



Health Assistant - B

Flexible Instruction Day

Assignment #4

Learning Standard	Health/Medical Assisting Services, Other CIP 51.0899
Task # & Description	#828 Identify basic medical coding, billing, insurance, filing and appointment scheduling procedures in a physical and virtual environment

CONTACT INFORMATION/ASSISTANCE

Instructor Name & E-mail:

Tami Bruni RN, Health Assistant Instructor: brunit@butlertec.us

We will be available by email and the Remind app from 7:40-12, and 12:30-3:10 to answer your questions. Please reach out if you are having difficulty completing your assignments.

INSTRUCTIONS

✓ All work is due on the day we return to school. This is counted towards your attendance and as a classroom assignment.

1. Complete reading of Chapter 10 Billing, Collections and Accounting
2. Complete Chapter 10 worksheet

Name: _____

Session: _____

_____/ 50 points

10

Billing, Collections, and Accounting

Case Study: Denise

Jenny's husband is on a 6-month research assignment in Germany. Her mother, Denise, agrees to stay with her during his absence to help with her three children and interior design business. Denise has no health insurance. Denise's case will be used to illustrate key points in this chapter.

1. Discuss physician fees and patient billing

The primary purpose of a medical office is to provide healthcare services, but no practice can survive without careful financial management. Every practice has *income* (money earned for healthcare services) and *expenses* (money owed by the practice). Some examples of expenses are employee salaries, utilities, medical supplies, equipment purchases, and service contracts. A healthy medical practice must have steady income to offset these expenses. MAs may perform many accounting tasks, including bookkeeping, banking, and billing. They often record income (**credits**) and expenses (**debits**). It is critical that they understand these tasks and perform billing practices accurately.

Each medical practice has **physician fee schedules**. Fee schedules set the cost of services provided by licensed healthcare providers. This includes physicians, physician assistants, and nurse practitioners. Fees are based on the *usual, customary, and reasonable* costs of similar

services provided in nearby healthcare facilities. Fees can vary by region due to factors such as the cost of resources needed to provide services. CMS publishes its own physician fee schedule every year (Fig. 10-1). Insurance companies also have fee schedules for healthcare services. These schedules are used by most medical practices to determine the cost of services.

HCPCS Code	Modifier	Short Description	Mac Locality	Non-Facility Price	Facility Price
99202		Office o/p new sf 15-29 min	0421205	\$70.54	\$48.53
99203		Office o/p new low 30-44 min	0421205	\$109.36	\$83.00
99204		Office o/p new mod 45-59 min	0421205	\$163.54	\$134.08
99205		Office o/p new hi 60-74 min	0421205	\$216.51	\$181.79
99211		Off/op est may x req phylqhp	0421205	\$21.83	\$8.80
99212		Office o/p est sf 10-19 min	0421205	\$54.65	\$36.04
99213		Office o/p est low 20-29 min	0421205	\$88.09	\$66.08
99214		Office o/p est mod 30-39 min	0421205	\$124.31	\$96.71
99215		Office o/p est hi 40-54 min	0421205	\$176.07	\$143.82

Fig. 10-1. CMS sets physician fee schedules for facility (inpatient) and non-facility (outpatient) care.

The fees vary by region. (REPRINTED FROM WWW.CMS.GOV/MEDICARE/PHYSICIAN-FEE-SCHEDULE/SEARCH)

Most medical offices require the patient to pay for services at each visit. When the patient has insurance, the amount that must be paid is usually the copayment or coinsurance. The remaining expenses of the visit are billed to the insurance company. Each patient visit creates an encounter summary that lists the diagnosis and procedure codes along with charges. It is important to record every patient encounter even if there are no charges. The MA uses this information to bill insurance for the encounter. After the claim has been submitted, the billing date should be recorded in the patient's account.

When payment is received from an insurance company, the MA should record it in the practice's day sheet or ledger. **Ledgers** are used to record financial transactions. These include patient payments, insurance payments, and expenses paid out. Ledgers may be paper or electronic, but electronic forms are much more common. MAs should check patient encounter summaries against the practice's ledger daily for accuracy. The entries should match.

The amount shown on an insurance company's remittance advice (RA) form is recorded as a payment in the patient's account. Any necessary adjustments are made to the charges. There should be no remaining balance if the patient paid the full copayment/coinsurance amount at the time of service and the provider is in the insurer's network. If the patient made a partial payment or the provider is out of network for the patient's insurer, the remaining balance is billed to the patient.

Patient billing is a common MA task. This usually occurs throughout the month in **billing cycles**. Billing cycles can be created by dividing patients into groups. Each office uses its own system. Grouping patients alphabetically or by date of service are common ways to create billing cycles. For example, patients whose last names begin with A–G may be billed in week one, H–N in week two, O–T in week three, and U–Z in the final week of the month. Most medical offices send monthly bills to patients with outstanding balances (money owed).

Medical offices often provide care for patients who are uninsured or need help paying for health care. Patients with insurance plans with high deductibles or patients who need expensive care may not be able to pay for services all at once. MAs may act as a patient navigator in finding out if the patient is eligible for public insurance or financial assistance with medical bills. Federal agencies, nonprofit social services, and *indigent programs*, often run by county

governments, can help patients with low incomes pay medical expenses. A person who lives in extreme poverty may be referred to legally as *indigent*. These patients may be eligible for Medicaid or other programs that support low-income people. MAs should keep a current list of agencies and programs that help patients in need.

