CMS Survey and Certification Group  
CMS Webcast – February 19, 2009  
Overview of the New Hospice Conditions of Participation, Subpart D  

Webcast Summary

This webcast was aired on February 19, 2009 for CMS Regional Office staff and State agency Hospice surveyors. Hospice providers were invited by CMS to watch the webcast as well. This is a summary of the points presented in this webcast prepared by the NHPCO Regulatory Department. Information presented below is from verbal communication and written slide information in the webcast.

Subpart D is related to the administration of hospice services.

§418.100 Condition of Participation: Organization and administration of services.

The hospice must organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related conditions.

§418.100(a) Standard: Serving the hospice patient and family

The hospice must provide hospice care that-

1. Optimizes comfort and dignity; and  
2. Is consistent with patient and family needs and goals, with patient needs and goals as priority.

★ The highest priority for the hospice is meeting the patient’s needs.

- Surveyors are instructed to focus on patient health and safety and to look at outcomes or potential for poor outcomes.

§418.100(b) Standard: Governing body and administrator

- A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice’s governing body.

Hospice Administrator
- Hospice employee
- Has required education and experience
- Responsible for hospice daily operations
- Reports to the governing body
§418.100(c) Standard: Services

(1) A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice:
   (i) Nursing services.
   (ii) Medical social services.
   (iii) Physician services.
   (iv) Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling.
   (v) Hospice aide, volunteer, and homemaker services.
   (vi) Physical therapy, occupational therapy, and speech-language pathology services.
   (vii) Short-term inpatient care.
   (viii) Medical supplies (including drugs and biologicals) and medical appliances.

(2) Nursing services, physician services, and drugs and biologicals (as specified in §418.106) must be made routinely available on a 24-hour basis 7 days a week. Other covered services must be available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family.

§418.100(d) Standard: Continuation of care

A hospice may not discontinue or reduce care provided to a Medicare or Medicaid beneficiary because of the beneficiary's inability to pay for that care.
Interpretive Guidelines §418.100(d)

★ This condition applies to Medicare and Medicaid beneficiaries only.

§418.100(e) Standard: Professional management responsibility – not new

A hospice that has a written agreement with another agency, individual, or organization to furnish any 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.
The hospice must retain administrative and financial management responsibility, and oversight of staff and services provided under arrangement.

§418.100(f) Standard: Hospice multiple locations – previously located in the State Operations Manual (SOM)

If a hospice operates multiple locations, it must meet the following requirements:
(1) Medicare approval. (prior to providing care to MCA pts)

- All hospice multiple locations must be approved by Medicare before providing hospice care and services to Medicare patients.

- The multiple location must be part of the hospice and must share administration, supervision, and services with the hospice.

- 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 issued the certification number.

- 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.

- 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.

§418.100(g) Standard: Training – strengthened in new regulations

(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.

(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.

§418.102 Condition of Participation: Medical director –

★ new regulation; does not need to be a direct hospice employee

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 designated by the hospice assumes the same responsibilities and obligations as the medical director.

§418.102(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.

§418.102(b) Standard: Initial certification of terminal illness

The medical director or physician designee 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.
§418.104 Condition of participation: Clinical records

* more detail in this regulation than in previous CoP

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.

§418.104(a) Standard: Content

Each patient’s record must include the following:

1. The initial plan of care, updated plans of care, initial assessment, 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.

§418.104(b) Standard: Authentication

All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.
§418.104(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.

§418.104(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.

§418.104(e) Standard: Discharge or transfer of care - new

(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 by (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.

§418.104(f) Standard: 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.

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**Pop Quiz**

- What happens when the patient is transferred to another Medicare/Medicaid-certified facility:
  - A. The hospice must always send a copy of the patient’s discharge summary with the patient.
  - B. The hospice must always send a copy of the patient’s clinical record with the patient.
§418.106 Condition of participation: Drugs and biologicals, medical supplies, and durable medical equipment

Medical supplies and appliances, as described in §410.36 of this chapter; durable medical equipment, as described in §410.38 of this chapter; and drugs and biologicals related to the palliation and management of the terminal illness and related conditions, as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care.

