Designated Record Set & Legal Health Record
This is a basic educational course on the Designated Record Set and Legal Health Record. This course provides the definition of each term, the purpose and use including interconnection of each term based on the HIPAA Privacy Rule and AHIMA, along with the fact that one must check with their employer/organizational policies for changes or variations from this basic course guidance.

- The Acronyms
- The Definitions
- The Interconnections
- The Purpose and Use
- Organizational Responsibility

As we go through this series, remember the Designated Record Set and Legal Health Record are terms used in regard to a Covered Entity (CE). Per HIPAA, a CE is an organization that transmits protected health information (PHI) electronically. Some examples of a CE include healthcare providers, hospitals, clinics, nursing homes, health insurance companies, healthcare clearing houses.

The Acronyms

Let's begin with the acronyms used in healthcare articles, forms, letters, policies and procedures that refer to both of these very important terms associated with the medical record:

- Designated Record Set is referred to as DRS
- Legal Health Record is referred to as LHR

The Definitions

Moving on to the definitions of these commonly used medical record terms.

- DRS is a group of records that is maintained and collected for each patient that receives care and includes both the medical and billing records.
  - Of note, it also includes enrollment, payments, claims, adjudication, case or medical management record systems maintained by or for a health plan; other medical management record systems maintained by or for a health plan; or information used in whole or in part to make other care related decisions about patients.
LHR is the collection of health information of a patient that is created and maintained in the regular course of business during the patient’s healthcare delivery.

Documentation may exist in multiple sources consisting of electronic and/or paper-based systems.

The Interconnection

The DRS incorporates the LHR

- The DRS does contain documents, however, that are not part of the LHR such as committee reports of patient specific care decisions, administrative and financial reports such as superbills, case management records, and personal health records in which the organization should define such records destination in policy.

The LHR is a subset of the DRS

- An example of the interconnection would be the Clinical Record which may contain documents such as the ancillary reports such as x-rays and lab reports, history and physical and/or operative reports as such are incorporated in both the DRS and the LHR.

- Another example of the interconnection would be external records if they were used for healthcare decision-making during patient’s encounter and, if so, would be incorporated within both the DRS and the LHR.

The Purpose & Uses

The DRS is used to clarify the rights of the patient such as to:

- Access
- Amend
- Restrict
- Request and obtain an accounting of disclosure

The LHR is the official business record of healthcare services delivered by the CE for regulatory and disclosure purposes.

- Supports the decisions made in a patient's care
- Supports the revenue sought from third-party payers
- Documents services provided for legal cases if applicable
- Excludes administrative, derived, and aggregate data
Release-of-Information purposes

- The DRS is the record released for a patient request or a patient-directed request.
- The LHR is the record released for legal proceedings or in response to requests for release of patient medical records for responding to formal requests.
- When there are requests, for example, of itemized bills or financial data, the organizational policy needs to be followed on who is responsible to release such documents.

Organizational Responsibility

The CE/Organization's responsibility is to develop a policy for the Designated Record Set and the Legal Health Record and all the documents therein.

- For patients safety and quality care, organizations need to define the content of the health record and a matrix denoting which documents are either paper-based or which electronic system they reside.
For understanding of this course, please answer the following questions.

1. The four acronyms discussed in this course: Please provide definitions.
   a. CE: ________________________________
   b. PHI: ________________________________
   c. DRS: ________________________________
   d. LHR: ________________________________

2. Mr. Billings was a patient at Mountain General Hospital for one week of his insurance company requested a billing statement of all his charges.
   a. DRS
   b. LHR
   c. Both

3. What is considered the official business record of healthcare services delivered by the CE for regulatory and disclosure purposes?
   a. DRS
   b. LHR

4. Per HIPAA, an accounting of disclosure report is considered part of the:
   a. DRS
   b. LHR

5. An example of a medical document that would be interconnected and considered within both the DRS and the LHR is:
   a. Laboratory Results
   b. Case Management Record
Knowledge Check - Answer Key

1. (definitions are easily found in course)
2. a
3. b
4. a
5. a