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Reassociating Healthcare Payments White Paper

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

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

I. Change Log

Date	Description of Change
12/6/13	Original version finalized
12/9/14	Updated to include a new section for payers on the Effective Entry Date (Section X.A). Based upon a survey done by the WEDI EFT and 835 sub-workgroups in early 2014, feedback was received that payers have difficulty determining what the Effective Entry Date should be, and how to identify and incorporate bank holidays. The EFT SWG determined that including this information in the existing Reassociation document was preferable to creating a separate document. The Reassociation document also had to be updated to conform to a new format adopted by WEDI.

II. Introduction

The process of matching up the healthcare claim payment and the remittance advice can be frustrating and challenging for Providers. Gaining a good understanding of the process needed to do this, along with recommended best practices and tools for overcoming obstacles, will allow Providers to manage the reassociation process more easily, reducing resources required for working through the process of matching the payments to the remittance, and enabling more timely posting of the information. Ensuring a good understanding of the process benefits payers as well, in reducing phone calls for research, and increasing adoption of the electronic transactions.

Payments for healthcare claims can be made either electronically or via paper checks. To transmit healthcare claim payments electronically using the Healthcare EFT Standard adopted by the Department of Health and Human Services (HHS), the ACH Corporate Credit or Debit Entry Plus Addenda (CCD+) transaction is utilized to provide Electronic Funds Transfer (EFT) payment information for the Provider. The Provider also needs to receive remittance advice information on the claims included in that payment amount. This information can be received electronically using the ASC X12 Healthcare Claim Payment / Advice (835) transaction or via a paper or online remittance advice / Explanation of Benefits (EOB) / Explanation of Payment (EOP). Because the Provider receives the EFT and remittance information at different times, both sets of

information include specific data elements needed to reassociate (match) the EFT and remittance advice to each other, and to post the information to Providers' accounts receivable systems. The Provider must be able to match the two transactions (EFT and remittance advice) using information that correlates between them.

In order to standardize the process and transactions used for electronic healthcare payments, HHS has published the EFT Standards Final Rule[1] for EFT transactions sent through the ACH Network. These standards make the EFT transaction a HIPAA transaction, requiring Health Plans to provide the payment with an EFT via the ACH Network if requested by the Provider. In addition, the standards require use of the CCD+ Addenda for Stage One payment initiation for ACH transactions sent from the payer to the payer's financial institution, and also requiring information contained in the Payment Related Information field of the Addenda Record of the CCD+ transaction to be compliant with the ASC X12/005010x221 Health Care Claim Payment/Advice (835) TR3 requirements for the TRN segment. The EFT Trace Number[2] / Check Number (data element TRN02 in the 835 transaction) and Company ID (data element TRN03 in the 835 transaction) are key data elements used to match the EFT payment file with the Remittance Advice.

In addition, Operating Rules have been published in a Final Rule, dated April 19, 2013[3], 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 was mandatory by January 1, 2014. Section 1104 (124 STAT. 150) of the Affordable Care Act (ACA) includes a requirement that any entity (Business Associate) that provides services under contract to a Health Plan also meet all compliance requirements.

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 financial institution. 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 financial institution, which will then provide a notification of payment to the Provider, along with the Payment Related Information used for reassociation.

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[1] 45 CFR Parts 160 and 162, "Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice"

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

[3] 45 CFR Part 162, "Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice Transactions; Final Rule"

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 such as 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.

III. Scope

Payments and remittance information can be received in a variety of formats, but still need to go through the reassociation process. Payments can be received via paper check or EFT, remittance advices can be received as a paper EOB, or as an electronic 835 file. This paper will address the reassociation process of all the formats, with an emphasis on electronic formats, and on non-zero payments. With zero payments, there is usually no check or EFT, but there will be a remittance advice that is important to receive and post. It is important to note that in order to further administrative simplification, electronic formats of both transactions are preferred whenever possible. While the primary audience for this paper is the Provider, there is payer impact as well, which is also included.

