GUIDE TO RECORD RETENTION

Medical Records *

Patient Charts . . . . .Permanently

Patient Charts – Alternative (adults) . . . . Seven (7) years after the most recent encounter*, but recommendation of ten (10) years

Patient Charts - Alternative (minors) . . . . Age of majority plus statute of limitations

Medical Correspondence
(to patients, to referrers
about patients, etc.) . . . . Permanently with chart

X-rays . . . . Permanently with chart

*As a general rule, however, if your organization bills any federal program for services rendered, retain those records for at least 10 years pursuant to the False Claims Act and recent Supreme Court decisions.

In *Cochise Consultancy, Inc. v. U.S. ex rel. Hunt*, the Supreme Court clarified the statute of limitations for most False Claims Act ("FCA") lawsuits—those filed by *qui tam* relators in which the government does not intervene. The Court held that such suits must be brought within either six years of the FCA violation, under 31 U.S.C. § 3731(b)(1), or "three years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances," but never "more than 10 years after" the violation, under § 3731(b)(2).

Retention requirements

The principal legal requirements governing retention of office medical records are found in the physician licensing regulations.

In the case of an adult patient, physicians are required to maintain the patient's medical record for seven years from the last date-of service.

In the case of a minor patient, physicians are required to maintain the patient's medical record for the **longer** of:

- State law dictates retention periods
- Seven years from the last date-of-service, and
- An extended period after the patient reaches 18 (one year if the physician is a medical doctor and two years if the physician is an osteopathic physician).

Physicians also should consider the following when establishing a retention policy for office medical records:

- **Documentation requirements for claims payment**
  Some payers require medical records to be maintained for a specified period. For example, although the Medicare law and regulations do not explicitly require retention of medical records, physicians who submit claims electronically must sign an agreement that requires them to "retain all original source documentation and medical records pertaining to any such particular Medicare claim for a period of at least six years, three months after the bill is paid."
  In addition, regardless of whether a payer explicitly imposes a medical records retention requirement, payers usually require documentation to support payment of a claim. As a practical matter, the medical record for a service should be maintained if payment of the claim can be challenged.

* State Guidelines vary – check with your professional liability carrier or your healthcare attorney.

Generally, compliance with the licensure board retention requirements is sufficient. For example, the Medicare program generally cannot recoup overpayments after four years in the absence of fraud or similar fault, or impose civil monetary penalties, assessments, and exclusions after six years.

- **Defense of medical liability actions**

  Medical liability actions generally must be brought within the shorter of two years from the date of reasonable discovery (the statute of limitations), or seven years of the incident (the statute of repose). However, there is no seven-year limit in the case of foreign objects left in the body and minors can bring actions until they are 20.

  In addition, there is some uncertainty in this area, as new statutory language enacted in 2003 has yet to be interpreted by the courts.

  Consequently, it still generally is best to retain medical records if feasible, especially in the case of surgery and minors.

- **Immunization records**

  The American Medical Association's Council on Ethical and Judicial Affairs has recommended that immunization records be maintained indefinitely.

- **Retention of minimal information**

  Even when medical records may be "safely" disposed, it may be prudent to maintain some minimal information.

  Certain information may be needed to reconstruct that the record was legitimately destroyed or to document that the statute of limitation or repose expired—e.g., the patient's name, date of birth, Social Security number, dates of first and last visit, and possibly even a short description of the patient's problems and care provided in the office.

Disposal requirements

Medical records should be disposed in a manner that protects the patient's privacy. They should not just be placed in the regular trash.

Attorneys generally recommend that medical records be incinerated, shredded, pulped, or pulverized beyond readability and reconstruction.

When records are sent outside the office for destruction, care should be taken to ensure that the firm is reputable and that safeguards are in place to ensure that confidentiality is not breached during the process. In the case of an outside vendor, a HIPAA privacy rule business associate agreement may be appropriate.

It often will be prudent to maintain a record of the disposal that includes:

- Identification information for the disposed records
- Date of the disposal
- Method of disposal
- Name of any outside vendor contracted to dispose the records
- Statement that the records were disposed in the normal course of business
- Signatures of the persons who authorized and witnessed the disposal

Given that most medical records today are electronic, retention of medical records takes little room and should be retained as long as the patients are being retained by the practice or practitioner or

copies provided to any practitioner taking over the patient care. When going out of business, notice should be provided to the patient to obtain their records and then a guardian of the records should be arranged by the retiring practitioner.

Other Medical Record Issues:

Patient Requests Transfer

When transferring medical records, the physician should maintain the original record and transfer only a copy. You may charge the patient a reasonable fee to reflect the cost of the materials used, the time required to prepare the material and the direct cost of sending the material to the requesting physician.

(Note: This may be determined by state law.)

The obligation to pay for the record rests with the patient or with the third party who has requested the information. Since this is generally an uninsured service, reasonable attempts may be made on the part of the physician to collect the fee in advance. Nonpayment of the fee, however, is not a reason to withhold the information.

Physician Relocates

Physicians relocating their practice may take the medical records with them or leave the records with a designated custodian with an agreement that they will be permitted ready access to them as required in the future upon request.

Physician Ceases Practice

If a physician ceases to practice medicine, he or she may be obligated to either transfer their patients' medical records to another physician at a local address and phone number, or notify each patient that their medical records will be destroyed in (state specific) ___ years unless they collect the records or request a transfer of the records to another physician within two years.

You may wish to contact your liability insurer for additional guidance.

