

Date: March 2, 1994 BQC-94-018  
To: Hospitals HOSP 6  
From: Judy Fryback, Director  
Bureau of Quality Compliance  
Subject: Interpretive Guidelines and Clarifying Information for Hospitals

Our records indicate that you may not have received the enclosed copy of Health Care Financing Administration, Division of Health Standards and Quality Regional Program letters of clarification.

The purpose of [Regional Program Letter No. 93-04 \(first memo\)](#) is to inform you of changes in the interpretive guidelines for data tags A-23 and A-24 of Appendix A - Interpretive Guidelines for Hospitals, State Operations manual. This guideline explains that a hospital is not prohibited from requiring board certification when considering a physician for its medical staff.

[Regional Program Letter No. 93-26 \(second memo\)](#) which deals with information concerning the Autoauthentication of Medical Records was originally sent to hospitals via BQC numbered memo 93-035. Subsequent to the dissemination of Regional program Letter 93-26 we received [Regional Program Letter 93-45](#). In Regional program Letter 93-45 the Office of Survey and Certification explains its position concerning autoauthentication and the limited exceptions to this rule. A [subsequent letter dated January 4, 1994](#), summarizes a December 13, 1993 meeting of the Practicing Physician Advisory Committee in which the issue of autoauthentication was discussed.

Please share this information with the appropriate staff. Questions regarding this letter should be forwarded to Stephen D. Schlough, Chief, Hospital and Health Services Section, Bureau of Quality Compliance, at the above address or telephone him at (608) 266-3878.

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Enclosure

cc: -BQC Staff  
-Office of Legal Counsel  
-Ann Haney, DOH Admin.  
-Kevin Piper, BHCF Dir.  
-HCFA, Region V  
-Illinois State Agency  
-Ohio State Agency  
-Michigan State Agency  
-Indiana State Agency  
-Minnesota State Agency  
-WI Coalition for Advocacy  
-Serv. Employees Internat'l Union  
-WI Counties Assn.  
-Mark Bunge, BPH  
-Renal Dialysis Network-WI Assn. of Medical Directors  
-Admin., Division of Care and Treatment Facilities  
-WI Assn. of Hospital SW and Discharge Planners  
-Bureau of DD Services  
-WI Hospital Association  
-Non-LTC BQC Memo Subscribers

Department of Health & Human Services  
Health Care Financing Administration  
Region V  
105 West Adams Street  
15<sup>th</sup> Floor  
Chicago, Illinois 60603-6201

February 1993

Refer to: CR12

**Division Of Health Standards And Quality Regional Program Letter No. 93-04**

**Subject:** Interpretive Guidelines for Hospitals, 42 CFR 482.12(a)(6)&(7), Data Tags A-23 and A-24

The purpose of this program letter is to inform you of a change in the interpretive guidelines for data Tags A-23 and A-24 of Appendix A – Interpretive Guidelines for Hospitals, State Operations Manual. The enclosed guidelines clarify that a hospital is not prohibited from requiring board certification when considering a physician for its medical staff. This supersedes the interpretive guidance as written in Transmittal 228, Page A-5.

If you have any questions regarding this matter please contact Gwendolyn Michel at (312) 886-5211 or Sally Jo Wieling at (312) 353-8853.

/s/ Charles Bennett  
Branch Chief  
Survey & Certification Operations Branch  
Division of Health Standards and Quality

Enclosure

March 1993

Refer to: CO4

**Division Of Health Standards And Quality Regional Program Letter No. 93-26**

**Subject:** Auto-authentication of Hospital Medical Records

The purpose of this program letter is to transmit to you the enclosed change in interpretive guidance regarding the use of auto-authentication systems by physicians to authenticate hospital medical records. Auto-authentication (or blanket authentication as it is commonly referred to) is not consistent with the Medicare hospital condition of participation (COP) – Medical Record Services (42 CFR 482.24). The Medicare COP at 42 CFR 482.24(c)(1), 482.24(c)(1)(i), and 482.24(c)(1)(ii) requires the following:

All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified in 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. Authentication may include a signature, written initials, or computer entry.

The typical auto-authentication procedure is as follows:

- (1) The physician keys in a digit identification code into the dictation system.
- (2) The transcription clerk, who prepares a "scan sheet" to accompany each cassette, notes whether the physician participates in the auto-authentication program.
- (3) After transcribing the report, the transcription clerk types "dictated and authenticated by XXX, M.D.," and the report is considered signed.
- (4) The medical records department sends a copy of the transcribed report to the physician's office.
- (5) If a physician wants to change or correct the report, he or she makes the changes and sends the report back to the medical records department. The transcriptionist makes the change and reprints the report, including the auto-authentication line. The report does not go back to the physician. (If a report has blanks in it, the physician must fill in the blanks.)
- (6) If a report is sent to a physician's office and the physician makes no comments within 14 days, the medical records staff considers the report complete and the report becomes part of the permanent medical record.

