14

INSURANCE REIMBURSEMENT FOR MASSAGE THERAPY SERVICES

OUTLINE

Complementary and Alternative Medicine
Massage as a Reimbursable Treatment
Health Insurance Benefits Programs
Indemnity
Capitation
Alternative Benefit Plans
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Clearinghouse Method
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Insurance Pay System
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Insurance Fraud
Summary

KEY TERMS

Administrator
Alternative benefit plan
Cafeteria plan
Capitation
Claim form
Closed panel system
Copayment
Covered services
Customary fee
Deductible
Direct reimbursement
Fee schedule
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Health maintenance organization (HMO)
Insurer
Limitations
Medicaid
Preferred provider organization (PPO) plan
Premium
Reasonable and customary (R&C) plan
Reimbursement
Usual fee

LEARNING OUTCOMES

Mastery of the content in this chapter will enable the reader to:

- Define key terms
- Describe massage as a reimbursable treatment for complementary and alternative medicine (CAM)
- Explain health insurance benefits programs and how claims are made

Guidelines for the Learning Activities and answers to the Workbook questions are located on Evolve at http://evolve.elsevier.com/Fritz/business.

The eligibility of therapeutic massage for health insurance benefits continues to be a controversial issue. This textbook does not attempt to take a position on the benefits or difficulties of various forms of insurance *reimbursement*. Instead, circumstances such as state regulations, type of massage business (e.g., spa services, hospital), and the nature of the client's goals will determine whether the massage application qualifies for insurance compensation. There is a trend toward increasing access for coverage for complementary and alterative health care services, but the process remains confusing, and continuity among providers does not exist. The Internet allows access to health information on general and alternative therapies, empowering consumers to seek a variety of approaches to healing and wellness.

As massage therapy becomes more common in health care settings that typically used health insurance for service compensation, it is important to understand how the health insurance system functions. It is not necessary for massage therapists to accept health care insurance reimbursement for the massage services they offer. The client cash-pay system has many advantages. Many health care practitioners that used to take insurance payments are now or considering opting out and returning to a cash-for-services-rendered system. You may choose a career path that requires you to bill insurance directly or maintain necessary documentation so that the insurance biller can adequately request payment for service, and clients will ask questions about the availability of health care insurance reimbursement for massage.

COMPLEMENTARY AND ALTERNATIVE MEDICINE

The globalization of society and the interweaving of cultural diversity have influenced the demand for a variety of healing practices. Escalating costs and decreasing patient satisfaction have encouraged many to explore multidisciplinary health care services.

When surveys conducted in the 1990s discovered how many Americans were using complementary and alternative medicine (CAM) and how many were willing to pay out-of-pocket expenses for these additional products and services, *insurers* felt some pressure to include at least some of these treatments in their plans. This occurred despite the fact that scientific evidence did not uniformly support their effectiveness (and still does not).

Millions of Americans use complementary and alternative health care approaches every year, often in conjunction with conventional medical care. However, because qualified integrated care is not covered by Medicare or Medicaid and other insurers, it is not equally available to all Americans. The Integrated Healthcare Policy Consortium (IHPC) is a broad coalition of health care professionals and organizations driving public policy to ensure all Americans access to a safe, high-quality, health care system that includes conventional, complementary, and alternative approaches, practiced by qualified providers working in respectful collaboration to offer effective patient-centered care.

The Academic Consortium for Complementary and Alternative Health Care (ACCAHC) was formed in 2004 under the auspices of IHPC's Education Task Force. Because ACCAHC has a strong commitment to public safety and accountability, it works only with health care professions that have established clear regulatory mechanisms in the United States or are in the process of doing so. The fully regulated CAM professions in the United States include the following:

- Acupuncture and Oriental medicine
- Chiropracticm edicine
- Direct-entrym idwifery
- Massaget herapy
- Naturopathicm edicine

IHPC has documented notable events in the development of integrative health care in the United States (http://ihpc.info/resources/timeline.shtml). The following reports from 2001 through 2006 reflect of progress of integrative health care development. The links and brief description of each report are provided on the Evolve Web site. It would be prudent in your professional development to review these documents:

National Policy Dialogue Final Report, 2001 (http://ihpc.info/resources/NPDFR.pdf)

White House Commission on Complementary and Alternative Medicine Policy Final Report, 2002 (http://ihpc.info/resources/WHCCAM.pdf)

Institute of Medicine Report on Complementary and Alternative Medicine in the United States, 2002 (http://ihpc.info/resources/IMRCAM.pdf)

Mapping the Emergence of Integrative Medicine, 2003 (http://ihpc.info/resources/Clohesy2003.pdf)

National Education Dialogue Progress Report, 2005 (http://ihpc.info/resources/NEDPR.pdf)

Coalition for Patients' Rights Statement, 2006 (http://ihpc.info/resources/statement.shtml)

These initiatives and developments have and will continue to have implications for massage therapy practice as part of an integrated health care system. You need to

SELF-REFLECTION

What type of CAM health care services do I use? How do I pay for it? How much do I pay? Am I willing to pay additional premiums for health insurance to have benefits that cover CAM health care? How much am I willing to pay? What types of coverage do I want? What does integrated health care mean? Is health care the same or different from medical care?

be able to function as a massage professional within these environments, especially when considering health insurance coverage for massage services.

The increasing research on the benefits of therapeutic massage and the establishment of the underlying physiologic mechanisms related to these benefits are beginning to influence the insurance providers. Coverage of CAM is largely determined on a state-by-state basis, but certain plans are more flexible than others. Clients need to inquire regarding their insurance reimbursement options. Some CAM-friendly states, such as Connecticut or Washington, where "naturopathic doctors" are state-licensed are setting the example. One example of a CAM-friendly managed care company is Oxford Health Insurance, based in Connecticut.

Most health care plans cover chiropractic and osteopathic manipulation. Acupuncture has gained licensure in many states and is becoming more routinely covered. Some plans also cover treatments such as massage. One popular area of CAM that is almost never covered by insurance is the use of dietary and herbal supplements.

Some insurers include CAM providers in their networks, offering discounted fees. Other insurers may pay part of the cost of CAM treatments if they are ordered by a medical doctor. For the most part, insurance plans that cover CAM treatments have high deductibles, and people must pay a higher amount out of pocket before the insurance steps in to help cover costs. Most insurers pay only for a limited number of visits, which is usually far fewer than the number recommended for complete treatment. Some insurance carriers offer a policy rider, which is extra insurance (for an extra fee) that covers CAM treatments. These are available from a number of reputable insurance companies.

Health spending accounts, also known as health savings accounts (HSAs), are savings accounts specifically set aside to pay for health care services that are often offered outside traditional health insurance plans. Individuals are able to pay for most CAM treatments with HSA funds. The money put in these accounts is tax deductible, which can mean great savings.

MASSAGE AS A REIMBURSABLE TREATMENT

A common question is whether massage therapy should be covered by health insurance as a medical treatment. There is agreement that massage is a valuable heath service. The question is whether it is a medical treatment. Massage application that is result oriented and treatment that is specifically directed to resolve conditions that have been diagnosed and supervised by a physician are most likely to be eligible for insurance coverage. The focus of the massage treatment is on the areas of the body related to the medical diagnosis and prescription, and massage usually is billed in 15-minute segments using current procedural terminology and adhering to the usual and customary reimbursement *fee schedule*.

For massage therapists to state that they are treating someone, they must first be able to legally determine what it is that they are treating. Because it is beyond massage therapists' scope of practice to diagnose and prescribe, they must work from a doctor's prescription if they are claiming to treat a specific condition. The massage therapist must also follow the prescribing physician's treatment orders. The only requirement for being eligible to provide massage that qualifies for insurance payment is that massage therapists are practicing legally in their jurisdictions. There is no specific certification for so-called medical massage that increases the chances that massage will be covered.

Four states mandate that massage be included in health insurance coverage. According to the Council for Affordable Health Care (see Evolve Annotated Web Links at the end of this chapter), they are Washington, New Hampshire, Utah, and Maryland. Other states such as Florida and New York have regulations providing for reimbursement of services for therapeutic massage. The therapists must be licensed in that particular state, and to be licensed, they must have met the state's required educational standards. Because these regulations change, check with the regulatory agencies and individual insurance companies to confirm ability to receive coverage (Box 14-1). Figure 14-1 shows the sources of U.S. health care financing.

Many states allow licensed therapists to bill for personal injuries (e.g., car accidents) if there is a referring physician involved in the case. Some of these states also allow for workers' compensation reimbursement. In some unlicensed states, a person who practices massage therapy without a license may be able to bill insurance for personal injury to a client, such as a car accident, but these are determined on an individual basis. The health insurance world is very complex, and most providers rely on specially trained insurance billers to handle these matters.

HEALTH INSURANCE BENEFITS PROGRAMS

The insurance carrier's method of reimbursement depends on the plan design. The two basic models of benefits programs are indemnity and capitation, although many variationsofea chm odelexi st(Fig.14- 2).

Indemnity

Indemnity programs are most often referred to as fee-for-service programs. This type of program provides payment on a service-by-service basis, and reimbursement may be made to the enrollee or, by assignment, to the service provider. The following list describes types of fee-for-service programs:

EXPERT Outlook

The owner and director of the College of Integrative Healthcare in Oceanside, California, Dr. Randy Snyder, gives his perspective on the role of massage in health care.

There is currently an increased trend in health care to move more services into the purview of vocationally trained individuals. Some of the reasons include greater cost effectiveness and greater access to larger pools of trained individuals. This will help the massage profession in many ways, as massage therapists are one of the few vocationally trained professionals in the complementary and alternative health care arena. Your services will continue to grow in demand, and your skills will continually need to be updated and enhanced to accommodate this growth. Health care will become a team approach, requiring you to work and communicate more effectively in a variety of environments and under the supervision of other healthcare professionals. You will have opportunities you never expected if you expand your knowledge and thinking and become a lifelong learner!

I work as a utilization manager for an insurance company and have reviewed many treatment plans submitted by massage therapists. Although managed care is new to most massage therapists, it is not new to most health care providers. There are several things you must know about insurance reimbursement. First, realize that most insurance companies have resources that allow you to access information about clinical reasoning and treatment planning. These resources are generally provided through an operations manual or by electronic access via a CD or the Internet. Often we tend to overlook this because we want to speed through the process as easily as possible. This often hinders our ability to work adequately within the system and can cause frustration. Think of it this way: if you're going to play the game, you need to learn the rules.

It is important to have certain information presented through medical records or insurance forms (now mostly electronic) that give the patient's complaints and medical history. The frequency and duration of complaints, as well as the mechanism of injury, if available, should be described. This is usually recorded on a patient intake form by the patient and includes biographical information such as name, address, date of birth, and so forth. In addition, you will need to provide assessment information in the form of postural evaluation, gait, and/or palpation. These findings can be further clarified using graded information (mild, moderate, severe) with regard to range of motion, tenderness, muscle tone, and trigger points. Although it is not necessary to have all this information recorded for every complaint, you should provide enough findings to adequately evaluate all complaints. If you intend to treat something, you need assessment findings that justify the treatment plan, and are reasonable based on the magnitude of the complaints. Once you have assessed the patient, your treatment frequency and duration should be based on the particular needs of the patient, taking all historical and assessment information into consideration. This information should include any historical information about comorbidities (e.g., diabetes, fibromyalgia) that might influence how the patient responds to care. It is not necessary to have a physician's referral with all insurance companies, but referral and comanagement to or from another health care professional must be recorded when indicated. All these things have to do with the accountability factors in health care that other health care professionals must adhere to. The documentation should support and justify your treatment request in a rational manner based on the available evidence-based literature and/or consensus of the profession. Outcomes measurements and tools should be used to gauge client progress.

If someone else is going to pay the bill, they have the right and obligation to review this information. In fact, it goes farther than that. It is also based on health and safety concerns for which the insurance company is held accountable by regulators and accreditation agencies. As our government wrestles with a health care reform bill, there is much talk of comparative effectiveness research where treatments will be compared to one another. This is to help determine which treatments (including massage therapy) are safest as well as most therapeutic and cost effective.

Think, learn, and grow. Don't just graduate and remain stagnant. In this day and age, you will never succeed in any profession unless you stay actively involved in professional development.

BOX 14-1 Regulation of Insurance Billing for Therapeutic Massage

The information covers who may treat and the procedures and the authorization requirements for outpatient therapy services.

Who may perform physical, occupational, or massage therapy?

QUALIFICATIONS	Physical Therapist (PT)	Occupational Therapy (OT)	Massage Therapy (MT)
Mustbe	Licensed physical therapist	Licensed occupational therapist	Licensed massage practitioner (LMP)
May be	PT assistant under the direction of a licensed PT	OT assistant under the direction of a licensed OT	Not applicable

BOX 14-1 Regulation of Insurance Billing for Therapeutic Massage—cont'd

Who else may perform these services?

- Medical or osteopathic physicians who are board qualified or board certified in medicine and rehabilitation
- Attending physicians who are not board qualified or board certified in physical medicine and rehabilitation. Special payment policies apply. See the Physical Medicine chapter in the Payment Policies book (http://www.lni.wa.gov/ClaimsIns/Files/ProviderPay/FeeSchedules/2008FS/Marfsall.pdf).

Can I get paid for services performed by other personnel?

No. The department of labor and industries (L&I) does not pay for services provided by

- Exerciseph ysiologists
- Kinesiologists
- Athletict rainers
- Students
- Aides
- Otherun licensedper sonnel

Do I need to obtain authorization for the first 12 (PT/OT) or 6 (MT) visits?

No, but the services need to be ordered by the injured worker's attending doctor, physician assistant, or nurse practitioner.

What needs to be done to treat beyond the first 12 (PT/OT) or 6 (MT) visits?

You must do the following:

- Document improvement in the worker's condition
- Document continued referral from the attending physician
- Obtaina uthorization

Further treatment may be denied by the claim manager if documentation is not available or authorization is not obtained.

How do I obtain authorization for additional (outpatient) visits?

