EFT Relationship to the 835 Issue Brief

Electronic Funds Transfer Payments’ relationship to the Electronic Remittance Advice transaction – The one-to-one relationship between the EFT and ERA

September 17, 2015
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I. Introduction

Payments for healthcare claims can be made either electronically or via paper checks. To transmit healthcare claim payments electronically using the Healthcare Electronic Funds Transfer (EFT) Standard adopted by the Department of Health and Human Services (HHS), the ACH Corporate Credit or Debit Entry Plus Addenda (CCD+) transaction is utilized. The Provider also needs to receive remittance advice information for the claims included in that payment. This information can be received electronically using the ASC X12N Healthcare Claim Payment / Advice (835)\(^1\) transaction or via a paper or online remittance advice / Explanation of Benefits (EOB) / Explanation of Payment (EOP).

Because the Provider may receive the EFT and remittance advice information at different times, both sets of information include specific data elements needed to reassociate (match) the EFT and remittance advice to each other, and to post the information to Provider’s accounts receivable systems or Payer’s systems. The Provider must be able to match the two transactions (EFT and remittance advice) using information that correlates between them.

This process of matching up the healthcare claim and the remittance advice can be frustrating and challenging for Providers. When the payment included in the EFT or check do not correspond to the payment amount and claims included in the remittance advice, this reassociation process becomes even more complex and can even pose a compliance issue. An industry survey conducted in early 2014 through the joint efforts of the WEDI 835 and EFT subworkgroups indicated that providers and health plans were continuing to have challenges with Electronic Remittance Advices (ERA) and their relationship to the corresponding EFT files.

II. Purpose of this Issue Brief

The purpose of this issue brief is to respond to the challenges that came to light in the 2014 survey and to assist providers and payers with the challenges of processing the 835 payment transactions, offering clarification on how EFT payments should be issued, and describing how the corresponding 835 remittance advice should be created to allow for reassociation of the EFT files. While this issue brief focuses on EFT transactions sent via the ACH Network, the same challenges apply to any payment type (paper or electronic) and must be considered so that reassociation is possible by the provider.

The 820 transaction (for Healthcare Premium Payments) has similar challenges; however, for clarity’s sake these are not addressed in this document. A separate document has been prepared to address these concerns with the 820 transaction, “The one-to-one relationship between the EFT and Premium Payment.”

III. Definitions

ASC X12N 835/ERA – The 835 is the ASC X12 transaction for the Healthcare Claim Payment / Electronic Remittance Advice (ERA), and is the HIPAA-required transaction set to use for healthcare claim payments, using the ASC X12N/0005010x221 Health Care Claim Payment/Advice (835) TR3.

ACH – Automated Clearing House Network. The Automated Clearing House is used by government and commercial sectors for financial institutions in the United States to transfer funds from one account to another. An electronic funds transfer system that provides for the distribution and

\(^1\) ASC X12N/0005010x221 Health Care Claim Payment/Advice (835)
settlements of payments among financial institutions. The ACH Network is governed by the *NACHA Operating Rules & Guidelines*.

ASC X12 – The Accredited Standards Committee X12 was chartered by the American National Standards Institute (ANSI) to drive global business processes. ASC X12 develops and maintains electronic data interchange (EDI) standards, as well as, other standards and schemas (CICA, XML) for many industries (healthcare, insurance, transportation, supply chain, etc.).

CAQH CORE - Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE) is a national multi-stakeholder initiative that streamlines electronic healthcare administrative data exchange and improves health plan-Provider interoperability through the development of industry-wide operating rules. CAQH CORE has been designated by the Department of Health and Human Services (HHS) as the operating rule authoring entity for Federal mandates related to healthcare standards under ACA Section 1104.

CCD - is an ACH Corporate Credit or Debit Entry. A NACHA format used to deliver payments through the ACH Network. X12 documentation continues to refer to the CCD using older terminology as a Cash Concentration or Disbursement transaction. The CCD+ format is the CCD with the additional Addenda Record included in the file (CCD Plus Addenda).

