Test Bank for Kinn's the Clinical Medical Assistant 13th Proctor

MULTIPLE CHOICE

1. Which of the following is *not* a method of organizing a medical record?
   a. Source oriented
   b. Problem oriented
   c. Progressively
   d. Chronologically

   ANS: C
   Medical records can be organized chronologically or as source-oriented or problem-oriented records. There is no such thing as a progressive type of record organization.

   REF: p. 31 | CAAHEP: VI.C.5 | ABHES: 8.a
   OBJ: 12. Identify and discuss the two methods of organizing a patient's paper medical record: source-oriented records and problem-oriented records.

2. Information that is gained by questioning the patient or that is taken from a form is called _____ information.
   a. confidential
   b. subjective
   c. objective
   d. necessary

   ANS: B
   Subjective information is gained by questioning the patient or is taken from a form.

   REF: p. 17 | CAAHEP: V.C.16 | ABHES: 9.b
   OBJ: 4. Differentiate between subjective and objective information and create a patient's health record.

3. Which of the following is *not* needed when describing a patient's chief complaint?
   a. Remedies the patient has tried to relieve symptoms
   b. The duration of pain
   c. The time when symptoms were first noticed
   d. How many family members are healthy

   ANS: D
   The chief complaint is the main problem the patient is currently experiencing. The medical assistant should note the remedies the patient has tried, the duration of any pain, and the time that symptoms were first noticed. The number of healthy family members is not necessary information about the chief complaint but would be part of the family history.

   REF: p. 20 | CAAHEP: V.C.16 | ABHES: 9.b
   OBJ: 4. Differentiate between subjective and objective information and create a patient's health record.

4. A filing system in which an intermediary source of reference, such as a file card, must be consulted to locate specific files is called a(n) _____ *system*.

a. shelf filing
b. indirect filing
c. direct filing
d. shingling

ANS: B
An *indirect filing system* uses an intermediary source of reference, such as a file card, to locate specific files.

REF: p. 39 | CAAHEP: VI.C.7 | ABHES: 8.a
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

5. How would you properly index the name "Jill Freeman, M.D." for filing if you had another patient with the same name but without the title?
a. Dr. Jill Freeman
b. Freeman, Dr. Jill
c. Freeman, Jill
d. Freeman, Jill M.D.

ANS: D
The title should be used in filing systems to distinguish a person from one who does not have a title.

REF: p. 37 | CAAHEP: VI.C.7 | ABHES: 8.a
OBJ: 16. Describe indexing rules, as well as create and organize a patient's health record.

6. How would you properly index the name "Amanda M. Stiles-Duncan" for filing?
a. Stilesduncan, Amanda M.
b. Stiles Duncan, Amanda M.
c. Duncanstiles, Amanda M.
d. Duncan, Amanda M. Stiles

ANS: A
Hyphenated names are treated as one unit when filing.

REF: p. 37 | CAAHEP: VI.C.7 | ABHES: 8.a
OBJ: 16. Describe indexing rules, as well as create and organize a patient's health record.

7. Who is the legal owner of the information stored in a patient's record?
a. The patient
b. The physician or agency where services were provided
c. The patient's insurance company
d. Both the patient and the physician

ANS: B
The physician, agency, or facility where a record is created is the legal owner of that record.

REF: p. 41 | CAAHEP: X.A.1 | CAAHEP: X.A.2 | ABHES: 7.c
OBJ: 5. Explain who owns the health record.

8. *Continuity of care* means
a. an aggregate of activities designed to ensure adequate quality, especially in

manufactured products or in the service industries.
b. a formal examination of an organization's or individual's accounts.
c. medical attention that continues smoothly from one provider to another so that the patient receives the most benefit.
d. granted or endowed with a particular authority.

ANS: C
Continuity of care is medical attention that moves smoothly from one provider to another so that the patient receives the most benefit.

REF: p. 17 | CAAHEP: X.C.4 | ABHES: 1.b
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

9. Which of the following are common types of filing equipment found in a medical office?
a. Rotary circular files
b. Lateral files
c. Automated files
d. All of the above

ANS: D
Rotary circular files, lateral files, and automated files are all types of filing equipment that might be found in a medical office.

REF: p. 35 | CAAHEP: VI.C.6 | ABHES: 8.a
OBJ: 15. Identify filing equipment and filing supplies needed to create, store, and maintain medical records.

10. Which of the following is *not* an advantage of color-coded filing systems?
a. Patient charts can be found quickly.
b. It is easy to tell when a file has been misplaced.
c. Patient charts can be re-filed quickly.
d. All of the above are advantages.

ANS: D
Color-coded charts allow staff members to find medical records quickly; they also make it easy to detect when files have been misplaced and to re-file them.

REF: p. 40 | CAAHEP: VI.P.5 | ABHES: 8.a
OBJ: 17. Discuss the pros and cons of various filing methods, as well as file patient health records.

11. Which statement is *not* true regarding the reasons for keeping accurate medical records?
a. The medical record provides critical information for other caregivers.
b. Effects of various treatments can be tracked and statistics gleaned from them.
c. The patient's family may want to examine the records and correct errors.
d. Accurate records are vital for financial reimbursements.

ANS: C
Accurate records are not kept to appease the patient's family; they are kept, ultimately, to provide appropriate patient care.

REF: p. 17 | CAAHEP: X.P.3 | CAAHEP: X.A.2 | ABHES: 4.a
OBJ: 3. State several reasons accurate health records are important.

12. Which of the following is *not* objective information?
    a. Progress notes
    b. Family history
    c. Diagnosis
    d. Physical examination and findings

    ANS: B
    The family history is subjective, not objective, information.

    REF: p. 21 | CAAHEP: V.C.16 | ABHES: 9.b
    OBJ: 4. Differentiate between subjective and objective information and create a patient's health record.

13. What is the most important reason for telling the physician when a charting error is discovered later?
    a. To protect the patient's health and well-being
    b. To protect the medical assistant's job
    c. To make sure the medical assistant is not accused of making the error
    d. To keep the patient from discovering the error

    ANS: A
    The most important reason to report errors in the medical record is to make sure the patient's health and well-being are not jeopardized.

    REF: p. 33 | CAAHEP: X.A.2 | ABHES: 7.c
    OBJ: 3. State several reasons accurate health records are important.

14. Which statement is *not* accurate about correcting charting errors?
    a. Insert the correction above or immediately after the error.
    b. Draw two clear lines through the error.
    c. In the margin, initial and date the error correction.
    d. Do not hide charting errors.

    ANS: B
    Only one line should be drawn through errors when corrections are made.

    REF: p. 33 | CAAHEP: X.A.2 | ABHES: 7.c
    OBJ: 13. Discuss how to document in an EHR and a paper health record, and how to make corrections/alterations to health records.