For state fund claims, effective July 1, 2007, the following rules apply:

Standard outpatient and work conditioning services: action required

No. of Visits	PT Only or OT Only	PT/OT Combined
Visits 1-12	No authorization is needed.	If fewer than 12 visits for both disciplines, no authorization is needed.
Visits 13-24	Fax OT/PT Treatment Authorization Fax Request (F248-055-000) form for authorization. (http://www.lni.wa.gov/FormPub/Detail.asp?DocID=1657)	If visits are between 13 and 24 for either discipline, fax OT/PT Treatment Authorization Fax Request (F248-055-000) form for authorization. (http://www.lni.wa.gov/FormPub/Detail.asp?DocID=1657)
Visits beyond 24	Request Utilization Review from Qualis directly. Claim manager will authorize or deny.(http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/UtilReview/Therapy/requestUR.asp)	If more than 24 visits for either discipline, request Utilization Review from Qualis directly. Claim manager will authorize or deny. (http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/UtilReview/Therapy/requestUR.asp)

Visit counts are the total number of visits per claim. New referrals, restart of therapy after surgery, or treatment of new conditions on the same claim do not start again at visit 1. Physical and occupational therapy visits accumulate separately. If work conditioning is provided by PT and OT and more than 24 visits have previously occurred for either therapy discipline, utilization review is required. If work conditioning is denied, L&I will allow up to 12 visits for the discipline that has not reached 12 visits.

Work Hardening	Action Required
All services	Request authorization from claim manager. Claim manager will authorize or deny.

Massage (MT)	Action Required
Visitsbey ondfi rst 6	Use the Massage Practitioner Treatment Authorization Fax Request (F248-357-000) form (http://www.lni.wa.gov/FormPub/Detail.asp?DocID=2229), or make a referral to the claim manager using the Provider Hotline 1-800-848-0811.

For Self-Insured claims, contact the self-insured employer's claim manager.

From Washington State Department of Labor and Industries.

Usual, customary, and reasonable (UCR) plan: Payment for covered benefits is based on a combination of usual, customary, and reasonable fee criteria.

Reasonable and customary (R&C) plan: Payment for covered benefits is based on *reasonable and customary feec* riteria.

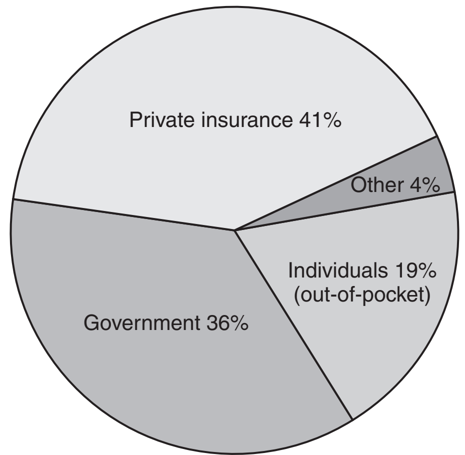


FIGURE 14-1. Sourcesoffi nancingfor h ealth care. *(From Yoder-Wise PS:* Leading and Managing in Nursing, *ed 4, St. Louis, 2007, Mosby.)*

Preferred provider organization (PPO) plan: A participating massage therapist agrees to accept discounted fees for *covered services* rendered to plan enrollees.

Exclusive provider organization (EPO) plan: Benefits are provided only if care is rendered by institutional and professional providers with whom the plan contracts. Some exceptions may be allowed for emergency and out-of-areaser vices.

Point of service plan: Benefit carrier reimbursement levels are determined by the participation status of the massage therapist rendering treatment.

Table of allowances plan: Covered services have an assigned dollar amount that represents the total dollar amount payable for each service.

Open panel system: Any service provider may participate, enrollees may receive massage treatment from any licensed massage therapist, benefits may be payable to the enrollee or the massage therapist, and the massage therapist may accept or refuse any enrollee.

Closed panel system: Enrollees can receive benefits only when services are provided by massage therapists who have signed an agreement with the benefit plan to provide treatment to eligible clients.

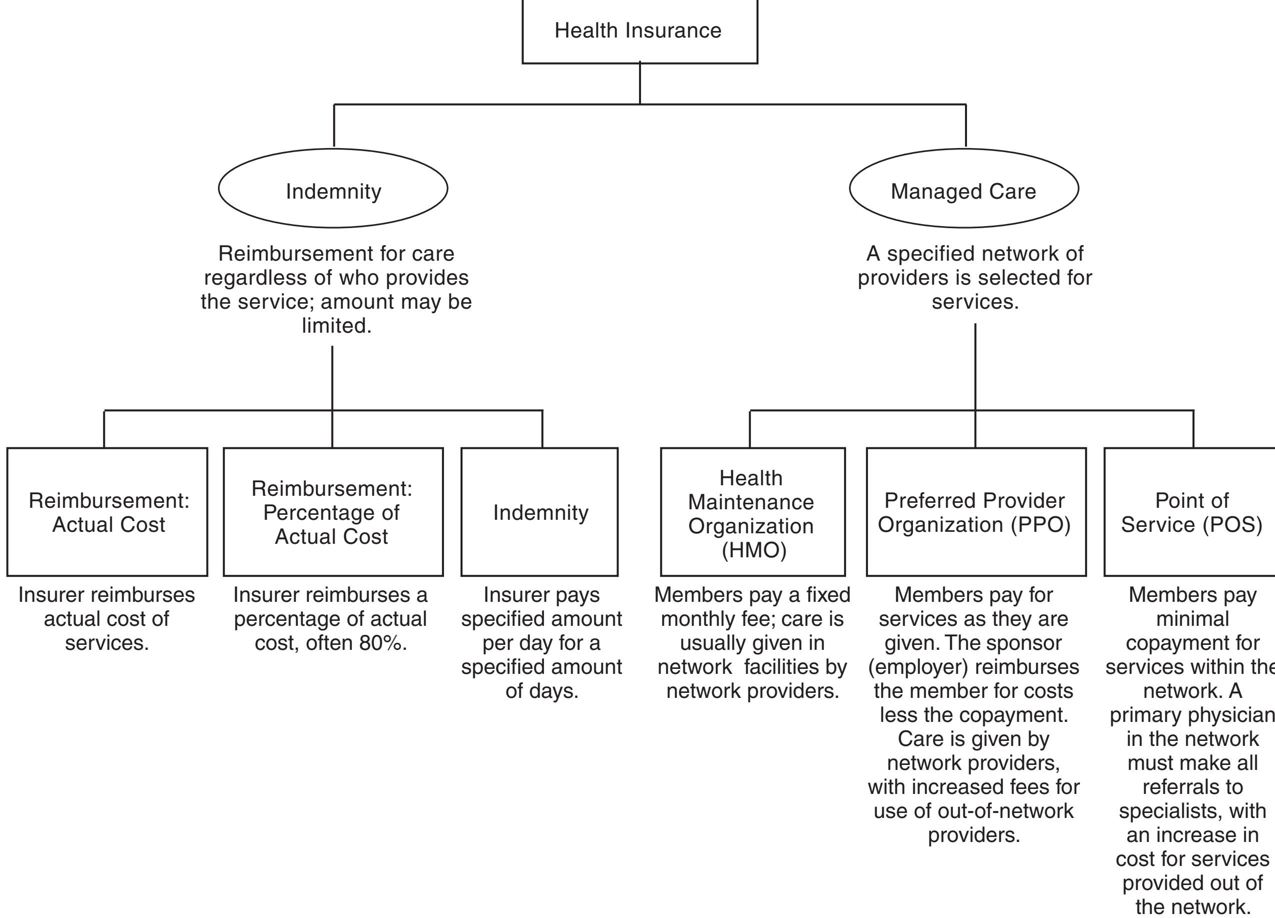


FIGURE 14-2. Formsofh ealthi nsurance. *(From Gerdin J:* Health Careers Today, *ed. 4, St. Louis, Mosby, 2007.)*

Capitation

Capitation is a benefits delivery system in which a health care professional contracts with the program's sponsor or *administrator* to provide all or most of the health services covered under the program in return for a fixed monthly payment per covered person (per capita). Such a program is also called a *health maintenance organization* (HMO), and it typically is a closed panel system; that is, enrollees select a primary care physician from a list of participating providers, and they go to that office for all their health care unless the primary care physician provides a written referral to a specialist. Some exceptions are made for emergency and out-of-area services. Enrollees usually have no out-of-pocket costs for routine services.

Alternative Benefit Plans

Employers or associations may elect to offer an *alternative benefit plan* for supplemental massage coverage. In most cases, the enrollee pays the massage therapist directly. Examples of this type of plan include discount cards, HSAs, and direct reimbursement.

Large employers or associations may contract with massage clinics to deliver massage services to their enrollees for a discounted rate (i.e., use of a discount card). Many massage benefit carriers recruit massage therapist to participate in their programs. Although the massage therapist may be required to discount fees to enrollees, participation is a proven method for obtaining clients contributing to practice building. When massage therapists sign a participation contract with a benefits carrier, they agree to certain terms and conditions of payment for services rendered to enrollees. Each carrier has a unique set of terms of participation.

HSAs allow individuals to create a tax-free savings account that can be used to pay for deductibles or medical expenses not covered by a health insurance plan. The federal government allows eligible employers to offer their employees a pretax salary savings account for payment assistance with health care–related expenses. The maximum amount employees can contribute is $4000 per year for eligible medical, dental, vision, and prescription expenses. Massage may be covered. Contributions to the account are made by payroll deduction, and employees save money because no federal or state taxes or Federal Insurance Contributions Act (FICA) withdrawals are taken out of their earnings. As of January 1, 2004, millions of Americans younger than 65 years old had access to HSAs, which promise to revolutionize health care in America. An HSA is a tax-free savings account that works like an Individual Retirement Account (IRA), except that the money is intended to be used for qualified health care costs. Most rules and procedures that apply to IRAs also apply to HSAs. Massage may be a qualified expense if a physician or chiropractor recommends it, but not if clients decide to seek it on their own. More information is provided in IRS Publication 502 (Box 14-2)

Direct reimbursement plans offer another alternative. An employer or organization can set up a self-funded program for reimbursing covered individuals based on a percentage oft hea mountspen tfor m assagec are(Box 14-3).

BOX 14-2 The Basics of Health Savings Accounts

What is a health savings account?

A health savings account (HSA) is an alternative to traditional health insurance. It is a savings product that offers a different way for consumers to pay for their health care. HSAs enable you to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis.

You must be covered by a high-deductible health plan (HDHP) to take advantage of HSAs. An HDHP usually costs less than traditional health care coverage, and the money that you save on insurance can be put into the HSA.

You own and you control the money in your HSA. Decisions on how to spend or invest the money are made by you without relying on a third party or a health insurer. You decide what types of investments to make with the money in the account to make it grow.

What is a high-deductible health plan?

You must have an HDHP if you want to open an HSA. Sometimes referred to as a "catastrophic" health insurance plan, an HDHP is an inexpensive health insurance plan that usually does not pay for the first several thousand dollars of health care expenses (i.e., your deductible) but does cover your medical expenses after that. The savings part of your policy is available to help you pay for the expenses your plan does not cover.

To qualify to open an HSA in 2008, your HDHP minimum deductible had to be at least $1100 (self-only coverage) or $2,200 (family coverage). The annual out-of-pocket (including deductibles and copays) for 2008 cannot exceed $5500 (self-only coverage) or $11,200 (family coverage). HDHPs can have first-dollar coverage (no deductible) for preventive care and apply higher out-of-pocket limits (plus copays and coinsurance) for non-network services.

How can I get a health savings account?

Consumers can sign up for HSAs with banks, credit unions, insurance companies, and other approved companies. Your employer may also set up a plan for employees.

How much does an HSA cost?

An HSA is a savings account into which you can deposit money on a tax-preferred basis. You purchase an HDHP, an inexpensive plan that will cover you if your medical expenses exceed the funds you have in your HSA.

From United States Department of the Treasury, http://www.ustreas.gov/offices/public-affairs/hsa/faq-basics.shtml

BOX 14-3 Employment-Based Health Insurance Surveys

DEFINITIONS OF HEALTH INSURANCE TERMS

In February 2002, the federal government's Interdepartmental Committee on Employment-Based Health Insurance Surveys approved the following set of definitions for use in federal surveys collecting employer-based health insurance data. The U.S. Bureau of Labor Statistics (BLS) National Compensation Survey uses these definitions in its data collection procedures and publications. The definitions are periodically reviewed and updated by the Committee.

Administrative Services Only (ASO): An arrangement in which an employer hires a third party to deliver to the employer administrative services, such as claims processing and billing; the employer bears the risk for claims. This is common in self-insured health carepla ns.

Coinsurance: A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid. After any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges; the individual also may be responsible for any charges in excess of what the insurer determines to be "usual, customary, and reasonable." Coinsurance rates may differ if services are received from an approved provider (i.e., a provider with whom the insurer has a contract or an agreement specifying payment levels and other contract requirements) or if received by providers not on the approved list. In addition to overall coinsurance rates, rates may also be different for different types of services.

Copayment: A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement. There may be separate copayments for different services. Some plans require that a deductible first be met for some specific services before a copayment applies.

Deductible: A fixed dollar amount during the benefit period, usually a year, that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have per-individual and family deductibles. Some plans may have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission. Deductibles may be different if services are received from an approved provider or received from providers not on the approved list.

Flexible spending accounts or arrangements (FSA): Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance *premiums* or medical expenses not covered by the employer's health plan. The employer may also make contributions to an FSA. Typically, benefits or cash must be used within the given benefit year, or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Flexible benefits plan (cafeteria plan or IRS 125 Plan): A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits, including cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans, and child care. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes, employee contributions may be made for additional coverage.

Fully insured plan: A plan in which the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.

Gatekeeper: Under some health insurance arrangements, a gatekeeper is responsible for the administration of the patient's treatment; the gatekeeper coordinates and authorizes all medical services, laboratory studies, specialty referrals, and hospitalizations.

Group purchasing arrangement: Any of a wide array of arrangements in which two or more small employers purchase health insurance collectively, often through a common intermediary who acts on their collective behalf. Such arrangements may be called cooperatives, alliances, or business groups on health. They are different from one another along a number of dimensions, including governance, functions, and status under federal and state laws. Some are set up or chartered by states, whereas others are entirely private enterprises. Some centralize more of the purchasing functions than others, including functions such as risk pooling, price negotiation, choice of health plans offered to employees, and various administrative tasks. Depending on their functions, they may be subject to different state and federal rules. For example, they may be regulated as Multiple Employer Welfare Arrangements (MEWAs).

Association health plans: This term is sometimes used loosely to refer to any health plan sponsored by an association. It also has a precise definition under the Health Insurance Portability and Accountability Act of 1996 that exempts from certain requirements insurers that sell insurance to small employers only through association health plans that meet the definition.

HEALTH CARE PLANS AND SYSTEMS

Indemnity plan: A type of medical plan that reimburses the patient or provider as expenses are incurred.

Conventional indemnity plan: An indemnity that allows the participant the choice of any provider without effect on reimbursement. These plans reimburse the patient or provider as expenses are incurred.