IV. Definitions

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

ACH – Automated Clearing House Network. The Automated Clearing House is used by government and commercial sectors for financial institutions in the United States to transfer funds from one account to another. An electronic funds transfer system that provides for the distribution and settlements of payments among financial institutions. The ACH Network is governed by the *NACHA Operating Rules & Guidelines.*

ASC X12 – The Accredited Standards Committee X12 was chartered by the American National Standards Institute (ANSI) to drive global business processes. ASC X12 develops and maintains electronic data interchange (EDI) standards, as well as, other

standards and schemas (CICA, XML) for many industries (healthcare, insurance, transportation, supply chain, etc.).

Business Associate - person or organization that conducts business with a covered entity that involves the use or disclosure of individually identifiable health information. Business associates include those that perform services on behalf of the covered entity, such as claims processing, data analysis, utilization review, and billing, or provide services to the covered entity, such as legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services. To be a business associate, the work of an organization must deal directly with the use or disclosure of protected health information. [4]

Business Associate Agreement - A covered entity's contract or other written arrangement with its business associate must contain the elements specified at 45 CFR 164.504(e). For example, the contract must: Describe the permitted and required uses of protected health information by the business associate; Provide that the business associate will not use or further disclose the protected health information other than as permitted or required by the contract or as required by law; and Require the business associate to use appropriate safeguards to prevent a use or disclosure of the protected health information other than as provided for by the contract. Where a covered entity knows of a material breach or violation by the business associate of the contract or agreement, the covered entity is required to take reasonable steps to cure the breach or end the violation, and if such steps are unsuccessful, to terminate the contract or arrangement. If termination of the contract or agreement is not feasible, a covered entity is required to report the problem to the Department of Health and Human Services (HHS) Office for Civil Rights (OCR). [5]

Banking Days - Pursuant to U.C.C. § 4-104, a banking day means a day on which a financial institution is open to the public for carrying on substantially all of its banking functions. Banking day is the business day of a financial institution. Banking days include all the days when offices of a financial institution are open for business to the public. Business includes all banking functions. Usually a banking day is any day except Saturday, Sunday and legally defined holidays. Regulations D and CC of Federal Reserve Regulations deal with public holidays.[6]

Business Days - A business day consists of the 24 hours commencing with 12:00 am (Midnight or 00:00 hours) of each designated day through 11:59 pm (23:59 hours) of

[4] http://www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/PrivacyandSecurity/associateshipaa.html

[5] http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html

[6] CAQH CORE Rule 370 version 3.0.0, page 16

that same designated day. The actual calendar day(s) constituting business days are defined by and at the discretion of each health plan.[7]

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 - is an ACH Corporate Credit or Debit Entry.X12 documentation continues to refer to the CCD using older terminology as a Cash Concentration or Disbursement transaction. 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.

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

Effective Entry Date - Effective Entry Date is the date specified by the Originator on which it intends a batch of Entries to be settled.[8] It is date the payer intends funds to be made available to the payee via EFT as specified in the ACH CCD+ Standard in Field #9 of the Company Batch Header Record 5.37. The Effective Entry Date is dependent on valid Banking Days, and can be impacted if the intended date does not fall on a valid Banking Day. See section X.A below for additional information.

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, wire transfers, and credit cards.

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

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

[7] CAQH CORE Rule 370 version 3.0.0, page 16

[8] 2014 *NACHA Operating Rules*, Subsection 3.2.2

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

NACHA Operating Rules –

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

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

ODFI – the Originating Depository Financial Institution is the originator of the ACH transaction. The ODFI enters the payment entry (a credit or debit) into the ACH Network. For the purpose of this paper, it is the payer's financial institution – the sender of the remittance payment.

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

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 financial institution to transfer funds to or from another company's account. For the purposes of this paper, the Originator is the payer.

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.[9]

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.

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

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

Settlement Date - on the Settlement Date, all the ODFI, RDFI, and ACH Operator effect the appropriate settlement of funds, and the RDFI posts the entries to the Receiver's account.

Value-Added Network - a hosted service offering that acts as an intermediary between business partners sharing standards based or proprietary data via shared business processes.[10]

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).

