

MEDICAL RECORDS RETENTION

Managing the information accumulating daily is one of the biggest burdens of a medical practice. Being able to effectively utilize available storage space is vital, so it is important to be aware of the state regulations for retention to cut down on such burden and costs.

Regulations of the Board of Medicine ([18VAC85-20-26](#)) state that practitioners must maintain a patient record for a **minimum of six years following the last patient encounter** with the following exceptions:

1. Records of a minor child, including immunizations, must be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child;
2. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative; or
3. Records that are required by contractual obligation or federal law to be maintained for a longer period of time.

Other laws and regulations may apply.

- Virginia follows a continuous course of treatment rule, which postpones the onset of the two-year statute of limitations period until treatment related to the alleged malpractice discontinues.
- **Children:** If the patient was a child under the age of eight years at the time of time of the alleged malpractice, a claim may be filed on behalf of the child for malpractice until the child reaches age 10, and if the child is eight years of age or older, the action generally must be commenced within two years after the alleged malpractice, subject to the extensions above.
- Given the variance in the statutes of limitations, providers often retain records for at least 10 years from the last date of service.
- Review your managed care contracts to determine what individual requirements they have. The Centers for Medicare & Medicaid Services (CMS) requires Medicare Managed Care Program providers to [retain records for 10 years](#).
- Records of employee exposure to blood borne pathogens ([OSHA requirements](#)) need to be obtained for a minimum of 30 years.

Retention of associated documents

- Charge tickets/encounter forms, superbills and remittances should be kept for a minimum of six years, since the False Claims Act has a six-year statute of limitations. These items are not necessarily considered part of the medical record. Other retention guidelines may apply. Check with your payers for contract retention requirements, retention of certain documents for IRS purposes and consult with your accountant.
- Records of deceased or mentally incapacitated patients

According to Virginia law, medical records of the deceased should also be maintained for six years following the last patient encounter (minus any exceptions listed in 18VAC85-20-26). Health care entities may, and, when required by other provisions of state law, shall, disclose health records of a deceased or mentally incapacitated individual:

- to the personal representative or executor of the deceased individual or the legal guardian or committee of the incompetent or incapacitated individual; or
- if there is no personal representative, executor, legal guardian or committee appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, a parent, an adult sibling or any other relative of the deceased individual in order of blood relationships.

Medical record destruction, retention and storage

Practitioners must post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records can only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

There are several different options a practitioner can take to ensure that their patients have access to medical records after closing or selling a practice. The following means for storage and retention should all be considered:

- A custodial agreement can be signed with a third party vendor or commercial firm who is certified as a medical records manager. Per the agreement, the custodian of the records must maintain records in the condition they were received, have no right to access the information contained in records without a signed release by patient, will release copies of records to patient or patient's authorized representative, shall comply with all applicable state and federal laws, and shall notify provider of any change in address or phone number of custodian. If the records are being stored at a unit, is important to be aware of the vendor's rights if payment is not made on the unit.
- Records can be passed on to a like-regulated provider. Practitioners should ensure future access through a written agreement.
- Practitioners may decide on self-storage. However, providers must still ensure that patients are able to obtain their records from within the last six years of patient encounters and other provisions of 18VAC85-20-26 and that the records are kept in a climate controlled and secure area. This option could create an administrative burden on the practitioner.
- Paper medical records can be transferred to a technological means of storage. If the technological means is unalterable, the paper records may be destroyed per [§ 54.1-2403.2](#).