Clearinghouse - “healthcare clearinghouses” are defined as organizations that send or receive nonstandard / standard data content and then format it into standard / nonstandard data elements or transactions.

DFI – Depository Financial Institution: A bank, credit union, or savings institution.

EFT - Electronic Funds Transfer (EFT) is any electronic mechanism that payers use to instruct one DFI to move money from one account to another account at the same or at another DFI. The term includes ACH transfers, wire transfers, and credit cards.

ERA – The Electronic Remittance Advice is an EDI transaction describing the payer, payee, payment amount, and other identifying information about the payment. It also includes other information that resulted from the adjudication process, including denial information and adjustment reasons and amounts.

Health Plan - For the purposes of this paper, “Health Plan”, or its agent, is used interchangeably with “Payer”, and means a plan, program or organization that pays for the cost of healthcare services.

NACHA – The Electronic Payments Association manages the development, administration, and governance of the ACH Network. NACHA is responsible for the administration, development, and enforcement of the *NACHA Operating Rules* which provide a legal framework for the ACH Network and guide risk management and create payment certainty for all participants.

**NACHA Operating Rules –**

- **Delivery of payment related data from financial institution to healthcare Provider:** Effective September 20, 2013 the *NACHA Operating Rules* require that all RDFIs include one secure electronic delivery option available for Providers in addition to any other method to deliver the payment-related information to the Provider. However, the *NACHA Operating Rules* require that, upon the request of the Provider (the Receiver), the Provider’s financial institution (RDFI) must provide all information contained within the Payment Related Information field in the CCD Addenda Record. The Provider’s financial institution must have procedures in place to respond to requests from Providers (Receivers) that desire to receive payment-related information transmitted with these entries. The *NACHA Operating Rules & Guidelines* encourages RDFIs to
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determine, in conjunction with the Receiver, the method by which the addenda record information will be provided. See Subsection 3.1.5.3 of the 2013 NACHA Operating Rules & Guidelines.

NPI: the National Provider Identifier is a unique 10-digit identification number assigned to healthcare Providers in the United States by CMS.

Operating Rules - The Patient Protection and Affordable Care Act defines operating rules as “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.”

Payer - For the purposes of this paper, “payer” is defined as an organization that pays for the cost of health care services.

Pre-Note - A pre-note / prenotification is a non-monetary entry sent through the ACH Network by an Originator to a Receiving Depository Financial Institution (RDFI). It conveys the same information (with the exception of the dollar amount and transaction code) that will be carried on subsequent entries, and it allows the RDFI to verify the accuracy of the account number. It is used to validate account information before any monies are sent through.

Provider - For the purposes of this paper, “Provider” is defined as an individual or organization that provides health care services.

Reassociation - Matching a payment to the remittance advice data received.

Vendor - For the purposes of this paper, “vendors” are being defined as organizations that create health care data (e.g., practice management systems, billing systems, and billing services).

IV. Determining the Payee in the EFT and 835

Providers have differing needs when it comes to receiving their payments. Some may have a single facility, a centralized billing service, or single accounts receivable system, and wish to receive all their payments in a consolidated fashion for reconcilment and posting. Others may have multiple facilities or multiple accounts receivable systems and need to have their payments broken up in such a way that the information flows to the correct location for posting.

When contracting with payers, when enrolling for EDI transactions with payers, and then when submitting claims for payment, Providers must keep in mind their requirements for the grouping of their payments, and how they need to convey that to the payer. For contracted providers, Payers may set up tables or databases linked to contracts and payment rules (frequency/remit to/correspondence addresses) by rendering provider, facility, group or billing provider, which defines in their system how the payments will be generated for a specific payee. As a result, Providers must clearly define how they need to be paid. During the enrollment process for both EFT and ERA, Providers have the opportunity to specify how they want their information grouped in their files/payment. Providers should

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2 Note: There are a number of terms in the health care industry that are identical to terms used in the financial industry but they mean very different things. For example, “Provider,” “trace number” and “clearinghouse” are used in both industries but have different definitions. In any discussion with a financial institution, qualify terms so their meanings are clear.

