
RETAINING AND DISCARDING PSYCHIATRIC RECORDS

It should go without saying that a patient record exists for a reason -- it exists *primarily* to support good patient care. A good patient record accomplishes several things: It substantiates clinical judgment and choices; it demonstrates the knowledge and skill exercised during treatment; it provides a contemporary assessment of the patients' needs and behaviors; and it documents explanations of the provider's decisions, significant events, and revisions to the treatment plan. In short, it allows someone else (e.g., another physician) to know and understand what has happened during treatment and why.

A secondary benefit derived from a good patient record is the ability to provide a defense in an adversarial situation such as litigation or an administrative or ethics complaint. The importance of patient records in these types of situations cannot be overemphasized.

Retaining Records

How long should records be kept? There is no clear answer. Due to the variety of statutes, regulations, legal principles, and professional obligations affecting psychiatric records, the best risk management advice dictates that records should be kept for as long as possible. The safest and most conservative option is to keep records indefinitely. Perpetual maintenance may seem excessive, but there are many reasons your records may be needed in the future. If records cannot be kept indefinitely, they should be kept as long as possible.

How long am I "legally" required to keep records?

Many states have statutes and/or regulations governing the creation and maintenance of patient records, including the time period for which records must be kept. Federal statutes and/or regulations may also address record maintenance. The time periods mandated in these statutes and regulations represent the length of time you are "legally" required to keep patient records, *at a minimum*.

In addition to statutory and/or regulatory requirements, there may be contractual obligations regarding record creation and maintenance in provider contracts, both explicit and implicit. Frequently, provider contracts include provisions mandating how long records must remain available to patients and insurance companies. If a contract requires you to keep records for a different amount of time than is laid out in the relevant statutes and/or regulations, then you should keep the records for whichever time period is the longest, at a minimum.

Absent explicit requirements, records should be kept *at least* until well after your state's statute of limitation for medical malpractice actions and/or statute of repose have run. The statute of limitations laws and/or the statutes of repose establish the time period during which a legal action may be brought against you. However, you cannot absolutely rely on these statutes to protect you from litigation. Depending on the nature and wording of a complaint, an action may be brought against you even though it is not brought within the limitation periods. In addition, statutes of limitations or repose do not apply to disciplinary actions by licensing/medical boards or to ethics proceedings. Professional complaints may be made against you at any time.

Why should I keep records indefinitely?

1) Continuity of Care

One of the most important reasons for retaining records is continuity of care. Patients may receive care from a patchwork of healthcare providers over time, and the psychiatric records may be necessary to ensure that patients continue to receive the care they need. Patients who find that they are unable to obtain their medical information whenever requested can initiate complaints with professional and licensing bodies. Increasingly, medical boards and state/federal regulators are starting to insist that patient records be available *whenever needed*.

2) Potential Lawsuits

Another reason records may be needed is litigation. In a legal proceeding against you, the record is the primary means of supporting and defending the care that was given. As mentioned above, your state's statute of limitations laws and/or statutes of repose exist to limit the time period during which an action may be filed, however there are exceptions to these statutes. For example, state law usually also contains provisions for "tolling" the statute of limitations in cases where the patient (i.e., prospective litigant) is a minor or suffers under some other legal disability or incompetence. This means that for some patients, the time in which a suit can be filed is extended.

Additionally, your state's statutes of limitations that limit the time during which malpractice actions may be filed against physicians may not limit the time litigation resulting from allegations involving fraud, conspiracy, or criminal acts may be brought against you. Furthermore, these laws are not applicable to professional and ethical complaints or allegations involving federal laws, rules, and regulations (e.g., Medicare billing complaints).

3) Other Situations

There are other situations in which a record may be needed, besides defending you. For example, a patient may need the record to support his case against another individual (e.g., another healthcare professional or an employer) or to back-up a claim for disability benefits. Custody proceedings are another common example.

How do I store records?

Records should *always* be stored somewhere safe and secure, and should be accessible only to authorized individuals. All psychiatrists are ethically obligated to keep the psychiatric record secure. There may also be legal requirements under state

law, as well as federal law. For instance, per HIPAA's privacy and security regulations, covered providers must comply with standards to ensure security and prevent unauthorized disclosure. Remember that the duty to maintain the confidentiality of patient records does not diminish over time, nor does it cease to exist upon the death of the patient.

Should you choose to keep your records indefinitely or for an extended period of time, you may want to consider using a professional records storing company. Such companies may be found online or through the records department of the local hospital or medical society. Your personal attorney or accountant may also be able to suggest a company.

If a storage company is used, it should have experience handling confidential medical information, guarantee the security and confidentiality of records, and allow access by authorized individuals. You should have a written agreement with the storage company. Topics which should be addressed specifically in the written agreement include but are not limited to confidentiality and privilege, release of information, time in which it will take to retrieve records, and destruction of information. If you are a covered provider under HIPAA's Privacy Rule, you will need a "Business Associate Agreement" with the storage company. All contracts should be reviewed by personal counsel.