Creating a Resource List

MAs can find nonprofit and government agencies and programs available to assist patients from different sources. Many city and county governments list resources on their websites. The United Way is a nonprofit organization that raises funds for other nonprofits all across the US. Each United Way chapter creates a list of the organizations they fund. These lists are published on local chapter websites, along with the services provided. The site *findhelp.org* is another resource for finding assistance programs in a community. An MA can use these resources to create a list of service providers in their area. They should consider the needs, cultures, and socioeconomic factors most common among patients seen in their office.

A healthcare provider may adjust customary fees for patients with low incomes. These adjustments are often made using **sliding scales**. A sliding scale uses the patient's household income (the total income that all individuals in the family earn) to set the cost of services (Fig. 10-2). The cost of services rises as income rises. For example, a family of three earning less than \$22,000 per year would be charged less than a similar family earning \$44,000 per year.

MAs must follow policies for using sliding scales. They must keep accurate records of patient accounts. The patient's eligibility is always verified before fees are adjusted. Patients provide proof of income, such as the most recent year's tax return. This can show that they are eligible for adjustments. It is important that systems such as a sliding scale be used the same way for all patients. If a provider's fees are not consistent and clearly documented, the provider could be accused of discrimination.



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Sliding Scale for Medical Services

Number in household	Income for \$20 fee (100% federal poverty guideline)	25% of charges (income up to/ including 150% FPG)	50% of charges (income up to/ including 175% FPG)	75% of charges (income up to/ including 200% FPG)	Full charge (income above 200% FPG; income more than)
1	\$12,880.00	\$19,320.00	\$22,540.00	\$25,760.00	\$25,760.00
2	\$17,420.00	\$26,130.00	\$30,485.00	\$34,840.00	\$34,840.00
3	\$21,960.00	\$32,940.00	\$38,430.00	\$43,920.00	\$43,920.00
4	\$26,500.00	\$39,750.00	\$46,375.00	\$53,000.00	\$53,000.00
5	\$31,040.00	\$46,560.00	\$54,320.00	\$62,080.00	\$62,080.00
6	\$35,580.00	\$53,370.00	\$62,265.00	\$71,160.00	\$71,160.00
7	\$40,120.00	\$60,180.00	\$70,210.00	\$80,240.00	\$80,240.00
8	\$44,660.00	\$66,990.00	\$78,155.00	\$89,320.00	\$89,320.00
If more than 8 individuals in household, add this amount for each person	\$4,540.00	\$6,810.00	\$7,945.00	\$9,080.00	\$9,080.00

Fig. 10-2. Sliding scales are used to adjust customary fees for patients with low incomes.

Case Study: Denise

Denise makes an appointment with Dr. Adenaike for an annual physical exam. She is concerned about the cost of the visit since she has no health insurance. Dr. Adenaike's MA, Jake, tells her that Hartman Physicians' Group uses a sliding scale to determine the cost of care for patients without insurance. What information will Jake need to let Denise know how much her physical will cost? What kinds of organizations might she be referred to for help?

Most practices offer discounts to patients in certain cases. Cash discounts may be given to uninsured patients. Professional courtesy discounts may be offered to other healthcare providers and staff members. Each practice must have clear, written policies for lowering rates or making any change to their usual fee schedules. These must be applied consistently to avoid charges of discrimination or breaching agreements with insurers. MAs must know their office's policies for offering discounts. Fees must never be adjusted in a way not supported by written office policy.

2. Describe patient accounts and statements

Patient accounts and statements can be managed manually or electronically. Most practices use an electronic system. A few practices, though, still use manual systems of accounting. One benefit of electronic systems is that they reduce the risk of calculation errors. A practice may use separate practice management software or an EHR that can manage patient accounts. All electronic programs must be HIPAA-compliant to secure patients' protected health information.

Some offices use both electronic and manual bookkeeping methods. For example, an MA may enter payments manually into a ledger or on a day sheet at the time of the visit and also record transactions in the patient's electronic account record. The MA must be able to work with both manual and electronic bookkeeping methods.

Accuracy is vital when dealing with patient accounts. MAs should carefully follow office policies for recording account information.

Guidelines: Managing Patient Accounts and Financial Transactions

- G Schedule a regular time and location to perform accounting tasks.
- G Keep financial documents well organized.
- G Write clearly when recording transactions manually.
- G Double-check all entries. Calculation errors are less likely in an electronic system, but when numbers are entered incorrectly, the calculations will not be correct.
- G Write your initials by entries if using a manual system. Electronic record entries are tracked by username and password.
- G Organize manual financial records chronologically (ordered by date). These records

must be kept by the practice for a minimum of three years after a tax return has been filed for a particular year.

As discussed previously, patients with outstanding balances are billed monthly. Account statements are used by most offices to bill patients (Fig. 10-3). These can be created electronically by printing account statements or manually by making copies of patient ledgers. Statements should include the provider's and patient's names and addresses, the date or dates of service, and an itemized list of services and charges. The account statement also shows payments made by the patient and his insurer, and the total balance that is due to the practice. Any adjustments (discounts) that have been made to the account are also shown. For example, if the patient's insurance allows \$100 for a procedure that normally costs \$125, the MA would record a \$25 discount to the patient's balance.

