Learning Outcomes

After studying this chapter, you should be able to:

1.1 Explain how healthy practice finances depend on correctly accomplishing administrative tasks in the medical office.
1.2 Compare coinsurance and copayment requirements for health plan benefits.
1.3 Identify the key steps in the medical billing cycle.
1.4 Discuss the impact of electronic health records on clinical and billing workflow.
1.5 Evaluate the importance of professional certification and of medical liability insurance for career advancement.
Patients who come to physicians’ practices for medical care are obligated to pay for the services they receive. Some patients pay these costs themselves, while others have medical insurance to help them cover medical expenses. Administrative staff members help collect the maximum appropriate payments by handling patients’ financial arrangements, billing insurance companies, and processing payments to ensure both top-quality service and profitable operation.

1.1 Working with Medical Insurance

The trillion-dollar health care industry—including pharmaceutical companies, hospitals, doctors, medical equipment makers, nursing homes, assisted-living centers, and insurance companies—is a fast-growing and dynamic sector of the American economy.

Spending on health care in the United States continues to rise. Advances in medical technology improve health care delivery but are expensive. Health care reform legislation requires insurance coverage for a growing number of people. Perhaps most importantly, the aging American population requires more health care services. Average life expectancy is increasing and a larger percentage of the population is over age 65. Older people need more health care services than do younger people. Two-thirds of Americans over 65 and three-quarters of those over 80 have multiple chronic diseases, such as diabetes, hypertension, osteoporosis, and arthritis.

Since medical costs are rising faster than the overall economy is growing, more of everyone’s dollars are spent on health care. Federal and state government budgets increase to pay for medical services, employers pay more each year for medical services for their employees, and patients also pay higher costs. These rising costs increase the financial pressure on physicians’ practices. To remain profitable, physicians must carefully manage the business side of their practices. Knowledgeable administrative medical office employees are in demand to help.

Medical administration tasks in medical offices may be handled by employees who have various educational backgrounds and work experience, such as administrative medical assistants, medical assistants, medical billers, patient services specialists, and receptionists. (In this text, for simplicity, the term medical assistant includes all of these administrative medical employees.) Their effective and efficient work is critical for the satisfaction of the patients—the physician’s customers—and for the financial success of the practice.

To maintain a regular cash flow—the movement of monies into or out of a business—specific tasks must be completed on a regular schedule before, during, and after a patient visit. Managing cash flow means making sure that sufficient monies flow into the practice from patients and insurance companies paying for medical services, referred to as accounts receivable (AR), to pay the practice’s operating expenses, such as for overhead, salaries, supplies, and insurance—called accounts payable (AP). Tracking AR and AP is an accounting job. Accounting, often referred to as “the language of business,” is a financial information system that records, classifies, reports on, and interprets financial data. Its purpose is to analyze the financial condition of a business following generally accepted accounting principles. The practice accountant sets up accounts such as AR, AP, and Patient Accounts for all aspects of running the practice and then prepares financial statements that show whether the cash flow is adequate. These statements are monitored regularly to see if revenues are sufficient or need improving.

For this reason, revenue cycle management (RCM)—acting to ensure that the practice receives all appropriate payments from both insurance companies and patients, and gets them on time—is critical to practice success. Medical assistants have an important role in revenue cycle management. They help to ensure financial success by (1) carefully following procedures, (2) communicating effectively, and (3) using health information technology—medical billing software, electronic health records, Microsoft Office, and the Internet—to improve efficiency and contribute to better health outcomes.
Following Procedures

Medical administrative work requires following a set of procedures. Some procedures involve administrative duties, such as entering data, updating patients’ records, and billing insurance companies. Other procedures are done to comply with government regulations, such as keeping computer files secure from unauthorized viewing. In most offices, policy and procedure manuals are available that describe how to perform major duties.

For most procedures, medical assistants work in teams with both licensed medical professionals and other administrative staff members. Providers include physicians and nurses as well as physician assistants (PAs), nurse-practitioners (NPs), clinical social workers, physical therapists, occupational therapists, audiologists, and clinical psychologists. Administrative staff may be headed by an office manager, practice manager, or practice administrator to whom medical assistants, patient services representatives or receptionists, and billing, insurance, and collections specialists report.

Communicating with Physicians and Patients

Communication skills are as important as knowing about specific forms and regulations. Using a pleasant tone, a friendly attitude, and a helpful manner when gathering information increases patient satisfaction. Having interpersonal skills enhances the billing and reimbursement process by establishing professional, courteous relationships with people of different backgrounds and communication styles. Patients may need help with their questions about insurance reimbursement and the health care claim process. Patients also need assistance when problems with payments arise. Effective communicators have the skill of empathy; their actions convey that they understand the feelings of others.

Equally important are effective communications with physicians, other professional staff members, and all members of the administrative team. Conversations must be brief and to the point, showing that the speaker values the provider’s time. People are more likely to listen when the speaker is smiling and has an interested expression, so speakers should be aware of their facial expressions and should maintain moderate eye contact. In addition, good listening skills are important.

Using Health Information Technology

Medical assistants use health information technology (HIT)—computer hardware and software information systems that record, store, and manage patient information—in almost all physician practices.

Practice Management Programs

A good example of HIT is practice management programs (PMPs), specialized accounting software programs used in almost all medical offices for tracking charges for patients’ services and treatments, billing insurance companies and patients, recording payments, and collecting overdue accounts. Most programs also have the ability to schedule patient appointments. Since PMPs can send information electronically, rather than just on paper, cash flow is improved because physicians receive payment in less time than when they send in paper claims and wait for checks to arrive in the mail.

Practice management programs facilitate the day-to-day financial operations of a medical practice. Before PMPs became so universally used, manual accounting systems logged all of this information by hand, a time-consuming and cumbersome process. Now PMPs automate that work, so staff members can work more efficiently and in a timely manner.

Not all medical offices use the same PMP, but most programs operate in a similar manner. Initially, the program is prepared for use by entering basic facts about
the practice. Often a computer consultant or an accountant helps set up these records. Information about many aspects of the business is entered, including:

- **Patient data** Information about each patient, such as name, address, contact numbers, and insurance coverage.
- **Provider data** Information about each provider, including facts about providers, referring providers, and outside providers such as labs, radiology, and ambulatory surgery centers.
- **Health plan data** Details about the companies that insure the practice’s patients.
- **Transaction data** The dates of patients’ past visits along with records of their illness and treatments, as well as payments collected.

Once the initial setup and data entry are complete, the PMP is ready to be used to accomplish many of the daily tasks of a medical practice.

