

NASFM Survey Concerning Dual Codes in CMS paid facilities.

We are trying to find out if any states have successfully received a waiver from Centers for Medicare and Medicaid Services (CMS) for their state code (particularly the ICC code set) for critical access hospitals. We are running into problems where hospitals have to build to both the ICC codes and the Life Safety Code in Colorado. This is causing unnecessary expenses for our hospitals and some real problems when they find out they have to retrofit changes to meet CMS's requirements even though they were approved under the ICC codes. We just had a hospital document an additional \$1 million in construction expenses based upon the need to simultaneously meet the local ICC codes and the CMS mandated Life Safety Code. CMS Section 485.623(d)(2) states: "If CMS finds that the State has a fire and safety code imposed by State law that adequately protects patients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC."

My questions are:

- 1) Does your state have a waiver from CMS to apply your state code instead of the Life Safety Code?
- 2) Is this an issue in your state?
- 3) If so, would you be interested in helping lobby for a change in law that would allow CMS to automatically recognize the ICC codes as well as the Life Safety Code?

State	CMS Waiver	Is it an Issue	Interested in Lobbying	Comments
Colorado	No	Yes	Yes	We are running into problems where hospitals have to build to both the ICC codes and the Life Safety Code in Colorado. This is causing unnecessary expenses for our hospitals and some real problems when they find out they have to retrofit changes to meet CMS's requirements even though they were approved under the ICC codes. We just had a hospital document an additional \$1 million in construction expenses based upon the need to simultaneously meet the local ICC codes and the CMS mandated Life Safety Code.

State	CMS Waiver	Is it an Issue	Interested in Lobbying	Comments
Delaware	No	No	No	No, we use the Life Safety Code
Georgia	No	Yes	Yes	<p>Although I know this said to reply to Colorado State Fire Marshal Kevin Klein, I wanted you all to know what we have been trying to do through the ICC. First let me answer Kevin's question. In Georgia, we utilize both the 2006 IBC and IFC and the 2000 edition of the Life Safety Code NFPA 101. Yes, this is an issue in our state and yes I would be glad to assist in helping lobby.</p> <p>This is what the Joint Fire Service Review Committee has been trying to achieve with the support of NASFM's model code's committee. We have been somewhat successful in making the ICC codes meet the CMS requirements. During this current Code change cycle, I personally have submitted two code changes that will and an appendix in both the IFC and the IBC that has all of the CMS survey form inserted in the appendix. The idea behind this was to allow those states who adopt the I codes to adopt the respective appendix so that the building is constructed to the minimum federal standards. This will also allow the inspection of these facilities under the IFC and also hopeful allow CMS to accept the ICC codes as equivalent.</p> <p>PS. I have attached the form so you can see what was submitted to the IFC the IBC would be the same but would be Appendix L.</p>
Idaho	No	No	No	<p>In response to the questions posed in the inquiry... I would respond no to all three.</p> <p>I am attaching a document sent to me by the program manager for the state of Idaho that deals with these issues. The memorandum, dated September 8, 2008 addresses some of the same questions we are discussing amongst ourselves. It was authored by the Director of the Survey and Certification Group within the CMS folks.</p>
Iowa	No	No	No	<p>2) Is this an issue in your state? Not necessarily since the State Fire Code is referencing the Life Safety Code 2000 (with CMS amendments) and if the State Building Code applies, we adopted a provision which states that if two codes are in conflict, the Life Safety Code takes precedence. This is the Code Section addressing this issue:</p>

State	CMS Waiver	Is it an Issue	Interested in Lobbying	Comments
				<p>301.3(1) Hospitals and health care facilities.</p> <p>a. A hospital, as defined in rule 661—205.1(100), that is required to meet the provisions of the state building code shall be deemed to be in compliance with the fire safety requirements of the state building code if the hospital is in compliance with the provisions of rule 661—205.5(100). In any other case in which an applicable requirement of the Life Safety Code, 2000 edition, is inconsistent with an applicable requirement of the state building code, the hospital shall be deemed to be in compliance with the state building code requirement if the Life Safety Code requirement is met.</p> <p>b. A nursing facility or hospice, as defined in rule 661—205.1(100), that is required to meet the provisions of the state building code shall be deemed to be in compliance with the fire safety requirements of the state building code if the nursing facility or hospice is in compliance with the provisions of rule 661—205.10(100). In any other case in which an applicable requirement of the Life Safety Code, 2000 edition, is inconsistent with an applicable requirement of the state building code, the nursing facility or hospice shall be deemed to be in compliance with the state building code requirement if the Life Safety Code requirement is met.</p> <p>c. An intermediate care facility for the mentally retarded, as defined in rule 661—205.1(100), or intermediate care facility for persons with mental illness that is required to meet the provisions of the state building code shall be deemed to be in compliance with the fire safety requirements of the state building code if the intermediate care facility is in compliance with the provisions of rule 661—205.15(100). In any other case in which an applicable requirement of the Life Safety Code, 2000 edition, is inconsistent with an applicable requirement of the state building code, the intermediate care facility shall be deemed to be in compliance with the state building code requirement if the Life Safety Code requirement is met.</p> <p>d.</p>

