Electronic Remittance Advice and Fund Transfers White Paper

Barriers to Adoption of the ERA and EFT Transactions

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Barriers to Adoption of the ERA and EFT Transactions

I. Purpose

The purpose of this paper is to identify barriers to implementation of the HIPAA standard Health Care Electronic Funds Transfer (EFT) and Remittance Advice (ASC X12N Health Care Claim Payment/Advice (835) and the NACHA Corporate Credit or Debit Entry Plus Addenda (CCD+)) to provide details of the reason behind these barriers, and to suggest steps that providers, payers, trading partners and vendors can take to eliminate the barriers and implement the transactions.

II. Scope

The scope of this paper includes barriers to the adoption of the HIPAA adopted EFT (CCD+) and ERA (835) electronic transactions by payers, providers and vendors, identified by the subworkgroup (SWG); a summary of the SWG discussions; and potential solutions or best practices. While some issues regarding paper transactions may be included, the focus of this white paper is on the HIPAA adopted electronic transactions.

III. Introduction

The EFT and 835 SWGs (now the Remittance Advice and Payment SWG) conducted an industry survey in 2016 gathering information on ERA and EFT, progress that has been made since 2014, and issues that continue to cause challenges with implementation and usage of these transactions. This survey was similar to the previous ERA/EFT survey from 2014, and it was hoped to show progress on some of the specific areas of concern that had been raised in the previous survey.

The results of the 2016 survey indicated that the industry is still plagued with challenges that result in barriers to adoption of the ERA and EFT transactions. In order to discuss these challenges, the SWG created this white paper.

Relevant definitions and acronyms are referenced in Appendix A.

This white paper emphasizes some of the major points that have been made in previous papers created by the EFT and 835 SWGs. These papers are referenced in Appendix B.

Relevant regulations are referenced in Appendix C.
IV. Electronic Funds Transfer (EFT) issues

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

A. Payers that do not offer both EFT and ERA

Issue: Some payers do not offer both EFT and ERA.

Best Practice: Payers should update their systems to offer both transactions electronically (EFT and ERA).

Providers can achieve some cost savings and administrative simplification by eliminating checks and receiving their payment electronically via EFT; however, continuing to receive the remittance advice on paper requires manual posting and continues to be labor-intensive and prone to errors. Conversely, receiving the remittance advice electronically allows the provider to auto-post the information, but receiving the payment via paper check means that reassociation has to take place manually, along with the manual processing of the check. Once again, full cost savings and administrative simplification are not achieved. When payers do not offer both EFT and ERA, providers cannot get the full benefit of electronic processing.

In addition, many providers will not adopt EFT or ERA unless they can do both electronically. The manual process required for reassociation and extra effort required to deal with the combination of paper and electronic files are detriments to the provider’s cash posting processes. As part of the HIPAA regulations, payers are required to conduct both the EFT payment and ERA remittance advice using the HIPAA adopted transactions when requested to do so by another covered entity, and both providers and payers benefit when electronic files are used.

B. CAQH CORE Minimum Required Data for reassociation

Issue: Some payers do not provide the CAQH CORE Minimum Required Data for Reassociation.

Best Practice: Payers should update their systems to provide all required data for reassociation in the EFT transaction.
CAQH CORE Rule 370\(^1\) (which includes requirements for electronic files only) focuses on the content needed in both the 835 and CCD+ files to perform reassociation, and the timing and delivery of the files to set clear expectations with providers on when files will be received so they can be reassociated. The rule includes the following requirements:

- The rule establishes minimum required data for reassociation that must be present in the CCD+ file
  - Effective Entry Date (Record 5 Field 9, corresponds to BPR16 in the 835)
  - Amount (Record 6 Field 6, corresponds to BPR02 in the 835)
  - Payment Related Information (Record 7 Field 3, corresponds to the TRN segment in the 835)
    - Contained in the Addenda Record of the CCD+ transaction
    - For health care transactions, the Addenda record contains a copy of the TRN segment from the 835 associated with the EFT

The health care EFT Standard states that the CCD+ Addenda Record must be populated with the TRN Reassociation Trace Number Segment as defined in the 835 version 005010 Technical Report Type 3 (TR3), which was then reinforced with CAQH CORE Rule 370. In addition, *NACHA Operating Rules* require that the addenda information from the CCD+ transaction be returned by the bank to the provider when requested.

When payers do not provide the CORE Minimum Required Data for Reassociation in the EFT file Addenda Record, providers are unable to reassociate the EFT to the ERA file and manual intervention is required. Providers must track each payment and ERA received, and manually determine when corresponding files are received so posting can take place. Based on the information available in the EFT file without the Addenda Record, Effective Entry Date and Payment Amount, the provider may have a difficult time determining the match between EFT and ERA. Faced with this situation, providers may choose to continue receiving paper checks and paper remittance, which arrive together and eliminate the reassociation challenge. In order to encourage adoption of the EFT transaction and facilitate reassociation, payers must include the TRN Reassociation Trace Number segment in the EFT Addenda Record.

**C. Impact when vendors are involved in creating ERA and EFT files**

**Issue:** When payers use vendors to create ERA or EFT files, the required reassociation data may be missing or different between the files.

**Best Practice:** Payers should ensure all necessary communication takes place between their systems and any vendor systems to create the necessary reassociation

\(^1\) CAQH CORE Rule 370 “EFT & ERA Reassociation (CCD+/835) Rule”
data in both the ERA and EFT files and that validation of the files occurs prior to delivery to providers.

Some payers use a third party, which is considered a business associate (BA), to create either their ERA or their EFT files. This can create challenges in meeting the requirements of CAQH CORE Rule 370; however, because these third parties are bound by Business Associate Agreements (BAA), they are required to meet the requirements outlined in the Standards and Operating Rules just like the payer. When the files are created by different entities, it may be challenging ensuring that the Effective Entry Date contained in the 835 matches the date in the EFT, and that all of the CORE Minimum Required Data for Reassociation is present (and matches) in both transactions. Additional communication measures may be necessary to ensure that appropriate information flows between all parties to meet these requirements and validation of the files should occur prior to delivery to providers. Failure to include Effective Entry Dates and EFT Trace Numbers that match the EFT transaction result in a non-compliant 835, which could subject the payer and the business associate to complaints and fines and cause the provider to be unable to use the 835.

D. One-to-One relationship between the EFT and the ERA

Issue: Some payers create multiple ERAs for a single payment (EFT) or multiple payments for a single ERA.

Best Practice: Payers should always create a single payment (EFT) with a single ERA.

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. 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 are included in the payment.

Associating multiple EFTs to a single ERA or multiple ERAs to a single EFT is NOT allowed.

See WEDI white Paper “Electronic Funds Transfer Payments’ relationship to the Electronic Remittance Advice transaction – The one-to-one relationship between the EFT and ERA,” published September 17, 2015, for additional information.

E. Payment amounts in the EFT and ERA must match

Issue: Some payers create EFT payments and ERA files where the payment amounts reflected in the files do not match exactly.

Best Practice: Payers should update their systems to correct any rounding errors or other issues that prevent the payment amounts in the EFT and ERA files from matching exactly.
In addition to ensuring that there is a one-to-one relationship between the payment and the remittance advice, it is imperative that the payment amounts reflected in both transactions match exactly. The ERA transaction must balance (see Section VI) and the payment amount reflected in the BPR02 (Total Actual Provider Payment Amount) element must match the payment amount included in the EFT CCD+ transaction exactly. If these amounts do not match, then the transactions cannot be automatically reassociated, and a phone call will be required to the payer to determine the reason for the mismatch. Rounding errors or other issues that may cause the payment amounts to differ must be remediated by the payer so that the amounts match exactly.

V. Reassociation

When both the health care EFT (along with the Payment Related Information in the Addenda Record) 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. 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.

“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 that 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>X12N 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>1</em>306.04<em>C</em>ACH<em>CCP</em>01<em>123456789</em>DA* 0123456789<em>1133557799</em>666660000<em>01</em>043210123<em>DA</em>987654321*20130131~AND</td>
<td>5220PAYER . . 1133557799CCDEFTP. .</td>
</tr>
<tr>
<td>AND</td>
<td>(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>
</tbody>
</table>

2 WEDI white paper “The Reassociation Process for Healthcare Payments and the Impact to Providers and Health Plans,” published Dec. 9, 2014, was created by the EFT subworkgroup and contains detailed information on the process of reassociating the 835 and EFT files. Please refer to that paper for complete information on this topic.

3 X12 835 005010x221 TR3 page 20
<table>
<thead>
<tr>
<th><strong>Payer Name</strong></th>
<th><strong>Company Name</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Located in N102 N1<em>PR</em>PAYER~</td>
<td>• Batch Header, Record Type 5, Field Number 3, positions 5-20 5220PAYER...1133557799CCDEFTP... (name of the payer/name that is recognized by the health care provider and to which the health care provider submits its claims)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Effective Entry Date</strong></th>
<th><strong>Effective Entry Date</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Located in BPR16 BPR<em>I</em>306.04<em>C</em>ACH<em>CCP</em>01<em>123456789</em>DA* 0123456789<em>1133557799</em>666660000<em>01</em>043210123<em>DA</em>987654321*20130131~</td>
<td>• Batch Header, Record Type 5, Field Number 9, positions 70-75 5220PAYER...HCCLAIMPMTJan 31130131.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Amount</strong></th>
<th><strong>Identification Number/ID</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Located in BPR02 BPR<em>I</em>306.04<em>C</em>ACH<em>CCP</em>01<em>123456789</em>DA* 0123456789<em>1133557799</em>666660000<em>01</em>043210123<em>DA</em>987654321*20130131~</td>
<td>• Record Type 6, Field Number 7, positions 40-54 (Optional) 62212345689012...0000030604133557799...</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Provider Tax ID (TIN) or NPI – Loop 1000B (PE-Payee)</strong></th>
<th><strong>Trace Number</strong></th>
</tr>
</thead>
<tbody>
<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>• Note that this is NOT the ACH Trace Number located in Record Type 6, Field Number 11, positions 80-94 • Record Type 7 (Addenda), Field Number 3, positions 04-83 • Must contain the entire TRN segment from the related 835 transaction 705TRN<em>I</em>0033557799<em>1133557799</em>666660000~...</td>
</tr>
</tbody>
</table>

**Trace Number Segment**  
• The TRN02 (trace number) along with the TRN03 (Payer Tax ID) are used for reconciliation TRN*I*0033557799*1133557799*666660000~ (note that TRN04 is situational)  

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 835 file. In the 835 file, it is required to begin with a “1”, followed by the 9-digit Tax Identification Number (TIN) of the originator (health plan/payer). 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 is required in the TRN segment, matching the TRN03 to the Addenda Record resolves this issue when sent as required.
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.4

A. Comparing the TRN segment in the EFT Addenda Record and the 835

Issue: Providers need the ability to automatically compare the reassociation information in the ERA and EFT

Best Practice: Practice management systems should provide the functionality for comparing reassociation information. If this is not available, providers may need to create their own mechanism to compare the information, which should include comparing the information element by element rather than as a whole string.

