To increase cash flow, consider using a presubmission review process that can shorten collections and reduce workload.

To get started, review rejected claims from the Explanation of Benefits to identify problem areas. Most electronic claims processes provide rejected claims reports, and timely review and follow-up action can improve turnaround on payment from insurance companies and patients.

Use a manual review of pre-submission claim reports to highlight problems in the billing system. Once you establish search parameters, run the report on all claims.

Correctly capturing patient names, addresses and birthdates is essential for efficient operations and billing. Accurate demographics decrease rejected claims and ensure good patient tracking. Generate exception reports through your computer system to identify misspellings and illogical data.

It takes about a half hour to review daily claims for office-based physicians, and 15 minutes per rejected claim to identify problems and resubmit them. Therefore, it takes two missed entry items daily to justify a presubmission process, and it is common to uncover four or more problematic claims per day.

Develop written billing policies to ensure consistency, and include:

- Fees
- Claim filing policies
- Expectation of payment or copayments
- Expectation of time-of-service payments for known deductibles and noncovered services
- Balance due after insurance
- Delinquent accounts

Establish a baseline to measure status and show progress. Measurement tools may include statistical analysis, event recordings (tally marks), soliciting feedback, questionnaires, focused audits and sampling reviews. Share measurement results with staff to build support and maintain momentum.

Maximize practice income
Presubmission reviews can save time, money

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