Record Retention Requirements

Rev 06/14/2018

The requirement to retain care records varies by provider type and regulatory authority. The following requirements were gleaned from both Idaho and Federal regulatory requirements:

**SNF (16.03.02 - Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities)**

IDAPA 16.03.02.203.04 requires 7 years
04. Retention. (7-1-93) a. There shall be adequate filing equipment and space to store closed charts and facilitate retrieval. (1-1-88) b. Records shall be preserved in a safe location protected from fire, theft, and water damage for a period of time not less than seven (7) years. If the patient/resident is a minor, the record shall be preserved for a period of not less than seven (7) years following his eighteenth birthday. (1-1-88) 05. Confidentiality. The facility shall safeguard medical record information against loss, destruction, and unauthorized use. (1-1-88)

42 CFR 483.75(1)(2) states 5 years when there is no state requirement.
Clinical records must be retained for the period of time required by state law; or five years from the date of discharge when there is no requirement in State law; or, for a minor, three years after a resident reaches legal age under State law.

**Hospitals**

Short answer—there is no definitive time frame except below. Joint Commission states that they must meet state and federal requirements and the best interests of their patients. So—you will see a variety of retention requirements depending on services delivered, policies and procedures with input from legal counsel. For minors the national standard is the age of majority plus 3 years. There are other entities that also influence record retention such as FDA.

IDAPA 16.03.14.360.07 states
07. Retention. Records shall be retained to conform with Section 39-1394, Idaho Code. (10-14-88)
(a) Hospital records relating to the care and treatment of a patient may be preserved in microfilm, other photographically reproduced form or electronic medium. Such reproduced and preserved copies shall be deemed originals for purposes of section 74-120, Idaho Code.
(b) Clinical laboratory test records and reports may be destroyed five (5) years after the date of the test recorded or reported therein, pursuant to paragraph (d) of this subsection.

(c) X-ray films may be destroyed five (5) years after the date of exposure, or five (5) years after the patient reaches the age of majority, whichever is later, pursuant to paragraph (d) of this subsection, if there are in the hospital record written findings of a physician who has read such x-ray films.

(d) At any time after the retention periods specified in paragraphs (b) and (c) of this subsection, the hospital may, without thereby incurring liability, destroy such records, by burning, shredding or other effective method in keeping with the confidential nature of their contents, provided, however, that destruction of such records must be in the ordinary course of business and no record shall be destroyed on an individual basis.

(e) For purposes of this section, the term "hospital" shall include all facilities defined as hospitals in Title 39, Chapter 13, Idaho Code.

42 CFR 485.638(c) for Critical Access hospitals requires—6 years.

The records are retained for at least 6 years from date of last entry, and longer if required by State statute, or if the records may be needed in any pending proceeding.

Medical records are retained in their original form or legally reproduced form in hard copy, microfilm, or computer memory banks. The CAH must be able to promptly retrieve the complete medical record of every individual evaluated or treated in any part or location of the CAH within the last 6 years.

In accordance with Federal and State law and regulations, certain medical records may have retention requirements that exceed 6 years (for example: FDA, OSHA, EPA).

42 CFR 482.24(b)(1) for Acute Care Hospitals—requires 5 years

Medical records must be maintained in their original or legally reproduced form for a period of at least 5 years.

Medical records are retained in their original or legally reproduced form in hard copy, microfilm, computer memory, or other electronic storage media. The hospital must be able to promptly retrieve the complete medical record of every individual evaluated or treated in any part or location of the hospital within the last 5 years.

In accordance with Federal and State law and regulations, certain medical records may have retention requirements that exceed 5 years (for example: FDA, OSHA, EPA).

42 CFR 482.60(c)

Psychiatric hospitals must maintain clinical records on all patients, including records sufficient to permit CMS to determine the degree and intensity of treatment furnished to Medicare beneficiaries, as specified in §482.61.
42 CFR 418.104(d) Hospice

Patient clinical records must be retained for 6 years after the death or discharge of the patient, unless State law stipulates a longer period of time. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform its State agency and its CMS Regional office where such clinical records will be stored and how they may be accessed.

42 CFR 494.170(c) ESRD

In accordance with 45 CFR §164.530(j)(2), all patient records must be retained for 6 years from the date of the patient's discharge, transfer or death. These retention requirements also apply to the records of machine maintenance, dialyzer reprocessing/reuse, water treatment and dialysate preparation as each of these records is part of the medical record for the patients on service at the time those records were completed. Documentation of these processes is retained in logs rather than individual patient records. Since many patients are treated on the equipment each day, determination of the retention period may be difficult. Facility policy should address retention of these records."

42 CFR 491.10(c) Rural Health Clinic

The patient's records are retained for at least 6 years from the date of last entry, and longer if required by State statute.

42 CFR 485.721(d) OPT/OSP

Clinical records are retained for at least: (1) The period determined by the respective State statute, or the statute of limitations in the State, or (2) In the absence of a State statute: (i) Five years after the date of discharge, or (ii) In the case of a minor, 3 years after the patient becomes of age under State law or 5 years after the date of discharge, whichever is longer.

The Medicaid Provider Handbook states—5 years

2.1.2.1. Medical Record Requirements
Idaho Code Section 56-209h requires that providers generate records at the time the service is delivered, and maintain all records necessary to fully document the extent of services submitted for Medicaid reimbursement. This includes documentation of referrals made or received on behalf of Medicaid participants enrolled in the Healthy Connections (HC) Program. Providers are required to retain records to document services submitted for Medicaid reimbursement for at least five years after the date of service.
Example of others that influence record retention:

**FDA’s POLICY**

“The QS regulation in section 820.180(b) requires that all records pertaining to a device shall be retained for a period of time equivalent to the design and expected life of the device, but in no case less than two years from the date of release for commercial distribution by the manufacturer. Manufacturers of longlife products should make prudent decisions as to how long to keep records.”

**HIPAA**

Health care providers billing Medicare must retain required medical records for a period of “six years from the date of its creation or the date when it last was in effect, whichever is later.”

HIPAA requirements preempt State laws if the State laws require a shorter medical records retention period.

The Association of Health Information recommends a minimum of 10 years. A study completed in 2008 finds that many hospitals keep records permanently, the next most frequent standard was 20 years.

**Other References**

AHIMA Best Practices - Federal Record Retention Practices