

§ 418.102

services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of quality care. Arranged services must be supported by written agreements that require that all services be—

- (1) Authorized by the hospice;
- (2) Furnished in a safe and effective manner by qualified personnel; and
- (3) Delivered in accordance with the patient's plan of care.

(f) *Standard: Hospice multiple locations.* If a hospice operates multiple locations, it must meet the following requirements:

- (1) Medicare approval.
 - (i) All hospice multiple locations must be approved by Medicare before providing hospice care and services to Medicare patients.
 - (ii) The multiple location must be part of the hospice and must share administration, supervision, and services with the hospice issued the certification number.
 - (iii) The lines of authority and professional and administrative control must be clearly delineated in the hospice's organizational structure and in practice, and must be traced to the location which was issued the certification number.
 - (iv) The determination that a multiple location does or does not meet the definition of a multiple location, as set forth in this part, is an initial determination, as set forth in § 498.3.

(2) The hospice must continually monitor and manage all services provided at all of its locations to ensure that services are delivered in a safe and effective manner and to ensure that each patient and family receives the necessary care and services outlined in the plan of care, in accordance with the requirements of this subpart and subparts A and C of this section.

(g) *Standard: Training.* (1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact.

(2) A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties.

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(3) A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months.

[73 FR 32204, June 5, 2008, as amended at 74 FR 39413, Aug. 6, 2009]

§ 418.102 Condition of participation: Medical director.

The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee or is under contract with the hospice. When the medical director is not available, a physician designee as defined at § 418.3 assumes the same responsibilities and obligations as the medical director.

(a) *Standard: Medical director contract.* (1) A hospice may contract with either of the following—

- (i) A self-employed physician; or
- (ii) A physician employed by a professional entity or physicians group. When contracting for medical director services, the contract must specify the physician who assumes the medical director responsibilities and obligations.

(b) *Standard: Initial certification of terminal illness.* The medical director (or physician designee, as defined in § 418.3, if the medical director is unavailable) or physician member of the IDG reviews the clinical information for each hospice patient and provides written certification that it is anticipated that the patient's life expectancy is 6 months or less if the illness runs its normal course. The physician must consider the following when making this determination:

- (1) The primary terminal condition;
- (2) Related diagnosis(es), if any;
- (3) Current subjective and objective medical findings;
- (4) Current medication and treatment orders; and
- (5) Information about the medical management of any of the patient's

conditions unrelated to the terminal illness.

(c) *Standard: Recertification of the terminal illness.* Before each recertification period for each patient, as described in §418.21(a), the medical director (or physician designee, as defined in §418.3, if the medical director is unavailable) or physician member of the IDG must review the patient's clinical information.

(d) *Standard: Medical director responsibility.* The medical director or physician designee has responsibility for the medical component of the hospice's patient care program.

[73 FR 32204, June 5, 2008, as amended at 89 FR 64272, Aug. 6, 2024]

§418.104 Condition of participation: Clinical records.

A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically.

(a) *Standard: Content.* Each patient's record must include the following:

(1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.

(2) Signed copies of the notice of patient rights in accordance with §418.52 and election statement in accordance with §418.24.

(3) Responses to medications, symptom management, treatments, and services.

(4) Outcome measure data elements, as described in §418.54(e) of this subpart.

(5) Physician certification and recertification of terminal illness as required in §§418.22 and 418.25 and described in §§418.102(b) and 418.102(c) respectively, if appropriate.

(6) Any advance directives as described in §418.52(a)(2).

(7) Physician orders.

(b) *Standard: Authentication.* All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice pol-

icy and currently accepted standards of practice.

(c) *Standard: Protection of information.* The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use. The hospice must be in compliance with the Department's rules regarding personal health information as set out at 45 CFR parts 160 and 164.

(d) *Standard: Retention of records.* Patient clinical records must be retained for 6 years after the death or discharge of the patient, unless State law stipulates a longer period of time. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform its State agency and its CMS Regional office where such clinical records will be stored and how they may be accessed.

(e) *Standard: Discharge or transfer of care.* (1) If the care of a patient is transferred to another Medicare/Medicaid-certified facility, the hospice must forward to the receiving facility, a copy of—

(i) The hospice discharge summary; and

(ii) The patient's clinical record, if requested.

(2) If a patient revokes the election of hospice care, or is discharged from hospice in accordance with §418.26, the hospice must forward to the patient's attending physician, a copy of—

(i) The hospice discharge summary; and

(ii) The patient's clinical record, if requested.

(3) The hospice discharge summary as required in paragraph (e)(1) and (e)(2) of this section must include—

(i) A summary of the patient's stay including treatments, symptoms and pain management.

(ii) The patient's current plan of care.

(iii) The patient's latest physician orders. and

(iv) Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.

(f) *Standard: Retrieval of clinical records.* The clinical record, whether hard copy or in electronic form, must