Authentication of Health Record Entries (2000 update)

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Editor's note: The following information supplants information contained in the September 1996 "Authentication of Medical Record Entries" practice brief.

Background

In 1996, the Joint Commission on Accreditation of Healthcare Organizations changed its requirements for authentication of some entries in the health record. Although the Joint Commission no longer requires physician signatures on verbal orders (except medication orders in behavioral healthcare) or certain other record entries, authentication of these entries may be required by other accrediting agencies, the Medicare Conditions of Participation, or state laws and regulations. Healthcare organizations should research these requirements carefully before developing organization-wide authentication policies and procedures.

Accreditation Requirements

Joint Commission on Accreditation of Healthcare Organizations

Effective July 1, 1996, the Joint Commission requires the following for authentication of health record entries for its hospital accreditation program:

- **Verbal Orders:** Each verbal order must be dated and identified by the names of the individuals who gave it and received it, and the record must document who implemented it. When required by state or federal law and regulation, verbal orders are authenticated within the specified time frame.
- **Health Record Entries:** Every health record entry must be dated, its author identified, and, when necessary, authenticated. Authors must authenticate those entries required by hospital policy. Hospitals may set their own policies, provided they ensure authentication of at least these entries: history and physical examinations, operative reports, consultations, and discharge summaries. Note that consultations requiring authentication are defined by the Joint Commission to exclude routine pathology, laboratory, and x-ray reports.

See Exhibit 1 for the full text of these standards and their intents.

Effective January 1, 1997, the Joint Commission requires the following for authentication of health record entries for its **behavioral healthcare** accreditation program:

- **Verbal Orders:** Each verbal order must be dated and identified by the names of the individuals who gave it and received it, and the record must document who implemented it. When required by state or federal law and regulation, verbal orders are authenticated within the specified time frame. Medication orders must be authenticated.
- **Health Record Entries:** Every clinical record entry must be dated, its author identified, and, when necessary, authenticated. Authors must authenticate those entries required by organization policy. Organizations may set their own policies, provided they ensure authentication of at least these entries: history and physical examinations, evaluations and assessments, progress notes, medication orders, and discharge summaries.

See Exhibit 2 for the full text of these standards and their intents.

Effective January 1, 1997, the Joint Commission requires the following for authentication of health record entries for its **ambulatory care** accreditation program:

- **Verbal Orders:** Each verbal order must be dated and identified by the names of the individuals who gave it and received it, and the record must document who implemented it. When required by state or federal law and regulation, verbal orders must be authenticated within the specified time frame.
- **Health Record Entries:** Every clinical record entry must be dated, its author identified, and, when necessary, authenticated. Authors must authenticate those entries required by organization policy. Organizations may set their own policies, provided they ensure authentication of at least these entries: history and physical examinations, operative reports, diagnostic and therapeutic procedures, consultations, and follow-up/discharge summaries.

See Exhibit 3 for the full text of these standards and their intent statements.

Effective January 1, 1998, the Joint Commission requires the following for authentication of health record entries for its **long term care** accreditation program:

- **Verbal Orders:** Each verbal order must be dated and identified by the names of the individuals who gave it and received it, and the record must document who implemented it. When required by state or federal law and regulation, verbal orders are authenticated within the specified time frame.
- **Health Record Entries:** Every clinical record entry must be dated, its author identified, and, when necessary, authenticated. Authors must authenticate those entries required by organization policy. Organizations may set their own policies, provided they ensure authentication of at least these entries: history and physical examinations, operative reports, diagnostic and therapeutic procedures, consultations, and follow-up/discharge summaries.

See Exhibit 4 for the full text of these standards and their intent statements.

The **Home Health** Professional and Technical Advisory Committee has chosen not to discuss authentication issues at this time. This issue is not applicable to the **Healthcare Networks** accreditation program.

Restraint Orders: The Joint Commission's standards on verbal orders affect restraint orders as well. Standards addressing restraint have been standardized for all accreditation programs, so the following requirements apply to any care setting accredited by the Joint Commission.

Restraint or seclusion is ordered by a licensed independent practitioner who provides verbal or written orders for initial use or to reauthorize continuing emergency use. Verbal orders for restraint do not require physician signature, unless otherwise required by federal or state law or statute. After the original order expires, the patient must receive a face-to-face reassessment by a licensed independent practitioner who writes a new order if restraint or seclusion is to be continued.

National Committee for Quality Assurance (NCQA)

NCQA accredits managed care plans like health maintenance organizations. It evaluates how well a health plan manages all parts of its delivery system, including physicians, hospitals, other providers, and administrative services.

