THIS IS WHERE IT STARTS:

FRONT OFFICE TRAINING

Inspiring healthcare excellence.℠

MGMA®

WELCOME TO

THIS IS WHERE IT STARTS: FRONT OFFICE TRAINING

This book is filled with definitions, forms, checklists, and additional instructions to help you perform your duties with confidence and expertise.

This role is absolutely crucial to ensuring patients get the care they deserve. Thank you for rising to the challenge!

Copyright: This is where it starts: front office training. MGMA 2023.

CONTENT

The Roles in a Medical Practice 3

Checklist: The Beginning of the Day..... 5

Patient Intake & Insurance Verification 7

After the Appointment 8

Scheduling..... 9

Collecting Payment..... 10

Types of Insurance 11

Components of Payment..... 13

How to Verify Insurance..... 14

How to Read an Insurance Card..... 15

How to Take Great Notes..... 18

How to be Great on the Phone..... 19

What is HIPAA? 21

How to be a Great Colleague..... 22

What's the Next Step? 23

Vocabulary..... 24

THE ROLES IN A MEDICAL PRACTICE

Organizational structures in medical practices can vary, but these are the common roles that most practices employ:

1. **Physicians/Doctors:** These are the licensed medical professionals who diagnose and treat patients. They may specialize in various areas such as family medicine, internal medicine, pediatrics, surgery, etc.

2. **Medical Director/Chief Medical Officer:** This role is responsible for overseeing the medical practice, ensuring quality care, and providing leadership to the physicians and staff. They may also handle administrative duties and work closely with the practice manager.

3. **Practice Manager/Administrator:** The practice manager is responsible for the overall operations and administration of the medical practice. They handle tasks such as staffing, financial management, regulatory compliance, patient scheduling, and coordination with external entities.

4. **Non-Physician Practitioner (NPP):** Qualified healthcare professionals credentialed to provide and bill for services rendered. NPPs include physician assistant, advanced nurse practitioner, certified nurse midwife, clinical nurse specialist, pediatric nurse partitioner, and family nurse practitioner.

5. **Nurses:** Registered nurses (RNs) and licensed practical nurses (LPNs) play a crucial role in patient care. They assist physicians, administer medications, perform procedures, coordinate patient education, and provide direct patient care.

6. **Medical Assistants:** Medical assistants support physicians and nurses by taking patient histories, measuring vital signs, preparing patients for examinations, and conducting basic laboratory tests. They also handle administrative tasks like scheduling appointments and maintaining medical records.

7. **Front Desk/Reception Staff:** These staff members are responsible for greeting patients, scheduling appointments, managing phone calls, verifying insurance information, and handling patient registration and check-in processes.

8. **Billing and Coding Specialists:** These professionals handle medical coding, billing, and insurance claims. They ensure accurate coding of medical procedures and diagnoses, submit claims to insurance companies, and handle reimbursement processes.

9. **Medical Records/Health Information Technicians:** They are responsible for managing patient records, maintaining electronic health records (EHRs), organizing and processing medical documentation, and ensuring compliance with privacy regulations.

10. **Laboratory Technicians:** In practices with in-house laboratories, technicians collect and process samples, conduct tests, and report results to physicians for diagnosis and treatment.

11. **Ancillary Staff:** This category may include various specialized roles, such as radiology technicians, pharmacy personnel, physical therapists, occupational therapists, social workers, MAs, nurses and other healthcare professionals who work in specific areas of patient care.

It's important to note that the actual structure and titles within a medical practice can vary depending on the practice's size, specialty, and specific needs. Some roles may be combined or expanded, while others may not be present in smaller practices.



CHECKLIST: THE BEGINNING OF THE DAY

The beginning of the day will vary from practice to practice, but these are the basic steps for most practices.

1. Preparing the office for the day:

- Sweep the patient waiting areas for trash and straighten up.
- Sanitize by wiping down touch points such as furniture, pens, counter, etc.
- Be sure the waiting area is safe for patients and visitors by fixing or removing trip hazards, broken furniture, loose cords, etc.
- The above-mentioned duties are performed throughout the day.

2. Check supplies:

- Ensure the examination rooms are clean and properly stocked with necessary supplies.
- Check that the equipment, such as stethoscopes, blood pressure monitors, and otoscopes, are in good working condition.
- Make sure the reception area is tidy and organized.