A system of auto-authentication allows the absence of action by the physician to indicate that the report is accurate and complete and should become part of the medical record. This is not consistent with the requirement that physicians authenticate that the medical record is accurate and complete. Enclosed is a change in the interpretive guidance for hospitals at 42 CFR 482.24(c)(1) – data tags A102, A103, and A104 which addresses this issue.

HCFA Central Office contacted the Joint Commission on Accreditation of Healthcare Organizations to inquire about its policy on auto-authentication systems. In its September/October 1991 issue of Perspectives, the Joint Commission published a response to a question on the use of blanket authentication (auto-authentication). In that response, the Joint

Commission informed hospitals that auto-authentication is not acceptable. The Joint Commission continues to maintain this policy. Please note that this issue is not related to the physician attestation requirement for PPS purposes.

In conclusion, auto-authentication is not consistent with Medicare requirements and should be cited as a deficiency when identified during a survey. Please advise the hospitals in your state of this change in HCFA policy.

If you have any questions regarding this, please contact your program representative.

/s/ William F. Pfeifer  
Branch Chief  
Survey & Certification Operations Branch  
Division of Health Standards and Quality

Enclosures

Department of Health & Human Services  
Health Care Financing Administration  
Region V  
105 West Adams Street  
15<sup>th</sup> Floor  
Chicago, Illinois 60603-6201

July 1993

Refer to: CR5

**Division Of Health Standards And Quality Regional Program Letter No. 93-45**

**Subject:** Autoauthentication of Medical Records

Our Office of Survey and Certification (OSC) has reaffirmed its position that with limited exception autoauthentication is inconsistent with the Medicare hospital condition of participation (CoP)—medical records services (42 CFR 482.24).

The regulation at 42 CFR 482.24(c)(1)(i) and (ii) states, "The author of each entry must be identified and must authenticate his or her entry. Authentication may include signatures, written initials or computer entry."

Autoauthentication systems are computer based entries into medical records. Although requiring post-prescription signatures does not ensure that the document was actually read or is, in fact accurate, the Medicare hospital CoP at 42 CFR 482.24(c)(1)(ii) requires entries to be authenticated.

Some autoauthentication systems require the physician to review the transcribed document and then, if the transcribed document is accurate, authenticate the document. Other autoauthentication systems do not require any action by the physician after he or she dictates the report, unless the document is incomplete. The Medicare hospital CoP, as presently written, requires the author to authenticate the entry into the medical record.

There may be systems in use by hospitals that do meet the Medicare requirement for authentication. For example, some systems require the physician to review the transcribed report on-line and indicate that it has been read by entering a computer code. Such a system would satisfy the regulatory requirement. Until our regulations are changed, we must enforce the regulation for certification requirement as written.

OSC has addressed with the Bureau of Policy Development (BDP), the issue of the purpose of these requirements and how they may best be achieved. The matter is presently under review by BPD.

We hope this information has been helpful. If you have any questions or comments, please feel free to contact Sally Jo Wieling of my staff at (312) 353-8853 or Gwendolyn Michel of my staff at (312) 886-5211 or.

/s/ Sally Jo Wieling for Charles Bennett  
Branch Chief  
Survey & Certification Operations Branch  
Division of Health Standards and Quality

Enclosure

DATE: January 4, 1994

FROM: Director  
Health Standards and Quality Bureau

SUBJECT: Authentication of Medical Records

TO: Steven D. Helgerson, M.D., M.P.H.  
Associate Regional Administrator  
Division of Health Standards and Quality  
Region X

This is in followup to my interim response to you regarding the Health Care Financing Administration's (HCFA) policy on authentication of medical records. This issue was discussed during the December 13 meeting of the Practicing Physician Advisory Committee (PPAC).

In summary, the PPAC agreed that there must be an exclusive act or gesture on the part of the physician that signifies that he or she is authenticating a document. The PPAC also agreed that most autoauthentication systems, in which a presumption that no response (no action) represents a positive gesture of authentication by the physician, are not adequate because they rely on absence of action on the part of the physician. (This does not mean that all autoauthentication systems are inadequate. Some would meet the authentication requirements if they rely on a positive action by the physician). The PPAC indicated that HCFA and the Joint Commission on Accreditation of Healthcare Organizations should continue to enforce their authentication requirements but should be as flexible as possible to assure that no unnecessary burden is placed on physicians.

The Health Standards and Quality Bureau, Office of Survey and Certification (OSC) is now charged with issuing interpretive guidelines that are more expansive on the issue of authentication. OSC will work with the Bureau of Policy Development on this task and will share our draft guidelines with you for your review. Once the interpretive guidelines for authentication are completed, they will be mailed to all regional offices with instructions to inform the State agencies of the new guidelines.

I hope this information has been helpful. If you have any further questions, please let me know.

/s/ Barbara J. Gagel

cc: Tom Hoyer, BPD  
RA, Region X  
ARAs, Regions I-IX

Prepared By:HSQB\OSC\DHAS\ACSB\Rweinstein\12-17-93  
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