



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

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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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Payment Reconciliation and Financial Oversight: Managing Your Cash Flow

Remittance, the pivotal process of receiving payment, involves the transmission of claim payment information through an Electronic Remittance Advice (ERA) or 835 file. These electronic files offer a comprehensive breakdown of submitted claims, delineating reasons for payment, adjustment, or denial.

Upon receipt, ERA or 835 files can be seamlessly integrated into your PM system, streamlining payment reconciliation. Insurers typically furnish two types of statements elucidating claim payment or denial—remittance advice provided to healthcare providers and an Explanation of Benefits (EOB) statements dispatched to patients.

Following payment adjudication, the insurance company initiates payment deposition into the FQHC's account via electronic funds transfer (EFT). However, it's essential to note that your health center may still need to collect copayments, coinsurance, or deductibles from patients. Subsequently, the medical billing staff reconciles payments with respective patient accounts, ensuring alignment between received payments and claim details. This process involves scrutinizing ERA or EOB statements to identify denials, review line items, transfer balances to patient responsibility for billing, make necessary write-offs or adjustments, and address in-person patient collection issues.





Synergy's Tips:

1. Daily payment posting: Enhance cash flow management by posting claim payments daily and reconciling them with the bank. This includes payments from 835 files, paper checks from insurers, insurance credit card payments, patient checks, and patient credit cards.
2. Document organization: Maintain an organized document management system to retain original claim files, remittance advice, and EOB statements. This facilitates efficient follow-up on denials and subsequent appeals.
3. Zero-dollar remittance posting: Even zero-dollar remittances containing denial codes and pertinent information should be posted. Familiarize yourself with payer remittance schedules to capture these remittances, aiding in denial reworking and appeals submission.
4. Correspondence tracking: Document correspondence related to transactions, such as prior authorization or physician credentialing information, as they may impact revenue. These records serve as valuable resources for claims follow-up and revenue protection.





Claims Follow-Up and Denial Management: Maximizing Revenue Recovery

Effective follow-up on denials is crucial for optimizing revenue earned by your FQHC. While most centers adhere to timely filing standards for initial claim submissions, it's equally important to meet deadlines for reworking and appealing denials. Insurance payers convey claim denials to providers using remittance advice codes accompanied by brief explanations. Reviewing these codes enables the determination of whether to correct and resubmit the claim or bill the patient directly. Denials can stem from various reasons, including lack of medical necessity, services rendered outside the appropriate timeframe, or non-coverage by the patient's insurance plan.

Understanding Medicare Payment Adjustment Communication

Following claim processing by Medicare, either an ERA or a Standard Paper Remit (SPR) is issued, containing final claim adjudication and payment details. Detailed itemization in the ERA or SPR facilitates associating adjudications with the respective claims or line items. These documents report the reasons for each adjustment and the value of each adjustment, employing three sets of codes:

- Claim Adjustment Group Code: Assigns financial responsibility for the unpaid portion of the claim to either the provider or the patient.
- Claim Adjustment Reason Code: Offers an overall explanation for the financial adjustment.

Exploring Your Options

A denied claim does not signify the end of the road. For Medicare denials, resubmission of the claim to CMS for redetermination or reconsideration is an option. Commercial insurers typically offer an internal appeal process comprising multiple levels of internal appeals, external reviews, and a grievance process in case of disagreement with the outcome. Ultimately, Medicare denials can be appealed through the federal court system, while grievances with commercial insurers can be escalated to the state insurance commission.

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Synergy's Tips:

1. Tracking and sharing denial information: Monitor denials month-over-month to identify patterns and track denial volume, root causes, and appeal success rates.
2. Updating your rules engine: Address recurring denials by updating your rules engine to mitigate future errors or omissions. Choose an EHR and PM solution that allows flexibility in rule updates to prevent recurring denials.
3. Determining processable claims: Be vigilant about ensuring Medicare claims contain complete and valid information to prevent them from being returned as "unprocessable." Correct and resubmit such claims within the stipulated timeframe to avoid forfeiture of appeal rights.
4. Provider network identification: Ensure all providers affiliated with your health center are appropriately credentialed and associated with the proper billing group, mainly if some services are contracted out. Mismatches in National Provider Identifier (NPI) and tax ID information can lead to out-of-network denials.





Reporting & Analytics: Monitoring Practice Health

Consistent formatting of accurate and timely reporting and analytics is imperative for understanding and improving the health of your FQHC. A robust foundation in data empowers you to:

- Measure health center financial performance, manage costs, and enhance revenue
- Enhance administrative efficiency and the quality of care
- Minimize the risk of revenue loss
- Analyze the efficacy of claims management and evaluate accounts receivable (AR) Reporting functionalities should be integrated into your PM solution, offering both ad hoc and automated reports.

Key Reports:

Timely reports provide a comprehensive overview of your revenue cycle, enabling process improvement, trend identification, achievement of key performance indicators (KPIs), and identification of potential revenue collection obstacles. Examples of revenue cycle reports include:

- Monthly changes in AR: Offers insights into aging totals, charges, payments, adjustments, and ending aging totals.
- Insurance aging less credits: Displays open insurance balances without credits (overpayments) and associates balances with their respective financial classes (e.g., Medicare, Medicaid, Blue Cross Blue Shield, UnitedHealthcare, Cigna, or other commercial payers).
- Patient aging less credits: Highlights open patient balances minus any overpayments.
- Bad debt AR: Identifies outstanding patient balances referred to collections.
- Receivables analysis: Categorizes accounts receivable by type—insurance, patient, and credits.
- Charges by financial class: Indicates the amount of charges sent to various payers for processing.
- Payments by financial class and date of service: Illustrates payment turnaround times from major payers after charge submission.
- Service item summary: Provides a breakdown of billed services organized by CPT code.
- Denials by reason code: Details reasons for denial according to payer.
- Standard monthly reports: Includes additional reports necessary for board review, practice management, clinical management, or other departmental needs.





Synergy's Tips:

1. Establish a regular reporting schedule: Set up routines to run daily, weekly, and monthly reports to monitor financial trends, establish KPIs, and achieve long-term financial objectives.
 - Daily reports may encompass reconciliation of generated and submitted claims.
 - Weekly reports may involve reviews of the Revenue Cycle Management (RCM) system and clearinghouse edits, AR aging, and denial management activities.
 - Monthly reports typically cover charges, payments, and adjustments; AR balance trends; gross collection rates; and provider productivity.

What's Next?

Download Our FREE Revenue Assessment

Are you an FQHC executive who is ready to increase revenue, recover old revenue, decrease AR, and improve the overall financial efficiency and health of your organization? Get started today with a free revenue assessment from the experts at Synergy Billing.

Here's How It Works:

1. Discovery: We learn more about you and your health center by discussing your challenges.
2. Recommendations: We present recommendations and a customized solution for your health center.
3. Action: Our expert team of FQHC billers, trainers, and credentialing specialists gets to work!

[Click here to get started.](#)





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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