3 CAQH CORE Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule version 3.0.0 June 2012, p. 19
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review their initial setup with the payer to ensure that their current needs are consistent with the terms of the contract. If the enrollment conflicts with the payer configuration for that Provider, the Provider may not have their payments grouped as expected. In many cases, payments to the Provider are driven by their initial setup/contract and not necessarily by the EFT / ERA EDI enrollment form.

While many Payers do not use this information, a best practice would be to gather this information and create EFT and ERA files based upon the Provider’s stated preferences. In addition, as medical claims are submitted, the Provider indicates the billing / pay-to provider on the claims that are submitted. This is yet another opportunity for the Payer to gather information on the Provider’s preferences for creation of the payment and remittance advice and for non-contracted is the only setup/configuration that the payer may receive.

A. Challenges Introduced by the NPI

As the healthcare industry implemented the NPI, complexity for determining the payee increased. Prior to the NPI, processing was primarily by TIN, so there was one unique identifier for the payee. With the introduction of the NPI, however, the Provider could enumerate to any granularity to best fit their business practices. Now, a specific TIN could be represented by several (or hundreds of) NPIs. The impacts were (and remain) considerable as the industry continues to adapt to what that means to the grouping of claim payments in the 835 delivered to the provider.

In prior years, the payers determined how the payments were distributed without input from the providers, overly complicating the payment posting processes employed by the provider, as well as adding to their administrative costs. In most cases, payments were made at the TIN level and grouped together by the payer’s processing rules such as: self-funded, zero payments, paid claims, etc., regardless of what came in on the claim or what made business sense to the Provider’s operations. Implementing the NPI provided a means to group the payment information in a way that better facilitated automation for the provider. So an example might be:

A large hospital has multiple facilities, including Radiology, Oncology, and Physical Therapy. These entities have different practice management systems and are autonomous - they act completely independently of each other. In this example, the hospital can enumerate to the level that facilitates their business practices and get a different NPI for each of the different groups (total of three). This prevents the hospital from having to divide payments and manually handle the remittance advice. Because transactions can be routed to the correct location by NPI, funds are directed to the correct bank accounts and posting automation is now possible.

Pharmacy may also have unique situations, for example a non-covered entity such as a corporate office receiving the payments that need to be grouped by TIN. Other types of providers may arrange with their payers to receive payments by TIN as well so that they can get a single payment for multiple NPIs when their facilities share a billing office or accounts receivable system. It is extremely important for Payers and Providers to communicate regarding the requirements for grouping both the payment and the remittance advice.

V. Requirements in the 835 showing that there is a one to one relationship

In order to ensure that providers can reassociate the EFT and remittance advice (835), there is a requirement for a one to one relationship between the EFT and the 835. Due to its importance, this requirement was referenced in section II.F of the EFT Standards Final Rule:

45 CFR Parts 160 and 162, “Administrative Simplification: Adoption of Standards for Health Care
II.F. Other Factors in the Reassociation of the EFT with the ERA

- According to the X12 835 TR3, the total amount of payment transmitted in the health care EFT must equal the total amount of payment indicated on an associated ERA. If a health plan does not comply with this implementation specification, then reassociation will be difficult.

The 835 Technical Report Type 3 (TR3) contains multiple references to the fact that there is a one to one relationship between the payment and the 835 transaction set. Because this TR3 has been adopted as one of the HIPAA standard transactions, failure to comply with these requirements in the 835 makes the transaction non-compliant.

