



# BECOMING A STELLAR CHIROPRACTIC ASSISTANT

Packet

## Intention of Packet

A guide to provide a Chiropractic Assistant (CA) the basic tools to assist in managing a  
Chiropractic Clinic

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## NCCA CA Track Questions

During any seminar, you are listening to the speaker and questions will randomly pop-up that you want to be able to ask to speaker, your team member, your provider. Use this space for questions, ideas, brainstorming... or just draw funny picture!

**CA Roles/Responsibilities**

**Insurance (Major Medical/Medicare/Worker's Comp/Personal Injury)**

**CPT Coding/Diagnosis Coding**

**Patient Experience**

**Additional Questions**

**List 5 Takeways that You Would like to Implement on Monday?**

## Phone Etiquette Dos & Don'ts

Phone etiquette is very important when receiving or making calls for your clinic. You are an extension of the clinic and you want to leave a lasting impression with the caller that creates a positive clinic/patient experience.

DO	DON'T
Smile before you answer the phone	Sound rushed or frazzled when you answer the phone—it makes the caller feel like he/she is a burden
Keep a pen/pencil and notepad, know your office information (address, phone/fax, office hours, driving directions, etc.) and any other information that you might be asked during a call near your phone	Shuffling paper, hum, eat, smacking gum, or make other sounds while speaking to the caller. If you must attend to something urgent, ask the caller if you can put him/her on hold; complete the other task quickly, and then thank the original caller for waiting before you resume the conversation
Practice your greeting ahead of time so it feels comfortable, and the delivery sounds natural	Speak in an unnatural, loud or harsh tone. You may be the caller's first contact with the clinic—make it a good one!
Pause before answering the phone; be prepared to give the caller your undivided attention	Act distracted or disinterested. The caller will detect it in the tone in your voice. You may have to ask him/her to repeat information when given
Speak clearly, enunciating your words	Eat, drink or chew gum while on the phone; not only is that rude, but it makes it difficult to understand you
Use proper names. If your provider approves, call the patients by their first names with their permission.	Use slang, office jargon or acronyms the caller might not understand. Vulgar or inappropriate language is <b>never</b> ok
Use the hold button when necessary	Use speakerphone or leave the line open. You may accidentally reveal a patient's PHI
Ask permission before placing a caller on hold	Interrupt the caller while he/she is speaking. Give the caller time to complete the sentence/phrase—it will be quick!
Use a headset (when possible) to leave your hands free to take notes or locate forms or other resources	Hold the phone on your shoulder. You work for an amazing Chiropractor! Have good sitting posture—poor posture can lead to injuries
Allow the caller to end the call	Hang up first; the caller may want to ask a question or confirm information one more time
Take detailed messages for all sales calls. Tell the sales rep that if the provider is interested, he/she will return the call	Promise anyone that the doctor will return a call by end of day—circumstances may change and a callback may not be possible
Gather information before forwarding calls to other staff members. Pass the information along so the patient doesn't have to repeat it	Forward a call without giving the staff member the caller's name & information. Never forward the call without an introduction

## Customizable Scheduling Options

Every clinic has its own individual needs when it comes to scheduling, and there are several methods that can meet the different needs of the clinic. Understanding which Scheduling style works for your office can assist in helping your office succeed.

Type of Scheduling	Definition
<b>Stream Scheduling</b>	Also known as time-specific scheduling, this involves scheduling patients at a specific time. Stream scheduling minimizes patient wait time and generates a steady flow of patients throughout the clinic (like a stream of water). The amount of time allotted for a time-specific appointment depends on the reason for the visit. Each clinic determines the time needed for different types of visits (e.g., new patient, established patients, re-exams, report of findings, etc.)
<b>Wave Scheduling</b>	When a clinic utilizes scheduling, a certain number of patients are scheduled at specific intervals (e.g., three to five patients every half hour) and the patients are then seen in the order in which they arrived at the office. The resulting wave effect means there is always a patient waiting to be seen. The scheduling system assumes that not all patients will be on time
<b>Cluster Booking</b>	In a chiropractic clinic, this is basically blocking specific time in the schedule for different types of appointments (e.g., new patients, established patients, report of findings, and re-exams). This also allows time to be set aside each day for administrative work
<b>Double Booking</b>	With this type of scheduling, two patients are scheduled in the same time slot. This method compensates for the varying times patients arrive creating smooth patient flow. Patients arrive on-time 50% of the time. Therefore, if two patients are scheduled at the same time, chances are good that they will not arrive at the same time
<b>Open Booking</b>	Open booking gives patients a range of time to arrive for their appointments (e.g., between 9:00 AM & 11:00 AM). These patients are then seen in the order in which they arrive. If multiple patients arrive at the same time, triage the patients so that the most critical are seen first

## Important Billing & Collections Terminology

<b>Acceptance of Assignment</b>	A physician's agreement to accept the amount established by Medicare, Medicaid, or a private insurer as full payment for covered services. The patient is not billed for the difference because the agreement makes it illegal to bill the patient for the balance.
<b>Acute Treatment</b>	CMS considers a patient's condition acute when the patient is being treated for a new injury, identified by x-ray or physical exam. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression of, the patient's condition. Locate the Medical Review Policy for each carrier to identify what qualifies as an acute condition as it varies from payer to payer.
<b>Aging</b>	A formal medical billing term that refers to insurance claims that haven't been paid or balances owed by patients overdue more than 30 days. Aging claims may be denied if they aren't promptly filed with a health insurance company.
<b>Allowed charge</b>	The maximum charge an insurance carrier/ government program covers for specific services. Allowed charges are detailed in the carrier's explanation of benefits (EOB).
<b>Appeal</b>	Appeal occurs when a patient or a provider tries to convince an insurance company to pay for healthcare after it has decided not to cover costs for someone on a claim. Medical billing specialists deal with appeals after a claim is denied or rejected by an insurance company.
<b>Applied to Deductible (ATD)</b>	The amount of money a patient owes a provider that is applied to his/her yearly deductible. A patient's deductible is determined by his/her insurance plan and can range in price.
<b>Assignment of Benefits</b>	An insurance company's authorization to make payments directly to physicians.
<b>Authorization</b>	When a patient's health insurance plan requires him/her to get permission from the insurance providers before receiving certain healthcare services. A patient may be denied coverage if s/he sees a provider for a service that required authorization before consulting the insurance company.
<b>Auto Posting</b>	EOBs /ERAs are downloaded directly into the provider's billing software requiring little to no data entry by a staff member.
<b>Balance Billing</b>	Billing a patient for services not paid for by insurance. <b>Note:</b> Managed Care plans in which the doctor participates generally prohibit balance billing. Allowed amounts such as deductibles and co-payment are the exception.
<b>Basic Medical</b>	Covers some or all non-surgical services provided by a physician, whether in the office, the patient's home, or a hospital. Each time a service is rendered, there is usually a copayment or coinsurance charge and a deductible amount that must be paid by the patient.
<b>Beneficiary</b>	The person named in an insurance policy to receive the benefits.
<b>Benefit Maximum</b>	Policy limits. Benefit maximums are usually a set dollar amount or a set number of visits per benefit period.
<b>Benefit Period</b>	The patient's benefit period or benefit year is the length of time benefits are paid. Most plans run on a calendar year—January through December; however, some plans run on a plan year—any specified 12-month period.
<b>Birthday Rule</b>	A common claims practice health insurance companies use when children are listed as dependents on two parents' group health plans. The rule helps determine which health plan is primary and which is secondary so that total coverage does not exceed 100% of the charges. The rule states that the primary payer is determined by the parent whose birthday falls first within the calendar year. If both parents share the same birthday, the health insurance plan that has provided coverage longest is the primary payer.
<b>Calendar Year</b>	The term used to indicate an insurance plan in effect from 01/01 – 12/31.

