EFT Process Implementation White Paper

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

July 16, 2012
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Document is for Education and Awareness Use Only
Introduction

To improve the efficiency and effectiveness of the health care system, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which included a series of “administrative simplification” provisions that required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. These standards became effective October 16, 2003, and included transaction standards for Electronic Remittance Advice transactions. EFT transactions were not required 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 or 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, which puts in place comprehensive health insurance reforms that will roll out over four years and beyond, with most changes taking place by 2014. The Affordable Care Act (ACA) includes requirements for an EFT standard, EFT and ERA operating rules, and requirements for usage of EFT for Medicare by 2014. Because the EFT transactions is being defined as a HIPAA transaction, this now includes requirements to conform with the defined standards (CCD+) when the transaction is requested by the provider.

To comply with the ACA requirements, the National Committee on Vital and Health Statistics (NCVHS), an advisory body to the Secretary of Health and Human Services, has made several recommendations to the Secretary regarding the standards and operating rules for EFT and ERA1, specifically:

- Define health care EFT transaction as the electronic message used by health plans to order, instruct or authorize a depository financial institution (DFI) to electronically transfer funds through the ACH network from one account to another
- Define health care EFT standard as the format and content required for health plans to perform an EFT transaction
- Adopt as the standard format for the health care EFT standard the NACHA CCD+ format, in conformance with the NACHA Operating Rules (which provide guidance for utilization of transactions like the CCD+ transaction through the ACH Network)
- Identify NACHA as the standards development organization for maintenance of the health care EFT standard
- Adopt as the implementation specification for the content for the addenda in the CCD+ the content requirements specified in the X12 835 TR3 Report (ASC X12N/005010X221A1) particular to the CCD+
- Consider the implications of the fact that, as the result of the adoption of the health care EFT standard, some banks may become de facto health care clearinghouses as defined by HIPAA

In a subsequent letter on 3/23/112, NCVHS also recommended to the Secretary that CAQH CORE, in collaboration with NACHA, be named as the authoring entity for the ERA and EFT Operating Rules, on the

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1 NCVHS Letter to the Secretary - Affordable Care Act (ACA), Administrative Simplification: Standard for Health Care Electronic Funds Transfers and Operating Rules for Electronic Funds Transfers and Health Care Payment and Remittance Advice 02/17/11

2 NCVHS Letter to the Secretary - Affordable Care Act (ACA), Administrative Simplification: Standard for Health Care Electronic Funds Transfers and Operating Rules for Electronic Funds Transfers and Health Care Payment and Remittance Advice 02/17/11
condition that a set of fully vetted EFT and ERA operating rules be submitted for consideration by August 1, 2011. These proposed operating rules have been developed by CAQH CORE, and submitted to HHS for inclusion in a final rule. Information on these operating rules is expected in the summer of 2012.

The Department of Health and Human Services (HHS) has now published an Interim Final Rule with Comment Period (IFC) requiring use of the CCD+ transaction (when requested from the provider) from the payer to the payer’s bank, and also requiring the TRN segment included in the Addenda record of the CCD+ transaction to be compliant with the 835 TR3 requirements (the Healthcare EFT Standards IFC). The CCD+ transaction includes the entire TRN segment from the 835 transaction, for use in reassociating the 835 and the EFT transactions. Specifically the Trace Number (TRN02) and Company ID (TRN03) are the key data elements used to match the payment record with the 835 Electronic Remittance Advice. As of the effective date of the IFC (January 1, 2014), customization of the CCD+ Addenda record to include any additional information other than the TRN segment as it appears in the 835 takes the transaction out of HIPAA compliance due to restrictions in the 835 TR3, so efforts should be made to include the information within the standard fields in the transaction.

Note that effective July 11, 2012, HHS published that no changes would be made as a result of comments to the IFC, so it is now considered a final rule.

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 standards included in the Healthcare EFT Standards IFC, and the process needed to implement and utilize these standards by January 2014, the date mandated in the ACA.

This document clarifies the requirements of the Healthcare EFT Standards IFC, but goes further and outlines the process for how payers and providers can exchange healthcare claim payments via EFT in such a way as to achieve the most efficiency from the transaction.

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2 NCVHS Letter to the Secretary - Affordable Care Act (ACA), Administrative Simplification: Recommendation for entity to submit proposed operating rules to support the Standards for Health Care Electronic Funds Transfers and Health Care Payment and Remittance Advice 03/23/11

3 CMS-0024-IFC: Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, January 10, 2012

4 CMS-0024-IFC Announcement to Industry July 10, 2012
A full understanding, by payers, providers, and their vendors of both the EFT and the ERA process will enable entities to create business processes to take full advantage of the capabilities of the transaction and automate back office functions. A lack of understanding of the transactions and how they work together for reassociation and automated posting can negatively impact usage of both transactions.

An electronic payment (EFT) can be received in conjunction with either an 835 (ERA) or paper EOB, and the reassociation processes at the provider may be different in each of these cases. This document will include process for utilization of EFT with either paper or electronic remittance advices.

**Definitions**

835/ERA – The 835 is the ASC X12 transaction name for the Electronic Remittance Advice.

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.).

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.

Clearinghouse - For the purposes of this paper, “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

NACHA – The National Automated Clearing House Association (National Association) is an entity that governs ACH and authors the rules by which ACH transactions must comply. NACHA is the organization responsible for the administration, development, and enforcement of the NACHA Operating Rules and risk management practices for the ACH Network

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. From a healthcare perspective, 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.

