**Summary:** This final rule revises the requirements that PPS and Critical Access Hospitals (CAHs) must meet to participate in the Medicare and Medicaid programs. These changes are an integral part of CMS’ efforts to reduce procedural burdens on providers.

**Effective Date:** July 12, 2012.

**Single governing body for multiple hospitals §482.12:**
- Allows one governing body to oversee multiple hospitals in a multi-hospital system
- Added requirement for one or more members of hospital medical staff to be included on governing body as a means of ensuring communication/coordination between a single governing body and medical staffs of individual hospitals in system. (KHA recently submitted a letter to CMS requesting that the physician trustee requirement be eliminated as governmental hospitals often have elected or appointed trustees).

**Reporting of Restraint-Related Deaths §482.13:**
- Replaced requirement that hospitals must report deaths that occur while patient is only in soft, 2-point wrist restraints with requirement that hospitals must maintain a log (or other system) of all such deaths.
  - Log must be made available to CMS immediately upon request; log can be internal to hospital; name of practitioner responsible for care of patient may be used in log in lieu of name of attending physician if patient was under the care of a non-physician practitioner and not a physician.

**Role of other practitioners on the Medical Staff §482.22:**
- CMS broadened the concept of “medical staff” and allows hospitals flexibility to include other practitioners as eligible candidates for the medical staff with hospital privileges to practice in hospital in accordance with State law.
  - Hospitals may broaden concept of “medical staff” through appointment of non-physician practitioners to medical staff so that they may perform the duties for which they are qualified through training and education and as allowed within State scope-of-practice laws. Non-physician practitioners, e.g., APRNs, PAs, pharmacists, will enable physicians to more effectively manage their time so that they may focus on the more medically complex patients
- All practitioners will function under the same Conditions of Participation as the medical staff. Permits hospitals to allow other practitioners (e.g. APRNs, PAs, pharmacists) to perform all functions within their scope of practice.
  - Requires medical staff to examine credentials of all eligible candidates (defined by governing body) and make recommendations for privileges and medical staff membership to governing body.

**Medical staff leadership §482.22:**
- Allows podiatrists to be responsible for organization and conduct of the medical staff; podiatrists as well as MD/DO/dentists can assume new leadership roles within hospitals, if hospitals so choose.

**Nursing care plan §482.23:**
- Allows hospitals option of having stand-alone nursing care plan or a single interdisciplinary care plan that addresses nursing and other disciplines.
- A single, interdisciplinary care plan can improve care coordination and can result in significant cost reductions and efficiencies.
Administration of medications §482.23(c)(6):
- Allows hospitals to have optional program for patients/support persons on self-administration of appropriate medications.
  - Program must address safe accurate administration of specified medications; ensure process for medication security; address self-administration training and supervision and document medication self-administration.

Administration of blood transfusions and intravenous medications §482.23(c)(3):
- Eliminates requirement for non-physician personnel to have special training in administering blood transfusions and intravenous medications
- Revises requirement to clarify that those who administer blood transfusions and intravenous medications do so in accordance with State law and approved medical staff policies & procedures. Clarification makes requirement consistent with current standards of practice.

Orders by other practitioners §482.24:
- Allows drugs and biologicals to be prepared and administered on the orders of practitioners (other than a doctor), in accordance with hospital policy and State law;
- Allows orders for drugs and biologicals to be documented and signed by practitioners (other than a doctor), in accordance with hospital policy and State law.

Standing Orders §482.24:
- Allows hospitals flexibility to use standing orders
- Added requirement for medical staff, nursing, and pharmacy to approve written and electronic standing orders, order sets, and protocols. Orders and protocols must be based on nationally recognized and evidence-based guidelines and recommendations.

Verbal Orders §482.24:
- Eliminates requirement for authentication of verbal orders within 48-hours; defers to applicable State law to establish authentication timeframes.
  - Kansas Regulation, K.A.R. 28-34-6a – verbal order must be authenticated by the prescribing or covering practitioner within 72 hours of the patient’s discharge or 30 days, whichever occurs first.

Authentication of Orders §482.24:
- Made permanent the requirement that all orders, including verbal orders, must be dated, timed, and authenticated by either the ordering practitioner or another practitioner who is responsible for care of patient and who is authorized to write orders by hospital policy in accordance with State law, not CoP. Kansas Law – Co-signatures are not required for PAs or APRNs.

Infection Control Log §482.42:
- Eliminates requirement for hospitals to maintain an infection control log. Hospitals are already required to monitor infections through various surveillance methods including electronic systems.

Outpatient services director §482.54:
- Removes requirement for a single Director of Outpatient Services position that oversees all outpatient departments in a hospital.
  - Hospitals already have separate directors for individual outpatient departments, a single overall Director position is seen as duplicative and unnecessary. Allows hospitals flexibility and freedom to determine best way to oversee and manage outpatients.

Transplant Center Process Requirements §482.92:
- Eliminates duplicative requirement that organ recovery team working for transplant center conduct a “blood type and other vital data verification” before organ recovery when recipient is known.
  - Verification will continue to be completed at two other times in transplant process.
CAH Definitions §485.602 and Provision of Services §485.635:

- Eliminates requirement that CAHs must furnish diagnostic, therapeutic, laboratory, radiology services, and emergency procedures directly by CAH staff.
  - Allows CAHs to provide such services under arrangement with entities such as community physicians, laboratories, or radiology services.
- Eliminates definition of “Direct Services” at §485.602 since it will no longer be applicable.
- Provision of Surgical services (§485.639) is not a required CAH service - introductory text changed to clarify that surgical services are optional services for CAHs to provide.

Clarifying Changes:

- Infection Control: CMS has made a technical change to replace the term “quality assurance program” with the more current term “quality assessment and performance improvement program.” Hospital’s quality assurance program would be become the quality assessment and performance improvement program = QA becomes QAPI. A QAPI program must address drug errors, adverse reactions and drug incompatibilities. This name change was also made for pharmaceutical services.

SOURCE: http://www.ofr.gov/OFRUpload/OFRData/2012-11548_PI.pdf