Designated Record Set (DRS)

Policy Number: 1234

I. POLICY

In accordance with Federal, State, and Local Privacy & Security rules, the organization must specifically define, maintain and allow persons served or a persons served personal representative (as defined by HIPAA and state law) certain rights to a designated record set (DRS) per the procedure outlined below. The DRS will encompass information beyond the traditional health, medical and billing records. The organization will include information received from another facility during the persons served visit/stay in their DRS unless they have documented facts that the information was not used in whole or in part to make a decision about the person served. Information received from other facilities after the person is discharged must be sent back to the originator, placed into the shredding bin and destroyed or incorporated into the DRS.

The DRS impacts the definition of electronic health information (EHI) for purposes of and the Information Blocking restrictions set forth at 45 CFR Part 171 and issued pursuant to the 21st Century Cures Act. Electronic PHI that is part of the DRS will be considered EHI. EHI is not limited to information that is created or received by a health care provider, health plan, health care clearinghouse, public health authority, employer, life insurer, school, or university. EHI may be provided, directly from an individual, or from technology that the individual has elected to use, to an actor covered by the information blocking provisions.

II. PURPOSE

To facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, and the Information Blocking restrictions set forth at 45 CFR Part 171 and issued pursuant to the 21st Century Cures Act, and all Federal regulations and interpretive guidelines promulgated thereunder. To establish guidelines for the definition and content of the designated record set (§164.501).

III. DEFINITION

Designated Record Set (DRS): The DRS is defined as a group of records, paper or electronic, maintained by and for the organization that is:

- The medical and billing records about persons served maintained by and for the organization;
- The payment, claims adjudication, and case management notes maintained by the organization; and
- Those medical and billing records used, in whole or in part, by the organization to make decisions about the person served.

Psychotherapy Notes (45 CFR § 164.501): Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy

notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items - diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

IV. STANDARDS & PROCEDURES

1. DRS Information Included: The organization will identify which forms and reports, when present in a persons paper or electronic file, will be included in the DRS based on the HIPAA DRS definition. At a minimum, the following forms and reports must be included in the organizations DRS:

    a. Medical Record/Clinical Information: Including but not limited to advanced directives, care plans, consent forms, consultation reports, correspondence (such as referral records and records requests), discharge reports, documented communication between the provider and persons served or family members regarding care and support, emergency department/care records, history and physicals, immunization records, lab results, medication administration records, nursing records (such as assessments and case notes), procedure records, diagnostic reports (such as EEG, EKG, ENG, etc.), pathology reports, problem lists, progress notes, provider orders, registration records, selected photographs, transfer records and transport reports.

    b. Billing Record Information: complete statements of accounts (including billing history), open balance statements, financial agreements, financial payment arrangements, encounter forms, paper claim forms, other claims information (including claims, remittance, eligibility response, claim status response, statement of account balance/outstanding claims, etc.).

    c. Business Associate Records & Information: any records held by an organizations Business Associate that meets the organizations definition of the DRS.

2. Source Documentation & Records: The following information is usually considered part of the source data of the DRS. A narrative of the interpretation from the source data would generally be acceptable. In most cases, individuals cannot interpret source data, so such data is meaningless. Examples may include EKG/EEG tracing information from which interpretations are derived. There may be times, however, when an individual has a legitimate need to access source data. When such a need arises, the organization will want to provide the individual with greater rights of access, allowing the individual access to or copies of the source data when possible. A specific request, authorization or subpoena is required to produce the original or to obtain a copy (if retained and/or able to copy) of this information:

    a. Birth certificates, birth certificate worksheets, paternity papers;
    b. Videotapes and digital recordings of procedures;
    c. Photographs that are not maintained as part of the medical record;

d. All release of information related correspondence (such as requests for copies from insurance companies, authorization forms, interdepartmental requests for records, and fax cover sheets); and
e. Copies of driver's licenses, insurance or social security cards.

3. Records NOT part of the DRS: The following information and records are NOT part of the DRS:

    a. Psychotherapy notes as defined by the Standards for Privacy of Individually Identifiable Health Information (§164.501);
    b. Peer review information as related to incidents and incident management;
    c. Incident reports
    d. Infection control reports
    e. Administrative, attorney-client privileged and any other protected reports
    f. Temporary notes or worksheets, reminders, and coding worksheets
    g. Pricing information not included in the patient's billing records, such as payer contract terms

4. Request to Access or Amend DRS Information: The organization will establish a process for the person served or their personal representative to access and amend on the use or disclosure of their DRS.

    a. If a person or their personal representative requests access to health information under the organizations policy on Right to Access, Inspect and/or Obtain a Copy of PHI, or requests to amend or correct health information under the organization policy on Right to Request Amendment to health information, the individual shall be given access to the DRS.
    b. On the applicable request form, the person or their personal representative should specify whether the information requested is to be accessed or amended.
    c. When a request is made to access or amend information not maintained in the applicable organizations health information management department, the organization will inform the holder of the requested information so that the holder may respond pursuant to the applicable policy.
    d. Procedures for access to and amendment of any records are contained in the applicable policy.

5. Violations: Knowledge of any violations of this policy should be reported to the organizations Compliance Officer.