November 2, 2010

Dear Doctor :

Physicians in New York State must maintain a copy of their patients' records and x-rays for certain applicable time periods. Medical records and x-rays must be retained for the period required by Section 6530(32) of the Education Law.

According to the section, unprofessional conduct includes:

> "Failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Unless otherwise provided by law, all patient records must be retained for at least six years[1]. **Obstetrical records and records of minor patients must be retained for at least six years, and until one year after the minor patient reaches the age of twenty (20)".**

An intentional violation of this section of the Education Law can constitute grounds for disciplinary proceedings.

According to the aforementioned section, you can destroy records and x-rays if a minimum period of six years has elapsed from the last date of treatment. Keep in mind that this is a minimum requirement. You may keep records and x-rays for a period longer than six years. It is generally recommended that records and x-rays be kept at least seven years, as an added safeguard. Two exceptions provided in the Education Law include records relating to the treatment of infants (patients who were under 18 at the time of treatment) and obstetric records. ***Records relating to the treatment of infants/minors should be kept for a least six years or until the infant/minor reaches 21 years of age, whichever is longer. Obstetric records should be retained until the infant/minor reaches 21 years of age.***

If you have signed HMO or managed care agreements, check them. Generally, HMO agreements require the physician to retain copies of medical records of HMO enrollees for a period longer than as stated above. Most HMO agreements provide that records of a minor patient must be retained for six years after the date of service or three years after the minor attains 18 years of age, whichever is longer. If it is not possible to distinguish between the records of HMO patients and non-HMO patients, it may be necessary to retain all records and minor records for the longer period.

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[1] In cases of continuing treatment for the same illness, injury or medical condition, it is recommended that the entire medical record relating to the continuing treatment be retained for at least six years from the last date of treatment.

It is advisable that physicians maintain all Medicare patient records for ten (10) years to protect themselves in the event there is a Federal False Claims Act investigation. The False Claims Act permits the government to commence an action up to 10 years after the date in which the claim was submitted for payment.

New York State Regulations, 18 N.Y.C.R.R. section 517.3(b) provides that health care providers must prepare and retain records demonstrating their right to receive payment under the Medicaid program. Records must be kept for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later (keep in mind, we recommend a minimum of seven years, as an added safeguard).

The requirement regarding retaining medical records should not be confused with the statute of limitations. The statute of limitations is the period of time in which a plaintiff will be able to bring a lawsuit without being time barred. After July 1, 1975, the statute of limitations for a medical malpractice action has been two years, six months from the date of the alleged malpractice. Prior to July 1, 1975, the statute of limitations for a medical malpractice action was three years.

The statute of limitations has an exception to it in regard to actions brought on behalf of minors. Again, July 1, 1975 is the watershed date because of changes in the statute of limitations law. In an action brought on behalf of a minor for malpractice which occurred prior to July 1, 1975, the statute of limitations does not begin to run until after a minor reaches the age of majority (18 years of age). Technically, this suspension in time in which a minor is able to commence a lawsuit is called "tolling". If the alleged malpractice occurred after July 1, 1975, the maximum time "within which the action must be commenced shall not be extended...beyond ten years" after the incident took place, (Civil Practice Law and Rules, Section 208).

The following examples will illustrate how these rules apply to minors:

EXAMPLE 1

SITUATION	APPLICABLE LAW
- Alleged malpractice occurred in 1970 to a five-year old child	- Statute of limitations of three years

In Example 1, the child would have the right to sue until three years after he reaches his 18th birthday.

EXAMPLE 2

- Alleged malpractice occurred in 1977 to a five-year old child	- Minors are subject to a statute of limitations cap of ten years under the tolling provision for any medical malpractice which occurred to a minor after July 1, 1975.

In Example 2, the child who was five years old at the time of the alleged malpractice will be able to sue only until his 15th birthday.

Physicians are advised to retain their medical records for the duration of the statute of limitations. While section 6530(32) is not to be confused with the statute of limitations, by complying with Section 6530(32), the physician also protects himself under the statute of limitations.

It is conceivable that a medical malpractice action can be commenced after six years in an action where the plaintiff alleges that a foreign medical object was left in his body. In an alleged "foreign object" case, the plaintiff has until one year after the discovery of the foreign object, or of the date of the discovery of facts which would reasonably lead to the discovery of the foreign object, in which to bring the action.

Public Health Law Section 17 and Section 18

Public Health Law Section 17 and Section 18 generally require the physician to transfer a ***copy*** of the medical record. Public Health Law Section 17 applies when the patient wants a copy of the record to be transferred to another physician or hospital designated by the patient. Public Health Law Section 18 applies when the patient or other qualified person wants direct access to a copy of the medical records. Public Health Law section 18 applies to release of copies of medical records directly to a "qualified person". "Qualified persons" include the patient or an incapacitated adult patient's legal guardian. A parent or legal guardian of a minor may access the minor's records when the parent or guardian consented to the care and treatment described in the record or when the care was provided without consent in an emergency resulting from an accidental injury or the unexpected onset of serious illness. "Qualified persons" include holders of health care proxies for living patients, the executors and administrators of estates of deceased patients, and if there is no will, the distributes of the estate under the Estates, Powers and Trusts Law. An attorney representing a "qualified person" is also a "qualified person", provided that the attorney has a signed power of attorney specifically authorizing the attorney to request medical records. Health care providers, insurance companies, other corporate entities and attorneys lacking a power of attorney are not qualified persons. In reference to the fees that may be charged, section 18(1)(e) provides:

> "The provider may impose a reasonable charge for all inspections and copies, not exceeding the costs incurred by such provider, provided, however, that a provider may not impose a charge for copying an original mammogram when the original has been furnished to any qualified person and provided, further, that any charge for furnishing an original mammogram pursuant to this section shall not exceed the documented costs associated therewith. However, the reasonable charge for paper copies shall not exceed ***seventy-five ($.75) cents per page***. A qualified person shall not be denied access to patient information solely because of inability to pay".

