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

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Introduction

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 included a series of “administrative simplification” provisions to improve the efficiency and effectiveness of the health care system, and included transaction standards for Electronic Remittance Advice transactions. EFT transactions were not included in the original HIPAA legislation; but are in use (and have been for quite some time) by healthcare entities to exchange funds electronically. Because these transactions were not required, and not standardized, adoption is slow and usage of the transactions by providers can be problematic.

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA), which includes requirements for identification of an EFT standard, development of EFT and ERA operating rules, and requirements for usage of EFT for Medicare by 2014. This legislation makes the EFT transaction and associated operating rules part of the HIPAA requirements, and mandated requirements for all HIPAA covered entities.

As a result of these requirements, a Final Rule was published in July 2012 establishing the EFT transaction as a HIPAA transaction, requiring health plans to support this transaction if requested by a provider. The CCD+ format is required for “Stage 1” payment initiation by the health plan, and the addenda record contained within the CCD+ transaction is required to comply with the format defined in the ASC X12N/5010x221 Health Care Claim Payment /Advice (835) TR3.¹

In addition, Operating Rules have been published in an Interim Final Rule with Comments (IFC), dated August 10, 2012, 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 is mandatory by January 1, 2014. CMS announced on April 19, 2013, that this IFC is now considered a final rule, with no changes made based upon comments received.

Background

The CAQH CORE Operating Rules are being implemented in Phases, and documentation for all phases of operating rules is available at www.caqh.org. Phase I addressed the Eligibility process and Phase II added Claim Status as well as enhancing the Eligibility rules that were addressed in Phase I.

¹ 45 CFR Parts 160 and 162, “Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice”
Phase III focuses on the Electronic Remittance Advice (ERA) and the Electronic Funds Transfer (EFT) process.

The Phase III CAQH CORE EFT and ERA Operating Rule Set includes:

- Phase III CORE 350 Health Care Claim Payment / Advice (835) Infrastructure Rule Version 3.0.0 (with the exception of the requirement for acknowledgements) (referred to hereafter as “CAQH CORE 350: Health Care Claim Payment / Advice (835) Infrastructure Rule”)
- Phase III CORE 360 Uniform use of CARCs and RARCs (835) Rule, with accompanying document “CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule” (referred to hereafter as “CAQH CORE 360: Uniform use of CARCs and RARCs (835) Rule”)
- Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule (referred to hereafter as CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule”)
- Phase III CORE 380 EFT Enrollment Data Rule (referred to hereafter as “CAQH CORE 380: EFT Enrollment Data Rule”)
- Phase III CORE 382 ERA Enrollment Data Rule (referred to hereafter as “CAQH CORE 382: ERA Enrollment Data Rule”)

The Phase III CAQH CORE EFT and ERA Operating Rules were developed to help the health care industry migrate from a paper-based process to utilizing electronic transactions.

Using the EFT transaction with the ERA transaction automates the payment process and reduces the need for paper checks and the manual processing required to handle the paper checks.

In today’s environment, each health plan may have different enrollment requirements for providers to receive EFT payments. Based on the number of payers that a provider is dealing with, this can become a very time-consuming process.

Between the payers, there may be wide variety of data elements required for enrollment and they may also have different enrollments processes based on their internal requirements.

With operating rules that identify common data elements that must be used for enrollment, the process for providers will be greatly improved.

While the payers may experience a number of changes to their current enrollment process, overall the number of EFT and ERA enrollments may increase based on a consistent process and reduce their costs needed to generate paper remittance advices and paper checks.
Scope

Because of the increased visibility of ERA and EFT resulting from the ACA, and the imminent new requirements being put in place, the WEDI EFT Subworkgroup was formed, and began creation of educational material to provide information and clarification on the EFT and ERA standards and operating rules being proposed, and the process needed to implement and utilize these requirements.

The enrollment process for EFT and ERA varies widely throughout the industry today. This document will include an overview of the Phase III CAQH CORE EFT and ERA Operating Rules that address the EFT and ERA enrollment process for both paper and electronic enrollments and requirements for payers, providers, and clearinghouses.

Definitions

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

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

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

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

CCD - ACH Corporate Credit or Debit Entry (as named in the NACHA Operating Rules section 8.20) or Cash Concentration or Disbursement transaction (as termed in the 835 TR3). A NACHA format
used to deliver payments through the ACH Network. The CCD+ format is the CCD with the additional Addenda record included in the file (CCD Plus Addenda).

Clearinghouse - For the purposes of this paper, “healthcare clearinghouses” are being defined as organizations that send or receive nonstandard data content and then formats it into standard data elements or transactions.