Hartman Physical Therapy Group
1140 Natalie Ave NW
Albuquerque, NM 87107
Phone: 505.243.1276

Patient Information:
Name: [Redacted]
Address: [Redacted]
City: [Redacted] State: [Redacted] Zip: [Redacted]

Statement Summary:

DATE	DESCRIPTION	CHARGE	INSURANCE	PATIENT
07/07/2021	Office or other outpatient visit, established patient, moderate complexity	\$121.00	\$121.00	\$0.00
07/07/2021	Home visitation, progressive, as in 94000	\$179.50	\$179.50	\$0.00
10/05/2021	Discounted Adjustment from Insurance		\$ -125.82	\$0.00
10/05/2021	Payment from Insurance		\$ -179.21	\$0.00
10/05/2021	Transfer from Insurance		\$ -15.47	\$0.00
	BALANCE			\$15.47

Summary:
Total Charges: \$300.50
Total Payments: \$315.47
Total Balance: \$15.47

Fig. 10-3. Account statements are often used to bill patients for healthcare services.

Patient account statements should be addressed to the patient's guarantor. This is the person who is financially responsible for the account.

Large medical practices may use an outside agency for patient billing, but MAs still manage patient accounting records in the office.

Medical offices typically accept many forms of payment. These include cash, personal check, and credit or debit cards. A **check** is a bank draft that directs funds to be taken from a bank account to pay an expense. Many practices also accept electronic payments from a smartphone (Fig. 10-4).

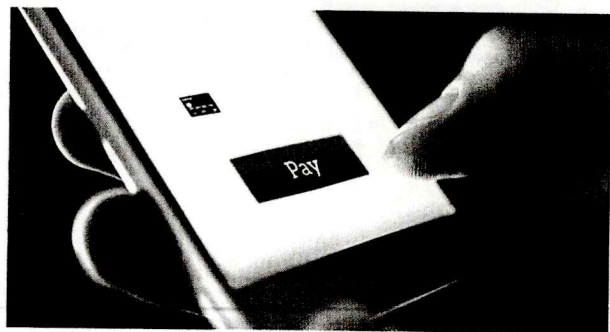


Fig. 10-4. Phone payment systems are becoming more common.

Care should be taken with each method. Cash should be counted in front of the patient and a receipt provided. This protects both the medical practice and the patient by making sure that the correct amount is paid. The MA should match a patient's identification to the name printed on a personal check. Checks may be returned to the practice for *nonsufficient funds (NSF)* if there is not enough money in the patient's bank account to cover the amount of the check. This is known as a *bounced check*. The medical office's bank may charge a service fee when a check is returned. Another form of payment may be required if a patient bounces checks often.

Most offices also accept debit, or bank, cards and credit cards for payment. Debit card payments come directly from the patient's bank account. Credit card payments are paid immediately by the credit card company and then billed to the cardholder. The practice pays a small fee for each debit or credit card transaction. Cards are easier to manage than cash.

They guarantee payment without the NSF risk of checks. For this reason, most practices consider the fees to be worth paying. Many practices also allow patients to make online payments, either through a patient portal or a payment site.

Patients cannot always make full payment at the time of service. The medical office may enter into a payment plan agreement with a patient who cannot pay in full. Payment plans allow patients to pay part of their balance each month. The office may charge interest on the unpaid amount and add extra fees for late payments.

Interest is money that is paid at a set percentage rate for a debt. For example, a 5% interest charge may be added to the total amount of outstanding (unpaid) debt at the end of each billing cycle. If interest is charged, it must be charged to all patients according to the same rules (e.g., paid on balances over 30 days past due).

Accounts that require more than four months to pay are regulated by the federal Truth in Lending Act (TILA). TILA is part of the Consumer Credit Protection Act. It requires that patients be told the total costs of payment plans, including any interest. They must also be told in advance about payment due dates and late fees. This is known as a *TILA disclosure*.

Payment Plan Calculations

If a facility charges \$4,800 for a procedure and the patient has a 20% coinsurance plan, the patient's responsibility is calculated by multiplying \$4,800 by 20% ($\$4,800 \times 0.20 = \$960$). This amount (\$960) is known as the *principal*, or amount of the loan. Interest is calculated on this loan on a monthly basis. The interest is based on the amount of the principal. If the interest rate is 5% annually (per year), the first month's interest is calculated by multiplying the principal by 5% ($\$960 \times 0.05 = \$48$) and then dividing by 12, the number of months in a year ($\$48 \div 12 = \$4$). The amount of interest will be different each month since the principal balance will be lower with each payment. If electronic methods are used to manage patient accounts, the software calculates costs automatically.

Payment agreements with TILA disclosures must be documented in writing and signed by both the patient and the provider. The disclosure is kept on file as long as the patient has an outstanding balance. MAs are responsible for explaining payment plan policies and information about TILA to patients. They must make sure that proper procedures are followed with these agreements.

Case Study: Denise

Denise's income and household size are used to calculate her payment using the office's sliding scale. Jake tells her that her physical exam will be discounted from \$175 to \$87.50. She is unable to pay more than \$20 per month. Describe how Jake will arrange a payment plan and inform her of the office's payment policies. Will this payment agreement require a TILA disclosure?

