I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which Tenet Healthcare Corporation or an Affiliate either manages or controls the day-to-day operations of the facility (each, a “Tenet Hospital”) (collectively, “Tenet”).

II. PURPOSE:

The purpose of this policy is to define the use of advanced practice practitioners and residents in the Inpatient Rehabilitation Facility (IRF) setting in order to comply with federal guidelines for patient visits and documentation. The use of advanced practice practitioners and residents is common in many settings however, inpatient rehab facilities have specific regulatory standards for their practice.

III. DEFINITIONS:

A. An “advanced practice practitioner” is a licensed health care provider who is not a physician but who performs medical activities typically performed by a physician. This policy includes those clinicians such as Advanced Practice Nurse (APN), Nurse Practitioner (NP), and Physician’s Assistant (PA).

B. A “resident” is a resident physician who performs medical activities under the supervision of a licensed physician. Medical students are not recognized as official personnel and do not fulfill any IRF coverage requirements. 1

C. The term “extender” is used in this policy to mimic the language used in the regulatory guidance. This includes all advanced practice practitioners and resident physicians.

D. A “rehab physician” is a licensed doctor of medicine or osteopathy with specialized training and experience in rehabilitation. 3, 4, 5, 7 The IRF must meet hospital conditions of participation specified in 42 CFR 482.22 regarding documentation of staff qualifications.

IV. POLICY:
Only a rehab physician may: provide written approval of a patient’s acceptance on the Pre-Admission Screening, completion of the Post Admission Physician Evaluation, three documented Face to Face visits per week, document the integration of the overall Plan of Care by day 4, and lead Team Conference.

V. PROCEDURE:

A. PRE-ADMISSION ASSESSMENT ("PAS")

Physician extenders may make recommendations to the rehabilitation physician. The decision regarding if a patient meets criteria for admission requires physician judgment and cannot be delegated to a physician extender. The rehab physician, not an extender, must document his or her review and concurrence with the findings of the preadmission screening prior to the IRF admission. 1, 3, 4, 5

B. HISTORY AND PHYSICAL ("H&P")

Standard Medicare regulations regarding the use of physician extenders in providing services to Medicare beneficiaries apply to completion of the history and physical. 1, 3, 4, 6

C. POST ADMISSION PHYSICIAN EVALUATION ("PAPE")

If a physician extender has completed the history and physical in the first 24 hours the patient has admitted to the IRF, the rehab physician is not required to repeat the H&P. They must authenticate the document within 24 hours of admission as this is a required element of the PAPE. Additionally, it is the responsibility of the rehab physician to visit the patient and complete the other required elements of the PAPE within the first 24 hours after the patient has been admitted. This includes the patient’s status on admission to the IRF, comparison to the preadmission screening documentation and identifies changes, begin the development of the expected course of treatment, and include a review of the patient’s prior and current medical and functional conditions and comorbidities. The rehab physician’s examination of the patient must be adequate to establish the individual plan of care. The PAPE cannot be completed by, contributed to, or delegated to a physician extender. 1, 2, 3, 4, 6

D. INDIVIDUALIZED DAY 4 PLAN OF CARE
Individual assessments of appropriate clinical staff may be used to contribute to the plan of care. Physician extenders may work in collaboration with the rehab physician to develop the plan of care. However, it is the sole responsibility of the rehab physician to integrate the information and to document it in the patient’s medical record no later than day 4 of the stay. 1, 3, 4, 5

E. FACE TO FACE VISITS

Extenders may assist the physician in providing clinical data to the face-to-face progress note documentation, however, the IRF requirement for Physician Supervision is only met if the rehab physician assesses the patient both medially and functionally, as well as provides modifications to the course of treatment as needed, and it is documented in the record by the rehab physician as such. The rehab physician is responsible for visiting and documenting the minimum 3 face-to-face physician visits per week. This responsibility cannot be delegated to anyone other than another rehab physician. 1, 3, 4, 5

Other specialties or extenders may treat and visit the patient as needed. Use of an extender as a “scribe”, must follow the policy COMP-RCC 4.62, Scribes in the Hospital Provider Based Setting. 2

F. TEAM CONFERENCE

A physician extender may attend and contribute to the Interdisciplinary Team Conference. However, a rehab physician must lead the team conference and the documentation must clearly demonstrate the rehab physician’s involvement in leading the conference. 1, 3, 4, 5

