AGENDA ITEM 10

DISCUSSION AND CONSIDERATION OF RECORD RETENTION REQUIREMENTS IF A BUSINESS IS SOLD OR CLOSED.

Physical Therapy Laws & Regulations Relating to Patient Records

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What Does a Physical Therapist Have To Include In A Patient's Record?

The Physical Therapy Practice Act requires all physical therapists to create for all patients a record including the evaluation, goals, treatment plan and summary of treatment in the patient record.

Does A Physical Therapist Have To Keep Patient Records When A Physical Therapist Assistant Provides Part Of The Care?

Yes. When a physical therapist utilizes a physical therapist assistant to provide physical care the following additional information must be included in the patient record:

- When the patient will be reevaluated
- All reevaluations
- The physical therapist assistant must document each treatment
- The supervising physical therapist must cosign the physical therapist assistant's entry, or document a case conference within seven days of the care being provided
- A discharge plan

Does A Physical Therapist Have To Keep Patient Records When A Physical Therapy Aide Provides Part Of The Care?

Yes. When a physical therapist utilizes a physical therapy aide to provide physical therapy care the following additional information must be included in the patient record.

- Which elements of the treatment plan may be assigned to the physical therapy aide
- The patient related tasks rendered by the physical therapy aide, including the signature of the person performing the tasks
- All reevaluations and any changes in the treatment plan
- The countersignature of the physical therapist on the same day as patient related tasks were provided by the physical therapy aide

How Long Does A Physical Therapist Have To Keep Patient Records?

The patient records must be maintained for at least seven years following the discharge, except the records of unemancipated minors must be maintained for at least seven years and at least one year after the minor reaches the age of 18.

The Laws

Physical Therapy Practice Act (Business & Professions Code)

2620.7. A physical therapist shall document his or her evaluation, goals, treatment plan, and summary of treatment in the patient record. Patient records shall be maintained for a period of no less than seven years following the discharge of the patient, except that the records of unemancipated minors shall be maintained at least one year after the minor has reached the age of 18 years, and not in any case less than seven years.

2630. It is unlawful for any person or persons to practice, or offer to practice, physical therapy in this state for compensation received or expected, or to hold himself or herself out as a physical therapist, unless at the time of so doing the person holds a valid, unexpired, and unrevoked license issued under this chapter. Nothing in this section shall restrict the activities authorized by their licenses on the part of any persons licensed under this code or any initiative act, or the activities authorized to be performed pursuant to Article 4.5 (commencing with Section 2655) or Chapter 7.7 (commencing with Section 3500). A physical therapist licensed pursuant to this chapter may utilize the services of one aide engaged in patient-related tasks to assist the physical therapist in his or her practice of physical therapy. "Patient-related task" means a physical therapy service rendered directly to the patient by an aide, excluding non-patient-related tasks. "Non-patient-related task" means a task related to observation of the patient, transport of the patient, physical support only during gait or transfer training, housekeeping duties, clerical duties, and similar functions. The aide shall at all times be under the orders, direction, and immediate supervision of the physical therapist. Nothing in this section shall authorize an aide to independently perform physical therapy or any physical therapy procedure. The board shall adopt regulations that set forth the standards and requirements for the orders, direction, and immediate supervision of an aide by a physical therapist. The physical therapist shall provide continuous and immediate supervision of the aide. The physical therapist shall be in the same facility as, and in proximity to, the location where the aide is performing patient-related tasks, and shall be readily available at all times to provide advice or instruction to the aide. When patient-related tasks are provided to a patient by an aide, the supervising physical therapist shall, at some point during the treatment day, provide direct service to the patient as treatment for the patient's condition, or to further evaluate and monitor the patient's progress, and shall correspondingly document the patient's record. The administration of massage, external baths, or normal exercise not a part of a physical therapy treatment shall not be prohibited by this section.

THE REGULATIONS

Physical Therapy Regulations (California Code of Regulations, Title 16, Division 13.2)

PHYSICAL THERAPIST ASSISTANT SUPERVISION

1398.44. Adequate Supervision Defined.

A licensed physical therapist shall at all times be responsible for all physical therapy services provided by the physical therapist assistant. The supervising physical therapist has continuing responsibility to follow the progress of each patient, provide direct care to the patient and to assure that the physical therapist assistant does not function autonomously. Adequate supervision shall include all of the following:

(a) The supervising physical therapist shall be readily available in person or by telecommunication to the physical therapist assistant at all times while the physical therapist assistant is treating patients. The supervising physical therapist shall provide periodic on site supervision and observation of the assigned patient care rendered by the physical therapist assistant.

(b) The supervising physical therapist shall initially evaluate each patient and document in the patient record, along with his or her signature, the evaluation and when the patient is to be reevaluated.

(c) The supervising physical therapist shall formulate and document in each patient's record, along with his or her signature, the treatment program goals and plan based upon the evaluation and any other information available to the supervising physical therapist. This information shall be communicated verbally, or in writing by the supervising physical therapist to the physical therapist assistant prior to initiation of treatment by the physical therapist assistant. The supervising physical therapist shall determine which elements of the treatment plan may be assigned to the physical therapist assistant. Assignment of these responsibilities must be commensurate with the qualifications, including experience, education and training, of the physical therapist assistant.

(d) The supervising physical therapist shall reevaluate the patient as previously determined, or more often if necessary, and modify the treatment, goals and plan as needed. The reevaluation shall include treatment to the patient by the supervising physical therapist. The reevaluation shall be documented and signed by the supervising physical therapist in the patient's record and shall reflect the patient's progress toward the treatment goals and when the next reevaluation shall be performed.

(e) The physical therapist assistant shall document each treatment in the patient record, along with his or her signature. The physical therapist assistant shall document in the patient record and notify the supervising physical therapist of any change in the patient's condition not consistent with planned progress or treatment goals. The change in condition necessitates a reevaluation by a supervising physical therapist before further treatment by the physical therapist assistant.

(f) Within seven (7) days of the care being provided by the physical therapist assistant, the supervising physical therapist shall review, cosign and date all documentation by the physical therapist assistant or conduct a weekly case conference and document it in the patient record. Cosigning by the supervising physical therapist indicates that the supervising physical therapist has read the documentation, and unless the supervising physical therapist indicates otherwise, he or she is in agreement with the contents of the documentation.

(g) There shall be a regularly scheduled and documented case conference between the supervising physical therapist and physical therapist assistant regarding the patient. The frequency of the conferences is to be determined by the supervising physical therapist based on the needs of the patient, the supervisory needs of the physical therapist assistant and shall be at least every thirty calendar days.

(h) The supervising physical therapist shall establish a discharge plan. At the time of discharge, or within 7 (seven) days thereafter, a supervising physical therapist shall document in the patient's record, along with his or her signature, the patient's response to treatment in the form of a reevaluation or discharge summary.

PHYSICAL THERAPY AIDE SUPERVISION

1399. Requirements for Use of Aides.

A physical therapy aide is an unlicensed person who assists a physical therapist and may be utilized by a physical therapist in his or her practice by performing nonpatient related tasks, or by performing patient related tasks.

(a) As used in these regulations:

(1) A "patient related task" means a physical therapy service rendered directly to the patient by an aide, excluding nonpatient related tasks as defined below.

(2) A "nonpatient related task" means a task related to observation of the patient, transport of patients, physical support only during gait or transfer training, housekeeping duties, clerical duties and similar functions.

(b) "Under the orders, direction and immediate supervision" means:

(1) Prior to the initiation of care, the physical therapist shall evaluate every patient prior to the performance of any patient related tasks by the aide. The evaluation shall be documented in the patient's record.

(2) The physical therapist shall formulate and record in the patient's record a treatment program based upon the evaluation and any other information available to the physical therapist, and shall determine those patient related tasks which may be assigned to an aide. The patient's record shall reflect those patient related tasks that were rendered by the aide, including the signature of the aide who performed those tasks.

(3) The physical therapist shall assign only those patient related tasks that can be safely and effectively performed by the aide. The supervising physical therapist shall be responsible at all times for the conduct of the aide while he or she is on duty.

(4) The physical therapist shall provide continuous and immediate supervision of the aide. The physical therapist shall be in the same facility as and in immediate proximity to the location where the aide is performing patient related tasks, and shall be readily available at all times to provide advice or instruction to the aide. When patient related tasks are provided a patient by an aide the supervising physical therapist shall at some point during the treatment day provide direct service to the patient as treatment for the patient's condition or to further evaluate and monitor the patient's progress, and so document in the patient's record.

