744</td>
<td>SNF (405.1130(a)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F745</td>
<td>Services are provided to meet the social and emotional needs of residents by qualified staff of the facility, or by referral, based on established procedures, to appropriate social agencies.</td>
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<tr>
<td>F746</td>
<td>ICF (442.344(b))</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td>The facility either provides these services itself or arranges for them with qualified outside resources.</td>
</tr>
<tr>
<td>F747</td>
<td>SNF (405.1130(b)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
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</tr>
<tr>
<td>F748</td>
<td>1. If the facility offers social services, a member of the staff of the facility is designated as responsible for social services.</td>
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<tr>
<td>F749</td>
<td>2. If the designated person is not a qualified social worker, the facility has a written agreement with a qualified social worker or recognized social agency for consultation and assistance on a regularly scheduled basis. (See §405.1101(a).)</td>
<td></td>
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</tr>
<tr>
<td>F750</td>
<td>3. The social service also has sufficient supportive personnel to meet resident needs.</td>
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<tr>
<td>F751</td>
<td>4. Facilities are adequate for social service personnel, easily accessible to residents and medical and other staff, and ensure privacy for interviews.</td>
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</tr>
<tr>
<td>CODE</td>
<td>SOCIAL SERVICES/ACTIVITIES</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
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<tr>
<td>F752</td>
<td>ICF (442.944(c))</td>
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<tr>
<td>F753</td>
<td>The facility designates one staff member, qualified by training or experience, to be responsible for:</td>
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<tr>
<td></td>
<td>a. Arranging for social services; and</td>
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<tr>
<td>F754</td>
<td>b. Integrating social services with other elements of the plan of care.</td>
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<tr>
<td></td>
<td>C. Records and Confidentiality</td>
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<tr>
<td>F755</td>
<td>SNF (405.1130(c)) (Standard)</td>
<td>MET</td>
<td></td>
<td>NOT MET</td>
<td></td>
</tr>
<tr>
<td>F756</td>
<td>Records of pertinent social data about personal and family problems medically related to the resident’s illness and care, and of action taken to meet the resident’s needs, are maintained in the resident’s medical records.</td>
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<tr>
<td>F757</td>
<td>If social services are provided by an outside resource, a record is maintained of each referral to such resource.</td>
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<tr>
<td></td>
<td>Activities (Condition of Participation)</td>
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<tr>
<td>F758</td>
<td>SNF (405.1131)</td>
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<tr>
<td></td>
<td>The facility provides for an activities program, appropriate to the needs and interests of each resident, to encourage self care, resumption of normal activities, and maintenance of an optimal level of psychosocial functioning.</td>
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</table>
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>ACTIVITIES/MEDICAL RECORDS</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F759</td>
<td>SNF (405.1131(a)) (Standard)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>F760</td>
<td>A member of the facility’s staff is designated as responsible for the activities program.</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>F761</td>
<td>If not a qualified activities coordinator, this staff member functions with frequent, regularly scheduled consultation from a person so qualified. (See §405.1101(c).)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>F762</td>
<td>ICF (442.345(b))</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>The facility designates one staff member, qualified by training or experience in directing group activity, to be responsible for activity service.</td>
</tr>
<tr>
<td>F763</td>
<td>SNF (405.1132)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>The facility maintains clinical (medical) records on all residents in accordance with accepted professional standards and practices. The medical record service has sufficient staff, facilities, and equipment to provide medical records that are completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.</td>
</tr>
<tr>
<td>F764</td>
<td>ICF (442.318(a))</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>The facility maintains an organized resident record system that contains a record for each resident.</td>
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<td>NAME OF FACILITY</td>
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</tr>
<tr>
<td>CODE</td>
<td>MEDICAL RECORDS</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
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</tr>
<tr>
<td>A. Staffing</td>
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<tr>
<td>F765</td>
<td>SNF (405.1132(a)) (Standard)</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>F766</td>
<td>Overall supervisory responsibility for the medical record service is assigned to a full-time employee of the facility.</td>
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<tr>
<td>F767</td>
<td>The facility also employs sufficient supportive personnel competent to carry out the functions of the medical record service.</td>
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<tr>
<td>F768</td>
<td>If the medical record supervisor is not a qualified medical record practitioner, this person functions with consultation from a person qualified. (See §405.1101(b).)</td>
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<tr>
<td>B. Protection of Medical Record Information</td>
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<tr>
<td>F769</td>
<td>SNF (405.1132(b)) (Standard)</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>F770</td>
<td>ICF (442.318(d))</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>F771</td>
<td>The facility safeguards medical record information against loss, destruction, or unauthorized use.</td>
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<tr>
<td>C. Physician Documentation</td>
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<tr>
<td>F772</td>
<td>SNF (405.1132(c)) (Standard)</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>F773</td>
<td>Only physicians enter or authenticate in medical records opinions that require medical judgment (in accordance with medical staff bylaws, rules, and regulations, if applicable).</td>
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<tr>
<td>F774</td>
<td>All physicians sign their entries into the medical record.</td>
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</tr>
<tr>
<td>CODE</td>
<td>MEDICAL RECORDS</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
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<tr>
<td>D. Completion of Records and Centralization of Reports</td>
<td></td>
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</tr>
<tr>
<td>F775 SNF (405.1132(a)) (Standard)</td>
<td>□ MET</td>
<td>□ NOT MET</td>
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</tr>
<tr>
<td>F776</td>
<td>1. Current medical records and those of discharged residents are completed promptly.</td>
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<tr>
<td>F777</td>
<td>2. All clinical information pertaining to a resident’s stay is centralized in the resident’s medical record.</td>
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<tr>
<td>E. Retention and Preservation</td>
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</tr>
<tr>
<td>F778 SNF (405.1132(f)) (Standard)</td>
<td>□ MET</td>
<td>□ NOT MET</td>
<td></td>
<td>Medical records are retained for a period of time not less than that determined by the respective State statute, the statute of limitations in the State, or 5 years from the date of discharge in the absence of a State statute, or, in the case of a minor, 3 years after the resident becomes of age under State law.</td>
<td></td>
</tr>
<tr>
<td>F779 ICF (442.318(e))</td>
<td>□ MET</td>
<td>□ NOT MET</td>
<td></td>
<td>The facility must keep a resident’s record for at least 3 years after the resident is discharged.</td>
<td></td>
</tr>
<tr>
<td>F780 SNF (405.1132(hl)) (Standard)</td>
<td>□ MET</td>
<td>□ NOT MET</td>
<td></td>
<td>The facility maintains adequate facilities and equipment, conveniently located to provide efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval).</td>
<td></td>
</tr>
</tbody>
</table>
### § 488.100

**NAME OF FACILITY**

<table>
<thead>
<tr>
<th>CODE</th>
<th>TRANSFER AGREEMENT</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
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<tbody>
<tr>
<td>F781</td>
<td>Transfer Agreement (Condition of Participation)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F782</td>
<td>ICF (442.316) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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</tr>
<tr>
<td>F783</td>
<td>The facility has in effect a transfer agreement with one or more hospitals approved for participation under the programs, which provides the basis for effective working arrangements under which inpatient hospital care or other hospital services are available promptly to the facility's residents when needed. (A facility that has been unable to establish a transfer agreement with the hospital(s) in the community or service area after documented attempts to do so is considered to have such an agreement in effect.) Exception: A facility that has been unable to establish a written agreement after documented attempts to do so, is considered to have such an agreement.</td>
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</tr>
<tr>
<td>F784</td>
<td>Resident Transfer</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
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</tr>
<tr>
<td>F785</td>
<td>A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case of two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that: 1. Transfer of patients will be effected between the hospital and the skilled nursing facility, ensuring timely admission, whenever such transfer is medically appropriate as determined by the attending physician.</td>
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</tbody>
</table>
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>TRANSFER AGREEMENT/PHYSICAL ENVIRONMENT</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F786</td>
<td>2. There will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.</td>
<td></td>
<td></td>
<td>N/A</td>
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</tr>
<tr>
<td>F787</td>
<td>3. Security and accountability for residents' personal effects are provided on transfer.</td>
<td></td>
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</tr>
<tr>
<td>F788</td>
<td>Physical Environment (Condition of Participation)</td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SNF (405.1134) (Standard)</td>
<td>MET</td>
<td>NOT MET</td>
<td></td>
<td>The facility is constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.</td>
</tr>
<tr>
<td></td>
<td>ICF (442.2321) (Standard)</td>
<td>MET</td>
<td>NOT MET</td>
<td></td>
<td>(See appropriate HCFA Fire Safety survey form.)</td>
</tr>
<tr>
<td></td>
<td>B. Maintenance of Equipment, Building, and Grounds</td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>F789</td>
<td>SNF (405.1134)(i) (Standard)</td>
<td>MET</td>
<td>NOT MET</td>
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<tr>
<td>F790</td>
<td>The facility establishes a written preventative maintenance program to ensure that all equipment is operative.</td>
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</tr>
<tr>
<td>CODE</td>
<td>INFECTION CONTROL</td>
<td>YES</td>
<td>NO</td>
<td>NIA</td>
<td>EXPLANATORY STATEMENT</td>
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<tr>
<td>F791</td>
<td>SNF (405.1135)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td>The facility establishes an infection control committee of representative professional staff with responsibility for overall infection control in the facility. All necessary housekeeping and maintenance services are provided to maintain a sanitary and comfortable environment and to help prevent the development and transmission of infection.</td>
</tr>
<tr>
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<td></td>
<td>A. Infection Control Committee</td>
</tr>
<tr>
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<td></td>
<td>F792 SNF (405.1135(a)) (Standard)</td>
</tr>
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<td></td>
<td>1. The infection control committee is composed of members of the medical and nursing staffs, administration, and the dietetic, pharmacy, housekeeping, maintenance, and other services.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>F793 1. The infection control committee is composed of members of the medical and nursing staffs, administration, and the dietetic, pharmacy, housekeeping, maintenance, and other services.</td>
</tr>
<tr>
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<td></td>
<td>2. The committee establishes policies and procedures for investigating, controlling, and preventing infection in the facility.</td>
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<tr>
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<td></td>
<td>F794 2. The committee establishes policies and procedures for investigating, controlling, and preventing infection in the facility.</td>
</tr>
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<td>3. The committee monitors staff performance to ensure that the policies and procedures are executed.</td>
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<td>F795 3. The committee monitors staff performance to ensure that the policies and procedures are executed.</td>
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<td></td>
<td>B. Aseptic and Isolation Techniques</td>
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<td>F796 SNF (405.1135(b)) (Standard)</td>
</tr>
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<td></td>
<td>1. The facility has written procedures for aseptic and isolation techniques.</td>
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<td></td>
<td>F797 1. The facility has written procedures for aseptic and isolation techniques.</td>
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<td></td>
<td>2. These procedures are reviewed and revised for effectiveness and improvement as necessary.</td>
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<td></td>
<td>F798 2. These procedures are reviewed and revised for effectiveness and improvement as necessary.</td>
</tr>
</tbody>
</table>
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>INFECTION CONTROL</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C. Housekeeping</td>
<td></td>
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<tr>
<td>F799</td>
<td>SNF (405.1135(c))</td>
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<tr>
<td></td>
<td>(Standard)</td>
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<tr>
<td></td>
<td>1. The facility employs sufficient housekeeping personnel.</td>
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<tr>
<td>F801</td>
<td>2. Provides all necessary equipment to maintain a safe,</td>
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<tr>
<td></td>
<td>clean and orderly interior.</td>
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</tr>
<tr>
<td>F802</td>
<td>3. A full-time employee is designated responsible for the</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>services and for supervision and training of personnel.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F803</td>
<td>4. If a facility has a contract with an outside resource for</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>housekeeping services, the facility and/or outside resource meets the requirements of the standards.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>D. Pest Control</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F804</td>
<td>SNF (405.1135(e))</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Standard)</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>The facility has an ongoing pest control program.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CODE</td>
<td>DISASTER PREPAREDNESS</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>F805</td>
<td>Disaster Preparedness (Condition of Participation)</td>
<td></td>
<td></td>
<td></td>
<td>The facility has a written plan, periodically rehearsed, with procedures to be followed in the event of an internal or external disaster and for the care of casualties (residents and personnel) arising from such disasters.</td>
</tr>
<tr>
<td>F806</td>
<td>ICF (442.313) (Standard)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F807</td>
<td>1. The facility has a written plan for staff and residents to follow in case of emergencies such as fire or explosion.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F808</td>
<td>2. The facility rehearses the plan regularly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F809</td>
<td>3. The facility has written procedures for the staff to follow in case of an emergency involving an individual resident.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F810</td>
<td>4. These procedures include:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Caring for the resident.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F811</td>
<td>b. Notifying the attending physician and other individuals responsible for the resident.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F812</td>
<td>c. Arranging for transportation, hospitalization, and other appropriate services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F813</td>
<td>SNF (405.1136(a)) (Standard)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F814</td>
<td>1. The facility has an acceptable written plan in operation, with procedures to be followed in the event of fire, explosion, or other disaster.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F815</td>
<td>2. The plan is developed and maintained with the assistance of qualified fire, safety, and other appropriate experts.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CODE</td>
<td>DISASTER PREPAREDNESS/UTILIZATION REVIEW</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------------</td>
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</tr>
<tr>
<td>F816</td>
<td>3. Includes procedures for prompt transfer of casualties and records.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F817</td>
<td>4. Instructions regarding the location and use of alarm systems and signals and of fire-fighting equipment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F818</td>
<td>5. Information regarding methods of containing fire.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F819</td>
<td>6. Procedures for notification of appropriate persons.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F820</td>
<td>7. Specifications of evacuation routes and procedures. (See §405.1134(a).)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Orientation and training

<table>
<thead>
<tr>
<th>CODE</th>
<th>DISASTER PREPAREDNESS/UTILIZATION REVIEW</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F821</td>
<td>SNF (405.1136(b)(j)) (Standard) ☐ MET ☐ NOT MET</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F822</td>
<td>The disaster program includes orientation and ongoing training and drills for all personnel in all procedures so that each employee promptly and correctly carries out a specific role in case of a disaster (See §405.1121(h).)</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Utilization Review (Condition of Participation)

<table>
<thead>
<tr>
<th>CODE</th>
<th>DISASTER PREPAREDNESS/UTILIZATION REVIEW</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F823</td>
<td>SNF (405.1137) ☐ MET ☐ NOT MET</td>
<td></td>
<td></td>
<td></td>
<td>The facility carries out utilization review of the services provided in the facility to residents who are entitled to benefits under the program(s). Utilization review assures the maintenance of high quality care and appropriate and efficient utilization of facility services. There are two elements to utilization review: medical care evaluation studies and review of extended duration cases.</td>
</tr>
<tr>
<td>CODE</td>
<td>UTILIZATION REVIEW</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>F824</td>
<td>SNF (405.1137(aii) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>F825</td>
<td>1. The facility has a currently applicable written description of its utilization review plan.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F826</td>
<td>2. Such description includes:</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>a. The organization and composition of the committee or group which will be responsible for the utilization review function.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F827</td>
<td>b. Methods of criteria (including norms where available) to be used to define periods of continuous extended duration and to assign or select subsequent dates for continued stay review.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F828</td>
<td>c. Methods for selection and conduct of medical care evaluation studies.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F829</td>
<td>SNF (405.1137(bii) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>F830</td>
<td>1. The utilization review (UR) function is conducted by:</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>a. A staff committee of the skilled nursing facility which is composed of two or more physicians, with participation of other professional personnel; or,</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>CODE</td>
<td>UTILIZATION REVIEW</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>F831</td>
<td>b. A group outside the facility which is similarly composed and which is established by the local medical or osteopathic society and some or all of the hospitals and skilled nursing facilities in the locality; or (indicate name of the outside group and briefly describe the organization.)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F832</td>
<td>c. A group established and organized in a manner approved by the Secretary that is capable of performing such function.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F833</td>
<td>2. The medical care evaluation studies, educational duties of the review program, and the review of admissions and long-stay cases are performed by:</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>a. the same committee or group;</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F834</td>
<td>b. or more committees or groups.</td>
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<tr>
<td></td>
<td>Briefly explain who performs these functions.</td>
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</tr>
<tr>
<td></td>
<td>C. Medical Care Evaluation Studies</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>F835</td>
<td>SNF (405.1137(c)) (Standard) ☐ MET ☐ NOT MET</td>
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<td></td>
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</tr>
<tr>
<td>F836</td>
<td>1. Medical care evaluation studies are performed to promote the most effective and efficient use of available health facilities and services consistent with resident needs and professionally recognized standards of health care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F837</td>
<td>2. Studies emphasize identification and analysis of patterns of resident care and suggest, where appropriate, possible changes for maintaining consistently high quality care and effective and efficient use of services.</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>UTILIZATION REVIEW</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>FB88</td>
<td>3. Each medical care evaluation study identifies and analyzes factors related to the care rendered in the facility and where indicated, results in recommendations for change beneficial to residents, staff, the facility, and the community.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>FB89</td>
<td>4. Studies, on a sample or other basis, include, but need not be limited to, admissions, durations of stay, ancillary services furnished (including drugs and biologicals), and professional services performed on premises.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>FB40</td>
<td>At least one study was completed during the last year. Type of study last completed:</td>
<td></td>
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</tr>
</tbody>
</table>

**D. Extended Stay Review**

<table>
<thead>
<tr>
<th>FB41</th>
<th>SNF (405.1137(d)) (Standard)</th>
<th>☐ MET</th>
<th>☐ NOT MET</th>
</tr>
</thead>
<tbody>
<tr>
<td>FB42</td>
<td>1. Periodic review is made of each current inpatient skilled nursing facility beneficiary case of continuous extended duration, and the length of which is defined in the utilization review plan to determine whether further inpatient stay is necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FB43</td>
<td>2. The review is based on the attending physician’s reasons for and plan for continued stay and any other documentation the committee or group deems appropriate.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| FB44 | 3. Cases are screened by:  
   a. A qualified non-physician representative of the committee. |    |    |    |                        |
| FB45 | b. The group. |    |    |    |                        |
| FB46 | c. The reviewer uses criteria established by the physician members of the committee. |    |    |    |                        |
## NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>UTILIZATION REVIEW</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F847</td>
<td>4. In instances when non-physician members are utilized, those cases are referred to a physician member for further review when it appears that the resident no longer requires further inpatient care.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F848</td>
<td>5. Non-physician representatives used to screen extended stay review cases, have experience in such screening or appropriate training in the application of the screening criteria used, or both.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>F849</td>
<td>6. Before the expiration of each new period, the case must be reviewed again in like manner with such reviews being repeated as long as the stay continues beyond the scheduled review dates and notice has not been given pursuant to paragraph (e) of this section.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>E. Further Stay Not Medically Necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F850</td>
<td>F851</td>
<td>1. A final determination of the committee or group that continued stay is not medically necessary is made by at least two physician members of the committee or group, except that the final determination may be made by one physician where the attending physician, when given an opportunity to express his views, does not do so, or does not contest the finding that the continued stay is not medically necessary.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F852</td>
<td>2. If the committee or group, or its nonphysician representative where a physician member concurs, has reason to believe from the review of an extended duration case or a case reviewed as part of a medical care evaluation study that further stay is no longer medically necessary, the committee or group shall notify the individual's attending physician and afford him an opportunity to present his views before it makes a final determination.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>UTILIZATION REVIEW</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F853</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. If the final determination of the committee or group is that further stay is no longer medically necessary, written notification of the finding is given to the facility, the attending physician, and the individual (or where appropriate, his next of kin) no later than 2 days after such final determination is made and, in no event in the case of an extended duration case, later than 3 working days after the end of the extended duration period specified pursuant to paragraph (d) of this section.</td>
</tr>
</tbody>
</table>

**F. Administrative Responsibilities**

<table>
<thead>
<tr>
<th>F854</th>
<th>SNF (405.1137(f)) (Standard)</th>
<th>MET</th>
<th>NOT MET</th>
</tr>
</thead>
<tbody>
<tr>
<td>F855</td>
<td>The administrative staff of the facility is kept directly and fully informed of committee activities to facilitate support and assistance. (Explain)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**G. Utilization Review Records**

<table>
<thead>
<tr>
<th>F856</th>
<th>SNF (405.1137(g)) (Standard)</th>
<th>MET</th>
<th>NOT MET</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>F857</th>
<th>1. Written records of committee activities are maintained.</th>
</tr>
</thead>
<tbody>
<tr>
<td>F858</td>
<td>2. Appropriate reports, signed by the committee chairman, are made regularly to the medical staff, administrative staff, governing body, and sponsors (if any).</td>
</tr>
<tr>
<td>F859</td>
<td>3. Minutes of each committee meeting is maintained and include at least:</td>
</tr>
<tr>
<td></td>
<td>a. Name of committee.</td>
</tr>
<tr>
<td></td>
<td>b. Date and duration of meeting.</td>
</tr>
<tr>
<td></td>
<td>c. Names of committee members present and absent.</td>
</tr>
<tr>
<td>CODE</td>
<td>UTILIZATION REVIEW</td>
</tr>
<tr>
<td>------</td>
<td>-------------------</td>
</tr>
<tr>
<td>F862</td>
<td>4. Description of activities presently in progress to satisfy the requirements for medical care evaluation studies, including the subject, reason for study, dates of commencement and expected completion, summary of studies completed since the last meeting, conclusions and follow-up on implementation of recommendations made from previous studies.</td>
</tr>
<tr>
<td>F863</td>
<td>5. Summary of extended duration cases reviewed including the number of cases, identification number, admission and review dates, and decision reached, including the basis for each determination and action taken for each case not approved for extended care.</td>
</tr>
<tr>
<td>F864</td>
<td>H. Discharge Planning</td>
</tr>
<tr>
<td></td>
<td>SNF (405.1137(h)) (Standard)</td>
</tr>
<tr>
<td></td>
<td>The facility maintains a centralized, coordinated program to ensure that each resident has a planned program of continuing care which meets his postdischarge needs.</td>
</tr>
<tr>
<td>F865</td>
<td>1. The facility has in operation an organized discharge planning program.</td>
</tr>
<tr>
<td>F866</td>
<td>The utilization review committee, in its evaluation of the current status of each extended duration case, has information on alternative available community resources to which the resident may be referred.</td>
</tr>
<tr>
<td>F867</td>
<td>2. The facility maintains written discharge planning procedures which describe:</td>
</tr>
<tr>
<td></td>
<td>a. How the discharge coordinator will function, and his authority and relationships with the facility’s staff.</td>
</tr>
<tr>
<td>F868</td>
<td>b. The maximum time period after which reevaluation of each resident’s discharge plan is made.</td>
</tr>
<tr>
<td>CODE</td>
<td>UTILIZATION REVIEW</td>
</tr>
<tr>
<td>------</td>
<td>--------------------</td>
</tr>
<tr>
<td>F869</td>
<td>c. Local resources available to the facility, the resident, and the attending physician to assist in developing and implementing individual discharge plans; and</td>
</tr>
<tr>
<td>F870</td>
<td>d. Provisions for periodic review and reevaluation of the facility’s discharge planning program.</td>
</tr>
<tr>
<td>F871</td>
<td>3. At the time of discharge, the facility provides those responsible for the resident’s post discharge care with appropriate summary of information about the discharged resident to ensure the optimal continuity of care.</td>
</tr>
<tr>
<td>F872</td>
<td>The discharge summary includes at least the following:</td>
</tr>
<tr>
<td>F872</td>
<td>a. Current information relative to diagnoses.</td>
</tr>
<tr>
<td>F873</td>
<td>b. Rehabilitation potential.</td>
</tr>
<tr>
<td>F874</td>
<td>c. A summary of the course of prior treatment.</td>
</tr>
<tr>
<td>F875</td>
<td>d. Physician orders for the immediate care of the resident.</td>
</tr>
<tr>
<td>F876</td>
<td>e. Pertinent social information.</td>
</tr>
</tbody>
</table>
§ 488.105 Long term care survey forms, Part B.

CENTERS FOR MEDICARE & MEDICAID SERVICES, HHS § 488.105

PART B

MEDICARE / MEDICAID SKILLED NURSING FACILITY AND INTERMEDIATE CARE FACILITY SURVEY REPORT

<table>
<thead>
<tr>
<th>PROVIDER NUMBER</th>
<th>FACILITY NAME AND ADDRESS (City, State, Zip)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VENDOR NUMBER</td>
<td></td>
</tr>
<tr>
<td>SURVEY DATE</td>
<td></td>
</tr>
</tbody>
</table>

SURVEYORS' NAMES

<table>
<thead>
<tr>
<th>TITLES</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SURVEY TEAM COMPOSITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1 Indicate the Number of Surveyors According to Disciplines</td>
</tr>
<tr>
<td>A. Administrator</td>
</tr>
<tr>
<td>B. Nurse</td>
</tr>
<tr>
<td>C. Dietitian</td>
</tr>
<tr>
<td>D. Pharmacist</td>
</tr>
<tr>
<td>E. Records Administrator</td>
</tr>
<tr>
<td>F. Social Worker</td>
</tr>
<tr>
<td>G. Qualified Mental Health Professional</td>
</tr>
<tr>
<td>H. Life Safety Code Specialist</td>
</tr>
<tr>
<td>I. Laboratorian</td>
</tr>
<tr>
<td>J. Sanitarian</td>
</tr>
<tr>
<td>K. Therapist</td>
</tr>
<tr>
<td>L. Physician</td>
</tr>
<tr>
<td>M. National Institute of Mental Health</td>
</tr>
<tr>
<td>N. Other</td>
</tr>
</tbody>
</table>

Note: More than one discipline may be marked for surveyors qualified in multiple disciplines.

F2 Indicate the Total Number of Surveyors Onsite: ________________________________

Form HCFA-619 (2008) (CONTINUED ON REVERSE)
<table>
<thead>
<tr>
<th>PROVIDER NO.</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>TOTAL RESIDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODE</td>
<td>MEDICARE</td>
<td>MEDICAID</td>
<td>OTHER</td>
<td></td>
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</tr>
<tr>
<td>BATHING</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F7</td>
<td>Number of residents requiring assistance in bathing more than one part of body—or does not bathe self.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F8</td>
<td>Number of residents requiring assistance in bathing only a single part (as back or disabled extremity) or bathes self completely.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F9</td>
<td>TOTAL*</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>DRESSING</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F10</td>
<td>Number of residents totally dressed by another person.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F11</td>
<td>Number of residents needing assistance to dress self or remain partly dressed. (Exclude those residents totally dressed.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F12</td>
<td>Number of residents able to get clothes from closets and drawers puts on clothes, outer garments, braces-manages fasteners. Act of tying shoes is excluded.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F13</td>
<td>TOTAL*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOILETING</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F14</td>
<td>Number of residents not toileted. (Use protective padding, catheter.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F15</td>
<td>Number of residents who must use a bedpan or commode and/or receive assistance in getting to and using a toilet.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F16</td>
<td>Number of residents able to get to toilet—gets on and off toilet—cleans self—arranges clothes.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F17</td>
<td>TOTAL*</td>
<td></td>
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<tr>
<td>TRANSFERRING</td>
<td></td>
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<tr>
<td>F18</td>
<td>Number of residents needing assistance in all transfers (moving in or out of bed and/or chair, toilet, tub transfers).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F19</td>
<td>Number of residents needing assistance in transferring to toilet and tub only.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F20</td>
<td>Number of residents able to complete all transfers independently (may or may not be using mechanical support).</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F21</td>
<td>TOTAL*</td>
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</tr>
<tr>
<td>CONTINENCE</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F22</td>
<td>Number of residents with indwelling or external catheters.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F23</td>
<td>Number of residents with partial or total incontinence in urination or incontinence—partial or total control by suppositories or enemas, regulated use of urinals and/or bedpans.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F24</td>
<td>Number of residents with incontinence entirely self-controlled.</td>
<td></td>
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<tr>
<td>F25</td>
<td>TOTAL*</td>
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<tr>
<td>FEEDING</td>
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<tr>
<td>F26</td>
<td>Number of residents who receive perorally/parenteral feedings.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F27</td>
<td>Number of residents who receive NG tube feedings.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F28</td>
<td>Number of residents who require assistance in act of eating.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F29</td>
<td>Number of residents who get food from plate or its equivalent into mouth—pre-cutting of meat and preparation of food, buttering bread, opening cans, removing plate covers, etc., are excluded from evaluation.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F30</td>
<td>TOTAL*</td>
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*Must equal total number of residents in facility
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>GOVERNING BODY (CONDITION OF PARTICIPATION)</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
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<tbody>
<tr>
<td>F50</td>
<td>SNF (405.1121)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>RESIDENT RIGHTS</strong></td>
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<tr>
<td>F51</td>
<td>SNF (405.1121)(k) (Standard)</td>
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<tr>
<td></td>
<td>Indicators A thru K apply to this standard for SNFs.</td>
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<tr>
<td>F52</td>
<td>ICF (422.311) (Standard)</td>
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<tr>
<td></td>
<td>Indicators A thru K apply to this standard for ICFs.</td>
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<tr>
<td>A. Information</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F53</td>
<td>1. The facility informs each resident, before or at the time of admission, of his/her rights and responsibilities.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F54</td>
<td>2. The facility informs each resident, before or at the time of admission, of all rules governing resident conduct.</td>
<td></td>
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</tr>
<tr>
<td>F55</td>
<td>3. The facility informs each resident of amendments to their policies on residents' rights and responsibilities and rules governing conduct.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F56</td>
<td>4. Each resident acknowledges in writing receipt of residents' rights information and any amendment to it.</td>
<td></td>
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</tr>
<tr>
<td>F57</td>
<td>5. The resident must be informed in writing of all services and charges for services.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F58</td>
<td>6. The resident must be informed in writing of all changes in services and charges before or at the time of admission and on a continuing basis.</td>
<td></td>
<td></td>
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<tr>
<td>F59</td>
<td>7. The resident must be informed of services not covered by Medicare or Medicaid and not covered in the basic rate.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>CODE</td>
<td>GOVERNING BODY</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
<tr>
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</tr>
<tr>
<td>B. Medical Condition and Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F60</td>
<td>1. Each resident is informed by a physician of his/her health and medical condition unless the physician decides that informing the resident is medically contraindicated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F61</td>
<td>2. Each resident is given an opportunity to participate in planning his/her total care and medical treatment.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F62</td>
<td>3. Each resident is given an opportunity to refuse treatment.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F63</td>
<td>4. Each resident gives informed, written consent before participating in experimental research.</td>
<td></td>
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</tr>
<tr>
<td>F64</td>
<td>5. If the physician decides that informing the resident of his/her health and medical condition is medically contraindicated, the physician has documented this decision in the resident's medical record.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>C. Transfer and Discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F65</td>
<td>Each resident is transferred or discharged only for:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F66</td>
<td>1. Medical reasons.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F67</td>
<td>2. His/her welfare or that of other residents.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| F68  | 3. "Becomes a patient of the Medicare or Medicaid program."

D. Exercising Rights |
<p>| F69  | 1. Each resident is encouraged and assisted to exercise his/her rights as a resident of the facility and as a citizen. |
| F70  | 2. Each resident is allowed to submit complaints and recommendations concerning the policies and services of the facility to staff or to outside representatives of the resident's choice or both. |</p>
<table>
<thead>
<tr>
<th>CODE</th>
<th>GOVERNING BODY</th>
</tr>
</thead>
<tbody>
<tr>
<td>F71</td>
<td>3. Such complaints are submitted free from restraint, coercion, discrimination, or reprisal.</td>
</tr>
<tr>
<td>F72</td>
<td>1. Residents are allowed to manage their own personal financial affairs.</td>
</tr>
<tr>
<td>F73</td>
<td>2. The facility establishes and maintains a system that assures full and complete accounting of residents' personal funds. An accounting report is made to each resident in a skilled nursing facility at least on a quarterly basis.</td>
</tr>
<tr>
<td>F74</td>
<td>3. The facility does not commingle resident funds with any other funds.</td>
</tr>
<tr>
<td>F75</td>
<td>4. If a resident requests assistance from the facility in managing his/her personal financial affairs, resident's delegation is in writing.</td>
</tr>
<tr>
<td>F76</td>
<td>5. The facility system of accounting includes written receipts for: All personal possessions and funds received by or deposited with the facility.</td>
</tr>
<tr>
<td>F77</td>
<td>All disbursements made to or for the resident.</td>
</tr>
<tr>
<td>F78</td>
<td>6. The financial record must be available to the resident and his/her family.</td>
</tr>
<tr>
<td>F79</td>
<td>F. Freedom from Abuse and Restraints</td>
</tr>
<tr>
<td>F80</td>
<td>1. Each resident is free from mental and physical abuse.</td>
</tr>
<tr>
<td></td>
<td>2. Chemical and physical restraints are only used when authorized by a physician in writing for a specified period of time or in emergencies.</td>
</tr>
</tbody>
</table>
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>GOVERNING BODY</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F81</td>
<td>3. If used in emergencies, they are necessary to protect the resident from injury to himself/herself or others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F82</td>
<td>4. The emergency use is authorized by a professional staff member identified in the written policies and procedures of the facility.</td>
<td></td>
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</tr>
<tr>
<td>F83</td>
<td>5. The emergency use is reported promptly to the resident's physician by the staff member.</td>
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</tbody>
</table>

#### G. Privacy

<table>
<thead>
<tr>
<th>CODE</th>
<th>GOVERNING BODY</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F84</td>
<td>1. Each resident is treated with respect, consideration and full recognition of his/her dignity and individuality.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F85</td>
<td>2. Each resident is given privacy during treatment and care of personal needs.</td>
<td></td>
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</tr>
<tr>
<td>F86</td>
<td>3. Each resident's records, including information in an automated data bank, are treated confidentially.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F87</td>
<td>4. Each resident must give written consent before the facility releases information from his/her record to someone not otherwise authorized to receive it.</td>
<td></td>
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</tr>
<tr>
<td>F88</td>
<td>5. Married residents are given privacy during visits by their spouses.</td>
<td></td>
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</tr>
<tr>
<td>F89</td>
<td>6. Married residents are permitted to share a room.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

#### H. Work

<table>
<thead>
<tr>
<th>CODE</th>
<th>GOVERNING BODY</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F90</td>
<td>No resident may be required to perform services for the facility.</td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>GOVERNING BODY</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F91</td>
<td>I. Freedom of Association and Correspondence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Each resident is allowed to communicate, associate and meet privately with individuals of his/her choice unless this infringes upon the rights of another resident.</td>
<td></td>
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</tr>
<tr>
<td>F92</td>
<td>2. Each resident is allowed to send and receive personal mail unopened.</td>
<td></td>
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</tr>
<tr>
<td>F93</td>
<td>J. Activities</td>
<td></td>
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<tr>
<td></td>
<td>Each resident is allowed to participate in social, religious, and community group activities.</td>
<td></td>
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</tr>
<tr>
<td>F94</td>
<td>K. Personal Possessions</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Each resident is allowed to retain and use his/her personal possessions and clothing as space permits.</td>
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<tr>
<td>F95</td>
<td>L. Delegation of Rights and Responsibilities</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>ICF (442.312) (Standard)</td>
<td>MET</td>
<td>NOT MET</td>
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</tr>
<tr>
<td>F96</td>
<td>1. All the rights and responsibilities of a resident pass to the resident’s guardian, next of kin or sponsoring agency or agencies if the resident is adjudicated incompetent under State law or is determined by his/her physician to be incapable of understanding his/her rights and responsibilities.</td>
<td></td>
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</tr>
<tr>
<td>F97</td>
<td>2. Physician determinations of incapability and the specific reasons thereof are recorded by the physician in the resident’s record.</td>
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</tr>
<tr>
<td>NAME OF FACILITY</td>
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<td>CODE</td>
<td>GOVERNING BODY</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
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<tr>
<td>F98</td>
<td>SNF (405.1121(N)) (Standard)</td>
<td>MET</td>
<td>NOT MET</td>
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<tr>
<td>F99</td>
<td>ICF (442.314) (Standard)</td>
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<tr>
<td>F100</td>
<td>1. Facility staff are knowledgeable about the problems and needs of the aged, ill, and disabled.</td>
<td></td>
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</tr>
<tr>
<td>F101</td>
<td>2. Facility staff practices proper techniques in providing care to the aged, ill, and disabled.</td>
<td></td>
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</tr>
<tr>
<td>F102</td>
<td>3. Facility staff practice proper techniques for prevention and control of infection, fire prevention and safety, accident prevention, confidentiality of resident information, and preservation of resident dignity, including protection of privacy and personal and property rights.</td>
<td></td>
<td></td>
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<tr>
<td>F103</td>
<td>SNF (405.1121(N)) (Standard)</td>
<td>MET</td>
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<tr>
<td>F104</td>
<td>ICF (442.307) (Standard)</td>
<td>Met</td>
<td>Not Met</td>
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<tr>
<td>F105</td>
<td>1. The facility notifies the resident's attending physician and other responsible persons in the event of an accident involving the resident, or other significant change in the resident's physical, mental, or emotional status, or resident charges, billings, and related administrative matters.</td>
<td></td>
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<tr>
<td>F106</td>
<td>2. Except in a medical emergency, a resident is not transferred or discharged, nor is treatment altered radically, without consultation with the resident or, if the resident is incompetent, without prior notification of next of kin or sponsor.</td>
<td></td>
<td></td>
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<tr>
<td>CODE</td>
<td>PHYSICIANS' SERVICES (CONDITION OF PARTICIPATION)</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
<tr>
<td>------</td>
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<tr>
<td>P107</td>
<td>SNF (405.1123)</td>
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<tr>
<td>P108</td>
<td>SNF (405.1123)(Standard)</td>
<td>MET</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P109</td>
<td>1. There is made available to the facility prior to or at the time of admission, resident information which includes current medical findings, diagnoses, and orders from a physician for immediate care of the resident.</td>
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</tr>
<tr>
<td>P110</td>
<td>2. Information about the rehabilitation potential of the resident and a summary of prior treatment are made available to the facility at the time of admission or within 48 hours thereafter.</td>
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</tr>
<tr>
<td>CODE</td>
<td>PHYSICIANS’ SERVICES</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
<tr>
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<tr>
<td>F11</td>
<td>SNF (405.11230f) (Standard)</td>
<td>☐ MET</td>
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<td>This standard for SNFs.</td>
</tr>
<tr>
<td>F12</td>
<td>ICF (442.346) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td>☐</td>
<td>This standard for ICFs.</td>
</tr>
<tr>
<td>F13</td>
<td>1. Every resident must be under the supervision of a physician.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Exception: Not required for SNFs.</td>
</tr>
<tr>
<td>F14</td>
<td>2. A physician prescribes a planned regimen of care based on a medical evaluation of each resident’s immediate and long-term care needs.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Exception: Not required for SNFs.</td>
</tr>
<tr>
<td>F15</td>
<td>3. A physician is available to provide care in the absence of any resident’s attending physician.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Exception: Not required for SNFs.</td>
</tr>
<tr>
<td>F16</td>
<td>4. Medical evaluation is done within 48 hours of admission unless done within 5 days prior to admission.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Exception: Not required for SNFs.</td>
</tr>
<tr>
<td>F17</td>
<td>5. Each resident is seen by their attending physician at least once every 30 days for the first 90 days after admission.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Exception: ICF residents must be seen every 60 days unless otherwise justified and documented by the attending physician.</td>
</tr>
<tr>
<td>F18</td>
<td>6. Each resident’s total program of care including medications and treatments is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days and revised as necessary.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Exception: Only medications must be reviewed quarterly for ICF residents.</td>
</tr>
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<td>CODE</td>
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<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
<tr>
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</tr>
<tr>
<td>F119</td>
<td>7. Progress notes are written and signed by the physician at the time of each visit, and all orders are signed by the physician.</td>
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<tr>
<td>F120</td>
<td>8. Alternate physician visit schedules that exceed a 30-day schedule adopted after the 90th day following admission are justified by the attending physician in the medical record. These visits cannot exceed 60 days or apply to residents who require specialized rehabilitation schedules.</td>
<td></td>
<td></td>
<td></td>
<td>EXCEPTION: Not required for ICF residents.</td>
</tr>
<tr>
<td>F21</td>
<td>C. Emergency Services</td>
<td></td>
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<tr>
<td></td>
<td>SNF (405.1123(c)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F22</td>
<td>Emergency services from a physician are available and provided to each resident who requires emergency care.</td>
<td></td>
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</tr>
<tr>
<td>F23</td>
<td>NURSING SERVICES (CONDITION OF PARTICIPATION)</td>
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<tr>
<td></td>
<td>SNF (405.1124)</td>
<td>☐ MET</td>
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<td>F24</td>
<td>SNF (405.1124(c)) (Standard)</td>
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<td>☐ Not Met</td>
<td>Indicators A and B apply to this standard for SNFs.</td>
<td></td>
</tr>
<tr>
<td>F25</td>
<td>ICF (442.338)</td>
<td>☐ Met</td>
<td>☐ Not Met</td>
<td>Indicators A thru E apply to this standard for ICFs except where noted.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| F126 | A. The facility provides nursing services which are sufficient to meet nursing needs of all residents all hours of each day, |     |    |     |                        |
|      | 1. Each resident receives all treatments, medications and diet as prescribed. Deviations are reported and appropriate action is taken. |     |    |     |                        |</p>
<table>
<thead>
<tr>
<th>CODE</th>
<th>NURSING SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F127</td>
<td>2. Each resident receives daily personal hygiene as needed to assure cleanliness, good skin care, good grooming, and oral hygiene taking into account individual preferences. Residents are encouraged to engage in self care activity.</td>
<td></td>
<td></td>
<td>N/A</td>
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</tr>
<tr>
<td>F128</td>
<td>3. Each resident receives care necessary to prevent skin breakdown.</td>
<td></td>
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<tr>
<td>F129</td>
<td>4. Each resident with a decubitus receives care necessary to promote the healing of the decubitus including proper dressing.</td>
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<tr>
<td>F130</td>
<td>5. When residents require restraints the application is ordered by the physician, applied properly, and released at least every 2 hours.</td>
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<tr>
<td>F131</td>
<td>6. Each resident with incontinence is provided with care necessary to encourage continence including frequent toileting and opportunities for rehabilitative training.</td>
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</tr>
<tr>
<td>F132</td>
<td>7. Each resident with a urinary catheter receives proper routine care including periodic evaluation.</td>
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</tr>
</tbody>
</table>
| F133 | 8. Each resident receives proper care for the following needs:  
- Injections  
- Parenteral Fluids  
- Colostomy/ileostomy  
- Respiratory Care  
- Tracheostomy Care  
- Suctioning  
- Tube Feeding |   |    |     |                        |
| F134 | 9. Infection Control Techniques are properly carried out in the provision of care to each resident. |   |    |     |                        |
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>NURSING SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F135</td>
<td>10. Proper nursing and sanitary procedures and techniques are used when medications are given to residents.</td>
<td></td>
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</tr>
<tr>
<td>F136</td>
<td>11. Adequate resident care supplies are available for providing treatments.</td>
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</tr>
</tbody>
</table>

### B. Twenty-Four Hour Nursing Service

1. Nursing personnel, including registered nurses, licensed practical (vocational) nurses, nurse aids, orderlies, and ward clerks, are assigned duties consistent with their education and experience, and based on the characteristics of the resident load.

   **EXCEPTION:** Not required for ICFs.

2. Weekly time schedules are maintained and indicate the number and classifications of nursing personnel including relief personnel, who worked on each unit for each tour of duty.

   (If a distinct part certification, show the staffing for the DP and, if appropriate, any nonparticipating remainder and explain any sharing of nursing personnel.)

   **Exception:** Not required for Freestanding ICFs.

3. There is a sufficient number of nursing staff available to meet the total needs of all residents.

4. There is a registered nurse on the day tour of duty 7 days a week.

   **Exception:** Not required for ICF residents.
<table>
<thead>
<tr>
<th>CODE</th>
<th>NURSING SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>C. Charge Nurse SNF (405.112(4)(b)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F141</td>
<td>1. A registered nurse or a qualified licensed practical (or vocational) nurse is designated as charge nurse by the director of nursing for each tour of duty.</td>
<td></td>
<td></td>
<td></td>
<td>Exception: Not required for ICFs.</td>
</tr>
<tr>
<td>F142</td>
<td>2. The director of nursing services does not serve as charge nurse in a facility with an average daily total occupancy of 60 or more residents.</td>
<td></td>
<td></td>
<td></td>
<td>Exception: Not required for ICFs.</td>
</tr>
<tr>
<td>F143</td>
<td>3. The ICF must have a registered nurse, or a licensed practical or vocational nurse full-time, 7 days a week, on the day shift.</td>
<td></td>
<td></td>
<td></td>
<td>Exception: Not required for SNFs.</td>
</tr>
</tbody>
</table>
List the number of full-time equivalents of RN’s, LPN’s, Aides/Orderlies assigned to nursing duty from the last 3 complete weeks. (Note only actual staff on duty.)

<table>
<thead>
<tr>
<th>Shift</th>
<th>CODE</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
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<td>Entire Facility</td>
<td>F146</td>
<td></td>
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<td>Evening</td>
<td>DP</td>
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<td></td>
<td></td>
<td>Entire Facility</td>
<td>F148</td>
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</tr>
<tr>
<td>Night</td>
<td>DP</td>
<td>F149</td>
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<td></td>
<td></td>
<td>Entire Facility</td>
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<table>
<thead>
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<th>Shift</th>
<th>CODE</th>
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<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
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</thead>
<tbody>
<tr>
<td>Day</td>
<td>DP</td>
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<td>Entire Facility</td>
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<tr>
<td>Evening</td>
<td>DP</td>
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<td>Entire Facility</td>
<td>F148</td>
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<td>DP</td>
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### Staffing Pattern Worksheets Day of Survey (Optional)

#### Entire Facility Staffing Pattern (Day of Survey)

<table>
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<tr>
<th>Shift</th>
<th>Code</th>
<th>RN</th>
<th>PN</th>
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<tr>
<td>EVENING</td>
<td>DP</td>
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#### Unit Staffing Pattern Worksheet (Day of Survey)

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<tbody>
<tr>
<td>DAY</td>
<td>F163</td>
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<tr>
<td>EVENING</td>
<td>F164</td>
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<tr>
<td>NIGHT</td>
<td>F165</td>
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<td>CENSUS</td>
<td>F166</td>
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</table>
NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>NURSING SERVICES</th>
<th>YES</th>
<th>NO</th>
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<tr>
<td>P167</td>
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<tr>
<td>P168</td>
<td>ICF (442.341) (Standard)</td>
<td>□ MET</td>
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<tr>
<td>P169</td>
<td>Each resident’s needs are addressed in a written plan of care which demonstrates that the plans of all services are integrated, consonant with the physician’s plan of medical care, and implemented shortly after admission.</td>
<td></td>
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</tr>
<tr>
<td>P170</td>
<td>Each professional service identifies needs, goals, plans, and evaluates the effectiveness of interventions, plus institutes changes in the plan of care in a timely manner.</td>
<td></td>
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<tr>
<td>P171</td>
<td>SNF (405.1124(a)) (Standard)</td>
<td>□ MET</td>
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<tr>
<td>P172</td>
<td>ICF (442.342) (Standard)</td>
<td>□ MET</td>
<td>□ NOT MET</td>
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</tr>
<tr>
<td>P173</td>
<td>1. Each resident receives rehabilitative nursing care to promote maximum physical functioning to prevent immobility, deformities, and contractures.</td>
<td></td>
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</tr>
<tr>
<td>P174</td>
<td>2. There is an ongoing evaluation of each resident’s rehabilitative nursing needs. This may include;</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>P175</td>
<td>(a) Range of motion, ambulation, turning and positioning and other activities;</td>
<td></td>
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</tr>
<tr>
<td>P176</td>
<td>(b) Assistance and instruction in the activities of daily living such as feeding, dressing, grooming, oral hygiene and toilet activities;</td>
<td></td>
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</tr>
<tr>
<td>P177</td>
<td>(c) Retraining therapy and/or reality orientation when appropriate;</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>P178</td>
<td>3. These activities are coordinated with other resident care services.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>CODE</td>
<td>NURSING SERVICES</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
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<tr>
<td>21</td>
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<td></td>
<td></td>
<td>y. The facility has an awareness of nutritional needs and fluid intake of residents and provides prompt assistance where necessary in feeding residents.</td>
</tr>
<tr>
<td>210</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SNF (405.1124[1]) (Standard) ☐ MET ☐ NOT MET</td>
</tr>
<tr>
<td>2110</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. Each resident is provided with the amount of food and fluid on a daily basis necessary to maintain their appropriate minimum average weight. Between meal feedings are offered and the amount consumed is observed. Daily food and fluid intake is observed and encouraged.</td>
</tr>
<tr>
<td>2111</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Each resident needing assistance in eating or drinking is provided prompt assistance. Specific self-help devices are available when necessary.</td>
</tr>
<tr>
<td>2112</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Deviations from normal food and fluid intake are recorded and reported to the charge nurse and the attending physician.</td>
</tr>
</tbody>
</table>
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>NURSING SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F183</td>
<td>SNF (405.1124(g)) (Standard)</td>
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<tr>
<td>F184</td>
<td>ICF (442.337) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
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</tr>
<tr>
<td>F185</td>
<td>1. The resident is identified prior to administration of a drug.</td>
<td></td>
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</tr>
<tr>
<td>F186</td>
<td>2. Drugs and biologicals are administered as soon as possible after doses are prepared.</td>
<td></td>
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</tr>
<tr>
<td>F187</td>
<td>3. Administered by same person who prepared the doses for administration except under single unit dose package distribution systems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F188</td>
<td>Exception: ICF residents may self-administer medication only with their physician's permission.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>F189</td>
<td>SNF (405.1124(h)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F190</td>
<td>ICF (442.334) (Standard)</td>
<td>☐ MET</td>
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</tr>
<tr>
<td>F191</td>
<td>Drugs are administered in accordance with written orders of the attending physician.</td>
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</tr>
<tr>
<td>F192</td>
<td>Drug Error Rate $%$</td>
<td></td>
<td></td>
<td></td>
<td>(See Form HCFA-522)</td>
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</tbody>
</table>

Form: HCFA-518 (2-88)
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>DIETETIC SERVICES (CONDITION OF PARTICIPATION)</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F193</td>
<td>SNF (405.1125)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F194</td>
<td>ICF (442.332) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td>Indicators A and B apply to this standard for ICFs.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>A. Menus and Nutritional Adequacy</td>
</tr>
<tr>
<td>F195</td>
<td>SNF (405.1125(b)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F196</td>
<td>Menus are planned and followed to meet the nutritional needs of each resident in accordance with physicians' orders and, to the extent medically possible, based on the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>B. Therapeutic Diets</td>
</tr>
<tr>
<td>F197</td>
<td>SNF (405.1125(c)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F198</td>
<td>1. Therapeutic diets are prescribed by the attending physician.</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>F199</td>
<td>2. Therapeutic menus are planned in writing, prepared, and served as ordered with supervision from the dietitian and advice from the physician whenever necessary.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

F200 Number of Regular Diets________

F201 Number of Therapeutic Diets________

F202 Number of Mechanically Altered Diets________

F203 Number of Tube Feedings________
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>DIETETIC SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>C. Preparation</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F204</td>
<td>SNF (405.1125(e)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
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</tr>
<tr>
<td>F205</td>
<td>1. Food is prepared by methods that conserve its nutritive value and flavor.</td>
<td></td>
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</tr>
<tr>
<td>F206</td>
<td>2. Meals are palatable, served at proper temperatures. They are cut, ground, chopped, pureed or in a form which meets individual resident needs.</td>
<td></td>
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</tr>
<tr>
<td>F207</td>
<td>3. If a resident refuses food served, appropriate substitutes of similar nutritive value are offered.</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>D. Frequency</td>
<td></td>
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</tr>
<tr>
<td>F208</td>
<td>SNF (405.1125(d)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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<tr>
<td>F209</td>
<td>ICF (442.331) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
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</tr>
<tr>
<td>F210</td>
<td>1. At least three meals are served daily at regular hours with not more than a 14-hour span between a substantial evening meal and breakfast.</td>
<td></td>
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</tr>
</tbody>
</table>
| F211 | 2. To the extent medically possible, bedtime nourishments are offered to all residents.  

**Exception:** Not required for ICF Residents.  |

<table>
<thead>
<tr>
<th></th>
<th>E. Staffing</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>F212</td>
<td>SNF (405.1125(a)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
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</tr>
<tr>
<td>F213</td>
<td>1. Food service personnel are on duty daily over a period of 12 or more hours.</td>
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</table>
### NAME OF FACILITY

<table>
<thead>
<tr>
<th>CODE</th>
<th>SPECIALIZED REHABILITATIVE SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
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<tbody>
<tr>
<td>F214</td>
<td>SPECIALIZED REHABILITATIVE SERVICES (CONDITION OF PARTICIPATION)</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>SNF (405.1126)</td>
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<tr>
<td></td>
<td>SNF (405.1126)(ii) (Standard)</td>
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<tr>
<td></td>
<td>ICF (442.343) (Standard)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>A. Plan of Care</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Rehabilitation services are provided under a written plan of care, initiated by the attending physician and developed in consultation with appropriate therapist(s) and the nursing service.</td>
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<tr>
<td></td>
<td>B. Therapy</td>
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<tr>
<td></td>
<td>Therapy is provided according to orders of the attending physician in accordance with accepted professional practices by qualified therapists or qualified assistants.</td>
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<tr>
<td></td>
<td>C. Progress</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>1. A report of the resident’s progress is communicated to the attending physician within 2 weeks of the initiation of specialized rehabilitative services.</td>
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<tr>
<td></td>
<td>Exception: ICF resident’s progress must be reviewed regularly.</td>
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</tr>
<tr>
<td>CODE</td>
<td>SPECIALIZED REHABILITATIVE SERVICES/PHARMACEUTICAL SERVICES</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
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<tr>
<td>F220</td>
<td>2. The resident's progress is thereafter reviewed regularly, and the plan of rehabilitative care is reevaluated as necessary, but at least every 30 days, by the physician and the therapist. Exceptions: ICF residents' plans must be revised as necessary.</td>
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<tr>
<td></td>
<td>PHARMACEUTICAL SERVICES (CONDITION OF PARTICIPATION)</td>
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</tr>
<tr>
<td>F221</td>
<td>SNF (405.1127)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. Supervision</td>
<td></td>
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<tr>
<td>F222</td>
<td>SNF (405.1127(a)) (Standard)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>F223</td>
<td>ICF (442.336) (Standard)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>F224</td>
<td>The pharmacist reviews the drug regimen of each resident at least monthly and reports any irregularities to the medical director and administrator</td>
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</tr>
<tr>
<td>CODE</td>
<td>PHARMACEUTICAL SERVICES</td>
<td>LABORATORY AND RADIOLOGIC SERVICES/SOCIAL SERVICES</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
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<tr>
<td>F225</td>
<td>B. Labeling of Drugs and Biologicals</td>
<td>SNF (405.1127(c)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td>☐</td>
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<tr>
<td>F226</td>
<td>ICF (442.333) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td>☐</td>
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<tr>
<td>F227</td>
<td></td>
<td>The labeling of drugs and biologics is based on currently accepted professional principles and includes the appropriate accessory and cautionary instructions as well as an expiration date when applicable.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>F228</td>
<td>LABORATORY AND RADIOLOGIC SERVICES (CONDITION OF PARTICIPATION)</td>
<td>SNF (405.1128)</td>
<td>☐ MET</td>
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<tr>
<td>F229</td>
<td></td>
<td>SNF (405.1128(a)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Provision of Services**

1. All services are provided only on the orders of a physician.
2. The attending physician is notified promptly of diagnostic findings.
3. Signed and dated reports of a clinical laboratory, X-ray and other diagnostic services are filed with the resident's medical record.
<table>
<thead>
<tr>
<th>CODE</th>
<th>SOCIAL SERVICES/ACTIVITIES</th>
<th>YES</th>
<th>NO</th>
<th>NIA</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F233</td>
<td>SNF (405.1130)</td>
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<tr>
<td>F234</td>
<td>SNF (405.1130)(a) (Standard)</td>
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<tr>
<td>F235</td>
<td>ICF (442.344) (Standard)</td>
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</tbody>
</table>

A. Plan

The medically related social and emotional needs of the resident are identified.

B. Provision of Services

1. Services are provided to meet the social and emotional needs by the facility or by referral to an appropriate social agency.

2. If financial assistance is indicated, arrangements are made promptly for referral to an appropriate agency.
<table>
<thead>
<tr>
<th>CODE</th>
<th>ACTIVITIES</th>
<th>YES/NO/N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F241</td>
<td>ICF (442.345)</td>
<td>[standard]</td>
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<td>F242</td>
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<td>F243</td>
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<td>F245</td>
<td></td>
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<tr>
<td>CODE</td>
<td>MEDICAL RECORDS (CONDITION OF PARTICIPATION)</td>
<td>YES</td>
<td>NO</td>
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<td>F247</td>
<td>SNF (405.1132)</td>
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<td>F249</td>
<td>ICF (442.318) (Standard)</td>
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<tr>
<td>CODE</td>
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<td>TRANSFER AGREEMENT (CONDITION OF PARTICIPATION)</td>
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<td>F266</td>
<td>SNF (405.1133(a)) (Standard)</td>
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<tr>
<td>F267</td>
<td>ICF (442.316) (Standard)</td>
<td>☐ MET ☐ NOT MET</td>
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<tr>
<td>F268</td>
<td>A. Whenever the attending physician determines that a transfer is medically appropriate between a hospital or a facility providing more specialized care and the nursing facility, admission to the new facility shall be effected in a timely manner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F269</td>
<td>B. Information necessary for providing care and treatment to transferred individuals is provided.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## NAME OF FACILITY

### PHYSICAL ENVIRONMENT

<table>
<thead>
<tr>
<th>CODE</th>
<th>PHYSICAL ENVIRONMENT (CONDITION OF PARTICIPATION)</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
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<tbody>
<tr>
<td>F270</td>
<td>SNF (405.1134)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. Nursing Unit</td>
<td></td>
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<tr>
<td>F271</td>
<td>SNF (405.1134)(d) (Standard)</td>
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</tr>
<tr>
<td>F272</td>
<td>1. The unit is properly equipped for preparation and storage of drugs and biologicals.</td>
<td></td>
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</tr>
<tr>
<td>F273</td>
<td>2. Utility and storage rooms are adequate in size.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>F274</td>
<td>3. The unit is equipped to register resident calls with a functioning communication system from resident areas including resident rooms and toilet and bathing facilities.</td>
<td></td>
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<tr>
<td></td>
<td>B. Dining and Activities Area</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F275</td>
<td>SNF (405.1134)(g) (Standard)</td>
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<tr>
<td>F276</td>
<td>ICF (442.329) (Standard)</td>
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<tr>
<td>F277</td>
<td>1. The facility provides one or more clean, orderly and appropriately furnished rooms of adequate size designated for resident dining and resident activities.</td>
<td></td>
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<tr>
<td>F278</td>
<td>2. Dining and activity rooms are well lighted and ventilated.</td>
<td></td>
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</tr>
<tr>
<td>F279</td>
<td>3. Any multipurpose room used for dining and resident activities has sufficient space to accommodate all activities and prevent their interference with each other.</td>
<td></td>
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</tbody>
</table>
## NAME OF FACILITY

<table>
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<th>CODE</th>
<th>PHYSICAL ENVIRONMENT</th>
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<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
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</thead>
<tbody>
<tr>
<td>F280</td>
<td>SNF (405.1134(e)) (Standard)</td>
<td>□ MET</td>
<td>□ NOT MET</td>
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</tr>
<tr>
<td></td>
<td>INDICATORS C AND D APPLY TO THIS STANDARD FOR SNF</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>C. Resident Rooms</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>F281</td>
<td>ICF (442.325) (Standard)</td>
<td>□ MET</td>
<td>□ NOT MET</td>
<td></td>
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</tr>
<tr>
<td>F282</td>
<td>1. Single resident rooms have at least 100 square feet.</td>
<td></td>
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<tr>
<td>F283</td>
<td>2. Multiple resident rooms have no more than four residents and at least 80 square feet per resident.</td>
<td></td>
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</tr>
<tr>
<td>F284</td>
<td>3. Each room is equipped with or conveniently located near toilet and bathing facilities.</td>
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<tr>
<td>F285</td>
<td>4. There is capability of maintaining privacy in each.</td>
<td></td>
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<tr>
<td>F286</td>
<td>5. There is adequate storage space for each resident.</td>
<td></td>
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<tr>
<td>F287</td>
<td>6. There is a comfortable and functioning bed and chair plus a functional cabinet and light.</td>
<td></td>
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</tr>
<tr>
<td>F288</td>
<td>7. The resident call system functions in resident rooms.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F289</td>
<td>8. Each room is designed and equipped for adequate nursing care and the comfort and privacy of the residents.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F290</td>
<td>9. Each room is at or above grade level.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F291</td>
<td>10. Each room has direct access to a corridor and outside exposure.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|      | | | | | |
|      | Exception: Not required for ICF residents. | | | | |
### NAME OF FACILITY

#### PHYSICAL ENVIRONMENT

<table>
<thead>
<tr>
<th>CODE</th>
<th>PHYSICAL ENVIRONMENT</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F292</td>
<td>D. Toilet and Bath Facilities ICF (442.326) (Standard)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F323 1. Facilities are clean, sanitary and free of odors.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F324 2. Facilities have safe and comfortable hot water temperatures.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F325 3. Facilities maintain privacy.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>F326 4. Facilities have grab bars and other safeguards against slipping.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F327 5. Facilities have fixtures in good condition.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F328 6. The resident call system functions in toilet and bath facilities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F299</td>
<td>E. Social Service Area SNF (408.1130[b][1]) (Standard)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F300 1. Ensures privacy for social service interviewing.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F301 2. Adequate space for clerical and interviewing functions is provided.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F302 3. Facilities are easily accessible to residents and staff.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CODE</td>
<td>PHYSICAL ENVIRONMENT</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td></td>
<td>F. Therapy Areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F303</td>
<td>SNF (405.112(a))</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>F304</td>
<td>ICF (442.328(a))</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F305</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. Space is adequate for proper use of equipment by all residents receiving treatments.</td>
</tr>
<tr>
<td>F306</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Equipment is safe and in proper working condition.</td>
</tr>
<tr>
<td></td>
<td>G. Facilities for Special Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F307</td>
<td>SNF (405.1134(f))</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F308</td>
<td>ICF (442.328(b))</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F309</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. Single rooms with private toilet and handwashing facilities are available for isolating residents.</td>
</tr>
<tr>
<td>F310</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Precautionary signs are used to identify these rooms when in use.</td>
</tr>
<tr>
<td></td>
<td>H. Common Resident Areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F311</td>
<td>SNF (405.1134(i))</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F312</td>
<td>ICF (442.324)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F313</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. All common resident areas are clean, sanitary and free of odors.</td>
</tr>
<tr>
<td>F314</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Provision is made for adequate and comfortable lighting levels in all areas.</td>
</tr>
<tr>
<td>F315</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. There is limitation of sounds at comfort levels.</td>
</tr>
<tr>
<td>CODE</td>
<td>PHYSICAL ENVIRONMENT</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>F316</td>
<td>4. A comfortable room temperature is maintained.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F317</td>
<td>5. There is adequate ventilation through windows or mechanical means or a combination of both.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F318</td>
<td>6. Corridors are equipped with firmly secured handrails on each side.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F319</td>
<td>7. Staff are aware of procedures to ensure water to all essential areas in the event of loss of normal supply.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F320</td>
<td>I. Maintenance of Building and Equipment</td>
<td>MET</td>
<td>NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNF (405.1134(d)) (Standard)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F321</td>
<td>1. The interior and exterior of the building are clean and orderly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F322</td>
<td>2. All essential mechanical and electrical equipment is maintained in safe operating condition.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F323</td>
<td>3. Sufficient storage space is available and used for equipment to ensure that the facility is orderly and safe.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F324</td>
<td>4. Resident care equipment is clean and maintained in safe operating condition.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F325</td>
<td>ICF (442.331(b))</td>
<td>MET</td>
<td>NOT MET</td>
<td></td>
<td>Indicators J thru L apply to ICFs.</td>
</tr>
<tr>
<td>F326</td>
<td>J. Dietetic Service Area</td>
<td>MET</td>
<td>NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNF (405.1134(h)) (Standard)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F327</td>
<td>1. Kitchen and dietetic service areas are adequate to insure proper, timely food services for all residents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F328</td>
<td>2. Kitchen areas are properly ventilated, arranged, and equipped for storage and preparation of food as well as for dish and utensil cleaning, and refuse storage and removal.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CODE</td>
<td>PHYSICAL ENVIRONMENT/INFECTION CONTROL</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------</td>
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</tr>
<tr>
<td>F329</td>
<td>SNF (405.1125(f)) (Standard)</td>
<td></td>
<td></td>
<td></td>
<td>F329</td>
</tr>
<tr>
<td>F330</td>
<td>Diabetic service personnel practice hygienic food handling techniques</td>
<td></td>
<td></td>
<td></td>
<td>F330</td>
</tr>
<tr>
<td>F331</td>
<td>SNF (405.1125(g)) (Standard)</td>
<td></td>
<td></td>
<td></td>
<td>F331</td>
</tr>
<tr>
<td>F332</td>
<td>1. Food is stored, refrigerated, prepared, distributed, and served under sanitary conditions</td>
<td></td>
<td></td>
<td></td>
<td>F332</td>
</tr>
<tr>
<td>F333</td>
<td>2. Waste is disposed of properly</td>
<td></td>
<td></td>
<td></td>
<td>F333</td>
</tr>
<tr>
<td>F334</td>
<td>SNF (405.1134(b)) (Standard)</td>
<td></td>
<td></td>
<td></td>
<td>F334</td>
</tr>
<tr>
<td>F335</td>
<td>1. An emergency source of electrical power necessary to protect the health and safety of residents is available in the event the normal electrical supply is interrupted.</td>
<td></td>
<td></td>
<td></td>
<td>F335</td>
</tr>
<tr>
<td>F336</td>
<td>2. Emergency power is adequate at least for lighting in all means of egress; equipment to maintain fire detection, alarm, and extinguishing systems; and life safety support systems.</td>
<td></td>
<td></td>
<td></td>
<td>F336</td>
</tr>
<tr>
<td>F337</td>
<td>3. Emergency power is provided by an emergency electrical generator located on the premises where life support systems are used.</td>
<td></td>
<td></td>
<td></td>
<td>F337</td>
</tr>
<tr>
<td>F338</td>
<td>SNF (405.1135)</td>
<td></td>
<td></td>
<td></td>
<td>F338</td>
</tr>
<tr>
<td>F339</td>
<td>SNF (405.1135(b)) (Standard)</td>
<td></td>
<td></td>
<td></td>
<td>F339</td>
</tr>
<tr>
<td>F340</td>
<td>A. Infection Control</td>
<td></td>
<td></td>
<td></td>
<td>F340</td>
</tr>
</tbody>
</table>

**INFECTION CONTROL (CONDITION OF PARTICIPATION)**

- **A. Infection Control**
  - SNF (405.1135(b)) (Standard) | MET | NOT MET | F339
  - Aseptic and isolation techniques are followed by all personnel. | | | F340
<table>
<thead>
<tr>
<th>CODE</th>
<th>INFECTION CONTROL/DISASTER PREPAREDNESS</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>EXPLANATORY STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>F341</td>
<td>SNF (405.1135(d)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F342</td>
<td>The facility maintains a safe, clean, and orderly interior.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F343</td>
<td>SNF (405.1135(d)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F344</td>
<td>ICF (442.327) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F345</td>
<td>1. The facility has available at all times a quantity of linens essential for proper care and comfort of residents.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F346</td>
<td>2. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F347</td>
<td>SNF (405.1135(e)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F348</td>
<td>ICF (442.315(c)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F349</td>
<td>The facility is maintained free from insects and rodents.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F350</td>
<td>SNF (405.1136)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F351</td>
<td>SNF (405.1136(a)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F352</td>
<td>ICF (442.313) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F353</td>
<td>A. Disaster Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Facility staff are aware of plans, procedures to be followed for fire, explosion or other disaster.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CODE</td>
<td>DISASTER PREPAREDNESS</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
<td>EXPLANATORY STATEMENT</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>F354</td>
<td>2. Facility staff are knowledgeable about evacuation routes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F355</td>
<td>3. Facility staff are aware of their specific responsibilities in regard to evaluation and protection of residents.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F356</td>
<td>4. Facility staff are aware of methods of containing fire.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>B. Drills</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F357</td>
<td>SNF (405.1136(b)) (Standard)</td>
<td>☐ MET</td>
<td>☐ NOT MET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F358</td>
<td>1. All employees are trained, as part of their employment orientation in all aspects of preparedness for any disaster.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F359</td>
<td>2. Facility staff participate in ongoing training and drills in all procedures so that each employee promptly and correctly carries out a specific role in case of a disaster.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
§ 488.105  
42 CFR Ch. IV (10–1–16 Edition)

SKILLED NURSING FACILITY & INTERMEDIATE CARE FACILITY  
SURVEY REPORT   PART B   
CRUCIAL DATA EXTRACT  
(To be used with 2-86 Revision of Form HCFA-618)

<table>
<thead>
<tr>
<th>PROVIDER NO.</th>
<th>FACILITY NAME</th>
<th>SURVEY DATE</th>
</tr>
</thead>
</table>

SURVEY TEAM COMPOSITION

- **F1: INDICATE THE NUMBER OF SURVEYORS ACCORDING TO DISCIPLINE:**
  
<table>
<thead>
<tr>
<th></th>
<th>ADMINISTRATOR</th>
<th>LIFE SAFETY CODE SPECIALIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td>H.</td>
</tr>
<tr>
<td>B</td>
<td>NURSE</td>
<td>I. LABORATORIAN</td>
</tr>
<tr>
<td>C</td>
<td>DIETITIAN</td>
<td>J. SANITARIAN</td>
</tr>
<tr>
<td>D</td>
<td>PHARMACIST</td>
<td>K. THERAPIST</td>
</tr>
<tr>
<td>E</td>
<td>RECORDS ADMINISTRATOR</td>
<td>L. PHYSICIAN</td>
</tr>
<tr>
<td>F</td>
<td>SOCIAL WORKER</td>
<td>M. NATIONAL INSTITUTE OF</td>
</tr>
<tr>
<td>G</td>
<td>QUALIFIED MENTAL RETARDATION PROFESSIONAL</td>
<td>N. OTHER</td>
</tr>
</tbody>
</table>

NOTE: MORE THAN ONE DISCIPLINE MAY BE MARKED FOR SURVEYORS QUALIFIED IN MULTIPLE DISCIPLINES.

- **F2: INDICATE THE TOTAL NUMBER OF SURVEYORS ONSITE:**

  *P193* DRUG ERROR RATE: Percentage (Round % to nearest whole number.)

- **SPS Survey Form Indicator (Check one)**
  
  Traditional Survey New LTC Survey
  
  (1) [ ] (2) [ ]

NOTE: PLEASE ATTACH COPY OF PAGES 2, 14 AND 15.

*Mandatory

Form HCFA-618 (2-86)
### TOUR NOTES WORKSHEET

#### PROVIDER NUMBER | SURVEY DATE | INDEPTH SAMPLE
--- | --- | ---

<table>
<thead>
<tr>
<th>INSTRUCTIONS</th>
<th>INDEPTH SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Note care and problems in care on all units.</td>
<td>Facility</td>
</tr>
<tr>
<td>2. Report deficiencies directly to survey report form or evaluate further during indepth sample review.</td>
<td>Census: 0-50</td>
</tr>
<tr>
<td>3. Select a proportionate number from each section.</td>
<td>Sample: 25</td>
</tr>
<tr>
<td>4. Select a proportionate number from each section.</td>
<td>Size: (Min:10)</td>
</tr>
</tbody>
</table>

#### GROOMING/PERSONAL HYGIENE

- [ ]

#### POSITIONING

- [ ]

#### ASSISTIVE DEVICES

- [ ]

#### AMBULATION

- [ ]

#### RESTRAINTS

- [ ]

#### HYDRATION

- [ ]

#### INFECTION CONTROL

- [ ]

#### PATIENT RIGHTS

- [ ]

#### OTHER

- [ ]

---

FORM HCFA-521 (2-95)
# OBSERVATION / INTERVIEW RECORD REVIEW WORKSHEET

## PROVIDER NUMBER  SURVEY DATE  OBSERVATION/INTERVIEW OF: (RESIDENT IDENTIFIER)

## INSTRUCTIONS
1. Observe each resident in sample to identify ADL needs and potential problems. Check appropriate blocks.
2. Interview only residents in sample who are capable and willing.
3. Review each resident's record to ensure assessments, plans, interventions and evaluations are appropriate and current.
4. Note deficiencies on survey form after reviewing all residents in sample.

## RESIDENT NEEDS

<table>
<thead>
<tr>
<th>ADL's</th>
<th>GROOMING/HYGIENE</th>
<th>RESIDENTS</th>
<th>FEEDING</th>
<th>ONG &amp; MOV</th>
<th>RESPIRATORY</th>
<th>AUTONOMIC/ENDOCRINE</th>
<th>URINATION</th>
<th>DEFECATION</th>
<th>INJECTIONS</th>
<th>DRESSINGS</th>
<th>HANDLING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>Dressing</td>
<td>Toileting</td>
<td>Transferring</td>
<td>Grooming</td>
<td>PH Level</td>
<td>Glucose</td>
<td>Insulin</td>
<td>Diet</td>
<td>Activity</td>
<td>Feeding</td>
<td>N/G Tube</td>
</tr>
<tr>
<td>Transferring</td>
<td>Toileting</td>
<td>Transferring</td>
<td>Grooming</td>
<td>PH Level</td>
<td>Glucose</td>
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<td>Grooming</td>
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## NOTES:

Form HCFA 124 (2-89)  SEE REVERSE

$488.105$
Centers for Medicare & Medicaid Services, HHS § 488.105

DRUG PASS WORKSHEET

<table>
<thead>
<tr>
<th>PROVIDER NUMBER</th>
<th>SURVEY DATE</th>
<th>ERROR RATE</th>
</tr>
</thead>
</table>

**INSTRUCTIONS**
2. Record Observation of each Opportunity.
3. Compare Observation Notes with Physician Orders.
4. Calculate and Note Error Rate.
5. Note Deficiencies on Survey Report Form.

**DEFICIENCY FORMULA**
1. One or more Significant Errors = Deficiency
2. Significant + Non-significant = $X$ 100

**RECORD**

<table>
<thead>
<tr>
<th>IDENTIFIER</th>
<th>POURED</th>
<th>PASSED</th>
<th>RECORDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESIDENT'S FULL NAME, ROOM NUMBER, TIME</td>
<td>DRUG PRESCRIPTION NAME, DOSE AND FORM</td>
<td>OBSERVATION OF ADMINISTRATION</td>
<td>DRUG ORDER WRITTEN AS: (IF DIFFERS FROM ADMIN'S ONLY)</td>
</tr>
</tbody>
</table>

FORM HCFA-S22 (2-96) SEE REVERSE

VerDate Sep<11>2014 13:33 Nov 18, 2016 Jkt 238196 PO 00000 Frm 00351 Fmt 8010 Sfmt 8006 Q:\42\42V5.TXT 31
DRUG ERROR CALCULATION
(SEE SOM Appendix N Part 2)

How to Calculate a Medication Error Rate—In calculating the percentage of errors, the numerator in the ratio is the total number of errors that you observe, both significant and non-significant. The denominator is all the doses observed being administered plus the doses ordered but not administered. The equation for calculating a medication error rate is as follows:

\[
\text{Medication Error Rate} = \frac{\text{Number of errors observed}}{\text{Opportunities for errors}} \times 100
\]

Where: Opportunities for errors equals the number of doses administered plus the number of doses ordered but not administered.

Comments

For example, you observed the administration of drugs to 20 patients. There were a total of 47 drugs administered (47 opportunities for errors). At the completion of the reconciliation of your Observations with the physicians' orders, you find that three medication errors were made in administration and one medication was omitted (ordered but not administered). The omitted dose is included in both the numerator and the denominator. Therefore, following the above formula, your equation would be as follows:

\[
\frac{3 + 1}{47 + 1} \times 100 = 8.3\%
\]
## DINING AREA & EATING ASSISTANCE WORKSHEET

### PROVIDER NUMBER

<table>
<thead>
<tr>
<th>SURVEY DATE</th>
</tr>
</thead>
</table>

### INSTRUCTIONS

**TASKS**

1. **Observe Dining Area**
   - a. Size does not restrict movement.
   - b. Accommodates all residents.
   - c. Cleanliness.
   - d. Adequate/comfortable lighting.
   - e. Adequate/comfortable ventilation.

2. **Note Meals Served/Review Physicians Orders**
   - a. Number of meals/timespan between meals.
   - b. Conformance to physicians order.
   - c. Nutritional adequacy.
   - d. Adequacy of portions.
   - e. Residents eat approximately 75% of meals.
   - f. Puree dishes served individually.
   - g. Food cut, chopped or ground for individual resident needs.
   - h. Acceptable taste.
   - i. Proper temperature.
   - j. Plates covered.

3. **Note Assistance Provided**

4. **Note Deficiencies on Survey Summary Form**

*Sample a minimum of five (5) residents.*
§ 488.110 Procedural guidelines.

SNF/ICF Survey Process. The purpose for implementing a new SNF/ICF survey process is to assess whether the quality of care, as intended by the law and regulations, and as needed by the resident, is actually being provided in nursing homes. Although the onsite review procedures have been changed, facilities must continue to meet all applicable Conditions/Standards, in order to participate in Medicare/Medicaid programs. That is, the methods used to

2. SERVING OF MEALS *(continued)*

k. Served promptly.

l. Residents ready for meal when served.

m. Attractive.

n. Utensils available.

o. Functional trays for bedfast residents.

p. Salt, pepper, sugar, other condiments on resident's trays unless contraindicated.

q. Medically able residents eating in dining area.

r. Bedtime nourishment offered.

3. SUPERVISION OF RESIDENT NUTRITION

a. Prompt assistance.

b. Proper assistance (spoon-feeding, supervision or instruction to develop eating skills).

c. Courteous and unhurried assistance.

d. Self-help devices present (straws, easy grip utensils, special cup, etc.).

e. Intake recorded/deviations from normal are reported.
Centers for Medicare & Medicaid Services, HHS § 488.110

compile information about compliance with law and regulations are changed; the law and regulations themselves are not changed. The new process differs from the traditional process, principally in terms of its emphasis on resident outcomes. In ascertaining whether grooming and personal hygiene needs are met, for example, surveyors will no longer routinely evaluate a facility’s written policies and procedures. Instead, surveyors will observe residents in order to make that determination. In addition, surveyors will confirm, through interviews with residents and staff, that such needs are indeed met on a regular basis. In most reviews, then, surveyors will ascertain whether the facility is actually providing the required and needed care and services, rather than whether the facility is capable of providing the care and services.

THE OUTCOME-ORIENTED SURVEY PROCESS—SKILLED NURSING FACILITIES (SNFs) AND INTERMEDIATE CARE FACILITIES (ICFs)

(a) General.
(b) The Survey Tasks.
(c) Task 1—Entrance Conference.
(d) Task 2—Resident Sample—Selection Methodology.
(e) Task 3—Tour of the Facility.
(f) Task 4—Observation/Interview/Medical Record Review (including drug regimen review).
(g) Task 5—Drug Pass Observation.
(h) Task 6—Dining Area and Eating Assistance Observation.
(i) Task 7—Forming the Deficiency Statement (if necessary).
(j) Task 8—Exit Conference.
(k) Plan of Correction.
(l) Followup Surveys.
(m) Role of Surveyor.
(n) Confidentiality and Respect for Resident Privacy.
(o) Team Composition.
(p) Type of Facility—Application of SNF or ICF Regulations.

(a) General. A complete SNF/ICF facility survey consists of three components:

- Life Safety Code requirements;
- Administrative and structural requirements (Part A of the Survey Report, Form CMS–525); and
- Direct resident care requirements (Part B of the Survey Report, Form CMS–519), along with the related worksheets (CMS–520 through 524).

Use this survey process for all surveys of SNFs and ICFs—whether free-standing, distinct parts, or dually certified. Do not use this process for surveys of Intermediate Care Facilities for Mentally Retarded (ICFs/IID), swing-bed hospitals or skilled nursing sections of hospitals that are not separately certified as SNF distinct parts. Do not announce SNF/ICF surveys ahead of time.

(b) The Survey Tasks. Listed below are the survey tasks for easy reference:

- Task 1. Entrance Conference.
- Task 2. Resident Sample—Selection Methodology.
- Meeting with Resident Council Representatives. Tour Summation and Focus of Remaining Survey Activity.
- Task 4. Observation/Interview/Medical Record. Review of Each Individual in the Resident Sample (including drug regimen review).
- Task 5. Drug Pass Observation.
- Task 6. Dining Area and Eating Assistance Observation.
- Task 7. Forming the Deficiency Statement (if necessary).
- Task 8. Exit Conference.

(c) Task 1—Entrance Conference. Perform these activities during the entrance conference in every certification and recertification survey:

- Introduce all members of the team to the facility staff, if possible, even though the whole team may not be present for the entire entrance conference. (All surveyors wear identification tags.)

- Explain the SNF/ICF survey process as resident centered in focus, and outline the basic steps.
- Ask the facility for a list showing names of residents by room number with each of the following care needs/treatments identified for each resident to whom they apply:
  - Decubitus care
  - Restraints
  - Catheters
  - Injections
  - Parenteral fluids
  - Rehabilitation service
  - Colostomy/ileostomy care
  - Respiratory care
§ 488.110—Tracheostomy care
—Suctioning
—Tube feeding

Use this list for selecting the resident sample.

• Ask the facility to complete page 2 of Form CMS–519 (Resident Census) as soon as possible, so that the information can further orient you to the facility’s population. In a survey of a SNF with a distinct part ICF, you may collect two sets of census data. However, consolidate the information when submitting it to the regional office. You may modify the Resident Census Form to include the numbers of licensed and certified beds, if necessary.

• Ask the facility to post signs on readily viewed areas (at least one on each floor) announcing that State surveyors are in the facility performing an “inspection,” and are available to meet with residents in private. Also indicate the name and telephone number of the State agency. Hand-printed signs with legible, large letters are acceptable.

• If the facility has a Resident Council, make mutually agreeable arrangements to meet privately with the president and officers and other individuals they might invite.

• Inform the facility that interviews with residents and Resident Councils are conducted privately, unless they independently request otherwise, in order to enhance the development of rapport as well as to allay any resident anxiety. Tell the facility that information is gathered from interviews, the tour, observations, discussions, record review, and facility officials. Point out that the facility will be given an opportunity to respond to all findings.

(d) Task 2—Resident Sample—Selection Methodology. This methodology is aimed at formulating a sample that reflects the actual distribution of care needs/treatments in the facility population.

Primarily performed on a random basis, it also ensures representation in the sample of certain care needs and treatments that are assessed during the survey.

(1) Sample Size. Calculate the size of the sample according to the following guide:

<table>
<thead>
<tr>
<th>Number of residents in facility</th>
<th>Number of residents in sample ¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–60 residents.</td>
<td>25% of residents (minimum—10).</td>
</tr>
<tr>
<td>61–120 residents.</td>
<td>20% of residents (minimum—15).</td>
</tr>
<tr>
<td>121–200 residents.</td>
<td>15% of residents (minimum—24).</td>
</tr>
<tr>
<td>201 + residents.</td>
<td>10% of residents (minimum—30).</td>
</tr>
</tbody>
</table>

¹ Maximum—50.

Note that the calculation is based on the resident census, not beds. After determining the appropriate sample size, select residents for the sample in a random manner. You may, for example, select every fifth resident from the resident census, beginning at a random position on the list. For surveys of dually certified facilities or distinct part SNFs/ICFs, first use the combined SNF/ICF population to calculate the size of the sample, and then select a sample that reflects the proportions of SNF and ICF residents in the facility’s overall population.

(2) Special Care Needs/Treatments. The survey form specifies several care needs/treatments that must always be reviewed when they apply to any facility residents. These include:

• Decubitus Care
• Restraints
• Catheters
• Injections, Parenteral Fluids, Colostomy/Ileostomy, Respiratory Care, Tracheostomy Care, Suctioning, Tube Feeding
• Rehabilitative Services (physical therapy, speech pathology and audiology services, occupational therapy)

Due to the relatively low prevalence of these care needs/treatments, appropriate residents may be either underrepresented or entirely omitted from the sample. Therefore, determine during the tour how many residents in the random selection fall into each of these care categories. Then, compare the number of such residents in the random selection with the total number of residents in the facility with each specified care need/treatment (based on either the resident census or other information provided by the facility).

Review no less than 25 percent of the residents in each of these special care needs/treatments categories. For example, if the facility has 10 residents with...
decubitus ulcers, but only one of these residents is selected randomly, review two more residents with decubitis ulcers (25% of 10 equals 2.5, so review a total of 3). Or, if the facility has two residents who require tube feeding, neither of whom is in the random selection, review the care of at least one of the these residents. This can be accomplished in the following manner:

Conduct in-depth reviews of the randomly selected residents and then perform limited reviews of additional residents as needed to cover the specified care categories. Such reviews are limited to the care and services related to the pertinent care areas only, e.g., catheters, restraints, or colostomy. Utilize those worksheets or portions of worksheets which are appropriate to the limited review. Refer to the Care Guidelines, as a resource document, when appropriate.

Always keep in mind that neither the random selection approach nor the review of residents within the specified care categories precludes investigation of other resident care situations that you believe might pose a serious threat to a resident’s health or safety. Add to the sample, as appropriate.

(e) Task 3—Tour of the Facility—(1) Purpose. Conduct the tour in order to:

• Develop an overall picture of the types and patterns of care delivery present within the facility;
• View the physical environment; and
• Ascertain whether randomly selected residents are communicative and willing to be interviewed.

(2) Protocol. You may tour the entire facility as a team or separately, as long as all areas of the facility are examined by at least one team member. Success of the latter approach, however, is largely dependent on open intra-team communication and the ability of each team member to identify situations for further review by the team member of the appropriate discipline. You may conduct the tour with or without facility staff accompanying you, as you prefer. Facilities, however, vary in staff member availability. Record your notes on the Tour Notes Worksheet, Form CMS–521.

Allow approximately three hours for the tour. Converse with residents, family members/significant others (if present), and staff, asking open-ended questions in order to confirm observations, obtain additional information, or corroborate information, (e.g., accidents, odors, apparent inappropriate dress, adequacy and appropriateness of activities). Converse sufficiently with residents selected for in-depth review to ascertain whether they are willing to be interviewed and are communicative. Observe staff interactions with other staff members as well as with residents for insight into matters such as resident rights and assignments of staff responsibilities.

Always knock and/or get permission before entering a room or interrupting privacy. If you wish to inspect a resident’s skin, observe a treatment procedure, or observe a resident who is exposed, courteously ask permission from the resident if she/he comprehends, or ask permission from the staff nurse if the resident cannot communicate. Do not do “hands-on” monitoring such as removal of dressings; ask staff to remove a dressing or handle a resident.

(3) Resident Needs. While touring, focus on the residents’ needs—physical, emotional, psychosocial, or spiritual—and whether those needs are being met. Refer to the following list as needed:

—Personal hygiene, grooming, and appropriate dress
—Position
—Assistive and other restorative devices
—Rehabilitation issues
—Functional limitations in ADL
—Functional limitations in gait, balance and coordination
—Hydration and nutritional status
—Resident rights
—Activity for time of day (appropriate or inappropriate)
—Emotional status
—Level of orientation
—Awareness of surroundings
—Behaviors
—Cleanliness of immediate environment (wheelchair, bed, bedside table, etc.)
—Odors
—Adequate clothing and care supplies as well as maintenance and cleanliness of same

(4) Review of the Physical Environment. As you tour each resident’s room and
auxiliary rooms, also examine them in connection with the physical environment requirements. You need not document physical environment on the Tour Notes Worksheet. Instead, you may note any negative findings directly on the Survey Report Form in the remarks section.

(5) Meeting With Resident Council Representatives. If a facility has a Resident Council, one or more surveyors meet with the representatives in a private area. Facility staff members do not attend unless specifically requested by the Council. Explain the purpose of the survey and briefly outline the steps in the survey process, i.e., entrance conference * * * exit conference. Indicate your interest in learning about the strengths of the facility in addition to any complaints or shortcomings. State that this meeting is one part of the information gathering; the findings have not yet been completed nor the conclusions formulated. Explain further, however, that the official survey findings are usually available within three months after the completion of the survey, and give the telephone number of the State agency office.

Use this meeting to ascertain strengths and/or problems, if any, from the consumer's perspective, as well as to develop additional information about aspects of care and services gleaned during the tour that were possibly substandard.

Conduct the meeting in a manner that allows for comments about any aspect of the facility. (See the section on Interview Procedures.) Use open-ended questions such as:
- “What is best about this home?”
- “What is worst?”
- “What would you like to change?”

In order to get more detail, use questions such as:
- “Can you be more specific?”
- “Can you give me an example?”
- “What can anyone else tell me about this?”

If you wish to obtain information about a topic not raised by the residents, use an approach like the following:
- “Tell me what you think about the food/staff/cleanliness here.”
- “What would make it better?”
- “What don’t you like? What do you like?”

(6) Tour Summation and Focus of Remaining Survey Activity. When the tour is completed, review the resident census data provided by the facility. Determine if the care categories specified in the section on Resident Sample are sufficiently represented in the random selection, make adjustments as needed, and complete the listing of residents on the worksheet labeled “Residents Selected for In-depth Review”, Form CMS–520. Transcribe notes of a negative nature onto the SRF in the “Remarks” column under the appropriate rule. Findings from a later segment in the survey or gathered by another surveyor may combine to substantiate a deficiency. You need not check “met” or “not met” at this point in the survey. Discuss significant impressions/conclusions at the completion of each subsequent survey task, and transfer any negative findings onto the Survey Report Form in the Remarks section.

(f) Task 4—Observation/Interview/Medical Record Review (including drug regimen review). Perform the in-depth review of each individual in the resident sample in order to ascertain whether the facility is meeting resident needs. Evaluate specific indicators for each resident, utilizing the front and back of the “Observation/Interview/Record Review (OIRR)” worksheet, Form CMS–524. You may prefer to perform the record review first, complete resident/staff/family observations and interviews, and finally, return to the record for any final unresolved issues. On the other hand, you may prefer to do the interviews first. Either method is acceptable. Whenever possible, however, complete one resident’s observation/interview/medical record review and document the OIRR before moving onto another resident. If because of the facility layout, it is more efficient to do more than one record review at a time, limit such record review to two or three residents so your familiarity with the particular resident and continuity of the OIRR are not compromised.

(1) Observation. Conduct observations concurrently with interviews of residents, family/significant others, and
discussions with direct care staff [of the various disciplines involved. In multi-facility operations, whenever possible, observe staff that is regularly assigned to the facility in order to gain an understanding of the care and services usually provided.] Maintain respect for resident privacy. Minimize disruption of the operations of the facility or impositions upon any resident as much as possible. Based upon your observations of the residents’ needs, gather information about any of the following areas, as appropriate:

- Bowel and bladder training
- Catheter care
- Restraints
- Parenteral fluids
- Tube feeding/gastrostomy
- Colostomy/ileostomy
- Respiratory therapy
- Tracheostomy care
- Suctioning

(2) Interviews. Interview each resident in private unless he/she independently requests that a facility staff member or other individual be present. Conduct the in-depth interview in a nonthreatening and noninvasive fashion so as to decrease anxiety and defensiveness. The open-ended approach described in the section on the Resident Council is also appropriate for the in-depth interview. While prolonged time expenditure is not usually a worthwhile use of resources or the resident’s time, do allow time initially to establish rapport.

At each interview:

- Introduce yourself.
- Address the resident by name.
- Explain in simple terms the reason for your visit (e.g., to assure that the care and services are adequate and appropriate for each resident).
- Briefly outline the process—entrance conference, tour, interviews, observations, review of medical records, resident interviews, and exit conference.
- Mention that the selection of a particular resident for an interview is not meant to imply that his/her care is substandard or that the facility provides substandard care. Also mention that most of those interviewed are selected randomly.
- Assure that you will strive for anonymity for the resident and that the interview is used in addition to medical records, observations, discussions, etc., to capture an accurate picture of the treatment and care provided by the facility. Explain that the official findings of the survey are usually available to the public about three months after completion of the survey, but resident names are not given to the public.
- When residents experience difficulty expressing themselves:
  - Avoid pressuring residents to verbalize
  - Accept and respond to all communication
  - Ignore mistakes in word choice
  - Allow time for recollection of words
  - Encourage self-expression through any means available
- When interviewing residents with decreased receptive capacity:
  - Speak slowly and distinctly
  - Speak at conversational voice level
  - Sit within the resident’s line of vision
- Listen to all resident information/allegations without judgment. Information gathered subsequently may substantiate or repudiate an allegation.

The length of the interview varies, depending on the condition and wishes of the resident and the amount of information supplied. Expect the average interview, however, to last approximately 15 minutes. Courteously terminate an interview whenever the resident is unable or unwilling to continue, or is too confused or disoriented to continue. Do, however, perform the other activities of this task (observation and record review). If, in spite of your conversing during the tour, you find that less than 40 percent of the residents in your sample are sufficiently alert and willing to be interviewed, try to select replacements so that a complete OIRR is performed for a group this size, if possible. There may be situations, however, where the resident population has a high percentage of confused individuals and this percentage is not achievable. Expect that the information from confused individuals can be, but is not necessarily, less
reliable than that from more alert individuals.

Include the following areas in the interview of each resident in the sample:

- Activities of daily living
- Grooming/hygiene
- Nutrition/dietary
- Restorative/rehabilitation care and services
- Activities
- Social services
- Resident rights

Refer to the Care Guidelines ‘evaluation factors’ as a resource for possible elements to consider when focusing on particular aspects of care and resident needs.

Document information obtained from the interviews/observations on the OIRR Worksheet. Record in the ‘Notes’ section any additional information you may need in connection with substandard care or services. Unless the resident specifically requests that he/she be identified, do not reveal the source of the information gleaned from the interview.

(3) Medical Record Review. The medical record review is a three-part process, which involves first reconciling the observation/interview findings with the record, then reconciling the record against itself, and lastly performing the drug regimen review.

Document your findings on the OIRR Worksheet, as appropriate, and summarize on the Survey Report Form the findings that are indicative of problematic or substandard care. Be alert for repeated similar instances of substandard care developing as the number of completed OIRR Worksheets increases.

NOTE: The problems related to a particular standard or condition could range from identical (e.g., meals not in accordance with dietary plan) to different but related (e.g., nursing services—lapse in care provided to residents with catheters, to residents with contractures, to residents needing assistance for personal hygiene and residents with improperly applied restraints).

(i) Reconciling the observation/interview findings with the record. Determine if:

- An assessment has been performed.
- A plan with goals has been developed.
- The interventions have been carried out.
- The resident has been evaluated to determine the effectiveness of the interventions.

For example, if a resident has developed a decubitus ulcer while in the facility, record review can validate staff and resident interviews regarding the facility’s attempts at prevention. Use your own judgment; review as much of the record(s) as necessary to evaluate the care planning. Note that facilities need not establish specific areas in the record stating ‘Assessment,’ ‘Plan,’ ‘Intervention,’ or ‘Evaluation’ in order for the documentation to be considered adequate.

(ii) Reconciling the record with itself. Determine:

- If the resident has been properly assessed for all his/her needs.
- That normal and routine nursing practices such as periodic weights, temperatures, blood pressures, etc., are performed as required by the resident’s conditions.

(iii) Performing the drug regimen review. The purpose of the drug regimen review is to determine if the pharmacist has reviewed the drug regimen on a monthly basis. Follow the procedures in Part One of Appendix N, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care Facilities. Fill in the appropriate boxes on the top left hand corner of the reverse side of the OIRR Worksheet, Form CMS–524. Appendix N lists many irregularities that can occur. Review at least six different indicators on each survey. However, the same six indicators need not be reviewed on every survey.

NOTE: If you detect irregularities and the documentation demonstrates that the pharmacist has notified the attending physician, do not cite a deficiency. Do, however, bring the irregularity to the attention of the medical director or other facility official, and note the official’s name and date of notification on the Survey Report Form.

(g) Task 5—Drug Pass Observation. The purpose of the drug pass observation is to observe the actual preparation and administration of medications to residents. With this approach, there is no doubt that the errors detected, if any, are errors in drug administration, not
Centers for Medicare & Medicaid Services, HHS § 488.110

documentation. Follow the procedure in Part Two of Appendix N, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care Facilities, and complete the Drug Pass Worksheet, Form CMS–522. Be as neutral and unobtrusive as possible during the drug pass observation. Whenever possible, select one surveyor, who is a Registered Nurse or a pharmacist, to observe the drug pass of approximately 20 residents. In facilities where fewer than 20 residents are receiving medications, review as many residents receiving medications as possible. Residents selected for the in-depth review need not be included in the group chosen for the drug pass; however, their whole or partial inclusion is acceptable. In order to get a balanced view of a facility’s practices, observe more than one person administering a drug pass, if feasible. This might involve observing the morning pass one day in Wing A, for example, and the morning pass the next day in Wing B.

Transfer findings noted on the “Drug Pass” worksheet to the SRF under the appropriate rule. If your team concludes that the facility’s medication error rate is 5 percent or more, cite the deficiency under Nursing Services/Administration of Drugs. Report the error rate under F209. If the deficiency is at the standard level, cite it in Nursing Services, rather than Pharmacy.

(h) Task 6—Dining Area and Eating Assistance Observation. The purpose of this task is to ascertain the extent to which the facility meets dietary needs, particularly for those who require eating assistance. This task also yields information about staff interaction with residents, promptness and appropriateness of assistance, adaptive equipment usage and availability, as well as appropriateness of dress and hygiene for meals.

For this task, use the worksheet entitled “Dining Area and Eating Assistance Observation” (Form CMS–523). Observe two meals; for a balanced view, try to observe meals at different times of the day. For example, try to observe a breakfast and a dinner rather than two breakfasts. Give particular care to performing observations as unobtrusively as possible. Chatting with residents and sitting down nearby may help alleviate resident anxiety over the observation process.

Select a minimum of five residents for each meal observation and include residents who have their meals in their rooms. Residents selected for the in-depth review need not be included in the dining and eating assistance observation; however, their whole or partial inclusion is acceptable. Ascertain the extent to which the facility assesses, plans, and evaluates the nutritional care of residents and eating assistance needs by reviewing the sample of 10 or more residents. If you are unable to determine whether the facility meets the standards from the sample reviewed, expand the sample and focus on the specific area(s) in question, until you can formulate a conclusion about the extent of compliance. As with the other survey tasks, transfer the findings noted on the “Dining & Eating Assistance Observation” worksheet to the Survey Report Form.

(i) Task 7—Forming the Deficiency Statement—(1) General. The Survey Report Form contains information about all of the negative findings of the survey. Be sure to transfer to the Survey Report Form data from the tour, drug pass observation, dining area and eating assistance observation, as well as in-depth review of the sample of residents. Transfer only those findings which could possibly contribute to a determination that the facility is deficient in a certain area.

Meet as a group in a pre-exit conference to discuss the findings and make conclusions about the deficiencies, subject to information provided by facility officials that may further explain the situation. Review the summaries/conclusions from each task and decide whether any further information and/or documentation is necessary to substantiate a deficiency. As the facility for additional information for clarification about particular findings, if necessary. Always consider information provided by the facility. If the facility considers as acceptable, practices which you believe are not acceptable, ask the facility to backup its contention with suitable reference material or sources and submit them for your consideration.
§ 488.110 42 CFR Ch. IV (10–1–16 Edition)

(2) Analysis. Analyze the findings on the Survey Report Form for the degree of severity, frequency of occurrence and impact on delivery of care or quality of life. The threshold at which the frequency of occurrences amounts to a deficiency varies from situation to situation. One occurrence directly related to a life-threatening or fatal outcome can be cited as a deficiency. On the other hand, a few sporadic occurrences may have so slight an impact on delivery of care or quality of life that they do not warrant a deficiency citation. Review carefully all the information gathered. What may appear during observation as a pattern, may or may not be corroborated by records, staff, and residents. For example, six of the 32 residents in the sample are dressed in mismatched, poorly buttoned clothes. A few of the six are wearing slippers without socks. A few others are wearing worn clothes. Six occurrences might well be indicative of a pattern of substandard care. Close scrutiny of records, discussions with staff, and interviews reveal, however, that the six residents are participating in dressing retraining programs. Those residents who are without socks, chose to do so. The worn clothing items were also chosen—they are favorites.

Combinations of substandard care such as poor grooming of a number of residents, lack of ambulation of a number of residents, lack of attention to positioning, poor skin care, etc., can yield a deficiency in nursing services just as 10 out of 10 residents receiving substandard care for decubiti yields a deficiency.

(3) Deficiencies Alleged by Staff or Residents. If staff or residents allege deficiencies, but records, interviews, and observation fail to confirm the situation, it is unlikely that a deficiency exists. Care and services that are indeed confirmed by the survey to be in compliance with the regulatory requirements, but considered deficient by residents or staff, cannot be cited as deficient for certification purposes. On the other hand, if an allegation is of a very serious nature (e.g., resident abuse) and the tools of record review and observation are not effective because the problem is concealed, obtain as much information as possible or necessary to ascertain compliance, and cite accordingly. Residents, family, or former employees may be helpful for information gathering.

(4) Composing the Deficiency Statement. Write the deficiency statement in terms specific enough to allow a reasonably knowledgeable person to understand the aspect(s) of the requirement(s) that is (are) not met. Do not delve into the facility’s policies and procedures to determine or speculate on the root cause of a deficiency, or sift through various alternatives in an effort to prescribe an acceptable remedy. Indicate the data prefix tag and regulatory citation, followed by a summary of the deficiency and supporting findings using resident identifiers, not resident names, as in the following example.

F102 SNF 405.1123(b).—Each resident has not had a physician’s visit at least once every 30 days for the first 90 days after admission. Resident #1602 has not been seen by a physician since she was admitted 50 days ago. Her condition has deteriorated since that time (formulation of decubiti, infections).

When the data prefix tag does not repeat the regulations, also include a short phrase that describes the prefix tag (e.g., F117 decubitus ulcer care). List the data tags in numerical order, whenever possible.

(5) Task 8—Exit Conference. The purpose of the exit conference is to inform the facility of survey findings and to arrange for a plan of correction, if needed. Keep the tone of the exit conference consistent with the character of the survey process—inspection and enforcement. Tactful, business-like, professional presentation of the findings is of paramount importance. Recognize that the facility may wish to respond to various findings. Although deficiency statements continue to depend, in part, on surveyor professional judgment, support your conclusions with resident-specific examples (identifiers other than names) whenever you can do so without compromising confidentiality. Before formally citing deficiencies, discuss any allegations or findings that could not be substantiated during earlier tasks in the process. For example, if information is gathered that suggests a newly hired
R.N. is not currently licensed, ask the facility officials to present current licensure information for the nurse in question. Identify residents when the substandard care is readily observed or discerned through record review. Ensure that the facility improves the care provided to all affected residents, not only the identified residents. Make clear to the facility that during a follow-up visit the surveyors may review residents other than those with significant problems from the original sample, in order to see that the facility has corrected the problems overall. Do not disclose the source of information provided during interviews, unless the resident has specifically requested you to inform the facility of his/her comments or complaints. In accordance with your Agency’s policy, present the Statement of Deficiencies, form CMS–2567, on site or after supervisory review, no later than 10 calendar days following the survey.

(k) Plan of Correction. Explain to the facility that your role is to identify care and services which are not consistent with the regulatory requirements, rather than to ascertain the root causes of deficiencies. Each facility is expected to review its own care delivery. Subsequent to the exit conference, each facility is required to submit a plan of correction that identifies necessary changes in operation that will assure correction of the cited deficiencies. In reviewing and accepting a proposed plan of correction, apply these criteria:

- Does the facility have a reasonable approach for correcting the deficiencies?
- Is there a high probability that the planned action will result in compliance?
- Is compliance expected timely?

Plans of correction specific to residents identified on the deficiency statement are acceptable only where the deficiency is determined to be unique to that resident and not indicative of a possible systemic problem. For example, as a result of an aide being absent, two residents are not ambulated three times that day as called for in their care plans. A plan of correction that says "Ambulate John Jones and Mary Smith three times per day," is not acceptable. An acceptable plan of correction would explain changes made to the facility’s staffing and scheduling in order to guarantee that staff is available to provide all necessary services for all residents.

Acceptance of the plan of correction does not absolve the facility of the responsibility for compliance should the implementation not result in correction and compliance. Acceptance indicates the State agency’s acknowledgement that the facility indicated a willingness and ability to make corrections adequately and timely.

Allow the facility up to 10 days to prepare and submit the plan of correction to the State agency, however, follow your SA policy if the timeframe is shorter. Retain the various survey worksheets as well as the Survey Report Form at the State agency. Forward the deficiency statement to the CMS regional office.

(l) Follow-up Surveys. The purpose of the follow-up survey is to re-evaluate the specific types of care or care delivery patterns that were cited as deficient during the original survey. Ascertain the corrective status of all deficiencies cited on the CMS–2567. Because this survey process focuses on the actual provision of care and services, revisits are almost always necessary to ascertain whether the deficiencies have indeed been corrected. The nature of the deficiencies dictates the scope of the follow-up visit. Use as many tasks or portions of the Survey Report Form(s) as needed to ascertain compliance status. For example, you need not perform another drug pass if no drug related deficiencies were cited on the initial survey. Similarly, you need not repeat the dining area and eating assistance observations if no related problems were identified. All or some of the aspects of the observation/interview/medical record review, however, are likely to be appropriate for the follow-up survey.

When selecting the resident sample for the follow-up, determine the sample size using the same formula as used earlier in the survey, with the following exceptions:

- The maximum sample size is 30 residents, rather than 50.
- The minimum sample size of 10 residents does not apply if only one care category was cited as deficient and the total number of residents in the facility in that category was less than 10 (e.g., deficiency cited under catheter care and only five residents have catheters).

Include in the sample those residents who, in your judgment, are appropriate for reviewing vis-a-vis the cited substandard care. If possible, include some residents identified as receiving substandard care during the initial survey. If after completing the follow-up activities you determine that the cited deficiencies were not corrected, initiate adverse action procedures, as appropriate.

(m) Role of Surveyor. The survey and certification process is intended to determine whether providers and suppliers meet program participation requirements. The primary role of the surveyor, then, is to assess the quality of care and services and to relate those findings to statutory and regulatory requirements for program participation.

When you find substandard care or services in the course of a survey, carefully document your findings. Explain the deficiency in sufficient detail so that the facility officials understand your rationale. If the cause of the deficiency is obvious, share the information with the provider. For example, if you cite a deficiency for restraints (F118), indicate that restraints were applied backwards on residents 1621, 1634, 1646, etc.

In those instances where the cause is not obvious, do not delve into the facility's policies and procedures to determine the root cause of any deficiency. Do not recommend or prescribe an acceptable remedy. The provider is responsible for deciding on and implementing the action(s) necessary for achieving compliance. For the restraint situation in the example above, you would not ascertain whether the improper application was due to improper training or lack of training, nor would you attempt to identify the staff member who applied the restraints. It is the provider’s responsibility to make the necessary changes or corrections to ensure that the restraints are applied properly.

A secondary role for the surveyor is to provide general consultation to the provider/consumer community. This includes meeting with provider/consumer associations and other groups as well as participating in seminars. It also includes informational activities, whereby you respond to oral or written inquiries about required outcomes in care and services.

(n) Confidentiality and Respect for Resident Privacy. Conduct the survey in a manner that allows for the greatest degree of confidentiality for residents, particularly regarding the information gathered during the in-depth interviews. When recording observations about care and resident conditions, protect the privacy of all residents. Use a code such as resident identifier number rather than names on worksheets whenever possible. Never use a resident’s name on the Deficiency Statement, Form CMS-2567. Block out resident names, if any, from any document that is disclosed to the facility, individual or organization.

When communicating to the facility about substandard care, fully identify the resident(s) by name if the situation was identified through observation or record review. Improperly applied restraints, expired medication, cold food, gloves not worn for a sterile procedure, and diet inconsistent with order, are examples of problems which can be identified to the facility by resident name. Information about injuries due to broken equipment, prolonged use of restraints, and opened mail is less likely to be obtained through observation or record review. Do not reveal the source of information unless actually observed, discovered in the record review, or requested by the resident or family.

(o) Team Composition. Whenever possible, use the following survey team model:

SNF/ICF Survey Team Model

In facilities with 200 beds or less, the team size may range from 2 to 4 members. If the team size is:

- 2 members: The team has at least one RN plus another RN or a dietitian or a pharmacist.


- 3-4 member: In addition to the composition described above, the team has one or two members of any discipline such as a social worker, sanitarian, etc.

If the facility has over 200 beds and the survey will last more than 2 days, the team size may be greater than 4 members. Select additional disciplines as appropriate to the facility’s compliance history.

Average onsite time per survey: 60 person hours (Number of surveyors multiplied by the number of hours on site).

Preferably, team members have gerontological training and experience. Any member may serve as the team leader, consistent with State agency procedures. In followup surveys, select disciplines based on major areas of correction. Include a social worker, for example, if the survey revealed major psychosocial problems. This model does not consider integrated survey and Inspection of Care review teams, which typically would be larger.

(p) Type of Facility—Application of SNF or ICF Regulations. Apply the regulations to the various types of facilities in the following manner:

- Freestanding Skilled Nursing Facility (SNF)
- Freestanding Intermediate Care Facility (ICF)
- SNF Distinct Part of a Hospital
- ICF Distinct Part of a Hospital
- Dually Certified SNF/ICF
- Freestanding SNF with ICF Distinct Part (Regardless of the proportion of SNF and ICF beds, the facility type is determined by the higher level of care. Therefore, LTC facilities with distinct parts are defined as SNFs with ICF distinct parts.)

(q) Use of Part A and Part B of the Survey Report—(1) Use of Part A (CMS–525). Use Part A for initial certification surveys only, except under the following circumstances:

- When a terminated facility requests program participation 60 days or more after termination. Treat this situation as a request for initial certification and complete Part A of the survey report in addition to Part B.
- If an ICF with a favorable compliance history requests to covert a number of beds to SNF level, complete both Part A and Part B for compliance with the SNF requirements. If distinct part status is at issue, also examine whether it meets the criteria for certification as a distinct part.

(i) Addendum for Outpatient Physical Therapy (OPT) or Speech Pathology Services. Use the Outpatient Physical Therapy—Speech Pathology SRF (CMS–1893) as an addendum to Part A.

(ii) Resurvey of Participating Facilities. Do not use Part A for resurveys of participating SNFs and ICFs. A determination of compliance, based on documented examination of the written policies and procedures and other pertinent documents during the initial survey, establishes the facility’s compliance status with Part A requirements. This does not preclude citing deficiencies if they pertain to administrative or structural requirements from Part A that are uncovered incidental to a Part B survey. As an assurance measure, however, each facility at the time of recertification must complete an affidavit (on the CMS–1516) attesting that no substantive changes have occurred that would affect compliance. Each facility must also agree to notify the State agency immediately of any upcoming changes in its organization or management which may affect its compliance status. If a new administrator is unable to complete the affidavit, proceed with the survey using the Part B form and worksheets; do not use the Part A form. The survey cannot be considered complete, however, until the affidavit is signed. If the facility fails to complete the affidavit, it cannot participate in the program.

(iii) Substantial Changes in a Facility’s Organization and Management. If you receive such information, review the changes to ensure compliance with the regulations. Request copies of the appropriate documents (e.g., written policies and procedures, personnel qualifications, or agreements) if they were
§ 488.110

If the changes have not submitted. If the changes have made continued compliance seem doubtful, determine through a Part B survey whether deficiencies have resulted. Cite any deficiencies on the CMS-2567 and follow the usual procedures.

(2) Use of Part B (CMS–519). Use Part B and the worksheets for all types of SNF and ICF surveys—initials, recertifications, followup, complaints, etc.

The worksheets are:

• CMS–520—Residents Selected for In-depth Review
• CMS–521—Tour Notes Worksheet
• CMS–522—Drug Pass Worksheet
• CMS–533—Dining Area and Eating Assistance Worksheet
• CMS–5245—Observation/Interview/Record Review Worksheet

For complaint investigations, perform a full or partial Part B survey based on the extent of the allegations. If the complaint alleges substandard care in a general fashion or in a variety of services and care areas, perform several tasks or a full Part B survey, as needed. If the complaint is of a more specific nature, such as an allegation of improper medications, perform an appropriate partial Part B survey, such as a drug pass review and a review of selected medical records.
### §488.115 Care guidelines.

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<tr>
<th>SURVEY AREA</th>
<th>OBSERVATION</th>
<th>INTERVIEWING</th>
<th>RECORD REVIEW</th>
<th>EVALUATION FACTORS</th>
<th>CROSS REFERENCE</th>
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<td>3. Resident Acknowledgement</td>
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### INTENT

To assure that the resident maintains, in so far as possible, those personal rights that are a part of normal, adult life, and including the right to personal dignity.

*Information concerning incompetent residents is given in 1. Delegation of Rights and Responsibilities.
<table>
<thead>
<tr>
<th>SURVEY AREA</th>
<th>OBSERVATION</th>
<th>INTERVIEWING</th>
<th>RECORD REVIEW</th>
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<tr>
<td>F58 SNF 485.121(a)(2) ICF 482.311(a)(4) 4. Resident informed in writing of changes in services and charges for services.</td>
<td>Ask Resident: - If there are changes in services or costs does someone explain these? Ask Administrative Staff: - How do residents learn what is expected of them? - How do they learn about any changes in the facility's procedures and/or costs?</td>
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<tr>
<td>F59 SNF 485.121(b)(2) ICF 482.311(a)(4) 5. Information to resident of services not covered by Medicare or Medicaid and not covered in the basic rate.</td>
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LONG TERM CARE SURVEY
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<th>Survey Area</th>
<th>Observation</th>
<th>Interviewing</th>
<th>Record Review</th>
<th>Evaluation Factors</th>
<th>Cross Reference</th>
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<td>B. Medical Condition &amp; Treatment</td>
<td>Ask Resident: - Has your doctor discussed your health with you, how is it, what’s wrong, and what you can expect in the future? - Have you had the opportunity to help plan what you need and how you are taken care of? - Do you know that you can refuse treatment or medication? - Have you ever refused medication or treatment? - What happened when you did?</td>
<td>Ask Staff: - Is the facility participating in any experimental research? If yes, ask what residents are involved. Interview a sample of these residents.</td>
<td>If the resident has not been informed of his/her medical condition, physician notes should document that the resident was not informed because it was medically contraindicated. Do care plans or other documentation reflect resident participation in care planning? If resident states he/she has refused treatment or medication does documentation indicate adherence to violation of resident rights. Review records of residents identified as participating in a clinical research study. Are informed consent forms signed? Do these signed forms list all known risks for the resident? All needed informed consent statements are present and properly signed.</td>
<td>Unless there is documentation that the resident medical condition should not be discussed with him/her resident interviews/record reviews should indicate that the resident and physician have discussed his/her medical condition.</td>
<td>Patient Care Management 489.112(1)(d) 442.310 442.341</td>
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<td>Ask Resident (or Guardian): - Are you participating in the study? - Was this explained to you well enough so that you understand what the study is about and any risks that may be involved?</td>
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*Residents do have the right to refuse medication or other treatment, but you would expect that the facility would discuss the implications of this refusal with the resident and possibly do some “gentle persuasion.”*
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<td>F60-64 (cont'd)</td>
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<td>However, except in an emergency situation force should never be used to compel a resident to accept medication or treatment.</td>
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Deception is also a violation of resident rights, except in the case of therapeutically indicated placebos ordered by the physician.

Any resident participating in research studies should fully understand the implications of the study.

The facility is not in compliance with the resident rights regulation if the resident consents to participate in a clinical study without full knowledge of the study. (Record review only as other nonclinical studies may not require informed consent).
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<td>C. Transfer and Discharge</td>
<td>Look for residents that may be inappropriately placed physically—an alert resident roaming with a confused, nasty resident; very ill resident placed far from the nurses station; residents not compatible with each other, (e.g., different life-styles, habits, etc.).</td>
<td>Ask Resident: - How well do you get along with your roommate? - Have you ever been moved from one room to another? If yes, why? - How were you involved in the decision to move? - How much time was there between the time they told you you were to be moved, and when you were moved? - Have you asked for your room to be changed?</td>
<td>Nursing, physician, and/or social service progress notes should indicate reasons for transfer and discussion with resident and/or family/guardian. If staff interviews give you cause to feel that transfers and discharges may be in violation of these regulations, review a sample of closed records for transfer information on how it was handled.</td>
<td>To be in compliance with transfer and discharge regulations the facility must be able to confirm that all discharges/ transfers were for medical or resident welfare reasons, or non-payment. Welfare reasons include physical, emotional, social issues.</td>
<td>Status Change Notification 482.112(1) Medical Records 482.112(2) Transfer Agreement 482.113(a)(2) 442.380(c)(1)(ii)</td>
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### Long Term Care Survey

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<thead>
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<th>Survey Area</th>
<th>Observation</th>
<th>Interviewing</th>
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<th>Cross Reference</th>
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| D. Exercising Rights | Do residents appear comfortable when speaking to the surveyors as opposed to being afraid that someone may see them or overhear their conversation? | **Ask Resident:**  
- Do you belong to, or have representation on the resident council?  
- Have you been informed of changes in the facility that will affect you?  
- Are you given a chance to express views on these changes prior to their implementation?  
- Does the facility assist in working toward the residents' vote either at the polls or via absentee ballots?  
- Are you assisted in obtaining legal or Social Services if needed?  
- Do you feel comfortable in expressing yourself freely or are you concerned about retaliation?  
- Is staff/administration responsive to complaints? Do you know who to complain to?  
| Review resident council documentation, as available, to determine level of activity.  
| Compliance determinations will be made based primarily on resident/staff interviews and the correlation of interview information with documentation in the Medical record.  
If residents ask, they should be allowed to speak to the surveyor without facility personnel being present. However, the resident has the right to have a third party of their choosing present during an interview.  
| Social Services  
485.1130  
442.364  
|
### Long Term Care Survey

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| E. Financial Affairs | Ask Residents:  
- Are you able to take care of your own financial affairs?  
- Does the facility keep some money for you that you can have when you request it?  
- When you ask for this money, how quickly do you get it?  
- Do you know the amount of money you have available at this time?  
- If the facility pays bills for you do they periodically provide an itemized listing of the transactions they have made?  
- When did you receive the last itemized statement?  
- Are you comfortable that your funds are taken care of correctly?  
- If you deposit money or valuables with the facility, do you receive a receipt for this deposit?  
- Are you or your family able to review your financial records when you request to do so?  
- Have you ever had money or anything else stolen? If so, what was done about it? | A copy of the statement should be in the residents financial record and given to the resident at least quarterly.  
Receipts, account logs showing deposits/withdrawals, authorizations/reasons for withdrawals, and interest earned should be reviewed. If resident indicates there may be a problem, an in-depth interview should be conducted. | Resident records indicate separate financial records from facility records. | Social Services 405.11301(a) | 

Residents should have reasonable access to their funds (may not be available at 2 A.M.) and should have at least a quarterly accounting of their funds. If questions arise they should be resolved. 
Personal possessions and funds received from the residents should be protected from theft and other loss. If losses do occur there should be:  
1. a procedure which is implemented to investigate the loss, and  
2. a plan to prevent recurrence. Resident funds must not be appropriated for facility furnishings, linen, direct care supplies, etc.
### LONG TERM CARE SURVEY

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<th>OBSERVATION</th>
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<th>CROSS REFERENCE</th>
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| F72-7B (cont'd) | - Does the home provide safe-keeping for valuables?  
          - Have they ever lost anything of yours?  
          Ask Staff:  
          - What is the procedure when residents lose personal belongings?  
          - How are resident personal funds handled?  
          - What is your procedure when a resident asks to get an accounting of their funds?  
          * The special needs of residents with Alzheimer's disease who "lose" personal possessions should be noted. Individuals in stages 2 and 3 of Alzheimer's disease sometimes believe their personal possessions were stolen. | | | | |
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<th>SURVEY AREA</th>
<th>OBSERVATION</th>
<th>INTERVIEWING</th>
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</table>
| F. Freedom from Abuse and Restraints | - How many residents are physically restrained?  
- What type or restraints are used?  
- Are they applied correctly?  
- What is the apparent physical/mental condition of those residents restrained?  
- Do you observe the release of restraints every 2 hours and the provision of at least 10 minutes exercise for the resident?  
- Do staff respond to request for water, assistance to bathroom, etc., from a resident who is restrained?  
- What is the interval between request and response? | Ask Resident:  
- Why are you wearing this?  
- How often is it worn?  
- Do you know what would happen if it were removed?  
- How often is it removed?  
- What is done for you when the restraint is removed?  
- For nonrestrained resident:  
- Have you ever been restrained?  
- For what reason?  
- What explanation was given for the restraint?  
- Do you ever feel that you receive medication when you don’t need it? | Look for a physician’s order for the restraint.  
Review nurses’, physicians’ progress notes re: reason for restraints and resident reaction to them.  
Also any alternative methods tried.  
What time of day are restraints most often applied?  
Review schedule of releasing restraints.  
Care plans:  
- When restraint is to be used.  
- For how long.  
- What are plans for alternative measures.  
- Is the resident periodically re-evaluated?  
If appropriate are the Social Service or activity departments involved in providing different directions for resident attention? | There must be a physician’s order for all restraints, including “safety devices” which are defined in some State laws.  
Progress notes should show evidence that methods other than restraints were initially used to protect the resident from injury, and that restraints were used only when other methods were not adequate.  
If used in an “emergency” the reason for use must be documented and show that:  
a. its use was necessary to protect the resident from injury.  
b. its use was necessary to protect others from injury.  
The resident must be observed by a staff member at least every 30 min. while restrained.  
The restraints must be released and the resident exercised, toileted, etc. at least every 2 hours. | Nursing Services 485.1124(c)(5)  
Rehab Nursing 485.1124(e)  
Patient Care Management 485.1124(d) |
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<tr>
<td>F79-83 (cont'd)</td>
<td>- How often are restrained residents observed by staff?</td>
<td>Ask Staff:</td>
<td>Who authorizes the use of restraints in an emergency?</td>
<td>The restraint must be applied correctly.</td>
<td>Centers for Medicare &amp; Medicaid Services, HHS § 488.115</td>
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<td>- Observe effect on residents. Do you see what may be signs of over-medication?</td>
<td>- What is the facility policy regarding restraints?</td>
<td>Do progress notes indicate that a professional staff member authorized the use of &quot;emergency&quot; restraints?</td>
<td>If the use of restraints increased during evening and night hours, review progress notes, nurses notes, and staffing to make a determination as to whether the restraints are justified or if they are for staff convenience.</td>
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<td>- How often is this observed?</td>
<td>- What is considered an &quot;emergency&quot; need for restraints?</td>
<td>There should be documentation that the use of &quot;emergency&quot; restraint has been promptly reported to the residents physician.</td>
<td>Care plans should plan not only for care while the resident is restrained but should show effort to find alternative treatments to restraints, or there should be documentation in the medical record that no alternative is appropriate.</td>
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<td>- Residents should be free from mental and physical abuse.</td>
<td>- What is the most common reason for use of restraints?</td>
<td>Review incident and accident reports to identify any problematic trends.</td>
<td>An appropriate drug regimen review should be conducted on the resident.</td>
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<td>- Observe interaction of staff and residents for any sign of harassment, humiliation or threats.</td>
<td>- Do you try any alternative measures before using restraints?</td>
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<td>Your observations should show interaction between residents and staff to be, except in unusual situations, free from tension and hostility.</td>
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<td></td>
<td>- Do residents appear comfortable with staff?</td>
<td>- What information do you give the physician to help him make the decision to order restraints?</td>
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<td>Staff should step into situation where one resident may be abusing another.</td>
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<td>- Look for numbers of residents with bruises or other injuries (skin of the elderly bruises easily, so do not automatically assume abuse or injury).</td>
<td>- What do you routinely do for the resident when you periodically release the restraints?</td>
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<td>- Observe resident to resident interactions and staff response to any physical or mental abuse of one resident to another.</td>
<td>- Does use of restraints increase on evenings or nights when there are fewer staff members?</td>
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<td>- Have you had any accidents or incidents in the last year while residents were restrained?</td>
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### Long Term Care Survey

<table>
<thead>
<tr>
<th>Survey Area</th>
<th>Observation</th>
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</table>
| F79-83 (cont'd) | - Observe for evidence of resident neglect, residents left in urine/feces without cleaning. | Ask Resident:  
- Do you feel safe in the facility?  
- Do you ever feel intimidated, harassed, or otherwise abused?  
- How are confused residents treated?  
- Is anyone ever hit or treated roughly?  
- Do you feel as if you are treated with respect /dignity?  
- Is the staff/administration responsive to complaints?  
- Do you know who to complain to? | Resident should feel free to voice complaints. If no complaints are noted in records or on record review, why not?  
Residents should seem comfortable in relating how they are treated. |
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<td><strong>G. Privacy</strong></td>
<td><strong>FBA-89</strong>&lt;br&gt;SNF 485.1132(k)(8)&lt;br&gt;ICF 442.331(g)</td>
<td>- Observe interactions between staff and residents for indications of respect, consideration, dignity, and individuality.</td>
<td>Review progress notes for indications that staff see resident as an individual - i.e., resident eats breakfast in bed because he/she enjoys it.  Signed consent for release of information.  Do maintenance of and content of medical records indicate confidentiality is practiced.</td>
<td>Observations and interviews will give you information to determine if residents are respected and treated as individuals.  In privacy available - e.g., access to a private place to meet or make phone calls, ability to shut door when having visitors, etc.</td>
<td>Medical Records  485.1132(b)  442.331(d)</td>
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370

§ 488.115

LONG TERM CARE SURVEY

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<thead>
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<td>F34-09 (cont'd)</td>
<td>- Are medical records kept in their assigned spots and not carelessly left for unauthorized persons to view?</td>
<td>- Are married residents sharing rooms?</td>
<td>- Observe for negative attitudes toward aging-in-facility and respectful treatment of residents.</td>
<td>- If residents undress in public area, how does staff handle this?</td>
<td>- Listen to staff conversation in public places (elevator, lobby). Are resident issues being discussed?</td>
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LONG TERM CARE SURVEY

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| M. Work     | - Are residents doing any type of work such as picking up dirty trays, pushing laundry hampers, etc.?  
- What about clerical work? | Ask Resident:  
- Are you ever asked to help put in the facility such as pick up dirty trays or staple mail?  
- If yes, do you do this?  
- Do you want to, or do you feel it is expected of you?  
- Do you feel you can say "no"?  
Ask Staff:  
- Are residents asked to help with facility staff if you are shorthanded?  
- What is their reaction?  
- What useful work is available for residents who want/need to be "employed"? | If residents are performing services for the facility, is that included in their care plan with specific therapeutic goals defined?  
If appropriate does the family concur?  
Are results documented in progress notes? | Services performed by a resident should be part of the resident's plan of care and should be done only if the resident is in full agreement.  
Service rewards are specifically identified and not obtained using the residents own funds. | 488.115(d)  
482.341 |

Services performed by a resident should be part of the resident's plan of care and should be done only if the resident is in full agreement. Service rewards are specifically identified and not obtained using the residents own funds.
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<td>I. Freedom of Association and Correspondence</td>
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<td>F91-92</td>
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<td>SNR 405.312(1)(f)(1)</td>
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<td>ICF 442.311(1)</td>
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<td>1. Freedom of Association and Correspondence</td>
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<td>ARE there areas in the facility—e.g., small lounges, etc., where residents can and do meet privately?</td>
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<td>IS mail delivered opened or unopened?</td>
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<td>ARE facility personnel assisting residents, if needed, in opening and/or reading mail?</td>
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<td>Ask Residents:</td>
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<td>— Can you have visits from anyone?</td>
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<td>— Can you find a private place to visit?</td>
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<td>— Do you receive your mail unopened unless you request otherwise?</td>
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<td>— Are there telephones you have access to?</td>
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<td>— Does the staff or volunteers assist you in reading or sending mail, if needed?</td>
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<td>— How timely is your mail delivered?</td>
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<td>— How do you receive incoming calls?</td>
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<td>Ask Staff:</td>
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<td>— Where do residents go when they want privacy?</td>
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<tr>
<td>— What telephones are available to residents?</td>
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<td>— What is the facility visiting policy?</td>
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<td>Physician orders and care plans for indications of restrictions on visitors and/or receiving and sending mail.</td>
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<td>All residents may have access to and maintain contact with the community and members of that community have access to them.</td>
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<tr>
<td>Subject to reasonable scheduling restrictions, residents may receive visits from anyone they wish. A particular visitor may be restricted by the facility for one or more of the following reasons:</td>
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<td>— The resident refuses to see the visitor.</td>
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<td>— The resident's physician documents specific reasons why such a visit would be harmful to the resident's health.</td>
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<td>— The visitor's behavior is unreasonably disruptive of the functioning of the facility (reasons are documented and kept on file).</td>
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<td>Decisions to restrict a visitor are reviewed and reevaluated each time the resident's plan of care and medical orders are reviewed by the physician and nursing staff or at the resident's request.</td>
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<td>F91-92 (cont'd)</td>
<td>Do the available telephones accommodate the physically handicapped (e.g., wheelchair bound, hearing impaired, etc.).</td>
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<td>Space is provided for residents to receive visitors in reasonable comfort and privacy. Telephones, consistent with ANSI standards (40.1134(c)), are made available and accessible for residents to make and receive calls with privacy. Residents who need help are assisted in using the phone. The fact that telephone communication is possible, as well as any restrictions, is made known to residents. Arrangements are made to provide assistance to residents who require help in reading or sending mail.</td>
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Centers for Medicare & Medicaid Services, HHS § 488.115
### Survey Area: Activities

<table>
<thead>
<tr>
<th>Observation</th>
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<tr>
<td>- What planned activities are occurring?</td>
<td>- Ask Residents: What do you like to do?</td>
<td>Care plans or other documentation should indicate resident preferences for both facility and non-facility planned activities.</td>
<td>Compliance with this element is determined by evidence that residents are given the opportunity to participate in available activities they choose unless medically contraindicated.</td>
<td>Patient Activities 483.131(b) 482.345(a)(c)</td>
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<tr>
<td>- What unplanned activities are occurring—individual, 2 or 3 persons, or a larger group.</td>
<td>- What did you do yesterday? (Compare answers)</td>
<td>- Is participation in activities optional?</td>
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<td>- If there is a facility chapel, is it open?</td>
<td>- Are you encouraged to participate?</td>
<td>- Is pressure exerted on you to attend specific activities?</td>
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<td>- Are activities posted at wheelchair level and kept up-to-date?</td>
<td>- Are activities listed in a front of a T.V. in a common room for hours?</td>
<td>- Which ones? Surveyors should be aware of special encouragement—“gentle persuasion,” which might be important for the depressed or withdrawn resident.</td>
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<td>- Are residents lined up in front of a T.V. in a common room for hours?</td>
<td>- Are residents notified of community activities?</td>
<td>- Are residents notified of community activities?</td>
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<td>- Are activities offered during the evening and on weekends?</td>
<td>- Are arrangements made for transportation, etc. so that residents can participate?</td>
<td>- Can residents go to religious services if they wish?</td>
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**Note:**
- Ask Staff:
  - Are arrangements ever made to take residents to community activities?  
  - Do friends and relatives ever take them to community activities?  
  - Do your residents attend religious service at their choice?  
  - How are residents kept informed/notified of activities?
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| K. Personal Possessions | Are residents wearing their own clothing or facility nightgowns, robes, etc.? | **Ask Residents:**<br>- What clothing and personal belongings can you have?  
- Is there a place that you can secure any valuables that you may not want to keep in your room? | Admission notes on personal property inventory (e.g., the record should indicate a list of any personal property secured by the facility). The record should indicate how personal clothing will be laundered. | Residents are permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility and such personal property is kept in a safe location which is convenient to the resident. The amount that is reasonable will be dependent on space available in the facility. Patients are advised, prior to or at admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items (e.g., cleaning and laundry). Any personal clothing or possessions retained by the facility for the patient during his stay is identified. The facility is responsible for secure storage of such items, and they are returned to the patient promptly upon request or upon discharge from the facility. | |
| F94 | In resident rooms observe for personal belongings. | **Ask Staff:**<br>- What personal belongings may residents have?  
- What do you do to secure valuables and other personal property?  
- What provisions are made for the care of personal clothing? | | | |
| SNF 405.11(2)(k)(13) | Ask residents if you can look in the closet for personal clothing in there? | | | | |
| ILF 402.31(k) | Ask residents if belongings such as clothing are identified with name tags or other identifying methods? | | | | |
| | Is there enough space to store clothing? | | | | |
### Long Term Care Survey

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| L. Delegation of Rights and Responsibilities | *Ask Administrative Staff:*  
- When do you have relatives make decisions for residents? I.e., how do you decide when the resident isn't capable of making decisions himself?  
- Have any legal steps been taken?  

*Ask Resident and/or Guardian:*  
- Do you feel that you are given all pertinent information?  
- What opportunities do you have to make decisions regarding clothing, meals, bathing schedules, etc.?  
- For guardian: are you notified/informed in a timely manner as appropriate? |                                                                                     | Review physician progress notes—incapability must be documented.  
  - Is there clear documentation as to whom rights and responsibilities have been assigned?  
  - Are pertinent consents/documents signed by appointed guardian? | The fact that a resident has been judged incompetent, is medically incapable of understanding, or exhibits a communication barrier, does not absolve the facility from advising the resident of their rights to the extent the patient is able to understand them. If the resident is incapable of understanding their rights, the facility advises the guardian or sponsor and acquires a statement indicating an understanding of the resident's rights.  
  - The surveyor reviews records of residents selected for indepth review who are classified either incompetent, medically incapable of understanding their rights, or have a communication barrier to verify documented evidence (signed acknowledgment) that the guardian or other sponsor has been advised of these resident rights and understand their role in acting on behalf of the resident. | Resident Rights  
483.112(4)(1)  
442.311(a) |
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<td>F100</td>
<td>1. Facility staff are knowledgeable about the problems and needs of the aged, ill, and disabled.</td>
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<td>How do staff relate to residents? Does the facility reflect adaptations for the elderly, i.e., information given in large print, floors covered with materials that allow for ease of movement with walkers, wheel chairs, etc.?</td>
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<td>Ask Residents - Does staff know how to take care of you? - What things do they do to help you accommodate your (poor vision, unsteady walking, arthritis, etc.)?</td>
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<td>Ask Staff - What, if any, training have you had here to learn about unique problems and needs of the aged? - What training have you had during the last 12 months? - How have you learned about facility policies and procedures? - Does the facility ask your needs when they develop a training program? - In what areas would you like to have training?</td>
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<td>F102</td>
<td>2. Facility staff practices proper techniques in providing care to the aged, ill, and disabled.</td>
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<td>Is resident care given using accepted professional standards?</td>
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<td>In privacy maintained during bathing, toileting? Are housekeeping staff courteous and responsive to resident needs?</td>
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<tr>
<td>F103</td>
<td>3. Facility staff practice proper techniques for prevention and control of infection, fire prevention</td>
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|          | | Care plans reflect staff's knowledge of the problems and needs of the residents and special adaptations that are needed. Progress notes indicate that the special needs are considered in implementing planned care. | facility staff adjusts care to needs/problems of resident. Staff is knowledgeable concerning facility policies and procedures. Staff practices correct techniques, i.e., infection control rehabilitation nursing techniques, etc. Staff interacts and treats residents in a kind, caring way. | |

Residents Rights
SNF 405.131
ECC 442.311
Infection Control 405.1315(a)(b)(c)
(e)(e)
442.327(b)
Physical Environment 405.1314(a)
442.315(b)(c)
442.326(a)(e)
Nursing Services 405.1324(a)(c)(e)
442.328(a)(e)
Social Services 405.1328(a)
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<th>Evaluation Factors</th>
<th>Cross Reference</th>
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<tr>
<td>F102 (cont'd) and safety, accident prevention, confidentiality of resident information, and preservation of resident dignity including protection of privacy and personal and property rights.</td>
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<td><strong>Intent</strong></td>
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<td>To assure that facility provides ongoing training to staff so that they will be knowledgeable in current practices, use proper techniques, and interact with residents in a kind, caring way.</td>
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### Long Term Care Survey

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<th>Survey Area</th>
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<th>Interviewing</th>
<th>Record Review</th>
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<tbody>
<tr>
<td>Status Change Notifications</td>
<td>Note residents condition: - Clean - Well groomed - Well adjusted - Casts - Bruises - Decubitus Ulcer - Multiple sites of edema - Aberrant behavior, e.g., abusive, disruptive, not reasonable, etc.</td>
<td>Ask Resident: - Have you been injured since you have been in the facility? - If you are injured or become ill, is your physician called? - Are your relatives notified? - Do you know who is notified if administrative changes such as changes in charges, billings, etc. occur?</td>
<td>Progress note should document injury/change in condition plus notification of physician and appropriate family member/guardian.</td>
<td>- All injuries and changes in condition must be documented. - The resident's physician must be notified of significant changes. This should be documented, but this notification should be confirmed by the resident if possible.</td>
<td>Resident Supervision by Physician 485.1123(b)(13) Emergency Services 485.1123(c)</td>
</tr>
</tbody>
</table>

1. The facility notifies the resident's attending physician and other responsible persons in the event of an accident involving the resident, or other significant change in the resident's physical, mental, or emotional status, or patient charges, billings, and related administrative matters.
LONG TERM CARE SURVEY

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<th>SURVEY AREA</th>
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| F106        | Ask Resident:  
  - Have you ever been or do you know if others have been transferred or discharged without discussing it with you first? | - Nursing, physician and social work progress notes should be reviewed for evidence of discussion of transfer/discharge with resident or other designated person. | - Except in an emergency, all transfers or discharges are first discussed with the resident or next of kin as evidenced by documentation in the medical record or confirmed by asking resident. | | |

**INTENT**

To assure that:
- the resident receives proper treatment in the event of an accident or change of condition;
- resident and/or next of kin or responsible party is aware in advance of any changes;
- resident is not discharged to gain a higher source payment for that bed or facility convenience.
## Long Term Care Survey

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</table>
| Physician’s Services | F107 SNF 405.1123 A. Medical Findings and Orders At Time of Admission F108 SNF 405.1123(a) F109 1. There is made available to the facility prior to or at the time of admission, resident information which includes current medical findings, diagnoses, and orders from a physician for immediate care of the resident. F110 2. Information about the rehabilitation potential of Ask Staff:  
- Interview nursing staff to determine if they receive transfer information and admission orders on day of admission.  
- Ask Administrator and Director of Nursing to explain procedure if a resident arrives without adequate medical information and or orders. | Review records of residents selected for in-depth review to ascertain that:  
- There is a referral form from the transferring facility that was received in advance of admission or on the date of admission that includes current medical findings, diagnosis and orders from a physician for the immediate care of the resident.  
- If medical orders were not obtained from the residents attending physician, there are temporary orders from the emergency care physician.  
- Information on the rehabilitation potential (prognosis) of the resident and a summary of the course of treatment followed in the transferring facility were transmitted within 48 hours of admission.  
- The summary of treatment should include discharge summaries from therapies, or special services when appropriate.  
- For residents admitted directly from the | Examine medical records of the residents selected for in-depth review to determine if data of orders, medical data and other required information is the date of admission or within 48 hours of admission. The facility should receive sufficient information and orders to provide continuity of care for all residents. | |
## LONG TERM CARE SURVEY

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<td>F110 (cont'd)</td>
<td>the resident and a summary of prior treatments are made available to the facility at the time of admission, or within 48 hours thereafter.</td>
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<td>Community, the attending physician provided current medical findings, diagnosis, prognosis, and orders.</td>
<td>The order should cover:</td>
<td>+ Medications and treatments</td>
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<td></td>
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<td></td>
<td>+ Diet</td>
<td>+ Therapies (P.T., O.T., Speech)</td>
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<td>+ Activities (bedrest, ambulatory, able to participate with any specific limitations on activity).</td>
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<td>SURVEY AREA</td>
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<tr>
<td>Resident Supervision by Physician</td>
<td>Observe resident for any problem/conditions that should be addressed by physician, e.g., edema, loss of appetite, weight loss, etc.</td>
<td>Ask Resident: - How often physician visits. - If physician discussed plan of care and medical treatment. - If resident feels treatment and/or plan of care meets his/her needs. - What kind of questions do you ask the physician about your health problem? (Cite examples).</td>
<td>Review medical records of selected for indepth review for: - A current plan of care that is based upon physician’s orders and resident needs. - Evidence that the plan is reviewed and revised as needed. - Evidence through physician’s progress notes, nurses notes, physician’s orders, that the physician participates in the resident’s overall plan of care. - Evidence that rehabilitation potential is addressed. - Long range plans include an estimate of the length of time for skilled nursing care and a discharge plan. - Physician’s orders for medications and treatments on admission and during stay. - A medical evaluation completed within 48 hours of admission unless done within 5 days prior to admission that includes attention to needs such as diet, vision, hearing, speech</td>
<td>Medical records should provide evidence that the residents are under the supervision of a physician by the coordination of physician’s orders and progress notes with the resident’s plan of care and observations of resident’s needs. There is evidence that the physician reviews and revises the plan of care as needed. There is evidence that the physician services are available to the residents when the residents need such services. An alternate schedule for physician visits may be established if the attending physician determines that the resident need not be seen every 30 days. Justification for the decision is placed in the resident’s medical record and is reviewed by the U.S. Committee and State medical review team. Where there is a change in the resident’s condition and the physician has failed to document his findings or evaluation of the condition, the physician has failed to provide</td>
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## Long Term Care Survey

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<td>F114 (cont'd)</td>
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<td>F115</td>
<td>3. A physician is available to provide care in the absence of any resident's attending physician.</td>
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<td>level of activity, emotional adjustment.</td>
<td>evidence of his evaluation of resident needs and supervised care. A physician is available to respond within a reasonable time when a resident needs medical attention.</td>
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<tr>
<td>F116</td>
<td>4. Medical evaluation is done within 48 hours of admission unless done within 5 days prior to admission. NOT ICF's.</td>
<td></td>
<td>A few closed records should be reviewed to determine if residents were appropriately discharged by an order written by the attending physician. Also review</td>
<td>Although medical evaluation can be noted as a revision of the previous HRF. A statement such as &quot;no change&quot; when in conflict with the status of the</td>
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<td>F117</td>
<td>5. Each SNF resident is seen by their attending physician at least once every 30 days for the first 90 days after admission.</td>
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Exception: ICF residents must be seen every 60 days unless otherwise justified and documented by the attending physician.

F117

6. Each resident's total program of care including medications and treatments is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days and revised as necessary.

discharge plans to assure that they were adequate and implemented.
Verbal medication orders are countersigned by a physician.
Physician is reviewing all medication orders every quarter.

residents on this admission to the facility, does not constitute a medical evaluation.
Verbal medication orders must be countersigned with 48 hours.
### LONG TERM CARE SURVEY

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<thead>
<tr>
<th>SURVEY AREA</th>
<th>OBSERVATION</th>
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<td><strong>F119</strong></td>
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<td>7. Progress notes are written and signed by the physician at the time of each visit, and all orders are signed by the physician.</td>
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<td><strong>F120</strong></td>
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<td>8. Alternate physician visit schedules that exceed a 30-day schedule adopted after the 90th day following admission are justified by the attending physician in</td>
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*Exception:* Only medications must be reviewed quarterly for ICF residents.
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<td>F120 (cont'd)</td>
<td>the medical record.</td>
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<td>These visits cannot exceed 60 days or apply to patients who require specialized rehabilitation schedules.</td>
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<td>Exception ICF residents must be seen every 60 days unless justified otherwise documented by the attending physician.</td>
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<td>C. Emergency Services</td>
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<td>F121</td>
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<td>SNF 405.1123(c)</td>
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<tr>
<td>F122</td>
<td>Emergency services from a physician are available and provided to each resident who requires emergency care.</td>
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**Ask Staff:**
- Are you aware of physician reporting procedures and medical protocols to be followed during a fire emergency?
- Do you know where names and telephone numbers of physicians to be called in case of emergency?

**Record Review:**
- If records document an accident or a medical emergency, was the patient seen by a physician or was the physician notified promptly of the emergency?
- Review physician's orders to see if specific medications or treatments were ordered to treat emergency situation if applicable.

**Evaluation Factors:**
- Surveyor verifies that there are readily available written procedures for securing a physician in case of emergency.
- Names and telephone numbers are posted or on rolodex.
- An alternate physician is designated.

**Cross Reference:**
Status Change Notification 405.1123(i)(j)
### Observation

- Review physicians progress notes to see if emergency situation was addressed.

### Evaluating Factors

- There is provision for:
  - Notification of attending physician/ emergency and other responsible person.
  - Arrangements for transportation.
  - Preparation of reports.
  - There is evidence in the medical records that proper procedures have been carried out.
  - Residents with sudden changes in condition have been evaluated by the physician.

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<th>Cross Reference</th>
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<tr>
<td>F122 (cont'd)</td>
<td>- Review physicians progress notes to see if emergency situation was addressed.</td>
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<td>Survey Area</td>
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<td>Nursing Services</td>
<td>F124</td>
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<td></td>
<td>SNF 405.1124(c)</td>
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<td>F126</td>
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<td></td>
<td>ICF 642.1124(c)</td>
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<td></td>
<td>A facility provides nursing services sufficient to meet nursing needs of</td>
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<td></td>
<td>all residents all hours of each day.</td>
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<td>F127 Grooming and</td>
<td>Basic care provided to residents:</td>
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<tr>
<td>Personal Hygiene</td>
<td>Surveyors should observe the basic care provided by staff to the residents.</td>
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<td>SNF 405.1124(c)</td>
<td>Listed below are suggested areas of attention which may provide evidence</td>
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<td>of the quality of personal care:</td>
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<td>- Eyes/Ears/Mouth Presenes/absence of:</td>
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<td></td>
<td>+ Secretions forming around eyelids,</td>
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<td>+ Redness or irritation of eyes.</td>
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<td>+ Eyeglasses worn when appropriate are clean, in good repair and fit</td>
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<td>properly.</td>
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<td>+ Backs of ears scaly, obvious wax build-up, discharge, odor.</td>
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<td>+ Hearing aid worn when appropriate is in good repair and working.</td>
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<td>+ Dried food particles or drool around mouth.</td>
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<td>Ask Resident:</td>
<td>If the resident's clothing is inappropriate, ask:</td>
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<td>+ Did you choose your clothing today?</td>
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<td>+ Is this what you want to wear?</td>
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<td>+ Do you have other clothing available?</td>
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<td></td>
<td>+ If the resident is not clean, poorly groomed, or inappropriately</td>
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<td>groomed, ask the resident.</td>
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<td>Have you had any help in caring for yourself today (e.g., washing your</td>
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<td>face, brushing your teeth, etc.?</td>
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<td>How often do you have a bath/shower?</td>
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<td>How often is your hair washed?</td>
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<td>How often do you brush your teeth/ clean your dentures?</td>
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<td>Were there extenuating circumstances (e.g., nursing notes, flow sheets or</td>
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<td>bathing records should indicate that the care plan for grooming and</td>
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<td>personal hygiene is being followed. For example:</td>
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<td>- Bathing schedules are being followed (including the use of any soaps</td>
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<td></td>
<td>or special lotions).</td>
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<td>- Assistance instruction and/or supervision is being provided as</td>
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<td>identified for each activity.</td>
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<td>Nursing documentation should also indicate resident response or any changes</td>
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<td>in the resident’s behavior, reaction to an activity, or the ability to</td>
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<td>carry out grooming and personal hygiene activities. Look for indications</td>
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<td>of progress toward a goal or further determination of resident functioning.</td>
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<td>Refer to information on observation. A pattern of evidence of poor personal</td>
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<td>care indicates non-compliance unless the care plan specifically deals with</td>
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<td>this and appropriate planning and implementation is occurring.</td>
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<td>The regulations require that individual preferences are taken into</td>
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<td>account when providing for grooming and personal hygiene and that residents</td>
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<td>are encouraged in self-care activity. Do your patient interviews</td>
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<td>substantiate compliance with the regulations?</td>
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<td>Resident Rights</td>
<td>405.1124(b)(16)(13)</td>
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<td>Social Services</td>
<td>642.311</td>
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<td>Activities</td>
<td>405.1131</td>
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<td>Patient Care</td>
<td>405.1124(d)</td>
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<td>Management</td>
<td>442.341</td>
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<td>Training</td>
<td>405.1124(h)</td>
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<tr>
<td>F12 (cont’d)</td>
<td>- Dentures worn when appropriate and in good repair.</td>
<td>- Oral hygiene.</td>
<td>- Resident is participating in dressing retraining program?</td>
<td>- Special consideration might be given to the demented patient who frequently “borrows” clothes and for whom removal may elicit catastrophic reaction—whether clothing “matches” may not be the most important issue in the care of these patients.</td>
<td>Ask Direct Care Staff: - How do you choose what clothing each of your residents wear each day? - Do you have a specific schedule for washing residents’ hair? - How did you learn to bathe residents? - How do you learn to wash residents hair? - How did you learn to shave residents? - How do you handle situations when residents want to wear dirty clothes, or mismatched clothes?</td>
</tr>
</tbody>
</table>
### Long Term Care Survey

<table>
<thead>
<tr>
<th>Survey Area</th>
<th>Observation</th>
<th>Interviewing</th>
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<th>Evaluation Factors</th>
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<tbody>
<tr>
<td>F127 (cont'd)</td>
<td>Amputees with elastic bandage or sock removed.</td>
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**Skin Condition F128-129**

<table>
<thead>
<tr>
<th>Observation</th>
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<th>Evaluation Factors</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Observe with residents' permission:</td>
<td></td>
<td>Preventable pressure sores are not occurring. Ulcers present are treated on a routine basis according to P.O.C.</td>
<td>Dietetic Services 405.1125(1)(c)(1)(a) 442.332(a)(1)(b)(1) Activities 405.1125(b) 442.345(a) Patient Care Management 405.1124(d) 442.341 Training 405.1124(e) 442.342 Rehabilitation Nursing 405.1124(f) 442.342 Supervision of Patient Nutrition 405.1124(f) 442.332(b)(2)</td>
</tr>
<tr>
<td>General condition of skin</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Redness</td>
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<td></td>
<td></td>
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<tr>
<td>Blushing</td>
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<tr>
<td>Soft/dry/rough etc.</td>
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<td></td>
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<tr>
<td>Rashes/irritation</td>
<td></td>
<td></td>
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<tr>
<td>Bruises</td>
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<td></td>
<td></td>
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<tr>
<td>Scabs</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Free of above</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Measures taken to prevent skin breakdown</td>
<td></td>
<td></td>
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<tr>
<td>Pressure sores</td>
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<tr>
<td>Pressure sores Rx</td>
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<tr>
<td>Factors contributing to prevention of pressure sores</td>
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<tr>
<td>Overall cleanliness and maintenance of dry and averted skin uncompromised by urine/vomit/perspiration</td>
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<tr>
<td>Padding for pressure points and bony prominences including padding on bed/Chair</td>
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<tr>
<td>Proper gentle massage to bony areas several times a day</td>
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<tr>
<td>Ask Residents:</td>
<td>Look at nursing notes and P.O.C. for evidence of:</td>
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<tr>
<td>- Are your feet usually swollen?</td>
<td>- Planned preventive measures</td>
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<tr>
<td>- Do you know what causes the swelling?</td>
<td>- Treatments/Intervention including nutrition</td>
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<tr>
<td>- What do you do to alleviate it?</td>
<td>- Routine assessment/evaluation of skin condition</td>
<td></td>
<td></td>
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<tr>
<td>- Is this discoloration normal for you?</td>
<td>- Documentation of specific skin problems with location, number, severity, measurements as appropriate, and cause</td>
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<tr>
<td>- How did this wound/bruisel develop?</td>
<td>- Progress or lack of progress in healing</td>
<td></td>
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<tr>
<td>- Are the treatments done about the same time every day?</td>
<td>- Assessment/Reevaluation of interventions with alterations in plan</td>
<td></td>
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<tr>
<td>- What staff person has looked at your skin recently?</td>
<td>- Appropriate nutritional plan</td>
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<tr>
<td></td>
<td>- Methods to control edema of lower extremities</td>
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</tbody>
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391

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lpowell on DSK54DXVN1OFR with $$_JOB"
### Long Term Care Survey

<table>
<thead>
<tr>
<th>Survey Area</th>
<th>Observation</th>
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</thead>
<tbody>
<tr>
<td>F128-129 (cont’d)</td>
<td>- Regular assistance for resident to turn or shift weight (bed rails, footboards, trapeze)</td>
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<tr>
<td></td>
<td>- Bed linens, clothing, underpads smooth and free from wrinkles.</td>
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<tr>
<td></td>
<td>- Elastic bandages or hose are smooth and wrinkle free.</td>
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<tr>
<td></td>
<td>- Elastic bandages wrapped smooth with appropriate overlap.</td>
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<tr>
<td></td>
<td>- Dietary/nutritional support for skin integrity. (See Guidelines for Dietary/Nutrition)</td>
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<tr>
<td></td>
<td>- Prevention of shearing force when resident's position altered by staff.</td>
</tr>
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<td></td>
<td>- Turning and repositioning as needed.</td>
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<tr>
<td></td>
<td>- Care and treatment:</td>
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<tr>
<td></td>
<td>- Turning and repositioning every two hours or as needed (e.g., alternative approach that is justified by the facility.)</td>
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<tr>
<td></td>
<td>- Positioning of the ulcer site or protection of affected areas.</td>
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<td></td>
<td>- Use of effective pressure relief devices.</td>
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</table>

<table>
<thead>
<tr>
<th>Interviewing</th>
<th>Record Review</th>
<th>Evaluation Factors</th>
<th>Cross Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask Direct Care Staff:</td>
<td>- What can you tell me about Mr./Mrs. ______ swollen feet/wounds/ bruises/etc.?</td>
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<td></td>
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<tr>
<td></td>
<td>- What do you do for them?</td>
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<tr>
<td>Ask Charge Nurse:</td>
<td>- How did ______ get cuts, bruises, etc.?</td>
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<td></td>
<td>- What is being done to prevent further occurrence?</td>
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<td></td>
<td>- What treatment is he/she receiving?</td>
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Resident Supervision by Physician 488.123(b)
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Wounds/Wound Dressings</td>
<td>- Condition of dressing — i.e., clean, firmly secured unless contraindicated. - Observe, if possible, and with resident's permission, a dressing change - Pre-dressing Removal Equipment and supplies organized Hands washed Residents provided with privacy - Dressing is: - Old dressing observed for drainage? - Wound examined - Appropriate technique used - Proper disposal of old dressing? - Post dressing - Does staff wash hands? - Return resident to comfortable position or previous activity?</td>
<td>Ask Resident: - How often is the dressing changed? - By whom is the dressing changed? - Does it seem dressing changes are frequent enough? - Are there any odors from the dressing? - Is the dressing change always done in a similar way? - If not, what are the differences? - Do you feel confident that the wound is being well cared for? - Is the area/wound healing? - What caused the ulcer, wound, etc.? Is it healing? Does the staff keep you informed of its status? Ask Staff: - Specific treatment and schedule for each resident?</td>
<td>- Physician orders for wound care - Progress notes detailing condition of wound — i.e., size, drainage, surrounding tissue, odor - Treatment provided - Progress/change - Plan of Care (POC) - The plan of care should address: - Area in need of treatment, treatment to be performed, frequency, and responsible staff. - All necessary solutions, ointments, irrigations, types of dressings, and materials. - Any necessary precautions, drains, if present, sutures and tubing. - Specific goals of treatment as well as any problems or limitations imposed as a result of treatment.</td>
<td>Physician orders, your observations, progress notes and POC should reflect the same information. Treatment provided over a period of time with no improvement and no re-evaluation also would represent non-compliance unless nursing/physician progress notes address the &quot;no improvement&quot; problem. Compliance is evidenced by: - Treatment given according to doctor's orders and POC. - Use of appropriate technique when caring for wound/changing dressing (e.g., follows facility's written procedures). - Periodic evaluation of healing process and revision of care plan as needed.</td>
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<td></td>
<td>Physician Services 405.112 442.341 Infection Control 405.1135(b) Pt. Care Management 405.1124 442.341 Dietetic Services 405.1125(b)(1)(a) 442.352(a)(1)(b)(1) Medical Records 405.1122 442.318</td>
</tr>
</tbody>
</table>
### Long Term Care Survey

<table>
<thead>
<tr>
<th>Restraints Area</th>
<th>Observation</th>
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</thead>
</table>
| Direct to evidence of: | - Proper application  
- Proper use  
- Maintenance of good body alignment  
- Resident observation, release and exercise  
- Observe frequently throughout your visit to validate care. Specific observations should include the following items:  
  - Type of restraint: belts, wrist or ankle cuffs, blanket restraints, waste, bed nets, locked, etc.  
  - When locked restraints are used can you readily find the key and/ or fob.  
  - As well as geriatric chair or goni-table/tray in place for prolonged periods.  
  - Protective devices and/or safety devices that are used as restraints must be evaluated as restraints.  
  - Appropriate application: skin protected from injury (restraint neither too loose nor too tight to prevent use of restraints may be precipitated by an 'emergency' situation in which there is a threat to the resident's health or safety, or a threat to the health and safety of others due to the resident's behavior.  
  
  | - Use of restraint may include appropriate questions as to when the staff last assisted him or her to move about or whether the resident would like to get out of the chair. Staff interviews focus on the reason why the resident is restrained.  
  | Ask Direct Care Staff and Charge Nurse:  
  - Why, when, and how to release and apply restraints?  
  - Why is the resident  
  | - Physician orders for restraint: reason, length of time, type  
- Progress notes  
- Describe the resident's status/behavior which prompted the use of the restraint.  
- If a chemical restraint, the order should indicate a specific time period for its use as well as a stop date.  
- Plan of Care should  
  - Identify other methods or therapies that are being used in conjunction with restraints.  
  - What alternatives to restraints have been considered.  
  - Identify staff responsible for observing the resident (every 30 minutes), and releasing and exercising the resident (every 2 hours for at least 10 minutes). Time intervals should be identified.  
  - Indicate involvement and input of other disciplines necessary to overcome the problem.  
  - Indicate a specific period of time for  
  | - Is there a physician's order, including the circumstances in which they will be used, the length of use, and the type of restraint?  
- Is the restraint applied properly?  
- Is it released at least every two hours and the resident provided with exercise and toilet facilities if needed?  
- Does the staff observe the resident frequently while he/she is restrained?  
- Are chemical restraints administered in accordance with physician's orders?  
- Is the order for restraints renewed only after a reassessment of the patient? |  

#### Patient Rights

- 483.12(k)(1)(i)(7)

- 483.31(f)(2)
<table>
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<tbody>
<tr>
<td>F130 (cont'd)</td>
<td>Rubbing and blistering or impeded circulation - Body alignment and support: use of pillows, footboards, and wheelchair footrests to maintain appropriate posture, circulation, and to prevent skin injury or breakdown. - Periodic release and exercise: exercise may include ambulation, range of motion, massage, or other opportunities for motion (at least 10 minutes every 2 hours during day and evening hours). - Chemical restraints: residents appear drowsy throughout the day (may indicate tranquilizers or other drugs are being used to limit or control behavior for staff convenience).</td>
<td>Restrainted? - Was the resident given an option of restraint? - When were you taught the use of restraints? By whom? - If chemically restrained (excessively sedated) - Why is this done? - Whether alternate means of restraint have been attempted, for how long this will continue, etc. This should elucidate from staff whether the chemical restraint is necessary, or whether it is done for staff convenience by controlling resident behavior - Do you ask the resident for permission before using restraints? - How does the restrained resident summon assistance? - What is the usual time-frame for assistance to reach the restrained resident? Ask resident: - Why are you restrained? - What would happen if the restraint were removed? - When do you use bed rails? - What purpose do they serve? - How do you gain assistance?</td>
<td>Using the restraint.</td>
<td>- Indication of assessment of factors which precipitate residents behavior which has warranted restraints and plans to intervene early enough to prevent occurrence. - Type, duration and frequency of exercise should be documented. - An assessment of why restraints are continued should be documented.</td>
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## Long Term Care Survey

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</table>
| Bowel and Bladder           | - There should be a chart/record in the resident's room on which the program is documented accurately. | - Both the resident and direct care staff should be interviewed and should exhibit a good understanding of the importance of maintaining a regular schedule of elimination. If neither are aware of the intake and toileting schedule, then determine whether they are appropriately planning the resident or carrying out a retraining program. | - Physician orders if required by facility policy. | - Are all incontinent patients assessed for cause of incontinence and ability to be helped by a bowel/bladder rehabilitative training program or an incontinence management program? | Nursing Services 405.1124(a)  
Dietetic Services 405.1125(c) |
<p>| F(3) SNF 605.1124(c)        | Each resident with incontinence is provided with care necessary to encourage continence including frequent toileting and opportunities for rehabilitative training. | - Ask resident: Suggested questions are: | | | |</p>
<table>
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<tr>
<td>F133 (cont'd)</td>
<td>- When a resident puts on his/her call bell for toileting assistance, how long is it before assistance is given? - Observe pre-meal toileting. - Privacy provided. - Schedule for toileting should allow for resident's normal sleep pattern to avoid disrupted sleep.</td>
<td>Ask Nurses Aides and Charge Nurse: - Will you describe this resident's bowel/bladder (B/B) training program? - How long has it been in effect? - When will you evaluate the results? - If this program is not successful - What assessment was done to determine B/B status - For residents not on B/B retraining program what is the facility program for managing incontinence?</td>
<td>at least 7 days for the cause of incontinence and when appropriate an intensive bowel and bladder B/B training program should be instuted. - A trial B/B training program is suggested for all residents with incontinence problems.</td>
<td>1 &amp; 0</td>
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<tr>
<td>Catheter Care F132 SNF 405.1124(c)</td>
<td>Each resident with a urinary catheter receives proper routine care including periodic evaluation</td>
<td>The indwelling catheter should promote a continuous flow of urine unless ordered otherwise. The surveyor should also observe for the following: - Ampule supplies for catheter insertion and care. - Proper positioning of the tubing and drainage bag. - Cleanliness of the</td>
<td>Ask Resident: - What is the tubing/catheter for? - Why do you have one? - Does it cause any discomfort? - If it does, what is done about it? - How do you feel about having the catheter? - Is any special care given in relation to the catheter?</td>
<td>The surveyor should verify that there is a physician's order for an indwelling catheter, including the type and frequency of catheter care. If irrigation is ordered, the order should include type of solution and frequency of irrigation. The record should also indicate the color, consistency, and amount of urinary drainage.</td>
<td>Infection Control 405.1135(a)</td>
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</table>

*The facility should follow accepted professional standards in their catheter care.*
There should be medical reasons for catheter insertion - staff convenience cannot be justification.
Direct care staff should know signs and symptoms of urinary tract
<table>
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<tr>
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</table>
| F132 (cont'd) | Tubing and drainage bag. | Ask Nursing Aide and Charge Nurse: + How do you routinely position and secure catheters and drainage bags? + How often is each part of the system changed? + What are the indications for insertion of the catheter? + What is the facility's procedure for routine catheter care? + How do you observe for U.T.I.'s in residents with indwelling catheters? + What is the facility's procedure for the cleansing and storage of reusable catheter equipment and drainage receptacles? + How do you care for catheter tubing? | - Assessment should address: + Need for an indwelling catheter. + Resultant problems or limitations. | - Plan of Care should address: + Type of catheter and type and frequency of care. + For irrigation, the rationale, the type of solution, amount, and frequency of irrigation. + Frequency of symptoms which would precipitate catheter change. + Time frames of catheter change and responsible staff. + Appropriate increase in oral fluid intake. + Intervention: The record must reflect: + When and by whom the catheter was inserted and for what reason. + Any special care provided + New problems or changes + Only appropriately trained staff should deliver catheter care. + Only licensed staff should insert | Infections (U.T.I.'s) and these should be reported and treated promptly. *The Center for Disease Control has developed standards for catheter care which may be used but it is not a requirement.
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<tr>
<td>F132 (cont'd)</td>
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<td>indwelling catheter.</td>
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<td>The specific type and size of equipment used should be noted.</td>
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<td>Signs and symptoms of urinary tract infections (UTI) should be acted upon and documented as to follow-up.</td>
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<td>Evaluation/Reevaluation The record should reflect that the resident:</td>
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<td>* Is assessed for UTI.</td>
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<td>* Has no abdominal distention.</td>
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<td>Notes should also include:</td>
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<td></td>
<td>* The color and odor of urine and the development of any problems after insertion of indwelling catheter.</td>
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<td></td>
<td>* Verify that catheter is patent.</td>
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<td>SURVEY AREA</td>
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<td>CROSS REFERENCES</td>
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<tr>
<td>Injections</td>
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<tr>
<td>SNF 1124(c)</td>
<td>- Observe for preparation of injection - i.e. maintenance of sterility; correct dilution, handwashing, before preparation, etc.</td>
<td>- Observe injection site for:</td>
<td>- Physician order sheet</td>
<td>- Is the medication</td>
<td>Staff Development</td>
</tr>
<tr>
<td></td>
<td>- Observe injection site</td>
<td>- Redness</td>
<td>- Nursing notes for:</td>
<td>administered according</td>
<td>405.112(c)(1)(v)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Discoloration</td>
<td>- Resident response to medication if appropriate</td>
<td>to the physicians order?</td>
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<tr>
<td></td>
<td></td>
<td>- Swelling</td>
<td>- Any problems noted at injection site</td>
<td>- Is proper technique used in preparation and administration including site rotation?</td>
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<td></td>
<td></td>
<td>- Lesions</td>
<td>- Any other adverse reactions</td>
<td>- Does the nurse administering the medication know the expected action of the drug?</td>
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<td></td>
<td></td>
<td>- Observe for proper technique when injection is given</td>
<td>- Site of injection</td>
<td>- If infection control reports show infections at injection sites.</td>
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<tr>
<td></td>
<td></td>
<td>- Correct site</td>
<td>- Plan of care</td>
<td>- Is the resident's response to the medication noted in the progress notes?</td>
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<tr>
<td></td>
<td></td>
<td>- Correct needle size</td>
<td>- Rotation of injection site</td>
<td>- Infection Control: reports for any infections connected with injections.</td>
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<td>- Correct volume of drug</td>
<td>- Care for any special problems related to the injection.</td>
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<tr>
<td></td>
<td>- Resident is observed for any adverse reaction</td>
<td>- Adverse reaction occur, how soon are they reported?</td>
<td>- Infection Control:</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>- What is the disposal method for used needles or syringes?</td>
<td>- Could this be given by</td>
<td>reports for any infections connected with injections.</td>
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<td></td>
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<td>any other route?</td>
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LONG TERM CARE SURVEY

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<tr>
<td>Parenteral Fluids</td>
<td>The surveyor should observe that parenteral fluids are administered with safe, aseptic technique providing fluids as ordered by the physician. Safety and comfort measures are to be taken insuring maximum protection and optimum hydration of the resident. The surveyor should note the following times: - Labeling of the solution bottle/bag, - Rate of infusion/cc/ml per hour, - Date and time started, additives, if any, - Any signs of swelling or redness at site, - Site dressing is clean, dry and dated. - Accurate I&amp;O of parenteral and P.O. fluids. - If splint (armboard) is used, it is applied to prevent movement but not impede circulation. - Positioning of I.V. tubing. - Comfort of restraint used to allow for maximum resident freedom while preventing movement of I.V. site.</td>
<td>Ask Resident: - Why do you have this tube in your arm/leg? - Is it comfortable? - Is there a way it would be more comfortable? - How long has it been in? - How much longer will it stay in?</td>
<td>Ask Appropriate Staff: - Why is the resident is receiving I.V. therapy? - What is the drip rate (the amount of fluid to be received per hour)? - How often the dressing is changed? - How often the tubing is changed? - What are possible side effects? - How often is the site changed? - How often is the infusion checked for drip rate and the remaining volume to be administered?</td>
<td>Ask Nursing Aide: - What are your responsibilities when caring for a resident receiving IV fluids? - What training have you had?</td>
<td>- Physician's order for parenteral therapy specifying type of fluid, rate of infusion/hour, and additives, if any, is available and current. - Twenty-four hour I&amp;O record. Nursing documentation indicates physician's orders are being followed. - Any adverse reactions are noted in the medical record.</td>
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<td>F133 (cont'd)</td>
<td>specified goals for correction, time frames, and responsible staff.</td>
<td>- Documentation must include time administered and by whom, the amount of fluid infused, and any other special care administered as a result of IV therapy (i.e., mouth care, assistance with ADLs, etc.).</td>
<td>- The record must reflect: - Conditions of site and any infusions, phlebitis, necrosis, etc. noted, along with measures taken to correct these. - The resident's response to therapy - Changes in laboratory studies. *Plan of care would not be modified for a one-time IV infusion.</td>
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<tr>
<td>Colostomy/Ileostomy F133 §405.1124(c)</td>
<td>The surveyor should ascertain that the facility is providing appropriate nursing care to those residents who have had bowel surgery resulting in a colostomy or ileostomy. It is recommended that the surveyor, with the resident, determine that: - Why was the ostomy performed? - How do you feel about the ostomy? - Does it ever cause you problems (e.g., pain, skin problems, odors, accidents)? If so, what</td>
<td>The surveyor should determine that: - Colostomy irritations, if ordered, are documented as performed by the resident or appropriately trained staff. - In the case of sigmoid colostomy regular patterns of bowel elimination are</td>
<td>Compliance would be indicated if residents are physically and emotionally comfortable with the ostomy with minimal or no skin problems. If residents are not comfortable with the ostomy, are having skin or other problems, the facility</td>
<td>Patient Care Management §405.1124(d)</td>
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### Long Term Care Survey

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<th>Survey Area</th>
<th>Observation</th>
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<td>Colostomy/Ileostomy F133 (cont'd)</td>
<td>Her acceptance of the colostomy/ileostomy. - The surveyor should observe the staff giving ostomy care to verify that proper technique is used.</td>
<td>Ostomy residents? - What do you do when skin becomes excoriated? - What teaching do you do with the residents? - What in general is the response to this teaching?</td>
<td>Self-care performed or assistance needed. - Special skin care needs. - Special dietary needs. - Emotional support. - Medications and treatments if needed. - Plan of Care The plan of care should clearly address: + Specific goals to overcome or improve the problems(s) identified. + Methods to accomplish the goal (training, assistance, supervision, treatments, emotional support). + Services necessary and who will perform the services. + Time frame for accomplishing goals.</td>
<td>Social Services 480.1150(a) 442.33(a)(b)</td>
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## Long Term Care Survey

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| Respiratory Therapy | - Aerosol Compressor or IPPB (Intermittent Positive Pressure Breathing Machine) | The surveyor must determine that the facility is providing respiratory therapy as ordered by the physician. Observation for this indicator should focus on the necessary equipment as well as on the resident. In order to determine that the necessary equipment is available, the surveyor must look for the following: | - Ask Resident:  
  - Do you ever feel short of breath?  
  - If yes, what is done when this occurs?  
  - Is the therapy helping you to feel better?  
  - Are there any problems with it?  
  - If so, how does the staff respond?  
  - Is the therapy consistently performed — both concerning time and method of providing it. | - Only qualified (trained) personnel should administer/assist with respiratory therapy. Therapy must be provided as ordered. The effectiveness of the therapy must be periodically evaluated and therapy revised as appropriate. Effective infection control measures must be practiced. Needed safety precautions for the use of oxygen must be practiced. Equipment should be available and in working order. | - Staff Development  
 405.1121 (b)  
442.314  
Infection Control  
405.1135(b)  
Patient Care Management  
405.1124(d)  
442.341 |

| F133 | SNF 405.1124(c) | While interviewing the resident, observe for sounds of congestion. Note color of lips and nail beds.  
- Ask Staff:  
  - What is the reason the resident is getting this therapy?  
  - What is the expected result?  
  - Can you demonstrate how you use the equipment?  
  - How often is the equipment cleaned?  
  - What are the infection control procedures in regard to use of res- |

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<tr>
<td>Respiratory Therapy [cont'd]</td>
<td>stored wet. If it is not attached to the tubing, ask to see it. The mouthpiece is connected to the nebulizer cup. The surveyor should also check that all involved equipment is clean. - Oxygen Therapy: The surveyor must establish that the facility is meeting the oxygen needs of the resident. When the facility does not have wall units, check that:</td>
<td>- What training was given you in the use of this equipment? - Where is the emergency oxygen supply?</td>
<td>problems and/or limitations. + Specific methods to accomplish the goals (observation, supervision, training, etc.). + Who is responsible to perform therapy or assist in accomplishment of goal. - Intervention - The record should display evidence that: + The plan of care is functional. + The therapy was administered in accordance with physician's order for the specified reason(s) by an appropriately trained staff member. + Change in condition is documented and acted upon promptly. - Evaluation/Reevaluation The record should reflect: + The resident's response to therapy. + If response was undesirable, evidence of further intervention. + Any progress, deterioration, or development of new problems.</td>
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<td>Respiratory Therapy F133 (cont’d)</td>
<td>the carrier, sitting on a metal skirt, or otherwise secured.</td>
<td>Based on the above information, possible modification of goals.</td>
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<td>* There should be other necessary equipment available such as humidifiers, nebulizers, masks, nasal cannulas, 1-piece, etc.; all should be dry and clean when stored.</td>
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<td>* Check to see that non bed-bound residents are not limited to their own chair/room when using oxygen (portable units will prevent social isolation).</td>
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<td>* Water reservoir is appropriately filled per manufacturer’s instructions.</td>
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<td>* Check to make certain the tank is not empty and that any tank is labeled as such.</td>
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<td>* Check for good oral hygiene of resident.</td>
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<td>* The room should be posted with a “No Smoking” sign.</td>
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<td>- Residents on respirators:</td>
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<td>* Are alarm systems turned on?</td>
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<td>Residents on Respirators Ask Staff (all levels):</td>
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<td></td>
<td>* What training have you had in caring for</td>
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<tr>
<td>Respiratory Therapy</td>
<td>* Is sufficient oxygen supply available?</td>
<td>residents on respirators?</td>
<td>- Can you show me how the alarm system works?</td>
<td>- What is your procedure for pulmonary care?</td>
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<td></td>
<td>* Is the ventilator accessible to an emergency outlet?</td>
<td>* How does the resident communicate with staff?</td>
<td>- What is your procedure for changing tubing and the water reservoir?</td>
<td>- What happens if the power goes off?</td>
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<td>* Is the resident in a location that allows for frequent observation by staff?</td>
<td>* What level of staff (aide, LPN, RN) is caring for the resident?</td>
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<td>* Is such equipment at bedside?</td>
<td>* Is there reserve back-up equipment?</td>
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<td></td>
<td>* What is the condition of the residents skin around intubation tube/ tracheostomy?</td>
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<td>* Does the care given use appropriate technique in caring of the patient?</td>
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| Tracheostomy Care    | Satisfactory tracheostomy care is a procedure which promotes a clean, unobstructed air passageway and maintains the skin integrity surrounding the tracheostomy site. | - The surveyor should determine whether:  
  - Adequate supplies are available for the care of the tracheostomy such as tracheostomy kits, hydrogen peroxide, normal saline or sterile water, suction machine, catheter, sterile gloves, and cleaning dressing.  
  - The resident is breathing without difficulty and is comfortable.  
  - The dressing is clean, dry, and intact; the cannula is clean, in the proper position, and secured.  
  - The skin surrounding the trach is clean and dry with no redness or inflammation.  
  - The resident has adequate oral hygiene.  
  - An extra tube, the same size as the one in place, is clean and dry with no redness or inflammation.  
  - The resident interviews must be guided by the resident's communication ability.  
  - Ask Resident:  
    - How long will you have it?  
    - What care can you do for yourself?  
    - What do you need help with?  
    - Who helps you?  
    - Is someone always available to suction him/her when needed?  
    - If the suction equipment is always available in working order?  
    - If the dressing kept clean and comfortable?  
    - If the tube was kept clean and changed as needed?  
    - How often are the tubes and dressings changed?  
    - Does he/she feel confident in the personnel caring for the trach?  
    - What is communicating with staff and other residents like?  
    - Are staff patient and do they allow you enough time to express your needs/thoughts/feelings?  
    - May I observe your tracheostomy care?  
  - Ask Staff:  
    - Why does resident have a tracheostomy?  
    - How often is the tracheostomy dressing changed?  
    - How often is the tube suctioned?  
    - Are there any complications or problems with the tracheostomy site?  
    - What are the resident's goals and how are they being met?  | - Stoma and surrounding skin should be in good condition and if not, there should be treatment directed to resolving this problem.  
  - All staff caring for the tracheostomy must be trained and emergency procedures must be known.  
  - All needed equipment must be available and in working order.  
  - Resident must at all times have readily available a means of communicating with the staff in an emergency. |  |

<p>| Source: Centers for Medicare &amp; Medicaid Services, HHS, § 488.115(c) |  |  |  |  |  |</p>
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<tr>
<td>Tracheostomy Care F133 (cont'd)</td>
<td>place, is available at bedside. Does resident have an adequate method of communicating with the staff? Does staff allow enough time for residents to communicate?</td>
<td>tracheostomy? What training were you given to enable you to care for tracheostomies? What is the procedure for tracheostomy care? How often is the tube changed? What do you do if the tube comes out? May I watch you do a dressing change? If not convenient, describe what you do. How do you communicate with a tracheostomized resident?</td>
<td>listed in goals. Plan for periodic assessment of appropriateness of person's own self care re: teaching or nursing assuming more responsibility as appropriate. Intervention - The surveyor should look for documentation of: Trach care and oral hygiene administration, including responsible personnel, time and date, and effects.</td>
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<td>Tracheostomy Care F133 (cont'd)</td>
<td>Suctioning is necessary for any resident who is unable to cough up secretions that are obstructing his airway. Suctioning may occur via the oral or nasal route, or stoma route with sterile technique. Attempts should be made to observe a resident being suctioned should such an opportunity arise. If so, observe that a clean/jaseptic technique is observed throughout and that the resident tolerated the procedure. There should not be bloody aspirate, cyanosis, or bronchospasm. Check that equipment is in good working order, frequency of procedure, etc. Resident observations which indicate need for intervention include: - Secretions are draining from a resident's mouth or trach and the resident is unable to</td>
<td>Since this may require additional care planning.</td>
<td>- Assessment - The record should reflect that: + The resident is frequently observed for suctioning needs. + Any limitations a resident has as a result of his suctioning needs should be specifically noted. + Any problems resulting must be specified. - Plan of Care should include: + Awareness of the resident's suctioning needs, goals, approaches, and responsible staff needed to improve the problem or at least maintain the resident at his present status without further deterioration. The plan must clearly indicate specific approaches towards: Prevention of skin problems around the trach if one exists. - Correction of any existing skin</td>
<td>- All equipment must be available and in working order. - All staff caring for the resident must know what to do in an emergency. - Current professionally accepted standards of care must be maintained.</td>
<td>Infection Control 489.1135(b) Patient Care Management 489.1124(a)</td>
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**LONG TERM CARE SURVEY**

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<tr>
<th>SURVEY AREA</th>
<th>OBSERVATION</th>
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<tr>
<td>Suctioning</td>
<td>Cough or clear himself.</td>
<td>- Where are your emergency electrical outlets?</td>
<td>Blows.</td>
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<td>F133 (cont'd)</td>
<td>- There are audible crackles or wheezes and/or diminished breath sounds.</td>
<td>- What is your procedure for disposing of the secretions from suctioning?</td>
<td>- Provision of good oral hygiene including a rigid schedule for mouth care, schedules, or procedures for maintaining clean equipment at bedside, as well as disposal of used (dirty) equipment.</td>
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<td>- The resident is dyspneic.</td>
<td>- How often does Mrs./Mr. need to be suctioned?</td>
<td>- Route of suctioning (i.e., oral/nasal/ trach).</td>
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<td>- Restlessness or agitation may also be an indication that suctioning is needed.</td>
<td>- May I observe you when you suction Mrs./Mr.?</td>
<td>- Intervention - The record should indicate clearly that:</td>
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<td>Upon completion of suctioning above symptoms should, in most cases, be relieved. The surveyor should observe that the resident is positioned to facilitate breathing (usually at a 45 degree angle). Check to see that the facility has an ample supply of suction machines and suction catheters to meet the needs of residents requiring them and that they are clean and properly stored.</td>
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<td>+ The plan of care is being implemented. Documentation should reflect:</td>
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<td>The number of times the resident required suctioning, for what specific reason, and by whom the resident was suctioned.</td>
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<td>+ Any special treatment the resident received in conjunction with suctioning</td>
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<td>Suctioning</td>
<td>F133 (cont'd)</td>
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<td>(i.e., oral hygiene, skin care, etc.).</td>
<td>Evaluation/Redetermination. The record should reflect.</td>
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<td>- How well the resident tolerates suctioning procedures.</td>
<td>- Any bloody aspirant, cardiac arrhythmia, cyanosis, or broncho-spasm.</td>
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<td>- Further interventions utilized to overcome or improve these.</td>
<td>- The amount of sputum as well as its color and consistency.</td>
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<td>- Any progress or lack of progress, deterioration, and/or the development of new problems.</td>
<td>- The evaluation should determine whether goals are being reached or if new goals must be addressed.</td>
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<tr>
<td>Tube Feedings</td>
<td>F133</td>
<td>Staff use proper technique in administering feedings and medications. Check to see that staff checks location of tube before feeding and that tubing is properly connected.</td>
<td>If the resident is able to be interviewed, suggested questions may be: Do you feel comfortable/safe with all the staff who perform the feeding?</td>
<td>Tube Feeding Review: Plan of care - Must document tube placement and formula potency prior to each feeding.</td>
<td>Nursing Services 485.112(a)(1) 442.330(a)(2) 442.331(c)</td>
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<tr>
<td>Tube Feedings</td>
<td>is irritated before and after addition of medication.</td>
<td>- The tube is clean and formula flows freely.</td>
<td>- In the case of continuous feeding, tube placement must be documented at least every 4 hours.</td>
<td>- Is skin free from irritation; mouth care is given several times daily? (More frequent mouth care in the case of continuous feeding.)</td>
<td>Gastrostomy Services 485.1125(c)</td>
</tr>
<tr>
<td>F133 (cont'd)</td>
<td>- The equipment is clean and protected. If dressings are ordered, they are in place, clean, and dry.</td>
<td>- Nose gastric tube must be secured in a manner that avoids creating pressure on the nose and nasopharynx.</td>
<td>- Have changes in resident condition been noted and addressed (weight loss, constipation, diarrhea, skin condition)?</td>
<td>- Have observed problems been coordinated with other departments and resolved?</td>
<td>- Variability in supplements as preferences allow?</td>
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<td>- The nasal tube is securely but comfortably secured on the face with skin maintained intact and without irritation.</td>
<td>- Identify frequency, amount, of feeding based on the physician's order and time span over which each feeding is accomplished.</td>
<td>- Is feeding being monitored to ensure that feeding is occurring at the ordered/appropriate rate?</td>
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<td>- The skin around the gastrostomy is kept clean and free from irritation or infection. It should be checked carefully for leakage of gastric contents.</td>
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<td>- A resident who has a NG tube for a prolonged period of time should be observed for possible complications, such as malnutrition, sinusitis, esophagitis, gastric ulceration, and pulmonary infection.</td>
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<td>- Resident is fed slowly with head elevated to 45° during feeding and at least 1 hour post-feeding.</td>
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### Tube Feedings

**F133 (cont'd)**

- Supplies for mouth care are in evidence, observe if possible for technique; mouth shows evidence of good care (i.e., moist, clean).

<table>
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<td>Nursing Services</td>
<td>F137</td>
<td>SNF (405.1124)</td>
<td>ICF (442.318)</td>
<td>B. Twenty-four hour nursing.</td>
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<tr>
<td>F138</td>
<td>1. Assigned duties consistent with their education and experience based on the characteristics of the resident load.</td>
<td>Are personnel performing duties that are allowed under the State Nurse Practice Act?</td>
<td>Do you observe care being rendered in an appropriate, competent manner?</td>
<td>Does the time schedule posted indicate that at least the minimum required personnel are scheduled and actually on duty?</td>
<td>What is the usual response time before a call bell is answered?</td>
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<tr>
<td>F139</td>
<td>2. Weekly time schedules are maintained.</td>
<td>In SNF's is an RN on duty during the day?</td>
<td>Are licensed staff and aide staff functioning in appropriate roles?</td>
<td>Where are staff spending their time?</td>
<td>Ask Resident:</td>
</tr>
<tr>
<td></td>
<td>3. There is a sufficient number of nursing staff.</td>
<td>Ask Staff:</td>
<td>Do you feel qualified to do all the work you are assigned to do?</td>
<td>Do you feel you have enough training to keep up with the care the residents require?</td>
<td>All nursing personnel must function within their State Nurse Practice Act.</td>
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<td>Levels of staffing meet at least minimum requirements.</td>
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<td>Nursing care needs must be identified by the facility &amp; documentation, resident and staff interviews should determine if these needs are met.</td>
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<td>All nursing staff should have education or training to prepare them for the care they perform.</td>
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415

Centers for Medicare & Medicaid Services, HHS

§488.115

Long Term Care Survey

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Nursing Services</td>
<td>F137</td>
<td>SNF (405.1124)</td>
<td>ICF (442.318)</td>
<td>B. Twenty-four hour nursing.</td>
<td></td>
</tr>
<tr>
<td>F138</td>
<td>1. Assigned duties consistent with their education and experience based on the characteristics of the resident load.</td>
<td>Are personnel performing duties that are allowed under the State Nurse Practice Act?</td>
<td>Do you observe care being rendered in an appropriate, competent manner?</td>
<td>Does the time schedule posted indicate that at least the minimum required personnel are scheduled and actually on duty?</td>
<td>What is the usual response time before a call bell is answered?</td>
</tr>
<tr>
<td>F139</td>
<td>2. Weekly time schedules are maintained.</td>
<td>In SNF's is an RN on duty during the day?</td>
<td>Are licensed staff and aide staff functioning in appropriate roles?</td>
<td>Where are staff spending their time?</td>
<td>Ask Resident:</td>
</tr>
<tr>
<td></td>
<td>3. There is a sufficient number of nursing staff.</td>
<td>Ask Staff:</td>
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415

Centers for Medicare & Medicaid Services, HHS

§488.115
### LONG TERM CARE SURVEY

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<tr>
<th>SURVEY AREA</th>
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<tr>
<td>F139 (cont'd)</td>
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<td>F140</td>
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</table>

F139 (cont'd) available to meet the total needs of all residents.

F140
4. There is a registered nurse on the day tour of duty 7 days a week (for SNF only).

Intent
That all residents are cared for by personnel qualified to provide the care & that sufficient numbers & classifications of personnel are available.
<table>
<thead>
<tr>
<th>SURVEY AREA</th>
<th>OBSERVATION</th>
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<th>RECORD REVIEW</th>
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<tbody>
<tr>
<td>Patient Care Management</td>
<td></td>
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<tr>
<td>F167</td>
<td>SMF 405.1124(a)</td>
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<tr>
<td>F168</td>
<td>ICF 442.341</td>
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</table>

F169
A. Each resident's needs are addressed in a written plan of care which demonstrates that the plans of all services are integrated, consistent with the physician's plan of medical care, and is implemented shortly after admission.

F170
B. Each professional service identifies needs.

LONG TERM CARE SURVEY

Ask Resident:
- Are you aware that you have a plan of care?
- Did you participate in developing a plan of care?
- Do you or your family know what the plan is and details? (e.g., diet, ambulation, dressing, etc.)
- Do you attend and participate in the plan of care meetings?
- Who else attends the plan of care meetings?
- When do you last attend the meetings for your plan of care?
- Does the staff assist you in achieving the goals on the plan of care? If not, who does or why not?
- Do you have all necessary assistive devices and equipment?
- Is there anything that is not part of your plan of care that you think should be included? What happens if you question any treatment or procedure? Can you give an example?

Review:
- Plan of care
  - The content of the plan of care is of primary importance rather than the format. Separate care plans are not required for each discipline, but may be accepted if there is evidence that the various disciplines coordinate their planning.
  - Nursing assessment/re-assessments and notes.
  - Physician orders.
  - Physician notes.
  - Assessments/evaluations and progress notes from all professional disciplines are appropriate.
  - Medication and treatment records as applicable.
  - Lab reports, as applicable.

- Are all resident's needs/problems identified?
- Is the plan developed to meet these needs?
- Does the plan demonstrate an interdisciplinary approach and include:
  - Goals stated in measurable/observable terms?
  - Approaches (staff action) to meet the resident action goals?
  - Responsible disciplines/staff responsible for approaches to assist resident in achieving goal/goals?
  - Is plan being reassessed and changed as needed to reflect current status?
  - Does plan of care accurately reflect information gained from observation, interview and record review?

- Physician Services 405.1124
  - 442.341
- Medical Records 405.1132
  - 442.318
- Resident Rights 405.1124
  - 442.338
- 24 Hour Nursing Service 405.1124
  - 442.338
- Specialized Rehabilitation Services 405.1124
  - 442.341
- Training 405.1124
  - 442.316
- Resident Rooms 405.1134(a)
  - 442.325
  - 442.326
- Infection Control 405.1135
  - 442.328
  - 442.324
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>F170 (cont'd)</td>
<td>Ask Staff: - What is your input into resident's plan of care? - What aspect of the resident plan of care are you carrying out? - What is this particular resident's plan of care? - How do you assist the resident in carrying out the plan of care? - Who attends the care planning meeting? - Is the plan of care useful to you in caring for the resident? - Is there anything the resident needs that is not addressed in the plan of care? - How often is it reassessed?</td>
<td></td>
<td></td>
<td></td>
<td>Social Services 405.1130 405.1130(a) 442.344(d) Activities 405.1131 442.345 Dietetic Services 442.1135 442.332</td>
</tr>
</tbody>
</table>

INTENT

The intent is to ensure that the facility identifies the resident's (with residents' family input, if applicable) needs through the coordinated efforts of all disciplines.
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</thead>
<tbody>
<tr>
<td>Restorative Nursing Activities of Daily Living</td>
<td>A. Observe residents in need of assistance.</td>
<td>Ask Resident:</td>
<td>Review:</td>
<td>Are patient needs identified? Verify that the plan of care addresses resident needs and is implemented as scheduled and that all appropriate information is documented. If goals are not reached, has a reevaluation been performed and goals revised? Does restorative nursing assist the resident to acquire a higher level of independence? Is sufficient time allowed to resident for learning to increase his/her level of independence? Are assistive devices used regularly as per plan and are they in good repair? Is there an assessment, and if appropriate, a plan for each ADL that the resident needs to gain independence? Maintenance goals should be noted as appropriate.</td>
<td></td>
</tr>
<tr>
<td>ICF 442.342</td>
<td>442.343(a)(c)</td>
<td>405.1124(a)(b)</td>
<td>Nursing Services 405.1124(a)(b)</td>
<td>(c) 442.345(a)(b)</td>
<td>Specialized Rehab Services 405.1129</td>
</tr>
</tbody>
</table>

**Intent:**
To assist the resident to attain or maintain his/her maximum level of independence and function.
### Long Term Care Survey

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<tbody>
<tr>
<td>FIT1-176 (cont'd)</td>
<td>Prosthetic devices (e.g., braces, artificial extremities), Adaptive equipment (e.g., built-up spoon, reachers), Orthotic devices (e.g., splints, AFO's), Restraints (e.g., vest, waist, wrist, ankle, mitts, nits, geri-chairs), Grooming items (e.g., comb, brush, shaver), Oral hygiene items (e.g., toothbrush, toothpaste, mouthwash, denture cup), Self-feeding devices, Assistive devices for special sensory loss needs (e.g., communication boards, large print books, magnifiers, writing tablets, picture cards, talking books)</td>
<td>being helped? Are staff members encouraging you to do things for yourself? Do you have any problems getting to the bathroom on time? Do you have any problems with leakage when you sneeze, laugh or at any other particular time? How does the staff help you with these problems? Are they aware of the problems? Do you bowels move regularly? If not, what do you/ staff do about this? Are you able to feed yourself? Are you able to get to the dining room by yourself? If not, why? In that case, what does staff do about this? How long have you been up today? Do you usually lie down for a rest? If you need help getting into or out of bed, is staff available to help you when you need it? Where do you spend most of your time - in your chair, wheelchair or in bed?</td>
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<tr>
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</table>
| F171-176 (cont'd) | Colostomy/Ileostomy Care  
Respiratory Care  
(Oxygen Inhalation)  
Speech  
Mobility  
Upper extremity dressing  
Lower extremity dressing  
Observe at mealtime whether staff encourages/  
guides residents in self-feeding or feeds the residents. | Does anyone move your arms or legs or help you with exercises?  
- Have your sleeping habits changed since you came to the nursing home? If yes, in what way?  
- Are you able to get help during the night if needed?  
- What kind of help is needed?  
- Is staff response timely?  
- Do you feel there are adequate care supplies at this facility?  
- If not, can you give me an example of why you feel this way?  
- Is your family involved in assisting you or if learning to help you?  
- Do you feel there is adequate staff at this facility?  
- If not, can you give me an example of why you feel this way?  
- Does staff assist and/or encourage activities (e.g., R.U.M., Ambulation A.D.L., Communication programs, feeding)?  
- How often does staff assist in activities?  
- Is there anything resident would like to do | | | |
**LONG TERM CARE SURVEY**

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<tr>
<td>F171-176 (cont'd)</td>
<td>for himself/herself that staff is doing?</td>
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<tr>
<td></td>
<td>Is resident comfortable (e.g., free from pain)?</td>
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<td>Is your cane/walker/crutches comfortable for you to use?</td>
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<td></td>
<td>Did anyone measure you so you have the right size cane/walker/crutches?</td>
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<td>If the facility arranged so that you can get around easily?</td>
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<td></td>
<td><strong>Ask Activities Staff</strong></td>
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<td></td>
<td>Do you provide information to nursing staff about time and place of activities, plus names of residents who are to attend or those who might be interested in attending?</td>
</tr>
<tr>
<td></td>
<td><strong>Chair-bound Resident</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Ask Resident:</strong></td>
</tr>
<tr>
<td></td>
<td>Does he/she know why he/she is in a chair?</td>
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<tr>
<td></td>
<td>Is resident assisted to use bathroom?</td>
</tr>
<tr>
<td></td>
<td>Is resident comfortable?</td>
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<tr>
<td></td>
<td>Does he/she see therapist? [O.T., Speech, P.T.] and how often?</td>
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</table>
|                   | Does resident go to a
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<tr>
<td>F071-176 (cont'd)</td>
<td>therapy area or does therapist come to resident?</td>
<td>- Is able to reach items needed?</td>
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<td></td>
<td>Ask Nurse Aide</td>
<td>- Who give you information about the time and place of activities and which residents are to attend? How are you given this information?</td>
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<td></td>
<td>- How do you encourage a resident to do the most for themselves?</td>
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<td></td>
<td>Wheelchair Resident</td>
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<tr>
<td></td>
<td>Ask Resident</td>
<td>- Does he/she know why he/she needs a wheelchair?</td>
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<td></td>
<td>- Is resident trained and/or encouraged in independent wheelchair ambulation and activity?</td>
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<tr>
<td></td>
<td>- Does resident know how to lock and unlock wheelchair?</td>
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<td></td>
<td>Ask Staff</td>
<td>- How is a resident set up for independent wheelchair ambulation?</td>
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<td></td>
<td>- Nurse Aide</td>
<td>- Has resident received instruction in transfer techniques?</td>
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<tr>
<td></td>
<td>- Bed Bound Resident</td>
<td>In addition to appropriate interview questions above</td>
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</table>
| F171-176 (cont'd) | Ask Resident:  
- How do you spend your day?  
- Can you do some things for yourself?  
- Does the staff give you a chance to learn self-care skills?  

Ask Nurse:  
- If the resident had access to a recliner chair, would he/she be able to be out of bed?  
- Is the time out of bed coordinated with the activity schedule and necessary care?  

