TELCOR®

Empowering Labs to Reach for More™

Efficient Front-End Processing:

Automating the Simple, Tedious Tasks

With TELCOR RCM, inbound and outbound data is controlled through interfaces requiring no manual intervention. From receiving patient demographic, tracking down missing information, getting prior authorizations to checking benefits, these tasks can be automated and audited. This processing reduces labor on the front end and produces compliant claims the first time, so less time is spent working claim denials.

Demographics

As a leader in connectivity and interfacing, TELCOR has extensive knowledge and expertise in managing demographic information. We are vendor-neutral, allowing customers to select the vendor that works best for their business. We have developed proprietary mapping tools and processes, allowing us to interface with any laboratory information system (LIS) for seamless transfer of patient demographics and billing data.

Missing Information

Missing patient information can be automatically faxed, emailed, or presented in the client portal to allow the information to be obtained efficiently. Prior to claim submission, the TELCOR RCM allows an organization to use payer jurisdictional rules to ensure the claims are directed to the right payer the first time.

Prior Authorization

TELCOR RCM can be configured to identify claims requiring a prior authorization and stop the claim submission until it is obtained. In most cases, the prior authorization should be obtained by the ordering provider before sending the testing to the laboratory. If this is done, the prior authorization number can be sent from the LIS and added to the patient account to be automatically included on the claim.

Rules can be configured by payer, procedure, and more to stop transactions requiring authorization but do not yet have an authorization in the system. If the laboratory chooses to obtain the authorization in place of the ordering provider, transactions can be sent to a prior authorization workqueue allowing users to compile the prior authorization documentation and submit to the payer.

This process can then be tracked by claim and payer to make sure responses are received timely, as each payer and plan can handle the prior authorization process differently causing timelines to vary.

Benefits Eligibility

To reduce claim denials, TELCOR RCM allows for upfront benefits eligibility checking, as well as prior authorization and medical records gathering. Benefits Eligibility interfaces allow payer information to be verified through the clearinghouse and payer then pulls the responses back into the application for processing.

Batch and real-time eligibility are available in the application. Real-time eligibility can be requested by a user at any time and for any payer that is configured to do so. Batch eligibility is run on patient payer records as they are added to the application. Batch is only run for the payer indicated on the patient's account. The returned response is visible in full on the patient's account or in the benefit response workqueue.

For both types of checking, there are fully configurable rules to define which payers are checked, how often they are checked, which fields are checked, and how their responses are flagged. Rules are set to automatically update patient information based on the payer response.

Rules can also be defined to discontinue the current payer and add a new payer based on the information returned in the response. Unique flags can be defined for different types of errors or responses so users are able to sort, filter, and work similar errors at one time.

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