(5) The physical therapist shall perform periodic re-evaluation of the patient as necessary and make adjustments in the patient's treatment program. The re-evaluation shall be documented in the patient's record.(6) The supervising physical therapist shall countersign with their first initial and last name, and date all entries in the patient's record, on the same day as patient related tasks were provided by the aide.

Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – On June 18, 2010, the Office of the National Coordinator for Health Information Technology (ONC) issued a final rule to establish a temporary certification program for electronic health record (EHR) technology. To see the press release related to this rule, visit *http://www.hhs.gov/news/press/2010pres/06/20100618d.html* on the Internet.

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Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Medical Record Retention and Media Formats for Medical Records

Provider Types Affected

This is an informational article for physicians, non-physician practitioners, suppliers, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and Medicare Administrative Contractors (MAC)) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This Special Edition is informational in nature. There are no additions or changes to current policies and procedures.

CAUTION – What You Need to Know

This article provides guidance for physicians, suppliers, and providers on record retention timeframes.

GO – What You Need to Do

Review the information in this article and ensure that you are in compliance. Be sure to inform your staff.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Retention Periods

State laws generally govern how long medical records are to be retained. However, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA) administrative simplification rules require a covered entity, such as a physician billing Medicare, to retain required documentation for **six years from the date of its creation or the date when it last was in effect, whichever is later.** HIPAA requirements preempt State laws if they require shorter periods. **Your State may require a longer retention period**. The HIPAA requirements are available at 45 CFR 164.316(b)(2) (*http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl*) on the Internet.

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. The Privacy Rule is available at 45 CFR 164.530(c) (*http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl*) on the Internet.

The Centers for Medicare & Medicaid Services (CMS) requires records of providers submitting cost reports to be retained in their original or legally reproduced form for a period of at least 5 years after the closure of the cost report. This requirement is available at 42 CFR 482.24[b][1] (*http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr482_05.html*) on the Internet.

CMS requires Medicare managed care program providers to retain records for 10 years. This requirement is available at 42 CFR 422.504 [d][2][iii] (*http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=ab240bf0e5f6388a75cbe07cc5cf1d21;rgn=div5;view=text;node=42%3A3.0.1.1.9;idno=42;cc=ecfr*) on the Internet.

Providers/suppliers should maintain a medical record for each Medicare beneficiary that is their patient. Remember that medical records must be accurately written, promptly completed, accessible, properly filed and retained. Using a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries is a good practice.

The Medicare program does not have requirements for the media formats for medical records. However, the medical record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may

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be reviewed and audited by authorized entities. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly.

Providers may want to obtain legal advice concerning record retention after these time periods and medical document format.

Additional Information

CMS is currently engaged in a multi-year project to offer incentives to eligible providers that meaningfully use certified electronic health records (EHRs). In close coordination with this incentive program, the Office of the National Coordinator for Health IT (ONC) has developed the initial set of standards and certification requirements for EHRs in order to promote health information exchange and interoperability. You may be eligible to receive incentive payments to assist in implementing certified EHR technology systems.

Use of "certified EHR technology" is a core requirement for physicians and other providers who seek to qualify to receive incentive payments under the Medicare and Medicaid Electronic Health Record Incentive Programs provisions authorized in the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH was enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

Additional information about this initiative may be found at *http://www.cms.gov/EHRIncentivePrograms/* on the CMS website.

If you have any questions, please contact your carrier, FI or A/B MAC, at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

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Table 3: Federal Record Retention Requirements

Type of Documentation	Retention Period	Citation/Reference
Abortions and related medical services documentation	Maintained for three years.	42 CFR 36.56 42 CFR 50.309
Ambulatory surgical services	Retention periods are not specified.	42 CFR 416.47
Clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services	As determined by the respective state statute, or the statute of limitations in the state. In the absence of a state statute, five years after the date of discharge; or in the case of a minor, three years after the patient becomes of age under state law or five years after the date of discharge, whichever is longer.	42 CFR 485.721(d) 42 CFR 486.161(d)
Clinics, rural health	Six years from date of last entry and longer if required by state statute.	42 CFR 491.10(c)
Competitive medical plans (see HMOs, competitive medical plans, healthcare prepayment plans)		
Comprehensive outpatient rehabilitation facilities (CORFs)	Five years after patient discharge.	42 CFR 485.60(c)
Critical access hospitals (CAHs)	Six years from date of last entry, and longer if required by state statute, or if the records may be needed in any pending proceeding.	42 CFR 485.638(c)
Department of Veterans Affairs—Diagnostic and operation index file	Destroy monthly listing after receipt of consolidated biannual listing. Destroy consolidated biannual listing or prior equivalent 20 years after date of report.	Records Control Schedule (RCS)10-1, Section XXII—Medical Administration Service (136) (1985)
Department of Veterans Affairs—Disposition data files (PTF)	Destroy after one year and after a PTF master record has been created at the data processing center.	Records Control Schedule (RCS)10-1, Section XXII—Medical Administration Service (136) (1985)
Department of Veterans Affairs—Gains and losses file	Destroy master set after one year.	Records Control Schedule (RCS)10-1, Section XXII—Medical Administration Service (136) (1985)
Department of Veterans Affairs—Medical record or consolidated health record	Pending approval of reappraisal for destruction, 75 years from the last date of activity. *Note: All medical records of veterans are under moratorium against destruction placed by the Administrator 6/20/79 and approved by GSA/NARA (General Services Administration/National Archives and Records Administration).* This applies to medical records or consolidated health records for inpatients, ambulatory care patients, and tumor registry patients, including active records (hospital, domiciliary, nursing home units, ambulatory care, or other outpatient records), inactive records, perpetual medical records, medical records, and administrative records.	Records Control Schedule (RCS)10-1, Section XXII—Medical Administration Service (136) (1985)
Department of Veterans Affairs—Patient locator file	Destroy 50 years after last episode of care and/or only after perpetual medical record is destroyed.	Records Control Schedule (RCS)10-1, Section XXII—Medical Administration Service (136) (1985)

Table 3: Federal Record Retention Requirements (cont.)

Type of Documentation	Retention Period	Citation/Reference
Department of Veterans Affairs—Register file	Destroy when no longer needed.	Records Control Schedule (RCS) 10-1, Section XXII—Medical Administration Service (136) (1985)
Department of Veterans Affairs—Tumor registry records and index cards	Live patients—destroy when 20 years old. Deceased patients or patients lost to follow up—destroy when five years old.	Records Control Schedule (RCS) 10-1, Section XXII—Medical Administration Service (136) (1985)
Device tracking (see Medical device tracking)		
Drug test results, students	Education records are those records that are directly related to a student and maintained by an education agency or institution or by a party acting for the agency or institution. Disclosure of education records is addressed. However, record retention periods are not specified.	34 CFR 99 Family Educational Rights and Privacy Act (20 USC §1232g)
Drug use review (DUR) (see Outpatient drug claims—Pharmacists participating in DUR program and electronic claims management system)		
End stage renal disease (ESRD) services	Not less than that determined by the state statute governing record retention or statute of limitations. In the absence of a state statute, five years from the date of discharge; or in the case of a minor, three years after the patient becomes of age under state law, whichever is longest.	42 CFR 405.2139(e)
HMOs, competitive medical plans, healthcare prepayment plans	Retention periods are not specified.	42 CFR 417
Healthcare prepayment plans (see HMOs, competitive medical plans, healthcare prepayment plans)		
Hearing aid devices, dispensers	The dispenser shall retain for three years after dispensing of a hearing aid a copy of any written statement from a physician or any written statement waiving medical evaluation.	21 CFR 801.421(d)
Home health agencies	Five years after the month the cost report to which the records apply is filed with the intermediary, unless state law stipulates a longer period of time.	42 CFR 484.48(a)
Hospice care	Retention periods are not specified.	42 CFR 418.74
Hospitals	Five years.	42 CFR 482.24(b)(1)
Hospitals—Nuclear medicine services	Report copies will be retained for five years.	42 CFR 482.53(d)
Hospitals—Radiologic services	Report copies and printouts, films, scans, and other image records will be retained for five years.	42 CFR 482.26(d)
Hospitals and other dispensers of drugs used for treatment of narcotic addicts, i.e., methadone	Three years.	21 CFR 291.505(d)(13)(ii)

Table 3: Federal Record Retention Requirements (cont.)

