# Medical Filing

Welcome to the KMCB 0110 Medical Filing course. This course allows for self-paced, competency-based, individualized student training. Concepts and rules governing alphabetic, numeric, and color coded filing as well as theory will be covered.

## Competency

Upon completion of this course, you will be able to:

- Demonstrate how to correctly code and file medical records.

Read the Syllabus

Settings

- Preview
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- Alternative formats

To understand the expectations for this course. The instructor will go through the syllabus and review the textbook with you on your first day of class. You will demonstrate your competency through a theory exam and production test.

In the left navigation bar is a Course Tools menu. It provides information about what tools you need for the course and how to navigate in Canvas.

Start the course with **Begin Here** by clicking on the link below. Download the links to the files in the Begin Here folder and save them to your flash drive. Print the Recording Sheet and Student Class Directions. Read the Student Class Directions before you begin the Unit (Chapter) modules. You may print the other documents, if you wish. You can also click on the **Modules** link in the left navigation bar and start there. Remember to complete each chapter in the order below and follow instructions carefully.

Begin Here

Unit 1

Unit 2

Unit 3

Unit 4

Unit 5

Unit 6

Unit 7

Review for Final Test

Final Theory and Production Tests

# KMCB 0110 MEDICAL FILING

## STUDENT CLASS DIRECTIONS

Download all the documents in the "Begin Here" module in Canvas and save them to your flash drive. It might be helpful to create a folder to keep all your Medical Filing documents in. These documents will be helpful as you work through the course. Thoroughly read the syllabus before beginning the Unit modules. If you have any questions, check with your instructor. Next, print a copy of the recording sheet for your own use. You may also want to print these class directions.

Each student should have the *Medical Filing* 2nd edition textbook by Terese Claeys. The book is divided into seven units. You will be using the Alphabetic, Numeric, Color-coding, and Final Project cards located in the back of your textbook to complete the unit exercises and Final Project test. There are also blank cards to use for the Final Project. If you need any extra cards, you can cut them from blank paper. The answer key for the Check Your Understanding exercises is found on page 73. (Check the "Errors in the Medical Filing Book" document.) Download the *Medical Filing Student Answer Key* in Canvas to check your answers for the *Check Your Knowledge* and *Apply Your Knowledge* exercises.

**Unit 1** is an overview of medical filing. Each additional unit covers different aspects of the medical filing process. As you read through each chapter, highlight important information. After you finish reading, complete the Check Your Knowledge assignment on pages 13 and 14. Check your answers with the *Medical Filing Student Answer Key* you downloaded in the "Begin Here" module. Correct anything you missed. Show your corrected work to your instructor. If you have any questions on the assignment, ask your instructor. Record your points on your Recording Sheet.

**Unit 2** teaches basic alphabetical filing. **Do not do the phonetic filing on pages 22-23**. Be sure to do the Check Your Understanding assignments as you work through each unit. The Check Your Understanding exercises can be checked with the Answer Key on page 73 of your textbook. Check the "Errors in the Medical Filing book" document. There are errors in the textbook Answer Key for Rules 2, 3, & 4 (pg.19) #7 and Rule 6 (pg. 21). When you reach the Check Your Knowledge on page 26, **do not do questions 11 and 12**. Cross them out in your book. To complete the Apply Your Knowledge exercise on Page 27, you will need to tear out the 30 alphabetic cards from the back of your book, write the names in the correct indexing order on the top of the card, and file them in the correct alphabetical order.

As you work through each unit, be sure you have completed the Check Your Understanding, Check Your Knowledge and Apply Your Knowledge questions. The cards for each unit beginning

with Alphabetic Filing are found beginning on page 87. You will find the answers to the Check Your Understanding questions on pages 73-76 in your book. Correct the Check Your Knowledge and Apply Your Knowledge exercises with the *Medical Filing Student Answer Key*.

**Units 3-7** – Continue working through the remaining units in your textbook, checking the Unit instructions in the Canvas modules for each Unit. When you complete a unit, check the answers with the answer key on pgs. 73-76 for the *Check Your Understanding* questions. Download the *Medical Filing Student Answer Key* in Canvas to check your answers for the *Check Your Knowledge* and *Apply Your Knowledge* exercises. Correct anything you missed. Show your corrected work to your instructor. If you have any questions on the assignment, ask your instructor. Record your points on your Recording Sheet.