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: The method the provider’s bank uses to transmit the payment-related information to the provider, including the TRN Segment, is not prescribed by the NACHA Operating Rules. However, the NACHA Operating Rules require that, upon the request of the provider (the Receiver), the provider’s bank (RDFI) must provide all payment related information contained within 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 & Guidance 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.

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

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

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

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

Background and Timelines

5 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 that their meanings are clear.

6 CAQH CORE Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule version 3.0.0 June 2012, p. 19
Payers and providers both must work with their banks in order to set up the flow of the EFT transaction from the payer to the provider. All entities should include this step in their implementation timelines in order to ensure that this important step is completed. The time required to coordinate the EFT transaction flow may differ from bank to bank and from payer to payer.

Initial discussion between the payer, the provider, and their respective banks should be dedicated to outlining the approximate timeline and benchmarks for the set up process. These benchmarks include when the EFTs will begin transmission, as well as other important steps outlined in detail in the following sections. Working with your bank to implement the EFT transaction is key to a smooth transition from paper to electronic payments.

**EFT and ERA Operating Rules**

The ACA included requirements for Operating Rules to be defined and adopted for both EFT and ERA by 2014. CAQH CORE has prepared some proposed operating rules for this purpose, and submitted those to NCVHS. An Interim Final Rule is expected around July 2012 that will provide information as to what the final Operating Rules will include.

The proposed Operating Rules include:

- Requirements for the timing of delivery of non-pharmacy EFT and ERA files, that they be within 3 days of each other. Pharmacy ERA files can be any time prior to EFT delivery.

- Requirements for standardization of enrollments for both EFT and ERA, including a maximum set of data elements that can be required for enrollment, and requirement for an electronic option to perform enrollment functions

- Requirements for standardization of Claims Adjustment Reason Codes (CARC)/ Remittance Advice Remark Codes (RARC) used in the ERA, with exceptions included for pharmacy transactions.

Because these items are proposed, but not final, we do not know which will become final and may impact usage of EFT and ERA.

**National Health Plan ID**

The ACA included a requirement for implementation of a National Health Plan ID (HPID), with specific requirements for compliance dates. On April 10, 2012, a proposed rule\(^7\) was published beginning the process of defining the HPID.

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\(^7\) CMS-0040-P: Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for ICD-10-CM and ICD-10-PCS Medical Data Code Sets, April 10, 2012
The current recommendations from NCVHS include:

- Clarifying the definition of health plan as defined in the HIPAA regulations, including property & casualty insurers and worker’s compensation plans
- Determine at what level, including product (benefit package) level or other categorization, a health plan should also be enumerated
- Consider that the effective date of October 1, 2012 be interpreted as the date to begin registering for an HPID, with a final implementation date of October 1, 2013
- Pharmacy uses RxBIN/PCN identifier, recommendation from NCVHS to not require the HPID to be used in place of the existing RxBIN/PCN identifier in retail pharmacy business and transactions, but do require the use of HPID on the HIPAA-named standard transactions for retail pharmacy, where appropriately defined by industry through the ASC X12 and NCPDP processes.

The Proposed Rule proposes adoption of the HPID as the standard for the unique identifier for health plans in all covered transactions, and differentiates between “Controlling Health Plan” and “Subhealth Plan” to distinguish entities required to obtain a HPID versus those eligible to obtain a HPID. The rule also proposes adoption of a data element, Other Entity ID (OEID), to identify entities that are not health plans, health care providers, or individuals, but need to be identified, e.g. third party administrators, transaction vendors, and clearinghouses. The Proposed Rule defines the “effective date” of the HPID, October 1, 2012, to be the beginning of the implementation period for the HPID and the first day health plans could begin to apply to receive an HPID. The Compliance Date is defined as October 1, 2014.

The HPID could provide additional information that would aid in the routing and reassociation of EFT and ERA. In the X12 835 TR3 Report (ASC X12N/005010X221A1) description of the TRN segment (used as the reassociation trace number segment in the 835 and EFT), the TRN_03 element is reserved for the payer’s EIN or TIN. HPID is not currently allowed (but could be allowed in future versions of the transaction). TRN_04, which is the Originating Company Supplemental Code, could be utilized to hold the HPID (but only if BPR11 is not used). This then would place the HPID in the EFT transaction also, since the TRN segment is included in its entirety in the addenda record. This should (dependent upon the definitions mentioned above) provide explicit information about the source of the payment and COULD aid in routing based upon facility’s contracts with specific payers / plans. As the Final Rule is made available, and additional clarification is received regarding use of the HPID and OEID within the 5010 version of the 835 transaction (and potential situational rules allowing the HPID to be included in the TRN segment), additional guidance from this workgroup can clarify the effect upon the EFT transaction.

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8 NCVHS Letter to the Secretary - Affordable Care Act (ACA), Administrative Simplification: Health Plan Identifier 09/30/10

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Benefits and Challenges of EFT

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
- Manual handling of the mail and paper checks
- Cost of associating the paper check with the electronic EOP/EOB/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 835’s 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 $'s match
  - Auto bill secondary insurance (in non-pharmacy situations).
    - 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.
Exceptions – missing data or missing dollars - can be handled as exceptions

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.

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 with 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 re-association, and is required to be considered compliant with the 835 TR3.
  - Large provider systems may utilize a “gateway” that needs a value like the NPI in order to correctly route the transactions coming in, and therefore need this value in both the EFT and ERA transaction. The WEDI Issues Brief document, “NPI Utilization in Healthcare EFT Transactions” describes this scenario in more detail, along with steps needed to resolve the issue.