Preferred provider organization (PPO) plan: An indemnity plan by which coverage is provided to participants through a network of selected health care providers (e.g., hospitals, physicians). The enrollees may go outside the network but would then incur larger costs in the form of higher deductibles, higher coinsurance rates, or nondiscounted charges from the providers.

Exclusive provider organization (EPO) plan: A more restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider, except in an emergency situation.

BOX 14-3 Employment-Based Health Insurance Surveys—cont'd

Health maintenance organization (HMO): A health care system that assumes the financial risks associated with providing comprehensive medical services (i.e., insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO.

Group Model HMO: An HMO that contracts with a single multispecialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it also may provide services to non-HMO patients. The HMO pays the medical group a negotiated, per capita rate, which the group distributes among its physicians, usually on a salaried basis.

Staff Model HMO: A type of closed-panel HMO (in which patients can receive services only through a limited number of providers) in which physicians are employees of the HMO. The physicians see patients in the HMO's own facilities.

Network Model HMO: An HMO model that contracts with multiple physician groups to provide services to HMO members; it may involve large single and multispecialty groups. The physician groups may provide services to both HMO and non-HMO plan participants.

Individual Practice Association (IPA) HMO: A type of health care provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs. An IPA may contract with and provide services to both HMO and non-HMO plan participants.

Point-of-service (POS) plan: A POS plan is an HMO/PPO hybrid, sometimes referred to as an open-ended HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans (i.e., provider reimbursement based on a fee schedule or usual, customary, and reasonablec harges).

Physician-hospital organization (PHO): Alliances between physicians and hospitals to help providers attain market share, improve bargaining power, and reduce administrative costs. These entities sell their services to managed care organizations or directly to employers.

Managed care plans: Managed care plans usually provide comprehensive health services to their members and offer financial incentives for patients to use the providers who belong to the plan. Examples of managed care plans include HMOs, PPOs, EPOs, and POSs.

Managed care provisions: Features within health plans that provide insurers with a way to manage the cost, use, and quality of health care services received by group members.

Examples of managed care provisions include:

- *Preadmission certification:* An authorization for hospital admission given by a health care provider to a group member before their hospitalization. Failure to obtain a preadmission certification in non-emergency situations reduces or eliminates the health care provider's obligation to pay for services rendered.
- *Utilization review:* The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during, or after the services are rendered.
- *Preadmission testing:* A requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis before non-emergency hospital admission. The testing is designed to reduce the length of a hospital stay.
- *Non-emergency weekend admission restriction:* A requirement that imposes limits on reimbursement to patients for non-emergency weekend hospital admissions.
- *Second surgical opinion:* A cost-management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended that a non-emergency or elective surgery be performed. Programs may be voluntary or mandatory in that reimbursement is reduced or denied if the participant does not obtain the second opinion. Plans usually require that such opinions be obtained from board-certified specialists with no personal or financial interest in the outcome.
- *Maximum plan dollar limit:* The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while covered under the health plan. Plans can have a yearly or a lifetime maximum dollar limit. The most typical maximum is a lifetime amount of $1 million per individual.
- *Maximum out-of-pocket expense:* The maximum dollar amount a group member is required to pay out of pocket during a year. Until this maximum is met, the plan and group member shares in the cost of covered expenses. After the maximum is reached, the insurance carrier pays all covered expenses, often up to a lifetime maximum (see previous definition).

Medical savings accounts (MSAs): Savings accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pretax basis and carry over the unused funds at the end of the year.

Minimum premium plan (MPP): A plan in which the employer and the insurer agree that the employer will be responsible for paying all claims up to an agreed-on aggregate level, with the insurer responsible for the excess. The insurer usually is also responsible for processing claims and administrative services.

Multiple Employer Welfare Arrangement (MEWA): MEWA is a technical term under federal law that encompasses any arrangement not maintained pursuant to a collective bargaining agreement (other than a state-licensed insurance company or an HMO) that provides health insurance benefits to the employees of two or more private employers. Some MEWAs are sponsored by associations that are local, specific to a trade or industry, and exist for business purposes other than providing health insurance. Such MEWAs most often are regulated as employee health benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA),

(Continued)

BOX 14-3 Employment-Based Health Insurance Surveys—cont'd

although states generally retain the right to regulate them, much the way states regulate insurance companies. They can be funded through tax-exempt trusts known as Voluntary Employees Beneficiary Associations (VEBAs), and they can and often do use these trusts to self-insure rather than to purchase insurance policies. Other MEWAs are sponsored by Chambers of Commerce or similar organizations of relatively unrelated employers. MEWAs are not considered to be health plans under ERISA. Instead, each participating employer's plan is regulated separately under ERISA. States are free to regulate the MEWAs themselves. These MEWAs tend to serve as vehicles for participating employers to buy insurance policies from state-licensed insurance companies or HMOs. They do not tend to self-insure.

Multi-employer health plan: An employee health benefit plan maintained pursuant to a collective bargaining agreement that includes employees of two or more employers. These plans are also known as Taft-Hartley plans or jointly administered plans. They are subject to federal but not state law (although states may regulate any insurance policies that they buy). They often self-insure.

Premium: Agreed on fees paid for coverage of medical benefits for a defined benefit period. Premiums can be paid by employers, unions, employees, or shared by the insured individual and the plan sponsor.

Premium equivalent: For self-insured plans, the cost per covered employee or the amount the firm would expect to reflect the cost of claims paid, administrative costs, and stop-loss premiums.

Primary care physician (PCP): A physician who serves as a group member's primary contact within the health plan. In a managed care plan, the primary care physician provides basic medical services, coordinates, and if required by the plan, authorizes referrals to specialists and hospitals.

Reinsurance: The acceptance by one or more insurers, called reinsurers or assuming companies, of a portion of the risk underwritten by another insurer that has contracted with an employer for the entire coverage.

Self-insured plan: A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured plans bear the entire risk. Other self-insured employers insure against large claims by purchasing stop-loss coverage. Some self-insured employers contract with insurance carriers or third-party administrators for claims processing and other administrative services; other self-insured plans are self-administered. Minimum Premium Plans (MPPs) are included in the self-insured health plan category. All types of plans (i.e., conventional indemnity, PPO, EPO, HMO, POS, and PHOs) can be financed on a self-insured basis. Employers may offer self-insured and fully insured plans to their employees.

Stop-loss coverage: A form of reinsurance for self-insured employers that limits the amount the employers have to pay for each person's health care (individual limit) or for the total expenses of the employer (group limit).

Third-party administrator (TPA): An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer.

TYPES OF HEALTH CARE PROVIDER ARRANGEMENTS

Exclusive providers: Enrollees must go to providers associated with the plan for all non-emergency care for the costs to be covered.

Any providers: Enrollees may go to providers of their choice with no cost incentives to use a particular subset of providers.

Mixture of providers: Enrollees may go to any provider, but there is a cost incentive to use a particular subset of providers.

Usual, customary, and reasonable (UCR) charges: Conventional indemnity plans operate based on UCR charges. The UCR charge is the provider's *usual fee* for a service that does not exceed the customary fee in that geographic area and that is reasonable based on the circumstances. Instead of UCR charges, PPO plans often operate based on a negotiated (fixed) schedule of fees that recognize charges for covered services up to a negotiated fixed dollar amount.

SOURCES

Surveyd efinitions are available from the National Compensation Survey (BLS), the Medical Expenditure Panel Survey (AHRQ), and the National Employer Health Insurance Survey (NCHS). Definitions also are available from other federal agencies and surveys, such as the Current Population Survey (BLS/Census) and the Employee Retirement Income Security Act of 1974 (ERISA) (from U.S. Department of Labor—Pension and Welfare Benefits Administration).

Glossaries and informational papers from the Web sites of OPM's Federal Employees Health (http://www.dol.gov/ebsa/), Benefit Plans (glossary and specificpla nboo klets) (http://www.opm.gov/INSURE/HEALTH/), Blue Cross/Blue Shield (http://www.individual-health-plans.com/bluecrossblueshield.htm?source=google), the National Center for Policy Analysis (http://www.ncpa.org/),a ndt heHea lthIn surance Association of America (http://www.ahip.org/).

Severalpubli cations are available.

From Lafferty WE et al: Insurance coverage and subsequent utilization of complementary and alternative medicine providers. *Am J Manag Care* 12:397-404, 2006.

PREPARING MASSAGE CLAIM FORMS

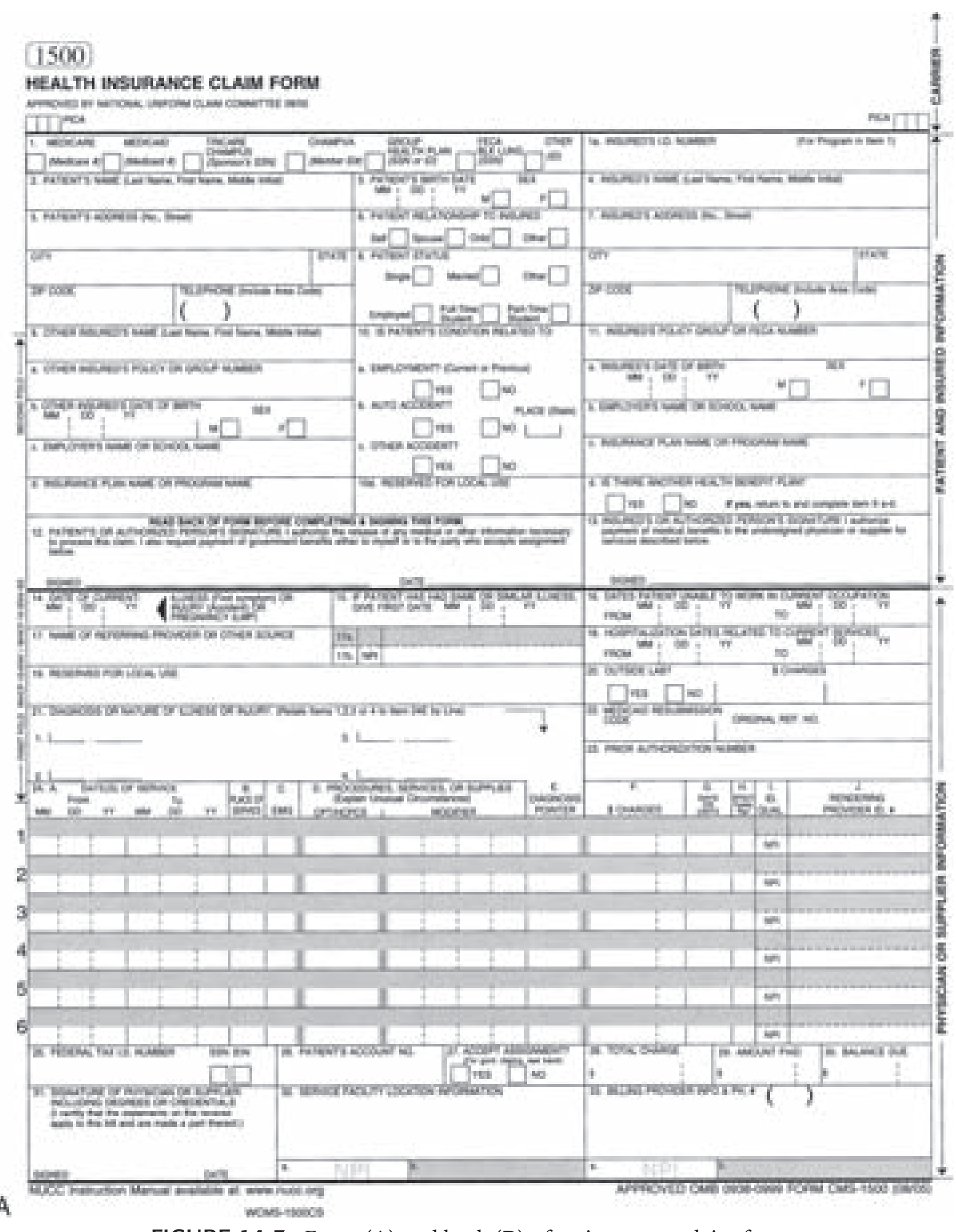
A *claim form* is used to apply for benefits and can be submitted on paper or electronically. With both formats, the same information is required on all claim forms. The trend for paperless business transactions supports the electronic claim process.

Paper Claim Form

There are no standardized forms for massage therapy insurancec laims(Fig.14- 3).

Electronic Claim Form

In computerized offices with access to the Internet, claim forms can be filed electronically. Under a provision of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA), effective October 2002, all health care providers, health plans, and health care clearinghouses that transmit data electronically must use a universal language and a standard format. Claims can be filed electronically through a clearinghouse or directly with the carrier.



1500

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1 2 3 4 5 6

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

A

FIGURE 14-3. Front (**A**) and back (**B**) of an insurance claim form.

(Continued)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

B

FIGURE 14-3, cont'd

Clearinghouse Method

With the clearinghouse method, batches of claims are transmitted to a clearinghouse, which scans the forms for errors or missing information and transmits error-free claims to the appropriate carrier. Claims with errors are electronically returned to the massage office for correction and resubmission. The clearinghouse prints and mails a paper claim for the few carriers unable to accept electronic claims. The advantages of using a clearinghouse are verification of claims and distribution of batches to multiple carriers. The disadvantage is the per-claim charge.

Direct to Carrier Method

With the direct to carrier method, the massage office staff members sort claims according to carrier and transmit the claims for each carrier separately. The carrier receives electronic claims the same day they are transmitted, and because the claims enter the carrier's processing system directly, turnaround time is reduced by an average of 2 to 4 days. Claim payment statements usually are available from the carrier's Web site, which can be accessed only by submitting a password. Many carriers also offer electronic funds transfer (i.e., direct deposit) of claim payments to the massage office's

bank account. If both of these electronic systems are used, the benefit payment can reach the massage office's bank account within 24 to 48 hours of transmission of the claim.

Procedural Codes

The American Medical Association (AMA) produces a manual containing thousands of codes for known medical procedures. Because of the ever-changing field of medicine, this manual is revised yearly. Combined with the World Health Association's International Classification of Disease (ICD) codes, the Current Procedural Terminology (CPT) codes offer a concise and accurate description of the medical professional's actions. CPT codes are developed, maintained, and copyrighted by the AMA. As the practice of health care changes, new codes are developed for new services, current codes may be revised, and old, unused codes are discarded. There are thousands of codes in use, and they are updated annually. Development and maintenance of these codes is overseen by AMA editorial boards, and the publication of all the software, books, and manuals needed by those who use them brings an estimated $70 million to the AMA each year.