<b>CHAMPVA:</b>	<u>C</u> ivilian <u>H</u> ealth and <u>M</u> edical <u>P</u> rogram of the <u>V</u> eterans <u>A</u> dministration. It covers the expenses for families of veterans with total, permanent, service-connected disabilities. It also covers surviving spouses and dependent children of veterans who died in the line of duty.
<b>Chronic Treatment</b>	The term used when a patient's condition is not expected to significantly improve or be resolved with further treatment (e.g., an acute condition), but continued therapy may result in some functional improvement. If the clinical status for the condition is stable, and additional improvement is not expected, further manipulative treatment becomes maintenance therapy and is not covered.
<b>Claim Appeal</b>	A written request asking a carrier for a review of reimbursement. It is usually filed because there was no preauthorization due to unusual circumstances; inadequate reimbursement for a complicated procedure; the physician disagrees that the patient's condition was pre-existing; or there were unusual circumstances that affected medical treatment.
<b>Clean Claim</b>	A medical claim filed with a health insurance company that is free of errors and processed in a timely manner. Some providers may send claims to organizations that specialize in producing clean claims (e.g., clearinghouses).
<b>Clearinghouse</b>	Facilities that review and correct medical claims before sending them to insurance companies for final processing. This meticulous editing process for claims is known in the medical billing industry as "scrubbing."
<b>CMS</b>	<u>C</u> enter for <u>M</u> edicare and <u>M</u> edicaid <u>S</u> ervices: part of the Federal Department of <u>H</u> ealth and <u>H</u> uman <u>S</u> ervices (HHS) that administers Medicare and Medicaid.
<b>CMS 1500</b>	CMS-1500 is the standard paper claim form used by health care professionals and suppliers to bill insurance carriers and Medicare.
<b>CMT</b>	<u>C</u> hiropractic <u>M</u> anipulative <u>T</u> reatment
<b>COB</b>	<u>C</u> oordination of <u>B</u> enefits- used to establish the order in which claims are paid (e.g., when primary and secondary carriers coordinate benefits).
<b>COBRA</b>	<u>C</u> onsolidated <u>O</u> mnibus <u>B</u> udget <u>R</u> econciliation <u>A</u> ct- a federal regulation that allows employees and certain dependents to continue group health insurance coverage for a set period of time when coverage is lost following a qualified event (e.g., job termination, reduced work hours, etc.).
<b>Coding</b>	The process of translating a physician's documentation about a patient's medical condition and health services into medical codes that are then plugged into a claim for processing with an insurance company. Medical billing specialists must be familiar with a wide variety of code sets in order to perform their job duties effectively.
<b>Coinsurance</b>	A percentage of total costs for which the patient is responsible. In managed care plans this is often called a copayment. The physician can bill for coinsurance that was not collected at the time of service.
<b>Contractual Adjustment</b>	A binding agreement between a provider, patient, and insurance company wherein the provider agrees to write off charges on behalf of the patient. Contractual adjustments may occur when there is a discrepancy between what a provider charges for healthcare services and what an insurance company is willing to pay for that service.
<b>Coordination of Benefits</b>	Prevents duplicate payment for the same service (e.g., if a child is covered by both parents' insurance, a primary carrier is designated to pay benefits according to the terms of the policy. The secondary plan covers any remaining charges.)
<b>Copayment (Co-Pay)</b>	A fixed amount paid by the patient on each visit. Insurance pays the remaining, allowable amount for services. <b>Note:</b> A carrier's policy may require the patient to pay one co-pay for chiropractic manipulation and another for therapy. Verify and note all details to take them into consideration when you calculate the patient's financial responsibility.

<b>CPT Codes:</b>	<u>C</u> urrent <u>P</u> rocedural <u>T</u> erminology- codes that are designated to describe services rendered in the office. When placed on a CMS-1500 form, they explain the service to the insurance company representative, so payment can be made. These codes are typically 5-digits long (see the American Medical Association's (AMA) annual coding update books for the most common codes and additional information.)
<b>Credentialing</b>	The application process for a provider to coordinate with an insurance company. Once providers are credentialed with an insurance company they can work with that company to provide affordable healthcare to patients.
<b>Credit Balance</b>	The sum shown in the "balance" column of a billing statement that reflects the amount due for services rendered.
<b>Crossover Claim</b>	When claim information is sent from a primary insurance carrier to a secondary insurance carrier, or vice versa.
<b>DC</b>	<u>D</u> octor of <u>C</u> hiropractic
<b>Date of Service (DOS)</b>	The date when a provider performed healthcare services and procedures.
<b>Day Sheet</b>	A document that summarizes the services, treatments, payments, and charges a patient received on a given day.
<b>Deductible</b>	A fixed amount of money that must be paid annually, by the patient, before insurance begins paying benefits.
<b>Deemed Provider</b>	The designation given to a physician who is out of network but bills certain Medicare Private Fee for Service (PFFS) plans on behalf of the patient. The act of billing "deems" the provider as "in-network" <i>for that patient</i> . This forces the provider to accept the fee schedule of the plan, and s/he may not balance bill the patient beyond the stated patient responsibility.
<b>DEERS</b>	<u>D</u> efense <u>E</u> nrollment <u>E</u> ligibility <u>R</u> eporting <u>S</u> ystem—maintained by the Department of Defense—it is a worldwide database of people covered by TRICARE.
<b>DME</b>	<u>D</u> urable Medical Equipment
<b>DMEPOS</b>	<u>D</u> urable <u>M</u> edical <u>E</u> quipment, <u>p</u> rosthesis, <u>o</u> rthotics, and <u>s</u> upplies
<b>DOA</b>	<u>D</u> ate of <u>A</u> ccident/ <u>I</u> njury
<b>DOB</b>	<u>D</u> ate of <u>B</u> irth
<b>DOI</b>	<u>D</u> ate of <u>I</u> llness/ <u>I</u> njury
<b>Down coding</b>	Occurs when an insurance company finds there is insufficient evidence on a claim to prove the provider performed coded medical services and as a result, the codes are reduced or removed. Down coding usually reduces the cost of a claim.
<b>Dual Coverage</b>	When a patient's health care is covered by more than one insurance plan. "Coordination of benefits" is the process insurance companies follow to ensure the combined benefits from all insurance plans do not exceed 100% of the fee.
<b>Duplicate Coverage Inquiry (DCI)</b>	A formal request typically submitted by an insurance carrier to determine if a patient has other health coverage.
<b>DX</b>	The abbreviation for diagnosis codes, also known as ICD-10 codes.
<b>EFT</b>	<u>E</u> lectronic <u>F</u> unds <u>T</u> ransfer
<b>E/M</b>	<u>E</u> valuation and <u>M</u> anagement Services
<b>EHR</b>	<u>E</u> lectronic <u>H</u> ealth <u>R</u> ecords- an individual's aggregate, electronic record of health-related information created and gathered cumulatively across more than one healthcare organization. It is managed and consulted by licensed clinicians and staff members involved with the individual's health and care.
<b>Electronic Billing</b>	Submission of charges to an insurance company via electronic means—either directly to the carrier or through a clearing house.
<b>EMR</b>	<u>E</u> lectronic <u>M</u> edical <u>R</u> ecords - an individual's electronic record of health-related information. It is created, gathered, managed, and consulted by licensed clinicians and staff members, from a single organization, involved in the individual's health and care.
<b>Enrollee</b>	A person covered by a health insurance plan.

<b>EOB</b>	<u>Explanation of Benefits</u> . This is the portion of a payment that explains how the bill was processed and how the payments were assigned to each service. It is usually attached to the check and/or sent, as a separate document, with the check. The data contained on the EOB helps the staff apply the payment to the correct dates of service.
<b>EOMB</b>	<u>Explanation of Medicare Benefits</u> . This is the same as an EOB, but it comes from Medicare regarding a Medicare beneficiary.
<b>EP</b>	<u>Established Patient</u> - a patient that has received professional services in the last three years from the treating physician or another physician in the same group and specialty.
<b>EPO</b>	An <u>Exclusive Provider Organization</u> that provides health insurance coverage using a group of providers, hospitals, and healthcare personnel but does not cover out-of-network services.
<b>Electronic Remittance Advice (ERA)</b>	<u>Electronic Remittance Advice</u> : An electronic report in a standard, computer-readable format sent by insurance companies to providers as an explanation of payment similar to the paper EOBs mailed to providers.
<b>ERISA</b>	<u>Employee Retirement Income Security Act</u> - laws that protect plan funds and ensure that qualified participants receive their benefits.
<b>Exclusions</b>	Expenses that may not be covered under the insured's contract. The insured is required to pay for services not covered by the health plan.
<b>Fee Schedule</b>	A price list for medical practices that lists services offered and the corresponding charges for those services.
<b>Fee for Service</b>	A type of health insurance that pays the provider for every service s/he performs. People with fee-for-service plans choose whatever hospitals and physicians they want to use for care in exchange for higher deductibles and co-pays.
<b>Financial Report of Findings (FROF)</b>	Part of the New Patient Procedure that takes place after the clinical report of findings. Finances are discussed and financial agreements are made once the patient accepts care.
<b>Fraud</b>	<u>Knowingly and willfully executing</u> or attempting to execute a scheme or act to defraud any healthcare benefit program. To obtain by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.
<b>Front Desk Collections</b>	Total collections taken from patients at the front desk (e.g., cash, checks & credit cards).
<b>Government Insurance Policies</b>	Government-sponsored insurance coverage for eligible individuals. Federal coverage includes Medicare, Medicaid, TRICARE, or CHAMPUS/ CHAMPVA.
<b>Group Insurance Policy</b>	Covers groups of people under a master contract that is generally issued to employers for the benefit of their employees. These plans usually provide greater benefits at lower premiums than individual plans. Everyone in a group contract has identical coverage. Physicals aren't required for coverage.
<b>Group Number</b>	A number given to a patient by their insurance carrier that identifies the group or plan under which they are covered.
<b>Guarantor</b>	A person (other than the patient) who is paying for an insurance plan (e.g., parents are the guarantors for their children's health insurance.)
<b>Hardship Agreement</b>	A financial agreement established when a patient is unable to pay the actual fees charged or their percentage (if insured). The practice must establish a hardship policy and ensure, through verification, that the patient qualifies.
<b>HCFA</b>	Health Care Financing Administration, pronounced HICK-fah. HCFA establishes standards for medical providers that require compliance to meet certification requirements. The preferred term is now Centers for Medicare & Medicaid Services—CMS. As a result, the term CMS 1500 form is used rather than HCFA 1500 form.
<b>HCPCS</b>	The standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes (e.g., ambulance services, durable medical equipment, prosthetics, orthotics, supplies, etc.).
<b>HDHP</b>	A <u>High Deductible Health Plan</u> is a health insurance plan with lower premiums and higher deductibles than a traditional health plan.

