Legislature institutes new requirements for the retention of medical records

On December 28, 2006, a new statute, MCL 333.1621 to 1623, was enacted that sets forth new requirements for the maintenance and retention of patients’ records. The statute applies to all individuals licensed under the Public Health Code, including physicians, osteopaths, dentists, and physical therapists, amongst others. Under this statute, a licensee has a duty to keep and maintain records for those patients whom he/she has provided medical services for a minimum of seven years from the date the service was performed. Each licensee has an obligation to maintain the index, accuracy, and accessibility of the record for each patient or the entity for which the person is employed.

Absent a federal or state law or regulation stating otherwise, MCL 333.1621(2) provides an exception that allows a patient’s medical records to be destroyed before the statute has specified that they must be retained. In order to qualify for this exception, the licensee must mail the patient a written notice informing him/her of the intent to destroy the record and affirming that he/she has had the opportunity to obtain a copy of the higher medical records. In addition, the notice must be signed by the person who is authorized to destroy the records. Only after the licensee receives such written authorization is the patient (or the patient’s legal representative) permitted to destroy the records that are less than seven years old.

For example, Dr. Buchanan, MD, plans on retiring and closing his practice in Flint, Michigan, after 30 years of service. His records include thousands of patients over the years, and he has an entire basement filled with medical records to prove it. In accordance with the applicable law and his retention policy, Dr. Buchanan has notified the MDCH of his planned retirement and his contract to transfer his medical records to the new administrator. The administrator, who has actually agreed to protect and provide access to the records, is responsible for shipping the records. Dr. Buchanan wants to properly dispose of many of his patient medical records, specifically in light of the costs to store and maintain the files, which are based on the volume and nature of the information. Specifically, he is concerned with disposing of the medical records of three particular patients: George Wilson, Myrtle Wilson, and Nick Carraway.

Myrtle Wilson has been a loyal patient of Dr. Buchanan for over 40 years. Despite her death, he plans to destroy her records. Over five years ago, she also convinced her husband, who now works as Dr. Buchanan’s primary physician. However, after seeing Dr. Buchanan a couple of times, Mr. Wilson decided to return to his private, on-station, inpatient hospital. Dr. Buchanan saw Myrtle Wilson for two years, and now he’s afraid of her, so he can’t give her any other medical services to George in over eight years. All three of these records are the same, but Dr. Buchanan’s notes to both George and Myrtle telling them he is retiring and asking for authorization to dispose of their records. Myrtle sends back her authorization, giving Dr. Buchanan permission to destroy the records, but after only he has provided her with a copy of the record for her next physician. And Dr. Buchanan does not receive an authorization from George to destroy those records, so he has brought an action seeking explicit authorization. Under MCL 333.1621, Buchanan still has the ability to destroy George’s records because he gave George the requisite 30 days to respond to the notice and request for authorization, and the medical records are older than seven years. Therefore, Dr. Buchanan does not have the ability to destroy the medical records of George by mail as Myrtle Wilson requested.

Nick Carraway saw Dr. Buchanan on one occasion, five years ago, for a respiratory ailment. Again, he received a notice to Nick’s last known address, requesting authorization to destroy his medical records. Nick never returned the authorization to Dr. Buchanan because he had relocated to Long Island in New York. Despite the fact that the law gives Buchanan 30 days to mail the records, the notice was sent, Dr. Buchanan could not destroy these records, pursuant to MCL 333.1621, because the records were not seven years or older. Thus, in accordance with the laws, Buchanan notified the MDCH and Dr. Buchanan transferred Nick’s medical records to Safe Medical Records, Inc. Buchanan transferred the retention of medical records, the statute also permits Buchanan to transfer the records to those medical records that are eligible to be destroyed. Accordingly to MCL 333.1621(3), the statute also permits Buchanan to transfer the records to those medical records that are eligible to be destroyed. The state can now assess the records and either electronically delete, or otherwise dispose of them. Buchanan must also confirm the destruction of the personal health information and other personal information. Failure to adhere to these provisions can result in civil and criminal penalties.

