**Basics of EDI(x12) in Healthcare - Fundamentals**

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This video helps you gain a basic understanding of the EDI standards and the EDI in Healthcare Industry.
It covers the following topics

- What is EDI & EDI Standards
- EDI(x12) in Healthcare
- EDI Transactions in Healthcare - 837,835,834,270/271,276/277,278
- Terminologies
- Claims workflow
- Understand the EDI transactions

# EDI *in* HEALTHCARE

## What is EDI

- Electronic data interchange (EDI) is the electronic transmission of information between computers or trading partners or systems.
- The EDI process allows the computer-to-computer exchange of business documents from one company to another, thereby enabling automated, paperless communication that is secure, efficient and reliable.
- EDI is used across multiple industries, including:
  - Healthcare
  - Financial services
  - Retail
  - Automotive, etc

## EDI in Healthcare

- EDI provides **secure electronic data interchange between healthcare providers, Health Insurance companies, sponsors,3rd parties, Govt and patients**, and allows for more secure and efficient data processing, including healthcare claims processing.
- Most health care organizations use applications and systems that are different from those of their trading partners, standardization of forms, codes and procedures was required.
- The EDI transaction sets in Healthcare:
  - 837: Health Care Claim.
  - 835: Health Care Claim Payment/Advice.
  - 834: Benefit Enrollment and Maintenance.
  - 820: Premium billing (Receipt).
  - 278: Request for review and response.
  - 270/271: Health Care Eligibility Benefit Inquiry and Response.

KSY

# ANSI X12

- X12, chartered by the American National Standards Institute for more than 40 years, develops and maintains EDI standards and XML schemas which drive business processes globally.
- X12 has two committees, the Accredited Standards Committee (ASC) and Registered Standards Committee (RSC). The ASC is responsible for developing, maintaining, and interpreting X12 standards eligible for submission as American National Standards or UN/EDIFACT International Electronic Data Interchange Standards.
- For each of the industry mentioned above – there exists X12 standards developed across the various EDI transactions.

# EDI standards

**ANSI ASC X12 –** Predominant in North America

**UN/EDIFACT** - is the only international standard and is predominant outside of North America

**Tradacoms** - is predominant in the UK retail industry

**ODETTE** - used within the European automotive industry

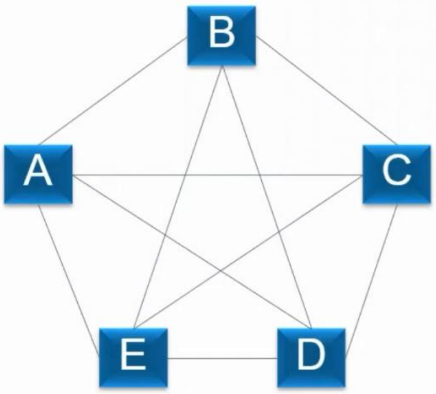
**NCPDP** - developed and maintained by the National Council for Prescription Drug Programs - electronic transmission of medical prescriptions in the United States

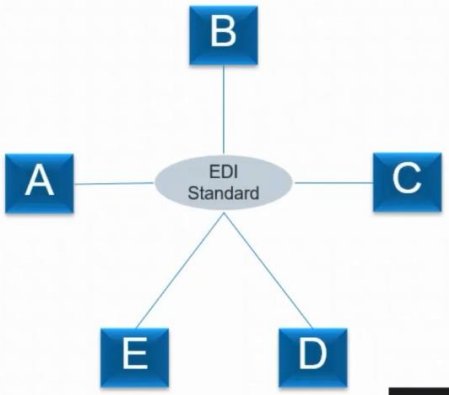
**HL7** - a semantic interoperability standard used for healthcare data

**HIPAA** -The Health Insurance Portability and Accountability ACT (HIPAA), requires millions of healthcare entities who electronically transmit data to use

