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Chapter 02: Health Records
Niedzwiecki: Kinn's The Clinical Medical Assistant, 15th Edition

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: pp. 39-40 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
   MSC: CAAHEP: N/A | ABHES: 7.b.

2. 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. 37 OBJ: 2 TOP: Patient Care: Conduct History and Chief Complaint
   MSC: CAAHEP: VI.C.6 | ABHES: 8.b.

3. A filing system in which an alphabetic cross-reference 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 alphabetic cross-reference to locate specific files.

   REF: p. 50 OBJ: 5 TOP: Clerical Procedures: Medical Records/EMR
   MSC: CAAHEP: N/A | ABHES: 7.b.

4. 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

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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: pp. 49-50 OBJ: 4 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: N/A | ABHES: 7.b.

5. *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. 34 OBJ: 2 TOP: Clerical Procedures: Medical Records/EMR
   MSC: CAAHEP: X.C.4 | ABHES: 1.d.

6. 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. 34 OBJ: 2 TOP: Clerical Procedures: Medical Records/EMR
   MSC: CAAHEP: X.P.3 | ABHES: 4.a.

7. What is the most important reason for telling the provider when a documentation 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. 40 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
   MSC: CAAHEP: XI.C.4 | ABHES: 7.b.

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8. Which statement is *not* accurate about correcting documentation 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: pp. 40-42 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
   MSC: CAAHEP: XI.C.4 | ABHES: 7.b.

9. 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. 44 OBJ: 3
   TOP: Law and Ethics: HIPAA Regulations/Confidentiality/Pt. Bill of Rights
   MSC: CAAHEP: X.C.3 | ABHES: 4.b.

10. 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 the statute of limitations

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

    REF: p. 44 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
    MSC: CAAHEP: N/A | ABHES: 4.b.

11. Files for patients who have died, moved away, or otherwise terminated their relationship with the provider 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 provider, are called *closed files.*

    REF: p. 44 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
    MSC: CAAHEP: N/A | ABHES: 8.a.

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12. 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. 44 OBJ: 3
    TOP: Law and Ethics: HIPAA Regulations/Confidentiality/Pt. Bill of Rights
    MSC: CAAHEP: X.C.3 | ABHES: 4.h.

13. 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. 44 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
    MSC: CAAHEP: 5 | ABHES: 4.a.

14. The actual health record belongs to the:
    a. patient.
    b. physician or provider.
    c. insurance company.
    d. All are correct

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

    REF: p. 39 OBJ: 2 TOP: Clerical Procedures: Medical Records/EMR
    MSC: CAAHEP: N/A | CAAHEP: N/A | ABHES: 4.c.

15. 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 are correct

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

    REF: pp. 40-42 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
    MSC: CAAHEP: XI.C.4 | ABHES: 7.b.

16. The "E" entry in the SOAPIER charting method means:

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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. 40 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: N/A | ABHES: 7.b.

17. The "R" entry in the SOAPIER 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. 40 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: N/A | ABHES: 7.b.

18. _____ software can be used for transcription and authentication.
a. voice-activated
b. voice recognition
c. voice registry
d. voice-controlled

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

REF: p. 42 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: N/A | ABHES: 7.b.

19. 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. 44 OBJ: 3
TOP: Law and Ethics: HIPAA Regulations/Confidentiality/Pt. Bill of Rights
MSC: CAAHEP: X.C.3 | ABHES: 4.b.

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20. 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: pp. 29-31 OBJ: 1 TOP: Clerical Procedures: Medical Records/EMR
    MSC: CAAHEP: VI.C.6 | ABHES: 7.b.

21. 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: pp. 29-31 OBJ: 1 TOP: Clerical Procedures: Medical Records/EMR
    MSC: CAAHEP: VI.C.6 | ABHES: 7.b.

22. 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. 42 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
    MSC: CAAHEP: VI.C.6 | ABHES: 7.b.

23. 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.

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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. 38 OBJ: 2 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: X.C.6 | ABHES: 7.b.