15. The medical record should be released only with a
    a. verbal order from the physician.
    b. written order from the physician.
    c. written release from the patient.
    d. verbal order from the office manager.

    ANS: C
    Records should be released only with a written authorization from the patient.

    REF: p. 41 | CAAHEP: X.C.3 | ABHES: 7.c
    OBJ: 11. Describe how and when to release health record information and discuss health information exchanges.

16. Medical facilities should keep records on minors for how long?
    a. Indefinitely
    b. Until the minor is deceased
    c. For 10 years
    d. Until the minor reaches the age of majority, plus 3 years

    ANS: D
    Medical records should be kept until minors reach the age of majority, plus 3 years.

    REF: p. 29 | CAAHEP: X.A.2 | ABHES: 7.c
    OBJ: 10. Discuss backup systems for the EHR, as well as the transfer, destruction, and retention of health records as related to the EHR.

17. Which of the following is *not* an advantage of a numeric filing system?
    a. It allows periodic expansion without shifting folders.
    b. It provides additional confidentiality to the chart.
    c. Filing activity is greatest when the system is initiated.
    d. It saves time in record retrieval and re-filing.

    ANS: C
    Most filing activity is required when a numeric filing system is instituted. Once the system is in place, it is easy to maintain.

    REF: p. 39 | CAAHEP: VI.P.5 | ABHES: 8.a
    OBJ: 17. Discuss the pros and cons of various filing methods, as well as file patient health records.

18. Many healthcare facilities now use voice recognition software for transcription. The system can be used to dictate which types of reports?
    a. Progress notes
    b. Letters
    c. E-mails
    d. All of the above

    ANS: D
    Many healthcare facilities now use voice recognition software for transcription. The system can be used to dictate progress notes, letters, e-mails, and virtually any document in the medical office that is needed.

    REF: p. 33 | CAAHEP: VI.C.6 | ABHES: 7.b
    OBJ: 14. Discuss dictation and transcription, and discuss transfer, destruction, and retention of medical records as related to paper records.

19. The most frequently used follow-up method is a
    a. tickler file.
    b. transitory file.
    c. practice management file.
    d. None of the above

    ANS: A
    The most frequently used follow-up method is a tickler file, so called because it tickles the memory that something needs to be done or followed upon on a particular date.

REF: p. 40 | CAAHEP: VI.P.5 | ABHES: 8.a
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

20. Files for patients who have died, moved away, or otherwise terminated their relationship with the physician are called _____ files.
    a. inactive
    b. closed
    c. active
    d. dead

    ANS: B
    The files of patients who are no longer active, such as those who have moved away, died, or otherwise terminated their relationship with the physician, are called *closed files.*

    REF: p. 28 | CAAHEP: VI.P.5 | ABHES: 8.a
    OBJ: 17. Discuss the pros and cons of various filing methods, as well as file patient health records.

21. HIPAA recommends that physicians keep the records on patients for at least
    a. 1 year.
    b. 2 years.
    c. 3 years.
    d. HIPAA does not recommend a number of years.

    ANS: D
    HIPAA does not offer a recommendation on record retention; it prompts facilities to follow their individual state laws.

    REF: p. 29 | CAAHEP: X.C.3 | ABHES: 7.c
    OBJ: 19. Discuss patient education, as well as legal and ethical issues, related to the health record.

22. The medical assistant should consider which of the following when selecting filing equipment?
    a. Fire protection
    b. Cost of space and equipment
    c. Confidentiality requirements
    d. All of the above

    ANS: D
    Many considerations should be evaluated when considering filing equipment.

    REF: p. 35 | CAAHEP: VI.C.6 | ABHES: 8.e
    OBJ: 15. Identify filing equipment and filing supplies needed to create, store, and maintain medical records.

23. A strong, highly glazed composition paper or heavy card stock is called
    a. augment.
    b. pressboard.
    c. microfilm.
    d. shingle.

    ANS: B

Pressboard is a strong, highly glazed composition paper or heavy card stock.

REF: p. 36 | CAAHEP: VI.C.6 | ABHES: 8.e
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

24. The process of moving an active file to inactive status is called
    a. purging.
    b. indexing.
    c. coding.
    d. conditioning.

ANS: A
Purging is the process of moving active files into inactive status.

REF: p. 29 | CAAHEP: VI.P.5 | ABHES: 8.a
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

25. The physical medical record belongs to the
    a. patient.
    b. physician or provider.
    c. insurance company.
    d. All of the above

ANS: B
The physical medical record belongs to the physician or provider who created it.

REF: p. 41 | CAAHEP: X.A.1 | CAAHEP: X.A.2 | ABHES: 7.c
OBJ: 5. Explain who owns the health record.

26. A correction to a medical record can be made by
    a. drawing a line through the entry and writing the correct information.
    b. whiting out the entry and writing over it.
    c. rewriting the entire page of progress notes with the error corrected.
    d. All of the above

ANS: A
The medical assistant should never obliterate a medical record or try to hide an error by rewriting information in the record.

REF: p. 33 | CAAHEP: X.A.2 | ABHES: 7.c
OBJ: 13. Discuss how to document in an EHR and a paper health record, and how to make corrections/alterations to health records.

27. The “E” entry in the SOAPER charting method means
    a. entry.
    b. evaluation.
    c. education.
    d. exclude.

ANS: C
The “E” entry signifies patient education that occurred during the encounter with the patient.

REF: p. 31 | CAAHEP: VI.C.5 | ABHES: 8.a

OBJ: 12. Identify and discuss the two methods of organizing a patient's paper medical record: source-oriented records and problem-oriented records.

28. The "R" entry in the SOAPER charting method means
    a. rationale.
    b. response.
    c. repeat.
    d. reinforce.

    ANS: B
    The "R" entry signifies the patient's response during the encounter and indicates the person's understanding of the treatment plan or instructions.

    REF: p. 31 | CAAHEP: VI.C.5 | ABHES: 8.a
    OBJ: 12. Identify and discuss the two methods of organizing a patient's paper medical record: source-oriented records and problem-oriented records.

29. The preferred filing method for a physician's office is
    a. alphabetic.
    b. numeric.
    c. alphanumeric.
    d. the one most preferred by the staff.

    ANS: D
    The facility should use the filing method most preferred by staff members that allows quick retrieval of patients' records.

    REF: p. 31 | CAAHEP: VI.P.5 | ABHES: 8.a
    OBJ: 17. Discuss the pros and cons of various filing methods, as well as file patient health records.

30. The newest component used today to complete transcription and authenticate records is _____ software.
    a. voice-activated
    b. voice recognition
    c. voice registry
    d. voice-controlled

    ANS: B
    Voice recognition software is popular today for transcription and authentication purposes.

    REF: p. 33 | CAAHEP: VI.C.6 | ABHES: 7.b
    OBJ: 14. Discuss dictation and transcription, and discuss transfer, destruction, and retention of medical records as related to paper records.

