Texas Medical Board

The Texas Medical Board has issued regulations specifying the time periods for which physicians should retain medical records. According to those rules a licensed physician shall maintain adequate medical records of a patient for a minimum of seven years from the anniversary date of last treatment by the physician. If a patient was younger than 18 years of age when last treated by the physician, the medical records of the patient shall be maintained by the physician until the patient reaches age 21 or for seven years from the date of last treatment, whichever is longer. A physician may not destroy medical records that relate to any civil, criminal, or administrative proceeding if the physician knows the proceeding has not been finally resolved. Physicians shall retain medical records for such longer length of time than that imposed by the regulations when mandated by other federal or state statute or regulation.¹

As that last sentence hints, the medical board regulations are not the only laws or regulations with which physicians may need to comply. The following are other laws that influence how long a physician should retain medical records.

Medicare

Medicare Part B Newsletters have, over the years, stressed the need to maintain medical records to substantiate payment. The Medicare Conditions of Participation may require retention of medical records for at least five years. However, the government is authorized to impose civil monetary penalties up to six years from the date a claim is submitted.² Thus, practices may consider a retention period of at least six years for Medicare billing and medical records.

Medicare Advantage health insurers are required to ensure that all contracts with physicians contain “accountability provisions.” Among these required provisions is a mandate that the physician will “maintain records a minimum of 10

¹ See 22 TAC §§ 165.1-165.3
² 42 CFR 1003.132.
Again, it is very important to review any contracts the practice may have with Medicare carriers to determine the necessary retention period.

**Medicare Managed Care Records**

Federal regulations specify the types of records that cost based and risk based HMOs and "competitive medical plans" (CMP) must maintain. A provider contract may provide that a provider shall maintain Medicare managed care-related records for the same period of time that the HMO/CMP must itself maintain records (three years from the settlement date of the contract between the HMO/CMP and CMS). Federal regulations also specify that CMS has access to the books and records of the HMO/CMP in order to evaluate the quality, appropriateness and timeliness of services. Thus the contract may require providers to grant similar access to the HMO/CMP and CMS. Practices might want to review your various managed care contracts and become familiar with the retention and access to records provisions contained within them.

**Medicaid**

In the Medicaid program, all records should be kept for a period of five years from the date of services or until all audit questions, appeal hearings, investigations or court cases are resolved. The term "Medicaid records" includes not only medical records, but financial records as well (claims, Remittance and Status Reports, checks, etc.). Previously, NHIC requested physicians sign a written “Agreement for Automatic Claims Submission” which obligates one to keep “source documents pertaining to each machine readable claim” for a six year period “after the month in which the claim was submitted.” The new claims manager is TMHP and practices will want to review any agreements for the retention policy. You also may want to visit TMHP’s website at: www.tmhp.com.

**Drug Records**

Physicians who maintain stocks of "dangerous drugs" in their office are required to maintain records of acquisition and disposal of such drugs for two years. (Note: pharmacists, not physicians, retain dangerous drug prescriptions for two years). Physicians who maintain inventories of controlled substances for administration, dispensing, or research must maintain records of their inventories for two years from the date of the inventory. An inventory must be taken every two years.

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3 Medicare Managed Care Manual, 100.4 - Provider and Supplier Contract Requirements.
4 42 CFR §§ 417.480 & 417.481.
5 42 CFR §417.482.
6 Texas Medicaid Provider Procedures Manual, 1.2.3, Retention of Records.
7 TEX. HEALTH & SAFETY CODE ANN. § 483.024.
8 21 CFR §1304.04.
9 21 CFR §1304.11(c).
Official Prescription Program

In 1997, the Legislature revised the sections of the Health and Safety Code that had once required the use and retention of “Triplicate Prescriptions.” Under the current system, only the pharmacist is responsible for maintaining records of controlled substance prescriptions and reporting to the DPS. Physicians are charged with taking reasonable precautionary measures to ensure that others do not use the official prescription forms.\(^{10}\)

Deceased Patients

The medical records of deceased patients should be kept at least seven years from the date of last treatment.

OSHA

Since 1992, the Occupational Safety and Health Administration has required that all physicians who have employees with "occupational exposure" (meaning reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from performance of the employee's duties) to maintain records (pertaining to blood borne pathogen exposure) on such employees for the duration of employment plus 30 years.\(^{11}\) If a medical practice is to be closed with no new physician taking it over, the Director of OSHA must be contacted within three months of the disposal of such records. The Director may require that the records be sent to OSHA.