The following sections from the 005010x221 835 TR3 clearly reference the requirement regarding this relationship:

1.10.1.1 Payment

One 835 transaction set reflects a single payment device. In other words, one 835 corresponds to one check or one EFT payment. Multiple claims can be referenced within one 835.⁵

1.10.1.4 Remittance

The 835 must be balanced whenever remittance information is included in an 835 transaction. For a balanced 835, the total payment must agree with the remittance information detailing that payment. The remittance information must also reflect an internal numeric consistency.⁶

1.10.2.2 Remittance Tracking

NOTE

Due to the need for remittance tracking, there is a one to one relationship between any specific 835 and the related payment mechanism (check or EFT). One 835 must only relate to a single payment mechanism and one payment mechanism must only relate to a single 835. The only exception is a non-payment 835 (BPR02=0) where there is no associated payment mechanism.⁷

TRN – Reassociation Trace Number Segment⁸

TR3 Note: This segment’s purpose is to uniquely identify this transaction set and to aid in reassociating payments and remittances that have been separated.

TRN02 Element Note: This number must be unique within the sender/receiver relationship. The number is assigned by the sender. If payment is made by check, this must be the check number. If payment is made by EFT, this must be the EFT reference number. If this is a nonpayment 835, this must be a unique remittance advice identification number.

VI. Structure of the Payment and Remittance Transactions

A. EFT – how payments are grouped in the EFT

⁵ ASC X12 835 5010x221 TR3 page 7
⁶ ASC X12 835 5010x221 TR3 page 12
⁷ ASC X12 835 5010x221 TR3 page 19
⁸ ASC X12 835 5010x221 TR3 page 77
The EFT CCD+ file begins with a File Header Record and ends with a File Control Record. After the File Header Record may be any number of batches, identified by a Company / Batch Header Record and ending with a Company / Batch Control Record. Batches are grouped by the Company Name and Effective Entry Date. Each batch contains one or more Entry Detail Records, accompanied by an Addenda Record for each Entry Detail Record.

The CCD+ Entry Detail Record contains information about the payment, and the receiver of the payment (Provider for claim payments). It includes the name and identification number for the Receiver (usually the TIN), their bank account number, and amount of the payment. It also includes an ACH Trace Number, which is assigned by the Originator’s Depository Financial Institution (ODFI) for tracking and routing within the ACH Network. This ACH Trace Number is not the same as the TRN Reassociation Trace Number assigned in the corresponding 835 file by the Payer (found in the TRN segment of the 835).

The CCD+ Addenda record includes information needed to reassociate the CCD+ file to the corresponding ASC X12 file by the Provider. For Healthcare Claim Payments, the Payment Related Information field in the Addenda record contains an exact copy of the entire TRN segment from the corresponding 835 file in order to provide information needed to reassociate the files.

A CCD+ batch can contain entry detail records for multiple receivers at the RDFI, but all must have the same Effective Entry Date. To include payments for another Effective Entry Date, a new batch must be started.

Example:

**Batch #1, Effective Entry Date 1/5/15**

Entry Detail Record #1 – Receiver #1, TIN 123456789, Payment Amount $100.00
Addenda Record #1 – Payment Related Information
TRN*1*1234567896*1326549870*PLAN123~

Entry Detail Record #2 – Receiver #1, TIN 123456789, Payment Amount $350.00
Addenda Record #2 – Payment Related Information
TRN*1*2345678912*1326549870*PLAN123~

Entry Detail Record #3 – Receiver #2, TIN 234567891, Payment Amount $1000.00
Addenda Record #3 – Payment Related Information
TRN*1*3456789123*1326549870*PLAN123~

**Batch #2, Effective Entry Date 1/7/15**

Entry Detail Record #1 – Receiver #1, TIN 123456789, Payment Amount $250.00
Addenda Record #1 – Payment Related Information
TRN*1*4567891234*1326549870*PLAN123~

