Record and Data Retention Schedule

A comprehensive guide for hospitals and other health care providers

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Eighth Edition
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Health care providers create volumes of records dealing with a variety of matters. Some concern the corporate, business and administrative aspects of their operations. Others document unique areas, such as medical staff activities at hospitals. Still others trace the course of care given to patients. Providers naturally consider retaining any record that is of more than passing interest. However, as records accumulate, they occupy valuable space that often could be put to better use. Storing records off-site or in electronic form may alleviate the problem. However, these alternatives are likely to be expensive and do not address the basic question of which records should be kept and for how long.

If health care providers are to deal intelligently with the problem, they must base their decisions upon a firm knowledge of legal requirements and policy considerations. This guide discusses those requirements and considerations, and recommends specific periods for the retention of various classes of records.

The guide contains two sections. The first is a discussion of retention considerations as they pertain to various kinds of records.

The second section is a Recommended Retention Schedule. It contains tables listing typical records, legal citations applicable to each health care provider type, and recommended retention periods. This schedule does not list every possible record that may be produced or retained by a health care provider but rather provides recommendations and cites legal requirements for the most common documents. For those records not specifically addressed in this guide, CHA recommends considering retention periods for records listed which are of a similar nature or purpose and consulting your legal counsel.

The guide is not designed to serve as a substitute for legal counsel. If there are differences of opinion, or where the law is unclear, a provider should consult legal counsel and then make retention decisions based on the law and its own philosophy, mission and purpose.

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should be documented in a log. A sample certificate of records destruction that providers may adapt to fit their needs may be found at http://hcaethics.icu.ehc.com/CPM/EC014.doc.

IX. CHA’S RECOMMENDED RETENTION SCHEDULE

A. General Retention Period

CHA’s Recommended Retention Schedule (starting on page 19) recommends a retention period of six years for general records that might prove valuable for litigation, statistical or business purposes. CHA has chosen this period because the utility of most records declines significantly after six years. The six-year period meets or exceeds the normal statute of limitations for civil actions. However, it would not be sufficient when a claimant alleges fraudulent concealment of a wrongful act, or some other occurrence prolongs the limitation period.

After establishing a general retention period, the Schedule was refined to account for particular demands. For example, it is suggested that providers preserve annual reports and significant statistical compilations longer, as these materials do not demand significant storage space and may be useful for historical, research, or business planning purposes. Additionally, special legal requirements that govern the retention of records needed to support tax returns have been taken into account (see “Internal Revenue Service Actions,” page 6). Also recommended is permanent retention of credentialing and other medical staff records, as these contain information that is increasingly the subject of litigation. Finally, a two- or three-year retention period is assigned to various other records that are usually of only short-term interest.

NOTE: CHA’s Recommended Retention Schedule does not include record retention requirements mandated by the Sarbanes-Oxley Act, which applies only to for-profit organizations that are publicly traded. For-profit organizations that are publicly traded should consult legal counsel regarding additional record retention requirements.

B. How to Interpret the Schedule

Column 1: “Record”

This column describes a document, record, or data that a hospital may generate.

Column 2: “Provider Types”

This column describes the types of providers that must comply with the retention requirement described in the row.

Column 3: “Legal Requirements”

This column provides any legal requirements that pertain to the providers listed in column 2 regarding the document described in column 1. The provider is legally required to follow the retention period stated in this column.

Column 4: “Recommended Retention Period”

This column provides CHA’s recommendation regarding how long to keep the document described in column 1. Please note that this is only a recommendation, not a le-
gal requirement. A particular provider may wish to keep the document longer than the recommended retention period. On the other hand, a provider may wish to destroy or delete the document sooner than the recommended retention period. Each health care provider should consider the factors described in III. “Primary Considerations in Developing a Record Retention Schedule,” page 4, and develop its own retention schedule. It is not mandatory to comply with CHA’s recommended retention period.

C. Frequently Asked Questions

Q1: Is every document that a hospital may generate included in the Schedule?

A1: No. It is not possible to list every document that a hospital may generate. The Schedule contains those documents that are commonly used by hospitals and other health care providers, and those documents to which the government has assigned a required record retention period.

Q2: Why is the time period under the fourth column, “Recommended Retention Period,” sometimes longer than the legally-required retention period stated in the third column, “Legal Requirements”?