EFT - Electronic Funds Transfer (EFT) is the 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, Fedwire transfers, transfers made at ATMs, and point of sale terminals. The EFT transaction is required under the HIPAA regulation to be supported by health plans when requested by a provider.

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 Terms:

- Originator – The entity that initiates a payment (credit or debit) with their financial institution to or from the account of a receiver. The Originator is usually a company directing their bank to transfer funds to or from another company’s account. For the purposes of this paper, the Originator is the payer.

- 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.

- Receiver: The entity that has authorized an Originator to initiate a payment to or from the Receiver’s account. The Receiver is usually a company that is accepting payment from another company (Originator) or allowing a debit to pay the Originator. For the purposes of this paper, the Receiver is the provider.
• 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.

NACHA Rules –

• Transfer of Payment data from Bank to Health Care Provider: Effective September 20, 2013 the NACHA Operating Rules require that all RDFIs include on secure electronic deliver 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 bank (RDFI) must provide all information contained within the Payment Related Information field in the CCD Addenda record. The provider’s bank 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 Section III, Chapter 24; page OG 83, 2011 NACHA Operating Rules & Guidelines.

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

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

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

Pre-Note - A pre-note is a non-monetary entry transmitted through the ACH Network by an Originator to an RDFI. It conveys the same information (with the exception of the dollar amount and transaction code) that will be carried on subsequent entries, and allows the RDFI to verify the accuracy of the account data. The Pre-Note verifies that the account number is a valid account number at the RDFI it does not verify that the name on the account matches the name on the ACH entry.

Provider - For the purposes of this paper, “provider”, or their agent, is defined as an individual or organization that provides health care services.²

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

**Credentialing / Registration / Enrollment**

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/835) to a designated location. 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.

Enrollment for EFT/ERA is not to be confused with ‘credentialing’; which is the action that providers must take with their payers to contract and “record” their demographic and professional information so they can receive payment for health care claims from the payer. Credentialing can also be considered “the process of reviewing a health professional’s credentials, training, experience, or demonstrated ability, practice history and medical certification or license to determine if clinical privileges to practice in a particular place are to be granted.”

Payers may set up information on the provider in internal tables or databases to reference during adjudication and when making payments.

The Phase III CAQH CORE EFT and ERA Operating Rules included in the IFC being discussed in this paper pertain to the EDI enrollment process, and do not pertain to the credentialing / registration process.

**Benefits and Challenges of Enrolling for EFT and/or ERA**

**Benefits**

Implementing an electronic payment process can provide many benefits to both providers and payers, regardless of the format of the remittance advice received (electronic or paper). Because the EFT process eliminates the physical requirements for printing checks and utilizing the postal service, EFT payments reduce administrative steps and costs, including

- Costs of creating and mailing the paper check by the payer
- Manual Deposits by the provider

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• Manual handling of the mail and paper checks
• Cost of associating the paper check with the electronic Explanation of Payment (EOP)/Explanation of Benefits (EOB)/Remittance Advice (RA), which can be an extremely difficult task
• Manual cash posting to patient receivable system – electronic files allow more timely reassociation of the payment and ERA

Additional benefits of moving to an electronic remittance and payment process include:
• Providing a mechanism and standard data content through which the provider can standardize their process to
  • Reconcile bank deposits,
  • As 835s are received, the reassociation with the EFT ensures that the funds have been deposited in the bank
  • Auto post payments to receivable,
  • View payment data, and
  • As EFTs are received, reassociation with the 835 ensures all the 835 files have been received and the dollars match
  • Auto bill secondary insurance (in non-pharmacy situations).
    o Receiving and processing medical claim payments more quickly allows quicker turnaround on secondary billing and those associated payments as well
• EFT and 835 also facilitates and provides rich data for research into payments to ensure contract adherence, denial management (when the 835 is used to report denials), reimbursement levels for services rendered, etc.
  o Exceptions – missing data or missing dollars - can be handled as exceptions
  o Proper use of the EFT transaction and 835 TRN segment helps ensure the minimum number of exceptions that need addressing and will improve the accuracy of the automated matching that occurs.
• The EFT enrollment process itself allows the payer to validate
  • The provider is a valid provider
  • The bank account information is accurate
  • They have the proper authorization from the provider organization to send the claim payments using EFT
Challenges
Use of EFT may also introduce some challenges or items to consider:

- Fees may be involved for EFT processing at the bank. Any fees to willing trading partners will accrue to the entity who has the relationship with the bank
  - Payers may have transactional fees payable to their bank of choice for sending EFT
  - Providers may have transactional fees to their choice of deposit bank for payment receipt
- Providers working with multiple payers, some who offer EFT and some who do not, will be required to have different processes (some manual, some automated) between payers for reconciliation. As more payers offer EFT, this challenge is reduced.
- Payers who pay to the Taxpayer Identifier Number (TIN) level instead of to the Pay-To NPI billed on the claim may cause challenges in getting the 835 and EFT data to the appropriate practice management systems within the provider organization, and with the reconciliation and balancing process. Payers are allowed to pay at the higher TIN level upon mutual agreement between provider and payer, and some providers have a specific business need for payment at the TIN level.  
  
