



Medical Record Issues in the Transfer or Closing of a Medical Practice: Address Them Upfront to Avoid Problems Later

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Details regarding how medical records will be handled in the sale or closing of a medical practice are sometimes relegated to general boilerplate provisions and viewed as side issues during the negotiation process. Yet, how the rights and responsibilities of the parties regarding the transfer, retention, maintenance, and accessibility of medical records are (or are not) addressed in the underlying agreement(s) can have far-reaching and long-lasting implications.

Transactions involving the transfer of medical records can be triggered by various circumstances, such as the sale or lease of a medical practice, consolidation into a larger group practice, departure of one or more physician owners to a different practice, or the death or retirement of a physician. These transactions are often asset sales, but may also be structured as sales of ownership interests in a medical entity or other arrangements

involving health systems or private equity firms. Transfers may occur when a retiring physician refers her patients to another physician to assure the patients have continuity of care. These referral arrangements may or may not be associated with the sale of other assets.

For simplicity, this article uses the terms “*seller*” to include the physician who departs the practice or the medical practice entity selling the practice, even if there is not a formal sale (e.g., retirement), and “*acquirer*” to denote the physician or entity that assumes the practice, even if there is not a formal purchase (e.g., a retiring physician’s recommendation to patients on a successor physician).

As of 2015, over 78% of United States office-based physicians had adopted a certified electronic health record (EHR) system.¹ Given the prevalence of EHR systems, the article



focuses primarily on electronic records, though many of the issues discussed can also apply to paper records. In either case—paper or electronic—a multitude of potential issues may arise regarding the handling and accessibility of medical records when a practice is sold, leased or shut down, or when a physician departs, retires, or passes away. Assuring compliance with legal and professional standards requires careful attention, and how the parties divide the responsibilities for the affected medical records may impact the ultimate price paid in the sale of a practice. The division (or absence) of such responsibilities also may impose ongoing costs on one or both parties.

Medical records typically warrant a more customized approach than most other medical practice assets due to the long term implications as well as legal, professional, strategic, and operational issues involved. It is therefore crucial for parties and attorneys involved in the sale or closing of a medical practice to plan ahead for medical record issues, including how the records will be transferred and integrated, how they can be accessed by the parties and by patients, who will be responsible for responding to patient requests, and how the parties will allocate the costs of these arrangements. How these and other relevant issues are addressed will vary depending on a number of factors, including the parties involved, the circumstances, and attention devoted to each issue.

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Benefit or Burden?

In many states, medical records are owned by the provider (such as an individual physician or medical practice). Physician employment agreements often include provisions granting ownership to the practice entity for which the physician works. While patients may not have an actual ownership stake in the records, they do have a number of rights, including, the right to review, obtain copies, submit corrections, and restrict access to the records, as well as obtain an accounting of disclosures. In the event of a transfer of medical records, the parties should agree on how to notify patients, who will be responsible for maintaining the records (custodianship), and who will respond to requests from patients (including personal representatives).

The laws of some states establish minimum record retention periods, such as seven years from the last date of service. In some states, the period can stretch to 10 years, or longer for specific types of records for minors.² While federal law is generally silent on general retention periods for medical records of a physician practice, regulations require retention of records (six years)³ to support an accounting of disclosures under the Health Insurance Portability and Accountability Act (HIPAA),⁴ and 10 years for Medicare Advantage.⁵

A seller may also have an interest in assuring that it retains the right to access medical records if it needs to defend itself in the event of a medical malpractice suit or other action (e.g., governmental investigation, disciplinary action, or payer audit). In many states, the statute of repose for professional liability actions is four years from the time at which the act, error, or omission giving rise to the injury occurred. Some states may have longer statute of repose periods,⁶ or they may impose tolling if the physician knew but did not disclose relevant information⁷ or if the act, error, or omission involved a specific type of injury, such as foreign objects being left in the patient.⁸ In some cases, a state's statute of limitations in written contracts—which can be as long as 10 years—also may influence the retention decision.

In some cases, the angry departure of a physician from a group practice may raise issues as to the appropriate handling of medical records for patients who were being treated by the departing physician. The group practice may try to have the affected patients seen by one of the group's remaining physicians. Depending on the terms of the departing physician's contract, issues may arise concerning his or her ability to make and take copies of patients' medical records; post-departure access to records; the medical group's need to retain copies

of the affected records; and potential data breach and unauthorized access to records. A medical group may be able to address these issues early on by carefully crafting its notice of privacy practices and patient consent forms to make it clear that the group, its physicians, and staff may access the patient's protected health information (PHI).

A little extra attention early on can avoid significant problems down the road, such as failing to satisfy record retention responsibilities, being unprepared to respond to patient requests or lawsuits, and disagreements over storage costs and administrative burdens.

Clean Up Your Storage Room (Virtual or Otherwise)!

One of the challenges that an acquirer faces is that medical records typically contain records for both active and inactive patients, i.e., those who have not been under the care of the seller for some time. In the case of paper records, it may not be practical or economical to separate records between active and inactive patients. An EHR, on the other hand, can easily identify active patients by sorting records by date of last service. This quick and simple assessment can help an acquirer assess the burden of assuming the responsibility for maintaining the acquired records.