Mammograms

While Public Health Law section 17 and section 18 generally require the physician to transfer copies of medical records, an exception applies to mammograms. Effective April 28, 1999 Public Health Law section 17 and 18 require a physician to transfer the original mammogram if requested by the patient or other qualified person. Generally, the physician may not impose a charge for copying a mammogram when the original mammogram has been furnished to a qualified person. Furthermore, the charge for delivery of an original mammogram may not exceed the documented costs of delivery.

Education Law section 6530(32) [see above] has been revised to state that a physician is under no obligation to maintain the original or copy of a mammogram if the original mammogram is transferred to a medical institution, to a physician or health care provider of the patient, to the patient directly, or as otherwise provided by law. While Education Law 6530(32) does not under such circumstances require a physician to maintain a copy of the mammogram, professional medical liability insurance carriers generally recommend the physician to maintain a copy of the mammogram. If a physician leaves mammograms in the safekeeping of another physician, an agreement must be made concerning which physician will incur the costs of copying the mammogram.

As stated above, the New York State Education Law § 6530(32) provides the minimum period of time that medical records must be retained. However, federal law, the Mammography Quality Standards Act (MQSA) provided a longer period of time that mammograms and associated medical records must be retained. If the mammograms are the last mammograms performed by the facility, the mammograms and associated records must be retained for ten years [unless the original mammograms have been released to the patient or other qualified person]. If additional mammograms have been performed, the earlier set of mammograms should be retained for at least the six-year period required under state law.

Section 18 of the Public Health Law, which became effective on January 1, 1987, gives the patients the right to inspect and/or receive copies of their medical records. A provider may deny access if (a) the provider determines that the requested review of the information can reasonably be expected to cause harm to the subject or others, (b) the information requested constitutes "personal notes", (c) the data was disclosed in confidence by persons other than the patient, and (d) the parents or guardian of an infant seek information pertaining to the treatment of an infant and the provider determines that access would have a detrimental effect on the provider's professional relationship with the infant. In cases where the denial of access is disputed, the matter is reviewed by a Medical Records Access Review Committee. In the event access is denied because of the determination that access can cause harm to the patient or access would have a detrimental effect on the professional relationship with an infant, there is a right to judicial review.

Physicians are advised that this form letter is for <u>general information only</u> and is <u>NOT</u> intended as legal advice. Physicians are advised to contact their private attorney prior to using any form letter.

I trust this information will be of assistance.

Very truly yours,

<u>REMINDER</u> - Physicians who entrust their records with a succeeding physician should have the succeeding physician agree in writing:

1. The records are the property of the physician who prepared the records and the succeeding physician holds the records for safekeeping only.

2. The physician owner of the records is entitled access to his/her records during business hours.

3. The physician who holds the records for safekeeping should not commingle them with his/her own records, but records held for safekeeping should be separately stored for six years.

4. Because of physician-patient confidentiality requirements, the physician who holds the records for safekeeping should not access the records without the patient's consent. With the patient's consent, the safekeeping physician may review the records and incorporate information and history in his/her own records, but the original record should continue to be separately stored (3 above).

5. The medical records should be retained for at least the period of time required by Education Law section 6530(32) - Six years from the last date of treatment. For records relating to care or treatment for a specific illness injury or medical condition over a period of time, the entire record for the care or treatment relating to the illness, injury or medical condition should be retained for at least six years form the last date of treatment. Records relating to minor patients

(a patient under 18 years of age at the time of treatment) and obstetric records should be kept until the minor patient is 19 years of age, or six years, whichever period is longer. Although the law requires records to be kept for not less than six years, the Office of General Counsel recommends seven years. It is possible that the Medical Liability Carrier will recommend that medical records retained for even a longer period.

6. If the physician has signed HMO or managed care agreements, check them. Some HMO agreements may require the physician to retain copies of medical records of HMO enrollees for a period longer than as stated above. As an example, some HMO agreements provide that records of a minor patient must be retained for six years or three years after the minor attains 18 years of age, whichever is longer.

[Under the Federal Mammography Quality Standards Act (MQSA), the period of time that mammograms and associated records must be retained is stricter than the State law requirements. If the mammograms are the last mammograms performed by the facility, the mammograms and associated records must be retained for ten years. If additional mammograms have been performed the earlier mammograms should be retained at least six years].

7. If the patient requests that copies of the records be made available to the patient or to a designated physician, the succeeding physician must make copies available in accordance with legal requirements. The law permits a charge of up to 75 cents per page. For x-rays and other records that cannot be photocopied, the law permits a "reasonable" charge, but the charge for duplication should not exceed the costs incurred.

[Mammograms - The Federal MASA, and state law, Public Health Law section 17 and 18 require a physician to release the original mammogram. A physician may retain a duplicate of the mammogram but may not impose a charge for the costs incurred to duplicate the mammogram].

It should be understood that even if the above principles are included in a written agreement between the physician and the succeeding physician, the physician may suffer adverse consequences including adverse financial consequences in the event of a third party payor audit if the succeeding physician fails to comply with the agreement. To avoid this risk, the physician may consider personally retaining his/her records.