- Payers who do not format the EFT Addenda record in the CCD+ transaction correctly can cause significant challenges in reassociating the EFT payment to the 835 transaction. The required format of the Addenda record is outlined in the 835 TR3 document and adherence to that standard is necessary to allow automated reassociation, and is required to be considered compliant with the 835 TR3.

Use of ERA can introduce challenges also, including the need for providers to have processes in place to reassociate the ERA with a paper check, and for dealing with receiving an ERA for zero payments when a corresponding EFT may not be received. (Additional information regarding zero payments can be found in the WEDI white paper “Implementing a Healthcare Payment EFT Process to Accompany a Healthcare Claim Payment Remittance Advice” available at www.wedi.org.) Using both ERA and EFT together can help alleviate these challenges.

4 Example: due to contracting with commercial payers at a TIN level (mutual agreement), payments are made at a TIN level. Batching the 835 and EFT transactions by NPI would increase the number of files required to be reconciled due to the number of NPIs associated to each TIN. The reconciliation process would become unwieldy, and the cost associated with the additional EFT deposits would increase.
Format and Requirements of the EFT Enrollment Operating Rule

CAQH CORE Rule 380: EFT Enrollment Data Rule defines a maximum set of allowable data elements that can be included on an EFT enrollment form (either paper or electronic), as well as a “controlled vocabulary” for the naming conventions used for the allowable data elements (both the name and description from the operating rule must be included). This provides for consistency across payers for what can be requested during the enrollment process, and clarity for exactly what data elements are being requested.

Data elements are grouped into the following Data Element Groups, each representing a set of data elements that may need to be collected more than once for a specific context:

- DEG1: Provider Information
- DEG2: Provider Identifiers Information
- DEG3: Provider Contact Information
- DEG4: Provider Agent Information
- DEG5: Federal Agency Information
- DEG6: Retail Pharmacy Information
- DEG7: Financial Institution Information
- DEG8: Submission Information

Specific Data Elements and Data Element Groups are included in Table 4.2.1 of the CAQH CORE Rule 380: EFT Enrollment Data Rule.

The EFT Enrollment Rule also includes a requirement that the paper-based forms and electronic screens follow a “master template” for format, flow, field names and descriptions, and data set. The health plan must provide written instructions for how to complete the form, exact address or email address for delivery of the paper form (if applicable), and contact information (including telephone number and email address) at the health plan (page 20 of CAQH CORE Rule 380: EFT Enrollment Data Rule). The health plan must also provide instructions for how to access online instructions for determining the status of the EFT enrollment, and instruct providers to contact their financial institution to arrange for delivery of the CAQH CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA. For an XML-based electronic EFT enrollment method, some additional specific requirements are included in the rule.

The EFT Enrollment Rule specifies that all health plans and their respective agents must implement and offer to any trading partner (e.g., a healthcare provider) an electronic method (actual method to be determined by health plan or its agent) and process for collecting the CAQH CORE-required Maximum EFT Enrollment Data Set.
Electronic enrollment methods must comply with CAQH CORE Rule 380: EFT Enrollment Data Rule by the mandated compliance date (January 1, 2014). Paper enrollment forms must be updated within 6 months of the mandated compliance date (July 1, 2014).

Sample EFT Enrollment Form

Below is a sample of an EFT Enrollment form which could be used either on paper or electronically that complies with the master template defined within the EFT Enrollment Operating Rule. This sample includes some, but not all of the optional fields from the Operating Rules, and may need to be expanded based upon specific payer requirements:
Sample EFT Enrollment Form

Provider Information (DEG1 R)

Provider Name (DEG1 R)

Provider Address (DEG1 O)

Street (R)

City (R)

State/Province (R)

Zip Code / Postal Code (R)

Provider Identifiers Information (DEG2 R)

Provider Identifiers (R)

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) (R)

National Provider Identifier (NPI) (R when provider has an NPI)

Provider Contact Information (DEG3 O)

Provider Contact Name (R)

Telephone Number (R)

Email Address (R when provider has an email address)

Fax Number (O)

Financial Institution Information (DEG7 R)

Financial Institution Name (R)

Financial Institution Routing Number (R)

Type of Account at Financial Institution (R)

O Checking

O Savings

Provider’s Account Number with Financial Institution (R)

