Medical Accounting

- **Fee for Service vs Value Based Care Payment Models**
  Fee for Service vs Value Based Care Payment Models How HCC Coding Affects Risk Adjustment Scores DRGs and Their Role in Hospital Reimbursement Medicare Advantage and Risk Adjustment Strategies Addressing Disparities in Reimbursement Rates Understanding ESRD Risk Adjustment Models The Impact of Chronic Conditions on Reimbursement Optimizing Documentation for Risk Adjustment Challenges in Bundled Payment Models Auditing Risk Adjustment Coding Accuracy State Variations in Medicaid Reimbursement Future of Reimbursement in Telehealth Services
- **Improving Charge Capture Processes in Healthcare**
  Improving Charge Capture Processes in Healthcare Reducing Denial Rates Through Better Documentation Automating Claim Submission for Faster Payments Strategies for Efficient Payment Posting Managing Denials Due to Prior Authorization Using Analytics to Track Revenue Cycle Performance Training Teams for Revenue Cycle Efficiency Addressing Coding Errors in Claim Denials Streamlining Patient Registration Workflows The Role of Clearinghouses in Revenue Cycle Balancing Cost Control and Revenue Growth Case Studies in Revenue Cycle Turnaround
- **About Us**

The Medicaid program, a cornerstone of the American healthcare system, provides essential medical coverage to millions of low-income individuals and families. Funded jointly by state and federal governments, Medicaid is designed to ensure that vulnerable populations have access to necessary healthcare services. However, one of the most complex facets of this program is the variation in Medicaid reimbursement rates across different states, which significantly impacts healthcare providers.

State variations in Medicaid reimbursement are primarily due to the flexibility given to states in administering their own programs within broad federal guidelines. Each state determines its own payment rates for services provided under Medicaid, leading to a wide disparity in reimbursements nationwide. This disparity arises because states take into account their budgetary constraints, local economic conditions, and the cost of living when setting these rates. As a result, what might be considered an adequate rate in one state could be insufficient in another.

These differences have profound implications for healthcare providers. Medical staffing agencies focus on sourcing professionals with specific certifications and skills **source medical staffing** overhead. In states where reimbursement rates are low, providers may struggle financially because the payments they receive do not cover the costs incurred from treating Medicaid patients. This financial pressure can lead some providers to limit the number of Medicaid patients they accept or even opt out of the program entirely. Consequently, access to care for Medicaid beneficiaries may be compromised as fewer providers are available to meet their needs.

On the other hand, states with higher reimbursement rates might experience less difficulty retaining and attracting healthcare providers willing to serve Medicaid populations. These better-funded programs can improve patient access and ensure more comprehensive care delivery. Nonetheless, even in these states, challenges remain as higher reimbursement does not always equate with higher quality or efficiency in service delivery.

Moreover, disparities in reimbursement affect competition among healthcare markets within different states. Providers operating near state borders often find themselves navigating differing payment structures which can complicate cross-state operations and influence decisions about expansion or relocation.

In summary, while Medicaid plays a crucial role in providing health coverage for millions across America's socio-economic spectrum, state variations in reimbursement present ongoing challenges for healthcare providers. These discrepancies can hinder access to

care for recipients and strain resources at facilities that serve large numbers of Medicaid patients. Moving forward, balancing state autonomy with equitable provider compensation will be essential in ensuring that all Americans have access to quality healthcare regardless of where they live.

Key Differences Between Fee for Service and Value Based Care Payment Models —

- **Overview of Medical Coding and Its Role in Healthcare Payment Systems**
- **Key Differences Between Fee for Service and Value Based Care Payment Models**
- **Impact of Fee for Service on Medical Coding Practices**
- **How Value Based Care Influences Medical Coding and Documentation Requirements**
- **Challenges and Benefits of Transitioning from Fee for Service to Value Based Care in Medical Coding**
- **Case Studies Highlighting the Effects of Different Payment Models on Medical Coding Efficiency**
- **Future Trends: The Evolving Role of Medical Coders in a Value-Based Healthcare Environment**

State variations in Medicaid reimbursement rates are a significant aspect of the United States healthcare system, reflecting the complex interplay between federal guidelines and state-specific policies. These variations can affect not only the quality and accessibility of care for Medicaid recipients but also the financial dynamics of healthcare providers working within different states.

At its core, Medicaid is a jointly funded program between state governments and the federal government designed to provide healthcare to low-income individuals. The federal government sets broad guidelines, but each state has considerable discretion in how it administers its Medicaid program, including determining reimbursement rates. This flexibility allows states to tailor their programs based on local needs, budgetary constraints, and political climates.

One primary reason for variation in Medicaid reimbursement rates is the difference in cost of living across states. For instance, states with higher costs of living often have correspondingly higher reimbursement rates to ensure that healthcare providers can cover their operating expenses while serving Medicaid patients. Conversely, states with lower costs of living might offer lower reimbursement rates.

Additionally, political priorities can significantly impact these rates. Some states prioritize expanding access to care and may set higher reimbursement rates to encourage more providers to participate in the Medicaid program. In contrast, other states may focus on controlling spending and thus set lower rates as part of broader budgetary constraints or fiscal conservatism.

Economic factors also play a crucial role. During economic downturns, states might face budget shortfalls that necessitate cuts across various sectors, including healthcare. As a result, they may reduce Medicaid reimbursement rates as a cost-saving measure. Conversely, during periods of economic growth or when there is increased federal funding support or incentives-such as through expanded coverage under the Affordable Care Act-states might increase these rates.

Furthermore, differences in healthcare infrastructure and workforce availability contribute to this variation. States with robust healthcare systems might negotiate differently than those struggling with shortages of medical professionals or facilities.

The implications of these variations are profound. For patients, especially those reliant on Medicaid for essential health services, disparities in reimbursement can translate into unequal access to care depending on geographic location. Providers operating in low-reimbursement-rate environments may limit the number of Medicaid patients they see or even opt out of the program altogether due to financial infeasibility.

In conclusion, understanding state variations in Medicaid reimbursement requires examining an intricate web of economic conditions, political decisions, demographic needs, and systemic capacities unique to each state. While this complexity can facilitate tailored approaches that meet specific local needs effectively, it also poses challenges by creating disparities that affect patient access and provider participation nationwide. Addressing these challenges requires ongoing dialogue among policymakers at both state and federal levels to ensure equitable access and sustainable operation within America's diverse healthcare landscape.