9 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.

10 http://www.wedi.org/snip/public/articles/dis_publicDisplay.cfm?docType=6&wptype=3
• It is important to note that the delimiters required in the ACH CCD+ Addenda record section that reflects the TRN segment from the 835 are "*" and "\", and that these may not necessarily be the same delimiters used in the actual 835 file. This can cause a challenge if the process used to match the EFT to the 835 goes character by character rather than element by element. (i.e. the process cannot just use a “string compare” of the entire record).

Format and Requirements of the CCD Plus Addenda (CCD+)
transaction
The CCD transaction, 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), when used as a credit transaction, is used by an Originator (payer) to initiate payment of a healthcare claim.

The CCD Plus Addenda transaction is the same transaction, but includes an additional “Addenda” record to include supplemental information. This transaction moves money and up to 80 characters of remittance data, enough to reassociate EFT dollars and remittance data when the dollars are sent through the ACH and the
remittance data is sent on a separate path. For healthcare EFT, this additional 80 characters of data is the TRN segment from the 835 transaction that must be reassOCIated to the EFT transaction.

Format of an ACH Transaction

ACH transactions consist of fixed length records with specific requirements for each field within the record. Specifics on these requirements can be found at www.nacha.org.

ACH transactions include records used for grouping or batching the data, a file header record and batch header record, and then contain multiple detail records to include the financial information being transferred. The batch header record contains the Company ID, which is the Originator’s (Payer’s) Tax ID. It begins with a “1” and is followed by the 9-digit TIN.

The Entry Detail Record includes an Individual Identification Number which is an identifying number by which the receiver (provider) is known to the originator (Payer). In addition, the Entry Detail Record includes a Trace Number, which is the trace or tracking number of the EFT CCD+ file assigned and used by the financial institutions processing the CCD+ through the ACH network. It is in no way related to the EFT Trace Number that appears in the 835 TRN segment. Although the two data values have the same name, they are not the same number and should not be used interchangeably.

The CCD+ transaction includes an additional record, called the Addenda Record, which provides additional business transaction information in a machine-readable format. 11

The ACH CCD+ Addenda Record

The CCD+ Addenda Record information “may only be used for the purpose of transmitting payment related information; any other use is prohibited.” (NACHA Operating Rules, Appendix One, Part 1.4., Page OR 60 in 2011 edition).

For healthcare EFT, the payment-related information is conveyed in an additional 80 characters of data that is the TRN segment from the 835 transaction. This additional data is used to reassociate the 835 to the EFT transaction.

“The NACHA Operating Rules state that for the CCD+ the Payment Related information in the Addenda Record must contain valid payment-related ANSI ASC X12 data segments or NACHA endorsed banking conventions (chart on page OR 61), and that the delimiters used are "*" for the element delimiter and "\\" for the segment terminator.” (NACHA Operating Guidelines Section V, Chapter 39, page OG 141 in 2011 edition).

The Healthcare EFT Standards IFC12 requires that the standard for the data content of the CCD+ Addenda record comply with the X12 835 TR3 TRN specifications (Section II.D). The TRN segment contains the following elements:

11 For additional information on the CCD+Addenda format go to the NACHA website at https://healthcare.nacha.org/node/387
• TRN01 – Trace Type Code
  • Value is always “1”

• TRN02 – Reference Identification
  • EFT Trace Number

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

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

Example: 705TRN*1*1234567896*1326549870\n
The Reassociation Trace Number segment (TRN) is 112 bytes when filled to maximum field lengths. It is not typical for a payer to send the maximum number of bytes (50) for the reference Identification number (TRN_04). However, in order for this process to be predictable and reliable, the 80 bytes needs to be reserved entirely for the TRN segment and only the TRN segment. Additional information beyond the TRN segment must not be added to the Addenda record, and if the correct data is contained within the EFT transaction and the 835 TRN segment, then additional data values should not be needed for reassociation and routing. The combination of information contained in the TRN_02 and TRN_03 (reflected then in the addenda record) gives a reference specific to that Originating Company (payer) that is needed for reassociation of the EFT and 835.

Requiring a bank or provider to parse the 7 Addenda record in different ways for different payers to separate out the TRN information and other identifiers or values added to the addenda will promote inconsistency and increase the overhead administrative burden on the provider. In the unusual circumstance that additional data is necessary for the provider to reconcile to the ERA beyond what is currently available in the EFT CCD+ transaction – request the business need be addressed within NACHA formats / Operating Rules.

• It is important to note that the delimiters required in the ACH CCD+ Addenda record section that reflects the TRN segment from the 835 are “*” and “\", and that these may not necessarily be the same delimiters used in the actual 835 file. This can cause a challenge if the process used to match the EFT to the 835 goes character by character rather than element by element. (i.e. the process cannot just use a “string compare” of the entire record).

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12 CMS-0024-IFC: Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, January 10, 2012
Format and Requirements of the 835 Healthcare Claim Payment transaction

The 835 Electronic Remittance Advice (ERA) provides detailed payment information for health care claims; and, if applicable, describes why the total original charges were not paid in full. This remittance information is provided as detailed documentation / itemization for the payment, as well as input to the payee’s patient accounting system/accounts receivable (A/R) and general ledger applications.

The remittance information consists of a header level, which contains general payment information, such as the payment amount, the payee, the payer, check or EFT trace number, and payment method. Grouped within the header level is the detail information, containing the explanation of benefits for the payment. Detail for each finalized claim included in the payment appears in the detail level. Finally, the summary level includes adjustment information that is specific to the provider but is not related to any one specific claim in the remittance.

