The Kendrick Law Group

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Answers and Overview to your Legal Inquiries

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DOCUMENT RETENTION

Basis for Keeping Medical Records

The most important reason for keeping a medical record is to provide information on a patient's care to other healthcare professionals. Another major reason is that a well-documented medical record provides support for the physician's defense in the event of a medical malpractice action.

Entries made in the medical record at or near the time of the event are regarded as highly reliable evidence in subsequent judicial procedures. Without the medical record, the physician might not be able to show that the care he or she provided was appropriate and, thereby, met the standard of care.

Relying on the practitioner's general habit and practice to show that the standard of care was met—without supporting documentation to establish what treatment was actually rendered—often fails to convince the finder of fact that the treatment the patient received was consistent with community standards**.**

State and Federal Laws

For the most part, state and federal laws regarding mandatory record retention requirements apply to hospitals or similar facilities rather than to physician practices.

- The Medicare Conditions of Participation (COP) require hospitals to retain records for five years (six years for critical access hospitals)

- OSHA requires an employer to retain medical records for 30 years for employees who have been exposed to toxic substances and harmful agents.

- HIPAA privacy regulations require records to be retained for six years from when the record was created, which follows the federal statute of limitations for civil penalties.

According to Rule 64B8-10.002(3), FAC : A licensed physician shall keep adequate written medical records, as required by Section 458.331(1)(m), Florida Statutes, for a period of at least five years from the last patient contact; however, medical malpractice law requires records to be kept for at least seven years.

Recommendations

- Adult patients, 10 years from the date the patient was last seen.
- Minor patients, 28 years from the date of birth.
- Deceased patients, five years from the date of death**.**

What Records Should You Retain?

Retain all records that reflect the clinical care provided to a patient, including provider notes, nurses' notes, diagnostic testing, and medication lists. Retain records obtained from another provider for the same length of time as those in your record. This is especially true if you have relied on any of the previous records or information when making your clinical decisions.

Review patient bills for any reference to care provided. For example, review a bill to determine if it shows a limited examination or an annual physical with diagnostic tests obtained or requested. If the billing document shows that care was provided, it may be in your best interest to keep the bill for as long as you retain the medical record. Otherwise, you need to retain the bill for the same length of time as other business records and in accordance with federal and state income tax requirements

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Storing medical records for the recommended time can have a financial effect on the physician or practice. Given the importance of the medical record in defending a malpractice action, however, it is vital to ensure that the record is available to defend proper care.

Record Retention FAQ's

Is information stored in other formats, such as videos, x-ray films, ECGs, fetal monitor strips, and photos, part of the medical record?
Yes. Regardless of format, any and all data collected at the time of a patient encounter is part of the medical/legal document.

How long should billing records, telephone calls/messages, and appointment books be kept?
Billing records in all states should be retained for seven years according to Internal Revenue Service standards. They may be kept in a separate file Telephone calls that pertain to medical care should be documented in the medical record and kept according to the above-referenced medical record retention guidelines. Appointment books may be kept for one year.

If a patient brings his or her past medical records to my office, am I required to maintain all of the copies?
No, however, the physician should review, extract, and photocopy any information that he or she might need from that record and then return the original documents to the patient. The retained information or documentation then becomes part of the patient's permanent office record. Be aware that if the physician keeps all of the patient's medical records, he or she could be held liable for information related to other specialties.

How should hard copy paper records be destroyed?
The only safe methods for destroying paper records are incineration or shredding. A destruction method for electronic medical records has yet to be determined.

Where can medical records be stored?
Inactive records may be thinned from the active patient cases and stored outside the office suite. Take the following factors into consideration when making arrangements for long-term storage:

- Privacy. Will the records be protected from unauthorized persons in a manner that is consistent with federal and state privacy laws?
- Safety. Will the records be protected from fire or flood damage and from unauthorized access or theft?
- Accessibility. Will the records be easy to retrieve and copy?

Can records be transferred to disk or stored in a computer?

Yes. The factors in the previous question can also guide you on transferring records to disk and on storing records in a computer. As of March 26, 2013, protected health information (PHI) transferred or stored electronically must be encrypted. Computer data should be backed up at regular intervals and stored off site, as in the previous question.

Is it sufficient to back up a copy of an electronic health record (EHR) onto a disk?
Yes. However, you should store a copy of the EHR software, along with the data itself, to make sure the records can be read in the future. Alternatively, you could save the data in PDF format so it can be read without special software. Regardless, all PHI stored electronically must be encrypted. If you use an application service provider—where your data is stored by the EHR vendor and you access it online—your contract should include terms that ensure your data will be available to you when you're ready to make arrangements for long-term storage.

