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CLINICAL STANDARDS FOR RETENTION AND DESTRUCTION OF PATIENT FILES

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Purging patient records is NOT a clear process.

Before purging records, it is important keep up with all known rules and regulations and to develop your own internal "clinic standard for retention and destruction of clinic records" which includes Medical Record Purging/Destruction Log and a Record Destruction Policy.

This is for written files (patient and business) and/or x-rays.

This is designed to help you research and develop your own clinical standard for the retention and destruction of clinical records.

Developing a clinic standard for retention and destruction of clinic records:

When deciding to establish a clinic standard for retention and destruction of clinic records, it is important to review all known references and review those references on a regular basis to ensure they are up to date.

To follow are some areas to consider:

Wisconsin administrative codes, HIPAA, OSHA, CMS, and other rules:

- DHS 21.03 (1) Minimum Standards for Patient Health Records.
- DHS 124.14 Medical Record Services
    - Both of these statutes state that healthcare records shall be maintained for a minimum period of 5 years.
- Chir Chapter 6.02(27)
    - This states to maintain patient records for a minimum period of 7 years after the last treatment or after the patient reaches the age of maturity whichever is greater.
- OSHA regulations
    - Employers must retain SDSs for the duration of employment plus 30 years for all employees exposed to the chemical in question, unless there is some other record of the identity of the substance or chemical, where it was used and when it was used. The employer must also be sure it has a copy of all SDSs for all chemicals that are currently in use. It is also advisable for employers to retain employee hazard communication training records for the duration of employment.

- HIPAA rules
  - 6-year retention of HIPAA Policy and Procedures Records.
  - There is NO Rules as it relates to Retention of Medical Records. Retention of Healthcare Records follows State Guidelines.
- Medicare policies for the retention and destruction of clinic records.
  - CMS requires Medicare managed care program providers to retain records for 10 years.
- How to handle records of minors.
- Employee records
- Business records
- And others

Once we feel we have all the appropriate information we can then develop a "clinical standard" for retention, destruction, and preservation of clinic records.

To follow are examples of clinical standards, logs and other information. These examples are to be used as a guideline to help us think through the development of a clinical standard for the retention, destruction and/or preservation of clinic records for our individual situation.

XXX Chiropractic - Clinic Standard for Retention and Destruction of Clinic Records.

Record destruction may be implemented for XXX Chiropractic Clinic based on the following time frames:

Healthcare records

- Medicare – 10+ years.
- Workers compensation/Auto Accident and Personal injury – TBD
- Minors – Healthcare record: when they reach 18 + 7 years or at age 25.
  - X-rays - age 18 + 10 years.
- All other Healthcare record classes – 7+ years.
- X-rays – 10 years.

Healthcare business documents:

- HIPAA Policies, Procedures, incidents or other – 6 years after any changes of policies, procedures, following any incidents, etc.
- Employee records – 7+ years
- OSHA – documents 30 years
- Compliance related records – TBD (possible 6 years with the HIPAA information)

XXX Chiropractic - Medical Record Purging/Destruction Log

A log must be completed of records destroyed.

The following log will be kept as the Record Destruction Log:

- Name of Clinic
- Date of destruction company
- Method of destruction
- Attach all supporting documentation of destruction company
- Patient Name
- Date of Birth
- Time frame of services destructed for each patient

XXX Chiropractic – Medical Record Retention & Purge Log

Disposal of Records Containing Personal Information-WI Statute 134.97

(2) Disposal of records containing personal information. A financial institution, medical business or tax preparation business may not dispose of a record containing personal information unless the financial institution, medical business, tax preparation business or other person under contract with the financial institution, medical business or tax preparation business does any of the following:

(a) Shreds the record before the disposal of the record.

(b) Erases the personal information contained in the record before the disposal of the record.

(c) Modifies the record to make the personal information unreadable

(d) Takes actions that it reasonably believes will ensure that no unauthorized person will have access to the personal information contained in the record for the period between the record's disposal and the record's destruction.

XXX Chiropractic – Medical Record Destruction Clinical Standard.

Medical records:

- XXX Chiropractic contracts with ZZZ Shredding Company. ZZZ Shredding Company will come and bring containers and shred onsite. This is the HIPAA approved method. Per guidelines, protected health information (PHI) must be destroyed following HIPAA guidelines. The number for ZZZ Shredding Company is (000) 000-0000.
- All records/invoices are kept with the Medical Record Purging/Destruction Log.

X-rays:

- LLL X-ray purging company picks up x-rays.
- Date is documented on log sheets.
- All records/invoices are kept with the Medical Record Purging/Destruction Log.

XXX Chiropractic Clinic implemented this retention and destruction of clinic records standard on October xx, 20xx.

XXX Chiropractic Clinic began purging patient records on October xx, 20xx and purge records based on the standard.

The Clinic Standard for Preservation of Medical Records for XXX Chiropractic Clinic is based on the following:

Chir Chapter 6.02(27) it states to **maintain patient records** for a minimum **period of 7 years** after the last treatment or after the patient reaches the age of maturity whichever is greater.

There is no mention of retaining **original copies**, nor does Chapter Med 21, DHS 21.03 minimum standards for patient healthcare records.

DHS 124.14 Medical record services.

(2) Service.

(a) *General requirement.* The hospital shall have a medical records service with administrative responsibility for all medical records maintained by the hospital.

(b) *Confidentiality.*

1. Written consent of the patient or the patient's legally authorized representative shall be presented as authority for release of medical information to persons not otherwise authorized to receive this information.

2. Original medical records may not be removed from the hospital except by authorized persons who are acting in accordance with a court order, a subpoena issued under s. 908.03 (6m), Stats., or in accordance with contracted services, and where measures are taken to protect the record from loss, defacement, tampering and unauthorized access.

(c) *Preservation.* There shall be a written policy for the preservation of medical records, either the original record or in the form of microfiche. The retention period shall be determined by each hospital based on historical research, legal, teaching, and patient care needs but records shall be maintained for at least 5 years.

XXX Chiropractic - Preservation of Medical Records Clinical Standard:

Healthcare record preservation may be implemented for XXX Chiropractic Clinic based on the following:

Preservation of the original healthcare record will be in the original record or in the form of (microfiche, scanning into digital format, or whatever format you choose) and will be preserved for a minimum of 7 years.

XXX Chiropractic - Medical Record Preservation Log

A log should be completed of records preserved.

The following log will be kept as the Record Preservation Log:

- Name of Clinic
- Date of Preservation
- Method of Preservation
- Attach all supporting documentation of the preservation process or the preservation company
- Patient Name
- Date of Birth
- Time frame of when services were preserved for each patient
- Preservation of the entire medical record for the timeframe preserved
- How and where to gather the preserved Medical Record information if/when requested