Discarding & Destroying Records

If, after careful consideration, you do decide to discard and destroy patient records, there are some important considerations to keep in mind. Primarily, you should develop and implement a retention schedule and destruction policies and procedures. Records involved in open litigation, investigation, or audit should *not* be destroyed.

How do I discard & destroy records?

Should you choose to discard and destroy records, it is *imperative* that you establish and follow written policies and procedures for doing so. Following an established procedure may help to mitigate potential allegations that a record was destroyed in order to conceal unfavorable information. It *cannot* be guaranteed to protect you from situations in which you need the record; the absence of a record is problematic in any type of proceeding.

Some jurisdictions require that you notify patients that their records will be destroyed. Even if not required, notifying patients is always prudent. Patients may want copies forwarded to them or their current physician for future use. Remember to always obtain a proper release authorization prior to releasing any information.

Destroy *completely* all records and copies of records selected for discarding. Different media require different methods of destruction: shred, burn, or pulverize paper records; recycle or shred microfilm or microfiche; purge and destroy computerized records. Whatever method is used, ensure that third parties cannot discern or reconstruct patient information from destroyed records.

Retain a log of what records were destroyed, how and when they were destroyed, the inclusive dates covered, what method of destruction was used, a statement that the records were destroyed in the normal course of business, and the signatures of the individuals supervising and witnessing the destruction. Maintain destruction documentation permanently.

In addition, you may want to consider keeping an abbreviated patient record containing basic information, including the intake form, dates of treatment, diagnosis, release of information forms, termination forms, and case summaries, etc.

Who else can I contact for information?

For additional information on retaining and discarding records, contact your state medical board, your local medical society, your local APA district branch, and other professional medical organizations to which you belong. The American Health Information Management Association (AHIMA), a professional healthcare information organizations, is an invaluable resource.

Below are some risk management tips regarding retaining & discarding psychiatric records.

DO review and be familiar with statutory, regulatory, and contractual obligations regarding records creation, retention, and discarding. In addition to federal law, including HIPAA, most states have statutes and/or regulations governing the creation, maintenance, and discarding of patient records. Even when such requirements are absent, it is the standard of care to create and maintain a record for each patient. The safest and most conservative option is to never destroy patient records.

DO understand that you cannot absolutely rely on your state's statute of limitations for medical malpractice or the statute of repose to protect you from legal actions. Depending on the nature and wording of a complaint, a legal action may be brought against you even though it is not brought within the limitation period.

DO understand that the records of minors and patients with some other legal disability or incompetence may fall under statutory tolling provisions. This means that for some patients, the time in which a suit can be filed is extended.

DO understand that your state's statutes that limit the time during which malpractice actions may be filed against physicians would not be applicable in litigation resulting from complaints or allegations involving fraud, conspiracy, criminal acts, or federal laws, rules, and regulations. For example, your state's statute of limitations laws would not apply to allegations of Medicare billing fraud.

DO remember that there is no "statute of limitations" or "statute of repose" for disciplinary actions by licensing/medical boards or for ethics proceedings. Absent state and/or federal or contractual requirements, legal experts advise keeping records indefinitely and, *at a minimum*, until well after your state's statute of limitations for medical malpractice and/or statute of repose have run.

DO keep records somewhere safe and accessible only to those who have authorization.

DO consider using a professional records storage company. Since you are responsible for ensuring the confidentiality of your patients' records, make sure that the records storage company agrees to protect patients' confidentiality in your agreement/contract with the company. If you are a covered provider under HIPAA's Privacy Rule, the confidentiality agreement with the records storage company is a "Business Associate Contract", containing all the elements required under that regulation.

DO develop and implement a retention schedule and written policies and procedures for destroying records. Following an established procedure may help to mitigate future potential allegations that a record was destroyed in order to conceal unfavorable information. It *cannot* be guaranteed to protect you from situations in which you need the record.

DO NOT destroy records involved in open litigation, investigation, or audit.

DO destroy *completely* all records selected for discarding. Different media require different methods of destruction. Ensure that third parties cannot discern or reconstruct patient information from destroyed records.

DO retain a log of the destruction. Include information about what records were destroyed, how and when they were destroyed, the inclusive dates covered, what method of destruction was used, a statement that the records were destroyed in the normal course of business, and the signatures of the individuals supervising and witnessing the destruction. Maintain destruction documentation permanently.

Additional Resources:

American Health Information Management Association (AHIMA): www.ahima.org

American Psychiatric Association (APA): www.psych.org

American Medical Association (AMA): www.ama-assn.org

American Hospital Association (AHA): <http://www.aha.org>

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