Account Number Linkage to Provider Identifier (R)

(Must match ERA Preference)

O Provider Tax Identification Number (TIN)

O National Provider Identification Number (NPI)

Reason for Submission (DEG8 R)

O New Enrollment

O Change Enrollment

O Cancel Enrollment

Include with Enrollment Submission (DEG8 O)

O Voided Check

O Bank Letter

Authorized Signature (DEG4 R)

Electronic Signature of Person Submitting Enrollment (O)

Printed Title of Person Submitting Enrollment (O)

Submission Date (O)

Requested EFT Start/Change/Cancel Date (O)
Sample Instructions for completing the EFT Enrollment form

Please type or print legibly.
Use only black or blue ink to complete paper form.
Online form can be accessed at www.xxxxx.com
Please allow 4 weeks for enrollment process which includes pre-note verification. If after 4 weeks you do not start receiving EFT payments, you may contact the EDI Team at x-xxx-xxx-xxxx or go to www.xxxxxxxxxx.com for other contact information.

For questions about the paper or electronic enrollment process, please call the EDI Team at x-xxx-xxx-xxxx.

Provider Information – Please fill out completely

Provider Name – Complete legal name of institution, corporate entity, practice or individual provider.
Provider Address
Street – The number and street name where a person or organization can be found.
City - City associated with provider address field.
State Province – ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country
Zip Code/Postal Code – System of postal-zone codes (zip stands for “zone improvement plan”) introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.

Provider Identifiers

Provider Federal Tax Identification Number (TIN) – A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.
National Provider Identifier (NPI) – A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Provider Contact Information

Provider Contact Name - Name of a contact in provider office for handling EFT issues
Telephone Number - Associated with contact person
Email Address - An electronic mail address at which the health plan might contact the provider
Fax Number - A number at which the provider can be sent facsimiles

Financial Institution Information

Financial Institution Name - Official name of the provider’s financial institution
Financial Institution Routing Number - A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited
Type of Account at Financial Institution: - The type of account the provider will use to receive EFT payments. e.g., Checking, Saving
Provider Account Number with Financial Institution - Provider’s account number at the financial institution to which EFT payments are to be deposited
Account Number Linkage to Provider Identifier: Provider preference for grouping (bulking) claim payments – must match preference for v5010 X 12 835 remittance advice
Must fill out one of the two options below.
Providers Tax Identification Number (TIN)
National Provider Identifier (NPI)

Reason for Submission: Must select one from below

New Enrollment.
Change Enrollment
Cancel Enrollment

Include with Submission: Must select one from below, note that a copy of a voided check is needed if checking account is being used.
EFT and ERA Enrollment Process to Support Healthcare Claim Payments and Remittance Advices

Voided Check - A voided check is attached to provide confirmation of Identification/Account Numbers
Bank Letter - A letter on bank letterhead that formally certifies the account owners routing and account numbers

Authorized Signature - The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment

Written Signature of Person Submitting Enrollment - A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity
Printed Name of Person Submitting Enrollment – The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment
Printed Title of Person Submitting Enrollment - The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment
Submission Date - The date on which the enrollment is submitted
Requested EFT Start/Change/Cancel Date – The date on which the requested action is to begin

Fax the completed form to: x-xxx-xxx-xxxx.

For questions about this form, please call the EDI Unit at x-xxx-xxx-xxxx.

The provider must contact its financial institution to arrange for the delivery of the CORE required Minimum CCD+ data elements needed for reassociation of the payment and the ERA. See Phase III CORE EFT & ERA Reassociation (CCD+/835) Rule Version 3.0.0.

Researching Missing / Late Files

EFT files that have not been received after 4 business days of receipt of the corresponding ERA file can be researched by calling the EDI Helpdesk at x-xxx-xxx-xxxx or online at www.xxxxxxxxxxxxx.com.
Sample EFT Enrollment Bank Letter

Below is a sample bank letter that is sometimes used during the EFT enrollment process to validate the bank account information involved in the enrollment, in lieu of a voided check.

Sample Bank Letter, to be produced on company letterhead:

Month  Day, Year

To Whom it May Concern,

This letter is to verify the following account information for facility name:

Name on account:
Account number:
ABA routing number:
Account type:

Please contact me at the following number with any additional questions: xxx-xxx-xxxx.

Sincerely,

Signature
Title
Address
Format and Requirements of the ERA Enrollment Operating Rule

As with CAQH CORE Rule 380: EFT Enrollment Data Rule, CAQH CORE Rule 382: ERA Enrollment Data Rule defines a maximum allowable data set and controlled vocabulary for use in collecting the maximum data set. The ERA Data Rule is very similar to the EFT Data Rule, with just a few differences.