Mammography

The Texas Department of State Health Services requires that “clinical images” of mammography be retained by the entity that produces them. The retention schedule is:

a. Five years, or

b. Ten years “if an additional mammogram of the same patient is not performed by the facility.” This essentially means the retention period is ten years for single-encounter mammograms.

c. If a patient’s medical records are “permanently” sent to another medical institution, the receiving institution will maintain and become responsible for the original film until the fifth or tenth anniversary as specified above.\(^{12}\)

Comments on Federal and State Tax Records

For those records that are kept for federal tax purposes, the law is somewhat unclear. The Internal Revenue Service regulations simply provide that “any person subject to tax...shall keep such complete and detailed records as are sufficient to enable the [IRS] to determine accurately the amount of liability....”

\(^{10}\) See TEX. HEALTH & SAFETY CODE ANN. § 481.075.
\(^{11}\) See 29 CFR §§ 1910.1020 and 1910.1030.
\(^{12}\) See 25 TAC § 289.230(c)(4)(D).
• Keep tax returns and supporting information 3 years from the date the return was filed. IRS Publication 552 advises keeping records 2 years from the date the tax was paid, or 3 years from the date the return was filed, whichever is longer.
• Keep records pertaining to deprecating assets indefinitely. (IRS Publication 552)
• Keep records of amounts paid to employees for 4 years after the date the return is filed, or the due date of the tax, whichever is longer. IRS Publication 552
• The IRS can bring a legal action to recover unpaid tax based on unreported income that is more than 25% of the income shown on the return for 6 years after the filing of the return.
• The IRS can bring a legal action based on the filing of a false or fraudulent tax return indefinitely, because a fraud action can be brought at any time.
• The rules do not seem to distinguish between taxpaying entities that are sole proprietorships, partnerships, or professional corporations.

Because of highly technical aspects of federal tax law, it is strongly recommended that you consult with your accountant and/or tax attorney to determine the proper retention period for your practice. Readers may want to obtain IRS Publication 552, “Record keeping for Individuals.” There is also a highly technical, “Guide to Record Retention Requirements,” published by CCH and available through internet booksellers, covering many situations. The guide is intended for accountants and tax attorneys. Google maintains a preview of this book at http://books.google.com. Perform a search for “Guide to Record Retention Requirements.”

If you are subject to the state franchise tax the Texas Tax Code provides that such taxes may be assessed up to four years after the time the tax becomes payable. This arguably translates into a four year retention period for financial records of the physician practice. As particular tax circumstances may dictate differing retention periods, again, it is prudent to contact your tax advisor for advice.

Managed Care Plans
Texas law does not govern the length of time a managed care plan must require physicians with which it contracts to retain records. These matters are left to terms of that contract as an item for negotiation. Many managed care plans will place provisions in either the contract or the physician manual dictating a retention schedule. Managed Care Plans are subject to certification examinations under NCQA and Healthcare Effectiveness Data and Information Set (HEDIS). To obtain certification, chart reviews are sometimes performed and the health plan will want to ensure that records are available for review.

13 26 CFR § 301.6501(a)-1.
14 26 CFR § 31.6001-1(e)(2).
15 26 CFR § 301.6501(e)-1.
16 26 CFR § 301.6501(c)-1
17 TEXAS TAX CODE § 111.201.
Hospitals
Texas law requires that hospitals retain all medical records for a period of ten years.\textsuperscript{18}

Medical Professional Liability
The statute of limitations for an adult person to file a personal injury action is two years.\textsuperscript{19} However, in certain types of cases, the courts have ruled that a plaintiff may show evidence that they could not have discovered the particular negligence until after two years had run from the date of last treatment, thus allowing the statute of limitations to be extended.\textsuperscript{20} In addition, the seventy five day statute of limitations “tolling” provision may apply under the Civil Practice and Remedies Code, so one might keep records for a minimum of two years plus seventy-five days. Although medical liability lawsuits are naturally a concern, physicians should be mindful that there are other regulatory mandates that dictate a greater period of retention.

Constructing a records retention policy that addresses potential professional liability claims is an uncertain process. Many physicians may worry: “if I destroy my old medical records, and then get sued, does that mean I will lose the lawsuit?” No definite conclusions can be drawn because the area continues to be litigated without any clear trends emerging. While it is clear that an absence of records deprives a defendant physician of the most important defense tool, it also deprives the plaintiff of evidence as well.

