

February 14, 2022

Nadine Pfeiffer  
DHSR Rule-Review Manager  
NC Division of Health Service Regulation  
809 Ruggles Drive, 2701  
Raleigh, NC 27699-2701

**Ref: Readoption of Hospital Rules: 10A NCAC 13B .3903, Preservation of Hospital Records**

*Submitted via email to [DHSR.RulesCoordinator@dhhs.nc.gov](mailto:DHSR.RulesCoordinator@dhhs.nc.gov)*

Dear Ms. Pfeiffer:

The North Carolina Healthcare Association (NCHA) represents over 130 hospitals and health systems in North Carolina who care for North Carolinians. Our mission is to improve the health of the communities where we live and work by advocating for sound public policy and collaborative partnerships. NCHA believes in a North Carolina where high-quality health care is accessible and equitable for all.

NCHA welcomes the opportunity to provide comments on 10A NCAC 13B .3903, Preservation of Hospital Records. The proposed repeal of notification prior to destruction of records is very helpful, and NCHA supports that change. After further review of the rule, NCHA requests additional conforming and clarifying revisions as noted below, with recommended language included in the attached appendix.

**Modify Section D to add a clause regarding the Destruction of Microfilmed Records**

Subsection D currently states that the original of microfilmed medical records shall not be destroyed until the medical records department has had an opportunity to review the processed film for content. Many hospitals maintain a substantial amount of paper records and are not contemplating converting to film/fiche. This is an area that has limited guidance on destroying records once outside of the age of retention. NCHA recommends the inclusion of verbiage to help guide hospitals in documenting a destruction policy for legacy paper records.

**Additional Modifications to modernize the current version of the rule**

NCHA recommends the following updates for the sections below:

- **Section A/B/C** – Recommendation for the use of retention regulation along the lines of federal record retention guidelines. The regulation requires you to maintain medical records for 7 years from the Date of Service (DOS).
- **Section E** – Recommendation to add language around information blocking. Information blocking is an action that is likely to obstruct, impede, or discourage electronic health information (EHI) access, sharing, or usage.



- **Section F** – Recommendation to add in references to “recipients of medical records” to reflect current practices.
- **Section G** – Recommendation to revise the language about authorized access to records to reflect updated language regarding the removal of records from hospital property.

Please refer to Appendix A of this document to find the specific language recommendations that are designated in blue.

If you have questions, please contact me at [slawler@ncha.org](mailto:slawler@ncha.org) or Makeda Harris at [mharris@ncha.org](mailto:mharris@ncha.org). We look forward to continued involvement in the readoption process.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen J. Lawler". The signature is fluid and cursive, with a large initial "S" and "L".

Stephen J. Lawler  
President and CEO  
North Carolina Healthcare Association

## Appendix A: Proposed Revisions to 10A NCAC 13B .3903, Preservation of Medical Records

### 10A NCAC 13B .3903 PRESERVATION OF MEDICAL RECORDS

(a) The manager of medical records service shall maintain medical records, whether original, computer media, or microfilm, for a ~~minimum of~~ 11 years following the discharge of an adult patient.

(b) The manager of medical records shall maintain medical records of a patient who is a minor until the patient's 30<sup>th</sup> birthday.

**Recommendation (a)-(b):** The manager of medical records services shall maintain medical records, whether original, computer media, microfilm, for at least 7 years from the date of service; for minors, 7 years after the minor turns the age of 18 (i.e., 25 years old)

(c) If a hospital discontinues operation, its management shall make known to the Division where its records are stored. Records shall be stored in a business offering retrieval services for ~~at least~~ 11 years after the closure date.

**Recommendation (c):** For facilities that discontinue operation, records shall be stored in a business offering retrieval services for 7 years after the closure date

(c1) A hospital may destroy medical records after the required retention period.

~~(d) The hospital shall give public notice prior to destruction of its records, to permit former patients or representatives of former patients to claim the record of the former patient. Public notice shall be in at least two forms: written notice to the former patient or their representative and display of an advertisement in a newspaper of general circulation in the area of the facility.~~

~~(e)~~(d) The manager of medical records may authorize the microfilming of medical records. Microfilming may be done on or off the premises. If done off the premises, the facility shall provide for the confidentiality and safekeeping of the records. The original of microfilmed medical records shall not be destroyed until the medical records department has had an opportunity to review the processed film for content.

**Recommendation (d):** The manager of medical records may authorize the digital conversion (i.e., document imaging/scanning/conversion) of paper records. Digital conversion may be done on or off premises. The facility shall provide for the confidentiality and safekeeping of records throughout the digital conversion process. The original medical records shall not be destroyed until the medical records department can review the processed records for content and accuracy. For historical records that are already digitized from use/originated from electronic medical record systems, organizations must abide by the same diligence for retention, destruction, conversion, confidentiality, and safekeeping as paper medical records.

~~(f)~~(e) Nothing in this Section shall be construed to prohibit the use of automation in the medical records service, if all of the provisions in this Rule are met and the information is readily available for use in patient care.

**Recommendation (e):** Nothing in this Section shall be construed to prohibit the use of automation of medical record services if: (i) all the provisions in this Rule are met; and (ii) the information is readily available for patient care and does not constitute information blocking as defined by the Office of Inspector General.

~~(g)~~(f) Only personnel authorized by state laws and Health Insurance Portability and Accountability Act (HIPAA) regulations shall have access to medical records. Where the written authorization of a patient is required for the release or disclosure of health information, the written authorization of the patient or authorized representative shall be maintained in the original record as authority for the release or disclosure.

**Recommendation (f):** Only personnel authorized by state laws, 42 C.F.R. Part 2, and Health Insurance Portability and Accountability Act (HIPAA) regulations shall have access to medical records. Where the written authorization of a patient or written assurances of the recipient of the information is required for the release or disclosure of health information, the written authorization of the patient or authorized representative, or the written assurances of the recipient, shall be maintained in the original record as authority for the release or disclosure.

~~(h)~~(g) Medical records are the property of the hospital, and they shall not be removed from the facility jurisdiction except through a court order. Copies shall be made available for authorized purposes such as insurance claims and physician review.

**Recommendation (g):** Medical records, and copies thereof, are the property of the hospital, and they shall not be removed without the facility's consent except as required by law or regulation.