NCQA standards for ambulatory records (Medical Record standard 3) require the provider to be identified on each medical record entry, and all entries must be dated. Author identification may be a handwritten signature, an initials-stamped signature, or a unique electronic identifier. Consultations, laboratory reports, and imaging reports filed in the chart must be initialed by the primary care physician (PCP) to signify review. Review and signature by professionals other than PCPs, such as nurse practitioners and physician assistants, do not meet this requirement. If the reports are presented electronically, or by some other method, there is also a requirement for representation of physician review. Verbal orders are not addressed in NCQA standards.

Commission on Accreditation of Rehabilitation Facilities (CARF)

CARF standards require that the record of each person served include signed and dated reports from each service. "Dated" refers to the month, day, and year, but does not require the specific time of day. The standards also require that organizations develop a policy that specifies time frames for record entries such as clinical information, reports of critical incidents or interactions, progress notes, and discharge summaries. The interpretive guideline states that the timeliness of admission notes, assessments, treatment plans, and progress notes is an important monitoring tool and that each program should establish in writing the time frame for each specific type of entry.

Accreditation Association for Ambulatory Health Care (AAAHC)

AAAHC standards require that reports, histories and physicals, progress notes, and other patient information (such as laboratory reports, x-ray readings, operative reports, and consultations) are reviewed and incorporated into the record in a timely manner. AAAHC standards also require that entries in a patient's record for each visit include authentication and verification of contents by the practitioner.

Legal and Regulatory Requirements

Medicare Conditions of Participation

To participate in the Medicare program, healthcare organizations must comply with federal regulations promulgated by the Health Care Financing Administration (HCFA), commonly called the Medicare Conditions of Participation. **These Conditions currently require authentication of various health record entries.**

42 Code of Federal Regulations Paragraph 482.24, Conditions of Participation for **Hospitals**, Condition of Participation: Medical Record Services (c)(1) and (c)(1)(i) state, "All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and authenticate his or her entry."

The Interpretive Guidelines for Hospitals (c)(1) state, "Entries in the medical records may be made only by individuals as specified in hospital and medical staff policies. All entries in the medical record must be dated and authenticated....The parts of the medical record that are the responsibility of the physician must be authenticated by this individual. When nonphysicians have been approved for such duties as taking medical histories or documenting aspects of a physician examination, such information shall be appropriately authenticated by the responsible physician. Any entries in the medical record by house staff or nonphysicians that require countersigning by supervisory or attending medical staff members shall be defined in the medical staff rules and regulations."

The Medicare Conditions of Participation for Hospitals are currently under revision. On December 19, 1997, a proposed rule was published regarding revisions to the Conditions of Participation for Hospitals, with a request for public comments. The new final Conditions of Participation (other than the Patient Rights section published in 1999) are expected to be published in the first quarter of 2000. Until the new Conditions become effective, HCFA's Hospital Standards Quality Bureau has indicated that hospitals are expected to comply with the existing Conditions of Participation.

On February 12, 1998, AHIMA submitted the following comments to HCFA regarding the proposed rule regarding revisions to the Conditions of Participation for Hospitals:

We do not support the proposed language "all patient record entries, including those made as a result of verbal orders, must be legible, dated and authenticated in written or electronic form by whomever is responsible for ordering or providing the service."

AHIMA believes that patients have a right to complete, accurate, timely documentation in their health records, completed by healthcare practitioners at the point of care. Obtaining retrospective signatures is a costly and time-consuming practice that adds no value to the delivery of care or patient outcome.

AHIMA recommends that each hospital determine its own policy regarding authentication of entries and utilize quality improvement processes to monitor and improve the adequacy and timeliness of documentation. ***We would recommend the following language: "Every medical record entry is dated, its author identified and, when necessary, authenticated as required by the medical staff bylaws, rules and regulations."***

For verbal orders, the Medicare Conditions of Participation for Hospitals, Nursing Services Paragraph 482.23 (c)(2), require the following:

All orders for drugs and biologicals must be in writing and signed by the practitioner or practitioner(s) responsible for the care of the patient as specified under 482.12(c). When telephone or oral orders must be used, they must be: accepted only by

personnel that are authorized to do so by the medical staff policies and procedures, consistent with federal and state law; signed or initialed by the prescribing practitioner as soon as possible; and used infrequently.

