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2011 EDI Administrative Transaction Review

Electronic data interchange (EDI) is a standardized method for transferring data between different computer systems or networks.[1] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the adoption of national standards for electronic transactions between payers and providers.[2] Electronic health claims generate cost savings when compared to paper health claims by creating efficiencies, such as replacing information flows that require human intervention such as sorting, distributing, organizing, and searching paper documents. Additionally, EDI can reduce errors by eliminating the need to reenter documents and by reducing claims processing times, enabling faster payment cycles with electronic payments available. COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks*, requires payers with an annual premium exceeding $1 million to report the volume of electronic and paper claims and other administrative transactions processed in each calendar year to the Maryland Health Care Commission (MHCC) by June 30th. The MHCC uses the information provided by the payers to develop a brief that reports on the trends by the payers and providers in increasing the use of electronic claims technology.

A total of 42 payers submitted data this year including six large private payers (Aetna, CareFirst, CIGNA, Kaiser, MAMSI, and United Healthcare), 27 other private payers, and government payers (Medicare, Medicaid, and the seven Medicaid Health Choice Managed Care Organizations (MCOs)). EDI volumes increased approximately 3.3 percent from 2009 to 2010, which was more than twice the increase reported in the prior year's report from 2008 to 2009 (*Table 1*). Both the government and private payers experienced an increase in the number of electronic transactions processed in 2010.

The number of hospital and practitioner electronic claims processed increased by about 1.3 percent in 2010. The number of dental claims submitted electronically in 2010 rose by around 34 percent due to the nearly 84 percent increase in claims submitted electronically to government payers. As of 2010, Medicaid participating providers are required to submit dental claims electronically through an administrative service organization[3] (ASO). With a change in the federal poverty guidelines that allowed more Marylanders to become eligible to receive Medicaid benefits, the number of people receiving care from one of the seven MCOs increased as enrollments rose and increased the MCOs share in total electronic claims by one to 9 percent. The increase in the enrollment in the MCOs is significant when one takes into account that dental claims transactions previously provided to women and children under the HealthChoice Program and reported by the MCOs is now covered as of July 1, 2009 and reported under the Medicaid program.

Table 1

Maryland EDI Activity Overview (%)

Provider Type	Government		Variance	Private		Percent Change	Total Payers		% Change
	2009	2010	+/-	2009	2010	+/-	2009	2010	+/-
Practitioner	91.1	91.3	0.2	82.4	84.8	2.4	86.9	88.1	1.2
Hospital	91.3	92.4	1.1	85.4	87.7	2.3	88.5	90.2	1.7
Subtotal	**91.1**	**91.5**	0.3	**82.7**	**85.1**	2.4	**87.1**	**88.3**	**1.3**
Dental	14.7	98.6	84.0	40.5	43.5	2.9	33.8	67.8	34.0
Total	**88.6**	**91.9**	3.2	**78.8**	**82.1**	3.3	**83.7**	**87.0**	**3.3**

Figure 1

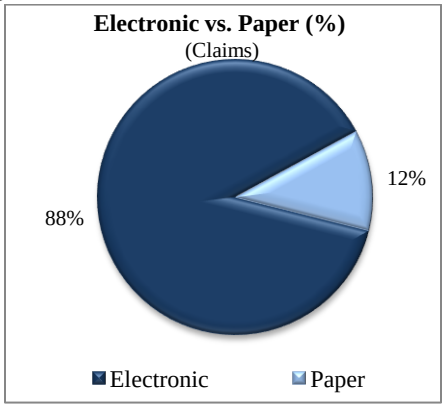


Figure 2

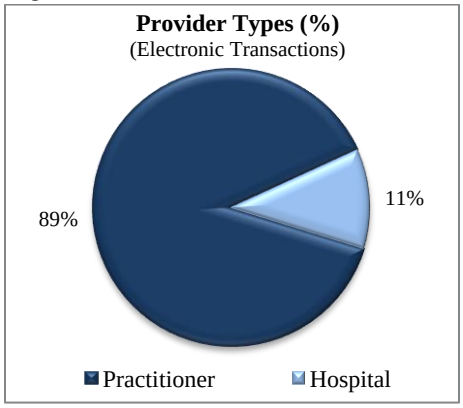
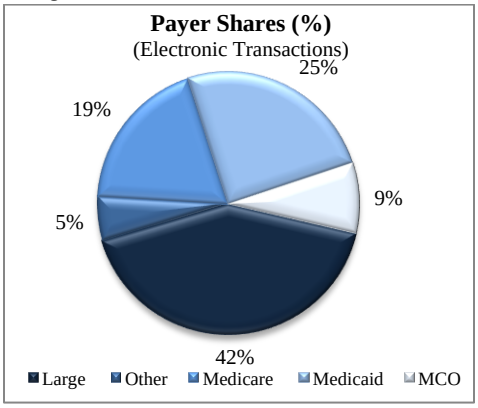