**Tests – To master competency for this course, you will be required to complete a Final Theory Test and a Final Project/Production Test. You must obtain a 70% average on these tests to pass the course.**

After completing all 7 units, you will take **two** final exams. **Both tests must be taken in the classroom.** The **Final Theory test** is a 50-question multiple-choice exam, which will be taken in Canvas. The test must be taken using Lockdown Browser, and your instructor will need to enter a security code. You may retake the test one time and the highest score will be counted as your final grade. Before taking this test, you will want to download and review the *Medical Filing Test Study Guide*, *Medical Filing Terms* document, and the *Medical Filing Test Review* document to make sure you are prepared for the test. The *Medical Filing Test Study Guide* is especially useful to prepare you for all the questions on the test! These items are located in the "Modules" section of your course.

The **Final Project** is a production test. You will use the cards in the back of your filing textbook. They will say "FINAL PROJECT" across the bottom of the cards. You may retake the test one time and the highest score will be counted as your final grade. Before taking the test, **check your cards** with the *Medical Filing Final Correct Card Order* document. This document can be downloaded in the Final Project instructions in Canvas. Some of the filing books have had the final test cards misprinted with the incorrect numbers for the names. Consequently, when students take the final, their cards don't match the answer key. You will take these cards with you to complete the Final Project test.

Before you attempt the Final Project, make sure you have reviewed the Alphabetic, Numeric, and Cross-Referencing rules in your textbook. The test will consist of alphabetic filing, terminal-digit numeric filing, cross-referencing, and creating new Master Patient Index Cards for new patients and filing these alphabetically and numerically. It will be helpful if you will put your

# MEDICAL FILING – UNIT 1 INSTRUCTIONS

The first chapter in the book gives you an **overview** of medical filing. At the beginning of each chapter, you will find a list of objectives for the chapter. Read through the chapter carefully, highlighting important information. After completing the chapter, go back over the list of information and make sure you have met the objectives.

**As you study the information, keep in mind the following:**

1. The main purpose of a medical record is to provide continuity of care. A complete, accurate medical record is important in order for the physician to have a good reference when treating patients and managing their care.

2. It is vitally important that you not reveal information regarding a patient outside of work and not discuss patient information at work where others may hear your conversation. Remember, patients own the information on their medical record and they have a right to confidentiality! You will learn more about HIPAA Laws as you progress through your classes.

3. While the Association of Records Managers and Administrators (ARMA) rules for alphabetic storage are used in this textbook, there are other rules. Consistency is the key regardless of which rules are used.

4. A master patient index can be a card file or a computerized file. The main purposed of a master patient index is to have basic information about a patient readily available. It is important not to list more information than is necessary on the master patient index.

5. Cross-referencing is preparing an aid that indicates another way a medical record may be filed.

6. Space is always at a premium and, along with cost, must be taken into consideration when selecting filing equipment.

7. Be sure you know the medical records life cycle, how it begins, and examples of each part of the cycle.

After completing the chapter, complete the "Check Your Knowledge" on pages 13 and 14 of your book. Check your answers with the Medical Filing Student Answer Key you downloaded in the Begin Here module. Correct anything you missed. Show your corrected work to your instructor. If you have any questions on the assignment, ask your instructor. Record your points on your Recording Sheet. Move on to Unit 2.

# MEDICAL FILING – UNIT 2 INSTRUCTIONS

You will begin basic alphabetic filing in this second chapter. Remember to look at the objectives on page 14. Read through the chapter carefully, highlighting important information. After completing the chapter, go back over the list and make sure you have met the objectives.

As you study the information, keep in mind the following:

1. An advantage to alphabetic filing is the ease in training individuals to file medical records. Disadvantages of filing names alphabetically include: (1) people may change names, (2) spelling of a name may be unique, and (3) it is difficult to determine how much space to leave in the files for expansion.

2. When registering a patient, it is important to obtain the complete name.

3. When filing, it is vital to compare each unit in personal names.

4. All punctuation is disregarded when indexing to simplify the process. Names are indexed **as written.**

5. A foreign article or particle in a person's name is combined with the part of the name following it to form a single indexing unit.

6. A title before a name (such as Dr. or Miss) or a seniority suffix (such as Jr. or II) or professional suffixes (such as MD or PhD) are all used as the last indexing unit. Numeric suffixes (II, III) are filed before alphabetic suffixes (Jr., Sr., or PhD). If a name contains both a title and suffix, the **title is the last unit**.

7. When filing identical names ARMA rules use the address as the next indexing unit. The city first, then the two-letter state abbreviation, then street names. If all of that information is identical, the street number is used.

**Remember that you do not have to do the "Phonetic Filing" section on pages 22-23 in your book.**

After completing the chapter, complete the "Check Your Knowledge" on page 25 of your book. Skip questions 11 and 12 on Phonetic filing. Next, tear out the 30 alphabetic cards you will find beginning on page 89 in the book and complete the "Apply Your Knowledge" exercise on pages 27 and 28. Check your answers with the Medical Filing Student Answer Key you downloaded in the Begin Here module. Correct anything you missed. Show your corrected work to your instructor. If you have any questions on the assignment, ask your instructor. Record your points on your Recording Sheet. Move on to Unit 3.