The 835 information is “batched” or grouped by payee. Each transaction set (ST/SE) contains information for one specific check/EFT payment for one payee. When the payee is a covered healthcare provider, the 835 must be grouped by NPI. If the provider is not covered or required to have an NPI, the 835 is grouped by the TIN.

Payer Implementation of EFT

Information for the Healthcare EFT and 835 transactions begins with the payer, who creates the transactions and forwards them to their appropriate trading partners. In the case of EFT, the payer forwards information to their bank / ODFI. To meet the requirements of the Healthcare EFT Standards IFC, this must be done in the CCD+ format and include the TRN segment from the corresponding 835 transaction. The payer’s bank will then forward the EFT transaction through the ACH Network to the provider’s bank / RDFI, who may then notify the provider of the deposit information. While the transaction should flow through this process with the EFT information remaining intact, each touch point does provide an opportunity for the transaction to be modified, and the provider may need to interact with their bank and their payer to ensure that no such modifications take place.
Establishing a Relationship with a Partner Bank and Initiating the EFT Transaction

In order to offer EFT payments to providers, payers must have a relationship with a partner bank (ODFI) to facilitate the ACH transactions with the providers’ banks, including originating the payments and initiating pre-notes. This may involve developing a relationship with a new bank, or working with their existing bank to include this process. Payers should discuss the process with their bank to determine what is needed to initiate the EFT transaction. One item that must be determined is the format of the data to be sent to the bank to initiate the transaction.

The Healthcare EFT Standards IFC requires that the ACH CCD+ transaction be utilized for this “stage 1” payment initiation. The payer and their bank should discuss this requirement and the method that best serves the payer to meet the requirement.

- The payer can send the CCD+ to their bank,
- the payer can partner with a vendor to create the CCD+ on their behalf,
- the payer and the bank can agree to act as partners, where the payer sends a non-CCD+ transaction to the bank and the bank then creates the CCD+ transaction (bank acts as a clearinghouse).  

In the case of a bank taking a non-CCD+ format and translating it into the CCD+ format, the Health Care EFT Standards IFC states that “[T]he health care EFT standards... apply to health plans, and health plans are ultimately responsible for ensuring compliance with the standards regardless of whether a health plan puts the data into a standard format itself or uses a financial institutions to do so.” If a health plan has a financial institution translate a non-CCD+ into a CCD+ and “the bank does so in a way that is noncompliant with the standards... the health plan may be responsible for the noncompliance.”

Once the technical details of the EFT format are worked out between the payer and their bank, then the process of pre-notifications should occur to verify the bank information supplied from the provider.

Once the pre-notification is complete, the payer can start sending EFT transactions to the provider’s bank across the ACH network, completing the process of initiating the EFT transaction.

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13. “In summary, we anticipate that after the adoption of the health care EFT standards, some financial institutions will continue to translate nonstandard payment/processing information received from health plans into the CCD format. With the adoption of the health care EFT standards, these financial institutions will, by virtue of performing these activities, become de facto clearinghouses as defined by HIPAA. To the extent, however, those entities engage in activities of a financial institution, as defined in section1101 of the Right to Financial Privacy Act of 1978, they will be exempt from having to comply with these HIPAA standards with respect to those activities. (Federal Register/Vol. 77, page 1568, II, H (1)

14 Health Care EFT Standards IFC, p. 1568.

15 Ibid.
The Prenotification Process for Credit ACH Files

As part of the setup for EFT, the banking information provided by the provider must be verified to ensure that production financial transactions will flow correctly. In order to do this, the prenotification process is used.

Prenotification Definition - NACHA

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

Prenotification Process – Credit ACH Interface File

It is optional for an originator (payer) to complete the prenotification process for the CCD+ transaction.

An Originator (payer) receives a completed EFT enrollment form from a provider or vendor (payee). This enrollment form contains the payee's banking information. In order to validate the received banking information (account numbers), an Originator may initiate a prenotification entry for any ACH transaction. This process ensures subsequent entries (monetary transactions) to a Receiver's account at an RDFI are posted properly. However, if the prenotification is utilized, an Originator must fulfill all other requirements as provided in the NACHA Operating Rules, as outlined below.

- Prenotification entry may be created at any time.
- Originator may not initiate live dollar entries for this account until at least six banking days following the Settlement Date of the prenotification, i.e. actual funds may not be deposited into the account for six days.
- Prenotification entry must transmit an appropriate Effective Entry Date (Settlement Date) to be processed through the ACH system (it is not the date of the first live entry).
- Any prenotification entry with an Effective Entry Date that falls outside of the processing window will be rejected by the ACH Operator – same as a live entry.
- Prenotification entry format is the same as a live dollar entry, except in the Entry Detail Record – the dollar amount is zero and the transaction code indicates a pre-notification entry.
- Prenotification can be intermingled within a credit batch of live dollar entries.

Technical descriptions and specifications for the prenote transaction can be reviewed in the documentation available on the NACHI website, or at www.achrulesonline.org.

16 Information included in this section of the document was obtained from the 2011 NACHA Operating Rules and Guidelines
Response to Prenotification Returns and Notifications of Change

During the prenotification process, communication is needed between the payer and provider to ensure that all are aware of the transactions being exchanged, and of the status of those transactions. Relying solely on electronic acknowledgments or responses may cause delays or limit awareness of errors or telecommunication failures that occur.

Positive acknowledgements are not always sent, but when used can include either the ASC X12 824 or ASC X12 827 transactions, which are described in subsequent sections.