<b>HIPAA</b>	<u>H</u> <u>e</u> <u>a</u> <u>l</u> <u>t</u> <u>h</u> <u>i</u> <u>n</u> <u>s</u> <u>u</u> <u>r</u> <u>e</u> <u> </u> <u>P</u> <u>o</u> <u>r</u> <u>t</u> <u>a</u> <u>b</u> <u>i</u> <u>l</u> <u>i</u> <u>t</u> <u>y</u> <u> </u> <u>a</u> <u>n</u> <u>d</u> <u> </u> <u>A</u> <u>c</u> <u>c</u> <u>o</u> <u>u</u> <u>n</u> <u>t</u> <u>a</u> <u>b</u> <u>i</u> <u>l</u> <u>i</u> <u>t</u> <u>y</u> <u> </u> <u>A</u> <u>c</u> <u>t</u> - this Act is the most comprehensive protection for patient's privacy rights in history. HIPAA controls how health care professionals use a patient's PHI. HIPAA includes Coding and Transactions Rules, Privacy Rules, and Security Rules.
<b>HIPAA Eligibility Transaction System (HETS)</b>	The HIPAA (Health Insurance Portability and Accountability Act) Eligibility Transaction System (HETS) allows you to check Medicare beneficiary eligibility data in real-time. Use HETS to prepare accurate Medicare claims, determine beneficiary liability, or check eligibility for specific services.
<b>HITECH</b>	<u>H</u> <u>e</u> <u>a</u> <u>l</u> <u>t</u> <u>h</u> <u> </u> <u>I</u> <u>n</u> <u>f</u> <u>o</u> <u>r</u> <u>m</u> <u>a</u> <u>t</u> <u>i</u> <u>o</u> <u>n</u> <u> </u> <u>a</u> <u>n</u> <u>d</u> <u> </u> <u>T</u> <u>e</u> <u>c</u> <u>h</u> <u>n</u> <u>o</u> <u>l</u> <u>o</u> <u>g</u> <u>y</u> <u> </u> <u>f</u> <u>o</u> <u>r</u> <u> </u> <u>E</u> <u>c</u> <u>o</u> <u>n</u> <u>o</u> <u>m</u> <u>i</u> <u>c</u> <u> </u> <u>a</u> <u>n</u> <u>d</u> <u> </u> <u>C</u> <u>l</u> <u>i</u> <u>n</u> <u>i</u> <u>c</u> <u>a</u> <u>l</u> <u> </u> <u>H</u> <u>e</u> <u>a</u> <u>l</u> <u>t</u> <u>h</u> . HITECH legislation was created to stimulate the adoption of electronic health records.
<b>HMO</b>	A <u>H</u> <u>e</u> <u>a</u> <u>l</u> <u>t</u> <u>h</u> <u> </u> <u>M</u> <u>a</u> <u>i</u> <u>n</u> <u>t</u> <u>e</u> <u>n</u> <u>a</u> <u>n</u> <u>c</u> <u>e</u> <u> </u> <u>O</u> <u>r</u> <u>g</u> <u>a</u> <u>n</u> <u>i</u> <u>z</u> <u>a</u> <u>t</u> <u>i</u> <u>o</u> <u>n</u> <u> </u> <u>p</u> <u>r</u> <u>o</u> <u>v</u> <u>i</u> <u>d</u> <u>e</u> <u>s</u> <u> </u> <u>h</u> <u>e</u> <u>a</u> <u>l</u> <u>t</u> <u>h</u> <u> </u> <u>i</u> <u>n</u> <u>s</u> <u>u</u> <u>r</u> <u>a</u> <u>n</u> <u>c</u> <u>e</u> <u> </u> <u>c</u> <u>o</u> <u>v</u> <u>e</u> <u>r</u> <u>a</u> <u>n</u> <u>c</u> <u>e</u> <u> </u> <u>t</u> <u>o</u> <u> </u> <u>i</u> <u>t</u> <u>s</u> <u> </u> <u>m</u> <u>e</u> <u>m</u> <u>b</u> <u>e</u> <u>r</u> <u>s</u> <u> </u> <u>t</u> <u>h</u> <u>r</u> <u>o</u> <u>u</u> <u>g</u> <u>h</u> <u> </u> <u>a</u> <u> </u> <u>n</u> <u>e</u> <u>t</u> <u>w</u> <u>o</u> <u>r</u> <u>k</u> <u> </u> <u>o</u> <u>f</u> <u> </u> <u>p</u> <u>a</u> <u>r</u> <u>t</u> <u>i</u> <u>c</u> <u>i</u> <u>p</u> <u>a</u> <u>t</u> <u>i</u> <u>c</u> <u>i</u> <u>p</u> <u>a</u> <u>t</u> <u>i</u> <u>n</u> <u>g</u> <u> </u> <u>p</u> <u>r</u> <u>o</u> <u>v</u> <u>i</u> <u>d</u> <u>e</u> <u>r</u> <u>s</u> , <u>h</u> <u>o</u> <u>s</u> <u>p</u> <u>i</u> <u>t</u> <u>a</u> <u>l</u> <u>s</u> , <u>a</u> <u>n</u> <u>d</u> <u> </u> <u>o</u> <u>t</u> <u>h</u> <u>e</u> <u>r</u> <u> </u> <u>h</u> <u>e</u> <u>a</u> <u>l</u> <u>t</u> <u>h</u> <u>c</u> <u>a</u> <u>r</u> <u>e</u> <u> </u> <u>p</u> <u>r</u> <u>o</u> <u>v</u> <u>i</u> <u>d</u> <u>e</u> <u>r</u> <u>s</u> .
<b>HRA</b>	The <u>H</u> <u>e</u> <u>a</u> <u>l</u> <u>t</u> <u>h</u> <u> </u> <u>R</u> <u>e</u> <u>i</u> <u>m</u> <u>b</u> <u>u</u> <u>r</u> <u>s</u> <u>e</u> <u>m</u> <u>e</u> <u>n</u> <u>t</u> <u> </u> <u>A</u> <u>c</u> <u>c</u> <u>o</u> <u>u</u> <u>n</u> <u>t</u> <u> </u> <u>i</u> <u>s</u> <u> </u> <u>a</u> <u>n</u> <u> </u> <u>e</u> <u>m</u> <u>p</u> <u>l</u> <u>o</u> <u>y</u> <u>e</u> <u>r</u> <u>-</u> <u>f</u> <u>u</u> <u>n</u> <u>d</u> <u>e</u> <u>d</u> <u> </u> <u>p</u> <u>l</u> <u>a</u> <u>n</u> <u> </u> <u>t</u> <u>h</u> <u>a</u> <u>t</u> <u> </u> <u>r</u> <u>e</u> <u>i</u> <u>m</u> <u>b</u> <u>u</u> <u>r</u> <u>s</u> <u>e</u> <u>s</u> <u> </u> <u>e</u> <u>m</u> <u>p</u> <u>l</u> <u>o</u> <u>y</u> <u>e</u> <u>e</u> <u>s</u> <u> </u> <u>f</u> <u>o</u> <u>r</u> <u> </u> <u>h</u> <u>e</u> <u>a</u> <u>l</u> <u>t</u> <u>h</u> <u> </u> <u>c</u> <u>a</u> <u>r</u> <u>e</u> <u> </u> <u>e</u> <u>x</u> <u>p</u> <u>e</u> <u>n</u> <u>s</u> <u>e</u> <u>s</u> <u> </u> <u>n</u> <u>o</u> <u>t</u> <u> </u> <u>c</u> <u>o</u> <u>v</u> <u>e</u> <u>r</u> <u>e</u> <u>d</u> <u> </u> <u>b</u> <u>y</u> <u> </u> <u>t</u> <u>h</u> <u>e</u> <u> </u> <u>e</u> <u>m</u> <u>p</u> <u>l</u> <u>o</u> <u>y</u> <u>e</u> <u>r</u> <u>'</u> <u>s</u> <u> </u> <u>h</u> <u>e</u> <u>a</u> <u>l</u> <u>t</u> <u>h</u> <u> </u> <u>i</u> <u>n</u> <u>s</u> <u>u</u> <u>r</u> <u>a</u> <u>n</u> <u>c</u> <u>e</u> <u> </u> <u>p</u> <u>l</u> <u>a</u> <u>n</u> .
<b>HSA</b>	<u>H</u> <u>e</u> <u>a</u> <u>l</u> <u>t</u> <u>h</u> <u> </u> <u>S</u> <u>a</u> <u>v</u> <u>i</u> <u>n</u> <u>g</u> <u>s</u> <u> </u> <u>A</u> <u>c</u> <u>c</u> <u>o</u> <u>u</u> <u>n</u> <u>t</u> <u> </u> – an account into which yearly limited maximum contributions are made by the member or his/her employer. The HSA offers tax savings implications and is used for medical expenses not covered by the member's health plan or for which the member has a high deductible
<b>ICD Codes</b>	<u>I</u> <u>n</u> <u>t</u> <u>e</u> <u>r</u> <u>n</u> <u>a</u> <u>t</u> <u>i</u> <u>o</u> <u>n</u> <u>a</u> <u>l</u> <u> </u> <u>C</u> <u>l</u> <u>a</u> <u>s</u> <u>s</u> <u>i</u> <u>f</u> <u>i</u> <u>c</u> <u>a</u> <u>t</u> <u>i</u> <u>o</u> <u>n</u> <u> </u> <u>D</u> <u>i</u> <u>s</u> <u>e</u> <u>a</u> <u>s</u> <u>e</u> <u>s</u> <u>-</u> <u>C</u> <u>o</u> <u>d</u> <u>e</u> <u>s</u> <u> </u> <u>t</u> <u>h</u> <u>a</u> <u>t</u> <u> </u> <u>d</u> <u>e</u> <u>s</u> <u>c</u> <u>r</u> <u>i</u> <u>b</u> <u>e</u> <u> </u> <u>a</u> <u> </u> <u>p</u> <u>a</u> <u>t</u> <u>i</u> <u>e</u> <u>n</u> <u>t</u> <u>'</u> <u>s</u> <u> </u> <u>d</u> <u>i</u> <u>a</u> <u>g</u> <u>n</u> <u>o</u> <u>s</u> <u>i</u> <u>s</u> . These codes are based on the diagnosis and are typically three digits and may have additional digits after the decimal. These codes are used to describe the condition being treated, and since insurance companies determine coverage based on the condition being treated, it's imperative to make this diagnosis as specific as possible to justify the treatment rendered. We currently use the 10 <sup>th</sup> Edition, referred to as ICD-10.
<b>Indemnity Insurance</b>	The insurer pays the subscriber a set amount for each service or procedure performed due to illness or injury. These fees are usually paid directly to the insured unless previous arrangements were made for them to go to the provider. A fee schedule is provided to the purchaser at the start of the contract; benefits are determined on a fee-for-service basis.
<b>Individual Insurance Policies</b>	Individuals who do not qualify for group policies may apply for individual policies. Premiums are often higher, and the benefits aren't as good as those for group policies. Individual policies usually require applicants to pass physical examinations for coverage.
<b>In-Network/Out-of-Network</b>	Indicates whether a provider has contracted with a particular health care plan or not.
<b>Insurance Benefits</b>	The list of services and amounts paid by the insurance carrier. The schedule of benefits may indicate the carrier only pays 80% of all medical fees for Chiropractic services, leaving the subscriber responsible for the coinsurance (the remaining 20% of the medical fees). These plans are often referred to as 80:20 plans.
<b>ITIN</b>	<u>I</u> <u>n</u> <u>d</u> <u>i</u> <u>v</u> <u>i</u> <u>d</u> <u>u</u> <u>a</u> <u>l</u> <u> </u> <u>T</u> <u>a</u> <u>x</u> <u>p</u> <u>a</u> <u>y</u> <u>e</u> <u>r</u> <u> </u> <u>I</u> <u>d</u> <u>e</u> <u>n</u> <u>t</u> <u>i</u> <u>f</u> <u>i</u> <u>c</u> <u>a</u> <u>t</u> <u>i</u> <u>o</u> <u>n</u> <u> </u> <u>N</u> <u>u</u> <u>m</u> <u>b</u> <u>e</u> <u>r</u> <u> </u> (Also known as TID- <u>T</u> <u>a</u> <u>x</u> <u>I</u> <u>d</u> <u>e</u> <u>n</u> <u>t</u> <u>i</u> <u>f</u> <u>i</u> <u>c</u> <u>a</u> <u>t</u> <u>i</u> <u>o</u> <u>n</u> )
<b>Independent Practice Association (IPA)</b>	The IPA is a professional organization of physicians who have a contract with an HMO.
<b>LCD</b>	<u>L</u> <u>o</u> <u>c</u> <u>a</u> <u>l</u> <u> </u> <u>C</u> <u>o</u> <u>v</u> <u>e</u> <u>r</u> <u>a</u> <u>g</u> <u>e</u> <u> </u> <u>D</u> <u>e</u> <u>t</u> <u>e</u> <u>r</u> <u>m</u> <u>i</u> <u>n</u> <u>a</u> <u>t</u> <u>i</u> <u>o</u> <u>n</u> <u>s</u> <u>-</u> a determination issued by a Medicare fiscal intermediary or a carrier under part A or part B, indicating whether or not a particular item or service is covered on an intermediary- or carrier-wide basis.
<b>Lifetime Maximum Benefit</b>	The total amount a health plan pays out over a patient's lifetime.
<b>Line Item Posting</b>	Posting a payment against the patient encounter and/or date of service for each line item, rather than posting a payment for all services across a single visit or multiple visits without itemizing
<b>LMBT</b>	<u>L</u> <u>i</u> <u>c</u> <u>e</u> <u>n</u> <u>s</u> <u>e</u> <u>d</u> <u> </u> <u>M</u> <u>a</u> <u>s</u> <u>s</u> <u>a</u> <u>g</u> <u>e</u> <u> </u> <u>B</u> <u>o</u> <u>d</u> <u>y</u> <u> </u> <u>T</u> <u>h</u> <u>e</u> <u>r</u> <u>a</u> <u>p</u> <u>i</u> <u>s</u> <u>t</u>