# MEDICAL FILING – UNIT 3 INSTRUCTIONS

Numeric filing is a method of storage where records are assigned numbers and then stored in one of various numeric sequences. There are two major reasons for using a numeric storage method: 1) the ease with which people recognize and use numbers, and 2) the infinite set of numbers available.

Usually a six-digit number is used for either terminal-digit or middle-digit filing, and it is broken into three parts, divided with hyphens. Regardless of which numeric filing system is being used, you look at the individual units within the six-digit number to decide its proper position in a file. However, when you write the number down on the answer sheet, it remains the same six-digit number (including the hyphens) as it originally appeared.

For example: When using **terminal-digit** filing, the number 12-32-44 is considered as the primary unit being 44, the secondary unit being 32, and the tertiary (3rd) unit being 12 when you are determining where it would be located in the file. But on your answer sheet, you would still write it down as 12-32-44.

For **middle-digit** filing, that same number would be considered as the primary number being 32, the secondary number being 12 and the tertiary number being 44. After determining the correct location in your file, you would still write the number down on your answer sheet as 12-32-44. ONLY six-digit numbers can be used for middle-digit filing and middle-digit filing is not frequently used.

| **Numeric Filing Systems** | |
|---|---|
| **Type of numeric system** | **Filing (Reading) Order** |
| Consecutive | Left to right |
| Terminal-digit | Right to left |
| Middle-digit | 2 1 3<br>Middle, First, Last (23-48-91) |

**As you study the information, keep in mind the following:**

1. Numeric filing requires a tracking system for numbers issued (the **accession ledger**) and a cross-reference of alphabetical patient cards (the **master patient index**). They can be kept manually or computerized.

2. It is vital the **accession ledger** be kept up to date in order that the same number is not issued to more than one patient.

3. It is important to identify whether or not the patient has been seen previously at the medical facility under the current name or a different name. A patient must NOT receive two numbers. This can happen when a patient's name changes. It is important to inquire if a patient has visited the medical facility in the past and under what name.

4. Patient cards are a cross-reference to the location of medical records filed by number. Remember: **patient cards** are filed according to alphabetic rules.

5. The use of a social security number may be adapted to unit numbering, although the Social Security Administration does not recommend the use of social security numbers. The advantage of using social security numbers is that every number is unique to the individual. The disadvantages are 1) the health care facility does not control the numbers and cannot

verify them, 2) some individuals may not have a social security number and must be assigned a “pseudo” number, and 3) there may be gaps in the shelf files.

After completing the chapter, complete the “Check Your Knowledge” on page 37 of your book. Next, tear out the 30 **numeric** cards from your filing book and complete the “Apply Your Knowledge” exercise on pages 39 and 40. Check your answers with the Medical Filing Student Answer Key you downloaded in the Begin Here module. Correct anything you missed. Show your corrected work to your instructor. If you have any questions on the assignment, ask your instructor. Record your points on your Recording Sheet. Move on to Unit 4.

# MEDICAL FILING – UNIT 4 INSTRUCTIONS

Cross-referencing is a means by which a notation is made in one location to indicate that the medical record may be stored elsewhere. In alphabetic filing, medical records or master patient index cards are filed under the name most likely to be requested (usually the name being currently used). Other possible names are considered, and a cross-reference is created directing personnel to where the medical record or master patient index card is located.

Alphabetic cross-referencing is used when a name might be indexed in more than one way. It may be used for: unusual names, alternate names, hyphenated names, and similar names. Names may change frequently and it is important to know all the names a patient may use to determine if a patient was seen at the medical facility previously in order to provide continuity of care.

**As you study the information, keep in mind the following:**

1. In numeric filing, an alphabetic card file is used for cross-referencing the patient name and number.

2. Remember that the hyphen is disregarded in alphabetic filing.

3. If cross-referencing is not done for alphabetic filing, then all possible ways to spell names of name variations must be considered and looked up if a medical record cannot be located under the presumed name.

4. The medical facility may elect not to cross-reference all the different possible ways to spell a name due to the cost, time, and space. While cross-referencing is a great means by which to locate the medical record files that may be filed several different ways, it must be used with discretion. Time, cost, and space will enter into the decision of how much cross-referencing will be done at a medical facility.