State	CMS Waiver	Is it an Issue	Interested in Lobbying	Comments
				<p>An ambulatory health care facility, as defined in rule 661—205.1(100), that is required to meet the provisions of the state building code shall be deemed to be in compliance with the fire safety requirements of the state building code if the ambulatory health care facility is in compliance with the provisions of rule 661—205.20(100). In any other case in which an applicable requirement of the Life Safety Code, 2000 edition, is inconsistent with an applicable requirement of the state building code, the ambulatory health care facility shall be deemed to be in compliance with the state building code requirement if the Life Safety Code requirement is met.</p> <p>e.</p> <p>A religious nonmedical health care institution that is required to meet the provisions of the state building code shall be deemed to be in compliance with the provisions of the state building code if the institution is in compliance with the provisions of rule 661—205.25(100). In any other case in which an applicable requirement of the Life Safety Code, 2000 edition, is inconsistent with an applicable requirement of the state building code, the religious nonmedical health care institution shall be deemed to be in compliance with the state building code requirement if the Life Safety Code requirement is met.</p>
Kansas	No	No	No	No, when we review any plan review on any facility that is CMS certified we will review under the LSC 2000 – however, if a Local Jurisdiction has a code (i.e. IFC or IBC) that goes over and above the LSC 2000 – they still must comply.
Maine	No	No	No	Our office reviews all commercial building construction plans and we use have both ICC Building Codes and NFPA Fire and Life Safety Codes in Maine and we have had no significant conflicts or other problems in the design of any medical facilities. In fact, medical facilities are being reviewed and permitted on a regular basis even in this economy. If there were any real costs issues due to conflicts, we would certainly hear about it. We do all of the inspections of medical facilities for CMS in the state and haven't run into any problem there either.
Maryland	No	No	No	The State of Maryland has adopted the Life Safety Code as part of the State Fire Prevention Code. NASFM unsuccessfully tried to include several provisions in the 2009 edition of ICC Codes to address this issue.

State	CMS Waiver	Is it an Issue	Interested in Lobbying	Comments
Minnesota	No	No	Yes	Not at this time – we do however wish to participate in the NASFM project to identify the current issues with the whole CMS program.
Montana	No	No	No	Our understanding is if you take federal dollars you have to follow 101. This applies to nursing homes as well.
New Hampshire	No	No	No	In New Hampshire we apply both the NFPA 101 Life Safety Code and the ICC IBC. We have not had any issues and the most stringent code applies which eliminates any conflict for us.
New Mexico	No	No	No	Mr. Klein, In New Mexico new construct is under the ICC specifically our office imposes the IFC 2003. Existing facilities are inspected by 1997 NFPA 101. We have no MOU or any agreements only the state statute. The ICC references the NFPA constantly I would be We have had no problems.
New York	No	Yes	Yes	YES, we are currently engaged in with a special Task Force (see attached) that will be looking at this very issue as well as others in the wake of the quadruple fatal fire in a state operated group home on 3/21/09
North Carolina	No	No	No	It is important to first note that Chapter 10 of the ICC code and NFPA 101 are loosely based on each other. In North Carolina, the ICC set is modified by the NC Building Code Council and adopted for all construction. The Department of Health and Human Services has a Construction Section that evaluates the buildings for compliance with both the ICC set (NC) and NFPA 101 for licensure. When a difference occurs between the code and the standard during their evaluation, they use the most stringent requirement.
Utah	No	No	No	In the State of Utah we also use both the ICC (IBC & IFC) and NFPA 101 - Life Safety Code. We are currently in the process of adopting certain needed chapters of the 2009 edition of NFPA 101. Our office reviews the plans and the Utah State Department of Health also reviews the plans. The Department of Health has an architect that does the plan review who is also a Special Deputy State Fire Marshal for our office. We haven't had any problems because we have recognized the need of both codes and work to make them fit together. We have spoken about trying to get the ICC IBC substituted for NFPA 101 by CMS for the State of Utah, but it seemed to be a daunting task, and our office and the health department decided to let some other state take up the challenge and get it completed first. A unified effort by NASFM would surely have more impact

State	CMS Waiver	Is it an Issue	Interested in Lobbying	Comments
				than states trying to complete it by themselves. Thank you.
Virginia	No	No	No	<p>The VA SFMO enforces the LSC for CMS. In can be an issue when our interpretation of the LSC differs from the local building officials interpretations of the same issue in the State Building Code (ICC) for which they have full authority. The issue is the fact that CMS regulations overrule the local building official if the facility wants the money. I do not think that would change regardless of code.</p> <p>One other thought as indicated in Marshal Larson’s email with attachment, states could lose some of their federal monies for doing the surveys if the state code is approved. Every time I have asked that question over the years of CMS or their predecessor</p> <p>Also See Below</p>
Washington	No	Yes	No	We utilize both, with the life safety code prevailing where conflict exists. Is this an issue in your state? It has been in certain circumstances such as humidity requirements – these have been costly for facilities to meet.



PUBLIC CODE CHANGE PROPOSAL FORM FOR PUBLIC PROPOSALS IN THE INTERNATIONAL CODES

2009/2010 CODE DEVELOPMENT CYCLE

CLOSING DATE: All Proposals Must Be Received by June 1, 2009

The 2009/2010 Code Development Hearings are tentatively scheduled for
October 24-November 11, 2009, Baltimore, MD.

1)

Name: M. Dwayne Garriss		Date: 5/29/2009	
Jurisdiction/Company: State of Georgia / Georgia- State Fire Marshal's Office			
Submitted on Behalf of: State of Georgia – Federal CMS Life Safety Administrator			
Address: 2 Martin Luther King Jr. Drive, Suite 620 West Tower			
City: Atlanta		State: GA	Zip Code: 30334
Phone: 404-783-7081	Ext.	Fax: 404-657-6971	
E-mail address: engineering@sfm.ga.gov			

2)

Copyright Release: In accordance with Council Policy #28 Code Development, all Code Change Proposals, Floor Modifications and Public Comments are required to include a copyright release. A copy of the copyright release form is included at the end of this form. Please follow the directions on the form. This form as well as an alternative release form can also be downloaded from the ICC website at www.iccsafe.org. If you have previously executed the copyright release for this cycle, please check the box below:

2009/2010 Cycle copyright release on file

3)

Indicate appropriate International Code(s) associated with this Public Proposal – Please use Acronym: __IFC__

If you have also submitted a separate coordination change to another I-Code, please indicate the code: __IBC__
(See section below for list of names and acronyms for the International Codes).

