DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/ Quality, Safety and Oversight Group

Ref: QSOG 18-10-*Hospital, CAHs*
REVISED 01.05.2018

DATE: **December 28, 2017**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety and Oversight Group *(formerly Survey & Certification Group)*

SUBJECT: Texting of Patient Information among Healthcare Providers *in Hospitals and Critical Access Hospitals (CAHs)*

****Revised to clarify providers affected by this policy are Hospitals and CAHs****

Memorandum Summary

- **Texting patient information** among members of the *Hospital and CAHs* health care team is permissible if accomplished through a secure platform.
- **Texting of patient orders** is prohibited regardless of the platform utilized.
- **Computerized Provider Order Entry (CPOE)** is the preferred method of order entry by a provider.

Background

In an effort to clarify the position of the Centers for Medicare & Medicaid Services (CMS) as it relates to texting, CMS does not permit the texting of orders by physicians or other health care providers. The practice of texting orders from a provider to a member of the care team is not in compliance with the Conditions of Participation (CoPs). The following CMS hospital *and CAHs* Condition*s* of Participation for Medical Records requirements apply:

Hospitals:
§*482*.24(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.

And

(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.
§*482*.24(c) Standard: Content of record

(4) All records must document the following, as appropriate:
(i) Evidence of—

(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.

Critical Access Hospitals:

§485.638(a) Standard: Records System:
(1) The CAH maintains a clinical records system in accordance with written policies and procedures.
(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized.
The CAH must have a system of patient records, pertinent medical information, author identification, and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

(4) For each patient receiving health care services, the CAH maintains a record that includes, as applicable—
(i) Identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;
(ii) Reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings;
(iii) All orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress, such as temperature graphics, progress notes describing the patient's response to treatment; and
(iv)Dated signatures of the doctor of medicine or osteopathy or other health care professional.

(b) Standard: Protection of record information:
(1) The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use.
(2) Written policies and procedures govern the use and removal of records from the CAH and the conditions for the release of information.
(3) The patient's written consent is required for release of information not required by law.

(c) Standard: Retention of records. The records are retained for at least 6 years from date of last entry, and longer if required by State statute, or if the records may be needed in any pending proceeding.
For CAH DPUs, the hospital medical record CoPs applies in those units.

Computerized Provider Order Entry (CPOE) is the preferred method of order entry by a provider. CMS has held to the long standing practice that a physician or Licensed Independent Practitioner (LIP) should enter orders into the medical record via a hand written order or via CPOE. An order if entered via CPOE, with an immediate download into the provider's electronic health records (EHR), is permitted as the order would be dated, timed, authenticated, and promptly placed in the medical record.

CMS recognizes that the use of texting as a means of communication with other members of the *hospital and CAH* healthcare team*s* has become an essential and valuable means of communication among the team members. In order to be compliant with the CoPs, all providers must utilize and maintain systems/platforms that are secure, encrypted, and minimize the risks to patient privacy and confidentiality as per HIPAA regulations and the *hospital and CAH* CoPs. It is expected that providers will implement procedures/processes that routinely assess the security and integrity of the texting systems/platforms that are being utilized, in order to avoid negative outcomes that could compromise the care of patients.

Contact: Questions regarding this memorandum should be sent to Marie.Vasbinder1@cms.hhs.gov

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
David R. Wright

cc: Survey and Certification Regional Office Management

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C 18-10-ALL

DATE: **December 28, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Texting of Patient Information among Healthcare Providers

Memorandum Summary

- **Texting patient information** among members of the health care team is permissible if accomplished through a secure platform.
- **Texting of patient orders** is prohibited regardless of the platform utilized.
- **Computerized Provider Order Entry (CPOE)** is the preferred method of order entry by a provider.

Background

In an effort to clarify the position of the Centers for Medicare & Medicaid Services (CMS) as it relates to texting, CMS does not permit the texting of orders by physicians or other health care providers. The practice of texting orders from a provider to a member of the care team is not in compliance with the Conditions of Participation (CoPs) or Conditions for Coverage (CfCs). The following CMS hospital Condition of Participation for Medical Records requirements apply:

§489.24(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.

And

(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.

§489.24(c) Standard: Content of record

(4) All records must document the following, as appropriate:
(i) Evidence of—

(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.

Computerized Provider Order Entry (CPOE) is the preferred method of order entry by a provider. CMS has held to the long standing practice that a physician or Licensed Independent Practitioner (LIP) should enter orders into the medical record via a hand written order or via CPOE. An order if entered via CPOE, with an immediate download into the provider's electronic health records (EHR), is permitted as the order would be dated, timed, authenticated, and promptly placed in the medical record.

CMS recognizes that the use of texting as a means of communication with other members of the healthcare team has become an essential and valuable means of communication among the team members. In order to be compliant with the CoPs or CfCs, all providers must utilize and maintain systems/platforms that are secure, encrypted, and minimize the risks to patient privacy and confidentiality as per HIPAA regulations and the CoPs or CfCs. It is expected that providers/organizations will implement procedures/processes that routinely assess the security and integrity of the texting systems/platforms that are being utilized, in order to avoid negative outcomes that could compromise the care of patients.

Contact: Questions regarding this memorandum should be sent to Marie.Vasbinder1@cms.hhs.gov

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

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