**B. 835 – how payments are grouped in the 835**

The 835 Transaction Set is included in an Interchange, beginning with an ISA segment (like a File Header) and ending with an IEA segment (like a File Trailer). Within the Interchange, a Functional Group (beginning with a GS segment and ending with a GE segment) incorporates one or more transaction sets. The Transaction Set begins with an ST segment (like a batch header) and ends with an SE segment (like a batch trailer). The 835 Transaction Set (835) contains information about the
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payer, the payee, the amount, and detail about the claims that are included in the payment amount. One 835 Transaction Set contains information for one payment to one payee. More than one 835 Transaction Set can be included in the Functional Group, but each 835 Transaction Set is associated with a unique Payee / Payment combination (i.e. the Payee, payment amount, payment date, EFT Trace # / Check Number would all have to be unique in each 835). The Payee is identified within the 835 with a name and identifier, which is usually a National Provider Identifier (NPI) unless the Payee does not have an NPI, then only the TIN is used for identification. When NPI is used as the identifier, the TIN is present in the 835 also in the 1000B REF*TJ segment.9

The 835 includes the ability to batch or group payments together more granularly by using the 2000 loop, which includes the LX and TS3 segments. In the TS3 segment, the first element identifies a specific provider identifier related to all claims within that iteration of the 2000 loop. Using this mechanism, the payment can be made at a higher level (e.g. Group NPI), and then the payment detail can be batched by subsidiary identifiers (like individual NPIs) to further meet the needs of Providers. For example, the payment may be made to the Clinic group NPI, with a 2000 loop for each rendering NPI included in that payment.

a. Identifiers in the EFT related to the 835

As described in Section VI.A, the identifier in the Healthcare Claim Payment EFT is typically the TIN in the Entry Detail Record, even when the payment is broken down to the NPI level. NPI is the required identifier in the 835 for the payee with the exception of atypical providers, pharmacy, and other situations. The TIN will appear in the 835 to aid in reassociation in the TRN03 element, and the EFT Trace Number (TRN02) assigned by the payer must be unique to that specific payment and 835 in this sender/receiver relationship and must appear in both the EFT Addenda Record and the 835 TRN segment.

b. Non-Payments and the 835

In situations where the payment to the provider is zero (different than a pre-note), the 835 TR3 prohibits an EFT transaction from being generated. When the payment amount is zero, the 835 TR3 has specific requirements: BPR01 must be “H”, BPR04 must be “NON”, and BPR05 is not sent. No identifying information (transaction type, ABA number, or account number) is allowed to be sent. Therefore, while the NACHA Operating Rules allow a zero dollar transaction to be included in the CCD+ transaction through the ACH Network, the 835 requirements do not allow an EFT transaction to be generated for a remittance advice that equals a zero payment.

When a zero payment occurs, an 835 is generated that reflects the zero payment amount, and includes all the claim detail for the payment, and this 835 still needs to be retrieved by the provider (or their agent) for posting to their PMS. Since no EFT / CCD+ accompanies the 835, there is no file to reassociate to the 835, so these 835s will create an exception during any automated reassociation process. Once recognized as a zero payment, these 835s can be posted.

9 RFI 1682 clarifies the requirement for TIN when the NPI is used as the identifier. http://www.x12.org/x12org/subcommittees/x12rfi.cfm
C. How do the transactions tie together?

The EFT and the 835 have a one-to-one relationship. One payment reflected in a CCD+ Entry Detail Record must have a corresponding 835 Transaction Set containing the Payee and claim detail describing what claims comprise the payment. If the payment is made at the provider’s TIN level, the 835 must still include an NPI identifier for the Payee (where applicable), usually their “main” NPI or group-level NPI, based upon the agreement made between the payer and provider during registration, or even a cross-reference table in the payer’s system. The TIN will also be included in the 835 as an “additional identifier” for the Payee. If the payment is made at the provider’s NPI level, the TIN is the identifier included in the EFT. The entity identified by the NPI receiving the payment is included in the 835 as the Payee’s NPI. In each case, a unique EFT Trace Number value is required to be assigned by the Payer and included in the CCD+ Addenda Record and the 835 TRN segment.
VII. How the EFT and ERA are reassociated

During the process of enrolling to receive EFT payments, the Provider must contact their financial institution to arrange to receive the CCD+ Payment Related Information that is needed for reassociation. When both the healthcare EFT (along with that Payment Related Information) and the ERA to which it corresponds, arrive at the Provider’s office or are downloaded into the Provider’s practice management system (PMS) (often at different times), the two transmissions must be matched back together. Ideally, reassociation of the ERA with the EFT is automated through functionality provided by the Provider’s PMS system. In practice, the process of matching the payment to the associated remittance advice must often be done manually by administrative staff. Information from the 835 such as Trace Number, Payment Amount, and Effective Entry Date must be matched against information in the CCD+ to determine which 835 matches to which EFT. Once a match is determined, the practice management system / accounts receivable system / processing system can be updated.

