Easing the
For busy physician practices and outpatient care facilities, the appropriate management of health records is vital. As such, practice managers and staff need to be familiar with a range of legal and professional rules and guidelines associated with record keeping, including those governing record retention requirements.

Admittedly, record retention can be a detailed and challenging responsibility. The requirements involve critical legal, financial, and quality-of-care issues. For those who are organized and knowledgeable, however, the challenge of managing record retention issues is just that—manageable.

**Laws and orders**
What should practice managers and staff know about record retention rules and requirements? First, legal requirements for record retention are largely determined on the state level, reports Robert M. Tennant, MA, director of health information technology policy for the Medical Group Management Association (MGMA) in Washington, DC.
“There’s surprisingly little federal guidance in this area,” says Tennant, pointing to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which governs privacy and security rules for health care providers. “HIPAA … does not mandate a particular time frame to retain the records. It does say you must protect the records [and] … take all appropriate precautions to ensure they’re not improperly disclosed. But it basically defers to the states on retention requirements.”

Under the 2005 final HIPAA Security Rule, a health care provider considered a covered entity is required to maintain documented records of policies and procedures for at least six years from the date of creation or the last date they were in effect, whichever is later. As such, the six-year retention requirement applies to the supporting compliance documentation, rather than the medical records per se.

The Medicare Learning Network (MLN) provides further elaboration of the HIPAA privacy obligations in this area. While the HIPAA Privacy Rule does not include medical record retention requirements, it does require that covered entities apply appropriate administrative, technical, and physical safeguards to protect the privacy of medical records and other protected health information (PHI) for whatever period such information is maintained by a covered entity, including through disposal.

“Because HIPAA requirements can be audited going back six years, it’s necessary to keep copies of your risk assessments, policies and procedures, disclosures of PHI, and such for that minimum length of time,” adds David J. Zetter, PHR, SHRM-CP, principal consultant for Zetter Healthcare in Mechanicsburg, Pennsylvania, and a member of the National Society of Certified Healthcare Business Consultants (NSCHBC). Zetter reminds us that policies and procedures governing the medical practice’s HIPAA privacy and security rules need to be documented in writing.

As with many federal requirements, there is more to the story. “The issue becomes a little more complicated or nuanced with CMS [Centers for Medicare & Medicaid Services], which has its own retention requirements in certain areas,” says Tennant. “For example, CMS requires providers submitting cost reports to retain those for at least five years after the closure of the cost report. If it’s a managed care program, CMS requires providers to retain records for 10 years. So, there are some of these individual program requirements, which can make the retention issue a little more challenging.”

What other legal considerations are involved in record retention requirements? “The principal legal requirements governing retention of office medical records are found in the physician licensing regulations,” explains Zetter. For adult patients, Zetter says physicians should maintain the medical record for at least seven years from the last date of service. The recommendation is based, he says, “on what most payers or the federal government [can] go back and audit, unless it has to do with false claims, and then it is 10 years.”

“With records retention, the two most important words in practice administration apply here: ‘What if?’ What if we did have a lawyer come ask for a record? Could we produce it? What if we had a fire in the practice? What would happen to our records? What if we had a ransomware attack? Every office should ask these questions as part of their general security risk assessment or risk analysis as required under law.”

—Robert M. Tennant, MA, director of health information technology policy, Medical Group Management Association (MGMA)
Other special types of documentation requirements may be based on tax returns or a practice’s legal history. “A malpractice carrier may have different recommendations than the state,” continues Zetter. “If [the practice is] a specific type of provider, for example, or [the practice has] had liability issues in the past, a malpractice carrier may require the retention time frame to be longer.”

Another point of note is that record retention requirements for minors will also differ from those for adults. “The area of retention requirements for minors is its own special case,” Tennant notes. “Traditionally, the approach taken by medical practices is to retain the record of the child until the child becomes of legal age. That may be dependent on state law, as well. But once that date has been achieved, a strong argument is that you should keep the records until any potential statute of limitations has passed. If there’s a potential issue in terms of a legal action, and the statute of limitations is six years, then it would be six years past the date that the child comes of age.”

What if federal and state laws conflict or providers have practices in multiple states? “If there is a discrepancy between any state and federal requirement, the more stringent requirement prevails,” says Tennant. “There could be situations in which the HIPAA requirement preempts the state law if it is more stringent. Similarly, this also can be an issue for medical groups that have multiple locations in different states. Again, they must go with the most stringent state law.”