Medical Records in a Group Practice that is Changing

Physicians in a group practice setting usually have an arrangement that clarifies ownership of the records and a transferring policy with respect to patient records. Despite the existence of any such arrangements, it is important to note that physicians in any setting e.g., solo practice, group practice, hospital, etc., are ultimately individually responsible for their own patient records. Physicians must be aware that agreements made with their associates do not supersede their responsibility to patients.

Typically, most physicians in a group practice arrangement will have an agreement with their associates that addresses such items as:

- The method for division of medical records upon termination of the practice arrangement. This agreement usually specifies a method for determining custody of the medical records.

- Some reassurance that each physician will have reasonable access to the content of the medical records for preparing medico-legal reports, defending actions, or responding to a complaint investigation.

Often, if no such agreement exists, physicians dissolving their joint practice try to agree on a system to determine who is the "most responsible physician" for each record. For example, the physician who has created the greatest percentage of the entries in a patient record may be expected to continue to maintain it.

While the above-mentioned approach is customary in most group practices, it is not mindful of the patient's needs. See details in "Ask the Patient" below.

Ask The Patient

Members of a group practice must be cognizant of the fact that it is the *patient's privilege* to choose which doctor they wish to maintain their patient records and provide continuing medical care, regardless of the existence of an agreement.

A copy (or original) of that patient's records should be transferred and physicians should agree how the cost of copying and transferring records will be divided within the group. In the case of planned group practice dissolution, the cost cannot be charged to the patient.

Unexpected Dissolution of A Group Practice

Unexpected dissolutions of group practices create special difficulties. Ideally, physicians involved should amicably agree on a strategy for informing patients and dealing with the medical records. In the case of a sudden, unforeseen departure of a partner or associate, records should be kept at their present location until the patient directs where they wish to receive their ongoing health care. Reasonable access to medical records must be given to all former partners and associates.

Statutory Requirements

There are some statutory requirements on the keeping of medical records. For example, certain Medicaid/Medicare reimbursement regulations require that the medical records of recipients be available for review for seven years.

Tax & Financial Records *

Accounts Payable Ledger . . . . Permanently

Accounts Receivable Ledger-Annual . . . . Six (6) years after the due date of the practice tax return

Accounts Receivable Ledger-Monthly . . . . Two (2) years

Bank Statements with cancelled checks . . . . Six (6) years after the due date of the practice tax return

Capital Asset Records . . . . Six (6) years after the due date of the practice tax return for the year in which the asset is disposed

Record	Retention Period
Cash Receipts Journals	Six (6) years after the due date of the practice tax return
Check Register	Six (6) years after the due date of the practice tax return
Daysheets	Six (6) years after the due date of the practice tax return
Deeds, Mortgages, and Bills of Sale	Permanently
Deposit Books & Slips	Six (6) years after the due date of the practice tax return
Depreciation Schedules	Permanently
Encounter Forms	Six (6) years after the due date of the practice tax return
Financial Statements – Annual (year-end)	Permanently
Financial Statements – Periodic	Two (2) years
General Ledger	Permanently
Income Tax Returns (Correspondence & Audits)	Permanently
Income Tax Returns (Federal & State)	Permanently
Insurance Policies (expired)	Three (3) years
Insurance Records, Current Accident Reports, Claims, Policies, etc.	Permanently
IRA and Keogh Plan Contributions, Rollovers, Transfers and Distributions	Permanently
Paid Invoice-Expenses	Six (6) years after the due date of the practice tax return.
Payroll Ledger.	Six (6) years after the due date of the practice tax return.
Payroll Tax Returns	Permanently
Petty Cash Vouchers	Three (3) years
Stock and Bond Certificates (canceled)	Seven (7) years
Vouchers for Payments to Vendors, Employees, etc. (includes allowances and reimbursement of employees, officers, etc., for travel and entertainment expenses)	Seven (7) years

* Many of these documents are obviously maintained electronically. We recommend downloading this file to a disk or CD for storage as indicated.

Employer

Record	Retention Period
Employee Personnel Records (after termination)	Two (2) years
Employment Applications.	One (1) year

Employee Eligibility Form (I-9) *	Three (3) years after date of hire **Or** One (1) year after date of termination, whichever is later

Employee Medical Records should not be kept in employee personnel files at any time. Health records of any type should be kept separately, and access should only be provided to licensed clinicians in the practice and no other individual should have access to these records.

Payroll Records

Employee Demographics – name, address, SSN, gender, DOB, occupation, job classification	Four (4) years
Records of Total Compensation	Four (4) years
Tax Forms	Permanently
Records of Time Worked (Timecards/Attendance Sheets).	Four (4) years
Record of Payments to Annuity, Pension, Accident, Health or Other Fringe benefit plans.	Four (4) years
Reports of wages subject to withholding and actual taxes withheld.	Four (4) years

* Employee I-9 Forms should be kept in a separate file from personnel file and in a separate file cabinet from personnel files to ensure any DOL audit does not have access to personnel records which could be potentially troublesome for the practice

Other

Accident Reports/Claims (settled cases)	Seven (7) years
Correspondence, General	Two (2) years
Correspondence, Legal and Important Matters	Permanently
Correspondence, Routine with Customers or Vendors	Two (2) years
Explanation of Benefits (EOBs)	Seven (7) years
Minute Books of Directors, Stockholders, Bylaws and Charter	Permanently
OSHA Medical Records	30 years plus term of employment
OSHA Training Records	Three years (3) from training date
Trademark Registrations, Patents and Copyrights	Permanently

* These should be kept separate from employee's personnel file.