AHIMA also submitted the following comments to HCFA regarding the proposed rule for verbal orders:

There should be no time frame for signing of verbal orders. **The process of signing verbal orders after the order has been carried out produces no added value to patient care. We would recommend the following language:** ***"Verbal orders of authorized individuals are accepted and transcribed by qualified personnel who are identified by title or category in the medical staff bylaws, rules and regulations."***

Medicare Conditions of Participation for other care settings also have requirements that entries be signed. Conditions of Participation for **Ambulatory Care Surgical Services** (42 CFR Ch. IV, part 416, Paragraph 416.48 (a)(3)) states, "Orders given orally for drugs and biologicals must be followed by a written order, signed by the prescribing physician."

Requirements for States and **Long Term Care Facilities** (42 CFR Ch. IV, Part 483, Subpart A, Paragraph 483.40) states that physicians must "write, sign, and date progress notes at each visit and sign and date all orders. The resident must be seen by a physician at least once every 30 days for the first 90 days and at least once every 60 days thereafter."

Conditions of Participation for **Hospice Care** (42 CFR Ch. IV, Subpart C, Paragraph 418.74) requires that "entries are made for all services provided. Entries are made and signed by the person providing the services." Section 418.100 (k)(2) outlines requirements for verbal orders: "If the medication order is verbal (A) the physician must give it only to a licensed nurse, pharmacist, or another physician; and (B) the individual receiving the order must record and sign it immediately and have the prescribing physician sign it in a manner consistent with good medical practice."

Conditions of Participation for **Home Health Agencies** (42 CFR, Ch. IV, Paragraph 484.48) requires "signed and dated clinical and progress notes." Section 484.18(c) addresses physician orders: "Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medicines a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medication, and promptly report any problems to the physician."

Conditions of Participation for **Rural Primary Care Hospitals** (42 CFR Ch. IV, Paragraph 485.638) requires "dated signatures of the doctor of medicine or osteopathy or other healthcare professional." Section 485.635 outlines these requirements for orders: "All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by state law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and federal and state laws."

Medicare Conditions of Participation for **Comprehensive Outpatient Rehabilitation Facilities** (42 CFR Ch. IV, Paragraph 485.60(a)) requires that "entries in the clinical record must be made as frequently as is necessary to insure effective treatment and must be signed by personnel providing services. All entries made by assistant level personnel must be countersigned by the corresponding professional." The Conditions do not address requirements for verbal orders.

State Laws and Regulations

State laws and regulations on authentication of health records vary widely. Some are silent on authentication of medical records. Others simply require medical records to be maintained according to recognized professional standards. Others outline specific requirements for authentication, including methods of authentication and time frames in which certain entries must be authenticated.

Debate has centered on compliance with this requirement, the intent of the requirement, and the labor-intensive process involved in achieving compliance. With changes in the Joint Commission standards and the anticipated changes in the Conditions of Participation for Hospitals, some states have changed their authentication requirements. For an example of how HIM professionals initiated a change in their state regulation, see "To Sign or Not to Sign Verbal Orders," in the May 1998 *Journal of AHIMA,* pages 62-64. Check with your state licensing authority (usually the state health department's division of

healthcare licensure) for specific requirements for your state. Additional requirements may be outlined by a state's medical practice act or the state board of pharmacy.

Recommendations

Healthcare organizations should develop organization-wide policies to address authentication requirements and acceptable methods of authenticating medical record entries. To assure compliance with legal, regulatory, and accreditation requirements, AHIMA recommends that healthcare organizations take the following steps:

- Review any requirements outlined in state law, regulation, or healthcare facility licensure standards. If your state requires that verbal orders be authenticated within a specified time frame, accrediting and licensing agencies will survey for compliance with that requirement.
- Review the Medicare Conditions of Participation and Interpretive Guidelines for your type of organization. **At this time, HCFA expects healthcare organizations to comply with the existing Conditions of Participation.** If any of the standards for your care setting are unclear, ask your regional HCFA office to provide written interpretation outlining how you should comply with those standards. Individuals should monitor the *Federal Register* for proposed changes to the Conditions of Participation and submit comments within the requested time frame.
- Establish quality controls to assure the accuracy of entries that are not authenticated. For example, transcribed reports should not be released for patient care until blanks are filled in and any unclear or questionable dictation is clarified by the author.

References

Commission on Accreditation of Rehabilitation Facilities. *1997 Standards Manual and Interpretive Guidelines for Behavioral Health.* Tucson, AZ: 1997.

Accreditation Association for Ambulatory Health Care. *1999 Accreditation Handbook for Ambulatory Health Care.* Skokie, IL: 1999.

Joint Commission on Accreditation of Healthcare Organizations. *1997-98 Comprehensive Accreditation Manual for Behavioral Health Care.* Oakbrook Terrace, IL: 1998.