[9] 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.

[10] http://en.wikipedia.org/wiki/Value-added_network

V. Format of an ACH Transaction

A detailed discussion about the format and structure of ACH transactions is held in the "*NACHA Operating Rules* Healthcare Updates and their Impact to Providers and Health Plans" paper at www.wedi.org. The format specification for the CCD can be found in the *NACHA Operating Rules* that can be viewed at http://www.achrulesonline.org/

A. Format and Requirements of the CCD Plus Addenda (CCD+) transaction

The CCD transaction, Corporate Credit or Debit Entry, when used as a credit transaction, is used by an Originator (health plan) to initiate payment of a healthcare claim.

The CCD+ 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 Network and the remittance data is sent on a separate path. For healthcare EFT, these additional 80 characters of data contain the TRN segment from the ASC X12 835 transaction that must be reassociated to the EFT transaction.

B. The ACH CCD+ Addenda Record

The Addenda Record of the CCD+Addenda is used to convey 80 characters of payment related information to provide information to reassociate the payment with the remittance advice. The Healthcare EFT Standard states that the CCD+Addenda Record must be populated with the TRN Reassociation Trace Number Segment as defined in the ASC X12 835 version 5010 TR3. The Payment Related Information field of the CCD+Addenda Record is limited to a maximum of 80 characters. Note that this is fewer characters than defined by the ASC X12 TR3 if all required data elements (TRN01, TRN02, TRN03 plus the situational TRN04) are used. In this situation, NACHA, working with ASC X12, has determined that the TRN04 data segment should be truncated. The TRN Reassociation Trace Number Segment is carried in the ASC X12 835 (ERA) and the EFT (ACH CCD+Addenda) and used by the Providers to match the payment to the ERA.

The *NACHA Operating Rules* state that for the CCD+, the Payment Related information in the Addenda Record must contain valid payment-related ANSI ASC X12 data segments or NACHA endorsed banking conventions (chart in Appendix One Part 1.4), and that the asterisk "*" is used for the element

delimiter and backslash "\" or tilde "~" for the segment terminator. (*NACHA Operating Guidelines* Section V, Chapter 39, page OG 141 in 2013 edition).

The Healthcare EFT Standards IFC[11] requires that the standard for the data content of the CCD+ Addenda record comply with the ASC X12/005010x221 835 TR3 TRN specifications (Section II.D). The TRN segment contains the following elements:

- TRN01 – Trace Type Code
    - Value is always "1"
- TRN02 – Reference Identification
    - EFT Trace Number (different from the ACH Trace Number as mentioned above)
- TRN03 – Originating Company Identifier (Payer Identifier)
    - This must be a 1 followed by the payer's EIN (or TIN). (note that the *NACHA Operating Rules* do not require the Originating Company ID to be the TIN, so there may be situations where these values do not match)
- TRN04 - Originating Company Supplemental Code
    - Situational value - Required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.

TRN Segment Example from the 835:

TRN*1***1234567896*1326549870*PLAN123~**

Full Addenda Record Example from the CCD+ file (note that the Addenda record contains the TRN segment from the 835):

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

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

VI. Format and Requirements of the ASC X12 835 Healthcare Claim Payment Transaction

The ASC X12 835 Electronic Remittance Advice (ERA) provides detailed payment information for healthcare 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 ASC X12 835 information is “batched” / “bulked” / grouped by payee. Each transaction set (ST/SE) contains the remittance information for one specific check/EFT payment for one payee, and the transaction set itself is referred to as “an 835.” Similar transactions sets can be grouped together within a “functional group” (GS/GE), and multiple functional groups can be sent within a single “interchange” (ISA/IEA). A common practice is for an interchange to correspond to a single physical file (while this is not a requirement of the 835 TR3, it may be easier for the receiver to understand and process if information is received in separate physical files). For example:

Interchange Header (ISA)
- Functional Group Header (GS)
  - Transaction Set Header (ST)
    - 835 Detail
  - Transaction Set Trailer (SE)
  - Transaction Set Header (ST)
    - More 835 Detail for a different payee / trace number combination
  - Transaction Set Trailer (SE)
- Functional Group Trailer (GE)

Interchange Trailer (IEA)

VII. CAQH CORE Rule 370 EFT & ERA Reassociation Requirements[12]

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.