Type of Documentation	Retention Period	Citation/Reference
Hospitals, critical access (see Critical access hospitals)		
Immunizations (see Vaccine)		
Institutional review board (IRB) for clinical devices	Two years after the latter of the following two dates: The date on which the investigation is terminated or completed, or the date that the records are no longer required for purposes of supporting a pre-market approval application or notice of completion of a product development protocol.	21 CFR 812.140(d)
IRB or institutions that review a clinical investigation documentation	Three years after completion of research.	21 CFR 56.115(b) 38 CFR 16.115(b)
Intermediate care, mentally retarded	Retention periods are not specified.	42 CFR 482.410
Investigator—Investigators in clinical devices	Two years after the latter of the following two dates: The date on which the investigation is terminated or completed, or the date that the records are no longer required for purposes of supporting a premarket approval application or notice of completion of a product development protocol.	
Investigator—Investigators of new drugs and antibiotic drugs for investigational use	Two years following the date a marketing application is approved for the drug for the indication for which it is being investigated. If no application is to be filed or if the application is not approved for such indication, until two years after the investigation is discontinued and the FDA is notified.	21 CFR 312.62(c)
Laboratory—immunohematology	Five years.	42 CFR 493.1777(d)(1) 42 CFR 493.1780(e)(1)
Laboratory—pathology tests	Ten years after the date of reporting.	42 CFR 493.1777(d)(2) 42 CFR 493.1780(e)(3)
Laboratory—all other records	Two years.	42 CFR 493.1777(d)(3) 42 CFR 493.1780(e)(4)
Laboratory stains and specimen blocks—histopathology, oral pathology	Stained slides—10 years from the date of examination. Specimen blocks—two years from the date of examination.	42 CFR 493.1259(b)
Long-term care facilities	As required by state law; or five years from the date of discharge when there is no requirement in state law; or for a minor, three years after a resident reaches legal age under state law.	42 CFR 483.75(l)(2)
Mammography—screening and/or diagnostic mammography services	Five years, or not less than 10 years, if no additional mammograms of the patient are performed at the facility, or longer if mandated by state or local law.	21 CFR 900.12(e)(1)(i)
Medical device tracking	Maintain such records for the useful life of each tracked device manufactured or distributed. The useful life of a device is the time a device is in use or in distribution for use.	21 CFR 821.60
Mental retardation intermediate care (see Intermediate care, mentally retarded)		
Methadone (see Hospitals and other dispensers of drugs used for treatment of narcotic addicts, i.e., methadone)		

Table 3: Federal Record Retention Requirements (cont.)

Type of Documentation	Retention Period	Citation/Reference
Vaccine	Retention periods are not specified. However, each healthcare provider who administers a vaccine set forth in the Vaccine Injury Table (42 CFR 100.3) to any person shall record, or ensure that there is recorded, in such person's permanent medical record (or in a permanent office log or file to which a legal representative shall have access upon request) with respect to each such vaccine the date of administration of the vaccine, the vaccine manufacturer and lot number of the vaccine, the name and address and, if appropriate, the title of the healthcare provider administering the vaccine, and any other identifying information on the vaccine required pursuant to regulation promulgated by the Secretary. *Note: For injuries, claims can be filed within 36 months after the first symptoms appeared. In the case of death, the claim must be filed within 24 months of the death and within 48 months after the onset of the vaccine-related injury from which the death occurred. AHIMA recommends that records be retained at least through this period.*	42 CFR 300aa-11 42 CFR 300aa-25
Veterans Administration (see Department of Veterans Affairs)		

CFR: Code of Federal Regulations (includes Conditions of Participation, Food and Drug Administration, Department of Health and Human Services, Health Care Financing Administration, Public Health Service, Occupational Safety and Health Administration, and other federal agencies)

USC: United States Code

LEGAL MEDICAL RECORD STANDARDS

PURPOSE

To establish guidelines for the contents, maintenance, and confidentiality of patient Medical Records that meet the requirements set forth in federal and State laws and regulations, and to define the portion of an individual's healthcare information, whether in paper or electronic format, that comprises the medical record. Patient medical information is contained within multiple electronic records systems in combination with financial and other types of data. This policy defines requirements for those components of information that comprise a patient's complete "*Legal Medical Record.*"

DEFINITIONS

Medical Record: The collection of information concerning a patient and his or her health care that is created and maintained in the regular course of UC__ business in accordance with UC__ policies, made by a person who has knowledge of the acts, events, opinions or diagnoses relating to the patient, and made at or around the time indicated in the documentation.

- The medical record may include records maintained in an electronic medical / record system, e.g., an electronic system framework that integrates data from multiple sources, captures data at the point of care, and supports caregiver decision making.
- The medical record excludes health records that are not official business records of UC, such as personal health records managed by the patient.

Each Medical Record shall contain sufficient, accurate information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers. The information may be from any source and in any format, including, but not limited to print medium, audio/visual recording, and/or electronic display.

The Medical Record may also be known as the "***Legal Medical Record***" or "***LMR***" in that it serves as the documentation of the healthcare services provided to a patient by a UC__ hospital, clinic, physician or provider and can be certified by the UC__ Record Custodian(s) as such. .

The Legal Medical Record is a subset of the ***Designated Record Set*** and is the record that will be released for legal proceedings or in response to a request to release patient medical records. The Legal Medical Record can be certified as such in a court of law.

Designated Record Set ("DRS"): A group of records that include protected health information (PHI) and that is maintained, collected, used or disseminated by, or for, a covered entity (e.g. the UC Medical Center) for each individual that receives care from a covered individual or institution. The DRS includes:

1. The medical records and billing records about individuals maintained by or for a covered health care provider (can be in a business associate's records);
2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
3. The information used, in part or in whole, to make decisions about individuals.

Any research activities that create PHI should be maintained as a part of the DRS and are

accessible to research participants unless there is a HIPAA Privacy Rule permitted exception.

Protected Health Information ("PHI"): PHI is individually identifiable health information that is transmitted or maintained in any medium, including oral statements.

Authentication: The process that ensures that users are who they say they are. The aim is to prevent unauthorized people from accessing data or using another person's identity to sign documents.

Signature: A signature identifies the author or the responsible party who takes ownership of and attests to the information contained in a record entry or document.

Clinic Record / Shadow File: A folder containing COPIES ONLY of information from the medical record used primarily by clinicians in their office or clinic setting. These COPIES of the relevant documents from the original medical record are NOT part of the legal medical record.

Macros: Macros allow a provider to record and replay a series of typed characters or other keystrokes (e.g., hot keys, one or more keys at the same time, or one-word commands) in a manner that makes it possible for a physician or a provider to quickly document an entire medical note while avoiding the cost of transcription and/or the time of repetitive documentation.

POLICY / PROCEDURES

I. Maintenance of the Medical Record

A. A Medical Record shall be maintained for every individual who is evaluated or treated as an inpatient, outpatient, or emergency patient of a UC__ hospital, clinic, or physician's office.

B. Currently, the Medical Record is considered a hybrid record, consisting of both electronic and paper documentation. Documentation that comprises the Medical Record may physically exist in separate and multiple locations in both paper-based and electronic formats. (See Appendix A).

C. The medical record contents can be maintained in either paper (hardcopy) or electronic formats, including digital images, and can include patient identifiable source information, such as photographs, films, digital images, and fetal monitor strips and/or a written or dictated summary or interpretation of findings.

D. The current electronic components of the Medical Record consist of patient information from multiple Electronic Health Record source systems. The intent of UC__ is to integrate all electronic documents into a permanent electronic repository.

E. Original Medical Record documentation must be sent to the designated Medical Records department or area. Whenever possible, the paper chart shall contain original reports. Shadow files maintained by some clinics or care sites contain

copies of selected material, the originals of which are filed in the patient's permanent Medical Record.

II. Confidentiality

The Medical Record is confidential and is protected from unauthorized disclosure by law. The circumstances under which UC__ may use and disclose confidential medical record information is set forth in the Notice of Privacy Practices (*see*: Privacy Policy and Procedure No. _____, "*Notice of Privacy Practices*") and in other UC__ Privacy Policies and Procedures.

III. Content

A. Medical Record content shall meet all State and federal legal, regulatory and accreditation requirements including but not limited to Title 22 California *Code of Regulations,* sections 70749, 70527 and 71549, and the Medicare Conditions of Participation 42 CFR Section 482.24. Appendix A contains a listing of required Medical Record documentation content, and current electronic or paper format status.

B. Additionally, all hospital records and hospital-based clinic records must comply with the applicable hospital's Medical Staff Rules and Regulations requirements for content and timely completion.