<b>Maintenance Treatment</b>	According to CMS, chiropractic maintenance therapy is not considered medically reasonable or necessary under the Medicare program, and so is not payable. Maintenance therapy is defined as a treatment plan that is designed to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is considered maintenance therapy.
<b>Major Medical</b>	Policy to help with medical expenses resulting from catastrophic /prolonged illnesses/injuries.
<b>Managed Care Organizations</b>	Organizations that manage, negotiate, and contract for health care in order to keep costs down. They contract with health-care providers that agree to charge fixed fees for services. The fees are set by the managed care organization or by the government agency responsible for managed care.
<b>Maximum Out of Pocket</b>	The amount a patient is required to pay. After a patient reaches their maximum out of pocket level, healthcare costs should be covered by his/her plan.
<b>MD</b>	<u>M</u> edical <u>D</u> octor
<b>Medi/Medi</b>	Older or disabled patients with Medicare that cannot pay the difference between a bill and the Medicare payment may qualify for Medicare and Medicaid aka Medi/Medi. In such cases, Medicare is the primary payer and Medicaid is the secondary payer.
<b>Medicaid</b>	<p>A health benefit program designed for low-income people (people on welfare or other kinds of public assistance) who cannot pay medical bills. People with Medicaid coverage are medically indigent. Eligibility for coverage might vary from month-to-month based on the recipient's income. Medicaid is a health-cost assistance program, not an insurance program. Physicians may choose not to accept Medicaid patients. Within broad national guidelines established by Federal statutes, regulations, and policies, each State:</p> <ul style="list-style-type: none"> <li>• Establishes its own eligibility standards</li> <li>• Determines the type, amount, duration, and scope of services</li> <li>• Sets the rate of payment for services</li> <li>• Administers its own program</li> </ul>
<b>Medicaid Plan</b>	A health benefit program designed for low-income people (people on welfare or other kinds of public assistance) who cannot pay medical bills. People with Medicaid coverage are medically indigent. Eligibility for coverage might vary from month-to-month based on the recipient's income. Medicaid is a health-cost assistance program, not an insurance program. Physicians may choose not to accept Medicaid patients.
<b>Medical Coverage Guidelines</b>	An insurance carrier's guidelines used to determine coverage decisions.
<b>Medical Record Number</b>	A unique number assigned to a person's medical record to differentiate it from other medical records.
<b>Medical Review Policy (MRP)</b>	This document is often available to clinics through a provider portal. Look for terms such as <i>Clinical Coverage Bulletin</i> , <i>Provider Tools</i> , <i>Reimbursement Policy</i> , and <i>Medical Review Policy and Treatment Guidelines</i> . These documents contain information about covered and non-covered services, medical necessity guidelines, visit limitations, non-covered procedure codes, documentation requirement, etc.
<b>Medicare Advantage Plan</b>	A Medicare health plan, also known as Medicare Part C, offered by private companies approved by Medicare. The Medicare Advantage Plan provides Part A and Part B coverage, and may offer additional coverage such as vision, hearing, dental, and prescription drug coverage. Also known as a Medicare Replacement Plan, it resembles managed care coverage in the traditional insurance world.
<b>Medigap</b>	Supplemental health insurance under Medicaid for eligible persons who need help covering co-pays, deductibles, and other large fees.