3. Understand the collection process and the life cycle of a patient bill

One advantage of an electronic billing program is the ability to run reports and collect information about payments and outstanding balances. These reports provide a good picture of a practice's financial situation. An **aging report** shows the length of time that has passed since a charge was posted to an account, such as 30 days, 60 days, or 90 days. This report allows the office to see if an account is **delinquent**, or overdue for payment. Typically a patient's account is considered delinquent when a payment is more than 120 days past due. The aging report is often included on the patient's account statement. This alerts patients to past-due payments.

MAs must try to collect payment from patients in a timely manner. Account statements should inform the patient when payment is overdue. A brightly colored sticker or a handwritten note may be used to call attention to the overdue balance.

Sometimes further action is needed to collect payment. For example, MAs may contact patients by telephone to request payment. When trying to collect payments, medical offices should follow federal Fair Debt Collection Practices Act (FDCPA) regulations. This act prohibits abusive, deceptive (dishonest), and unfair debt collection practices, such as making threats. It was created to apply to *third-party* debt collectors. These are companies that work to get payment on behalf of the original service provider. Some states, however, have laws similar to the FDCPA that apply to all businesses collecting payments. Following FDCPA practices is also an ethical way to collect on patient accounts.

Ethical Debt Collection

The Fair Debt Collection Practices Act established actions that are illegal to use to collect a debt. Based on these regulations, the following must be avoided:

- Contacting the patient at unusual times, such as before 8:00 a.m. or after 9:00 p.m.
- Contacting the patient at their place of employment
- Speaking with someone other than the patient (or guarantor) about the debt
- Leaving details about the debt on voicemail messages
- Making harassing or abusive statements, such as threats and insults
- Making false or misleading statements, such as implying that the patient has committed a crime by not paying the debt

In addition to following the law, collecting debt ethically shows compassion. Patients who are financially stressed are more likely to work with an office that provides flexibility and treats them with dignity.

MAs should be professional when communicating with a patient about debt. The goal is to collect payment for services. The MA should ask for payment of the debt and offer to create a payment plan (according to practice policy) if the patient cannot pay the full amount due

(Fig. 10-5). The patient's debt should never be discussed with anyone other than the patient or the patient's guarantor, who is responsible for payment.



Fig. 10-5. Patients with past due balances are often willing to discuss a payment plan.

If the patient does not make payment after a first collection call, additional phone calls should be made regularly, for example on a weekly basis. If phone calls do not work, a collection letter may be sent to the patient. This letter should be respectful and professional. It should invite the patient to contact the office to discuss payment of their bill. If there is no response to the first letter, a second letter may be sent. Letters should follow FDCPA regulations and address payment without using unfair practices.

A patient account is generally considered **uncollectible** after three letters have been sent with no response from the patient. The last

letter should let the patient know that the remaining balance will be sent to a collection agency if it is not paid within a set number of days, according to office policy. In this case, the office may terminate the patient-provider relationship by sending a certified letter to the patient. (Chapter 7 includes more information about terminating services.) A notice that the provider plans to terminate the patient-provider relationship should be included in the last letter.

Accounts that are considered uncollectible may be turned over to a **collection agency**. These agencies work to collect old debts. They keep a percentage of the debt they collect. After a debt is sent to a collection agency, there are different ways the office may account for the balance. The amount owed may be transferred to an accounting category called **bad debt**. It may also be left as a debit on the patient's account until the collection agency has tried to recover the money.

If the patient pays, the collection agency deducts its payment. The agency then sends the remainder to the medical office. This payment, and the agency's fee, are recorded according to policy. For example, if the original bill was \$150 and the collection agency paid \$75 to the office, that amount would be recorded in the patient's account or the bad debt account, along with a \$75 adjustment for the agency's fees.

The charges for an encounter can be tracked from the time of the visit to the date that the charge is paid in full. Although practices vary, the life cycle of a charge generally includes the following:

- The patient sees their healthcare provider and pays their copay and/or coinsurance at the time of the visit.
- Immediately following the encounter, the MA records the cost of the service in the patient's account statement.

- The amount paid in copayment/coinsurance is credited against the total cost (subtracted from the amount due).
- A claim is made with the patient's insurance company for the remaining amount; the date of the claim is noted in the patient's account.
- The insurance company processes the claim and sends payment and RA to the provider.
- The MA records the payment in the patient's account along with any charge adjustments shown on the RA statement.
- The patient is billed for any remaining balance for which they are responsible.
- If payment is not made, a second bill is sent. This bill should include a notice that the account is past due.
- After the second billing cycle, the MA should contact the patient to ask about the balance and request payment.
- If the balance is not paid by the third billing cycle, that bill may include a warning that it will be submitted to a collection agency.
- When the balance exceeds 120 days, the practice may choose to send a certified letter of termination to the patient and send the account to collections.

Sometimes efforts to collect payment do not succeed. When it is clear that a payment will not be collected, the amount should be removed from the practice's expected income. This is known as a *write-off*. Write-offs are performed by making an adjustment in the account record for the amount of the expense that is being removed.