After completing the chapter, complete the “Check Your Knowledge” on page 45 of your book. In this section the “Name” column refers to the name the patient’s file was originally filed under. The “Primary Medical File” column refers to what the patient’s file should NOW be filed under with the circumstances given, along with any cross-references. For example:

**Name:** JoAnn Palmer. Her original file was listed as **Palmer, JoAnn**. She marries Henry Ford.

Now her primary medical file now becomes: **Ford, JoAnn**

Two cross-references would be created under: **Palmer, JoAnn and Ford, Henry, Mrs.**

Check your answers with the Medical Filing Student Answer Key you downloaded in the Begin Here module. Correct anything you missed. Show your corrected work to your instructor. If you have any questions on the assignment, ask your instructor. Record your points on your Recording Sheet. Move on to Unit 5.

# MEDICAL FILING – UNIT 5 INSTRUCTIONS

Color coding of medical records is used in many health facilities for ease in filing and retrieval of medical records. Color coding makes filing more efficient and helps to reduce misfiles. This unit discusses both alphabetic and numeric color coding.

**As you study the information, keep in mind the following:**

1. Color coding of folders creates patterns of colored blocks. A break in the color pattern will signify a misfile.

2. Color coding does NOT eliminates misfiles; it only helps to reduce misfiles.

3. Color coding may be used to indicate information not associated with filing such as the year of the patient's last visit or the patient's primary physician.

4. It is important to color code only information that will make filing and retrieval more efficient. Color coding too much information may be confusing.

5. While this textbook shows color coding of the first two letters of the last name and then filing the rest of the name according to alphabetic rules, there are other methods. Again, consistency in your medical filing system is the key.

6. It is important for a medical facility to research what is available and learn the advantages and disadvantages of each method before deciding which color coding system to use.

After completing the chapter, complete the "Check Your Knowledge" on pages 53-54 of your book. When doing the "Apply Your Knowledge" on pages 55-56, be sure to lay the cards out on a flat surface so you can easily see the color patterns just like the illustrations shown in Fig. 5.3 on page 49 and Fig. 5.6 on page 51. Check your answers with the Medical Filing Student Answer Key you downloaded in the Begin Here module. Correct anything you missed. Show your corrected work to your instructor. If you have any questions on the assignment, ask your instructor. Record your points on your Recording Sheet. Move on to Unit 6.

# MEDICAL FILING – UNIT 6 INSTRUCTIONS

Records control refers to procedures used to keep track of medical records once they are created. Some of the uses of the medical record are in managing patient care, processing financial reimbursement and legal claims, and supporting research and education. It is essential for a medical record to be available for any of these uses when required. Consistency is the key to quality in records control. This unit discusses charge-out procedures, automated tracking systems, retention and transfer of medical records, transfer procedures, and identification of active and inactive records.

**As you study the information, keep in mind the following:**

1. A good records control system will allow for retrieval of medical records that are not in the file.

2. If the medical record is not available when the patient is being treated, unnecessary or even unsafe treatment may be provided which may be harmful to the patient.

3. Charge-out procedures will assist in keeping track of medical records. A charge-out system is similar to the check-out system in a library. When a medical record is removed from a file, someone is responsible for its return.

4. Records personnel check to assure timely return of borrowed medical records.

5. Charge-out procedures should be followed regardless of who removes the medical record from the files, for what reason, or for how long.

6. A charge-out system consists of a requisition, OUT guide, and follow-up.

7. It is necessary for all the information to be completed on the requisitions form. The form may be a three-part form with one copy clipped to the medical record, one in the file where the medical was removed, and one placed in a tickler file.

8. A **tickler file** serves as a reminder that a specific action is to be taken on a specific date. It is a tool to keep track of borrowed records and to indicate when to contact the borrower to return overdue records. A tickler file is an efficient way to keep track of borrowed records.

9. An **OUT guide** is a special guide that is placed in the file when a medical record is removed from the file and remains in the file until the record is returned. OUT guides may be colored and should be of sturdy construction as they are reused many times.

10. No matter what type of OUT guide is used, it will not be of value unless all personnel utilize it when removing medical records from the file.

11. In order to ensure that all medical records are returned within a reasonable length of time, a follow-up system must be in place. Follow-up means checking for medical records that are not returned within a specified period of time.

12. The longer the medical record is out, the more difficult the return becomes and the more likely the record may be misplaced. A maximum time of two weeks is recommended.

13. Not all states have statutes concerning the retention of medical records. Unless there is a state statute specifying the length of time medical records must be kept, it is recommended by the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA) that medical records are kept for ten years after the most recent patient usage. Any statutes of limitations time limits in which legal action can be initiated must also be considered. For minors, statutes of limitations usually expire two or three years after a minor reaches maturity.

14. Due to demands for storage space, medical records are often transferred to another location. Before medical records are transferred, four key questions must be answered: WHAT, HOW, WHEN and WHERE. A medical facility should determine the transfer method best suited to their needs. The perpetual transfer method is the most common.

