CHAPTER 2 REVIEW

THE USE OF HEALTH INFORMATION TECHNOLOGY IN PHYSICIAN PRACTICES

USING TERMINOLOGY

1. h
2. k
3. i
4. g
5. d
6. j
7. e
8. l
9. a
10. b
11. c
12. f

CHECK YOUR UNDERSTANDING

1. T
2. T
3. T
4. F
5. T
6. T
7. F
1. a
2. b
3. c
4. a
5. c
6. c

APPLYING YOUR KNOWLEDGE

2.1 Paper medical records could only be viewed by one person at a time; health information networks provide many points of access to patient information. Paper files did not commonly leave a physician office or hospital facility; the increase in the use of portable computing and storage devices means that health information can be moved from place to place with ease. This increases the possibility of data being lost or devices being stolen.

THINKING ABOUT IT

2.1 A medical insurance specialist needs to understand the role of electronic health records in the billing cycle. During or after a patient visit, the patient’s diagnosis and the procedures performed by the physician are recorded in an electronic health record program. This information is transmitted to the practice management program, where it is used to create an insurance claim. The insurance claim is then submitted to the payer for reimbursement. In short, the information needed to bill for services comes from the notes recorded in an electronic health record.

2.2 A medical office that does not follow HIPAA privacy and security guidelines may be subject to monetary fines and lawsuits.