Healthcare Common Procedure Coding System Codes

These Healthcare Common Procedure Coding System (HCPCS) numbers are the codes used by Medicare (Centers for Medicare and Medicaid Services [CMS]). There are two sets of codes. The first set, HCPCS level I, is based on and identical to the CPT codes described previously. Level II HCPCS codes are used by medical suppliers other than physicians, such as ambulance services or durable medical equipment suppliers. They are typically not costs that get passed through a physician's office, so they must be dealt with by Medicare or Medicaid differently from the way a health insurance company would deal with them (Box 14-4). The insurance biller is the expert on how to code for insurance reimbursement.

Massage therapists may be able to use a few codes from the Physical Medicine and Rehabilitation section of the CPT manual. It is questionable whether this is an appropriate use of the codes because they typically apply to physical therapists; ****97140 Manual Therapy Techniques is the code used.

In chiropractic practice, CPT code 97124 is used for Massage. Chiropractic Manipulative Treatment (CMT) codes are 98940 through 98943. CPT code 97124 describes work including effleurage, pétrissage, or tapotement (e.g., stroking, compression, percussion), each for 15 minutes. Massage (CPT code 97124) describes a service that is separate and distinct from those described by Chiropractic Manipulative Treatment, Osteopathic Manipulative Treatment, and Manual Therapy Techniques. Massage, unlike those techniques, is often considered totally passive in nature. The patient did not participate in the procedure, and the various massage techniques are applied to the patient.

Massage is applied to a large area, often crossing over several types of soft tissue and several areas of soft tissue, and it is used primarily for its restorative effects. In some cases, massage may be used for stimulating soft tissue (i.e., tapotement). The expected outcomes of massage are more general in nature and may be what the patient can tolerate at the more acute stage of their treatment plans. This includes goals such as increasing circulation, decreasing muscle soreness, and decreasing muscle spasm. The research available on massage techniques and their impact on the recovery of muscle function after exercise and on any one of the physiologic factors related to the recovery process shows that these techniques have very little impact. Its greatest influence is on the broad factors of pain modulation, muscle tightness, and blood flow to the related tissues.

The goal of therapeutic massage is to increase circulation and promote tissue relaxation to the muscles. It is of particular value when used in conjunction with other therapeutic procedures on the same day; the treatment plan is designed to restore muscle function, reduce edema, improve joint motion, and provide relief of muscle spasm. Therapeutic procedures can include superficial, effleurage,

BOX 14-4 Learn more about CPT and HCPCS Codes

Each year in the United States, health care insurers process more than 5 billion claims for payment. For Medicare and other health insurance programs to ensure that these claims are processed in an orderly and consistent manner, standardized coding systems are essential. The HCPCS level II code set is one of the standard sets of codes used for this purpose.

The HCPCS is divided into two principal subsystems: level I and level II. Level I of the HCPCS is composed of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. These health care professionals use the CPT to identify services and procedures for which they bill public or private health insurance programs. Decisions regarding the addition, deletion, or revision of CPT codes are made by the AMA. The CPT codes are updated annually by the AMA. Level I of the HCPCS, the CPT codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians.

Links to more information about CPT and HCPCS codes are available on the Evolve Web site (http://evolve.elsevier.com/Fritz/business).

From http://www.cms.hhs.gov/MedHCPCSGeninfo/.

pétrissage, percussion, pressure-point work (i.e., acupressure and shiatsu), trigger-point work, and deep-tissue techniques. Also included in the CPT code 97124 is the use of a Genie Rub, Thumper, G5, or other device, so long as it is manually applied. Use of handheld tools or probes includes the application of manual pressure, which would likely fall under the massage description. Massage usually is applied to a large area, often crossing over several types of soft tissue and several regions. The code requires that the doctor or therapist be hands-on and constantly attending to the patient, and massage beds, tables, or chairs do not qualify for this code description; for those units, the unlisted modality code would be more appropriate.

Manual Therapy (CPT 97140) describes multiple manually applied services, including manual traction, myofascial release, joint mobilization, manual lymphatic drainage, and manipulation (nonchiropractic). For myofascial release work, the targeted region is a specific muscle or other soft tissue. Findings usually involve an adhesion or area of fibrosis exhibited by a painful band or "knot" within the muscle and subsequent limited range of motion. This code describes manually applied techniques that increase active pain-free range of motion and increase extensibility of myofascial tissue, with the goal of restoring function of the muscle or soft tissue. A variety of active manual techniques that achieve these goals can reasonably be coded with 97140. The specific technique usually is described as active or passive, or both. *Active* or *passive* indicates the method of stretching or elongation of the soft tissue. This procedure is typically considered painful and may need some analgesia before and after service. When documenting the service, the interaction between the patient and therapist should be reported. The chart notes should clearly indicate what style or procedure was performed, with the appropriate reporting of the targeted soft tissue, the technique used, time spent, goals, and the response to the treatment.

Neuromuscular Re-education (CPT 97112) is intended to identify therapeutic exercise designed to retrain a body part (i.e., re-educate the muscle) to perform some task that the body part was previously able to do. This usually is in the form of some commonly performed task for that body part. It is most commonly used for patients after a stroke or surgery. Specific goals typically include work to improve balance, coordination, kinesthetic sense, posture, and proprioception. The idea is that the motor system needs to be "repatterned" for normal activities. Also included are services to retrain poor static or dynamic sitting or standing balance and loss of gross or fine motor coordination. Neuromuscular re-education techniques are usually applied progressively by using active movements under a variety of mechanical conditions. Examples include proprioceptive neuromuscular facilitation, Janda, Feldenkrais, Bobath, Alexander, and cross-crawl techniques. Balance boards and similar equipment also can be documented under this code.

SELF-REFLECTION

How do I feel as I read all of this information? Excited? Interested? Overwhelmed? Frustrated? Nothing? Do I want to be accountable for the record keeping necessary to receive health insurance reimbursement for massage services? If I work for a business that has a biller who does the paperwork, what are my responsibilities? Would that make a difference in my opinion of insurance billing for massage services?

Because massage therapists do not diagnose conditions, the ICD code must be acquired from a prescribing medical specialist. The easiest and most reliable way to obtain the correct codes for massage is to check directly with the insurance company to be billed. Codes can change yearly; do not assume that codes will remain the same.

INSURANCE PAY SYSTEM

Organization

The insurance pay system has four parts:

1. Client
2. Group or program sponsor (e.g., employer, union, businessa ssociation)
3. Insurance benefits carrier, which may be an insurer, a third-party administrator (TPA), or insurance service corporation
4. Prescribing physician and massage therapist

For the process to succeed, a system of communication and information sharing must connect all four parties. The massage therapist communicates regarding services, coding, and fees for treatment with the client to verify carrier information, benefits, and payment acceptance and with the carrier for billing, payment, and benefit information. This job requires organization, perseverance, and strict attention to detail. The following points can assist in organizing the process. Document each subscriber's scope of coverage (excluding maximums, *limitations*, and deductibles), and obtain the complete mailing address and telephone number for claims and inquiries. Note any special information the carrier requires.

- Keep these materials organized in a notebook or file.
- Inform each client about his or her benefits and the amount for which the client is responsible.
- Set aside a specific time to complete the claim forms or prepare each claim form at the completion of treatment.
- Keep a current file or computer record of outstanding claims, and review it regularly.

- When required, request preauthorization for treatment.
- Regularly verify and update clients' general information.
- Maintain an adequate supply of claim forms.
- Be accurate, and answer all questions on the claim form completely, providing details as required. If a question does not apply, leave it blank.
- Whenever possible, attend seminars presented by benefits carriers to keep current on billing practices.

Insurance Fraud

It is illegal to misrepresent treatment or to inaccurately report fees and dates of service to benefits carriers. The following actions, whether deliberate or unintentional, constitute fraud:

- Billing the benefits carrier for higher fees than the client is charged
- Billing before completion of service
- Predating or postdating services on claim forms
- Improperly reporting treatment (e.g., physical therapy instead of massage therapy)
- Billing for services not rendered

Accuracy and honesty are crucial. Those defrauding benefits carriers may be liable for legal prosecution (Box 14-5).

LEARNING ACTIVITY

Review this chapter, and make a list of the activities involved in billing insurance companies for massage services.

CD Using your practice management software, add a new client into the system. You can base the "client" on someone you know or make up a client. This client will receive insurance coverage for massage. Fill out the proper documents for insurance reimbursement. Continue to update the scheduling and history information and SOAP documentation for a total of 6 sessions for this client, then run a summary report of progress as an update on the progress of the client to be transmitted to the insurance company.

SUMMARY

All parties involved with insurance—the client, massage therapist, the group or program sponsor of the insurance, and the insurance benefits carrier—must communicate effectively to have a successful insurance relationship. The success comes from correctly coding the insurance claims and getting to the appropriate party. Whether the plan is an

BOX 14-5 Abstract: Insurance Coverage and Subsequent Utilization of Complementary and Alternative Medicine Providers

Background: Since 1996, Washington State law has required that private health insurance cover licensed complementary and alternative medicine (CAM) providers.

Objective: To evaluate how insured people used CAM providers and what role this played in health care utilization and expenditures.

Study Design: Cross-sectional analysis of insurance enrollees from western Washington in 2002.

Methods: Analysis of insurance demographic data, claims files, benefit information, diagnoses, CAM and conventional provider utilization, and health care expenditures for 3 large health insurance companies.

Results: Among more than 600,000 enrollees, 13.7% made CAM claims. This included 1.3% of enrollees with claims for acupuncture, 1.6% for naturopathy, 2.4% for massage, and 10.9% for chiropractic. Patients enrolled in preferred provider organizations and point-of-service products were notably more likely to use CAM than those with health maintenance organization coverage. The use of CAM was greater among women and among persons 31 to 50 years of age. The use of chiropractic was more frequent in less populous counties. The CAM provider visits usually focused on musculoskeletal complaints except for naturopathic physicians, who treated a broader array of problems. The median per-visit expenditures were $39.00 for CAM care and $74.40 for conventional outpatient care. The total expenditures per enrollee were $2589, of which $75 (2.9%) was spent on CAM.

Conclusions: The number of people using CAM insurance benefits was substantial; the effect on insurance expenditures was modest. Because the long-term trajectory of CAM cost under third-party payment is unknown, utilization of these services should be followed.

From Lafferty WE et al: Insurance coverage and subsequent utilization of complementary and alternative medicine providers [abstract]. *Am J Manag Care* 12:397-404, 2006.

Good Stuff from the Government

NATIONAL INSTITUTES OF HEALTH

The National Institutes of Health provides a wealth of information about complementary and alternative medicine (CAM), including definitions, typical costs for treatment, and eligibility insurance reimbursement.

A health savings account (HSA) is a type of tax-exempt account. It is for people who participate in a high-deductible health plan (i.e., catastrophic health plan). In an HSA, you—not your employer—establish and maintain the account, although some employers make contributions. You can also invest your HSA funds to earn tax-deductible interest. Similar options include a flexible spending account (FSA) and a health reimbursement arrangement (HRA).

The Internal Revenue Service (IRS) has further information on these accounts. The IRS does not allow the same expenses to be reimbursed through an FSA or HSA and to be claimed as tax deductions. In tax year 2005, the IRS allowed taxpayers to deduct medical expenses for a limited number of CAM services and products, such as acupuncture and chiropractic care.

GovBenefits (http://www.govbenefits.gov/) and USA.gov (http://www.usa.gov/) are two Internet resources that explain federal health benefit programs. GovBenefits has a test you can take about qualifying for programs. State and local departments of health or social services also have financial assistance programs for eligible residents, and you can contact them directly to inquire.

The National Center for Complementary and Alternative Medicine (NCCAM) Clearinghouse provides information on CAM and NCCAM, including publications and searches of federal databases of scientific and medical literature. Two of its publications are *Selecting a CAM Practitioner* and *Are You Considering Using CAM?* The Clearinghouse does not provide medical advice, treatment recommendations, or referrals to practitioners.

PUBMED

A service of the National Library of Medicine (NLM), PubMed contains publication information and, in most cases, brief summaries of articles from scientific and medical journals. CAM on PubMed, developed jointly by NCCAM and NLM, is a subset of the PubMed system and focuses on the topic of CAM.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

The Agency for Healthcare Research and Quality (AHRQ) conducts research on health care outcomes, quality, costs, use, and access. Publications for consumers include *Choosing and Using a Health Plan* and *Checkup on Health Insurance Choices*.

DEPARTMENT OF LABOR

The Department of Labor (DOL) has publications on federal health care laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Consolidated Omnibus Budget Reconciliation Act (COBRA), that apply to job seekers, workers, and retirees.

INTERNAL REVENUE SERVICE

The IRS is the nation's tax collection agency. Among its services are publications for consumers:

- Publication 969: *Health Savings Accounts and Other Tax-Favored Health Plans*
- Publication 502: *Medical and Dental Expenses*

All links are available on the Evolve Web site.

HMO, HSA, or something else, each has appropriate codes and methods that must be used to achieve the desired results. Some therapists may prefer to outsource to an insurance biller to have the most effective insurance outcomes. The CPT codebook provides a concise and accurate description of codes a type of dictionary for insurance billing. However, the therapist needs to understand and use the codes accurately to be successful at this component of the business.

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United States Department of Health & Human Services Agency for Healthcare Research and Quality: Information about insurance. Available at http://www.ahrq.gov/consumer/insuranceqa/ (accessed June 2009).

