Medical Records: Definition, Retention, and Completion

What's the Risk?

Medical records serve a number of different purposes, depending on the audience. For practitioners and clinical staff members, the medical record serves as a chronology of the patient's medical history. For coders, billers, and third-party payers, the documentation in a medical record serves as substantiation for reimbursement purposes. For regulatory agencies, professional boards, and attorneys, the medical record may serve as evidence. The Centers for Medicare and Medicaid Services (CMS) specify that every patient should have a medical record, and "medical records must be accurately written, promptly completed, accessible, properly filed, and retained."[1]

This chapter covers the general risks associated with a medical record, regardless of whether the record is paper, electronic, or a combination of both (hybrid). General medical record risks include:

- Failing to define what constitutes a medical record.
- Failing to retain medical records for the appropriate length of time.
- Failing to ensure that medical records are complete and accurate.

When Is This Risk an Issue?

Defining the Medical Record

Patient information comes in many forms from many sources. In addition to documents and information created by the practice's staff members, records may come from other healthcare organizations, diagnostic testing centers, insurance companies, third-party payers, and governmental and regulatory agencies. Patient information may also come in different formats, such as paper records (office notes, reports, forms, photographs, and flow sheets) or electronic records (digitally stored office notes, electronically received reports/information, digital images, voicemail, email, and/or information received through a portal, from a health information exchange, from a monitoring device or system, and/or in the form of a personal health record). Sorting through all of the available information and determining what is appropriate to include in the patient's medical record can be challenging.

It is helpful to think of a medical record in terms of two sets: the designated record set and the legal health record. HIPAA regulations define the designated record set (in part) as:

- A group of records maintained by or for a covered entity that is:
    - The medical records and billing records about individuals maintained by or for a covered health care provider;

COPYRIGHTED

This document is a work product of Coverys' Risk Management Department. This information is intended to provide general guidelines for risk management. It is not intended and should not be construed as legal or medical advice. The links included in this document are being provided as a convenience and for informational purposes only; they are not intended and should not be construed as legal or medical advice. Coverys Risk Management bears no responsibility for the accuracy, legality or content of the external site or for that of subsequent links. Contact the external site for answers to questions regarding its content.

Updated: September 2021

- The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
- Used, in whole or in part, by or for the covered entity to make decisions about individuals.[2]

The designated record set is composed of the records necessary for the business functions of the organization (treatment, payment, and healthcare operations). More specifically, the designated record is used to comply with the HIPAA rights of individuals to access, amend, restrict, inspect, and obtain a copy of and request amendments to their medical record, as well as restrict the release of medical and billing information.

The legal health record "serves to identify what information constitutes the official business record of an organization for evidentiary purposes."[3] For example, the AHIMA publication cited states: "The legal health record is the documentation of healthcare services provided to an individual during any aspect of healthcare delivery in any type of healthcare organization." [3] It is the subset of clinical documents released in response to legal requests, such as a subpoena, court order, or request from an attorney.

In litigation, the process of obtaining information that may be pertinent to the claims and defenses is called discovery. It is essential to carefully and clearly define the legal health record as the organization may assert applicable privileges to restrict certain components of information related to the patient's care from discovery. For example, documentation related to quality improvement and risk management is often subject to privilege and excluded from discovery. The rationale for the privilege is that practitioners and organizations may be more likely to participate in quality and risk activities in a comprehensive way if the results of these processes cannot be used against them in court.

Record Retention

Federal and state regulations govern how long to maintain and retain medical records. Retention lengths vary based on the type of document. Failure to appropriately retain records may result in regulatory or accreditation actions.

Medical record retention is also driven by statutes of limitation, which are laws specifying the maximum time a claimant can wait before filing a lawsuit. Statutes of limitation are set by state and federal law. Failing to maintain the records for at least the length of time dictated by the applicable statute of limitation may result in a spoliation of evidence charge against the practice.

Incomplete Medical Records

Medical records must be current and accurate to serve their purposes. An incomplete record is of reduced evidentiary value in a regulatory or legal investigation, presents a patient safety risk

COPYRIGHTED

This document is a work product of Coverys' Risk Management Department. This information is intended to provide general guidelines for risk management. It is not intended and should not be construed as legal or medical advice. The links included in this document are being provided as a convenience and for informational purposes only; they are not intended and should not be construed as legal or medical advice. Coverys Risk Management bears no responsibility for the accuracy, legality or content of the external site or for that of subsequent links. Contact the external site for answers to questions regarding its content.

Updated: September 2021

COVERYS

for ongoing care, and cannot be billed. The medical record serves as the legal record of a patient's care, and it must be credible. In order for a record to be credible, it must be completed in a timely manner and be truthful, accurate, and authenticated by the practitioner. Incomplete records are difficult to defend, and sloppy or inaccurate records and pose significant legal risks to both the practitioner and the organization.