G. TIMELINESS OF DOCUMENTATION

Any History and Physical contributed to by a physician extender must be authenticated by the rehab physician within 24 hours of the patient’s admission to the IRF. 1, 3, 4, 8

Any face to face notes contributed by a physician extender, must be authenticated the same date of service, along with the rehabilitation physician’s medical and functional assessment and any relevant changes. If a physician extender’s note cannot be authenticated on the same date of service, the physician is responsible
for completing their own documentation with the required elements on the same day of service. 8

H. AUDITING AND MONITORING

Each IRF Program Director is responsible for a concurrent self-auditing process. The IRF Medical Director is responsible for monitoring the performance of rehab physicians in the IRF. Non-adherence to this policy shall be reported to the Hospital Compliance Officer.

I. ENFORCEMENT

All parties whose responsibilities are affected by this policy are expected to be familiar with the procedures created by this policy. Any party who fails to comply with this policy will be subject to appropriate performance management, including referral to the hospital’s Utilization Review Committee or Peer Review Committee, up to and including termination. Such performance may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by law.

VI. REFERENCES:

- Complete List of IRF Clarifications, 2017

- Tenet COMP-RCC_4.62 Scribes in the Hospital Provider Based Setting

- CMS, Pub 100-02 Medicare Benefit Policy Manual, Chapter 1, Section 110.1-110.3, Rev 119, 01-15-10

- Code of Federal Regulations, Title 42, Chapter IV, Subchapter B, Part 412, Subpart P, Section 42 CFR §412.622 Basis of Payment

- Code of Federal Regulations, Title 42, Chapter IV, Subchapter B, Part 412, Subpart B, Section 42 CFR §412.29 Classification criteria for payment under the inpatient rehabilitation facility prospective payment system.

- Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 482 Conditions of Participation, Subpart C, Section 42 CFR §482.24 Conditions of Participation: Medical Record Services
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- Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 482 Conditions of Participation, Subpart D, Section 42 CFR §482.56 Conditions of Participation: Rehabilitation Services

- Tenet COMP-RCC_4.03 Health Information Management Operations, Hospital Chart Completion, Documentation and Security

**VII. ATTACHMENTS**

- Attachment A– 42 CFR 412.622 Basis of Payment

- Attachment B– 42 CFR 412.29 Classification criteria for payment under the IRF PPS

- Attachment C– 42 CFR 482.24 Medical Record Services
ATTACHMENT A

§412.622  Basis of payment.

(A) Method of payment.

(1) Under the prospective payment system, inpatient rehabilitation facilities receive a predetermined amount per discharge for inpatient services furnished to Medicare Part A fee-for-service beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate, including adjustments described in §412.624 and, if applicable, during a transition period, on a blend of the Federal payment rate and the facility-specific payment rate described in §412.626.

(3) IRF coverage criteria. In order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation that the patient meets all of the following requirements at the time of the patient's admission to the IRF—

(i) Requires the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.

(ii) Generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF. Benefit from this intensive rehabilitation therapy program is demonstrated by measurable improvement that will be of practical value to the patient in improving the patient's functional capacity or adaptation to impairments. The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF.

(iii) Is sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation therapy program that is described in paragraph (a)(3)(ii) of this section.
(iv) Requires physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

(4) 

Documentation. To document that each patient for whom the IRF seeks payment is reasonably expected to meet all of the requirements in paragraph (a)(3) of this section at the time of admission, the patient's medical record at the IRF must contain the following documentation—

(i) A comprehensive preadmission screening that meets all of the following requirements—

(a) It is conducted by a licensed or certified clinician(s) designated by a rehabilitation physician described in paragraph (a)(3)(iv) of this section within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted in person or by telephone to update the patient's medical and functional status within the 48 hours immediately preceding the IRF admission and is documented in the patient's medical record.

(b) It includes a detailed and comprehensive review of each patient's condition and medical history.

(c) It serves as the basis for the initial determination of whether or not the patient meets the requirements for an IRF admission to be considered reasonable and necessary in paragraph (a)(3) of this section.

(d) It is used to inform a rehabilitation physician who reviews and documents his or her concurrence with the findings and results of the preadmission screening.

(e) It is retained in the patient's medical record at the IRF.

(ii) A post-admission physician evaluation that meets all of the following requirements—

(a) It is completed by a rehabilitation physician within 24 hours of the patient's admission to the IRF.
(b) It documents the patient's status on admission to the IRF, includes a comparison with the information noted in the preadmission screening documentation, and serves as the basis for the development of the overall individualized plan of care.