15. Whenever records are transferred, a notation needs to be made on the master patient index to ensure location of records when needed.

16. Active medical records are those that are frequently used by the medical facility. A medical record may be inactive when a patient is deceased, has moved or is no longer seen at that facility. For all practical purposes, the chief criterion for determining inactive records is the availability of file space.

17. When inactive records are removed, a notation must be made on the master patient index as to the location of the record to eliminate searching for the record should it be needed again.

After completing the chapter, complete the “Check Your Knowledge” on page 64 of your book. Check your answers with the Medical Filing Student Answer Key you downloaded in the Begin Here module.

Correct anything you missed. Show your corrected work to your instructor. If you have any questions on the assignment, ask your instructor. Record your points on your Recording Sheet. Move on to Unit 7.

# MEDICAL FILING – UNIT 7 INSTRUCTIONS

Administrative, financial, and clinical computer applications are used in medical facilities. This unit discusses these three types of computer applications and some of the databases used in each of the three areas. It is important to gather accurate information correctly into the computer. Inaccurate information is of no value and may be harmful to the patient.

**As you study the information, keep in mind the following:**

1. The **patient registration information database** may serve as a master patient index and as a means of assigning numbers. Patient registration is a basic database to which additional information may be added in order to generate a variety of reports.

2. A **computerized record location and tracking system** will provide information as to the location of a medical record at any given point. An advantage of a computerized tracking system is that OUT Guides would not be necessary. Again, consistency is the key to efficiency.

3. It is sound **financial management** for medical facility personnel to know facility income and expenses at any given time.

4. It is vital to process insurance claims on a timely basis. **Electronic claims processing** is frequently used due to the speed at which claims can be filed and payments made.

5. **Medical records** are an important tool for research. Studying patients with a specific condition and their treatment will assist physicians in providing patients with the best possible care.

6. Regardless of the type of medical facility, all computer applications may be used. Specific usage may vary due to the needs of each medical facility. It is important to select the computer and software that meet the facility's needs.

7. Confidentiality is of extreme importance; so is the need for a mechanism to assure that no unauthorized person has access to the information stored on a computer.

8. Information sharing is a key to a successful health care data system. Once a database is created, other departments may build on this information, generating reports that will allow them to better assess their services.

After completing the chapter, complete the "Check Your Knowledge" on pages 71 and 72 of your book. Check your answers with the Medical Filing Student Answer Key you downloaded in the Begin Here module. Correct anything you missed. Show your corrected work to your instructor. If you have any questions on the assignment, ask your instructor. Record your points on your Recording Sheet.

**You now need to prepare for your final tests.** Go back to your Student Class directions and read the information on the Final Theory Test and Final Project Test. Both tests must be taken in the classroom. Before testing, scroll to the bottom of the Modules screen and read through the Medical Filing Test Review and Medical Filing Study Guide documents. You may want to print these documents to help you prepare for the finals. You must receive a 70% average on these two tests to receive competency (MC) for this course.

You will take the Theory Test in Canvas using Lockdown Browser. The Theory Test is a multiple choice test. The Medical Filing Study Guide document will be very helpful in preparing you to take the theory test.

The Project/Production Test is not taken in Canvas. This test must be taken in the classroom. You will use the Final cards located in the back of your textbook and file the cards using the various methods you learned in the textbook. Check with your instructor for further information.

# MEDICAL FILING

## FINAL TEST REVIEW

Know the purpose of medical filing

Know how the medical records life cycle begins

If there is no state statue of retention, know how long medical records should be kept

Know the medical records life cycle

Who does the medical record information belong to

Know which list of patients is put in alphabetical order

Know the different types of filing equipment and which one takes up the least space

Know the definition of out guides, tabs, file guides, folders

Review the rules for alphabetic filing

Know the following definitions: terminal digit, middle digit, serial numeric, straight numeric, unit, serial, serial unit, consecutive number

Know what numbering system uses pseudo numbers

Know the steps involved in assigning a number to a patient

Know which files require back shifting as the files expand

Know when to cross-reference a file

Know what color coding is and what its purpose is

Know the main criteria for determining when a medical record is inactive

Know the basic computer applications used in medical facilities

Know what the medical record databases are and what they are used for

Know what has to be done in order to release a patient's medical records to an insurance company

What photographic process is used to store medical records

Know what has to be considered when destroying medical records

Know what makes up an efficient records management system

Know what information is contained in a medical record

Know the definitions of: microfiche, microfilm reels, microfilm jackets, microfilm cartridge.