**Electronic Health Records**

Another HIT application is rapidly becoming critical in physician practices: electronic health records, or EHRs. While patients’ financial records have been electronic for over a decade, clinical records—the documentation of a patient’s health entered by doctors, nurses, and other health care professionals—until recently, have been stored in paper charts. An electronic health record (EHR) is a computerized lifelong health care record for an individual that incorporates data from all sources that provide treatment for the individual. EHR systems are set up to gather patients’ clinical information using the computer rather than paper. Most EHR systems are designed to exchange information with—to talk to—the PMP and to cut out the need for many paper forms.

**PM/EHRs**

Some software programs combine both a PMP and an EHR in a single product called an integrated PM/EHR. Data entered in either the PMP or the EHR can be used in all applications, such as scheduling, billing, and clinical care. For example, if a receptionist enters basic information about a patient in the electronic health record during the patient’s first visit to the practice, that data is automatically available for the medical assistant to use in the billing program. Facts such as the patient’s identifying information, type of health insurance, and previous health care records must be entered only once, rather than in both programs. PM/EHRs greatly improve administrative efficiency.

**A Note of Caution: What Health Information Technology Cannot Do**

Although computers increase efficiency and reduce errors, they are not more accurate than the individual who is entering the data. If people make mistakes while entering data, the information the computer produces will be incorrect. Computers are very precise and also very unforgiving. While the human brain knows that flu is short for influenza, the computer regards them as two distinct conditions. If a computer user accidentally enters a name as ORourke instead of O’Rourke, a human might know what is meant; the computer does not. It might respond with the message “No such patient exists in the database.”

**THINKING IT THROUGH 1.1**

1. The Internet is a valuable source of information about many topics of interest to those who will be working in the health care industry. Explore career opportunities by studying the job statistics for medical assistants in the Occupational Outlook Handbook of the Bureau of Labor Statistics at www.bls.gov/oco. Based on your research, would you say the prospects were favorable or unfavorable for growth in this profession?
1.2 Paying for Medical Services

People need preventive care, such as routine checkups and vaccinations, to stay healthy. They also need treatment for sicknesses, accidents, and injuries. A person who receives medical care is charged for the medical services and supplies that are involved. To be able to afford the charges, many people in the United States have medical insurance, which is an agreement between a person, who is called the policyholder, and a health plan. Health plans, also called insurance companies, are organizations that offer financial protection in case of illness or accidental injury.

There are actually three participants in the medical insurance relationship. The patient (policyholder) is the first party, and the physician is the second party. Legally, a patient–physician contract is created when a physician agrees to treat a patient who is seeking medical services. Through this unwritten contract, the patient is legally responsible for paying for services. The patient may have a policy with a health plan, the third party, which agrees to carry some of the risk of paying for those services and therefore is called a third-party payer, often referred to just as a payer. The physician usually sends the health care claim—a formal insurance claim in either electronic or hard copy format that reports data about the patient and the services provided by the physician—to the payer on behalf of the patient.

Insured versus Noninsured Patients

Medical insurance helps pay for the policyholder’s medical treatment. Nearly 250 million people in the United States have medical coverage through commercial payers or are eligible for government programs. Nearly 50 million people—about 16 percent of the population—have no insurance. Many of the uninsured people work for employers that either do not offer health benefits or do not cover certain employees, such as temporary workers or part-time employees. People without insurance are responsible for their own bills without benefit of insurance.

Insurance Basics

A person who buys medical insurance pays a premium to a health plan. In exchange for the premium, the health plan agrees to pay amounts, called benefits, for medical services. Most health plans require the beneficiary to pay an annual amount called a deductible before they make any payments on the patient’s behalf. Medical services include the care supplied by providers—hospitals, physicians, and other medical staff members and facilities.

The health plan issues the policyholder an insurance policy that contains a list of covered services that is called a schedule of benefits. Benefits commonly include payment of medically necessary medical treatments received by policyholders and their dependents. The Health Insurance Association of America defines the insurance term medically necessary as “medical treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice.” The place of service must also be appropriate for the diagnosis and care provided. In general, the procedure must meet these conditions to be considered necessary:

- Procedures or services match the patient’s illness.
- Procedures are not elective (that is, they are required to treat a condition, rather than being elected to be done by the patient).
- Procedures are not experimental. The procedures must be approved by the appropriate federal regulatory agency, such as the Food and Drug Administration.
- Procedures are furnished at an appropriate level. Simple diagnoses need simple procedures; complex or time-consuming procedures are reserved for complex conditions.

Typical covered medical services include surgical, primary care, emergency care, and specialists’ services. Other medically related expenses, such as hospital-based services,
are usually included. Many health plans also cover preventive medical services, such as annual physical examinations, pediatric and adolescent immunizations, prenatal care, and routine cancer screening procedures such as mammograms. Policies list treatments that are covered at different rates and medical services that are not covered. For example, a plan may pay 80 percent of most physically related treatments but a smaller percentage of the charges for drugs and medications. The medical insurance policy also describes noncovered (excluded) services—what it does not pay for. For example, dental care is generally not included. (However, separate dental insurance plans are available for purchase.) Table 1.1 shows the basic types of insurance that can be bought.

**Private Insurance**

Private (also known as commercial) health plans offer a variety of types of medical insurance coverage. Most people enrolled in private insurance are covered under group contracts—policies that cover people who work for the same employer or belong to the same organization, such as school employees and labor unions. Other plans are offered as individual contracts, which are policies purchased by people who do not qualify as members of a group.

Some employers have established themselves as self-insured health plans. Rather than paying a premium to an insurance carrier, the organization assumes the risk of paying directly for medical services, establishes contracts with local physician practices, and sets up a fund with which it pays for claims. The organization itself establishes the benefit levels and the plan types it will offer.

People may also have medical coverage through their liability insurance and automobile insurance. For example, people injured in automobile accidents may be insured through the medical benefit of their or another party’s automobile policy. Coverage varies by state.

**Government Plans**

The most common government plans in effect in the United States are:

- Medicare—Medicare is a federal health plan that covers most citizens aged 65 and over, people with disabilities, end-stage renal disease (ESRD), and dependent widows.
Medicaid—Individuals with low income who cannot afford medical care are covered by Medicaid, which is cosponsored by federal and state governments. (Medicaid is a state-run program; there are matching federal dollars available for states that satisfy certain requirements, such as providing prenatal care and child vaccinations.) Qualifications and benefits vary by state.

Workers’ Compensation—People with job-related illnesses or injuries are covered under workers’ compensation insurance through their employer. Workers’ compensation benefits vary according to state law.

TRICARE—Covers expenses for dependents of active-duty members of the uniformed services and for retired military personnel. It also covers dependents of military personnel who were killed while on active duty.

