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IN DEPTH: HEALTHCARE

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Physicians and insurers battle over timeliness

Medical billing standards missing quick turnaround

Diane Faulkner

If you provide a service, you should get paid. Preferably immediately before or after services are rendered.

Too much to ask? It may be if you provide medical care, and not just to the underinsured.

A recent study by the Medical Group Management Association shows it takes an average of 74 days from the date of the claim for doctors to get paid by insurance carriers. In dollars, that translates to $20 billion wasted on processing flawed claims.

In order for an insurance carrier to pay a claim, the information filed must contain everything needed to verify the coverage, provider participation and payment information. The difficulty is each carrier is different. Some want complete client file copies along with each diagnosis, while others need only summaries of service.

"It depends upon the benefit package," said Jack Dennis, business development director for Athenahealth, a Massachusetts-based company that provides technological solutions for practice management, billing and collection. "The problem is, there are 800,000 different packages available through 2,000 carriers across the country -- all with different ID cards, different deductibles, co-pays, authorizations and benefit levels."

Documentation is increasingly complicated. "Claims get denied at the rate of three out of 10 times because something is filed incorrectly," he said. Something as small as a mis-keyed number can result in denial of a claim.

"Health care is one of the few transaction-based businesses that doesn't have standardization requirements," said Mary Anne Shoemake, a senior manager in Ernst & Young's health actuarial services division. "Not only is the nature of the managed care environment complex with varied contracts, etc., the average doctor's office is not technologically equipped for fast claims turnaround."

Another complication "is that people in the business of paying claims no longer fully understand the payment processing," she said. "Before HMOs, everyone knew the process, because they grew up in the system. Now, processors only know their specific section of the cycle and never leave that section. That's detrimental to the process."

Diane Faulkner is a correspondent with The Business Journal.

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