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“Two key pieces of information facilitate reassociation -- the trace number in the Reassociation Key Segment, TRN02, and the Company ID Number, TRN03. The trace number in conjunction with the company ID number provides a unique number that identifies the transaction.”

The table below outlines the data elements which can be used to reassociate the 835 to the EFT transaction, and where those data elements are located in the two transactions.

<table>
<thead>
<tr>
<th>ASC X12 835 ERA Data</th>
<th>ACH – CCD+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Federal Tax ID (Payer)</strong></td>
<td><strong>Company ID</strong></td>
</tr>
<tr>
<td>• Located in BPR10 and TRN03</td>
<td>• Batch Header, Record Type 5, Field Number 5, positions 41-50</td>
</tr>
<tr>
<td>BPR<em>I</em>306.04<em>C</em>ACH<em>CCP</em>01<em>123456789</em>DA<em>0123456789</em>1133557799<em>666660000</em>01<em>043210123</em>DA<em>987654321</em>20130131<del>AND TRN<em>1</em>0057940746*1133557799</del></td>
<td>5220HEALTHPLAN . . . 1133557799CCDEFTP. . . (note that this value may or may not begin with “1”, while the value in the 835 is required to begin with “1”)</td>
</tr>
<tr>
<td><strong>Payer Name</strong></td>
<td><strong>Company Name</strong></td>
</tr>
<tr>
<td>• Located in N102 N1<em>PR</em>HEALTHPLAN~</td>
<td>• Batch Header, Record Type 5, Field Number 3, positions 5-20</td>
</tr>
<tr>
<td>5220HEALTHPLAN . . . 1133557799CCDEFTP. . . (name of the health plan / name that is recognized by the healthcare Provider and to which the healthcare Provider submits its claims)</td>
<td></td>
</tr>
<tr>
<td><strong>Effective Entry Date</strong></td>
<td><strong>Effective Entry Date</strong></td>
</tr>
<tr>
<td>• Located in BPR16</td>
<td>• Batch Header, Record Type 5, Field Number 9, positions 70-75</td>
</tr>
<tr>
<td>BPR<em>I</em>306.04<em>C</em>ACH<em>CCP</em>01<em>123456789</em>DA<em>0123456789</em>1133557799<em>666660000</em>01<em>043210123</em>DA<em>987654321</em>20130131~</td>
<td>5220HEALTHPLAN . . . HCCLAIMPMTJan 3130131.</td>
</tr>
<tr>
<td><strong>Amount</strong></td>
<td><strong>Amount</strong></td>
</tr>
<tr>
<td>• Located in BPR02</td>
<td>• Record Type 6, Field Number 6, positions 30-39</td>
</tr>
<tr>
<td>BPR<em>I</em>306.04<em>C</em>ACH<em>CCP</em>01<em>123456789</em>DA<em>0123456789</em>1133557799<em>666660000</em>01<em>043210123</em>DA<em>987654321</em>20130131~</td>
<td>62212345689012 . . 0000030604133557799 . .</td>
</tr>
<tr>
<td><strong>Provider Tax ID (TIN) or NPI – Loop 1000B (PE-Payee)</strong></td>
<td><strong>Identification Number / ID</strong></td>
</tr>
<tr>
<td>• Located in N104 N1<em>PE</em>PROVIDER SITE NAME<em>FI</em>133557799~ OR N1<em>PE</em>PROVIDER SITE NAME<em>XX</em>2244668800<del>REF<em>TJ</em>133557799</del></td>
<td>• Record Type 6, Field Number 7, positions 40-54 (Optional) 62212345689012 . . 133557799 . .</td>
</tr>
<tr>
<td><strong>Trace Number Segment</strong></td>
<td><strong>Trace Number</strong></td>
</tr>
<tr>
<td>• The TRN02 (trace number) along with the TRN03 (payer tax ID) are used for reconcilement</td>
<td>• Note that this is NOT the ACH Trace Number located in Record Type 6, Field Number 11, positions 80-94</td>
</tr>
</tbody>
</table>

