Legislature institutes new requirements for the retention of medical records

Business of Medicine

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On December 22, 2006, a new statute, MCL 333.16213, was effectuated that set forth new requirements for the maintenance and retention of patients' records. The statute applies to all individuals licensed under the Public Health Code, including medical doctors, 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 integrity and confidentiality, and ensure accessibility, of the record for each patient or that patient's representative.

Absent a federal or state law or regulation stating otherwise, MCL 333.16213(1) provides an exception that allows a patient's medical records to be destroyed before the seven-year period has expired. In order to qualify for this exception, the licensee must mail the patient a written notice to the patient's last known address informing him/her of the intent to dispose of his/her medical records and offering the patient an opportunity to obtain a copy his/her medical records. In addition, the notice must contain a request by the licensee for patient's written authorization for the disposal of his/her medical records. Only after the licensee receives such written authorization from the patient (or the patient's authorized representative), may the records that are less than seven years old be destroyed. Fortunately, MCL 333.16213(2) does allow a licensee to engage the assistance of certain others (e.g., a medical records company) to help the licensee comply with these provisions.

Importantly, the statute also provides medical record retention requirements for licensees who choose to sell or close their practice, retire from practice, or otherwise cease to practice. A licensee (or a licensee's authorized representative if said licensee is deceased) who no longer practices must still comply with the record requirements set forth in this statute. In fact, the licensee (or his/her authorized representative) must send a written notice to the Michigan Department of Community of Health (MDCH) informing the MDCH who will have custody of the medical records and how a patient may access and/or obtain a copy of his/her medical records. In addition, pursuant to MCL 333.16213(3), a licensee (or the licensee's authorized representative) whose practice has ceased must transfer all patient medical records that are less than seven years old to one or more of the following:

- A successor licensee;
- To the patient or a specific health care agency, facility or provider, if so requested by the patient;
- An entity that contracts with the licensee to protect, maintain and provide access to the records.

By properly notifying the MDCH and transferring the record in accordance with the statute, a licensee who ceases to practice will satisfy the record retention provisions of this statute.

However, prior to disposing of any medical records, the licensees who are no longer practicing must forward to each and every patient a written notice and request for authorization to destroy the records. This notice must provide the patient 30 days to respond and give the patient the option to obtain a copy of the records or designate a place where the patient would like the records transferred. The patient also has 30 days to provide written authorization to the licensee to destroy the records. If the patient fails to respond within 30 days, the licensee may destroy those records that are seven years or older, but they must preserve those records that are less than seven years old. MCL 333.16213(3)(b).

For example, Tom Buchannan, MD, plans on retiring and closing his private practice in Flint, Michigan, after 30 years in internal medicine. He has cared for 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. Buchannan has notified the MDCH of his planned retirement and his contract to transfer his medical records to Safe Medical Records, Inc., who has contractually agreed to protect and provide access to these patient records. Prior to shipping the records, Dr. Buchannan wants to properly dispose of many his patients' records, especially in light of the costs to store and maintain the files which are based on the volume of records. 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. Buchannan for over eleven years. Over eight years ago, she even convinced George, her husband, to see Dr. Buchannan as his primary physician. However, after seeing Dr. Buchannan a couple of times, George decided to return to his previous internist. Dr. Buchannan saw Myrtle as recently as two months ago for a strep infection, but he has not provided any medical service to George in over eight years. Before disposing of the records, Dr. Buchannan mails a notice 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. Buchannan permission to destroy the records, but only after he has provided her with a copy of the records for her next physician. In the meantime, over a month passes and Dr. Buchannan does not receive an authorization from George to destroy the records. Despite not receiving explicit authorization, under MCL 333.16213, Buchannan 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, after sending Myrtle a copy of her medical records, Dr. Buchannan properly destroyed the records of George and Myrtle Wilson.

Nick Carraway saw Dr. Buchannan on one occasion, five years ago, for a respiratory ailment. Again, Dr. Buchannan sent a notice to Nick's last known address, requesting authorization to dispose of his medical records. Nick never returned the authorization to Dr. Buchannan because he had relocated to Long Island in New York. Despite the fact, that like George Wilson, 30 days had elapsed since the notice was sent, Dr. Buchannan could not destroy these records, pursuant to MCL 333.16213, because the records were not seven years or older. Thus, in accordance with Michigan's new retention law, Dr. Buchannan transferred Nick's medical records to Safe Medical Records, Inc.

