



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-27

DATE: July 13, 2007

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Emergency Medical Screening in Critical Access Hospitals (CAHs)

Memorandum Summary

- Critical Access Hospital (CAH) regulations at 42 CFR 485.618(d) were amended on November 24, 2006. The regulations now permit a CAH to include a registered nurse (RN), who has training and experience in emergency care and is on site at the CAH, among the qualified medical personnel available to conduct emergency medical screening examinations of individuals who present to the CAH emergency department.
- If the nature of the individual's medical condition falls outside the RN's scope of practice, then other CAH qualified medical personnel must see the patient within specified timeframes.

42 CFR 485.618(a) of the CAH emergency services Condition of Participation (CoP) requires a CAH to have emergency services available 24 hours a day, while §485.618(d) sets standards for emergency services personnel, including response times for personnel to be available on site. The CAH provider community requested that the Centers for Medicare & Medicaid Services (CMS) change the CAH emergency services personnel standard at §485.618(d) to conform to the provisions of the Emergency Medical Treatment and Labor Act (EMTALA) regulations at 42 CFR 489.24(a)(1)(i), concerning the types of personnel who may conduct the medical screening examination required under EMTALA. The EMTALA regulations require the screening examination of individuals who come to a hospital or CAH's emergency department to be conducted by qualified medical personnel, as determined by the hospital/CAH's bylaws or rules and regulations, who are qualified in emergency care and are supervised by a member of the medical staff. Qualified medical personnel must be practicing within the scope of practice allowed them under State law.

On November 24, 2006 CMS published a final rule (71 FR 68159) amending the CAH CoPs at 42 CFR 485.618(d). This revised final rule allows an RN with training and experience in emergency care to conduct some medical screening examinations.

This is permitted only if:

- the RN is on site and immediately available when an individual comes to the CAH's emergency department and requests examination or treatment;
- the RN has training and experience in emergency care; and
- the nature of the request for medical care is within the scope of practice of an RN and consistent with applicable State laws and the CAH's bylaws or rules and regulations.

If the RN knows initially that the medical screening examination for the presenting complaint is outside his or her scope of practice, or if the RN begins the emergency medical screening and determines that the nature of the individual's condition is outside his or her scope of practice, the CAH's physician, physician assistant, nurse practitioner or clinical nurse specialist must be contacted to see the patient within 30 minutes (or 60 minutes if in a remote area, or permissible under the State's rural health care plan), as specified at 42 CFR 485.618(d)(1).

Surveyors reviewing compliance with the CAH emergency services CoP must determine whether the CAH uses RNs to conduct medical screening examinations of individuals coming to the CAH's emergency department. If so, surveyors must confirm that the CAH's bylaws or rules and regulations provide for RNs to conduct screening examinations within their scope of practice, consistent with State law, and that the RN(s) performing such examinations have documented training and experience in emergency care. Surveyors must review at least one medical record of an emergency department patient whose screening examination was conducted by an RN, to confirm that the examination was within the scope of practice permitted an RN, consistent with State law and the CAH's bylaws or rules and regulations.

If you have any questions concerning this memorandum, please contact Cindy Melanson at (410) 786-0310 or via e-mail at cindy.melanson@cms.hhs.gov.

Effective Date: This policy is effective immediately. The State Agency should disseminate this information within 30 days of the date of this memorandum.

Training: This information should be shared with all appropriate survey and certification staff, surveyors, and their managers.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

examination, which is described by CPT code 76775. Therefore, in this final rule with comment period, we are finalizing this assignment for CY 2007. That is, we are basing the CY 2007 payment for HCPCS code G0389 on equivalent hospital resources and intensity to those contained in CPT code 76775, which is assigned to APC 0266 (Level II Diagnostic and Screening Ultrasound) under the OPPS for CY 2007. We believe that the hospital costs associated with the screening study are very similar to those of the limited retroperitoneal ultrasound diagnostic examination and, therefore, the screening and diagnostic studies should be assigned to the same clinical APC for reasons of clinical and resource homogeneity. Thus, we are assigning G0389 to APC 0266 with a median cost of \$95.37 for CY 2007. Consistent with the statute, no Medicare beneficiary deductible will be applied to payment for this AAA screening service.