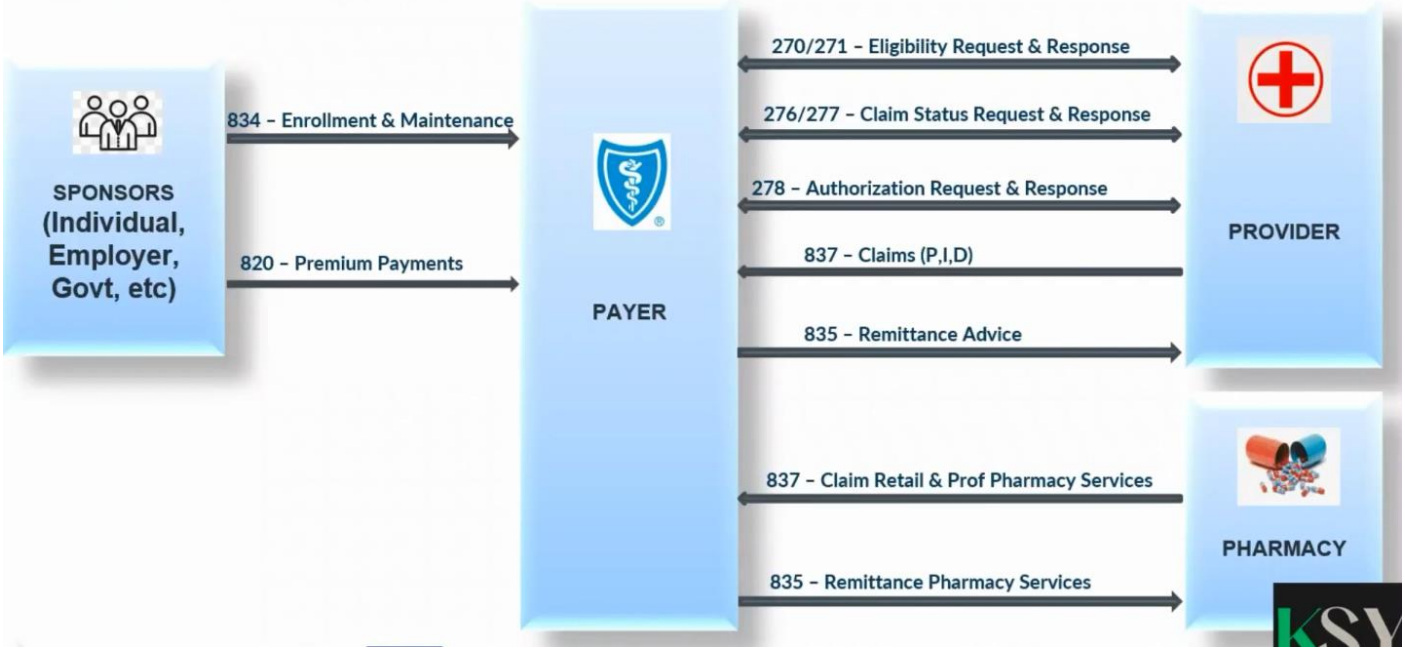
And others

# Traditional point-to-point vs standard data interchanges



# EDI – Healthcare




# Terminologies – Familiarize yourself

- Member
- Payer
- Provider
- Government
- Groups/Employers
- TPA/Clearing Houses/Exchanges
- Claims – Professional, Institutional, Dental, Pharmacy
- Patient Statements, EOB(Explanation of Benefits),ERA (Electronic Remittance Advice)

- **Subscriber/Member**:
  - A subscriber is the primary policyholder who holds the Insurance plan and is responsible for premium payments.
  - A member is any individual who is covered under the policy held by the Subscriber (e.g. Spouse, Children, other dependents)

- **Providers**:
  - Person's or healthcare entities or organizations who provide services to the patient.
  - Diagnoses and provide services to the patients
  - Get paid for the services provided
    e.g. Hospitals, Facilities, Clinics, Nursing Homes, Home Health etc

- **Payers/Health Insurers**:
  - Provide Health Insurance through various health plans, to the Employer Groups and the Individuals
  - Pays for the services provided according to the Health Plan benefits and the Insurance terms

