Authentication of Medical Record Entries (1996)

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Background

Recently, the Joint Commission on Accreditation of Healthcare Organizations changed its requirements for authentication of some entries in the medical record. (See the "Accreditation Requirements" section of this brief for details.) 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 an organization-wide policy and procedures for authentication of medical record entries.

Accreditation Requirements

Joint Commission on Accreditation of Healthcare Organizations (Joint Commission)

Effective July 1, 1996, the Joint Commission requires the following for authentication of medical 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 documents who implemented it. When required by state or federal law and regulation, verbal orders are authenticated within the specified time frame.

- **Medical Record Entries:** Every medical 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.

For the full text of these standards, their intents, and scoring guidelines, please see Exhibit 1.

Effective January 1, 1997, the Joint Commission requires the following for authentication of medical 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 documents 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, however.

- **Medical 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.

Note: These changes have been approved by the Joint Commission's Standards and Survey Process Committee, but at press time they awaited final approval from the Joint Commission's Board. For the full text of these standards and their intent statements, please see Exhibit 2.

Changes to the Joint Commission's authentication requirements for **ambulatory care** are effective January 1, 1997.

- **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 documents who implemented it. When required by state or federal law and regulation, verbal orders are authenticated within the specified time frame.

- **Medical 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.

Note: These changes have been approved by the Joint Commission's Standards and Survey Process Committee, but at press time they awaited final approval from the Joint Commission's Board. For the full text of these standards and their intent statements, please see Exhibit 3.

Authentication issues will be discussed by the Joint Commission's **Long Term Care** Professional and Technical Advisory Committee (PTAC) at its 1996 fall meeting. The **Home Health** PTAC has chosen not to discuss authentication issues at this time. This issue is not applicable to the **Network** accreditation program.

Restraint Orders: The Joint Commission's new 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 such as 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. Authentication of these entries is not required. Consultant summaries, laboratory, and imaging study results must reflect review by the primary care physician. 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 service and progress notes 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.

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), which are commonly called the Medicare Conditions of Participation. **These Conditions currently require authentication of various medical 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."

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 Paragraph 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.

The Medicare Conditions of Participation for Hospitals are under revision. Proposed new Conditions are expected to be published in the *Federal Register* during 1996, with a request for public comments. Until new Conditions become effective, HCFA's Hospital Standards Quality Bureau has indicated that hospitals are expected to comply with the existing Conditions of Participation.

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." The Medicare Conditions of Participation forHospice Care are under revision. Proposed new Conditions are expected to be published in the *Federal Register* in late 1996, with a request for public comments. Until new Conditions become effective, compliance with the existing Conditions is expected.

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. Oral orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist responsible for furnishing or supervising the ordered services. Oral orders are only accepted by personnel authorized to do so by applicable State and Federal laws and regulations as well as by the Home Health Agency's internal policies." The Medicare Conditions of Participation for Home Health are under revision. Proposed new Conditions are expected to be published in the *Federal Register* in late 1996, with a request for public comments. Until new Conditions become effective, compliance with the existing Conditions is expected.

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 health care 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 medical 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.

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 in hospitals, hospices, and home health agencies should monitor the *Federal Register* for proposed changes to these 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 with the author

References

Commission on Accreditation of Rehabilitation Facilities. *1995 Standards Manual and Interpretive Guidelines for Medical Rehabilitation.* Tucson, AZ: Commission on Accreditation of Rehabilitation Facilities, 1995.

Health Care Financing Administration. *Hospitals Interpretive Guidelines and Survey Procedures.* Springfield, VA: US Department of Commerce, 1986.

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

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Joint Commission on Accreditation of Healthcare Organizations. *1997 Comprehensive Accreditation Manual for Behavioral Health Care*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 1996.

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. *1996 Standards for Accreditation of Managed Care Organizations*. Washington, DC: National Committee for Quality Assurance, 1995."

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Acknowledgments

Assistance from the following individuals is gratefully acknowledged:

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Kathleen Frawley, JD, MS, RRA
Joanne Kerwin, RRA
Susie McBeth, MS, MPH
Harry Rhodes, MBA, RRA

Issued: September 1996

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

Management of Information
Revised definition that will appear in Glossary of *1997 Accreditation Manual for Hospitals*. The new definition reads "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.

Scoring for IM.7.7

a. Do only qualified personnel, as determined by the medical staff and defined in their rules and regulations, accept verbal orders?
b. In what percentage of medical records reviewed were verbal orders as required by state or federal law and regulation authenticated within the defined time frame?
c. Are all verbal orders identified as indicated in the intent?

Score 1
a. Yes
b. 90% to 100%
c. 90% to 100%

Score 2
b. 75% to 89%
c. 75% to 89%

Score 3
a. Some unauthorized personnel accept verbal orders.
b. 50% to 74%
c. 50% to 74%

Score 4
b. 25% to 49%
c. 25% to 49%

Score 5
a. The medical staff has not determined who is qualified to accept verbal orders.
b. Less than 25%
c. Less than 25%

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 it is complete, accurate, and final.

The author authenticates those entries required by hospital policy. The hospital ensures that, at a minimum, entries of histories and physical examinations, operative procedures, consultations,[1] and discharge summaries are authenticated. Other entries are authenticated as specified by the hospital policy or medical staff bylaws 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, or computer "signatures" (or sequence of keys). The medical staff rules and regulations or policies define which entries, if any, by house staff or nonphysicians must be countersigned by supervising physicians.

Scoring for IM.7.8
Are all medical record entries dated, their authors identified and, when necessary, authenticated as described in the intent?

Score 1	90% to 100% of those reviewed
Score 2	75% to 89% of those reviewed
Score 3	50% to 74% of those reviewed
Score 4	25% to 49% of those reviewed
Score 5	Less than 25% of those reviewed

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 1997 *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, 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 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; 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, 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 1997 *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, and 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,*[1] *and follow-up/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.

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.