

items and services to patients, which is contrary to conventional nursing practice. Currently the only standardization for RNHCI nurse credentials exists for those individuals prepared in religious group nurse training programs and involved in the practice of that religion.

The phrase “grounded in the religious beliefs” of an RNHCI is not intended to mean that religious nonmedical nursing personnel must “accept or practice” a particular religious belief. The phrase “grounded in the religious beliefs” means that nonmedical nursing personnel must be appropriately familiar with the culture and religious beliefs of the RNHCI to care for the physical needs of patients.

For purposes of writing the rule, it was necessary to choose those requirements that would provide a level of standardization for providing nonmedical nursing care to beneficiaries. We are retaining the definition of religious nonmedical nursing personnel as set forth in the interim final rule.

Similar to other provider types, the issue of nurse trainees was not addressed in the rule. The per-diem rate includes payment for RNHCI nurses responsible for the care of beneficiaries, and they may also supervise those aspects of care provided by trainees. While trainees can provide care under the supervision of an RNHCI nurse, any cost or payment attributed to the trainee is not to be considered a component of the Medicare or Medicaid per diem rate.

*Comment:* The commenter suggested that we expand the term “legal representative” that is included in the definition of “election” to include someone acting under a valid health care durable power of attorney or an equivalent instrument.

*Response:* The term “legal representative” as used in the definition of “election” is considered appropriate to safeguard the interest of the beneficiary, and we are not making any revisions. The designation of a legal representative is a serious responsibility that should follow accepted legal protocols and therefore does not require further definition in the rule. In this matter, we generally defer to the States in deciding who qualifies as a “legal representative” since State law governs these questions.

#### Elections and Revocations § 403.724

*Comment:* The commenter suggested that for practical purposes an election be considered valid without notarization under certain circumstances. The commenter requested a grace period to cover those

periods when the business office is not open, such as evenings, nights, weekends, and holidays.

*Response:* Since we consider obtaining notary authority for individual staff members to be a relatively straightforward process, there can be several notaries in a facility to meet beneficiary needs when the business office is not open. Additionally, the RNHCI can establish relationships with notaries within the community to provide assistance in emergency situations. Therefore, we are retaining the election policy as established in the interim final rule.

*Comment:* The commenter suggested that care be covered without an election under certain limited circumstances. The commenter requested a grace period of at least 72 hours to provide care for a patient in distress, or to locate a legal representative or have one appointed in the case of admitting an unresponsive or incompetent Medicare beneficiary, before fully executing the election for RNHCI care.

*Response:* We do not believe we have the authority for the requested grace period. The statute requires a valid election to be in place for RNHCI services to be covered and paid for. Delaying the election process is of concern particularly for an individual in distress and unable to make his or her personal wishes known.

*Comment:* The commenter recommended that an election be effective retroactively for care provided up to 72 hours before the election is signed. If the patient expires before the execution of a valid election, the commenter requested that Medicare pay for the care provided by the RNHCI to the beneficiary.

*Response:* We do not believe we have the authority to accommodate the requested pre-election coverage period.

#### Election Revocation § 403.724(a)(1)(iii)

*Comment:* The commenter indicated an inconsistency between section 1821(b)(3) of the Act and § 403.724(a)(1)(iii) of the regulation, regarding payment being received versus payment being requested. The commenter believes that the election should be revoked only if Medicare makes payment rather than when Medicare medical care is merely sought.

*Response:* Section 403.724(a)(1)(iii) of our regulations implements section 1821(b)(3) of the Act, which set forth the information that must be included in the election form. This section specifies that receipt of nonexcepted medical services constitutes a revocation of an election. Seeking Medicare medical care indicates that a beneficiary anticipates

that the program will pay for the service under the statute. It is the payment for that Medicare claim that actually triggers the revocation of the RNHCI election and (if applicable) the start of the waiting period that determines when a new RNHCI election may be filed.

#### Condition of Participation: Patient Rights § 403.730(c)(4)

*Comment:* The commenter requested that the utilization review committee have the power to authorize the limited use of restraints when the patient poses a danger to self, other patients, or staff. The commenter indicated that since the UR committee could make an initial determination for coverage under Medicare and Medicaid, it could also be capable of determining if and when those rare occasions existed when there would be a need to protect the safety of a patient and the staff. Additionally, the commenter stated that it would be appropriate to place specific requirements on the use of restraints, such as—

- Choosing the least restrictive manner for the least amount of time as possible;
- Placing time limits for using restraints without additional review by the UR committee;
- Not permitting standing orders for the use of restraints;
- Using restraints only when absolutely necessary and other interventions have been ineffective; and
- Requiring RNHCI staff to frequently check on the restrained patient.

*Response:* Section 1866(ss)(1) of the Act and the related legislative history underscore the centrality of nonmedical interventions to the care provided by RNHCI. The statute requires active patient choice and limits the benefit to those for whom the “acceptance of medical health services would be inconsistent with their religious beliefs.” Under this model, chemical restraints (drugs) would clearly be antithetical, as well against the statute. On the other hand, “assistive devices” (such as crutches, canes, and walkers, etc.), used only on a voluntary basis by the patient, would not constitute a “restraint.” We currently define “physical restraint” in our hospital condition of participation at § 482.13 as “any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient’s body that he or she cannot easily remove [and] that restricts freedom of movement or normal access to one’s body.” In thinking about whether a device or practice may be considered a restraint, the RNHCI