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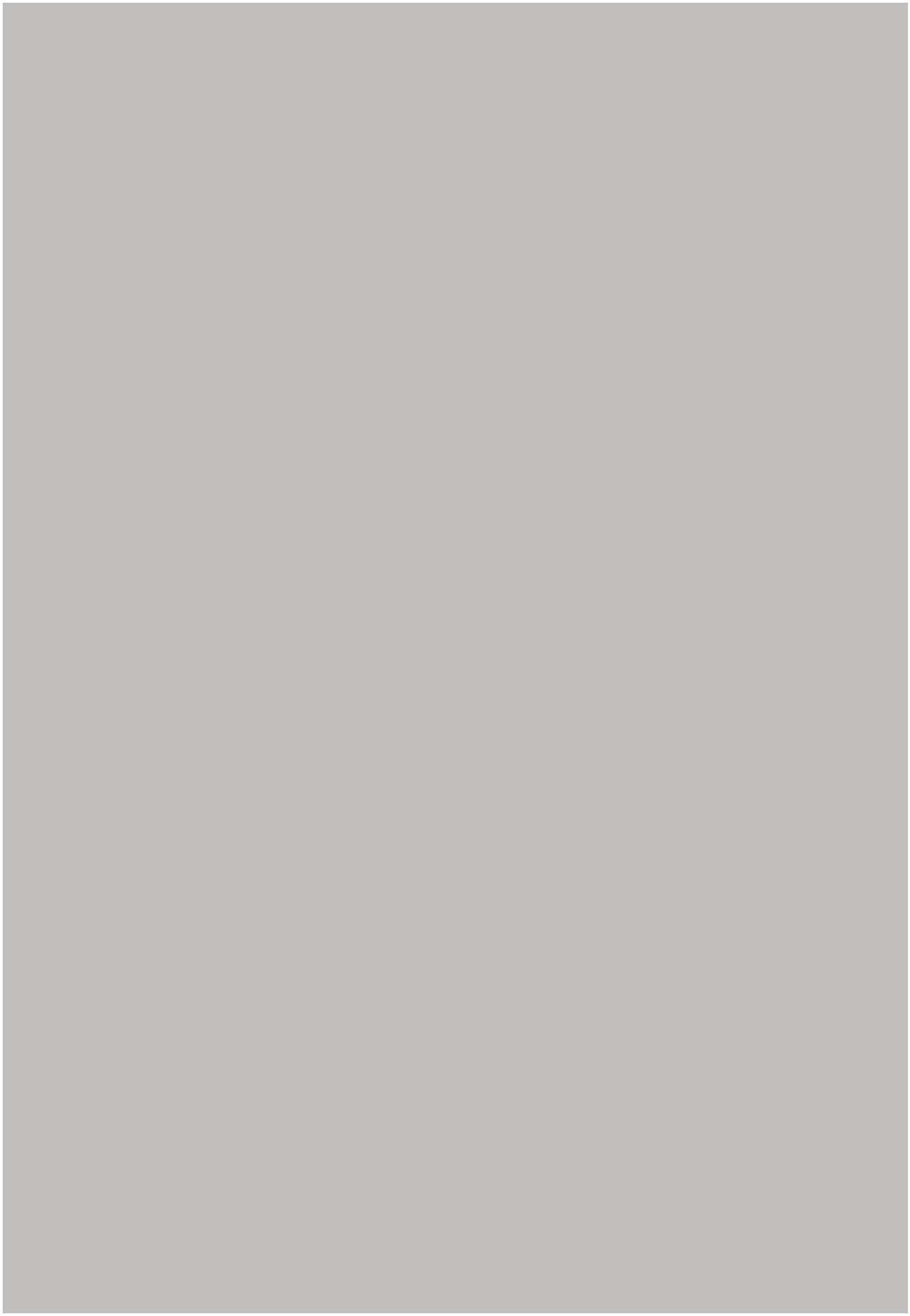

Impact of Fee for Service on Medical Coding Practices

Medicaid, a critical component of the American healthcare system, provides essential services to millions of low-income individuals and families. However, one of the challenges within this program is the significant variation in reimbursement rates across different states. These variations can affect access to care and the quality of services provided, ultimately impacting patient outcomes. Understanding the factors that contribute to these differences is crucial for policymakers aiming to create equitable healthcare solutions.

Firstly, one major factor influencing Medicaid reimbursement discrepancies is state-level policy decisions. Medicaid is jointly funded by federal and state governments but administered by individual states, giving them considerable leeway in determining how their programs operate. States have discretion over aspects such as eligibility criteria, scope of benefits, and provider payment rates. Consequently, political ideologies and priorities significantly influence how each state structures its Medicaid program. A state with a government inclined toward expansive social welfare policies might opt for higher reimbursement rates to encourage provider participation and enhance service availability.

Economic conditions also play a pivotal role in shaping Medicaid reimbursement rates. States with robust economies typically generate more tax revenue, enabling them to allocate more funds towards healthcare services. Conversely, states facing economic hardships may struggle to maintain competitive reimbursement rates due to budget constraints. This economic variability can lead to disparities where wealthier states are better positioned to offer higher payments compared to their less prosperous counterparts.

The cost of living in various states further contributes to differences in Medicaid reimbursements. In regions where living expenses are high, healthcare providers face increased operational costs for staff salaries, office space rental, and medical supplies. To ensure that providers can remain financially viable while serving low-income populations covered by Medicaid, higher reimbursement rates may be necessary in these areas compared to those with lower living costs.

Healthcare infrastructure within a state also influences its ability to set certain reimbursement levels. States with well-established networks of hospitals and clinics might negotiate lower rates due to competition among providers seeking inclusion in Medicaid's network. On the other hand, rural or underserved areas often face shortages of healthcare professionals willing to accept lower-paying Medicaid clients unless offered incentivizing reimbursement incentives.

