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Medical Record Retention Requirements

DC Insights

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Separating Fact from Myth

There is a great deal of conflicting information about how long to retain medical records. Many providers refer to HIPAA laws when building their record retention policies, while others follow their colleagues' recommendations and default to the seven-year rule. Some providers hesitate to discard anything at all and have massive amounts of patient data stored in a variety of places (basements, attics, storage rooms) which increases the threat of unauthorized disclosure. Let us clear up some of the confusion!

There is often confusion on how HIPAA Privacy Rules come into play. Many providers are so consumed with HIPAA compliance that they neglect to consider state guidelines. It is a mistake, as your state law is truly the determining factor here. You may be surprised to learn that HIPAA does not have requirements for the length of time records must be kept.

The following is from *HHS.gov* FAQ (Frequently Asked Questions):

> ***Does the HIPAA Privacy Rule require covered entities to keep patients' medical records for any period of time?*** *No, the HIPAA Privacy Rule does not include medical record retention requirements. State laws generally govern how long to retain medical records. However, the HIPAA Privacy Rule* ***does require*** *that covered entities apply appropriate administrative, technical, and physical safeguards to protect the privacy of medical records and other protected health information (PHI) for whatever period such information is maintained by a covered entity, including through disposal. See 45 CFR 164.530(c).*

State Law

Current law requires most healthcare providers to retain patient records for seven to ten years after a patient's last visit. In the case of a minor patient, doctors must keep the record for at least 10 years following the final office visit or until the child is 19 years old, whichever is longer. Keep in mind that this rule may vary with individual state law. For example, in some states, it's the standard number of years past the last visit after the child has turned 18. If the child was 15 at the last visit, and the state law requires records retention for 7 years, records for that child must be kept 10 years after that last appointment.

It is crucial to remember that where and how long you keep records on file is a key component of your compliance policy. We recommend that you consult online resources for your state often as the requirements can change over time. A helpful resource is available by HealthIT.gov at:

https://www.healthit.gov/sites/default/files/appa7-1.pdf

Suggestions for Retaining Records:

1. Scan patient records into an electronic format. Don't use EHR (Electronic Health Records)? No problem. Utilize paper files only for the most recent day-to-day use. Scan any completed episodes of care, along with any other records to a network drive or other device that is backed up regularly and encrypted.
2. Periodically dispose of any archived or inactive patient files. We suggest scanning the entire file and then shredding it. Create and implement a policy that indicates at what length of time a file should be considered inactive and should be scanned and shredded. Adhere to HIPAA guidelines for the disposal of PHI such as documenting in your PHI Destruction Log and obtaining a certificate of destruction if you utilize a shredding company.
3. Exclude insurance information from patient files (such as EOBs (Explanation of Benefits)). File these in a daily bundle style format with other important documents such as sign-in sheets, deposit tickets, daily EOB postings, credit card vouchers, etc. Do not keep these items with patient records. To save space and optimize organization, file this information by date, and periodically archive it. You may opt to eventually scan and shred these records as well.

A compliance policy that describes how you manage each aspect of the retention and destruction of patient records is a must-have for every office and should be included in your HIPAA and OIG (Office of Inspector General) Compliance Policy Manuals.

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The Provider's Story Through Diagnoses

Coders often say, "the diagnosis tells the patient's story." It is because a payer has limited information about the patient's treatment since they have no access to the patient's medical record during the claim submission process. They rely on the diagnosis codes reported on the claim form to capture the patient's condition and the necessity for care.

Once a patient walks through your door a story begins. If the patient is self-pay, the story will have a limited audience. If the patient is insured, the story will be read by many different parties with individual expectations. As compliance specialists, we know that the diagnoses tell the provider's story as well. Payers collect and analyze data constantly. They are looking for outliers in everything related to claim submission and reporting. Therefore, what is reported can affect reimbursement for the provider as well as the profession. Many times, reimbursement policies, Medical Review Policies (MRP), and code edits are built upon the data collected from claim submissions.