11 ASC X12 835 5010x221 TR3 page 20
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| TRN*1*0033557799*1133557799*666660000~ (note that TRN04 is situational) | • Record Type 7 (Addenda), Field Number 3, positions 04-83
• Use the entire TRN segment from the related 835 transaction
  705TRN*1*0033557799*1133557799*666660000~. . |

The batch header record in the CCD+ contains the Company ID, which is an alphanumeric code used to identify an Originator and is assigned by the ODFI. This Company ID value also appears in the corresponding ASC X12 835 file. In the ASC X12 835 file, it is required to begin with a “1”, followed by the 9-digit TIN of the Originator (Health Plan). (Note that the NACHA Operating Rules do not require the Originating Company ID to be the TIN, so there may be situations where these values do not match, which may cause challenges for reassociation. Because this value appears in the TRN segment also, matching the TRN03 to the addenda record should alleviate this issue.)

Note that the data element “Trace Number” exists in both the NACHA CCD+ format Detail Record Type 6, and in the 835 TRN segment, element 2. While these data values exist in both formats, they do not contain the same information, and cannot be used interchangeably. The “Trace Number” field in the CCD+ format is a sequential number used within the CCD+ itself to order the Record Type 6 Detail records in the file. The “Trace Number” used within the 835 format contains the Check or EFT Number assigned by the Payer, and is used to link the 835 transaction to the payment medium. The TRN segment from the 835 is copied exactly into the CCD+ Addenda record for reassociation purposes.\(^\text{12}\)

**VIII. Summary**

This process of matching up the healthcare claim payment and the remittance advice can be frustrating and challenging for Providers. When the payments included in the EFT or check do not correspond to the payment amounts and claims included in the remittance advice, this reassociation process becomes even more complex. The 835 transaction includes requirements to relate a single payment to a single remittance advice transaction. Ensuring compliance with this requirement will assist Providers with the process of reconciling, and facilitate adoption of electronic transactions.

**IX. Acknowledgements**

WEDI EFT SWG Co-Chairs
- Pam Grosze, PNC Bank
- Deb Strickland, Xerox
- Ron Meier, HealthNet (retired)
- Margaret Richardson, HealthNet
- Dora Lambert, ASC X12 TGB/WG4 (Premium Payment) Co-Chair

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\(^{12}\) CAQH CORE Rule 370, section 2.1.1.1 has some additional discussion on this topic of the variance between the Trace Number included in the CCD+ file and the EFT Trace Number included in the TRN02 of the 835.
X. Resources

Additional papers published by the WEDI Electronic Funds Transfer Subworkgroup, available at www.wedi.org:

“The Reassociation Process for Healthcare Payments and the Impact to Providers and Health Plans”

“NACHA Operating Rules Healthcare Updates and their Impact to Providers and Health Plans”

“Enrollment Process for Healthcare Claim Electronic Funds Transfer (EFT) Payments and Healthcare Electronic Remittance Advices (ERA)”

“Implementing a Healthcare Payment EFT Process to Accompany a Healthcare Claim Payment Remittance Advice”

“NPI Utilization in Healthcare EFT Transactions”

“EFT Addenda Record for Paper Remittance Advices”

“Best Practices – Reassociation” at www.x12.org

2014 NACHA Operating Rules at www.nacha.org

CAQH CORE Rule 370 and associated FAQs are available at www.caqh.org.

AMA Free online toolkits on each transaction, including EFT and ERA www.ama-assn.org/go/electronictransactions