Ask Nurses Aide:  
- Does this resident do any self-care? Why not?  
- If no, has anyone tried to teach him/her to do some care? | | | | | |
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<tr>
<td>Positioning</td>
<td>Observe residents in bed, chairs, restrained, or in &quot;protective devices&quot; for body alignment. Contractures when they occur and what is being done. ROM program (observe extent &amp; technique of provider). Assistive devices (overhead pulleys, slings, splints, etc.) Furnishing &amp; repositioning schedule and adherence to the schedule. Devices to maintain positioning, i.e., sandbags, extra pillows, etc.</td>
<td>Ask Resident: How often are you turned/repositioned by the staff? Is that often enough? Are you comfortable now? Do you have any pain or discomfort? Where? How long have you had joint stiffness (contractures)? What kind of exercise do you do every day, including range of motion (ROM)? How long does the exercise last and how frequently do you exercise each week? Do you wear special devices? How often? Consistently? Are they always applied and removed appropriately and promptly? How often? By whom?</td>
<td>MD orders for non-nursing interventions/treatments. Plan of care should include at least 6x per week. Restorative goals. Specific joints to be exercised. Devices to be used in positioning. Frequency of treatment or repositioning. Resident teaching information. Services responsible for carrying out the procedures. Time frames for reaching goals. Nursing progress notes indicate: Has plan been implemented. Progress toward goals. Response to information from reevaluation. Look for actual turning/repositioning schedule.</td>
<td>Plan of care should be complete (addressing resident positioning needs) and plan is implemented on a daily basis. Care givers are knowledgeable re plan content. Residents are turned as scheduled. In good body alignment with proper assistive devices &amp; equipment. Contractures are prevented and/or treated. Plan is reviewed, reevaluated and revised at least quarterly, but must be done as often as patient condition dictates. Ask aide assigned to demonstrate the hand holds he/she uses for ROM. If aide doesn't know, ROM is probably not being done. Does it &quot;at bath time&quot; is not sufficient.</td>
<td>Rehabilitation Services 483.152(e) 442.343(c)(2) MD Orders Activities Resident Rights Nursing-Staffing Social Services Dietary</td>
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| F175 (cont'd) | Blankets/pillows, clean, smooth linen, clean, appropriate bed or wheelchair | - When?  
- Does staff answer call bell promptly?  
- How much confidence do you have when the nurses are helping you transfer, or turn and so on?  
- Does resident go to therapy area or does therapist come to resident?  
- Bed Rest Resident  
- Ask Staff:  
  - How often is position changed?  
  - What activity is done at the time (e.g., R.O.M., toileting, O.B., grooming)?  
  - Is equipment available?  
  - Who maintains and cleans the equipment?  
  - What is the schedule for this?  
  - What training have you had to learn to position patients correctly? | | | |
| | Turning schedules, ROM schedule, O.B.B. (as tolerated)  
Water available  
All adaptive devices are clean and in good repair  
All assistive devices are clean and in good repair.  
Specific Observation for the Geri-Chair/Long Chair  
(geri-chair, lounge chair in room, as appropriate to condition)  
Arrangement of room facilitates residents optimal independence (e.g., independent eating, grooming, I.V., radio, water).  
Positioning/body alignment:  
Blankets/lap robe, pillows, foot stool, hand rails, splints, clean, dry attire, pressure relief device, restraints, with release & activity schedule. (call bell available.) | | | | |
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<td>F175 (cont'd)</td>
<td>Specific Observation for the Wheel Chair Resident (as appropriate to condition, including deliberate alterations made to equipment for specific reasons.)</td>
<td>- Proper fit - Good working condition - Appropriate arm rest, footrest, leg support, lap tray - Proper positioning - Pressure relief aids. (e.g., gel flotation pads, egg crate mattress, sheepskin) - Set up for independent WC ambulation - Functional adapted toilet area - Transfer techniques: Observe how staff wheel the resident, e.g., do they inform before starting movement? Are patients moved wheeling forward and facing elevator doors? Observe staff for: - verbal cues - physical support - body mechanics</td>
<td>- Was there any part of your orientation when you first came to work here that addressed positioning? - Do you have any periodic reviews/updates on positioning? Chair Bound Resident Ask Staff: - How often is resident repositioned/taken out of chair? - What is the activity at time of repositioning and/or release of the restraint? - What can resident do independently? Ambulatory Resident Ask Staff: - Is resident encouraged to independently ambulate to and from activities and dining room (with or without personal assistance)? - Does resident do as much as he/she can independently? - What does resident do? - How do you know that resident is maximally independent? - If it is not working independently, how do...</td>
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<tr>
<td>F17S (cont'd)</td>
<td>ambulation (e.g., cane, crutches, hemi-sling)</td>
<td>you deal with it?</td>
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<td></td>
<td>- Posture</td>
<td>- Is there something resident would like to do that he/she is not allowed to do (e.g., shave self, apply makeup, style own hair)?</td>
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<td></td>
<td>- Appropriate staff assistance in ambulation</td>
<td>- What training have you had in learning to position residents and do range of motion?</td>
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<td></td>
<td>- Grab bars (halls, bath/shower area)</td>
<td>- What opportunity do you have for ongoing training?</td>
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<td></td>
<td>- Functionally adapted toilet area</td>
<td>- Who does the actual training?</td>
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<td></td>
<td></td>
<td>Check question placement under Interviewing. May be more appropriate for resident's rights section. Observe wheeling technique used by staff.</td>
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Nursing Services 0. Administration of Drugs F185-184 SNF 405.1124(g) ICT 442.357 F186 1. The patient is identified prior to administration of a drug. 

| F186 | | | | | |
|      | Observe a drug pass with at least 20 residents receiving medication. See SDM Appendix N Transmittal No. 174 for details of the Surveyor Methodology for Detecting Medication Errors. | Ask Resident | Review the medication administration record. (as appropriate) See S.O.H. Appendix N Transmittal No. 174 for details of the record review. | | |
|      | - Observe medication administration techniques (e.g., hand- | - Do you always receive your medication on time? (as appropriate) | | | |
|      | | - If not, what is the problem? | | | |
|      | | - Do you receive the correct medication? | | | |
|      | | - What does it look like? | | | |
|      | | - Who explained your medications to you? | | | |
|      | | - What reactions do you have? | | | |
|      | | - What happens if you have a question or refuse to take your medication? | | | |
|      | | - Who gives you your medication? | | | |
|      | | - Do your medications change in appearance? | | | |

If the combined total of significant & non-significant errors is 5% or above, a deficiency is present. Any significant error is cause for a deficiency. See Appendix N for details.
<table>
<thead>
<tr>
<th>Survey Area</th>
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<th>Interviewing</th>
<th>Record Review</th>
<th>Evaluation Factors</th>
<th>Cross Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>F187</td>
<td>Washing, pouring of dosage, position of resident</td>
<td>- Do the nurses stay with you when you take your medication?</td>
<td>- Do any of the medications bother you?</td>
<td>Ask Staff:</td>
<td>- Do you generally have available the medications you need? - Are there any problems in administering medications? Note drug doses refused by resident and how handled by staff.</td>
</tr>
<tr>
<td>F188</td>
<td>Administered by same person who prepared the doses for administration except under single unit dose packet distribution system</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Long Term Care Survey

<table>
<thead>
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<th>Observation</th>
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<tbody>
<tr>
<td>H. Conformance with Physician Drug Orders</td>
<td>Combine with observation of drug pass.</td>
<td></td>
<td>- Review the latest recap of the physicians orders</td>
<td>See Appendix N for details</td>
<td>Physician Services 405.1123(b)(1)</td>
</tr>
<tr>
<td>F129</td>
<td></td>
<td></td>
<td>- Review the medication administration record (as appropriate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F120</td>
<td></td>
<td></td>
<td>- See 504.1 Appendix N, Transmittal No. 174 for details of the record review.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F121</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAR 405.1124(b)</td>
<td>ICF 442.330(a) Drugs are administered in accordance with written orders of the attending physician.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intent</td>
<td>All residents receive medications as ordered by the physician.</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Note: The table provides a summary of survey areas and observations related to long-term care facilities, focusing on the conformance of physician drug orders. Evaluation factors include review of the latest recap of physicians' orders and medication administration records.*
### Long Term Care Survey

<table>
<thead>
<tr>
<th>SURVEY AREA CROSS REFERENCE</th>
<th>OBSERVATION</th>
<th>INTERVIEWING</th>
<th>RECORD REVIEW</th>
<th>EVALUATION FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dietetic Services</strong> (Condition of Participation)</td>
<td>o Specific Observations which might be indicative of possible nutrition problems</td>
<td>Ask dietary manager to explain the procedure for making substitutions and recording the changes. If menu usually followed?</td>
<td></td>
<td>o Were physician diet orders followed?</td>
</tr>
<tr>
<td>F193</td>
<td>o Clumenal - underweight/overweight - dehydration - edema - cracked lips - pallor - dull or dry hair - swollen or red tongue - bleeding gums - decubitus ulcers - infections</td>
<td>Ask Resident: 1. How are your meals? 2. Are there foods you are not allowed to have? 3. Are you on a special diet?</td>
<td></td>
<td>o Did nursing plan for feeding and assistance at mealtimes?</td>
</tr>
<tr>
<td></td>
<td>o Physiologic factors which may affect intake: - Swallowing difficulties - Vomiting - Food intolerance - Poor dentition - Sore mouth - Constipation - Diarrhea - Inability to feed self - Decreased visual and olfactory acuity - Unable to communicate - Loss of appetite</td>
<td>o Review, nutrition assessment for the following documentation: - Usual/ideal body weight/height - Dietary allergies/sensitivities, ability to chew and swallow regular foods without difficulty - Full or partial dentures - Mental and emotional condition - Physical appearance, skin condition - Appetite and food preference - Vitamin and mineral supplements - Food and fluid intake in measurable terms and frequency of meals - Degree of assistance needed in eating, related mobility, vision, or other identified problems - Medications (e.g., diuretics, insulin, antibiotics, etc.) - Related laboratory findings (e.g., fasting blood sugar, cholesterol, sodium, potassium, hemoglobin, BUN, serum albumin, transferrin or creatinine-height index if available).</td>
<td></td>
<td>o Is there rehabilitative use of assistive devices, if appropriate?</td>
</tr>
<tr>
<td></td>
<td>o Psychological/Social - Confusion</td>
<td></td>
<td></td>
<td>o Is modification of consistency of meals made if resident has a problem or change in condition?</td>
</tr>
<tr>
<td>A. Menus and Nutritional Adequacy</td>
<td></td>
<td></td>
<td></td>
<td>o Are between meal and bedtime snacks provided as needed?</td>
</tr>
<tr>
<td>F194</td>
<td></td>
<td></td>
<td></td>
<td>o Is nutrition counseling at meals provided?</td>
</tr>
<tr>
<td>SNF (405.1125(b))</td>
<td></td>
<td></td>
<td></td>
<td>o Has dietitian provided counseling of resident and family as needed (related to diet)?</td>
</tr>
<tr>
<td>F194</td>
<td></td>
<td></td>
<td></td>
<td>o Usual body weight is maintained/supported?</td>
</tr>
<tr>
<td>ICF 442.332(a)(1)</td>
<td></td>
<td></td>
<td></td>
<td>o Is there evidence that the plan is being carried out (e.g., documentation in the resident's chart, observation by the surveyor, and resident/staff interviews)? If the resident refuses meals or does not respond to intervention, the notes in the chart should indicate efforts to intervene or provide counseling.</td>
</tr>
<tr>
<td>SURVEY AREA</td>
<td>OBSERVATION</td>
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<td>RECORD REVIEW</td>
<td>EVALUATION FACTORS</td>
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<tr>
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<td>--------------------</td>
</tr>
<tr>
<td>FL96(cont'd)</td>
<td>- Excessive food likes and dislikes - Refusal to eat - Selected biochemical changes which might indicate changes in nutritional status: Visceral protein status - Serum albumin transferrin BUN - Serum electrolytes</td>
<td>During mealtime observe the resident for: - Adherence to food preferences - Adequate space for eating - Self-feeding skills - Proper position for eating - Ability to eat foods served - Use of adaptive feeding devices - Amount of food actually eaten - Protection of resident's clothes - Amount of time resident is allowed to chew and swallow - Assistance provided as needed in and from dining area - All beverages are covered</td>
<td>- Food/drug interactions - Mental/emotional assessment as it relates to resident's food habits: Review - Plan of Care - Nursing Notes - Review: - Physicians orders - Progress notes - Notes from other professional disciplines as appropriate. Nutritional status depends not only on adequacy of menu planning but also whether the resident eats the food and how the body uses it. While the surveyor is not responsible for individual nutritional assessments of residents, when specific information is needed during the survey to make a compliance decision, the surveyor will utilize the following minimum assessment guidelines. <strong>Menu Evaluation:</strong> - Adequate in energy and nutrients - Protein - Calories</td>
<td>Is there evidence that the resident's progress is regularly observed (e.g., awareness of food and fluid intake such as acceptance of foods, food consumed, and resident's appetite)? - Is fluid intake for resident encouraged? Is the Foley catheter, problem feeders monitored? - Is there evidence to suggest the facility has taken appropriate measures to prevent or resolve problems? - Is there general evidence as to whether poor resident conditions are due to poor care or whether the facility has taken appropriate measures to prevent or resolve problems? - Is there indication of progress toward desired outcomes? If not, is the evidence of re-evaluation available within specified time frames? - When the anthropometric and clinical data do not correlate with dietary data, (food intake, dietary supplements) the surveyor should take note that the problem may not be nutritional.</td>
</tr>
<tr>
<td>SURVEY AREA</td>
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<td>--------------</td>
<td>----------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>F198(cont'd)</td>
<td>Assistance being provided in case of choking, incontinence, falling, or other emergencies.</td>
<td></td>
<td>- Vitamin C</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nursing Staff supervision of dining areas including residents' rooms during meal times.</td>
<td></td>
<td>- Calcium</td>
<td>Selected evaluation of residents for in depth review:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A check list can be used to evaluate daily menus for basic foods:</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Use standard serving portions)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Daily food plan should include:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Milk GROUP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 pt milk</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MEAT GROUP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5 equivalents:* 1 equivalent equals 1 oz. of meat (edible portion)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>weighed after cooking (this includes eggs, dried peas, beans, nuts, and all meat, fish and poultry).</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>VEGETABLE AND FRUIT GROUP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5 services or more, including a dark green or deep yellow vegetable for vitamin A value every other day and a citrus fruit or other fruit rich in vitamin C daily.</td>
<td></td>
</tr>
</tbody>
</table>
### Long Term Care Survey

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<tbody>
<tr>
<td>F196 (cont'd)</td>
<td>Observe serving portions sizes on all menu items:</td>
<td></td>
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<tr>
<td></td>
<td><strong>Milk Group</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>- 1 pint daily</td>
<td></td>
<td></td>
<td>BREAD-CEREAL-POTATO-LEGUME-PASTA GROUP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Source of: Protein</td>
<td></td>
<td></td>
<td>7 servings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Calcium</td>
<td></td>
<td></td>
<td>FATS AND SWEETS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phosphorus</td>
<td></td>
<td></td>
<td>(Without this group the diet contains 1,415 Kcal)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B Complex</td>
<td></td>
<td></td>
<td>Diets should be adapted from facility's currently approved diet manual.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Meat Group</strong></td>
<td></td>
<td></td>
<td>Menus are dated and contain minimum portion sizes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- 5 lean meat equivalents</td>
<td></td>
<td></td>
<td>Are substitutions noted on the file copy?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(1 meat equivalent = 1 oz meat, poultry, fish, cheese &amp; eggs; also dried</td>
<td></td>
<td></td>
<td>Are substitutions made within the same food group I.e., meat for another</td>
<td></td>
</tr>
<tr>
<td></td>
<td>peas, beans, and nuts)</td>
<td></td>
<td></td>
<td>source of protein in the meat group, or vegetable of similar nutritional value?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Source of: Protein</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>Iron</td>
<td></td>
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<tr>
<td></td>
<td>Vitamin B12</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td><strong>Vegetable and Fruit Group</strong></td>
<td></td>
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<tr>
<td></td>
<td>- 5 servings or more</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>(1/2 cup = 1 serving)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Source of: Vitamin A, C, B6, Folic acid, Fiber</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td><strong>Bread-Cereal-Potato-Legume-Pasta Group</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- 7 servings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(1 serving = 1 slice bread: 1/2 cup other: 3/4 cup flake-type cereal)</td>
<td></td>
<td></td>
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<tr>
<td>SURVEY AREA</td>
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</tr>
<tr>
<td>FLG (cont'd)</td>
<td>FATS AND SWEETS (to increase caloric intake)</td>
<td>Documentation of decision to withdraw or begin artificial feeding and hydration.</td>
<td>Check menus for variety</td>
<td>Are they specific (i.e., states kinds of fruit, juice, vegetable)?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IODIZED SALT (unless contraindicated)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adequate fiber in diet</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

NOTES:
- The basal energy expenditure (BEE) and calorie requirement using Harris-Benedict formula recognizes the variation in energy needs for individuals.
1. **Anthropometry**: Height/Weight

**NOTE:** The following sample formulas and guidelines are not the only acceptable guides available. The surveyor should ask to use the assessment guidelines used by the facility before using the ones provided here.

- An important indicator of nutritional outcome.
- Disease state can have adverse effect on desired body weight.
<table>
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<th>Survey Area</th>
<th>Observation</th>
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<th>Evaluation Factors</th>
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<tbody>
<tr>
<td>F196 (cont'd)</td>
<td></td>
<td></td>
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</tbody>
</table>

2. **Height for Height Calculation**
   - **Females:**
     - Allow 100 lbs. for first 5 ft. of height plus 5 lbs. for each additional inch.
   - **Males:**
     - Allow 106 lbs. for first 5 ft. of height plus 6 lbs. for each additional inch.

**Estimating Caloric Needs**
1. **FORMULA: Harris-Benedict Equation**
   - **Men:**
     - \(566 + (13.7 \times \text{Wt. in Kg}) + (5 \times \text{Ht. in cm}) - (6.8 \times \text{Age}) = \text{BEE}\)
   - **Women:**
     - \(655 + (9.6 \times \text{Wt. in Kg}) + (1.7 \times \text{Ht. in cm}) - (4.7 \times \text{Age}) = \text{BEE}\)

- **Parenteral Anabolic:**
  - \(1.75 \times \text{BEE}\)
- **Oral Anabolic:**
  - \(1.5 \times \text{BEE} \) (Kcals)
### Long Term Care Survey

<table>
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</table>
| F196 [cont'd] | Oral Maintenance: 1.20 x BEE (Kcals) | Metric Conversions  
Approx:  
Pounds (lb.) x 0.45 = kilograms (Kg)  
Inches (in.) x 2.5 = centimeters (cm) | Estimating Protein Needs  
1. Allow 0.8 gram protein per kilogram of ideal body weight.  
2. Increase to 1.2 - 1.5 gm/kg for patients with depleted protein stores (decubitus, draining wounds, fractures, etc.). | Fluid Requirement  
Based on actual body weight:  
Over 55 years with no major cardiac or renal diseases. (Note: 2.2 lbs. equals 1 kg of body weight) |
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</table>
| F100 (cont’d) | Example: 120 lbs/2.2 lbs. = 54.5 kg (55 kgs) 55 kg x 30 cc = 1,650 cc/day Note: Isotonic Standard Tube Feeding: Approximately 80% water. Amputation % of Body Weight
| Leg | 20% |
| Below Knees | 10% |
| Arm | 6% |
| At Elbow | 3.6% |
| Suggested Standards for Evaluating Significance of Weight Loss
| % of body weight loss
| Inter- | Significant | Severe |
| Value | Loss | Loss |
| 1 week | 1-2% | 2% |
| 1 month | 5% | 5% |
| 3 months | 7 1/2% | 7 1/2% |
| 6 months | 10% | 10% |

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</thead>
<tbody>
<tr>
<td>F196 (cont'd)</td>
<td>Lab Indices for Visceral Protein</td>
<td>Mild Deficiency</td>
<td>Moderate Deficiency</td>
<td>Severe Deficiency</td>
<td></td>
</tr>
<tr>
<td>Albumin g/dl</td>
<td>3.5-3.2</td>
<td>3.2-2.0</td>
<td>2.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Lymphocyte Count (x10^6/mm³)</td>
<td>1800-1500</td>
<td>1500-900</td>
<td>900</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transferrin (If Available)</td>
<td>200-100</td>
<td>180-160</td>
<td>160</td>
<td></td>
<td></td>
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</tbody>
</table>
## LONG TERM CARE SURVEY

<table>
<thead>
<tr>
<th>SURVEY AREA</th>
<th>OBSERVATION</th>
<th>INTERVIEWING</th>
<th>RECORD REVIEW</th>
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</thead>
<tbody>
<tr>
<td>B. Therapeutic Diets</td>
<td>System for the provision of diets:</td>
<td>Ask Staff:</td>
<td>Review:</td>
<td>Nursing Services 405.1124</td>
<td>(e.) Patient care plan (f.) Supervision of patients nutrition</td>
</tr>
<tr>
<td></td>
<td>o Dietetic service Kardex or file</td>
<td>o Number, type of therapeutic diets?</td>
<td>- Physician diet orders in medical record</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Therapeutic menus</td>
<td>o Time of nutrition activity, who’s responsible?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>o Nourishment preparation and service</td>
<td>o Nourishment provided for day of survey?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Adequacy of nourishment</td>
<td></td>
<td>- Nurses' Kardex</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Individual menus or diet cards</td>
<td></td>
<td>- Dietary Kardex</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SPECIAL FEEDINGS:</td>
<td></td>
<td>- Therapeutic diet menu</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The surveyor should also attempt to observe that:</td>
<td></td>
<td>- Diet cards</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Staff use proper technique in administering feedings and medications. Check to see that staff checks for location of tube before feeding and that tubing is irrigated before and after addition of medication.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>o Unused milk-based tube feeding should be discarded in a timely manner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F197</td>
<td>SNF 405.1125(c)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F198</td>
<td>ICF 405.1125(c)(2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F199</td>
<td>1. Therapeutic diets are prescribed by the attending physician.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F182</td>
<td>2. Therapeutic menus are planned in writing, prepared, and served as ordered with supervision from the dietician and advice from the attending physician whenever necessary.</td>
<td></td>
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**On pureed diets:**
- Ordered by physician
- Prepared fresh daily
- Same calories and/or food groups as food served whole.

Pureed foods are coordinated with general/regular menu.

**On tube feeding:**
- Has the feeding been ordered by physician?
- Is tube feeding nutritionally adequate?
- Have attempts been made to progress tube feeding?
- Have changes in resident condition been noted and addressed.

On tube feeding:
- Plan of Care
- Identify frequency, amt. of feeding based on the physician’s order and the time span over which each feeding is accomplished.
- Medication and treatment records
- Fluid intake records
- Number of calories
### Long Term Care Survey

<table>
<thead>
<tr>
<th>Survey Area</th>
<th>Observation</th>
<th>Interviewing</th>
<th>Record Review</th>
<th>Evaluation Factors</th>
<th>Cross Reference</th>
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</table>
| F197-199 (cont'd) | 4. Does the staff help you in feeding? Do you feel comfortable/safe with all the staff who perform the feeding? If not, what happens? | Interview staff regarding knowledge of diabetic diets.  
- What nourishment does the diabetic patient receive?  
- If diabetic patient refuses the meal, what is done to supplement the meal?  
If resident is able to be interviewed, suggested questions:  
1. How long have you been on your diabetic diet?  
2. Do you know some of foods you must avoid? What are they? | Well as amount of additional water  
- Periodic reassessment of ability to swallow  
- Record should indicate measures taken to prevent diarrhea and constipation and to treat if they have developed. | weight loss, constipation, diarrhea, skin condition?  
- Have observed problems been coordinated with other departments and resolved?  
- Is feeding being monitored to ensure that feeding is occurring at the ordered/appropriate rate?  
- Varied nourishments as preferences allow? | On Diabetic Diets and Other Therapeutic Diets  
- Ordered by Physician  
- Varied, nutritionally adequate  
- Individualized to suit resident  
- Re-evaluation indicates diet meets objectives. If not appropriate, documentation is provided  
- Laboratory results support diagnosis  
- Between meals nourishment provided as needed and recorded in measurable amounts. |
<table>
<thead>
<tr>
<th>SURVEY AREA</th>
<th>OBSERVATION</th>
<th>INTERVIEWING</th>
<th>RECORD REVIEW</th>
<th>EVALUATION FACTORS</th>
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<tr>
<td>F197-199 (cont'd)</td>
<td>Observe tray/meal service: o Low sodium diets are platable (taste) o Sugar sources on diabetic diet trays o Salt sources on sodium restricted diet trays.</td>
<td>3. Do you receive a nourishment between meals or before going to bed?</td>
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<tr>
<td>F198</td>
<td>Therapeutic diets prescribed by the attending physician</td>
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<tr>
<td>F199</td>
<td>Therapeutic menus are planned in writing, prepared and served as ordered with supervision from the dietician and advice from the physician whenever necessary.</td>
<td>Functioning system to provide the needed nutrients: o Resident's general appearance o Meal service o Food acceptance o Adherence to food preferences o Food supplement o Type to support o Method of service o Assistance provided o Timely provision as ordered o Portion sizes o Conforms to physicians orders</td>
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FOR THE RESIDENT WITH DECUBITUS ULCERS

Ask Staff:
1. Regarding knowledge of dietary needs.
2. What do you do when this resident refuses milk, meat, bread, etc.?
3. What nourishments are provided to this resident? How often?
4. What happens when a weight loss is noticed with this resident?

Ask Resident:
1. Has anyone talked with you about the importance of eating your meals?
2. Do you get foods that you don't eat on your tray?
3. When do you feel hungry?
4. Do you get between meal nourishments?

1. Identify residents with conditions that immobilize or prevent voluntary body movement.
2. Identify location, number, size and depth of decubitus ulcers.
3. Calculations of kilocaloric and protein levels as needed.
4. Micronutrient need assessment and recommendation.
5. Progress notes o monitor weight o monitor healing of decubitus ulcers.
6. Pertinent Laboratory Data o Hemoglobin/Hematocrit o Serum Albumin o Total Lymphocyte Count o Fluid Intake o Sufficient to maintain hydration

A system is in place to provide the type and amount of nutritional support needed by the residents who have developed decubitus ulcers. Food and supplementation are provided in a method to ensure intake of nutrients needed by residents with decubitus ulcers.

Nutritional intervention is assessed and reassessed to ensure appropriate intervention for acceptable health care outcome.

Nursing Service 401.1124 (d) Patient Care Plan (f) Supervision of Patient Nutrition
<table>
<thead>
<tr>
<th>Survey Area</th>
<th>Observation</th>
<th>Interviewing</th>
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</tr>
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<tr>
<td>F107-199 (cont'd)</td>
<td>RENAL REVIEW: System in place for the correct provision of renal diets.</td>
<td>Interview Staff regarding knowledge of renal diets: 1. What foods should be restricted when a patient has kidney problems? 2. What nourishments are given to these patients? 3. Are fluids restricted?</td>
<td><strong>Renal Patient Diet Review</strong>  - Pertinent Laboratory Data  - Serum Sodium  - BUN  - Serum Potassium  - Albumin  - Hematocrit  - Creatinine  - Pertinent Medications  - Vitamin/Mineral  - Supplements  - Weight gains/losses</td>
<td>On Renal Diets  - Ordered by physician  - Written menu nutritionally complete in so far as medically possible, including calories  - Individualized to suit resident  - Laboratory testing as needed  - Coordination with dialysis unit to determine effectiveness of diet</td>
<td>Nursing Service 405.1124 (d) Patient Care Plan  (f) Supervision of Patient Nutrition</td>
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### LONG TERM CARE SURVEY

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<thead>
<tr>
<th>SURVEY AREA</th>
<th>OBSERVATION</th>
<th>INTERVIEWING</th>
<th>RECORD REVIEW</th>
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<tr>
<td>C. Preparation</td>
<td><strong>Observation:</strong>&lt;br&gt;a) Feeding assistance is provided or not provided by staff&lt;br&gt;b) Length of time residents sit and wait for meal service&lt;br&gt;c) Food is served soon after cooking or refrigerated&lt;br&gt;d) Utensils are clean, sanitary and greaseless&lt;br&gt;e) Refrigerated foods must be covered&lt;br&gt;f) Leftover and pre-cooked foods must be dated and labeled&lt;br&gt;g) All cooked food stored above raw meats in refrigerator&lt;br&gt;h) Temperature gauge on or in refrigerator to record temperature&lt;br&gt;i) Shelving to allow air circulation&lt;br&gt;j) Food not stored in refrigerator must be stored off the floor (this is applicable to food stored in walk-in refrigerator and freezer.)</td>
<td><strong>Review:</strong>&lt;br&gt;a) Plan of Care&lt;br&gt;b) Progress notes&lt;br&gt;c) Notes from other professional disciplines to determine rehabilitation potential to self feed, use of assistance devices&lt;br&gt;d) Record of food substitution to determine alternate choice provided&lt;br&gt;e) Standardized recipes</td>
<td>The facility has kitchen and dietary service areas adequate to meet the food service needs. These areas are properly ventilated, arranged, and equipped for sanitary refrigeration, storage, and preparation of food. Equipment and storage areas are clean, well maintained, within proper temperatures ranges, and safe. Proper temperatures: (Fahrenheit)&lt;br&gt;1. Frozen food storage — 0 or below&lt;br&gt;2. Cold food storage — 40-45 degrees&lt;br&gt;3. Hot food holding equipment — 140 degrees minimum&lt;br&gt;Dishwasher wash cycle — 150 - 160 degrees&lt;br&gt;Dishwasher rinse cycle — 160-180 degrees or a color change in thermopaper; or adherence to manufacturers recommendations</td>
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## LONG TERM CARE SURVEY

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<th>OBSERVATION</th>
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<tr>
<td>F207 (Cont'd)</td>
<td>- No rust on shelves &lt;br&gt;- No dripping or spillage on shelves and floors &lt;br&gt;- Degree to which diet modification is commensurate with residents' tolerance and capability &lt;br&gt;- Residents for meal satisfaction &lt;br&gt;- Observe appearance of food color, texture, aroma, and flavor &lt;br&gt;- Less than 75% of meal is consumed &lt;br&gt;- Type of substitutions provided</td>
<td>- Progress notes &lt;br&gt;- Diet card &lt;br&gt;- Day's menu substitute record</td>
<td>Dietary personnel are clean and free of infectious disease. They practice acceptable techniques and procedures to keep foods at proper temperatures and protected against contamination. &lt;br&gt;Is dietary information pertinent to dietary modification? &lt;br&gt;Has resident been assessed for eating program to maintain independence?</td>
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SNF 495.1125(e)
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<th>SURVEY AREA</th>
<th>OBSERVATION</th>
<th>INTERVIEWING</th>
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<tr>
<td>D. Frequency</td>
<td>o Menus as under A on page 63</td>
<td>Interview various residents about the nourishment service:</td>
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<td>F208 SNF 405.1124(d)</td>
<td>o Who serves nourishments o Nourishment list and schedule</td>
<td>o Are nourishments offered routinely?</td>
<td>o Nourishment List</td>
<td>Three meals or their equivalent are served daily with not more than a 16-hour span between the evening meal and breakfast. The nourishment service is more difficult to evaluate: must find evidence that patients are offered nourishments on a planned basis and documented.</td>
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<td>F209 ICF 442.333(a)</td>
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<tr>
<td>F210 1. At least three meals are served daily at regular hours with not more than a 16-hour span between a substantial evening meal and breakfast.</td>
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<td>F211 2. To the extent medically possible, bedtime nourishments are offered to all residents</td>
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### E. Staffing

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| F212        | - Food service personnel are on duty for all defined dietary responsibilities:  
  - Supervision  
  - Food Preparation  
  - Dishwashing  
  - Cleaning |
| SNF 405.1125 (a) | - Duty Schedules |

#### F213

1. Food service personnel are on duty daily over a period of 12 or more hours.

**Intent:**

Persons are providing services commensurate with their level of training; and at the level of sophistication needed by the residents.
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<tr>
<th>SURVEY AREA</th>
<th>OBSERVATION</th>
<th>INTERVIEWING</th>
<th>RECORD REVIEW</th>
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<th>CROSS REFERENCE</th>
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<tr>
<td>SPECIALIZED SERVICES</td>
<td><strong>F214</strong></td>
<td>405.1126</td>
<td>405.1126(e)(2)(b)</td>
<td>405.1126</td>
<td>442, 343</td>
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<tr>
<td>F215</td>
<td>405.1126(b)</td>
<td>405.1126(b)</td>
<td>405.1126(b)</td>
<td>405.1126</td>
<td>442, 343</td>
</tr>
<tr>
<td>F216</td>
<td>405.1126</td>
<td>405.1126</td>
<td>405.1126</td>
<td>405.1126</td>
<td>442, 343</td>
</tr>
<tr>
<td><strong>A. PLAN OF CARE</strong></td>
<td><strong>ICF 442, 343(e)(1)(2)</strong></td>
<td>405.1126</td>
<td>405.1126</td>
<td>405.1126</td>
<td>442, 343</td>
</tr>
<tr>
<td><strong>F217</strong></td>
<td><strong>Rehabilitative services are provided under a written plan of care, initiated by the attending physician and developed in consultation with appropriate therapists and the nursing service.</strong></td>
<td>405.1126</td>
<td>405.1126</td>
<td>405.1126</td>
<td>442, 343</td>
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<tr>
<td><strong>B. THERAPY</strong></td>
<td><strong>ICF 442, 343(c)(1)(a)</strong></td>
<td>405.1126</td>
<td>405.1126</td>
<td>405.1126</td>
<td>442, 343</td>
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<tr>
<td><strong>F218</strong></td>
<td><strong>Therapy is provided according to orders of the attending physician in accordance with accepted</strong></td>
<td>405.1126</td>
<td>405.1126</td>
<td>405.1126</td>
<td>442, 343</td>
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**INTERVIEWING:**
- **Observe residents as per "Restorative Nursing Activities of Daily Living."**
- **SNF 405.1126(e)(2)(b)**
- **Also:**
  - **Observe residents in therapy areas:**
    - Is privacy provided during treatment, as applicable (e.g., cubicle curtains, room dividers, one to one areas)?
    - Are there appropriate, courteous resident/staff interaction?
    - Are therapy areas appropriately equipped (e.g., small, quiet area for speech/language therapy, hearing testing and sessions, large for P.T., exercise and therapy groups, O.T., physical therapy/occupational therapy, A.D.L. adaptations, etc.)?
    - Is equipment clean and in good working condition? Is it operating as per manufacturer's instructions (e.g., hydrocollator temperature, paraffin, whirlpool, etc.)?

**REVIEW:**
- **Ask resident:**
  - (Or ask staff, if resident has severe communication problem):
    - Are you receiving any kind of therapy? (P.T. or O.T. or Speech?)
    - What kinds of therapy are you receiving? (P.T. or O.T. or Speech?)
    - What kinds of therapists have instructed you on how to improve your swallowing?
    - How do the methods to improve swallowing help you?
    - How often do you see the therapist?
    - What happens if the therapist is absent for scheduled treatments?
    - Where do you receive your therapy?
    - How long have you been receiving therapy?
    - Do other staff members assist with therapy? Who and in what way?
    - Are you in a comfortable environment (room temperature, privacy, etc.)?
    - Do you have input into developing or revising your therapy treatments?
    - What things did you do immediately before entering this facility, that you are unable to do now?

**SMU THERAPY SERVICES:***
- How many days/hours per week do you provide therapy?
- Do you participate in the development of the resident's overall plan of care? In what way?
- Do you utilize P.T.
### Long Term Care Survey

<table>
<thead>
<tr>
<th>Survey Area</th>
<th>Observation</th>
<th>Interviewing</th>
<th>Record Review</th>
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</tr>
</thead>
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<tr>
<td>F21B (cont'd)</td>
<td>- Are assistive devices being provided as needed?</td>
<td>&quot;Aides&quot; In what way (if interviewing the registered physical therapist)?</td>
<td>- Identifies modalities that will be delegated to non-skill staff.</td>
<td>Physical Environment 485.1134 442.324 442.325 442.326 442.328 442.329 442.330</td>
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<td></td>
<td>- Do assistive devices fit well, function and are used properly (e.g., wheelchairs, crutches, braces, glasses, hearing aids, canes, artificial limbs, assistive eating devices)?</td>
<td>- How do you assure carry-over of Therapeutics in your absence?</td>
<td>- Progress notes indicate that plan of rehabilitation care has been re-evaluated by the physician and therapist as necessary but at least every 30 days.</td>
<td>Dietetic Services 485.1125(e) 442.329 442.333(c)</td>
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<td></td>
<td>- Is staff responsive to resident expressions of discomfort?</td>
<td>- How often do you provide inservice to staff? What topics are covered?</td>
<td>- Communication with physician: + 2 week progress after initiation + monthly progress + discharge summary</td>
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<td></td>
<td>- How are the prescribed treatments and training meeting the needs of the resident?</td>
<td>- Do you have opportunities to attend inservices?</td>
<td>- Treatment documentation: + frequency + summary</td>
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<td>- Are parallel bars sturdy and well secured to floor? Are systems designed for weight lifting sturdy and well secured; if attached to wall with rigging and hand grips in good conditions?</td>
<td>- How do you communicate patient progress/regression, etc. with physician, nursing personnel, family, other disciplines?</td>
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<td></td>
<td>- Are nonverbal residents provided with means of communication (e.g., writing tablets and utensils, picture cards)?</td>
<td>- How many residents currently are receiving P.T., O.T., Speech-Language pathology and audiology therapy (S/L/P/A)?</td>
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<td>- Are visually impaired residents provided with</td>
<td>- Do you utilize the services of a certified occupational/therapy assistant (if interviewing the registered occupational therapist)? If so, in what ways?</td>
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<td>- Is equipment readily available to meet resident needs?</td>
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<td>Exceptions:</td>
<td>ICF resident's progress must be reviewed regularly.</td>
<td>- Is there a coordinated interdisciplinary</td>
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**ICF 442.345(f)**

1. A report of the resident's progress is communicated to the attending physician within 2 weeks of the initiation of specialized rehabilitative services.
<table>
<thead>
<tr>
<th>SURVEY AREA</th>
<th>OBSERVATION</th>
<th>INTERVIEWING</th>
<th>RECORD REVIEW</th>
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<tr>
<td>F220</td>
<td>magnifiers and large print books?</td>
<td>approach toward rehabilitation of the geriatric resident evident in your facility? In what way do you see this?</td>
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**2. The resident's progress is reviewed regularly and the plan of rehabilitative care is re-evaluated as necessary, but at least every 30 days by the physician and therapist.**
LONG TERM CARE SURVEY

<table>
<thead>
<tr>
<th>SURVEY AREA</th>
<th>OBSERVATION</th>
<th>INTERVIEWING</th>
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</table>
| Pharmaceutical Services | - Observe residents for excess sedation or adverse effects:  
|                   | - drooling  
|                   | - flushing gait  
|                   | - involuntary movements of limbs, tongue, facial muscles  
|                   | - loss of affect  
|                   | - drowsiness  
|                   | - postural abnormalities  
|                   | - pill rolling movement  
|                   | - Observe for depression agitation                | Ask Resident:  
|                   | - Are you aware of the medications you are taking—use, frequency, contraindications?  
|                   | - Has your physician discussed the medications you are taking, with you?  
|                   | - How many medications are you taking?  
|                   | - How do you feel the medication helps you?  
|                   | - How do medications bother you? (e.g., make you feel nauseated or dizzy?)  
|                   | - Have you told anyone about this?                | Review medical record:  
|                   | - to see if pharmacist or nurse has reviewed a drug regimen on a monthly basis.  
|                   | - for evidence that the reviewer has reported irregularities to the physician or other who has authority to correct the irregularities for evidence that the irregularities have been evaluated.  
|                   | - review nurses notes, progress notes, care plan, etc. for any adverse reaction to medication and indication that corrective action was taken.  
|                   | - screen the drug therapy of the residents included in the sample using the indicators (forms if prepared) outlined in SOM Appendix N Transmittal 4174.  
|                   | - review pharmacists drug regimen monthly reports to determine if pharmacist has commented on potential irregularities, screened out through this process (need full year).  
|                   | - ask staff:  
|                   | - How often does the pharmacist review the resident's medications?  
|                   | - To whom does he report any irregularities?  
|                   | - When the pharmacist reports irregularities, what is done about it?  
|                   | - To whom do you report any problems about medication?  
|                   | - Do you feel the residents are receiving the proper medications, amount and kind?  
|                   | - Is the pharmacist available to you for consultation?  

A registered nurse may be utilized to perform this monthly review for ICF residents. Also the attending or staff physician must review medication quarterly.

Reviews were performed in the facility. There was evidence of a review performed on every resident whose record was reviewed indepth. In records reviewed, the average prescription utilization was not substantially over 6.1 if it is, review for appropriateness. Apparent irregularities were identified and reported.

* Refer to SOM Appendix N in 4174 for further information on drug regimen review.
<table>
<thead>
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<th>OBSERVATION</th>
<th>INTERVIEWING</th>
<th>RECORD REVIEW</th>
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<td>F224 (cont'd)</td>
<td>- Where does the pharmacist perform his drug regimen review?</td>
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B. Labeling of Drugs and Biologicals
F225
SF 485.1121(c)
F226
DCF 462.333
F227
The labeling of drugs and biologicals is based on currently accepted professional practices and must identify the appropriate accessory and cautionary instructions as well as an expiration date when applicable.

To ensure that residents receive medications as ordered and that they are monitored for possible side effects.

Observe labels of medications for residents observed on drug pass tour for:
- Name of drug
- Dose from
- Strength of drug
- Quantity of drug
- Expiration date
- Presence of a control number
- Appropriate accessory or cautionary statement
<table>
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<tr>
<td>Laboratories and Radiological Services</td>
<td>Observe symptoms of targeted residents, e.g., drainage, odors, jaundice, fevers, edema, etc.</td>
<td>Ask Nursing/Rehabilitative Staff: - What do you do when you think a resident needs laboratory work done - blood work, cultures, etc.? - How long does it take to get lab results back? - What do you do with the results when they do come back? - Do you have any problems with your laboratory services? - How are lab specimens stored? - Do you have any instruction from the lab regarding collection and storage of specimens?</td>
<td>Review the physician's order sheet to see if: - orders for lab services are signed - that there are orders for tests that have been done. Nursing progress notes are reviewed for documentation of physician notification of lab results. Physician progress notes or other documentation indicating that the physician is aware of lab results. There are lab reports on the medical record for all tests ordered (except if just performed).</td>
<td>There must be signed physician orders for all lab/radiology services performed. Record results of all testing in the medical record. There is documentation in nursing or physician notes to indicate the results of lab tests were promptly communicated to the physician. When lab tests are performed the resident should be informed of significant findings and the possible therapeutic alternatives.</td>
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<tr>
<td>F228</td>
<td>SNF 405.1128</td>
<td>A. Provision of Services</td>
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<td>Nursing Services 405.1124(a)(b)(c) 442.343</td>
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<tr>
<td>F229</td>
<td>SNF 405.1128 (a)</td>
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<td>Physician Services 405.1123(b)</td>
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<tr>
<td>F231</td>
<td>1. All services are provided only on the orders of a physician.</td>
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<td>2. The attending physician is notified promptly of findings.</td>
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<td>3. Signed and dated reports of a clinical laboratory, x-ray and other diagnostic services are filled with the patient's medical record.</td>
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**INTENT**

To assure that lab tests are performed as ordered and findings are reported to physicians are made aware of symptoms that may require lab tests.
## Long Term Care Survey

<table>
<thead>
<tr>
<th>Survey Area</th>
<th>Observation</th>
<th>Interviewing</th>
<th>Record Review</th>
<th>Evaluation Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Services</td>
<td>Observe resident for:</td>
<td>How long have you been in the facility?</td>
<td>Review medical records of residents selected for in-depth review to determine</td>
<td>The residents social and emotional needs are identified. The plan of care addresses those needs. The plan of care is being followed, reviewed and revised as necessary. The facility's needs and concerns are addressed if applicable. There is referral to appropriate agencies if necessary. Sufficient space is provided for private meetings and discussions. While it is not a program requirement a social worker or other staff may contribute to the resident's care plan by indicating personal strengths that can be used to build upon.</td>
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<tr>
<td></td>
<td>- Level of alertness</td>
<td>- Can you explain to me why you are here?</td>
<td>assessment and plan of care identifies residents medically related social and emotional needs and/or problems. Resident's family and home situation, information related to medical and nursing requirements, and community resources are considered in making decisions regarding the residents care. Medical records contain current specific information and dated which highlights the social and emotional needs of the resident and significant findings and actions are entered promptly in the medical record.</td>
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<td></td>
<td>- Behavior exhibited (disoriented, confused, uncooperative, disruptive, aggressive, anxious, withdrawn, isolated, lonely).</td>
<td>- Have you had any problem adjusting to the facility i.e., loss of independence?</td>
<td>- Have you had any other problems? Has staff been helpful, e.g., financial?</td>
<td>- Do you have any family or any other visitors?</td>
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<td></td>
<td>- Personal appearance</td>
<td>- Have you had any similar problem with this facility has not been helpful?</td>
<td>- Do they have any problems with which this facility has not been helpful?</td>
<td>- If exhibiting disruptive behavior, agitated, anxious, etc., behavior have you noticed that you are upset (quiet, nervous, unhappy) today. Can you tell me what has bothered you?</td>
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<td></td>
<td>- Apparent disabilities</td>
<td>- Therapeutic staff intervention: constructive reaction to resident's behavior</td>
<td>- Does staff respond to your suggestions about your own care?</td>
<td>- Did you participate in planning what care you will get and who will give it to you?</td>
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<td></td>
<td>- Apparent vision and/or hearing problems</td>
<td>- Resident's participation on policy making bodies and committees of facility, e.g., resident councils.</td>
<td>- Do you make use of the dining, activity, community room, and/or outdoor area?</td>
<td>- Do you make use of the dining, activity, community room, and/or outdoor area?</td>
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<td>- Independence in activities, decision making</td>
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<td>- Social service notes address the following, if applicable:</td>
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<td>- Losses due to aging</td>
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<td>- Relationship with staff and other residents</td>
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<td>- Mental status</td>
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<td>- Behavior problems</td>
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<td>- Adjustment to the facility</td>
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<td>- Illness</td>
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### Services Provided
- Services are provided to meet the social and emotional needs by the facility or by referral to an appropriate social agency.
<table>
<thead>
<tr>
<th>SURVEY AREA</th>
<th>OBSERVATION</th>
<th>INTERVIEWING</th>
<th>RECORD REVIEW</th>
<th>EVALUATION FACTORS</th>
<th>CROSS REFERENCE</th>
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<tr>
<td>F233-23B (cont'd)</td>
<td>- Can you tell me about your life here? What do you do in a usual day? - Are things like getting up, bathing, dressing, eating, done at the same time for everyone? - If you could change some things about living here, what would you change? Ask Social Worker/Nurse - When the social worker is readily available, delete &quot;ask the nurse&quot;. - How often is the resident seen by a social worker? - Who is responsible for identifying the resident's: + social and emotional needs + family and home situation + problem and needs + financial needs + how are needs identified and reported? - Does resident participate in the development of his/her care plan? - Ask nursing how often the social worker sees resident. - Does the social worker discuss resident's needs/problems with nursing staff if there is a need for nursing to be involved?</td>
<td>- Plan of care, social service notes, reflect the current status of the resident. - There is evidence that the resident's mental status has been considered when plan of care was developed. - Vision and hearing problems have been addressed. - Plan of care addresses residents needs as observed by the surveyor and stated by the resident. - Notes and plan indicate that needs have been re-evaluated and care plan changed as necessary. - There is evidence that the problems and needs of the family have been addressed. - There are indications that a referral has been made to the appropriate agency and a statement describing why. - There is documentation from the outside agency indicating what actions were taken and any plan for follow-up.</td>
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<td>F233-238 (cont'd)</td>
<td>- How is physician notified and involved in plan of care? - Ask social service staff their role, function, and what services they provide. - Ask staff what referral services are available. - If services are being provided by outside resource, are resources documented work service? - Ask social service staff about their background and education. - If there is a consultant ask staff: + How often does the person come? + How long do they stay? + What does the person do while in the facility? + What assistance, consultation is being provided? + Ask social service staff if adequate space is provided for them by the facility to conduct private interviews and meetings.</td>
<td>- The time period between date of referral and date of services is reasonable and if not, there is evidence of follow-thru by staff. - The outside agency has documented their involvement and activities. - Plan of care demonstrates awareness of behavior, articulates the reasons for it, and indicates in the plan of care an approach to the behavior. - Assessment should contain: + a flexible approach to each resident (should be individualized), + awareness of a mental status evaluation, + resident history, + family availability for planning, resident support, etc. + Identification of problems resulting from placement. + Recent social adjustment. + Discharge planning. + The record reflects cooperation/collaboration of social and nursing teams</td>
<td>- There is documentation of collaboration between nursing and social work for meeting emotional needs.</td>
<td>Patient Care Management 485.1124(d)</td>
<td></td>
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</table>
## Survey Area: F233-238 (cont'd)

### Observation
- **Activities**
  - **F239**: General level of activities throughout the facility, as well as in specifically designated areas.
  - **F240**: How many residents are lying on their beds or sitting in chairs staring at the walls during waking hours?
  - **F241**: What is the level of residents' interest in activities they are doing?
  - **F242**: Are residents positioned correctly for activity?

### Interviewing
- **Social Service interview**
  - Review integrated plan of care for:
    - Plan for concerted social services.
    - Plan for supportive services for adjustment.
    - Adjustment goals.
    - Interventions for specific conditions.

### Record Review
- **Activities Assessment**
  - Interests of the resident (past and present) are identified as to resident's current capabilities and necessary adaptations to pursue their interests.
  - Documentation about social history, medical problems, and limitations impacting residents' activities have been communicated to activities personnel and used in assessment and development of activities portion of care plan.

### Evaluation Factors
- Are each resident's personal interests known? If not, what actions are being taken to identify them? Residents in facility 60 days should not be without some identified interests.

### Cross Reference
- **Nursing Services**
  - 405.1124
  - 442.319
- **Social Services**
  - 405.1138
  - 442.344
- **Social Rehabs Services**
  - 405.1126
  - 442.363
- **Physician Services**
  - 405.1123
  - 442.329

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*Source: Long Term Care Survey (42 CFR Ch. IV)*
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<th>OBSERVATION</th>
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<td>F242-(cont'd)</td>
<td>Are needed personal equipment (e.g., splints, glasses) and adaptations for limitations and safety (e.g., cardholder, goggles, footrests) used in activities?</td>
<td>- Does resident get out of facility to activities? - Does resident have problems getting to activities? If so, does the staff assist? - Does the staff encourage residents to go to activities? - Does resident participate in Resident Council? - Does resident have free choice of activities? - What kind of activities do best help residents engage in?</td>
<td>- Needs of the resident in the following areas are identified: - social interaction - creative expression - work and service opportunities - intellectual stimulation or activities - adaptation - physical exercise - spiritual or religious expression - Plan of care used all available information about: - interests - needs - indications and contraindications for activities from other assessments - physician orders and progress notes</td>
<td>Does each resident's activities promote his physical, social and mental well-being?</td>
<td>Physical Environment 405.1134 442.329 Infection Control 405.1135 442.328 Resident Rights 405.1121(k) 405.311 Medical Records 405.1132 405.318 Patient Care Management 405.1120(f) 442.341</td>
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<tr>
<td>F243</td>
<td>2. Unless contraindicated by the attending physician, all residents are encouraged to participate in activities.</td>
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<td>F244</td>
<td>3. The activities promote the physical, social and mental well-being of the residents.</td>
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### Long Term Care Survey

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<th>Survey Area</th>
<th>Observation</th>
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<td>F245</td>
<td>Is lighting adequate throughout the facility for activities in which residents are engaged?</td>
<td>- Do they know the interests of residents under their care? Are programs designed to meet these needs?</td>
<td>Activities notes spell out implementation of plan, resident’s reactions to specific activities, approaches, and people.</td>
<td>Are equipment and supplies to meet residents’ interests available and maintained in good working order?</td>
<td>Are residents evaluated periodically with emphasis on participation levels and desired outcomes?</td>
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<tr>
<td>F246</td>
<td>Do men and women have activities of interest to them? Do residents communicate with each other in activities? Are methods of communicating upcoming activities appropriate to the resident populations? Specific observation for physically impaired/aged residents: Activities adapted to meet specific needs of the resident. Alert residents have activities of interest and at their cognitive functional level. Specific observations for confused/disoriented, emotionally disturbed, and mentally retarded residents. There are current calendars, clocks and patients.</td>
<td>- Do they know the personal equipment needed (e.g., glasses, hearing aids, walker)? - Do they know the adaptive equipment used by residents for specific activities (e.g., talking books, built-up tools)? - Do they talk to residents to identify new interests and report these “likes” to activities personnel?</td>
<td>Plans are revised as needed.</td>
<td>Residents in the facility more than 60 days should have at least two activities per week of interest to them personally.</td>
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### LONG TERM CARE SURVEY

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<th>OBSERVATION</th>
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<th>RECORD REVIEW</th>
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<td>F246 (cont'd)</td>
<td>and patients' names or symbols visible to all the residents.</td>
<td>- If he/she does not participate, why?</td>
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<td>Staff consistently use techniques such as reality orientation, empathy, and/or validation therapy as per each individual's needs.</td>
<td>- Which activities appear to relax/calm the resident? How? How often?</td>
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<td>Resident has familiar items if available in room (e.g., family pictures, artwork, afghan, chair from home).</td>
<td>- How does staff manage maladaptive behavior (e.g., abusive, disruptive, combative)?</td>
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<td>Residents in restraints have activities of interest geared to their abilities when restrained (e.g., table-top activity, music, radio, reading and writing material); when out of restraints (e.g., walks, exercise, group, Tai Chi).</td>
<td>- Is direct care staff involved in resident activities? How? When (weekends, evenings)?</td>
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<td>Small group and one-on-one involvement with staff reinforcing appropriate responses.</td>
<td>- Does resident have one-to-one assistance in activities?</td>
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<td>Staff reaction to resident behavior during activities (e.g., crying, whining, demanding, non-verbal, aggression).</td>
<td>- Why do these residents have so little interest?</td>
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<td>- What is your plan to find more activities of interest to them that will meet their needs?</td>
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<td>- What types of residents seem not to be interested in activities?</td>
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<td>- How many (who) residents have only passive activities?</td>
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<td>SURVEY AREA</td>
<td>OBSERVATION</td>
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</table>
| F 246 (cont'd.) | Loudness.  
Specific observation for comatose or terminally ill resident:  
- Appropriate items for sensory enrichment in room (e.g., TV, radio, adequate lighting)  
- Resident placed in supportive living environment (e.g., around people, in hall, activities room, sunshine, fresh air), when appropriate to the resident needs and consistent with the resident’s choice.  
Specific observation of environment for conducting activity program:  
- Adequate lighting.  
- Functional area is appropriate for activities of interest (e.g., religious services, arts and crafts, cooking, reading, TV watching, card playing, parties, discussion groups, gardening). | - How do you adapt activities for needs of residents who are:  
- Confused/disoriented  
- Emotionally disturbed  
- Mentally retarded  
- Physically impaired but alert  
- Terminally ill?  
- Are community volunteers utilized in the activities program? In what way?  
- Are the residents encouraged to offer suggestions for new activities? If so, what activities have been instituted as a result?  
- How they manage maladaptive behavior (e.g., abusive, disruptive, combative)?  
- How do they help depressed residents (e.g., tearful, emotionally labile)? | | | |
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</thead>
</table>
| F246 (cont’d) | - Multi-purpose room use and timing of activities does not conflict.  
- Outdoor activity area.  
- Functional furniture, indoors and outdoors.  
- Evidence of free choice activities:  
  - newspapers  
  - magazines  
  - record player  
  - radios  
  - games  
  - TV's  
  - reading  
  - sewing  
  - personal visits  
  - church services  
- Activities, equipment and supplies are appropriate and sufficient to meet interest of residents.  
- Activities equipment and supplies sufficient for conducting activities.  
- Activities equipment clean, safe, and in working order.  
- Residents rooms contain independent project materials, as appropriate.  
- Residents have access to the total activity environment (e.g., lobby, sunroom, dayroom, porch, dining room). | | | | |
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<table>
<thead>
<tr>
<th>Survey Area</th>
<th>Observation</th>
<th>Interviewing</th>
<th>Record Review</th>
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<tbody>
<tr>
<td>Medical Records</td>
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<td>All information required is present in the record.</td>
<td>Does the record document all observable resident needs/problems?</td>
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<tr>
<td>F247</td>
<td>SNF 405.1132</td>
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<tr>
<td>Content</td>
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<td>F248</td>
<td>SNF 405.1132(c)</td>
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<td>F249</td>
<td>ICF 442.31B(a)(c)</td>
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<td>F250</td>
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<tr>
<td>1. The medical record contains sufficient information to identify the resident clearly to justify diagnoses and treatment and to document results accurately.</td>
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<td>F251</td>
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<td>2. The medical record contains the following information.</td>
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<td>a. Identification information.</td>
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<td>b. Admission data including past medical social history.</td>
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<td>c. Transfer form, discharge summary from any transferring facility.</td>
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<td>e. Report of physical examinations.</td>
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<td>f. Reports of physicians’ periodic evaluations and progress notes.</td>
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<td>g. Diagnostic reports and therapeutic orders.</td>
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<td>h. Reports of treatments.</td>
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<td>i. Medications administered.</td>
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<td>j. An overall plan of care setting forth goals to be accomplished through each service’s designed activities, therapies and treatments.</td>
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<td>Assessments</td>
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<td>Treatments</td>
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<td>Progress</td>
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<td>F264 (cont'd)</td>
<td>INTENT</td>
<td>Brings together all resident information. Reflects the care being given to the residents and helps all care givers to make decisions on care needed.</td>
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<td>TRANSFER AGREEMENT</td>
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<td>F265</td>
<td>SF 405.1133</td>
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<td>F266</td>
<td>SF 405.1133(a)</td>
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<td>F267</td>
<td>ICF 442.316</td>
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<tr>
<td></td>
<td>F268</td>
<td>A. Whenever the physician determines that a transfer is medically appropriate between a</td>
<td>Ask Staff:</td>
<td>Review information on medical record of resident who was temporarily transferred and is again back in the facility.</td>
<td>All pertinent resident information must be documented on the medical record at the time of transfer.</td>
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<td></td>
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<td></td>
<td>- What is the routine information you provide to a new facility when you transfer a resident?</td>
<td>- Who provides this?</td>
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<td>The resident was not injured in any way by a delay in the transfer process.</td>
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### Long Term Care Survey

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<tr>
<td>F268 (cont'd)</td>
<td>![Image](173x140 to 439x610)</td>
<td></td>
<td>Is transfer form complete with all data, with appropriate signatures? Does the medical record indicate that adequate and pertinent aspects of the discharge planning portion of the patient care plan accompany the patient on transfer?</td>
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<td>F269</td>
<td>B. Information necessary for providing care and treatment to transferred individuals is provided.</td>
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<td><strong>Physical Environment</strong></td>
<td><strong>SNF 405.1134</strong></td>
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<tr>
<td>F271</td>
<td>A. Nursing Unit</td>
<td>There is adequate light to prepare medications.</td>
<td>Ask Nursing Staff:</td>
<td>Medication preparation and storage areas provide adequate space and light to prepare medication and to store medication and needed supplies.</td>
<td>Nursing Service 489.1124(g) 442.337</td>
</tr>
<tr>
<td></td>
<td>WM 489.1131(d)</td>
<td>There is sufficient space to prepare medications for administration in a safe and effective manner.</td>
<td>What do you use the medication area?</td>
<td>Light is available where the medication cart is in use. A medication refrigerator is available and does not contain patient or employee snacks, juice, etc., used in administering medication is allowed.</td>
<td>Infection Control 489.1135</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There is sufficient space for storage of medications.</td>
<td>Where is the handwashing sink?</td>
<td>Clean and dirty areas must be separated, preferably in separate rooms.</td>
<td>Governing Body 442.325</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unit dose carts are protected from tampering and theft.</td>
<td>Do you have enough, convenient storage area for I.V. fluids and medications needing refrigeration?</td>
<td>Storage space must be available for bulky items and supplies so that they can be stored without blocking corridors and exits.</td>
<td>Resident Rooms 489.1134(e) 442.325</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medications are stored in a locked area. Refrigeration facilities are available for medications.</td>
<td>Where are the keys for the medication room and unit dose carts?</td>
<td>Medications are protected from unauthorized use.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>There is sufficient storage space for I.V. fluids.</td>
<td>Do you feel you have adequate storage space for supplies and equipment?</td>
<td>Call bells must be in working order and must be present in all resident bedrooms, toilets and bathing facilities.</td>
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<tr>
<td></td>
<td></td>
<td>Handwashing facilities are readily accessible either in the medication preparation area or adjacent to it.</td>
<td>If no, what problems does that cause?</td>
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<td></td>
<td></td>
<td></td>
<td>Does the resident call system function properly?</td>
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<td></td>
<td></td>
<td></td>
<td>Ask Residents: Do the call bells in your room and in the toilets and bathing areas always work?</td>
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| F274 (cont'd) | Audible call system is on and working. Long cards are available for chair bound patients. | - If no:  
  - How often is it that they do not work?  
  - How long does it take to get them fixed? | | Audible signals, if in the system, must be in working order and turned on. | |}
| B. Dining and activities area | Area is clean and well maintained.  
There is sufficient space between tables to allow for safe passage of wheelchairs and residents with walkers, canes and other assistive devices. | Ask Residents:  
- Is there enough room between tables to allow you to feel safe in getting to your table?  
- Can you sit comfortably in your wheelchair at the table?  
- How is the lighting and ventilation level for you?  
- Are sitting preferences permitted?  
- Do you go to the dining room for meals? | Regulations clearly set out conditions for compliance. Refer to the regulations. | Dietary Services  
483.1125  
442.331 | Patient Activities  
485.1131  
442.345 |
| F275  
SNF 485.1134(g)  
F276  
ICF 482.329 | Table height or design allows residents in wheelchairs to sit a normal distance from the table.  
Lighting and ventilation in the dining/activity areas is provided according to recommended standards.  
A multi-purpose room should not be used for storage of items such as beds, mattresses, boxes, etc. | | | |
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<tr>
<td>F278</td>
<td>2. Dining and activity rooms are well lighted and ventilated.</td>
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<td></td>
<td>Are dining areas utilized at meal service?</td>
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<tr>
<td>F279</td>
<td>3. Any multipurpose room used for dining and resident activities has sufficient space to accommodate all activities and prevent their interference with each other.</td>
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| F280       | SNF 405.1134(e)  
Indicators (4D) apply to SNFs |              |               |                   |                 |
### Long Term Care Survey

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<tr>
<td>C. Resident Rooms</td>
<td>Observe rooms and furnishings for maintenance, cleanliness and safety. Look for dust/dirt on sills, high surfaces, under heating units, and in corners. Use a flashlight. Are beds, lights, plumbing all in working order? Are privacy curtains present, and appropriate to maintain resident privacy? Test several call lights. Are call lights within reach, including emergency lights in toilets and bathing areas? Are toilet and bathing facilities appropriate in number, size, and design to meet resident needs? What personal belongings do residents have in their rooms? Is there</td>
<td>Ask Residents:</td>
<td>Refer to the regulations.</td>
<td>Resident Rights 405.113(d)(1) and (5) (1)(i)(v) 442.311(a)(1)(d); 442.312(a)(1)(ii) (b)(3) (b)(k) Physical Environment 405.1134(e) 442.326</td>
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<tr>
<td>F285</td>
<td>4. There is a capability of maintaining privacy in each.</td>
<td>sufficien storage and security for their belongings?</td>
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<tr>
<td>F286</td>
<td>5. There is adequate storage space for each resident.</td>
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<tr>
<td>F287</td>
<td>6. There is a comfortable and functioning bed and chair, plus a functional cabinet and light.</td>
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<td>F288</td>
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<tr>
<td>7. The resident call system functions in resident rooms.</td>
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<td>F289</td>
<td>8. Each room is designed and equipped for adequate nursing care and the comfort and privacy of residents.</td>
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<tr>
<td>F290</td>
<td>9. Each room is at or above grade level.</td>
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<tr>
<td>F291</td>
<td>10. Each room has direct access to a corridor and outside exposure.</td>
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<td>Exception: Not required for ICF residents.</td>
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<tr>
<td>0. Toilet and bath facilities</td>
<td>Are there adequate numbers of toilets, baths, and showers for the residents that are accessible to, and functional for all residents?</td>
<td>Ask Residents:</td>
<td>Bathing schedule for patients in your in-depth review.</td>
<td>Privacy is maintained for residents in toilet and bathing areas.</td>
<td></td>
</tr>
<tr>
<td>1. Facilities are clean, sanitary and free of odors.</td>
<td>Are these conveniently located in or near resident rooms?</td>
<td>- When was your last bath?</td>
<td></td>
<td>Toilet and bathing areas are clean. Water is removed from floors immediately upon completion of bathing.</td>
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<tr>
<td>2. Facilities have safe and comfortable hot water temperatures.</td>
<td>Check for water on floors of bath and shower rooms.</td>
<td>- What safety precautions are used for getting in and out of the bathtub?</td>
<td></td>
<td>Hot water is within the acceptable temperature range.</td>
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<tr>
<td>3. Facilities maintain privacy.</td>
<td>Is privacy provided?</td>
<td>- What equipment is needed to get in and out of the tub, and how do you feel about it?</td>
<td></td>
<td>Soap, toilet paper and towels are available in the bathrooms.</td>
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<tr>
<td>4. Facilities have grab bars and other safe guards against slipping.</td>
<td>Are bathrooms equipped with soap, toilet tissue, towels, etc.? Hot water is between 110-120 degrees or the acceptable state level. Hot water temperature control must be maintained. Single use, disposable towels should be available for handwashing purposes. Note also condition of grab bars, plumbing and fixtures. Bath areas are not used for storage.</td>
<td>- How do you get your wheelchair into the toilet or bathroom?</td>
<td></td>
<td>Grab bars are present and securely fastened to the wall.</td>
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<td></td>
<td></td>
<td>- When, if ever, do you refuse to be bathed?</td>
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<td>Ventilation and lighting systems are correctly functioning.</td>
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<td>Plumbing and other fixtures are in good condition.</td>
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<td>F299</td>
<td>5. Facilities have fixtures in good condition.</td>
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<td>F298</td>
<td>6. The resident call system functions in toilet and bath facilities.</td>
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<td>F300</td>
<td>E. Social Service Area</td>
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<td>F299</td>
<td>SNF 485.11(b) ICF 445.354</td>
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<td>F301</td>
<td>1. Ensures privacy for social service interviewing.</td>
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<td>F302</td>
<td>2. Adequate space for clerical and interviewing functions is provided.</td>
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<td>F302</td>
<td>3. Facilities are easily accessible to residents and staff.</td>
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<tr>
<td>F. Therapy areas</td>
<td>Therapy areas are accessible to all residents needing the facilities.</td>
<td>Refer to regulations.</td>
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<tr>
<td>F303</td>
<td>Space allows for safe maneuvering of residents and equipment and staff.</td>
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<td>F304</td>
<td>All residents are able to be observed and supervised during therapy.</td>
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<td>F305</td>
<td>1. Space is adequate for proper use of equipment by all residents receiving treatment.</td>
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<td>G. Facilities for special care</td>
<td>Are therapy areas properly ventilated to effectively reduce heat, moisture, and odors?</td>
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<td>F307</td>
<td>Are private rooms available that meet regulatory criteria.</td>
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<td>F308</td>
<td>If a resident is infected and in isolation, are precautionary signs posted, and are they legible and understandable?</td>
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<td><strong>Ask Resident:</strong></td>
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<td></td>
<td>- Do you feel that the equipment you use is safe?</td>
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<td>- Do you have enough room for your treatment?</td>
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<td><strong>Ask Therapy Staff:</strong></td>
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<td></td>
<td>- Is your equipment adequately maintained?</td>
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<td></td>
<td>- Do you have enough room to safely and adequately provide treatment?</td>
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<td></td>
<td><strong>Ask Supervisory personnel:</strong></td>
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<td></td>
<td>- What rooms do you use for isolation?</td>
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<td></td>
<td>- What is your procedure if the room is already occupied when you need it for isolation?</td>
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<td>- Will you show me the signs you use to identify the isolation room?</td>
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<td></td>
<td>Rooms meeting the regulatory requirements are available in the facility.</td>
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<td></td>
<td><strong>Resident Rights</strong> 405.112(1)(4) 442.311(c)(2) <strong>Infection Control</strong> 405.1135(b)</td>
</tr>
<tr>
<td></td>
<td>There is a procedure that is implemented when an isolation is needed, but it is already occupied.</td>
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<td>Isolation signs are visible and clearly convey the intended message.</td>
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<tr>
<td>F309</td>
<td>1. Single rooms with private toilet and handwashing facilities are available for isolating residents.</td>
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<tr>
<td>F310</td>
<td>2. Precautionary signs are used to identify these rooms when in use.</td>
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LONG TERM CARE SURVEY
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<tr>
<td>H. Common Resident Areas</td>
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<tr>
<td>F311</td>
<td>SNF 405.133(j)</td>
<td>1. Use senses - sight, hearing, olfactory when surveying common areas as lounge, lobby, corridors. Note levels of lighting for both reading and non-reading areas. Is it bright enough but without glare? Are areas clean and without offensive odors? Do background sound levels allow for ease of communication and comfort for residents/visitors? Do residents seem comfortable at the room temperature? Are the lights on in the corridors? Are there handrails on each side of the corridor and are they secure? Are smoking/no smoking areas designated?</td>
<td>Ask Residents: - Do you think the lounges and corridors are usually clean? - Do they have any unpleasant odors? - Is the lighting level comfortable for you to read? Is it adequate for you to feel safe walking? - Do you have any difficulty with the noise level? - Is the temperature usually comfortable for you? - Do you feel there is adequate ventilation? - Are there handrails in all of the corridors? - Are they securely fastened to the wall? Ask Supervisory Staff: - If there is a water main break or other interruption in the water supply, how do you obtain water for essential areas and duties?</td>
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<tr>
<td>F312</td>
<td>ICF 442.324</td>
<td></td>
<td></td>
<td></td>
<td>Infection Control 405.133(c)</td>
</tr>
<tr>
<td>F333</td>
<td>1. All common areas are clean, sanitary and free of odors.</td>
<td></td>
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<tr>
<td>F334</td>
<td>2. Provision is made for adequate and comfortable lighting levels in all areas.</td>
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<tr>
<td>F335</td>
<td>3. There is limitation of sounds at comfort levels.</td>
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</table>

Floors and furniture should appear clean - free of gross contamination.

Residents should have lighting bright enough to safely negotiate corridors, lobbies, etc., and in reading area, be bright enough to read. But the brightness should be free of glare. Remember, the elderly need a higher level of lighting as their sight diminishes.

Exception for times when a louder level of sound is necessary for communication, sounds should be unobtrusive and "comfortable."

Room temperature comfort levels vary widely, and in general the elderly will require a higher temperature for comfort than younger people. Use information from resident interviews and your observations to determine if the temperature is "comfortable" for most residents.

All corridors in
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<tr>
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<tbody>
<tr>
<td>F316</td>
<td></td>
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<td></td>
<td>resident-used areas are equipped with handrails on each side. These rails securely fastened provide the residents with a firm support. Supervisory staff are able to tell you how they will obtain water for drinking, cleaning, bathing of residents, and other essential functions if their normal water supply is interrupted.</td>
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<td>F317</td>
<td>4. A comfortable room temperature is maintained.</td>
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<td>F318</td>
<td>5. There is adequate ventilation thru windows or mechanical measures or a combination of both.</td>
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<tr>
<td>F319</td>
<td>6. Corridors are equipped with firmly secured handrails on each side.</td>
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<tr>
<td>F320</td>
<td>7. Staff are aware of procedures to ensure water to all essential areas in the event of loss of normal supply.</td>
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<td></td>
<td>Disaster Preparedness 482.1136 442.313</td>
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## Long Term Care Survey

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<th>Observation</th>
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<th>Record Review</th>
<th>Evaluation Factors</th>
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</thead>
<tbody>
<tr>
<td>1. Maintenance of Building and Equipment</td>
<td>F320 SNF 405.1134(d)</td>
<td>- Ceiling and floor tile in good condition</td>
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<td></td>
<td>Physical Environ-ment 405.1134(d)</td>
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<tr>
<td></td>
<td></td>
<td>- Paint in good repair</td>
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<td></td>
<td></td>
<td>- No holes in walls</td>
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<td></td>
<td></td>
<td>- Look for rat and other rodent trails outside and inside</td>
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<td></td>
<td></td>
<td>- Preventive maintenance program for all equipment is followed</td>
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<td></td>
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<td>- Wheelchairs not stored in hallways, bathrooms, etc.</td>
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<td></td>
<td></td>
<td>- Window screens are in good repair</td>
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<tr>
<td></td>
<td></td>
<td>- Check overbed tables, wheelchairs, etc., for cleanliness and operation</td>
<td></td>
<td></td>
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<tr>
<td>2. The interior and exterior of the building are clean and orderly.</td>
<td>F321</td>
<td>Ask Staff:</td>
<td></td>
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<tr>
<td>3. All essential mechanical and electrical equipment is maintained in safe operating condition.</td>
<td>F322</td>
<td>- How many housekeeping staff are available?</td>
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<tr>
<td>4. Sufficient storage space is available and used for equipment to ensure that the facility is orderly and safe.</td>
<td>F323</td>
<td>- How late are housekeepers on duty during the week?</td>
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<td></td>
<td></td>
<td>- How is weekend coverage different?</td>
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<td>SURVEY AREA</td>
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<tr>
<td>F324 4. Resident care equipment is clean and maintained in safe operating condition.</td>
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LONG TERM CARE SURVEY
LONG TERM CARE SURVEY

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<tr>
<td>indicator 3 applies to ICUs, Dietetic Service Area F326 SNF 405.1134(h)</td>
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<td></td>
<td>Dietetic Services 405.1125(g) 442.331(h)</td>
</tr>
<tr>
<td>1. Kitchen and dietetic service areas are adequate to ensure proper, timely service for all patients.</td>
<td>Observe for: - needed space to carry out routine operations - maintenance of working surfaces equipment, utensils, and serving dishes - operable dish washer machine - 3-sink method of pot/ dish washing properly carried out/for written procedure posted - operable and clean exhaust fan - stored dishes and pots are free of baked-on food particles and chipped/tracked surfaces - food stored off floor - protective covers for fluorescent lights - handwashing sink readily accessible</td>
<td>Ask Staff: - what have you been trained to do? - what type of dishwasher machine do you have? How does it operate?</td>
<td>The proper temperature for the dishwasher wash cycle is 150-160 degrees Fahrenheit. The dishwasher rinse cycle is acceptable at temperature of 180 degrees Fahrenheit or when there is a change in the temperature-sensitive tape (thermocell). The individual manufacturers' specifications may countermand these instructions, particularly in the case of chemical sanitization.</td>
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### Long Term Care Survey

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<tbody>
<tr>
<td>Indicators K applies to ICF K. Dietary Staff Hygiene</td>
<td>F329</td>
<td>SNF 405.1125(f)</td>
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<tr>
<td></td>
<td>F330</td>
<td>1. Dietetic service personnel practice hygienic food handling techniques</td>
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<td></td>
<td>F331</td>
<td>SNF 405.1125(g)</td>
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<tr>
<td></td>
<td>F332</td>
<td>1. Food is stored, refrigerated, prepared, distributed, and served under sanitary conditions</td>
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<td></td>
<td></td>
<td>2. Waste is disposed of properly</td>
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**Ask Staff:**
- What happens when you report to work with a cold, a cut or sore on your hand?
- Where is handwashing sink for dietary staff?
- Do you use disposable plastic hand covers? If so, when?
- Where are your serving utensils located?
- What are temperatures for the refrigerators and freezers? Who is responsible for checking temperatures?
- Do you have thermometers to check water and food temperatures? (ask them to demonstrate how they take temperatures)

**Diabetic Services:**
405.1125(e)(f)(g)
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| F333 (cont'd) | - check that the refrigerators are equipped with an accurate thermometer  
- Food does not have an "off" or bad odor  
- Cracked eggs are discarded  
- Foods are dated and then stored as to their preparation date.  
Observe that waste is in covered containers, bagged and tied for disposal, and that dumpsters are covered. | INTERVIEWING | RECORD REVIEW | EVALUATION FACTORS | CROSS REFERENCE |
<table>
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<tbody>
<tr>
<td>L. Emergency Power F334 SNF 405.1134(b)</td>
<td>Is an emergency generator available? Test generator under full load conditions. Check items of emergency power: - lighting - fire detection - alarms - extinguishing systems - life support systems Transfer time from normal power to emergency power to occur within 10 seconds. Check for gounded exten- sion cords at nurses stations. Where are emergency out- lets?</td>
<td>As per regulations and covered by the Life Safety Code surveyor</td>
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<tr>
<td>Infection Control F338 SNF 405.1135</td>
<td>Observation of dressing technique to identify if infection control principles are being adhered to: sterile technique, sterile/clean field, disposal of dressing, handwashing, use of gloves.</td>
<td>Ask Staff: What type of dressing changes are you performing? How often are dressings changed? Why is resident on isolation/precautions? Do laundry/housekeeping personnel/aides know procedures?</td>
<td>Review records of residents selected for in-depth review for infection.</td>
<td>Compliance will be based mainly on your observations. Deficiencies will be cited if you see: breaks in aseptic or isolation technique, clutter or unclean conditions that would cause unsafe conditions, inadequate supplies of linen to provide proper care and comfort for residents, inadequate techniques for handling clean and dirty linen, evidence of insect or rodent infestation, use flash light to check for roaches in closets, cabinets.</td>
<td>Nursing Services 405.1124 442.338</td>
</tr>
<tr>
<td>A. Infection Control F339 SNF 405.1135(b)</td>
<td>Aseptic and isolation techniques are followed by all personnel.</td>
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<tr>
<td>F340</td>
<td>Observation of isolation precautions: signs, linens, double bagged, soiled linens, double bagged, gowns/masks, gloves, handwashing, disposable dishes, information for visitors.</td>
<td>Ask Resident: Do you know why you have dressings? Do you know why you are on isolation/precautions? Do you have clean linen when you need it?</td>
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<tr>
<td>B. Sanitation F341 SNF 405.1135(c)</td>
<td>The facility maintains a safe, clean, and orderly interior.</td>
<td>Procedures followed by: laundry, housekeeping How is dirty linen transported to laundry or holding area? Do aides wash hands after cleaning dirty linen? How do aides handle clean/dirty linen while changing beds?</td>
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<td>F342</td>
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<tr>
<td>C. Linen F343 SNF 405.1135(d)</td>
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<td>F344</td>
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<td>ICF 442.327</td>
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<tr>
<td>F345</td>
<td>1. The facility has available at all times a quantity of linen essential for proper care and comfort of residents.</td>
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<tr>
<td>F346</td>
<td>2. Linens are handled: stored, processed, and transported in such a manner as to prevent the spread of infection.</td>
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<tr>
<td>F347</td>
<td>D. Pest Control</td>
<td>Look for evidence of insect or rodent presence (mouse or rat droppings, roaches, ants, flies around trash)</td>
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<td></td>
<td></td>
<td>- Screen doors closed</td>
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<td></td>
<td></td>
<td>- Windows that can be opened have screens that are in good repair</td>
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<td>F348</td>
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<tr>
<td>ICF 442.315(c)</td>
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<tr>
<td>F349</td>
<td>The facility is maintained free from insects and rodents.</td>
<td>Ask Staff:</td>
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<tr>
<td></td>
<td></td>
<td>- Have you seen insects (roaches, ants, flies, etc.)?</td>
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<td></td>
<td></td>
<td>- Have you seen rodents and/or droppings?</td>
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<td></td>
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<td>- What foods are residents permitted to keep in their rooms?</td>
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| **Disaster Preparedness** | **F350**  
SNF 405.1136 | **Ask Residents:**  
- Do you know what to do in case of fire?  
- How often do you rehearse it? | | **A disaster plan is available and facility staff know their roles.** | **Physical Environment**  
405.1134(a)(b)  
442.321 |
| | **F351**  
SNF 405.1136(a) | **Ask Staff:**  
- What are your responsibilities at a fire drill?  
- What is the facilities disaster plan? (Specify types, i.e., fire, flood, etc.)  
- How you undergone disaster training?  
- Have you participated in a fire disaster drill? When?  
- How frequently are drills held?  
- Have you been trained/instructed in the use of fire equipment, fire containment methods?  
- Have you been trained in transfer or casualties and routes?  
- How would staff meet emotional needs of residents during/following a "disaster", e.g., fire | | | |
| | **F352**  
ICF 442.313 | | | | |
<p>| | <strong>Indicators A and B apply to ICFs.</strong> | | | | |
| <strong>A. Disaster Plan</strong> | <strong>F353</strong> | <strong>1. Facility staff are aware of plans, procedures to be followed for fire, explosion or other disaster.</strong> | | | |
| | <strong>F354</strong> | <strong>2. Facility staff are knowledgeable about evacuation routes.</strong> | | | |</p>
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<td>F355</td>
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<tr>
<td>3. Facility staff are aware of their specific responsibilities in regard to evaluation and protection of residents.</td>
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<td>F356</td>
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<tr>
<td>4. Facility staff are aware of methods of containing fire.</td>
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<td>B. Drills</td>
<td>F357</td>
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<td></td>
<td>SMF 405.1136(b)</td>
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<td>F358</td>
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<tr>
<td>1. All employees are trained as part of their employment orientation in all aspects of preparedness for any disaster.</td>
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<td>F359</td>
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<td>2. Facility staff participate in ongoing training and drills in all procedures so that each employee promptly and correctly carries out a specific role in case of a disaster.</td>
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INITIAL
To ensure a clean, safe environment for residents.
§ 488.201 Reconsideration.

(a) Right to reconsideration. (1) A national accreditation organization dissatisfied with a determination that its accreditation requirements do not provide (or do not continue to provide) reasonable assurance that the entities accredited by the accreditation organization meet the applicable long-term care requirements, conditions for coverage, conditions of certification, conditions of participation, or CLIA condition level requirements is entitled to a reconsideration as provided in this subpart.

(2) A State dissatisfied with a determination that the requirements it imposes on laboratories in that State and under the laws of that State do not provide (or do not continue to provide) reasonable assurance that laboratories licensed or approved by the State meet applicable CLIA requirements is entitled to a reconsideration as provided in this subpart.

(b) Eligibility for reconsideration. CMS will reconsider any determination to deny, remove or not renew the approval of deeming authority to private accreditation organizations, or any determination to deny, remove or not renew the approval of a State laboratory program for the purpose of exempting the State’s laboratories from CLIA requirements, if the accreditation organization or State files a written request for a reconsideration in accordance with paragraphs (c) and (d) of this section.

(1) A national accreditation organization or a State laboratory program described in paragraph (b), dissatisfied with a determination with respect to its deeming authority, or, in the case of a State, a determination with respect to the exemption of the laboratories in the State from CLIA requirements, may request a reconsideration of the determination by filing a request with CMS either directly by its authorized officials or through its legal representative. The request must be filed within 60 days of the receipt of notice of an adverse determination or nonrenewal as provided in subpart A of part 488 or subpart E of part 493, as applicable.

(2) Reconsideration procedures are available after the effective date of the decision to deny, remove, or not renew the approval of an accreditation organization or State laboratory program.

(d) Content of request. The request for reconsideration must specify the findings or issues with which the accreditation organization or State disagrees and the reasons for the disagreement.

§ 488.203 Withdrawal of request for reconsideration.

A requestor may withdraw its request for reconsideration at any time before the issuance of a reconsideration determination.

§ 488.205 Right to informal hearing.

In response to a request for reconsideration, CMS will provide the accreditation organization or the State laboratory program the opportunity for an informal hearing as described in § 488.207 that will—

(a) Be conducted by a hearing officer appointed by the Administrator of CMS; and

(b) Provide the accreditation organization or State laboratory program the opportunity to present, in writing or in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew deeming authority or the exemption of a State’s laboratories from CLIA requirements.

§ 488.207 Informal hearing procedures.

(a) CMS will provide written notice of the time and place of the informal hearing at least 10 days before the scheduled date.

(b) The informal reconsideration hearing will be conducted in accordance with the following procedures—
(1) The hearing is open to CMS and the organization requesting the reconsideration, including—
   (i) Authorized representatives;
   (ii) Technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts); and
   (iii) Legal counsel;
(2) The hearing is conducted by the hearing officer who receives testimony and documents related to the proposed action;
(3) Testimony and other evidence may be accepted by the hearing officer even though it would be inadmissible under the usual rules of court procedures;
(4) Either party may call witnesses from among those individuals specified in paragraph (b)(1) of this section; and
(5) The hearing officer does not have the authority to compel by subpoena the production of witnesses, papers, or other evidence.

§ 488.209 Hearing officer's findings.
   (a) Within 30 days of the close of the hearing, the hearing officer will present the findings and recommendations to the accreditation organization or State laboratory program that requested the reconsideration.
   (b) The written report of the hearing officer will include—
      (1) Separate numbered findings of fact; and
      (2) The legal conclusions of the hearing officer.

§ 488.211 Final reconsideration determination.
   (a) The hearing officer's decision is final unless the Administrator, within 30 days of the hearing officer's decision, chooses to review that decision.
   (b) The Administrator may accept, reject or modify the hearing officer's findings.
   (c) Should the Administrator choose to review the hearing officer's decision, the Administrator will issue a final reconsideration determination to the accreditation organization or State laboratory program on the basis of the hearing officer's findings and recommendations and other relevant information.
   (d) The reconsideration determination of the Administrator is final.
   (e) A final reconsideration determination against an accreditation organization or State laboratory program will be published by CMS in the Federal Register.

Subpart E—Survey and Certification of Long-Term Care Facilities

SOURCE: 59 FR 56238, Nov. 10, 1994, unless otherwise noted.

§ 488.300 Statutory basis.
Sections 1819 and 1919 of the Act establish requirements for surveying SNFs and NFs to determine whether they meet the requirements for participation in the Medicare and Medicaid programs.

§ 488.301 Definitions.
As used in this subpart—
Abbreviated standard survey means a survey other than a standard survey that gathers information primarily through resident-centered techniques on facility compliance with the requirements for participation. An abbreviated standard survey may be premised on complaints received; a change of ownership, management, or director of nursing; or other indicators of specific concern.
Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.
Deficiency means a SNF's or NF's failure to meet a participation requirement specified in the Act or in part 483, subpart B of this chapter.
Dually participating facility means a facility that has a provider agreement in both the Medicare and Medicaid programs.
Extended survey means a survey that evaluates additional participation requirements subsequent to finding substandard quality of care during a standard survey.
Facility means a SNF or NF, or a distinct part SNF or NF, in accordance with §483.5 of this chapter.
Immediate family means husband or wife; natural or adoptive parent, child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild.

Immediate jeopardy means a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent.

Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

Noncompliance means any deficiency that causes a facility to not be in substantial compliance.

Nurse aide means an individual, as defined in §483.75(e)(1) of this chapter.

Nursing facility (NF) means a Medicaid nursing facility.

Paid feeding assistant means an individual who meets the requirements specified in §483.35(h)(2) of this chapter and who is paid to feed residents by a facility, or who is used under an arrangement with another agency or organization.

Partial extended survey means a survey that evaluates additional participation requirements subsequent to finding substandard quality of care during an abbreviated standard survey.

Skilled nursing facility (SNF) means a Medicare nursing facility.

Standard survey means a periodic, resident-centered inspection which gathers information about the quality of service furnished in a facility to determine compliance with the requirements for participation.

Substandard quality of care means one or more deficiencies related to participation requirements under §483.13, Resident behavior and facility practices, §483.15, Quality of life, or §483.25, Quality of care of this chapter, which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

Validation survey means a survey conducted by the Secretary within 2 months following a standard survey, abbreviated standard survey, partial extended survey, or extended survey for the purpose of monitoring State survey agency performance.

§488.303 State plan requirement.

(a) A State plan must provide that the requirements of this subpart and subpart F of this part are met, to the extent that those requirements apply to the Medicaid program.

(b) A State may establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to Medicaid residents. For purposes of section 1903(a)(7) of the Social Security Act, proper expenses incurred by a State in carrying out such a program are considered to be expenses necessary for the proper and efficient administration of the State plan.

(c) A State must conduct periodic educational programs for the staff and residents (and their representatives) of NFs in order to present current regulations, procedures, and policies under this subpart and subpart F of this part.

(d) Required remedies for a non-State operated NF. A State must establish, in addition to termination of the provider agreement, the following remedies or an approved alternative to the following remedies for imposition against a non-State operated NF:

(1) Temporary management.

(2) Denial of payment for new admissions.

(3) Civil money penalties.

(4) Transfer of residents.

(5) Closure of the facility and transfer of residents.

(6) State monitoring.
(e) Optional remedies for a non-State operated NF. A State may establish the following remedies for imposition against a non-State operated NF:
   (1) Directed plan of correction.
   (2) Directed in-service training.
   (3) Alternative or additional State remedies.
   (f) Alternative or additional State remedies. If a State uses remedies that are in addition to those specified in paragraph (d) or (e) of this section, or alternative to those specified in paragraph (d) of this section (other than termination of participation), it must—
      (1) Specify those remedies in the State plan; and
      (2) Demonstrate to CMS's satisfaction that those alternative remedies are as effective in deterring noncompliance and correcting deficiencies as the remedies listed in paragraphs (d) and (e) of this section.

§ 488.305 Standard surveys.
   (a) For each SNF and NF, the State survey agency must conduct standard surveys that include all of the following:
      (1) A case-mix stratified sample of residents;
      (2) A survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment;
      (3) An audit of written plans of care and residents’ assessments to determine the accuracy of such assessments and the adequacy of such plans of care; and
      (4) A review of compliance with residents’ rights requirements set forth in sections 1819(c) and 1919(c) of the Act.
   (b) The State survey agency’s failure to follow the procedures set forth in this section will not invalidate otherwise legitimate determinations that a facility’s deficiencies exist.

§ 488.307 Unannounced surveys.
   (a) Basic rule. All standard surveys must be unannounced.

   (b) Review of survey agency’s scheduling and surveying procedures. (1) CMS reviews on an annual basis each State survey agency’s scheduling and surveying procedures and practices to ensure that survey agencies avoid giving notice of a survey through the scheduling procedures and the conduct of the surveys.
      (2) CMS takes corrective action in accordance with the nature and complexity of the problem when survey agencies are found to have notified a SNF or NF through their scheduling or procedural policies. Sanctions for inadequate survey performance are in accordance with § 488.320.
   (c) Civil money penalties. An individual who notifies a SNF or NF, or causes a SNF or NF to be notified, of the time or date on which a standard survey is scheduled to be conducted is subject to a Federal civil money penalty not to exceed $2,000 as adjusted annually under 45 CFR part 102.

§ 488.308 Survey frequency.
   (a) Basic period. The survey agency must conduct a standard survey of each SNF and NF not later than 15 months after the last day of the previous standard survey.
   (b) Statewide average interval. (1) The statewide average interval between standard surveys must be 12 months or less, computed in accordance with paragraph (d) of this section.
      (2) CMS takes corrective action in accordance with the nature of the State survey agency’s failure to ensure that the 12-month statewide average interval requirement is met. CMS’s corrective action is in accordance with § 488.320.
   (c) Other surveys. The survey agency may conduct a survey as frequently as necessary to—
      (1) Determine whether a facility complies with the participation requirements; and
      (2) Confirm that the facility has corrected deficiencies previously cited.
   (d) Computation of statewide average interval. The statewide average interval is computed at the end of each Federal fiscal year by comparing the last day of the most recent standard survey for
each participating facility to the last
day of each facility's previous standard
survey.
(e) Special surveys. (1) The survey
agency may conduct a standard or an
abbreviated standard survey to deter-
mine whether certain changes have
caused a decline in the quality of care
furnished by a SNF or a NF, within 60
days of a change in the following:
(i) Ownership;
(ii) Entity responsible for manage-
ment of a facility (management firm);
(iii) Nursing home administrator; or
(iv) Director of nursing;
(2) The survey agency must review
all complaint allegations and conduct
a standard or an abbreviated standard
survey to investigate complaints of
violations of requirements by SNFs
and NFs if its review of the allegation
concludes that—
(i) A deficiency in one or more of the
requirements may have occurred; and
(ii) Only a survey can determine
whether a deficiency or deficiencies
exist.
(3) The survey agency does not con-
duct a survey if the complaint raises
issues that are outside the purview of
Federal participation requirements.
§ 488.310 Extended survey.
(a) Purpose of survey. The purpose of
an extended survey is to identify the
policies and procedures that caused the
facility to furnish substandard quality
of care.
(b) Scope of extended survey. An ex-
tended survey includes all of the fol-
lowing:
(1) Review of a larger sample of resi-
dent assessments than the sample used
in a standard survey.
(2) Review of the staffing and in-serv-
ice training.
(3) If appropriate, examination of the
contracts with consultants.
(4) A review of the policies and proce-
dures related to the requirements for
which deficiencies exist.
(5) Investigation of any participation
requirement at the discretion of the
survey agency.
(c) Timing and basis for survey. The
survey agency must conduct an ex-
tended survey not later than 14 cal-
endar days after completion of a stand-
ard survey which found that the facil-
ity had furnished substandard quality
of care.
§ 488.312 Consistency of survey re-
results.
CMS does and the survey agency
must implement programs to measure
accuracy and improve consistency in
the application of survey results and
enforcement remedies.
§ 488.314 Survey teams.
(a) Team composition. (1) Surveys
must be conducted by an interdiscipli-
ary team of professionals, which must
include a registered nurse.
(2) Examples of professionals include,
but are not limited to, physicians, phy-
sician assistants, nurse practitioners,
physical, speech, or occupational
therapists, registered professional
nurses, dieticians, sanitarians, engi-
neers, licensed practical nurses, or so-
cial workers.
(3) The State determines what con-
stitutes a professional, subject to CMS
approval.
(4) Any of the following cir-
cumstances disqualifies a surveyor for
surveying a particular facility:
(i) The surveyor currently works, or,
within the past two years, has worked
as an employee, as employment agency
staff at the facility, or as an officer,
consultant, or agent for the facility to
be surveyed.
(ii) The surveyor has any financial
interest or any ownership interest in
the facility.
(iii) The surveyor has an immediate
family member who has a relationship
with a facility described in paragraphs
(a)(4)(i) or paragraph (a)(4)(ii) of this
section.
(iv) The surveyor has an immediate
family member who is a resident in the
facility to be surveyed. For purposes of
this section, an immediate family
member is defined at §488.301 of this
part.
(b) CMS training. CMS provides com-
prehensive training to surveyors, in-
cluding at least the following:
(1) Application and interpretation of
regulations for SNFs and NFs.
(2) Techniques and survey procedures
for conducting standard and extended
surveys.
(3) Techniques for auditing resident assessments and plans of care.

(c) Required surveyor training. (1) Except as specified in paragraph (c)(3) of this section, the survey agency may not permit an individual to serve as a member of a survey team unless the individual has successfully completed a training and testing program prescribed by the Secretary.

(2) The survey agency must have a mechanism to identify and respond to in-service training needs of the surveyors.

(3) The survey agency may permit an individual who has not completed a training program to participate in a survey as a trainee if accompanied onsite by a surveyor who has successfully completed the required training and testing program.

[59 FR 56238, Nov. 10, 1994; 60 FR 50118, Sept. 28, 1995]

§ 488.318 Inadequate survey performance.

(a) CMS considers survey performance to be inadequate if the State survey agency—

(1) Indicates a pattern of failure to—

(i) Identify deficiencies and the failure cannot be explained by changed conditions in the facility or other case specific factors;

(ii) Cite only valid deficiencies;

(iii) Conduct surveys in accordance with the requirements of this subpart; or

(iv) Use Federal standards, protocols, and the forms, methods and procedures specified by CMS in manual instructions; or

(2) Fails to identify an immediate jeopardy situation.

(b) Inadequate survey performance does not—

(1) Relieve a SNF or NP of its obligation to meet all requirements for program participation; or

(2) Invalidate adequately documented deficiencies.

§ 488.320 Sanctions for inadequate survey performance.

(a) Annual assessment of survey performance. CMS assesses the performance of the State’s survey and certification program annually.

(b) Sanctions for inadequate survey performance. When a State demonstrates inadequate survey performance, as specified in §488.318, CMS notifies the survey agency of the inadequacy and takes action in accordance with paragraphs (c) and (d) of this section.

(c) Medicaid facilities. (1) For a pattern of failure to identify deficiencies in Medicaid facilities, CMS—

(i) Reduces FFP, as specified in paragraph (e) of this section, and if appropriate;

(ii) Provides for training of survey teams.

(2) For other survey inadequacies in Medicaid facilities, CMS provides for training of survey teams.

(d) Medicare facilities. For all survey inadequacies in Medicare facilities, CMS—

(1) Requires that the State survey agency submit a plan of correction;

(2) Provides for training of survey teams;

(3) Provides technical assistance on scheduling and procedural policies;

(4) Provides CMS-directed scheduling; or

(5) Initiates action to terminate the agreement between the Secretary and the State under section 1864 of the Act, either in whole or in part.

(e) Reduction of FFP. In reducing FFP for inadequate survey performance, CMS uses the formula specified in section 1919(g)(3)(C) of the Act, that is 33 percent multiplied by a fraction—

(1) The numerator of which is equal to the total number of residents in the NFs that CMS found to be noncompliant during validation surveys for that quarter; and

(2) The denominator of which is equal to the total number of residents in the NFs in which CMS conducted validation surveys during that quarter.

(f) Appeal of FFP reduction. When a State is dissatisfied with CMS’s determination to reduce FFP, the State may appeal the determination to the Departmental Appeals Board, using the procedures specified in 45 CFR part 16.

§ 488.325 Disclosure of results of surveys and activities.

(a) Information which must be provided to the public. As provided in sections 1819(g)(5) and 1919(g)(5) of the Act, the
following information must be made available to the public, upon the public's request, by the State or CMS for all surveys and certifications of SNFs and NFs:

(1) Statements of deficiencies and providers' comments.

(2) A list of isolated deficiencies that constitute no actual harm, with the potential for minimal harm.

(3) Approved plans of correction.

(4) Statements that the facility did not submit an acceptable plan of correction or failed to comply with the conditions of imposed remedies.

(5) Final appeal results.

(6) Notice of termination of a facility.

(7) Medicare and Medicaid cost reports.

(8) Names of individuals with direct or indirect ownership interest in a SNF or NF, as defined in §420.201 of this chapter.

(9) Names of individuals with direct or indirect ownership interest in a SNF or NF, as defined in §420.201 of this chapter, who have been found guilty by a court of law of a criminal offense in violation of Medicare or Medicaid law.

(b) Charge to public for information. CMS and the State may charge the public for specified services with respect to requests for information in accordance with—

(1) Section 401.140 of this chapter, for Medicare; or

(2) State procedures, for Medicaid.

(c) How public can request information. The public may request information in accordance with disclosure procedures specified in 45 CFR part 5.

(d) When information must be disclosed. The disclosing agency must make available to the public, upon the public's request, information concerning all surveys and certifications of SNFs and NFs, including statements of deficiencies, separate listings of any isolated deficiencies that constitute no actual harm, with the potential for minimal harm, and plans of correction (which contain any provider response to the deficiency statement) within 14 calendar days after each item is made available to the facility.

(e) Procedures for responding to requests. The procedures and time periods for responding to requests are in accordance with—

(1) Section 401.136 of this chapter for documents maintained by CMS; and

(2) State procedures for documents maintained by the State.

(f) Information that must be provided to the State's long-term care ombudsman. The State must provide the State's long-term care ombudsman with the following:

(1) A statement of deficiencies reflecting facility noncompliance, including a separate list of isolated deficiencies that constitute no harm with the potential for minimal harm.

(2) Reports of adverse actions specified at §488.406 imposed on a facility.

(3) Written response by the provider.

(4) A provider's request for an appeal and the results of any appeal.

(g) Information which must be provided to State by a facility with substandard quality of care. (1) To provide for the notice to physicians required under sections 1819(g)(3)(C) and 1919(g)(5)(C) of the Act, not later than 10 working days after receiving a notice of substandard quality of care, a SNF or NF must provide the State with a list of—

(1) Each resident in the facility with respect to which such finding was made; and

(ii) The name and address of his or her attending physician.

(2) Failure to disclose the information timely will result in termination of participation or imposition of alternative remedies.

(h) Information the State must provide to attending physician and State board. Not later than 20 calendar days after a SNF or NF complies with paragraph (g) of this section, the State must provide written notice of the noncompliance to—

(1) The attending physician of each resident in the facility with respect to which a finding of substandard quality of care was made; and

(2) The State board responsible for licensing the facility's administrator.

(i) Access to information by State Medicaid fraud control unit. The State must provide access to any survey and certification information incidental to a SNF's or NF's participation in Medicare or Medicaid upon written request by the State Medicaid fraud control
§ 488.330 Certification of compliance or noncompliance.

(a) General rules—(1) Responsibility for certification. (i) The State survey agency surveys all facilities for compliance or noncompliance with requirements for long term care facilities. The survey by the State survey agency may be followed by a Federal validation survey.

(A) The State certifies the compliance or noncompliance of non-State operated NFs. Regardless of the State entity doing the certification, it is final, except in the case of a complaint or validation survey conducted by CMS, or CMS review of the State’s findings.

(B) CMS certifies the compliance or noncompliance of all State-operated facilities.

(C) The State survey agency certifies the compliance or noncompliance of a non-State operated SNF, subject to the approval of CMS.

(D) The State survey agency certifies compliance or noncompliance for a dually participating SNF/NF. In the case of a disagreement between CMS and the State survey agency, a finding of noncompliance takes precedence over that of compliance.

(ii) In the case of a validation survey, the Secretary’s determination as to the facility’s noncompliance is binding, and takes precedence over a certification of compliance resulting from the State survey.

(2) Basis for certification. (i) Certification by the State is based on the survey agency findings.

(ii) Certification by CMS is based on either the survey agency findings (in the case of State-operated facilities), or, in the case of a validation survey, on CMS’s own survey findings.

(b) Effect of certification. (1) Certification of compliance. A certification of compliance constitutes a determination that the facility is in substantial compliance and is eligible to participate in Medicaid as a NF, or in Medicare as a SNF, or in Medicare and Medicaid as a dually participating facility.

(2) Certification of noncompliance. A certification of noncompliance requires denial of participation for prospective providers and enforcement action for current providers in accordance with subpart F of this part. Enforcement action must include one of the following:

(i) Termination of any Medicare or Medicaid provider agreements that are in effect.

(ii) Application of alternative remedies instead of, or in addition to, termination procedures.

(c) Notice of certification of noncompliance and resulting action. The notice of certification of noncompliance is sent in accordance with the timeframes specified in §488.402(f), and resulting action is issued by CMS, except when the State is taking the action for a non-State operated NF.

(d) Content of notice of certification of noncompliance. The notice of certification of noncompliance is sent in accordance with the timeframes specified in §488.402(f) and includes information on all of the following:

(1) Nature of noncompliance.

(2) Any alternative remedies to be imposed under subpart F of this part.

(3) Any termination or denial of participation action to be taken under this part.

(4) The appeal rights available to the facility under this part.

(5) Timeframes to be met by the provider and certifying agency with regard to each of the enforcement actions or appeal procedures addressed in the notice.

(e) Appeals. (1) Notwithstanding any provision of State law, the State must impose remedies promptly on any provider of services participating in the Medicaid program—

(i) After promptly notifying the facility of the deficiencies and impending remedy or remedies; and

(ii) Except for civil money penalties, during any pending hearing that may be requested by the provider of services.

(2) CMS imposes remedies promptly on any provider of services participating in the Medicare or Medicaid program or any provider of services
§ 488.331 Informal dispute resolution.

(a) Opportunity to refute survey findings. (1) For non-Federal surveys, the State must offer a facility an informal opportunity, at the facility’s request, to dispute survey findings upon the facility’s receipt of the official statement of deficiencies.

(2) For Federal surveys, CMS offers a facility an informal opportunity, at the facility’s request, to dispute survey findings upon the facility’s receipt of the official statement of deficiencies.

(3) For SNFs, dually-participating SNF/NFs, and NF-only facilities that have civil money penalties imposed by CMS that will be placed in a CMS escrow account, CMS also offers the facility an opportunity for independent informal dispute resolution, subject to the terms of paragraphs (b), (c), and (d) of this section and of §488.431. The facility must request independent informal dispute resolution in writing within 10 days of receipt of CMS’s offer. However, a facility may not use the dispute resolution processes at both §§488.331 and 488.431 for the same deficiency citation arising from the same survey unless the informal dispute resolution process at §488.331 was completed prior to the imposition of the civil money penalty.

(b) (1) Failure of the State or CMS, as appropriate, to complete informal dispute resolution timely cannot delay the effective date of any enforcement action against the facility.

(2) A facility may not seek a delay of any enforcement action against it on the grounds that informal dispute resolution has not been completed before the effective date of the enforcement action.

(c) If a provider is subsequently successful, during the informal dispute resolution process, at demonstrating that deficiencies should not have been cited, the deficiencies are removed from the statement of deficiencies and any enforcement actions imposed solely as a result of those cited deficiencies are rescinded.
Centers for Medicare & Medicaid Services, HHS

§ 488.335  Action on complaints of resident neglect and abuse, and misappropriation of resident property.

(a) Investigation. (1) The State must review all allegations of resident neglect and abuse, and misappropriation of resident property and follow procedures specified in §488.332.

(2) If there is reason to believe, either through oral or written evidence that an individual used by a facility to provide services to residents could have abused or neglected a resident or misappropriated a resident’s property, the State must investigate the allegation.

(3) The State must have written procedures for the timely review and investigation of allegations of resident abuse and neglect, and misappropriation of resident property.

(b) Source of complaints. The State must review all allegations regardless of the source.

(c) Notification—(1) Individuals to be notified. If the State makes a preliminary determination, based on oral or written evidence and its investigation, that the abuse, neglect or misappropriation of property occurred, it must notify in writing—

(i) The individuals implicated in the investigation; and

(ii) The current administrator of the facility in which the incident occurred.

(2) Timing of the notice. The State must notify the individuals specified in paragraph (c)(1) of this section in writing within 10 working days of the State’s investigation.

(3) Contents of the notice. The notice must include the—

(i) Nature of the allegation(s);

(ii) Date and time of the occurrence;

(iii) Right to a hearing;

(iv) Intent to report the substantiated findings in writing, once the individual has had the opportunity for a hearing, to the nurse aide registry or appropriate licensure authority;

(v) Fact that the individual’s failure to request a hearing in writing within 30 days from the date of the notice will
result in reporting the substantiated findings to the nurse aide registry or appropriate licensure authority.

(vi) Consequences of waiving the right to a hearing;

(vii) Consequences of a finding through the hearing process that the alleged resident abuse or neglect, or misappropriation of resident property did occur; and

(viii) Fact that the individual has the right to be represented by an attorney at the individual's own expense.

(d) Conduct of hearing. (1) The State must complete the hearing and the hearing record within 120 days from the day it receives the request for a hearing.

(2) The State must hold the hearing at a reasonable place and time convenient for the individual.

(e) Factors beyond the individual's control. A State must not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

(f) Report of findings. If the finding is that the individual has neglected or abused a resident or misappropriated resident property or if the individual waives the right to a hearing, the State must report the findings in writing within 10 working days to—

(1) The individual;

(2) The current administrator of the facility in which the incident occurred; and

(3) The administrator of the facility that currently employs the individual, if different than the facility in which the incident occurred;

(4) The licensing authority for individuals used by the facility other than nurse aides, if applicable; and

(5) The nurse aide registry for nurse aides. Only the State survey agency may report the findings to the nurse aide registry, and this must be done within 10 working days of the findings, in accordance with §483.156(c) of this chapter. The State survey agency may not delegate this responsibility.

(g) Contents and retention of report of finding to the nurse aide registry. (1) The report of finding must include information in accordance with §483.156(c) of this chapter.

(2) The survey agency must retain the information as specified in paragraph (g)(1) of this section, in accordance with the procedures specified in §483.156(c) of this chapter.

(h) Survey agency responsibility. (1) The survey agency must promptly review the results of all complaint investigations and determine whether or not a facility has violated any requirements in part 483, subpart B of this chapter.

(2) If a facility is not in substantial compliance with the requirements in part 483, subpart B of this chapter, the survey agency initiates appropriate actions, as specified in subpart F of this part.

[59 FR 56238, Nov. 10, 1994; 60 FR 50118, Sept. 28, 1995]

Subpart F—Enforcement of Compliance for Long-Term Care Facilities with Deficiencies

§ 488.400 Statutory basis.

Sections 1819(h) and 1919(h) of the Act specify remedies that may be used by the Secretary or the State respectively when a SNF or a NF is not in substantial compliance with the requirements for participation in the Medicare and Medicaid programs. These sections also provide for ensuring prompt compliance and specify that these remedies are in addition to any other available under State or Federal law, and, except, for civil money penalties imposed on NFs-only by the State, are imposed prior to the conduct of a hearing.

[76 FR 15126, Mar. 18, 2011]

§ 488.401 Definitions.

As used in this subpart—

New admission means a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date. Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor subject to the denial of payment.
Plan of correction means a plan developed by the facility and approved by CMS or the survey agency that describes the actions the facility will take to correct deficiencies and specifies the date by which those deficiencies will be corrected.  

[59 FR 56243, Nov. 10, 1994; 60 FR 50118, Sept. 28, 1995]

§ 488.402 General provisions.

(a) Purpose of remedies. The purpose of remedies is to ensure prompt compliance with program requirements.  

(b) Basis for imposition and duration of remedies. When CMS or the State chooses to apply one or more remedies specified in § 488.406, the remedies are applied on the basis of noncompliance found during surveys conducted by CMS or by the survey agency.

(c) Number of remedies. CMS or the State may apply one or more remedies for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance.

(d) Plan of correction requirement. (1) Except as specified in paragraph (d)(2) of this section, regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements must submit a plan of correction for approval by CMS or the survey agency.  

(2) Isolated deficiencies. A facility is not required to submit a plan of correction when it has deficiencies that are isolated and have a potential for minimal harm, but no actual harm has occurred.

(e) Disagreement regarding remedies. If the State and CMS disagree on the decision to impose a remedy, the disagreement is resolved in accordance with § 488.432.

(f) Notification requirements—(1) Except when the State is taking action against a non-State operated NF, CMS or the State (as authorized by CMS) gives the provider notice of the remedy, including the—  

(i) Nature of the noncompliance;  

(ii) Which remedy is imposed;  

(iii) Effective date of the remedy; and  

(iv) Right to appeal the determination leading to the remedy.  

(2) When a State is taking action against a non-State operated NF, the State’s notice must include the same information required by CMS in paragraph (f)(1) of this section.  

(3) Immediate jeopardy—2 day notice. Except for civil money penalties and State monitoring imposed when there is immediate jeopardy, the notice must be given at least 2 calendar days before the effective date of the enforcement action.

(4) No immediate jeopardy—15 day notice. Except for civil money penalties and State monitoring, notice must be given at least 15 calendar days before the effective date of the enforcement action in situations in which there is no immediate jeopardy.

(5) Date of enforcement action. The 2- and 15-day notice periods begin when the facility receives the notice.

(6) Civil money penalties. For civil money penalties, the notices must be given in accordance with the provisions of §§ 488.434 and 488.440.

(7) State monitoring. For State monitoring, no prior notice is required.  

[59 FR 56243, Nov. 10, 1994; 60 FR 50118, Sept. 28, 1995, as amended at 64 FR 13360, Mar. 18, 1999]

§ 488.404 Factors to be considered in selecting remedies.

(a) Initial assessment. In order to select the appropriate remedy, if any, to apply to a facility with deficiencies, CMS and the State determine the seriousness of the deficiencies.

(b) Determining seriousness of deficiencies. To determine the seriousness of the deficiency, CMS considers and the State must consider at least the following factors:

(1) Whether a facility’s deficiencies constitute—  

(i) No actual harm with a potential for minimal harm;  

(ii) No actual harm with a potential for more than minimal harm, but not immediate jeopardy;  

(iii) Actual harm that is not immediate jeopardy; or  

(iv) Immediate jeopardy to resident health or safety.  

(2) Whether the deficiencies—  

(i) Are isolated;  

(ii) Constitute a pattern; or  

(iii) Are widespread.


§ 488.406 Available remedies.

(a) General. In addition to the remedy of termination of the provider agreement, the following remedies are available:

(1) Temporary management.
(2) Denial of payment including—
   (i) Denial of payment for all individuals, imposed by CMS, to—
      (A) Skilled nursing facility, for Medicare;
      (B) State, for Medicaid; or
   (ii) Denial of payment for all new admissions.
(3) Civil money penalties.
(4) State monitoring.
(5) Transfer of residents.
(6) Closure of the facility and transfer of residents.
(7) Directed plan of correction.
(8) Directed in-service training.
(9) Alternative or additional State remedies approved by CMS.

(b) Remedies that must be established. At a minimum, and in addition to termination of the provider agreement, the State must establish the following remedies or approved alternatives to the following remedies:

(1) Temporary management.
(2) Denial of payment for new admissions.
(3) Civil money penalties.
(4) Transfer of residents.
(5) Closure of the facility and transfer of residents.

(c) State plan requirement. If a State wishes to use remedies for noncompliance that are either additional or alternative to those specified in paragraphs (a) or (b) of this section, it must—

(1) Specify those remedies in the State plan; and
(2) Demonstrate to CMS’s satisfaction that those remedies are as effective as the remedies listed in paragraph (a) of this section, for deterring noncompliance and correcting deficiencies.

(d) State remedies in dually participating facilities. If the State’s remedy is unique to the State plan and has been approved by CMS, then that remedy, as imposed by the State under its Medicaid authority, may be imposed by CMS against the Medicare provider agreement of a dually participating facility.

[59 FR 56243, Nov. 10, 1994; 60 FR 50118, Sept. 28, 1995]

§ 488.408 Selection of remedies.

(a) Categories of remedies. In this section, the remedies specified in § 488.406(a) are grouped into categories and applied to deficiencies according to how serious the noncompliance is.

(b) Application of remedies. After considering the factors specified in § 488.404, as applicable, if CMS and the State choose to impose remedies, as provided in paragraphs (c)(1), (d)(1) and (e)(1) of this section, for facility noncompliance, instead of, or in addition to, termination of the provider agreement, CMS does or the State must follow the criteria set forth in paragraphs (c)(2), (d)(2), and (e)(2) of this section, as applicable.

(c) Category 1. (1) Category 1 remedies include the following:

   (i) Directed plan of correction.
   (ii) State monitoring.
   (iii) Directed in-service training.

(2) CMS does or the State must apply one or more of the remedies in Category 1 when there—

   (i) Are isolated deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
   (ii) Is a pattern of deficiencies that constitutes no actual harm with a potential for more than minimal harm but not immediate jeopardy.

(3) Except when the facility is in substantial compliance, CMS or the State may apply one or more of the remedies in Category 1 to any deficiency.

(d) Category 2. (1) Category 2 remedies include the following:

   (i) Denial of payment for new admissions.
(ii) Denial of payment for all individuals imposed only by CMS.

(iii) Civil money penalties of $50–3,000 as adjusted annually under 45 CFR part 102 per day.

(iv) Civil money penalty of $1,000–$10,000 as adjusted annually under 45 CFR part 102 per instance of noncompliance.

(2) CMS applies one or more of the remedies in Category 2, or, except for denial of payment for all individuals, the State must apply one or more of the remedies in Category 2 when there are—

(i) Widespread deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or

(ii) One or more deficiencies that constitute actual harm that is not immediate jeopardy.

(3) CMS or the State may apply one or more of the remedies in Category 2 to any deficiency except when—

(i) The facility is in substantial compliance; or

(ii) CMS or the State imposes a civil money penalty for a deficiency that constitutes immediate jeopardy, the penalty must be in the upper range of penalty amounts, as specified in §488.438(a).

(e) Category 3. (1) Category 3 remedies include the following:

(i) Temporary management.

(ii) Immediate termination.

(iii) Civil money penalties of $3,050–$10,000 as adjusted annually under 45 CFR part 102 per day.

(iv) Civil money penalty of $1,000–$10,000 as adjusted annually under 45 CFR part 102 per instance of noncompliance.

(2) When there are one or more deficiencies that constitute immediate jeopardy to resident health or safety—

(i) CMS does and the State must do one or both of the following:

(A) Impose temporary management; or

(B) Terminate the provider agreement;

(ii) CMS and the State may impose a civil money penalty of $3,050–$10,000 as adjusted annually under 45 CFR part 102 per day or $1,000–$10,000 as adjusted annually under 45 CFR part 102 per instance of noncompliance, in addition to imposing the remedies specified in paragraph (e)(2)(i) of this section.

(3) When there are widespread deficiencies that constitute actual harm that is not immediate jeopardy, CMS and the State may impose temporary management, in addition to Category 2 remedies.

(f) Plan of correction. (1) Except as specified in paragraph (f)(2) of this section, each facility that has a deficiency with regard to a requirement for long term care facilities must submit a plan of correction for approval by CMS or the State, regardless of—

(i) Which remedies are imposed; or

(ii) The seriousness of the deficiencies.

(2) When there are only isolated deficiencies that CMS or the State determines constitute no actual harm with a potential for minimal harm, the facility need not submit a plan of correction.

(g) Appeal of a certification of noncompliance. (1) A facility may appeal a certification of noncompliance leading to an enforcement remedy.

(2) A facility may not appeal the choice of remedy, including the factors considered by CMS or the State in selecting the remedy, specified in §488.404.

§488.410 Action when there is immediate jeopardy.

(a) If there is immediate jeopardy to resident health or safety, the State must (and CMS does) either terminate the provider agreement within 23 calendar days of the last date of the survey or appoint a temporary manager to remove the immediate jeopardy. The rules for appointment of a temporary manager in an immediate jeopardy situation are as follows:

(1) CMS does and the State must notify the facility that a temporary manager is being appointed.

(2) If the facility fails to relinquish control to the temporary manager, CMS does and the State must terminate the provider agreement within 23 calendar days of the last day of the survey, if the immediate jeopardy is not removed. In these cases, State
monitoring may be imposed pending termination.

(3) If the facility relinquishes control to the temporary manager, the State must (and CMS does) notify the facility that, unless it removes the immediate jeopardy, its provider agreement will be terminated within 23 calendar days of the last day of the survey.

(4) CMS does and the State must terminate the provider agreement within 23 calendar days of the last day of survey if the immediate jeopardy has not been removed.

(b) CMS or the State may also impose other remedies, as appropriate.

(c)(1) In a NF or dually participating facility, if either CMS or the State finds that a facility’s noncompliance poses immediate jeopardy to resident health or safety, CMS or the State must notify the other of such a finding.

(2) CMS will or the State must do one or both of the following:

(i) Take immediate action to remove the jeopardy and correct the noncompliance through temporary management.

(ii) Terminate the facility’s participation under the State plan. If this is done, CMS will also terminate the facility’s participation in Medicare if it is a dually participating facility.

(d) The State must provide for the safe and orderly transfer of residents when the facility is terminated.

(e) If the immediate jeopardy is also substandard quality of care, the State survey agency must notify the facility administrator of the finding of substandard quality of care, as specified in §488.325(h).

§488.414 Action when there is repeated substandard quality of care.

(a) General. If a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys, as defined in §488.305, regardless of other remedies provided—

(1) CMS imposes denial of payment for all new admissions, as specified in §488.417, or denial of all payments, as specified in §488.418;

(2) The State must impose denial of payment for all new admissions, as specified in §488.417; and

(3) CMS does and the State survey agency must impose State monitoring, as specified in §488.422, until the facility has demonstrated to the satisfaction of CMS or the State, that it is in substantial compliance with all requirements and will remain in substantial compliance with all requirements.
(b) Repeated noncompliance. For purposes of this section, repeated noncompliance is based on the repeated finding of substandard quality of care and not on the basis that the substance of the deficiency or the exact tag number for the deficiency was repeated.

(c) Standard surveys to which this provision applies. Standard surveys completed by the State survey agency on or after October 1, 1990, are used to determine whether the threshold of three consecutive standard surveys is met.

(d) Program participation. (1) The determination that a certified facility has repeated instances of substandard quality of care is made without regard to any variances in the facility’s program participation (that is, any standard survey completed for Medicare, Medicaid or both programs will be considered).

(2) Termination would allow the count of repeated substandard quality of care surveys to start over.

(3) Change of ownership. (i) A facility may not avoid a remedy on the basis that it underwent a change of ownership.

(ii) In a facility that has undergone a change of ownership, CMS does not and the State may not restart the count of repeated substandard quality of care surveys unless the new owner can demonstrate to the satisfaction of CMS or the State that the poor past performance no longer is a factor due to the change in ownership.

(e) Facility alleges corrections or achieves compliance after repeated substandard quality of care is identified. (1) If a penalty is imposed for repeated substandard quality of care, it will continue until the facility has demonstrated to the satisfaction of CMS or the State that it is in substantial compliance with the requirements and that it will remain in substantial compliance with the requirements for a period of time specified by CMS or the State.

(2) A facility will not avoid the imposition of remedies or the obligation to demonstrate that it will remain in compliance when it—

(i) Alleges correction of the deficiencies cited in the most recent standard survey; or

(ii) Achieves compliance before the effective date of the remedies.

§ 488.415 Temporary management.

(a) Definition. Temporary management means the temporary appointment by CMS or the State of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility’s operation.

(b) Qualifications. The temporary manager must—

(1) Be qualified to oversee correction of deficiencies on the basis of experience and education, as determined by the State;

(2) Not have been found guilty of misconduct by any licensing board or professional society in any State;

(3) Have, or a member of his or her immediate family have, no financial ownership interest in the facility; and

(4) Not currently serve or, within the past 2 years, have served as a member of the staff of the facility.

(c) Payment of salary. The temporary manager’s salary—

(1) Is paid directly by the facility while the temporary manager is assigned to that facility; and

(2) Must be at least equivalent to the sum of the following—

(i) The prevailing salary paid by providers for positions of this type in what the State considers to be the facility’s geographic area;

(ii) Additional costs that would have reasonably been incurred by the provider if such person had been in an employment relationship; and

(iii) Any other costs incurred by such a person in furnishing services under such an arrangement or as otherwise set by the State.

(3) May exceed the amount specified in paragraph (c)(2) of this section if the State is otherwise unable to attract a qualified temporary manager.

(d) Failure to relinquish authority to temporary management—(1) Termination of provider agreement. If a facility fails to relinquish authority to the temporary manager as described in this section, CMS will or the State must terminate the provider agreement in accordance with § 488.456.

(2) Failure to pay salary of temporary manager. A facility’s failure to pay the
salary of the temporary manager is considered a failure to relinquish authority to temporary management.

(e) Duration of temporary management. Temporary management ends when the facility meets any of the conditions specified in §488.454(c).

§488.417 Denial of payment for all new admissions.

(a) Optional denial of payment. Except as specified in paragraph (b) of this section, CMS or the State may deny payment for all new admissions when a facility is not in substantial compliance with the requirements, as defined in §488.401, as follows:

(1) Medicare facilities. In the case of Medicare facilities, CMS may deny payment to the facility.

(2) Medicaid facilities. In the case of Medicaid facilities—

(i) The State may deny payment to the facility; and

(ii) CMS may deny payment to the State for all new Medicaid admissions to the facility.

(b) Required denial of payment. CMS does or the State must deny payment for all new admissions when—

(1) The facility is not in substantial compliance, as defined in §488.401, 3 months after the last day of the survey identifying the noncompliance; or

(2) The State survey agency has cited a facility with substandard quality of care on the last three consecutive standard surveys.

(c) Resumption of payments: Repeated instances of substandard quality of care. When a facility has repeated instances of substandard quality of care, payments to the facility or, under Medicaid, CMS payments to the State on behalf of the facility, resume prospectively on the date that the facility achieves substantial compliance, as indicated by a revisit or written credible evidence acceptable to CMS (under Medicare) or the State (under Medicaid).

(d) Resumption of payments: No repeated instances of substandard quality of care. When a facility does not have repeated instances of substandard quality of care, payments to the facility or, under Medicaid, CMS payments to the State on behalf of the facility, resume prospectively on the date that the facility achieves substantial compliance, as indicated by a revisit or written credible evidence acceptable to CMS (under Medicare) or the State (under Medicaid).

(e) Restriction. No payments to a facility or, under Medicaid, CMS payments to the State on behalf of the facility, are made for the period between the date that the—

(1) Denial of payment remedy is imposed; and

(2) Facility achieves substantial compliance, as determined by CMS or the State.

§488.418 Secretarial authority to deny all payments.

(a) CMS option to deny all payment. If a facility has not met a requirement, in addition to the authority to deny payment for all new admissions as specified in §488.417, CMS may deny any further payment for all Medicare residents in the facility and to the State for all Medicaid residents in the facility.

(b) Prospective resumption of payment. Except as provided in paragraphs (d) and (e) of this section, if the facility achieves substantial compliance, CMS resumes payment prospectively from the date that it verifies as the date that the facility achieved substantial compliance.

(c) Restriction on payment after denial of payment is imposed. If payment to the facility or to the State resumes after denial of payment for all residents, no payment is made for the period between the date that—

(1) Denial of payment was imposed; and

(2) CMS verifies as the date that the facility achieved substantial compliance.
§ 488.426 Retroactive resumption of payment.

Except when a facility has repeated instances of substandard quality of care, as specified in paragraph (e) of this section, when CMS or the State finds that the facility was in substantial compliance before the date of the revisit, or before CMS or the survey agency received credible evidence of such compliance, payment is resumed on the date that substantial compliance was achieved, as determined by CMS.

(e) Resumption of payment—repeated instances of substandard care. When CMS denies payment for all Medicare residents for repeated instances of substandard quality of care, payment is resumed when—

(1) The facility achieved substantial compliance, as indicated by a revisit or written credible evidence acceptable to CMS; and

(2) CMS believes that the facility will remain in substantial compliance.

§ 488.422 State monitoring.

(a) A State monitor—

(1) Oversees the correction of deficiencies specified by CMS or the State survey agency at the facility site and protects the facility’s residents from harm;

(2) Is an employee or a contractor of the survey agency;

(3) Is identified by the State as an appropriate professional to monitor cited deficiencies;

(4) Is not an employee of the facility;

(5) Does not function as a consultant to the facility; and

(6) Does not have an immediate family member who is a resident of the facility to be monitored.

(b) A State monitor must be used when a survey agency has cited a facility with substandard quality of care deficiencies on the last 3 consecutive standard surveys.

(c) State monitoring is discontinued when—

(1) The facility has demonstrated that it is in substantial compliance with the requirements, and, if imposed for repeated instances of substandard quality of care, will remain in compliance for a period of time specified by CMS or the State; or

(2) Termination procedures are completed.

[59 FR 56243, Nov. 10, 1994; 60 FR 50119, Sept. 28, 1995]

§ 488.424 Directed plan of correction.

CMS, the State survey agency, or the temporary manager (with CMS or State approval) may develop a plan of correction and CMS, the State, or the temporary manager require a facility to take action within specified time-frames.

§ 488.425 Directed inservice training.

(a) Required training. CMS or the State agency may require the staff of a facility to attend an inservice training program if—

(1) The facility has a pattern of deficiencies that indicate noncompliance; and

(2) Education is likely to correct the deficiencies.

(b) Action following training. After the staff has received inservice training, if the facility has not achieved substantial compliance, CMS or the State may impose one or more other remedies specified in §488.406.

(c) Payment. The facility pays for directed inservice training.

[59 FR 56243, Nov. 10, 1994; 60 FR 50119, Sept. 28, 1995]

§ 488.426 Transfer of residents, or closure of the facility and transfer of residents.

(a) Transfer of residents, or closure of the facility and transfer of residents in an emergency. In an emergency, the State has the authority to—

(1) Transfer Medicaid and Medicare residents to another facility; or

(2) Close the facility and transfer the Medicaid and Medicare residents to another facility.

(b) Required transfer when a facility’s provider agreement is terminated. When the State or CMS terminates a facility’s provider agreement, the State will arrange for the safe and orderly transfer of all Medicare and Medicaid residents to another facility, in accordance with §483.75(r) of this chapter.

(c) Required notifications when a facility’s provider agreement is terminated. When the State or CMS terminates a
facility’s provider agreement, CMS determines the appropriate date for notification, in accordance with §483.75(r)(1)(ii) of this chapter.


§488.430 Civil money penalties: Basis for imposing penalty.

(a) CMS or the State may impose a civil money penalty for either the number of days a facility is not in substantial compliance with one or more participation requirements or for each instance that a facility is not in substantial compliance, regardless of whether or not the deficiencies constitute immediate jeopardy.

(b) CMS or the State may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

59 FR 56243, Nov. 10, 1994, as amended at 64 FR 13360, Mar. 18, 1999

§488.431 Civil money penalties imposed by CMS and independent informal dispute resolution: for SNFS, dually-participating SNF/NFs, and NF-only facilities.

(a) Opportunity for independent review.

CMS retains ultimate authority for the survey findings and imposition of civil money penalties, but provides an opportunity for independent informal dispute resolution within 30 days of notice of imposition of a civil money penalty that will be placed in escrow in accordance with paragraph (b) of this section. An independent informal dispute resolution will—

(i) Be completed within 60 days of facility’s request if an independent informal dispute resolution is timely requested by the facility.

(ii) Generate a written record prior to the collection of the penalty.

(iii) Include notification to an involved resident or resident representative, as well as the State’s long term care ombudsman, to provide opportunity for written comment.

(iv) Be approved by CMS and conducted by the State under section 1864 of the Act, or by an entity approved by the State and CMS, or by CMS or its agent in the case of surveys conducted only by federal surveyors where the State independent dispute resolution process is not used, and which has no conflict of interest, such as:

(i) A component of an umbrella State agency provided that the component is organizationally separate from the State survey agency.

(ii) An independent entity with a specific understanding of Medicare and Medicaid program requirements selected by the State and approved by CMS.

(b) Collection and placement in escrow account. (1) For both per day and per instance civil money penalties, CMS may collect and place the imposed civil money penalties in an escrow account on whichever of the following occurs first:

(i) The date on which the independent informal dispute resolution process is completed under paragraph (a) of this section.

(ii) The date that is 90 days after the date of the notice of imposition of the penalty.

(2) For collection and placement in escrow accounts of per day civil money penalties, CMS may collect the portion of the per day civil money penalty that has accrued up to the time of collection as specified in paragraph (b)(1) of this section. CMS may make additional collections periodically until the full amount is collected, except that the full balance must be collected once the facility achieves substantial compliance or is terminated from the program and CMS determines the final amount of the civil money penalty imposed.

(3) CMS may provide for an escrow payment schedule that differs from the collection times of paragraph (1) of this subsection in any case in which CMS determines that more time is necessary for deposit of the total civil money penalty into an escrow account, not to
exceed 12 months, if CMS finds that immediate payment would create substantial and undue financial hardship on the facility.

(4) If the full civil money penalty is not placed in an escrow account within 30 calendar days from the date the provider receives notice of collection, or within 30 calendar days of any due date established pursuant to a hardship finding under paragraph (b)(3), CMS may deduct the amount of the civil money penalty from any sum then or later owed by CMS or the State to the facility in accordance with §488.442(c).

(5) For any civil money penalties that are not collected and placed into an escrow account under this section, CMS will collect such civil money penalties in the same manner as the State in accordance with §488.432.

(c) Maintenance of escrowed funds. CMS will maintain collected civil money penalties in an escrow account pending the resolution of any administrative appeal of the deficiency findings that comprise the basis for the civil monetary penalty imposition. CMS will retain the escrowed funds on an on-going basis and, upon a final administrative decision that upholds the State’s determination of noncompliance after the facility achieves substantial compliance or is terminated, will periodically disburse the funds to States or other entities in accordance with §488.432.

(d) When a facility requests a hearing. (1) A facility must request a hearing on the determination of the noncompliance that is the basis for imposition of the civil money penalty as specified in §498.40 of this chapter.

(2) If the administrative law judge reverses deficiency findings that comprise the basis of a civil money penalty in whole or in part, the escrowed amounts continue to be held pending expiration of the time for CMS to appeal the decision or, where CMS does appeal, a Departmental Appeals Board decision affirming the reversal of the pertinent deficiency findings. Any collected civil money penalty amount owed to the facility based on a final administrative decision will be returned to the facility with applicable interest as specified in section 1878(f)(2) of the Act.

§488.432 Civil money penalties imposed by the State: NF-only.

(a) When a facility requests a hearing. (1) When the State imposes a civil money penalty against a non-State operated NF that is not subject to imposition of remedies by CMS, the facility must request a hearing on the determination of noncompliance that is the basis for imposition of the civil money penalty within the time specified in §431.153 of this chapter.

(2)(i) If a facility requests a hearing within the time frame specified in paragraph (a)(1) of this section, for a civil money penalty imposed per day, the State initiates collection of the penalty when there is a final administrative decision that upholds the pertinent deficiency findings. Any collected civil money penalty amount owed to the facility based on a final administrative decision will be returned to the facility with applicable interest as specified in section 1878(f)(2) of the Act.

(ii) If a facility requests a hearing for a civil money penalty imposed per instance of noncompliance within the time specified in paragraph (a)(1) of this section, the State initiates collection of the penalty when there is a final administrative decision that upholds the State’s determination of noncompliance.

(b) When a facility does not request a hearing for a civil money penalty imposed per day. (1) If a facility does not request a hearing in accordance with paragraph (a) of this section, the State initiates collection of the penalty when the facility—

(i) Achieves substantial compliance; or

(ii) Is terminated.

(2) When a facility does not request a hearing for a civil money penalty imposed per instance of noncompliance. If a facility does not request a hearing in accordance with paragraph (a) of this section, the State initiates collection of the penalty when the time frame for requesting a hearing expires.

(c) When a facility waives a hearing. (1) If a facility waives, in writing, its right to a hearing as specified in
§ 488.433 Civil money penalties: Uses and approval of civil money penalties imposed by CMS.

(a) Ten percent of the collected civil money penalty funds that are required to be held in escrow pursuant to § 488.431 and that remain after a final administrative decision will be deposited with the Department of the Treasury in accordance with § 488.442(f). The remaining ninety percent of the collected civil money penalty funds that are required to be held in escrow pursuant to § 488.431 and that remain after a final administrative decision must be used entirely for activities that protect or improve the quality of care or quality of life for residents consistent with paragraph (b) of this section and may not be used for survey and certification operations or State expenses, except that reasonable expenses necessary to administer, monitor, or evaluate the effectiveness of projects utilizing civil money penalty funds may be permitted.

(b) All activities and plans for utilizing civil money penalty funds, including any expense used to administer grants utilizing civil money penalty funds, must be approved in advance by CMS and may include, but are not limited to:

(1) Support and protection of residents of a facility that closes (voluntarily or involuntarily).

(2) Time-limited expenses incurred in the process of relocating residents to home and community-based settings or another facility when a facility is closed (voluntarily or involuntarily) or downsized pursuant to an agreement with the State Medicaid agency.

(3) Projects that support resident and family councils and other consumer involvement in assuring quality care in facilities.

(4) Facility improvement initiatives, such as joint training of facility staff and surveyors or technical assistance for facilities implementing quality assurance and performance improvement programs.

(5) Development and maintenance of temporary management or receivership capability such as but not limited to, recruitment, training, retention or other system infrastructure expenses. However, as specified in § 488.415(c), a temporary manager’s salary must be paid by the facility. In rare situations, if the facility is closing, CMS plans to stop or suspend continued payments to the facility under § 489.55 of this chapter during the temporary manager’s duty period, and CMS determines that extraordinary action is necessary to protect the residents until relocation efforts are successful, civil money penalty funds may be used to pay the manager’s salary.

(c) At a minimum, proposed activities submitted to CMS for prior approval must include a description of the intended outcomes, deliverables, and sustainability; and a description of the methods by which the activity results will be assessed, including specific measures.

(d) Civil money penalty funds may not be used for activities that have been disapproved by CMS.

(1) Solicit, accept, monitor, and track projects utilizing civil money penalty funds including any funds used for state administration.
(2) Make information about the use of civil money penalty funds publicly available, including about the dollar amount awarded for approved projects, the grantee or contract recipients, the results of projects, and other key information.

(3) Ensure that:
(i) A core amount of civil money penalty funds will be held in reserve for emergencies, such as relocation of residents pursuant to an involuntary termination from Medicare and Medicaid.
(ii) A reasonable amount of funds, beyond those held in reserve under paragraph (e)(3)(i) of this section, will be awarded or contracted each year for the purposes specified in this section.

(f) If CMS finds that a State has not spent civil money penalty funds in accordance with this section, or fails to make use of funds to benefit the quality of care or life of residents, or fails to maintain an acceptable plan for the use of funds that is approved by CMS, then CMS may withhold future disbursements of civil money penalty funds to the State until the State has submitted an acceptable plan to comply with this section.

[79 FR 45658, Aug. 5, 2014]

§ 488.434 Civil money penalties: Notice of penalty.

(a) CMS notice of penalty. (1) CMS sends a written notice of the penalty to the facility for all facilities except non-State operated NFs when the State is imposing the penalty.

(2) Content of notice. The notice that CMS sends includes—
(i) The nature of the noncompliance;
(ii) The statutory basis for the penalty;
(iii) The amount of penalty per day of noncompliance or the amount of the penalty per instance of noncompliance;
(iv) Any factors specified in §488.438(f) that were considered when determining the amount of the penalty;
(v) The date of the instance of noncompliance or the date on which the penalty begins to accrue;
(vi) When the penalty stops accruing, if applicable;
(vii) When the penalty is collected; and
(viii) Instructions for responding to the notice, including a statement of the facility’s right to a hearing, and the implication of waiving a hearing, as provided in §488.436.

(b) State notice of penalty. (1) The State must notify the facility in accordance with State procedures for all non-State operated NFs when the State takes the action.

(2) The State’s notice must—
(i) Be in writing; and
(ii) Include, at a minimum, the information specified in paragraph (a)(2) of this section.

[59 FR 56243, Nov. 10, 1994; 60 FR 50119, Sept. 28, 1995, as amended at 64 FR 13360, Mar. 18, 1999]

§ 488.436 Civil money penalties: Waiver of hearing, reduction of penalty amount.

(a) Waiver of a hearing. The facility may waive the right to a hearing, in writing, within 60 days from the date of the notice imposing the civil money penalty.

(b) Reduction of penalty amount. (1) If the facility waives its right to a hearing in accordance with the procedures specified in paragraph (a) of this section, CMS or the State reduces the civil money penalty by 35 percent, as long as the civil money penalty has not also been reduced by 50 percent under §488.438.

(2) If the facility does not waive its right to a hearing in accordance with the procedures specified in paragraph (a) of this section, the civil money penalty is not reduced by 35 percent.


§ 488.438 Civil money penalties: Amount of penalty.

(a) Amount of penalty. (1) The penalties are within the following ranges, set at $50 increments:

(i) Upper range. Penalties in the range of $3,050—$10,000 as adjusted annually under 45 CFR part 102 per day are imposed for deficiencies constituting immediate jeopardy, and as specified in paragraph (d)(2) of this section.

(ii) Upper range. Penalties in the range of $50—$3,000 as adjusted annually
under 45 CFR part 102 per day are imposed for deficiencies that do not constitute immediate jeopardy, but either caused actual harm, or caused no actual harm, but have the potential for more than minimal harm.

(2) Per instance penalty. When penalties are imposed for an instance of noncompliance, the penalties will be in the range of $1,000-$10,000 as adjusted annually under 45 CFR part 102 per instance.

(b) Basis for penalty amount. The amount of penalty is based on CMS’s or the State’s assessment of factors listed in paragraph (f) of this section.

(c) Decreased penalty amounts. (1) Except as specified in paragraph (d)(2) of this section, if immediate jeopardy is removed, but the noncompliance continues, CMS or the State will shift the penalty amount imposed per day to the lower range.

(2) When CMS determines that a SNF, dually-participating SNF/NF, or NF-only facility subject to a civil money penalty imposed by CMS self-reports and promptly corrects the noncompliance for which the civil money penalty was imposed, CMS will reduce the amount of the penalty by 50 percent, provided that all of the following apply—

(i) The facility self-reported the noncompliance to CMS or the State before it was identified by CMS or the State and before it was reported to CMS or the State by means of a complaint lodged by a person other than an official representative of the nursing home;

(ii) Correction of the self-reported noncompliance occurred on whichever of the following occurs first:

(A) 15 calendar days from the date of the circumstance or incident that later resulted in a finding of noncompliance; or

(B) 10 calendar days from the date the civil money penalty was imposed;

(iii) The facility waives its right to a hearing under §488.436;

(iv) The noncompliance that was self-reported and corrected did not constitute a pattern of harm, widespread harm, immediate jeopardy, or result in the death of a resident;

(v) The civil money penalty was not imposed for a repeated deficiency, as defined in paragraph (d)(3) of this section, that was the basis of a civil money penalty that previously received a reduction under this section; and

(vi) The facility has met mandatory reporting requirements for the incident or circumstance upon which the civil money penalty is based, as required by Federal and State law.

(3) Under no circumstances will a facility receive both the 50 percent civil money penalty reduction for self-reporting and correcting under this section and the 35 percent civil money penalty reduction for waiving its right to a hearing under §488.436.

(d) Increased penalty amounts. (1) Before a hearing requested in accordance with §488.431(d) or §488.432(a), CMS or the State may propose to increase the per day penalty amount for facility noncompliance which, after imposition of a lower level penalty amount, becomes sufficiently serious to pose immediate jeopardy.

(2) CMS does and the State must increase the per day penalty amount for any repeated deficiencies for which a lower level penalty amount was previously imposed, regardless of whether the increased penalty amount would exceed the range otherwise reserved for nonimmediate jeopardy deficiencies.

(3) Repeated deficiencies are deficiencies in the same regulatory grouping of requirements found at the last survey, subsequently corrected, and found again at the next survey.

(e) Review of the penalty. When an administrative law judge or State hearing officer (or higher administrative review authority) finds that the basis for imposing a civil money penalty exists, as specified in §488.430, the administrative law judge or State hearing officer (or higher administrative review authority) may not—

(1) Set a penalty of zero or reduce a penalty to zero;

(2) Review the exercise of discretion by CMS or the State to impose a civil money penalty; and

(3) Consider any factors in reviewing the amount of the penalty other than those specified in paragraph (f) of this section.
(f) Factors affecting the amount of penalty. In determining the amount of penalty, CMS does or the State must take into account the following factors:

(1) The facility’s history of noncompliance, including repeated deficiencies.
(2) The facility’s financial condition.
(3) The factors specified in §488.404.
(4) The facility’s degree of culpability. Culpability for purposes of this paragraph includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty.


§488.440 Civil money penalties: Effective date and duration of penalty.

(a)(1) The per day civil money penalty may start accruing as early as the date that the facility was first out of compliance, as determined by CMS or the State.
(2) A civil money penalty for each instance of noncompliance is imposed in a specific amount for that particular deficiency.
(b) The per day civil money penalty is computed and collectible, as specified in §§488.431, 488.432, and 488.442 for the number of days of noncompliance until the date the facility achieves substantial compliance, or, if applicable, the date of termination when—

(1) The determination of noncompliance is upheld after a final administrative decision for NFs-only subject to civil money penalties imposed by the state or for civil money penalties imposed by CMS that are not collected and placed into an escrow account;
(2) The facility waives its right to a hearing in accordance with §488.436; or
(3) The time for requesting a hearing has expired and CMS or the State has not received a hearing request from the facility.
(c)(1) For NFs-only subject to civil money penalties imposed by the State and for civil money penalties imposed by CMS that may not be placed in an escrow account, the entire penalty, whether imposed on a per day or per instance basis, is due and collectible as specified in the notice sent to the provider under paragraphs (d) and (e) of this section.
(2) For SNFs, dually-participating SNF/NFs, or NFs subject to civil money penalties imposed by CMS, collection is made in accordance with §488.431.
(d)(1) When a civil money penalty is imposed on a per day basis and the facility achieves substantial compliance, CMS does or the State must send a separate notice to the facility containing the following information:
(i) The amount of penalty per day.
(ii) The number of days involved.
(iii) The total amount due.
(iv) The due date of the penalty.
(v) The rate of interest assessed on the unpaid balance beginning on the due date, as provided in §488.442.
(2) When a civil money penalty is imposed for an instance of noncompliance, CMS does or the State must send a separate notice to the facility containing the following information:
(i) The amount of the penalty.
(ii) The total amount due.
(iii) The due date of the penalty.
(iv) The rate of interest assessed on the unpaid balance beginning on the due date, as provided in §488.442.
(e) In the case of a facility for which the provider agreement has been terminated and on which a civil money penalty was imposed on a per day basis, CMS does or the State must send this penalty information after the—

(1) Final administrative decision is made;
(2) Facility has waived its right to a hearing in accordance with §488.436; or
(3) Time for requesting a hearing has expired and CMS or the State has not received a hearing request from the facility.
(f) Accrual of penalties when there is no immediate jeopardy. (1) In the case of noncompliance that does not pose immediate jeopardy, the daily accrual of per day civil money penalties is imposed for the days of noncompliance prior to the notice specified in §488.434 and an additional period of no longer than 6 months following the last day of the survey.
(2) After the period specified in paragraph (f)(1) of this section, if the facility has not achieved substantial compliance, CMS terminates the provider agreement and the State may terminate the provider agreement.

(g)(1) In a case when per day civil money penalties are imposed, when a facility has deficiencies that pose immediate jeopardy, CMS does or the State must terminate the provider agreement within 23 calendar days after the last day of the survey if the immediate jeopardy remains.

(2) The accrual of the civil money penalty imposed on a per day basis stops on the day the provider agreement is terminated.

(h)(1) If an on-site revisit is necessary to confirm substantial compliance and the provider can supply documentation acceptable to CMS or the State agency that substantial compliance was achieved on a date preceding the revisit, penalties imposed on a per day basis only accrue until that date of correction for which there is written credible evidence.

(2) If an on-site revisit is not necessary to confirm substantial compliance, penalties imposed on a per day basis only accrue until the date of correction for which CMS or the State receives and accepts written credible evidence.

[59 FR 56243, Nov. 10, 1994, as amended at 64 FR 13361, Mar. 18, 2001]

§ 488.442 Civil money penalties: Due date for payment of penalty.

(a) When payments are due for a civil money penalty. (1) Payment for a civil money penalty is due in accordance with § 488.431 of this chapter for CMS-imposed penalties and 15 days after the State initiates collection pursuant to § 488.432 of this chapter for State-imposed penalties, except as provided in paragraphs (a)(2) and (3) of this section.

(2) After a request to waive a hearing or when a hearing was not requested. Except as provided for in § 488.431, a civil money penalty is due 15 days after receipt of a written request to waive a hearing in accordance with § 488.436 or 15 days after the time period for requesting a hearing has expired and a hearing request was not received when:

(i) The facility achieved substantial compliance before the hearing request was due; or

(ii) The effective date of termination occurs before the hearing request was due.

(b) After the effective date of termination. A civil money penalty payment is due 15 days after the effective date of termination, if that date is earlier than the date specified in paragraph (a)(1) of this section.

(b) [Reserved]

(c) Deduction of penalty from amount owed. The amount of the penalty, when determined, may be deducted from any sum then or later owing by CMS or the State to the facility.

(d) Interest—(1) Assessment. Interest is assessed on the unpaid balance of the penalty, beginning on the due date.

(2) Medicare interest. Medicare rate of interest is the higher of—

(i) The rate fixed by the Secretary of the Treasury after taking into consideration private consumer rates of interest prevailing on the date of the notice of the penalty amount due (published quarterly in the Federal Register by HHS under 45 CFR 30.13(a)); or

(ii) The current value of funds (published annually in the Federal Register by the Secretary of the Treasury, subject to quarterly revisions).

(3) Medicaid interest. The interest rate for Medicaid is determined by the State.

(e) Penalties collected by CMS. Civil money penalties and corresponding interest collected by CMS from—

(1) Medicare-participating facilities are deposited and disbursed in accordance with § 488.433; and

(2) Medicaid-participating facilities are returned to the State.

(f) Collection from dually participating facilities. Civil money penalties collected from dually participating facilities are deposited and disbursed in accordance with § 488.433 and returned to the State in proportion commensurate with the relative proportions of Medicare and Medicaid beds at the facility actually in use by residents covered by the respective programs on the date the civil money penalty begins to accrue.

(g) Penalties collected by the State. Civil money penalties collected by the
States must be applied to the protection of the health or property of residents of facilities that the State or CMS finds noncompliant, such as—

(1) Payment for the cost of relocating residents to other facilities;
(2) State costs related to the operation of a facility pending correction of deficiencies or closure; and
(3) Reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or by individuals used by the facility to provide services to residents.

§ 488.450 Continuation of payments to a facility with deficiencies.

(a) Criteria. (1) CMS may continue payments to a facility not in substantial compliance for the periods specified in paragraph (c) of this section if the following criteria are met:
   (i) The State survey agency finds that it is more appropriate to impose alternative remedies than to terminate the facility;
   (ii) The State has submitted a plan and timetable for corrective action approved by CMS; and
   (iii) The facility, in the case of a Medicare SNF, or the State, in the case of a Medicaid NF, agrees to repay the Federal government payments received under this provision if corrective action is not taken in accordance with the approved plan and timetable for corrective action.

(2) CMS or the State may terminate the SNF or NF agreement before the end of the correction period if the criteria in paragraph (a)(1) of this section are not met.

(b) Cessation of payments. If termination is not sought, either by itself or along with another remedy or remedies, or any of the criteria set forth in paragraph (a)(1) of this section are not met or agreed to by either the facility or the State, the facility or State will receive no Medicare or Federal Medicaid payments, as applicable, from the last day of the survey.

§ 488.446 Administrator sanctions: long-term care facility closures.

Any individual who is or was the administrator of a facility and fails or failed to comply with the requirements at §483.75(r) of this chapter—

(a) Will be subject to a civil monetary penalty as follows:
   (1) A minimum of $500 as adjusted annually under 45 CFR part 102 for the first offense.
   (2) A minimum of $1,500 as adjusted annually under 45 CFR part 102 for the second offense.
   (3) A minimum of $3,000 as adjusted annually under 45 CFR part 102 for the third and subsequent offenses.

(b) May be subject to exclusion from participation in any Federal health care program (as defined in section 1129B(f) of the Act); and
(c) Will be subject to any other penalties that may be prescribed by law.

§ 488.444 Civil money penalties: Settlement of penalties.

(a) CMS has authority to settle cases at any time prior to a final administrative decision for Medicare-only SNFs, State-operated facilities, or other facilities for which CMS’s enforcement action prevails, in accordance with §488.330.

(b) The State has the authority to settle cases at any time prior to the evidentiary hearing decision for all cases in which the State’s enforcement action prevails.
substantial compliance by the end of the period specified in paragraph (c) of this section,

(i) CMS will—

(i) Terminate the provider agreement of the Medicare SNF in accordance with §488.456; or

(ii) Discontinue Federal funding to the SNF for Medicare; and

(iii) Discontinue FFP to the State for the Medicaid NF.

(2) The State may terminate the provider agreement for the NF.

(3) When CMS finds that a NF or a dually participating facility is in substantial compliance with the participation requirements; and

(i) CMS finds that a NF or a dually participating facility has not achieved substantial compliance; and

(ii) The State finds that a NF or a dually participating facility is in substantial compliance with the participation requirements.

(4) When CMS finds that a NF or a dually participating facility has not achieved substantial compliance; and

(i) CMS finds that a NF or a dually participating facility has not achieved substantial compliance; and

(ii) The State finds that a NF or a dually participating facility is in substantial compliance with the participation requirements.

When CMS’s survey findings take precedence, CMS may—

(1) Impose any of the alternative remedies specified in §488.406;

(2) Terminate the provider agreement subject to the applicable conditions of §488.450; and

(3) Stop FFP to the State for a NF.

(b) Disagreement over decision to terminate. (1) CMS’s decision to terminate the participation of a facility takes precedence when—

(i) Both CMS and the State find that the facility has not achieved substantial compliance; and

(ii) CMS, but not the State, finds that the facility’s participation should be terminated. CMS will permit continuation of payment during the period prior to the effective date of termination not to exceed 6 months, if the applicable conditions of §488.450 are met.

(2) The State’s decision to terminate a facility’s participation and the procedures for appealing such termination, as specified in §421.153(c) of this chapter, takes precedence when—

(i) The State, but not CMS, finds that a NF’s participation should be terminated; and

(ii) The State’s effective date for the termination of the NF’s provider agreement is no later than 6 months after the last day of survey.

(c) Disagreement over timing of termination of facility. The State’s timing of termination takes precedence if it does not occur later than 6 months after the last day of the survey when both CMS and the State find that—

(1) A facility is not in substantial compliance; and

(2) The facility’s participation should be terminated.

(d) Disagreement over remedies. (1) When CMS or the State, but not both, establishes one or more remedies, in addition to or as an alternative to termination, the additional or alternative remedies will also apply when—

(i) Both CMS and the State find that a facility has not achieved substantial compliance; and

(ii) Both CMS and the State find that no immediate jeopardy exists.

(2) Overlap of remedies. When CMS and the State establish one or more remedies, in addition to or as an alternative to termination, only the CMS remedies apply when both CMS and the State find that a facility has not achieved substantial compliance.

(e) Regardess of whether CMS’s or the State’s decision controls, only one noncompliance and enforcement decision is applied to the Medicaid agreement, and for a dually participating facility, that same decision will apply to the Medicare agreement.
§ 488.454 Duration of remedies.
(a) Except as specified in paragraphs (b) and (d) of this section, alternative remedies continue until—
(1) The facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit; or
(2) CMS or the State terminates the provider agreement.
(b) In the cases of State monitoring and denial of payment imposed for repeated substandard quality of care, remedies continue until—
(1) CMS or the State determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; or
(2) CMS or the State terminates the provider agreement.
(c) In the case of temporary management, the remedy continues until—
(1) CMS or the State determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; or
(2) CMS or the State terminates the provider agreement.
(d) The facility which has not achieved substantial compliance re-assumes management control. In this case, CMS or the State initiates termination of the provider agreement and may impose additional remedies.
(e) If the facility can supply documentation acceptable to CMS or the State survey agency that it was in substantial compliance and was capable of remaining in substantial compliance, if necessary, on a date preceding that of the revisit, the remedies terminate on the date that CMS or the State can verify as the date that substantial compliance was achieved and the facility demonstrated that it could maintain substantial compliance, if necessary.

§ 488.456 Termination of provider agreement.
(a) Effect of termination. Termination of the provider agreement ends—
(1) Payment to the facility; and
(2) Any alternative remedy.
(b) Basis for termination. (1) CMS and the State may terminate a facility’s provider agreement if a facility—
(i) Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present; or
(ii) Fails to submit an acceptable plan of correction within the timeframe specified by CMS or the State.
(2) CMS and the State terminate a facility’s provider agreement if a facility—
(i) Fails to relinquish control to the temporary manager, if that remedy is imposed by CMS or the State; or
(ii) Does not meet the eligibility criteria for continuation of payment as set forth in §488.412(a)(1).
(c) Notice of termination. Before terminating a provider agreement, CMS does and the State must notify the facility and the public—
(1) At least 2 calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and
(2) At least 15 calendar days before the effective date of termination for a facility with non-immediate jeopardy deficiencies that constitute noncompliance.
(d) Procedures for termination. (1) CMS terminates the provider agreement in accordance with procedures set forth in §489.53 of this chapter; and
(2) The State must terminate the provider agreement of a NF in accordance with procedures specified in parts 431 and 442 of this chapter.
§ 488.604 Termination of Medicare coverage.

(a) Except as otherwise provided in this subpart, failure of a supplier of ESRD services to meet one or more of the conditions for coverage set forth in part 494 of this chapter will result in termination of Medicare coverage of the services furnished by the supplier.

(b) If termination of coverage is based solely on a supplier’s failure to participate in network activities and pursue network goals, as required at §494.180(i) of this chapter, coverage may be reinstated when CMS determines that the supplier is making reasonable and appropriate efforts to meet that condition.

(c) If termination of coverage is based on failure to meet any of the other conditions specified in part 494 of this chapter, coverage will not be reinstated until CMS finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

§ 488.606 Alternative sanctions.

(a) Basis for application of alternative sanctions. CMS may, as an alternative to termination of Medicare coverage, impose one of the sanctions specified in paragraph (b) of this section if CMS finds that—

1. The supplier fails to participate in the activities and pursue the goals of the ESRD network that is designated to encompass the supplier’s geographic area; and

2. This failure does not jeopardize patient health and safety.

(b) Alternative sanctions. The alternative sanctions that CMS may apply in the circumstances specified in paragraph (a) of this section include the following:

1. Denial of payment for services furnished to patients first accepted for care after the effective date of the sanction as specified in the sanction notice.

2. Reduction of payments, for all ESRD services furnished by the supplier, by 20 percent for each 30-day period after the effective date of the sanction.

3. Withholding of all payments, without interest, for all ESRD services furnished by the supplier to Medicare beneficiaries.

(c) Duration of alternative sanction. An alternative sanction remains in effect until CMS finds that the supplier is in substantial compliance with the requirement to cooperate in the network plans and goals, or terminates coverage of the supplier’s services for lack of compliance.

§ 488.608 Notice of alternative sanction and appeal rights: Termination of coverage.

(a) Notice of alternative sanction. CMS gives the supplier and the general public notice of the alternative sanction and of the effective date of the sanction. The effective date of the alternative sanction is at least 30 days after the date of the notice.

(b) Appeal rights. Termination of Medicare coverage of a supplier’s ESRD services because the supplier no longer meets the conditions for coverage of its services is an initial determination appealable under part 498 of this chapter.


If CMS proposes to apply an alternative sanction specified in §488.606(b), the following rules apply:

(a) CMS gives the facility notice of the proposed alternative sanction and 15 days in which to request a hearing.

(b) If the facility requests a hearing, CMS provides an informal hearing by a CMS official who was not involved in making the appealed decision.

(c) During the informal hearing, the facility—

1. May be represented by counsel;

2. Has access to the information on which the allegation was based; and

3. May present, orally or in writing, evidence and documentation to refute the finding of failure to participate in network activities and pursue network goals.

(d) If the written decision of the informal hearing supports application of the alternative sanction, CMS provides the facility and the public, at least 30 days before the effective date of the alternative sanction, a written notice that specifies the effective date and the reasons for the alternative sanction.
Subpart I—Survey and Certification of Home Health Agencies

SOURCE: 77 FR 67164, Nov. 8, 2012, unless otherwise noted.

§ 488.700 Basis and scope.

Section 1891 of the Act establishes requirements for surveying HHAs to determine whether they meet the Medicare conditions of participation.

§ 488.705 Definitions.

As used in this subpart—

Abbreviated standard survey means a focused survey other than a standard survey that gathers information on an HHA’s compliance with fewer specific standards or conditions of participation. An abbreviated standard survey may be based on complaints received, a change of ownership or management, or other indicators of specific concern such as reapplication for Medicare billing privileges following a deactivation.

Complaint survey means a survey that is conducted to investigate specific allegations of noncompliance.

Condition-level deficiency means noncompliance as described in § 488.24 of this part.

Deficiency is a violation of the Act and regulations contained in part 484, subparts A through C of this chapter, and can be either standard or condition-level.

Extended survey means a survey that reviews additional conditions of participation not examined during a standard survey. It may be conducted at any time but must be conducted when substandard care is identified.

Noncompliance means any deficiency found at the condition-level or standard-level.

Partial extended survey means a survey conducted to determine if deficiencies and/or deficient practice(s) exist that were not fully examined during the standard survey. The surveyors may review any additional requirements which would assist in making a compliance finding.

Standard-level deficiency means noncompliance with one or more of the standards that make up each condition of participation for HHAs.

Standard survey means a survey conducted in which the surveyor reviews the HHA’s compliance with a select number of standards and/or conditions of participation in order to determine the quality of care and services furnished by an HHA as measured by indicators related to medical, nursing, and rehabilitative care.

Substandard care means noncompliance with one or more conditions of participation identified on a standard survey, including deficiencies which could result in actual or potential harm to patients of an HHA.

Substantial compliance means compliance with all condition-level requirements, as determined by CMS or the State.

§ 488.710 Standard surveys.

(a) For each HHA, the survey agency must conduct a standard survey not later than 36 months after the date of the previous standard survey that includes, but is not limited to, all of the following (to the extent practicable):

(1) A case-mix stratified sample of individuals furnished items or services by the HHA.

(2) Visits to the homes of patients, (the purpose of the home visit is to evaluate the extent to which the quality and scope of services furnished by the HHA attained and maintained the highest practicable functional capacity of each patient as reflected in the patient’s written plan of care and clinical records), but only with their consent, and, if determined necessary by CMS or the survey team, other forms of communication with patients including telephone calls.

(3) Review of indicators that include the outcomes of quality care and services furnished by the agency as indicated by medical, nursing, and rehabilitative care.

(4) Review of compliance with a select number of regulations most related to high-quality patient care.

(b) The survey agency’s failure to follow the procedures set forth in this section will not invalidate otherwise legitimate determinations that deficiencies exist at an HHA.
§ 488.715 Partial extended surveys.

A partial extended survey is conducted to determine if standard or condition-level deficiencies are present in the conditions of participation not fully examined during the standard survey and there are indications that a more comprehensive review of conditions of participation would determine if a deficient practice exists.

§ 488.720 Extended surveys.

(a) Purpose of survey. The purpose of an extended survey is:

(1) To review and identify the policies and procedures that caused an HHA to furnish substandard care.

(2) To determine whether the HHA is in compliance with one or more or all additional conditions of participation not examined during the standard survey.

(b) Timing and basis for survey. An extended survey must be conducted not later than 14 calendar days after completion of a standard survey which found that a HHA was out of compliance with a condition of participation.

§ 488.725 Unannounced surveys.

(a) Basic rule. All HHA surveys must be unannounced and conducted with procedures and scheduling that renders the onsite surveys as unpredictable in their timing as possible.

(b) State survey agency’s scheduling and surveying procedures. CMS reviews each survey agency’s scheduling and surveying procedures and practices to assure that the survey agency has taken all reasonable steps to avoid giving notice of a survey through the scheduling procedures and conduct of the surveys.

(c) Civil money penalties. Any individual who notifies an HHA, or causes an HHA to be notified, of the time or date on which a standard survey is scheduled to be conducted is subject to a Federal civil money penalty not to exceed $2,000 as adjusted annually under 45 CFR part 102.

[77 FR 67164, Nov. 8, 2012, as amended at 81 FR 61563, Sept. 6, 2016]

§ 488.730 Survey frequency and content.

(a) Basic period. Each HHA must be surveyed not later than 36 months after the last day of the previous standard survey. Additionally, a survey may be conducted as frequently as necessary to—

(1) Assure the delivery of quality home health services by determining whether an HHA complies with the Act and conditions of participation; and

(2) Confirm that the HHA has corrected deficiencies that were previously cited.

(b) Change in HHA information. A standard survey or an abbreviated standard survey may be conducted within 2 months of a change, or knowledge of a change, in any of the following:

(1) Ownership;

(2) Administration; or,

(3) Management of the HHA.

(c) Complaints. A standard survey, or abbreviated standard survey—

(1) Must be conducted of an HHA within 2 months of when a significant number of complaints against the HHA are reported to CMS, the State, the State or local agency responsible for maintaining a toll-free hotline and investigative unit, or any other appropriate Federal, State, or local agency; or

(2) As otherwise required to determine compliance with the conditions of participation such as the investigation of a complaint.

§ 488.735 Surveyor qualifications.

(a) Minimum qualifications. Surveys must be conducted by individuals who meet minimum qualifications prescribed by CMS. In addition, before any State or Federal surveyor may serve on an HHA survey team (except as a trainee), he/she must have successfully completed the relevant CMS-sponsored Basic HHA Surveyor Training Course and any associated course prerequisites. All surveyors must follow the principles set forth in §488.24 through §488.28 according to CMS policies and procedures for determining compliance with the conditions of participation.

(b) Disqualifications. Any of the following circumstances disqualifies a
surveyor from surveying a particular agency:

(1) The surveyor currently works for, or, within the past two years, has worked with the HHA to be surveyed as:
   (i) A direct employee;
   (ii) An employment agency staff at the agency; or
   (iii) An officer, consultant, or agent for the agency to be surveyed concerning compliance with conditions of participation specified in or pursuant to sections 1861(o) or 1891(a) of the Act.
(2) The surveyor has a financial interest or an ownership interest in the HHA to be surveyed.
(3) The surveyor has a family member who has a relationship with the HHA to be surveyed.
(4) The surveyor has an immediate family member who is a patient of the HHA to be surveyed.

§ 488.740 Certification of compliance or noncompliance.
Rules to be followed for certification, documentation of findings, periodic review of compliance and approval, certification of noncompliance, and determining compliance of HHAs are set forth, respectively, in §§ 488.12, 488.18, 488.20, 488.24, and 488.26 of this part.

§ 488.745 Informal Dispute Resolution (IDR).
(a) Opportunity to refute survey findings. Upon the provider’s receipt of an official statement of deficiencies, HHAs are afforded the option to request an informal opportunity to dispute condition-level survey findings.
(b) Failure to conduct IDR timely. Failure of CMS or the State, as appropriate, to complete IDR shall not delay the effective date of any enforcement action.
(c) Revised statement of deficiencies as a result of IDR. If any findings are revised or removed by CMS or the State based on IDR, the official statement of deficiencies is revised accordingly and any enforcement actions imposed solely as a result of those cited deficiencies are adjusted accordingly.
(d) Notification. When the survey findings indicate a condition-level deficiency, CMS or the State, as appropriate, must provide the agency with written notification of the opportunity for participating in an IDR process at the time the official statement of deficiencies is issued. The request for IDR must be submitted in writing to the State or CMS, must include the specific deficiencies that are disputed, and must be made within the same 10 calendar day period that the HHA has for submitting an acceptable plan of correction.

Subpart J—Alternative Sanctions for Home Health Agencies With Deficiencies

SOURCE: 77 FR 67165, Nov. 8, 2012, unless otherwise noted.

§ 488.800 Statutory basis.
Section 1891(e) through (f) of the Act authorizes the Secretary to take actions to remove and correct deficiencies in an HHA through an alternative sanction or termination or both. Furthermore, this section specifies that these sanctions are in addition to any others available under State or Federal law, and, except for the final determination of civil money penalties, are imposed prior to the conduct of a hearing.

§ 488.805 Definitions.
As used in this subpart—
Directed plan of correction means CMS or the temporary manager (with CMS/SA approval) may direct the HHA to take specific corrective action to achieve specific outcomes within specific timeframes.
Immediate jeopardy means a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a patient(s).
New admission means an individual who becomes a patient or is readmitted to the HHA on or after the effective date of a suspension of payment sanction.
Per instance means a single event of noncompliance identified and corrected through a survey, for which the statute authorizes CMS to impose a sanction.
Plan of correction means a plan developed by the HHA and approved by CMS
that is the HHA’s written response to survey findings detailing corrective actions to cited deficiencies and specifies the date by which those deficiencies will be corrected.

Repeat deficiency means a condition-level citation that is cited on the current survey and is substantially the same as or similar to, a finding of a standard-level or condition-level deficiency citation cited on the most recent previous standard survey or on any intervening survey since the most recent standard survey.

Temporary management means the temporary appointment by CMS or by a CMS authorized agent, of a substitute manager or administrator based upon qualifications described in §§484.4 and 484.14(c) of this chapter. The HHA’s governing body must ensure that the temporary manager has authority to hire, terminate or reassign staff, obligate funds, alter procedures, and manage the HHA to correct deficiencies identified in the HHA’s operation.

§ 488.810 General provisions.

(a) Purpose of sanctions. The purpose of sanctions is to ensure prompt compliance with program requirements in order to protect the health and safety of individuals under the care of an HHA.

(b) Basis for imposition of sanctions. When CMS chooses to apply one or more sanctions specified in §488.820, the sanctions are applied on the basis of noncompliance found through a survey and may be based on failure to correct previous deficiency findings as evidenced by repeat deficiencies.

(c) Number of sanctions. CMS may apply one or more sanctions for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance.

(d) Extent of sanctions imposed. When CMS imposes a sanction, the sanction applies to the parent HHA and its respective branch offices.

(e) Plan of correction requirement. Regardless of which sanction is applied, a non-compliant HHA must submit a plan of correction for approval by CMS.

(f) Notification requirements—(1) Notice. CMS provides written notification to the HHA of the intent to impose the sanction.

(2) Date of enforcement action. The notice periods specified in §488.825(b) and §488.830(b) begin the day after the HHA receives the notice.

(g) Appeals. (1) The provisions of part 498 of this chapter apply when the HHA requests a hearing on a determination of noncompliance leading to the imposition of a sanction, including termination of the provider agreement.

(2) A pending hearing does not delay the effective date of a sanction, including termination, against an HHA. Sanctions continue to be in effect regardless of the timing of any appeals proceedings.

§ 488.815 Factors to be considered in selecting sanctions.

CMS bases its choice of sanction or sanctions on consideration of one or more factors that include, but are not limited to, the following:

(a) The extent to which the deficiencies pose immediate jeopardy to patient health and safety.

(b) The nature, incidence, manner, degree, and duration of the deficiencies or noncompliance.

(c) The presence of repeat deficiencies, the HHA’s overall compliance history and any history of repeat deficiencies at either the parent or branch location.

(d) The extent to which the deficiencies are directly related to a failure to provide quality patient care.

(e) The extent to which the HHA is part of a larger organization with performance problems.

(f) An indication of any system-wide failure to provide quality care.

§ 488.820 Available sanctions.

In addition to termination of the provider agreement, the following alternative sanctions are available:

(a) Civil money penalties.

(b) Suspension of payment for all new admissions.

(c) Temporary management of the HHA.

(d) Directed plan of correction, as set out at §488.850.

(e) Directed in-service training, as set out at §488.855.
§ 488.825 Action when deficiencies pose immediate jeopardy.

(a) Immediate jeopardy. If there is immediate jeopardy to the HHA’s patient health or safety—

(1) CMS immediately terminates the HHA provider agreement in accordance with §489.53 of this chapter.

(2) CMS terminates the HHA provider agreement no later than 23 days from the last day of the survey, if the immediate jeopardy has not been removed by the HHA.

(3) In addition to a termination, CMS may impose one or more alternative sanctions, as appropriate.

(b) 2-day notice. Except for civil money penalties, for all sanctions specified in §488.820 that are imposed when there is immediate jeopardy, notice must be given at least 2 calendar days before the effective date of the enforcement action.

(c) Transfer of care. An HHA, if its provider agreement terminated, is responsible for providing information, assistance, and arrangements necessary for the proper and safe transfer of patients to another local HHA within 30 days of termination. The State must assist the HHA in the safe and orderly transfer of care and services for the patients to another local HHA.

§ 488.830 Action when deficiencies are at the condition-level but do not pose immediate jeopardy.

(a) Noncompliance. If the HHA is no longer in compliance with the conditions of participation, either because the deficiency or deficiencies substantially limit the provider’s capacity to furnish adequate care but do not pose immediate jeopardy, have a condition-level deficiency or deficiencies that do not pose immediate jeopardy, or because the HHA has repeat noncompliance that results in a condition-level deficiency based on the HHA’s failure to correct and sustain compliance, CMS will:

(1) Terminate the HHA’s provider agreement; or

(2) Impose one or more alternative sanctions set forth in §488.820(a) through (f) of this part as an alternative to termination, for a period not to exceed 6 months.

(b) 15-day notice. Except for civil money penalties, for all sanctions specified in §488.820 imposed when there is no immediate jeopardy, notice must be given at least 15 calendar days before the effective date of the enforcement action. The requirements of the notice are set forth in §488.810(f) of this part.

(c) Not meeting criteria for continuation of payment. If an HHA does not meet the criteria for continuation of payment under §488.860(a) of this part, CMS will terminate the HHA’s provider agreement in accordance with §488.865 of this part.

(d) Termination time frame when there is no immediate jeopardy. CMS terminates an HHA within 6 months of the last day of the survey, if the HHA is not in compliance with the conditions of participation, and the terms of the plan of correction have not been met.

(e) Transfer of care. An HHA, if its provider agreement terminated, is responsible for providing information, assistance, and arrangements necessary for the proper and safe transfer of patients to another local HHA within 30 days of termination. The State must assist the HHA in the safe and orderly transfer of care and services for the patients to another local HHA.

§ 488.835 Temporary management.

(a) Application. CMS may impose temporary management of an HHA if it determines that an HHA has a condition-level noncompliance and CMS determines that management limitations or the deficiencies are likely to impair the HHA’s ability to correct deficiencies and return the HHA to full compliance with the conditions of participation within the timeframe required.

(b) Procedures. (1) CMS notifies the HHA that a temporary manager is being appointed.

(2) CMS notifies the HHA that a temporary manager is being appointed.

(3) CMS notifies the HHA that a temporary manager is being appointed.

(c) Duration and effect of sanction. Temporary management continues until—

(1) CMS determines that the HHA has achieved substantial compliance and
§ 488.840 Suspension of payment for all new patient admissions.

(a) Application. (1) CMS may suspend payment for all new admissions if an HHA is found to have condition-level deficiencies, regardless of whether those deficiencies pose immediate jeopardy.

(2) CMS will consider this sanction for any deficiency related to poor patient care outcomes, regardless of whether the deficiency poses immediate jeopardy.

(b) Procedures—(1) Notices. (i) Before suspending payments for new admissions, CMS provides the HHA notice of the suspension of payment for all new admissions as set forth in §488.810(f).

The CMS notice of suspension will include the nature of the noncompliance; the effective date of the sanction; and the right to appeal the determination leading to the sanction.

(ii) The HHA may not charge a newly admitted HHA patient who is a Medicare beneficiary for services for which Medicare payment is suspended unless the HHA can show that, before initiating care, it gave the patient or his or her representative oral and written notice of the suspension of Medicare payment in a language and manner that the beneficiary or representative can understand.

(2) Restriction. (i) Suspension of payment for all new admissions sanction may be imposed anytime an HHA is found to be out of substantial compliance.

(ii) Suspension of payment for patients with new admissions will remain in place until CMS determines that the HHA has achieved substantial compliance or is involuntarily terminated with the conditions of participation, as determined by CMS.

(3) Resumption of payments. Payments to the HHA resume prospectively on the date that CMS determines that the HHA has achieved substantial compliance with the conditions of participation.

(c) Duration and effect of sanction. This sanction ends when:

(1) CMS determines that the HHA is in substantial compliance with all of the conditions of participation; or

(2) When the HHA is terminated or CMS determines that the HHA is not in compliance with the conditions of participation at a maximum of 6 months from the date noncompliance was determined.

§ 488.845 Civil money penalties.

(a) Application. (1) CMS may impose a civil money penalty against an HHA for either the number of days the HHA is not in compliance with one or more conditions of participation or for each instance that an HHA is not in compliance, regardless of whether the HHA’s deficiencies pose immediate jeopardy.
(2) CMS may impose a civil money penalty for the number of days of immediate jeopardy.

(3) A per-day and a per-instance CMP may not be imposed simultaneously for the same deficiency.

(b) Amount of penalty—(1) Factors considered. CMS takes into account the following factors in determining the amount of the penalty:

(i) The factors set out at §488.815.

(ii) The size of an agency and its resources.

(iii) Accurate and credible resources, such as PECOS, Medicare cost reports and Medicare/Medicaid claims information that provide information on the operation and resources of the HHA.

(iv) Evidence that the HHA has a built-in, self-regulating quality assessment and performance improvement system to provide proper care, prevent poor outcomes, control patient injury, enhance quality, promote safety, and avoid risks to patients on a sustainable basis that indicates the ability to meet the conditions of participation and to ensure patient health and safety.

(2) Adjustments to penalties. Based on revisit survey findings, adjustments to penalties may be made after a review of the provider’s attempted correction of deficiencies.

(i) CMS may increase a CMP in increments based on a HHA’s inability or failure to correct deficiencies, the presence of a system-wide failure in the provision of quality care, or a determination of immediate jeopardy with actual harm versus immediate jeopardy with potential for harm.

(ii) CMS may also decrease a CMP in increments to the extent that it finds, pursuant to a revisit, that substantial and sustainable improvements have been implemented even though the HHA is not yet in full compliance with the conditions of participation.

(iii) No penalty assessment will exceed $10,000 as adjusted annually under 45 CFR part 102 for each day of noncompliance.

(3) Upper range of penalty. Penalties in the upper range of $8,500 to $10,000 as adjusted under 45 CFR part 102 per day of noncompliance are imposed for a condition-level deficiency that is immediate jeopardy. The penalty in this range will continue until compliance can be determined based on a revisit survey.

(i) $10,000 as adjusted annually under 45 CFR part 102 per day for a deficiency or deficiencies that are immediate jeopardy and that result in actual harm.

(ii) $9,000 as adjusted annually under 45 CFR part 102 per day for a deficiency or deficiencies that are immediate jeopardy and that result in a potential for harm.

(iii) $8,500 as adjusted annually under 45 CFR part 102 per day for an isolated incident of noncompliance in violation of established HHA policy.

(4) Middle range of penalty. Penalties in the range of $1,500-$3,500 as adjusted annually under 45 CFR part 102 per day of noncompliance are imposed for a repeat and/or condition-level deficiency that does not constitute immediate jeopardy, but is directly related to poor quality patient care outcomes.

(5) Lower range of penalty. Penalties in this range of $500-$4,000 as adjusted annually under 45 CFR part 102 are imposed for a repeat and/or condition-level deficiency that does not constitute immediate jeopardy and that are related predominately to structure or process-oriented conditions (such as OASIS submission requirements) rather than directly related to patient care outcomes.

(6) Per instance penalty. Penalty imposed per instance of noncompliance may be assessed for one or more singular events of condition-level noncompliance that are identified and where the noncompliance was corrected during the onsite survey. When penalties are imposed for per instance of noncompliance, or more than one per instance of noncompliance, the penalties will be in the range of $1,000 to $10,000 as adjusted annually under 45 CFR part 102 per instance, not to exceed $10,000 as adjusted annually under 45 CFR part 102 each day of noncompliance.

(7) Decreased penalty amounts. If the immediate jeopardy situation is removed, but condition-level noncompliance continues, CMS will shift the penalty amount imposed per day from the upper range to the middle or lower range. An earnest effort to correct any
systemic causes of deficiencies and sustain improvement must be evident.

(8) Increased penalty amounts. (i) In accordance with paragraph (b)(2) of this section, CMS will increase the per day penalty amount for any condition-level deficiency or deficiencies which, after imposition of a lower-level penalty amount, become sufficiently serious to pose potential harm or immediate jeopardy.

(ii) CMS increases the per day penalty amount for deficiencies that are not corrected and found again at the time of revisit survey(s) for which a lower-level penalty amount was previously imposed.

(iii) CMS may impose a more severe amount of penalties for repeated noncompliance with the same condition-level deficiency or uncorrected deficiencies from a prior survey.

(c) Procedures—(1) Notice of intent. CMS provides the HHA with written notice of the intent to impose a civil money penalty. The notice includes the amount of the CMP being imposed, the basis for such imposition and the proposed effective date of the sanction.

(2) Appeals. (i) Appeals procedures. An HHA may request a hearing on the determination of the noncompliance that is the basis for imposition of the civil money penalty. The request must meet the requirements in §498.40 of this chapter.

(ii) Waiver of a hearing. An HHA may waive the right to a hearing, in writing, within 60 days from the date of the notice imposing the civil money penalty. If an HHA timely waives its right to a hearing, CMS reduces the penalty amount by 35 percent, and the amount is due within 15 days of the HHAs agreeing in writing to waive the hearing. If the HHA does not waive its right to a hearing in accordance to the procedures specified in this subsection, the civil money penalty is not reduced by 35 percent.

(d) Accrual and duration of penalty. (1)(i) The per day civil money penalty may start accruing as early as the beginning of the last day of the survey that determines that the HHA was out of compliance, as determined by CMS.

(ii) A civil money penalty for each per instance of noncompliance is imposed in a specific amount for that particular deficiency, with a maximum of $10,000 as adjusted annually under 45 CFR part 102 per day per HHA.

(2) A penalty that is imposed per day and per instance of noncompliance may not be imposed simultaneously.

(3) Duration of per day penalty when there is immediate jeopardy. (i) In the case of noncompliance that poses immediate jeopardy, CMS must terminate the provider agreement within 23 calendar days after the last day of the survey if the immediate jeopardy is not removed.

(ii) A penalty imposed per day of noncompliance will stop accruing on the day the provider agreement is terminated or the HHA achieves substantial compliance, whichever occurs first.

(4) Duration of penalty when there is no immediate jeopardy. (i) In the case of noncompliance that does not pose immediate jeopardy, the daily accrual of per day civil money penalties is imposed for the days of noncompliance prior to the notice specified in paragraph (c)(1) of this section and an additional period of no longer than 6 months following the last day of the survey.

(ii) If the HHA has not achieved compliance with the conditions of participation, CMS terminates the provider agreement. The accrual of civil money penalty stops on the day the HHA agreement is terminated or the HHA achieves substantial compliance, whichever is earlier.

(e) Computation and notice of total penalty amount. (1) When a civil money penalty is imposed on a per day basis and the HHA achieves compliance with the conditions of participation as determined by a revisit survey, CMS sends a final notice to the HHA containing all of the following information:

(i) The amount of penalty assessed per day.

(ii) The total number of days of noncompliance.

(iii) The total amount due.

(iv) The due date of the penalty.

(v) The rate of interest to be assessed on any unpaid balance beginning on the due date, as provided in paragraph (f)(4) of this section.
(2) When a civil money penalty is imposed for per instance of noncompliance, CMS sends a notice to the HHA containing all of the following information:

(i) The amount of the penalty that was assessed.
(ii) The total amount due.
(iii) The due date of the penalty.
(iv) The rate of interest to be assessed on any unpaid balance beginning on the due date, as provided in paragraph (f)(6) of this section.

(3) In the case of an HHA for which the provider agreement has been involuntarily terminated and for which a civil money penalty was imposed on a per day basis, CMS sends this penalty information after one of the following actions has occurred:

(i) Final administrative decision is made.
(ii) The HHA has waived its right to a hearing in accordance with paragraph (c)(2)(ii) of this section.
(iii) Time for requesting a hearing has expired and CMS has not received a hearing request from the HHA.

(f) Due date for payment of penalty. A penalty is due and payable 15 days from notice of the final administrative decision.

(i) Payments are due for all civil money penalties within 15 days:
   (i) After a final administrative decision when the HHA achieves substantial compliance before the final decision or the effective date of termination before final decision,
   (ii) After the time to appeal has expired and the HHA does not appeal or fails to timely appeal the initial determination,
   (iii) After CMS receives a written request from the HHA requesting to waive its right to appeal the determinations that led to the imposition of a sanction,
   (iv) After substantial compliance is achieved, or
   (v) After the effective date of termination.

(2) A request for hearing does not delay the imposition of any penalty; it only potentially delays the collection of the final penalty amount.

(3) If an HHA waives its right to a hearing, according to paragraph (c)(2)(ii) of this section, CMS will apply a 35 percent reduction to the CMP amount when:

(i) The HHA achieved compliance with the conditions of participation before CMS received the written waiver of hearing; or
(ii) The effective date of termination occurs before CMS received the written waiver of hearing.

(4) The period of noncompliance may not extend beyond 6 months from the last day of the survey.

(5) The amount of the penalty, when determined, may be deducted (offset) from any sum then or later owing by CMS or State Medicaid to the HHA.

(6) Interest is assessed and accrues on the unpaid balance of a penalty, beginning on the due date. Interest is computed at the rate specified in §405.378(d) of this chapter.

(g) Penalties collected by CMS—(1) Disbursement of CMPs. Civil money penalties and any corresponding interest collected by CMS from Medicare and Medicaid participating HHAs are disbursed in proportion to average dollars spent by Medicare and Medicaid at the national level based on MSIS and HHA PPS data for a three year fiscal period.

(i) Based on expenditures for the FY 2007–2009 period, the initial proportions to be disbursed are 63 percent returned to the U.S. Treasury and 37 percent returned to the State Medicaid agency.

(ii) Beginning one year after the effective date of this section, CMS shall annually update these proportions based on the most recent 3-year fiscal period, prior to the year in which the CMP is imposed, for which CMS determines that the relevant data are essentially complete.

(iii) The portion corresponding to the Medicare payments is returned to the U.S. Department of Treasury as miscellaneous receipts.

(iv) The portion corresponding to the Medicaid payments is returned to the State Medicaid agency.

(2) Penalties may not be used for Survey and Certification operations nor as the State’s Medicaid non-Federal medical assistance or administrative match.

(h) Review of the penalty. When an administrative law judge or state hearing officer (or higher administrative review authority) finds that the basis for
imposing a civil monetary penalty exists, as specified in this part, the administrative law judge, State hearing officer (or higher administrative review authority) may not—

(1) Set a penalty of zero or reduce a penalty to zero;

(2) Review the exercise of discretion by CMS to impose a civil monetary penalty; and

(3) Consider any factors in reviewing the amount of the penalty other than those specified in paragraph (b) of this section.

[77 FR 67165, Nov. 8, 2012, as amended at 79 FR 66118, Nov. 6, 2014; 81 FR 61563, Sept. 6, 2016]

§ 488.850 Directed plan of correction.

(a) Application. CMS may impose a directed plan of correction when an HHA:

(1) Has one or more deficiencies that warrant directing the HHA to take specific actions; or

(2) Fails to submit an acceptable plan of correction.

(b) Procedures. (1) Before imposing this sanction, CMS provides the HHA notice of the impending sanction.

(2) CMS or the temporary manager (with CMS approval) may direct the HHA to take corrective action to achieve specific outcomes within specific timeframes.

(c) Duration and effect of sanction. If the HHA fails to achieve compliance with the conditions of participation within the timeframes specified in the directed plan of correction, CMS:

(1) May impose one or more other sanctions set forth in §488.820; or

(2) Terminates the provider agreement.

§ 488.855 Directed in-service training.

(a) Application. CMS may require the staff of an HHA to attend in-service training program(s) if CMS determines that—

(1) The HHA has deficiencies that indicate noncompliance;

(2) Education is likely to correct the deficiencies; and

(3) The programs are conducted by established centers of health education and training or consultants with background in education and training with Medicare Home Health Providers, or as deemed acceptable by CMS and/or the State (by review of a copy of curriculum vitae(s) and/or resumes/references to determine the educator’s qualifications).

(b) Procedures—(1) Action following training. After the HHA staff has received in-service training, if the HHA has not achieved compliance, CMS may impose one or more other sanctions specified in §488.820.

(2) Payment. The HHA pays for the directed in-service training for its staff.

§ 488.860 Continuation of payments to an HHA with deficiencies.

(a) Continued payments. CMS may continue payments to an HHA with condition-level deficiencies that do not constitute immediate jeopardy for up to 6 months from the last day of the survey if the criteria in paragraph (a)(1) of this section are met.

(i) Criteria. CMS may continue payments to an HHA not in compliance with the conditions of participation for the period specified in paragraph (a) of this section if all of the following criteria are met:

(i) The HHA has been imposed an alternative sanction or sanctions and termination has not been imposed.

(ii) The HHA has submitted a plan of correction approved by CMS.

(iii) The HHA agrees to repay the Federal government payments received under this provision if corrective action is not taken in accordance with the approved plan and timetable for corrective action.

(2) CMS may terminate the HHA’s provider agreement any time if the criteria in paragraph (a)(1) of this section are not met.

(b) Cessation of payments for new admissions. If termination is imposed, either on its own or in addition to an alternative sanction or sanctions, or if any of the criteria set forth in paragraph (a)(1) of this section are not met, the HHA will receive no Medicare payments, as applicable, for new admissions following the last day of the survey.

(c) Failure to achieve compliance with the conditions of participation. If the HHA does not achieve compliance with the conditions of participation by the end of the period specified in paragraph (a) of this section, CMS will terminate
§ 488.865 Termination of provider agreement.

(a) Effect of termination by CMS. Termination of the provider agreement ends—

(1) Payment to the HHA; and

(2) Any alternative sanction(s).

(b) Basis for termination. CMS terminates an HHA’s provider agreement under any one of the following conditions—

(1) The HHA is not in compliance with the conditions of participation.

(2) The HHA fails to submit an acceptable plan of correction within the timeframe specified by CMS.

(3) The HHA fails to relinquish control to the temporary manager, if that sanction is imposed by CMS.

(4) The HHA fails to meet the eligibility criteria for continuation of payment as set forth in §488.860(a)(1).

(c) Notice. CMS notifies the HHA and the public of the termination, in accordance with procedures set forth in §489.53 of this chapter.

(d) Procedures for termination. CMS terminates the provider agreement in accordance with procedures set forth in §489.53 of this chapter.

(e) Appeal. An HHA may appeal the termination of its provider agreement by CMS in accordance with part 498 of this chapter.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

Subpart A—General Provisions

Sec.
489.1 Statutory basis.
489.2 Scope of part.
489.3 Definitions.
489.10 Basic requirements.
489.11 Acceptance of a provider as a participant.
489.12 Decision to deny an agreement.
489.13 Effective date of agreement or approval.
489.18 Change of ownership or leasing: Effect on provider agreement.

Subpart B—Essentials of Provider Agreements

489.20 Basic commitments.
489.21 Specific limitations on charges.

489.22 Special provisions applicable to prepayment requirements.
489.23 Specific limitation on charges for services provided to certain enrollees of fee-for-service FEHB plans.
489.24 Special responsibilities of Medicare hospitals in emergency cases.
489.25 Special requirements concerning CHAMPUS and CHAMPVA programs.
489.26 Special requirements concerning veterans.
489.27 Beneficiary notice of discharge rights.
489.28 Special capitalization requirements for HHAs.
489.29 Special requirements concerning beneficiaries served by the Indian Health Service, Tribal health programs, and urban Indian organization health programs.

Subpart C—Allowable Charges

489.30 Allowable charges: Deductibles and coinsurance.
489.31 Allowable charges: Blood.
489.32 Allowable charges: Noncovered and partially covered services.
489.34 Allowable charges: Hospitals participating in State reimbursement control systems or demonstration projects.
489.35 Notice to intermediary.

Subpart D—Handling of Incorrect Collections

489.40 Definition of incorrect collection.
489.41 Timing and methods of handling.
489.42 Payment of offset amounts to beneficiary or other person.

Subpart E—Termination of Agreement and Reinstatement After Termination

489.52 Termination by the provider.
489.53 Termination by CMS.
489.54 Termination by the OIG.
489.55 Exceptions to effective date of termination.
489.57 Reinstatement after termination.

Subpart F—Surety Bond Requirements for HHAs

489.60 Definitions.
489.61 Basic requirement for surety bonds.
489.62 Requirement waived for Government-operated HHAs.
489.63 Parties to the bond.
489.64 Authorized Surety and exclusion of surety companies.
489.65 Amount of the bond.
489.66 Additional requirements of the surety bond.
489.67 Term and type of bond.
489.68 Effect of failure to obtain, maintain, and timely file a surety bond.
§ 489.1 Statutory basis.

(a) This part implements section 1866 of the Social Security Act (the Act). Section 1866 of the Act specifies the terms of provider agreements, the grounds for terminating a provider agreement, the circumstances under which payment for new admissions may be denied, and the circumstances under which payment may be withheld for failure to make timely utilization review. The sections of the Act specified in paragraphs (a)(1) through (a)(4) of this section are also pertinent.

(1) Section 1861 of the Act defines the services covered under Medicare and the providers that may be reimbursed for furnishing those services.

(2) Section 1864 of the Act provides for the use of State survey agencies to ascertain whether certain entities meet the conditions of participation.

(3) Section 1865(a)(1) of the Act provides that an entity accredited by a national accreditation body found by the Secretary to satisfy the Medicare conditions of participation, conditions for coverage, or conditions of certification or requirements for participation shall be treated as meeting those requirements. Section 1865(a)(2) of the Act requires the Secretary to consider when making such a finding, among other things, the national accreditation body’s accreditation requirements and survey procedures.

(4) Section 1871 of the Act authorizes the Secretary to prescribe regulations for the administration of the Medicare program.

(b) Although section 1866 of the Act speaks only to providers and provider agreements, the following rules in this part also apply to the approval of supplier entities that, for participation in Medicare, are subject to a determination by CMS on the basis of a survey conducted by the SA or CMS surveyors; or, in lieu of an SA or CMS-conducted survey, accreditation by an accrediting organization whose program has CMS approval in accordance with the requirements of part 488 of this chapter at the time of the accreditation survey and accreditation decision, in accordance with the following:

(1) The definition of immediate jeopardy at § 489.3.

(2) The effective date rules specified in § 489.13.

(3) The requirements specified in § 489.53(a)(2), (13), and (18), related to termination by CMS of participation in Medicare.

(c) Section 1861(o)(7) of the Act requires each HHA to provide CMS with a surety bond.

§ 489.2 Scope of part.

(a) Subpart A of this part sets forth the basic requirements for submittal and acceptance of a provider agreement under Medicare. Subpart B of this part specifies the basic commitments and limitations that the provider must agree to as part of an agreement to provide services. Subpart C specifies the limitations on allowable charges to beneficiaries for deductibles, coinsurance, copayments, blood, and services that must be part of the provider agreement. Subpart D of this part specifies how incorrect collections are to be handled. Subpart F sets forth the circumstances and procedures for denial of payments for new admissions and for withholding of payment as an alternative to termination of a provider agreement.

(b) The following providers are subject to the provisions of this part:
(1) Hospitals.
(2) Skilled nursing facilities (SNFs).
(3) Home health agencies (HHAs).
(4) Clinics, rehabilitation agencies, and public health agencies.
(5) Comprehensive outpatient rehabilitation facilities (CORFs).
(6) Hospices.
(7) Critical access hospital (CAHs).
(8) Community mental health centers (CMHCs).
(9) Religious nonmedical health care institutions (RNHCIs).

(c)(1) Clinics, rehabilitation agencies, and public health agencies may enter into provider agreements only for furnishing outpatient physical therapy, and speech pathology services.

(2) CMHCs may enter into provider agreements only to furnish partial hospitalization services.

§ 489.10 Basic requirements.

(a) Any of the providers specified in § 489.2 may request participation in Medicare. In order to be accepted, it must meet the conditions of participation or requirements (for SNFs) set forth in this section and elsewhere in this chapter. The RNHCIs must meet the conditions for coverage, conditions for participation and the requirements set forth in this section and elsewhere in this chapter.

(b) In order to participate in the Medicare program, the provider must meet the applicable civil rights requirements of:

(1) Title VI of the Civil Rights Act of 1964, as implemented by 45 CFR part 80, which provides that no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under, any program or activity receiving Federal financial assistance (section 601);

(2) Section 504 of the Rehabilitation Act of 1973, as implemented by 45 CFR part 84, which provides that no qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination under any program or activity receiving Federal financial assistance;

(3) The Age Discrimination Act of 1975, as implemented by 45 CFR part 90, which is designed to prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance. The Age Discrimination Act also permits federally assisted programs and activities, and beneficiaries of Federal funds, to continue to use certain age distinctions, and factors other than age, that meet the requirements of the Act.

§ 489.10 Basic requirements.

(a) Any of the providers specified in § 489.2 may request participation in Medicare. In order to be accepted, it must meet the conditions of participation or requirements (for SNFs) set forth in this section and elsewhere in this chapter. The RNHCIs must meet the conditions for coverage, conditions for participation and the requirements set forth in this section and elsewhere in this chapter.

(b) In order to participate in the Medicare program, the provider must meet the applicable civil rights requirements of:

(1) Title VI of the Civil Rights Act of 1964, as implemented by 45 CFR part 80, which provides that no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under, any program or activity receiving Federal financial assistance (section 601);

(2) Section 504 of the Rehabilitation Act of 1973, as implemented by 45 CFR part 84, which provides that no qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination under any program or activity receiving Federal financial assistance;

(3) The Age Discrimination Act of 1975, as implemented by 45 CFR part 90, which is designed to prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance. The Age Discrimination Act also permits federally assisted programs and activities, and beneficiaries of Federal funds, to continue to use certain age distinctions, and factors other than age, that meet the requirements of the Act.

(4) Other pertinent requirements of the Office of Civil Rights of HHS.
§ 489.11 Acceptance of a provider as a participant.

(a) Action by CMS. If CMS determines that the provider meets the requirements, it will send the provider—

(1) Written notice of that determination; and

(2) Two copies of the provider agreement.

(b) Action by provider. If the provider wishes to participate, it must return both copies of the agreement, duly signed by an authorized official, to CMS, together with a written statement indicating whether it has been adjudged insolvent or bankrupt in any State or Federal court, or whether any insolvency or bankruptcy actions are pending.

(c) Notice of acceptance. If CMS accepts the agreement, it will return one copy to the provider with a written notice that—

(1) Indicates the dates on which it was signed by the provider’s representative and accepted by CMS; and

(2) Specifies the effective date of the agreement.


§ 489.12 Decision to deny an agreement.

(a) Bases for denial. CMS may refuse to enter into an agreement for any of the following reasons:

(1) Principals of the prospective provider have been convicted of fraud (see § 420.204 of this chapter);

(2) The prospective provider has failed to disclose ownership and control interests in accordance with § 420.206 of this chapter;

(3) The prospective provider is a physician-owned hospital as defined in § 489.3 and does not have procedures in place for making physician ownership disclosures to patients in accordance with § 489.20(u); or

(4) The prospective provider is unable to give satisfactory assurance of compliance with the requirements of title XVIII of the Act.

(b) [Reserved]

(c) Compliance with civil rights requirements. CMS will not enter into a provider agreement if the provider fails to comply with civil rights requirements set forth in 45 CFR parts 80, 84, and 90, subject to the provisions of § 489.10.


§ 489.13 Effective date of agreement or approval.

(a) Applicability—(1) General rule. Except as provided in paragraph (a)(2) of this section, this section applies to Medicare provider agreements with, and supplier approval of, entities that, as a basis for participation in Medicare, are subject to a determination by CMS on the basis of—

(i) A survey conducted by the State survey agency or CMS surveyors; or

(ii) In lieu of such State survey agency or CMS conducted survey, accreditation by an accreditation organization whose program has CMS approval in accordance with section 1865 of the Act at the time of the accreditation survey and accreditation decision.

(2) Exceptions. (1) For an agreement with a community mental health center (CMHC) or a federally qualified health center (FQHC), the effective date is the date on which CMS accepts a signed agreement which assures that
the CMHC or FQHC meets all Federal requirements.

(ii) A Medicare supplier approval of a laboratory is effective only while the laboratory has in effect a valid CLIA certificate issued under part 493 of this chapter, and only for the specialty and subspeciality tests it is authorized to perform.

(b) All health and safety standards are met on the date of survey. The agreement or approval is effective on the date the State agency, CMS, or the CMS contractor survey (including the Life Safety Code survey, if applicable) is completed, or on the effective date of the accreditation decision, as applicable, if on that date the provider or supplier meets all applicable Federal requirements as set forth in this chapter. (If the agreement or approval is time-limited, the new agreement or approval is effective on the day following the expiration of the current agreement or approval.) However, the effective date of the agreement or approval may not be earlier than the latest of the dates on which CMS determines that each applicable Federal requirement is met. Federal requirements include, but are not limited to—

(1) Enrollment requirements established in part 424, subpart P, of this chapter. CMS determines, based upon its review and verification of the prospective provider’s or supplier’s enrollment application, the date on which enrollment requirements have been met;

(2) The requirements identified in §§489.10 and 489.12; and

(3) The applicable Medicare health and safety standards, such as the applicable conditions of participation, the requirements for participation, the conditions for coverage, or the conditions for certification.

(c) All health and safety standards are not met on the date of survey. If, on the date the survey is completed, the provider or supplier has failed to meet any one of the applicable health and safety standards, the following rules apply for determining the effective date of the provider agreement or supplier approval, assuming that no other Federal requirements remain to be satisfied. However, if other Federal requirements remain to be satisfied, notwithstanding the provisions of paragraphs (c)(1) through (c)(3) of this section, the effective date of the agreement or approval may not be earlier than the latest of the dates on which CMS determines that each applicable Federal requirement is met.

(1) For an agreement with an SNF, the effective date is the date on which—

(i) The SNF is in substantial compliance (as defined in §488.301 of this chapter) with the requirements for participation; and

(ii) CMS or the State survey agency receives from the SNF, if applicable, an approvable waiver request.

(2) For an agreement with, or an approval of, any other provider or supplier, (except those specified in paragraph (a)(2) of this section), the effective date is the earlier of the following:

(i) The date on which the provider or supplier meets all applicable conditions of participation, conditions for coverage, or conditions for certification; or, if applicable, the date of a CMS-approved accreditation organization program’s positive accreditation decision, issued after the accreditation organization has determined that the provider or supplier meets all applicable conditions.

(ii) The date on which a provider or supplier is found to meet all conditions of participation, conditions for coverage, or conditions for certification, but has lower-level deficiencies, and—

(A) CMS or the State survey agency receives an acceptable plan of correction for the lower-level deficiencies (the date of receipt is the effective date regardless of when the plan of correction is approved); or, if applicable, a CMS-approved accreditation organization program issues a positive accreditation decision after it receives an acceptable plan of correction for the lower-level deficiencies; or

(B) CMS receives an approvable waiver request (the date of receipt is the effective date regardless of when CMS approves the waiver request).

(3) For an agreement with any other provider or an approval of any other supplier (except those specified in paragraph (a)(2) of this section) that is
found to meet all conditions of participation, conditions for coverage, or conditions for certification, but has lower-level deficiencies and has submitted both an approvable plan of correction/positive accreditation decision and an approvable waiver request, the effective date is the later of the dates that result when calculated in accordance with paragraph (c)(2)(ii)(A) or (c)(2)(ii)(B) of this section.

[75 FR 50418, Aug. 16, 2010]

§ 489.18 Change of ownership or leasing: Effect on provider agreement.

(a) What constitutes change of ownership—(1) Partnership. In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law, constitutes change of ownership.

(2) Unincorporated sole proprietorship. Transfer of title and property to another party constitutes change of ownership.

(3) Corporation. The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.

(4) Leasing. The lease of all or part of a provider facility constitutes change of ownership of the leased portion.

(b) Notice to CMS. A provider who is contemplating or negotiating a change of ownership must notify CMS.