3. Check messages and correspondence:

- Review any voicemails, emails, or other messages received after closing the previous day.
- As soon as possible, notify a Provider (usually a Physician, PA, RN, or NP) of any message that could be an emergency for a patient. These include:
  — Chest pains, Injuries, bad reactions to medication, immediate need for a prescription refill.
- Respond to urgent messages or inquiries promptly.

4. Review the schedule:

- Become familiar with patients due to arrive to help preparation of check-in process.
- Check the day's schedule to accommodate any special requirements such as interpreter or accessibility impediment.
- Ensure patient files are up-to-date and flag items needing attention.

5. Review appointments:

- Confirm appointments for the day, including any necessary reminders or rescheduling.
- Verify insurance coverage and eligibility for patients as needed.

6. Coordinate with the support staff:

- Communicate with nurses, medical assistants, and other staff members to ensure smooth workflow and coordination.
- Discuss any special requirements or instructions for the day.

7. Anticipate emergencies:

- Familiarize yourself with emergency protocols and ensure that emergency equipment, such as defibrillators or emergency medications, are readily accessible.
- Review the location of emergency exits and evacuation procedures.
- Provider might have an emergent reason to not come into the office or have modifications to their schedule. Therefore, front office staff will need to contact patients, if needed.

8. Daily preparation:

- Wash hands or use hand sanitizer thoroughly between patient contact.
- Mentally prepare for the day by focusing on providing compassion and professional interaction.
- Set goals or reminders to support staff and patients throughout the day, such as reviewing specific medical cases or learning opportunities.

Remember, this checklist can be customized to suit the needs and workflows of your specific practice. Adapt it as necessary and develop routines that work best for you and your team.

PATIENT INTAKE & INSURANCE VERIFICATION

Here's a checklist of what to do when a patient arrives at your practice.

1. **Greeting:**
   - Speak with empathy and explain each step of the process, such as accepting a photo ID to ensure identification or insurance card to verify up-to-date and correct information.
   - Smile and handle the interaction with sincere consideration as most are not feeling well, concerned, anxious, emotional, or other feelings.

2. **Patient Registration:**
   - Gather patient demographics by verifying with government issued ID or acceptable form of verification.
   - Ensure insurance information is up-to-date by requesting current insurance card.
   - Confirm contact preference and details, such as email or phone number for text messages.
   - Be sure to always have a current signed and dated financial responsibility agreement on file.
     - **Note**: if it's a patient's first visit to your practice, there may be additional intake forms to complete.

3. **Patient Financial Responsibility:**
   - Clearly communicate payment expectations and acceptable methods of payment.
   - Copayment must always be collected at check-in
   - Collect any payment patient is responsible for, such as copayment, deductible, coinsurance, outstanding balance.
   - Verify with insurance amounts owed per contractual agreement and notify patient.

4. **Communicate:**
   - Let patient know of any delays and expected time.

AFTER THE APPOINTMENT

The patient typically returns to the same staff that checked the patient in to check-out after their visit with a provider. Here are some factors to consider after the appointment.

1. Appointment Wrap-up and Check Out

- Ensure patient receives after-visit summary and care instructions.
- Confirm patient's understanding of post-visit instructions.
- Validate follow-up appointment with same provider, specialists, laboratory, radiology, etc.
- Verify referrals to other specialists.
- Provide patient with post-visit forms needing signatures, such as release of information, medical record transfer, preoperative forms, etc.
- Collect any post-visit patient financial responsibility due.
- Thank patient for visiting the provider and choosing the practice to receive care.

Please note that the above-mentioned points may vary upon specialty of the practice and staff roles. Adjustments can be made based on the unique requirements and resources available to optimize patient intake and enhance the overall patient experience.

SCHEDULING

Essential guidelines of scheduling are:

1. Not every appointment type takes the same amount of time.

   For example:
   - Sick visit might take 20 minutes
   - Minor procedure might take 30-45 minutes
   - Annual physical might take 30-45 minutes

2. Some providers have different preferences.
3. Try to thoroughly fill the schedule accordingly.
4. Become familiar with provider's scheduling preferences.
5. If possible, confirm the patient's insurance and the way their name is spelled on their insurance card.
6. When scheduling follow-up appointments, repeat the date, time and provider and provide notification via written, text or email.
7. Remind patient of their financial responsibility amount owed at the next appointment.
8. Be considerate and confirm patient's understanding of post-visit directives.