Evolve Annotated Web Links

http://evolve.elsevier.com/Fritz/business

Academic Consortium for Complementary and Alternative Health Care(http://ihpc.info/accahc/accahc.shtml)

Agency for Healthcare Research and Quality (AHRQ) (http://www.ahrq.gov)

Bodyworker (thebodyworker.com) and Massage School Notes (www.thebodyworker.com)

Complementary and alternative medicine (CAM) on PubMed (http://www.nccam.nih.gov/camonpubmed/

Council for Affordable Health Care (http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf)

Definitions of health insurance terms (http://www.bls.gov/ncs/ebs/sp/healthterms.pdf)

Department of Health and Human Services, Centers for Medicare andM edicaidSer vices:(http://www.cms.hhs.gov/)

DepartmentofL abor (DOL) (http://www.dol.gov/)

Department of Labor (DOL), Consumer Health Plans and Benefits Information (http://www.dol.gov/dol/topic/health-plans/index.htm)

FederalT radeCom mission (http://www.ftc.gov/)

IntegratedHea lthcare Policy Consortium (http://ihpc.info/)

Internal Revenue Service (IRS) (http://www.irs.gov/)

Internal Revenue Service (IRS), Publication 502, Medical and Dental Expenses (http://www.irs.gov/pub/irs-pdf/p502.pdf)

Internal Revenue Service (IRS), Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans (http://www.irs.gov/pub/irs-pdf/p969.pdf)

MedlinePlus, drugs, supplements, and herbal information (http://www.nlm.nih.gov/medlineplus/druginformation.html)

National Cancer Institute, search for clinical trials (http://www.cancer.gov/clinicaltrials/search)

National Center for Complementary and Alternative Medicine (NCCAM) Clearinghouse (nccam.nih.gov)

PubMed (http://www.ncbi.nlm.nih.gov/sites/entrez?db-pubmed)

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, questions and answers about health insurance (http://www.ahrq.gov/consumer/insuranceqa/; http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf)

U.S. Food and Drug Administration (http://www.fda.gov/)

U.S. Food and Drug Administration, dietary supplements overview (www.fda.gov/Food/DietarySupplements/default.html)

U.S. Government official Web portal (http://www.usa.gov/)

Workbook

1. Identifyt hefour pa rtiesa ffectedby i nsuranceben efits and the roles of each.

2. Identifyt het ypesofi nsuranceben efitspr ograms.

3. Explaina st andardi nsurancec laimfo rm.

4. What are the differences between using a paper claim form and an electronic claim form?

5. Identifyfi ve actions that constitute benefitsfr aud.

6. Explainpr ocedurec odes.

15

ACCOUNTING CONCEPTS

OUTLINE

Financial Systems
Understanding Basic Mathematical Computations
Decimals
Percentages
Bookkeeping Systems
Types of Systems
Components of a Computerized Bookkeeping System
Payment Policies and Statements
Using a Credit Bureau
Collecting Fees
Fair Debt Collection Practices Act
Collection Letters
Telephone as a Collection Instrument
Collection Agency
Summary

KEY TERMS

Accounting
Accounts payable
Accounts receivable
Adjustment
Balance
Bookkeeping
Credit balance
Credit bureau
Nonsufficient funds (NSF) check
Receipt
Statement

LEARNING OUTCOMES

Mastery of the content in this chapter will enable the reader to:

- Define key terms
- Define bookkeeping
- Define accounting
- Explain basic mathematical procedures
- Describe common bookkeeping systems in massage therapy
- Explain the function of a computerized accounts receivable program
- Describe the components of a pegboard bookkeeping system
- Explain the procedures used in a pegboard bookkeeping system
- Explain the common systems of statement production
- Identify common payment and credit policies
- Describe the various laws affecting credit policies and collection procedures
- Identify common problems in maintaining a credit policy
- Identify the functions of a credit bureau
- Explain the function of a collection agency
- Compose collection letters

Guidelines for the Learning Activities and answers to the Workbook questions are located on Evolve at http://evolve.elsevier.com/Fritz/business.

Certain things are best left to the professionals. This means that a small business owner will need to hire an accountant at one time or another. If you are an employee, you will not be directly responsible for accounting and bookkeeping. It is important, however, to understand the demands of the accounting process. *Accounting*, which is the recording, classifying, and summarizing of financial and business records, usually is the job of an accountant. If self-employed (i.e., business owner), it is highly recommended that you have an accountant who audits the books and computes a variety of tax reports and financial statements. There are too many changes in tax law yearly to keep up with while you run your business.

Although this textbook gives you a brief introduction to business accounting, the intricate and ongoing changes of finances and taxes mandate an expert. You can, however, make the accountant's job much more efficient and more cost effective by keeping the bookkeeping process in order.

Bookkeeping, or the recording of financial transactions, typically is the responsibility of the business owner. This may be your employer or you if you own the business.

Just as with massage therapy, the best way to find an accountant is the recommendation of other satisfied business owners. Small business accounting is much the same for all types of business. Do not look only for tax preparation services. If the size of your business warrants, you should look for more than simple tax preparation from an accountant. The small business owner should contract with the accountant to provide advice in the areas of business structuring, record keeping, timing of expenses or payments, and reduction of tax liability.

FINANCIAL SYSTEMS

Because massage therapy is a business as well as a health profession, sound business practices must be integrated into the management of the massage business office. The two financial systems used in a massage business office are *accounts receivable* and *accounts payable*. If you are self-employed, you are responsible for both. If you are an employee, your paycheck is part of accounts payable, because you are receiving a paycheck from the business.

The accounts receivable system includes all production; data are entered for treatment rendered and payments received, and new balances are calculated. After all computations have been made, the current accounts receivable amount, or the amount of money owed to the massage therapist (i.e., incoming money), is determined. Accounts payable refers to all of the massage therapist's financial obligations, or money the massage therapist owes (i.e., outgoing money). This chapter discusses accounts receivable; Chapter 16 details accounts payable and other financial systems.

Records management is a primary business responsibility. Financial records are as important as clinical records but should be maintained separately. They provide (1) protection for both the massage therapist and the client, (2) information for tax purposes, and (3) data for a business analysis. Inaccurate records result in poor public relations and may create unnecessary litigation with the state or federal government.

UNDERSTANDING BASIC MATHEMATICAL COMPUTATIONS

Before you can become proficient at computing financial activity on various records, you must review some basic mathematical rules. Because computers are used to produce so many documents, it often is easy to forget how to perform basic calculations.

Although a computer with the appropriate software can make the necessary calculations, you are responsible for entering the data in the appropriate fields to ensure that the final figures are accurate. You often need to add and subtract figures with decimals and perform other business-related computations. Most people use manual or electronic calculators for these tasks; however, relying solely on technological devices without having an understanding of basic computation can result in embarrassment, client dissatisfaction, and possibly loss of cash flow when errors are detected. The following descriptions cover basic mathematical procedures used for routine bookkeeping entries.

Decimals

ADDING AND SUBTRACTING DECIMALS

Place the numbers to be added or subtracted in a vertical column, aligning the decimal points, before performing the addition or subtraction. To add columns of figures with decimals, add the numbers in each column, beginning with the column farthest to the right and working your way to the left:

$$\begin{array}{r} 0.5 \\ 2.8 \\ 30.50 \\ 67.945 \\ +\underline{750.000} \\ 851.745 \end{array}$$

To subtract, follow the same procedure. Place the numbers to be subtracted in a vertical column, aligning the decimal points. Each amount must have the same number of decimals, and it may be necessary to add zeros before performing this procedure. For example, to subtract 1.75 from 3.876, add one zero at the end of the 1.75:

$$\begin{array}{r} 3.876 \\ -\underline{1.750} \\ 2.126 \end{array}$$

MULTIPLYING DECIMALS

To multiply decimals, perform the procedure as you would for all whole numbers, except the decimal point must be placed correctly in the answer. Count the number of digits to the right of the decimal point in the multiplicand and in the multiplier; then count the same number of places from right to left in the product and insert the decimal point:

600.75	2 decimals (multiplicand)
× .20	2 decimals (multiplier)
120.1500	2 + 2 = 4 decimals

or

$800.50	2 decimals
× .75	2 decimals
400250	
560350	
$ 600.3750	2 + 2 = 4 decimals

or

$800	0 decimals
×.75	2 decimals
$600.00	0 + 2 = 2 decimals

Percentages

Working with percentages is a common function of routine posting of accounts receivable data. To change a percent to a fraction, drop the percent sign, place the number over 100, and reduce the fraction to the lowest terms. If the numerator is a decimal, multiply both the numerator and denominator by an appropriate power of 10 to clear the decimal. For instance,

$$5\% = \frac{5}{100} = \frac{1}{20}$$

or

$$7.5\% = \frac{7.5}{100} = \frac{75}{1000} = \frac{3}{4}$$

To change a percent to a decimal, move the decimal point two places to the left and drop the percent sign.

15% = 0.15

2% = 0.02

110% = 1.1

To find a certain percentage of a number, convert the percent amount to a decimal amount, and multiply by the number. The following computation shows how to calculate 80% of $670:

$670
× .80
$536

LEARNING ACTIVITY

List additional areas in the massage therapy practice in which a working knowledge of basic math is necessary.

____

____

____

____

BOOKKEEPING SYSTEMS

Types of Systems

Bookkeeping is the recording of financial transactions. If you are responsible for bookkeeping, you can select from a variety of bookkeeping systems, including the pegboard ("write it once") system, which, until the 1990s, was the system most often used in small business offices. With the pegboard system, one notation provided an entry on the daily journal sheet, the ledger card, the *receipt,* and in some cases, a statement. The current system of choice is a computer software program, which goes beyond the basic transactions of the pegboard system to provide all financial records, insurance claim forms (if applicable), future appointments, and recall management, and documents for practice analysis.

A computerized bookkeeping system can be integrated into total records management. In other words, you can make a clinical entry on a client's record that can then be transferred to a financial record. Using designated codes, you can transfer this information to a client's statement, and an insurance claim form can be generated from the original data entry. This type of system is more than a mechanism for bookkeeping. The CD that accompanies this book has a basic bookkeeping system.

Components of a Computerized Bookkeeping System

Chapter 5 described the use of massage office management software. One component of most of these systems is the accounts receivable program. By entering data for a client account it is also possible to generate myriad reports, forms, or other types of information.

To generate accounts receivable data, you follow specific steps outlined in the software package. The following description is an overview of some of the common steps in basic data entry on the CD at the back of the book. Table 15-1 presents some common commands used in a variety of accounts receivable programs.

OPENING THE PROGRAM

When you open the program, you commonly are required to enter your name or your user name and a password. When you enter a password, the characters are not displayed on the screen as you key them in. Most systems allow for reentry of your password in case you make an error, but after a specified number of erroneous entries, the program may abort.

TABLE 15-1 Common Commands in Accounts Receivable Software

COMMAND	MEANING
ADD	Enter additional data; create a new record
APPOINTMENT/ SCHEDULER	Enter data for a client appointment
DEL	Delete; to eliminate part or all of the data entry
EDIT	Alter or change data
ENTER	Insertda ta
ESC	Leave the screen
FILE	Open, close, print, or take action on files
INSURANCE	Make a data entry or obtain a hard copy of a claim form
LIST	Provides a screen view or hard copy of lists of clients, accounts, or other data
LOCATE	Find a client, an account, or other data
N	No
CLIENT	Enter a field of client records
POST	Enter data, financial or other
PRINT	Produce a hard copy of a document
RECALL	Enter data about a client for recall
REPORTS	Obtain some form of report programmed into the system
SYSTEM	Change the system setting, log in, or password
TRANSACTION	Reference to financial activity
VIEW	Changes the format of the screen view
WINDOW	Allows a different configuration of the screen
WORD PROCESSOR	Program that allows letter writing
Y	Yes

LOCATING ACCOUNT INFORMATION

When you make a selection, such as Clients, a box opens; you then find a list of your current clients. Click on the name of one client. The account information window opens (Fig. 15-1). If no account appears, one can be added by clicking on the NEW button and creating a new client record (Fig. 15-2). Certain basic account information is common to most systems, such as an identification (ID) number, massage therapist (the primary provider if an office has several massage therapists), user codes, name and address, personal data (e.g., telephone number or numbers, Social Security number, date of birth, gender, age), insurance, employment, and special notes, such as last update, last payment, date of admission, and insurance numbers.

EDITING ACCOUNT INFORMATION

Sometimes, you need to edit account information, such as when a client's name or address changes. To do this, you enter the client window and select Edit (which refers to the task of changing existing data).

ADDING OR DELETING A CLIENT

You may add clients to an account in the system shown by selecting the NEW command. This is commonly done to add a spouse or dependent to an account, but it also may be required in the case of marriage, divorce, or death or when older children are transferred to their own accounts. If your client has not visited in a given amount of time, you can simply move the account to the inactive tab rather than deletingi t.

POSTING TRANSACTIONS

A common daily activity in bookkeeping is entering transaction data. From the transaction screen (Fig. 15-3), most systems are designed to allow you to enter clinical data about treatment, for which you may insert appropriate codes. When the data are entered, the program computes the financial activity and produces an account *balance*. Before these data are stored, fill out any necessary insurance claim forms or other activity (e.g., recall or appointment scheduling). A walk-out statement (Fig. 15-4) and an insurance claim form should be generated after these data entries are complete.

BACKING UP DATA

Maintaining all the practice data on a computer's hard drive is dangerous. Valuable information can be lost as the result of a power surge, computer crash, or misdirected ERASE or DEL command. For this reason, the hard drive must be backed up regularly. This can be done using a CD-ROM, DVD, or some other type of storage device. The office procedures manual must describe the backup procedure step by step, and a backup log must be maintained (Fig. 15-5).

SELF-REFLECTION

How do I feel about math? Is it difficult or easy for me? How did I do in math in school? Am I afraid of a computer, or am I comfortable with computers? Do I remember how to do basic math computations? Do I trust my accuracy? How well can I use a calculator? Do I double-check my calculations? Do I enjoy this type of activity? If not, can I still motivate myself to keep up with the financial obligations? How will this influence whether I am an employee or self-employed?

SPECIAL PROBLEMS

A day would not be complete without some unusual activity that cannot be recorded using the procedure exactly as listed previously. Several such situations and their solutions are presented in the following discussion.

A *credit balance* often occurs when payment is made in advance, such as when a client buys a gift certificate for a massage or a massage package such as 10 massage sessions for the price of 9 sessions. A credit balance of $50, for example, can be noted in three ways: (1) with the amount preceded by *CR* (CR$50); (2) with the amount preceded by a minus sign (−$50) as shown in Figure 15-6; and (3) with the amount in color and enclosed in parentheses ($50).

When a gift certificate is redeemed or a massage is received, charges are made against the credit balance, reducing it. The credit balance represents what is owed to the client in services. The credit balance is also shown when a client pays on thea ccount(Fig. 15-7).

Nonsufficient funds (NSF) checks, or checks returned to the office because of a lack of account funds, require some form of adjustment to the account. You may redeposit the check and not make an entry on the books. However, it may be necessary to charge the account with this returned check. Collection fees are paid to an agency for collecting a delinquent account, and these fees usually are deducted from the payment before it is sent to the massage therapist. For the returned check in Figure 15-8, an NSF notation has been made, and a service charge of $25 has been assessed to the account.

A courtesy discount is given when the massage therapist extends a professional courtesy to a client. The courtesy discounti sen teredi nt hea djustmentc olumn (Fig. 15-9).