CAQH CORE Rule 370 (which includes requirements for electronic files only) focuses on the content needed in both files to perform reassociation, and the timing and delivery of the files to set clear expectations with Providers on when files will be received so they can be reassociated. The rule includes the following requirements:

- The rule establishes minimum required data for reassociation that must be present in the CCD+ file
  - Effective Entry Date (Record 5 Field 9, corresponds to BPR16)
  - Amount (Record 6 Field 6, corresponds to BPR02)
  - Payment Related Information (Record 7 Field 3, corresponds to the TRN segment)
    - Contained in the Addenda Record of the CCD+ transaction
    - For healthcare transactions, the Addenda records contains a copy of the TRN segment from the 835 associated with the EFT
- The health plan must notify the Provider during the enrollment process that it must request delivery of the reassociation data from its financial institution
- The health plan must release the 835 to the Provider
  - No sooner than 3 business days before and no later than 3 business days after the Effective Entry Date of the EFT
  - Retail Pharmacy any time prior, but no later than 3 business days after, the Effective Entry Date

[12] CAQH CORE Rule 370 version 3.0.0, as mandated by the Affordable Care Act

  - The health plan must be able to track and audit this requirement to show compliance at least 90% of the time each month.

- A health plan must ensure that the CCD+ Effective Entry Date is a valid banking day and that the corresponding v5010 X12 835 BPR16 date is the same valid banking day.
- The health plan must have written procedures for the Provider to use for researching and resolving a late or missing EFT or ERA file
  - The rule defines "Late" as 4 business days after receipt of the corresponding EFT or ERA file
  - These procedures must be delivered to the Provider during the enrollment process, and can be part of the written enrollment procedures.
- Sample instructions can be found in the previous WEDI paper, "Enrollment Process for Healthcare Claim Electronic Funds Transfer (EFT) Payments and Healthcare Electronic Remittance Advices (ERA)", available at www.wedi.org in the knowledge center.

VIII. Data Elements Required for Reassociation of EFT and ERA

A Provider must contact their financial institution to arrange to receive the CCD+ Payment Related Information that is needed for reassociation. When both the healthcare EFT (along with that Payment Related Information) and the ERA to which it corresponds, arrive at the Provider (often at different times), the two transmissions must be matched back together by the Provider. 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 such as Trace Number, Payment Amount, and Effective Entry Date must be matched against information in the CCD+ to determine which 835 matches to which EFT. Once a match is determined, the practice management system / accounts receivable system can be updated.

"Two key pieces of information facilitate reassociation -- the trace number in the Reassociation Key Segment, TRN02, and the Company ID Number, TRN03. The trace number in conjunction with the company ID number provides a unique number that identifies the transaction."[13]