COLLECTING PAYMENT

Patients MUST expect to pay their portion at the same time of service. It is NOT optional as it is patient responsibility per agreement when patient selects their health insurance.

However, we cannot deny emergency care and some patients may be eligible for financial assistance or payment plans. Your practice should have policies about this.

When should you collect payment?

Always address payment at initial engagement with the patient. Do not give the patient the option of opting out of paying. It is best practice to advise of accepted payment methods and amount owed. This applies to co-payment, deductible, co-insurance, and balance owed.

What if the patient owes a balance?

Collect the balance or set up a reasonable payment plan. It is imperative to have a payment policy the patient must adhere to. It must specify amount, due date, and patient's signature confirming the agreement. Offer payment plan or financial assistance, when patient qualifies and if applicable.

Emergency care cannot be denied but this is a rational reason to offer payment options and include in patient financial agreement. Review policies and procedures to reflect patient payment obligations.

TYPES OF INSURANCE

Insurance is a contract between an individual and an insurance company. The individual pays regular premiums to the insurance company in exchange for financial protection against specific risks or events, such as medical expenses. Insurance helps cover the costs of certain healthcare services, treatments, or medications. Most patients will have some form of insurance. This could be public insurance (like Medicare or Medicaid), semi-public (like Medicare Advantage), or Employer-Sponsored. Here is a list of the types of insurance you may encounter:

1. Employer-Sponsored Health Insurance:

- Many employers offer health insurance coverage as part of employee benefits.
- These plans are typically negotiated by the employer with insurance companies and can vary in terms of coverage, cost-sharing, and network restrictions.

2. Individual Health Insurance:

- Individuals who are not eligible for employer-sponsored insurance or government programs can purchase health insurance coverage directly from insurance providers.
- These plans are regulated by the Affordable Care Act (ACA) and are available through state or federal health insurance marketplaces or directly from insurance companies.

3. Medicaid:

- Medicaid is a joint federal and state program that provides health insurance coverage to low-income individuals and families.
- Eligibility criteria and coverage details vary by state, but Medicaid generally covers essential health benefits and may include long-term care services.

4. Medicare:

- Medicare is a federal health insurance program primarily for individuals aged 65 and older.
- It also provides coverage for certain younger individuals with disabilities or specific medical conditions.
- Medicare has several parts, including Part A (hospital insurance), Part B (medical insurance), Part C (Medicare Advantage plans), and Part D (prescription drug coverage).

5. Children's Health Insurance Program (CHIP):

- CHIP is a state and federal program that provides low-cost or free health insurance coverage for eligible children.
- It offers coverage to children in families with incomes too high to qualify for Medicaid but can't afford private health insurance.

6. TRICARE:

- TRICARE is a healthcare program for military service members, retirees, and their families.
- It provides comprehensive coverage for medical services, including hospital care, prescription drugs, and preventive care.

7. Veterans Health Administration (VHA):

- The VHA provides healthcare services to eligible veterans of the U.S. military.
- It operates a network of hospitals, clinics, and medical centers throughout the country.

8. Health Maintenance Organization (HMO):

- HMOs are a type of managed care health insurance plan.
- They typically require members to choose a primary care physician (PCP) and receive referrals to see specialists within the plan's network.
- HMOs often emphasize preventive care and have lower out-of-pocket costs but have more restrictions on accessing out-of-network providers.

9. Preferred Provider Organization (PPO):

- PPOs are another type of managed care plan that offers a network of preferred providers to members.
- Unlike HMOs, PPO members can see specialists without a referral and have the option to receive care from out-of-network providers, although at a higher cost.

10.Exclusive Provider Organization (EPO):

- An EPO is a plan in which patients do not need a referral from primary care to see a specialist. This plan does not cover out-of-network providers.

11. High-Deductible Health Plan (HDHP):

- An HDHP is a health plan that requires maximum out-of-pocket be met before the plan pays 100% of medical care. Some plans provide the option of offering a health savings account (HSA) to cover out-of-pocket expenses for medical services, such as co-pays, co-insurance and other expenses.

12.Point of Service (POS) Plans:

- POS plans combine features of HMOs and PPOs.
- Members typically choose a primary care physician but can also see specialists directly.
- POS plans offer lower costs for in-network providers but allow some coverage for out-of-network providers, although with higher cost-sharing.

