TOP TEN LIST

Perhaps we can focus on several issues or some combination of issues listed below to develop a collaborative effort with selected payors to standardize the format of claims data in the 835 transmission (and paper EOB's) that is similar to the Patient Friendly Billing Project for patient statements. Or, establish a collaborative effort to standardize provider enrollment/credentialing procedures or at least obtain consensus from payors to develop a "how to" process, brochure, or website posting that describes the enrollment process, timeframe, contact information and accountability for completion within a reasonable timeframe. Why can't it be completed similar to Medicare's timeframe? Just some ideas…

1. 835 Issues:
    a. Inconsistent/confusing denial codes and descriptions.
    b. Inconsistent and/or missing information in 835 payment files that prevent electronic processing of payments. For example, lack of line item detail for certain types of payments and/or recoupments, and files missing the network information the carrier is using to take contractual discounts.
    c. Carriers taking contractual discounts when there is no contract with the provider in place.
2. For payors that do not provide electronic payments; there is inconsistent paper EOB layouts and information, and some payors send checks and related EOB's separately.
3. Inefficient processes for claim appeal. Many times we have to submit same appeal multiple times, and it is difficult to obtain status information on the appeal.
4. Recoupments on previously paid claims with little ability to collect monies form other payors because the date of service for the claim is beyond timely filing deadline to rebill to another payor.
5. Denial for multiple visits on the same day by different specialists.
6. Payor adjudicates the claim incorrectly based on physician registered with dual specialties, e.g. internist and endocrinologist. (There are different copayments depending on whether the patient is seeing the physician as his/her primary care physician or whether patient is being seen for a consult.)
7. Payors have multiple claims/contracting systems and many times the correct contract payment terms are not loaded into all of their systems causing some claims to be paid correctly while others are paid incorrectly. This is huge problem with Aetna.
8. Payor website issues:
    a. Lack of provider access for eligibility and/or claim status information.

    b. Payor websites often provide incorrect information due to slow update of information on their websites
9. A better process for managing paper authorizations that are faxed to payors, because frequently payors do not update their systems which require a second phone call and fax to get a claim paid.
10. Commercial payor credentialing process is not regulated so the time it takes to enroll a provider can be several months to possibly a year or more.