CHAMPVA—The Civilian Health and Medical Program of the Department of Veterans Affairs is for the dependents of veterans with permanent service-related disabilities. It also covers surviving spouses and dependent children of veterans who died from service-related disabilities.

Indemnity Plans

In the last century, most medical insurance policies in the United States were indemnity plans. Under an indemnity plan, the medical costs policyholders incur when they receive treatment for accidents and illnesses are paid by the insurance carrier. If a policyholder or a covered dependent (a spouse, child, or other relative specified in the insurance policy) gets sick, the health plan pays most of the bill. Benefits are determined on a fee-for-service basis. In other words, benefits are based on the fees physicians charge for the services.

For each claim, four conditions must be met before the payer makes a payment:

1. The medical charge must be for medically necessary services and covered by the insured's health plan.
2. The insured's payment of the premium must be up-to-date. Unless the premium is current, the insured is not eligible for benefits and the insurance company will not make any payment.
3. If part of the policy, a deductible—the amount that the insured pays on covered services before benefits begin—must have been met (paid). Deductibles range widely, usually from $200 to thousands of dollars annually. Higher deductibles generally mean lower premiums.
4. Any coinsurance—the percentage of each claim that the insured pays—must be taken into account. The coinsurance rate states the health plan's percentage of the charge, followed by the insured's percentage, such as 80/20. This means that the payer pays 80 percent of the covered amount and the patient pays 20 percent after the premiums and deductibles are paid.

The formula is as follows:

\[
\text{Charge} - \text{Deductible} - \text{Patient Coinsurance} = \text{Health Plan Payment}
\]

Example

An indemnity policy states that the deductible is the first $200 in covered annual medical fees and that the coinsurance rate is 80/20. A patient whose first medical charge of the year was $2,000 would owe $560:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge</td>
<td>$2,000</td>
</tr>
<tr>
<td>Patient owes the deductible</td>
<td>200</td>
</tr>
<tr>
<td>Balance</td>
<td>$1,800</td>
</tr>
<tr>
<td>Patient also owes coinsurance (20% of the balance)</td>
<td>$360</td>
</tr>
<tr>
<td>Total balance due from patient</td>
<td>$200 + $360 = $560</td>
</tr>
</tbody>
</table>
In this case, the patient must pay an \textit{out-of-pocket} expense of $560 this year before benefits begin. The health plan will pay $1,440, or 80 percent of the balance:

\begin{align*}
\text{Charge} & \quad 2,000 \\
\text{Patient payment} & \quad -560 \\
\text{Health plan payment} & \quad 1,440
\end{align*}

If the patient has already met the annual deductible, the patient’s benefits apply to the charge, as in this example:

\begin{align*}
\text{Charge} & \quad 2,000 \\
\text{Patient coinsurance (20%)} & \quad -400 \\
\text{Health plan payment (80%)} & \quad 1,600
\end{align*}

\section*{Managed Care Plans: PPOs, HMOs, and CDHPs}

Under indemnity plans, it is difficult for insurance carriers to control costs because there have been few restrictions on providers’ charges, especially for new technology, drugs, and procedures. To counter this trend, the concept of \textit{managed care} was introduced. Managed care is a way of supervising medical care with the goal of ensuring that patients get needed services in the most appropriate, cost-effective setting.

To accomplish managed care goals, the financing and management of health care are combined with the delivery of services. \textit{Managed care organizations (MCOs)} establish links among provider, patient, and payer. Instead of only the patient’s having a policy with the health plan, under managed care both the patient and the provider have agreements with the MCO. The patient agrees to the payments for the services, and the provider agrees to accept the fees the MCO offers for services. This arrangement gives the managed care plan more control over the services the provider performs and the fees the plan pays.

Managed care is the leading type of health plan, and many different kinds of managed care programs are available. The basic types are introduced below.

\subsection*{Preferred Provider Organizations}

The most common type of managed care health plan is a \textit{preferred provider organization (PPO)}. A PPO is a network of providers under contract with a managed care organization to perform services for plan members at discounted fees. Usually, members may choose to receive care from other doctors or providers outside the network, but they pay a higher cost.

\subsection*{Health Maintenance Organizations}

Another common type of managed care system is a \textit{health maintenance organization (HMO)}. In one typical arrangement, providers are paid fixed rates at regular intervals, such as monthly, to provide necessary contracted services to patients who are plan members. This fixed payment is referred to as \textit{capitation}.

The rate the provider is paid is based on several factors, including the number of plan members in the insured pool and their ages. The capitated rate per enrollee is paid to the provider even if the provider does not provide any medical services to the patient during the time period covered by the payment. Similarly, the provider receives the same capitated rate if a patient is treated more than once during the time period. In other plans, negotiated per-service fees are paid. These fees are less than the regular rate for a service that the provider normally charges.

\subsection*{Consumer-Driven Health Plans}

A \textit{consumer-driven health plan (CDHP)} is a type of managed care insurance in which a high-deductible low-premium insurance plan is combined with a pretax savings
account to cover out-of-pocket medical expenses. These plans typically include two elements. The first is an insurance plan, usually a PPO, with a high deductible (such as $2,500), for which the policyholder pays a lower premium than for a plan with a lower deductible.

The second element is a designated health savings account (HSA) that is used to pay medical bills before the deductible has been met. The savings account, similar to an individual retirement account (IRA), lets people set aside untaxed wages to cover their out-of-pocket medical expenses. Some employers contribute to employees' accounts as a benefit. If money is left in the account at the end of a plan year, it rolls over to help cover the next year's health expenses.

Cost Containment

Most health plans, including indemnity plans, now have cost-containment practices to help control costs. For example, patients may be required to choose from a specific group of physicians and hospitals for all medical care. A visit to specialists may require a referral from the patient's primary care physician. A second physician's opinion may be required before surgery can be reimbursed. Also, many services that previously involved overnight hospital stays are now covered only if done during daytime hospital visits, with patients recuperating at home.

In some cases, patients pay fixed premiums at regular time periods, such as monthly. A patient may also pay a copayment—a small fixed fee, such as $10, for each office visit. In some plans, this “copay” is a percentage of the amount the provider receives. In either case, the copayment must always be paid by the patient at the time of service. This is considered to encourage patients to use medical services more carefully.

Preauthorization is another example of a cost-containment practice. If preauthorization is required, the health plan must approve a procedure before it is done in order for the procedure to be covered. For example, many nonemergency services must be approved before patients are admitted to the hospital. Also, shorter hospital stays are encouraged, and weekend hospital admissions for Monday services may not be permitted.

THINKING IT THROUGH 1.2

1. A patient has a health plan with a 70/30 coinsurance requirement. The patient has met the annual deductible for the plan. If today's fees are $800, what amount is billed on a health care claim and what amount does the patient owe?