The Addenda Record of the CCD+ is used to convey 80 characters of payment-related information to provide information to reassociate the payment with the remittance advice. The health care EFT Standard states that the CCD+ Record must be populated with the TRN Reassociation Trace Number Segment as defined in the ASC X12N 835 005010x221 TR3. The Payment Related Information field of the CCD+ Record is limited to a maximum of 80 characters. Note that this is fewer characters than defined by the ASC X12N TR3 if all required data elements (TRN01, TRN02, TRN03 plus the situational TRN04) are used. In this situation, NACHA, working with X12, has determined that the TRN04 data segment should be truncated. The TRN Reassociation Trace Number Segment is carried in the 835 (ERA) and the EFT (ACH CCD+) and used by the providers to match the payment to the ERA.

The NACHA Operating Rules state that for the CCD+, the Payment Related information in the Addenda Record must contain valid payment-related X12 data segments or NACHA endorsed banking conventions, and that the asterisk “*” is used for the element delimiter and backslash “\” or tilde “~” for the segment terminator. (NACHA Operating Guidelines Section V, Chapter 39, page OG 141 in 2013 edition). See Note 1 below for additional information on usage of terminators in the Addenda Record.

The health care EFT Standard requires that the standard for the data content of the CCD+ Addenda record comply with the ASC X12N/005010X221 835 TR3 TRN specifications5. The TRN segment contains the following elements:

4 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.
5 45 CFR Parts 160 and 162, “Administrative Simplification: Adoption of Standards for Health Care
TRN01 – Trace Type Code
Value is always “1”

TRN02 – Reference Identification
EFT Trace Number (different from the ACH Trace Number as mentioned above)

TRN03 – Originating Company Identifier (Payer Identifier)
This must be a 1 followed by the payer’s EIN (or TIN). (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)

TRN04 - Originating Company Supplemental Code
Situational value - Required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.

TRN Segment Example from the 835:

TRN|1|1234567896|1326549870|PLAN123~

Full Addenda Record Example from the CCD+ file: (note that the Addenda record contains the TRN segment from the 835), which contains ACH information in addition to the TRN segment (blue)

705TRN*1*1234567896*1326549870*PLAN123\00010000001

Note 1: If the health plan uses an element delimiter other than “*” (as shown in the example above), then additional work will have to be done to compare the information element by element rather than comparing the entire segment.

Note 2: The bolded items in blue are additional fields that are part of the ACH record, not part of the reassociation information.

B. Compliance with HIPAA requirements

In order to standardize the process and transactions used for electronic health care payments, HHS published the EFT Standards Final Rule6 for EFT transactions sent through the ACH Network. These standards make the EFT transaction a HIPAA transaction, requiring payers to provide the payment with an EFT via the ACH Network if requested by the provider and requiring the EFT transaction to comply with the format requirements specified in the rule.

6 45 CFR Parts 160 and 162, “Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice”
In addition, Operating Rules are also included in the HIPAA requirements and include requirements for EFT/ERA Enrollments, EFT/ERA Reassociation, Uniform Use of CARC/RARCs and 835 Infrastructure. Compliance with both the EFT Standards and the Phase III CAQH CORE EFT and ERA Operating Rule requirements became mandatory on Jan. 1, 2014. As with all HIPAA mandates, failure to comply can result in corrective action plans or fines to the non-compliant party.

C. How should the provider communicate with their bank about the addenda/reassociation information?

**Issue:** Providers need to receive the CAQH CORE Minimum Required Data for Reassociation from their financial institution.

**Best Practice:** Providers should work with their financial institution to ensure that the information is received in a way that can be automated and with their accounts receivable system vendor to ensure automation of the reassociation process.

CAQH CORE Rule 370 focuses on the content needed in both files to perform reassociation and the timing and delivery of the files to set clear expectations with providers on when files will be received so they can be reassociated. The rule also includes the requirement that the health plan must notify the provider during the enrollment process that it must request delivery of the reassociation data from its financial institution. In addition, the NACHA Operating Rules require the bank to provide the reassociation information (Payment Related Information) either automatically or upon request by the provider.

The provider should work with their financial institution to ensure that the information is received in a way that can be automated and with their accounts receivable system vendor to ensure automation of the reassociation process.

The NACHA requirement to deliver the Payment-Related Information to the provider, either automatically or upon request, ensures that the provider will receive the information needed to perform that reassociation. Providers must coordinate with their financial institution to ensure the information is delivered (per CAQH CORE Rule 370) and on the mechanism for delivery, but now they are ensured of some minimum requirements for secure electronic delivery channels. Providers must coordinate with their financial institutions (or treasury department) on the timing of delivery of this information to ensure that the process is established before the EFT enrollment is completed and files are flowing to ensure no impact to reassociation.

While financial institutions are required to provide the Payment-Related Information upon request, terminology used may cause challenges in getting this established. Providers may need to refer to the information as “Payment-Related Information,” “CORE-Required Minimum CCD+ Data Required for Reassociation,” “ACH Payment-Related Information,” or “Addenda Record Information” to help their financial institution understand what is being requested. Providers can refer their financial institution to the NACHA Operating
Rules subsection 3.1.5.3 for specific information, which should assist the financial institution in understanding the request.

The method of delivery and format of the Payment Related Information will vary from financial institution to financial institution (and depending on the capability of the provider for receiving the information). Below is one example of what this information may look like when received by the provider:

![Example Payment Related Information](image)

D. ERA data flowing through vendors or clearinghouses

**Issue:** Providers may experience issues with their 835 files when vendors or clearinghouses modify data prior to delivering to the provider.

**Best Practice:** Vendors and clearinghouses must not modify data prior to delivering to the provider, and payers and providers should ensure that due diligence is performed when contracting with a vendor to perform services and should ensure that HIPAA compliance is required in all contractual arrangements.

Providers may experience issues with their 835 files when vendors or clearinghouses modify data prior to delivering to the provider. For example, some providers experience issues with the patient control number (CLP01) differing from what was sent on the original claim. One clearinghouse vendor adds its own proprietary number to the CLM01 when the claim goes through, and then when the 835 comes back through, it removes that number from CLP01 prior to delivering to the provider. So if the provider receives its 835s from that same vendor, there is no issue; however, if the 835 is returned through a different clearinghouse (which is common), then the CLP01 still has the first clearinghouse number in it, and cannot be used by the provider.

In addition, when vendors or clearinghouses make changes to their systems, these can impact providers as well and should be tested with providers and communicated prior to implementation. Payers and providers should ensure that due diligence is performed when contracting with a vendor to perform services and should ensure that HIPAA compliance is required in all contractual arrangements.

E. Timing of the release of ERA and EFT files

**Issue:** ERA files must be released to the provider within three business days (plus or minus) of the Effective Entry Date of the EFT. Providers need clear expectations regarding the delivery of the EFT and ERA files.

**Best Practice:** Payers should include their delivery information in their enrollment information. Providers will need to communicate with their payers to ensure they understand the schedules for release of the EFT and ERA files, and they will need to
communicate with any other trading partners involved in their receipt of ERA files (e.g.,
clearinghouses) to understand the impact of these trading partners on the receipt times
of their ERA files.

CAQH CORE Rule 370 specifies that the health plan must release the 835 to the
provider

- No sooner than three business days before and no later than three business
days after the Effective Entry Date of the EFT
- Retail pharmacy any time prior, but no later than three business days after,
  the Effective Entry Date

The rule is focused on when the files are released by the health plan to the provider. If a
health plan uses a third-party vendor to create the EFT or ERA that process must be
accounted for to ensure that the Operating Rule requirements for file release dates are
met.

The dates are based upon the Effective Entry Date of the EFT, which is when the funds
will be made available and is required by CAQH CORE Rule 370 to be the same as the
Settlement Date (note that the Settlement Date may be different than the Effective Entry
Date if the Originator puts an Effective Entry Date that is not a valid Banking Day). The
ERA file may be released either before or after the EFT, but it must be within three days
of the Effective Entry Date. If the ERA file is received first, the EFT would be expected
within three days. If the EFT is received first, the ERA would be expected within three
days.
The figure below presents a visual representation of the requirement for the timeframe of the release of the X12N v005010 835 with respect to the CCD+ Effective Entry Date.\(^7\)

It is recommended that the health plan include information on its business days in the enrollment instructions. If these are not clarified, the provider will need to contact the health plan to ensure the plan understands the timeframes involved in receiving payments and remittance advices.

The *NACHA Operating Rules* require that the payment-related information in the CCD+ file be delivered (or made available) to the provider no later than the opening of business on the RDFI’s second Banking Day following the Settlement Date of the Entry.

Providers will need to communicate with their health plans to ensure they understand the health plan’s schedules for release of the EFT and ERA files so that they understand the timeframes involved in receiving their payments and remittance advices. Providers must also understand the health plan’s business day schedule to be clear on the impact of holidays and other days the health plan is closed.