C. All documentation and entries in the Medical Record, both paper and electronic, must be identified with the patient's full name and a unique UC__ Medical Record number. Each page of a double-sided or multi-page forms must be marked with both the patient's full name and the unique Medical Record number, since single pages may be photocopied, faxed or imaged and separated from the whole.

D. All Medical Record entries should be made as soon as possible after the care is provided, or an event or observation is made. An entry should never be made in the Medical Record in advance of the service provided to the patient. Pre-dating or backdating an entry is prohibited.

IV. Medical Record vs. Designated Record Set

A. Under the HIPAA Privacy Rule, an individual has the right to access and/or amend his or her protected health (medical record) information that is contained in a "designated record set." The term "designated record set" is defined within the Privacy Rule to include medical and billing records, and any other records used by the provider to make decisions about an individual. In accordance with the HIPAA Privacy Rule, UC__ has defined a "designated record set" to mean the group of records maintained for each individual who receives healthcare services delivered by a healthcare provider, which is comprised of the following elements:

1. The Medical Record whether in paper or electronic format, to include patient identifiable source information such as photographs, films, digital images, and fetal monitor strips when a written or dictated summary or interpretation of finding has not been prepared;

2. Billing records including claim information; and

3. All physician or other provider notes, written or dictated, in which medical decision-making is documented, and which are not otherwise included in the Legal Medical Record (e.g., outside records, email when applicable for treatment).

B. The Medical Record generally excludes records from non-UC providers (i.e., health information that was not documented during the normal course of business at a UC__ facility or by a UC__ provider). However, if information from another provider or healthcare facility, or personal health record, is used in providing patient care or making medical decisions, it may be considered part of the UC__ Designated Record Set, and may be subject to disclosure on specific request or under subpoena. Disclosures from medical records in response to subpoenas will be made in accordance with applicable Campus policies.

V. Who May Document Entries in the Medical Record: Multidisciplinary Notes

Only the following types of UC__ employees and/or employees of UC__-contracted clinical and social services providers may document entries in the Multidisciplinary Notes section of the Medical Record:

1. Child Life Specialists
2. Clinical Social Workers
3. Dentists
4. Dietitians/Diet Technicians
5. Emergency Trauma Technicians
6. Fellows
7. Home Health Coordinators
8. Clinical Care Partners
9. Hyperbaric Technicians/Observers
10. Interns
11. Interpreters (Employees of UC__)
12. Lactation Specialists
13. Licensed Vocational Nurses
14. Medical Assistants
15. Medical Ethicists
16. Nurse Practitioners
17. Nurses employed by physicians (exceptions)
18. Occupational Therapists
19. Osteopathic Students
20. Pastoral Care Providers

21. Pharmacists
22. Physical Therapists
23. Physician Assistants
24. Physicians including MD's and DO's
25. Podiatrists
26. Psychologists
27. Registered Nurses
28. Mental Health Practitioners
29. Licensed Psychiatric Technicians
30. Midwives
31. Residents
32. Respiratory Therapists
33. School Teachers
34. Speech Pathologists
35. Students, e.g., MD, RN, Occupational Therapy, etc. (Notations in the record must be co-signed by a supervising clinician)
36. Students, e.g., MD, RN
37. Others as designated by Medical Center Policies and /or Medical Staff Bylaws

VI. Completion, Timeliness and Authentication of Medical Records

A. All inpatient Medical Records must be completed within 14 days from the date of discharge (California Code of Regulations, Title 22, section 70751). Additional requirements may also be included in the applicable UC__ hospital Medical Staff By-Laws and/or Rules and Regulations.

B. All operative and procedure reports must be completed immediately after surgery.

C. All Medical Record entries are to be dated, the time entered, and signed.

D. Certain electronic methods of authenticating the Medical Record, including methods such as passwords, access codes, or key cards may be allowed provided certain requirements are met. The methodology for authenticating the document electronically must comply with UC__ electronic signature standards (*See Section XII below: Authentication of Entries*). The entries may be authenticated by a signature stamp or computer key, in lieu of a medical staff member's signature, only when that medical staff member has placed a signed statement with the Medical Center to the effect that the member is the only person who: 1) has possession of the stamp or key (or sequence of keys); and 2) will use the stamp or key (or sequence of keys).

E. Fax signatures are acceptable.

VII. Routine Requests for Medical Records for Purposes of Treatment, Payment and Healthcare Operations ("TPO")

The Health Information Management Services staff will process routine requests for Medical Records. All charts physically removed from the Medical Record storage areas will be logged, e.g., using a computerized tracking system

Only authorized UC__ workforce members may access Medical Records in accordance with Privacy Policy and Procedure No. ____, *"Employee Access to Protected Health Information ("PHI")."* UC__ Workforce members (as defined in Policy No. ____) who access Medical Records for payment or healthcare operations are responsible to access only the amount of information in medical records which is necessary to complete job responsibilities.

A. Access to Medical Records for Treatment Purposes.

Healthcare providers who are directly involved in the care of the patient may access the full Medical Record in accordance with Policy No. ____.

B. Payment Purposes.

Authorized and designated UC__ workforce members may access the patient's medical record for purposes of obtaining payment for services, including the following uses:

1. Coding and abstracting;
2. Billing including claims preparation, claims adjudication and substantiation of services;
3. Utilization Review; and
4. Third Party Payor Reviews (including Quality Improvement Organization reviews).

C. Healthcare Operations.

Patient medical records may be accessed for routine healthcare operation purposes, including, but not limited to:

1. Peer Review Committee activities;
2. Quality Management reviews including outcome and safety reviews;
3. Documentation reviews; and
4. Teaching.

D. Requests for Electronic Components of the Medical Record.

Personnel who access the electronic Medical Record are required to have a unique User ID and password, and access to information is limited according to the minimum necessary rule and managed by role, as approved by designated management personnel.

VIII. Ownership, Responsibility and Security of Medical Records

A. All Medical Records of UC__ patients, regardless of whether they are created at, or received by, UC__, and patient lists and billing information, are the property of UC__ and The Regents of the University of California. The information contained

within the Medical Record must be accessible to the patient and thus made available to the patient and/or his or her legal representative upon appropriate request and authorization by the patient or his or her legal representative.

B. Responsibility for the Medical Record. The UC__ Director of Medical Information (Health Information Services) is designated as the person responsible for assuring that there is a complete and accurate medical record for every patient. The medical staff and other health care professionals are responsible for the documentation in the medical record within required and appropriate time frames to support patient care.

C. **Original records may not be removed from UC__ facilities and/or offices except by court order, subpoena, or as otherwise required by law.** If an employed physician or provider separates from or is terminated by the University for any reason, he or she may not remove any original Medical Records, patient lists, and/or billing information from UC__ facilities and/or offices. For continuity of care purposes, and in accordance with applicable laws and regulations, patients may request a copy of their records be forwarded to another provider upon written request to UC__.

D. Medical records shall be maintained in a safe and secure area. Safeguards to prevent loss, destruction and tampering will be maintained as appropriate. Records will be released from Health Information Management Services only in accordance with the provisions of this policy and other UC__ Privacy Policies and Procedures.

E. Special care must be exercised with Medical Records protected by the State and federal laws covering mental health records, alcohol and substance abuse records, reporting forms for suspected elder/dependent adult abuse, child abuse reporting, and HIV-antibody testing and AIDS research. (Refer to Policy No. _____. "*Authorization for Use/Disclosure of PHI*".)

F. Chronology is essential and close attention shall be given to assure that documents are filed properly, and that information is entered in the correct encounter record for the correct patient, including appropriate scanning and indexing of imaged documents.

IX. Retention and Destruction of Medical Records

All Medical Records are retained for at least as long as required by State and federal law and regulations, and UC__ policies and procedures (*see*: *"Records Retention"* and No. ____, *"Records Storage and Destruction*"). The electronic version of the record must be maintained per the legal retention requirements as specified in Policy No. _____ (UC Campus) "*Record Retention*" or consult with Campus Legal Counsel.

A. In the event that an original Medical Record cannot be located, a temporary medical record folder will be created as follows:

1. All identified original documentation held for filing in the original record will be included in the temporary folder;

2. A notation will be made in the record by the Medical Records Department Supervisor or Manager that the record is a temporary chart being used until the original can be located;
3. As needed, online documents will be printed and filed into the temporary folder;
4. The temporary folder will be tracked in the computerized chart tracking system by means of a special volume number to distinguish it from the original and to indicate that it is a temporary chart;
5. Upon location of the original record, all material from both the original and temporary folder will be incorporated into the original folder, and the temporary folder will be removed from the computerized tracking system.

