Time per Transaction for Providers

Providers spend many hours interacting with health plans. This time could be used more efficiently, on patient care or other business needs, particularly in settings where clinical staff are involved in conducting these business processes. This year, for the first time, the CAQH Index reports the average amount of time providers spend conducting each transaction, by type and method (manual vs. electronic). Providers were asked about the average and range of time it takes to conduct each transaction type. For eligibility and benefit verifications and claim status inquiries, these time estimates include both transmission of the transaction and receipt of a response. For the other transactions, the time does not include additional follow up that may be involved, such as managing claim denials, responding to health plan requests for additional information, or sending attachments. The results are presented in Table 9. On average, providers spend 8.5 more minutes conducting manual transactions compared to electronic transactions. Depending on the transaction type, this time difference can be as high as 29 minutes.

Processing for a single claim that required one of each of these six transactions electronically instead of manually could save a provider a minimum of 51 minutes. If providers fully adopt automated processes for these six transactions, a minimum of 1.1 million hours of administrative work could be saved per business week each year.

TABLE 9:
Average Time Providers Spend Conducting Manual and Electronic Transactions

TRANSACTION	METHOD	TIME PROVIDERS SPEND PER TRANSACTION (minutes)	
		AVERAGE	MINIMUM – MAXIMUM
Claim Submission/ Receipt	Manual	5	4 – 9
	Electronic	1	<1 – 4
Eligibility and Benefit Verification	Manual	10	6 – 21
	Electronic	1	1 – 3
Prior Authorization	Manual	20	10 – 27
	Electronic	6	4 – 9
Claim Status Inquiry	Manual	12	9 – 29
	Electronic	5	3 – 8
Claim Payment	Manual	7	5 – 17
	Electronic	2	1 – 4
Claim Remittance Advice	Manual	15	6 – 31
	Electronic	3	2 – 7