Data elements are grouped into the following Data Element Groups, each representing a set of data elements that may need to be collected more than once for a specific context:

- DEG1: Provider Information
- DEG2: Provider Identifiers Information
- DEG3: Provider Contact Information
- DEG4: Provider Agent Information
- DEG5: Federal Agency Information
- DEG6: Retail Pharmacy Information
- DEG7: Electronic Remittance Advice Information
- DEG8: Electronic Remittance Advice Clearinghouse Information
- DEG9: Electronic Remittance Advice Vendor Information
- DEG10: Submission Information

Specific Data Elements and Data Element Groups are included in Table 4.2.1 of the CAQH CORE Rule 382: ERA Enrollment Data Rule.

Like the EFT Enrollment Rule, the ERA Enrollment Rule also includes a requirement that the paper-based forms and electronic screens follow a “master template” for format, flow, field names and descriptions, and data set. The health plan must provide written instructions for how to complete the form, exact address for delivery of the paper form (if applicable), and contact information (including telephone number and email address) at the health plan. The health plan must also provide instructions for how to access online instructions for determining the status of the ERA enrollment. For an XML-based electronic ERA enrollment method, some additional specific requirements are included in the rule.

The ERA Enrollment Rule specifies that all health plans and their respective agents must implement and offer to any trading partner (e.g., a healthcare provider) an electronic method (actual method to be determined by health plan or its agent) and process for collecting the CAQH CORE-required Maximum ERA Enrollment Data Set.
Electronic enrollment methods must comply with CAQH CORE Rule 382: ERA Enrollment Data Rule by the mandated compliance date (January 1, 2014). Paper enrollment forms must be updated within 6 months of the mandated compliance date (July 1, 2014).

Sample ERA Enrollment Form

Below is an example of an ERA Enrollment form which could be used either on paper or electronically that complies with the master template defined within the CAQH CORE Rule 382: ERA Enrollment Data Rule. This sample includes some, but not all of the optional fields from the Operating Rules, and may need to be expanded based upon specific payer requirements:
Sample ERA Enrollment Form

Provider Information (DEG1 R)
Provider Name (DEG1 R) 

Provider Address (DEG1 O)
Street (R) 
City (R) State/Province (R) Zip Code/Postal Code (R)

Provider Identifiers Information (DEG2 R)
Provider Identifiers (R)
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) (R) 
National Provider Identifier (NPI) (R when provider has an NPI)
Other Identifiers Assigning Authority (R) Trading Partner ID (O)

Provider Contact Information (DEG3 O)
Provider Contact Name (R) 
Telephone Number (R) 
Email Address (O when provider has an email address) 
Fax Number (O)

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier) (DEG7 R)
(Must match EFT Preference)
O Provider Tax Identification Number (TIN) 
O National Provider Identification Number (NPI)

Method of Retrieval (O)

Electronic Remittance Advice Clearinghouse Information (DEG8 O)
Clearinghouse Name (R) 
Telephone Number (O) 
Email Address (O)

Reason for Submission (DEG8 R)
O New Enrollment 
O Change Enrollment 
O Cancel Enrollment

Authorized Signature (DEG8 R)
Electronic Signature of Person Submitting Enrollment (O) 
Printed Title of Person Submitting Enrollment (O) 
Submission Date (O) Requested ERA Effective Date (O)
Sample Instructions for completing the ERA Enrollment form
Please type or print legibly.
Use only black or blue ink to complete paper form.
Online form can be accessed at www.xxxxxx.com
Please allow 4 weeks for enrollment process which includes pre-note verification. If after 4 weeks you do not start receiving ERA files, you may contact the EDI Team at x-xxx-xxx-xxxx or go to www.xxxxxxxxxxxxx.com for other contact information.

For questions about the paper or electronic enrollment process, please call the EDI Team at x-xxx-xxx-xxxx.

Provider Information – Please fill out completely

Provider Name – Complete legal name of institution, corporate entity, practice or individual provider.
Provider Address
Street – The number and street name where a person or organization can be found.
City - City associated with provider address field.
State/Province – ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country
Zip Code/Postal Code – System of postal-zone codes (zip stands for “zone improvement plan”) introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.

Provider Identifiers
Provider Federal Tax Identification Number (TIN) – A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.
National Provider Identifier (NPI) – A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearings must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Other Identifiers:
Assigning Authority – Organization that issues and assigns the additional identifier requested on the form, e.g., Medicare, Medicaid
Trading Partner ID – The provider’s submitter ID assigned by the health plan or the provider’s clearinghouse or vendor.