§418.106(a) Standard: Managing drugs and biologicals

(1) The hospice must ensure that the interdisciplinary group confers with an individual with education and training in drug management as defined in hospice policies and procedures and State law, who is an employee of or under contract with the hospice to ensure that drugs and biologicals meet each patient's needs.

§418.106(b) Standard: Ordering of drugs

(1) Only a physician as defined by section 1861(r)(1) of the Act, or a nurse practitioner in accordance with the plan of care and State law, may order drugs for the patient.
(2) If the drug order is verbal or given by or through electronic transmission—
   (i) It must be given only to a licensed nurse, nurse practitioner (where appropriate), pharmacist, or physician; and
   (ii) The individual receiving the order must record and sign it immediately and have the prescribing person sign it in accordance with State and Federal regulations.

§418.106(c) Standard: Dispensing of drugs and biologicals

The hospice may obtain drugs and biologicals from community or institutional pharmacists or stock drugs and biologicals itself. (Mail order pharmacies are allowable)

§418.106(d) Standard: Administration of drugs and biologicals

(1) The interdisciplinary group, as part of the review of the plan of care, must determine the ability of the patient and/or family to safely self-administer drugs and biologicals to the patient in his or her home.

(2) Patients receiving care in a hospice that provides inpatient care directly in its own facility may only be administered medications by the following individuals:
   (i) A licensed nurse, physician, or other health care professional in accordance with their scope of practice and State law;
   (ii) An employee who has completed a State-approved training program in medication administration; and
   (iii) The patient, upon approval by the interdisciplinary group.

Interpretive Guidelines §418.106(d)

§418.106(e) Standard: Labeling, disposing, and storing of drugs and biologicals

(1) Labeling. Drugs and biologicals must be labeled in accordance with currently accepted professional practice and must include appropriate usage and cautionary instructions, as well as an expiration date (if applicable).
(2) Disposing. (i) Safe use and disposal of controlled drugs in the patient’s home. The hospice must have written policies and procedures for the management and disposal of controlled drugs in the patient’s home. At the time when controlled drugs are first ordered the hospice must:

(Provide a copy of the hospice written policies and procedures on the management and disposal of controlled drugs to the patient or patient representative and family.

★ The hospice must discuss the drug disposal policy with the patient and family in a manner and language the patient/ family understands, and document discussion in the clinical record.

Disposal of controlled drugs in hospices that provide inpatient care directly. The hospice that provides inpatient care directly in its own facility must dispose of controlled drugs in compliance with the hospice policy and in accordance with State and Federal requirements. The hospice must maintain current and accurate records of the receipt and disposition of all controlled drugs.

(3) Storing. The hospice that provides inpatient care directly in its own facility must comply with the following additional requirements-

(i) All drugs and biologicals must be stored in secure areas. All controlled drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1976 must be stored in locked compartments within such secure storage areas. Only personnel authorized to administer controlled drugs as noted in paragraph (d)(2) of this section may have access to the locked compartments;

(ii) Discrepancies in the acquisition, storage, dispensing, administration, disposal, or return of controlled drugs must be investigated immediately by the pharmacist and hospice administrator and where required reported to the appropriate State authority. A written account of the investigation must be made available to State and Federal officials if required by law or regulation.

§418.106(f) Standard: Use and maintenance of equipment and supplies

(2) The hospice must ensure that the patient, where appropriate, as well as the family and/or other caregiver(s), receive instruction in the safe use of durable medical equipment and supplies. The hospice may use persons under contract to ensure patient and family instruction. The patient, family,
and/or caregiver must be able to demonstrate the appropriate use of durable medical equipment to the satisfaction of the hospice staff.

(3) Hospices may only contract for durable medical equipment services with a durable medical equipment supplier that meets the Medicare DMEPOS Supplier Quality and Accreditation Standards at 42 CFR §424.57.

