TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 10 MEDICINE AND SURGERY PRACTITIONERS
PART 17 MANAGEMENT OF MEDICAL RECORDS

16.10.17.1 ISSUING AGENCY. New Mexico Medical Board hereafter called the board.
[16.10.17.1 NMAC - N, 7/1/2006]

16.10.17.2 SCOPE. This part governs the use management of medical records that are created and maintained as part of the practice of a physician who has physical possession or ownership of the records.
[16.10.17.2 NMAC - N, 7/1/2006]

16.10.17.3 STATUTORY AUTHORITY. These rules are promulgated pursuant to and in accordance with the Medical Practice Act, sections 61-6-1 through 61-6-35 NMSA 1978.
[16.10.17.3 NMAC - N, 7/1/2006]

16.10.17.4 DURATION. Permanent
[16.10.17.4 NMAC - N, 7/1/2006]

16.10.17.5 EFFECTIVE DATE. July 1, 2006, unless a later date is cited at the end of a section.
[16.10.17.5 NMAC - N, 7/1/2006]

16.10.17.6 OBJECTIVE. This part establishes requirements and procedures for management of medical records.
[16.10.17.6 NMAC - N, 7/1/2006]

16.10.17.7 DEFINITIONS.

A. "Electronic medical billing" means all data defined in Subsection D of this section that is kept by computer hard drive or disk, server hard drives or other media which is printer capable upon request.

B. "Electronic medical records" means all information contained in Subsection E of this section that is kept by computer hard drive or disk, server hard drives or other media, which is printer capable upon request.

C. "Group practice" means an association of providers who practice jointly. Providers need not be of the same specialty; however, they shall practice under a common entity. Group practice does not include any government agency or non-profit organization that employs providers.

D. "Medical billing" means all data kept by a physician to procure payment including, but not limited to, claims processing, forms, submissions, correspondence, and accounting ledgers.

E. "Medical record" means all information maintained by a physician relating to the past, present or future physical or mental health of a patient, and for the provision of health care to a patient. This information includes, but is not limited to: the physician's notes; reports and summaries; x-rays and laboratory results; other diagnostic test results. A patient's complete medical record includes information generated and maintained by the physician, as well as information provided to the physician by the patient, by any other physician who has consulted with or treated the patient, and other information acquired by the physician about the patient in connection with the provision of health care to the patient. Medical record does not include medical billing, insurance forms or correspondence related thereto.

F. "Established physician- or physician assistant-patient relationship" means a relationship between a physician or physician assistant and a patient that is for the purpose of maintaining the patient's well-being. At a minimum, this relationship is established by an interactive encounter between patient and physician or physician assistant involving an appropriate history and physical or mental status examination sufficient to make a diagnosis and to provide, prescribe or recommend treatment, with the informed consent from the patient and availability of the physician or physician assistant or coverage for the patient for appropriate follow-up care. A medical record must be generated by the encounter.

G. "Psychotherapy notes" means notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude information that is found in the medical record, including medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, the treatment

plan, symptoms, prognosis and progress to date. To meet the definition of psychotherapy notes, the information must be separated from the rest of the individual's medical record.
[16.10.17.7 NMAC - N, 7/1/2006; A, 1/1/2009]

16.10.17.8 RELEASE OF MEDICAL RECORDS. Physicians must provide complete copies of medical records to a patient or to another physician in a timely manner when legally requested to do so by the patient or by a legally designated representative of the patient. This should occur with a minimum of disruption in the continuity and quality of medical care being provided to the patient. If the medical records are the property of a separate and independent organization, the physician should act as the patient's advocate and work to facilitate the patient's request for records.

A. Medical records may not be withheld because an account is overdue or a bill for treatment, medical records, or other services is owed.

B. A reasonable cost-based charge may be made for the cost of duplicating and mailing medical records. A reasonable charge is not more than $30 for the first 15 pages, and $0.25 per page thereafter. Patients may be charged the actual cost of reproduction for electronic records and record formats other than paper, such as x-rays. The board will review the reasonable charge periodically. Physicians charging for the cost of reproduction of medical records shall give consideration to the ethical and professional duties owed to other physicians and their patients.

C. Psychotherapy notes must be maintained separately from the patient's medical record, and may be withheld from the patient. The patient does not have the right to read, amend or have a copy of psychotherapy notes. Release of psychotherapy notes to other health care providers requires express authorization from the patient.
[16.10.17.8 NMAC - N, 7/1/2006; A, 1/1/2009]

16.10.17.9 CLOSING, SELLING, RELOCATING OR LEAVING A PRACTICE. Due care should be taken when closing or departing from a practice to ensure a smooth transition from the current physician to the new treating physician. This should occur with a minimum of disruption in the continuity and quality of medical care being provided to the patient. Whenever possible, notification of patients is the responsibility of the current treating physician.

