



FQHC leader's comprehensive guide to increasing revenue and boosting efficiencies.

Vol 1 - of 3



PREPARED BY
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Introduction

In this three-part series titled, "FQHC leader's comprehensive guide to increasing revenue and boosting efficiencies," we will share the Synergy Billing strategies for enhancing patient convenience, boosting efficiency, and optimizing revenue.

Revenue Cycle Management for your community health center is a vital component that impacts various facets across the board, such as financial health, patient contentment, provider satisfaction, and clinical efficacy. Any hiccups within this cycle not only escalate administrative burdens but can also lead to potential revenue loss. Discover insights within this guide to streamline your revenue cycle, ensuring billing processes are more efficient and convenient for both your staff and patients alike.



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Understanding the Lifecycle of a Claim: Unraveling the Revenue Chain

It's crucial to comprehend the intricacies of accurate billing and prompt follow-up within Federally Qualified Community Health Centers (FQHC). Across most states, health insurers are obligated to settle claims within specified periods, typically ranging from 30 to 45 days, contingent upon the insurance provider. Familiarizing yourself with this procedural framework empowers you to pinpoint potential issues and rectify any broken links that could result in claim denials.

Effective management at every stage of the revenue cycle is paramount to guarantee equitable compensation for healthcare providers and ensure that patients receive the insurance coverage they're entitled to for the services rendered.

Patient Eligibility and Demographics: Ensuring Accuracy from the Start

At the forefront of the revenue cycle lies the critical task of gathering patient information during every visit. Front office staff play a pivotal role in this process by collecting demographic details and understanding the purpose of the patient's visit. Errors in demographic data collection stand as a leading cause for claim denials by insurance payers, underscoring the importance of meticulous attention to detail at this stage.

Additionally, verifying insurance coverage is imperative. To streamline this process, your Practice Management (PM) solution should integrate a remote transaction server (RTS) capable of interfacing with payer systems. This integration enables real-time validation of patient benefit eligibility, coverage determination, and estimation of patient responsibilities—all accessible online. By eliminating the need for individual payer calls or logging into various payer websites, this system also facilitates the upfront collection of patient copayments.

Preauthorization represents another vital aspect of registration, particularly for procedures beyond primary care physician visits, as failure to obtain it can result in non-payment by insurers.

Did You Know?

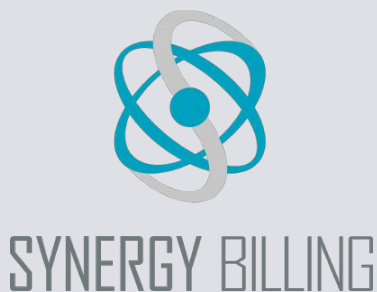
Enhanced RCM processes & specialized technology can prevent 90% of claims errors.





Synergy's Tips:

1. **Identify the patient's insurance plan accurately:** During registration, ensure precise identification of the patient's insurance provider and specific plan. Failure to do so may lead to missed filing deadlines and payment delays. For example, distinguish between different types of Medicare cards or know for certain if Medicaid is part of a managed care plan.
2. **Obtain eligibility information during appointment scheduling:** Utilize the RTS for verification well in advance, allowing office staff to reconfirm details during check-in.
3. **Understand your practice's payer mix:** Having insight into your payer mix enables accurate identification of patient plans and insurance eligibility. Proactive communication with patients regarding uncovered services is essential, alongside awareness of insurers requiring preauthorization before billing for services.
4. **Maintain policies and procedures:** Establish and uphold standardized operating procedures for patient eligibility and registration to ensure consistency and accuracy.
5. **Leverage automated outreach:** Integrate automated outreach solutions with your Electronic Health Record (EHR) and appointment-scheduling technology. Schedule patient reminders via text, email, or voice messages according to individual preferences, enhancing communication efficiency.