X. Maintenance and Legibility of Record

All Medical Records, regardless of form or format, must be maintained in their entirety, and no document or entry may be deleted from the record, except in accordance with the destruction policy (refer to section IX).

Handwritten entries should be made with permanent black or blue ink, with medium point pens. This is to ensure the quality of electronic scanning, photocopying and faxing of the document. All entries in the medical record must be legible to individuals other than the author.

XI. Corrections and Amendments to Records

When an error is made in a medical record entry, the original entry must not be obliterated, and the inaccurate information should still be accessible.

The correction must indicate the reason for the correction, and the correction entry must be dated and signed by the person making the revision. Examples of reasons for incorrect entries may include "wrong patient," etc. The contents of Medical Records must not otherwise be edited, altered, or removed. Patients may request a medical record amendment and/or a medical record addendum. *(Refer to UC__ policy for handling patient requests for record amendment and record addendums.)*

A. Documents created in a paper format:

1. Do not place labels over the entries for correction of information.
2. If information in a paper record must be corrected or revised, draw a line through the incorrect entry and annotate the record with the date and the reason for the revision noted, and signature of the person making the revision.
3. If the document was originally created in a paper format, and then scanned electronically, the electronic version must be corrected by printing the documentation, correcting as above in (2), and rescanning the document.

B. Documents that are created electronically must be corrected by one of the following mechanisms:

1. Adding an addendum to the electronic document indicating the corrected information, the identity of the individual who created the addendum, the date created, and the electronic signature of the individual making the addendum.
2. Preliminary versions of transcribed documents may be edited by the author prior to signing. A transcription analyst may also make changes when a non-clinical error is discovered prior to signing (i.e., wrong work type, wrong date, wrong attending assigned). If the preliminary document is visible to providers other than the author, then this document needs to be part of the legal health record.
3. Once a transcribed document is final, it can only be corrected in the form of an addendum affixed to the final copy as indicated above. Examples of documentation errors that are corrected by addendum include: wrong date, location, duplicate documents, incomplete documents, or other errors. The amended version must be reviewed and signed by the provider.
4. Sometimes it may be necessary to re-create a document (e.g., wrong work type) or to move a document, for example, if it was originally posted incorrectly or indexed to the incorrect patient record.

C. When a pertinent entry was missed or not written in a timely manner, the author must meet the following requirements:

1. Identify the new entry as a "late entry"
2. Enter the current date and time – do not attempt to give the appearance that the entry was made on a previous date or an earlier time. The entry must be signed.
3. Identify or refer to the date and circumstance for which the late entry or addendum is written.
4. When making a late entry, document as soon as possible. There is no time limit for writing a late entry; however, the longer the time lapse, the less reliable the entry becomes.

D. An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry.

1. Document the date and time on which the addendum was made.
2. Write "addendum" and state the reason for creating the addendum, referring back to the original entry.
3. When writing an addendum, complete it as soon as possible after the original note.

E. Errors in Scanning Documents

If a document is scanned with wrong encounter date or to the wrong patient, the following must be done:

1. Reprint the scanned document.
2. Rescan the document to the correct date or patient, and void the incorrectly scanned document in the permanent document repository.

F. Electronic Documentation – Direct Online Data Entry

Note: The following are guidelines for making corrections to direct entry of clinical documentation, and mechanisms may vary from one system to another.

1. In general, correcting an error in an electronic/computerized medical record should follow the same basic principles as corrections to the paper record.
2. The system must have the ability to track corrections or changes to any documentation once it has been entered or authenticated.
3. When correcting or making a change to a signed entry, the original entry must be viewable, the current date and time entered, and the person making the change identified.

G. Copy and Paste Guidelines

The "copy and paste" functionality available for records maintained electronically eliminates duplication of effort and saves time, but must be used carefully to ensure accurate documentation and must be kept to a minimum.

1. Copying from another clinician's entry: If a clinician copies all or part of an entry made by another clinician, the clinician making the entry is responsible for assuring the accuracy of the copied information.
2. Copying test results/data: If a clinician copies and pastes test results into an encounter note, the clinical-provider is responsible for ensuring the copied data is relevant and accurate.
3. Copying for re-use of data: A clinician may copy and past entries made in a patient's record during a previous encounter into a current record as long as care is taken to ensure that the information actually applies to the current visit, that applicable changes are made to variable data, and that any new information is recorded.

XII. Authentication of Entries

A. Electronic signatures must meet standards for:

1. Data integrity to protect data from accidental or unauthorized change (for example "locking" of the entry so that once signed no further untracked changes can be made to the entry);
2. Authentication to validate the correctness of the information and confirm the identity of the signer (for example requiring signer to authenticate with password or other mechanism);
3. Non-repudiation to prevent the signer from denying that he or she signed the document (for example, public/private key architecture).

At a minimum, the electronic signature must include the full name and either the credentials of the author or a unique identifier, and the date and time signed.*

B. Electronic signatures must be affixed only by that individual whose name is being affixed to the document and no other individual.

C. Countersignatures or dual signatures must meet the same requirements, and are used as required by State law and Medical Staff Rules and Regulations.

D. Initials may be used to authenticate entries on flow sheets or medication records, and the document must include a key to identify the individuals whose initials appear on the document.

E. Rubber stamp signatures: *Refer to Section VI (D).*

F. Documents with multiple sections or completed by multiple individuals should include a signature area on the document for all applicable staff to sign and date. Staffs who have completed sections of a form should either indicate the sections they completed at the signature line or initial the sections they completed.

G. No individual shall share electronic signature keys with any other individual.

H. *Macros & Checklists*. Pre-printed forms, checklists, patient questionnaires, and word-processing macros can be used to supplement written or dictated notes. When using an electronic medical record, it is acceptable for the teaching physician to use a macro as the required personal documentation, if the teaching physician adds it personally in a secured (password protected) system. In addition to the teaching physician's macro, either the resident or the teaching physician must provide customized, patient specific information that is sufficient to support a medical necessity determination. The note in the record must sufficiently describe the specific services furnished to the specific patient on the specific date. It is insufficient documentation if both the resident and the teaching physician use macros which do not contain patient specific information. Medical record macros and checklists may be used to supplement provider written or dictated notes.

XIII. Designation of Secondary Patient Information

The following three categories of data contain secondary patient information and must be afforded the same level of confidentiality as the LMR, but are not considered part of the legal medical record.

A. Patient-identifiable source data are data from which interpretations, summaries, notes, etc. are derived. They often are maintained at the department level in a separate location or database, and are retrievable only upon request. Examples:

1. Photographs for identification purposes
2. Audio recordings of dictation notes or patient phone calls.
3. Video recordings of an office visit, if taken for other than patient care purposes

** Acknowledge that there may be older systems that do not have this capability. Future plans for all system to meet this minimum requirement.*

4. Video recordings/pictures of a procedure, if taken for other than patient care purposes

5. Video recordings of a telemedicine consultation

6. Communication tools (i.e., Kardex, patient lists, work lists, administrative in-baskets messaging, sign out reports, FYI, drafts of notes, or summary reports prepared by clinicians, etc.)

7. Protocols/clinical pathways, best practice alerts, and other knowledge sources.

8. A Patient's personal health record provided by the patient to his or her care provider.

9. Alerts, reminders, pop-ups and similar tools used as aides in the clinical decision making process. The tools themselves are not considered part of the legal medical record. However, the associated documentation of subsequent actions taken by the provider, including the condition acted upon and the associated notes detailing the exam, are considered as component of the legal medical record. Similarly, any annotations, notes and results created by the provider as a result of the alert, reminder or pop-up are also considered part of the legal medical record.

Some source data are not maintained once the data has been converted to text. Certain communication tools are part of workflow and are not maintained after patient's discharge.

B. Administrative Data is patient-identifiable data used for administrative, regulatory, healthcare operations and payment purposes. Examples include but are not limited to:

1. Authorization forms for release of information

2. Correspondence concerning requests for records.

3. Birth and death certificates.

4. Event history/audit trails.

5. Patient-identifiable abstracts in coding system.

6. Patient identifiable data reviewed for quality assurance or utilization management.

7. Administrative reports.

C. Derived Data consists of information aggregated or summarized from patient records so that there are no means to identify patients. Examples:

1. Accreditation reports

2. Best practice guidelines created from aggregate patient data.

3. ORYX reports, public health records and statistical reports.

D. Draft Documents / Work in Progress. Electronic processes and workflow

management require methods to manage work in progress. These work-in-progress documents often are available in the system as "draft documents, viewable to a limited number of users. They generally are not viewable to clinicians until the document is sent for final signature. Draft documents are not considered an official medical record document until it has been signed by an authorized signer.