4)

Be sure to format your proposal and include all information as indicated below and in the Code Change Proposal Instructions' section on Page 2 of this form.

5)

Proposals should be sent to the following offices via regular mail or email. An e-mail submittal is preferred, including an electronic version, in either WordPerfect or Word. The only formatting that is needed is **BOLDING, STRIKEOUT AND UNDERLINING**. Please do not provide additional formatting such as tabs, columns, etc., as this will be done by ICC. **REMOVE TRACKING CHANGES, AUTOMATIC NUMBERING, OR ANY OTHER ADVANCED FORMATTING TOOLS THAT ARE PROVIDED BY WORD, FROM FILES CONTAINING YOUR CODE CHANGE PROPOSAL THAT YOU SEND TO ICC.**

Please use a separate form (see page 3) for each proposal submitted. Note: All code changes received will receive an acknowledgment by approximately June 21, 2009. Please contact the ICC staff listed below if you do not receive an acknowledgment by June 21, 2009.

Please check here if separate graphic file provided. Graphic materials (Graphs, maps, drawings, charts, photographs, etc.) must be submitted as separate electronic files in .CDR, IA, TIF or .JPG format (300 DPI Minimum resolution; 600 DPI or more preferred) even though they may also be embedded in your Word or WordPerfect submittal.

Code

- IBC - International Building Code
- IEBC - International Existing Building Code
- IFC - International Fire Code
- IFGC - International Fuel Gas Code
- ICC PC - ICC Performance Code
- IPC - International Plumbing Code
- IPSDC - International Private Sewage Disposal Code
- IPMC - International Property Maintenance Code
- IWUIC - International Wildland-Urban Interface Code
- IZC - International Zoning Code

Send to:

International Code Council
Chicago District Office
Attn: Diane Schoonover
4051 West Flossmoor Road
Country Club Hills, IL 60478-5795
Fax: 708/799-0320
codechanges@iccsafe.org

-
- IECC - International Energy Conservation Code
 - IMC - International Mechanical Code
 - IRC - International Residential Code

International Code Council
Birmingham District Office
Attn: Annette Sundberg
900 Montclair Road
Birmingham, AL 35213-1206
Fax: 205/592-7001
codechangesbhm@iccsafe.org

CODE CHANGE PROPOSAL FORM

(See instructions on page 2)

Code: IFC -09/10 (IBC, IEBC, IECC, IFC, IFGC, IMC, IPC, IPSCDC, IPM, IRC, ICCPC, IWUIC, IZC)
Code Sections/Tables/Figures Proposed for Revision (3.3.2); Note: *If the proposal is for a new section, indicate (new).*

Proponent: Name/Company/Representing (3.3.1): (NOTE: DO NOT USE ACRONYMS FOR YOUR COMPANY OR ORGANIZATIONAL NAME)

Dwayne Garriss / Georgia - State Fire Marshal's Office, / Representing Georgia State Fire Marshal's Office – Centers for Medicare and Medicaid Services Life Safety Administration

Revise IFC by adding a new Appendix K as follows:

APPENDIX K CMS FORMS

The provisions contained in this appendix are not mandatory unless specifically adopted or referenced in an adopting ordinance.

SECTION K101 **GENERAL**

K101.1 Scope. The provisions of this appendix apply to all new and existing facilities where a provider or supplier has voluntarily applied for certification or accreditation in the Medicare/Medicaid program meeting the requirements of and approved by CMS as specified in 42 CFR. The survey forms in this appendix are used for all Life Safety Compliance surveys (initial and recertification) of facilities subject to Survey and Certification inspections for Medicare/Medicaid certification. This includes, but is not limited to, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs) whether freestanding, distinct parts, or dually certified, Intermediate Care Facilities for Mentally Retarded (ICFs/MR), Ambulatory Surgical Centers (ASC), inpatient Hospice facilities, Program for All inclusive Care for the Elderly (PACE) facilities, Critical Access Hospitals (CAH), Psychiatric and General Hospitals, including validation surveys of accredited facilities. These survey forms also apply to complaint investigations.

K101.2 Purpose. Certification is a recommendation made by the State survey agency on the compliance of providers and suppliers with the conditions of participation, requirements for Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs) whether freestanding, distinct parts, or dually certified, Intermediate Care Facilities for Mentally Retarded (ICFs/MR), Ambulatory Surgical Centers (ASC), inpatient Hospice facilities, Program for All inclusive Care for the Elderly (PACE) facilities, Critical Access Hospitals (CAH), Psychiatric and General Hospitals. In order to safeguard the health, welfare and safety of individuals served within a facility, it is imperative that a facility not only attain substantial compliance in each area of identified deficiency (ies), but that it maintain/remain in continuous compliance. The provisions established in this appendix provided the minimum standards for new facilities which voluntarily seek certification or accreditation in the Medicare/Medicaid program. These minimum standards do exceed some of the minimum occupancy requirements established within the body of this Code which are necessary to meet the requirements of the Centers for Medicare and Medicaid Services as specified in 42 CFR.

K101.3 Application. The following forms shall be used to verify substantial compliance with regards to Life Safety for the Department of Health and Human Services Centers for Medicare and Medicaid Services.

K101.3.1 Form CMS-2786M entitled, Worksheet for Rating Residents.

