Maintaining Your Records: In What Form and for How Long?

By Jennifer Kirschenbaum, Esq

For those asking whether managed care will still be around in 5 or 10 years, or whether certain treatments for stage IV cancer will be relevant at the end of that timeframe, uncertainty clouds any potential answer. In contrast, the fact remains that regardless of the payer or the treatment, you will be required to document the care provided by your practice. In addition, you will most likely be required to maintain your documentation. Whether the form of your documentation and/or the maintenance requirements will be the same as today remains unclear, we do have some insight into what the future may hold.

CMS Leading the Way

The Centers for Medicare & Medicaid Services (CMS) is widely accepted as the industry trendsetter when it comes not only to reimbursement rates but also to documentation requirements related to reimbursement. As such, CMS began taking steps to encourage the switch to electronic health records (otherwise known as EHR) with its "carrots and stick" incentives. Practices that have switched to EHR that meet the established CMS standard (otherwise known as qualified for "meaningful use") by the end of 2012 will be rewarded with an incentive payment of up to $44,000. Furthermore, practices that fail to implement the EHR requirement by 2015 are scheduled to incur a reimbursement deduction of 1% in 2015, followed by an additional 1% deduction for each year that practice fails to comply, with a maximum potential deduction of 5%.

If you are wondering why CMS is so eager for practices to adopt EHR, one answer is that once a practice has accepted EHR, CMS will be better positioned to survey each practice for inefficiency and waste, which is readily apparent on an even cursory review of CMS's recovery audit contractor (RAC) program. Briefly, under the RAC program, CMS is authorized to contract with third parties to audit healthcare providers to identify fraud, abuse, and waste in the Medicare program. Many of these RAC audits are based on data mining. For example, RAC auditors may audit based solely on uncovering a pattern of a practice's use of a certain high-paying CPT code. Because the RAC program contractors are paid on contingency based on recovery, the process is rarely fair, and providers should not engage in an audit without proper legal representation, to ensure that their rights are being protected.

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Documentation Form

For any practice that has not yet made the switch to EHR, keep in mind that doing so is no small task. Selecting the right EHR system is a monumental process. To make such election, we recommend basing your decision on recommendations from similarly situated practices or oncology-specific professional associations as opposed to making such election solely based on cost. Choosing the wrong EHR system may likely cost you much more on the back end than the right one would cost you on the front end.

Once you have made your selection, the transition to EHR is its own project. An often overlooked element in the transition to EHR is the additional policy and procedure requirements mandated by government authorities. For instance, the Office for Civil Rights enforces the federal HITECH Act requirement that all practices utilizing EHR are required to have a security policy detailing the protections that have been put in place to safeguard electronic data. Ensuring that a practice is in compliance with applicable regulatory requirements is only one of the many steps toward adopting a proper EHR, and is an example that highlights the need to work with the right professionals who could provide knowledgeable healthcare counsel throughout the process.

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them once I've transitioned to EHR?" The answer is that although there are no federal regulations that require practices to maintain original records once an EHR system has been implemented, states are authorized to enact stricter requirements, and they often do so (New York, for example, currently does not require that original documents be maintained).

Regardless of whether your jurisdiction requires maintenance of original records, maintaining original records may prove useful. For example, a medical practice represented by our firm was recently investigated for allegedly providing "phantom" treatments. We were able to successfully defend that allegation and forego paying or having to negotiate a hefty recoupment demand by producing the originally dated patient sign-in sheets, as well as patient signatures in their individual charts that were dated with the treatment date, both of which happened to be maintained by our client. In this matter, our client's diligence in her record keeping aided our defense in staving off a massive potential repayment, as well as a potential fraud allegation.

Should you decide to destroy original records, be advised that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules you are required to safeguard "protected health information" and to ensure that confidential patient information is not disclosed to any unauthorized parties: HIPAA and other regulations authorize severe penalties should a breach result. As such, be sure that all paper records are destroyed properly.

Documentation Maintenance

Another question our practice is frequently asked is, "How long am I required to maintain my records for?" The answer is that record-retention requirements are confusing, mainly because varying regulations exist on multiple levels on this topic. Federal regulations require that Medicare fee-for-service physician providers retain medical records for 6 years from the date of creation.[1] But under the Federal False Claims Act, the government may request records for up to 10 years after treatment.[2] To make matters even more confusing, states are also authorized under HIPAA to enact their own more-stringent record-keeping requirements. New York, for example, requires the retention of all patient records for a minimum of 6 years, but also requires that obstetrics records and records of minor patients are retained for a minimum of 6 years, or until 1 year after the minor patient reaches the age of 18 years, whichever is longer.[3]

So, which record-keeping requirements are you required to abide by? Regretfully, the answer is—any and all legitimate requirements that apply to your practice. This, however, provides us the opportunity to highlight a major benefit (and liability) of switching to EHR: once an electronic record is created, it will likely exist in some form on some server to be discoverable at any time after that. And, electronic maintenance of any such record will likely be remarkably more affordable than physical storage options. It is, therefore, unclear whether record maintenance requirements will change along with technology. Requiring records to be maintained for the lifetime of a patient and beyond may not be viewed as unreasonable once that record is electronic.

Conclusion

Creating and maintaining proper documentation in compliance with applicable form, substance, and maintenance requirements is a challenge for any practice, regardless of its size, as is staying abreast of required policies and procedures. The best way to protect your practice with the many likely changes ahead is to continue to educate yourself and to avail yourself to the right resources. ●

References

1. 64 Fed. Reg. 59994.
2. 31 U.S.C. §§ 3729–3733.
3. NY Education Law §6530(32).

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