Originators can receive the following negative responses to a prenotification:

- **ACH Operator Returns Prenotification as Unable to Process**
  RDFI has not received the entry. Originator needs to determine the reason, make the necessary corrections, and then transmit the corrected entry.

- **RDFI Returns Prenotification**
  Originator needs to determine the reason, make the necessary corrections, and then transmit the corrected entry.

- **RDFI issue a Notification of Change (NOC) – (see following sections)**
  Originator need to make the required change within six banking days of receiving NOC information or before transmitting another entry, whichever is later, or issue a Refused Notification of Change.

A listing of Return Codes can be found in Appendix Three of the NACHA Operating Rules.

EFT Enrollments – Payer Perspective

In order for a provider organization to receive their claim payments electronically using EFT, they must first enroll with the Payer. The purpose of the enrollment process is to let the payer know that they want to receive EFT payments and provide the required information to complete the EFT enrollment process. An EFT payments can be made regardless of the method of receipt of the remittance data – 835, online representation of the ERA or EOB, or paper remittance (EOB). All of the benefits outlined earlier in this document are realized with EFT, regardless of the mode of delivery of the remittance advice.

While the enrollment process should be relatively simple for the provider organization, the payer needs to take the appropriate steps to ensure they are receiving valid bank account information and have the proper authorization. Since the payer is the one initiating the EFT transaction they are responsible for ensuring the funds are deposited into the correct account.

The key elements that the payer requires in order to enroll a provider organization in the EFT Process are:

- Provider Name
- Provider Identification Number (Tax ID or NPI)
- Bank Information – routing number and account number
- Authorization that the payer is authorized to deposit their claim payment into their bank account – usually the signature of the CFO
• Copy of a voided check

The above elements are standard in any EFT enrollment process.

For the payer, it is imperative that they take the appropriate steps to ensure the following:

• 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

Most payers provide an EFT enrollment form that can be downloaded or printed from their website. Once the form is filled out, it is faxed or mailed back to the payer with the appropriate supporting documentation based on the payer’s instruction. While there has been some discussion of automating the enrollment process for providers, payers still need to ensure that they have valid bank account information and they have the proper authorization. That is the reason many payers require the signature of the CFO from the provider organization and a copy of a voided check. If the enrollment process is automated, steps need to be taken to ensure the payer can demonstrate that they have the proper bank account information and they have the proper authorization. If there are any questions in the future from the provider organization as to what account the funds are being deposited into or who authorized the process, the payer will need to provide the supporting documentation.

Once the payer has validated that the provider information is correct, they may initiate a pre-notification transaction to ensure that bank account information is valid before they actually start transferring funds through EFT. This is a standard process and it usually requires a 10 day waiting period before the provider goes live with EFT payments.

The payer also needs to take steps with their internal systems to ensure the bank account information is secure and cannot be modified without authorization from the provider. If the data is not properly secured, it would be possible for someone to make a change to the bank account number and have the funds deposited into a different account. Some payers accomplish this by having two different business areas within their organization involved in the enrollment process. One area would do the enrollment minus the bank account information and another area would then validate the information and add the bank account number. Once the account number is entered, then the first area would validate that the account number matches what is on the enrollment form.

Information provided during the EFT enrollment process should include steps the provider needs to take should any of their information change (e.g. bank account changes, address changes, acquisitions), what will happen if the EFT process fails (will a paper check be produced, what notifications will the provider receive), receipt of all information needed for reassociation, and points of contact for future questions.
EFT Acknowledgements

EFT Processing Utilizing EDI Transactions

In order to properly support the EFT payment process, there are several EDI transactions that can be used to ensure that the EFT transactions have been processed successfully. One is the ASC X12 824 Application Advice and the other is the ASC X12 827 Return. By utilizing these transactions, the originator of the Healthcare EFT payment can ensure that the payee received the funds in a timely manner.

When the payer sends an EFT file to their bank, they need to ensure that their bank received the file, processed all of the transactions within their system and sent them to the ACH for processing. The payer also needs to know if the funds were successfully deposited into the payee’s account. Within the banking industry, reporting is based on exception reporting. That means that if the EFT transaction was successfully processed and deposited into the payee’s account, there will be no report going back to the payer indicating the payment was made. If there was a problem with depositing the funds into the payee’s account then the payer will be notified. It is critical that the payer implement the proper controls and balancing to ensure that the EFT transactions were successfully processed. The ASC X12 824 and the ASC X12 827 can be used to provide the appropriate reporting to ensure that the funds were deposited into the correct account.

ASC X12 824 Application Advice

ASC X12 definition: The transaction can be used to provide the ability to report the results of an application system’s data content edits of transaction sets. The results of editing transaction sets can be reported at the functional group and transaction set level in either coded or free form format. It is designed to accommodate the business need of reporting acceptance, rejection, or acceptance with change of any transaction set.

Because the ASC X12 824 supports a free form format it can be used to provide reporting information back to the submitter.

For healthcare EFT processing, payer would send the EFT file (CCD+) to their bank. The bank would perform their editing process before they send the records to the ACH for processing. The results of the editing process would be sent back to the payer on the ASC X12 824 transaction. Typically the information contained on the ASC X12 824 includes: Trace Number, Dollar Amount, Total Dollar Amount of records accepted, total dollar amount of records rejected and the grand total amount of all records on the file. The ASC X12 824 will also indicate if the EFT record was accepted, rejected (with explanation), and any changes. In some situations if the effective date on the EFT transaction (835 or 820) has past, the bank will change the effective date to the current date.