XIV. Emergency Medical Screening in Critical Access Hospitals (CAHs)

A. Background

Section 1820 of the Act, as amended by section 4201 of the Balanced Budget Act of 1997, provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPs), under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participations (CoPs) under 42 CFR Part 485, Subpart F, will be certified as CAHs by CMS. The MRHFP replaced the Essential Access Community Hospital (EACH)/Rural Primary Care Hospital (RPCH) program.

B. Proposed Policy Change

Existing regulations governing CAHs at § 485.618(d) require on-call doctors and nonphysician practitioners who may be attending to urgent/acute medical problems in other areas of the CAH or outside the CAH to report to the CAH's emergency room within 30 minutes (60 minutes if the CAH is located in a frontier or remote area or permissible under the State's rural health care plan) to see a patient in the emergency room of a CAH. Often, these patients do not have emergency medical conditions. With changes to the regulations at § 489.24 that implement the Emergency Medical Treatment and Labor Act (EMTALA) over the past few years, some practitioners have noted to CMS that the requirements regarding who should respond to calls to see patients who present to the emergency

department of a CAH are more stringent than for general hospitals.

The provider community recently requested that we change the emergency on-call personnel requirements for CAHs to conform to the regulatory changes published in the **Federal Register** on September 9, 2003 (68 FR 53262). In response to this request, in the proposed rule published in the **Federal Register** on August 23, 2006 (71 FR 49623), we proposed to revise the current CAH CoPs to align the emergency medical screening requirements in CAHs with those applicable to acute care hospitals. We proposed to allow registered nurses, in addition to the personnel currently required at § 485.618(d), to serve as qualified medical personnel to screen individuals who present to the CAH emergency room if the nature of the patient's request is within the registered nurse's scope of practice under State law and such screening is permitted by the CAH's bylaws. This proposed change would effectively eliminate the need for a doctor or nonphysician practitioner to report to the emergency department to attend to a nonemergent request for medical care if a registered nurse is on site at the CAH and has made a determination that the care needed is of a nonemergent nature.

The EMTALA statute at section 1867 of the Act states that a hospital in this context must provide an appropriate (suitable for the symptoms presented) medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition exists (section 1866(a)(1)(I) of the Act imposes the section 1867 requirements on a CAH). The EMTALA regulations at § 489.24(a) state that the examination must be conducted by qualified medical personnel. These qualified medical personnel designated to perform medical screening examinations must be determined qualified by the hospital's bylaws or rules and regulations and must be practicing within the scope of practice under State law.

The regulations at § 489.24(c) relating to the use of a dedicated emergency department for nonemergency services were added in September 2003 (68 FR 53262) to state that if an individual goes to a hospital's dedicated emergency department to request medical treatment, and 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 to determine that the individual does

not have an emergency medical condition.

Although EMTALA also applies to CAHs, the CoP for CAH emergency services (§ 485.618(d)) states that a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care, must be on call and available onsite at a CAH within a specified timeframe. Therefore, under this CAH CoP, these are the only CAH personnel who are currently permitted to conduct an appropriate medical screening to determine that an individual, who presents in the manner described above, does not have an emergency medical condition (as required under § 489.24(c)). In contrast, the emergency services CoP for acute care hospitals at § 482.55 does not specify the type of personnel who must be available to provide emergency services and who would, therefore, perform assessments and screenings. The regulation states only that the services must be organized and supervised under the direction of a qualified member of the medical staff and that there must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility. Therefore, an acute care hospital may, if it chooses, have protocols that permit a registered nurse to conduct specific emergency medical screenings if the nature of the individual's request for examination and treatment is within the scope of practice of a registered nurse. For emergencies that are outside of a registered nurse's scope of practice, another qualified medical personnel (operating within his or her scope of practice under State law) would conduct the emergency medical screening.