<b>Med-Pay</b>	<u>Medical Payments Benefits</u> - an option you can add to your automobile insurance policy; it is intended to cover reasonable medical expenses for insured drivers and/or their passengers incurred because of an auto accident.
<b>Member Services</b>	A department designed to help patients with inquiries and/or concerns that may arise.
<b>MMI/MCI</b>	<u>Maximum Medical Improvement/Maximum Chiropractic Improvement</u> - a determination that a patient has reached maximum improvement for this condition or pre-injury status or has reached the end of an episode of care. Any care beyond this point is not “medically necessary.” It becomes maintenance care and is not billable to a third-party carrier.
<b>Modalities</b>	Physiotherapies such as traction, ultrasound, electrical muscle stimulation, and hot or cold packs.
<b>Modifier</b>	A modifier is a two-digit or letter suffix added to a CPT code to “modify”, clarify, and better define the procedure identified by the CPT code. Its purpose is to augment and further clarify.
<b>MSP</b>	<u>Medicare is the Secondary Payer</u> when the beneficiary has coverage through a group health plan, worker's compensation, or there is some other third-party liability. Certain rules and procedures apply when Medicare is secondary, rather than primary
<b>MVA</b>	<u>Motor Vehicle Accident</u>
<b>National Standard Format (NSF):</b>	The most widely accepted format for electronically transmitting CMS forms.
<b>NCD</b>	<u>National Coverage Determinations</u> - Medicare releases NCDs when changes are made to medical services/treatments evaluated by the Centers for Medicare and Medicaid Services (CMS) that are now covered or not covered by Medicare. Determination of coverage is often related to specific Medicare criteria and guidelines.
<b>NMR</b>	<u>Neuromuscular Re-education</u> - a therapeutic activity service provided to patients as part of an active care treatment protocol where improved proprioception is the primary desired outcome.
<b>No-Fault System</b>	A type of insurance contract under which insureds are covered for losses by their own insurance companies, regardless of fault in the incident generating losses. In this sense, it is no different from first-party coverage. Typically, in the no-fault system, the patient’s own car insurance pays his/her medical expenses after an accident.
<b><u>Non-Covered Charge (N/C)</u></b>	Procedures and services not covered by a person’s health insurance plan.
<b><u>Not Elsewhere Classifiable (NEC)</u></b>	A procedure or service that can’t be described within the available code set.
<b>Notice of Doctor’s Lien</b>	Doctors ask their patients and their attorneys to sign this document wherein the doctor agrees to treat a patient immediately and wait to be paid until the case is settled or won. The attorney agrees to pay the doctor’s bill at settlement.
<b>NP</b>	<u>New Patient</u> - a qualified NP is someone who has never been to the practice before, or who has not been treated there in the last three years.
<b>NPI</b>	<u>National Provider Identification Number</u> .
<b>OIG</b>	<u>Office of the Inspector General</u> from the Department of Health and Human Services. This department is assigned to ensure that rules are followed with regard to compliance and relative to fraud and abuse in Federal health care programs (e.g., Medicare, Medicaid, Tri-Care, (formerly Champus), and sometimes the Federal Employee Health Benefits Program (FEHBP).)
<b>OON</b>	<u>Out of Network</u>
<b>Ordering Provider</b>	The individual who requested services or items. This is reported as a specific line item on a 1500 Claim form (e.g., provider ordering diagnostic tests, medical equipment, or supplies).

<b>Out of Pocket Max</b>	Also known as stop loss. Out of pocket maximum refers to a set dollar amount that the patient will pay out of pocket. Once satisfied, the insurance company pays 100% of eligible expenses for the rest of the benefit period.
<b>Overpayment</b>	Payment by the insurer or the patient that was more than the amount due.
<b>Pain and Suffering</b>	A legal term for the physical and emotional stress caused from an injury. It is also the monetary amount designated for the physical pain and emotional distress the patient endures as a result of a personal injury accident.
<b>Paper Claim</b>	Aka: the universal claim or the CMS-1500 claim form (or the CMS-1500). Practices that use paper claims must have two versions of their medical billing software: one to capture the necessary data for HIPAA-compliant electronic Medicare claims and an older version to generate CMS-1500 claims.
<b>Payment</b>	Cash, check, credit card payment, insurance payment, or money order received for professional services rendered.
<b>Payor ID</b>	Insurance carrier reference number for electronic billing.
<b>PCP</b>	<u>P</u> ri <u>m</u> ary <u>C</u> are <u>P</u> hysician.
<b>Peer Review Organizations</b>	Groups of practicing physicians paid by insurance companies to review medical records for effectiveness and efficiency. The reviews are to monitor the validity of diagnoses, the quality of care, and to evaluate the appropriateness of hospital admissions and discharges.
<b>Personal Injury Protection (PIP)</b>	An extension of car insurance that covers medical expenses and, in many cases, lost wages. Often called “no-fault” coverage because claims are paid regardless of who was at fault.
<b>PFFS</b>	A <u>P</u> ri <u>v</u> ate <u>F</u> ee- <u>F</u> or- <u>S</u> ervice plan is a Medicare Advantage (MA) health plan that provides beneficiaries with Medicare benefits plus any additional benefits the company decides to provide. Beneficiaries can see any provider eligible to receive payment from Medicare and agrees to accept payment from the PFFS MA. (See Deemed Provider)
<b>PIP</b>	<u>P</u> ersonal <u>I</u> njury <u>P</u> rotection-if you live in certain states, you may be required to carry PIP insurance. It pays for covered medical expenses for any injuries you suffer in an automobile accident. This coverage pays the injured party’s medical expenses up to the stated limit.
<b>Plan Year</b>	The 12-month period in which an insurance plan is effective. A policy with a <i>plan year</i> (instead of a <i>calendar year</i> ) does not start January 1 and end December 31. Instead, effective dates are verified during the benefit verification process.
<b>Portal</b>	A website that requires a user name and password in order to access confidential provider and/or patient information.
<b>POS</b>	A <u>P</u> oint <u>o</u> f <u>S</u> ervice carrier that provides health insurance coverage and allows members to go outside of provider and hospital networks, but results in higher out-of-pocket costs.
<b>PPACA</b>	<u>P</u> atient <u>P</u> rotection and <u>A</u> ffordable <u>C</u> are <u>A</u> ct- a health care reform bill, signed into law in March 2010, to give citizens easier access to healthcare. Changes are ongoing and are being implemented over time. (AKA: Obamacare or ACA).
<b>PPI (Michigan)</b>	<u>P</u> roperty <u>P</u> rotection Insurance- provides protection if you cause damage to properly parked vehicles or fixed properties such as buildings or lampposts in the state of Michigan. Outside Michigan, your Property Damage Liability Insurance covers your legal liability for property damage.
<b>PPO</b>	A <u>P</u> referred <u>P</u> rovider <u>O</u> rganization provides health insurance coverage using a group of providers, hospitals, and other healthcare providers that contract with the carrier to provide services at a discounted/contracted rate. The PPO also provides health insurance coverage for services rendered by out-of-network providers, but at a higher out-of-pocket cost to the member.
<b>Practice Management Software</b>	Office software used for scheduling, billing, and recordkeeping.
<b>Preauthorization</b>	Permissions granted by the insurance carrier that must be obtained before starting certain treatments for patients.

<b>Precertification</b>	A call to the patient's insurance carrier to find out whether the treatment, surgery, tests, or hospitalization is covered under the patient's health insurance policy.
<b>Pre-Existing</b>	A condition the patient had prior to enrolling for insurance, which may or may not preclude coverage.
<b>Premium</b>	The amount charged for a medical insurance policy. The insurer agrees to provide certain benefits in return for the premium - aka coverage cost.
<b>Primary Carrier</b>	When there's more than one insurance carrier, <i>coordination of benefits</i> rules decide which one pays first. The primary payer pays first and the secondary payer covers the balance.
<b>Proactive Calls</b>	Calls made to insurance companies when an aging report indicates that a bill or date-of-service is at least 30 days old. The call is proactive because the staff member used an aging report to determine the bill was overdue and called to find out the current status of the payment.
<b>Protected Health Information (PHI)</b>	A subset of health information (including demographic information) that: <ol style="list-style-type: none"> <li>1. Is created or received by a health-care provider, health plan, employer, or health-care clearinghouse</li> <li>2. Relates to the past, present, or future physical or mental health or condition; or to the provision of health care for an individual</li> <li>3. Identifies the individual</li> <li>4. Leaves reason to believe the information can be used to identify an individual</li> </ol>
<b>Provider Nonparticipating (Non-PAR)</b>	A physician or other health-care provider that has not joined a particular insurance plan. Patients obtaining services from non-PAR providers often pay more of the costs than those receiving services from PAR Providers (aka In-Network).
<b>Provider Participating (Par)</b>	A physician or other health-care provider that participates in an insurance carrier's plan. Participating providers must write off (not charge a patient for) disallowed and/or ineligible charges (aka <i>In-Network</i> ).
<b>Provider Relations</b>	Department designed to help physician's office personnel with inquiries about capitation, contracts, credentialing, physician appeals, formularies, etc.
<b>PT</b>	Physical Therapist
<b>PTA</b>	Physical Therapy Assistant
<b>PTAN</b>	<u>Provider Transaction Access Number</u> - a number assigned to a Medicare provider required for ID when billing inquiries are made to the carrier.
<b>Reactivation</b>	When a previous patient returns for an active episode of care.
<b>Reactive calls</b>	A holding place for items that are a “reaction” to something else and that require discussion before they can be resolved. These are generated by a variety of scenarios (e.g., denial for payment, payments with incorrect information, claims that need to be reprocessed).
<b>Referrals</b>	In managed care, the primary care physician must refer a patient to a specialist before the patient can make an appointment with the specialist. A referral form must be completed listing the following: <ul style="list-style-type: none"> <li>• Referring physician</li> <li>• Specialist to whom the patient is being referred</li> <li>• Diagnosis</li> <li>• Treatment (past and present, including medications)</li> <li>• Chart notes</li> <li>• Minor surgical procedures</li> </ul>
<b>Referring Provider</b>	The individual who directed the patient to the provider rendering the reported services (e.g., primary care provider refers patient to a specialist; orthodontist refers to an oral surgeon; physician refers to a physical therapist; provider refers to a home health agency).
<b>Remittance Advice Remark Codes</b>	Codes on an explanation of benefits (EOB) or remittance advice explaining claim processing.