[13] ASC X12 835 5010x228 TR3 page 20

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

ASC X12 835 ERA Data	ACH – CCD+
Federal Tax ID (Payer) • Located in BPR10 and TRN03 BPR*I*306.04*C*ACH*CCP*01*123456789*DA*0123456789*1133557799*666660000*01**043210123*DA*987654321*20130131~ AND TRN*1*0057940746*1133557799~	Company ID • Batch Header, Record Type 5, Field Number 5, positions 41-50 5220HEALTHPLAN . . . 1133557799CCDEFTP. . . (note that this value may not begin with "1", while the value in the 835 is required to begin with "1")
Payer Name • Located in N104 N1*PR*HEALTHPLAN~	Company Name • Batch Header, Record Type 5, Field Number 3, positions 5-20 5220HEALTHPLAN . . . 1133557799CCDEFTP. . . (name of the health plan / name that is recognized by the healthcare Provider and to which the healthcare Provider submits its claims)
Effective Entry Date • Located in BPR16 BPR*I*306.04*C*ACH*CCP*01*123456789*DA*0123456789*1133557799*666660000*01**043210123*DA*987654321*20130131~	Effective Entry Date • Batch Header, Record Type 5, Field Number 9, positions 70-75 5220HEALTHPLAN . . . HCCLAIMPMTJan 31130131.
Amount • Located in BPR02 BPR*I*306.04*C*ACH*CCP*01*123456789*DA*0123456789*1133557799*666660000*01**043210123*DA*987654321*20130131~	Amount • Record Type 6, Field Number 6, positions 30-39 • 62212345689012 . . . 0000030604133557799 . . .
Provider Site Tax ID (TIN) or NPI – Loop 1000B (PE-Payee) • Located in N104 N1*PE*PROVIDER SITE NAME*FI*133557799~ OR N1*PE*PROVIDER SITE NAME*XX*2244668800~ REF*TJ*133557799~	Identification Number / ID • Record Type 6, Field Number 7, positions 40-54 (Optional) 62212345689012 . . . 133557799 . . .
Trace Number Segment • The TRN02 (trace number) along with the TRN03 (payer tax ID) are used for reconcilement TRN*1*0033557799*1133557799*PLAN01~ (note that TRN04 is situational)	Trace Number • Record Type 7 (Addenda), Field Number 3, positions 04-83 • Use the entire TRN segment from the related 835 transaction 705TRN*1*0033557799*1133557799*PLAN01~. . .

The batch header record contains the Company ID, which is an alphanumeric code used to identify an Originator and is assigned by the Originators financial institution (ODFI). This Company ID value also appears in the corresponding ASC X12 835 file, where it is required to begin with a "1", followed by the 9-digit TIN of the Originator (Health Plan). (Note that the *NACHA Operating Rules* do not require the Originating Company ID to be the TIN, so there may be situations where these values do not match)

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.[14]

Reassociation requirements for non-electronic formats are addressed in a later section.

IX. Delivery Timing of EFT and ERA files

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

- No sooner than 3 business days before and no later than 3 business days after the Effective Entry Date of the EFT
- Retail Pharmacy any time prior, but no later than 3 business days after, the Effective Entry Date

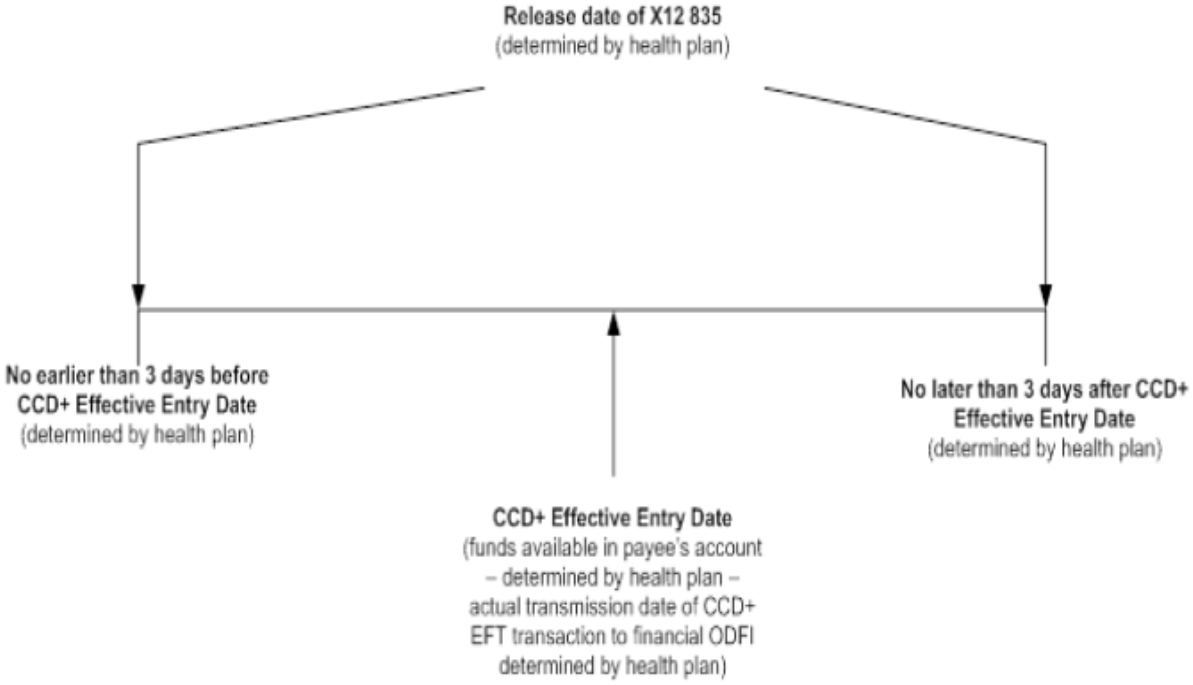
The rule is focused on when the files are released by the health plan (and must take into account timing required by any business associates that the health plan has contracted with to produce EFT and/or ERA files), and does not include time that may be added due to flow of an ERA file through a clearinghouse or other Value-Added Network (VAN) to reach the Provider. The dates are based upon the Effective Entry Date of the EFT, which is when the funds will be made available and is required by CAQH CORE Rule 370 to be the same as the Settlement Date (note that the Settlement