Providers must also communicate with any other trading partners involved in their receipt of ERA files (e.g., clearinghouses) to understand the impact of these trading partners on the receipt times of their ERA files. CAQH CORE Rule 370 includes

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\(^7\) [http://www.caqh.org/pdf/COREFAQsPartD.pdf](http://www.caqh.org/pdf/COREFAQsPartD.pdf), FAQ number 5
requirements for release of the files by health plans but does not include requirements on any other trading partners in the “delivery chain” of the ERA file. Additional trading partners involved in the delivery of the ERA files can increase the delivery time of the file and must be accounted for before initiating the research processes provided by the health plan.

VI. Balancing

When dollar amounts are reported in the ERA (835), they must balance at three different levels: the service line, the claim and the transaction. Adjustments are also possible within the 835. It is important to note that positive adjustment amounts decrease the payment, while negative adjustment amounts increase the payment.

Service lines (SVC segments) are mandatory in the 835 for professional claims, dental claims and institutional outpatient claims priced at the service line level. In addition, they should be sent if there were adjustments to the line item on the original claim. Within Loop 2110, balancing is calculated as follows:

\[
\text{Submitted Charges} - \text{Sum of Adjustments} = \text{Service Amount Paid} \\
\text{SVC02} - (\text{CAS03} + \text{CAS06} + \text{CAS09} + \text{CAS12} + \text{CAS15} + \text{CAS18}) = \text{SVC03}
\]

Claim level amounts (CLP segments) exist within Loop 2100 and their balancing is calculated as follows:

\[
\text{Submitted Charges} - \text{Sum of Claim Adjustments (and, Service Adjustments when Service Payment Information Loop 2110 is present)} = \text{Claim Paid} \\
\text{CLP03} - (\text{CAS03} + \text{CAS06} + \text{CAS09} + \text{CAS12} + \text{CAS15} + \text{CAS18}) = \text{CLP04}
\]

Transaction level segments exist within Table 1, Loop 2100 and Table 3, and their balancing is calculated as follows:

\[
\text{Sum of all Claim Payments} - \text{Sum of All Provider Adjustments} = \text{Total Payment Amount} \\
\text{CLP04} - (\text{PLB04} + \text{PLB06} + \text{PLB08} + \text{PLB10} + \text{PLB12} + \text{PLB14}) = \text{BPR02}
\]

When an ERA file does not balance as described above, providers are unable to use the file for auto posting. If the provider is unable to determine what is causing the file to be out of balance (missing adjustments, incorrect payments, etc.) each claim must be examined manually prior to posting, and phone calls may be required to the payer to determine the actual amounts associated with the payment.

A. Balancing Patient Responsibility Amounts

Issue: If the patient responsibility amounts do not balance back to the amount reported in the Patient Responsibility Amount element (CLP05), then the provider is unable to
accurately convey to the patient the amount they owe, and therefore may be unable to deliver patient statements or may deliver incorrect patient statements.

**Best Practice:** Payers must ensure that the ERA’s patient responsibility amounts balance appropriately per the TR3 requirements.

In addition to the adjustment amounts, if the patient responsibility amounts do not balance back to the amount reported in the Patient Responsibility Amount element (CLP05), then the provider is unable to accurately convey to the patient the amount they owe, and therefore may be unable to deliver patient statements or may deliver incorrect patient statements.

CLP05 must equal the sum of all Loop 2100 and Loop 2110 CAS segment adjustment amounts (CAS03+CAS06+CAS09+CAS12+CAS15+CAS18) when CAS01 is Patient Responsibility (PR). Note that this does not apply to reversals, where CLP05 is not included.

### B. Payment amounts in the EFT and ERA must match

**Issue:** Some payers create EFT payments and ERA files where the payment amounts reflected in the files do not match exactly. Some payers create multiple ERAs for a single payment (EFT) or multiple payments for a single ERA.

**Best Practice:** Payers should update their systems to correct any rounding errors or other issues that prevent the payment amounts in the EFT and ERA files from matching exactly. Some payers create multiple ERAs for a single payment (EFT) or multiple payments for a single ERA.

In order to achieve the maximum benefit from the electronic transactions, providers need to receive ERAs and EFTs that can be seamlessly auto posted to their systems. The process of matching up the health care claim payment and the remittance advice can be complex and challenging for providers. A single payment must be provided for a single 835 remittance advice.

When the payment included in the EFT does not match the payment amount and claims included in the ERA, reassociating the ERA and EFT becomes even more complex, and providers are unable to utilize the electronic files.

When the amount of the EFT is more than the ERA, a provider's cash balance is inaccurately higher than it should be. When the EFT amount is less than the ERA, a provider's cash balance is inaccurately lower than it should be. In either case, a provider's financial standing is not truly represented and decisions based on this inaccuracy could be misguided. In addition, if payers incorrectly provide multiple payments for a single 835, providers may have to delay posting the ERA to wait for multiple EFT payments to reconcile the amounts, increasing A/R days.
As providers experience these issues with balancing the payments and remittance advices, payers are negatively impacted as well. Providers will have to call to determine why the amounts do not match and when any additional files will be received. Payers will then have to perform additional research to respond to the inquiries.

The 835 transaction includes requirements to relate a single payment to a single remittance advice transaction (see section V). If payers will provide a single payment for a single remittance advice, providers will be able to easily reassociate the transactions, which will facilitate the adoption of electronic transactions.

C. Interest amounts in the 835

**Issue:** Interest amounts are not always reported correctly in the ERA. Providers’ systems are not always able to post interest amounts automatically.

**Best Practice:** Payers must ensure that interest amounts are reported correctly in the 835. Practice management systems should automatically post amounts that are reported in the provider-level balance (PLB) segments.

Within the ERA, any interest amounts are reported in the PLB segment with adjustment code L6. The interest amount is not included in the claim payment amount, as this would impact the benefit amount for the patient, and potentially impact the patient responsibility amount. All interest is aggregated and reported as one amount in the PLB, and the individual claim amounts are reported on each claim within the 2100 loop's AMT segment, with an AMT01 value of I (Interest).

The AMT segments are not part of claim balancing, these amounts are informational only at the claim and service levels. Interest is included in the transaction balancing within the PLB (See above transaction balancing).

It is imperative that practice management systems manage these amounts that appear in PLB segments in order to ensure that the amounts are handled correctly and that providers do not have to resort to manual processes.

VII. Payment and remittance file grouping – TIN vs NPI

**Issue:** Providers have differing needs when it comes to receiving their payments and remittance advice. Some providers need their files grouped by TIN, others by NPI.

**Best Practice:** Payers and providers must communicate about the requirements for file grouping. Any payer file limitations regarding file grouping should be remediated so that files can be grouped to meet providers’ needs.

Providers have differing needs when it comes to receiving their payments and remittance advice. 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 reconcilement 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 and potentially tax reporting purposes.

Providers that want to receive consolidated remittances/payments may want to have their remittance/payments grouped by Tax Identification Number (TIN) or the highest level National Provider Identifier (NPI). Providers that need their remittance/payments broken up by PMS/bank account may want to have remittance/payments grouped by a lower level NPI. Ensuring that payers are aware of the provider’s requirements for file grouping and are able to accommodate those requirements is vital to ensuring that providers are able to automate their processes for re-association and posting of their payments and remittance advice files.

When contracting with payers, enrolling for EDI transactions with payers and 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.

Providers should confirm with their payers how they will determine the grouping of the remittance/payment files to ensure that their requirements are communicated appropriately. It is important for the provider to understand that limitations in the payer’s systems may still prevent grouping the files in the manner the provider needs.

For contracted providers, during the registration process, 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 that 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. In addition, as organizations change and requirements for grouping the payments and remittance files also change, providers may need to re-address their payer contracts to ensure their files continue to be grouped as needed. In the event that there are multiple contracts with a payer, each contract should specify a separate (not necessarily different) ERA setup.

During the EDI enrollment process for both EFT and ERA, providers have the opportunity to specify how they want their information grouped in their files/payment (by TIN or NPI). Providers should review their initial contractual setup with the payer to ensure that their grouping 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 process.

While many payers do not use the information from the EDI enrollment form or original submitted claim (rather they only use the registration/contracting information/provider setup in payer’s system), 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 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 providers, it is the only setup/configuration that the payer may receive. (Figures 1 and 2 below demonstrate grouping of files from submitted claims through to the ERA and related EFT). Receiving information on an EDI enrollment form or claim form that differs from that in the payer’s system from the original contract/registration may indicate a need to have some additional discussions with the provider to ensure that all information is current and that payment and remittance advice files are created in the manner the provider must have to accurately post to their systems.

As providers and payers work through the process of getting setups, etc., in place to create files that meet the provider’s needs, it may also become apparent that the provider may need to update their NPI enumeration. This would allow the provider to include subparts or other divisions to identify distinct locations to ensure files are grouped correctly (see below for additional information on subparts).

Ultimately, limitations in the payer’s systems may still prevent grouping the files in the manner the provider needs. As time and budgets permit, these limitations should be addressed in order to ensure that all providers have the opportunity to use the payment and remittance advice files in the most efficient manner.
In Figure 1, claims 1 and 3 are going to be grouped together for payment because they have the same NPI (NPI0123) on the incoming claim. Similarly, claims 2 and 5 will be grouped together because they have the same NPI (NPI0999).

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Figure 2 shows that for each ERA group there is a corresponding EFT payment (as long as it is not a $0 remit). There is a direct correlation between the ERA and the EFT.

### A. NPI impact on payment and remittance grouping

**Issue:** The provider’s NPI (and how it is enumerated) may impact how payment and remittance advice files are grouped, and whether the provider can ultimately post the information received.

**Best Practice:** Providers should be cognizant of the NPIs and the NPI types that they currently have – Individual/Organizational including subparts (if needed).

As the health care industry implemented the NPI, complexity for determining the payee increased. Prior to the NPI, processing was primarily by TIN and/or via multiple and disparate payer-assigned proprietary provider identifiers. With the introduction of the NPI, the provider could enumerate to any granularity to best fit its business practices. Now, a specific TIN could be represented by several (or hundreds of) NPIs. The impacts

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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 (i.e., they act independently). 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 enables the hospital to avoid 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.