Federal matching funds contribute another layer of complexity in this landscape. The Federal Medical Assistance Percentage (FMAP) determines the federal contribution towards each state's Medicaid expenditures based on per capita income relative to national averages; poorer states receive higher federal matches than wealthier ones do which affects their ability-and sometimes willingness-to fund enhanced provider payments independently without relying heavily on federal support mechanisms like waivers or adjustments from standard FMAP calculations under exceptional circumstances such as disasters or public health emergencies which could alter normal funding dynamics temporarily until resolved adequately elsewhere if needed at all parts concerned equally regardless any difference already mentioned previously before now still applies here anyway too then again always depends context specifics involved every time situation arises accordingly because nothing ever stays same indefinitely forevermore ultimately speaking generally though overall conclusion remains constant throughout discussion examined thus far hereinabove elucidated sufficiently hopefully beyond reasonable doubt whatsoever finally concluding remarks follow next thereafter shortly soon enough indeed sure thing alright!

In conclusion: several interconnected factors determine why some states reimburse more generously than others through their respective medicaid systems today presently currently ongoing basis ongoingly continuously perpetually incessantly constantly nonstop relentlessly unceasingly persistently determinedly unwaveringly steadfastly unyieldingly resolutely staunchly adamantly doggedly stubbornly indefatigably tirelessly indefatigably tenaciously persistently perseveringly diligently industriously assiduously sedulously studiously conscientiously meticulously painstakingly scrupulously thoroughly exhaustively comprehensively completely entirely fully wholly altogether utterly absolutely totally integrally inclusively

How Value Based Care Influences Medical Coding and Documentation Requirements

Medical coders play a pivotal role in the healthcare industry by ensuring that medical services are accurately coded for billing and reimbursement purposes. However, their work is often complicated by state-specific reimbursement policies, particularly within Medicaid programs. These challenges can be daunting, as they require coders to navigate a complex labyrinth of regulations that vary significantly from one state to another.

One of the primary challenges faced by medical coders is the variability in Medicaid reimbursement rates across different states. Each state has its own set of guidelines and fee schedules, which means that a procedure reimbursed at one rate in California might be compensated differently in Texas or New York. This lack of standardization necessitates that coders possess an in-depth understanding of each state's unique policies to ensure accurate billing. The need to stay updated on these ever-evolving rules adds an additional layer of complexity and demands continuous education and training.

Furthermore, state-specific policies can also impact how certain services are coded and billed. For example, some states may have specific mandates regarding telemedicine services or behavioral health treatments that differ from national coding standards or those used by private insurers. Coders must therefore be adept at interpreting these localized regulations and translating them into appropriate codes that comply with both federal and state laws.

In addition to varying reimbursement rates and coding requirements, administrative burdens also pose significant challenges. The documentation required for Medicaid claims can be extensive, with each state imposing its own set of paperwork and verification processes. Medical coders must meticulously manage this documentation to prevent claim denials or delays, which could ultimately impact a healthcare provider's revenue cycle management.

Moreover, changes in political leadership at the state level can lead to shifts in Medicaid policies, creating an unpredictable environment for medical coders. Legislative updates may result in new coding requirements or modifications to existing ones, compelling coders to adapt quickly while maintaining accuracy under pressure.

To address these challenges, many healthcare organizations invest heavily in training programs for their coding staff, ensuring they are well-versed in both national coding standards like ICD-10-CM/PCS and CPT as well as state-specific nuances. Some organizations also employ advanced software solutions designed to assist with compliance tracking across different jurisdictions.

In conclusion, while medical coders face significant challenges due to state-specific reimbursement policies within Medicaid programs, their expertise remains essential for the seamless operation of healthcare facilities. By staying informed about regulatory changes and utilizing technological aids where possible, these professionals continue to navigate the complexities inherent in their field with skill and precision.

Challenges and Benefits of Transitioning from Fee for Service to Value Based Care in Medical Coding

Navigating the complex landscape of Medicaid reimbursement can be a daunting task for healthcare providers, particularly when considering the state-by-state variations that exist. These differences can significantly impact medical coding practices and ultimately affect the financial health of medical facilities. Understanding and effectively managing these variations is crucial for ensuring accurate billing and maximizing reimbursements.

One key strategy for navigating state variations in Medicaid reimbursement is to stay informed about the specific policies and guidelines applicable in each state where services are provided. This involves regularly reviewing updates from state Medicaid agencies, as regulations can change frequently. Providers should subscribe to relevant newsletters, attend webinars, and participate in professional associations that offer insights on state-specific Medicaid policies.

Another important approach is to invest in robust training programs for coding staff. Accurate medical coding is essential for correct reimbursement, and coders must be well-versed in both national coding standards such as ICD-10, CPT, and HCPCS, as well as any additional requirements imposed by individual states. Training should emphasize the importance of compliance with these standards while highlighting any unique aspects of a state's Medicaid

program that could affect coding practices.

Collaboration between departments within a healthcare organization can also aid in managing state variations effectively. For example, billing teams should work closely with coders to ensure that all claims are submitted accurately according to both federal and state guidelines. Regular meetings or workshops can facilitate this collaboration by providing opportunities to discuss challenges related to state-specific requirements and brainstorm solutions collectively.

Utilizing technology can further streamline efforts to navigate Medicaid's complexities. Implementing advanced electronic health record (EHR) systems that integrate up-to-date Medicaid information across different states can enhance accuracy in medical documentation and coding processes. Such systems may include automated alerts or checks that prompt coders when discrepancies arise due to differing state regulations.

Engaging with external experts such as consultants who specialize in Medicaid reimbursement can provide an additional layer of support for healthcare organizations striving to master state-level nuances. These professionals often have deep expertise in navigating intricate policy landscapes and can offer tailored advice on optimizing coding practices for better financial outcomes.

Lastly, establishing open lines of communication with representatives from state Medicaid offices can prove beneficial. Building relationships with these officials allows providers to gain clarity on ambiguous guidelines or address specific concerns related to their practice area. Being proactive about seeking guidance directly from authoritative sources helps minimize errors that could lead to denied claims or audits down the line.

In conclusion, successfully managing variations in Medicaid reimbursement across different states requires a multifaceted approach involving ongoing education, interdepartmental cooperation, technological investments, expert consultation, and direct engagement with regulatory bodies. By adopting these strategies diligently, healthcare providers can ensure accurate medical coding while safeguarding their revenue streams against the unpredictability inherent in diverse Medicaid programs nationwide.

