§ 418.104 Condition of Participation: Clinical Records

For each hospice patient, the hospice must maintain an accurate clinical record of past and current findings that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically.

Content of the clinical record

- Each patient's record must include:
  - The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.
  - Signed copies of the notice of patient rights in accordance with § 418.52 and election statement in accordance with § 418.24.
  - Election of hospice care. (Election Statement)
  - Responses to medications, symptom management, treatments, and services.
  - Outcome measure data elements, as described in § 418.54(e) of this subpart.
  - Physician certification and recertification of terminal illness, if appropriate.
  - Any advance directives.
  - Physician orders.
- Additional information that should be included in the clinical record, but not required by this CoP include:
  - Certification of terminal illness forms.
    - Certification with 6 month prognosis statement and physician narrative statement, with signature and date below the attestation.
    - Face-to-face attestation statements.
  - Change of attending physician forms (if any).
- **NOTE:** ***The measure data elements required in the clinical record are also required of the comprehensive assessment for each patient and allow for measurement of outcomes. These elements should be identified and documented upon compilation of the comprehensive assessment.***

Authentication of the clinical record

- All entries must be:
  - Legible, clear and complete.
  - Appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.
  - Physician signatures shall be handwritten or electronic to sign orders and other medical record documentation.
  - Facsimile of original written or electronic signatures are acceptable for the certification of terminal illness for hospice. **No stamped** physician signatures are acceptable unless the physician has a physical disability and can provide proof to a CMS contractor of an inability to sign due to that disability .

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 (The HIPAA Privacy Rule).

Retention of records

- Patient clinical records must be retained for 6 years after the death or discharge of the patient, unless State law stipulates that the records must be retained for a longer period of time.
  - Some states may have a longer medical record retention rule. If that is the case, the hospice provider **must follow the most stringent regulation**.
- If the hospice discontinues operation, hospice must retain and store 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.

Discharge or transfer of care

- The hospice discharge summary must include:
  - A summary of the patient's stay including treatments, symptoms and pain management.
  - The patient's current plan of care.
  - The patient's latest physician orders.
  - Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.
  - A discharge summary should only be completed for a patient who is discharged live from hospice care.
- If a hospice transfers the care of a patient to another Medicare/Medicaid-certified facility, the hospice must send the facility a copy of:
  - The hospice discharge summary.
  - The patient's clinical record, if requested.
- 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:
  - The hospice discharge summary.
  - The patient's clinical record, if requested.

Retrieval of clinical records

- The clinical record, whether hard copy or in electronic form, must be made readily available on request by an appropriate authority.

Compliance Suggestions for Hospice Providers

- Policy should incorporate electronic signature security process.
- Review and revise current discharge summaries to ensure that they include required criteria.
- Incorporate education about clinical record requirements into your orientation program and continuing education for all IDT staff.

Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).

Resources

- NHPCO Regulatory & Compliance Center, Certification and Recertification
- Complying with Medicare Signature Requirements

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
  42 CFR Part 418 Medicare Hospice Care Regulations eCFR :: 42 CFR Part 418 -- Hospice Care