While a physician practice might purge paper records that have sat in storage for many years, the low cost of storage, inertia, and challenges of using purge functions in an EHR system may prevent the same level of housekeeping for electronic records. As a result, the acquirer may be faced with the substantial burden of maintaining records that are unlikely to correspond to patients who will continue to seek care from the acquirer. The burden can be magnified when the acquirer has its own EHR system and wishes to convert records from the seller's EHR into the acquirer's EHR, especially because conversion costs are often driven in part by the number of records to be converted. Added costs also may be incurred by the acquirer if part of the ongoing EHR-related costs takes into account the number of patient records that must be maintained in the EHR system.

Another factor that often mitigates against conversion of records is concern about the quality of those records. Many providers experienced a significant learning curve when they adopted EHRs, which inevitably impacted the quality and completeness of the records. In many cases, for example, physicians treated the dictated note—which is a free text field—as the primary documentation, leaving discrete fields incomplete or in conflict with the dictated note. Thus, the acquirer may

not wish to convert records that do not meet current standards for data quality.

If only records for active patients are transferred, the seller may be faced with the responsibility of providing appropriate custodial services for the records that the acquirer refused to accept. In many cases, identifying and purging records from an EHR system may require more work than either party is willing to undertake or fund, especially when sufficient records must be retained to meet requirements under state and federal laws.

If the parties decide to purge records, the deletion should be carried out in a manner that complies with HIPAA's requirements regarding the destruction of PHI.⁹ This will require physical destruction by a vendor or personnel with appropriate training in information disposal in accordance with industry best practices.¹⁰ The parties should also assure that appropriate records regarding the disposal activities are maintained and that the disposal process addresses backup media or services that may contain copies of PHI within purged records.

The Tip of the Iceberg

Medical record discussions often focus on the chart itself, but there may be adjuncts to the chart that also must be considered. For example, if the physician practice had a laboratory or other diagnostic testing facility, the parties may need to address the transfer and handling of specimens, computer or paper files associated with any laboratory information and lab automation systems, and their underlying software, contracts, and support agreements. Similar issues with other systems and data repositories may arise if the seller provided imaging services and had other standalone systems, such as PACS.¹¹

Unless the acquirer continues to use and maintain the existing systems in the acquired practice, issues with metadata need to be addressed. Metadata, which includes audit logs, may be needed to respond to medical malpractice claims (e.g., to show when a record was created, accessed, reviewed, or updated and by whom); provide a means for review and audit of the complete record in the event of a Medicare claims audit;¹² or respond to requests for an accounting of disclosure under HIPAA.¹³ Metadata is often not converted when the main clinical and billing records are moved into the acquirer's EHR system, so provisions may need to be made to maintain access to the old EHR platform—which may have significant ongoing costs—or export the files to searchable media so that the seller can access the metadata when necessary.

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Custodial Arrangements

As discussed above, both the acquirer and the seller have an ongoing interest in the medical records. The acquirer will likely need access to the records of patients who continue to seek care in the acquired practice, but may have less interest in the records of inactive patients. On the flip side, the seller needs to maintain access to records to defend against medical malpractice, overpayment, disciplinary or other claims and actions, and to respond to patient requests. In addition, some states may prohibit or severely restrict the sale of medical records. In that case, it may be a good idea to address the transfer of medical records through a custodial agreement rather than having them transferred with the other assets.

While electronic records could be held by both the seller and the acquirer, this may not be a realistic option for the seller, especially if he or she is retiring from the practice of medicine or taking on a new role that does not involve maintaining a medical practice. Whether the medical records are paper or electronic, maintaining them is a substantial burden; the holder must, under HIPAA and state laws, act to assure the confidentiality, integrity, and accessibility of those records.

In addition, increase in cybercrime means that risks to electronic records are mounting daily. If the seller retains possession of the records, the seller would need to provide appropriate security for the records, assure ongoing cyber liability insurance coverage as needed, and provide for the technical environment in which the records would be maintained in an accessible manner. The seller may also need to make arrangements for a license from the EHR vendor, pay the costs of conversion to a more generally accessible format, or arrange for the acquirer to assume these costs.

Alternatively, the seller could enter into a custodial agreement with the buyer wherein the buyer would maintain custody over the records and perhaps assume responsibility for the duties the seller has to release information to patients, as well as provide the seller with access to the records to support a seller's response to suits and claims. Even if the acquirer assumes responsibility for managing the release of information, the underlying duty to the patient remains with the seller, who may potentially be held responsible if the acquirer fails to fully perform its agreed upon duties. Thus, a seller may seek to include indemnification from the acquirer for any such failures in the sale or transfer agreement.

If, on the other hand, the acquirer assumes custody for all of the records from the practice, there will inevitably be a subset of patients who choose to use a different provider, as well as a number of records that belong to inactive patients. The acquirer effectively may not have a treatment relationship with these patients who have found different providers or are now considered inactive. As such, depending on the nature of the transaction, the acquirer may lack patient consent to access these records. The seller may therefore want to assure that a business associate agreement is in place, with the acquirer being identified as the business associate.