XIV. ENFORCEMENT, CORRECTIVE & DISCIPLINARY ACTIONS

Compliance with the above policy is monitored by UC__ Department of _____. Violations of any of the above policy will be reported to the appropriate supervising authority for potential disciplinary action, up to and including termination and/or restriction of privileges in accordance with UC__ Medical Staff ByLaws, and Human Resource / Personnel Policies.

RELATED POLICIES

- *Each UC may insert a list of related policies and forms or include the list as a separate Appendix,*
- Authorization for Release of Information; and Access to the medical record
- Patient Requests for Record Amendment and Record Addendums
- Auditing of access to medical records
- "Notice of Privacy Practices"; and in other UC__ Privacy Policies and Procedures.
- "Authorization for Use/Disclosure of PHI"
- Employee Access to Protected Health Information ("PHI")
- "Records Retention"
- "Records Storage and Destruction
- Verbal / Telephone Orders

APPROVAL

REVISION HISTORY

REFERENCES

Health Insurance Portability and Accountability Act (HIPAA) Privacy & Security Rule, 45 CFR 160-164
California Medical Information Act, California Civil Code Section 56 *et seq*.
Medicare Conditions of Participation, 42 CFR Section 482.24
Title 22 California Code of Regulations, Sections 70749, 70527, and 71549
Business Records Exception, Federal Evidence 803(6)
California Code of Regulations, Title 22, Section 70751
California Healthcare Association Manual – Authentication sections

Appendix A

Documentation Contents of the Medical Record

The medical record shall include, at a minimum, the following items (if applicable):

A. Identification information, which include but are not limited to the following:

1) Name.
2) Address on admission.
3) Identification number (if applicable).
    1. Medicare.
    2. Medi-Cal.
    3. Hospital Number
    4. Social Security Number.
4) Age.
5) Sex.
6) Marital status.
7) Legal status.
8) Mother's Maiden name
    (i) Patient's Mother's maiden name
    (ii) Place of Birth
9) Legal Authorization for admission (if applicable).
10) School Grade, if applicable
11) Religious Preference.
12) Date and time of admission (or arrival for outpatients).
13) Date of time discharge (departure for outpatients).
14) Name, address and telephone number of person or agency responsible for patient.
15) Name of patient's admitting/attending physician.
16) Initial diagnostic impression.
17) Discharge or final diagnosis and disposition.
18) Allergy records.
19) Advance Directives (if applicable).
20) Medical History including, as appropriate: immunization record, screening tests, allergy record, nutritional evaluation, psychiatric, surgical and past medical history, social and family history, and for pediatric patients a neonatal history.
21) Physical examination.
22) Consultation reports.
23) Orders including those for medication, treatment, prescriptions, diet orders, lab, radiology and other ancillary services.
24) Progress notes including current or working diagnosis (excluding psychotherapy notes).
25) Nurses' notes, which shall include, but not be limited to, the following:
    i. Nursing assessment including nutritional, psychosocial and functional assessments.

ii. Concise and accurate record of nursing care administered.
iii. Record of pertinent observations including psychosocial and physical manifestations and relevant nursing interpretation of such observations.
iv. Name, dosage and time of administration of medications and treatment. Route of administration and site of injection shall be recorded if other than by oral administration.
v. Record of type of restraint and time of application and removal.
vi. Record of seclusion and time of application and removal. (NPH)

25) Graphic and vital sign sheet.

26) Results of all laboratory tests performed.

27) Results of all X-ray examinations performed.

28) Consent forms for care, treatment and research, when applicable.

29) Problem List (outpatient records only).

30) Emergency Department record.

31) Anesthesia record including preoperative diagnosis, if anesthesia has been administered.

32) Operative and procedures report including preoperative and postoperative diagnosis, description of findings, technique used, and tissue removed or altered, if surgery was performed.

33) Pathology report, if tissue or body fluid was removed.

34) Written record of preoperative and postoperative instructions.

35) Labor record, if applicable.

36) Delivery record, if applicable.

37) Physical, Occupational and/or respiratory therapy assessments and treatment records, when applicable.

38) Patient/Family Education Plan (NPH Only)

39) Clinical Data set from other providers.

40) Master Data Sets (as applicable to record type) including but not limited to : MDS (Skilled Nursing), OASIS (Home Health), IRF and PAI (Rehabilitation).

41) Patient Photographs when used for identification or treatment.

42) Master Treatment Plan and Reassessment (NPH only).

43) Discharge Instructions

44) A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, final diagnoses, his/her condition on discharge and the recommendations and arrangements for future care. If applicable it shall include diet and self-care instructions.

45) Copies of letters to patients.

46) Email communications between the patients and the provider regarding the care and treatment of the patient.

47) Telephone Encounters. Documentation is required for telephone encounters with patients and/or their caregivers, or other care providers that:

1. Provide new or renewal of prescription for medications
2. Alter the current plan of care, including treatments and medications
3. Identify a new system or problem and provide a plan of care
4. Provide home care advice for symptom/problem management
5. Provide authorization for care
6. Provides or reinforces patient education

Documentation should include the date and time of call, name of caller and relationship to patient (if different from patient), date and time of the response (or attempts to return call), the response given, and the signature and professional title of provider or clinic staff handling the call.

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HEALTH CARE RECORDS RETENTION MANUAL

JUNE 2013

SBM STATE BAR OF MICHIGAN

HEALTH CARE LAW SECTION

Health Care Records Retention Manual

FOREWORD

The Publications Committee, a Committee of the State Bar of Michigan, Health Care Law Section, is extremely pleased to offer the 2013 Edition of the Health Care Records Retention Manual. The 2013 Edition is the third edition of this Manual, having been first created in 2002 and then updated in 2009.

The 2013 Edition was updated by Publications Committee Member **Sheerin Siddique**, who devoted substantial time and resources to this project. Sheerin was assisted by earlier versions of this Manual, which provided an important starting point for the 2013 Edition, and was supported in her efforts by the Publications Committee of the Health Law Section, whose members include:

Monica P. Navarro, Chair
Gregory Nowakowski
Mercedes Dordeski
Sheerin Siddique
Tariq S. Hafeez

One of the Health Care Law Section's primary goals is to help lawyers serve their health care clients more effectively through education and information. We hope this Health Care Records Retention Manual will be a lasting contribution to achieving that goal.

Monica P. Navarro
Council Member of the Health Law Section and
Publications Committee Chair

INTRODUCTION

The 2013 Edition of the Health Care Records Retention Manual, like the previous editions, was prepared to assist lawyers of the State of Michigan in researching the retention requirements for the types of records prepared by health care facilities and providers such as hospitals, clinical laboratories, health maintenance organizations, and pharmacies. In their efforts to abide by sound health care business practices and to comply with state and federal statutes, rules and regulations and accreditation and contractual requirements, health care facilities and providers prepare countless records pertaining to almost every aspect of their operations. Record keeping is tremendously expensive due to the cost of equipment and space and the time spent by health care professionals, administrative staff and executives in preparing, organizing, developing, managing, accessing and storing patient clinical records and other documents. Faced with burgeoning files, limited storage space, and administrative cost restraints, health care clients often ask their attorneys how long they must retain records. To help members of the Health Care Law Section and other lawyers answer these questions, this Manual, as updated, provides a reference to record retention laws.

The editors of the Manual endeavored to be thorough in researching federal and state statutes, rules, and regulations. In using the Manual as a research aid, attorneys should be aware that record retention requirements are often contained in contracts, policies and procedures of third-party payers and other entities with whom a health care provider transacts business. For example, a hospital's contract with a health maintenance organization or Blue Cross Shield of Michigan may require the hospital to retain certain records for longer periods than the periods prescribed by the state and the federal statutes, or rules and regulations applicable to the hospital. In addition, accrediting and other professional and industry organizations may recommend different retention periods. For this reason, the authors and editors decided *not* to make recommendations concerning appropriate retention periods. With respect to many records, however, experience in a particular case or cases may dictate longer retention periods than mandated by statutes, regulations, or written standards and guidelines. Records relating to the Medicare and Medicaid programs and physical plant are examples of such records.

