CLOSING OR RELOCATING A HEALTHCARE PRACTICE

A Patient Safety and Risk Management Guide for Members

We provide expert guidance and resources that keep you in the know, no matter how you practice.

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CONTACT US

Our patient safety risk managers are here to assist you:

CALL 800.421.2368
EMAIL patientsafety@thedoctors.com
VISIT thedoctors.com/patientsafety

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CLOSING OR RELOCATING A HEALTHCARE PRACTICE

Physician practices close for many reasons, including physician illness or death or a decision to sell, practice solo, join another group, relocate, or retire. The Patient Safety and Risk Management Department provides this guide to make the transition easier for members.

> Of paramount concern during any change in practice is the continuity of patient care to ensure that no patient is neglected.

NOTIFICATIONS IN EMERGENT SITUATIONS

Of paramount concern during any change in practice is the continuity of patient care to ensure that no patient is neglected. If the change is abrupt, as in the circumstance of a death or sudden illness, the measures below will assist in safeguarding continuity of care. Once continuity of care has been addressed, notify the individuals and entities listed in the "Notifications in Nonemergent Situations" section that follows. Contact The Doctors Company for additional guidance and assistance.

- Transfer all inpatient care to another physician immediately. Use the services of the hospital risk manager if you are unable to locate an available physician.
- Review all previously scheduled office appointments to determine the appropriate action; immediately contact a physician of the same specialty to arrange patient care or provide patients with a list of practitioners of the same specialty within the area.
- Post a notice of practice closure in the office, on the practice's website, and in the local newspaper. (See the sample notice on page 7.) Follow state regulations for specific posting requirements.
- Send a letter to active patients notifying them of the practice closure. (See the sample letter for emergent situations on page 8.)
- Call all physicians who customarily refer patients to the practice, all contracted managed care organizations, and local hospitals to advise them of the practice closure.
- Ensure the availability and accessibility of office medical records as needed for the continuity of patient care.

NOTIFICATIONS IN NONEMERGENT SITUATIONS

If the relocation or closure is planned (nonemergent), advise the individuals and entities listed below.

- Patients (or their legal representatives) who are active in the practice. This includes any patient seen in the past six months to one year, others the physician considers active, and any patient in an acute phase of treatment.
- Employees.
- Business and contracted associates, including affiliated hospitals, healthcare plans, and hospital referral services.
- Third-party vendors, suppliers, and utility providers.
- Third-party payers and managed care organizations. Send written notification via certified mail. Review your participation agreements for continuation-of-care obligations.
- Professional associations, including memberships in local, county, state, or national medical or specialty societies.
- CPA or financial adviser.
- Landlords, lenders, and creditors.
- Agents or brokers and insurers that cover the practice, the employees, and the physical facility.
- Community entities, including local hospitals, the post office, and banks.

GOVERNMENT AGENCY NOTIFICATION

Various state and federal agencies require notice of practice closure.

Send written notification to the following agencies:

- State licensing board(s).
- U.S. Drug Enforcement Administration (DEA) (**dea.gov**).
- Centers for Medicare and Medicaid Services (**cms.gov**). To deactivate Medicare enrollment, follow the tutorial in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) (**pecos.cms.hhs.gov**).
- If you have a National Provider Identifier (NPI), notify the National Plan and Provider Enumeration System (NPPES) (**nppes.cms.hhs.gov**). For more information, see the NPPES FAQs (**https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html**).

LETTERS AND NOTICES

Draft a detailed letter to each patient. Stress the importance of continuing care for all patients. Provide information about where patients can locate a new physician, such as a list from their health insurer, the local medical society, or the local hospital referral line. If you are relocating, include your new address and contact information.

You can adapt the same letter for every individual and organization on the list. (See a sample letter on page 9.) For assistance, contact your patient safety risk manager at 800.421.2368 or **patientsafety@thedoctors.com**.

We recommend sending letters by first-class mail and keeping a copy of the letter in the patient's record. If a patient is considered high risk or is in an acute phase of treatment, consider sending the letter certified mail with return receipt requested. Keep a copy of the letter and return receipt or returned letter in the patient's record.

Send the notice at least 60 days prior to the anticipated closure to give patients an opportunity to locate a new physician, ensure that all prescriptions are adequate to cover the intervening period, and obtain copies of their medical records.

Post a notice of closure on the practice's website and in a local newspaper to inform inactive patients or those who have moved away. (See the sample notice on page 7.)

Write a short script announcing the practice closure or relocation that your staff can use when discussing the issue with patients. Also, change your office's voicemail message announcing the date that the practice will close or relocate, and include any new contact information. You can also include an announcement on any social media accounts.