The Bigger Picture

Diagnosis codes submitted to insurance companies are reported federally, and that data is shared internationally with the World Health Organization (WHO). Back pain and headache sufferers are found throughout the world, and it is important to know what type of treatment works. This data is collected and analyzed on a micro to macro level, from a pocket within a city, to an area of a state, to a region of the country, and to the country as a whole. Unlike WHO, insurance carriers are often more interested in the bottom line, reducing costs, and eliminating unnecessary procedures. If providers code without thought or understanding, they could be telling a story they did not intend.

What is Your Story?

When a provider uses a code that is no longer active or valid, it tells the payer that the provider does not keep up with yearly updates and more than likely is coding from a cheat sheet. When the provider codes pain first, it tells the payer that the provider does not understand the hierarchy of diagnosing. When a provider utilizes unspecified codes, it tells the payer that the provider did little to nothing to fully evaluate the patient's condition.

When choosing a diagnosis for the patient, it is important to give thoughtful consideration to the code chosen, including the definitions, exclusions, and alternate codes. Poor storytelling can impact reimbursement now and in the future with regard to coverage and benefits.

Not sure about what we mean by coding hierarchy? Check out the Rapid Solution titled ***Diagnosis Hierarchy- What You Need to Know***

https://learn.kmcuniversity.com/rapid-solution/diagnosis-hierarchy-chiropractic-services/

Help Desk
Frequently Asked Questions

I have heard a great deal about the No Surprises Act Update that was released in August. What applies to me?

Yes, there was some 'decision making' with regard to implementation of the Affordable Care Act, title I, No Surprises Act. Most of the changes are focused on calculating the qualifying payment amount (QPA) when a provider enters the Independent Dispute Resolution (IDR) process. The IDR process is for providers who are out of network but rendering service in an in-network facility. This would apply to the one percent of chiropractors who have hospital privileges. Most DCs should focus on the rules surrounding Good Faith Estimates (GFE) . Simply put, offer a GFE to all patients who are self-pay or not utilizing their insurance and post on your website or office wall the Good Faith Estimate Notice. Need to know more? Check out KMC University's Rapid Solution titled ***No Surprises Act- Good Faith Estimate.***

https://learn.kmcuniversity.com/rapid-solution/no-surprises-act-good-faith-estimate/

We are not contracted with a payer and do not submit claims on behalf of the patient, yet the payer is sending checks to us. What should we do?

If you are not contracted with an insurance plan, and the patient submitted the superbill, yet the payer paid you (the provider) directly, this payment is not your money. At KMC University we have seen a growing number of these situations with out of network providers. It appears that payers have applied a blanket policy for all out of network providers due to the No Surprises Act (NSA) Balance Billing Protection rule. This portion of NSA does NOT apply to providers who are out of network and only providing service in their stand-alone clinic. We would recommend that you contact the payer directly and ask them why the payments are being sent directly to you; best to communicate through a payer portal messaging system. If they are applying NSA rules, then educate them on the proper application. The other option is to locate the overpayment rules for that payer and treat it as an overpayment. For more information, see KMC University's Practice Finance module titled ***Managing Over-Payments & Refund Requests.***

https://learn.kmcuniversity.com/rapid-solution/managing-over-payments-refund-requests/

Can shockwave treatment be reported with procedure code 97140?

Shockwave treatment should be billed with procedure code 97039. It is often found to be classified as experimental and investigational by insurance companies. Verify coverage and exceptions with each insurance company. Be sure to consult the Medical Review Policy for additional details and requirements. For additional information check out the KMC University module titled ***Coding Non-Traditional Physical Medicine***

https://learn.kmcuniversity.com/courses/cpt-coding-according-documentation/lessons/non-traditional-physical-medicine/topic/medical-necessity-for-non-traditional-physical-medicine/

Quick Tip

Overwhelmed with Documentation?