Figure 3



[1] Available at: http://www.techterms.com/definition/edi.
[2] Centers for Medicare and Medicaid Services. Available at: http://www.cms.gov/hipaageninfo/.
[3] Definition from Department of Health and Mental Hygiene, an organization retained to provide administrative services, such as utilization review, preauthorization of services, and payment of claims. Available at: http://dhmh.maryland.gov/csrrc/glossary.htm.

Other Administrative Transactions

HIPAA standard transactions promote administrative simplification by providing strict format rules to ensure the integrity and maintain the efficiency of the interchange.[4] The American National Standards Institute Accredited Standards Committee X12 (ANSI ASC X12) adopted standards for eight health care transactions that include health care claims, eligibility, claim status, claim payment and remittance advice, enrollment and disenrollment in a health plan, referral certification and authorization, and the plan premium payments. These transaction standards help ensure the integrity and increase the operating efficiencies for electronic transactions. During this reporting period, a total of four private payors began processing in 2010 an 834 transaction (*enrollment/disenrollment in a health plan*). Similarly, another group of four payors started processing an 835 transaction; with this year, *claim payments and remittance advice* has moved ahead with regard to the other administrative transaction processed by private payors (*Table 2*).

Table 2

Payers Supporting Other Administrative Transactions

Other Administrative Transaction Types	2008 (n = 20)	2009 (n = 25)	2010 (n = 30)
Health Plan Eligibility (270/271)	17	22	22
Health Claim Status (276/277)	16	21	22
Referral Certification & Authorization (278)	8	9	11
Health Plan Premium Payments (820)	3	4	6
Enrollment/Disenrollment in a Health Plan (834)	10	12	16
Claim Payment & Remittance Advice (835)	17	21	25

Web and Batch Transactions

Payers can support other administrative transactions through batch files or through web portals. Web portals allow providers to verify individual patient information at the time care is rendered, while batch transactions allow a single, simultaneous file transmitted to payers for multiple patients. Most payers provide either batch or web-based transactions, or a combination of both, offering the batch mode for one transaction, and web-based access for another. MAMSI and CareFirst started processing additional other administrative transactions in 2010, with MAMSI now capable of supporting both web and batch transactions for all eight of the ANSI ASC X12 health care transactions. Five of the six payers can process either a web based 270/271 or 276/277 transaction, with Kaiser the one exception for both transactions. Similarly, excluding Aetna, five payers can process a batch type 835 transaction. (*Table 3*).

Table 3

Large Private Payers Supporting Web-Based (W) vs. Batch (B) Transactions

Payer	270/271				276/277				278				820				834				835			
	2009		2010		2009		2010		2009		2010		2009		2010		2009		2010		2009		2010	
	W	B	W	B	W	B	W	B	W	B	W	B	W	B	W	B	W	B	W	B	W	B	W	B
Aetna	x		x		x		x		x		x										x		x	
CareFirst	x		x		x		x		x		*						x		x	x		x		x
CIGNA	x		x		x		x		x		x			x		x		x		x	x	x	x	x
Kaiser		x		x		x		**														x		x
MAMSI	x	x	x	x	x	x	x	x	x	x	x	x			x	x		x	x	x		x	x	x
United Healthcare	x	x	x	x	x	x	x	x	x	x	x	x		x		x		x		x	x	x	x	x
Total	**5**	**3**	**5**	**3**	**5**	**3**	**5**	**2**	**5**	**2**	**4**	**2**	**0**	**2**	**1**	**3**	**1**	**3**	**2**	**4**	**3**	**5**	**4**	**5**

*CareFirst did not implement 278 transactions in 2009 and did not process these transactions in 2010.

** Kaiser replaced 276/277 transactions with 277U transactions. While 277U is in the same format as the 276/277, the 277U is not required by HIPAA.

[4] American Medical Association Practice Management Center, *Understanding the HIPAA Standard Transactions: The HIPAA Transactions and Code Set Rule*, 2009, P. 1. Available at www.ama-assn.org/ama1/pub/upload/mm/368/hipaa-tcs.pdf.