We proposed to revise the CAH standard at § 485.618(d) to allow a CAH, if applicable, the flexibility of including a registered nurse, with training and experience in emergency care and who is on site at the CAH, as one of the qualified medical personnel available for emergency services, particularly emergency medical screenings, if the nature of the individual's request for medical care is within the registered nurse's scope of practice and is consistent with applicable State laws. If the registered nurse begins the emergency medical screening and determines that the nature of the individual's conditions is outside his or her scope of practice under State law, the physician, physician assistant, nurse practitioner or a clinical nurse specialist must be contacted to see the patient

within 30 or 60 minutes to conduct the emergency medical screening and provide stabilizing treatment. If the registered nurse knows initially that the medical screening for the presenting complaint is outside the applicable scope of practice under State law, the physician or other nonphysician practitioner must see the individual within the 30 or 60 minute timeframes (as currently specified in § 485.618(d)(1)).

We recognize that not all CAHs will be able to utilize this flexibility. Some State licensure boards have stated that it is not within the authorized scope of practice for a registered nurse to independently perform an appropriate emergency medical screening for the purpose of determining if an emergency medical condition exists. However, the licensure boards in these States further maintain that it is within the scope of practice for a registered nurse to assess the health status of an individual to determine a nonemergent condition and to provide nursing care or to refer the individual to appropriate medical resources. Therefore, based on State law, some CAHs will not be able to designate registered nurses as qualified medical personnel under our proposed revision to the regulations governing CAHs. However, as we wished to provide flexibility to CAHs and to be consistent with existing EMTALA policy, we proposed the revision to the regulation at § 485.618(d).

C. Public Comments Received on the Proposal

We received 12 comments on our proposal. Our response follows each comment summary.

Comment: All of the commenters supported the proposed revision of the current CoP to allow registered nurses with training and experience in emergency care to conduct specific medical screening examinations under certain provisions. Several of the commenters commended CMS for proposing a rule change that would afford CAHs the staffing flexibility needed to maintain access and to provide efficient emergency and urgent care services for their patients.

Response: We appreciate the support of the provider community and believe that this revision to the current CoP will most likely decrease the regulatory burden for CAHs by allowing them greater staffing flexibility.

Comment: Several commenters pointed out an inconsistency between the preamble language in the proposed rule, which notes that medical screening examinations by a registered nurse would be allowed only if such screenings were permitted by the CAH's bylaws, and the proposed regulation text, which does not mention the bylaws.

Response: We appreciate the commenters bringing this inadvertent omission to our attention. We are revising the regulatory text at § 485.618(d)(2)(ii) in this final rule to indicate that the nature of a patient's request for medical care must be within the scope of practice and consistent with applicable State laws and the CAH's bylaws or rules and regulations in order for a registered nurse to conduct a medical screening examination. This revision to the language is also consistent with the EMTALA regulations at § 489.24(a)(1)(i), which refer to hospital "bylaws or rules and regulations."

Comment: One commenter questioned the impact that this change may have on payment and encouraged CMS to ensure that it does not adversely affect the payment that CAHs receive for screening services.

Response: The change being made affects only the CAH CoPs and does not revise the CAH payment regulations, which are codified at 42 CFR 413.70.

Comment: One commenter noted that, in the FY 2007 IPPS proposed rule for EMTALA false labor certifications, care roles and responsibilities were to be documented in the "the medical staff bylaws or rules and regulations," while under the FY 2007 IPPS final rule, these roles and responsibilities are to be documented in "medical staff bylaws." The commenter requested a clarification on this issue due to concern that the final rule imposed a more restrictive requirement than was proposed by limiting documentation to the bylaws only.

Response: The FY 2007 final IPPS rule is outside the scope of this rule and cannot be addressed here. We will address this comment in a future document.

D. Final Policy

After consideration of the public comments received on the proposed rule, we are adopting the proposed change to § 485.618(d), with minor modifications, to allow a CAH, if

applicable, the flexibility of utilizing a registered nurse, with training and experience in emergency care, to conduct specific medical screening examinations only if the registered nurse is on site and immediately available at the CAH when a patient requests medical care and if the nature of the individual's request is within the registered nurse's scope of practice and consistent with applicable State laws and the CAH's bylaws or rules and regulations. As noted above, we have revised the regulatory text to include language regarding the CAH's bylaws, rules, and regulations. The revised regulatory text is now consistent with the preamble language contained in both the proposed rule and this final rule, and with the language in the EMTALA regulations at § 489.24(a).