It's important to note that the availability and specifics of these health insurance programs may vary based on the state and individual circumstances. Additionally, there may be other specialized health insurance programs or variations of the mentioned programs depending on the region and specific population groups.

COMPONENTS OF PAYMENT

There are several components of payment that you need to understand:

1. **Co-insurance:** Co-insurance refers to the percentage of costs shared between the insured individual and the insurance company after the deductible has been met. For example, if the insurance plan has a 20% co-insurance rate, the insured individual will pay 20% of the covered expenses, while the insurance company will cover the remaining 80%.

2. **Co-pay:** A co-pay, short for "copayment," is a fixed amount that an insured individual pays out of pocket for a specific healthcare service or medication.

   Co-pays are typically required at the time of service and are predetermined by the insurance plan. For instance, a plan might require a $20 co-pay for doctor visits or a $10 co-pay for generic prescriptions.

3. **Deductible:** A deductible is the amount an insured individual must pay out of pocket for covered healthcare services before the insurance company begins to contribute. Deductibles can vary depending on the insurance plan and are typically set on an annual basis. For example, if an insurance plan has a $1,000 deductible, the insured individual will be responsible for paying the first $1,000 of covered expenses, and the insurance company will start sharing costs afterward.

4. **Out-of-pocket maximum:** The out-of-pocket maximum, also known as the out-of-pocket limit, is the maximum amount an insured individual has to pay for covered healthcare services during a specific period, usually a year. Once the out-of-pocket maximum is reached, the insurance company will typically cover 100% of the remaining covered expenses. The out-of-pocket maximum includes deductibles, co-pays, and co-insurance, but it may not include premiums or expenses for services not covered by the insurance plan.

HOW TO VERIFY INSURANCE

1. Obtain a copy of the patient's insurance card(s) and photo identification. See below for instructions on how to read an insurance card.

2. Contact the insurance company or use an online portal to verify coverage and gather relevant details. This step can be completed before the patient's visit or shortly after their appointment is scheduled.

    - Look to see if the spelling of the patient's name on the I.D. matches the spelling in the Electronic Medical Record or Insurance Card.

        — **Important: i**f it doesn't match, make a note of it, but use the spelling on the Insurance Card

3. Verify the patient's insurance eligibility, coverage, deductible, copay, and any preauthorization requirements.



HOW TO READ AN INSURANCE CARD

Different insurance companies offer different types of insurance cards, but the components of the cards are essentially the same.

The member ID number, policy number, member number, ID number is a set of unique numbers and/or alpha characters that is used to identify a member or beneficiary on a healthcare policy determines coverage and benefits.

The group number, contract type, effective date, and plan code is all information the health plan uses to identify the employer and the date coverage started. Additional information will be provided on the insurance card for prescription coverage if included in the same healthcare plan.

A co-payment, also known as co-pay, is a fixed amount determined by the healthcare plan used to pay for covered healthcare service, such as medical or prescription service.

The health insurance card will have a list of phone numbers to include but not limited to:

- Customer or member services
- Precertification, pre-authorization or prior authorization
- Provider locator or provider services
- Pharmacy line
- Nurse line
- Dental

Most health insurance cards have the address listed as to where to send claims for medical or dental services rendered. The vast majority of claims are submitted via electronic payer portal but it is important to note that the address might be used for paper claims or to determine the correct healthcare plan.

Here is a generic card with call-outs to help you learn how they work:

Front of Card



1. Member ID Number

The member ID number, policy number, member number, or ID number is a set of unique numbers and/or alpha characters that are used to identify a member of beneficiary on a healthcare policy and determines coverage and benefits.

2. Group Number

The group number, contract type, effective date and plan code are used by the health plan to identify the employer and the date coverage started.
Additional information will be provided on the insurance card for prescription coverage if included in the same healthcare plan.

3. Co-payment

A co-payment, also known as co-pay, is a fixed amount determined by the healthcare plan used to pay for covered healthcare service, such as medical or prescription service.

