CHAPTER 3

The Complete Medical Record and Electronic Charting

FIELD RELEVANCY AND BENEFITS

The medical record is the most important record kept in the medical office. Whether you are working in an office that uses paper files or in a paperless office, understanding the components of the medical record and where information is stored in the record is essential. Electronic medical records (EMRs) are booming in today’s health care culture, and having a basic understanding of how to use an EMR system should make you more marketable. Learning information in this chapter is applicable to all types of medical practices.

NOTE SHEET

The Medical Record

Contents of the Medical Record

Medical Record Formats

Creating and Maintaining the Medical Record
**Laws That Affect the Medical Record**

**Ownership, Retention, and Disposal of Medical Records**

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### VOCABULARY REVIEW

**Assignment 3-1: Matching**

Match the term with its definition and place the corresponding letter in the blank.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>1. Shingling</td>
<td>A patient's medical record in digital format</td>
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<tr>
<td>2. Assessment</td>
<td>B. Describes exactly how protected information is to be handled between business partners.</td>
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<td>3. Electronic health record</td>
<td>C. Provider's plans to perform diagnostic and lab testing to assist in confirming a diagnosis and plans for treating the patient</td>
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<td>4. Business associate agreement</td>
<td>D. The heart of the patient record; a chronological listing of the patient's overall health status</td>
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<td>5. Notice of privacy practices</td>
<td>E. The way information is stored within the patient's chart; the most recent notes, reports, and forms are always on top</td>
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<td>6. Subjective impressions</td>
<td>F. The method for filing lab reports when reports are not the size of a standard piece of paper</td>
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<td>7. Problem list</td>
<td>G. An interpretation of the subjective and objective findings</td>
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<td>8. Reverse chronological order</td>
<td>H. Logs found in the patient’s chart that assist the provider in monitoring specific repetitive information, at one glance</td>
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<tr>
<td>9. Progress note</td>
<td>I. A record of specific problems that are identified from the patient history form; it should list new problems as they arise; each problem is numbered and should include the name of the problem or diagnosis</td>
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<td>10. Objective impressions</td>
<td>J. Patients should receive a notice for how their personal medical information may be used</td>
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<tr>
<td>11. Flow sheets</td>
<td>K. “A generic term for all electronic patient care systems”</td>
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<td>12. Plans</td>
<td>L. A type of medicine in which the patient pays an annual fee for special services</td>
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<tr>
<td>13. Electronic medical record</td>
<td>M. Patient’s vital signs, height and weight, laboratory results, or other diagnostic data</td>
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<tr>
<td>14. Personal health record</td>
<td>N. A copy of the patient’s own personal health information that can be shared with all providers</td>
</tr>
<tr>
<td>15. Concierge medicine</td>
<td>O. The patient’s chief complaint or an explanation of why the patient is here</td>
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</table>
CHAPTER REVIEW

Assignment 3-2: Acronym Review
Write what each of the following acronyms stands for.

1. CCHIT:

2. HIT:

3. HIPAA:

4. IIPI:

5. PHI:

6. POMR:

7. SOAP:

8. SOMR:

Assignment 3-3: Short Answer

1. List the commission responsible for certifying electronic medical records.

2. Why are flow sheets used in the medical record?

3. List the two major types of formats which are used for documenting in the patient's record.
   A. ____________________________
   B. ____________________________

4. List what each of the letters stand for in the SOAP acronym and describe information that would be included in each section.

5. List four advantages of the POMR.
   A. ____________________________
   B. ____________________________
   C. ____________________________
   D. ____________________________

6. Describe how long medical records need to be retained and how to properly dispose of medical records.
7. EMR has many positives, but what may be some “pitfalls” associated with EMR?

8. Provide at least three examples of phone reports that may need to be documented either on a progress note or onto a special phone form.

9. List six functions of EMR.

10. Explain the shingling method for filing and list examples of some reports that may be shingled.

11. Why would an office manager conduct a comprehensive audit trail?
Assignment 3-4: Matching I

Information found in a SOAP note is listed below. Identify the part of the note in which the information would be found. Match the information with the answers listed. Record the answer in the blank provided. Each answer may be used more than once.

S—Subjective  A—Assessment

O—Objective  P—Plan

A. Temperature 99.9°F
B. Patient c/o sore throat
C. Lymph nodes enlarged upon palpation
D. Strep throat
E. Abdomen and groin area shows rash
F. Lungs are clear
G. Patient states slight headache above right eye
H. Will perform an EKG and run a metabolic panel
I. Results of rapid strep test

Assignment 3-5: Matching II

Match the section of the chart in which you would find the following information.

Sections of the chart:

A. Demographic information
B. Insurance section
C. Correspondence
D. Diagnostic/x-ray reports
E. Lab reports
F. Medication information
G. Progress note
H. Medical history
I. Consultation report

Assignment 3-6: Certification Practice

Choose the best answer and place the corresponding letter in the blank.

1. This is an analysis of the patient’s health status.
   A. Patient’s record
   B. Medical record
   C. Flow sheets
   D. Objective impressions

2. This is the person who developed the POMR system.
   A. Larry Word
   B. Larry Reed
   C. Lawrence Weed
   D. Robert Weed
3. This is the section of the medical record that contains letters written about the patient from an assessment made by a specialist.
   A. Progress notes
   B. Discharge summary
   C. Correspondence
   D. Consultation reports

4. This is the section of the chart in which you would find a biopsy study.
   A. Laboratory section (pathology report)
   B. Correspondence
   C. Insurance section
   D. Progress notes

5. A Lipid Panel and Chem 21 would be filed in which of the following sections of the chart?
   A. Diagnostic section
   B. Laboratory section
   C. Progress notes
   D. Medication section

6. Which of the following does not belong with the others?
   A. Assessment
   B. Impression
   C. Diagnosis
   D. Examination

7. Which of the following is not a use of the medical record?
   A. Medical research and education
   B. Legal documentation
   C. Tracking patient's progress
   D. To check the patient's financial balance

8. All of the following are found in the administrative section of the record except:
   A. demographics.
   B. patient insurance.
   C. correspondence.
   D. prescription info.