Can I sell my records when I sell my practice?
Yes. We suggest that you include the recommended retention time and access capability as part of your sales agreement.

If I move to another state, can I take my records with me?
Yes, with the same condition for retention and accessibility that prevails in a sale. It might be reasonable to alert your active/current caseload of your move in order to give patients an opportunity to request a copy of their medical records.

If a patient requests a copy before I move, can I hand over the original record?
No. The original is the property of the physician, who has a duty to maintain the record.

If someone claiming to be a representative of a deceased patient's estate requests a copy of the chart, what should I do?
You must first verify through your own records or from a death certificate that the patient has expired. Then, ensure that the individual is a qualified representative of the decedent's estate (for example, the executor). The individual should provide a copy of an official document from the state as proof.

LEGAL REQUESTS
When and how to handle

If a patient record is requested by anyone other than the patient, what should I do?
Call your attorney! At that point we will discuss the treatment of the patient, what dould possible be the reason for the request and instruct you on how to protect oneself both professionally and personally. ALWAYS GET PATIENT PERMISSION TO RELEASE THE FILE. DIRECT HIPAA RELEASE SIGNED FROM PATIENT ON YOUR GROUP'S LETTERHEAD.

Who should be fielding the document requests?
Only one to two office staff should be reviewing and answering document requests. This limits error and allows complete diligence to protect the physician(s) and the practice.

We received a subpoena for medical records, do we have to respond?
YES. Again, once a case is in litigation; your first call should be your attorney and the second should be your carrier if the case is against you. This would be something your corporate/business attorney can quickly discuss with you to determine what needs to be disclose and what does not. READ THE REQUEST CAREFULLY. The biggest errors physician practices make is turning over a whole patirent record when the request only ask for a specific document. There is no need to open yourself up for scrutiny if not necessary.

How to handle different legal requests from attorneys?
These are general overviews of what to consider when you first analyze the request:
Physician-patient privilege

Preservation of the physician-patient privilege should be the primary concern in each of these situations. Communications between a patient and physician for the purposes of evaluation, diagnosis, and treatment are privileged . The improper disclosure of privileged information exposes the physician to a claim by the patient for damages. This privilege, however, may be waived. The waiver may come from the patient or an authorized representative.

Liability exposure

The second consideration is that these contacts can expose you to some form of a liability claim. The most obvious exposure is to a health care liability claim based on negligence in providing care and treatment to the patient in question.

Responsible expression of opinions

This last consideration applies primarily when an attorney seeks an opinion about the propriety of the patient's care and treatment, the cause of the patient's medical conditions or problems, or the patient's future needs and prognosis. Make sure that your opinions are based on the proper standard and on thorough, accurate, and complete information. There is nothing improper about expressing opinions on these issues. Problems arise for everyone involved, including the patient, when strong opinions are provided based on personal standards of care, assumptions, and/or incomplete and inaccurate information.

The simple rule is to keep in mind the proper standard and to make sure that you obtain all of the relevant information that is available before expressing a final opinion on these types of issues.

If you receive a demand for medical malpractice, request for records on ANY of your patients, or any legal document request from an attorney—CALL YOUR LAWYER IMMEDIATELY. The first call should be to your corporate/business attorney and the second should be to your carrier.

Duties of the carrier in a Medical Malpractice Situation

Defense and indemnity. The carrier has 2 primary obligations under a medical malpractice policy: the duty to defend and the duty to indemnify. The duty to defend requires the carrier to retain a lawyer to defend legal claims that are brought against the physician. This duty also requires the carrier to pay expenses relating to the defense. The duty to indemnify requires the carrier to pay an amount up to the policy limits for a settlement or judgment on any covered claim against the physician.

Assignment of counsel. An insurance carrier will generally retain counsel for a physician when a lawsuit is filed, although some will do so early on when the notice letter is received. Typically, the carrier will assign a lawyer who has been approved to work on its cases, and a carrier will often honor a physician's request for a specific attorney. The carrier pays the fees of the lawyer it ultimately retains.

While the physician may obtain a personal lawyer in addition to counsel retained by the carrier, the carrier will not pay those fees.

Consent to settle. Some insurance policies have a "consent clause" that requires the insurance carrier to obtain the physician's consent in order to settle a case. By giving consent, the physician places the power of decision regarding settlement in the hands of the insurance company. Settlements, like adverse judgments, are reported to the National Practitioner Data Bank.