Do you have a hard time keeping up with documentation requirements? Are you documenting certain details out of habit while overlooking key components that lead to proving medical necessity? Understanding the difference between the initial visit of an episode of care and the subsequent visit in the episode helps define the documentation requirements. In this helpful video, Kathy Mills Chang (KMC) addresses the most common questions we receive about documenting Routine Office Visits (ROV). She explains what the auditors are looking for and provides practical suggestions for success

https://kmcuniversity.com/free-stuff/blog/2022/08/daily-routine-office-visits-documentation-lite/

What's New in KMC University Library?

The Phone Lines are Open!

Library members can now access personal assistance with finding resources in the KMC University Library. Save time and get instant answers to your questions by contacting us at (855) KMCU-NOW or (855) 562-8669. Phone support hours are 8am – 12pm MT, Monday – Friday.

Orthotic Resources

Do you want to increase cash flow and provide a service that will benefit your patients for a lifetime? At KMC University we recommend scanning every new patient with the Foot Levelers kiosk. We partnered with Foot Levelers to develop a training course on documenting, coding, and billing custom orthotics. Get Started Today! The free course titled ***Orthotics-From Prescription to Payment*** can be found at the following link.

https://learn.kmcuniversity.com/courses/orthotics-from-perscription-to-payment/

Update Your ICD-10 Codes

The KMC University Library has the 2023 revisions and Addenda documents for your team to utilize when updating your practice management software diagnosis coding. Library members can learn more about these changes by locating the Help Desk FAQs in the Dashboard, under Announcements. Be sure to take note of the following changes by October 1st.

M51 series contains new codes that define lumbosacral annulus fibrosus. Be sure to review the coding instructions when reporting disc herniation at the same time.

M62 series contains new codes that define muscle wasting and atrophy.

Chapter 19 has nearly 100 new codes for reporting traumatic brain injury.

Chapter 20 has over 500 new codes to report external causes.

https://learn.kmcuniversity.com/courses/diagnosis-coding-according-to-documentation/lessons/icd-10-basics/topic/icd-10-coding-basics-reference-documents/

Upcoming Events, Seminars, and Webinars

Annual Fraud, Waste & Abuse (FWA) Training Is Not Optional

If you treat Medicare, Medicaid, or Medicare Advantage patients, this requirement applies to YOU! Providers and staff must complete and document FWA training within 90 days (about 3 months) of hire and annually thereafter. There is no small provider exception.

KMC University has your back! If you have not completed and documented your training for 2022, you can mark it off your list now. Attend this live, Chiropractic specific training (CE Credit is included for live attendees, where applicable) or view the recording to confirm attendance and receive a certificate of completion. Library Members have access to this yearly training. Not yet a KMC University Library member? Purchase your training at the following link:

https://learn.kmcuniversity.com/product/ce-webinar-fraud-waste-and-abuse/

Keep Your Eye Out for Certified Training!

The summer months have allowed our development team to focus on creating new courses that will assist clinics nationwide. KMC University will be the resource for Chiropractic Assistants (CA) who want to be nationally certified. The ***Certified Chiropractic Clinical Assistant (CCCA)*** course will be available for library members at ***no additional cost.*** This robust training will provide a potential certified chiropractic clinic assistant with the required 24 hours of course work to qualify for the certification test. If a CA has met the 2000 hours of experience, this course can prepare them for the key areas of the test plan.

CE Webinars

Diagnostic Synthesis-The Art of Accurate Diagnosis Coding

https://learn.kmcuniversity.com/2022/08/09/rsvp-august-9th-ce-webinar-diagnostic-synthesis-the-art-of-accurate-diagnosis-coding/

Payer Updates

Optum Chiropractic Policy Update

This recent update may impact a provider who is rendering procedure code 98943 on the same date as procedure code 97140. Be sure to check out the Payer Update at the following link:

https://learn.kmcuniversity.com/2022/09/02/provider-impact-on-coding-98943/

Optum Policy on Routine Chiropractic Services

If you treat Optum Medicare Advantage patients, you will want to take a closer look at this policy that includes a benefit for routine care verses active care. Find out more on KMC University's Payer Update site:

https://learn.kmcuniversity.com/2022/09/06/optum-announces-coverage-for-routine-chiropractic-services/