- **Employers/Groups**:
  - Pay the Health Insurance premiums to the Insurance Companies
  - Have contracts with the Payers for the Group Insurance

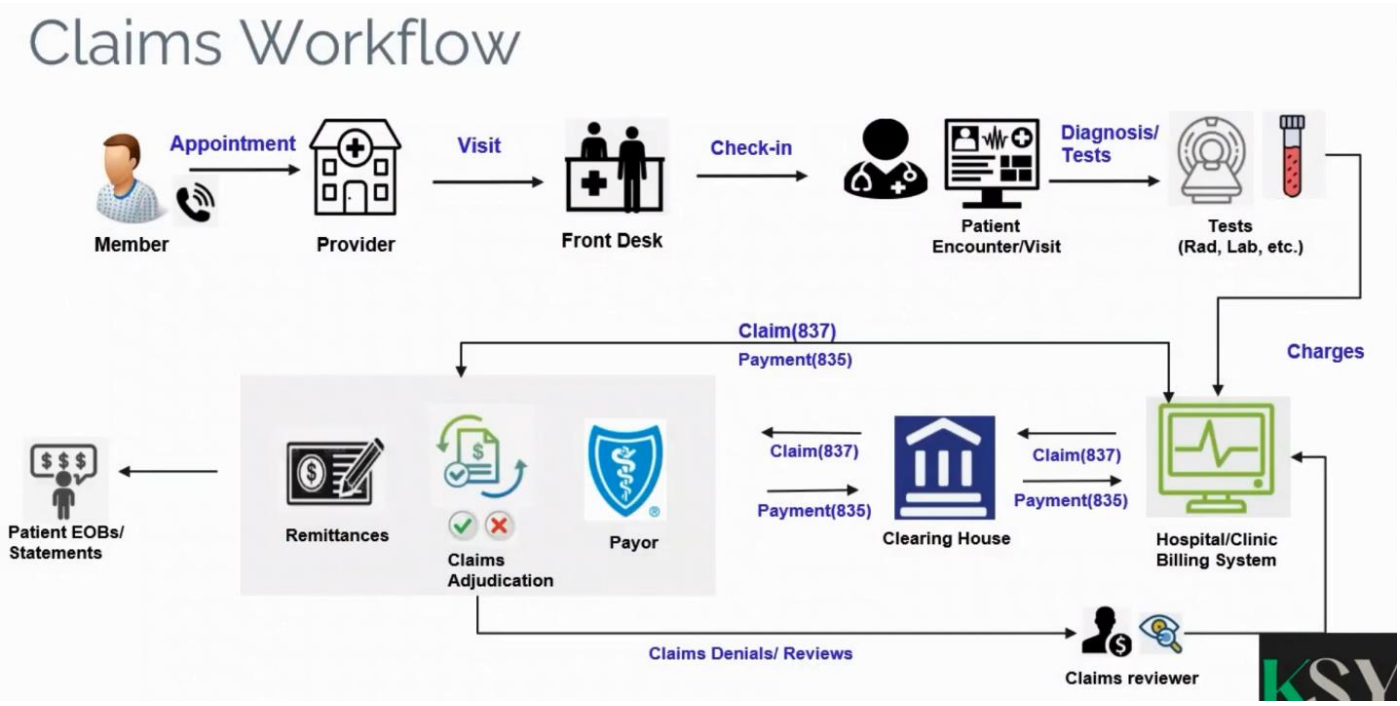
- **Government**:
  - Determines the type of Healthcare insurance to be provided to the uninsured.
  - Plans like Medicare and Medicaid are formulated by Govt.
  - Formulates the Regulates and/or Mandates (e.g HIPAA, etc)

- **Clearing Houses/3rd parties**:
  - Administers or processes the administrative activities on behalf of the Payers/Providers
  - Checks and Scrubs the Claims or payments for any errors and helps transfer the data electronically
    e.g. Emdeon (Clearing House), Administrative Service Organization (ASO)

