Numbering and Filing Systems

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A well-organized numbering and filing system is essential to the effectiveness of the storage and retrieval of patient records. These numbering and filing systems are in regards to paper-based records. However, it is still good for you to have a proficient understanding of.

We will begin our discussion with numbering systems. There are three basic systems that are utilized in the healthcare setting: serial, unit, and serial-unit.

In the **serial system**, the patient is assigned a new number for each admission to the hospital. A new medical record is also generated for the patient. So to summarize this system, if the patient was admitted five times, he/she would have five different medical record numbers and they would be filed in five different locations. This makes the process very time consuming when a physician calls the HIM department and wants the records pulled on a particular patient. The file specialist would need to look and pull records from five different locations for a patient who has been admitted five times.

The second system is the **unit system**. With the unit system, the patient receives a number on his/her first admission and retains that number for all subsequent admissions. To summarize this system, if the patient was admitted five times they would always receive the first number that was assigned to them on their first admission. Also the patient's medical record would be filed in one location. This is why the Admission Specialist should always ask the patient if they were admitted before. If the answer is yes, they will assign the patient to their old number. If the answer is no, they will receive a new number. The Joint Commission recommends the use of the unit system as all patient information can be found in one location.

There are two associated unit systems that have been developed, the social security numbering system, used by the Veterans Affairs Medical Center (VAMC), and the family numbering system.

The Veterans Administration Medical Centers utilize the use of social security numbering as the patient's medical record number. If a patient does not have a social security number a pseudonumber is assigned. It is important to note that the pseudonumber has the same format as the social security number 000-00-000. Here are the rules for assigning a pseudonumber –

You will need to use the following information to assign a pseudonumber:

abc = 1

def = 2

ghi = 3

jkl = 4

mno = 5

pqr = 6

stu = 7

vwx = 8

yz = 9

First you will need to use the letter/number grid that I have given you to assign a number to the first letter of the patient's first, middle, and last name. If the patient has no middle initial, you will assign a "0." Secondly, you will use the patient's date of birth. You will use the digits for the month, date, and year. Enter a "0" before a one-digit month and day. So, take a little time now and assign yourself a pseudonumber. My initials are SEC and my birthdate is 01.14.73, so my number would be 721-01-0114.

The second associated unit system is the family numbering system. *I don't agree with this system, as I believe and have always been taught that each patient should have their record. Hopefully, once you have completed this course you too will realize that this is not a system to recommend to others.* With this system each household is assigned a unique patient number, and each family member is assigned a two-digit modifier number that serves as a prefix to the patient number:

01 – head of household (this maybe father or mother)

02 – spouse

03 – first born child

04 – second child and so on

The major concern that is always cited for this system is the change in family structure such as death, divorce, remarriage, and the children marrying.

The last of the three systems is a combination of the serial systems and the unit system. It is referred to as the **serial-unit numbering system**. With the serial-unit system the patient receives a new number each time they are registered by the facility, and records from a previous admission or encounter are reassigned the new number. This results in all patient records being filed in the most current folder in one location. So to summarize this system, if the patient was admitted five times, he/she would have five different medical record numbers and they would be filed in one location.

We will now move onto filing systems. There two basic filing systems that are utilized in healthcare facilities: alphabetical and numeric.

We will start with **alphabetical filing system**. The alphabetical filing system utilizes the patient's last name, first name, and middle initial to file patient records. The Association of Record Managers and Administrators (AMRA) have developed guidelines, which are referred to as the Simplification Filing

Standard Rules and Specific Filing Guidelines. Here are three simple rules to remember when filing alphabetically:

- Arrange patient names according to the alphabet, starting with the last name, first name, and middle name or initial
- Disregard all punctuation used in the patient name
- Disregard all professional and religious titles and suffixes

The second filing system is the **numeric filing system**. The numeric filing system uses a number to file patient records. There are three types of numerical filing systems that are utilized in healthcare: straight or consecutive numeric filing, terminal digit or reverse, and middle digit.