# Medical Filing Study Guide

1. The purpose of having an efficient medical filing system is for the **maintenance, retrieval, and security of medical records** and health information in order that the medical record is available when needed. (Pg. 2)

2. The medical records life cycle begins with the **creation of the medical record**. (Pg. 2)

3. The medical record contains identification data about a patient; facts about the patient illnesses and treatment; information about family history and illnesses; and clinical information about the patient, such as x-ray or test results. **It does not contain personal correspondence such as thank you letters**. (Pg. 2)

4. If a clinic responds to a request from an insurance company for information on a patient, the medical records life cycle phase involved is **use of the medical record**. (Pg. 3)

5. The AMA and the American Health Information Management Association recommend that medical records be kept **ten years** after the patient is no longer seen at the health care facility if there is no state statute that specifies otherwise. (Pg. 3)

6. The **patient** owns the information in the medical record. (Pg. 3)

7. Information in a patient's medical record cannot be released to anyone, including insurance companies, **unless the patient signs an authorization**. (Pg. 3)

8. The **master patient index** is a card file or computerized system that contains a listing of patients in alphabetical order. (Pg. 5)

9. **Open-shelf files** are the most popular method of filing equipment, but offer the least security. (Pg. 7)

10. **File guides** are dividers that guide the way to the location of the record being retrieved. These would be the main guides like "A", "B", that the files would fall under in alphabetic filing. (Pg. 9)

11. **Microfilming** is a photographic process that reduces a document to a very small size and is an alternate means of storing medical records. (Pg. 11)

12. An advantage of a **microfilm jacket** is that it utilizes or maintains a unit patient record because it can be updated by inserting new images into the channel. (Pg. 11)

13. An **optical disk** is an alternate storage method that uses a laser to etch data onto a permanent surface. (Pg. 11)

14. The easiest and most commonly used system for organizing medical records in a small facility is the **alphabetic method.** The main advantage to alphabetic filing is that it is easy to learn and personnel can be trained quickly. However, if a name is misspelled, it will be misfiled. As new files are added, medical records must be shifted to allow for additional records, and alphabetic filing makes medical records easily accessible to unauthorized personnel. To retrieve information efficiently, a set of filing standards and rules must be followed. Indexing means selecting the filing segment under which a record will be filed. The filing segment is the name by which the record is stored and requested. Each filing segment, or name, is broken into units. The key unit is the first unit of the filing segment and the one by which the record is

stored. Units 2, 3, 4, and so on, are the subsequent units considered when determining placement of a record in the file. (Pgs. 15-20) The alphabetic filing rules used in the Medical Filing book are as follows:

**Rule 1: Personal Names** – Names are indexed in the following order: (1) the last name (surname) is the key unit, (2) the first name (given name or first initial) is the second unit, and (3) the middle name or initial is the third unit. If determining the surname is difficult, consider the last name as the surname. Initials are considered separate indexing units. When a unit consists of just an initial (a single letter), it precedes a unit that consists of a complete name beginning with the same letter. **Remember, nothing goes before something**. Punctuation is omitted.

**Rule 2: Punctuation and Possessives** – All punctuation is disregarded when indexing personal names. Commas, periods, hyphens, apostrophes, and dashes are disregarded; and names are indexed as written.

**Rule 3: Abbreviations, Nicknames, and Shortened Names** – Abbreviations of personal names (such as Wm., Jos., Thos.), nicknames (such as, Bud, Guy), and shortened names (such as, Liz, Bill) are indexed as they are written.

**Rule 4: Prefixes, Foreign Articles, and Particles** – A foreign article or particle in a person's name is combined with the part of the name following it to form a single indexing unit. The indexing order is not affected by a space between a prefix and the rest of the name, and the space is disregarded when indexing. Examples of articles and particles are: a la, D', Da, De, Del, De la, Della, Den, Des, Di, Dos, Du, El, Fitz, Il, L', La, Las, Le, Les, Lo, Los, MI, Mac, Mc, O', Per, Saint, San, Santa, Santo, St., Ste., Te, Ten, Ter, Van, Vande, Vander, Von, Von der.

**Rule 5: Titles and Suffixes** – A title before a name (such as, Dr., Miss, Mr., Mrs., Ms., Prof.), a seniority suffix (such as, II, III, Jr., Sr.), or a professional suffix (such as, CRM, DDS, MD, PhD) after a name is the last indexing unit. Numeric suffixes (such as, II, III) are filed before alphabetic suffixes (such as, Jr., PhD, Sr.). If a name contains both a title and a suffix, the title is the last unit. Royal and religious titles followed by either a given name or a surname only (such as, Father Leo) are indexed and filed as written. When royal or religious titles are followed by both a given name and a surname, the title is indexed last (such as Sister Monica Riley).