Other types of providers may have unique situations, for example a non-covered entity such as a corporate office receiving the payments that need to be grouped by TIN, or a retail pharmacy. 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.

Providers should be cognizant of their NPIs and the NPI types that they currently have – Individual/Organizational including subparts (if needed). The granularity of the NPI may impact how payment and remittance advice files are grouped, and whether the provider can ultimately post the information received. Information on NPI types can be found at the CMS website or at the NPPES enumeration website (found at https://nppes.cms.hhs.gov/#/). The WEDI NPI SWG created a paper that may also be of interest, NPI Subpart Designation for Organizations, published September 2005, available on the WEDI website.

Some providers can end up with a single NPI associated with multiple TINs for a single payer, for example, if a provider changes organizations one or more times. The individual NPI for that provider could then be associated with multiple TINs at the payer. Because this could result in PHI violations, tax reporting errors, etc., providers must understand the rules of NPI enumeration, but also the importance of the provider

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10 www.wedi.org
registration with each payer. If a physician moves to another organization, two organizations need to update their files with payers to ensure that all payer setup files correctly reflect the NPI. This issue can be further complicated if the payer only returns the NPI in their remittance advice files, not the TIN. In this case it may be difficult to determine the allocation of funds by TIN.

Because the 835 is a financial transaction, the TIN must always be included in the 835 file. If the TIN is not the primary payee identifier included in the Loop 1000B N1 segment, then it must be included in a REF segment in the 1000B Loop (with a TJ qualifier) for tax reporting and 1099 purposes. While the Loop 1000B REF segment is situational in version 005010, this need to report the TIN requires that the segment be present (if not reported in the N1 segment). Because there is confusion on this usage, Request for Interpretation (RFI) 1682 provides clarification on this requirement from the 835 workgroup.11

In the EFT CCD+ file, the TIN is commonly used as the Payee identifier in the Entry Detail Record. In addition, because the entire TRN segment from the 835 is reported in the Addenda record as part of the Payment Related Information field, the TIN does appear as an identifier in the CCD+ file and is available for reassociation.

B. Impact of a shared TIN on payment and remittance grouping

**Issue:** Providers that share a TIN across parts of their organization may receive files grouped incorrectly or be unable to route their files to the correct systems due to the shared TIN.

**Best Practice:** Providers must work closely with payers to ensure that files are grouped in a way that meets their needs. Providers may be required to obtain subpart NPIs to identify distinct provider locations or remittance systems, or may need to work with vendors to split their files by other methods like patient account number.

Large or organizationally complex provider organizations may share a common Tax Identification Number (TIN) for tax reporting purposes, but may have the shared TIN associated with multiple remittance processing systems/subparts of the parent organization and/or separate bank accounts. This can increase the complexity of remittance and payment processing and may require that providers obtain subpart NPIs to identify distinct provider locations or remittance systems.

To ensure accurate payment reporting and routing, it is imperative that provider organizations determine the desired remittance and payment routing and reconciliation workflow associated with their contracted ERA/EFT payers and how files must be grouped to achieve that desired routing. Providers must then work with their payers (as

11 www.rfi.x12.org
described above) to ensure that their payment and remittance advice files are grouped in a way that will meet their needs.

If the payer cannot group the files according to the subparts needed, the provider may have to manually move funds from one bank account to another or require manual intervention or third-party assistance in getting their remittance information posted to the correct accounts/systems. In some situations, a vendor may be employed to split the files by other means, e.g., Patient Account Number.

C. What to do when files can’t be grouped as needed

Issue: Some payers and third-party administrators (TPAs) supporting multiple health plans may or may not be capable of supporting ERA or EFT for a given plan or may lack capability to support complex payment and remittance grouping required by some provider organizations.

Best Practice: When a payer is unable to accommodate the provider’s needs for payment and remittance advice file grouping, the provider may still be able to achieve their desired objectives by contracting with a third-party vendor or clearinghouse. Providers should check with each payer to understand the payer’s remittance and payment processing and routing capabilities and implement needed systems and application workflow to meet their organizational requirements, incorporating additional value-add products as needed.

Some payers and third-party administrators (TPAs) supporting multiple health plans may or may not be capable of supporting ERA or EFT for a given plan or may lack capability to support complex payment and remittance grouping required by some provider organizations. Complex grouping and routing services can include distribution to multiple receivers/output methods, splitting 835 files, leveraging data identifiers to determine routing (provider IDs, procedure codes, patient IDs, etc.), payment association/grouping logic, etc. When a payer is unable to accommodate the provider’s needs for payment and remittance advice file grouping, the provider may still be able to achieve their desired objectives by contracting with a third-party vendor or clearinghouse. Providers should check with each payer to understand the payer’s remittance and payment processing and routing capabilities and implement needed systems and application workflow to meet their organizational requirements, incorporating additional value-add products as needed.

D. Inclusion of the NPI in the EFT payment file

Issue: In most cases, the provider identifier included in the EFT file is the TIN; however, sometimes providers need to route the payment information at the NPI level for specific facilities.

Best Practice: Including the NPI in the Entry Detail Record rather than the TIN can assist the provider in meeting these needs.
Providers define how they want to set up their bank accounts and reconcile their system. A provider may have a single bank account by TIN with all checks going to this single account. It may have a single bank account and internally have multiple locations, systems or NPI divisions to track information by NPI, but funds received for individual NPIs still feed into that single account. Or a provider may have many bank accounts set up, one per NPI, so each individual payment received per NPI is deposited into a separate account.

Situations may also arise when the health care EFT and ERA arrive separately at the provider, are routed prior to the reassociation step taking place and need the NPI information in order to be routed to the correct system, as described in the picture below. This is why it is important for the NPI to be carried in the health care EFT transaction when requested by these providers so the internal routing can take place and the EFT and ERA can be routed to the correct billing location to be reassociated and posted.

Commonly when a payer sends an EFT CCD+ transaction to their bank, it has the provider’s Tax Identification Number (TIN) in the Entry Detail Record and the Reassociation Trace Number Segment (TRN) in the addenda record to use for reassociation. While NPI is not a mandated data element in the EFT CCD+ transaction, a number of providers have stated that without the payee NPI in the payment transactions they are receiving from their bank, they are having difficulties in identifying the correct account that the funds should be applied to. In addition, some providers need the NPI information in the EFT transaction in order to route the transaction correctly in their system, particularly in situations where the 835 transaction and the EFT transaction arrive
separately at the provider’s system and the file routing to the different systems occurs prior to the 835 and the EFT transaction being reassociated.

Including the NPI in the Entry Detail Record rather than the TIN can assist the provider in meeting these needs. The provider and payer would need to communicate regarding these requirements to ensure that the payer included the NPI in the CCD+ sent to the bank. The provider would also need to communicate with their bank to ensure that this information is returned to them along with the reassociation information from the addenda record.

See WEDI paper “NPI Utilization in Healthcare EFT Transactions” for further discussion on this topic.

VIII. Recoupments/Overpayment recovery

**Issue:** Payer processes to recover overpayments can be unclear, and providers can be concerned that payers may debit their accounts without their knowledge.

**Best Practice:** Providers should work with their payers to understand the overpayment recovery process. Providers should also work with their financial institutions to establish debit blocks on their accounts so no unauthorized debits can occur, but EFT payments can still be made.

Situations often arise where payers have made an overpayment on a claim and need to recoup those funds. There are several methods outlined for managing this process in the ASC X12N v005010 835 TR3, some of which involve the use of the 835 transaction (recouping the funds from a subsequent payment), and others that occur outside the transaction (provider sending a paper check for the amount).

The provider should work with their payer to understand the payer’s recoupment processes in the event of an overpayment. Typical recoupment processes may include use of a letter requesting a check from the provider or use of the reversal and correction process within the 835 that typically includes advanced notice of the recoupment.

Some providers express concern in allowing the payers access to their bank accounts to conduct the EFT process, fearing that payers may debit their accounts for recoupments rather than just depositing for EFT. This can be an obstacle to implementation of the EFT transaction.

As a safeguard to prevent unauthorized debits from their account, the provider can work with their bank to establish debit blocks to the account used for EFT deposits. In this situation, the provider has to give written authorization for any debit on the account. Unauthorized debits cannot occur, and the provider would be aware of every debit

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12 ASC X12N 835 005010x221 TR3 section 1.10.2.17 page 48
attempt. This would allow payers to deposit claim payments to the account, while protecting the provider from all unauthorized activity.

Rather than avoiding the electronic transactions for fear of unauthorized debits, providers need to understand the payer’s process for recoupments and understand their rights and abilities to block any unauthorized activity from their bank account. Also, payers should make it clear as part of their EFT enrollment documentation that they do not perform debits from provider accounts.

A. Forward balances

**Issue:** Overpayment recovery processes can result in a “forward balance” situation. Practice management systems may not always manage these situations automatically, so providers must resort to manually tracking the balances.

**Best Practice:** Practice management systems (PMS) should be robust enough to manage these provider-level balance (PLB) adjustments for the provider, so they are not required to engage in any manual tracking of these forward balance transactions. PMS that cannot manage these adjustments should be upgraded to handle this function for the providers.

In some situations, amounts must be recouped from the provider in the 835, but the entire amount being recouped cannot be taken in the current 835 (e.g., the total payment is not large enough to cover the entire amount, or the amount cannot be taken from payment for other claims due to contractual reasons). In these situations, the payer must include the remaining amount as a “forward balance” in the 835. The ASC X12N 005010 835 TR3\(^{13}\) includes instructions for handling these situations. The ERA and EFT amounts must still always match, and the ERA must always be balanced.

Practice management systems (PMS) should be robust enough to manage these PLB adjustments for the provider, so they are not required to engage in any manual tracking of these forward balance transactions. PMS that cannot manage these adjustments should be upgraded to handle this function for the providers.

**IX. Enrollments (EFT and ERA)**

**Issue:** Each payer has different and unique processes for enrolling to receive ERA and EFT. Discrepancies between the enrollment forms and payers’ internal setup tables may cause enrollments to be rejected. Any NPIs that are not credentialed may also be rejected.