PAYMENT POLICIES AND STATEMENTS

Many payment policies are used in massage business, but a few are common to all practices:

Cash only: The cash-only system is common and eliminates much paperwork in the business office, but it may place limitations on the massage practice.

Payment of statement in full: Unless other arrangements have been made with the office, the client is expected to pay in

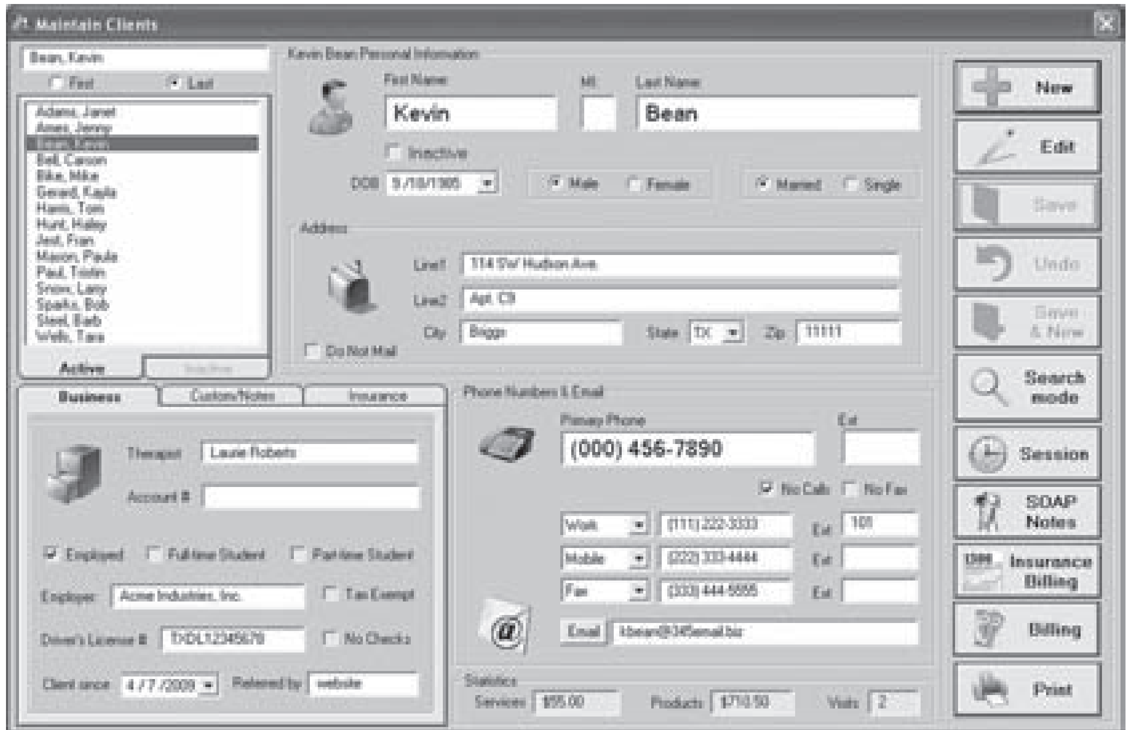


FIGURE 15-1. Account information screen. *(Courtesy of Island Software.)*

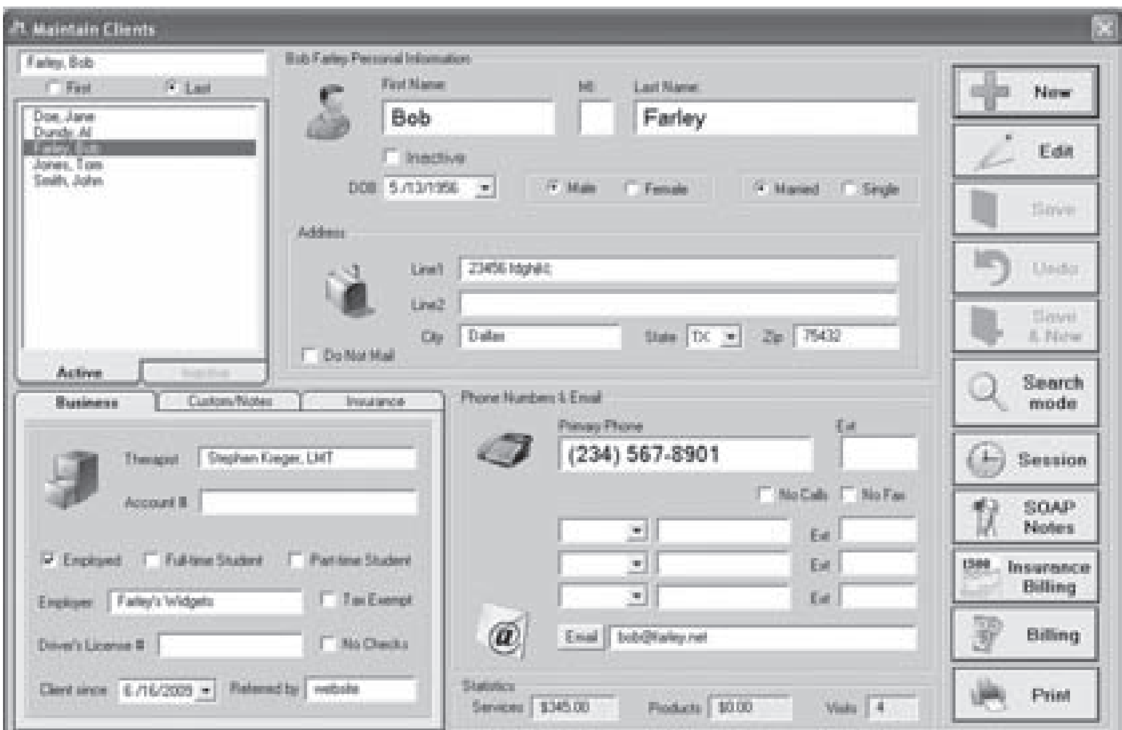


FIGURE 15-2. New client information screen. *(Courtesy of Island Software.)*

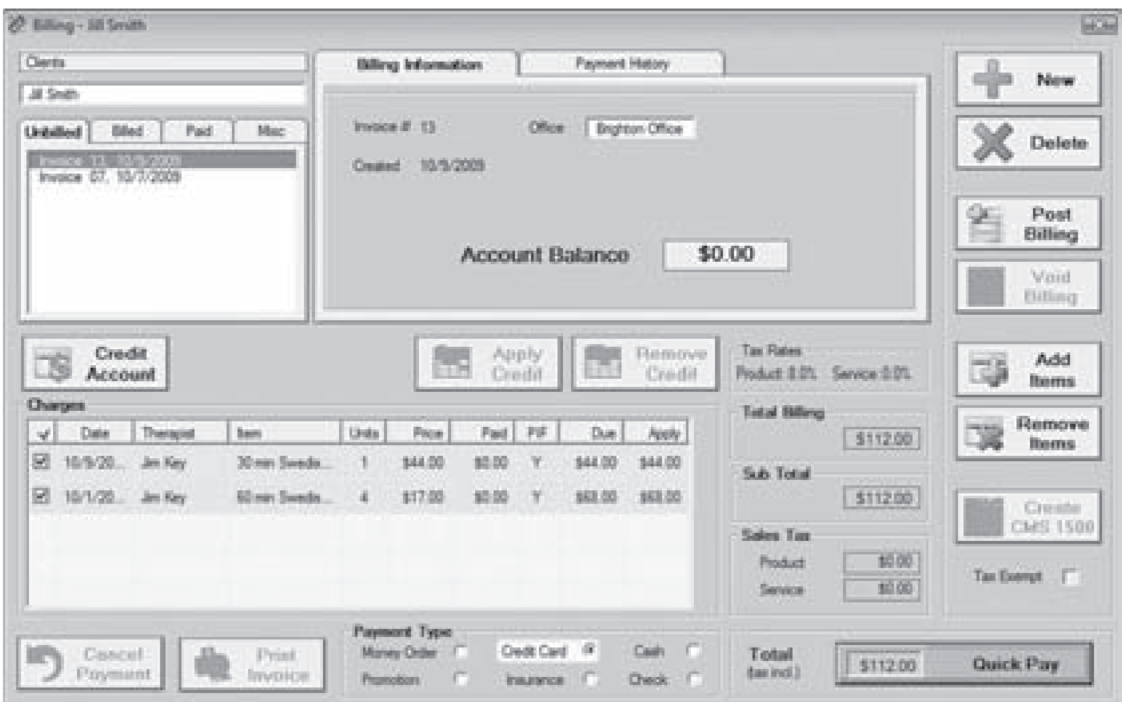
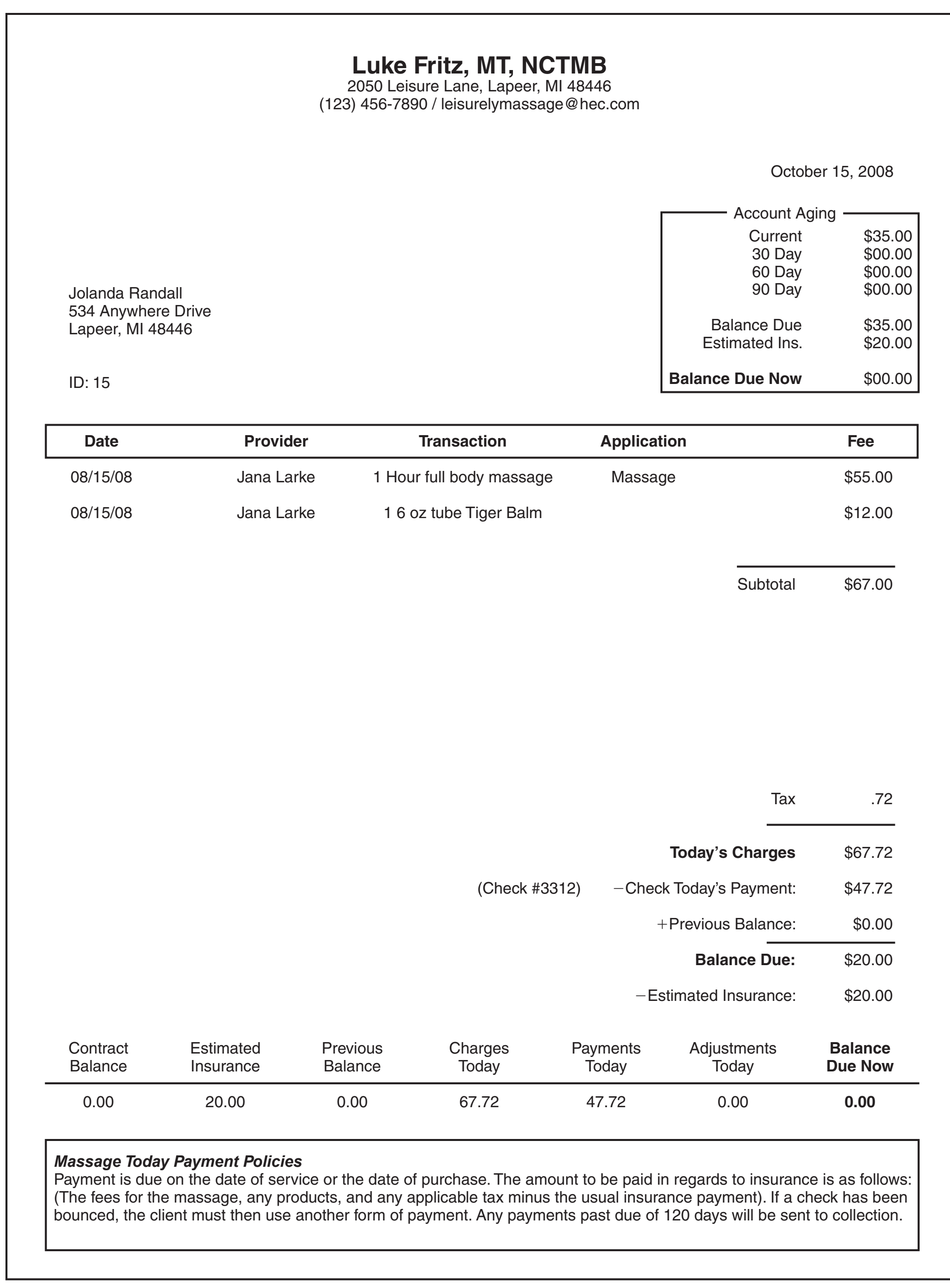


FIGURE 15-3. Transaction screen. *(Courtesy of Island Software.)*

full within 10 days of receipt of the statement. Some form of notice, such as appropriate signage or a written policy statement, must be presented to the client.

Extended payment: Regulation 2 of the Truth in Lending Act requires that an agreement exists between the massage therapist and the client if payment for services is to be made in more than four installments. Even if no finance charge is involved, the truth in lending form (Fig. 15-10) must be completed to verify that such a payment agreement has been reached.



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October 15, 2008

Account Aging

Current	$35.00
30 Day	$00.00
60 Day	$00.00
90 Day	$00.00
Balance Due	$35.00
Estimated Ins.	$20.00
Balance Due Now	$00.00

Jolanda Randall
534 Anywhere Drive
Lapeer, MI 48446

ID: 15

Date	Provider	Transaction	Application	Fee
08/15/08	Jana Larke	1 Hour full body massage	Massage	$55.00
08/15/08	Jana Larke	1 6 oz tube Tiger Balm		$12.00

	Subtotal	$67.00
	Tax	.72
	Today's Charges	$67.72
(Check #3312)	−Check Today's Payment:	$47.72
	+Previous Balance:	$0.00
	Balance Due:	$20.00
	−Estimated Insurance:	$20.00

Contract Balance	Estimated Insurance	Previous Balance	Charges Today	Payments Today	Adjustments Today	**Balance Due Now**
0.00	20.00	0.00	67.72	47.72	0.00	**0.00**

Massage Today Payment Policies
Payment is due on the date of service or the date of purchase. The amount to be paid in regards to insurance is as follows: (The fees for the massage, any products, and any applicable tax minus the usual insurance payment). If a check has been bounced, the client must then use another form of payment. Any payments past due of 120 days will be sent to collection.

FIGURE 15-4. Walk-out statement.

A *statement* informs clients of their financial status with the massage therapist and indicates the charges, payments, and balances of their accounts for the month just concluded. The statement is also a request for payment. Monthly statements may be sent on day 1, 15, or 30 or on a staggered basis according to the alphabet. The important factor is consistency; be sure to send the statements at the same time each month.

A statement can be generated on the computer with an automated bookkeeping system. The itemized statement shows the dates of payments and the treatments for each member of the family during the month. With a computerized system, you can add special messages or aging columns to statements to enhance the collection process.