DMEPOS is the acronym for Durable Medical Equipment Prosthetics, Orthotics and Supplies. All DMEPOS suppliers are required under separate rulemaking to be accredited by October, 2009.

§418.108 Condition of participation: Short-term inpatient care

Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating Medicare or Medicaid facility.

§418.108(a) Standard: Inpatient care for symptom management and pain control

Inpatient care for pain control and symptom management must be provided in one of the following:

1. A Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly as specified in §418.110.

2. A Medicare-certified hospital or a skilled nursing facility that also meets the standards specified in §418.110(b) and (e) regarding 24-hour nursing services and patient areas.

Inpatient care for respite purposes must be provided by one of the following:

1. A provider specified in paragraph (a) of this section.

2. A Medicare or Medicaid-certified nursing facility that also meets the standards specified in §418.110(f) hospital; or SNF

(2) The facility providing respite care must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient’s plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

This is a change from old CoP – comments received during 60 day comment period on proposed CoPs stated that respite care does not always require an RN 24 hrs; The CoP was changed to require nursing to meet patient’s needs.

§418.108(c) Standard: Inpatient care provided under arrangements

If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies—

1. That the hospice supplies the inpatient provider a copy of the patient’s plan of care and specifies the inpatient services to be furnished;
(2) That the inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients;

(3) That the hospice patient's inpatient clinical record includes a record of all inpatient services furnished and events regarding care that occurred at the facility; that a copy of the discharge summary be provided to the hospice at the time of discharge; and that a copy of the inpatient clinical record is available to the hospice at the time of discharge;

(4) That the inpatient facility has identified an individual within the facility who is responsible for the implementation of the provisions of the agreement;

(5) That the hospice retains responsibility for ensuring that the training of personnel who will be providing the patient’s care in the inpatient facility has been provided and that a description of the training and the names of those giving the training are documented; and

§418.108(d) Standard: Inpatient care limitation  - no change

The total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12-month period in a particular hospice may not exceed 20 percent of the total number of hospice days consumed in total by this group of beneficiaries.

§418.110 Condition of participation: Hospices that provide inpatient care directly

The hospice is responsible for ensuring that staffing for all services reflects its volume of patients, their acuity, and the level of intensity of services needed to ensure that plan of care outcomes are achieved and negative outcomes are avoided.  - NEW

§418.110(b) Standard: Twenty-four hour nursing services

(1) The hospice facility must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient’s plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

(2) If at least one patient in the hospice facility is receiving general inpatient care, then each shift must include a registered nurse who provides direct patient care.
§418.110(c) Standard: Physical environment

- The hospice must maintain a safe physical environment free of hazards for patients, staff, and visitors.
- The hospice must have a written disaster preparedness plan in effect.
- Physical plant and equipment. The hospice must develop procedures for controlling the reliability and quality of:
  - (i) The routine storage and prompt disposal of trash and medical waste;
  - (ii) Light, temperature, and ventilation/air exchanges throughout the hospice;
  - (iii) Emergency gas and water supply; and
  - (iv) The scheduled and emergency maintenance and repair of all equipment.

§418.110(d) Standard: Fire protection

Must meet the provisions applicable to nursing homes of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA)

§418.110(e) Standard: Patient areas

The hospice must provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort, and privacy of patients.

The hospice must provide—
  - (i) Physical space for private patient and family visiting;
  - (ii) Accommodations for family members to remain with the patient throughout the night; and
  - (iii) Physical space for family privacy after a patient's death.

§418.110(f) Standard: Patient rooms

  (1) The hospice must ensure that patient rooms are designed and equipped for nursing care, as well as the dignity, comfort, and privacy of patients.
  (2) The hospice must accommodate a patient and family request for a single room whenever possible.

(For a facility occupied by a Medicare-participating hospice on December 2, 2008, CMS may waive the space and occupancy requirements of paragraphs (f)(2)(iv) and (f)(2)(v) of this section if it determines that—
Imposition of the requirements would result in unreasonable hardship on the hospice.