Case Studies Highlighting the Effects of Different Payment Models on Medical Coding

Efficiency

Title: Case Studies Illustrating the Impact of State-Level Differences on Healthcare Practices: State Variations in Medicaid Reimbursement

In the complex landscape of American healthcare, Medicaid serves as a critical safety net for millions of low-income individuals. However, the administration and reimbursement policies of Medicaid can vary significantly from state to state, leading to disparate impacts on healthcare practices. Understanding these variations is crucial for policymakers, healthcare providers, and patients alike. This essay explores case studies that illustrate how state-level differences in Medicaid reimbursement affect healthcare delivery and outcomes.

One illustrative case study comes from California and Texas-two states with markedly different approaches to Medicaid reimbursement. California has historically adopted higher reimbursement rates due to its expanded Medicaid program under the Affordable Care Act (ACA). This expansion has enabled broader access to services and a greater number of participating healthcare providers willing to accept Medicaid patients. As a result, Californians have experienced improved health outcomes and increased access to preventative care.

In contrast, Texas did not expand its Medicaid program under the ACA, resulting in lower reimbursement rates compared to California. Healthcare providers in Texas often face financial challenges when treating Medicaid patients due to these reduced rates. Consequently, many physicians limit the number of Medicaid patients they see or opt out of the program entirely. This scenario leads to longer wait times for appointments and limited access to specialists, particularly impacting rural areas where medical resources are already sparse.

The impact of these reimbursement disparities is further illustrated by examining maternal health outcomes in both states. In California, higher reimbursements have facilitated better prenatal care services and postnatal support systems. The state's focus on comprehensive maternal health programs has led to a decline in maternal mortality rates over recent years. Conversely, Texas struggles with higher maternal mortality rates partly due to insufficient access resulting from lower reimbursement levels that deter provider participation.

Another compelling example can be found by comparing New York and Mississippi's approaches towards mental health services within their respective Medicaid programs. New York's relatively high reimbursement rates for mental health professionals have fostered robust networks of psychologists and psychiatrists who participate in the state's Medicaid program. This inclusion results in more timely interventions and continuity of care for individuals struggling with mental illnesses.

Mississippi paints a different picture; its lower reimbursement rates create significant barriers for mental health treatment within its Medicaid system. With fewer mental health professionals accepting Medicaid patients, residents often face extended wait times or must travel long distances for care-a burdensome challenge for those already facing socio-economic hardships.

These case studies underscore the profound implications state-level differences have on healthcare practices through varied Medicaid reimbursements. While some states offer models demonstrating improved access and favorable patient outcomes through increased investment in their programs, others highlight challenges that arise from limited funding allocations.

Addressing these disparities requires thoughtful collaboration between federal entities and individual states-balancing autonomy with accountability-to ensure equitable access across all regions irrespective of geographic location or political climate.
Ultimately understanding how state variations influence practice is essential not only for creating parity but also enhancing overall quality standards nationwide-a goal worth striving toward given our collective commitment toward healthier communities everywhere we call home!

Future Trends: The Evolving Role of Medical Coders in a

Value-Based Healthcare Environment

The landscape of Medicaid reimbursement policies is an ever-evolving tapestry, intricately woven by state-specific regulations and national directives. As we look towards the future, it becomes increasingly evident that understanding the potential changes in these policies requires a nuanced appreciation of both historical trends and emerging challenges. State variations in Medicaid reimbursement are significant, as they directly impact healthcare providers' financial stability and beneficiaries' access to essential services.

Historically, Medicaid has been characterized by its flexibility, allowing states to tailor programs to meet their unique demographic needs. This has resulted in a diverse array of reimbursement rates and methodologies across the country. Some states have adopted more generous reimbursement strategies to attract healthcare providers to underserved areas, while others have implemented cost-containment measures to manage budgetary constraints. This patchwork approach underscores the complexity of predicting future trends.

One potential trend is the increasing adoption of value-based care models. These models aim to shift the focus from quantity to quality, rewarding healthcare providers for outcomes rather than services rendered. States may explore innovative payment structures that prioritize patient outcomes, potentially leading to more uniformity in how reimbursements are structured across various regions. However, implementing these changes will require significant investment in data infrastructure and provider education.

Another critical factor influencing state-level Medicaid reimbursement policies is the ongoing political discourse surrounding healthcare funding and policy reform. Changes at the federal level can precipitate shifts in state strategies, particularly when it comes to block grants or capped funding proposals. Such reforms could lead states to reassess their reimbursement approaches, possibly resulting in reduced rates or altered eligibility criteria.

Furthermore, technological advancements offer opportunities for states to rethink their reimbursement frameworks. Telehealth services have gained prominence during recent global health challenges, prompting many states to expand coverage and enhance reimbursement rates for virtual care delivery. As technology continues to evolve, states may increasingly incorporate digital health solutions into their Medicaid programs, necessitating adjustments in reimbursement structures.

Lastly, demographic shifts cannot be overlooked when considering future changes in Medicaid policies. An aging population and rising prevalence of chronic diseases may compel states to re-evaluate how resources are allocated within their Medicaid systems. This could involve shifting funds towards preventive care initiatives or increasing reimbursements for long-term care services.

In conclusion, while predicting precise changes in state-level Medicaid reimbursement policies involves navigating a complex interplay of factors, certain trends seem poised for growth. Value-based care models, political influences on funding mechanisms, technological integration into healthcare delivery, and demographic shifts all play pivotal roles in shaping future directions. As states grapple with these dynamics, stakeholders must remain adaptable and collaborative to ensure that Medicaid continues serving as a vital safety net for millions of Americans across diverse communities.

About bookkeeping

For the computer programming concept, see **Boilerplate code**.