The payer can then use the ASC X12 824 file and reconcile that information to the EFT file they sent to the bank. This way the payer can ensure that the proper controls and balancing are in place. Note: any records that were rejected by the bank need to be corrected and re-sent.

ASC X12 824 or ASC X12 827 NOC (Notice of Change)

There is another usage of the ASC X12 824 and ASC X12 827 Application Advice transaction and that is for what is called a Notice of Change. A Notice of Change occurs when the receiving bank of the EFT transaction, determined that they could deposit the funds into the correct account but some of the information on the
transaction needs to be updated. This usually occurs when a bank acquires or merges with another bank. Usually the ABA (Routing Number) on the transaction needs to be updated with the correct routing information.

In this situation, the receiving bank will initiate the Notice of Change. The NOC will be sent back to the payer’s bank and the payer’s bank will then send an ASC X12 824 NOC to the payer. When the payer receives the NOC, they need to update their internal records so that any future transactions will contain the correct information.

**ASC X12 827 Return**

The ASC X12 827 Return transaction can be used when the receiving bank is unable to deposit the funds into the account indicated on the EFT transaction. This usually occurs when the payee (provider) changes their bank account and they do not notify the payer of the change.

The receiving bank will send notification back to the payer’s bank that they could not deposit the funds in the account indicated on the transaction. The payer’s bank will then send an ASC X12 827 Return transaction to the payer to inform them that the funds could not be deposited.

The payer will then need to contact the payee to obtain the correct information and then the payer will have to reissue the payment.

Information regarding the Financial transactions used can be found at ASC X12 finance.

**End-to-End Testing of the EFT Transaction**

The Pre-Note process allows validation of the account number information to ensure all setup is correct and that financial transactions will flow correctly in production. Some payers, however, take this a step further and perform a true end-to-end testing process to ensure that everything will work as expected in production.

For this process, a payer may initiate a deposit of a very small dollar amount (e.g. $.01) which must be acknowledged by the provider before the EFT process can begin in production. Once this process is completed, a start date for production EFT can then be established based upon the payer's processes (this is one of the items that should be discussed between the payer and provider during their initial discussions).

Because the Pre-note process provides validation of the accounting information utilized by the financial transactions, that process should be sufficient to confirm that the EFT transaction will operate successfully in production. This end-to-end testing process introduces inconsistency in the overall EFT implementation process, and is not advocated by this workgroup.

**Zero-dollar Payments and EFT in Production**

While the ACH does allow a $0 CCD+ transaction as part of its processing, the 835 transaction does not allow reporting of $0 EFT transactions in production. When the payment amount (BPR02) is 0, the Transaction Handling Code (BPR01) must be “H” and the Payment Method Code (BPR04) must be “NON”, thus eliminating the possibility of a corresponding “ACH” transaction.
Currently, some payers do provide an EFT transaction for $0 transactions, which is non-compliant with the 835 TR3. In most situations, providers will not receive an EFT transaction for $0 transactions (and should not, to be compliant). Because providers will not receive an EFT transaction corresponding to each 835 received, there will be exceptions that must be handled manually to determine why the EFT transaction was not received, and if a file is missing during the reassociation process. Providing $0 EFT transactions by some payers introduces inconsistency in the overall EFT implementation process, and is not advocated by this workgroup.

**Unauthorized Debit Transactions**

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 rather than just depositing for EFT. This can be an obstacle to implementation of the EFT transaction. While the Debit/Credit indication is within BPR03 this is not to indicate that the payer may debit the provider’s account. The following note is on the Debit Qualifier within the 5010 835 TR3:

“Use this code to indicate a debit to the payer’s account and a credit to the provider’s account, initiated by the provider at the instruction of the payer. Extreme caution must be used when using Debit transactions. Contact your VAB for information about debit transactions. The rest of this segment and document assumes that a credit payment is being used.”

In the case of the ERA and Debit notification, the ERA with Debit selected acts as the authority (in conjunction with a written authorization from the Provider to the Health Plan) to allow the provider’s bank to take the authorized funds from the payer’s bank account supplied within the transaction and not the other way around. The writers of the TR3 did not believe this would be heavily used in the industry or desired by the payers. Since this is a section of the TR3 that is shared with the 820 transaction, the debit option must be included in both. The 835 TR3 clearly states that before the Debit is used the payer must meet with the ODFI to set up that process AND suggests extreme caution.

The 835 TR3 did not intend for this to be used in a healthcare setting and because there is a considerable amount of set up between the payer and the banks involved, the authors did not detail the entire process. At this time, this workgroup is unaware of any payer that is allowing debits of their accounts; hence, this field is likely not used.

If a debit occurs under other non-compliant circumstances, inquiries should be made to the payer. As a safeguard, the provider can work with their bank to establish debit blocks to the account used for EFT deposits.

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17 Pg. 71, 835 5010 TR3
1.10.1.2.5 ERA with Debit EFT

Figure 1.6 - ERA with Debit EFT

- Payer sends 835 with ERA and debit authorization to Payee.
- Payee instructs DFI to take funds from the Payer’s DFI.
- Payee’s DFI gets funds from Payer’s DFI and notifies Payee. (Reassociation of dollars and data is necessary.)

NOTE
A debit EFT transaction is not explained in this guide. Should any Payer decide to support the Debit EFT, detailed instructions must be obtained from the applicable DFIs and provided to the affected providers.