Write-offs may also be used to discount services when patients are unable to pay for medical care or for unpaid balances small enough that they would cost more to collect than they are worth. Providers should follow policy carefully when using write-offs to discount services or remove small past-due balances. The Equal Credit

Opportunity Act (ECOA) prohibits discrimination against applicants for credit. A patient in a similar situation may be able to file discrimination charges unless he is provided with the same discount.

Case Study: Denise

Two months have passed since Denise's examination. She made an initial payment of \$20 at the time of her visit. She has received two patient account statements with no response. Describe what actions Jake can take to collect payment.

4. Explain accounts payable and receivable and practice assets and liabilities

The medical office has both **accounts payable (A/P)**, or planned expenses, and **accounts receivable (A/R)**, or expected income. For the practice to be successful, accounts receivable should be a larger amount than accounts payable. When the income of the office is greater than the expenses, the practice is said to be operating at a *profit*. When expenses exceed income, the office is operating at a *loss*. MAs often keep a daily record of all A/P and A/R transactions. These records are sent regularly to a practice's accountant or other financial manager to produce reports about the financial health of the business.

Most accounts payable need to be categorized in order to track expenses. Each disbursement, or payment, is categorized when it is recorded on the daily record. Common expense categories include payroll (one of the largest expenses), taxes, equipment, supplies, utilities, and services. A service category can be used for companies that provide necessary services to the practice. Examples include a biohazardous waste management company that handles sharps disposal or an office cleaning service (Fig. 10-6). MAs may pay A/P expenses electronically using a bank's bill payment application or with a paper check (described in the next learning objective). Financial

management software makes it easy to categorize expenses and track expenses.



Fig. 10-6. Medical offices may need services from a variety of outside vendors.

Accounts receivable, or money that is owed to the practice, should also be categorized to track income. Common categories include patient payments, insurance payments, and interest earned on bank accounts.

The **assets** and **liabilities** of a practice provide important information about its financial health. Assets are what the business owns, such as the practice's income, money held in bank accounts, an office building (if it is owned rather than leased), medical equipment, and furniture. Accounts receivable are counted as part of the practice's assets. A liability is an expense item, or an account payable, such as a utility, a service contract fee, or taxes owed. An

example of a liability is an expensive piece of medical equipment, such as an X-ray machine, that cannot be purchased in one payment. The machine could be purchased and paid for over time by making monthly payments, or installments. The loan for the machine becomes a liability for the business.

A medical practice that is in good financial shape should have more assets than liabilities. The practice's *net worth* is a measure of its financial stability. It is calculated by subtracting the practice's liabilities from its assets. If assets are greater than liabilities, the practice has a positive net worth. If there are more liabilities than assets, the practice has a negative net worth. Net worth may be used by financial institutions to make decisions about giving credit to the practice.

5. Discuss bank accounts and check handling

MAs may have administrative duties related to the medical office's bank accounts. Bank accounts are used to deposit income and pay the expenses of the practice. The office may have one or more types of accounts. Checking accounts are essential. They are used for daily financial transactions. Some practices also have savings accounts. Savings accounts, unlike most checking accounts, pay interest. They may be used to hold funds that are not needed for daily operations.

Banking transactions may be done manually or electronically. Most medical offices use accounting software to manage business finances. These programs require training to use but have many advantages, such as built-in calculations and the ability to run reports to track income and expenses. Practices may use both manual and electronic forms of financial recordkeeping. For example, the office may use accounting software to manage bank accounts as well as a manual ledger to record daily financial transactions.

A practice's bank accounts must be managed securely. Unauthorized users should not be able to access them. Paper bank records, such as receipts for deposits, must be filed in a locked area. Authorized users should have a unique username and password for the account. This information should never be shared.

The financial duties of the practice are divided among the authorized users to provide accountability. MAs may be authorized to enter (or *post*) transactions, make deposits, and prepare checks. They do not usually have the authority to sign checks. This separation of duties guards against **embezzlement**. Embezzlement is a type of theft in which an employee steals from their employer.

MAs who receive patient payments must be familiar with the information on a check. When payments are made, the account owner is known as the *payer*, and the person who receives payment is the *payee*. Checks contain bank information that directs payment from the payer's account. The check lists the account holder's name and address in the upper left corner. The name of the payee is written below the account holder's information. A date line appears near the upper right corner of the check.

The payment amount is recorded twice on each check. The amount box appears to the right of the payee's name. The amount, or legal line, is below the payee's name with the word *dollars* usually printed to the right of the line. The payment amount is listed here in written words. The memo line is at the bottom left of the check. It provides a space to note the purpose of the check (if desired). The signature line at the bottom right of the check is for authorized account holders to sign.

Checks must have several elements in order to be **negotiable**, or payable. These include the following:

- The payee's name should be recorded along with the amount of the payment.

- The amounts in the amount box and legal line should match.
- The check must be signed by the payer.
- The date must be entered on the check. It should be noted before a check is accepted. Most checks are valid for six months.

A negotiable check must contain information about the bank in order for payment to be made from the correct account. The American Banking Association (ABA) assigns a unique number, known as an **ABA number**, to each bank in the US. This number appears as a fraction and is printed on the upper right corner of the check. The bank's logo and other information is printed on the left side of the check just above the memo line.