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

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. 33 OBJ: 1 TOP: Law and Ethics: Acts and Legislation
MSC: CAAHEP: X.C.10.a | ABHES: 4.h.

25. 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: pp. 31-32 OBJ: 1 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: VI.P.3.b | ABHES: 7.b.

26. 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.

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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. 44 OBJ: 3
TOP: Law and Ethics: HIPAA Regulations/Confidentiality/Pt. Bill of Rights
MSC: CAAHEP: X.C.3 | ABHES: 4.h.

27. 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 are correct

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. 46 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: XI.C.4 | ABHES: 7.b.

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28. HIPAA requirements include which of the following?
a. Hourly external hard drive backup
b. Daily offsite software backup
c. Yearly full server backup
d. All choices

ANS: B
HIPAA requires that the facility adopt a backup and recovery plan that includes daily offsite software backup for the EHR system.

REF: pp. 43-44 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: VI.C.5 | ABHES: 7.b.

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. 39 OBJ: 2 TOP: Clerical Procedures: Medical Records/EMR

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MSC: CAAHEP: N/A| CAAHEP: N/A | ABHES: 7.c.

2. Subjective information is that which the provider observes during the physical examination of the patient.

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

   REF: p. 37 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
   MSC: CAAHEP: V.C.12 | ABHES: 7.b.

3. 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. 44 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
   MSC: CAAHEP: X.C.3 | ABHES: 4.h.

4. 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. 37 OBJ: 2 TOP: Clerical Procedures: Medical Records/EMR
   MSC: CAAHEP: V.P.2 | ABHES: 3.a.

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5. Health records offer protection to the provider during legal proceedings if they are accurate and complete.

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

   REF: p. 34 OBJ: 2 TOP: Clerical Procedures: Medical Records/EMR
   MSC: CAAHEP: X.C.7.b | ABHES: 1.d.

6. By legal definition, if it is not documented, then it did not happen.

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

   REF: p. 34 OBJ: 2 TOP: Clerical Procedures: Medical Records/EMR
   MSC: CAAHEP: X.P.3 | ABHES: 4.a.

7. Numeric filing provides extra confidentiality to medical records.

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

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REF: p. 50 OBJ: 5 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: X.C.3 | ABHES: 4.h.

8. 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: pp. 50-51 OBJ: 5 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: VI.P.5 | ABHES: 7.b.

9. 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. 30 OBJ: 1 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: X.P.3 | ABHES: 7.b.

10. The patient's health record should never leave the office.

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

REF: p. 39 OBJ: 2 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: XI.C.4 | ABHES: 4.b.

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11. 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. 33 OBJ: 1 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: X.C.10.a | ABHES: 4.h.

12. 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: pp. 30-31 OBJ: 1 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: N/A | ABHES: 7.b.

13. PHI stands for "private health information."

ANS: F

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PHI stands for "protected health information."

REF: p. 31 OBJ: 1 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: X.C.3 | ABHES: 4.h.

14. 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. 31 OBJ: 1 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: VI.P.3 | ABHES: 7.b.

15. 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. 34 OBJ: 1 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: VI.P.3 | ABHES: 7.b.

16. 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. 31 OBJ: 1 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: VI.P.3 | ABHES: 7.b.

17. 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. 31 OBJ: 1 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: VI.C.1 | ABHES: 7.e.

18. *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: pp. 31-32 OBJ: 1 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: VI.P.3 | ABHES: 7.b.

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

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

REF: pp. 31-32 OBJ: 1 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: VI.P.3 | ABHES: 7.b.

20. Providers 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 EHR system.

REF: p. 32 OBJ: 1 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: X.C.3 | ABHES: 4.b.

21. Full server backup should be done quarterly.

ANS: F
It is recommended that full server backup be done monthly

REF: p. 44 OBJ: 3 TOP: Clerical Procedures: Medical Records/EMR
MSC: CAAHEP: VI.C.5 | ABHES: 4.b.

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