(c) Assignment of agreement. When the effective date is a change of ownership as specified in paragraph (a) of this section, the existing provider agreement will automatically be assigned to the new owner.

(d) Conditions that apply to assigned agreements. An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Compliance with applicable health and safety standards.

(3) Compliance with the ownership and financial interest disclosure requirements of part 420, subpart C, of this chapter.

(4) Compliance with civil rights requirements set forth in 45 CFR parts 80, 84, and 90.

(e) Effect of leasing. The provider agreement will be assigned to the lessee only to the extent of the leased portion of the facility.


§ 489.20 Basic commitments.

The provider agrees to the following:

(a) To limit its charges to beneficiaries and to other individuals on their behalf, in accordance with provisions of subpart C of this part.

(b) To comply with the requirements of subpart D of this part for the return or other disposition of any amounts incorrectly collected from a beneficiary or any other person in his or her behalf.

(c) To comply with the requirements of § 420.203 of this chapter when it hires certain former employees of intermediaries.

(d) In the case of a hospital or a CAH that furnishes services to Medicare beneficiaries, either to furnish directly or to make arrangements (as defined in § 409.3 of this chapter) for all Medicare-covered services to inpatients and outpatients of a hospital or a CAH except the following:

(1) Physicians’ services that meet the criteria of § 415.102(a) of this chapter for payment on a reasonable charge basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act, that are furnished after December 31, 1990.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse-midwife services, as defined in section 1861(ff) of the Act, that are furnished after December 31, 1990.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act, that are furnished after December 31, 1990.
(6) Services of an anesthetist, as defined in §410.69 of this chapter.

(e) In the case of a hospital or CAH that furnishes inpatient hospital services or inpatient CAH services for which payment may be made under Medicare, to maintain an agreement with a QIO for that organization to review the admissions, quality, appropriateness, and diagnostic information related to those inpatient services. The requirement of this paragraph (e) applies only if, for the area in which the hospital or CAH is located, there is a QIO that has a contract with CMS under part B of title XI of the Act.

(f) To maintain a system that, during the admission process, identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented.

(g) To bill other primary payers before Medicare.

(h) If the provider receives payment for the same services from Medicare and another payer that is primary to Medicare, to reimburse Medicare any overpaid amount within 60 days.

(i) If the provider receives, from a payer that is primary to Medicare, a payment that is reduced because the provider failed to file a proper claim—

(1) To bill Medicare for an amount no greater than would have been payable as secondary payment if the primary insurer’s payment had been based on a proper claim; and

(2) To charge the beneficiary only:

(i) The amount it would have been entitled to charge if it had filed a proper claim and received payment based on such a claim; and

(ii) An amount equal to any primary payment reduction attributable to failure to file a proper claim, but only if the provider can show that—

(A) It failed to file a proper claim solely because the beneficiary, for any reason other than mental or physical incapacity, failed to give the provider the necessary information; or

(B) The beneficiary, who was responsible for filing a proper claim, failed to do so for any reason other than mental or physical incapacity.

(j) In the State of Oregon, because of a court decision, and in the absence of a reversal on appeal or a statutory clarification overturning the decision, hospitals may bill liability insurers first. However, if the liability insurer does not pay “promptly”, as defined in §411.50 of this chapter, the hospital must withdraw its claim or lien and bill Medicare for covered services.

(k) In the case of home health agencies that provide home health services to Medicare beneficiaries under subpart E of part 409 and subpart C of part 410 of this chapter, to offer to furnish catheters, catheter supplies, ostomy bags, and supplies related to ostomy care to any individual who requires them as part of their furnishing of home health services.

(l) In the case of a hospital as defined in §489.24(b) to comply with §489.24.

(m) In the case of a hospital as defined in §489.24(b), to report to CMS or the State survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the requirements of §489.24(e).

(n) In the case of inpatient hospital services, to participate in any health plan contracted for under 10 U.S.C. 1079 or 1086 or 38 U.S.C. 613, in accordance with §489.25.

(o) In the case of inpatient hospital services, to admit veterans whose admission has been authorized under 38 U.S.C. 603, in accordance with §489.26.

(p) To comply with §489.27 of this part concerning notification of Medicare beneficiaries of their rights associated with the termination of Medicare services.

(q) In the case of a hospital as defined in §489.24(b)—

(1) To post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area), a sign (in a form specified by the Secretary) specifying rights of individuals under Section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and
(2) To post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital participates in the Medicaid program under a State plan approved under title XIX.

(r) In the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain—

(1) Medical and other records related to individuals transferred to or from the hospital for a period of 5 years from the date of the transfer;

(2) An on-call list of physicians who are on the hospital’s medical staff or who have privileges at the hospital, or who are on the staff or have privileges at another hospital participating in a formal community call plan, in accordance with §489.24(j)(2)(iii), available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under §489.24 in accordance with the resources available to the hospital; and

(3) A central log on each individual who comes to the emergency department, as defined in §489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.

(s) In the case of an SNF, either to furnish directly or make arrangements (as defined in §409.3 of this chapter) for all Medicare-covered services furnished to a resident (as defined in §411.15(p)(3) of this chapter) of the SNF, except the following:

(1) Physicians’ services that meet the criteria of §415.102(a) of this chapter for payment on a fee schedule basis.

(2) Services performed under a physician’s supervision by a physician assistant who meets the applicable definition in section 1861(aa)(5) of the Act.

(3) Services performed by a nurse practitioner or clinical nurse specialist who meets the applicable definition in section 1861(aa)(5) of the Act and is working in collaboration (as defined in section 1861(aa)(6) of the Act) with a physician.

(4) Services performed by a certified nurse-midwife, as defined in section 1861(gg) of the Act.

(5) Services performed by a qualified psychologist, as defined in section 1861(ii) of the Act.

(6) Services performed by a certified registered nurse anesthetist, as defined in section 1861(bb) of the Act.

(7) Dialysis services and supplies, as defined in section 1861(s)(2)(F) of the Act, and those ambulance services that are furnished in conjunction with them.

(8) Erythropoietin (EPO) for dialysis patients, as defined in section 1861(s)(2)(O) of the Act.

(9) Hospice care, as defined in section 1861(dd) of the Act.

(10) An ambulance trip that initially conveys an individual to the SNF to be admitted as a resident, or that conveys an individual from the SNF in connection with one of the circumstances specified in §411.15(p)(3) through (p)(3)(iv) of this chapter as ending the individual’s status as an SNF resident.

(11) The transportation costs of electrocardiogram equipment (HCPCS code H0076), but only with respect to those electrocardiogram test services furnished during 1998.

(12) Services described in paragraphs (s)(1) through (6) of this section when furnished via telehealth under section 1834(m)(4)(C)(i)(VII) of the Act.


(14) Those chemotherapy administration services identified, as of July 1, 1999, by HCPCS codes 36260–36262; 36489; 36530–36535; 36640; 36823; and 96405–96542.

(15) Those radioisotope services identified, as of July 1, 1999, by HCPCS codes 79030–79440.

(16) Those customized prosthetic devices (including artificial limbs and their components) identified, as of July 1, 1999, by HCPCS codes L5050–L5340; L5500–L5611; L5613–L5986; L5988; L6050–L6370; L6400–6688; L6920–L7274; and L7362–L7366, which are delivered for a resident’s use during a stay in the SNF.
Centers for Medicare & Medicaid Services, HHS § 489.20

and intended to be used by the resident after discharge from the SNF.

(17) Those RHC and FQHC services that are described in §405.2411(b)(2) of this chapter.

t) Hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under section 18(b) of the Occupational Safety and Health Act) must comply with the bloodborne pathogens (BBP) standards under 29 CFR 1910.1030. A hospital that fails to comply with the BBP standards may be subject to a civil money penalty in accordance with section 17 of the Occupational Safety and Health Act of 1970, including any adjustments of the civil money penalty amounts under the Federal Civil Penalties Inflation Adjustment Act, for a violation of the BBP standards. A civil money penalty will be imposed and collected in the same manner as civil money penalties under section 1128A(a) of the Social Security Act.

u) Except as provided in paragraph (v) of this section, in the case of a physician-owned hospital as defined at §489.3—

(1) To furnish written notice to each patient at the beginning of the patient’s hospital stay or outpatient visit that the hospital is a physician-owned hospital, in order to assist the patient in making an informed decision regarding his or her care, in accordance with §482.13(b)(2) of this subchapter. The notice should disclose, in a manner reasonably designed to be understood by all patients, the fact that the hospital meets the Federal definition of a physician-owned hospital specified in §489.3 and that the list of the hospital’s owners or investors who are physicians or immediate family members (as defined at §411.351 of this chapter) of physicians is available upon request and must be provided to the patient at the time the request for the list is made by or on behalf of the patient. For purposes of this paragraph (u)(1), the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or an outpatient service.

(2) To require each physician who is a member of the hospital’s medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose, in writing, to all patients the physician refers to the hospital any ownership or investment interest in the hospital that is held by the physician or by an immediate family member (as defined at §411.351 of this chapter) of the physician. Disclosure must be required at the time the referral is made.

(v) The requirements of paragraph (u) of this section do not apply to any physician-owned hospital that does not have at least one referring physician (as defined at §411.351 of this chapter) who has an ownership or investment interest in the hospital or who has an immediate family member who has an ownership or investment interest in the hospital, provided that such hospital signs an attestation statement to that effect and maintains such attestation in its records.

(w)(1) In the case of a hospital as defined in §489.24(b), to furnish written notice to all patients at the beginning of their planned or unplanned inpatient hospital stay or at the beginning of any planned or unplanned outpatient visit for observation, surgery or any other procedure requiring anesthesia, if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week, in order to assist the patients in making informed decisions regarding their care, in accordance with §482.13(b)(2) of this subchapter. For purposes of this paragraph, a planned hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or outpatient service. An unplanned hospital stay or outpatient visit begins at the earliest point at which the patient presents to the hospital.

(2) In the case of a hospital that is a main provider and has one or more remote locations of a hospital or one or more satellites, as these terms are defined in §413.65(a)(2), §412.22(h), or §412.23(e) of this chapter, as applicable, the determination is made separately for the main provider and each remote
§ 489.20

42 CFR Ch. IV (10–1–16 Edition)

location or satellite whether notice to patients is required. Notice is required at each location at which inpatient services are furnished at which a doctor of medicine or doctor of osteopathy is not present 24 hours per day, 7 days per week.

(3) The written notice must state that the hospital does not have a doctor of medicine or a doctor of osteopathy present in the hospital 24 hours per day, 7 days per week, and must indicate how the hospital will meet the medical needs of any patient who develops an emergency medical condition, as defined in §489.24(b), at a time when there is no doctor of medicine or doctor of osteopathy present in the hospital.

(4) Before admitting a patient or providing an outpatient service to outpatients for whom a notice is required, the hospital must receive a signed acknowledgment from the patient stating that the patient understands that a doctor of medicine or doctor of osteopathy may not be present during all hours services are furnished to the patient.

(5) Each dedicated emergency department, as that term is defined in §489.24(b), in a hospital in which a doctor of medicine or doctor of osteopathy is not present 24 hours per day, 7 days per week must post a notice conspicuously in a place or places likely to be noticed by all individuals entering the dedicated emergency department. The posted notice must state that the hospital does not have a doctor of medicine or a doctor of osteopathy present in the hospital 24 hours per day, 7 days per week, and must indicate how the hospital will meet the medical needs of any patient with an emergency medical condition, as defined in §489.24(b), at a time when there is no doctor of medicine or doctor of osteopathy present in the hospital.

(x) To comply with §488.30 of this chapter, to pay revisit user fees when and if assessed.

(y) In the case of a hospital or critical access hospital, to provide notice, as specified in paragraphs (y)(1) and (2) of this section, to each individual entitled to Medicare benefits under Title XVIII of the Act when such individual receives observation services as an outpatient for more than 24 hours. Notice must be provided to the individual not later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged, or admitted. Notice may be provided before such individual receives 24 hours of observation services as an outpatient.

(1) Written notice. Hospitals and critical access hospitals must use a standardized written notice, as specified by the Secretary, which includes the following information:

(i) An explanation of the status of the individual as an outpatient receiving observation services and not as an inpatient of the hospital or critical access hospital and the reason for status as an outpatient receiving observation services; and

(ii) An explanation of the implications of such status as an outpatient on services furnished by the hospital or critical access hospital (including services furnished on an inpatient basis), such as Medicare cost-sharing requirements, and subsequent eligibility for Medicare coverage for skilled nursing facility services.

(2) Oral notice. The hospital must give an oral explanation of the written notification described in paragraph (y)(1) of this section.

(3) Signature requirements. The written notice specified in paragraph (y)(1) of this section must either—

(i) Be signed by the individual who receives observation services as an outpatient or a person acting on the individual’s behalf to acknowledge receipt of such notification; or

(ii) If the individual who receives observation services as an outpatient or the person acting on behalf of the individual refuses to provide the signature described in paragraph (y)(1) of this section, is signed by the staff member of the hospital or critical access hospital who presented the written notification and includes the name and title of the staff member, a certification that the notification was presented, and the date and time the notification was presented.

[45 FR 22937, Apr. 4, 1980]

EDITORIAL NOTE: For Federal Register citations affecting §489.20, see the List of CFR Sections Affected, which appears in the
§ 489.21 Specific limitations on charges.

Except as specified in subpart C of this part, the provider agrees not to charge a beneficiary for any of the following:

(a) Services for which the beneficiary is entitled to have payment made under Medicare.

(b) Services for which the beneficiary would be entitled to have payment made if the provider—

(1) Had in its files the required certification and recertification by a physician relating to the services furnished to the beneficiary;

(2) Had furnished the information required by the intermediary in order to determine the amount due the provider on behalf of the individual for the period with respect to which payment is to be made or any prior period;

(3) Had complied with the provisions requiring timely utilization review of long stay cases so that a limitation on days of service has not been imposed under section 1866(d) of the Act (see subpart K of part 405 and part 482 of this chapter for utilization review requirements); and

(4) Had obtained, from the beneficiary or a person acting on his or her behalf, a written request for payment to be made to the provider, and had properly filed that request. (If the beneficiary or person on his or her behalf refuses to execute a written request, the provider may charge the beneficiary for all services furnished to him or her.)

(c) Inpatient hospital services furnished to a beneficiary who exhausted his or her Part A benefits, if CMS reimburses the provider for those services.

(d) Custodial care and services not reasonable and necessary for the diagnosis or treatment of illness or injury, if—

(1) The beneficiary was without fault in incurring the expenses; and

(2) The determination that payment was incorrect was not made until after the third year following the year in which the payment notice was sent to the beneficiary.

(e) Inpatient hospital services for which a beneficiary would be entitled to have payment made under Part A of Medicare but for a denial or reduction in payments under regulations at §412.48 of this chapter or under section 1886(f) of the Act.

(f) Items and services furnished to a hospital inpatient (other than physicians’ services as described in §415.102(a) of this chapter or the services of an anesthetist as described in §405.553(b)(4) of this chapter) for which Medicare payment would be made if furnished by the hospital or by other providers or suppliers under arrangements made with them by the hospital. For this purpose, a charge by another provider or supplier for such an item or service is treated as a charge by the hospital for the item or service, and is also prohibited.

(g) [Reserved]

(h) Items and services (other than those described in §489.20(s)(1) through (15)) required to be furnished under §489.20(s) to a resident of an SNF (defined in §411.15(p) of this chapter), for which Medicare payment would be made if furnished by the SNF or by other providers or suppliers under arrangements made with them by the SNF. For this purpose, a charge by another provider or supplier for such an item or service is treated as a charge by the SNF for the item or service, and is also prohibited.


§ 489.22 Special provisions applicable to prepayment requirements.

(a) A provider may not require an individual entitled to hospital insurance benefits to prepay in part or in whole for inpatient services as a condition of admittance as an inpatient, except where it is clear upon admission that payment under Medicare, Part A cannot be made.
§ 489.23 Specific limitation on charges for services provided to certain enrollees of fee-for-service FEHB plans.

A provider that furnishes inpatient hospital services to a retired Federal worker age 65 or older who is enrolled in a fee-for-service FEHB plan and who is not covered under Medicare Part A, must accept, as payment in full, an amount that approximates as closely as possible the Medicare inpatient hospital prospective payment system (PPS) rate established under part 412. The payment to the provider is composed of a payment from the FEHB plan and a payment from the enrollee. This combined payment approximates the Medicare PPS rate. The payment from the FEHB plan approximates, as closely as possible, the Medicare PPS rate minus any applicable enrollee deductible, coinsurance, or copayment amount. The payment from the enrollee is equal to the applicable deductible, coinsurance, or copayment amount.


§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(a) Applicability of provisions of this section. (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) “comes to the emergency department”, as defined in paragraph (b) of this section, the hospital must—

(i) Provide an appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of § 482.55 of this chapter concerning emergency services personnel and direction; and

(ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital’s obligation under this section ends, as specified in paragraph (d)(2) of this section.

(2)(i) When a waiver has been issued in accordance with section 1135 of the Act that includes a waiver under section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met:

(A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.

(B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.

(C) The hospital does not discriminate on the basis of an individual’s source of payment or ability to pay.

(D) The hospital is located in an emergency area during an emergency...
period, as those terms are defined in section 1135(g)(1) of the Act.

(E) There has been a determination that a waiver of sanctions is necessary.

(ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under section 1135(e)(1)(B) of the Act.

(b) Definitions. As used in this subpart—

Capacity means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital’s past practices of accommodating additional patients in excess of its occupancy limits.

Comes to the emergency department means, with respect to an individual who is not a patient (as defined in this section), the individual—

(1) Has presented at a hospital’s dedicated emergency department, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual’s appearance or behavior, that the individual needs examination or treatment for a medical condition;

(2) Has presented on hospital property, other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual’s appearance or behavior, that the individual needs emergency examination or treatment;

(3) Is in a ground or air ambulance owned and operated by the hospital for purposes of examination and treatment for a medical condition at a hospital’s dedicated emergency department, even if the ambulance is not on hospital grounds. However, an individual in an ambulance owned and operated by the hospital is not considered to have “come to the hospital’s emergency department” if—

(i) The ambulance is operated under communitywide emergency medical service (EMS) protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance; for example, to the closest appropriate facility. In this case, the individual is considered to have come to the emergency department of the hospital to which the individual is transported, at the time the individual is brought onto hospital property;

(ii) The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance; or

(4) Is in a ground or air nonhospital-owned ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital’s dedicated emergency department. However, an individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital’s emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. The hospital may direct the ambulance to another facility if it is in “diversionary status,” that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital’s diversion instructions and transports the individual onto hospital property, the individual is considered to have come to the emergency department.
Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:  
(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;  
(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or  
(3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Emergency medical condition means—  
(1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in—  
(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;  
(ii) Serious impairment to bodily functions; or  
(iii) Serious dysfunction of any bodily organ or part; or  
(2) With respect to a pregnant woman who is having contractions—  
(i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or  
(ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Hospital includes a critical access hospital as defined in section 1861(mm)(1) of the Act.

Hospital property means the entire main hospital campus as defined in §413.65(b) of this chapter, including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital’s main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.

Hospital with an emergency department means a hospital with a dedicated emergency department as defined in this paragraph (b).

Inpatient means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services as described in §409.10(a) of this chapter with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.

Participating hospital means (1) a hospital or (2) a critical access hospital as defined in section 1861(mm)(1) of the Act that has entered into a Medicare provider agreement under section 1866 of the Act.

Patient means—  
(1) An individual who has begun to receive outpatient services as part of an encounter, as defined in §410.2 of this chapter, other than an encounter that the hospital is obligated by this section to provide;  
(2) An individual who has been admitted as an inpatient, as defined in this section.

Stabilized, with respect to an “emergency medical condition” as defined in this section under paragraph (1) of that definition, that no material deterioration of the condition is likely, within reasonable medical probability.
Centers for Medicare & Medicaid Services, HHS § 489.24

To result from or occur during the transfer of the individual from a facility or, with respect to an “emergency medical condition” as defined in this section under paragraph (2) of that definition, that the woman has delivered the child and the placenta.

To stabilize means, with respect to an “emergency medical condition” as defined in this section under paragraph (1) of that definition, to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or that, with respect to an “emergency medical condition” as defined in this section under paragraph (2) of that definition, the woman has delivered the child and the placenta.

Transfer means the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person.

(c) Use of dedicated emergency department for nonemergency services. If an individual comes to a hospital’s dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

(d) Necessary stabilizing treatment for emergency medical conditions—(1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.

(ii) For transfer of the individual to another medical facility in accordance with paragraph (e) of this section.

(2) Exception: Application to inpatients. (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual.

(ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.

(3) Refusal to consent to treatment. A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual’s behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual’s behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual’s written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

(4) Delay in examination or treatment. (i) A participating hospital may not delay providing an appropriate medical screening examination required under paragraph (a) of this section or further
medical examination and treatment required under paragraph (d)(1) of this section in order to inquire about the individual’s method of payment or insurance status.

(ii) A participating hospital may not seek, or direct an individual to seek, authorization from the individual’s insurance company for screening or stabilization services to be furnished by a hospital, physician, or nonphysician practitioner to an individual until after the hospital has provided the appropriate medical screening examination required under paragraph (a) of this section, and initiated any further medical examination and treatment that may be required to stabilize the emergency medical condition under paragraph (d)(1) of this section.

(iii) An emergency physician or nonphysician practitioner is not precluded from contacting the individual’s physician at any time to seek advice regarding the individual’s medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation does not inappropriately delay services required under paragraph (a) or paragraphs (d)(1) and (d)(2) of this section.

(iv) Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.

(5) **Refusal to consent to transfer.** A hospital meets the requirements of paragraph (d)(1)(ii) of this section with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with paragraph (e) of this section and informs the individual (or a person acting on his or her behalf) of the risks and benefits to the individual of the transfer, but the individual (or a person acting on the individual’s behalf) does not consent to the transfer. The hospital must take all reasonable steps to secure the individual’s written informed refusal (or that of a person acting on his or her behalf). The written document must indicate the person has been informed of the risks and benefits of the transfer and state the reasons for the individual’s refusal. The medical record must contain a description of the proposed transfer that was refused by or on behalf of the individual.

(e) **Restricting transfer until the individual is stabilized**—(1) General. If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless—

(i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and

(ii)(A) The individual (or a legally responsible person acting on the individual’s behalf) requests the transfer, after being informed of the hospital’s obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;

(B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or

(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its by-laws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.
(2) A transfer to another medical facility will be appropriate only in those cases in which—

(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual’s health and, in the case of a woman in labor, the health of the unborn child;

(ii) The receiving facility—

(A) Has available space and qualified personnel for the treatment of the individual; and

(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual’s emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital’s files) must be sent as soon as practicable after transfer; and

(iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

(3) A participating hospital may not penalize or take adverse action against a physician or a qualified medical person described in paragraph (e)(1)(ii)(C) of this section because the physician or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of this section.

(f) Recipient hospital responsibilities. A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive case units, or, with respect to rural areas, regional referral centers (which, for purposes of this subpart, mean hospitals meeting the requirements of referral centers found at §412.96 of this chapter)) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

(1) The provisions of this paragraph (f) apply to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

(2) The provisions of this paragraph (f) do not apply to an individual who has been admitted to a referring hospital under the provisions of paragraph (d)(2)(i) of this section.

(g) Termination of provider agreement. If a hospital fails to meet the requirements of paragraph (a) through (f) of this section, CMS may terminate the provider agreement in accordance with §489.53.

(h) Consultation with Quality Improvement Organizations (QIOs)—(1) General. Except as provided in paragraph (h)(3) of this section, in cases where a medical opinion is necessary to determine a physician’s or hospital’s liability under section 1867(d)(1) of the Act, CMS requests the appropriate QIO (with a contract under Part B of title XI of the Act) to review the alleged section 1867(d) violation and provide a report on its findings in accordance with paragraph (h)(2)(iv) and (v) of this section.

CMS provides to the QIO all information relevant to the case and within its possession or control. CMS, in consultation with the OIG, also provides to the QIO a list of relevant questions to which the QIO must respond in its report.

(2) Notice of review and opportunity for discussion and additional information. The QIO shall provide the physician
and hospital reasonable notice of its review, a reasonable opportunity for discussion, and an opportunity for the physician and hospital to submit additional information before issuing its report. When a QIO receives a request for consultation under paragraph (h)(1) of this section, the following provisions apply—

(i) The QIO reviews the case before the 15th calendar day and makes its tentative findings.

(ii) Within 15 calendar days of receiving the case, the QIO gives written notice, sent by certified mail, return receipt requested, to the physician or the hospital (or both if applicable).

(iii)(A) The written notice must contain the following information:

(1) The name of each individual who may have been the subject of the alleged violation.

(2) The date on which each alleged violation occurred.

(3) An invitation to meet, either by telephone or in person, to discuss the case with the QIO, and to submit additional information to the QIO within 30 calendar days of receipt of the notice, and a statement that these rights will be waived if the invitation is not accepted. The QIO must receive the information and hold the meeting within the 30-day period.

(d) A copy of the regulations at 42 CFR 489.24.

(B) For purposes of paragraph (h)(2)(iii)(A) of this section, the date of receipt is presumed to be 5 days after the certified mail date on the notice, unless there is a reasonable showing to the contrary.

(iv) The physician or hospital (or both where applicable) may request a meeting with the QIO. This meeting is not designed to be a formal adversarial hearing or a mechanism for discovery by the physician or hospital. The meeting is intended to afford the physician and/or the hospital a full and fair opportunity to present the views of the physician and/or hospital regarding the case. The following provisions apply to that meeting:

(A) The physician and/or hospital has the right to have legal counsel present during that meeting. However, the QIO may control the scope, extent, and manner of any questioning or any other presentation by the attorney. The QIO may also have legal counsel present.

(B) The QIO makes arrangements so that, if requested by CMS or the OIG, a verbatim transcript of the meeting may be generated. If CMS or OIG requests a transcript, the affected physician and/or the affected hospital may request that CMS provide a copy of the transcript.

(C) The QIO affords the physician and/or the hospital an opportunity to present, with the assistance of counsel, expert testimony in either oral or written form on the medical issues presented. However, the QIO may reasonably limit the number of witnesses and length of such testimony if such testimony is irrelevant or repetitive. The physician and/or hospital, directly or through counsel, may disclose patient records to potential expert witnesses without violating any non-disclosure requirements set forth in part 476 of this chapter.

(D) The QIO is not obligated to consider any additional information provided by the physician and/or the hospital after the meeting, unless, before the end of the meeting, the QIO requests that the physician and/or hospital submit additional information to support the claims. The QIO then allows the physician and/or the hospital an additional period of time, not to exceed 5 calendar days from the meeting, to submit the relevant information to the QIO.

(v) Within 60 calendar days of receiving the case, the QIO must submit to CMS a report on the QIO’s findings. CMS provides copies to the OIG and to the affected physician and/or the affected hospital. The report must contain the name of the physician and/or the hospital, the name of the individual, and the dates and times the individual arrived at and was transferred (or discharged) from the hospital. The report provides expert medical opinion regarding whether the individual involved had an emergency medical condition, whether the individual’s emergency medical condition was stabilized, whether the individual was transferred appropriately, and whether there were any medical utilization or quality of care issues involved in the case.
(vi) The report required under paragraph (h)(2)(v) of this section should not state an opinion or conclusion as to whether section 1867 of the Act or §489.24 has been violated.

(3) If a delay would jeopardize the health or safety of individuals or when there was no screening examination, the QIO review described in this section is not required before the OIG may impose civil monetary penalties or an exclusion in accordance with section 1867(d)(1) of the Act and 42 CFR part 1003 of this title.

(4) If the QIO determines after a preliminary review that there was an appropriate medical screening examination and the individual did not have an emergency medical condition, as defined by paragraph (b) of this section, then the QIO may, at its discretion, return the case to CMS and not meet the requirements of paragraph (h) except for those in paragraph (h)(2)(v).

(i) **Release of QIO assessments.** Upon request, CMS may release a QIO assessment to the physician and/or hospital, or the affected individual, or his or her representative. The QIO physician’s identity is confidential unless he or she consents to its release. (See §§476.132 and 476.133 of this chapter.)

(j) **Availability of on-call physicians.** In accordance with the on-call list requirements specified in §489.20(c)(2), a hospital must have written policies and procedures in place—

(1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician’s control; and

(2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to—

(i) Permit on-call physicians to schedule elective surgery during the time that they are on call;

(ii) Permit on-call physicians to have simultaneous on-call duties; and

(iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community plan must include the following elements:

(A) A clear delineation of on-call coverage responsibilities; that is, when each hospital participating in the plan is responsible for on-call coverage.

(B) A description of the specific geographic area to which the plan applies.

(C) A signature by an appropriate representative of each hospital participating in the plan.

(D) Assurances that any local and regional EMS system protocol formally includes information on community on-call arrangements.

(E) A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation under §489.24 to provide a medical screening examination and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations under §489.24 governing appropriate transfers.

(F) An annual assessment of the community call plan by the participating hospitals.


**EFFECTIVE DATE NOTE:** At 59 FR 32120, June 22, 1994, §489.24 was added. Paragraphs (d) and (g) contain information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

§489.25 Special requirements concerning CHAMPUS and CHAMPVA programs.

For inpatient services, a hospital that participates in the Medicare program must participate in any health plan contracted under 10 U.S.C. 1079 or 1086 (Civilian Health and Medical Program of the Uniformed Services) and under 38 U.S.C. 613 (Civilian Health and Medical Program of the Veterans Administration) and accept the CHAMPUS/CHAMPVA-determined allowable amount as payment in full, less applicable deductible, patient cost-share, and noncovered items. Hospitals
§ 489.26 Special requirements concerning veterans.

For inpatient services, a hospital that participates in the Medicare program must admit any veteran whose admission is authorized by the Department of Veterans Affairs under 38 U.S.C. 603 and must meet the requirements of 38 CFR part 17 concerning admissions practices and payment methodology and amounts. This section applies to services furnished to veterans admitted on and after July 1, 1987.

[59 FR 32123, June 22, 1994]

§ 489.27 Beneficiary notice of discharge rights.

(a) A hospital that participates in the Medicare program must furnish each Medicare beneficiary or enrollee, (or an individual acting on his or her behalf), timely notice as required by section 1866(A)(1)(M) of the Act and in accordance with § 405.1205 and § 422.620. The hospital must be able to demonstrate compliance with this requirement.

(b) Notification by hospitals and other providers. Hospitals and other providers (as identified at 489.2(b)) that participate in the Medicare program must furnish each Medicare beneficiary, or representative, applicable CMS notices in advance of discharge or termination of Medicare services, including the notices required under § 405.1200, § 405.1202, § 405.1206, and § 422.624 of this chapter.

[71 FR 68724, Nov. 27, 2006]

§ 489.28 Special capitalization requirements for HHAs.

(a) Basic rule. An HHA entering the Medicare program on or after January 1, 1998, including a new HHA as a result of a change of ownership, if the change of ownership results in a new provider number being issued, must have available sufficient funds, which we term “initial reserve operating funds,” at the time of application submission and at all times during the enrollment process up to the expiration of the 3-month period following the conveyance of Medicare billing privileges to operate the HHA for the three-month period after Medicare billing privileges are conveyed by the Medicare contractor, exclusive of actual or projected accounts receivable from Medicare.

(b) Standard. Initial reserve operating funds are sufficient to meet the requirement of this section if the total amount of such funds is equal to or greater than the product of the actual average cost per visit of three or more similarly situated HHAs in their first year of operation (selected by CMS for comparative purposes) multiplied by the number of visits projected by the HHA for its first three months of operation—or 22.5 percent (one fourth of 90 percent) of the average number of visits reported by the comparison HHAs—whichever is greater.

(c) Method. CMS, through the intermediary, will determine the amount of the initial reserve operating funds using reported cost and visit data from submitted cost reports for the first full year of operation from at least three HHAs that the intermediary serves that are comparable to the HHA that is seeking to enter the Medicare program, considering such factors as geographic location and urban/rural status, number of visits, provider-based versus free-standing, and proprietary versus non-proprietary status. The determination of the adequacy of the required initial reserve operating funds is based on the average cost per visit of the comparable HHAs, by dividing the sum of total reported costs of the HHAs in their first year of operation by the sum of the HHAs’ total reported visits. The resulting average cost per visit is then multiplied by the projected visits for the first three months of operation of the HHA seeking to enter the program, but not less than 90 percent of average visits for a three month period for the HHAs used in determining the average cost per visit.

(1) In selecting the comparative HHAs as described in this paragraph (c), the CMS contractor shall only select HHAs that have provided cost reports to Medicare. When selecting cost reports for the comparative analysis,
CMS will exclude low utilization or no utilization cost reports.

(2) [Reserved]

(d) Required proof of availability of initial reserve operating funds. The HHA must provide CMS with adequate proof of the availability of initial reserve operating funds. Such proof, at a minimum, will include a copy of the statement(s) of the HHA’s savings, checking, or other account(s) that contains the funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and that the funds are immediately available to the HHA. In some cases, an HHA may have all or part of the initial reserve operating funds in cash equivalents. For the purpose of this section, cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and that present insignificant risk of changes in value. A cash equivalent that is not readily convertible to a known amount of cash as needed during the initial three month period for which the initial reserve operating funds are required does not qualify in meeting the initial reserve operating funds requirement. Examples of cash equivalents for the purpose of this section are Treasury bills, commercial paper, and money market funds. As with funds in a checking, savings, or other account, the HHA also must be able to document the availability of any cash equivalents. CMS later may require the HHA to establish another attestation from the financial institution that the funds remain available, until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization.

(e) Borrowed funds. If borrowed funds are not in the same account(s) as the HHA’s own non-borrowed funds, the HHA also must provide proof that the borrowed funds are available for use in operating the HHA, by providing, at a minimum, a copy of the statement(s) of the HHA’s savings, checking, or other account(s) containing the borrowed funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and are immediately available to the HHA. As with the HHA’s own (that is, non-borrowed) funds, CMS later may require the HHA to establish the current availability of such borrowed funds, including furnishing an attestation from a financial institution or other source, as may be appropriate, and to establish that such funds will remain available until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization.

(f) Line of credit. If the HHA chooses to support the availability of a portion of the initial reserve operating funds with a line of credit, it must provide CMS with a letter of credit from the lender. CMS later may require the HHA to furnish an attestation from the lender that the HHA, upon its certification into the Medicare program, continues to be approved to borrow the amount specified in the letter of credit.

(g) Billing Privileges. (1) CMS may deny Medicare billing privileges to an HHA unless the HHA meets the initial reserve operating funds requirements of this section.

(2) CMS may revoke the Medicare billing privileges of an HHA that fails to maintain and comply with the initial reserve operating funds requirements of this section.

§ 489.28

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§ 489.29 Special requirements concerning beneficiaries served by the Indian Health Service, Tribal health programs, and urban Indian organization health programs.

(a) Hospitals (as defined in sections 1861(e) and (f) of the Social Security Act) and critical access hospitals (as defined in section 1861(mm)(1) of the Social Security Act) that participate in the Medicare program and furnish inpatient hospital services must accept the payment methodology and no more than the rates of payment established under 42 CFR part 136, subpart D as payment in full for the following programs:

(1) A contract health service (CHS) program under 42 CFR part 136, subpart C, of the Indian Health Service (IHS);

(2) A CHS program under 42 CFR part 136, subpart C, carried out by an Indian Tribe or Tribal organization pursuant to the Indian Self-Determination and Education Assistance Act, as amended, Public Law 93–638, 25 U.S.C. 450 et seq.; and

(3) A program funded through a grant or contract by the IHS and operated by an urban Indian organization under which items and services are purchased for an eligible urban Indian (as those terms are defined in 25 U.S.C. 1603(f) and (h)).

(b) Hospitals and critical access hospitals may not refuse service to an individual on the basis that the payment for such service is authorized under programs described in paragraph (a) of this section.

[72 FR 30711, June 4, 2007]

Subpart C—Allowable Charges

§ 489.30 Allowable charges: Deductibles and coinsurance.

(a) Part A deductible and coinsurance. The provider may charge the beneficiary or other person on his or her behalf:

(1) The amount of the inpatient hospital deductible or, if less, the actual charges for the services;

(2) The amount of inpatient hospital coinsurance applicable for each day the individual is furnished inpatient hospital services after the 60th day, during a benefit period; and

(3) The posthospital SNF care coinsurance amount.

(4) In the case of durable medical equipment (DME) furnished as a home health service, 20 percent of the customary charge for the service.

(b) Part B deductible and coinsurance.

(1) The basic allowable charges are the $75 deductible and 20 percent of the customary (insofar as reasonable) charges in excess of that deductible.

(2) For hospital outpatient services, the allowable deductible charges depend on whether the hospital can determine the beneficiary’s deductible status.

(i) If the hospital is unable to determine the deductible status, it may charge the beneficiary its full customary charges up to $75.

(ii) If the beneficiary provides official information as to deductible status, the hospital may charge only the unmet portion of the deductible.

(3) In either of the cases discussed in paragraph (b)(2) of this section, the hospital is required to file with the intermediary, on a form prescribed by CMS, information as to the services, charges, and amounts collected.

(4) The intermediary must reimburse the beneficiary if reimbursement is authorized and credit the expenses to the beneficiary’s deductible if the deductible has not yet been met.

(5) In the case of DME furnished as a home health service under Medicare Part B, the coinsurance is 20 percent of the customary (insofar as reasonable) charge for the services, with the following exception: If the DME is used DME purchased by or on behalf of the beneficiary at a price at least 25 percent less than the reasonable charge for comparable new equipment, no coinsurance is required.


§ 489.31 Allowable charges: Blood.

(a) Limitations on charges. (1) A provider may charge the beneficiary (or other person on his or her behalf) only for the first three pints of blood or units of packed red cells furnished under Medicare Part A during a calendar year, or furnished under Medicare Part B during a calendar year.
(2) The charges may not exceed the provider’s customary charges.

(3) The provider may not charge for any whole blood or packed red cells in any of the circumstances specified in § 409.67(c)(2) of this chapter.

(b) Offset for excessive charges. If the charge exceeds the cost to the provider, that excess will be deducted from any Medicare payments due the provider.


§ 489.32 Allowable charges: Non-covered and partially covered services.

(a) Services requested by beneficiary. If services furnished at the request of a beneficiary (or his or her representative) are more expensive than, or in excess of, services covered under Medicare—

(1) A provider may charge the beneficiary an amount that does not exceed the difference between—

(i) The provider’s customary charges for the services furnished; and

(ii) The provider’s customary charges for the kinds and amounts of services that are covered under Medicare.

(2) A provider may not charge for the services unless they have been requested by the beneficiary (or his or her representative) nor require a beneficiary to request services as a condition of admission.

(3) To avoid misunderstanding and disputes, a provider must inform any beneficiary who requests a service for which a charge will be made that there will be a specified charge for that service.

(b) Services not requested by the beneficiary. For special provisions that apply when a provider customarily furnishes more expensive services, see § 413.35 of this chapter.

[54 FR 41747, Oct. 11, 1989]

§ 489.35 Notice to intermediary.

The provider must inform its intermediary of any amounts collected from a beneficiary or from other persons on his or her behalf.

Subpart D—Handling of Incorrect Collections

§ 489.40 Definition of incorrect collection.

(a) As used in this subpart, “incorrect collections” means any amounts collected from a beneficiary (or someone on his or her behalf) that are not authorized under subpart C of this part.

(b) A payment properly made to a provider by an individual not considered entitled to Medicare benefits will be deemed to be an “incorrect collection” when the individual is found to be retroactively entitled to benefits.

§ 489.41 Timing and methods of handling.

(a) Refund. Prompt refund to the beneficiary or other person is the preferred method of handling incorrect collections.

(b) Setting aside. If the provider cannot refund within 60 days from the date on the notice of incorrect collection, it must set aside an amount, equal to the amount incorrectly collected, in a separate account identified as to the individual to whom the payment is due. This amount incorrectly collected must be carried on the provider’s
§ 489.42 Payment of offset amounts to beneficiary or other person.

(a) In order to carry out the commitment to refund amounts incorrectly collected, CMS may determine that amounts offset in accordance with §489.41 are to be paid directly to the beneficiary or other person from whom the provider received the incorrect collection, if:

(1) CMS finds that the provider has failed, following written request, to refund the amount of the incorrect collection to the beneficiary or other person; and

(2) The provider agreement has been terminated in accordance with the provisions of subpart E of this part.

(b) Before making a determination to make payment under paragraph (a) of this section, CMS will give written notice to the provider (1) explaining that an incorrect collection was made and the amount; (2) requesting the provider to refund the incorrect collection to the beneficiary or other person; and (3) advising of CMS’s intention to make a determination under paragraph (a) of this section.

(c) The notice will afford an authorized official of the provider an opportunity to submit, within 20 days from the date on the notice, written statement or evidence with respect to the incorrect collection and/or offset amounts. CMS will consider any written statement or evidence in making a determination.

(d) Payment to a beneficiary or other person under the provisions of paragraph (a) of this section:

(1) Will not exceed the amount of the incorrect collection; and

(2) May be considered as payment made to the provider.

Subpart E—Termination of Agreement and Reinstatement After Termination

§ 489.52 Termination by the provider.

(a) Notice to CMS. (1) A provider that wishes to terminate its agreement, except for a SNF as specified in paragraph (a)(2) of this section, must send CMS written notice of its intention in accordance with paragraph (a)(3) of this section.

(2) A SNF that wishes to terminate its agreement due to closure of the facility must send CMS written notice of its intention at least 60 days prior to the date of closure, as required at §483.75(r) of this chapter.

(3) The notice may state the intended date of termination which must be the first day of the month.

(b) Termination date. (1) If the notice does not specify a date, or the date is not acceptable to CMS, CMS may set a date that will not be more than 6 months from the date on the provider’s notice of intent.

(2) CMS may accept a termination date that is less than 6 months after the date on the provider’s notice if it determines that to do so would not unduly disrupt services to the community or otherwise interfere with the effective and efficient administration of the Medicare program.

(3) A cessation of business is deemed to be a termination by the provider, effective with the date on which it stopped providing services to the community.

(c) Public notice. (1) The provider must give notice to the public at least 15 days before the effective date of termination.

(2) The notice must be published in one or more local newspapers and must—

(i) Specify the termination date; and

(ii) Explain to what extent services may continue after that date, in accordance with the exceptions set forth in §489.55.

[45 FR 22937, Apr. 4, 1980, as amended at 76 FR 9512, Feb. 18, 2011]

§ 489.53 Termination by CMS.

(a) Basis for termination of agreement. CMS may terminate the agreement
with any provider if CMS finds that any of the following failings is attributable to that provider, and may, in addition to the applicable requirements in this chapter governing the termination of agreements with suppliers, terminate the agreement with any supplier to which the failings in paragraphs (a)(2), (13) and (18) of this section are attributable:

(1) It is not complying with the provisions of title XVIII and the applicable regulations of this chapter or with the provisions of the agreement.

(2) The provider or supplier places restrictions on the persons it will accept for treatment and it fails either to exempt Medicare beneficiaries from those restrictions or to apply them to Medicare beneficiaries the same as to all other persons seeking care.

(3) It no longer meets the appropriate conditions of participation or requirements (for SNFs and NFs) set forth elsewhere in this chapter. In the case of RNHCl no longer meets the conditions for coverage, conditions of participation and requirements set forth elsewhere in this chapter.

(4) It fails to furnish information that CMS finds necessary for a determination as to whether payments are or were due under Medicare and the amounts due.

(5) It refuses to permit examination of its fiscal or other records by, or on behalf of CMS, as necessary for verification of information furnished as a basis for payment under Medicare.

(6) It failed to furnish information on business transactions as required in §420.205 of this chapter.

(7) It failed at the time the agreement was entered into or renewed to disclose information on convicted individuals as required in §420.204 of this chapter.

(8) It failed to furnish ownership information as required in §420.206 of this chapter.

(9) It failed to comply with civil rights requirements set forth in 45 CFR parts 80, 84, and 90.

(10) In the case of a hospital or a critical access hospital as defined in section 1861(mm)(1) of the Act that has reason to believe it may have received an individual transferred by another hospital in violation of §489.24(d), the hospital failed to report the incident to CMS or the State survey agency.

(11) In the case of a hospital requested to furnish inpatient services to CHAMPUS or CHAMPVA beneficiaries or to veterans, it failed to comply with §489.25 or §489.26, respectively.

(12) It failed to furnish the notice of discharge rights as required by §489.27.

(13) The provider or supplier refuses to permit copying of any records or other information by, or on behalf of, CMS, as necessary to determine or verify compliance with participation requirements.

(14) The hospital knowingly and willfully fails to accept, on a repeated basis, an amount that approximates the Medicare rate established under the inpatient hospital prospective payment system, minus any enrollee deductibles or copayments, as payment in full from a fee-for-service FEHB plan for inpatient hospital services provided to a retired Federal enrollee of a fee-for-service FEHB plan, age 65 or older, who does not have Medicare Part A benefits.

(15) It had its enrollment in the Medicare program revoked in accordance to §424.535 of this chapter.

(16) It has failed to pay a revisit user fee when and if assessed.

(17) In the case of an HHA, it failed to correct any deficiencies within the required time frame.

(18) The provider or supplier fails to grant immediate access upon a reasonable request to a state survey agency or other authorized entity for the purpose of determining, in accordance with §488.3, whether the provider or supplier meets the applicable requirements, conditions of participation, conditions for coverage, or conditions for certification.

(b) Termination of agreements with certain hospitals. In the case of a hospital or critical access hospital that has an emergency department, as defined in §489.24(b), CMS may terminate the provider agreement if—

(1) The hospital fails to comply with the requirements of §489.24 (a) through (e), which require the hospital to examine, treat, or transfer emergency medical condition cases appropriately, and require that hospitals with specialized...
§ 489.54 Termination by the OIG.

(a) Basis for termination. (1) The OIG may terminate the agreement of any provider if the OIG finds that any of the following failings can be attributed to that provider. (i) It has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application or request for payment under Medicare.

(2) If CMS finds that a hospital is in violation of § 489.24(a) through (f), and CMS determines that the violation poses immediate jeopardy to the health or safety of individuals who present themselves to the hospital for emergency services, CMS—

(A) Gives the hospital a preliminary notice indicating that its provider agreement will be terminated in 23 days if it does not correct the identified deficiencies or refute the finding; and

(B) Gives a final notice of termination, and concurrent notice to the public, at least 2, but not more than 4, days before the effective date of termination of the provider agreement.

(ii) Skilled nursing facilities (SNFs). For an SNF with deficiencies that pose immediate jeopardy to the health or safety of residents, CMS gives notice at least 2 days before the effective date of termination of the provider agreement.

(iii) Home health agencies (HHAs). For an HHA with deficiencies that pose immediate jeopardy to the health and safety of patients, CMS gives notice to the HHA at least 2 days before the effective date of termination of the provider agreement.

(3) Notice of LTC facility closure. In the case of a facility where CMS terminates a facility's participation under Medicare or Medicaid in the absence of immediate jeopardy, CMS determines the appropriate date for notification.

(4) Content of notice. The notice states the reasons for, and the effective date of, the termination, and explains the extent to which services may continue after that date, in accordance with § 489.55.

(5) Notice to public. CMS concurrently gives notice of the termination to the public.

(e) Appeal by the provider. A provider may appeal the termination of its provider agreement by CMS in accordance with part 498 of this chapter.

[51 FR 24492, July 3, 1986]

EDITORIAL NOTE: For Federal Register citations affecting § 489.53, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.fdsys.gov.
(ii) It has submitted, or caused to be submitted, requests for Medicare payment of amounts that substantially exceed the costs it incurred in furnishing the services for which payment is requested.

(iii) It has furnished services that the OIG has determined to be substantially in excess of the needs of individuals or of a quality that fails to meet professionally recognized standards of health care. The OIG will not terminate a provider agreement under paragraph (a) if CMS has waived a disallowance with respect to the services in question on the grounds that the provider and the beneficiary could not reasonably be expected to know that payment would not be made. (The rules for determining such lack of knowledge are set forth in §§ 405.330 through 405.334 of this chapter.)

(b) Notice of termination. The OIG will give the provider notice of termination at least 15 days before the effective date of termination of the agreement, and will concurrently give notice of termination to the public.

(c) Appeal by the provider. A provider may appeal a termination of its agreement by the OIG in accordance with subpart O of part 405 of this chapter.

(d) Other applicable rules. The termination of a provider agreement by the OIG is subject to the additional procedures specified in §§ 1001.105 through 1001.109 of this title for notice and appeals.

[51 FR 24493, July 3, 1986]

§ 489.57 Reinstatement after termination.

When a provider agreement has been terminated by CMS under § 489.53, or by the OIG under § 489.54, a new agreement with that provider will not be accepted unless CMS or the OIG, as appropriate, finds—

(a) That the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and

(b) That the provider has fulfilled, or has made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement.

[76 FR 9512, Feb. 18, 2011, as amended at 78 FR 16805, Mar. 19, 2013]

Subpart F—Surety Bond Requirements for HHAs

SOURCE: 63 FR 313, Jan. 5, 1998, unless otherwise noted.

§ 489.60 Definitions.

As used in this subpart unless the context indicates otherwise—

Assessment means a sum certain that CMS may assess against an HHA in lieu of damages under Titles XI, XVIII, or XXI of the Social Security Act or under regulations in this chapter.

Assets includes but is not limited to any listing that identifies Medicare beneficiaries to whom home health services were furnished by a participating or formerly participating HHA.

Civil money penalty means a sum certain that CMS has the authority to impose on an HHA as a penalty under Titles XI, XVIII, or XXI of the Social Security Act or under regulations in this chapter.
Participating home health agency means a “home health agency” (HHA), as that term is defined by section 1861(o) of the Social Security Act, that also meets the definition of a “provider” set forth at § 400.202 of this chapter.

Rider means a notice issued by a Surety that a change in the bond has occurred or will occur.

Surety bond means one or more bonds issued by one or more surety companies under 31 U.S.C. 9304 to 9308 and 31 CFR parts 223, 224, and 225, provided the bond otherwise meets the requirements of this section.

Unpaid civil money penalty or assessment means a civil money penalty or assessment imposed by CMS on an HHA under Titles XI, XVIII, or XXI of the Social Security Act, plus accrued interest, that, after the HHA or Surety has exhausted all administrative appeals, remains unpaid (because the civil money penalty or assessment has not been paid to, or offset or compromised by, CMS) and is not the subject of a written arrangement, acceptable to CMS, for payment by the HHA. In the event a written arrangement for payment, acceptable to CMS, is made, an unpaid civil money penalty or assessment also means such civil money penalty or assessment, plus accrued interest, that remains due 60 days after the HHA’s default on such arrangement.

Unpaid claim means a Medicare overpayment for which the HHA is responsible, plus accrued interest, that, 90 days after the date of the agency’s notice to the HHA of the overpayment, remains due (because the overpayment has not been paid to, or recouped or compromised by, CMS) and is not the subject of a written arrangement, acceptable to CMS, for payment by the HHA. In the event a written arrangement for payment, acceptable to CMS, is made, an unpaid claim also means a Medicare overpayment for which the HHA is responsible, plus accrued interest, that remains due 60 days after the HHA’s default on such arrangement.

[63 FR 313, Jan. 5, 1998, as amended at 63 FR 29655, June 1, 1998]
(c) CMS determines that a surety company is an unauthorized Surety under this section—
   (1) If, upon request by CMS, the surety company fails to furnish timely confirmation of the issuance of, and the validity and accuracy of information appearing on, a surety bond an HHA presents to CMS that shows the surety company as Surety on the bond;
   (2) If, upon presentation by CMS to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company’s liability on the bond, the surety company fails to timely pay CMS in full the amount requested, up to the face amount of the bond; or
   (3) For other good cause.
(d) Any determination CMS makes under paragraph (c) of this section is effective immediately when notice of the determination is published in the FEDERAL REGISTER and remains in effect until a notice of reinstatement is published in the FEDERAL REGISTER.
(e) Any determination CMS makes under paragraph (c) of this section does not affect the Surety’s liability under any surety bond issued by a surety company to an HHA before notice of such determination is published in accordance with paragraph (d) of this section.
(f) A determination by CMS that a surety company is an unauthorized Surety under this section is not a barment, suspension, or exclusion for the purposes of Executive Order No. 12549 (3 CFR, 1986 comp., p. 189).
§ 489.65 Amount of the bond.
(a) Basic rule. The amount of the surety bond must be $50,000 or 15 percent of the Medicare payments made by CMS to the HHA in the HHA’s most recent fiscal year for which a cost report has been accepted by CMS, whichever is greater.
(b) Computation of the 15 percent: Participating HHA. The 15 percent is computed as follows:
   (1) For the initial bond—on the basis of Medicare payments made by CMS to the HHA in the HHA’s most recent fiscal year as shown in the HHA’s most recent cost report that has been accepted by CMS. If the initial bond will cover less than a full fiscal year, the computation of the 15 percent will be based on the number of months of the fiscal year that the bond will cover.
   (2) For subsequent bonds—on the basis of Medicare payments made by CMS in the most recent fiscal year for which a cost report has been accepted. However, if payments in the first six months of the current fiscal year differ from such an amount by more than 25 percent, then the amount of the bond is 15 percent of such payments projected on an annualized basis.
   (c) Computation of 15 percent: An HHA that seeks to become a participating HHA by obtaining assets or ownership interest. For an HHA that seeks to become a participating HHA by purchasing the assets or the ownership interest of a participating or formerly participating HHA, the 15 percent is computed on the basis of Medicare payments made by CMS to the participating or formerly participating HHA in the most recent fiscal year that a cost report has been accepted.
   (d) Change of ownership. For an HHA that undergoes a change of ownership the 15 percent is computed on the basis of Medicare payments made by CMS to the HHA for the most recently accepted cost report.
   (e) An HHA that seeks to become a participating HHA without obtaining assets or ownership interest. For an HHA that seeks to become a participating HHA without purchasing the assets or the ownership interest of a participating or formerly participating HHA, the 15 percent computation does not apply.
(f) Exception to the basic rule. If an HHA’s overpayment in the most recently accepted cost report exceeds 15 percent of annual payments, CMS may require the HHA to secure a bond in an amount up to or equal to the amount of overpayment, provided the amount of the bond is not less than $50,000.
(g) Expiration of the 15 percent provision. For an annual surety bond, or for a rider on a continuous surety bond, that is required to be submitted on or after June 1, 2005, notwithstanding any reference in this subpart to 15 percent as a basis for determining the amount of the bond, the amount of the bond or rider, as applicable, must be $50,000 or
§ 489.66 Additional requirements of the surety bond.

The surety bond that an HHA obtains under this subpart must meet the following additional requirements:

(a) The bond must guarantee that within 30 days of receiving written notice from CMS of an unpaid claim or unpaid civil money penalty or assessment, which notice contains sufficient evidence to establish the Surety’s liability under the bond, the Surety will pay CMS, up to the stated amount of the bond—

(1) The full amount of any unpaid claim, plus accrued interest, for which the HHA is responsible; and

(2) The full amount of any unpaid civil money penalty or assessment imposed by CMS on the HHA, plus accrued interest.

(b) The bond must provide the following:

(1) The Surety is liable for unpaid claims, unpaid civil money penalties, and unpaid assessments that are discovered when the surety bond is in effect, regardless of when the payment, overpayment, or other event giving rise to the claim, civil money penalty, or assessment occurred, provided CMS makes a written demand for payment from the Surety during, or within 90 days after, the term of the bond.

(2) If the HHA fails to furnish a bond meeting the requirements of this subpart F for the year following expiration of the term of an annual bond, or if the HHA fails to submit a rider when a rider is required to be submitted under this subpart, or if the HHA’s provider agreement is terminated, the last bond or rider, as applicable, submitted by the HHA to CMS, which bond or applicable rider meets the requirements of this subpart, remains effective and the Surety remains liable for unpaid claims, civil money penalties, and assessments that—

(i) CMS determines or imposes on or asserts against the HHA based on overpayments or other events that took place during or prior to the term of the last bond or rider; and

(ii) Were determined or imposed during the 2 years following the date the HHA failed to submit a bond or required rider or the date the HHA’s provider agreement is terminated, whichever is later.

(c) The bond must provide that the Surety’s liability to CMS under the bond is not extinguished by any action of the HHA, the Surety, or CMS, including but not necessarily limited to any of the following actions:

(1) Action by the HHA or the Surety to terminate or limit the scope or term of the bond. The Surety’s liability may be extinguished, however, when—

(i) The Surety furnishes CMS with notice of such action not later than 10 days after receiving notice from the HHA of action by the HHA to terminate or limit the scope of the bond, or not later than 60 days before the effective date of such action by the Surety; or

(ii) The HHA furnishes CMS with a new bond that meets the requirements of this subpart.

(2) The Surety’s failure to continue to meet the requirements of § 489.64(a) or CMS’s determination that the surety company is an unauthorized Surety under § 489.64(b).

(3) Termination of the HHA’s provider agreement.

(4) Any action by CMS to suspend, offset, or otherwise recover payments to the HHA.

(5) Any action by the HHA to—

(i) Cease operation;

(ii) Sell or transfer any asset or ownership interest;

(iii) File for bankruptcy; or

(iv) Fail to pay the Surety.

(6) Any fraud, misrepresentation, or negligence by the HHA in obtaining the surety bond or by the Surety (or by the Surety’s agent, if any) in issuing the surety bond, except that any fraud, misrepresentation, or negligence by the HHA in identifying to the Surety (or to the Surety’s agent) the amount of Medicare payments upon which the amount of the surety bond is determined will not cause the Surety’s liability to CMS to exceed the amount of the bond.

[63 FR 313, Jan. 5, 1998, as amended at 63 FR 29655, June 1, 1998]
(7) The HHA’s failure to exercise available appeal rights under Medicare or to assign such rights to the Surety.

(d) The bond must provide that actions under the bond may be brought by CMS or by CMS’s fiscal intermediaries.

(e) The bond must provide the Surety’s name, street address or post office box number, city, state, and zipcode to which the CMS notice provided for in paragraph (a) of this section is to be sent.

(63 FR 313, Jan. 5, 1998, as amended at 63 FR 29655, June 1, 1998)

§ 489.67 Term and type of bond.

(a) Each participating HHA that does not meet the criteria for waiver under §489.62 must submit to CMS in a form as CMS may specify, a surety bond for a term beginning January 1, 1998. If an annual bond is submitted for the initial term, it must be effective through the end of the HHA’s current fiscal year.

(b) Type of bond. The type of bond required to be submitted by an HHA under this subpart may be either—

(1) An annual bond (that is, a bond that specifies an effective annual period corresponding to the HHA’s fiscal year); or

(2) A continuous bond (that is, a bond that remains in full force and effect from term to term unless it is terminated or canceled as provided for in the bond or as otherwise provided by law) that is updated by the Surety, via the issuance of a rider, for a particular fiscal year for which the bond amount has changed or will change.

(c) HHA that seeks to become a participating HHA. (1) An HHA that seeks to become a participating HHA must submit a surety bond with its enrollment application (Form CMS–855, OMB number 0938–0685). The term of the initial surety bond must be effective from the effective date of provider agreement as specified in §489.13 of this part. However, if the effective date of the provider agreement is less than 30 days before the end of the HHA’s current fiscal year, the HHA may obtain a bond effective through the end of the next fiscal year, provided the amount of the bond is the greater of $75,000 or 20 percent of the amount determined from the computation specified in §489.65(c) as applicable.

(2) An HHA that seeks to become a participating HHA through the purchase or transfer of assets or ownership interest of a participating or formerly participating HHA must also ensure that the surety bond is effective from the date of such purchase or transfer.

(d) Change of ownership. An HHA that undergoes a change of ownership must submit the surety bond to CMS not later than the effective date of the change of ownership and the bond must be effective from the effective date of the change of ownership through the remainder of the HHA’s fiscal year.

(e) Government-operated HHA that loses its waiver. A government-operated HHA that, as of January 1, 1998, meets the criteria for waiver under §489.62 but thereafter is determined by CMS to not meet such criteria, must submit a surety bond to CMS not later than 60 days after it receives notice from CMS that it no longer meets the criteria for waiver.

(f) Change of Surety. An HHA that obtains a replacement surety bond from a different Surety to cover the remaining term of a previously obtained bond must submit the new surety bond to CMS within 30 days of obtaining the bond from the new Surety.

(Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh))


§ 489.68 Effect of failure to obtain, maintain, and timely file a surety bond.

(a) The failure of a participating HHA to obtain, file timely, and maintain a surety bond in accordance with this subpart F and CMS’s instructions is sufficient under §489.53(a)(1) for CMS to terminate the HHA’s provider agreement.

(b) The failure of an HHA seeking to become a participating HHA to obtain and file timely a surety bond in accordance with this Subpart F and CMS’s instructions is sufficient under §489.12(a)(3) for CMS to refuse to enter into a provider agreement with the HHA.
§ 489.69 Evidence of compliance.

(a) CMS may at any time require an HHA to make a specific showing of being in compliance with the requirements of this Subpart F and may require the HHA to submit such additional evidence as CMS considers sufficient to demonstrate the HHA’s compliance.

(b) If requested by CMS to do so, the failure of an HHA to timely furnish sufficient evidence to CMS to demonstrate compliance with the requirements of this Subpart F is sufficient for CMS to terminate the HHA’s provider agreement under § 489.53(a)(1) or to refuse to enter into a provider agreement with the HHA under § 489.12(a)(3), as applicable.

§ 489.70 Effect of payment by the Surety.

A Surety’s payment to CMS under a bond for an unpaid claim or an unpaid civil money penalty or assessment, constitutes—

(a) Collection of the unpaid claim or unpaid civil money penalty or assessment (to the extent the Surety’s payment on the bond covers such unpaid claim, civil money penalty, or assessment); and

(b) A basis for termination of the HHA’s provider agreement under § 489.53(a)(1).

§ 489.71 Surety’s standing to appeal Medicare determinations.

A Surety has standing to appeal any matter that the HHA could appeal, provided the Surety satisfies all jurisdictional and procedural requirements that would otherwise have applied to the HHA, and provided the HHA is not, itself, actively pursuing its appeal rights under this chapter, and provided further that, with respect to unpaid claims, the Surety has paid CMS all amounts owed to CMS by the HHA on such unpaid claims, up to the amount of the bond.

[63 FR 29656, June 1, 1998]

§ 489.72 Effect of review reversing determination.

If, in the event a Surety has paid CMS on the basis of liability incurred under a bond obtained by an HHA under this subpart F, and to the extent the HHA that obtained such bond (or the Surety under § 489.71) is subsequently successful in appealing the determination that was the basis of the unpaid claim or unpaid civil money penalty or assessment that caused the Surety to pay CMS under the bond, CMS will refund to the Surety the amount the Surety paid to CMS to the extent such amount relates to the matter that was successfully appealed by the HHA (or by the Surety), provided all review, including judicial review, has been completed on such matter. Any additional amounts owing as a result of the appeal will be paid to the HHA.

§ 489.73 Effect of conditions of payment.

If a Surety has paid an amount to CMS on the basis of liability incurred under a bond obtained by an HHA under this subpart F, and CMS subsequently collects from the HHA, in whole or in part, on such unpaid claim, civil money penalty, or assessment that was the basis for the Surety’s liability, CMS reimburses the Surety such amount as CMS collected from the HHA, up to the amount paid by the Surety to CMS, provided the Surety has no other liability to CMS under the bond.

(Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh))

[63 FR 29656, June 1, 1998]

§ 489.74 Incorporation into existing provider agreements.

The requirements of this subpart F are deemed to be incorporated into existing HHA provider agreements effective January 1, 1998.

[63 FR 315, Jan. 5, 1998. Redesignated at 63 FR 29656, June 1, 1998]

Subparts G–H [Reserved]

Subpart I—Advance Directives

SOURCE: 57 FR 8203, Mar. 6, 1992, unless otherwise noted.

§ 489.100 Definition.

For purposes of this part, advance directive means a written instruction, such as a living will or durable power
of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

§ 489.102 Requirements for providers.

(a) Hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious nonmedical health care institutions must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care, or patient care in the case of a patient in a religious nonmedical health care institution, by or through the provider and are required to:

(1) Provide written information to such individuals concerning—
   (i) An individual’s rights under State law (whether statutory or recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual’s option, advance directives. Providers are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. Providers are to update and disseminate amended information as soon as possible, but no later than 90 days from the effective date of the changes to State law; and
   (ii) The written policies of the provider or organization respecting the implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience. At a minimum, a provider’s statement of limitation should:
      (A) Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;
      (B) Identify the state legal authority permitting such objection; and
      (C) Describe the range of medical conditions or procedures affected by the conscience objection.
   (2) Document in a prominent part of the individual’s current medical record, or patient care record in the case of an individual in a religious nonmedical health care institution, whether or not the individual has executed an advance directive;
   (3) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
   (4) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives. The provider must inform individuals that complaints concerning the advance directive requirements may be filed with the State survey and certification agency;
   (5) Provide for education of staff concerning its policies and procedures on advance directives; and
   (6) Provide for community education regarding issues concerning advance directives that may include material required in paragraph (a)(1) of this section, either directly or in concert with other providers and organizations. Separate community education materials may be developed and used, at the discretion of providers. The same written materials do not have to be provided in all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual’s control over medical treatment, and describe applicable State law concerning advance directives. A provider must be able to document its community education efforts.

(b) The information specified in paragraph (a) of this section is furnished:

(1) In the case of a hospital, at the time of the individual’s admission as an inpatient.
(2) In the case of a skilled nursing facility at the time of the individual’s admission as a resident.
(3)(i) In the case of a home health agency, in advance of the individual coming under the care of the agency.
The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.

(ii) In the case of personal care services, in advance of the individual coming under the care of the personal care services provider. The personal care provider may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.

(4) In the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program.

(c) The providers listed in paragraph (a) of this section—

(1) Are not required to provide care that conflicts with an advance directive.

(2) Are not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and State law allows any health care provider or any agent of such provider to conscientiously object.

(d) Prepaid or eligible organizations (as specified in sections 1833(a)(1)(A) and 1875(b) of the Act) must meet the requirements specified in §417.436 of this chapter.

(e) If an adult individual is incapacitated at the time of admission or at the start of care and is unable to receive information (due to the incapacitating conditions or a mental disorder) or articulate whether or not he or she has executed an advance directive, then the provider may give advance directive information to the individual’s family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The provider is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.


§ 489.104 Effective dates.

These provisions apply to services furnished on or after December 1, 1991 payments made under section 1833(a)(1)(A) of the Act on or after December 1, 1991, and contracts effective on or after December 1, 1991.

PART 491—CERTIFICATION OF CERTAIN HEALTH FACILITIES

Subpart A—Rural Health Clinics: Conditions for Certification; and FQHCs Conditions for Coverage

Sec.

491.1 Purpose and scope.
491.2 Definitions.
491.3 Certification procedures.
491.4 Compliance with Federal, State and local laws.
491.5 Location of clinic.
491.6 Physical plant and environment.
491.7 Organizational structure.
491.8 Staffing and staff responsibilities.
491.9 Provision of services.
491.10 Patient health records.
491.11 Program evaluation.
491.12 Emergency preparedness.

AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302); and sec. 353 of the Public Health Service Act (42 U.S.C. 263a).

Subpart A—Rural Health Clinics: Conditions for Certification; and FQHCs Conditions for Coverage

§ 491.1 Purpose and scope.

This subpart sets forth the conditions that rural health clinics or FQHCs must meet in order to qualify for reimbursement under Medicare (title XVIII of the Social Security Act) and that rural health clinics must meet in order to qualify for reimbursement under Medicaid (title XIX of the Act).

[57 FR 24982, June 12, 1992]
§ 491.2 Definitions.

As used in this subpart, unless the context indicates otherwise:

Direct services means services provided by the clinic’s staff.

FQHC means an entity as defined in §405.2401(b).

Nurse practitioner means a registered professional nurse who is currently licensed to practice in the State, who meets the State’s requirements governing the qualifications of nurse practitioners, and who meets one of the following conditions:
(1) Is currently certified as a primary care nurse practitioner by the American Nurses’ Association or by the National Board of Pediatric Nurse Practitioners and Associates; or
(2) Has satisfactorily completed a formal 1 academic year educational program that:
   (i) Prepares registered nurses to perform an expanded role in the delivery of primary care;
   (ii) Includes at least 4 months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and
   (iii) Awards a degree, diploma, or certificate to persons who successfully complete the program; or
(3) Has successfully completed a formal educational program (for preparing registered nurses to perform an expanded role in the delivery of primary care) that does not meet the requirements of paragraph (2) of this definition and assisted primary care physicians for a total of 12 months during the 18-month period immediately preceding the effective date of this subpart.

Physician assistant means a person who meets the applicable State requirements governing the qualifications for assistants to primary care physicians, and who meets at least one of the following conditions:
(1) Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or
(2) Has satisfactorily completed a program for preparing physician’s assistants that:
   (i) Was at least 1 academic year in length;
   (ii) Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and
   (iii) Was accredited by the American Medical Association’s Committee on Allied Health Education and Accreditation; or
(3) Has satisfactorily completed a formal educational program (for preparing physician assistants) that does not meet the requirements of paragraph (2) of this definition and assisted primary care physicians for a total of 12 months during the 18-month period that ended on December 31, 1986.

Rural area means an area that is not delineated as an urbanized area by the Bureau of the Census.

Rural health clinic or clinic means a clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements of this subpart.

Physician means the following:
(1) As it pertains to the supervision, collaboration, and oversight requirements in sections 1861(aa)(2)(B) and (aa)(3) of the Act, a doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State in which the function is performed; and
(2) Within limitations as to the specific services furnished, a doctor of dental surgery or of dental medicine, a doctor of optometry, a doctor of podiatry or surgical chiropody or a chiropractor (see section 1861(r) of the Act for specific limitations).
§ 491.3 Certification procedures.

A rural health clinic will be certified for participation in Medicare in accordance with subpart S of 42 CFR part 405. The Secretary will notify the State Medicaid agency whenever he has certified or denied certification under Medicare for a prospective rural health clinic in that State. A clinic certified under Medicare will be deemed to meet the standards for certification under Medicaid.

[71 FR 55346, Sept. 22, 2006]

§ 491.4 Compliance with Federal, State and local laws.

The rural health clinic or FQHC and its staff are in compliance with applicable Federal, State and local laws and regulations.

(a) Licensure of clinic or center. The clinic or center is licensed pursuant to applicable State and local law.

(b) Licensure, certification or registration of personnel. Staff of the clinic or center are licensed, certified or registered in accordance with applicable State and local laws.

[57 FR 24982, June 12, 1992]

§ 491.5 Location of clinic.

(a) Basic requirements.

1. An RHC is located in a rural area that is designated as a shortage area.

2. An FQHC is located in a rural or urban area that is designated as either a shortage area or an area that has a medically underserved population.

(b) Exceptions.

1. CMS does not disqualify an RHC approved under this subpart if the area in which it is located subsequently fails to meet the definition of a rural, shortage area.

2. A private, nonprofit facility that meets all other conditions of this subpart except for location in a shortage area will be certified if, on July 1, 1977, it was operating in a rural area that is determined by the Secretary (on the basis of the ratio of primary care physicians to the general population) to have an insufficient supply of physicians to meet the needs of the area served.

3. Determinations on these exceptions will be made by the Secretary upon application by the facility.

(c) Criteria for designation of rural areas. (1) Rural areas are areas not delineated as urbanized areas in the last census conducted by the Census Bureau.

2. Excluded from the rural area classification are:

(i) Central cities of 50,000 inhabitants or more;

(ii) Cities with at least 25,000 inhabitants which, together with contiguous areas having stipulated population density, have combined populations of 50,000 and constitute, for general economic and social purposes, single communities;

(iii) Closely settled territories surrounding cities and specifically designated by the Census Bureau as urban.

3. Included in the rural area classification are those portions of extended cities that the Census Bureau has determined to be rural.

(d) Criteria for designation of shortage areas.

1. The criteria for determination of shortage of personal health services (under section 1302(7) of the Public Health Services Act), are:

(i) The ratio of primary care physicians practicing within the area to the resident population;

(ii) The infant mortality rate;

(iii) The percent of the population 65 years of age or older; and

(iv) The percent of the population with a family income below the poverty level.
(2) The criteria for determination of shortage of primary medical care manpower (under section 332(a)(1)(A) of the Public Health Services Act) are:
(i) The area served is a rational area for the delivery of primary medical care services;
(ii) The ratio of primary care physicians practicing within the area to the resident population; and
(iii) The primary medical care manpower in contiguous areas is overutilized, excessively distant, or inaccessible to the population in this area.

(c) Medically underserved population. A medically underserved population includes the following:
(1) A population of an urban or rural area that is designated by PHS as having a shortage of personal health services.
(2) A population group that is designated by PHS as having a shortage of personal health services.

(e) Requirements specific to FQHCs. An FQHC approved for participation in Medicare must meet one of the following criteria:
(1) Furnish services to a medically underserved population.
(2) Be located in a medically underserved area, as demonstrated by an application approved by PHS.


(3) The premises are clean and orderly.

$\S$ 491.7 Organizational structure.

(a) Basic requirements. (1) The clinic or center is under the medical direction of a physician, and has a health care staff that meets the requirements of §491.8.
(2) The organization’s policies and its lines of authority and responsibilities are clearly set forth in writing.

(b) Disclosure. The clinic or center discloses the names and addresses of:
(1) Its owners, in accordance with section 1124 of the Social Security Act (42 U.S.C. 132–3);
(2) The person principally responsible for directing the operation of the clinic or center; and
(3) The person responsible for medical direction.

$\S$ 491.8 Staffing and staff responsibilities.

(a) Staffing. (1) The clinic or center has a health care staff that includes one or more physicians. Rural health clinic staffs must also include one or more physician’s assistants or nurse practitioners.
(2) The physician member of the staff may be the owner of the rural health clinic, an employee of the clinic or center, or under agreement with the clinic or center to carry out the responsibilities required under this section.
(3) The physician assistant, nurse practitioner, nurse-midwife, clinical social worker or clinical psychologist member of the staff may be the owner or an employee of the clinic or center, or may furnish services under contract to the clinic or center. In the case of a
§ 491.9 Provision of services.

(a) Basic requirements. (1) All services offered by the clinic or center are furnished in accordance with applicable Federal, State, and local laws; and

(2) The clinic or center is primarily engaged in providing outpatient health services and meets all other conditions of this subpart.

(3) The laboratory requirements in paragraph (c)(2) of this section apply to RHCs, but do not apply to FQHCs.

(b) Patient care policies. (1) The clinic’s or center’s health care services are furnished in accordance with appropriate written policies which are consistent with applicable State law.

(2) The policies are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners. At least one member is not a member of the clinic or center staff.

(3) The policies include:

(i) A description of the services the clinic or center furnishes directly and those furnished through agreement or arrangement.

(ii) Guidelines for the medical management of health problems which include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the clinic or center.

(iii) Rules for the storage, handling, and administration of drugs and biologicals.

42 CFR Ch. IV (10–1–16 Edition)
(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph (b)(2) of this section and reviewed as necessary by the clinic or center.

c) Direct services—(1) General. The clinic or center staff furnish those diagnostic and therapeutic services and supplies that are commonly furnished in a physician’s office or at the entry point into the health care delivery system. These include medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions.

(2) Laboratory. These requirements apply to RHCs but not to FQHCs. The RHC provides laboratory services in accordance with part 493 of this chapter, which implements the provisions of section 353 of the Public Health Service Act. The RHC provides basic laboratory services essential to the immediate diagnosis and treatment of the patient, including:

(i) Chemical examinations of urine by stick or tablet method or both (including urine ketones);
(ii) Hemoglobin or hematocrit;
(iii) Blood glucose;
(iv) Examination of stool specimens for occult blood;
(v) Pregnancy tests; and
(vi) Primary culturing for transmittal to a certified laboratory.

(3) Emergency. The clinic or center provides medical emergency procedures as a first response to common life-threatening injuries and acute illness and has available the drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, sera and toxoids.

d) Services provided through agreements or arrangements. (1) The clinic or center has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to its patients, including:

(i) Inpatient hospital care;
(ii) Physician(s) services (whether furnished in the hospital, the office, the patient’s home, a skilled nursing facility, or elsewhere); and

(iii) Additional and specialized diagnostic and laboratory services that are not available at the clinic or center.

(2) If the agreements are not in writing, there is evidence that patients referred by the clinic or center are being accepted and treated.


§ 491.10 Patient health records.

(a) Records system. (1) The clinic or center maintains a clinical record system in accordance with written policies and procedures.

(2) A designated member of the professional staff is responsible for maintaining the records and for insuring that they are completely and accurately documented, readily accessible, and systematically organized.

(3) For each patient receiving health care services, the clinic or center maintains a record that includes, as applicable:

(i) Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;
(ii) Reports of physical examinations, diagnostic and laboratory test results, and consultative findings;
(iii) All physician’s orders, reports of treatments and medications, and other pertinent information necessary to monitor the patient’s progress;
(iv) Signatures of the physician or other health care professional.

(b) Protection of record information. (1) The clinic or center maintains the confidentiality of record information and provides safeguards against loss, destruction or unauthorized use.

(2) Written policies and procedures govern the use and removal of records from the clinic or center and the conditions for release of information.

(3) The patient’s written consent is required for release of information not authorized to be released without such consent.

c) Retention of records. The records are retained for at least 6 years from
§ 491.11 Program evaluation.

(a) The clinic or center carries out, or arranges for, an annual evaluation of its total program.

(b) The evaluation includes review of:

(1) The utilization of clinic or center services, including at least the number of patients served and the volume of services;

(2) A representative sample of both active and closed clinical records; and

(3) The clinic's or center's health care policies.

(c) The purpose of the evaluation is to determine whether:

(1) The utilization of services was appropriate;

(2) The established policies were followed; and

(3) Any changes are needed.

(d) The clinic or center staff considers the findings of the evaluation and takes corrective action if necessary.

§ 491.12 Emergency preparedness.

The Rural Health Clinic/Federally Qualified Health Center (RHC/FQHC) must comply with all applicable Federal, State, and local emergency preparedness requirements. The RHC/ FQHC must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

(a) Emergency plan. The RHC/FQHC must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The plan must do all of the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.

(2) Include strategies for addressing emergency events identified by the risk assessment.

(3) Address patient population, including, but not limited to, the type of services the RHC/FQHC has the ability to provide in an emergency, and continuity of operations, including delegations of authority and succession plans.

(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the RHC/FQHC’s efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

(b) Policies and procedures. The RHC/FQHC must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

(1) Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.

(2) A means to shelter in place for patients, staff, and volunteers who remain in the facility.

(3) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

(4) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

(c) Communication plan. The RHC/FQHC must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually.
The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients’ physicians.
(iv) Other RHCs/FQHCs.
(v) Volunteers.
(2) Contact information for the following:
(i) Federal, State, tribal, regional, and local emergency preparedness staff.
(ii) Other sources of assistance.
(3) Primary and alternate means for communicating with the following:
(i) RHC/FQHC’s staff.
(ii) Federal, State, tribal, regional, and local emergency management agencies.
(4) A means of providing information about the general condition and location of patients under the facility’s care as permitted under 45 CFR 164.510(b)(4).
(5) A means of providing information about the RHC/FQHC’s needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.
(d) Training and testing. The RHC/FQHC must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.
(1) Training program. The RHC/FQHC must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(2) Testing. The RHC/FQHC must conduct exercises to test the emergency plan at least annually. The RHC/FQHC must do the following:
(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the RHC/FQHC experiences an actual natural or man-made emergency that requires activation of the emergency plan, the RHC/FQHC is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.
(ii) Conduct an additional exercise that may include, but is not limited to following:
(A) A second full-scale exercise that is community-based or individual, facility-based.
(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the RHC/FQHC’s response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the RHC/FQHC’s emergency plan, as needed.
(e) Integrated healthcare systems. If a RHC/FQHC is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the RHC/FQHC may choose to participate in the healthcare system’s coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:
(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.
(2) Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered.
(3) Demonstrate that each separately certified facility is capable of actively
using the unified and integrated emergency preparedness program and is in compliance with the program.

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include all of the following:

(i) A documented community-based risk assessment, utilizing an all-hazards approach.

(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

EFFECTIVE DATE NOTE: At 81 FR 64041, Sept. 16, 2016, §491.12 was added, effective Nov. 15, 2016.

PART 493—LABORATORY REQUIREMENTS

Subpart A—General Provisions

Sec.

493.1 Basis and scope.

493.2 Definitions.

493.3 Applicability.

493.5 Categories of tests by complexity.

493.15 Laboratories performing waived tests.

493.17 Test categorization.

493.19 Provider-performed microscopy (PPM) procedures.

493.20 Laboratories performing tests of moderate complexity.

493.25 Laboratories performing tests of high complexity.

Subpart B—Certificate of Waiver

493.35 Application for a certificate of waiver.

493.37 Requirements for a certificate of waiver.

493.39 Notification requirements for laboratories issued a certificate of waiver.

Subpart C—Registration Certificate, Certificate for Provider-performed Microscopy Procedures, and Certificate of Compliance

493.43 Application for registration certificate, certificate for provider-performed microscopy (PPM) procedures, and certificate of compliance.

493.45 Requirements for a registration certificate.

493.47 Requirements for a certificate for provider-performed microscopy (PPM) procedures.

493.49 Requirements for a certificate of compliance.

493.51 Notification requirements for laboratories issued a certificate of compliance.

493.53 Notification requirements for laboratories issued a certificate for provider-performed microscopy (PPM) procedures.

Subpart D—Certificate of Accreditation

493.55 Application for registration certificate and certificate of accreditation.

493.57 Requirements for a registration certificate.

493.61 Requirements for a certificate of accreditation.

493.63 Notification requirements for laboratories issued a certificate of accreditation.

Subpart E—Accreditation by a Private, Nonprofit Accreditation Organization or Exemption Under an Approved State Laboratory Program

493.551 General requirements for laboratories.

493.553 Approval process (application and reapplication) for accreditation organizations and State licensure programs.

493.555 Federal review of laboratory requirements.

493.557 Additional submission requirements.

493.559 Publication of approval of deeming authority or CLIA exemption.

493.561 Denial of application or reapplication.

493.563 Validation inspections—Basis and focus.

493.565 Selection for validation inspection—laboratory responsibilities.

493.567 Refusal to cooperate with validation inspection.

493.569 Consequences of a finding of noncompliance as a result of a validation inspection.

493.571 Disclosure of accreditation, State and CMS validation inspection results.
Centers for Medicare & Medicaid Services, HHS

493.573 Continuing Federal oversight of private nonprofit accreditation organizations and approved State licensure programs.
493.575 Removal of deeming authority or CLIA exemption and final determination review.

Subpart F—General Administration

493.602 Scope of subpart.
493.606 Applicability of subpart.
493.638 Certificate fees.
493.639 Fee for revised certificate.
493.643 Fee for determination of program compliance.
493.645 Additional fee(s) applicable to approved State laboratory programs and laboratories issued a certificate of accreditation, certificate of waiver, or certificate for PPM procedures.
493.646 Payment of fees.
493.649 Methodology for determining fee amount.

Subpart G [Reserved]

Subpart H—Participation in Proficiency Testing for Laboratories Performing Nonwaived Testing

493.801 Condition: Enrollment and testing of samples.
493.803 Condition: Successful participation.
493.807 Condition: Reinstatement of laboratories performing nonwaived testing.

Proficiency Testing by Specialty and Subspecialty for Laboratories Performing Tests of Moderate Complexity (Including the Subcategory), High Complexity, or Any Combination of These Tests

493.821 Condition: Microbiology.
493.823 Standard: Bacteriology.
493.825 Standard: Mycobacteriology.
493.827 Standard: Mycology.
493.829 Standard: Parasitology.
493.833 Condition: Diagnostic immunology.
493.835 Standard: Syphilis serology.
493.837 Standard: General immunology.
493.839 Condition: Chemistry.
493.841 Standard: Routine chemistry.
493.843 Standard: Endocrinology.
493.845 Standard: Toxicology.
493.849 Condition: Hematology.
493.851 Standard: Hematology.
493.853 Condition: Pathology.
493.857 Condition: Immunohematology.
493.859 Standard: ABO group and D (Rho) typing.
493.861 Standard: Unexpected antibody detection.
493.863 Standard: Compatibility testing.

Subpart I—Proficiency Testing Programs for Nonwaived Testing

493.901 Approval of proficiency testing programs.
493.903 Administrative responsibilities.
493.905 Nonapproved proficiency testing programs.

Proficiency Testing Programs by Specialty and Subspecialty

493.909 Microbiology.
493.911 Bacteriology.
493.913 Mycobacteriology.
493.915 Mycology.
493.917 Parasitology.
493.919 Virology.
493.921 Diagnostic immunology.
493.923 Syphilis serology.
493.927 General immunology.
493.929 Chemistry.
493.931 Routine chemistry.
493.933 Endocrinology.
493.937 Toxicology.
493.941 Hematology (including routine hematology and coagulation).
493.945 Cytology: gynecologic examinations.
493.959 Immunohematology.

Subpart J—Facility Administration for Nonwaived Testing

493.1100 Condition: Facility administration.
493.1101 Standard: Facilities.
493.1103 Standard: Requirements for transfusion services.
493.1105 Standard: Retention requirements.

Subpart K—Quality System for Nonwaived Testing

493.1200 Introduction.
493.1201 Condition: Bacteriology.
493.1202 Condition: Mycobacteriology.
493.1203 Condition: Mycology.
493.1204 Condition: Parasitology.
493.1205 Condition: Virology.
493.1207 Condition: Syphilis serology.
493.1208 Condition: General immunology.
493.1209 Condition: Routine chemistry.
493.1211 Condition: Urinalysis.
493.1212 Condition: Endocrinology.
493.1213 Condition: Toxicology.
493.1215 Condition: Hematology.
493.1217 Condition: Immunohematology.
493.1219 Condition: Histopathology.
493.1220 Condition: Oral pathology.
493.1221 Condition: Cytology.
493.1225 Condition: Clinical cytogentic.
493.1226 Condition: Radiobiological.
493.1227 Condition: Histocompatibility.

General Laboratory Systems

493.1230 Condition: General laboratory systems.
493.1231 Standard: Confidentiality of patient information.
Pt. 493

493.1232 Standard: Specimen identification and integrity.
493.1233 Standard: Complaint investigations.
493.1234 Standard: Communications.
493.1235 Standard: Personnel competency assessment policies.
493.1239 Standard: General laboratory systems quality assessment.

PREANALYTIC SYSTEMS

493.1240 Condition: Preanalytic systems.
493.1241 Standard: Test request.
493.1242 Standard: Specimen submission, handling, and referral.

ANALYTIC SYSTEMS

493.1250 Condition: Analytic systems.
493.1252 Standard: Test systems, equipment, instruments, reagents, materials, and supplies.
493.1254 Standard: Maintenance and function checks.
493.1255 Standard: Calibration and calibration verification procedures.
493.1256 Standard: Control procedures.
493.1261 Standard: Bacteriology.
493.1262 Standard: Mycobacteriology.
493.1263 Standard: Mycology.
493.1264 Standard: Parasitology.
493.1265 Standard: Virology.
493.1267 Standard: Routine chemistry.
493.1269 Standard: Hematology.
493.1271 Standard: Immunohematology.
493.1273 Standard: Histopathology.
493.1274 Standard: Cytology.
493.1276 Standard: Clinical cytogenetics.
493.1278 Standard: Histocompatibility.
493.1281 Standard: Comparison of test results.
493.1282 Standard: Corrective actions.
493.1283 Standard: Test records.

POSTANALYTIC SYSTEMS

493.1290 Condition: Postanalytic systems.
493.1291 Standard: Test report.
493.1299 Standard: Postanalytic systems quality assessment.

Subpart L [Reserved]

Subpart M—Personnel for Nonwaived Testing

493.1351 General.

LABORATORIES PERFORMING PROVIDER-PERFORMED MICROSCOPY (PPM) PROCEDURES

493.1353 Scope.
493.1355 Condition: Laboratories performing PPM procedures; laboratory director.
493.1357 Standard; laboratory director qualifications.
493.1359 Standard; PPM laboratory director responsibilities.
493.1361 Condition; Laboratories performing PPM procedures; testing personnel.
493.1363 Standard; PPM testing personnel qualifications.
493.1365 Standard; PPM testing personnel responsibilities.

LABORATORIES PERFORMING MODERATE COMPLEXITY TESTING

493.1403 Condition: Laboratories performing moderate complexity testing; laboratory director.
493.1405 Standard; Laboratory director qualifications.
493.1406 Standard; Laboratory director qualifications on or before February 28, 1992.
493.1407 Standard; Laboratory director responsibilities.
493.1409 Condition: Laboratories performing moderate complexity testing; technical consultant.
493.1411 Standard; Technical consultant qualifications.
493.1413 Standard; Technical consultant responsibilities.
493.1415 Condition: Laboratories performing moderate complexity testing; clinical consultant.
493.1417 Standard; Clinical consultant qualifications.
493.1419 Standard; Clinical consultant responsibilities.
493.1421 Condition: Laboratories performing moderate complexity testing; testing personnel.
493.1423 Standard; Testing personnel qualifications.
493.1425 Standard; Testing personnel responsibilities.

LABORATORIES PERFORMING HIGH COMPLEXITY TESTING

493.1441 Condition: Laboratories performing high complexity testing; laboratory director.
493.1443 Standard; Laboratory director qualifications.
493.1445 Standard; Laboratory director responsibilities.
493.1447 Condition: Laboratories performing high complexity testing; technical supervisor.
493.1449 Standard; Technical supervisor qualifications.
493.1451 Standard; Technical supervisor responsibilities.
Centers for Medicare & Medicaid Services, HHS

493.1453 Condition: Laboratories performing high complexity testing; clinical consultant.
493.1455 Standard; Clinical consultant qualifications.
493.1457 Standard; Clinical consultant responsibilities.
493.1459 Condition: Laboratories performing high complexity testing; general supervisor.
493.1461 Standard; General supervisor qualifications.
493.1462 General supervisor qualifications on or before February 28, 1992.
493.1463 Standard; General supervisor responsibilities.
493.1465 Standard; Cytotechnologist qualifications.
493.1467 Condition: Laboratories performing high complexity testing; cytology general supervisor.
493.1469 Standard; Cytology general supervisor qualifications.
493.1471 Standard; Cytology general supervisor responsibilities.
493.1473 Condition: Laboratories performing high complexity testing; cytotechnologist.
493.1483 Standard; Cytotechnologist qualifications.
493.1485 Standard; Cytotechnologist responsibilities.
493.1487 Condition: Laboratories performing high complexity testing; cytotechnologist.
493.1489 Standard; Testing personnel qualifications.
493.1491 Technologist qualifications on or before February 28, 1992.
493.1495 Standard; Testing personnel responsibilities.

Subparts N-P [Reserved]

Subpart Q—Inspection

493.1771 Condition: Inspection requirements applicable to all CLIA-certified and CLIA-exempt laboratories.
493.1773 Standard; Basic inspection requirements for all laboratories issued a CLIA certificate and CLIA-exempt laboratories.
493.1775 Standard; Inspection of laboratories issued a certificate of waiver or a certificate for provider-performed microscopy procedures.
493.1777 Standard; Inspection of laboratories that have requested or have been issued a certificate of compliance.
493.1780 Standard; Inspection of CLIA-exempt laboratories or laboratories requesting or issued a certificate of accreditation.

Subpart R—Enforcement Procedures

493.1800 Basis and scope.
493.1804 General considerations.
493.1806 Available sanctions: All laboratories.
493.1807 Additional sanctions: Laboratories that participate in Medicare.
493.1808 Adverse action on any type of CLIA certificate: Effect on Medicare approval.
493.1809 Limitation on Medicaid payment.
493.1810 Imposition and lifting of alternative sanctions.
493.1812 Action when deficiencies pose immediate jeopardy.
493.1814 Action when deficiencies are at the condition level but do not pose immediate jeopardy.
493.1815 Action when deficiencies are at the condition level.
493.1816 Action when deficiencies are not at the condition level.
493.1820 Ensuring timely correction of deficiencies.
493.1826 Suspension of part of Medicare payments.
493.1828 Suspension of all Medicare payments.
493.1832 Directed plan of correction and directed portion of a plan of correction.
493.1834 Civil money penalty.
493.1836 State onsite monitoring.
493.1838 Training and technical assistance for unsuccessful participation in proficiency testing.
493.1840 Suspension, limitation, or revocation of any type of CLIA certificate.
493.1842 Cancellation of Medicare approval.
493.1844 Appeals procedures.
493.1846 Civil action.
493.1850 Laboratory registry.

Subpart S [Reserved]

Subpart T—Consultations

493.2001 Establishment and function of the Clinical Laboratory Improvement Advisory Committee.

AUTHORITY: Sec. 353 of the Public Health Service Act, secs. 1102, 1861(e), the sentence following sections 1861(s)(11) through 1861(s)(16) of the Social Security Act (42 U.S.C. 263a, 1302, 1395x(e), the sentence following 1395x(s)(11) through 1395x(s)(16)), and the Pub. L. 112–202 amendments to 42 U.S.C. 263a.

SOURCE: 55 FR 9576, Mar. 14, 1990, unless otherwise noted.

Subpart A—General Provisions

SOURCE: 57 FR 7139, Feb. 28, 1992, unless otherwise noted.

§ 493.1 Basis and scope.

This part sets forth the conditions that all laboratories must meet to be certified to perform testing on human
specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). It implements sections 1861(e) and (j), the sentence following section 1861(a)(13), and 1902(a)(9) of the Social Security Act, and section 353 of the Public Health Service Act, as amended by section 2 of the Taking Essential Steps for Testing Act of 2012. This part applies to all laboratories as defined under “laboratory” in §493.2 of this part. This part also applies to laboratories seeking payment under the Medicare and Medicaid programs. The requirements are the same for Medicare approval as for CLIA certification.

§ 493.2 Definitions.

As used in this part, unless the context indicates otherwise—

Accredited institution means a school or program which—

(a) Admits as regular student only persons having a certificate of graduation from a school providing secondary education, or the recognized equivalent of such certificate;

(b) Is legally authorized within the State to provide a program of education beyond secondary education;

(c) Provides an educational program for which it awards a bachelor’s degree or provides not less than a 2-year program which is acceptable toward such a degree, or provides an educational program for which it awards a master’s or doctoral degree;

(d) Is accredited by a nationally recognized accrediting agency or association.

This definition includes any foreign institution of higher education that HHS or its designee determines meets substantially equivalent requirements.

Accredited laboratory means a laboratory that has voluntarily applied for and been accredited by a private, nonprofit accreditation organization approved by CMS in accordance with this part;

Adverse action means the imposition of a principal or alternative sanction by CMS.

ALJ stands for Administrative Law Judge.

Alternative sanctions means sanctions that may be imposed in lieu of or in addition to principal sanctions. The term is synonymous with “intermediate sanctions” as used in section 1846 of the Act.

Analyte means a substance or constituent for which the laboratory conducts testing.

Approved accreditation organization for laboratories means a private, nonprofit accreditation organization that has formally applied for and received CMS’s approval based on the organization’s compliance with this part.

Approved State laboratory program means a licensure or other regulatory program for laboratories in a State, the requirements of which are imposed under State law, and the State laboratory program has received CMS approval based on the State’s compliance with this part.

Authorized person means an individual authorized under State law to order tests or receive test results, or both.

Calibration means a process of testing and adjusting an instrument or test system to establish a correlation between the measurement response and the concentration or amount of the substance that is being measured by the test procedure.

Calibration verification means the assaying of materials of known concentration in the same manner as patient samples to substantiate the instrument or test system’s calibration throughout the reportable range for patient test results.

Challenge means, for quantitative tests, an assessment of the amount of substance or analyte present or measured in a sample. For qualitative tests, a challenge means the determination of the presence or the absence of an analyte, organism, or substance in a sample.

CLIA means the Clinical Laboratory Improvement Amendments of 1988.

CLIA certificate means any of the following types of certificates issued by CMS or its agent:

(1) Certificate of compliance means a certificate issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable condition level requirements, or reissued before the expiration date, pending an appeal, in accordance with
§ 493.49, when an inspection has found the laboratory to be out of compliance with one or more condition level requirements.

(2) Certificate for provider-performed microscopy (PPM) procedures means a certificate issued or reissued before the expiration date, pending an appeal, in accordance with §493.47, to a laboratory in which a physician, midlevel practitioner or dentist performs no tests other than PPM procedures and, if desired, waived tests listed in §493.15(c).

(3) Certificate of accreditation means a certificate issued on the basis of the laboratory’s accreditation by an accreditation organization approved by CMS (indicating that the laboratory is deemed to meet applicable CLIA requirements) or reissued before the expiration date, pending an appeal, in accordance with §493.61, when a validation or complaint survey has found the laboratory to be noncompliant with one or more CLIA conditions.

(4) Certificate of registration or registration certificate means a certificate issued or reissued before the expiration date, pending an appeal, in accordance with §493.45, that enables the entity to conduct moderate or high complexity laboratory testing or both until the entity is determined to be in compliance through a survey by CMS or its agent; or in accordance with §493.57 to an entity that is accredited by an approved accreditation organization.

(5) Certificate of waiver means a certificate issued or reissued before the expiration date, pending an appeal, in accordance with §493.37, to a laboratory to perform only the waived tests listed at §493.15(c).

CLIA-exempt laboratory means a laboratory that has been licensed or approved by a State where CMS has determined that the State has enacted laws relating to laboratory requirements that are equal to or more stringent than CLIA requirements and the State licensure program has been approved by CMS in accordance with subpart E of this part.

Condition level deficiency means noncompliance with one or more condition level requirements.

Condition level requirements means any of the requirements identified as “conditions” in subparts G through Q of this part.

Confirmatory testing means testing performed by a second analytical procedure that could be used to substantiate or bring into question the result of an initial laboratory test.

Credible allegation of compliance means a statement or documentation that—

(1) Is made by a representative of a laboratory that has a history of having maintained a commitment to compliance and of taking corrective action when required;

(2) Is realistic in terms of its being possible to accomplish the required corrective action between the date of the exit conference and the date of the allegation; and

(3) Indicates that the problem has been resolved.

Dentist means a doctor of dental medicine or doctor of dental surgery licensed by the State to practice dentistry within the State in which the laboratory is located.

Distributive testing means laboratory testing performed on the same specimen, or an aliquot of it, that requires sharing it between two or more laboratories to obtain all data required to complete an interpretation or calculation necessary to provide a final reportable result for the originally ordered test. When such testing occurs at multiple locations with different CLIA certificates, it is considered distributive testing.

Equivalency means that an accreditation organization’s or a State laboratory program’s requirements, taken as a whole, are equal to or more stringent than the CLIA requirements established by CMS, taken as whole. It is acceptable for an accreditation organization’s or State laboratory program’s requirements to be organized differently or otherwise vary from the CLIA requirements, as long as (1) all of the requirements taken as a whole would provide at least the same protection as the CLIA requirements taken as a whole; and (2) a finding of noncompliance with respect to CLIA requirements taken as a whole would be matched by a finding of noncompliance with the accreditation or State requirements taken as a whole.
CMS agent means an entity with which CMS arranges to inspect laboratories and assess laboratory activities against CLIA requirements and may be a State survey agency, a private, non-profit organization other than an approved accreditation organization, a component of HHS, or any other governmental component CMS approves for this purpose. In those instances where all of the laboratories in a State are exempt from CLIA requirements, based on the approval of a State’s exemption request, the State survey agency is not the CMS agent.

FDA-cleared or approved test system means a test system cleared or approved by the FDA through the premarket notification (510(k)) or premarket approval (PMA) process for in vitro diagnostic use. Unless otherwise stated, this includes test systems exempt from FDA premarket clearance or approval.

HHS means the Department of Health and Human Services, or its designee.

Immediate jeopardy means a situation in which immediate corrective action is necessary because the laboratory’s noncompliance with one or more condition level requirements has already caused, is causing, or is likely to cause, at any time, serious injury or harm, or death, to individuals served by the laboratory or to the health or safety of the general public. This term is synonymous with imminent and serious risk to human health and significant hazard to the public health.

Intentional violation means knowing and willful noncompliance with any CLIA condition.

Kit means all components of a test that are packaged together.

Laboratory means a facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

Midlevel practitioner means a nurse midwife, nurse practitioner, or physician assistant, licensed by the State within which the individual practices, if such licensing is required in the State in which the laboratory is located.

Nonwaived test means any test system, assay, or examination that has not been found to meet the statutory criteria specified at section 353(d)(3) of the Public Health Service Act.

Operator means the individual or group of individuals who oversee all facets of the operation of a laboratory and who bear primary responsibility for the safety and reliability of the results of all specimen testing performed in that laboratory. The term includes—

1. A director of the laboratory if he or she meets the stated criteria; and

2. The members of the board of directors and the officers of a laboratory that is a small corporation under subchapter S of the Internal Revenue Code.

Owner means any person who owns any interest in a laboratory except for an interest in a laboratory whose stock and/or securities are publicly traded. (That is e.g., the purchase of shares of stock or securities on the New York Stock Exchange in a corporation owning a laboratory would not make a person an owner for the purpose of this regulation.)

Party means a laboratory affected by any of the enforcement procedures set forth in this subpart, by CMS or the OIG, as appropriate.

Performance characteristic means a property of a test that is used to describe its quality, e.g., accuracy, precision, analytical sensitivity, analytical specificity, reportable range, reference range, etc.

Performance specification means a value or range of values for a performance characteristic, established or verified by the laboratory, that is used to describe the quality of patient test results.
Physician means an individual with a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine degree who is licensed by the State to practice medicine, osteopathy, or podiatry within the State in which the laboratory is located.

Principal sanction means the suspension, limitation, or revocation of any type of CLIA certificate or the cancellation of the laboratory’s approval to receive Medicare payment for its services.

Prospective laboratory means a laboratory that is operating under a registration certificate or is seeking any of the three other types of CLIA certificates.

Rate of disparity means the percentage of sample validation inspections for a specific accreditation organization or State where CMS, the State survey agency or other CMS agent finds noncompliance with one or more condition level requirements but no comparable deficiencies were cited by the accreditation organization or the State, and it is reasonable to conclude that the deficiencies were present at the time of the most recent accreditation organization or State licensure inspection.

Example: Assume the State survey agency, CMS or other CMS agent performs 200 sample validation inspections for laboratories accredited by a single accreditation organization or licensed in an exempt State during a validation review period and finds that 60 of the 200 laboratories had one or more condition level requirements out of compliance. CMS reviews the validation and accreditation organization’s or State’s inspections of the validated laboratories and determines that deficiencies were present in the remaining 38 laboratories at the time of the most recent accreditation organization’s or State’s inspection. Thirty-eight divided by 200 equals a 19 percent rate of disparity.

Referee laboratory means a laboratory currently in compliance with applicable CLIA requirements, that has had a record of satisfactory proficiency testing performance for all testing events for at least one year for a specific test, analyte, subspecialty, or specialty and has been designated by an HHS approved proficiency testing program as a referee laboratory for analyzing proficiency testing specimens for the purpose of determining the correct response for the specimens in a testing event for that specific test, analyte, subspecialty, or specialty.

Reference range means the range of test values expected for a designated population of individuals, e.g., 95 percent of individuals that are presumed to be healthy (or normal).

Reflex testing means confirmatory or additional laboratory testing that is automatically requested by a laboratory under its standard operating procedures for patient specimens when the laboratory’s findings indicate test results that are abnormal, are outside a predetermined range, or meet other pre-established criteria for additional testing.

Repeat proficiency testing referral means a second instance in which a proficiency testing sample, or a portion of a sample, is referred, for any reason, to another laboratory for analysis prior to the laboratory’s proficiency testing program event cut-off date within the period of time encompassing the two prior survey cycles (including initial certification, recertification, or the equivalent for laboratories surveyed by an approved accreditation organization).

Reportable range means the span of test result values over which the laboratory can establish or verify the accuracy of the instrument or test system measurement response.

Sample in proficiency testing means the material contained in a vial, on a slide, or other unit that contains material to be tested by proficiency testing program participants. When possible, samples are of human origin.

State includes, for purposes of this part, each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands and a political subdivision of a State where the State, acting pursuant to State law, has expressly delegated powers to the political subdivision sufficient to authorize the political subdivision to act for the State in enforcing requirements equal to or more stringent than CLIA requirements.

State licensure means the issuance of a license to, or the approval of, a laboratory by a State laboratory program
§ 493.3 Applicability.

(a) Basic rule. Except as specified in paragraph (b) of this section, a laboratory will be cited as out of compliance with section 353 of the Public Health Service Act unless it—

(1) Has a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of

Unsuccessful proficiency testing performance means any of the following:

(1) Unsatisfactory performance for the same analyte in two consecutive or two out of three testing events.

(2) Repeated unsatisfactory overall testing event scores for two consecutive or two out of three testing events for the same specialty or subspecialty.

(3) An unsatisfactory testing event score for those subspecialties not graded by analyte (that is, bacteriology, mycobacteriology, virology, parasitology, mycology, blood compatibility, immunohematology, or syphilis serology) for the same subspecialty for two consecutive or two out of three testing events.

(4) Failure of a laboratory performing gynecologic cytology to meet the standard at § 493.855.

Unsuccessful proficiency testing performance means a failure to attain the minimum satisfactory score for an analyte, test, subspecialty, or specialty for two consecutive or two of three consecutive testing events.

Validation review period means the one year time period during which CMS conducts validation inspections and evaluates the results of the most recent surveys performed by an accreditation organization or State laboratory program.

Waived test means a test system, assay, or examination that HHS has determined meets the CLIA statutory criteria as specified for waiver under section 353(b)(3) of the Public Health Service Act.

compliance, certificate for PPM procedures, or certificate of accreditation issued by HHS applicable to the category of examinations or procedures performed by the laboratory; or

(2) Is CLIA-exempt.

(b) Exception. These rules do not apply to components or functions of—

(1) Any facility or component of a facility that only performs testing for forensic purposes;
(2) Research laboratories that test human specimens but do not report patient specific results for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of individual patients; or
(3) Laboratories certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), in which drug testing is performed which meets SAMHSA guidelines and regulations. However, all other testing conducted by a SAMHSA-certified laboratory is subject to this rule.

(c) Federal laboratories. Laboratories under the jurisdiction of an agency of the Federal Government are subject to the rules of this part, except that the Secretary may modify the application of such requirements as appropriate.


§ 493.15 Laboratories performing waived tests.

(a) Requirement. Tests for certificate of waiver must meet the descriptive criteria specified in paragraph (b) of this section.

(b) Criteria. Test systems are simple laboratory examinations and procedures which—

(1) Are cleared by FDA for home use;
(2) Employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible; or
(3) Pose no reasonable risk of harm to the patient if the test is performed incorrectly.

(c) Certificate of waiver tests. A laboratory may qualify for a certificate of waiver under section 353 of the PHS Act if it restricts the tests that it performs to one or more of the following tests or examinations (or additional tests added to this list as provided under paragraph (d) of this section) and no others:

(1) Dipstick or Tablet Reagent Urinalysis (non-automated) for the following:
   (i) Bilirubin;
   (ii) Glucose;
   (iii) Hemoglobin;
   (iv) Ketone;
   (v) Leukocytes;
   (vi) Nitrite;
   (vii) pH;
   (viii) Protein;
   (ix) Specific gravity;
   (x) Urobilinogen.
(2) Fecal occult blood;
(3) Ovulation tests—visual color comparison tests for human luteinizing hormone;
(4) Urine pregnancy tests—visual color comparison tests for human chorionic gonadotropin;
(5) Erythrocyte sedimentation rate—non-automated;
(6) Hemoglobin—copper sulfate—non-automated;
(7) Blood glucose by glucose monitoring devices cleared by the FDA specifically for home use;
(8) Spun microhematocrit; and
(9) Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/
(d) Revisions to criteria for test categorization and the list of waived tests. HHS will determine whether a laboratory test meets the criteria listed under paragraph (b) of this section for a waived test. Revisions to the list of waived tests approved by HHS will be published in the Federal Register in a notice with opportunity for comment.

(e) Laboratories eligible for a certificate of waiver must—
(1) Follow manufacturers’ instructions for performing the test; and
(2) Meet the requirements in subpart B, Certificate of Waiver, of this part.


§ 493.17 Test categorization.

(a) Categorization by criteria. Notices will be published in the Federal Register which list each specific test system, assay, and examination categorized by complexity. Using the seven criteria specified in this paragraph for categorizing tests of moderate or high complexity, each specific laboratory test system, assay, and examination will be graded for level of complexity by assigning scores of 1, 2, or 3 within each criteria. The score of “1” indicates the lowest level of complexity, and the score of “3” indicates the highest level. These scores will be totaled. Test systems, assays or examinations receiving scores of 12 or less will be categorized as moderate complexity, while those receiving scores above 12 will be categorized as high complexity.

NOTE: A score of “2” will be assigned to a criteria heading when the characteristics for a particular test are intermediate between the descriptions listed for scores of “1” and “3.”

(1) Knowledge—
(A) Minimal scientific and technical knowledge is required to perform the test; and
(B) Knowledge required to perform the test may be obtained through on-the-job instruction.

(2) Training and experience—
(A) Minimal training is required for preanalytic, analytic and postanalytic phases of the testing process; and
(B) Limited experience is required to perform the test.

(ii) Score 3. (A) Specialized training is essential to perform the preanalytic, analytic or postanalytic testing process; or
(B) Substantial experience may be necessary for analytic test performance.

(3) Reagents and materials preparation—
(A) Reagents and materials are generally stable and reliable; and
(B) Reagents and materials are generally stable and reliable.

(ii) Score 3. (A) Specialized training is essential to perform the preanalytic, analytic or postanalytic testing process; or
(B) Substantial experience may be necessary for analytic test performance.

(4) Characteristics of operational steps—
(i) Score 1. Operational steps are either automatically executed (such as pipetting, temperature monitoring, or timing of steps), or are easily controlled.

(ii) Score 3. Operational steps in the testing process require close monitoring or control, and may require special specimen preparation, precise temperature control or timing of procedural steps, accurate pipetting, or extensive calculations.

(5) Calibration, quality control, and proficiency testing materials—
(A) Calibration materials are stable and readily available;
(B) Quality control materials are stable and readily available; and
(C) External proficiency testing materials, when available, are stable.

(ii) Score 3. (A) Calibration materials, if available, may be labile;
(B) Quality control materials may be labile, or not available; or
(C) External proficiency testing materials, if available, may be labile.

(6) Test system troubleshooting and equipment maintenance—
(A)
Centers for Medicare & Medicaid Services, HHS

§ 493.19

Test system troubleshooting is automatic or self-correcting, or clearly described or requires minimal judgment; and

(B) Equipment maintenance is provided by the manufacturer, is seldom needed, or can easily be performed.

(ii) Score 3. (A) Troubleshooting is not automatic and requires decision-making and direct intervention to resolve most problems; or

(B) Maintenance requires special knowledge, skills, and abilities.

(7) Interpretation and judgment—(i) Score 1. (A) Minimal interpretation and judgment are required to perform preanalytic, analytic and postanalytic processes; and

(B) Resolution of problems requires limited independent interpretation and judgment; and

(ii) Score 3. (A) Extensive independent interpretation and judgment are required to perform the preanalytic, analytic or postanalytic processes; and

(B) Resolution of problems requires extensive interpretation and judgment.

(b) Revisions to the criteria for categorization. The Clinical Laboratory Improvement Advisory Committee, as defined in subpart T of this part, will conduct reviews upon request of HHS and recommend to HHS revisions to the criteria for categorization of tests.

(c) Process for device/test categorization utilizing the scoring system under § 493.17(a). (1)(i) For new commercial test systems, assays, or examinations, the manufacturer, as part of its 510(k) and PMA application to FDA, will submit supporting data for device/test categorization. FDA will determine the complexity category, notify the manufacturer directly, and will simultaneously inform both CMS and CDC of the device/test category. FDA will consult with CDC concerning test categorization in the following three situations:

(A) When categorizing previously uncategorized new technology;

(B) When FDA determines it to be necessary in cases involving a request for a change in categorization; and

(C) If a manufacturer requests review of a categorization decision by FDA in accordance with 21 CFR 10.75.

(ii) Test categorization will be effective as of the notification to the applicant.

(2) For test systems, assays, or examinations not commercially available, a laboratory or professional group may submit a written request for categorization to PHS. These requests will be forwarded to CDC for evaluation; CDC will determine complexity category and notify the applicant, CMS, and FDA of the categorization decision. In the case of request for a change of category or for previously uncategorized new technology, PHS will receive the request application and forward it to CDC for categorization.

(3) A request for recategorization will be accepted for review if it is based on new information not previously submitted in a request for categorization or recategorization by the same applicant and will not be considered more frequently than once per year.

(4) If a laboratory test system, assay or examination does not appear on the lists of tests in the Federal Register notices, it is considered to be a test of high complexity until PHS, upon request, reviews the matter and notifies the applicant of its decision. Test categorization is effective as of the notification to the applicant.

(5) PHS will publish revisions periodically to the list of moderate and high complexity tests in the Federal Register in a notice with opportunity for comment.

§ 493.19

Provider-performed microscopy (PPM) procedures.

(a) Requirement. To be categorized as a PPM procedure, the procedure must meet the criteria specified in paragraph (b) of this section.

(b) Criteria. Procedures must meet the following specifications:

(1) The examination must be personally performed by one of the following practitioners:

(i) A physician during the patient’s visit on a specimen obtained from his or her own patient or from a patient of a group medical practice of which the physician is a member or an employee.

(ii) A midlevel practitioner, under the supervision of a physician or in
§ 493.20 Laboratories performing tests of moderate complexity.

(a) A laboratory may qualify for a certificate to perform tests of moderate complexity provided that it restricts its test performance to waived tests or examinations and one or more tests or examinations meeting criteria for tests of moderate complexity including the subcategory of PPM procedures.

(b) A laboratory that performs tests or examinations of moderate complexity must meet the applicable requirements in subpart C or subpart D, and subparts F, H, J, K, and M of this part. Under a registration certificate or certificate of compliance, laboratories also performing PPM procedures must meet the inspection requirements at §§ 493.1773 and 493.1775.

(c) If the laboratory also performs waived tests, compliance with subparts H, J, K, and M of this part is not applicable to the waived tests. However, the laboratory must comply with the requirements in §§ 493.15(e), 493.1773, and 493.1775.

§ 493.25 Laboratories performing tests of high complexity.

(a) A laboratory must obtain a certificate for tests of high complexity if it performs one or more tests that meet the criteria for tests of high complexity as specified in § 493.17(a).
(b) A laboratory performing one or more tests of high complexity must meet the applicable requirements of subpart C or subpart D, and subparts F, H, J, K, M, and Q of this part.

(c) If the laboratory also performs tests of moderate complexity, the applicable requirements of subparts H, J, K, M, and Q of this part must be met. Under a registration certificate or certificate of compliance, PPM procedures must meet the inspection requirements at §§ 493.1773 and 493.1777.

(d) If the laboratory also performs waived tests, the requirements of subparts H, J, K, and M are not applicable to the waived tests. However, the laboratory must comply with the requirements in §§ 493.15(e), 493.1773, and 493.1775.


Subpart B—Certificate of Waiver

SOURCE: 57 FR 7142, Feb. 28, 1992, unless otherwise noted.

§ 493.35 Application for a certificate of waiver.

(a) Filing of application. Except as specified in paragraph (b) of this section, a laboratory performing only one or more waived tests listed in § 493.15 must file a separate application for each laboratory location.

(b) Exceptions. (1) Laboratories that are not at a fixed location, that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations may be covered under the certificate of the designated primary site or home base, using its address.

(2) Not-for-profit or Federal, State, or local government laboratories that engage in limited (not more than a combination of 15 moderately complex or waived tests per certificate) public health testing may file a single application.

(3) Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction may file a single application or multiple applications for the laboratory sites within the same physical location or street address.

(c) Application format and contents. The application must—

(1) Be made to HHS or its designee on a form or forms prescribed by HHS;

(2) Be signed by an owner, or by an authorized representative of the laboratory who attests that the laboratory will be operated in accordance with requirements established by the Secretary under section 353 of the PHS Act; and

(3) Describe the characteristics of the laboratory operation and the examinations and other test procedures performed by the laboratory including—

(i) The name and the total number of test procedures and examinations performed annually (excluding tests the laboratory may run for quality control, quality assurance or proficiency testing purposes;

(ii) The methodologies for each laboratory test procedure or examination performed, or both; and

(iii) The qualifications (educational background, training, and experience) of the personnel directing and supervising the laboratory and performing the laboratory examinations and test procedures.

(d) Access requirements. Laboratories that perform one or more waived tests listed in § 493.15(c) and no other tests must meet the following conditions:

(1) Make records available and submit reports to HHS as HHS may reasonably require to determine compliance with this section and § 493.15(e);

(2) Agree to permit announced and unannounced inspections by HHS in accordance with subpart Q of this part under the following circumstances:

(i) When HHS has substantive reason to believe that the laboratory is being operated in a manner that constitutes an imminent and serious risk to human health.

(ii) To evaluate complaints from the public.

(iii) On a random basis to determine whether the laboratory is performing tests not listed in § 493.15.

(iv) To collect information regarding the appropriateness of waiver of tests listed in § 493.15.
§ 493.37 Requirements for a certificate of waiver.

(a) HHS will issue a certificate of waiver to a laboratory only if the laboratory meets the requirements of § 493.35.

(b) Laboratories issued a certificate of waiver—

(1) Are subject to the requirements of this subpart and § 493.15(e) of subpart A of this part; and

(2) Must permit announced or unannounced inspections by HHS in accordance with subpart Q of this part.

(c) Laboratories must remit the certificate of waiver fee specified in subpart F of this part.

(d) In accordance with subpart R of this part, HHS will suspend or revoke or limit a laboratory’s certificate of waiver for failure to comply with the requirements of this subpart. In addition, failure to meet the requirements of this subpart will result in suspension or denial of payments under Medicare and Medicaid in accordance with subpart R of this part.

(e)(1) A certificate of waiver issued under this subpart is valid for no more than 2 years. In the event of a non-compliance determination resulting in HHS action to revoke, suspend, or limit the laboratory’s certificate of waiver, HHS will provide the laboratory with a statement of grounds on which the determination of non-compliance is based and offer an opportunity for appeal as provided in subpart R of this part.

(2) If the laboratory requests a hearing within the time specified by HHS, it retains its certificate of waiver or re-issued certificate of waiver until a decision is made by an administrative law judge, as specified in subpart R of this part, except when HHS finds that conditions at the laboratory pose an imminent and serious risk to human health.

(3) For laboratories receiving payment from the Medicare or Medicaid program, such payments will be suspended on the effective date specified in the notice to the laboratory of a non-compliance determination even if there has been no appeals decision issued.

(f) A laboratory seeking to renew its certificate of waiver must—

(1) Complete the renewal application prescribed by HHS and return it to HHS not less than 9 months nor more than 1 year before the expiration of the certificate; and

(2) Meet the requirements of §§ 493.35 and 493.37.

(g) A laboratory with a certificate of waiver that wishes to perform examinations or tests not listed in the waiver test category must meet the requirements set forth in subpart C or subpart D of this part, as applicable.

§ 493.39 Notification requirements for laboratories issued a certificate of waiver.

Laboratories performing one or more tests listed in § 493.15 and no others must notify HHS or its designee—

(a) Before performing and reporting results for any test or examination that is not specified under § 493.15 for which the laboratory does not have the appropriate certificate as required in subpart C or subpart D of this part, as applicable; and

(b) Within 30 days of any change(s) in—

(1) Ownership;

(2) Name;

(3) Location; or
§ 493.43 Application for registration certificate, certificate for provider-performed microscopy (PPM) procedures, and certificate of compliance.

(a) Filing of application. Except as specified in paragraph (b) of this section, all laboratories performing non-waived testing must file a separate application for each laboratory location.

(b) Exceptions. (1) Laboratories that are not at a fixed location, that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations may be covered under the certificate of the designated primary site or home base, using its address.

(2) Not-for-profit or Federal, State, or local government laboratories that engage in limited (not more than a combination of 15 moderately complex or waived tests per certificate) public health testing may file a single application.

(3) Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction may file a single application or multiple applications for the laboratory sites within the same physical location or street address.

(c) Application format and contents. The application must—(1) Be made to HHS or its designee on a form or forms prescribed by HHS;

(2) Be signed by an owner, or by an authorized representative of the laboratory who attests that the laboratory will be operated in accordance with the requirements established by the Secretary under section 353 of the Public Health Service Act; and

(3) Describe the characteristics of the laboratory operation and the examinations and other test procedures performed by the laboratory including—

(i) The name and total number of test procedures and examinations performed annually (excluding waived tests or tests for quality control, quality assurance or proficiency testing purposes);

(ii) The methodologies for each laboratory test procedure or examination performed, or both;

(iii) The qualifications (educational background, training, and experience) of the personnel directing and supervising the laboratory and performing the examinations and test procedures.

(d) Access and reporting requirements. All laboratories must make records available and submit reports to HHS as HHS may reasonably require to determine compliance with this section.

§ 493.45 Requirements for a registration certificate.

Laboratories performing only waived tests, PPM procedures, or any combination of these tests, are not required to obtain a registration certificate.

(a) A registration certificate is required—(1) Initially for all laboratories performing test procedures of moderate complexity (other than the subcategory of PPM procedures) or high complexity, or both; and

(2) For all laboratories that have been issued a certificate of waiver or certificate for PPM procedures that intend to perform tests of moderate or high complexity, or both, in addition to those tests listed in §493.15(c) or specified as PPM procedures.

(b) HHS will issue a registration certificate if the laboratory—

(1) Complies with the requirements of §493.43;

(2) Agrees to notify HHS or its designee within 30 days of any changes in ownership, name, location, director or technical supervisor (laboratories performing high complexity testing only);
§ 493.47 Requirements for a certificate for provider-performed microscopy (PPM) procedures.

(a) A certificate for PPM procedures is required—
(1) Initially for all laboratories performing test procedures specified as PPM procedures; and
(2) For all certificate of waiver laboratories that intend to perform only test procedures specified as PPM procedures in addition to those tests listed in §493.15(c).

(b) HHS will issue a certificate for PPM procedures if the laboratory—
(1) Complies with the requirements of §493.43; and
(2) Remits the fee for the certificate, as specified in subpart F of this part.

(c) Laboratories issued a certificate for PPM procedures are subject to—
(1) The notification requirements of §493.53;
(2) The applicable requirements of this subpart and subparts H, J, K, and M of this part; and
(3) Inspection only under the circumstances specified under §§493.1773 and 493.1775, but are not routinely inspected to determine compliance with the requirements specified in paragraphs (c) (1) and (2) of this section.

(d) In accordance with subpart R of this part, HHS will initiate suspension, limitation, or revocation of a laboratory’s certificate for PPM procedures for failure to comply with the applicable requirements set forth in this subpart. HHS may also impose certain alternative sanctions. In addition, failure to meet the requirements of this subpart may result in suspension of all or part of payments under Medicare and Medicaid, as specified in subpart R of this part.
(e) A certificate for PPM procedures is valid for a period of no more than 2 years.

§ 493.49 Requirements for a certificate of compliance.

A certificate of compliance may include any combination of tests categorized as high complexity or moderate complexity or listed in § 493.15(c) as waived tests. Moderate complexity tests may include those specified as PPM procedures.

(a) HHS will issue a certificate of compliance to a laboratory only if the laboratory—

(1) Meets the requirements of §§ 493.43 and 493.45;
(2) Remits the certificate fee specified in subpart F of this part; and
(3) Meets the applicable requirements of this subpart and subparts H, J, K, M, and Q of this part.

(b) Laboratories issued a certificate of compliance—

(1) Are subject to the notification requirements of § 493.51; and
(2) Must permit announced or unannounced inspections by HHS in accordance with subpart Q of this part—

(i) To determine compliance with the applicable requirements of this part;
(ii) To evaluate complaints;
(iii) When HHS has substantive reason to believe that tests are being performed, or the laboratory is being operated in a manner that constitutes an imminent and serious risk to human health; and
(iv) To collect information regarding the appropriateness of tests listed in § 493.15 or tests categorized as moderate complexity (including the subcategory) or high complexity.

(c) Failure to comply with the requirements of this subpart will result in—

(1) Suspension, revocation or limitation of a laboratory’s certificate of compliance in accordance with subpart R of this part; and
(2) Suspension or denial of payments under Medicare and Medicaid in accordance with subpart R of this part.

(d) A certificate of compliance issued under this subpart is valid for no more than 2 years.

(e) In the event of a noncompliance determination resulting in an HHS action to revoke, suspend or limit the laboratory’s certificate of compliance, HHS will—

(1) Provide the laboratory with a statement of grounds on which the determination of noncompliance is based; and
(2) Offer an opportunity for appeal as provided in subpart R of this part. If the laboratory requests a hearing within 60 days of the notice of sanction, it retains its certificate of compliance or reissued certificate of compliance until a decision is made by an administrative law judge (ALJ) as provided in subpart R of this part, except when HHS finds that conditions at the laboratory pose an imminent and serious risk to human health or when the criteria at § 493.1840(a) (4) and (5) are met.

(f) For laboratories receiving payment from the Medicare or Medicaid program, such payments will be suspended on the effective date specified in the notice to the laboratory of a noncompliance determination even if there has been no appeals decision issued.

(g) A laboratory seeking to renew its certificate of compliance must—

(1) Complete and return the renewal application to HHS 9 to 12 months prior to the expiration of the certificate of compliance; and
(2) Meet the requirements of § 493.43 and paragraphs (a)(2) and (b)(2) of this section.

(h) If HHS determines that the application for the renewal of a certificate of compliance must be denied or limited, HHS will notify the laboratory in writing of the—

(1) Basis for denial of the application; and
(2) Opportunity for appeal as provided in subpart R of this part.

(i) If the laboratory requests a hearing within the time period specified by HHS, the laboratory retains its certificate of compliance or reissued certificate of compliance until a decision is made by an ALJ as provided in subpart
§ 493.51 Notification requirements for laboratories issued a certificate of compliance.

Laboratories issued a certificate of compliance must meet the following conditions:

(a) Notify HHS or its designee within 30 days of any change in—

   (1) Ownership;
   (2) Name;
   (3) Location;
   (4) Director; or
   (5) Technical supervisor (laboratories performing high complexity only).

(b) Notify HHS no later than 6 months after performing any test or examination within a specialty or subspecialty area that is not included on the laboratory’s certificate of compliance, so that compliance with requirements can be determined.

(c) Notify HHS no later than 6 months after any deletions or changes in test methodologies for any test or examination included in a specialty or subspecialty, or both, for which the laboratory has been issued a certificate of compliance.

§ 493.53 Notification requirements for laboratories issued a certificate for provider-performed microscopy (PPM) procedures.

Laboratories issued a certificate for PPM procedures must notify HHS or its designee—

(a) Before performing and reporting results for any test of moderate or high complexity, or both, in addition to tests specified as PPM procedures or any test or examination that is not specified under § 493.15(c), for which it does not have a registration certificate as required in subpart C or subpart D, as applicable, of this part; and

(b) Within 30 days of any change in—

   (1) Ownership;
   (2) Name;
   (3) Location; or
   (4) Director.

§ 493.55 Application for registration certificate and certificate of accreditation.

(a) Filing of application. A laboratory may be issued a certificate of accreditation in lieu of the applicable certificate specified in subpart B or subpart C of this part provided the laboratory—

   (1) Meets the standards of a private non-profit accreditation program approved by HHS in accordance with subpart E; and

   (2) Files a separate application for each location, except as specified in paragraph (b) of this section.

(b) Exceptions. (1) Laboratories that are not at fixed locations, that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations may file a single application.

   (2) Not-for-profit or Federal, State, or local government laboratories that engage in limited (not more than a combination of 15 moderately complex or waived tests per certificate) public health testing may file a single application.

   (3) Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction may file a single application or multiple applications for the laboratory sites within the same physical location or street address.

(c) Application format and contents. The application must—

   (1) Be made to HHS on a form or forms prescribed by HHS;
(2) Be signed by an owner or authorized representative of the laboratory who attests that the laboratory will be operated in accordance with the requirements established by the Secretary under section 353 of the Public Health Service Act; and

(3) Describe the characteristics of the laboratory operation and the examinations and other test procedures performed by the laboratory including—

   (i) The name and total number of tests and examinations performed annually (excluding waived tests and tests for quality control, quality assurance or proficiency testing purposes);

   (ii) The methodologies for each laboratory test procedure or examination performed, or both; and

   (iii) The qualifications (educational background, training, and experience) of the personnel directing and supervising the laboratory and performing the laboratory examinations and test procedures.

(d) Access and reporting requirements.

All laboratories must make records available and submit reports to HHS as HHS may reasonably require to determine compliance with this section.


§ 493.57 Requirements for a registration certificate.

A registration certificate is required for all laboratories seeking a certificate of accreditation, unless the laboratory holds a valid certificate of compliance issued by HHS.

(a) HHS will issue a registration certificate if the laboratory—

(1) Complies with the requirements of § 493.55;

(2) Agrees to notify HHS within 30 days of any changes in ownership, name, location, director, or supervisor (laboratories performing high complexity testing only);

(3) Agrees to treat proficiency testing samples in the same manner as it treats patient specimens; and

(4) Remits the fee for the registration certificate specified in subpart F of this part.

(b)(1) The laboratory must provide HHS with proof of accreditation by an approved accreditation program—

   (i) Within 11 months of issuance of the registration certificate; or

   (ii) Prior to the expiration of the certificate of compliance.

(2) If such proof of accreditation is not supplied within this timeframe, the laboratory must meet, or continue to meet, the requirements of § 493.49.

(c) In accordance with subpart R of this part, HHS will initiate suspension, revocation, or limitation of a laboratory’s registration certificate and will deny the laboratory’s application for a certificate of accreditation for failure to comply with the requirements set forth in this subpart. In addition, failure to meet the requirements of this subpart will result in suspension or denial of payments under Medicare and Medicaid as specified in subpart R of this part.

(d) A registration certificate is valid for a period of no more than 2 years. However, it may be reissued if the laboratory is subject to subpart C of this part, as specified in § 493.57(b)(2) and compliance has not been determined by HHS before the expiration date of the registration certificate.

(e) In the event that the laboratory does not meet the requirements of this subpart, HHS will—

   (1) Deny a laboratory’s request for certificate of accreditation;

   (2) Notify the laboratory if it must meet the requirements for a certificate as defined in subpart C of this part;

   (3) Provide the laboratory with a statement of grounds on which the application denial is based;

   (4) Offer an opportunity for appeal on the application denial as provided in subpart R of this part. If the laboratory requests a hearing within the time specified by HHS, the laboratory will retain its registration certificate or reissued registration certificate until a decision is made by an administrative law judge as provided in subpart R, unless HHS finds that conditions at the laboratory pose an imminent and serious risk to human health; and

   (5) For those laboratories receiving payment from the Medicare or Medicaid program, such payments will be suspended on the effective date specified in the notice to the laboratory of
§ 493.61

Requirements for a certificate of accreditation.

(a) HHS will issue a certificate of accreditation to a laboratory if the laboratory—
(1) Meets the requirements of § 493.57 or, if applicable, § 493.49 of subpart C of this part; and
(2) Remits the certificate of accreditation fee specified in subpart F of this part.

(b) Laboratories issued a certificate of accreditation must—
(1) Treat proficiency testing samples in the same manner as patient samples;
(2) Meet the requirements of § 493.63;
(3) Comply with the requirements of the approved accreditation program;
(4) Permit random sample validation and complaint inspections as required in subpart Q of this part;
(5) Permit HHS to monitor the correction of any deficiencies found through the inspections specified in paragraph (b)(4) of this section;
(6) Authorize the accreditation program to release to HHS the laboratory’s inspection findings whenever HHS conducts random sample or complaint inspections; and
(7) Authorize its accreditation program to submit to HHS the results of the laboratory’s proficiency testing.

(c) A laboratory failing to meet the requirements of this section—
(1) Will no longer meet the requirements of this part by virtue of its accreditation in an approved accreditation program;
(2) Will be subject to full determination of compliance by HHS;
(3) May be subject to suspension, revocation or limitation of the laboratory’s certificate of accreditation or certain alternative sanctions; and
(4) May be subject to suspension of payments under Medicare and Medicaid as specified in subpart R.

(d) A certificate of accreditation issued under this subpart is valid for no more than 2 years. In the event of a non-compliance determination as a result of a random sample validation or complaint inspection, a laboratory will be subject to a full review by HHS in accordance with § 488.11 of this chapter.

(e) Failure to meet the applicable requirements of part 493, will result in an action by HHS to suspend, revoke or limit the certificate of accreditation. HHS will—
(1) Provide the laboratory with a statement of grounds on which the determination of noncompliance is based;
(2) Notify the laboratory if it is eligible to apply for a certificate as defined in subpart C of this part; and
(3) Offer an opportunity for appeal as provided in subpart R of this part.

(f) If the laboratory requests a hearing within the time frame specified by HHS—
(1) It retains its certificate of accreditation or reissued certificate of accreditation until a decision is made by an administrative law judge as provided in subpart R of this part, unless HHS finds that conditions at the laboratory pose an imminent and serious risk to human health; and
(2) For those laboratories receiving payments from the Medicare or Medicaid program, such payments will be suspended on the effective date specified in the notice to the laboratory even if there has been no appeals decision issued.

(g) In the event the accreditation organization’s approval is removed by HHS, the laboratory will be subject to the applicable requirements of subpart C of this part or § 493.37.

(h) A laboratory seeking to renew its certificate of accreditation must—
(1) Complete and return the renewal application to HHS 9 to 12 months prior to the expiration of the certificate of accreditation;
(2) Meet the requirements of this subpart; and
(3) Submit the certificate of accreditation fee specified in subpart F of this part.

(i) If HHS determines that the renewal application for a certificate of accreditation is to be denied or limited, HHS will notify the laboratory in writing of—
(1) The basis for denial of the application;
(2) Whether the laboratory is eligible for a certificate as defined in subpart C of this part;
(3) The opportunity for appeal on HHS’s action to deny the renewal application for certificate of accreditation as provided in subpart R of this part. If the laboratory requests a hearing within the time frame specified by HHS, it retains its certificate of accreditation or reissued certificate of accreditation until a decision is made by an administrative law judge as provided in subpart R of this part, unless HHS finds that conditions at the laboratory pose an imminent and serious risk to human health; and

(4) Suspension of payments under Medicare or Medicaid for those laboratories receiving payments under the Medicare or Medicaid programs.


§ 493.551 General requirements for laboratories.

Subpart E—Accreditation by a Private, Nonprofit Accreditation Organization or Exemption Under an Approved State Laboratory Program

SOURCE: 63 FR 26732, May 14, 1998, unless otherwise noted.

§ 493.551 General requirements for laboratories.

(a) Applicability. CMS may deem a laboratory to meet all applicable CLIA program requirements through accreditation by a private nonprofit accreditation program (that is, grant deemed status), or may exempt from CLIA program requirements all State licensed or approved laboratories in a State that has a State licensure program established by law, if the following conditions are met:

(1) The requirements of the accreditation organization or State licensure program are equal to, or more stringent than, the CLIA condition-level requirements specified in this part, and the laboratory would meet the condition-level requirements if it were inspected against these requirements.

(2) The accreditation program or the State licensure program meets the requirements of this subpart and is approved by CMS.

(3) The laboratory authorizes the approved accreditation program to release to CMS all records and information required and permits inspections as outlined in this part.

(b) Meeting CLIA requirements by accreditation. A laboratory seeking to meet CLIA requirements through accreditation by an approved accreditation organization must do the following:

(1) Obtain a certificate of accreditation as required in subpart D of this part.

(2) Pay the applicable fees as required in subpart F of this part.

(3) Meet the proficiency testing (PT) requirements in subpart H of this part.

(4) Authorize its PT organization to furnish to its accreditation organization the results of the laboratory’s participation in an approved PT program.
for the purpose of monitoring the laboratory's PT and for making the annual PT results, along with explanatory information required to interpret the PT results, available on a reasonable basis, upon request of any person. A laboratory that refuses to authorize release of its PT results is no longer deemed to meet the condition-level requirements and is subject to a full review by CMS, in accordance with subpart Q of this part, and may be subject to the suspension or revocation of its certificate of accreditation under §493.1840.

(5) Authorize its accreditation organization to release to CMS or a CMS agent the laboratory's PT results that constitute unsuccessful participation in an approved PT program, in accordance with the definition of "unsuccessful participation in an approved PT program," as specified in §493.2 of this part, when the laboratory has failed to achieve successful participation in an approved PT program.

(6) Authorize its accreditation organization to release to CMS a notification of the actions taken by the organization as a result of the unsuccessful participation in a PT program within 30 days of the initiation of the action. Based on this notification, CMS may take an adverse action against a laboratory that fails to participate successfully in an approved PT program.

(c) Withdrawal of laboratory accreditation. After an accreditation organization has withdrawn or revoked its accreditation of a laboratory, the laboratory retains its certificate of accreditation for 45 days after the laboratory receives notice of the withdrawal or revocation of the accreditation, or the effective date of any action taken by CMS, whichever is earlier.

§493.553 Approval process (application and reapplication) for accreditation organizations and State licensure programs.

(a) Information required. An accreditation organization that applies or re-applies to CMS for deeming authority, or a State licensure program that applies or re-applies to CMS for exemption from CLIA program requirements of licensed or approved laboratories within the State, must provide the following information:

1. A detailed comparison of the individual accreditation, or licensure or approval requirements with the comparable condition-level requirements; that is, a crosswalk.

2. A detailed description of the inspection process, including the following:

   i. Frequency of inspections.
   ii. Copies of inspection forms.
   iii. Instructions and guidelines.
   iv. A description of the review and decision-making process of inspections.
   v. A statement concerning whether inspections are announced or unannounced.
   vi. A description of the steps taken to monitor the correction of deficiencies.

3. A description of the process for monitoring PT performance, including action to be taken in response to unsuccessful participation in a CMS-approved PT program.

4. Procedures for responding to and for the investigation of complaints against its laboratories.

5. A list of all its current laboratories and the expiration date of their accreditation or licensure, as applicable.

6. Procedures for making PT information available (under State confidentiality and disclosure requirements, if applicable) including explanatory information required to interpret PT results, on a reasonable basis, upon request of any person.

(b) CMS action on an application or reapplication. If CMS receives an application or reapplication from an accreditation organization, or State licensure program, CMS takes the following actions:

1. CMS determines if additional information is necessary to make a determination for approval or denial of the application and notifies the accreditation organization or State to afford it an opportunity to provide the additional information.

2. CMS may visit the accreditation organization or State licensure program offices to review and verify the policies and procedures represented in its application and other information, including, but not limited to, review
and examination of documents and interviews with staff.

(3) CMS notifies the accreditation organization or State licensure program indicating whether CMS approves or denies the request for deeming authority or exemption, respectively, and the rationale for any denial.

(c) **Duration of approval.** CMS approval may not exceed 6 years.

(d) **Withdrawal of application.** The accreditation organization or State licensure program may withdraw its application at any time before official notification, specified at §493.553(b)(3).

§493.555 Federal review of laboratory requirements.

CMS’s review of an accreditation organization or State licensure program includes, but is not limited to, an evaluation of the following:

(a) Whether the organization’s or State’s requirements for laboratories are equal to, or more stringent than, the condition-level requirements for laboratories.

(b) The organization’s or State’s inspection process to determine the comparability of the full inspection and complaint inspection procedures and requirements to those of CMS, including, but not limited to, inspection frequency and the ability to investigate and respond to complaints against its laboratories.

(c) The organization’s or State’s agreement with CMS that requires it to do the following:

(1) Notify CMS within 30 days of the action taken, of any laboratory that has—
   (i) Had its accreditation or licensure suspended, withdrawn, revoked, or limited;
   (ii) In any way been sanctioned; or
   (iii) Had any adverse action taken against it.

(2) Notify CMS within 10 days of any deficiency identified in an accredited or CLIA-exempt laboratory if the deficiency poses an immediate jeopardy to the laboratory’s patients or a hazard to the general public.

(3) Notify CMS, within 30 days, of all newly—
   (i) Accredited laboratories (or laboratories whose areas of specialty/subspecialty testing have changed); or
   (ii) Licensed laboratories, including the specialty/subspecialty areas of testing.

(4) Notify each accredited or licensed laboratory within 10 days of CMS’s withdrawal of the organization’s deeming authority or State’s exemption.

(5) Provide CMS with inspection schedules, as requested, for validation purposes.

§493.557 Additional submission requirements.

(a) **Specific requirements for accreditation organizations.** In addition to the information specified in §§493.553 and 493.555, as part of the approval and review process, an accreditation organization applying or reapplying for deeming authority must also provide the following:

(1) The specialty or subspecialty areas for which the organization is requesting deeming authority and its mechanism for monitoring compliance with all requirements equivalent to condition-level requirements within the scope of the specialty or subspecialty areas.

(2) A description of the organization’s data management and analysis system with respect to its inspection and accreditation decisions, including the kinds of routine reports and tables generated by the systems.

(3) Detailed information concerning the inspection process, including, but not limited to the following:

(i) The size and composition of individual accreditation inspection teams.

(ii) Qualifications, education, and experience requirements that inspectors must meet.

(iii) The content and frequency of training provided to inspection personnel, including the ability of the organization to provide continuing education and training to inspectors.

(4) Procedures for removal or withdrawal of accreditation status for laboratories that fail to meet the organization’s standards.

(5) A proposed agreement between CMS and the accreditation organization with respect to the notification requirements specified in §493.555(c).

(6) Procedures for monitoring laboratories found to be out of compliance.
with its requirements. (These monitoring procedures must be used only when the accreditation organization identifies noncompliance. If noncompliance is identified through validation inspections, CMS or a CMS agent monitors corrections, as authorized at § 493.565(d)).

(7) A demonstration of its ability to provide CMS with electronic data and reports in compatible code, including the crosswalk specified in § 493.553(a)(1), that are necessary for effective validation and assessment of the organization’s inspection process.

(8) A demonstration of its ability to provide CMS with electronic data, in compatible code, related to the adverse actions resulting from PT results constituting unsuccessful participation in PT programs as well as data related to the PT failures, within 30 days of the initiation of adverse action.

(9) A demonstration of its ability to provide CMS with electronic data, in compatible code, for all accredited laboratories, including the area of specialty or subspecialty.

(10) Information defining the adequacy of numbers of staff and other resources.

(11) Information defining the organization’s ability to provide adequate funding for performing required inspections.

(12) Any facility-specific data, upon request by CMS, which includes, but is not limited to, the following:
  (i) PT results that constitute unsuccessful participation in a CMS-approved PT program.
  (ii) Notification of the adverse actions or corrective actions imposed by the accreditation organization as a result of unsuccessful PT participation.

(13) An agreement to provide written notification to CMS at least 30 days in advance of the effective date of any proposed change in its requirements.

(14) An agreement to disclose any laboratory’s PT results upon reasonable request by any person.

(b) Specific requirements for a State licensure program. In addition to requirements in §§ 493.553 and 493.555, as part of the approval and review process, when a State licensure program applies for exemption from the CLIA program, the State must do the following:

(1) Demonstrate to CMS that it has enforcement authority and administrative structures and resources adequate to enforce its laboratory requirements.

(2) Permit CMS or a CMS agent to inspect laboratories in the State.

(3) Require laboratories in the State to submit to inspections by CMS or a CMS agent as a condition of licensure or approval.

(4) Agree to pay the cost of the validation program administered in that State as specified in §§ 493.645(a) and 493.646(b).

(5) Take appropriate enforcement action against laboratories found by CMS not to be in compliance with requirements equivalent to CLIA requirements.

(6) Submit for Medicare and Medicaid payment purposes, a list of the specialties and subspecialties of tests performed by each laboratory.

(7) Submit a written presentation that demonstrates the agency’s ability to furnish CMS with electronic data in compatible code, including the crosswalk specified in § 493.553(a)(1).

(8) Submit a statement acknowledging that the State will notify CMS through electronic transmission of the following:
  (i) Any laboratory that has had its licensure or approval revoked or withdrawn or has been in any way sanctioned by the State within 30 days of taking the action.
  (ii) Changes in licensure or inspection requirements.
  (iii) Changes in specialties or subspecialties under which any licensed laboratory in the State performs testing.

(9) Provide information for the review of the State’s enforcement procedures for laboratories found to be out of compliance with the State’s requirements.

(10) Submit information that demonstrates the ability of the State to provide CMS with the following:
  (i) Electronic data and reports in compatible code with the adverse or corrective actions resulting from PT results that constitute unsuccessful participation in PT programs.
§ 493.563 Validation inspections—Basis and focus.

(a) Basis for validation inspection—(1) Laboratory with a certificate of accreditation. (i) CMS or a CMS agent may conduct an inspection of an accredited laboratory that has been issued a certificate of accreditation on a representative sample basis or in response to a substantial allegation of noncompliance.

(ii) CMS uses the results of these inspections to validate the accreditation organization's accreditation process.

(b) Laboratory in a State with an approved State licensure program. (i) CMS
§ 493.565 Selection for validation inspection—laboratory responsibilities.

A laboratory selected for a validation inspection must do the following:

(a) Authorize its accreditation organization or State licensure program, as applicable, to release to CMS or a CMS agent, on a confidential basis, a copy of the laboratory’s most recent full, and any subsequent partial inspection.

(b) Authorize CMS or a CMS agent to conduct a validation inspection.

(c) Provide CMS or a CMS agent with access to all facilities, equipment, materials, records, and information that CMS or a CMS agent determines have a bearing on whether the laboratory is being operated in accordance with the requirements of this part, and permit CMS or a CMS agent to copy material or require the laboratory to submit material.

(d) If the laboratory possesses a valid certificate of accreditation, authorize CMS or a CMS agent to monitor the correction of any deficiencies found through the validation inspection.

§ 493.567 Refusal to cooperate with validation inspection.

(a) Laboratory with a certificate of accreditation. A laboratory with a certificate of accreditation that refuses to cooperate with a validation inspection by failing to comply with the requirements in § 493.565—

(1) A review of documents.

(2) An audit of meetings concerning the accreditation process.

(3) Evaluation of accreditation inspection results and the accreditation decision-making process.

(4) Interviews with the accreditation organization’s staff.

(b) Validation inspection conducted on a representative sample basis. (1) If CMS or a CMS agent conducts a validation inspection on a representative sample basis, the inspection is comprehensive, addressing all condition-level requirements, or it may be focused on a specific condition-level requirement.

(2) The number of laboratories sampled is sufficient to allow a reasonable estimate of the performance of the accreditation organization or State.

(c) Validation inspection conducted in response to a substantial allegation of noncompliance. (1) If CMS or a CMS agent conducts a validation inspection in response to a substantial allegation of noncompliance, the inspection focuses on any condition-level requirement that CMS determines to be related to the allegation.

(2) If CMS or a CMS agent substantiates a deficiency and determines that the laboratory is out of compliance with any condition-level requirement, CMS or a CMS agent conducts a full CLIA inspection.

(d) Inspection of operations and offices. As part of the validation review process, CMS may conduct an onsite inspection of the operations and offices to verify the following:

(1) The accreditation organization’s representations and to assess the accreditation organization’s compliance with its own policies and procedures.

(2) The State’s representations and to assess the State’s compliance with its own policies and procedures, including verification of State enforcement actions taken on the basis of validation inspections performed by CMS or a CMS agent.

(e) Onsite inspection of an accreditation organization. An onsite inspection of an accreditation organization may include, but is not limited to, the following:

(1) A review of documents.

(2) An audit of meetings concerning the accreditation process.

(3) Evaluation of accreditation inspection results and the accreditation decision-making process.

(4) Interviews with the accreditation organization’s staff.

(f) Onsite inspection of a State licensure program. An onsite inspection of a State licensure program office may include, but is not limited to, the following:

(1) A review of documents.

(2) An audit of meetings concerning the licensure or approval process.

(3) Evaluation of State inspection results and the licensure or approval decision-making process.

(4) Interviews with State employees.
(i) Is subject to full review by CMS or a CMS agent, in accordance with this part; and

(ii) May be subject to suspension, revocation, or limitation of its certificate of accreditation under this part.

(2) A laboratory with a certificate of accreditation is again deemed to meet the condition-level requirements by virtue of its accreditation when the following conditions exist:

(i) The laboratory withdraws any prior refusal to authorize its accreditation organization to release a copy of the laboratory’s current accreditation inspection, PT results, or notification of any adverse actions resulting from PT failure.

(ii) The laboratory withdraws any prior refusal to allow a validation inspection.

(iii) CMS finds that the laboratory meets all the condition-level requirements.

(b) CLIA-exempt laboratory. If a CLIA-exempt laboratory fails to comply with the requirements specified in §493.565, CMS notifies the State of the laboratory’s failure to meet the requirements.

§493.569 Consequences of a finding of noncompliance as a result of a validation inspection.

(a) Laboratory with a certificate of accreditation. If a validation inspection results in a finding that the accredited laboratory is out of compliance with one or more condition-level requirements, the laboratory is subject to—

(1) The same requirements and survey and enforcement processes applied to laboratories that are not accredited and that are found out of compliance following an inspection under this part; and

(2) Full review by CMS, in accordance with this part; that is, the laboratory is subject to the principal and alternative sanctions in §493.1806.

(b) CLIA-exempt laboratory. If a validation inspection results in a finding that a CLIA-exempt laboratory is out of compliance with one or more condition-level requirements, CMS directs the State to take appropriate enforcement action.

§493.571 Disclosure of accreditation, State and CMS validation inspection results.

(a) Accreditation organization inspection results. CMS may disclose accreditation organization inspection results to the public only if the results are related to an enforcement action taken by the Secretary.

(b) State inspection results. Disclosure of State inspection results is the responsibility of the approved State licensure program, in accordance with State law.

(c) CMS validation inspection results. CMS may disclose the results of all validation inspections conducted by CMS or its agent.

§493.573 Continuing Federal oversight of private nonprofit accreditation organizations and approved State licensure programs.

(a) Comparability review. In addition to the initial review for determining equivalency of specified organization or State requirements to the comparable condition-level requirements, CMS reviews the equivalency of requirements in the following cases:

(1) When CMS promulgates new condition-level requirements.

(2) When CMS identifies an accreditation organization or a State licensure program whose requirements are no longer equal to, or more stringent than, condition-level requirements.

(3) When an accreditation organization or State licensure program adopts new requirements.

(4) When an accreditation organization or State licensure program adopts changes to its inspection process, as required by §493.575(b)(1), as applicable.

(5) Every 6 years, or sooner if CMS determines an earlier review is required.

(b) Validation review. Following the end of a validation review period, CMS evaluates the validation inspection results for each approved accreditation organization and State licensure program.

(c) Reapplication procedures. (1) Every 6 years, or sooner, as determined by CMS, an approved accreditation organization must reapply for continued approval of deeming authority and a State licensure program must reapply
§ 493.575 Removal of deeming authority or CLIA exemption and final determination review.

(a) CMS review. CMS conducts a review of the following:

(1) A deeming authority review of an accreditation organization’s program if the comparability or validation review produces findings, as described at §493.573. CMS reviews, as appropriate, the criteria described in §§493.555 and 493.557(a) to reevaluate whether the accreditation organization continues to meet all these criteria.

(2) An exemption review of a State’s licensure program if the comparability or validation review produces findings, as described at §493.573. CMS reviews, as appropriate, the criteria described in §§493.555 and 493.557(b) to reevaluate whether the licensure program continues to meet all these criteria.

(3) A review of an accreditation organization or State licensure program, at CMS’s discretion, if validation review findings, irrespective of the rate of disparity, indicate widespread or systematic problems in the organization’s accreditation or State’s licensure process that provide evidence that the requirements, taken as a whole, are no longer equivalent to CLIA requirements, taken as a whole.

(4) A review of the accreditation organization or State licensure program whenever validation inspection results indicate a rate of disparity of 20 percent or more between the findings of the organization or State and those of CMS or a CMS agent for the following periods:

(i) One year for accreditation organizations.

(ii) Two years for State licensure programs.

(b) CMS action after review. Following the review, CMS may take the following action:

(1) If CMS determines that the accreditation organization or State has failed to adopt requirements equal to, or more stringent than, CLIA requirements, CMS may give a conditional approval for a probationary period of its deeming authority to an organization 30 days following the date of CMS’s determination, or exempt status to a State within 30 days of CMS’s determination, both not to exceed 1 year, to

§ 493.575 for continued approval of a CLIA exemption. CMS provides notice of the materials that must be submitted as part of the reapplication procedure.

(2) An accreditation organization or State licensure program that does not meet the requirements of this subpart, as determined through a comparability or validation review, must furnish CMS, upon request, with the reapplication materials CMS requests. CMS establishes a deadline by which the materials must be submitted.

(d) Notice. (1) CMS provides written notice, as appropriate, to the following:

(i) An accreditation organization indicating that its approval may be in jeopardy if a comparability or validation review reveals that it is not meeting the requirements of this subpart and CMS is initiating a review of the accreditation organization’s deeming authority.

(ii) A State licensure program indicating that its CLIA exemption may be in jeopardy if a comparability or validation review reveals that it is not meeting the requirements of this subpart and that a review is being initiated of the CLIA exemption of the State’s laboratories.

(2) The notice contains the following information:

(i) A statement of the discrepancies that were found as well as other related documentation.

(ii) An explanation of CMS’s review process on which the final determination is based and a description of the possible actions, as specified in §493.575, that CMS may impose based on the findings from the comparability or validation review.

(iii) A description of the procedures available if the accreditation organization or State licensure program, as applicable, desires an opportunity to explain or justify the findings made during the comparability or validation review.

(iv) The reapplication materials that the accreditation organization or State licensure program must submit and the deadline for that submission.
afford the organization or State an opportunity to adopt equal or more stringent requirements.

(2) If CMS determines that there are widespread or systematic problems in the organization’s or State’s inspection process, CMS may give conditional approval during a probationary period, not to exceed 1 year, effective 30 days following the date of the determination.

c Final determination. CMS makes a final determination as to whether the organization or State continues to meet the criteria described in this subpart and issues a notice that includes the reasons for the determination to the organization or State within 60 days after the end of any probationary period. This determination is based on an evaluation of any of the following:

(1) The most recent validation inspection and review findings. To continue to be approved, the organization or State must meet the criteria of this subpart.

(2) Facility-specific data, as well as other related information.

(3) The organization’s or State’s inspection procedures, surveyors’ qualifications, ongoing education, training, and composition of inspection teams.

(4) The organization’s accreditation requirements, or the State’s licensure or approval requirements.

d Date of withdrawal of approval. CMS may withdraw its approval of the accreditation organization or State licensure program, effective 30 days from the date of written notice to the organization or State of this proposed action, if improvements acceptable to CMS have not been made during the probationary period.

e Continuation of validation inspections. The existence of any validation review, probationary status, or any other action, such as a deeming authority review, by CMS does not affect or limit the conduct of any validation inspection.

f Federal Register notice. CMS publishes a notice in the Federal Register containing a justification for removing the deeming authority from an accreditation organization, or the CLIA-exempt status of a State licensure program.

(g) Withdrawal of approval-effect on laboratory status—(1) Accredited laboratory. After CMS withdraws approval of an accreditation organization’s deeming authority, the certificate of accreditation of each affected laboratory continues in effect for 60 days after it receives notification of the withdrawal of approval.

(2) CLIA-exempt laboratory. After CMS withdraws approval of a State licensure program, the exempt status of each licensed or approved laboratory in the State continues in effect for 60 days after a laboratory receives notification from the State of the withdrawal of CMS’s approval of the program.

(3) Extension. After CMS withdraws approval of an accreditation organization or State licensure program, CMS may extend the period for an additional 60 days for a laboratory if it determines that the laboratory submitted an application for accreditation to an approved accreditation organization or an application for the appropriate certificate to CMS or a CMS agent before the initial 60-day period ends.

(h) Immediate jeopardy to patients. (1) If at any time CMS determines that the continued approval of deeming authority of any accreditation organization poses immediate jeopardy to the patients of the laboratories accredited by the organization, or continued approval otherwise constitutes a significant hazard to the public health, CMS may immediately withdraw the approval of deeming authority for that accreditation organization.

(2) If at any time CMS determines that the continued approval of a State licensure program poses immediate jeopardy to the patients of the laboratories in that State, or continued approval otherwise constitutes a significant hazard to the public health, CMS may immediately withdraw the approval of that State licensure program.

(i) Failure to pay fees. CMS withdraws the approval of a State licensure program if the State fails to pay the applicable fees, as specified in §§493.645(a) and 493.646(b).

(j) State refusal to take enforcement action. (1) CMS may withdraw approval of a State licensure program if the State
§ 493.602 Scope of subpart.

This subpart sets forth the methodology for determining the amount of the fees for issuing the appropriate certificate, and for determining compliance with the applicable standards of the Public Health Service Act (the PHS Act) and the Federal validation of accredited laboratories and of CLIA-exempt laboratories.

Source: 57 FR 7138, 7213, Feb. 28, 1992, unless otherwise noted.

§ 493.606 Applicability of subpart.

The rules of this subpart are applicable to those laboratories specified in §493.3.

Source: 58 FR 5212, Jan. 19, 1993

§ 493.638 Certificate fees.

(a) Basic rule. Laboratories must pay a fee for the issuance of a registration certificate, certificate for PPM procedures, certificate of waiver, certificate of accreditation, or a certificate of compliance, as applicable. Laboratories must also pay a fee to reapply for a certificate for PPM procedures, certificate of waiver, certificate of accreditation, or a certificate of compliance. The total of fees collected by HHS under the laboratory program must be sufficient to cover the general costs of administering the laboratory certification program under section 353 of the PHS Act.

(1) For registration certificates and certificates of compliance, the costs include issuing the certificates, collecting the fees, evaluating and monitoring proficiency testing programs, evaluating which procedures, tests or examinations meet the criteria for inclusion in the appropriate complexity category, and implementing section 353 of the PHS Act.

(2) For a certificate of waiver, the costs include issuing the certificate, collecting the fees, determining if a certificate of waiver should be issued, evaluating which tests qualify for inclusion in the waived category, and other direct administrative costs.

(3) For a certificate for PPM procedures, the costs include issuing the certificate, collecting the fees, determining if a certificate for PPM procedures should be issued, evaluating which procedures meet the criteria for inclusion in the subcategory of PPM procedures, and other direct administrative costs.

(4) For a certificate of accreditation, the costs include issuing the certificate, collecting the fees, evaluating the programs of accrediting bodies, and other direct administrative costs.

(b) Fee amount. The fee amount is set annually by HHS on a calendar year basis and is based on the category of test complexity, or on the category of test complexity and schedules or ranges of annual laboratory test volume (excluding waived tests and tests performed for quality control, quality assurance, and proficiency testing purposes) and specialties tested, with the amounts of the fees in each schedule being a function of the costs for all aspects of general administration of CLIA as set forth in §493.649 (b) and (c). This fee is assessed and payable at least biennially. The methodology used to determine the amount of the fee is found in §493.649. The amount of the fee applicable to the issuance of the registration certificate or the issuance or renewal of the certificate for PPM procedures, certificate of waiver, certificate of accreditation, or certificate of compliance is the amount in effect at the time the application is received.

Source: 57 FR 7138, 7213, Feb. 28, 1992, unless otherwise noted.
Upon receipt of an application for a certificate, HHS or its designee notifies the laboratory of the amount of the required fee for the requested certificate. (60 FR 20047, Apr. 24, 1995)

§ 493.639 Fee for revised certificate.

(a) If, after a laboratory is issued a registration certificate, it changes its name or location, the laboratory must pay a fee to cover the cost of issuing a revised registration certificate. The fee for the revised registration certificate is based on the cost to issue the revised certificate to the laboratory.

(b) A laboratory must pay a fee to cover the cost of issuing a revised certificate in any of the following circumstances:

(1) The fee for issuing an appropriate revised certificate is based on the cost to issue the revised certificate to the laboratory as follows:

(i) If a laboratory with a certificate of waiver wishes to perform tests in addition to those listed in § 493.15(c) as waived tests, it must, as set forth in § 493.638, pay an additional fee for the appropriate certificate to cover the additional testing.

(ii) If a laboratory with a certificate for PPM procedures wishes to perform tests in addition to those specified as PPM procedures or listed in § 493.15(c) as waived tests, it must, as set forth in § 493.638, pay an additional fee for the appropriate certificate to cover the additional testing.

(2) A laboratory must pay a fee to cover the cost of issuing a revised certificate when—

(i) A laboratory changes its name, location, or its director; or

(ii) A laboratory deletes services or wishes to add services and requests that its certificate be changed. (An additional fee is also required under § 493.643(d) if it is necessary to determine compliance with additional requirements.)

[57 FR 7213, Feb. 28, 1992, as amended at 60 FR 20047, Apr. 24, 1995]

§ 493.643 Fee for determination of program compliance.

(a) Fee requirement. In addition to the fee required under § 493.638, a laboratory subject to routine inspections must pay a fee to cover the cost of determining program compliance. Laboratories issued a certificate for PPM procedures, certificate of waiver, or a certificate of accreditation are not subject to this fee for routine inspections.

(b) Costs included in the fee. Included in the fee for determining program compliance is the cost of evaluating qualifications of personnel; monitoring proficiency testing; conducting onsite inspections; documenting deficiencies; evaluating laboratories’ plans to correct deficiencies; and necessary administrative costs. HHS sets the fee amounts annually on a calendar year basis. Laboratories are inspected biennially; therefore, fees are assessed and payable biennially. If additional expenses are incurred to conduct follow up visits to verify correction of deficiencies, to impose sanctions, and/or for surveyor preparation for and attendance at ALJ hearings, HHS assesses an additional fee to include these costs. The additional fee is based on the actual resources and time necessary to perform the activities.

(c) Classification of laboratories that require inspection for purpose of determining amount of fee. (1) There are ten classifications (schedules) of laboratories for the purpose of determining the fee amount a laboratory is assessed. Each laboratory is placed into one of the ten following schedules based on the laboratory’s scope and volume of testing (excluding tests performed for quality control, quality assurance, and proficiency testing purposes).

(i) (A) Schedule A Low Volume. The laboratory performs not more than 2,000 laboratory tests annually.

(B) Schedule A. The laboratory performs tests in no more than 3 specialties of service with a total annual volume of more than 2,000 but not more than 10,000 laboratory tests.

(ii) Schedule B. The laboratory performs tests in at least 4 specialties of service with a total annual volume of not more than 10,000 laboratory tests.

(iii) Schedule C. The laboratory performs tests in no more 3 specialties of service with a total annual volume of more than 10,000 but not more than 25,000 laboratory tests.
(iv) Schedule D. The laboratory performs tests in at least 4 specialties with a total annual volume of more than 10,000 but not more than 25,000 laboratory tests.

(v) Schedule E. The laboratory performs more than 25,000 but not more than 50,000 laboratory tests annually.

(vi) Schedule F. The laboratory performs more than 50,000 but not more than 75,000 laboratory tests annually.

(vii) Schedule G. The laboratory performs more than 75,000 but not more than 100,000 laboratory tests annually.

(viii) Schedule H. The laboratory performs more than 100,000 but not more than 500,000 laboratory tests annually.

(ix) Schedule I. The laboratory performs more than 500,000 but not more than 1,000,000 laboratory tests annually.

(x) Schedule J. The laboratory performs more than 1,000,000 laboratory tests annually.

(2) For purposes of determining a laboratory’s classification under this section, a test is a procedure or examination for a single analyte. (Tests performed for quality control, quality assurance, and proficiency testing are excluded from the laboratory’s total annual volume). Each profile (that is, group of tests) is counted as the number of separate procedures or examinations; for example, a chemistry profile consisting of 18 tests is counted as 18 separate procedures or tests.

(3) For purposes of determining a laboratory’s classification under this section, the specialties and subspecialties of service for inclusion are:

(i) The specialty of Microbiology, which includes one or more of the following subspecialties:
   (A) Bacteriology.
   (B) Mycobacteriology.
   (C) Mycology.
   (D) Parasitology.
   (E) Virology.

(ii) The specialty of Serology, which includes one or more of the following subspecialties:
   (A) Syphilis Serology.
   (B) General immunology

(iii) The specialty of Chemistry, which includes one or more of the following subspecialties:
   (A) Routine chemistry.
   (B) Endocrinology.

(C) Toxicology.

(D) Urinalysis.

(iv) The specialty of Hematology.

(v) The specialty of Immunohematology, which includes one or more of the following subspecialties:
   (A) ABO grouping and Rh typing.
   (B) Unexpected antibody detection.
   (C) Compatibility testing.
   (D) Unexpected antibody identification.

(vi) The specialty of Pathology, which includes the following subspecialties:
   (A) Cytology.
   (B) Histopathology.
   (C) Oral pathology.

(vii) The specialty of Radiobioassay.

(viii) The specialty of Histocompatibility.

(ix) The specialty of Clinical Cyto genetics.

(d) Additional fees. (1) If after a certificate of compliance is issued, a laboratory adds services and requests that its certificate be upgraded, the laboratory must pay an additional fee if, in order to determine compliance with additional requirements, it is necessary to conduct an inspection, evaluate personnel, or monitor proficiency testing performance. The additional fee is based on the actual resources and time necessary to perform the activities. HHS revokes the laboratory’s certificate for failure to pay the compliance determination fee.

(2) If it is necessary to conduct a complaint investigation, impose sanctions, or conduct a hearing, HHS assesses the laboratory holding a certificate of compliance a fee to cover the cost of these activities. If a complaint investigation results in a complaint being unsubstantiated, or if an HHS adverse action is overturned at the conclusion of the administrative appeals process, the government’s costs of these activities are not imposed upon the laboratory. Costs for these activities are based on the actual resources and time necessary to perform the activities and are not assessed until after the laboratory concedes the existence of deficiencies or an ALJ rules in favor of HHS. HHS revokes the laboratory’s
§ 493.6445 Additional fee(s) applicable to approved State laboratory programs and laboratories issued a certificate of accreditation, certificate of waiver, or certificate for PPM procedures.

(a) Approved State laboratory programs. State laboratory programs approved by HHS are assessed a fee for the following:

(1) Costs of Federal inspections of laboratories in that State (that is, CLIA-exempt laboratories) to verify that standards are being enforced in an appropriate manner.

(2) Costs incurred for investigations of complaints against the State’s CLIA-exempt laboratories if the complaint is substantiated.

(3) Costs of the State’s prorata share of general overhead to develop and implement CLIA.

(b) Accredited laboratories. (1) In addition to the certificate fee, a laboratory that is issued a certificate of accreditation is also assessed a fee to cover the cost of evaluating individual laboratories to determine overall whether an accreditation organization’s standards and inspection policies are equivalent to the Federal program. All accredited laboratories share in the cost of these inspections. These costs are the same as those that are incurred when inspecting nonaccredited laboratories.

(2) If a laboratory issued a certificate of accreditation has been inspected and followup visits are necessary because of identified deficiencies, HHS assesses the laboratory a fee to cover the cost of these visits. The fee is based on the actual resources and time necessary to perform the followup visits. HHS is assessed the laboratory’s certificate for failure to pay the assessed fee.

(c) If, in the case of a laboratory that has been issued a certificate of accreditation, certificate of waiver, or certificate for PPM procedures, it is necessary to conduct a complaint investigation, impose sanctions, or conduct a hearing, HHS assesses that laboratory a fee to cover the cost of these activities. Costs are based on the actual resources and time necessary to perform the activities and are not assessed until after the laboratory concedes the existence of deficiencies or an ALJ rules in favor of HHS. HHS revokes the laboratory’s certificate for failure to pay the assessed costs. If a complaint investigation results in a complaint being unsubstantiated, or if an HHS adverse action is overturned at the conclusion of the administrative appeals process, the costs of these activities are not imposed upon the laboratory.

§ 493.646 Payment of fees.

(a) Except for CLIA-exempt laboratories, all laboratories are notified in writing by HHS or its designee of the appropriate fee(s) and instructions for submitting the fee(s), including the due date for payment and where to make payment. The appropriate certificate is not issued until the applicable fees have been paid.

(b) For State-exempt laboratories, HHS estimates the cost of conducting validation surveys within the State for a 2-year period. HHS or its designee notifies the State by mail of the appropriate fees, including the due date for payment and the address of the United States Department of Treasury designated commercial bank to which payment must be made. In addition, if complaint investigations are conducted in laboratories within these States and are substantiated, HHS bills the State(s) the costs of the complaint investigations.

§ 493.649 Methodology for determining fee amount.

(a) General rule. The amount of the fee in each schedule for compliance determination inspections is based on the average hourly rate (which includes the costs to perform the required activities and necessary administration costs) multiplied by the average number of hours required or, if activities are performed by more than one of the entities listed in paragraph (b) of this section, the sum of the products of the
§493.801  **Condition: Enrollment and testing of samples.**

Each laboratory must enroll in a proficiency testing (PT) program that meets the criteria in subpart I of this part and is approved by HHS. The laboratory must enroll in an approved program or programs for each of the specialties and subspecialties for which it seeks certification. The laboratory must test the samples in the same manner as patients’ specimens. For laboratories subject to 42 CFR part 493 published on March 14, 1990 (55 FR 9538) prior to September 1, 1992, the rules of this subpart are effective on September 1, 1992. For all other laboratories, the rules of this subpart are effective January 1, 1994.
(a) **Standard: Enrollment.** The laboratory must—

(1) Notify HHS of the approved program or programs in which it chooses to participate to meet proficiency testing requirements of this subpart.

(2)(i) Designate the program(s) to be used for each specialty, subspecialty, and analyte or test to determine compliance with this subpart if the laboratory participates in more than one proficiency testing program approved by CMS; and

(ii) For those tests performed by the laboratory that are not included in subpart I of this part, a laboratory must establish and maintain the accuracy of its testing procedures, in accordance with §493.1236(c)(1).

(3) For each specialty, subspecialty and analyte or test, participate in one approved proficiency testing program or programs, for one year before designating a different program and must notify CMS before any change in designation; and

(4) Authorize the proficiency testing program to release to HHS all data required to—

(i) Determine the laboratory’s compliance with this subpart; and

(ii) Make PT results available to the public as required in section 353(f)(3)(F) of the Public Health Service Act.

(b) **Standard: Testing of proficiency testing samples.** The laboratory must examine or test, as applicable, the proficiency testing samples it receives from the proficiency testing program in the same manner as it tests patient specimens. This testing must be conducted in conformance with paragraph (b)(4) of this section. If the laboratory’s patient specimen testing procedures would normally require reflex, distributive, or confirmatory testing at another laboratory, the laboratory should test the proficiency testing sample as it would a patient specimen until the point it would refer a patient specimen to a second laboratory for any form of further testing.

(1) The samples must be examined or tested with the laboratory’s regular patient workload by personnel who routinely perform the testing in the laboratory, using the laboratory’s routine methods. The individual testing or examining the samples and the laboratory director must attest to the routine integration of the samples into the patient workload using the laboratory’s routine methods.

(2) The laboratory must test samples the same number of times that it routinely tests patient samples.

(3) Laboratories that perform tests on proficiency testing samples must not engage in any inter-laboratory communications pertaining to the results of proficiency testing sample(s) until after the date by which the laboratory must report proficiency testing results to the program for the testing event in which the samples were sent. Laboratories with multiple testing sites or separate locations must not participate in any communications or discussions across sites/locations regarding proficiency testing sample results until after the date by which the laboratory must report proficiency testing results to the program.

(4) The laboratory must not send proficiency testing samples or portions of proficiency testing samples to another laboratory for any analysis for which it is certified to perform in its own laboratory. Any laboratory that CMS determines intentionally referred a proficiency testing sample to another laboratory for analysis may have its certification revoked for at least 1 year. If CMS determines that a proficiency testing sample was referred to another laboratory for analysis, but the requested testing was limited to reflex, distributive, or confirmatory testing that, if the sample were a patient specimen, would have been in full conformance with written, legally accurate and adequate standard operating procedures for the laboratory’s testing of patient specimens, and if the proficiency testing referral is not a repeat proficiency testing referral, CMS will consider the referral to be improper and subject to alternative sanctions in accordance with §493.1804(c), but not intentional. Any laboratory that receives a proficiency testing sample from another laboratory for testing must notify CMS of the receipt of that sample regardless of whether the referral was made for reflex or confirmatory testing, or any other reason.

(5) The laboratory must document the handling, preparation, processing,
examination, and each step in the testing and reporting of results for all proficiency testing samples. The laboratory must maintain a copy of all records, including a copy of the proficiency testing program report forms used by the laboratory to record proficiency testing results including the attestation statement provided by the PT program, signed by the analyst and the laboratory director, documenting that proficiency testing samples were tested in the same manner as patient specimens, for a minimum of two years from the date of the proficiency testing event.

(6) PT is required for only the test system, assay, or examination used as the primary method for patient testing during the PT event.


§ 493.803 Condition: Successful participation.

(a) Each laboratory performing nonwaived testing must successfully participate in a proficiency testing program approved by CMS, if applicable, as described in subpart I of this part for each specialty, subspecialty, and analyte or test in which the laboratory is certified under CLIA.

(b) Except as specified in paragraph (c) of this section, if a laboratory fails to participate successfully in proficiency testing for a given specialty, subspecialty, and analyte or test, as defined in this section, or fails to take remedial action when an individual fails gynecologic cytology, CMS imposes sanctions, as specified in subpart R of this part.

(c) If a laboratory fails to perform successfully in a CMS-approved proficiency testing program, for the initial unsuccessful performance, CMS may direct the laboratory to undertake training of its personnel or to obtain technical assistance, or both, rather than imposing alternative or principle sanctions except when one or more of the following conditions exists:

(1) There is immediate jeopardy to patient health and safety.

(2) The laboratory fails to provide CMS or a CMS agent with satisfactory evidence that it has taken steps to correct the problem identified by the unsuccessful proficiency testing performance.

(3) The laboratory has a poor compliance history.


§ 493.807 Condition: Reinstatement of laboratories performing nonwaived testing.

(a) If a laboratory’s certificate is suspended or limited or its Medicare or Medicaid approval is cancelled or its Medicare or Medicaid payments are suspended because it fails to participate successfully in proficiency testing for one or more specialties, subspecialties, analyte or test, or voluntarily withdraws its certification under CLIA for the failed specialty, subspecialty, or analyte, the laboratory must then demonstrate sustained satisfactory performance on two consecutive proficiency testing events, one of which may be on site, before CMS will consider it for reinstatement for certification and Medicare or Medicaid approval in that specialty, subspecialty, analyte or test.

(b) The cancellation period for Medicare and Medicaid approval or period for suspension of Medicare or Medicaid payments or suspension or limitation of certification under CLIA for the failed specialty, subspecialty, or analyte or test is for a period of not less than six months from the date of cancellation, limitation or suspension of the CLIA certificate.

[58 FR 5228, Jan. 19, 1993, as amended at 60 FR 20048, Apr. 24, 1995]

PROFICIENCY TESTING BY SPECIALTY AND SUBSPECIALTY FOR LABORATORIES PERFORMING TESTS OF MODERATE COMPLEXITY (INCLUDING THE SUBCATEGORY), HIGH COMPLEXITY, OR ANY COMBINATION OF THESE TESTS

§ 493.821 Condition: Microbiology.

The specialty of microbiology includes, for purposes of proficiency testing, the subspecialties of bacteriology, mycobacteriology, mycology, parasitology and virology.
§ 493.823 Standard; Bacteriology.

(a) Failure to attain an overall testing event score of at least 80 percent is unsatisfactory performance.

(b) Failure to participate in a testing event is unsatisfactory performance and results in a score of 0 for the testing event. Consideration may be given to those laboratories failing to participate in a testing event only if—

(1) Patient testing was suspended during the time frame allotted for testing and reporting proficiency testing results;

(2) The laboratory notifies the inspecting agency and the proficiency testing program within the time frame for submitting proficiency testing results of the suspension of patient testing and the circumstances associated with failure to perform tests on proficiency testing samples; and

(3) The laboratory participated in the previous two proficiency testing events.

(c) Failure to return proficiency testing results to the proficiency testing program within the time frame specified by the program is unsatisfactory performance and results in a score of 0 for the testing event.

(d)(1) For any unsatisfactory testing event for reasons other than a failure to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure.

(2) Remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event.

(e) Failure to achieve an overall testing event score of satisfactory performance for two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

§ 493.825 Standard; Mycobacteriology.

(a) Failure to attain an overall testing event score of at least 80 percent is unsatisfactory performance.

(b) Failure to participate in a testing event is unsatisfactory performance and results in a score of 0 for the testing event. Consideration may be given to those laboratories failing to participate in a testing event only if—

(1) Patient testing was suspended during the time frame allotted for testing and reporting proficiency testing results;

(2) The laboratory notifies the inspecting agency and the proficiency testing program within the time frame for submitting proficiency testing results of the suspension of patient testing and the circumstances associated with failure to perform tests on proficiency testing samples; and

(3) The laboratory participated in the previous two proficiency testing events.

(c) Failure to return proficiency testing results to the proficiency testing program within the time frame specified by the program is unsatisfactory performance and results in a score of 0 for the testing event.

(d)(1) For any unsatisfactory testing event for reasons other than a failure to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure.

(2) Remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event.

(e) Failure to achieve an overall testing event score of satisfactory performance for two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.
for submitting proficiency testing results of the suspension of patient testing and the circumstances associated with failure to perform tests on proficiency testing samples; and

(3) The laboratory participated in the previous two proficiency testing events.

(c) Failure to return proficiency testing results to the proficiency testing program within the time frame specified by the program is unsatisfactory performance and results in a score of 0 for the testing event.

(d)(1) For any unsatisfactory testing event for reasons other than a failure to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure.

(2) Remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event.

(e) Failure to achieve an overall testing event score of satisfactory performance for two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

§ 493.831 Standard; Virology.

(a) Failure to attain an overall testing event score of at least 80 percent is unsatisfactory performance.

(b) Failure to participate in a testing event is unsatisfactory performance and results in a score of 0 for the testing event. Consideration may be given to those laboratories failing to participate in a testing event only if—

(1) Patient testing was suspended during the time frame allotted for testing and reporting proficiency testing results;

(2) The laboratory notifies the inspecting agency and the proficiency testing program within the time frame for submitting proficiency testing results of the suspension of patient testing and the circumstances associated with failure to perform tests on proficiency testing samples; and

(3) The laboratory participated in the previous two proficiency testing events.

(c) Failure to return proficiency testing results to the proficiency testing program within the time frame specified by the program is unsatisfactory performance and results in a score of 0 for the testing event.

(d)(1) For any unsatisfactory testing event for reasons other than a failure to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure.

(2) Remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event.

(e) Failure to achieve an overall testing event score of satisfactory performance for two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.
to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure.

(2) For any unsatisfactory testing events, remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event.

(e) Failure to achieve an overall testing event score of satisfactory performance for two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

§ 493.833 Condition: Diagnostic immunology.

The specialty of diagnostic immunology includes for purposes of proficiency testing the subspecialties of syphilis serology and general immunology.

§ 493.835 Standard; Syphilis serology.

(a) Failure to attain an overall testing event score of at least 80 percent is unsatisfactory performance.

(b) Failure to participate in a testing event is unsatisfactory performance and results in a score of 0 for the testing event. Consideration may be given to those laboratories failing to participate in a testing event only if—

(1) Patient testing was suspended during the time frame allotted for testing and reporting proficiency testing results;

(2) The laboratory notifies the inspecting agency and the proficiency testing program within the time frame for submitting proficiency testing results of the suspension of patient testing and the circumstances associated with failure to perform tests on proficiency testing samples; and

(3) The laboratory participated in the previous two proficiency testing events.

(c) Failure to return proficiency testing results to the proficiency testing program within the time frame specified by the program is unsatisfactory performance and results in a score of 0 for the testing event.

(d)(1) For any unsatisfactory testing event for reasons other than a failure to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure.

(2) For any unacceptable testing event score, remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event.

(e) Failure to achieve an overall testing event score of satisfactory performance for two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

§ 493.837 Standard; General immunology.

(a) Failure to attain a score of at least 80 percent of acceptable responses for each analyte in each testing event is unsatisfactory analyte performance for the testing event.

(b) Failure to attain an overall testing event score of at least 80 percent is unsatisfactory performance.

(c) Failure to participate in a testing event is unsatisfactory performance and results in a score of 0 for the testing event. Consideration may be given to those laboratories failing to participate in a testing event only if—

(1) Patient testing was suspended during the time frame allotted for testing and reporting proficiency testing results;

(2) The laboratory notifies the inspecting agency and the proficiency testing program within the time frame for submitting proficiency testing results of the suspension of patient testing and the circumstances associated with failure to perform tests on proficiency testing samples; and

(3) The laboratory participated in the previous two proficiency testing events.

(d) Failure to return proficiency testing results to the proficiency testing program within the time frame specified by the program is unsatisfactory performance and results in a score of 0 for the testing event.

(e)(1) For any unsatisfactory analyte or test performance or testing event.
for reasons other than a failure to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure.

(2) For any unacceptable analyte or testing event score, remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event.

(f) Failure to achieve satisfactory performance for the same analyte or test in two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

(g) Failure to achieve an overall testing event score of satisfactory performance for two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

§ 493.839 Condition: Chemistry.

The specialty of chemistry includes for the purposes of proficiency testing the subspecialties of routine chemistry, endocrinology, and toxicology.

§ 493.841 Standard; Routine chemistry.

(a) Failure to attain a score of at least 80 percent of acceptable responses for each analyte in each testing event is unsatisfactory analyte performance for the testing event.

(b) Failure to attain an overall testing event score of at least 80 percent is unsatisfactory performance.

(c) Failure to participate in a testing event is unsatisfactory performance and results in a score of 0 for the testing event. Consideration may be given to those laboratories failing to participate in a testing event only if—

(1) Patient testing was suspended during the time frame allotted for testing and reporting proficiency testing results;

(2) The laboratory notifies the inspecting agency and the proficiency testing program within the time frame for submitting proficiency testing results of the suspension of patient testing and the circumstances associated with failure to perform tests on proficiency testing samples; and

(3) The laboratory participated in the previous two proficiency testing events.

(d) Failure to return proficiency testing results to the proficiency testing program within the time frame specified by the program is unsatisfactory performance and results in a score of 0 for the testing event.

(e)(1) For any unsatisfactory analyte or test performance or testing event for reasons other than a failure to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure.

(2) For any unacceptable analyte or testing event score, remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event.

(f) Failure to achieve satisfactory performance for the same analyte or test in two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

(g) Failure to achieve an overall testing event score of satisfactory performance for two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

§ 493.843 Standard; Endocrinology.

(a) Failure to attain a score of at least 80 percent of acceptable responses for each analyte in each testing event is unsatisfactory analyte performance for the testing event.

(b) Failure to attain an overall testing event score of at least 80 percent is unsatisfactory performance.

(c) Failure to participate in a testing event is unsatisfactory performance and results in a score of 0 for the testing event. Consideration may be given to those laboratories failing to participate in a testing event only if—

(1) Patient testing was suspended during the time frame allotted for testing and reporting proficiency testing results;

(2) The laboratory notifies the inspecting agency and the proficiency testing program within the time frame
for submitting proficiency testing results of the suspension of patient testing and the circumstances associated with failure to perform tests on proficiency testing samples; and

(3) The laboratory participated in the previous two proficiency testing events.

(d) Failure to return proficiency testing results to the proficiency testing program within the time frame specified by the program is unsatisfactory performance and results in a score of 0 for the testing event.

(e)(1) For any unsatisfactory analyte or test performance or testing event for reasons other than a failure to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure.

(2) For any unacceptable analyte or testing event score, remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event.

(f) Failure to achieve satisfactory performance for the same analyte or test in two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

(g) Failure to achieve an overall testing event score of satisfactory performance for two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

§ 493.845 Standard; Toxicology.

(a) Failure to attain a score of at least 80 percent of acceptable responses for each analyte in each testing event is unsatisfactory analyte performance for the testing event.

(b) Failure to attain an overall testing event score of at least 80 percent is unsatisfactory performance.

(c) Failure to participate in a testing event is unsatisfactory performance and results in a score of 0 for the testing event. Consideration may be given to those laboratories failing to participate in a testing event only if—

(1) Patient testing was suspended during the time frame allotted for testing and reporting proficiency testing results;

(2) The laboratory notifies the inspecting agency and the proficiency testing program within the time frame for submitting proficiency testing results of the suspension of patient testing and the circumstances associated with failure to perform tests on proficiency testing samples; and

(3) The laboratory participated in the previous two proficiency testing events.

(d) Failure to return proficiency testing results to the proficiency testing program within the time frame specified by the program is unsatisfactory performance and results in a score of 0 for the testing event.

(e)(1) For any unsatisfactory analyte or test performance or testing event for reasons other than a failure to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure.

(2) For any unacceptable analyte or testing event score, remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event.

(f) Failure to achieve satisfactory performance for the same analyte or test in two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

(g) Failure to achieve an overall testing event score of satisfactory performance for two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

§ 493.849 Condition: Hematology.

The specialty of hematology, for the purpose of proficiency testing, is not subdivided into subspecialties of testing.

§ 493.851 Standard; Hematology.

(a) Failure to attain a score of at least 80 percent of acceptable responses for each analyte in each testing event is unsatisfactory analyte performance for the testing event.

(b) Failure to attain an overall testing event score of at least 80 percent is unsatisfactory performance.
§ 493.853 Condition: Pathology.

The specialty of pathology includes, for purposes of proficiency testing, the subspecialty of cytology limited to gynecologic examinations.

§ 493.855 Standard: Cytology: gynecologic examinations.

To participate successfully in a cytology proficiency testing program for gynecologic examinations (Pap smears), the laboratory must meet the requirements of paragraphs (a) through (c) of this section.

(a) The laboratory must ensure that each individual engaged in the examination of gynecologic preparations is enrolled in a proficiency testing program approved by CMS by January 1, 1995, if available in the State in which he or she is employed. The laboratory must ensure that each individual is tested at least once per year and obtains a passing score. To ensure this annual testing of individuals, an announced or unannounced testing event will be conducted on-site in each laboratory at least once each year. Laboratories will be notified of the time of each announced on-site testing event at least 30 days prior to each event. Additional testing events will be conducted as necessary in each State or region for the purpose of testing individuals who miss the on-site testing event and for retesting individuals as described in paragraph (b) of this section.

(b) The laboratory must ensure that each individual participates in an annual testing event that involves the examination of a 10-slide test set as described in § 493.945. Individuals who fail this testing event are retested with another 10-slide test set as described in paragraphs (b)(1) and (b)(2) of this section. Individuals who fail this second test are subsequently retested with a 20-slide test set as described in paragraphs (b)(2) and (b)(3) of this section. Individuals are given not more than 2 hours to complete a 10-slide test and not more than 4 hours to complete a 20-slide test. Unexcused failure to appear by an individual for a retest will result in test failure with resulting remediation and limitations on slide examinations as specified in (b)(1), (b)(2), and (b)(3) of this section.

(1) An individual is determined to have failed the annual testing event if he or she scores less than 90 percent on a 10-slide test set as described in § 493.945. Individuals who fail this testing event are retested with another 10-slide test set as described in paragraphs (b)(1) and (b)(2) of this section. Individuals who fail this second test are subsequently retested with a 20-slide test set as described in paragraphs (b)(2) and (b)(3) of this section. Individuals are given not more than 2 hours to complete a 10-slide test and not more than 4 hours to complete a 20-slide test. Unexcused failure to appear by an individual for a retest will result in test failure with resulting remediation and limitations on slide examinations as specified in (b)(1), (b)(2), and (b)(3) of this section.
Centers for Medicare & Medicaid Services, HHS § 493.859

retesting event which must take place not more than 45 days after receipt of the notification of failure.

(2) An individual is determined to have failed the second testing event if he or she scores less than 90 percent on a 10-slide test set. For an individual who fails a second testing event, the laboratory must provide him or her with documented, remedial training and education in the area of failure, and must assure that all gynecologic slides evaluated subsequent to the notice of failure are reexamined until the individual is again retested with a 20-slide test set and scores at least 90 percent. Reexamination of slides must be documented.

(3) An individual is determined to have failed the third testing event if he or she scores less than 90 percent on a 20-slide test set. An individual who fails the third testing event must cease examining gynecologic slide preparations immediately upon notification of test failure and may not resume examining gynecologic slides until the laboratory assures that the individual obtains at least 35 hours of documented, formally structured, continuing education in diagnostic cytopathology that focuses on the examination of gynecologic preparations, and until he or she is retested with a 20-slide test set and scores at least 90 percent.

(c) If a laboratory fails to ensure that individuals are tested or those who fail a testing event are retested, or fails to take required remedial actions as described in paragraphs (b)(1), (b)(2) or (b)(3) of this section, CMS will initiate intermediate sanctions or limit the laboratory’s certificate to exclude gynecologic cytology testing under CLIA, and, if applicable, suspend the laboratory’s Medicare and Medicaid payments for gynecologic cytology testing in accordance with subpart R of this part.


§ 493.857 Condition: Immunohematology.

The specialty of immunohematology includes four subspecialties for the purposes of proficiency testing: ABO group and D (Rh) typing; unexpected antibody detection; compatibility testing; and antibody identification.

§ 493.859 Standard; ABO group and D (Rh) typing.

(a) Failure to attain a score of at least 100 percent of acceptable responses for each analyte or test in each testing event is unsatisfactory analyte performance for the testing event.

(b) Failure to attain an overall testing event score of at least 100 percent is unsatisfactory performance.

(c) Failure to participate in a testing event is unsatisfactory performance and results in a score of 0 for the testing event. Consideration may be given to those laboratories failing to participate in a testing event only if—

(1) Patient testing was suspended during the time frame allotted for testing and reporting proficiency testing results;

(2) The laboratory notifies the inspecting agency and the proficiency testing program within the time frame for submitting proficiency testing results of the suspension of patient testing and the circumstances associated with failure to perform tests on proficiency testing samples; and

(3) The laboratory participated in the previous two proficiency testing events.

(d) Failure to return proficiency testing results to the proficiency testing program within the time frame specified by the program is unsatisfactory performance and results in a score of 0 for the testing event.

(e)(1) For any unsatisfactory testing event for reasons other than a failure to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure.

(2) For any unacceptable analyte or unsatisfactory testing event score, remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event.

(f) Failure to achieve satisfactory performance for the same analyte in two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.
Failure to achieve an overall testing event score of satisfactory for two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

§ 493.861 Standard; Unexpected antibody detection.

(a) Failure to attain an overall testing event score of at least 80 percent is unsatisfactory performance.

(b) Failure to participate in a testing event is unsatisfactory performance and results in a score of 0 for the testing event. Consideration may be given to those laboratories failing to participate in a testing event only if—

(1) Patient testing was suspended during the time frame allotted for testing and reporting proficiency testing results;

(2) The laboratory notifies the inspecting agency and the proficiency testing program within the time frame for submitting proficiency testing results of the suspension of patient testing and the circumstances associated with failure to perform tests on proficiency testing samples; and

(3) The laboratory participated in the previous two proficiency testing events.

(c) Failure to return proficiency testing results to the proficiency testing program within the time frame specified by the program is unsatisfactory performance and results in a score of 0 for the testing event.

(d)(1) For any unsatisfactory testing event for reasons other than a failure to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure.

(2) For any unsatisfactory testing event score, remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event.

(e) Failure to achieve an overall testing event score of satisfactory for two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

§ 493.863 Standard; Compatibility testing.

(a) Failure to attain an overall testing event score of at least 100 percent is unsatisfactory performance.

(b) Failure to participate in a testing event is unsatisfactory performance and results in a score of 0 for the testing event. Consideration may be given to those laboratories failing to participate in a testing event only if—

(1) Patient testing was suspended during the time frame allotted for testing and reporting proficiency testing results;

(2) The laboratory notifies the inspecting agency and the proficiency testing program within the time frame for submitting proficiency testing results of the suspension of patient testing and the circumstances associated with failure to perform tests on proficiency testing samples; and

(3) The laboratory participated in the previous two proficiency testing events.

(c) Failure to return proficiency testing results to the proficiency testing program within the time frame specified by the program is unsatisfactory performance and results in a score of 0 for the testing event.

(d)(1) For any unsatisfactory testing event for reasons other than a failure to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure.

(2) For any unsatisfactory testing event score, remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event.

(e) Failure to achieve an overall testing event score of satisfactory for two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

§ 493.865 Standard; Antibody identification.

(a) Failure to attain an overall testing event score of at least 80 percent is unsatisfactory performance.

(b) Failure to participate in a testing event is unsatisfactory performance.
and results in a score of 0 for the testing event. Consideration may be given to those laboratories failing to participate in a testing event only if—

(1) Patient testing was suspended during the time frame allotted for testing and reporting proficiency testing results;

(2) The laboratory notifies the inspecting agency and the proficiency testing program within the time frame for submitting proficiency testing results of the suspension of patient testing and the circumstances associated with failure to perform tests on proficiency testing samples; and

(3) The laboratory participated in the previous two proficiency testing events.

(c) Failure to return proficiency testing results to the proficiency testing program within the time frame specified by the program is unsatisfactory performance and results in a score of 0 for the testing event.

(d)(1) For any unsatisfactory testing event for reasons other than a failure to participate, the laboratory must undertake appropriate training and employ the technical assistance necessary to correct problems associated with a proficiency testing failure.

(2) For any unsatisfactory testing event score, remedial action must be taken and documented, and the documentation must be maintained by the laboratory for two years from the date of participation in the proficiency testing event.

(e) Failure to identify the same antibody in two consecutive or two out of three consecutive testing events is unsuccessful performance.

(f) Failure to achieve an overall testing event score of satisfactory for two consecutive testing events or two out of three consecutive testing events is unsuccessful performance.

Subpart I—Proficiency Testing Programs for Nonwaived Testing

Source: 57 FR 7151, Feb. 28, 1992, unless otherwise noted.

§ 493.901 Approval of proficiency testing programs.

In order for a proficiency testing program to receive HHS approval, the program must be offered by a private nonprofit organization or a Federal or State agency, or entity acting as a designated agent for the State. An organization, Federal, or State program seeking approval or reapproval for its program for the next calendar year must submit an application providing the required information by July 1 of the current year. The organization, Federal, or State program must provide technical assistance to laboratories seeking to qualify under the program, and must, for each specialty, subspecialty, and analyte or test for which it provides testing—

(a) Assure the quality of test samples, appropriately evaluate and score the testing results, and identify performance problems in a timely manner;

(b) Demonstrate to HHS that it has—

(1) The technical ability required to—

(i) Prepare or purchase samples from manufacturers who prepare the samples in conformance with the appropriate good manufacturing practices required in 21 CFR parts 606, 640, and 820; and

(ii) Distribute the samples, using rigorous quality control to assure that samples mimic actual patient specimens when possible and that samples are homogeneous, except for specific subspecialties such as cytology, and will be stable within the time frame for analysis by proficiency testing participants;

(2) A scientifically defensible process for determining the correct result for each challenge offered by the program;

(3) A program of sufficient annual challenge and with the frequency specified in §§ 493.909 through 493.959 to establish that a laboratory has met minimum performance requirements;

(4) The resources needed to provide Statewide or nationwide reports to regulatory agencies on individual’s performance for gynecologic cytology and on individual laboratory performance on testing events, cumulative reports and scores for each laboratory or individual, and reports of specific laboratory failures using grading criteria acceptable to HHS. These reports must be provided to HHS on a timely basis when requested;

(5) Provisions to include on each proficiency testing program report form
used by the laboratory to record testing event results, an attestation statement that proficiency testing samples were tested in the same manner as patient specimens with a signature block to be completed by the individual performing the test as well as by the laboratory director;

(6) A mechanism for notifying participants of the PT shipping schedule and for participants to notify the proficiency testing program within three days of the expected date of receipt of the shipment that samples have not arrived or are unacceptable for testing. The program must have provisions for replacement of samples that are lost in transit or are received in a condition that is unacceptable for testing; and

(7) A process to resolve technical, administrative, and scientific problems about program operations;

(c) Meet the specific criteria for proficiency testing programs listed by specialty, subspecialty, and analyte or test contained in §§ 493.901 through 493.959 for initial approval and thereafter provide HHS, on an annual basis, with the information necessary to assure that the proficiency testing program meets the criteria required for approval; and

(d) Comply with all applicable packaging, shipment, and notification requirements of 42 CFR part 72.

§ 493.903 Administrative responsibilities.

The proficiency testing program must—

(a)(1) Provide HHS or its designees and participating laboratories with an electronic or a hard copy, or both, of reports of proficiency testing results and all scores for each laboratory’s performance in a format as required by and approved by CMS for each CLIA-certified specialty, subspecialty, and analyte or test within 60 days after the date by which the laboratory must report proficiency testing results to the proficiency testing program.

(2) Provide HHS with reports of PT results and scores of individual performance in cytology and provide copies of reports to participating individuals, and to all laboratories that employ the individuals, within 15 working days of the testing event;

(b) Furnish to HHS cumulative reports on an individual laboratory’s performance and aggregate data on CLIA-certified laboratories for the purpose of establishing a system to make the proficiency testing program’s results available, on a reasonable basis, upon request of any person, and include such explanatory information as may be appropriate to assist in the interpretation of the proficiency testing program’s results;

(c) Provide HHS with additional information and data upon request and submit such information necessary for HHS to conduct an annual evaluation to determine whether the proficiency testing program continues to meet the requirements of §§ 493.901 through 493.959;

(d) Maintain records of laboratories’ performance for a period of five years or such time as may be necessary for any legal proceedings; and

(e) Provide HHS with an annual report and, if needed, an interim report which identifies any previously unrecognized sources of variability in kits, instruments, methods, or PT samples, which adversely affect the programs’ ability to evaluate laboratory performance.

§ 493.905 Nonapproved proficiency testing programs.

If a proficiency testing program is determined by HHS to fail to meet any criteria contained in §§ 493.901 through 493.959 for approval of the proficiency testing program, CMS will notify the program and the program must notify all laboratories enrolled of the non-approval and the reasons for non-approval within 30 days of the notification.

§ 493.909 Microbiology.

The subspecialties under the specialty of microbiology for which a program may offer proficiency testing are
Centers for Medicare & Medicaid Services, HHS § 493.911

bacteriology, mycobacteriology, mycology, parasitology and virology. Specific criteria for these subspecialties are found at §§ 493.911 through 493.919.

§ 493.911 Bacteriology.

(a) Types of services offered by laboratories. In bacteriology, for proficiency testing purposes, there are five types of laboratories:

1. Those that interpret Gram stains or perform primary inoculation, or both; and refer cultures to another laboratory appropriately certified for the subspecialty of bacteriology for identification;

2. Those that use direct antigen techniques to detect an organism and may also interpret Gram stains or perform primary inoculation, or perform any combination of these;

3. Those that, in addition to interpreting Gram stains, performing primary inoculations, and using direct antigen tests, also isolate and identify aerobic bacteria from throat, urine, cervical, or urethral discharge specimens to the genus level and may also perform antimicrobial susceptibility tests on selected isolated microorganisms;

4. Those that perform the services in paragraph (a)(3) of this section and also isolate and identify aerobic bacteria from any source to the species level and may also perform antimicrobial susceptibility tests; and

5. Those that perform the services in paragraph (a)(4) of this section and also isolate and identify anaerobic bacteria from any source.