USING A CREDIT BUREAU

Perhaps the best way to define a *credit bureau* or *consumer reporting agency* (CRA) is to explain what it does not do. It does not lend money; it does not deny credit; and it is not a collection agency. A credit bureau reports specific information about a person's previous payment habits on deferred

BACKUP LOG

Date	Disk/Tape	Initials	Storage Location

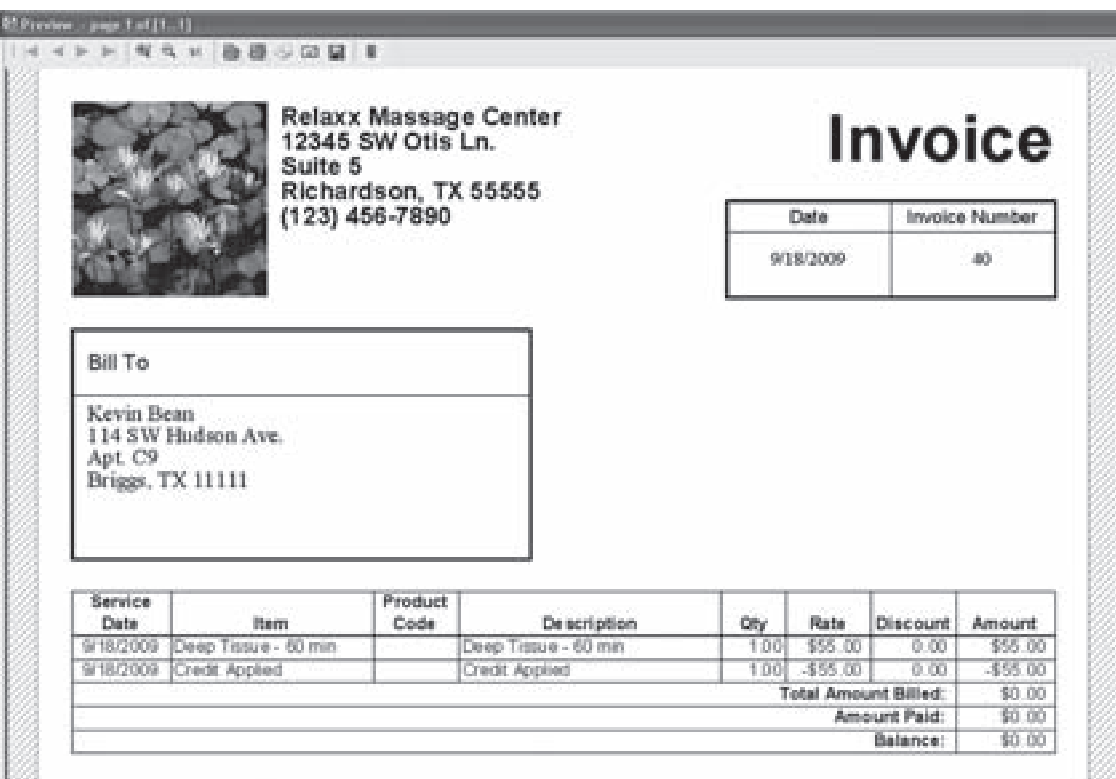
FIGURE 15-5. Backuplog. *(From Finkbeiner BL, Finkbeiner CA:* Practice Management for the Dental Team, *ed 6, St. Louis, 2006, Mosby.)*

payment plans. It reports on accounts placed for collection and provides information of public interest, such as that regarding bankruptcies, judgments, and lawsuits.

The Fair Credit Reporting Act (FCRA) was passed in 1992 to promote accuracy, fairness, and privacy of information in the files of all CRAs. Most CRAs are credit bureaus that gather and sell information about a person (e.g., whether a person pays bills on time or has filed bankruptcy) to creditors, employers, landlords, and other businesses. The full text of this legislation is available on the Federal Trade Commission (FTC) Web site. Consumers may have additional rights under state law, and a state or local consumer protection agency or a state attorney general can provide that information.

CRAs charge a nominal fee for supplying information. When seeking information from a credit bureau, complete data should be given about the prospective credit applicant. This information should include the following information about the individual:

- Full name, including first and middle names, is supplied. Accurate spelling is essential. The spouse's name should be used as a cross-reference for identification purposes only.
- Address or addresses for the past 3 years
- Place of employment for the past 3 years
- Names of stores and firms where credit has been established
- Name of bank or banks
- SocialSec urityn umber



Relaxx Massage Center
12345 SW Otis Ln.
Suite 5
Richardson, TX 55555
(123) 456-7890

Invoice

Date	Invoice Number
9/18/2009	40

Bill To

Kevin Bean
114 SW Hudson Ave.
Apt. C9
Briggs, TX 11111

Service Date	Item	Product Code	Description	Qty	Rate	Discount	Amount
9/18/2009	Deep Tissue - 60 min		Deep Tissue - 60 min	1.00	$55.00	0.00	$55.00
9/18/2009	Credit Applied		Credit Applied	1.00	-$55.00	0.00	-$55.00
						Total Amount Billed:	$0.00
						Amount Paid:	$0.00
						Balance:	$0.00

FIGURE 15-6. The current credit balance on the account is indicated by the amount preceded by a minus sign on the invoice. *(Courtesy of Island Software.)*

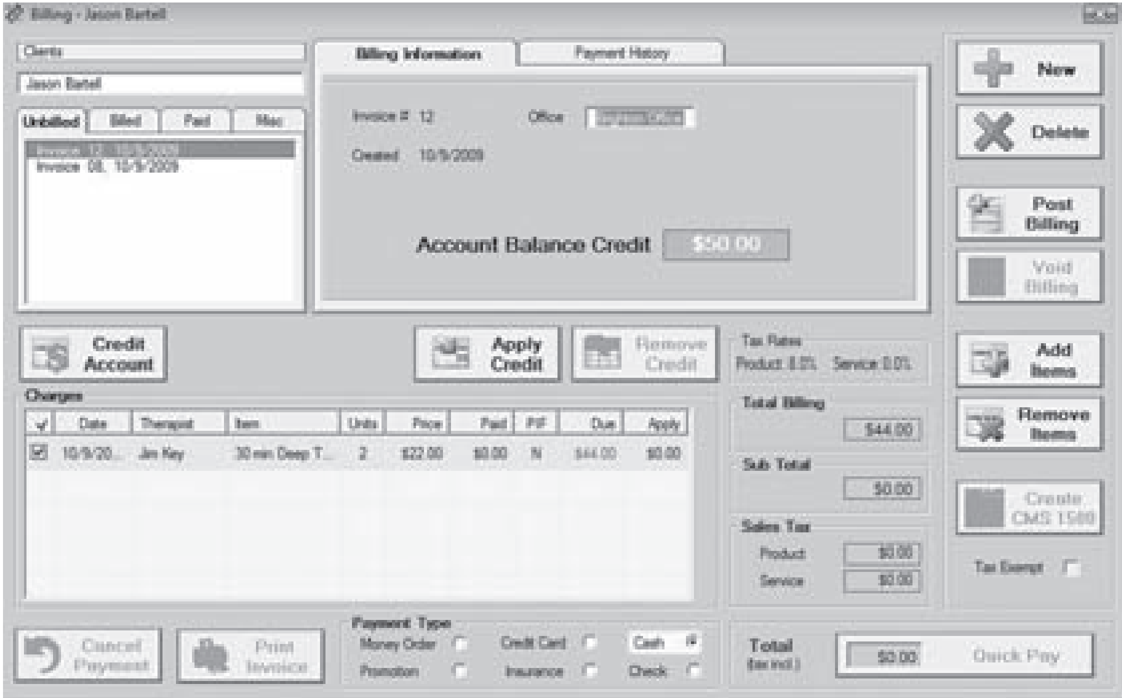


FIGURE 15-7. Credit is adjusted on receipt of a payment by the client. *(Courtesy of Island Software.)*

After this information has been given to the credit bureau, you will receive a credit report on the applicant. Care must be taken to record the information accurately. The Associated Credit Bureaus of America have designed a common language, which incorporates symbols, for reporting this information (Table 15-2). The symbols should mean the same things throughout the consumer credit industry, such as *O* for open, *R* for revolving, and *I* for installment.

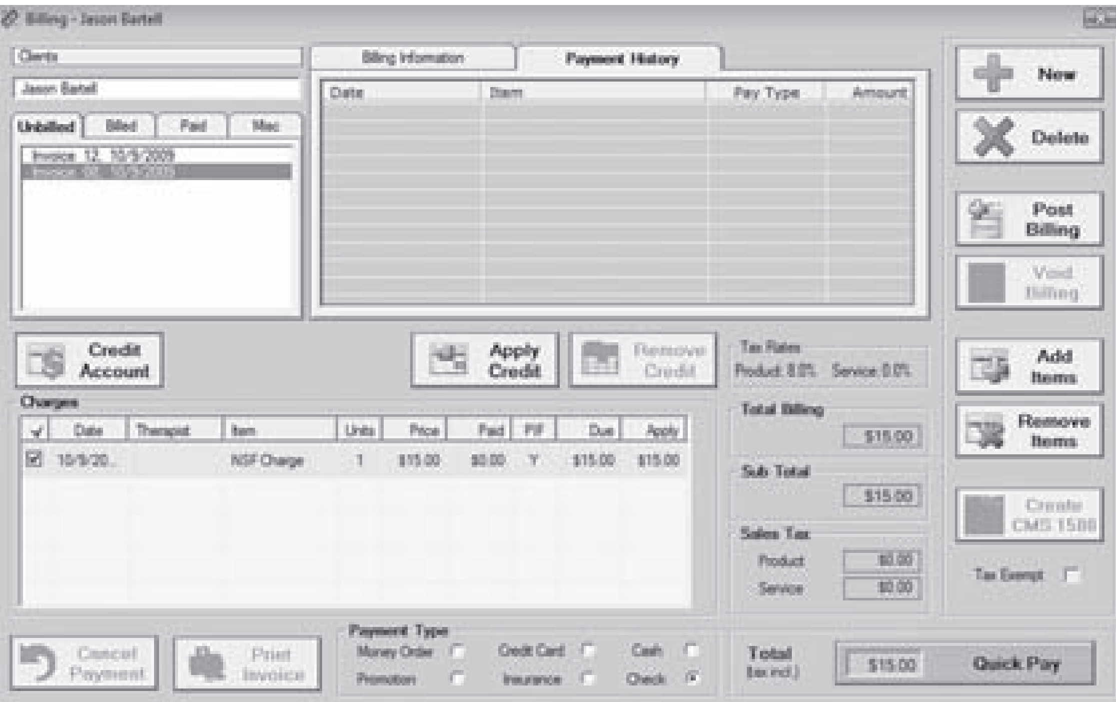
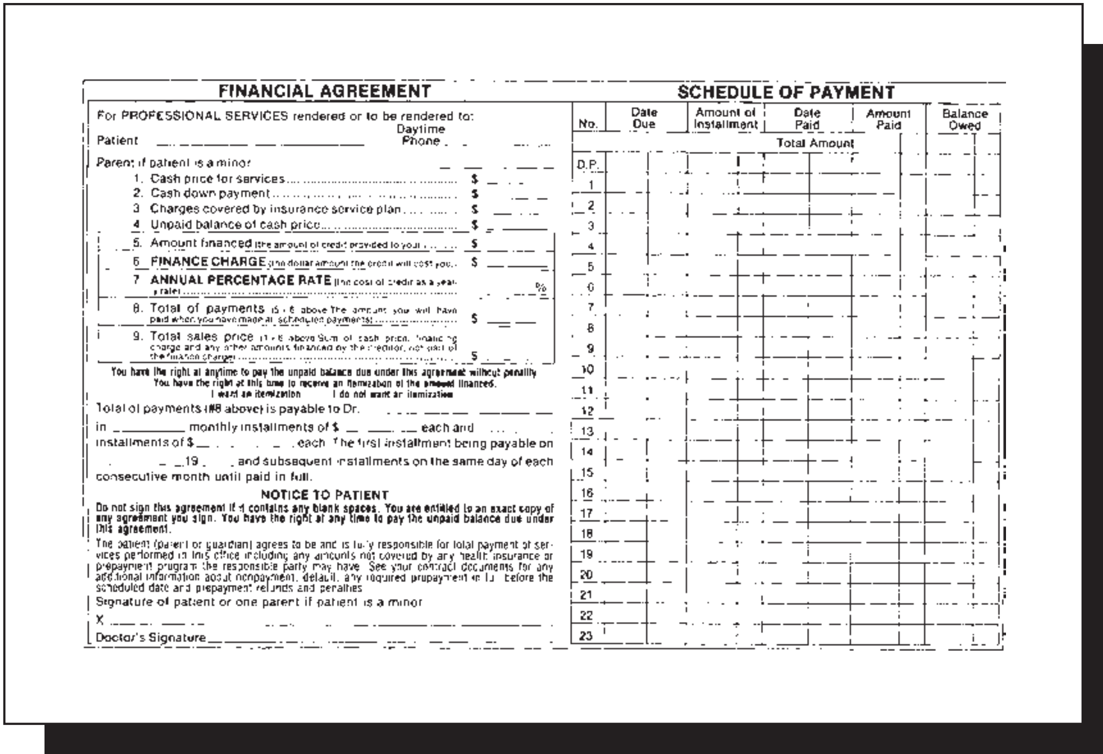


FIGURE 15-8. A ccountt ransactionsc reeni ndicates a nonsufficient funds (NSF) check with a service charge attached. *(Courtesy of Island Software.)*

FIGURE 15-9. A courtesy discount is entered as a credit to the account. *(Courtesy of Island Software.)*



FINANCIAL AGREEMENT

For PROFESSIONAL SERVICES rendered or to be rendered to:

Patient ______________ Daytime Phone ______

Parent if patient is a minor ______

1. Cash price for services .... $ ____
2. Cash down payment .... $ ____
3. Charges covered by insurance service plan .... $ ____
4. Unpaid balance of cash price .... $ ____
5. Amount financed (the amount of credit provided to you) .... $ ____
6. **FINANCE CHARGE** (the dollar amount the credit will cost you) .... $ ____
7. **ANNUAL PERCENTAGE RATE** (the cost of credit as a yearly rate) .... ____%
8. Total of payments (5 + 6 above The amount you will have paid when you have made all scheduled payments) .... $ ____
9. Total sales price (1 + 6 above Sum of cash price, financing charge and any other amounts financed by the creditor, not part of the finance charge) .... $ ____

You have the right at anytime to pay the unpaid balance due under this agreement without penalty. You have the right at this time to receive an itemization of the amount financed.

