

Federal statutes and regulations applicable to the CAH's exchange of patient health information.

(2) The system sends notifications that must include at least patient name, treating practitioner name, and sending institution name.

(3) To the extent permissible under applicable federal and state law and regulations, and not inconsistent with the patient's expressed privacy preferences, the system sends notifications directly, or through an intermediary that facilitates exchange of health information, at the time of:

(i) The patient's registration in the CAH's emergency department (if applicable).

(ii) The patient's admission to the CAH's inpatient services (if applicable).

(4) To the extent permissible under applicable federal and state law and regulations, and not inconsistent with the patient's expressed privacy preferences, the system sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to, or at the time of:

(i) The patient's discharge or transfer from the CAH's emergency department (if applicable).

(ii) The patient's discharge or transfer from the CAH's inpatient services (if applicable).

(5) The CAH has made a reasonable effort to ensure that the system sends the notifications to all applicable post-acute care services providers and suppliers, as well as to any of the following practitioners and entities, which need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes:

(i) The patient's established primary care practitioner;

(ii) The patient's established primary care practice group or entity; or

(iii) Other practitioner, or other practice group or entity, identified by the patient as the practitioner, or practice group or entity, primarily responsible for his or her care.

[58 FR 30671, May 26, 1993, as amended at 62 FR 46037, Aug. 29, 1997; 85 FR 25638, May 1, 2020]

**§ 485.639 Condition of participation: Surgical services.**

If a CAH provides surgical services, surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body, or responsible individual, of the CAH in accordance with the designation requirements under paragraph (a) of this section.

(a) *Designation of qualified practitioners.* The CAH designates the practitioners who are allowed to perform surgery for CAH patients, in accordance with its approved policies and procedures, and with State scope of practice laws. Surgery is performed only by—

(1) A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;

(2) A doctor of dental surgery or dental medicine; or

(3) A doctor of podiatric medicine.

(b) *Anesthetic risk and evaluation.* (1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.

(2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia.

(3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.

(c) *Administration of anesthesia.* The CAH designates the person who is allowed to administer anesthesia to CAH patients in accordance with its approved policies and procedures and with State scope-of-practice laws.

(1) Anesthesia must be administered by only—

(i) A qualified anesthesiologist;

(ii) A doctor of medicine or osteopathy other than an anesthesiologist; including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;

(iii) A doctor of dental surgery or dental medicine;

(iv) A doctor of podiatric medicine;

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(v) A certified registered nurse anesthetist (CRNA), as defined in § 410.69(b) of this chapter;

(vi) An anesthesiologist's assistant, as defined in § 410.69(b) of this chapter; or

(vii) A supervised trainee in an approved educational program, as described in § 413.85 or § 413.86 of this chapter.

(2) In those cases in which a CRNA administers the anesthesia, the anesthetist must be under the supervision of the operating practitioner except as provided in paragraph (e) of this section. An anesthesiologist's assistant who administers anesthesia must be under the supervision of an anesthesiologist.

(d) *Discharge.* All patients are discharged in the company of a responsible adult, except those exempted by the practitioner who performed the surgical procedure.

(e) *Standard: State exemption.* (1) A CAH may be exempted from the requirement for physician supervision of CRNAs as described in paragraph (c)(2) of this section, if the State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from physician supervision for CRNAs. The letter from the Governor must attest that he or she has consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with State law.

(2) The request for exemption and recognition of State laws and the withdrawal of the request may be submitted at any time, and are effective upon submission.

[60 FR 45851, Sept. 1, 1995, as amended at 62 FR 46037, Aug. 29, 1997; 66 FR 39938, Aug. 1, 2001; 66 FR 56769, Nov. 13, 2001; 77 FR 29076, May 16, 2012]

**42 CFR Ch. IV (10-1-20 Edition)**

**§ 485.640 Condition of participation: Infection prevention and control and antibiotic stewardship programs.**

The CAH must have active facility-wide programs, for the surveillance, prevention, and control of HAIs and other infectious diseases and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic-resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in coordination with the facility-wide quality assessment and performance improvement (QAPI) program.

(a) *Standard: Infection prevention and control program organization and policies.* The CAH must demonstrate that:

(1) An individual (or individuals), who is qualified through education, training, experience, or certification in infection prevention and control, is appointed by the governing body, or responsible individual, as the infection preventionist(s)/infection control professional(s) responsible for the infection prevention and control program and that the appointment is based on the recommendations of medical staff leadership and nursing leadership;

(2) The infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the CAH and between the CAH and other healthcare settings;

(3) The infection prevention and control includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and that the program also addresses any infection control issues identified by public health authorities; and

(4) The infection prevention and control program reflects the scope and complexity of the CAH services provided.