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Bookkeeping

Key concepts

- Daybooks
- Double-entry
- General ledger
- T Accounts
- Trial balance
- Journal
- Debits and credits
- Chart of accounts
- Petty cash
- Imprest system
- Bank reconciliation
- Ledger
- Single-entry
- Bookkeeper
- Assets
- Liabilities
- Equity
- Income
- Expenses
- Depreciation
- Accruals
- Prepayments
- VAT/GST

Financial statements

- Balance sheet
- Income statement

Related professions

- Accountant
- Accounting technician
- Accounts clerk

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Part of a series on

Accounting

Early 19th-century German ledger

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- **Constant purchasing power**
- **Historical cost**
- **Management**
- **Tax**

Major types

- **Audit**
- **Budget**
- **Cost**
- **Forensic**
- **Financial**
- **Fund**
- **Governmental**
- **Management**
- **Social**
- **Tax**

Key concepts

- **Accounting period**
- **Accrual**
- **Constant purchasing power**
- **Economic entity**
- **Fair value**
- **Going concern**
- **Historical cost**
- **Matching principle**
- **Materiality**
- **Revenue recognition**
- **Unit of account**

Selected accounts

- **Assets**
- **Cash**
- **Cost of goods sold**
- **Depreciation** / **Amortization (business)**
- **Equity**
- **Expenses**
- **Goodwill**
- **Liabilities**
- **Profit**
- **Revenue**

- **Accounting standards**
  - **Generally-accepted principles**
  - **Generally-accepted auditing standards**
  - **Convergence**
  - **International Financial Reporting Standards**
  - **International Standards on Auditing**
  - **Management Accounting Principles**
- **Financial statements**
  - **Annual report**
  - **Balance sheet**
  - **Cash-flow**
  - **Equity**
  - **Income**
  - **Management discussion**
  - **Notes to the financial statements**
- **Bookkeeping**
  - **Bank reconciliation**
  - **Debits and credits**
  - **Double-entry system**
  - **FIFO and LIFO**
  - **Journal**
  - **Ledger** / **General ledger**
  - **Trial balance**
- **Auditing**
  - **Financial**
  - **Internal**
  - **Firms**
  - **Report**
  - **Sarbanes–Oxley Act**
- People and organizations
  - **Accountants**
  - **Accounting organizations**
  - **Luca Pacioli**
- Development
  - **History**
  - **Research**
  - **Positive accounting**
  - **Sarbanes–Oxley Act**

Misconduct

- **Creative**
- **Earnings management**
- **Error account**
- **Hollywood**
- **Off-balance-sheet**
- **Two sets of books**

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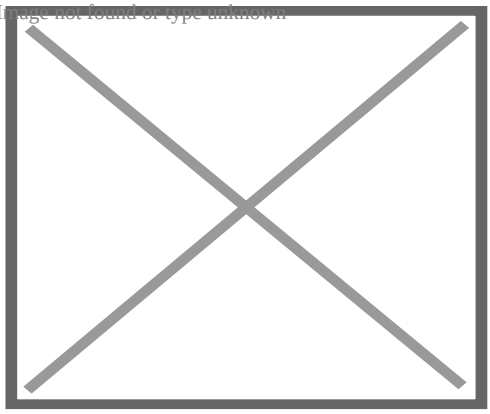

*Portrait of the Italian **Luca Pacioli***, painted by **Jacopo de' Barbari**, 1495, (**Museo di Capodimonte**). Pacioli is regarded as the Father of Accounting.

Bookkeeping is the recording of financial transactions, and is part of the process of **accounting** in **business** and other organizations.**[1]** It involves preparing source documents for all transactions, operations, and other events of a business. Transactions include purchases, sales, receipts and payments by an individual person, organization or corporation. There are several standard methods of bookkeeping, including the **single-entry** and **double-entry** bookkeeping systems. While these may be viewed as "real" bookkeeping, any process for recording financial transactions is a bookkeeping process.

The person in an organisation who is employed to perform bookkeeping functions is usually called the **bookkeeper** (or book-keeper). They usually write the ***daybooks*** (which contain records of sales, purchases, receipts, and payments), and document each financial transaction, whether cash or credit, into the correct daybook—that is, petty cash book, suppliers ledger, customer ledger, etc.—and the **general ledger**. Thereafter, an accountant can create **financial reports** from the information recorded by the bookkeeper. The bookkeeper brings the books to the **trial balance** stage, from which an accountant may prepare financial reports for the organisation, such as the **income statement** and **balance sheet**.

History

[edit]

The origin of book-keeping is lost in obscurity, but recent research indicates that methods of keeping accounts have existed from the remotest times of human life in cities. Babylonian records written with **styli** on small slabs of clay have been found dating to 2600 BC.**[2]** **Mesopotamian** bookkeepers kept records on clay tablets that may date back as far as 7,000 years. Use of the modern double entry bookkeeping system was described by **Luca Pacioli** in 1494.**[3]**

The term "**waste book**" was used in colonial America, referring to the documenting of daily transactions of receipts and expenditures. Records were made in chronological order, and for temporary use only. Daily records were then transferred to a daybook or account ledger to balance the accounts and to create a permanent journal; then the waste book could be discarded, hence the name.**[4]**

Process

[edit]

The primary purpose of bookkeeping is to record the *financial effects* of transactions. An important difference between a manual and an electronic accounting system is the former's latency between the recording of a financial transaction and its posting in the relevant account. This delay, which is absent in electronic accounting systems due to nearly instantaneous posting to relevant accounts, is characteristic of manual systems, and gave rise to the primary books of accounts—cash book, purchase book, sales book, etc.—for immediately documenting a financial transaction.

In the normal course of business, a document is produced each time a transaction occurs. Sales and purchases usually have **invoices** or **receipts**. Historically, deposit slips were produced when lodgements (deposits) were made to a **bank account**; and checks (spelled "cheques" in the UK and several other countries) were written to pay money out of the account. Nowadays such transactions are mostly made electronically. Bookkeeping first involves recording the details of all of these ***source documents*** into multi-column *journals* (also known as *books of first entry* or *daybooks*). For example, all credit sales are recorded in the sales journal; all cash payments are recorded in the cash payments journal. Each column in a journal normally corresponds to an account. In the **single entry system**, each transaction is recorded only once. Most individuals who balance their check-book each month are using such a system, and most personal-finance software follows this approach.

After a certain period, typically a month, each column in each **journal** is totalled to give a summary for that period. Using the rules of double-entry, these journal summaries are then transferred to their respective accounts in the **ledger**, or *account book*. For example, the entries in the Sales Journal are taken and a debit entry is made in each

customer's account (showing that the customer now owes us money), and a credit entry might be made in the account for "Sale of class 2 widgets" (showing that this activity has generated revenue for us). This process of transferring summaries or individual transactions to the ledger is called *posting*. Once the posting process is complete, accounts kept using the "T" format (debits on the left side of the "T" and credits on the right side) undergo *balancing*, which is simply a process to arrive at the balance of the account.