**Getting technical**

The advent of electronic health records (EHRs) also has had a notable impact on record retention practices. Nearly 9 in 10 of office-based physicians had adopted EHR systems by 2015.4

Significantly, adoption of this technology among physician offices more than doubled between 2008 and 2015. To note, as of 2015, about 78 percent of EHR systems in use also met U.S. Department of Health and Human Services (HHS) standards for certification.5 As the trend continues, it raises questions about what to do with old paper records in the office.

“A lot of practices have made the migration to electronic health records and may have old paper records still in their possession,” observes Tennant. “So, the question becomes, Do we store our old paper records or do we try to scan them all into the EHR for a complete record of the patient, and then destroy the old paper copies? This is a business decision made by the practice.”

**Minding the storage**

As technology develops and is implemented, many organizations lack the capacity to go backward and scan records to free up storage space. Consequently, health information ends up residing in multiple storage media and locations, creating the need for a clearly defined record retention plan.7

At a minimum, record retention schedules must do the following:

- Ensure patient health information is available to meet the needs of continued patient care, legal requirements, research, education, and other legitimate uses of the organization.
- Specify what information to keep, the period for which it will be kept, and the storage medium on which it will be maintained (e.g., paper, microfilm, optical disk, magnetic tape).
- Include clear destruction policies and procedures that cover appropriate methods of destruction for each medium on which information is maintained.

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In the transition from paper to electronics, Tennant notes that some practices might decide to go forward with electronic records and not scan every old record, but only the most relevant records. “Not all patients come back to the practice, so they may have a record for a patient who they’ll never see again, and it would be costly to scan those records,” he explains. “So, a practice may decide only to retain the records of current patients. But what do you do with the old records? Well, you store them for at least the state minimum requirement, and maybe a little longer just to be on the safe side.”

These questions, if familiar ones, also reflect shifting practices in a changing technology landscape for Mary Pat Whaley, FACMPE, CPC, a practice management consultant based in Morrisville, North Carolina.

“One question I often hear is, How long do I have to keep a paper document such as a superbill or encounter form or charge ticket?” she says. “But what’s changed the conversation in recent years is that superbills have largely gone away. The question is, If the provider is pushing the charges from the EMR [electronic medical record] into the billing side, and there’s no document of origination, then what is the superbill for? What’s the value of the superbill? Because a lot of what’s really underlying the charge is the medical record itself and then, of course, the claim. So, in a lot of ways that piece of paper, its importance as the central document, has now become kind of a bit part on the stage.”

Many practical challenges are involved in scanning paper charts to electronic files. In some cases, offices will hire outside firms to scan all charts and records into the EHR system. The nature of the work may still entail an allotment of staff time and effort to coordinate such endeavors. In his work with physician practices, Zetter will sometimes suggest a sensible approach to this transitional task. “My advice is usually to look at the schedule two weeks or a month or so in advance, then scan those patient charts on the upcoming schedule into the EHR,” he says. “This way you have the ability to look at those records when you’re with that patient; it’s part of their electronic file now.”

Naturally, the transition to EHR systems is driven by the many benefits modern technology brings to records management. The ease of inputting electronic data certainly has many advantages for staff, but with convenience come some risks. For one, proper record retention practices will not mean much if the records themselves are inaccurate. One potential risk is that staff may rush inputting information into the EHR as records and charts are updated, reports Lythia Bynum, CMA (AAMA), a medical assisting educator at Gaston College in Dallas, North Carolina.

“Charting is really great with electronic health records because often it’s just click, click, click,” says Bynum. “You don’t neces-

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**Binders, keepers**

Those looking for guidance on where to start in crafting or reassessing a record retention plan should know what their state requires:

- **Office of the National Coordinator for Health Information Technology (ONC)** offers a detailed table of retention periods for medical records by state. Website: [https://www.healthit.gov/sites/default/files/appa7-1.pdf](https://www.healthit.gov/sites/default/files/appa7-1.pdf).

sarily have to think that much about what you need to put into the charting. But it’s for this reason that we still teach our students how to manually chart and to put that thought process together, along with teaching EHRs in the classroom. In fact, we’ve had our students in offices when the electronic systems went down due to a power outage, and our students were the ones able to keep the office going. They still knew what to do with the paper chart and weren’t dependent on an EHR template.”

For managers and staff, keeping accurate electronic records of the current status of patients is a related and ongoing responsibility, says Bynum. “Retain up-to-date records on the active [and] inactive statuses of patients,” she urges. “It sounds simple, but it’s the easiest mistake to make.” As she explains, when a patient’s status has been moved to inactive, it is not necessarily going to be reflected in the EHR if the patient later returns to the practice, unless staff members also check the electronic archives. Consequently, staff might assume the returning patient is a new patient. Thus, when an inactive patient makes a new appointment, Bynum advises updating the active and inactive dates in the record.