4. Plan Type

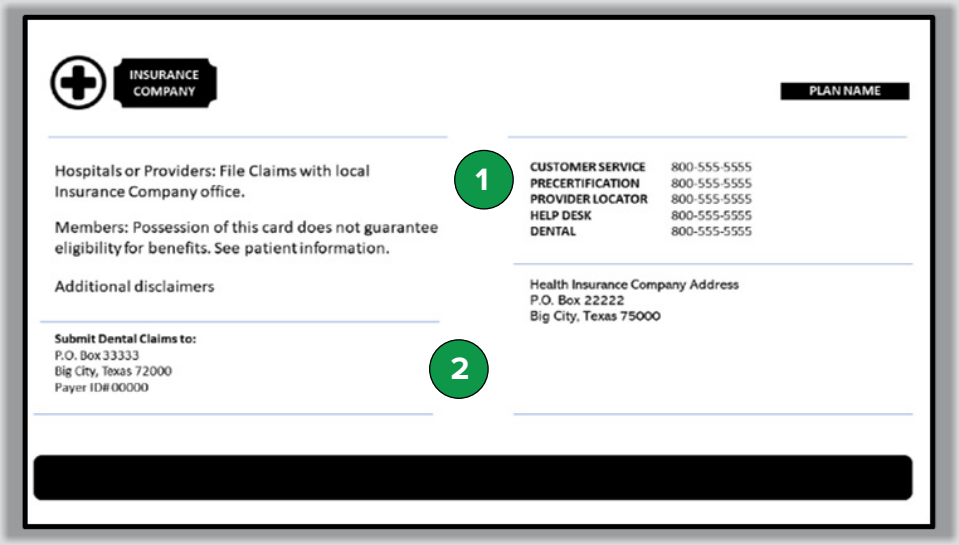
The hexagon will tell you the type of plan the patient has.

The main plan types are:

- HMO
- PPO
- Medicare
- Medicaid

Explanations of these other plans are covered elsewhere.

Back of Card



1. Phone Numbers

The health insurance card will have a list of phone numbers to include but not limited to:

- Customer or member services
- Pre-certification, pre-authorization, or prior authorization
- Provider locator or provider services
- Pharmacy line
- Nurse line
- Dental

2. Important Addresses

Most health insurance cards have the address listed as to where to send claims for medical or dental services rendered.

The vast majority of claims are submitted via electronic payer portal, but it is important note that the address might be used for paper claims or to determine the correct healthcare plan.

Remember: if the names on the insurance card and the patient's other identification do not match perfectly, make a note of it, but use the precise spelling on the insurance card when billing.

HOW TO TAKE GREAT NOTES

Great note-taking is a learned skill. No one is born with it. In medical practices, it can mean the difference between someone getting or not getting the care they need, and the difference between the practice getting paid or working for free.

Here are some tips on great note-taking:

1. Include details that differentiate. For example, you may have several patients named Linda Martinez, but none of those Linda's will have the same Medical Record Number. To ensure you can figure out which Linda the note is about, always use the Medical Record Number.

2. Avoid "leetspeak", in which numbers or symbols are used instead of letters, like "gr8" instead of "great." The reason to avoid this is because it can confuse others in the practice, and the abbreviation may already be a medical or financial code for a condition, a procedure, etc.

3. Date your notes. This can help you remember the circumstances in which the note was taken, for example by looking back at that day's schedule.

4. For notes to yourself (not the notes you put into your EMR or Practice Management System), feel free to develop your own codes. For example, when a patient checked in, Christy would draw a square check box beside the patient's name or Medical Record Number. When the patient went in to see the doctor, she would check the box. That helped her to be able to quickly know who was in the waiting room and who was with the doctor.

5. For notes to others, ask them if the notes were helpful and easy to decipher. If they weren't, maybe you can work together to ensure you are understood.

6. Do highlighters or sticky notes help you? Use 'em! Your note-taking will develop with time. They will become the best memory aids you have.

HOW TO BE GREAT ON THE PHONE

You've probably had a few terrible phone experiences with customer service staff. You can make sure your patients don't have that experience with this list and whatever other tactics you develop:

1. The person on the phone is as important as the person in the office.
2. The caller may not hear well for any number of reasons - you might have to speak louder or be patient.
3. Whatever the caller is calling about is extremely important to them, so it should be to you too.
4. The caller wants help. Listen to them, of course, but it's okay for you to take charge and direct the conversation. You are the expert they are looking for.
5. The caller may have an account balance. This is a great time to collect it.
6. The caller may have pushed the wrong button in the call system. We've all been there. Help get them where they need to be. Transfer them if possible.
7. The caller may have already gone through a confusing system and may not be sure where she arrived. You can help her right at the beginning by stating your name and department.
8. You don't have to be fake, but patients can hear a smile, and good will is contagious.
9. The caller may have a different code of respect than you do - they may want to be called "Miss" or "Mister," or they may hate that. No problem - make a note of their preference if you can and roll with it.
10. If you have to put someone on hold, give them a reason if possible, and don't forget about them! Make a note and get back to them as quickly as possible.
11. If a caller is looking for someone who is not available, you don't need to tell them why they are unavailable. "Dr. Smith is unavailable but I will pass along this message" is sufficient.

