HC HEALTH CARE LAW

FELDMAN KIEFFER

HIPAA AND MEDICAL RECORDS RETENTION

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Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

HIPAA is the federal law enacted to protect "patient health information" which is defined as "individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or medium, whether electronic, on paper, or oral." The protected health information includes demographic information about a patient including but not limited to, past and present medical conditions, provision of healthcare to an individual, and billing information pertaining to the patient.

HIPAA applies to "covered entities", including: Health plans, Health care clearinghouses, Health care providers who transmit PHI in electronic form; and Medicare prescription drug card sponsors.

Further, HIPAA prohibits the disclosure of patient information except under the following circumstances: i) Pursuant to Patient Authorization; ii) For Treatment Purposes; iii) For Claims Processing and Payment; iv) To the Government; and v) To a Business Associate that has entered into a Business Associate Agreement.

Failure to comply with HIPAA

HIPAA does not provide a private right of action to individuals, meaning an individual cannot file a lawsuit against a medical provider for breaching HIPAA. However, there is no prohibition against an individual filing suit, in the event of a breach, against the medical provider, alleging failure to supervise, or failure to train employees to comply with the HIPAA requirements.

While individuals do not have a private cause of action for breach of privacy in the case of a HIPAA breach, the Office for Civil Rights and other government agencies may levy fines against the practice. Below is an example of possible action against a medical provider in the case of a HIPAA breach:

HIPAA Violation	Minimum Penalty	Maximum Penalty
Unknowing	$100 per violation, with an annual maximum of $25,000 for repeat violations	$50,000 per violation, with an annual maximum of $1.5 million
Reasonable Cause	$1,000 per violation, with an annual maximum of $100,000 for repeat violations	$50,000 per violation, with an annual maximum of $1.5 million
Willful neglect but violation is corrected within the required time period	$10,000 per violation, with an annual maximum of $250,000 for repeat violations	$50,000 per violation, with an annual maximum of $1.5 million
Willful neglect and is not corrected within required time period	$50,000 per violation, with an annual maximum of $1.5 million	$50,000 per violation, with an annual maximum of $1.5 million

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Medical Records Retention

The New York State Codes, Rules, and Regulations ("NYCRR") establishes the minimum retention period for medical records in New York State. Please note at the outset that these are the minimum standards, providers are free to maintain records for longer than the minimum prescribed period.

In general, a medical provider must retain a patient's records for at least six (6) years following a patient's discharge. Specifically, 10 NYCRR § 405.10 requires that "medical records shall be retained in their original or legally produced form for a period of at least six years from the date of discharge or three years after the patient's age of majority (18 years), whichever is longer, or at least six years after death." In addition, there are certain situations, including those related to a minor patient, which require that a patient's medical records be retained for longer than six (6) years.

The general time period above does not apply to minors. Instead of the general rule, the medical records of a minor patient records must be retained for either the six (6) year period, or for three (3) years after the patient turns eighteen (18), whichever is longer. This difference with minor patient records is critical and can be illustrated through an example. If a patient is ten (10) years old upon discharge, the records must be retained for three (3) years after he/she turns eighteen, or until the patient is twenty-one (21). However, if the patient is seventeen (17), the records must be retained for the six (6) year period, or until the patient is twenty-three (23).

In general, there are also different rules for radiological records, including films and slides, which must be maintained for the same time periods indicated above. However, there is one key distinction with mammography films. These films must be retained for a period of ten (10) years, pursuant to 10 NYCRR § 16.22.

Finally, if there is pending litigation which involves medical records, the records must be maintained. Furthermore, records should be maintained in the event there is notice of any litigation before a lawsuit is commenced. For example, a letter or phone call from plaintiff's counsel before a lawsuit has even started would constitute proper notice and mandate extended record keeping.

Medical Records Best Practices

The documenting of medical procedures and all aspects of the patient encounter should be treated with the same attention to detail as patient care. Proper documentation of a patient's symptoms, history, and all procedures and conversations with the patient is paramount in providing the best treatment to the patient, and equally paramount at protecting the medical provider through demonstrating compliance with the law, and in case of an audit or malpractice claim. Accordingly, it is important to spend the extra time to document in detail all parts of the encounter.

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