Duties of the Insured Physician in a Medical Malpractice Situation

Prompt notice. To preserve coverage, the policy typically requires insureds to provide the carrier with prompt notice of any potential claims or lawsuits against them. An insured physician's failure to provide prompt notice could jeopardize the carrier's obligations both to defend and to indemnify. As such, with respect to coverage, it is in a physician's best interest to provide prompt notice.

Cooperation. A policy also typically contains a "cooperation clause," which requires insured physicians to cooperate in the defense of a legal claim.

What if we receive a subpoena for written answers/depositions?
Depositions on written questions, more commonly called records subpoenas, are the most common manner in which defendants obtain records in the course of a legal proceeding. The records are sought in this manner so that they are authentic and admissible under the applicable legal rules of evidence and procedure Additionally, when records are obtained in this manner, it is not necessary to have the physician who maintains the records, or a "records custodian" from his office, testify in person at trial to legally establish that the records are authentic and admissible evidence. Production of a patient's records in response to a subpoena constitutes a proper disclosure of patient records

What are the different types of subpoenas?
There are two types of subpoenas. The first, called subpoena to testify requires you to testify before a court, or other legal authority. The second, called subpoena duces tecum, requires you to produce documents, materials, or other tangible evidence. If you are required to testify, there needs to be proper notice. A lot of times we are able to strike you from testifying if proper notice was not provided.

I was asked to testify as a medical expert, what can I charge?
The median testimony hourly fee for medical expert witnesses is $500/hour. On average, expert witnesses who testify mostly for defendants command higher fees than expert witnesses who testify mostly for plaintiffs. Truly you can make your own fee based request based on experience in medicine, experience in court, specialty, and time prior to testimony vs. review. YOU NEED TO CREATE A FEE SCHEDULE; to include but not limited to time to prepare, travel, in person work, minimum commitment, cancellations, hotel accomodations, per diem, etc.

If I am requested to provide documents to an attorney, can I charge for these documents?
YES.

For patients and government entities, the maximum fees shall not exceed the following:

- $1 per page for the first 25 pages
- $0.25 per page for each page in excess of 25 pages.

For all other entities, the fee is $1 per page

I was called to testify in a deposition, what should I do and what should I avoid?
A deposition is a question-and-answer session, under oath in front of a court reporter, in the course of a civil lawsuit, or less frequently, in an administrative or criminal proceeding. Physicians are commonly called on to give deposition testimony as treating physicians for patients who are claiming injuries in a lawsuit, such as an automobile accident case.

Mistake 1 Ignoring Requests for Depositions
A physician who is asked to give a deposition should accept the inevitable and cooperate with counsel in scheduling the deposition for a time and place that is convenient for the physician.

Mistake 2 Failing to Seek Advice
A physician who is requested to give a deposition should consult with a lawyer or, if practicing in a group setting, the group's designated risk manager.

Mistake 3 Failing to Review Chart Entries
It is crucial for physicians to carefully review their chart entries before the deposition to make sure that they know exactly what they did for the patient and why.

Mistake 4 Overpreparing
When preparing for a deposition, a physician should avoid reviewing information that is not directly pertinent to his or her role in the care of the patient.

Mistake 5 Failing to Address Fee Issues
A physician should discuss fee issues with counsel well before the deposition. Physicians who are represented by a lawyer should discuss the fee issue with their own lawyer. A physician who is a retained expert should discuss fees with the hiring lawyer. Physicians who are not represented by counsel or hired as an expert should discuss fees with the lawyer who makes the deposition request.

Mistake 6 Forgetting the Ground Rules
Physicians should strive to follow the ground rules for depositions so that their testimony can be taken down clearly and accurately.

Mistake 7 Guessing or Speculating
Physicians should not guess or speculate when answering questions in a deposition. They should stick to their own personal knowledge or, when asked for opinion testimony, testify only as to the opinions they have formed to a reasonable degree of medical certainty.

Mistake 8 Volunteering Information Beyond the Question
Physicians must answer deposition questions truthfully, but they should strive to keep their answers direct and to the point. They should avoid volunteering information that is not specifically requested by the deposing lawyer.

Mistake 9 Venturing Outside the Physician's Area of Expertise
Physicians should avoid answering deposition questions in areas outside of their medical specialty.

Mistake 10 Becoming Hostile or Argumentative
Physicians should strive to maintain a calm, professional demeanor during a deposition, and avoid any temptation to argue with the deposing lawyer.