As a partial check that the posting process was done correctly, a working document called an *unadjusted trial balance* is created. In its simplest form, this is a three-column list. Column One contains the names of those accounts in the **ledger** which have a non-zero balance. If an account has a *debit* balance, the balance amount is copied into Column Two (the *debit column*); if an account has a *credit* balance, the amount is copied into Column Three (the *credit column*). The debit column is then totalled, and then the credit column is totalled. The two totals must agree—which is not by chance—because under the double-entry rules, whenever there is a posting, the debits of the posting equal the credits of the posting. If the two totals do not agree, an error has been made, either in the journals or during the posting process. The error must be located and rectified, and the totals of the debit column and the credit column recalculated to check for agreement before any further processing can take place.

Once the accounts balance, the accountant makes a number of adjustments and changes the balance amounts of some of the accounts. These adjustments must still obey the double-entry rule: for example, the ***inventory*** account and asset account might be changed to bring them into line with the actual numbers counted during a **stocktake**. At the same time, the *expense* account associated with use of inventory is adjusted by an equal and opposite amount. Other adjustments such as posting **depreciation** and prepayments are also done at this time. This results in a listing called the *adjusted trial balance*. It is the accounts in this list, and their corresponding debit or credit balances, that are used to prepare the financial statements.

Finally **financial statements** are drawn from the trial balance, which may include:

- the **income statement**, also known as the *statement of financial results*, *profit and loss account*, or *P&L*
- the **balance sheet**, also known as the *statement of financial position*
- the **cash flow statement**
- the **statement of changes in equity**, also known as the *statement of total recognised gains and losses*

Single-entry system

[**edit**]
Main article: **single-entry bookkeeping**

The primary bookkeeping record in single-entry bookkeeping is the *cash book*, which is similar to a checking account register (in UK: cheque account, current account), except all entries are allocated among several categories of income and expense accounts. Separate account records are maintained for petty cash, **accounts payable** and **accounts receivable**, and other relevant transactions such as **inventory** and travel expenses. To save time and avoid the errors of manual calculations, single-entry bookkeeping can be done today with do-it-yourself bookkeeping software.

Double-entry system

[**edit**]
Main article: **double-entry bookkeeping**

A *double-entry bookkeeping system* is a set of rules for recording financial information in a **financial accounting** system in which every transaction or event changes at least two different ledger accounts.

Daybooks

[**edit**]

A *daybook* is a descriptive and chronological (diary-like) record of day-to-day **financial transactions**; it is also called a *book of original entry*. The daybook's details must be transcribed formally into journals to enable posting to ledgers. Daybooks include:

- Sales daybook, for recording sales invoices.
- Sales credits daybook, for recording sales credit notes.
- Purchases daybook, for recording purchase invoices.
- Purchases debits daybook, for recording purchase debit notes.
- Cash daybook, usually known as the cash book, for recording all monies received and all monies paid out. It may be split into two daybooks: a receipts daybook documenting every money-amount received, and a payments daybook recording every payment made.
- General Journal daybook, for recording journal entries.

Petty cash book

[**edit**]

A ***petty cash*** book is a record of small-value purchases before they are later transferred to the ledger and final accounts; it is maintained by a petty or junior cashier. This type of cash book usually uses the **imprest system**: a certain amount of money is provided to the petty cashier by the senior cashier. This money is to cater for minor expenditures (hospitality, minor stationery, casual postage, and so on) and is

reimbursed periodically on satisfactory explanation of how it was spent. The balance of petty cash book is **Asset**.

Journals

[edit]

Journals are recorded in the general journal daybook. A journal is a formal and chronological record of **financial transactions** before their values are accounted for in the general ledger as **debits and credits**. A company can maintain one journal for all transactions, or keep several journals based on similar activity (e.g., sales, cash receipts, revenue, etc.), making transactions easier to summarize and reference later. For every **debit** journal entry recorded, there must be an equivalent **credit** journal entry to maintain a balanced accounting equation.**[5][6]**

Ledgers

[edit]

A ***ledger*** is a record of **accounts**. The ledger is a permanent summary of all amounts entered in supporting Journals which list individual transactions by date. These accounts are recorded separately, showing their beginning/ending **balance**. A journal lists **financial transactions** in chronological order, without showing their balance but showing how much is going to be entered in each account. A ledger takes each financial transaction from the journal and records it into the corresponding accounts. The ledger also determines the balance of every account, which is transferred into the **balance sheet** or the **income statement**. There are three different kinds of ledgers that deal with book-keeping:

- Sales ledger, which deals mostly with the accounts receivable account. This ledger consists of the records of the financial transactions made by customers to the business.
- Purchase ledger is the record of the company's purchasing transactions; it goes hand in hand with the Accounts Payable account.
- General ledger, representing the original five, main accounts: **assets**, **liabilities**, **equity**, **income**, and **expenses**.

Abbreviations used in bookkeeping

[edit]

- A/c or Acc – Account
- A/R – Accounts receivable
- A/P – Accounts payable
- B/S – Balance sheet

- c/d – Carried down
- b/d – Brought down
- c/f – Carried forward
- b/f – Brought forward
- Dr – Debit side of a ledger. "Dr" stands for "**D**ebit **r**egister"
- Cr – Credit side of a ledger. "Cr" stands for "**C**redit **r**egister"
- G/L – General ledger; (or N/L – nominal ledger)
- PL – Profit and loss; (or I/S – income statement)
- P/L – Purchase Ledger (Accounts payable)
- P/R – Payroll
- PP&E – Property, plant and equipment
- S/L - Sales Ledger (Accounts receivable)
- TB – Trial Balance
- GST – **Goods and services tax**
- SGST – State goods & service tax
- CGST – Central goods & service tax
- IGST- integrated goods & service tax
- VAT – **Value added tax**
- CST – Central sale tax
- TDS – Tax deducted at source
- AMT – Alternate minimum tax
- EBT – Earnings before tax
- EAT – Earnings after tax
- PAT – Profit after tax
- PBT – Profit before tax
- Dep or Depr – Depreciation
- CPO – Cash paid out
- CP - Cash Payment
- w.e.f. - with effect from
- @ - at the rate of
- L/F – ledger folio
- J/F – Journal Folio
- M/s- Messrs Account
- Co- Company
- V/N or V.no. – voucher number
- In no -invoice Number