§418.110(g) Standard: Toilet and bathing facilities

Each patient room must be equipped with, or conveniently located near, toilet and bathing facilities.

§418.110(i) Standard: Infection control

The hospice must maintain an infection control program that protects patients, staff and others by preventing and controlling infections and communicable disease as stipulated in §418.60.
§418.110(j) Standard: Sanitary environment

The hospice must provide a sanitary environment by following current standards of practice.

§418.110(k) Standard: Linen

Linens must be handled, stored, processed, and transported in such a manner as to prevent the spread of contaminants.

§418.110(l) Standard: Meal service and menu planning

The hospice must furnish meals to each patient that are consistent with the patient’s plan of care, nutritional needs, and therapeutic diet;

§418.110(m) Standard: Restraint or seclusion

All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

(1) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.

(2) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

(3) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

Unless superseded by State law that is more restrictive--

(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or
others may only be renewed in accordance with the following limits for up to a total of 24 hours:
   4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1 hour for children under 9 years of age; and

§418.110(n) Standard: Restraint or seclusion staff training requirements

The patient has the right to safe implementation of restraint or seclusion by trained staff.

(1) Training intervals. All patient care staff working in the hospice inpatient facility must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion—
   (i) Before performing any of the actions specified in this paragraph;
   (ii) As part of orientation; and
   (iii) Subsequently on a periodic basis consistent with hospice policy.

§418.110(o) Standard: Death reporting requirements

Hospices must report deaths associated with the use of seclusion or restraint.

(1) The hospice must report the following information to CMS:
   (i) Each unexpected death that occurs while a patient is in restraint or seclusion.
   (ii) Each unexpected death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
   (iii) Each death known to the hospice that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

(2) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient’s death.
(3) Staff must document in the patient's clinical record the date and time the death was reported to CMS.
  ★ Document in clinical record when reported to CMS

§418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/MR.

Guidance located previously in the SOM

In addition to meeting the conditions of participation at §418.10 through §418.116, a hospice that provides hospice care to residents of a SNF/NF or ICF/MR must abide by the following additional standards.

§418.112(a) Standard: Resident eligibility, election, and duration of benefits

Medicare patients receiving hospice services and residing in a SNF, NF, or ICF/MR are subject to the Medicare hospice eligibility criteria set out at §418.20 through §418.30.
§418.112(b) Standard: Professional management

The hospice must assume responsibility for professional management of the resident’s hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to §418.100 and §418.108.

§418.112(c) Standard: Written agreement

The written agreement must include at least the following:

- Communication and documentation strategy
- Facility notifies hospice of specific patient conditions
- Hospice determines appropriate hospice care
- Facility responsibility for 24 hour r/b & personal care
- Hospice provides drugs & DME r/t terminal illness

- Hospice provide same services as patients at home
- Hospice use of facility personnel
- Hospice responsibility to report violations to facility
- Provision of bereavement services

§418.112(d) Standard: Hospice plan of care – deficiencies for POC’s frequently cited

- In accordance with §418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this hospice plan of care.

- The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.

- The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/MR, and the patient and family to the extent possible.

- Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/MR representatives, and must be approved by the hospice before implementation.

§418.112(e) Standard: Coordination of services

The hospice must:

(1) Designate a member of each interdisciplinary group that is responsible for a patient who is a resident of a SNF/NF or ICF/MR. The designated interdisciplinary group member is responsible for:
(i) Providing overall coordination of the hospice care of the SNF/NF or ICF/MR resident with SNF/NF or ICF/MR representatives; and
(ii) Communicating with SNF/NF or ICF/MR representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient and family.

(2) Ensure that the hospice IDG communicates with the SNF/NF or ICF/MR medical director, the patient's attending physician, and other physicians participating in the provision of care to the patient as needed to coordinate the hospice care of the hospice patient with the medical care provided by other physicians.

