

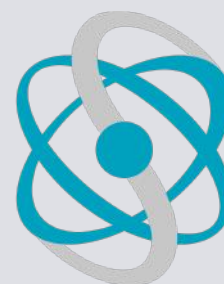


FQHC leader's comprehensive guide to increasing revenue and boosting efficiencies.

Vol 2 - of 3



PREPARED BY
Synergy Billing



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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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Claims Creation and Scrubbing: Precision from the Outset

The process of coding necessitates staff to gather pertinent information from medical records and other documentation for billing purposes. These codes serve as the foundation for generating insurance claims, which are subsequently submitted to third-party payers. Claims creation marks the pivotal juncture where coding is translated, either manually or electronically, into billing.

Central to this process are superbills, serving as the primary data source for claim creation—an itemized record of services rendered to a patient. Medical billers utilize information from superbills to generate claims, either manually or electronically, through the Practice Management system. While the CMS-1500 form, devised by Medicare, is universally accepted by most third-party payers, Medicaid, and other payers may utilize alternative claim forms tailored to their specific requisites.

During claim preparation, a crucial step known as claims scrubbing is undertaken by medical billers or coders to meticulously review for errors. This process aims to ensure the completeness and accuracy of all information, encompassing patient details, provider information, visit specifics, as well as procedure, diagnosis, and modifier codes. The ultimate objective is to produce a clean claim, thereby mitigating the risk of denials.

Much of the claims scrubbing process may be automated, with claims editing tools playing a vital role in error detection. These tools help identify discrepancies such as missing CPT code modifiers or incorrect diagnosis codes, preempting potential denials. It's imperative to validate claims against the National Correct Coding Initiative edits established by CMS to uphold proper coding practices. Leveraging claims scrubbing software that seamlessly integrates with your EHR and PM system facilitates accurate billing, ensuring claims are processed promptly and billed at the contracted rate.



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Synergy's Tips:

1. Implement a charge review rules engine: Automate the comparison of charges against standards delineated by Medicare, Medicaid, and private payers. This engine conducts millions of coding rule checks before charge importation from the EHR to the PM system, flagging errors for correction prior to claim submission. By reducing reliance on manual charge reviews, this tool streamlines the billing process.
2. Address recurring coding errors: Identify and rectify the underlying issue contributing to persistent claim edits to enhance billing accuracy and efficiency.



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Claims Submission: Ensuring Timely and Efficient Processing

It's crucial to understand that payers enforce specific deadlines for claims submission, known as timely filing limits. Failure to adhere to these deadlines can result in claim denials without the opportunity for appeal, leading to forfeiture of potential revenue. For instance, Medicare mandates claims to be submitted within one year of the service date, while other payers may impose varying deadlines, typically around 90 days from the date of service, based on contractual agreements.

The initial phase of submission commences when a claim departs from your practice for review, often facilitated by a clearinghouse service. Clearinghouses play a pivotal role in aggregating vast volumes of electronic claim data, primarily managed through software. Subsequently, this information is transmitted to third-party payers in the form of an 837 file, which is a HIPAA-compliant electronic format designed for the transmission of healthcare claims.



Synergy's Tips:

