MEDICAL PROTECTIVE
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Guidelines

Record Retention

Introduction.

Patient records are maintained in order to document the patient care process. They also assist in a provider's defense should a patient bring a claim regarding that care. The Medical Protective Company data collected from 1998-2002 indicates that:

- Seventy-nine percent of claims are opened within three years of the date of service
- Ninety-three percent of claims are opened within five years of the date of service
- Ninety-five percent of claims are opened within 10 years of the date of service.

While most states require maintenance of medical records for seven (7) years, providers are advised to use this guideline as a *minimum* rather than as a standard. And, certain records should be maintained for as long as possible, including: pediatric records; records of patients who complained about the outcome of their care; cases in which the physician was displeased with the outcome; cases involving implanted devices and records of patients involved in research.

Since the statute may not begin to toll in certain types of claims until the patient realizes that s/he has a basis for a claim (and since the statute is often considerably longer for minors), many practices automatically retain the records for a *minimum* of 23 years. If a practice determines that it must purge some records, it would be wise to seek legal advice before proceeding.

Old records may also be very useful in cases involving recalls or advisories by medication or implants manufacturers. Long-term unexpected outcomes may require years and perhaps generations of follow up. The DES babies provide a tragic example. In this case, women were identified as being at high risk for cervical cancers because, years earlier they had taken this drug during pregnancy. Not only were they at risk but evidence suggests that the children born of those pregnancies also have significant cancer risks.

Practices should also establish a policy that precludes the immediate destruction of records just because a patient has passed away. Such records should be maintained, at a minimum, for the length of the statute of limitations, but it is advisable to consult with your attorney who may advise to retain even longer.

Guidelines.

- A provider's accounting firm or the Internal Revenue Service may offer useful information about the retention of *business records*.

- Federal and state government guidelines may specify record-retention requirements for employee files and other personnel information. The provider's personal attorney and management consultant should be asked for advice related to the maintenance of *personnel records*.

- State laws generally determine how long *medical records* should be retained. In a state that offers no specific guidance, risk management policy generally suggests that records be retained *indefinitely*. However, an attorney's advice should help determine *exact* requirements

- From a risk management perspective, records should be retained forever; however, the logistics of such a policy often make it impractical. Therefore, the general rule below should be *used* as a *guide* to determine length of retention:

    - Competent adults: At least *7 to 10 years after* the *last date of service*. This usually allows significant time for the statute to run and to include sufficient time for extension, delays, etc. to be exhausted.

    - Incompetent adults: Until/unless they become competent, as a claimant's insanity tolls the limitation statute.

    - Minors: At least 7 to 10 years *after* the child reaches the age of majority: 18 or 21 years old.

- The physician's specialty or the nature of the procedures most often performed may influence the length of retention. For example, if a prosthesis or implanted device is involved it may be prudent to keep the records even longer, while for simpler

treatments or conditions; a shorter retention period might be reasonable. For example, the provider who is an ophthalmologist who provided annual eye exams for a now-deceased patient. In this instance, a shorter retention period is reasonable. Best advice: Each practice should *err* on the *side of caution* by retaining them as long as reasonably possible.

- The following should be retained for at least five years: X-rays and other imaging records; raw psychological testing data; fetal monitoring tracings; electroencephalograms; electrocardiograms, etc.

- A resource for document retention guidelines is the American Health Information Management Association (AHIMA) at www.AHIMA.ORG under "Practice Brief": Retention of Health Information. AHIMA recommends that health organizations keep adult patient records 10 years beyond the most recent encounter, pediatric records up to the age of majority plus the statute of limitations.

- AHIMA advises keeping master patient/person indexes, birth and death registries and registries of surgical procedures permanently.

- In the event you plan to destroy any records, check the AHIMA site for their Practice Brief: Destruction of Patient Health Information which provides a sample "Certificate of Destruction." When paper records are to be destroyed, they should be shredded, preferably by a company that provides such services to ensure they're unreadable and unrecoverable. They should *never* be thrown away.

- Prior to selling or destroying computers delete electronic documents and database records by wiping them from local, network and backup drives and/or disks. To be thorough, include backup disks stored off-site.

- Establish a *formal* record retention policy and procedure to defend against allegations that records were destroyed deliberately and maliciously. At a minimum the procedure should include:

    - Length of time records will be kept.
    - Which records will be kept on-site and which off-site.
    - Designate someone responsible for deciding what to keep and what to purge.

- Develop a log that lists which records were destroyed as well as when and how.
- Provide a method of disposal, e.g., shred, incinerate etc. that destroys all information in the record to preserve confidentiality.
- Check with your State law or attorney as they may require a practice to post a notice in local newspaper regarding proposed destruction, e.g., "unless contacted by INSERT DATE, Dr. _____ office will destroy records of all patients who have not been seen by Dr. _____since INSERT DATE.
- Retain certificates of destruction for all discarded records.
- Identify the documents destroyed, the date, and the method of disposal.
- Attach any newspaper notices to the certificates.
- If you bill insurance company's check with each agency to determine any document retention requirements, e.g., Medicare defers to the State.

Additional Resources.

- Internal Revenue Service: www.irs.gov
- U.S. Code of Federal Regulations: www.access.gpo.gov
- National Archives and Records Administration: www.nara.gov
- Association for Information Management Professionals: www.arma.org
- U.S. Department of Labor: www.dol.gov
- Centers for Medicare and Medicaid Services: www.cms.gov
- Society for Human Resource Management: www.shrm.org
- American Society of Association Executives: www.asaenet.org
- American Health Information Management Association: www.ahima.org
- Risk Management Foundation of the Harvard Medical Institutions: www.rmf.harvard.edu
- American Medical Association: www.ama.com
- State Medical Society