BILLING TIP

Administrative Complexity

The average practice works with nearly twenty different health plans, and some with over eighty of them.

1.3 The Medical Billing Cycle

It is clear that teamwork is essential in the medical office. The administrative staff members work closely with the professional staff of physicians and nonphysician practitioners. An overall focus is smoothing the way for payments from health plans and from patients. Managing revenue includes much more than entering data in a billing program to complete a health care claim. It requires knowledge of the billing and reimbursement process and the ability to work with a variety of complex insurance plans.

In small physician practices, medical assistants handle a variety of billing and collections tasks. In larger medical practices, duties may be more specialized. Billing, insurance, and collections duties may be separated, or one individual may work exclusively with claims sent to just one of many payers, such as Medicare or workers'
compensation. The administrative functions in larger groups or networks are usually headed by a practice manager, office manager, or administrator to whom the administrative staff, such as clinical/administrative medical assistants, transcriptionists, receptionists, accounting personnel, and billers, report.

The physicians and, often, the practice manager determine the medical assistant’s administrative job duties. Examples include gathering patient information and signatures, filing health care claims, reviewing payments, and helping patients understand insurance procedures. These medical billing tasks, as shown in Table 1.2 and in the inner circle of Figure 1.2 on page 17, require knowledge of the office workflow relating to claims and skills in using the medical billing program, accurately entering data, and carefully proofreading data.

**Table 1.2 Steps in the Medical Billing Cycle**

<table>
<thead>
<tr>
<th>Before the encounter</th>
<th>Step 1: Preregister patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the encounter</td>
<td>Step 2: Establish financial responsibility</td>
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<tr>
<td></td>
<td>Step 3: Check in patients</td>
</tr>
<tr>
<td></td>
<td>Step 4: Review coding compliance</td>
</tr>
<tr>
<td></td>
<td>Step 5: Review billing compliance</td>
</tr>
<tr>
<td></td>
<td>Step 6: Check out patients</td>
</tr>
<tr>
<td>After the encounter</td>
<td>Step 7: Prepare and transmit claims</td>
</tr>
<tr>
<td></td>
<td>Step 8: Monitor payer adjudication</td>
</tr>
<tr>
<td></td>
<td>Step 9: Generate patient statements</td>
</tr>
<tr>
<td></td>
<td>Step 10: Follow up payments and collections</td>
</tr>
</tbody>
</table>

**Step 1: Preregister Patients**

The first step in the medical billing cycle is to gather information to preregister patients before their office visits. This information includes:

- The patient’s name.
- The patient’s contact information; at the minimum, address and phone number.
- The patient’s reason for the visit, such as a medical complaint or a need for an immunization. (The visit reason is used to calculate an estimated visit length for scheduling appointments, often done at this time as well.)
- Whether the patient is new or returning to the practice (different information is gathered in these two situations).

The information is obtained over the telephone or via the Internet, if the practice has a website.

**Step 2: Establish Financial Responsibility for Visit**

The second step is very important: determine financial responsibility for the visit. For insured patients, these questions must be answered:

- What services are covered under the plan? What medical conditions establish medical necessity for these services?
- What services are not covered?
- What are the billing rules of the plan?
- What is the patient responsible for paying?

Knowing the answers to these questions is essential to correctly billing payers for patients’ covered services. This knowledge also helps medical assistants ensure that patients will pay their bills when benefits do not apply.

To determine financial responsibility, these procedures are followed:

- Verify patients’ eligibility for their health plan.
- Check the health plan’s coverage.
- Determine the first payer if more than one health plan covers the patient (this is the payer to whom the first claim will be sent).
- Meet payers’ conditions for payment, such as preauthorization, ensuring that the correct procedures are followed to meet them.

The practice’s financial policy—when bills have to be paid—is explained so that patients understand the medical billing cycle. Patients are told that they are
responsible for paying charges that are not covered under their health plans. Unin-
sured patients are informed of their responsibility for the entire charge. Payment
options are presented if the bill will be substantial.

Step 3: Check In Patients
The third step is to check in individuals as patients of the practice. When new
patients arrive for their appointments, detailed and complete demographic and
medical information is collected at the front desk (the common term for the recep-
tion area). Returning patients are asked to review the information that is on file
for them, making sure that demographics and medical data are accurate and up-
to-date. Their financial records are also checked to see if balances are due from
previous visits.

Both the front and back of insurance cards and other identification cards such as
driver’s licenses are scanned or photocopied and stored in the patient’s record. If the
health plan requires a copayment, the correct amount is noted for the patient. Co-
payments should always be collected at the time of service. Some practices collect
copayments before the patient’s encounter with the physician; others collect them
after the visit.

Also, during the office visit, a physician evaluates, treats, and documents a pa-
tient’s condition. The notes taken at this time include the procedures performed
and treatments provided, as well as the physician’s determination of the patient’s
complaint or condition.

Steps 1–3 are covered in Chapters 2 and 3 of this text.

Step 4: Review Coding Compliance
Office visit physician notes contain two very important pieces of information—the
diagnosis, which is the physician’s opinion of the nature of the patient’s illness or
injury, and the procedures, which are the services and treatments performed. When
diagnoses and procedures are reported to health plans, code numbers are used in
place of descriptions. Coding is the process of translating a description of a diagno-
sis or procedure into a standardized code. Standardization allows information to be
shared among physicians, office personnel, health plans, and so on, without losing
the precise meaning.

Visit Coding
The patient’s primary complaint (the illness or condition that is the reason for the
visit) is assigned a diagnosis code from the International Classification of Diseases
(see Chapter 4). Until October 1, 2014, these codes are taken from the Interna-
tional Classification of Diseases, Ninth Revision, Clinical Modification (ICD-
9-CM). Beginning on October 1, 2014, the International Classification of Diseases,
Tenth Revision, Clinical Modification (ICD-10-CM) will be used for diagnosis
coding.

Examples of ICD-10-CM Codes

The ICD-10-CM code for Alzheimer’s disease is G30.9 [F02.80].
The ICD-10-CM code for influenza with other respiratory manifestations is
J11.1.

Similarly, each procedure the physician performs is assigned a procedure code that
stands for the particular service, treatment, or test. This code is selected from the
Current Procedural Terminology (CPT). A large group of codes covers the
physician’s evaluation and management of a patient’s condition during office visits or visits at other locations, such as nursing homes. Other codes cover groups of specific procedures, such as surgery, pathology, and radiology. Yet another group of codes covers supplies and other services.

**Examples of CPT Codes**

99460 is the CPT code for the physician’s examination of a normal newborn infant in a hospital or birthing center.

27130 is the CPT code for a total hip replacement operation.

