

FREE GUIDE

The Front End Fix

*A No Fluff Revenue Cycle Guide
for Small Healthcare Practices*

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A Note From Tamika

If you're reading this, you're either launching a new healthcare practice or you've been in the game a while and something in your revenue cycle just isn't clicking. Either way, welcome. You're in the right place.

I created this guide because I've spent over 12 years in healthcare operations and front-end revenue cycle, and I've seen the same mistakes happen over and over in small practices. Not because providers aren't talented. But because nobody ever sat down and explained the front end clearly, practically, and without the jargon.

This guide is that conversation. Walk away with real, actionable insight you can use starting today.

With warmth,

Tamika L. Tabb, CRCR

Founder, Maison Lue Healthcare LLC

SECTION 1

What Is Front End Revenue Cycle?

Revenue cycle is the full financial journey of a patient visit, from scheduling to payment. It has two sides: front end and back end. The front end happens BEFORE and AT the time of service.

The Front End includes:

- Patient scheduling and appointment coordination
- Registration and demographic data collection
- Insurance verification and eligibility checks
- Prior authorization requests
- Copay and cost-share collection at time of service
- Financial screening and assistance enrollment

MANY CLAIM DENIALS START AT THE FRONT END, AND MOST ARE PREVENTABLE

Your back office cannot fix what your front door breaks.

Large health systems have entire departments for each piece of the front end. Small practices often have one or two people managing everything at once. Without clear systems, errors are inevitable. This guide breaks it down so your team, no matter how small, can operate with confidence.

SECTION 2

The Big 3 Front End Mistakes

Most front end revenue cycle problems come down to three core areas.

Mistake #1 — Inaccurate Patient Registration

Registration is the foundation of every claim. A misspelled name, wrong date of birth, or incorrect insurance ID will cause that claim to fail, often not caught until after submission.

IMPACT

A single registration error can delay payment 30 to 60 days and require significant staff rework time.

Mistake #2 — Skipping Insurance Verification

Verifying coverage BEFORE the appointment is the single most important front end habit a practice can build. Coverage changes, plans lapse, and patients don't always know what their insurance covers.

IMPACT

Seeing a patient without verifying active coverage can result in a full claim denial with zero reimbursement.

Mistake #3 — Missing Prior Authorizations

Prior authorization is the process of getting insurance approval before providing certain services. Many small practices don't know which services require auth, submit too late, or skip it altogether.

IMPACT

Providing a service without required prior auth almost always results in a denial, even when medically necessary.

SECTION 3

Insurance Verification Done Right

Insurance verification confirms a patient's coverage, benefits, and eligibility BEFORE services are rendered. Done correctly, it protects your revenue and sets accurate patient expectations.

When to Verify

- At scheduling, always collect insurance information upfront
- 24 to 48 hours before the appointment, verify active coverage
- At check-in, confirm no changes since last verification
- Returning patients, reverify before every visit

Quick Verification Checklist

- ☐ Patient name matches insurance card exactly
- ☐ Date of birth confirmed
- ☐ Insurance ID and group number verified
- ☐ Plan is active and effective on date of service
- ☐ Copay, deductible, and coinsurance confirmed
- ☐ Referral and prior auth requirements identified
- ☐ Coordination of benefits confirmed (if secondary insurance exists)

★ PRO TIP

Always document who you spoke with, the date, time, and reference number when verifying by phone. That documentation is your proof if a claim is later denied.

SECTION 4

Prior Authorization Basics

Prior authorization (PA) is advance approval from insurance before delivering specific services, procedures, or referrals. Knowing what requires auth, and when to request it, is essential.

Services That Commonly Require Prior Auth

- Specialist referrals (especially HMO plans)
- Elective surgeries and procedures
- Diagnostic imaging: MRI, CT, PET scans
- Durable medical equipment (DME)
- Home health and skilled nursing services
- Behavioral health services beyond initial visits
- Physical, occupational, and speech therapy

Basic Prior Auth Workflow

- 1 Confirm whether the service requires prior auth: check payer website or call
- 2 Collect required clinical documentation from the provider
- 3 Submit the request via payer portal, fax, or phone and document the date
- 4 Follow up if no response within 3 to 5 business days
- 5 Document auth number, approval date, and expiration date
- 6 Attach auth number to the claim before submission

SECTION 5

Top Denial Reasons and Prevention

Most front end denials are preventable. Here are the top reasons and how to stop them.

#1 Invalid or Inactive Insurance

Verify coverage before every appointment. Never assume last visit's insurance is still active.

#3 No Prior Authorization

Check auth requirements before scheduling procedures or referrals.

#5 Wrong Payer Billed

Confirm primary vs. secondary insurance and bill in the correct order.

#7 Timely Filing Exceeded

Know each payer's filing deadline and track submission dates carefully.

#2 Incorrect Patient Demographics

Verify name, DOB, and ID against the insurance card at every visit.

#4 Eligibility Issues

Confirm the patient is eligible on the actual date of service, not just enrolled.

#6 Referral Not Obtained

HMO plans often require a PCP referral before specialist visits. Missing this means denial.

#8 Non-Covered Service

Verify the specific service is covered under the patient's plan before providing it.

SECTION 6

Your Front End Checkup

Use this quick self-assessment to see where your front end stands. Check every box that currently applies to your practice.

REGISTRATION AND DEMOGRAPHICS

- ☐ We verify patient demographics at every visit
- ☐ We confirm insurance at the time of scheduling
- ☐ We have a process for updating patient information when it changes

INSURANCE VERIFICATION

- ☐ We verify eligibility 24 to 48 hours before every appointment
- ☐ We document verification with date, time, and reference number
- ☐ We identify copay, deductible, and coinsurance before the visit

PRIOR AUTHORIZATION

- ☐ We know which services require auth by payer
- ☐ We submit auth requests before scheduling procedures
- ☐ We track auth numbers, approval dates, and expiration dates

DENIAL PREVENTION

- ☐ We track our top denial reasons monthly
- ☐ We know each payer's timely filing deadline
- ☐ Staff receive ongoing training on front end accuracy

Score	What It Means	Next Step
10-12	Strong foundation!	Document your SOPs.
6-9	Gaps in key areas.	Address highest risk areas first.
0-5	Needs attention now.	Consider a workflow audit.

Thank You for Reading

I hope this guide gave you clarity and a clearer picture of where your front end stands and where it can grow.

Your practice deserves a front end that works as hard as you do.

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