Chart of accounts

[**edit**]

A **chart of accounts** is a list of the **accounts** codes that can be identified with numeric, alphabetical, or alphanumeric codes allowing the account to be located in the general ledger. The equity section of the chart of accounts is based on the fact that the legal

structure of the entity is of a particular legal type. Possibilities include *sole trader*, *partnership*, *trust*, and *company*.[7]

Computerized bookkeeping

[edit]

Computerized bookkeeping removes many of the paper "books" that are used to record the financial transactions of a business entity; instead, relational databases are used today, but typically, these still enforce the norms of bookkeeping including the **single-entry** and **double-entry** bookkeeping systems. **Certified Public Accountants** (CPAs) supervise the internal controls for computerized bookkeeping systems, which serve to minimize errors in documenting the numerous activities a business entity may initiate or complete over an accounting period.

See also

[edit]

- **Accounting**
- **Comparison of accounting software**
- **POS system**: records sales and updates stock levels
- **Bookkeeping Associations**

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- **Guide to the Account Book from Italy 1515–1520**

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About patient

For the state of being, see Patience. For other uses, see Patient (disambiguation).

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Part of a series on Patients

Patients

Concepts

- Doctor-patient relationship
- Medical ethics
- Patient participation
- Patient-reported outcome
- Patient safety

Consent

- Informed consent
- Adherence
- Informal coercion
- Motivational interviewing
- Involuntary treatment

Rights

- Patients' rights
- Pregnant patients' rights
- Disability rights movement
- Patient's Charter
- Medical law

Approaches

- Patient advocacy
- Patient-centered care
- Patient and public involvement

Abuse

- Patient abuse
- Elder abuse

Medical sociology

- Sick role

A **patient** is any recipient of health care services that are performed by healthcare professionals. The patient is most often ill or injured and in need of treatment by a physician, nurse, optometrist, dentist, veterinarian, or other health care provider.

Etymology

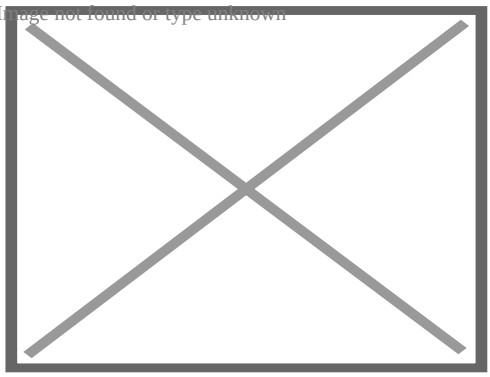
[edit]

The word patient originally meant 'one who suffers'. This English noun comes from the Latin word *patiens*, the present participle of the deponent verb, *patior*, meaning 'I am suffering', and akin to the Greek verb ?ÃŽÂ¬????? (*paskhein* 'to suffer') and its cognate noun ?ÃŽÂ¬??? (*pathos*).

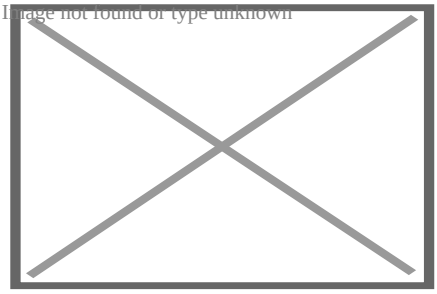
This language has been construed as meaning that the role of patients is to passively accept and tolerate the suffering and treatments prescribed by the healthcare providers, without engaging in shared decision-making about their care.[1]

Outpatients and inpatients

[edit]



Patients at the Red Cross Hospital in Tampere, Finland during the 1918 Finnish Civil War



Receptionist in Kenya attending to an outpatient

An **outpatient** (or **out-patient**) is a patient who attends an outpatient clinic with no plan to stay beyond the duration of the visit. Even if the patient will not be formally admitted with a note as an outpatient, their attendance is still registered, and the provider will usually give a note explaining the reason for the visit, tests, or procedure/surgery, which should include the names and titles of the participating personnel, the patient's name and date of birth, signature of informed consent, estimated pre-and post-service time for history and exam (before and after), any anesthesia, medications or future treatment plans needed, and estimated time of discharge absent any (further) complications. Treatment provided in this fashion is called ambulatory care. Sometimes surgery is performed without the need for a formal hospital admission or an overnight stay, and this is called outpatient surgery or day surgery, which has many benefits including lowered healthcare cost, reducing the amount of medication prescribed, and using the physician's or surgeon's time more efficiently. Outpatient surgery is suited best for more healthy patients undergoing minor or intermediate procedures (limited urinary-tract, eye, or ear, nose, and throat procedures and procedures involving superficial skin and the extremities). More procedures are being performed in a surgeon's office, termed *office-based surgery*, rather than in a hospital-based operating room.

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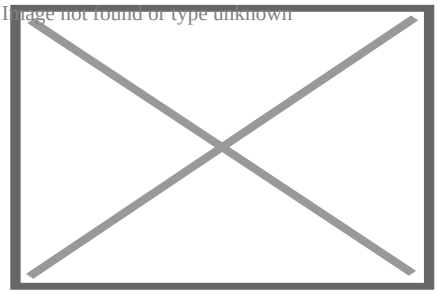

A mother spends days sitting with her son, a hospital patient in Mali

An **inpatient** (or **in-patient**), on the other hand, is "admitted" to stay in a hospital overnight or for an indeterminate time, usually, several days or weeks, though in some extreme cases, such as with coma or persistent vegetative state, patients can stay in hospitals for years, sometimes until death. Treatment provided in this fashion is called inpatient care. The admission to the hospital involves the production of an admission note. The leaving of the hospital is officially termed *discharge*, and involves a corresponding discharge note, and sometimes an assessment process to consider ongoing needs. In the English National Health Service this may take the form of "Discharge to Assess" - where the assessment takes place after the patient has gone home.[2]

Misdiagnosis is the leading cause of medical error in outpatient facilities. When the U.S. Institute of Medicine's groundbreaking 1999 report, *To Err Is Human*, found up to 98,000 hospital patients die from preventable medical errors in the U.S. each year,[3] early efforts focused on inpatient safety.[4] While patient safety efforts have focused on inpatient hospital settings for more than a decade, medical errors are even more likely to happen in a doctor's office or outpatient clinic or center.[*citation needed*]

Day patient

[edit]

A **day patient** (or **day-patient**) is a patient who is using the full range of services of a hospital or clinic but is not expected to stay the night. The term was originally used by psychiatric hospital services using of this patient type to care for people needing support to make the transition from in-patient to out-patient care. However, the term is now also heavily used for people attending hospitals for day surgery.