Joint Commission on Accreditation of Healthcare Organizations. *1997-98 Accreditation Manual for Home Care.* Oakbrook Terrace, IL: 1996.

Joint Commission on Accreditation of Healthcare Organizations. *1998-99 Accreditation Manual for Ambulatory Care. Oakbrook Terrace, IL: 1998.*

Joint Commission on Accreditation of Healthcare Organizations. 1998-99 Accreditation Manual for Long Term Care. Oakbrook Terrace, IL: 1998.

Joint Commission on Accreditation of Healthcare Organizations. *1999 Comprehensive Accreditation Manual for Hospitals.* Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 1999.

Joint Commission on Accreditation of Healthcare Organiations. "Standards for Restraint and Seclusion." *Joint Commission Perspectives* 16, no. 1 (1996): RS1-RS8.

Medicare Conditions of Participation for Ambulatory Surgical Services, 42 CFR Ch. IV, Part 416.

Medicare Conditions of Participation for Home Health Agencies, 42 CFR Ch. IV, Paragraph 484.48.

Medicare Conditions of Participation for Hospice Care, 42 CFR Ch. IV, Subpart C, Paragraph 418.74.

Medicare Conditions of Participation for Rural Primary Care Hospitals, 42 CFR Ch. IV, Paragraph 485.638.

Medicare Conditions of Participation for States and Long Term Care Facilities, 42 CFR Ch. IV, Part 483, Subpart A, Paragraph 483.40.

National Committee for Quality Assurance. *1999 Standards for Accreditation of Managed Care Organizations.* Washington, DC: 1998.

Exhibit 1-Authentication Standards from the *1999 Comprehensive Accreditation Manual for Hospitals*, Joint Commission on Accreditation of Healthcare Organizations

Management of Information

The definition from the Glossary of the *1999 Accreditation Manual for Hospitals* for the term authenticate: The process used to verify that an entry is complete, accurate, and final.

Standard

IM.7.7 Verbal orders of authorized individuals are accepted and transcribed by qualified personnel who are identified by title or category in the medical staff rules and regulations.

Intent of IM.7.7

Practitioners often give orders verbally in the course of patient care. The quality of patient care may suffer if such orders are not received and recorded in a standard way. Each verbal order is dated and is identified by the names of the individuals who gave it and received it, and implemented it. The record indicates who implemented it. Individuals who receive verbal orders are qualified to do so and are authorized by the medical staff to do so as identified by title or category of personnel.

When required by state or federal law and regulation, verbal orders are authenticated within the specified time frame.

Standard

IM 7.8 Every medical record entry is dated, its author identified, and, when necessary, authenticated.

Intent of IM 7.8

The hospital has a system in place to:

- assure that only authorized individuals make entries into medical records
- identify the date and author of every entry in the medical record
- enable the author to authenticate an entry to verify that is it complete, accurate, and final

The author authenticates those entries required by organization policy. The organization ensures that, at a minimum, entries of *histories and physical examinations, operative reports, diagnostic and therapeutic procedures, consultations, and discharge summaries* are authenticated. [1] Other entries are authenticated as specified by organization policy or as required by state or federal law and regulation.

Hospitals establish policies and mechanisms to assure that only an author can authenticate his or her own entry. Indications of authentication can include written signatures or initials, rubber stamps, and computer "signatures" (or sequence of keys). The medical staff rules and regulations or policies define which entries, if any, by house staff or non-physicians must be countersigned by supervising physicians.

1. *consultation* The consultation report is a signed (authenticated) opinion of the consultant's findings for making a diagnosis for a specific patient or providing treatment advice on a specific patient. For the purpose of this standard, routine pathology and clinical laboratory reports and x-ray reports do not require authentication.

Exhibit 2-Authentication Requirements from the *1998 Comprehensive Accreditation Manual for Behavioral Health Care*, Joint Commission on Accreditation of Healthcare Organizations

Standard

IM.7.6 Verbal orders of authorized individuals are accepted and transcribed by designated qualified personnel.

Intent of IM.7.6

Processes for receiving, transcribing, and authenticating verbal orders are established to protect the quality of care to the individual served. Qualified personnel are identified and authorized to receive and record verbal orders. Each verbal order is dated, and is identified by the names of the individuals who gave it, and received it. The record indicates who implemented it. When required by state or federal law and regulation, verbal orders are authenticated within the specified time frame.

Standard

IM.7.7 Every clinical record entry is dated, its author identified and, when necessary, authenticated.