(Insert Federal Form CMS-2786M here 3 pages)

K101.3.2 Form CMS-2786R entitled, “FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE Medicare – Medicaid”

(Insert Federal Form CMS- 2786R here 27 pages)

K101.3.3 Form CMS-2786S entitled, “FIRE SAFETY SURVEY REPORT SHORT FORM Medicare – Medicaid”

(Insert Federal Form CMS-2786S here 15 pages)

K101.3.4 Form CMS-2786T entitled, “FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES”

(Insert Federal Form CMS-2786T here 5 pages)

K101.3.5 Form CMS-2786U entitled, “FIRE SAFETY SURVEY REPORT - AMBULATORY SURGICAL CENTERS Medicare”

(Insert Federal Form CMS-2786U here 11 pages)

K101.3.6 Form CMS-2786V entitled, “FIRE SAFETY SURVEY REPORT - 2000 LIFE SAFETY CODE Intermediate Care Facilities for the Mentally Retarded – SMALL”

(Insert Federal Form CMS-2786V here 26 pages)

K101.3.7 Form CMS-2786W entitled, “FIRE SAFETY SURVEY REPORT - 2000 LIFE SAFETY CODE Intermediate Care Facilities for the Mentally Retarded – LARGE”

(Insert Federal Form CMS-2786W here 24 pages)

K101.3.8 FORM CMS-2786X entitled, “FIRE SAFETY SURVEY REPORT - 2000 LIFE SAFETY CODE Intermediate Care Facilities for the Mentally Retarded - APARTMENT HOUSE”

(Insert Federal Form CMS-2786X here 16 pages)

K101.3.9 Form CMS-2786Y entitled, “FIRE SAFETY SURVEY REPORT - 2000 LIFE SAFETY CODE Intermediate Care Facilities for the Mentally Retarded - SMALL FSES”

(Insert Federal Form CMS-2786Y here 6 pages)

K101.4 Construction Types. For the purposes of this appendix chapter, Table 1 shall be utilized for cross-referencing the various construction types for use in the applicable CMS forms which are in the terms of the NFPA 220, entitled, “Standard on Types of Building Construction.”

Table 1 Conversion Table to NFPA 220 Construction Types for CMS Forms										
<u>NFPA 220</u>	<u>Type I 443</u>	<u>Type I 332</u>	<u>Type II 222</u>	<u>Type II 111</u>	<u>Type II 000</u>	<u>Type III 211</u>	<u>Type III 200</u>	<u>Type IV 2HH</u>	<u>Type V 111</u>	<u>Type V 000</u>
<u>SBC</u>	<u>I</u>	<u>II</u>	<u>----</u>	<u>IV 1HR</u>	<u>IV UNP</u>	<u>V 1HR</u>	<u>V UNP</u>	<u>III</u>	<u>VI 1HR</u>	<u>VI UNP</u>
<u>UBC</u>	<u>---</u>	<u>I FR</u>	<u>II FR</u>	<u>II-1HR</u>	<u>II N</u>	<u>III-1HR</u>	<u>III N</u>	<u>IV HT</u>	<u>V 1HR</u>	<u>V-N</u>
<u>B/NBC</u>	<u>1A</u>	<u>1B</u>	<u>2A</u>	<u>2B</u>	<u>2C</u>	<u>3A</u>	<u>3B</u>	<u>4</u>	<u>5A</u>	<u>5B</u>
<u>IBC</u>	<u>---</u>	<u>IA</u>	<u>IB</u>	<u>IIA</u>	<u>IIB</u>	<u>IIIA</u>	<u>IIIB</u>	<u>IV</u>	<u>VA</u>	<u>VB</u>

SECTION K102
DEFINITIONS

K102.1 Definitions. For the purposes of this appendix chapter, the terms, phrases and words listed in this section and their derivatives shall have the indicated meanings.

ACCREDITED PROVIDER or SUPPLIER. A provider or supplier that has voluntarily applied for and has been accredited by a national accreditation program meeting the requirements of and approved by CMS in accordance with § 488.5 or § 488.6.

CMS. The Centers for Medicare & Medicaid Services. Formerly known as the Health Care Financing Administration (HCFA), which is the federal agency responsible for administering the Medicare and Medicaid programs.

Reason:

The provisions established in this appendix will provided the minimum standards for new facilities which voluntarily seek certification or accreditation in the Medicare/Medicaid program. These minimum standards **do exceed** some of the minimum occupancy requirements established within the body of this Code **but are** necessary to meet the requirements of the Centers for Medicare and Medicaid Services as specified in 42 CFR. It is absolutely absurd to have a new facility to be permitted and constructed in compliance with the body of the IBC and then **be immediately cited as ineligible for certification or accreditation** in the Medicare/Medicaid program because the body of the IBC did not take into account all the requirements of the Centers for Medicare and Medicaid Services as specified in 42 CFR. This will allow for those states and jurisdictions that adopt the International Codes to also adopt this appendix if desired to help deliver and administer the federal CMS programs utilizing the IBC.

The construction type conversion Table 1 was placed in the appendix to assist code officials in all parts of the county in assessing the appropriate construction type for use in the CMS forms.

This appendix will allow states to adopt the additional requirements of the Centers for Medicare and Medicaid Services as specified in 42 CFR so that compliance with this appendix can allow for the certification recommendation to be made by the State survey agency on the compliance of providers and suppliers with the conditions of participation, requirements for Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs) whether freestanding, distinct parts, or dually certified, Intermediate Care Facilities for Mentally Retarded (ICFs/MR), Ambulatory Surgical Centers (ASC), inpatient Hospice facilities, Program for All inclusive Care for the Elderly (PACE) facilities, Critical Access Hospitals (CAH), Psychiatric and General Hospitals.