The Manual covers patient medical records and other selected topics thought to be appropriate and helpful. The Manual does not address general business and financial records.

Previous versions of the Manual contained a separate section entitled "Impact of Statutes of Limitations on Record Retention." That section is currently being updated and will be provided as a supplement to this Manual when the update is completed.

Because health care providers often are plaintiffs, petitioners, defendants or respondents in civil and criminal actions before state and federal courts and regulatory agencies, their attorneys should consider record retention requirements in the context of potential investigations or litigation. The minimum record retention periods prescribed by state licensing laws may not be sufficient to ensure that adequate records will be available to a health care provider defending against, for example, an alleged violation of the state or federal fraud and abuse laws, or a medical malpractice action by an individual who allegedly suffered an injury at birth.

The Manual is a tool to assist in researching record retention questions and requires the user's skillful application. The Health Care Law Section makes no representation or guarantee with respect to the contents herein and specifically disclaims any implied guarantee of suitability for any specific purpose. The Health Care Law Section has no liability or responsibility to any person or entity for loss or damage caused by the use of this Manual.

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CLINICAL INFORMATION

Electrocardiograms, Electroencephalograms, and Electromyograms	42 CFR § 482.26(d)(2): Hospital must retain records of radiologic services for at least five (5) years: (i) copies of reports and printouts; (ii) films, scans, and other image records, as appropriate.	Not found.	None.
Emergency Room Central Logs	42 CFR § 489.20(r)(3): Hospitals must maintain a central log on each individual who comes to the emergency department (as defined in Sec. 489.24(b)) seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred or discharged. These records likely must be retained for five (5) years. (See 489.20(r)(1)).	Not found.	None.
Emergency Room Physician-On-Call Lists	42 CFR § 489.20(r)(2): Hospitals must maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize individuals with emergency medical condition. These records likely must also be maintained for 5 years. (See 489.20(r)(1)).	Not found.	None.
Emergency Room – Transfer	42 CFR§ 489.20(r)(1): Hospitals must maintain medical and other records related to individuals transferred to or from the hospital for a period of five (5) years from the date of transfer.	Not found.	None.
Fetal Heart Monitor Strips	42 CFR § 482.24(b)(1): Medical records	American Health Information	

	must be retained in their original or legally reproduced form for at least five (5) years.	Management Association Position Statement (June 1999): The AHIMA recommends that fetal heart monitor strips be retained for ten (10) years after infant reaches age of majority.	
Laboratory, Blood and Pathology Reports	42 CFR § 493.1107; 42 CFR § 493.1109: Preliminary and final test reports, including, if applicable, instrument printout, must be retained by the testing laboratory for at least two (2) years after date of report. Immunohematology records and transfusion records must be retained by the laboratory for at least five (5) years in accordance with 21 CFR part 606, subpart I. Records of blood and blood product testing must be retained for at least five (5) years after completion of processing records or six (6) months after latest expiration date, whichever is later, in accordance with 21 CFR § 606.160(d). Pathology test reports must be retained for at least ten (10) years after date of report. This information may be maintained as part of patient's chart or medical record which must be readily available to lab and HHS.	Not found.	The record system must provide documentation of information specified in Sec. 493.1105(a) through (f) and include the information specified in Sec. 493.1107(a) through (d).
Mammograms	42 USC § 263b(f)(1)(G); 21 CFR § 900.12(c)(4)(i): Mammography facilities must maintain original mammography reports in permanent medical record for not less than five (5) years, or not less than ten (10) years if no additional mammograms	Not found.	Note: There are also very specific training and continuing education requirements and records should probably be kept demonstrating compliance.

	are performed, or longer if State or local law mandates. MCL § 333.13523: (i) The facility which has authorized a radiation machine to be used for mammography must at least annually have a qualified radiation physicist provide on-site consultation to the facility, including, but not limited to, a complete evaluation of the entire mammography system to ensure compliance with this part of the rules. The records of the consultation required under (i) and the findings must be maintained for seven (7) years. MCL § 333.13523(2)(g)(v): Facility maintains annual reports concerning outcome data for correlation of positive mammograms to biopsies done and the number of cancers detected. MCL 333.20175: A health facility or agency must keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization. Unless a longer retention period is otherwise required under federal or state laws or regulations or by generally accepted standards of medical practice, a health facility or agency shall keep and		

	retain each record for a minimum of seven (7) years from the date of service to which the record pertains. Mich. Admin. Code R 325.5657: Mammography facilities must maintain original mammography reports in permanent medical record for not less than seven (7) years.		
Medical Records: Health Facilities Generally	42 CFR § 482.24(b)(1): Inpatient and outpatient records must be retained in their original or legally reproduced form for at least five (5) years. MCL § 333.20175(1): A health facility or agency must keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided and, in the case of a hospital, the purpose of hospitalization. Unless a longer retention period is otherwise required under federal or state laws or regulations or by generally accepted standards of medical practice, a health facility or agency shall keep and retain each record for a minimum of seven (7) years from the date of service to which the record pertains. MCL § 400.111b(8): Providers must retain records necessary to document fully the extent and cost of services, supplies or	American College of Obstetricians and Gynecologists, Guidelines for Women's Health Care (1996); American Academy of Pediatrics, American College of Obstetricians and Gynecologists, Guidelines for Perinatal Care (3d ed. 1992): Retain records in accordance with law and good medical practice. American Hospital Association, Management Advisory (1990): Retention period varies depending on purpose for which record is being kept. Such purposes include a health care institution's needs relating to patient care, clinical and/or scientific research, assessment	None.

	equipment provided to a medically indigent individual for (seven) 7 years after the date of service. MCL § 750.492a: A healthcare provider or other person, knowing that information is misleading or inaccurate, shall not intentionally, willfully or recklessly place or direct another to place in a patient's medical record or chart misleading or inaccurate information regarding the diagnosis, treatment or cause of a patient's condition. The above does not apply to either of the following: (a) All information contained in the medical record or chart is otherwise retained by means of photography, mechanical or electronic recording, chemical reproduction, or other equivalent techniques which accurately reproduce all information contained in original; (b) Supplementation or correction of an error in a patient's medical record or chart in a manner that reasonably discloses the supplementation or correction was performed and that does not conceal or alter prior entries. Mich. Admin. Code R 325.1028(5): A hospital shall require accurate and complete	activities pertaining to the quality of patient care, and the possibility of future patient litigation. The appropriate period of retention may also be affected by state or local statutes relating to the retention of medical records as well as the statute of limitations for bringing a legal action for an injury or breach of contract. Because a health care institution is seldom requested to produce medical records older than ten (10) years, it is recommended that complete patient medical records be retained, either in the original or reproduced form, for ten (10) years after the most recent date of patient care, in the absence of legal considerations and unless destruction of the original/reproduced record is specifically prohibited by statute, ordinance, regulation, or laws. After ten (10) years, at least the following information should be retained:	

	medical records be preserved as original records, abstracts, microfilms or otherwise so as to afford a basis for a complete audit of professional information.	(i) dates of all visits; (ii) admission and discharge dates; (iii) names of responsible physicians; (iv) records of diagnoses and procedures, including any applicable physician attestations; (v) history and physical records; (vi) operative and pathology reports; and (vii) discharge summaries. Additionally, the complete medical records of minors should be retained for the period of minority plus any applicable period of time specified in state statutes relating to retention of records of minors and/or the statute of limitations. Complete medical records may be retained longer when	

		requested in writing by any of the following individuals: (i) an attending or consulting physician of the patient; (ii) the patient or someone acting legally on the patient's behalf; or (iii) legal counsel for an individual having an interest affected by the medical records. Medical records shall be retained for a period of time established by the statutes of limitation in the state. American Medical Association, 1994 Code of Medical Ethics, 7.05(2): (1) AMA has actively supported and advocated the implementation of E-7.05. (2) Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes and chemotherapy should	

		always be part of a patient's chart. In deciding whether to keep certain parts of the record, an appropriate criteria is whether the physician would want the information if he/she were seeing the patient for the first time. (3) If a particular record no longer needs to be kept for medical reasons, the physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board. (4) In all cases, if a particular record is no longer needed for medical purposes, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice. (5) Whatever the statute of limitations, a physician should measure time from the last professional contact with the patient.	