Provider Implementation of EFT

Information for the EFT and 835 transactions begins with the payer, who creates the transactions and forwards to the appropriate trading partners, but the actual implementation process for EFT begins with a request from the provider (who should have discussions with the payer to understand their processes and requirements). In the case of EFT, the payer forwards information to their bank / Originating Depository Financial Institution (ODFI). The ODFI will then forward the EFT transaction through the ACH Network to the provider’s bank / Receiving Depository Financial Institution (RDFI), who may then notify the provider of the deposit information. In order to receive an EFT transaction, a provider must have a relationship with a partner bank through which they can receive the EFT payments.

Establishing a relationship with a bank for EFT transactions

A provider will need to work with a bank in order to receive EFT transactions. Providers currently have bank accounts in order to do business, and these existing accounts can be used for the EFT if desired. It isn’t

necessary to have separate accounts or a separate bank, it is only necessary to work with a bank to establish the EFT process.

In establishing a relationship with a bank to receive EFT transactions, the provider should ensure that all necessary information is discussed upfront to ensure that the bank in question can provide the information needed by the provider to successfully receive and process the EFT information. The initial information that must be discussed is the agreement to deliver the information needed for reassociation (the addenda record information from the CCD+ transaction). The provider must request this information be supplied, so it is extremely important to ensure that this is part of the agreement with the bank.

The provider and bank must then discuss requirements regarding bank account setup and file delivery. Is there a single TIN, or are multiple TINs involved? One or many NPIs? What bank accounts are needed in order to correctly receive payment files and associate them to the correct facility? Are payments needed separately for each NPI, or is a single payment needed for all? Are payments made to the Pay-To provider on the claim, or based upon contracts the provider has with the payer? The provider must clearly understand these issues to then clearly communicate their requirements to the bank and the payer.

Once account requirements are clearly identified, it is then important to discuss and understand what acknowledgements and reports will be available from the bank, and how (or if) the notification of deposit will be received. Will reports or files be pushed to the provider, or will the provider be required to access an online system to review information? Are notifications / acknowledgements provided when errors occur or only when successful transactions are posted? What automation is available?

**Delivery of funds to the provider**

Once the EFT transaction has processed through the ACH Network and the funds have been received by the RDFI, the bank may issue a notification of deposit to the provider to make them aware of the funds received (if the RDFI has agreed to do so). The method of notification for these funds should be agreed upon between the provider and their bank during the process of establishing their initial relationship. If there is no agreement in place between the RDFI and Receiver the entry will be reflected on the periodic statement (DDA statement) and no other notice is required.

**EFT Enrollments – Provider Perspective**

In order for a provider organization to receive their claim payments electronically using EFT, they must first enroll with the Payer. The purpose of the enrollment process is to let the payer know that they want to receive EFT payments and provide the required information to complete the EFT enrollment process. In order to clearly identify to the payer how they want to receive their EFT payments, the provider must first understand their organizational and banking structure. Is there a single TIN, or are multiple TINs involved? One or many NPIs? Are payments needed separately for each NPI, or is a single payment needed for all? Is an 835 needed also, or is there no ability to auto-post remittance data? The provider must clearly understand these issues to then clearly communicate their requirements to the payer.
Because each payer has different requirements for enrolling for EFT transactions, it is imperative to understand what each payer requires in terms of documentation, and whether their systems and processes support providing the payment in the manner needed by the provider (i.e. per NPI or TIN). “Wet signatures” and/or voided checks may be required, or the entire process may be able to be completed online. Some payers may require that 835 and EFT be used together. Understanding the requirements and processes for each payer will ensure that the EFT process will work as expected and needed by the provider, and avoid unexpected outcomes as EFT payments begin to flow.

The provider should clearly communicate with both their payer and their bank to ensure that all the information needed is provided in the EFT transaction, including the addenda record information needed for Reassociation. The bank must provide this information if requested, but the provider must know to request it. Clear communication with all parties is vital throughout the EFT process, and the provider must be involved to ensure their needs are met.

It is also imperative to follow through and monitor the pre-note process, if available. Understanding if the payer will utilize a true pre-note or a small monetary entry is critical – if a pre-note is not confirmed, the EFT setup will not be completed and will not go to production. Validating these initial transactions also allow the provider to confirm that payments are being received in the manner needed by the provider’s accounts.

Information discussed with the payer during the EFT enrollment process should include steps the provider needs to take should any of their information change (e.g. bank account changes, address changes, acquisitions), what will happen if the EFT process fails (will a paper check be produced, what notifications will the provider receive), receipt of all information needed for reassociation, and points of contact for future questions.

**Reporting / Acknowledgements**

It is critical for the provider, bank, and payer to discuss and understand what acknowledgements and reports will be available from the payer and the bank, and how (or if) the notification of deposit will be received. Will reports or files be pushed to the provider, or will the provider be required to access an online system to review information? Are notifications / acknowledgements provided when errors occur or only when successful transactions are posted? What automation is available? How much delay from the actual time of deposit is the notification of deposit available (e.g. is there an overnight delay while systems are updated)?

It is also important for the provider to understand what the process is in the event of a failure of the EFT transaction as it moves through the ACH system. What notifications will be made available, and will the transaction be retried, or will a paper check be produced? How will this then be reassigned to the 835 transaction?