12. If a caller is making an impossible request, don't equivocate. Just tell them no and propose another solution.

13. If a caller has called to complain, own it on behalf of the practice. They need to hear that someone cares about the feedback.

14. Repeating back to a caller what they have said is always a good idea. "Let me make sure I understand you: you need a refill on your blood pressure medication" can ensure that you understand and that the caller feels confident that they have communicated the important stuff.

Remember: if a caller leaves a call confused or angry, their chances of not getting the care they need go way up. A phone call is part of their care.



WHAT IS HIPAA?

HIPAA stands for the Health Insurance Portability and Accountability Act. It is a law enacted in the United States to safeguard the privacy and security of individuals' personal health information (PHI).

HIPAA aims to protect patients' rights by setting standards for the confidentiality and security of their health-related data. It applies to healthcare providers, health plans, medical office staff, and anyone else who handles PHI. It covers electronic medical records, transactions, phone calls, and office chatter.

What it means for you: don't share health information with anyone except providers and the patients themselves. Be careful about how loudly you are discussing sensitive information in the office, be careful about capturing sensitive data on your phone or any other device, and don't share patients' health information to family and friends.

Your personal policy is: anything relating to a patient's health belongs to them and their provider. If you keep that in the forefront of your mind, you should be fine.



HOW TO BE A GREAT COLLEAGUE

You are probably already a terrific colleague. But it never hurts to be reminded, so here is some wisdom from experience:

1. You don't need to be best friends with your colleagues. If you make great friends, great! But you're going to be spending many hours with these people, so if you want to keep it strictly professional and keep your private life to yourself, do it. At the same time, you should show your coworkers the same respect.

2. Compliment your coworkers when they do something great. Did you see someone have a really great interaction with a patient or anticipate the needs of a busy doctor? Tell them! Everyone loves a little positive reinforcement. And when you do that, you become a builder of a positive culture, and the love will come back around to you.

3. Know your strengths and your weaknesses. Maybe you are great with people, but your coworker is awkward or shy. That's okay. Your coworker will learn from watching you. And vice-versa. As you build a great culture, you can ask a coworker how they got so good at something, and you can share your skills with them.

4. Help each other out. Sometimes we get in the groove of our own day, and that's fine. But if you see that somebody needs a little help, give it to them.

5. When you're angry, count to ten. They told it to us when we were little kids. We still need the lesson. If somebody says something rude or treats you disrespectfully, take a deep breath. Count to ten. Chances are very good that they acted out of frustration and that whatever they did may not be about you at all. Sometimes a good pause can work wonders.

7. Own your mistakes. Remember, messing up is part of the job. When you do, just admit it, learn from it, and move on.

8. Forgive others for their mistakes. To repeat: messing up is part of the job. Others will do it, too. Give them the same respect you expect from them!

WHAT'S THE NEXT STEP?

The Front Office is where great careers begin. If you are seeking to move up within your practice or in the industry itself, here are some great next steps:

Billing and Coding Specialists: Billers and coders are also in high demand. They handle medical coding, billing, and insurance claims. They ensure accurate coding of medical procedures and diagnoses, submit claims to insurance companies, and handle reimbursement processes. These roles are best for those who like extended periods of solitary work and are extremely detail-oriented.

Medical Assistant (MA). MAs are in high demand and typically require only a little additional training. Medical assistants support physicians and nurses by taking patient histories, measuring vital signs, preparing patients for examinations, and conducting basic laboratory tests. They also handle administrative tasks like scheduling appointments and maintaining medical records. This role is great for those who like a lot of day-to-day variety and enjoy working with people.

Physician's Assistants (PA) and Nurses typically command higher wages and entail more advanced training than other roles. While customer service is an essential aspect of every job in a medical practice, these roles also have a strong medical component. In some cases, practices will pay or help pay to train talented Front Office workers who wish to move up into these more lucrative roles. They are something to consider.