No additional cost for those facilities desiring to seek voluntarily certification or accreditation in the Medicare/Medicaid program since they are already required to meet these minimum provisions and requirements.

Cost Impact: The code change proposal will not increase the cost of construction.

Public Hearing: Committee: AS AM D
Assembly: ASF AMF DF



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Center for Medicaid and State Operations/Survey & Certification Group

Ref: S&C-08-34

DATE: September 5, 2008

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Compliance With State Fire and Safety Code in Lieu of Life Safety Code

Memorandum Summary

- The Centers for Medicare & Medicaid Services (CMS) has adopted the 2000 edition of the National Fire Protection Association's (NFPA) Life Safety Code (LSC) as part of the Medicare health and safety standards for certified providers and suppliers.
- It is permissible to use a State fire and safety code (State Code) in lieu of the NFPA 2000 LSC, *if* CMS finds that the State Code is imposed by State law and that it adequately protects residents or patients. There are also financial implications for State Survey Agencies (SAs).

The Social Security Act (SSA) provides, under certain circumstances, for use of a State Code in lieu of the NFPA LSC provisions adopted by CMS for nursing homes, skilled nursing facilities, and small rural hospitals. Additionally, by regulation, CMS has adopted the 2000 edition of the NFPA LSC for the following types of certified providers and suppliers: nursing homes (NHs), skilled nursing facilities (SNFs), hospitals, critical access hospitals (CAHs), intermediate care facilities for the mentally retarded (ICFs/MR), ambulatory surgical centers (ASCs), hospices providing inpatient care, and end-stage renal dialysis (ESRD) facilities. In these regulations CMS also provides for use of a State Code in lieu of the adopted LSC under certain conditions. (Attachment) In all instances, a State must apply to CMS for approval to use the State Code and must provide CMS sufficient documentation for CMS to determine whether the State Code is imposed by State law and adequately protects residents or patients.

The purpose of this memorandum is to clarify the process to be followed when a State seeks approval to use its State fire and safety code in lieu of the edition of the NFPA LSC currently adopted by CMS regulations. We also point out fiscal implications for SAs, should CMS approve such a request.

Requirements for Using a State Fire and Safety Code in Lieu of the LSC

Currently no State is approved to use its State Code for Federal certification purposes. Any State that wishes to apply its State Code in lieu of the CMS-adopted LSC requirements must submit an application, signed by the Governor, to CMS that documents the following:

1. The State Code must apply to all of the above-listed provider/supplier types for which there are Medicare-certified providers or suppliers in the State. If the State Code exempts from its purview a class of health care providers or suppliers for which CMS has adopted a specific edition of the NFPA LSC, and there are such Medicare-certified providers or suppliers in the State, then the State Code may not be approved for use in lieu of the LSC. On the other hand, for example, if a State does not have any CAHs, it would not be expected to have its State Code apply to CAHs. The application must provide details of the State Code provisions that apply to each provider/supplier type.
2. The State must be seeking approval to use its State Code in lieu of the LSC for all of the above-listed provider/supplier types for which there are Medicare-certified providers or suppliers in the State. CMS will not consider applications in which the State proposes to use the State Code in lieu of the LSC for selected provider/supplier types only. For example, CMS will not approve a State application to use the State Code in lieu of the LSC only for its NHs, SNFs, and hospitals, but not for its ASCs, ESRDs, CAHs, etc.
3. The State Code must be imposed by State law. Therefore, a copy of the pertinent sections of the State statute and/or regulation imposing the State Code must be submitted with the application.
4. The application must include evidence as well as an assurance by the State that the State Code applies consistently in all locations within the State. CMS cannot approve a State Code in States where local jurisdictions are exempt from application of such State Code in lieu of a locally-adopted code, or no code.
5. The State Code must adequately protect patients/ residents in both new and existing facilities. The State must demonstrate not only how the State Code adequately protects patients or residents when health care facilities are first constructed, but also how it accomplishes this on an ongoing basis for existing health care facilities. Accordingly, the State's application must include at least the following:
 - a. Evidence that the State Code assures that buildings used by providers or suppliers offer a level of protection that is equal to or higher than the level of protection offered by buildings subject to CMS requirements, including the LSC as adopted by CMS and other applicable CMS standards. The application must specifically identify the features of the State Code that provide such assurance.
 - b. Evidence that the State Code has operational features (for example, provider/supplier maintenance or training requirements) that assure ongoing compliance with the State Code by providers or suppliers and furnish at least the same level of assurance as do the operational features found in the applicable LSC provisions and CMS requirements for each provider/supplier type.

- c. Evidence that the State verifies both initial and ongoing compliance. The application must describe the verification process in detail, including who assesses/determines initial and ongoing compliance of health care facilities with the State Code; what methodology is used, frequency of compliance determinations, and qualifications and training requirements of staff performing those functions. If the State does not use an ongoing survey/inspection process, it is unlikely that CMS would approve its application.
- d. Evidence that the State takes enforcement actions when it determines that a health care facility is out of compliance with the State Code, including description of the enforcement mechanisms in place. Inclusion of examples of cases where noncompliance was enforced is encouraged. The State must have the authority and a mechanism to address noncompliance with the State Code in a manner that adequately protects residents/patients.
- e. Evidence of whether and how the State Code provides for permanent or temporary waivers of some or all of the State Code requirements; the standards and processes for review, approval, and monitoring/enforcement of such waivers. This would include describing who is authorized to approve waivers and criteria for approval/denial. (CMS will no longer be the waiver-granting authority or the reviewer of the FSES.)