**Visit Data**
The physician identifies the patient’s diagnoses and procedures. This information is used by the medical assistant after the visit to update the patient’s account. The transactions for the visit, which include both the charges and any payment the patient made, are entered in the PMP and the patient’s balance is updated. Following is an example of a manual account for one patient’s recent series of visits:

<table>
<thead>
<tr>
<th>Date/Procedure</th>
<th>Charge</th>
<th>Payment</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/2/16 OV</td>
<td>200.00</td>
<td>200.00</td>
<td>—</td>
</tr>
<tr>
<td>7/3/16 OV</td>
<td>150.00</td>
<td></td>
<td>—</td>
</tr>
<tr>
<td>7/4/16 INS</td>
<td>—</td>
<td>—</td>
<td>150.00</td>
</tr>
<tr>
<td>7/13/16 PMT</td>
<td>Insurance</td>
<td>120.00</td>
<td>30.00</td>
</tr>
<tr>
<td>7/25/16 STM</td>
<td>—</td>
<td>—</td>
<td>30.00</td>
</tr>
<tr>
<td>7/30/16 PMT</td>
<td>Patient</td>
<td>30.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

This formula is followed to calculate the current balance:

\[
\text{Previous Balance} + \text{Charge} - \text{Payment} = \text{Current Balance}
\]

In this example, on 7/2 the patient’s office visit (OV) resulted in a $200 charge. The patient paid this bill, so there is no current balance. The patient’s next office visit, 7/3, resulted in a charge of $150. The medical assistant sent a health care claim to the health plan (INS for insurance) the next day, and the payer paid $120 (PMT) on 7/13. This payment is subtracted from the charge to equal the current balance of $30.

**Step 5: Review Billing Compliance**
Medical practices bill numerous health plans and government payers. The provider’s fees for services are listed on the medical practice’s fee schedule. A fee schedule is a listing of standard charges for procedures. Each charge, or fee, is related to a specific procedure code. However, the fees listed on the master fee schedule are not necessarily the amount the provider will be paid. Instead, each of the health plans and government payers reimburses the practice according to its own negotiated or government-mandated fee schedule. Many providers enter into contracts with health plans that require a discount from standard fees. In addition, although there is a separate fee associated with each code, each code is not necessarily billable. Whether it can be billed depends on the payer’s particular rules. Following these rules when preparing claims results in billing compliance.

Steps 4 and 5 are covered in Chapters 4 and 5 of this text.
Step 6: Check Out Patients

Checkout is the last step that occurs while the patient is still in the office. The medical codes have been assigned and checked, and the amounts to be billed have also been verified according to payers’ rules. The charges for the visit are calculated, and payment for these types of charges is usually collected at time of service:

- Previous balances
- Copayments
- Coinsurance
- Noncovered or overlimit fees
- Charges of nonparticipating providers
- Charges for self-pay patients
- Deductibles for patients with certain types of health plans
- Billing for supplies

A receipt is prepared for the payments made by the patients, and follow-up work is scheduled as ordered by the physician.

Step 6 is covered in Chapter 6 of this text.

Step 7: Prepare and Transmit Claims

A major step in the medical billing cycle is the preparation of accurate, timely health care claims. Most practices prepare claims for their patients and send them electronically; these are electronic claims or e-claims. A claim communicates information about the diagnosis, procedures, and charges to a payer. The practice has a schedule for transmitting claims, such as daily or every other day, which is followed. When a patient is covered by more than one health plan, the second and any other plans must be sent claims after the primary payer sends a payment on the account.

General information on claims is found in Chapter 7. Chapters 8 through 12 explain how to prepare correct claims for each major payer group:

- Private payers/Blue Cross and Blue Shield
- Medicare
- Medicaid
- TRICARE and CHAMPVA
- Workers’ compensation and disability/liability insurance

A related topic, hospital billing, is covered in Chapter 14.

Step 7 is covered in Chapters 7–12 of this text.

Step 8: Monitor Payer Adjudication

When the payer receives the claim, it goes through a series of steps designed to determine whether the claim should be paid, a process called adjudication. Claims may be paid in full, partially paid, or denied. Payments from insurance companies are listed on a remittance advice, which is sent to the provider along with the payment. The remittance advice (RA) lists the transactions included on the claims, states the amount billed and the amount paid, and provides an explanation of why certain charges were not paid in full or were denied entirely. The remittance advice provides details about each patient transaction, such as:

- Date of service
- Services provided
- Patient name and control number
- Provider identifier number
- Amount allowed by contract
- Amount paid to provider
- Amount owed by patient
When the RA arrives at the provider’s office, it is reviewed for accuracy by the medical assistant, who compares each payment and explanation with the claim to check that:

- All procedures that were listed on the claim also appear on the payment transaction.
- Any unpaid charges are explained.
- The codes on the payment transactions match those on the claim.
- The payment listed for each procedure is as expected.

If any discrepancies are found, a request for a review of the claim is filed with the payer. If no issues are discovered, the amount of the payment is recorded in the PMP program. The payment is usually an electronic payment transmitted from the payer to the practice’s bank, called an electronic funds transfer (EFT), or, occasionally, a paper check that must be deposited. Depending on the rules of the health plan, the patient may be billed for an outstanding balance. In other circumstances, an adjustment is made and the patient is not billed. Occasionally, an overpayment may be received, and a refund check is issued by the medical practice.

**Step 9: Generate Patient Statements**

Payers’ payments are applied to the appropriate patients’ accounts and patient statements are generated. In most cases, payer payments do not fully pay the bills, and patients will be billed for the rest. The amount paid by all payers (the primary insurance and any other insurance) plus the amount to be billed to the patient should equal the expected fee. Bills that are mailed to patients list the dates and services provided, any payments made by the patient and the payer, and the balances now due.

**Step 10: Follow Up Patient Payments and Collections**

Practice management programs (PMPs) are used to track accounts receivable (AR) and to produce financial reports that are used to manage the revenue cycle by following up on late or reduced payments.

**Day Sheets**

One key report is a day sheet, produced at the end of each day. This report lists all charges, payments, and adjustments that occurred during that day for each patient (see Figure 1.1). To balance out a day, all transactions and totals from bank deposit entries are compared against an end-of-day report.

**Monthly Report**

A monthly report summarizes the financial activity of the entire month. This report lists charges, payments, adjustments, and the total accounts receivable for the month. It is possible to balance out the month by totaling the daily charges, payments, and adjustments and then comparing the totals to the amounts listed on the monthly report.

**Outstanding Balances**

It is also good practice to print reports that list the outstanding balances owed to the practice by insurance companies and by patients. Regularly printing and reviewing the reports can alert medical assistants to accounts that require action to collect the amount due. A collection process is often started when patient payments are later than permitted under the practice’s financial policy.