(b) Program content and frequency of challenge. To be approved for proficiency testing for bacteriology, the annual program must provide a minimum of five samples per testing event. There must be at least three testing events at approximately equal intervals per year. The samples may be provided to the laboratory through mailed shipments or, at HHS’ option, may be provided to HHS or its designee for on-site testing. For the types of laboratories specified in paragraph (a) of this section, an annual program must include samples that contain organisms that are representative of the six major groups of bacteria: anaerobes, Enterobacteriaceae, gram-positive bacilli, gram-positive cocci, gram-negative cocci, and miscellaneous gram-negative bacteria, as appropriate. The specific organisms included in the samples may vary from year to year. The annual program must include samples for bacterial antigen detection, bacterial isolation and identification, Gram stain, and antimicrobial susceptibility testing.

1. An approved program must furnish HHS with a description of samples that it plans to include in its annual program no later than six months before each calendar year. At least 50 percent of the samples must be mixtures of the principal organism and appropriate normal flora. The program must include other important emerging pathogens (as determined by HHS) and either organisms commonly occurring in patient specimens or opportunistic pathogens. The program must include the following two types of samples; each type of sample must meet the 50 percent mixed culture criterion:

(i) Samples that require laboratories to report only organisms that the testing laboratory considers to be a principal pathogen that is clearly responsible for a described illness (excluding immuno-compromised patients). The program determines the reportable isolates, including antimicrobial susceptibility for any designated isolate; and

(ii) Samples that require laboratories to report all organisms present. Samples must contain multiple organisms frequently found in specimens such as urine, blood, abscesses, and aspirates where multiple isolates are clearly significant or where specimens are derived from immuno-compromised patients. The program determines the reportable isolates.

2. An approved program may vary over time. For example, the types of organisms that might be included in an approved program over time are—

Anaerobes: Bacteroides fragilis group Clostridium perfringens Peptostreptococcus anaerobius Enterobacteriaceae Citrobacter freundii Enterobacter aerogenes Escherichia coli Klebsiella pneumoniae Proteus mirabilis Salmonella typhimurium
§493.911  42 CFR Ch. IV (10–1–16 Edition)

Serratia marcescens
Shigella sonnei
Yersinia enterocolitica
Gram-positive bacilli:
Listeria monocytogenes
Corynebacterium species CDC Group JK

Gram-positive cocci:
Staphylococcus aureus
Streptococcus Group A
Streptococcus Group B
Streptococcus Group D (S. bovis and enterococcus)
Streptococcus pneumoniae

Gram-negative cocci:
Branhamella catarrhalis
Neisseria gonorrhoeae
Neisseria meningitidis
Miscellaneous Gram-negative bacteria:
Campylobacter jejuni
Haemophilus influenza, Type B
Pseudomonas aeruginosa

(3) For antimicrobial susceptibility testing, the program must provide at least one sample per testing event that includes gram-positive or gram-negative strains that have a predetermined pattern of sensitivity or resistance to the common antimicrobial agents.

(c) Evaluation of a laboratory’s performance. HHS approves only those programs that assess the accuracy of a laboratory’s responses in accordance with paragraphs (c)(1) through (7) of this section.

(1) The program determines staining characteristics to be interpreted by Gram stain. The program determines the reportable bacteria to be detected by direct antigen techniques or isolation. To determine the accuracy of a laboratory’s response for Gram stain interpretation, direct antigen detection, identification, or antimicrobial susceptibility testing, the program must compare the laboratory’s response for each sample with the response which reflects agreement of either 80 percent of ten or more referee laboratories or 80 percent or more of all participating laboratories.

(2) To evaluate a laboratory’s response for a particular sample, the program must determine a laboratory’s type of service in accordance with paragraph (a) of this section. A laboratory must isolate and identify the organisms to the same extent it performs these procedures on patient specimens. A laboratory’s performance will be evaluated on the basis of its final answer, for example, a laboratory specified in paragraph (a)(3) of this section will be evaluated on the basis of the average of its scores for paragraphs (c)(3) through (c)(6) as determined in paragraph (c)(7) of this section.

(3) Since laboratories may incorrectly report the presence of organisms in addition to the correctly identified principal organism(s), the grading system must provide a means of deducting credit for additional erroneous organisms that are reported. Therefore, the total number of correct responses for organism isolation and identification submitted by the laboratory divided by the number of organisms present plus the number of incorrect organisms reported by the laboratory must be multiplied by 100 to establish a score for each sample in each testing event. For example, if a sample contained one principal organism and the laboratory reported it correctly but reported the presence of an additional organism, which was not considered reportable, the sample grade would be 1/(1 + 1) × 100 = 50 percent.

(4) For antimicrobial susceptibility testing, a laboratory must indicate which drugs are routinely included in its test panel when testing patient samples. A laboratory’s performance will be evaluated for only those antibiotics for which service is offered. A correct response for each antibiotic will be determined as described in §493.911(c)(1) using criteria such as the guidelines established by the National Committee for Clinical Laboratory Standards. Grading is based on the number of correct susceptibility responses reported by the laboratory divided by the actual number of correct susceptibility responses determined by the program, multiplied by 100. For example, if a laboratory offers susceptibility testing for Enterobacteriaceae using amikacin, cephalothin, and tobramycin, and the organism in the proficiency testing sample is an Enterobacteriaceae, and the laboratory reports correct responses for two of three antimicrobial agents, the laboratory’s grade would be 2/3 × 100 = 67 percent.

(5) The performance criterion for qualitative antigen tests is the presence or absence of the bacterial antigen. The score for antigen tests is the
number of correct responses divided by the number of samples to be tested for the antigen, multiplied by 100.

(6) The performance criteria for Gram stain is staining reaction, i.e., gram positive or gram negative. The score for Gram stain is the number of correct responses divided by the number of challenges to be tested, multiplied by 100.

(7) The score for a testing event in bacteriology is the average of the scores determined under paragraphs (c)(3) through (c)(6) of this section based on the type of service offered by the laboratory.

§ 493.913 Mycobacteriology.

(a) Types of services offered by laboratories. In mycobacteriology, there are five types of laboratories for proficiency testing purposes:

(1) Those that interpret acid-fast stains and refer specimen to another laboratory appropriately certified in the subspecialty of mycobacteriology;

(2) Those that interpret acid-fast stains, perform primary inoculation, and refer cultures to another laboratory appropriately certified in the subspecialty of mycobacteriology for identification;

(3) Those that interpret acid-fast stains, isolate and perform identification and/or antimycobacterial susceptibility of Mycobacterium tuberculosis, but refer other mycobacteria species to another laboratory appropriately certified in the subspecialty of mycobacteriology for identification and/or susceptibility tests;

(4) Those that interpret acid-fast stains, isolate and identify all mycobacteria to the extent required for correct clinical diagnosis, but refer antimycobacterial susceptibility tests to another laboratory appropriately certified in the subspecialty of mycobacteriology; and

(5) Those that interpret acid-fast stains, isolate and identify all mycobacteria to the extent required for correct clinical diagnosis, and perform antimycobacterial susceptibility tests on the organisms isolated.

(b) Program content and frequency of challenge. To be approved for proficiency testing for mycobacteriology, the annual program must provide a minimum of five samples per testing event. There must be at least two testing events per year. The samples may be provided through mailed shipments or, at HHS' option, provided to HHS or its designee for on-site testing events. For types of laboratories specified in paragraphs (a)(1) and (a)(3) through (5) of this section, an annual program must include samples that contain species that are representative of the 5 major groups (complexes) of mycobacteria encountered in human specimens. The specific mycobacteria included in the samples may vary from year to year.

(1) An approved program must furnish HHS and its agents with a description of samples that it plans to include in its annual program no later than six months before each calendar year. At least 50 percent of the samples must be mixtures of the principal mycobacteria and appropriate normal flora. The program must include mycobacteria commonly occurring in patient specimens and other important emerging mycobacteria (as determined by HHS). The program determines the reportable isolates and correct responses for antimycobacterial susceptibility for any designated isolate.

(2) An approved program may vary over time. For example, the types of mycobacteria that might be included in an approved program over time are—

- TB Mycobacterium tuberculosis
- Mycobacterium bovis
- Group I Mycobacterium kansasii
- Mycobacterium szulgai
- Group III Mycobacterium avium-intracellulare
- Mycobacterium terrae
- Group IV Mycobacterium fortuitum

(3) For antimycobacterial susceptibility testing, the program must provide at least one sample per testing event that includes mycobacterium tuberculosis that has a predetermined pattern of sensitivity or resistance to the common antimycobacterial agents.
§ 493.915 Mycology.

(a) Types of services offered by laboratories. In mycology, there are four types of laboratories for proficiency testing purposes that may perform different levels of service for yeasts, dimorphic fungi, dermatophytes, and aerobic actinomyces:

1. Those that isolate and identify only yeasts and/or dermatophytes to the genus level;
2. Those that isolate and identify yeasts and/or dermatophytes to the species level;
3. Those that isolate and perform identification of all organisms to the genus level; and

4. For antimycobacterial susceptibility testing, a laboratory must indicate which drugs are routinely included in its test panel when testing patient samples. A laboratory’s performance will be evaluated for only those antibiotics for which susceptibility testing is routinely performed on patient specimens. A correct response for each antibiotic will be determined as described in §493.913(c)(1). Grading is based on the number of correct susceptibility responses reported by the laboratory divided by the actual number of correct susceptibility responses as determined by the program, multiplied by 100. For example, if a laboratory offers susceptibility testing using three antimycobacterial agents and the laboratory reports correct response for two of the three antimycobacterial agents, the laboratory’s grade would be 

\[
\frac{2}{3} \times 100 = 67\% 
\]

(b) Evaluation of a laboratory’s performance. HHS approves only those programs that assess the accuracy of a laboratory’s response in accordance with paragraphs (c)(1) through (6) of this section.

1. The program determines the reportable mycobacteria to be detected by acid-fast stain, for isolation and identification, and for antimycobacterial susceptibility. To determine the accuracy of a laboratory’s response, the program must compare the laboratory’s response for each sample with the response that reflects agreement of either 80 percent of ten or more referee laboratories or 80 percent or more of all participating laboratories.

2. To evaluate a laboratory’s response for a particular sample, the program must determine a laboratory’s type of service in accordance with paragraph (a) of this section. A laboratory must interpret acid-fast stains and isolate and identify the organisms to the same extent it performs these procedures on patient specimens. A laboratory’s performance will be evaluated on the basis of the average of its scores as determined in paragraph (c)(6) of this section.

3. Since laboratories may incorrectly report the presence of organisms in addition to the correctly identified principal organism(s), the grading system must provide a means of deducting credit for additional erroneous organisms reported. Therefore, the total number of correct responses submitted by the laboratory divided by the number of organisms present plus the number of incorrect organisms reported by the laboratory must be multiplied by 100 to establish a score for each sample in each testing event. For example, if a sample contained one principal organism and the laboratory reported it correctly but reported the presence of an additional organism, which was not present, the sample grade would be

\[
\frac{1}{(1 + 1)} \times 100 = 50\% 
\]
(4) Those that isolate and perform identification of all organisms to the species level.

(b) Program content and frequency of challenge. To be approved for proficiency testing for mycology, the annual program must provide a minimum of five samples per testing event. There must be at least three testing events at approximately equal intervals per year. The samples may be provided through mailed shipments or, at HHS’s option, may be provided to HHS or its designee for on-site testing. An annual program must include samples that contain organisms that are representative of five major groups of fungi: Yeast or yeast-like fungi; dimorphic fungi; dematiaceous fungi; dermatophytes; and saprophytes, including opportunistic fungi. The specific fungi included in the samples may vary from year to year.

(1) An approved program must, before each calendar year, furnish HHS with a description of samples that it plans to include in its annual program no later than six months before each calendar year. At least 50 percent of the samples must be mixtures of the principal organism and appropriate normal background flora. Other important emerging pathogens (as determined by HHS) and organisms commonly occurring in patient specimens must be included periodically in the program.

(2) An approved program may vary over time. As an example, the types of organisms that might be included in an approved program over time are—

- Candida albicans
- Candida (other species)
- Cryptococcus neoformans
- Sporothrix schenckii
- Exophiala jeanneli
- Fonsecaea pedrosoi
- Microsporum sp.
- Acremonium sp.
- Trichophyton sp.
- Aspergillus fumigatus
- Nocardia sp.
- Blastoscyces dermatitidis
- Zygomycetes sp.

1 Note: Provided as a nonviable sample.

(c) Evaluation of a laboratory’s performance. HHS approves only those programs that assess the accuracy of a laboratory’s response, in accordance with paragraphs (c)(1) through (5) of this section.

(1) The program determines the reportable organisms. To determine the accuracy of a laboratory’s response, the program must compare the laboratory’s response for each sample with the response that reflects agreement of either 80 percent of ten or more referee laboratories or 80 percent or more of all participating laboratories.

(2) To evaluate a laboratory’s response for a particular sample, the program must determine a laboratory’s type of service in accordance with paragraph (a) of this section. A laboratory must isolate and identify the organisms to the same extent it performs these procedures on patient specimens.

(3) Since laboratories may incorrectly report the presence of organisms in addition to the correctly identified principal organism(s), the grading system must deduct credit for additional erroneous organisms reported. Therefore, the total number of correct responses submitted by the laboratory divided by the number of organisms present plus the number of incorrect organisms reported by the laboratory must be multiplied by 100 to establish a score for each sample in each shipment or testing event. For example, if a sample contained one principal organism and the laboratory reported it correctly but reported the presence of an additional organism, which was not present, the sample grade would be $1/(1 + 1)\times100 = 50$ percent.

(4) The score for the antigen tests is the number of correct responses divided by the number of samples to be tested for the antigen, multiplied by 100.

(5) The score for a testing event is the average of the sample scores as determined under paragraph (c)(3) or (c)(4), or both, of this section.

§ 493.917 Parasitology.

(a) Types of services offered by laboratories. In parasitology there are two types of laboratories for proficiency testing purposes—

(1) Those that determine the presence or absence of parasites by direct observation (wet mount) and/or pinworm preparations and, if necessary, refer
specimens to another laboratory appropriately certified in the subspecialty of parasitology for identification;

(2) Those that identify parasites using concentration preparations and/or permanent stains.

(b) Program content and frequency of challenge. To be approved for proficiency testing in parasitology, a program must provide a minimum of five samples per testing event. There must be at least three testing events at approximately equal intervals per year. The samples may be provided through mailed shipments or, at HHS’s option, may be provided to HHS or its designee for on-site testing. An annual program must include samples that contain parasites that are commonly encountered in the United States as well as those recently introduced into the United States. Other important emerging pathogens (as determined by HHS) and parasites commonly occurring in patient specimens must be included periodically in the program.

(1) An approved program must, before each calendar year furnish HHS with a description of samples that it plans to include in its annual program no later than six months before each calendar year. Samples must include both formalized specimens and PVA (polyvinyl alcohol) fixed specimens as well as blood smears, as appropriate for a particular parasite and stage of the parasite. The majority of samples must contain protozoa or helminths or a combination of parasites. Some samples must be devoid of parasites.

(2) An approved program may vary over time. As an example, the types of parasites that might be included in an approved program over time are—

Enterobius vermicularis
Entamoeba histolytica
Entamoeba coli
Giardia lamblia
Endolimax nana
Dientamoeba fragilis
Iodamoeba butschli
Chilomastix mesnili
Hookworm
Ascaris lumbricoides
Strongyloides stercoralis
Trichuris trichiura
Diphyllobothrium latum
Cryptosporidium sp.
Plasmodium falciparum

(3) For laboratories specified in paragraph (a)(1) of this section, the program must provide at least five samples per testing event that include challenges which contain parasites and challenges that are devoid of parasites.

(c) Evaluation of a laboratory’s performance. HHS approves only those programs that assess the accuracy of a laboratory’s responses in accordance with paragraphs (c)(1) through (6) of this section.

(1) The program must determine the reportable parasites. It may elect to establish a minimum number of parasites to be identified in samples before they are reported. Parasites found in rare numbers by referee laboratories are not considered in scoring a laboratory’s performance; such findings are neutral. To determine the accuracy of a laboratory’s response, the program must compare the laboratory’s response with the response that reflects agreement of either 80 percent of ten or more referee laboratories or 80 percent or more of all participating laboratories.

(2) To evaluate a laboratory’s response for a particular sample, the program must determine a laboratory’s type of service in accordance with paragraph (a) of this section. A laboratory must determine the presence or absence of a parasite(s) or concentrate and identify the parasites to the same extent it performs these procedures on patient specimens.

(3) Since laboratories may incorrectly report the presence of parasites in addition to the correctly identified principal parasite(s), the grading system must deduct credit for these additional erroneous parasites reported and not found in rare numbers by the program’s referencing process. Therefore, the total number of correct responses submitted by the laboratory divided by the number of parasites present plus the number of incorrect parasites reported by the laboratory must be multiplied by 100 to establish a score for each sample in each testing event. For example, if a sample contained one principal parasite and the laboratory reported it correctly but reported the presence of an additional parasite, which was not present, the sample grade would be

\[
\frac{1}{1 + 1} \times 100 = 50\%.
\]
§493.919 Virology.

(a) Types of services offered by laboratories. In virology, there are two types of laboratories for proficiency testing purposes—

(1) Those that only perform tests that directly detect viral antigens or structures, either in cells derived from infected tissues or free in fluid specimens; and

(2) Those that are able to isolate and identify viruses and use direct antigen techniques.

(b) Program content and frequency of challenge. To be approved for proficiency testing in virology, a program must provide a minimum of five samples per testing event. There must be at least three testing events at approximately equal intervals per year. The samples may be provided to the laboratory through mailed shipments or, at HHS’s option, may be provided to HHS or its designee for on-site testing.

An annual program must include viral species that are the more commonly identified viruses. The specific organisms found in the samples may vary from year to year. The annual program must include samples for viral antigen detection and viral isolation and identification.

(1) An approved program must furnish HHS with a description of samples that it plans to include in its annual program no later than six months before each calendar year. The program must include other important emerging viruses (as determined by HHS) and viruses commonly occurring in patient specimens.

(2) An approved program may vary over time. For example, the types of viruses that might be included in an approved program over time are the more commonly identified viruses such as Herpes simplex, respiratory syncytial virus, adenoviruses, enteroviruses, and cytomegaloviruses.

(c) Evaluation of laboratory’s performance. HHS approves only those programs that assess the accuracy of a laboratory’s response in accordance with paragraphs (c)(1) through (c)(5) of this section.

(1) The program determines the reportable viruses to be detected by direct antigen techniques or isolated by laboratories that perform viral isolation procedures. To determine the accuracy of a laboratory’s response, the program must compare the laboratory’s response for each sample with the response that reflects agreement of either 80 percent of ten or more referee laboratories or 80 percent or more of all participating laboratories.

(2) To evaluate a laboratory’s response for a particular sample, the program must determine a laboratory’s type of service in accordance with paragraph (a) of this section. A laboratory must isolate and identify the viruses to the same extent it performs these procedures on patient specimens.

(3) Since laboratories may incorrectly report the presence of viruses in addition to the correctly identified principal virus, the grading system must provide a means of deducting credit for additional erroneous viruses reported. Therefore, the total number of correct responses determined by virus culture techniques submitted by the laboratory divided by the number of viruses present plus the number of incorrect viruses reported by the laboratory must be multiplied by 100 to establish a score for each sample in each testing event. For example, if a sample contained one principal virus and the laboratory reported it correctly but reported the presence of an additional virus, which was not present, the sample grade would be $1/(1 + 1) \times 100 = 50\%$.

(4) The performance criterion for qualitative antigen tests is presence or absence of the viral antigen. The score for the antigen tests is the number of correct responses divided by the number of samples to be tested for the antigen, multiplied by 100.
(5) The score for a testing event is the average of the sample scores as determined under paragraph (c)(3) and (c)(4) of this section.

§ 493.921 Diagnostic immunology.

The subspecialties under the specialty of immunology for which a program may offer proficiency testing are syphilis serology and general immunology. Specific criteria for these subspecialties are found at §§ 493.923 and 493.927.

§ 493.923 Syphilis serology.

(a) Program content and frequency of challenge. To be approved for proficiency testing in syphilis serology, a program must provide a minimum of five samples per testing event. There must be at least three testing events at approximately equal intervals per year. The samples may be provided through mailed shipments or, at HHS’ option, may be provided to HHS or its designee for on-site testing. An annual program must include samples that cover the full range of reactivity from highly reactive to non-reactive.

(b) Evaluation of test performance. HHS approves only those programs that assess the accuracy of a laboratory’s responses in accordance with paragraphs (b)(1) through (4) of this section.

(1) To determine the accuracy of a laboratory’s response for qualitative and quantitative syphilis tests, the program must compare the laboratory’s response with the response that reflects agreement of either 80 percent of ten or more referee laboratories or 80 percent or more of all participating laboratories. The proficiency testing program must indicate the minimum concentration, by method, that will be considered as indicating a positive response. The score for a sample in syphilis serology is the average of scores determined under paragraphs (b)(2) and (b)(3) of this section.

(2) For quantitative syphilis tests, the program must determine the correct response for each method by the distance of the response from the target value. After the target value has been established for each response, the appropriateness of the response must be determined by using fixed criteria. The criterion for acceptable performance for quantitative syphilis serology tests is the target value ±1 dilution.

(3) The criterion for acceptable performance for qualitative syphilis serology tests is reactive or nonreactive.

(4) To determine the overall testing event score, the number of correct responses must be averaged using the following formula:

\[
\frac{\text{Number of acceptable responses for all challenges}}{\text{Total number of all challenges}} \times 100 = \text{Testing event score}
\]

§ 493.927 General immunology.

(a) Program content and frequency of challenge. To be approved for proficiency testing for immunology, the annual program must provide a minimum of five samples per testing event. There must be at least three testing events at approximately equal intervals per year. The annual program must provide samples that cover the full range of reactivity from highly reactive to nonreactive. The samples may be provided through mailed shipments or, at HHS’ option, may be provided to HHS or its designee for on-site testing.

(b) Challenges per testing event. The minimum number of challenges per testing event the program must provide for each analyte or test procedure is five. Analytes or tests for which laboratory performance is to be evaluated include:

- Analyte or Test Procedure
- Alpha-1 antitrypsin
Centers for Medicare & Medicaid Services, HHS  § 493.927

Alpha-fetoprotein (tumor marker)
Antinuclear antibody
Antistreptolysin O
Anti-human immunodeficiency virus (HIV)
Complement C3
Complement C4
Hepatitis markers (HBsAg, anti-HBc, HBeAg)
IgA
IgG
IgE
IgM
Infectious mononucleosis
Rheumatoid factor
Rubella

Evaluation of a laboratory’s analytic or test performance. HHS approves only those programs that assess the accuracy of a laboratory’s responses in accordance with paragraphs (c)(1) through (5) of this section.

(1) To determine the accuracy of a laboratory’s response for quantitative and qualitative immunology tests or analytes, the program must compare the laboratory’s response for each analyte with the response that reflects agreement of either 80 percent of ten or more referee laboratories or 80 percent or more of all participating laboratories. The proficiency testing program must indicate the minimum concentration that will be considered as indicating a positive response. The score for a sample in general immunology is either the score determined under paragraph (c)(2) or (3) of this section.

(2) For quantitative immunology analytes or tests, the program must determine the correct response for each analyte by the distance of the response from the target value. After the target value has been established for each response, the appropriateness of the response must be determined by using either fixed criteria or the number of standard deviations (SDs) the response differs from the target value.

Criteria for Acceptable Performance

The criteria for acceptable performance are—

<table>
<thead>
<tr>
<th>Analyte or test</th>
<th>Criteria for acceptable performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha-1 antitrypsin</td>
<td>Target value ±3 SD.</td>
</tr>
<tr>
<td>Alpha-fetoprotein (tumor marker)</td>
<td>Target value ±3 SD.</td>
</tr>
<tr>
<td>Antinuclear antibody</td>
<td>Target value ±2 dilutions or positive or negative.</td>
</tr>
<tr>
<td>Antistreptolysin O</td>
<td>Target value ±2 dilution or positive or negative.</td>
</tr>
<tr>
<td>Anti-Human Immunodeficiency virus.</td>
<td>Target value ±3 SD.</td>
</tr>
<tr>
<td>Complement C3</td>
<td>Target value ±3 SD.</td>
</tr>
<tr>
<td>Complement C4</td>
<td>Target value ±3 SD.</td>
</tr>
<tr>
<td>Hepatitis (HBsAg, anti-HBc, HBeAg)</td>
<td>Target value ±25%.</td>
</tr>
<tr>
<td>IgA</td>
<td>Target value ±3 SD.</td>
</tr>
<tr>
<td>IgE</td>
<td>Target value ±2 dilutions or positive or negative.</td>
</tr>
<tr>
<td>IgG</td>
<td>Target value ±2 dilutions or positive or negative.</td>
</tr>
<tr>
<td>IgM</td>
<td>Target value ±2 dilutions or immune or nonimmune or positive or negative.</td>
</tr>
<tr>
<td>Infectious mononucleosis</td>
<td>Target value ±2 dilutions or positive or negative.</td>
</tr>
<tr>
<td>Rheumatoid factor</td>
<td>Target value ±2 dilutions or positive or negative.</td>
</tr>
<tr>
<td>Rubella</td>
<td>Target value ±2 dilutions or immune or nonimmune or positive or negative.</td>
</tr>
</tbody>
</table>

(3) The criterion for acceptable performance for qualitative general immunology tests is positive or negative.

(4) To determine the analyte testing event score, the number of acceptable analyte responses must be averaged using the following formula:

\[
\text{Analyte score for the testing event} = \frac{\text{Number of acceptable responses for the analyte}}{\text{Total number of challenges for the analyte}} \times 100
\]

(5) To determine the overall testing event score, the number of correct responses for all analytes must be averaged using the following formula:

\[
\text{Testing event score} = \frac{\text{Number of acceptable responses for all challenges}}{\text{Total number of all challenges}} \times 100
\]
§ 493.929 Chemistry.

The subspecialties under the specialty of chemistry for which a proficiency testing program may offer proficiency testing are routine chemistry, endocrinology, and toxicology. Specific criteria for these subspecialties are listed in §§ 493.931 through 493.939.

§ 493.931 Routine chemistry.

(a) Program content and frequency of challenge. To be approved for proficiency testing for routine chemistry, a program must provide a minimum of five samples per testing event. There must be at least three testing events at approximately equal intervals per year. The annual program must provide samples that cover the clinically relevant range of values that would be expected in patient specimens. The specimens may be provided through mailed shipments or, at HHS’ option, may be provided to HHS or its designee for on-site testing.

(b) Challenges per testing event. The minimum number of challenges per testing event a program must provide for each analyte or test procedure listed below is five serum, plasma or blood samples.

Analyte or Test Procedure

Alanine aminotransferase (ALT/SGPT)
Albumin
Alkaline phosphatase
Amylase
Aspartate aminotransferase (AST/SGOT)
Bilirubin, total
Blood gas (pH, pO2, and pCO2)
Calcium, total
Chloride
Cholesterol, total
Cholesterol, high density lipoprotein
Creatine kinase
Creatine kinase isoenzymes
Creatinine
Glucose (Excluding measurements on devices cleared by FDA for home use)
Iron, total
Lactate dehydrogenase (LDH)
LDH isoenzymes
Magnesium
Potassium
Sodium
Total Protein
Triglycerides
Urea Nitrogen

(c) Evaluation of a laboratory’s analytic or test performance. HHS approves only those programs that assess the accuracy of a laboratory’s responses in accordance with paragraphs (c)(1) through (5) of this section.

(1) To determine the accuracy of a laboratory’s response for qualitative and quantitative chemistry tests or analytes, the program must compare the laboratory’s response with the response that reflects agreement of either 80 percent of ten or more referee laboratories or 80 percent or more of all participating laboratories. The score for a sample in routine chemistry is either the score determined under paragraph (c)(2) or (3) of this section.

(2) For quantitative chemistry tests or analytes, the program must determine the correct response for each analyte by the distance of the response from the target value. After the target value has been established for each response, the appropriateness of the response must be determined by using either fixed criteria based on the percentage difference from the target value or the number of standard deviations (SDs) the response differs from the target value.

Criteria for Acceptable Performance

The criteria for acceptable performance are—

<table>
<thead>
<tr>
<th>Analyte or test</th>
<th>Criteria for acceptable performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alanine aminotransferase (ALT/SGPT)</td>
<td>Target value ±20%</td>
</tr>
<tr>
<td>Albumin</td>
<td>Target value ±10%</td>
</tr>
<tr>
<td>Alkaline phosphatase</td>
<td>Target value ±30%</td>
</tr>
<tr>
<td>Amylase</td>
<td>Target value ±30%</td>
</tr>
<tr>
<td>Aspartate aminotransferase (AST/SGOT)</td>
<td>Target value ±20%</td>
</tr>
<tr>
<td>Bilirubin, total</td>
<td>Target value ±0.4 mg/dL or ±20% (greater)</td>
</tr>
<tr>
<td>Blood gas pO2</td>
<td>Target value ±3 SD</td>
</tr>
<tr>
<td>Calcium, total</td>
<td>Target value ±4 mm Hg or ±18% (greater)</td>
</tr>
<tr>
<td>Chloride</td>
<td>Target value ±0.04</td>
</tr>
<tr>
<td>Cholesterol, total</td>
<td>Target value ±1.0 mg/dL</td>
</tr>
<tr>
<td>Cholesterol, high density lipoprotein</td>
<td>Target value ±10%</td>
</tr>
<tr>
<td>Creatine kinase</td>
<td>Target value ±30%</td>
</tr>
<tr>
<td>Creatine kinase isoenzymes</td>
<td>Target value ±30%</td>
</tr>
<tr>
<td>Creatinine</td>
<td>Target value ±30%</td>
</tr>
<tr>
<td>Glucose (excluding measurements on devices cleared by FDA for home use)</td>
<td>Target value ±30%</td>
</tr>
<tr>
<td>Iron, total</td>
<td>Target value ±30%</td>
</tr>
<tr>
<td>Lactate dehydrogenase (LDH)</td>
<td>Target value ±30%</td>
</tr>
<tr>
<td>LDH isoenzymes</td>
<td>Target value ±30%</td>
</tr>
<tr>
<td>Magnesium</td>
<td>Target value ±30%</td>
</tr>
<tr>
<td>Potassium</td>
<td>Target value ±30%</td>
</tr>
<tr>
<td>Sodium</td>
<td>Target value ±30%</td>
</tr>
<tr>
<td>Total Protein</td>
<td>Target value ±30%</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>Target value ±30%</td>
</tr>
<tr>
<td>Urea Nitrogen</td>
<td>Target value ±30%</td>
</tr>
</tbody>
</table>

Uric Acid

<table>
<thead>
<tr>
<th>Analyte or test</th>
<th>Criteria for acceptable performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target value ±10%</td>
<td></td>
</tr>
<tr>
<td>Target value ±30%</td>
<td></td>
</tr>
<tr>
<td>Target value ±30%</td>
<td></td>
</tr>
<tr>
<td>Target value ±30%</td>
<td></td>
</tr>
<tr>
<td>Target value ±30%</td>
<td></td>
</tr>
<tr>
<td>Target value ±30%</td>
<td></td>
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<tr>
<td>Target value ±30%</td>
<td></td>
</tr>
<tr>
<td>Target value ±30%</td>
<td></td>
</tr>
<tr>
<td>Target value ±30%</td>
<td></td>
</tr>
<tr>
<td>Target value ±30%</td>
<td></td>
</tr>
</tbody>
</table>
### Analyte or Test

<table>
<thead>
<tr>
<th>Analyte or Test</th>
<th>Criteria for acceptable performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucose (excluding glucose performed on monitoring devices cleared by FDA for home use.)</td>
<td>Target value ±6 mg/dl or ±10% (greater).</td>
</tr>
<tr>
<td>Iron, total</td>
<td>Target value ±20%.</td>
</tr>
<tr>
<td>Lactate dehydrogenase (LDH). LDH isoenzymes</td>
<td>Target value ±20%.</td>
</tr>
<tr>
<td>Magnesium</td>
<td>Target value ±20%.</td>
</tr>
<tr>
<td>Potassium</td>
<td>Target value ±10%.</td>
</tr>
<tr>
<td>Sodium</td>
<td>Target value ±25%.</td>
</tr>
<tr>
<td>Total Protein</td>
<td>Target value ±10%.</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>Target value ±25%.</td>
</tr>
<tr>
<td>Urea nitrogen</td>
<td>Target value ±2 mg/dL or ±9% (greater).</td>
</tr>
<tr>
<td>Uric acid</td>
<td>Target value ±17%.</td>
</tr>
</tbody>
</table>

(3) The criterion for acceptable performance for qualitative routine chemistry tests is positive or negative.

(4) To determine the analyte testing event score, the number of acceptable analyte responses must be averaged using the following formula:

\[
\frac{\text{Number of acceptable responses for the analyte}}{\text{Total number of challenges for the analyte}} \times 100 = \text{Analyte score for the testing event}
\]

(5) To determine the overall testing event score, the number of correct responses for all analytes must be averaged using the following formula:

\[
\frac{\text{Number of acceptable responses for all challenges}}{\text{Total number of all challenges}} \times 100 = \text{Testing event score}
\]

§ 493.933 Endocrinology.

(a) Program content and frequency of challenge. To be approved for proficiency testing for endocrinology, a program must provide a minimum of five samples per testing event. There must be at least three testing events at approximately equal intervals per year. The annual program must provide samples that cover the clinically relevant range of values that would be expected in patient specimens. The samples may be provided through mailed shipments or, at HHS’ option, may be provided to HHS or its designee for on-site testing.

(b) Challenges per testing event. The minimum number of challenges per testing event a program must provide for each analyte or test procedure is five serum, plasma, blood, or urine samples.

(c) Evaluation of a laboratory’s analyte or test performance. HHS approves only those programs that assess the accuracy of a laboratory’s responses in accordance with paragraphs (c)(1) through (5) of this section.

(1) To determine the accuracy of a laboratory’s response for qualitative and quantitative endocrinology tests or analytes, a program must compare the laboratory’s response for each analyte with the response that reflects agreement of either 80 percent of ten or more referee laboratories or 80 percent or more of all participating laboratories. The score for a sample in endocrinology is either the score determined under paragraph (c)(2) or (c)(3) of this section.
(2) For quantitative endocrinology tests or analytes, the program must determine the correct response for each analyte by the distance of the response from the target value. After the target value has been established for each response, the appropriateness of the response must be determined by using either fixed criteria based on the percentage difference from the target value or the number of standard deviations (SDs) the response differs from the target value.

**Criteria for Acceptable Performance**

The criteria for acceptable performance are—

<table>
<thead>
<tr>
<th>Analyte or test</th>
<th>Criteria for acceptable performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cortisol</td>
<td>Target value ±25%</td>
</tr>
<tr>
<td>Free Thyroxine</td>
<td>Target value ±3 SD</td>
</tr>
<tr>
<td>Human Chorionic</td>
<td>Target value ±3 SD positive or negative</td>
</tr>
<tr>
<td>Gonadotropins (excluding urine pregnancy tests done by visual color comparison categorized as waived tests).</td>
<td>Target value ±3 SD</td>
</tr>
<tr>
<td>T3 Uptake</td>
<td>Target value ±3 SD</td>
</tr>
<tr>
<td>Thyroid-stimulating hormone</td>
<td>Target value ±3 SD</td>
</tr>
<tr>
<td>Thyroxine</td>
<td>Target value ±20% or 1.0 mcg/dL (greater)</td>
</tr>
</tbody>
</table>

(3) The criterion for acceptable performance for qualitative endocrinology tests is positive or negative.

(4) To determine the analyte testing event score, the number of acceptable analyte responses must be averaged using the following formula:

\[
\frac{\text{Number of acceptable responses for the analyte}}{\text{Total number of challenges for the analyte}} \times 100 = \text{Analyte score for the testing event}
\]

(5) To determine the overall testing event score, the number of correct responses for all analytes must be averaged using the following formula:

\[
\frac{\text{Number of acceptable responses for all challenges}}{\text{Total number of all challenges}} \times 100 = \text{Testing event score}
\]


§ 493.937 Toxicology.

(a) Program content and frequency of challenge. To be approved for proficiency testing for toxicology, the annual program must provide a minimum of five samples per testing event. There must be at least three testing events at approximately equal intervals per year. The annual program must provide samples that cover the clinically relevant range of values that would be expected in specimens of patients on drug therapy and that cover the level of clinical significance for the particular drug. The samples may be provided through mailed shipments or, at HHS’ option, may be provided to HHS or its designee for on-site testing.

(b) Challenges per testing event. The minimum number of challenges per testing event a program must provide for each analyte or test procedure is five serum, plasma, or blood samples.

<table>
<thead>
<tr>
<th>Analyte or Test Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol (blood)</td>
</tr>
<tr>
<td>Blood lead</td>
</tr>
<tr>
<td>Carbamazepine</td>
</tr>
<tr>
<td>Digoxin</td>
</tr>
<tr>
<td>Ethosuximide</td>
</tr>
<tr>
<td>Gentamicin</td>
</tr>
<tr>
<td>Lithium</td>
</tr>
<tr>
<td>Phenobarbital</td>
</tr>
</tbody>
</table>

(c) Evaluation of a laboratory’s analyte or test performance. HHS approves only
those programs that assess the accuracy of a laboratory's responses in accordance with paragraphs (c)(1) through (4) of this section.

(1) To determine the accuracy of a laboratory's responses for quantitative toxicology tests or analytes, the program must compare the laboratory's response for each analyte with the response that reflects agreement of either 80 percent of ten or more referee laboratories or 80 percent or more of all participating laboratories. The score for a sample in toxicology is the score determined under paragraph (c)(2) of this section.

(2) For quantitative toxicology tests or analytes, the program must determine the correct response for each analyte by the distance of the response from the target value. After the target value has been established for each response, the appropriateness of the response must be determined by using fixed criteria based on the percentage difference from the target value.

Criteria for Acceptable Performance

The criteria for acceptable performance are:

<table>
<thead>
<tr>
<th>Analyte or test</th>
<th>Criteria for acceptable performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol, blood</td>
<td>Target Value ±25%</td>
</tr>
<tr>
<td>Blood lead</td>
<td>Target Value ± 10% or 4 mcg/dL (greater)</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>Target Value ±25%</td>
</tr>
<tr>
<td>Digoxin</td>
<td>Target Value ±20% or ±0.2 ng/mL (greater)</td>
</tr>
<tr>
<td>Ethosuximide</td>
<td>Target Value ±20%</td>
</tr>
<tr>
<td>Gentamicin</td>
<td>Target Value ±25%</td>
</tr>
<tr>
<td>Lithium</td>
<td>Target Value ±0.3 mmol/L or ±20% (greater)</td>
</tr>
<tr>
<td>Phenobarbital</td>
<td>Target Value ±25%</td>
</tr>
<tr>
<td>Phenytoin</td>
<td>Target Value ±25%</td>
</tr>
<tr>
<td>Primidone</td>
<td>Target Value ±25%</td>
</tr>
<tr>
<td>Procainamide (and metabolite)</td>
<td>Target Value ±25%</td>
</tr>
<tr>
<td>Quinidine</td>
<td>Target Value ±25%</td>
</tr>
<tr>
<td>Tobramycin</td>
<td>Target Value ±25%</td>
</tr>
<tr>
<td>Theophylline</td>
<td>Target Value ±25%</td>
</tr>
<tr>
<td>Valproic Acid</td>
<td>Target Value ±25%</td>
</tr>
</tbody>
</table>

(3) To determine the analyte testing event score, the number of acceptable analyte responses must be averaged using the following formula:

\[
\frac{\text{Number of acceptable responses for the analyte}}{\text{Total number of challenges for the analyte}} \times 100 = \text{Analyte score for the testing event}
\]

(4) To determine the overall testing event score, the number of correct responses for all analytes must be averaged using the following formula:

\[
\frac{\text{Number of acceptable responses for all challenges}}{\text{Total number of all challenges}} \times 100 = \text{Testing event score}
\]


§493.941 Hematology (including routine hematology and coagulation).

(a) Program content and frequency of challenge. To be approved for proficiency testing for hematology, a program must provide a minimum of five samples per testing event. There must be at least three testing events at approximately equal intervals per year. The annual program must provide samples that cover the full range of values that would be expected in patient specimens. The samples may be provided through mailed shipments or, at HHS' option, may be provided to HHS and its designee for on-site testing.

(b) Challenges per testing event. The minimum number of challenges per testing event a program must provide for each analyte or test procedure is five.

Analyte or Test Procedure

Cell identification or white blood cell differential

Erythrocyte count
§ 493.941

Hematocrit (excluding spun microhematocrit)
Hemoglobin
Leukocyte count
Platelet count
Fibrinogen
Partial thromboplastin time
Prothrombin time

(1) An approved program for cell identification may vary over time. The types of cells that might be included in an approved program over time are—
Neutrophilic granulocytes
Eosinophilic granulocytes
Basophilic granulocytes
Lymphocytes
Monocytes
Major red and white blood cell abnormalities
Immature red and white blood cells

(2) White blood cell differentials should be limited to the percentage distribution of cellular elements listed above.

(c) Evaluation of a laboratory’s analytic or test performance. HHS approves only those programs that assess the accuracy of a laboratory’s responses in accordance with paragraphs (c) (1) through (5) of this section.

(1) To determine the accuracy of a laboratory’s responses for qualitative and quantitative hematology tests or analytes, the program must compare the laboratory’s response for each analyte with the response that reflects agreement of either 80 percent of ten or more referee laboratories or 80 percent or more of all participating laboratories. The score for a sample in hematology is either the score determined under paragraph (c) (2) or (3) of this section.

(2) For quantitative hematology tests or analytes, the program must determine the correct response for each analyte by the distance of the response from the target value. After the target value has been established for each response, the appropriateness of the response is determined using either fixed criteria based on the percentage difference from the target value or the number of standard deviations (SDs) the response differs from the target value.

Criteria for Acceptable Performance

The criteria for acceptable performance are:

<table>
<thead>
<tr>
<th>Analyte or test</th>
<th>Criteria for acceptable performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell identification</td>
<td>90% or greater consensus on identification.</td>
</tr>
<tr>
<td>White blood cell differential</td>
<td>Target ±3SD based on the percentage of different types of white blood cells in the samples.</td>
</tr>
<tr>
<td>Erythrocyte count</td>
<td>Target ±6%.</td>
</tr>
<tr>
<td>Hematocrit (Excluding spun hematocrits)</td>
<td>Target ±7%.</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>Target ±8%.</td>
</tr>
<tr>
<td>Leukocyte count</td>
<td>Target ±15%.</td>
</tr>
<tr>
<td>Platelet count</td>
<td>Target ±20%.</td>
</tr>
<tr>
<td>Fibrinogen</td>
<td>Target ±25%.</td>
</tr>
<tr>
<td>Partial thromboplastin time</td>
<td>Target ±15%.</td>
</tr>
<tr>
<td>Prothrombin time</td>
<td>Target ±15%.</td>
</tr>
</tbody>
</table>

(3) The criterion for acceptable performance for the qualitative hematology test is correct cell identification.

(4) To determine the analyte testing event score, the number of acceptable analyte responses must be averaged using the following formula:

\[
\text{Analyte score for the testing event} = \frac{\text{Number of acceptable responses for the analyte}}{\text{Total number of challenges for the analyte}} \times 100
\]

(5) To determine the overall testing event score, the number of correct responses for all analytes must be averaged using the following formula:

\[
\text{Testing event score} = \frac{\text{Number of acceptable responses for all challenges}}{\text{Total number of all challenges}} \times 100
\]
§ 493.945 Cytology; gynecologic examinations.

(a) Program content and frequency of challenge.

(1) To be approved for proficiency testing for gynecologic examinations (Pap smears) in cytology, a program must provide test sets composed of 10- and 20-glass slides. Proficiency testing programs may obtain slides for test sets from cytology laboratories, provided the slides have been retained by the laboratory for the required period specified in §§ 493.1105(a)(7)(i)(A) and 493.1274(f)(2). If slide preparations are still subject to retention by the laboratory, they may be loaned to a proficiency testing program if the program provides the laboratory with documentation of the loan of the slides and ensures that slides loaned to it are retrievable upon request. Each test set must include at least one slide representing each of the response categories described in paragraph (b)(3)(ii)(A) of this section, and test sets should be comparable so that equitable testing is achieved within and between proficiency testing providers.

(2) To be approved for proficiency testing in gynecologic cytology, a program must provide announced and unannounced on-site testing for each individual at least once per year and must provide an initial retesting event for each individual within 45 days after notification of test failure and subsequent retesting events within 45 days after completion of remedial action described in §493.855.

(b) Evaluation of an individual’s performance. HHS approves only those programs that assess the accuracy of each individual’s response on a particular challenge (slide), the program must compare the individual’s response for each slide preparation with the response that reflects the predetermined consensus agreement or confirmation on the diagnostic category, as described in the table in paragraph (b)(3)(i)(A) of this section. For all slide preparations, a 100% consensus agreement among a minimum of three physicians certified in anatomic pathology is required. In addition, for premalignant and malignant slide preparations, confirmation by tissue biopsy is required either by comparison of the reported biopsy results or re-evaluation of biopsy slide material by a physician certified in anatomic pathology.

(2) An individual qualified as a technical supervisor under §493.1449 (b) or (k) who routinely interprets gynecologic slide preparations only after they have been examined by a cytotechnologist can either be tested using a test set that has been screened by a cytotechnologist in the same laboratory or using a test set that has not been screened. A technical supervisor who screens and interprets slide preparations that have not been previously examined must be tested using a test set that has not been previously screened.

(3) The criteria for acceptable performance are determined by using the scoring system in paragraphs (b)(3) (i) and (ii) of this section.

(i) Each slide set must contain 10 or 20 slides with point values established for each slide preparation based on the significance of the relationship of the interpretation of the slide to a clinical condition and whether the participant in the testing event is a cytotechnologist qualified under §493.1469 or §493.1483 or functioning as a technical supervisor in cytology qualified under §493.1449 (b) or (k) of this part.

(ii) The scoring system rewards or penalizes the participants in proportion to the distance of their answers from the correct response or target diagnosis and the penalty or reward is weighted in proportion to the severity of the lesion.

(A) The four response categories for reporting proficiency testing results and their descriptions are as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A ..........</td>
<td>Unsatisfactory for diagnosis due to:</td>
</tr>
<tr>
<td>(1) Scant cellularity.</td>
<td></td>
</tr>
<tr>
<td>(2) Air drying.</td>
<td></td>
</tr>
</tbody>
</table>
§ 493.945

42 CFR Ch. IV (10–1–16 Edition)

(B) In accordance with the criteria for the scoring system, the charts in paragraphs (b)(3)(ii)(C) and (D) of this section, for technical supervisors and cytotechnologists, respectively, provide a maximum of 10 points for a correct response and a maximum of minus five (−5) points for an incorrect response on a 10-slide test set. For example, if the correct response on a slide is "high grade squamous intraepithelial lesion" (category "D" on the scoring system chart) and an examinee calls it "normal or negative" (category "B" on the scoring system chart), then the examinee’s point value on that slide is calculated as minus five (−5). Each slide is scored individually in the same manner. The individual’s score for the testing event is determined by adding the point value achieved for each slide preparation, dividing by the total points for the testing event and multiplying by 100.

(C) Criteria for scoring system for a 10-slide test set. (See table at paragraph (b)(3)(ii)(A) of this section for a description of the response categories.) For technical supervisors qualified under § 493.1449(b) or (k):

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B ..........</td>
<td>Normal or Benign Changes—includes: (1) Normal, negative or within normal limits. (2) Infection other than Human Papillomavirus (HPV) (e.g., Trichomonas vaginalis, changes or morphology consistent with Candida spp., Actinomyces spp. or Herpes simplex virus). (3) Reactive and reparative changes (e.g., inflammation, effects of chemotherapy or radiation).</td>
</tr>
<tr>
<td>C ..........</td>
<td>Low Grade Squamous Intraepithelial Lesion—includes: (1) Cellular changes associated with HPV. (2) Mild dysplasia/CIN–1.</td>
</tr>
<tr>
<td>D ..........</td>
<td>High Grade Lesion and Carcinoma—includes: (1) High grade squamous intraepithelial lesions which include moderate dysplasia/CIN–2 and severe dysplasia/carcinoma in-situ/CIN–3. (2) Squamous cell carcinoma. (3) Adenocarcinoma and other malignant neoplasms.</td>
</tr>
</tbody>
</table>

(D) Criteria for scoring system for a 10-slide test set. (See table at paragraph (b)(3)(ii)(A) of this section for a description of the response categories.) For cytotechnologists qualified under § 493.1449 or § 493.1469:

<table>
<thead>
<tr>
<th>Examinee’s response:</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correct response category:</td>
<td>A</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>5</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C</td>
<td>5</td>
<td>0</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>D</td>
<td>0</td>
<td>−5</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

(E) In accordance with the criteria for the scoring system, the charts in paragraphs (b)(3)(ii)(F) and (G) of this section, for technical supervisors and cytotechnologists, respectively, provide maximums of 5 points for a correct response and minus ten (−10) points for an incorrect response on a 20-slide test set.

(F) Criteria for scoring system for a 20-slide test set. (See table at paragraph (b)(3)(ii)(A) of this section for a description of the response categories.) For technical supervisors qualified under § 493.1449(b) or (k):

<table>
<thead>
<tr>
<th>Examinee’s response:</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correct response category:</td>
<td>A</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>2.5</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C</td>
<td>2.5</td>
<td>0</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td>D</td>
<td>0</td>
<td>−10</td>
<td>2.5</td>
<td>5</td>
</tr>
</tbody>
</table>

(G) Criteria for scoring system for a 20-slide test set. (See table at paragraph (b)(3)(ii)(A) of this section for a description of the response categories.) For cytotechnologists qualified under § 493.1449 or § 493.1469:

<table>
<thead>
<tr>
<th>Examinee’s response:</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correct response category:</td>
<td>A</td>
<td>5</td>
<td>0</td>
<td>2.5</td>
</tr>
<tr>
<td>B</td>
<td>2.5</td>
<td>5</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>C</td>
<td>2.5</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>D</td>
<td>0</td>
<td>−10</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

§ 493.959 Immunohematology.

(a) Types of services offered by laboratories. In immunohematology, there are four types of laboratories for proficiency testing purposes—

(1) Those that perform ABO group and/or D (Rho) typing;

(2) Those that perform ABO group and/or D (Rho) typing, and unexpected antibody detection;

(3) Those that in addition to paragraph (a)(2) of this section perform compatibility testing; and

(4) Those that perform in addition to paragraph (a)(3) of this section antibody identification.

(b) Program content and frequency of challenge. To be approved for proficiency testing for immunohematology, a program must provide a minimum of five samples per testing event. There must be at least three testing events at approximately equal intervals per year. The annual program must provide samples that cover the full range of interpretation that would be expected in patient specimens. The samples may be provided through mailed shipments or, at HHS’ option, may be provided to HHS or its designee for on-site testing.

(c) Challenges per testing event. The minimum number of challenges per testing event a program must provide for each analyte or test procedure is five.

Analyte or Test Procedure

ABO group (excluding subgroups)
D (Rho) typing
Unexpected antibody detection
Compatibility testing
Antibody identification

(d) Evaluation of a laboratory’s analyte or test performance. HHS approves only those programs that assess the accuracy of a laboratory’s response in accordance with paragraphs (d)(1) through (5) of this section.

(1) To determine the accuracy of a laboratory’s response, a program must compare the laboratory’s response for each analyte with the response that reflects agreement of either 100 percent of ten or more referee laboratories or 95 percent or more of all participating laboratories except for unexpected antibody detection and antibody identification. To determine the accuracy of a laboratory’s response for unexpected antibody detection and antibody identification, a program must compare the laboratory’s response for each analyte with the response that reflects agreement of either 95 percent of ten or more referee laboratories or 95 percent or more of all participating laboratories. The score for a sample in immunohematology is either the score determined under paragraph (d)(2) or (3) of this section.

(2) Criteria for acceptable performance. The criteria for acceptable performance are—

<table>
<thead>
<tr>
<th>Analyte or test</th>
<th>Criteria for acceptable performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABO group</td>
<td>100% accuracy.</td>
</tr>
<tr>
<td>D (Rho) typing</td>
<td>100% accuracy.</td>
</tr>
<tr>
<td>Unexpected antibody detection</td>
<td>80% accuracy.</td>
</tr>
<tr>
<td>Compatibility testing</td>
<td>100% accuracy.</td>
</tr>
<tr>
<td>Antibody identification</td>
<td>80% accuracy.</td>
</tr>
</tbody>
</table>

(3) The criterion for acceptable performance for qualitative immunohematology tests is positive or negative.

(4) To determine the analyte testing event score, the number of acceptable analyte responses must be averaged using the following formula:

\[
\text{Analyte score for the testing event} = \frac{\text{Number of acceptable responses for the analyte}}{\text{Total number of challenges for the analyte}} \times 100
\]

(5) To determine the overall testing event score, the number of correct responses for all analytes must be averaged using the following formula:
Subpart J—Facility Administration for Nonwaived Testing

SOURCE: 68 FR 3703, Jan. 24, 2003, unless otherwise noted.

§ 493.1100 Condition: Facility administration.

Each laboratory that performs nonwaived testing must meet the applicable requirements under §§ 493.1101 through 493.1105, unless HHS approves a procedure that provides equivalent quality testing as specified in Appendix C of the State Operations Manual (CMS Pub. 7).

§ 493.1101 Standard: Facilities.

(a) The laboratory must be constructed, arranged, and maintained to ensure the following:

1. The space, ventilation, and utilities necessary for conducting all phases of the testing process.

2. Contamination of patient specimens, equipment, instruments, reagents, materials, and supplies is minimized.

3. Molecular amplification procedures that are not contained in closed systems have a uni-directional workflow. This must include separate areas for specimen preparation, amplification and product detection, and, as applicable, reagent preparation.

(b) The laboratory must have appropriate and sufficient equipment, instruments, reagents, materials, and supplies for the type and volume of testing it performs.

(c) The laboratory must be in compliance with applicable Federal, State, and local laboratory requirements.

(d) Safety procedures must be established, accessible, and observed to ensure protection from physical, chemical, biochemical, and electrical hazards, and biohazardous materials.

(e) Records and, as applicable, slides, blocks, and tissues must be maintained and stored under conditions that ensure proper preservation.

§ 493.1103 Standard: Requirements for transfusion services.

A facility that provides transfusion services must meet all of the requirements of this section and document all transfusion-related activities.

(a) Arrangement for services. The facility must have a transfusion service agreement reviewed and approved by the responsible party(ies) that govern the procurement, transfer, and availability of blood and blood products.

(b) Provision of testing. The facility must provide prompt ABO grouping, D(Rho) typing, unexpected antibody detection, compatibility testing, and laboratory investigation of transfusion reactions on a continuous basis through a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by CMS.

(c) Blood and blood products storage and distribution. (1) If a facility stores or maintains blood or blood products for transfusion outside of a monitored refrigerator, the facility must ensure the storage conditions, including temperature, are appropriate to prevent deterioration of the blood or blood product.

(2) The facility must establish and follow policies to ensure positive identification of a blood or blood product beneficiary.

(d) Investigation of transfusion reactions. The facility must have procedures for preventing transfusion reactions and when necessary, promptly identify, investigate, and report blood and blood product transfusion reactions to the laboratory and, as appropriate, to Federal and State authorities.

§ 493.1105 Standard: Retention requirements.

(a) The laboratory must retain its records and, as applicable, slides, blocks, and tissues as follows:

1. Test requisitions and authorizations. Retain records of test requisitions and test authorizations, including the patient’s chart or medical record if used...
as the test requisition or authorization, for at least 2 years.

(2) Test procedures. Retain a copy of each test procedure for at least 2 years after a procedure has been discontinued. Each test procedure must include the dates of initial use and discontinuance.

(3) Analytic systems records. Retain quality control and patient test records (including instrument printouts, if applicable) and records documenting all analytic systems activities specified in §§ 493.1252 through 493.1289 for at least 2 years. In addition, retain the following:

(i) Records of test system performance specifications that the laboratory establishes or verifies under §493.1253 for the period of time the laboratory uses the test system but no less than 2 years.

(ii) Immunohematology records, blood and blood product records, and transfusion records as specified in 21 CFR 606.160(b)(3)(ii), (b)(3)(iv), (b)(3)(v) and (d).

(4) Proficiency testing records. Retain all proficiency testing records for at least 2 years.

(5) Quality system assessment records. Retain all laboratory quality systems assessment records for at least 2 years.

(6) Test reports. Retain or be able to retrieve a copy of the original report (including final, preliminary, and corrected reports) at least 2 years after the date of reporting. In addition, retain the following:

(i) Immunohematology reports as specified in 21 CFR 606.160(d).

(ii) Pathology test reports for at least 10 years after the date of reporting.

(7) Slide, block, and tissue retention—(i) Slides. (A) Retain cytology slide preparations for at least 5 years from the date of examination (see §493.1274(f) for proficiency testing exception).

(B) Retain histopathology slides for at least 10 years from the date of examination.

(ii) Blocks. Retain pathology specimen blocks for at least 2 years from the date of examination.

(iii) Tissue. Preserve remnants of tissue for pathology examination until a diagnosis is made on the specimen.

(b) If the laboratory ceases operation, the laboratory must make provisions to ensure that all records and, as applicable, slides, blocks, and tissue are retained and available for the time frames specified in this section.


Subpart K—Quality System for Nonwaived Testing

§ 493.1200 Introduction.

(a) Each laboratory that performs nonwaived testing must establish and maintain written policies and procedures that implement and monitor a quality system for all phases of the total testing process (that is, preanalytic, analytic, and postanalytic) as well as general laboratory systems.

(b) The laboratory’s quality systems must include a quality assessment component that ensures continuous improvement of the laboratory’s performance and services through ongoing monitoring that identifies, evaluates, and resolves problems.

(c) The various components of the laboratory’s quality system are used to meet the requirements in this part and must be appropriate for the specialties and subspecialties of testing the laboratory performs, services it offers, and clients it serves.


§ 493.1201 Condition: Bacteriology.

If the laboratory provides services in the subspecialty of Bacteriology, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, § 493.1261, and §§ 493.1281 through 493.1299.

§ 493.1202 Condition: Mycobacteriology.

If the laboratory provides services in the subspecialty of Mycobacteriology, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, § 493.1262, and §§ 493.1281 through 493.1299.
§ 493.1203 Condition: Mycology.

If the laboratory provides services in the subspecialty of Mycology, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, § 493.1263, and §§ 493.1281 through 493.1299.

§ 493.1204 Condition: Parasitology.

If the laboratory provides services in the subspecialty of Parasitology, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, § 493.1264, and §§ 493.1281 through 493.1299.

§ 493.1205 Condition: Virology.

If the laboratory provides services in the subspecialty of Virology, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, § 493.1265, and §§ 493.1281 through 493.1299.

§ 493.1207 Condition: Syphilis serology.

If the laboratory provides services in the subspecialty of Syphilis serology, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, and §§ 493.1281 through 493.1299.

§ 493.1208 Condition: General immunology.

If the laboratory provides services in the subspecialty of General immunology, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, and §§ 493.1281 through 493.1299.

§ 493.1210 Condition: Routine chemistry.

If the laboratory provides services in the subspecialty of Routine chemistry, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, § 493.1267, and §§ 493.1281 through 493.1299.

§ 493.1211 Condition: Urinalysis.

If the laboratory provides services in the subspecialty of Urinalysis, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, and §§ 493.1281 through 493.1299.

§ 493.1212 Condition: Endocrinology.

If the laboratory provides services in the subspecialty of Endocrinology, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, and §§ 493.1281 through 493.1299.

§ 493.1213 Condition: Toxicology.

If the laboratory provides services in the subspecialty of Toxicology, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, and §§ 493.1281 through 493.1299.

§ 493.1215 Condition: Hematology.

If the laboratory provides services in the specialty of Hematology, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, § 493.1269, and §§ 493.1281 through 493.1299.

§ 493.1217 Condition: Immunohematology.

If the laboratory provides services in the specialty of Immunohematology, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, § 493.1271, and §§ 493.1281 through 493.1299.

§ 493.1219 Condition: Histopathology.

If the laboratory provides services in the subspecialty of Histopathology, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, § 493.1273, and §§ 493.1281 through 493.1299.

§ 493.1220 Condition: Oral pathology.

If the laboratory provides services in the subspecialty of Oral pathology, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, and §§ 493.1281 through 493.1299.

§ 493.1221 Condition: Cytology.

If the laboratory provides services in the subspecialty of Cytology, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, § 493.1274, and §§ 493.1281 through 493.1299.

§ 493.1225 Condition: Clinical cytogenetics.

If the laboratory provides services in the specialty of Clinical cytogenetics,
the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, §§ 493.1276, and §§ 493.1281 through 493.1299.

§ 493.1226 Condition: Radiobioassay.  
If the laboratory provides services in the specialty of Radiobioassay, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, and §§ 493.1281 through 493.1299.

§ 493.1227 Condition: Histocompatibility.  
If the laboratory provides services in the specialty of Histocompatibility, the laboratory must meet the requirements specified in §§ 493.1230 through 493.1256, § 493.1278, and §§ 493.1281 through 493.1299.

General Laboratory Systems  
§ 493.1230 Condition: General laboratory systems.  
Each laboratory that performs non-waived testing must meet the applicable general laboratory systems requirements in §§ 493.1231 through 493.1236, unless HHS approves a procedure, specified in Appendix C of the State Operations Manual (CMS Pub. 7), that provides equivalent quality testing. The laboratory must monitor and evaluate the overall quality of the general laboratory systems and correct identified problems as specified in § 493.1239 for each specialty and subspecialty of testing performed.

§ 493.1231 Standard: Confidentiality of patient information.  
The laboratory must ensure confidentiality of patient information throughout all phases of the total testing process that are under the laboratory’s control.

§ 493.1232 Standard: Specimen identification and integrity.  
The laboratory must establish and follow written policies and procedures that ensure positive identification and optimum integrity of a patient’s specimen from the time of collection or receipt of the specimen through completion of testing and reporting of results.

§ 493.1233 Standard: Complaint investigations.  
The laboratory must have a system in place to ensure that it documents all complaints and problems reported to the laboratory. The laboratory must conduct investigations of complaints, when appropriate.

§ 493.1234 Standard: Communications.  
The laboratory must have a system in place to identify and document problems that occur as a result of a breakdown in communication between the laboratory and an authorized person who orders or receives test results.


§ 493.1235 Standard: Personnel competency assessment policies.  
As specified in the personnel requirements in subpart M, the laboratory must establish and follow written policies and procedures to assess employee and, if applicable, consultant competency.

(a) The laboratory must review and evaluate the results obtained on proficiency testing performed as specified in subpart H of this part.  
(b) The laboratory must verify the accuracy of the following:  
(1) Any analyte or subspecialty without analytes listed in subpart I of this part that is not evaluated or scored by a CMS-approved proficiency testing program.  
(2) Any analyte, specialty or subspecialty assigned a proficiency testing score that does not reflect laboratory test performance (that is, when the proficiency testing program does not obtain the agreement required for scoring as specified in subpart I of this part, or the laboratory receives a zero score for nonparticipation, or late return of results).  
(c) At least twice annually, the laboratory must verify the accuracy of the following:  
(1) Any test or procedure it performs that is not included in subpart I of this part.
(2) Any test or procedure listed in subpart I of this part for which compatible proficiency testing samples are not offered by a CMS-approved proficiency testing program.

(d) All proficiency testing evaluation and verification activities must be documented.

§ 493.1239 Standard: General laboratory systems quality assessment.

(a) The laboratory must establish and follow written policies and procedures for an ongoing mechanism to monitor, assess, and, when indicated, correct problems identified in the general laboratory systems requirements specified at §§ 493.1231 through 493.1236.

(b) The general laboratory systems quality assessment must include a review of the effectiveness of corrective actions taken to resolve problems, revision of policies and procedures necessary to prevent recurrence of problems, and discussion of general laboratory systems quality assessment reviews with appropriate staff.

(c) The laboratory must document all general laboratory systems quality assessment activities.


PREANALYTIC SYSTEMS

§ 493.1240 Condition: Preanalytic systems.

Each laboratory that performs non-waived testing must meet the applicable preanalytic system(s) requirements in §§ 493.1241 and 493.1242, unless HHS approves a procedure, specified in Appendix C of the State Operations Manual (CMS Pub. 7), that provides equivalent quality testing. The laboratory must monitor and evaluate the overall quality of the preanalytic systems and correct identified problems as specified in § 493.1249 for each specialty and subspecialty of testing performed.

§ 493.1241 Standard: Test request.

(a) The laboratory must have a written or electronic request for patient testing from an authorized person.

(b) The laboratory may accept oral requests for laboratory tests if it solicits a written or electronic authorization within 30 days of the oral request and maintains the authorization or documentation of its efforts to obtain the authorization.

(c) The laboratory must ensure the test requisition solicits the following information:

(1) The name and address or other suitable identifiers of the authorized person requesting the test and, if appropriate, the individual responsible for using the test results, or the name and address of the laboratory submitting the specimen, including, as applicable, a contact person to enable the reporting of imminently life threatening laboratory results or panic or alert values.

(2) The patient’s name or unique patient identifier.

(3) The sex and age or date of birth of the patient.

(4) The test(s) to be performed.

(5) The source of the specimen, when appropriate.

(6) The date and, if appropriate, time of specimen collection.

(7) For Pap smears, the patient’s last menstrual period, and indication of whether the patient had a previous abnormal report, treatment, or biopsy.

(8) Any additional information relevant and necessary for a specific test to ensure accurate and timely testing and reporting of results, including interpretation, if applicable.

(d) The patient’s chart or medical record may be used as the test requisition or authorization but must be available to the laboratory at the time of testing and available to CMS or a CMS agent upon request.

(e) If the laboratory transcribes or enters test requisition or authorization information into a record system or a laboratory information system, the laboratory must ensure the information is transcribed or entered accurately.

§ 493.1242 Standard: Specimen submission, handling, and referral.

(a) The laboratory must establish and follow written policies and procedures for each of the following, if applicable:

(1) Patient preparation.

(2) Specimen collection.

(3) Specimen labeling, including patient name or unique patient identifier
and, when appropriate, specimen source.
(4) Specimen storage and preservation.
(5) Conditions for specimen transportation.
(6) Specimen processing.
(7) Specimen acceptability and rejection.
(8) Specimen referral.
(b) The laboratory must document the date and time it receives a specimen.
(c) The laboratory must refer a specimen for testing only to a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by CMS.
(d) If the laboratory accepts a referral specimen, written instructions must be available to the laboratory’s clients and must include, as appropriate, the information specified in paragraphs (a)(1) through (a)(7) of this section.

(a) The laboratory must establish and follow written policies and procedures for an ongoing mechanism to monitor, assess, and when indicated, correct problems identified in the preanalytic systems specified at §§ 493.1241 through 493.1242.
(b) The preanalytic systems quality assessment must include a review of the effectiveness of corrective actions taken to resolve problems, revision of policies and procedures necessary to prevent recurrence of problems, and discussion of preanalytic systems quality assessment reviews with appropriate staff.
(c) The laboratory must document all preanalytic systems quality assessment activities.

ANALYTIC SYSTEMS

§ 493.1250 Condition: Analytic systems.

Each laboratory that performs non-waived testing must meet the applicable analytic systems requirements in §§ 493.1251 through 493.1283, unless HHS approves a procedure, specified in Appendix C of the State Operations Manual (CMS Pub. 7), that provides equivalent quality testing. The laboratory must monitor and evaluate the overall quality of the analytic systems and correct identified problems as specified in § 493.1289 for each specialty and subspecialty of testing performed.

(a) A written procedure manual for all tests, assays, and examinations performed by the laboratory must be available to, and followed by, laboratory personnel. Textbooks may supplement but not replace the laboratory’s written procedures for testing or examining specimens.
(b) The procedure manual must include the following when applicable to the test procedure:
(1) Requirements for patient preparation; specimen collection, labeling, storage, preservation, transportation, processing, and referral; and criteria for specimen acceptability and rejection as described in § 493.1242.
(2) Microscopic examination, including the detection of inadequately prepared slides.
(3) Step-by-step performance of the procedure, including test calculations and interpretation of results.
(4) Preparation of slides, solutions, calibrators, controls, reagents, stains, and other materials used in testing.
(5) Calibration and calibration verification procedures.
(6) The reportable range for test results for the test system as established or verified in § 493.1253.
(7) Control procedures.
(8) Corrective action to take when calibration or control results fail to meet the laboratory’s criteria for acceptability.
(9) Limitations in the test methodology, including interfering substances.
(10) Reference intervals (normal values).
(11) Imminently life-threatening test results, or panic or alert values.
(12) Pertinent literature references.
(13) The laboratory’s system for entering results in the patient record and reporting patient results including, when appropriate, the protocol for reporting imminently life-threatening results, or panic, or alert values.
§ 493.1252 Standard: Test systems, equipment, instruments, reagents, materials, and supplies.

(a) Test systems must be selected by the laboratory. The testing must be performed following the manufacturer’s instructions and in a manner that provides test results within the laboratory’s stated performance specifications for each test system as determined under §493.1253.

(b) The laboratory must define criteria for those conditions that are essential for proper storage of reagents and specimens, accurate and reliable test system operation, and test result reporting. The criteria must be consistent with the manufacturer’s instructions, if provided. These conditions must be monitored and documented and, if applicable, include the following:

1. Water quality.
2. Temperature.
3. Humidity.
4. Protection of equipment and instruments from fluctuations and interruptions in electrical current that adversely affect patient test results and test reports.

(c) Reagents, solutions, culture media, control materials, calibration materials, and other supplies, as appropriate, must be labeled to indicate the following:

1. Identity and when significant, titer, strength or concentration.
2. Storage requirements.
3. Preparation and expiration dates.
4. Other pertinent information required for proper use.

(d) Reagents, solutions, culture media, control materials, calibration materials, and other supplies must not be used when they have exceeded their expiration date, have deteriorated, or are of substandard quality.

(e) Components of reagent kits of different lot numbers must not be interchanged unless otherwise specified by the manufacturer.


(a) Applicability. Laboratories are not required to verify or establish performance specifications for any test system used by the laboratory before April 24, 2003.

(b)(1) Verification of performance specifications. Each laboratory that introduces an unmodified, FDA-cleared or approved test system must do the following before reporting patient test results:

(i) Demonstrate that it can obtain performance specifications comparable to those established by the manufacturer for the following performance characteristics:

(A) Accuracy.
(B) Precision.
(C) Reportable range of test results for the test system.

(ii) Verify that the manufacturer’s reference intervals (normal values) are appropriate for the laboratory’s patient population.

(2) Establishment of performance specifications. Each laboratory that modifies an FDA-cleared or approved test system, or introduces a test system not subject to FDA clearance or approval (including methods developed in-house and standardized methods such as text book procedures), or uses a test system in which performance specifications are not provided by the manufacturer must, before reporting patient test results, establish for each test system the performance specifications for the following performance characteristics, as applicable:
Centers for Medicare & Medicaid Services, HHS

§ 493.1255

(i) Accuracy.
(ii) Precision.
(iii) Analytical sensitivity.
(iv) Analytical specificity to include interfering substances.
(v) Reportable range of test results for the test system.
(vi) Reference intervals (normal values).
(vii) Any other performance characteristic required for test performance.
(3) Determination of calibration and control procedures. The laboratory must determine the test system’s calibration procedures and control procedures based upon the performance specifications verified or established under paragraph (b)(1) or (b)(2) of this section.
(c) Documentation. The laboratory must document all activities specified in this section.


§ 493.1254 Standard: Maintenance and function checks.

(a) Unmodified manufacturer’s equipment, instruments, or test systems. The laboratory must perform and document the following:
(1) Maintenance as defined by the manufacturer and with at least the frequency specified by the manufacturer.
(2) Function checks as defined by the manufacturer and with at least the frequency specified by the manufacturer. Function checks must be within the manufacturer’s established limits before patient testing is conducted.
(b) Equipment, instruments, or test systems developed in-house, commercially available and modified by the laboratory, or maintenance and function check protocols are not provided by the manufacturer. The laboratory must do the following:
(1)(i) Establish a maintenance protocol that ensures equipment, instrument, and test system performance that is necessary for accurate and reliable test results and test result reporting.
(ii) Perform and document the maintenance activities specified in paragraph (b)(1)(i) of this section.
(2)(i) Define a function check protocol that ensures equipment, instrument, and test system performance that is necessary for accurate and reliable test results and test result reporting.
(ii) Perform and document the function checks, including background or baseline checks, specified in paragraph (b)(2)(i) of this section. Function checks must be within the laboratory’s established limits before patient testing is conducted.
§ 493.1255 Standard: Calibration and calibration verification procedures.

Calibration and calibration verification procedures are required to substantiate the continued accuracy of the test system throughout the laboratory’s reportable range of test results for the test system. Unless otherwise specified in this subpart, for each applicable test system the laboratory must do the following:
(a) Perform and document calibration procedures—
(1) Following the manufacturer’s test system instructions, using calibration materials provided or specified, and with at least the frequency recommended by the manufacturer;
(2) Using the criteria verified or established by the laboratory as specified in §493.1253(b)(3)—
(i) Using calibration materials appropriate for the test system and, if possible, traceable to a reference method or reference material of known value; and
(ii) Including the number, type, and concentration of calibration materials, as well as acceptable limits for and the frequency of calibration; and
(3) Whenever calibration verification fails to meet the laboratory’s acceptable limits for calibration verification.
(b) Perform and document calibration verification procedures—
(1) Following the manufacturer’s calibration verification instructions;
(2) Using the criteria verified or established by the laboratory under §493.1253(b)(3)—
(i) Including the number, type, and concentration of the materials, as well as acceptable limits for calibration verification; and
(ii) Including at least a minimal (or zero) value, a mid-point value, and a maximum value near the upper limit of
§ 493.1256 Standard: Control procedures.

(a) For each test system, the laboratory is responsible for having control procedures that monitor the accuracy and precision of the complete analytic process.

(b) The laboratory must establish the number, type, and frequency of testing control materials using, if applicable, the performance specifications verified or established by the laboratory as specified in § 493.1233(b)(3).

(c) The control procedures must—

(1) Detect immediate errors that occur due to test system failure, adverse environmental conditions, and operator performance.

(2) Monitor over time the accuracy and precision of test performance that may be influenced by changes in test system performance and environmental conditions, and variance in operator performance.

(d) Unless CMS approves a procedure, specified in Appendix C of the State Operations Manual (CMS Pub. 7), that provides equivalent quality testing, the laboratory must—

(1) Perform control procedures as defined in this section unless otherwise specified in the additional specialty and subspecialty requirements at §§ 493.1261 through 493.1278.

(2) For each test system, perform control procedures using the number and frequency specified by the manufacturer or established by the laboratory when they meet or exceed the requirements in paragraph (d)(3) of this section.

(3) At least once each day patient specimens are assayed or examined perform the following for—

(i) Each quantitative procedure, include two control materials of different concentrations;

(ii) Each qualitative procedure, include a negative and positive control material;

(iii) Test procedures producing graded or titered results, include a negative control material and a control material with graded or titered reactivity, respectively;

(iv) Each test system that has an extraction phase, include two control materials, including one that is capable of detecting errors in the extraction process; and

(v) Each molecular amplification procedure, include two control materials and, if reaction inhibition is a significant source of false negative results, a control material capable of detecting the inhibition.

(4) For thin layer chromatography—

(i) Spot each plate or card, as applicable, with a calibrator containing all known substances or drug groups, as appropriate, which are identified by thin layer chromatography and reported by the laboratory; and

(ii) Include at least one control material on each plate or card, as applicable, which must be processed through each step of patient testing, including extraction processes.

(5) For each electrophoretic procedure include, concurrent with patient specimens, at least one control material containing the substances being identified or measured.

(6) Perform control material testing as specified in this paragraph before resuming patient testing when a complete change of reagents is introduced;
major preventive maintenance is performed; or any critical part that may influence test performance is replaced.

(7) Over time, rotate control material testing among all operators who perform the test.

(8) Test control materials in the same manner as patient specimens.

(9) When using calibration material as a control material, use calibration material from a different lot number than that used to establish a cut-off value or to calibrate the test system.

(10) Establish or verify the criteria for acceptability of all control materials.

(i) When control materials providing quantitative results are used, statistical parameters (for example, mean and standard deviation) for each batch and lot number of control materials must be defined and available.

(ii) The laboratory may use the stated value of a commercially assayed control material provided the stated value is for the methodology and instrumentation employed by the laboratory and is verified by the laboratory.

(iii) Statistical parameters for unassayed control materials must be established over time by the laboratory through concurrent testing of control materials having previously determined statistical parameters.

(e) For reagent, media, and supply checks, the laboratory must do the following:

(1) Check each batch (prepared in-house), lot number (commercially prepared) and shipment of reagents, disks, stains, antisera, (except those specifically referenced in §493.1261(a)(3)) and identification systems (systems using two or more substrates or two or more reagents, or a combination) when prepared or opened for positive and negative reactivity, as well as graded reactivity, if applicable.

(2) Each day of use (unless otherwise specified in this subpart), test staining materials for intended reactivity to ensure predictable staining characteristics. Control materials for both positive and negative reactivity must be included, as appropriate.

(3) Check fluorescent and immunohistochemical stains for positive and negative reactivity each time of use.

(4) Before, or concurrent with the initial use—

(i) Check each batch of media for sterility if sterility is required for testing;

(ii) Check each batch of media for its ability to support growth and, as appropriate, select or inhibit specific organisms or produce a biochemical response; and

(iii) Document the physical characteristics of the media when compromised and report any deterioration in the media to the manufacturer.

(5) Follow the manufacturer's specifications for using reagents, media, and supplies and be responsible for results.

(f) Results of control materials must meet the laboratory’s and, as applicable, the manufacturer’s test system criteria for acceptability before reporting patient test results.

(g) The laboratory must document all control procedures performed.

(h) If control materials are not available, the laboratory must have an alternative mechanism to detect immediate errors and monitor test system performance over time. The performance of alternative control procedures must be documented.


§ 493.1261 Standard: Bacteriology.

(a) The laboratory must check the following for positive and negative reactivity using control organisms:

(1) Each day of use for beta-lactamase methods other than Cefinase™.

(2) Each week of use for Gram stains.

(3) Each day tests are performed, the laboratory must use the appropriate control organism(s) to check the procedure.

(b) For antimicrobial susceptibility tests, the laboratory must check each batch of media and each lot number and shipment of antimicrobial agent(s) before, or concurrent with, initial use, using approved control organisms.

(1) Each day tests are performed, the laboratory must use the appropriate control organism(s) to check the procedure.

(2) The laboratory’s zone sizes or minimum inhibitory concentration for
control organisms must be within established limits before reporting patient results.

(c) The laboratory must document all control procedures performed, as specified in this section.

§ 493.1262 Standard: Mycobacteriology.

(a) Each day of use, the laboratory must check all reagents or test procedures used for mycobacteria identification with at least one acid-fast organism that produces a positive reaction and an acid-fast organism that produces a negative reaction.

(b) For antimycobacterial susceptibility tests, the laboratory must check each batch of media and each lot number and shipment of antimycobacterial agent(s) before, or concurrent with, initial use, using an appropriate control organism(s).

(1) The laboratory must establish limits for acceptable control results.

(2) Each week tests are performed, the laboratory must use the appropriate control organism(s) to check the procedure.

(3) The results for the control organism(s) must be within established limits before reporting patient results.

(c) The laboratory must document all control procedures performed, as specified in this section.

§ 493.1263 Standard: Mycology.

(a) The laboratory must check each batch (prepared in-house), lot number (commercially prepared), and shipment of lactophenol cotton blue when prepared or opened for intended reactivity with a control organism(s).

(b) For antifungal susceptibility tests, the laboratory must check each batch of media and each lot number and shipment of antifungal agent(s) before, or concurrent with, initial use, using an appropriate control organism(s).

(1) The laboratory must establish limits for acceptable control results.

(2) Each day tests are performed, the laboratory must use the appropriate control organism(s) to check the procedure.

(3) The results for the control organism(s) must be within established limits before reporting patient results.

(c) The laboratory must document all control procedures performed, as specified in this section.

§ 493.1264 Standard: Parasitology.

(a) The laboratory must have available a reference collection of slides or photographs and, if available, gross specimens for identification of parasites and use these references in the laboratory for appropriate comparison with diagnostic specimens.

(b) The laboratory must calibrate and use the calibrated ocular micrometer for determining the size of ova and parasites, if size is a critical parameter.

(c) Each month of use, the laboratory must check permanent stains using a fecal sample control material that will demonstrate staining characteristics.

(d) The laboratory must document all control procedures performed, as specified in this section.

§ 493.1265 Standard: Virology.

(a) When using cell culture to isolate or identify viruses, the laboratory must simultaneously incubate a cell substrate control or uninoculated cells as a negative control material.

(b) The laboratory must document all control procedures performed, as specified in this section.

§ 493.1267 Standard: Routine chemistry.

For blood gas analyses, the laboratory must perform the following:

(a) Calibrate or verify calibration according to the manufacturer's specifications and with at least the frequency recommended by the manufacturer.

(b) Test one sample of control material each 8 hours of testing using a combination of control materials that include both low and high values on each day of testing.

(c) Test one sample of control material each time specimens are tested unless automated instrumentation internally verifies calibration at least every 30 minutes.

(d) Document all control procedures performed, as specified in this section.
§ 493.1269 Standard: Hematology.

(a) For manual cell counts performed using a hemocytometer—
   (1) One control material must be tested each 8 hours of operation; and
   (2) Patient specimens and control materials must be tested in duplicate.

(b) For all nonmanual coagulation test systems, the laboratory must include two levels of control material each 8 hours of operation and each time a reagent is changed.

(c) For manual coagulation tests—
   (1) Each individual performing tests must test two levels of control materials before testing patient samples and each time a reagent is changed; and
   (2) Patient specimens and control materials must be tested in duplicate.

(d) The laboratory must document all control procedures performed, as specified in this section.

§ 493.1271 Standard: Immunohematology.

(a) Patient testing. (1) The laboratory must perform ABO grouping, D(Rho) typing, unexpected antibody detection, antibody identification, and compatibility testing by following the manufacturer’s instructions, if provided, and as applicable, 21 CFR 606.151(a) through (e).

(2) The laboratory must determine ABO group by concurrently testing unknown red cells with, at a minimum, anti-A and anti-B grouping reagents. For confirmation of ABO group, the unknown serum must be tested with known A1 and B red cells.

(3) The laboratory must determine the D(Rho) type by testing unknown red cells with anti-D (anti-Rho) blood typing reagent.

(b) Immunohematological testing and distribution of blood and blood products. Blood and blood product testing and distribution must comply with 21 CFR 606.100(b)(12); 606.160(b)(3)(ii) and (b)(3)(v); 610.40; 640.5(a), (b), (c), and (e); and 640.11(b).

(c) Blood and blood products storage. Blood and blood products must be stored under appropriate conditions that include an adequate temperature alarm system that is regularly inspected.

(d) Retention of samples of transfused blood. According to the laboratory’s established procedures, samples of each unit of transfused blood must be retained for further testing in the event of transfusion reactions. The laboratory must promptly dispose of blood not retained for further testing that has passed its expiration date.

(e) Investigation of transfusion reactions. (1) According to its established procedures, the laboratory that performs compatibility testing, or issues blood or blood products, must promptly investigate all transfusion reactions occurring in facilities for which it has investigational responsibility and make recommendations to the medical staff regarding improvements in transfusion procedures.

(2) The laboratory must document, as applicable, that all necessary remedial actions are taken to prevent recurrences of transfusion reactions and that all policies and procedures are reviewed to assure they are adequate to ensure the safety of individuals being transfused.

(f) Documentation. The laboratory must document all control procedures performed, as specified in this section.

§ 493.1273 Standard: Histopathology.

(a) As specified in §493.1256(e)(3), fluorescent and immunohistochemical stains must be checked for positive and negative reactivity each time of use. For all other differential or special stains, a control slide of known reactivity must be stained with each patient slide or group of patient slides. Reaction(s) of the control slide with each special stain must be documented.

(b) The laboratory must retain stained slides, specimen blocks, and tissue remnants as specified in §493.1105. The remnants of tissue specimens must be maintained in a manner that ensures proper preservation of the tissue specimens until the portions submitted for microscopic examination have been examined and a diagnosis
§ 493.1274 Standard: Cytology.

(a) Cytology slide examination site. All cytology slide preparations must be evaluated on the premises of a laboratory certified to conduct testing in the subspecialty of cytology.

(b) Staining. The laboratory must have available and follow written policies and procedures for each of the following, if applicable:

(1) All gynecologic slide preparations must be stained using a Papanicolaou or modified Papanicolaou staining method.

(2) Effective measures to prevent cross-contamination between gynecologic and nongynecologic specimens during the staining process must be used.

(3) Nongynecologic specimens that have a high potential for cross-contamination must be stained separately from other nongynecologic specimens, and the stains must be filtered or changed following staining.

(c) Control procedures. The laboratory must establish and follow written policies and procedures for a program designed to detect errors in the performance of cytologic examinations and the reporting of results. The program must include the following:

(1) A review of slides from at least 10 percent of the gynecologic cases interpreted by individuals qualified under § 493.1469 or § 493.1483, to be negative for epithelial cell abnormalities and other malignant neoplasms (as defined in paragraph (e)(1) of this section).

(i) The review must be performed by an individual who meets one of the following qualifications:

(A) A technical supervisor qualified under § 493.1449(b) or (k).

(B) A cytology general supervisor qualified under § 493.1469.

(C) A cytotechnologist qualified under § 493.1483 who has the experience specified in § 493.1469(b)(2).

(ii) Cases must be randomly selected from the total caseload and include negatives and those from patients or groups of patients that are identified as having a higher than average probability of developing cervical cancer based on available patient information.

(iii) The review of those cases selected must be completed before reporting patient results.

(2) Laboratory comparison of clinical information, when available, with cytology reports and comparison of all gynecologic cytology reports with a diagnosis of high-grade squamous intraepithelial lesion (HSIL), adenocarcinoma, or other malignant neoplasms with the histopathology report, if available in the laboratory (either on-site or in storage), and determination of the causes of any discrepancies.

(3) For each patient with a current HSIL, adenocarcinoma, or other malignant neoplasm, laboratory review of all normal or negative gynecologic specimens received within the previous 5 years, if available in the laboratory (either on-site or in storage). If significant discrepancies are found that will affect current patient care, the laboratory must notify the patient’s physician and issue an amended report.

(4) Records of initial examinations and all rescreening results must be documented.

(5) An annual statistical laboratory evaluation of the number of—

(i) Cytology cases examined;

(ii) Specimens processed by specimen type;

(iii) Patient cases reported by diagnosis (including the number reported
as unsatisfactory for diagnostic interpretation;
(iv) Gynecologic cases with a diagnosis of HSIL, adenocarcinoma, or other malignant neoplasm for which histology results were available for comparison;
(v) Gynecologic cases where cytology and histology are discrepant; and
(vi) Gynecologic cases where any re-screen of a normal or negative specimen results in reclassification as low-grade squamous intraepithelial lesion (LSIL), HSIL, adenocarcinoma, or other malignant neoplasms.
(6) An evaluation of the case reviews of each individual examining slides against the laboratory’s overall statistical values, documentation of any discrepancies, including reasons for the deviation and, if appropriate, corrective actions taken.
(d) Workload limits. The laboratory must establish and follow written policies and procedures that ensure the following:
(1) The technical supervisor establishes a maximum workload limit for each individual who performs primary screening.
(i) The workload limit is based on the individual’s performance using evaluations of the following:
(A) Review of 10 percent of the cases interpreted as negative for the conditions defined in paragraph (e)(1) of this section.
(B) Comparison of the individual’s interpretation with the technical supervisor’s confirmation of patient smears specified in paragraphs (e)(1) and (e)(3) of this section.
(ii) Each individual’s workload limit is reassessed at least every 6 months and adjusted when necessary.
(2) The maximum number of slides examined by an individual in each 24-hour period does not exceed 100 slides (one patient specimen per slide; gynecologic, nongynecologic, or both) irrespective of the site or laboratory. This limit represents an absolute maximum number of slides and must not be employed as an individual’s performance target. In addition—
(i) The maximum number of 100 slides is examined in no less than an 8-hour workday;
(ii) For the purposes of establishing workload limits for individuals examining slides in less than an 8-hour workday (includes full-time employees with duties other than slide examination and part-time employees), a period of 6 hours is used to prorate the number of slides that may be examined. The formula—

\[
\text{Number of hours examining slides} \times \frac{100}{8}
\]

is used to determine maximum slide volume to be examined;
(iii) Nongynecologic slide preparations made using liquid-based slide preparatory techniques that result in cell dispersion over one-half or less of the total available slide may be counted as one-half slide; and
(iv) Technical supervisors who perform primary screening are not required to include tissue pathology slides and previously examined cytology slides (gynecologic and nongynecologic) in the 100 slide workload limit.
(3) The laboratory must maintain records of the total number of slides examined by each individual during each 24-hour period and the number of hours spent examining slides in the 24-hour period irrespective of the site or laboratory.
(4) Records are available to document the workload limit for each individual.
(e) Slide examination and reporting. The laboratory must establish and follow written policies and procedures that ensure the following:
(1) A technical supervisor confirms each gynecologic slide preparation interpreted to exhibit reactive or reparative changes or any of the following epithelial cell abnormalities:
(i) Squamous cell.
(A) Atypical squamous cells of undetermined significance (ASC-US) or cannot exclude HSIL (ASC-H).
(B) LSIL-Human papillomavirus (HPV)/mild dysplasia/cervical intraepithelial neoplasia 1 (CIN 1).
(C) HSIL-moderate and severe dysplasia, carcinoma in situ (CIS)/CIN 2 and CIN 3 or with features suspicious for invasion.
(D) Squamous cell carcinoma.
(ii) Glandular cell.
(A) Atypical cells not otherwise specified (NOS) or specified in comments (endocervical, endometrial, or glandular).

(B) Atypical cells favor neoplastic (endocervical or glandular).

(C) Endocervical adenocarcinoma in situ.

(D) Adenocarcinoma endocervical, adenocarcinoma endometrial, adenocarcinoma extrauterine, and adenocarcinoma NOS.

(iii) Other malignant neoplasms.

(2) The report of gynecologic slide preparations with conditions specified in paragraph (e)(1) of this section must be signed to reflect the technical supervisory review or, if a computer report is generated with signature, it must reflect an electronic signature authorized by the technical supervisor who performed the review.

(3) All nongynecologic preparations are reviewed by a technical supervisor. The report must be signed to reflect technical supervisory review or, if a computer report is generated with signature, it must reflect an electronic signature authorized by the technical supervisor who performed the review.

(4) Unsatisfactory specimens or slide preparations are identified and reported as unsatisfactory.

(5) The report contains narrative descriptive nomenclature for all results.

(6) Corrected reports issued by the laboratory indicate the basis for correction.

(f) Record and slide retention.

(1) The laboratory must retain all records and slide preparations as specified in §493.1105.

(2) Slides may be loaned to proficiency testing programs in lieu of maintaining them for the required time period, provided the laboratory receives written acknowledgment of the receipt of slides by the proficiency testing program and maintains the acknowledgment to document the loan of these slides.

(3) Documentation of slides loaned or referred for purposes other than proficiency testing must be maintained.

(4) All slides must be retrievable upon request.

(g) Automated and semi-automated screening devices. When performing evaluations using automated and semi-automated screening devices, the laboratory must follow manufacturer’s instructions for preanalytic, analytic, and postanalytic phases of testing, as applicable, and meet the applicable requirements of this subpart K.

(h) Documentation. The laboratory must document all control procedures performed, as specified in this section.

§ 493.1278 Standard: Histocompatibility.

(a) General. The laboratory must have policies and procedures for ensuring accurate and reliable patient specimen identification during the process of accessioning, cell preparation, photographing or other image reproduction technique, photographic printing, and reporting and storage of results, karyotypes, and photographs.

(b) The laboratory must have records that document the following:

(1) The media used, reactions observed, number of cells counted, number of cells karyotyped, number of chromosomes counted for each metaphase spread, and the quality of the banding.

(2) The resolution is appropriate for the type of tissue or specimen and the type of study required based on the clinical information provided to the laboratory.

(3) An adequate number of karyotypes are prepared for each patient.

(c) Determination of sex must be performed by full chromosome analysis.

(d) The laboratory report must include a summary and interpretation of the observations, number of cells counted and analyzed, and use the International System for Human Cytogenetic Nomenclature.

(e) The laboratory must document all control procedures performed, as specified in this section.
(1) An audible alarm system must be used to monitor the storage temperature of specimens (donor and beneficiary) and reagents. The laboratory must have an emergency plan for alternate storage.

(2) All patient specimens must be easily retrievable.

(3) Reagent typing sera inventory prepared in-house must indicate source, bleeding date and identification number, reagent specificity, and volume remaining.

(4) If the laboratory uses immunologic reagents (for example, antibodies, antibody-coated particles, or complement) to facilitate or enhance the isolation of lymphocytes, or lymphocyte subsets, the efficacy of the methods must be monitored with appropriate quality control procedures.

(5) Participate in at least one national or regional cell exchange program, if available, or develop an exchange system with another laboratory in order to validate interlaboratory reproducibility.

(b) HLA typing. The laboratory must do the following:

(1) Use a technique(s) that is established to optimally define, as applicable, HLA Class I and II specificities.

(2) HLA type all potential transplant beneficiaries at a level appropriate to support clinical transplant protocol and donor selection.

(3) HLA type cells from organ donors referred to the laboratory.

(4) Use HLA antigen terminology that conforms to the latest report of the World Health Organization (W.H.O.) Committee on Nomenclature. Potential new antigens not yet approved by this committee must have a designation that cannot be confused with W.H.O. terminology.

(5) Have available and follow written criteria for the following:

(i) The preparation of cells or cellular extracts (for example, solubilized antigens and nucleic acids), as applicable to the HLA typing technique(s) performed.

(ii) Selecting typing reagents, whether prepared in-house or commercially.

(iii) Ensuring that reagents used for typing are adequate to define all HLA-A, B, and DR specificities that are officially recognized by the most recent W.H.O. Committee on Nomenclature and for which reagents are readily available.

(iv) The assignment of HLA antigens.

(v) When antigen redefinition and retyping are required.

(6) Check each HLA typing by testing, at a minimum the following:

(i) A positive control material.

(ii) A negative control material in which, if applicable to the technique performed, cell viability at the end of incubation is sufficient to permit accurate interpretation of results. In assays in which cell viability is not required, the negative control result must be sufficiently different from the positive control result to permit accurate interpretation of results.

(iii) Positive control materials for specific cell types when applicable (that is, T cells, B cells, and monocytes).

(c) Disease-associated studies. The laboratory must check each typing for disease-associated HLA antigens using control materials to monitor the test components and each phase of the test system to ensure acceptable performance.

(d) Antibody Screening. The laboratory must do the following:

(1) Use a technique(s) that detects HLA-specific antibody with a specificity equivalent or superior to that of the basic complement-dependent microlymphocytotoxicity assay.

(2) Use a method that distinguishes antibodies to HLA Class II antigens from antibodies to Class I antigens to detect antibodies to HLA Class II antigens.

(3) Use a panel that contains all the major HLA specificities and common splits. If the laboratory does not use commercial panels, it must maintain a list of individuals for fresh panel bleeding.

(4) Make a reasonable attempt to have available monthly serum specimens for all potential transplant beneficiaries for periodic antibody screening and crossmatch.

(5) Have available and follow a written policy consistent with clinical transplant protocols for the frequency of screening potential transplant beneficiary sera for preformed HLA-specific antibodies.
(6) Check each antibody screening by testing, at a minimum the following:
   (i) A positive control material containing antibodies of the appropriate isotype for the assay.
   (ii) A negative control material.
(7) As applicable, have available and follow written criteria and procedures for antibody identification to the level appropriate to support clinical transplant protocol.
(e) Crossmatching. The laboratory must do the following:
   (1) Use a technique(s) documented to have increased sensitivity in comparison with the basic complement-dependent microlymphocytotoxicity assay.
   (2) Have available and follow written criteria for the following:
      (i) Selecting appropriate patient serum samples for crossmatching.
      (ii) The preparation of donor cells or cellular extracts (for example, solubilized antigens and nucleic acids), as applicable to the crossmatch technique(s) performed.
(3) Check each crossmatch and compatibility test for HLA Class II antigenic differences using control materials to monitor the test components and each phase of the test system to ensure acceptable performance.
(f) Transplantation. Laboratories performing histocompatibility testing for transfusion and transplantation purposes must do the following:
   (1) Have available and follow written policies and protocols specifying the histocompatibility testing (that is, HLA typing, antibody screening, compatibility testing and crossmatching) to be performed for each type of cell, tissue or organ to be transfused or transplanted. The laboratory’s policies must include, as applicable—
      (i) Testing protocols for cadaver donor, living, living-related, and combined organ and tissue transplants;
      (ii) Testing protocols for patients at high risk for allograft rejection; and
      (iii) The level of testing required to support clinical transplant protocols (for example, antigen or allele level).
   (2) For renal allotransplantation and combined organ and tissue transplants in which a kidney is to be transplanted, have available results of final crossmatches before the kidney is transplanted.
(3) For nonrenal transplantation, if HLA testing and final crossmatches were not performed prospectively because of an emergency situation, the laboratory must document the circumstances, if known, under which the emergency transplant was performed, and records of the transplant must reflect any information provided to the laboratory by the patient’s physician.
(g) Documentation. The laboratory must document all control procedures performed, as specified in this section.

§ 493.1281 Standard: Comparison of test results.
(a) If a laboratory performs the same test using different methodologies or instruments, or performs the same test at multiple testing sites, the laboratory must have a system that twice a year evaluates and defines the relationship between test results using the different methodologies, instruments, or testing sites.
(b) The laboratory must have a system to identify and assess patient test results that appear inconsistent with the following relevant criteria, when available:
   (1) Patient age.
   (2) Sex.
   (3) Diagnosis or pertinent clinical data.
   (4) Distribution of patient test results.
   (5) Relationship with other test parameters.
(c) The laboratory must document all test result comparison activities.

§ 493.1282 Standard: Corrective actions.
(a) Corrective action policies and procedures must be available and followed as necessary to maintain the laboratory’s operation for testing patient specimens in a manner that ensures accurate and reliable patient test results and reports.
(b) The laboratory must document all corrective actions taken, including actions taken when any of the following occur:
   (1) Test systems do not meet the laboratory’s verified or established performance specifications, as determined
in § 493.1253(b), which include but are not limited to—

(i) Equipment or methodologies that perform outside of established operating parameters or performance specifications;

(ii) Patient test values that are outside of the laboratory’s reportable range of test results for the test system; and

(iii) When the laboratory determines that the reference intervals (normal values) for a test procedure are inappropriate for the laboratory’s patient population.

(2) Results of control or calibration materials, or both, fail to meet the laboratory’s established criteria for acceptability. All patient test results obtained in the unacceptable test run and since the last acceptable test run must be evaluated to determine if patient test results have been adversely affected. The laboratory must take the corrective action necessary to ensure the reporting of accurate and reliable patient test results.

(3) The criteria for proper storage of reagents and specimens, as specified under § 493.1252(b), are not met.

§ 493.1283 Standard: Test records.

(a) The laboratory must maintain an information or record system that includes the following:

(1) The positive identification of the specimen.

(2) The date and time of specimen receipt into the laboratory.

(3) The condition and disposition of specimens that do not meet the laboratory’s criteria for specimen acceptability.

(4) The records and dates of all specimen testing, including the identity of the personnel who performed the test(s).

(b) Records of patient testing including, if applicable, instrument printouts, must be retained.


(a) The laboratory must establish and follow written policies and procedures for an ongoing mechanism to monitor, assess, and when indicated, correct problems identified in the analytic systems specified in §§ 493.1251 through 493.1283.

(b) The analytic systems quality assessment must include a review of the effectiveness of corrective actions taken to resolve problems, revision of policies and procedures necessary to prevent recurrence of problems, and discussion of analytic systems quality assessment reviews with appropriate staff.

(c) The laboratory must document all analytic systems quality assessment activities.

§ 493.1290 Condition: Postanalytic systems.

Each laboratory that performs non-waived testing must meet the applicable postanalytic systems requirements in § 493.1291 unless HHS approves a procedure, specified in Appendix C of the State Operations Manual (CMS Pub. 7) that provides equivalent quality testing. The laboratory must monitor and evaluate the overall quality of the postanalytic systems and correct identified problems as specified in § 493.1299 for each specialty and subspecialty of testing performed.

§ 493.1291 Standard: Test report.

(a) The laboratory must have an adequate manual or electronic system(s) in place to ensure test results and other patient-specific data are accurately and reliably sent from the point of data entry (whether interfaced or entered manually) to final report destination, in a timely manner. This includes the following:

(1) Results reported from calculated data.

(2) Results and patient-specific data electronically reported to network or interfaced systems.

(3) Manually transcribed or electronically transmitted results and patient-specific information reported directly or upon receipt from outside referral laboratories, satellite or point-of-care testing locations.

(b) Test report information maintained as part of the patient’s chart or
medical record must be readily available to the laboratory and to CMS or a CMS agent upon request.

(c) The test report must indicate the following:

(1) For positive patient identification, either the patient’s name and identification number, or a unique patient identifier and identification number.

(2) The name and address of the laboratory location where the test was performed.

(3) The test report date.

(4) The test performed.

(5) Specimen source, when appropriate.

(6) The test result and, if applicable, the units of measurement or interpretation, or both.

(7) Any information regarding the condition and disposition of specimens that do not meet the laboratory’s criteria for acceptability.

(d) Pertinent “reference intervals” or “normal” values, as determined by the laboratory performing the tests, must be available to the authorized person who ordered the tests and, if applicable, the individual responsible for using the test results.

(e) The laboratory must, upon request, make available to clients a list of test methods employed by the laboratory and, as applicable, the performance specifications established or verified as specified in §493.1253. In addition, information that may affect the interpretation of test results, for example test interferences, must be provided upon request. Pertinent updates on testing information must be provided to clients whenever changes occur that affect the test results or interpretation of test results.

(f) Except as provided in §493.1291(l), test results must be released only to authorized persons and, if applicable, the persons responsible for using the test results and the laboratory that initially requested the test.

(g) The laboratory must immediately alert the individual or entity requesting the test and, if applicable, the individual responsible for using the test results when any test result indicates an imminently life-threatening condition, or panic or alert values.

(h) When the laboratory cannot report patient test results within its established time frames, the laboratory must determine, based on the urgency of the patient test(s) requested, the need to notify the appropriate individual(s) of the delayed testing.

(i) If a laboratory refers patient specimens for testing—

(1) The referring laboratory must not revise results or information directly related to the interpretation of results provided by the testing laboratory;

(2) The referring laboratory may permit each testing laboratory to send the test result directly to the authorized person who initially requested the test. The referring laboratory must retain or be able to produce an exact duplicate of each testing laboratory’s report; and

(3) The authorized person who orders a test must be notified by the referring laboratory of the name and address of each laboratory location where the test was performed.

(j) All test reports or records of the information on the test reports must be maintained by the laboratory in a manner that permits ready identification and timely accessibility.

(k) When errors in the reported patient test results are detected, the laboratory must do the following:

(1) Promptly notify the authorized person ordering the test and, if applicable, the individual using the test results of reporting errors.

(2) Issue corrected reports promptly to the authorized person ordering the test and, if applicable, the individual using the test results.

(3) Maintain duplicates of the original report, as well as the corrected report.

(l) Upon request by a patient (or the patient’s personal representative), the laboratory may provide patients, their personal representatives, and those persons specified under 45 CFR 164.524(c)(3)(ii), as applicable, with access to completed test reports that, using the laboratory’s authentication process, can be identified as belonging to that patient.

§ 493.1299 Standard: Postanalytic systems quality assessment.

(a) The laboratory must establish and follow written policies and procedures for an ongoing mechanism to monitor, assess and, when indicated, correct problems identified in the postanalytic systems specified in § 493.1291.

(b) The postanalytic systems quality assessment must include a review of the effectiveness of corrective actions taken to resolve problems, revision of policies and procedures necessary to prevent recurrence of problems, and discussion of postanalytic systems quality assessment reviews with appropriate staff.

(c) The laboratory must document all postanalytic systems quality assessment activities.


Subpart L [Reserved]

Subpart M—Personnel for Nonwaived Testing

Source: 57 FR 7172, Feb. 28, 1992, unless otherwise noted.

§ 493.1351 General.

This subpart consists of the personnel requirements that must be met by laboratories performing moderate complexity testing, PPM procedures, high complexity testing, or any combination of these tests.

[60 FR 20049, Apr. 24, 1995]

§ 493.1353 Scope.

In accordance with §493.19(b), the moderate complexity procedures specified as PPM procedures are considered such only when personally performed by a health care provider during a patient visit in the context of a physical examination. PPM procedures are subject to the personnel requirements in §§ 493.1355 through 493.1365.

§ 493.1355 Condition: Laboratories performing PPM procedures; laboratory director.

The laboratory must have a director who meets the qualification requirements of §493.1357 and provides overall management and direction in accordance with §493.1359.

§ 493.1357 Standard; laboratory director qualifications.

The laboratory director must be qualified to manage and direct the laboratory personnel and the performance of PPM procedures as specified in §493.19(c) and must be eligible to be an operator of a laboratory within the requirements of subpart R of this part.

(a) The laboratory director must possess a current license as a laboratory director issued by the State in which the laboratory is located, if the licensing is required.

(b) The laboratory director must meet one of the following requirements:

(1) Be a physician, as defined in §493.2.

(2) Be a midlevel practitioner, as defined in §493.2, authorized by a State to practice independently in the State in which the laboratory is located.

(3) Be a dentist, as defined in §493.2.

§ 493.1361 Condition: Laboratories performing PPM procedures; testing personnel.

The laboratory must have a sufficient number of individuals who meet the qualification requirements of § 493.1363 to perform the functions specified in § 493.1365 for the volume and complexity of testing performed.

§ 493.1363 Standard: PPM testing personnel qualifications.

Each individual performing PPM procedures must—
(a) Possess a current license issued by the State in which the laboratory is located if the licensing is required; and
(b) Meet one of the following requirements:
(1) Be a physician, as defined in § 493.2.
(2) Be a midlevel practitioner, as defined in § 493.2, under the supervision of a physician or in independent practice if authorized by the State in which the laboratory is located.
(3) Be a dentist as defined in § 493.2 of this part.

§ 493.1365 Standard: PPM testing personnel responsibilities.

The testing personnel are responsible for specimen processing, test performance, and for reporting test results. Any PPM procedure must be—
(a) Personally performed by one of the following practitioners:
   (1) A physician during the patient’s visit on a specimen obtained from his or her own patient or from a patient of a group medical practice of which the physician is a member or employee.
   (2) A midlevel practitioner, under the supervision of a physician or in independent practice if authorized by the State in which the laboratory is located, during the patient’s visit on a specimen obtained from his or her own patient or from the patient of a clinic, group medical practice, or other health care provider, in which the midlevel practitioner is a member or an employee.
   (3) A dentist during the patient’s visit on a specimen obtained from his or her own patient or from a patient of a group dental practice of which the dentist is a member or an employee; and
   (b) Performed using a microscope limited to a brightfield or a phase/contrast microscope.

LABORATORIES PERFORMING MODERATE COMPLEXITY TESTING

§ 493.1403 Condition: Laboratories performing moderate complexity testing; laboratory director.

The laboratory must have a director who meets the qualification requirements of § 493.1405 of this subpart and provides overall management and direction in accordance with § 493.1407 of this subpart.

§ 493.1405 Standard; Laboratory director qualifications.

The laboratory director must be qualified to manage and direct the laboratory personnel and the performance of moderate complexity tests and must be eligible to be an operator of a laboratory within the requirements of subpart R of this part.
(a) The laboratory director must possess a current license as a laboratory director issued by the State in which the laboratory is located, if such licensing is required; and
(b) The laboratory director must—
   (1) (i) Be a doctor of medicine or doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; and
   (ii) Be certified in anatomic or clinical pathology, or both, by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification; or
   (2)(i) Be a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located; and
   (ii) Have had laboratory training or experience consisting of:
      (A) At least one year directing or supervising non-waived laboratory testing; or
      (B) Beginning September 1, 1993, have at least 20 continuing medical education credit hours in laboratory practice commensurate with the director responsibilities defined in § 493.1407; or
      (C) Laboratory training equivalent to paragraph (b)(2)(i)(B) of this section
obtained during medical residency. (For example, physicians certified either in hematology or hematology and medical oncology by the American Board of Internal Medicine); or

(3) Hold an earned doctoral degree in a chemical, physical, biological, or clinical laboratory science from an accredited institution; and

(i) Be certified by the American Board of Medical Microbiology, the American Board of Clinical Chemistry, the American Board of Bioanalysis, or the American Board of Medical Laboratory Immunology; or

(ii) Have had at least one year experience directing or supervising non-waived laboratory testing;

(4)(i) Have earned a master’s degree in a chemical, physical, biological or clinical laboratory science or medical technology from an accredited institution;

(ii) Have at least one year of laboratory training or experience, or both in non-waived testing; and

(iii) In addition, have at least one year of supervisory laboratory experience in non-waived testing; or

(5)(i) Have earned a bachelor’s degree in a chemical, physical, or biological science or medical technology from an accredited institution;

(ii) Have at least 2 years of laboratory training or experience, or both in non-waived testing; and

(iii) In addition, have at least 2 years of supervisory laboratory experience in non-waived testing;

(6) Be serving as a laboratory director and must have previously qualified or could have qualified as a laboratory director under §493.1406; or

(7) On or before February 28, 1992, qualified under State law to direct a laboratory in the State in which the laboratory is located.


§ 493.1406 Standard; Laboratory director qualifications on or before February 28, 1992.

The laboratory director must be qualified to manage and direct the laboratory personnel and test performance.

(a) The laboratory director must possess a current license as a laboratory director issued by the State, if such licensing exists; and

(b) The laboratory director must:

(1) Be a physician certified in anatomical or clinical pathology (or both) by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification;

(2) Be a physician who:

(i) Is certified by the American Board of Pathology or the American Osteopathic Board of Pathology in at least one of the laboratory specialties; or

(ii) Is certified by the American Board of Medical Microbiology, the American Board of Clinical Chemistry, the American Board of Bioanalysis, or other national accrediting board in one of the laboratory specialties; or

(iii) Is certified by the American Society of Cytopathology to practice cytopathology or possesses qualifications that are equivalent to those required for such certification; or

(iv) Subsequent to graduation, has had 4 or more years of full-time general laboratory training and experience of which at least 2 years were spent acquiring proficiency in one of the laboratory specialties;

(3) For the subspecialty of oral pathology only, be certified by the American Board of Oral Pathology, American Board of Pathology or the American Osteopathic Board of Pathology or possesses qualifications that are equivalent to those required for certification:

(4) Hold an earned doctoral degree from an accredited institution with a chemical, physical, or biological science as a major subject and

(i) Is certified by the American Board of Medical Microbiology, the American Board of Clinical Chemistry, the American Board of Bioanalysis, or other national accrediting board acceptable to HHS in one of the laboratory specialties; or

(ii) Subsequent to graduation, has had 4 or more years of full-time general laboratory training and experience of which at least 2 years were spent acquiring proficiency in one of the laboratory specialties;

(5) With respect to individuals first qualifying before July 1, 1971, have
been responsible for the direction of a laboratory for 12 months between July 1, 1961, and January 1, 1968, and, in addition, either:

(i) Was a physician and subsequent to graduation had at least 4 years of pertinent full-time laboratory experience;

(ii) Held a master’s degree from an accredited institution with a chemical, physical, or biological science as a major subject and subsequent to graduation had at least 4 years of pertinent full-time laboratory experience;

(iii) Held a bachelor’s degree from an accredited institution with a chemical, physical, or biological science as a major subject and subsequent to graduation had at least 6 years of pertinent full-time laboratory experience; or

(iv) Achieved a satisfactory grade through an examination conducted by or under the sponsorship of the U.S. Public Health Service on or before July 1, 1970; or

(6) Qualify under State law to direct the laboratory in the State in which the laboratory is located.

NOTE: The January 1, 1968 date for meeting the 12 months’ laboratory direction requirement in paragraph (b)(5) of this section may be extended 1 year for each year of full-time laboratory experience obtained before January 1, 1958 required by State law for a laboratory director license. An exception to the July 1, 1971 qualifying date in paragraph (b)(5) of this section was made provided that the individual requested qualification approval by October 21, 1975 and had been employed in a laboratory for at least 3 years of the 5 years preceding the date of submission of his qualifications.

[58 FR 5233, Jan. 19, 1993]

§ 493.1407 Standard; Laboratory director responsibilities.

The laboratory director is responsible for the overall operation and administration of the laboratory, including the employment of personnel who are competent to perform test procedures, and record and report test results promptly, accurately, and proficiently and for assuring compliance with the applicable regulations.

(a) The laboratory director, if qualified, may perform the duties of the technical consultant, clinical consultant, and testing personnel, or delegate these responsibilities to personnel meeting the qualifications of §§ 493.1409, 493.1415, and 493.1421, respectively.

(b) If the laboratory director reappor- tions performance of his or her responsibilities, he or she remains responsible for ensuring that all duties are properly performed.

(c) The laboratory director must be accessible to the laboratory to provide onsite, telephone or electronic consultation as needed.

(d) Each individual may direct no more than five laboratories.

(e) The laboratory director must—

1. Ensure that testing systems developed and used for each of the tests performed in the laboratory provide quality laboratory services for all aspects of test performance, which includes the preanalytic, analytic, and postanalytic phases of testing;

2. Ensure that the physical plant and environmental conditions of the laboratory are appropriate for the testing performed and provide a safe environment in which employees are protected from physical, chemical, and biological hazards;

3. Ensure that—

(i) The test methodologies selected have the capability of providing the quality of results required for patient care;

(ii) Verification procedures used are adequate to determine the accuracy, precision, and other pertinent performance characteristics of the method; and

(iii) Laboratory personnel are performing the test methods as required for accurate and reliable results;

4. Ensure that the laboratory is enrolled in an HHS approved proficiency testing program for the testing performed and that—

(i) The proficiency testing samples are tested as required under subpart H of this part;

(ii) The results are returned within the timeframes established by the proficiency testing program;

(iii) All proficiency testing reports received are reviewed by the appropriate staff to evaluate the laboratory’s performance and to identify any problems that require corrective action; and

(iv) An approved corrective action plan is followed when any proficiency
Centers for Medicare & Medicaid Services, HHS § 493.1411

(5) Ensure that the quality control and quality assessment programs are established and maintained to assure the quality of laboratory services provided and to identify failures in quality as they occur;

(6) Ensure the establishment and maintenance of acceptable levels of analytical performance for each test system;

(7) Ensure that all necessary remedial actions are taken and documented whenever significant deviations from the laboratory’s established performance specifications are identified, and that patient test results are reported only when the system is functioning properly;

(8) Ensure that reports of test results include pertinent information required for interpretation;

(9) Ensure that consultation is available to the laboratory’s clients on matters relating to the quality of the test results reported and their interpretation concerning specific patient conditions;

(10) Employ a sufficient number of laboratory personnel with the appropriate education and either experience or training to provide appropriate consultation, properly supervise and accurately perform tests and report test results in accordance with the personnel responsibilities described in this subpart;

(11) Ensure that prior to testing patients’ specimens, all personnel have the appropriate education and experience, receive the appropriate training for the type and complexity of the services offered, and have demonstrated that they can perform all testing operations reliably to provide and report accurate results;

(12) Ensure that policies and procedures are established for monitoring individuals who conduct preanalytical, analytical, and postanalytical phases of testing to assure that they are competent and maintain their competency to process specimens, perform test procedures and report test results promptly and proficiently, and whenever necessary, identify needs for remedial training or continuing education to improve skills;

(13) Ensure that an approved procedure manual is available to all personnel responsible for any aspect of the testing process; and

(14) Specify, in writing, the responsibilities and duties of each consultant and each person, engaged in the performance of the preanalytic, analytic, and postanalytic phases of testing, that identifies which examinations and procedures each individual is authorized to perform, whether supervision is required for specimen processing, test performance or results reporting, and whether consultant or director review is required prior to reporting patient test results.


§ 493.1409 Condition: Laboratories performing moderate complexity testing; technical consultant.

The laboratory must have a technical consultant who meets the qualification requirements of § 493.1411 of this subpart and provides technical oversight in accordance with § 493.1413 of this subpart.

§ 493.1411 Standard; Technical consultant qualifications.

The laboratory must employ one or more individuals who are qualified by education and either training or experience to provide technical consultation for each of the specialties and subspecialties of service in which the laboratory performs moderate complexity tests or procedures. The director of a laboratory performing moderate complexity testing may function as the technical consultant provided he or she meets the qualifications specified in this section.

(a) The technical consultant must possess a current license issued by the State in which the laboratory is located, if such licensing is required.

(b) The technical consultant must—

(1) (i) Be a doctor of medicine or doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; and

(ii) Be certified in anatomic or clinical pathology, or both, by the American Board of Pathology or the American Osteopathic Board of Pathology or
§ 493.1413 Standard; Technical consultant responsibilities.

The technical consultant is responsible for the technical and scientific oversight of the laboratory. The technical consultant is not required to be onsite at all times testing is performed; however, he or she must be available to the laboratory on an as needed basis to provide consultation, as specified in paragraph (a) of this section.

(a) The technical consultant must be accessible to the laboratory to provide on-site, telephone, or electronic consultation; and

(b) The technical consultant is responsible for—

(1) Selection of test methodology appropriate for the clinical use of the test results;

(2) Verification of the test procedures performed and the establishment of the laboratory’s test performance characteristics, including the precision and accuracy of each test and test system;

(3) Enrollment and participation in an HHS approved proficiency testing program commensurate with the services offered;

(4) Establishing a quality control program appropriate for the testing performed and establishing the parameters for acceptable levels of analytic performance and ensuring that these levels are maintained throughout the entire testing process from the initial receipt of the specimen, through sample analysis and reporting of test results;

(5) Resolving technical problems and ensuring that remedial actions are taken whenever test systems deviate from the laboratory’s established performance specifications;

(6) Ensuring that patient test results are not reported until all corrective actions have been taken and the test system is functioning properly;

(7) Identifying training needs and assuring that each individual performing tests receives regular in-service training and education appropriate for the type and complexity of the laboratory services performed;

(8) Evaluating the competency of all testing personnel and assuring that the staff maintain their competency to perform test procedures and report test

Note: The technical consultant requirements for “laboratory training or experience, or both” in each specialty or subspecialty may be acquired concurrently in more than one of the specialties or subspecialties of service, excluding waived tests. For example, an individual who has a bachelor’s degree in biology and additionally has documentation of 2 years of work experience performing tests of moderate complexity in all specialties and subspecialties of service, would be qualified as a technical consultant in a laboratory performing moderate complexity testing in all specialties and subspecialties of service.

Centers for Medicare & Medicaid Services, HHS § 493.1423

results promptly, accurately and proficiently. The procedures for evaluation of the competency of the staff must include, but are not limited to—

(i) Direct observations of routine patient test performance, including patient preparation, if applicable, specimen handling, processing and testing;
(ii) Monitoring the recording and reporting of test results;
(iii) Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventive maintenance records;
(iv) Direct observation of performance of instrument maintenance and function checks;
(v) Assessment of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples; and
(vi) Assessment of problem solving skills; and
(9) Evaluating and documenting the performance of individuals responsible for moderate complexity testing at least semiannually during the first year the individual tests patient specimens. Thereafter, evaluations must be performed at least annually unless test methodology or instrumentation changes, in which case, prior to reporting patient test results, the individual’s performance must be reevaluated to include the use of the new test methodology or instrumentation.

§ 493.1415 Condition: Laboratories performing moderate complexity testing; clinical consultant.

The laboratory must have a clinical consultant who meets the qualification requirements of § 493.1417 of this part and provides clinical consultation in accordance with § 493.1419 of this part.

§ 493.1417 Standard; Clinical consultant qualifications.

The clinical consultant must be qualified to consult with and render opinions to the laboratory’s clients concerning the diagnosis, treatment and management of patient care. The clinical consultant must—

(a) Be qualified as a laboratory director under § 493.1405(b)(1), (2), or (3)(i); or
(b) Be a doctor of medicine, doctor of osteopathy or doctor of pediatric medicine and possess a license to practice medicine, osteopathy or podiatry in the State in which the laboratory is located.


§ 493.1419 Standard; Clinical consultant responsibilities.

The clinical consultant provides consultation regarding the appropriateness of the testing ordered and interpretation of test results. The clinical consultant must—

(a) Be available to provide clinical consultation to the laboratory’s clients;
(b) Be available to assist the laboratory’s clients in ensuring that appropriate tests are ordered to meet the clinical expectations;
(c) Ensure that reports of test results include pertinent information required for specific patient interpretation; and
(d) Ensure that consultation is available and communicated to the laboratory’s clients on matters related to the quality of the test results reported and their interpretation concerning specific patient conditions.

§ 493.1421 Condition: Laboratories performing moderate complexity testing; testing personnel.

The laboratory must have a sufficient number of individuals who meet the qualification requirements of § 493.1423, to perform the functions specified in § 493.1425 for the volume and complexity of tests performed.

§ 493.1423 Standard; Testing personnel qualifications.

Each individual performing moderate complexity testing must—

(a) Possess a current license issued by the State in which the laboratory is located, if such licensing is required; and
(b) Meet one of the following requirements:
(1) Be a doctor of medicine or doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located or have earned a doctoral, master’s, or bachelor’s degree in a chemical, physical,
§ 493.1425  Standard; Testing personnel responsibilities.

The testing personnel are responsible for specimen processing, test performance, and for reporting test results.

(a) Each individual performs only those moderate complexity tests that are authorized by the laboratory director and require a degree of skill commensurate with the individual’s education, training or experience, and technical abilities.

(b) Each individual performing moderate complexity testing must—

(1) Follow the laboratory’s procedures for specimen handling and processing, test analyses, reporting and maintaining records of patient test results;

(2) Maintain records that demonstrate that proficiency testing samples are tested in the same manner as patient samples;

(3) Adhere to the laboratory’s quality control policies, document all quality control activities, instrument and procedural calibrations and maintenance performed;

(4) Follow the laboratory’s established corrective action policies and procedures whenever test systems are not within the laboratory’s established acceptable levels of performance;

(5) Be capable of identifying problems that may adversely affect test performance or reporting of test results and either must correct the problems or immediately notify the technical consultant, clinical consultant or director;

(6) Document all corrective actions taken when test systems deviate from the laboratory’s established performance specifications.

§ 493.1441 Condition: Laboratories performing high complexity testing; laboratory director.

The laboratory must have a director who meets the qualification requirements of §493.1443 of this subpart and provides overall management and direction in accordance with §493.1445 of this subpart.

§ 493.1443 Standard; Laboratory director qualifications.

The laboratory director must be qualified to manage and direct the laboratory personnel and performance of
The laboratory director must possess a current license as a laboratory director issued by the State in which the laboratory is located, if such licensing is required; and
(b) The laboratory director must—
(1)(i) Be a doctor of medicine or doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; and
(ii) Be certified in anatomic or clinical pathology, or both, by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification; or
(2) Be a doctor of medicine, a doctor of osteopathy or doctor of podiatric medicine licensed to practice medicine, osteopathy or podiatry in the State in which the laboratory is located; and
(i) Have at least one year of laboratory training during medical residency (for example, physicians certified either in hematology or hematology and medical oncology by the American Board of Internal Medicine); or
(ii) Have at least 2 years of experience directing or supervising high complexity testing; or
(3) Hold an earned doctoral degree in a chemical, physical, biological, or clinical laboratory science from an accredited institution and—
(i) Be certified and continue to be certified by a board approved by HHS; or
(ii) Before February 24, 2003, must have served or be serving as a director of a laboratory performing high complexity testing and must have at least—
(A) Two years of laboratory training or experience, or both; and
(B) Two years of laboratory experience directing or supervising high complexity testing.
(4) Be serving as a laboratory director and must have previously qualified or could have qualified as a laboratory director under regulations at 42 CFR 493.1415, published March 14, 1990 at 55 FR 9638, or on or before February 28, 1992; or
(5) On or before February 28, 1992, be qualified under State law to direct a laboratory in the State in which the laboratory is located; or
(6) For the subspecialty of oral pathology, be certified by the American Board of Oral Pathology, American Board of Pathology, the American Osteopathic Board of Pathology, or possess qualifications that are equivalent to those required for certification.

§ 493.1445 Standard; Laboratory director responsibilities.

The laboratory director is responsible for the overall operation and administration of the laboratory, including the employment of personnel who are competent to perform test procedures, record and report test results promptly, accurately and proficiently, and for assuring compliance with the applicable regulations.
(a) The laboratory director, if qualified, may perform the duties of the technical supervisor, clinical consultant, general supervisor, and testing personnel, or delegate these responsibilities to personnel meeting the qualifications under §§493.1447, 493.1453, 493.1459, and 493.1487, respectively.
(b) If the laboratory director reappor- tions performance of his or her responsibilities, he or she remains responsible for ensuring that all duties are properly performed.
(c) The laboratory director must be accessible to the laboratory to provide onsite, telephone or electronic consultation as needed.
(d) Each individual may direct no more than five laboratories.
(e) The laboratory director must—
(1) Ensure that testing systems developed and used for each of the tests performed in the laboratory provide quality laboratory services for all aspects of test performance, which includes the preanalytic, analytic, and postanalytic phases of testing;
(2) Ensure that the physical plant and environmental conditions of the
(3) Ensure that—
   (i) The test methodologies selected have the capability of providing the quality of results required for patient care;
   (ii) Verification procedures used are adequate to determine the accuracy, precision, and other pertinent performance characteristics of the method; and
   (iii) Laboratory personnel are performing the test methods as required for accurate and reliable results;
(4) Ensure that the laboratory is enrolled in an HHS-approved proficiency testing program for the testing performed and that—
   (i) The proficiency testing samples are tested as required under subpart H of this part;
   (ii) The results are returned within the timeframes established by the proficiency testing program;
   (iii) All proficiency testing reports received are reviewed by the appropriate staff to evaluate the laboratory’s performance and to identify any problems that require corrective action; and
   (iv) An approved corrective action plan is followed when any proficiency testing result is found to be unacceptable or unsatisfactory;
(5) Ensure that the quality control and quality assessment programs are established and maintained to assure the quality of laboratory services provided and to identify failures in quality as they occur;
(6) Ensure the establishment and maintenance of acceptable levels of analytical performance for each test system;
(7) Ensure that all necessary remedial actions are taken and documented whenever significant deviations from the laboratory’s established performance characteristics are identified, and that patient test results are reported only when the system is functioning properly;
(8) Ensure that reports of test results include pertinent information required for interpretation;
(9) Ensure that consultation is available to the laboratory’s clients on matters relating to the quality of the test results reported and their interpretation concerning specific patient conditions;
(10) Ensure that a general supervisor provides on-site supervision of high complexity test performance by testing personnel qualified under §493.1489(b)(4);
(11) Employ a sufficient number of laboratory personnel with the appropriate education and either experience or training to provide appropriate consultation, properly supervise and accurately perform tests and report test results in accordance with the personnel responsibilities described in this subpart;
(12) Ensure that prior to testing patients’ specimens, all personnel have the appropriate education and experience, receive the appropriate training for the type and complexity of the services offered, and have demonstrated that they can perform all testing operations reliably to provide and report accurate results;
(13) Ensure that policies and procedures are established for monitoring individuals who conduct preanalytical, analytical, and postanalytical phases of testing to assure that they are competent and maintain their competency to process specimens, perform test procedures and report test results promptly and proficiently, and whenever necessary, identify needs for remedial training or continuing education to improve skills;
(14) Ensure that an approved procedure manual is available to all personnel responsible for any aspect of the testing process; and
(15) Specify, in writing, the responsibilities and duties of each consultant and each supervisor, as well as each person engaged in the performance of the preanalytic, analytic, and postanalytic phases of testing, that identifies which examinations and procedures each individual is authorized to perform, whether supervision is required for specimen processing, test performance or result reporting and whether supervisory or director review
§ 493.1447 Condition: Laboratories performing high complexity testing; technical supervisor.

The laboratory must have a technical supervisor who meets the qualification requirements of § 493.1449 of this subpart and provides technical supervision in accordance with § 493.1451 of this subpart.

§ 493.1449 Standard; Technical supervisor qualifications.

The laboratory must employ one or more individuals who are qualified by education and either training or experience to provide technical supervision for each of the specialties and subspecialties of service in which the laboratory performs high complexity tests or procedures. The director of a laboratory performing high complexity testing may function as the technical supervisor provided he or she meets the qualifications specified in this section.

(a) The technical supervisor must possess a current license issued by the State in which the laboratory is located, if such licensing is required; and

(b) The laboratory may perform anatomic and clinical laboratory procedures and tests in all specialties and subspecialties of services except histocompatibility and clinical cytogentics services provided the individual functioning as the technical supervisor—

(1) Is a doctor of medicine or doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; and

(2) Is certified in both anatomic and clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possesses qualifications that are equivalent to those required for such certification; or

(2)(i) Be a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located; and

(ii) Have at least one year of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of bacteriology; or

(3)(i) Have an earned doctoral degree in a chemical, physical, biological or clinical laboratory science from an accredited institution; and

(ii) Have at least one year of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of bacteriology; or

(4)(i) Have earned a master’s degree in a chemical, physical, biological or clinical laboratory science or medical technology from an accredited institution; and

(ii) Have at least 2 years of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of bacteriology; or

(5)(i) Have earned a bachelor’s degree in a chemical, physical, or biological science or medical technology from an accredited institution; and

(ii) Have at least 4 years of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of bacteriology.

(d) If the requirements of paragraph (b) of this section are not met and the
laboratory performs tests in the subspecialty of mycobacteriology, the individual functioning as the technical supervisor must—

(1)(i) Be a doctor of medicine or doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; and
(ii) Be certified in clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification; or

(2)(i) Be a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located; and
(ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of mycobacteriology; or

(3)(i) Have an earned doctoral degree in a chemical, physical, biological or clinical laboratory science from an accredited institution; and
(ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of mycobacteriology; or

(4)(i) Have earned a master’s degree in a chemical, physical, biological, or clinical laboratory science or medical technology from an accredited institution; and
(ii) Have at least 2 years of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of mycobacteriology; or

(5)(i) Have earned a bachelor’s degree in a chemical, physical, or biological science or medical technology from an accredited institution; and
(ii) Have at least 4 years of laboratory training or experience, or both, in high complexity testing within the subspecialty of mycobacteriology.

(e) If the requirements of paragraph (b) of this section are not met and the laboratory performs tests in the subspecialty of mycology, the individual functioning as the technical supervisor must—

(1)(i) Be a doctor of medicine or doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; and
(ii) Be certified in clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification; or

(2)(i) Be a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located; and
(ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of mycology; or

(3)(i) Have an earned doctoral degree in a chemical, physical, biological or clinical laboratory science from an accredited institution; and
(ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of mycology; or

(4)(i) Have earned a master’s degree in a chemical, physical, biological, or clinical laboratory science or medical technology from an accredited institution; and
(ii) Have at least 2 years of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of mycology; or

(5)(i) Have earned a bachelor’s degree in a chemical, physical, or biological science or medical technology from an accredited institution; and
(ii) Have at least 4 years of laboratory training or experience, or both, in high complexity testing within the subspecialty of mycology; or
high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of mycology.

(f) If the requirements of paragraph (b) of this section are not met and the laboratory performs tests in the subspecialty of parasitology, the individual functioning as the technical supervisor must—

   (1)(i) Be a doctor of medicine or a doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; and
   (ii) Be certified in clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification; or

   (2)(i) Be a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located; and
   (ii) Have at least one year of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of parasitology;

   (3)(i) Have an earned doctoral degree in a chemical, physical, biological or clinical laboratory science from an accredited institution; and
   (ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of parasitology; or

   (4)(i) Have earned a master’s degree in a chemical, physical, biological or clinical laboratory science or medical technology from an accredited institution; and
   (ii) Have at least 2 years of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of parasitology; or

   (5)(i) Have earned a bachelor’s degree in a chemical, physical or biological science or medical technology from an accredited institution; and
   (ii) Have at least 4 years of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of parasitology.

(g) If the requirements of paragraph (b) of this section are not met and the laboratory performs tests in the subspecialty of virology, the individual functioning as the technical supervisor must—

   (1)(i) Be a doctor of medicine or doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; and
   (ii) Be certified in clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification; or

   (2)(i) Be a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located; and
   (ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of virology; or

   (3)(i) Have an earned doctoral degree in a chemical, physical, biological or clinical laboratory science from an accredited institution; and
   (ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of virology; or

   (4)(i) Have earned a master’s degree in a chemical, physical, biological or clinical laboratory science or medical technology from an accredited institution; and
   (ii) Have at least 2 years of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of virology; or

   (5)(i) Have earned a bachelor’s degree in a chemical, physical or biological science or medical technology from an accredited institution; and
   (ii) Have at least 4 years of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of virology.
of 6 months experience in high complexity testing within the subspecialty of virology; or

(5)(i) Have earned a bachelor’s degree in a chemical, physical or biological science or medical technology from an accredited institution; and

(ii) Have at least 4 years of laboratory training or experience, or both, in high complexity testing within the specialty of microbiology with a minimum of 6 months experience in high complexity testing within the subspecialty of virology.

(h) If the requirements of paragraph (b) of this section are not met and the laboratory performs tests in the specialty of diagnostic immunology, the individual functioning as the technical supervisor must—

(1)(i) Be a doctor of medicine or a doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; and

(ii) Be certified in clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification; or

(2)(i) Be a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located; and

(ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing for the specialty of diagnostic immunology; or

(3)(i) Have an earned doctoral degree in a chemical, physical, biological or clinical laboratory science from an accredited institution; and

(ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing within the specialty of diagnostic immunology; or

(4)(i) Have earned a master’s degree in a chemical, physical, biological or clinical laboratory science or medical technology from an accredited institution; and

(ii) Have at least 2 years of laboratory training or experience, or both, in high complexity testing for the specialty of diagnostic immunology; or

(5)(i) Have earned a bachelor’s degree in a chemical, physical or biological science or medical technology from an accredited institution; and

(ii) Have at least 4 years of laboratory training or experience, or both, in high complexity testing for the specialty of diagnostic immunology.

(i) If the requirements of paragraph (b) of this section are not met and the laboratory performs tests in the specialty of chemistry, the individual functioning as the technical supervisor must—

(1)(i) Be a doctor of medicine or doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; and

(ii) Be certified in clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification; or

(2)(i) Be a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located; and

(ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing for the specialty of chemistry; or

(3)(i) Have an earned doctoral degree in a chemical, physical, biological or clinical laboratory science from an accredited institution; and

(ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing within the specialty of chemistry; or

(4)(i) Have earned a master’s degree in a chemical, physical, biological or clinical laboratory science or medical technology from an accredited institution; and

(ii) Have at least 2 years of laboratory training or experience, or both, in high complexity testing for the specialty of chemistry; or

(5)(i) Have earned a bachelor’s degree in a chemical, physical or biological science or medical technology from an accredited institution; and

(ii) Have at least 4 years of laboratory training or experience, or both, in high complexity testing for the specialty of chemistry.
Centers for Medicare & Medicaid Services, HHS
§ 493.1449

Laboratory performs tests in the specialty of hematology, the individual functioning as the technical supervisor must—

(1)(i) Be a doctor of medicine or a doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; and

(ii) Be certified in clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification; or

(2)(i) Be a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located; and

(ii) Have at least one year of laboratory training or experience, or both, in high complexity testing for the specialty of hematology (for example, physicians certified either in hematology or hematology and medical oncology by the American Board of Internal Medicine); or

(3)(i) Have an earned doctoral degree in a chemical, physical, biological or clinical laboratory science from an accredited institution; and

(ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing for the specialty of hematology; or

(4)(i) Have earned a master’s degree in a chemical, physical, biological or clinical laboratory science or medical technology from an accredited institution; and

(ii) Have at least 2 years of laboratory training or experience, or both, in high complexity testing for the specialty of hematology; or

(5)(i) Have earned a bachelor’s degree in a chemical, physical or biological science or medical technology from an accredited institution; and

(ii) Have at least 4 years of laboratory training or experience, or both, in high complexity testing for the specialty of hematology.

(k)(1) If the requirements of paragraph (b) of this section are not met and the laboratory performs tests in the subspecialty of cytology, the individual functioning as the technical supervisor must—

(i) Be a doctor of medicine or a doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; and

(ii) Meet one of the following requirements—

(A) Be certified in anatomic pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification; or

(B) Be certified by the American Society of Cytopathology to practice cytopathology or possess qualifications that are equivalent to those required for such certification;

(2) An individual qualified under § 493.1449(b) or paragraph (k)(1) of this section may delegate some of the cytology technical supervisor responsibilities to an individual who is in the final year of full-time training leading to certification specified in paragraphs (b) or (k)(1)(ii)(A) of this section provided the technical supervisor qualified under § 493.1449(b) or paragraph (k)(1) of this section remains ultimately responsible for ensuring that all of the responsibilities of the cytology technical supervisor are met.

(l) If the requirements of paragraph (b) of this section are not met and the laboratory performs tests in the subspecialty of histopathology, the individual functioning as the technical supervisor must—

(1) Meet one of the following requirements—

(i) (A) Be a doctor of medicine or a doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; and

(B) Be certified in anatomic pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification;

(ii) An individual qualified under § 493.1449(b) or paragraph (l)(1) of this section may delegate to an individual who is a resident in a training program leading to certification specified in paragraph (b) or (l)(1)(ii)(B) of this section, the responsibility for examination and interpretation of histopathology specimens.
(2) For tests in dermatopathology, meet one of the following requirements:

(i) (A) Be a doctor of medicine or doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located and—
   (B) Meet one of the following requirements:
      (1) Be certified in anatomic pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification; or
      (2) Be certified in dermatopathology by the American Board of Dermatology and the American Board of Pathology or possess qualifications that are equivalent to those required for such certification; or
      (3) Be certified in dermatology by the American Board of Dermatology or possess qualifications that are equivalent to those required for such certification; or
   (ii) An individual qualified under § 493.1449(b) or paragraph (1)(3)(i) of this section may delegate to an individual who is a resident in a training program leading to certification specified in paragraphs (b) or (1)(3)(i)(B) of this section, the responsibility for examination and interpretation of dermatopathology specimens; or

(m) If the requirements of paragraph (b) of this section are not met and the laboratory performs tests in the subspecialty of oral pathology, the individual functioning as the technical supervisor must meet one of the following requirements:

(1)(i) Be a doctor of medicine or a doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located and—
   (ii) Be certified in anatomic pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification; or

(2) Be certified in oral pathology by the American Board of Oral Pathology or possess qualifications for such certification; or

(n) If the requirements of paragraph (b) of this section are not met and the laboratory performs tests in the specialty of radiobioassay, the individual functioning as the technical supervisor must—

(i) Be a doctor of medicine or a doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located and—
   (ii) Be certified in clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification; or

(ii) Be a doctor of medicine, doctor of osteopathy, or doctor of pediatric
Centers for Medicare & Medicaid Services, HHS § 493.1449

medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located; and

(ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing for the specialty of radiobioassay; or

(ii) Have training or experience that meets one of the following requirements:
(A) Have 4 years of laboratory training or experience, or both, within the specialty of histocompatibility; or
(B)(i) Have 2 years of laboratory training or experience, or both, in the specialty of general immunology; and
(2) Have 2 years of laboratory training or experience, or both, in the specialty of histocompatibility.

(o) If the laboratory performs tests in the specialty of histocompatibility, the individual functioning as the technical supervisor must—

(1)(i) Be a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located; and
(ii) Have training or experience that meets one of the following requirements:
(A) Have 4 years of laboratory training or experience, or both, within the specialty of histocompatibility; or
(B)(i) Have 2 years of laboratory training or experience, or both, in the specialty of general immunology; and
(ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing for the specialty of radiobioassay; or

(ii) Have an earned doctoral degree in a chemical, physical, biological or clinical laboratory science from an accredited institution; and

(ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing within the specialty of radiobioassay; or

(ii) Have at least 1 year of laboratory training or experience, or both, in the specialty of histocompatibility.

(p) If the laboratory performs tests in the specialty of clinical cytogenetics, the individual functioning as the technical supervisor must—

(1)(i) Be a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located; and
(ii) Have 4 years of training or experience, or both, in genetics, 2 of which have been in clinical cytogenetics; or

(2)(i) Hold an earned doctoral degree in a biological science, including biochemistry, or clinical laboratory science from an accredited institution; and
(ii) Have at least one year of laboratory training or experience, or both, in genetics, 2 of which have been in clinical cytogenetics.

(q) If the requirements of paragraph (b) of this section are not met and the laboratory performs tests in the specialty of immunohematology, the individual functioning as the technical supervisor must—

(1)(i) Be a doctor of medicine or a doctor of osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located; and
(ii) Be certified in clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications that are equivalent to those required for such certification; or

(2)(i) Be a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located; and
(ii) Have at least one year of laboratory training or experience, or both, in high complexity testing for the specialty of immunohematology.

The technical supervisor is responsible for the technical and scientific oversight of the laboratory. The technical supervisor is not required to be on site at all times testing is performed; however, he or she must be available to the laboratory on an as needed basis to provide supervision as specified in (a) of this section.

(a) The technical supervisor must be accessible to the laboratory to provide on-site, telephone, or electronic consultation; and

(b) The technical supervisor is responsible for—

(1) Selection of the test methodology that is appropriate for the clinical use of the test results;

(2) Verification of the test procedures performed and establishment of the laboratory’s test performance characteristics, including the precision and accuracy of each test and test system;

(3) Enrollment and participation in an HHS approved proficiency testing program commensurate with the services offered;

(4) Establishing a quality control program appropriate for the testing performed and establishing the parameters for acceptable levels of analytic performance and ensuring that these levels are maintained throughout the entire testing process from the initial receipt of the specimen, through sample analysis and reporting of test results;

(5) Resolving technical problems and ensuring that remedial actions are taken whenever test systems deviate from the laboratory’s established performance specifications;

(6) Ensuring that patient test results are not reported until all corrective actions have been taken and the test system is functioning properly;

(7) Identifying training needs and assuring that each individual performing tests receives regular in-service training and education appropriate for the type and complexity of the laboratory services performed;

(8) Evaluating the competency of all testing personnel and assuring that the staff maintain their competency to perform test procedures and report test results promptly, accurately and proficiently. The procedures for evaluation of the competency of the staff must include, but are not limited to—

(i) Direct observations of routine patient test performance, including patient preparation, if applicable, specimen handling, processing and testing;

(ii) Monitoring the recording and reporting of test results;

(iii) Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventive maintenance records;

(iv) Direct observation of performance of instrument maintenance and function checks;

(v) Assessment of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples; and

(vi) Assessment of problem solving skills; and

(9) Evaluating and documenting the performance of individuals responsible for high complexity testing at least semiannually during the first year the individual tests patient specimens. Thereafter, evaluations must be performed at least annually unless test methodology or instrumentation changes, in which case, prior to reporting patient test results, the individual’s performance must be reevaluated to include the use of the new test methodology or instrumentation.

(c) In cytology, the technical supervisor or the individual qualified under § 493.1449(k)(2)—
§ 493.1453 Condition: Laboratories performing high complexity testing; clinical consultant.

The laboratory must have a clinical consultant who meets the requirements of §493.1455 of this subpart and provides clinical consultation in accordance with §493.1457 of this subpart.

§ 493.1455 Standard; Clinical consultant qualifications.

The clinical consultant must be qualified to consult with and render opinions to the laboratory’s clients concerning the diagnosis, treatment and management of patient care. The clinical consultant must—

(a) Be qualified as a laboratory director under §493.1443(b)(1), (2), or (3)(i) or, for the subspecialty of oral pathology, §493.1443(b)(6); or

(b) Be a doctor of medicine, doctor of osteopathy, doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located.


§ 493.1457 Standard; Clinical consultant responsibilities.

The clinical consultant provides consultation regarding the appropriateness of the testing ordered and interpretation of test results. The clinical consultant must—

(a) Be available to provide consultation to the laboratory’s clients;

(b) Be available to assist the laboratory’s clients in ensuring that appropriate tests are ordered to meet the clinical expectations;

(c) Ensure that reports of test results include pertinent information required for specific patient interpretation; and

(d) Ensure that consultation is available and communicated to the laboratory’s clients on matters related to the quality of the test results reported and their interpretation concerning specific patient conditions.

§ 493.1459 Condition: Laboratories performing high complexity testing; general supervisor.

The laboratory must have one or more general supervisors who are qualified under §493.1461 of this subpart to provide general supervision in accordance with §493.1463 of this subpart.

§ 493.1461 Standard; General supervisor qualifications.

The laboratory must have one or more general supervisors who, under the direction of the laboratory director and supervision of the technical supervisor, provides day-to-day supervision of testing personnel and reporting of test results. In the absence of the director and technical supervisor, the general supervisor must be responsible for the proper performance of all laboratory procedures and reporting of test results.

(a) The general supervisor must possess a current license issued by the State in which the laboratory is located, if such licensing is required; and

(b) The general supervisor must be qualified as a—

(1) Laboratory director under §493.1443; or

(2) Technical supervisor under §493.1449.

(c) If the requirements of paragraph (b)(1) or paragraph (b)(2) of this section
are not met, the individual functioning as the general supervisor must—

(1)(i) Be a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located or have earned a doctoral, master's, or bachelor's degree in a chemical, physical, biological or clinical laboratory science, or medical technology from an accredited institution; and

(ii) Have at least 1 year of laboratory training or experience, or both, in high complexity testing; or

(2)(i) Qualify as testing personnel under §493.1489(b)(2); and

(ii) Have at least 2 years of laboratory training or experience, or both, in high complexity testing; or

(3)(i) Except as specified in paragraph (3)(ii) of this section, have previously qualified as a general supervisor under §493.1462 on or before February 28, 1992.

(ii)

Exception. An individual who achieved a satisfactory grade in a proficiency examination for technologist given by HHS between March 1, 1986 and December 31, 1987, qualifies as a general supervisor if he or she meets the requirements of §493.1462 on or before January 1, 1994."

(4) On or before September 1, 1992, have served as a general supervisor of high complexity testing and as of April 24, 1995—

(i) Meet one of the following requirements:

(A) Have graduated from a medical laboratory or clinical laboratory training program approved or accredited by the Accrediting Bureau of Health Education Schools (ABHES), the Commission on Allied Health Education Accreditation (CAHEA), or other organization approved by HHS.

(B) Be a high school graduate or equivalent and have successfully completed an official U.S. military medical laboratory procedures course of at least 50 weeks duration and have held the military enlisted occupational specialty of Medical Laboratory Specialist (Laboratory Technician).

(ii) Have at least 2 years of clinical laboratory training, or experience, or both, in high complexity testing; or

(5) On or before September 1, 1992, have served as a general supervisor of high complexity testing and—

(i) Be a high school graduate or equivalent; and

(ii) Have had at least 10 years of laboratory training or experience, or both, in high complexity testing, including at least 6 years of supervisory experience between September 1, 1982 and September 1, 1992.

(d) For blood gas analysis, the individual providing general supervision must—

(1) Be qualified under §493.1461(b) (1) or (2), or §493.1461(c); or

(2)(i) Have earned a bachelor's degree in respiratory therapy or cardiovascular technology from an accredited institution; and

(ii) Have at least one year of laboratory training or experience, or both, in blood gas analysis; or

(3)(i) Have earned an associate degree related to pulmonary function from an accredited institution; and

(ii) Have at least two years of training or experience, or both in blood gas analysis.

(e) The general supervisor requirement is met in histopathology, oral pathology, dermatopathology, and ophthalmic pathology because all tests and examinations, must be performed:

(1) In histopathology, by an individual who is qualified as a technical supervisor under §493.1449(b) or §493.1449(l)(1);

(2) In dermatopathology, by an individual who is qualified as a technical supervisor under §493.1449(b) or §493.1449(l) or (2);

(3) In ophthalmic pathology, by an individual who is qualified as a technical supervisor under §493.1449(b) or §493.1449(1)(3); and

(4) In oral pathology, by an individual who is qualified as a technical supervisor under §493.1449(b) or §493.1449(m).

must have met or could have met the following qualifications as they were in effect on or before February 28, 1992.
(a) Each supervisor possesses a current license as a laboratory supervisor issued by the State, if such licensing exists; and
(b) The laboratory supervisor—
(1) Who qualifies as a laboratory director under §493.1406(b)(1), (2), (4), or (5) is also qualified as a general supervisor; therefore, depending upon the size and functions of the laboratory, the laboratory director may also serve as the laboratory supervisor; or
(2)(i) Is a physician or has earned a doctoral degree from an accredited institution with a major in one of the chemical, physical, or biological sciences; and
(ii) Subsequent to graduation, has had at least 2 years of experience in one of the laboratory specialties in a laboratory; or
(3)(i) Holds a master’s degree from an accredited institution with a major in one of the chemical, physical, or biological sciences; and
(ii) Subsequent to graduation has had at least 4 years of pertinent full-time laboratory experience of which not less than 2 years have been spent working in the designated specialty in a laboratory; or
(4)(i) Is qualified as a laboratory technologist under §493.1491; and
(ii) After qualifying as a laboratory technologist, has had at least 6 years of pertinent full-time laboratory experience of which not less than 2 years have been spent working in the designated laboratory specialty in a laboratory; or
(5) With respect to individuals first qualifying before July 1, 1971, has had at least 15 years of pertinent full-time laboratory experience before January 1, 1968; this required experience may be met by the substitution of education for experience.

The general supervisor is responsible for day-to-day supervision or oversight of the laboratory operation and personnel performing testing and reporting test results.

(a) The general supervisor—(1) Must be accessible to testing personnel at all times testing is performed to provide on-site, telephone or electronic consultation to resolve technical problems in accordance with policies and procedures established either by the laboratory director or technical supervisor;
(2) Is responsible for providing day-to-day supervision of high complexity test performance by a testing personnel qualified under §493.1489;
(3) Except as specified in paragraph (c) of this section, must be onsite to provide direct supervision when high complexity testing is performed by any individuals qualified under §493.1489(b)(5); and
(4) Is responsible for monitoring test analyses and specimen examinations to ensure that acceptable levels of analytic performance are maintained.

(b) The director or technical supervisor may delegate to the general supervisor the responsibility for—
(1) Assuring that all remedial actions are taken whenever test systems deviate from the laboratory’s established performance specifications;
(2) Ensuring that patient test results are not reported until all corrective actions have been taken and the test system is properly functioning;
(3) Providing orientation to all testing personnel; and
(4) Annually evaluating and documenting the performance of all testing personnel.

(c) Exception. For individuals qualified under §493.1489(b)(5), who were performing high complexity testing on or before January 19, 1993, the requirements of paragraph (a)(3) of this section are not effective, provided that all high complexity testing performed by the individual in the absence of a general supervisor is reviewed within 24 hours by a general supervisor qualified under §493.1461.

[58 FR 39153, July 22, 1993]
§ 493.1467 Condition: Laboratories performing high complexity testing; cytology general supervisor.

For the subspecialty of cytology, the laboratory must have a general supervisor who meets the qualification requirements of §493.1469 of this subpart, and provides supervision in accordance with §493.1471 of this subpart.

§ 493.1469 Standard: Cytology general supervisor qualifications.

The cytology general supervisor must be qualified to supervise cytology services. The general supervisor in cytology must possess a current license issued by the State in which the laboratory is located, if such licensing is required, and must—

(a) Be qualified as a technical supervisor under §493.1449 (b) or (k); or

(b)(1) Be qualified as a cytotechnologist under §493.1483; and

(2) Have at least 3 years of full-time (2,080 hours per year) experience as a cytotechnologist within the preceding 10 years.

§ 493.1471 Standard: Cytology general supervisor responsibilities.

The technical supervisor of cytology may perform the duties of the cytology general supervisor or delegate the responsibilities to an individual qualified under §493.1469.

(a) The cytology general supervisor is responsible for the day-to-day supervision or oversight of the laboratory operation and personnel performing testing and reporting test results.

(b) The cytology general supervisor must—

(1) Be accessible to provide on-site, telephone, or electronic consultation to resolve technical problems in accordance with policies and procedures established by the technical supervisor of cytology;

(2) Document the slide interpretation results of each gynecologic and nongynecologic cytology case he or she examined or reviewed (as specified under §493.1274(c));

(3) For each 24-hour period, document the total number of slides he or she examined or reviewed in the laboratory as well as the total number of slides examined or reviewed in any other laboratory or for any other employer; and

(4) Document the number of hours spent examining slides in each 24-hour period.

§ 493.1481 Condition: Laboratories performing high complexity testing; cytotechnologist.

For the subspecialty of cytology, the laboratory must have a sufficient number of cytotechnologists who meet the qualifications specified in §493.1483 to perform the functions specified in §493.1485.

§ 493.1483 Standard: Cytotechnologist qualifications.

Each person examining cytology slide preparations must meet the qualifications of §493.1449 (b) or (k), or—

(a) Possess a current license as a cytotechnologist issued by the State in which the laboratory is located, if such licensing is required; and

(b) Meet one of the following requirements:

(1) Have graduated from a school of cytotechnology accredited by the Committee on Allied Health Education and Accreditation or other organization approved by HHS; or

(2) Be certified in cytotechnology by a certifying agency approved by HHS; or

(3) Before September 1, 1992—

(i) Have successfully completed 2 years in an accredited institution with at least 12 semester hours in science, 8 hours of which are in biology; and

(A) Have had 12 months of training in a school of cytotechnology accredited by an accrediting agency approved by HHS; or

(B) Have received 6 months of formal training in a school of cytotechnology accredited by an accrediting agency approved by HHS and 6 months of full-time experience in cytotechnology in a laboratory acceptable to the pathologist who directed the formal 6 months of training; or

(ii) Have achieved a satisfactory grade to qualify as a cytotechnologist in a proficiency examination approved by HHS and designed to qualify persons as cytotechnologists; or

(4) Before September 1, 1994, have full-time experience of at least 2 years
or equivalent within the preceding 5 years examining slide preparations under the supervision of a physician qualified under §493.149(b) or (k)(1), and before January 1, 1969, must have—

(i) Graduated from high school;
(ii) Completed 6 months of training in cytotechnology in a laboratory directed by a pathologist or other physician providing cytology services; and
(iii) Completed 2 years of full-time supervised experience in cytotechnology; or

(5)(i) On or before September 1, 1994, have full-time experience of at least 2 years or equivalent examining cytology slide preparations within the preceding 5 years in the United States under the supervision of a physician qualified under §493.149(b) or (k)(1); and

(ii) On or before September 1, 1995, have met the requirements in either paragraph (b)(1) or (2) of this section.

§ 493.1495 Standard; Cytotechnologist responsibilities.

The cytotechnologist is responsible for documenting—

(a) The slide interpretation results of each gynecologic and nongynecologic cytology case he or she examined or reviewed (as specified in §493.1274(c));

(b) For each 24-hour period, the total number of slides examined or reviewed in the laboratory as well as the total number of slides examined or reviewed in any other laboratory or for any other employer; and

(c) The number of hours spent examining slides in each 24-hour period.

§ 493.1487 Condition: Laboratories performing high complexity testing; testing personnel.

The laboratory has a sufficient number of individuals who meet the qualification requirements of §493.149 of this subpart to perform the functions specified in §493.1495 of this subpart for the volume and complexity of testing performed.

§ 493.1489 Standard; Testing personnel qualifications.

Each individual performing high complexity testing must—

(a) Possess a current license issued by the State in which the laboratory is located, if such licensing is required; and

(b) Meet one of the following requirements:

(1) Be a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine licensed to practice medicine, osteopathy, or podiatry in the State in which the laboratory is located or have earned a doctoral, master's or bachelor's degree in a chemical, physical, biological or clinical laboratory science, or medical technology from an accredited institution;

(2)(i) Have earned an associate degree in a laboratory science, or medical laboratory technology from an accredited institution or—

(ii) Have education and training equivalent to that specified in paragraph (b)(2)(i) of this section that includes—

(A) At least 60 semester hours, or equivalent, from an accredited institution that, at a minimum, include either—

(1) 24 semester hours of medical laboratory technology courses; or

(2) 24 semester hours of science courses that include—

(i) Six semester hours of chemistry;

(ii) Six semester hours of biology; and

(iii) Twelve semester hours of chemistry, biology, or medical laboratory technology in any combination; and

(B) Have laboratory training that includes either of the following:

(1) Completion of a clinical laboratory training program approved or accredited by the ABHES, the CAHEA, or other organization approved by HHS. (This training may be included in the 60 semester hours listed in paragraph (b)(2)(i)(A) of this section.)

(2) At least 3 months documented laboratory training in each specialty in which the individual performs high complexity testing.

(3) Have previously qualified or could have qualified as a technologist under §493.1491 on or before February 28, 1992.
(4) On or before April 24, 1995 be a high school graduate or equivalent and have either—
   (i) Graduated from a medical laboratory or clinical laboratory training program approved or accredited by ABHES, CAHEA, or other organization approved by HHS; or
   (ii) Successfully completed an official U.S. military medical laboratory procedures training course of at least 50 weeks duration and have held the military enlisted occupational specialty of Medical Laboratory Specialist (Laboratory Technician);
(5)(i) Until September 1, 1997—
   (A) Have earned a high school diploma or equivalent; and
   (B) Have documentation of training appropriate for the testing performed before analyzing patient specimens. Such training must ensure that the individual has—
      (1) The skills required for proper specimen collection, including patient preparation, if applicable, labeling, handling, preservation or fixation, processing or preparation, transportation and storage of specimens;
      (2) The skills required for implementing all standard laboratory procedures;
      (3) The skills required for performing each test method and for proper instrument use;
      (4) The skills required for performing preventive maintenance, troubleshooting, and calibration procedures related to each test performed;
      (5) A working knowledge of reagent stability and storage;
      (6) The skills required to implement the quality control policies and procedures of the laboratory;
      (7) An awareness of the factors that influence test results; and
      (8) The skills required to assess and verify the validity of patient test results through the evaluation of quality control values before reporting patient test results; and
   (ii) As of September 1, 1997, be qualified under §493.1489(b)(1), (b)(2), (b)(3), (b)(4), or (b)(5):
      (i) Be qualified under §493.1489(b)(1), (b)(2), (b)(3), (b)(4), or (b)(5);
      (ii) Have earned a bachelor’s degree in respiratory therapy or cardiovascular technology from an accredited institution; or
      (iii) Have earned an associate degree related to pulmonary function from an accredited institution; or
(7) For histopathology, meet the qualifications of §493.1449 (b) or (l) to perform tissue examinations.

§ 493.1491 Technologist qualifications on or before February 28, 1992.

In order to qualify as high complexity testing personnel under §493.1489(b)(3), the individual must have met or could have met the following qualifications for technologist as they were in effect on or before February 28, 1992. Each technologist must—
(a) Possess a current license as a laboratory technologist issued by the State, if such licensing exists; and
   (b)(1) Have earned a bachelor’s degree in medical technology from an accredited university; or
   (2) Have successfully completed 3 years of academic study (a minimum of 90 semester hours or equivalent) in an accredited college or university, which met the specific requirements for entrance into a school of medical technology accredited by an accrediting agency approved by the Secretary, and has successfully completed a course of training of at least 12 months in such a school; or
   (3) Have earned a bachelor’s degree in one of the chemical, physical, or biological sciences and, in addition, has at least 1 year of pertinent full-time laboratory experience or training, or both, in the specialty or subspecialty in which the individual performs tests; or
   (4)(i) Have successfully completed 3 years (90 semester hours or equivalent) in an accredited college or university with the following distribution of courses—
      (A) For those whose training was completed before September 15, 1963. At least 24 semester hours in chemistry and biology courses of which—
(1) At least 6 semester hours were in inorganic chemistry and at least 3 semester hours were in other chemistry courses; and
(2) At least 12 semester hours in biology courses pertinent to the medical sciences; or
(B) For those whose training was completed after September 14, 1963. (1) 16 semester hours in chemistry courses that included at least 6 semester hours in inorganic chemistry and that are acceptable toward a major in chemistry; (2) 16 semester hours in biology courses that are pertinent to the medical sciences and are acceptable toward a major in the biological sciences; and (3) 3 semester hours of mathematics; and
(ii) Has experience, training, or both, covering several fields of medical laboratory work of at least 1 year and of such quality as to provide him or her with education and training in medical technology equivalent to that described in paragraphs (b)(1) and (2) of this section; or
(5) With respect to individuals first qualifying before July 1, 1971, the technologist—
(i) Was performing the duties of a laboratory technologist at any time between July 1, 1961, and January 1, 1968, and
(ii) Has had at least 10 years of pertinent laboratory experience prior to January 1, 1968. (This required experience may be met by the substitution of education for experience); or
(6) Achieves a satisfactory grade in a proficiency examination approved by HHS.

§493.1495 Standard; Testing personnel responsibilities.

The testing personnel are responsible for specimen processing, test performance and for reporting test results.
(a) Each individual performs only those high complexity tests that are authorized by the laboratory director and require a degree of skill commensurate with the individual’s education, training or experience, and technical abilities.
(b) Each individual performing high complexity testing must—
(1) Follow the laboratory’s procedures for specimen handling and processing, test analyses, reporting and maintaining records of patient test results;
(2) Maintain records that demonstrate that proficiency testing samples are tested in the same manner as patient specimens;
(3) Adhere to the laboratory’s quality control policies, document all quality control activities, instrument and procedural calibrations and maintenance performed;
(4) Follow the laboratory’s established policies and procedures whenever test systems are not within the laboratory’s established acceptable levels of performance;
(5) Be capable of identifying problems that may adversely affect test performance or reporting of test results and either must correct the problems or immediately notify the general supervisor, technical supervisor, clinical consultant, or director;
(6) Document all corrective actions taken when test systems deviate from the laboratory’s established performance specifications; and
(7) Except as specified in paragraph (c) of this section, if qualified under §493.1489(b)(5), perform high complexity testing only under the onsite, direct supervision of a general supervisor qualified under §493.1461.
(c) Exception. For individuals qualified under §493.1489(b)(5), who were performing high complexity testing on or before January 19, 1993, the requirements of paragraph (b)(7) of this section are not effective, provided that all high complexity testing performed by the individual in the absence of a general supervisor is reviewed within 24 hours by a general supervisor qualified under §493.1461.


Subparts N–P [Reserved]

Subpart Q—Inspection

SOURCE: 57 FR 7184, Feb. 28, 1992, unless otherwise noted.

681
§ 493.1771 Condition: Inspection requirements applicable to all CLIA-certified and CLIA-exempt laboratories.

(a) Each laboratory issued a CLIA certificate must meet the requirements in § 493.1773 and the specific requirements for its certificate type, as specified in §§ 493.1775 through 493.1780.

(b) All CLIA-exempt laboratories must comply with the inspection requirements in §§ 493.1773 and 493.1780, when applicable.

[63 FR 26737, May 14, 1998]

§ 493.1773 Standard: Basic inspection requirements for all laboratories issued a CLIA certificate and CLIA-exempt laboratories.

(a) A laboratory issued a certificate must permit CMS or a CMS agent to conduct an inspection to assess the laboratory’s compliance with the requirements of this part. A CLIA-exempt laboratory and a laboratory that requests, or is issued a certificate of accreditation, must permit CMS or a CMS agent to conduct validation and complaint inspections.

(b) General requirements. As part of the inspection process, CMS or a CMS agent may require the laboratory to do the following:

(1) Test samples, including proficiency testing samples, or perform procedures.

(2) Permit interviews of all personnel concerning the laboratory’s compliance with the applicable requirements of this part.

(3) Permit laboratory personnel to be observed performing all phases of the total testing process (preanalytic, analytic, and postanalytic).

(4) Permit CMS or a CMS agent access to all areas encompassed under the certificate including, but not limited to, the following:

(i) Specimen procurement and processing areas.

(ii) Storage facilities for specimens, reagents, supplies, records, and reports.

(iii) Testing and reporting areas.

(5) Provide CMS or a CMS agent with copies or exact duplicates of all records and data it requires.

(c) Accessible records and data. A laboratory must have all records and data accessible and retrievable within a reasonable time frame during the course of the inspection.

(d) Requirement to provide information and data. A laboratory must provide, upon request, all information and data needed by CMS or a CMS agent to make a determination of the laboratory’s compliance with the applicable requirements of this part.

(e) Reinspection. CMS or a CMS agent may reinspect a laboratory at any time to evaluate the ability of the laboratory to provide accurate and reliable test results.

(f) Complaint inspection. CMS or a CMS agent may conduct an inspection when there are complaints alleging noncompliance with any of the requirements of this part.

(g) Failure to permit an inspection or reinspection. Failure to permit CMS or a CMS agent to conduct an inspection or reinspection results in the suspension or cancellation of the laboratory’s participation in Medicare and Medicaid for payment, and suspension or limitation of, or action to revoke the laboratory’s CLIA certificate, in accordance with subpart R of this part.

[63 FR 26737, May 14, 1998; 63 FR 32699, June 15, 1998]

§ 493.1775 Standard: Inspection of laboratories issued a certificate of waiver or a certificate for provider-performed microscopy procedures.

(a) A laboratory that has been issued a certificate of waiver or a certificate for provider-performed microscopy procedures is not subject to biennial inspections.

(b) If necessary, CMS or a CMS agent may conduct an inspection of a laboratory issued a certificate of waiver or a certificate for provider-performed microscopy procedures at any time during the laboratory’s hours of operation to do the following:

(1) Determine if the laboratory is operated and testing is performed in a manner that does not constitute an imminent and serious risk to public health.

(2) Evaluate a complaint from the public.

(3) Determine whether the laboratory is performing tests beyond the scope of the certificate held by the laboratory.
(4) Collect information regarding the appropriateness of tests specified as waived tests or provider-performed microscopy procedures.

(c) The laboratory must comply with the basic inspection requirements of §493.1773.

§ 493.1777 Standard: Inspection of laboratories that have requested or have been issued a certificate of compliance.

(a) Initial inspection. (1) A laboratory issued a registration certificate must permit an initial inspection to assess the laboratory’s compliance with the requirements of this part before CMS issues a certificate of compliance. (2) The inspection may occur at any time during the laboratory’s hours of operation.

(b) Subsequent inspections. (1) CMS or a CMS agent may conduct subsequent inspections on a biennial basis or with such other frequency as CMS determines to be necessary to ensure compliance with the requirements of this part. (2) CMS bases the nature of subsequent inspections on the laboratory’s compliance history.

(c) Provider-performed microscopy procedures. The inspection sample for review may include testing in the subcategory of provider-performed microscopy procedures.

(d) Compliance with basic inspection requirements. The laboratory must comply with the basic inspection requirements of §493.1773.

§ 493.1780 Standard: Inspection of CLIA-exempt laboratories or laboratories requesting or issued a certificate of accreditation.

(a) Validation inspection. CMS or a CMS agent may conduct a validation inspection of any accredited or CLIA-exempt laboratory at any time during its hours of operation.

(b) Complaint inspection. CMS or a CMS agent may conduct a complaint inspection of a CLIA-exempt laboratory or a laboratory requesting or issued a certificate of accreditation at any time during its hours of operation upon receiving a complaint applicable to the requirements of this part.

(c) Noncompliance determination. If a validation or complaint inspection results in a finding that the laboratory is not in compliance with one or more condition-level requirements, the following actions occur:

(1) A laboratory issued a certificate of accreditation is subject to a full review by CMS, in accordance with subpart E of this part and §488.11 of this chapter.

(2) A CLIA-exempt laboratory is subject to appropriate enforcement actions under the approved State licensure program.

(d) Compliance with basic inspection requirements. CLIA-exempt laboratories and laboratories requesting or issued a certificate of accreditation must comply with the basic inspection requirements in §493.1773.

§ 493.1800 Basis and scope.

Subpart R—Enforcement Procedures

SOURCE: 57 FR 7237, Feb. 28, 1992, unless otherwise noted.
(iii) Grants the Secretary broad enforcement authority, including—
(A) Use of intermediate sanctions;
(B) Suspension, limitation, or revocation of the certificate of a laboratory that is out of compliance with one or more requirements for a certificate; and
(C) Civil suit to enjoin any laboratory activity that constitutes a significant hazard to the public health.

(3) Section 353 also—
(i) Provides for imprisonment or fine for any person convicted of intentional violation of CLIA requirements;
(ii) Specifies the administrative hearing and judicial review rights of a laboratory that is sanctioned under CLIA; and
(iii) Requires the Secretary to publish annually a list of all laboratories that have been sanctioned during the preceding year.

(b) Scope and applicability. This subpart sets forth—
(1) The policies and procedures that CMS follows to enforce the requirements applicable to laboratories under CLIA and under section 1846 of the Act; and
(2) The appeal rights of laboratories on which CMS imposes sanctions.

§ 493.1804 General considerations.

(a) Purpose. The enforcement mechanisms set forth in this subpart have the following purposes:
(1) To protect all individuals served by laboratories against substandard testing of specimens.
(2) To safeguard the general public against health and safety hazards that might result from laboratory activities.
(3) To motivate laboratories to comply with CLIA requirements so that they can provide accurate and reliable test results.

(b) Basis for decision to impose sanctions. (1) CMS’s decision to impose sanctions is based on one or more of the following:
(i) Deficiencies found by CMS or its agents in the conduct of inspections to certify or validate compliance with Federal requirements, or through review of materials submitted by the laboratory (e.g., personnel qualifications).
(ii) Unsuccessful participation in proficiency testing.
(2) CMS imposes one or more of the alternative or principal sanctions specified in §§ 493.1806 and 493.1807 when CMS or CMS’s agent finds that a laboratory has condition-level deficiencies.

(c) Imposition of alternative sanctions.
(1) CMS may impose alternative sanctions in lieu of, or in addition to principal sanctions, (CMS does not impose alternative sanctions on laboratories that have certificates of waiver because those laboratories are not inspected for compliance with condition-level requirements.)
(2) CMS may impose alternative sanctions other than a civil money penalty after the laboratory has had an opportunity to respond, but before the hearing specified in § 493.1844.

(d) Choice of sanction: Factors considered. CMS bases its choice of sanction on consideration of one or more factors that include, but are not limited to, the following, as assessed by the State or by CMS, or its agents:
(1) Whether the deficiencies pose immediate jeopardy.
(2) The nature, incidence, severity, and duration of the deficiencies or noncompliance.
(3) Whether the same condition level deficiencies have been identified repeatedly.
(4) The accuracy and extent of laboratory records (e.g., of remedial action) in regard to the noncompliance, and their availability to the State, to other CMS agents, and to CMS.
(5) The relationship of one deficiency or group of deficiencies to other deficiencies.
(6) The overall compliance history of the laboratory including but not limited to any period of noncompliance that occurred between certifications of compliance.
(7) The corrective and long-term compliance outcomes that CMS hopes to achieve through application of the sanction.
(8) Whether the laboratory has made any progress toward improvement following a reasonable opportunity to correct deficiencies.
(9) Any recommendation by the State agency as to which sanction would be appropriate.

e) **Number of alternative sanctions.** CMS may impose a separate sanction for each condition level deficiency or a single sanction for all condition level deficiencies that are interrelated and subject to correction by a single course of action.

(f) **Appeal rights.** The appeal rights of laboratories dissatisfied with the imposition of a sanction are set forth in §493.1844.

§ 493.1807 **Additional sanctions: Laboratories that participate in Medicare.**

The following additional sanctions are available for laboratories that are out of compliance with one or more CLIA conditions and that have approval to receive Medicare payment for their services.

(a) **Principal sanction.** Cancellation of the laboratory’s approval to receive Medicare payment for its services.

(b) **Alternative sanctions.** (1) Suspension of payment for tests in one or more specific specialties or subspecialties, performed on or after the effective date of sanction.

(2) Suspension of payment for all tests in all specialties and subspecialties performed on or after the effective date of sanction.

§ 493.1808 **Adverse action on any type of CLIA certificate: Effect on Medicare approval.**

(a) **Suspension or revocation of any type of CLIA certificate.** When CMS suspends or revokes any type of CLIA certificate, CMS concurrently cancels the laboratory’s approval to receive Medicare payment for its services.

(b) **Limitation of any type of CLIA certificate.** When CMS limits any type of CLIA certificate, CMS concurrently limits Medicare approval to only those specialties or subspecialties that are authorized by the laboratory’s limited certificate.

§ 493.1809 **Limitation on Medicaid payment.**

As provided in section 1902(a)(9)(C) of the Act, payment for laboratory services may be made under the State plan only if those services are furnished by a laboratory that has a CLIA certificate or is licensed by a State whose licensure program has been approved by the Secretary under this part.

§ 493.1810 **Imposition and lifting of alternative sanctions.**

(a) **Notice of noncompliance and of proposed sanction: Content.** If CMS or its agency identifies condition level noncompliance in a laboratory, CMS or its
agent gives the laboratory written notice of the following:

(1) The condition level noncompliance that it has identified.

(2) The sanction or sanctions that CMS or its agent proposes to impose against the laboratory.

(3) The rationale for the proposed sanction or sanctions.

(4) The projected effective date and duration of the proposed sanction or sanctions.

(5) The authority for the proposed sanction or sanctions.

(6) The time allowed (at least 10 days) for the laboratory to respond to the notice.

(b) Opportunity to respond. During the period specified in paragraph (a)(6) of this section, the laboratory may submit to CMS or its agent written evidence or other information against the imposition of the proposed sanction or sanctions.

(c) Notice of imposition of sanction—(1) Content. CMS gives the laboratory written notice that acknowledges any evidence or information received from the laboratory and specifies the following:

(i) The sanction or sanctions to be imposed against the laboratory.

(ii) The authority and rationale for the imposing sanction or sanctions.

(iii) The effective date and duration of sanction.

(2) Timing. (i) If CMS or its agent determines that the deficiencies pose immediate jeopardy, CMS provides notice at least 5 days before the effective date of sanction.

(ii) If CMS or its agent determines that the deficiencies do not pose immediate jeopardy, CMS provides notice at least 15 days before the effective date of the sanction.

(d) Duration of alternative sanctions. An alternative sanction continues until the earlier of the following occurs:

(1) The laboratory corrects all condition level deficiencies.

(2) CMS’s suspension, limitation, or revocation of the laboratory’s CLIA certificate becomes effective.

(e) Lifting of alternative sanctions—(1) General rule. Alternative sanctions are not lifted until a laboratory’s compliance with all condition level requirements is verified.

(2) Credible allegation of compliance. When a sanctioned laboratory submits a credible allegation of compliance, CMS’s agent determines whether—

(i) It can certify compliance on the basis of the evidence presented by the laboratory in its allegation; or

(ii) It must revisit to verify whether the laboratory has, in fact, achieved compliance.

(3) Compliance achieved before the date of revisit. If during a revisit, the laboratory presents credible evidence (as determined by CMS or its agent) that it achieved compliance before the date of revisit, sanctions are lifted as of that earlier date.

§ 493.1812 Action when deficiencies pose immediate jeopardy.

If a laboratory’s deficiencies pose immediate jeopardy, the following rules apply:

(a) CMS requires the laboratory to take immediate action to remove the jeopardy and may impose one or more alternative sanctions to help bring the laboratory into compliance.

(b) If the findings of a revisit indicate that a laboratory has not eliminated the jeopardy, CMS suspends or limits the laboratory’s CLIA certificate no earlier than 5 days after the date of notice of suspension or limitation. CMS may later revoke the certificate.

(c) In addition, if CMS has reason to believe that the continuation of any activity by any laboratory (either the entire laboratory operation or any specialty or subspecialty of testing) would constitute a significant hazard to the public health, CMS may bring suit and seek a temporary injunction or restraining order against continuation of that activity by the laboratory, regardless of the type of CLIA certificate the laboratory has and of whether it is State-exempt.

§ 493.1814 Action when deficiencies are at the condition level but do not pose immediate jeopardy.

If a laboratory has condition level deficiencies that do not pose immediate jeopardy, the following rules apply:
(a) Initial action. (1) CMS may cancel the laboratory’s approval to receive Medicare payment for its services.

(2) CMS may suspend, limit, or revoke the laboratory’s CLIA certificate.

(3) If CMS does not impose a principal sanction under paragraph (a)(1) or (a)(2) of this section, it imposes one or more alternative sanctions. In the case of unsuccessful participation in proficiency testing, CMS may impose the training and technical assistance requirement set forth at § 493.1838 in lieu of, or in addition to, one or more alternative sanctions.

(b) Failure to correct condition level deficiencies. If CMS imposes alternative sanctions for condition level deficiencies that do not pose immediate jeopardy, and the laboratory does not correct the condition level deficiencies within 12 months after the last day of inspection, CMS—

(1) Cancels the laboratory’s approval to receive Medicare payment for its services, and discontinues the Medicare payment sanctions as of the day cancellation is effective.

(2) Following a revisit which indicates that the laboratory has not corrected its condition level deficiencies, notifies the laboratory that it proposes to suspend, limit, or revoke the certificate, as specified in § 493.1816(b), and the laboratory’s right to hearing; and

(3) May impose (or continue, if already imposed) any alternative sanctions that do not pertain to Medicare payments. (Sanctions imposed under the authority of section 353 of the PHS Act may continue for more than 12 months from the last date of inspection, while a hearing on the proposed suspension, limitation, or revocation of the certificate of compliance, registration certificate, certificate of accreditation, or certificate for PPM procedures is pending.)

(4) Action after hearing. If a hearing decision upholds a proposed suspension, limitation, or revocation of a laboratory’s CLIA certificate, CMS discontinues any alternative sanctions as of the day it makes the suspension, limitation, or revocation effective.

§ 493.1816 Action when deficiencies are not at the condition level.

If a laboratory has deficiencies, that are not at the condition level, the following rules apply:

(a) Initial action. The laboratory must submit a plan of correction that is acceptable to CMS in content and time frames.

(b) Deficiencies corrected before a visit. If during a visit, a laboratory produces credible evidence that it achieved compliance before the visit, the sanctions are lifted as of that earlier date.

(c) Failure to correct deficiencies. If during a visit it is found that the laboratory has not corrected its deficiencies, CMS may propose to suspend, limit, or revoke the laboratory’s CLIA certificate.

(d) Additional time for correcting lower level deficiencies not at the condition level. If at the end of the plan of correction period all condition level deficiencies have been corrected, and there are deficiencies, that are not at the condition level, CMS may request a revised plan of correction. The revised plan may not extend beyond 12 months from the last day of the inspection that originally identified the cited deficiencies.

(e) Persistence of deficiencies. If at the end of the period covered by the plan of correction, the laboratory still has deficiencies, the rules of §§ 493.1814 and 493.1816 apply.
§ 493.1826 Suspension of part of Medicare payments.

(a) Application. (1) CMS may impose this sanction if a laboratory—
   (i) Is found to have condition level deficiencies with respect to one or more specialties or subspecialties of tests; and
   (ii) Agrees (in return for not having its Medicare approval cancelled immediately) not to charge Medicare beneficiaries or their private insurance carriers for the services for which Medicare payment is suspended.

(2) CMS suspends Medicare payment for those specialties or subspecialties of tests for which the laboratory is out of compliance with Federal requirements.

(b) Procedures. Before imposing this sanction, CMS provides notice of sanction and opportunity to respond in accordance with §493.1810.

(c) Duration and effect of sanction. This sanction continues until the laboratory corrects the condition level deficiencies or CMS cancels the laboratory’s approval to receive Medicare payment for its services, but in no event longer than 12 months.

(1) If the laboratory corrects all condition level deficiencies, CMS resumes Medicare payment effective for all services furnished on or after the date the deficiencies are corrected.

(2) [Reserved]

§ 493.1828 Suspension of all Medicare payments.

(a) Application. (1) CMS may suspend payment for all Medicare-approved laboratory services when the laboratory has condition level deficiencies.

(2) CMS suspends payment for all Medicare covered laboratory services when the following conditions are met:

(i) Either—
   (A) The laboratory has not corrected its condition level deficiencies included in the plan of correction within 3 months from the last date of inspection; or
   (B) The laboratory has been found to have the same condition level deficiencies during three consecutive inspections; and

(ii) The laboratory has chosen (in return for not having its Medicare approval immediately cancelled), not to charge Medicare beneficiaries or their private insurance carriers for services for which Medicare payment is suspended.

(3) CMS suspends payment for services furnished on and after the effective date of sanction.

(b) Procedures. Before imposing this sanction, CMS provides notice of sanction and opportunity to respond in accordance with §493.1810.

(c) Duration and effect of sanction. (1) Suspension of payment continues until all condition level deficiencies are corrected, but never beyond twelve months.

(2) If all the deficiencies are not corrected by the end of the 12 month period, CMS cancels the laboratory’s approval to receive Medicare payment for its services.

§ 493.1832 Directed plan of correction and directed portion of a plan of correction.

(a) Application. CMS may impose a directed plan of correction as an alternative sanction for any laboratory that has condition level deficiencies. If CMS does not impose a directed plan of correction as an alternative sanction for a laboratory that has condition level deficiencies, it at least imposes a directed portion of a plan of correction when it imposes any of the following alternative sanctions:

(1) State onsite monitoring.

(2) Civil money penalty.

(3) Suspension of all or part of Medicare payments.

(b) Procedures—(1) Directed plan of correction. When imposing this sanction, CMS—

(i) Gives the laboratory prior notice of the sanction and opportunity to respond in accordance with §493.1810;

(ii) Directs the laboratory to take specific corrective action within specific time frames in order to achieve compliance; and

(iii) May direct the laboratory to submit the names of laboratory clients for notification purposes, as specified in paragraph (b)(3) of this section.

(2) Directed portion of a plan of correction. CMS may decide to notify clients
of a sanctioned laboratory, because of the seriousness of the noncompliance (e.g., the existence of immediate jeopardy) or for other reasons. When imposing this sanction, CMS takes the following steps—

(1) Directs the laboratory to submit to CMS, the State survey agency, or other CMS agent, within 10 calendar days after the notice of the alternative sanction, a list of names and addresses of all physicians, providers, suppliers, and other clients who have used some or all of the services of the laboratory since the last certification inspection or within any other timeframe specified by CMS.

(ii) Within 30 calendar days of receipt of the information, may send to each laboratory client, via the State survey agency, a notice containing the name and address of the laboratory, the nature of the laboratory’s noncompliance, and the kind and effective date of the alternative sanction.

(iii) Sends to each laboratory client, via the State survey agency, notice of the recission of an adverse action within 30 days of the rescission.

(3) Notice of imposition of a principal sanction following the imposition of an alternative sanction. If CMS imposes a principal sanction following the imposition of an alternative sanction, and for which CMS has already obtained a list of laboratory clients, CMS may use that list to notify the clients of the imposition of the principal sanction.

(c) Duration of a directed plan of correction. If CMS imposes a directed plan of correction, and on revisit it is found that the laboratory has not corrected the deficiencies within 12 months from the last day of inspection, the following rules apply:

(1) CMS cancels the laboratory’s approval for Medicare payment of its services, and notifies the laboratory of CMS’s intent to suspend, limit, or revoke the laboratory’s CLIA certificate.

(2) The directed plan of correction continues in effect until the day suspension, limitation, or revocation of the laboratory’s CLIA certificate.

§ 493.1834 Civil money penalty.

(a) Statutory basis. Sections 1846 of the Act and 353(h)(2)(B) of the PHS Act authorize the Secretary to impose civil money penalties on laboratories. Section 1846(b)(3) of the Act specifically provides that incrementally more severe fines may be imposed for repeated or uncorrected deficiencies.

(b) Scope. This section sets forth the procedures that CMS follows to impose a civil money penalty in lieu of, or in addition to, suspending, limiting, or revoking the certificate of compliance, registration certificate, certificate of accreditation, or certificate for PPM procedures of a laboratory that is found to have condition level deficiencies.

(c) Basis for imposing a civil money penalty. CMS may impose a civil money penalty against any laboratory determined to have condition level deficiencies regardless of whether those deficiencies pose immediate jeopardy.

(d) Amount of penalty—(1) Factors considered. In determining the amount of the penalty, CMS takes into account the following factors:

(i) The nature, scope, severity, and duration of the noncompliance.

(ii) Whether the same condition level deficiencies have been identified during three consecutive inspections.

(iii) The laboratory’s overall compliance history including but not limited to any period of noncompliance that occurred between certifications of compliance.

(iv) The laboratory’s intent or reason for noncompliance.

(v) The accuracy and extent of laboratory records and their availability to CMS, the State survey agency, or other CMS agent.

(2) Range of penalty amount. (i) For a condition level deficiency that poses immediate jeopardy, the range is $3,050–$10,000 as adjusted annually under 45 CFR part 102 per day of noncompliance or per violation.

(ii) For a condition level deficiency that does not pose immediate jeopardy, the range is $50–$3,000 as adjusted annually under 45 CFR part 102 per day of noncompliance or per violation.

(3) Decreased penalty amounts. If the immediate jeopardy is removed, but the deficiency continues, CMS shifts the penalty amount to the lower range.
(4) Increased penalty amounts. CMS may, before the hearing, propose to increase the penalty amount for a laboratory that has deficiencies which, after imposition of a lower level penalty amount, become sufficiently serious to pose immediate jeopardy.

(c) Procedures for imposition of civil money penalty—(1) Notice of intent. (i) CMS sends the laboratory written notice of CMS’s intent to impose a civil money penalty. (ii) The notice includes the following information: 
   (A) The statutory basis for the penalty.
   (B) The proposed daily or per violation amount of the penalty.
   (C) The factors (as described in paragraph (d)(1) of this section) that CMS considered.
   (D) The opportunity for responding to the notice in accordance with §493.1810(c).
   (E) A specific statement regarding the laboratory’s appeal rights.

(2) Appeal rights. (i) The laboratory has 60 days from the date of receipt of the notice of intent to impose a civil money penalty to request a hearing in accordance with §493.1844(g).
   (ii) If the laboratory requests a hearing, all other pertinent provisions of §493.1844 apply.
   (iii) If the laboratory does not request a hearing, CMS may reduce the proposed penalty amount by 35 percent.

(f) Accrual and duration of penalty—(1) Accrual of penalty. The civil money penalty begins accruing as follows:
   (i) 5 days after notice of intent if there is immediate jeopardy.
   (ii) 15 days after notice of intent if there is not immediate jeopardy.

(2) Duration of penalty. The civil money penalty continues to accrue until the earliest of the following occurs:
   (i) The laboratory’s compliance with condition level requirements is verified on the basis of the evidence presented by the laboratory in its credible allegation of compliance or at the time or revisit.
   (ii) Based on credible evidence presented by the laboratory at the time of revisit, CMS determines that compliance was achieved before the revisit.

(g) Computation and notice of total penalty amount—(1) Computation. CMS computes the total penalty amount after the laboratory’s compliance is verified or CMS suspends, limits, or revokes the laboratory’s CLIA certificate but in no event before—
   (i) The 60 day period for requesting a hearing has expired without a request or the laboratory has explicitly waived its right to a hearing; or
   (ii) Following a hearing requested by the laboratory, the ALJ issues a decision that upholds imposition of the penalty.

(2) Notice of penalty amount and due date of penalty. The notice includes the following information:
   (i) Daily or per violation penalty amount.
   (ii) Number of days or violations for which the penalty is imposed.
   (iii) Total penalty amount.
   (iv) Due date for payment of the penalty.

(h) Due date for payment of penalty. (1) Payment of a civil money penalty is due 15 days from the date of the notice specified in paragraph (g)(2) of this section.

(2) CMS may approve a plan for a laboratory to pay a civil money penalty, plus interest, over a period of up to one year from the original due date.

(i) Collection and settlement—(1) Collection of penalty amounts. (i) The determined penalty amount may be deducted from any sums then or later owing by the United States to the laboratory subject to the penalty.
   (ii) Interest accrues on the unpaid balance of the penalty, beginning on the due date. Interest is computed at the rate specified in §405.378(d) of this chapter.

(2) Settlement. CMS has authority to settle any case at any time before the ALJ issues a hearing decision.

§ 493.1836 State onsite monitoring.

(a) Application. (1) CMS may require continuous or intermittent monitoring of a plan of correction by the State survey agency to ensure that the laboratory makes the improvements necessary to bring it into compliance with the condition level requirements. (The State monitor does not have management authority, that is, cannot hire or fire staff, obligate funds, or otherwise dictate how the laboratory operates. The monitor’s responsibility is to oversee whether corrections are made.)

(2) The laboratory must pay the costs of onsite monitoring by the State survey agency.

(i) The costs are computed by multiplying the number of hours of onsite monitoring in the laboratory by the hourly rate negotiated by CMS and the State.

(ii) The hourly rate includes salary, fringe benefits, travel, and other direct and indirect costs approved by CMS.

(b) Procedures. Before imposing this sanction, CMS provides notice of sanction and opportunity to respond in accordance with § 493.1810.

(c) Duration of sanction. (1) If CMS imposes onsite monitoring, the sanction continues until CMS determines that the laboratory has the capability to ensure compliance with all condition level requirements.

(2) If the laboratory does not correct all deficiencies within 12 months, and a revisit indicates that deficiencies remain, CMS cancels the laboratory’s approval for Medicare payment for its services and notifies the laboratory of its intent to suspend, limit, or revoke the laboratory’s certificate of compliance, registration certificate, certificate of accreditation, or certificate for PPM procedures.

(3) If the laboratory still does not correct its deficiencies, the Medicare sanction continues until the suspension, limitation, or revocation of the laboratory’s certificate of compliance, registration certificate, certificate of accreditation, or certificate for PPM procedures is effective.

[57 FR 7237, Feb. 28, 1992, as amended at 60 FR 20051, Apr. 24, 1995]

§ 493.1838 Training and technical assistance for unsuccessful participation in proficiency testing.

If a laboratory’s participation in proficiency testing is unsuccessful, CMS may require the laboratory to undertake training of its personnel, or to obtain necessary technical assistance, or both, in order to meet the requirements of the proficiency testing program. This requirement is separate from the principal and alternative sanctions set forth in §§ 493.1806 and 493.1807.

§ 493.1840 Suspension, limitation, or revocation of any type of CLIA certificate.

(a) Adverse action based on actions of the laboratory’s owner, operator or employees. CMS may initiate adverse action to suspend, limit or revoke any CLIA certificate if CMS finds that a laboratory’s owner or operator or one of its employees has—

(1) Been guilty of misrepresentation in obtaining a CLIA certificate;

(2) Performed, or represented the laboratory as entitled to perform, a laboratory examination or other procedure that is not within a category of laboratory examinations or other procedures authorized by its CLIA certificate;

(3) Failed to comply with the certificate requirements and performance standards;

(4) Failed to comply with reasonable requests by CMS for any information or work on materials that CMS concludes is necessary to determine the laboratory’s continued eligibility for its CLIA certificate or continued compliance with performance standards set by CMS;

(5) Refused a reasonable request by CMS or its agent for permission to inspect the laboratory and its operation and pertinent records during the hours that the laboratory is in operation;

(6) Violated or aided and abetted in the violation of any provisions of CLIA and its implementing regulations;

(7) Failed to comply with an alternative sanction imposed under this subpart; or

(8) Within the preceding two-year period, owned or operated a laboratory that had its CLIA certificate revoked.
§ 493.1840 42 CFR Ch. IV (10–1–16 Edition)

(This provision applies only to the owner or operator, not to all of the laboratory’s employees.)

(b) Adverse action based on improper referrals in proficiency testing. If CMS determines that a laboratory has intentionally referred its proficiency testing samples to another laboratory for analysis, CMS does one of the following:

1. Revokes the laboratory’s CLIA certificate for at least 1 year, prohibits the owner and operator from owning or operating a CLIA-certified laboratory for at least 1 year, and may impose a civil money penalty in accordance with § 493.1834(d), if CMS determines that—

   (A) A proficiency testing referral is a repeat proficiency testing referral as defined at § 493.2; or
   (B) On or before the proficiency testing event close date, a laboratory reported proficiency testing results obtained from another laboratory to the proficiency testing program.

   (ii) Following the revocation of a CLIA certificate in accordance with paragraph (b)(1)(i) of this section, CMS may exempt a laboratory owner from the generally applicable prohibition on owning or operating a CLIA-certified laboratory under paragraph (a)(8) of this section on a laboratory-by-laboratory basis if CMS finds, after review of the relevant facts and circumstances, that there is no evidence that—

   (A) Patients would be put at risk as a result of the owner being exempted from the ban on a laboratory-by-laboratory basis;
   (B) The laboratory for which the owner is to be exempted from the general ownership ban participated in or was otherwise complicit in the PT referral of the laboratory that resulted in the revocation; and
   (C) The laboratory for which the owner is to be exempted from the general ownership ban received a PT sample from another laboratory in the prior two survey cycles, and failed to immediately report such receipt to CMS or to the appropriate CMS-approved accrediting organization.

2. Suspends or limits the CLIA certificate for less than 1 year based on the criteria in § 493.1804(d) and imposes alternative sanctions as appropriate, in accordance with §§ 493.1804(c) and (d), 493.1806(c), 493.1807(b), 493.1809 and, in the case of civil money penalties, §493.1834(d), when CMS determines that paragraph (b)(1)(i)(A) or (B) of this section does not apply but that the laboratory obtained test results for the proficiency testing samples from another laboratory on or before the proficiency testing event close date. Among other possibilities, alternative sanctions will always include a civil money penalty and a directed plan of correction that includes required training of staff.

3. Imposes alternative sanctions in accordance with §§ 493.1804(c) and (d), 493.1806(c), 493.1807(b), 493.1809 and, in the case of civil money penalties, §493.1834(d), when CMS determines that paragraph (b)(1)(i) or (2) of this section do not apply, and a PT referral has occurred, but no test results are received prior to the event close date by the referring laboratory from the laboratory that received the referral. Among other possibilities, alternative sanctions will always include a civil money penalty and a directed plan of correction that includes required training of staff.

(c) Adverse action based on exclusion from Medicare. If the OIG excludes a laboratory from participation in Medicare, CMS suspends the laboratory’s CLIA certificate for the period during which the laboratory is excluded.

(d) Procedures for suspension or limitation—(1) Basic rule. Except as provided in paragraph (d)(2) of this section, CMS does not suspend or limit a CLIA certificate until after an ALJ hearing decision (as provided in § 493.1844) that upholds suspension or limitation.

(2) Exceptions. CMS may suspend or limit a CLIA certificate before the ALJ hearing in any of the following circumstances:

   (i) The laboratory’s deficiencies pose immediate jeopardy.
   (ii) The laboratory has refused a reasonable request for information or work on materials.
   (iii) The laboratory has refused permission for CMS or a CMS agent to inspect the laboratory or its operation.

(e) Procedures for revocation. (1) CMS does not revoke any type of CLIA certificate until after an ALJ hearing that upholds revocation.

(2) CMS may revoke a CLIA certificate after the hearing decision even if
Centers for Medicare & Medicaid Services, HHS § 493.1844

It had not previously suspended or limited that certificate.

(f) Notice to the OIG. CMS notifies the OIG of any violations under paragraphs (a)(1), (a)(2), (a)(6), and (b) of this section within 30 days of the determination of the violation.


§ 493.1842 Cancellation of Medicare approval.

(a) Basis for cancellation. (1) CMS always cancels a laboratory’s approval to receive Medicare payment for its services if CMS suspends or revokes the laboratory’s CLIA certificate.

(2) CMS may cancel the laboratory’s approval under any of the following circumstances:

(i) The laboratory is out of compliance with a condition level requirement.

(ii) The laboratory fails to submit a plan of correction satisfactory to CMS.

(iii) The laboratory fails to correct all its deficiencies within the time frames specified in the plan of correction.

(b) Notice and opportunity to respond. Before canceling a laboratory’s approval to receive Medicare payment for its services, CMS gives the laboratory—

(1) Written notice of the rationale for, effective date, and effect of, cancellation;

(2) Opportunity to submit written evidence or other information against cancellation of the laboratory’s approval.

This sanction may be imposed before the hearing that may be requested by a laboratory, in accordance with the appeals procedures set forth in § 493.1844.

(c) Effect of cancellation. Cancellation of Medicare approval terminates any Medicare payment sanctions regardless of the time frames originally specified.

§ 493.1844 Appeals procedures.

(a) General rules. (1) The provisions of this section apply to all laboratories and prospective laboratories that are dissatisfied with any initial determination under paragraph (b) of this section.

(2) Hearings are conducted in accordance with procedures set forth in subpart D of part 498 of this chapter, except that the authority to conduct hearings and issue decisions may be exercised by ALJs assigned to, or detailed to, the Departmental Appeals Board.

(3) Any party dissatisfied with a hearing decision is entitled to request review of the decision as specified in subpart E of part 498 of this chapter, except that the authority to review the decision may be exercised by the Departmental Appeals Board.

(4) When more than one of the actions specified in paragraph (b) of this section are carried out concurrently, the laboratory has a right to only one hearing on all matters at issue.

(b) Actions that are initial determinations. The following actions are initial determinations and therefore are subject to appeal in accordance with this section:

(1) The suspension, limitation, or revocation of the laboratory’s CLIA certificate by CMS because of noncompliance with CLIA requirements.

(2) The denial of a CLIA certificate.

(3) The imposition of alternative sanctions under this subpart (but not the determination as to which alternative sanction or sanctions to impose).

(4) The denial or cancellation of the laboratory’s approval to receive Medicare payment for its services.

(c) Actions that are not initial determinations. Actions that are not listed in paragraph (b) of this section are not initial determinations and therefore are not subject to appeal under this section. They include, but are not necessarily limited to, the following:

(1) The finding that a laboratory accredited by a CMS-approved accreditation organization is no longer deemed to meet the conditions set forth in subparts H, J, K, M, and Q of this part. However, the suspension, limitation or revocation of a certificate of accreditation is an initial determination and is appealable.

(2) The finding that a laboratory determined to be in compliance with condition-level requirements but has deficiencies that are not at the condition level.
(3) The determination not to reinstate a suspended CLIA certificate because the reason for the suspension has not been removed or there is insufficient assurance that the reason will not recur.

(4) The determination as to which alternative sanction or sanctions to impose, including the amount of a civil money penalty to impose per day or per violation.

(5) The denial of approval for Medicare payment for the services of a laboratory that does not have in effect a valid CLIA certificate.

(6) The determination that a laboratory’s deficiencies pose immediate jeopardy.

(7) The amount of the civil money penalty assessed per day or for each violation of Federal requirements.

(d) Effect of pending appeals—(1) Alternative sanctions. The effective date of an alternative sanction (other than a civil money penalty) is not delayed because the laboratory has appealed and the hearing or hearing decision is pending.

(2) Suspension, limitation, or revocation of a laboratory’s CLIA certificate—(i) General rule. Except as provided in paragraph (d)(2)(ii) of this section, suspension, limitation, or revocation of a CLIA certificate is not effective until after a hearing decision by an ALJ is issued.

(ii) Exceptions. (A) If CMS determines that conditions at a laboratory pose immediate jeopardy, the effective date of the suspension or limitation of a CLIA certificate is not delayed because the laboratory has appealed and the hearing or the hearing decision is pending.

(B) CMS may suspend or limit a laboratory’s CLIA certificate before an ALJ hearing or hearing decision if the laboratory has refused a reasonable request for information (including but not limited to billing information), or for work on materials, or has refused permission for CMS or a CMS agent to inspect the laboratory or its operation.

(3) Cancellation of Medicare approval. The effective date of the cancellation of a laboratory’s approval to receive Medicare payment for its services is not delayed because the laboratory has appealed and the hearing or hearing decision is pending.

