

# Health Information Technology Terminology

From the American Medical Association

## Application Service Provider (ASP)

ASP software products are web-based applications that do not require a physician to own or maintain the server. The software and database contents (patient data) are remotely stored, backed-up, serviced and upgraded by the vendor. Typically ASP products reduce the cost to implement a software product because the physician does not have to purchase a server or hire technical support. However, if internet service is out or slow, the practice will not be able to access the EMR applications.

## Computerized Physician Order Entry (CPOE)

Software used by physicians to electronically submit requests for diagnostic exams/tests and receive test results electronically. Can be used in an inpatient setting or an outpatient setting, assuming the clinical departments conducting the exams/tests are capable of transmitting electronic messages to the physician's system.

## CPT Category I Codes

AMA's list of clinical procedures used for administrative documentation and billing. There are over 8,000 codes in the CPT dictionary. More information on AMA's [CPT Codes](#)

## CPT Category II Codes

AMA's list of codes to track Physician Consortium performance measures. More information on AMA's [CPT Codes](#)

## CPT Category III Codes

AMA's list of temporary codes for tracking and reporting of new and emerging technologies. Payment for these codes is at the discretion of the payor.

## EHR (Electronic Health Record) and EMR (Electronic Medical Record)

A record consisting of an individual's history of health status and medical care.

## EHR vs EMR

There are many definitions of EHR and EMR—for almost every person there may be just as many definitions. The terms are frequently used interchangeably.

EMRs may not be interoperable outside of the “home” enterprise (i.e. with other EMRs). The term EHR implies a level of interoperability with other EMRs. The implication of “Health” rather than “Medical” record in the term EHR is that it is a longitudinal record across time and providers. The EHR is generally not considered “owned” by any one physician because the information is not generally sourced by a single provider.

## **Electronic Prescribing**

Software that allows for prescriptions to be transmitted electronically to the pharmacy's computer system. Other functions of electronic prescribing may include patient eligibility verification with health plan, copay information, formulary data, medication history, “fill” status and medication alerts. Electronic prescribing may be part of an EMR application or a stand-alone software system

## **Fax Prescribing**

Some pharmacies are not set up to receive electronic prescription information. In this case, some EMR vendors will convert the electronic information received from a physician to a paper form to be faxed by a third party service to the pharmacy.

## **Health IT (Health Information Technology)**

The software and infrastructure used in the clinical practice of medicine to support documentation, storage and exchange of patient data. Examples include EMRs, eprescribing and CPOE.

## **Interoperability**

The ability of clinical or patient data to transfer between providers in various settings and their various software packages. If a physician's EMR is not interoperable, physicians would only be able to access information within their own EMR application's database.

## **LOINCS (Logical Observation Identifiers Names and Codes)**

The universal identifiers/language for lab testing and results. There are approximately 32,000 terms in LOINC.

## **NHIN (National Health Information Network)**

The infrastructure that would be used to connect local and regional networks to provide access to all medical history for a patient nation-wide. Without the infrastructure, each medical record is “standalone” at each provider and information exchange is significantly limited. There are several prototypes currently being developed with grants from The ONC.

Note: the model of information exchange is a “network of networks” where patient information is consolidated only when clinicians request the information. The model is not likely to be a centralized database of medical history stored at a single location.

## **Pay for Performance**

Pay for Performance programs are incentive programs that provide monetary bonuses or non-financial benefits to physician practices that make progress in achieving or attaining specific quality and/or efficiency (cost of care) benchmarks or standards that are established by the program.

## **Pay for Use**

Some health payors will reward physicians for adopting Health IT such as eprescribing or EMRs. These programs are less common than Pay for Performance.

## **PHRs (Personal Health Records)**

The PHR includes data such as critical current health and medical history information. It also includes information that is tracked by the patient such as personal health maintenance and over the counter medications. For example, it would include daily tracking of insulin levels for diabetics.

## **Practice Management System**

The software used by physicians for scheduling, registration, billing and receivables management. Many EMR vendors also offer practice management systems that are fully integrated with the clinical EHR software. If the EMR vendor does not offer a practice management system or the practice does not want to change systems, it is important to understand how the practice management system and EHR will interface so patient information is consistent between the two systems.

## **RHIO (Regional Health Information Organization)**

RHIOs provide the organizational and technical infrastructure to exchange data among health care providers in a geographic region.

## **SNOMED (Systematized Nomenclature of Medicine)**

A map of clinical concepts with standard descriptive terms. SNOMED currently has approximately 355,000 concepts and is the core terminology for EMRs.

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