<b>Rendering Provider</b>	The person or company (laboratory or other facility) that rendered care (e.g., a substitute provider [locum tenens]). Individuals performing services in support roles, such as lab technicians or radiology technicians are not considered Rendering Providers.
<b>Report of Findings (ROF)</b>	A process the doctor uses to explain clinical findings and his/her recommendations for care. Typically performed on the patient's second visit. If the patient is accepted for care and agrees to treatment, it is usually followed by the Financial Report of Findings.(See FROF)
<b>Revalidation</b>	Provisions in the Affordable Care Act (ACA) require all providers to revalidate or renew Medicaid and/or Medicare provider agreements every five years. Most state Medicaid carriers terminate provider agreements for failure to revalidate on time or if the revalidation application is not completed.
<b>RVU</b>	<u>Relative Value Unit</u> - one component used to calculate the dollar value of a particular CPT code. When calculated against geographic indices, this unit value helps determine the appropriate fee for a code.
<b>SBC (Summary of Benefits &amp; Coverage)</b>	Companies must provide patients with a short, plain-language summary and a Uniform Glossary of terms. The SBC includes details (aka coverage examples) that often address coverage for diabetes care and childbirth.
<b>Scrubbing</b>	A process by which insurance claims are checked for errors before being sent to an insurance company for final processing. Providers scrub claims to reduce denied or rejected claims.
<b>Self-Pay</b>	Payment the patient makes to a provider for healthcare at the time the care is rendered.
<b>Self-Referral</b>	When a patient does his/her own research to find a provider and acts outside the primary care physician's referral.
<b>Signature on File (SOF)</b>	A patient's official signature kept on file for the purpose of billing and claims processing.
<b>Slip and Fall</b>	A term used for a personal injury case in which a person slips/trips and is injured on someone else's property (AKA: "premises liability" claims).
<b>Stark Laws</b>	Federal laws governing how referrals can be made, remuneration for referrals, and referrals to entities in which the referring physician (or his/her relatives) has a financial interest.
<b>Subrogation</b>	A clause that gives the insurance company the right to recover the amount paid on behalf of the insured from the adverse party that caused the loss.
<b>Subscriber</b>	The principal in an insurance contract.
<b>Summary Plan Documents (SPD)</b>	A detailed guide (can be more than 150 pages) to benefits the plan provides and explanations of how the plan works. It is the main vehicle used to communicate plan rights and obligations to participants and beneficiaries.
<b>Supervising Provider</b>	The individual who oversees the Rendering Provider and the care being reported (e.g., supervisor watching a resident).
<b>Supplemental Health Plan</b>	Policies that pay in addition to a patient's comprehensive major medical coverage.
<b>Third-Party Payer</b>	A health plan or other entity that agrees to carry the risk of paying for a patient's medical services.
<b>Tax Identification Number (TIN)</b>	A unique number for billing purposes that a patient or company may have to produce in order to receive healthcare from a provider. The TIN is also known as the employment identification number (EIN).
<b>Taxonomy Code</b>	Medical billing specialists use this unique code set to identify a healthcare provider's specialty field.
<b>Term Date</b>	The insurance policy contract end date, or the date after which a person no longer receives or is eligible for coverage from the company. Term dates are set on a case-by-case basis.
<b>Tertiary Insurance Claim</b>	A claim filed by a provider after filing claims for primary and secondary health insurance coverage on behalf of a patient. Tertiary insurance claims often cover the remaining healthcare costs such as deductibles and co-pays remaining after the primary and secondary claims are processed.

<b>Tickler System</b>	A file or electronic system that provides reminders daily/monthly about previously scheduled activities and tasks.
<b>Time-of-Service Discount (TOS)</b>	Also known as a prompt payment discount, this is a set discount allowed when the patient pays at the time of service. The OIG determined that 5-15% is an appropriate Time-of-Service discount for federally insured patients. Some states have specific laws that may allow larger time-of-service discounts for non-federally insured patients.
<b>TPA:</b>	<u>Third Party Administrator</u> - agencies that process claims and perform administrative services as part of a service contract with an insurance carrier.
<b>Treatment Authorization Request (TAR)</b>	A unique number the insurance company gives the provider for billing purposes. A provider must have the insurance company's TAR number before administering healthcare to a patient covered by the company.
<b>TRICARE Insurance</b>	TRICARE (aka CHAMPUS/ CHAMPVA) are the most common health-care policies for military personnel and their families. These agencies are run by the Defense Department. TRICARE is a Health care benefit specifically for families of uniformed personnel and retirees from the uniformed services (e.g., Army, Navy, Marines, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration).
<b>TX</b>	<u>Treatment</u>
<b>UCC Lien</b>	( <u>U</u> niform <u>C</u> ommercial <u>C</u> ode Lien) A legal form that creditors file to give notice that they have or may have an interest in the settlement of a personal injury claim. This lien differs from a Notice of Doctor's Lien in that providers file the lien directly depending on their state and county requirements. The lien provides the doctor an assignment of benefits in a 3 <sup>rd</sup> party claim.
<b>UCR</b>	<u>U</u> sual, <u>C</u> ustomary, and <u>R</u> easonable (aka - R&C for reasonable and customary). This is verbiage used by an insurance company to define the "standard" number of visits required for a patient's condition. UCR or R&C can also be used to determine fees for certain codes. Insurance companies use geographic averages or other published data to determine appropriate fees.
<b>UIM</b>	<u>U</u> nder <u>I</u> nured <u>M</u> otorist coverage- Uses a patient's own auto insurance policy when an accident occurs with an at-fault driver whose liability limits are too low to cover the damages or medical expenses.
<b>UM</b>	<u>U</u> ninsured <u>M</u> otorist <u>C</u> overage- Part of a policy that activates when the insured is involved in an accident with an at-fault driver with no liability insurance— technically, it becomes the third-party coverage. When patients file claims against their own UM coverage, they are "suing" their own insurance for damages, pain and suffering, and medical expenses.
<b>UM BI</b>	<u>U</u> ninsured <u>M</u> otorist <u>B</u> odily Injury coverage pays bodily injury or death expenses for you and/or any passengers in your vehicle up to the policy limit if struck by an uninsured driver or if you're struck by a "hit-and-run" driver that cannot be identified.
<b>Unbundling</b>	The fraudulent practice of ascribing more than one code to a service or procedure on a superbill or claim form when only one is necessary.
<b>Untimely Submission</b>	There is a specific timeframe in which claims can be submitted to an insurance company for processing. If a provider fails to file a claim in that timeframe, it is marked for untimely submission and will be denied by the company.
<b>Up coding</b>	The fraudulent practice of ascribing a higher ICD-9 code to a healthcare procedure in an attempt to get more money than necessary from the insurance company or patient.
<b>Utilization Review</b>	Examination of services by an outside group. A utilization review committee looks at individual cases to make sure that services were medically necessary.

<b>Virtual Credit Cards (VCC)</b>	A 16-digit credit card number generated for a single payment and for a predetermined amount—there is no physical card. These may appear on EOBs as payments instead of EFTs or paper checks.
<b>WC</b>	<u>Worker's Compensation</u> - Insurance covering employees' injuries or illnesses arising from the course of their employment.
<b>Workers' Compensation Claims Processing</b>	Follow these guidelines: Records of the workers' compensation case should be kept separate from the patient's regular history. The insurance carrier is entitled to receive copies of all records pertaining to the industrial injury. The injured person's records must be personally signed by the physician. The insurance carrier may supply its own billing forms. Payment is usually made on the basis of a fee schedule. At the termination of the treatment, a final report and bill are sent to the insurance carrier.
<b>Write offs</b>	Total dollar amount written off due to contractual obligations, non-covered services, bad debts, or financial agreements.