In a June 5, 1998 decision, the Texas Supreme Court held that “spoliation does not give rise to independent damages, and because it is better remedied within the lawsuit affected by spoliation, we decline to recognize spoliation as a tort cause of action.”\textsuperscript{21} (Spoliation is the intentional destruction or concealment of evidence in litigation). Although the Court declined to recognize an independent cause of action for spoliation of evidence, it shared the plaintiff’s concern that defendants should be subject to penalties for spoliation of evidence. The court concluded that “trial judges have broad discretion to take measures ranging from a jury instruction on the spoliation presumption to, in the most egregious cases, death penalty sanctions.”\textsuperscript{22} A “death penalty” sanction occurs when a judge strikes the pleadings of the offending party. This means the arguments of the offending party are removed from the record, leaving a decision to be made only on the remaining injured party’s filings. Plainly, the intentional destruction or alteration of medical records during the pendency of a malpractice case can have severe legal consequences. A practice is also at risk of receiving a spoliation instruction if its maintenance of medical records is negligent and are the records are lost – thereby depriving the patient of evidence.

\textsuperscript{18}TEX. HEALTH & SAFETY CODE ANN. § 241.103.
\textsuperscript{19}Texas Civil Practice and Remedies Code §74.251.
\textsuperscript{20}Morrison v. Chan, 699 S.W.2d 205 (Tex. 1985).
\textsuperscript{21}Trevino v. Ortega, 969 S.W.2d 950, 951 (1998).
\textsuperscript{22}Id. at 953.
Lost Medical Records
A permanently misplaced or lost medical record is likely to be viewed as a failure to maintain records in accord with TMB regulations or other law. A practice may find itself subject to TMB sanctions where a file is carelessly lost. In regard to natural disasters or other “acts of God,” it is possible a practice may avoid a sanction as the Texas Medical Practice Act (MPA) as the TMB may utilize its discretion and not impose a sanction for “good cause shown.”23 Perhaps destruction in a natural disaster is good cause for a failure to maintain records. The “crash” of an electronic medical records system – without a backup – may not be considered as good cause. Unfortunately, there is no accurate prediction one can make regarding the use of discretion in imposition of sanctions.

A practice that loses a medical record should do its best to reconstruct the record – but should not re-create a record without noting it is a reconstructed document. Perhaps some information relevant to the practice is also maintained by a hospital where the practice physician performed a surgical procedure on the patient. Should the records be recoverable in some fashion, there are services that can aid practices in salvaging the record. In an article appearing in MGMA Connexion, a practice manager details her practice’s recovery from a fire and water damage. The practice utilized the services of a document reprocessing company who sent the records to be freeze-dried and reprocessed.24 This eventually permitted the practice to recover some of what had been lost.

Electronic Health Records
The use of electronic health records is not directly addressed in Texas statutory law. Indirectly, one can infer that electronic health records are a valid method of maintaining medical records. For instance, the MPA states that when responding to a request for a copy of the medical record a physician “… may provide the copy, summary, or narrative on paper or using any other appropriate medium ….”25 This could include electronic records.

In legal proceedings, facts must be proven by the "best evidence" obtainable, and no evidence which is "merely substitutionary" in its nature may be received by a court so long as original evidence can be had. This is the real source of any worry - that is, an electronically generated medical record is not the "best evidence.” The general rule in Texas is, when the original document cannot be produced, a photocopy is admissible so long as there is no real dispute as to its being an accurate reproduction of the original. Thus, a computer generated printout of information stored electronically is admissible on the arguments that either 1) it is the best evidence (since there is no original hard copy) or 2) as acceptable secondary evidence on grounds that the original cannot be reproduced in court.

Fears that electronic health records are not acceptable to courts are likely unfounded. In a lawsuit between Baylor Medical Center and Travelers Insurance Company, the insurer argued that the electronic medical records were unreliable and required

23 Texas Occupations Code §164.001.
25 Texas Occupations Code §159.007.
additional testimony before they could be admitted as evidence.\textsuperscript{26} The appeals court almost summarily dismissed the insurer’s argument stating “the trial court properly admitted” the electronic records into evidence.\textsuperscript{27}

The same can likely be said of any fears related to scanned copies of medical records. A Texas court, in a dispute between two businesses, ruled upon the reliability and admissibility of electronic printouts that were copies of originals. The court held that the fact that the electronic printouts appeared to be copies of the originals did not render the records inadmissible. This was because an employee testified to their authenticity and accuracy.\textsuperscript{28} It is the authenticity of the electronic record that is at the heart of the issue. That is why electronic medical record systems allow for constant electronic surveillance to detect unauthorized access and provide audit trails for tracing leaks and alterations. It is so the electronic record can be said to be accurate and reliable. Nonetheless, so long as the copies to be admitted can be said to be authentic and accurate, a court will likely admit them into evidence.