(4) Effect of ALJ decision. (i) An ALJ decision is final unless, as provided in paragraph (a)(3) of this section, one of the parties requests review by the Departmental Appeals Board within 60 days, and the Board reviews the case and issues a revised decision.

(ii) If an ALJ decision upholds a suspension imposed because of immediate jeopardy, that suspension becomes a revocation.

(e) Appeal rights for prospective laboratories—(1) Reconsideration. Any prospective laboratory dissatisfied with a denial of a CLIA certificate, or of approval for Medicare payment for its services, may initiate the appeals process by requesting reconsideration in accordance with §§ 498.22 through 498.25 of this chapter.

(2) Notice of reopening. If CMS reopens an initial or reconsidered determination, CMS gives the prospective laboratory notice of the revised determination in accordance with § 498.32 of this chapter.

(3) ALJ hearing. Any prospective laboratory dissatisfied with a reconsidered determination under paragraph (e)(1) of this section or a revised reconsidered determination under § 498.30 of this chapter is entitled to a hearing before an ALJ, as specified in paragraph (a)(2) of this section.

(4) Review of ALJ hearing decisions. Any prospective laboratory that is dissatisfied with an ALJ’s hearing decision or dismissal of a request for hearing may file a written request for review by the Departmental Appeals Board as provided in paragraph (a)(3) of this section.

(f) Appeal rights of laboratories—(1) ALJ hearing. Any laboratory dissatisfied with the suspension, limitation, or revocation of its CLIA certificate, with the imposition of an alternative sanction under this subpart, or with cancellation of the approval to receive Medicare payment for its services, is entitled to a hearing before an ALJ as specified in paragraph (a)(2) of this section and has 60 days from the notice of sanction to request a hearing.

(2) Review of ALJ hearing decisions. Any laboratory that is dissatisfied
with an ALJ’s hearing decision or dismissal of a request for hearing may file a written request for review by the Departmental Appeals Board, as provided in paragraph (a)(3) of this section.

(3) Judicial review. Any laboratory dissatisfied with the decision to impose a civil money penalty or to suspend, limit, or revoke its CLIA certificate may, within 60 days after the decision becomes final, file with the U.S. Court of Appeals of the circuit in which the laboratory has its principal place of business, a petition for judicial review.

(g) Notice of adverse action. (1) If CMS suspends, limits, or revokes a laboratory’s CLIA certificate or cancels the approval to receive Medicare payment for its services, CMS gives notice to the laboratory, and may give notice to physicians, providers, suppliers, and other laboratory clients, according to the procedures set forth at §493.1832. In addition, CMS notifies the general public each time one of these principal sanctions is imposed.

(2) The notice to the laboratory—
   (i) Sets forth the reasons for the adverse action, the effective date and effect of that action, and the appeal rights if any; and
   (ii) When the certificate is limited, specifies the specialties or subspecialties of tests that the laboratory is no longer authorized to perform, and that are no longer covered under Medicare.

(3) The notice to other entities includes the same information except the information about the laboratory’s appeal rights.

(h) Effective date of adverse action. (1) When the laboratory’s deficiencies pose immediate jeopardy, the effective date of the adverse action is at least 5 days after the date of the notice.

(2) When CMS determines that the laboratory’s deficiencies do not pose immediate jeopardy, the effective date of the adverse action is at least 15 days after the date of the notice.

§493.1846 Civil action.

If CMS has reason to believe that continuation of the activities of any laboratory, including a State-exempt laboratory, would constitute a significant hazard to the public health, CMS may bring suit in a U.S. District Court to enjoin continuation of the specific activity that is causing the hazard or to enjoin the continued operation of the laboratory if CMS deems it necessary. Upon proper showing, the court shall issue a temporary injunction or restraining order without bond against continuation of the activity.

§493.1850 Laboratory registry.

(a) Once a year CMS makes available to physicians and to the general public specific information (including information provided to CMS by the OIG) that is useful in evaluating the performance of laboratories, including the following:

(1) A list of laboratories that have been convicted, under Federal or State laws relating to fraud and abuse, false billing, or kickbacks.

(2) A list of laboratories that have had their CLIA certificates suspended, limited, or revoked, and the reason for the adverse actions.

(3) A list of persons who have been convicted of violating CLIA requirements, as specified in section 353(1) of the PHS Act, together with the circumstances of each case and the penalties imposed.

(4) A list of laboratories on which alternative sanctions have been imposed, showing—
   (i) The effective date of the sanctions;
   (ii) The reasons for imposing them;
   (iii) Any corrective action taken by the laboratory; and
   (iv) If the laboratory has achieved compliance, the verified date of compliance.

(5) A list of laboratories whose accreditation has been withdrawn or revoked and the reasons for the withdrawal or revocation.

(6) All appeals and hearing decisions.

(7) A list of laboratories against which CMS has brought suit under §493.1846 and the reasons for those actions.

(8) A list of laboratories that have been excluded from participation in Medicare or Medicaid and the reasons for the exclusion.

(b) The laboratory registry is compiled for the calendar year preceding
§ 493.2001 Establishment and function of the Clinical Laboratory Improvement Advisory Committee.

(a) HHS will establish a Clinical Laboratory Improvement Advisory Committee to advise and make recommendations on technical and scientific aspects of the provisions of this part 493.

(b) The Clinical Laboratory Improvement Advisory Committee will be comprised of individuals involved in the provision of laboratory services, utilization of laboratory services, development of laboratory testing or methodology, and others as approved by HHS.

(c) HHS will designate specialized subcommittees as necessary.

(d) The Clinical Laboratory Improvement Advisory Committee or any designated subcommittees will meet as needed, but not less than once each year.

(e) The Clinical Laboratory Improvement Advisory Committee or subcommittee, at the request of HHS, will review and make recommendations concerning:

(1) Criteria for categorizing non-waived testing;

(2) Determination of waived tests;

(3) Personnel standards;

(4) Facility administration and quality systems standards;

(5) Proficiency testing standards;

(6) Applicability to the standards of new technology; and

(7) Other issues relevant to part 493, if requested by HHS.

(f) HHS will be responsible for providing the data and information, as necessary, to the members of the Clinical Laboratory Improvement Advisory Committee.

Centers for Medicare & Medicaid Services, HHS

§ 494.30

their dependent children with ESRD who require dialysis or transplantation.

(2) Section 1861(e)(9) of the Act, which requires hospitals to meet such other requirements as the Secretary finds necessary in the interest of health and safety of individuals who are furnished services in the institution.

(3) Section 1861(s)(2)(F) of the Act, which describes "medical and other health services" covered under Medicare to include home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies.

(4) Section 1862(a) of the Act, which specifies exclusions from coverage.

(5) Section 1881 of the Act, which authorizes Medicare coverage and payment for the treatment of ESRD in approved facilities, including institutional dialysis services, transplantation services, self-care home dialysis services, and the administration of erythropoiesis-stimulating agent(s).

(6) Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Pub. L. 104–113), which requires Federal agencies to use technical standards that are developed or adopted by voluntary consensus standards bodies, unless their use would be inconsistent with applicable law or otherwise impractical.

(b) Scope. The provisions of this part establish the conditions for coverage of services under Medicare and are the basis for survey activities for the purpose of determining whether an ESRD facility’s services may be covered.

§ 494.10 Definitions.

As used in this part—

Dialysis facility means an entity that provides outpatient maintenance dialysis services, or home dialysis training and support services, or both. A dialysis facility may be an independent or hospital-based unit (as described in §413.174(b) and (c) of this chapter) that includes a self-care dialysis unit that furnishes only self-dialysis services.

Discharge means the termination of patient care services by a dialysis facility or the patient voluntarily terminating dialysis when he or she no longer wants to be dialyzed by that facility.

Furnishes directly means the ESRD facility provides the service through its own staff and employees or through individuals who are under direct contract to furnish these services personally for the facility.

Home dialysis means dialysis performed at home by an ESRD patient or caregiver who has completed an appropriate course of training as described in §494.100(a) of this part.

Self-dialysis means dialysis performed with little or no professional assistance by an ESRD patient or caregiver who has completed an appropriate course of training as specified in §494.100(a) of this part.

Transfer means a temporary or permanent move of a patient from one dialysis facility to another that requires a transmission of the patient’s medical record to the facility receiving the patient.

§ 494.20 Condition: Compliance with Federal, State, and local laws and regulations.

The facility and its staff must operate and furnish services in compliance with applicable Federal, State, and local laws and regulations pertaining to licensure and any other relevant health and safety requirements.

Subpart B—Patient Safety

§ 494.30 Condition: Infection control.

The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.

(a) Standard: Procedures for infection control. The facility must demonstrate that it follows standard infection control precautions by implementing—

(1)(i) The recommendations (with the exception of screening for hepatitis C), found in "Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients," developed by the Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, volume 50, number RR05, April 27, 2001,
§ 494.40 Condition: Water and dialysate quality.

The facility must be able to demonstrate the following:

(a) Standard: Water purity. Water and equipment used for dialysis meets the water and dialysate quality standards and equipment requirements found in the Association for the Advancement of Medical Instrumentation (AAMI) publication, “Dialysate for hemodialysis,” ANSI/AAMI RD52: 2004. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. This publication is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html.

(3) Patient isolation procedures to minimize the spread of infectious agents and communicable diseases; and

(4) Maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the—

(i) Handling, storage, and disposal of potentially infectious waste; and

(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.

(b) Standard: Oversight. The facility must—

(1) Monitor and implement biohazard and infection control policies and activities within the dialysis unit;

(2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and

(3) Require all clinical staff to report infection control issues to the dialysis facility’s medical director (see § 494.150 of this part) and the quality improvement committee.

(c) Standard: Reporting. The facility must report incidences of communicable diseases as required by Federal, State, and local regulations.
Centers for Medicare & Medicaid Services, HHS § 494.50

(federal_register/code_of_regulations/ibr_locations.html. Copies may be purchased from the Association for the Advancement of Medical Instrumentation, 3300 Washington Boulevard, Suite 400, Arlington, VA 22201–4598.

(b) Standard: Chlorine/chloramines. (1) The water treatment system must include a component or carbon tank which removes chlorine/chloramine along with a backup component or second carbon tank in series for chlorine/chloramine removal;

(2)(i) If the test results from the port of the initial component or carbon tank referred to in section 6.2.5 of AAMI RD52:2004 are greater than 0.5 mg/L for free chlorine or 0.1 mg/L for chloramines, or equal to or greater than 0.1 mg/L of total chlorine, then the second component or carbon tank which removes chlorine/chloramine must be tested;

(ii) If the test results from the last component or carbon tank are greater than the parameters for chlorine or chloramine specified in paragraph (b)(2)(i) of this section the facility must—

(A) Immediately take corrective action to bring chlorine or chloramine levels into compliance with paragraph (b)(2)(i) of this section and confirm through testing that the corrective action has been effective, or terminate dialysis treatment to protect patients from exposure to chlorine/chloramine;

(B) Only allow use of purified water in a holding tank, if appropriate, and if testing shows water chlorine or chloramine levels that are in compliance with paragraph (b)(2)(i) of this section; and

(C) Immediately notify the medical director; and

(D) Take corrective action to ensure ongoing compliance with acceptable chlorine and chloramine levels as described in paragraph (b)(2)(i) of this section.

(c) Standard: Corrective action plan. Water testing results including, but not limited to, chemical, microbial, and endotoxin levels which meet AAMI action levels or deviate from the AAMI standards must be addressed with a corrective action plan that ensures patient safety.

(d) Standard: Adverse events. A dialysis facility must maintain active surveillance of patient reactions during and following dialysis. When clinically indicated (for example, after adverse patient reactions) the facility must—

(1) Obtain blood and dialysate cultures and endotoxin levels;

(2) Evaluate the water purification system; and

(3) Take corrective action.

(e) Standard: In-center use of preconfigured hemodialysis systems. When using a preconfigured, FDA-approved hemodialysis system designed, tested and validated to yield AAMI quality (which includes standards for chemical and chlorine/chloramine testing) water and dialysate, the system’s FDA-approved labeling must be adhered to for machine use and monitoring of the water and dialysate quality. The facility must meet all AAMI RD52:2004 requirements for water and dialysate. Moreover, the facility must perform bacteriological and endotoxin testing on a quarterly, or more frequent basis, as needed, to ensure that the water and dialysate are within AAMI limits.

§ 494.50 Condition: Reuse of hemodialyzers and bloodlines.

(a) Standard: General requirements for the reuse of hemodialyzers and bloodlines. Certain hemodialyzers and bloodlines—

(1) May be reused for certain patients with the exception of Hepatitis B positive patients;

(2) Must be reused only for the same patient; and

(3) Must be labeled for multiple reuse in accordance with the premarket notification provisions of section 510(k) of the Food, Drug, and Cosmetics Act and 21 CFR 876.5860.

(b) Standard: Reprocessing requirements for the reuse of hemodialyzers and bloodlines. A dialysis facility that reuses hemodialyzers and bloodlines must adhere to the following reprocessing guidelines:

§ 494.60 Condition: Physical environment.

The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment.

(a) Standard: Building. The building in which dialysis services are furnished must be constructed and maintained to ensure the safety of the patients, the staff, and the public.

(b) Standard: Equipment maintenance. The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer’s recommendations.

(c) Standard: Patient care environment.

(1) The space for treating each patient must be sufficient to provide needed care and services, prevent cross-contamination, and to accommodate medical emergency equipment and staff.

(2) The dialysis facility must:

(i) Maintain a comfortable temperature within the facility; and

(ii) Make reasonable accommodations for the patients who are not comfortable at this temperature.

(3) The dialysis facility must make accommodations to provide for patient privacy when patients are examined or treated and body exposure is required.

(4) Patients must be in view of staff during hemodialysis treatment to ensure patient safety (video surveillance will not meet this requirement).

(d) Standard: Emergency preparedness. The dialysis facility must implement processes and procedures to manage medical and nonmedical emergencies that are likely to threaten the health or safety of the patients, the staff, or the public. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility’s geographic area.

(1) Emergency preparedness of staff. The dialysis facility must provide appropriate training and orientation in emergency preparedness to the staff. Staff training must be provided and
evaluated at least annually and include the following:

(i) Ensuring that staff can demonstrate a knowledge of emergency procedures, including informing patients of—

(A) What to do;

(B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated;

(C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and

(D) How to disconnect themselves from the dialysis machine if an emergency occurs.

(ii) Ensuring that, at a minimum, patient care staff maintain current CPR certification; and

(iii) Ensuring that nursing staff are properly trained in the use of emergency equipment and emergency drugs.

(2) Emergency preparedness patient training. The facility must provide appropriate orientation and training to patients, including the areas specified in paragraph (d)(1)(i) of this section.

(3) Emergency equipment. Emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, must be on the premises at all times and immediately available.

(4) Emergency plans. The facility must—

(i) Have a plan to obtain emergency medical system assistance when needed;

(ii) Evaluate at least annually the effectiveness of emergency and disaster plans and update them as necessary; and

(iii) Contact its local disaster management agency at least annually to ensure that such agency is aware of dialysis facility needs in the event of an emergency.

(e) Standard: Fire safety. (1) Except as provided in paragraph (e)(2) of this section, by February 9, 2009, dialysis facilities that are located adjacent to high hazardous occupancies or do not provide one or more exits to the outside at grade level from the patient treatment area level, must comply with applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association (which is incorporated by reference at §403.744(a)(1)(i) of this chapter).

(2) Notwithstanding paragraph (e)(1) of this section, dialysis facilities participating in Medicare as of October 14, 2008 that require sprinkler systems are those housed in multi-story buildings construction Types II(000), III(200), or V(000), as defined in the 2000 edition of the Life Safety Code of the National Fire Protection Association (which is incorporated by reference at §403.744(a)(1)(i) of this chapter), section 21.1.6.3, which were constructed after January 1, 2008, and those housed in high rise buildings over 75 feet in height, which were constructed after January 1, 2008.

(3) If CMS finds that a fire and safety code imposed by the facility’s State law adequately protects a dialysis facility’s patients, CMS may allow the State survey agency to apply the State’s fire and safety code instead of the Life Safety Code.

(4) After consideration of State survey agency recommendations, CMS may waive, for individual dialysis facilities and for appropriate periods, specific provisions of the Life Safety Code, if the following requirements are met:

(i) The waiver would not adversely affect the health and safety of the dialysis facility’s patients; and

(ii) Rigid application of specific provisions of the Life Safety Code would result in an unreasonable hardship for the dialysis facility.


Effective Date Note: At 81 FR 64042, Sept. 16, 2016, §494.60 was amended by removing paragraph (d) and redesignating paragraph (e) as paragraph (d), effective Nov. 15, 2016.
§ 494.62 Condition of participation: Emergency preparedness.

The dialysis facility must comply with all applicable Federal, State, and local emergency preparedness requirements. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. The dialysis facility must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

(a) Emergency plan. The dialysis facility must develop and maintain an emergency preparedness plan that must be evaluated and updated at least annually. The plan must do all of the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.

(2) Include strategies for addressing emergency events identified by the risk assessment.

(3) Address patient population, including, but not limited to, the type of services the dialysis facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility’s efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility’s needs in the event of an emergency.

(b) Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility’s geographic area. At a minimum, the policies and procedures must address the following:

(1) A system to track the location of on-duty staff and sheltered patients in the dialysis facility’s care during and after an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the dialysis facility must document the specific name and location of the receiving facility or other location.

(2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.

(3) A means to shelter in place for patients, staff, and volunteers who remain in the facility.

(4) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

(5) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federalally designated health care professionals to address surge needs during an emergency.

(6) The development of arrangements with other dialysis facilities or other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to dialysis facility patients.

(7) The role of the dialysis facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

(8) How emergency medical system assistance can be obtained when needed.

(9) A process by which the staff can confirm that emergency equipment, including, but not limited to, oxygen,
airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, are on the premises at all times and immediately available.

(c) Communication plan. The dialysis facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

(1) Names and contact information for the following:
   (i) Staff.
   (ii) Entities providing services under arrangement.
   (iii) Patients’ physicians.
   (iv) Other dialysis facilities.
   (v) Volunteers.

(2) Contact information for the following:
   (i) Federal, State, tribal, regional or local emergency preparedness staff.
   (ii) Other sources of assistance.

(3) Primary and alternate means for communicating with the following:
   (i) Dialysis facility’s staff.
   (ii) Federal, State, tribal, regional, or local emergency management agencies.

(4) A method for sharing information and medical documentation for patients under the dialysis facility’s care, as necessary, with other health care providers to maintain the continuity of care.

(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).

(6) A means of providing information about the general condition and location of patients under the facility’s care as permitted under 45 CFR 164.510(b)(4).

(7) A means of providing information about the dialysis facility’s needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.

(d) Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing, and patient orientation program must be evaluated and updated at least annually.

(1) Training program. The dialysis facility must do all of the following:
   (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

   (ii) Provide emergency preparedness training at least annually. Staff training must:

      (iii) Demonstrate staff knowledge of emergency procedures, including informing patients of—

         (A) What to do;

         (B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated;

         (C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and

         (D) How to disconnect themselves from the dialysis machine if an emergency occurs.

   (iv) Demonstrate that, at a minimum, its patient care staff maintains current CPR certification; and

   (v) Properly train its nursing staff in the use of emergency equipment and emergency drugs.

   (vi) Maintain documentation of the training.

(2) Testing. The dialysis facility must conduct exercises to test the emergency plan at least annually. The dialysis facility must do all of the following:

   (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the dialysis facility experiences an actual natural or man-made emergency
that requires activation of the emergency plan, the ESRD is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

(ii) Conduct an additional exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based.

(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the dialysis facility’s response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the dialysis facility’s emergency plan, as needed.

(3) Patient orientation: Emergency preparedness patient training. The facility must provide appropriate orientation and training to patients, including the areas specified in paragraph (d)(1) of this section.

(e) Integrated healthcare systems. If a dialysis facility is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the dialysis facility may choose to participate in the healthcare system’s coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. 

(2) Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered.

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include all of the following:

(i) A documented community-based risk assessment, utilizing an all-hazards approach.

(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

EFFECTIVE DATE NOTE: At 81 FR 64042, Sept. 16, 2016, §494.62 was added, effective Nov. 15, 2016.

Subpart C—Patient Care

§494.70 Condition: Patients’ rights.

The dialysis facility must inform patients (or their representatives) of their rights (including their privacy rights) and responsibilities when they begin their treatment and must protect and provide for the exercise of those rights.

(a) Standard: Patients’ rights. The patient has the right to—

(1) Respect, dignity, and recognition of his or her individuality and personal needs, and sensitivity to his or her psychological needs and ability to cope with ESRD;

(2) Receive all information in a way that he or she can understand;

(3) Privacy and confidentiality in all aspects of treatment;

(4) Privacy and confidentiality in personal medical records;

(5) Be informed about and participate, if desired, in all aspects of his or her care, and be informed of the right to refuse treatment, to discontinue treatment, and to refuse to participate in experimental research;

(6) Be informed about his or her right to execute advance directives, and the
(7) Be informed about all treatment modalities and settings, including but not limited to, transplantation, home dialysis modalities (home hemodialysis, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis), and in-facility hemodialysis. The patient has the right to receive resource information for dialysis modalities not offered by the facility, including information about alternative scheduling options for working patients;

(8) Be informed of facility policies regarding patient care, including, but not limited to, isolation of patients;

(9) Be informed of facility policies regarding the reuse of dialysis supplies, including hemodialyzers;

(10) Be informed by the physician, nurse practitioner, clinical nurse specialist, or physician’s assistant treating the patient for ESRD of his or her own medical status as documented in the patient’s medical record, unless the medical record contains a documented contraindication;

(11) Be informed of services available in the facility and charges for services not covered under Medicare;

(12) Receive the necessary services outlined in the patient plan of care described in §494.90;

(13) Be informed of the rules and expectations of the facility regarding patient conduct and responsibilities;

(14) Be informed of the facility’s internal grievance process;

(15) Be informed of external grievance mechanisms and processes, including how to contact the ESRD Network and the State survey agency;

(16) Be informed of his or her right to file internal grievances or external grievances or both without reprisal or denial of services; and

(17) Be informed that he or she may file internal or external grievances, personally, anonymously or through a representative of the patient’s choosing.

(b) Standard: Right to be informed regarding the facility’s discharge and transfer policies. The patient has the right to—

(1) Be informed of the facility’s policies for transfer, routine or involuntary discharge, and discontinuation of services to patients; and

(2) Receive written notice 30 days in advance of an involuntary discharge, after the facility follows the involuntary discharge procedures described in §494.180(f)(4). In the case of immediate threats to the health and safety of others, an abbreviated discharge procedure may be allowed.

(c) Standard: Posting of rights. The dialysis facility must prominently display a copy of the patient’s rights in the facility, including the current State agency and ESRD network mailing addresses and telephone complaint numbers, where it can be easily seen and read by patients.

§ 494.80  Condition: Patient assessment.

The facility’s interdisciplinary team consists of, at a minimum, the patient or the patient’s designee (if the patient chooses), a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietitian. The interdisciplinary team is responsible for providing each patient with an individualized and comprehensive assessment of his or her needs. The comprehensive assessment must be used to develop the patient’s treatment plan and expectations for care.

(a) Standard: Assessment criteria. The patient’s comprehensive assessment must include, but is not limited to, the following:

(1) Evaluation of current health status and medical condition, including co-morbid conditions.

(2) Evaluation of the appropriateness of the dialysis prescription, blood pressure, and fluid management needs.

(3) Laboratory profile, immunization history, and medication history.

(4) Evaluation of factors associated with anemia, such as hematocrit, hemoglobin, iron stores, and potential treatment plans for anemia, including administration of erythropoiesis-stimulating agent(s).


(6) Evaluation of nutritional status by a dietitian.

(7) Evaluation of psychosocial needs by a social worker.
§ 494.90 Condition: Patient plan of care.

The interdisciplinary team as defined at § 494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient’s needs, as identified by the comprehensive assessment and changes in the patient’s condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.

(a) Standard: Development of patient plan of care. The interdisciplinary team must develop a plan of care for each patient. The plan of care must address, but not be limited to, the following:

(1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient’s volume status; and achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis.

(2) Nutritional status. The interdisciplinary team must provide the necessary care and counseling services to achieve and sustain an effective nutritional status. A patient’s albumin level and body weight must be measured at least monthly. Additional evidence-based professionally-accepted
Centers for Medicare & Medicaid Services, HHS § 494.90

clinical nutrition indicators may be monitored, as appropriate.

(3) Mineral metabolism. Provide the necessary care to manage mineral metabolism and prevent or treat renal bone disease.

(4) Anemia. The interdisciplinary team must provide the necessary care and services to achieve and sustain the clinically appropriate hemoglobin/hematocrit level. The patient’s hemoglobin/hematocrit must be measured at least monthly. The dialysis facility must conduct an evaluation of the patient’s anemia management needs. For a home dialysis patient, the facility must evaluate whether the patient can safely, aseptically, and effectively administer erythropoiesis-stimulating agents and store this medication under refrigeration if necessary. The patient’s response to erythropoiesis-stimulating agent(s), including blood pressure levels and utilization of iron stores, must be monitored on a routine basis.

(5) Vascular access. The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement. The patient’s vascular access must be monitored to prevent access failure, including monitoring of arteriovenous grafts and fistulae for symptoms of stenosis.

(6) Psychosocial status. The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis.

(7) Modality—(1) Home dialysis. The interdisciplinary team must identify a plan for the patient’s home dialysis or explain why the patient is not a candidate for home dialysis.

(ii) Transplantation status. When the patient is a transplant referral candidate, the interdisciplinary team must develop plans for pursuing transplantation. The patient’s plan of care must include documentation of the—

(A) Plan for transplantation, if the patient accepts the transplantation referral;

(B) Patient’s decision, if the patient is a transplantation referral candidate but declines the transplantation referral; or

(C) Reason(s) for the patient’s non-referral as a transplantation candidate as documented in accordance with §494.80(a)(10).

(8) Rehabilitation status. The interdisciplinary team must assist the patient in achieving and sustaining an appropriate level of productive activity, as desired by the patient, including the educational needs of pediatric patients (patients under the age of 18 years), and make rehabilitation and vocational rehabilitation referrals as appropriate.

(b) Standard: Implementation of the patient plan of care. (1) The patient’s plan of care must—

(i) Be completed by the interdisciplinary team, including the patient if the patient desires; and

(ii) Be signed by team members, including the patient or the patient’s designee; or, if the patient chooses not to sign the plan of care, this choice must be documented on the plan of care, along with the reason the signature was not provided.

(2) Implementation of the initial plan of care must begin within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. Implementation of monthly or annual updates of the plan of care must be performed within 15 days of the completion of the additional patient assessments specified in §494.80(d).

(3) If the expected outcome is not achieved, the interdisciplinary team must adjust the patient’s plan of care to achieve the specified goals. When a patient is unable to achieve the desired outcomes, the team must—

(i) Adjust the plan of care to reflect the patient’s current condition;
(ii) Document in the record the reasons why the patient was unable to achieve the goals; and
(iii) Implement plan of care changes to address the issues identified in paragraph (b)(3)(ii) of this section.

(4) The dialysis facility must ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician’s assistant providing ESRD care at least monthly, as evidenced by a monthly progress note placed in the medical record, and periodically while the hemodialysis patient is receiving in-facility dialysis.

(c) Standard: Transplantation referral tracking. The interdisciplinary team must—

1. Track the results of each kidney transplant center referral;
2. Monitor the status of any facility patients who are on the transplant wait list; and
3. Communicate with the transplant center regarding patient transplant status at least annually, and when there is a change in transplant candidate status.

(d) Standard: Patient education and training. The patient care plan must include, as applicable, education and training for patients and family members or caregivers or both, in aspects of the dialysis experience, dialysis management, infection prevention and personal care, home dialysis and self-care, quality of life, rehabilitation, transplantation, and the benefits and risks of various vascular access types.

§494.100 Condition: Care at home.

A dialysis facility that is certified to provide services to home patients must ensure through its interdisciplinary team, that home dialysis services are at least equivalent to those provided to in-facility patients and meet all applicable conditions of this part.

(a) Standard: Training. The interdisciplinary team must oversee training of the home dialysis patient, the designated caregiver, or self-dialysis patient before the initiation of home dialysis or self-dialysis (as defined in §494.10) and when the home dialysis caregiver or home dialysis modality changes. The training must—

1. Be provided by a dialysis facility that is approved to provide home dialysis services;
2. Be conducted by a registered nurse who meets the requirements of §494.140(b)(2); and
3. Be conducted for each home dialysis patient and address the specific needs of the patient, in the following areas:
   (i) The nature and management of ESRD,
   (ii) The full range of techniques associated with the treatment modality selected, including effective use of dialysis supplies and equipment in achieving and delivering the physician’s prescription of Kt/V or URR, and effective administration of erythropoiesis-stimulating agent(s) (if prescribed) to achieve and maintain a target level hemoglobin or hematocrit as written in patient’s plan of care,
   (iii) How to detect, report, and manage potential dialysis complications, including water treatment problems,
   (iv) Availability of support resources and how to access and use resources,
   (v) How to self-monitor health status and record and report health status information,
   (vi) How to handle medical and non-medical emergencies,
   (vii) Infection control precautions,
   (viii) Proper waste storage and disposal procedures.

(b) Standard: Home dialysis monitoring. The dialysis facility must—

1. Document in the medical record that the patient, the caregiver, or both received and demonstrated adequate comprehension of the training;
2. Retrieve and review complete self-monitoring data and other information from self-care patients or their designated caregiver(s) at least every 2 months; and
3. Maintain this information in the patient’s medical record.

(c) Standard: Support services. (1) A home dialysis facility must furnish (either directly, under agreement, or by arrangement with another ESRD facility) home dialysis support services regardless of whether dialysis supplies are provided by the dialysis facility or a durable medical equipment company. Services include, but are not limited to, the following:
(i) Periodic monitoring of the patient’s home adaptation, including visits to the patient’s home by facility personnel in accordance with the patient’s plan of care.

(ii) Coordination of the home patient’s care by a member of the dialysis facility’s interdisciplinary team.

(iii) Development and periodic review of the patient’s individualized comprehensive plan of care that specifies the services necessary to address the patient’s needs and meets the measurable and expected outcomes as specified in §494.90 of this part.

(iv) Patient consultation with members of the interdisciplinary team, as needed.

(v) Monitoring of the quality of water and dialysate used by home hemodialysis patients including conducting an onsite evaluation and testing of the water and dialysate system in accordance with—

(A) The recommendations specified in the manufacturers’ instructions; and

(B) The system’s FDA-approved labeling for preconfigured systems designed, tested, and validated to meet AAMI quality (which includes standards for chemical and chlorine/chloramine testing) water and dialysate. The facility must meet testing and other requirements of AAMI RD52:2004. In addition, bacteriological and endotoxin testing must be performed on a quarterly, or more frequent basis as needed, to ensure that the water and dialysate are within the AAMI limits.

(C) The dialysis facility must correct any water and dialysate quality problem for the home hemodialysis patient, and if necessary, arrange for backup dialysis until the problem is corrected if—

(1) Analysis of the water and dialysate quality indicates contamination; or

(2) The home hemodialysis patient demonstrates clinical symptoms associated with water and dialysate contamination.

(vi) Purchasing, leasing, renting, delivering, installing, repairing and maintaining medically necessary home dialysis supplies and equipment (including supportive equipment) prescribed by the attending physician.

(vii) Identifying a plan and arranging for emergency back-up dialysis services when needed.

(2) The dialysis facility must maintain a recordkeeping system that ensures continuity of care and patient privacy. This includes items and services furnished by durable medical equipment (DME) suppliers referred to in §414.330(a)(2) of this chapter.

§494.110 Condition: Quality assessment and performance improvement.

The dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The program must reflect the complexity of the dialysis facility’s organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its quality improvement and performance improvement program for review by CMS.

(a) Standard: Program scope. (1) The program must include, but not be limited to, an ongoing program that achieves measurable improvement in health outcomes and reduction of medical errors by using indicators or performance measures associated with improved health outcomes and with the identification and reduction of medical errors.

(2) The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. The program must include, but not be limited to, the following:

(i) Adequacy of dialysis.

(ii) Nutritional status.

(iii) Mineral metabolism and renal bone disease.

(iv) Anemia management.

(v) Vascular access.
(vi) Medical injuries and medical errors identification.
(vii) Hemodialyzer reuse program, if the facility reuses hemodialyzers.
(viii) Patient satisfaction and grievances.
(ix) Infection control; with respect to this component the facility must—
(A) Analyze and document the incidence of infection to identify trends and establish baseline information on infection incidence;
(B) Develop recommendations and action plans to minimize infection transmission, promote immunization; and
(C) Take actions to reduce future incidents.
(b) Standard: Monitoring performance improvement. The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time.
(c) Standard: Prioritizing improvement activities. The dialysis facility must set priorities for performance improvement, considering prevalence and severity of identified problems and giving priority to improvement activities that affect clinical outcomes or patient safety. The facility must immediately correct any identified problems that threaten the health and safety of patients.

§ 494.120 Condition: Special purpose renal dialysis facilities.

A special purpose renal dialysis facility is approved to furnish dialysis on a short-term basis at special locations. Special purpose dialysis facilities are divided into two categories: vacation camps (locations that serve ESRD patients while the patients are in a temporary residence) and facilities established to serve ESRD patients under emergency circumstances.

(a) Standard: Approval period. The period of approval for a special purpose renal dialysis facility may not exceed 8 months in any 12-month period.
(b) Standard: Service limitation. Special purpose renal dialysis facilities are limited to areas in which there are limited dialysis resources or access-to-care problems due to an emergency circumstance. A special purpose renal dialysis facility may provide services only to those patients who would otherwise be unable to obtain treatments in the geographic locality served by the facility.

(c) Standard: Scope of requirements—(1) Scope of requirements for a vacation camp. A vacation camp that provides dialysis services must be operated under the direction of a certified renal dialysis facility that assumes full responsibility for the care provided to patients. A special purpose renal dialysis facility established as a vacation camp must comply with the following conditions for coverage—
(i) Infection control at § 494.30;
(ii) Water and dialysate quality at § 494.40 (except as provided in paragraph (c)(1)(viii) of this section);
(iii) Reuse of hemodialyzers at § 494.50 (if reuse is performed);
(iv) Patients’ rights and posting of patients’ rights at § 494.70(a) and § 494.70(c);
(v) Laboratory services at § 494.130;
(vi) Medical director responsibilities for staff education and patient care policies and procedures at § 494.150(c) and § 494.150(d);
(vii) Medical records at § 494.170; and
(viii) When portable home water treatment systems are used in place of a central water treatment system, the facility may adhere to § 494.100(c)(1)(v) (home monitoring of water quality), in place of § 494.40 (water quality).
(2) Scope of requirements for an emergency circumstance facility. A special purpose renal dialysis facility set up due to emergency circumstances may provide services only to those patients who would otherwise be unable to obtain treatments in the geographic areas served by the facility. These types of special purpose dialysis facilities must comply with paragraph (c)(1) of this section and addition to complying with the following conditions:
(i) Section 494.20 (compliance with Federal, State, and local laws and regulations);
(ii) Section 494.60 (physical environment);
(iii) Section 494.70(a) through section 494.70(c) (patient rights);
(iv) Section 494.140 (personnel qualifications);
(v) Section 494.150 (medical director);
(vi) Section 494.180 (governance).
Centers for Medicare & Medicaid Services, HHS

§ 494.140

(d) Standard: Physician contact. The facility must contact the patient’s physician, if possible, prior to initiating dialysis in the special purpose renal dialysis facility, to discuss the patient’s current condition to assure care provided in the special purpose renal dialysis facility is consistent with the patient plan of care (described in §494.90).

(e) Standard: Documentation. All patient care provided in the special purpose facility is documented and forwarded to the patient’s usual dialysis facility, if possible, within 30 days of the last scheduled treatment in the special purpose renal dialysis facility.

§ 494.130 Condition: Laboratory services.

The dialysis facility must provide, or make available, laboratory services (other than tissue pathology and histocompatibility) to meet the needs of the ESRD patient. Any laboratory services, including tissue pathology and histocompatibility must be furnished by or obtained from, a facility that meets the requirements for laboratory services specified in part 493 of this chapter.

Subpart D—Administration

§ 494.140 Condition: Personnel qualifications.

All dialysis facility staff must meet the applicable scope of practice board and licensure requirements in effect in the State in which they are employed. The dialysis facility’s staff (employee or contractor) must meet the personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The dialysis facility’s staff must have the ability to demonstrate and sustain the skills needed to perform the specific duties of their positions.

(a) Standard: Medical director. (1) The medical director must be a board-certified physician in internal medicine or pediatrics by a professional board who has completed a board-approved training program in nephrology and has at least 12-months of experience providing care to patients receiving dialysis.

(2) If a physician, as specified in paragraph (a)(1) of this section, is not available to direct a certified dialysis facility another physician may direct the facility, subject to the approval of the Secretary.

(b) Standard: Nursing services—(1) Nurse manager. The facility must have a nurse manager responsible for nursing services in the facility who must—

(i) Be a full time employee of the facility;

(ii) Be a registered nurse; and

(iii) Have at least 12 months of experience in clinical nursing, and an additional 6 months of experience in providing nursing care to patients on maintenance dialysis.

(2) Self-care and home dialysis training nurse. The nurse responsible for self-care and/or home care training must—

(i) Be a registered nurse; and

(ii) Have at least 12 months experience in providing nursing care and an additional 3 months of experience in the specific modality for which the nurse will provide self-care training.

(3) Charge nurse. The charge nurse responsible for each shift must—

(i) Be a registered nurse, a licensed practical nurse, or vocational nurse who meets the practice requirements in the State in which he or she is employed;

(ii) Have at least 12 months experience in providing nursing care, including 3 months of experience in providing nursing care to patients on maintenance dialysis; and

(iii) If such nurse is a licensed practical nurse or licensed vocational nurse, work under the supervision of a registered nurse in accordance with state nursing practice act provisions.

(4) Staff nurse. Each nurse who provides care and treatment to patients must be either a registered nurse or a practical nurse who meets the practice requirements in the State in which he or she is employed.

(c) Standard: Dietitian. The facility must have a dietitian who must—

(1) Be a registered dietitian with the Commission on Dietetic Registration; and

(2) Have a minimum of 1 year professional work experience in clinical nutrition as a registered dietitian.
§ 494.150  Condition: Responsibilities of the medical director.

The dialysis facility must have a medical director who meets the qualifications of §494.140(a) to be responsible for the delivery of patient care and outcomes in the facility. The medical director is accountable to the governing body for the quality of medical care provided to patients. Medical director responsibilities include, but are not limited to, the following:

(a) Quality assessment and performance improvement program.

(b) Staff education, training, and performance.

(c) Policies and procedures. The medical director must—

(1) Participate in the development, periodic review and approval of a “patient care policies and procedures manual” for the facility; and

(2) Ensure that—

(i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; and

(ii) The interdisciplinary team adheres to the discharge and transfer policies and procedures specified in §494.180(f).

§ 494.160  [Reserved]

§ 494.170  Condition: Medical records.

The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients.
whose care is under the supervision of the facility.

(a) **Standard: Protection of the patient's record.** The dialysis facility must—

(1) Safeguard patient records against loss, destruction, or unauthorized use; and

(2) Keep confidential all information contained in the patient's record, except when release is authorized pursuant to one of the following:

(i) The transfer of the patient to another facility.

(ii) Certain exceptions provided for in the law.

(iii) Provisions allowed under third party payment contracts.

(iv) Approval by the patient.

(v) Inspection by authorized agents of the Secretary, as required for the administration of the dialysis program.

(3) Obtaining written authorization from the patient or legal representative before releasing information that is not authorized by law.

(b) **Standard: Completion of patient records and centralization of clinical information.**

(1) Current medical records and those of discharged patients must be completed promptly.

(2) All clinical information pertaining to a patient must be centralized in the patient's record, including whether the patient has executed an advance directive. These records must be maintained in a manner such that each member of the interdisciplinary team has access to current information regarding the patient's condition and prescribed treatment.

(3) The dialysis facility must complete, maintain, and monitor home care patients' records, including the records of patients who receive supplies and equipment from a durable medical equipment supplier.

(c) **Standard: Record retention and preservation.** In accordance with 45 CFR §164.530(k)(2), all patient records must be retained for 6 years from the date of the patient's discharge, transfer, or death.

(d) **Standard: Transfer of patient record information.** When a dialysis patient is transferred, the dialysis facility releasing the patient must send all requested medical record information to the receiving facility within 1 working day of the transfer.

§ 494.180 Condition: Governance.

The ESRD facility is under the control of an identifiable governing body, or designated person(s) with full legal authority and responsibility for the governance and operation of the facility. The governing body adopts and enforces rules and regulations relative to its own governance and to the health care and safety of patients, to the protection of the patients' personal and property rights, and to the general operation of the facility.

(a) **Standard: Designating a chief executive officer or administrator.** The governing body or designated person responsible must appoint a person who serves as the dialysis facility's chief executive officer or administrator who exercises responsibility for the management of the facility and the provision of all dialysis services, including, but not limited to—

(1) Staff appointments;

(2) Fiscal operations;

(3) The relationship with the ESRD networks; and

(4) Allocation of necessary staff and other resources for the facility's quality assessment and performance improvement program as described in §494.110.

(b) **Standard: Adequate number of qualified and trained staff.** The governing body or designated person responsible must ensure that—

(1) An adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients; and the registered nurse, social worker and dietitian members of the interdisciplinary team are available to meet patient clinical needs;

(2) A registered nurse, who is responsible for the nursing care provided, is present in the facility at all times that in-center dialysis patients are being treated;

(3) All staff, including the medical director, have appropriate orientation to the facility and their work responsibilities; and

(4) All employees have an opportunity for continuing education and related development activities.
(c) **Standard: Medical staff appointments.** The governing body—

(1) Is responsible for all medical staff appointments and credentialing in accordance with State law, including attending physicians, physician assistants, nurse practitioners, and clinical nurse specialists; and

(2) Ensures that all medical staff who provide care in the facility are informed of all facility policies and procedures, including the facility’s quality assessment and performance improvement program specified in §494.110.

(3) Communicates expectations to the medical staff regarding staff participation in improving the quality of medical care provided to facility patients.

(d) **Standard: Furnishing services.** The governing body is responsible for ensuring that the dialysis facility furnishes services directly on its main premises or on other premises that are contiguous with the main premises and are under the direction of the same professional staff and governing body as the main premises (except for services provided under §494.100).

(e) **Standard: Internal grievance process.** The facility’s internal grievance process must be implemented so that the patient may file an oral or written grievance with the facility without reprisal or denial of services. The grievance process must include:

(1) A clearly explained procedure for the submission of grievances.

(2) Timeframes for reviewing the grievance.

(3) A description of how the patient or the patient’s designated representative will be informed of steps taken to resolve the grievance.

(f) **Standard: Involuntary discharge and transfer policies and procedures.** The governing body must ensure that all staff follow the facility’s patient discharge and transfer policies and procedures. The medical director ensures that no patient is discharged or transferred from the facility unless—

(1) The patient or payer no longer reimburses the facility for the ordered services;

(2) The facility ceases to operate;

(3) The transfer is necessary for the patient’s welfare because the facility can no longer meet the patient’s documented medical needs; or

(4) The facility has reassessed the patient and determined that the patient’s behavior is disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired, in which case the medical director ensures that the patient’s interdisciplinary team—

(i) Documents the reassessments, ongoing problem(s), and efforts made to resolve the problem(s), and enters this documentation into the patient’s medical record;

(ii) Provides the patient and the local ESRD Network with a 30-day notice of the planned discharge;

(iii) Obtains a written physician’s order that must be signed by both the medical director and the patient’s attending physician concurring with the patient’s discharge or transfer from the facility;

(iv) Contacts another facility, attempts to place the patient there, and documents that effort; and

(v) Notifies the State survey agency of the involuntary transfer or discharge.

(5) In the case of immediate severe threats to the health and safety of others, the facility may utilize an abbreviated involuntary discharge procedure.

(g) **Standard: Emergency coverage.** (1) The governing body is responsible for ensuring that the dialysis facility provides patients and staff with written instructions for obtaining emergency medical care.

(2) The dialysis facility must have available at the nursing/monitoring station, a roster with the names of physicians to be called for emergencies, when they can be called, and how they can be reached.

(3) The dialysis facility must have an agreement with a hospital that can provide inpatient care, routine and emergency dialysis and other hospital services, and emergency medical care which is available 24 hours a day, 7 days a week. The agreement must:

(i) Ensure that hospital services are available promptly to the dialysis facility’s patients when needed;

(ii) Include reasonable assurances that patients from the dialysis facility
are accepted and treated in emergencies.

(h) Standard: Furnishing data and information for ESRD program administration. Effective February 1, 2009, the dialysis facility must furnish data and information to CMS and at intervals as specified by the Secretary. This information is used in a national ESRD information system and in compilations relevant to program administration, including claims processing and reimbursement, quality improvement, and performance assessment. The data and information must—

1. Be submitted at the intervals specified by the Secretary;
2. Be submitted electronically in the format specified by the Secretary;
3. Include, but not be limited to—
   i. Cost reports;
   ii. ESRD administrative forms;
   iii. Patient survival information; and
   iv. Existing ESRD clinical performance measures, and any future clinical performance standards developed in accordance with a voluntary consensus standards process identified by the Secretary.

(i) Standard: Relationship with the ESRD network. The governing body receives and acts upon recommendations from the ESRD network. The dialysis facility must cooperate with the ESRD network designated for its geographic area, in fulfilling the terms of the Network’s current statement of work. Each facility must participate in ESRD network activities and pursue network goals.

(j) Standard: Disclosure of ownership. In accordance with §420.200 through §420.206 of this chapter, the governing body must report ownership interests of 5 percent or more to its State survey agency.

PART 495—STANDARDS FOR THE ELECTRONIC HEALTH RECORD TECHNOLOGY INCENTIVE PROGRAM

Subpart A—General Provisions

Sec.

495.2 Basis and purpose.
495.4 Definitions.

495.5 Requirements for EPs seeking to reverse a hospital-based determination under §495.4.
495.20 Meaningful use objectives and measures for EPs, eligible hospitals, and CAHs before 2015.
495.22 Meaningful use objectives and measures for EPs, eligible hospitals, and CAHs for 2015 through 2017.
495.24 Stage 3 meaningful use objectives and measures for EPs, eligible hospitals, and CAHs for 2018 and subsequent years.
495.40 Demonstration of meaningful use criteria.
495.60 Participation requirements for EPs, eligible hospitals, and CAHs.

Subpart B—Requirements Specific to the Medicare Program

495.100 Definitions.
495.102 Incentive payments to EPs.
495.104 Incentive payments to eligible hospitals.
495.106 Incentive payments to CAHs.
495.108 Posting of required information.
495.110 Preclusion on administrative and judicial review.

Subpart C—Requirements Specific to Medicare Advantage (MA) Organizations

495.200 Definitions.
495.204 Incentive payments to qualifying MA organizations for qualifying MA–EPs and qualifying MA-affiliated eligible hospitals.
495.206 Timeframe for payment to qualifying MA organizations.
495.208 Avoiding duplicate payment.
495.210 Meaningful EHR user attestation.
495.211 Payment adjustments effective for 2015 and subsequent MA payment years with respect to MA EPs and MA-affiliated eligible hospitals.
495.212 Limitation on review.

Subpart D—Requirements Specific to the Medicaid Program

495.300 Basis and purpose.
495.302 Definitions.
495.304 Medicaid provider scope and eligibility.
495.306 Establishing patient volume.
495.308 Net average allowable costs as the basis for determining the incentive payment.
495.310 Medicaid provider incentive payments.
495.312 Process for payments.
495.314 Activities required to receive an incentive payment.
§ 495.2 Basis and purpose.

This part implements the following:
(a) Section 1848(o) of the Act by establishing payment incentives under Medicare Part B for eligible professionals who adopt and meaningfully use certified electronic health record (EHR) technology.
(b) Section 1853(1) of the Act to provide incentive payments to Medicare Advantage organizations for certain affiliated professionals who meaningfully use certified EHR technology and meet certain other requirements.
(c) Section 1886(a) of the Act by establishing incentives payments for the meaningful use of certified EHR technology by subsection (d) hospitals, as defined under section 1886(d)(1)(B) of the Act, participating in the Medicare FFS program.
(d) Section 1814(1) of the Act to provide an incentive payment to critical access hospitals that meaningfully use certified EHR technology based on the hospitals' reasonable costs.
(e) Section 1853(m) of the Act to provide incentive payments to MA organizations for certain affiliated hospitals that meaningfully use certified EHR technology.
(f) Sections 1903(a)(3)(F) and 1903(t) of the Act to provide 100 percent Federal financial participation (FFP) to States for incentive payments to certain eligible providers participating in the Medicaid program to purchase, implement, and operate (including support services and training for staff) certified EHR technology and 90 percent FFP for State administrative expenses related to such incentive payments.
(g) Sections 1848(a)(7), 1853(1)(4), 1866(b)(3)(B)(ix)(1), and 1853(m)(4) of the Act, providing for payment reductions for inpatient services furnished on or after October 1, 2014 to Medicare beneficiaries by hospitals that are not meaningful users of certified EHR technology, and for covered professional services furnished on or after January 1, 2015 to Medicare beneficiaries by certain professionals who are not meaningful users of certified EHR technology.

§ 495.4 Definitions.

In this part, unless otherwise indicated—
APl stands for application programming interface.
Certified electronic health record technology (CEHRT) means the following:
(1) For any Federal fiscal year or calendar year before 2018, EHR technology
(which could include multiple technologies) certified under the ONC Health IT Certification Program that meets one of the following:

(i) The 2014 Edition Base EHR definition (as defined at 45 CFR 170.102) and has been certified to the certification criteria that are necessary to be a Meaningful EHR User (as defined in this section), including the applicable measure calculation certification criterion at 45 CFR 170.314(g)(1) or (2) for all certification criteria that support a meaningful use objective with a percentage-based measure.

(ii) Certification to—

(A) The following certification criteria:

(i) CPOE at—

(1) 45 CFR 170.314(a)(1), (18), (19) or (20); or

(2)(i) Record demographics at 45 CFR 170.314(a)(3); or

(ii) 45 CFR 170.315(a)(5).

(3)(i) Problem list at 45 CFR 170.314(a)(5); or

(ii) 45 CFR 170.315(a)(6).

(4)(i) Medication list at 45 CFR 170.314(a)(6); or

(ii) 45 CFR 170.315(a)(7).

(5)(i) Medication allergy list 45 CFR 170.314(a)(7); or

(ii) 45 CFR 170.315(a)(8).

(ii) Clinical decision support at 45 CFR 170.314(a)(8); or

(ii) 45 CFR 170.315(a)(9).

(7) Health information exchange at transitions of care at one of the following:

(i) 45 CFR 170.314(b)(1) and (2).

(ii) 45 CFR 170.314(b)(1), (b)(2), and (h)(1).

(iii) 45 CFR 170.314(b)(1), (b)(2), and (b)(8).

(iv) 45 CFR 170.314(b)(1), (b)(2), (b)(8), and (h)(1).

(v) 45 CFR 170.314(b)(8) and (h)(1).

(vi) 45 CFR 170.314(b)(1), (b)(2), and 170.315(h)(2).

(vii) 45 CFR 170.314(b)(1), (b)(2), (h)(1), and 170.315(h)(2).

(viii) 45 CFR 170.314(b)(1), (b)(2), (b)(8), and 170.315(h)(2).

(ix) 45 CFR 170.314(b)(1), (b)(2), (b)(8), (h)(1), and 170.315(h)(2).

(x) 45 CFR 170.314(b)(8), (h)(1), and 170.315(h)(2).

(xi) 45 CFR 170.314(b)(1), (b)(2), and 170.315(b)(1).

(xii) 45 CFR 170.314(b)(1), (b)(2), (h)(1), and 170.315(b)(1).

(xiii) 45 CFR 170.314(b)(1), (b)(2), (b)(8), and 170.315(b)(1).

(xiv) 45 CFR 170.314(b)(1), (b)(2), (b)(8), (h)(1), and 170.315(b)(1).

(xv) 45 CFR 170.314(b)(8), (h)(1), and 170.315(b)(1).

(xvi) 45 CFR 170.314(b)(1), (b)(2), (b)(8), (h)(1), 170.315(b)(1), and 170.315(h)(1).

(xvii) 45 CFR 170.314(b)(1), (b)(2), (b)(8), (h)(1), 170.315(b)(1), and 170.315(h)(2).

(xviii) 45 CFR 170.314(h)(1) and 170.315(b)(1).

(xix) 45 CFR 170.315(b)(1) and (h)(1).

(xx) 45 CFR 170.315(b)(1) and (h)(2).

(xxi) 45 CFR 170.315(b)(1), (b)(2), and (h)(2); and

(B) Clinical quality measures at—

(i) 45 CFR 170.314(c)(1) or 170.315(c)(1); or

(ii) 45 CFR 170.314(c)(2) or 170.315(c)(2); or

(iii) Clinical quality measure certification criteria that support the calculation and reporting of clinical quality measures at 45 CFR 170.314(c)(2) and (3); or 45 CFR 170.315(c)(3)(i) and (ii); and can be electronically accepted by CMS if the provider is submitting electronically.

(C) Privacy and security at—

(i) 45 CFR 170.314(d)(1) or 170.315(d)(1); or

(ii) 45 CFR 170.314(d)(2) or 170.315(d)(2); or

(iii) 45 CFR 170.314(d)(3) or 170.315(d)(3); or

(iv) 45 CFR 170.314(d)(4) or 170.315(d)(4); or

(v) 45 CFR 170.314(d)(5) or 170.315(d)(5); or

(vi) 45 CFR 170.314(d)(6) or 170.315(d)(6); or

(vii) 45 CFR 170.314(d)(7) or 170.315(d)(7); or

(viii) 45 CFR 170.314(d)(8) or 170.315(d)(8); and

(D) The certification criteria that are necessary to be a Meaningful EHR User (as defined in this section), including the applicable measure calculation certification criterion at 45 CFR 170.314(g)(1) or (2) or 45 CFR 170.315(g)(1) or (2) for all certification criteria that support a meaningful use objective with a percentage-based measure.

(iii) The definition for 2018 subsequent years specified in paragraph (2) of this definition.

(2) For 2018 and subsequent years, EHR technology (which could include multiple technologies) certified under the ONC Health IT Certification Program that meets the 2015 Edition Base EHR definition (as defined at 45 CFR 170.315(b)(1).
§ 495.4

170.102) and has been certified to the 2015 Edition health IT certification criteria—

(i) At 45 CFR 170.315(a)(12) (family health history) and 45 CFR 170.315(e)(3) (patient health information capture); and

(ii) Necessary to be a Meaningful EHR User (as defined in this section), including the following:

(A) The applicable measure calculation certification criterion at 45 CFR 170.315(g)(1) or (2) for all certification criteria that support a meaningful use objective with a percentage-based measure.

(B) Clinical quality measure certification criteria that support the calculation and reporting of clinical quality measures at 45 CFR 170.315(c)(2) and (c)(3)(i) and (ii), and can be electronically accepted by CMS.

Critical access hospital (CAH) means a facility that has been certified as a critical access hospital under section 1820(e) of the Act and for which Medicare payment is made under section 1814(l) of the Act for inpatient services and under section 1834(g) of the Act for outpatient services.

EHR reporting period. Except with respect to payment adjustment years, EHR reporting period means either of the following:

(1) For an eligible EP—

(i) The following are applicable before 2015:

(A) For the payment year in which the EP is first demonstrating he or she is a meaningful EHR user, any continuous 90-day period within the calendar year;

(B) Except as specified in paragraphs (1)(ii) and (1)(iv) of this definition, for the subsequent payment years following the payment year in which the EP first successfully demonstrates he or she is a meaningful EHR user, the calendar year.

(C) For an EP seeking to demonstrate he or she is a meaningful EHR user for the Medicare EHR Incentive program for CY 2014, any of the following 3-month periods:


(2) April 1, 2014 through June 30, 2014.

(3) July 1, 2014 through September 30, 2014.

(2) For an EP seeking to demonstrate he or she is a meaningful EHR user for the Medicaid EHR incentive program for CY 2014 any continuous 90-day period within CY 2014.

(ii) The following are applicable for 2015, 2016, and 2017:

(A) For the CY 2015 payment year, any continuous 90-day period within CY 2015.

(B) For the CY 2016 payment year:

(1) For the EP first demonstrating he or she is a meaningful EHR user, any continuous 90-day period within CY 2016.

(2) For the EP who has successfully demonstrated he or she is a meaningful EHR user in any prior year, the CY 2016.

(C) For the CY 2017 payment year under the Medicaid EHR Incentive Program:

(1) For the EP first demonstrating he or she is a meaningful EHR user, any continuous 90-day period within CY 2017.

(2) For the EP who has successfully demonstrated he or she is a meaningful EHR user in any prior year, the CY 2017.

(3) For the EP demonstrating the Stage 3 objectives and measures at §495.24, any continuous 90-day period within CY 2017.

(iii) The following are applicable beginning with the CY 2018 payment year under the Medicaid EHR Incentive Program:

(A) For the payment year in which the EP is first demonstrating he or she is a meaningful EHR user, any continuous 90-day period within the calendar year.

(B) For the subsequent payment years following the payment year in which the EP first successfully demonstrates he or she is a meaningful EHR user, the calendar year.

(2) For an eligible hospital or CAH—

(i) The following are applicable before 2015:

(A) For the payment year in which the eligible hospital or CAH is first demonstrating it is a meaningful EHR user, any continuous 90-day period within the Federal fiscal year;
(B) Except as specified in paragraph (2)(iii) of this definition, for the subsequent payment years following the payment year in which the eligible hospital or CAH first successfully demonstrates it is a meaningful EHR user, the Federal fiscal year.

(C) For an eligible hospital or CAH seeking to demonstrate it is a meaningful EHR user for FY 2014, any of the following 3-month periods:

1. October 1, 2013 through December 31, 2013.

(ii) The following are applicable for 2015, 2016, and 2017:

(A) For the FY 2015 payment year, any continuous 90-day period within the period beginning on October 1, 2014 and ending on December 31, 2015.

(B) For the FY 2016 payment year as follows:

1. For the eligible hospital or CAH first demonstrating it is a meaningful EHR user, any continuous 90-day period within CY 2016.

2. For the eligible hospital or CAH that has successfully demonstrated it is a meaningful EHR user in any prior year, the CY 2016.

(C) For the FY 2017 payment year under the Medicaid EHR Incentive Program:

1. For the eligible hospital or CAH first demonstrating it is a meaningful EHR user, any continuous 90-day period within CY 2017.

2. For the eligible hospital or CAH that has successfully demonstrated it is a meaningful EHR user in any prior year, the CY 2017.

3. For the eligible hospital or CAH demonstrating the Stage 3 objectives and measures at §495.24, any continuous 90-day period within CY 2017.

(iii) The following are applicable beginning with the FY 2018 payment year under the Medicaid EHR Incentive Program:

(A) For the payment year in which the eligible hospital or CAH is first demonstrating it is a meaningful EHR user, any continuous 90-day period within the calendar year.

(B) For the subsequent payment years following the payment year in which the eligible hospital or CAH first successfully demonstrates it is a meaningful EHR user, the calendar year.

EHR reporting period for a payment adjustment year. For a payment adjustment year, the EHR reporting period means the following:

1. For an EP—

(i) The following are applicable before 2015:

(A)(1) Except as provided in paragraphs (1)(i)(A)(2), (1)(i)(B), and (1)(i)(C) of this definition, the calendar year that is 2 years before the payment adjustment year.

(2) The special EHR reporting period for CY 2014 (specified in paragraph (1)(i)(C) of this definition, as applicable) of the definition of “EHR Reporting Period” that occurs within the calendar year that is 2 years before the payment adjustment year and is only for EHR reporting periods in CY 2014.

(B) If an EP is demonstrating he or she is a meaningful EHR user for the first time in the calendar year, that is 2 years before the payment adjustment year, then any continuous 90-day period within such (2 years prior) calendar year.

(C)(1) If in the calendar year that is 2 years before the payment adjustment year and in all prior calendar years, the EP has not successfully demonstrated he or she is a meaningful EHR user, then any continuous 90-day period that both begins in the calendar year 1 year before the payment adjustment year and ends at least 3 months before the end of such prior year.

(2) Under this exception, the provider must successfully register for and attest to meaningful use no later than the date October 1 of the year before the payment adjustment year.

(ii) The following are applicable for 2015, 2016, and 2017:

(A) In 2015 as follows:

(1) If an EP has not successfully demonstrated he or she is a meaningful EHR user in a prior year, the EHR reporting period is any continuous 90-day period within CY 2015 and applies for the CY 2016 and 2017 payment adjustment years.

(2) If in a prior year an EP has successfully demonstrated he or she is a
meaningful EHR user, the EHR reporting period is any continuous 90-day period within CY 2015 and applies for the CY 2017 payment adjustment year.

(B) In 2016 as follows:

(1) If an EP has not successfully demonstrated he or she is a meaningful EHR user in a prior year, the EHR reporting period is any continuous 90-day period within CY 2016 and applies for the CY 2017 and 2018 payment adjustment years. For the CY 2017 payment adjustment year, the EHR reporting period must end before and the EP must successfully register for and attest to meaningful use no later than October 1, 2016.

(2) If in a prior year an EP has successfully demonstrated he or she is a meaningful EHR user, the EHR reporting period is CY 2016 and applies for the CY 2018 payment adjustment year.

(C) In 2017 as follows:

(1) If an EP has not successfully demonstrated he or she is a meaningful EHR user in a prior year, the EHR reporting period is any continuous 90-day period within CY 2017 and applies for the CY 2018 payment adjustment year. For the CY 2018 payment adjustment year, the EHR reporting period must end before and the EP must successfully register for and attest to meaningful use no later than October 1, 2017.

(2) Under this exception, the eligible hospital must successfully register for and attest to meaningful use no later than July 1 of the year before the payment adjustment year.

(ii) The following are applicable for 2015, 2016, and 2017:

(A) In 2015 as follows:

(1) If an eligible hospital has not successfully demonstrated it is a meaningful EHR user, the EHR reporting period is any continuous 90-day period within the period beginning on October 1, 2014 and ending on December 31, 2015 and applies for the FY 2016 and 2017 payment adjustment years.

(2) If in a prior year an eligible hospital has successfully demonstrated it is a meaningful EHR user, the EHR reporting period is any continuous 90-day period within the period beginning on October 1, 2014 and ending on December 31, 2015 and applies for the FY 2017 payment adjustment years.

(B) In 2016 as follows:

(1) If an eligible hospital has not successfully demonstrated it is a meaningful EHR user, the EHR reporting period is any continuous 90-day period within CY 2016 and 2017 applies for the FY 2017 and 2018 payment adjustment years. For the FY 2017 payment adjustment year, the EHR reporting period must end before and the eligible hospital must successfully register for and attest to meaningful use no later than October 1, 2016.

(2) If in a prior year an eligible hospital has successfully demonstrated it is a meaningful EHR user, the EHR reporting period is CY 2016 and applies for the FY 2018 payment adjustment year.

(C) In 2017 as follows:

(1) If an eligible hospital has not successfully demonstrated it is a meaningful EHR user for the first time in the Federal fiscal year that is 2 years before the payment adjustment year and for all prior Federal fiscal years the eligible hospital has not successfully demonstrated it is a meaningful EHR user, then any continuous 90-day period that both begins in the Federal fiscal year that is 1 year before the payment adjustment year and ends at least 3 months before the end of such prior Federal fiscal year.

(2) Under this exception, the eligible hospital must successfully register for and attest to meaningful use no later than July 1 of the year before the payment adjustment year.
reporting period is any continuous 90-day period within CY 2017 and applies for the FY 2018 and 2019 payment adjustment years. For the FY 2018 payment adjustment year, the EHR reporting period must end before and the eligible hospital must successfully register for and attest to meaningful use no later than October 1, 2017.

(2) If an eligible hospital is demonstrating Stage 3 of meaningful use under § 495.24, the EHR reporting period is any continuous 90-day period within CY 2017 and applies for the FY 2019 payment adjustment year.

(3) If in a prior year an eligible hospital has successfully demonstrated it is a meaningful EHR user, the EHR reporting period is CY 2017 and applies for the FY 2019 payment adjustment year.

(iii) The following are applicable beginning in 2018:

(A) Except as provided in paragraph (2)(iii)(B) of this definition, the EHR reporting period is the calendar year that is 2 years before the payment adjustment year.

(B) If an eligible hospital is demonstrating under the Medicaid EHR Incentive Program that it is a meaningful EHR user for the first time in the calendar year that is 2 years before the payment adjustment year, the EHR reporting period for that payment adjustment year is the same continuous 90-day period that is the EHR reporting period for the Medicaid incentive payment within the calendar year that is 2 years before that payment adjustment year.

(3) For a CAH—

(i) The following are applicable before 2015:

(A) Except as provided in paragraph (3)(i)(B) of this definition, the Federal fiscal year that is the payment adjustment year.

(B) If the CAH is demonstrating it is a meaningful EHR user for the first time in the payment adjustment year, any continuous 90-day period within the calendar year that is 2 years before that payment adjustment year.

(ii) The following are applicable for 2015, 2016, and 2017:

(A) In 2015 as follows:

(1) The EHR reporting period is any continuous 90-day period within the period beginning on October 1, 2014 and ending on December 31, 2015 and applies for the FY 2015 payment adjustment year.

(2) [Reserved]

(B) In 2016 as follows:

(1) If a CAH has not successfully demonstrated it is a meaningful EHR user in a prior year, the EHR reporting period is any continuous 90-day period within CY 2016 and applies for the FY 2016 payment adjustment year.

(2) If in a prior year a CAH has successfully demonstrated it is a meaningful EHR user, the EHR reporting period is CY 2016 and applies for the FY 2016 payment adjustment year.

(C) In 2017 as follows:

(1) If the CAH has not successfully demonstrated meaningful EHR use in a prior year the EHR reporting period is any continuous 90-day period within CY 2017 and applies for the FY 2017 payment adjustment year.

(2) If a CAH is demonstrating Stage 3 of meaningful use under § 495.24, the EHR reporting period is any continuous 90-day period within CY 2017 and applies for that begins on the first day of second quarter of the FY 2017 payment adjustment year.

(3) If in a prior year a CAH has successfully demonstrated it is a meaningful EHR user, the EHR reporting period is CY 2017 and applies for the FY 2017 payment adjustment year.

(iii) The following are applicable beginning in 2018:

(A) Except as provided in paragraph (3)(iii)(B) of this definition, the EHR reporting period is the calendar year that begins on the first day of the second quarter of the Federal fiscal year that is the payment adjustment year.

(B) If a CAH is demonstrating under the Medicaid EHR Incentive Program that it is a meaningful EHR user for the first time in the calendar year that begins on the first day of the second quarter of the Federal fiscal year that is the payment adjustment year, then any continuous 90-day period within such calendar year. The EHR reporting period for that payment adjustment year is the same continuous 90-day period that begins on the first day of the second quarter of the Federal fiscal year that is the payment adjustment year.
quarter of the Federal fiscal year that is the payment adjustment year.

Eligible hospital means an eligible hospital as defined under §495.100 or Medicaid eligible hospital under subpart D of this part.

Eligible professional (EP) means an eligible professional as defined under §495.100 or a Medicaid eligible professional under subpart D of this part.

First, second, third, fourth, fifth, or sixth payment years mean as follows:

(1) The first payment year is: with respect to an EP, the first calendar year for which the EP receives an incentive payment under this part; and with respect to an eligible hospital or CAH, the first FY for which the hospital receives an incentive payment under this part.

(2) The second, third, fourth, fifth, or sixth payment year is:

(i) With respect to a Medicare EP, the second, third, fourth or fifth successive CY immediately following the first payment year; and with respect to a Medicare eligible hospital or CAH, the second, third, or fourth successive Federal FY immediately following the first payment year. (Note: Medicare EPs are not eligible for a sixth payment year and Medicare eligible hospitals are not eligible for a fifth or sixth payment year.)

(ii) (A) With respect to a Medicaid EP, the second, third, fourth, fifth, or sixth CY for which the EP receives an incentive payment under subpart D, regardless of whether the year immediately follows the prior payment year; and

(B) With respect to a Medicaid eligible hospital, for years prior to FY 2017, the second, third, fourth, fifth, or sixth Federal FY for which the hospital receives an incentive payment under subpart D of this part, regardless of whether the year immediately follows the prior payment year. Beginning with FY 2017, payments to Medicaid eligible hospitals must be consecutive, and the hospital is not eligible for an incentive payment under subpart D of this part unless it received such incentive payment for the prior fiscal year.

Hospital-based EP. Unless it meets the requirements of §495.5, a hospital-based EP means an EP who furnishes 90 percent or more of his or her covered professional services in sites of service identified by the codes used in the HIPAA standard transaction as an inpatient hospital or emergency room setting in the year preceding the payment year, or in the case of a payment adjustment year, in either of the 2 years before the year preceding such payment adjustment year.

(1) For Medicare, this is calculated based on—

(i) The Federal fiscal year preceding the payment year; and

(ii) For the payment adjustments, based on—

(A) The Federal fiscal year 2 years before the payment adjustment year; or

(B) The Federal fiscal year 3 years before the payment adjustment year.

(2) For Medicaid, it is at the State’s discretion if the data are gathered on the Federal fiscal year or calendar year preceding the payment year.

(3) For the CY 2013 payment year only, an EP who furnishes services billed by a CAH receiving payment under Method II (as described in §413.70(b)(3) of this chapter) is considered to be hospital-based if 90 percent or more of his or her covered professional services are furnished in sites of service identified by the codes used in the HIPAA standard transaction as an inpatient hospital or emergency room setting in each of the Federal fiscal years 2012 and 2013.

Meaningful EHR user means:

(1) Subject to paragraph (3) of this definition, an EP, eligible hospital or CAH that, for an EHR reporting period for a payment year or payment adjustment year, demonstrates in accordance with §495.40 meaningful use of Certified EHR Technology by meeting the applicable objectives and associated measures under §§495.20, 495.22, and 495.24 and successfully reporting the clinical quality measures selected by CMS to CMS or the States, as applicable, in the form and manner specified by CMS or the States, as applicable; and

(2)(i) Except as specified in paragraph (2)(ii) of this definition, a Medicaid EP or Medicaid eligible hospital, that meets the requirements of paragraph (1) of this definition and any additional criteria for meaningful use imposed by the State and approved by CMS under §§495.316 and 495.332.
(ii) An eligible hospital or CAH is deemed to be a meaningful EHR user for purposes of receiving an incentive payment under subpart D of this part, if the hospital participates in both the Medicare and Medicaid EHR incentive programs, and the hospital meets the requirements of paragraph (1) of this definition.

(3) To be considered a meaningful EHR user, at least 50 percent of an EP’s patient encounters during an EHR reporting period for a payment year (or, in the case of a payment adjustment year, during an applicable EHR reporting period for such payment adjustment year) must occur at a practice/location or practices/locations equipped with Certified EHR Technology.

Payment adjustment year means either of the following:

(1) For an EP, a calendar year beginning with CY 2015.
(2) For a CAH or an eligible hospital, a Federal fiscal year beginning with FY 2015.

Payment year means:

(1) For an EP, a calendar year beginning with CY 2011; and
(2) For a CAH or an eligible hospital, a Federal fiscal year beginning with FY 2011.

Qualified EHR has the same definition as this term is defined at 45 CFR 170.102.

§ 495.5 Requirements for EPs seeking to reverse a hospital-based determination under § 495.4.

(a) Exception for certain EPs. Beginning with payment year 2013, an EP who meets the definition of hospital-based EP specified in § 495.4 but who can demonstrate to CMS that the EP funds the acquisition, implementation, and maintenance of Certified EHR Technology, including supporting hardware and interfaces needed for meaningful use without reimbursement from an eligible hospital or CAH, and uses such Certified EHR Technology in the inpatient or emergency department of a hospital (instead of the hospital’s Certified EHR Technology), may be determined by CMS to be a nonhospital-based EP.

(b) Process for determining a nonhospital-based EP. When an EP registers for a given payment year they should receive a determination of whether they have been determined “hospital-based.”

(1) An EP determined “hospital-based,” but who wishes to be determined nonhospital-based as specified in paragraph (a) of section, may use an administrative process to provide documentation and seek a nonhospital-based determination. Such administrative process will be available throughout the incentive payment year and including the 2 months following the incentive payment year in which the EP may attest to being a meaningful EHR user.

(2) If an EP is determined nonhospital-based under paragraph (a) of this section, to be considered nonhospital-based for subsequent payment years, the EP must attest in such payment year (or by the time the EP must attest it is a meaningful EHR user for such year) that the EP continues to meet the criteria of paragraph (a) of this section.

(c) Requirements for nonhospital-based EPs. An EP determined nonhospital-based must—

(1) Continue to meet all applicable requirements to receive an incentive payment, including meeting all requirements for meaningful use; and

(2) Demonstrate meaningful use using all encounters at all locations equipped with Certified EHR Technology, including those in the inpatient and emergency departments of the hospital.

§ 495.20 Meaningful use objectives and measures for EPs, eligible hospitals, and CAHs before 2015.

The following criteria are applicable before 2015:

(a) Stage 1 criteria for EPs—(1) General rule regarding Stage 1 criteria for meaningful use for EPs. Except as specified in paragraphs (a)(2) and (a)(3) of this section, EPs must meet all objectives and associated measures of the Stage 1 criteria specified in paragraph (d) of this section and five objectives of the EP's
choice from paragraph (e) of this section to meet the definition of a meaningful EHR user.

(2) Exclusion for non-applicable objectives. (i) An EP may exclude a particular objective contained in paragraphs (d) or (e) of this section, if the EP meets all of the following requirements:

(A) Must ensure that the objective in paragraph (d) or (e) of this section includes an option for the EP to attest that the objective is not applicable.

(B) Meets the criteria in the applicable objective that would permit the attestation.

(C) Attests.

(ii) (A) An exclusion will reduce (by the number of exclusions applicable) the number of objectives that would otherwise apply. For example, an EP that has an exclusion from one of the objectives in paragraph (e) of this section must meet four (and not five) objectives of the EP’s choice from such paragraph to meet the definition of a meaningful EHR user.

(B) Beginning 2014, an exclusion does not reduce (by the number of exclusions applicable) the number of objectives that would otherwise apply. For example, an EP that is excluded from one of the objectives in paragraph (g) of this section must meet four (and not five) objectives of the hospital’s choice from such paragraph to meet the definition of a meaningful EHR user.

(3) Exception for Medicaid EPs who adopt, implement or upgrade in their first payment year. For Medicaid EPs who adopt, implement, or upgrade certified EHR technology in their first payment year, the meaningful use objectives and associated measures of the Stage 1 criteria specified in paragraphs (d) and (e) apply beginning with the second payment year, and do not apply to the first payment year.

(A) Flexible options for using certified EHR technology in 2014. For an EHR reporting period in 2014, if an EP could not fully implement 2014 Edition certified EHR technology due to delays in availability and uses—

(i) Only 2011 Edition certified EHR technology, the EP must satisfy the objectives and associated measures of the Stage 1 criteria that were applicable for 2013; or

(ii) A combination of 2011 Edition certified EHR technology and 2014 Edition certified EHR technology, the EP may choose to satisfy one of the following sets of objectives and associated measures:

(A) The Stage 1 criteria that were applicable for 2013.

(B) The Stage 1 criteria that are applicable beginning 2014.

(C) If the EP is scheduled to begin Stage 2 in 2014, the Stage 2 criteria.

(b) Stage 1 criteria for eligible hospitals and CAHs—(1) General rule regarding Stage 1 criteria for meaningful use for eligible hospitals or CAHs. Except as specified in paragraphs (b)(2) and (b)(3) of this section, eligible hospitals and CAHs must meet all objectives and associated measures of the Stage 1 criteria specified in paragraph (f) of this section and five objectives of the eligible hospital’s or CAH’s choice from paragraph (g) of this section to meet the definition of a meaningful EHR user.

(2) Exclusions for nonapplicable objectives. (i) An eligible hospital or CAH may exclude a particular objective that includes an option for exclusion contained in paragraphs (f) or (g) of this section, if the hospital meets all of the following requirements:

(A) The hospital meets the criteria in the applicable objective that would permit an exclusion.

(B) The hospital so attests.

(ii) (A) An exclusion will reduce (by the number of exclusions received) the number of objectives that would otherwise apply. For example, an eligible hospital that is excluded from one of the objectives in paragraph (g) of this section must meet four (and not five) objectives of the hospital’s choice from such paragraph to meet the definition of a meaningful EHR user.

(B) Beginning 2014, an exclusion does not reduce (by the number of exclusions applicable) the number of objectives that would otherwise apply in paragraph (g) of this section. Eligible
hospitals or CAHs must meet five of the objectives and associated measures specified in paragraph (g) of this section, one which must be specified in paragraph (g)(8), (9), or (10) of this section.

(3) Exception for Medicaid eligible hospitals that adopt, implement or upgrade in their first payment year. For Medicaid eligible hospitals that adopt, implement, or upgrade certified EHR technology in their first payment year, the meaningful use objectives and associated measures of the Stage 1 criteria specified in paragraphs (f) and (g) of this section apply beginning with the second payment year, and do not apply to the first payment year.

(4) Flexible options for using certified EHR technology in 2014. For an EHR reporting period in 2014, if an eligible hospital or CAH could not fully implement 2014 Edition certified EHR technology due to delays in availability and use—

(i) Only 2011 Edition certified EHR technology, the eligible hospital or CAH must satisfy the objectives and associated measures of the Stage 1 criteria that were applicable for 2013;

(ii) A combination of 2011 Edition certified EHR technology and 2014 Edition certified EHR technology, the eligible hospital or CAH may choose to satisfy one of the following sets of objectives and associated measures:

(A) The Stage 1 criteria that were applicable for 2013.

(B) The Stage 1 criteria that are applicable beginning 2014.

(C) If the eligible hospital or CAH is scheduled to begin Stage 2 in 2014, the Stage 2 criteria.

(c) Many of the objective and associated measures in paragraphs (d) through (m) of this section rely on measures that count unique patients or actions.

(1) If a measure (or associated objective) in paragraphs (d) through (g) of this section references paragraph (c) of this section, then the measure may be calculated by reviewing only the actions for patients whose records are maintained using certified EHR technology. A patient’s record is maintained using certified EHR technology if sufficient data was entered in the certified EHR technology to allow the record to be saved, and not rejected due to incomplete data.

(2) If the objective and associated measure does not reference this paragraph (c) of this section, then the measure must be calculated by reviewing all patient records, not just those maintained using certified EHR technology.

(d) Stage 1 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (a)(2) of this section specified in this paragraph:

(1)(i) Objective. Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

(ii) Measure. (A) Subject to paragraph (c) of this section, more than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.

(B) Subject to paragraph (c) of this section, more than 30 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry, or the measure specified in paragraph (d)(1)(ii)(A) of this section.

(iii) Exclusion in accordance with paragraph (a)(2) of this section. Any EP who writes fewer than 100 prescriptions during the EHR reporting period.


(ii) Measure. The EP has enabled this functionality for the entire EHR reporting period.

(3)(i) Objective. Maintain an up-to-date problem list of current and active diagnoses.

(ii) Measure. More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.

(4)(i) Objective. Generate and transmit permissible prescriptions electronically (eRx).

(ii) Measure. Subject to paragraph (c) of this section, more than 40 percent of all permissible prescriptions written by
the EP are transmitted electronically using certified EHR technology.

(iii) Exclusion in accordance with paragraph (a)(2) of this section

(A) Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

(B) Beginning 2013, any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP’s practice location at the start of his/her EHR reporting period, or the exclusion specified in (d)(4)(iii)(A) of this section.

(5)(i) Objective. Maintain active medication list.

(ii) Measure. More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

(6)(i) Objective. Maintain active medication allergy list.

(ii) Measure. More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

(7)(i) Objective. Record all of the following demographics:

(A) Preferred language.
(B) Gender.
(C) Race.
(D) Ethnicity.
(E) Date of birth.

(ii) Measure. More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.

(8)(i) Objective. Record and chart changes in the following vital signs:

(A) Height.
(B) Weight.
(C) Blood pressure.
(D) Calculate and display body mass index (BMI).

(E)(1) Plot and display growth charts for children 2–20 years, including BMI.

(2) For 2013, plot and display growth charts for patients 0–20 years, including body mass index, or paragraph (d)(8)(i)(E)(1) of this section.

(3) Beginning 2014, plot and display growth charts for patients 0–20 years, including body mass index.

(ii) Measure. Subject to paragraph (c) of this section, more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structured data.

(B) For 2013—(1) Subject to paragraph (c) of this section, more than 50 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data; or

(2) The measure specified in paragraph (d)(8)(ii)(A) of this section.

(C) Beginning 2014, only the measure specified in paragraph (d)(8)(ii)(B)(1) of this section.

(iii) Exclusion in accordance with paragraph (a)(2) of this section. (A) Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.

(B) For 2013, either of the following:

(i) Sees no patients 3 years or older is excluded from recording blood pressure;

(ii) Believes that all three vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them;

(iii) Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or

(iv) Believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.

(C) Beginning 2014, only the exclusion specified in paragraph (d)(8)(iii)(A) of this section.

(9)(i) Objective. Record smoking status for patients 13 years old or older.

(ii) Measure. Subject to paragraph (c) of this section, more than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

(B) For 2013—(1) Subject to paragraph (c) of this section, more than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data; or

(2) The measure specified in paragraph (d)(8)(ii)(B)(1) of this section.

(C) Beginning 2014, only the exclusion specified in paragraph (d)(8)(iii)(A) of this section.
(10)(i) **Objective.** (A) Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States.

(B) Beginning 2013, this objective is reflected in the definition of a meaningful EHR user in § 495.4 and is no longer listed as an objective in this paragraph (d).

(ii) **Measure.** (A) Subject to paragraph (c) of this section, successfully report to CMS (or, in the case of Medicaid EPs, the States) ambulatory clinical quality measures selected by CMS in the manner specified by CMS (or in the case of Medicaid EPs, the States).

(B) Beginning 2013, this measure is reflected in the definition of a meaningful EHR user in § 495.4 and no longer listed as a measure in this paragraph (d).

(11)(i) **Objective.** Implement one clinical decision support rules relevant to specialty or high clinical priority along with the ability to track compliance with that rule.

(ii) **Measure.** Implement one clinical decision support rule.

(12)(i) **Objective.** (A) Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request.

(B) Beginning 2014, provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

(ii) **Measure.** (A) Subject to paragraph (c) of this section, more than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.

(B) Beginning 2014, subject to paragraph (c) of this section, more than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information subject to the EP’s discretion to withhold certain information.

(iii) **Exclusion in accordance with paragraph (a)(2) of this section.** (A) Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.

(B) Beginning 2014, any EP who neither orders nor creates any of the information listed for inclusion as part of this measure.

(13)(i) **Objective.** Provide clinical summaries for patients for each office visit.

(ii) **Measure.** Subject to paragraph (c) of this section, clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.

(iii) **Exclusion in accordance with paragraph (a)(2) of this section.** Any EP who has no office visits during the EHR reporting period.

(14)(i) **Objective.** (A) Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.

(B) Beginning 2013, this objective is no longer required as part of the core set.

(ii) **Measure.** (A) Performed at least one test of certified EHR technology’s capacity to electronically exchange key clinical information.

(B) Beginning 2013, this measure is no longer required as part of the core set.

(e) **Stage 1 menu set criteria for EPs.** An EP must meet five of the following objectives and associated measures, one of which must be either paragraph (e)(9) or (e)(10) of this section, except that the required number of objectives and associated measures is reduced by an EP’s paragraph (a)(2) of this section exclusions specified in this paragraph. Beginning 2014, an EP must meet five of the following objectives and associated measures, one of which must be either paragraph (e)(9) or (e)(10) of this section unless the EP has an exclusion from five or more objectives in this
paragraph (e), in which case the EP must meet all remaining objectives and associated measures in paragraph (e) of this section.

(1)(i) Objective. Implement drug-formulary checks.

(ii) Measure. The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.

(iii) Exclusion in accordance with paragraph (a)(2) of this section. Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

(2)(i) Objective. Incorporate clinical lab-test results into EHR as structured data.

(ii) Measure. Subject to paragraph (c) of this section, more than 40 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.

(iii) Exclusion in accordance with paragraph (a)(2) of this section. An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.

(3)(i) Objective. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

(ii) Measure. Subject to paragraph (c) of this section, generate at least one report listing patients of the EP with a specific condition.

(4)(i) Objective. Send reminders to patients per patient preference for preventive/follow-up care.

(ii) Measure. Subject to paragraph (c) of this section, more than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.

(iii) Exclusion in accordance with paragraph (a)(2) of this section. An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.

(5)(i) Objective. (A) Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.

(B) Beginning 2014, this objective is no longer included in the menu set.

(ii) Measure. (A) At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP’s discretion to withhold certain information.

(B) Beginning 2014, this measure is no longer included in the menu set.

(iii) Exclusion in accordance with paragraph (a)(2) of this section. Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) during the EHR reporting period.

(6)(i) Objective. Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

(ii) Measure. More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.

(7)(i) Objective. The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

(ii) Measure. Subject to paragraph (c) of this section, the EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

(iii) Exclusion in accordance with paragraph (a)(2) of this section. An EP who was not the beneficiary of any transitions of care during the EHR reporting period.

(8)(i) Objective. The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

(ii) Measure. Subject to paragraph (c) of this section, the EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.
An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period,

(ii) **Objective.** (A) Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.

(B) Beginning 2013, capability to submit electronic data to immunization registries or immunization information systems and actual submission except where prohibited and according to applicable law and practice.

(iii) **Exclusion in accordance with paragraph (a)(2) of this section.** An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.

(f) **Stage I core criteria for eligible hospitals or CAHs.** An eligible hospital or CAH must meet the following objectives and associated measures except those objectives and associated measures for which an eligible hospital or CAH qualifies for a paragraph (b)(2) of this section exclusion specified in this paragraph:

(i) **Objective.** Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local, and professional guidelines.

(ii) **Measure.** Performed at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).

(iii) **Exclusion in accordance with paragraph (a)(2) of this section.** An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.

(t) **Stage I core criteria for eligible hospitals or CAHs.** An eligible hospital or CAH must meet the following objectives and associated measures except those objectives and associated measures for which an eligible hospital or CAH qualifies for a paragraph (b)(2) of this section exclusion specified in this paragraph:

1. **Objective.** Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local, and professional guidelines.

2. **Measure.** Performed at least one test of certified EHR technology’s capacity to provide electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.

3. **Objective.** Implement drug-drug and drug-allergy interaction checks.

4. **Objective.** Maintain an up-to-date problem list of current and active diagnoses.

5. **Objective.** Maintain active medication list.

(ii) **Measure.** More than 80 percent of all unique patients admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE.

(ii) **Measure.** The eligible hospital or CAH has enabled this functionality for the entire EHR reporting period.

(iii) **Exclusion in accordance with paragraph (a)(2) of this section.** An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.

729
emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

5(i) Objective. Maintain active medication allergy list.

(ii) Measure. More than 80 percent of all unique patients admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

6(i) Objective. Record all of the following demographics;

(A) Preferred language.
(B) Gender.
(C) Race.
(D) Ethnicity.
(E) Date of birth.
(F) Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.

(ii) Measure. More than 50 percent of all unique patients admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.

7(i) Objective. Record and chart changes in the following vital signs:

(A) Height.
(B) Weight.
(C) Blood pressure.
(D) Calculate and display body mass index (BMI).

(ii) Measure. For 2013,

(1) Beginning 2014, plot and display growth charts for children 2–20 years, including BMI.
(2) For 2013, plot and display growth charts for patients 0–20 years, including body mass index, or paragraph (f)(7)(i)(E)(1) of this section.
(3) Beginning 2014, plot and display growth charts for patients 0–20 years, including body mass index.

(iii) Exclusion in accordance with paragraph (b)(2) of this section. Any eligible hospital or CAH that admits no patients 13 years or older to their inpatient or emergency department (POS 21 or 23).

8(i) Objective. Record smoking for patients 13 years old or older.

(ii) Measure. Subject to paragraph (c) of this section, more than 50 percent of all unique patients 13 years old or older or admitted to the eligible hospital’s inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.

9(i) Objective. (A) Report hospital clinical quality measures to CMS or, in the case of Medicaid eligible hospitals, the States.

(B) Beginning 2013, this objective is reflected in the definition of a meaningful EHR user in §495.4 and no longer listed as an objective in this paragraph (f).

(ii) Measure. (A) Subject to paragraph (c) of this section, successfully report to CMS (or, in the case of Medicaid eligible hospitals or CAHs, the States) hospital clinical quality measures selected by CMS in the manner specified by CMS (or, in the case of Medicaid eligible hospitals or CAHs, the States).

(B) Beginning 2013, this measure is reflected in the definition of a meaningful EHR user in §495.4 and no longer listed as a measure in this paragraph (f).

10(i) Objective. Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule.

(ii) Measure. Implement one clinical decision support rule.

11(i) Objective. (A) Provide patients with an electronic copy of their health information (including diagnostic test
results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request.

(B) Beginning 2014, this objective is no longer required as part of the core set.

(ii) Measure. (A) Subject to paragraph (c) of this section, more than 50 percent of all patients of the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days.

(B) Beginning 2014, this measure is no longer required as part of the core set.

(iii) Exclusion in accordance with paragraph (b)(2) of this section. Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.

(12)(i) Objective. (A) Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.

(B) Beginning 2014, provide patients the ability to view online, download, and transmit information about a hospital admission.

(ii) Measure. (A) Subject to paragraph (c) of this section, more than 50 percent of all patients who are discharged from an eligible hospital or CAH’s inpatient or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.

(B) Beginning 2014, subject to paragraph (c) of this section, more than 50 percent of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge.

(iii) Exclusion in accordance with paragraph (b)(2) of this section. (A) Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of the discharge information available online within 36 hours of discharge.

(13)(i) Objective. (A) Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.

(B) Beginning 2013, this objective is no longer required as part of the core set.

(ii) Measure. Performed at least one test of certified EHR technology’s capacity to electronically exchange key clinical information.

(B) Beginning 2013, this measure is no longer required as part of the core set.

(14)(i) Objective. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.

(ii) Measure. Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.

(g) Stage I menu set criteria for eligible hospitals or CAHs. Eligible hospitals or CAHs must meet five of the following objectives and associated measures, one which must be specified in paragraph (g)(8), (g)(9), or (g)(10) of this section, except that the required number of objectives and associated measures is reduced by a hospital’s paragraph (b)(2) of this section exclusions specified in this paragraph. Beginning 2014, eligible hospitals or CAHs must meet five of the following objectives and associated measures, one which must be specified in paragraph (g)(8), (9), or (10) of this section:

(1)(i) Objective. Implement drug-formulary checks.

(ii) Measure. The eligible hospital or CAH has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.

(2)(i) Objective. Record advance directives for patient 65 years old or older.

(ii) Measure. Subject to paragraph (c) of this section, more than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital’s or CAH’s inpatient (POS 21) have an indication of an advance directive status recorded as structured data.

(iii) Exclusion in accordance with paragraph (b)(2) of this section. An eligible
hospital or CAH that admits no patients age 65 years old or older during the EHR reporting period.

(3)(i) Objective. Incorporate clinical lab-test results into EHR as structured data.

(ii) Measure. Subject to paragraph (c) of this section, more than 40 percent of all clinical lab test results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.

(4)(i) Objective. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

(ii) Measure. Subject to paragraph (c) of this section, generate at least one report listing patients of the eligible hospital or CAH with a specific condition.

(5)(i) Objective. Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

(ii) Measure. More than 10 percent of all unique patients admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources.

(6)(i) Objective. The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

(ii) Measure. Subject to paragraph (c) of this section, the eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.

(8)(i) Objective. (A) Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.

(B) Beginning 2013, Capability to submit electronic data to immunization registries or immunization information systems and actual submission except where prohibited and according to applicable law and practice.

(ii) Measure. Performed at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically).

(iii) Exclusion in accordance with paragraph (b)(2) of this section. An eligible hospital or CAH that administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.

(9)(i) Objective. (A) Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission according to applicable law and practice.

(B) Beginning 2013, capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission except where prohibited according to applicable law and practice.

(ii) Measure. Performed at least one test of certified EHR technology’s capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or CAH submits such information has the capacity to receive the information electronically).
(iii) Exclusion in accordance with paragraph (b)(2) of this section. No public health agency to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically.

(10)(i) Objective. (A) Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.

(B) Beginning 2013, capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and according to applicable law and practice.

(ii) Measure. Performed at least one test of certified EHR technology’s capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or CAH submits information has the capacity to receive the information electronically).

(iii) Exclusion in accordance with paragraph (a)(2) of this section. No public health agency to which the eligible hospital or CAH submits information has the capacity to receive the information electronically.

(h) Stage 2 criteria for EPs—(1) General rule regarding Stage 2 criteria for meaningful use for EPs. Except as specified in paragraph (h)(2) of this section, EPs must meet all objectives and associated measures of the Stage 2 criteria specified in paragraph (j) of this section and 3 objectives of the EP’s choice from paragraph (k) of this section to meet the definition of a meaningful EHR user.

(2) Exclusion for nonapplicable objectives. (i) An EP may exclude a particular objective contained in paragraph (j) or (k) of this section, if the EP meets all of the following requirements:

(A) Must ensure that the objective in paragraph (j) or (k) of this section includes an option for the EP to attest that the objective is not applicable.

(B) Meets the criteria in the applicable objective that would permit the attestation.

(C) Attestation.

(ii)(A) An exclusion will reduce (by the number of exclusions applicable) the number of objectives that would otherwise apply in paragraph (j) of this section. For example, an EP that has an exclusion from one of the objectives in paragraph (j) of this section must meet 16 objectives from such paragraph to meet the definition of a meaningful EHR user.

(B) An exclusion does not reduce (by the number of exclusions applicable) the number of objectives that would otherwise apply in paragraph (k) of this section unless four or more exclusions apply. For example, an EP that has an exclusion for one of the objectives in paragraph (k) of this section must meet three of the five non- excluded objectives from such paragraph to meet the definition of a meaningful EHR user. If an EP has an exclusion for four of the objectives in paragraph (k) of this section, then he or she must meet the remaining two non- excluded objectives from such paragraph to meet the definition of a meaningful EHR user.

(3) Flexible options for using certified EHR technology in 2014. For an EHR reporting period in 2014, if an EP is scheduled to begin Stage 2 in 2014, but is unable to fully implement all the functions of 2014 Edition certified EHR technology required for the objectives and associated measures of the Stage 2 criteria due to delays in availability, the EP may choose to satisfy the objectives and associated measures of the Stage 1 criteria that are applicable beginning 2014 using 2014 Edition certified EHR technology.

(i) Stage 2 criteria for eligible hospitals and CAHs—(1) General rule regarding Stage 2 criteria for meaningful use for eligible hospitals or CAHs. Except as specified in paragraph (i)(2) of this section, eligible hospitals and CAHs must meet all objectives and associated measures of the Stage 2 criteria specified in paragraph (l) of this section and three objectives of the eligible hospital’s or CAH’s choice from paragraph (m) of this section to meet the definition of a meaningful EHR user.

(2) Exclusions for nonapplicable objectives. (i) An eligible hospital or CAH may exclude a particular objective that includes an option for exclusion...
contained in paragraphs (l) or (m) of this section, if the hospital meets all of the following requirements:

(A) The hospital meets the criteria in the applicable objective that would permit an exclusion.

(B) The hospital so attests.

(ii)(A) An exclusion will reduce (by the number of exclusions applicable) the number of objectives that would otherwise apply in paragraph (l) of this section. For example, an eligible hospital that has an exclusion from 1 of the objectives in paragraph (l) of this section must meet 15 objectives from such paragraph to meet the definition of a meaningful EHR user.

(B) An exclusion does not reduce (by the number of exclusions applicable) the number of objectives that would otherwise apply in paragraph (m) of this section. For example, an eligible hospital that has an exclusion for one of the objectives in paragraph (m) of this section must meet three of the five nonexcluded objectives from such paragraph to meet the definition of a meaningful EHR user.

(3) Flexible options for using certified EHR technology in 2014. For an EHR reporting period in 2014, if an eligible hospital or CAH is scheduled to begin Stage 2 in 2014, but is unable to fully implement all the functions of 2014 Edition certified EHR technology required for the objectives and associated measures of the Stage 2 criteria due to delays in availability, the eligible hospital or CAH may choose to satisfy the objectives and associated measures of the Stage 1 criteria that are applicable beginning 2014 using 2014 Edition certified EHR technology.

(j) Stage 2 core criteria for EPs. An EP must satisfy the following objectives and associated measures, except those objectives and associated measures for which an EP qualifies for an exclusion under paragraph (h)(2) of this section specified in this paragraph (j).

(1)(i) Objective. Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local, and professional guidelines.

(ii) Measures. Subject to paragraph (c) of this section—

(A) More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry;

(B) More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry; and

(C) More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

(iii) Exclusions in accordance with paragraph (h)(2) of this section. (A) For the measure specified in paragraph (j)(1)(ii)(A) of this section, any EP who writes fewer than 100 medication orders during the EHR reporting period.

(B) For the measure specified in paragraph (j)(1)(ii)(B) of this section, any EP who writes fewer than 100 laboratory orders during the EHR reporting period.

(C) For the measure specified in paragraph (j)(1)(ii)(C), any EP who writes fewer than 100 radiology orders during the EHR reporting period.

(2)(i) Objective. Generate and transmit permissible prescriptions electronically (eRx).

(ii) Measure. Subject to paragraph (c) of this section, more than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using Certified EHR Technology.

(iii) Exclusion in accordance with paragraph (h)(2) of this section. Any EP who—

(A) Writes fewer than 100 permissible prescriptions during the EHR reporting period; or (B) Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.

(3)(i) Objective. Record all of the following demographics:

(A) Preferred language.

(B) Sex.

(C) Race.

(D) Ethnicity.

(E) Date of birth.
(ii) Measure. More than 80 percent of all unique patients seen by the EP during the EHR reporting period have demographics recorded as structured data.

(4)(i) Objective. Record and chart changes in the following vital signs:
(A) Height/Length.
(B) Weight.
(C) Blood pressure (ages 3 and over).
(D) Calculate and display body mass index (BMI).
(E) Plot and display growth charts for patients 0–20 years, including body mass index.

(ii) Measure. Subject to paragraph (c) of this section, more than 80 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data.

(iii) Exclusion in accordance with paragraph (h)(2) of this section. Any EP who—
(A) Sees no patients 3 years or older is excluded from recording blood pressure;
(B) Believes that all three vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them;
(C) Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or
(D) Believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.

(5)(i) Objective. Record smoking status for patients 13 years old or older.

(ii) Measure. Subject to paragraph (c) of this section, more than 80 percent of all unique patients 13 years old or older seen by the EP during the EHR reporting period have smoking status recorded as structured data.

(iii) Exclusion in accordance with paragraph (h)(2) of this section. Any EP who sees no patients 13 years old or older.

(6)(i) Objective. Use clinical decision support to improve performance on high priority health conditions.

(ii) Measures. (A) Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions; and
(B) The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

(iii) Exclusion in accordance with paragraph (h)(2) of this section for paragraph (j)(6)(ii)(B) of this section. An EP who writes fewer than 100 medication orders during the EHR reporting period.

(7)(i) Objective. Incorporate clinical lab test results into Certified EHR Technology as structured data.

(ii) Measure. Subject to paragraph (c) of this section, more than 55 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in Certified EHR Technology as structured data.

(iii) Exclusion in accordance with paragraph (h)(2) of this section. Any EP who orders no lab tests whose results are either in a positive/negative affirmation or numerical format during the EHR reporting period.

(8)(i) Objective. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

(ii) Measure. Generate at least one report listing patients of the EP with a specific condition.

(9)(i) Objective. Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminder, per patient preference.

(ii) Measure. Subject to paragraph (c) of this section, more than 10 percent of all unique patients who have had two or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.
§ 495.20  

(iii) Exclusion in accordance with paragraph (h)(2) of this section. Any EP who has had no office visits in the 24 months before the beginning of the EHR reporting period.

(10)(i) Objective. Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

(ii) Measures. (A) More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information subject to the EP’s discretion to withhold certain information; and

(B) More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download or transmit to a third party their health information.

(iii) Exclusion in accordance with paragraph (h)(2) of this section. Any EP who—

(A) Neither orders nor creates any of the information listed for inclusion as part of the measures in paragraphs (j)(10)(i)(A) and (B) of this section, except for “Patient name” and “Provider’s name and office contact information,” is excluded from both paragraphs (j)(10)(i)(A) and (B) of this section; or

(B) Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period is excluded from paragraph (j)(10)(i)(B) of this section.

(11)(i) Objective. Provide clinical summaries for patients for each office visit.

(ii) Measure. Subject to paragraph (c) of this section, clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50 percent of office visits.

(iii) Exclusion in accordance with paragraph (h)(2) of this section. Any EP who has no office visits during the EHR reporting period.

(12)(i) Objective. Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.

(ii) Measure. Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.

(iii) Exclusion in accordance with paragraph (h)(2) of this section. Any EP who has no office visits during the EHR reporting period.

(13)(i) Objective. The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

(ii) Measure. Subject to paragraph (c) of this section, the EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

(iii) Exclusion in accordance with paragraph (h)(2) of this section. Any EP who was not the beneficiary of any transitions of care during the EHR reporting period.

(14)(i) Objective. The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.

(ii) Measures. (A) Subject to paragraph (c) of this section, the EP that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals;

(B) Subject to paragraph (c) of this section, the EP that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either—

(1) Electronically transmitted using Certified EHR Technology to a beneficiary; or

(2) Where the beneficiary receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a
manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network, and
(C) Subject to paragraph (c) of this section an EP must satisfy one of the following:
(1) Conducts one or more successful electronic exchanges of a summary of care record meeting the measure specified in paragraph (j)(14)(i)(B) of this section with a beneficiary using technology to receive the summary of care record that was designed by a different EHR developer than the sender’s EHR technology certified at 45 CFR 170.314(b)(2); or
(2) Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.
(iii) Exclusion in accordance with paragraph (h)(2) of this section. Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.
(15)(i) Objective. Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.
(ii) Measure. Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.
(iii) Exclusion in accordance with paragraph (h)(2) of this section. Any EP that meets one or more of the following criteria:
(A) Does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction’s immunization registry or immunization information system during the EHR reporting period.
(B) Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required by Certified EHR Technology at the start of his or her EHR reporting period.
(C) Operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data.
(D) Operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by Certified EHR Technology at the start of his or her EHR reporting period can enroll additional EPs.
(16)(i) Objective. Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.
(ii) Measure. Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data stored in Certified EHR Technology in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP’s risk management process.
(17)(i) Objective. Use secure electronic messaging to communicate with patients on relevant health information.
(ii) Measure. A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.
(iii) Exclusion in accordance with paragraph (h)(2) of this section. Any EP who meets one or more of the following criteria:
(A) Has no office visits during the EHR reporting period.
(B) Who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of their EHR reporting period.
(k) Stage 2 menu set criteria for EPs. An EP must meet 3 of the following objectives and associated measures, unless the EP has an exclusion from 4 or more objectives in this paragraph (k) of this section, in which case the EP must meet all remaining objectives and associated measures.
(1)(i) **Objective.** Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology.

(ii) **Measure.** Subject to paragraph (c) of this section, more than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through Certified EHR Technology.

(iii) **Exclusion in accordance with paragraph (h)(2) of this section.** Any EP who meets one or more of the following criteria:

A. Orders less than 100 tests whose result is an image during the EHR reporting period.

B. Has no access to electronic imaging results at the start of the EHR reporting period.

(2)(i) **Objective.** Record patient family health history as structured data.

(ii) **Measure.** More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.

(iii) **Exclusion in accordance with paragraph (h)(2) of this section.** Any EP who has no office visits during the EHR reporting period.

(3)(i) **Objective.** Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.

(ii) **Measure.** Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.

(iii) **Exclusion in accordance with paragraph (h)(2) of this section.** Any EP that meets one or more of the following criteria:

A. Is not in a category of providers who collect ambulatory syndromic surveillance information on their patients during the EHR reporting period.

B. Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from Certified EHR Technology at the beginning of their EHR reporting period.

C. Operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data.

D. Operates in a jurisdiction for which no public health agency is capable of accepting the specific standards required by Certified EHR Technology at the start of their EHR reporting period can enroll additional EPs.

(4)(i) **Objective.** Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.

(ii) **Measure.** Successful ongoing submission of cancer case information from Certified EHR Technology to a public health central cancer registry for the entire EHR reporting period.

(iii) **Exclusion in accordance with paragraph (h)(2) of this section.** Any EP who meets one or more of the following:

A. Does not diagnose or directly treat cancer.

B. Operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required for Certified EHR Technology at the beginning of their EHR reporting period.

C. Operates in a jurisdiction where no public health agency provides information timely on capability to receive electronic cancer case information.

D. Operates in a jurisdiction for which no public health agency that is capable of receiving electronic cancer case information in the specific standards required by Certified EHR Technology at the beginning of their EHR reporting period can enroll additional EPs.

(5)(i) **Objective.** Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.

(ii) **Measure.** Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period.

(iii) **Exclusion in accordance with paragraph (h)(2) of this section.** Any EP who meets one or more of the following criteria:
(A) Does not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society for which the EP is eligible, or the public health agencies in their jurisdiction;

(B) Operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible is capable of receiving electronic specific case information in the specific standards required by Certified EHR Technology at the beginning of their EHR reporting period;

(C) Operates in a jurisdiction where no public health agency or national specialty society for which the EP is eligible provides information timely on capability to receive information into their specialized registries; or

(D) Operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible that is capable of receiving electronic specific case information in the specific standards required by Certified EHR Technology at the beginning of his or her EHR reporting period can enroll additional EPs.

(6)(i) Objective. Record electronic notes in patient records.

(ii) Measure. Enter at least one electronic progress note created, edited, and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text-searchable and may contain drawings and other content.

(1) Stage 2 core criteria for eligible hospitals or CAHs. An eligible hospital or CAH must meet the following objectives and associated measures except those objectives and associated measures for which an eligible hospital or CAH qualifies for an exclusion under paragraph (1)(2) of this section.

(1)(i) Objective. Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local, and professional guidelines.

(ii) Measure. Subject to paragraph (c) of this section, more than—

(A) Sixty percent of medication orders created by authorized providers of the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

(B) Thirty percent of laboratory orders created by authorized providers of the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

(C) Thirty percent of radiology orders created by authorized providers of the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

(2)(i) Objective. Record all of the following demographics:

(A) Preferred language.

(B) Sex.

(C) Race.

(D) Ethnicity.

(E) Date of birth.

(F) Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.

(ii) Measure. More than 80 percent of all unique patients admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period have demographics recorded as structured data.

(3)(i) Objective. Record and chart changes in the following vital signs:

(A) Height/Length.

(B) Weight.

(C) Blood pressure (ages 3 and over).

(D) Calculate and display body mass index (BMI).

(E) Plot and display growth charts for patients 0–20 years, including body mass index.

(ii) Measure. Subject to paragraph (c) of this section, more than 80 percent of all unique patients admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data.
(4)(i) **Objective.** Record smoking status for patients 13 years old or older.

(ii) **Measure.** Subject to paragraph (c) of this section, more than 80 percent of all unique patients 13 years old or older admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data.

(iii) **Exclusion in accordance with paragraph (i)(2) of this section.** Any eligible hospital or CAH that admits no patients 13 years old or older to their inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

(5)(i) **Objective.** Use clinical decision support to improve performance on high priority health conditions.

(ii) **Measures.** (A) Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an eligible hospital or CAH’s patient population, the clinical decision support interventions must be related to high-priority health conditions; and

(B) The eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

(6)(i) **Objective.** Incorporate clinical lab test results into Certified EHR Technology as structured data.

(ii) **Measure.** Subject to paragraph (c) of this section, more than 55 percent of all clinical lab test results ordered by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in Certified EHR Technology as structured data.

(7)(i) **Objective.** Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.

(ii) **Measure.** Generate at least one report listing patients of the eligible hospital or CAH with a specific condition.

(8)(i) **Objective.** Provide patients the ability to view online, download, and transmit information about a hospital admission.

(ii) **Measures.** (A) More than 50 percent of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge; and

(B) More than 5 percent of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or their authorized representative) view, download or transmit to a third party their information during the EHR reporting period.

(iii) **Exclusion in accordance with paragraph (i)(2) of this section.** Any eligible hospital or CAH that is located in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period is excluded from paragraph (l)(8)(ii)(B) of this section.

(9)(i) **Objective.** Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.

(ii) **Measure.** More than 10 percent of all unique patients admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources identified by Certified EHR Technology.

(10)(i) **Objective.** The eligible hospital or CAH that receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

(ii) **Measure.** Subject to paragraph (c) of this section, the eligible hospital or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23).

(11)(i) **Objective.** The eligible hospital or CAH that transitions their patient to another setting of care or provider
of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.

(ii) Measures. (A) Subject to paragraph (c) in this section, the eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.

(B) Subject to paragraph (c) in this section, the eligible hospital or CAH that transitions their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either—

(1) Electronically transmitted using Certified EHR Technology to a beneficiary; or

(2) Where the beneficiary receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network; and

(C) Subject to paragraph (c) of this section an eligible hospital or CAH must satisfy one of the following:

(1) Conducts one or more successful electronic exchanges of a summary of care record meeting the measure specified in paragraph (l)(1)(ii)(B) of this section with a beneficiary using technology to receive the summary of care record that was designed by a different EHR developer than the sender's EHR technology certified at 45 CFR 107.314(b)(2); or

(2) Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.

(iii) Exclusion in accordance with paragraph (i)(2) of this section. Any eligible hospital or CAH that meets one or more of the following criteria:

(A) The eligible hospital or CAH does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period.

(B) The eligible hospital or CAH operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for Certified EHR Technology at the start of their EHR reporting period.

(C) The eligible hospital or CAH operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data.

(D) Operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by Certified EHR Technology at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.

(13)(i) Objective. Capability to submit electronic reportable laboratory results to public health agencies, where except where prohibited, and in accordance with applicable law and practice.

(ii) Measure. Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to a public health agency for the entire EHR reporting period.

(iii) Exclusion in accordance with paragraph (i)(2) of this section. Any eligible hospital or CAH that meets one or more of the following criteria:

(A) Operates in a jurisdiction for which no public health agency is capable of receiving electronic reportable laboratory results in the specific standards required for Certified EHR Technology at the start of their EHR reporting period.

(B) Operates in a jurisdiction for which no public health agency provides information timely on capability to receive electronic reportable laboratory results.
(C) Operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by Certified EHR Technology at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.

(14)(i) Objective. Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.

(ii) Measure. Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.

(iii) Exclusion in accordance with paragraph (i)(2) of this section. Any eligible hospital or CAH that meets one or more of the following criteria:

(A) Does not have an emergency or urgent care department.

(B) Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required for Certified EHR Technology at the start of their EHR reporting period or can enroll additional eligible hospitals or CAHs.

(C) Operates in a jurisdiction for which no public health agency provides information timely on capability to receive syndromic surveillance data.

(D) Operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by Certified EHR Technology at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.

(15)(i) Objective. Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.

(ii) Measure. Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data stored in Certified EHR Technology in accordance with requirements under 45 CFR 164.312(a)(1)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the eligible hospital’s or CAH’s risk management process.

(16)(i) Objective. Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).

(ii) Measure. Subject to paragraph (c) of this section, more than 10 percent of medication orders created by authorized providers of the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked using eMAR.

(iii) Exclusion in accordance with paragraph (i)(2) of this section. Any eligible hospital or CAH with an average daily inpatient census of fewer than 10 patients.

(m) Stage 2 menu set criteria for eligible hospitals or CAHs. An eligible hospital or CAH must meet the measure criteria for three of the following objectives and associated measures.

(1)(i) Objective. Record whether a patient 65 years old or older has an advance directive.

(ii) Measure. Subject to paragraph (c) of this section, more than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital’s or CAH’s inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.

(iii) Exclusion in accordance with paragraph (i)(2) of this section. Any eligible hospital or CAH that admits no patients age 65 years old or older during the EHR reporting period.

(2)(i) Objective. Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology.

(ii) Measure. Subject to paragraph (c) of this section, more than 10 percent of all tests whose result is an image ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period are accessible through Certified EHR Technology.

(3)(i) Objective. Record patient family health history as structured data.
Centers for Medicare & Medicaid Services, HHS

§ 495.22 Meaningful use objectives and measures for EPs, eligible hospitals, and CAHs for 2015 through 2017.

(a) General rules. (1) The criteria specified in this section are applicable for all EPs, eligible hospitals, and CAHs for 2015 through 2017.

(2) For 2017 only, EPs, eligible hospitals, and CAHs have the option to use the criteria specified for 2018 (as outlined at § 495.24) instead of the criteria specified in this section.

(b) Criteria for EPs for 2015 through 2017—(1) General rule regarding criteria for meaningful use for 2015 through 2017 for EPs. Except as specified in paragraph (b)(2) of this section, EPs must meet all objectives and associated measures of the meaningful use criteria specified under paragraph (e) of this section to meet the definition of a meaningful EHR user.

(2) Exclusion for non-applicable objectives. (i) An EP may exclude a particular objective contained in paragraph (e) of this section, if the EP meets all of the following requirements:

(A) Must ensure that the objective in paragraph (e) of this section includes an option for the EP to attest that the objective is not applicable.

(B) Meets the criteria in the applicable objective that would permit the attestation to the exclusion.

(C) Attests.

(ii) An exclusion will reduce (by the number of exclusions applicable) the number of objectives that would otherwise apply in paragraph (e) of this section.

(c) Criteria for eligible hospitals and CAHs for 2015 through 2017—(1) General rule regarding criteria for meaningful use for 2015 through 2017 for eligible hospitals and CAHs. Except as specified in paragraph (c)(2) of this section, eligible hospitals and CAHs must meet all objectives and associated measures of the meaningful use criteria specified under paragraph (e) of this section to meet the definition of a meaningful EHR user.

(2) Exclusion for non-applicable objectives. (i) An eligible hospital or CAH may exclude a particular objective contained in paragraph (e) of this section, if the eligible hospital or CAH meets all of the following requirements:

(1) More than 20 percent of all unique patients admitted to the eligible hospital or CAH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives.

(2) Subject to paragraph (c) of this section, more than 10 percent of hospital discharge medication orders for permissible prescriptions (for new, changed and refilled prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology.

(3) Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions and there are no pharmacies that accept electronic prescriptions within 10 miles at the start of its EHR reporting period.

(4) Record electronic notes in patient records.

(5) Enter at least one electronic progress note created, edited and signed by an authorized provider of the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) for more than 30 percent of unique patients admitted to the eligible hospital or CAH’s inpatient or emergency department during the EHR reporting period. The text of the electronic note must be text-searchable and may contain drawings and other content.

(6) Provide structured electronic lab results to ambulatory providers.

Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20 percent of—

(A) The electronic lab orders received; or

(B) The lab orders received.

(A) Must ensure that the objective in paragraph (e) of this section includes an option for the eligible hospital or CAH to attest that the objective is not applicable.

(B) Meets the criteria in the applicable objective that would permit the attestation to the exclusion.

(C) Attests.

(ii) An exclusion will reduce (by the number of exclusions applicable) the number of objectives that would otherwise apply in paragraph (e) of this section.

(d) Many of the objectives and associated measures in paragraph (e) of this section rely on measures that count unique patients or actions.

(1) If a measure (or associated objective) in paragraph (e) of this section references paragraph (d) of this section, then the measure may be calculated by reviewing only the actions for patients whose records are maintained using CEHRT.

A patient’s record is maintained using CEHRT if sufficient data was entered in the CEHRT to allow the record to be saved, and not rejected due to incomplete data.

(2) If the objective and associated measure does not reference this paragraph (d) of this section, then the measure must be calculated by reviewing all patient records, not just those maintained using CEHRT.

(e) Meaningful use objectives and measures for 2015 through 2017—(1) Protect patient health information—(i) Objective. Protect electronic protected health information created or maintained by the CEHRT in accordance with the requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary, and correct identified security deficiencies as part of the eligible hospital’s or CAH’s risk management process.

(2) Clinical decision support—(i) Objective. Use clinical decision support to improve performance on high-priority health conditions.

(ii) EP measures—(A) Measure. In order for EPs to meet the objective they must satisfy both of the following measures:

(1) Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

(2) Enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

(B) Exclusion in accordance with paragraph (b)(2) of this section. An EP who writes fewer than 100 medication orders during the EHR reporting period may be excluded from the measure under paragraph (e)(2)(i)(A)(2) of this section.

(C) Alternate specifications. An EP previously scheduled to be in Stage 1 in 2015 may meet an alternate objective and measure specified in paragraph (e)(2)(ii)(C)(1) and (2) in place of the measure outlined under paragraph (e)(2)(ii)(A)(1) of this section for an EHR reporting period in 2015 only.

(1) Alternate objective. Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.

(2) Alternate measure. Implement one clinical decision support rule.

(iii) Eligible hospital and CAH measures—(A) Measure. In order for eligible hospitals and CAHs to meet the objective they must satisfy both of the following measures:
(1) Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an eligible hospital or CAH’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

(2) Enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

(B) Alternate specifications. An eligible hospital or CAH previously scheduled to be in Stage 1 in 2015 may meet an alternate measure described in paragraph (e)(2)(iii)(B)(2) of this section in place of the measure described in paragraph (e)(2)(iii)(A)(1) of this section for an EHR reporting period in 2015.

(1) Alternate objective. Implement one clinical decision support rule relevant to a high priority hospital condition along with the ability to track compliance with that rule.

(2) Alternate measure. Implement one clinical decision support rule.

(3) Computerized provider order entry—

(i) Objective. Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.

(ii) EP measures—(A) Measures. An EP must meet the following 3 measures, subject to paragraph (d) of this section:

(1) More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

(2) More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

(3) More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

(B) Exclusion in accordance with paragraph (b)(2) of this section. (1) For the measure specified in paragraph (e)(3)(ii)(A)(1) of this section, any EP who writes fewer than 100 medication orders during the EHR reporting period.

(2) For the measure specified in paragraph (e)(3)(ii)(A)(2) of this section, any EP who writes fewer than 100 laboratory orders during the EHR reporting period.

(3) For the measure specified in paragraph (e)(3)(ii)(A)(3) of this section, any EP who writes fewer than 100 radiology orders during the EHR reporting period.

(C) Alternate exclusions and specifications. An EP previously scheduled to be in Stage 1 in 2015 may meet an alternate measure (e)(3)(ii)(C)(1) in place of the measure outlined under paragraph (e)(3)(ii)(A)(1) of this section, and may exclude the measures outlined under paragraphs (e)(3)(ii)(A)(2) and (3) of this section for an EHR reporting period in 2015. An EP previously scheduled to be in Stage 1 in 2016 may exclude the measures outlined under paragraphs (e)(3)(ii)(A)(2) and (3) of this section for an EHR reporting period in 2016.

(1) Alternate measure 1 in 2015. Subject to paragraph (d) of this section—

(i) More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period have at least one medication order entered using CPOE; or

(ii) More than 30 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.


(iii) Eligible hospital and CAH measures. (A) An eligible hospital or CAH must meet the following 3 measures, subject to paragraph (d) of this section:

(1) More than 60 percent of medication orders created by authorized providers of the eligible hospital’s or...
CAH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

(2) More than 30 percent of laboratory orders created by authorized providers of the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

(3) More than 30 percent of radiology orders created by authorized providers of the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

(B) **Alternate exclusions and specifications.** (1) An eligible hospital or CAH previously scheduled to be in Stage 1 in 2015 may meet an alternate measure specified in paragraph (e)(3)(iii)(B)(2) of this section in place of the measure outlined under paragraph (e)(3)(iii)(A)(1) of this section, and may exclude the measures outlined under paragraphs (e)(3)(iii)(A)(2) and (e)(3)(iii)(A)(3) of this section for an EHR reporting period in 2015. An eligible hospital or CAH previously scheduled to be in Stage 1 in 2016 may exclude the measures outlined under paragraphs (e)(3)(iii)(A)(2) and (3) of this section for an EHR reporting period in 2016.

(2) **Alternate measure 1 in 2015.** Subject to paragraph (d) of this section—

(i) More than 30 percent of all unique patients with at least one medication in their medication list admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE; or

(ii) More than 30 percent of medication orders created by the authorized providers of the eligible hospital or CAH for patients admitted to their inpatient or emergency departments (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

(3) **Alternate exclusions in 2015 and 2016.** An eligible hospital or CAH scheduled to be in Stage 1 in 2015 may exclude the following measures in 2015 and eligible hospital or CAH scheduled to be in Stage 1 in 2016 may exclude the following measures in 2016:

   (i) The measure specified in paragraph (e)(3)(iii)(A)(2) of this section.

   (ii) The measure specified in paragraph (e)(3)(iii)(A)(3) of this section.

(4) **Electronic prescribing—(i) Objective.** For EPs, generate and transmit permissible prescriptions electronically (eRx); and, for eligible hospitals and CAHs, generate, and transmit permissible discharge prescriptions electronically (eRx).

(ii) **EP measure—(A) Measure.** Subject to paragraph (d) of this section, more than 50 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

(B) **Exclusion in accordance with paragraph (b)(2) of this section.** Any EP who—

   (1) Writes fewer than 100 permissible prescriptions during the EHR reporting period; or

   (2) Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP’s practice location at the start of his or her EHR reporting period.

(C) **Alternate specification.** In 2015 an EP—

   (1) Previously scheduled to be in Stage 1 in 2015 may meet an alternate measure under paragraph (e)(4)(ii)(C)(2) of this section in place of the measure outlined under paragraph (e)(4)(ii)(A) of this section; and

   (2) Subject to paragraph (d) of this section, more than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using CEHRT.

(iii) **Eligible hospital and CAH measure—(A) Measure.** Subject to paragraph (d) of this section, more than 10 percent of hospital discharge medication orders for permissible prescriptions are queried for a drug formulary and transmitted electronically using CEHRT.

(B) **Exclusion in accordance with paragraph (c)(2) of this section.** Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions and is not located within 10 miles of any pharmacy that accepts electronic prescriptions at
the start of their EHR reporting period.

(C) **Alternate exclusions.** (1) An eligible hospital or CAH previously scheduled to be in—

(i) Stage 1 in 2015 may exclude the measure specified in paragraph (e)(4)(iii)(A) of this section for an EHR reporting period in 2015; or

(ii) Stage 2 in 2015 may exclude the measure specified in paragraph (e)(4)(iii)(A) of this section for an EHR reporting period in 2015.

(2) An eligible hospital or CAH previously scheduled to be in—

(i) Stage 1 in 2016, may exclude the measure specified in paragraph (e)(4)(iii)(A) of this section for an EHR reporting period in 2016; or

(ii) Stage 2 in 2016, may exclude the measure specified in paragraph (e)(4)(iii)(A) of this section for an EHR reporting period in 2016.

(5) **Health Information Exchange**—(1) **Objective.** The EP, eligible hospital or CAH who transitions a patient to another setting of care or provider of care or refers a patient to another provider of care provides a summary care record for each transition of care or referral.

(ii) **EP measure**—(A) **Measure.** Subject to paragraph (d) of this section, the EP who transitions or refers his or her patient to another setting of care or provider of care must do the following:

(1) Use CEHRT to create a summary of care record.

(2) Electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.

(B) **Alternate exclusion.** An eligible hospital or CAH previously scheduled to be in Stage 1 in 2015 may exclude the measure specified in paragraph (e)(5)(iii)(A) of this section for an EHR reporting period in 2015.

(6) **Patient specific education**—(i) **Objective.** Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.

(ii) **EP measure**—(A) **Measure.** Patient-specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.

(B) **Exclusion in accordance with paragraph (b)(2) of this section.** Any EP who has no office visits during the EHR reporting period.

(C) **Alternate exclusion.** An EP previously scheduled to be in Stage 1 in 2015 may exclude the measure specified in paragraph (e)(6)(ii)(A) of this section for an EHR reporting period in 2015.

(iii) **Eligible hospital and CAH measure**—(A) **Measure.** More than 10 percent of all unique patients admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources identified by CEHRT.

(B) **Alternate exclusion.** An eligible hospital or CAH previously scheduled to be in Stage 1 in 2015 may exclude the measure specified in paragraph (e)(6)(iii)(A) of this section for an EHR reporting period in 2015.

(7) **Medication reconciliation**—(i) **Objective.** The EP, eligible hospital or CAH that receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.

(ii) **EP measure**—(A) **Measure.** Subject to paragraph (d) of this section, the EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

(B) **Exclusion in accordance with paragraph (b)(2) of this section.** Any EP who
was not the recipient of any transitions of care during the EHR reporting period.

(C) Alternate exclusion. An EP previously scheduled to be in Stage 1 in 2015 may exclude the measure specified in paragraph (e)(7)(ii)(A) of this section for an EHR reporting period in 2015.

(iii) Eligible hospital or CAH measure. An eligible hospital or CAH must meet the following measure, subject to paragraph (d) of this section:

(A) Measure. Subject to paragraph (d) of this section, the eligible hospital or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23).

(B) Alternate exclusion. An eligible hospital or CAH previously scheduled to be in Stage 1 in 2015 may exclude the measure specified in paragraph (e)(7)(iii)(A) of this section for an EHR reporting period in 2015.

(8) Patient electronic access—(i) EP objective. Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

(A) EP measures. An EP must meet the following 2 measures:

(1) Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download and transmit to a third party their health information subject to the EP’s discretion to withhold certain information.

(2) Measure 2: For an EHR reporting period—

(i) In 2015 and 2016, at least 1 patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period.

(ii) In 2017, more than 5 percent of unique patients seen by the EP during the EHR reporting period (or their authorized representatives) views, downloads or transmits their health information to a third party during the EHR reporting period.

(B) Exclusion in accordance with paragraph (b)(2) of this section—(1) Any EP who neither orders nor creates any of the information listed for inclusion as part of the measure in paragraph (e)(8)(i)(A)(1) or (2) of this section, except for “Patient name” and “Provider’s name and office contact information,” is excluded from paragraphs (e)(8)(i)(A)(1) and (2) of this section.

(2) Any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission on the first day of the EHR reporting period is excluded from paragraph (e)(8)(i)(A)(2) of this section.

(C) Alternate exclusion. An EP previously scheduled to be in Stage 1 in 2015 may exclude the measure specified in paragraph (e)(8)(ii)(A)(2) of this section for an EHR reporting period in 2015.

(ii) Eligible hospital and CAH objective. Provide patients the ability to view online, download, and transmit information within 36 hours of hospital discharge.

(A) Eligible hospital and CAH measures. An eligible hospital or CAH must meet the following 2 measures:

(1) Measure 1. More than 50 percent of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have timely access to view online, download and transmit to a third party their health information.

(2) Measure 2. For an EHR reporting period—

(i) In 2015 or 2016, at least 1 patient (or patient-authorized representative) who is discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH during the EHR reporting period views, downloads or transmits to a third party his or her information during the EHR reporting period; and

(ii) In 2017, more than 5 percent of unique patients (or patient-authorized representatives) discharged from the inpatient or emergency department (POS 21 or POS 23) of an eligible hospital or CAH during the EHR reporting period views, downloads or transmits to a third party their health information.
period view, download or transmit to a third party their health information during the EHR reporting period.

(B) Exclusion applicable under paragraph (c)(2) of this section. Any eligible hospital or CAH that is located in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period is excluded from paragraph (e)(9)(ii)(A)(2) of this section.

(C) Alternate exclusion. Any eligible hospital or CAH previously scheduled to be in Stage 1 in 2015 may exclude the measure specified in paragraph (e)(9)(ii)(A)(2) of this section for an EHR reporting period in 2015.

(9) Secure messaging—(i) EP objective. Use secure electronic messaging to communicate with patients on relevant health information.

(ii) EP measure—(A) Measure. For an EHR reporting period—

(1) In 2015, the capability for patients to send and receive a secure electronic message with the EP was fully enabled during the EHR reporting period;

(2) In 2016, for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period; and

(3) In 2017, for more than 5 percent of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.

(B) Exclusion in accordance with paragraph (b)(2) of this section. An EP may exclude from the measure if he or she—

(1) Has no office visits during the EHR reporting period; or

(2) Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission on the first day of the EP’s EHR reporting period.

(C) Alternate specification. An EP previously scheduled to be in Stage 1 in 2015 may exclude the measure specified in paragraph (e)(9)(ii)(A) of this section for an EHR reporting period in 2015.

(10) Public Health Reporting—(i) EP Public Health Reporting—(A) Objective. The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT, except where prohibited, and in accordance with applicable law and practice.

(B) Measures. In order to meet the objective under paragraph (e)(10)(i)(A) of this section, an EP must choose from measures 1 through 3 (as specified in paragraphs (e)(10)(i)(B)(1) through (3) of this section) and must successfully attest to any combination of two measures. The EP may attest to measure 3 (as specified in paragraph (e)(10)(i)(B)(3) of this section more than one time. These measures may be met by any combination in accordance with applicable law and practice.

(1) Immunization registry reporting. The EP is in active engagement with a public health agency to submit immunization data.

(2) Syndromic surveillance reporting. The EP is in active engagement with a public health agency to submit syndromic surveillance data.

(3) Specialized registry reporting. The EP is in active engagement to submit data to specialized registry.

(C) Exclusions in accordance with paragraph (b)(2) of this section. (1) Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure in paragraph (e)(10)(i)(B)(1) of this section if the EP:

(i) Does not administer any immunizations to any of the populations for which data is collected by his or her jurisdiction’s immunization registry or immunization information system during the EHR reporting period.
§495.22 42 CFR Ch. IV (10–1–16 Edition)

(i) Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

(ii) Operates in a jurisdiction in which no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period.

(iii) Operates in a jurisdiction where no specialized registry for which no public health agency is capable of receiving electronic syndromic surveillance reporting measure described in paragraph (e)(10)(i)(B)(2) of the section if the EP:

1. Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction’s syndromic surveillance system;

2. Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

3. Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.

(iv) Any EP who meets one or more of the following criteria may be excluded from the syndromic surveillance reporting measure described in paragraph (e)(10)(i)(b)(2) of this section if the EP:

1. Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period;

2. Operates in a jurisdiction in which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period;

3. Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

(D) Alternate specifications. An EP previously scheduled to be in Stage 1 in 2015 may choose from measures 1 through 3 (as specified in paragraphs (e)(10)(i)(b)(1) through (3) of this section) and must successfully attest to any one measure in accordance with applicable law and practice for an EHR reporting period in 2015.

(ii) Eligible hospital and CAH Public Health and Clinical Data Registry reporting objective—(A) Objective. The eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT, except where prohibited, and in accordance with applicable law and practice.

(B) Measures. In order to meet the objective under paragraph (e)(10)(i)(A) of this section, an eligible hospital or CAH must choose from measures 1 through 4 (as described in paragraphs (e)(10)(i)(b)(1) through (4) of this section) and must successfully attest to any combination of three measures. These measures may be met by any combination, including meeting the measure specified in paragraph (e)(10)(i)(b)(3) of this section multiple times, in accordance with applicable law and practice:

1. Immunization registry reporting. The eligible hospital or CAH is in active engagement with a public health agency to submit immunization.

2. Syndromic surveillance reporting. The eligible hospital or CAH is in active engagement with a public health agency to submit syndromic surveillance data.

3. Specialized registry reporting. The eligible hospital or CAH is in active engagement to submit data to a specialized registry.

4. Electronic reportable laboratory result reporting. The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results.

(C) Exclusions in accordance with paragraph (c)(2) of this section. (1) Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the immunization registry reporting measure specified in paragraph (e)(10)(i)(b)(1) of this section if the eligible hospital or CAH:

750
(i) Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction’s immunization registry or immunization information system during the EHR reporting period.

(ii) Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

(iii) Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the eligible hospital or CAH at the start of the EHR reporting period.

(2) Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure specified in paragraph (e)(10)(i)(B)(2) of this section if the eligible hospital or CAH:

(i) Does not have an emergency or urgent care department.

(ii) Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from eligible hospitals or CAHs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

(iii) Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from eligible hospitals or CAHs at the start of the EHR reporting period.

(3) Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the specialized registry reporting measure described in paragraph (e)(10)(i)(B)(3) of this section if the eligible hospital or CAH:

(i) Does not diagnose or directly treat any disease associated with or collect relevant data is required by a specialized registry for which the eligible hospital or CAH is eligible in their jurisdiction.

(ii) Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or

(iii) Operates in a jurisdiction where no specialized registry for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

(d) Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the electronic reportable laboratory result reporting measure specified in paragraph (d)(10)(i)(B)(4) of this section if the eligible hospital or CAH:

(i) Does not perform or order laboratory tests that are reportable in the eligible hospital’s or CAH’s jurisdiction during the EHR reporting period.

(ii) Operates in a jurisdiction for which no public health agency that is capable of accepting the specific ELR standards required to meet the CEHRT definition at the start of the EHR reporting period.

(iii) Operates in a jurisdiction where no public health agency has declared readiness to receive electronic reportable laboratory results from eligible hospitals or CAHs at the start of the EHR reporting period.

(D) Alternate specification. An eligible hospital or CAH previously scheduled to be in Stage 1 in 2015 may choose from measures 1 through 4 (as specified in paragraphs (e)(10)(i)(B)(1)) through (d) of this section) and must successfully attest to any 2 measures. These measures may be met by any combination, including meeting the measures specified in paragraph (e)(10)(i)(B)(3) of this section multiple times, in accordance with applicable law and practice.

[80 FR 62943, Oct. 16, 2015, as amended at 81 FR 11449, Mar. 4, 2016]

§ 495.24 Stage 3 meaningful use objectives and measures for EPs, eligible hospitals, and CAHs for 2018 and subsequent years.

The following criteria are optional for EPs, eligible hospitals, and CAHs in 2017 as outlined at § 495.40(a)(2)(i)(E)(3) and (b)(2)(E)(3) and applicable for all EPs, eligible hospitals, and CAHs for 2018 and subsequent years:
(a) Stage 3 criteria for EPs—(1) General rule regarding Stage 3 criteria for meaningful use for EPs. Except as specified in paragraphs (a)(2) through (a)(3) of this section, EPs must meet all objectives and associated measures of the Stage 3 criteria specified in paragraph (d) of this section to meet the definition of a meaningful EHR user.

(2) Selection of measures for specified objectives in paragraph (d) of this section. An EP may meet the criteria for 2 out of the 3 measures associated with an objective, rather than meeting the criteria for all 3 of the measures, if the EP meets all of the following requirements:

(i) Must ensure that the objective in paragraph (d) of this section includes an option to meet 2 out of the 3 associated measures.

(ii) Meets the threshold for 2 out of the 3 measures for that objective.

(iii) Attests to all 3 of the measures for that objective.

(3) Exclusion for non-applicable objectives and measures. (i) An EP may exclude a particular objective that includes an option for exclusion contained in paragraph (d) of this section, if the EP meets all of the following requirements:

(A) Meets the criteria in the applicable objective that would permit the exclusion.

(B) Attests to the exclusion.

(ii) An EP may exclude a measure within an objective which allows for a provider to meet the threshold for 2 of the 3 measures, as outlined in paragraph (a)(2) of this section, in the following manner:

(A)(1) Meets the criteria in the applicable measure or measures that would permit the exclusion; and

(A)(2) Attests to the exclusion or exclusions.

(B)(1) Meets the threshold; and

(B)(2) Attests to any remaining measure or measures.

(4) Exception for Medicaid EPs who adopt, implement or upgrade in their first payment year. For Medicaid EPs who adopt, implement or upgrade its CEHRT in their first payment year, the meaningful use objectives and associated measures of the Stage 3 criteria specified in paragraph (d) of this section apply beginning with the second payment year, and do not apply to the first payment year.

(b) Stage 3 criteria for eligible hospitals and CAHs—(1) General rule regarding Stage 3 criteria for meaningful use for eligible hospitals or CAHs. Except as specified in paragraphs (b)(2) and (3) of this section, eligible hospitals and CAHs must meet all objectives and associated measures of the Stage 3 criteria specified in paragraph (d) of this section to meet the definition of a meaningful EHR user.

(2) Selection of measures for specified objectives in paragraph (d) of this section. An eligible hospital or CAH may meet the criteria for 2 out of the 3 measures associated with an objective, rather than meeting the criteria for all 3 of the measures, if the eligible hospital or CAH meets all of the following requirements:

(i) Must ensure that the objective in paragraph (d) of this section includes an option to meet 2 out of the 3 associated measures.

(ii) Meets the threshold for 2 out of the 3 measures for that objective.

(iii) Attests to all 3 of the measures for that objective.

(3) Exclusion for non-applicable objectives and measures. (i) An eligible hospital or CAH may exclude a particular objective that includes an option for exclusion contained in paragraph (d) of this section, if the eligible hospital or CAH meets all of the following requirements:

(A) Meets the criteria in the applicable objective that would permit the exclusion.

(B) Attests to the exclusion.

(ii) An eligible hospital or CAH may exclude a measure within an objective which allows for a provider to meet the threshold for 2 of the 3 measures, as outlined in paragraph (b)(2) of this section, in the following manner:

(A)(1) Meets the criteria in the applicable measure or measures that would permit the exclusion; and

(A)(2) Attests to the exclusion or exclusions.

(B)(1) Meets the threshold; and

(B)(2) Attests to any remaining measure or measures.

(4) Exception for Medicaid eligible hospitals or CAHs that adopt, implement or upgrade in their first payment year. For
Centers for Medicare & Medicaid Services, HHS

Medicaid eligible hospitals or CAHs who adopt, implement or upgrade CEHRT in their first payment year, the meaningful use objectives and associated measures of the Stage 3 criteria specified in paragraph (d) of this section apply beginning with the second payment year, and do not apply to the first payment year.

(c) Objectives and associated measures in paragraph (d) of this section that rely on measures that count unique patients or actions. (1) If a measure (or associated objective) in paragraph (d) of this section references paragraph (c) of this section, then the measure may be calculated by reviewing only the actions for patients whose records are maintained using CEHRT. A patient’s record is maintained using CEHRT if sufficient data was entered in the CEHRT to allow the record to be saved, and not rejected due to incomplete data.

(2) If the objective and associated measure does not reference this paragraph (c) of this section, the measure must be calculated by reviewing all patient records, not just those maintained using CEHRT.

(d) Stage 3 objectives and measures for EPs, eligible hospitals, and CAHs—(1) EP protect patient health information—(A) Objective. Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.

(B) Measure. Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the provider’s risk management process.

(2) Electronic prescribing—(i) EP electronic prescribing—(A) Objective. Generate and transmit permissible prescriptions electronically (eRx).

(B) Measure. Subject to paragraph (c) of this section, more than 60 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

(C) Exclusions in accordance with paragraph (a)(3) of this section. (1) Any EP who writes fewer than 100 permissible prescriptions during the EHR reporting period; or

(2) Any EP who does not have a pharmacy within its organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP’s practice location at the start of his/her EHR reporting period.

(ii) Eligible hospital/CAH electronic prescribing—(A) Objective. Generate and transmit permissible discharge prescriptions electronically (eRx).

(B) Measure. Subject to paragraph (c) of this section, more than 25 percent of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.

(C) Exclusions in accordance with paragraph (b)(3) of this section. Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions and there are no pharmacies that accept electronic prescriptions within 10 miles at the start of the eligible hospital or CAH’s EHR reporting period.

(3) Clinical decision support—(i) EP clinical decision support—(A) Objective. Implement clinical decision support
(CDS) interventions focused on improving performance on high-priority health conditions.

(B) Measures. (1) Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions; and

(2) The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

(C) Exclusion in accordance with paragraph (a)(3) of this section for paragraph (d)(3)(i)(B)(2) of this section. An EP who writes fewer than 100 medication orders during the EHR reporting period.

(ii) Eligible hospital/CAH clinical decision support—(A) Objective. Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

(B) Measures. (1) Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an eligible hospital or CAH’s patient population, the clinical decision support interventions must be related to high-priority health conditions; and

(2) The eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

(C) Exclusions in accordance with paragraph (a)(3) of this section. (1) For the measure specified in paragraph (d)(4)(i)(B)(1) of this section, any EP who writes fewer than 100 medication orders during the EHR reporting period.

(2) For the measure specified in paragraph (d)(4)(i)(B)(2) of this section, any EP who writes fewer than 100 laboratory orders during the EHR reporting period.

(3) For the measure specified in paragraph (d)(4)(i)(B)(3) of this section, any EP who writes fewer than 100 diagnostic imaging orders during the EHR reporting period.

(ii) Eligible hospital and CAH CPOE—(A) Objective. Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant; who can enter orders into the medical record per state, local, and professional guidelines.

(B) Measures. Subject to paragraph (c) of this section—

(1) More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry;

(2) More than 60 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry; and

(3) More than 60 percent of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

(C) Exclusions in accordance with paragraph (a)(3) of this section. (1) For the measure specified in paragraph (d)(4)(ii)(B)(1) of this section, any EP who writes fewer than 100 medication orders during the EHR reporting period.

(2) For the measure specified in paragraph (d)(4)(ii)(A)(1) of this section, any EP who writes fewer than 100 medication orders during the EHR reporting period.

(3) For the measure specified in paragraph (d)(4)(ii)(A)(2) of this section, any EP who writes fewer than 100 diagnostic imaging orders during the EHR reporting period.

(ii) Eligible hospital CPOE—(A) Objective. Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant; who can enter orders into the medical record per state, local, and professional guidelines.

(B) Measures. Subject to paragraph (c) of this section—

(1) More than 60 percent of medication orders created by authorized providers of the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry;

(2) More than 60 percent of laboratory orders created by authorized providers of the eligible hospital’s or
CAH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry; and

(3) More than 60 percent of diagnostic imaging orders created by authorized providers of the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

(5) Patient electronic access to health information—(i) EP patient electronic access to health information—(A) Objective. The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

(B) Measures. EPs must meet the following two measures:

(1) For more than 80 percent of all unique patients seen by the EP—

(i) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and

(ii) The provider ensures the patient’s health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the API in the provider’s CEHRT.

(2) The EP must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients seen by the EP during the EHR reporting period.

(C) Exclusions in accordance with paragraph (a)(3) of this section. (1) Any EP who has no office visits during the reporting period may exclude from the measures specified in paragraphs (d)(5)(i)(B)(1) and (B)(2) of this section.

(2) Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude from the measures specified in paragraphs (d)(5)(i)(B)(1) and (2) of this section.

(ii) Eligible hospital and CAH patient electronic access to health information—(A) Objective. The eligible hospital or CAH provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

(B) Measures. Eligible hospitals and CAHs must meet the following two measures:

(1) For more than 80 percent of all unique patients seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23):

(i) The patient (or patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and

(ii) The provider ensures the patient’s health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the API in the provider’s CEHRT.

(2) The eligible hospital or CAH must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

(C) Exclusion in accordance with paragraph (b)(3) of this section. Any eligible hospital or CAH that is located in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period is excluded from the measures specified in paragraphs (d)(5)(i)(B)(1) and (2) of this section.

(6) Coordination of care through patient engagement—(1) EP coordination of care through patient engagement—(A) Objective. Use CEHRT to engage with patients or their authorized representatives about the patient’s care.

(B) Measures. In accordance with paragraph (a)(2) of this section, an EP must satisfy 2 out of the 3 following measures in paragraphs (d)(6)(i)(B)(1),
§495.24
42 CFR Ch. IV (10–1–16 Edition)

(2), and (3) of this section except those measures for which an EP qualifies for an exclusion under paragraph (a)(3) of this section.

(1) During the EHR reporting period, more than 10 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either of the following:

(i) View, download or transmit to a third party their health information;

(ii) Access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider’s CEHRT; or

(iii) A combination of paragraphs (d)(6)(i)(B)(I)(i) and (ii).

(iv) For an EHR reporting period in 2017 only, an EP may meet a threshold of 5 percent instead of 10 percent for the measure at paragraph (d)(6)(i)(B)(I) of this section.

(2) During the EHR reporting period—

(i) For an EHR reporting period in 2017 only, for more than 5 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or their authorized representatives), or in response to a secure message sent by the patient; or

(ii) For an EHR reporting period other than 2017, for more than 25 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or their authorized representatives), or in response to a secure message sent by the patient.

(3) Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the EHR reporting period.

(C) Exclusions in accordance with paragraph (a)(3) of this section. (1) Any EP who has no office visits during the reporting period may exclude from the measures specified in paragraphs (d)(6)(i)(B)(I), (2), and (3) of this section.

(2) Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude from the measures specified in paragraphs (d)(6)(i)(B)(I), (2), and (3) of this section.

(ii) Eligible hospital and CAH coordination of care through patient engagement—

(A) Objective. Use CEHRT to engage with patients or their authorized representatives about the patient’s care.

(B) Measures. In accordance with paragraph (b)(2) of this section, an eligible hospital or CAH must satisfy 2 of the 3 following measures in paragraph (d)(6)(ii)(B)(I), (2), and (3) of this section, except those measures for which an eligible hospital or CAH qualifies for an exclusion under paragraph (b)(3) of this section.

(i) For an EHR reporting period in 2017 only, an eligible hospital or CAH inpatient or emergency department (POS 21 or 23) actively engage with the electronic health record made accessible by the provider and one of the following:

(ii) View, download or transmit to a third party their health information.

(iii) Access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider’s CEHRT.

(iv) A combination of paragraphs (d)(6)(ii)(B)(I)(i) and (ii).

(iv) For an EHR reporting period in 2017, an eligible hospital or CAH may meet a threshold of 5 percent instead of 10 percent for the measure at paragraph (d)(6)(ii)(B)(I) of this section.

(2) During the EHR reporting period—

(i) For an EHR reporting period in 2017 only, for more than 5 percent of all unique patients discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to
the patient (or their authorized representatives), or in response to a secure message sent by the patient (or their authorized representatives).

(ii) For an EHR reporting period other than 2017, for more than 25 percent of all unique patients discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or their authorized representatives), or in response to a secure message sent by the patient (or their authorized representatives).

(3) Patient generated health data or data from a non-clinical setting is incorporated into the CEHRT for more than 5 percent of unique patients discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

(C) Exclusions under paragraph (b)(3) of this section. Any eligible hospital or CAH operating in a location that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude from the measures specified in paragraphs (d)(1)(i)(B)(1), (B)(2), and (B)(3) of this section.

(7) Health information exchange—(i) EP health information exchange—(A) Objective. The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.

(B) Measures. In accordance with paragraph (a)(3) of this section, an EP must attest to all 3 measures, but must meet the threshold for 2 of the 3 measures in paragraph (d)(7)(i)(B)(1), (2), and (3), in order to meet the objective. Subject to paragraph (c) of this section—

(1) Measure 1. For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care—

(i) Creates a summary of care record using CEHRT; and

(ii) Electronically exchanges the summary of care record.

(2) Measure 2. For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient’s EHR an electronic summary of care document.

(3) Measure 3. For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs clinical information reconciliation. The EP must implement clinical information reconciliation for the following three clinical information sets:

(i) Medication. Review of the patient’s medication, including the name, dosage, frequency, and route of each medication.

(ii) Medication allergy. Review of the patient’s known allergic medications.

(iii) Current problem list. Review of the patient’s current and active diagnoses.

(C) Exclusions in accordance with paragraph (a)(3) of this section. An EP must be excluded when any of the following occur:

(1) Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period must be excluded from paragraphs (d)(7)(i)(B)(1) of this section.

(2) Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period may be excluded from paragraphs (d)(7)(i)(B)(2) and (d)(7)(i)(B)(3) of this section.

(3) Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude from the measures specified in paragraphs (d)(7)(i)(B)(1) and (2) of this section.
(ii) Eligible hospitals and CAHs health information exchange—(A) Objective. The eligible hospital or CAH provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.

(B) Measures. In accordance with paragraph (b)(2) of this section, an eligible hospital or CAH must attest to all three measures, but must meet the threshold for 2 of the 3 measures in all three measures, but must meet the threshold for 2 of the 3 measures in all three measures, but must meet the threshold for 2 of the 3 measures in paragraph (d)(7)(ii)(B)(1), (2), and (3). Subject to paragraph (c) of this section—

(1) Measure 1. For more than 50 percent of transitions of care and referrals, the eligible hospital or CAH that transitions or refers its patient to another setting of care or provider of care—

(i) Creates a summary of care record using CEHRT; and

(ii) Electronically exchanges the summary of care record.

(2) Measure 2. For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the eligible hospital or CAH incorporates into the patient’s EHR an electronic summary of care document.

(3) Measure 3. For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the eligible hospital or CAH performs a clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets:

(i) Medication. Review of the patient’s medication, including the name, dosage, frequency, and route of each medication.

(ii) Medication allergy. Review of the patient’s known allergic medications.

(iii) Current problem list. Review of the patient’s current and active diagnoses.

(C) Exclusions in accordance with paragraph (b)(3) of this section. (1) Any eligible hospital or CAH for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period may be excluded from paragraphs (d)(7)(i)(B)(2) and (3) of this section.

(2) Any eligible hospital or CAH operating in a location that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude from the measures specified in paragraphs (d)(7)(i)(B)(1), and (2) of this section.

(8) Public Health and Clinical Data Registry Reporting—(i) EP Public Health and Clinical Data Registry: Reporting objective—(A) Objective. The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.

(B) Measures. In order to meet the objective under paragraph (d)(8)(i)(A) of this section, an EP must choose from measures 1 through 5 (paragraphs (d)(8)(i)(B)(1) through (d)(8)(i)(B)(5) of this section) and must successfully attest to any combination of two measures. These measures may be met by any combination, including meeting measure specified in paragraph (d)(8)(i)(B)(4) or (5) of this section multiple times, in accordance with applicable law and practice:

(1) Immunization registry reporting.

The EP is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/imunization information system (IIS).

(2) Syndromic surveillance reporting.

The EP is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.

(3) Electronic case reporting. The EP is in active engagement with a public health agency to submit case reporting of reportable conditions.
(4) Public health registry reporting. The EP is in active engagement with a public health agency to submit data to public health registries.

(5) Clinical data registry reporting. The EP is in active engagement to submit data to a clinical data registry.

(C) Exclusions in accordance with paragraph (a)(3) of this section. (1) Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure in paragraph (d)(8)(i)(B)(1) of this section if the EP:

(i) Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction’s immunization registry or immunization information system during the EHR reporting period.

(ii) Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of its EHR reporting period.

(iii) Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the EHR reporting period.

(2) Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure described in paragraph (d)(8)(i)(B)(2) of this section if the EP:

(i) Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction’s syndromic surveillance system.

(ii) Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

(iii) Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the EHR reporting period.

(3) Any EP meeting one or more of the following criteria may be excluded from the case reporting measure at paragraph (d)(8)(i)(B)(3) of this section if the EP:

(i) Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction’s reportable disease system during the EHR reporting period.

(ii) Operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

(iii) Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the EHR reporting period.

(4) Any EP meeting at least one of the following criteria may be excluded from the public health registry reporting measure specified in paragraph (d)(8)(i)(B)(4) of this section if the EP:

(i) Does not diagnose or directly treat any disease or condition associated with a public health registry in the EP’s jurisdiction during the EHR reporting period.

(ii) Operates in a jurisdiction for which no public health registry for which the EP, eligible hospital, or CAH is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the EHR reporting period.

(5) Any EP meeting at least one of the following criteria may be excluded from the clinical data registry reporting measure specified in paragraph (d)(8)(i)(B)(5) of this section if the EP:

(i) Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the EHR reporting period.

(ii) Operates in a jurisdiction for which no clinical data registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition.
§495.24  42 CFR Ch. IV (10–1–16 Edition)

at the start of the EHR reporting period.

(iii) Operates in a jurisdiction where no clinical data registry for which the EP, eligible hospital, or CAH is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the EHR reporting period.

(ii) Eligible hospital and CAH Public Health and Clinical Data Registry Reporting objective—(A) Objective. The eligible hospital or CAH is in active engagement with a public health agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.

(B) Measures. In order to meet the objective under paragraph (d)(8)(ii)(A) of this section, an eligible hospital or CAH must choose from measures 1 through 6 (as described in paragraphs (d)(8)(ii)(B)(1) through (6) of this section) and must successfully attest to any combination of four measures. These measures may be met by any combination, including meeting the measure specified in paragraph (d)(8)(ii)(B)(2) of this section if the eligible hospital or CAH:

(1) Immunization registry reporting. The eligible hospital or CAH is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).

(2) Syndromic surveillance reporting. The eligible hospital or CAH is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.

(3) Case reporting. The eligible hospital or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions.

(4) Public health registry reporting. The eligible hospital or CAH is in active engagement with a public health agency to submit data to public health registries.

(5) Clinical data registry reporting. The eligible hospital or CAH is in active engagement to submit data to a clinical data registry.

(6) Electronic reportable laboratory result reporting. The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results.

(C) Exclusions in accordance with paragraph (b)(3) of this section. (i) Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from to the immunization registry reporting measure specified in paragraph (d)(8)(ii)(B)(1) of this section if the eligible hospital or CAH:

(i) Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction’s immunization registry or immunization information system during the EHR reporting period.

(ii) Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

(iii) Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the EHR reporting period.

(2) Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure specified in paragraph (d)(8)(ii)(B)(2) of this section if the eligible hospital or CAH:

(i) Does not have an emergency or urgent care department.

(ii) Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

(iii) Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from eligible hospitals or CAHs as of 6 months prior to the start of the EHR reporting period.

(3) Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the case
Centers for Medicare & Medicaid Services, HHS § 495.40

reporting measure specified in paragraph (d)(8)(ii)(B)(3) of this section if the eligible hospital or CAH:
(i) Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction’s reportable disease system during the EHR reporting period.
(ii) Operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of their EHR reporting period.
(iii) Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the EHR reporting period.

(4) Any eligible hospital or CAH meeting at least one of the following criteria may be excluded from the public health registry reporting measure specified in paragraph (d)(8)(ii)(B)(4) of this section if the eligible hospital or CAH:
(i) Does not diagnose or directly treat any disease or condition associated with a public health registry in its jurisdiction during the EHR reporting period.
(ii) Operates in a jurisdiction for which no public health agency is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.
(iii) Operates in a jurisdiction where no public health registry for which the EP, eligible hospital, or CAH is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the EHR reporting period.

(5) Any eligible hospital or CAH meeting at least one of the following criteria may be excluded from the clinical data registry reporting measure specified in paragraph (d)(8)(ii)(B)(5) of this section if the eligible hospital or CAH:
(i) Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the EHR reporting period.
(ii) Operates in a jurisdiction for which no clinical data registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.
(iii) Operates in a jurisdiction where no clinical data registry for which the EP, eligible hospital, or CAH is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the EHR reporting period.

(6) Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the electronic reportable laboratory result reporting measure specified in paragraph (d)(8)(ii)(B)(6) of this section if the eligible hospital or CAH:
(i) Does not perform or order laboratory tests that are reportable in its jurisdiction during the EHR reporting period.
(ii) Operates in a jurisdiction for which no public health agency that is capable of accepting the specific ELR standards required to meet the CEHRT definition at the start of the EHR reporting period.
(iii) Operates in a jurisdiction where no public health agency has declared readiness to receive electronic reportable laboratory results from an eligible hospital or CAH as of 6 months prior to the start of the EHR reporting period.

[80 FR 62948, Oct. 16, 2015, as amended at 81 FR 11449, Mar. 4, 2016; 81 FR 34909, June 1, 2016]

§ 495.40 Demonstration of meaningful use criteria.

(a) Demonstration by EPs. An EP must demonstrate that he or she satisfies each of the applicable objectives and associated measures under §495.20 or §495.24 as follows:
(1) For CY 2011—(i) Attestation. Attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid EP, in a manner specified by the State), that during the EHR reporting period, the EP—
(A) Used certified EHR technology, and specify the technology used;
(B) Satisfied the required objectives and associated measures under §495.20 or §495.24;
(C) Must specify the EHR reporting period and provide the result of each applicable measure for all patients seen during the EHR reporting period for which a selected measure is applicable;

(ii) Additional requirements for Medicaid EPs. For Medicaid EPs, if, in accordance with §495.316 and §495.332, CMS has approved a State’s revised definition for meaningful use, in addition to meeting paragraphs (a)(1)(i) through (ii) of this section, the EP must also demonstrate meeting the State revised definition using the method approved by CMS; and

(iii) Exception for Medicaid EPs. If a Medicaid EP has adopted, implemented or upgraded certified EHR technology in the first payment year, the EP need not demonstrate meaningful use until the second payment year, as described in §495.20 or §§495.24 and 495.40.

(2) For CY 2012 and subsequent years—

(i) Attestation. Attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid EP, in a manner specified by the State) that during the EHR reporting period, the EP—

(A) Used certified EHR technology and specify the technology used.

(B) For calendar years before 2015, satisfied the required objectives and associated measures under §495.20 for the EP’s stage of meaningful use.

(C) Must specify the EHR reporting period and provide the result of each applicable measure for all patients seen during the EHR reporting period for which a selected measure is applicable.

(D) For 2014 only, if the EP uses one of the options specified in §495.20(a)(4) or (h)(3), the EP must attest that he or she is unable to fully implement 2014 Edition certified EHR technology for an EHR reporting period in 2014 due to delays in 2014 Edition certified EHR technology availability.

(E) For CYs 2015 through 2017, satisfied the required objectives and associated measures under §495.22(e) for meaningful use.

(F) For CY 2017 only, an EP may satisfy either of the following objectives and measures for meaningful use:

(1) Objectives and measures specified in §495.22 (e); or

(2) Objectives and measures specified in §495.24 (d).

(ii) Reporting clinical quality information. Successfully report the clinical quality measures selected by CMS to CMS or the States, as applicable, in the form and manner specified by CMS or the States, as applicable.

(iii) Additional requirements for Medicaid EPs. For Medicaid EPs, if, in accordance with §495.316 and §495.332, CMS has approved a State’s additional criteria for meaningful use, in addition to meeting paragraphs (a)(2)(i) through (iii), the EP must also demonstrate meeting such additional criteria using the method approved by CMS.

(iv) Exception for Medicaid EPs. If a Medicaid EP has adopted, implemented, or upgrade certified EHR technology in the first payment year, the EP need not demonstrate that it is a meaningful EHR user until the second payment year, as described in §495.20 or §§495.24 and 495.40.

(v) Exception for Medicare EPs for 2012 and 2013—Participation in the Physician Quality Reporting System-Medicare EHR Incentive Pilot. To satisfy the clinical quality measure reporting requirements of meaningful use, aside from attestation, an EP participating in the Physician Quality Reporting System may also participate in the Physician Quality Reporting System-Medicare EHR Incentive Pilot through one of the following methods:

(A) Submission of data extracted from the EP’s certified EHR technology through a Physician Quality Reporting System qualified EHR data submission vendor; or

(B) Submission of data extracted from the EP’s certified EHR technology, which must also be through a Physician Quality Reporting System qualified EHR.

(3) For all CYs, an EP who practices in multiple physical locations, not all of which have certified EHR technology available, will demonstrate meaningful use using only the locations where the EP has certified EHR technology available. (See also §495.4 regarding the definition of meaningful EHR user).
(b) Demonstration by eligible hospitals and CAHs. To successfully demonstrate that it is a meaningful EHR user, an eligible hospital or CAH must the following requirements:

(1) For FY 2011—

(i) Attestation. Attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid eligible hospital, in a manner specified by the State), that during the EHR reporting period, the eligible hospital or CAH—

(A) Used certified EHR and specify the technology used.

(B) Satisfied the required objectives and associated measures under §495.20 or §495.24.

(C) Must specify the EHR reporting period and provide the result of each applicable measure for all patients admitted to the inpatient or emergency department (POS 21 or 23) of the hospital during the EHR reporting period for which a selected measure is applicable.

(ii) Additional requirements for Medicaid eligible hospitals. For Medicaid eligible hospitals, if, in accordance with §495.316 and §495.332, CMS has approved a State’s revised definition for meaningful use, in addition to meeting paragraphs (b)(1)(i) through (ii) of this section, the eligible hospital must also demonstrate meeting the State’s revised definition using the method approved by CMS.

(iii) Exception for Medicaid eligible hospitals. If a Medicaid eligible hospital has adopted, implemented or upgraded certified EHR technology in the first payment year, the eligible hospital need not demonstrate meaningful use until the second payment year, as described in §495.20 or §§495.24 and 495.40.

(2) For FY 2012 and subsequent years—

(i) Attestation. Attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid eligible hospital, in a manner specified by the State), that during the EHR reporting period, the eligible hospital or CAH—

(A) Used certified EHR and specify the technology used;

(B) For fiscal years before 2015, satisfied the required objectives and associated measures under §495.20 for the eligible hospital or CAH’s stage of meaningful use.

(C) Must specify the EHR reporting period and provide the result of each applicable measure for all patients admitted to the inpatient or emergency department (POS 21 or 23) of the hospital during the EHR reporting period for which a selected measure is applicable.

(D) For 2014 only, if the eligible hospital or CAH uses one of the options specified in §495.20(b)(4) or (b)(3), it must attest that it is unable to fully implement 2014 Edition certified EHR technology for an EHR reporting period in 2014 due to delays in 2014 Edition certified EHR technology availability.

(E) For CYs 2015 through 2017, satisfied the required objectives and associated measures under §495.22(e) for meaningful use.

(F) For CY 2017 only, an eligible hospital or CAH may satisfy either of the following objectives and measures for meaningful use:

(1) Objectives and measures specified at §495.22(e); or

(2) Objectives and measures specified at §495.24(d).

(G) For CY 2018 and subsequent years, satisfied the required objectives and associated measures under §495.24(d) for meaningful use.

(ii) Reporting clinical quality information. Successfully report the clinical quality measures selected by CMS to CMS or the States, as applicable, in the form and manner specified by CMS or the States, as applicable.

(iii) [Reserved]

(iv) Additional requirements for Medicaid eligible hospitals. For Medicaid eligible hospitals if, in accordance with §495.316 and §495.332, CMS has approved a State’s revised definition for meaningful use, in addition to meeting paragraphs (b)(2)(i) through (iii) of this section, the eligible hospital must also demonstrate meeting the State’s revised definition using the method approved by CMS.

(v) Exception for Medicare EPs for 2012 and 2013—Participation in the Physician Quality Reporting System-Medicare EHR Incentive Pilot. To satisfy the clinical quality measure reporting requirements of meaningful use, aside from attestation, an EP participating in the Physician Quality Reporting System...
§ 495.60 Participation requirements for EPs, eligible hospitals, and CAHs.

(a) An eligible hospital, CAH or EP must submit in a manner specified by CMS the following information in the first payment year:

(1) Name of the EP, eligible hospital or CAH.

(2) National Provider Identifier (NPI).

(3) Business address, business email address, and phone number.

(4) Such other information as specified by CMS.

(b) In addition to the information submitted under paragraph (a) of this section, an eligible hospital or CAH must, in the first payment year, submit in a manner specified by CMS its CMS Certification Number (CCN) and its Taxpayer Identification Number (TIN).

(c) Subject to paragraph (f) of this section, in addition to the information submitted under paragraph (a) of this section, an EP must submit in a manner specified by CMS, the Taxpayer Identification Number (TIN) which may be the EP’s Social Security Number (SSN) to which the EP’s incentive payment should be made.

(d) In the event the information specified in paragraphs (a) through (c) of this section as previously submitted to CMS is no longer accurate, the EP, eligible hospital or CAH must provide updated information to CMS or the State on a timely basis in the manner specified by CMS or the State.

(e) An EP that qualifies as both a Medicaid EP and Medicare EP—

(1) Must notify CMS in the manner specified by CMS as to whether he or she elects to participate in the Medicare or the Medicaid EHR incentive program;

(2) After receiving at least one EHR incentive payment, may switch between the two EHR incentive programs only one time, and only for a payment year before 2015;

(3) Must, for each payment year, meet all of the applicable requirements, including applicable patient volume requirements, for the program in which he or she chooses to participate (Medicare or Medicaid);

(4) Is limited to receiving, in total, the maximum payments the EP would receive under the Medicaid EHR program, as described in subpart D of this part; and

(5) Is placed in the payment year the EP would have been in had the EP begun in and remained in the program to which he or she has switched. For example, an EP that begins receiving Medicaid incentive payments in 2011, and then switches to the Medicare program for 2012, is in his or her second payment year in 2012.

(f) Limitations on incentive payment reassignments. (1) EPs are permitted to reassign their incentive payments to their employer or to an entity with which they have a contractual arrangement allowing the employer or entity
to bill and receive payment for the EP’s covered professional services.

(2)(i) Assignments in Medicare must be consistent with Section 1842(b)(6)(A) of the Act and 42 CFR part 424 subpart F.

(ii) Medicaid EPs may also assign their incentive payments to a TIN for an entity promoting the adoption of EHR technology, consistent with subpart D of this part.

(3) Each EP may reassign the entire amount of the incentive payment to only one employer or entity.

§495.102 Incentive payments to EPs.

(a) General rules. (1) Subject to paragraph (b) of this section, in addition to the amount otherwise paid under section 1848 of the Act, there must be paid to a qualifying EP (or to an employer or entity in the cases described in section 1842(b)(6)(A) of the Act) for a payment year an amount equal to 75 percent of the estimated allowed charges for covered professional services furnished by the EP during the payment year.

                (2) For purposes of this paragraph (a) of this section, the estimated allowed charges for the qualifying EP’s covered professional services during the payment year are determined based on claims submitted for the payment year and, in the case of a qualifying EP who furnishes covered professional services in more than one practice, are determined based on claims submitted for the EP’s covered professional services across all such practices.

                (b) Limitations on amounts of incentive payments. (1) Except as otherwise provided in paragraphs (b)(2) and (c) of this section, the amount of the incentive payment under paragraph (a) of this section for each payment year is limited to the following amounts:

                       (i) For the first payment year, $15,000 (or, if the first payment year for such qualifying EP is 2011 or 2012, $18,000).

                       (ii) For the second payment year, $12,000.

                       (iii) For the third payment year, $8,000.

§495.100 Definitions.

In this subpart unless otherwise indicated—

Covered professional services means (as specified in section 1848(k)(3) of the Act) services furnished by an EP for which payment is made under, or is based on, the Medicare physician fee schedule.

Eligible hospital means a hospital subject to the prospective payment system specified in §412.1(a)(1) of this chapter, excluding those hospitals specified in §412.23 of this chapter, and excluding those hospital units specified in §412.25 of this chapter.

Eligible professional (EP) means a physician as defined in section 1861(r) of the Act, which includes, with certain limitations, all of the following types of professionals:

(1) A doctor of medicine or osteopathy.

(2) A doctor of dental surgery or medicine.

(3) A doctor of podiatric medicine.

(4) A doctor of optometry.

(5) A chiropractor.

Geographic health professional shortage area (HPSA) means a geographic area that is designated by the Secretary under section 332(a)(1)(A) of the PHS Act as of December 31 of the year prior to the payment year as having a shortage of health professionals.

Qualifying CAH means a CAH that is a meaningful EHR user for the EHR reporting period applicable to a payment year or payment adjustment year in which a cost reporting period begins.

Qualifying eligible professional (qualifying EP) means an EP who is a meaningful EHR user for the EHR reporting period applicable to a payment or payment adjustment year and who is not a hospital-based EP, as determined for that payment or payment adjustment year.

Qualifying hospital means an eligible hospital that is a meaningful EHR user for the EHR reporting period applicable to a payment or payment adjustment year.
(iv) For the fourth payment year, $4,000.
(v) For the fifth payment year, $2,000.
(vi) For any succeeding payment year for such professional, $0.

(2)(i) If the first payment year for a qualifying EP is 2014, then the payment limit for a payment year for a qualifying EP is the same as the amount specified in paragraph (b)(1) of this section for such payment year for a qualifying EP whose first payment year is 2013.

(ii) If the first payment year for a qualifying EP is after 2014, then the payment limit specified in this paragraph for such EP for such year and any subsequent year is $0.

(c) Increase in incentive payment limit for EPs who predominantly furnish services in a geographic HPSA. In the case of a qualifying EP who furnishes more than 50 percent of his or her covered professional services during the payment year in a geographic HPSA that is designated as of December 31 of the prior year, the incentive payment limit determined under paragraph (b) of this section is to be increased by 10 percent.

(d) Payment adjustment effective in CY 2015 and subsequent years for nonqualifying EPs. (1)(i) Subject to paragraphs (d)(3) and (4) of this section, beginning 2015, for covered professional services furnished by an EP who is not hospital-based, and who is not a qualifying EP by virtue of not being a meaningful EHR user (for the EHR reporting period applicable to the payment adjustment year), the payment amount for such services is equal to the product of the applicable percent specified in paragraph (d)(2) of this section and the Medicare physician fee schedule amount for such services.

(2) Applicable percent. Applicable percent is as follows:

(i) For 2015, 99 percent if the EP is not subject to the payment adjustment for an EP who is not a successful electronic prescriber under section 1848(a)(5) of the Act, or 98 percent if the EP is subject to the payment adjustment for an EP who is not a successful electronic prescriber under section 1848(a)(5) of the Act.

(ii) For 2016, 98 percent.

(iii) For 2017, 97 percent.

(iv) For 2018 and subsequent years, 97 percent, except as provided in paragraph (d)(3) of this section.

(3) Decrease in applicable percent in certain circumstances. If, beginning CY 2018 and for each subsequent year, the Secretary finds that the proportion of EPs who are meaningful EHR users is less than 75 percent, the applicable percent must be decreased by 1 percentage point for EPs from the applicable percent in the preceding year, but in no case will the applicable percent be less than 95 percent.

(4) Exceptions. The Secretary may, on a case-by-case basis, exempt an EP from the application of the payment adjustment under paragraph (d)(1) of this section if the Secretary determines that compliance with the requirement for being a meaningful EHR user would result in a significant hardship for the EP. To be considered for an exception, an EP must submit, in the manner specified by CMS, an application demonstrating that it meets one or more of the criteria in this paragraph (d)(4) unless otherwise specified in the criteria. The Secretary’s determination to grant an EP an exemption may be renewed on an annual basis, provided that in no case may an EP be granted an exemption for more than 5 years.

(i) During any 90-day period from the beginning of the year that is 2 years before the payment adjustment year to July 1 of the year preceding the payment adjustment year, or a later date specified by CMS, the EP was located in an area without sufficient Internet access to comply with the meaningful use objectives requiring internet connectivity, and faced insurmountable barriers to obtaining such internet connectivity. Applications requesting this exception must be submitted no later than July 1 of the year before the applicable payment adjustment year, or a later date specified by CMS.

(ii) The EP has been practicing for less than 2 years.

(iii)(A) During the calendar year that is 2 calendar years before the payment adjustment year, the EP that has previously demonstrated meaningful use...
faces extreme and uncontrollable circumstances that prevent it from becoming a meaningful EHR user. Applications requesting this exception must be submitted no later than July 1 of the year before the applicable payment adjustment year, or a later date specified by CMS.

(B) During the calendar year preceding the payment adjustment year, the EP that has not previously demonstrated meaningful use faces extreme and uncontrollable circumstances that prevent it from becoming a meaningful EHR user. Applications requesting this exception must be submitted by July 1 of the year before the applicable payment adjustment year, or a later date specified by CMS.

(iv) An EP may request an exception through an application submitted by July 1 of the year before the applicable payment adjustment year, or a later date specified by CMS due to difficulty in meeting meaningful use based on any one of the following during the period that begins 2 calendar years before the payment adjustment year through the application deadline:

(A) The EP practices at multiple locations and can demonstrate inability to control the availability of Certified EHR Technology at one such practice location or a combination of practice locations, and where the location or locations constitute more than 50 percent of their patient encounters.

(B) The EP can demonstrate difficulty in meeting meaningful use on the basis of lack of face-to-face or telemedicine interaction with patients and lack of need for follow up with patients.

(C) The EP has a primary specialty listed in PECOS as anesthesiology, radiology or pathology 6 months prior to the first day of the payment adjustment year that would otherwise apply. Such an EP may be deemed to qualify for this exception, subject to the 5-year limit that applies to all exceptions under this paragraph.

(5) Payment adjustments not applicable to hospital-based EPs. No payment adjustment under paragraphs (d)(1) through (3) of this section may be made in the case of a hospital-based eligible professional, as defined in §495.4.

§495.104 Incentive payments to eligible hospitals.

(a) General rule. A qualifying hospital (as defined in this subpart) must receive the special incentive payment as determined under the formulas described in paragraph (c) of this section for the period specified in paragraph (b) of this section.

(b) Transition periods. Subject to paragraph (d) of this section and the payment formula specified in paragraph (c) of this section, qualifying hospitals may receive incentive payments during transition periods which comprise the following fiscal years:

(1) Hospitals whose first payment year is FY 2011 may receive such payments for FYs 2011 through 2014.

(2) Hospitals whose first payment year is FY 2012 may receive such payments for FYs 2012 through 2015.

(3) Hospitals whose first payment year is FY 2013 may receive such payments for FYs 2013 through 2016.

(4) Hospitals whose first payment year is FY 2014 may receive such payments for FY 2014 through 2016.

(5) Hospitals whose first payment year is FY 2015 may receive such payments for FY 2015 through 2016.

(c) Payment methodology. (1) The incentive payment for each payment year is calculated as the product of the following:

(i) The initial amount determined under paragraph (c)(3) of this section.

(ii) The Medicare share fraction determined under paragraph (c)(4) of this section.

(iii) The transition factor determined under paragraph (c)(5) of this section.

(2) Interim and final payments. CMS uses data on hospital acute care inpatient discharges, Medicare Part A acute care inpatient bed-days, Medicare Part C acute care inpatient bed-days, and total acute care inpatient bed-days from the latest submitted 12-month hospital cost report as the basis for making preliminary incentive payments. Final payments are determined at the time of settling the first 12-
§ 495.106 Incentive payments to CAHs.

(a) Definitions. In this section, unless otherwise indicated—

Payment year means a Federal fiscal year beginning after FY 2010 but before FY 2016.

Qualifying CAH means a CAH that would meet the definition of a meaningful EHR user at §495.4, if it were an eligible hospital.

Reasonable costs incurred for the purchase of certified EHR technology for a qualifying CAH means the reasonable acquisition costs incurred for the purchase of depreciable assets as described in part 413 subpart G of this chapter.
such as computers and associated hardware and software, necessary to administer certified EHR technology as defined in §495.4, excluding any depreciation and interest expenses associated with the acquisition.

(b) General rule. A qualifying CAH receives an incentive payment for its reasonable costs incurred for the purchase of certified EHR technology, as defined in paragraph (a) of this section, in the manner described in paragraph (c) of this section for a cost reporting period beginning during a payment year as defined in paragraph (a) of this section.

(c) Payment methodology—(1) Payment amount. A qualifying CAH receives an incentive payment amount equal to the product of its reasonable costs incurred for the purchase of certified EHR technology and the Medicare share percentage.

(2) Calculation of reasonable costs. CMS or its Medicare contractor computes a qualifying CAH's reasonable costs incurred for the purchase of certified EHR technology, as defined in paragraph (a) of this section, as the sum of—

(i) The reasonable costs incurred for the purchase of certified EHR technology during the cost reporting period that begins in a payment year; and

(ii) Any reasonable costs incurred for the purchase of certified EHR technology in cost reporting periods beginning in years prior to the payment year which have not been fully depreciated as of the cost reporting period beginning in the payment year.

(3) Medicare share percentage. Notwithstanding the percentage applicable under §413.70(a)(1) of this chapter, the Medicare share percentage equals the lesser of—

(i) 100 percent; or

(ii) The sum of the Medicare share fraction for the CAH as calculated under §495.104(c)(4) of this subpart and 20 percentage points.

(d) Incentive payments made to CAHs. (1) The amount of the incentive payment made to a qualifying CAH under this section represents the expensing and payment of the reasonable costs computed in paragraph (c) of this section in a single payment year and, as specified in §413.70(a)(5) of this chapter, such payment is made in lieu of payment that would have been made under §413.70(a)(1) of this chapter for the reasonable costs of the purchase of certified EHR technology including depreciation and interest expenses associated with the acquisition.

(2) The amount of the incentive payment made to a qualifying CAH under this section is paid through a prompt interim payment for the applicable payment year after—

(i) The CAH submits the necessary documentation, as specified by CMS or its Medicare contractors, to support the computation of the incentive payment amount under this section; and

(ii) CMS or its Medicare contractor reviews such documentation and determines the interim amount of the incentive payment.

(3) The interim incentive payment made under this paragraph is subject to a reconciliation process as specified by CMS and the final incentive payment as determined by CMS or its Medicare contractor is considered payment in full for the reasonable costs incurred for the purchase of certified EHR technology in a single payment year.

(4) In no case may an incentive payment be made with respect to a cost reporting period beginning during a payment year before FY 2011 or after FY 2015 and in no case may a CAH receive an incentive payment under this section with respect to more than 4 consecutive payment years.

(e) Reductions in payment to CAHs. For cost reporting periods beginning in FY 2015, if a CAH is not a qualifying CAH for a payment adjustment year, then the payment for inpatient services furnished by a CAH under §413.70(a) of this chapter is adjusted by the applicable percentage described in §413.70(a)(6) of this chapter unless otherwise exempt from such adjustment.

(f) Administrative or judicial review. There is no administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, of the—

(1) Methodology and standards for determining the amount of payment, the reasonable cost, and adjustments described in this section including selection of periods for determining, and making estimates or using proxies of,
§ 495.108 Posting of required information.

(a) CMS posts, on its Internet Web site, the following information regarding EPs, eligible hospitals, and CAHs receiving an incentive payment under subparts B and C of this part:

(1) Name.
(2) Business address.
(3) Business phone number.
(4) Such other information as specified by CMS.

(b) CMS posts, on its Internet Web site, the following information for qualifying MA organizations that receive an incentive payment under subpart C of this part—

(1) The information specified in paragraph (a) of this section for each of the qualifying MA organization’s MA plan information; and
(2) The information specified in paragraph (a) of this section for each of the qualifying MA organization’s MA EPs and MA-affiliated eligible hospitals.

§ 495.110 Preclusion on administrative and judicial review.

There is no administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, of the following:

(a) For EPs—

(1) The methodology and standards for determining EP incentive payment amounts;
(2) The methodology and standards for determining the payment adjust-

ments that apply to EPs beginning with 2015;

(3) The methodology and standards for determining whether an EP is a meaningful EHR user, including—

(i) The selection of clinical quality measures; and
(ii) The means of demonstrating meaningful EHR use.

(4) The methodology and standards for determining the hardship exception to the payment adjustments;

(5) The methodology and standards for determining whether an EP is hospital-based; and

(6) The specification of the EHR reporting period, as well as whether payment will be made only once, in a single consolidated payment, or in periodic installments.

(b) For eligible hospitals—

(1) The methodology and standards for determining the incentive payment amounts made to eligible hospitals, including—

(i) The estimates or proxies for determining discharges, inpatient-bed-days, hospital charges, charity charges, and Medicare share; and
(ii) The period used to determine such estimate or proxy;

(2) The methodology and standards for determining the payment adjustments that apply to eligible hospitals beginning with FY 2015;

(3) The methodology and standards for determining whether an eligible hospital is a meaningful EHR user, including—

(i) The selection of clinical quality measures; and
(ii) The means of demonstrating meaningful EHR use.

(4) The methodology and standards for determining the hardship exception to the payment adjustments; and

(5) The specification of the EHR reporting period, as well as whether payment will be made only once, in a single consolidated payment, or in periodic installments.

Subpart C—Requirements Specific to Medicare Advantage (MA) Organizations

§ 495.200 Definitions.

As used in this subpart:
First payment year means with respect to—

(1) Covered professional services furnished by a qualifying MA EP, the first calendar year for which an incentive payment is made for such services under this subsection to a qualifying MA organization.

(2) Qualifying MA-affiliated eligible hospitals, the first fiscal year for which an incentive payment is made for qualifying MA-affiliated eligible hospitals under this section to a qualifying MA organization.

Inpatient-bed-days is defined in the same manner and is used in the same manner as that term is defined and used for purposes of implementing section 4201(a) of the American Recovery and Reinvestment Act of 2009 with respect to the Medicare FFS hospital EHR incentive program in §495.104 of this part.

MA payment adjustment year means—

(1) For qualifying MA organizations that receive an MA EHR incentive payment for at least 1 payment year, calendar years beginning with CY 2015.

(2) For MA-affiliated eligible hospitals, the applicable EHR reporting period for purposes of determining whether the MA organization is subject to a payment adjustment is the federal fiscal year ending in the MA payment adjustment year.

(3) For MA EPs, the applicable EHR reporting period for purposes of determining whether the MA organization is subject to a payment adjustment is the calendar year concurrent with the payment adjustment year.

Patient care services means health care services for which payment would be made under, or for which payment would be based on, the fee schedule established under Medicare Part B if they were furnished by an EP to a Medicare beneficiary.

Payment year means—

(1) For a qualifying MA EP, a calendar year (CY) beginning with CY 2011 and ending with CY 2016; and

(2) For an eligible hospital, a Federal fiscal year (FY) beginning with FY 2011 and ending with FY 2016.

Potentially qualifying MA EPs and potentially qualifying MA-affiliated eligible hospitals are defined for purposes of this subpart in §495.202(a)(4).

Qualifying MA-affiliated eligible hospital means an eligible hospital under section 1886(n)(6) of the Act that is under common corporate governance with a qualifying MA organization, for which at least two thirds of the Medicare hospital discharges (or bed-days) are of (or for) Medicare individuals enrolled under MA plans, and that is a meaningful user of certified EHR technology as defined by §495.4 of this part. In the case of a hospital for which at least one-third of whose Medicare bed-days for the year are covered under Part A rather than Part C, payment for that payment year must only be made under section 1886(n) of the Act and not under this section.

Qualifying MA EP means all of the following:

(1) A physician (as described in section 1861(r) of the Act), including a doctor of medicine or osteopathy who is either of the following:

(ii) Employed by, or is a partner of, an entity that through a contract with a qualifying MA organization furnishes at least 80 percent of the entity’s Medicare patient care services to enrollees of such organization.

(2) Furnishes at least 80 percent of his or her professional services covered under Title XVIII to enrollees of the qualifying MA organization during the EHR reporting period.

(3) Is a meaningful user of certified EHR technology in accordance with §495.4 of this part.

(5) Is not a “hospital-based EP” (as defined in §495.4 of this part) and in determining whether 90 percent or more of his or her covered professional services were furnished in a hospital setting, only covered professional services furnished to MA plan enrollees of the qualifying MA organization, in lieu of FFS patients, will be considered.

Qualifying MA organization means a MA organization that is organized as a health maintenance organization (HMO) as defined in section 2791(b)(3) of the Public Health Service (PHS) Act which includes a Federally qualified...

(a) Identification of qualifying MA organizations. (1) Beginning with bids due in June 2011 (for plan year 2012), MA organizations seeking reimbursement for qualifying MA EPs and qualifying MA–affiliated eligible hospitals under the MA EHR incentive program are required to identify themselves to CMS in a form and manner specified by CMS, as part of submissions of initial bids under section 1854(a)(1)(A) of the Act. MA organizations seeking reimbursement for MA–affiliated eligible hospitals have a common parent corporation, that one is a subsidiary of the other, or that the organization and the hospital have a common board of directors.

(2) Qualifying MA organizations offering MA HMO plans, absent evidence to the contrary, are deemed to meet the definition of HMO in 42 U.S.C. 300gg–91(b)(3)—section 2791(b)(3) of the PHS Act.

(3) Qualifying MA organizations offering MA plan types other than HMOs, must attest to the fact that they meet the definition of HMO in 42 U.S.C. 300gg–91(b)(3)—section 2791(b)(3) of the PHS Act.

(4) Beginning with bids due in June 2014 (for plan year 2015), all MA organizations with potentially qualifying MA EPs or potentially qualifying MA–affiliated eligible hospitals under the MA EHR incentive program must identify themselves to CMS in a form and manner specified by CMS, as part of submissions of initial bids under section 1854(a)(1)(A) of the Act. "Potentially qualifying MA EPs" and "potentially qualifying MA–affiliated eligible hospitals" are those EPs and hospitals that meet the respective definitions of "qualifying MA EP" and "qualifying MA–affiliated eligible hospital" in §495.200 but who (or which) are not meaningful users of certified EHR technology.

(b) Identification of qualifying MA EPs and qualifying MA–affiliated eligible hospitals. (1) A qualifying MA organization, as part of its initial bid starting with plan year 2012, must make a preliminary identification of MA EPs and MA–affiliated eligible hospitals that the MA organization believes will be qualifying MA EPs and MA–affiliated eligible hospitals for which the organization is seeking incentive payments for the current plan year.

(2) A qualifying MA organization must provide CMS with the following for each MA EP or eligible hospital when reporting under either paragraph (b)(1) or (4) of this section:

(i) The MA EP’s or MA–affiliated eligible hospital’s name.

(ii) The address of the MA EP’s practice or MA–affiliated eligible hospital’s location.

(iii) NPI or CCN.

(iv) An attestation by MA organization specifying that the MA EP or MA–affiliated eligible hospital meets the eligibility criteria.

(3) When reporting under either paragraph (b)(1) or (4) of this section for purposes of receiving an incentive payment, a qualifying MA organization must also indicate whether more than 50 percent of the covered Medicare professional services being furnished by a qualifying MA EP to MA plan enrollees of the MA organization are being furnished in a designated geographic area.
Final identification of qualifying and potentially qualifying, as applicable, MA EPs and MA-affiliated eligible hospitals must be made within 2 months of the close of the payment year or the EHR reporting period that applies to the payment adjustment year as defined in §495.200.

(5) Beginning plan year 2015 and for subsequent plan years, all qualifying MA organizations, as part of their initial bids in June for the following plan year must—

(i) Identify all MA EPs and MA-affiliated eligible hospitals of the MA organization that the MA organization believes will be either qualifying or potentially qualifying;

(ii) Include information specified in paragraph (b)(2)(i) through (iii) of this section for each professional or hospital; and

(iii) Include an attestation that each professional and hospital either meets or does not meet the EHR incentive payment eligibility criteria.

§ 495.204 Incentive payments to qualifying MA organizations for qualifying MA—EPs and qualifying MA-affiliated eligible hospitals.

(a) General rule. A qualifying MA organization receives an incentive payment for its qualifying MA—EPs and its qualifying MA—eligible hospitals. The incentive payment amount paid to a qualifying MA organization for a—

(1) Qualifying MA—EP is the amount determined under paragraph (b) of this section; and

(2) Qualifying MA—eligible hospital is the amount determined under paragraph (c) of this section.

(b) Amount payable to qualifying MA organization for qualifying MA EPs. (1) CMS substitutes an amount determined to be equivalent to the amount computed under §495.102 of this part.

(2) The qualifying MA organization must report to CMS within 2 months of the close of the calendar year, the aggregate annual amount of revenue attributable to providing services that would otherwise be covered as professional services under Part B received by each qualifying MA EP for enrollees in MA plans of the MA organization in the payment year.

(3) CMS calculates the incentive amount for the MA organization for each qualifying MA EP as an amount equal to 75 percent of the reported annual revenue specified in paragraph (b)(2) of this section, up to the maximum amounts specified under section 1848(o)(1)(B) of the Act.

(4) CMS requires the qualifying MA organization to develop a methodological proposal for estimating the portion of each qualifying MA EP’s salary or revenue attributable to providing services that would otherwise be covered as professional services under Part B to MA plan enrollees of the MA organization in the payment year. The methodological proposal—

(i) Must be approved by CMS; and

(ii) May include an additional amount related to overhead, where appropriate, estimated to account for the MA-enrollee related Part B practice costs of the qualifying MA EP.

(iii) Methodological proposals must be submitted to CMS by June of the payment year and must be auditable by an independent third-party. CMS will review and approve or disapprove such proposals in a timely manner.

(5) For qualifying MA EPs who are not salaried, qualifying MA organizations may obtain attestations from such qualifying MA EPs (or from entities that the MA EPs are employed by or with which they have a partnership interest) as to the amount of compensation received by such EPs for MA plan enrollees of the MA organization. The organizations may submit to CMS compensation information for each such MA EP based on such attestations.

(6) For qualifying MA EPs who are not salaried, qualified MA organizations may have qualifying MA EPs (or from entities that the MA EPs are employed by or with which they have a partnership interest) send MA organization compensation information directly to CMS. CMS will use the information provided in this subparagraph or paragraph (b)(5) of this section for no other purpose than to compute the amount of EHR incentive payment due the MA organization.
(c) Amount payable to qualifying MA organization for qualifying MA-affiliated eligible hospitals. (1)(i) CMS substitutes an amount determined to be equivalent to the amount computed under §495.104, to the extent data are not available to compute payments for qualifying MA-affiliated eligible hospitals under the Medicare FFS EHR hospital incentive program.

(ii) CMS uses the same methodology and defines “inpatient-bed-days” and other terms as used under the Medicare FFS EHR hospital incentive program in §495.104 of this part in computing amounts due qualifying MA organizations for MA-affiliated eligible hospitals.

(2) To the extent data are available, qualifying MA organizations must receive hospital incentive payments through their affiliated hospitals under the Medicare FFS EHR hospital incentive program, rather than through the MA EHR hospital incentive program.

(d) Payment to qualifying MA organizations. CMS makes payment to qualifying MA organizations for qualifying MA EPs only under the MA EHR incentive program and not under the Medicare FFS EHR incentive program to the extent an EP has earned less than the maximum incentive payment for the same period under the Medicare FFS EHR incentive program.

(e) Potential increase in incentive payment for furnishing services in a geographic HPSA. In the case of a qualifying MA EP who furnishes more than 50 percent of his or her covered professional services to MA plan enrollees of the qualifying MA organization during a payment year in a geographic HPSA, the maximum amounts referred to in paragraph (b)(3) of this section are increased by 10 percent.

(f) Payment review under MA. To ensure the accuracy of the incentive payments, CMS conducts selected compliance reviews of qualifying MA organizations to ensure that EPs and eligible hospitals for which such qualifying organizations received incentive payments were meaningful EHR users in accordance with §422.504 of this chapter.

(1) The reviews include validation of the status of the organization as a qualifying MA organization, verification of meaningful use and review of data used to calculate incentive payments.

(2) MA organizations are required to maintain evidence of their qualification to receive incentive payments and the data necessary to accurately calculate incentive payments.

(3) Documents and records must be maintained for 6 years from the date such payments are made with respect to a given payment year.

(4) Payments that result from incorrect or fraudulent attestations, cost data, or any other submission required to establish eligibility or to qualify for such payment, will be recouped by CMS from the MA organization.

(5) If an MA EP, or entity that employs an MA EP, or in which an MA EP has a partnership interest, MA-affiliated eligible hospital, or other party contracting with the MA organization, fails to comply with an audit request to produce applicable documents or data, CMS recoups all or a portion of the incentive payment, based on the lack of applicable documents or data.

(g) Coordination of payment with FFS or Medicaid EHR incentive programs. (1) If, after payment is made to an MA organization for an MA EP, it is determined that the MA EP is eligible for the full incentive payment under the Medicare FFS EHR Incentive Program or has received a payment under the Medicaid EHR Incentive Program, CMS recoups amounts applicable to the given MA EP from the MA organization’s monthly MA payment, or otherwise recoups the applicable amounts.

(2) If, after payment is made to an MA organization for an MA-affiliated eligible hospital, it is determined that the hospital is ineligible for the incentive payment under the MA EHR Incentive Program, or has received a payment under the Medicare FFS EHR Incentive Program, or if it is determined that all or part of the payment should not have been made on behalf of the MA-affiliated eligible hospital, CMS recoups amounts applicable to the given MA-affiliated eligible hospital from the MA organization’s monthly MA payment, or otherwise recoups the applicable amounts.

§ 495.206 Timeframe for payment to qualifying MA organizations.

(a) CMS makes payment to qualifying MA organizations for qualifying MA EPs under the MA EHR incentive program after computing incentive payments due under the Medicare FFS EHR incentive program according to § 495.102.

(b) Payments to qualifying MA organizations for qualifying MA-affiliated eligible hospitals under common corporate governance are made under the Medicare FFS EHR incentive program, following the timeline specified in § 495.104 of this part. To the extent sufficient data do not exist to pay qualifying MA-affiliated eligible hospitals under common corporate governance under the Medicare FFS EHR incentive program, payment is made under the MA EHR incentive program, following the same timeline in § 495.104 of this part.

§ 495.208 Avoiding duplicate payment.

(a) CMS requires a qualifying MA organization that registers MA EPs for the purpose of participating in the MA EHR Incentive Program to notify each of the MA EPs for which it is claiming an incentive payment that the MA organization intends to claim, or has claimed, the MA EP for the current plan year under the MA EHR Incentive Program.

(b) The notice must make clear that the MA EP may still directly receive an EHR incentive payment if the MA EP is entitled to a full incentive payment under the FFS portion of the EHR Incentive Program, or if the MA EP registered to participate under the Medicaid portion of the EHR Incentive Program and is entitled to payment under that program—in both of which cases no payment would be made for the EP under the MA EHR incentive program.

(c) An attestation by the qualifying MA organization that the qualifying MA organization provided notice to its MA EPs in accordance with this section must be required at the time that meaningful use attestations are due with respect to MA EPs for the payment year.

(d) Unless a qualifying MA EP is entitled to a maximum payment for a year under the Medicare FFS EHR incentive program, payment for such an individual is only made under the MA EHR incentive program to a qualifying MA organization.

(e) Payment to qualifying MA organizations for a qualifying MA-affiliated eligible hospital under common governance only occurs under the MA EHR incentive program to the extent that sufficient data does not exist to pay such hospital under the Medicare FFS hospital incentive program under § 495.104 of this part. In no event are EHR incentive payments made for a hospital for a payment year under this section to the extent they have been made for the same hospital for the same payment year under § 495.104 of this part.

(f) Each qualifying MA organization must ensure that all potentially qualifying MA EPs are enumerated through the NPI system and that other identifying information required under § 495.202(b) is provided to CMS.


§ 495.210 Meaningful EHR user attestation.

(a) Qualifying MA organizations are required to attest, in a form and manner specified by CMS, that each qualifying MA EP and qualifying MA-affiliated eligible hospitals is a meaningful EHR user.

(b) Qualifying MA organizations are required to attest within 2 months after close of the FY whether each qualifying MA-affiliated eligible hospital is a meaningful EHR user.

(c) Qualifying MA organizations are required to attest within 2 months after close of the FY whether each qualifying MA EP is a meaningful EHR user.


§ 495.211 Payment adjustments effective for 2015 and subsequent MA payment years with respect to MA EPs and MA-affiliated eligible hospitals.

(a) In general. Beginning for MA payment adjustment year 2015, payment adjustments set forth in this section are made to prospective payments.
§ 495.211

(issued under section 1853(a)(1)(A) of the Act) of qualifying MA organizations that previously received incentive payments under the MA EHR Incentive Program, if all or a portion of the MA–EPs and MA-affiliated eligible hospitals that would meet the definition of qualifying MA–EPs or qualifying MA-affiliated eligible hospitals (but for their demonstration of meaningful use) are not meaningful EHR users.

(b) Adjustment based on payment adjustment year. The payment adjustment is calculated based on the payment adjustment year.

(c) Separate application of adjustments for MA–EPs and MA-affiliated eligible hospitals. The payment adjustments identified in paragraphs (d) and (e) of this section are applied separately. Paragraph (d) of this section applies only to qualifying MA organizations that received payment for any MA payment year for qualifying MA–EPs under § 495.204. Paragraph (e) of this section applies only to qualifying MA organizations that received payment for any MA payment year for qualifying MA-affiliated eligible hospitals under § 495.204.

(d) Payment adjustments effective for 2015 and subsequent years with respect to MA–EPs. (1) For payment adjustment year 2015, and subsequent payment adjustment years, if a qualifying MA EP is not a meaningful EHR user during the payment adjustment year, CMS—

(i) Determines a payment adjustment based on data from the payment adjustment year; and

(ii) Collects the payment adjustment owed by adjusting a subsequent year’s prospective payment or payments (issued under section 1853(a)(1)(A) of the Act), or by otherwise collecting the payment adjustment, if, in the year of collection, the MA organization does not have an MA contract with CMS.

(2) Beginning for payment adjustment year 2015, a qualifying MA organization that previously received incentive payments must, for each payment adjustment year, report to CMS the following:

([the total number of potentially qualifying MA–EPs]/([the total number of potentially qualifying MA–EPs] +

(the total number of qualifying MA EPs))].

(3) The monthly prospective payment amount paid under section 1853(a)(1)(A) of the Act for the payment adjustment year is adjusted by the product of—

(i) The percent calculated in accordance with paragraph (d)(2) of this section;

(ii) The Medicare Physician Expenditure Proportion percent, which is CMS’s estimate of proportion of expenditures under Parts A and B that are not attributable to Part C that are attributable to expenditures for physicians’ services, adjusted for the proportion of expenditures that are provided by EPs that are neither qualifying nor potentially qualifying MA EPs with respect to a qualifying MA organization; and

(iii) The applicable percent identified in paragraph (d)(4) of this section.

(4) Applicable percent. The applicable percent is as follows:

(i) For 2015, 1 percent;

(ii) For 2016, 2 percent;

(iii) For 2017, 3 percent.

(iv) For 2018, 3 percent, except, in the case described in paragraph (d)(4)(vi) of this section, 4 percent.

(v) For 2019 and each subsequent year, 3 percent, except, in the case described in paragraph (d)(4)(vi) of this section, the percent from the prior year plus 1 percent. In no case will the applicable percent be higher than 5 percent.

(vi) Beginning with payment adjustment year 2018, if the percentage in paragraph (d)(2) of this section is more than 25 percent, the applicable percent is increased in accordance with paragraphs (d)(4)(iv) and (v) of this section.

(e) Payment adjustments effective for 2015 and subsequent years with respect to MA-affiliated eligible hospitals. (1)(i) The payment adjustment set forth in this paragraph (e) applies if a qualifying MA organization that previously received an incentive payment (or a potentially qualifying MA-affiliated eligible hospital on behalf of its qualifying MA organization) attests that a qualifying MA-affiliated eligible hospital is not a meaningful EHR user for a payment adjustment year.

(ii) The payment adjustment is calculated by multiplying the qualifying
MA organization’s monthly prospective payment for the payment adjustment year under section 1853(a)(1)(A) of the Act by the percent set forth in paragraph (e)(2) of this section.

(2) The percent set forth in this paragraph (e) is the product of—

(i) The percentage point reduction to the applicable percentage increase in the market basket index for the relevant Federal fiscal year as a result of §412.64(d)(3) of this chapter;

(ii) The Medicare Hospital Expenditure Proportion percent specified in paragraph (e)(3) of this section; and

(iii) The percent of qualifying and potentially qualifying MA-affiliated eligible hospitals that are not meaningful EHR users. Qualifying MA organizations are required to report to CMS [the number of potentially qualifying MA-affiliated eligible hospitals] / [(the total number of potentially qualifying MA-affiliated eligible hospitals) + (the total number of qualifying MA-affiliated eligible hospitals)].

(3) The Medicare Hospital Expenditure Proportion for a year is the Secretary’s estimate of expenditures under Parts A and B that are not attributable to Part C, that are attributable to expenditures for inpatient hospital services, adjusted for the proportion of expenditures that are provided by hospitals that are neither qualifying nor potentially qualifying MA-affiliated eligible hospitals with respect to a qualifying MA organization.

[77 FR 54159, Sept. 4, 2012]

§ 495.212 Limitation on review.