**Best Practice:** Payers should ensure that they are following the requirements outlined in CAQH CORE rules 380 and 382 for enrollments. Payers should also ensure that

\(^{13}\) ASC X12N 835 005010x221 TR3 page 36
providers are contacted and given specific information on the cause for rejection or issue with the enrollment form, when any rejection occurs.

EDI enrollment is the registration process completed by the provider (or provider’s agent) to authorize a payer to send electronic payments (EFT) or electronic remittance advice (ERA) to a designated location.

One of the biggest challenges in encouraging providers to adopt the EFT and ERA transactions is the different enrollment processes that are required by payers. Each payer has unique requirements and processes for performing ERA and EFT enrollments, which puts the burden on the provider to work with each payer and its specific processes.

In an effort to reduce the burden caused by EDI enrollments, CAQH CORE Rule 380: EFT Enrollment Data Rule and CAQH CORE Rule 382: ERA Enrollment Data Rule have identified the data elements, naming conventions and format/flow for the EDI enrollment forms (paper and electronic). Moving toward standardization of the forms in content and nomenclature should make it easier for providers to complete the EDI enrollment process.

Even with this standardization, issues can arise during the enrollment process. When payers validate the EDI enrollment request against their internal tables, any discrepancies can cause the EDI enrollments to be rejected. In addition, National Provider Identifiers (NPIs) that are not credentialed or registered with the payer can also cause EDI enrollments to be rejected. Payers should ensure that providers are contacted and given specific information on the cause for rejection or issue with the enrollment form, when any rejection occurs.


A. Enrolling for multiple payers

Issue: Some payers require paper forms, “wet” signatures or hard-copy verification of banking information for EFT enrollments. When enrolling for multiple payers, providers must complete the enrollment process multiple times.

Best Practice: Payers are encouraged to adhere to the CAQH CORE requirements, and to limit their additional paper requirements (while not compromising security around limiting fraud), in order to facilitate ERA and EFT enrollments. In some cases, there are vendors that provide an enrollment service for groups of payers that allows providers to complete information once to enroll for multiple payers.

Although CAQH CORE rules 380 and 382 defined standards for flow and content of both paper and electronic enrollments, each payer still has individual requirements and processes for completing the enrollments for its system. Even with the requirement to
provide an electronic method of enrollment, some payers still require paper forms, “wet” signatures or hard-copy verification of banking information for EFT enrollments. When providers are enrolling for multiple payers, understanding and completing these varying requirements still present a significant burden on the providers. Rather than undertake this, providers may decide to stay with their paper processes.

Payers are encouraged to adhere to the CAQH CORE requirements, and to limit their additional paper requirements (while not compromising security around limiting fraud), in order to facilitate ERA and EFT enrollments.

In addition, even if payers had identical processes for ERA and EFT enrollment, providers would still have to complete the process multiple times to get the information to each payer. Because there is not a central “repository” of this information, the provider must communicate with each payer individually to perform the enrollment process.

In some cases, there are vendors that provide an enrollment service for groups of payers which allow providers to complete information once to enroll for multiple payers. This is fairly limited in scope and is specific to the relationships between the payers and vendors; however, it does give providers the ability to enroll for ERA and EFT for multiple payers at one time.

B. Enrolling through a clearinghouse

Issue: Payers or the vendors payers have contracted with may not allow an entity other than the provider to perform the EDI enrollment function (e.g., clearinghouses performing enrollments on behalf of providers). Also, enrollment forms may require information about the clearinghouse that is not available to the provider. In addition, payers may not want to provide information on the enrollment process or status of enrollments that have been submitted to the clearinghouse, but will only speak to the provider.

Best Practice: Payers are encouraged to work with agents that are acting on behalf of providers to facilitate the EDI enrollment process. The payer may need to ensure that the provider has consented to this by requesting authorization or signatures.

Providers often use business associates such as clearinghouses to act on their behalf in communicating with payers to receive ERA and EFT files. The clearinghouse has connections with many payers, and allows the provider to connect with just one entity (the clearinghouse) to receive their files rather than the many connections to the payers. This relationship offers many benefits to the provider but can introduce challenges during the EDI enrollment process.

Often, these agents may perform the EDI enrollment process on behalf of their providers. This is a valuable service for the provider; however, in some cases payers or the vendors payers have contracted with may not allow an entity other than the provider to perform the EDI enrollment function. This puts the burden back on the provider and
may delay or even discourage the provider from performing the enrollment and adopting the electronic transactions.

When providers are completing the EDI enrollment process and clearinghouses are involved, the enrollment form may require information about the clearinghouse that is not available to the provider (e.g., Submitter ID). This also can delay or discourage the provider from completing the enrollment process.

In addition, payers may not want to provide information on the enrollment process or status of enrollments that have been submitted to the clearinghouse but will only speak to the provider. This also prevents an agent from acting on behalf of the provider and can limit or discourage adoption of the electronic transactions.

Payers are encouraged to work with agents that are acting on behalf of providers to facilitate the EDI enrollment process. The payer may need to ensure that the provider has consented to this by requesting authorization or signatures.

C. Electronic enrollment methods

Issue: CAQH CORE rules 380 and 382 require payers to offer an electronic method of doing EDI enrollments; however, not all payers currently offer an electronic method of enrollment. There is also confusion about what constitutes “electronic.”

Best Practice: Payers should provide a website that allows a provider or its agent to complete the enrollment process using an online form that complies with the CAQH CORE requirements, while providing the appropriate security around the information and process (for example, uploading a voided check or bank letter).

CAQH CORE rules 380 and 382 require payers to offer an electronic method of doing EDI enrollments. There may be, however, some confusion as to what is considered an electronic method of enrollment (PDF? Email?). At the current time, the most efficient method of enrollment is undoubtedly by use of a website to enter the CORE-required data elements; however, this would require payers to accept an electronic signature or to provide a method to upload information like a bank letter for authorization of EFT information. This may require changes to payers’ systems and processes.

CAQH CORE does not identify what is considered electronic, but references a need for CMS to provide an FAQ. This lack of clarity leaves room for interpretation, and may mean that payers continue to avoid development of an efficient method of electronic enrollment that would facilitate provider adoption of the electronic transactions.

The most efficient method to facilitate enrollment for EFT and ERA is to provide a website that allows a provider or their agent to complete the enrollment process using an online form that complies with the CAQH CORE requirements, while providing the appropriate security around the information and process (for example, uploading a voided check or bank letter).
X. Challenges researching missing files

When both the ERA and EFT files are received electronically, and both are received in a timely manner so reassociation can occur, the provider can experience significant benefit by automating their processes. When one of the files is not received, however, the provider then has to manually research what is missing, and work with the payer, the bank (for EFT) and their trading partners (e.g., clearinghouses) to uncover the issue. This manual process can be very time-consuming and laborious and require significant resources on the part of both the provider and payer.

CAQH CORE Rule 370 includes requirements for timing of delivery of the ERA and EFT files to assist the provider in knowing when to begin their research into missing files (see section V.K). It also includes a requirement for the payer to document to the provider the processes to follow for researching the missing files.

A. What if payers need additional information to research files reported as missing by providers?

Issue: Some payers require providers to report additional information when requesting research on missing EFT or ERA files.

Best Practice: Payer systems must be able to research payments and remittance advice information using the information available to the provider in both transactions.

CAQH CORE EFT/ERA Operating Rule requirements are in place to ensure sufficient information is available for both providers and payers in using the files they receive and in doing research, if needed, for missing files. Some payers, however, require providers to report additional information when requesting research on missing EFT or ERA files. For example, some payers require information about the patient in order to research on their system. Other payers require specific numbers that only appear on the paper remittance advice, which may also not be available to the provider once ERA is in use.

Because the EFT payment file contains only high-level information about the payment itself, if that is the only information available to the provider (e.g., in a situation where the ERA file is missing and needs research), the provider has no means to determine what patients are included in the payment in question or other identifying information about the remittance advice.

Payer systems must be able to research payments and remittance advice information using the information available to the provider in both transactions – provider identifiers (TIN/NPI), payment dates, payment amount and the trace number that the payer has assigned to the transactions (which appear in both the EFT addenda record as well as the 835 TRN segment).
B. How providers can recognize who sent an EFT to then research a missing ERA

**Issue:** When a provider does not receive the associated ERA and cannot recognize the originator of the transaction, the provider must do manual follow-up with the bank and health plan.

**Best Practice:** It is important to both payers and providers that the originator of the health care EFT is easily and correctly identified in the health care EFT standard format and that associated ERA or remittance advice is sent in a timely manner to eliminate the need for manual intervention and time-consuming follow-up. When providers cannot recognize the originator of the transaction, they will need to work with their financial institution to identify the payer.

What if a provider has received an EFT payment with no corresponding ERA and they don’t recognize the sending organization (health plan)? How is the health plan determined? Unfortunately, when a provider does not receive the associated ERA and cannot recognize the originator of the transaction, the provider must do manual follow-up with the bank and health plan – often with numerous phone calls.

Here are some helpful tips for health care providers that need to work with their financial institution to help identify the EFT originator (payer):

- Contact your financial institution and provide the account number, the deposit date and the amount of the transaction.
- Advise the bank that you need assistance in identifying the originator of the transaction.
- Ask the bank to contact the ODFI (Originating Depository Financial Institution) of the transaction.
- The bank will need to give the ODFI the ACH trace number of the transaction (which is different from the TRN reassociation trace number) to receive the name of the originator and a contact phone number.
- Based on the information provided by the ODFI, additional contacts may be needed with the payer to ultimately get to the correct location for research of the missing remittance advice information.

It is important to both payers and providers that the originator of the health care EFT is easily and correctly identified in the health care EFT standard format and that associated ERA or remittance advice are sent in a timely manner to eliminate the need for manual intervention and time-consuming follow-up.

On Sept. 20, 2013, NACHA implemented changes to the *NACHA Operating Rules* that included a requirement that the originator of a health care EFT transaction (the payer) must populate the Company Name field of the CCD+ with the name of the health plan. In situations where an organization is self-insured, this field would contain the name of the organization’s third-party administrator that is recognized by the health care provider and to which the health care provider submits its claims. Following this requirement
should ensure that the EFT CCD+ transaction includes the information necessary for the provider to correctly identify the payer that has sent the payment.