REGULATORY COMPLIANCE

The OIG has issued comprehensive guidelines for compliance programs for Individual and Group Rractice Physicians. The comprehensive guidelines can be found here https://oig.hhs.gov/authorities/docs/physician.pdf.

This compliance program guidance for individual and small group physician practices contains seven components that provide a solid basis upon which a physician practice can create a voluntary compliance program:

- Conducting internal monitoring and auditing;
- Implementing compliance and practice standards;
- Designating a compliance officer or contact;
- Conducting appropriate training and education;
- Responding to detected offenses and developing corrective action;
- Developing open lines of communication; and
- Enforcing disciplinary standards through well-publicized guidelines.

Step One: Auditing and Monitoring

An audit is an excellent way for a physician practice to ascertain what, if any, problem areas exist and focus on the risk areas that are associated with those problems.

There are two types of reviews that can be performed as part of this evaluation: (1) A standards and procedures review; and (2) a claims submission audit.

1. Standards and Procedures
An individual in the physician practice should be charged with the responsibility of periodically reviewing the practice's standards and procedures to determine if they are current and complete. If the standards and procedures are found to be ineffective or outdated, they should be updated to reflect changes in Government regulations or compendiums generally relied upon by physicians and insurers (i.e., changes in Current Procedural Terminology (CPT) and ICD–9–CM codes).

2. Claims Submission Audit
In addition to the standards and procedures themselves, it is advisable that bills and medical records be reviewed for compliance with applicable coding, billing and documentation requirements. The individuals from the physician practice involved in these self-audits would ideally include the person in charge of billing (if the

practice has such a person) and a medically trained person (e.g., registered nurse or preferably a physician (physicians can rotate in this position)). Each physician practice needs to decide for itself whether to review claims retrospectively or concurrently with the claims submission.

Step 2: Establish Practice Standards and Procedures

After the internal audit identifies the practice's risk areas, the next step is to develop a method for dealing with those risk areas through the practice's standards and procedures. Written standards and procedures are a central component of any compliance program.

Those standards and procedures help to reduce the prospect of erroneous claims and fraudulent activity by identifying risk areas for the practice and establishing tighter internal controls to counter those risks, while also helping to identify any aberrant billing practices.

If your practice does not already have something similar to this - documented ''practice standards'' that include practice policy statements regarding patient care, personnel matters and practice standards and procedures on complying with Federal and State law. It is highly recommended that you work with an attorney to establish these policies.

Step Three: Designation of a Compliance Officer/Contact(s)

After the audits have been completed and the risk areas identified, ideally one member of the physician practice staff needs to accept the responsibility of developing a corrective action plan, if necessary, and oversee the practice's adherence to that plan. This person can either be in charge of all compliance activities for the practice or play a limited role merely to resolve the current issue.

In a formalized institutional compliance program there is a compliance officer who is responsible for overseeing the implementation and day-to-day operations of the compliance program. However, the resource constraints of physician practices make it so that it is often impossible to designate one person to be in charge of compliance functions.

It is acceptable for a physician practice to designate more than one employee with compliance monitoring responsibility. In lieu of having a designated compliance officer, the physician practice could instead describe in its standards and

procedures the compliance functions for which designated employees, known as ‘‘compliance contacts,’’ would be responsible.

In situations where staffing limitations mandate that the practice cannot afford to designate a person(s) to oversee compliance activities, the practice could outsource all or part of the functions of a compliance officer to a third party, such as a consultant, PPMC, MSO, IPA or third-party billing company. However, if this role is outsourced, it is beneficial for the compliance officer to have sufficient interaction with the physician practice to be able to effectively understand the inner workings of the practice.

Step Four: Conducting Appropriate Training and Education

Education is an important part of any compliance program and is the next step after problems have been identified and the practice has designated a person to oversee educational training. Ideally, education programs will be tailored to the physician practice’s needs, specialty and size and will include both compliance and specific training.

There are three basic steps for setting up educational objectives:

• Determining who needs training (both in coding and billing and in compliance);
• Determining the type of training that best suits the practice’s needs (e.g., seminars, in-service training, self-study or other programs); and
• Determining when and how often education is needed and how much each person should receive.

Training may be accomplished through a variety of means, including in-person training sessions, distribution of newsletters, or even a readily accessible office bulletin board.

Regardless of the training modality used, a physician practice should ensure that the necessary education is communicated effectively and that the practice’s employees come away from the training with a better understanding of the issues covered.