(a) There is no administrative or judicial review under section 1869 or 1878 of the Act, or otherwise, of the methodology and standards for determining payment amounts and payment adjustments under the MA EHR EP incentive program. This includes provisions related to duplication of payment avoidance. It also includes the methodology and standards developed for determining qualifying MA-affiliated eligible hospitals and the methodology and standards for determining a meaningful EHR user, including the means of demonstrating meaningful use and the selection of measures.

(b) There is no administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, of the methodology and standards for determining payment amounts and payment adjustments under the MA EHR hospital incentive program. This includes provisions related to duplication of payment avoidance. It also includes the methodology and standards developed for determining qualifying MA-affiliated eligible hospitals and the methodology and standards for determining a meaningful EHR user, including the means of demonstrating meaningful use and the selection of measures.

Subpart D—Requirements Specific to the Medicaid Program

§ 495.300 Basis and purpose.

This subpart implements section 4201 of the American Reinvestment and Recovery Act of 2009 and sections 1903(a)(3)(F) and 1903(t) of the Act, which authorize States, at their option, to provide for incentive payments to Medicaid providers for adopting, implementing, or upgrading certified EHR technology or for meaningful use of such technology. This subpart also provides enhanced Federal financial participation (FFP) to States to administer these incentive payments.

§ 495.302 Definitions.

As used in this subpart—

Acceptance documents mean written evidence of satisfactory completion of an approved phase of work or contract and acceptance thereof by the State agency.

Acquisition means to acquire health information technology (HIT) equipment or services for the purpose of implementation and administration under this part from commercial sources or from State or local government resources.

Acute care hospital means a health care facility—

(1) Where the average length of patient stay is 25 days or fewer; and
(2) With a CMS certification number (previously known as the Medicare provider number) that has the last four digits in the series 0001–0879 or 1300–1399

Adopt, implement or upgrade means—

(1) Acquire, purchase, or secure access to certified EHR technology capable of meeting meaningful use requirements;

(2) Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements;

or

(3) Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.

(4) For payment year 2014, the references to “certified EHR technology” in paragraphs (1) through (3) of this definition are deemed to be references to paragraph (2) of the definition of “Certified EHR Technology” under 45 CFR 170.102 (that is, the definition of “Certified EHR Technology” for FY and CY 2015 and subsequent years).

Children’s hospital means a separately certified children’s hospital, either freestanding or hospital-within-hospital that—

(1) Has a CMS certification number (CCN), (previously known as the Medicare provider number), that has the last 4 digits in the series 3300–3399; or

(2) Does not have a CCN but has been provided an alternative number by CMS for purposes of enrollment in the Medicaid EHR Incentive Program as a children’s hospital and;

or

(3) Predominantly treats individuals under 21 years of age.

Entities promoting the adoption of certified electronic health record technology means the State-designated entities that are promoting the adoption of certified EHR technology by enabling oversight of the business, operational and legal issues involved in the adoption and implementation of certified EHR technology or by enabling the exchange and use of electronic clinical and administrative data between participating providers, in a secure manner, including maintaining the physical and organizational relationship integral to the adoption of certified EHR technology by eligible providers.

Health information technology planning advance planning document (HIT PAPD) means a plan of action that requests FFP and approval to accomplish the planning necessary for a State agency to determine the need for and plan the acquisition of HIT equipment or services or both and to acquire information necessary to prepare a HIT implementation advanced planning document or request for proposal to implement the State Medicaid HIT plan.

HIT implementation advance planning document (HIT IAPD) means a plan of action that requests FFP and approval to acquire and implement the proposed State Medicaid HIT plan services or equipment or both.

Medicaid information technology architecture (MITA) is both an initiative and a framework. It is a national framework to support improved systems development and health care management for the Medicaid enterprise. It is an initiative to establish national guidelines for technologies and processes that enable improved program administration for the Medicaid enterprise. The MITA initiative includes an architecture framework, models, processes, and planning guidelines for enabling State Medicaid enterprises to meet common objectives with the framework while supporting unique local needs.

Medicaid management information system (MMIS) means a mechanized claims processing and information retrieval system—referred to as Medicaid Management Information Systems (MMIS)—that meets specified requirements and that the Department has found (among other things) is compatible with the claims processing and information retrieval systems used in the administration of the Medicare program. The objectives of the MMIS are to include claims processing and retrieval of utilization and management information necessary for program administration and audit and must coordinate with other mechanized systems and subsystems that perform other functions, such as eligibility determination.
Centers for Medicare & Medicaid Services, HHS § 495.304

Needy individuals mean individuals that meet one of following:
(1) Received medical assistance from Medicaid or the Children’s Health Insurance Program, (or a Medicaid or CHIP demonstration project approved under section 1115 of the Act).
(2) Were furnished uncompensated care by the provider.
(3) Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individuals’ ability to pay.

Patient volume means the minimum participation threshold (as described at § 495.304(c) through (e)) that is estimated through a numerator and denominator, consistent with the SMHP, and that meets the requirements of § 495.306.

Practices predominantly means an EP for whom the clinical location for over 50 percent of his or her total patient encounters over a period of 6 months (within the most recent calendar year or, as an optional State alternative beginning for payment year 2013, within the 12-month period preceding attestation)occurs at a federally qualified health center or rural health clinic.

Service oriented architecture or service component based architecture means organizing and developing information technology capabilities as collaborating services that interact with each other based on open standards.

State Medicaid health information technology plan (SMHP) means a document that describes the State’s current and future HIT activities.

State self-assessment means a process that a State uses to review its strategic goals and objectives, measure its current business processes and capabilities against the (MITA) business capabilities and ultimately develops target capabilities to transform its Medicaid enterprise to be consistent with the MITA principles.

§ 495.304 Medicaid provider scope and eligibility.

(a) General rule. The following Medicaid providers are eligible to participate in the HIT incentives program:
(1) Medicaid EPs.
(2) Acute care hospitals.
(3) Children’s hospitals.
(b) Medicaid EP. The Medicaid professional eligible for an EHR incentive payment is limited to the following when consistent with the scope of practice regulations, as applicable for each professional (§§ 440.50, 440.60, 440.100; §§ 440.165, and 440.166):
(1) A physician.
(2) A dentist.
(3) A certified nurse-midwife.
(4) A nurse practitioner.
(c) Additional requirements for the Medicaid EP. To qualify for an EHR incentive payment, a Medicaid EP must, for each year for which the EP seeks an EHR incentive payment, not be hospital-based as defined at § 495.4 of this subpart, and meet one of the following criteria:
(1) Have a minimum 30 percent patient volume attributable to individuals enrolled in a Medicaid program.
(2) Have a minimum 20 percent patient volume attributable to individuals enrolled in a Medicaid program, and be a pediatrician.
(3) Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals, as defined at § 495.302.
(d) Exception. The hospital-based exclusion in paragraph (c) of this section does not apply to the Medicaid-EP qualifying based on practicing predominantly at a FQHC or RHC.
(e) Additional requirement for the eligible hospital. To be eligible for an EHR incentive payment for each year for which the eligible hospital seeks an EHR incentive payment, the eligible hospital must meet the following criteria:
(1) An acute care hospital must have at least a 10 percent Medicaid patient volume for each year for which the hospital seeks an EHR incentive payment.
(2) A children’s hospital is exempt from meeting a patient volume threshold.
(f) Further patient volume requirements for the Medicaid EP. For payment year...
§ 495.306 Establishing patient volume.

(a) General rule. A Medicaid provider must annually meet patient volume requirements of § 495.304, as these requirements are established through the State’s SMHP in accordance with the remainder of this section.

(b) State option(s) through SMHP. (1) A State must submit through the SMHP the option or options it has selected for measuring patient volume.

(2)(i) A State must select the method described in either paragraph (c) or paragraph (d) of this section (or both methods).

(ii) Under paragraphs (c)(1)(i), (c)(2)(i), (c)(3)(i), (d)(1)(i), and (d)(2)(i) of this section, States may choose whether to allow eligible providers to calculate total Medicaid or total needy individual patient encounters in any representative, continuous 90-day period in the calendar year preceding the EP’s payment year, or in the 12 months before the EP’s attestation; by

(2) The total encounters in the same 90-day period.

(3) Needy individual patient volume. To calculate needy individual patient volume, an EP must divide—

(i) The total needy individual patient encounters in any representative, continuous 90-day period in the calendar year preceding the EP’s payment year, or in the 12 months before the EP’s attestation; by

(ii) The total patient encounters in the same 90-day period.

(d) Methodology, patient panel—(1) EPs. To calculate Medicaid patient volume, an EP must divide:

(i) The total Medicaid encounters in any representative, continuous 90-day period in the fiscal year preceding the hospitals’ payment year or in the 12 months before the hospital’s attestation; by

(ii) The total encounters in the same 90-day period.

(2) Needy individual patient volume. To calculate needy individual patient volume, an EP must divide—

(i) The total Needy Individual patients assigned to the panel in any representative, continuous 90-day period in the calendar year preceding the EP’s payment year, or in the 12 months before the EP’s attestation when at least one Medicaid encounter took place with the individual in the 24 months before the beginning of the 90-day period; plus

(B) Unduplicated Medicaid encounters in the same 90-day period; by

(ii)(A) The total patients assigned to the provider in that same 90-day period with at least one encounter taking place with the patient during the 24 months before the beginning of the 90-day period; plus

(B) All unduplicated patient encounters in the same 90-day period.

(2) Needy individual patient volume. To calculate needy individual patient volume an EP must divide—

(i) The total Needy Individual patients assigned to the EP’s panel in any representative, continuous 90-day period in the calendar year preceding the EP’s payment year, or in the 12 months before the EP’s attestation when at least one Needy Individual encounter took place with the individual in the 24 months before the beginning of the same 90-day period; plus
(B) Unduplicated Needy Individual encounters in the same 90-day period, by
(ii)(A) The total patients assigned to the provider in that same 90-day period with at least one encounter taking place with the patient during the 24 months before the beginning of the 90-day period, plus
(B) All unduplicated patient encounters in the same 90-day period.
(e) For purposes of this section, the following rules apply:
(i) A Medicaid encounter means services rendered to an individual on any one day where:
(A) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service.
(B) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual’s premiums, co-payments, and cost-sharing.
(ii) The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

(2) For purposes of calculating hospital patient volume, both of the following definitions in paragraphs (e)(2)(i) and (e)(2)(ii) of this section may apply:
(i) A Medicaid encounter means services rendered to an individual per inpatient discharge when any of the following occur:
(A) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service.
(B) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual’s premiums, co-payments, and cost-sharing.
(C) The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

(3) For purposes of calculating needy individual patient volume, a needy patient encounter means services rendered to an individual on any 1 day if any of the following occur:
(i) Medicaid or CHIP (or a Medicaid or CHIP demonstration project approved under section 1115 of the Act) paid for part or all of the service.
(ii) Medicaid or CHIP (or a Medicaid or CHIP demonstration project approved under section 1115 of the Act) paid all or part of the individual’s premiums, co-payments, or cost-sharing.

(iii) The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

(iv) The services were furnished at no cost; and calculated consistent with §495.310(h).

(v) The services were paid for at a reduced cost based on a sliding scale determined by the individual’s ability to pay.

(5) Exception. A children’s hospital is not required to meet Medicaid patient volume requirements.

(g) Establishing an alternative methodology. A State may submit to CMS for review and approval through the SMHP an alternative from the options included in paragraphs (c) and (d) of this section, so long as it meets the following requirements:
(1) It is submitted consistent with all rules governing the SMHP at §495.332.
(2) Has an auditable data source.
(3) Has received input from the relevant stakeholder group.
(4) It does not result, in the aggregate, in fewer providers becoming eligible than the methodologies in either paragraphs (c) and (d) of this section.

(h) Group practices. Clinics or group practices will be permitted to calculate
patient volume at the group practice/clinic level, but only in accordance with all of the following limitations:

(1) The clinic or group practice’s patient volume is appropriate as a patient volume methodology calculation for the EP.

(2) There is an auditable data source to support the clinic’s or group practice’s patient volume determination.

(3) All EPs in the group practice or clinic must use the same methodology for the payment year.

(4) The clinic or group practice uses the entire practice or clinic’s patient volume and does not limit patient volume in any way.

(5) If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP’s outside encounters.

§ 495.308 Net average allowable costs as the basis for determining the incentive payment.

(a) The first year of payment. (1) The incentive is intended to offset the costs associated with the initial adoption, implementation or upgrade of certified electronic health records technology.

(2) The maximum net average allowable costs for the first year are $25,000.

(b) Subsequent payment years. (1) The incentive is intended to offset maintenance and operation of certified EHR technology.

(2) The maximum net average allowable costs for each subsequent year are $10,000.

§ 495.310 Medicaid provider incentive payments.

(a) Rules for Medicaid EPs. The Medicaid EP’s incentive payments are subject to all of the following limitations:

(1) First payment year. (i) For the first payment year, payment under this subpart may not exceed 85 percent of the maximum threshold of $25,000, which equals $21,250.

(ii) [Reserved]

(iii) An EP may not begin receiving payments any later than CY 2016.

(2) Subsequent annual payment years.

(1) For subsequent payment years, payment may not exceed 85 percent of the maximum threshold of $10,000, which equals $8,500.

(ii) [Reserved]

(iii) Payments after the first payment year may continue for a maximum of 5 years.

(iv) Medicaid EPs may receive payments on a non-consecutive, annual basis.

(v) No payments may be made after CY 2021.

(3) Maximum incentives. In no case may a Medicaid EP participate for more than a total of 6 years, and in no case will the maximum incentive over a 6-year period exceed $63,750.

(4) Limitation. For a Medicaid EP who is a pediatrician described in paragraph (b) of this section payment is limited as follows:

(i) The maximum payment in the first payment year is further reduced by two-thirds, which equals $14,167.

(ii) The maximum payment in subsequent payment years is further reduced by two-thirds, which equals $5,667.

(iii) In no case will the maximum incentive payment to a pediatrician under this limitation exceed $42,500 over a 6-year period.

(b) Optional exception for pediatricians. A pediatrician described in this paragraph is a Medicaid EP who does not meet the 30 percent patient volume requirements described in §§ 495.304 and 495.306, but who meets the 20 percent patient volume requirements described in such sections.

(c) Limitation to only one EHR incentive program. An EP may only receive an incentive payment from either Medicare or Medicaid in a payment year, but not both.

(d) Exception for EPs to switch programs. An EP may change his or her EHR incentive payment program election once, consistent with § 495.60.

(e) Limitation to one State only. A Medicaid EP or eligible hospital may receive an incentive payment from only one State in a payment year.

(f) Incentive payments to hospitals. Incentive payments to an eligible hospital under this subpart are subject to all of the following conditions:
(1) The payment is provided over a minimum of a 3-year period and maximum of a 6-year period.
(2) The total incentive payment received over all payment years of the program is not greater than the aggregate EHR incentive amount, as calculated under paragraph (g) of this section.
(3) No single incentive payment for a payment year may exceed 50 percent of the aggregate EHR hospital incentive amount calculated under paragraph (g) of this section for an individual hospital.
(4) No incentive payments over a 2-year period may exceed 90 percent of the aggregate EHR hospital incentive amount calculated under paragraph (g) of this section for an individual hospital.
(5) No hospital may begin receiving incentive payments for any year after FY 2016, and after FY 2016, a hospital may not receive an incentive payment unless it received an incentive payment in the prior fiscal year.
(6) Prior to FY 2016, payments can be made to an eligible hospital on a non-consecutive, annual basis for the fiscal year.
(7) A multi-site hospital with one CMS Certification Number is considered one hospital for purposes of calculating payment.
(8) The aggregate EHR hospital incentive amount calculated under paragraph (g) of this section is determined by the State from which the eligible hospital receives its first payment year incentive. If a hospital receives incentive payments from other States in subsequent years, total incentive payments received over all payment years of the program can be no greater than the aggregate EHR incentive amount calculated by the initial State.

(g) Calculation of the aggregate EHR hospital incentive amount. The aggregate EHR hospital incentive amount is calculated as the product of the overall EHR amount times (the Medicaid Share).

(i) Initial amount. The initial amount is equal to the sum of—
(A) The base amount which is set at $2,000,000 for each of the theoretical 4 years; plus
(B) The discharge-related amount for the most recent continuous 12-month period selected by the State, but ending before the federal fiscal year that serves as the first payment year. The discharge-related amount is the sum of the following, with acute-care inpatient discharges over the 12-month period and based upon the total acute-care inpatient discharges for the eligible hospital (regardless of any source of payment):
(I) For the first through 1,149th acute-care inpatient discharge, $0.
(II) For the 1,150th through the 23,000th acute-care inpatient discharge, $200.
(III) For any acute-care inpatient discharge greater than the 23,000th, $0.
(C) For purposes of calculating the discharge-related amount under paragraph (g)(1)(i)(B) of this section, for the last 3 of the theoretical 4 years of payment, acute-care inpatient discharges are assumed to increase by the provider’s average annual rate of growth for the most recent 3 years for which data are available per year. Negative rates of growth must be applied as such.
(ii) Medicare share. The Medicare share, which equals 1.
(iii) Transition factor. The transition factor which equals as follows:
(A) For the first of the theoretical 4 years, 1.
(B) For the second of the theoretical 4 years, 3/4.
(C) For the third of the theoretical 4 years, 1/2.
(D) For the fourth of the theoretical 4 years, 1/4.

(2) Medicaid share. The Medicaid share specified under this paragraph for an eligible hospital is equal to a fraction—
(i) The numerator of which is the sum (for the 12-month period selected by the State and with respect to the eligible hospital) of—
(A) The estimated number of acute-care inpatient-bed-days which are attributable to Medicaid individuals; and
§ 495.312 Process for payments.

(a) General rule. States must have a process for making payments consistent with the requirements in subparts A and D of this part.

(b) Reporting data consistent with this subpart. In order to receive a payment under this part, a provider must report the required data under subpart A and this subpart within the EHR reporting period described in §495.4.

(c) State’s role. (1) Except as specified in paragraph (c)(2) of this section, the State determines the provider’s eligibility for the EHR incentive payment under subparts A and D of this part and approves, processes, and makes timely payments using a process approved by CMS.

(2) At the State’s option, CMS conducts the audits and handles any subsequent appeals, of whether eligible hospitals are meaningful EHR users on the States’ behalf.

(d) State disbursement. The State disburses an incentive payment to the

Medicaid if it meets all eligibility criteria in the payment year.

(k) Payments to State-designated entities. Payments to entities promoting the adoption of certified EHR technology as designated by the State must meet the following requirements:

(1) A Medicaid EP may reassign his or her incentive payment to an entity promoting the adoption of certified EHR technology, as defined in §495.302, and as designated by the State, only under the following conditions:

(i) The State has established a method to designate entities promoting the adoption of EHR technology that complies with the Federal definition in §495.302.

(ii) The State publishes and makes available to all EPs a voluntary mechanism for reassigning annual payments and includes information about the verification mechanism the State will use to ensure that the reassignment is voluntary and that no more than 5 percent of the annual payment is retained by the entity for costs not related to certified EHR technology.

(2) [Reserved]
Centers for Medicare & Medicaid Services, HHS

§ 495.314 Activities required to receive an incentive payment.

(a) First payment year. (1) In the first payment year, to receive an incentive payment, the Medicaid EP or eligible hospital must meet one of the following:
   (i) Demonstrate that during the payment year, it has adopted, implemented, or upgraded certified EHR technology, as defined in § 495.302.
   (ii) Demonstrate that during the EHR reporting period for a payment year, it is a meaningful EHR user as defined in § 495.4.

(b) Subsequent payment years. (1) In the second, third, fourth, fifth, and sixth payment years, to receive an incentive payment, the Medicaid EP or eligible hospital must demonstrate that during the EHR reporting period for the applicable payment year, it is a meaningful EHR user, as defined in § 495.4.

(2) The automated reporting of the clinical quality measures will be accomplished using certified EHR technology interoperable with the system designated by the State to receive the data.

§ 495.316 State monitoring and reporting regarding activities required to receive an incentive payment.

(a) Subject to § 495.332 the State is responsible for tracking and verifying the activities necessary for a Medicaid EP or eligible hospital to receive an incentive payment for each payment year, as described in § 495.314.

(b) Subject to § 495.332, the State must submit a State Medicaid HIT Plan to CMS that includes—
   (1) A detailed plan for monitoring, verifying and periodic auditing of the requirements for receiving incentive payments, as described in § 495.314; and
   (2) A description of the how the State will collect and report on provider meaningful use of certified EHR technology.

(c) Subject to §§ 495.332 and 495.352, the State is required to submit to CMS annual reports, in the manner prescribed by CMS, on the following:
   (1) Provider adoption, implementation, or upgrade of certified EHR technology activities and payments; and
   (2) Aggregated, de-identified meaningful use data.

(d)(1) The annual report described in paragraph (c) of this section must include, but is not limited to the following:
   (i) The number and type of providers who qualified for an incentive payment on the basis of having adopted, implemented, or upgraded certified EHR technology.
   (ii) The number and type of providers who qualified for an incentive payment on the basis of demonstrating that they are meaningful users of certified EHR technology;
   (iv) Aggregated data tables representing the provider’s clinical quality measures data; and
   (v) A description and quantitative data on how its incentive payment program addressed individuals with unique needs such as children.

   (2)(i) Subject to § 495.332, the State may propose a revised definition for Stage 1 of meaningful use of certified EHR technology, subject to CMS prior
approval, but only with respect to the following objectives:

(A) Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.

(B) Capability to submit electronic data to immunization registries or immunization information systems and actual submission except where prohibited, and according to applicable law and practice.

(C) Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission except where prohibited according to applicable law and practice.

(D) Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and according to applicable law and practice.

(ii) Subject to §495.332, the State may propose a revised definition for Stage 2 of meaningful use of certified EHR technology, subject to CMS prior approval, but only with respect to the following objectives:

(A) Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

(B) Capability to submit electronic data to immunization registries or immunization information systems except where prohibited and according to applicable law and practice.

(C) Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice.

(D) Capability to provide electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.

(E) Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.

(F) Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.

(iii) Subject to §495.332, the State may propose a revised definition for Stage 3 of meaningful use of CEHRT, subject to CMS prior approval, but only with respect to the public health and clinical data registry reporting objective described in §495.24(d)(9).

(e) State failure to submit the required reports to CMS may result in discontinued or disallowed funding.

(f) Each State must submit to CMS the annual report described in paragraph (c) of this section within 60 days of the end of the second quarter of the Federal fiscal year.

(g) The State must, on a quarterly basis and in the manner prescribed by CMS, submit a report(s) on the following:

(1) The State and payment year to which the quarterly report pertains.

(2) Subject to paragraph (h)(2) of this section, provider-level attestation data for each EP and eligible hospital that attests to demonstrating meaningful use for each payment year beginning with 2013.

(h)(1) Subject to paragraph (h)(2) of this section, the quarterly report described in paragraph (g) of this section must include the following for each EP and eligible hospital:

(i) The payment year number.

(ii) The provider’s National Provider Identifier or CCN, as appropriate.

(iii) Attestation submission date.

(iv) The state qualification.

(v) The state qualification date, which is the beginning date of the provider’s EHR reporting period for which it demonstrated meaningful use.

(vi) The State disqualification, if applicable.

(vii) The State disqualification date, which is the beginning date of the provider’s EHR reporting period to which the provider attested but for which it did not demonstrate meaningful use, if applicable.

(2) The quarterly report described in paragraph (g) of this section is not required to include information on EPs who are eligible for the Medicaid EHR incentive program on the basis of being a nurse practitioner, certified nurse-midwife or physician assistant.

§ 495.318 State responsibilities for receiving FFP.

In order to be provided FFP under section 1903(a)(3)(F) of the Act, a State must demonstrate to the satisfaction of HHS, that the State is—

(a) Using the funds provided for the purposes of administering incentive payments to providers under this program, including tracking of meaningful use by Medicaid providers of EHR technology;

(b) Conducting adequate oversight of the program, including routine tracking of meaningful use attestations and reporting mechanisms; and

(c) Is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information, subject to applicable laws and regulations governing such exchange.

§ 495.320 FFP for payments to Medicaid providers.

Subject to the requirements outlined in this subpart, FFP is available at 100 percent of State expenditures for payments to Medicaid eligible providers to encourage the adoption and meaningful use of certified EHR technology.

§ 495.322 FFP for reasonable administrative expenses.

Subject to prior approval conditions at § 495.324 of this subpart, FFP is available at 90 percent in State expenditures for administrative activities in support of implementing incentive payments to Medicaid eligible providers.

§ 495.324 Prior approval conditions.

(a) A State must obtain prior written approval as specified in paragraph (b) of this section, when the State plans to initiate planning and implementation activities in support of Medicaid provider incentive payments encouraging the adoption and meaningful use of certified EHR technology with proposed Federal financial participation.

(b) To receive 90 percent match, each State must receive prior approval for all of the following:

(1) The HIT advance planning document and the implementation advance planning document.

(2) A request for proposal and any contract that a State may utilize to complete activities under this subpart, unless specifically exempted by the Department of Health and Human Services, prior to release of the request for proposal or prior to execution of a contract.

(3) For contract amendments, unless specifically exempted by HHS, before execution of the contract amendment, involving contract cost increases exceeding $100,000 or contract time extensions of more than 60 days.

(4) The State Medicaid HIT plan.

(c) Failure to submit any of the information specified in paragraph (b) of this section to the satisfaction of HHS may result in disapproval or suspension of project funding.

(d) A State must obtain prior written approval from HHS of its justification for a sole source acquisition, when it plans to acquire non-competitively from a nongovernmental source HIT equipment or services, with proposed FFP under this subpart if the total State and Federal acquisition cost is more than $100,000.

§ 495.326 Disallowance of FFP.

If the HHS finds that any acquisition approved or modified under the provisions of this subpart fails to comply with the criteria, requirements, and other undertakings described in the approved HIT planning advance planning document and HIT implementation advance planning document to the detriment of the proper and efficient operation of the Medicaid program, payment of FFP may be disallowed. In the case of a suspension of approval of a HIT planning advance planning document and HIT implementation advance planning document, suspension would occur in the same manner as 45 CFR 205.37(c) and 307.40(a).

§ 495.328 Request for reconsideration of adverse determination.

If CMS disapproves a State request for any elements of a State’s advance planning document or State Medicaid HIT Plan under this subpart, or determines that requirements are met for approval on a date later than the date requested, the decision notice includes the following:

(a) The finding of fact upon which the determination was made.
§ 495.330 Termination of FFP for failure to provide access to information.

(a) HHS terminates FFP at any time if the Medicaid agency fails to provide State and Federal representatives with full access to records relating to HIT planning and implementation efforts, and the systems used to interoperate with electronic HIT, including on-site inspection.

(b) The Department may request such access at any time to determine whether the conditions in this subpart are being met.

§ 495.332 State Medicaid health information technology (HIT) plan requirements.

Each State Medicaid HIT plan must include all of the following elements:

(a) State systems. For State systems, interoperability, and the current and future visions:

(i) A baseline assessment of the current HIT landscape environment in the State including the inventory of existing HIT in the State. The assessment must include a comprehensive—

(ii) Description of the HIT “as-is” landscape;

(ii) Description of the HIT “to-be” landscape; and

(iii) HIT roadmap and strategic plan for the next 5 years.

(ii) A description of how the State Medicaid HIT plan will be planned, designed, developed and implemented, including how it will be implemented in accordance with the Medicaid Information Technology Architecture (MITA) principles as described in the Medicaid Information Technology Framework 2.0. The MITA initiative—

(i) Establishes national guidelines for technologies and processes that enable improved program administration for the Medicaid enterprise;

(ii) Includes business, information and technology architectures that provide an overall framework for interoperability, as well as processes and planning guidelines for enabling State Medicaid enterprises to meet common objectives within the framework while supporting unique local needs; and

(iii) Is important to the design and development of State EHR incentive payment systems.

(3) A description of how intrastate systems, including the Medicaid Management Information System (MMIS) and other automated mechanized claims processing and information retrieval systems—

(i) Have been considered in developing a HIT solution; and

(ii) A plan that incorporates the design, development, and implementation phases for interoperability of such State systems with a description of how any planned systems enhancements support overall State and Medicaid goals.

(4) A description of data-sharing components of HIT solutions.

(5) A description of how each State will promote secure data exchange, where permissible under the Health Insurance Portability and Accountability Act (HIPAA) and other requirements included in ARRA.

(6) A description of how each State will promote the use of data and technical standards to enhance data consistency and data sharing through common data-access mechanisms.

(7) A description of how each State will support integration of clinical and administrative data.

(8) A description of the process in place for ensuring improvements in health outcomes, clinical quality, or efficiency resulting from the adoption of certified EHR technology by beneficiaries of Medicaid incentive payments and a methodology for verifying such information.

(9) A description of the process in place for ensuring that any certified EHR technology used as the basis for a payment incentive to Medicaid providers is compatible with State or Federal administrative management systems, including the MMIS or other automated claims processing system or information retrieval system and a methodology for verifying such information.

(10) A description of how each State will adopt national data standards for health and data exchange and open standards for technical solutions as they become available.
Centers for Medicare & Medicaid Services, HHS  § 495.332

(11) A description of how the State intends to address the needs of underserved and vulnerable populations such as children, individuals with chronic conditions, Title IV–E foster care children, individuals in long-term care settings and the aged, blind, and disabled. This description must address the following:

(i) Person centered goals and objectives and shared decision-making;

(ii) Coordination of care across multiple service providers, funding sources, settings, and patient conditions—

(iii) Universal design to ensure access by people with disabilities and older Americans; and

(iv) Institutional discharge planning and diversion activities that are tied to community based service availability.

(b) Eligibility. For eligibility, a description of the process in place for all of the following:

(1) For ensuring that each EP and eligible hospital meets all provider enrollment eligibility criteria upon enrollment and re-enrollment to the Medicaid EHR payment incentive program.

(2) For ensuring patient volume consistent with the criteria in §§ 495.304 and 495.306 for each EP who practices predominantly in a FQHC or RHC and for each Medicaid EP who is a physician, pediatrician, nurse practitioner, certified nurse midwife or dentist and a methodology in place used to verify such information.

(3) For ensuring that the EP or eligible hospital is a provider who meets patient volume consistent with the criteria in §§ 495.304 and 495.306 and a methodology in place used to verify such information.

(4) For ensuring that each Medicaid EP is not hospital-based and a methodology in place used to verify such information.

(5) To ensure that a hospital eligible for incentive payments has demonstrated an average length of stay of 25 days or less and a methodology for verifying such information.

(6) For ensuring that at least one clinical location used for the calculation of the EP’s patient volume has Certified EHR Technology during the payment year for which the EP is attesting.

(c) Monitoring and validation. Subject to paragraph (g) of this section, for monitoring and validation of information States must include the following:

(1) A description of the process in place for ensuring that, because of CMS’ and the States’ oversight responsibilities, all provider information for attestations including meaningful use, efforts to adopt, implement, or upgrade and any information added to the CMS Single Provider Repository including all information related to patient volume, NPI, Tax identification number (TIN), are all true and accurate and that any concealment or falsification of a material fact related to the attestation may result in prosecution under Federal and State laws and a methodology in place used to verify such information.

(2) A description of the process in place for ensuring that the EP or eligible hospital is eligible to receive an incentive payment consistent with the criteria outlined in § 495.314 and a methodology in place used to verify such information.

(3) A description of the process in place for capturing attestations from each EP or eligible hospital that they have meaningfully used certified EHR technology during the EHR reporting period, and that they have adopted, implemented, or upgraded certified EHR technology and a description of the methodology in place used to verify such information.

(4) A description of the process in place for capturing clinical quality data from each EP or eligible hospital and a description of the methodology in place used to verify such information.

(5) A description of the process in place for monitoring the compliance of providers coming onto the program with different requirements depending upon their participation year and a methodology for verifying such information.

(6) A list of the specific actions planned to implement the EHR incentive program, including a description and organizational charts for workgroups within State government including external partners.

(7) A description of the process in place to ensure that no amounts higher
than 100 percent of FFP will be claimed by the State for reimbursement of expenditures for State payments to Medicaid eligible providers for the certified EHR technology incentive payment program and a methodology for verifying such information.

(8) A description of the process in place to ensure that no amounts higher than 90 percent of FFP will be claimed by the State for administrative expenses in administering the certified EHR technology incentive payment program and a methodology for verifying such information.

(9) A description of the process and methodology for ensuring and verifying the following:

(i) Amounts received under section 1903(a)(3)(F) of the Act with respect to payments to a Medicaid EP or eligible hospital are paid directly to such provider (or to an employer or facility to which such provider has assigned payments) without any deduction or rebate.

(ii) All incentive payment reassignments to an entity promoting the adoption of certified EHR technology, as designated by the State, are voluntary for the Medicaid EP involved.

(iii) Entities promoting the adoption of certified EHR technology do not retain more than 5 percent of such payments for costs not related to certified EHR technology (and support services including maintenance and training) that is for, or is necessary for the operation of, such technology.

(10) A description of the process in place for ensuring that each Medicaid EP or eligible hospital that collects an EHR payment incentive has collected a payment incentive from only one State even if the provider is licensed to practice in multiple States and a methodology for verifying such information.

(11)(i) A description of the process in place for ensuring that each EP or eligible hospital that wishes to participate in the EHR incentive payment program will receive a NPI; and

(ii) A description of how the NPI will be used to coordinate with the CMS so that the EP will choose only one program from which to receive the incentive payment and the hospital payments are tracked accordingly.

(12) A description of the process in place for ensuring that each EP or eligible hospital who wishes to participate in the EHR incentive payment program will provide a TIN to the State for purposes of the incentive payment.

(d) Payments. For payments, States must provide descriptions of the following processes that are in place:

(1) The process in place for ensuring that there is no duplication of Medicare and Medicaid incentive payments to EPs and a methodology for verifying such information.

(2) The process in place to ensure that any existing fiscal relationships with providers to disburse the incentive payments through Medicaid managed care plans does not result in payments that exceed 105 percent of the capitation rate, in order to comply with the Medicaid managed care incentive payment rules at §438.6(b)(2) of this chapter and a methodology for verifying such information.

(3) The process in place to ensure that only appropriate funding sources are used to make Medicaid EHR incentive payments and the methodology for verifying such information.

(4) The process in place and the methodology for verifying that information is available in order to ensure that Medicaid EHR incentive payments are made for no more than a total of 6 years; that no EP or eligible hospital begins receiving payments after 2016; that incentive payments cease after 2021; and that an eligible hospital does not receive incentive payments after FY 2016 unless the hospital received an incentive payment in the prior fiscal year.

(5) The process in place to ensure that Medicaid EHR incentive payments are not paid at amounts higher than 85 percent of the net average allowable cost of certified EHR technology and the yearly maximum allowable payment thresholds and a methodology for verifying such information.

(6) The process in place to ensure that all hospital calculations and hospital payment incentives are made consistent with the requirements of this part and a methodology for verifying such information.
(7) The process in place to provide for the timely and accurate payment of incentive payments to EPs and eligible hospitals, including the timeframe specified by the State to meet the timely payment requirement.

(8) The process in place and a methodology for verifying such information to provide that any monies that have been paid inappropriately as an improper payment or otherwise not in compliance with this subpart will be recouped and FFP will be repaid.

(e) For combating fraud and abuse and for provider appeals. (1) A description of the process in place for a provider to appeal consistent with the criteria described in § 495.370 and a methodology for verifying the following related to the EHR incentives payment program:

(i) Incentive payments.

(ii) Provider eligibility determinations.

(iii) Demonstration of efforts to adopt, implement or upgrade and meaningful use eligibility for incentive payments under this part.

(2) A description of the process in place, and a methodology for verifying such information, to address Federal laws and regulations designed to prevent fraud, waste, and abuse, including, but not limited to applicable provisions of Federal criminal law, the False Claims Act (32 U.S.C. 3729 et seq.), and the anti-kickback statute (section 1128B(b) of the Act).

(f) Optional—proposed alternatives. A State may choose to propose any of the following, but they must be included as an element in the State Medicaid HIT Plan for review and approval:

(1) An alternative methodology for measuring patient volume, consistent with § 495.306(g).

(2) A revised definition of meaningful use of certified EHR technology consistent with §§ 495.4 and 495.316(d)(2) of this part.

(i) Any revised definition of meaningful use may not require additional functionality beyond that of certified EHR technology and conform with CMS guidance on Stage 1. See also § 495.316(d)(2).

(g) Optional—signed agreement. At the State’s option, the State may include a signed agreement indicating that the State does all of the following:

(1) Designates CMS to conduct all audits and appeals of eligible hospitals’ meaningful use attestations.

(2) Is bound by the audit and appeal findings described in paragraph (g)(1) of this section.

(3) Performs any necessary recoupments if audits (and any subsequent appeals) described in paragraph (g)(1) of this section determine that an eligible hospital was not a meaningful EHR user.

(4) Is liable for any FFP granted to the State to pay eligible hospitals that, upon audit (and any subsequent appeal) are determined not to have been meaningful EHR users.

§ 495.334 [Reserved]

§ 495.336 Health information technology planning advance planning document requirements (HIT PAPD).

Each State’s HIT PAPD must contain the following:

(a) A statement of need and objective which clearly state the purpose and objectives of the project to be accomplished and the necessity for the project.

(b) A project management plan which addresses the following:

(1) The planning project organization.

(2) Planning activities and deliverables.

(3) State and contractor resource needs.

(4) Planning project procurement activities and schedule.

(c) A specific budget for the planning of the project.

(d) An estimated total project cost and a prospective State and Federal cost distribution, including planning and implementation.

(e) A commitment to submit a HIT implementation advance planning document.

(f) A commitment to conduct and complete activities which will result in the production of the State Medicaid HIT plan that includes conduct of the following activities:

(1) A statewide HIT environmental baseline self-assessment.
(2) An assessment of desired HIT future environment.
(3) Development of benchmarks and transition strategies to move from the current environment to the desired future environment.
(g) A commitment to submit the plan to CMS for approval.

§ 495.338 Health information technology implementation advance planning document requirements (HIT IAPD).

Each State's HIT IAPD must contain the following:

(a) The results of the activities conducted as a result of the HIT planning advance planning document, including the approved state Medicaid HIT plan.
(b) A statement of needs and objectives.
(c) A statement of alternative considerations.
(d) A personnel resource statement indicating availability of qualified and adequate staff, including a project director to accomplish the project objectives.
(e) A detailed description of the nature and scope of the activities to be undertaken and the methods to be used to accomplish the project.
(f) The proposed activity schedule for the project.
(g) A proposed budget including a consideration of all HIT implementation advance planning document activity costs, including but not limited to the following:
(1) The cost to implement and administer incentive payments.
(2) Procurement or acquisition.
(3) State personnel.
(4) Contractor services.
(5) Hardware, software, and licensing.
(6) Equipment and supplies.
(7) Training and outreach.
(8) Travel.
(9) Administrative operations.
(10) Miscellaneous expenses for the project.
(h) An estimate of prospective cost distribution to the various State and Federal funding sources and the proposed procedures for distributing costs including:
(1) Planned annual payment amounts;
(2) Total of planned payment amounts; and
(3) Calendar year of each planned annual payment amount.

§ 495.340 As-needed HIT PAPD update and as-needed HIT IAPD update requirements.

Each State must submit a HIT PAPD update or a HIT IAPD no later than 60 days after the occurrence of project changes including but not limited to any of the following:

(a) A projected cost increase of $100,000 or more.
(b) A schedule extension of more than 60 days for major milestones.
(c) A significant change in planning approach or implementation approach, or scope of activities beyond that approved in the HIT planning advance planning document or the HIT implementation advance planning document.
(d) A change in implementation concept or a change to the scope of the project.
(e) A change to the approved cost allocation methodology.

§ 495.342 Annual HIT IAPD requirements.

Each State is required to submit the HIT IAPD Updates 12 months from the date of the last CMS approved HIT IAPD and must contain the following:

(a) A reference to the approved HIT PAPD/IAPD and all approved changes.
(b) A project activity status which reports the status of the past year's major project tasks and milestones, addressing the degree of completion and tasks/milestones remaining to be completed and discusses past and anticipated problems or delays in meeting target dates in the approved HIT technology PAPD/IAPD and approved changes to it.
(c) A report of all project deliverables completed in the past year and degree of completion for unfinished products.
(d) A project activity schedule for the remainder of the project.
(e) A project expenditure status which consists of a detailed accounting
of all expenditures for project development over the past year and an explanation of the differences between projected expenses in the approved HIT PAPD/IAPD and actual expenditures for the past year.

(f) A report of any approved or anticipated changes to the allocation basis in the advance planning document’s approved cost methodology.

§ 495.344 Approval of the State Medicaid HIT plan, the HIT PAPD and update, the HIT IAPD and update, and the annual HIT IAPD.

HHS will not approve the State Medicaid HIT plan, HIT PAPD and update, HIT-IAPD and update, or annual IAPD if any of these documents do not include all of the information required under this subpart.

§ 495.346 Access to systems and records.

The State agency must allow HHS access to all records and systems operated by the State in support of this program, including cost records associated with approved administrative funding and incentive payments to Medicaid providers. State records related to contractors employed for the purpose of assisting with implementation or oversight activities or providing assistance, at such intervals as are deemed necessary by the Department to determine whether the conditions for approval are being met and to determine the efficiency, economy, and effectiveness of the program.

§ 495.348 Procurement standards.

(a) General rule. Procurements of HIT equipment and services are subject to the following procurement standards in paragraphs (b) through (f) of this section regardless of any conditions for prior approval. These standards—

(1) Include a requirement for maximum practical open and free competition regardless of whether the procurement is formally advertised or negotiated.

(2) Are established to ensure that such materials and services are obtained in a cost effective manner and in compliance with the provisions of applicable Federal statutes and executive orders.

(3) Apply when the cost of the procurement is treated as a direct cost of an award.

(b) Grantee responsibilities. The standards contained in this section do not relieve the Grantee of the contractual responsibilities arising under its contract(s).

(1) The grantee is the responsible authority, without recourse to the Departmental awarding agency, regarding the settlement and satisfaction of all contractual and administrative issues arising out of procurements entered into in support of an award or other agreement. This includes disputes, claims, and protests of award, source evaluation or other matters of a contractual nature.

(2) Matters concerning violation of statute are to be referred to such Federal, State or local authority as may have proper jurisdiction.

(c) Codes of conduct. The grantee must maintain written standards of conduct governing the performance of its employees engaged in the award and administration of contracts.

(1) No employee, officer, or agent must participate in the selection, award, or administration of a contract supported by Federal funds if a real or apparent conflict of interest would be involved.

(2) Such a conflict would arise when the employee, officer, or agent, or any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in the firm selected for an award.

(3) The officers, employees, and agents of the grantee must neither solicit nor accept gratuities, favors, or anything of monetary value from contractors, or parties to sub agreements.

(4) Grantees may set standards for situations in which the financial interest is not substantial or the gift is an unsolicited item of nominal value.

(5) The standards of conduct provide for disciplinary actions to be applied for violations of such standards by officers, employers, or agents of the grantees.
(d) **Competition.** All procurement transactions must be conducted in a manner to provide, to the maximum extent practical, open and free competition.

(1) The grantee must be alert to organizational conflicts of interest as well as noncompetitive practices among contractors that may restrict or eliminate competition or otherwise restrain trade.

(2) In order to ensure objective contractor performance and eliminate unfair competitive advantage, contractors that develop or draft grant applications, or contract specifications, requirements, statements of work, invitations for bids and requests for proposals must be excluded from competing for such procurements.

(3) Awards must be made to the bidder or offer or whose bid or offer is responsive to the solicitation and is most advantageous to the grantee, price, quality, and other factors considered.

(4) Solicitations must clearly set forth all requirements that the bidder or offer or must fulfill in order for the bid or offer to be evaluated by the grantee.

(5) Any and all bids or offers may be rejected when it is in the grantee’s interest to do so.

(e) **Procurement procedures.** All grantees must establish written procurement procedures. These procedures must provide, at a minimum, the following:

(1) Grantees avoid purchasing unnecessary items.

(2) When appropriate, an analysis is made of lease and purchase alternatives to determine which would be the most economical and practical procurement for the grantee and the Federal government.

(3) Solicitations for goods and services provide for all of the following:

(i) A clear and accurate description of the technical requirements for the material, product or service to be procured. In competitive procurements, such a description must not contain features which unduly restrict competition.

(ii) Requirements which the bidder or offer must fulfill and all other factors to be used in evaluating bids or proposals.

(iii) A description, whenever practicable, of technical requirements in terms of functions to be performed or performance required, including the range of acceptable characteristics or minimum acceptable standards.

(iv) The specific features of brand name or equal descriptions that bidders are required to meet when such items are included in the solicitation.

(v) The acceptance, to the extent practicable and economically feasible, of products and services dimensioned in the metric system of measurement.

(vi) Preference, to the extent practicable and economically feasible, for products and services that conserve natural resources and protect the environment and are energy efficient.

(4) Positive efforts must be made by grantees to utilize small businesses, minority-owned firms, and women’s business enterprises, whenever possible. Grantees of Departmental awards must take all of the following steps to further this goal:

(i) Ensure that small businesses, minority-owned firms, and women’s business enterprises are used to the fullest extent practicable.

(ii) Make information on forthcoming opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms, and women’s business enterprises.

(iii) Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women’s business enterprises.

(iv) Encourage contracting with consortia of small businesses, minority-owned firms and women’s business enterprises when a contract is too large for one of these firms to handle individually.

(v) Use the services and assistance, as appropriate, of such organizations as the Small Business Administration and the Department of Commerce’s Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women’s business enterprises.
(5) The type of procuring instruments used (for example, fixed price contracts, cost reimbursable contracts, purchase orders, and incentive contracts) must be determined by the grantee but must be appropriate for the particular procurement and for promoting the best interest of the program or project involved.

(6) The “cost-plus-a-percentage-of-cost” or “percentage of construction cost” methods of contracting must not be used.

(7) Contracts must be made only with responsible contractors who possess the potential ability to perform successfully under the terms and conditions of the proposed procurement.

(8) Consideration must be given to such matters as contractor integrity, record of past performance, financial and technical resources or accessibility to other necessary resources.

(9) In certain circumstances, contracts with certain parties are restricted by agencies’ implementation of Executive Orders 12549 and 12689, “Debarment and Suspension” as described in 2 CFR part 376.

(10) Some form of cost or price analysis must be made and documented in the procurement files in connection with every procurement action.

(11) Price analysis may be accomplished in various ways, including the comparison of price quotations submitted, market prices, and similar indicia, together with discounts.

(12) Cost analysis is the review and evaluation of each element of cost to determine reasonableness, allocability, and allowability.

(13) Procurement records and files for purchases in excess of the simplified acquisition threshold must include the following at a minimum:

(i) Basis for contractor selection.

(ii) Justification for lack of competition when competitive bids or offers are not obtained.

(iii) Basis for award cost or price.

(f) Contract administration. A system for contract administration must be maintained to ensure contractor conformance with the terms, conditions and specifications of the contract and to ensure adequate and timely follow up of all purchases. Grantees must evaluate contractor performance and document, as appropriate, whether contractors have met the terms, conditions, and specifications of the contract.

(g) Additional contract requirements. The grantee must include, in addition to provisions to define a sound and complete agreement, the following provisions in all contracts, which must also be applied to subcontracts:

(1) Contracts in excess of the simplified acquisition threshold must contain contractual provisions or conditions that allow for administrative, contractual, or legal remedies in instances in which a contractor violates or breaches the contract terms, and provide for such remedial actions as may be appropriate.

(2) All contracts in excess of the simplified acquisition threshold (currently $100,000) must contain suitable provisions for termination by the grantee, including the manner by which termination must be effected and the basis for settlement.

(h) Conditions for default or termination. Such contracts must describe conditions under which the contract may be terminated for default as well as conditions where the contract may be terminated because of circumstances beyond the control of the contractor.

(i) Access to contract materials and staff. All negotiated contracts (except those for less than the simplified acquisition threshold) awarded by grantees must include a provision to the effect that the grantee, the Departmental awarding agency, the U.S. Comptroller General, or any of their duly authorized representatives, must have access to any books, documents, papers and records and staff of the contractor which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions.
§ 495.352 Reporting requirements.

(a) Beginning with the first quarter of calendar year 2016, each State must submit to HHS on a quarterly basis a progress report, in the manner prescribed by HHS, documenting specific implementation and oversight activities performed during the quarter, including progress in implementing the State's approved Medicaid HIT plan.

(b) The quarterly progress reports must include, but need not be limited to providing, updates on the following:

(1) State system implementation dates.
(2) Provider outreach.
(3) Auditing.
(4) State-specific State Medicaid HIT Plan tasks.
(5) State staffing levels and changes.
(6) The number and type of providers that qualified for an incentive payment on the basis of having adopted, implemented or upgraded CEHRT and the amounts of incentive payments.
(7) The number and type of providers that qualified for an incentive payment on the basis of having demonstrated that they are meaningful users of CEHRT and the amounts of incentive payments.

(c) States must submit the quarterly progress reports described in this section within 30 days after the end of each federal fiscal year quarter.

[80 FR 62955, Oct. 16, 2015]

§ 495.354 Rules for charging equipment.

Equipment acquired under this subpart is subject to the public assistance program requirements concerning the computation of claims for Federal financial participation in accordance with the provisions of 45 CFR part 95, subpart G.

§ 495.356 Nondiscrimination requirements.

State agencies and any other beneficiaries or subbeneficiaries of Federal financial assistance provided under this subpart are subject to the nondiscrimination requirements in 45 CFR parts 80, 84, and 91.

(a) These regulations in 45 CFR parts 80, 84, and 91 prohibit individuals from being excluded from participation in, being denied the benefits of, or being otherwise subjected to discrimination under any program or activity which received Federal financial assistance.

(b) Specifically, 45 CFR part 80 prohibits discrimination on the basis of race, color, or national origin; 45 CFR part 84 prohibits discrimination on the basis of disability; and 45 CFR part 91 prohibits discrimination on the basis of age.

§ 495.358 Cost allocation plans.

State agencies that acquire HIT equipment and services under this subpart are subject to cost allocation plan requirements in 45 CFR part 95.

§ 495.360 Software and ownership rights.

(a) General rule. The State or local government must include a clause in all procurement instruments that provides that the State or local government will have all ownership rights in software or modifications thereof and associated documentation designed, developed or installed with FFP under this Subpart.

(b) Federal license. HHS reserves a royalty-free, non-exclusive, and irrevocable license to reproduce, publish or otherwise use and to authorize others to use for Federal government purposes, the software, modifications, and documentation designed, developed or installed with FFP under this Subpart.

(c) Proprietary software. Proprietary operating/vendor software packages such as software that is owned and licensed for use by third parties, which are provided at established catalog or market prices and sold or leased to the general public must not be subject to the ownership provisions in paragraphs (a) and (b) of this section.

(d) Limitation. Federal financial participation is not available for proprietary applications software developed specifically for the public assistance programs covered under this subpart.
§ 495.362 Retroactive approval of FFP with an effective date of February 18, 2009.

For administrative activities performed by a State, without obtaining prior approval, which are in support of planning for incentive payments to providers, a State may request consideration of FFP by recorded request in a HIT advance planning document or implementation advance planning document update. In such a consideration, the agency takes into consideration overall Federal interests which may include any of the following:

(a) The acquisition must not be before February 18, 2009.
(b) The acquisition must be reasonable, useful, and necessary.
(c) The acquisition must be attributable to payments for reasonable administrative expenses under section 1903(a)(3)(F)(ii) of the Act.

§ 495.364 Review and assessment of administrative activities and expenses of Medicaid provider health information technology adoption and operation.

(a) CMS conducts periodic reviews on an as needed basis to assess the State’s progress described in its approved HIT planning advance planning document and health information technology implementation advance planning document.

(b) During planning, development, and implementation, these reviews will generally be limited to the overall progress, work performance, expenditure reports, project deliverables, and supporting documentation.

(c) CMS assesses the State’s overall compliance with the approved advance planning document and provide technical assistance and information sharing from other State projects.

(d) CMS will, on a continuing basis, review, assess and inspect the planning, design, development, implementation, and operation of activities and payments for reasonable administrative expenses related to the administration of payment for Medicaid provider HIT adoption and operation payments to determine the extent to which such activities meet the following:

(1) All requirements of this subpart.

(2) The goals and objectives stated in the approved HIT implementation advance planning document and State Medicaid HIT plan.
(3) The schedule, budget, and other conditions of the approved HIT implementation advance planning document and State Medicaid HIT plan.

§ 495.366 Financial oversight and monitoring of expenditures.

(a) General rule. (1) The State must have a process in place to estimate expenditures for the Medicaid EHR payment incentive program using the Medicaid Budget Expenditure System.
(2) The State must have a process in place to report actual expenditures for the Medicaid EHR payment incentive program using the Medicaid Budget Expenditure System.
(3) The State must have an automated payment and information retrieval mechanized system, (Medicaid Management Information System) to ensure Medicaid provider eligibility, to ensure the accuracy of payment incentives, and to identify potential improper payments.

(b) Provider eligibility as basis for making payment. Subject to §495.332, the State must do all of the following:

(1) Collect and verify basic information on Medicaid providers to assure provider enrollment eligibility upon enrollment or re-enrollment to the Medicaid EHR payment incentive program.
(2) Collect and verify basic information on Medicaid providers to assure patient volume.

(3) Collect and verify basic information on Medicaid providers to assure that EPs are not hospital-based including the determination that substantially all health care services are not furnished in a hospital inpatient or emergency room setting.

(4) Collect and verify basic information on Medicaid providers to assure that they are practicing predominantly in a Federally-qualified health center or rural health clinic.

(5) Have a process in place to assure that Medicaid providers who wish to participate in the EHR incentive payment program have or will have a NPI and will choose only one program from

797
which to receive the incentive payment using the NPI, a TIN, and CMS’ national provider election database.

(c) Meaningful use and efforts to adopt, implement, or upgrade to certified electronic health record technology to make payment. Subject to §495.312, 495.314, and §495.332, the State must annually collect and verify information regarding the efforts to adopt, implement, or upgrade certified EHR technology and the meaningful use of said technology before making any payments to providers.

(d) Claiming Federal reimbursement for State expenditures. Subject to §495.332, the State must do the following:

(1) Assure that State expenditures are claimed in accordance with, including but not limited to, applicable Federal laws, regulations, and policy guidance.

(2) Have a process in place to assure that expenditures for administering the Medicaid EHR incentive payment program will not be claimed at amounts higher than 90 percent of the cost of such administration.

(3) Have a process in place to assure that expenditures for payment of Medicaid EHR incentive payments will not be claimed at amounts higher than 100 percent of the cost of such payments to Medicaid providers.

(e) Improper Medicaid electronic health record payment incentives. (1) Subject to §495.332, the State must have a process in place to assure that no duplicate Medicaid EHR payment incentives are paid between the Medicare and Medicaid programs, or paid by more than one State even if the provider is licensed to practice in multiple States, or paid within more than one area of a State.

(2) Subject to §495.332, the State must have a process in place to assure that Medicaid EHR incentive payments are made without reduction or rebate, have been paid directly to an eligible provider or to an employer, a facility, or an eligible third-party entity to which the Medicaid eligible provider has assigned payments.

(3) Subject to §495.332, the State must have a process in place to assure that Medicaid EHR incentive payments are made without reduction or rebate, have been paid directly to an eligible provider or to an employer, a facility, or an eligible third-party entity to which the Medicaid eligible provider has assigned payments.

(4) Subject to §495.332, the State must have a process in place to assure that only appropriate funding sources are used to make Medicaid EHR incentive payments.

(5) Subject to §495.332, the State must have a process in place to assure that Medicaid EHR incentive payments are not paid at amounts higher than 85 percent of the net average allowable cost of certified EHR technology and the yearly maximum allowable payment thresholds.

(6) Subject to §495.332, the State must have a process in place to assure that Medicaid EHR incentive payments are paid on a voluntary basis and that these entities do not retain more than 5 percent of such payments for costs not related to certified EHR technology.

(7) Subject to §495.332, the State must have a process in place to assure that any existing fiscal relationships with providers to disburse the incentive through Medicaid managed care plans does not exceed 105 percent of the capitation rate, in order to comply with the Medicaid managed care incentive payment rules at §438.6(b)(2) of this chapter and a methodology for verifying such information.

(8) The State must not request reimbursement for Federal financial participation unless all requirements of this subpart have been satisfied.

§495.368 Combating fraud and abuse.

(a) General rule. (1) The State must comply with Federal requirements to—

(i) Ensure the qualifications of the providers who request Medicaid EHR incentive payments;

(ii) Detect improper payments; and

(iii) In accordance with §455.15 and §455.21 of this chapter, refer suspected cases of fraud and abuse to the Medicaid Fraud Control Unit.

(2) The State must take corrective action in the case of improper EHR payment incentives to Medicaid providers.

(b) Providers’ statements regarding submission of documentation containing falsification or concealment of a material fact on EHR incentive payment documentation. For any forms on which a provider submits information necessary to the determination of eligibility to receive EHR payments, the State must obtain a statement that meets the following requirements:

(1) Is signed by the provider and contains the following statement: “This is to certify that the foregoing information is true, accurate, and complete. I understand that Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.”

(2) Appears directly above the claimant’s signature, or if it is printed on the reverse of the form, a reference to the statements must appear immediately preceding the provider’s signature.

(3) Is resubmitted upon a change in provider representative.

(4) Is updated as needed.

(c) Overpayments. States must repay to CMS all Federal financial participation received by providers identified as an overpayment regardless of recoupment from such providers, within 60 days of discovery of the overpayment, in accordance with sections 1903(a)(1), (d)(2), and (d)(3) of the Act and part 433 subpart F of the regulations.

(d) Complying with Federal laws and regulations. States must comply with all Federal laws and regulations designed to prevent fraud, waste, and abuse, including, but not limited to applicable provisions of Federal criminal law, the False Claims Act (32 U.S.C. 3729 et seq.), and the anti-kickback statute (section 1128B(b) of the Act).

PART 498—APPEALS PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTICIPATION OF ICFs/IID AND CERTAIN NFs IN THE MEDICAID PROGRAM

Subpart A—General Provisions

§ 495.370 Appeals process for a Medicaid provider receiving electronic health record incentive payments.

(a) The State must have a process in place consistent with the requirements established in § 447.253(e) of this chapter for a provider or entity to appeal the following issues related to the HIT incentives payment program:

(1) Incentive payments.

(2) Incentive payment amounts.

(3) Provider eligibility determinations.

(4) Demonstration of adopting, implementing, and upgrading, and meaningful use eligibility for incentives under this subpart.

(b) Subject to paragraph (a) of this section, the State’s process must ensure the following:

(1) That the provider (whether individual or an entity) has an opportunity to challenge the State’s determination under this part by submitting documents or data or both to support the provider’s claim.

(2) That such process employs methods for conducting an appeal that are consistent with the State’s Administrative Procedure law(s).

(c) The State must provide that the provider (whether individual or entity) is also given any additional appeals rights that would otherwise be available under procedures established by the State.

(d) This section does not apply in the case that CMS conducts the audits and handles any subsequent appeals under § 495.312(c)(2) of this part.

§ 498.1 Statutory basis.

(a) Section 1866(h) of the Act provides for a hearing and for judicial review of the hearing for any institution or agency dissatisfied with a determination that it is not a provider, or with any determination described in section 1866(b)(2) of the Act.

(b) Section 1866(b)(2) of the Act lists determinations that serve as a basis for termination of a provider agreement.

(c) Sections 1128 (a) and (b) of the Act provide for exclusion of certain individuals or entities because of conviction of crimes related to their participation in Medicare and section 1128(f) provides for hearing and judicial review for exclusions.

(d) Section 1156 of the Act establishes certain obligations for practitioners and providers of health care services, and provides sanctions and penalties for those that fail to meet those obligations.

(e)–(f) [Reserved]

(g) Section 1866(j) of the Act provides for a hearing and judicial review for any provider or supplier whose application for enrollment or reenrollment in Medicare is denied or whose billing privileges are revoked.

42 CFR Ch. IV (10–1–16 Edition)
(h) Section 1128A(c)(2) of the Act provides that the Secretary may not collect a civil money penalty until the affected entity has had notice and opportunity for a hearing.

(i) Section 1819(h) of the Act—

(1) Provides that, for SNFs found to be out of compliance with the requirements for participation, specified remedies may be imposed instead of, or in addition to, termination of the facility’s Medicare provider agreement; and

(2) Makes certain provisions of section 1128A of the Act applicable to civil money penalties imposed on SNFs.

(j) Section 1891(e) of the Act provides that, for home health agencies (HHAs) found to be out of compliance with the conditions of participation, specified remedies may be imposed instead of, or in addition to, termination of the HHA’s Medicare provider agreement.

(k) Section 1891(f) of the Act—

(1) Requires the Secretary to develop a range of such remedies; and

(2) Makes certain provisions of section 1128A of the Act applicable to civil money penalties imposed on HHAs.

§ 498.2 Definitions.

As used in this part—

Affected party means a provider, prospective provider, supplier, prospective supplier, or practitioner that is affected by an initial determination or by any subsequent determination or decision issued under this part, and “party” means the affected party or CMS, as appropriate. For provider or supplier enrollment appeals, an affected party includes CMS or a CMS contractor.

ALJ stands for Administrative Law Judge.

Departmental Appeals Board or Board means a Board established in the Office of the Secretary to provide impartial review of disputed decisions made by the operating components of the Department.

OIG stands for the Department’s Office of the Inspector General.

Prospective provider means any of the entities specified in the definition of provider under this section that seeks to be approved for coverage of its services by Medicare or to have any facility or organization determined to be a department of the provider or provider-based entity under §413.65 of this chapter.

Prospective supplier means any of the listed entities specified in the definition of supplier in this section that seek to be approved for coverage of its services by Medicare.

Provider means either of the following:

(1) Any of the following entities that have in effect an agreement to participate in Medicare:

(i) Hospital.

(ii) Transplant center.

(iii) Critical access hospital (CAH).

(iv) Skilled nursing facility (SNF).

(v) Comprehensive outpatient rehabilitation facility (CORF).

(vi) Home health agency (HHA).

(vii) Hospice.

(viii) Religious nonmedical health care institution (RNHCI).

(2) Any of the following entities that have in effect an agreement to participate in Medicare but only to furnish outpatient physical therapy or outpatient speech pathology services:

(i) Clinic.

(ii) Rehabilitation agency.

(iii) Public health agency.

Supplier means any of the following entities that have in effect an agreement to participate in Medicare:

(1) An independent laboratory.

(2) Supplier of durable medical equipment prosthetics, orthotics, or supplies (DMEPOS).

(3) Ambulance service provider.

(4) Independent diagnostic testing facility.

(5) Physician or other practitioner such as physician assistant.

(6) Physical therapist in independent practice.

(7) Supplier of portable X-ray services.

(8) Rural health clinic (RHC).

(9) Federally qualified health center (FQHC).

(10) Ambulatory surgical center (ASC).

(11) An entity approved by CMS to furnish outpatient diabetes self-management training.

(12) End-stage renal disease (ESRD) treatment facility that is approved by
§ 498.3 Scope and applicability.

(a) Scope. (1) This part sets forth procedures for reviewing initial determinations that CMS makes with respect to the matters specified in paragraph (b) of this section, and that the OIG makes with respect to the matters specified in paragraph (c) of this section. It also specifies, in paragraph (d) of this section, administrative actions that are not subject to appeal under this part.

(2) The determinations listed in this section affect participation in the Medicare program. Many of the procedures of this part also apply to other determinations that do not affect participation in Medicare. Some examples follow:

(i) CMS’s determination to terminate an NF’s Medicaid provider agreement.

(ii) CMS’s determination to cancel the approval of an ICF/IID under section 1910(b) of the Act.

(iii) CMS’s determination, under the Clinical Laboratory Improvement Act (CLIA), to impose alternative sanctions or to suspend, limit, or revoke the certificate of a laboratory even though it does not participate in Medicare.

(iv) CMS’s determination to impose sanctions on the individual who is the administrator of a NF for failure to comply with the requirements at § 483.75(c) of this chapter.

(3) The following parts of this chapter specify the applicability of the provisions of this part 498 to sanctions or remedies imposed on the indicated entities or individuals:

(i) Part 431, subpart D—for nursing facilities (NFs).

(ii) Part 488, subpart E (§ 488.330(e))—for SNFs and NFs.

(iii) Part 488, subpart E (§ 488.330(e)) and subpart F (§ 488.446)—for SNFs and NFs and their administrators.

(b) Initial determinations by CMS. CMS makes initial determinations with respect to the following matters:

(1) Whether a prospective provider qualifies as a provider.

(2) Whether a prospective department of a provider, remote location of a hospital, satellite facility, or provider-based entity qualifies for provider-based status under § 413.65 of this chapter, or whether such a facility or entity currently treated as a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity no longer qualifies for that status under § 413.65 of this chapter.

(3) Whether an institution is a hospital qualified to elect to claim payment for all emergency hospital services furnished in a calendar year.

(4) Whether an institution continues to remain in compliance with the qualifications for claiming reimbursement for all emergency services furnished in a calendar year.

(5) Whether a prospective supplier meets the conditions for coverage of its services as those conditions are set forth elsewhere in this chapter.

(6) Whether the services of a supplier continue to meet the conditions for coverage.

(7) Whether a physical therapist in independent practice or a chiropractor meets the requirements for coverage of his or her services as set forth in subpart D of part 486 of this chapter and § 410.22 of this chapter, respectively.

(8) The termination of a provider agreement in accordance with § 489.53 of this chapter, or the termination of a rural health clinic agreement in accordance with § 405.2404 of this chapter, or the termination of a Federally qualified health center agreement in accordance with § 405.2406 of this chapter.

(9) CMS’s cancellation, under section 1910(b) of the Act, of an ICF/IID’s approval to participate in Medicaid.

(10) Whether, for purposes of rate setting and reimbursement, an ESRD treatment facility is considered to be hospital-based or independent.

(11) [Reserved]
(12) Whether a hospital, skilled nursing facility, home health agency, or hospice program meets or continues to meet the advance directives requirements specified in subpart I of part 489 of this chapter.

(13) Except as provided at paragraph (d)(12) of this section for SNFs, NFs, and HHAs, the finding of noncompliance leading to the imposition of enforcement actions specified in §488.406 or §488.620 of this chapter, but not the determination as to which sanction was imposed. The scope of review on the imposition if a civil money penalty is specified in §§488.438(e) and 488.845(h) of this chapter.

(14) The level of noncompliance found by CMS in a SNF, NF, or HHA but only if a successful challenge on this issue would affect—

(i) The range of civil money penalty amounts that CMS could collect (for SNFs or NFs, the scope of review during a hearing on the imposition of a civil money penalty is set forth in §488.438(e) of this chapter and for HHAs, the scope of review during a hearing on the imposition of a civil money penalty is set forth in §488.845(h) of this chapter); or

(ii) A finding of substandard quality of care that results in the loss of approval for a SNF or NF of its nurse aide training program.

(15) The effective date of a Medicare provider agreement or supplier approval.

(16) The finding of substandard quality of care that leads to the loss by a SNF or NF of the approval of its nurse aide training program.

(17) Whether to deny or revoke a provider or supplier's Medicare enrollment in accordance with §424.530 or §424.535 of this chapter.

(18) The level of noncompliance found by CMS with respect to the failure of an individual who is the administrator of a SNF to comply with the requirements at §483.75(r) of this chapter, and the appropriate sanction to be imposed under §488.446 of this chapter.

(19) Whether a physician or practitioner has failed to properly opt-out, failed to maintain opt-out, failed to timely renew opt-out, failed to privately contract, or failed to properly terminate opt-out.

(c) Initial determinations by the OIG. The OIG makes initial determinations with respect to the following matters:

(1) The termination of a provider agreement in accordance with part 1001, subpart C of this title.

(2) The suspension, or exclusion from coverage and the denial of reimbursement for services furnished by a provider, practitioner, or supplier, because of fraud or abuse, or conviction of crimes related to participation in the program, in accordance with part 1001, subpart B of this title.

(3) The imposition of sanctions in accordance with part 1004 of this title.

(d) Administrative actions that are not initial determinations. Administrative actions that are not initial determinations (and therefore not subject to appeal under this part) include but are not limited to the following:

(1) The finding that a provider or supplier determined to be in compliance with the conditions or requirements for participation or for coverage has deficiencies.

(2) The finding that a prospective provider does not meet the conditions of participation set forth elsewhere in this chapter, if the prospective provider is, nevertheless, approved for participation in Medicare on the basis of special access certification, as provided in subpart B of part 488 of this chapter.

(3) The refusal to enter into a provider agreement because the prospective provider is unable to give satisfactory assurance of compliance with the requirements of title XVIII of the Act.

(4) The finding that an entity that had its provider agreement terminated may not file another agreement because the reasons for terminating the previous agreement have not been removed or there is insufficient assurance that the reasons for the exclusion will not recur.

(5) The determination not to reinstate a suspended or excluded practitioner, provider, or supplier because the reason for the suspension or exclusion has not been removed, or there is insufficient assurance that the reason will not recur.

(6) The finding that the services of a laboratory are covered as hospital services or as physician’s services, rather
than as services of an independent laboratory, because the laboratory is not independent of the hospital or of the physician’s office.

(7) The refusal to accept for filing an election to claim payment for all emergency hospital services furnished in a calendar year because the institution—
   (i) Had previously charged an individual or other person for services furnished during that calendar year;
   (ii) Submitted the election after the close of that calendar year; or
   (iii) Had previously been notified of its failure to continue to comply.

(8) The finding that the reason for the revocation of a supplier’s right to accept assignment has not been removed or there is insufficient assurance that the reason will not recur.

(9) The finding that a hospital accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association is not in compliance with a condition of participation, and a finding that that hospital is no longer deemed to meet the conditions of participation.

(10) For a SNF, NF, or HHA—
   (i) The finding that the provider’s deficiencies pose immediate jeopardy to the health or safety of the residents or patients;
   (ii) Except as provided in paragraph (b)(13) of this section, a determination by CMS as to the provider’s level of noncompliance; and
   (iii) For SNFs and NFs, the imposition of State monitoring.

(11) The choice of alternative sanction or remedy to be imposed on a provider or supplier.

(12) The determination that the accreditation requirements of a national accreditation organization do not provide (or do not continue to provide) reasonable assurance that the entities accredited by the accreditation organization meet the applicable long-term care requirements, conditions for coverage, conditions of certification, conditions of participation, or CLIA condition level requirements.

(13) The determination that requirements imposed on a State’s laboratories under the laws of that State do not provide (or do not continue to provide) reasonable assurance that laboratories licensed or approved by the State meet applicable CLIA requirements.

(14) The choice of alternative sanction or remedy to be imposed on a provider or supplier.

(15) A decision by the State survey agency as to when to conduct an initial survey of a prospective provider or supplier.

(e) Exclusion of civil rights issues. The procedures in this subpart do not apply to the adjudication of issues relating to a provider’s compliance with civil rights requirements that are set forth in part 489 of this chapter. Those issues are handled through the Department’s Office of Civil Rights.

§ 498.4 NFs subject to appeals process in part 498.

A NF is considered a provider for purposes of this part when it has in effect an agreement to participate in Medicaid, including an agreement to participate in both Medicaid and Medicare and it is a—

(a) State-operated NF; or

(b) Non State-operated NF that is subject to compliance action as a result of—

   (1) A validation survey by CMS; or

   (2) CMS’s review of the State’s survey findings.

§ 498.5 Appeal rights.

(a) Appeal rights of prospective providers. (1) Any prospective provider dissatisfied with an initial determination or revised initial determination that it does not qualify as a provider may request reconsideration in accordance with §498.22(a).

   (2) Any prospective provider dissatisfied with a reconsidered determination under paragraph (a)(1) of this section, or a revised reconsidered determination under §498.30, is entitled to a hearing before an ALJ.

   (b) Appeal rights of providers. Any provider dissatisfied with an initial determination to terminate its provider
agreement is entitled to a hearing before an ALJ.

(c) Appeal rights of providers and prospective providers. Any provider or prospective provider dissatisfied with a hearing decision may request Departmental Appeals Board review, and has a right to seek judicial review of the Board’s decision.

(d) Appeal rights of prospective suppliers. (1) Any prospective supplier dissatisfied with an initial determination or a revised initial determination that its services do not meet the conditions for coverage may request reconsideration in accordance with §498.22(a).

(2) Any prospective supplier dissatisfied with a reconsidered determination under paragraph (d)(1) of this section, or a revised reconsidered determination under §498.30, is entitled to a hearing before an ALJ.

(e) Appeal rights of suppliers. Any supplier dissatisfied with an initial determination that the services subject to the determination no longer meet the conditions for coverage, is entitled to a hearing before an ALJ.

(f) Appeal rights of suppliers and prospective suppliers. (1) Any supplier or prospective supplier dissatisfied with the hearing decision may request Departmental Appeals Board review of the ALJ’s decision.

(2) A supplier or prospective supplier dissatisfied with an ALJ decision may request Board review, and has a right to seek judicial review of the Board’s decision.

(g) Appeal rights for certain practitioners. A physical therapist in independent practice or a chiropractor dissatisfied with a determination that he or she does not meet the requirements for coverage of his or her services has the same appeal rights as suppliers have under paragraphs (d), (e) and (f) of this section.

(h) Appeal rights for nonparticipating hospitals that furnish emergency services. A nonparticipating hospital dissatisfied with a determination or decision that it does not qualify to elect to claim payment for all emergency services furnished during a calendar year has the same appeal rights that providers have under paragraph (a), (b), and (c) of this section.

(i) Appeal rights for suspended or excluded practitioners, providers, or suppliers. (1) Any practitioner, provider, or supplier who has been suspended, or whose services have been excluded from coverage in accordance with §498.3(c)(2), or has been sanctioned in accordance with §498.3(c)(3), is entitled to a hearing before an ALJ.

(2) Any suspended or excluded practitioner, provider, or supplier dissatisfied with a hearing decision may request Departmental Appeals Board review and has a right to seek judicial review of the Board’s decision by filing an action in Federal district court.

(j) Appeal rights for Medicaid ICFs/IID terminated by CMS. (1) Any Medicaid ICF/IID that has had its approval cancelled by CMS in accordance with §498.3(b)(8) has a right to a hearing before an ALJ, to request Departmental Appeals Board review of the hearing decision, and to seek judicial review of the Board’s decision.

(2) The Medicaid agreement remains in effect until the period for requesting a hearing has expired or, if the facility requests a hearing, until a hearing decision is issued, unless CMS—

(i) Makes a written determination that continuation of provider status for the SNF or ICF constitutes an immediate and serious threat to the health and safety of patients and specifies the reasons for that determination; and

(ii) Certifies that the facility has been notified of its deficiencies and has failed to correct them.

(k) Appeal rights of NFs. Under the circumstances specified in §431.153 (g) and (h) of this chapter, an NF has a right to a hearing before an ALJ, to request Board review of the hearing decision, and to seek judicial review of the Board’s decision.

(l) Appeal rights related to provider enrollment. (1) Any prospective provider, an existing provider, prospective supplier or existing supplier dissatisfied with an initial determination or revised initial determination related to the denial or revocation of Medicare billing privileges may request reconsideration in accordance with §498.22(a).

(2) CMS, a CMS contractor, any prospective provider, an existing provider,
§ 498.10 Appointment of representatives.

(a) An affected party may appoint as its representative anyone not disqualified or suspended from acting as a representative in proceedings before the Secretary or otherwise prohibited by law.

(b) If the representative appointed is not an attorney, the party must file written notice of the appointment with CMS, the ALJ, or the Departmental Appeals Board.

(c) If the representative appointed is an attorney, the attorney’s statement that he or she has the authority to represent the party is sufficient.

§ 498.11 Authority of representatives.

(a) A representative appointed and qualified in accordance with § 498.10 may, on behalf of the represented party—

(1) Give and accept any notice or request pertinent to the proceedings set forth in this part;

(2) Present evidence and allegations as to facts and law in any proceedings affecting that party to the same extent as the party; and

(3) Obtain information to the same extent as the party.

(b) A notice or request may be sent to the affected party, to the party’s representative, or to both. A notice or request sent to the representative has the same force and effect as if it had been sent to the party.

§ 498.13 Fees for services of representatives.

Fees for any services performed on behalf of an affected party by an attorney appointed and qualified in accordance with § 498.10 are not subject to the provisions of section 206 of Title II of the Act, which authorizes the Secretary to specify or limit those fees.

§ 498.15 Charge for transcripts.

A party that requests a transcript of prehearing or hearing proceedings or Board review must pay the actual or estimated cost of preparing the transcript unless, for good cause shown by that party, the payment is waived by the ALJ or the Departmental Appeals Board, as appropriate.

§ 498.17 Filing of briefs with the ALJ or Departmental Appeals Board, and opportunity for rebuttal.

(a) Filing of briefs and related documents. If a party files a brief or related document such as a written argument, contention, suggested finding of fact, conclusion of law, or any other written statement, it must submit an original and one copy to the ALJ or the Departmental Appeals Board, as appropriate.

The material may be filed by mail or in person and must include a statement certifying that a copy has been furnished to the other party.
(b) Opportunity for rebuttal. (1) The other party will have 20 days from the date of mailing or personal service to submit any rebuttal statement or additional evidence. If a party submits a rebuttal statement or additional evidence, it must file an original and one copy with the ALJ or the Board and furnish a copy to the other party. (2) The ALJ or the Board will grant an opportunity to reply to the rebuttal statement only if the party shows good cause.

Subpart B—Initial, Reconsidered, and Revised Determinations

§ 498.20 Notice and effect of initial determinations.

(a) Notice of initial determination—(1) General rule. CMS or the OIG, as appropriate, mails notice of an initial determination to the affected party, setting forth the basis or reasons for the determination, the effect of the determination, and the party’s right to reconsideration, if applicable, or to a hearing. (2) Special rules: Independent laboratories and suppliers of portable x-ray services. If CMS determines that an independent laboratory or a supplier of portable x-ray services no longer meets the conditions for coverage of some or all of its services, the notice— (i) Specifies an effective date of termination of coverage that is at least 15 days after the date of the notice; (ii) Is also sent to physicians, hospitals, and other parties that might use the services of the laboratory or supplier; and (iii) In the case of laboratories, specifies the categories of laboratory tests that are no longer covered. (3) Special rules: Nonparticipating hospitals that elect to claim payment for emergency services. If CMS determines that a nonparticipating hospital no longer qualifies to elect to claim payment for all emergency services furnished in a calendar year, the notice— (i) States the calendar year to which the determination applies; (ii) Specifies an effective date that is at least 5 days after the date of the notice; and (iii) Specifies that the determination applies to services furnished, in the specified calendar year, to patients accepted (as inpatients or outpatients) on or after the effective date of the determination. (4) Other special rules. Additional rules pertaining, for example, to content and timing of notice, notice to the public and to other entities, and time allowed for submittal of additional information, are set forth elsewhere in this chapter, as follows: Part 405 Subpart X—for rural health clinics. Part 416—for ambulatory surgical centers. Part 489—for providers, when their provider agreements have been terminated. Part 1001, Subpart B—for excluded or suspended providers, suppliers, physicians, or practitioners. Part 1001, Subpart C—for providers, when their provider agreements are terminated by the OIG. Part 1004—for sanctioned providers and practitioners.

(b) Effect of initial determination. An initial determination is binding unless it is— (1) Reconsidered in accordance with § 498.24; (2) Reversed or modified by a hearing decision in accordance with § 498.78; or (3) Revised in accordance with § 498.32 or § 498.100.

§ 498.22 Reconsideration.

(a) Right to reconsideration. CMS or one of its contractors reconsider an initial determination that affects a prospective provider or supplier, or a hospital seeking to qualify to claim payment for all emergency hospital services furnished in a calendar year, if the affected party files a written request in accordance with paragraphs (b) and (c) of this section. For denial or revocation of enrollment, prospective providers and suppliers and providers and suppliers have a right to reconsideration.

(b) Request for reconsideration: Manner and timing. The affected party specified in paragraph (a) of this section, if dissatisfied with the initial determination may request reconsideration by filing the request— (1) With CMS or with the State survey agency, or in the case of prospective supplier the entity specified in the notice of initial determination; (2) Directly or through its legal representative or other authorized official; and
§ 498.23 Withdrawal of request for reconsideration.
A request for reconsideration is considered withdrawn if the requestor files a written withdrawal request before CMS mails the notice of reconsidered determination, and CMS approves the withdrawal request.

§ 498.24 Reconsidered determination.
When a request for reconsideration has been properly filed in accordance with § 498.22, CMS—
(a) Receives written evidence and statements that are relevant and material to the matters at issue and are submitted within a reasonable time after the request for reconsideration;
(b) Considers the initial determination, the findings on which the initial determination was based, the evidence considered in making the initial determination, and any other written evidence submitted under paragraph (a) of this section, taking into account facts relating to the status of the prospective provider or supplier subsequent to the initial determination; and
(c) Makes a reconsidered determination, affirming or modifying the initial determination and the findings on which it was based.

§ 498.25 Notice and effect of reconsidered determination.
(a) Notice. (1) CMS mails notice of a reconsidered determination to the affected party.
(2) The notice gives the reasons for the determination.
(3) If the determination is adverse, the notice specifies the conditions or requirements of law or regulations that the affected party fails to meet, and informs the party of its right to a hearing.
(b) Effect. A reconsidered determination is binding unless—
(1) CMS or the OIG, as appropriate, further revises the revised determination; or
(2) The revised determination is reversed or modified by a hearing decision.

Subpart C—Reopening of Initial or Reconsidered Determinations
§ 498.30 Limitation on reopening.
An initial or reconsidered determination that a prospective provider is a provider or that a hospital qualifies to elect to claim payment for all emergency services furnished in a calendar year may not be reopened. CMS or the OIG, as appropriate, may on its own initiative, reopen any other initial or reconsidered determination, within 12 months after the date of notice of the initial determination.

§ 498.32 Notice and effect of reopening and revision.
(a) Notice. (1) CMS or the OIG, as appropriate, gives the affected party notice of reopening and of any revision of the reopened determination.
(2) The notice of revised determination states the basis or reason for the revised determination.
(3) If the determination is that a supplier or prospective supplier does not meet the conditions for coverage of its services, the notice specifies the conditions with respect to which the affected party fails to meet the requirements of law and regulations, and informs the party of its right to a hearing.
(b) Effect. A revised determination is binding unless
(1) The affected party requests a hearing before an ALJ; or
(2) CMS or the OIG further revises the revised determination.

**Subpart D—Hearings**

§ 498.40 Request for hearing.

(a) Manner and timing of request. (1) An affected party entitled to a hearing under § 498.5 may file a request for a hearing with the ALJ office identified in the determination letter.

(2) The affected party or its legal representative or other authorized official must file the request in writing within 60 days from receipt of the notice of initial, reconsidered, or revised determination unless that period is extended in accordance with paragraph (c) of this section. (Presumed date of receipt is determined in accordance with § 498.22(b)(3)).

(b) Content of request for hearing. The request for hearing must—

(1) Identify the specific issues, and the findings of fact and conclusions of law with which the affected party disagrees; and

(2) Specify the basis for contending that the findings and conclusions are incorrect.

(c) Extension of time for filing a request for hearing.

(1) The affected party or its legal representative or other authorized official may file a request for extension of time stating the reasons why the request was not filed within 60 days—

(1) The affected party or its legal representative or other authorized official may file a request for extension of time stating the reasons why the request was not filed timely.

(2) For good cause shown, the ALJ may extend the time for filing the request for hearing.

(3) If the request was not filed within 60 days—

(1) The affected party or its legal representative or other authorized official may file with the ALJ a written request for extension of time stating the reasons why the request was not filed timely.

(2) For good cause shown, the ALJ may extend the time for filing the request for hearing.

[52 FR 22446, June 12, 1987, as amended at 73 FR 36462, June 27, 2008]

§ 498.45 Disqualification of Administrative Law Judge.

(a) An ALJ may not conduct a hearing in a case in which he or she is prejudiced or partial to the affected party or has any interest in the matter pending for decision.

(b) A party that objects to the ALJ designated to conduct the hearing must give notice of its objections at the earliest opportunity.

(c) The ALJ will consider the objections and decide whether to withdraw or proceed with the hearing.

(1) If the ALJ withdraws, another will be designated to conduct the hearing.

(2) If the ALJ does not withdraw, the objecting party may, after the hearing, present its objections to the Departmental Appeals Board as reasons for changing, modifying, or reversing the ALJ’s decision or providing a new hearing before another ALJ.

[52 FR 22446, June 12, 1987, as amended at 73 FR 36462, June 27, 2008]

§ 498.47 Prehearing conference.

(a) At any time before the hearing, the ALJ may call a prehearing conference for the purpose of delineating the issues in controversy, identifying the evidence and witnesses to be presented at the hearing, and obtaining stipulations accordingly.

(b) On the request of either party or on his or her own motion, the ALJ may adjourn the prehearing conference and reconvene at a later date.

§ 498.48 Notice of prehearing conference.

(a) Timing of notice. The ALJ will fix a time and place for the prehearing conference and mail written notice to the parties at least 10 days before the scheduled date.

(b) Content of notice. The notice will inform the parties of the purpose of the
conference and specify what issues are sought to be resolved, agreed to, or excluded.

(c) Additional issues. Issues other than those set forth in the notice of determination or the request for hearing may be considered at the prehearing conference if—
(1) Either party gives timely notice to that effect to the ALJ and the other party; or
(2) The ALJ raises the issues in the notice of prehearing conference or at the conference.

§ 498.49 Conduct of prehearing conference.

(a) The prehearing conference is open to the affected party or its representative, to the CMS or OIG representatives and their technical advisors, and to any other persons whose presence the ALJ considers necessary or proper.

(b) The ALJ may accept the agreement of the parties as to the following:
(1) Facts that are not in controversy.
(2) Questions that have been resolved favorably to the affected party after the determination in dispute.
(3) Remaining issues to be resolved.

(c) The ALJ may request the parties to indicate the following:
(1) The witnesses that will be present to testify at the hearing.
(2) The qualifications of those witnesses.
(3) The nature of other evidence to be submitted.

§ 498.50 Record, order, and effect of prehearing conference.

(a) Record of prehearing conference. (1) A record is made of all agreements and stipulations entered into at the prehearing conference.
(2) The record may be transcribed at the request of either party or the ALJ.

(b) Order and opportunity to object. (1) The ALJ issues an order setting forth the results of the prehearing conference, including the agreements made by the parties as to facts not in controversy, the matters to be considered at the hearing, and the issues to be resolved.
(2) Copies of the order are sent to all parties and the parties have 10 days to file objections to the order.

(3) After the 10 days have elapsed, the ALJ settles the order.

(c) Effect of prehearing conference. The agreements and stipulations entered into at the prehearing conference are binding on all parties, unless a party presents facts that, in the opinion of the ALJ, would make an agreement unreasonable or inequitable.

§ 498.52 Time and place of hearing.

(a) The ALJ fixes a time and place for the hearing and gives the parties written notice at least 10 days before the scheduled date.

(b) The notice informs the parties of the general and specific issues to be resolved at the hearing.

§ 498.53 Change in time and place of hearing.

(a) The ALJ may change the time and place for the hearing either on his or her own initiative or at the request of a party for good cause shown, or may adjourn or postpone the hearing.

(b) The ALJ may reopen the hearing for receipt of new evidence at any time before mailing the notice of hearing decision.

(c) The ALJ gives the parties reasonable notice of any change in time or place or any adjournment or reopening of the hearing.

§ 498.54 Joint hearings.

When two or more affected parties have requested hearings and the same or substantially similar matters are at issue, the ALJ may, if all parties agree, fix a single time and place for the prehearing conference or hearing and conduct all proceedings jointly. If joint hearings are held, a single record of the proceedings is made and a separate decision issued with respect to each affected party.

§ 498.56 Hearing on new issues.

(a) Basic rules. (1) Within the time limits specified in paragraph (b) of this section, the ALJ may, at the request of either party, or on his or her own motion, provide a hearing on new issues that impinge on the rights of the affected party.

(2) Except for provider or supplier enrollment appeals which are addressed in §498.56(e), the ALJ may consider new
issues even if CMS or the OIG has not made initial or reconsidered determinations on them, and even if they arose after the request for hearing was filed or after the prehearing conference.

(3) The ALJ may give notice of hearing on new issues at any time after the hearing request is filed and before the hearing record is closed.

(b) Time limits. The ALJ will not consider any issue that arose on or after any of the following dates:

(1) The effective date of the termination of a provider agreement.
(2) The date on which it is determined that a supplier no longer meets the conditions for coverage of its services.
(3) The effective date of the notice to a hospital of its failure to remain in compliance with the qualifications for claiming reimbursement for all emergency services furnished to Medicare beneficiaries during the calendar year.
(4) The effective date of the suspension, or of the exclusion from coverage of services furnished by a suspended or excluded practitioner, provider, or supplier.
(5) With respect to Medicaid SNFs or ICFs surveyed under section 1910(c) of the Act—

(i) The completion date of the survey or resurvey that is the basis for a proposed cancellation of approval; or
(ii) If approval was cancelled before the hearings, because of immediate and serious threat to patient health and safety, the effective date of cancellation.

(c) Notice and conduct of hearing on new issues. (1) Unless the affected party waives its right to appear and present evidence, notice of the time and place of hearing on any new issue will be given to the parties in accordance with §498.52.

(2) After giving notice, the ALJ will, except as provided in paragraph (d) of this section, proceed to hearing on new issues in the same manner as on an issue raised in the request for hearing.

(d) Remand to CMS or the OIG. At the request of either party, or on his or her own motion, in lieu of a hearing under paragraph (c) of this section, the ALJ may remand the case to CMS or the OIG for consideration of the new issue and, if appropriate, a determination. If necessary, the ALJ may direct CMS or the OIG to return the case to the ALJ for further proceedings.

(e) Provider and supplier enrollment appeals: Good cause requirement—(1) Examination of any new documentary evidence. After a hearing is requested but before it is held, the ALJ will examine any new documentary evidence submitted to the ALJ by a provider or supplier to determine whether the provider or supplier has good cause for submitting the evidence for the first time at the ALJ level.

(2) Determining if good cause exists—(i) If good cause exists. If the ALJ finds that there is good cause for submitting new documentary evidence for the first time at the ALJ level, the ALJ must include evidence and may consider it in reaching a decision.

(ii) If good cause does not exist. If the ALJ determines that there was not good cause for submitting the evidence for the first time at the ALJ level, the ALJ must exclude the evidence from the proceeding and may not consider it in reaching a decision.

(2) Notification to all parties. As soon as possible, but no later than the start of the hearing, the ALJ must notify all parties of any evidence that is excluded from the hearing.

§498.58 Subpoenas.

(a) Basis for issuance. The ALJ, upon his or her own motion or at the request of a party, may issue subpoenas if they are reasonably necessary for the full presentation of a case.

(b) Timing of request by a party. The party must file a written request for a subpoena with the ALJ at least 5 days before the date set for the hearing.

(c) Content of request. The request must:

(1) Identify the witnesses or documents to be produced;
(2) Describe their addresses or location with sufficient particularity to permit them to be found; and
(3) Specify the pertinent facts the party expects to establish by the witnesses or documents, and indicate why
§ 498.60 Conduct of hearing.

(a) Participants in the hearing. The hearing is open to the parties and their representatives and technical advisors, and to any other persons whose presence the ALJ considers necessary or proper.

(b) Hearing procedures. (1) The ALJ inquires fully into all of the matters at issue, and receives in evidence the testimony of witnesses and any documents that are relevant and material.

(2) If the ALJ believes that there is relevant and material evidence available which has not been presented at the hearing, he may, at any time before mailing of notice of the decision, reopen the hearing to receive that evidence.

(3) The ALJ decides the order in which the evidence and the arguments of the parties are presented and the conduct of the hearing.

(c) Scope of review: Civil money penalty. In civil money penalty cases—

(1) The scope of review is as specified in §§ 488.438(e) and 488.845(h) of this chapter; and

(2) CMS’ determination as to the level of noncompliance of a SNF, NF, or HHA must be upheld unless it is clearly erroneous.

[52 FR 22446, June 12, 1987, as amended at 61 FR 32350, June 24, 1996; 79 FR 66118, Nov. 6, 2014]

§ 498.61 Evidence.

Evidence may be received at the hearing even though inadmissible under the rules of evidence applicable to court procedure. The ALJ rules on the admissibility of evidence.

[59 FR 56252, Nov. 10, 1994, as amended at 61 FR 32350, June 24, 1996]

§ 498.62 Witnesses.

Witnesses at the hearing testify under oath or affirmation. The representative of each party is permitted to examine his or her own witnesses subject to interrogation by the representative of the other party. The ALJ may ask any questions that he or she deems necessary. The ALJ rules upon any objection made by either party as to the propriety of any question.

§ 498.63 Oral and written summation.

The parties to a hearing are allowed a reasonable time to present oral summation and to file briefs or other written statements of proposed findings of fact and conclusions of law. Copies of any briefs or other written statements must be sent in accordance with § 498.17.

§ 498.64 Record of hearing.

A complete record of the proceedings at the hearing is made and transcribed in all cases.

§ 498.66 Waiver of right to appear and present evidence.

(a) Waiver procedures. (1) If an affected party wishes to waive its right to appear and present evidence at the hearing, it must file a written waiver with the ALJ.

(2) If the affected party wishes to withdraw a waiver, it may do so, for good cause, at any time before the ALJ mails notice of the hearing decision.

(b) Effect of waiver. If the affected party waives the right to appear and present evidence, the ALJ need not conduct an oral hearing except in one of the following circumstances:

(1) The ALJ believes that the testimony of the affected party or its representatives or other witnesses is necessary to clarify the facts at issue.

(2) CMS or the OIG shows good cause for requiring the presentation of oral evidence.

(c) Dismissal for failure to appear. If, despite the waiver, the ALJ sends notice of hearing and the affected party fails to appear, or to show good cause for the failure, the ALJ will dismiss the appeal in accordance with § 498.69.

(d) Hearing without oral testimony. When there is no oral testimony, the ALJ will—

(1) Make a record of the relevant written evidence that was considered
in making the determination being appealed, and of any additional evidence submitted by the parties;

(2) Furnish to each party copies of the additional evidence submitted by the other party; and

(3) Give both parties a reasonable opportunity for rebuttal.

(e) Handling of briefs and related statements. If the parties submit briefs or other written statements of evidence or proposed findings of facts or conclusions of law, those documents will be handled in accordance with §498.17.

§ 498.68 Dismissal of request for hearing.

(a) The ALJ may, at any time before mailing the notice of the decision, dismiss a hearing request if a party withdraws its request for a hearing or the affected party asks that its request be dismissed.

(b) An affected party may request a dismissal by filing a written notice with the ALJ.

§ 498.69 Dismissal for abandonment.

(a) The ALJ may dismiss a request for hearing if it is abandoned by the party that requested it.

(b) The ALJ may consider a request for hearing to be abandoned if the party or its representative—

(1) Fails to appear at the prehearing conference or hearing without having previously shown good cause for not appearing; and

(2) Fails to respond, within 10 days after the ALJ sends a “show cause” notice, with a showing of good cause.

§ 498.70 Dismissal for cause.

On his or her own motion, or on the motion of a party to the hearing, the ALJ may dismiss a hearing request either entirely or as to any stated issue, under any of the following circumstances:

(a) Res judicata. There has been a previous determination or decision with respect to the rights of the same affected party on the same facts and law pertinent to the same issue or issues which has become final either by judicial affirmation or, without judicial consideration, because the affected party did not timely request reconsideration, hearing, or review, or commenced a civil action with respect to that determination or decision.

(b) No right to hearing. The party requesting a hearing is not a proper party or does not otherwise have a right to a hearing.

(c) Hearing request not timely filed. The affected party did not file a hearing request timely and the time for filing has not been extended.

§ 498.71 Notice and effect of dismissal and right to request review.

(a) Notice of the ALJ’s dismissal action is mailed to the parties. The notice advises the affected party of its right to request that the dismissal be vacated as provided in §498.72.

(b) The dismissal of a request for hearing is binding unless it is vacated by the ALJ or the Departmental Appeals Board.

§ 498.72 Vacating a dismissal of request for hearing.

An ALJ may vacate any dismissal of a request for hearing if a party files a request to that effect within 60 days from receipt of the notice of dismissal and shows good cause for vacating the dismissal. (Date of receipt is determined in accordance with §498.22(b)(3).)

§ 498.74 Administrative Law Judge’s decision.

(a) Timing, basis and content. As soon as practical after the close of the hearing, the ALJ issues a written decision in the case. The decision is based on the evidence of record and contains separate numbered findings of fact and conclusions of law.

(b) Notice and effect. A copy of the decision is mailed to the parties and is binding on them unless—

(1) A party requests review by the Departmental Appeals Board within the time period specified in §498.82, and the Board reviews the case;

(2) The Departmental Appeals Board denies the request for review and the party seeks judicial review by filing an action in a United States District Court or, in the case of a civil money penalty, in a United States Court of Appeals;

(3) The decision is revised by an ALJ or the Departmental Appeals Board; or
§ 498.76 Removal of hearing to Departmental Appeals Board.
(a) At any time before the ALJ receives oral testimony, the Board may remove to itself any pending request for a hearing.
(b) Notice of removal is mailed to each party.
(c) The Board conducts the hearing in accordance with the rules that apply to ALJ hearings under this subpart.

§ 498.78 Remand by the Administrative Law Judge.
(a) If CMS requests a remand, the ALJ may remand any case properly before him or her to CMS.
(b) The ALJ may remand at any time before notice of hearing decision is mailed.

§ 498.79 Timeframes for deciding an enrollment appeal before an ALJ.
When a request for an ALJ hearing is filed after CMS or a FFS contractor has denied an enrollment application, the ALJ must issue a decision, dismissal order or remand to CMS, as appropriate, no later than the end of the 180-day period beginning from the date the appeal was filed with an ALJ.

Subpart E—Departmental Appeals Board Review
§ 498.80 Right to request Departmental Appeals Board review of Administrative Law Judge’s decision or dismissal.
Either of the parties has a right to request Departmental Appeals Board review of the ALJ’s decision or dismissal, and the parties are so informed in the notice of the ALJ’s action.

§ 498.82 Request for Departmental Appeals Board review.
(a) Manner and time of filing. (1) Any party that is dissatisfied with an ALJ’s decision or dismissal of a hearing request, may file a written request for review by the Departmental Appeals Board.
(2) The requesting party or its representative or other authorized official must file the request with the OHA within 60 days from receipt of the notice of decision or dismissal, unless the Board, for good cause shown by the requesting party, extends the time for filing. The rules set forth in § 498.40(c) apply to extension of time for requesting Departmental Appeals Board review. (The date of receipt of notice is determined in accordance with § 498.22(c)(3).)
(b) Content of request for review. A request for review of an ALJ decision or dismissal must specify the issues, the findings of fact or conclusions of law with which the party disagrees, and the basis for contending that the findings and conclusions are incorrect.

§ 498.83 Departmental Appeals Board action on request for review.
(a) Request by CMS or the OIG. The Departmental Appeals Board may dismiss, deny, or grant a request made by CMS or the OIG for review of an ALJ decision or dismissal.
(b) Request by the affected party. The Board will grant the affected party’s request for review unless it dismisses the request for one of the following reasons:
(1) The affected party requests dismissal of its request for review.
(2) The affected party did not file timely or show good cause for late filing.
(3) The affected party does not have a right to review.
(4) A previous determination or decision, based on the same facts and law, and regarding the same issue, has become final through judicial affirmation or because the affected party failed to timely request reconsideration, hearing, Board review, or judicial review, as appropriate.
(c) Effect of dismissal. The dismissal of a request for Departmental Appeals Board review is binding and not subject to further review.
(d) Review panel. If the Board grants a request for review of the ALJ’s decision, the review will be conducted by a
§ 498.85 Procedures before the Departmental Appeals Board on review.

The parties are given, upon request, a reasonable opportunity to file briefs or other written statements as to fact and law, and to appear before the Departmental Appeals Board to present evidence or oral arguments. Copies of any brief or other written statement must be sent in accordance with § 498.17.

§ 498.86 Evidence admissible on review.

(a) Except for provider or supplier enrollment appeals, the Board may admit evidence into the record in addition to the evidence introduced at the ALJ hearing (or the documents considered by the ALJ if the hearing was waived) if the Board considers that the additional evidence is relevant and material to an issue before it.

(b) If it appears to the Board that additional relevant evidence is available, the Board will require that it be produced.

(c) Before additional evidence is admitted into the record—
   (1) Notice is mailed to the parties (unless they have waived notice) stating that evidence will be received regarding specified issues; and
   (2) The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues.

(d) If additional evidence is presented orally to the Board, a transcript is prepared and made available to any party upon request.

[52 FR 22446, June 12, 1987, as amended at 73 FR 36463, June 27, 2008]

§ 498.88 Decision or remand by the Departmental Appeals Board.

(a) When the Departmental Appeals Board reviews an ALJ’s decision or order of dismissal, or receives a case remanded by a court, the Board may either issue a decision or remand the case to an ALJ for a hearing and decision or a recommended decision for final decision by the Board.

(b) In a remanded case, the ALJ initiates additional proceedings and takes other actions as directed by the Board in its order of remand, and may take other action not inconsistent with that order.

(c) Upon completion of all action called for by the remand order and any other consistent action, the ALJ promptly makes a decision or, as specified by the Board, certifies the case to the Board with a recommended decision.

(d) The parties have 20 days from the date of a notice of a recommended decision to submit to the Board any exception, objection, or comment on the findings of fact, conclusions of law, and recommended decision.

(e) After the 20-day period, the Board issues its decision adopting, modifying or rejecting the ALJ’s recommended decision.

(f) If the Board does not remand the case to an ALJ, the following rules apply:
   (1) The Board’s decision—
      (i) Is based upon the evidence in the hearing record and any further evidence that the Board receives during its review;
      (ii) Is in writing and contains separate numbered findings of fact and conclusions of law; and
      (iii) May modify, affirm, or reverse the ALJ’s decision.
   (2) A copy of the Board’s decision is mailed to each party.

(g) When a request for Board review of a denial of an enrollment application is filed after an ALJ has issued a decision or dismissal order, the Board must issue a decision, dismissal order or remand to the ALJ, as appropriate, no later than 180 days after the appeal was received by the Board.

[52 FR 22446, June 12, 1987, as amended at 73 FR 36463, June 27, 2008]

§ 498.90 Effect of Departmental Appeals Board decision.

(a) General rule. The Board’s decision is binding unless—
   (1) The affected party has a right to judicial review and timely files a civil action in a United States District Court or, in the case of a civil money penalty, in a United States Court of Appeals; or
§ 498.95 Extension of time for seeking judicial review.

(a) Any affected party that is dissatisfied with an Departmental Appeals Board decision and is entitled to judicial review must commence civil action within 60 days from receipt of the notice of the Board’s decision (as determined under § 498.22(c)(3)), unless the Board extends the time in accordance with paragraph (c) of this section.

(b) The request for extension must be filed in writing with the Board before the 60-day period ends.

(c) For good cause shown, the Board may extend the time for commencing civil action.

Subpart F—Reopening of Decisions Made by Administrative Law Judges or the Departmental Appeals Board

§ 498.100 Basis, timing, and authority for reopening an ALJ or Board decision.

(a) Basis and timing for reopening. An ALJ of Departmental Appeals Board decision may be reopened, within 60 days from the date of the notice of decision, upon the motion of the ALJ or the Board or upon the petition of either party to the hearing.

(b) Authority to reopen. (1) A decision of the Departmental Appeals Board may be reopened only by the Departmental Appeals Board.

(2) A decision of an ALJ may be reopened by that ALJ, by another ALJ if that one is not available, or by the Departmental Appeals Board. For purposes of this paragraph, an ALJ is considered to be unavailable if the ALJ has died, terminated employment, or been transferred to another duty station, is on leave of absence, or is unable to conduct a hearing because of illness.

§ 498.102 Revision of reopened decision.

(a) Revision based on new evidence. If a reopened decision is to be revised on the basis of new evidence that was not included in the record of that decision, the ALJ or the Departmental Appeals Board—

(1) Notifies the parties of the proposed revision; and

(2) Unless the parties waive their right to hearing or appearance—

(i) Grants a hearing in the case of an ALJ revision; and

(ii) Grants opportunity to appear in the case of a Board revision.

(b) Basis for revised decision and right to review. (1) If a revised decision is necessary, the ALJ or the Departmental Appeals Board, as appropriate, renders it on the basis of the entire record.

(2) If the decision is revised by an ALJ, the Departmental Appeals Board may review that revised decision at the request of either party or on its own motion.

§ 498.103 Notice and effect of revised decision.

(a) Notice. The notice mailed to the parties states the basis or reason for the revised decision and informs them of their right to Departmental Appeals Board review of an ALJ revised decision, or to judicial review of a Board reviewed decision.

(b) Effect—(1) ALJ revised decision. An ALJ revised decision is binding unless it is reviewed by the Departmental Appeals Board.

(2) Departmental Appeals Board revised decision. A Board revised decision is binding unless a party files a civil action in a district court of the United States within the time frames specified in § 498.95.
SUBCHAPTER H—HEALTH CARE INFRASTRUCTURE AND MODEL PROGRAMS

PART 505—ESTABLISHMENT OF THE HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM

Subpart A—Loan Criteria

Sec.
505.1 Basis and scope.
505.3 Definitions.
505.5 Loan criteria.
505.7 Terms of the loan.
505.9 State and local permits.
505.11 Loan application requirements and procedures.

Subpart B—Forgiveness of Indebtedness

505.13 Conditions for loan forgiveness.
505.15 Plan criteria for meeting the conditions for loan forgiveness.
505.17 Reporting requirements for meeting the conditions for loan forgiveness.
505.19 Approval or denial of loan forgiveness.

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C 1302 and 1395hh).
SOURCE: 70 FR 57374, Sept. 30, 2005, unless otherwise noted.

Subpart A—Loan Criteria

§ 505.1 Basis and scope.

This part implements section 1016 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) which amends section 1897 of the Act. Section 1897 of the Act as amended by section 6045 of the Tsunami Relief Act of 2005 authorizes the Secretary to establish a loan program by which qualifying hospitals may apply for a loan for the capital costs of the health care infrastructure improvement projects. Section 1897 of the Act appropriates $142,000,000 for the loan program including program administration. The funds are available beginning July 1, 2004 through September 30, 2008. This part sets forth the criteria that CMS uses to select among qualifying hospitals.

§ 505.3 Definitions.

For purposes of this subpart, the following definitions apply:

Eligible project means the project of a qualifying hospital that is designed to improve the health care infrastructure of the hospital, including construction, renovation, or other capital improvements.

Entity is an entity described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of the code. An entity must also have at least one existing memorandum of understanding or affiliation agreement with a hospital located in the State in which the entity is located and retains clinical outpatient treatment for cancer on site as well as laboratory research, education, and outreach for cancer in the same facility.

Outreach programs mean formal cancer programs for teaching, diagnostic screening, therapy or treatment, prevention, or interventions to enhance the health and knowledge of their designated population(s).

Qualifying hospital means a hospital as defined at section 1861(e) of the Act (42 U.S.C. 1395x(e)) or an entity (as defined in this section) that is engaged in research in the causes, prevention, and treatment of cancer; and is either designated as a cancer center for the National Cancer Institute; or designated by the State legislature as the official cancer institute of the State before December 8, 2003.

Unique research resources means resources that are used for the purpose of discovering or testing options related to the causes, prevention, and treatment of cancer.

[70 FR 57374, Sept. 30, 2005, as amended at 71 FR 48143, Aug. 18, 2006]

§ 505.5 Loan criteria.

(a) Qualifying criteria. To qualify for the loan program, the applicant must meet the following conditions:

(1) Meet the definition of a “qualifying hospital” as set forth in §505.3 of this part.

(2) Request a loan for the capital costs of an “eligible project” as defined in §505.3 of this part. The capital costs
§ 505.7 Terms of the loan.

All loan beneficiaries must agree to the following loan terms:

(a) Loan obligation. An authorized official of a qualifying hospital must execute a promissory note, loan agreement, or a form approved by CMS and accompanied by any other documents CMS may designate. The loan beneficiary must provide required documentation in a timely manner.

(b) Schedule of loan. A loan beneficiary receives a lump sum distribution for which payment of principal and interest is deferred for 60 months beginning with the day of award notification from CMS. The loan repayment period is 20 years.

(c) Bankruptcy protection. In the event a loan beneficiary files for bankruptcy protection in a court of competent jurisdiction or otherwise proves to be insolvent, CMS may terminate the deferment period described in paragraph (b) of this section and require immediate payment of the loan. If a loan beneficiary should file for bankruptcy protection in a court of competent jurisdiction or should otherwise evidence insolvency after the deferment period we will require immediate repayment of the outstanding principal and interest due. Those payments may be deducted from any Medicare payments otherwise due that hospital.

(d) Loan forgiveness. CMS does not require a loan beneficiary to begin making payments of principal or interest at the end of the 60-month deferment period if it determines that the loan beneficiary meets the criteria for loan forgiveness under section 1897 of the Act, as determined by the Secretary.

(e) Default. If a loan beneficiary fails to make any payment in repayment of a loan under this subpart within 10 days of its due date, the loan beneficiary may be considered to have defaulted on the loan. Upon default, all principal and accrued interest become due immediately, and CMS may require immediate payment of any outstanding principal and interest due. Those payments may be deducted from any Medicare payments otherwise due that hospital.

(f) Loan repayment. The loan beneficiary must meet the following conditions:

(1) Make payments every month for 20 years until the loan, including interest payments, are paid in full.

(2) Pay interest on the unpaid principal until the full amount of principal has been paid.

(3) Pay interest at a yearly rate based upon the rate as fixed by the Secretary of the Treasury and set forth at 45 CFR 30.13(a).

(4) If a loan beneficiary fails to make any payment in repayment of a loan under this subpart within 10 days of its ...
due date, that payment may be de-
ducted from any Medicare payments
otherwise due to the beneficiary.

(g) **Interest rate and monthly payment charges.** CMS calculates interest
charges and payments consistent with
§405.378 of this chapter.

(h) **Loan recipient’s right to prepay.** A
loan beneficiary has the right to make
payments of principal at any time be-
fore they are due. A loan beneficiary
may make full prepayment or partial
prepayment without paying any pre-
payment charge. If a prepayment is
made, the loan beneficiary must pro-
vide written notice to CMS at CMS, Di-
vision of Accounting Operations, P.O.
Box 75120, Baltimore, MD 21207–0520.

§ 505.9 **State and local permits.**

With respect to an eligible project,
the provision of a loan under this part
shall not—

(a) Relieve the beneficiary of the
loan or any obligation to obtain any
required State or local permit or ap-
proval with respect to the project.

(b) Limit the right of any unit of
State or local government to approve
or regulate any rate of return on pri-
vate equity invested in the project.

(c) Supersede any State or local law
(including any regulation) applicable
to the construction or operation of the
project.

§ 505.11 **Loan application require-
ments and procedures.**

(a) The loan application must be re-
ceived by CMS no later than 5 p.m.
ed.t. on December 29, 2005.

(b) The requested information must
be typed or clearly printed in ink and
the loan beneficiary must mail or de-
deliver an original copy of the loan to
CMS. The loan application must con-
tain the following information:

(1) Qualifying hospital’s name and
street address.

(2) Qualifying hospital’s Medicare
provider number.

(3) Name, title, and telephone num-
ber of a contact person submitting the
application.

(4) Provide all appropriate supporting
documentation for each answer made
on the loan application.

Subpart B—Forgiveness of
Indebtedness

SOURCE: 71 FR 48144, Aug. 18, 2006, unless
otherwise noted.

§ 505.13 **Conditions for loan forgive-
ness.**

The Secretary may forgive a loan
provided under this part if the quali-
fying hospital—

(a) Has been selected to participate
in the loan program specified in
§505.5(c).

(b) Has established the following in
accordance with a plan that meets the
criteria specified in §505.15:

(1) An outreach program for cancer
prevention, early diagnosis, and treat-
ment that provides services to a sub-
stantial majority of the residents of a
State or region, including residents of
rural areas;

(2) An outreach program for cancer
prevention, early diagnosis, and treat-
ment that provides services to multiple
Indian tribes; and

(3) Unique research resources (such
as population databases) or an affili-
ation with an entity that has unique
research resources.

(c) Submits to CMS, within the time-
frame specified by the Secretary, a—

(1) Written request for loan forgive-
ness; and

(2) Loan forgiveness plan that meets
the criteria specified in §505.15 of this
subpart.

§ 505.15 **Plan criteria for meeting the
conditions for loan forgiveness.**

The qualifying hospital requesting
loan forgiveness must submit to CMS a
plan specifying how it will develop, im-
plement, or maintain an existing out-
reach program for cancer prevention,
early diagnosis, and treatment for a
substantial majority of the residents of
a State or region, including residents
of rural areas and for multiple Indian
tribes and specifying how the quali-
fying hospital will establish or main-
tain existing unique research resources
or an affiliation with an entity that
has unique research resources.

(a) **Outreach programs.** The initial
plan must specify how the hospital will
establish or develop, implement, or
maintain existing outreach programs. The plan must—
(1) Address cancer prevention for cancers that are prevalent in the designated populations or cancers that are targeted by the qualifying hospital, interventions, and goals for decreasing the targeted cancer rates during the loan deferment program; and
(2) Address early diagnosis of cancers that are prevalent in the designated populations or cancers that are targeted by the qualifying hospital, interventions, and goals for improving early diagnosis rates for the targeted cancer(s) during the loan deferment period;
(3) Address cancer treatment for cancers that are prevalent in the designated populations or cancers that are targeted by the qualifying hospital, interventions, and goals for improving cancer treatment rates for the targeted cancer(s) during the loan deferment; and
(4) Identify the measures that will be used to determine the qualifying hospital’s annual progress in meeting the initial goals specified in paragraphs (a)(1) through (a)(3) of this section.
(b) Unique research resources. The plan must specify how the qualifying hospital will establish or maintain existing unique research resources or an affiliation with an entity that has unique research resources.

§ 505.17 Reporting requirements for meeting the conditions for loan forgiveness.

(a) Annual reporting requirements. On an annual basis, beginning one year from the date that CMS notified the qualifying hospital of the loan award, the qualifying hospital must submit a report to CMS that updates the plan specified in §505.15 by—
(1) Describing the qualifying hospital’s progress in meeting its initial plan goals;
(2) Describing any changes to the qualifying hospital’s initial plan goals; and
(3) Including at least one measure used to track the qualifying hospital’s progress in meeting its plan goals.
(b) Review of annual reports. CMS will review each qualifying hospital’s annual report to provide the hospital with feedback regarding its loan forgiveness status. If CMS determines that the annual report shows that the qualifying hospital has fulfilled the conditions, plan criteria, and reporting requirements for loan forgiveness specified in §§505.13, 505.15, and 505.17, CMS will notify the qualifying hospital in writing that the loan is forgiven.

(c) Final annual reporting requirements. A qualifying hospital must submit its final report to CMS at least 6 months before the end of the loan deferment period specified in §505.7(b).

§ 505.19 Approval or denial of loan forgiveness.

(a) Approval of loan forgiveness. If CMS determines that a qualifying hospital has met the conditions, plan criteria, and reporting requirements for loan forgiveness specified in §§505.13, 505.15, and 505.17, CMS will send a written notification of approval for loan forgiveness to the qualifying hospital by the earlier of—
(1) 30 days from the date of receipt of the annual report that shows the qualifying hospital has satisfied the requirements for loan forgiveness; or
(2) 90 days before the end of the loan deferment period defined in §505.7(b).
(b) Denial of loan forgiveness. If CMS determines that a qualifying hospital has not met the conditions, plan criteria, or reporting requirements for loan forgiveness specified in §505.13, §505.15, or §505.17 of this part, CMS will send a written notification of denial of loan forgiveness to the qualifying hospital at least 30 days before the end of the loan deferment period defined in §505.7(b).
§ 510.2 Definitions.

For the purposes of this part, the following definitions are applicable unless otherwise stated:

ACO stands for accountable care organization.

Actual episode payment means the sum of Medicare claims payments for items and services that are included in the episode in accordance with § 510.200(b), excluding the items and services described in § 510.200(d).

Alignment payment means a payment from a CJR collaborator to a participant hospital under a sharing arrangement, for only the purpose of sharing the participant hospital’s responsibility for repayments to Medicare.

Anchor hospitalization means the initial hospital stay upon admission for a lower extremity joint replacement.

BPCI stands for the Bundled Payment for Care Improvement initiative.

CCN stands for CMS certification number.

CEC stands for Comprehensive ESRD Care Initiative.

CJR collaborator means one of the following Medicare-enrolled persons or
entities that enters into a sharing arrangement:

1. Skilled nursing facility (SNF).
2. Home health agency (HHA).
3. Long-term care hospital (LTCH).
4. Inpatient rehabilitation facility (IRF).
5. Physician.
7. Provider or supplier of outpatient therapy services.
8. Physician group practice (PGP).

CJR reconciliation report means the report prepared after each reconciliation that CMS provides to each participant hospital notifying the participant hospital of the outcome of the reconciliation.

Collaborator agreement means a written, signed agreement between a CJR collaborator and a participant hospital that meets the requirements of §510.500(c).

Composite quality score means a score computed for each participant hospital to summarize the hospital's level of quality performance and improvement on specified quality measures as described in §510.315.

Core-based statistical area (CBSA) means a statistical geographic entity consisting of the county or counties associated with at least one core (urbanized area or urban cluster) of at least 10,000 population, plus adjacent counties having a high degree of social and economic integration with the core as measured through commuting ties with the counties containing the core.

Critical access hospital (CAH) means a hospital designated under subpart F of part 485 of this chapter.

Distribution arrangement means a financial arrangement between a PGP that is a CJR collaborator and a practice collaboration agent in which the PGP distributes some or all of a gainsharing payment that it received from a participant hospital.

Distribution payment means a payment made by a PGP that is a CJR collaborator to a practice collaboration agent under a distribution arrangement.

DME stands for durable medical equipment.

EFT stands for electronic funds transfer.

Episode of care (or Episode) means all Medicare Part A and B items and services described in §510.200(b) (and excluding the items and services described in §510.200(d)) that are furnished to a beneficiary described in §510.205 during the time period that begins with the beneficiary's admission to an anchor hospitalization and ends on the 90th day after the date of discharge from the anchor hospitalization, with the day of discharge itself being counted as the first day of the 90-day post-discharge period.

Episode target price means the amount determined in accordance with §510.300 and applied to an episode in determining a net payment reconciliation amount.

ESRD stands for end stage renal disease.

Gainsharing payment means a payment from a participant hospital to a CJR collaborator, under a sharing arrangement, composed of only reconciliation payments or internal cost savings or both.

HCAHPS stands for Hospital Consumer Assessment of Healthcare Providers and Systems.

HCPCS stands for CMS Common Procedure Coding System.

HHA stands for home health agency. Historical episode payment means the most recent 3 years of expenditures for an episode in a given participant hospital.

ICD-CM stands for International Classification of Diseases, Clinical Modification.

Inpatient prospective payment systems (IPPS) means the payment systems for subsection (d) hospitals as defined in section 1886(d)(1)(B) of the Act.

Internal cost savings means the measurable, actual, and verifiable cost savings realized by the participant hospital resulting from care redesign undertaken by the participant hospital in connection with providing items and services to beneficiaries within specific CJR episodes of care. Internal cost savings does not include savings realized by any individual or entity that is not the participant hospital.

IPF stands for inpatient psychiatric facility.

IPPS hospital (or hospital) means a provider subject to the prospective
Centers for Medicare & Medicaid Services, HHS

§ 510.2

payment system specified in § 412.1(a)(1) of this chapter.

IRF stands for inpatient rehabilitation facility.

Lower-extremity joint replacement (LEJR) means any procedure that is within MS–DRG 469 or 470, including lower-extremity joint replacement procedures or reattachment of a lower extremity.

LTCH stands for long-term care hospital.

Medicare severity diagnosis-related group (MS–DRG) means, for the purposes of this model, the classification of inpatient hospital discharges updated in accordance with § 412.10 of this chapter.

Medicare-dependent, small rural hospital (MDH) means a specific type of hospital that meets the classification criteria specified under § 412.108 of this chapter.

Member of the PGP or PGP member means a physician, nonphysician practitioner, or therapist who is an owner or employee of the PGP and who has reassigned to the PGP his or her right to receive Medicare payment.

Metropolitan Statistical Area (MSA) means a core-based statistical area associated with at least one urbanized area that has a population of at least 50,000.

Net payment reconciliation amount (NPRA) means the amount determined in accordance with § 510.305(e).

Nonphysician practitioner means (except for purposes of subpart G of this part) one of the following:

1. A physician assistant who satisfies the qualifications set forth at § 410.74(a)(2)(i) and (ii) of this chapter.

2. A nurse practitioner who satisfies the qualifications set forth at § 410.75(b) of this chapter.

3. A clinical nurse specialist who satisfies the qualifications set forth at § 410.76(b) of this chapter.

4. A certified registered nurse anesthetist (as defined at § 410.69(b)).

5. A clinical social worker (as defined at § 410.73(a)).

6. A registered dietitian or nutrition professional (as defined at § 410.134).

NPI stands for National Provider Identifier.


PAC stands for post-acute care.

Participant hospital means an IPPS hospital (other than those hospitals specifically excepted under § 510.100(b)) with a CCN primary address in one of the geographic areas selected for participation in the CJR model in accordance with § 510.105, as of the date of selection or any time thereafter during any performance period.

PBPM stands for per-beneficiary-per-month.

Performance year means one of the years in which the CJR model is being tested. Performance years for the model correlate to calendar years with the exception of performance year 1, which is April 1, 2016 through December 31, 2016.

PGP stands for physician group practice.

Physician has the meaning set forth in section 1861(r) of the Act.

Post-episode spending amount means the sum of Medicare Parts A and B payments for items and services that are furnished to a beneficiary within 30 days after the end of the beneficiary’s episode.

Practice collaboration agent means a PGP member who has entered into a distribution arrangement with the same PGP of which he or she is a member and who has not entered into a collaborator agreement with a participant hospital.

Provider of outpatient therapy services means a provider or supplier furnishing one or more of the following:

1. Outpatient physical therapy services as defined in § 410.60 of this chapter.

2. Outpatient occupational therapy services as defined in § 410.59 of this chapter.

3. Outpatient speech-language pathology services as defined in § 410.62 of this chapter.

Quality improvement points are points that CMS adds to a participant hospital’s composite quality score for a measure if the hospital’s performance percentile on an individual quality measure increases from the previous performance year by at least 3 deciles on the performance percentile scale.
§ 510.100  Episodes being tested.

(a) Initiation of an episode. An episode is initiated when a participant hospital admits a Medicare beneficiary described in §510.205 for an anchor hospitalization.

(b) Exclusions. A hospital is excluded from being a participant hospital, but only so long as any of the following conditions apply:

(1) The hospital is an episode initiator for an LEJR episode in the risk-bearing period of Models 2 or 4 of BPCI.

(2) The hospital is participating in Model 1 of BPCI.

(3) These exclusions cease to apply as of the date that the hospital no longer meets any of the conditions specified in this paragraph.

§ 510.105  Geographic areas.

(a) General. The geographic areas for inclusion in the CJR model are obtained based on a stratified random sampling of certain MSAs in the United States. All counties within each of the selected MSAs are selected for inclusion in the CJR model.

(b) Stratification criteria. Geographic areas in the United States are stratified according to the characteristics that CMS determines are necessary to ensure that the model is tested on a broad range of different types of hospitals that may face different obstacles and incentives for improving quality and controlling costs.

(c) Exclusions. CMS excludes from the selection of geographic areas MSAs that met the following criteria:

(1) Had fewer than 400 episodes between July 1, 2013 and June 30, 2014.

(2) Had fewer than 400 non-Model 1, 2, or 4 BPCI episodes as of October 1, 2015.

(3) Failed either or both of the following rules regarding participation in BPCI:

(i) More than 50 percent of eligible episodes initiated in a BPCI Model 2 or 4 initiating hospital.

(ii) More than 50 percent of eligible episodes that included SNF or HHA services, where the SNF or HHA services were furnished by a BPCI Model 3 initiating HHA or SNF.

(4) For MSAs including both Maryland and non-Maryland counties, more than 50 percent of eligible episodes were initiated at a Maryland hospital.
Subpart C—Scope of Episodes

§ 510.200 Time periods, included and excluded services, and attribution.

(a) **Time periods.** All episodes must begin on or after April 1, 2016 and end on or before December 31, 2020.

(b) **Included services.** All Medicare Parts A and B items and services are included in the episode, except as specified in paragraph (d) of this section. These services include, but are not limited to, the following:

1. Physicians’ services.
2. Inpatient hospital services (including hospital readmissions).
3. IPF services.
4. LTCH services.
5. IRF services.
6. SNF services.
7. HHA services.
8. Hospital outpatient services.
9. Outpatient therapy services.
10. Clinical laboratory services.
11. DME.
12. Part B drugs and biologicals.
13. Hospice services.
14. PBPM payments under models tested under section 1115A of the Act.

(c) **Episode attribution.** All items and services included in the episode are attributed to the participant hospital at which the anchor hospitalization occurs.

(d) **Excluded services.** The following items, services, and payments are excluded from the episode:

1. Hemophilia clotting factors provided in accordance with §412.115 of this chapter.
2. New technology add-on payments, as defined in part 412, subpart F of this chapter.
3. Transitional pass-through payments for medical devices as defined in §419.66 of this chapter.
4. Items and services unrelated to the anchor hospitalization, as determined by CMS. Excluded services include, but are not limited to, the following:
   i. Inpatient hospital admissions for MS–DRGs that group to the following categories of diagnoses:
      A. Oncology.
      B. Trauma medical.
      C. Chronic disease surgical, such as prostatectomy.
   ii. Medicare Part B services, as identified by the principal ICD–CM diagnosis code on the claim (based on the ICD–CM version in use during the performance year) that group to the following categories of diagnoses:
      A. Acute disease diagnoses, such as severe head injury.
      B. Certain chronic disease diagnoses, as specified by CMS on a diagnosis-by-diagnosis basis depending on whether the condition was likely to have been affected by the LEJR procedure and recovery period or whether substantial services were likely to be provided for the chronic condition during the episode. Such chronic disease diagnoses are posted on the CMS Web site and may be revised in accordance with paragraph (e) of this section.
      C. Certain PBPM payments under models tested under section 1115A of the Act. PBPM model payments that CMS determines to be primarily used for care coordination or care management services for clinical conditions in excluded categories of diagnoses, as described in this paragraph.
      D. Acute disease surgical, such as appendectomy.
   iii. Certain PBPM payments under models tested under section 1115A of the Act. PBPM model payments that CMS determines to be primarily used for care coordination or care management services for clinical conditions in excluded categories of diagnoses, as described in this paragraph.
   iv. Certain incentive programs and add-on payments under existing Medicare payment systems in accordance with §510.300(b)(6) of this chapter.
   v. Payments for otherwise included items and services in excess of 2 standard deviations above the mean regional episode payment in accordance with §510.300(b)(5) of this chapter.

(e) **Updating the lists of excluded services.**
   1. The list of excluded MS–DRGs, ICD–CM diagnosis codes, and CMS model PBPM payments are posted on the CMS Web site.
   2. On an annual basis, or more frequently as needed, CMS updates the list of excluded services to reflect annual coding changes or other issues brought to CMS’s attention.
   3. CMS applies the following standards when revising the list of excluded
services for reasons other than to reflect annual coding changes:
  (i) Items or services that are directly related to the LEJR procedure or the quality or safety of LEJR care would be included in the episode.
  (ii) Items or services for chronic conditions that may be affected by the LEJR procedure or post-surgical care would be related and included in the episode.
  (iii) Items and services for chronic conditions that are generally not affected by the LEJR procedure or post-surgical care would be excluded from the episode.
  (iv) Items and services for acute clinical conditions not arising from existing, episode-related chronic clinical conditions or complications of LEJR surgery would be excluded from the episode.
  (v) PBPM payments under CMS models determined to be primarily used for care coordination or care management services for clinical conditions in excluded categories of diagnoses, as described in §510.200(d), would be excluded from the episode.
(b) CMS posts the following to the CMS Web site:
  (i) Potential revisions to the exclusion list for public comment; and
  (ii) An updated exclusions list after consideration of public comment.
§ 510.205 Beneficiary inclusion criteria.
(a) Episodes tested in the CJR model include only those in which care is furnished to beneficiaries who meet all of the following criteria upon admission to the anchor hospitalization:
  (1) Are enrolled in Medicare Parts A and Part B.
  (2) Eligibility for Medicare is not on the basis of end stage renal disease, as described in §406.13 of this chapter.
  (3) Are not enrolled in any managed care plan (for example, Medicare Advantage, health care prepayment plans, or cost-based health maintenance organizations).
  (4) Are not covered under a United Mine Workers of America health care plan.
  (5) Have Medicare as their primary payer.
(b) If at any time during the episode a beneficiary no longer meets all of the criteria in this section, the episode is canceled in accordance with §510.210(b).
§ 510.210 Determination of the episode.
(a) General. The episode begins with the admission of a Medicare beneficiary described in §510.205 to a participant hospital for an anchor hospitalization and ends on the 90th day after the date of discharge, with the day of discharge itself being counted as the first day in the 90-day post-discharge period.
(b) Cancellation of an episode. The episode is canceled and is not included in the determination of NPRA as specified in §510.205 if the beneficiary does any of the following during the episode:
  (1) Ceases to meet any criterion listed in §510.205.
  (2) Is readmitted to any participant hospital for another anchor hospitalization.
  (3) Initiates an LEJR episode under BPCI.
  (4) Dies.
Subpart D—Pricing and Payment
§ 510.300 Determination of episode target prices.
(a) General. CMS establishes episode target prices for participant hospitals for each performance year of the model as specified in this section. Episode target prices are established according to the following:
  (1) MS–DRG assigned at discharge for anchor hospitalization and presence of hip fracture diagnosis for anchor hospitalization—
    (i) MS–DRG 469 with hip fracture;
    (ii) MS–DRG 469 without hip fracture;
    (iii) MS–DRG 470 with hip fracture;
    (iv) MS–DRG 470 without hip fracture.
  (2) Applicable time period for performance year episode target prices. Episode target prices are updated to account for Medicare payment updates no less than 2 times per year, for updated episode target prices effective October 1 and January 1, and at other intervals if necessary.
  (3) Episodes that straddle performance years or payment updates. The episode
target price that applies to the type of episode as of the date of admission for the anchor hospitalization is the episode target price that applies to the episode.

(4) Identifying episodes with hip fracture. CMS develops a list of ICD–CM hip fracture diagnosis codes that, when reported in the principal diagnosis code files on the claim for the anchor hospitalization, represent a bone fracture for which a hip replacement procedure, either a partial hip arthroplasty or a total hip arthroplasty, could be the primary surgical treatment. The list of ICD–CM hip fracture diagnosis codes used to identify hip fracture episodes is posted on the CMS Web site.

(i) On an annual basis, or more frequently as needed, CMS updates the list of ICD–CM hip fracture diagnosis codes to reflect coding changes or other issues brought to CMS’ attention.

(ii) CMS applies the following standards when revising the list of ICD–CM hip fracture diagnosis codes.

(A) The ICD–CM diagnosis code is sufficiently specific that it represents a bone fracture for which a physician could determine that a hip replacement procedure, either a PHA or a THA, could be the primary surgical treatment.

(B) The ICD–CM diagnosis code is the primary reason (that is, principal diagnosis code) for the anchor hospitalization.

(iii) CMS posts the following to the CMS Web site:

(A) Potential ICD–CM hip fracture diagnosis codes for public comment; and

(B) A final ICD–CM hip fracture diagnosis code list after consideration of public comment.

(b) Episode target price. (1) CMS calculates episode target prices based on a blend of each participant hospital’s hospital-specific and regional episode expenditures. The region corresponds to the U.S. Census Division associated with the primary address of the CCN of the participant hospital and the regional component is based on all hospitals in said region, except as follows. In cases where an MSA selected for participation in CJR spans more than one U.S. Census Division, the entire MSA will be grouped into the U.S. Census Division where the largest city by population in the MSA is located for target price and reconciliation calculations. The calendar years used for historical expenditure calculations are as follows:

(i) Episodes beginning in 2012 through 2014 for performance years 1 and 2.


(iii) Episodes beginning in 2016 through 2018 for performance year 5.

(2) Specifically, the blend consists of the following:

(i) Two-thirds of the participant hospital’s own historical episode payments and one-third of the regional historical episode payments for performance years 1 and 2.

(ii) One-third of the hospital’s own historical episode payments and two-thirds of the regional historical episode payments for performance year 3.

(iii) Regional historical episode payments for performance years 4 and 5.

(3) Exception for low-volume hospitals. Episode target prices for participant hospitals with fewer than 20 CJR episodes in total across the 3 historical years of data used to calculate the episode target price are based on 100 percent regional historical episode payments.

(4) Exception for recently merged or split hospitals. Hospital-specific historical episode payments for participant hospitals that have undergone a merger, consolidation, spin off or other reorganization that results in a new hospital entity without 3 full years of historical claims data are determined using the historical episode payments attributed to their predecessor(s).

(5) Exception for high episode spending. Episode payments are capped at 2 standard deviations above the mean regional episode payment for both the hospital-specific and regional components of the target price.

(6) Exclusion of incentive programs and add-on payments under existing Medicare payment systems. Certain incentive programs and add-on payments are excluded from historical episode payments by using the CMS Price (Payment) Standardization Detailed Methodology used for the Medicare spending
§ 510.305 Determination of the NPRA and reconciliation process.

(a) General. Providers and suppliers furnishing items and services included in the episode bill for such items and services in accordance with existing rules and as if this part were not in effect.

(b) Reconciliation. CMS uses a series of reconciliation processes, which CMS performs as described in paragraphs (d) and (f) of this section after the end of each performance year, to establish final payment amounts to participant hospitals for CJR episodes for a given performance year. Following the end of each performance year, CMS determines actual episode payments for each episode for the performance year (other than episodes that have been canceled in accordance with §510.210(b)) and determines the amount of a reconciliation payment or repayment amount.

(c) Data used. CMS uses the most recent claims data available to perform each reconciliation calculation.

(d) Annual reconciliation.

(1) Beginning 2 months after the end of each performance year, CMS performs a reconciliation calculation to establish an NPRA for each participant hospital. (2) CMS—

(i) Calculates the NPRA for each participant hospital in accordance with paragraph (e) of this section including the adjustments provided for in paragraph (e)(1)(iv) of this section; and

(ii) Assesses whether hospitals meet specified quality requirements under §510.315.

(e) Calculation of the NPRA. By comparing the episode target prices described in §510.300 and the participant hospital’s actual episode spending for...
the performance year and applying the adjustments in paragraph (e)(1)(v) of this section, CMS establishes an NPRA for each participant hospital for each performance year.

(1) Initial calculation. In calculating the NPRA for each participant hospital for each performance year, CMS does the following:

(i) Determines actual episode payments for each episode included in the performance year (other than episodes that have been canceled in accordance with §510.210(b)) using claims data that is available 2 months after the end of the performance year. Actual episode payments are capped at the amount determined in accordance with §510.300(b)(5) for the performance year.

(ii) Multiplies each episode target price, after applying any reduction to the discount percentage as provided in §510.315(f) by the number of episodes included in the performance year (other than episodes that have been canceled in accordance with §510.210(b)) to which that episode target price applies.

(iii) Aggregates the amounts computed in paragraph (e)(1)(ii) of this section for all episodes included in the performance year (other than episodes that have been canceled in accordance with §510.210(b)).

(iv) Subtracts the amount determined under paragraph (e)(1)(i) of this section from the amount determined under paragraph (e)(1)(iii) of this section.

(v) Makes the following adjustments:

(A) Increases in post-episode spending. If the average post-episode Medicare Parts A and B spending for a participant hospital in any given performance year is greater than 3 standard deviations above the regional average post-episode spending for the same performance year, then the spending amount exceeding three standard deviations above the regional average post-episode spending for the same performance year is applied to the NPRA.

(B) Limitation on loss. Except as provided in paragraph (e)(1)(v)(D) of this section, the total amount any participant hospital is responsible for repaying to Medicare for a performance year cannot exceed the following:

(1) For performance year 2 only, 5 percent of the amount calculated in paragraph (e)(1)(iii) of this section for the performance year.

(2) For performance year 3, 10 percent of the amount calculated in paragraph (e)(1)(iii) of this section for the performance year.

(3) For performance years 4, and 5, 20 percent of the amount calculated in paragraph (e)(1)(iii) of this section for the performance year.

(4) As provided in paragraph (h)(6)(i) of this section, the subsequent reconciliation calculation reassesses the limitation on loss for a given performance year by applying the limitations on loss to the aggregate of the 2 reconciliation calculations.

(C) Limitation on gain. The total amount of any reconciliation payment made to a participant hospital for a performance year cannot exceed the following:

(1) For performance years 1 and 2, 5 percent of the amount calculated in paragraph (e)(1)(iii) of this section for the performance year.

(2) For performance year 3, 10 percent of the amount calculated in paragraph (e)(1)(iii) of this section for the performance year.

(3) For performance years 4, and 5, 20 percent of the amount calculated in paragraph (e)(1)(iii) of this section for the performance year.

(4) As provided in paragraph (h)(6)(i) of this section, the subsequent reconciliation calculation reassesses the limitation on gain for a given performance year by applying the limitation on gain limits to the aggregate of the two reconciliation calculations.

(D) Financial loss limits for rural hospitals, SCHs, MDHs, and RRCs. If a participant hospital is a rural hospital, SCH, MDH or RRC, then for performance year 2, the total repayment amount for which the participant hospital is responsible cannot exceed 3 percent of the amount calculated in paragraph (e)(1)(iii) of this section. For performance years 3 through 5, the total repayment amount cannot exceed 5 percent of the amount calculated in paragraph (e)(1)(iii) of this section.

(f) Determination of reconciliation or repayment amount—(1) Determination of the reconciliation or repayment amount.

(i) Subject to paragraph (f)(1)(ii) of this section, for performance year 1,
§ 510.305  

the reconciliation payment (if any) is equal to the NPRA.

(ii) Subject to paragraph (f)(1)(iii) of this section, for performance years 2 through 5, results from the subsequent reconciliation calculation for a prior year’s reconciliation, as described in paragraph (h)(6)(i) of this section, are applied to the current year’s NPRA in order to determine the reconciliation or repayment amount.

(iii) The reconciliation or repayment amount may be adjusted as provided in §510.410(b).

(2) Reconciliation payment. If the amount described in paragraph (f)(1) of this section is positive and the composite quality score described in §510.315 is acceptable (defined as greater than or equal to 4.00), good (defined as greater than or equal to 6.0 and less than or equal to 13.2), or excellent (defined as greater than 13.2), Medicare pays the participant hospital a reconciliation payment in an amount equal to the amount described in paragraph (f)(1) of this section.

(3) Repayment amount. If the amount described in paragraph (f)(1) of this section is negative, the participant hospital pays to Medicare an amount equal to the amount described in paragraph (f)(1) of this section, in accordance with §405.371 of this chapter. CMS waives this requirement for performance year 1.

(g) Determination of eligibility for reconciliation based on quality. (1) CMS assesses each participant hospital’s performance on quality metrics, as described in §510.315, to determine whether the participant hospital is eligible to receive a reconciliation payment for a performance year.

(2) If the hospital’s composite quality score described in §510.315 is acceptable (defined as greater than or equal to 4.00), good (defined as greater than or equal to 6.0 and less than or equal to 13.2), or excellent (defined as greater than 13.2), and the hospital is determined to have a positive NPRA under §510.305(e), the hospital is eligible for a reconciliation payment.

(3) If the hospital’s composite quality score described in §510.315 is below acceptable, defined as less than 4.00 for a performance year, the hospital is not eligible for a reconciliation payment.

(4) If the hospital is found to be engaged in an inappropriate and systemic under delivery of care, the quality of the care provided must be considered to be seriously compromised and the hospital must be ineligible to receive or retain a reconciliation payment for any period in which such under delivery of care was found to occur.

(h) Reconciliation report. CMS issues each participant hospital a CJR reconciliation report for the performance year. Each CJR reconciliation report contains the following:

(1) Information on the participant hospital’s composite quality score described in §510.315.

(2) The total actual episode payments for the participant hospital.

(3) The NPRA.

(4) Whether the participant hospital is eligible for a reconciliation payment or must make a repayment to Medicare.

(5) The NPRA and subsequent reconciliation calculation amount for the previous performance year, as applicable.

(6) The reconciliation payment or repayment amount.

(1) Subsequent reconciliation calculation. (A) Fourteen months after the end of each performance year, CMS performs an additional calculation, using claims data available at that time, to account for final claims run-out and any additional overlap between the CJR model and other CMS models and programs as described in paragraph (h)(6)(i)(B) of this section.

(B) The subsequent reconciliation calculation accounts for cases in which a portion of the CJR discount percentage is paid out to an ACO as shared savings by reducing the reconciliation payment amount for a CJR hospital, if available, by the amount of the discount percentage paid out to the ACO as shared savings. This adjustment is only made when the participant hospital is a participant or provider/supplier in the ACO and the beneficiary in the CJR episode is assigned to one of the following ACO models or program:

(1) The Pioneer ACO model.

(2) The Medicare Shared Savings Program.

(3) The Next Generation ACO model.
(d) The Comprehensive ESRD Care Initiative.
(C) The additional calculation occurs concurrently with the reconciliation process for the most recent performance year. If the result of the subsequent calculation is different than zero, CMS applies the stop-loss and stop-gain limits in paragraph (e) of this section to the calculations in aggregate for that performance year (the initial reconciliation and the subsequent calculation) to ensure the amount does not exceed the stop-loss or stop-gain limits. CMS then applies the subsequent calculation amount to the NPRA for the most recent performance year in order to determine the reconciliation amount or repayment amount for the most recent performance year. Because hospitals will not have financial repayment responsibility for performance year 1, for the performance year 2 reconciliation report only, the subsequent calculation amount (for performance year 1) is applied to the performance year 1 NPRA to ensure that the combined amount is not less than 0. If the combined performance year 1 NPRA and subsequent calculation for performance year 1 is less than 0, the subsequent calculation amount would be capped at the value that would result in a net amount of 0 for the combined performance year 1 NPRA and subsequent calculation.

[80 FR 73540, Nov. 24, 2015, as amended at 81 FR 11451, Mar. 4, 2016]

§510.310 Appeals process.

(a) Notice of calculation error (first level of appeal). Subject to the limitations on review in subpart d of this part, if a participant hospital wishes to dispute the calculation that involves a matter related to payment, reconciliation amounts, repayment amounts, or determinations associated with quality measures affecting payment, the hospital is required to provide written notice of the error, in a form and manner specified by CMS.

(1) Unless the participant hospital provides such notice, the CJR reconciliation report is deemed final 45 calendar days after it is issued.

(2) If CMS receives a timely notice of a calculation error, CMS responds in writing within 30 calendar days to either confirm that there was an error in the calculation or verify that the calculation is correct, although CMS reserves the right to an extension upon written notice to the participant hospital.

(3) If a participant hospital does not submit timely notice of a calculation error in accordance with the timelines and processes specified by CMS, then CMS deems the CJR reconciliation report and proceeds with the payment or repayment processes, as applicable.

(4) Only participant hospitals may use the dispute resolution process described in this part.

(b) Dispute resolution process (second level of appeal). (1) If the participant hospital is dissatisfied with CMS’s response to the notice of a calculation error, the participant hospital may request a reconsideration review in a form and manner as specified by CMS.

(2) The reconsideration review request must provide a detailed explanation of the basis for the dispute and include supporting documentation for the participant hospital’s assertion that CMS or its representatives did not accurately calculate the NPRA, the reconciliation payment, or the repayment amount in accordance with §510.305.

(3) If CMS does not receive a request for reconsideration from the participant hospital within 10 calendar days of the issue date of CMS’s response to the participant hospital’s notice of calculation error, then CMS’s response to the calculation error is deemed final and CMS proceeds with reconciliation payment or repayment processes, as applicable, as described in §510.305.

(4) A CMS reconsideration official notifies the participant hospital in writing within 15 calendar days of receiving the participant hospital’s review request of the following:

(i) The date, time, and location of the review.

(ii) The issues in dispute.

(iii) The review procedures.

(iv) The procedures (including format and deadlines) for submission of evidence.

(5) The CMS reconsideration official takes all reasonable efforts to schedule the review to occur no later than 30
§ 510.315

Composite quality scores for determining reconciliation payment eligibility and quality incentive payments.

(a) General. A participant hospital’s eligibility for a reconciliation payment under §510.305(g), and the determination of quality incentive payments under paragraph (f) of this section, for a performance year depend on the hospital’s composite quality score (including any quality performance points and quality improvement points earned) for that performance year.

(b) Composite quality score. CMS calculates a composite quality score for each participant hospital for each performance year, which equals the sum of the following:

(1) The hospital’s quality performance points for the hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty measure (NQF #1550) described in §510.400(a)(1). This measure is weighted at 50 percent of the composite quality score.

(2) The hospital’s quality performance points for the Hospital Consumer Assessment of Healthcare Providers and Systems Survey measure (NQF #0166) described in §510.400(a)(2). This measure is weighted at 40 percent of the composite quality score.

(3) Any additional quality improvement points the hospital may earn as a result of demonstrating improvement on either or both of the quality measures in paragraphs (b)(1) and (2) of this section, as described in paragraph (d) of this section.

(4) If applicable, 2 additional points for successful THA/TKA voluntary data submission of patient-reported outcomes and limited risk variable data, as described in §510.400(b). Successful submission is weighted at 10 percent of the composite quality score.

(c) Quality performance points. CMS computes quality performance points for each quality measure based on the participant hospital’s performance percentile relative to the national distribution of all hospitals’ performance on that measure.

(1) For the hospital-level risk-standardized complication rate following elective primary total hip arthroplasty...
and/or total knee arthroplasty measure (NQF #1550) described in §510.400(a)(1), CMS assigns the participant hospital measure value to a performance percentile and then quality performance points are assigned based on the following performance percentile scale:

(i) 10.00 points for ≥90th.
(ii) 9.25 points for ≥80th and <90th.
(iii) 8.50 points for ≥70th and <80th;
(iv) 7.75 points for ≥60th and <70th.
(v) 7.00 points for ≥50th and <60th.
(vi) 6.25 points for ≥40th and <50th.
(vii) 5.50 points for ≥30th and <40th.
(viii) [Reserved]
(ix) 0.0 points for <30th.

(2) For the Hospital Consumer Assessment of Healthcare Providers and Systems Survey measure (NQF #0166) described in §510.400(a)(2), CMS assigns the participant hospital measure value to a performance percentile and quality performance points are assigned based on the following performance percentile scale:

(i) 8.00 points for ≥90th.
(ii) 7.40 points for ≥80th and <90th.
(iii) 6.80 points for ≥70th and <80th.
(iv) 6.20 points for ≥60th and <70th.
(v) 5.60 points for ≥50th and <60th.
(vi) 5.00 points for ≥40th and <50th.
(vii) 4.40 points for ≥30th and <40th.
(viii) [Reserved]
(ix) 0.0 points for <30th.

(d) Quality improvement points. If a participant hospital’s quality performance percentile on an individual measure described in §510.400(a) increases from the previous performance year by at least 3 deciles on the performance percentile scale, then the hospital is eligible to receive quality improvement points equal to 10 percent of the total available points for that individual measure.

(e) Exception for hospitals without a measure value. In the case of a participant hospital without a measure value that would allow CMS to assign quality performance points for that quality measure, CMS assigns the 50th percentile quality performance points to the hospital for the individual measure.

(1) A participant hospital will not have a measure value for the—

(i) Hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty measure (NQF #1550) described in §510.400(a)(1) if the hospital does not meet the minimum 25 case count; or

(ii) Hospital Consumer Assessment of Healthcare Providers and Systems Survey measure (NQF #0166) described in §510.400(a)(2) if the hospital does not meet the minimum of 100 completed survey and does not have 4 consecutive quarters of HCAHPS data.

(f) Quality incentive payments. CMS provides incentive payments to participant hospitals that demonstrate good or excellent quality performance on the composite quality scores described in paragraph (b) of this section. These incentive payments are implemented in the form of the following reductions to the applicable discount factors described in §510.300(c):

(1) A 1.0 percentage point reduction to the applicable discount factor for participant hospitals with good quality performance, defined as composite quality scores that are greater than or equal to 6.0 and less than or equal to 13.2.

(2) A 1.5 percentage point reduction to the applicable discount factor for participant hospitals with excellent quality performance, defined as composite quality scores that are greater than 13.2.

§510.320 Treatment of incentive programs or add-on payments under existing Medicare payment systems.

The CJR model does not replace any existing Medicare incentive programs or add-on payments. The target price and NPRAs for a participant hospital are independent of, and do not affect, any incentive programs or add-on payments under existing Medicare payment systems.

§510.325 Allocation of payments for services that straddle the episode.

(a) General. Services included in the episode that straddle the episode are prorated so that only the portion attributable to care furnished during the
§ 510.400  Quality measures and reporting.

(a) Reporting of quality measures. The following quality measures are used for public reporting, for determining whether a participant hospital is eligible for reconciliation payments under §510.305(g), and whether a participant hospital is eligible for quality incentive payments under §510.315(f) in the performance year:

1. Hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty.


(b) Requirements for successful voluntary data submission of patient-reported outcomes and limited risk variable data. To be eligible to receive the additional points added to the composite quality score for successful voluntary data submission of patient-reported outcomes and limited risk variable data, as described in §510.315(b)(4), participant hospitals must submit the THA/TKA patient-reported outcome and limited risk variable data requested by CMS related to the pre- and post-operative periods for elective primary total hip and/or total knee arthroplasty procedures. The data must be submitted within 60 days of the end of the most recent performance period and be accompanied by the patient-reported outcomes and limited risk variable data, as outlined in §510.315(b)(4).

1. For each eligible procedure all eleven risk variable data elements are required to be submitted. The eleven risk variables are as follows:

(i) Date of birth.
(ii) Race.
(iii) Ethnicity.
(iv) Date of admission to anchor hospitalization.
(v) Medicare Health Insurance Claim Number.
(vi) Body mass index.
(vii) Use of chronic (>90 day) narcotics.
(ix) Total painful joint count.
(x) Quantified spinal pain.
(xi) Single Item Health Literacy Screening (SILS2) questionnaire.

2. Hospitals must also submit the amount of requested THA/TKA patient-reported outcomes data required for...
Centers for Medicare & Medicaid Services, HHS

§ 510.405

Beneficiary choice and beneficiary notification.

(a) Beneficiary choice. The CJR model does not restrict Medicare beneficiaries’ ability to choose any Medicare enrolled provider or supplier, or any physician or practitioner who has opted out of Medicare.

(b) Pre-operative data on primary elective THA/TKA procedures for ≥70% or ≥200 procedures performed between July 1, 2016 and June 30, 2017; and

(c) Public reporting. CMS—

(1) Makes the quality measurement results calculated for the complication and patient survey quality measures described in paragraph (a) of this section for each participant hospital in each performance year publicly available on the CMS Web site in a form and manner as determined by CMS;

(2) Shares each participant hospital’s quality metrics with the hospital prior to display on the Web site; and

(3) Does not publicly report the voluntary patient-reported outcomes and limited risk variable data during this model, but does indicate whether a hospital has voluntarily submitted such data.
§ 510.405  
(1) As part of discharge planning and referral, participant hospitals must inform beneficiaries of all Medicare participating post-acute care providers in an area and must identify those post-acute care providers with whom they have sharing arrangements. Participant hospitals may recommend preferred providers and suppliers, consistent with applicable statutes and regulations. Participant hospitals may not limit beneficiary choice to any list of providers or suppliers in any manner other than that permitted under applicable statutes and regulations. Participant hospitals must respect patient and family preferences when they are expressed.

(2) Participant hospitals may not charge any CJR collaborator a fee to be included on any list of preferred providers or suppliers, nor may the participant hospital accept such payments.

(b) Required beneficiary notification—

(1) Hospital detailed notification. Each participant hospital must provide written notice to any Medicare beneficiary that meets the criteria in §510.205 of his or her inclusion in the CJR model. The notice must be upon admission to the participant hospital or immediately following the decision to schedule an LEJR surgery, whichever occurs later. The beneficiary notification must contain all of the following:

(i) A detailed explanation of the model and how it might be expected to affect the beneficiary’s care.
(ii) Notification that the beneficiary retains freedom of choice to choose providers and services.
(iii) Explanation of how patients can access care records and claims data through an available patient portal, and how they can share access to their Blue Button® electronic health information with caregivers.
(iv) A statement that all existing Medicare beneficiary protections continue to be available to the beneficiary. These include the ability to report concerns of substandard care to Quality Improvement Organizations and 1–800–MEDICARE.
(v) A list of the providers and suppliers with whom the participant hospital has a collaborator agreement.

(2) Physician provision of notice. A participant hospital must require any physician that is a CJR collaborator to provide written notice of the structure of the model and the existence of the physician’s sharing arrangement with the participant hospital to any Medicare beneficiary that meets the criteria specified in §510.205. The notice must be provided at the time that the decision to undergo LEJR surgery is made.

(3) PAC provider/supplier notification. A participant hospital must require any provider or supplier, other than the treating physician discussed in paragraph (b)(2) of this section, with whom it has executed a collaborator agreement to provide written notice of the existence of its sharing arrangement with the participant hospital to any Medicare beneficiary that meets the criteria specified in §510.205. The notice must be provided no later than the time at which the beneficiary first receives services from the provider or supplier during the CJR episode.

(4) Discharge planning notice. A participant hospital must provide the beneficiary with a written notice of any potential financial liability, associated with non-covered services recommended or presented as an option as part of discharge planning, no later than the time that the beneficiary discusses a particular PAC option or at the time the beneficiary is discharged, whichever occurs earlier.

(i) If the hospital knows or should have known that the beneficiary is considering or has decided to receive a non-covered post-acute service or other non-covered associated service or supply, the hospital must notify the beneficiary that the service would not be covered by Medicare.

(ii) If the hospital is discharging a beneficiary to a SNF prior to the occurrence of a 3 day hospital stay, and the beneficiary is being transferred to or is considering a SNF that would not qualify under the SNF 3-day waiver in §510.610, the hospital notify the beneficiary in accordance with paragraph (b)(4)(i) of this section that the beneficiary will be responsible for costs associated with that stay except those which would be covered by Medicare Part B during a non-covered inpatient SNF stay.
§ 510.410 Compliance enforcement.

(a) General. Participant hospitals must comply with all of the requirements outlined in this part. Except as specifically noted in this part, the regulations under this part must not be construed to affect the payment, coverage, program integrity, or other requirements (such as those in parts 412 and 482 of this chapter) that apply to providers and suppliers under this chapter.

(b) Failure to comply. (1) CMS may take one or more of the remedial actions set forth in paragraph (b)(2) of this section if a participant hospital or any of the participant hospital’s CJR collaborators—

(i) Fails to comply with any applicable requirements of this part or is identified as noncompliant through monitoring by HHS (including CMS and OIG) of the CJR model, including but not limited to the following:

(A) Avoiding potentially high cost patients.

(B) Targeting potentially low cost patients.

(C) Failing to provide medically appropriate services or systematically engaging in the over or under delivery of appropriate care.

(D) Failing to provide beneficiaries with complete and accurate information, including required notices.

(E) Failing to allow beneficiary choice of medically necessary options, including non-surgical options.

(F) Failing to follow the requirements related to collaborator agreements;

(ii) Has signed a collaborator agreement with a CJR collaborator if the agreement is noncompliant with the requirements of this part;

(iii) Takes any action that threatens the health or safety of patients;

(iv) Avoids at-risk Medicare beneficiaries, as this term is defined in § 425.20;

(v) Avoids patients on the basis of payer status;

(vi) Is subject to sanctions or final actions of an accrediting organization or federal, state, or local government agency that could lead to the inability to comply with the requirements and provisions of this part;

(vii) Takes any action that CMS determines for program integrity reasons is not in the best interests of the CJR model, or fails to take any action that CMS determines for program integrity reasons should have been taken to further the best interests of the CJR model;

(viii) Is subject to action by HHS (including OIG and CMS) or the Department of Justice to redress an allegation of fraud or significant misconduct, including intervening in a False Claims Act qui tam matter, issuing a pre-demand or demand letter under a civil sanction authority, or similar actions; or

(ix) Is subject to action involving violations of the physician self-referral law, civil monetary penalties law, federal anti-kickback statute, antitrust laws, or any other applicable Medicare laws, rules, or regulations that are relevant to the CJR model.

(2) Remedial actions include the following:

(i) Issue a warning letter to the participant hospital.

(ii) Require the participant hospital to develop a corrective action plan, commonly referred to as a CAP.

(iii) Reduce or eliminate a participant hospital’s reconciliation payment.

(iv) Require a participant hospital to terminate a collaborator agreement with a CJR collaborator and prohibit further engagement in the CJR model by that CJR collaborator.

(v) Terminate the participant hospital’s participation in the CJR model.

(3) CMS may add 25 percent to a repayment amount on a participant hospital’s reconciliation report if all of the following criteria are satisfied:

(i) CMS has required a corrective action plan from a participant hospital.

(ii) The participant hospital is not due a positive reconciliation payment but instead owes a repayment amount to CMS.

(iii) The participant hospital fails to timely comply with the corrective action plan or is noncompliant with the model’s requirements.
§ 510.500 Financial arrangements under the CJR model.

(a) General. (1) A participant hospital may elect to enter into sharing arrangements.

(2) A participant hospital must not make a gainsharing payment or receive an alignment payment except in accordance with a sharing arrangement. Any gainsharing payments or alignment payments made in accordance with a sharing arrangement must be made only from the participant hospital to the CJR collaborator with whom the participant hospital has signed a collaborator agreement containing a sharing arrangement.

(3) CMS may review any sharing arrangement for compliance with the requirements of this part and to ensure that it does not pose a risk to beneficiary access, beneficiary freedom of choice, or quality of care.

(4) The participant hospital has ultimate responsibility for fully complying with all provisions of the CJR model.

(5) If a participant hospital enters into a sharing arrangement, it must update its compliance program to include oversight of sharing arrangements and compliance with the requirements of the CJR model.

(6) The board or other governing body of the participant hospital must have responsibility for overseeing the participant hospital’s participation in the CJR model, its arrangements with CJR collaborators, its payment of gainsharing payments and receipt of alignment payments, and its use of beneficiary incentives in the CJR model.

(7) Participant hospitals must develop and maintain a written set of policies for selecting providers and suppliers for sharing gains and risk as CJR collaborators. This set of policies must contain criteria for selection of CJR collaborators related to, and inclusive of, the quality of care to be delivered by the CJR collaborator to beneficiaries during a CJR episode. The selection criteria cannot be based directly or indirectly on the volume or value of referrals or business otherwise generated by, between or among the participant hospital, CJR collaborators, and any individual or entity affiliated with a participant hospital or CJR collaborator. All collaborator agreements must require the CJR collaborator to have met, or agree to meet, the quality criteria for selection.

(b) Sharing arrangement requirements. Each sharing arrangement must comply with the following criteria:

(1) The sharing arrangement must be set forth in a collaborator agreement that complies with the requirements of paragraph (c) of this section.

(2) The sharing arrangement must comply with all relevant laws and regulations, including the applicable fraud and abuse laws and all applicable payment and coverage requirements.

(3) An individual or entity’s participation in a sharing arrangement must be voluntary and without penalty for nonparticipation.

(4) The parties must enter into a sharing arrangement before care is furnished to CJR beneficiaries under the terms of the sharing arrangement.

(5)(i) To be eligible to receive a gainsharing payment, a CJR collaborator must meet quality criteria for the calendar year for which the gainsharing payment is determined by the participant hospital. The quality criteria must be established by the participant hospital and directly related to CJR episodes of care.

(ii) To be eligible to receive a gainsharing payment or make an alignment payment, a CJR collaborator other than a PGP must directly furnish a billable service to a CJR beneficiary during a CJR episode that occurred in the calendar year in which the savings or loss was created.

(iii) To be eligible to receive a gainsharing payment, a PGP that is a CJR collaborator must meet the following criteria:

(A) The PGP must have billed for an item or service that was rendered by one or more members of the PGP to a CJR beneficiary during a CJR episode that occurred during the calendar year in which the participant hospital’s internal cost savings was generated, or to which the NPRA applied, the latter of which is contained in a reconciliation payment.
(B) The PGP must contribute to a participant hospital's care redesign in the CJR model and be clinically involved in the care of CJR beneficiaries. The following is a non-exhaustive list of ways in which a PGP might be clinically involved in the care of CJR beneficiaries:

(1) Provide care coordination services to CJR beneficiaries during and/or after inpatient admission.

(2) Engage with a participant hospital in care redesign strategies, and actually perform a role in implementing such strategies, that are designed to improve the quality of care for LEJR episodes and reduce the LEJR episode spending.

(3) In coordination with other providers and suppliers (such as members of the PGP, participant hospitals, post-acute care providers), implement strategies designed to address and manage the comorbidities of CJR beneficiaries.

(4) No entity or individual, whether a party to a collaborator agreement or not, may condition the opportunity to make or receive gainsharing payments or to make or receive alignment payments on the volume or value of referrals or business otherwise generated by, between or among the participant hospital, CJR collaborators, and any individual or entity affiliated with a participant hospital or CJR collaborator.

(5) Gainsharing payments, if any, must be—

(i) Derived solely from reconciliation payments, or internal cost savings, or both; and

(ii) Actually and proportionally related to the care of beneficiaries in a CJR episode; and

(iii) Distributed on an annual basis (not more than once per calendar year); and

(iv) Not be a loan, advance payments, or payments for referrals or other business; and

(v) Be clearly identified and comply with all provisions in this part, as well as all applicable laws, statutes, and rules.

(6) Alignment payments from a CJR collaborator to a participant hospital may be made at any interval that is agreed upon by both parties, and must—

(i) Not be issued, distributed, or paid prior to the calculation by CMS of a repayment amount reflected in a reconciliation report; and

(ii) Not be a loan, advance payments, or payments for referrals or other business.

(9) A participant hospital must not make a gainsharing payment to a CJR collaborator that is subject to any action for noncompliance with this part or the fraud and abuse laws, or for the provision of substandard care in CJR episodes or other integrity problems.

(10) In a calendar year, the aggregate amount of all gainsharing payments distributed by a participant hospital that are derived from a CJR reconciliation payment may not exceed the amount of the reconciliation payment the participant hospital receives from CMS.

(11) In a calendar year, the aggregate amount of all alignment payments received by the participant hospital must not exceed 50 percent of the participant hospital’s repayment amount. No alignment payments may be collected by a participant hospital if it does not owe a repayment amount.

(12) The aggregate amount of all alignment payments from any one CJR collaborator to a participant hospital must not be greater than 25 percent of the participant hospital’s repayment amount.

(13) A sharing arrangement must not induce the participant hospital, CJR collaborator, or any employees or contractors of the participant hospital or CJR collaborator to make decisions in the best interests of its patients, including the selection of devices, supplies, and treatments.

(14) A sharing arrangement must not restrict the ability of a CJR collaborator to make decisions in the best interests of its patients, including the selection of devices, supplies, and treatments.

(15) The methodology for determining gainsharing payments must be based, at least in part, on criteria related to, and inclusive of, the quality of care to be delivered to CJR beneficiaries during an episode and must not directly account for the volume or value of referrals or business otherwise generated by, between or among the participant hospital, CJR collaborators, and any
individual or entity affiliated with a participant hospital or CJR collaborator.

(16) The methodology for determining alignment payments must not directly account for the volume or value of referrals or business otherwise generated by, between or among the participant hospital, CJR collaborators, and any individual or entity affiliated with a participant hospital or CJR collaborator.

(17) The total amount of a gainsharing payment for a calendar year paid to an individual physician or nonphysician practitioner who is a CJR collaborator must not exceed 50 percent of the total Medicare approved amounts under the Physician Fee Schedule (PFS) for services furnished to the participant hospital’s CJR beneficiaries during a CJR episode by that physician or nonphysician practitioner.

(18) The total amount of gainsharing payments for a calendar year paid to a PGP that is a CJR collaborator must not exceed 50 percent of the total Medicare approved amounts under the Physician Fee Schedule for services that are billed by the PGP and furnished during a calendar year by members of the PGP to the participant hospital’s CJR beneficiaries during CJR episodes.

(19) The participant hospital’s determination of internal cost savings must satisfy the following criteria:

(i) Internal cost savings are calculated in accordance with generally accepted accounting principles and Government Auditing Standards (The Yellow Book).

(ii) All amounts determined to be internal cost savings must reflect actual, internal cost savings achieved by the participant hospital through implementation of care redesign elements identified and documented by the participant hospital. Internal cost savings does not include savings realized by any individual or entity that is not the participant hospital.

(iii) Internal cost savings may not reflect “paper” savings from accounting conventions or past investment in fixed costs.

(20) All gainsharing payments and any alignment payments must meet the requirements set forth in this section and be administered by the participant hospital in accordance with generally accepted accounting principles. In no event may the participant hospital receive any amounts from a CJR collaborator under a sharing arrangement that are not alignment payments.

(21) All gainsharing payments and alignment payments must be made through EFT.

(c) Contents of collaborator agreement. Each collaborator agreement must satisfy the following criteria:

(1) The collaborator agreement must contain a description of the sharing arrangement between the participant hospital and the CJR collaborator regarding gainsharing payments and alignment payments. This description must specify the following:

(i) The parties to the sharing arrangement.

(ii) The date of the sharing arrangement.

(iii) The purpose and scope of the sharing arrangement.

(iv) The financial or economic terms of the sharing arrangement, including the frequency of payment, and the methodology and accounting formula for determining the amount of any gainsharing payment or alignment payment.

(v) Safeguards to ensure that alignment payments are made solely for purposes related to sharing responsibility for funds needed to repay Medicare in the CJR model.

(vi) Plans regarding care redesign.

(vii) Changes in care coordination or delivery that is applied to the participant hospital or CJR collaborators or both.

(viii) A description of how success will be measured.

(ix) Management and staffing information, including type of personnel or contractors that will be primarily responsible for carrying out changes to care under the CJR model.

(2) The collaborator agreement must contain a requirement that the CJR collaborator and its employees and contractors must comply with the applicable provisions of this part (including requirements regarding beneficiary notifications, access to records, record retention, and participation in any evaluation, monitoring, compliance,
and enforcement activities performed by CMS or its designees) and all other applicable laws and regulations.

(3) The collaborator agreement must require the CJR collaborator to be in compliance with all Medicare provider enrollment requirements at § 424.500 of this chapter, including having a valid and active TIN or NPI, during the term of the agreement.

(4) The collaborator agreement must require the CJR collaborator to have a compliance program that includes oversight of the collaborator agreement and compliance with the requirements of the CJR model.

(5) The collaborator agreement must set forth a specific methodology for accruing, calculating, and verifying the internal cost savings generated by the participant hospital based on the care redesign elements specifically associated with the particular CJR collaborator.

(i) The methodology must set out the specific care redesign elements to be undertaken by the participant hospital or the CJR collaborator or both.

(ii) The methodology must be based, at least in part, on criteria related to, and inclusive of, the quality of care to be delivered to CJR beneficiaries during an episode and must not directly account for the volume or value of referrals or business otherwise generated by, between or among the participant hospital, CJR collaborators, and any individual or entity affiliated with a participant hospital or CJR collaborator.

(iii) The specific methodologies for accruing and calculating internal cost savings must be transparent, measurable, and verifiable in accordance with generally accepted accounting principles and Government Auditing Standards (The Yellow Book).

(6) The collaborator agreement must set forth the quality criteria established by the participant hospital that will be used in determining the gainsharing payment.

(7) The collaborator agreement must require the participant hospital to recoup gainsharing payments paid to CJR collaborators if gainsharing payments contain funds derived from a CMS overpayment on a reconciliation report, or were based on the submission of false or fraudulent data.

(d) Documentation requirements. (1) Documentation of any collaborator agreement containing a sharing arrangement must be contemporaneous with the establishment of the arrangement.

(2) A participant hospital must maintain accurate current and historical lists of all CJR collaborators, including names and addresses of each CJR collaborator. The participant hospital must update the lists on at least a quarterly basis and publicly report the current and historical lists of CJR collaborators on a public-facing Web page on the participant hospital’s Web site.

(3) The participant hospital and CJR collaborator must maintain contemporaneous documentation of the payment or receipt of any gainsharing payment or alignment payment. The documentation must identify at least the following: The nature of the payment (gainsharing payment or alignment payment); the identity of the parties making and receiving the payment; the date of the payment; the amount of the payment; and the date and amount of any recoupment of all or a portion of a CJR collaborator’s gainsharing payment.

(4) The participant hospital must keep records of the following:

(i) Its process for determining and verifying the eligibility of CJR collaborators to participate in Medicare.

(ii) Information confirming the organizational readiness of the participant hospital to measure and track internal cost savings.

(iii) The participant hospital’s plan to track internal cost savings.

(iv) Information on the accounting systems used to track internal cost savings.

(v) A description of current health information technology, including systems to track reconciliation payments and internal cost savings.

(vi) The participant hospital’s plan to track gainsharing payments and alignment payments.

(vii) Whether the participant hospital recouped any gainsharing payments received by a CJR collaborator that contain funds derived from a CMS overpayment on a reconciliation report, or
were based on the submission of false or fraudulent data.

(e) Access to records and record retention. All participant hospitals and CJR collaborators who enter into sharing arrangements must:

(1) Provide to CMS, the OIG, and the Comptroller General or their designees scheduled and unscheduled access to all books, contracts, records, documents, and other evidence (including data related to utilization and payments, quality criteria, billings, lists of CJR collaborators, sharing arrangements, and distribution arrangements, and the documentation required under paragraph (d) of this section) sufficient to enable the audit, evaluation, inspection, or investigation of the individual’s or entity’s compliance with CJR requirements, the quality of services furnished, the obligation to repay any reconciliation payments owed to CMS, or the calculation, distribution, receipt, or recoupment of gainsharing payments, alignment payments, or distribution payments.

(2) Maintain all such books, contracts, records, documents, and other evidence for a period of 10 years from the last day of the participant hospital’s participation in the CJR model or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless—

(i) CMS determines that there is a special need to retain a particular record or group of records for a longer period and notifies the participant hospital at least 30 calendar days before the normal disposition date; or

(ii) There has been a dispute or allegation of fraud or similar fault against the participant hospital or any CJR collaborator, in which case the records must be maintained for an additional 6 years from the date of any resulting final resolution of the dispute or allegation of fraud or similar fault.

§ 510.505 Distribution arrangements.

(a) General. (1) A PGP that has entered into a collaborator agreement with a participant hospital may distribute all or a portion of any gainsharing payment it receives from the hospital only in accordance with a distribution arrangement.

(2) All distribution arrangements must comply with the provisions of paragraph (b) of this section and all applicable laws and regulations, including the fraud and abuse laws.

(b) Requirements. (1) All distribution arrangements must be in writing and signed by the PGP and practice collaboration agent.

(2) Participation in a distribution arrangement must be voluntary and without penalty for nonparticipation.

(3) The distribution arrangement must require the practice collaboration agent to comply with the requirements set forth in this part.

(4) The opportunity to receive a distribution payment must not be conditioned directly or indirectly on the volume or value of referrals or business otherwise generated by, between or among the participant hospital, PGP, other CJR collaborators, practice collaboration agents, and any individual or entity affiliated with a participant hospital, CJR collaborator, or practice collaboration agent.

(5) Methodologies for determining distribution payments must not directly account for volume or value of referrals, or business otherwise generated by, between or among the participant hospital, PGP, other CJR collaborators, practice collaboration agents, and any individual or entity affiliated with a participant hospital, CJR collaborator, or practice collaboration agent.

(6) A practice collaboration agent is eligible to receive a distribution payment only if the PGP billed for an item or service furnished by the practice collaboration agent to a CJR beneficiary during a CJR episode that occurred during the calendar year in which the participating hospital accrued the internal cost savings or earned the reconciliation payment that comprise the gainsharing payment made to the PGP.

(7) When a PGP receives a gainsharing payment from a participant hospital in accordance with a sharing arrangement, all monies contained in such a gainsharing payment must be shared only with the physician or nonphysician practitioners that are PGP members that furnished a service to a CJR beneficiary during an episode
of care in the calendar year from which the NPRA, as that term is defined in this part, or internal cost savings was generated, either or both of which are the only permitted sources of funds for a gainsharing payment.

(8) The total amount of distribution payments for a calendar year paid to a practice collaboration agent must not exceed 50 percent of the total Medicare approved amounts under the Physician Fee Schedule for services billed by the PGP and furnished by the practice collaboration agent to the participant hospital’s CJR beneficiaries during a CJR episode.

(9) With respect to the distribution of any gainsharing payment received by a PGP, the total amount of all distribution payments must not exceed the amount of the gainsharing payment.

(10) All distribution payments must be made through EFT.

(11) The practice collaboration agents must retain their ability to make decisions in the best interests of the patient, including the selection of devices, supplies, and treatments.

(12) The distribution arrangement must not—

(i) Induce a practice collaboration agent to reduce or limit medically necessary services to any Medicare beneficiary; or

(ii) Reward the provision of items and services that are medically unnecessary.

(13) The PGP must maintain contemporaneous documentation regarding distribution arrangements in accordance with §510.500(e), including the relevant written agreements, the date and amount of any distribution payment, the identity of each practice collaboration agent who received a distribution payment, and a description of the methodology and accounting formula for determining the amount of any distribution payment.

(14) The PGP may not enter into a distribution arrangement with any member of the PGP that has a collaborator agreement in effect with a participant hospital.

§ 510.510 Enforcement authority.

(a) OIG authority. OIG authority is not limited or restricted by the provisions of the CJR model, including the authority to audit, evaluate, investigate, or inspect the participant hospital, CJR collaborators, or any other person or entity or their records, data, or information, without limitation.

(b) Other authorities. None of the provisions of the CJR model limits or restricts the authority of any other government agency permitted by law to audit, evaluate, investigate, or inspect the participant hospital, CJR collaborators, or any other person or entity or their records, data, or information, without limitation.

§ 510.515 Beneficiary incentives under the CJR model.

(a) General. Participant hospitals may choose to provide in-kind patient engagement incentives to beneficiaries in a CJR episode, subject to the following conditions:

(1) The incentive must be provided directly by the participant hospital or by an agent of the hospital under the hospital’s direction and control to the beneficiary during a CJR episode.

(2) The item or service provided must be reasonably connected to medical care provided to a beneficiary during an episode.

(3) The item or service must be a preventive care item or service or an item or service that advances a clinical goal, as listed in paragraph (b) of this section, for a beneficiary in a CJR episode by engaging the beneficiary in better managing his or her own health.

(4) The item or service must not be tied to the receipt of items or services outside the CJR episode of care.

(5) The item or service must not be tied to the receipt of items or services from a particular provider or supplier.

(6) The availability of the items or services must not be advertised or promoted except that a beneficiary may be made aware of the availability of the items or services at the time the beneficiary could reasonably benefit from them.

(7) The cost of the items or services must not be shifted to another federal health care program, as defined at section 1228B(f) of the Act.

(b) Goals of the CJR model. The following are the particular clinical goals
of the CJR model, which may be advanced through beneficiary incentives:

1. Beneficiary adherence to drug regimens.
2. Beneficiary adherence to a care plan.
3. Reduction of readmissions and complications resulting from LEJR procedures.
4. Management of chronic diseases and conditions that may be affected by the lower extremity joint replacement procedure.

(c) Documentation of beneficiary incentives. (1) Participant hospitals must maintain documentation of items and services furnished as beneficiary incentives that exceed $25 in retail value.

(2) The documentation must be contemporaneous with the provision of the items and services and must include at least the following:
   (i) The date the incentive is provided.
   (ii) The identity of the beneficiary to whom the item or service was provided.

(3) The participant hospital must retain the required documentation in accordance with paragraph (e) of this section.

(d) Technology provided to a beneficiary. (1) Items or services involving technology provided to a beneficiary may not exceed $1,000 in retail value for any one beneficiary in any one CJR episode.

(2) Items or services involving technology provided to a beneficiary may be the minimum necessary to advance a clinical goal, as listed in paragraph (b) of this section, for a beneficiary in a CJR episode.

(3) Items of technology exceeding $100 in retail value must—
   (i) Remain the property of the participant hospital; and
   (ii) Be retrieved from the beneficiary at the end of the CJR episode. The participant hospital must document all retrieval attempts, including the ultimate date of retrieval. Documented, diligent, good faith attempts to retrieve items of technology will be deemed to meet the retrieval requirement.

(e) Documentation and maintenance of records. All participant hospitals that provide in-kind patient engagement incentives to beneficiaries in CJR episodes must:

1. Provide to CMS, the OIG, and the Comptroller General or their designee(s) scheduled and unscheduled access to all books, contracts, records, documents, and other evidence sufficient to enable the audit, evaluation, inspection, or investigation of the participant hospital’s compliance with CJR requirements for beneficiary incentives.

2. Maintain all such books, contracts, records, documents, and other evidence for a period of 10 years from the last day of the participant hospital’s participation in the CJR model or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless—
   (i) CMS determines that there is a special need to retain a particular record or group of records for a longer period and notifies the participant hospital at least 30 calendar days before the normal disposition rate; or
   (ii) There has been a dispute or allegation of fraud or similar fault against the participant hospital, in which case the records must be maintained for an additional 6 years from the date of any resulting final resolution of the dispute or allegation of fraud or similar fault.

Subpart G—Waivers

§ 510.600 Waiver of direct supervision requirement for certain post-discharge home visits.

(a) General. CMS waives the requirement in §410.26(b)(5) of this chapter that services and supplies furnished incident to a physician’s service must be furnished under the direct supervision of the physician (or other practitioner) to permit home visits as specified in this section. The services furnished under this waiver are not considered to be “hospital services,” even when furnished by the clinical staff of the hospital.

(b) General supervision of qualified personnel. The waiver of the direct supervision requirement in §410.26(b)(5) of this chapter applies only in the following circumstances:

1. The home visit is furnished during the episode to a beneficiary who has been discharged from an anchor hospitalization.
(2) The home visit is furnished at the beneficiary’s home or place of residence.

(3) The beneficiary does not qualify for home health services under sections 1835(a) and 1814(a) of the Act at the time of any such home visit.

(4) The visit is furnished by clinical staff under the general supervision of a physician or non-physician practitioner. Clinical staff are individuals who work under the supervision of a physician or other qualified health care professional, and who are allowed by law, regulation, and facility policy to perform or assist in the performance of a specific professional service, but do not individually report that professional service.

(5) No more than 9 visits are furnished to the beneficiary during the episode.

(c) Payment. Up to 9 post-discharge home visits per CJR episode may be billed under Part B by the physician or nonphysician practitioner or by the participant hospital to which the supervising physician has reassigned his or her billing rights.

(d) Other requirements. All other Medicare rules for coverage and payment of services incident to a physician’s service continue to apply.

§ 510.605 Waiver of certain telehealth requirements.

(a) Waiver of the geographic site requirements. Except for the geographic site requirements for a face-to-face encounter for home health certification, CMS waives the geographic site requirements of section 1834(m)(4)(C)(i)(I) through (III) of the Act for episodes being tested in the CJR model, but only for services that—

(1) May be furnished via telehealth under existing requirements; and

(2) Are included in the episode in accordance with §510.200(b).

(b) Waiver of the originating site requirements. Except for the originating site requirements for a face-to-face encounter for home health certification, CMS waives the originating site requirements under section 1834(m)(4)(C)(ii)(I) through (VIII) of the Act for episodes being tested in the CJR model to permit a telehealth visit to originate in the beneficiary’s home or place of residence, but only for services that—

(1) May be furnished via telehealth under existing requirements; and

(2) Are included in the CJR episode in accordance with §510.200(b).

(c) Waiver of selected payment provisions. (1) CMS waives the payment requirements under section 1834(m)(2)(A) so that the facility fee normally paid by Medicare to an originating site for a telehealth service is not paid if the service is originated in the beneficiary’s home or place of residence.

(2) CMS waives the payment requirements under section 1834(m)(2)(B) to allow the distant site payment for telehealth home visit HCPCS codes unique to this model to more accurately reflect the resources involved in furnishing these services in the home by basing payment upon the comparable office visit relative value units for work and malpractice under the Physician Fee Schedule.

(d) Other requirements. All other requirements for Medicare coverage and payment of telehealth services continue to apply, including the list of specific services approved to be furnished by telehealth.

§ 510.610 Waiver of SNF 3-day rule.

(a) Waiver of the SNF 3-day rule. For episodes being tested in the CJR model in performance years 2 through 5, CMS waives the SNF 3-day rule for coverage of a SNF stay for a CJR beneficiary following the anchor hospitalization, but only if the SNF is identified on the applicable calendar quarter list of qualified SNFs at the time of CJR beneficiary admission to the SNF.

(1) CMS determines the qualified SNFs for each calendar quarter based on a review of the most recent rolling 12 months of overall star ratings on the Five-Star Quality Rating System for SNFs on the Nursing Home Compare Web site. Qualified SNFs are rated an overall of 3 stars or better for at least 7 of the 12 months.

(2) CMS posts to the CMS Web site the list of qualified SNFs in advance of the calendar quarter and the waiver only applies for a beneficiary who has been discharged from an anchor hospitalization if the SNF is included on the applicable calendar quarter list for
§ 510.615 Waiver of certain post-operative billing restrictions.

(a) Waiver to permit certain services to be billed separately during the 90-day post-operative global surgical period. CMS waives the billing requirements for global surgeries to allow the separate billing of certain post-discharge home visits described under §510.600, including those related to recovery from the surgery, as described in paragraph (b) of this section, for episodes being tested in the CJR model.

(b) Services to which the waiver applies. Up to 9 post-discharge home visits, including those related to recovery from the surgery, per CJR episode may be billed separately under Part B by the physician or nonphysician practitioner, or by the participant hospital to which the physician or nonphysician practitioner has reassigned his or her billing rights.

(c) Other requirements. All other Medicare rules for global surgery billing during the 90-day post-operative period continue to apply.

§ 510.620 Waiver of deductible and coinsurance that otherwise apply to reconciliation payments or repayments.

(a) Waiver of deductible and coinsurance. CMS waives the requirements of sections 1813 and 1822(a) of the Act for Medicare Part A and Part B payment systems only to the extent necessary to make reconciliation payments or receive repayments based on the NPRA that reflect the episode payment methodology under the final payment model for CJR participant hospitals.

(b) Reconciliation payments or repayments. Reconciliation payments or repayments do not affect the beneficiary cost-sharing amounts for the Part A and Part B services provided under the CJR model.

Subparts H–J [Reserved]

Subpart K—Model Termination

§ 510.900 Termination of the CJR model.

CMS may terminate the CJR model for reasons including but not limited to the following:

(a) CMS determines that it no longer has the funds to support the CJR model.

(b) CMS terminates the model in accordance with section 1115A(b)(3)(B) of the Act. As provided by section 1115A(d)(2) of the Act, termination of the model is not subject to administrative or judicial review.
SUBCHAPTER I—BASIC HEALTH PROGRAM

PART 600—ADMINISTRATION, ELIGIBILITY, ESSENTIAL HEALTH BENEFITS, PERFORMANCE STANDARDS, SERVICE DELIVERY REQUIREMENTS, PREMIUM AND COST SHARING, ALLOTMENTS, AND RECONCILIATION

Subpart A—General Provisions and Definitions

Sec. 600.1 Scope.
600.5 Definitions and use of terms.

Subpart B—Establishment and Certification of State Basic Health Programs

600.100 Program description.
600.105 Basis, scope, and applicability of subpart B.
600.110 BHP Blueprint.
600.115 Development and submission of the BHP Blueprint.
600.120 Certification of a BHP Blueprint.
600.125 Revisions to a certified BHP Blueprint.
600.130 Withdrawal of a BHP Blueprint prior to implementation.
600.135 Notice and timing of HHS action on a BHP Blueprint.
600.140 State termination of a BHP.
600.142 HHS withdrawal of certification and termination of a BHP.
600.145 State program administration and operation.
600.150 Enrollment assistance and information requirements.
600.155 Tribal consultation.
600.160 Protections for American Indian and Alaska Natives.
600.165 Nondiscrimination standards.
600.170 Annual report content and timing.

Subpart C—Federal Program Administration

600.200 Federal program compliance reviews and audits.

Subpart D—Eligibility and Enrollment

600.300 Basis, scope, and applicability.
600.305 Eligible individuals.
600.310 Application.
600.315 Certified application counselors.
600.320 Determination of eligibility for and enrollment in a standard health plan.
600.330 Coordination with other insurance affordability programs.
600.335 Appeals.
600.340 Periodic determination and renewal of BHP eligibility.
600.345 Eligibility verification.
600.350 Privacy and security of information.

Subpart E—Standard Health Plan

600.400 Basis, scope, and applicability.
600.405 Standard health plan coverage.
600.410 Competitive contracting process.
600.415 Contracting qualifications and requirements.
600.420 Enhanced availability of standard health plans.
600.425 Coordination with other insurance affordability programs.

Subpart F—Enrollee Financial Responsibilities

600.500 Basis, scope, and applicability.
600.505 Premiums.
600.510 Cost-sharing.
600.515 Public schedule of enrollee premium and cost sharing.
600.520 General cost-sharing protections.
600.525 Disenrollment procedures and consequences for nonpayment of premiums.

Subpart G—Payment to States

600.600 Basis, scope, and applicability.
600.605 BHP payment methodology.
600.610 Secretarial determination of BHP payment amount.
600.615 Deposit of Federal BHP payment.

Subpart H—BHP Trust Fund

600.700 Basis, scope, and applicability.
600.705 BHP trust fund.
600.710 Fiscal policies and accountability.
600.715 Corrective action, restitution, and disallowance of questioned BHP transactions.


Source: 79 FR 14140, Mar. 12, 2014, unless otherwise noted.

Subpart A—General Provisions and Definitions

§ 600.1 Scope.

Section 1331 of the Affordable Care Act provides for the establishment of the Basic Health Program (BHP) under
which a State may enter into contracts for standard health plans providing at least essential health benefits to eligible individuals in lieu of offering such individuals the opportunity to enroll in coverage through an Affordable Insurance Exchange. States that elect to operate a BHP will receive federal funding based on the amount of the premium tax credit and cost-sharing reductions that would have been available if enrollees had obtained coverage through the Exchange.

§ 600.5 Definitions and use of terms.

For purposes of this part, the following definitions apply:

Advance payments of the premium tax credit means payment of the tax credit authorized by 26 U.S.C. 36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act.


Basic Health Program (BHP) Blueprint is the operational plan that a State must submit to the Secretary of Health and Human Services (HHS) for certification to operate a BHP.

Certification means authority to operate the program which is required for program operations but it does not create an obligation on the part of the State to implement a BHP.


Cost sharing means any expenditure required by or on behalf of an enrollee with respect to covered health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers and spending for non-covered services.

Enrollee means an eligible individual who is enrolled in a standard health plan contracted to operate as part of a BHP.

Essential health benefits means the benefits described under section 1302(b) of the Affordable Care Act, as determined in accordance with implementing regulations at 45 CFR 156.100 through 156.110 and 156.122 regarding prescription drugs.

Family and family size is as defined at 26 CFR 1.36B–1(d).

Federal fiscal year means the time period beginning October 1st and ending September 30th.

Federal poverty level or FPL means the most recently published Federal poverty level, updated periodically in the Federal Register by the secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2).

Household income is as defined in 26 CFR 1.36B–1(e)(1) and is determined in the same way as it is for purposes of eligibility for coverage through the Exchange.

Indian means any individual as defined in section 4 (d) of the Indian Self-Determination and Education Assistance Act (Pub. L 93–638).

Interim certification is an approval status for the initial design of a state’s Basic Health Program. It does not confer any permission to begin enrollment or seek federal funding.

Lawfully present has the meaning given in 45 CFR 152.2.

Minimum essential coverage has the meaning set forth at 26 CFR 1.5000A–2, including coverage recognized by the Secretary as minimum essential coverage pursuant to 26 CFR 1.5000A–2(f). Under that authority, the Secretary recognizes coverage through a BHP standard health plan as minimum essential coverage.

Modified adjusted gross income is as defined in 26 CFR 1–36B–1(e)(2).

Network of health care providers means an entity capable of meeting the provision and administration of standard health plan coverage, including but not limited to, the provision of benefits, administration of premiums and applicable cost sharing and execution of innovative features, such as care coordination and care management, and other requirements as specified under the Basic Health Program. Such entities may include but are not limited to: Accountable Care Organizations, Independent Physician Associations, or a large health system.
Centers for Medicare & Medicaid Services, HHS

§ 600.110

Premium means any enrollment fee, premium, or other similar charge paid to the standard health plan offeror.

Preventive health services and items includes those services and items specified in 45 CFR 147.130(a).

Program year means a calendar year for which a standard health plan provides coverage for eligible BHP enrollees.

Qualified health plan or QHP means a health plan that has in effect a certification that it meets the standards described in subpart C of 45 CFR part 156 issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of 45 CFR part 156, except that such term must not include a qualified health plan which is a catastrophic plan described in 45 CFR 155.20.

Reference plan is a synonym for the EHB base benchmark plan and is defined at 45 CFR 155.100.

Regional compact means an agreement between two or more States to jointly procure and enter into contracts with standard health plan offeror(s) for the administration and provision of a standard health plan under the BHP to eligible individuals in such States.

Residency is determined in accordance with 45 CFR 155.305(a)(3).

Single streamlined application has the same meaning as application defined at 42 CFR 431.907(b)(1) of this chapter and 45 CFR 155.405(a) and (b).

Standard health plan means a health benefits package, or product, that is provided by the standard health plan offeror.

Standard health plan offeror means an entity that is eligible to enter into contracts with the State for the administration and provision of a standard health plan under the BHP.

State means each of the 50 states and the District of Columbia as defined by section 1304 of the Act.

Subpart B—Establishment and Certification of State Basic Health Programs

§ 600.100 Program description.

A State Basic Health Program (BHP) is operated consistent with a BHP Blueprint that has been certified by the Secretary to meet the requirements of this part. The BHP Blueprint is developed by the State for certification by the Secretary in accordance with the processes described in this subpart.

§ 600.105 Basis, scope, and applicability of subpart B.

(a) Statutory basis. This subpart implements the following sections of the Act:

1. Section 1331(a)(1) which defines a Basic Health Program.

2. Section 1331(a)(2) which requires the Secretary to certify a Basic Health Program before it may become operational.

3. Section 1331(f) which requires Secretarial oversight through annual reviews.

(b) Scope and applicability. (1) This subpart sets forth provisions governing the administration of the BHP, the general requirements for development of a BHP Blueprint required for certification, for program operations and for voluntary program termination.

(2) This subpart applies to all States that submit a BHP Blueprint and request certification to operate a BHP.

§ 600.110 BHP Blueprint.

The BHP Blueprint is a comprehensive written document submitted by the State to the Secretary for certification of a BHP in the form and manner specified by HHS which will include an opportunity for states to submit a limited set of elements necessary for interim certification at the state option. The program must be administered in accordance with all aspects of section 1331 of the Affordable Care Act and other applicable law, this chapter, and the certified BHP Blueprint.

(a) Content of a Blueprint. The Blueprint will establish compliance with applicable requirements by including a description, or if applicable, an assurance of the following:

1. The minimum benefits offered under a standard health plan that assures inclusion of essential health benefits as described in section 1302(b) of the Affordable Care Act, in accordance with §600.405.

(2) The competitive process, consistent with §600.410, that the State...
§ 600.115 Development and submission of the BHP Blueprint.

(a) State authority to submit the State Blueprint. A State BHP Blueprint must be signed by the State’s Governor or by the official with delegated authority from the Governor to sign it. A State may choose to submit its BHP Blueprint in two parts: The first limited submission to secure interim certification and the second full submission to secure full certification.

(b) State Basic Health Program officials. The State must identify in the BHP Blueprint the agency and officials within that agency, by position or title, who are responsible for program administration, operations, and financial oversight.

(c) Opportunity for public comment. The State must provide an opportunity for public comment on the BHP Blueprint content described in §600.110 before submission to the Secretary for certification.

(1) The State must seek public comment on any significant subsequent revisions prior to submission of those revisions to the Secretary for certification. Significant revisions are those that alter core program operations required by §600.145(f), as well as changes that alter the BHP standard health plan benefit package, or enrollment, disenrollment and verification policies.
(2) The process of seeking public comment must include Federally recognized tribes as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a, located in the State.

(d) Submission and timing. The BHP Blueprint must be submitted in a manner and format specified by HHS. States may not implement the BHP prior to receiving full certification. The date of implementation for this purpose is the first day enrollees would receive coverage under the BHP. Following the 2015 initial implementation year, a state implementing a BHP must coordinate implementation with open enrollment of the state’s exchange.

§ 600.120 Certification of a BHP Blueprint.

(a) Effective date of certification. The effective date of either interim or full certification is the date of signature by the Secretary.

(b) Payments for periods prior to certification. No payment may be made under this part for periods of BHP operation prior to the date of full certification.

(c) Period in which a certified Blueprint remains in effect. The certified Blueprint remains in effect until:

(1) The Blueprint is replaced by Secretarial certification of updated Blueprint containing revisions submitted by the State.

(2) The State terminates the program consistent with §600.140.

(3) The Secretary makes a finding that the BHP Blueprint no longer meets the standards for certification based on findings in the annual review, or reports significant evidence of beneficiary harm, financial malfeasance, fraud, waste or abuse by the BHP agency or the State consistent with §600.142.

(d) Blueprint approval standards for certification. The Secretary will certify a BHP Blueprint provided it meets all of the following standards:

(1) The Blueprint contains sufficient information for the Secretary to determine that the BHP will comply with the requirements of section 1331 of the Affordable Care Act and this part.

(2) The BHP Blueprint demonstrates adequate planning for the integration of BHP with other insurance affordability programs in a manner that will permit a seamless, coordinated experience for a potentially eligible individual.

(3) The Blueprint is a complete and comprehensive description of the BHP and its operations, demonstrating thorough planning and a concrete program design, without reserved decisions on operational features.

§ 600.125 Revisions to a certified BHP Blueprint.

(a) Submission of revisions. In the event that a State seeks to make significant change(s) that alter program operations the BHP benefit package, enrollment, disenrollment and verification policies described in the certified BHP Blueprint, the State must submit a revised Blueprint to the Secretary for review and certification.

(b) Continued operation. The State is responsible for continuing to operate under the terms of the existing certified Blueprint until and unless a revised Blueprint is certified.

§ 600.130 Withdrawal of a BHP Blueprint prior to implementation.

To the extent that a State has not enrolled eligible individuals into the BHP:

(a) The State may submit a written request to stop any further consideration of a previously submitted BHP Blueprint, whether certified or not.

(b) The written request must be signed by the governor, or the State official delegated to sign the BHP Blueprint by the governor.

(c) HHS will respond with a written confirmation that the State has withdrawn the Blueprint.

§ 600.135 Notice and timing of HHS action on a BHP Blueprint.

(a) Timely response. HHS will act on all certification and revision requests in a timely manner.

(b) Issues preventing certification. HHS will notify the State in writing of any impediments to certification that arise in reviewing a proposed BHP Blueprint.

(c) Reconsideration of decision. HHS will accept a State request for reconsideration of a certification decision and provide an impartial review
§ 600.140 State termination of a BHP.

(a) If a State decides to terminate its BHP, the State must complete all of the following prior to the effective date of the termination or the indicated dates:

(1) Submit written notice to the Secretary no later than 120 days prior to the proposed termination date accompanied by a proposed transition plan that describes procedures to assist consumers with transitioning to other insurance affordability programs.

(2) Resolve concerns expressed by the Secretary and obtain approval by the Secretary of the transition plan.

(3) Submit written notice to all participating standard health plan offerors, and enrollees that it intends to terminate the program at least 90 days prior to the termination date. The notices to enrollees must include information regarding the State’s assessment of their eligibility for all other insurance affordability programs in the State. Notices must meet the accessibility and readability standards at 45 CFR 155.230(b).

(4) Transmit all information provided as part of an application, and any information obtained or verified by the State or other agencies administering insurance affordability programs via secure electronic interface, promptly and without undue delay to the agency administering the Exchange and the Medicaid agency as appropriate.

(5) Fulfill its contractual obligations to participating standard health plan offerors including the payment of all negotiated rates for participants, as well as plan oversight ensuring that participating standard health plan offerors fulfill their obligation to cover benefits for each enrollee.

(6) Fulfill data reporting requirements to HHS.

(7) Complete the annual financial reconciliation process with HHS to ensure full compliance with Federal financial obligations.

(8) Refund any remaining balance in the BHP trust fund.

(b) [Reserved]

§ 600.142 HHS withdrawal of certification and termination of a BHP.

(a) The Secretary may withdraw certification for a BHP Blueprint based on a finding that the BHP Blueprint no longer meets the standards for certification based on findings in the annual review, findings from a program review conducted in accordance with §600.200 or from significant evidence of beneficiary harm, financial malfeasance, fraud, waste or abuse.

(b) Withdrawal of certification for a BHP Blueprint shall occur only after the Secretary provides the State with notice of the proposed finding that the standards for certification are not met or evidence of harm or misconduct in program operations, a reasonable period for the State to address the finding (either by substantiating compliance with the standards for certification or submitting revisions to the Blueprint, or securing HHS approval of a corrective action plan), and an opportunity for a hearing before issuing a final finding.

(c) The Secretary shall make every reasonable effort to resolve proposed findings without requiring withdrawal of BHP certification and in the event of a decision to withdraw certification, will accept a request from the State for reconsideration.

(d) The effective date of an HHS determination withdrawing BHP certification shall not be earlier than 120 days following a final finding of noncompliance with the standards for certification.

(e) Within 30 days following a final finding of noncompliance with the standards for certification, the State shall submit a transition plan that describes procedures to assist consumers with transitioning to other insurance affordability programs, and shall comply with the procedures described in §600.140(a)(2) through (8).

§ 600.145 State program administration and operation.

(a) Program operation. The State must implement its BHP in accordance with the approved and fully certified State BHP Blueprint, any approved modifications to the State BHP Blueprint and the requirements of this chapter and applicable law.
(b) Eligibility. All persons have a right to apply for a determination of eligibility and, if eligible, to be enrolled into coverage that conforms to the regulations in this part.

(c) Statewide program operation. A state choosing to operate a BHP must operate it statewide.

(d) No caps on program enrollment. A State implementing a BHP must not be permitted to limit enrollment by setting an income level below the income standard prescribed in section 1331 of the Affordable Care Act, having a fixed enrollment cap or imposing waiting lists.

(e) Transition plan. States implementing in 2015 may identify a transition period following initial implementation during which the state may propose alternative enrollment strategies for approval. The transition plan is required to be submitted as part of the state’s BHP Blueprint consistent with § 600.110.

(f) Core operations. A State operating a BHP must perform all of the following core operating functions:

(1) Eligibility determinations as specified in § 600.320.

(2) Eligibility appeals as specified in § 600.330.

(3) Contracting with standard health plan offerors as specified in § 600.410.

(4) Oversight and financial integrity including, but not limited to, operation of the Trust Fund specified at §§ 600.705 and 600.710, compliance with annual reporting at § 600.170, and providing data required by § 600.610 for Federal funding and reconciliation processes.

(5) Consumer assistance as required in § 600.150.

(6) Extending protections to American Indian/Alaska Natives specified at § 600.160, as well as comply with the Civil Rights and nondiscrimination provisions specified at § 600.165.