Provider Contact Information
Provider Contact Name - Name of a contact in provider office for handling EFT issues
Telephone Number - Associated with contact person
Email Address - An electronic mail address at which the health plan might contact the provider
Fax Number - A number at which the provider can be sent facsimiles

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier): Provider preference for grouping (bulking) claim payments – must match preference for EFT payment
Must fill out one of the two options below.

Providers Tax Identification Number (TIN)
National Provider Identifier (NPI)

Method of Retrieval – Method in which provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.)

Clearinghouse Information
Clearinghouse Name – Official Name of the provider’s clearinghouse.
Telephone Number – Telephone number of contact.
Email Address – An electronic mail address at which the health plan might contact the provider’s clearinghouse

Reason for Submission: Must select one from below

New Enrollment
Change Enrollment
Cancel Enrollment.

**Authorized Signature** - The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment.

**Written Signature of Person Submitting Enrollment** - A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity.

**Printed Title of Person Submitting Enrollment** - The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment.

**Submission Date** - The date on which the enrollment is submitted.

**Requested ERA Effective Date** – Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner.

Fax the completed paper form to: x-xxx-xxx-xxxx

For questions about this form, please call the EDI Unit at x-xxx-xxx-xxxx.

**Researching Missing / Late Files**

ERA files that have not been received after 4 business days of receipt of the corresponding EFT file can be researched by calling the EDI Helpdesk at x-xxx-xxx-xxxx or online at www.xxxxxxxxx.com.
Differences between the EFT Enrollment Operating Rule and the ERA Enrollment Operating Rule

The EFT Enrollment Rule and ERA Enrollment Rule are structurally very similar. Most of the Data Element Groups and Data Elements are the same between the two rules. There are some elements, however, that differ between the two rules.

Areas in which the EFT Enrollment Rule differs from the ERA Enrollment Rule are:

- **DEG 7:**
  - EFT Rule - labeled: “Financial Institution Information”
  - ERA Rule - labeled: “Electronic Remittance Advice Information”
  - Both rules include a Data Element that requests the provider specify grouping or bulking the EFT or ERA data, by either TIN or NPI. The provider must specify the same data element (TIN / NPI) on both the EFT and ERA enrollment form. The Data Element labels are:
    - EFT – “Account Number Linkage to Provider Identifier”
    - ERA – “Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)”
  - These items are included for data collection purposes only, to provide information to the health plan for aggregation of payment and remittance advice data.

- **DEG8:**
  - EFT Rule - not included
  - ERA Rule - labeled “Electronic Remittance Advice Clearinghouse” Information

- **DEG9:**
  - EFT Rule - not included
  - ERA Rule - labeled – “Electronic Remittance Advice Vendor”

Identifiers included in the EFT and ERA Enrollment Forms in DEG2 and DEG7

The maximum allowed data set for the EFT and ERA Enrollment forms includes identification of the TIN and NPIs to be enrolled for the electronic transactions, as well as identification of TIN / NPI for bulking or grouping of the payment and ERA. Because these identifiers are included in both locations, the EFT workgroup requested clarification from CAQH CORE on how these identifiers should be used.

Per the response received from CAQH CORE:
The identifiers in DEG2 are specific to the provider being enrolled, which was previously identified in DEG1. These identifiers should reflect the numbers requested for enrollment in the electronic transaction by the provider.

DEG7 is used for indicating to the health plan how the provider would like to have their transaction grouped, either by TIN or NPI. The provider should then note the identifier (TIN or NPI respectively) that is associated with the account at their financial institution. These identifiers may or may not be the same as those listed in DEG2. The “bulking indicator” and identifier listed must be the same on the EFT and ERA enrollment forms.

The information collected in DEG7 is for informational purposes only. The operating rule does not require the health plan to make changes or act upon the information provided in DEG7.

**Payer Implementation of EFT/ERA Enrollment Process**

**EFT Enrollments for Payer**

Payers that provide EFT today have an EFT Enrollment form they use to enroll providers for EFT. It can be a paper form or Web template or other electronic format that is used. Once the provider completes the information and submits it to the payer, the payer will then validate the information to ensure that the submitter of the form is a valid provider and is eligible for receiving EFT payments. Most payers will validate the identifying provider information – Tax Id, NPI, etc. to ensure it is what is reflected in the payer’s internal provider database. If it is valid, the payer may generate a pre-note transaction (see definitions section) and send it to the provider’s bank to ensure the account information is a valid account at that institution before they actually start sending EFT payments for claims.

The optional pre-note process can take up 10 days (6 banking days from the settlement date of the pre-note) to ensure that the receiving bank has time to validate on their side that the account is good. If there is an issue with the account information, the payer will be notified and they will need to contact the submitter of the enrollment form to obtain the correct information. Once the correct information is received the payer will generate a new pre-note to ensure the account information is correct. The payer should ensure that information regarding the pre-note process is included in the enrollment instructions made available to the provider. Additional information regarding the pre-note process can be found in the WEDI white paper “Implementing a Healthcare Payment EFT Process to Accompany a Healthcare Claim Payment Remittance Advice” available at www.wedi.org.