Expect to see more use of electronic medical records. Electronic records offer many advantages over paper records: paper records can be read, copied and altered without anyone knowing, and can be easily lost or destroyed. Electronic records are kept in systems to prevent such alteration. Also, electronic records cannot be lost or destroyed easily, if backups are maintained (which is a requirement under the HIPAA security regulations).

**Disposal**

As far as disposal is concerned, there is no Texas law on the subject. However, in order to avoid breaches of confidentiality, some risk managers suggest the complete destruction of any medical records that meet the practice’s criteria for disposal under the document retention policy. Merely throwing records out with the trash can lead to breaches of confidentiality and there have been several negative television investigative news reports upon this practice. Further, the federal government has stated that “requiring … documents containing protected health information be shredded” prior to disposal is an appropriate safeguard under the HIPAA privacy regulations.\textsuperscript{29} Despite this statement, the government does not expressly require shredding under the regulation. Nonetheless, this government perspective should be given some weight when deciding upon HIPAA safeguards. There are businesses that offer a "document destruction” service and will provide a "certificate of destruction” should you ever want or need to definitively prove that a particular medical record was destroyed. Some risk managers suggest that a list of patient names and addresses be maintained indefinitely, along with a document asserting the records were destroyed in accordance with the practice’s document retention policy. This ensures that patient requests for appropriately destroyed medical records can be distinguished from requests that lead to the discovery of a lost medical record.

\textsuperscript{27} Id.
\textsuperscript{28} Texas Warehouse Co. v Springs Mills, Inc., 511 SW2d 735 (Tex Civ App 10th Dist, 1974, writ ref n r e)
\textsuperscript{29} 65 Fed. Reg. 82562.
Pathology and Retention of Records, Slides and Paraffin Blocks Under CLIA

Each laboratory that performs nonwaived testing is subject to CLIA regulations. Those regulations require the retention of pathology reports for a period of 10 years. All other reports must be maintained for 2 years. Also, records of test requisitions and authorizations must be maintained for at least 2 years. Immunohematology records, blood and blood product records, and transfusion records must be maintained for the later of 5 years after processing records have been completed or six months after the latest expiration date. If there is no expiration date the retention period is indefinite.

CLIA regulations contain retention schedules for materials in addition to reports and records. The regulations require histopathology slides to be maintained for a 10 year period. Cytology slide preparations must be retained for at least 5 years from the date of examination. Pathology specimen blocks are to be retained for at least 2 years from the date of the examination.

Should a laboratory cease operation, provision must be made to ensure that all records, slides, blocks and tissues are retained and available as required by the regulations. These are the regulatory minimums, individual pathologists may decide to retain these materials for a longer period.

AMA Policy

E-7.05 Retention of Medical Records

Physicians have an obligation to retain patient records which may reasonably be of value to a patient. The following guidelines are offered to assist physicians in meeting their ethical and legal obligations: (1) Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be part of the patient’s chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time. (2) If a particular record no longer needs to be kept for medical reasons, the physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board. (3) In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information. (4) Whatever the statute of limitations, a physician should

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31 42 CFR § 493.1105(a)(6).
32 42 CFR § 493.1105(a)(1).
34 21 CFR 606.160(d).
36 42 CFR § 493.1105(a)(7).
38 42 CFR § 493.1105(b).
measure time from the last professional contact with the patient. (5) If a patient is a minor, the statute of limitations for medical malpractice claims may not apply until the patient reaches the age of majority. (6) Immunization records always must be kept. (7) The records of any patient covered by Medicare or Medicaid must be kept at least five years. (8) In order to preserve confidentiality when discarding old records, all documents should be destroyed. (9) Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity. (IV, V) Issued June 1994.

NOTICE:
PLEASE CHECK THE TEXAS MEDICAL BOARD WEBSITE (www.tmb.state.tx.us) FOR CURRENT UPDATES ON ITS RULES AND POLICIES WITH RESPECT TO THIS ISSUE.

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