Alternative terminology

[edit]

Because of concerns such as dignity, human rights and political correctness, the term "patient" is not always used to refer to a person receiving health care. Other terms that

are sometimes used include **health consumer**, **healthcare consumer**, **customer** or **client**. However, such terminology may be offensive to those receiving public health care, as it implies a business relationship.

In veterinary medicine, the **client** is the owner or guardian of the patient. These may be used by governmental agencies, insurance companies, patient groups, or health care facilities. Individuals who use or have used psychiatric services may alternatively refer to themselves as consumers, users, or survivors.

In nursing homes and assisted living facilities, the term **resident** is generally used in lieu of *patient*.[5] Similarly, those receiving home health care are called *clients*.

Patient-centered healthcare

[edit]
See also: Patient participation

The doctor–patient relationship has sometimes been characterized as silencing the voice of patients.[6] It is now widely agreed that putting patients at the centre of healthcare[7] by trying to provide a consistent, informative and respectful service to patients will improve both outcomes and patient satisfaction.[8]

When patients are not at the centre of healthcare, when institutional procedures and targets eclipse local concerns, then patient neglect is possible.[9] Incidents, such as the Stafford Hospital scandal, Winterbourne View hospital abuse scandal and the Veterans Health Administration controversy of 2014 have shown the dangers of prioritizing cost control over the patient experience.[10] Investigations into these and other scandals have recommended that healthcare systems put patient experience at the center, and especially that patients themselves are heard loud and clear within health services.[11]

There are many reasons for why health services should listen more to patients. Patients spend more time in healthcare services than regulators or quality controllers, and can recognize problems such as service delays, poor hygiene, and poor conduct.[12] Patients are particularly good at identifying soft problems, such as attitudes, communication, and 'caring neglect',[9] that are difficult to capture with institutional monitoring.[13]

One important way in which patients can be placed at the centre of healthcare is for health services to be more open about patient complaints.[14] Each year many hundreds of thousands of patients complain about the care they have received, and these complaints contain valuable information for any health services which want to learn about and improve patient experience.[15]

See also

[edit]

- Casualty
- e-Patient
- Mature minor doctrine
- Nurse-client relationship
- Patient abuse
- Patient advocacy
- Patient empowerment
- Patients' Bill of Rights
- Radiological protection of patients
- Therapeutic inertia
- Virtual patient
- Patient UK

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- "Time Magazine's Dr. Scott Haig Proves that Patients Need to Be Googlers!" – Mary Shomons response to the Time Magazine article "When the Patient is a Googler"

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Articles about hospitals

History of hospitals, Hospital network, Category:Hospitals

Common hospital components	Accreditation Bed Coronary care unit Emergency department Emergency codes Hospital administrators Hospital information system Hospital medicine Hospital museum Hospitalist Intensive care unit Nocturnist On-call room Operating theater Orderly Patients Pharmacy Wards
Archaic forms	Almshouse Asclepeion (Greece) Bimaristan (Islamic) Cottage hospital (England) Hôtel-Dieu (France) Valetudinaria (Roman) Vaishya lying in houses (India) Xenodochium (Middle Ages)
Geographic service area	Base hospital (Australia) Community hospital General hospital Regional hospital or District hospital Municipal hospital

Complexity of services	○ Day hospital ○ Secondary hospital ○ Tertiary referral hospital ○ Teaching hospital ○ Specialty hospital
Unique physical traits	○ Hospital ship ○ Hospital train ○ Mobile hospital ○ Underground hospital ○ Virtual Hospital
Limited class of patients	○ Military hospital ○ Combat support hospital ○ Field hospital ○ Prison hospital ○ Veterans medical facilities ○ Women's hospital
Funding	○ Charitable hospital ○ For-profit hospital ○ Non-profit hospital ○ State hospital ○ Private hospital ○ Public hospital ○ Voluntary hospital
Condition treated	○ Defunct ○ Cancer ○ Children's hospital ○ Eye hospital ○ Fever hospital ○ Leper colony ○ Lock hospital ○ Maternity hospital ○ Psychiatric hospital ○ Rehabilitation hospital ○ Trauma center ○ Verterinary hospital

Century established	○ 5th ○ 6th ○ 7th ○ 8th ○ 9th ○ 10th ○ 11th ○ 12th ○ 13th ○ 14th ○ 15th ○ 16th ○ 17th ○ 18th ○ 19th ○ 20th ○ 21st
Lists of hospitals in: Africa, Asia, Europe, North America, Oceania, South America	
Authority control databases: National	○ Germany ○ United States ○ Japan ○ Czech Republic ○ 2 ○ Latvia ○ Israel

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State variations affect coding practices by requiring coders to understand different reimbursement rates and policies for each states Medicaid program. Coders must ensure that documentation aligns with specific state guidelines to secure appropriate payments.

What factors contribute to differences in Medicaid reimbursement rates across states?

Factors include state-level policy decisions, cost of living, healthcare needs, budget constraints, and negotiation processes between states and healthcare providers. These elements create distinct reimbursement structures that vary widely from one state to another.

Are there resources available for coders to stay updated on these state-specific variations?

Yes, resources such as the Centers for Medicare & Medicaid Services (CMS) website, state-specific Medicaid manuals, coding associations like AAPC or AHIMA, and continuous education programs can help coders stay informed about changes in reimbursement policies.

How can discrepancies in Medicaid reimbursements be addressed by medical coders?

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