(3) Provide the SNF/NF or ICF/MR with the following information:
   (i) The most recent hospice plan of care specific to each patient;
   (ii) Hospice election form and any advance directives specific to each patient;
   (iii) Physician certification and recertification of the terminal illness specific to each patient;
   (iv) Names and contact information for hospice personnel involved in hospice care of each patient;
   (v) Instructions on how to access the hospice’s 24-hour on-call system;
   (vi) Hospice medication information specific to each patient; and
   (vii) Hospice physician and attending physician (if any) orders specific to each patient.

§418.112(f) Standard: Orientation and training of staff

Hospice staff must assure orientation of SNF/NF or ICF/MR staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.

CMS states that in the preamble for 418.112 it is explained that there must be a single plan for each patient that designates which provider is responsible for which interventions. Here is the preamble section:

“The plan would have to reflect the hospice philosophy in all aspects, be based on an assessment of the patient’s needs and unique living situation in the facility, and be updated at least every 14 calendar days. In addition to the standard plan of care requirements, the plan of care for a patient residing in a SNF/NF, ICF/MR, or other facility would be required to be coordinated with and developed by the hospice IDG and SNF/NF, ICF/MR, or other facility in collaboration with the attending physician. Furthermore, the plan of care would have to specify which provider would be responsible for providing a particular form of care. The performance of the functions would reflect the participation of the hospice, SNF/NF, ICF/MR, or other facility, and the patient and family to the extent possible.”

§418.114 Condition of participation: Personnel qualifications

§418.114(a): General qualification requirements

Except as specified in paragraph (c) of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified or registered) in accordance with applicable Federal, State and local laws, and must act only within the scope of his or her State license, or State certification, or registration. All personnel qualifications must be kept current at all times.

Personnel qualifications for certain disciplines. The following qualifications must be met:

- **Physician.** Physicians must meet the qualifications and conditions as defined in section 1861(r) of the Act and implemented at §410.20 of this chapter.
- **Hospice aide.** Hospice aides must meet the qualifications required by section 1891(a)(3) of the Act and implemented at §418.76.
- **Social worker.** A person who—
  
  1. Has a Master of Social Work (MSW) degree from a school of social work accredited by the Council on Social Work Education; or
  2. Has a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education; or a baccalaureate degree in psychology, sociology, or other field related to social work and is supervised by an MSW as described in paragraph (b)(3)(i)(A) of this section; and
  3. Has one year of social work experience in a health care setting; or
  4. Has a baccalaureate degree from a school of social work accredited by the Council on Social Work Education, is employed by the hospice before December 2, 2008, and is not required to be supervised by an MSW.

- **Registered nurse.** must be a graduate of a school of professional nursing.
- **Licensed practical nurse.** Is a person who has completed a practical nursing program.
Standard: Criminal background checks – new

- The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records.

- Criminal background checks must be obtained in accordance with State requirements. In the absence of State requirements, criminal background checks must be obtained within three months of the date of employment for all states that the individual has lived or worked in the past 3 years.

- Since the release of the CoPs in June 2008, hospice providers have had concerns about including the requirement of criminal background checks in their written agreements. Inpatient facilities have stated that they will not continue their contracts with the hospice provider with the criminal background check requirements included. Facilities do not have this requirement under their provider regulations. CMS is currently facilitating a revision to the language. In the meantime, CMS’s message to surveyors is to focus on ensuring that hospice staff have criminal background checks and not focus on inpatient criminal background checks at this time.

§418.116 Condition of participation: Compliance with Federal, State, and local laws and regulations related to the health and safety of patients.

The hospice and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations related to the health and safety of patients. If State or local law provides for licensing of hospices, the hospice must be licensed.

§418.116(a) Standard: Multiple locations

Every hospice must comply with the requirements of §420.206 of this chapter regarding disclosure of ownership and control information. All hospice multiple locations must be approved by Medicare and licensed in accordance with State licensure laws, if applicable, before providing Medicare reimbursed services.

§418.116(b) Standard: Laboratory services

(1) If the hospice engages in laboratory testing other than assisting a patient in self-administering a test with an appliance that has been approved for that purpose by the FDA, the hospice must be in compliance with all applicable requirements of part 493 of this chapter. (CLIA)