The medical record also serves to assist the patient care team in providing safe and effective care. Accordingly, the treatment plan, visit notes, and medication, allergy, and problem lists must be as current as possible. Failure to maintain a current and accurate record presents significant safety risk to the patient. Incomplete records decrease the ability of subsequent practitioners to provide safe and effective care and increase the risk of error.

Medicare and other third-party payers will not accept incomplete, unsigned records for billing purposes.

How Can I Reduce Risk?

Define the Legal Health Record	
Classify record components	• Recognize that: The determining factor in whether information is to be considered part of the legal health record is not where it resides or the format it takes, but rather how it is used and whether it may be reasonably expected to be routinely released when a request for a complete medical record is received.[3] • Develop and maintain an inventory of documents and data that comprise the legal health record. • Recognize that: ○ Information used for clinical decision-making, such as clinical notes, reports, and diagnostic findings, are generally part of the legal health record. ○ Billing records may or may not be part of the legal health record, depending on the organization's policy and any supervening state requirements.

COPYRIGHTED

This document is a work product of Coverys' Risk Management Department. This information is intended to provide general guidelines for risk management. It is not intended and should not be construed as legal or medical advice. The links included in this document are being provided as a convenience and for informational purposes only; they are not intended and should not be construed as legal or medical advice. Coverys Risk Management bears no responsibility for the accuracy, legality or content of the external site or for that of subsequent links. Contact the external site for answers to questions regarding its content.

Updated: September 2021

COVERYS

Define the Legal Health Record	
	◦ The clinical documentation created to support billing is part of the legal health record. ◦ Clinical documentation improvement (CDI) communication with practitioners would not be considered part of the legal health record. ◦ Bills, explanation of benefit statements, and notes in the billing system are not usually included in the legal health record, but may be specifically requested by a regulatory agency or an attorney. Their release, as required, may be authorized by the patient or guardian.
Manage external records	• Recognize that records created by another provider or organization, called external records, are included in the HIPAA-defined designated record set. Unless state law is more restrictive, consider these records as part of the legal health record as well. • Work with practitioners to identify which elements of external records have been or will be used to make patient care decisions. Retain these documents in the patient's medical record. • Return unsolicited and/or unused portions of external records to the patient, or appropriately destroy them.
Implement policies and procedures	• Define the legal health record in the form of a policy. Consider developing a document matrix that identifies how each type of patient information is classified. See the sample ***Health Record Matrix***. • Develop and implement procedures to clarify when the legal health record will be released. • Include external record management strategies, as appropriate.

Retain Records as Required	
Understand record retention requirements	• Federal record retention requirements are limited, as federal agencies tend to defer to the states on record retention requirements. Most states have developed guidelines for record retention. These requirements may be found in general statutes or,

COPYRIGHTED

This document is a work product of Coverys' Risk Management Department. This information is intended to provide general guidelines for risk management. It is not intended and should not be construed as legal or medical advice. The links included in this document are being provided as a convenience and for informational purposes only; they are not intended and should not be construed as legal or medical advice. Coverys Risk Management bears no responsibility for the accuracy, legality or content of the external site or for that of subsequent links. Contact the external site for answers to questions regarding its content.

Updated: September 2021

COVERYS

Retain Records as Required	
	in some cases, in the regulations and guidelines of regulatory agencies/bodies.
Comply with federal record retention requirements	• Retain HIPAA-related policies, procedures, and documents for six years from the date of creation or the date when the policy, procedures, or document was last in effect, whichever is later.[4] • Retain employee exposure records, employee medical records, and chemical inventory or Safety Data Sheets for 30 years.[5] • Retain rural health clinic records for six years from date of last entry.[6] Please note: Coverys recommends retaining clinical records for 10 years after the date of the last entry – please see below. • Retain drug treatment clinic records for three years.[7] • Retain mammograms for five years, or not less than 10 years, if no additional mammograms of the patient are performed at the facility.[8]
Comply with state record retention requirements	• Determine the record retention requirements in your state and comply with them.
Develop a policy and procedures	• Develop a record retention schedule and codify it in policy and procedures. • Designate individuals responsible for ensuring compliance with the record retention policy and procedures. • Periodically audit records for compliance.
Retain clinical records for 10 years	• In the absence of formal federal or state requirements, and/or when federal and state requirements are less strict, retain clinical records for: o 10 years after the patient's most recent visit, o 10 years after the patient's death, or o 10 years after the patient reaches the age of majority.
Thin and purge, if necessary	• Recognize that, depending on record format and storage site capacity, it may become necessary to reduce the volume of a clinical record. This process

COPYRIGHTED

This document is a work product of Coverys' Risk Management Department. This information is intended to provide general guidelines for risk management. It is not intended and should not be construed as legal or medical advice. The links included in this document are being provided as a convenience and for informational purposes only; they are not intended and should not be construed as legal or medical advice. Coverys Risk Management bears no responsibility for the accuracy, legality or content of the external site or for that of subsequent links. Contact the external site for answers to questions regarding its content.