Blue Cross Blue Shield Low Back Imaging Update

BCBS of Illinois released a 'tip sheet' on low back imaging. The recommendation is to "avoid ordering diagnostic studies in the first four weeks of new-onset back pain if there aren't indications of underlying conditions." See more on KMC University's Payer Update site:

https://learn.kmcuniversity.com/2022/09/04/bcbs-low-back-imaging-requirements/

A BAA- The Magic HIPAA Document? Not So Fast!

A Business Associate Agreement (BAA) is a written contract between a covered entity and a business associate. The key word in that statement is "contract." It means both parties agree to the terms listed. Unfortunately, some professionals have regarded this document as the 'magic piece of paper' that releases the provider from ALL responsibility if the business associate (vendor) has a breach. In fact, we heard one consultant say, "if there is a breach, the doctor is free and clear and DOES NOT have to report the breach to HHS (Health and Human Services)" Trust us, this is not true!

The fact is, according to HHS, "If a breach of unsecured protected health information **occurs at or by a business associate, the business associate must notify the covered entity following the discovery** of the breach. A business associate must provide notice to the covered entity without unreasonable delay and no later than 60 days from the discovery of the breach. To the extent possible, the business associate should provide the covered entity with the identification of each individual affected by the breach, as well as any other available information required to be provided by the covered entity in its notification to affected individuals."

It is the responsibility of the Covered Entity (aka provider) to report a breach to the HHS. So, if a business associate mishandles protected health information, the provider is not "free and clear." Although the provider may not be the responsible party, and the vendor must provide all the details, the provider is responsible for all the fact gathering and submission of the breach notification. It is one of the reasons some BAAs (Business Associate Agreement) provide an option for covered entities to review the business associate's compliance activities. In other words, the covered entity looks closely at the business associate's HIPAA safeguards and security promises before engaging in business.

Another misconception is the belief that a signed BAA means that the provider is HIPAA compliant. Many of the vendors that are larger in size offer the BAA online. A provider can download the BAA, file it away, and assume they are compliant. A provider should review the Terms of Use, Privacy Policy, along with a downloadable BAA. For example, Google Workspace and Microsoft Office 365 provide specific directions for how to set up (configure) the applications in order for the BAA to apply. They also list services that are NOT included in the BAA. If a clinic does not follow these guidelines, it could be in violation of the contract agreement (BAA). And as a reminder, if the service is FREE there is a 99% chance that the product is not the HIPAA-compliant version. Most BAAs apply to paid services only and business or enterprise-level products. Keep this in mind the next time you download a BAA from a vendor's website.

If you are feeling a bit lost with this topic, feel free to check out the KMC University library module titled ***PHI, TPO, BAA- oh my!***

https://learn.kmcuniversity.com/courses/hipaa-compliance/lessons/what-is-phi-tpo-baa/

If you prefer to have a Specialist take a closer look at your HIPAA program, including your BAAs, please schedule a consultation.

https://kmcuniversity.com/discovery-consultation/

Managing Modifier Usage

Has your clinic experienced denials when submitting claims with physical therapy procedure codes? We field a large amount of help desk inquiries each week and many are about modifiers -59,-96,-97. In most cases, the provider has overlooked a payer's reimbursement policy update, which results in denied claims.

Modifier -59

Although the -59 subset modifiers, also referred to as the 'X' modifiers were implemented back in 2015, some payers have taken their time in implementing code edits; which means you could choose either one and the claim was payable. Based on CPT (Current Procedural Terminology) coding instructions, a provider must choose the more descriptive modifier if one is available. Which definition listed below would best describe procedure code 97140 when performed in a separate region from CMT (Chiropractic Manipulative Treatment)?

