§ 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.

(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 con-
strued to limit the authority of a doc-
tor of medicine or osteopathy to dele-
gate 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 den-
tal 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 le-
gally authorized to practice optometry
by the State in which he or she prac-
tices;
(v) A chiropractor who is licensed by
the State or legally authorized to per-
form the services of a chiropractor, but
only with respect to treatment by
means of manual manipulation of the
spine to correct a subluxation dem-
onstrated 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 serv-
ices as defined in §410.71 of this chapter
and only to the extent permitted by
State law.
(2) Patients are admitted to the hos-
pital 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 osteop-
athy is on duty or on call at all times.
(4) A doctor of medicine or osteop-
athy is responsible for the care of each
Medicare patient with respect to any
medical or psychiatric problem that—
(i) is present on admission or de-
velops 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 chiro-
practor; or clinical psychologist, as
that scope is—
(A) Defined by the medical staff;
(B) Permitted by State law; and
(C) Limited, under paragraph (o)(1)(v)
of this section, with respect to chiro-
practors.
(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 ac-
cording to generally accepted account-
ing principles.
(2) The budget must include all antici-
pated income and expenses. This
provision does not require that the
budget identify item by item the com-
ponents of each anticipated income or
expense.
(3) The plan must provide for capital
expenditures for at least a 3-year pe-
riod, including the year in which the
operating budget specified in para-
graph (d)(2) of this section is applica-
ble.
(4) The plan must include and iden-
tify 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 equip-
ment.
(5) The plan must be submitted for
review to the planning agency des-
ignated 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 expendi-
ture 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 cap-
ital expenditure is for services and fa-
cilities that are needed by the HMO or
CMP in order to operate efficiently and
Centers for Medicare & Medicaid Services, HHS

§ 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-campus 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.