What about staff turnover in the medical group? “If a physician leaves the practice, retires, or passes away, it’s important that the practice keep a copy of the medical record,” says Tennant. “Often, especially if there’s been a bad break, the physician who’s leaving wants to take all their records. But [the records] are the legal property of the LLC [limited liability company] in most cases. Certainly, the departing physician can get a copy of their records, because maybe they’ll continue to treat these patients. But for legal reasons the practice will want to protect itself and make sure they’ve got a legal copy of the medical record.”

As Tennant notes, there is the related issue with patients: Who owns the medical record? “Does the patient have the right to come in and take the record if they’re going to a new practice?” he asks. “Of course, they have a legal right to a copy of that record, but they do not have the right to take the original record and leave the practice with no record.”

Safe keeping
With vast amounts of information to manage, developing a more streamlined overall approach to records retention can make a lot of sense. “You would have to be very organized to separate what can be shredded in one year, three years, six years, seven years, and so on,” says Whaley, who prefers to categorize everything into three basic categories and retention periods:

- **Corporate paperwork and financials:** Save all permanently. These include, among others, such items as tax records, legal correspondence, licenses, annual financial statements, loan documents, Occupational Safety and Health (OSH) Act medical records for employee accidents and exposures, and workers’ compensation records.

- **Accounting records and miscellaneous records:** Seven years. These include human resource records (ex-employees), bank statements, accounts payable records, canceled checks, expired contracts and leases, electronic fund transfers, payroll records, sales records, reimbursement records for employee expenses, and explanation of benefits (EOB) forms from payers.

- **Patient medical records:** Guided by state regulation or physician preference, whichever is longer. These include recommendations to save adult records permanently, or at least 10 years past the date of the last encounter. For minors, records can be saved permanently, says Whaley, or a minimum of the state statute of limitations past the age of majority. Providers of Medicare Advantage programs should keep patient records for 10 years.
On files

How are active and inactive records defined? **Active** means that the records are consulted or used on a routine basis. **Inactive** means that the records are rarely used but must be retained for reference or to meet the full retention requirement. Inactive records usually involve a patient who has not sought treatment for some time or one who completed a course of treatment.7

Each organization should determine a cutoff point (typically a discharge date) that signals the time at which a record becomes inactive. While determining the appropriate cutoff, consider the following:

- **How often the records are accessed** (e.g., daily, weekly, monthly)
- **The total retention requirement**
- **The size of the record** (e.g., a large long-stay record versus a short emergency record)
- **The physical constraints** (e.g., lack of file space, lack of off-site storage)
- **What activities or functions require routine access to the record** (e.g., quality reviews, release of information)

Indeed, with the advent of electronic records, including expansion of low-cost cloud storage services, some experts now suggest practices consider keeping all or most patient charts permanently. “There are so many different laws and regulations that place requirements on different types of records or documentation in a medical practice,” says Zetter. “Given the ability to keep everything in digital format, there is no reason why anything cannot be kept, literally forever. It just makes sense to protect yourself and keep copies of everything in an organized and obtainable fashion, with data backups.”

The availability of cloud services for health care providers offers new options in this regard. “One big change in the past few years is the willingness of cloud providers to sign HIPAA business associate agreements, or BAAs as they’re called,” says Whaley. “Obviously, because HIPAA requires medical practices to have a BAA with anyone that handles protected health information, you’re not going to put anything in the cloud without one. But now a lot of practices do have access to secure cloud storage, in addition to the ways they’ve already been keeping some records electronically. This change, along with a more general acceptance of the technology, is expanding the use of cloud services.”

Of course, most experts agree medical practices are well advised to take extra care to guarantee records are safe and appropriately retained. “Err on the side of caution in terms of retention of records,” says Tennant. “This is particularly true in terms of HIPAA privacy and security issues. If, for example, a patient has decided to leave the practice, and staff has access to part of the records, they might guess they can throw these records out. Well, no, you can’t. You’ve got to keep them. It’s especially important to train staff to be cautious and always ask questions; for the front-end clerical staff to say, let me go talk to John or Mary, the practice administrator, before I make a decision about these records.”

In fact, caution is often the watchword when it comes to office retention practices, reports Whaley of her experience working with physician practices. “I think we do tend to err on the side of keeping too much information for fear either that we will need a record to answer a question or respond to some allegation,” she says. “The important thing is to think it all through. And, when necessary, to call on your advisers, the practice’s CPA [certified public accountant], legal counsel, or malpractice carrier for accurate information on retention issues.”

