N.C. Nursing Home Licensure Rules

Fiscal Impact Analysis

Agency: North Carolina Medical Care Commission

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Impact: State government impact: No

Local government impact: No Federal government impact: No Substantial economic impact: No

Statutory Authority: G.S. 131E-104

Rule Change Summary:

Rule 10A NCAC 13D .2402, Preservation of Medical Records was originally published in the N.C. Register on December 16, 2013. During the public comment period, the agency received feedback on this rule. The agency has accepted the recommendation and has incorporated those changes into the rule language. The amended rule text clarifies the requirements for licensed providers and updates the rule to reflect current medical records preservation practices. There is little to no fiscal impact as a result of these changes. If anything, the amended rule seeks to lessen the burden on the regulated provider, particularly in the requirements for medical record storage which has been reduced from eleven years to five. This reduction in time may result in a small cost savings to providers.

Exhibit B

APPENDIX

10A NCAC 13D .2402 is proposed for amendment as follows:

10A NCAC 13D .2402 PRESERVATION OF MEDICAL RECORDS

(a) The manager of medical records Medical records are the property of a facility. A facility shall ensure that keep

both hard copy and electronic medical records records, whether original, computer media or microfilm, be kept on

file for a minimum of five years following the discharge of an adult patient.

(b) The manager of medical records shall ensure that if If the patient is a minor when discharged from the nursing

facility, then the records shall be kept on file until his or her 19th birthday and, then, for plus an additional five

years.

(c) If a facility discontinues operation, the licensee shall make known to inform the Division of Health Service

Regulation where its records are stored. Records are to shall be stored in a business offering retrieval services for

at least 11 five years after the closure date.

(d) The manager of medical records A facility may authorize the microfilming copying of medical records.

Microfilming Copying may be done on or off the premises. If done off the premises, the facility shall take

precautions to ensure the confidentiality and safekeeping of the records. The original of the microfilmed medical

records shall not be destroyed until the manager of medical records has had an opportunity to review the

processed film for content.

(e) Nothing in this Subchapter shall be construed to prohibit the use of automation of medical records, provided

that all of the provisions in this Rule are met and the medical record is readily available for use in patient care.

(f) (e) All medical records are confidential. Only authorized personnel shall have access to the records. Signed

authorization forms concerning approval or disapproval of release of medical information outside the facility shall

be a part of each patient's medical record. The facility shall be compliant with the Health Insurance Portability and

Accountability Act. Representatives of the Department shall be notified at the time of inspection of the name and

record number of any patient who has denied medical record access to the Department.

(f) At the time of inspection, the facility shall inform the surveyor of the name of any patient who has denied the

Department access to their medical record.

(g) Medical records are the property of the facility, and they shall not be removed from the facility except through

a court order. Copies shall be made available for authorized purposes such as insurance claims and physician

review.

History Note:

Authority G.S. 131E-104; <u>131E-105</u>;

Eff. January 1, 1996.

Amended Eff. November 1, 2014.

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