(c) It is retained in the patient's medical record at the IRF.

(iii) An individualized overall plan of care for the patient that meets all of the following requirements—

(a) It is developed by a rehabilitation physician, as defined in paragraph (a)(3)(iv) of this section, with input from the interdisciplinary team within 4 days of the patient's admission to the IRF.

(b) It is retained in the patient's medical record at the IRF.

(5) Interdisciplinary team approach to care. In order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, the patient must require an interdisciplinary team approach to care, as evidenced by documentation in the patient's medical record of weekly interdisciplinary team meetings that meet all of the following requirements—

(i) The team meetings are led by a rehabilitation physician as defined in paragraph (a)(3)(iv) of this section, and further consist of a registered nurse with specialized training or experience in rehabilitation; a social worker or case manager (or both); and a licensed or certified therapist from each therapy discipline involved in treating the patient. All team members must have current knowledge of the patient's medical and functional status.

(ii) The team meetings occur at least once per week throughout the duration of the patient's stay to implement appropriate treatment services; review the patient's progress toward stated rehabilitation goals; identify any problems that could impede progress towards those goals; and, where necessary, reassess previously established goals in light of impediments, revise the treatment plan in light of new goals, and monitor continued progress toward those goals.

(iii) The results and findings of the team meetings, and the concurrence by the rehabilitation physician with those results and findings, are retained in the patient's medical record.

(B) Payment in full.

(1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as described in subpart G of part 409 of this subchapter) for
inpatient operating and capital-related costs associated with furnishing Medicare covered services in an inpatient rehabilitation facility, but not for the cost of an approved medical education program described in §§413.75 and 413.85 of this chapter.

(2) In addition to payments based on prospective payment rates, inpatient rehabilitation facilities receive payments for the following:

   (i) Bad debts of Medicare beneficiaries, as provided in §413.80 of this chapter; and

   (ii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

ATTACHMENT B

§412.29   Classification criteria for payment under the inpatient rehabilitation facility prospective payment system.

To be excluded from the prospective payment systems described in §412.1(a)(1) and to be paid under the prospective payment system specified in §412.1(a)(3), an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital (otherwise referred to as an IRF) must meet the following requirements:

(A) Have (or be part of a hospital that has) a provider agreement under part 489 of this chapter to participate as a hospital.

(B) Except in the case of a “new” IRF or “new” IRF beds, as defined in paragraph (c) of this section, an IRF must show that, during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the Medicare contractor), it served an inpatient population that meets the following criteria:

(1) For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the IRF served an inpatient population of whom at least 50 percent, and for cost reporting periods beginning on or after July 1, 2005, the IRF served an inpatient population of whom at least 60 percent required intensive rehabilitation services for treatment of one or more of the conditions specified at paragraph (b)(2) of this section. A patient with a comorbidity, as defined at §412.602 of this part, may be included in the inpatient population that counts toward the required applicable percentage if—

   (i) The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified in paragraph (b)(2) of this section;

   (ii) The patient has a comorbidity that falls in one of the conditions specified in paragraph (b)(2) of this section; and

   (iii) The comorbidity has caused significant decline in functional ability in the individual that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under subpart P of this part and that cannot be appropriately performed in another care setting covered under this title.

(2) List of conditions.

   (i) Stroke.

   (ii) Spinal cord injury.
(iii) Congenital deformity.

(iv) Amputation.

(v) Major multiple trauma.

(vi) Fracture of femur (hip fracture).

(vii) Brain injury.

(viii) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

(ix) Burns.

(x) Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

(xi) Systemic vasculitides with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

(xii) Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)
(xiii) Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one or more of the following specific criteria:

(a) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.

(b) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.

(c) The patient is age 85 or older at the time of admission to the IRF.

(C) In the case of new IRFs (as defined in paragraph (c)(1) of this section) or new IRF beds (as defined in paragraph (c)(2) of this section), the IRF must provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b) of this section. This written certification will apply until the end of the IRF's first full 12-month cost reporting period or, in the case of new IRF beds, until the end of the cost reporting period during which the new beds are added to the IRF.

(1) New IRFs. An IRF hospital or IRF unit is considered new if it has not been paid under the IRF PPS in subpart P of this part for at least 5 calendar years. A new IRF will be considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost reporting period.