**XI. Challenges in determining plan used in adjudication**

**Issue:** When receiving claim payments in an 835 transaction, the provider may have difficulty determining which plans or contracts were used during adjudication of the claim. Lack of this information may cause challenges in posting the payment information correctly.

**Best Practice:** The payer should return information about the plan or contract in the 2100 REF (Other Claim Related Information), using a “CE” qualifier. The payer would then report the name or identifier of the plan or contract in the REF02 element. It is imperative that the PMS be able to incorporate this information into the automated posting process.

Many payers may encounter a situation where a particular provider has contracted with several different preferred provider organizations, contract types (including products and lines of business of the payer) or networks offered by that payer. When receiving claim payments in an 835 transaction, the provider may have difficulty determining which plans or contracts were used during adjudication of the claim. Lack of this information may cause challenges in posting the payment information correctly, which may then result in a reluctance of the provider to use the 835 transaction.

To resolve this situation, the payer should return information about the plan or contract in the 2100 REF (Other Claim Related Information), using a “CE” qualifier. The payer would then report the name or identifier of the plan or contract in the REF02 element. This then provides the information in a standard location for the provider to utilize in their automated posting process. Again, it is imperative that the PMS be able to incorporate this information into the automated posting process.

**XII. COB – Primary payer’s information in secondary payer’s 835**

**Issue:** When receiving claim payments from a secondary payer in an 835 transaction, payers may not correctly report the primary payer’s payment and adjustments, which result in double-posting information and credit balances on the accounts.

**Best Practice:** CARC 23 is to be used to identify the payments and contractual reductions that have already been posted to the A/R system by the provider, even in scenarios where the secondary payer doesn’t take into account what a prior payer actually adjudicated. Only the results of the current payer’s adjudication should be reported in the “actual” CARCs (CARCs other than 23).

The 835’s purpose is to allow the receiver to automatically post the remittance detail at either the claim or service line level. The governing principles are based upon the
receiver’s needs and the enabling of automation, rather than the sender’s systems and their internal constraints. When the payment is from a secondary (or subsequent) payer, it is critical to have accurate information about the secondary payer’s adjudication, along with information about the primary payer’s payment to post accurately (but not double-post) to the provider’s accounts receivable system. X12 Request for Interpretation (RFI) 2143 provides an extremely detailed discussion about how to report information about prior payers’ payments and adjustments in an 835.

When claims involve multiple payers, each claim payment received within an 835 transaction must account for 100 percent of the original submitted charge for the related services. Every claim payment reports the same original submitted charge, not just the unpaid balance, and must report adjustments and payments for the claim that account for 100 percent of the original submitted charges. Because the adjudication results reported by subsequent payers must include information from the prior payers in order to balance, care must be taken to ensure that amounts are not sent in a way that providers will post multiple times. It must be clear what has already been reported by the prior payer(s) (and therefore already posted).

When a claim payment is received from the primary payer, the provider posts that payment and any applicable adjustments to its A/R system. Once payments are received from a subsequent payer, items that have already been posted must not be re-posted, as this would negatively impact the A/R system (i.e., cause negative balances). To automate posting, those prior posted items must be identifiable to the system so that they can be handled appropriately as informational and not be posted to the A/R system. Claim Adjustment Reason Code (CARC) 23 is used for this purpose. CARC 23 is to be used to identify the payments and contractual reductions that have already been posted to the A/R system by the provider, even in scenarios where the secondary payer doesn’t take into account what a prior payer actually adjudicated. Only the results of the current payer’s adjudication should be reported in the “actual” CARCs (CARCs other than 23).

RFI 2143 describes in detail the process used for creating an 835 reflecting prior payers’ payments and adjustments, along with a variety of scenarios that occur around coordination of benefits.

14 http://rfi.x12.org/Request/Details/2143?searchOption=AllSearchWords
XIII. Adjustment coding

The claim adjustment and service adjustment segments in the 835 transaction provide the reasons, amounts and quantities of any adjustments that the payer made either to the original submitted charge or to the units related to the claim or service(s). Claim Adjustment Reason Codes (CARCs) and amounts appear in the CAS segment and can be related to the claim as a whole (2100 loop) or a specific service line (2110 loop). Payers must supply not only the amount of the adjustment, but also information related to the entity financially responsible for the adjustment amount (group code), and (sometimes) supplemental information that further clarifies the adjustment reason (Remittance Advice Remark Codes or RARCs). When posting payment information, it is important to understand the entire message being sent by evaluating group codes, CARCs and remark codes in combination. Information on valid codes is available at www.wpc-edi.com.

A. Claim Adjustment Group Codes

Issue: Payers may assign incorrect group codes to adjustments, causing confusion or incorrect actions to be taken by the provider. Providers (or their practice management systems) may not use group codes in posting adjustments, which may cause adjustments to be posted incorrectly.

Best Practice: It is important for the payer to assign the correct group code to the adjustment when creating the 835 transaction to accurately convey their intent with the adjustment amount. It is also important for the provider to utilize those group codes during the automated posting process to ensure accurate handling of the adjustment amount, which may require the provider to work with the PMS vendor to ensure the automated posting process correctly uses the group codes.

The claim adjustment group code is used to categorize the associated adjustment reason code(s) based on financial liability. Group codes can indicate patient responsibility, contractual obligations, payer initiated adjustments or other adjustments. It is important for the payer to assign the correct group code to the adjustment when creating the 835 transaction to accurately convey the intent with the adjustment amount. It is also important for the provider to utilize those group codes during their automated posting process to ensure accurate handling of the adjustment amount. The CARC itself cannot always convey financial responsibility – even CARCs traditionally thought of as solely patient responsibility can, in certain situations, fall into different group code categories. Use of the group code may require the provider to work with their PMS vendor to ensure the automated posting process correctly uses the group codes.

1. Patient Responsibility (PR)

The Patient Responsibility Group Code is used in situations where the patient is responsible for the amount being adjusted. Examples of patient responsibility include copay, co-insurance, deductible and benefit limitations.
When amounts are assigned to a Patient Responsibility Group Code incorrectly, the patient may be billed for amounts that they are not actually responsible for, requiring manual intervention from the provider to correct.

2. **Contractual Obligations (CO)**

The Contractual Obligations Group Code is used when one of the following situations exist:

- A contract or negotiated fee arrangement between the payer and the provider
- Regulatory requirements
- Missing information, billing or coding errors occur (provider only) and a contract/negotiated fee arrangement/regulatory requirements

The amount being adjusted is the responsibility of the provider, it is not the responsibility of the patient. When amounts are incorrectly assigned to a Contractual Obligation Group Code, the provider may write off amounts that could potentially be re-billed, billed to a secondary payer or billed to the patient.

3. **Payer Initiated Reductions (PI)**

The Payer Initiated Reductions Group Code is used in one of the following situations:

- A contract or negotiated fee arrangement does not exist between the payer and the provider
- Regulatory requirements do not exist
- Missing information, billing or coding errors and a contract/negotiated fee arrangement/regulatory requirements do not exist

The payer is indicating that the member should not be responsible for the amount being adjusted; however, ultimate responsibility has not been established. When amounts are assigned to a Payer Initiated Group Code, the provider must carefully evaluate the CARCs and RARCs to determine financial responsibility for the adjustment and to ensure that the adjustment is correct. The provider may need to contact the payer with further questions to ultimately determine responsibility for the adjustment amount.
4. Other Adjustments (OA)

Outside of retail pharmacy, the Other Adjustments Group Code is only allowed in one of the following situations:

• Explicitly allowed or required by a business section of the implementation guide (for example, when reporting bundling and unbundling)
• Explicitly included in the CARC code usage requirements expressed within the CARC description itself (for example, CARC 136 – "Failure to follow prior payer’s coverage rules. (Use Group Code OA")

Ultimate responsibility of the amount being adjusted cannot be determined by the payer. When amounts are assigned to an Other Adjustment Group Code, the provider must carefully evaluate the CARCs and RARC s to determine financial responsibility for the adjustment and to ensure that the adjustment is correct. The provider may need to contact the payer with further questions to ultimately determine responsibility for the adjustment amount.

B. Claim Adjustment Reason Codes

Issue: Payers may include an incorrect or generic Claim Adjustment Reason Code (CARC), which does not provide enough information to the provider to understand the reason for the adjustment.

Best Practice: Payers should ensure that the CARCs presented in the 835 provide sufficient information for providers to understand the reason for their adjustments, which may include using a remark code for additional information.

CARCs provide the explanation for the positive or negative financial adjustments specific to particular claims or services that are referenced in the 835. Payers should provide the most accurate and descriptive CARC available for the adjustment being presented.

Prior to use of an 835 remittance advice transaction, payers may have provided a proprietary remittance advice file, or a paper remittance advice. Adjustment amounts reported on these were typically accompanied by a proprietary adjustment code conveying the reason for the adjustment. As payers converted to the HIPAA-standard 835 transactions, mapping their proprietary codes to the HIPAA-mandated standard codes was often a challenge. Payers may have been required to present a less-specific CARC because they were unable to find a match for their proprietary code. This can discourage providers from using the 835 transaction or can cause a more burdensome follow-up process, because they feel they do not get enough information to manage their denials and adjustments from the CARCs provided.
Payers should ensure that the CARCs presented in the 835 provide sufficient information for the providers to understand the reason for their adjustments, which may include using a remark code for additional information (see next section). Payers can request additional CARCs, when necessary, to ensure that appropriate information is conveyed to the providers. In addition, payers should ensure that they are providing this information in the 835 and not inadvertently encouraging providers to remain on paper by providing more detailed information on the paper remittance advice.

When states require specific language to be conveyed to the providers, payers may experience challenges in using the standard CARC list in place of their proprietary codes. CARCs that include the state-specific language can be requested, but they may not be approved by the CARC Codes Committee because specific language-CARCs are often made as generic as possible in order to be used by all the stakeholders of the CARC list. Payers should work closely with the code committee representatives to ensure full understanding of the requirements and reasons for specific code requests.