Copy that

In the everyday rush of office life, record retention issues related to emergency preparedness may tend to be overlooked. They shouldn’t be. “This is another issue I would argue is critical,” cautions Tennant. “Let’s say you’ve gone electronic in your office, you’ve destroyed your old paper records, and then you have a natural disaster or a fire or ransomware attack, and your data is lost. That could be catastrophic to patients and the practice.” Tennant recommends taking a serious look at data backup systems and disaster recovery protocols.

The latter would probably entail storing at least a copy of the electronic record off-site, says Tennant. “Today, many practices are using cloud services, but if you use a tape drive system, which is somewhat out-of-date but still in use, many practices put that tape drive right in the server room. They can change the tape so if they had a problem with the server they would still have a backup. But what if they have a fire or a flood? I would argue records retention becomes a business priority, whether you’ve got paper or electronic records.”

In fact, the natural disasters of 2017 are a cautionary reminder that such events “don’t just happen to other folks,” warns Tennant. “Medical practices need to take these issues seriously, not just for legal reasons in terms of retention times but also for ensuring that records are protected under any unusual or unexpected circumstances, including theft.”

In any eventuality, whether managing routine issues or an unexpected crisis, the lesson is always there: the integrity of medical and office records must always be protected, under any circumstances. As the repository for all pertinent information related to a patient’s medical history and care, proper record retention management is an essential element of any provider’s ability to deliver high-quality patient care. Accurate, well-documented patient records are also necessary for efficient billing and claims processing. As well, office records
serve as legal documentation of the care and services provided, which can prove essential in circumstances in which payment disputes, issues of malpractice, or other legal issues arise.

“As medical assistants, we need to think of the medical record as part of the continuity of care, the proven documentation of what we did or didn’t do, and how we instructed the patient,” concludes Bynum.

Nor are appropriately maintained records just for the practice’s benefit. “It’s not just about protecting our own assets against litigation,” adds Bynum. “A patient may at some point also need some information that’s in their record. We certainly don’t want to have neglected to include some information that’s important to them.”

### Shelf life
Admittedly, records retention is a challenging, detail-oriented endeavor and responsibility. Successful, ongoing implementation requires trained and knowledgeable staff, led by managers familiar with the legal and professional guidelines that apply to this area of practice management.

“Ultimately, the office manager or practice administrator, whoever is the leader of the practice, is responsible for managing the records,” concludes Zetter. “This individual should be aware of all the record retention requirements, both federal and state, that apply to the practice. [Staff] need to know the practice doesn’t discard, destroy, or shred anything unless there are specific guidelines on what should be done and when. As such, every new hire should be trained in the office’s retention practices.”

Depending on its size, a medical practice may have a dedicated health information manager assigned to record retention responsibilities. Smaller offices without such dedicated resources may find it helpful to take advantage of professional training and education opportunities for managers and staff.

### For keeps’ sakes
Keep these considerations in mind when establishing record retention policies, says David J. Zetter, PHR, SHRM-CP:

- **Defense of medical liability actions.** Medical liability actions generally must be brought within the shorter of either two years from the date of reasonable discovery (the statute of limitations) or seven years after 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 years old. Keep in mind that uncertainties may arise as new statutory language enacted in 2003 has yet to be interpreted by the courts. Consequently, it is best to retain medical records as long as feasible, especially in the case of surgery and minors.

- **Immunization records.** The Council on Ethical and Judicial Affairs (a part of the American Medical Association) has recommended that immunization records be maintained indefinitely.

- **Retention of minimal information.** Even when medical records may be safely destroyed, 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 limitations 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 of 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.
“One of the challenges these days is that everyone has an avalanche of paper,” concludes Tennant. “If there’s any sort of discouragement to records retention, it’s exactly that. Because you’ve got so much paper, you’re trying to decide what’s important, what you need to keep, and for how long. Fortunately, the nice thing about modern technology is that storage for computers has become incredibly cheap. It used to be you filled up your hard drives very quickly, and it was expensive. Those days are gone. Now, you can store records, including complicated images using terabytes of data, for a relatively low cost. So, there’s really no excuse now to do one of two things: be sloppy with retention or try to keep everything on paper.”

In the end, the issue of record retention occupies a place of singular importance in the larger risk management responsibilities of a medical practice. Being knowledgeable and conscientious about the issues involved is the starting point for every health care provider concerned with both protecting the practice and serving the needs of patients.

References