A2: It is common to find that the retention period listed under “Recommended Retention Period” is longer than the legally-required retention period listed in the “Legal Requirements” column. This is because there are other factors to be considered when determining the minimum retention period in addition to the legal requirement that is specific to that document.

For example, the Clinical Laboratory Improvement Amendments (CLIA), a federal law, requires many laboratory documents to be retained for two years. However, California law requires that all documents evidencing compliance with CLIA be retained for three years. In addition, Medicare law requires all books and records to be kept for four years, and the general federal statute governing the time for the federal government to seek civil monetary penalties against a provider for filing a false claim is six years. Therefore, the “Recommended Retention Period” for many laboratory records is six years, so that the records are available to the hospital to defend itself should the federal government assert that the hospital unlawfully billed Medicare for laboratory services.

Q3: Does the “Legal Requirements” column list all possible laws that apply to the document described in the first column?

A3: No. The “Legal Requirements” column lists all the laws that are specific to the document described in column 1. However, it does not list all of the laws that represent more general retention considerations.

Taking the example given in Question 2 above, column 3 will list the CLIA citation and the California law citation that are specific to laboratory records. However, it does not list all of the laws that represent more general record retention considerations, such as statutes of limitations. The laws that represent more general retention considerations are discussed under III. “Primary Considerations in Developing a Record Retention Schedule,” page 4.
Recommended Retention Schedule

Health care providers, particularly hospitals, are among the most heavily regulated entities in the United States. State and federal laws specify who is qualified to deliver safe and effective health care, and under what circumstances that care may be provided. In addition, providers are required to meet standards imposed under corporate, labor, tax, workers’ compensation, environmental, and criminal law and many, many others.

In order to show that legally-required standards are being met, facilities must document compliance with the law. Records are required by law to be kept by every department of a California health care provider’s facility. Sometimes the government specifies precisely how those records are to be maintained and for how long. Most of the time the government does not.

The Schedule that follows gives recommended retention periods for records that are common to health care providers and have statutorily- or regulatorily-mandated retention periods, or are representative of documents that have no legal retention requirements.

Retention Tip: For a document not listed in the Schedule, CHA recommends using the retention period listed for a similar document or for a document required for a similar purpose.

The Schedule gives recommendations for a wide variety of health care providers. In the “Provider Types” column, the following definitions apply:

1. “All providers” includes:
   a. Health facilities,
   b. Home health agencies,
   c. Primary care clinics,
   d. Psychology clinics,
   e. Individual practitioners,
   f. Groups of practitioners,
   g. Surgery centers, and
   h. Unlicensed outpatient facilities.
2. **“Health facilities”** means a facility that treats persons who are admitted for a 24-hour stay or longer. The term “health facilities” includes the following types of providers:
   a. General acute care hospitals (GACHs),
   b. Acute psychiatric hospitals (APHs),
   c. Skilled nursing facilities (SNFs),
   d. Intermediate care facilities (ICFs),
   e. Special hospitals,
   f. Congregate living health facilities,
   g. Correctional treatment centers,
   h. Psychiatric health facilities (PHFs), and
   i. Chemical dependency recovery hospitals (CDRHs).

[Health and Safety Code Sections 1250 and 1250.2]

In the “Reference/Remarks” column, the following acronyms are used:
1. **“C.C.R.”** means California Code of Regulations.

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**Retention Tip:** See “Where to Find the Laws Referenced in the Manual,” page 67, for instructions on how to find the exact language of the statutes and regulations on the internet.

