



**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](mailto: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

*The contents of this letter support activities or actions to improve patient or resident safety and increase quality and reliability of care for better outcomes.*