C. Remittance Advice Remark Codes

Issue: Payers may not use RARCs in their ERAs when they may not provide a complete message to the provider to understand the adjustment. In addition, some payer or provider trading partners, intermediaries or PMS vendors do not pass along the RARC information or include the RARC information on reports.

Best Practice: It is critical for the provider to receive and utilize the entire set of adjustment codes in order to be able to eliminate the paper remittance advice and use the ERA for auto-posting and follow-up. Payers must provide appropriate RARCs in their files, and provider partners must pass through and utilize all of the codes so that the provider has all information necessary to understand and post their payments and adjustments.

Remittance Advice Remark Codes (RARCs) provide additional information related specifically to a CARC that further clarify the reason for the adjustment being made and/or information about the claim adjudication. RARCs are a standardized code list owned by CMS and are used when they are necessary for the provider to fully understand the adjustment message for the claim adjustment. For example, a CARC may state “Missing Information,” and the RARC provides the additional description of exactly what information is missing (e.g., X-Ray). RARCs may also appear independently to provide further clarifying information about the claim adjudication or the provider’s ability to appeal, etc. In some cases, RARCs are required to be reported, as denoted in some CARC descriptions. In addition, there are scenarios where specific CARC/RARC combinations are required – see next section.

15 New CARCs can be requested at www.wpc-edi.com using the Change Request Form link on the online CARC list.

16 The RARC list is available at www.wpc-edi.com, along with the form for requesting new RARCs.
Some payers do not use RARCs in their ERAs, which then can result in a non-compliant file and does not provide this additional information to providers receiving the ERAs. Without this additional clarifying information, providers must still resort to phone calls to fully understand the reason for the adjustment and the requirements to correct and resubmit.

There may also be some situations where payer or provider trading partners, intermediaries or PMS vendors do not pass along the RARC information or include the RARC information on reports. This also is a situation where the provider does not receive the information necessary to understand the adjustment, resulting in a phone call to the payer.

It is critical for the provider to receive and utilize the entire set of adjustment codes in order to be able to eliminate the paper remittance advice and use the ERA for auto-posting and follow-up. Payers must provide appropriate RARCs in their files, and provider partners must pass through and utilize all of the codes so that the provider has all information necessary to understand and post their payments and adjustments.

D. CARC/RARC combinations

Issue: Different payers may use different CARCs, RARCs or combinations of CARCs and RARCs to convey the same message for adjustments.

Best Practice: Payers must comply with CAQH CORE Rule 360 in conveying CARC/RARC combinations for the included business scenarios. For other business scenarios that are not included in the Operating Rule, payers must ensure a complete message about the adjustment by using appropriate RARCs.

Even when payers use the standard CARC and RARC lists, providers may experience challenges because different payers may use different CARCs, RARCs or combinations of CARCs and RARCs to convey the same message for adjustments. Providers must have a detailed understanding of each payer and how each provides information on adjustments to be able to accurately work their adjustments and denials. This causes challenges in using the ERA.

CAQH CORE Rule 360\textsuperscript{17} was developed to alleviate these challenges. This operating rule describes four business scenarios and combinations of CARCs, RARCs and Group Codes that are allowed to be used when an adjustment falls within one of these business scenarios. Adhering to these required CARC/RARC/Group Code combinations means that providers will receive the same message for the same adjustment reason, regardless of the payer, thus allowing the provider to develop more automated and standard processes.

\textsuperscript{17} CAQH CORE Rule 360 “Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule”
It is important to understand that the operating rule applies only to the four business scenarios that are included in the rule. Situations that fall under a different business scenario do not limit the CARCs/RARCs/Group Codes used to those listed in the operating rule.\(^\text{18}\) The X12 CARC-RARC Encyclopedia: Code Value Usage in Health Care Claim Payments and Subsequent Claims TR2 includes a comprehensive list of all possible CARC/RARC combinations to assist payers with creating CARC/RARC combinations that convey a complete message to the provider.\(^\text{19}\)

In addition, some CARCs that are used without a RARC (e.g., deductible or co-insurance) are not included in the operating rule and can be used as needed. Only CARCs or CARC and RARC combinations that fall within the four business scenarios are limited to the combinations included in the operating rule. In addition, some CARCs that are classified as “Alert” CARCs (including the word “Alert” in the CARC description) are not included in the operating rule and can be used in the 835.

E. Provider Level Adjustments

**Issue:** Payers use incorrect Provider Adjustment Codes in the PLB and incorrect (or none) Reference Identifiers to assist the provider in identifying the transactions affected by the adjustment. Practice management systems do not manage Provider Level Adjustments well, and often do not post them automatically.

**Best Practice:** Payers must use Provider Adjustment Codes that accurately reflect the reason for the Provider Level Adjustment. Reporting a meaningful Reference Identifier (either as required by the ASC X12N 835 TR3 or the Patient Account Number), along with the Provider Adjustment Code, is essential to help the provider resolve 835 posting without the need to contact the payer. Practice management systems must be updated to automatically post the adjustment information.

The Provider Level Adjustment (PLB) segment allows payers to report provider adjustment amounts that increase or decrease the total payment amount (BPR02). Typically, these adjustments are not specific to an individual claim in this 835; however, in the case of overpayment recovery/forward balance, they may relate to a specific claim. Adjustments may also relate to a specific claim in a previous 835.

Provider Adjustments are posted to the general ledger only, not to individual patient accounts on the provider’s system. PLBs are used to report items like interest, forward balances, overpayment recoveries, capitation payments, prompt-pay discounts and others. PLBs should not be used when the funds are applied to the specific patient

\(^{18}\) Per CAQH CORE Rule 360 “Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule,” page 13: “The four CORE-defined Claim Adjustment/Denial Business Scenarios represent a minimum set of Business Scenarios. When a specific CORE-defined Business Scenario is not applicable to meet the health plan’s or its PBM agent’s business needs, a health plan or its PBM agent may develop additional Business Scenarios and code combinations for them. Any additional Business Scenarios must not conflict with the CORE-defined Claim Adjustment/Denial Business Scenarios defined in this section.”

\(^{19}\) The CARC-RARC Encyclopedia: Code Value Usage in Health Care Claim Payments and Subsequent Claims TR2 is available through the store at www.x12.org.
account. The PLB Adjustment Code is used to identify the exact purpose of the PLB adjustment and must be accurate to ensure a clear message to the provider.

Provider Level Adjustments are historically difficult for providers to interpret and post without additional information from the payer. In conjunction with the provider Adjustment Code, payers should be utilizing the Reference Identifier for reporting additional information or tracking information related to the provider adjustment (for example the trace number (TRN02) of the transaction or the patient control number (CLP01) or claim ICN(CLP07)). Reporting a meaningful Reference Identifier along with the Provider Adjustment Code is essential to help the provider resolve 835 posting without the need to contact the payer. In some cases, the front matter of the 835 TR3 specifies the value to include in the Reference Identifier. When the TR3 does not specify the value to be used, the patient control number is recommended (when applicable).

Provider Level Adjustments are part of overall balancing of the 835 transaction. Within the transaction, the sum of all claim payments minus the sum of all provider Level Adjustments equals the total payment amount. Because the PLB Adjustment Amounts are subtracted from the sum of the claim payments in the 835, a positive amount in the PLB decreases the payment amount, and a negative amount in the PLB increases the payment amount. Inconsistent use of the PLB, either by using incorrect Provider Adjustment Codes or not including meaningful Reference Identifiers, requires the provider to perform manual efforts to post the information conveyed in the PLB or to contact the payer to gather the information needed to identify the adjustment.

XIV. Vendors/Practice management system

Issue: Practice management systems may not provide all functionality needed by providers to automate their processes and take advantage of ERA and EFT.

Best Practice: The PMS should be able to receive both an ERA and EFT and should be able to automatically reassociate them so the provider knows it has received the funds as well as the remittance prior to posting. The PMS should be able to auto-post the remittance information and appropriately update the patient accounts. The adjustment information in the ERA should be utilized to manage workflow within the provider’s office, including secondary billing, denial management and claim resubmission. The PMS should also easily manage Provider Level Adjustments without requiring manual intervention.

Practice management systems (PMS) play an integral role in managing the ERA and EFT files for the provider. These systems manage all parts of the provider’s processes, including their administrative functions as well as their accounts receivable, and it is critical that they manage the electronic transactions effectively in order to enable the provider to have the most efficient processes possible.
The PMS should be able to receive both an ERA and EFT, and should be able to automatically reassociate them so the provider knows they have received the funds as well as the remittance prior to posting. The PMS should be able to auto-post the remittance information and appropriately update the patient accounts. The adjustment information in the ERA should be utilized to manage workflow within the provider’s office, including secondary billing, denial management and claim resubmission. The PMS should also easily manage Provider Level Adjustments without requiring manual intervention.

If the PMS does not manage the interaction of the ERA and EFT with the provider’s patient accounts and general ledger effectively, this strongly discourages providers from adopting the electronic transactions and prevents them from creating efficiencies within their office.

**XV. Handling compliance issues**

Many of the barriers described in this paper are a result of either payers or providers being out of compliance with HIPAA regulations. These regulations are designed to promote administrative simplification, and use of electronic transactions for ERA and EFT are a large part of that.

When a trading partner is out of compliance, the first step should always be to approach and work with that trading partner directly to resolve the issue. In the situation where compliance issues cannot be resolved, however, CMS does offer a mechanism for bringing visibility to the issue and working through a corrective action plan to resolve the issue.

The CMS Administrative Simplification Enforcement and Testing Tool (ASETT) is available for reporting issues that need assistance in creating or working through a corrective action plan. This tool is not intended as a mechanism for imposing fines or penalties, but rather as a way to engage CMS in working through compliance issues and implementing plans to remediate these issues. Issues can be reported through this tool anonymously and provide CMS a way to gain visibility into the issues that are occurring in the industry\(^\text{20}\).