Step Five: Responding To Detected Offenses and Developing Corrective Action Initiatives

When a practice determines it has detected a possible violation, the next step is to develop a corrective action plan and determine how to respond to the problem.

Violations of a physician practice's compliance program, significant failures to comply with applicable Federal or State law, and other types of misconduct threaten a practice's status as a reliable, honest, and trustworthy provider of health care.

Consequently, upon receipt of reports or reasonable indications of suspected noncompliance, it is important that the compliance contact or other practice employee look into the allegations to determine whether a significant violation of applicable law or the requirements of the compliance program has indeed occurred, and, if so, take decisive steps to return of any overpayments, a report to the and/or a referral to law enforcement authorities.

Step Six: Developing Open Lines of Communication

In order to prevent problems from occurring and to have a frank discussion of why the problem happened in the first place, physician practices need to have open lines of communication. Especially in a smaller practice, an open line of communication is an integral part of implementing a compliance program.

In the physician practice setting, the communication element may be met by implementing a clear ''open door'' policy between the physicians and compliance personnel and practice employees. This policy can be implemented in conjunction with less formal communication techniques, such as conspicuous notices posted in common areas and/or the development and placement of a compliance bulletin board where everyone in the practice can receive up-to-date compliance information.

A compliance program's system for meaningful and open communication can include the following:

• The requirement that employees report conduct that a reasonable person would, in good faith, believe to be erroneous or fraudulent;

• The creation of a user-friendly process (such as an anonymous drop box for larger practices) for effectively reporting erroneous or fraudulent conduct;

• Provisions in the standards and procedures that state that a failure to report erroneous or fraudulent conduct is a violation of the compliance program;

• The development of a simple and readily accessible procedure to process reports of erroneous or fraudulent conduct;

• If a billing company is used, communication to and from the billing company's compliance officer/contact and other responsible staff to coordinate billing and compliance activities of the practice and the billing company, respectively. Communication can include, as appropriate, lists of reported or identified concerns, initiation and the results of internal assessments, training needs, regulatory changes, and other operational and compliance matters;

• The utilization of a process that maintains the anonymity of the persons involved in the reported possible erroneous or fraudulent conduct and the person reporting the concern; and

• Provisions in the standards and procedures that there will be no retribution for reporting conduct that a reasonable person acting in good faith would have believed to be erroneous or fraudulent.

Step Seven: Enforcing Disciplinary Standards Through Well-Publicized Guidelines

Finally, the last step that a physician practice may wish to take is to incorporate measures into its practice to ensure that practice employees understand the consequences if they behave in a non-compliant manner.

An effective physician practice compliance program includes procedures for enforcing and disciplining individuals who violate the practice's compliance or other practice standards.

Enforcement and disciplinary provisions are necessary to add credibility and integrity to a compliance program.

PAYOR CONTRACT NEGOTIATION

1. Organize your contracts into a matrix so that you can easily see contact information, your reimbursement history and key provisions such as termination requirements, your claims filing deadline, and how much time you have to respond to proposed amendments (which may indicate lower fees).

2. Schedule reminders for renegotiation, giving yourself enough time to handle them appropriately. If a contract is set to expire on December 31, and there is a 90-day termination provision. That means you should start the renegotiation process in July, so that you can have new terms set by mid- August – before the 90-day termination deadline.

3. Examine your payment vouchers and audit your Explanation of Benefits (EOB) documents routinely. Verify if you're getting paid correctly by looking at your top 5 to 10 payers for payment inconsistencies and keep in mind that if you are not being paid fairly or accurately, the onus is on you to alert the payer and help ensure a correction. During a recent engagement with a radiology practice, we discovered that the practice had been getting paid at much lower rates than their contracts from two different payers stipulated. And, these underpayments had been going on for at least five years.

4. Realize that payers are under increased scrutiny and cost pressures. Like all businesses, payers operate from a position of what's best for the payer. It is, therefore, your responsibility to advocate for what is best for your practice. If you are unprepared to educate payers about key market issues and be flexible, you may wind up settling for nothing at all. When you negotiate, be prepared with solid data and a firm understanding of what compromises you are willing to accept..

5. Balance aggressive negotiation and the ability to be reasonable. Don't be afraid to compare similar payers – and tell them if you believe that they are below market for practices like yours. At the same time, you should work to establish relationships with contacts in your payer organizations. Even as companies move to more automation, there is still value in person-to-person interaction. If you are able to make friends within a payer's organization, they may be able to help you. Likewise, be reasonable when you renegotiate. If you insist on terms that are far above market or otherwise excessive, the payer will not consider you to be negotiating in good faith. Offer a compromise and you stand a better chance of achieving results.