31. The advantages of using the color-coding filing system are the following:
    a. a misfiled record is easily spotted even from a distance.
    b. the use of color visually restricts the area of search for a specific record.
    c. you can use either the alphabetic or numeric color-coding system.
    d. All of the above

    ANS: D

When a color-coded system is used, both filing files and finding files are easier, and misfiled folders are kept to a minimum.

REF: p. 40 | CAAHEP: VI.P.5 | ABHES: 8.a
OBJ: 17. Discuss the pros and cons of various filing methods, as well as file patient health records.

32. Who ultimately decides whether a medical record can be released?
    a. The physician
    b. The office manager
    c. The medical assistant
    d. The patient

    ANS: D
    The patient ultimately decides whether his or her medical record can be released.

    REF: p. 41 | CAAHEP: X.A.1 | CAAHEP: X.A.2 | ABHES: 7.c
    OBJ: 5. Explain who owns the health record.

33. Advantages of the EHR system include
    a. ability of the physician to see more patients in a day.
    b. cost of implementation.
    c. possibility of a breach of confidentiality.
    d. concern of patients over privacy.

    ANS: A
    Once the physician and staff become used to the system, they usually find that they can see more patients throughout the course of a day.

    REF: p. 23 | CAAHEP: VI.P.6 | ABHES: 7.b
    OBJ: 8. Explore the advantages, disadvantages, and capabilities of an electronic health record system, as well as organize a patient's health record.

34. Disadvantages of the EHR system include
    a. cost.
    b. training time.
    c. learning curve.
    d. All of the above

    ANS: D
    Despite the disadvantages, the advantages of the EHR system in most cases far outweigh the disadvantages.

    REF: p. 23 | CAAHEP: VI.P.6 | ABHES: 7.b
    OBJ: 8. Explore the advantages, disadvantages, and capabilities of an electronic health record system, as well as organize a patient's health record.

35. A set of physical properties, the values of which determine characteristics or behavior, is called
    a. interoperables.
    b. parameters.
    c. informatics.
    d. gauges.

ANS: B
Parameters are a set of physical properties, the values of which determine characteristics or behavior.

REF: p. 16 | CAAHEP: V.C.7 | ABHES: 8.e
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

36. The type of electronic record of health-related information about a patient that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff from more than one healthcare organization is a(n)
    a. EMH.
    b. EHR.
    c. EMR.
    d. PHI.

ANS: B
The EHR can be created, managed, and consulted by authorized clinicians and staff from more than one healthcare organization.

REF: p. 22 | CAAHEP: VI.P.6 | ABHES: 7.b
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary. 6. Distinguish between an electronic health record (EHR) and an electronic medical record (EMR).

37. The type of electronic record of health-related information about an individual that can be created, gathered, managed, and consulted only by authorized clinicians and staff in a single healthcare organization is a(n)
    a. PHR.
    b. EHR.
    c. EMR.
    d. PHI.

ANS: C
The EMR is compiled by the staff at a single organization involved in the patient's care.

REF: p. 22 | CAAHEP: VI.P.6 | ABHES: 7.b
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary. 6. Distinguish between an electronic health record (EHR) and an electronic medical record (EMR).

38. How can the EHR function to *best* help improve a facility's appointment show rate?
    a. The system can matrix the schedule with input from a staff member.
    b. The system can be programmed to initiate reminder and confirmation calls to patients.
    c. The system will allow searches for patient appointments based on a few parameters.
    d. The system can generate a list of the confirmed appointments.

ANS: B
Reminder and confirmation calls play an important role in increasing a physician's show rates, and when they are automated, the medical assistant is free to complete other duties.

REF: p. 26 | CAAHEP: VI.P.6 | ABHES: 7.b
OBJ: 8. Explore the advantages, disadvantages, and capabilities of an electronic health record system, as well as organize a patient's health record.

39. How are corrections made to the electronic health record?
    a. Corrections can be noted by hand and entered, as long as they are initialed.
    b. A new entry or addendum must be added close to the original entry with the correct information and then initialed.
    c. The incorrect entry is deleted and the new one is written in.
    d. The error is brought to the attention of the office manager for instructions on how to correct it.

    ANS: B
    When electronic health records are corrected, the record must be entered (through the log-on process) and then an addendum can be made to correct the information in the record. The addendum is initialed by the person who makes the correction.

    REF: p. 33 | CAAHEP: X.A.2 | ABHES: 7.c
    OBJ: 13. Discuss how to document in an EHR and a paper health record, and how to make corrections/alterations to health records.

40. Perhaps the most essential action for the medical assistant working with a patient and using an electronic record is to
    a. make frequent eye contact with the patient and smile.
    b. type in every word the patient says.
    c. make sure the patient is not hiding any part of the health history.
    d. sit in a chair across from the patient so that the person cannot see the screen.

    ANS: A
    The medical assistant must be personable and keep good eye contact with patients while taking the medical history information so that patients do not feel as if they are talking with a machine instead of a human.

    REF: p. 27 | CAAHEP: V.C.2 | CAAHEP: VI.P.6 | ABHES: 8.f
    OBJ: 9. Discuss the importance of nonverbal communication with patients when an EHR system is used.

41. Which EHR system backup is probably the least trouble and requires the least amount of hardware?
    a. Online backup system
    b. External hard drives
    c. Full server backup
    d. Thumb drive backup

    ANS: A
    Although the online backup system may cost slightly more than other methods, it is easy to use, because there is no external drive to carry and no CD or thumb drive to put through the process of downloading data. Still, most IT professionals suggest that clinics maintain two separate backup methods.

    REF: p. 28 | CAAHEP: VI.P.6 | ABHES: 7.b
    OBJ: 10. Discuss backup systems for the EHR, as well as the transfer, destruction, and retention of

health records as related to the EHR.

42. Medical assistants can encourage other staff members during a conversion to an electronic health record system by
    a. assisting whenever possible as co-workers perform their duties.
    b. welcoming a call for help if asked to provide assistance.
    c. working as a team to help clarify confusing technical instructions.
    d. All of the above

    ANS: D
    The more the medical assistants work together as a team, the more successful they will be in getting the electronic health record system off the ground and running; this, in turn, will help them learn the system more quickly and grow more comfortable with its use.

    REF: p. 42 | CAAHEP: VI.P.6 | ABHES: 1.b
    OBJ: 2. Name and discuss the two types of patient records.

43. Who is responsible for calming patients' fears and concerns about switching to an electronic medical record system?
    a. The physician
    b. The front office medical assistants
    c. The back office medical assistants
    d. The entire team at the office

    ANS: D
    The entire office team must be supportive and help patients feel more comfortable about the conversion process.

    REF: p. 24 | CAAHEP: VI.P.6 | CAAHEP: VI.A.1 | ABHES: 1.b
    OBJ: 19. Discuss patient education, as well as legal and ethical issues, related to the health record.