Overdue accounts require diligent follow-up to maintain the practice’s cash flow. Insurance claims that are not paid in a timely manner also require follow-up to determine the reason for the nonpayment and to resubmit or appeal as appropriate.

Steps 8, 9, and 10 are covered in Chapter 13 of this text.
Every time a patient is treated by a health care provider, documentation of the visit is created. This chronological medical record, or chart, includes information that the patient provides, such as medical history, as well as the physician’s assessment, diagnosis, and treatment plan. Records also contain laboratory test results, X-rays and other...
diagnostic images, a list of medications prescribed, and reports that indicate the results of operations and other medical procedures. They contain information from a number of different physicians as well as from pharmacies, laboratories, hospitals, insurance carriers, and so on. Patients today use several providers to meet their health care needs, and each physician maintains a separate medical record for each patient. Unless the patient volunteers information, providers do not know whether the patient is being treated by another physician or what medications might have been prescribed. With an EHR, information is added to the record by health care professionals working in a variety of settings, and the record can be accessed by other professionals when needed.

Features of EHRs
While paper and electronic health records serve many of the same purposes, the electronic record is much more than a computerized version of a paper record. The Institute of Medicine has suggested that an EHR should include eight core functions (Key Capabilities of an Electronic Health Record System, 2003):

1. Health information and data elements
2. Results management
3. Order management
4. Decision support
5. Electronic communication and connectivity
6. Patient support
7. Administrative support
8. Population reporting and management

Electronic health records also save valuable time for health care providers by reducing the time needed to enter information about patients. Currently, physicians spend almost 40 percent of their time documenting patient cases. EHRs provide tools that make documentation more efficient, such as entering notes by typing or voice recognition, or completing templates during the patient examination.

With EHRs, physicians are finished entering notes when the patient leaves the examination room or shortly after. Nurses and medical assistants record information directly into the computer, so there is no need to copy information to a paper chart. EHRs also

► Improve the overall efficiency of the workflow.
► Speed the delivery of diagnostic test results to the physician and the patient through electronic transmission.
► Allow two or more people to work with a patient’s record at the same time.
► Eliminate the need to search for a misplaced or lost patient chart.
► Reduce the time it takes to refill a prescription through electronic prescribing.
► Organize all information in one place, including in-house messages, telephone messages, requests for information, and referral letters.
► Enable physicians to receive payment for services more quickly because patient visit information is automatically transferred to the billing software.

Integrated Workflow
The increased use of electronic health records in physician practices has changed office workflow. In a medical office, a flow of work must be in place that provides medical care to patients and collects payment for these services. When integrated PM/EHRs are used, previous paper-based tasks, such as pulling file folders and making photocopies, are replaced by efficient electronic processes.

The medical documentation and billing cycle explains how using EHRs is integrated with practice management programs as the 10-step billing process is performed. This cycle is illustrated in Figure 1.2. The inner circle represents the billing cycle, as explained in the previous section; the outer circle contains the medical documentation cycle.
As the illustration shows, the two cycles are interrelated. For example, during preregistration, a new patient phones for an appointment. Both billing and clinical information must be collected during the phone call. From a billing perspective, the office wants to know whether the patient has insurance that will cover some or all of the cost of the visit, or whether the patient will pay for the visit. From a health or medical perspective, the staff wants to know the reason the person needs to see the doctor, known as the chief complaint.

Following the billing steps that establish financial responsibility and handle check-in, the professional medical staff gather clinical information. Often, a medical assistant measures and inputs vital signs, such as the patient’s temperature, pulse, respirations, and blood pressure, as well as height and weight, in the EHR. The physician then documents the results of the physical examination, relevant history, and planned treatments.

As the medical documentation and billing cycle continues, so does the interaction between the two types of information. The physician or a medical coder assigns medical codes to the patient’s diagnosis and procedures, and the charges for those procedures are determined. Based on this information, the biller reviews coding and billing compliance, after which the patient is checked out. When the biller then prepares and transmits claims, documentation may be studied to support...
medical necessity during claim creation and later during adjudication, if a payer requires it. During the steps of claim follow-up, patients’ statements, and payment and collections, on the documentation side, the process of managing and retaining patient data according to regulations is carried out.

Even a partially electronic workflow is more efficient than a paper-based workflow. In a paper-based workflow, the coding and billing process normally takes anywhere from three to 14 days. As a result, there is an extended lag between the time the service was provided and the time the provider receives reimbursement. Also, it has been estimated that physicians lose as much as 10 percent of potential revenue as a result of forgetting to bill for services, losing patients’ paperwork, making errors when preparing claims, and other reasons.

Medical assistants become knowledgeable about the connection between PMs and EHRs in the medical practices where they are employed so that they can access the clinical information they need as they complete claims and provide documentation in support of their medical necessity.

THINKING IT THROUGH 1.4

1. Which program, a PMP or an EHR, do you think would handle each of the following tasks?

A. The medical assistant verifies and documents a patient’s medications and allergies during an examination.

B. A patient’s payment of coinsurance is entered.

C. A physician enters needed prescriptions and orders tests following a patient’s examination.

D. A medical assistant sends a claim for the encounter to the patient’s health plan.

E. A payment from the health plan is received via EFT and checked.

1.5 Set for Success

Personal Skills and Attributes

A number of skills and attributes are required for successful mastery of the tasks of a medical assistant.

Skills

► Knowledge of medical terminology, anatomy, physiology, and medical coding: Medical assistants must analyze physicians’ descriptions of patients’ conditions and treatments and relate these descriptions to the systems of diagnosis and procedure codes used in the health care industry.

► Communication skills: The job of a medical assistant requires excellent communication skills, both oral and written. For example, patients often need explanations of insurance benefits or clarification of instructions such as how to obtain referrals. Courteous, helpful answers to questions strongly influence patients’ desire to continue to use the practice's services. Memos, letters, the telephone, and e-mail are used to research and follow up on changes in health plans’ billing rules. These skills also are needed to send claim attachments that explain special conditions or treatments to obtain maximum reimbursement from payers, and to create and send effective collection letters.

► Attention to detail: Many aspects of the job involve paying close attention to detail, such as correctly completing health care claims, filing patients’ medical records, recording preauthorization numbers, calculating the correct payments, and posting payments for services.
Flexibility: Working in a changing environment requires the ability to adapt to new procedures, multitask to handle varying kinds of problems and interactions during a busy day, and work successfully with different types of people with various cultural backgrounds.