**EFT Timing and Delivery**

The provider must gain a clear understanding from the payer on the timing and delivery of the EFT and 835 files. Because both files are required for reassociation (see section below), the provider needs to understand
when each of these files will be received to know how long to wait before reporting to the payer that an issue has occurred. If a provider receives an EFT deposit, but has not received the corresponding 835 file, the reassociation process cannot occur, and the provider must wait indefinitely on the 835 file. If the provider knows that the payer’s process creates the 835 file 2 days after the Settlement Date of the EFT file, then when the file is not received within those time limits, the payer should be contacted. Even in the situation where a paper remittance is involved, knowledge of the timing and delivery of the EFT file is critical. Reassociation must occur even with paper remittances, and therefore, understanding when to report an EFT file missing is critical to avoid unnecessary delays.

Reassociation and Balancing

Typically, ERA and healthcare EFT files are processed on different systems, at different times by payers. ERA files are released to providers at different times, often days apart, from when the payment is originated and EFT information sent to the payer’s bank. These files also follow different paths to reach the provider. An ERA file may be downloaded directly by the provider, or may travel through a clearinghouse or other VAN. The EFT information travels through the ACH Network ultimately to the provider’s bank, which will then provide a notification of payment to the provider.

When both the healthcare EFT and the ERA to which it corresponds arrive at the provider (often at different times), the two transmissions must be matched back together by the provider. This process is referred to as “reassociation.” Ideally, reassociation of the ERA with the EFT is automated through the provider’s practice management system. In practice, the process of matching the payment to the associated remittance advice must often be done manually by administrative staff. Information from the 835 like Trace Number, Payment Amount, and Effective Entry Date must be matched against information in the EFT to determine which 835 matches to which EFT. Once a match is determined, the practice management system / accounts receivable system can be updated.

“It is important to facilitate re-association when the remittance data is sent separately from the monetary amounts. Reassociation requires that both remittance and monetary data contain information that allows a system to match the items received. The provider should have a method to ensure that payment and remittance advice are reconciled in the patient accounting/accounts receivable system.”

“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 used to reassociate the 835 to the EFT transaction, and where those data elements are located in the two transactions.

19 ASC X12 835 5010x228 TR3 page 19
20 ASC X12 835 5010x228 TR3 page 20
### X12 835 ERA Data

<table>
<thead>
<tr>
<th>Federal Tax ID (Payer)</th>
<th>Company ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Located in BPR10 and TRN03 BPR<em>I</em>306.04<em>C</em>ACH<em>CCP</em>01<em>123456789</em>DA<em>0123456789</em>1133557799<em>666660000</em>01<em>043210123</em>DA<em>987654321</em>20120131~ AND TRN<em>1</em>0057940746*1133557799~</td>
<td>• Batch Header, Record Type 5, Field Number 5, positions 41-50 5200HEALTHPLAN . . . 1133557799CCDEFTP.</td>
</tr>
</tbody>
</table>

### ACH – CCD+

<table>
<thead>
<tr>
<th>Identification Number / ID</th>
<th>Trace Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Record Type 6, Field Number 7, positions 40-54 (Optional) 62212345689012 . . . 2244668800 . . .</td>
<td>• Record Type 7 (Addenda), Field Number 3, positions 04-83 Use the entire TRN segment from the related 835 transaction 705TRN<em>1</em>0033557799*1133557799~</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Site Tax ID (TIN) or NPI – Loop 1000B (PE-Payee)</th>
<th>Trace Number Segment</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~</td>
<td>• The TRN02 (trace number) is used for reconciliation as well as the payer tax ID TRN03 TRN<em>1</em>0033557799*1133557799~</td>
</tr>
</tbody>
</table>

Note that the data element “Trace Number” exists in both the NACHA CCD+ format Detail Record Type 6, and in the ASC X12 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 ASC X12 835 format contains the Check or EFT Number, and is used to link the 835 transaction to the payment medium. This value from the 835 is what is then copied into the CCD+ Addenda record to be used for re-association.

Because the ERA and EFT files arrive at the provider’s site at different times, files must be retained indefinitely until it is determined that a match can be made, or sufficient time has elapsed to make the determination that an issue has occurred. Researching these exceptions requires manual intervention by both the payer and provider to determine the disposition of the missing data, either ERA or EFT. Increasing the provider’s ability to easily reassociate their data reduces these manual steps required, thus decreasing costs for both provider and payer, and will increase adoption of EFT.
Summary

EFT transactions offer a great opportunity to streamline healthcare payments and truly add administrative simplification to the process, especially when used in conjunction with the 835 transaction. When payers and providers implement EFT and ERA transactions correctly:

- Payments can be posted more quickly, thereby closing outstanding third-party accounts
- Credits to patients accounts are received and processed more timely
- Payment transactions balance to 835 files received
- EFT payments are received faster than paper checks
  - Most payers deliver EFT when they generate their 835 and print checks. For many providers, eliminating the post office delay of delivering checks provides:
    - Quicker access to the cash
    - Payments are deposited even when the provider staff is not able to go to the bank
- There is more consistency in matching trace numbers of EFT and 835
- Quicker access to the cash and posting data allows the provider to accelerate the secondary billing process – resulting in quicker turn around of those payments as well.
- Overall resulting in fewer calls to payers for missing checks

There are many steps that need to be followed when implementing an EFT process from both a payer and provider perspective, and communication among all parties involved is critical to ensuring the success of that implementation.
Appendix A – Checklists for process – Payer and Provider

Checklists for the EFT Implementation Process for both Payers and Providers are provided in a separate document, “Implementing a Healthcare Payment EFT Process – Payer and Provider Checklists”, available on the WEDI website.

Acknowledgments

WEDI EFT SWG Co-Chairs

Pam Grosze, PNC Bank
Deb Strickland, TIBCO
Ron Meier, HealthNet

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