(2) New IRF beds. Any IRF beds that are added to an existing IRF must meet all applicable State Certificate of Need and State licensure laws. New IRF beds may be added one time at any point during a cost reporting period and will be considered new for the rest of that cost reporting period. A full 12-month cost reporting period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF beds to that IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the CMS RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds delicensed or decertified. New IRF beds are included in the compliance review calculations under paragraph (b) of this section from the time that they are added to the IRF.

(3) Change of ownership or leasing. An IRF hospital or IRF unit that undergoes a change of ownership or leasing, as defined in §489.18 of this chapter, retains its excluded status and will continue to be paid under the prospective payment system specified in §412.1(a)(3) before and after the change of ownership or leasing if the new owner(s) of the IRF accept assignment of the previous owners' Medicare provider agreement and the IRF continues to meet all of the requirements for payment under the IRF prospective payment system. If
the new owner(s) do not accept assignment of the previous owners' Medicare provider agreement, the IRF is considered to be voluntarily terminated and the new owner(s) may re-apply to participate in the Medicare program. If the IRF does not continue to meet all of the requirements for payment under the IRF prospective payment system, then the IRF loses its excluded status and is paid according to the prospective payment systems described in §412.1(a)(1).

(4) Mergers. If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s) of the merged hospital accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the prospective payment system specified in §412.1(a)(3) before and after the merger, as long as the IRF hospital or IRF unit continues to meet all of the requirements for payment under the IRF prospective payment system. If the owner(s) of the merged hospital do not accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may reapply to the Medicare program to operate a new IRF.

(D) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program. This procedure must ensure that the preadmission screening for each Medicare Part A Fee-for-Service patient is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.

(E) Have in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

(F) Furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.

(G) Have a director of rehabilitation who—

(1) Provides services to the IRF hospital and its inpatients on a full-time basis or, in the case of a rehabilitation unit, at least 20 hours per week;
(2) Is a doctor of medicine or osteopathy;

(3) Is licensed under State law to practice medicine or surgery; and

(4) Has had, after completing a one-year hospital internship, at least 2 years of training or experience in the medical-management of inpatients requiring rehabilitation services.

(H) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.

(I) Use a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment and discharge plans, and that team conferences are held at least once per week to determine the appropriateness of treatment.

(J) *Retroactive adjustments.* If a new IRF (or new beds that are added to an existing IRF) are excluded from the prospective payment systems specified in §412.1(a)(1) and paid under the prospective payment system specified in §412.1(a)(3) for a cost reporting period under paragraph (c) of this section, but the inpatient population actually treated during that period does not meet the requirements of paragraph (b) of this section, we adjust payments to the IRF retroactively in accordance with the provisions in §412.130.

- [76 FR 47891, Aug. 5, 2011, as amended at 78 FR 47934, Aug. 6, 2013]
ATTACHMENT C

§482.24  Condition of participation: Medical record services.

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

(A) **Standard: Organization and staffing.** The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records.

(B) **Standard: Form and retention of record.** The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

1. Medical records must be retained in their original or legally reproduced form for a period of at least 5 years.

2. The hospital must have a system of coding and indexing medical records. The system must allow for timely retrieval by diagnosis and procedure, in order to support medical care evaluation studies.

3. The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released by the hospital only in accordance with Federal or State laws, court orders, or subpoenas.

(C) **Standard: Content of record.** The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

1. All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

2. All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.
(3) Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders only if the hospital:

(i) Establishes that such orders and protocols have been reviewed and approved by the medical staff and the hospital's nursing and pharmacy leadership;

(ii) Demonstrates that such orders and protocols are consistent with nationally recognized and evidence-based guidelines;

(iii) Ensures that the periodic and regular review of such orders and protocols is conducted by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the orders and protocols; and

(iv) Ensures that such orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or by another practitioner responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

(4) All records must document the following, as appropriate:

(i) Evidence of—

(a) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

(b) An updated examination of the patient, including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration. Documentation of the updated examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

(ii) Admitting diagnosis.

(iii) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.

(iv) Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.
(v) Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.

(vi) All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.

(vii) Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.

(viii) Final diagnosis with completion of medical records within 30 days following discharge.

- [51 FR 22042, June 17, 1986, as amended at 71 FR 68694, Nov. 27, 2006; 72 FR 66933, Nov. 27, 2007; 77 FR 29074, May 16, 2012]