Each check contains a series of magnetic ink character recognition (MICR) codes that appear along the bottom of the check below the memo and signature lines. These codes are printed in magnetic ink that can be read by bank equipment to process transactions. The series of numbers on the left is the **routing transit number (RTN)** of the bank. In the US, the RTN is nine digits, and each bank has a unique number. The account holder's account number follows the routing number. This is followed by the check number, which also appears at the top right of the check (Fig. 10-7).

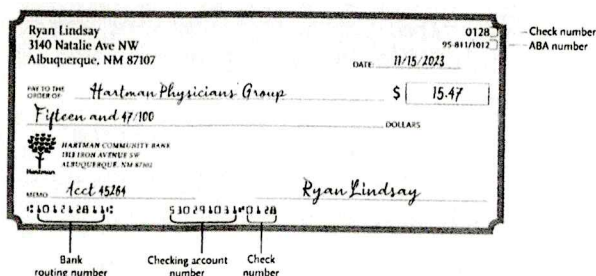


Fig. 10-7. The MA must recognize when a check is filled out correctly and should know what each part of the check means.

When checks are received, they must be **endorsed** before they can be deposited into the

practice's bank account. This involves signing or stamping the back of the check. It shows that the check has been accepted for payment. MAs should endorse checks right away and place them in a locked box or drawer. There are several types of endorsements.

A blank endorsement is made with the signature of the payee. It is the most common endorsement. It is most often used by personal account holders.

A restrictive endorsement directs the payment to a specific account. This is the type of endorsement used by businesses. An example of a restrictive endorsement is *For Deposit Only, Hartman Physicians' Group, account #258830718*. Many businesses have a stamp to use for restrictive endorsements (Fig. 10-8).

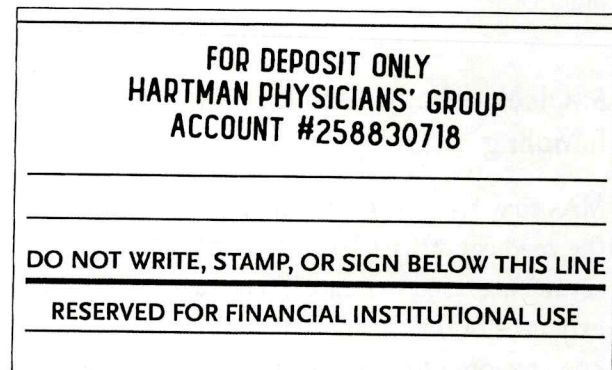


Fig. 10-8. The back of a check has an area for endorsement. The payee should endorse the check in the proper area.

A special endorsement occurs when someone other than the account holder endorses a check for payment. A patient who receives a check for payment of an insurance claim may endorse the check to the medical practice for payment. A check endorsed to the practice by a payee is called a **third-party check**. Checks from an insurance company are likely to be trustworthy. Other types of third-party checks may require the MA to contact the payer's bank to make sure that the check is valid. Third-party payments should be accepted with caution. They are more likely to be rejected for payment.

Checks are not used as often now as they were in the past. In many cases they have been replaced by electronic forms of payment. Many companies use **electronic funds transfer (EFT)** to deposit employees' pay into their personal bank accounts. Most insurance companies use EFT to send payment to providers. Many practices use systems that can process a personal check using EFT. The check is passed through a machine that scans it for deposit. The actual check does not need to be deposited if it is processed as an EFT. It does, however, still need to be recorded.

The record for a checking account is known as a *check register*. The check register may be managed manually or electronically. Although it is called a check register, it is actually a record of all account debits and credits. On a paper register these may be recorded using a one-line or two-line system. Each new credit or debit is recorded on a single line in a one-line system. The two-line system uses two lines to record each transaction. For debits, or money leaving the account, the first line lists the date, who was paid, and the payment amount. For credits, or money entering the account, the date, the source of the funds, and the amount deposited is recorded on the first line. The line below is used to record additional information about the transaction, such as the purpose (Fig. 10-9). Most electronic registers have a field for entering this type of information.

Check number/ transaction type	Date	Transaction description	Withdrawal	Deposit	Balance
3421	9-NOV	Aspen Properties	\$2,350.00		\$10,340.00
DEP	9-NOV	Deposit, patient payments		\$2,540.00	\$12,880.00
3422	9-NOV	John Blackburn	\$200.00		\$12,680.00

Check number/ transaction type	Date	Transaction description	Withdrawal	Deposit	Balance
3421	9-NOV	Aspen Properties	\$2,350.00		\$10,340.00
		Rent 11/5 through 12/4			
DEP	9-NOV	Deposit		\$2,540.00	\$12,880.00
		Patient payments, 11/8			
3422	9-NOV	John Blackburn	\$200.00		\$12,680.00
		Computer network management			

Fig. 10-9. Banking transactions may be recorded in a checkbook register using a one-line or two-line system.

Case Study: Denise

Denise sends a check to Hartman Physicians' Group for the full amount due for her office visit. What parts of the check should Jake inspect to make sure it is negotiable? Explain how this check will be recorded and deposited into the practice's bank account.

6. Describe supply purchasing and the management of petty cash

In addition to paying regular bills, MAs may be involved in making purchases. Supplies are items that are *consumable*, or items that can only be used once and must be replaced (Fig. 10-10). Each office has different supply needs depending on the type of practice. For example, an orthopedic practice needs supplies to apply casts and splints. An inventory listing the supplies on hand provides a clear picture of what items need to be purchased. More information about this process is found in the next chapter.