MEDICAL RECORDS

The information below can help you in addressing medical records requirements:

- Make provisions for completing all medical records, especially inpatient hospital records.
- Provide patients with easy access to their medical records by enclosing a HIPAA-compliant authorization form in the notification letter you send to them. A copy of the records can be released to their new provider or the patient. (See page 10 for a sample authorization form. Texas members: You can download the state-approved form at **texasattorneygeneral.gov/consumer-protection/health-care/patient-privacy**.) When the signed authorization is returned, provide the patient with copies and apply charges as permitted by state law. Do not give original records to patients.
- Provide patients with information on where their medical records will be stored in the future and the length of time (in years) that the records will be retained. Include a permanent mailing address or post office box number for future record requests.
- Arrange a secure storage place consistent with federal and state privacy laws for the original medical records that is safe from theft, vermin, fire, flood, or other weather-related disasters. (More information about medical record custodians is included below.)

Whether you are closing a practice or relocating, you must comply with state and federal laws that govern medical record retention (both paper and electronic formats). The possibility of a lawsuit after a physician has left or a practice has closed always exists. To help defend against any future claims, HIPAA-compliant medical record retention is paramount.

Some states have very specific guidelines or laws that must be followed. Where no statutory requirement exists, The Doctors Company makes the following recommendations for retaining medical records:

- 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.

Check any signed HMO or managed care agreements to ensure compliance with the medical records retention requirements of those agreements.

If a physician chooses to destroy clinical records after a set period of time, confidentiality must not be compromised. Use a record destruction service that guarantees records will be properly destroyed without releasing any information. Records that are destroyed should be listed on a log with the date of destruction.

When a practice closes, patients should be notified that they may designate a new provider who can receive a copy of the records. Original records should never be given to the patient.

Original medical records may be transferred to a custodian for storage. Custodians who agree to retain records can be replacement physicians, nonphysicians, or commercial storage facilities. Commercial custodial arrangements for retaining records are usually entered into for a fee, but all agreements should be in writing. A written custodial agreement should guarantee future access to the records for both the physician and patients and should include the following points:

- Fees for maintaining the records—including fees for retention and continued access to electronic records.
- The custodian will keep and maintain the medical records for the retention times specified above.
- The custodian will comply with state and federal laws governing medical record confidentiality, access, disclosure, and charges for copies of the records.
- The information contained in the medical records cannot be accessed without a signed release from the patient or a properly executed subpoena or court order.
- Copies of medical records will be released to a person designated by the patient only with the patient's written request.
- If the custodian is another physician, the agreement addresses any future personal practice decisions (for example, retiring, selling, or moving) and makes provisions to ensure the safety of and continued access to the records by the original physician or the physician's personal representative.
- The original physician or the physician's personal representative will be notified of any change of the custodian's address or phone number.
- Terms of the agreement apply to everyone in the custodian's employment and facility.

Medical records should be inventoried prior to transfer or storage, and the physician should retain a copy of the inventory.

MEDICATIONS

Any inventory of drugs must be disposed of, sold, transferred, or donated in accordance with federal and state requirements.

- Visit the DEA website (**deadiversion.usdoj.gov/drug_disposal/index.html**) to check federal requirements for disposal of unused drugs or drug samples.
- Contact your state Department of Health, Bureau of Controlled Substances, to check state requirements for disposal of unused drugs or drug samples.
- Keep records of medication disposal per federal and state requirements.
- Destroy remaining prescription pads.

OFFICE SPACE AND EQUIPMENT

- Evaluate the leasing terms for your office space and give appropriate notice to your landlord.
- Create a plan to sell or dispose of your medical and office equipment. Check for state requirements on the sale or disposal of any medical imaging equipment.

LEGAL ISSUES

If appropriate, you will need to take steps to dissolve your professional entity. This is usually done with the assistance of your accountant and corporate attorney.

- File the final annual report and final tax returns.
- Adopt a dissolution plan and file the appropriate certifications and/or forms with the state and federal government.

RETIRING MEMBERS

Find a retirement checklist and information about Tribute® Plan award payments at **thedoctors.com/retirementchecklist**.

WE CAN HELP

A patient safety risk manager is available to provide guidance and help you through the process. Contact us at **patientsafety@thedoctors.com** or at 800.421.2368.

SAMPLE DOCUMENT: Notice of Practice Closure

The practice of Dr(s). _____ [name(s)] is announcing its closure as of _____ [date]. Patients needing assistance in locating another physician should contact their health insurer, the local medical society at _____ [phone number], or the local hospital referral line at _____ [phone number]. With written patient authorization, a copy of the medical record will be available at _____ [address] or by calling _____ [phone number] until _____ [date].

SAMPLE DOCUMENT: Letter to Current/Active Patients for Emergent Situations (such as death or sudden illness)

(Place a copy in the patient's chart.)

[Date]

[Patient's Name and Address]

Dear [Patient],

This is to advise you that [Dr. (Name) passed away on *or* due to a sudden illness, Dr. (Name) is no longer able to provide care as of] [Date].

It is important that you continue with appropriate medical care; therefore, you should establish contact with another physician as soon as possible.

In order to help you find another doctor, the following information is provided:

Option I: You may wish to continue with Dr. [Name] of this office. If so, please contact the office.