Health information technology (HIT) skills: Most medical practices use computers to handle billing and to process claims. Many also use computers to keep patients’ medical records. General computer literacy, including a working knowledge of (1) the Microsoft Windows operating system, (2) Microsoft office, (3) a PMP, and (4) Internet-based research, is essential. Data-entry skills are also necessary. Many human errors occur during data entry, such as pressing the wrong key on the keyboard. Other errors are a result of a lack of computer literacy—not knowing how to use a program to accomplish tasks. For this reason, proper training in data-entry techniques so that errors are caught, as well as knowing how to use computer programs, are both essential for medical assistants.

Honesty and integrity: Medical assistants work with patients’ medical records and with finances. It is essential to maintain the confidentiality of patient information and communications, as well as to act with integrity when handling these tasks.

Ability to work as a team member: Patient service is a team effort. To do their part, medical assistants are cooperative and focus on the best interests of patients and the practice.

Attributes
A number of attributes are also very important for success as a medical assistant. Most have to do with the quality of professionalism, which is key to getting and keeping employment. These factors include:

- Appearance: A neat, clean, professional appearance increases confidence in your skills and abilities. Being well-groomed, with clean hair, nails, and clothing, presents a businesslike demeanor to patients and other staff members.
- Attendance: Being on time for work demonstrates that you are reliable and dependable.
- Initiative: Being able to start a course of action and stay on task is an important quality to demonstrate.
- Courtesy: Treating patients and fellow workers with dignity and respect is an interpersonal quality that helps build good professional relationships at work.

Ethics and Etiquette in the Medical Office
Licensed medical staff members and other employees working in physicians’ practices share responsibility for observing a code of ethics and for following correct etiquette.

Ethics
Medical ethics are standards of behavior requiring truthfulness, honesty, and integrity. Ethics guide the behavior of physicians, who have the training, the primary responsibility, and the legal right to diagnose and treat human illnesses and injuries. All medical office employees and those working in health-related professions share responsibility for observing the ethical code.

Each professional organization has a code of ethics that is to be followed by its members. In general, this code states that information about patients, other employees, and confidential business matters should not be discussed with anyone not directly concerned with them. Behavior should be consistent with the values of the profession. For example, it is unethical for an employee to take money or gifts from a company in exchange for giving them business.

Etiquette
Professional etiquette is also important for medical assistants. Correct behavior in the office is generally covered in the practice’s employee policy and procedure manual.
For example, guidelines establish which types of incoming calls must go immediately to a physician or to a nurse or assistant, and which require a message to be taken.

**Certification and Continuing Education**

Completion of a medical insurance specialist program, coding specialist program, or medical assisting or health information technology program at a postsecondary institution provides an excellent background for many types of positions in the medical insurance field. Another possibility is to earn an associate degree or a certificate of proficiency by completing a program in a curriculum area such as health care business services. Further baccalaureate and graduate study enables advancement to managerial positions.

Moving ahead in a career is often aided by membership in professional organizations that offer certification in various areas. **Certification** by a professional organization provides evidence to prospective employers that the applicant has demonstrated a superior level of skill on a national test. Certification is the process of earning a credential through a combination of education and experience followed by successful performance on a national examination.

**Medical Assisting Certification**

Two organizations offer tests in the professional area of medical assisting. After earning a diploma in medical assisting from an accredited school (or having a year's work experience for the RMA only), medical assistants may sit for the Certified Medical Assistant (CMA) titles from the American Association of Medical Assistants or the Registered Medical Assistant (RMA) designation from the American Medical Technologists.

**Health Information Certification**

Students who are interested in the professional area of health information (also known as medical records) may complete an associate degree from an accredited college program and pass a credentialing test to be certified as a Registered Health Information Technician, or RHIT. An RHIT examines medical records for accuracy, reports patient data for reimbursement, and helps with information for medical research and statistical data.

Also offered is the Registered Health Information Administrator (RHIA), requiring a baccalaureate degree and national certification. RHIAs are skilled in the collection, interpretation, and analysis of patient data. Additionally, they receive the training necessary to assume managerial positions related to these functions. RHIAs interact with all levels of an organization—clinical, financial, and administrative—that use patient data in decision making and everyday operations.

**Coding Certification**

Medical coders are expert in classifying medical data. They assign codes to physicians’ descriptions of patients’ conditions and treatments. For employment as a medical coder, employers typically prefer—or may require—certification. AHIMA offers three coding certifications: the Certified Coding Associate (CCA), intended as a starting point for entering a new career as a coder; the Certified Coding Specialist (CCS); and the Certified Coding Specialist-Physician-based (CCS-P). The American Academy of Professional Coders (AAPC) grants the Certified Professional Coder (CPC); the CPC-A, an apprentice level for those who do not yet have medical coding work experience; and a number of advanced specialty coding certifications.

**Continuing Education**

Most professional organizations require certified members to keep up-to-date by taking annual training courses to refresh or extend their knowledge. Continuing education sessions are assigned course credits by the credentialing organizations.
and satisfactory completion of a test on the material is often required for credit. Employers often approve attendance at seminars that apply to the practice's goals and ask the person who attends to update other staff members.

**Medical Liability Insurance**

Because of the risk of liability, medical practices must be sure that treatment and billing rules are followed by all staff members. In addition to responsibility for their own actions, physicians are liable for the professional actions of employees they supervise. This responsibility is a result of the law of *respondeat superior*, which states that an employer is responsible for an employee's actions. Physicians are held to this doctrine, so they can be charged for the fraudulent behavior of any staff member.

Medical liability cases for fraud often result in lawsuits. Physicians purchase professional liability insurance to cover such legal expenses. Although they are covered under the physician's policy, other medical professionals often purchase their own liability insurance. Those who perform clinical or administrative tasks are advised to have professional liability insurance called error and omission (E&O) insurance, which protects against financial loss due to intentional or unintentional failure to perform work correctly.

**THINKING IT THROUGH 1.5**

1. Why is it important for administrative medical office employees to become certified in their area of expertise? At this point, what are your personal goals relating to certification?