A. Whenever possible, active patients and patients seen within the previous three years must be notified at least 30 days before closing, selling, relocating or leaving a practice. The method of notification is established in Subsection C of this section.

B. The executor of the physician's estate or his designee shall notify patients within at least thirty (30) days after the death of the physician and indicate how to obtain patient records from the closed practice. The method of notification is established in Subsection C of this section.

C. Notification may be satisfied using any of the following methods:

(1) by placing a notice in at least one newspaper in the local practice area; notice should advise patients where their medical records will be stored; notice should include any pertinent information the patient may need for obtaining or transferring the records, including the name, mailing address and telephone number of a contact person with access to the stored records; notification should run a minimum of two times per month for three months to reach a maximum number of patients; or

(2) by written or electronic mail; or

(3) by individual correspondence to the patient's last known physical or electronic mail address.

D. A physician or physician group should not withhold patient lists or other information from a departing physician that is necessary for notification of patients.

E. Patients of a physician who leaves a group practice must be notified the physician is leaving, notified of the physician's new address and offered the opportunity to have their medical records transferred to the departing physician at his new practice.

F. When a practice is sold, all active patients must be notified that the physician is transferring the practice to another physician or entity who will retain custody of their records and that at their written request the records (or copies) will be sent to another physician or entity of their choice.

G. When a physician closes a practice and the practice retains an inventory of drugs, contact the board of pharmacy for proper disposition, inventory, or inspection in accordance with the Pharmacy Act, the Drug Device and Cosmetic Act, and the Controlled Substances Act.

H. A physician or group practice shall develop a procedure for closing a practice and patient notification in the event a physician becomes incompetent or deceased. This procedure shall be available upon request by the board.

I. Notification shall also be sent to the board office within at least thirty (30) days before closing by electronic mail, facsimile, or letter.

[16.10.17.9 NMAC - N, 7/1/2006; A, 1/1/2009]

16.10.17.10 RETENTION, MAINTENANCE AND DESTRUCTION OF MEDICAL RECORDS.

A. Improper management of medical records, including failure to maintain timely, accurate, legible and complete medical records constitutes a violation of 61-6-15.D(33). Physicians must provide every patient with a written copy of their policy or their employer's policy for medical record retention, maintenance and destruction.

B. Written medical record policy shall include:

(1) responsible entity/agent name of contact to obtain records or request transfer of records, telephone number and mailing address;

(2) how the records can be obtained or transferred;

(3) how long the records will be maintained before they are destroyed; and

(4) cost of obtaining copies of records, and of recovering records/transferring records.

C. Electronic medical record policy shall include:

(1) responsible entity/agent to obtain records, requests for transfer of records, telephone number and mailing address;

(2) how the records can be obtained or transferred;

(3) how long the records will be maintained before they are destroyed or purged;

(4) a data backup plan, disaster recovery plan and storage which ensures retrievability into reasonably usable form on a timely basis upon any request; and

(5) transfer of data via electronic file with appropriate safeguards to ensure patient confidentiality.

D. Physicians must retain medical records that they own for at least ten (10) years after the date of last treatment or the time frame set by state or federal insurance laws or by medicare and medicaid regulation. Medical records for patients who are minors must be retained until the date that the patient is twenty-one (21) years old. If a physician converts hard copies of medical records to electronic medical records, the hard copy shall be retained by the physician for a minimum of thirty (30) days after electronic transfer has occurred.

E. Physicians shall retain medical billing information for at least two (2) years after the date of last treatment.

F. The board adopts the ethical standards for medical record retention and maintenance set forth in the latest published version of the "c*ode of medical ethics current opinions with annotations*" of the council on ethical and judicial affairs of the American medical association. Physicians have an obligation to retain patient records which may reasonably be of value to a patient. Beyond the time frame established in Subsection D of this section, medical considerations are the primary basis for deciding how long to retain medical records. In deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time. For example, operative notes, chemotherapy records and immunization records must remain part of the patient's chart.

G. Destruction of medical records must be such that confidentiality is maintained. Records must be destroyed by shredding, incinerating (where permitted) or by other method of permanent destruction, including purging of medical records from a computer hard drive, server hard drive or other computer media or disk in accordance with existing practices for data deletion then available.

H. A log must be kept of all charts destroyed, including the patient's name and date of record destruction in accordance and under the same time frame established in Subsection D of this section.

[16.10.17.10 NMAC - N, 7/1/2006; A, 1/1/2009]

History of 16.10.17 NMAC: [RESERVED]