## General Phone Scripts Guidelines

The suggested phone script guidelines give you a general idea of what to say for certain situations. These suggestions are designed to help give you confidence when you encounter callers into your clinic. It is important to use language that sounds and feels natural and is comfortable for you. Phone scripts are not meant to be memorized and delivered verbatim—make it fit to how you would naturally say it to your family or friends.

Scenario	Phone Dialogue Suggestions
Opening/Greeting	<p>(Before lifting the phone, be sure to SMILE)</p> <p><b><i>“Good &lt;Morning/Afternoon/Evening&gt;, Family Chiropractic, this is Liz”</i></b></p> <p>Try avoiding long introductions—the caller may become impatient</p> <p>Smile—this will cause you a pleasant inflection in your voice and can convey friendliness and a willingness to help without extra verbiage</p>
Placing a Call on Hold	<p>If you must place a call on hold, wait for a pause in the conversation and then ask if you can place the caller on hold. Allow them to respond—it is important for the caller to feel valued and not rushed.</p> <p><b><i>“May I please place you on hold for a moment?”</i></b></p>
Taking a Message for a Team Member	<p>Do not share that the person is too busy, getting coffee, using the bathroom or etc.</p> <p><b><i>“I’m sorry but Sarah is assisting another patient at the moment. May I take a message and her return your call by end of day today?”</i></b></p>
Calls from Vendors or Other Solicitors	<p>During a typically day, you will encounter a phone call from a vendor or SPAM caller offering a variety of products or services. Be mindful that some of these callers will give the impression that they have a personal relationship with the provider and will sometimes call them by their first name to give that impression. Your provider’s time during Patient Time should be focused on the patients within the office.</p> <p>Suggestions:</p> <p><b><i>“I’m sorry, the doctor is with a patient at this time. Is there something that I can assist with?”</i></b></p> <p>If the caller requests to leave a message, be sure to capture the caller’s name (check spelling if necessary), a number where he/she can be reached at and the date and time the message was received. It is important to include why the caller wants to speak with the provider in the message.</p> <p><b><i>“May I tell the doctor what this is regarding?”</i></b></p> <p><b>Note:</b> the provider may choose not to return a call if he/she is not interested in the caller’s products or services. To avoid committing the provider to a call back, the call can be closed with:</p> <p><b><i>“I will give the message to the doctor. If he is interested, he will give you a call back.”</i></b></p>
Calls from Patients Asking to Speak to the Doctor	<p>Patient asks to speak to the doctor:</p> <p><b><i>“I’m sorry Jake, he/she is with a patient right now? Is there something that I can assist with?”</i></b></p> <p>The progression of the call will determine whether you can assist the patient or the provider needs to call them back. Make sure to take a detailed message for the provider and confirm the best phone number the patient can be reached at.</p> <p><b>DO NOT</b> offer any medical advice unless you have been trained to do so.</p>

# Collection Process

It is important to understand the different components of the collections process. Addressing one of the many components of the whole process can put a practice at risk and negatively affect the bottom line.



# Handling Patient Objections

Some patients will have objections on your clinic’s financial policies and will dispute/challenge why they owe. Remember the following:

1. Communicate with the patient why he/she is financially responsible for the services rendered or the products received
2. Be prepared to handle objections—know your clinic’s financial policy, clinic fees & payers fee schedules and know options on how to handle patient objections
3. Always end your response with a question (For Example—“How would you like to handle that?” or “Would you like to pay with cash, check or credit card?”)
4. Make eye contact with the patient when discussing finances—be polite

The Patient Says...	Possible Response...
<b>I forgot my checkbook</b>	That is not a problem. We also accept credit cards.
<b>I don’t have cash</b>	We do take other forms of payment. We happily accept check, credit or debit card.
<b>I didn’t bring my wallet</b>	Here is an address/stamped envelope so when you get home you can mail your payment in.
<b>My spouse/parent handles paying the bills</b>	<i>Give the patient a printout of their statement...</i> Here is a statement for your visit today--- it will show your (spouse/parent) the amount due. <i>If a HIPAA agreement is signed to discuss finances with spouse—</i> “Would you like me to contact your spouse directly to set up a payment plan?”
<b>Let it go to insurance first</b>	We will be more than happy to file it to your insurance, but just so you know, these products are not covered by insurance  <b>-OR-</b>  Unfortunately, our contact with your insurance company states that we have to collect the patient portion at each visit.
<b>Let me know when I have a balance of \$_____ so I can pay at once</b>	I’m sorry Mr./Ms./Mrs. _____, our office policy doesn’t allow us to do that. I will need to collect for today’s visit and we can send you a statement for the remaining balance for you to pay that outstanding balance off.
<b>I didn’t know that I had to pay every visit</b>	I completely understand Mr./Ms./Mrs. _____, but unfortunately your insurance company requires that we collect the patient portion at each visit.

## Advantages & Disadvantages of Reviewing Office Financial Policy

Review Office Financial Policy	Advantages	Disadvantage
<b>When the Patient fills out New Patient Paperwork</b>	<ul style="list-style-type: none"> <li>• Patient's concerns about costs may be reassured if discussed upfront</li> <li>• No financial surprises for the patient</li> </ul>	Some patients may not know financial options are available or why treatment is needed
<b>During the provider's consultation and before services are rendered</b>	<ul style="list-style-type: none"> <li>• Office expectations for payment are clear before services are rendered</li> <li>• Patient feels that they are a part of the discussion and making the best decision for themselves</li> </ul>	If finances are discussed before the consultation, then the patient will not understand the importance of care within the office and he/she may refuse continuing with treatment, even if a payment plan option is available
<b>After the initial visit is complete</b>	<ul style="list-style-type: none"> <li>• Patient has a chance to visit with the provider</li> <li>• Gives off that patient care is primary and finances are secondary</li> <li>• Offers the patient payment plan options to assist with financial matters</li> <li>• Care Comes First Impression</li> </ul>	Patient receives services that they didn't know the cost and couldn't afford and once services are rendered, the clinic will have to sort out how the patient will pay for services

## In-Office Patient Collections Scripting

Role playing through scenarios are helpful in talking through how to handle different financial situations and how the clinic will handle these discussion points

Scenario	CA	Patient	CA
<b>Mrs. Smith has an outstanding balance from last year and has returned to the office for care.</b>  <b>Goal:</b> Collect outstanding balance and today's visit			
<b>Mrs. Smith's credit card declined for her payment</b>  <b>Goal:</b> Obtain a different payment type			
<b>The provider prescribed Mrs. Smith a cervical pillow. Your clinic's policy is that payment for all DMEs is collected at the time of dispensing the item but the patient wants to file it to her insurance</b>  <b>Goal:</b> Collect for DME product			
<b>Mr. Jones' personal check was returned for insufficient funds. An alert was placed on the patient's account</b>  <b>Goal:</b> Collect past due balance plus NSF fee and today's visit			
<b>Mr. Jones has been dismissed from Active Care and must begin to pay cash for treatment. Mr. Jones doesn't understand why the visit cannot continue to be billed to insurance</b>  <b>Goal:</b> Explain clinic office financial policy & collect for today's visit			

In-Office Patient Collections Scripting

Scenario	CA	Patient	CA
<p>Mr. Graham is a Medicare patient who received ultrasound treatment. At the beginning of the treatment plan, the patient was given a <i>Special Notice for Medicare Patients</i> outlining the <i>excluded services</i> that are the patient's responsibility.</p> <p>Goal: Collect today's visit</p>			
<p>Ms. Yates thought that she had met her deductible and only paid for the coinsurance portion on the last visit.</p> <p>Goal: Collect the outstanding balance</p>			
<p>Mrs. London's insurance policy is inactive at the time of service despite what the insurance verification states.</p> <p>Goal: Collect outstanding balance</p>			

