LOS ANGELES GENERAL MEDICAL CENTER POLICY

Subject: **HEALTH/MEDICAL RECORD: RETENTION OF RECORD**	Original Issue Date: 1/03/77	Policy # **404**
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Policy Owner(s): Director of Health Information Management
Executive Sponsor(s): Chief Operations Officer

Departments Consulted:	Reviewed & approved by:	Approved by:
Health Information Management Information Systems Medical Administration Health Information Committee	Attending Staff Association Executive Committee Senior Executive Officer	Chief Operations Officer Chief Executive Officer

PURPOSE

To provide guidance regarding medical record retention and destruction for all Department of Health Services facilities in compliance with regulatory requirements.

DEFINITIONS:

1. Retention Period: The total time a medical record is kept. For DHS, the retention period for paper medical records is 20 years following discharge/treatment.
2. Disposition: The action which accomplishes the preservation, storage, and disposal of records.
3. Disposal: The elimination of records by destruction.
4. Minor Patient: Person younger than 18 years of age, unemancipated.
5. Emancipated Minor: Considered to be an adult for the purpose of consenting to medical care. A minor that comes with the any of the following categories:

    a. Emancipated by court order. Minors 14 years of age or older may petition a state court or emancipation.

    b. Minors on active duty with U.S. Armed forces regardless of age.

    c. Married or formally married.

Electronic Medical Records: Collection of patient health information stored in digital format, including point of care documentation.

POLICY

I. RETENTION PERIOD FOR PAPER MEDICAL RECORDS

A. Paper medical records of adult patients shall be retained 20 years following discharge/last encounter.

B. Paper medical records of minor patients shall be retained 20 years following discharge/last encounter.

C. Fetal monitoring strips have not been consistently filed within the paper medical records and have been stored separately. These will be maintained for 20 years following discharge/last encounter.

D. Medical records involved in civil or criminal litigation or regulatory activities, shall be maintained until DHS legal counsel determines the medical records may be destroyed, but not before 20 years following discharge/last encounter.

E. Current patients' paper medical records for encounters beyond 20 years will be destroyed. Current patients include those with encounters occurring during the 20-year retention period.

F. The facility must obtain Department of Health Services' Chief Financial Officer approval to maintain medical records beyond the retention period.

G. Medical records involved in financial audits shall be maintained until DHS' Chief Financial Officer determines they may be destroyed, but not before 20 years following discharge/last encounter.

H. Destruction of records shall be approved by the facility's Chief Financial Officer to ensure there are no outstanding audits, consistent with DHS Policies and Procedures.

I. Paper documents digitized to comprise the electronic medical record shall not be maintained once uploaded to the EMR.

J. The retention of medical records is further defined by two tiers to distinguish the extent to which records shall be produced for release of information purposes versus financial audits as directed by DHS finance. The following tiers outline the specific types of information that will be retained to satisfy minimum requirements for the legal statute of limitations, specific needs directed by financial audit requirements, and information technology governance.

a. Tier 1: The information systems that contain patient information, both downstream applications and legacy systems, shall be maintained for ten years in accordance with regulatory requirements. Information from downstream applications can be found in the repository legal medical record system.
b. Tier 2: The legal medical record retained for twenty years to satisfy requirements related to legal proceedings and financial audits. For specific document types that comprise the legal medical record, see DHS policy number "Legal Medical Record".

II. RETENTION and DESTRUCTION OF ELECTRONIC RECORDS

A. Electronic Medical Record System

a. The legal medical record generated electronically will be subject to retention periods in accordance with regulatory requirements.
b. DHS will implement policies and procedures to address the final disposition of electronic health information.
c. Retention policies for electronic records must address both transferring information for longer-term storage and purging of information from the system.
d. DHS shall ensure the safety and integrity of all electronic media used to store medical records by employing:
    i. An offsite backup storage system
    ii. A mechanism to ensure that once a record is input, it is unalterable.

III. X-RAY FILMS RETENTION PERIOD

A. X-ray films must be kept for the time prescribed for retention of paper medical records.

IV. PROCEDURES

A. Onsite Preparation for Destruction of Medical Records

a. HIM Staff will recall paper medical records stored offsite using established tracking systems.
b. HIM Staff will conduct a review of recalled paper medical records to identify the records reflecting dates of services that exceed retention periods.
c. Paper medical records identified as exceeding the retention periods will be discarded via appropriate service (destruction vendor) at each facility.
d. HIM staff conducting review of medical records recalled from offsite storage will transfer the records to the designated containers designated for destruction.
e. Method of destruction– shredding or other method via contracted services that ensure safeguards against breaches of confidentiality.

B. Outsourced Destruction of Medical Records

a. When services are outsourced, the business associate will establish the permitted and required uses and disclosures and include the following elements:
   i. The Method of destruction or disposal
   ii. The time that will elapse between acquisition and destruction or disposal.
   iii. Safeguards against breaches.
   iv. Indemnification for the organization or provide for loss due to unauthorized disclosure.

C. Documentation of Medical Records Destroyed (Certification of Destruction)

a. Roster of medical records destroyed, generated onsite by HIM, will contain the following information:
   i. Date of destruction
   ii. Method of destruction
   iii. Description of disposed records
   iv. Patient Medical Record Number
   v. Patient Name
   vi. Inclusive Dates
   vii. A statement that the records were destroyed in the normal course of business.
   viii. Signature of the individuals conducting and supervising the destruction
   ix. Signature of facility HIM Director

1. AUTHORITY:

1. Title 22, California Code of Regulations, Section 70751 and 71551 establish the following minimum standards:

- Patients' records including x-ray films or reproductions thereof, must be preserved for a minimum of seven years following discharge of the patient, except that the records of unemancipated minors must be kept at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.

If a hospital ceases operation, arrangements must be made within 48 hours for the transfer and safe preservation of medical records for the time period required by the regulations. (DHS Policy 390.3, Protecting Health Information after Facility Closure).

2. A Guide to Hospital Record Retention — Published by California Association of Hospitals and Health Systems (CAHHS).

- Health facilities should retain the medical records of pregnant women for as long as they keep the records of their children, for at least 19 years.

3. 42CFR 482.24(b)(1), 42CFR 422.504(d)(2)(iii): The hospital maintains a medical record for each patient. Medical records must be accurately written, properly completed, properly filed, and retained and accessible. Medical Records must be retained in their original or legally reproduced form. The Organization maintains records for 10 years.

4. RC 01.05.01, The Joint Commission: The hospital retains its Medical Records. The retention time of the original or legally reproduced medical record is determined by its use and hospital policy in accordance with law and regulations. Patient health and medical records adults, 10 years after most recent encounter.

5. AHIMA, Retention and Destruction of Medical Records: Recommendation, Patient health and medical records (Adults) 10 years after the most recent encounter.

REVISION DATES:

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