XV. OPPS Payment Status and Comment Indicators

A. CY 2007 Status Indicator Definitions

The OPPS payment status indicators (SIs) that we assign to HCPCS codes and APCs play an important role in determining payment for services under the OPPS. They indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. Our CY 2007 final status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively. We are using the status indicators and definitions that are listed in Addendum D1, which we discuss below in greater detail.

1. Payment Status Indicators To Designate Services That Are Paid Under the OPPS

The table of proposed status indicators in section XV. of the proposed rule (71 FR 49625) inadvertently listed radiopharmaceuticals under status indicator "H" rather than under status indicator "K." Consistent with our CY 2007 proposed payment policy for radiopharmaceuticals (as discussed in section V.B.3.a.(3) of this preamble) and their associated status indicators as correctly listed in Addenda A and B of the CY 2007 proposed rule, the list of status indicators, the items, and their OPPS payment status descriptions are noted in the corrected table below.

MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the eligible providers' covered services for the geographic locale in which the qualified chain provider's home office is physically located.

(3) As MAC contractors become available, qualified chain providers, granted approval by CMS to enroll with and bill a single intermediary on behalf of their eligible member providers prior to October 1, 2005, will be assigned at an appropriate time to the MAC contracted by CMS to administer claims for the applicable Medicare benefit category for the geographic locale in which the chain provider's home office is physically located. The qualified chain provider will not need to request an exception to the requirement of paragraph (b)(1) of this section in order for this assignment to take effect.

(4) CMS may grant an exception to the requirement of paragraph (b)(1) of this section to eligible providers that are not under the common ownership or common control of a qualified chain provider, as well as ineligible providers, only if CMS finds the exception will support the implementation of MACs or will serve some other compelling interest of the Medicare program.

(c) *Assignment of suppliers to MACs.* (1) Suppliers, including physicians and other practitioners, but excluding suppliers of DMEPOS, enroll with and receive Medicare payment and other Medicare services from the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the supplier's covered services for the geographic locale in which the supplier furnished such services.

(2) Suppliers of DMEPOS receive Medicare payment and other Medicare services from the MAC assigned to administer claims for DMEPOS for the regional area in which the beneficiary receiving the DMEPOS resides. The terms of §§ 421.210 and 421.212 continue to apply to suppliers of DMEPOS.

(3) CMS may allow a group of ESRD suppliers under common ownership and common control to enroll with the MAC contracted by CMS to administer ESRD claims for the geographic locale in which the group's home office is located only if—

- (i) The group of ESRD suppliers requests such privileges; and
- (ii) CMS finds the exception will support the implementation of MACs or will serve some other compelling interest of the Medicare program.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

■ 37. The authority citation for Part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

- 38. Section 485.618 is amended by—
 - a. Revising paragraph (d)(1) introductory text.
 - b. Redesignating paragraphs (d)(2) and (d)(3) as paragraphs (d)(3) and (d)(4), respectively.
 - c. Adding a new paragraph (d)(2).
 - d. In redesignated paragraph (d)(3)(iv), removing the cross-reference “paragraph (d)(2)(iii)” and adding the cross-reference “paragraph (d)(3)(iii)” in its place.
 - e. In redesignated paragraph (d)(4), removing the cross-reference “paragraph (d)(2)(iii)” and adding the cross-reference “paragraph (d)(3)(iii)” in its place.

The revisions and additions read as follows:

§ 485.618 Condition of participation: Emergency services.

* * * * *

(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:

* * * * *

(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.

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PART 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

■ 39. The authority citation for Part 488 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 41. In § 488.1, the definition of “supplier” is revised to read as follows:

§ 488.1 Definitions.

* * * * *

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.

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(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 27, 2006.

Leslie Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: October 31, 2006.

Michael O. Leavitt,

Secretary.