**Chapter Summary**

<table>
<thead>
<tr>
<th>Learning Outcomes</th>
<th>Key Concepts/Examples</th>
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</table>
| **1.1** Explain how healthy practice finances depend on correctly accomplishing administrative tasks in the medical office. Pages 2–3 | • Cash flow must be monitored and managed to make sure that sufficient money comes into the practice from patients and insurance companies.  
• To remain profitable physicians must carefully manage the business side of their practice by employing knowledgeable administrative medical office employees.  
• Medical assistants ensure financial success by carefully following procedures, communicating effectively, and using health information technology to improve efficiency. |
| **1.2** Compare coinsurance and copayment requirements for health plan benefits. Pages 3–9 | • Insurance is based on one of two types of plans, indemnity and managed care.  
• Coinsurance, the amount that the payer and the insured pay on a claim, is based on a percentage.  
• Copayment, the fixed amount that the patient pays, must always be paid at the time of service. |
| **1.3** Identify the key steps in the medical billing cycle. Pages 9–15 | • The ten steps in the billing cycle are  
1. Preregister patients  
2. Establish financial responsibility for visits  
3. Check in patients  
4. Review coding compliance  
5. Review billing compliance  
6. Check out patients  
7. Prepare and transmit claims  
8. Monitor payer adjudication  
9. Generate patient statements  
10. Follow up patient payments and handle collections |
### Learning Outcomes

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<thead>
<tr>
<th>Learning Outcome</th>
<th>Key Concepts/Examples</th>
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| 1.4 Discuss the impact of electronic health records on clinical and billing workflow. Pages 15–18 | • Improve the overall efficiency of workflow.  
• Speed the delivery of diagnostic test results to the physician and the patient.  
• Allow two or more people to work with a patient’s record at the same time.  
• Eliminate the need to search for a misplaced or lost patient chart.  
• Reduce the time it takes to refill a prescription.  
• Organize all information in one place.  
• Enable physicians to receive payment for services quickly. |
| 1.5 Evaluate the importance of professional certification and medical liability insurance for career advancement. Pages 18–21 | • Certification by a professional organization provides evidence to prospective employers that an applicant has demonstrated a superior level of skill.  
• Professional liability insurance can protect administrative and clinical medical assistants against financial loss due to intentional or unintentional failure to perform work correctly. |

### Using Terminology

Match the key terms in the left column with the definitions in the right column.

1. [LO 1.2] Third-party payer  
2. [LO 1.2] Copayment  
3. [LO 1.2] Managed care  
4. [LO 1.1] Accounts receivable (AR)  
5. [LO 1.2] Indemnity plan  
6. [LO 1.2] Coinsurance  
7. [LO 1.2] Premium  
8. [LO 1.2] Benefits  
9. [LO 1.2] Deductible  
10. [LO 1.2] Fee-for-service

A. Monies owed to a medical practice by its patients and third-party payers.  
B. The amount of money a health plan pays for services covered in an insurance policy.  
C. The portion of charges that an insured person must pay for health care services after payment of the deductible amount; usually stated as a percentage.  
D. An amount that a health plan requires a beneficiary to pay at the time of service for each health care encounter.  
E. An amount that an insured person must pay, usually on an annual basis, for health care services before a health plan’s payment begins.  
F. Method of charging under which a provider’s payment is based on each service performed.  
G. Type of medical insurance that reimburses a policyholder for medical services under the terms of its schedule of benefits.  
H. System that combines financing and the delivery of appropriate, cost-effective health care services to its members.  
I. Money the insured pays to a health plan for a health care policy.  
J. Private or government organization that insures or pays for health care on the behalf of beneficiaries.
Checking Your Understanding

Write the letter of the choice that best completes the statement or answers the question.

1. [LO 1.1] Monies used by the physician practice to pay for operating expenses such as salaries, supplies, and utilities are called ________.
   A. Accounts receivable  
   B. Accounts payable  
   C. Purchase order  
   D. Accounting

2. [LO 1.1] Which of the following data is stored in a practice management program? ________
   A. Transaction data  
   B. Provider data  
   C. Health plan data  
   D. All of these

3. [LO 1.1] A system used to gather a patient’s clinical information is a(n) ________.
   A. Practice management program  
   B. Revenue cycle management  
   C. Electronic health record  
   D. Electronic claim

4. [LO 1.2] Participants in the medical insurance relationship include ________.
   A. Provider  
   B. Patient  
   C. Health plan  
   D. All of these

5. [LO 1.2] Health plans pay for ________ services.
   A. Indemnity  
   B. Covered  
   C. Coded  
   D. Out-of-network

6. [LO 1.2] Coinsurance is calculated based on ________.
   A. The number of policyholders in a plan  
   B. A fixed charge for each visit  
   C. A capitation rate  
   D. A percentage of a charge

7. [LO 1.2] The major government-sponsored health programs are ________.
   A. Medicare, Medicaid, TRICARE, and CHAMPVA  
   B. HEDIS, Medicare, Medicaid, and CHAMPUS  
   C. Blue Cross and Blue Shield  
   D. Medicare, Medicaid, and Coventry

8. [LO 1.3] If a patient’s payment is later than permitted under the financial policy of the practice, the ________ may be started.
   A. Copayment process  
   B. Appeal process  
   C. Coding process  
   D. Collection process

9. [LO 1.3] When a patient has insurance coverage for which the practice will create a claim, the patient bill is usually done ________.
   A. Before the patient encounter  
   B. During the patient encounter  
   C. After the health claim has been transmitted and the payer’s payment is posted  
   D. When the health claim is transmitted

10. [LO 1.5] Insurance that protects against financial loss as a result of unintentional failed work performance is ________.
    A. Errors and omissions  
    B. Workers’ compensation  
    C. Medical liability  
    D. Workplace insurance

Define the following abbreviations:

1. [LO 1.1] AP ____________
2. [LO 1.1] AR ____________
3. [LO 1.1] EHR ____________
4. [LO 1.1] HIT ____________
5. [LO 1.2] MCO ____________
6. [LO 1.1] PM ____________
7. [LO 1.3] RA ____________
8. [LO 1.1] RCM ____________
Answer the following questions:

1. [LO 1.3] List the ten steps in the billing cycle.
2. [LO 1.5] List at least four important skills of a medical assistant.

**Applying Your Knowledge**

**Case 1.1 Abstracting Insurance Information**

A patient shows the following insurance identification card to the medical assistant.

**Front of card**

Connecticut HealthPlan
I.D. #: 1002.9713
Employee: DANIEL ANTHONY
Group #: A0000323
Eff. date: 03/01/2016
Status: Dependent Coverage? F
In-network: $10 Co-Pay
Out-of-network: $250 Ded; 80%/20%

**Back of card**

**IMPORTANT INFORMATION**

Notice to Members and Providers of Care
To avoid a reduction in your hospital benefits, you are responsible for obtaining certification for hospitalization and emergency admissions. The review is required regardless of the reason for hospital admission. For specified procedures, Second Surgical Opinions may be mandatory.

Connecticut HealthPlan C/O Robert S. Weiss & Company
Silver Hill Business Center
500 S. Broad Street
P.O. Box 1034
Meriden, CT 06450
(800) 466-7900

**Case 1.2 Calculating Insurance Math**

Calculate the payment(s) billed in each of the following situations.

A. [LO 1.2] What copayment is due when the patient sees a network physician?

B. [LO 1.2] What payment rules apply when the patient sees an out-of-network physician?

C. [LO 1.2] What rules apply when the patient needs to be admitted to the hospital?