**Rule 6: Identical Names of Persons** – If all units, including titles, in the names of two or more persons are identical, filing order is determined by addresses. Cities are considered first, followed by states or provinces (considered by their two letter abbreviated form), street names, and then house numbers or building numbers. Zip codes are not considered in indexing.

Numbers spelled out (such as, seven) are filed alphabetically. Numbers written in digit form are filed before alphabetic letters or words (7 comes before one). Numbers written in digits are filed in ascending (lowest to highest) order. Arabic numerals are filed before Roman numerals (2, 3, II, III).

In some medical facilities, dates of admission or birth dates may be used rather than addresses when names are identical. The latest admission date or birth date is usually sequenced first. The key is consistency.

15. In a numeric filing system, the first step is entering the patient's name and assigning the next available number in the **accession ledger or book**. (Pg. 29)

16. In **numeric** filing, the key to locating the patient medical record is the **master patient index**. The master patient index or card file contains an alphabetical listing of patients. When a patient comes in, a number is assigned to the patient. Then a master patient index card is prepared listing the patient's name in alphabetical filing order. The cards are filed alphabetically by name. In retrieving a medical record filed numerically, the patient's card is located by looking up their name alphabetically and then the patient number is identified from the card. The patient folder is then located in the file matching the number on the patient card file. Numbering systems include serial, unit, serial-unit, and social security numbers. (Pg. 30, 31)

17. In **serial numbering**, the patient receives a new number for each visit or admission and the old patient records are *not* brought forward. (Pg. 31)

18. In **unit numbering,** a patient is assigned one number on the first visit, which they keep for subsequent visits. **The main advantage is that it provides for continuity of care** because all the medical records for a patient are filed in one place. (Pg. 31)

19. In **serial-unit numbering**, the patient receives a new number with each visit, and the patient's older medical records *are* brought forward and filed with the newest assigned number. (Pg. 32)

20. In a unit numbering system that uses social security numbers to identify patients, the medical facility would have to assign a "**pseudo**" (fake or false) social security number for patients who do not have a social security number. (Pg. 32)

21. The three types of numeric filing systems often used in medical facilities include **consecutive numeric, terminal-digit, and middle-digit**. (Pg. 32)

22. The **consecutive numeric** filing system is also known as **straight numeric** where numbers are filed in consecutive order starting with the lowest number and ending with the highest. (for example: 1, 2, 3, etc.) (Pg. 32)

23. The greatest advantage of using **straight numeric** filing is the **ease of training personnel**. (Pg. 32)

24. In **terminal digit filing**, digits are read from right to left. The last two digits of a number are the **first** indexing unit and are called primary digits. The secondary digits are the middle two digits and are the **second** indexing unit. The tertiary digits are the first two digits and are the **third** indexing unit. Pg. 33)

25. A disadvantage of terminal-digit filing is that **more training time may be required** than with straight numeric filing. (Pg. 34)

26. In **middle-digit filing**, primary numbers are the middle two digits of a six digit number, secondary numbers are the first two numbers, and tertiary numbers are the last two digits of a number. (Pg. 35)

| **Numeric Filing Systems** | |
|---|---|
| **Type of numeric system** | **Filing (Reading) Order** |
| Consecutive | Left to right |
| Terminal-digit | Right to left |
| Middle-digit | 2 1 3<br>Middle, First, Last (23-48-91) |

27. **Cross-referencing** is a means by which a notation is made in one location to indicate that a medical record or master patient index card may be stored elsewhere. (Pg. 41)

28. **Alphabetic cross-referencing** is used when a name might be indexed in more than one way such as:

*Unusual Names* – It is hard to determine which name is the last name (Thomas Gregory) or foreign names.

*Alternate Names* – When a patient goes by more than one name or changes names such as: use of a husband's name, married name, nickname, professional name, return to maiden name, or adoption.

*Hyphenated Names* – In indexing hyphenated names, the hyphen is disregarded. It may be confusing to determine the last name if the hyphen is left out and the names separated.

*Similar Names* – These are names that sound alike but are spelled differently such as Maki or Macke. (Pg. 41-43)

29. The purpose of **color coding** is to not only make filing more efficient, but the **main advantage is that it helps reduce misfiles.** (Pg. 47)

30. **Color coding** of files can signify or be assigned to letters (in alphabetic filing); a **number** (in numeric filing); or information not associated with filing, such as the last year a patient was last seen in the medical facility or the patient's primary physician. One of the main advantages of color coding is that it simplifies checking for misfiled records, as a break in the color pattern will signal a misfiled medical record. (Pgs. 47-48)