44. In most cases, does the electronic health record system require more or less storage space than a paper filing system?
    a. More
    b. Less
    c. About the same

    ANS: B
    An electronic system should require much less physical space than the system of rows and cabinets of paper charts that are used in a paper filing system.

    REF: p. 24 | CAAHEP: VI.P.5 | ABHES: 8.a
    OBJ: 2. Name and discuss the two types of patient records.

45. What is one of the benefits of using a paper health record?
    a. Multiple users can access the record at the same time
    b. Fewer errors
    c. Good evidence of patient care
    d. Links clinical information for billing purposes
    e. All of the above

    ANS: C

The paper-based record is good evidence of patient care, but it is not nearly as useful in other capacities. The electronic health record is much more efficient than the paper record. Multiple users can access the record at the same time. There are fewer errors because handwritten notes do not have to be interpreted. In addition, most electronic health records also include practice management capabilities that allow for patient scheduling and generation of reports needed for research and quality control and link the clinical information needed for billing purposes.

REF: p. 17 | CAAHEP: VI.C.2 | ABHES: 8.a
OBJ: 2. Name and discuss the two types of patient records.

46. For a record to be admissible as evidence in court, the person dictating or writing the entries must be able to attest that they were true and correct at the time they were written. The best indication of this is the provider's signature or initials on the typed or EHR entry.
    a. Both statements are true.
    b. Both statements are false.
    c. The first statement is true; the second is false.
    d. The first statement is false; the second is true.

    ANS: A
    For a record to be admissible as evidence in court, the person dictating or writing the entries must be able to attest that they were true and correct at the time they were written. The best indication of this is the provider's signature or initials on the typed entry. In an EHR the provider's electronic signature is proof of the accuracy of the entries.

    REF: p. 22 | CAAHEP: X.P.3 | ABHES: 7.c
    OBJ: 19. Discuss patient education, as well as legal and ethical issues, related to the health record.

47. Which section of the law, commonly known as the Economic Stimulus Package, pertains to healthcare?
    a. ARRA
    b. HITECH Act
    c. HIPAA
    d. None of the above

    ANS: B
    The sections of the ARRA that pertain to healthcare are collectively known as the Health Information Technology for Economic and Clinical Health Act, or HITECH Act. The American Recovery and Reinvestment Act of 2009 (ARRA), commonly known as the Economic Stimulus Package, was passed to promote economic recovery.

    REF: p. 23 | CAAHEP: X.C.10.a | ABHES: 7.c
    OBJ: 19. Discuss patient education, as well as legal and ethical issues, related to the health record.

48. Improved outcomes is part of which of the stages of meaningful use?
    a. Stage 1
    b. Stage 2
    c. Stage 3
    d. Stage 4

    ANS: C

Criteria for meaningful use were designed to be implemented in three stages: Stage 1 (2011 and 2012): Electronic data capture and sharing. Stage 2 (2014): Advance clinic processes. Stage 3 (expected to be implemented in 2016): Improved outcomes.

REF: p. 23 | CAAHEP: VI.C.12 | ABHES: 7.c
OBJ: 7. Do the following related to healthcare legislation and electronic health records: Explain how the American Recovery and Reinvestment Act applies to the healthcare industry. Define meaningful use and relate it to the healthcare industry. List the three main components of meaningful use legislation.

49. Which of the following functions of an electronic record can store lists of billing codes and current procedural terminology?
    a. Appointment scheduler
    b. Charge capture
    c. Referral management
    d. Medical billing system

ANS: B
The charge capture functions can store lists of billing codes (e.g., International Classification of Diseases [ICD] and Current Procedural Terminology [CPT]) in addition to charges associated with procedures, supplies, and laboratory tests. The appointment scheduler allows the staff to track and schedule appointments, matrix the schedule, and account for recurring time blocks. Current and referring providers can be coordinated and automated, allowing the provider to share patient information with another provider. The EHR billing system can manage all of the practice's billing and accounting systems.

REF: p. 26 | CAAHEP: VI.P.6 | ABHES: 7.b
OBJ: 8. Explore the advantages, disadvantages, and capabilities of an electronic health record system, as well as organize a patient's health record.

50. What is the HIPAA privacy rule requirement for the retention of health records?
    a. HIPAA does not include requirements.
    b. Records must be kept for at least 10 years.
    c. For at least the period of the statute of limitations for medical malpractice claims
    d. Until the minor reaches the age of majority plus the statute of limitations

ANS: A
The HIPAA privacy rule does not include requirements for the retention of health records. However, the privacy rule does require that appropriate administrative, technical, and physical safeguards be applied so that the privacy of health records is maintained. The records of any patient covered by Medicare or Medicaid must be kept at least 10 years. In all cases, health records should be kept for at least the period of the statute of limitations for medical malpractice claims, which may be 3 years or longer, depending on state law.

REF: p. 29 | CAAHEP: X.C.3 | ABHES: 7.c
OBJ: 19. Discuss patient education, as well as legal and ethical issues, related to the health record.

51. Which of the following health information exchanges allows providers to find and/or request information on a patient from other providers?
    a. Direct exchange
    b. Query-based exchange

c. Consumer mediated exchange
d. All of the above

ANS: B
Query-based exchange — ability for providers to find and/or request information on a patient from other providers, often used for unplanned care. Directed exchange — ability to send and receive secure information electronically between care providers to support coordinated care. Consumer mediated exchange — ability for patient to aggregate and control the use of their health information among providers.

REF: p. 31 | CAAHEP: X.A.2 | ABHES: 7.c
OBJ: 11. Describe how and when to release health record information and discuss health information exchanges.

52. In a paper record, which of the following is never an acceptable method of correction to a handwritten entry?
a. Draw a line through the error.
b. Erase or use a correction fluid.
c. Insert the correction above the error.
d. Write initials or signature below the correction and date.
e. All of the above are acceptable.

ANS: B
Erasing, using correction fluid, or any other type of obliteration is never acceptable. To correct a handwritten entry, draw a line through the error. Insert the correction above or immediately after the error, in a spot where it can be read clearly. If indicated by the policy and procedures manual, write “Error” or “Err.” in the margin. The person making the correction should write his or her initials or signature below the correction and the date.

REF: p. 33 | CAAHEP: X.A.2 | ABHES: 7.c
OBJ: 13. Discuss how to document in an EHR and a paper health record, and how to make corrections/alterations to health records.