Option II: Dr. [Name] will be taking over Dr. [Name's] practice. If you wish to place yourself under this physician's care, please contact the office, or you can contact the local medical society at [telephone number] for a referral.

Option III: If you are in a managed care situation, you may need to contact your healthcare insurer for a referral.

The enclosed HIPAA-compliant authorization form is necessary to release a copy of your medical records to you or a new physician. Please complete the form and return it as soon as possible. On receipt of the signed form, this office will forward a copy of your medical records to you or to the physician you designate.

After the close of this practice, signed requests for copies of medical records may be directed to [indicate the name, address, and phone number for access to medical records or the hospital or organization that has agreed *in writing* to assume this responsibility for you].

Sincerely yours,

[The Estate of/On Behalf of] Dr. [Name]

Enclosure: Authorization for Use or Disclosure of Health Information

SAMPLE DOCUMENT: Letter to Current/Active Patients for Nonemergent Situations (such as retirement, relocation, or leaving a group)

(Place a copy in the patient's chart.)

[Date]

[Patient's Name and Address]

Dear [Patient],

To begin, I would like to thank you for the trust you have given me over the years as your physician. Taking care of you [and your family] has been an honor for my staff and me. Your continuing wellness and health are priorities for us.

I am writing today to inform you that I will be closing my practice due to [state reason] effective as of [date]. I will be available until that date for your urgent care.

It is important that you continue with appropriate medical care; therefore, you should establish contact with another physician as soon as possible.

In order to help you find another doctor, the following information is provided:

Option I: You may wish to continue with Dr. [Name] of this office.

Option II: Dr. [Name] will be taking over my practice. You may wish to place yourself under [this physician's] care, or you can contact the local medical society at [telephone number] for a referral.

Option III: If you are in a managed care situation, you may need to contact your healthcare insurer for a referral within the network.

The enclosed HIPAA-compliant authorization form is necessary to release a copy of your medical records to you or your new physician. Please complete the form and return it as soon as possible. On receipt of this signed form, my office will forward a copy of your medical records to you or to the physician you designate. Please rest assured that our office will remain available during the next [insert time period] to consult with your new provider to promote a smooth transition and continuity of care.

After the close of my practice, signed requests for copies of medical records can be directed to [indicate the name, address, and phone number for access to medical records or the hospital or organization that has agreed *in writing* to assume this responsibility for you].

If you have not selected a new physician by the time my practice closes, you can obtain acute, critical, or emergency care by calling Dr. [Name] or the [local Emergency Department/Hospital].

Sincerely yours,

[Physician's Name]

Enclosure: Authorization for Use or Disclosure of Health Information

SAMPLE DOCUMENT: Authorization for Use or Disclosure of Health Information Form

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Texas practitioners: *The Texas Medical Records Privacy Act requires the Attorney General of Texas to adopt a standard Authorization to Disclose Protected Health Information form. Download the form at www.texasattorneygeneral.gov/consumer-protection/health-care/patient-privacy.*

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____
to release to: _____
[Persons/organizations authorized to receive the information] [Address, street, city, state, zip code]

a. The following information is to be released:
- ❑ Assessment/history and physical Date(s) of service: _____
- ❑ Discharge summary Date(s) of service: _____
- ❑ Lab tests Date(s) of service: _____
- ❑ Radiology reports Date(s) of service: _____
- ❑ Entire record Date(s) of service: _____
- ❑ Other (please specify needed information and date[s] of service if known): _____

_____

b. I specifically authorize the release of the following information (check as appropriate):
- ❑ Mental health treatment information[1]
  (A separate authorization is required to authorize the disclosure or use of psychotherapy notes.)
- ❑ HIV test results
- ❑ Alcohol/drug treatment information
- ❑ Genetic information/testing

Patient's Initials
_____ I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above.

Patient's Initials
_____ I understand my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Patient's Initials
_____ This authorization remains valid for two years from the date of signature.

Patient's Initials
_____ Any facsimile, copy, or photocopy of this authorization shall authorize you to release the records requested herein.

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and accreditation requirements, if any, and legal requirements of your individual state(s).

PURPOSE

The purpose of the release of this information is:

- ❑ Insurance or other third-party reimbursement
- ❑ Continuity of medical care
- ❑ Pending legal action
- ❑ At the request of the patient
- ❑ Other: (Specify) _____

RESTRICTIONS

According to federal and state regulations, if the medical information requested relates to AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limiting disclosure to third parties as required by law.

I understand that if the person or entity that receives the information is not a healthcare provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release _____ [Name of Physician, Professional Designation], and employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2]

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

_____

_____

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.[3]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient.

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and accreditation requirements, if any, and legal requirements of your individual state(s).

SIGNATURE

Date: _____

Time: _____ AM/PM

Print Name: _____

Signature: _____

(Circle one: patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

_____

_____

Witness: _____

_____

1 If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, or social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

2 If any of the HIPAA-recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment, or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

3 Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and accreditation requirements, if any, and legal requirements of your individual state(s).