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MCO 110

CH.4 Homework

[Chapter 4 Health Record Content and Documentation - KEY TERMS; Questions](https://cmconnect.cmcc.edu/ICS/Academics/MCO/MCO__110/1718_FA-MCO__110-51___N/Coursework.jnz?portlet=Coursework&screen=StudentAssignmentDetailView&screenType=change&id=31ed7c9b-8960-46c9-9fa3-338aee87ad0d)

1. Define the following KEY TERMS:

**Accreditation-** A determination by an accrediting body that an eligible organization, network, program, group, or individual complies with applicable standards.

**Acknowledgements-**a form that provides a mechanism for the resident to recognize receipt of important information.

**Ambulatory-** treatment provided on an outpatient basis.

Ambulatory surgery center (ASC)-under medicare, an outpatient surgical facility that has its own national identifier; is a separate entity with respect to its licensure, accreditation, governance, professional supervision, administrative functions, clinical services, record keeping, and financial and accounting systems; has its sole purpose the provision of services in connection with surgical procedures that do not require inpatient hospitalization; and meets the conditions and requirements set forth in the Medicare Conditions of Participation.

**AAAASF-** (American association for accreditation of ambulatory surgery facilities) an organization that provides an accreditation program to ensure the quality and safety of medical and surgical care provided in ambulatory surgery facilities.

**Ancillary services-** tests and procedures ordered by a physician to provide information for use in patient diagnosis or treatment.

**Authentication-** the process of identifying the source of health record entries by attaching a handwritten signature, the author’s initials, or an electronic signature.

**Authorization-** when a covered entity obtains or receives a valid authorization for its use or disclosure of protected health information, such use or disclosure must be consistent with the authorization.

**Autopsy report-** written documentation of the findings from a postmortem pathological examination.

**CAAs-(**care area assessments) the patient is assessed and reassessed at defined intervals as well as whenever there is significant change in his or her condition.

**Care plan-** the specific goals in the treatment of an individual patient, amended as the patients condition requires and the assessment of the outcomes of care; serves as the primary source for ongoing documentation of the resident’s care, condition, and needs.

**CMS-**(centers for medicare and medicaid services)CMS is responsible for the oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

**CARF-** (commission on accreditation of birth centers) a group that surveys and accredits birth centers in the united states.

**Conditions for Coverage-** standards applied to facilities that choose to participate in federal government reimbursement programs such as Medicare and Medicaid.

**Consent to treatment-** legal permission given by a patient or a patients legal representative to a healthcare provider allows the provider to administer care and treatment or to perform surgery or other medical procedures.

**Consultation report-** documentation of the clinical opinion of a physician other than the primary or attending physician.

**Documentation standards-** within the context of healthcare, describe those principles, codes, beliefs, guidelines, and regulations that guide health record documentation.

**Documents imaging-** the practice of electronically scanning written or printed paper documents into an optical or electronic system for later retrieval of the document or parts of the document if parts have been indexed.

**Expressed consent-** the spoken or written permission granted by a patient to a healthcare provider that allows the provider to perform medical or surgical services.

**EMTALA-** (emergency medical treatment and active labor act) a 1986 law enacted as part of the consolidated omnibus reconciliation act largely to combat “patient dumping” the transferring, discharging, or refusal to treat indigent emergency department patients because of their inability to pay.

**Hybrid record-**a combination of paper and electronic records; a health record that includes both paper and electronic elements.

**Joint Commission-** an independent, not for profit organization, the joint commission accredits and certifies more than 20,000 healthcare organizations and programs in the United States. Joint commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organizations commitment to meeting certain performance standards.

**Legal health record**- documents and data elements that a healthcare provider may include in response to legally permissible requests for patient information.

**MDS-** (minimum data set for long term care)- a federally mandated standard assessment form that medicare and medicaid-certified nursing facilities must use to collect demographic and clinical data on nursing home residents; includes screening, clinical, and functional status elements.

**PAI-** (patient assessment instrument) a standardized tool used to evaluate the patients condition after admission to, and at discharge from, the healthcare facility.

**RAI-** (resident assessment instrument) in skilled nursing facilities, the care plan is based on a format required by federal regulations

**SOAP-** (subjective, objective, assessment, plan) documentation method that refers to how each progress note contains documentation relative to subjective observations, objective observations, assessments, and plans.

**Standing orders-** orders medical staff or an individual physician has established as routine care for a specific diagnosis or procedure.

**Statute-** a piece of legislation written and approved by a state or federal legislature and then signed into law by the states governor or the president

**Transfer record-** a review of the patients acute stay along with current status, discharge and transfer orders, and any additional instructions that accompanies the patient when he or she is transferred to another facility.

**Universal chart order-** the health record post patient discharge is kept in reverse chronological order.

2. Internet activity: obtain state and federal regulatory documentation mandates as they relate to electronic health records.

Maine

No state law for retention of records for physician offices, only hospital

Records must be kept for everyone who receives hospital care

Records secured so there is no unauthorized access

Records need to be preserved for 7 years, or 6 years if the patient is a minor

Medicare Secondary Payer Questionnaires must be kept for 10 years

Federal

Records secured so there is no unauthorized access (same as above)

Records must be protected to make sure they are accurate and ready for retrieval throughout the records retention period.

Determination that the persons accessing the records have the training, experience, and education to perform their assigned tasks.

 3**. a.** Healthcare organizations must have an EHR system that complies with all the confidentiality, unauthorized access of records, and that the medical records are kept accessible for the appropriate amount of time.

     b. Healthcare providers should put quality control measures in place to make sure that there is no breach in confidentiality in health records. All records that are in the health record need to be accurate and free of errors. The providers should make sure that there are no duplicate patient charts in the health record. All healthcare staff should receive the proper training on HIPAA and the state and federal regulations on the health record to ensure that the documentation that is going in the health record is being done properly.