The submission should include a detailed crosswalk between the State Code and the CMS-adopted LSC provisions and other applicable Medicare fire safety requirements to facilitate CMS review.

The application package must be submitted to the appropriate CMS Regional Office, Survey and Certification Branch. Applications will be forwarded to CMS Central Office for review and approval or denial. CMS will publish a notice of its final decision in the *Federal Register*. No State may use its State Code in lieu of the CMS-adopted LSC until and unless it has received formal CMS approval and notice has been published in the *Federal Register*.

CMS' approval of a State's request to use its State Code in lieu of the CMS-adopted LSC is not open-ended; it is valid only so long as the State Code continues to adequately protect residents or patients. So, for example, it is expected that a State that has been granted approval by CMS to use its State Code will notify CMS (in writing) within a reasonable time (e.g., 60 days) of adoption of any changes to the State Code that affect a class of health care providers or suppliers subject to the State Code in lieu of the CMS-adopted LSC. This will enable CMS to perform its duty under the law and regulations to determine whether residents/patients are being adequately protected under the revised version of the State Code. In order to facilitate CMS' review, the State should provide a copy of the new code, explaining the changes in detail and providing a crosswalk between the new provisions and the pertinent provisions of the CMS-adopted LSC and/or additional fire safety requirements adopted in regulation by CMS. CMS will review the new information and determine whether the State Code may continue to be used in lieu of the CMS-adopted LSC.

Likewise, if at any time CMS adopts a different version of the NFPA LSC, or adopts specific fire safety provisions not found in the CMS-adopted LSC, any State using its State Code in lieu of the CMS-adopted LSC must submit a new application to CMS, providing a crosswalk to the newly-adopted CMS requirements and demonstrating how the State Code continues to

adequately protect patients/residents. Such re-application must be submitted within a reasonable amount of time (e.g., 60 days) after CMS' adoption of the new requirements.

CMS may at any time, based upon evidence that a State Code does not adequately protect residents/patients, rescind a prior approval of use of the State Code in lieu of the CMS-adopted LSC. Notice of such action will be published in the *Federal Register*. The CMS-adopted LSC provisions will take effect within the State within 60 days following publication of the notice of rescission/withdrawal of the prior approval of use of the State Code. Providers and suppliers determined to be out of compliance with the LSC would be subjected to CMS' normal enforcement processes, including consideration of applications for temporary or permanent waivers.

Impact on Deemed Providers

In a State where an approved State Code is used in lieu of the CMS-adopted LSC, providers or suppliers who have been deemed to meet Medicare's health and safety standards on the basis of accreditation by a CMS-recognized accreditation organization are expected to comply with CMS' LSC requirements rather than those of the State Code. The accreditation organizations' standards are required to meet or exceed the Medicare standards, including the LSC.

Funding Implications

If CMS approves a State's request to use the State Code in lieu of the LSC, there are implications for CMS' funding of SAs under the Section 1864 agreement between CMS and the State. Specifically, when a State Code is used in lieu of the CMS-adopted LSC, there is no federal LSC requirement in force, and thus CMS will not provide funding for conducting LSC surveys in those States, nor will CMS evaluate SA performance in enforcement of the State Code. This is the case even when the SA is utilized by the State to survey for compliance with the State Code. The only exception would be for validation surveys of providers/suppliers that have been deemed to meet Medicare requirements on the basis of their accreditation. For validation surveys conducted on either a representative sample basis or in response to a substantial allegation of noncompliance, and for full surveys following upon a validation substantial allegation survey that results in condition-level deficiency findings, SAs would continue to be expected to conduct LSC surveys in accredited deemed facilities in accordance with CMS requirements and would be funded accordingly.

Effective Date: Immediately. Please ensure that all appropriate staff are fully informed within 30 days of the date of this memorandum.

If you have additional questions or concerns, please contact James Merrill at 410-786-6998 or via e-mail at james.merrill@cms.hhs.gov

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Attachment: Statutory and Regulatory authorities

Social Security Act Provisions
Use of State Code in Lieu of NFPA Life Safety Code

Medicare Provisions

Section 1819 (42 USC1395i-3)

Requirements for, and assuring quality of care in, skilled nursing facilities

* * *

(d) Requirements relating to administration and other matters

(1) Administration

* * *

(B) Life Safety Code

A skilled nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

* * *

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in skilled nursing facilities.

Section 1861(42 USC Sec. 1395x). Definitions

(e) Hospital

* * *

The term “hospital” also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that--

* * *

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary ...

* * *

(ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

Medicaid Provisions (Nursing Homes)

Section 1919(d)(2)(B) (42 USC1396r). Requirements for nursing facilities

(a) “Nursing facility” defined

(d) Requirements relating to administration and other matters

* * *

(2) Licensing and Life Safety Code

(B) Life Safety Code

A nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

* * *

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in nursing facilities.

Regulatory Authority

There are no other statutory provisions specific to Life Safety Code for other facility types. However, by regulation CMS has adopted regulations repeating the statutory provisions for nursing homes and SNFs, and promulgating the same approach for hospitals, CAHs, ASCs, ICFs/MR, and hospices that provide inpatient care directly. There is no LSC standard for RHCs or FQHCs.

SNFs/NFs: § 483.70:

(a) *Life safety from fire.* (1) Except as otherwise provided in this section—

* * *

(i) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association...

* * *

(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.

Hospitals: § 482.41(b):

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

* * *

(i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association...

* * *

(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.

Critical Access Hospitals: § 485.623(d):

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

* * *

(i) The CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association...

* * *

(2) If CMS finds that the State has a fire and safety code imposed by State law that adequately protects patients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC.