53. Which of the following indirect filing systems is used by a majority of large clinics and hospitals?
a. Alphabetic filing
b. Numeric filing
c. Subject filing
d. Color-coded filing

ANS: B

Some form of numeric filing combined with color and shelf filing is used by practically every large clinic or hospital. Management consultants differ in their recommendations; some recommend numeric filing only if more than 5,000 to 10,000 records are involved. Others recommend nothing but numeric filing. Numeric filing is an indirect filing system, or one that requires use of an alphabetic cross-reference to find a given file. Alphabetic filing by name is the oldest, simplest, and most commonly used system. It is the system of choice for filing patients' records in most small providers' offices. The alphabetic system of filing is traditional and simple to set up, requiring only a file cabinet or shelf, folders, and some divider guides. It is a direct filing system in that the person filing needs to know only the name to find the desired file. Subject filing can be either alphabetic or alphanumeric (A 1-3, B 1-1, B 1-2, and so on) and is used for general correspondence. When a color-coding system is used, both filing and finding files is easier, and misfiling of folders is kept to a minimum.

REF: p. 39 | CAAHEP: VI.P.5 | ABHES: 8.a
OBJ: 17. Discuss the pros and cons of various filing methods, as well as file patient health records.

MULTIPLE RESPONSE

1. Match the EHR acronym with all the appropriate definitions. (*Select all that apply.*)
   a. Electronic record of health-related information
   b. Defined by the ONC
   c. Created and managed by authorized clinicians and staff from more than one healthcare organization
   d. Conforms to nationally recognized interoperability standards
   e. Can be drawn from multiple sources
   f. Managed, shared, and controlled by the individual
   g. Created and managed by authorized clinicians and staff within a single healthcare organization

   ANS: A, C, D
   The electronic health record (EHR) is an electronic record of health-related information about a patient that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff from more than one healthcare organization.

   REF: p. 22 | CAAHEP: VI.C.8 | ABHES: 7.b
   OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

2. Match the EMR acronym with all the appropriate definitions. (*Select all that apply.*)
   a. Electronic record of health-related information
   b. Defined by the ONC
   c. Created and managed by authorized clinicians and staff from more than one healthcare organization
   d. Conforms to nationally recognized interoperability standards
   e. Can be drawn from multiple sources
   f. Managed, shared, and controlled by the individual
   g. Created and managed by authorized clinicians and staff within a single healthcare organization

   ANS: A, G

The electronic medical record (EMR) is an electronic record of health-related information about an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within a single healthcare organization. An EMR is an electronic version of a paper record.

REF: p. 22 | CAAHEP: VI.C.8 | ABHES: 7.b
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

3. Match the PHR acronym with all the appropriate definitions. (*Select all that apply.*)
   a. Electronic record of health-related information
   b. Defined by the ONC
   c. Created and managed by authorized clinicians and staff from more than one healthcare organization
   d. Conforms to nationally recognized interoperability standards
   e. Can be drawn from multiple sources
   f. Managed, shared, and controlled by the individual
   g. Created and managed by authorized clinicians and staff within a single healthcare organization

   ANS: A, B, D, E, F
   A personal health record (PHR) is defined by the ONC as an electronic record of health-related information about an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources but that is managed, shared, and controlled by the individual.

   REF: p. 22 | CAAHEP: VI.C.8 | ABHES: 7.b
   OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

COMPLETION

1. _____ information is provided by the patient.

   ANS:
   Subjective
   Subjective information is provided by the patient.

   REF: p. 17 | CAAHEP: V.C.16 | ABHES: 9.b
   OBJ: 4. Differentiate between subjective and objective information and create a patient's health record.

2. To make greater, more numerous, larger, or more intense is to _____.

   ANS:
   augment
   To augment means to make greater, larger, or more numerous.

   REF: p. 16 | CAAHEP: V.C.7 | ABHES: 8.a
   OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

3. When a patient is transferred from one facility to another, _____ of care ensures that no lapses in treatment occur and that transitions are smooth.

ANS:
continuity
Continuity of care is designed to ensure that patients suffer no lapse of medical care between providers.

REF: p. 17 | CAAHEP: X.C.4 | ABHES: 8.a
OBJ: 19. Discuss patient education, as well as legal and ethical issues, related to the health record.

4. The concise account of the patient's symptoms in his or her own words is the _____.

ANS:
chief complaint
The concise account of the patient's symptoms in his or her own words is the chief complaint.

REF: p. 20 | CAAHEP: I.P.3 | ABHES: 9.b
OBJ: 4. Differentiate between subjective and objective information and create a patient's health record.

5. _____ of an entry in a medical record is never acceptable.

ANS:
Obliteration
Obliteration is the marking out of an entry and is never acceptable in the medical record.

REF: p. 33 | CAAHEP: X.A.2 | ABHES: 7.c
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

6. To be granted or endowed with a particular authority or right is to be _____.

ANS:
vested
To be granted or endowed with a particular authority or right is to be vested.

REF: p. 16 | CAAHEP: X.C.4 | ABHES: 7.c
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

7. _____ information is observed by the physician.

ANS:
Objective
Objective information is observed by the physician.

REF: p. 17 | CAAHEP: V.C.16 | ABHES: 9.b
OBJ: 4. Differentiate between subjective and objective information and create a patient's health record.

8. Deciding where to file a particular chart based on the patient's name is called _____.

ANS:
indexing

Indexing is the process of deciding where a particular medical record or chart is filed based on the patient's name.

REF: p. 37 | CAAHEP: VI.C.7 | ABHES: 8.a
OBJ: 16. Describe indexing rules, as well as create and organize a patient's health record.

9. A(n) _____ file is a follow-up system used to help the medical assistant remember when a certain task needs to be done.

ANS:
tickler
Tickler files are a type of follow-up system.

REF: p. 41 | CAAHEP: VI.P.5 | ABHES: 8.a
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

10. A filing system that uses a combination of letters and numbers is said to be _____.

ANS:
alphanumeric
An alphanumeric filing system uses both letters and numbers.

REF: p. 40 | CAAHEP: VI.P.5 | ABHES: 8.a
OBJ: 17. Discuss the pros and cons of various filing methods, as well as file patient health records.

11. The _____ diagnosis is temporary and is made before test results have been received.

ANS:
provisional
The provisional diagnosis is made before test results have been received.

REF: p. 21 | CAAHEP: VI.C.4 | ABHES: 2.c
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

12. A(n) _____ is made of heavy paper stock and is used to replace an entire folder that has been temporarily removed from its proper place.

ANS:
Outguide
An Outguide is made of heavy paper and is used to replace a folder that has been temporarily removed from the filing space.

REF: p. 36 | CAAHEP: VI.P.5 | ABHES: 8.a
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

13. Information picked up bit by bit is said to be _____.

ANS:
gleaned
Gleaned information is picked up bit by bit or picked over in search of relevant material.

REF: p. 16 | CAAHEP: V.C.1 | ABHES: 8.f

OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

14. A filing system in which an intermediary source of reference, such as a card file, must be consulted to locate specific files, is called a(n) _____ system.

ANS:
indirect
When a card file or other such item is needed to access files, the system is said to be indirect.