(7) Data collection and reporting as necessary for efficient and effective operation of the program and as specified by HHS to support program oversight.

(8) If necessary, program termination procedures at § 600.145.

§ 600.150 Enrollment assistance and information requirements.

(a) Information disclosure. (1) The State must make accurate, easily understood information available to potential applicants and enrollees about the BHP coverage option along with information about other insurance affordability programs.

(2) The State must provide accessible information on coverage, including additional benefits that may be provided outside of the standard health plan coverage, any tiers of coverage it has built into the BHP, including who is eligible for each tier.

(3) The State must require participating standard health plans to provide clear information on premiums; covered services including any limits on amount, duration and scope of those services; applicable cost-sharing using a standard format supplied by the State, and other data specified in, and in accordance with, 45 CFR 156.220.

(4) The State must provide information in a manner consistent with 45 CFR 155.205(c).

(5) The State must require participating standard health plans to make publicly available, and keep up to date (at least quarterly), the names and locations of currently participating providers.

(b) [Reserved]

§ 600.155 Tribal consultation.

The State must consult with Indian tribes located in the State on the development and execution of the BHP Blueprint using the tribal consultation policy approved by the State Exchange.

§ 600.160 Protections for American Indian and Alaska Natives.

(a) Enrollment. Indians must be extended the same special enrollment status in BHP standard health plans as applicable to enrollment in a QHP through the Exchange under 45 CFR 155.420(d)(8). Indians will be allowed to enroll in, or change enrollment in, standard health plans one time per month.

(b) Cost sharing. No cost sharing may be imposed on Indians under the standard health plan.

(c) Payments to providers. Equal to the protection extended to Indian health providers providing services to Indians enrolled in a QHP in the individual market through an Exchange at 45 CFR 156.430(g), BHP offerors may not reduce

853
§ 600.165 Nondiscrimination standards.

(a) The State and standard health plans, must comply with all applicable civil rights statutes and requirements, including Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act, and 45 CFR part 80, part 84, and part 91 and 28 CFR part 35.

(b) The State must comply with the nondiscrimination provision at 45 CFR 155.120(c)(2).

§ 600.170 Annual report content and timing.

(a) Content. The State must submit an annual report that includes any evidence of fraud, waste, or abuse on the part of participating providers, plans, or the State BHP agency known to the State, and a detailed data-driven review of compliance with the following:

(1) Eligibility verification requirements for program participation as specified in §600.345.

(2) Limitations on the use of Federal funds received by the BHP as specified in §600.705.

(3) Requirements to collect quality and performance measures from all participating standard health plans focusing on quality of care and improved health outcomes as specified in sections 1311(c)(3) and (4) of the Affordable Care Act and as further described in §600.415.

(4) Requirements specified by the Secretary at least 120 days prior to the date of the annual report as requiring further study to assess continued State compliance with Federal law, regulations and the terms of the State’s certified Blueprint, based on a Federal review of the BHP pursuant to §600.200, and/or a list of any outstanding recommendations from any audit or evaluation conducted by the HHS Office of Inspector General that have not been fully implemented, including a statement describing the status of implementation and why implementation is not complete.

(b) Timing. The annual reports, in the format specified by the Secretary, are due 60 days after the end of each operational year. Information that may be required to secure the release of funding for the subsequent year may be requested in advance.
Centers for Medicare & Medicaid Services, HHS

§ 600.305

(4) Improper use of BHP trust fund resources. The State and the BHP trustees shall be given an opportunity to review and resolve concerns regarding improper use of BHP trust funds, including failure to use these funds as specified in §600.705. As indicated in §600.715(a) through (c), the state may do this either by substantiating the proper use of trust fund resources as specified in §600.705(c) or by taking corrective action, which include changes to procedures to ensure proper use of trust fund resources, and restitution of improperly used resources to the trust fund.

(c) The HHS Office of Inspector General (OIG) may periodically audit State operations and standard health plan practices as described in §430.33 of this chapter. Final reports on those audits shall be transmitted to both the State and the Secretary for actions on findings. The State and the BHP trustees shall be given an opportunity to resolve concerns about improper use of BHP trust funds as indicated in §600.715(a) through (c); either by substantiating the proper use of trust fund resources as specified in §600.705(c) or by taking corrective action that includes changes to procedures to ensure proper use of trust fund resources, and restitution of improperly used resources to the trust fund.

Subpart D—Eligibility and Enrollment

§ 600.300 Basis, scope, and applicability.

(a) Statutory basis. This subpart interprets and implements section 1331(e) of the Affordable Care Act, which sets forth eligibility standards for the BHP and prohibits eligible individuals from being treated as qualified individuals under section 1332 of the Affordable Care Act and enrolling in qualified health plans offered through the Exchange.

(b) Scope and applicability. This subpart sets forth the requirements for all BHPs established under section 1331 of the Affordable Care Act regarding eligibility standards and application screening and enrollment procedures.

§ 600.305 Eligible individuals.

(a) Eligibility standards. The State must determine individuals eligible to enroll in a standard health plan if they:

(1) Are residents of the State.

(2) Have household income which exceeds 133 percent but does not exceed 200 percent of the FPL for the applicable family size, or, in the case of an individual who is a lawfully present non-citizen, ineligible for Medicaid or CHIP due to such immigration status, whose household income is between zero and 200 percent of the FPL for the applicable family size.

(3) Are not eligible to enroll in minimum essential coverage (other than a standard health plan). If an individual meets all other eligibility standards, and—

(i) Is eligible for, or enrolled in, coverage that does not meet the definition of minimum essential coverage, including Medicaid that is not minimum essential coverage, the individual is eligible to enroll in a standard health plan without regard to eligibility or enrollment in Medicaid; or

(ii) Is eligible for Employer Sponsored Insurance (ESI) that is unaffordable (as determined under section 36B(c)(2)(C) of the Internal Revenue Code), the individual is eligible to enroll in a standard health plan.

(4) Are 64 years of age or younger.

(5) Are either a citizen or lawfully present non-citizen.

(6) Are not incarcerated, other than during a period pending disposition of charges.

(b) Eligibility restrictions. With the exception of during an approved implementation period specified in a transition plan in accordance with §600.145, the State may not impose conditions of eligibility other than those identified
§ 600.310 Application.

(a) Single streamlined application. The State must use the single streamlined application used by the State in accordance with § 435.907(b) of this chapter and 45 CFR 155.405(a) and (b).

(b) Opportunity to apply and assistance with application. The terms of §§ 435.906, 435.907(g) and 435.908 of this chapter, requiring the State to provide individuals the opportunity to apply and receive assistance with an application in the Medicaid program, apply in the same manner to States in the administration of the BHP.

(c) Authorized representatives. The State may choose to permit the use of an authorized representative designated by an applicant or beneficiary to assist with the individual’s application, eligibility renewal and other ongoing communication with the BHP. If the State chooses this option, the State must follow the standards set forth at either 45 CFR 155.227 or 42 CFR 435.923.

§ 600.315 Certified application counselors.

The State may have a program to certify application counselors to assist individuals to apply for enrollment in the BHP and other insurance affordability programs. If the State chooses this option, the State must follow the procedures and standards for such a program set forth in the regulations at either 45 CFR 155.225 or 42 CFR 435.908.

§ 600.320 Determination of eligibility for and enrollment in a standard health plan.

(a) Determining eligibility to enroll in a standard health plan may be performed by a State or through delegation to a local governmental entity, including a governmental entity that determines eligibility for Medicaid or CHIP, and may be delegated by the State to an Exchange that is a government agency.

(b) Timely determinations. The terms of 42 CFR 435.912 (relating to timely determinations of eligibility under the Medicaid program) apply to eligibility determinations for enrollment in a standard health plan exclusive of § 435.912(c)(3)(i). The standards established by the State must be included in the BHP Blueprint.

(c) Effective date of eligibility. The State must establish a uniform method of determining the effective date of eligibility for enrollment in a standard health plan following either the Exchange standards at 45 CFR 155.420(b)(1) or the Medicaid process at 42 CFR 435.915 exclusive of § 435.915(a).

(d) Enrollment periods. The State must either offer enrollment and special enrollment periods no more restrictive than those required for an Exchange at 45 CFR 155.410 and 155.420 or follow the Medicaid process permitting continuous open enrollment throughout the year.

§ 600.330 Coordination with other insurance affordability programs.

(a) Coordination. The State must establish and maintain processes to maximize coordination with the Exchange, Medicaid and CHIP. The terms of 45 CFR 155.345(a) regarding the agreements between insurance affordability programs apply to a BHP. The State BHP agency must fulfill the requirements of 42 CFR 435.1200(d) and (e) and, if applicable, paragraph (c) for BHP eligible individuals.

(b) Coordinated determinations of eligibility. The agency administering BHP must establish and maintain processes to make income eligibility determinations using modified adjusted gross income, and to ensure that applications received by the agency, to the extent warranted and permitted under delegations from other agencies administering insurance affordability programs, also result in eligibility assessments or determinations for those other programs. The BHP must also accept applications transferred from other agencies administering insurance affordability programs, and ensure that individuals assessed or determined eligible for BHP by such other agencies are afforded the opportunity to enroll.
in a standard health plan without undue delay. Individuals submitting applications to any of the aforementioned agencies must not be required to duplicate the submission of information.

(c) Account transfers. The agency administering the BHP must participate in the secure exchange of information with agencies administering other insurance affordability programs, using the standards set forth under 45 CFR 155.345(h) regarding electronic account transfers.

(d) Notification to referring agency. The terms in §435.1200(d)(5) regarding the notification to other programs of the final determination of eligibility apply equally to States administering a BHP.

(e) Notice of decision concerning eligibility. Every application for BHP shall result in a determination of eligibility or ineligibility, unless the application has been withdrawn, the applicant has died, or the applicant cannot be located. Written notices of eligibility determinations shall be provided and shall be coordinated with other insurance affordability programs and Medicaid. Electronic notices shall be provided to the extent consistent with §435.918(b).

§ 600.340 Periodic redetermination and renewal of BHP eligibility.

(a) Periodic review of eligibility. An individual is subject to periodic review of eligibility every 12 months unless the eligibility is redetermined sooner based on new information received and verified from enrollee reports or data sources. The State must require enrollees to report changes in circumstances, at least to the extent that they would be required to report such changes if enrolled in coverage through the Exchange, consistent with 45 CFR 155.330(b).

(b) Renewal of coverage. If an enrollee remains eligible for coverage in the BHP, the enrollee will be afforded notice of a reasonable opportunity at least annually to change plans to the extent the BHP offers a choice of plans, and shall remain in the plan selected for the previous year unless such enrollee terminates coverage from the plan by selecting a new plan or withdrawing from a plan, or the plan is no longer available as a standard health plan in BHP. Enrollees in plans that are no longer available will be given a reasonable opportunity to select a new plan, and if they do not select a new plan will be enrolled in another plan pursuant to a methodology set forth in the State’s Blueprint.

(c) Procedures. The State shall choose to apply equally all the redetermination procedures described in either 45 CFR 155.335 or 42 CFR 435.916(a) in administering a BHP.

(d) Verification. The State must verify information needed to redetermine and renew eligibility in accordance with §600.345 and comply with the requirements set forth in §600.330 relating to screening individuals for other insurance affordability programs and transmitting such individuals’ electronic accounts and other relevant information to the other program, as appropriate.

(e) Notice to enrollee. The State must provide an enrollee with an annual notice of determination of eligibility. The annual notice should include all current information used for the most recent eligibility determination. The enrollee is required to report any changes with respect to information listed within the notice within 30 days of the date of the notice. The State must verify information in accordance with §600.345.

(f) Continuous eligibility. The state is not required to redetermine eligibility of BHP enrollees more frequently than every 12 months, regardless of changes
§ 600.345 Eligibility verification.
(a) The State must verify the eligibility of an applicant or beneficiary for BHP consistent either with the standards and procedures set forth in—
(1) Medicaid regulations at §§ 435.945 through 435.956 of this chapter; or
(2) Exchange regulations at 45 CFR 155.315 and 155.320.
(b) [Reserved]

§ 600.350 Privacy and security of information.
The State must comply with the standards and procedures set forth in 45 CFR 155.260(b) and (c) as are applicable to the operation of the BHP.

Subpart E—Standard Health Plan
§ 600.400 Basis, scope, and applicability.
(a) Statutory basis. This subpart implements sections 1331(b), (c), and (g) of the Affordable Care Act, which set forth provisions regarding the minimum coverage standards under BHP, as well as the delivery of such coverage, including the contracting process for standard health plan offerors participating in the BHP.
(b) Scope and applicability. This subpart consists of provisions relating to all BHPs for the delivery of, at a minimum, the ten essential health benefits as described in section 1302(b) of the Affordable Care Act, the contracting process by which States must contract for the provision of standard health plans, the minimum requirements States must include in their standard health plan contracts, the minimum coverage standards provided by the standard health plan offeror, and other applicable requirements to enhance the coordination of the provision of standard health plan coverage.

§ 600.405 Standard health plan coverage.
(a) Essential Health Benefits (EHB). Standard health plan coverage must include, at a minimum, the essential health benefits as determined and specified under 45 CFR 156.110, and 45 CFR 156.122 regarding prescription drugs, except that States may select more than one base benchmark option from those codified at 45 CFR 156.100 for establishing essential health benefits for standard health plans. Additionally, States must comply with 45 CFR 156.122(a)(2) by requiring participating plans to submit their drug list to the State.
(b) Additional required benefits. Where the standard health plan for BHP is subject to State insurance mandates, the State shall adopt the determination of the Exchange at 45 CFR 155.170(a)(3) in determining which benefits enacted after December 31, 2011 are in addition to EHB.
(c) Periodic review. Essential health benefits must include any changes resulting from periodic reviews required by section 1302(b)(4)(G) of the Affordable Care Act. The provision of such essential health benefits must meet all the requirements of 45 CFR 156.115.
(d) Non-discrimination in benefit design. The terms of 45 CFR 156.125 applies to standard health plans offered under the BHP.
(e) Compliance. The State and standard health plans must comply with prohibitions on federal funding for abortion services at 45 CFR 156.280.

§ 600.410 Competitive contracting process.
(a) General requirement. In order to receive initial HHS certification as described in §600.120, the State must assure in its BHP Blueprint that it complies with the requirements set forth in this section.
(b) Contracting process. The State must:
(1) Conduct the contracting process in a manner providing full and open competition consistent with the standards of 45 CFR 92.36(b) through (l);
(2) Include a negotiation of the elements described in paragraph (d) of this section on a fair and adequate basis; and
(3) Consider the additional elements described in paragraph (e) of this section.

§ 600.465 Standard health plan coverage.
(a) Essential Health Benefits (EHB). Standard health plan coverage must include, at a minimum, the essential health benefits as determined and specified under 45 CFR 156.110, and 45 CFR 156.122 regarding prescription drugs, except that States may select more than one base benchmark option from those codified at 45 CFR 156.100 for establishing essential health benefits for standard health plans. Additionally, States must comply with 45 CFR 156.122(a)(2) by requiring participating plans to submit their drug list to the State.
(b) Additional required benefits. Where the standard health plan for BHP is subject to State insurance mandates, the State shall adopt the determination of the Exchange at 45 CFR 155.170(a)(3) in determining which benefits enacted after December 31, 2011 are in addition to EHB.
(c) Periodic review. Essential health benefits must include any changes resulting from periodic reviews required by section 1302(b)(4)(G) of the Affordable Care Act. The provision of such essential health benefits must meet all the requirements of 45 CFR 156.115.
(d) Non-discrimination in benefit design. The terms of 45 CFR 156.125 applies to standard health plans offered under the BHP.
(e) Compliance. The State and standard health plans must comply with prohibitions on federal funding for abortion services at 45 CFR 156.280.

§ 600.410 Competitive contracting process.
(a) General requirement. In order to receive initial HHS certification as described in §600.120, the State must assure in its BHP Blueprint that it complies with the requirements set forth in this section.
(b) Contracting process. The State must:
(1) Conduct the contracting process in a manner providing full and open competition consistent with the standards of 45 CFR 92.36(b) through (l);
(2) Include a negotiation of the elements described in paragraph (d) of this section on a fair and adequate basis; and
(3) Consider the additional elements described in paragraph (e) of this section.
(c) Initial implementation exceptions. (1) If a State is not able to implement
a competitive contracting process described in paragraph (b) of this section for program year 2015, the State must include a justification as to why it cannot meet the conditions in paragraph (b), as well as a description of the process it will use to enter into contracts for the provision of standard health plans under BHP.

(2) The State must include a proposed timeline that implements a competitive contracting process, as described in paragraph (b) of this section, for program year 2016.

(3) Initial implementation exceptions are subject to HHS approval consistent with the BHP Blueprint review process established in §600.120, and may only be in effect for benefit year 2015.

(d) Negotiation criteria. The State must assure that its competitive contracting process includes the negotiation of:

(1) Premiums and cost sharing, consistent with the requirements at §§600.505 and 600.510(e);

(2) Benefits, consistent with the requirements at §600.405;

(3) Inclusion of innovative features, such as:

(i) Care coordination and care management for enrollees, with a particular focus on enrollees with chronic health conditions;

(ii) Incentives for the use of preventive services; and

(iii) Establishment of provider-patient relationships that maximize patient involvement in their health care decision-making, including the use of incentives for appropriate health care utilization and patient choice of provider.

(e) Other considerations: The State shall also include in its competitive process criteria to ensure:

(1) Consideration of health care needs of enrollees;

(2) Local availability of, and access, to health care providers to ensure the appropriate number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area (including but not limited to services provided by essential community providers, as defined in 45 CFR 156.235) so that access to services is at least sufficient to meet the access standards applicable under 42 CFR part 438, subpart D, or 45 CFR 156.230 and 156.235;

(3) Use of a managed care process, or a similar process to improve the quality, accessibility, appropriate utilization, and efficiency of services provided to enrollees;

(4) Performance measures and standards focused on quality of care and improved health outcomes as specified in §600.415;

(5) Coordination between other health insurance affordability programs to ensure enrollee continuity of care as described in §600.425; and

(6) Measures to prevent, identify, and address fraud, waste and abuse and ensure consumer protections.

(f) Discrimination. Nothing in the competitive process shall permit or encourage discrimination in enrollment based on pre-existing conditions or other health status-related factors.

§600.415 Contracting qualifications and requirements.

(a) Eligible offerors for standard health plan contracts. A State may enter into contracts for the administration and provision of standard health plans under the BHP with, but not limited to, the following entities:

(1) Licensed health maintenance organization.

(2) Licensed health insurance insurer.

(3) Network of health care providers demonstrating capacity to meet the criteria set forth in §600.410(d).

(4) Non-licensed health maintenance organizations participating in Medicaid and/or CHIP.

(b) General contract requirements. (1) A State contracting with eligible standard health plan offerors described in paragraph (a) of this section must include contract provisions addressing network adequacy, service provision and authorization, quality and performance, enrollment procedures, disenrollment procedures, noticing and appeals, provisions protecting the privacy and security of personally identifiable information, and other applicable contract requirements as determined by the Secretary to the extent that the service delivery model furthers the objectives of the program.

(2) All contracts under this part must include provisions that define a sound
§ 600.420 Enhanced availability of standard health plans.

(a) Choice of standard health plans offerors. (1) The State must assure that standard health plans from at least two offerors are available to enrollees under BHP. This assurance shall be reflected in the BHP Blueprint, which if applicable, shall also include a description of how it will further ensure enrollee choice of standard health plans.

(2) If a State is not able to assure choice of standard health plan offerors, the State may request an exception to the requirement set forth in paragraph (a)(1) of this section, which must include a justification as to why it cannot assure choice of standard health plan offeror as well as demonstrate that the State has reviewed its competitive contracting process to determine the following:

(i) Whether all contract requirements and qualifications are required under the federal framework for BHP;

(ii) Whether additional negotiating flexibility would be consistent with the minimum statutory requirements and available BHP funding; and

(iii) Whether potential bidders have received sufficient information to encourage participation in the BHP competitive contracting process.

(b) Use of regional compacts. (1) A State may enter into a joint procurement with other States to negotiate and contract with standard health plan offerors to administer and provide standard health plans statewide, or in geographically specific areas within the States, to BHP enrollees residing in the participating regional compact States.

(2) A State electing the option described in paragraph (b)(1) of this section that also contracts for the provision of a geographically specific standard health plan must assure that enrollees, regardless of residency within the State, continue to have choice of at least two standard health plans.

(c) Notification of State election. To receive HHS certification, the State must include in its BHP Blueprint the standard set of contract requirements described in paragraph (b) of this section that will be incorporated into its standard health plan contracts.

§ 600.425 Coordination with other insurance affordability programs.

A State must ensure coordination for the provision of health care services to promote enrollee continuity of care between Medicaid, CHIP, Exchange and any other state-administered health insurance programs. The State’s BHP Blueprint must describe how it will ensure such coordination.

Subpart F—Enrollee Financial Responsibilities

§ 600.500 Basis, scope, and applicability.

(a) Statutory basis. This subpart implements section 1331(a) of the Affordable Care Act, which sets forth provisions regarding the establishment of
the BHP and requirements regarding monthly premiums and cost sharing for enrollees.

(b) Scope and applicability. This subpart consists of provisions relating to the imposition of monthly premiums and cost-sharing under all state BHPs.

§ 600.505 Premiums.

(a) Premium requirements. (1) For premiums imposed on enrollees, the State must assure that the monthly premium imposed on any enrollee does not exceed the monthly premium that the enrollee would have been required to pay had he or she enrolled in a plan with a premium equal to the premium of the applicable benchmark plan, as defined in 26 CFR 1.36B–3(f). The State must assure that when determining the amount of the enrollee’s monthly premium, the State took into account reductions in the premium resulting from the premium tax credit that would have been paid on the enrollee’s behalf.

(2) This assurance must be reflected in the BHP Blueprint, which shall also include:
   (i) The group or groups of enrollees subject to premiums.
   (ii) The collection method and procedure for the payment of an enrollee’s premium.
   (iii) The consequences for an enrollee or applicant who does not pay a premium.

(b) [Reserved]

§ 600.510 Cost-sharing.

(a) Cost-sharing requirements. (1) For cost sharing imposed on enrollees, the State must assure the following:

   (i) The cost sharing imposed on enrollees meet the standards detailed in § 600.520(c).

   (ii) The establishment of an effective system to monitor and track the cost-sharing standards consistent with § 600.520(b) through (d).

   (2) This assurance must be reflected in the BHP Blueprint, which shall also include the group or groups of enrollees subject to the cost sharing.

(b) Cost sharing for preventive health services. A State may not impose cost sharing with respect to the preventive health services or items, as defined in, and in accordance with 45 CFR 147.130.

§ 600.515 Public schedule of enrollee premium and cost sharing.

(a) The State must ensure that applicants and enrollees have access to information about all of the following, either upon request or through an Internet Web site:

   (1) The amount of and types of enrollee premiums and cost sharing for each standard health plan that would apply for individuals at different income levels.

   (2) The consequences for an applicant or an enrollee who does not pay a premium.

(b) The information described in paragraph (a) of this section must be made available to applicants for standard health plan coverage and enrollees in such coverage, at the time of enrollment and reenrollment, after a redetermination of eligibility, when premiums, cost sharing, and annual limitations on cost sharing are revised, and upon request by the individual.

§ 600.520 General cost-sharing protections.

(a) Cost-sharing protections for lower income enrollees. The State may vary premiums and cost sharing based on household income only in a manner that does not favor enrollees with higher income over enrollees with lower income.

(b) Cost-sharing protections to ensure enrollment of Indians. A State must ensure that standard health plans meet the standards in accordance with 45 CFR 156.420(b)(1) and (d).

(c) Cost-sharing standards. A State must ensure that standard health plans meet:

   (1) The standards in accordance with 45 CFR 156.420(c) and (e); and

   (2) The cost-sharing reduction standards in accordance with 45 CFR 156.420(a)(1) for an enrollee with household income at or below 150 percent of the FPL, and 45 CFR 156.420(a)(2) for an enrollee with household income above 150 percent of the FPL.

   (3) The State must establish an effective system to monitor compliance with the cost-sharing reduction standards in paragraph (c) of this section, and the cost-sharing protections to ensure enrollment of Indians in paragraph (b) of this section to ensure that
enrollees are not held responsible for such monitoring activity.

(d) Acceptance of certain third party payments. States must ensure that standard health plans must accept premium and cost-sharing payments from the following third party entities on behalf of plan enrollees:

(1) Ryan White HIV/AIDS Programs under title XXVI of the Public Health Service Act;
(2) Indian tribes, tribal organizations or urban Indian organizations; and
(3) State and federal government programs.

§ 600.525 Disenrollment procedures and consequences for nonpayment of premiums.

(a) Disenrollment procedures due to nonpayment of premium. (1) A State must assure that it is in compliance with the disenrollment procedures described in 45 CFR 155.430. This assurance must be reflected in the state’s BHP Blueprint.

(2) A State electing to enroll eligible individuals in accordance with 45 CFR 155.410 and 155.420 must comply with the premium grace period standards set forth in 45 CFR 156.270 for required premium payment prior to disenrollment.

(3) A State electing to enroll eligible individuals throughout the year must provide an enrollee a 30-day grace period to pay any required premium prior to disenrollment.

(b) Consequences of nonpayment of premium. (1) A State electing to enroll eligible individuals in accordance with 45 CFR 155.410 and 155.420 may not restrict reenrollment to BHP beyond the next open enrollment period.

(2) A State electing to enroll eligible individuals throughout the year must comply with the reenrollment standards set forth in §457.570(c) of this chapter. If applicable, the State must define the length of its premium lock-out period in its BHP Blueprint.

Subpart G—Payment to States

§ 600.600 Basis, scope, and applicability.

(a) Statutory basis. This subpart implements section 1331(d)(1) and (3) of the Affordable Care Act regarding the transfer of Federal funds to a State’s BHP trust fund and the Federal payment amount to a State for the provision of BHP.

(b) Scope and applicability. This subpart consists of provisions relating to the methodology used to calculate the amount of payment to a state in a given Federal fiscal year for the provision of BHP and the process and procedures by which the Secretary establishes a State’s BHP payment amount.

§ 600.605 BHP payment methodology.

(a) General calculation. The Federal payment for an eligible individual in a given Federal fiscal year is the sum of the premium tax credit component, as described in paragraph (a)(1) of this section, and the cost-sharing reduction component, as described in paragraph (a)(2) of this section.

(1) Premium tax credit component. The premium tax credit component equals 95 percent of the premium tax credit for which the eligible individual would have qualified had he or she been enrolled in a qualified health plan through an Exchange in a given calendar year, adjusted by the relevant factors described in paragraph (b) of this section.

(2) Cost-sharing reduction component. The cost-sharing reduction component equals 95 percent of the cost of the cost-sharing reductions for which the eligible individual would have qualified had he or she been enrolled in a qualified health plan through an Exchange in a given calendar year adjusted by the relevant factors described in paragraph (b) of this section.

(b) Relevant factors in the payment methodology. In determining the premium tax credit and cost-sharing reductions components described in paragraph (a) of this section, the Secretary will consider the following factors to determine applicable adjustments:

(1) Age of the enrollee;
(2) Income of the enrollee;
(3) Self-only or family coverage;
(4) Geographic differences in average spending for health care across rating areas;
(5) Health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments had the enrollee been enrolled in
Centers for Medicare & Medicaid Services, HHS

§ 600.610 Secretarial determination of BHP payment amount.

(a) Proposed payment notice. (1) Beginning in FY 2015 and each subsequent year thereafter, the Secretary will determine and publish in a FEDERAL REGISTER document the next fiscal year’s BHP payment methodology. The Secretary will publish this document annually in October upon receiving certification from the Chief Actuary of CMS.

(2) A State may be required to submit data in accordance with the published proposed payment document in order for the Secretary to determine the State’s payment rate as described in paragraph (b) of this section.

(b) Final payment notice. (1) The Secretary will determine and publish the final BHP payment methodology and BHP payment amounts annually in February in a FEDERAL REGISTER document.

(2) Calculation of payment rates. State payment rates are determined by the Secretary using the final BHP payment methodology, data requested in the proposed payment notice described in paragraph (a) of this section, and, if needed, other applicable data as determined by the Secretary.

(c) State specific aggregate BHP payment amounts—(1) Prospective aggregate payment amount. The Secretary will determine, on a quarterly basis, the prospective aggregate BHP payment amount by multiplying the payment rates described in paragraph (b) of this section by the projected number of enrollees. This calculation would be made for each category of enrollees based on enrollee characteristics and the other relevant factors considered when determining the payment methodology. The prospective aggregate BHP payment amount would be the sum of the payments determined for each category of enrollees for a State.

(2) Retrospective adjustment to state specific aggregate payment amount for enrollment and errors. (i) Sixty days after the end of each fiscal year quarter, the Secretary will calculate a retrospective adjustment to the previous quarter’s specific aggregate payment amount by multiplying the payment rates described in paragraph (b) of this section by actual enrollment for the respective quarter. This calculation would be made for each category of enrollees based on enrollee characteristics and the other relevant factors considered when determining the payment methodology. The adjusted BHP payment amount would be the sum of the payments determined for each category of enrollees for a State.

(ii) Upon determination that a mathematical error occurred during the application of the BHP funding methodology, the Secretary will recalculate the state’s BHP payment amount and make any necessary adjustments in accordance with paragraph (c)(2)(iv) of this section.

(iii) To the extent that the final payment notice described in paragraph (b) of this section permits retrospective adjustments to the state’s BHP payment amount (due to the lack of necessary data for the Secretary to prospectively determine the relevant factors comprising the premium tax credit and cost-sharing reductions components of the BHP funding methodology), the Secretary will recalculate the state’s BHP payment amount and
make any necessary adjustments in accordance with paragraph (c)(2)(iv) of this section.

(iv) Any difference in the adjusted payment and the prospective aggregate payment amount will result in either:

(A) A deposit of the difference amount into the State's BHP trust fund; or

(B) A reduction in the upcoming quarter’s prospective aggregate payment as described in paragraph (c)(1) of this section by the difference amount.

§ 600.615 Deposit of Federal BHP payment.

HHS will make quarterly deposits into the state’s BHP trust fund based on the aggregate quarterly payment amounts described in §600.610(c).

Subpart H—BHP Trust Fund

§ 600.700 Basis, scope, and applicability.

(a) Statutory basis. This subpart implements section 1331(d)(2) of the Affordable Care Act, which set forth provisions regarding BHP trust fund expenditures, fiscal policies and accountability standards and restitution to the BHP trust fund for unallowable expenditures.

(b) Scope and applicability. This subpart sets forth a framework for BHP trust funds and accounting, establishing sound fiscal policies and accountability standards and procedures for the restitution of unallowable BHP trust fund expenditures.

§ 600.705 BHP trust fund.

(a) Establishment of BHP trust fund. (1) The State must establish a BHP trust fund with an independent entity, or in a segregated account within the State’s fund structure.

(2) The State must identify trustees responsible for oversight of the BHP trust fund.

(3) Trustees must specify individuals with the power to authorize withdrawal of funds for allowable trust fund expenditures.

(b) Non-Federal deposits. The State may deposit non-Federal funds, including such funds from enrollees, providers or other third parties for standard health plan coverage, into its BHP trust fund. Upon deposit, such funds will be considered BHP trust funds, must remain in the BHP trust fund and meet the standards described in paragraphs (c) and (d) of this section.

(c) Allowable trust fund expenditures. BHP trust funds may only be used to:

(1) Reduce premiums and cost sharing for eligible individuals enrolled in standard health plans under BHP; or

(2) Provide additional benefits for eligible individuals enrolled in standard health plans as determined by the State.

(d) Limitations. BHP trust funds may not be expended for any purpose other than those specified in paragraph (c) of this section. In addition, BHP trust funds may not be used for other purposes including but not limited to:

(1) Determining the amount of non-Federal funds for the purposes of meeting matching or expenditure requirements for Federal funding;

(2) Program administration of BHP or any other program;

(3) Payment to providers not associated with BHP services or requirements; or

(4) Coverage for individuals not eligible for BHP.

(e) Year-to-year carryover of trust funds. A State may maintain a surplus, or reserve, of funds in its trust through the carryover of unexpended funds from year-to-year. Expenditures from this surplus must be made in accordance with paragraphs (b) and (c) of this section.

§ 600.710 Fiscal policies and accountability.

The BHP administering agency must assure the fiscal policies and accountability set forth in paragraphs (a) through (g) of this section. This assurance must be reflected in the BHP Blueprint.

(a) Accounting records. Maintain an accounting system and supporting fiscal records to assure that the BHP trust funds are maintained and expended in accord with applicable Federal requirements, such as OMB Circulars A–87 and A–133.

(b) Annual certification. Obtain an annual certification from the BHP trustees, the State’s chief financial officer,
§ 600.715 Corrective action, restitution, and disallowance of questioned BHP transactions.

(a) Corrective action. When a question has been raised concerning the authority for BHP trust fund expenditures in an OIG report, other HHS compliance review, State audit or otherwise, the BHP trustees and the State shall review the issues and develop a written response no later than 60 days upon receipt of such a report, unless otherwise specified in the report, review or audit. To the extent determined necessary in that review, the BHP trustees and State shall implement changes to fiscal procedures to ensure proper use of trust fund resources.

(b) Restitution. To the extent that the State and BHP trustees determine that BHP trust funds may not have been properly spent, they must ensure restitution to the BHP trust fund of the funds in question. Restitution may be made directly by the BHP trustees, by the State, or by a liable third party. The State or the BHP trustees may enter into indemnification agreements assigning liability for restitution of funds to the BHP trust fund.

(c) Timing of restitution. Restitution to the BHP trust fund for any unallowable expenditure may occur in a lump sum amount, or in equal installment amounts. Restitution to the BHP trust fund cannot exceed a 2-year period from the date of the written response in accordance with paragraph (a) of this section.

(d) HHS disallowance of improper BHP trust fund expenditures. The State shall return to HHS the amount of federal BHP funding that HHS has determined was expended for unauthorized purposes, when no provision has been made to restore the funding to the BHP trust fund in accordance with paragraph (b) of this section (unless the restitution does not comply with the timing conditions described in paragraphs (c) of this section). When HHS determines that federal BHP funding is not allowable, HHS will provide written notice to the State and BHP Trustees containing:

(1) The date or dates of the improper expenditures from the BHP trust fund;
(2) A brief written explanation of the basis for the determination that the expenditures were improper; and

(3) Procedures for administrative reconsideration of the disallowance based on a final determination.

(e) Administrative reconsideration of BHP trust fund disallowances. (1) BHP Trustees or the State may request reconsideration of a disallowance within 60 days after receipt of the disallowance notice described in paragraph (d)(1) of this section by submitting a written request for review, along with any relevant evidence, documentation, or explanation, to HHS.

(2) After receipt of a reconsideration request, if the Secretary (or a designated hearing officer) determines that further proceedings would be warranted, the Secretary may issue a request for further information by a specific date, or may schedule a hearing to obtain further evidence or argument.

(3) The Secretary, or designee, shall issue a final decision within 90 days after the later of the date of receipt of the reconsideration request or date of the last scheduled proceeding or submission.

(f) Return of disallowed BHP funding. Disallowed federal BHP funding must be returned to HHS within 60 days after the later of the date of the disallowance notice or the final administrative reconsideration upholding the disallowance. Such repayment cannot be made from BHP trust funds, but must be made with other, non-Federal funds.

PARTS 601–699 [RESERVED]
CHAPTER V—OFFICE OF INSPECTOR
GENERAL-HEALTH CARE, DEPARTMENT OF
HEALTH AND HUMAN SERVICES

EDITORIAL NOTE: Nomenclature changes to chapter V appear at 66 FR 39452, July 31, 2001,

SUBCHAPTER A—GENERAL PROVISIONS

<table>
<thead>
<tr>
<th>Part</th>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000</td>
<td></td>
<td>Introduction; general definitions</td>
<td>869</td>
</tr>
</tbody>
</table>

SUBCHAPTER B—OIG AUTHORITIES

<table>
<thead>
<tr>
<th>Part</th>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1001</td>
<td></td>
<td>Program integrity—Medicare and State health care programs</td>
<td>872</td>
</tr>
<tr>
<td>1002</td>
<td></td>
<td>Program integrity—State-initiated exclusions from Medicaid</td>
<td>921</td>
</tr>
<tr>
<td>1003</td>
<td></td>
<td>Civil money penalties, assessments and exclusions</td>
<td>923</td>
</tr>
<tr>
<td>1004</td>
<td></td>
<td>Imposition of sanctions on health care practitioners and providers of health care services by a Quality Improvement Organization</td>
<td>940</td>
</tr>
<tr>
<td>1005</td>
<td></td>
<td>Appeals of exclusions, civil money penalties and assessments</td>
<td>949</td>
</tr>
<tr>
<td>1006</td>
<td></td>
<td>Investigational inquiries</td>
<td>957</td>
</tr>
<tr>
<td>1007</td>
<td></td>
<td>State Medicaid fraud control units</td>
<td>959</td>
</tr>
<tr>
<td>1008</td>
<td></td>
<td>Advisory opinions by the OIG</td>
<td>964</td>
</tr>
<tr>
<td>1009</td>
<td>–1099</td>
<td>[Reserved]</td>
<td></td>
</tr>
</tbody>
</table>
SUBCHAPTER A—GENERAL PROVISIONS

PART 1000—INTRODUCTION; GENERAL DEFINITIONS

Subpart A (Reserved)

Subpart B—Definitions

Sec. 1000.10 General definitions.

1000.20 Definitions specific to Medicare.

1000.30 Definitions specific to Medicaid.

AUTHORITY: 42 U.S.C. 1320 and 1395hh.

SOURCE: 51 FR 34766, Sept. 30, 1986, unless otherwise noted.

Subpart A (Reserved)

Subpart B—Definitions

§ 1000.10 General definitions.

In this chapter, unless the context indicates otherwise—

Act means the Social Security Act, and titles referred to are titles of that Act.

Administrator means the Administrator, Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA).

Beneficiary means any individual eligible to have benefits paid to him or her, or on his or her behalf, under Medicare or any State health care program.


CMS stands for Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration (HCFA).

Department means the Department of Health and Human Services (HHS), formerly the Department of Health, Education, and Welfare.

Directly, as used in the definition of “furnished” in this section, means the provision of items and services by individuals or entities (including items and services provided by them, but manufactured, ordered or prescribed by another individual or entity) who submit claims to Medicare, Medicaid or other Federal health care programs.

ESRD stands for end-stage renal disease.

FR stands for Federal Register.

Furnished refers to items or services provided or supplied, directly or indirectly, by any individual or entity. This includes items and services manufactured, distributed or otherwise provided by individuals or entities that do not directly submit claims to Medicare, Medicaid or other Federal health care programs, but that supply items or services to providers, practitioners or suppliers who submit claims to these programs for such items or services.

HHS stands for the Department of Health and Human Services.

HHA stands for home health agency.

HMO stands for health maintenance organization.

ICF stands for intermediate care facility.

Indirectly, as used in the definition of “furnished” in this section, means the provision of items and services manufactured, distributed or otherwise supplied by individuals or entities who do not directly submit claims to Medicare, Medicaid or other Federal health care programs, but that provide items and services to providers, practitioners or suppliers who submit claims to these programs for such items and services. This term does not include individuals and entities that submit claims directly to these programs for items and services ordered or prescribed by another individual or entity.


Medicaid means medical assistance provided under a State plan approved under Title XIX of the Act.

Medicare means the health insurance program for the aged and disabled under Title XVIII of the Act.

OIG means the Office of Inspector General within HHS.

QIO stands for Utilization and Quality Control Quality Improvement Organization.

Secretary means the Secretary of Health and Human Services.
SNF stands for skilled nursing facility.

Social security benefits means monthly cash benefits payable under section 202 or 223 of the Act.

SSA stands for Social Security Administration.

United States means the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.


§ 1000.20 Definitions specific to Medicare.

As used in connection with the Medicare program, unless the context indicates otherwise—

Carrier means an entity that has a contract with CMS to determine and make Medicare payments for Part B benefits payable on a charge basis and to perform other related functions.

Entitled means that an individual meets all the requirements for Medicare benefits.

Hospital insurance benefits means payments on behalf of, and in rare circumstances directly to, an entitled individual for services that are covered under Part A of Title XVIII of the Act.

Intermediary means an entity that has a contract with CMS to determine and make Medicare payments for Part A or Part B benefits payable on a cost basis and to perform other related functions.

Medicare Part A means the hospital insurance program authorized under Part A of Title XVIII of the Act.

Medicare Part B means the supplementary medical insurance program authorized under Part B of Title XVIII of the Act.

Provider means a hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has a similar agreement but only to furnish outpatient physical therapy or speech pathology services.


Services means medical care or services and items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital or SNF facilities.

Supplementary medical insurance benefits means payment to or on behalf of an entitled individual for services covered under Part B of Title XVIII of the Act.

Supplier means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare.

§ 1000.30 Definitions specific to Medicaid.

As used in connection with the Medicaid program, unless the context indicates otherwise—

Applicant means an individual whose written application for Medicaid has been submitted to the agency determining Medicaid eligibility, but has not received final action. This includes an individual (who need not be alive at the time of application) whose application is submitted through a representative or a person acting responsibly for the individual.

Federal financial participation (FFP) means the Federal Government’s share of a State’s expenditures under the Medicaid program.

FMAP stands for the Federal medical assistance percentage, which is used to calculate the amount of Federal share of State expenditures for services.

Medicaid agency or agency means the single State agency administering or supervising the administration of a State Medicaid plan.

Provider means any individual or entity furnishing Medicaid services under a provider agreement with the Medicaid agency.

Recipient means an individual who has been determined eligible for Medicaid.
Services means the types of medical assistance specified in sections 1905(a)(1) through (18) of the Act.

State means the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa and the Northern Mariana Islands.

State plan or the plan means a comprehensive written commitment by a Medicaid agency, submitted under section 1902(a) of the Act, to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.
SUBCHAPTER B—OIG AUTHORITIES

PART 1001—PROGRAM INTEGRITY—MEDICARE AND STATE HEALTH CARE PROGRAMS

Subpart A—General Provisions

Sec. 1001.1 Scope and purpose.
1001.2 Definitions.

Subpart B—Mandatory Exclusions

1001.101 Basis for liability.
1001.102 Length of exclusion.

Subpart C—Permissive Exclusions

1001.201 Conviction relating to program or health care fraud.
1001.301 Conviction relating to obstruction of an investigation.
1001.401 Conviction relating to controlled substances.
1001.501 License revocation or suspension.
1001.601 Exclusion or suspension under a Federal or State health care program.
1001.701 Excessive claims or furnishing of unnecessary or substandard items and services.
1001.801 Failure of HMOs and CMPs to furnish medically necessary items and services.
1001.901 False or improper claims.
1001.951 Fraud and kickbacks and other prohibited activities.
1001.1001 Exclusion of entities owned or controlled by a sanctioned person.
1001.1051 Exclusion of individuals with ownership or control interest in sanctioned entities.
1001.1101 Failure to disclose certain information.
1001.1201 Failure to provide payment information.
1001.1301 Failure to grant immediate access.
1001.1401 Violations of PPS corrective action.
1001.1501 Default of health education loan or scholarship obligations.
1001.1601 Violations of the limitations on physician charges.
1001.1701 Billing for services of assistant at surgery during cataract operations.

APPENDIX A TO SUBPART C OF PART 1001

Subpart D—Waivers and Effect of Exclusion

1001.1801 Waivers of exclusions.
1001.1901 Scope and effect of exclusion.

Subpart E—Notice and Appeals

1001.2001 Notice of intent to exclude.
1001.2002 Notice of exclusion.
1001.2003 Notice of proposal to exclude.
1001.2004 Notice to State agencies.
1001.2005 Notice to State licensing agencies.
1001.2006 Notice to others regarding exclusion.
1001.2007 Appeal of exclusions.

Subpart F—Reinstatement into the Programs

1001.3001 Timing and method of request for reinstatement.
1001.3002 Basis for reinstatement.
1001.3003 Approval of request for reinstatement.
1001.3004 Denial of request for reinstatement.
1001.3005 Reversed or vacated decisions.

AUTHORITY: 42 U.S.C. 1302, 1320a–7, 1320a–7b, 1395a(j), 1395a(k), 1395w–10(e)(6), 1395y(d), 1395y(e), 1395cc(b)(2)(D), (E) and (F), and 1396h; and sec. 2455, Pub. L. 103–355, 108 Stat. 3327 (31 U.S.C. 6101 note).

SOURCE: 57 FR 3330, Jan. 29, 1992, unless otherwise noted.

Subpart A—General Provisions

§ 1001.1 Scope and purpose.

(a) The regulations in this part specify certain bases upon which individuals and entities may, or in some cases must, be excluded from participation in Medicare, Medicaid and all other Federal health care programs. They also state the effect of exclusion, the factors that will be considered in determining the length of any exclusion, the provisions governing notices of exclusion, and the process by which an excluded individual or entity may seek reinstatement into the programs.

(b) The regulations in this part are applicable to and binding on the Office of Inspector General (OIG) in imposing and proposing exclusions, as well as to Administrative Law Judges (ALJs), the Departmental Appeals Board (DAB), and federal courts in reviewing the imposition of exclusions by the OIG (and,
§ 1001.2 Definitions.

Controlled substance means a drug or other substance, or immediate precursor:
(a) Included in schedules I, II, III, IV or V of part B of subchapter I in 21 U.S.C. chapter 13, or
(b) That is deemed a controlled substance by the law of any State.

Convicted means that:
(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
(1) There is a post-trial motion or an appeal pending, or
(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;
(b) A Federal, State or local court has made a finding of guilt against an individual or entity;
(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity; or
(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

Exclusion means that items and services furnished, ordered or prescribed by a specified individual or entity will not be reimbursed under Medicare, Medicaid and all other Federal health care programs until the individual or entity is reinstated by the OIG.

Federal health care program means any plan or program providing health care benefits, whether directly through insurance or otherwise, that is funded directly, in whole or part, by the United States Government (other than the Federal Employees Health Benefits Program), or any State health care program as defined in this section.

HHS means Department of Health and Human Services.

Incarceration means imprisonment or any type of confinement with or without supervised release, including, but not limited to, community confinement, house arrest and home detention.


Patient means any individual who is receiving health care items or services, including any item or service provided to meet his or her physical, mental or emotional needs or well-being (including a resident receiving care in a facility as described in part 483 of this chapter), whether or not reimbursed under Medicare, Medicaid and any other Federal health care program and regardless of the location in which such item or service is provided.


Professionally recognized standards of health care are Statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue, recognize as applying to those peers practicing or providing care within a State. When the Department has declared a treatment modality not to be safe and effective, practitioners who employ such a treatment modality will be deemed not to meet professionally recognized standards of health care. This definition will not be construed to mean that all other treatments meet professionally recognized standards.

Sole community physician means a physician who is the only physician who provides primary care services to Federal or State health care program beneficiaries within a defined service area.

Sole source of essential specialized services in the community means that an individual or entity—
(1) Is the only practitioner, supplier or provider furnishing specialized services in an area designated by the Health Resources Services Administration as a health professional shortage area for that medical specialty, as listed in 42 part 5, appendices B–F;
(2) Is a sole community hospital, as defined in § 412.92 of this title; or
§ 1001.101

(3) Is the only source of specialized services in a reasonably defined service area where services by a non-specialist could not be substituted for the source without jeopardizing the health or safety of beneficiaries.

State health care program means:
(a) A State plan approved under title XIX of the Act (Medicaid),
(b) Any program receiving funds under title V of the Act or from an allotment to a State under such title (Maternal and Child Health Services Block Grant program), or
(c) Any program receiving funds under title XX of the Act or from any allotment to a State under such title (Block Grants to States for Social Services).

State Medicaid Fraud Control Unit means a unit certified by the Secretary as meeting the criteria of 42 U.S.C. 1396b(q) and § 1002.305 of this chapter.

Subpart B—Mandatory Exclusions
§ 1001.102 Length of exclusion.

(a) No exclusion imposed in accordance with §1001.101 will be for less than 5 years.

(b) Any of the following factors may be considered to be aggravating and a basis for lengthening the period of exclusion—

(1) The acts resulting in the conviction, or similar acts, that caused, or were intended to cause, a financial loss to a Government program or to one or more entities of $5,000 or more. (The entire amount of financial loss to such programs or entities, including any amounts resulting from similar acts not adjudicated, will be considered regardless of whether full or partial restitution has been made);
(2) The acts that resulted in the conviction, or similar acts, were committed over a period of one year or more;

(3) The acts that resulted in the conviction, or similar acts, had a significant adverse physical, mental or financial impact on one or more program beneficiaries or other individuals;

(4) In convictions involving patient abuse or neglect, the action that resulted in the conviction was premeditated, was part of a continuing pattern of behavior, or consisted of non-consensual sexual acts;

(5) The sentence imposed by the court included incarceration;

(6) The convicted individual or entity has a prior criminal, civil or administrative sanction record;

(7) The individual or entity has at any time been overpaid a total of $1,500 or more by Medicare, Medicaid or any other Federal health care programs as a result of intentional improper billings;

(8) The individual or entity has previously been convicted of a criminal offense involving the same or similar circumstances; or

(9) Whether the individual or entity was convicted of 3 or fewer misdemeanor offenses, and the entire amount of financial loss (both actual loss and intended loss) to Medicare or any other Federal, State or local government health care program due to the acts that resulted in the conviction, and similar acts, is less than $1,500.

The OIG may exclude an individual or entity convicted under Federal or State law of—

(a) Conviction relating to program or health care fraud.

(1) A misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

(1) Others being convicted or excluded from Medicare, Medicaid and all other Federal health care programs,

(ii) Additional cases being investigated or reports being issued by the appropriate law enforcement agency identifying program vulnerabilities or weaknesses, or

(iii) The imposition against anyone of a civil money penalty or assessment under part 1003 of this chapter.

(d) In the case of an exclusion under this subpart, based on a conviction occurring on or after August 5, 1997, an exclusion will be—

(1) For not less than 10 years if the individual has been convicted on one other occasion of one or more offenses for which an exclusion may be effected under section 1128(a) of the Act (The aggravating and mitigating factors in paragraphs (b) and (c) of this section can be used to impose a period of time in excess of the 10-year mandatory exclusion); or

(2) Permanent if the individual has been convicted on two or more other occasions of one or more offenses for which an exclusion may be effected under section 1128(a) of the Act.

§ 1001.301 Conviction relating to obstruction of an investigation.

(a) Circumstance for exclusion. The OIG may exclude an individual or entity that has been convicted, under Federal or State law, in connection with the interference with or obstruction of any investigation into any criminal offense described in §1001.101 or §1001.201.

(b) Length of exclusion. (1) An exclusion imposed in accordance with this section will be for a period of 3 years, unless aggravating or mitigating factors listed in paragraphs (b)(2) and (b)(3) of this section form a basis for lengthening or shortening that period.

(2) Any of the following factors may be considered to be aggravating and a basis for lengthening the period of exclusion—

(i) The acts resulting in the conviction, or similar acts that caused, or reasonably could have been expected to cause, a financial loss of $5,000 or more to a Government program or to one or more other entities, or had a significant financial impact on program beneficiaries or other individuals. (The total amount of financial loss will be considered, including any amounts resulting from similar acts not adjudicated, regardless of whether full or partial restitution has been made);

(ii) The acts that resulted in the conviction, or similar acts, were committed over a period of one year or more;

(iii) The acts that resulted in the conviction, or similar acts, had a significant adverse physical or mental impact on one or more program beneficiaries or other individuals;

(iv) The sentence imposed by the court included incarceration;

(v) Whether the individual or entity has a documented history of criminal, civil or administrative wrongdoing; or

(vi) Whether the individual or entity was convicted of other offenses besides those which formed the basis for the exclusion, or has been the subject of any other adverse action by any Federal, State or local government agency or board, if the adverse action is based on the same set of circumstances that serves as the basis for the imposition of the exclusion.

(3) Only the following factors may be considered as mitigating and a basis for reducing the period of exclusion—

(i) The individual or entity was convicted of 3 or fewer offenses, and the entire amount of financial loss (both actual loss and reasonably expected loss) to a Government program or to other individuals or entities due to the acts that resulted in the conviction and similar acts is less than $1,500;

(ii) The record in the criminal proceedings, including sentencing documents, demonstrates that the court determined that the individual had a mental, emotional or physical condition, before or during the commission of the offense, that reduced the individual’s culpability;

(iii) The individual’s or entity’s cooperation with Federal or State officials resulted in—

(A) Others being convicted or excluded from Medicare, Medicaid or any of the other Federal health care programs, or

(B) Additional cases being investigated or reports being issued by the appropriate law enforcement agency identifying program vulnerabilities or weaknesses, or

(C) The imposition of a civil money penalty against others; or

(iv) Alternative sources of the type of health care items or services furnished by the individual or entity are not available.

unless aggravating or mitigating factors listed in paragraphs (b)(2) and (b)(3) of this section form the basis for lengthening or shortening that period.

(2) Any of the following factors may be considered to be aggravating and a basis for lengthening the period of exclusion—

(i) The interference with, or obstruction of, the investigation caused the expenditure of significant additional time or resources;

(ii) The interference or obstruction had a significant adverse mental, physical or financial impact on program beneficiaries or other individuals or on the Medicare, Medicaid or other Federal health care programs;

(iii) The interference or obstruction also affected a civil or administrative investigation;

(iv) The sentence imposed by the court included incarceration;

(v) Whether the individual or entity has a documented history of criminal, civil or administrative wrongdoing; or

(vi) Whether the individual or entity was convicted of other offenses besides those which formed the basis for the exclusion, or has been the subject of any other adverse action by any Federal, State or local government agency or board, if the adverse action is based on the same set of circumstances that serves as the basis for the imposition of the exclusion.

(3) Only the following factors may be considered as mitigating and a basis for reducing the period of exclusion—

(i) The record of the criminal proceedings, including sentencing documents, demonstrates that the court determined that the individual had a mental, emotional or physical condition, before or during the commission of the offense, that reduced the individual’s culpability;

(ii) The individual’s or entity’s cooperation with Federal or State officials resulted in—

(A) Others being convicted or excluded from Medicare, Medicaid and all other Federal health care programs;

(B) Additional cases being investigated or reports being issued by the appropriate law enforcement agency identifying program vulnerabilities or weaknesses, or

(C) The imposition of a civil money penalty against others; or

(iii) Alternative sources of the type of health care items or services furnished by the individual or entity are not available.


§ 1001.401 Conviction relating to controlled substances.

(a) Circumstance for exclusion. The OIG may exclude an individual or entity convicted under Federal or State law of a misdemeanor relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance, as defined under Federal or State law. This section applies to any individual or entity that—

(1) Is, or has ever been, a health care practitioner, provider or supplier;

(2) Holds or has held a direct or indirect ownership or control interest, as defined in section 1124(a)(3) of the Act, in an entity that is a health care provider or supplier, or is or has been an officer, director, agent or managing employee, as defined in section 1126(b) of the Act, of such an entity; or

(3) Is, or has ever been, employed in any capacity in the health care industry.

(b) For purposes of this section, the definition of controlled substance will be the definition that applies to the law forming the basis for the conviction.

(c) Length of exclusion. (1) An exclusion imposed in accordance with this section will be for a period of 3 years, unless aggravating or mitigating factors listed in paragraphs (b)(2) and (b)(3) of this section form a basis for lengthening or shortening that period.

(2) Any of the following factors may be considered to be aggravating and a basis for lengthening the period of exclusion—

(i) The acts that resulted in the conviction or similar acts were committed over a period of one year or more;

(ii) The acts that resulted in the conviction or similar acts had a significant adverse mental, physical or financial impact on program beneficiaries or other individuals or the Medicare, Medicaid or other Federal health care programs;
§ 1001.501 License revocation or suspension.

(a) Circumstance for exclusion. The OIG may exclude an individual or entity that has—

(1) Had a license to provide health care revoked or suspended by any State licensing authority, or has otherwise lost such a license (including the right to apply for or renew such a license), for reasons bearing on the individual’s or entity’s professional competence, professional performance or financial integrity; or

(2) Has surrendered such a license while a formal disciplinary proceeding concerning the individual’s or entity’s professional competence, professional performance or financial integrity was pending before a State licensing authority.

(b) Length of exclusion. (1) An exclusion imposed in accordance with this section will not be for a period of time less than the period during which an individual’s or entity’s license is revoked, suspended or otherwise not in effect as a result of, or in connection with, a State licensing agency action.

(2) Any of the following factors may be considered aggravating and a basis for lengthening the period of exclusion—

(i) The acts that resulted in the revocation, suspension or loss of the individual’s or entity’s license to provide health care had or could have had a significant adverse physical, emotional or financial impact on one or more program beneficiaries or other individuals;

(ii) Whether the individual or entity has a documented history of criminal, civil or administrative wrongdoing;

(iii) Whether the individual or entity has been the subject of any other adverse action by any other Federal, State or local government agency or board, if the adverse action is based on the same set of circumstances that serves as the basis for the imposition of the exclusion.

(3) Only if any of the aggravating factors listed in paragraph (b)(2) of this section justifies a longer exclusion may mitigating factors be considered as a basis for reducing the period of exclusion to a period not less than that set forth in paragraph (b)(1) of this section. Only the following factors may be considered mitigating—

(i) The individual’s or entity’s cooperation with a State licensing authority resulted in—

(A) The sanctioning of other individuals or entities, or

(B) Additional cases being investigated or reports being issued by the appropriate law enforcement agency identifying program vulnerabilities or weaknesses; or

(ii) Alternative sources of the type of health care items or services furnished by the individual or entity are not available.

(4) When an individual or entity has been excluded under this section, the OIG will consider a request for reinstatement in accordance with §1001.3001 if the individual or entity obtains a valid license in the State where the license was originally revoked, suspended, surrendered or otherwise lost.


§1001.601 Exclusion or suspension under a Federal or State health care program.

(a) Circumstance for exclusion. (1) The OIG may exclude an individual or entity suspended or excluded from participation, or otherwise sanctioned, under—

(i) Any Federal program involving the provision of health care, or

(ii) A State health care program, for reasons bearing on the individual’s or entity’s professional competence, professional performance or financial integrity.

(2) The term “or otherwise sanctioned” in paragraph (a)(1) of this section is intended to cover all actions that limit the ability of a person to participate in the program at issue regardless of what such an action is called, and includes situations where an individual or entity voluntarily withdraws from a program to avoid a formal sanction.

(b) Length of exclusion. (1) An exclusion imposed in accordance with this section will not be for a period of time less than the period during which the individual or entity is excluded or suspended from a Federal or State health care program.

(2) Any of the following factors may be considered aggravating and a basis for lengthening the period of exclusion—

(i) The acts that resulted in the exclusion, suspension or other sanction under Medicare, Medicaid and all other Federal health care programs had, or could have had, a significant adverse impact on Federal or State health care programs or the beneficiaries of those programs or other individuals;

(ii) Whether the individual or entity has a documented history of criminal, civil or administrative wrongdoing; or

(iii) The individual or entity has been the subject of any other adverse action by any Federal, State or local government agency or board, if the adverse action is based on the same set of circumstances that serves as the basis for the imposition of the exclusion.

(3) Only if any of the aggravating factors set forth in paragraph (b)(2) of this section justifies a longer exclusion may mitigating factors be considered as a basis for reducing the period of exclusion to a period not less than that set forth in paragraph (b)(1) of this section. Only the following factors may be considered mitigating—

(i) The individual’s or entity’s cooperation with Federal or State officials resulted in—

(A) The sanctioning of other individuals or entities, or

(B) Additional cases being investigated or reports being issued by the appropriate law enforcement agency identifying program vulnerabilities or weaknesses; or

(ii) Alternative sources of the types of health care items or services furnished by the individual or entity are not available.

(4) If the individual or entity is eligible to apply for reinstatement in accordance with §1001.3001 of this part, and the sole reason for the State denying reinstatement is the existing Medicare exclusion imposed by the OIG as a result of the original State action, the OIG will consider a request for reinstatement.


§1001.701 Excessive claims or furnishing of unnecessary or substandard items and services.

(a) Circumstance for exclusion. The OIG may exclude an individual or entity that has—

(1) Submitted, or caused to be submitted, bills or requests for payments under Medicare or any of the State health care programs containing charges or costs for items or services furnished that are substantially in excess of such individual’s or entity’s usual charges or costs for such items or services; or
(2) Furnished, or caused to be furnished, to patients (whether or not covered by Medicare or any of the State health care programs) any items or services substantially in excess of the patient’s needs, or of a quality that fails to meet professionally recognized standards of health care.

(b) The OIG’s determination under paragraph (a)(2) of this section—that the items or services furnished were excessive or of unacceptable quality—will be made on the basis of information, including sanction reports, from the following sources:

(1) The QIO for the area served by the individual or entity;

(2) State or local licensing or certification authorities;

(3) Fiscal agents or contractors, or private insurance companies;

(4) State or local professional societies; or

(5) Any other sources deemed appropriate by the OIG.

(c) Exceptions. An individual or entity will not be excluded for—

(1) Submitting, or causing to be submitted, bills or requests for payment that contain charges or costs substantially in excess of usual charges or costs when such charges or costs are due to unusual circumstances or medical complications requiring additional time, effort, expense or other good cause; or

(2) Furnishing, or causing to be furnished, items or services in excess of the needs of patients, when the items or services were ordered by a physician or other authorized individual, and the individual or entity furnishing the items or services was not in a position to determine medical necessity or to refuse to comply with the order of the physician or other authorized individual.

(d) Length of exclusion. (1) An exclusion imposed in accordance with this section will be for a period of 3 years, unless aggravating or mitigating factors set forth in paragraphs (d)(2) and (d)(3) of this section form a basis for lengthening or shortening the period. In no case may the period be shorter than 1 year for any exclusion taken in accordance with paragraph (a)(2) of this section.

(2) Any of the following factors may be considered aggravating and a basis for lengthening the period of exclusion—

(i) The violations were serious in nature, and occurred over a period of one year or more;

(ii) The violations had a significant adverse physical, mental or financial impact on program beneficiaries or other individuals;

(iii) Whether the individual or entity has a documented history of criminal, civil or administrative wrongdoing;

(iv) The violation resulted in financial loss to Medicare, Medicaid and all other Federal health care programs of $1,500 or more; or

(v) The individual or entity has been the subject of any other adverse action by any Federal, State or local government agency or board, if the adverse action is based on the same set of circumstances that serves as the basis for the imposition of the exclusion.

(3) Only the following factors may be considered mitigating and a basis for reducing the period of exclusion—

(i) There were few violations and they occurred over a short period of time; or

(ii) Alternative sources of the type of health care items or services furnished by the individual or entity are not available.

waiver or contract described in paragraph (a)(1) of this section to be provided to individuals covered by such plan, waiver or contract; and

(3) Where such failure has adversely affected or has a substantial likelihood of adversely affecting covered individuals.

(b) The OIG’s determination under paragraph (a)(2) of this section—that the medically necessary items and services required under law or contract were not provided—will be made on the basis of information, including sanction reports, from the following sources:

(1) The QIO or other quality assurance organization under contract with a State Medicaid plan for the area served by the HMO or competitive medical plan;

(2) State or local licensing or certification authorities;

(3) Fiscal agents or contractors, or private insurance companies;

(4) State or local professional societies;

(5) CMS’s HMO compliance office; or

(6) Any other sources deemed appropriate by the OIG.

(c) Length of exclusion. (1) An exclusion imposed in accordance with this section will be for a period of 3 years, unless aggravating or mitigating factors set forth in paragraphs (c)(2) and (c)(3) of this section form a basis for lengthening or shortening the period.

(2) Any of the following factors may be considered aggravating and a basis for lengthening the period of exclusion—

(i) The entity failed to provide a large number or a variety of items or services;

(ii) The failures occurred over a lengthy period of time;

(iii) The entity’s failure to provide a necessary item or service that had or could have had a serious adverse effect;

(iv) Whether the individual or entity has a documented history of criminal, civil or administrative wrongdoing; or

(v) The individual or entity has been the subject of any other adverse action by any Federal, State or local government agency or board, if the adverse action is based on the same set of circumstances that serves as the basis for the imposition of the exclusion.

(3) Only the following factors may be considered as mitigating and a basis for reducing the period of exclusion—

(i) There were few violations and they occurred over a short period of time; or

(ii) Alternative sources of the type of health care items or services furnished by the entity are not available.

(iii) The entity took corrective action upon learning of impermissible activities by an employee or contractor.


§ 1001.901 False or improper claims.

(a) Circumstance for exclusion. The OIG may exclude any individual or entity that it determines has committed an act described in section 1128A of the Act. The imposition of a civil money penalty or assessment is not a prerequisite for an exclusion under this section.

(b) Length of exclusion. In determining the length of an exclusion imposed in accordance with this section, the OIG will consider the following factors—

(1) The nature and circumstances surrounding the actions that are the basis for liability, including the period of time over which the acts occurred, the number of acts, whether there is evidence of a pattern and the amount claimed;

(2) The degree of culpability;

(3) Whether the individual or entity has a documented history of criminal, civil or administrative wrongdoing (The lack of any prior record is to be considered neutral);

(4) The individual or entity has been the subject of any other adverse action by any Federal, State or local government agency or board, if the adverse action is based on the same set of circumstances that serves as the basis for the imposition of the exclusion; or

(5) Other matters as justice may require.


§ 1001.951 Fraud and kickbacks and other prohibited activities.

(a) Circumstance for exclusion. (1) Except as provided for in paragraph (a)(2)(ii) of this section, the OIG may
§ 1001.952 Exceptions.

The following payment practices shall not be treated as a criminal offense under section 1128B of the Act and shall not serve as the basis for an exclusion:

(a) Investment interests. As used in section 1128B of the Act, “remuneration” does not include any payment that is a return on an investment interest, such as a dividend or interest income, made to an investor as long as all of the applicable standards are met within one of the following three categories of entities:

(1) If, within the previous fiscal year or previous 12 month period, the entity possesses more than $50,000,000 in undepreciated net tangible assets (based on the net acquisition cost of purchasing such assets from an unrelated entity) related to the furnishing of health care items and services, all of the following five standards must be met:

(i) With respect to an investment interest that is an equity security, the equity security must be registered with the Securities and Exchange Commission under 15 U.S.C. 781 (b) or (g).

(ii) The investment interest of an investor in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must be obtained on terms (including any direct or indirect transferability restrictions) and at a price equally available to the public when trading on a registered securities exchange, such as the New York Stock Exchange or the American Stock Exchange, or in accordance with the National Association of Securities Dealers Automated Quotation System.

(iii) The entity or any investor must not market or furnish the entity’s items or services (or those of another
entity as part of a cross referral agreement) to passive investors differently than to non-investors.

(iv) The entity or any investor (or other individual or entity acting on behalf of the entity or any investor in the entity) must not loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest.

(v) The amount of payment to an investor in return for the investment interest must be directly proportional to the amount of the capital investment of that investor.

(2) If the entity possesses investment interests that are held by either active or passive investors, all of the following eight applicable standards must be met—

(i) No more than 40 percent of the value of the investment interests of each class of investment interests may be held in the previous fiscal year or previous 12 month period by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity. (For purposes of paragraph (a)(2)(i) of this section, equivalent classes of equity investments may be combined, and equivalent classes of debt instruments may be combined.)

(ii) The terms on which an investment interest is offered to a passive investor, if any, who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must be no different from the terms offered to other passive investors.

(iii) The terms on which an investment interest is offered to an investor who is in a position to make or influence referrals to, furnish items or services furnished, or the amount of business otherwise generated from that investor to the entity.

(iv) There is no requirement that a passive investor, if any, make referrals to, be in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity as a condition for remaining as an investor.

(v) The entity or any investor must not market or furnish the entity’s items or services (or those of another entity as part of a cross referral agreement) to passive investors differently than to non-investors.

(vi) No more than 40 percent of the entity’s gross revenue related to the furnishing of health care items and services in the previous fiscal year or previous 12-month period may come from referrals or business otherwise generated from investors.

(vii) The entity or any investor (or other individual or entity acting on behalf of the entity or any investor in the entity) must not loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest.

(viii) The amount of payment to an investor in return for the investment interest must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.

(3)(i) If the entity possesses investment interests that are held by either active or passive investors and is located in an underserved area, all of the following eight standards must be met—

(A) No more than 50 percent of the value of the investment interests of each class of investments may be held in the previous fiscal year or previous 12-month period by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for, the entity. (For purposes of paragraph (a)(3)(i)(A) of this section, equivalent classes of equity investments may be combined, and equivalent classes of debt instruments may be combined.)

(B) The terms on which an investment interest is offered to a passive investor, if any, who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must be no different from the terms offered to other passive investors.
(C) The terms on which an investment interest is offered to an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must not be related to the previous or expected volume of referrals, items or services furnished, or the amount of business otherwise generated from that investor to the entity.

(D) There is no requirement that a passive investor, if any, make referrals to, be in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity as a condition for remaining as an investor.

(E) The entity or any investor must not market or furnish the entity’s items or services (or those of another entity as part of a cross-referral agreement) to passive investors differently than to non-investors.

(F) At least 75 percent of the dollar volume of the entity’s business in the previous fiscal year or previous 12-month period must be derived from the service of persons who reside in an underserved area or are members of medically underserved populations.

(G) The entity or any investor (or other individual or entity acting on behalf of the entity or any investor in the entity) must not loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest.

(H) The amount of payment to an investor in return for the investment interest must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.

(ii) If an entity that otherwise meets all of the above standards is located in an area that was an underserved area at the time of the initial investment, but subsequently ceases to be an underserved area, the entity will be deemed to comply with paragraph (a)(3)(i) of this section for a period equal to the lesser of:

(A) The current term of the investment remaining after the date upon which the area ceased to be an underserved area or

(B) Three years from the date the area ceased to be an underserved area.

(4) For purposes of paragraph (a) of this section, the following terms apply. **Active investor** means an investor either who is responsible for the day-to-day management of the entity and is a bona fide general partner in a partnership under the Uniform Partnership Act or who agrees in writing to undertake liability for the actions of the entity’s agents acting within the scope of their agency. **Investment interest** means a security issued by an entity, and may include the following classes of investments: shares in a corporation, interests or units in a partnership or limited liability company, bonds, debentures, notes, or other debt instruments. **Investor** means an individual or entity either who directly holds an investment interest in an entity, or who holds such investment interest indirectly by, including but not limited to, such means as having a family member hold such investment interest or holding a legal or beneficial interest in another entity (such as a trust or holding company) that holds such investment interest. **Passive investor** means an investor who is not an active investor, such as a limited partner in a partnership under the Uniform Partnership Act, a shareholder in a corporation, or a holder of a debt security. **Underserved area** means any defined geographic area that is designated as a Medically Underserved Area (MUA) in accordance with regulations issued by the Department.

(b) **Space rental.** As used in section 1128B of the Act, "remuneration" does not include any payment made by a lessee to a lessor for the use of premises, as long as all of the following six standards are met—

(1) The lease agreement is set out in writing and signed by the parties.

(2) The lease covers all of the premises leased between the parties for the term of the lease and specifies the premises covered by the lease.

(3) If the lease is intended to provide the lessee with access to the premises
for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals.

(4) The term of the lease is for not less than one year.

(5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or all other Federal health care programs.

(6) The aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental. Note that for purposes of paragraph (b) of this section, the term fair market value means the value of the rental property for general commercial purposes, but shall not be adjusted to reflect the additional value that one party (either the prospective lessee or lessor) would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid and all other Federal health care programs.

(c) Equipment rental. As used in section 1128B of the Act, “remuneration” does not include any payment made by a lessee of equipment to the lessor of the equipment for the use of the equipment, as long as all of the following seven standards are met—

(1) The lease agreement is set out in writing and signed by the parties.

(2) The lease covers all of the equipment leased between the parties for the term of the lease and specifies the equipment covered by the lease.

(3) If the lease is intended to provide for the services of the agent on a periodic, sporadic or part-time basis, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals.

(4) The term of the lease is for not less than one year.

(5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or all other Federal health care programs.

(6) The aggregate equipment rental does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental. Note that for purposes of paragraph (c) of this section, the term fair market value means the value of the equipment when obtained from a manufacturer or professional distributor, but shall not be adjusted to reflect the additional value one party (either the prospective lessee or lessor) would attribute to the equipment as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.

(d) Personal services and management contracts. As used in section 1128B of the Act, “remuneration” does not include any payment made by a principal to an agent as compensation for the services of the agent, as long as all of the following seven standards are met—

(1) The agency agreement is set out in writing and signed by the parties.

(2) The agency agreement covers all of the services the agent provides to the principal for the term of the agreement and specifies the services to be provided by the agent.

(3) If the agency agreement is intended to provide for the services of the agent on a periodic, sporadic or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals.

(4) The term of the agreement is for not less than one year.

(5) The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-
length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.

(6) The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.

(7) The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.

For purposes of paragraph (d) of this section, an agent of a principal is any person, other than a bona fide employee of the principal, who has an agreement to perform services for, or on behalf of, the principal.

(e) Sale of practice. (1) As used in section 1128B of the Act, ‘‘remuneration’’ does not include any payment made to a practitioner by another practitioner where the former practitioner is selling his or her practice to the latter practitioner, as long as both of the following two standards are met—

(i) The period from the date of the first agreement pertaining to the sale to the completion of the sale is not more than one year.

(ii) The practitioner who is selling his or her practice will not be in a professional position after completion of the sale to make or influence referrals to, or otherwise generate business for, the purchasing hospital or entity for which payment may be made under Medicare, Medicaid or other Federal health care programs.

(2) As used in section 1128B of the Act, ‘‘remuneration’’ does not include any payment made to a practitioner by a hospital or other entity where the practitioner is selling his or her practice to the hospital or other entity, so long as the following four standards are met:

(i) The period from the date of the first agreement pertaining to the sale to the completion date of the sale is not more than three years.

(ii) The practitioner who is selling his or her practice will not be in a professional position after completion of the sale to make or influence referrals to, or otherwise generate business for, the purchasing hospital or entity for which payment may be made under Medicare, Medicaid or other Federal health care programs.

(iii) The practice being acquired must be located in a Health Professional Shortage Area (HPSA), as defined in Departmental regulations, for the practitioner’s specialty area.

(iv) Commencing at the time of the first agreement pertaining to the sale, the purchasing hospital or entity must diligently and in good faith engage in commercially reasonable recruitment activities that:

(A) May reasonably be expected to result in the recruitment of a new practitioner to take over the acquired practice within a one year period and

(B) Will satisfy the conditions of the practitioner recruitment safe harbor in accordance with paragraph (n) of this section.

(f) Referral services. As used in section 1128B of the Act, ‘‘remuneration’’ does not include any payment or exchange of anything of value between an individual or entity (‘‘participant’’) and another entity serving as a referral service (‘‘referral service’’), as long as all of the following four standards are met:

(1) The referral service does not exclude as a participant in the referral service any individual or entity who meets the qualifications for participation.

(2) Any payment the participant makes to the referral service is assessed equally against and collected equally from all participants, and is only based on the cost of operating the referral service, and not on the volume or value of any referrals to or business otherwise generated by either party for the referral service for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.

(3) The referral service imposes no requirements on the manner in which the participant provides services to a referred person, except that the referral
service may require that the participant charge the person referred at the same rate as it charges other persons not referred by the referral service, or that these services be furnished free of charge or at reduced charge.

(4) The referral service makes the following five disclosures to each person seeking a referral, with each such disclosure maintained by the referral service in a written record certifying such disclosure and signed by either such person seeking a referral or by the individual making the disclosure on behalf of the referral service—

(i) The manner in which it selects the group of participants in the referral service to which it could make a referral;

(ii) Whether the participant has paid a fee to the referral service;

(iii) The manner in which it selects a particular participant from this group for that person;

(iv) The nature of the relationship between the referral service and the group of participants to whom it could make the referral; and

(v) The nature of any restrictions that would exclude such an individual or entity from continuing as a participant.

(g) Warranties. As used in section 1128B of the Act, “remuneration” does not include any payment or exchange of anything of value under a warranty provided by a manufacturer or supplier of an item to the buyer (such as a health care provider or beneficiary) of the item, as long as the buyer complies with all of the following standards in paragraphs (g)(1) and (g)(2) of this section and the manufacturer or supplier complies with all of the following standards in paragraphs (g)(3) and (g)(4) of this section—

(1) The buyer must fully and accurately report any price reduction of the item (including a free item), which was obtained as part of the warranty, on the invoice or statement submitted to the buyer, and inform the buyer of its obligations under paragraphs (a)(1) and (a)(2) of this section.

(ii) The manufacturer or supplier must fully and accurately report the price reduction of the item (including a free item), which was obtained as part of the warranty, on the invoice or statement submitted to the buyer, and inform the buyer of its obligations under paragraphs (a)(1) and (a)(2) of this section.

(i) Whether the amount of the price reduction is not known at the time of sale, the manufacturer or supplier must fully and accurately report the existence of a warranty on the invoice or statement, inform the buyer of its obligations under paragraphs (g)(1) and (g)(2) of this section, and, when the price reduction becomes known, provide the buyer with documentation of the calculation of the price reduction resulting from the warranty.

(4) The manufacturer or supplier must not pay any remuneration to any individual (other than a beneficiary) or entity for any medical, surgical, or hospital expense incurred by a beneficiary other than for the cost of the item itself.

For purposes of paragraph (g) of this section, the term warranty means either an agreement made in accordance with the provisions of 15 U.S.C. 2301(6), or a manufacturer’s or supplier’s agreement to replace another manufacturer’s or supplier’s defective item (which is covered by an agreement made in accordance with this statutory provision), on terms equal to the agreement that it replaces.

(h) Discounts. As used in section 1128B of the Act, “remuneration” does not include a discount, as defined in paragraph (h)(5) of this section, on an item or service for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs for a buyer as long as the buyer complies with the applicable standards of paragraph (h)(1) of this section; a seller as long as the seller complies with the applicable standards of paragraph (h)(2) of this section; and an offeror of a discount who is not a seller under paragraph (h)(2) of this section so long as such offeror complies
with the applicable standards of paragraph (h)(3) of this section.

(1) With respect to the following three categories of buyers, the buyer must comply with all of the applicable standards within one of the three following categories—

(i) If the buyer is an entity which is a health maintenance organization (HMO) or a competitive medical plan (CMP) acting in accordance with a risk contract under section 1876(g) or 1903(m) of the Act, or under another State health care program, it need not report the discount except as otherwise may be required under the risk contract.

(ii) If the buyer is an entity which reports its costs on a cost report required by the Department or a State health care program, it must comply with all of the following four standards—

(A) The discount must be earned based on purchases of that same good or service bought within a single fiscal year of the buyer;

(B) The buyer must claim the benefit of the discount in the fiscal year in which the discount is earned or the following year;

(C) The buyer must fully and accurately report the discount in the applicable cost report; and

(D) The buyer must provide, upon request by the Secretary or a State agency, information provided by the seller as specified in paragraph (h)(2)(ii) of this section, or information provided by the offeror as specified in paragraph (h)(3)(ii)(A) of this section.

(iii) If the buyer is an individual or entity in whose name a claim or request for payment is submitted for the discounted item or service and payment may be made, in whole or in part, under Medicare, Medicaid or other Federal health care programs (not including individuals or entities defined as buyers in paragraph (h)(1)(i) or (h)(1)(ii) of this section), the buyer must comply with both of the following standards—

(A) The discount must be made at the time of the sale of the good or service or the terms of the rebate must be fixed and disclosed in writing to the buyer at the time of the initial sale of the good or service; and

(B) the buyer (if submitting the claim) must provide, upon request by the Secretary or a State agency, information provided by the seller as specified in paragraph (h)(2)(ii)(B) of this section, or information provided by the offeror as specified in paragraph (h)(3)(ii)(A) of this section.

(2) The seller is an individual or entity that supplies an item or service for which payment may be made, in whole or in part, under Medicare, Medicaid or other Federal health care programs to the buyer and who permits a discount to be taken off the buyer's purchase price. The seller must comply with all of the applicable standards within one of the following three categories—

(i) If the buyer is an entity which is an HMO a CMP acting in accordance with a risk contract under section 1876(g) or 1903(m) of the Act, or under another State health care program, the seller need not report the discount to the buyer for purposes of this provision.

(ii) If the buyer is an entity that reports its costs on a cost report required by the Department or a State agency, the seller must comply with either of the following two standards—

(A) Where a discount is required to be reported to Medicare or a State health care program under paragraph (h)(1) of this section, the seller must fully and accurately report such discount on the invoice, coupon or statement submitted to the buyer; inform the buyer in a manner that is reasonably calculated to give notice to the buyer of its obligations to report such discount and to provide information upon request under paragraph (h)(1) of this section; and refrain from doing anything that would impede the buyer from meeting its obligations under this paragraph; or

(B) Where the value of the discount is not known at the time of sale, the seller must fully and accurately report the existence of a discount program on the invoice, coupon or statement submitted to the buyer; inform the buyer in a manner reasonably calculated to give notice to the buyer of its obligations to report such discount and to provide information upon request under paragraph (h)(1) of this section; when the value of the discount becomes
known, provide the buyer with documentation of the calculation of the discount identifying the specific goods or services purchased to which the discount will be applied; and refrain from doing anything which would impede the buyer from meeting its obligations under this paragraph.

(iii) If the buyer is an individual or entity not included in paragraph (h)(2)(i) or (h)(2)(ii) of this section, the seller must comply with either of the following two standards—

(A) Where the seller submits a claim or request for payment on behalf of the buyer and the item or service is separately claimed, the seller must provide, upon request by the Secretary or a State agency, information provided by the offeror as specified in paragraph (h)(3)(iii)(A) of this section; or

(B) Where the buyer submits a claim, the seller must fully and accurately report such discount on the invoice, coupon or statement submitted to the buyer; inform the buyer in a manner reasonably calculated to give notice to the buyer of its obligations to report such discount and to provide information upon request under paragraph (h)(1) of this section; and refrain from doing anything that would impede the buyer’s ability to meet its obligations under this paragraph.

(3) The offeror of a discount is an individual or entity who is not a seller under paragraph (h)(2) of this section, but promotes the purchase of an item or service by a buyer under paragraph (h)(1) of this section at a reduced price for which payment may be made, in whole or in part, under Medicare, Medicaid or other Federal health care programs (not including individuals or entities defined as buyers in paragraph (h)(1)(i) or (h)(1)(ii) of this section), the offeror must comply with the following three categories—

(i) If the buyer is an entity which is an HMO or a CMP acting in accordance with a risk contract under section 1376a(g) or 1903(m) of the Act, or under another State health care program, the offeror need not report the discount to the buyer for purposes of this provision.

(ii) If the buyer is an entity that reports its costs on a cost report required by the Department or a State agency, the offeror must comply with the following two standards—

(A) The offeror must inform the buyer in a manner reasonably calculated to give notice to the buyer of its obligations to report such a discount and to provide information upon request under paragraph (h)(1) of this section; and

(B) The offeror of the discount must refrain from doing anything that would impede the buyer’s ability to meet its obligations under this paragraph.

(iii) If the buyer is an individual or entity in whose name a request for payment is submitted for the discounted item or service and payment may be made, in whole or in part, under Medicare, Medicaid or other Federal health care programs (not including individuals or entities defined as buyers in paragraph (h)(1)(i) or (h)(1)(ii) of this section), the offeror must comply with the following two standards—

(A) The offeror must inform the individual or entity submitting the claim or request for payment in a manner reasonably calculated to give notice to the individual or entity of its obligations to report such a discount and to provide information upon request under paragraphs (h)(1) and (h)(2) of this section; and

(B) The offeror of the discount must refrain from doing anything that would impede the buyer’s or seller’s ability to meet its obligations under this paragraph.

(4) For purposes of this paragraph, a rebate is any discount the terms of which are fixed and disclosed in writing to the buyer at the time of the initial purchase to which the discount applies, but which is not given at the time of sale.

(5) For purposes of this paragraph, the term discount means a reduction in the amount a buyer (who buys either directly or through a wholesaler or a group purchasing organization) is charged for an item or service based on an arms-length transaction. The term discount does not include—

(i) Cash payment or cash equivalents (except that rebates as defined in paragraph (h)(4) of this section may be in the form of a check);

(ii) Supplying one good or service without charge or at a reduced charge to induce the purchase of a different good or service, unless the goods and
(i) Employees. As used in section 1128B of the Act, “remuneration” does not include any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs. For purposes of paragraph (i) of this section, the term employee has the same meaning as it does for purposes of 26 U.S.C. 3121(d)(2).

(j) Group purchasing organizations. As used in section 1128B of the Act, “remuneration” does not include any payment by a vendor of goods or services to a group purchasing organization (GPO), as part of an agreement to furnish such goods or services to an individual or entity as long as both of the following two standards are met—

(1) The GPO must have a written agreement with each individual or entity, for which items or services are furnished, that provides for either of the following—

(i) The agreement states that participating vendors from which the individual or entity will purchase goods or services will pay a fee to the GPO of 3 percent or less of the purchase price of the goods or services provided by that vendor.

(ii) In the event the fee paid to the GPO is not fixed at 3 percent or less of the purchase price of the goods or services, the agreement specifies the amount (or if not known, the maximum amount) the GPO will be paid by each vendor (where such amount may be a fixed sum or a fixed percentage of the value of purchases made from the vendor by the members of the group under the contract between the vendor and the GPO).

(2) Where the entity which receives the goods or service from the vendor is a health care provider of services, the GPO must disclose in writing to the entity at least annually, and to the Secretary upon request, the amount received from each vendor with respect to purchases made by or on behalf of the entity. Note that for purposes of paragraph (j) of this section, the term group purchasing organization (GPO) means an entity authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs, and who are neither wholly-owned by the GPO nor subsidiaries of a parent corporation that wholly owns the GPO (either directly or through another wholly-owned entity).

(k) Waiver of beneficiary coinsurance and deductible amounts. As used in section 1128B of the Act, “remuneration” does not include any reduction or waiver of a Medicare or a State health care program beneficiary’s obligation to pay coinsurance or deductible amounts as long as all of the standards are met within either of the following two categories of health care providers:

(1) If the coinsurance or deductible amounts are owed to a hospital for inpatient hospital services for which Medicare pays under the prospective payment system, the hospital must comply with all of the following three standards—

(i) The hospital must not later claim the amount reduced or waived as a bad debt for payment purposes under Medicare or otherwise shift the burden of the reduction or waiver onto Medicare, a State health care program, other payers, or individuals.

(ii) The hospital must offer to reduce or waive the coinsurance or deductible amount otherwise owed by the beneficiary.

(iii) The hospital must not later claim as a bad debt for payment purposes under Medicare or otherwise shift the burden of the reduction or waiver onto Medicare, a State health care program, other payers, or individuals.
Office of Inspector General—Health Care, HHS § 1001.952

amounts without regard to the reason for admission, the length of stay of the beneficiary, or the diagnostic related group for which the claim for Medicare reimbursement is filed.

(iii) The hospital's offer to reduce or waive the coinsurance or deductible amounts must not be made as part of a price reduction agreement between a hospital and a third-party payer (including a health plan as defined in paragraph (i)(2) of this section), unless the agreement is part of a contract for the furnishing of items or services to a beneficiary of a Medicare supplemental policy issued under the terms of section 1882(t)(1) of the Act.

(ii) If the coinsurance or deductible amounts are owed by an individual who qualifies for subsidized services under a provision of the Public Health Services Act or under titles V or XIX of the Act to a federally qualified health care center or other health care facility under any Public Health Services Act grant program or under title V of the Act, the health care center or facility may reduce or waive the coinsurance or deductible amounts for items or services for which payment may be made in whole or in part under part B of Medicare or a State health care program.

(i) Increased coverage, reduced cost-sharing amounts, or reduced premium amounts offered by health plans. (1) As used in section 1128B of the Act, “reimbursement” does not include the additional coverage of any item or service offered by a health plan to an enrollee or the reduction of some or all of the enrollee’s obligation to pay the health plan or a contract health care provider for cost-sharing amounts (such as coinsurance, deductible, or copayment amounts) or for premium amounts attributable to items or services covered by the health plan, the Medicare program, or a State health care program, as long as the health plan complies with all of the standards within one of the following two categories of health plans:

   (i) If the health plan is a risk-based health maintenance organization, competitive medical plan, prepaid health plan, or other health plan under contract with CMS or a State health care program and operating in accordance with section 1876(g) or 1903(m) of the Act, under a Federal statutory demonstration authority, or under other Federal statutory or regulatory authority, it must offer the same increased coverage or reduced cost-sharing or premium amounts to all Medicare or State health care program enrollees covered by the contract unless otherwise approved by CMS or by a State health care program.

   (ii) If the health plan is a health maintenance organization, competitive medical plan, health care prepayment plan, prepaid health plan or other health plan that has executed a contract or agreement with CMS or with a State health care program to receive payment for enrollees on a reasonable cost or similar basis, it must comply with both of the following two standards—

      (A) The health plan must offer the same increased coverage or reduced cost-sharing or premium amounts to all Medicare or State health care program enrollees covered by the contract or agreement unless otherwise approved by CMS or by a State health care program; and

      (B) The health plan must not claim the costs of the increased coverage or the reduced cost-sharing or premium amounts as a bad debt for payment purposes under Medicare or a State health care program or otherwise shift the burden of the increased coverage or reduced cost-sharing or premium amounts to the extent that increased payments are claimed from Medicare or a State health care program.

   (2) For purposes of paragraph (1) of this section, the terms—

   Contract health care provider means an individual or entity under contract with a health plan to furnish items or services to enrollees who are covered by the health plan, Medicare, or a State health care program.

   Enrollee means an individual who has entered into a contractual relationship with a health plan (or on whose behalf an employer, or other private or governmental entity has entered into such a relationship) under which the individual is entitled to receive specified health care items and services, or insurance coverage for such items and services, in return for payment of a premium or a fee.
§ 1001.952

Health plan means an entity that furnishes or arranges under agreement with contract health care providers for the furnishing of items or services to enrollees, or furnishes insurance coverage for the provision of such items and services, in exchange for a premium or a fee, where such entity:

(i) Operates in accordance with a contract, agreement or statutory demonstration authority approved by CMS or a State health care program;

(ii) Charges a premium and its premium structure is regulated under a State insurance statute or a State enabling statute governing health maintenance organizations or preferred provider organizations;

(iii) Is an employer, if the enrollees of the plan are current or retired employees, or is a union welfare fund, if the enrollees of the plan are union members; or

(iv) Is licensed in the State, is under contract with an employer, union welfare fund, or a company furnishing health insurance coverage as described in conditions (ii) and (iii) of this definition, and is paid a fee for the administration of the plan which reflects the fair market value of those services.

(m) Price reductions offered to health plans. (1) As used in section 1128B of the Act, “remuneration” does not include a reduction in price a contract health care provider offers to a health plan in accordance with the terms of a written agreement between the contract health care provider and the health plan for the sole purpose of furnishing to enrollees items or services that are covered by the health plan, Medicare, or a State health care program, as long as both the health plan and contract health care provider comply with all of the applicable standards within one of the following four categories of health plans:

(i) If the health plan is a risk-based health maintenance organization, competitive medical plan, health care prepayment plan, prepaid health plan, or other health plan that has executed a contract or agreement with CMS or a State health care program to receive payment for enrollees on a reasonable cost or similar basis, the health plan and contract health care provider must comply with the following four standards:

(A) The term of the agreement between the health plan and the contract health care provider must be for not less than one year;

(B) The agreement between the health plan and the contract health care provider must specify in advance the covered items and services to be furnished to enrollees, and the methodology for computing the payment to the contract health care provider;

(C) The health plan must fully and accurately report, on the applicable cost report or other claim form filed with the Department or the State health care program, the amount it has paid the contract health care provider under the agreement for the covered items and services furnished to enrollees; and

(D) The contract health care provider must not claim payment in any form from the Department or the State agency for items or services furnished in accordance with the agreement except as approved by CMS or the State health care program, or otherwise shift the burden of such an agreement to the extent that increased payments are claimed from Medicare or a State health care program.

(ii) If the health plan is a health maintenance organization, competitive medical plan, health care prepayment plan, prepaid health plan, or other health plan that has executed a contract or agreement with CMS or a State health care program to receive payment for enrollees on a reasonable cost or similar basis, the health plan and contract health care provider must comply with all of the following four standards:

(A) The term of the agreement between the health plan and the contract health care provider must be for not less than one year;

(B) The agreement between the health plan and the contract health care provider must specify in advance the covered items and services to be furnished to enrollees, and the methodology for computing the payment to the contract health care provider;

(C) The health plan must fully and accurately report, on the applicable cost report or other claim form filed with the Department or the State health care program, the amount it has paid the contract health care provider under the agreement for the covered items and services furnished to enrollees; and

(D) The contract health care provider must not claim payment in any form from the Department or the State agency for items or services furnished in accordance with the agreement except as approved by CMS or the State health care program, or otherwise shift the burden of such an agreement to the extent that increased payments are claimed from Medicare or a State health care program.

(iii) If the health plan is not described in paragraphs (m)(1)(i) or (m)(1)(ii) of this section and the contract health care provider is paid on an at-risk, capitated basis, both the health plan and contract health care
provider must comply with all of the following six standards—

(A) The term of the agreement between the health plan and the contract health care provider must be for not less than one year;

(B) The agreement between the health plan and the contract health care provider must specify in advance the covered items and services to be furnished to enrollees, which party is to file claims or requests for payment with Medicare or the State health care program for such items and services, and the schedule of fees the contract health care provider will charge for furnishing such items and services to enrollees;

(C) The fee schedule contained in the agreement between the health plan and the contract health care provider must remain in effect throughout the term of the agreement, unless a fee increase results directly from a payment update authorized by Medicare or the State health care program;

(D) The party submitting claims or requests for payment from Medicare or the State health care program for items and services furnished in accordance with the agreement must not claim or request payment for amounts in excess of the fee schedule;

(E) The contract health care provider and the health plan must fully and accurately report on any cost report filed with Medicare or a State health care program the fee schedule amounts charged in accordance with the agreement and, upon request, will report to the Medicare or a State health care program the terms of the agreement and the amounts paid in accordance with the agreement; and

(F) The party to the agreement, which does not have the responsibility under the agreement for filing claims or requests for payment, must not claim or request payment in any form from the Department, a State health care program or an enrollee for items and services covered by the agreement.

(ii) If the health plan is not described in paragraphs (m)(1)(i) or (m)(1)(ii) of this section, and the contract health care provider is paid on an at-risk, capitated basis, both the health plan and contract health care provider must comply with all of the following five standards—

(A) The term of the agreement between the health plan and the contract health care provider must be for not less than one year;

(B) The agreement between the health plan and the contract health care provider must specify in advance the covered items and services to be furnished to enrollees and the total amount per enrollee (which may be expressed in a per month or other time period basis) the contract health care provider will be paid by the health plan for furnishing such items and services to enrollees and must set forth any copayments, if any, to be paid by enrollees to the contract health care provider for covered services;

(C) The payment amount contained in the agreement between the health care plan and the contract health care provider must remain in effect throughout the term of the agreement;

(D) The contract health care provider and the health plan must fully and accurately report to the Medicare and State health care program upon request, the terms of the agreement and the amounts paid in accordance with the agreement; and

(E) The contract health care provider must not claim or request payment in any form from the Department, a State health care program or an enrollee (other than copayment amounts described in paragraph (m)(2)(iv)(B) of this section) and the health plan must not pay the contract care provider in excess of the amounts described in paragraph (m)(2)(iv)(B) of this section for items and services covered by the agreement.

(2) For purposes of this paragraph, the terms contract health care provider, enrollee, and health plan have the same meaning as in paragraph (l)(2) of this section.

(n) Practitioner recruitment. As used in section 1128B of the Act, “remuneration” does not include any payment or exchange of anything of value by an entity in order to induce a practitioner who has been practicing within his or
her current specialty for less than one year to locate, or to induce any other practitioner to relocate, his or her primary place of practice into a HPSA for his or her specialty area, as defined in Departmental regulations, that is served by the entity, as long as all of the following nine standards are met—

1. The arrangement is set forth in a written agreement signed by the parties that specifies the benefits provided by the entity, the terms under which the benefits are to be provided, and the obligations of each party.

2. If a practitioner is leaving an established practice, at least 75 percent of the revenues of the new practice must be generated from new patients not previously seen by the practitioner at his or her former practice.

3. The benefits are provided by the entity for a period not in excess of 3 years, and the terms of the agreement are not renegotiated during this 3-year period in any substantial aspect; provided, however, that if the HPSA to which the practitioner was recruited ceases to be a HPSA during the term of the written agreement, the payments made under the written agreement will continue to satisfy this paragraph for the duration of the written agreement (not to exceed 3 years).

4. There is no requirement that the practitioner make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the entity as a condition for receiving the benefits; provided, however, that for purposes of this paragraph, the entity may require as a condition for receiving benefits that the practitioner maintain staff privileges at the entity.

5. The practitioner is not restricted from establishing staff privileges at, referring any service to, or otherwise generating any business for any other entity of his or her choosing.

6. The amount or value of the benefits provided by the entity may not vary (or be adjusted or renegotiated) in any manner based on the volume or value of any expected referrals to or business otherwise generated for the entity by the practitioner for which payment may be made in whole or in part under Medicare, Medicaid or any other Federal health care programs.

7. The practitioner agrees to treat patients receiving medical benefits or assistance under any Federal health care program in a nondiscriminatory manner.

8. At least 75 percent of the revenues of the new practice must be generated from patients residing in a HPSA or a Medically Underserved Area (MUA) or who are part of a Medically Underserved Population (MUP), all as defined in paragraph (a) of this section.

9. The payment or exchange of anything of value may not directly or indirectly benefit any person (other than the practitioner being recruited) or entity in a position to make or influence referrals to the entity providing the recruitment payments or benefits of items or services payable by a Federal health care program.

(i) Obstetrical malpractice insurance subsidies. As used in section 1128B of the Act, “remuneration” does not include any payment made by a hospital or other entity to another entity that is providing malpractice insurance (including a self-funded entity), where such payment is used to pay for some or all of the costs of malpractice insurance premiums for a practitioner (including a certified nurse-midwife as defined in section 1861(gg) of the Act) who engages in obstetrical practice as a routine part of his or her medical practice in a primary care HPSA, as long as all of the following seven standards are met—

1. The payment is made in accordance with a written agreement between the entity paying the premiums and the practitioner, which sets out the payments to be made by the entity, and the terms under which the payments are to be provided.

2. The practitioner must certify that for the initial coverage period (not to exceed one year) the practitioner has a reasonable basis for believing that at least 75 percent of the practitioner’s obstetrical patients treated under the coverage of the malpractice insurance will either—

(A) Reside in a HPSA or MUA, as defined in paragraph (a) of this section; or

(B) Be part of a MUP, as defined in paragraph (a) of this section.
(i) Thereafter, for each additional coverage period (not to exceed one year), at least 75 percent of the practitioner’s obstetrical patients treated under the prior coverage period (not to exceed one year) must have—
   (A) Resided in a HPSA or MUA, as defined in paragraph (a) of this section; or
   (B) Been part of a MUP, as defined in paragraph (a) of this section.
(3) There is no requirement that the practitioner make referrals to, or otherwise generate business for, the entity as a condition for receiving the benefits.
(4) The practitioner is not restricted from establishing staff privileges at, referring any service to, or otherwise generating any business for any other entity of his or her choosing.
(5) The amount of payment may not vary based on the volume or value of any previous or expected referrals to or business otherwise generated for the entity by the practitioner for which payment may be made in whole or in part under Medicare, Medicaid or any other Federal health care programs.
(6) The practitioner must treat obstetrical patients who receive medical benefits or assistance under any Federal health care program in a non-discriminatory manner.
(7) The insurance is a bona fide malpractice insurance policy or program, and the premium, if any, is calculated based on a bona fide assessment of the liability risk covered under the insurance. For purposes of paragraph (o) of this section, costs of malpractice insurance premiums means:
   (i) For practitioners who engage in obstetrical practice full-time, any costs attributable to malpractice insurance; or
   (ii) For practitioners who engage in obstetrical practice on a part-time or sporadic basis, the costs:
      (A) Attributable exclusively to the obstetrical portion of the practitioner’s malpractice insurance and
      (B) Related exclusively to obstetrical services provided in a primary care HPSA.
(p) Investments in group practices. As used in section 1128B of the Act, “remuneration” does not include any payment made between a cooperative hospital service organization (CHSO) and its patron-hospital, both of which are described in section 501(e) of the Internal Revenue Code, where the CHSO is wholly owned by two or more patron-hospitals, as long as the following standards are met—
   (1) If the patron-hospital makes a payment to the CHSO, the payment must be for the purpose of paying for the bona fide operating expenses of the CHSO, or
   (2) If the CHSO makes a payment to the patron-hospital, the payment must be for the purpose of paying a distribution of net earnings required to be made under section 501(e)(2) of the Internal Revenue Code of 1986.
Ambulatory surgical centers. As used in section 1128B of the Act, “remuneration” does not include any payment that is a return on an investment interest, such as a dividend or interest income, made to an investor, as long as the investment entity is a certified ambulatory surgical center (ASC) under part 416 of this title, whose operating and recovery room space is dedicated exclusively to the ASC, patients referred to the investment entity by an investor are fully informed of the investor’s investment interest, and all of the applicable standards are met within one of the following four categories—

(i) Surgeon-owned ASCs—If all of the investors are general surgeons or surgeons engaged in the same surgical specialty, who are in a position to refer patients directly to the entity and perform surgery on such referred patients; surgical group practices (as defined in this paragraph) composed exclusively of such surgeons; or investors who are not employed by the entity or by any investor, are not in a position to provide items or services to the entity or any of its investors, and are not in a position to make or influence referrals directly or indirectly to the entity or any of its investors, all of the following six standards must be met—

(i) The terms on which an investment interest is offered to an investor must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor to the entity.

(ii) At least one-third of each surgeon investor’s medical practice income from all sources for the previous fiscal year or previous 12-month period must be derived from the surgeon’s performance of procedures (as defined in this paragraph).

(iii) The entity or any investor (or other individual or entity acting on behalf of the entity or any investor) must not loan funds to or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest.

(iv) The amount of payment to an investor in return for the investment must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.

(v) All ancillary services for Federal health care program beneficiaries performed at the entity must be directly and integrally related to primary procedures performed at the entity, and none may be separately billed to Medicare or other Federal health care programs.

(vi) The entity and any surgeon investors must treat patients receiving medical benefits or assistance under any Federal health care program in a nondiscriminatory manner.

(ii) Single-Specialty ASCs—If all of the investors are physicians engaged in the same medical practice specialty who are in a position to refer patients directly to the entity and perform procedures on such referred patients; group practices (as defined in this paragraph) composed exclusively of such physicians; or investors who are not employed by the entity or by any investor, are not in a position to provide items or services to the entity or any of its investors, and are not in a position to make or influence referrals directly or indirectly to the entity or any of its investors, all of the following six standards must be met—

(i) The terms on which an investment interest is offered to an investor must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor to the entity.

(ii) At least one-third of each physician investor’s medical practice income from all sources for the previous fiscal year or previous 12-month period must be derived from the surgeon’s performance of procedures (as defined in this paragraph).

(iii) The entity or any investor (or other individual or entity acting on behalf of the entity or any investor) must not loan funds to or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest.

(iv) The amount of payment to an investor in return for the investment must be directly proportional to the amount of the capital investment (including the fair market value of any
Office of Inspector General—Health Care, HHS  § 1001.952

pre-operational services rendered) of that investor.

(v) All ancillary services for Federal health care program beneficiaries performed at the entity must be directly and integrally related to primary procedures performed at the entity, and none may be separately billed to Medicare or other Federal health care programs.

(vi) The entity and any physician investors must treat patients receiving medical benefits or assistance under any Federal health care program in a nondiscriminatory manner.

(3) Multi-Specialty ASCs—If all of the investors are physicians who are in a position to refer patients directly to the entity and perform procedures on such referred patients; group practices, as defined in this paragraph, composed exclusively of such physicians; or investors who are not employed by the entity or by any investor, are not in a position to provide items or services to the entity or any of its investors, and are not in a position to make or influence referrals directly or indirectly to the entity or any of its investors, all of the following seven standards must be met—

(i) The terms on which an investment interest is offered to an investor must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor to the entity.

(ii) At least one-third of each physician investor’s medical practice income from all sources for the previous fiscal year or previous 12-month period must be derived from the physician’s performance of procedures (as defined in this paragraph).

(iii) At least one-third of the procedures (as defined in this paragraph) performed by each physician investor for the previous fiscal year or previous 12-month period must be performed at the investment entity.

(iv) The entity or any investor (or other individual or entity acting on behalf of the entity or any investor) must not loan funds to or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest.

(v) The amount of payment to an investor in return for the investment must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.

(vi) All ancillary services for Federal health care program beneficiaries performed at the entity must be directly and integrally related to primary procedures performed at the entity, and none may be separately billed to Medicare or other Federal health care programs.

(vii) The entity and any physician investors must treat patients receiving medical benefits or assistance under any Federal health care program in a nondiscriminatory manner.

(4) Hospital/Physician ASCs—If at least one investor is a hospital, and all of the remaining investors are physicians who meet the requirements of paragraphs (r)(1), (r)(2) or (r)(3) of this section; group practices (as defined in this paragraph) composed of such physicians; surgical group practices (as defined in this paragraph); or investors who are not employed by the entity or by any investor, are not in a position to provide items or services to the entity or any of its investors, and are not in a position to refer patients directly or indirectly to the entity or any of its investors, all of the following eight standards must be met—

(i) The terms on which an investment interest is offered to an investor must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor to the entity.

(ii) The entity or any investor (or other individual or entity acting on behalf of the entity or any investor) must not loan funds to or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest.

(iii) The amount of payment to an investor in return for the investment must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.
(iv) The entity and any hospital or physician investor must treat patients receiving medical benefits or assistance under any Federal health care program in a nondiscriminatory manner.

(v) The entity may not use space, including, but not limited to, operating and recovery room space, located in or owned by any hospital investor, unless such space is leased from the hospital in accordance with a lease that complies with all the standards of the space rental safe harbor set forth in paragraph (b) of this section; nor may it use equipment owned by or services provided by the hospital unless such equipment is leased in accordance with a lease that complies with the equipment rental safe harbor set forth in paragraph (c) of this section, and such services are provided in accordance with a contract that complies with the personal services and management contracts safe harbor set forth in paragraph (d) of this section.

(vi) All ancillary services for Federal health care program beneficiaries performed at the entity must be directly and integrally related to primary procedures performed at the entity, and none may be separately billed to Medicare or other Federal health care programs.

(vii) The hospital may not include on its cost report or any claim for payment from a Federal health care program any costs associated with the ASC (unless such costs are required to be included by a Federal health care program).

(viii) The hospital may not be in a position to make or influence referrals directly or indirectly to any investor or the entity.

(5) For purposes of paragraph (r) of this section, procedures means any procedure or procedures on the list of Medicare-covered procedures for ambulatory surgical centers in accordance with regulations issued by the Department and group practice means a group practice that meets all of the standards of paragraph (p) of this section and is composed exclusively of surgeons who meet the requirements of paragraph (r)(1) of this section.

(s) Referral arrangements for specialty services. As used in section 1128B of the Act, “remuneration” does not include any exchange of value among individuals and entities where one party agrees to refer a patient to the other party for the provision of a specialty service payable in whole or in part under Medicare, Medicaid or any other Federal health care programs in return for an agreement on the part of the other party to refer that patient back at a mutually agreed upon time or circumstance as long as the following four standards are met—

(1) The mutually agreed upon time or circumstance for referring the patient back to the originating individual or entity is clinically appropriate.

(2) The service for which the referral is made is not within the medical expertise of the referring individual or entity, but is within the special expertise of the other party receiving the referral.

(3) The parties receive no payment from each other for the referral and do not share or split a global fee from any Federal health care program in connection with the referred patient.

(4) Unless both parties belong to the same group practice as defined in paragraph (p) of this section, the only exchange of value between the parties is the remuneration the parties receive directly from third-party payors or the patient compensating the parties for the services they each have furnished to the patient.

(t) Price reductions offered to eligible managed care organizations. (1) As used in section 1128(B) of the Act, “remuneration” does not include any payment between:

(A) The eligible managed care organization and any first tier contractor for providing or arranging for items or services, as long as the following three standards are met—

(A) An eligible managed care organization and any first tier contractor for providing or arranging for items or services, as long as the following three standards are met—

(1) An eligible managed care organization and any first tier contractor for providing or arranging for items or services, as long as the following three standards are met—

(1) Is set out in writing and signed by both parties;

(2) Specifies the items and services covered by the agreement;
The eligible managed care organizations in paragraphs (u)(2)(ii)(A)–(F) of this section are only eligible with respect to items or services covered under the agreement, except for:

(i) HMOs and competitive medical plans with cost-based contracts under section 1876 of the Act where the agreement with the eligible managed care organization sets out the arrangements in accordance with which the first tier contractor is billing the Federal health care program;

(ii) Federally qualified HMOs without a contract under sections 1854 or 1876 of the Act, where the agreement with the eligible managed care organization sets out the arrangements in accordance with which the first tier contractor is billing the Federal health care program;

(iii) First tier contractors that are Federally qualified health centers that claim supplemental payments from a Federal health care program.

In establishing the terms of the agreement, neither party gives or receives remuneration in return for or to induce the provision or acceptance of business (other than business covered by the agreement) for which payment may be made in whole or in part by a Federal health care program on a fee-for-service or cost basis.

Neither party shifts the financial burden of the agreement to the extent that increased payments are claimed from a Federal health care program.

The agreement between the eligible managed care organization and first tier contractor covering the items or services that are covered by the agreement between the parties does not involve:

(i) A Federally qualified health center receiving supplemental payments;

(ii) A HMO or CMP with a cost-based contract under section 1876 of the Act;

(iii) A Federally qualified HMO, unless the items or services are covered by a risk based contract under sections 1854 or 1876 of the Act.

For purposes of this paragraph, the following terms are defined as follows:

(i) Downstream contractor means an individual or entity that has a subcontract directly or indirectly with a first tier contractor for the provision or arrangement of items or services that are covered by an agreement between an eligible managed care organization and the first tier contractor.

(ii) Eligible managed care organization means—

(A) A HMO or CMP with a risk or cost based contract in accordance with section 1876 of the Act;

(B) Any Medicare Part C health plan that receives a capitated payment from Medicare and which must have its total Medicare beneficiary cost sharing approved by CMS under section 1854 of the Act;

(C) Medicaid managed care organizations as defined in section 1903(m)(1)(A).

1The eligible managed care organizations in paragraphs (u)(2)(ii)(A)–(F) of this section are only eligible with respect to items or services covered by the contracts specified in those paragraphs.
that provide or arrange for items or services for Medicaid enrollees under a contract in accordance with section 1903(m) of the Act (except for fee-for-service plans or medical savings accounts);

(D) Any other health plans that provide or arrange for items and services for Medicaid enrollees in accordance with a risk-based contract with a State agency subject to the upper payment limits in §447.361 of this title or an equivalent payment cap approved by the Secretary;

(E) Programs For All Inclusive Care For The Elderly (PACE) under sections 1894 and 1934 of the Act, except for for-profit demonstrations under sections 4801(h) and 4802(h) of Pub. L. 105–33; or

(F) A Federally qualified HMO.

(iii) **First tier contractor** means an individual or entity that has a contract directly with an eligible managed care organization to provide or arrange for items or services.

(iv) **Items and services** means health care items, devices, supplies or services or those services reasonably related to the provision of health care items, devices, supplies or services including, but not limited to, non-emergency transportation, patient education, attendant services, social services (e.g., case management), utilization review and quality assurance. Marketing and other pre-enrollment activities are not "items or services" for purposes of this section.

(u) **Price reductions offered by contractors with substantial financial risk to managed care organizations.** (1) As used in section 1128(B) of the Act, "remuneration" does not include any payment between:

(i) A qualified managed care plan and first tier contractor for providing or arranging for items or services, where the following five standards are met—

(A) The agreement between the qualified managed care plan and first tier contractor must:

(1) Be in writing and signed by the parties;

(2) Specify the items and services covered by the agreement;

(3) Be for a period of at least one year;

(4) Require participation in a quality assurance program that promotes the coordination of care, protects against underutilization and specifies patient goals, including measurable outcomes where appropriate; and

(5) Specify a methodology for determining payment that is commercially reasonable and consistent with fair market value established in an arms-length transaction and includes the intervals at which payments will be made and the formula for calculating incentives and penalties, if any.

(B) If a first tier contractor has an investment interest in a qualified managed care plan, the investment interest must meet the criteria of paragraph (a)(1) of this section.

(C) The first tier contractor must have substantial financial risk for the cost or utilization of services it is obligated to provide through one of the following four payment methodologies:

(1) A periodic fixed payment per patient that does not take into account the dates services are provided, the frequency of services, or the extent or kind of services provided;

(2) Percentage of premium;

(3) Inpatient Federal health care program diagnosis-related groups (DRGs) (other than those for psychiatric services);

(4) Bonus and withhold arrangements, provided—

(i) The target payment for first tier contractors that are individuals or non-institutional providers is at least 20 percent greater than the minimum payment, and for first tier contractors that are institutional providers, i.e., hospitals and nursing homes, is at least 10 percent greater than the minimum payment;

(ii) The amount at risk, i.e., the bonus or withhold, is earned by a first tier contractor in direct proportion to the ratio of the contractor's actual utilization to its target utilization;

(iii) In calculating the percentage in accordance with paragraph (u)(1)(i)(C)(4)(i) of this section, both the target payment amount and the minimum payment amount include any performance bonus, e.g., payments for timely submission of paperwork, continuing medical education, meeting attendance, etc., at a level achieved by 75 percent of the first tier contractors who are eligible for such payments;
(iv) Payment amounts, including any bonus or withhold amounts, are reasonable given the historical utilization patterns and costs for the same or comparable populations in similar managed care arrangements; and

(v) Alternatively, for a first tier contractor that is a physician, the qualified managed care plan has placed the physician at risk for referral services in an amount that exceeds the substantial financial risk threshold set forth in 42 CFR 417.479(f) and the arrangement is in compliance with the stop-loss and beneficiary survey requirements of 42 CFR 417.479(g).

(D) Payments for items and services reimbursable by Federal health care program must comply with the following two standards—

(1) The qualified managed care plan (or in the case of a self-funded employer plan that contracts with a qualified managed care plan to provide administrative services, the self-funded employer plan) must submit the claims directly to the Federal health care program, in accordance with a valid reassignment agreement, for items or services reimbursed by the Federal health care program. (Notwithstanding the foregoing, inpatient hospital services, other than psychiatric services, will be deemed to comply if the hospital is reimbursed by a Federal health care program under a DRG methodology.)

(2) Payments to first tier contractors and any downstream contractors for providing or arranging for items or services reimbursable by a Federal health care program must comply with the following three standards—

(A) Both parties are being paid for the provision or arrangement of items or services in accordance with one of the payment methodologies set out in paragraph (u)(1)(i)(C) of this section;

(B) Payment arrangements for items and services reimbursable by a Federal health care program comply with paragraph (u)(1)(i)(D) of this section; and

(C) In establishing the terms of an arrangement—

(i) Neither party gives or receives remuneration in return for or to induce the provision or acceptance of business (other than business covered by the arrangement) for which payment may be made in whole or in part by a Federal health care program on a fee-for-service or cost basis; and

(ii) Neither party to the arrangement shifts the financial burden of such arrangement to the extent that increased payments are claimed from a Federal health care program.

(2) For purposes of this paragraph, the following terms are defined as follows:

(i) Downstream contractor means an individual or entity that has a subcontract directly or indirectly with a first tier contractor for the provision or arrangement of items or services that are covered by an agreement between a qualified managed care plan and the first tier contractor.

(ii) First tier contractor means an individual or entity that has a contract directly with a qualified managed care plan to provide or arrange for items or services.

(iii) Is obligated to provide for a contractor refers to items or services:

(A) Provided directly by an individual or entity and its employees;

(B) For which an individual or entity is financially responsible, but which...
are provided by downstream contractors; 
(C) For which an individual or entity makes referrals or arrangements; or
(D) For which an individual or entity receives financial incentives based on its own, its provider group’s, or its qualified managed care plan’s performance (or combination thereof).
(iv) Items and services means health care items, devices, supplies or services or those services reasonably related to the provision of health care items, devices, supplies or services including, but not limited to, non-emergency transportation, patient education, attendant services, social services (e.g., case management), utilization review and quality assurance. Marketing or other pre-enrollment activities are not “items or services” for purposes of this definition in this paragraph.
(v) Minimum payment is the guaranteed amount that a provider is entitled to receive under an agreement with a first tier or downstream contractor or a qualified managed care plan.
(vi) Qualified managed care plan means a health plan as defined in paragraph (l)(2) of this section that:
(A) Provides a comprehensive range of health services;
(B) Provides or arranges for—
(1) Reasonable utilization goals to avoid inappropriate utilization;
(2) An operational utilization review program;
(3) A quality assurance program that promotes the coordination of care, protects against underutilization, and specifies patient goals, including measurable outcomes where appropriate;
(4) Grievance and hearing procedures;
(5) Protection of enrollees from incurring financial liability other than copayments and deductibles; and
(6) Treatment for Federal health care program beneficiaries that is different than treatment for other enrollees because of their status as Federal health care program beneficiaries; and
(C) Covers a beneficiary population of which either—
(1) No more than 10 percent are Medicare beneficiaries, not including persons for whom a Federal health care program is the secondary payer; or
(2) No more than 50 percent are Medicare beneficiaries (not including persons for whom a Federal health care program is the secondary payer), provided that payment of premiums is on a periodic basis that does not take into account the dates services are rendered, the frequency of services, or the extent or kind of services rendered, and provided further that such periodic payments for the non-Federal health care program beneficiaries do not take into account the number of Federal health care program fee-for-service beneficiaries covered by the agreement or the amount of services generated by such beneficiaries.
(vii) Target payment means the fair market value payment established through arms length negotiations that will be earned by an individual or entity that:
(A) Is dependent on the individual or entity’s meeting a utilization target or range of utilization targets that are set consistent with historical utilization rates for the same or comparable populations in similar managed care arrangements, whether based on its own, its provider group’s or the qualified managed care plan’s utilization (or a combination thereof); and
(B) Does not include any bonus or fees that the individual or entity may earn from exceeding the utilization target.
(v) Ambulance replenishing. (1) As used in section 1128B of the Act, “remuneration” does not include any gift or transfer of drugs or medical supplies (including linens) by a hospital or other receiving facility to an ambulance provider for the purpose of replenishing comparable drugs or medical supplies (including linens) used by the ambulance provider (or a first responder) in connection with the transport of a patient by ambulance to the hospital or other receiving facility if all of the standards in paragraph (v)(2) of this section are satisfied and all of the applicable standards in either paragraph (v)(3)(i), (v)(3)(ii) or (v)(3)(iii) of this section are satisfied. However, to qualify under paragraph (v), the ambulance that is replenished must be used to provide emergency ambulance services an average of three times per week, as measured over a reasonable period of time. Drugs and medical supplies (including linens) initially used
903

Office of Inspector General—Health Care, HHS § 1001.952

by a first responder and replenished at
the scene of the illness or injury by the
ambulance provider that transports the
patient to the hospital or other receiv-
ing facility will be deemed to have
been used by the ambulance provider.
(2) To qualify under paragraph (v) of
this section, the ambulance replen-
ishing arrangement must satisfy all of
the following four conditions—
(i)(A) Under no circumstances may
the ambulance provider (or first re-
sponder) and the receiving facility both
bill for the same replenished drug or
supply. Replenished drugs or supplies
may only be billed (including claiming
bad debt) to a Federal health care pro-
gram by either the ambulance provider
(or first responder) or the receiving fa-
cility.
(B) All billing or claims submission
by the receiving facility, ambulance
provider or first responder for replen-
ished drugs and medical supplies used
in connection with the transport of a
Federal health care program benefi-
ciary must comply with all applicable
Federal health care program payment
and coverage rules and regulations.
(C) Compliance with paragraph
(v)(2)(ii)(B) of this section will be deter-
mained separately for the receiving fa-
cility and the ambulance provider (and
first responder, if any), so long as the
receiving facility, ambulance provider
(or first responder) refrains from doing
anything that would impede the other
party or parties from meeting their ob-
ligations under paragraph (v)(2)(ii)(B).
(ii)(A) The receiving facility or am-
bulance provider, or both, must
(1) Maintain records of the replen-
ished drugs and medical supplies and
the patient transport to which the re-
plenished drugs and medical supplies
related;
(2) Provide a copy of such records to
the other party within a reasonable
time (unless the other party is sepa-
rately maintaining records of the re-
plenished drugs and medical supplies);
and
(3) Make those records available to
the Secretary promptly upon request.
(B) A pre-hospital care report (in-
cluding, but not limited to, a trip
sheet, patient care report or patient
encounter report) prepared by the am-
bulance provider and filed with the re-
ceiving facility will meet the require-
ments of paragraph (v)(2)(ii)(A) of this
section, provided that it documents the
specific type and amount of medical
supplies and drugs used on the patient
and subsequently replenished.
(C) For purposes of paragraph
(v)(2)(ii) of this section, documentation
may be maintained and, if required,
filed with the other party in hard copy
or electronically. If a replenishing ar-
rangement includes linens, documenta-
tion need not be maintained for their
exchange. If documentation is not
maintained for the exchange of linens,
the receiving facility will be presumed
to have provided an exchange of com-
parable clean linens for soiled linens
for each ambulance transport of a pa-
tient to the receiving facility. Records
required under paragraph (v)(3)(ii)(A)
of this section must be maintained for
5 years.
(iii) The replenishing arrangement
must not take into account the volume
or value of any referrals or business
otherwise generated between the par-
ties for which payment may be made in
whole or in part under any Federal
health care program (other than the re-
ferral of the particular patient to
whom the replenished drugs and med-
ic supplies were furnished).
(iv) The receiving facility and the
ambulance provider otherwise comply
with all Federal, State, and local laws
regulating ambulance services, includ-
ing, but not limited to, emergency
services, and the provision of drugs and
medical supplies, including, but not
limited to, laws relating to the han-
dling of controlled substances.
(3) To qualify under paragraph (v) of
this section, the arrangement must
satisfy all of the standards in one of the
following three categories:
(i) General replenishing. (A) The re-
ceiving facility must replenish medical
supplies or drugs on an equal basis for
all ambulance providers that bring pa-
tients to the receiving facility in any
one of the categories described in para-
graph (v)(3)(i)(A)(1), (2), or (3) of this
section. A receiving facility may offer
replenishing to one or more of the cat-
egories and may offer different replen-
ishing arrangements to different cat-
egories, so long as the replenishing is
conducted uniformly within each category. For example, a receiving facility may offer to replenish a broader array of drugs or supplies for ambulance providers that do not charge for their services than for ambulance providers that charge for their services. Within each category, the receiving facility may limit its replenishing arrangements to the replenishing of emergency ambulance transports only. A receiving facility may offer replenishing to one or more of the categories—

(B)(1) The replenishing arrangement must be conducted in an open and public manner. A replenishing arrangement will be considered to be conducted in an open and public manner if one of the following two conditions are satisfied:

(i) A written disclosure of the replenishing program is posted conspicuously in the receiving facility’s emergency room or other location where the ambulance providers deliver patients and copies are made available upon request to ambulance providers, Government representatives, and members of the public (subject to reasonable photocopying charges). The written disclosure can take any reasonable form and should include the category of ambulance service providers that qualifies for replenishment; the drugs or medical supplies included in the replenishment program; and the procedures for documenting the replenishment. A sample disclosure form is included in appendix A to subpart C of this part for illustrative purposes only. No written contracts between the parties are required for purposes of paragraph (v)(3)(i)(B)(1)(i) of this section; or

(ii) The replenishment arrangement operates in accordance with a plan or protocol of general application promulgated by an Emergency Medical Services (EMS) Council or comparable entity, agency or organization, provided a copy of the plan or protocol is available upon request to ambulance providers. Government representatives and members of the public (subject to reasonable photocopying charges). While parties are encouraged to participate in collaborative, comprehensive, community-wide EMS systems to improve the delivery of EMS in their local communities, nothing in this paragraph shall be construed as requiring the involvement of such organizations or the development or implementation of ambulance replenishment plans or protocols by such organizations.

(2) Nothing in this paragraph (v)(3)(i) shall be construed as requiring disclosure of confidential proprietary or financial information related to the replenishing arrangement (including, but not limited to, information about cost, pricing or the volume of replenished drugs or supplies) to ambulance providers or members of the general public.

(ii) Fair market value replenishing. (A) Except as otherwise provided in paragraph (v)(3)(ii)(B) of this section, the ambulance provider must pay the receiving facility fair market value, based on an arms-length transaction, for replenished medical supplies; and

(B) If payment is not made at the same time as the replenishing of the medical supplies, the receiving facility and the ambulance provider must make commercially reasonable payment arrangements in advance.

(iii) Government mandated replenishing. The replenishing arrangement is undertaken in accordance with a State or local statute, ordinance, regulation or binding protocol that requires hospitals or receiving facilities in the area subject to such requirement to replenish ambulances that deliver patients to the hospital with drugs or medical supplies (including linens) that are used during the transport of that patient.

(4) For purposes of paragraph (v) of this section—
(i) A **receiving facility** is a hospital or other facility that provides emergency medical services.

(ii) An **ambulance provider** is a provider or supplier of ambulance transport services that provides emergency ambulance services. The term does not include a provider of ambulance transport services that provides only non-emergency transport services.

(iii) A **first responder** includes, but is not limited to, a fire department, paramedic service or search and rescue squad that responds to an emergency call (through 9–1–1 or other emergency access number) and treats the patient, but does not transport the patient to the hospital or other receiving facility.

(iv) An **emergency ambulance service** is a transport by ambulance initiated as a result of a call through 9–1–1 or other emergency access number or a call from another acute care facility unable to provide the higher level care required by the patient and available at the receiving facility.

(v) **Medical supplies** includes linens, unless otherwise provided.

(w) **Health centers.** As used in section 1128B of the Act, “remuneration” does not include the transfer of any goods, items, services, donations or loans (whether the donation or loan is in cash or in-kind), or combination thereof from an individual or entity to a health center (as defined in this paragraph), as long as the following nine standards are met—

1. The transfer is made pursuant to a contract, lease, grant, loan, or other agreement that—
   (A) Is set out in writing;
   (B) Is signed by the parties; and
   (C) Covers, and specifies the amount of, all goods, items, services, donations, or loans to be provided by the individual or entity to the health center as required by paragraph (w)(1)(i)(C) of this section if all separate agreements between the individual or entity and the health center incorporate each other by reference or if they cross-reference a master list of agreements that is maintained centrally, is kept up to date, and is available for review by the Secretary upon request. The master list should be maintained in a manner that preserves the historical record of arrangements.

2. The goods, items, services, donations, or loans are medical or clinical in nature or relate directly to services provided by the health center as part of the scope of the health center’s section 330 grant (including, by way of example, billing services, administrative support services, technology support, and enabling services, such as case management, transportation, and translation services, that are within the scope of the grant).

3. The health center reasonably expects the arrangement to contribute meaningfully to the health center’s ability to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center, and the health center documents the basis for the reasonable expectation prior to entering the arrangement. The documentation must be made available to the Secretary upon request.

4. At reasonable intervals, but at least annually, the health center must re-evaluate the arrangement to ensure that the arrangement is expected to continue to satisfy the standard set forth in paragraph (w)(3) of this section, and must document the re-evaluation contemporaneously. The documentation must be made available to the Secretary upon request. Renewed or renegotiated agreements must comply with the requirements of paragraph (w)(3) of this section.

5. The individual or entity does not require the health center (or its affiliated health care professionals) to
§ 1001.952

42 CFR Ch. V (10–1–16 Edition)

refer patients to a particular individual or entity, or
   (ii) restrict the health center (or its affiliated health care professionals) from referring patients to any individual or entity.

(6) Individuals and entities that offer to furnish goods, items, or services without charge or at a reduced charge to the health center must furnish such goods, items, or services to all patients from the health center who clinically qualify for the goods, items, or services regardless of the patient’s payor status or ability to pay. The individual or entity may impose reasonable limits on the aggregate volume or value of the goods, items, or services furnished under the arrangement with the health center, provided such limits do not take into account a patient’s payor status or ability to pay.

(7) The agreement must not restrict the health center’s ability, if it chooses, to enter into agreements with other providers or suppliers of comparable goods, items, or services, or with other lenders or donors. Where a health center has multiple individuals or entities willing to offer comparable remuneration, the health center must employ a reasonable methodology to determine which individuals or entities to select and must document its determination. In making these determinations, health centers should look to the procurement standards for beneficiaries of Federal grants set forth in 45 CFR 73.326 through 73.340.

(8) The health center must provide effective notification to patients of their freedom to choose any willing provider or supplier. In addition, the health center must disclose the existence and nature of an agreement under paragraph (w)(1) of this section to any patient who inquires. The health center must provide such notification or disclosure in a timely fashion and in a manner reasonably calculated to be effective and understood by the patient.

(9) The health center may, at its option, elect to require that an individual or entity charge a referred health center patient the same rate it charges other similarly situated patients not referred by the health center or that the individual or entity charge a referred health center patient a reduced rate (where the discount applies to the total charge and not just to the cost-sharing portion owed by an insured patient).

NOTE TO PARAGRAPH (w): For purposes of this paragraph, the term “health center” means a Federally Qualified Health Center under section 1905(l)(2)(B)(i) or 1905(l)(2)(B)(ii) of the Act, and “medically underserved population” means a medically underserved population as defined in regulations at 42 CFR 51c.102(e).

(x) Electronic prescribing items and services. As used in section 1128B of the Act, “remuneration” does not include nonmonetary remuneration (consisting of items and services in the form of hardware, software, or information technology and training services) necessary and used solely to receive and transmit electronic prescription information, if all of the following conditions are met:

(1) The items and services are provided by a—
   (i) Hospital to a physician who is a member of its medical staff;
   (ii) Group practice to a prescribing health care professional who is a member of the group practice; and
   (iii) A PDP sponsor or MA organization to pharmacists and pharmacies participating in the network of such sponsor or organization and to prescribing health care professionals.

(2) The items and services are provided as part of, or are used to access, an electronic prescription drug program that meets the applicable standards under Medicare Part D at the time the items and services are provided.

(3) The donor (or any person on the donor’s behalf) does not take any action to limit or restrict the use or compatibility of the items or services with other electronic prescribing or electronic health records systems.

(4) For items or services that are of the type that can be used for any patient without regard to payor status, the donor does not restrict, or take any action to limit, the recipient’s right or ability to use the items or services for any patient.

(5) Neither the beneficiary nor the recipient’s practice (or any affiliated individual or entity) makes the receipt of
items or services, or the amount or nature of the items or services, a condition of doing business with the donor.

(6) Neither the eligibility of a beneficiary for the items or services, nor the amount or nature of the items or services, is determined in a manner that takes into account the volume or value of referrals or other business generated between the parties.

(7) The arrangement is set forth in a written agreement that—

(i) Is signed by the parties;

(ii) Specifies the items and services being provided and the donor’s cost of the items and services; and

(iii) Covers all of the electronic prescribing items and services to be provided by the donor (or affiliated parties). This requirement will be met if all separate agreements between the donor (and affiliated parties) and the beneficiary incorporate each other by reference or if they cross-reference a master list of agreements that is maintained and updated centrally and is available for review by the Secretary upon request. The master list should be maintained in a manner that preserves the historical record of agreements.

(8) The donor does not have actual knowledge of, and does not act in reckless disregard or deliberate ignorance of, the fact that the beneficiary possesses or has obtained items or services equivalent to those provided by the donor.

NOTE TO PARAGRAPH (x): For purposes of paragraph (x) of this section, group practice shall have the meaning set forth at 42 CFR 411.352; member of the group practice shall mean all persons covered by the definition of “member of the group or member of a group practice” at 42 CFR 411.351, as well as other prescribing health care professionals who are owners or employees of the group practice; prescribing health care professional shall mean a physician or other health care professional licensed to prescribe drugs in the State in which the drugs are dispensed; PDP sponsor or MA organization shall have the meanings set forth at 42 CFR 422.1 and 422.2, respectively; prescription information shall mean information about prescriptions for drugs or for any other item or service normally accomplished through a written prescription; and electronic health record shall mean a repository of consumer health status information in computer processable form used for clinical diagnosis and treatment for a broad array of clinical conditions.

(y) Electronic health records items and services. As used in section 1123B of the Act, “remuneration” does not include nonmonetary remuneration (consisting of items and services in the form of software or information technology and training services) necessary and used predominantly to create, maintain, transmit, or receive electronic health records, if all of the following conditions are met:

(1) The items and services are provided to an individual or entity engaged in the delivery of health care by—

(i) An individual or entity, other than a laboratory company, that provides services covered by a Federal health care program and submits claims or requests for payment, either directly or through reassignment, to the Federal health care program; or

(ii) A health plan.

(2) The software is interoperable at the time it is provided to the recipient. For purposes of this subparagraph, software is deemed to be interoperable if, on the date it is provided to the recipient, it has been certified by a certifying body authorized by the National Coordinator for Health Information Technology to an edition of the electronic health record certification criteria identified in the then-applicable version of 45 CFR part 170.

(3) The donor (or any person on the donor’s behalf) does not take any action to limit or restrict the use, compatibility, or interoperability of the items or services with other electronic prescribing or electronic health records systems (including, but not limited to, health information technology applications, products, or services).

(4) Neither the beneficiary nor the recipient’s practice (or any affiliated individual or entity) makes the receipt of items or services, or the amount or nature of the items or services, a condition of doing business with the donor.

(5) Neither the eligibility of a beneficiary for the items or services, nor the amount or nature of the items or services, is determined in a manner that directly takes into account the volume or value of referrals or other business generated between the parties. For the purposes of this paragraph (y)(5), the determination is deemed not
to directly take into account the volume or value of referrals or other business generated between the parties if any one of the following conditions is met:

(i) The determination is based on the total number of prescriptions written by the beneficiary (but not the volume or value of prescriptions dispensed or paid by the donor or billed to a Federal health care program);

(ii) The determination is based on the size of the recipient’s medical practice (for example, total patients, total patient encounters, or total relative value units);

(iii) The determination is based on the total number of hours that the beneficiary practices medicine;

(iv) The determination is based on the recipient’s overall use of automated technology in his or her medical practice (without specific reference to the use of technology in connection with referrals made to the donor);

(v) The determination is based on whether the beneficiary is a member of the donor’s medical staff, if the donor has a formal medical staff;

(vi) The determination is based on the level of uncompensated care provided by the recipient; or

(vii) The determination is made in any reasonable and verifiable manner that does not directly take into account the volume or value of referrals or other business generated between the parties.

(6) The arrangement is set forth in a written agreement that —

(i) Is signed by the parties;

(ii) Specifies the items and services being provided, the donor’s cost of those items and services, and the amount of the recipient’s contribution; and

(iii) Covers all of the electronic health records items and services to be provided by the donor (or any affiliate). This requirement will be met if all separate agreements between the donor (and affiliated parties) and the beneficiary incorporate each other by reference or if they cross-reference a master list of agreements that is maintained and updated centrally and is available for review by the Secretary upon request. The master list should be maintained in a manner that preserves the historical record of agreements.

(7) The donor does not have actual knowledge of, and does not act in reckless disregard or deliberate ignorance of, the fact that the beneficiary possesses or has obtained items or services equivalent to those provided by the donor.

(8) For items or services that are of the type that can be used for any patient without regard to payor status, the donor does not restrict, or take any action to limit, the recipient’s right or ability to use the items or services for any patient.

(9) The items and services do not include staffing of the recipient’s office and are not used primarily to conduct personal business or business unrelated to the recipient’s clinical practice or clinical operations.

(10) [Reserved]

(11) Before receipt of the items and services, the beneficiary pays 15 percent of the donor’s cost for the items and services. The donor (or any affiliated individual or entity) does not finance the recipient’s payment or loan funds to be used by the beneficiary to pay for the items and services.

(12) The donor does not shift the costs of the items or services to any Federal health care program.

(13) The transfer of the items and services occurs, and all conditions in this paragraph (y) have been satisfied, on or before December 31, 2021.

NOTE TO PARAGRAPH (y): For purposes of paragraph (y) of this section, health plan shall have the meaning set forth at §1001.952(l)(2); interoperable shall mean able to communicate and exchange data accurately, effectively, securely, and consistently with different information technology systems, software applications, and networks, in various settings, and exchange data such that the clinical or operational purpose and meaning of the data are preserved and unaltered; and electronic health record shall mean a repository of consumer health status information in computer processable form used for clinical diagnosis
§ 1001.1001 Exclusion of entities owned or controlled by a sanctioned person.

(a) Circumstance for exclusion. (1) The OIG may exclude an entity if:
   (i) A person with a relationship with such entity—
      (A) Has been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2) or (3) of the Act;
      (B) Has had civil money penalties or assessments imposed under section 1128A of the Act; or
      (C) Has been excluded from participation in Medicare or any of the State health care programs, and
   (ii) Such a person—
      (A)(1) Has a direct or indirect ownership interest (or any combination thereof) of 5 percent or more in the entity;
      (2) Is the owner of a whole or part interest in any mortgage, deed of trust, note or other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceeds 5 percent of the total property and assets of the entity;
      (3) Is an officer or director of the entity, if the entity is organized as a corporation;
      (4) Is partner in the entity, if the entity is organized as a partnership;
      (5) Is an agent of the entity; or
      (6) Is a managing employee, that is, an individual (including a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity or part thereof, or directly or indirectly conducts the day-to-day operations of the entity or part thereof, or
   (B) Was formerly described in paragraph (a)(1)(ii)(A) of this section, but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the person’s household as defined in paragraph (a)(2) of this section, in anticipation of or following a conviction, assessment of a CMP, or imposition of an exclusion.

(2) For purposes of this section, the term:

   Agent means any person who has express or implied authority to obligate or act on behalf of an entity.

   Immediate family member means, a person’s husband or wife; natural or adoptive parent; child or sibling; step-parent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

   Indirect ownership interest includes an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue. (For example, an individual has a 10 percent ownership interest in the entity at issue if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the entity in issue.)

   Member of household means, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

   Ownership interest means an interest in:
   (i) The capital, the stock or the profits of the entity, or
   (ii) Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.

(b) Length of exclusion. (1) Except as provided in §1001.3002(c), exclusions under this section will be for the same period as that of the individual whose relationship with the entity is the basis for this exclusion, if the individual has been or is being excluded.

(2) If the individual was not excluded, the length of the entity’s exclusion will be determined by considering the factors that would have been considered if the individual had been excluded.

(3) An entity excluded under this section may apply for reinstatement at
§ 1001.1051 Exclusion of individuals with ownership or control interest in sanctioned entities.

(a) Circumstance for exclusion. The OIG may exclude any individual who—

(1) Has a direct or indirect ownership or control interest in a sanctioned entity, and who knows or should know (as defined in section 1128A(i)(6) of the Act) of the action constituting the basis for the conviction or exclusion set forth in paragraph (b) of this section; or

(2) Is an officer or managing employee (as defined in section 1126(b) of the Act) of such an entity.

(b) For purposes of paragraph (a) of this section, the term “sanctioned entity” means an entity that—

(1) Has been convicted of any offense described in §§ 1001.101 through 1001.401 of this part; or

(2) Has been terminated or excluded from participation in Medicare, Medicaid and all other Federal health care programs.

(c) Length of exclusion. (1) If the entity has been excluded, the length of the individual’s exclusion will be for the same period as that of the sanctioned entity with which the individual has the prohibited relationship.

(2) If the entity was not excluded, the length of the individual’s exclusion will be determined by considering the factors that would have been considered if the entity had been excluded.

(3) An individual excluded under this section may apply for reinstatement in accordance with the procedures set forth in §1001.3001.

[57 FR 3330, Jan. 29, 1992, as amended at 64 FR 39427, July 22, 1999]

§ 1001.1101 Failure to disclose certain information.

(a) Circumstance for exclusion. The OIG may exclude any entity that did not fully and accurately, or completely, make disclosures as required by section 1124, 1124A or 1126 of the Act, and by part 455, subpart B and part 420, subpart C of this title.

(b) Length of exclusion. The following factors will be considered in determining the length of an exclusion under this section—

(1) The number of instances where full and accurate, or complete, disclosure was not made;

(2) The significance of the undisclosed information;

(3) Whether the individual or entity has a documented history of criminal, civil or administrative wrongdoing (The lack of any prior record is to be considered neutral);

(4) Any other facts that bear on the nature or seriousness of the conduct;

(5) The availability of alternative sources of the type of health care services provided by the entity; and

(6) The extent to which the entity knew that the disclosures made were not full or accurate.


§ 1001.1201 Failure to provide payment information.

(a) Circumstance for exclusion. The OIG may exclude any individual or entity that furnishes items or services for which payment may be made under Medicare or any of the State health care programs and that:

(1) Fails to provide such information as is necessary to determine whether such payments are or were due and the amounts thereof; or

(2) Has refused to permit such examination and duplication of its records as may be necessary to verify such information.

(b) Length of exclusion. The following factors will be considered in determining the length of an exclusion under this section—

(1) The number of instances where information was not provided;

(2) The circumstances under which such information was not provided;

(3) The amount of the payments at issue;

(4) Whether the individual or entity has a documented history of criminal, civil or administrative wrongdoing (The lack of any prior record is to be considered neutral); and

(5) The availability of alternative sources of the type of health care items
Office of Inspector General—Health Care, HHS § 1001.1301

Failure to grant immediate access.

(a) Circumstance for exclusion. (1) The OIG may exclude any individual or entity that fails to grant immediate access upon reasonable request to—

(ii) The Secretary, a State survey agency or other authorized entity for the purpose of performing the reviews and surveys required under State plans in accordance with sections 1902(a)(26) (relating to inpatient mental hospital services), 1902(a)(31) (relating to intermediate care facilities for individuals with intellectual disabilities), 1919(g) (relating to nursing facilities), 1929(i) (relating to providers of home and community care and community care settings), 1902(a)(33) and 1903(g) of the Act;

(iii) The OIG for the purpose of reviewing records, documents and other data necessary to the performance of the Inspector General’s statutory functions; or

(iv) A State Medicaid fraud control unit for the purpose of conducting its activities.

(2) For purposes of paragraphs (a)(1)(i) and (a)(1)(ii) of this section, the term—

Failure to grant immediate access means the failure to grant access at the time of a reasonable request or to provide a compelling reason why access may not be granted.

Reasonable request means a written request made by a properly identified agent of the Secretary, of a State survey agency or of another authorized entity, during hours that the facility, agency or institution is open for business.

Reasonable request means a written request made by a properly identified agent of the Secretary, of a State survey agency or of another authorized entity, during hours that the facility, agency or institution is open for business.

(b) Reasonable request means a written request made by a properly identified agent of the Secretary, of a State survey agency or of another authorized entity, during hours that the facility, agency or institution is open for business.

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Reasonable request means a written request made by a properly identified agent of the Secretary, of a State survey agency or of another authorized entity, during hours that the facility, agency or institution is open for business.
§ 1001.1401 Violations of PPS corrective action.

(a) Circumstance for exclusion. The OIG may exclude any hospital that CMS determines has failed substantially to comply with a corrective action plan required by CMS under section 1886(f)(2)(B) of the Act.

(b) Length of exclusion. The following factors will be considered in determining the length of exclusion under this section—

(1) The impact of the hospital’s failure to comply on Medicare, Medicaid or any of the other Federal health care programs, program beneficiaries or other individuals;

(2) The circumstances under which the failure occurred;

(3) The nature of the failure to comply;

(4) The impact of the exclusion on Medicare, Medicaid or any of the other Federal health care programs, beneficiaries or the public; and

(5) Whether the individual or entity has a documented history of criminal, civil or administrative wrongdoing (The lack of any prior record is to be considered neutral).

§ 1001.1401 Violations of PPS corrective action.

(a) Circumstance for exclusion. The OIG may exclude any hospital that CMS determines has failed substantially to comply with a corrective action plan required by CMS under section 1886(f)(2)(B) of the Act.

(b) Length of exclusion. The following factors will be considered in determining the length of exclusion under this section—

(1) The impact of the hospital’s failure to comply on Medicare, Medicaid or any of the other Federal health care programs, program beneficiaries or other individuals;

(2) The circumstances under which the failure occurred;

(3) The nature of the failure to comply;

(4) The impact of the exclusion on Medicare, Medicaid or any of the other Federal health care programs, beneficiaries or the public; and

(5) Whether the individual or entity has a documented history of criminal, civil or administrative wrongdoing (The lack of any prior record is to be considered neutral).

§ 1001.1501 Default of health education loan or scholarship obligations.

(a) Circumstance for exclusion. (1) Except as provided in paragraph (a)(4) of this section, the OIG may exclude any
individual that the Public Health Service (PHS) determines is in default on repayments of scholarship obligations or loans in connection with health professions education made or secured in whole or in part by the Secretary.

(2) Before imposing an exclusion in accordance with paragraph (a)(1) of this section, the OIG must determine that PHS has taken all reasonable administrative steps to secure repayment of the loans or obligations. If PHS has offered a Medicare offset arrangement as required by section 1892 of the Act, the OIG will find that all reasonable steps have been taken.

(3) The OIG will take into account access of beneficiaries to physicians’ services for which payment may be made under Medicare, Medicaid or other Federal health care programs in determining whether to impose an exclusion.

(4) The OIG will not exclude a physician who is the sole community physician or the sole source of essential specialized services in a community if a State requests that the physician not be excluded.

(b) Length of exclusion. The individual will be excluded until such time as PHS notifies the OIG that the default has been cured or that there is no longer an outstanding debt. Upon such notice, the OIG will inform the individual of his or her right to apply for reinstatement.

§ 1001.1601 Violations of the limitations on physician charges.

(a) Circumstance for exclusion. (1) The OIG may exclude a physician whom it determines—

(i) Is a non-participating physician under section 1842(j) of the Act;

(ii) Furnished services to a beneficiary;

(iii) Knowingly and willfully billed—

(A) On a repeated basis for such services actual charges in excess of the maximum allowable actual charge determined in accordance with section 1842(j)(1)(C) of the Act for the period January 1, 1987 through December 31, 1990, or

(B) Individuals enrolled under part B of title XVIII of the Act during the statutory freeze for actual charges in excess of such physician’s actual charges determined in accordance with section 1842(j)(1)(A) of the Act for the period July 1, 1984 to December 31, 1986; and

(iv) Is not the sole community physician or sole source of essential specialized services in the community.

(2) The OIG will take into account access of beneficiaries to physicians’ services for which Medicare payment may be made in determining whether to impose an exclusion.

(b) Length of exclusion. (1) In determining the length of an exclusion in accordance with this section, the OIG will consider the following factors—

(i) The number of services for which the physician billed in excess of the maximum allowable charges;

(ii) The number of beneficiaries for whom services were billed in excess of the maximum allowable charges;

(iii) The amount of the charges that were in excess of the maximum allowable charges;

(iv) Whether the physician has a documented history of criminal, civil or administrative wrongdoing (The lack of any prior record is to be considered neutral); and

(v) The availability of alternative sources of the type of health care items or services furnished by the physician.

(2) The period of exclusion may not exceed 5 years.

§ 1001.1701 Billing for services of assistant at surgery during cataract operations.

(a) Circumstance for exclusion. The OIG may exclude a physician whom it determines—

(1) Has knowingly and willfully presented or caused to be presented a claim, or billed an individual enrolled under Part B of the Medicare program (or his or her representative) for:

(i) Services of an assistant at surgery during a cataract operation, or

(ii) Charges that include a charge for an assistant at surgery during a cataract operation;
(2) Has not obtained prior approval for the use of such assistant from the appropriate Utilization and Quality Control Quality Improvement Organization (QIO) or Medicare carrier; and

(3) Is not the sole community physician or sole source of essential specialized services in the community.

(b) The OIG will take into account access of beneficiaries to physicians' services for which Medicare payment may be made in determining whether to impose an exclusion.

(c) Length of exclusion. (1) In determining the length of an exclusion in accordance with this section, the OIG will consider the following factors—

(i) The number of instances for which claims were submitted or beneficiaries were billed for unapproved use of assistants during cataract operations;

(ii) The amount of the claims or bills presented;

(iii) The circumstances under which the claims or bills were made, including whether the services were medically necessary;

(iv) Whether approval for the use of an assistant was requested from the QIO or carrier;

(v) Whether the physician has a documented history of criminal, civil or administrative wrongdoing (The lack of any prior record is to be considered neutral); and

(vi) The availability of alternative sources of the type of health care items or services furnished by the physician.

(2) The period of exclusion may not exceed 5 years.


APPENDIX A TO SUBPART C OF PART 1001

The following is a sample written disclosure for purposes of satisfying the requirements of § 1001.952(v)(3)(i)(B)(1) of this part. This form is for illustrative purposes only; parties may, but are not required to, adapt this sample written disclosure form.

NOTICE OF AMBULANCE RESTOCKING PROGRAM

Hospital X offers the following ambulance restocking program:

1. We will restock all ambulance providers (other than ambulance providers that do not provide emergency services) that bring patients to Hospital X [or to a subpart of Hospital X, such as the emergency room] in the following category or categories: [insert description of category of ambulances to be restocked, i.e., all ambulance providers, all ambulance providers that do not charge patients or insurers for their services, or all nonprofit and Government ambulance providers]. [Optional: We only offer restocking of emergency transports.]

2. The restocking will include the following drugs and medical supplies, and linens, used for patient prior to delivery of the patient to Hospital X: [insert description of drugs and medical supplies, and linens to be restocked].

3. The ambulance providers [will/will not] be required to pay for the restocked drugs and medical supplies, and linens.

4. The restocked drugs and medical supplies, and linens, must be documented as follows: [insert description consistent with the documentation requirements described in §1001.952(v)]. By way of example only, documentation may be by a patient care report filed with the receiving facility within 24 hours of delivery of the patient that records the name of the patient, the date of the transport, and the relevant drugs and medical supplies.

5. This restocking program does not apply to the restocking of ambulances that only provide non-emergency services or to the general stocking of an ambulance provider's inventory.

6. To ensure that Hospital X does not bill any Federal health care program for restocked drugs or supplies for which a participating ambulance provider bills or is eligible to bill, all participating ambulance providers must notify Hospital X if they intend to submit claims for restocked drugs or supplies to any Federal health care program. Participating ambulance providers must agree to work with Hospital X to ensure that only one party bills for a particular restocked drug or supply.

7. All participants in this ambulance restocking arrangement that bill Federal health care programs for restocked drugs or supplies must comply with all applicable Federal program billing and claims filing rules and regulations.

8. For further information about our restocking program or to obtain a copy of this notice, please contact [name] at [telephone number].

Dated: [Signature]

[66 FR 62991, Dec. 4, 2001]

Subpart D—Waivers and Effect of Exclusion

§ 1001.1801 Waivers of exclusions.

(a) The OIG has the authority to grant or deny a request from a State
Office of Inspector General—Health Care, HHS § 1001.1901

health care program that an exclusion from that program be waived with respect to an individual or entity, except that no waiver may be granted with respect to an exclusion under §1001.101(b). The request must be in writing and from an individual directly responsible for administering the State health care program.

(b) With respect to exclusions under §1001.101(a), a request from a State health care program for a waiver of the exclusion will only be considered if the individual or entity is the sole community physician or the sole source of essential specialized services in a community.

(c) With respect to exclusions imposed under subpart C of this part, a request for waiver will only be granted if the OIG determines that imposition of the exclusion would not be in the public interest.

(d) If the basis for the waiver ceases to exist, the waiver will be rescinded, and the individual or entity will be excluded for the period remaining on the exclusion, measured from the time the exclusion would have been imposed if the waiver had not been granted.

(e) In the event a waiver is granted, it is applicable only to the program(s) for which waiver is requested.

(f) The decision to grant, deny or rescind a request for a waiver is not subject to administrative or judicial review.

(g) The Inspector General may waive the exclusion of an individual or entity from participation in the Medicare program in conjunction with granting a waiver requested by a State health care program. If a State program waiver is rescinded, the derivative waiver of the exclusion from Medicare is automatically rescinded.

§ 1001.1901 Scope and effect of exclusion.

(a) Scope of exclusion. Exclusions of individuals and entities under this title will be from Medicare, Medicaid and any of the other Federal health care programs, as defined in §1001.2.

(b) Effect of exclusion on excluded individuals and entities. (1) Unless and until an individual or entity is reinstated into the Medicare, Medicaid and other Federal health care programs in accordance with subpart F of this part, no payment will be made by Medicare, Medicaid or any of the other Federal health care programs for any item or service furnished, on or after the effective date specified in the notice period, by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion. This section applies regardless of whether an individual or entity has obtained a program provider number or equivalent, either as an individual or as a member of a group, prior to being reinstated.

(2) An excluded individual or entity may not take assignment of an enrollee’s claim on or after the effective date of exclusion.

(3) An excluded individual or entity that submits, or causes to be submitted, claims for items or services furnished during the exclusion period is subject to civil money penalty liability under section 1128A(a)(1)(D) of the Act, and criminal liability under section 1128B(a)(3) of the Act and other provisions. In addition, submitting claims, or causing claims to be submitted or payments to be made for items or services furnished, ordered or prescribed, including administrative and management services or salary, may serve as the basis for denying reinstatement to the programs.

(c) Exceptions to paragraph (b)(1) of this section. (1) If an enrollee of Part B of Medicare submits an otherwise payable claim for items or services furnished by an excluded individual or entity, or under the medical direction or on the prescription of an excluded physician or other authorized individual after the effective date of exclusion, CMS will pay the first claim submitted by the enrollee and immediately notify the enrollee of the exclusion.

(2) CMS will not pay an enrollee for items or services furnished by an excluded individual or entity, or under the medical direction or on the prescription of an excluded physician or other authorized individual more than 15 days after the date on the notice to the enrollee, or after the effective date of the exclusion, whichever is later.
(3) Unless the Secretary determines that the health and safety of beneficiaries receiving services under Medicare, Medicaid or any of the other Federal health care programs warrants the exclusion taking effect earlier, payment may be made under such program for up to 30 days after the effective date of the exclusion for—

(i) Inpatient institutional services furnished to an individual who was admitted to an excluded institution before the date of the exclusion,

(ii) Home health services and hospice care furnished to an individual under a plan of care established before the effective date of the exclusion, and

(iii) Any health care items that are ordered by a practitioner, provider or supplier from an excluded manufacturer before the effective date of the exclusion and delivered within 30 days of the effective date of such exclusion.

(For the period October 2, 1998, to October 4, 1999, payment may be made under Medicare or a State health care program for up to 60 days after the effective date of the exclusion for any health care items that are ordered by a practitioner, provider or supplier from an excluded manufacturer before the effective date of such exclusion and delivered within 60 days of the effect of the exclusion.)

(4) CMS will not pay any claims submitted by, or for items or services ordered or prescribed by, an excluded provider for dates of service 15 days or more after the notice of the provider’s exclusion was mailed to the supplier.

(5)(i) Notwithstanding the other provisions of this section, payment may be made under Medicare, Medicaid or other Federal health care programs for certain emergency items or services furnished by an excluded individual or entity, or at the medical direction or on the prescription of an excluded physician or other authorized individual during the period of exclusion. To be payable, a claim for such emergency items or services must be accompanied by a sworn statement of the person furnishing the items or services specifying the nature of the emergency and why the items or services could not have been furnished by an individual or entity eligible to furnish or order such items or services.

(ii) Notwithstanding paragraph (c)(5)(i) of this section, no claim for emergency items or services will be payable if such items or services were provided by an excluded individual who, through an employment, contractual or any other arrangement, routinely provides emergency health care items or services.


Subpart E—Notice and Appeals

§ 1001.2001 Notice of intent to exclude.

(a) Except as provided in paragraph (c) of this section, if the OIG proposes to exclude an individual or entity in accordance with subpart C of this part, or in accordance with subpart B of this part where the exclusion is for a period exceeding 5 years, it will send written notice of its intent, the basis for the proposed exclusion and the potential effect of an exclusion. Within 30 days of receipt of notice, which will be deemed to be 5 days after the date on the notice, the individual or entity may submit documentary evidence and written argument concerning whether the exclusion is warranted and any related issues.

(b) If the OIG proposes to exclude an individual or entity under the provisions of §1001.701 or §1001.801 of this part, in conjunction with the submission of documentary evidence and written argument, an individual or entity may request an opportunity to present oral argument to an OIG official.

(c) Exception. If the OIG proposes to exclude an individual or entity under the provisions of §1001.1301, §1001.1401 or §1001.1501 of this part, paragraph (a) of this section will not apply.

(d) If an entity has a provider agreement under section 1866 of the Act, and the OIG proposes to terminate that agreement in accordance with section 1866(b)(2)(C) of the Act, the notice provided for in paragraph (a) of this section will so state.

§ 1001.2002 Notice of exclusion.

(a) Except as provided in §1001.2003, if the OIG determines that exclusion is warranted, it will send a written notice of this decision to the affected individual or entity.

(b) The exclusion will be effective 20 days from the date of the notice.

(c) The written notice will state—

(1) The basis for the exclusion;
(2) The length of the exclusion and, where applicable, the factors considered in setting the length;
(3) The effect of the exclusion;
(4) The earliest date on which the OIG will consider a request for reinstatement;
(5) The requirements and procedures for reinstatement; and
(6) The appeal rights available to the excluded individual or entity.

(d) Paragraph (b) of this section does not apply to exclusions imposed in accordance with §1001.1301.

(e) No later than 15 days prior to the final exhibit exchanges required under §1005.8 of this chapter, the OIG may amend its notice letter if information comes to light that justifies the imposition of a different period of exclusion other than the one proposed in the original notice letter.


§ 1001.2003 Notice of proposal to exclude.

(a) Except as provided in paragraph (c) of this section, if the OIG proposes to exclude an individual or entity in accordance with §1001.901, §1001.951, §1001.1601 or §1001.1701, it will send written notice of this decision to the affected individual or entity. The written notice will provide the same information set forth in §1001.2002(c). If an entity has a provider agreement under section 1866 of the Act, and the OIG also proposes to terminate that agreement in accordance with section 1866(b)(2)(C) of the Act, the notice will so indicate. The exclusion will be effective 60 days after the receipt of the notice (as defined in §1005.2 of this chapter) unless, within that period, the individual or entity files a written request for a hearing in accordance with part 1005 of this chapter. Such request must set forth—

(1) The specific issues or statements in the notice with which the individual or entity disagrees;
(2) The basis for that disagreement;
(3) The defenses on which reliance is intended;
(4) Any reasons why the proposed length of exclusion should be modified; and
(5) Reasons why the health or safety of individuals receiving services under Medicare or any of the State health care programs does not warrant the exclusion going into effect prior to the completion of an administrative law judge (ALJ) proceeding in accordance with part 1005 of this chapter.

(b)(1) If the individual or entity does not make a written request for a hearing as provided for in paragraph (a) of this section, the OIG will send a notice of exclusion as described in §1001.2002.

(2) If the individual or entity makes a timely written request for a hearing and the OIG determines that the health or safety of individuals receiving services under Medicare or any of the State health care programs does not warrant immediate exclusion, an exclusion will only go into effect, with the date of the ALJ’s decision, if the ALJ upholds the decision to exclude.

(c) If, prior to issuing a notice of proposal to exclude under paragraph (a) of this section, the OIG determines that the health or safety of individuals receiving services under Medicare or any of the State health care programs warrants the exclusion taking place prior to the completion of an ALJ proceeding in accordance with part 1005 of this chapter, the OIG will proceed under §§1001.2001 and 1001.2002.


§ 1001.2004 Notice to State agencies.

HHS will promptly notify each appropriate State agency administering or supervising the administration of each State health care program of:

(a) The facts and circumstances of each exclusion, and

(b) The period for which the State agency is being directed to exclude the individual or entity.
§ 1001.2005 Notice to State licensing agencies.

(a) HHS will promptly notify the appropriate State(s) or local agencies or authorities having responsibility for the licensing or certification of an individual or entity excluded (or directed to be excluded) from participation of the facts and circumstances of the exclusion.

(b) HHS will request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and will request that the State or local agency or authority keep the Secretary and the OIG fully and currently informed with respect to any actions taken in response to the request.

§ 1001.2006 Notice to others regarding exclusion.

(a) HHS will give notice of the exclusion and the effective date to the public, to beneficiaries (in accordance with §1001.1901(c)), and, as appropriate, to—

(1) Any entity in which the excluded individual is known to be serving as an employee, administrator, operator, or in which the individual is serving in any other capacity and is receiving payment for providing services (The lack of this notice will not affect CMS’s ability to deny payment for services);

(2) State Medicaid Fraud Control Units;

(3) Utilization and Quality Control Quality Improvement Organizations;

(4) Hospitals, skilled nursing facilities, home health agencies and health maintenance organizations;

(5) Medical societies and other professional organizations;

(6) Contractors, health care prepayment plans, private insurance companies and other affected agencies and organizations;

(7) The State and Area Agencies on Aging established under title III of the Older Americans Act;

(b) The excluded individual or entity has 60 days from the receipt of notice of exclusion provided for in §1001.2002 to file a request for such a hearing.

(c) The standard of proof at a hearing is preponderance of the evidence.

(d) When the exclusion is based on the existence of a criminal conviction or a civil judgment imposing liability by Federal, State or local court, a determination by another Government agency, or any other prior determination where the facts were adjudicated and a final decision was made, the basis for the underlying conviction, civil judgment or determination is not reviewable and the individual or entity may not collaterally attack it either on substantive or procedural grounds in this appeal.

(e) The procedures in part 1005 of this chapter will apply to the appeal.

[57 FR 3330, Jan. 29, 1992, as amended at 67 FR 11935, Mar. 18, 2002]

Subpart F—Reinstatement into the Programs


(a) (1) Except as provided in paragraphs (a)(2) and (a)(3) of this section
§ 1001.3002 Basis for reinstatement.

(a)(1) The OIG will authorize reinstatement if it determines that—
   (i) The period of exclusion has expired;
   (ii) There are reasonable assurances that the types of actions that formed the basis for the original exclusion have not recurred and will not recur; and
   (iii) There is no additional basis under sections 1128(a) or (b) or 1128A of the Act for continuation of the exclusion.

(b) In making the reinstatement determination, the OIG will consider—
   (1) Conduct of the individual or entity occurring prior to the date of the notice of exclusion, if not known to the OIG at the time of the exclusion;
   (2) Conduct of the individual or entity after the date of the notice of exclusion;
   (3) Whether all fines, and all debts due and owing (including overpayments) to any Federal, State or local government that relate to Medicare, Medicaid and all other Federal health care programs, have been paid or satisfactory arrangements have been made to fulfill obligations;
   (4) Whether CMS has determined that the individual or entity complies with, or has made satisfactory arrangements to fulfill, all of the applicable conditions of participation or supplier conditions for coverage under the statutes and regulations; and
   (5) [Reserved]

(c) If the OIG determines that the criteria in paragraphs (a)(1)(ii) and (iii) of this section have been met, an entity excluded in accordance with §1001.1001 will be reinstated upon a determination by the OIG that the individual whose conviction, exclusion or civil money penalty was the basis for the entity’s exclusion—
   (1) Has properly reduced his or her ownership or control interest in the entity below 5 percent;
   (2) Is no longer an officer, director, agent or managing employee of the entity; or
   (3) Has been reinstated in accordance with paragraph (a) of this section or §1001.3005.
§ 1001.3003

(d) Reinstatement will not be effective until the OIG grants the request and provides notice under §1001.3003(a) of this part. Reinstatement will be effective as provided in the notice.

(e) A determination with respect to reinstatement is not appealable or reviewable except as provided in §1001.3004.

(f) An ALJ may not require reinstatement of an individual or entity in accordance with this chapter.


§ 1001.3004 Denial of request for reinstatement.

(a) If a request for reinstatement is denied, OIG will give written notice to the requesting individual or entity. Within 30 days of the date on the notice, the excluded individual or entity may submit:

(1) Documentary evidence and written argument against the continued exclusion.

(2) A written request to present written evidence and oral argument to an OIG official, or

(3) Both documentary evidence and a written request.

(b) After evaluating any additional evidence submitted by the excluded individual or entity (or at the end of the 30-day period, if none is submitted), the OIG will send written notice either confirming the denial, and indicating that a subsequent request for reinstatement will not be considered until at least one year after the date of denial, or approving the request consistent with the procedures set forth in §1001.3003(a).

(c) The decision to deny reinstatement will not be subject to administrative or judicial review.

PART 1002—PROGRAM INTEGRITY—STATE-INITIATED EXCLUSIONS FROM MEDICAID

Subpart A—General Provisions

§ 1002.1 Scope and purpose.

1002.2 General authority.

1002.3 Disclosure by providers and State Medicaid agencies.

1002.100 State plan requirement.

Subpart B—Mandatory Exclusion

1002.203 Mandatory exclusion.

Subpart C—Permissive Exclusions

1002.210 Permissive exclusions; general authority.

1002.211 Effect of exclusion.

1002.212 State agency notifications.

1002.213 Appeals of exclusions.

1002.214 Basis for reinstatement after State agency-initiated exclusion.

1002.215 Action on request for reinstatement.

Subpart D—Notification to OIG of State or Local Convictions of Crimes Against Medicaid

1002.230 Notification of State or local convictions of crimes against Medicaid.

Authority: 42 U.S.C. 1302, 1320a–3, 1320a–5, 1320a–7, 1396(a)(4)(A), 1396(p)(1), 1396a(30), 1396a(39), 1396b(a)(6), 1396b(b)(3), 1396b(1)(2) and 1396b(q).

Source: 57 FR 3343, Jan. 29, 1992, as amended at 64 FR 39428, July 22, 1999

§ 1002.3 Disclosure by providers and State Medicaid agencies.

(a) Information that must be disclosed.

Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person described in § 1001.1001(a)(1) of this chapter.

(b) Notification to Inspector General.

(1) The Medicaid agency must notify the Inspector General of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(2) The agency must promptly notify the Inspector General of any action it takes on the provider's application for participation in the program.

(3) The agency must also promptly notify the Inspector General of any action it takes to limit the ability of an individual or entity to participate in its program, regardless of what such an action is called. This includes, but is not limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the program to avoid a formal sanction.

(c) Denial or termination of provider participation.

(1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services program.
(2) The Medicaid agency may refuse to enter into, or terminate, a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

[57 FR 3343, Jan. 29, 1992, as amended at 63 FR 46691, Sept. 2, 1998]

§ 1002.100 State plan requirement.

The plan must provide that the requirements of this subpart are met. However, the provisions of these regulations are minimum requirements. The agency may impose broader sanctions if it has the authority to do so under State law.

Subpart B—Mandatory Exclusion

§ 1002.203 Mandatory exclusion.

(a) The State agency, in order to receive Federal financial participation (FFP), must provide that it will exclude from participation any HMO, or entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, if such organization or entity—

(1) Could be excluded under §1001.1001 or §1001.1051 of this chapter, or

(2) Has, directly or indirectly, a substantial contractual relationship with an individual or entity that could be excluded under §1001.1001 or §1001.1051 of this chapter.

(b) As used in this section, the term—

Exclude includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.

Substantial contractual relationship is one in which the sanctioned individual described in §1001.1001 of this chapter has direct or indirect business transactions with the organization or entity that, in any fiscal year, amount to more than $25,000 or 5 percent of the organization’s or entity’s total operating expenses, whichever is less. Business transactions include, but are not limited to, contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, space or salaried employment.

[57 FR 3343, Jan. 29, 1992, as amended at 63 FR 46691, Sept. 2, 1998]

§ 1002.210 Permissive exclusions; general authority.

The State agency must have administrative procedures in place that enable it to exclude an individual or entity for any reason for which the Secretary could exclude such individual or entity under parts 1001 or 1003 of this chapter. The period of such exclusion is at the discretion of the State agency.

§ 1002.211 Effect of exclusion.

(a) Denial of payment. Except as provided for in §1001.1901(c)(3), (c)(4) and (c)(5)(i) of this chapter, no payment may be made by the State agency for any item or service furnished on or after the effective date specified in the notice by an excluded individual or entity, or at the medical direction or on the prescription of a physician who is excluded when a person furnishing such item or service knew, or had reason to know, of the exclusion.

(b) Denial of FFP. FFP is not available where the State agency is required to deny payment under paragraph (a) of this section. FFP will be reinstated at such time as the excluded individual or entity is reinstated in the Medicaid program.

[57 FR 3343, Jan. 29, 1992, as amended at 63 FR 46691, Sept. 2, 1998]

§ 1002.212 State agency notifications.

When the State agency initiates an exclusion under §1002.210, it must provide to the individual or entity subject to the exclusion notification consistent with that required in subpart E of part 1001 of this chapter, and must notify other State agencies, the State medical licensing board (where applicable), the public, beneficiaries, and others as provided in §§1001.2005 and 1001.2006 of this chapter.

§ 1002.213 Appeals of exclusions.

Before imposing an exclusion under §1002.210, the State agency must give the individual or entity the opportunity to submit documents and written argument against the exclusion. The individual or entity must also be given any additional appeals rights that would otherwise be available.
under procedures established by the State.

§ 1002.214 Basis for reinstatement after State agency-initiated exclusion.

(a) The provisions of this section and §1002.215 apply to the reinstatement in the Medicaid program of all individuals or entities excluded in accordance with §1002.210, if a State affords reinstatement opportunity to those excluded parties.

(b) An individual or entity who has been excluded from Medicaid may be reinstated only by the Medicaid agency that imposed the exclusion.

(c) An individual or entity may submit to the State agency a request for reinstatement at any time after the date specified in the notice of exclusion.

§ 1002.215 Action on request for reinstatement.

(a) The State agency may grant reinstatement only if it is reasonably certain that the types of actions that formed the basis for the original exclusion have not recurred and will not recur. In making this determination, the agency will consider, in addition to any factors set forth in State law—

(1) The conduct of the individual or entity occurring prior to the date of the notice of exclusion, if not known to the agency at the time of the exclusion;

(2) The conduct of the individual or entity after the date of the notice of exclusion; and

(3) Whether all fines, and all debts due and owing (including overpayments) to any Federal, State or local government that relate to Medicare or any of the State health care programs, have been paid, or satisfactory arrangements have been made, that fulfill these obligations.

(b) Notice of action on request for reinstatement. (1) If the State agency approves the request for reinstatement, it must give written notice to the excluded party, and to all others who were informed of the exclusion in accordance with §1002.212, specifying the date on which Medicaid program participation may resume.

(2) If the State agency does not approve the request for reinstatement, it will notify the excluded party of its decision. Any appeal of a denial of reinstatement will be in accordance with State procedures and need not be subject to administrative or judicial review, unless required by State law.

Subpart D—Notification to OIG of State or Local Convictions of Crimes Against Medicaid

§ 1002.230 Notification of State or local convictions of crimes against Medicaid.

(a) The State agency must notify the OIG whenever a State or local court has convicted an individual who is receiving reimbursement under Medicaid of a criminal offense related to participation in the delivery of health care items or services under the Medicaid program, except where the State Medicaid Fraud Control Unit (MFCU) has so notified the OIG.

(b) If the State agency was involved in the investigation or prosecution of the case, it must send notice within 15 days after the conviction.

(c) If the State agency was not so involved, it must give notice within 15 days after it learns of the conviction.

PART 1003—CIVIL MONEY PENALTIES, ASSESSMENTS AND EXCLUSIONS

Sec. 1003.100 Basis and purpose.
1003.101 Definitions.
1003.102 Basis for civil money penalties and assessments.
1003.103 Amount of penalty.
1003.104 Amount of assessment.
1003.105 Exclusion from participation in Medicare, Medicaid and all Federal health care programs.
1003.106 Determinations regarding the amount of the penalty and assessment.
1003.107 Determinations regarding exclusion.
1003.108 Penalty, assessment, and exclusion not exclusive.
1003.109 Notice of proposed determination.
1003.110 Failure to request a hearing.
1003.114 Collateral estoppel.
1003.126 Settlement.
1003.127 Judicial review.
1003.128 Collection of penalty and assessment.
§ 1003.100 Basis and purpose.

(a) Basis. This part implements sections 1128(c), 1128A, 1140, 1860D–31(i)(3), 1877(g), 1882(d) and 1903(m)(5) of the Social Security Act; sections 421(c) and 427(b)(2) of Pub. L. 99–660; and section 201(i) of Pub. L. 107–188 (42 U.S.C. 1320–7(c), 1320a–7a, 1320b–10 and 262).

(b) Purpose. This part—

(1) Provides for the imposition of civil money penalties and, as applicable, assessments against persons who—

(i) Have knowingly submitted certain prohibited claims under Federal health care programs;

(ii) Seek payment in violation of the terms of an agreement or a limitation on charges or payments under the Medicare program, or a requirement not to charge in excess of the amount permitted under the Medicaid program;

(iii) Give false or misleading information that might affect the decision to discharge a Medicare patient from the hospital;

(iv)(A) Fail to report information concerning medical malpractice payments or who improperly disclose, use or permit access to information reported under part B of title IV of Pub. L. 99–660, and regulations specified in 45 CFR part 60, or

(B) Are health plans and fail to report information concerning sanctions or other adverse actions imposed on providers as required to be reported to the Healthcare Integrity and Protection Data Bank (HIPDB) in accordance with section 1128E of the Act;

(v) Misuse certain Departmental and Medicare and Medicaid program words, letters symbols or emblems;

(vi) Violate a requirement of section 1867 of the Act or § 489.24 of this title;

(vii) Substantially fail to provide an enrollee with required medically necessary items and services; engage in certain marketing, enrollment, reporting, claims payment, employment or contracting abuses; or do not meet the requirements for physician incentive plans for Medicare specified in § 417.479(d) through (f) of this title;

(viii) Present or cause to be presented a bill or claim for designated health services (as defined in § 411.351 of this title) that they know, or should know, were furnished in accordance with a referral prohibited under § 411.353 of this title;

(ix) Have collected amounts that they know or should know were billed in violation of § 411.353 of this title and have not refunded the amounts collected on a timely basis;

(x) Are physicians or entities that enter into an arrangement or scheme that they know or should know has as a principal purpose the assuring of referrals by the physician to a particular entity which, if made directly, would violate the provisions of § 411.353 of this title;

(xi) Are excluded, and who retain an ownership or control interest of five percent or more in an entity participating in Medicare or a State health care program, or who are officers or managing employees of such an entity (as defined in section 1126(b) of the Act);

(xii) Offer inducements that they know or should know are likely to influence Medicare or State health care program beneficiaries to order or receive particular items or services;

(xiii) Are physicians who knowingly misrepresent that a Medicare beneficiary requires home health services;

(xiv) Have submitted, or caused to be submitted, certain prohibited claims, including claims for services rendered by excluded individuals employed by or otherwise under contract with such person, under one or more Federal health care programs;

(xv) Violate the Federal health care programs' anti-kickback statute as set forth in section 1128B of the Act;

(xvi) Violate the provisions of part 73 of this title, implementing section 351A(b) and (c) of the Public Health
Office of Inspector General—Health Care, HHS § 1003.101

Service Act, with respect to the possession and use within the United States, receipt from outside the United States, and transfer within the United States, of select agents and toxins in use, or transfer of listed biological agents and toxins; or

(xvii) Violate the provisions of part 403, subpart H of this title, implementing the Medicare prescription drug discount card and transitional assistance program, by misleading or defrauding program beneficiaries, by overcharging a discount program enrollee, or by misusing transitional assistance funds.

(2) Provides for the exclusion of persons from the Medicare or State health care programs against whom a civil money penalty or assessment has been imposed, and the basis for reinstatement of persons who have been excluded; and

(3) Sets forth the appeal rights of persons subject to a penalty, assessment and exclusion.


§ 1003.101 Definitions.

For purposes of this part:

Act means the Social Security Act.

Adverse effect means medical care has not been provided and the failure to provide such necessary medical care has presented an imminent danger to the health, safety, or well-being of the patient or has placed the patient unnecessarily in a high-risk situation.

ALJ means an Administrative Law Judge.

Assessment means the amount described in § 1003.104, and includes the plural of that term.

Claim means an application for payment for an item or service to a Federal health care program (as defined in section 1128B(f) of the Act).

CMS stands for Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration (HCFA).

Contracting organization means a public or private entity, including of a health maintenance organization (HMO), competitive medical plan, or health insuring organization (HIO) which meets the requirements of section 1876(b) of the Act or is subject to the requirements in section 1903(m)(2)(A) of the Act and which has contracted with the Department or a State to furnish services to Medicare beneficiaries or Medicaid beneficiaries.

Department means the Department of Health and Human Services.

Enrollee means an individual who is eligible for Medicare or Medicaid and who enters into an agreement to receive services from a contracting organization that contracts with the Department under title XVIII or title XIX of the Act.

Exclusion means the temporary or permanent barring of a person from participation in a Federal health care program (as defined in section 1128B(f) of the Act).

Inspector General means the Inspector General of the Department or his or her designees.

Item or service includes—

(a) Any item, device, medical supply or service provided to a patient (i) which is listed in an itemized claim for program payment or a request for payment, or (ii) for which payment is included in other Federal or State health care reimbursement methods, such as a prospective payment system; and

(b) In the case of a claim based on costs, any entry or omission in a cost report, books of account or other documents supporting the claim.

Maternal and Child Health Services Block Grant program means the program authorized under Title V of the Act.

Medicaid means the program of grants to the States for medical assistance authorized under title XIX of the Act.

Medical malpractice claim or action means a written complaint or claim demanding payment based on a physician’s, dentist’s or other health care practitioner’s provision of, or failure to provide health care services, and includes the filing of a cause of action based on the law of tort brought in any State or Federal court or other adjudicative body.

Medicare means the program of health insurance for the aged and disabled authorized under Title XVIII of the Act.
§ 1003.101

Participating hospital means (1) a hospital or (2) a rural primary care hospital as defined in section 1861(mm)(1) of the Act that has entered into a Medicare provider agreement under section 1866 of the Act.

Penalty means the amount described in §1003.103 and includes the plural of that term.

Person means an individual, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.

Physician incentive plan means any compensation arrangement between a contracting organization and a physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to enrollees in the organization.

Preventive care, for purposes of the definition of the term Remuneration as set forth in this section and the preventive care exception to section 231(b) of HIPAA, means any service that—

(1) Is a prenatal service or a postnatal well-baby visit or is a specific clinical service described in the current U.S. Preventive Services Task Force's Guide to Clinical Preventive Services, and

(2) Is reimbursable in whole or in part by Medicare or an applicable State health care program.

Remuneration, as set forth in §1003.102(b)(13) of this part, is consistent with the definition contained in section 1128A(i)(6) of the Act, and includes the waiver of coinsurance and deductible amounts (or any part thereof) and transfers of items or services for free or for other than fair market value. The term “remuneration” does not include—

(1) The waiver of coinsurance and deductible amounts by a person, if the waiver is not offered as part of any advertisement or solicitation; the person does not routinely waive coinsurance or deductible amounts; and the person waives coinsurance and deductible amounts after determining in good faith that the individual is in financial need or failure by the person to collect coinsurance or deductible amounts after making reasonable collection efforts;

(2) Any permissible practice as specified in section 1128B(b)(3) of the Act or in regulations issued by the Secretary;

(3) Differentials in coinsurance and deductible amounts as part of a benefit plan design (as long as the differentials have been disclosed in writing to all beneficiaries, third party payers and providers), to whom claims are presented; or

(4) Incentives given to individuals to promote the delivery of preventive care services where the delivery of such services is not tied (directly or indirectly) to the provision of other services reimbursed in whole or in part by Medicare or an applicable State health care program. Such incentives may include the provision of preventive care, but may not include—

(i) Cash or instruments convertible to cash; or

(ii) An incentive the value of which is disproportionately large in relationship to the value of the preventive care service (i.e., either the value of the service itself or the future health care costs reasonably expected to be avoided as a result of the preventive care).

Request for payment means an application submitted by a person to any person for payment for an item or service.

Respondent means the person upon whom the Department has imposed, or proposes to impose, a penalty, assessment or exclusion.

Responsible physician means a physician who is responsible for the examination, treatment, or transfer of an individual who comes to a participating hospital’s emergency department seeking assistance and includes a physician on call for the care of such individual.

Secretary means the Secretary of the Department or his or her designee.

Select agents and toxins means agents and toxins that are listed by the HHS Secretary as having the potential to pose a severe threat to public health and safety, in accordance with section 351A(a)(1) of the Public Health Service Act.

Should know or should have known means that a person, with respect to information—

(1) Acts in deliberate ignorance of the truth or falsity of the information; or

926
(2) Acts in reckless disregard of the truth or falsity of the information. For purposes of this definition, no proof of specific intent to defraud is required.

Social Services Block Grant program means the program authorized under title XX of the Social Security Act.

State includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands.

State health care program means a State plan approved under title XIX of the Act, any program receiving funds under title V of the Act or from an allotment to a State under such title, or any program receiving funds under title XX of the Act or from an allotment to a State under such title.

Timely basis means, in accordance with §1003.102(b)(9) of this part, the 60-day period from the time the prohibited amounts are collected by the individual or the entity.

Transitional assistance means the subsidy funds that Medicare beneficiaries enrolled in the prescription drug discount card and transitional assistance program may apply toward the cost of covered discount card drugs in the manner described in §403.808(d) of this title.

§1003.102 Basis for civil money penalties and assessments.

(a) The OIG may impose a penalty and assessment against any person whom it determines in accordance with this part has knowingly presented, or caused to be presented, a claim which is for—

(1) An item or service that the person knew, or should have known, was not provided as claimed, including a claim that is part of a pattern or practice of claims based on codes that the person knows or should know will result in greater payment to the person than the code applicable to the item or service actually provided;

(2) An item or service for which the person knew, or should have known, that the claim was false or fraudulent, including a claim for any item or service furnished by an excluded individual employed by or otherwise under contract with that person;

(3) An item or service furnished during a period in which the person was excluded from participation in the Federal health care program to which the claim was made;

(4) A physician’s services (or an item or service) for which the person knew, or should have known, that the individual who furnished (or supervised the furnishing of) the service—

(i) Was not licensed as a physician;

(ii) Was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing); or

(iii) Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty board when he or she was not so certified;

(5) A payment that such person knows, or should know, may not be made under §411.353 of this title; or

(6) An item or service that a person knows or should know is medically unnecessary, and which is part of a pattern of such claims.

(b) The OIG may impose a penalty, and where authorized, an assessment against any person (including an insurance company in the case of paragraphs (b)(5) and (b)(6) of this section) whom it determines in accordance with this part—

(1) Has knowingly presented or caused to be presented a request for payment in violation of the terms of—

(i) An agreement to accept payments on the basis of an assignment under section 1842(b)(3)(B)(ii) of the Act;

(ii) An agreement with a State agency or other requirement of a State Medicaid plan not to charge a person for an item or service in excess of the amount permitted to be charged;

(iii) An agreement to be a participating physician or supplier under section 1842(h)(1); or

(iv) An agreement in accordance with section 1866(a)(1)(G) of the Act not to
charge any person for inpatient hospital services for which payment had been denied or reduced under section 1886(f)(2) of the Act.

(2)-(3) [Reserved]

(4) Has knowingly given or caused to be given to any person, in the case of inpatient hospital services subject to the provisions of section 1886 of the Act, information that he or she knew, or should have known, was false or misleading and that could reasonably have been expected to influence the decision when to discharge such person or another person from the hospital.

(5) Fails to report information concerning—

(i) A payment made under an insurance policy, self-insurance or otherwise, for the benefit of a physician, dentist or other health care practitioner in settlement of, or in satisfaction in whole or in part of, a medical malpractice claim or action or a judgment against such a physician, dentist or other practitioner in accordance with section 421 of Public Law 99–660 (42 U.S.C. 11131) and as required by regulations at 45 CFR part 60; or

(ii) An adverse action required to be reported to the Healthcare Integrity and Protection Data Bank as established by section 221 of Public Law 104–191 and set forth in section 1128E of the Act.

(6) Improperly discloses, uses or permits access to information reported in accordance with part B of title IV of Pub. L. 99–660, in violation of section 427 of Pub. L. 99–660 (42 U.S.C. 11137) or regulations at 45 CFR part 60. (The disclosure of information reported in accordance with part B of title IV in response to a subpoena or a discovery request is considered to be an improper disclosure in violation of section 427 of Pub. L. 99–660. However, disclosure or release by an entity of original documents or underlying records from which the reported information is obtained or derived is not considered to be an improper disclosure in violation of section 427 of Pub. L. 99–660.)

(7) Has made use of the words, letters, symbols or emblems as defined in paragraph (b)(7)(i) of this section in such a manner that such person knew or should have known would convey, or in a manner which reasonably could be interpreted or construed as conveying, the false impression that an advertisement, solicitation or other item was authorized, approved or endorsed by the Department or CMS, or that such person or organization has some connection with or authorization from the Department or CMS. Civil money penalties—

(i) May be imposed, regardless of the use of a disclaimer of affiliation with the United States Government, the Department or its programs, for misuse of:

(A) The words “Department of Health and Human Services,” “Health and Human Services,” “Centers for Medicare & Medicaid Services,” “Medicare,” or “Medicaid,” or any other combination or variation of such words;

(B) The letters “DHHS,” “HHS,” or “CMS,” or any other combination or variation of such letters; or

(C) A symbol or emblem of the Department or CMS (including the design of, or a reasonable facsimile of the design of, the Medicare card, the check used for payment of benefits under title II, or envelopes or other stationery used by the Department or CMS) or any other combination or variation of such symbols or emblems; and

(ii) Will not be imposed against any agency or instrumentality of a State, or political subdivision of the State, that makes use of any symbol or emblem, or any words or letters which specifically identifies that agency or instrumentality of the State or political subdivision.

(8) Is a contracting organization that CMS determines has committed an act or failed to comply with the requirements set forth in §417.500(a) or §434.67(a) of this title or failed to comply with the requirement set forth in §434.80(c) of this title.

(9) Has not refunded on a timely basis, as defined in §1003.101 of this part, amounts collected as the result of billing an individual, third party payer or other entity for a designated health service that was provided in accordance with a prohibited referral as described in §411.353 of this title.

(10) Is a physician or entity that enters into—
(ii) Any other arrangement or scheme that the physician or entity knows, or should know, has a principal purpose of circumventing the prohibitions of §411.353 of this title, or

(11) Has violated section 1128B of the Act by unlawfully offering, paying, soliciting or receiving remuneration in return for the referral of business paid for by Medicare, Medicaid or other Federal health care programs.

(12) Who is not an organization, agency or other entity, and who is excluded from participating in Medicare or a State health care program in accordance with sections 1128 or 1128A of the Act, and who—

(i) Knows or should know of the action constituting the basis for the exclusion, and retains a direct or indirect ownership or control interest of five percent or more in an entity that participates in Medicare or a State health care program; or

(ii) Is an officer or managing employee (as defined in section 1126(b) of the Act) of such entity.

(13) Offers or transfers remuneration (as defined in §1003.101 of this part) to any individual eligible for benefits under Medicare or a State health care program, that such person knows or should know is likely to influence such individual to order or to receive from a particular provider, practitioner or supplier any item or service for which payment may be made, in whole or in part, under Medicare or a State health care program.

(14) Is a physician and who executes a document falsely by certifying that a Medicare beneficiary requires home health services when the physician knows that the beneficiary does not meet the eligibility requirements set forth in sections 1814(a)(2)(C) or 1835(a)(2)(A) of the Act.

(15) Has knowingly and willfully presented, or caused to be presented, a bill or request for payment for items and services furnished to a hospital patient for which payment may be made under the Medicare or another Federal health care program, if that bill or request is inconsistent with an arrangement under section 1866(a)(1)(H) of the Act, or violates the requirements for such an arrangement.

(16) Is involved in the possession or use in the United States, receipt from outside the United States, or transfer within the United States, of select agents and toxins in violation of part 73 of this chapter as determined by the HHS Secretary, in accordance with sections 351A(b) and (c) of the Public Health Service Act.

(17) Is an endorsed sponsor under the Medicare prescription drug discount card program who knowingly misrepresented or falsified information in outreach material or comparable material provided to a program enrollee or other person.

(18) Is an endorsed sponsor under the Medicare prescription drug discount card program who knowingly charged a program enrollee in violation of the terms of the endorsement contract.

(19) Is an endorsed sponsor under the Medicare prescription drug discount card program who knowingly used transitional assistance funds of any program enrollee in any manner that is inconsistent with the purpose of the transitional assistance program.

(c)(1) The Office of the Inspector General (OIG) may impose a penalty for violations of section 1867 of the Act or §489.24 of this title against—

(i) Any participating hospital with an emergency department that—

(A) Knowingly violates the statute on or after August 1, 1986;

(B) Negligently violates the statute on or after May 1, 1991; and

(ii) Any responsible physician who—

(A) Knowingly violates the statute on or after August 1, 1986;

(B) Negligently violates the statute on or after May 1, 1991;

(C) Signs a certification under section 1867(c)(1)(A) of the Act if the physician knew or should have known that the benefits of transfer to another facility did not outweigh the risks of such a transfer; or

(D) Misrepresents an individual’s condition or other information, including a hospital’s obligations under this section.
§ 1003.103 Amount of penalty.

(a) Except as provided in paragraphs (b) through (k) of this section, the OIG may impose a penalty of not more than—

(1) $2,000 1 for each wrongful act occurring before January 1, 1997 that is subject to a determination under §1003.102; and

(2) $10,000 2 for each wrongful act occurring on or after January 1, 1997 that is subject to a determination under §1003.102.

(b) The OIG may impose a penalty of not more than $15,000 3 for each person with respect to whom a determination was made that false or misleading information was given under §1003.102(b)(4), or for each item and service that is subject to a determination under §1003.102(a)(5) or §1003.102(b)(9) of this part. The OIG may impose a penalty of not more than $100,000 4 for each arrangement or scheme that is subject to a determination under §1003.102(b)(10) of this part.

1This penalty amount is updated annually, as adjusted in accordance with the Federal Civil Monetary Penalty Inflation Adjustment Act of 1990 (Pub. L. 101–140), as amended by the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (section 701 of Pub. L. 114–74). Annually adjusted amounts are published at 45 CFR part 102.

2This penalty amount is adjusted annually for inflation, and is published at 45 CFR part 102.

3This penalty amount is adjusted annually for inflation, and is published at 45 CFR part 102.

4This penalty amount is adjusted annually for inflation, and is published at 45 CFR part 102.
(c) The OIG may impose a penalty of not more than $10,000 \(^5\) for each payment for which there was a failure to report required information in accordance with §1003.102(b)(5), or for each improper disclosure, use or access to information that is subject to a determination under §1003.102(b)(6).

(d)(1) The OIG may impose a penalty of not more than $5,000 \(^6\) for each violation resulting from the misuse of Departmental, CMS, Medicare or Medicaid program words, letters, symbols or emblems as described in §1003.102(b)(7) relating to printed media, and a penalty of not more than $25,000 \(^7\) in the case of such misuse related to a broadcast or telecast, that is related to a determination under §1003.102(b)(7).

(2) For purposes of this paragraph, a violation is defined as—

(i) In the case of a direct mailing solicitation or advertisement, each separate piece of mail which contains one or more words, letters, symbols or emblems related to a determination under §1003.102(b)(7);

(ii) In the case of a printed solicitation or advertisement, each reproduction, reprinting or distribution of such item related to a determination under §1003.102(b)(7); and

(iii) In the case of a broadcast or telecast, each airing of a single commercial or solicitation related to a determination under §1003.102(b)(7).

(e) For violations of section 1867 of the Act or §489.24 of this title, the OIG may impose—

(1) Against each participating hospital with an emergency department, a penalty of not more than $50,000 \(^8\) for each negligent violation occurring on or after May 1, 1991, except that if the participating hospital has fewer than 100 State-licensed, Medicare-certified beds on the date the penalty is imposed, the penalty will not exceed $25,000; and

(2) Against each responsible physician, a penalty of not more than $50,000 \(^9\) for each negligent violation occurring on or after May 1, 1991.

(1) The OIG may, in addition to or in lieu of other remedies available under law, impose a penalty of up to $25,000 \(^10\) for each determination by CMS that a contracting organization has—

(1) Failed substantially to provide an enrollee with required medically necessary items and services and the failure adversely affects (or has the likelihood of adversely affecting) the enrollee;

(ii) Imposed premiums on enrollees in excess of amounts permitted under section 1876 or title XIX of the Act;

(iii) Acted to expel or to refuse to re-enroll a Medicare beneficiary in violation of the provisions of section 1876 of the Act and for reasons other than the beneficiary’s health status or requirements for health care services;

(iv) Misrepresented or falsified information furnished to an individual or any other entity under section 1876 or section 1903(m) of the Act;

(v) Failed to comply with the requirements of section 1876(g)(6)(A) of the Act, regarding prompt payment of claims; or

(vi) Failed to comply with the requirements of §417.479 (d) through (i) of this title for Medicare, and §417.479 (d) through (g) and (i) of this title for Medicaid, regarding certain prohibited incentive payments to physicians.

(2) The OIG may, in addition to or in lieu of other remedies available under law, impose a penalty of up to $25,000 \(^11\) for each determination by CMS that a contracting organization has—

(1) Failed substantially to provide an enrollee with required medically necessary items and services and the failure adversely affects (or has the likelihood of adversely affecting) the enrollee;

(ii) Imposed premiums on enrollees in excess of amounts permitted under section 1876 or title XIX of the Act;

(iii) Acted to expel or to refuse to re-enroll a Medicare beneficiary in violation of the provisions of section 1876 of the Act and for reasons other than the beneficiary’s health status or requirements for health care services;

(iv) Misrepresented or falsified information furnished to an individual or any other entity under section 1876 or section 1903(m) of the Act;

(v) Failed to comply with the requirements of section 1876(g)(6)(A) of the Act, regarding prompt payment of claims; or

(vi) Failed to comply with the requirements of §417.479 (d) through (i) of this title for Medicare, and §417.479 (d) through (g) and (i) of this title for Medicaid, regarding certain prohibited incentive payments to physicians.

This penalty amount is adjusted annually for inflation, and is published at 45 CFR part 102.

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contracting organization with a contract under section 1876 of the Act—

(i) Employs or contracts with individuals or entities excluded, under section 1128 or section 1128A of the Act, from participation in Medicare for the provision of health care, utilization review, medical social work, or administrative services; or

(ii) Employs or contracts with any entity for the provision of services (directly or indirectly) through an excluded individual or entity.

(3) The OIG may, in addition to or in lieu of other remedies available under law, impose a penalty of up to $100,000 for each determination that a contracting organization has—

(i) Misrepresented or falsified information to the Secretary under section 1876 of the Act or to the State under section 1903(m) of the Act; or

(ii) Acted to expel or to refuse to re-enroll a Medicaid beneficiary because of the individual’s health status or requirements for health care services, or engaged in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by section 1876 or section 1903(m) of the Act) with the contracting organization by Medicare beneficiaries and Medicaid beneficiaries whose medical condition or history indicates a need for substantial future medical services.

(4) If enrollees are charged more than the allowable premium, the OIG will impose an additional penalty equal to double the amount of excess premium charged by the contracting organization. The excess premium amount will be deducted from the penalty and returned to the enrollee.

(5) The OIG will impose an additional $15,000 penalty for each individual not enrolled when CMS determines that a contracting organization has committed a violation described in paragraph (f)(3)(ii) of this section.

(6) For purposes of paragraph (f) of this section, a violation is each incident where a person has committed an act listed in §117.500(a) or §434.67(a) of this title, or failed to comply with a requirement set forth in §434.80(c) of this title.

(g) The OIG may impose a penalty of not more than $25,000 against a health plan for failing to report information on an adverse action required to be reported to the Healthcare Integrity and Protection Data Bank in accordance with section 1128E of the Act and §§1003.102(b)(1)(ii).

(h) For each violation of §§1003.102(b)(11), the OIG may impose—

(1) A penalty of not more than $50,000, and

(2) An assessment of up to three times the total amount of remuneration offered, paid, solicited or received, as specified in §1003.104(b).

(1) For violations of §1003.102(b)(14) of this part, the OIG may impose a penalty of not more than the greater of—

(1) $5,000, or

(2) Three times the amount of Medicare payments for home health services that are made with regard to the false certification of eligibility by a physician in accordance with sections 1814(a)(2)(C) or 1833(a)(2)(A) of the Act.

(j) The OIG may impose a penalty of not more than $10,000 per day for each day that the prohibited relationship described in §1001.102(b)(12) of this part occurs.

(k) For violations of section 1862(a)(14) of the Act and §§1003.102(b)(15), the OIG may impose a penalty of not more than $2,000 for each bill or request for payment for items and services furnished to a hospital patient.

(l) For violations of section 351A(b) or (c) of the Public Health Service Act
§ 1003.104 Amount of assessment.

(a) The OIG may impose an assessment, where authorized, in accordance with §1003.102, of not more than—

(1) Two times the amount for each item or service wrongfully claimed prior to January 1, 1997; and

(2) Three times the amount for each item or service wrongfully claimed on or after January 1, 1997.

(b) The assessment is in lieu of damages sustained by the Department or a State agency because of that claim.

§ 1003.105 Exclusion from participation in Medicare, Medicaid and all Federal health care programs.

(a)(1) Except as set forth in paragraph (b) of this section, the following persons may be subject, in lieu of or in addition to any penalty or assessment, to an exclusion from participation in Medicare for a period of time determined under §1003.107. There will be exclusions from Federal health care programs for the same period as the Medicare exclusion for any person who—

(i) Is subject to a penalty or assessment under §1003.102(a), (b)(1), (b)(4), (b)(12), (b)(13) or (b)(15); or

(ii) Commits a gross and flagrant, or repeated, violation of section 1867 of the Act or §489.24 of this title on or after May 1, 1991. For purposes of this section, a gross and flagrant violation is one that presents an imminent danger to the health, safety or well-being of the individual who seeks emergency examination and treatment or places that individual unnecessarily in a high-risk situation.

(b)(1)(i) With respect to any exclusion based on liability for a penalty or assessment under §1003.102 (a), (b)(1), or (b)(4), the OIG will consider an application from a State agency for a waiver if the person is the sole community physician or the sole source of essential specialized services in a community. With respect to any exclusion imposed under §1003.105(a)(1)(ii), the OIG will consider an application from a State agency for a waiver if the physician’s exclusion from the State health care program would deny beneficiaries access to medical care or would otherwise cause hardship to beneficiaries.

(ii) If a waiver is granted, it is applicable only to the State health care program for which the State requested the waiver.

(iii) If the OIG subsequently obtains information that the basis for a waiver no longer exists, or the State agency submits evidence that the basis for the waiver no longer exists, the waiver will cease and the person will be excluded from the State health care program for the remainder of the period that the person is excluded from Medicare.

(iv) The OIG notifies the State agency whether its request for a waiver has been granted or denied.

(v) The decision to deny a waiver is not subject to administrative or judicial review.

(b)(1)(ii) For purposes of this section, the definitions contained in §1001.2 of this chapter for “sole community physician” and “sole source of essential specialized services in a community” apply.

(c) When the Inspector General proposes to exclude a nursing facility from
§ 1003.106 Determinations regarding the amount of the penalty and assessment.