Updated: September 2021

COVERYS

Retain Records as Required

is called "thinning" or "purging." Thin or purge records as needed according to the following:

- Thin and store older and/or nonessential components of a medical record in long-term storage. Maintain documentation of what was removed, the storage location, and retrieval instructions.
- Remove and destroy duplicate documents and interim and draft reports, unless the final report is significantly different from the interim report and treatment decisions were based on the interim report.

Manage Incomplete Records

Define expectations

- Establish clear expectations for completing clinical documentation. For example:
  - Require progress notes to be finalized (closed and authenticated) within two working days.
  - Require practitioners to review, revise, and authenticate speech recognition dictation notes within two working days.
  - Require practitioners to review, correct, and authenticate transcribed notes within two working days of receipt.

Audit record completion

- Monitor compliance with record completion requirements. Share practitioner-specific completion rate information with practitioners during staff meetings. Practitioners who are performing below expectations may be encouraged to improve their own performance when presented with that of their peers.
- Establish corrective action plans for practitioners who are consistently late in completing records. Strategies that may prove effective include:
  - Re-examine practitioner workload to determine if revising the patient schedule or encouraging delegation of some tasks would result in more time to document.

COPYRIGHTED

This document is a work product of Coverys' Risk Management Department. This information is intended to provide general guidelines for risk management. It is not intended and should not be construed as legal or medical advice. The links included in this document are being provided as a convenience and for informational purposes only; they are not intended and should not be construed as legal or medical advice. Coverys Risk Management bears no responsibility for the accuracy, legality or content of the external site or for that of subsequent links. Contact the external site for answers to questions regarding its content.

Manage Incomplete Records	
	○ Assign a peer to evaluate the practitioner's time management and documentation skills. Provide additional training on the record system, as appropriate. ○ Consider the use of a scribe. ○ Consider disciplinary action when necessary. Some practices have achieved results by establishing sliding scale fines based on the number of records and/or total days delinquent. ○ Recognize that state medical boards may have specific rules related to medical record accuracy and completion. A physician who is consistently delinquent in record completion may be subject to medical board review. In fact, failure to maintain timely and accurate records may be a mandatory reportable event.
Manage open records	• Establish processes for other practitioners to manage patient information when the primary practitioner is out of the office for an extended period, such as on vacation or on a leave of absence. • Recognize that it is not acceptable to ask other practitioners to close and authenticate records pertaining to care that they were not directly involved in providing. • Develop a policy and procedures for filing records as incomplete or closed without completion. There may be occasions when a practitioner is unavailable or unable to complete records. When there is no chance that a record will be completed, designated practice leaders should make the determination to close the record. In a paper record, include a brief note (dated, timed, and signed) that the record has been closed without completion. Closing an electronic medical record without completion will require someone with system administrative privileges to complete the closure. Ensure that no billing has been submitted and return any received payments, including any copays.

COPYRIGHTED

This document is a work product of Coverys' Risk Management Department. This information is intended to provide general guidelines for risk management. It is not intended and should not be construed as legal or medical advice. The links included in this document are being provided as a convenience and for informational purposes only; they are not intended and should not be construed as legal or medical advice. Coverys Risk Management bears no responsibility for the accuracy, legality or content of the external site or for that of subsequent links. Contact the external site for answers to questions regarding its content.

Updated: September 2021

COVERYS

Manage Incomplete Records	
Do NOT bill open records	• Do NOT bill open records. Ensure that billing staff members review billing documentation appropriately and notify both the practitioner and practice manager when delinquent records affect the billing cycle.

References:

1. Centers for Medicare & Medicaid Services. *Medical Record Retention and Media Formats for Medical Records – JA1022.* https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/JA1022.pdf. Published August 23, 2010. Accessed August 11, 2021.
2. 45 CFR § 164.501.
3. AHIMA. Fundamentals of the legal health record and designated record set. *J AHIMA*, Vol. 82, No.2. February 2011 (expanded online version). https://library.ahima.org/doc?oid=104008#.YQxshYhKg2x. Accessed August 11, 2021.
4. 45 CFR § 164.316(b)(2)(i) and § 164.530(j)
5. 29 CFR § 1910.1020(d)(1), 29 CFR § 1915.1020, and 29 CFR § 1926.33.
6. 42 CFR § 491.10(c).
7. 21 CFR § 291.505(d)(13)(ii).
8. 21 CFR § 900.12(c)(4)(i).

COPYRIGHTED

This document is a work product of Coverys' Risk Management Department. This information is intended to provide general guidelines for risk management. It is not intended and should not be construed as legal or medical advice. The links included in this document are being provided as a convenience and for informational purposes only; they are not intended and should not be construed as legal or medical advice. Coverys Risk Management bears no responsibility for the accuracy, legality or content of the external site or for that of subsequent links. Contact the external site for answers to questions regarding its content.

Updated: September 2021

COVERYS