- **Claim (Paper/Electronic)**:
  - A form that a provider submits to the Insurance company in the form of a claim to get paid (It could be a paper form or an Electronic version that is called a Claim(837)

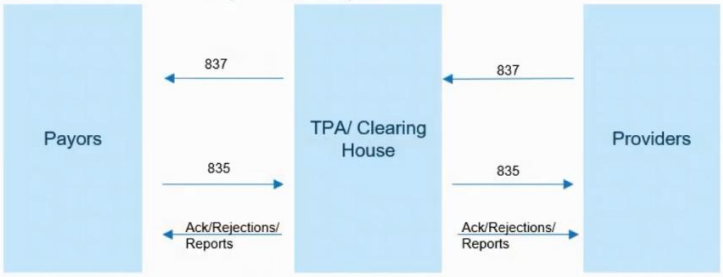
- **Payment/Remittance Advice**:
  - A form that a provider submits to the Insurance company in the form of a claim to get paid (It could be a paper form or an Electronic version that is called a Claim(837)

- **Patient EOBs/Statements**:
  - EOB referred to as 'Explanation of Benefits', is a document or a statement sent to the Member by the Insurance Company. It basically explains how the Insurance processed the claim for the services the member has received.



# Role of a Clearing House

- A Clearing House is a 3rd party organization that acts as an 'Intermediary' between the Providers and the Insurance Companies. They collect claims from the Providers, perform the scrubbing/basic error checking and routes them to the Insurance Companies. Also process the payments/Remittance advices from the Insurance Companies, Identifies any file format /standard errors prior to sending files to the Providers/Insurance companies.
- They charge standard fee for processing the claims/payments/other transactions and the fee depends on the contracts they have setup with.




# EDI format – cntd…

- Versions/Releases
  - Each EDI transaction is based on the version/release/sub-release of the ASC X12 standards

| EDI Transaction | Transaction Set | ASC X12 version | Release/Sub Release |
|---|---|---|---|
| 837P Professional Claim | 837 | 005010 | 005010X222 |
| 837I Institutional Claim | 837 | 005010 | 005010X223 |
| 837D Dental Claim | 837 | 005010 | 005010X224 |
| 835 Healthcare Claim Payment/Advice | 835 | 005010 | 005010X221 |
| 834 Benefit Enrollment & Maintenance | 834 | 005010 | 005010X220 |
| 834 Health Insurance Exchange : Enrollment | 834 | 005010 | 005010X307 |
| 820 Payroll Deducted/Group premium payment | 820 | 005010 | 005010X218 |
| 820 Health Insurance Exchange related payment | 820 | 005010 | 005010X306 |
| 270/271 – Healthcare Benefit Eligibility Inquiry & Response | 270/271 | 005010 | 005010X279 |
| 276/277 – Healthcare Claim status Request & Response | 276/277 | 005010 | 005010X212 |
| 278 – Review Request and Response | 278 | 005010 | 005010X217 |
| 997 – Functional Acknowledgement for HealthCare Insurance | 997 | 005010 | 005010X230 |
| 999 – Implementation Acknowledgement for HealthCare | 999 | 005010 | 005010X231 |

# 837 - Types of Claims

- 837 P – Professional claims
  - Claims covered for office visits, outpatient clinics, professionals including Therapists, etc.. Typically, outpatient/clinic oriented.
  - HCFA 1500 format(paper)
- 837 I – Institutional claims
  - Claims covered for Inpatient visits, Hospitalization, Nursing facilities etc.. Typically, hospital oriented.
  - UB-04 format(paper)
- 837 D – Dental claims
  - Claims covered for Dental services

CMS 1500 claim form template

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854
https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450

# 835 – ERA/Payment Advice

- The 835 contains information about the payee, payor, the amounts, identifying information of the mode of payment
- The payments are sent via the Cheques or the Electronic Transfer. ERA's can be sent directly or via 835
- One 835 transaction reflects one payment, i.e either a Cheque or the EFT transfer. Multiple claims can be referenced within one 835 file.