In summary, the judge found that Buchanan has not complied with the proper disposal of medical records. If Buchanan fails to comply with the statute, the court could assess the records and either electronically delete, or otherwise dispose of them. Buchanan must also confirm the destruction of the personal health information and other personal information. Failure to adhere to these provisions can result in civil and criminal penalties.

Court awards attorney fees against federal government in qui tam case

The United States justice system ordindly has each party bear its own attorney fees in contested matters because it is based on the “American Rule.”

Nevertheless, the prevailing party in litigation many times still feels like a loser anyway, regardless of whether or not it wins. And, in cases brought by the government against those alleged to have improperly billed the Medicare or Medicaid program, incurring substantial attorney fees and costs, it is a difficult thing to bear for a provider. The provider can also be subjected to potential criminal liability; or have damages assessed and payable to the government for improperly billing those programs.

In United States of America v. Medicare, Retina Associates, an employee — whom the court found was motivated by a desire to inflame public opinion in the form of in- sumum damage” on the government’s president — filed a qui tam suit against Medicare, Inc. The suit alleged that the company’s Medicare program had systematically over-paid Medicare beneficiaries for non-approved, palliative air mistresses by using the wrong billing code.

Allegations against the decision of the court specify the total amount of alleged overpayment, penalties and other damages sought by the government. The issue was probably quite large, inasmuch as Medicare Retina was reported to have been billed under code E0277. Further, prior to billing under code E0277, the company’s list of several carriers where it could properly bill under E0277, and it had received conflicting advice from the government directing it to use E0277 for the billing.

Based on the evidence, the court found that the company’s use of the E0277 was neither false nor fraudulent.

Because the government could not prove other claims that it was entitled to recover the amounts it claimed under code E0277, the government was not entitled to receive the amount of the overpayment due to “mistake” in the payment. The government alleged unexplained underpayments of the company during the receipt of payments.

These claims proceeded to trial, and once again, Medicare-Retina prevailed.

After expanding huge amounts in attorney fees in the lengthy litigation, Medicare-Retina asked the court to award it attorney fees in defending the case.

In a decision made in December 2006, the court found that Medicare-Retina was entitled to recover its fees due to the government’s continued bad faith in pursuing the litigation.

The government’s mandatory case offers a number of lessons for providers operating in today’s health care environment.

First, providers must understand that the government can seek to impose liability on health care entities even when it is premature to do so. Second, when seeking billing guidance, and, in pursuing the matter, a provider should carefully document all communications.

Third, the provider should seek advice from reimbursement or coding experts, and competent legal counsel, when questions arise over billing首创, or such billing actions might involve substantial amounts. U.S. Attorney’s in qui tam suits are not investigators or U.S. Attorneys who claim that certain billing actions are fraudulent, or medically unessential, so it is probably mean, that the violations are unlawful. U.S. Attorneys who work on qui tam suits are not medical or industry experts, and in many cases are not well-informed on the nuances of the particular cases. In such circumstances, they may be unwieldy swayed by claims of claimants who have their own agendas to pursue. If a provider is served with a qui tam suit, (i.e., if they are made aware of the qui tam suit by counsel) and someone has handled and are familiar with these cases.

Business of Medicine

By Robert S. Ivey, Esq. & Jeffrey R. Campbell, Esq.

Robert S. Ivey is a partner at Weech & Associates, P.C., where he focuses on health care practice in transactional, corporate matters, compliance, fraud defense, reimbursement and contracting matters, and staff privilege and third-party payor participation matters. He can be reached at (248) 544-0888 or rsivey@weechlaw.com.

Jeffrey R. Campbell is a principal at Weech & Associates, P.C., where he focuses on transactional and corporate matters, compliance, fraud defense, reimbursement and contracting matters, and staff privilege and third-party payor participation matters. He can be reached at (248) 544-0888 or jr Campbell@weechlaw.com.

Medical Litigation

By David A. French, Esq.

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