Universitas Esa Unggul

Smart, Creative and Entrepreneurial

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PERTEMUAN-13

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PENUGASAN

TUGAS

- Kerjakan soal di bawah ini secara individu dan dikumpulkan.

1. Jelaskan maksud dalam pernyataan di bawah ini:

- Dalam bukan Documentation for Health Records halaman 82 tercantum pernyataan berikut ini:

A traditional principle among health information managers—"if it wasn't documented, it didn't happen"—reflects the importance of complete, timely, and accurate clinical documentation. The quality of the information in health records is especially critical because of the complexity of patient care and the potentially serious consequences incorrect or incomplete information can have for patients and caregivers. Less obvious is the effect poor quality documentation can have on the facility's ability to claim appropriate reimbursement from patients and third-party payers. This, in turn, can damage the organization's short-term and long-term financial stability, affect its continued ability to provide high-quality patient care with the most cost-effective means, and hinder its ability to use technological advances.

2. Jelaskan maksud dalam pernyataan di bawah ini:

- Dalam bukan Documentation for Health Records halaman 82 tercantum pernyataan berikut ini:

Documentation must accurately reflect the healthcare services rendered to the patient. According to Bowman (2008):

Claims should be submitted only when appropriate documentation supporting them is present in the health record and available for audit and review. Processes for ensuring that health record documentation is adequate and appropriate to support the coded diagnoses and procedures need to be in place.

3. Jelaskan pertanyaan untuk evaluasi dokumentasi rekam kesehatan!

- Jelaskan pertanyaan untuk evaluasi dokumentasi rekam kesehatan sesuai dalam figure 3.2 halaman 83!

4. Jelaskan maksud dalam pernyataan di bawah ini:

- Dalam halaman 94 tercantum pernyataan berikut ini:

Subpoenas and Court Orders

When the court has determined that a health record is relevant to a particular case, the judge will issue a subpoena or a court order to the owner of the record. A **subpoena** is a direct command that requires an individual or a representative of an organization to appear in court or present an object to the court. The common elements in a valid subpoena are the following (McWay 2010, 54):

1. Name of the court where the lawsuit is brought
2. Names of parties to the lawsuit
3. Docket number of the case
4. Date, time, and place of requested appearance
5. Specific documents to be produced if a subpoena duce tecum is involved
6. Name and telephone number of the attorney who requested the subpoena
7. Signature, stamp, or seal of the official empowered to issue the subpoena
8. Witness fees, where provided by law

In the healthcare context, a **subpoena duces tecum** directs a hospital's representative (usually the director of HIM) to submit a specific health record or other business record to the court that holds jurisdiction over the pending proceedings. With the advice of legal counsel, an HIM director may decide that it is inappropriate for the hospital to release a subpoenaed record. In such cases, a **court order** must be issued in place of a subpoena when the disclosure of the material would otherwise be prohibited by state or federal statutes or regulations (McWay 2010, 54).