Charge Capture and Coding: Building the Foundation for Claims

At the core of revenue generation lies the pivotal process of charge capture, wherein physicians, healthcare providers, and medical staff meticulously record service-related information. This recorded data is subsequently translated into a claim and forwarded to third-party payers for reimbursement. Various code sets play distinct roles in this process, including:

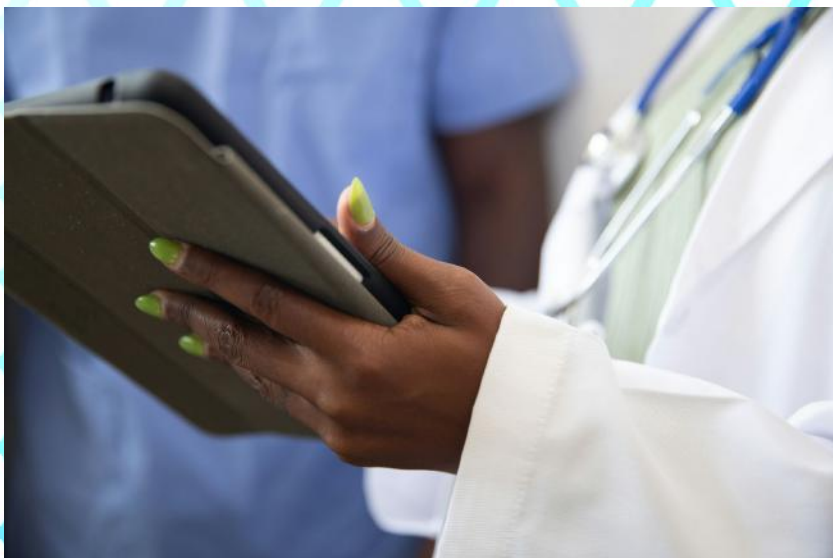
- ICD-10 diagnosis codes: Describing a patient's condition, injury, social determinants of health, and other relevant patient characteristics
- Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes: Indicating the actions performed by the provider during a patient encounter
- Charge capture codes: Associating physician order entries, patient care services, and clinical items with chargemaster codes, delineating prices for each service
- Professional codes: Capturing physician and clinical services rendered and linking them with billing codes
- Facility or place of service codes: Accounting for healthcare service costs and overheads, such as charges for space, equipment, and supplies.





Synergy's Tips:

1. **Embrace digitalization fully:** Encourage clinicians and staff to input all billing data directly into the EHR for streamlined efficiency.
2. **Ensure timely physician sign-offs:** Billing processes cannot commence until encounters are signed off within the EHR. Reminders to providers can expedite this crucial step.
3. **Optimize efficiency with mobile solutions:** Expedite the capture of diagnosis and procedure details with mobile solutions, enabling physicians and staff to dictate notes on the go via smartphones. Built-in voice dictation and transcription functionalities enhance convenience and accuracy. Seek a mobile solution that seamlessly integrates with your EHR system.
4. **Enhance accuracy with certified coders:** Given the increasing complexity of medical coding standards, employing certified medical coders ensures adherence to regulations and requirements. These professionals are adept at accurately translating physicians' reports into appropriate medical codes, minimizing errors, and optimizing reimbursement processes.





Final Thoughts



Understanding the intricacies of accurate billing and prompt follow-up within Federally Qualified Community Health Centers (FQHC) is vital for equitable compensation and patient coverage. Starting with precise patient information collection and insurance verification, followed by meticulous charge capture and coding, ensures a smooth revenue cycle. Enhanced by digitalization, certified coding, and proactive policies, this approach minimizes errors and optimizes reimbursement, securing sustainable healthcare operations.

Most FQHCs struggle to collect money. Synergy Billing works exclusively with community health centers. We offer a complimentary revenue cycle analysis that will provide you with a revenue proforma and staffing model for your billing operations. Contact us today to get started at **386.675.4709** or visit **www.synergybilling.com/contact**.



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