9. The physical outer part of the medical record belongs to the practice; however, information stored within the chart is property of the:
   A. patient.
   B. practice.
   C. both A and B.
   D. none of the above.

10. The information in a POMR includes:
    A. database.
    B. problem list.
    C. plans.
    D. progress notes.
    E. all of the above.

11. When filing in reverse chronologic order, which of the following is the correct sequence?
    A. Radiology report from June 20, 2011, would be in front of a radiology report dated June 30, 2011
    B. A referral letter from June 15, 2011, would be behind a referral letter dated December 15, 2010
    C. Laboratory test result dated May 25, 2011, would be in front of a lab test dated March 23, 2011
12. Which of the following would not be in a flow sheet?
   A. PT/INR results
   B. Drug allergies
   C. Blood pressure screenings
   D. Glucose results

13. In an executive order from President Bush, by what year should the majority of Americans have access to EMR?
   A. 2010
   B. 2012
   C. 2014
   D. 2016

14. An important rule for releasing medical records is:
   A. There is no need to gain written permission to release medical information as long as you have the patient’s verbal consent to release information.
   B. Have the patient sign a release form before giving out any information and send a copy of the medical record, not the original.
   C. Always give the patient the original medical record and keep a copy of the record for the office.
   D. none of the above.

15. Examples of internal security measures that should be implemented to protect the patient’s health information include:
   A. Back up your computer at the end of each day and store the backup in a secure place outside the office, such as a bank deposit box.
   B. Use encrypted passwords.
   C. Create limited accessibility accounts for employees.
   D. Change pass codes on a regular basis.
   E. all of the above.

16. Which of the following would not be an example of following HIPAA guidelines?
   A. Accessing the patient’s chart only when it is absolutely necessary
   B. Leaving computer monitors in plain sight for other patients to see
   C. Using sign-in sheets that require a minimal amount of information
   D. Allowing the patient to review his medical record and make requests for changes

17. In this system, there is no systematic cross-referencing of data from one section to the next.
   A. SOAP
   B. POMR
   C. POR
   D. SOMR

18. A notice of how a patient’s medical information will be used should be given to every patient and a form explaining that the patient received the information should be signed and filed in the chart. What is the name of the notice?
   A. Notice of Privacy Practices
   B. Notice of HIPAA
   C. Notice of Sharing Medical Information Practices
   D. None of the above

19. Which of the following would not be included in the initial database of a POMR record?
   A. Patient profile
   B. Baseline readings for diagnostic and laboratory testing
   C. Treatment plans
   D. None of the above
20. Important uses of the medical record include providing accurate, comprehensive medical information to assist the provider in:
   A. formulating an accurate diagnosis.
   B. planning an appropriate treatment.
   C. tracking the patient’s progress.
   D. formulating disease prevention measures.
   E. all of the above.

21. Penalties for violating HIPAA rules can be as high as:
   A. $50,000 and 1 year in prison.
   B. $100,000 and 5 years in prison.
   C. $250,000 and 10 years in prison.
   D. $500,000 and 20 years in prison.

**SKILL APPLICATION CHALLENGE**

**Assignment 3-7: Documentation Exercise**

From the following dictation put the information into a SOAP note format on the progress note provided on the next page.

“I have pain when I go to the bathroom. I go all the time, especially at night.” + abdominal pain(6), -back pain, + fever (“99.6° to 101°F”), LMP 05-06-2010. OTC; Urostat (no relief). Rx: Accutane. Allergies: Latex and SULFA. Vital Signs: T 99.2°F, BP 110/76, R: 20 P 78. Abdominal tenderness and guarding in the mid hypogastric region of the abdomen. Urinalysis: Urine bright orange due to the urostat: Unable to read urine dipstick. Microscopic examination of urine revealed a large amount of white blood cells and bacteria. Few red blood cells. Diagnosis: Urinary tract infection. Will send urine out for a C & S and start the patient on Bactrim DS, sig 1 tab/day X 7 days. Pt. to return to office in 10 days for a recheck on urine.
FIELD APPLICATION CHALLENGE
Assignment 3-8

Read the following Field Application Challenge and respond to the questions following the scenario.

Mr. Snodgrass calls to request his wife’s lab results. Mrs. Snodgrass is traveling today and will not have access to a phone until after the office is closed. Mr. Snodgrass states that his wife is most anxious about the results and does not want to wait until tomorrow for the results. Mr. Snodgrass is listed on the privacy sheet as being able to accept lab results for the patient. You just placed the chart on the provider’s desk because the results just came back. The results are normal but the provider is out of the office and will not return until the next day. The policy of the office is that no test results are given to a patient until they have been signed off by the provider.

1. What makes it all right for this particular patient’s spouse to receive his wife’s lab results?

2. Would it be okay to share the results with spouse since the results are normal?

3. Are there any other options for giving the spouse the information?

JOURNALING EXERCISE
Assignment 3-9

What content within this chapter was most meaningful to you? Why? List some examples of how you might apply information contained in this chapter, both during your training and after you enter the health care industry.