Some payers also require that the submitter provide a copy of a voided check or a bank letter that can be used to validate the account information. They may also require the signature of the financial officer of the organization to ensure the payer is being properly authorized by the provider to send
EFT transactions to that account. With an electronic enrollment method, this may not be necessary, as this validation can be done online.

With the implementation of the Phase III CAQH CORE EFT and ERA Operating Rules, it is likely the payer will be required to make changes to their existing enrollment process, and add an electronic enrollment method if one is not currently offered (and can be web-based or utilize an electronic file format). CAQH CORE Rule 380: EFT Enrollment Data Rule and CAQH CORE Rule 382: ERA Enrollment Data Rule have identified the data elements that are required and the ones that are optional. All payers will be required to have the ability to accept all of the required data elements. Inclusion of the optional fields in the enrollment process is determined by the payer’s requirements. If a payer requires a copy of a voided check and/or the signature of the Financial Officer, they can request that information as part of the enrollment process.

The payer must also modify their enrollment process to include instructions on completing the enrollment process for both new enrollments as well as changes and/or deletions, and on informing the provider to contact their financial institution to arrange for the delivery of the CAQH CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA (required in both CAQH CORE 370: EFT & ERA Reassociation (CCD+/835) Rule and CAQH CORE 380: EFT Enrollment Data Rule).

If a payer is using a third party or an external vendor to handle the EFT process and generate the EFT transactions, then the payer needs to develop a process that will support the exchange of the enrollment information between the payer and the vendor. The external vendor will also need to communicate to the payer once the pre-note was successful so the payer can start generating the EFT records instead of paper checks.

**ERA Enrollments for Payer**

The enrollment process for ERA involves different information than what is needed for EFT; and, there may be more systems involved in setting up the process for a provider to receive the ERA. With the EFT process, the payer initiates the EFT transaction with their bank, and the majority of the subsequent communication is between the payer and provider bank, and the provider and their bank. With the ERA process, the payer will send the ERA transaction directly to the provider or they may send the transaction to a clearinghouse who will in turn forward the transaction to the provider.

Depending on how the payer has their ERA process setup, they may allow for providers to receive the ERA directly from the payer or the payer may require the provider to receive their ERA through one or more of the clearinghouses that have an arrangement with the payer.

If the payer is sending the ERA transaction directly to the provider, then the payer needs to coordinate that data exchange process with the provider. While the ERA Enrollment data allows for the provider to communicate to the payer how they want to receive the ERA transaction (directly or
through a clearinghouse), there is no way in the ERA enrollment data set for the provider to communicate the telecommunication requirements to the payer if they want to receive the ERA directly from the payer.

In the case where the payer will be sending the ERA transaction to the provider, there needs to be a communication effort between the payer and the provider on how the information will be exchanged. Once that communication process has been developed, it is recommended that that process be thoroughly tested before the payer goes live with the ERA transaction for the provider.

If the provider has elected to receive the ERA from one of the payer’s clearinghouses, then there needs to be a coordination effort between the payer and the clearinghouse to ensure that both entities have the correct enrollment information and are setup at the same time.

Before the payer can start sending the ERA transactions to the clearinghouse, the clearinghouse must have enrolled the provider in the ERA process or they will be unable to deliver the ERA to the provider. If the clearinghouse enrolls the provider in the ERA process before the payer has enrolled the provider, the clearinghouse will not receive any ERA transactions to send to the provider.

For ERA transactions, while the common enrollment process will help simplify the effort required to enroll a provider for the ERA, there are some steps related to the delivery of the ERA transaction that still need to be coordinated with all the parties involved in the flow of the ERA transaction, for example, continuation of the paper remittance advice and “safe-harbor” connectivity requirements mandated in CAQH CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule.

**Provider Execution of the EFT/ERA Enrollment Process**

Below are steps the Provider needs to perform for **EFT Enrollment**:

- Determine list of TINs and NPIs that need to be enrolled for EFT, along with associated bank accounts for each

- Coordinate with the bank regarding receipt of the CAQH CORE minimum required data elements needed for reassociation from the EFT transaction, ensuring that the bank will deliver this information, and identifying how that information will be provided so that the EFT information can be reassociated with the ERA

- Validate that TINs / NPIs are credentialed / registered with the health plan under the correct address as needed by that payer

- Complete the health plan’s required enrollment process (either paper or electronic) per the provided written instructions, gathering appropriate signatures as necessary
If working through a clearinghouse, then the enrollment process must be coordinated with the clearinghouse. Often, the clearinghouse will perform the enrollment process on behalf of the provider.