6. Recognize when reimbursement is tied to the Medicare schedule. Analyze the best Medicare schedule for your practice and common procedures. Then negotiate with your payers to base reimbursements on the most favorable schedule – even it if is not the most commonly used one.

7. Verify termination deadlines – and pay attention to them. Contract termination can seem like a drastic last resort when a contract is unfavorable. Sometimes, however, it must be done, particularly if a payer refuses to communicate with you. Most contracts include a clause requiring a termination notice of at least 90 days. But if you need any paperwork or information from the payer, they may not release it until it's too late. If this happens, consider bringing in an external resource to help.

8. Be prepared for a complex process. The process of evaluating and renegotiating contracts with today's commercial payers is not simple or easy. Take a hard look at whether your business office can squeeze it in amongst their day-to-day responsibilities. If your staff has the bandwidth to handle it, that's outstanding. If you don't have the time or experience to handle contract evaluation and negotiation, consider bringing in an outside counsel to manage the process. It will save time – and potentially increase revenue for your practice.

PERSONNEL FILES

Certain items should never be in a personnel file. A former employee can also request a copy of his or her personnel records, but in Florida you are under no obligation to provide the file.

Employer's must take care to maintain unbiased, factual documentation of an employee's employment history in your personnel records.

These are general guidelines to the documentation that you retain in your s personnel records.

- Information in personnel records must be factual. Supervisor or Human Resources staff opinions; random notes; gossip; unfounded rumors; questions, reports, or tattletale allegations from other employees that are unexplored; allegations not pursued, investigated, and concluded; and any other non-factual information, commentary, or notes should be excluded from an employee's personnel file.
- Personnel records must be thoughtfully assigned to their appropriate file locations. Determine a protocol for your company personnel records based on state and Federal laws, employment laws such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and employer best practices.
- Supervisors, managers and other employees who place documentation in personnel records must be trained to appropriately write the documentation.
- Balance the information you place in personnel records to include both the positive and the negative aspects of an employee's employment history. Too often, personnel records emphasize every negative occurrence and miss the positive components.
- Recognize the difference between a supervisor's personal notes about his or her reporting staff and the official company personnel records. The supervisor's notes that are used for performance improvement, to track projects and goal completion, and to fairly determine raises and performance development plans, for example, belong in a supervisor's private file, not in the company's official personnel records.
- The supervisor's private notes can be subpoenaed in the instance of a lawsuit, so caution is recommended even for private notes.The practice of supervisors keeping copies of records that exist in the official employee personnel file in their management file is not recommended.

Hiring documentation and interview notes present a bit of a quandary. The best practice is to maintain a separate file for each position you fill that includes all documentation related to filling that position from the job posting to the reference checks. The applicants' resumes, cover letters, and applications belong in this file except that you should move the hired employee's application to the employee personnel file.

This file has the official checklists and forms that strive for unbiased representation about a potential employee's qualifications and support your decision to hire the most qualified candidate

Factual documentation about employment decisions such as promotion, transfer to a lateral opportunity, and salary increases belong in the personnel records. The supervisor's opinions about the employee do not. Official disciplinary action documentation such as a written warning also belongs in the employee's personnel file.

What Should Not Be in Personnel Records

The following information should not be placed in personnel records. The documentation may require a separate file, may be classified as supervisory or management notes, or should not be kept at all by an employer.

- Any medical information belongs in the medical file.
- Payroll information belongs in the payroll file.
- Documents that include employee Social Security Numbers or information about an employee's protected classifications such as age, race, gender, national origin, disability, marital status, religious beliefs and so forth should never be kept in the personnel files.
- Supervisory documentation for the purpose of managing an employee's work, setting goals, feedback provided and so forth should be filed in a private, supervisor or manager-owned folder.
- Investigation material including the employee complaint, witness interviews, employee interview, findings, attorney recommendations, and resolution, plus follow-up to ensure no retaliation, should reside in an investigation file that is separate from personnel records.
- File employee I-9 forms in an I-9 file or location, away from employee personnel records.

- Place background checks including criminal history, credit reports, and so forth, and the results of drug testing in a separate file that supervisors, managers, and the employee cannot access.
- Employee Equal Opportunity records such as self-identification forms and government reports should not be kept in the personal file nor anywhere the supervisor has access.