AMA
AMERICAN MEDICAL ASSOCIATION

Does Joint Commission require EHR orders for all procedures?

DEBUNKING THE MYTH

Joint Commission does not mandate a universal standard requiring that an order be entered in the EHR for every procedure when a clinician performs their own ambulatory procedure. However, if a hospital independently adopts a policy requiring an order for all procedures, that expectation would be enforceable under its own internal policy during accreditation review, but it is not a Joint Commission–imposed requirement applicable to all accredited hospitals. Whether an order is required is driven by who performs the procedure, state scope-of-practice laws, and organizational policy.

BACKGROUND

Some practices and health systems require that clinicians—including physicians and other licensed independent practitioners (LIPs)—enter an order for every procedure into the EHR to leverage automated, patient-specific alerts that support patient safety, reduce medication errors, and align with best practices. Even when an order is not required, sufficient documentation of intent to order and notes of medical necessity may be required.[1,2]

ADDITIONAL INFORMATION

According to Joint Commission, there is no accreditation requirement for an order when a physician or other LIP performs their own ambulatory procedure (e.g., a family medicine physician performing a knee joint injection) (R. Campbell, personal communication, June 2026).

When a procedure is performed on a clinician's behalf (e.g., a physician asks a nurse to perform an ear lavage), an order may be required depending on state scope-of-practice laws and organizational policies/workflows. However, this is not a universal requirement under Joint Commission standards.

Importantly, this clarification of Joint Commission accreditation requirements does not apply to billing rules, payer requirements, or internal organizational policies, which may still require orders for operational or compliance reasons.

KEY TAKEAWAY

In instances where organizations mandate that an order for every procedure be entered into the EHR, health system leaders—in collaboration with their clinician staff—should reassess these rules and streamline or de-implement unnecessary requirements that add burden without improving safety.

References

1. Centers for Medicare & Medicaid Services (CMS). Complying with Laboratory Services Documentation Requirements. MLN Fact Sheet. 2020. Accessed June 8, 2026. https://www.cms.gov/sites/default/files/2020-12/ProviderComplianceLabServices_Fact_Sheet_ICN909221.pdf
2. Centers for Medicare & Medicaid Services (CMS). Complying with Medical Record Documentation Requirements. MLN Fact Sheet. 2024. Accessed June 8, 2026. https://www.cms.gov/files/mln909160-complying-with-medical-record-documentation-requirements.pdf