ICFs/MR: § 483.470(j):

(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 of the 2000 edition of the Life Safety Code of the National Fire Protection Association...

* * *

(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.

ASCs: § 416.44(b):

(b) *Standard: Safety from fire.* (1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Centers of the 2000 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of patients served...

* * *

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

Hospices: § 418.100:

A hospice that provides inpatient care directly must comply with all of the following standards.

* * *

(d) *Standard: Fire protection.* (1) Except as otherwise provided in this section—

* * *

(i) The hospice must meet the provisions applicable to nursing homes of the 2000 edition of the Life Safety Code of the National Fire Protection Association...

* * *

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

ESRD: § 494.60:

(e) *Standard: Fire safety.* (1) Except as provided in paragraph (e)(2) of this section, by February 9, 2009 the dialysis facility 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).

* * *

(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.

Fire Safety - Panel of Experts

Panel Charge

The Fire Safety Panel of State and National Experts will provide policy level advice to the Commissioner of the NYS Office of Mental Retardation and Developmental Disabilities that allows the agency to balance its commitment to support people who have developmental disabilities in the most integrated and appropriate community settings possible, along with its critical responsibility for fire safety. New York's fire safety policy and practice for homes and program sites involving people who have developmental disabilities have been built around the three primary elements of the NFPA Life Safety Code:

- The Capacity of People to Evacuate
- The Capacity of Staff to Support Safe Evacuation
- The Fire Safety Features of the Home or Program Site

Using the findings and conclusions drawn from the multiple investigations into the fire event at the Wells, NY home of March 21, 2009 as a starting point, the Fire Safety Panel of National Experts will assess New York's fire safety policy and practice and make recommendations that strengthen OMRDD's capacity to prevent fires, contain fires that may occur, and maximize its capacity to assist people who have developmental disabilities and staff to safely evacuate or survive fires that do occur.

Proposed Questions for Fire Safety Panel of Experts

Capacity of a Person to Evacuate

1. How can policy and practice effectively balance the public responsibility to adequately protect a person who has developmental disability from risk of harm from a fire in the home or program site with their right to be fully integrated into their community?
2. How do the Life Safety Code and NYS Building Code compare in their capacity to support New York State's commitment to integrating people who have developmental disabilities into their community?
3. How should New York State determine the amount of time that is required for safe evacuation of any home or program site and what is the thinking regarding industry standards for acceptable evacuation times?
4. What does the Life Safety Code rating of "impractical" mean relative to acceptable evacuation times for people living in a home with that rating?
5. What guidance should OMRDD use as it determines a Life Safety Code or other code category designation for each home and/or program site?
6. How does the Life Safety Code scoring algorithm for calculating e-scores for individuals evaluate the risk from fire of a person who is immobile?

How does that differ from the Life Safety Code algorithm's capacity to effectively evaluate that risk for a person who is mobile but who might not follow evacuation instructions properly?

7. What are the key features of the Life Safety Code that allows people who are not self-preserving (but who do not need nursing care) to safely live in a "board and care" home?
8. Are there features of the NYS Building Code that enhance the Life Safety Code's capacity to provide safety for people living in the community?

How do these features differ with the differing capacities of the people who have developmental disabilities living in the community?

How would these features be integrated into OMRDD's use of the Life Safety Code?

9. Are there specific construction features that are particularly critical for the safety of people in New York's certified residences that OMRDD should require without a code upgrade?

10. What are the key features of effective training for fire prevention, fire safety and fire evacuation that OMRDD should integrate into its policy and training practices?

What role do independent, third party trainers, observers, and/or quality management efforts play in a state's effective training?

How would OMRDD guard against reductions in vigilance over time?

11. What are the key features of effective management oversight of fire drills, FSES updates, LCS waiver, staff activity related to fire safety, and evacuation planning that OMRDD should integrate into its policy and performance outcomes?

Close out questions

1. How would OMRDD assess whether the Riverview fire is predictive of a problem in its system or a "black swan"?

2. How would OMRDD assess whether the three primary elements of the Life Safety Code (capacity of the people to evacuate; capacity of staff to support safe evacuation; and fire safety features of the home or program site) – as currently conceptualized and translated into practice – remain sufficient to address fire safety concerns?



"Altizer, Ed (VDFFP)"
<Ed.Altizer@vdfp.virginia.gov>

07/24/2009 06:43 AM

To: "Erin Friel" <efriel@firemarshals.org>, "Alabama" <edward.paulk@insurance.alabama.gov>, "Alaska" <David.Tyler@alaska.gov>, "Arizona" <phil.mele@dfbls.az.gov>, <jnarva@narvaassociates.com>, <KFernico@aol.com>
Subject: RE: Critical Access Hospitals, CSM and Life Safety Code versus ICC Codes

Good morning all,

Sorry I am late joining in on this and that the following is so wordy. I have been involved with the BOCA/ICC and LSC since 1974 and have faced similar problems. If you want to skip my dissertation, my short answers are actually below following Kevin's questions in his email below my signature block.

We have had the two codes in Virginia since 1973 when the BOCA code was adopted as a state mini- max code. Local governments were and are required to enforce the code by state law. The 1967 LSC was in effect then and there were lots of conflicts. When the BOCA Code was amended in the 1987 edition to include most of the provisions of the LSC for I-2 uses many of those problems disappeared.

The SFMO makes LSC inspections under contract to the Virginia State Health Department, the "State Agency" for CMS. We also have been and are heavily involved with construction under the states building code, now the 2006 ICC. My staff indicates that the ICC code may actually be more restrictive now if applied correctly. From a chapter 18 – 19 LSC view, I do not see a lot of conflicts with the LSC.