(a) Amount of penalty. (1) In determining the amount of any penalty or assessment in accordance with §1003.102(a), (b)(1), (b)(4), and (b)(9) through (b)(16) of this part, the Department will take into account—

(i) The nature of the claim, referral arrangement or other wrongdoing;
(ii) The degree of culpability of the person against whom a civil money penalty is proposed;
(iii) The history of prior offenses of the person against whom a civil money penalty is proposed;
(iv) The financial condition of the person against whom a civil money penalty is proposed;
(v) The completeness and timeliness of the refund with respect to §1003.102(b)(9);
(vi) The amount of financial interest involved with respect to §1003.102(b)(12);
(vii) The amount of remuneration offered or transferred with respect to §1003.102(b)(13); and
(viii) Such other matters as justice may require.

(2) In determining the amount of any penalty in accordance with §1003.102(b)(5) and (b)(6), the Department will take into account—

(i) The nature and circumstances of the failure to properly report information, or the improper disclosure of information, as required;
(ii) The degree of culpability of the person in failing to provide timely and complete data or in improperly disclosing, using or permitting access to information, as appropriate;
(iii) The materiality, or significance of omission, of the information to be reported, or the materiality of the improper disclosure of, or use of, or access to information, as appropriate;
(iv) Any prior history of the person with respect to violations of these provisions; and
(v) Such other matters as justice may require.

(3)(i) In determining the amount of any penalty in accordance with §1003.102(b)(7), the OIG will take into account—

(A) The nature and objective of the advertisement, solicitation or other communication, and the degree to which it has the capacity to deceive members of the public;
(B) The degree of culpability of the individual, organization or entity in the use of the prohibited words, letters, symbols or emblems;
(C) The frequency and scope of the violation, and whether a specific segment of the population was targeted;
(D) The prior history of the individual, organization or entity in its willingness or refusal to comply with informal requests to correct violations;
(E) The history of prior offenses of the individual, organization or entity in its misuse of Departmental and program words, letters, symbols and emblems;
(F) The financial condition of the individual, organization or entity involved with the violation; and
(G) Such other matters as justice may require.

(ii) The use of a disclaimer of affiliation with the United States Government, the Department or its programs will not be considered as a mitigating factor in determining the amount of penalty in accordance with §1003.102(b)(7).

(4) In determining the amount of any penalty in accordance with §1003.102(c), the OIG takes into account—

(i) The degree of culpability of the respondent;
(ii) The seriousness of the condition of the individual seeking emergency medical treatment;
(iii) Any other instances where the respondent failed to provide appropriate emergency medical screening, stabilization and treatment of individuals coming to a hospital’s emergency department or to effect an appropriate transfer;
(iv) The respondent’s financial condition;
(v) The nature and circumstances of the violation; and
(vi) Such other matters as justice may require.
(5) In determining the appropriate amount of any penalty in accordance with §1003.103(f), the OIG will consider as appropriate—
(i) The nature and scope of the required medically necessary item or service not provided and the circumstances under which it was not provided;
(ii) The degree of culpability of the contracting organization;
(iii) The seriousness of the adverse effect that resulted or could have resulted from the failure to provide required medically necessary care;
(iv) The harm which resulted or could have resulted from the provision of care by a person that the contracting organization is expressly prohibited, under section 1876(i)(6) or section 1903(p)(2) of the Act, from contracting with or employing;
(v) The harm which resulted or could have resulted from the contracting organization’s expulsion or refusal to reenroll a Medicare beneficiary or Medicaid recipient;
(vi) The nature of the misrepresentation or fallacious information furnished by the contracting organization to the Secretary, State, enrollee or other entity under section 1876 or section 1903(m) of the Act;
(vii) The extent to which the failure to provide medically necessary services could be attributed to a prohibited inducement to reduce or limit services under a physician incentive plan and the harm to the enrollee which resulted or could have resulted from such failure. It would be considered an aggravating factor if the contracting organization knowingly or routinely engaged in any prohibited practice which acted as an inducement to reduce or limit medically necessary services provided with respect to a specific enrollee in the organization;
(viii) The history of prior offenses by the contracting organization or principals of the contracting organization, including whether, at any time prior to determination of the current violation or violations, the contracting organization or any of its principals were convicted of a criminal charge or were held liable for civil or administrative sanctions in connection with a program covered by this part or any other public or private program of payment for medical services; and
(ix) Such other matters as justice may require.
(b) Determining the amount of the penalty or assessment. As guidelines for taking into account the factors listed in paragraph (a)(1) of this section, the following circumstances are to be considered—
(1) Nature and circumstances of the incident. It should be considered a mitigating circumstance if all the items or services or incidents subject to a determination under §1003.102 included in the action brought under this part were of the same type and occurred within a short period of time, there were few such items or services or incidents, and the total amount claimed or requested for such items or services was less than $1,000. It should be considered an aggravating circumstance if—
(i) Such items or services or incidents were of several types, occurred over a lengthy period of time;
(ii) There were many such items or services or incidents (or the nature and circumstances indicate a pattern of claims or requests for payment for such items or services or a pattern of incidents);
(iii) The amount claimed or requested for such items or services was substantial; or
(iv) The false or misleading information given resulted in harm to the patient, a premature discharge or a need for additional services or subsequent hospital admission.
(2) Degree of culpability. It should be considered a mitigating circumstance if corrective steps were taken promptly after the error was discovered. It should be considered an aggravating circumstance if—
(i) The respondent knew the item or service was not provided as claimed or if the respondent knew that the claim was false or fraudulent;
(ii) The respondent knew that the items or services were furnished during
§ 1003.106 42 CFR Ch. V (10–1–16 Edition)

a period that he or she had been excluded from participation and that no payment could be made as specified in §§1003.102(a)(3) and 1003.102(b)(12), or because payment would violate the terms of an assignment or an agreement with a State agency or other agreement or limitation on payment under §1003.102(b);

(iii) The respondent knew that the information could reasonably be expected to influence the decision of when to discharge a patient from a hospital; or

(iv) The respondent knew that the offer or transfer of remuneration described in §1003.102(b)(13) of this part would influence a beneficiary to order or receive from a particular provider, practitioner or supplier items or services reimbursable under Medicare or a State health care program.

(3) Prior offenses. It should be considered an aggravating circumstance if at any time prior to the incident or presentation of any claim or request for payment which included an item or service subject to a determination under §1003.102, the respondent was held liable for criminal, civil or administrative sanctions in connection with a program covered by this part or any other public or private program of reimbursement for medical services.

(4) Other wrongful conduct. It should be considered an aggravating circumstance if at any time prior to the incident or presentation of any claim or request for payment which included an item or service subject to a determination under §1003.102, the respondent was held liable for criminal, civil or administrative sanctions in connection with a program covered by this part or any other public or private program of reimbursement for medical services.

(5) Financial condition. In all cases, the resources available to the respondent will be considered when determining the amount of the penalty and assessment.

(6) Other matters as justice may require. Other circumstances of an aggravating or mitigating nature should be taken into account if, in the interests of justice, they require either a reduction of the penalty or assessment or an increase in order to assure the achievement of the purposes of this part.

(c) In determining the amount of the penalty and assessment to be imposed for every item or service or incident subject to a determination under §1003.102(a), (b)(1) and (b)(4)—

(1) If there are substantial or several mitigating circumstances, the aggregate amount of the penalty and assessment should be set at an amount sufficiently below the maximum permitted by §§1003.103(a) and 1003.104, to reflect that fact.

(2) If there are substantial or several aggravating circumstances, the aggregate amount of the penalty and assessment should be set at an amount sufficiently close or at the maximum permitted by §§1003.103(a) and 1003.104, to reflect that fact.

(3) Unless there are extraordinary mitigating circumstances, the aggregate amount of the penalty and assessment should never be less than double the approximate amount of damages and costs (as defined in paragraph (f) of this section) sustained by the United States, or any State, as a result of claims or incidents subject to a determination under §1003.102(a), (b)(1) and (b)(4).

(d) In considering the factors listed in paragraph (a)(4) of this section for violations subject to a determination under §1003.103(e), the following circumstances are to be considered, as appropriate, in determining the amount of any penalty—

(1) Degree of culpability. It would be a mitigating circumstance if the respondent hospital had appropriate policies and procedures in place, and had effectively trained all of its personnel in the requirements of section 1867 of the Act and §489.24 of this title, but an employee or responsible physician acted contrary to the respondent hospital’s policies and procedures.

(2) Seriousness of individual’s condition. It would be an aggravating circumstance if the respondent’s violation(s) occurred with regard to an individual who presented to the hospital a request for treatment of a medical condition that was clearly an emergency, as defined by §489.24(b) of this title.
(3) Prior offenses. It would be an aggravating circumstance if there is evidence that at any time prior to the current violation(s) the respondent was found to have violated any provision of section 1867 of the Act or §489.24 of this title.

(4) Financial condition. In all cases, the resources available to the respondent would be considered when determining the amount of the penalty. A respondent’s audited financial statements, tax returns or financial disclosure statements, as appropriate, will be reviewed by OIG in making a determination with respect to the respondent’s financial condition.

(5) Nature and circumstances of the incident. It would be considered a mitigating circumstance if an individual presented a request for treatment, but subsequently exhibited conduct that demonstrated a clear intent to leave the respondent hospital voluntarily. In reviewing such circumstances, the OIG would evaluate the respondent’s efforts to—

(i) Provide the services required by section 1867 of the Act and §489.24 of this title, despite the individual’s withdrawal of the request for examination or treatment; and

(ii) Document any attempts to inform the individual (or his or her representative) of the risks of leaving the respondent hospital without receiving an appropriate medical screening examination or treatment, and obtain written acknowledgment from the individual (or his or her representative) prior to the individual’s departure from the respondent hospital that he or she is leaving contrary to medical advice.

(6) Other matters as justice may require.

(i) It would be considered a mitigating circumstance if the respondent hospital—

(A) Developed and implemented a corrective action plan;

(B) Took immediate appropriate action against any hospital personnel or responsible physician who violated section 1867 of the Act or §489.24 of this title prior to any investigation of the respondent hospital by CMS; or

(C) Is a rural or publicly-owned facility that is faced with severe physician staffing and financial deficiencies.

(ii) It would be considered an aggravating circumstance if an individual was severely harmed or died as a result, directly or indirectly, of the respondent’s violation of section 1867 of the Act or §489.24 of this title.

(iii) Other circumstances of an aggravating or mitigating nature will be taken into account if, in the interests of justice, they require either a reduction of the penalty or an increase in order to assure the achievement of the purposes of this part.

(e) In considering the factors listed in paragraph (a)(5) of this section for violations subject to a determination under §1003.103(f), the following circumstances are to be considered, as appropriate, in determining the amount of any penalty—

(f)(1) The standards set forth in this section are binding, except to the extent that their application would result in imposition of an amount that would exceed limits imposed by the United States Constitution.

(2) The amount imposed will not be less than the approximate amount required to fully compensate the United States, or any State, for its damages and costs, tangible and intangible, including but not limited to the costs attributable to the investigation, prosecution and administrative review of the case.

(3) Nothing in this section will limit the authority of the Department to settle any issue or case as provided by §1003.126, or to compromise any penalty and assessment as provided by §1003.128.

§1003.107 Determinations regarding exclusion.

(a) In determining whether to exclude a person under this part and the duration of any exclusion, the Department considers the circumstances described in §1003.106(a).

(b) With respect to determinations to exclude a person under §1003.102(a), (b)(1), (b)(4), (b)(12) or (b)(13) of this
part, the Department considers those circumstances described in §1003.106(b). Where there are aggravating circumstances with respect to such determinations, the person should be excluded.

(c) The guidelines set forth in this section are not binding. Nothing in this section limits the authority of the Department to settle any issue or case as provided by §1003.126 of this part.


§ 1003.108 Penalty, assessment, and exclusion not exclusive.

Penalties, assessments, and exclusions imposed under this part are in addition to any other penalties prescribed by law.

[59 FR 32126, June 22, 1994]

§ 1003.109 Notice of proposed determination.

(a) If the Inspector General proposes a penalty and, when applicable, assessment, or proposes to exclude a respondent from participation in a Federal health care program, as applicable, in accordance with this part, he or she must deliver or send by certified mail, return receipt requested, to the respondent written notice of his or her intent to impose a penalty, assessment and exclusion, as applicable. The notice includes—

(1) Reference to the statutory basis for the penalty, assessment and exclusion;
(2) A description of the claims, requests for payment, or incidents with respect to which the penalty, assessment and exclusion are proposed (except in cases where the Inspector General is relying upon statistical sampling in accordance with §1003.133 in which case the notice shall describe those claims and requests for payment comprising the sample upon which the Inspector General is relying and will also briefly describe the statistical sampling technique utilized by the Inspector General);
(3) The reason why such claims, requests for payments or incidents subject the respondent to a penalty, assessment and exclusion;
(4) The amount of the proposed penalty, assessment and the period of proposed exclusion (where applicable);
(5) Any circumstances described in §1003.106 that were considered when determining the amount of the proposed penalty and assessment and the period of exclusion;
(6) Instructions for responding to the notice, including—
   (i) A specific statement of respondent’s right to a hearing, and
   (ii) A statement that failure to request a hearing within 60 days permits the imposition of the proposed penalty, assessment and exclusion without right of appeal; and
(7) In the case of a notice sent to a respondent who has an agreement under section 1866 of the Act, the notice also indicates that the imposition of an exclusion may result in the termination of the provider’s agreement in accordance with section 1866(b)(2)(C) of the Act.

(b) Any person upon whom the Inspector General has proposed the imposition of a penalty, assessment or exclusion may appeal such proposed penalty, assessment or exclusion to the DAB in accordance with §1005.2 of this chapter. The provisions of part 1005 of this chapter govern such appeals.

(c) If the respondent fails, within the time permitted, to exercise his or her right to a hearing under this section, any exclusion, penalty, or assessment becomes final.


§ 1003.110 Failure to request a hearing.

If the respondent does not request a hearing within the time prescribed by §1003.109(a), the Inspector General may impose the proposed penalty, assessment, and exclusion, or any less severe penalty, assessment, and suspension. The Inspector General shall notify the respondent by certified mail, return receipt requested, of any penalty, assessment, and exclusion that has been imposed and of the means by which the respondent may satisfy the judgment. The respondent has no right to appeal a penalty, assessment, and exclusion,
§ 1003.114 Collateral estoppel.

(a) Where a final determination pertaining to the respondent’s liability under §1003.102 has been rendered in any proceeding in which the respondent was a party and had an opportunity to be heard, the respondent shall be bound by such determination in any proceeding under this part.

(b) In a proceeding under this part—

(1) Is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements, and

(2) Involves the same transactions as in the criminal action, the person is estopped from denying the essential elements of the criminal offense.

[57 FR 3348, Jan. 29, 1992, as amended at 64 FR 39429, July 22, 1999]

§ 1003.126 Settlement.

The Inspector General has exclusive authority to settle any issues or case, without consent of the ALJ.

[65 FR 24418, Apr. 26, 2000]

§ 1003.127 Judicial review.

Section 1128A(e) of the Act authorizes judicial review of a penalty, assessment or exclusion that has become final. Judicial review may be sought by a respondent only with respect to a penalty, assessment or exclusion with respect to which the respondent filed an exception under §1005.21(c) of this chapter unless the failure or neglect to urge such exception will be excused by the court in accordance with section 1128A(e) of the Act because of extraordinary circumstances.

[57 FR 3348, Jan. 29, 1992]

§ 1003.128 Collection of penalty and assessment.

(a) Once a determination by the Secretary has become final, collection of any penalty and assessment will be the responsibility of CMS, except in the case of the Maternal and Child Health Services Block Grant program, where the collection will be the responsibility of the PHS, and in the case of the Social Services Block Grant program, where the collection will be the responsibility of the Office of Human Development Services.

(b) A penalty or assessment imposed under this part may be compromised by the Inspector General, and may be recovered in a civil action brought in the United States district court for the district where the claim was presented, or where the respondent resides.

(c) The amount of a penalty and assessment when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States, or by a State agency, to the respondent.

(d) Matters that were raised or that could have been raised in a hearing before an ALJ or in an appeal under section 1128A(e) of the Act may not be raised as a defense in a civil action by the United States to collect a penalty under this part.


§ 1003.129 Notice to other agencies.

Whenever a penalty, assessment or exclusion become final, the following organizations and entities will be notified about such action and the reasons for it—the appropriate State or local medical or professional association; the appropriate Quality Improvement Organization; as appropriate, the State agency responsible or the administration of each State health care program; the appropriate Medicare carrier or intermediary; the appropriate State or local licensing agency or organization (including the Medicare and Medicaid State survey agencies); and the long-term care ombudsman. In cases involving exclusions, notice will also be given to the public of the exclusion and its effective date.

[57 FR 3349, Jan. 29, 1992]

§ 1003.132 Limitations.

No action under this part will be entertained unless commenced, in accordance with §1003.109(a) of this part,
within 6 years from the date on which
the claim was presented, the request
for payment was made, or the incident
occurred.

[57 FR 3349, Jan. 29, 1992]

§ 1003.133 Statistical sampling.

(a) In meeting the burden of proof set
forth in §1005.15, the Inspector General
may introduce the results of a statisti-
cal sampling study as evidence of the
number and amount of claims and/or
requests for payment as described in
§1003.102 that were presented or caused
to be presented by respondent. Such a
statistical sampling study, if based
upon an appropriate sampling and com-
puted by valid statistical methods,
shall constitute prima facie evidence of
the number and amount of claims or
requests for payment as described in
§1003.102.

(b) Once the Inspector General has
made a prima facie case as described in
paragraph (a) of this section, the bur-
den of production shall shift to re-
spondent to produce evidence reason-
ably calculated to rebut the findings of
the statistical sampling study. The In-
spector General will then be given the
opportunity to rebut this evidence.

[51 FR 34777, Sept. 30, 1986, as amended at 57
FR 3349, Jan. 29, 1992]

§ 1003.134 Effect of exclusion.

The effect of an exclusion will be as
set forth in §1001.1901 of this chapter.

[57 FR 3349, Jan. 29, 1992]

§ 1003.135 Reinstatement.

A person who has been excluded in
accordance with this part may apply
for reinstatement at the end of the pe-
riod of exclusion. The OIG will consider
any request for reinstatement in ac-
cordance with the provisions of
§§1001.3001 through 1001.3004 of this
chapter.

[57 FR 3349, Jan. 29, 1992]
(QIOs) when there is failure to meet those obligations;
(3) Specifying the policies and procedures for making determinations on violations and imposing sanctions; and
(4) Defining the procedures for appeals by the affected party and the procedures for reinstatements.

(b) Definitions. As used in this part, unless the context indicates otherwise—

Dentist is limited to licensed doctors of dental surgery or dental medicine.
Economically means the services are provided at the least expensive, medically appropriate type of setting or level of care available.
Exclusion means that items and services furnished or ordered (or at the medical direction or on the prescription of a physician) by a specified health care practitioner, provider or other person during a specified period are not reimbursed under titles V, XVIII, XIX, or XX of the Social Security Act and all other Federal non-procurement programs.
Gross and flagrant violation means a violation of an obligation has occurred in one or more instances which presents an imminent danger to the health, safety, or well-being of a program patient or places the program patient unnecessarily in high-risk situations.
Health care service or services means services or items for which payment may be made (in whole or in part) under the Medicare or State health care programs.
Health professional shortage area (HPSA) means an area designated by the Secretary and defined in 42 CFR 5.2.
Metropolitan Statistical Area means an area as defined by the Executive Office of Management and Budget.
Obligation means any of the obligations specified at section 1156(a) of the Act.
Other person means a hospital or other health care facility, an organization or an agency that provides health care services or which payment may be made (in whole or in part) under the Medicare or State health care programs.
Pattern or care means that the care under question has been demonstrated in more than three instances, each of which involved different admissions.
Pharmacy professional is a term limited to individuals who are licensed or registered to provide pharmaceutical services.
Podiatric professional is a term limited to licensed doctors of podiatric medicine.
Practice area means the location where over 50 percent of the practitioner’s or other person’s patients are seen.
Practitioner means a physician or other health care professional licensed under State law to practice his or her profession.
Primary medical care professional is a term limited to:
(i) Licensed doctors of medicine and doctors of osteopathy providing direct patient care who practice in the fields of general or family practice, general internal medicine, pediatrics, obstetrics and gynecology, surgery, and any other specialty that is not accommodated by the remaining specialty HPSA designator, or
(ii) Those facilities where care and treatment is provided to patients with health problems other than mental disorders.
Pro area means the geographic area subject to review by a particular QIO.
Provider means a hospital or other health care facility, agency, or organization.
Psychiatric professional is a term limited to licensed doctors of medicine who limit their practice to psychiatry or to those facilities where care and treatment is limited to patients with mental disorders.
Rural means any area outside an urban area.
Rural health professional shortage area means any health professional shortage area located outside a Metropolitan Statistical Area.
Sanction means an exclusion or monetary penalty that the Secretary may impose on a practitioner or other person as a result of a recommendation from a QIO.
Serious risk includes situations that may involve the risk of unnecessary treatment, prolonged treatment, lack of treatment, incorrect treatment,
medical complication, premature discharge, physiological or anatomical impairment, disability, or death.

State health care program means a State plan approved under title XIX, any program receiving funds under title V or from an allotment to a State under such title, or any program receiving funds under title XX or from an allotment to a State under such title.

Substantial violation in a substantial number of cases means a pattern of providing care, as defined in this section, that is inappropriate, unnecessary, or does not meet recognized professional standards of care, or is not supported by the necessary documentation of care as required by the QIO.

Urban means a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget.

Vision care professional is a term limited to licensed doctors of medicine who limit their practice to ophthalmology and to doctors of optometry.

Subpart B—Sanctions Under the QIO Program; General Provisions

§ 1004.10 Statutory obligations of practitioners and other persons.

It is the obligation of any health care practitioner or other person who furnishes or orders health care services that may be reimbursed under the Medicare or State health care programs to ensure, to the extent of his or her or its authority, that those services are—

(a) Provided economically and only when, and to the extent, medically necessary;

(b) Of a quality that meets professionally recognized standards of health care; and

(c) Supported by evidence of medical necessity and quality in the form and fashion and at such time that the reviewing QIO may reasonably require (including copies of the necessary documentation and evidence of compliance with pre-admission or pre-procedure review requirements) to ensure that the practitioner or other person is meeting the obligations imposed by section 1156(a) of the Act.

§ 1004.20 Sanctions.

In addition to any other sanction provided under the law, a practitioner or other person may be—

(a) Excluded from participating in programs under titles V, XVIII, XIX, and XX of the Social Security Act for a period of no less than 1 year; or

(b) In lieu of exclusion and as a condition for continued participation in titles V, XVIII, XIX, and XX of the Act, if the violation involved the provision or ordering of health care services (or services furnished at the medical direction or on the prescription of a physician) that were medically improper or unnecessary, required to pay an amount of up to $10,000 for each instance in which improper or unnecessary services were furnished or ordered (or prescribed, if appropriate). The practitioner or other person will be required either to pay the monetary assessment within 6 months of the date of notice or have it deducted from any sums the Federal Government owes the practitioner or other person.

Subpart C—QIO Responsibilities

§ 1004.30 Basic responsibilities.

(a) The QIO must use its authority or influence to enlist the support of other professional or government agencies to ensure that each practitioner or other person complies with the obligations specified in § 1004.10.

(b) When the QIO identifies situations where an obligation specified in § 1004.10 is violated, it will afford the practitioner or other person reasonable notice and opportunity for discussion and, if appropriate, a suggested method for correcting the situation and a time period for a corrective action in accordance with §§ 1004.40 and 1004.60.

(c) The QIO must submit a report to the OIG after the notice and opportunity provided under paragraph (b) of this section and, if appropriate, the opportunity to enter into and complete a corrective action plan (CAP) if the QIO finds that the practitioner or other person has—

(1) Failed substantially to comply with any obligation in a substantial number of admissions; or
(2) Grossly and flagrantly violated any obligation in one or more instances.

(d) The QIO report to the OIG must comply with the provisions of §1004.80.

(e) If a practitioner or other person relocates to another QIO area prior to a finding of a violation or sanction recommendation, and the originating QIO—

(1) Is able to make a finding, the originating QIO must, as appropriate, close the case or forward a sanction recommendation to the OIG; or

(2) Cannot make a finding, the originating QIO must forward all documentation regarding the case to the QIO with jurisdiction, and notify the practitioner or other person of this action.

(f) The QIO must deny payment for services or items furnished or ordered (or at the medical direction or on the prescription of an excluded physician) by an excluded practitioner or other person when the QIO identifies the services or items. It must report the findings to the Centers for Medicare & Medicaid Services.

§ 1004.40 Action on identification of a violation.

When a QIO identifies a violation, it must—

(a) Indicate whether the violation is a gross and flagrant violation or is a substantial violation in a substantial number of cases; and

(b) Send the practitioner or other person written notice of the identification of a violation containing the following information—

(1) The obligation(s) involved;

(2) The situation, circumstances or activity that resulted in a violation; or

(3) The authority and responsibility of the QIO to report violations of any obligation under section 1156(a) of the Act;

(4) A suggested method for correcting the situation and a time period for corrective action, if appropriate;

(5) The sanction that the QIO could recommend to the OIG;

(6) The right of the practitioner or other person to submit to the QIO within 30 days of receipt of the notice additional information or a written request for a meeting with the QIO to review and discuss the finding, or both. The date of receipt is presumed to be 5 days after the date on the notice, unless there is a reasonable showing to the contrary. The notice will also state that if a meeting is requested—

(i) It will be held within 30 days of receipt by the QIO of the request, but may be extended for good cause;

(ii) The practitioner or other person may have an attorney present; and

(iii) The attorney, if present, will be permitted to make opening and closing remarks, ask clarifying questions at the meeting and assist the practitioner or other person in presenting the testimony of expert witnesses who may appear on the practitioner’s or other person’s behalf; and

(7) A copy of the material used by the QIO in arriving at its finding except for QIO deliberations, as set forth in §476.139 of this part.

§ 1004.50 Meeting with a practitioner or other person.

If the practitioner or other person requests a meeting with the QIO—

(a) The QIO panel that meets with the practitioner or other person must consist of a minimum of 3 physicians;

(b) No physician member of the QIO panel may be in direct economic competition with the practitioner or other person being considered for sanction;

(c) The QIO must ensure that no physician member of the QIO panel has a substantial bias for or against the practitioner or other person being considered for sanction;

(d) At least one member of the QIO panel meeting with the practitioner or other person should practice in a similar area, e.g., urban or rural, and at least one member of the panel must be in the same specialty (both requirements could be met by a single individual);

(e) If the practitioner or other person has an attorney present, that attorney will be permitted to make opening and closing remarks, ask clarifying questions and assist the practitioner or other person in presenting the testimony of expert witnesses who may appear on the practitioner’s or other person’s behalf;

(f) The physician who recommends to the QIO that a practitioner or other
§ 1004.60 QIO finding of a violation.

(a) On the basis of any additional information received, the QIO will affirm or modify its finding. If the QIO affirms its finding, it may suggest in writing a method for correcting the situation and a time period for corrective action. This CAP could correspond with, or be a continuation of, a prior CAP or be a new proposal based on additional information received by the QIO. If the finding has been resolved to the QIO’s satisfaction, the QIO may modify its initial finding or recommendation or close the case.

(b) The QIO must give written notice to the practitioner or other person of any action it takes as a result of the additional information received, as specified in §1004.70.

(c) At least one member of the QIO participating in the process which resulted in a recommendation to the OIG that a practitioner or other person be sanctioned should practice in a similar geographic area, e.g. urban or rural, and at least one member of the panel must be in the same medical specialty. Both requirements can be met by a single individual. In addition, no one at the QIO who is a participant in such a finding may be in direct economic competition with, or have a substantial bias for or against, that practitioner or other person being recommended for sanction.

§ 1004.70 QIO action on final finding of a violation.

If the finding is not resolved to the QIO’s satisfaction as specified in §1004.60(a), the QIO must—

(a) Submit its report and recommendation to the OIG;

(b) Send the affected practitioner or other person a concurrent final notice, with a copy of all the material that is being forwarded to the OIG, advising that—

(1) The QIO recommendation has been submitted to the OIG;

(2) The practitioner or other person has 30 days from receipt of this final notice to submit any additional written material or documentary evidence to the OIG at its headquarters location. The date of receipt is presumed to be 5 days after the date on the notice, unless there is a reasonable showing to the contrary; and

(3) Due to the 120-day statutory requirement specified in §1004.100(e), the period for submitting additional information will not be extended and any material received by the OIG after the 30-day period will not be considered; and

(c) Provide notice to the State medical board or to other appropriate licensing boards for other practitioner types when it submits a report and recommendation to the OIG with respect to a physician or other person whom the board is responsible for licensing.

§ 1004.80 QIO report to the OIG.

(a) Manner of reporting. If the violation(s) identified by the QIO have not been resolved, it must submit a report and recommendation to the OIG at the field office with jurisdiction.

(b) Content of report. The QIO report must include the following information—

(1) Identification of the practitioner or other person and, when applicable, the name of the director, administrator or owner of the entity involved;

(2) The type of health care services involved;

(3) A description of each failure to comply with an obligation, including specific dates, places, circumstances and other relevant facts;

(4) Pertinent documentary evidence;

(5) Copies of written correspondence, including reports of conversations with the practitioner or other person regarding the violation and, if applicable, a copy of the verbatim transcript of the meeting with the practitioner or other person;

(6) The QIO’s finding that an obligation under section 1156(a) of the Act has been violated and that the violation is substantial and has occurred in
Subpart D—OIG Responsibilities

§ 1004.100 Acknowledgement and review of report.

(a) Acknowledgement. The OIG will inform the QIO of the date it received the QIO’s report and recommendation.

(b) Review. The OIG will review the QIO report and recommendation to determine whether—

(1) The QIO has followed the regulatory requirements of this part; and

(2) A violation has occurred.

(c) Rejection of the QIO recommendation. If the OIG decides that a sanction is not warranted, it will notify the QIO that recommended the sanction, the affected practitioner or other person, and the licensing board informed by the QIO of the sanction recommendation that the recommendation is rejected.

(d) Decision to sanction. If the OIG decides that a violation of obligations has occurred, it will determine the appropriate sanction by considering—

(1) The recommendation of the QIO;

(2) The type of offense;

(3) The severity of the offense;

(4) The previous sanction record of the practitioner or other person;

(5) The availability of alternative sources of services in the community;

(6) The county or counties in which the service provider or other person furnishes services.

Subpart E—OIG Responsibilities

§ 1004.110 Notice of sanction.

(a) The OIG must notify the practitioner or other person of the adverse determination and of the sanction to be imposed.

(b) The sanction is effective 20 days from the date of the notice. Receipt is presumed to be 5 days after the date on the notice, unless there is a reasonable showing to the contrary.

(c) The notice must specify—
(1) The legal and factual basis for the determination;
(2) The sanction to be imposed;
(3) The effective date and, if appropriate, the duration of the exclusion;
(4) The appeal rights of the practitioner or other person;
(5) The opportunity and the process necessary to provide alternative notification as set forth in paragraphs (d) and (e) of this section; and
(6) In the case of exclusion, the earliest date on which the OIG will accept a request for reinstatement.

(d) Patient notification. (1)(i) The OIG will provide a sanctioned practitioner or other person an opportunity to elect to inform each of their patients of the sanction action. In order to elect this option, the sanctioned practitioner or other person must, within 30 calendar days from receipt of the OIG notice, inform both new and existing patients through written notice—based on a suggested (non-mandatory) model provided to the sanctioned individual by the OIG—of the sanction and, in the case of an exclusion, its effective date. Receipt of the OIG notice is presumed to be 5 days after the date of the notice, unless there is a reasonable showing to the contrary. Within this same period, the practitioner or other person must also sign and return the certification that the OIG will provide with the notice. For purposes of this section, the term “all existing patients” includes all patients currently under active treatment with the practitioner or other person, as well as all patients who have been treated by the practitioner or other person within the last 3 years. In addition, the practitioner or other person must notify all prospective patients orally at the time such persons request an appointment. If the sanctioned party is a hospital, it must notify all physicians who have privileges at the hospital, and must post a notice in its emergency room, business office and in all affiliated entities regarding the exclusion. In addition, for purposes of this section, the term “in all affiliated entities” encompasses all entities and properties in which the hospital has a direct or indirect ownership interest of 5 percent or more and any management, partnership or control of the entity.

(ii) The certification will provide that the practitioner or other person—
(A) Has informed each of his, her or its patients in writing that the practitioner or other person has been sanctioned, and if a hospital, has informed all physicians having privileges at the hospital that it has been sanctioned;
(B) If excluded from Medicare and the State health care programs, has informed his, her or its existing patients in writing that the programs will not pay for items and services furnished or ordered (or at the medical direction or on the prescription of an excluded physician) by the practitioner or other person until they are reinstated, or if a hospital, has provided this information to all physicians having privileges at that hospital;
(C) If excluded from Medicare and State health care programs, will provide prospective patients—or if a hospital, physicians requesting privileges at that hospital prior to furnishing or ordering (or in the case of an excluded physician, medically directing or prescribing) services—oral information of both the sanction and that the programs will not pay for services provided and written notification of the same at the time of the provision of services;
(D) If excluded from Medicare and State health care programs and is an entity such as a hospital, has posted a notice in its emergency room, business office and in all affiliated entities that the programs will not pay for services provided; and
(E) Certifies to the truthfulness and accuracy of the notification and the statements in the certification.

(2) If the sanctioned practitioner or other person does not inform his, her or its patients and does not return the required certification within the 30-day period, or if the sanctioned practitioner or other person returns the certification within the 30-day period but the OIG obtains reliable evidence that such person nevertheless has not adequately informed new and existing patients of the sanction, the OIG—

(i) Will see that the public is notified directly of the identity of the sanctioned practitioner or other person, the finding that the obligation has been
violated, and the effective date of any exclusion; and
(ii) May consider this failure to adhere to the certification obligation as an adverse factor at the time the sanctioned practitioner or other person requests reinstatement.
(3) If the sanctioned practitioner or other person is entitled to a preliminary hearing in accordance with §1004.140(a) and requests such a preliminary hearing, and if the administrative law judge (ALJ) decides that he, she or it poses a risk to program beneficiaries, the sanctioned practitioner or other person would have 30 days from the date of receipt of the ALJ’s decision to provide certification to the OIG in accordance with §1004.110(d)(1). The date of receipt is presumed to be 5 days after the date of the ALJ’s decision, unless there is a reasonable showing to the contrary.
(e) Notice of the sanction is also provided to the following entities as appropriate—
(1) The QIO that originated the sanction report;
(2) QIOs in adjacent areas;
(3) State Medicaid fraud control units and State licensing and accreditation bodies;
(4) Appropriate program contractors and State agencies;
(5) Hospitals, including the hospital where the sanctioned individual’s case originated and where the individual currently has privileges, if known; skilled nursing facilities, home health agencies, and health maintenance organizations and Federally-funded community health centers where the practitioner or other person works;
(6) Medical societies and other professional organizations; and
(7) Medicare carriers and fiscal intermediaries, health care prepayment plans and other affected agencies and organizations.
(f) If an exclusion sanction is effectuated because a decision was not made within 120 days after receipt of the QIO recommendation, notification is as follows—
(1) As soon as possible after the 120th day, the OIG will issue a notice to the practitioner or other person, in compliance with the requirements of paragraph (c) of this section, affirming the QIO recommendation based on the OIG’s review of the case, and that the exclusion is effective 20 days from the date of the notice; and
(2) Notice of sanction is also provided as specified in paragraph (e) of this section.

Subpart E—Effect and Duration of Exclusion
§ 1004.120 Effect of an exclusion on program payments and services.
The effect of an exclusion is set forth in §1001.1901 of this chapter.
§ 1004.130 Reinstatement after exclusion.
(a) A practitioner or other person who has been excluded in accordance with this part may apply for reinstatement at the end of the period of exclusion. The OIG will consider any request for reinstatement in accordance with provisions of §§1001.3001 through 1001.3005 of this chapter.
(b) The OIG may also consider a practitioner’s or other person’s compliance with the certification obligation in §1004.110(d) at the time of reinstatement.

Subpart F—Appeals
§ 1004.140 Appeal rights.
(a) Right to preliminary hearing. (1)(i) A practitioner or other person excluded from participation in Medicare and any State health care programs under section 1156 of the Act may request a preliminary hearing if the location where services are rendered to over 50 percent of the practitioner’s or other person’s patients at the time of the exclusion notice is in a rural HPSA or in a county with a population of less than 70,000.
(ii) Unless the practitioner’s or other person’s practice meets the definition for psychiatric professional, vision care professional, dental professional, podiatric professional or pharmacy professional, the HPSA used by the OIG for determination of entitlement to a preliminary hearing will be the HPSA list for primary medical care professional.
(iii) Information on the population size of a county in order to determine entitlement to a preliminary hearing will be obtained by the OIG from the responsible officials of that county.

(2)(i) A request for a preliminary hearing must be made in writing and received by the Departmental Appeals Board (DAB) no later than the 15th day after the notice of exclusion is received by a practitioner or other person. The date of receipt of the notice of exclusion by the practitioner or other person is presumed to be 5 days after the date appearing on the notice, unless there is a reasonable showing to the contrary.

(ii) A request for a preliminary hearing will stay the effective date of the exclusion pending a decision of the ALJ at the preliminary hearing, and all the parties informed by the OIG of the exclusion will be notified of the stay.

(iii) A request for a preliminary hearing received after the 15-day period has expired will be treated as a request for a hearing before an ALJ in accordance with paragraph (b) of this section.

(iv) If the practitioner or other person exercises his, her or its right to a preliminary hearing, such a hearing must be held by the ALJ in accordance with paragraph (a)(3)(i) of this section unless the OIG waives it in accordance with paragraph (a)(6)(i) of this section.

(v) The ALJ cannot consolidate the preliminary hearing with a full hearing without the approval of all parties to the hearing.

(3)(i) The preliminary hearing will be conducted by an ALJ of the DAB in a city that the ALJ deems equitable to all parties. The ALJ will conduct the preliminary hearing and render a decision no later than 45 days after receipt of the request for such a hearing by the DAB. Unless there is a reasonable showing to the contrary, date of receipt by the DAB is presumed to be 5 days after the date on the request for a preliminary hearing or, if undated, the date of receipt will be the date the DAB actually received the request. A reasonable extension to the 45-day period of up to 15 days may be requested by any party to the preliminary hearing and such a request may be granted upon concurrence by all parties to the preliminary hearing. Such request must be received no later than 15 days prior to the scheduled date of the preliminary hearing.

(ii) The only issue to be heard and decided on by the ALJ at the preliminary hearing, based on the preponderance of the evidence, is whether the practitioner’s or other person’s continued participation in the Medicare and State health care programs during the appeal of the exclusion before an ALJ would place program beneficiaries at serious risk. The ALJ’s decision is to be based on the preponderance of the evidence.

(iii) In the interest of time, the ALJ may issue an oral decision to be followed by a written decision.

(iv) In those cases where the ALJ has stayed an exclusion after a preliminary hearing, a full hearing must be held and a decision rendered by the ALJ within 6 months. If, for any reason, the request for a full hearing before the ALJ is withdrawn or dismissed, the practitioner or other person will be excluded effective 5 days after the notice of the withdrawal or dismissal is received in the OIG headquarters.

(4) The preliminary hearing decision is not appealable or subject to further administrative or judicial review.

(5) A practitioner or other person found at the preliminary hearing not to place program beneficiaries at serious risk, but later determined to have been properly excluded from program participation after a full hearing before an ALJ, is not entitled to have the exclusion stayed further during an appeal to the DAB. Exclusions in such instances will be effective 5 days after the notice of the ALJ decision in the OIG headquarters.

(6)(i) After notice of a timely request for a preliminary hearing, the OIG may determine that the practitioner’s or other person’s continued program participation during the appeal before the ALJ will not place program beneficiaries at serious risk and waive the preliminary hearing. Under these circumstances, the exclusion will be stayed pending the decision of the ALJ after a full hearing. The hearing must be held, and a decision reached, within 6 months.
(ii) If the OIG decides to waive the preliminary hearing, the request for the preliminary hearing will be considered a request for a hearing before the ALJ in accordance with paragraph (b) of this section.

(b) Right to administrative review. (1) A practitioner or other person dissatisfied with an OIG determination, or an exclusion that results from a determination not being made within 120 days, is entitled to appeal such sanction in accordance with part 1005 of this chapter.

(2) Due to the 120-day statutory requirement specified in §1004.100(e), the following limitations apply—
(i) The period of time for submitting additional information will not be extended.
(ii) Any material received by the OIG after the 30-day period allowed will not be considered by the ALJ or the DAB.

(3) The OIG’s determination continues in effect unless reversed by a hearing.

(c) Rights to judicial review. Any practitioner or other person dissatisfied with a final decision of the Secretary may file a civil action in accordance with the provisions of section 205(g) of the Act.

PART 1005—APPEALS OF EXCLUSIONS, CIVIL MONEY PENALTIES AND ASSESSMENTS

§ 1005.2 Hearing before an administrative law judge.

(a) A party sanctioned under any criteria specified in parts 1001, 1003 and 1004 of this chapter may request a hearing before an ALJ.

(b) In exclusion cases, the parties to the proceeding will consist of the petitioner and the IG. In civil money penalty cases, the parties to the proceeding will consist of the respondent and the IG.

(c) The request for a hearing will be made in writing to the DAB; signed by the petitioner or respondent, or by his or her attorney; and sent by certified mail. The request must be filed within 60 days after the notice, provided in accordance with §1001.2002, §1001.203 or §1003.109, is received by the petitioner or respondent. For purposes of this section, the date of receipt of the notice letter will be presumed to be 5 days after the date of such notice unless there is a reasonable showing to the contrary.

(d) The request for a hearing will contain a statement as to the specific issues or findings of fact and conclusions of law in the notice letter with

1005.23 Harmless error.

AUTHORITY: 42 U.S.C. 405(a), 405(b), 1302, 1320a–7, 1320a–7a and 1320c–5.

SOURCE: 57 FR 3350, Jan. 29, 1992, unless otherwise noted.

§ 1005.1 Definitions.

Civil money penalty cases refer to all proceedings arising under any of the statutory bases for which the OIG has been delegated authority to impose civil money penalties under Medicare or the State health care programs.

DAB refers to the Departmental Appeals Board or its delegatee.

Exclusion cases refer to all proceedings arising under any of the statutory bases for which the OIG has been delegated authority to impose exclusions under Medicare or the State health care programs.

Inspector General (IG) means the Inspector General of the Department of Health and Human Services or his or her designees.

[57 FR 3350, Jan. 29, 1992, as amended at 65 FR 24418, Apr. 26, 2000]
§ 1005.3 Rights of parties.

(a) Except as otherwise limited by this part, all parties may—

(1) Be accompanied, represented and advised by an attorney;

(2) Participate in any conference held by the ALJ;

(3) Conduct discovery of documents as permitted by this part;

(4) Agree to stipulations of fact or law which will be made part of the record;

(5) Present evidence relevant to the issues at the hearing;

(6) Present and cross-examine witnesses;

(7) Present oral arguments at the hearing as permitted by the ALJ; and

(8) Submit written briefs and proposed findings of fact and conclusions of law after the hearing.

(b) Fees for any services performed on behalf of a party by an attorney are not subject to the provisions of section 206 of title II of the Act, which authorizes the Secretary to specify or limit these fees.

§ 1005.4 Authority of the ALJ.

(a) The ALJ will conduct a fair and impartial hearing, avoid delay, maintain order and assure that a record of the proceeding is made.

(b) The ALJ has the authority to—

(1) Set and change the date, time and place of the hearing upon reasonable notice to the parties; (2) Continue or recess the hearing in whole or in part for a reasonable period of time; (3) Hold conferences to identify or simplify the issues, or to consider other matters that may aid in the expeditious disposition of the proceeding; (4) Administer oaths and affirmations; (5) Issue subpoenas requiring the attendance of witnesses at hearings and the production of documents at or in relation to hearings; (6) Rule on motions and other procedural matters; (7) Regulate the scope and timing of documentary discovery as permitted by this part; (8) Regulate the course of the hearing and the conduct of representatives, parties, and witnesses; (9) Examine witnesses; (10) Receive, rule on, exclude or limit evidence; (11) Upon motion of a party, take official notice of facts; (12) Upon motion of a party, decide cases, in whole or in part, by summary judgment where there is no disputed issue of material fact; and (13) Conduct any conference, argument or hearing in person or, upon agreement of the parties, by telephone.

(c) The ALJ does not have the authority to—

(1) Find invalid or refuse to follow Federal statutes or regulations or secretarial delegations of authority; (2) Enter an order in the nature of a directed verdict; (3) Compel settlement negotiations; (4) Enjoin any act of the Secretary; (5) Review the exercise of discretion by the OIG to exclude an individual or entity under section 1128(b) of the Act, or determine the scope or effect of the exclusion; (6) Set a period of exclusion at zero, or reduce a period of exclusion to zero, in any case where the ALJ finds that an individual or entity committed an act described in section 1128(b) of the Act, or (7) Review the exercise of discretion by the OIG to impose a CMP, assessment or exclusion under part 1003 of this chapter.

§ 1005.5 Ex parte contacts.

No party or person (except employees of the ALJ’s office) will communicate in any way with the ALJ on any matter at issue in a case, unless on notice and opportunity for all parties to participate. This provision does not prohibit a person or party from inquiring about the status of a case or asking routine questions concerning administrative functions or procedures.

§ 1005.6 Prehearing conferences.

(a) The ALJ will schedule at least one prehearing conference, and may schedule additional prehearing conferences as appropriate, upon reasonable notice to the parties.

(b) The ALJ may use prehearing conferences to discuss the following—

(1) Simplification of the issues;

(2) The necessity or desirability of amendments to the pleadings, including the need for a more definite statement;

(3) Stipulations and admissions of fact or as to the contents and authenticity of documents;

(4) Whether the parties can agree to submission of the case on a stipulated record;

(5) Whether a party chooses to waive appearance at an oral hearing and to submit only documentary evidence (subject to the objection of other parties) and written argument;

(6) Limitation of the number of witnesses;

(7) Scheduling dates for the exchange of witness lists and of proposed exhibits;

(8) Discovery of documents as permitted by this part;

(9) The time and place for the hearing;

(10) Such other matters as may tend to encourage the fair, just and expeditious disposition of the proceedings; and

(11) Potential settlement of the case.

(c) The ALJ will issue an order containing the matters agreed upon by the parties or ordered by the ALJ at a prehearing conference.

§ 1005.7 Discovery.

(a) A party may make a request to another party for production of documents for inspection and copying which are relevant and material to the issues before the ALJ.

(b) For the purpose of this section, the term documents includes information, reports, answers, records, accounts, papers and other data and documentary evidence. Nothing contained in this section will be interpreted to require the creation of a document, except that requested data stored in an electronic data storage system will be produced in a form accessible to the requesting party.

(c) Requests for documents, requests for admissions, written interrogatories, depositions and any forms of discovery, other than those permitted under paragraph (a) of this section, are not authorized.

(d) This section will not be construed to require the disclosure of interview reports or statements obtained by any party, or on behalf of any party, of persons who will not be called as witnesses by that party, or analyses and summaries prepared in conjunction with the investigation or litigation of the case, or any otherwise privileged documents.

(e)(1) When a request for production of documents has been received, within 30 days the party receiving that request will either fully respond to the request, or state that the request is being objected to and the reasons for that objection. If objection is made to part of an item or category, the party seeking production may then, within 30 days or any other time frame set by the ALJ, file a motion for an order compelling discovery. (The party receiving a request for production may also file a motion for protective order any time prior to the date the production is due.)

(2) The ALJ may grant a motion for protective order or deny a motion for an order compelling discovery if the ALJ finds that the discovery sought—

(i) Is irrelevant,

(ii) Is unduly costly or burdensome,

(iii) Will unduly delay the proceeding, or

(iv) Seeks privileged information.

(3) The ALJ may extend any of the time frames set forth in paragraph (e)(1) of this section.
(4) The burden of showing that discovery should be allowed is on the party seeking discovery.

§ 1005.8 Exchange of witness lists, witness statements and exhibits.

(a) At least 15 days before the hearing, the ALJ will order the parties to exchange witness lists, copies of prior written statements of proposed witnesses and copies of proposed hearing exhibits, including copies of any written statements that the party intends to offer in lieu of live testimony in accordance with §1005.16.

(b)(1) If at any time a party objects to the proposed admission of evidence not exchanged in accordance with paragraph (a) of this section, the ALJ will determine whether the failure to comply with paragraph (a) of this section should result in the exclusion of such evidence.

(2) Unless the ALJ finds that extraordinary circumstances justified the failure to timely exchange the information listed under paragraph (a) of this section, the ALJ must exclude from the party’s case-in-chief:

(i) The testimony of any witness whose name does not appear on the witness list, and

(ii) Any exhibit not provided to the opposing party as specified in paragraph (a) of this section.

(3) If the ALJ finds that extraordinary circumstances existed, the ALJ must then determine whether the admission of such evidence would cause substantial prejudice to the objecting party. If the ALJ finds that there is no substantial prejudice, the evidence may be admitted. If the ALJ finds that there is substantial prejudice, the ALJ may exclude the evidence, or at his or her discretion, may postpone the hearing for such time as is necessary for the objecting party to prepare and respond to the evidence.

(c) Unless another party objects within a reasonable period of time prior to the hearing, documents exchanged in accordance with paragraph (a) of this section will be deemed to be authentic for the purpose of admissibility at the hearing.

§ 1005.9 Subpoenas for attendance at hearing.

(a) A party wishing to procure the appearance and testimony of any individual at the hearing may make a motion requesting the ALJ to issue a subpoena if the appearance and testimony are reasonably necessary for the presentation of a party’s case.

(b) A subpoena requiring the attendance of an individual in accordance with paragraph (a) of this section may also require the individual (whether or not the individual is a party) to produce evidence authorized under §1005.7 of this part at or prior to the hearing.

(c) When a subpoena is served by a respondent or petitioner on a particular individual or particular office of the OIG, the OIG may comply by designating any of its representatives to appear and testify.

(d) A party seeking a subpoena will file a written motion not less than 30 days before the date fixed for the hearing, unless otherwise allowed by the ALJ for good cause shown. Such request will:

(1) Specify any evidence to be produced,

(2) Designate the witnesses, and

(3) Describe the address and location with sufficient particularity to permit such witnesses to be found.

(e) The subpoena will specify the time and place at which the witness is to appear and any evidence the witness is to produce.

(f) Within 15 days after the written motion requesting issuance of a subpoena is served, any party may file an opposition or other response.

(g) If the motion requesting issuance of a subpoena is granted, the party seeking the subpoena will serve it by delivery to the individual named, or by certified mail addressed to such individual at his or her last dwelling place or principal place of business.

(h) The individual to whom the subpoena is directed may file with the ALJ a motion to quash the subpoena within 10 days after service.

(i) The exclusive remedy for contumacy by, or refusal to obey a subpoena...
§ 1005.10 Fees.

The party requesting a subpoena will pay the cost of the fees and mileage of any witness subpoenaed in the amounts that would be payable to a witness in a proceeding in United States District Court. A check for witness fees and mileage will accompany the subpoena when served, except that when a subpoena is issued on behalf of the IG, a check for witness fees and mileage need not accompany the subpoena.

§ 1005.11 Form, filing and service of papers.

(a) **Forms.** (1) Unless the ALJ directs the parties to do otherwise, documents filed with the ALJ will include an original and two copies.

(2) Every pleading and paper filed in the proceeding will contain a caption setting forth the title of the action, the case number, and a designation of the paper, such as motion to quash subpoena.

(3) Every pleading and paper will be signed by, and will contain the address and telephone number of the party or the person on whose behalf the paper was filed, or his or her representative.

(4) Papers are considered filed when they are mailed.

(b) **Service.** A party filing a document with the ALJ or the Secretary will, at the time of filing, serve a copy of such document on every other party. Service upon any party of any document will be made by delivering a copy, or placing a copy of the document in the United States mail, postage prepaid and addressed, or with a private delivery service, to the party’s last known address. When a party is represented by an attorney, service will be made upon such attorney in lieu of the party.

(c) **Proof of service.** A certificate of the individual serving the document by personal delivery or by mail, setting forth the manner of service, will be proof of service.

§ 1005.12 Computation of time.

(a) In computing any period of time under this part or in an order issued thereunder, the time begins with the day following the act, event or default, and includes the last day of the period unless it is a Saturday, Sunday or legal holiday observed by the Federal Government, in which event it includes the next business day.

(b) When the period of time allowed is less than 7 days, intermediate Saturdays, Sundays and legal holidays observed by the Federal Government will be excluded from the computation.

(c) Where a document has been served or issued by placing it in the mail, an additional 5 days will be added to the time permitted for any response. This paragraph does not apply to requests for hearing under § 1005.2.

§ 1005.13 Motions.

(a) An application to the ALJ for an order or ruling will be by motion. Motions will state the relief sought, the authority relied upon and the facts alleged, and will be filed with the ALJ and served on all other parties.

(b) Except for motions made during a prehearing conference or at the hearing, all motions will be in writing. The ALJ may require that oral motions be reduced to writing.

(c) Within 10 days after a written motion is served, or such other time as may be fixed by the ALJ, any party may file a response to such motion.

(d) The ALJ may grant a written motion before the time for filing responses has expired, except upon consent of the parties or following a hearing on the motion, but may overrule or deny such motion without awaiting a response.

(e) The ALJ will make a reasonable effort to dispose of all outstanding motions prior to the beginning of the hearing.

§ 1005.14 Sanctions.

(a) The ALJ may sanction a person, including any party or attorney, for failing to comply with an order or procedure, for failing to defend an action or for other misconduct that interferes with the speedy, orderly or fair conduct of the hearing. Such sanctions will reasonably relate to the severity
§ 1005.15 The hearing and burden of proof.

(a) The ALJ will conduct a hearing on the record in order to determine whether the petitioner or respondent should be found liable under this part.

(b) With regard to the burden of proof in civil money penalty cases under part 1003, in Quality Improvement Organization exclusion cases under part 1004, and in exclusion cases under §§1001.701, 1001.901 and 1001.951 of this chapter—

(1) The respondent or petitioner, as applicable, bears the burden of going forward and the burden of persuasion with respect to affirmative defenses and any mitigating circumstances; and

(2) The IG bears the burden of going forward and the burden of persuasion with respect to all other issues.

(c) Burden of proof in all other exclusion cases. In all exclusion cases except those governed by paragraph (b) of this section, the ALJ will allocate the burden of proof as the ALJ deems appropriate.

(d) The burden of persuasion will be judged by a preponderance of the evidence.

(e) The hearing will be open to the public unless otherwise ordered by the ALJ for good cause shown.

(f)(1) A hearing under this part is not limited to specific items and information set forth in the notice letter to the petitioner or respondent. Subject to the 15-day requirement under §1005.8, additional items and information, including aggravating or mitigating circumstances that arose or became known subsequent to the issuance of the notice letter, may be introduced by either party during its case-in-chief unless such information or items are—

(i) Privileged;

(ii) Disqualified from consideration due to untimeliness in accordance with §1001.130(a)(2)(ii); or

(iii) Deemed otherwise inadmissible under §1005.17.

(2) After both parties have presented their cases, evidence may be admitted on rebuttal even if not previously exchanged in accordance with §1005.8.

[57 FR 3350, Jan. 29, 1992, as amended at 63 FR 46691, Sept. 2, 2000]

§ 1005.16 Witnesses.

(a) Except as provided in paragraph (b) of this section, testimony at the hearing will be given orally by witnesses under oath or affirmation.

(b) At the discretion of the ALJ, testimony (other than expert testimony) may be admitted in the form of a written statement. The ALJ may, at his or her discretion, admit prior sworn testimony of experts which has been subject to adverse examination, such as a deposition or trial testimony. Any such written statement must be provided to all other parties along with the last known address of such witnesses, in a manner that allows sufficient time for other parties to subpoena such witness for cross-examination at the hearing. Prior written statements of witnesses proposed to testify at the hearing will be exchanged as provided in §1005.8.

(c) The ALJ will exercise reasonable control over the mode and order of interrogating witnesses and presenting evidence so as to:
(1) Make the interrogation and presentation effective for the ascertainment of the truth,
(2) Avoid repetition or needless consumption of time, and
(3) Protect witnesses from harassment or undue embarrassment.
(d) The ALJ will permit the parties to conduct such cross-examination of witnesses as may be required for a full and true disclosure of the facts.
(e) The ALJ may order witnesses excluded so that they cannot hear the testimony of other witnesses. This does not authorize exclusion of—
(1) A party who is an individual;
(2) In the case of a party that is not an individual, an officer or employee of the party appearing for the entity pro se or designated as the party’s representative; or
(3) An individual whose presence is shown by a party to be essential to the presentation of its case, including an individual engaged in assisting the attorney for the IG.
§ 1005.17 Evidence.
(a) The ALJ will determine the admissibility of evidence.
(b) Except as provided in this part, the ALJ will not be bound by the Federal Rules of Evidence. However, the ALJ may apply the Federal Rules of Evidence where appropriate, for example, to exclude unreliable evidence.
(c) The ALJ must exclude irrelevant or immaterial evidence.
(d) Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or by considerations of undue delay or needless presentation of cumulative evidence.
(e) Although relevant, evidence must be excluded if it is privileged under Federal law.
(f) Evidence concerning offers of compromise or settlement made in this action will be inadmissible to the extent provided in Rule 408 of the Federal Rules of Evidence.
(g) Evidence of crimes, wrongs or acts other than those at issue in the instant case is admissible in order to show motive, opportunity, intent, knowledge, preparation, identity, lack of mistake, or existence of a scheme. Such evidence is admissible regardless of whether the crimes, wrongs or acts occurred during the statute of limitations period applicable to the acts which constitute the basis for liability in the case, and regardless of whether they were referenced in the IG’s notice sent in accordance with §1001.2002, §1001.2003 or §1003.109.
(h) The ALJ will permit the parties to introduce rebuttal witnesses and evidence.
(i) All documents and other evidence offered or taken for the record will be open to examination by all parties, unless otherwise ordered by the ALJ for good cause shown.
(j) The ALJ may not consider evidence regarding the issue of willingness and ability to enter into and successfully complete a corrective action plan when such evidence pertains to matters occurring after the submittal of the case to the Secretary. The determination regarding the appropriateness of any corrective action plan is not reviewable.
§ 1005.18 The record.
(a) The hearing will be recorded and transcribed. Transcripts may be obtained following the hearing from the ALJ.
(b) The transcript of testimony, exhibits and other evidence admitted at the hearing, and all papers and requests filed in the proceeding constitute the record for the decision by the ALJ and the Secretary.
(c) The record may be inspected and copied (upon payment of a reasonable fee) by any person, unless otherwise ordered by the ALJ for good cause shown.
(d) For good cause, the ALJ may order appropriate redactions made to the record.
§ 1005.19 Post-hearing briefs.
The ALJ may require the parties to file post-hearing briefs. In any event, any party may file a post-hearing brief. The ALJ will fix the time for filing such briefs which are not to exceed 60 days from the date the parties receive the transcript of the hearing or, if applicable, the stipulated record. Such briefs may be accompanied by proposed
findings of fact and conclusions of law. The ALJ may permit the parties to file reply briefs.

§ 1005.20 Initial decision.

(a) The ALJ will issue an initial decision, based only on the record, which will contain findings of fact and conclusions of law.

(b) The ALJ may affirm, increase or reduce the penalties, assessment or exclusion proposed or imposed by the IG, or reverse the imposition of the exclusion. In exclusion cases where the period of exclusion commenced prior to the hearing, any period of exclusion imposed by the ALJ will be deemed to commence on the date such exclusion originally went into effect.

(c) The ALJ will issue the initial decision to all parties within 60 days after the time for submission of post-hearing briefs and reply briefs, if permitted, has expired. The decision will be accompanied by a statement describing the right of any party to file a notice of appeal with the DAB and instructions for how to file such appeal. If the ALJ fails to meet the deadline contained in this paragraph, he or she will notify the parties of the reason for the delay and will set a new deadline.

(d) Except for exclusion actions taken in accordance with §1001.2003 of this chapter and as provided in paragraph (e) of this section, unless the initial decision is appealed to the DAB, it will be final and binding on the parties 30 days after the ALJ serves the parties with a copy of the decision. If service is by mail, the date of service will be deemed to be 5 days from the date of mailing.

(e) If an extension of time within which to appeal the initial decision is granted under §1005.21(a), except as provided in §1005.22(a), the initial decision will become final and binding on the day following the end of the extension period.

§ 1005.21 Appeal to DAB.

(a) Any party may appeal the initial decision of the ALJ to the DAB by filing a notice of appeal with the DAB within 30 days of the date of service of the initial decision. The DAB may extend the initial 30 day period for a period of time not to exceed 30 days if a party files with the DAB a request for an extension within the initial 30 day period and shows good cause.

(b) If a party files a timely notice of appeal with the DAB, the ALJ will forward the record of the proceeding to the DAB.

(c) A notice of appeal will be accompanied by a written brief specifying exceptions to the initial decision and reasons supporting the exceptions. Any party may file a brief in opposition to exceptions, which may raise any relevant issue not addressed in the exceptions, within 30 days of receiving the notice of appeal and accompanying brief. The DAB may permit the parties to file reply briefs.

(d) There is no right to appear personally before the DAB or to appeal to the DAB any interlocutory ruling by the ALJ, except on the timeliness of a filing of the hearing request.

(e) The DAB will not consider any issue not raised in the parties’ briefs, nor any issue in the briefs that could have been raised before the ALJ but was not.

(f) If any party demonstrates to the satisfaction of the DAB that additional evidence not presented at such hearing is relevant and material and that there were reasonable grounds for the failure to adduce such evidence at such hearing, the DAB may remand the matter to the ALJ for consideration of such additional evidence.

(g) The DAB may decline to review the case, or may affirm, increase, reduce, reverse or remand any penalty, assessment or exclusion determined by the ALJ.

(h) The standard of review on a disputed issue of fact is whether the initial decision is supported by substantial evidence on the whole record. The standard of review on a disputed issue of law is whether the initial decision is erroneous.

(i) Within 60 days after the time for submission of briefs and reply briefs, if permitted, has expired, the DAB will issue to each party to the appeal a copy of the DAB’s decision and a statement describing the right of any petitioner or respondent who is found liable to seek judicial review.
(j) Except with respect to any penalty, assessment or exclusion remanded by the ALJ, the DAB’s decision, including a decision to decline review of the initial decision, becomes final and binding 60 days after the date on which the DAB serves the parties with a copy of the decision. If service is by mail, the date of service will be deemed to be 5 days from the date of mailing.

(k) (1) Any petition for judicial review must be filed within 60 days after the DAB serves the parties with a copy of the decision. If service is by mail, the date of service will be deemed to be 5 days from the date of mailing.

(2) In compliance with 28 U.S.C. 2112(a), a copy of any petition for judicial review filed in any U.S. Court of Appeals challenging a final action of the DAB will be sent by certified mail, return receipt requested, to the Chief Counsel to the IG. The petition copy will be time-stamped by the clerk of the court when the original is filed with the court.

(3) If the Chief Counsel to the IG receives two or more petitions within 10 days after the DAB issues its decision, the Chief Counsel to the IG will notify the U.S. Judicial Panel on Multidistrict Litigation of any petitions that were received within the 10-day period.

§ 1005.23 Harmless error.

No error in either the admission or the exclusion of evidence, and no error or defect in any ruling or order or in any act done or omitted by the ALJ or by any of the parties, including Federal representatives such as Medicare carriers and intermediaries and Quality Improvement Organizations, is ground for vacating, modifying or otherwise disturbing an otherwise appropriate ruling or order or act, unless refusal to take such action appears to the ALJ or the DAB inconsistent with substantial justice. The ALJ and the DAB at every stage of the proceeding will disregard any error or defect in the proceeding that does not affect the substantial rights of the parties.

PART 1006—INVESTIGATIONAL INQUIRIES

Sec. 1006.1 Scope.
1006.2 Contents of subpoena.
1006.3 Service and fees.
1006.4 Procedures for investigational inquiries.
1006.5 Enforcement of a subpoena.

AUTHORITY: 42 U.S.C. 405(d), 405(e), 1302 and 1320a–7a.

SOURCE: 57 FR 3354, Jan. 29, 1992, unless otherwise noted.

§ 1005.22 Stay of initial decision.

(a) In a CMP case under section 1128A of the Act, the filing of a respondent’s request for review by the DAB will automatically stay the effective date of the ALJ’s decision.

(b) (1) After the DAB renders a decision in a CMP case, pending judicial review, the respondent may file a request for stay of the effective date of any penalty or assessment with the ALJ. The request must be accompanied by a copy of the notice of appeal filed with the Federal court. The filing of such a request will automatically act to stay the effective date of the penalty or assessment until such time as the ALJ rules upon the request.

(2) The ALJ may not grant a respondent’s request for stay of any penalty or assessment unless the respondent posts a bond or provides other adequate security.

(3) The ALJ will rule upon a respondent’s request for stay within 10 days of receipt.

§ 1005.23 Harmless error.

No error in either the admission or the exclusion of evidence, and no error or defect in any ruling or order or in any act done or omitted by the ALJ or by any of the parties, including Federal representatives such as Medicare carriers and intermediaries and Quality Improvement Organizations, is ground for vacating, modifying or otherwise disturbing an otherwise appropriate ruling or order or act, unless refusal to take such action appears to the ALJ or the DAB inconsistent with substantial justice. The ALJ and the DAB at every stage of the proceeding will disregard any error or defect in the proceeding that does not affect the substantial rights of the parties.
§ 1006.2 Contents of subpoena.

A subpoena issued under this part will—

(a) State the name of the individual or entity to whom the subpoena is addressed;

(b) State the statutory authority for the subpoena;

(c) Indicate the date, time and place that the investigational inquiry at which the witness is to testify will take place;

(d) Include a reasonably specific description of any documents or items required to be produced; and

(e) If the subpoena is addressed to an entity, describe with reasonable particularity the subject matter on which testimony is required. In such event, the named entity will designate one or more individuals who will testify on its behalf, and will state as to each individual so designated that individual’s name and address and the matters on which he or she will testify. The individual so designated will testify as to matters known or reasonably available to the entity.

§ 1006.3 Service and fees.

(a) A subpoena under this part will be served by—

(1) Delivering a copy to the individual named in the subpoena;

(2) Delivering a copy to the entity named in the subpoena at its last principal place of business; or

(3) Registered or certified mail addressed to such individual or entity at its last known dwelling place or principal place of business.

(b) A verified return by the individual serving the subpoena setting forth the manner of service or, in the case of service by registered or certified mail, the signed return post office receipt, will be proof of service.

(c) Witnesses will be entitled to the same fees and mileage as witnesses in the district courts of the United States (28 U.S.C. 1821 and 1825). Such fees need not be paid at the time the subpoena is served.

§ 1006.4 Procedures for investigational inquiries.

(a) Testimony at investigational inquiries will be taken under oath or affirmation.

(b) Investigational inquiries are non-public investigatory proceedings. Attendance of non-witnesses is within the discretion of the OIG, except that—

(1) A witness is entitled to be accompanied, represented and advised by an attorney; and

(2) Representatives of the OIG are entitled to attend and ask questions.

(c) A witness will have an opportunity to clarify his or her answers on the record following the questions by the OIG.

(d) Any claim of privilege must be asserted by the witness on the record.

(e) Objections must be asserted on the record. Errors of any kind that might be corrected if promptly presented will be deemed to be waived unless reasonable objection is made at the investigational inquiry. Except where the objection is on the grounds of privilege, the question will be answered on the record, subject to the objection.

(f) If a witness refuses to answer any question not privileged or to produce requested documents or items, or engages in conduct likely to delay or obstruct the investigational inquiry, the OIG may seek enforcement of the subpoena under § 1006.5.

(g)(1) The proceedings will be recorded and transcribed.

(ii) Where the witness will be provided a copy of the transcript, the transcript will be submitted to the OIG for signature. The OIG may submit to the OIG written proposed corrections to the transcript, with such corrections attached to the transcript. If the witness does not return a signed copy of the transcript or proposed corrections within 30 days of its being submitted to him or her for signature, the witness will be deemed to have agreed
that the transcript is true and accurate.

(iii) Where, as provided in paragraph (g)(2) of this section, the witness is limited to inspecting the transcript, the witness will have the opportunity at the time of inspection to propose corrections to the transcript, with corrections attached to the transcript. The witness will also have the opportunity to sign the transcript. If the witness does not sign the transcript or offer corrections within 30 days of receipt of notice of the opportunity to inspect the transcript, the witness will be deemed to have agreed that the transcript is true and accurate.

(iv) The OIG’s proposed corrections the record of transcript will be attached to the transcript.

(b) Testimony and other evidence obtained in an investigational inquiry may be used by the OIG or DHHS in any of its activities, and may be used or offered into evidence in any administrative or judicial proceeding.

[57 FR 3354, Jan. 29, 1992, as amended at 65 FR 24419, Apr. 26, 2000]

§ 1006.5 Enforcement of a subpoena.

A subpoena to appear at an investigational inquiry is enforceable through the District Court of the United States and the district where the subpoenaed person is found, resides or transacts business.

PART 1007—STATE MEDICAID FRAUD CONTROL UNITS

Sec. 1007.1 Definitions.
1007.3 Scope and purpose.
1007.5 Basic requirement.
1007.7 Organization and location requirements.
1007.9 Relationship to, and agreement with, the Medicaid agency.
1007.11 Duties and responsibilities of the unit.
1007.13 Staffing requirements.
1007.15 Applications, certification and recertification.
1007.17 Annual report.
1007.19 Federal financial participation (FFP).
1007.20 Circumstances in which data mining is permissible and approval by HHS Office of Inspector General.
1007.21 Other applicable HHS regulations.

AUTHORITY: 42 U.S.C. 1396b(a)(6), 1396b(b)(3), 1396b(q), and 1302.

SOURCE: 57 FR 3355, Jan. 29, 1992, unless otherwise noted.

§ 1007.1 Definitions.

As used in this part, unless otherwise indicated by the context:

Data mining is defined as the practice of electronically sorting Medicaid or other relevant data, including but not limited to the use of statistical models and intelligent technologies, to uncover patterns and relationships within that data to identify aberrant utilization, billing, or other practices that are potentially fraudulent.

Employ or employee, as the context requires, means full-time duty intended to last at least a year. It includes an arrangement whereby an individual is on full-time detail or assignment to the unit from another government agency, if the detail or assignment is for a period of at least 1 year and involves supervision by the unit.

Provider means an individual or entity that furnishes items or services for which payment is claimed under Medicaid.

Unit means the State Medicaid fraud control unit.

[57 FR 3355, Jan. 29, 1992, as amended at 78 FR 29061, May 17, 2013]

§ 1007.3 Scope and purpose.

This part implements sections 1903(a)(6), 1903(b)(3), and 1903(q) of the Social Security Act, as amended by the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Pub. L. 95–142). The statute authorizes the Secretary to pay a State 90 percent of the costs of establishing and operating a State Medicaid fraud control unit, as defined by the statute, for the purpose of eliminating fraud in the State Medicaid program.

§ 1007.5 Basic requirement.

A State Medicaid fraud control unit must be a single identifiable entity of the State government certified by the Secretary as meeting the requirements of §§1007.7 through 1007.13 of this part.
§ 1007.7 Organization and location requirements.

Any of the following three alternatives is acceptable:

(a) The unit is located in the office of the State Attorney General or another department of State government which has Statewide authority to prosecute individuals for violations of criminal laws with respect to fraud in the provision or administration of medical assistance under a State plan implementing title XIX of the Act;

(b) If there is no State agency with Statewide authority and capability for criminal fraud prosecutions, the unit has established formal procedures that assure that the unit refers suspected cases of criminal fraud in the State Medicaid program to the appropriate State prosecuting authority or authorities, and provides assistance and coordination to such authority or authorities in the prosecution of such cases; or

(c) The unit has a formal working relationship with the office of the State Attorney General and has formal procedures for referring to the Attorney General suspected criminal violations occurring in the State Medicaid program and for effective coordination of the activities of both entities relating to the detection, investigation and prosecution of those violations. Under this requirement, the office of the State Attorney General must agree to assume responsibility for prosecuting alleged violation referred to it by the unit. However, if the Attorney General finds that another prosecuting authority has the demonstrated capacity, experience and willingness to prosecute an alleged violation, he or she may refer a case to that prosecuting authority, as long as the Attorney General’s Office maintains oversight responsibility for the prosecution and for coordination between the unit and the prosecuting authority.

§ 1007.9 Relationship to, and agreement with, the Medicaid agency.

(a) The unit must be separate and distinct from the Medicaid agency.

(b) No official of the Medicaid agency will have authority to review the activities of the unit or to overrule the referral of a suspected criminal violation to an appropriate prosecuting authority.

(c) The unit will not receive funds paid under this part either from or through the Medicaid agency.

(d) The unit will enter into an agreement with the Medicaid agency under which the Medicaid agency will agree to comply with all requirements of §455.21(a)(2) of this title.

(e)(1) The unit may refer any provider with respect to which there is pending an investigation of a credible allegation of fraud under the Medicaid program to the State Medicaid agency for payment suspension in whole or part under §455.23 of this title.

(2) Referrals may be brief, but must be in writing and include sufficient information to allow the State Medicaid agency to identify the provider and to explain the credible allegations forming the grounds for the payment suspension.

(f) Any request by the unit to the State Medicaid agency to delay notification to the provider of a payment suspension under §455.23 of this title must be in writing.

(g) When the unit accepts or declines a case referred by the State Medicaid agency, the unit notifies the State Medicaid agency in writing of the acceptance or declination of the case.


§ 1007.11 Duties and responsibilities of the unit.

(a) The unit will conduct a Statewide program for investigating and prosecuting (or referring for prosecution) violations of all applicable State laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the State Medicaid plan.

(b) (1) The unit will also review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan and may review complaints of the misappropriation of patient’s private funds in such facilities.

(2) If the initial review indicates substantial potential for criminal prosecution, the unit will investigate the complaint or refer it to an appropriate
Office of Inspector General—Health Care, HHS § 1007.15

(3) If the initial review does not indicate a substantial potential for criminal prosecution, the unit will refer the complaint to an appropriate State agency.

(c) If the unit, in carrying out its duties and responsibilities under paragraphs (a) and (b) of this section, discovers that overpayments have been made to a health care facility or other provider of medical assistance under the State Medicaid plan, the unit will either attempt to collect such overpayment or refer the matter to an appropriate State agency for collection.

(d) Where a prosecuting authority other than the unit is to assume responsibility for the prosecution of a case investigated by the unit, the unit will ensure that those responsible for the prosecutive decision and the preparation of the case for trial have the fullest possible opportunity to participate in the investigation from its inception and will provide all necessary assistance to the prosecuting authority throughout all resulting prosecutions.

(e) The unit will make available to Federal investigators or prosecutors all information in its possession concerning fraud in the provision or administration of medical assistance under the State plan and will cooperate with such officials in coordinating any Federal and State investigations or prosecutions involving the same suspects or allegations.

(f) The unit will safeguard the privacy rights of all individuals and will provide safeguards to prevent the misuse of information under the unit’s control.

§ 1007.15 Applications, certification and recertification.

(a) Initial application. In order to receive FFP under this part, the unit must submit to the Secretary, an application approved by the Governor, containing the following information and documentation—

(1) A description of the applicant’s organization, structure, and location within State government, and an indication of whether it seeks certification under §1007.7 (a), (b), or (c);

(2) A statement from the State Attorney General that the applicant has authority to carry out the functions and responsibilities set forth in this part. If the applicant seeks certification under §1007.7(b), the statement must also specify either that—

(i) There is no State agency with the authority to exercise Statewide prosecuting authority for the violations with which the unit is concerned, or

(ii) Although the State Attorney General may have common law authority for Statewide criminal prosecutions, he or she has not exercised that authority;

(3) A copy of whatever memorandum of agreement, regulation, or other document sets forth the formal procedures required under §1007.7(b), or the formal working relationship and procedures required under §1007.7(c);

(4) A copy of the agreement with the Medicaid agency required under §1007.9;

(5) A statement of the procedures to be followed in carrying out the functions and responsibilities of this part;

(2) One or more experienced auditors capable of supervising the review of financial records and advising or assisting in the investigation of alleged fraud; and

(3) A senior investigator with substantial experience in commercial or financial investigations who is capable of supervising and directing the investigative activities of the unit.
§ 1007.17  

(6) A projection of the caseload and a proposed budget for the 12-month period for which certification is sought; and

(7) Current and projected staffing, including the names, education, and experience of all senior professional staff already employed and job descriptions, with minimum qualifications, for all professional positions.

(b) Conditions for, and notification of certification. (1) The Secretary will approve an application only if he or she has specifically approved the applicant’s formal procedures under § 1007.7 (b) or (c), if either of those provisions is applicable, and has specifically certified that the applicant meets the requirements of § 1007.7;

(2) The Secretary will promptly notify the applicant whether the application meets the requirements of this part and is approved. If the application is not approved, the applicant may submit an amended application at any time. Approval and certification will be for a period of 1 year.

(c) Conditions for recertification. In order to continue receiving payments under this part, a unit must submit a reapplication to the Secretary at least 60 days prior to the expiration of the 12-month certification period. A reapplication must—

(1) Advise the Secretary of any changes in the information or documentation required under paragraphs (a) (1) through (5) of this section;

(2) Provide projected caseload and proposed budget for the recertification period; and

(3) Include or reference the annual report required under § 1007.17.

(d) Basis for recertification. (1) The Secretary will consider the unit’s reapplication, the reports required under § 1007.17, and any other reviews or information he or she deems necessary or warranted, and will promptly notify the unit whether he or she has approved the reapplication and recertified the unit.

(2) In reviewing the reapplication, the Secretary will give special attention to whether the unit has used its resources effectively in investigating cases of possible fraud, in preparing cases for prosecution, and in prosecuting cases or cooperating with the prosecuting authorities.

(Approved by the Office of Management and Budget under control number 0990-0162)

§ 1007.17  Annual report.

At least 60 days prior to the expiration of the certification period, the unit will submit to the Secretary a report covering the last 12 months (the first 9 months of the certification period for the first annual report), and containing the following information—

(a) The number of investigations initiated and the number of complaints re- closed, categorized by type of provider;

(b) The number of cases prosecuted or referred for prosecution; the number of cases finally resolved and their outcomes; and the number of cases investigated but not prosecuted or referred for prosecution because of insufficient evidence;

(c) The number of complaints received regarding abuse and neglect of patients in health care facilities; the number of such complaints investigated by the unit; and the number referred to other identified State agencies;

(d) The number of recovery actions initiated by the unit; the number of recovery actions referred to another agency; the total amount of overpayments identified by the unit; and the total amount of overpayments actually collected by the unit;

(e) The number of recovery actions initiated by the Medicaid agency under its agreement with the unit, and the total amount of overpayments actually collected by the Medicaid agency under this agreement;

(f) Projections for the succeeding 12 months for items listed in paragraphs (a) through (e) of this section;

(g) The costs incurred by the unit; and

(h) A narrative that evaluates the unit’s performance; describes any specific problems it has had in connection with the procedures and agreements required under this part; and discusses any other matters that have impaired its effectiveness.

(i) For those MFCUs approved to conduct data mining under §1007.20, all costs expended that year by the MFCU attributed to data mining activities;
§ 1007.20 Circumstances in which data mining is permissible and approval by HHS Office of Inspector General.

(a) Notwithstanding §1007.19(e)(2), a MFCU may engage in data mining as defined in this part and receive Federal financial participation only under the following conditions:

(1) The MFCU identifies the methods of coordination between the MFCU and State Medicaid agency, the individuals serving as primary points of contact for data mining, as well as the contact information, title, and office of such individuals;

(B) Continue as full-time employees after the unit is certified.

(ii) All establishment costs will be deemed made in the first quarter of certification.

(e) Costs not subject to FFP. FFP is not available under this part for expenditures attributable to—

1. The investigation of cases involving program abuse or other failures to comply with applicable laws and regulations, if these cases do not involve substantial allegations or other indications of fraud;

2. Routine verification with beneficiaries of whether services billed by providers were actually received, or, except as provided in §1007.20, efforts to identify situations in which a question of fraud may exist, including the screening of claims and analysis of patterns of practice that involve data mining as defined in §1007.1;

3. The routine notification of providers that fraudulent claims may be punished under Federal or State law;

4. The performance by a person other than a full-time employee of the unit of any management function for the unit, any audit or investigation, any professional legal function, or any criminal, civil or administrative prosecution of suspected providers;

5. The investigation or prosecution of cases of suspected beneficiary fraud not involving suspected conspiracy with a provider; or

6. Any payment, direct or indirect, from the unit to the Medicaid agency, other than payments for the salaries of employees on detail to the unit.

§ 1007.19 Federal financial participation (FFP).

(a) Rate of FFP. Subject to the limitation of this section, the Secretary will reimburse each State by an amount equal to 90 percent of the costs incurred by a certified unit which are attributable to carrying out its functions and responsibilities under this part.

(b) Retroactive certification. The Secretary may grant certification retroactive to the date on which the unit first met all the requirements of the statute and of this part. For any quarter with respect to which the unit is certified, the Secretary will provide reimbursement for the entire quarter.

(c) Amount of FFP. FFP for any quarter will not exceed the higher of $125,000 or one-quarter of 1 percent of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State Medicaid program.

(d) Costs subject to FFP. (1) FFP is available under this part for the expenditures attributable to the establishment and operation of the unit, including the cost of training personnel employed by the unit. Reimbursement will be limited to costs attributable to the specific responsibilities and functions set forth in this part in connection with the investigation and prosecution of suspected fraudulent activities and the review of complaints of alleged abuse or neglect of patients in health care facilities.

(2) (i) Establishment costs are limited to clearly identifiable costs of personnel that—

(A) Devote full time to the establishment of the unit which does achieve certification; and
(2) MFCU employees engaged in data mining receive specialized training in data mining techniques;

(3) The MFCU describes how it will comply with paragraphs (a)(1) and (2) of this section as part of the agreement required by §1007.9(d); and

(4) The Office of Inspector General, Department of Health and Human Services, in consultation with the Centers for Medicare & Medicaid Services, approves in advance the provisions of the agreement as defined in paragraph (a)(3) of this section.

   (i) OIG will act on a request from a MFCU for review and approval of the agreement within 90 days after receipt of a written request or the request shall be considered approved if OIG fails to respond within 90 days after receipt of the written request.

   (ii) If OIG requests additional information in writing, the 90-day period for OIG action on the request begins on the day OIG receives the information from the MFCU.

   (iii) The approval is for 3 years.

   (iv) A MFCU may request renewal of its data mining approval for additional 3-year periods by submitting a written request for renewal to OIG, along with an updated agreement with the State Medicaid agency.

(b) [Reserved]

[78 FR 29061, May 17, 2013]

§ 1007.21 Other applicable HHS regulations.

Except as otherwise provided in this part, the following regulations from 45 CFR subtitle A apply to grants under this part:

Part 16, subpart C—Department Grant Appeals Process—Special Provisions Applicable to Reconsideration of Disallowances [Note that this applies only to disallowance determinations and not to any other determinations, e.g., over certification or recertification];

Part 75—Informal Grant Appeals Procedures;

Part 80—Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services, Effectuation of title VI of the Civil Rights Act of 1964;
Subpart A—General Provisions

§ 1008.1 Basis and purpose.

(a) This part contains the specific procedures for the submission of requests by an individual or entity for advisory opinions to, and the issuance of advisory opinions by, the OIG, in consultation with the Department of Justice (DoJ), in accordance with section 1128D(b) of the Social Security Act (Act), 42 U.S.C. 1320a-7d(b). The OIG will issue such advisory opinions based on actual or proposed factual circumstances submitted by the requesting individual or entity, or by counsel on behalf of the requesting individual or entity, provided all other requirements of this part are satisfied (including the requirement that the requesting individual or entity provide the certifications required in accordance with §1008.38 of this part).

(b) An individual or entity may request an advisory opinion from the OIG regarding any of five specific subject matters described in §1008.5 of this part.

(c) The requesting party must provide a complete description of the facts as set forth in subpart B of this part, and pay the costs to the OIG of processing the request for an advisory opinion as set forth in subpart C of this part.

(d) Nothing in this part limits the investigatory or prosecutorial authority of the OIG, DoJ or any other agency of the Government.


§ 1008.3 Effective period.

The provisions in this part are applicable to requests for advisory opinions submitted on or after February 21, 1997, and before August 21, 2000, and to any requests submitted during any other time period for which the OIG is required by law to issue advisory opinions.

§ 1008.5 Matters subject to advisory opinions.

(a) An individual or entity may request an advisory opinion from the OIG regarding—

(1) What constitutes prohibited remuneration within the meaning of section 1128B(b) of the Act;

(2) Whether an arrangement, or proposed arrangement, satisfies the criteria set forth in section 1128B(b)(3) of the Act for activities that do not result in prohibited remuneration;

(3) Whether an arrangement, or proposed arrangement, satisfies the criteria set forth in §1001.952 of this chapter for activities that do not result in prohibited remuneration;

(4) What constitutes an inducement to reduce or limit services under section 1128A(b) of the Act to Medicare or Medicaid program beneficiaries; and

(5) Whether any activity, or proposed activity, constitutes grounds for the imposition of a sanction under sections 1128, 1128A or 1128B of the Act.

(b) Exceptions. The OIG will not address through the advisory opinion process—

(1) What the fair market value will be, or whether fair market value was paid or received, for any goods, services or property; or

(2) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.


Subpart B—Preliminary Obligations and Responsibilities of the Requesting Party

§ 1008.11 Who may submit a request.

Any individual or entity may submit a request to the OIG for an advisory opinion regarding an existing arrangement or one which the requestor in good faith specifically plans to undertake. The requestor must be a party to the arrangement, or proposed arrangement, that is the subject of the request.
§ 1008.15 Facts subject to advisory opinions.

(a) The OIG will consider requests from a requesting party for advisory opinions regarding the application of specific facts to the subject matters set forth in §1008.5(a) of this part. The facts must relate to an existing arrangement, or one which the requestor in good faith plans to undertake. The plans may be contingent upon receiving a favorable advisory opinion. The advisory opinion request should contain a complete description of the arrangement that the requestor is undertaking, or plans to undertake.

(b) Requests presenting a general question of interpretation, posing a hypothetical situation, or regarding the activities of third parties do not qualify as advisory opinion requests.

(c) Advisory opinion request will not be accepted, and/or opinions will not be issued when—

1. The request is not related to a named individual or entity;
2. The same, or substantially the same, course of action is under investigation, or is or has been the subject of a proceeding involving the Department of Health and Human Services or another governmental agency; or
3. An informed opinion cannot be made, or could be made only after extensive investigation, clinical study, testing, or collateral inquiry.


Subpart C—Advisory Opinion Fees

§ 1008.31 OIG fees for the cost of advisory opinions.

(a) Responsibility for fees. The requestor is responsible for paying a fee equal to the costs incurred by the Department in responding to the request for an advisory opinion.

(b) Payment Method. Payment for a request for an advisory opinion must be made to the Treasury of the United States, as directed by OIG.

(c) Calculation of costs: Prior to the issuance of the advisory opinion, the OIG will calculate the costs incurred by the Department in responding to the request. The calculation will include the costs of salaries and benefits payable to attorneys and others who have worked on the request in question, as well as administrative and supervisory support for such person. The OIG has the exclusive authority to determine the cost of responding to a request for an advisory opinion and such determination is not reviewable or waiveable.

(d) Agreement to pay all costs. (1) By submitting the request for an advisory opinion, the requestor agrees, except as indicated in paragraph (d)(4) of this section, to pay all costs incurred by the OIG in responding to the request for an advisory opinion.

2. In its request for an advisory opinion, the requestor may request a written estimate of the cost involved in processing the advisory opinion. Within 10 business days of receipt of the request, the OIG will notify in writing of such estimate. Such estimate will not be binding on the Department, and the actual cost to be paid may be higher or lower than estimated. The time period for issuing the advisory opinion will be tolled from the time the OIG notifies the requestor of the estimate until the OIG receives written confirmation from the requestor that the requestor wants the
Office of Inspector General—Health Care, HHS

§ 1008.36 Submission of a request.

(a) A request for a formal advisory opinion must be submitted in writing. An original and 2 copies of the request should be addressed to the headquarter offices of the OIG.

(b) Each request for an advisory opinion must include—

(1) To the extent known to the requestor, the identities, including the names and addresses, of the requestor required fees for expert opinions, if any, from outside sources, as described in §1008.33.

(2) If the OIG determines that it is necessary to obtain expert advice to issue a requested advisory opinion, the OIG will notify the requestor of that fact and provide the identity of the appropriate expert and an estimate of the costs of the expert advice.


§ 1008.33 Expert opinions from outside sources.

(a) The OIG may request expert advice from qualified sources on non-legal issues if necessary to respond to the advisory opinion request. For example, the OIG may require the use of appropriate medical reviewers, such as quality improvement organizations, to obtain medical opinions on specific issues.

(b) The time period for issuing an advisory opinion will be tolled from the time that the OIG notifies the requestor of the need for an outside expert opinion until the time the OIG receives the necessary expert opinion.

(c) Once payment is made for the cost of the expert opinion, as set forth in §1008.31(e) of this part, either directly to the expert or otherwise, the OIG will arrange for a prompt expert review of the issue or issues in question. Regardless of the manner of payment, the expert’s work and opinion will be subject to the sole direction of the OIG.


Subpart D—Submission of a Formal Request for an Advisory Opinion

§ 1008.36 Submission of a request.

(a) A request for a formal advisory opinion must be submitted in writing. An original and 2 copies of the request should be addressed to the headquarter offices of the OIG.

(b) Each request for an advisory opinion must include—

(1) To the extent known to the requestor, the identities, including the names and addresses, of the requestor required fees for expert opinions, if any, from outside sources, as described in §1008.33.

(2) If the OIG determines that it is necessary to obtain expert advice to issue a requested advisory opinion, the OIG will notify the requestor of that fact and provide the identity of the appropriate expert and an estimate of the costs of the expert advice.

§ 1008.37 Disclosure of ownership and related information.

Each individual or entity requesting an advisory opinion must supply full and complete information as to the identity of each entity owned or controlled by the individual or entity, and of each person with an ownership or control interest in the entity, as defined in section 1124(a)(1) of the Social Security Act (42 U.S.C. 1320a–3(a)(1)) and part 420 of this chapter.

(Approved by the Office of Management and Budget under control number 0990–0213)

§ 1008.38 Signed certifications by the requestor.

(a) Every request must include the following signed certification from all requestors: "With knowledge of the penalties for false statements provided by 18 U.S.C. 1001 and with knowledge that this request for an advisory opinion is being submitted to the Department of Health and Human Services, I certify that all of the information provided is true and correct, and constitutes a complete description of the facts regarding which an advisory opinion is sought, to the best of my knowledge and belief."

(b) If the advisory opinion relates to a proposed arrangement, the request must also include the following signed certification from all requestors: "The arrangement described in this request for an advisory opinion is one that [the requestor(s)] in good faith plan(s) to undertake. This statement may be made contingent on a favorable OIG advisory opinion, in which case, the phrase "if the OIG issues a favorable advisory opinion" should be added to the certification.

(c) The certification(s) must be signed by—

(1) The requestor, if the requestor is an individual;

(2) The name, title, address, and daytime telephone number of a contact person who will be available to discuss the request for an advisory opinion with the OIG on behalf of the requestor;

(3) A declaration of the subject category or categories as described in §1008.5 of this part for which the advisory opinion is requested. To the extent an individual or entity requests an advisory opinion in accordance with §1008.5(a)(3) or (a)(5) of this part, the requesting individual or entity should identify the specific subsections of sections 1128, 1128A or 1128B of the Act or the specific provision of §1001.952 of this chapter about which an advisory opinion is sought;

(4) A complete and specific description of all relevant information bearing on the arrangement for which an advisory opinion is requested and on the circumstances of the conduct, including—

(i) Background information,

(ii) For existing arrangements, complete copies of all operative documents,

(iii) For proposed arrangements, complete copies of all operative documents, if possible, and otherwise descriptions of proposed terms, drafts, or models of documents sufficient to permit the OIG to render an informed opinion,

(iv) Detailed statements of all collateral or oral understandings, if any, and

(v) If applicable, a designation of trade secrets or confidential commercial or financial information in the manner described in 45 CFR 5.65;

(5) Signed certifications by the requestor(s), as described in §1008.37 of this part;

(6) A declaration regarding whether an advisory opinion in accordance with part 411 of this title has been or will be requested from CMS about the arrangement that is the subject of the advisory opinion request; and

1 The requestor is under an affirmative obligation to make full and true disclosure with respect to the facts regarding the advisory opinion being requested.
Subpart D—Process for Requesting an Advisory Opinion

§ 1008.39 Additional information.

(a) If the request for an advisory opinion does not contain all of the information required by §1008.36 of this part, or the OIG believes it needs more information prior to rendering an advisory opinion, the OIG may, at any time, request whatever additional information or documents it deems necessary. The time period for the issuance of an advisory opinion will be tolled from the time the OIG requests the additional information from the requestor until such time as the OIG determines that it has received the requested information.

(b) The OIG may request additional information before or after the request for an advisory opinion has been accepted.

(c) Additional information should be provided in writing and certified to be a true, correct and complete disclosure of the requested information in a manner equivalent to that described in §1008.36 of this part.

(d) In connection with any request for an advisory opinion, the OIG or DoJ may conduct whatever independent investigation they believe appropriate.

(e) Requesting parties are required to notify the OIG if they request an advisory opinion in accordance with part 411 of this title from CMS about the arrangement that is the subject of their advisory opinion request.

(f) Where appropriate, after receipt of an advisory opinion request, the OIG may consult with the requesting parties to the extent the OIG deems necessary.

§ 1008.40 Withdrawal.

The requestor of an advisory opinion may withdraw the request prior to the issuance of a formal advisory opinion by the OIG. The withdrawal must be written and must be submitted to the same address as the submitted request, as indicated in §§1008.18(b) and 1008.36(a) of this part. Regardless of whether the request is withdrawn, the requestor must pay the costs expended by the OIG in processing the opinion, as discussed in §1008.31(d) of this part. The OIG reserves the right to retain any request for an advisory opinion, documents and information submitted to it under these procedures, and to use them for any governmental purposes.

Subpart E—Obligations and Responsibilities of the OIG

§ 1008.41 OIG acceptance of the request.

(a) Upon receipt of a request for an advisory opinion, the OIG will promptly make an initial determination whether the submission includes all of the information the OIG will require to process the request.

(b) Within 10 working days of receipt of the request, the OIG will—

(1) Formally accept the request for an advisory opinion,

(2) Notify the requestor of what additional information is needed, or

(3) Formally decline to accept the request.

(c) If the requestor provides the additional information requested, or otherwise resubmits the request, the OIG will process the resubmission in accordance with paragraphs (a) and (b) of this section as if it was an initial request for an advisory opinion.

(d) Upon acceptance of the request, the OIG will notify the requestor by regular U.S. mail of the date that the request for the advisory opinion was formally accepted.

(e) The 60-day period for issuance of an advisory opinion set forth in §1008.43(c) of this part will not commence until the OIG has formally accepted the request for an advisory opinion.

§ 1008.43 Issuance of a formal advisory opinion.

(a) An advisory opinion will be considered issued once payment is received and it is dated, numbered, and signed by an authorized official of the OIG.

(b) An advisory opinion will contain a description of the material facts provided to the OIG with regard to the arrangement for which an advisory opinion has been requested. The advisory opinion will state the OIG’s opinion regarding the subject matter of the request based on the facts provided to the OIG. If necessary, to fully describe the arrangement, the OIG is authorized to include in the advisory opinion the material facts of the arrangement, notwithstanding that some of these facts could be considered confidential information or trade secrets within the meaning of 18 U.S.C. 1905.

(c)(1) The OIG will issue an advisory opinion, in accordance with the provisions of this part, within 60 days after the request for an advisory opinion has been formally accepted:
   (2) If the 60th day falls on a Saturday, Sunday, or Federal holiday, the time period will end at the close of the next business day following the weekend or holiday;
   (3) The 60 day period will be tolled from the time the OIG—
      (i) Notifies the requestor that the costs have reached, or are likely to exceed, the triggering amount until the time when the OIG receives written notice from the requestor to continue processing the request;
      (ii) Requests additional information from the requestor until the time the OIG receives the requested information;
      (iii) Notifies the requestor of the full amount due until the time the OIG receives payment of the full amount owed; and
      (iv) Notifies the requestor of the need for expert advice until the time the OIG receives the expert advice.
   (d) After OIG has notified the requestor of the full amount owed and OIG has determined that the full payment of that amount has been properly paid by the requestor, OIG will issue the advisory opinion and promptly mail it to the requestor by regular first class U.S. mail.


§ 1008.45 Rescission, termination or modification.

(a) Any advisory opinion given by the OIG is without prejudice to the right of the OIG to reconsider the questions involved and, where the public interest requires, to rescind, terminate or modify the advisory opinion. Requestors will be given a preliminary notice of the OIG’s intent to rescind, terminate or modify the opinion, and will be provided a reasonable opportunity to respond. A final notice of rescission, termination or modification will be given to the requestor so that the individual or entity may discontinue or modify, as the case may be, the course of action taken in accordance with the OIG advisory opinion.

(b) For purposes of this part—
   (1) To rescind an advisory opinion means that the advisory opinion is revoked retroactively to the original date of issuance with the result that the advisory opinion will be deemed to have been without force and effect from the original date of issuance. Recission may occur only where relevant and material facts were not fully, completely and accurately disclosed to the OIG.
   (2) To terminate an advisory opinion means that the advisory opinion is revoked as of the termination date and is no longer in force and effect after the termination date. The OIG will not proceed against the requestor under this part if such action was promptly, diligently, and in good faith discontinued in accordance with reasonable time frames established by the OIG after consultation with the requestor.
   (3) To modify an advisory opinion means that the advisory opinion is amended, altered, or limited, and that the advisory opinion continues in full force and effect in modified form thereafter. The OIG will not proceed against the requestor under this part if such action was promptly, diligently, and in good faith modified in accordance with reasonable time frames established by...
§ 1008.47 Disclosure.
(a) Advisory opinions issued and released in accordance with the provisions set forth in this part will be available to the public.
(b) Promptly after the issuance and release of an advisory opinion to the requestor, a copy of the advisory opinion will be available for public inspection between the hours of 10:00 a.m. and 3:00 p.m. on normal business days at the headquarter offices of the OIG and on the DHHS/OIG web site.
(c) Any pre-decisional document, or part of such pre-decisional document, that is prepared by the OIG, DoJ, or any other Department or agency of the United States in connection with an advisory opinion request under the procedures set forth in this part generally will be exempt from disclosure under 5 U.S.C. 552, and will not be made publicly available.
(d) Documents submitted by the requestor to the OIG in connection with a request for an advisory opinion may be available to the public in accordance with 5 U.S.C. 552 through procedures set forth in 45 CFR part 5.
(e) Nothing in this section will limit the OIG’s right, in its discretion, to issue a press release or otherwise publicly disclose the identity of the requesting party or parties, and the nature of the action taken by the OIG upon the request.

Subpart F—Scope and Effect of OIG Advisory Opinions

§ 1008.51 Exclusivity of OIG advisory opinions.
The only method for obtaining a binding advisory opinion regarding any of the subject matters set forth in §1008.5(a) is through the procedures described in this part. No binding advisory opinion, oral or written, has or may be issued by the OIG regarding the specific matters set forth in §1008.5(a) except through written opinions issued in accordance with this part.

§ 1008.53 Affected parties.
An advisory opinion issued by the OIG will have no application to any individual or entity that does not join in the request for the opinion. No individual or entity other than the requestor(s) may rely on an advisory opinion.

§ 1008.55 Admissibility of evidence.
(a) The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A or 1128B of the Act.
(b) An advisory opinion may not be introduced into evidence by a person or entity that was not the requestor of the advisory opinion to prove that the person or entity did not violate the provisions of sections 1128, 1128A or 1128B of the Act or any other law.

§ 1008.59 Range of the advisory opinion.
(a) An advisory opinion will state only the OIG’s opinion regarding the subject matter of the request. If the arrangement for which an advisory opinion is requested is subject to approval or regulation by any other Federal, State or local government agency, such advisory opinion may not be taken to indicate the OIG’s views on the legal or factual issues that may be raised before that agency. The OIG will not provide any legal opinion on questions or issues regarding an authority which is vested in other Federal, State or local government agencies.
(b) An advisory opinion issued under this part will not bind or obligate any agency other than the Department. It will not affect the requestor’s, or anyone else’s, obligations to any other agency, or under any statutory or regulatory provision other than that which is the specific subject matter of the advisory opinion.

A list of CFR titles, subtitles, chapters, subchapters and parts and an alphabetical list of agencies publishing in the CFR are included in the CFR Index and Finding Aids volume to the Code of Federal Regulations which is published separately and revised annually.

Table of CFR Titles and Chapters
Alphabetical List of Agencies Appearing in the CFR
List of CFR Sections Affected
Table of CFR Titles and Chapters
(Revised as of October 1, 2016)

Title 1—General Provisions

I Administrative Committee of the Federal Register (Parts 1—49)
II Office of the Federal Register (Parts 50—299)
III Administrative Conference of the United States (Parts 300—399)
IV Miscellaneous Agencies (Parts 400—500)

Title 2—Grants and Agreements

SUBTITLE A—OFFICE OF MANAGEMENT AND BUDGET GUIDANCE FOR
GRANTS AND AGREEMENTS
I Office of Management and Budget Governmentwide Guidance for
Grants and Agreements (Parts 2—199)
II Office of Management and Budget Guidance (Parts 200—299)

SUBTITLE B—FEDERAL AGENCY REGULATIONS FOR GRANTS AND
AGREEMENTS
III Department of Health and Human Services (Parts 300—399)
IV Department of Agriculture (Parts 400—499)
VI Department of State (Parts 600—699)
VII Agency for International Development (Parts 700—799)
VIII Department of Veterans Affairs (Parts 800—899)
IX Department of Energy (Parts 900—999)
X Department of the Treasury (Parts 1000—1099)
XI Department of Defense (Parts 1100—1199)
XII Department of Transportation (Parts 1200—1299)
XIII Department of Commerce (Parts 1300—1399)
XIV Department of the Interior (Parts 1400—1499)
XV Environmental Protection Agency (Parts 1500—1599)
XVIII National Aeronautics and Space Administration (Parts 1800—
1899)
XX United States Nuclear Regulatory Commission (Parts 2000—2099)
XXII Corporation for National and Community Service (Parts 2200—
2299)
XXIII Social Security Administration (Parts 2300—2399)
XXIV Housing and Urban Development (Parts 2400—2499)
XXV National Science Foundation (Parts 2500—2599)
XXVI National Archives and Records Administration (Parts 2600—2699)
XXVII Small Business Administration (Parts 2700—2799)

975
Title 2—Grants and Agreements—Continued

XXVIII Department of Justice (Parts 2800—2899)

XXIX Department of Labor (Parts 2900—2999)

XXX Department of Homeland Security (Parts 3000—3099)

XXXI Institute of Museum and Library Services (Parts 3100—3199)

XXXII National Endowment for the Arts (Parts 3200—3299)

XXXIII National Endowment for the Humanities (Parts 3300—3399)

XXXIV Department of Education (Parts 3400—3499)

XXXV Export-Import Bank of the United States (Parts 3500—3599)

XXXVI Office of National Drug Control Policy, Executive Office of the President (Parts 3600—3699)

XXXVII Peace Corps (Parts 3700—3799)

LVIII Election Assistance Commission (Parts 5800—5899)

LIX Gulf Coast Ecosystem Restoration Council (Parts 5900—5999)

Title 3—The President

I Executive Office of the President (Parts 100—199)

Title 4—Accounts

I Government Accountability Office (Parts 1—199)

Title 5—Administrative Personnel

I Office of Personnel Management (Parts 1—1199)

II Merit Systems Protection Board (Parts 1200—1299)

III Office of Management and Budget (Parts 1300—1399)

IV Office of Personnel Management and Office of the Director of National Intelligence (Parts 1400—1499)

V The International Organizations Employees Loyalty Board (Parts 1500—1599)

VI Federal Retirement Thrift Investment Board (Parts 1600—1699)

VIII Office of Special Counsel (Parts 1800—1899)

IX Appalachian Regional Commission (Parts 1900—1999)

XI Armed Forces Retirement Home (Parts 2100—2199)

XIV Federal Labor Relations Authority, General Counsel of the Federal Labor Relations Authority and Federal Service Impasses Panel (Parts 2400—2499)

XVI Office of Government Ethics (Parts 2600—2699)

XXI Department of the Treasury (Parts 3100—3199)

XXII Federal Deposit Insurance Corporation (Parts 3200—3299)

XXIII Department of Energy (Parts 3300—3399)

XXIV Federal Energy Regulatory Commission (Parts 3400—3499)

XXV Department of the Interior (Parts 3500—3599)

XXVI Department of Defense (Parts 3600—3699)

XXVIII Department of Justice (Parts 3800—3899)
Title 5—Administrative Personnel—Continued

XXIX Federal Communications Commission (Parts 3900—3999)
XXX Farm Credit System Insurance Corporation (Parts 4000—4099)
XXXI Farm Credit Administration (Parts 4100—4199)
XXXIII Overseas Private Investment Corporation (Parts 4300—4399)
XXXIV Securities and Exchange Commission (Parts 4400—4499)
XXXV Office of Personnel Management (Parts 4500—4599)
XXXVI Department of Homeland Security (Parts 4600—4699)
XXXVII Federal Election Commission (Parts 4700—4799)
XL Interstate Commerce Commission (Parts 5000—5099)
XL I Commodity Futures Trading Commission (Parts 5100—5199)
XLII Department of Labor (Parts 5200—5299)
XLIII National Science Foundation (Parts 5300—5399)
XLV Department of Health and Human Services (Parts 5500—5599)
XLVI Postal Rate Commission (Parts 5600—5699)
XLVII Federal Trade Commission (Parts 5700—5799)
XLVIII Nuclear Regulatory Commission (Parts 5800—5899)
XLIX Federal Labor Relations Authority (Parts 5900—5999)
LI Department of Transportation (Parts 6000—6099)
LII Export-Import Bank of the United States (Parts 6200—6299)
LIII Department of Education (Parts 6300—6399)
LIV Environmental Protection Agency (Parts 6400—6499)
LV National Endowment for the Arts (Parts 6500—6599)
LVI National Endowment for the Humanities (Parts 6600—6699)
LVII General Services Administration (Parts 6700—6799)
LVIII Board of Governors of the Federal Reserve System (Parts 6800—6899)
LIX National Aeronautics and Space Administration (Parts 6900—6999)
LX United States Postal Service (Parts 7000—7099)
LXI National Labor Relations Board (Parts 7100—7199)
LXII Equal Employment Opportunity Commission (Parts 7200—7299)
LXIII Inter-American Foundation (Parts 7300—7399)
LXIV Merit Systems Protection Board (Parts 7400—7499)
LXV Department of Housing and Urban Development (Parts 7500—7599)
LXVI National Archives and Records Administration (Parts 7600—7699)
LXVII Institute of Museum and Library Services (Parts 7700—7799)
LXVIII Commission on Civil Rights (Parts 7800—7899)
LXIX Tennessee Valley Authority (Parts 7900—7999)
LXX Court Services and Offender Supervision Agency for the District of Columbia (Parts 8000—8099)
LXXI Consumer Product Safety Commission (Parts 8100—8199)
LXXIII Department of Agriculture (Parts 8200—8399)
LXXIV Federal Mine Safety and Health Review Commission (Parts 8400—8499)
Title 5—Administrative Personnel—Continued

LXXVI  Federal Retirement Thrift Investment Board (Parts 8600—8699)
LXXVII Office of Management and Budget (Parts 8700—8799)
LXXX Federal Housing Finance Agency (Parts 9000—9099)
LXXXIII Special Inspector General for Afghanistan Reconstruction (Parts 9300—9399)
LXXXIV Bureau of Consumer Financial Protection (Parts 9400—9499)
LXXXVI National Credit Union Administration (Parts 9600—9699)
XCVIII Council of the Inspectors General on Integrity and Efficiency (Parts 9800—9899)
XCIX Military Compensation and Retirement Modernization Commission (Parts 9900—9999)

National Council on Disability (Parts 10000—10049)

Title 6—Domestic Security

I Department of Homeland Security, Office of the Secretary (Parts 1—199)
X Privacy and Civil Liberties Oversight Board (Parts 1000—1099)

Title 7—Agriculture

SUBTITLE A—Office of the Secretary of Agriculture (Parts 0—26)
SUBTITLE B—Regulations of the Department of Agriculture

I Agricultural Marketing Service (Standards, Inspections, Marketing Practices), Department of Agriculture (Parts 27—209)
II Food and Nutrition Service, Department of Agriculture (Parts 210—299)
III Animal and Plant Health Inspection Service, Department of Agriculture (Parts 300—399)
IV Federal Crop Insurance Corporation, Department of Agriculture (Parts 400—499)
V Agricultural Research Service, Department of Agriculture (Parts 500—599)
VI Natural Resources Conservation Service, Department of Agriculture (Parts 600—699)
VII Farm Service Agency, Department of Agriculture (Parts 700—799)
VIII Grain Inspection, Packers and Stockyards Administration (Federal Grain Inspection Service), Department of Agriculture (Parts 800—899)
IX Agricultural Marketing Service (Marketing Agreements and Orders; Fruits, Vegetables, Nuts), Department of Agriculture (Parts 900—999)
X Agricultural Marketing Service (Marketing Agreements and Orders; Milk), Department of Agriculture (Parts 1000—1199)
Title 7—Agriculture—Continued

XI  Agricultural Marketing Service (Marketing Agreements and Orders; Miscellaneous Commodities), Department of Agriculture (Parts 1200—1299)

XIV  Commodity Credit Corporation, Department of Agriculture (Parts 1400—1499)

XV  Foreign Agricultural Service, Department of Agriculture (Parts 1500—1599)

XVI  Rural Telephone Bank, Department of Agriculture (Parts 1600—1699)

XVII  Rural Utilities Service, Department of Agriculture (Parts 1700—1799)

XVIII  Rural Housing Service, Rural Business-Cooperative Service, Rural Utilities Service, and Farm Service Agency, Department of Agriculture (Parts 1800—1899)

XX  Local Television Loan Guarantee Board (Parts 2200—2299)

XXV  Office of Advocacy and Outreach, Department of Agriculture (Parts 2500—2599)

XXVI  Office of Inspector General, Department of Agriculture (Parts 2600—2699)

XXVII  Office of Information Resources Management, Department of Agriculture (Parts 2700—2799)

XXVIII  Office of Operations, Department of Agriculture (Parts 2800—2899)

XXIX  Office of Energy Policy and New Uses, Department of Agriculture (Parts 2900—2999)

XXX  Office of the Chief Financial Officer, Department of Agriculture (Parts 3000—3099)

XXXI  Office of Environmental Quality, Department of Agriculture (Parts 3100—3199)

XXXII  Office of Procurement and Property Management, Department of Agriculture (Parts 3200—3299)

XXXIII  Office of Transportation, Department of Agriculture (Parts 3300—3399)

XXXIV  National Institute of Food and Agriculture (Parts 3400—3499)

XXXV  Rural Housing Service, Department of Agriculture (Parts 3500—3599)

XXXVI  National Agricultural Statistics Service, Department of Agriculture (Parts 3600—3699)

XXXVII  Economic Research Service, Department of Agriculture (Parts 3700—3799)

XXXVIII  World Agricultural Outlook Board, Department of Agriculture (Parts 3800—3899)

XL  [Reserved]

XLI  Rural Business-Cooperative Service and Rural Utilities Service, Department of Agriculture (Parts 4200—4299)

Title 8—Aliens and Nationality

I  Department of Homeland Security (Immigration and Naturalization) (Parts 1—499)
Title 8—Aliens and Nationality—Continued

V Executive Office for Immigration Review, Department of Justice (Parts 1000—1399)

Title 9—Animals and Animal Products

I Animal and Plant Health Inspection Service, Department of Agriculture (Parts 1—199)
II Grain Inspection, Packers and Stockyards Administration (Packers and Stockyards Programs), Department of Agriculture (Parts 200—299)
III Food Safety and Inspection Service, Department of Agriculture (Parts 300—599)

Title 10—Energy

I Nuclear Regulatory Commission (Parts 0—199)
II Department of Energy (Parts 200—699)
III Department of Energy (Parts 700—999)
X Department of Energy (General Provisions) (Parts 1000—1099)
XIII Nuclear Waste Technical Review Board (Parts 1300—1399)
XVII Defense Nuclear Facilities Safety Board (Parts 1700—1799)
XVIII Northeast Interstate Low-Level Radioactive Waste Commission (Parts 1800—1899)

Title 11—Federal Elections

I Federal Election Commission (Parts 1—9099)
II Election Assistance Commission (Parts 9400—9499)

Title 12—Banks and Banking

I Comptroller of the Currency, Department of the Treasury (Parts 1—199)
II Federal Reserve System (Parts 200—299)
III Federal Deposit Insurance Corporation (Parts 300—399)
IV Export-Import Bank of the United States (Parts 400—499)
V Office of Thrift Supervision, Department of the Treasury (Parts 500—599)
VI Farm Credit Administration (Parts 600—699)
VII National Credit Union Administration (Parts 700—799)
VIII Federal Financing Bank (Parts 800—899)
IX Federal Housing Finance Board (Parts 900—999)
X Bureau of Consumer Financial Protection (Parts 1000—1099)
XI Federal Financial Institutions Examination Council (Parts 1100—1199)
XII Federal Housing Finance Agency (Parts 1200—1299)
XIII Financial Stability Oversight Council (Parts 1300—1399)
XIV Farm Credit System Insurance Corporation (Parts 1400—1499)
Chap.  Title 12—Banks and Banking—Continued

XV Department of the Treasury (Parts 1500—1599)
XVI Office of Financial Research (Parts 1600—1699)
XVII Office of Federal Housing Enterprise Oversight, Department of Housing and Urban Development (Parts 1700—1799)
XVIII Community Development Financial Institutions Fund, Department of the Treasury (Parts 1800—1899)

Title 13—Business Credit and Assistance

I Small Business Administration (Parts 1—199)
III Economic Development Administration, Department of Commerce (Parts 300—399)
IV Emergency Steel Guarantee Loan Board (Parts 400—499)
V Emergency Oil and Gas Guaranteed Loan Board (Parts 500—599)

Title 14—Aeronautics and Space

I Federal Aviation Administration, Department of Transportation (Parts 1—199)
II Office of the Secretary, Department of Transportation (Aviation Proceedings) (Parts 200—399)
III Commercial Space Transportation, Federal Aviation Administration, Department of Transportation (Parts 400—1199)
V National Aeronautics and Space Administration (Parts 1200—1299)
VI Air Transportation System Stabilization (Parts 1300—1399)

Title 15—Commerce and Foreign Trade

SUBTITLE A—OFFICE OF THE SECRETARY OF COMMERCE (PARTS 0—29)
SUBTITLE B—REGULATIONS RELATING TO COMMERCE AND FOREIGN TRADE

I Bureau of the Census, Department of Commerce (Parts 30—199)
II National Institute of Standards and Technology, Department of Commerce (Parts 200—299)
III International Trade Administration, Department of Commerce (Parts 300—399)
IV Foreign-Trade Zones Board, Department of Commerce (Parts 400—499)
VII Bureau of Industry and Security, Department of Commerce (Parts 700—799)
VIII Bureau of Economic Analysis, Department of Commerce (Parts 800—899)
IX National Oceanic and Atmospheric Administration, Department of Commerce (Parts 900—999)
XI Technology Administration, Department of Commerce (Parts 1100—1199)
XIII East-West Foreign Trade Board (Parts 1300—1399)
Title 15—Commerce and Foreign Trade—Continued

Chap. XIV Minority Business Development Agency (Parts 1400—1499)

Subtitle C—Regulations Relating to Foreign Trade Agreements

XX Office of the United States Trade Representative (Parts 2000—2099)

Subtitle D—Regulations Relating to Telecommunications and Information

XXIII National Telecommunications and Information Administration, Department of Commerce (Parts 2300—2399)

Title 16—Commercial Practices

I Federal Trade Commission (Parts 0—999)
II Consumer Product Safety Commission (Parts 1000—1799)

Title 17—Commodity and Securities Exchanges

I Commodity Futures Trading Commission (Parts 1—199)
II Securities and Exchange Commission (Parts 200—399)
IV Department of the Treasury (Parts 400—499)

Title 18—Conservation of Power and Water Resources

I Federal Energy Regulatory Commission, Department of Energy (Parts 1—399)
III Delaware River Basin Commission (Parts 400—499)
VI Water Resources Council (Parts 700—799)
VIII Susquehanna River Basin Commission (Parts 800—899)
XIII Tennessee Valley Authority (Parts 1300—1399)

Title 19—Customs Duties

I U.S. Customs and Border Protection, Department of Homeland Security; Department of the Treasury (Parts 0—199)
II United States International Trade Commission (Parts 200—299)
III International Trade Administration, Department of Commerce (Parts 300—399)
IV U.S. Immigration and Customs Enforcement, Department of Homeland Security (Parts 400—599)

Title 20—Employees’ Benefits

I Office of Workers’ Compensation Programs, Department of Labor (Parts 1—199)
II Railroad Retirement Board (Parts 200—399)
III Social Security Administration (Parts 400—499)
IV Employees’ Compensation Appeals Board, Department of Labor (Parts 500—599)
Title 20—Employees' Benefits—Continued

V Employment and Training Administration, Department of Labor (Parts 600—699)
VI Office of Workers’ Compensation Programs, Department of Labor (Parts 700—799)
VII Benefits Review Board, Department of Labor (Parts 800—899)
VIII Joint Board for the Enrollment of Actuaries (Parts 900—999)
IX Office of the Assistant Secretary for Veterans' Employment and Training Service, Department of Labor (Parts 1000—1099)

Title 21—Food and Drugs

I Food and Drug Administration, Department of Health and Human Services (Parts 1—1299)
II Drug Enforcement Administration, Department of Justice (Parts 1300—1399)
III Office of National Drug Control Policy (Parts 1400—1499)

Title 22—Foreign Relations

I Department of State (Parts 1—199)
II Agency for International Development (Parts 200—299)
III Peace Corps (Parts 300—399)
IV International Joint Commission, United States and Canada (Parts 400—499)
V Broadcasting Board of Governors (Parts 500—599)
VI Overseas Private Investment Corporation (Parts 700—799)
IX Foreign Service Grievance Board (Parts 900—999)
X Inter-American Foundation (Parts 1000—1099)
XI International Boundary and Water Commission, United States and Mexico, United States Section (Parts 1100—1199)
XII United States International Development Cooperation Agency (Parts 1200—1299)
XIII Millennium Challenge Corporation (Parts 1300—1399)
XIV Foreign Service Labor Relations Board; Federal Labor Relations Authority; General Counsel of the Federal Labor Relations Authority; and the Foreign Service Impasse Disputes Panel (Parts 1400—1499)
XV African Development Foundation (Parts 1500—1599)
XVI Japan-United States Friendship Commission (Parts 1600—1699)
XVII United States Institute of Peace (Parts 1700—1799)

Title 23—Highways

I Federal Highway Administration, Department of Transportation (Parts 1—999)
II National Highway Traffic Safety Administration and Federal Highway Administration, Department of Transportation (Parts 1200—1299)
Title 23—Highways—Continued

III National Highway Traffic Safety Administration, Department of Transportation (Parts 1300—1399)

Title 24—Housing and Urban Development

SUBTITLE A—Office of the Secretary, Department of Housing and Urban Development (Parts 0—99)

SUBTITLE B—Regulations Relating to Housing and Urban Development

I Office of Assistant Secretary for Equal Opportunity, Department of Housing and Urban Development (Parts 100—199)

II Office of Assistant Secretary for Housing-Federal Housing Commissioner, Department of Housing and Urban Development (Parts 200—299)

III Government National Mortgage Association, Department of Housing and Urban Development (Parts 300—399)

IV Office of Housing and Office of Multifamily Housing Assistance Restructuring, Department of Housing and Urban Development (Parts 400—499)

V Office of Assistant Secretary for Community Planning and Development, Department of Housing and Urban Development (Parts 500—599)

VI Office of Assistant Secretary for Community Planning and Development, Department of Housing and Urban Development (Parts 600—699) [Reserved]

VII Office of the Secretary, Department of Housing and Urban Development (Housing Assistance Programs and Public and Indian Housing Programs) (Parts 700—799)

VIII Office of the Assistant Secretary for Housing—Federal Housing Commissioner, Department of Housing and Urban Development (Section 8 Housing Assistance Programs, Section 202 Direct Loan Program, Section 202 Supportive Housing for the Elderly Program and Section 811 Supportive Housing for Persons With Disabilities Program) (Parts 800—899)

IX Office of Assistant Secretary for Public and Indian Housing, Department of Housing and Urban Development (Parts 900—1699)

X Office of Assistant Secretary for Housing—Federal Housing Commissioner, Department of Housing and Urban Development (Interstate Land Sales Registration Program) (Parts 1700—1799)

XI Office of Inspector General, Department of Housing and Urban Development (Parts 2000—2099)

XV Emergency Mortgage Insurance and Loan Programs, Department of Housing and Urban Development (Parts 2700—2799) [Reserved]

XX Office of Assistant Secretary for Housing—Federal Housing Commissioner, Department of Housing and Urban Development (Parts 3200—3899)

XXIV Board of Directors of the HOPE for Homeowners Program (Parts 4000—4099) [Reserved]

XXV Neighborhood Reinvestment Corporation (Parts 4100—4199)
Title 25—Indians

I Bureau of Indian Affairs, Department of the Interior (Parts 1—299)

II Indian Arts and Crafts Board, Department of the Interior (Parts 300—399)

III National Indian Gaming Commission, Department of the Interior (Parts 500—599)

IV Office of Navajo and Hopi Indian Relocation (Parts 700—799)

V Bureau of Indian Affairs, Department of the Interior, and Indian Health Service, Department of Health and Human Services (Part 900)

VI Office of the Assistant Secretary-Indian Affairs, Department of the Interior (Parts 1000—1199)

VII Office of the Special Trustee for American Indians, Department of the Interior (Parts 1200—1299)

Title 26—Internal Revenue

I Internal Revenue Service, Department of the Treasury (Parts 1—End)

Title 27—Alcohol, Tobacco Products and Firearms

I Alcohol and Tobacco Tax and Trade Bureau, Department of the Treasury (Parts 1—399)

II Bureau of Alcohol, Tobacco, Firearms, and Explosives, Department of Justice (Parts 400—699)

Title 28—Judicial Administration

I Department of Justice (Parts 0—299)

III Federal Prison Industries, Inc., Department of Justice (Parts 300—399)

V Bureau of Prisons, Department of Justice (Parts 500—599)

VI Offices of Independent Counsel, Department of Justice (Parts 600—699)

VII Office of Independent Counsel (Parts 700—799)

VIII Court Services and Offender Supervision Agency for the District of Columbia (Parts 800—899)

IX National Crime Prevention and Privacy Compact Council (Parts 900—999)

XI Department of Justice and Department of State (Parts 1100—1199)

Title 29—Labor

Subtitle A—Office of the Secretary of Labor (Parts 0—99)

Subtitle B—Regulations Relating to Labor

I National Labor Relations Board (Parts 100—199)
Title 29—Labor—Continued

II Office of Labor-Management Standards, Department of Labor (Parts 200—299)
III National Railroad Adjustment Board (Parts 300—399)
IV Office of Labor-Management Standards, Department of Labor (Parts 400—499)
V Wage and Hour Division, Department of Labor (Parts 500—899)
IX Construction Industry Collective Bargaining Commission (Parts 900—999)
X National Mediation Board (Parts 1200—1299)
XII Federal Mediation and Conciliation Service (Parts 1400—1499)
XIV Equal Employment Opportunity Commission (Parts 1600—1699)
XVII Occupational Safety and Health Administration, Department of Labor (Parts 1900—1999)
XX Occupational Safety and Health Review Commission (Parts 2200—2499)
XXV Employee Benefits Security Administration, Department of Labor (Parts 2500—2599)
XXVII Federal Mine Safety and Health Review Commission (Parts 2700—2799)
XL Pension Benefit Guaranty Corporation (Parts 4000—4999)

Title 30—Mineral Resources

I Mine Safety and Health Administration, Department of Labor (Parts 1—199)
II Bureau of Safety and Environmental Enforcement, Department of the Interior (Parts 200—299)
IV Geological Survey, Department of the Interior (Parts 400—499)
V Bureau of Ocean Energy Management, Department of the Interior (Parts 500—599)
VII Office of Surface Mining Reclamation and Enforcement, Department of the Interior (Parts 700—999)
XII Office of Natural Resources Revenue, Department of the Interior (Parts 1200—1299)

Title 31—Money and Finance: Treasury

Subtitle A—Office of the Secretary of the Treasury (Parts 0—50)
Subtitle B—Regulations Relating to Money and Finance
I Monetary Offices, Department of the Treasury (Parts 51—199)
II Fiscal Service, Department of the Treasury (Parts 200—399)
IV Secret Service, Department of the Treasury (Parts 400—499)
V Office of Foreign Assets Control, Department of the Treasury (Parts 500—599)
VI Bureau of Engraving and Printing, Department of the Treasury (Parts 600—699)
VII Federal Law Enforcement Training Center, Department of the Treasury (Parts 700—799)
Title 31—Money and Finance: Treasury—Continued

Chap.

VIII Office of International Investment, Department of the Treasury (Parts 800—899)
IX Federal Claims Collection Standards (Department of the Treasury—Department of Justice) (Parts 900—999)
X Financial Crimes Enforcement Network, Department of the Treasury (Parts 1000—1099)

Title 32—National Defense

Subtitle A—Department of Defense

I Office of the Secretary of Defense (Parts 1—399)
V Department of the Army (Parts 400—699)
VI Department of the Navy (Parts 700—799)
VII Department of the Air Force (Parts 800—1099)

Subtitle B—Other Regulations Relating to National Defense

XII Defense Logistics Agency (Parts 1200—1299)
XVI Selective Service System (Parts 1600—1699)
XVII Office of the Director of National Intelligence (Parts 1700—1799)
XVIII National Counterintelligence Center (Parts 1800—1899)
XIX Central Intelligence Agency (Parts 1900—1999)
XX Information Security Oversight Office, National Archives and Records Administration (Parts 2000—2099)
XXI National Security Council (Parts 2100—2199)
XXIV Office of Science and Technology Policy (Parts 2400—2499)
XXVII Office for Micronesian Status Negotiations (Parts 2700—2799)
XXVIII Office of the Vice President of the United States (Parts 2800—2899)

Title 33—Navigation and Navigable Waters

I Coast Guard, Department of Homeland Security (Parts 1—199)
II Corps of Engineers, Department of the Army (Parts 200—399)
IV Saint Lawrence Seaway Development Corporation, Department of Transportation (Parts 400—499)

Title 34—Education

Subtitle A—Office of the Secretary, Department of Education (Parts 1—99)

Subtitle B—Regulations of the Offices of the Department of Education

I Office for Civil Rights, Department of Education (Parts 100—199)
II Office of Elementary and Secondary Education, Department of Education (Parts 200—299)
III Office of Special Education and Rehabilitative Services, Department of Education (Parts 300—399)
Title 34—Education—Continued

IV Office of Career, Technical and Adult Education, Department of Education (Parts 400—499)
V Office of Bilingual Education and Minority Languages Affairs, Department of Education (Parts 500—599) [Reserved]
VI Office of Postsecondary Education, Department of Education (Parts 600—699)
VII Office of Educational Research and Improvement, Department of Education (Parts 700—799) [Reserved]
SUBTITLE C—Regulations Relating to Education
XI [Reserved]
XII National Council on Disability (Parts 1200—1299)

Title 35 [Reserved]

Title 36—Parks, Forests, and Public Property

I National Park Service, Department of the Interior (Parts 1—199)
II Forest Service, Department of Agriculture (Parts 200—299)
III Corps of Engineers, Department of the Army (Parts 300—399)
IV American Battle Monuments Commission (Parts 400—499)
V Smithsonian Institution (Parts 500—599)
VI [Reserved]
VII Library of Congress (Parts 700—799)
VIII Advisory Council on Historic Preservation (Parts 800—899)
IX Pennsylvania Avenue Development Corporation (Parts 900—999)
X Presidio Trust (Parts 1000—1099)
XI Architectural and Transportation Barriers Compliance Board (Parts 1100—1199)
XII National Archives and Records Administration (Parts 1200—1299)
XV Oklahoma City National Memorial Trust (Parts 1500—1599)
XVI Morris K. Udall Scholarship and Excellence in National Environmental Policy Foundation (Parts 1600—1699)

Title 37—Patents, Trademarks, and Copyrights

I United States Patent and Trademark Office, Department of Commerce (Parts 1—199)
II U.S. Copyright Office, Library of Congress (Parts 200—299)
III Copyright Royalty Board, Library of Congress (Parts 300—399)
IV Assistant Secretary for Technology Policy, Department of Commerce (Parts 400—599)

Title 38—Pensions, Bonuses, and Veterans’ Relief

I Department of Veterans Affairs (Parts 0—199)
II Armed Forces Retirement Home (Parts 200—299)
Title 39—Postal Service

I United States Postal Service (Parts 1—999)
III Postal Regulatory Commission (Parts 3000—3099)

Title 40—Protection of Environment

I Environmental Protection Agency (Parts 1—1099)
IV Environmental Protection Agency and Department of Justice (Parts 1400—1499)
V Council on Environmental Quality (Parts 1500—1599)
VI Chemical Safety and Hazard Investigation Board (Parts 1600—1699)
VII Environmental Protection Agency and Department of Defense; Uniform National Discharge Standards for Vessels of the Armed Forces (Parts 1700—1799)
VIII Gulf Coast Ecosystem Restoration Council (Parts 1800—1899)

Title 41—Public Contracts and Property Management

SUBTITLE A—Federal Procurement Regulations System [Note]
SUBTITLE B—Other Provisions Relating to Public Contracts
50 Public Contracts, Department of Labor (Parts 50–1—50–999)
51 Committee for Purchase From People Who Are Blind or Severely Disabled (Parts 51–1—51–99)
60 Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor (Parts 60–1—60–999)
61 Office of the Assistant Secretary for Veterans’ Employment and Training Service, Department of Labor (Parts 61–1—61–999)
62—100 [Reserved]
SUBTITLE C—Federal Property Management Regulations System
101 Federal Property Management Regulations (Parts 101–1—101–99)
102 Federal Management Regulation (Parts 102–1—102–299)
103—104 [Reserved]
105 General Services Administration (Parts 105–1—105–999)
109 Department of Energy Property Management Regulations (Parts 109–1—109–99)
114 Department of the Interior (Parts 114–1—114–99)
115 Environmental Protection Agency (Parts 115–1—115–99)
128 Department of Justice (Parts 128–1—128–99)
129—200 [Reserved]
SUBTITLE D—Other Provisions Relating to Property Management [Reserved]
SUBTITLE E—Federal Information Resources Management Regulations System [Reserved]
SUBTITLE F—Federal Travel Regulation System
300 General (Parts 300–1—300–99)
301 Temporary Duty (TDY) Travel Allowances (Parts 301–1—301–99)
Title 41—Public Contracts and Property Management—Continued

302 Relocation Allowances (Parts 302–1—302–99)
303 Payment of Expenses Connected with the Death of Certain Employees (Part 303–1—303–99)
304 Payment of Travel Expenses from a Non-Federal Source (Parts 304–1—304–99)

Title 42—Public Health

I Public Health Service, Department of Health and Human Services (Parts 1—199)
IV Centers for Medicare & Medicaid Services, Department of Health and Human Services (Parts 400—599)
V Office of Inspector General-Health Care, Department of Health and Human Services (Parts 1000—1999)

Title 43—Public Lands: Interior

SUBTITLE A—OFFICE OF THE SECRETARY OF THE INTERIOR (PARTS 1—199)
SUBTITLE B—REGULATIONS RELATING TO PUBLIC LANDS
I Bureau of Reclamation, Department of the Interior (Parts 400—999)
II Bureau of Land Management, Department of the Interior (Parts 1000—9999)
III Utah Reclamation Mitigation and Conservation Commission (Parts 10000—10099)

Title 44—Emergency Management and Assistance

I Federal Emergency Management Agency, Department of Homeland Security (Parts 0—399)
IV Department of Commerce and Department of Transportation (Parts 400—499)

Title 45—Public Welfare

SUBTITLE A—DEPARTMENT OF HEALTH AND HUMAN SERVICES (PARTS 1—199)
SUBTITLE B—REGULATIONS RELATING TO PUBLIC WELFARE
II Office of Family Assistance (Assistance Programs), Administration for Children and Families, Department of Health and Human Services (Parts 200—299)
III Office of Child Support Enforcement (Child Support Enforcement Program), Administration for Children and Families, Department of Health and Human Services (Parts 300—399)
IV Office of Refugee Resettlement, Administration for Children and Families, Department of Health and Human Services (Parts 400—499)
V Foreign Claims Settlement Commission of the United States, Department of Justice (Parts 500—599)
Title 45—Public Welfare—Continued

VI National Science Foundation (Parts 600—699)
VII Commission on Civil Rights (Parts 700—799)
VIII Office of Personnel Management (Parts 800—899)
IX Denali Commission (Parts 900—999)
X Office of Community Services, Administration for Children and Families, Department of Health and Human Services (Parts 1000—1099)
XI National Foundation on the Arts and the Humanities (Parts 1100—1199)
XII Corporation for National and Community Service (Parts 1200—1299)
XIII Administration for Children and Families, Department of Health and Human Services (Parts 1300—1399)
XVI Legal Services Corporation (Parts 1600—1699)
XVII National Commission on Libraries and Information Science (Parts 1700—1799)
XVIII Harry S. Truman Scholarship Foundation (Parts 1800—1899)
XXI Commission on Fine Arts (Parts 2100—2199)
XXIII Arctic Research Commission (Part 2301)
XXIV James Madison Memorial Fellowship Foundation (Parts 2400—2499)
XXV Corporation for National and Community Service (Parts 2500—2599)

Title 46—Shipping

I Coast Guard, Department of Homeland Security (Parts 1—199)
II Maritime Administration, Department of Transportation (Parts 200—399)
III Coast Guard (Great Lakes Pilotage), Department of Homeland Security (Parts 400—499)
IV Federal Maritime Commission (Parts 500—599)

Title 47—Telecommunication

I Federal Communications Commission (Parts 0—199)
II Office of Science and Technology Policy and National Security Council (Parts 200—299)
III National Telecommunications and Information Administration, Department of Commerce (Parts 300—399)
IV National Telecommunications and Information Administration, Department of Commerce, and National Highway Traffic Safety Administration, Department of Transportation (Parts 400—499)

Title 48—Federal Acquisition Regulations System

1 Federal Acquisition Regulation (Parts 1—99)
2 Defense Acquisition Regulations System, Department of Defense (Parts 200—299)
3 Health and Human Services (Parts 300—399)
4 Department of Agriculture (Parts 400—499)
5 General Services Administration (Parts 500—599)
6 Department of State (Parts 600—699)
7 Agency for International Development (Parts 700—799)
8 Department of Veterans Affairs (Parts 800—899)
9 Department of Energy (Parts 900—999)
10 Department of the Treasury (Parts 1000—1099)
12 Department of Transportation (Parts 1200—1299)
13 Department of Commerce (Parts 1300—1399)
14 Department of the Interior (Parts 1400—1499)
15 Environmental Protection Agency (Parts 1500—1599)
16 Office of Personnel Management, Federal Employees Health Benefits Acquisition Regulation (Parts 1600—1699)
17 Office of Personnel Management (Parts 1700—1799)
18 National Aeronautics and Space Administration (Parts 1800—1899)
19 Broadcasting Board of Governors (Parts 1900—1999)
20 Nuclear Regulatory Commission (Parts 2000—2099)
21 Office of Personnel Management, Federal Employees Group Life Insurance Federal Acquisition Regulation (Parts 2100—2199)
23 Social Security Administration (Parts 2300—2399)
24 Department of Housing and Urban Development (Parts 2400—2499)
25 National Science Foundation (Parts 2500—2599)
28 Department of Justice (Parts 2800—2899)
29 Department of Labor (Parts 2900—2999)
30 Department of Homeland Security, Homeland Security Acquisition Regulation (HSAR) (Parts 3000—3099)
34 Department of Education Acquisition Regulation (Parts 3400—3499)
51 Department of the Army Acquisition Regulations (Parts 5100—5199)
52 Department of the Navy Acquisition Regulations (Parts 5200—5299)
53 Department of the Air Force Federal Acquisition Regulation Supplement (Parts 5300—5399) [Reserved]
54 Defense Logistics Agency, Department of Defense (Parts 5400—5499)
57 African Development Foundation (Parts 5700—5799)
61 Civilian Board of Contract Appeals, General Services Administration (Parts 6100—6199)
63 Department of Transportation Board of Contract Appeals (Parts 6300—6399)
Title 48—Federal Acquisition Regulations System—Continued

99 Cost Accounting Standards Board, Office of Federal Procurement Policy, Office of Management and Budget (Parts 9900—9999)

Title 49—Transportation

Subtitle A—Office of the Secretary of Transportation (Parts 1—99)

Subtitle B—Other Regulations Relating to Transportation

I Pipeline and Hazardous Materials Safety Administration, Department of Transportation (Parts 100—199)

II Federal Railroad Administration, Department of Transportation (Parts 200—299)

III Federal Motor Carrier Safety Administration, Department of Transportation (Parts 300—399)

IV Coast Guard, Department of Homeland Security (Parts 400—499)

V National Highway Traffic Safety Administration, Department of Transportation (Parts 500—599)

VI Federal Transit Administration, Department of Transportation (Parts 600—699)

VII National Railroad Passenger Corporation (AMTRAK) (Parts 700—799)

VIII National Transportation Safety Board (Parts 800—999)

X Surface Transportation Board (Parts 1000—1399)

XI Research and Innovative Technology Administration, Department of Transportation (Parts 1400—1499) [Reserved]

XII Transportation Security Administration, Department of Homeland Security (Parts 1500—1699)

Title 50—Wildlife and Fisheries

I United States Fish and Wildlife Service, Department of the Interior (Parts 1—199)

II National Marine Fisheries Service, National Oceanic and Atmospheric Administration, Department of Commerce (Parts 200—299)

III International Fishing and Related Activities (Parts 300—399)

IV Joint Regulations (United States Fish and Wildlife Service, Department of the Interior and National Marine Fisheries Service, National Oceanic and Atmospheric Administration, Department of Commerce); Endangered Species Committee Regulations (Parts 400—499)

V Marine Mammal Commission (Parts 500—599)

VI Fishery Conservation and Management, National Oceanic and Atmospheric Administration, Department of Commerce (Parts 600—699)
### Alphabetical List of Agencies Appearing in the CFR

*Revised as of October 1, 2016*

<table>
<thead>
<tr>
<th>Agency</th>
<th>CFR Title, Subtitle or Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Committee of the Federal Register</td>
<td>1, I</td>
</tr>
<tr>
<td>Administrative Conference of the United States</td>
<td>1, III</td>
</tr>
<tr>
<td>Advisory Council on Historic Preservation</td>
<td>36, VIII</td>
</tr>
<tr>
<td>Advocacy and Outreach, Office of</td>
<td>7, XXV</td>
</tr>
<tr>
<td>Afghanistan Reconstruction, Special Inspector General for</td>
<td>5, LXXXIII</td>
</tr>
<tr>
<td>African Development Foundation</td>
<td>22, XV</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 57</td>
</tr>
<tr>
<td>Agency for International Development</td>
<td>2, VII; 22, II</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 7</td>
</tr>
<tr>
<td>Agricultural Marketing Service</td>
<td>7, I, IX, X, XI</td>
</tr>
<tr>
<td>Agricultural Research Service</td>
<td>7, V</td>
</tr>
<tr>
<td>Agriculture Department</td>
<td>2, IV; 5, LXXXIII</td>
</tr>
<tr>
<td>Advocacy and Outreach, Office of</td>
<td>7, XXV</td>
</tr>
<tr>
<td>Agricultural Marketing Service</td>
<td>7, I, IX, X, XI</td>
</tr>
<tr>
<td>Agricultural Research Service</td>
<td>7, V</td>
</tr>
<tr>
<td>Animal and Plant Health Inspection Service</td>
<td>7, III; 9, I</td>
</tr>
<tr>
<td>Chief Financial Officer, Office of</td>
<td>7, XXX</td>
</tr>
<tr>
<td>Commodity Credit Corporation</td>
<td>7, XIV</td>
</tr>
<tr>
<td>Economic Research Service</td>
<td>7, XXXVII</td>
</tr>
<tr>
<td>Energy Policy and New Uses, Office of</td>
<td>2, IX; 7, XXIX</td>
</tr>
<tr>
<td>Environmental Quality, Office of</td>
<td>7, XXXI</td>
</tr>
<tr>
<td>Farm Service Agency</td>
<td>7, VII; XVIII</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 4</td>
</tr>
<tr>
<td>Federal Crop Insurance Corporation</td>
<td>7, IV</td>
</tr>
<tr>
<td>Food and Nutrition Service</td>
<td>7, II</td>
</tr>
<tr>
<td>Food Safety and Inspection Service</td>
<td>9, III</td>
</tr>
<tr>
<td>Foreign Agricultural Service</td>
<td>7, XV</td>
</tr>
<tr>
<td>Forest Service</td>
<td>36, II</td>
</tr>
<tr>
<td>Grain Inspection, Packers and Stockyards Administration</td>
<td>7, VIII; 9, II</td>
</tr>
<tr>
<td>Information Resources Management, Office of</td>
<td>7, XXVII</td>
</tr>
<tr>
<td>Inspector General, Office of</td>
<td>7, XXVI</td>
</tr>
<tr>
<td>National Agricultural Library</td>
<td>7, XLI</td>
</tr>
<tr>
<td>National Agricultural Statistics Service</td>
<td>7, XXXVI</td>
</tr>
<tr>
<td>National Institute of Food and Agriculture</td>
<td>7, XXXIV</td>
</tr>
<tr>
<td>Natural Resources Conservation Service</td>
<td>7, VI</td>
</tr>
<tr>
<td>Operations, Office of</td>
<td>7, XXVIII</td>
</tr>
<tr>
<td>Procurement and Property Management, Office of</td>
<td>7, XXXII</td>
</tr>
<tr>
<td>Rural Business-Cooperative Service</td>
<td>7, XVIII, XLI</td>
</tr>
<tr>
<td>Rural Development Administration</td>
<td>7, XLI</td>
</tr>
<tr>
<td>Rural Housing Service</td>
<td>7, XVIII, XXXV</td>
</tr>
<tr>
<td>Rural Telephone Bank</td>
<td>7, XVI</td>
</tr>
<tr>
<td>Rural Utilities Service</td>
<td>7, XVII, XVIII, XLI</td>
</tr>
<tr>
<td>Secretary of Agriculture, Office of</td>
<td>7, Subtitle A</td>
</tr>
<tr>
<td>Transportation, Office of</td>
<td>7, XXXIII</td>
</tr>
<tr>
<td>World Agricultural Outlook Board</td>
<td>36, XXXVIII</td>
</tr>
<tr>
<td>Air Force Department</td>
<td>32, VII</td>
</tr>
<tr>
<td>Federal Acquisition Regulation Supplement</td>
<td>48, 53</td>
</tr>
<tr>
<td>Air Transportation Stabilization Board</td>
<td>14, VI</td>
</tr>
<tr>
<td>Alcohol and Tobacco Tax and Trade Bureau</td>
<td>27, I</td>
</tr>
<tr>
<td>Alcohol, Tobacco, Firearms, and Explosives, Bureau of</td>
<td>27, II</td>
</tr>
<tr>
<td>AMTRAK</td>
<td>49, VII</td>
</tr>
<tr>
<td>American Battle Monuments Commission</td>
<td>36, IV</td>
</tr>
<tr>
<td>American Indians, Office of the Special Trustee</td>
<td>25, VII</td>
</tr>
<tr>
<td>Agency</td>
<td>CFR Title, Subtitle or Chapter</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Defense Department</td>
<td>2, XI; 5, XXVI; 32, Subtitle A; 40, VII</td>
</tr>
<tr>
<td>Advanced Research Projects Agency</td>
<td>32, I</td>
</tr>
<tr>
<td>Air Force Department</td>
<td>32, VII</td>
</tr>
<tr>
<td>Army Department</td>
<td>32, V; 33, II; 96, III; 48, 51</td>
</tr>
<tr>
<td>Defense Acquisition Regulations System</td>
<td>48, 2</td>
</tr>
<tr>
<td>Defense Intelligence Agency</td>
<td>32, I</td>
</tr>
<tr>
<td>Defense Logistics Agency</td>
<td>32, I, XII; 48, 54</td>
</tr>
<tr>
<td>Engineers, Corps of</td>
<td>33, II; 96, III</td>
</tr>
<tr>
<td>National Imagery and Mapping Agency</td>
<td>32, I</td>
</tr>
<tr>
<td>Navy Department</td>
<td>32, VI; 48, 52</td>
</tr>
<tr>
<td>Secretary of Defense, Office of</td>
<td>2, XI; 32, I</td>
</tr>
<tr>
<td>Defense Contract Audit Agency</td>
<td>32, I</td>
</tr>
<tr>
<td>Defense Intelligence Agency</td>
<td>32, I</td>
</tr>
<tr>
<td>Defense Logistics Agency</td>
<td>32, XII; 48, 54</td>
</tr>
<tr>
<td>Defense Nuclear Facilities Safety Board</td>
<td>10, XVII</td>
</tr>
<tr>
<td>Delaware River Basin Commission</td>
<td>18, III</td>
</tr>
<tr>
<td>Denali Commission</td>
<td>45, IX</td>
</tr>
<tr>
<td>District of Columbia, Court Services and Offender Supervision Agency for the</td>
<td>5, LXX; 28, VIII</td>
</tr>
<tr>
<td>Bilingual Education and Minority Languages Affairs, Office of</td>
<td>2, XXXIV; 5, LIII</td>
</tr>
<tr>
<td>Career, Technical and Adult Education, Office of</td>
<td>34, IV</td>
</tr>
<tr>
<td>Civil Rights, Office for</td>
<td>34, I</td>
</tr>
<tr>
<td>Educational Research and Improvement, Office of</td>
<td>34, VII</td>
</tr>
<tr>
<td>Elementary and Secondary Education, Office of</td>
<td>34, II</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 34</td>
</tr>
<tr>
<td>Postsecondary Education, Office of</td>
<td>34, VI</td>
</tr>
<tr>
<td>Secretary of Education, Office of</td>
<td>34, Subtitle A</td>
</tr>
<tr>
<td>Special Education and Rehabilitative Services, Office of</td>
<td>34, III</td>
</tr>
<tr>
<td>Career, Technical, and Adult Education, Office of</td>
<td>34, IV</td>
</tr>
<tr>
<td>Educational Research and Improvement, Office of</td>
<td>34, VII</td>
</tr>
<tr>
<td>Election Assistance Commission</td>
<td>2, I, VIII; 11, II</td>
</tr>
<tr>
<td>Emergency Oil and Gas Guaranteed Loan Board</td>
<td>13, V</td>
</tr>
<tr>
<td>Emergency Steel Guarantee Loan Board</td>
<td>13, IV</td>
</tr>
<tr>
<td>Employee Benefits Security Administration</td>
<td>29, XXV</td>
</tr>
<tr>
<td>Employees’ Compensation Appeals Board</td>
<td>20, IV</td>
</tr>
<tr>
<td>Employees Loyalty Board</td>
<td>5, V</td>
</tr>
<tr>
<td>Employment and Training Administration</td>
<td>20, V</td>
</tr>
<tr>
<td>Employment Standards Administration</td>
<td>20, VI</td>
</tr>
<tr>
<td>Endangered Species Committee</td>
<td>50, IV</td>
</tr>
<tr>
<td>Energy, Department of</td>
<td>2, IX; 5, XXXIII; 10, II, III, X</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 9</td>
</tr>
<tr>
<td>Federal Energy Regulatory Commission</td>
<td>5, XXXIV; 18, I</td>
</tr>
<tr>
<td>Property Management Regulations</td>
<td>41, 109</td>
</tr>
<tr>
<td>Energy, Office of</td>
<td>7, XXXIX</td>
</tr>
<tr>
<td>Engineers, Corps of</td>
<td>33, II; 96, III</td>
</tr>
<tr>
<td>Engraving and Printing, Bureau of</td>
<td>31, VI</td>
</tr>
<tr>
<td>Environmental Protection Agency</td>
<td>2, XV; 5, LIV; 40, I, IV, VII</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 15</td>
</tr>
<tr>
<td>Property Management Regulations</td>
<td>41, 115</td>
</tr>
<tr>
<td>Environmental Quality, Office of</td>
<td>7, XXXI</td>
</tr>
<tr>
<td>Equal Employment Opportunity Commission</td>
<td>5, LXII; 29, XIV</td>
</tr>
<tr>
<td>Equal Opportunity, Office of Assistant Secretary for</td>
<td>24, I</td>
</tr>
<tr>
<td>Executive Office of the President</td>
<td>3, I</td>
</tr>
<tr>
<td>Environmental Quality, Council on Management and Budget, Office of</td>
<td>46, V</td>
</tr>
<tr>
<td>Career, Technical and Adult Education, Office of</td>
<td>2, Subtitle A; 5, III, LXXVII; 14, VI; 48, 99</td>
</tr>
<tr>
<td>Agency</td>
<td>CFR Title, Subtitle or Chapter</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>National Drug Control Policy, Office of</td>
<td>2, XXXVI; 21, III</td>
</tr>
<tr>
<td>National Security Council</td>
<td>32, XXI; 47, 2</td>
</tr>
<tr>
<td>Presidential Documents</td>
<td>3</td>
</tr>
<tr>
<td>Science and Technology Policy, Office of</td>
<td>32, XXIV; 47, II</td>
</tr>
<tr>
<td>Trade Representative, Office of the United States</td>
<td>15, XX</td>
</tr>
<tr>
<td>Export-Import Bank of the United States</td>
<td>2, XXXV; 5, LII; 12, IV</td>
</tr>
<tr>
<td>Family Assistance, Office of</td>
<td>45, II</td>
</tr>
<tr>
<td>Farm Credit Administration</td>
<td>5, XXXI; 12, VI</td>
</tr>
<tr>
<td>Farm Credit System Insurance Corporation</td>
<td>5, XXX; 12, XIV</td>
</tr>
<tr>
<td>Farm Service Agency</td>
<td>7, VII; XVIII</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 1</td>
</tr>
<tr>
<td>Federal Aviation Administration</td>
<td>14, I</td>
</tr>
<tr>
<td>Commercial Space Transportation</td>
<td>14, III</td>
</tr>
<tr>
<td>Federal Claims Collection Standards</td>
<td>31, IX</td>
</tr>
<tr>
<td>Federal Communications Commission</td>
<td>5, XXIX; 47, I</td>
</tr>
<tr>
<td>Federal Contract Compliance Programs, Office of</td>
<td>41, 69</td>
</tr>
<tr>
<td>Federal Crop Insurance Corporation</td>
<td>7, IV</td>
</tr>
<tr>
<td>Federal Deposit Insurance Corporation</td>
<td>5, XXII; 12, III</td>
</tr>
<tr>
<td>Federal Election Commission</td>
<td>5, XXXVII; 11, I</td>
</tr>
<tr>
<td>Federal Emergency Management Agency</td>
<td>44, I</td>
</tr>
<tr>
<td>Federal Employees Group Life Insurance Federal Acquisition Regulation</td>
<td>48, 21</td>
</tr>
<tr>
<td>Federal Employees Health Benefits Acquisition Regulation</td>
<td>48, 16</td>
</tr>
<tr>
<td>Federal Energy Regulatory Commission</td>
<td>5, XXXIV; 18, I</td>
</tr>
<tr>
<td>Federal Financial Institutions Examination Council</td>
<td>12, XI</td>
</tr>
<tr>
<td>Federal Financing Bank</td>
<td>12, VIII</td>
</tr>
<tr>
<td>Federal Highway Administration</td>
<td>23, I, II</td>
</tr>
<tr>
<td>Federal Home Loan Mortgage Corporation</td>
<td>1, IV</td>
</tr>
<tr>
<td>Federal Housing Enterprise Oversight Office</td>
<td>12, XVII</td>
</tr>
<tr>
<td>Federal Housing Finance Agency</td>
<td>5, LXXX; 12, XII</td>
</tr>
<tr>
<td>Federal Housing Finance Board</td>
<td>12, IX</td>
</tr>
<tr>
<td>Federal Labor Relations Authority</td>
<td>5, XIV; XLIX; 22, XIV</td>
</tr>
<tr>
<td>Federal Law Enforcement Training Center</td>
<td>31, VII</td>
</tr>
<tr>
<td>Federal Management Regulation</td>
<td>41, 102</td>
</tr>
<tr>
<td>Federal Maritime Commission</td>
<td>46, IV</td>
</tr>
<tr>
<td>Federal Mediation and Conciliation Service</td>
<td>29, XII</td>
</tr>
<tr>
<td>Federal Mine Safety and Health Review Commission</td>
<td>5, LXXXIV; 29, XXVII</td>
</tr>
<tr>
<td>Federal Motor Carrier Safety Administration</td>
<td>49, III</td>
</tr>
<tr>
<td>Federal Prison Industries, Inc.</td>
<td>26, III</td>
</tr>
<tr>
<td>Federal Procurement Policy Office</td>
<td>48, 99</td>
</tr>
<tr>
<td>Federal Property Management Regulations</td>
<td>41, 101</td>
</tr>
<tr>
<td>Federal Railroad Administration</td>
<td>49, II</td>
</tr>
<tr>
<td>Federal Register, Administrative Committee of</td>
<td>1, I</td>
</tr>
<tr>
<td>Federal Reserve System</td>
<td>12, II</td>
</tr>
<tr>
<td>Board of Governors</td>
<td>5, LVII</td>
</tr>
<tr>
<td>Federal Retirement Thrift Investment Board</td>
<td>5, VI, LXXVI</td>
</tr>
<tr>
<td>Federal Service Impasses Panel</td>
<td>5, XIV</td>
</tr>
<tr>
<td>Federal Trade Commission</td>
<td>5, XLVII; 16, I</td>
</tr>
<tr>
<td>Federal Transit Administration</td>
<td>49, VI</td>
</tr>
<tr>
<td>Federal Travel Regulation System</td>
<td>41, Subtitle F</td>
</tr>
<tr>
<td>Financial Crimes Enforcement Network</td>
<td>31, X</td>
</tr>
<tr>
<td>Financial Research Office</td>
<td>12, XVI</td>
</tr>
<tr>
<td>Financial Stability Oversight Council</td>
<td>12, XIII</td>
</tr>
<tr>
<td>Fine Arts, Commission on</td>
<td>45, XXI</td>
</tr>
<tr>
<td>Fiscal Service</td>
<td>31, II</td>
</tr>
<tr>
<td>Fish and Wildlife Service, United States</td>
<td>50, I, IV</td>
</tr>
<tr>
<td>Food and Drug Administration</td>
<td>21, I</td>
</tr>
<tr>
<td>Food and Nutrition Service</td>
<td>7, II</td>
</tr>
<tr>
<td>Food Safety and Inspection Service</td>
<td>9, III</td>
</tr>
<tr>
<td>Foreign Agricultural Service</td>
<td>7, XV</td>
</tr>
<tr>
<td>Foreign Assets Control, Office of</td>
<td>31, V</td>
</tr>
<tr>
<td>Foreign Claims Settlement Commission of the United States</td>
<td>45, V</td>
</tr>
<tr>
<td>Foreign Service Grievance Board</td>
<td>22, IX</td>
</tr>
<tr>
<td>Foreign Service Impasses Disputes Panel</td>
<td>22, XIV</td>
</tr>
<tr>
<td>Foreign Service Labor Relations Board</td>
<td>22, XIV</td>
</tr>
<tr>
<td>Foreign-Trade Zones Board</td>
<td>15, IV</td>
</tr>
</tbody>
</table>

998
Agency

Forest Service
General Services Administration 36, II
Contract Appeals, Board of
Federal Acquisition Regulation 48, 61
Federal Management Regulation
Federal Property Management Regulations
Federal Travel Regulation System 41, Subtitle F
General 41, 300
Payment From a Non-Federal Source for Travel Expenses
Payment of Expenses Connected With the Death of Certain Employees
Temporary Duty (TDY) Travel Allowances
Geological Survey 41, 302
Government Accountability Office 30, IV
Government Ethics, Office of 5, XVI
Government National Mortgage Association 24, III
Grain Inspection, Packers and Stockyards Administration 7, VIII; 9, II
Gulf Coast Ecosystem Restoration Council 2, LIX; 40, VIII
Harry S. Truman Scholarship Foundation 45, XVIII
Health and Human Services, Department of 41, 301
Centers for Medicare & Medicaid Services 42, IV
Child Support Enforcement, Office of 45, III
Children and Families, Administration for 45, II, III, IV, X, XIII
Community Services, Office of 45, X
Family Assistance, Office of 45, II
Federal Acquisition Regulation
Food and Drug Administration 48, 3
Indian Health Service 25, V
Inspector General (Health Care), Office of 42, V
Public Health Service 42, I
Refugee Resettlement, Office of 45, IV
Homeland Security, Department of 2, XXX; 5, XXXVI; 6, I; 8, I
Coast Guard 33, I; 46, I; 49, IV
Coast Guard (Great Lakes Pilotage) 46, III
Customs and Border Protection 19, I
Federal Emergency Management Agency 44, I
Human Resources Management and Labor Relations Systems
Immigration and Customs Enforcement Bureau 49, XII
Transportation Security Administration 24, XXIV
HOPE for Homeowners Program, Board of Directors of
Housing and Urban Development, Department of 24, XXIV; 5, LXV; 24, Subtitle B
Community Planning and Development, Office of Assistant Secretary for
Equal Opportunity, Office of Assistant Secretary for
Federal Acquisition Regulation
Federal Housing Enterprise Oversight, Office of
Government National Mortgage Association 24, III
Housing—Federal Housing Commissioner, Office of 24, II, VIII, X, XX
Assistant Secretary for
Housing, Office of, and Multifamily Housing Assistance
Restructuring, Office of 24, IV
Inspector General, Office of 24, XII
Public and Indian Housing, Office of Assistant Secretary for
Secretary, Office of 24, Subtitle A. VII
Housing—Federal Housing Commissioner, Office of Assistant Secretary for
Housing, Office of, and Multifamily Housing Assistance 24, IV
Restructuring, Office of
Immigration and Customs Enforcement Bureau 19, IV
Immigration Review, Executive Office for 8, V
Independent Counsel, Office of 28, VII
Independent Counsel, Offices of 28, VI
<table>
<thead>
<tr>
<th>Agency</th>
<th>CFR Title, Subtitle or Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indian Affairs, Bureau of</td>
<td>25, I, V</td>
</tr>
<tr>
<td>Indian Affairs, Office of the Assistant Secretary</td>
<td>25, VI</td>
</tr>
<tr>
<td>Indian Arts and Crafts Board</td>
<td>25, II</td>
</tr>
<tr>
<td>Indian Health Service</td>
<td>25, V</td>
</tr>
<tr>
<td>Industry and Security, Bureau of</td>
<td>15, VII</td>
</tr>
<tr>
<td>Information Resources Management, Office of</td>
<td>7, XXVII</td>
</tr>
<tr>
<td>Information Security Oversight Office, National Archives and Records Administration</td>
<td>32, XX</td>
</tr>
<tr>
<td>Inspector General</td>
<td></td>
</tr>
<tr>
<td>Agriculture Department</td>
<td>7, XXVI</td>
</tr>
<tr>
<td>Health and Human Services Department</td>
<td>42, V</td>
</tr>
<tr>
<td>Housing and Urban Development Department</td>
<td>24, XII, XV</td>
</tr>
<tr>
<td>Institute of Peace, United States</td>
<td>22, XVII</td>
</tr>
<tr>
<td>Inter-American Foundation</td>
<td>5, LXIII; 22, X</td>
</tr>
<tr>
<td>Interior Department</td>
<td>2, XIV</td>
</tr>
<tr>
<td>American Indians, Office of the Special Trustee</td>
<td>25, VII</td>
</tr>
<tr>
<td>Endangered Species Committee</td>
<td>50, IV</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, I</td>
</tr>
<tr>
<td>Federal Property Management Regulations System</td>
<td>41, I</td>
</tr>
<tr>
<td>Fish and Wildlife Service, United States</td>
<td>50, I, IV</td>
</tr>
<tr>
<td>Geological Survey</td>
<td>30, IV</td>
</tr>
<tr>
<td>Indian Affairs, Bureau of</td>
<td>25, I, V</td>
</tr>
<tr>
<td>Indian Affairs, Office of the Assistant Secretary</td>
<td>25, VI</td>
</tr>
<tr>
<td>Indian Arts and Crafts Board</td>
<td>25, II</td>
</tr>
<tr>
<td>Land Management, Bureau of</td>
<td>43, II</td>
</tr>
<tr>
<td>National Indian Gaming Commission</td>
<td>25, III</td>
</tr>
<tr>
<td>National Park Service</td>
<td>36, I</td>
</tr>
<tr>
<td>Natural Resource Revenue, Office of</td>
<td>30, XII</td>
</tr>
<tr>
<td>Ocean Energy Management, Bureau of</td>
<td>30, V</td>
</tr>
<tr>
<td>Reclamation, Bureau of</td>
<td>43, I</td>
</tr>
<tr>
<td>Safety and Enforcement Bureau, Bureau of</td>
<td>30, II</td>
</tr>
<tr>
<td>Secretary of the Interior, Office of</td>
<td>2, XIV; 43, Subtitle A</td>
</tr>
<tr>
<td>Surface Mining Reclamation and Enforcement, Office of</td>
<td>30, VII</td>
</tr>
<tr>
<td>Internal Revenue Service</td>
<td>26, I</td>
</tr>
<tr>
<td>International Boundary and Water Commission, United States and Mexico, United States Section</td>
<td>22, XI</td>
</tr>
<tr>
<td>International Development, United States Agency for</td>
<td>22, II</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, V</td>
</tr>
<tr>
<td>International Development Cooperation Agency, United States</td>
<td>22, XII</td>
</tr>
<tr>
<td>International Joint Commission, United States and Canada</td>
<td>22, IV</td>
</tr>
<tr>
<td>International Organizations Employees Loyalty Board</td>
<td>5, V</td>
</tr>
<tr>
<td>International Trade Administration</td>
<td>15, III; 19, III</td>
</tr>
<tr>
<td>International Trade Commission, United States</td>
<td>19, II</td>
</tr>
<tr>
<td>Interstate Commerce Commission</td>
<td>5, XL</td>
</tr>
<tr>
<td>Investment Security, Office of</td>
<td>31, VIII</td>
</tr>
<tr>
<td>James Madison Memorial Fellowship Foundation</td>
<td>45, XXIV</td>
</tr>
<tr>
<td>Japan–United States Friendship Commission</td>
<td>22, XVI</td>
</tr>
<tr>
<td>Joint Board for the Enrollment of Actuaries</td>
<td>20, VIII</td>
</tr>
<tr>
<td>Justice Department</td>
<td>2, XXVIII; 5, XXVIII; 26, I, XI; 40, IV</td>
</tr>
<tr>
<td>Alcohol, Tobacco, Firearms, and Explosives, Bureau of</td>
<td>27, II</td>
</tr>
<tr>
<td>Drug Enforcement Administration</td>
<td>21, II</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>46, 28</td>
</tr>
<tr>
<td>Federal Claims Collection Standards</td>
<td>31, IX</td>
</tr>
<tr>
<td>Federal Prison Industries, Inc.</td>
<td>28, III</td>
</tr>
<tr>
<td>Foreign Claims Settlement Commission of the United States</td>
<td>45, V</td>
</tr>
<tr>
<td>Immigration Review, Executive Office for</td>
<td>8, V</td>
</tr>
<tr>
<td>Independent Counsel, Offices of</td>
<td>28, VI</td>
</tr>
<tr>
<td>Prisons, Bureau of</td>
<td>28, V</td>
</tr>
<tr>
<td>Property Management Regulations</td>
<td>41, 129</td>
</tr>
<tr>
<td>Labor Department</td>
<td>2, XXXIX; 5, XLII</td>
</tr>
<tr>
<td>Employee Benefits Security Administration</td>
<td>29, XXV</td>
</tr>
<tr>
<td>Employees’ Compensation Appeals Board</td>
<td>20, IV</td>
</tr>
<tr>
<td>Employment and Training Administration</td>
<td>20, V</td>
</tr>
<tr>
<td>Employment Standards Administration</td>
<td>20, VI</td>
</tr>
</tbody>
</table>

1000
<table>
<thead>
<tr>
<th>Agency</th>
<th>CFR Title, Subtitle or Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 29</td>
</tr>
<tr>
<td>Federal Contract Compliance Programs, Office of</td>
<td>41, 60</td>
</tr>
<tr>
<td>Federal Procurement Regulations System</td>
<td>41, 50</td>
</tr>
<tr>
<td>Labor-Management Standards, Office of</td>
<td>29, II, IV</td>
</tr>
<tr>
<td>Mine Safety and Health Administration</td>
<td>30, I</td>
</tr>
<tr>
<td>Occupational Safety and Health Administration</td>
<td>29, XVII</td>
</tr>
<tr>
<td>Public Contracts</td>
<td>41, 60</td>
</tr>
<tr>
<td>Secretary of Labor, Office of</td>
<td>29, Subtitle A</td>
</tr>
<tr>
<td>Veterans’ Employment and Training Service, Office of the Assistant Secretary for</td>
<td>41, 61; 20, IX</td>
</tr>
<tr>
<td>Wage and Hour Division</td>
<td>29, V</td>
</tr>
<tr>
<td>Labor-Management Standards, Office of</td>
<td>20, I, VII</td>
</tr>
<tr>
<td>Land Management, Bureau of</td>
<td>43, II</td>
</tr>
<tr>
<td>Legal Services Corporation</td>
<td>45, XVI</td>
</tr>
<tr>
<td>Library of Congress</td>
<td>36, VII</td>
</tr>
<tr>
<td>Copyright Royalty Board</td>
<td>37, III</td>
</tr>
<tr>
<td>U.S. Copyright Office</td>
<td>37, II</td>
</tr>
<tr>
<td>Local Television Loan Guarantee Board</td>
<td>7, XXI</td>
</tr>
<tr>
<td>Management and Budget, Office of</td>
<td>5, III, LXXVII; 14, VI; 48, 99</td>
</tr>
<tr>
<td>Marine Mammal Commission</td>
<td>50, V</td>
</tr>
<tr>
<td>Maritime Administration</td>
<td>46, II</td>
</tr>
<tr>
<td>Merit Systems Protection Board</td>
<td>5, II, LXIV</td>
</tr>
<tr>
<td>Micronesian Status Negotiations, Office for Military Compensation and Retirement Modernization</td>
<td>32, XXVII</td>
</tr>
<tr>
<td>Commission</td>
<td>5, XCIX</td>
</tr>
<tr>
<td>Millennium Challenge Corporation</td>
<td>22, XIII</td>
</tr>
<tr>
<td>Mine Safety and Health Administration</td>
<td>30, I</td>
</tr>
<tr>
<td>Minority Business Development Agency</td>
<td>15, XIV</td>
</tr>
<tr>
<td>Miscellaneous Agencies</td>
<td>1, IV</td>
</tr>
<tr>
<td>Monetary Offices</td>
<td>31, I</td>
</tr>
<tr>
<td>Morris K. Udall Scholarship and Excellence in National Environmental Policy Foundation</td>
<td>36, XVI</td>
</tr>
<tr>
<td>Museum and Library Services, Institute of National Archives and Records Administration</td>
<td>2, XXXXI</td>
</tr>
<tr>
<td>National Aeronautics and Space Administration</td>
<td>2, XVIII; 5, LIX; 14, V</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 18</td>
</tr>
<tr>
<td>National Agricultural Library</td>
<td>7, XXI</td>
</tr>
<tr>
<td>National Agricultural Statistics Service</td>
<td>7, XXXVI</td>
</tr>
<tr>
<td>National and Community Service, Corporation for</td>
<td>2, XXII; 45, XII, XXV</td>
</tr>
<tr>
<td>National Archives and Records Administration</td>
<td>2, XXVI; 5, LXVI; 36; XII</td>
</tr>
<tr>
<td>Information Security Oversight Office</td>
<td>32, XX</td>
</tr>
<tr>
<td>National Capital Planning Commission</td>
<td>1, IV</td>
</tr>
<tr>
<td>National Commission for Employment Policy</td>
<td>1, IV</td>
</tr>
<tr>
<td>National Commission on Libraries and Information Science</td>
<td>45, XVII</td>
</tr>
<tr>
<td>National Council on Disability</td>
<td>5, C; 31, XII</td>
</tr>
<tr>
<td>National Counterintelligence Center</td>
<td>32, XVIII</td>
</tr>
<tr>
<td>National Credit Union Administration</td>
<td>5, LXXXVI; 12, VII</td>
</tr>
<tr>
<td>National Crime Prevention and Privacy Compact Council</td>
<td>28, IX</td>
</tr>
<tr>
<td>National Drug Control Policy, Office of</td>
<td>2, XXXVI; 21, III</td>
</tr>
<tr>
<td>National Endowment for the Arts</td>
<td>2, XXXII</td>
</tr>
<tr>
<td>National Endowment for the Humanities</td>
<td>2, XXXIII</td>
</tr>
<tr>
<td>National Foundation on the Arts and the Humanities</td>
<td>45, XI</td>
</tr>
<tr>
<td>National Geospatial-Intelligence Agency</td>
<td>32, I</td>
</tr>
<tr>
<td>National Highway Traffic Safety Administration</td>
<td>23, II, III; 47, VI; 49, V</td>
</tr>
<tr>
<td>National Imagery and Mapping Agency</td>
<td>32, I</td>
</tr>
<tr>
<td>National Indian Gaming Commission</td>
<td>26, III</td>
</tr>
<tr>
<td>National Institute of Food and Agriculture</td>
<td>7, XXXIV</td>
</tr>
<tr>
<td>National Institute of Standards and Technology</td>
<td>15, II</td>
</tr>
<tr>
<td>National Intelligence, Office of Director of</td>
<td>5, IV; 32, XVII</td>
</tr>
<tr>
<td>National Labor Relations Board</td>
<td>5, LXI; 29, I</td>
</tr>
<tr>
<td>National Marine Fisheries Service</td>
<td>50, II, IV</td>
</tr>
<tr>
<td>National Mediation Board</td>
<td>29, X</td>
</tr>
<tr>
<td>National Oceanic and Atmospheric Administration</td>
<td>15, IX; 50, II, III, IV, VI</td>
</tr>
<tr>
<td>National Park Service</td>
<td>36, I</td>
</tr>
<tr>
<td>National Railroad Adjustment Board</td>
<td>29, III</td>
</tr>
<tr>
<td>Agency</td>
<td>CFR Title, Subtitle or Chapter</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>National Railroad Passenger Corporation (AMTRAK)</td>
<td>49, VII</td>
</tr>
<tr>
<td>National Science Foundation</td>
<td>2, XXV; 5, XLIII; 45, VI</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 25</td>
</tr>
<tr>
<td>National Security Council</td>
<td>32, XXI</td>
</tr>
<tr>
<td>National Security Council and Office of Science and Technology Policy</td>
<td>47, II</td>
</tr>
<tr>
<td>National Telecommunications and Information Administration</td>
<td>15, XXIII; 47, III, IV</td>
</tr>
<tr>
<td>National Transportation Safety Board</td>
<td>49, VIII</td>
</tr>
<tr>
<td>Natural Resources Conservation Service</td>
<td>7, VI</td>
</tr>
<tr>
<td>Natural Resource Revenue, Office of</td>
<td>30, XII</td>
</tr>
<tr>
<td>Navajo and Hopi Indian Relocation, Office of</td>
<td>25, IV</td>
</tr>
<tr>
<td>Navy Department</td>
<td>32, VI</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 52</td>
</tr>
<tr>
<td>Neighborhood Reinvestment Corporation</td>
<td>24, XXV</td>
</tr>
<tr>
<td>Northeast Interstate Low-Level Radioactive Waste Commission</td>
<td>10, XVIII</td>
</tr>
<tr>
<td>Nuclear Regulatory Commission</td>
<td>2, XX; 5, XLVIII; 10, I</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 29</td>
</tr>
<tr>
<td>Occupational Safety and Health Administration</td>
<td>29, XVII</td>
</tr>
<tr>
<td>Occupational Safety and Health Review Commission</td>
<td>29, XX</td>
</tr>
<tr>
<td>Ocean Energy Management, Bureau of</td>
<td>30, V</td>
</tr>
<tr>
<td>Oklahoma City National Memorial Trust</td>
<td>36, XV</td>
</tr>
<tr>
<td>Operations Office</td>
<td>7, XXVIII</td>
</tr>
<tr>
<td>Overseas Private Investment Corporation</td>
<td>5, XXXIII; 22, VII</td>
</tr>
<tr>
<td>Patent and Trademark Office, United States</td>
<td>37, I</td>
</tr>
<tr>
<td>Payment From a Non-Federal Source for Travel Expenses</td>
<td>41, 394</td>
</tr>
<tr>
<td>Payment of Expenses Connected With the Death of Certain Employees</td>
<td>41, 393</td>
</tr>
<tr>
<td>Peace Corps</td>
<td>2, XXXVII; 22, III</td>
</tr>
<tr>
<td>Pennsylvania Avenue Development Corporation</td>
<td>36, IX</td>
</tr>
<tr>
<td>Pension Benefit Guaranty Corporation</td>
<td>29, XL</td>
</tr>
<tr>
<td>Personnel Management, Office of</td>
<td>5, I, XXXV; 5, IV; 45, VIII</td>
</tr>
<tr>
<td>Human Resources Management and Labor Relations</td>
<td>5, XCVII</td>
</tr>
<tr>
<td>Systems, Department of Homeland Security</td>
<td></td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 17</td>
</tr>
<tr>
<td>Federal Employees Group Life Insurance Federal Acquisition Regulation</td>
<td>48, 21</td>
</tr>
<tr>
<td>Federal Employees Health Benefits Acquisition Regulation</td>
<td>48, 16</td>
</tr>
<tr>
<td>Pipeline and Hazardous Materials Safety Administration</td>
<td>49, I</td>
</tr>
<tr>
<td>Postal Regulatory Commission</td>
<td>5, XLVI; 39, III</td>
</tr>
<tr>
<td>Postal Service, United States</td>
<td>5, LX; 39, I</td>
</tr>
<tr>
<td>Postsecondary Education, Office of</td>
<td>34, VI</td>
</tr>
<tr>
<td>President's Commission on White House Fellowships</td>
<td>1, IV</td>
</tr>
<tr>
<td>Presidential Documents</td>
<td>3</td>
</tr>
<tr>
<td>Presidio Trust</td>
<td>36, X</td>
</tr>
<tr>
<td>Prisons, Bureau of</td>
<td>28, V</td>
</tr>
<tr>
<td>Privacy and Civil Liberties Oversight Board</td>
<td>6, X</td>
</tr>
<tr>
<td>Procurement and Property Management, Office of</td>
<td>7, XXXII</td>
</tr>
<tr>
<td>Productivity, Technology and Innovation, Assistant Secretary</td>
<td>37, IV</td>
</tr>
<tr>
<td>Public Contracts, Department of Labor</td>
<td>41, 50</td>
</tr>
<tr>
<td>Public and Indian Housing, Office of Assistant Secretary for</td>
<td>24, IX</td>
</tr>
<tr>
<td>Public Health Service</td>
<td>42, I</td>
</tr>
<tr>
<td>Railroad Retirement Board</td>
<td>20, II</td>
</tr>
<tr>
<td>Reclamation, Bureau of</td>
<td>43, I</td>
</tr>
<tr>
<td>Refugee Resettlement, Office of</td>
<td>45, IV</td>
</tr>
<tr>
<td>Relocation Allowances</td>
<td>41, 392</td>
</tr>
<tr>
<td>Research and Innovative Technology Administration</td>
<td>49, XI</td>
</tr>
<tr>
<td>Rural Business-Cooperative Service</td>
<td>7, XVIII, XLII</td>
</tr>
<tr>
<td>Rural Development Administration</td>
<td>7, XLII</td>
</tr>
<tr>
<td>Rural Housing Service</td>
<td>7, XVIII, XXXV</td>
</tr>
<tr>
<td>Rural Telephone Bank</td>
<td>7, XVI</td>
</tr>
<tr>
<td>Rural Utilities Service</td>
<td>7, XVII, XVIII, XLII</td>
</tr>
<tr>
<td>Safety and Environmental Enforcement, Bureau of</td>
<td>36, II</td>
</tr>
<tr>
<td>Saint Lawrence Seaway Development Corporation</td>
<td>33, IV</td>
</tr>
</tbody>
</table>

1002
<table>
<thead>
<tr>
<th>Agency</th>
<th>CFR Title, Subtitle or Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Science and Technology Policy, Office of</td>
<td>32, XXIV</td>
</tr>
<tr>
<td>Science and Technology Policy, Office of, and National Security Council</td>
<td>47, II</td>
</tr>
<tr>
<td>Secret Service</td>
<td>31, IV</td>
</tr>
<tr>
<td>Securities and Exchange Commission</td>
<td>5, XXXIV; 17, II</td>
</tr>
<tr>
<td>Selective Service System</td>
<td>32, XVI</td>
</tr>
<tr>
<td>Small Business Administration</td>
<td>2, XXVII; 13, I</td>
</tr>
<tr>
<td>Smithsonian Institution</td>
<td>36, V</td>
</tr>
<tr>
<td>Social Security Administration</td>
<td>2, XXIII; 20, III; 48, 23</td>
</tr>
<tr>
<td>Soldiers' and Airmen's Home, United States</td>
<td>5, XI</td>
</tr>
<tr>
<td>Special Counsel, Office of</td>
<td>5, VIII</td>
</tr>
<tr>
<td>Special Education and Rehabilitative Services, Office of State</td>
<td>34, III</td>
</tr>
<tr>
<td>Department</td>
<td>2, VI; 22, I; 28, XI</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 6</td>
</tr>
<tr>
<td>Surface Mining Reclamation and Enforcement, Office of</td>
<td>30, VII</td>
</tr>
<tr>
<td>Surface Transportation Board</td>
<td>49, X</td>
</tr>
<tr>
<td>Susquehanna River Basin Commission</td>
<td>18, VIII</td>
</tr>
<tr>
<td>Technology Administration</td>
<td>15, XI</td>
</tr>
<tr>
<td>Technology Policy, Assistant Secretary for</td>
<td>37, IV</td>
</tr>
<tr>
<td>Tennessee Valley Authority</td>
<td>5, LXIX; 18, XIII</td>
</tr>
<tr>
<td>Thrift Supervision Office, Department of the Treasury</td>
<td>12, V</td>
</tr>
<tr>
<td>Trade Representative, United States, Office of</td>
<td>15, XX</td>
</tr>
<tr>
<td>Transportation, Department of</td>
<td>2, XII; 5, L</td>
</tr>
<tr>
<td>Commercial Space Transportation</td>
<td>14, III</td>
</tr>
<tr>
<td>Contract Appeals, Board of</td>
<td>48, 63</td>
</tr>
<tr>
<td>Emergency Management and Assistance</td>
<td>44, IV</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 12</td>
</tr>
<tr>
<td>Federal Aviation Administration</td>
<td>14, I</td>
</tr>
<tr>
<td>Federal Highway Administration</td>
<td>23, I, II</td>
</tr>
<tr>
<td>Federal Motor Carrier Safety Administration</td>
<td>49, III</td>
</tr>
<tr>
<td>Federal Railroad Administration</td>
<td>49, II</td>
</tr>
<tr>
<td>Federal Transit Administration</td>
<td>49, VI</td>
</tr>
<tr>
<td>Maritime Administration</td>
<td>46, II</td>
</tr>
<tr>
<td>National Highway Traffic Safety Administration</td>
<td>23, II; III; 47, IV; 49, V</td>
</tr>
<tr>
<td>Pipeline and Hazardous Materials Safety Administration</td>
<td>49, I</td>
</tr>
<tr>
<td>Saint Lawrence Seaway Development Corporation</td>
<td>33, IV</td>
</tr>
<tr>
<td>Secretary of Transportation, Office of</td>
<td>14, II; 49, Subtitle A</td>
</tr>
<tr>
<td>Transportation Statistics Bureau</td>
<td>49, XI</td>
</tr>
<tr>
<td>Transportation, Office of</td>
<td>7, XXXIII</td>
</tr>
<tr>
<td>Transportation Security Administration</td>
<td>49, XII</td>
</tr>
<tr>
<td>Transportation Statistics Bureau</td>
<td>49, XI</td>
</tr>
<tr>
<td>Travel Allowances, Temporary Duty (TDY)</td>
<td>41, 301</td>
</tr>
<tr>
<td>Treasury Department</td>
<td>2, X, 5, XXI; 12, XV; 17, IV; 31, IX</td>
</tr>
<tr>
<td>Alcohol and Tobacco Tax and Trade Bureau</td>
<td>27, I</td>
</tr>
<tr>
<td>Community Development Financial Institutions Fund</td>
<td>12, XVIII</td>
</tr>
<tr>
<td>Comptroller of the Currency</td>
<td>12, I</td>
</tr>
<tr>
<td>Customs and Border Protection</td>
<td>19, I</td>
</tr>
<tr>
<td>Engraving and Printing, Bureau of</td>
<td>31, VI</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 10</td>
</tr>
<tr>
<td>Federal Claims Collection Standards</td>
<td>31, IX</td>
</tr>
<tr>
<td>Federal Law Enforcement Training Center</td>
<td>31, VII</td>
</tr>
<tr>
<td>Financial Crimes Enforcement Network</td>
<td>31, X</td>
</tr>
<tr>
<td>Fiscal Service</td>
<td>31, II</td>
</tr>
<tr>
<td>Foreign Assets Control, Office of</td>
<td>31, V</td>
</tr>
<tr>
<td>Internal Revenue Service</td>
<td>26, I</td>
</tr>
<tr>
<td>Investment Security, Office of</td>
<td>31, VIII</td>
</tr>
<tr>
<td>Monetary Offices</td>
<td>31, I</td>
</tr>
<tr>
<td>Secret Service</td>
<td>31, IV</td>
</tr>
<tr>
<td>Secretary of the Treasury, Office of</td>
<td>31, Subtitle A</td>
</tr>
<tr>
<td>Thrift Supervision, Office of</td>
<td>12, V</td>
</tr>
<tr>
<td>Truman, Harry S., Scholarship Foundation</td>
<td>45, XVIII</td>
</tr>
<tr>
<td>United States and Canada, International Joint Commission</td>
<td>22, IV</td>
</tr>
<tr>
<td>United States and Mexico, International Boundary and Water Commission</td>
<td>22, XI</td>
</tr>
<tr>
<td>United States Section</td>
<td></td>
</tr>
<tr>
<td>U.S. Copyright Office</td>
<td>37, II</td>
</tr>
<tr>
<td>Utah Reclamation Mitigation and Conservation Commission</td>
<td>43, III</td>
</tr>
<tr>
<td>Agency</td>
<td>CFR Title, Subtitle or Chapter</td>
</tr>
<tr>
<td>--------------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Veterans Affairs Department</td>
<td>2, VIII; 38, I</td>
</tr>
<tr>
<td>Federal Acquisition Regulation</td>
<td>48, 8</td>
</tr>
<tr>
<td>Veterans' Employment and Training Service, Office of the</td>
<td>41, 61; 20, IX</td>
</tr>
<tr>
<td>Assistant Secretary for</td>
<td></td>
</tr>
<tr>
<td>Vice President of the United States, Office of</td>
<td>32, XXVIII</td>
</tr>
<tr>
<td>Wage and Hour Division</td>
<td>29, V</td>
</tr>
<tr>
<td>Water Resources Council</td>
<td>18, VI</td>
</tr>
<tr>
<td>Workers' Compensation Programs, Office of</td>
<td>20, I, VII</td>
</tr>
<tr>
<td>World Agricultural Outlook Board</td>
<td>7, XXXVIII</td>
</tr>
</tbody>
</table>
List of CFR Sections Affected

All changes in this volume of the Code of Federal Regulations (CFR) that were made by documents published in the Federal Register since January 1, 2011 are enumerated in the following list. Entries indicate the nature of the changes effected. Page numbers refer to Federal Register pages. The user should consult the entries for chapters, parts and subparts as well as sections for revisions.


### 2011

<table>
<thead>
<tr>
<th>CFR Volume</th>
<th>Section</th>
<th>Change Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 FR</td>
<td>76 FR</td>
<td>42 CFR—Continued</td>
<td>Page</td>
</tr>
<tr>
<td>Chapter IV</td>
<td>42 CFR—Continued</td>
<td>(a)(8) and (9) added; revised</td>
<td>25562</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(a)(3) and (4) added; (c)(6) revised</td>
<td>25563</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Authority citation revised</td>
<td>9511</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(a)(8) and (9) added; (a)(9) redesignated as (a)(8); new (a)(8) added; interim</td>
<td>9511</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(r) and (s) added; interim</td>
<td>9511</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Revised</td>
<td>69807</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(c) added</td>
<td>25564</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(c)(5) added</td>
<td>25564</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(b)(4) revised</td>
<td>25564</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Authority citation revised</td>
<td>9511</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(e)(2)(ii) revised; eff. 1–1–12</td>
<td>15126</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(a)(3) added; eff. 1–1–12</td>
<td>15126</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Revised; eff. 1–1–12</td>
<td>15126</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(b) revised; (c) added; interim</td>
<td>9511</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Added; eff. 1–1–12</td>
<td>15126</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heading; (a), (b)(1) introductory text, (2), (c)(1) introductory text and (2) revised; (e) removed; eff. 1–1–12</td>
<td>15127</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Added; eff. 1–1–12</td>
<td>15127</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(b)(1) revised; eff. 1–1–12</td>
<td>15127</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(c) and (d)(1) revised; eff. 1–1–12</td>
<td>15127</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(b) and (c) revised; eff. 1–1–12</td>
<td>15128</td>
</tr>
</tbody>
</table>

### 2012

<table>
<thead>
<tr>
<th>CFR Volume</th>
<th>Section</th>
<th>Change Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 FR</td>
<td>77 FR</td>
<td>42 CFR—Continued</td>
<td>Page</td>
</tr>
<tr>
<td>Chapter IV</td>
<td>42 CFR—Continued</td>
<td>Introductory text revised</td>
<td>29074</td>
</tr>
</tbody>
</table>
Chapter IV—Continued

482.13 (g)(1), (2) and (3) revised; (g)(4) added .................................29074
482.22 (a) introductory text, (2) and (b)(3) revised ..............................29074
482.23 (b)(4) and (c) revised....................................................29074
482.24 (c)(1)(i), (ii) and (iii) removed; (c)(2) redesignated as (c)(4); new (c)(2) and (3) added..................................29075
482.25 (b)(6) revised .............................................................29075
482.42 (a) introductory text and (b)(1) revised.................................29075
482.54 (b) revised ...............................................................29076
482.92 (a) removed; (b) and (c) redesignated as new (a) and (b) ..........29076
484.250 (c)(3) added.................................................................67164
485.602 Removed .................................................................29076
485.604 (a) revised.................................................................29076
485.623 (a) revised.................................................................29076
485.635 (a)(3)(i) and (b) revised ..............................................29076
485.639 Introductory text revised..................................................29076
486.106 Introductory text, (a) and (b) revised..............................69372
486.302 Amended .................................................................29031
486.324 Second(e) removed......................................................29031
486.2 Amended .................................................................67164
486.26 (c)(2) and (e) revised ....................................................67164
486.28 Heading revised............................................................67164
488.700—488.745 (Subpart I) Added...........................................67164
488.745 Eff. 7-1-14—11-5-12 ..................................................67164
488.800—488.865 (Subpart J) Added...........................................67164
488.840 Eff. 7-1-14 .................................................................67165
488.845 Eff. 7-1-14 .................................................................67165
489 Technical correction.........................................................227, 24409
493.53 (a)(17) and (d)(2)(iii) added ..............................................67170
494.60 (e)(1) and (2) revised ......................................................29031
495 Technical correction.........................................................227, 24409
495.4 Amended; eff. in part 11-5-12 ........................................54148
495.5 Added; eff. 11-5-12 .........................................................54149

495.6 (a)(2)(i), (b)(2)(ii), (d)(1)(i), (d)(1)(ii), (4)(iii), (8)(i)(E), (ii), (iii), (10)(i), (i), (12)(i), (ii), (iii), (14)(i), (ii), (e)(5)(i), (ii), (9)(i), (10)(i), (i), (11)(i), (ii), (12)(i), (ii), (11), (iii), (13)(i), (ii), (g)(8)(i), (9)(i) and (10)(i) redesignated as (a)(2)(i)(A), (b)(2)(i)(A), (d)(1)(i)(A), (4)(iii)(A), (8)(i)(E)(i), (ii)(A), (iii)(A), (10)(i)(A), (ii)(A), (12)(i)(A), (ii)(A), (11)(i)(A), (ii)(A), (13)(i)(A), (ii)(A), (14)(i)(A), (ii)(A), (g)(8)(i)(A), (9)(i)(A) and (10)(i)(A); (a)(2)(i)(B), (b)(2)(i)(B), (d)(1)(i)(B), (4)(iii)(B), (8)(i)(E)(i), (3), (ii)(B), (C), (iii)(B), (C), (10)(i)(B), (ii)(B), (12)(i)(B), (11)(i)(B), (ii)(B), (13)(i)(B), (ii)(B), (14)(i)(B), (ii)(B), (e)(5)(i)(B), (ii)(B), (9)(i)(B), (10)(i)(B), (f)(1)(i)(ii)(B), (C), (7)(i)(E)(i), (3), (ii)(B), (C), (9)(i)(B), (ii)(B), (11)(i)(B), (ii)(B), (12)(i)(B), (ii)(B), (11)(i)(B), (ii)(B), (9)(i)(B), (10)(i)(B) and (j) through (m) added; (c) introductory text, (1), (e) introductory text and (g) introductory text amended; (h) and (i) revised; eff. in part 11-5-12 .................................54149
495.8 (a)(2)(i)(B), (ii)(B), (b)(2)(i)(B) and (ii) revised; eff. 11-5-12 ..54149
495.10 (a)(3) amended; eff. 11-5-12 ..........................................54149
495.100 Amended; eff. 11-5-12 ................................................54157
495.102 (c), (d)(1), (2)(iii) and (3) revised; (d)(2)(iv), (4) and (5) added; eff. in part 11-5-12 .................................54157
495.106 (e) amended; eff. 11-5-12 ....54158
495.200 Amended; eff. 11-5-12 .................................54158
### List of CFR Sections Affected

<table>
<thead>
<tr>
<th>42 CFR—Continued</th>
<th>80 FR Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>488.28 (a) revised</td>
<td>29839</td>
</tr>
<tr>
<td>489 Authority citation revised</td>
<td>29839</td>
</tr>
<tr>
<td>489.1 (b) revised</td>
<td>29839</td>
</tr>
<tr>
<td>489.3 Amended</td>
<td>29840</td>
</tr>
<tr>
<td>489.53 (a) introductory text, (2), (13) and (d)(2)(i) introductory text revised; (a)(18) added</td>
<td>29840</td>
</tr>
<tr>
<td>495.4 Amended</td>
<td>62940, 71386</td>
</tr>
<tr>
<td>495.6 Redesignated as 495.20</td>
<td>62943</td>
</tr>
<tr>
<td>495.8 Redesignated as 495.40</td>
<td>62943</td>
</tr>
<tr>
<td>495.10 Redesignated as 495.60</td>
<td>62943</td>
</tr>
<tr>
<td>495.20 Redesignated from 495.6; heading revised; introductory text added</td>
<td>62943</td>
</tr>
<tr>
<td>495.22 Added</td>
<td>62943</td>
</tr>
<tr>
<td>495.24 Added</td>
<td>62948</td>
</tr>
<tr>
<td>495.40 Redesignated from 495.8</td>
<td>62943</td>
</tr>
<tr>
<td>(b)(1)(iv) redesignated as (b)(1)(iii); (a) introductory text, (1)(1)(B), (iii), (2)(1)(D), (2)(iv), (b)(1)(i)(B), new (ii) and (2)(1)(D) amended; (a)(2)(1)(B), (b)(2)(i)(B) revised; (a)(2)(1)(E), (F), (b)(2)(i)(E), (F) and (G) added</td>
<td>62954</td>
</tr>
<tr>
<td>495.60 Redesignated from 495.10</td>
<td>62943</td>
</tr>
<tr>
<td>495.310 (d) removed; eff. 11-15-16</td>
<td>62943</td>
</tr>
<tr>
<td>495.316 (c) introductory text revised; (d)(1)(i) and (iii) amended; (d)(2)(iii), (f), (g) and (h) added</td>
<td>62954</td>
</tr>
<tr>
<td>495.352 Revised</td>
<td>62940-54</td>
</tr>
<tr>
<td>505—510 (Subchapter H) Heading revised</td>
<td>73540</td>
</tr>
<tr>
<td>510 Added</td>
<td>73540</td>
</tr>
</tbody>
</table>

### 2016

(Regulations published from January 1, 2016, through October 1, 2016)

<table>
<thead>
<tr>
<th>42 CFR—Continued</th>
<th>81 FR Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>482.15 Added; eff. 11-15-16</td>
<td>64028</td>
</tr>
<tr>
<td>482.41 (b)(4) and (5) removed; (b)(6) through (9) and (c) redesignated as new (b)(4) through (7) and (d); (b)(1)(i), (ii), (2) and new (7) revised; new (b)(8), (9), new (c) and (e) added</td>
<td>62899</td>
</tr>
<tr>
<td>(b)(1)(i) corrected</td>
<td>42548</td>
</tr>
<tr>
<td>482.68 Revised; eff. 11-15-16</td>
<td>64030</td>
</tr>
<tr>
<td>482.78 Added; eff. 11-15-16</td>
<td>64030</td>
</tr>
<tr>
<td>483.15 (h)(4) amended</td>
<td>26899</td>
</tr>
<tr>
<td>483.20 (j)(1)(i) and (ii) amended</td>
<td>61563</td>
</tr>
<tr>
<td>483.70 (a)(4) and (5) removed; (a)(6), (7), (8) and (b) through (h) redesignated as new (a)(4), (5), (6) and (c) through (i); (a)(1)(i), (ii), (2), new (4) revised; new (a)(7), (8), new (b) and (j) added</td>
<td>26899</td>
</tr>
<tr>
<td>(a)(6) introductory text corrected</td>
<td>42548</td>
</tr>
<tr>
<td>483.73 Added; eff. 11-15-16</td>
<td>64030</td>
</tr>
<tr>
<td>483.75 (m) removed; eff. 11-15-16</td>
<td>64032</td>
</tr>
<tr>
<td>483.151 (b)(2)(iv), (3)(iii) and (c)(1) amended</td>
<td>61563</td>
</tr>
<tr>
<td>483.470 (j)(5) and (6) removed; (j)(7) redesigned as new (j)(5); (j)(1)(i), (ii) and new (5) revised; (j)(1)(iii), (iv) and (m) added</td>
<td>26900</td>
</tr>
<tr>
<td>483.470 (h) removed; eff. 11-15-16</td>
<td>64032</td>
</tr>
<tr>
<td>483.475 Added; eff. 11-15-16</td>
<td>64032</td>
</tr>
<tr>
<td>484.22 Added; eff. 11-15-16</td>
<td>64033</td>
</tr>
<tr>
<td>485.64 Removed; eff. 11-15-16</td>
<td>64035</td>
</tr>
<tr>
<td>485.68 Added; eff. 11-15-16</td>
<td>64035</td>
</tr>
<tr>
<td>485.623 (d)(5) and (6) removed; (d)(7) redesignated as new (d)(5); (d)(1)(i), (ii), (2) and new (5) revised; new (d)(6), (e) and (f) added</td>
<td>26901</td>
</tr>
<tr>
<td>(c) removed; (d), (e) and (f) redesigned as new (c), (d) and (e); eff. 11-15-16</td>
<td>64036</td>
</tr>
<tr>
<td>485.625 Added; eff. 11-15-16</td>
<td>64036</td>
</tr>
<tr>
<td>485.727 Revised; eff. 11-15-16</td>
<td>64037</td>
</tr>
<tr>
<td>485.920 Added; eff. 11-15-16</td>
<td>64039</td>
</tr>
<tr>
<td>486.360 Added; eff. 11-15-16</td>
<td>64040</td>
</tr>
<tr>
<td>488.307 (c) amended</td>
<td>61563</td>
</tr>
<tr>
<td>488.408 (d)(1)(iii), (iv), (e)(1)(iii), (iv) and (2)(ii) amended</td>
<td>61563</td>
</tr>
<tr>
<td>488.438 (a)(1)(i), (ii) and (2) amended</td>
<td>61563</td>
</tr>
<tr>
<td>488.446 (a)(1), (2) and (3) amended</td>
<td>61563</td>
</tr>
<tr>
<td>488.725 (c) amended</td>
<td>61563</td>
</tr>
<tr>
<td>488.845 (b)(2)(iii), (3) introductory text, (1), (ii), (iii), (4), (5), (6) and (d)(1)(ii) amended</td>
<td>61563</td>
</tr>
<tr>
<td>489 Authority citation revised</td>
<td>57273</td>
</tr>
<tr>
<td>490.20 (y) added</td>
<td>57273</td>
</tr>
<tr>
<td>491.6 (c) removed; eff. 11-15-16</td>
<td>64041</td>
</tr>
<tr>
<td>491.12 Added; eff. 11-15-16</td>
<td>64041</td>
</tr>
</tbody>
</table>

1009
### 42 CFR—Continued

<table>
<thead>
<tr>
<th>493.1834 (d)(2)(i) and (ii) amended</th>
<th>61564</th>
</tr>
</thead>
<tbody>
<tr>
<td>494.60 (d) removed; (e) redesignated as new (d); eff. 11-15-16</td>
<td>64042</td>
</tr>
<tr>
<td>495.22 (e)(3)(ii)(C)(3) and (10)(i)(C)(3) introductory text correctly amended</td>
<td>11449</td>
</tr>
<tr>
<td>495.24 (d)(7)(i)(B)(3) introductory text and (ii)(B)(3) introductory text correctly amended</td>
<td>11449</td>
</tr>
<tr>
<td>495.300 (a)(4) correctly removed; (a)(5) correctly redesignated as new (a)(4); (c)(2)(i) correctly added</td>
<td>11451</td>
</tr>
<tr>
<td>495.305 (f)(1)(ii) correctly amended</td>
<td>11451</td>
</tr>
<tr>
<td>510.300 (w)(7) amended; undesignated text following (w)(9) designated as (w) Note; interim</td>
<td>10091</td>
</tr>
<tr>
<td>510.305 (f)(1)(ii) correctly amended</td>
<td>3012</td>
</tr>
<tr>
<td>600 Policy statement; eff. 1-1-17</td>
<td>10091</td>
</tr>
<tr>
<td>600 Policy statement; eff. 1-1-17</td>
<td>10091</td>
</tr>
</tbody>
</table>

---

**Chapter V**

1001.952 (w)(7) amended; undesignated text following (w)(9) designated as (w) Note; interim

1003.103 (a)(1), (2), (b), (c), (d)(1), (e)(1), (2), (f)(1) introductory text, (2) introductory text, (3) introductory text, (5), (g), (h)(1), (i)(1) and (j) through (m) amended

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Page 1010