Intent of IM.7.7

The organization has a way of

- assuring that only authorized individuals make entries into clinical records
- identifying the date and author of every entry in the clinical record
- enabling the author to authenticate an entry to verify that it is complete, accurate, and final

The author authenticates those entries required by organization policy. The organization ensures that, at a minimum, entries of *histories and physical examinations, evaluations and assessments, progress notes, medication orders, and discharge summaries* are authenticated. Other entries are authenticated as specified by organization policy or as required by state or federal law and regulation.

Organizations establish policies and mechanisms to assure that only an author can authenticate his or her own entry. Indications of authentication can include written signatures or initials, rubber stamps, and computer "signatures" (or sequence of keys).

Exhibit 3-Authentication Requirements from the *1998-99 Comprehensive Accreditation Manual for Ambulatory Care*, Joint Commission on Accreditation of Healthcare Organizations

Standard

IM.7.7 Verbal orders of authorized individuals are accepted and transcribed by designated qualified personnel.

Intent of IM.7.7

Processes for receiving, transcribing, and authenticating verbal orders are established to protect the quality of patient care. Qualified personnel are identified, as defined by organization policy and, as appropriate, in accordance with state and federal

law and authorized to receive and record verbal orders. Each verbal order is dated, and is identified by the names of the individuals who gave it, received it, and implemented it. The record indicates who implemented it. When required by state or federal law and regulation, verbal orders are authenticated within the specified time frame.

Standard

IM.7.8 Every medical record entry is dated, its author identified and, when necessary, authenticated.

Intent of IM.7.8

The organization has a way of

- limiting access to medical records to individuals authorized to make entries or involved in care and administrative functions
- identifying the date and author of every entry in the medical record
- and enabling the author to authenticate an entry to verify that it is complete, accurate, and final

The author authenticates those entries required by organization policy. The organization ensures that, at a minimum, entries of *histories and physical examinations, operative reports, diagnostic and therapeutic procedures, consultations, and follow-up/discharge summaries* are authenticated.[1] Other entries are authenticated as specified by organization policy or as required by state or federal law and regulation.

Organizations establish policies and mechanisms to assure that only an author can authenticate his or her own entry. Indications of authentication can include written signatures or initials, rubber stamps, and computer "signatures" (or sequence of keys). Organization policies define which entries, if any, by nonindependent practitioners must be countersigned.

1. *consultation* The consultation report is a signed (authenticated) opinion of the consultant's findings for making a diagnosis for a specific patient or providing treatment advice on a specific patient. For the purpose of this standard, routine pathology and clinical laboratory reports and x-ray reports do not require authentication.

Exhibit 4-Authentication Requirements from the *1998-99 Comprehensive Accreditation Manual for Long Term Care*, Joint Commission on Accreditation of Healthcare Organizations

Standard

IM.7.6 Verbal orders of authorized individuals are accepted and transcribed by designated qualified personnel.

Intent of IM.7.6

Processes for receiving, transcribing, and authenticating verbal orders are established to protect the quality of patient care. Qualified personnel are identified, as defined by organization policy and, as appropriate, in accordance with state and federal law and authorized to receive and record verbal orders. Each verbal order is dated, and is identified by the names of the individuals who gave it, received it, and implemented it. The record indicates who implemented it. When required by state or federal law and regulation, verbal orders are authenticated within the specified time frame.

Standard

IM.7.7 Every medical record entry is dated, its author identified and, when necessary, authenticated.

Intent of IM 7.7

The organization has a way of

- ensuring that only authorized individuals make entries into medical records
- identifying the date and author of every entry in the medical record
- enabling the author to authenticate an entry to verify that it is complete, accurate, and final

The author authenticates those entries required by organization policy. The organization ensures that, at a minimum, entries of *histories and physical examinations, practitioners orders, medication orders, and discharge summaries* are authenticated. Other entries are authenticated as specified by organization policy or as required by state or federal law and regulation. Organizations establish policies and mechanisms to assure that only an author can authenticate his or her own entry. Indications of authentication can include written signatures or initials, rubber stamps, and computer "signatures" (or sequence of keys). Organization policies define which entries, if any, by nonindependent practitioners must be countersigned.

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For More Information

Joint Commission on Accreditation of Healthcare Organizations Web site at www.jcaho.org.

Health Care Financing Administration Web site at www.hcfa.gov.

National Committee for Quality Assurance Web site at www.ncqa.org.

Accreditation Association for Ambulatory Health Care Web site at www.aaahc.org.

The Rehabilitation Accreditation Commission Web site at www.carf.org.

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