REF: p. 39 | CAAHEP: VI.C.7 | ABHES: 8.a
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

15. A filing system in which materials can be located without consulting an intermediary source of reference is said to be a(n) _____ system.

ANS:
direct
Direct filing systems allow direct access to information, without the need to go through an intermediary source of reference.

REF: p. 39 | CAAHEP: VI.C.7 | ABHES: 8.a
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

16. A(n) _____ schedule is a plan for keeping and purging medical records.

ANS:
retention
A retention schedule is a method or plan for retaining or keeping medical records and their movement from active to inactive to closed filing.

REF: p. 29 | CAAHEP: VI.P.5 | ABHES: 8.a
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

17. Entities considered essential or necessary are called _____.

ANS:
requisites
Requisites are necessary or essential entities, which often are required before a process can move to the next step or level.

REF: p. 16 | CAAHEP: V.C.7 | ABHES: 8.a
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

18. The type of record created by an entity that is a single organization involved in the patient's care is an electronic _____ record.

ANS:
medical
Electronic medical records (EMRs) are created by a licensed clinician and staff from a single organization involved in the patient's care.

REF: p. 22 | CAAHEP: VI.C.8 | ABHES: 7.b

OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary. 6. Distinguish between an electronic health record (EHR) and an electronic medical record (EMR).

19. The type of record that is created from more than one healthcare organization and can be managed and consulted by licensed clinicians and staff from those organizations who are involved in the patient's care is an electronic _____ record.

ANS:
health
The electronic health record (EHR) contains health-related information on a patient that is created and gathered cumulatively across more than one healthcare organization.

REF: p. 22 | CAAHEP: VI.C.8 | ABHES: 7.b
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary. 6. Distinguish between an electronic health record (EHR) and an electronic medical record (EMR).

20. Any of a set of physical properties, the value of which determines characteristics or behavior, is called a(n) _____.

ANS:
parameter
A parameter is any of a set of physical properties, the values of which determine characteristics or behavior.

REF: p. 16 | CAAHEP: V.C.7 | ABHES: 8.e
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

21. The business care and prudence expected from a person seeking to satisfy a legal requirement under similar circumstances is called _____.

ANS:
reasonable diligence
Reasonable diligence is the business care and prudence expected from a person seeking to satisfy a legal requirement under similar circumstances.

REF: p. 23 | CAAHEP: VI.P.6 | ABHES: 7.c
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

22. Most experts agree that the EHR system will help reduce medical _____.

ANS:
errors
Most experts agree that the EMR can reduce medical errors by keeping prescriptions, allergies, and other information organized, and that it will reduce costs by preventing duplicate tests.

REF: p. 23 | CAAHEP: VI.P.6 | ABHES: 7.b
OBJ: 8. Explore the advantages, disadvantages, and capabilities of an electronic health record system, as well as organize a patient's health record.

23. Perhaps the most difficult obstacle to overcome is the _____ of employees in physicians' offices who dislike change.

ANS:
reluctance
Many employees may be reluctant to learn a new electronic medical record system and must be encouraged that the system eventually will prove efficient and time-saving.

REF: p. 24 | CAAHEP: VI.P.6 | ABHES: 7.b
OBJ: 8. Explore the advantages, disadvantages, and capabilities of an electronic health record system, as well as organize a patient's health record.

24. Additional training on the EHR system is needed to run it at full _____.

ANS:
capacity
The initial training covers basic use of the system. More extensive training is needed to use the system at full capacity.

REF: p. 24 | CAAHEP: VI.P.6 | ABHES: 7.b
OBJ: 8. Explore the advantages, disadvantages, and capabilities of an electronic health record system, as well as organize a patient's health record.

25. A process of electronic data entry of medical practitioner or provider instructions for the treatment of patients is called _____.

ANS:
computerized physician/provider order entry (CPOE)
Computerized physician/provider order entry is the process of electronic data entry of medical practitioner or provider instructions for the treatment of patients.

REF: p. 23 | CAAHEP: V.C.8 | ABHES: 7.b
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

26. The EHR system's _____ component allows the physician's staff to communicate with and send claims electronically to insurance companies.

ANS:
medical billing
The EHR billing systems can manage all practice billing and accounting systems.

REF: p. 26 | CAAHEP: V.C.8 | ABHES: 7.b | ABHES: 8.c
OBJ: 8. Explore the advantages, disadvantages, and capabilities of an electronic health record system, as well as organize a patient's health record.

27. The EHR billing system can perform online insurance _____ and can capture demographic data.

ANS:
eligibility verification
Online functions that verify insurance benefits will be invaluable to the physician.

REF: p. 26 | CAAHEP: V.C.8 | ABHES: 7.b | ABHES: 8.c
OBJ: 8. Explore the advantages, disadvantages, and capabilities of an electronic health record system, as well as organize a patient's health record.

28. The medical assistant must always listen to the patient's _____ about the EHR system.

ANS:
concerns
Patients have legitimate concerns about their healthcare and the information put in the EHR system. Medical assistants must listen to them and put them at ease.

REF: p. 41 | CAAHEP: V.A.1 | ABHES: 8.f
OBJ: 19. Discuss patient education, as well as legal and ethical issues, related to the health record.

29. The medical assistant should expect _____ from some patients, who may worry that their information is being put "out on the Internet."

ANS:
concerns
The medical assistant may have to explain how the system works and show patients the log-on process so that they are more relaxed about using the EHR system.

REF: p. 41 | CAAHEP: V.A.1 | ABHES: 8.f
OBJ: 19. Discuss patient education, as well as legal and ethical issues, related to the health record.

30. A storage method that connects to the back of the main computer and can be unplugged and taken out of the facility is an external _____.

ANS:
hard drive
The external hard drive can hold an astonishing amount of information and is a good backup method.

REF: p. 28 | CAAHEP: VI.C.11 | ABHES: 8.e
OBJ: 10. Discuss backup systems for the EHR, as well as the transfer, destruction, and retention of health records as related to the EHR.

31. A computer that functions as a(n) _____ at the medical facility is another form of EHR system backup.

ANS:
server
A dedicated server may be used to back up the electronic health record system and is usually kept at the medical facility.

REF: p. 28 | CAAHEP: VI.C.11 | ABHES: 8.e
OBJ: 10. Discuss backup systems for the EHR, as well as the transfer, destruction, and retention of health records as related to the EHR.

32. The EHR system should be backed up _____.

ANS:

daily
For best recall, the system should be backed up daily.

REF: p. 28 | CAAHEP: VI.C.11 | ABHES: 8.e
OBJ: 10. Discuss backup systems for the EHR, as well as the transfer, destruction, and retention of health records as related to the EHR.

33. Remember that all backup systems need _____ to run.

ANS:
power
Larger medical clinics often have an alternative power source so that they can run machines in an emergency.

REF: p. 28 | CAAHEP: VI.C.11 | ABHES: 8.e
OBJ: 10. Discuss backup systems for the EHR, as well as the transfer, destruction, and retention of health records as related to the EHR.