In addition to provisions regarding the retention of medical records, the statute also sets forth the proper methods of disposal for those medical records that are eligible to be destroyed. According to MCL 333.16213(4), such records must be shredded, incinerated, electronically deleted, or otherwise disposed of in a manner that ensures continued confidentiality of the patient's health care and other personal information. Failure to adhere to these provisions may result in intervention by the MDCH, who is charged with overseeing the proper disposal of medical records. If the MDCH intervenes, it may assess the licensee with costs that the MDCH incurs for the proper destruction of the medical records.

Further, failure to comply with any of these patient record provisions could result in a hefty administrative fine of up to $10,000. Clearly, this new statute should alert current licensees, and those licensees who may cease practicing, to review their current retention and disposal policies to ensure compliance with MCL 333.16213.

Court awards attorney fees against federal government in qui tam case

Medical Litigation

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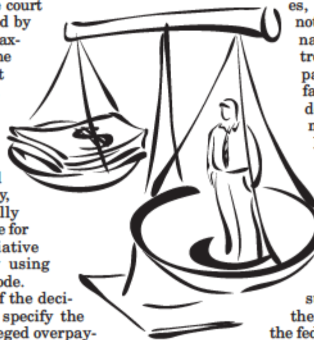
The United States justice system ordinarily requires that each party bear its own attorney fees in contested matters before the courts.

Nevertheless, the prevailing party in litigation many times still feels like a loser after absorbing a hefty bill from its attorneys. And, in cases brought by the government or qui tam relators for alleged improper billing to the Medicare or Medicaid program, incurring substantial attorney fees is only one potential adverse outcome for a provider. The provider can also be subjected to potential criminal liability, or huge damage awards and civil penalties for improperly billing these programs.

A recent case decided by a federal court in Texas, however, demonstrates that government authorities do not always have "the final say" in these billing disputes.

In *United States of America v. Medica-Rents*, a disgruntled former employee — whom the court found was motivated by a desire to inflict "maximum damage" on the company's president — filed a qui tam action against Medica-Rents.



The suit alleged that Medica-Rents, a durable medical equipment company, had systematically over-billed Medicare for nonpowered, palliative air mattresses by using the wrong billing code.

Although none of the decisions of the court specify the total amount of alleged overpayments, penalties and other damages sought by the government, the amount at issue was probably quite large, inasmuch as Medica-Rents reportedly expended $4,895,218.86 in attorney fees defending the case.

After the original filing of the case, the United States Attorney's Office decided to intervene in the action and take over the prosecution of the case.

The government claimed that between 1994 and 1996, the company submitted fraudulent billings in violation of the federal False Claims Act. The billings were allegedly false and fraudulent due to the fact that the company billed for its mattresses under code EO277 which had an official descriptor "alternating pressure mattress."

Since, according to the US Attorney, the company's mattresses were neither powered nor were true mattresses, the mattresses could not be considered alternating pressure mattresses. Thus, the company allegedly made false statements when it decided to bill for its mattress under code EO277.

In September 2006, the United States District Court for the Northern District of Texas disagreed with the government, and granted Medica-Rents summary judgment on the alleged violations of the federal False Claims Act.

Discovery showed that Medicare carriers allowed and, in some instances, authorized other mattresses (which were non-alternating pressure products) to be billed under code EO277. Further, prior to billing under code EO277, the company inquired of several carriers whether it could properly bill under EO277, and had received conflicting advice. Finally, the company received a letter from the government directing it to use EO277 when billing for the mattress. Based on this evidence, the court found that the company's use of the EO277 was neither false nor fraudulent.

Despite this decision, the government continued to press other claims that it was entitled to recover the amounts it paid the company under code EO277. The government claimed it was entitled to repayment due to "mistake" in the payment or due to alleged unjust enrichment of the company in receiving the payments.

These claims proceeded to trial, and once again, Medica-Rents prevailed.

After expending huge amounts in attorney fees in the lengthy litigation, Medica-Rents asked the court to award it attorney fees in defending the case.

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

This extraordinary 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 and penalties even in matters where honest differences of opinion over proper billing, or innocent errors, occur.

Second, when seeking billing guidance from a government entity, 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 — especially if such billings involve substantial amounts.

Fourth, the mere fact that government investigators or U.S. Attorneys claim that certain billings are false, fraudulent, or medically unnecessary does not necessarily mean that the billings are unlawful. U.S. Attorneys and government investigators are not medical or industry experts, and in many cases are not well-informed on the issues presented by particular cases. In such circumstances, they may be unduly swayed by complainants who have their own agendas to pursue. If a provider is served with a government or qui tam suit, it should therefore consult with counsel who have handled and are familiar with these cases.