

Definitions essay examples

[Health & Medicine](#), [Healthcare](#)



Introduction

In healthcare, there are several approaches used in the maintenance of standards and for communication between medical practitioners and insurers. Record keeping and coding make it easier for medical practitioners to maintain uniformity in service delivery and enhance clinical governance. Computers are utilized in the maintenance of electronic records in a manner which is secure, retrievable, editable and which can be used to track and maintain quality of care. Coding is used in the unification of medical language and diagnoses while specialized medical forms are used to collect patient information which is necessary to enable quality care. This paper provides ten important definitions which are employed in healthcare.

- (AMR) Ambulatory Medical Records

This is a file of the outpatient medical records of patients which have been stored electronically. An AMR also comprises of a list of the surgeries and care performed on them without having being admitted to the hospital. AMRs may be used to provide information on quality of healthcare, doctor-patient communication and prescriptions (Ramsdell, 2000).

- (CMR) Computerized Medical Records

They are patient records which are kept in computer systems for the purpose of enhancing clinical governance. This enhancement is achieved by increased level of accountability, ease in appraisal of quality, tracking patient outcomes and improvement through feedback (Fraser & Biondich, 2005). Keeping accurate CMRs involves incorporating computers in all clinical interaction aspects. This includes consulting, screening, online booking, recall etc. CMRs also make quality improvement through feedback

and audit processes possible. Using CMRs also has the advantage of enabling the quick retrieval and review of patient records. Medical records may also be edited and security of records may be enhanced.

- CMS (Center for Medicare and Medicaid)

This is a U. S. government agency that administrates various important Federal Healthcare programs. CMS, besides providing Medicare and Medicaid oversees healthcare insurance for children among other services (CMS, 2012). As from 2009, CMS was given the responsibility of enhancing healthcare IT such as overseeing Electronic Health Record (HER) implementation, defining standards of EHR use and updating privacy and security health information.

- CPT (Current Procedural Terminology)

CPT is a coding system used as a communication tool between medical service providers, physicians, accreditation organizations, health insurance firms as well as ambulatory services in some cases (Smith, 2013). The purpose of this method is to enable all the practitioners in the medical field such as nurses, physicians as well as patients and third parties to be aligned through uniform language.

- CMS-1500 (Centers for Medicare & Medicaid Services- Form 1500)

Form CMS-1500 is the paper claim form which is utilized by a non-institutional supplier or provider of healthcare to bill Medicare and Medicaid carriers when a provider has qualified for a waiver requirement for the submission of claims electronically (CMS, 2012). The CMS-1500 form may also be used to bill some government as well as private insurers.

- DRG (Diagnosis Related Group)

DRG is the method of hospital payment which is done “ per-case”. This implies that the DRG system is used to classify the type of medical case (Beaty, 2005). DRGs provide guidelines which are widely followed in the U. S. to ascertain hospital reimbursement for Medicaid, Medicare and other insurers. DRG codes are usually used together with CPT codes to determine the total reimbursement and claim required.

- EPR (Electronic Patient Records)

This is a system that is made up of various software applications which aggregate administrative and clinical data at a single point. Implementing EPR has some benefits such as better legibility of important clinical information and improved data accuracy (Oxford University Hospitals, 2013). One of the features of EPR is Positive Patient Identification (PPI). This means that physicians can use a scanner to scan a barcode at the bedside of the patient to identify them. This does away with cumbersome paperwork.

- (HL7) Health Level 7

This is a non-profit organization that seeks to ensure proper application of informatics in healthcare. It is the international authority on the standards of health information technology interoperability with members in more than 55 countries. This standard is necessary for the transmission of information such as patient records, billing information and laboratory results in one format through software applications suited to the healthcare industry.

- ICD-9 (International Classification of Disease)

This is the system used by the U. S. for classification and assignment of codes to health conditions as well as health-related information (CDC, 2013). This system helps by improving consistency among healthcare professionals

in terms of diagnosis information and symptoms. The “ 9” means that it is the 9th revision of the system. This system works by assigning alphanumeric codes corresponding to diagnoses and procedure records.

- UB-92 (Uniform Billing form 92)

According to Rizzo & Green, (2000), the UB-92 (Uniform Billing form 92) was used to summarize requirements (specific patient information) required by healthcare insurance providers. It was once the only form for medical insurance for use by hospitals and other institutions in the submitting of claims to healthcare insurers. However, its prevalence has decreased since 2007 since it was terminated and replaced with the UB-04. This was done to improve accuracy. UB-92 is not accepted today by Medicaid and Medicare.

Conclusion

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