# 834

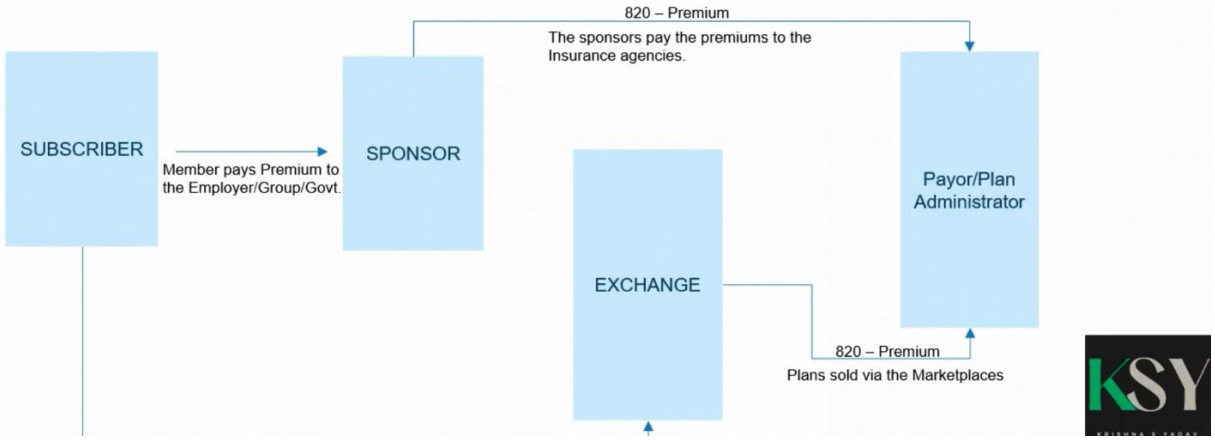
- EDI 834 transaction set is used for the Membership Benefits Enrollment & Maintenance. It contains the Subscribers information, Plan / Network information, Eligibility/Benefit information, Products/services information
- It is used by the Employers, Brokers, Exchanges, Unions, Government Agencies, Insurance agencies to Enroll the members into a Healthcare Plan.
- It primarily used for following:
  - New Membership Enrollment
  - Updates to Membership
  - Reinstating Membership Benefit Enrollment
  - Termination of Membership

# Health Insurance Exchanges

- A health insurance exchange a.k.a health insurance marketplace, is a comparison-shopping area for health insurance. Private health insurance companies list their health plans with the exchange, and people do the comparison shop on the exchange from among the available health plan listings.
- Public health insurance exchanges are used to buy individual and family health insurance plans that are compliant with the ACA ("individual and family" or "individual market" means health insurance that people buy on their own, as opposed to coverage that's obtained through an employer or via a government-run program like Medicare or Medicaid).
- The largest health insurance exchange, HealthCare.gov, is run by the federal government, serving health insurance shoppers in 36 states in 2021.
- The other 14 states and the District of Columbia each run their own exchanges (e.g., platforms such as Nevada Health Link, Pennie, New York State of Health, and Connect for Health Colorado).

# 820 - Premiums

These are the premium amounts that are paid by the Members or the Employers to the Insurance Companies, or to the Exchanges.




# 270/271 - Eligibility Request & Response

- 270: Member Eligibility Request sent by the Provider to the Payer
- 271: Response from the Payer indicating the response

# 276/277 – Claim Status Request/Response

- 276: Claim Status Request sent by the Provider to the Payer
- 277: Response from the Payer indicating the response of the claim status

# 278 – Healthcare Services Review

- 278: Request for review, certification, notification or reporting the outcome of a health care services review.
- 278 transaction set refers to Health Care Services Review Information. A healthcare provider sends a 278 transaction to request an authorization from a payer. The request can be to review the proposed healthcare services to be provided to a given patient and get an authorization for the provider to move ahead with the services.