34. Meriting condemnation, responsibility, or blame especially as wrong or harmful is called _____.

ANS:
culpability
The term *culpability* means meriting condemnation, responsibility, or blame especially as wrong or harmful.

REF: p. 16 | CAAHEP: X.C.6 | ABHES: 7.c
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

35. EHR systems must protect the patient's right to _____.

ANS:
confidentiality
Any record system must be dedicated to keeping patient confidentiality.

REF: p. 42 | CAAHEP: X.C.3 | ABHES: 7.c
OBJ: 19. Discuss patient education, as well as legal and ethical issues, related to the health record.

36. The healthcare industry is one of constant _____, and the medical assistant is expected to stay abreast of current trends, laws, and requirements.

ANS:
growth/change
All medical assistants should expect a degree of growth or change in their careers.

REF: p. 41 | CAAHEP: XI.A.1 | ABHES: 11.b
OBJ: 19. Discuss patient education, as well as legal and ethical issues, related to the health record.

TRUE/FALSE

1. The patient owns the medical record.

ANS: F
The maker of the medical record is its owner; in the physician's office, the physician is the maker/owner of patient medical records.

REF: p. 41 | CAAHEP: X.A.1 | CAAHEP: X.A.2 | ABHES: 7.c
OBJ: 5. Explain who owns the health record.

2. An aggregate of activities designed to ensure adequate quality is called *quality control*.

ANS: T
Quality control is a group of activities designed to ensure adequate quality.

REF: p. 16 | CAAHEP: I.C.12 | ABHES: 10.a
OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

3. Subjective information is that which the physician observes during the physical examination of the patient.

ANS: F
Objective information is observed during the physical examination.

REF: pp. 17-18 | CAAHEP: V.C.16 | ABHES: 9.b
OBJ: 4. Differentiate between subjective and objective information and create a patient's health record.

4. A standard, nationwide rule must be followed in establishing a records retention schedule.

ANS: F
No standard has been established nationally for the retention of medical records.

REF: p. 29 | CAAHEP: VI.P.5 | ABHES: 7.c
OBJ: 10. Discuss backup systems for the EHR, as well as the transfer, destruction, and retention of health records as related to the EHR. 14. Discuss dictation and transcription, and discuss transfer, destruction, and retention of medical records as related to paper records.

5. The three basic filing methods are alphabetic, numeric, and alphanumeric.

ANS: T
The three basic filing methods are alphabetic, numeric, and alphanumeric.

REF: p. 39 | CAAHEP: VI.P.5 | ABHES: 8.a
OBJ: 17. Discuss the pros and cons of various filing methods, as well as file patient health records.

6. Reverse chronologic order is where the most recent item is on the top and older items are filed farther back.

ANS: T
Reverse chronologic order is where the most recent item is on the top and older items are filed farther back.

REF: p. 31 | CAAHEP: VI.P.5 | ABHES: 8.a

OBJ: 17. Discuss the pros and cons of various filing methods, as well as file patient health records.

7. A provisional diagnosis is not a final diagnosis and usually is made before test results are received.

   ANS: T
   Provisional diagnoses usually are made before the final diagnosis and before all test results have been obtained.

   REF: p. 21 | CAAHEP: V.P.3 | ABHES: 3.a
   OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

8. When documents are added to a patient's chart, the most recent information should be placed on top.

   ANS: T
   The most recent information should be on top in patients' medical records.

   REF: p. 31 | CAAHEP: VI.P.5 | ABHES: 8.a
   OBJ: 17. Discuss the pros and cons of various filing methods, as well as file patient health records.

9. Medical records offer protection to the physician during legal proceedings if they are accurate and complete.

   ANS: T
   If medical records are accurate and complete, they will protect the actions of the physician during medical professional liability proceedings.

   REF: p. 17 | CAAHEP: X.A.2 | ABHES: 7.c
   OBJ: 19. Discuss patient education, as well as legal and ethical issues, related to the health record.

10. By legal definition, if it isn't charted, then it didn't happen.

    ANS: T
    If an action is not charted in the medical record, then it is considered not to have happened.

    REF: p. 17 | CAAHEP: X.P.3 | ABHES: 7.c
    OBJ: 19. Discuss patient education, as well as legal and ethical issues, related to the health record.

11. Outguides are heavy guides used to replace a folder that has been removed temporarily.

    ANS: T
    Outguides are heavy guides used to replace a folder that has been removed temporarily.

    REF: p. 36 | CAAHEP: VI.P.5 | ABHES: 8.a
    OBJ: 1. Define, spell, and pronounce the terms listed in the vocabulary.

12. Numeric filing provides extra confidentiality to medical records.

    ANS: T
    Numeric medical records are considered the most confidential.

REF: p. 39 | CAAHEP: VI.P.5 | ABHES: 8.a
OBJ: 17. Discuss the pros and cons of various filing methods, as well as file patient health records.

13. Color coding is used only for patients' records and not for business records.

ANS: F
Color coding can be used for both medical records and business records.

REF: p. 40 | CAAHEP: VI.P.5 | ABHES: 8.a
OBJ: 17. Discuss the pros and cons of various filing methods, as well as file patient health records.

14. The computer-based record has no disadvantages, whereas the paper-based record has numerous disadvantages.

ANS: F
Both computer-based and paper-based records have advantages and disadvantages.

REF: p. 24 | CAAHEP: X.P.3 | ABHES: 8.a
OBJ: 2. Name and discuss the two types of patient records.

15. The patient's medical record should never leave the office.

ANS: T
Patients' medical records should never leave the medical office.

REF: p. 22 | CAAHEP: X.A.1 | CAAHEP: X.A.2 | ABHES: 7.c
OBJ: 19. Discuss patient education, as well as legal and ethical issues, related to the health record.

16. HITECH Act stands for Health Information Technology for Economic and Clinical Health Act.

ANS: T
HITECH Act stands for Health Information Technology for Economic and Clinical Health Act.

REF: p. 23 | CAAHEP: X.C.10.a | ABHES: 7.c
OBJ: 7. Do the following related to healthcare legislation and electronic health records: Explain how the American Recovery and Reinvestment Act applies to the healthcare industry. Define meaningful use and relate it to the healthcare industry. List the three main components of meaningful use legislation.

17. The EMR relates to more than one healthcare organization.

ANS: F
The EMR is an electronic record of health-related information about an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff *within a single healthcare organization*.

REF: p. 22| CAAHEP: VI.P.6 | ABHES: 7.b
OBJ: 6. Distinguish between an electronic health record (EHR) and an electronic medical record (EMR).

18. PHI stands for “private health information.”

ANS: F
PHI stands for “protected health information.”

REF: p. 23 | CAAHEP: VI.C.4 | ABHES: 7.c
OBJ: 19. Discuss patient education, as well as legal and ethical issues, related to the health record.