Modifier -59 (Distinct Procedural Service) - identifies a procedure that is not normally reported together but are appropriate under the circumstances.

Modifier -XS (Separate Structure) - identifies a procedure that is distinct because it was performed on a separate organ/structure.

More than likely, you would choose the -XS modifier. Payers appear to be denying claims with the -59 modifier based on the fact that the 'X' modifiers provide greater reporting specificity. Be sure to check your payer policies and remittance advice codes for similar modifier coding expectations.

Modifiers -96 and -97

Since the roll out of the Affordable Care Act in 2010, payers had to include benefits for rehabilitative and habilitative services as part of the Essential Health Benefits (EHB). In order to manage coverage limitations, payers have required providers to identify these services by appending a modifier -96 or -97 (never at the same time).

Based on the definitions outlined in the federal regulation, most physical therapy services rendered by a Doctor of Chiropractic fall under Rehabilitative Services (-97) which is defined as a service that helps a person **regain, maintain or prevent deterioration** of a skill or function, **that has been acquired but then lost** or impaired due to illness, injury, or disabling condition.

It is vital that providers who are billing physical therapy services consult each payer's reimbursement guidelines. Be sure the claim form appends the required modifiers for each procedure code.

Check out Humana's Coding Resource on modifiers 96 and 97 at:

https://www.brainshark.com/1/player/humana?fb=0&r3f1=&custom=mods96and97v3

Check out Optum's Modifier -59 policy at:

https://www.myoptumhealthphysicalhealth.com/public/document/?documentType=ReimbursementPolicies&documentName=0050_Modifier59Policy.pdf

Commonly Used Modifier Cheat Sheet available in KMC University Library for members:

https://learn.kmcuniversity.com/courses/cpt-coding-according-documentation/lessons/coding-modifiers/topic/commonly-used-modifiers-quick-reference/

HIPAA Alert

On July 15th, the Office for Civil Rights rolled out eleven enforcement actions* on upholding the patients' rights under HIPAA. The penalties for not responding correctly to a patient's medical record request ranged from 5,000 to 240,000 dollars. And before you disregard this notice, the violations were not just hospitals, six were single-provider offices or smaller clinics.

As compliance specialists, we audit a variety of provider offices nationwide. Most clinics do not have a process to handle record requests and leave it up to chance. Offices are focused on record requests from payers or attorneys, but it is equally important to develop a medical record policy for patient requests. Staff should know the following:

- **How to obtain authorization from the patient.** For example, is a signed release necessary for patient requests? What if they cannot sign a release or fill out a request form? Can the office demand a signed release before releasing the records to the patient?
- **Who is responsible for fulfilling the request.** Is there someone in the clinic assigned to review and respond to the request? Is the clinic aware of the time frame to respond? Is there a process to document the request and the response?
- **How to fulfill the request.** Can you charge the patient? If so, how much? Can you hold records hostage until patients pay their balance? Can you email patient records if requested and still be HIPAA compliant?

Charging for Medical Records

Unfortunately, most clinics default to state law when developing their fees for record requests. This is not HIPAA compliant. A clinic must address both State and HIPAA regulations before implementing fees. The following is an example of where state law differs from HIPAA. In this case, the clinic should follow HIPAA.

Illinois Law states:

> *For electronic records, retrieved from scanning, digital imaging, electronic information, or other digital format in an electronic document, a charge of **50% of the per page** charge for paper copies listed above.*

HIPAA states:

> ***Per page fees are not permitted** for paper or electronic copies of PHI maintained electronically.*

Would you like to know more about the HIPAA Right of Access requirements for medical record requests? Check out the KMC University Library module titled ***HIPAA & Patient Access.***

https://learn.kmcuniversity.com/courses/hipaa-compliance/lessons/hipaa-patient-access/

More information is available on HHS (Health and Human Services) site at:

https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html

* *https://www.hhs.gov/about/news/2022/07/15/eleven-enforcement-actions-uphold-patients-rights-under-hipaa.html*