I want an itemization I do not want an itemization

Total of payments (#8 above) is payable to Dr. ______ in ______ monthly installments of $ ______ each and ______ installments of $ ______ each. The first installment being payable on ______ 19 ____ and subsequent installments on the same day of each consecutive month until paid in full.

NOTICE TO PATIENT

Do not sign this agreement if it contains any blank spaces. You are entitled to an exact copy of any agreement you sign. You have the right at any time to pay the unpaid balance due under this agreement.

The patient (parent or guardian) agrees to be and is fully responsible for total payment of services performed in this office including any amounts not covered by any health insurance or prepayment program the responsible party may have. See your contract documents for any additional information about nonpayment, default, any required prepayment in full before the scheduled date and prepayment refunds and penalties.

Signature of patient or one parent if patient is a minor

X ______________

Doctor's Signature ______________

SCHEDULE OF PAYMENT

No.	Date Due	Amount of Installment	Date Paid	Amount Paid	Balance Owed
				Total Amount	
D.P.					
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					

FIGURE 15-10. T ruthi nlen dingfor m. *(Courtesy of SYCOM, Madison, WI. In Finkbeiner BL, Finkbeiner CA:* Practice Management for the Dental Team, *ed 6, St. Louis, 2006, Mosby.)*

TABLE 15-2 Language Used in Consumer Credit Reports

USUAL MANNER OF PAYMENT	SYMBOL
Open account, 30-day account, 90-day account	0
Too new to rate; approved but not used	0-0
Pays (or paid) within 30 days of billing; pays 90-day accounts as agreed	0-1
Pays (or paid) in more than 30 days but not more than 60 days	0-2
Pays (or paid) in more than 60 days but not more than 90 days	0-3
Pays (or paid) in more than 90 days but not more than 120 days	0-4
Pays (or paid) in 120 days or more	0-5
Bad debt; placed for collection; suit; judgment; bankrupt; skip	0-9
Revolving or option account R or R $ _____*	R*
Too new to rate; approved but not used	R-0
Pays (or paid) according to the terms agreed	R-1
Not paying (or paid) as agreed but not more than one payment past due	R-2
Not paying (or paid) as agreed and two payments past due	R-3
Not paying (or paid) as agreed and three payments past due	R-4
Bad debt; placed for collection; suit; judgment; bankrupt; skip	R-9
Installment account I or I $ _____*	I*
Too new to rate; approved but not used	I-0
Pays (or paid) according to terms agreed	I-1
Not paying (or paid) as agreed but not more than one payment past due	I-2
Not paying (or paid) as agreed and two payments past due	I-3
Not paying (or paid) as agreed and three payments or more past due	I-4
Repossession	I-8
Bad debt; placed for collection; suit; judgment; bankrupt; skip	I-9

*When the monthly payment is known, it should be shown (e.g., R $20 or I $78).

Modified from the Associated Credit Bureau of America.

Extending credit to a client in the massage practice is not common but has the potential to increase. More people use massage on a regular basis and would prefer to pay a fixed amount each month. The massage therapist decides whether to extend credit to a client. If the client is denied credit, FCRA requires that the client be informed of the reason for denial of credit and the name of the bureau from which a credit report was obtained. It is not required to report the specific data obtained from the bureau; a client who wants this information should contact the bureau personally.

COLLECTING FEES

Collecting fees in the massage office can be easy or difficult. Collecting fees for a cash-only business is relatively easy. You can accept cash, credit or debit cards, or checks. Difficulties may include a client forgetting his checkbook or one who did not have enough cash. Another situation is NSF checks. Most clients pay when they receive their next massage, but not all do.

Experience has shown that clients pay health care bills last. People pay their rent for fear of eviction, their car payments for fear of repossession, utility bills for fear of losing service, and loans because banks usually adhere to stricter enforcement of collection procedures than the massage therapist does. Fortunately, only about 5% of clients become "uncollectable," but this 5% can be exasperating. A cash only policy prevents the need for collection.

SELF-REFLECTION

Have I ever been unable to pay all my bills? What was that like? What did I do? How did I respond when someone asked me for the money? Did I tell the truth and attempt to work out something? Did I avoid the collector or make excuses? What will I do when someone does not pay me for massage services? How will it feel to ask someone for the money? How will I ask to be paid? What will I do if I do not get paid?

Fair Debt Collection Practices Act

Collection procedures are regulated by the Fair Debt Collection Practices Act of 1996. This bill act was passed to protect the public from unethical collection procedures. The activities outlined in the law are listed in Box 15-1, and these regulations usually apply to collection agencies. When choosing a collection agency, it is important to verify debt collection regulations and ensure that the agents adhere to them. These same regulations should be considered when performing collection procedures in the office.

BOX 15-1 Provisions of the Fair Debt Collection Practices Act

- Debtors may not be subjected to harassment, oppressive tactics, or abusive treatment. The law prohibits the collector from making any false statements to a debtor, such as claiming to be an attorney or a government agency.
- Debtors may not be called at work if the employer or the debtor objects and requests no calls.
- Debtors may not be called at inconvenient places or times, such as before 9 AM or after 9 PM.
- No one except the debtors themselves may be told they are behind on their bills.

Collection Letters

Letters may be sent at the discretion of the massage therapist. In offices that use a computer, a reminder notice can be included on the statement, and the first collection letter (Fig. 15-11) is automatically generated when an account becomes past due. You may use a series of computer-generated reminder notices automatically sent at specified intervals (e.g., 30, 60, and 90 days past due) before assigning an account to a collector. Be responsible, however, in reviewing the list of delinquent accounts. One of these accounts may be a client of long standing who, because of extenuating circumstances, was unable to pay the account. It is not wise to risk the loss of a well-established client relationship by adding a message or sending an account to a collector without first checking to see if a reason exists for the oversight.

The collection process should have four stages: reminder, inquiry or discussion, urgency, and ultimatum. The previous discussion concerned the first stage (reminder), which is accomplished through a notice on the statement. In the second stage (inquiry), you personally contact the client to determine the problem. The final two stages can be completed with letters. The letter of urgency must be persuasive (Fig. 15-12). An urgent phone call may be used as a follow-up as long as it does not result in harassment. In either situation, you should be courteous, considerate, and helpful but firm.

The final stage, the ultimatum, arrives when a client has failed to respond to all messages sent. You must confront the client with an ultimatum. Refrain from referring directly to lawsuits, attorneys, or collection agencies unless you intend to follow through. Send only one ultimatum letter with a deadline date (Fig. 15-13). Send this letter by certified mail with a return receipt requested to prove that the debtor has received the letter. If payment is not received by the designated date, the account must be turned over immediately to an attorney or a collection agency. The following rules can guide the composition of collection letters:

1. Keep the letter brief.
2. Make sure that data about the account are complete and accurate.

Luke Fritz, MT, NCTMB
2050 Leisure Lane, Lapeer, MI 48446
(123) 456-7890 / leisurelymassage@hec.com

October 20, 20xx

Serena Jarvez
321 Counting Lane
Your Town, State 00000

Dear Ms Jarvez:

Your account of $160.00 is over 90 days past due. If you are unable to pay this account in full, perhaps we can help you make arrangements for a payment plan.

Please contact us before November 15, 20xx, at 5:00 PM.

Sincerely,

Your signature

Luke Fritz, MT, NCTMB
Massage Therapist

FIGURE 15-11. First collection letter.

Luke Fritz, MT, NCTMB
2050 Leisure Lane, Lapeer, MI 48446
(123) 456-7890 / leisurelymassage@hec.com

November 20, 20xx

REGISTERED

Serena Jarvez
321 Counting Lane
Your Town, State 00000

Dear Ms Jarvez:

Since we have not heard from you regarding your account of $160.00 from June 1, 20xx, please be informed that it will be necessary to transfer this account to a collection agency.

The account must be paid in full by Friday, December 1, 20xx, to avoid such action.

Sincerely,

Your signature

Luke Fritz, MT, NCTMB
Massage Therapist

FIGURE 15-12. Urgent collection letter.

3. Use simple words and uncomplicated sentences.
4. Use phrases that will motivate the client, such as “cooperation” or “maintenance of a good credit rating.”
5. Do not make statements that you do not intend to carry out. If you tell the client that the account will be sent to a collection agency in 10 days, give a specific date, and then follow through if necessary.
6. Set a specific date by which you expect payment, rather than saying “by the end of the month” or “in 10 days.”
7. Be firm and polite.
8. Include a “thank you” in the letter closing because this, too, can be an important part of the collection procedure, and it is a valuable aid to public relations.

Telephone as a Collection Instrument

Many find it difficult to use the telephone in collecting delinquent accounts. The telephone allows a more personal contact with a client. When a client who normally pays the account on time becomes delinquent, a phone call seems less formal

Luke Fritz, MT, NCTMB
2050 Leisure Lane, Lapeer, MI 48446
(123) 456-7890 / leisurelymassage@hec.com

December 3, 20xx

REGISTERED

Serena Jarvez
321 Counting Lane
Your Town, State 00000

Dear Ms Jarvez:

Please be informed that your account of $160.00 from June 1, 20xx, has been transferred to the Dunhill Collection Agency for collection.

Sincerely,

Your signature

Luke Fritz, MT, NCTMB
Massage Therapist

FIGURE 15-13. Final collection letter.

than a letter and helps maintain a friendly relationship. Specific rules should be followed when using the telephone for collections:

1. Do not call before 9 AM or after 9 PM.
2. Verify that you are speaking to the person whose account is overdue. Ask, "Is this Mr. Johnson?"
3. Identifyy ourself.
4. Ask whether it is a convenient time to talk. If not, ask when you may call back, or find out when the client will be able to call you. Do not give details to a third party or leave detailed messages on an answering machine or voicemail.
5. State the purpose of your call. Be friendly and display a helpinga ttitude.
6. Be positive. Do not say, "I'm sorry to call you." Act as though you know the client intends to pay and you are determining the arrangements for such a payment.
7. Have all of the information about the account in front ofy ou.
8. Attempt to obtain a definite commitment, including the date and the amount of the payment. Follow up with written confirmation of the telephone discussion.
9. Make calls in a private area out of the hearing range of anyone in the reception room.
10. Do not threaten the client.
11. Follow up on the promises the client makes.
12. Do not discuss the account with anyone else.

Collection Agency

After every attempt has been made to collect an account, it may be necessary to engage the services of a collection agency. These services are required when the client fails to respond to a final collection letter or can no longer be located and becomes a "skip."

Delay in sending the account to a collection agency results in less chance of recovering a portion of the fee. Although the agency's fee reduces the portion recovered, continued unsuccessful attempts by the office are even less rewarding.

A collection agency should be selected that maintains high standards of professionalism. Investigate the agency thoroughly to determine its ethics and reliability:

- Check the ownership of the agency through a banker, the local Chamber of Commerce, or the Better Business Bureau.
- Contact the National Retail Credit Association or the Associated Credit Bureaus of America for information about the agency.
- Find out whether the agency has contacts out of town to aid in collection of accounts.
- Make sure the agency will not start legal action without the massage therapist's consent.
- Make sure the agency understands your needs and that you want reports on its activities.

After the business has sought the services of an agency, the office should use these services routinely. To allow action to be taken promptly, complete data about each case should be given to the agency, including the following:

- Debtor's full name
- Last known address and phone number
- Total amount of account
- Date of last entry on account (credit or debit)
- Debtor'soc cupation
- Business address and phone number
- Any other pertinent information

When an account is turned over to a collection agency, you no longer pursue collection procedures on it. However, the massage office staff must cooperate with the agency. The staff should do the following:

- Send no more statements
- Indicate the transfer to the collection agency on the ledger card, giving the date of transfer
- Refer the client to the agency if the person contacts the office
- Report the amount to the agency when payment is received in the office
- Rely on the agency staff members to do the job (i.e., do not pester them with calls of inquiry about the account)

Good Stuff from the Government

The U.S. Small Business Association offers many free online training courses. You can log on and complete courses in financing and accounting, including the following:

- Finance Primer: Guide to SBA's Loan Guaranty Programs (http://www.sba.gov/financialassistance)
- How to Prepare a Loan Package
- Assessing Financial Needs
- Introduction to Accounting

Bean Counter (http://www.dwmbeancounter.com/) is an excellent nongovernment site that provides links to many Web sites, including government sites, and that offers free bookkeeping training.

SUMMARY

Unless the message therapist has studied accounting, she or he should probably hire an accountant to audit the books and compute a variety of tax reports and financial statements. The daily bookkeeping transactions remain the responsibility of the business owner. The two financial systems used are accounts payable and accounts receivable. A business owner who is not proficient in math can use the appropriate computer software to perform computations. However, basic mathematical procedures must be understood to detect errors.

Basic bookkeeping systems such as the pegboard system are being used less because of the many entries needed for basic transactions and the availability of software. The most popular system is a computerized bookkeeping system; from one entry, the system can produce an entry into a client's statement or insurance claim form and generated specific reports. This system also can generate accounts receivable and accounts payable summaries at the end of the day with a click of a button. The system can generate client statements to be mailed or given out to clients as they come in so they can keep payments up to date and keep track of the number of treatments. The reports generated can act as reminders that certain clients have payments due or have a birthday coming up.

A massage business requires common payment and credit policies, which can be printed on the client's statements. Common policies include when payments must be made, when payments are considered late, when unpaid bills will be turned over to collections, fees for missing appointments, and other rules. The laws must be adhered to and policies followed to support efficient work. If needed, a collection agency can be used for a fee.

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Evolve Annotated Web Links

http://evolve.elsevier.com/Fritz/business

Bean Counter (http://www.dwmbeancounter.com/index.html)

U.S. Small Business Association, online training courses (http://www.sba.gov/services/training/onlinecourses/index.html)

Workbook

1. Explaint hedi fferencesbet weena ccountinga ndbook keeping.

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2. Listt hec ommont ypesofbook keeping systems used in massaget herapy.

3. List and explain the function of the components of a pegboard system.

4. Lista ndexpla int hefun ctionoft hec omponentsofa c omputerbook keepingsy stem.

5. What are the advantages of an electronic bookkeeping system compared with a manual system?

6. Describeh owm onthlyst atementsa re prepared.

7. Identifyt hefun ctionofea choft hefol lowing:
   a. Creditpoli cy
   b. Creditbur eau
   c. Collectiona gency

8. Explaint hec ontentsofa neffec tivec ollectionlet ter.