You Are Not Good Enough for Me

A different type of challenge may arise when a health system acquires independent physician practices or enters into management or practice lease arrangements. In many instances, the health system may be unwilling to assume responsibility for the existing medical records.

A health system usually seeks to incorporate the acquired practice's medical records into its own EHR platform. As part of this process, patient records are usually only abstracted when an appointment is scheduled, with only clinical data relevant to the ongoing care of the patient being entered into the health system's EHR. Such abstraction of patient records often results in the original records remaining the property of the seller, with some or all of the seller's physicians becoming employees of the health system.

Some major considerations or factors driving this approach may be that the records of the acquired practice were created under less rigorous standards than those maintained by the health system's health information management (HIM) and quality control departments; the records may not conform to the health system's risk management protocols; and/or the health system may not have the bandwidth to handle a wide variety of medical record types, systems, and formats. The cost of maintaining the records could then fall to the seller, which can be an unanticipated cost. Further, when continuing patients request copies of their records, the request can create a bifurcated process, with release of information for records after the date of sale going through the health system's HIM department, but pre-sale records being handled by the seller. In some cases, health system protocols may limit the ability of the practice staff—who are now employees of the health system—to support this process on behalf of the seller.

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Where Danger Lives

In some situations, the transfer of the practice, or a part thereof, is precipitated by factors that make it difficult to plan for the orderly handling of records. For example, when a practice experiences bankruptcy, Section 351 of the Bankruptcy Code provides that the trustee may destroy medical records if adequate funds are not available to pay for their storage.¹⁴ While the Bankruptcy Code provides a year-long process, including notice to patients to provide them with the opportunity to request a copy of their records, those records may be destroyed at the end of the notice period.¹⁵ This bankruptcy

provision not only takes precedence over state law record retention requirements, but it also overrides any requirements under HIPAA to maintain the records that would otherwise be necessary to support an accounting of disclosures. While the destruction requirements under Section 351 are not as comprehensive as those under HIPAA, the trustee would be well advised to adhere to the requirements set forth in the HIPAA regulations¹⁶ to assure that records are destroyed so that they cannot be retrieved at a later time.¹⁷

It's Complicated

How to best handle medical records is one of the many issues that must be addressed when selling or closing a medical practice. How the parties agree to address those issues may impact the sale price of the practice and costs incurred by the parties in effectuating the transfer and transition of the records, including ongoing costs, liabilities, and exposures. By considering the rights and responsibilities of each party regarding medical record retention, transfer, maintenance, and access—as well as related nuances and potential complications—the parties and their attorneys will be better positioned to proactively address these issues when negotiating the transaction. A little extra attention early on can avoid significant problems down the road, such as failing to satisfy record retention responsibilities, being unprepared to respond to patient requests or lawsuits, and disagreements over storage costs and administrative burdens. **C**



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Endnotes

- 1 The Office of the National Coordinator for Health Information Technology, Percent of U.S. Physicians that Adopted Any, Basic, and Certified EHRs: 2015, Health IT Dashboard, available at <https://dashboard.healthit.gov/apps/health-information-technology-data-summaries.php?state=National&cat9=all+data&cat1=ehr+adoption#summary-data> (last accessed Nov. 1, 2017).
- 2 *State Medical Record Laws: Minimum Medical Record Retention Periods for Records Held by Medical Doctors and Hospitals*, Table A-7, available at <https://www.healthit.gov/sites/default/files/appa7-1.pdf> (last accessed Nov. 1, 2017).
- 3 45 C.F.R. § 164.528(a)(1).
- 4 The Privacy, Security and Breach Notification Rules under the Health Insurance Portability and Accountability Act at 45 C.F.R. Parts 160 and 164.
- 5 42 C.F.R. § 422.504 (d)(2)(iii).
- 6 Hawaii has a six-year statute of repose, HAWAII REV. STAT. § 657-7.3.
- 7 *Id.*
- 8 Ten years in North Carolina, N.C. GEN. STAT. § 1-15.
- 9 45 C.F.R. § 164.310(d)(2)(i), *et seq.*
- 10 See, e.g., National Institute of Standards and Technology Special Publication 800-88, Guidelines for Media Sanitization (NIST SP 800-88).
- 11 PACS (picture archiving and communication system) is used to analyze, store, and manage the images.
- 12 Centers for Medicare & Medicaid Services, *Medical Record Retention and Media Formats for Medical Records*, MLN Matters® Number: SE1022 (Aug. 21, 2012) (“[T]he medical record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may be reviewed and audited by authorized entities. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly.”).
- 13 45 C.F.R. § 164.528(a)(1).
- 14 11 U.S.C.A. § 351.
- 15 *Id.* The statute sets forth additional requirements, including notice to insurers and the appropriate federal agency.
- 16 See discussion *supra*, inclusive of notes 9 and 10.
- 17 11 U.S.C.A. § 351(3)(B).