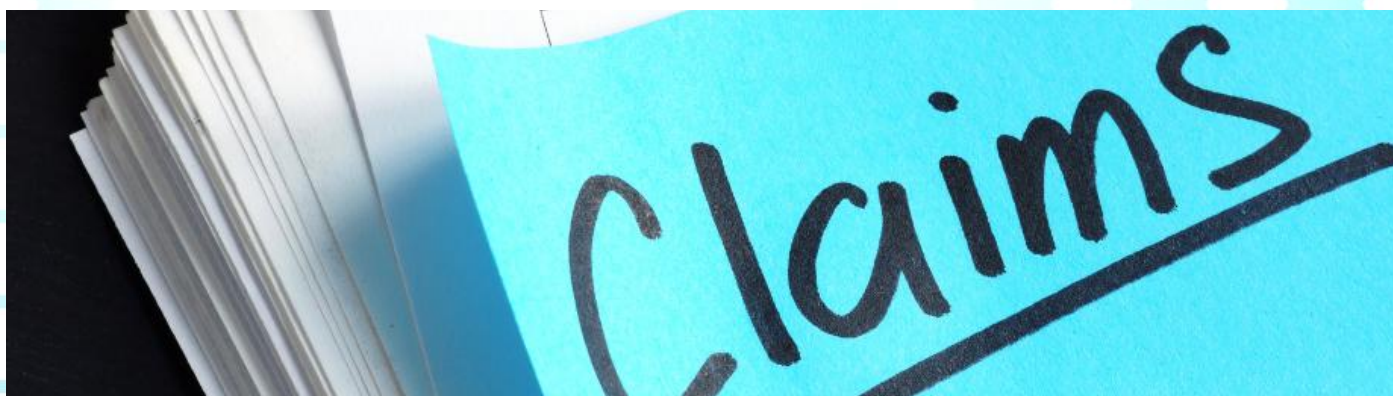
1. Monitor claim status regularly: Utilize the dashboard provided by clearinghouse services to track updates on the status of submitted claims. Clearinghouses continuously enroll new insurance payers, expanding the scope of coverage available on the dashboard. Additionally, digital documentation from clearinghouses serves as proof of timely filing, a more cumbersome process with paper-based claims.
2. Establish payment expectations: Familiarize yourself with typical payment timelines to set realistic expectations. While Medicare and many Blue Cross/Blue Shield payers often process payments within 14 to 21 days, other entities such as worker's compensation or Veteran's Affairs may necessitate longer processing times, ranging from 45 to 90 days before payment is received.



Clearinghouse Edits: Safeguarding Claims Integrity

Operating as a liaison between your FQHC and third-party payers, a claims clearinghouse plays a crucial role in the claims submission process. Upon receiving the 837 file generated during claims submission, the clearinghouse conducts its own set of edits on a computer platform before forwarding the claims information to insurance payers.

This stage of clearinghouse edits represents the final opportunity to verify the accuracy and completeness of a claim before it reaches the payer, thereby averting potential denials. Should the clearinghouse identify any issues with your claim, it will be rejected. While rejections from clearinghouses may not carry the same weight as denials from insurance payers, minimizing these rejections remains paramount. Vigilance in scrubbing claims and rectifying recurring errors is crucial to reducing clearinghouse rejections.



Synergy's Tips:

1. Understand the reasons for clearinghouse rejections: Familiarize yourself with seasonal trends that could impact the volume of claims returned from the clearinghouse. For instance, January tends to pose challenges for coders and billers due to payer-initiated coding changes at the onset of the new year, often resulting in a surge of clearinghouse edits.
2. Address clearinghouse rejections promptly: Establish a protocol for handling clearinghouse rejections promptly. Many centers adhere to a policy whereby most clearinghouse rejections are resolved within a 24-hour timeframe to minimize disruptions in claims processing.



Payer Adjudication: Evaluating and Deciding Claims

Upon receiving your claim, a third-party payer initiates the review process, known as adjudication. During this phase, the payer carefully assesses the information provided to determine the claim's validity and whether payment is warranted. Payers conduct thorough reviews to ensure the presence of supporting records, particularly for high-value claims, aiming to substantiate the claim's legitimacy. Healthcare payers utilize a standardized file format—the EDI 277 Health Care Claim Status Response transaction set—to communicate the status of claims. The 277 file, generated by the clearinghouse, indicates whether the payer has accepted the claim and can be seamlessly integrated into your PM system. In the event of a claim denial, the 277 file typically specifies the exact loop and segment where errors or omissions occurred, along with the reason for denial.

Synergy's Tips:

1. Leverage automation for 277 file processing: Opt for a billing and PM solution equipped with automation capabilities to extract clearinghouse information and verify claim acceptance status automatically.
2. Prepare for information requests: Anticipate potential requests for additional information from the insurer, particularly if a denial is indicated in the 277 file. In some cases, a registered nurse or physician employed by the insurance payer may conduct a manual review of relevant medical records to aid claim adjudication. Promptly provide any requested information to expedite payment processing and minimize accounts receivable aging.
3. Monitor outcomes: Maintain diligent tracking of payer adjudication outcomes to gauge the percentage of claims denied and identify clean claims. Additionally, tracking the effectiveness of appeals allows you to discern which denials warrant appeal efforts, facilitating proactive management of claim disputes.



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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 **www.synergybilling.com/contact**.



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