- Validate payer receipt of paper forms or processing of electronic submission as appropriate
- Validate completion of processing of enrollment by health plan
- Complete any process required by the health plan to validate small deposits made in lieu of a pre-note.
- Validate receipt of EFT payments and CAQH CORE minimum required data elements needed for reassociation

Below are steps the Provider needs to perform for ERA Enrollment:

- Determine list of TINs and NPIs that need to be enrolled for ERA
- Validate that TINs / NPIs are credentialed / registered with the health plan under the correct address as needed by that payer
- Complete the health plan’s required enrollment process (either paper or electronic) per the provided written instructions, gathering appropriate signatures as necessary
  - If working through a clearinghouse for delivery of the ERA, then the enrollment process must be coordinated with the clearinghouse. Often, the clearinghouse will perform the enrollment process on behalf of the provider
- Validate receipt of paper forms or processing of electronic submission as appropriate
- Validate completion of processing of enrollment by health plan
- Validate receipt of ERA files
- Confirm that EFT and ERA can be reassociated based upon information received
- Confirm ability to auto-post ERA files
- Coordinate with the health plan on continuation / discontinuation of the paper remittance based upon success of the auto-posting of the ERA files, per CAQH CORE 350: Health Care Claim Payment / Advice (835) Infrastructure Rule, if needed.
Clearinghouse Execution of EFT/ERA Enrollment Process

Acting as an agent on behalf of the provider for facilitating EFT and/or ERA, the clearinghouse must be involved in the EDI Enrollment process to ensure that the transactions are initiated and flow as desired by the provider. Typically, the clearinghouse will perform some or all of the enrollment process on behalf of the provider, and therefore must ensure the process is completed accurately. As an intermediary in the process, the clearinghouse must coordinate with both the provider and the payer to ensure the transactions are exchanged successfully.

Below are steps the clearinghouse needs to perform for **EFT Enrollment**:

- The clearinghouse must first coordinate with the payer to review the written instructions for EFT enrollment and ensure understanding of the requirements for that payer
- They must then work with the provider to document the list of TINs and NPIs that need to be enrolled for EFT, along with associated bank accounts for each
- The clearinghouse must then complete the health plan’s required enrollment process (either paper or electronic) per the provided written instructions, gathering appropriate signatures from the provider as necessary
- Once the enrollment process is completed, the clearinghouse should validate payer receipt of paper forms/submission of electronic data as well as validate completion of processing of enrollment by health plan
- Once the completion of the enrollment process has been confirmed, the clearinghouse should then work with the provider to validate receipt of EFT payments as expected, including providing information received from the health plan on any pre-note process involved

Below are steps the clearinghouse needs to perform for **ERA Enrollment**:

- The clearinghouse must first coordinate with the payer to review the written instructions for ERA enrollment and ensure understanding of the requirements for that payer
- They must then work with the provider to document the list of TINs and NPIs that need to be enrolled for ERA
- The clearinghouse must then complete the health plan’s required enrollment process (either paper or electronic) per the provided written instructions, gathering appropriate signatures from the provider as necessary
Once the enrollment process is completed, the clearinghouse should validate payer receipt of paper forms/submission of electronic data as well as validate completion of processing of enrollment by health plan

Once the completion of the enrollment process has been confirmed, the clearinghouse should then work with the provider to validate receipt of ERA files as expected

Summary

One of the biggest challenges in having the providers adopt the EFT and ERA transactions is the different enrollment processes that are required by the payers. This is the same challenge the providers faced before the implementation of the HIPAA Standard Transactions. Each payer used their own format, which put the burden on the provider to work with each payer and their specific format. With the implementation of the HIPAA Standard formats, that greatly reduced the effort by the providers to send their claims electronically. Today, the industry has the same challenge with the EFT and ERA registration process. Each payer has different requirements.

As the CAQH CORE EFT & ERA Operating Rules provide for a more consistent enrollment process across health plans, providers will be more likely to adopt the EFT and ERA transactions. Once they are enrolled with one payer then the enrollment process for the other payers should be relatively simple.

While the majority of the changes will need to be made in the payer community, the standardization of the enrollment processes should result in a significant increase in the number of providers requesting EFT and/or ERA. Increasing the utilization of the EFT and ERA will reduce the administrative costs that are normally associated with providing that information on paper, in addition to increasing efficiency for the providers.

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WEDI EFT SWG Co-Chairs

a. Pam Grosze, PNC Bank Healthcare
b. Deb Strickland, TIBCO
c. Ron Meier, Health Net

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