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## ADMINISTRATIVE RECORDS

<table>
<thead>
<tr>
<th>RECORD</th>
<th>PROVIDER TYPES</th>
<th>LEGAL REQUIREMENTS</th>
<th>RECOMMENDED RETENTION PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident reports</td>
<td></td>
<td>See “Incident reports,” page 21. If an employee is injured, see “Workers’ compensation self-insureds’ claims files,” page 43.</td>
<td></td>
</tr>
<tr>
<td>Accreditation/licensing surveys and plans of correction (TJC, AOA, DNV, CMS, CDPH, IMQ, CAP, etc.)</td>
<td>All providers</td>
<td>10 years (longer if continuing interest)</td>
<td></td>
</tr>
<tr>
<td>Adverse event reports to CDPH</td>
<td>Hospitals</td>
<td>6 years after any appeal is concluded</td>
<td></td>
</tr>
<tr>
<td>Aerosol transmissible disease and biosafety plan annual review</td>
<td>All providers</td>
<td>Must be kept for at least 3 years [8 C.C.R. Section 5199]. See regulation for required content of record.</td>
<td>6 years</td>
</tr>
<tr>
<td>Annual reports to CDPH (as required by CDPH)</td>
<td>GACHs, APHs, ICFs, home health agencies</td>
<td>Regulations require submission of report but do not specify retention period [22 C.C.R. Sections 70735, 71533, 73541 and 74729].</td>
<td>Permanent</td>
</tr>
<tr>
<td>Appraisal reports (property, building, equipment, etc.)</td>
<td>All providers</td>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>Birth records to local government</td>
<td>Hospitals, practitioners</td>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>Cancer/tumor registry</td>
<td>Hospitals, practitioners</td>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>Census (daily)</td>
<td>Health facilities</td>
<td>Regulations require health facilities to keep “patient admission rosters,” but do not specify a retention period [22 C.C.R. Sections 70733, 71531, 77127, and 79337].</td>
<td>6 years</td>
</tr>
<tr>
<td>Certificate of records destruction</td>
<td>All providers</td>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>Committee agendas, minutes (not otherwise specified in this retention schedule)</td>
<td></td>
<td>6 years</td>
<td></td>
</tr>
<tr>
<td>Communicable disease reports to state and local health departments</td>
<td>All providers</td>
<td>3 years</td>
<td></td>
</tr>
<tr>
<td>Construction project contracts and related documents</td>
<td>All providers</td>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>RECORD</td>
<td>PROVIDER TYPES</td>
<td>LEGAL REQUIREMENTS</td>
<td>RECOMMENDED RETENTION PERIOD</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Appointment calendars (patients’ appointments)</td>
<td>All providers</td>
<td></td>
<td>6 years</td>
</tr>
<tr>
<td>Birth records to local government</td>
<td></td>
<td>See “Birth records to local government,” page 19</td>
<td></td>
</tr>
<tr>
<td>Birth room registry</td>
<td>Hospitals</td>
<td></td>
<td>Permanent</td>
</tr>
<tr>
<td>Compliance audits/investigations (internal)</td>
<td>All providers</td>
<td>Regulations require these documents to be kept, but do not specify a retention period [22 C.C.R. Section 75189]. See 22 C.C.R. Sections 75189 and 75198 for details regarding content of required records.</td>
<td>6 years</td>
</tr>
<tr>
<td>Dialysis — hemodialyzer reuse records (procedure, training, equipment, audit records)</td>
<td>Dialysis clinics</td>
<td>Must be kept for at least 6 months after last reprocessing of dialyzer [22 C.C.R. Section 75198(b)(5)]. See 22 C.C.R. Sections 75189 and 75198 for details regarding content of required records.</td>
<td>Life of dialyzer, plus 6 years</td>
</tr>
<tr>
<td>Dialysis — dialyzer reuse records (device history records, including patient name, dates of treatment, dates of disinfectant rinsing, type and model, reuse number, results of performance tests, initials or other ID of reprocessing technician, reason for dialyzer failure and subsequent acceptance)</td>
<td>Dialysis clinics</td>
<td>Hospitals that participate in Medicare must maintain EMTALA-related records (records related to individuals transferred to or from the hospital) for at least 5 years [42 U.S.C. Section 1395cc; 42 C.F.R. Section 489.20].</td>
<td>6 years</td>
</tr>
<tr>
<td>Emergency department central log</td>
<td>Hospitals</td>
<td>Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)]. See also Health and Safety Code Section 1317.4 (specifying a 3-year retention period).</td>
<td>6 years</td>
</tr>
<tr>
<td>EMTALA-related records</td>
<td>Hospitals</td>
<td>Hospitals that participate in Medicare must maintain EMTALA-related records (records related to individuals transferred to or from the hospital) for at least 5 years [42 U.S.C. Section 1395cc; 42 C.F.R. Section 489.20].</td>
<td>6 years</td>
</tr>
<tr>
<td>Hardware and software operating instructions, warranties, system requirements, configurations, etc.</td>
<td>All providers</td>
<td></td>
<td>Life of product, plus 2 years</td>
</tr>
</tbody>
</table>