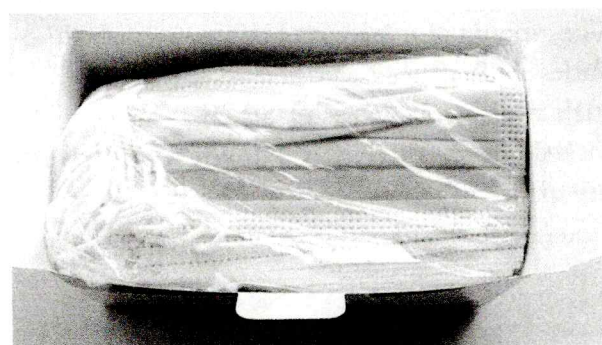


Fig. 10-10. Surgical masks are one type of consumable supply that may be ordered regularly at a medical office.

MAs may be assigned to maintain the supply inventory and make purchases. A *requisition*, often called a **purchase order (PO)**, is a request to make a purchase, and may be used for ordering supplies. Requisitions or POs may require approval from an office manager or a provider. A purchase order number is issued by the practice to confirm that payment is authorized for the supplies ordered. The PO is then sent to the **vendor**, or the business from whom the supplies are being ordered.

Practices may have *blanket purchase orders* that cover the purchase of supplies from frequently used vendors without having to request a new purchase order number. MAs should keep a list of regular vendors for both clinical and administrative supplies. The cost of supplies should be considered when making purchases. Many practices are members of purchasing groups, or groups of healthcare organizations that use the same vendors to purchase supplies at discounted prices.

When new supplies arrive, the packing slip should be compared with the requisition to make sure that all ordered supplies have been received. Most vendors will ship supplies to practices with a record of paying on time without advance payment. The vendor sends an **invoice** (bill) when the order is filled. A practice must make payment promptly, usually within 30 days, to remain in good standing.

Petty cash is cash kept on hand for smaller purchases, such as postage stamps and envelopes. The amount of money kept in a petty cash fund varies. Most offices keep at least \$50 in petty cash available. Petty cash is usually stored in a locked box or safe (Fig. 10-11). When purchases are made with this money, a receipt must be stored with the remaining petty cash.



Fig. 10-11. Petty cash is often kept in a simple locking box, along with receipts and a ledger for recording how the money is spent.

MAs may keep track of the petty cash available and add more when necessary. A transaction

ledger should be kept to record purchases and the current balance. When money needs to be added, a check can be written. The MA should write "Petty Cash" on the payee line of the check. The provider, practice manager, or another authorized person signs the check. The MA can then cash the check at the bank and add the money to the petty cash fund.

Case Study: Denise

Jake is preparing patient account statements, including a statement that shows Denise's payment has been received. He runs out of postage stamps and plans to use petty cash to purchase stamps. Explain what Jake will do to record this purchase.

Chapter Review

1. What is the difference between a physician fee schedule and a sliding scale?
2. Where are all of an office's financial transactions recorded?
3. List three forms of payment that may be accepted in a medical office.
4. Describe a situation in which a medical office may choose not to accept a patient's personal check.
5. After how many days is a patient's bill likely to be considered delinquent?
6. When would a medical office turn a patient's account over to a collection agency?
7. What is the accounting term for money owed to a business?
8. Why should a medical office have policies for separation of the duties related to financial management?
9. What are four features of a negotiable check?
10. Describe how a paper check may be processed as an EFT.
11. What types of purchases may be made using petty cash?

10

Billing, Collections, and Accounting

1. Discuss physician fees and patient billing

Matching

Use each letter only once.

1. ____ Sliding scale
 2. ____ Billing cycle
 3. ____ Credit
 4. ____ Debit
 5. ____ Ledger
 6. ____ Physician fee schedule
- (A) A record of all financial transactions
- (B) A list of the cost of services provided by licensed healthcare professionals
- (C) Created to collect outstanding balances; usually involves grouping patients alphabetically or by date of service
- (D) A set system for adjusting customary fees for patients with low incomes
- (E) Business expenses
- (F) Business income

Short Answer

7. List four examples of expenses a medical practice may have.

8. What is created at every patient visit and lists diagnosis and procedure codes along with any charges?

9. What could happen if a medical office gives discounted services to some patients and not to others?

10. What is the legal term for a person who lives in extreme poverty? What should an MA keep to help support patients in this situation?

11. After an insurance company has made its payment and the patient has paid the required copayment or coinsurance amount, what should the patient account show?

12. How should a medical practice manage discounts such as cash discounts for uninsured patients or professional courtesy discounts for other healthcare providers or staff members?

2. Describe patient accounts and statements

Fill in the Blank

1. Schedule a regular _____ to perform accounting tasks.
2. Calculation errors are _____ in an electronic system, but when numbers are entered _____, the calculations will not be correct.
3. Organize manual financial records _____.
4. Records must be kept a minimum of _____ years after a tax return has been filed for a particular year.
5. Patients with outstanding balances are billed _____.
6. If a patient's insurance allows \$100 for a procedure that normally costs \$125, the MA records a(n) _____ discount to the patient's balance.
7. A(n) _____ is a bank draft that directs funds to be taken from a bank account to pay an expense.
8. Checks may be returned to the practice for _____ if there is not enough money in the patient's _____ to cover the amount of the check.
9. The practice pays _____ for each debit or credit card transaction.
10. _____ is money that is paid at a set percentage rate for a debt.
11. The federal Truth in Lending Act (TILA) requires that patients be told the _____ of payment plans, including any _____. They must also be told in advance about payment due dates and _____.