31. **Color coding** of the last year the patient was seen in the medical facility would provide information for, or assist in identification of inactive medical records. Personnel could then remove the medical records from the active file and these records could be destroyed, microfilmed, or moved to inactive storage. Color coding cannot be used to identify patients who have not had a particular treatment or the reason for a visit within a certain time frame. (Pg. 48)

32. **Records controls** are procedures used to keep track of medical records once they have been created. When a request is made for a medical record a requisition is made. A **tickler file** is a tool that serves as a ready reference to identify overdue medical records and remind the borrower to return the record or that a specific action is to be taken on a specific date. (Pg. 58)

33. An **OUT guide** is a special guide used to replace any medical record removed from the file and remains in the file until the medical record is returned. Use of an OUT guide provides a means for record control. (Pg. 59)

34. An **automated tracking system** provides information on location of medical records at any given point in time using a computer. Advantages of using an automated record tracking system are that it improves record access, facilitates quick record retrieval of medical files, helps insure confidentiality of medical records, and helps reduce the incidence of misplaced medical records. It **does not** completely eliminate the incidence of misplaced records. An efficient records management system **does not reduce filing equipment costs**. It may cost more to have enough space and filing cabinets for storage; and an automated tracking system may be expensive. (Pg. 60, 62)

35. Many states have laws designating how long medical records should be retained. Retention of medical records may be determined by a **statute of limitations** or a time frame for keeping records. The American Health Information Management Association and American Hospital Association recommend ten years for retention of medical records if there is no state statute. In destroying medical records when there are no state retention laws, a medical facility should consider the **statute of limitations**. (Pg. 62)

36. **Active** medical records are those that are being used frequently in providing care to the patient. **Inactive** medical records are records that are not frequently used. **The chief criterion for determining inactivity** is the available space for efficient storage of newer medical records. (Pg. 63)

37. The three basic types of **computer applications** used in medical facilities include administrative, financial, and clinical applications. (Pg. 65)

**Administrative** computer applications include appointment scheduling, patient registration, and record location and tracking. A record location and tracking system will provide information about the location of a medical record at any given point. (Pg. 66-67)

**Financial** applications are related to billing and accounts management. This has to do with timely billing and processing of insurance claims. (Pg. 67, 70)

**Clinical** applications pertain to data used to diagnose and treat patients. A computerized medical record documents the health care provided by physicians, nurses, physical therapists, and others involved in health care. Information stored in a clinical database can be used to develop **research** reports. For

example, research of clinical records could provide information about treatment and response to treatment of all the patients that have been treated for a particular disease, such as cancer. (Pg. 69)

# Medical Filing Final Theory Test - Requires Respondus LockDown Browser

## Instructions

The Medical Filing Theory Test is a 50 question Multiple Choice test. You will take the Theory Test in Canvas using Lockdown Browser. To prepare for this test, make sure you have read and studied the Medical Filing Test Review and the Medical Filing Study Guide documents. These documents will be very helpful in preparing you to take the theory test. Do not attempt the test unless you have studied the Test Review and Study Guide documents thoroughly!

The test must be taken in the classroom. When you are ready to test, get into the LockDown Browser on a classroom computer. Your instructor will have to enter a security code to allow you access to the test. You must pass the Theory and Project tests with a 70% or higher average. You can retake the test one time and your highest score will count as your final test score.

## Project Final

The **Final Project** is a production test. You will use the cards in the back of your filing textbook. They will say "FINAL PROJECT" across the bottom of the cards. You may retake the test one time and the highest score will be counted as your final grade. You must pass with a 70% average on this test and the theory test to demonstrate competency and receive an MC (Mastered Competency) grade. Before taking the test, **check your cards** with the *Medical Filing Final Correct Card Order* document link below. Some of the filing books have had the final test cards misprinted with the incorrect numbers for the names. Consequently, when students take the final, their cards don't match the answer key. You will take these cards with you to complete the Final Project test.

Before you attempt the Final Project, make sure you have reviewed the Alphabetic, Numeric, and Cross-Referencing rules in your textbook. The test will consist of alphabetic filing, terminal-digit numeric filing, cross-referencing, and creating new Master Patient Index Cards for new patients and filing these alphabetically and numerically. It will be helpful if you will put your cards into two decks—one for alphabetic filing and one for numeric. When you are doing alphabetic filing, use the alphabet deck, and when you do numeric filing, use the numeric deck. **Read the instructions carefully. Be sure you list the names in all capital letters and in the correct indexing order! If you run out of blank cards, you can fold and cut blank paper to use for the test.**

The test must be taken in the classroom. When you are ready to test, bring your Final Project cards to class, and your instructor will provide instructions on completing the task.

Before you take the Project Final Exam, download the file below to check your cards and make sure they are in the proper order.

MEDICAL FILING FINAL CORRECT CARD ORDER.docx

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