## Electronic Health Records (EHRs) v. Paper Medical Records

### Electronic Health Records (EHRs)

PROs	CONs
<b>Costs</b>	
<ul style="list-style-type: none"> <li>Reduces printing cost (fewer dead trees)</li> </ul>	<ul style="list-style-type: none"> <li>Still printing paperwork to enter data</li> <li>Extra Charge for off-site data storage</li> <li>High purchase price or monthly subscription</li> </ul>
<b>Access</b>	
<ul style="list-style-type: none"> <li>All records, scripts, labs, testing, and billing are together</li> <li>One-Stop Shop</li> <li>Available anywhere with an internet connection</li> <li>Multiple staff can access a patient chart at once</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>Documentation</b>	
<ul style="list-style-type: none"> <li>Handwriting is not an issue—legible</li> <li>Auditors can easily read your notes</li> <li>Template help with basic encounter data</li> <li>Macros already exist</li> </ul>	<ul style="list-style-type: none"> <li>Much slower than paper</li> </ul>
<b>Customization</b>	
<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>Software customization can be limited</li> <li>Hard to change existing data once entered</li> </ul>
<b>Practice Management</b>	
<ul style="list-style-type: none"> <li>Any computer access are linked to practice management</li> <li>Patient Intake Part of Software</li> <li>Records Requests Received Digitally</li> <li>Scheduling Tracking Easier</li> <li>Staff Management</li> <li>Billing- Easily Move Documentation to billing</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>Storage</b>	
<ul style="list-style-type: none"> <li>Web Based programs don't need filing cabinets</li> <li>Server Based programs may require a dedicated/lockable room to hold server(s)</li> <li>Doesn't take up space</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>Experience</b>	
<ul style="list-style-type: none"> <li>Computers are easy for some providers to use</li> <li>Dragon or other dictation software are available</li> </ul>	<ul style="list-style-type: none"> <li>Cannot physically hold chart</li> <li>Most providers feel disconnected between patient care and documentation</li> <li>Computers are hard for some providers to use</li> </ul>
<b>Time Requirements</b>	
<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>Takes much longer to get all the required data into the software</li> </ul>

## Electronic Health Records (EHRs) v. Paper Medical Records

### Paper Medical Records

PROs	CONs
<b>Costs</b>	
<ul style="list-style-type: none"> <li>Low cost</li> <li>Additional printing only fiscal concern</li> </ul>	<ul style="list-style-type: none"> <li>A lot of dead trees</li> </ul>
<b>Access</b>	
<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>Chart must be carried around</li> <li>Everything is <b>NOT</b> in one place</li> <li>Only one person can have the patient chart at one time</li> <li>Encounter data often in different places</li> </ul>
<b>Documentation</b>	
<ul style="list-style-type: none"> <li>Much faster than EHR</li> </ul>	<ul style="list-style-type: none"> <li>Legibility is a concern</li> <li>Harder for an auditor to read</li> <li>Not all paperwork systems are good</li> <li>Easy to forget to enter important data</li> </ul>
<b>Customization</b>	
<ul style="list-style-type: none"> <li>Easy to customize—just make a few forms</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>Practice Management</b>	
<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>Systems are <b>NOT</b> linked</li> <li>Patient intake- must make system</li> <li>Billing— lose charges from encounter to billing</li> <li>Records request—endless faxes and deadlines</li> <li>Scheduling—outside system needs Metrics for tracking—tedious process w/o computer</li> <li>Staff management— must make system</li> </ul>
<b>Storage</b>	
<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>PHI cannot be stored offsite if it is needed to treat</li> <li>Rooms full of filing cabinets instead of treatment space</li> <li>Physical charts have to be kept for 7+ years</li> </ul>
<b>Experience</b>	
<ul style="list-style-type: none"> <li>Can physically hold chart</li> <li>Most providers feel its easier to write than type</li> <li>Most providers feel patient care is better</li> <li>Easier to hand a patient a form than a link</li> <li>Paper is what most providers already know</li> </ul>	<ul style="list-style-type: none"> <li>Dictation of encounter requires a trained scribe</li> </ul>
<b>Time Requirements</b>	
<ul style="list-style-type: none"> <li>It takes much less time to get a required data on the page and a scribe can help</li> </ul>	<ul style="list-style-type: none"> <li>Writing legibly can take longer for some individuals</li> </ul>

# Medical Records Request Checklist

Medical Records sent from your office should follow the Notice of Privacy Practices and HIPAA for rules with regards to the patient's request for records.

1. Do Not Ignore a Request
2. Do Not Alter Medical Records
3. Make Sure that Records are Legible & Complete
4. Include Sufficient Information to Prove Medical Necessity
5. Make sure the Provider Reviews Records Prior to Sending

Medical Records Request Response	Yes	No
1. Have you acted on the request?		
2. Have you preserved the original record?		
3. Are the records legible?		
4. Are the records complete?		
5. Have you proved medical necessity?		
6. Has the doctor reviewed the records?		
7. Is the documentation in chronological order?		

## Chiropractic CA Checklist

This checklist is a guide in regard to the roles of a Chiropractic CA to review areas that encompass a Chiropractic Clinic. Review the questions and if any question is marked as “No,” then please review with your provider on how to handle the process to better perform your role as a Stellar Chiropractic Assistant. Use the appropriate field “Notes” to list any questions &/or comments.

Questions	Yes	No	Notes
<b>Understanding Chiropractic</b>			
Have I taken the Certified Chiropractic Assistant Program offered by the NCBOE? (North Carolina Board of Chiropractic Examiners)			
Do I have a list of Chiropractic Anatomy & Terminology to reference?			
Do I understand the Key Facts & Figures of Chiropractic?			
Questions	Yes	No	Notes
<b>HIPAA</b>			
Does my clinic have a Compliance Officer?			<b>My Clinic's Compliance Officer is:</b>
Does my clinic have the following paperwork incorporated to ensure we are meeting HIPAA Compliance?  <div style="margin-left: 20px;"> 1. Identifying Protected Health Information (PHI)  2. HIPAA Administrative Simplification packet for Compliance Manual </div>			
Do I have a Business Associate Agreement with Third-Party Vendors that have access to Patient Health Information (PHI)?			
Does my clinic utilize a third party company to manage HIPAA training , provide clinic assessments/audits & Business Associate Agreements (BAA)?			

Questions	Yes	No	Notes
<b>Chiropractic Assistant</b>			
Is there a physical job description for the role or roles that I will be performing?			
Knowledgeable of the office's phone system & messaging system			
Answering and returning phone calls			
Knowledgeable of the office's Electronic Health Records (EHR) Program			
Knowledgeable of all contents of the New Patient Paperwork Packets: <ol style="list-style-type: none"> <li>1. Major Medical</li> <li>2. Cash</li> <li>3. Medicare/Medicaid</li> <li>4. Personal Injury</li> <li>5. Workers Comp</li> </ol>			
Can perform the functions of the office's EHR: <ol style="list-style-type: none"> <li>1. Enter new patient into software (all patient demographics)</li> <li>2. Enter insurance information</li> <li>3. Enter CPT Codes &amp; Diagnosis Codes</li> <li>4. Scan records into EHR</li> <li>5. Any additional functions of EHR</li> </ol>			
(Non-EHR Clinics) Can perform the functions of the office's filing system?			
Can operate the office's financial system (Credit Card Machine)?			
Welcome Patients to Office			

Questions	Yes	No	Notes
<b>Chiropractic Assistant</b>			
Welcome New Patient			
Can Take Payment			
Understand the Management of the Appointment Book or EHR Scheduling Program			
Understand the Scheduling Difference of your Office (including time limit) <ol style="list-style-type: none"> <li>1. New Patient</li> <li>2. Re-Exam Patient</li> <li>3. Report of Findings (ROF)</li> <li>4. Adjustment</li> <li>5. Therapies</li> <li>6. Massage Therapy</li> <li>7. Physical Therapy</li> <li>8.</li> <li>9.</li> <li>10.</li> </ol>			
Schedule Care Plans			
Open Office with assist of CA			
Can Run a Shift with assist of CA			
Close Office with assist of CA			
Monitor and Respond to Emails			
Understand the Office's X-Ray Procedures			
(Digital X-Ray) Can import x-ray images into patient's medical records within the EHR?			

Questions	Yes	No	Notes
<b>Chiropractic Assistant</b>			
(Digital X-Ray) Can burn x-ray images on a CD?			
(Physical X-Ray) Can process x-ray images on x-ray film?			
(Physical X-Ray) Can file x-ray images in office's x-ray filing system?			
Perform Patient Recalls & Reactivation Process			
Understand Office's Process for Medical Records Request to Outside Provider			
Understand Office's Process for Medical Records Request from Outside Provider			
Understand Office's Process for Referral to Outside Provider			
Understand Insurance Verification Process			
Performed Insurance Verification of the following Payer Types: <ol style="list-style-type: none"> <li>1. Major Medical</li> <li>2. Medicare</li> <li>3. Medicaid</li> <li>4. HMO/PPO</li> <li>5. Personal Injury</li> <li>6. Worker's Comp</li> <li>7. COBRA Plan</li> </ol>			

Questions	Yes	No	Notes
<b>Chiropractic Assistant</b>			
Understand the Appointment Reminder Process			
Know where the Office's Birthday, Get Well, Our Condolences Cards are located			
Schedule and Prepare for Community Events			
Reconciliation for the Day's Financial Transactions (Patient & Insurance Payments) to the Drawer			
Create Deposit Slip of Cash & Checks obtained for the Day			
Maintain Daily Clinic Stats			
Preparation for the Next Day/Shift			
Knowledgeable of Insurance Billing Processes			
Knowledgeable of Insurance Clearinghouse			
Knowledgeable of Electronic Claims Submission Process & Office's Schedule of Claims Submission			
Knowledgeable of Paper Claims Submission Process & Office's Schedule of Claims Submission			
Knowledgeable of Patient Statement Process			
Perform Electronic Claims Submission Process			



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