Practice Manager/Administrator: The practice manager or administrator is on the business side of the practice. They are ultimately responsible for the overall operations, including staffing, finances, payroll, and more. Some practice administrators have advanced degrees, like a Master in Business Administration (MBA), other rise up through the ranks by learning the ins and outs of a practice. In some cases, a Physician will double as the practice manager.

Professional Development is key to moving up. There are many Membership Associations that will provide tools, courses, webinars, and community to help you realize your ambitions. You can find associations specifically for Human Resource Managers, Billers and Coders, Medical Assistants, and many more. A great place to start is Medical Group Management Association (MGMA), the provider of this course. Visit **www.mgma.com** to see what's available. To get our free weekly emails full of tips, tricks, and industry news, email **mgma@info.mgma.com.**

Vocabulary

Here are some common terms you will encounter. Remember, your patients may be confused about some of these terms. As the first point of care for these patient, you can educate them.

Accounts Receivable: The outstanding amount owed to a medical practice by patients or insurance companies for services provided.

Allowable: The maximum amount determined by the insurance company that it will reimburse for a specific medical service.

Balance: The amount remaining to be paid for medical services after insurance payments and patient contributions.

Chart: A patient's medical record that contains information about their medical history, diagnoses, treatments, and other relevant data.

Claims: Formal requests submitted by a healthcare provider to an insurance company to receive payment for medical services rendered.

CNA: Certified Nursing Assistant; a healthcare professional who assists patients with daily activities under the supervision of a registered nurse.

Coinsurance: The percentage of medical expenses that a patient is responsible for paying after meeting the deductible.

Collections: The process of pursuing and collecting outstanding payments from patients or insurance companies.

Copay: The fixed amount that a patient pays for a specific medical service at the time of the visit.

Days in A/R: The average number of days it takes for a medical practice to receive payment for services rendered. Lowering the "Days in A/R" is critical to the financial health of a practice.

Deductible: The predetermined amount that a patient must pay out of pocket for covered medical services before the insurance company starts reimbursing.

Demographic: Pertaining to information about a patient's personal details such as age, gender, address, and contact information.

Denials: Claims that have been rejected or not reimbursed by an insurance company for various reasons.

Electronic Fund Transfer (EFT): The electronic transfer of funds between bank accounts, often used for insurance reimbursements or payment transactions.

Electronic Medical Record (EMR), also called Electronic Health Record (EHR): Digital documentation of a patient's health information, medical history, diagnoses, and treatments, accessible to authorized healthcare providers. Your practice should have instructions for your particular system.

Emergent: Referring to medical conditions or situations that require immediate attention or intervention due to their urgency.

Explanation of Benefits (EOB): A document provided by an insurance company that explains how a claim was processed and outlines the costs covered and the patient's responsibility.

HIPAA: The Health Insurance Portability and Accountability Act; a U.S. law that protects the privacy and security of individuals' health information.

ICD-10-CM: The International Classification of Diseases, 10th Edition; a standardized coding system used to classify and document medical diagnoses.

In-network: Healthcare providers or facilities that have agreed to accept specific insurance plans and have negotiated payment terms with those insurers.

Insurance: A contract between an individual and an insurance company that provides financial coverage for medical expenses and services.

Insurance verification: The process of confirming a patient's insurance coverage and determining the extent of their benefits.

Lobby Audit: A review of financial and administrative procedures within a medical practice, often focusing on billing, coding, and compliance.

LPN: Licensed Practical Nurse; a healthcare professional who provides basic nursing care under the supervision of registered nurses or physicians.

Medicaid: A government-funded healthcare program that provides medical coverage for low-income individuals and families.

Medicare: A federal health insurance program in the United States that primarily serves individuals aged 65 and older, as well as certain younger individuals with disabilities.

Out-of-network: Healthcare providers or facilities that do not have contracts or agreements with a specific insurance plan, resulting in higher patient costs.

Patient Portal: A secure online platform that allows patients to access their medical records, communicate with healthcare providers, and perform administrative tasks.

Payer: An insurance company, government agency, or other entity responsible for reimbursing healthcare services.

Prescriptions: Written orders from healthcare providers authorizing patients to obtain specific medications from pharmacies.

Primary Care: The initial point of medical care provided by healthcare professionals such as family doctors, internists, or pediatricians.

Prior Authorization: The process of obtaining approval from an insurance company before certain medical services or medications are covered.

Provider: A healthcare professional or entity that delivers medical services or care to patients.

Referral: A recommendation from a primary care physician to a specialist.