3. Understand the collection process and the life cycle of a patient bill

Multiple Choice

1. What does an aging report show?
 - (A) Patient demographic information sorted by age
 - (B) The length of time that has passed since a charge was posted to an account
 - (C) The length of time a practice has accepted a particular type of insurance
 - (D) The success of patient treatments sorted by patient age
2. When a patient account has a payment that is more than 120 days past due it is usually considered
 - (A) A total loss
 - (B) Criminally overdue
 - (C) Delinquent
 - (D) Written off
3. What regulations should a medical office follow to collect a past due balance ethically?
 - (A) The Truth in Lending Act (TILA)
 - (B) The Patient Protection and Affordable Care Act (ACA)
 - (C) The Healthcare Quality Improvement Act (HCQIA)
 - (D) The Fair Debt Collection Practices Act (FDCPA)
4. When is a patient debt usually considered uncollectible?
 - (A) After three letters have been sent with no response
 - (B) After 60 days
 - (C) After the patient has not returned three messages left by phone
 - (D) After a patient's check has bounced
5. How are collection agencies paid for their services?
 - (A) They receive a flat fee for every debt turned over to them.
 - (B) They charge a monthly fee to collect as many debts as a practice needs collected.
 - (C) They keep a percentage of the debt they collect.
 - (D) They collect more than what is owed to the provider and keep the extra.

Short Answer

Use numbers 1–11 to order the following steps in the life cycle of a patient bill.

6. ____ If payment is not made, a second bill is sent.
7. ____ A claim is made with the patient's insurance company for the remaining amount.
8. ____ The patient sees their provider and pays their copay at the time of the visit.
9. ____ The patient is billed for any remaining balance for which they are responsible.
10. ____ If the balance remains unpaid, the practice may choose to send a certified letter of termination to the patient and send the account to collections.
11. ____ Immediately following the encounter, the MA records the cost of the service in the patient's account.
12. ____ After the second billing cycle, the MA should contact the patient to ask about the balance and request payment.
13. ____ The amount paid in copayment/co-insurance is credited against the total cost (subtracted from the amount due).
14. ____ The insurer processes the claim and sends payment and RA to the provider.
15. ____ If the balance is not paid by the third billing cycle, that bill may include a warning that it will be submitted to a collection agency.
16. ____ The MA records the insurer's payment in the patient's account along with any charge adjustments shown on the RA statement.

4. Explain accounts payable and receivable and practice assets and liabilities**True or False**

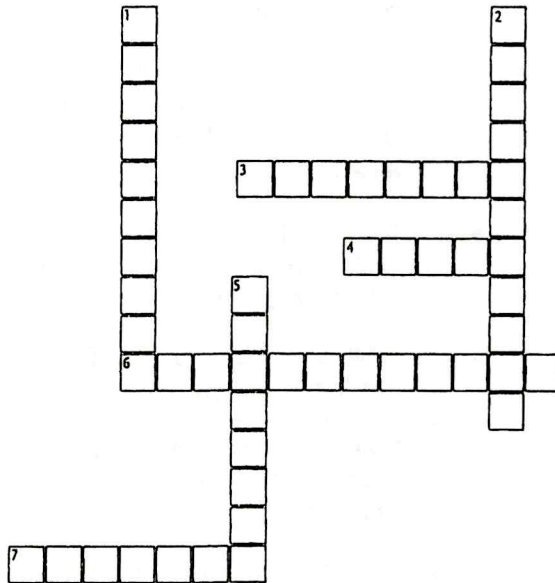
1. ____ A monthly bill from a company that manages biohazardous waste for a medical office is an example of an account payable.
2. ____ In order for a business to be successful, accounts payable should be a larger amount than accounts receivable.
3. ____ Expected payments from insurance companies are an example of accounts receivable.
4. ____ *Assets* and *liabilities* are different words for the same thing.
5. ____ A practice's net worth is calculated by subtracting the practice's liabilities from its assets.
6. ____ Accounts receivable are counted as part of a practice's assets.

5. Discuss bank accounts and check handling**Crossword****Across**

3. The manual or electronic record of all debits and credits to a bank account; may use a one-line or two-line system
4. The person who receives payment from a check
6. Separation of duties protects against this type of theft, in which an employee steals from their employer.
7. A number that is unique to a bank and is printed on a check along with the account number

Down

1. The term used to describe a check that has the proper elements to be payable
2. The signing or stamping of the back of a check
5. This type of bank account is used for daily financial transactions.



6. Describe supply purchasing and the management of petty cash

Short Answer

1. How is a blanket purchase order used?

2. What does *consumable* mean?

3. What are consumable items called?

4. What is the benefit of being part of a purchasing group?

5. How soon should an invoice be paid in order to remain in good standing with a vendor?

6. What is written on the payee line of a check used to get petty cash?

7. After a shipment of supplies arrives at a medical office, what must be done with the packing slip?
