How EDI Works and Helps Care Providers

Electronic Data Interchange (EDI) is the automated transfer of data between a care provider and a payer. The benefits to care providers include quicker turnaround of information, reducing administrative expenses and avoiding claim processing delays.

Using EDI allows payers and care providers to send and receive information faster, often at a lower cost. This overview explains the benefits of EDI to care providers and provides the types of electronic transactions used, in addition to other information on EDI.

EDI Benefits

Using EDI to exchange information with UnitedHealthcare and other payers may benefit care providers and their billing services. The benefits to care providers:

- **Sending and receiving information faster**
  Turnaround times are typically quicker than using manual processes. For example, a payer can receive a claim the same day the care provider sends it, and an eligibility inquiry can be received and responded to in seconds.
- **Identifying submission errors immediately and avoiding claim processing delays**
  Electronic claims are automatically checked for HIPAA and payer-specific requirements at the vendor, clearinghouse and payer levels. This process decreases the reasons a claim may be rejected by the payer. This same level of automated data verification can't be performed on paper claims.
- **Lowering account receivables**
  Electronic transactions, such as the eligibility transaction, provides the patient's current coinsurance, deductible and benefit information when they're in for an appointment and before the claim is submitted to the payer for processing. This allows the care provider to collect a copayment at the time of service.
- **Reducing administrative expenses**
  EDI cuts down on purchases of paper, forms, supplies and postage. It also saves time faxing, printing, sorting and stuffing envelopes.
- **Spending less time on the phone**
  EDI reduces calls your staff needs to make to UnitedHealthcare to obtain information on our members, claims, claim payments, authorizations and referrals.
- **Exchanging information with multiple payers**
  EDI lets you complete transactions for multiple payers at one time. Transactions can be set up to automatically generate in a practice's daily workflow. For example, a practice management system could perform a claim status inquiry at the same time it sends eligibility inquiries to verify a member's benefit coverage and copayment.

Types of EDI transactions

- 270/271: Eligibility and Benefit Inquiry and Response
- 276/277: Claim Status Inquiry and Response
- 278: Authorization and Referral Request
- 278I: Prior Authorization and Notification Inquiry
- 278N: Hospital Admission Notification
- 835: Electronic Remittance Advice (ERA)
- 837D: Dental Claim
- 837I: Institutional Claim
- 837P: Professional Claim or Vision Claim

How EDI Works

Often, care providers use a clearinghouse to exchange information between their practice and payers, such as transactions for verifying eligibility and benefits or checking the status of a claim. These electronic transactions are standard in the health care industry and not specific to UnitedHealthcare.

Steps of an EDI Transaction

1. EDI transactions start with an inquiry from the care provider and conclude with a response from the payer.
2. The inquiry is submitted by supplying certain required data fields, such as member ID number, date of birth and Payer ID.
3. This inquiry can go directly to the payer, but it often goes through a clearinghouse contracted by the care provider.
4. The clearinghouse facilitates the inquiry to the payers.
5. Once the payer receives the inquiry, they send the response back to the clearinghouse.
6. The clearinghouse then sends the data to the care provider's practice management system.
7. If there's an error in the data, the care provider will correct it and resubmit it to the clearinghouse for a response. EDI transactions can be completed for one or more members.

Sample scenario of how EDI works

A medical group is scheduled to see 100 patients from various payers on a Tuesday. They want to verify coverage and know how much to collect before the appointments. Using the 270 transaction for the inquiry for eligibility and benefit information, the payer returns the 271 transaction as the response. For this example, here's what would happen:

- The care provider's practice management system compiles the required information for the patients who have appointments on Tuesday.
- The 270 inquiry transaction goes to the clearinghouse, which sends the 270 transaction to each payer.
- The payer returns a 271 response transaction with confirmation of coverage/eligibility, copayment, coinsurance and deductible information and other benefit details.
- The 271 transaction is returned to the clearinghouse for formatting and transmitted into the care provider's practice management system.
- On Tuesday morning, the care provider staff sees confirmation of coverage and the cost sharing amounts on their computers before the patient arrives.
- If there were errors with any 270 transaction requests, the information can be corrected in the care provider's practice management system and resubmitted for an immediate response.
- If the care provider needs more information than the EDI transaction provides, they can use the Link self-service tools to get additional information at UHCprovider.com/Link. Information can also be provided with Application Programming Interface (API), set up by your vendor, clearinghouse or IT department. Visit UHCprovider.com/api for more information on our API solutions.

Cost Savings

- CAQH, a nonprofit alliance, is the leader in creating shared initiatives to streamline the business of health care. The 2019 CAQH Index shows that the average cost to conduct transactions manually is higher than the cost of electronic transactions for care providers and health plans. Review the complete CAQH Index for more details. Use the CAQH Index Savings Calculator to estimate potential cost and time savings for your organization.

Below is an excerpt from Table 1 in the 2019 CAQH Index. It shows the average cost and savings opportunity, per transaction, for health plans and care providers, related to manual and electronic transactions.

Transaction	Method	Plan Cost	Provider Cost	Industry Cost	Plan Savings Opportunity	Provider Savings Opportunity	Industry Savings Opportunity
Eligibility and Benefit Verification	Manual	$3.47	$5.30	$8.77	$3.43	$4.12	$7.55
	Electronic	$0.04	$1.18	$1.22			
Prior Authorization	Manual	$3.32	$10.92	$14.24	$3.27	$9.04	$12.31
	Electronic	$0.05	$1.88	$1.93			
Claim Submission	Manual	$0.92	$3.30	$4.22	$0.83	$2.33	$3.16
	Electronic	$0.09	$0.97	$1.06			
Attachments	Manual	$0.56	$4.50	$5.06	$0.34	$2.17	$2.51
	Electronic	$0.22	$2.33	$2.55			
Claims Status Inquiry	Manual	$3.48	$6.65	$10.13	$3.44	$4.28	$7.72
	Electronic	$0.04	$2.37	$2.41			
Claim Payment	Manual	$0.67	$2.51	$3.18	$0.59	$1.00	$1.59
	Electronic	$0.08	$1.51	$1.59			
Remittance Advice	Manual	$0.46	$3.76	$4.22	$0.41	$2.55	$2.96
	Electronic	$0.05	$1.21	$1.26			

Note: Costs include the labor time required to conduct the transaction, not the time and cost associated with gathering information for the transaction and follow-up. Does not include system costs. All participants were asked to report cost for each transaction by the two modes of completion (manual and electronic).

The CAQH Index was created as an industry-wide resource for tracking the transition from a paper- and phone-based system to an electronically-enabled system.

Digital Solutions

EDI: **UHCprovider.com/edi** for more information about EDI transactions.

API: **UHCprovider.com/api** to learn more about our Application Programming Interface solution.

Link: **UHCprovider.com/link** for using our self-service tools.

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