🚀 Case Study: Optimizing Revenue Cycle for a New York-Based FQHC

🛡️ Client Overview:

A leading **Federally Qualified Health Center (FQHC)** in New York delivering comprehensive, community-focused healthcare including:

- **Adult Care & Behavioural Health**
- **Family Medicine**
- **Paediatrics**
- **OB/GYN**
- **Dental**

Serving primarily Medicaid and uninsured populations, the FQHC operates under **HRSA guidelines** and relies on **Medicaid Wraparound funding** to sustain operations. The centre transitioned to a new billing platform for behavioural health in **August 2024**.

⚠️ Challenges Faced:

1. **Dual Billing Complexity**
   - Medicaid patients required two separate claims: **Medicaid MCO** + **Wraparound (rate codes 1609/4028)**.
   - Manual handling of rate codes often led to billing errors or underpayments.
2. **Credentialing Gaps**
   - Several providers were either not credentialed or became un-credentialed mid-cycle, resulting in preventable denials.
3. **Coding Discrepancies**
   - CPT codes were mismatched with diagnosis codes (e.g., E&M billed with wellness DX).
   - Claims required real-time clarification with providers before submission.
4. **Registrar-Level Errors**
   - Incorrect payer entries during registration led to eligibility issues, necessitating backend corrections and rebills.
5. **Zero Fee & Missing CPT Codes**
   - Newly introduced CPTs were missing from the charge master, leading to zero-fee claims and delayed billing.
6. **Software Transition & Backlog**
   - The move from old to new billing platform created a backlog of **1000+ unbilled charges** needing rapid turnaround to avoid timely filing issues.

🛠️ Our Strategic Interventions

✅ **Dual Billing Workflow Optimization:**
Implemented a standardized process to bill both MCO and Wraparound claims, applying appropriate rate codes (1609 for primary care, 4028 for behavioural health) based on denial patterns and eligibility.

✅ **Credentialing Watchlist:**
Integrated real-time credentialing checks and flagged un-credentialed provider claims early. Coordinated closely with the client to maintain an up-to-date roster.

✅ **Real-Time Code Validation:**
Collaborated with clinical teams to resolve mismatched CPT/DX codes instantly, improving clean claim rates.

✅ **Insurance Entry Review:**
Added a backend verification step to correct registrar-level errors through eligibility checks before submission.

✅ **Charge Master Maintenance:**
Raised clarifications for new CPTs with zero fees and ensured timely updates to prevent billing delays.

✅ **Backlog Management During System Migration:**
Deployed a dedicated team to clear the 629-charge backlog overnight during the August 2024 software transition.

📈 Results Delivered:

Initiative	Impact
Medicaid Wraparound Rebilling	$40K recovered from 450+ claims
MVP Denial Resolution	$10K recovered by correcting rev codes
Backlog Clearance During Migration	1000+ charges processed in <24 hours
AR Clean-Up Project	Reduced aging A/R; boosted collections

📣 Client Testimonials:

"Your team has been outstanding—especially during our system change. The proactive claim handling, timely billing, and Medicaid expertise helped us stay on track."
— Practice Manager, FQHC – New York (Oct 2024)

"I'm pleased and satisfied with your work and thank you team for the hard work and persistence to accomplish this breakthrough."
— Practice Manager, FQHC – New York (Mar 2025)

✅ Why It Worked

1. Deep understanding of **FQHC billing nuances**
2. Agile handling of **payer-specific rules**
3. Rapid support during **system migrations**
4. Clear communication and collaboration across clinical and admin teams

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📩 Get in Touch: 📧 Looking to Optimize Your FQHC Billing Operations?

Email: sales@ecareindia.com

Let’s talk about how we can help streamline your revenue cycle, reduce denials, and ensure timely collections.

✉️ **Contact Us** to learn how we can assist you.

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