Success Story

FQHC Revenue cycle

In Spring 2018, LHA was engaged to provide a billing assessment for a $28.5M non-profit organization that provides comprehensive healthcare and supportive services to people experiencing homelessness. These services are delivered at five locations as well as various mobile units. This FQHC has a mission to help move people from crisis to stability. Due to recent expansion, offerings have expanded thereby increasing the billing to Medicare and Medicaid.

OBJECTIVE

Provide executives with a thorough understanding of the billing process from registration to payment collection as well as an analysis of the staffing model

APPROACH

- *Provide the client with a billing assessment.*
- *Debrief the client on the "Centricity" software.*
- *Review the current staffing model/provide workflow recommendations.*
- *Identify efficient processes for proper charge capture.*
- *Review of policies and procedures.*

FINDINGS AND RECOMMENDATIONS

After interviewing staff, observing workflows and reviewing existing reports, LHA identified five areas of opportunity:

Client Access

Problem: The telephonic scheduler was only collecting basic demographic information at the time of appointment scheduling. The information collected was not sufficient enough to verify eligibility before the appointment.

Recommendation: LHA advised the non-profit organization to collect all insurance information prior to arrival. If this process is implemented, an eligibility verification check could occur in advance. This will save time and confirm insurance/identify clients who truly need enrollment services.

Provider Optimization

Problem: After meeting with the Billing Manager to review the claim submission process, LHA obtained knowledge that Medicare had been conducting audits and identified missing elements in the documentation for various visit types. Additionally, LHA observed a provider entering improper charges due to the lack of availability of diagnosis codes in the EHR.

Recommendation: Create templates in Centricity to ensure providers meet the required elements of documentation. Expand the providers access to all diagnoses codes in Centricity. LHA also recommended education for providers on diagnosis specificity.

Management Oversight

Problem: LHA identified deficiencies in provider coding and documentation. The policies and procedures needed to be updated and the organization did not routinely audit provider documentation.

Recommendation: LHA suggested engaging in annual external audits with provider education as well as utilizing a certified professional coder for smaller more focused audits based on the results of the external audits.
Recommendations were made to update billing policies to include system downtime procedures and guidelines for insurance verification.

Revenue Opportunity

Problem: Medicare pays for an Annual Wellness Visit using the code G0468. This code includes a bundle of services that would be furnished to a Medicare beneficiary. The organization was exclusively billing G0466. If the organization begins to implement the recommended code then the PPS (Prospective Payment System) rate will be adjusted by a factor of 1.3416. Last year, there were 1,367 Medicare patients seen. If the code G0468 was to be implemented there is an opportunity for over $120,000 in annual revenue.

Recommendation: LHA advised the non-profit organization to begin billing annual wellness visits utilizing code G0468. This change would result in a PPS (Prospective Payment System) rate increase of roughly 34%, which translates to an additional $126,635.76 of revenue. Additionally, providers were trained on the required elements of the visit and enlightened on how to utilize additional clinical staff (MAs and RNs) to operate at the top of their license during these visits.

G0466	**$**	**138.00**	
G0468	$	185.14	1.3416 adjustment factor
TOTAL NUMBER OF MEDICARE PATIENTS		1367	
		684	50%
ADDITIONAL ANNUAL REVENUE	$ 126,635.76		

Staffing

Problem: In 2017, the organization processed 115,463 claims. MGMA data shows that one full-time employee can maintain 10,000 claims per year. LHA observed that the job descriptions were well-defined, except, within the Clinical Billing Manager role. It was stated that the manager supervises a Financial Analyst, yet that role was vacant leaving the Billing Manager serving that additional role.

Recommendation: Advised client to consider adding a full-time employee, such as a Financial Analyst, who focuses their attention on reporting and denials management. Upon assessing the Medicare budget available, it was determined that hiring two additional FTEs would be beneficial.

Billing Team	Clinical Billing Manager	3 FTEs	9.65 FTEs
	Clinical Billing Specialist		
	Clinical Billing Specialist		
Beacon Team	Lead Benefits Specialist	2.5 FTEs	
	Client Access Associate I		
	Client Access Associate II		
Enrollment Team	Lead Benefits Specialist	4.15 FTEs	
	Client Access Associate II (2)		
	Client Access Associate II (5) Satellite Sites*		

CONCLUSION

The changes made in daily operations allowed the practice to continue taking the quality of care and access to care to a higher level. The use of new medical codes, acquiring more staff and learning new functions within the electronic health software, provided the client an opportunity for increased revenue. LHA's in-depth knowledge of healthcare management proved to be an invaluable learning opportunity for the executive members among the non-profit organization.

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