I would point out that the ICC is lobbying for the recognition. However, I would not be in favor of lobbying for this issue under the current CMS inspection and reporting system. It would be a nightmare from my view in Virginia. I do believe the current system used by CMS wastes a lot of money but I do not feel it is because of the code.

I do not know what the problem is in other states but my problem in Virginia is this. The authority to enforce the State Building Code in Virginia lies with each of the city, town or county building officials. Fire Officials are only involved if allowed by the building official. That includes the SFMO. In applying the LSC to health care facilities, we do find some problems because of modifications or interpretation differences between a local BO and the SFMO. When we are invited in early on, those problems usually do not exist. We normally come to an

understanding because the LSC must be met. Will CMS allow local officials to dictate modifications to the state code that they would have to be aware of and may not even want? If the SFMO the AHJ for all hospitals in their state, there may not be a problem. That is not the case in Virginia.

Right now CMS has 51 AHJ's but if the ICC was accepted, there would be triple that many in Virginia alone. Who would handle and coordinate the now cumbersome reporting system. Annual visits would also become a nightmare under the current reporting system. By Virginia Code, the SFMO and some 70 local fire officials would be making the inspections.

For those states in which the SFMO is the AHJ for both codes there could be a benefit, but for Virginia it would be a huge problem. As I said up above, I believe there are huge problems in the program, the LSC not being one in my opinion. One huge problem that I have had no success in solving with CMS is their Principals of Documentation (POD) which I believe are way out of line and extremely wasteful (money) for the LSC. Probably works well for the health side but I do not see improved safety through their reporting system.

I have addressed my concerns with our State Health Department and directly to CMS on this issue and would certainly be in favor of lobbying to make beneficial changes to the current documentation system. Then maybe the code issues could be resolved.

The LSC has forced several needed safety changes in the BOCA and ICC codes over the years, the most recent being those involving Ambulatory Surgical Centers.” Without the LSC safety requirements, I firmly believe they would still be classified normal business occupancies under the ICC Codes. While still a “B” use under the 2009 ICC, were able to get at least some safety built into that specific use because of the LSC. While out cold yesterday during an outpatient procedure in a building currently classified as Group B in Virginia, I greatly appreciate the new code provisions that will provide safety in the future.

I would suggest that the Model Code Committee look closely at all the issues and make a recommendation to the Board on future action.

Best regards to all.

Ed Altizer, P. E.
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Note: Phone Number 804-371-7170 is no longer in service

From: Erin Friel [mailto:efriel@firemarshals.org]

Sent: Friday, July 17, 2009 2:18 PM

To: 'Alabama'; 'Alaska'; 'Arizona'; 'Arkansas'; 'California'; 'Colorado'; 'Delaware'; 'Florida'; 'Georgia'; 'Hawaii'; 'Idaho'; 'Illinois'; 'Indiana'; 'Iowa'; 'Kansas'; 'Louisiana'; 'Maine'; 'Maryland'; 'Michigan'; 'Minnesota'; 'Mississippi'; 'Missouri'; 'Montana'; 'Nebraska'; 'New Hampshire'; 'New Jersey'; 'New Mexico'; 'New York'; 'North Carolina'; 'North Dakota'; 'Ohio'; 'Oklahoma'; 'Oregon'; 'Pennsylvania'; 'Rhode Island'; 'South Carolina'; 'South Dakota'; 'Texas'; 'Utah'; 'Vermont'; Altizer, Ed (VDFP); 'Washington'; 'WashingtonDC'; 'West Virginia'; 'Wisconsin'; 'Wyoming'; 'Delaware'; 'Georgia'; 'Kansas'; 'Maine'; 'Maryland'; 'Missouri'; 'Nebraska'; 'New Hampshire'; 'New Jersey'; 'New York'; 'Utah'; 'Washington'

Cc: jnarva@narvaassociates.com; KFernico@aol.com

Subject: Critical Access Hospitals, CSM and Life Safety Code versus ICC Codes

The following is being sent on behalf of Colorado State Fire Marshal Kevin Klein. Thank you in advance for your assistance.

Dear State Fire Marshals:

We are trying to find out if any states have successfully received a waiver from Centers for Medicare and Medicaid Services (CMS) for their state code (particularly the ICC code set) for critical access hospitals. We are running into problems where hospitals have to build to both the ICC codes and the Life Safety Code in Colorado. This is causing unnecessary expenses for our hospitals and some real problems when they find out they have to retrofit changes to meet CMS's requirements even though they were approved under the ICC codes. We just had a hospital document an additional \$1 million in construction expenses based upon the need to simultaneously meet the local ICC codes and the CMS mandated Life Safety Code. CMS Section 485.623(d)(2) states: "If CMS finds that the State has a fire and safety code imposed by State law that adequately protects patients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC."

My questions are:

1) Does your state have a waiver from CMS to apply your state code instead of the Life Safety Code?

Virginia does not.

2) Is this an issue in your state?

The VA SFMO enforces the LSC for CMS. It can be an issue when our interpretation of the LSC differs from the local building officials' interpretations of the same issue in the State Building Code (ICC) for which they have full authority. The issue is the fact that CMS regulations overrule the local building official if the facility wants the money. I do not think that would change regardless of code.

3) If so, would you be interested in helping lobby for a change in law that would allow CMS to automatically recognize the ICC codes as well as the Life Safety Code?

I would not for this particular issue alone but I would for a review of the entire system.

Please send your responses directly to me, kevin.klein@cdps.state.co.us. I will compile the information and share it with the membership.

Thanks!

Kevin

Kevin R. Klein, Director
Colorado Division of Fire Safety