		(6) If the patient is a minor, the statute of limitations may not apply until the patient reaches the age of majority. (7) In order to preserve confidentiality when discarding old records, all documents should be destroyed. (8) Before discarding old records, patients should be given the opportunity to claim them or have them sent to another physician. Joint Commission Accreditation Manual for Hospitals, IM.6.1: Retention time of record is determined by the hospital, based on law and regulation and the information's use for patient care, legal, research, and educational purposes. 1999 Accreditation Handbook for Ambulatory Care, Accreditation Association for Ambulatory Health Care (AAAHC): Requires organization to have policies that	

		address retention of active clinical records and the retirement of inactive clinical records and the retention of diagnostic images. American Health Information Management Association Position Statement (June 1999): Retain adult patient medical records for ten (10) years after most recent encounter and minor patient medical records until the age of majority plus the statute of limitations.	
Immunization/Vaccines	42 USC § 300aa-25: Retention periods are not specified. However, each healthcare provider who administers a vaccine set forth in the Vaccine Injury Table (42 CFR 100.3) to any person shall, within seven (7) days of administering the vaccine, record, or ensure that there is recorded, in such person's permanent medical record (or in a permanent office log or file to which a legal representative shall have access upon request) with respect to each such vaccine the date of administration of the vaccine, the vaccine manufacturer and lot number of the vaccine, the name and address and, if appropriate, the title of the healthcare provider administering the vaccine required pursuant to regulation promulgated by the	Not found.	None.

	Secretary.		
Nuclear Medicine	42 CFR § 482.53(d)(1): Retain copies of nuclear medicine reports for at least five (5) years.	Not found.	None.
Surgery Log Book	Not found.	American Health Information Management Association: The AHIMA recommends that surgery log books be retained permanently and the operative index be retained for ten (10) years.	None.
Video and Audio Tapes, Including Diagnostic Procedures	42 CFR § 482.26(d)(2): Hospital must retain records of radiologic services for at least five (5) years: (i) copies of reports and printouts; (ii) films, scans, and other image records, as appropriate.	American Hospital Association, Management Advisory (1990): Video and audio tapes are sometimes made during the patient's stay in the facility. The purposes for which these tapes are made vary and the hospital should establish retention requirements for them based upon the purposes for which they were made. There is no definitive standard that requires them to be treated as a part of the medical record.	None.
X-ray Films	42 CFR § 482.26(d)(2): Hospital must retain records of radiologic services for at least five (5) years: (i) copies of reports and printouts; (ii) films, scans, and other image records, as appropriate.	American Health Information Management Association (AHIMA): The AHIMA recommends retaining x-rays for five (5) years for adults and five (5) years after the	None.

		age of majority for minors.	
Abortions and Related Medical Services Documentation	42 CFR § 36.56: Medical Records for abortions received under federal programs (Indian health or research grant fund) must be retained for three (3) years.	Not found.	None.
Maternity Hospitals and Departments	Mich. Admin. Code R 325.1056(j): Records of the bacteriologic check of infant formulas and water solutions prepared in the formula room and the attached nipples shall be maintained for 1 year from the date of the bacteriologic check.	Not found.	None.
Transplantation of Human Tissue	21 CFR § 1270.33(h): All persons or establishments that generate records used in determining the suitability of the donor of human tissue for transplantation shall retain the records for at least ten (10) years beyond the date of transplantation, if known, distribution, disposition or expiration of the tissue.	Not found.	None.
Local Health Department Venereal Disease	Mich. Admin. Code R 325.177: Shall retain records for not less than five (5) years, as required under the Administrative Code, after the last reactive test in Syphilis cases; for not less than one (1) year for other venereal diseases, and for not less than three (3) calendar years after the termination of pregnancy.	Not found.	None.

The following is based solely on Arizona Law, is Not Comprehensive and does not address any Federal requirements *Note: All medical records and payment records (A.R.S. § 12-2292) are privileged and confidential and may be disclosed only as authorized by state or federal law or written authorization signed by the patient or the patient's healthcare decision maker.*

How long do I need to maintain my patient's records?
The statutes (A.R.S. § 12-2297) require a physician to retain the original or copies of a patient's medical records for a minimum of six years past the last visit if the patient is an adult. If the patient is a child, a doctor must maintain the records until the child is 21 or for at least six years past the last patient visit - whichever is longer.

The patient has had other providers before becoming a patient of mine. When the patient requests the medical records, do I need to give him all the records or just the ones I've created for his/her care?
The definition of "Medical Records" in the statutes (A.R.S. § 12-2291(5))"means all communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of patient diagnosis or treatment, including medical records that are prepared by a health care provider or other providers." So, if the patient asks for his/her medical records, that includes everything in the chart, whether you created it or not.

If the patient owes my practice money for visits or treatment, is it okay to withhold his requested medical records until he pays his bill?
A.R.S. §12-2293(B and C)specifies six conditions under which a health care provider may deny a request for access to or copies of medical records or payment records. Delinquent balances are not an identified reason for withholding records.

Are there other times when I would be required to release a patient's medical records to third parties without the patient's written authorization?
Yes. A.R.S. §12-2294 and §12-2294.01 require physicians to disclose medical records without the patient's written authorization as required by law or when ordered by a court or tribunal of competent jurisdiction. This includes subpoenas. When required for diagnosis or treatment of the patient, a physician may disclose the medical records without written authorization from the patient to other healthcare providers. And the doctor may disclose them to other healthcare providers who have previously treated the patient without the patient's written approval. Doctors may also release them to ambulance attendants, to a private agency that accredits healthcare providers, to the Arizona Medical Board, to healthcare providers for peer review, to a person or entity that provides billing and administrative services, to an attorney for the purpose of obtaining legal advice, to the patient's third party payor, or to the Industrial Commission of Arizona.

A patient has died. To whom may I release his records if I receive a written request?
A doctor may release records to the patient's personal representative or administrator of his estate (A.R.S. §12-2294(D)) If no one has been appointed, a physician may release the records to the persons identified in A.R.S. §12-2294(D).

I'm planning to retire (and/or sell my practice) in the next year or so. What should I do with the medical records?
When a health care provider retires or sells the provider's practice, the provider shall take reasonable measures to ensure that the records are retained for the appropriate period of time (see above). (A.R.S. §12-2297(B))Additionally, A.R.S. §32-3211 requires a healthcare professional to "prepare a written protocol for the secure storage, transfer and access of the medical records." This protocol must specify the procedure by which you "will notify each patient in a timely manner" before you terminate or sell the practice "in order to inform the patient regarding the future location of the patient's medical records and how the patient can access those records."

You may dispose of unclaimed medical records after the specified period of time (see above) and after you have made "good faith efforts to contact the patient." The statute states that not complying with the requirements is an act of unprofessional conduct. Also, once your practice address and practice phone numbers are no longer accurate, state law (A.R.S. §32-1435)requires you to update your contact information with the Arizona Medical Board in writing within 30 days. There is a "Change of Address" form available on this Web site (under "Physician Center" in the homepage menu) for you to use. You may provide the Board with a mailing address for patients to request medical records after you are no longer practicing in Arizona or anywhere.

Please note: These answers are meant as a baseline guide and are not an exclusive list of all the legal requirements regarding record retention and release. Please read the entire content of the statutes cited above and consult with your own legal counsel for proper legal advice in any given situation.

Closing a Practice

I am closing my practice - what notice do I have to give patients and what do I do with my patient records?

If you are transferring medical records in conjunction with the sale or closure of your practice, §54.1-2405 of the Code of Virginia states:

"A. No person licensed, registered, or certified by one of the health regulatory boards under the Department shall transfer records pertaining to a current patient in conjunction with the closure, sale or relocation of a professional practice until such person has first attempted to notify the patient of the pending transfer, by mail, at the patient's last known address, and by publishing prior notice in a newspaper of general circulation within the provider's practice area, as specified in § 8.01-324.

The notice shall specify that, at the written request of the patient or an authorized representative, the records or copies will be sent, within a reasonable time, to any other like-regulated provider of the patient's choice or provided to the patient pursuant to § 32.1-127.1:03. The notice shall also disclose whether any charges will be billed by the provider for supplying the patient or the provider chosen by the patient with the originals or copies of the patient's records. Such charges shall not exceed the actual costs of copying and mailing or delivering the records.

B. For the purposes of this section:
"Current patient" means a patient who has had a patient encounter with the provider or his professional practice during the two-year period immediately preceding the date of the record transfer.

"Relocation of a professional practice" means the moving of a practice located in Virginia from the location at which the records are stored at the time of the notice to another practice site that is located more than 30 miles away or to another practice site that is located in another state or the District of Columbia.

From Virginia Board of Medicine
http://www.dhp.virginia.gov/medicine/medicine_faq.htm