We will start with the **straight filing system**. The straight filing system is also referred to as the consecutive numeric filing system. Patient records are filed consecutively according to patient number from lowest to highest.

An example would be the following:

123451

123452

123453

123454

It is a common practice that medical record numbers contain six digits. The six digits are further subdivided into three parts using a hyphen, thus making it easier to read. For example, rather than reading 123451; you would read 12-34-51. The three subdivided sections are labeled as primary, secondary, and tertiary. The primary section is the first section, and in this case it would “12.” The secondary section is “34,” and the tertiary is the last section on the right which would be “51.”

The second numeric system is terminal digit filing system. The terminal digit filing system is also referred to as the reverse numeric filing system. The terminal system is opposite of the straight numeric. For example, medical record number 01-02-89, “89” is now the primary section, “02” is still the secondary section and “01” is the tertiary section.

The third numeric system is the middle digit filing. In the middle digit system, the middle digit is the primary section, the digits on the left are now in the secondary section and the digits on the right are now in the tertiary section. For example, medical record number 01-08-49, “08” is now considered the primary section, “01” is the secondary section, and “49” is the tertiary section.

It is important to note that there are 100 primary sections that range from 00 to 99 within each section.

We will now discuss two very important terms **centralized** and **decentralized** –

Centralized is defined as all patient records are organized in one central location under the control of the Health Information department.

The **decentralized** system has patient records throughout the facility. For example, if a patient was seen in a specialty clinic; the clinic would house that record. In other words, whoever creates the record, keeps the record. The decentralized system would not meet the requirements of a unitized record.

We will now discuss the various types of filing equipment for storing patient records. There are many options that are available from lateral files to digital scanning.

The most common storage unit that is used is the open shelving. The open shelving unit resembles that of book shelf. It provides twice as much filing space as a standard file drawer. It also requires less floor space than drawer files. Some open shelving units can be mounted on tracks that make the shelving units compressible. The moveable files are "moved" by the use of a handle, crank, or by touching an electronic sensor.

The next important area that we need to discuss is how to calculate record storage for the paper based medical record. Be sure to use the following guidelines: First, determine the linear filing inches used to store records. Second, estimate the linear filing inches needed for the time period during which records will be stored such as a five year period. Third, calculate the linear filing inches provided by the shelving units. And the last step is to convert the linear filing inches to the number of shelving units to be purchased. *Just a little heads up for the HIT students, you will need to know this for the RHIT exam.*

Let's review an example on how this works:

We have 15 shelving units with 50 inches per shelf. The facility has 15,000 current records and the facility needs 10,000 inches for the future:

> 15 x 50 = 750
>
> 15,000 + 10,000 = 25,000
>
> 25,000 / 750 = 33.33 units – it is important to note that you always need to round up as there is no such thing as 33.33 units. The correct answer is 34.

The next area to discuss is what to look for when purchasing file folders –

You need to be familiar with the term **scoring**. Scoring is accomplished by embossing a crisp line on the edge of the folder so it can be folded and also so it can expanded to its full capacity, as the record become thicker.

Color coding is also very important. Color coding can be defined as the assignment of colors to patient numbers or letters used for filing records. Color bars are placed on the sides/edges of the file folders so that when filed, all records with the same numbers have the same color pattern. This allows misfiles to be easily identified.

There are a couple of key terms to be familiar with, regarding filing controls –

The first is the use of a **chart tracking system**. The chart tracking system will basically tell you where the patient's record is located. A chart tracking system uses record requisitions forms to retrieve and track request for patient records.

An **outguide** should always be used when a record is removed from a filing area. The outguide should be inserted into the spot where the patient record was removed.

A **periodic audit** of file area should be done to ensure that all records removed from the file area are returned in a timely manner. The process of reviewing a filing system to locate misfiles is called auditing.

And finally **loose filing** involves filing reports in the record that are generated after a patient is discharged.

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