19. The American Recovery and Reinvestment Act of 2009 is commonly known as the Economic Stimulus Package and was meant to promote economic recovery.

ANS: T
The American Recovery and Reinvestment Act of 2009 is commonly known as the Economic Stimulus Package and was meant to promote economic recovery.

REF: p. 23 | CAAHEP: X.C.10.a | ABHES: 7.c
OBJ: 7. Do the following related to healthcare legislation and electronic health records: Explain how the American Recovery and Reinvestment Act applies to the healthcare industry. Define meaningful use and relate it to the healthcare industry. List the three main components of meaningful use legislation.

20. Usually, more staff members are needed when an office uses an EHR system.

ANS: F
EHR systems usually mean that an office can function with fewer staff members.

REF: p. 23 | CAAHEP: VI.P.6 | ABHES: 8.a
OBJ: 8. Explore the advantages, disadvantages, and capabilities of an electronic health record system, as well as organize a patient’s health record.

21. Less storage space is needed for EHR systems.

ANS: T
In general, EHR systems use much less storage space than paper medical record systems.

REF: p. 24 | CAAHEP: VI.P.5 | ABHES: 8.a
OBJ: 2. Name and discuss the two types of patient records.

22. Because some physicians’ handwriting is illegible, the electronic health record helps guarantee that the documents will be readable even several years after their creation.

ANS: T
Because data are typed into the EHR, the record is more easily read than a physician’s handwriting in a paper medical record.

REF: p. 24 | CAAHEP: VI.P.6 | ABHES: 8.a
OBJ: 2. Name and discuss the two types of patient records.

23. Files still must be purged annually when an EHR system is used.

ANS: F
Records can be kept indefinitely when an EHR system is used.

REF: p. 24 | CAAHEP: VI.P.5 | ABHES: 8.a
OBJ: 10. Discuss backup systems for the EHR, as well as the transfer, destruction, and retention of health records as related to the EHR.

24. Information contained in an electronic health record usually can be accessed from several different physical places.

ANS: T
One of the greatest advantages of an EHR system is its flexibility, because records can be accessed from virtually anywhere.

REF: p. 24 | CAAHEP: VI.P.6 | ABHES: 8.a
OBJ: 2. Name and discuss the two types of patient records.

25. The EHR allows access to patient information in an emergency.

ANS: T
Because patients' records are critical in emergencies, the electronic health record proves itself valuable in such situations.

REF: p. 24 | CAAHEP: VI.P.6 | ABHES: 8.a
OBJ: 2. Name and discuss the two types of patient records.

26. Very little statistical information can be gleaned from an EHR system.

ANS: F
An incredible amount and variety of statistics can be calculated from an EHR system.

REF: p. 24 | CAAHEP: VI.P.6 | ABHES: 8.a
OBJ: 2. Name and discuss the two types of patient records.

27. An electronic health record system conceivably could hold all the patients seen over the life of a physician's practice.

ANS: T
With external hard disk backup, a physician could store the records of all patients in the history of the practice.

REF: p. 24 | CAAHEP: VI.P.6 | ABHES: 8.a
OBJ: 2. Name and discuss the two types of patient records.

28. Physicians can expect reductions in the amounts that they are paid from Medicare and Medicaid if they are not in compliance by 2015.

ANS: T
Physicians can expect reductions in the amounts that they are paid from Medicare and Medicaid if they are not in compliance by 2015.

REF: p. 23 | CAAHEP: X.C.10.a | ABHES: 7.c
OBJ: 7. Do the following related to healthcare legislation and electronic health records: Explain how the American Recovery and Reinvestment Act applies to the healthcare industry. Define meaningful

use and relate it to the healthcare industry. List the three main components of meaningful use legislation.

29. In Subtitle D of the HITECH Act, the privacy and security concerns related to the electronic submission of health information are addressed.

    ANS: T
    In Subtitle D of the HITECH Act, the privacy and security concerns related to the electronic submission of health information are addressed.

    REF: p. 23 | CAAHEP: X.C.10.a | ABHES: 7.c
    OBJ: 7. Do the following related to healthcare legislation and electronic health records: Explain how the American Recovery and Reinvestment Act applies to the healthcare industry. Define meaningful use and relate it to the healthcare industry. List the three main components of meaningful use legislation.

30. Both the physician and staff members must receive training in the use of the EHR system.

    ANS: T
    Ongoing training in the system is needed, both for the physician and the office staff.

    REF: p. 24 | CAAHEP: VI.P.6 | ABHES: 1.b
    OBJ: 2. Name and discuss the two types of patient records.

31. The software of an EHR system can be designed to be compatible with a medical specialty office, such as pediatrics or oncology.

    ANS: T
    Patient data are captured and processed into the system, which is specialty specific, so that the terminology and patient care treatments are compatible with the physician's medical specialty.

    REF: p. 25 | CAAHEP: VI.P.6 | ABHES: 7.b
    OBJ: 8. Explore the advantages, disadvantages, and capabilities of an electronic health record system, as well as organize a patient's health record.

32. The EHR system can allow patients to set their own appointments using the Internet.

    ANS: T
    Patient portals allow many self-serve functions, including appointment setting.

    REF: p. 22 | CAAHEP: VI.C.8 | ABHES: 7.b
    OBJ: 6. Distinguish between an electronic health record (EHR) and an electronic medical record (EMR).

33. *Charge capture* relates to charges for missed appointments.

    ANS: F
    The charge capture functions can store lists of ICD and CPT codes, as well as the charges associated with procedures and supplies.

    REF: p. 26 | CAAHEP: VI.P.6 | ABHES: 7.b
    OBJ: 8. Explore the advantages, disadvantages, and capabilities of an electronic health record system,

as well as organize a patient's health record.

34. The system is not capable of telling whether a certain procedure matches a specific diagnosis code.

    ANS: F
    The EHR system is able to distinguish matching diagnosis and procedure codes.

    REF: p. 26 | CAAHEP: VI.P.6 | ABHES: 7.b
    OBJ: 8. Explore the advantages, disadvantages, and capabilities of an electronic health record system, as well as organize a patient's health record.

35. Physicians performing consultations still must request paper records on a patient, even if both the referring physician and the consulting physician are using an EHR system.

    ANS: F
    Records can be transferred back and forth between referring and consulting physicians through the EMR system.

    REF: p. 27 | CAAHEP: VI.P.6 | ABHES: 7.b
    OBJ: 2. Name and discuss the two types of patient records.

36. Brochures are helpful for explaining a new EHR system to patients.

    ANS: T
    A brochure describing the functions and advantages of the EHR system can be a very positive introduction for the patient.

    REF: p. 31 | CAAHEP: VI.P.6 | ABHES: 7.b
    OBJ: 2. Name and discuss the two types of patient records.