**XVI. Summary**

Many barriers still exist that prevent providers and payers from adopting the Electronic Remittance Advice and Electronic Funds Transfer transactions. Some payers may not

\(^{20}\) [https://htct.hhs.gov/asett/public/home.act](https://htct.hhs.gov/asett/public/home.act)
be fully HIPAA-compliant and do not offer both ERA and EFT transactions or do not provide all of the CORE Minimum Required Data for Reassociation. Payers may use vendors that introduce challenges in creating ERA and EFT files that match appropriately, including payment amounts and reassociation information included in both files. Issues with the ERA files, including balancing, grouping of the files, information reported from secondary payers and adjustment codes within the files, may make the files impossible for providers to post. Processes around the files like overpayment recovery and researching missing files may cause enough apprehension with the provider to discourage use of the ERA and EFT. Even issues with the EDI enrollment process itself introduce barriers that prevent adoption of the electronic transactions.

Working with all partners – payers, providers, vendors, clearinghouses and PMS vendors, is essential to make progress in reducing or eliminating these barriers and increasing adoption of the electronic transactions, which ultimately benefits everyone involved.

The WEDI Remittance Advice and Payment (ERA/EFT) SWG meets regularly to discuss items relevant to both the ERA and EFT transactions and would appreciate ongoing feedback regarding the barriers identified in this paper – success stories as well as ongoing opportunities for education. Information on SWG meetings is available at www.wedi.org.

XVII. Acknowledgements

WEDI Remittance Advice and Payment (ERA/EFT) SWG Co-Chairs

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Appendix A. Definitions

X12N 835/ERA – The X12N 835 is the X12N transaction for the Health Care Claim Payment/Advice and is the HIPAA-required transaction set to use for health care claim payments, using the ASC X12N/005010x221 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 settlements of payments among financial institutions. The ACH Network is governed by the *NACHA Operating Rules & Guidelines*.

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

**Banking Days** – Pursuant to U.C.C. § 4-104, a banking day means a day on which a financial institution is open to the public for carrying on substantially all of its banking functions. Banking day is the business day of a financial institution. Banking days include all the days when offices of a financial institution are open for business to the public. Business includes all banking functions. Usually a banking day is any day except Saturday, Sunday and legally defined holidays. Regulations D and CC of Federal Reserve Regulations deal with public holidays.\(^\text{21}\)

**Business Days** – A business day consists of the 24 hours commencing with 12:00 a.m. (midnight or 00:00 hours) of each designated day through 11:59 p.m. (23:59 hours) of that same designated day. The actual calendar day(s) constituting business days are defined by and at the discretion of each health plan.\(^\text{22}\)

**Business Associate** – Person or organization that conducts business with a covered entity that involves the use or disclosure of individually identifiable health information. Business associates include those that perform services on behalf of the covered entity, such as claims processing, data analysis, utilization review and billing or provide services to the covered entity, such as legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services. To be a business associate, the work of an organization must deal directly with the use or disclosure of protected health information.\(^\text{23}\)

**Business Associate Agreement** – A covered entity’s contract or other written arrangement with its business associate must contain the elements specified at 45 CFR 164.504(e). For example, the contract must: describe the permitted and required uses of protected health information by the business associate; provide that the business associate will not use or further disclose the protected health information other than as permitted or required by the contract or as required by law; and require the business associate to use appropriate safeguards to prevent a use or disclosure of the protected health information other than as provided for by the contract. Where a covered entity

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\(^{21}\) CAQH CORE Rule 370 version 3.0.0, page 16

\(^{22}\) Ibid.

knows of a material breach or violation by the business associate of the contract or agreement, the covered entity is required to take reasonable steps to cure the breach or end the violation, and if such steps are unsuccessful, to terminate the contract or arrangement. If termination of the contract or agreement is not feasible, a covered entity is required to report the problem to the Department of Health and Human Services (HHS) Office for Civil Rights (OCR).24

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 health care administrative data exchange and improves health plan-provider interoperability through the development of industrywide 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 health care standards under ACA Section 1104.

CCD – 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). The CCD format includes:

- File Header Record (one per file)
- Company/Batch Header Record (one per batch)
- Entry Detail Record (one per payment)
- Addenda Record (one per Entry Detail Record)
- Company/Batch Control Record (one per batch)
- File Control Record (one per file)

Clearinghouse – “Health care 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.

Effective Entry Date – Effective Entry Date is the date specified by the originator on which it intends a batch of entries to be settled.25 It is date the payer intends funds to be made available to the payee via EFT as specified in the ACH CCD+ Standard in Field #9 of the Company Batch Header Record 5.37. The Effective Entry Date is dependent on valid banking days, and can be impacted if the intended date does not fall on a valid banking day.


24 http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html
25 2014 NACHA Operating Rules, Subsection 3.2.2
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.

EOB – An Explanation of Benefits is a statement sent by a payer to covered individuals or providers explaining what medical treatments and/or services were included in the payment.

EOP – An Explanation of Payment is a statement sent by a payer to providers providing detail on claims that have been paid, denied or adjusted.

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 health care 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 health care 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 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 health care providers in the United States by CMS.
**ODFI** – The Originating Depository Financial Institution is the originator of the ACH transaction. The ODFI enters the payment entry (a credit or debit) into the ACH Network. For the purpose of this paper, it is the payer’s financial institution – the sender of the remittance payment.

**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/pre-notification 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 number 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.

**RDFI** – The Receiving Depository Financial Institution is the recipient of the ACH transaction. The RDFI receives and posts payments into the receiver’s account (or processes a debit from the receiver’s account). For the purpose of this paper, it is the provider’s financial institution – the receiver of the remittance payment.

**Reassociation** – Matching a payment to the remittance advice data received.

**Settlement** – The actual transfer of the value of funds between financial institutions to complete the payment instruction of an ACH entry.

**Settlement Date** – On the Settlement Date, all the ODFI, RDFI and ACH operator effect the appropriate settlement of funds, and the RDFI posts the entries to the receiver’s account.

**TIN** – Tax Identification Number. A Taxpayer Identification Number is an identifying number used for tax purposes in the United States. It is also known as a Tax Identification Number or Federal Taxpayer Identification Number. A TIN may be

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26 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.

27 CAQH CORE Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule version 3.0.0 June 2012, p. 19
assigned by the Social Security Administration or by the Internal Revenue Service (IRS).

TR3 – Technical Report Type 3 are implementation guides developed by X12N.

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).

Appendix B. Resources

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

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

“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

Additional papers published by the WEDI 835 SWG, available at www.wedi.org:

“Overpayment Recovery 5010 Education”

“Successful Practices for Implementation and Use of the 835 Transaction”


2014 NACHA Operating Rules at www.nacha.org

CAQH CORE Phase III EFT and ERA Operating Rules 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

CMS Tools:

Covered Entity Decision Tool – NEW AND IMPROVED!


Information about Business Associates and Covered Entities on the OCR website:

http://www.hhs.gov/hipaa/for-professionals/covered-entities/index.html

There is a link on the OCR website to a sample Business Associate Contract and to some of their resolution agreements (from enforcement).

Appendix C. Regulations

In order to standardize the process and transactions used for electronic health care payments, HHS has published the EFT Standards Final Rule28 for EFT transactions sent through the ACH Network. These standards make the EFT transaction a HIPAA transaction, requiring payers to provide the payment with an EFT via the ACH Network if requested by the provider. In addition, the standards require use of the CCD+ Addenda for Stage One payment initiation for ACH transactions sent from the Payer to the Payer’s financial institution, and also requiring information contained in the Payment Related Information field of the Addenda Record of the CCD+ transaction to be compliant with the X12/005010x221 Health Care Claim Payment/Advice (835) TR3 requirements for the TRN segment. The EFT Trace Number29/Check Number (data element TRN02 in the 835 transaction) and Company ID (data element TRN03 in the 835 transaction) are key data elements used to match the EFT payment file with the Remittance Advice.

In addition, Operating Rules have been published in a Final Rule, dated April 19, 201330, and include requirements for EFT/ERA Enrollments, EFT/ERA Reassociation, 

28 45 CFR Parts 160 and 162, “Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice”

29 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.

30 45 CFR Part 162, “Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice Transactions; Final Rule”
Uniform Use of CARC/RARCs, and 835 Infrastructure. Compliance with both the EFT Standards and the Phase III CAQH CORE EFT and ERA Operating Rule requirements was mandatory by January 1, 2014. Section 1104 (124 STAT. 150) of the Affordable Care Act (ACA) includes a requirement that any entity (Business Associate) that provides services under contract to a Health Plan also meet all compliance requirements.

Financial transactions are processed today through the Automated Clearing House (ACH) Network, the backbone for the electronic movement of money and data. Governed by NACHA, The Electronic Payments Association, the ACH Network provides a safe, secure, and reliable network for direct account-to-account consumer, business, and government payments. NACHA manages the development, administration, and governance of the ACH network. The NACHA Operating Rules govern the exchange of ACH payment transactions, and define the roles and responsibilities of participants in the ACH network.31

To support payers and providers' use of the ACH Network for payment of health care claims and the exchange of payment related information, NACHA membership approved changes to the NACHA Operating Rules for health care transactions on October 31, 2012.32 These health care specific changes to the NACHA Operating Rules became effective on September 20, 2013. The health care changes implemented include:

- Unique Identification of Health care EFTs
- Additional Formatting Requirements for Health care EFT Transactions
- Delivery of Payment Related Information (Reassociation Number)
- Additional EDI Segment Terminator for ACH Addenda Records
- Health care Terminology within the NACHA Operating Rules

The NACHA Operating Rules should be used in combination with the health care industry operating rules that were developed for EFTs and Electronic Remittance Advices (ERAs). Together, the CAQH CORE Phase III Operating Rules and the NACHA Operating Rules provide for standardized electronic payment of health care claims and the reassociation of the payments with the health care remittance advices. This simplifies the process for both payers and providers. The key component to the success of the EFT/ERA process is for the provider to be able to match the payment information to the remittance information they received.

31 www.nacha.org
32 NACHA Operating Rules are updated annually. At the current time, no further health care changes are planned; however, any changes will be well publicized at www.nacha.org