[14] CAQH CORE Rule 370, section 2.1.1.1 has some additional discussion on this topic of the variance between the Trace Number included in the CCD+ file and the EFT Trace Number included in the TRN02 of the 835.

Date may be different than the Effective Entry Date if the Originator puts an Effective Entry Date that is not a valid Banking Day).

The ERA file may be released either before or after the EFT, but it must be within 3 business days of the Effective Entry Date. If the ERA file is received first, the EFT would be expected within 3 business days. If the EFT is received first, the ERA would be expected within 3 business days. Note that these are business days of the Health Plan; so, for example, if an EFT contained an Effective Entry Date that was the Wednesday before Thanksgiving, and the Health Plan was closed Thanksgiving Day as well as the Friday after Thanksgiving, then releasing the 835 the Wednesday after Thanksgiving still meets the 3 business day requirement.

The figure below presents a visual representation of the requirement for the timeframe of the release of the X12 v5010 835 with respect to the CCD+ Effective Entry Date.[15]



It is recommended that the Health Plan include information on their business days in their enrollment instructions. If these are not clarified, the Provider will need to contact the Health Plan to ensure they understand the timeframes involved in receiving their payments and remittance advices.

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

[15] http://www.caqh.org/pdf/COREFAQsPartD.pdf, FAQ number 5

X. Reassociation Impact on Health Plans

Ensuring compliance with all Operating Rules and Standards for ERA, EFT, and Reassociation encourages adoption of the electronic transactions, reducing costs for Health Plans (along with preventing fines that may be incurred from non-compliance with the regulations). This also allows the Provider to streamline their processes, and ultimately will reduce phone calls and support costs for Health Plans as well.

A. Obtaining the Effective Entry Date

All ACH files must be originated through a financial institution. The Health Plan may work directly with their financial institution or with a third-party vendor that originates ACH files on their behalf to a financial institution. Whether the Health Plan works directly with their financial institution or through a vendor, they should receive a list of all banking holidays, parameters and timeframes for ACH file submissions. The Accounts Payables or Treasury Department at the Health Plan will also establish a payment cycle processing schedule or calendar of when files will be submitted to the vendor or financial institution to meet an expected Effective Entry Date.

a. Communication

Internal Communication

Coordination of the Effective Entry Date of the EFT and ERA to meet the CAQH CORE Rule 370 requirement of no more than 3 business days between the Effective Entry Date of the EFT and release date of the ERA to the Provider requires communication between departments within the Health Plan and/or their vendors. The Accounts Payables department has established a payment cycle calendar of when ACH files will be originated to the vendor or financial institution. The department responsible for creation of the corresponding ERA's must work with the Payables department to develop procedures for coordinating the Effective Entry Dates of the EFT and ERA files.

When either the EFT or ERA is created by an entity that is separate from the organization creating the corresponding file, additional communication is necessary to ensure coordination of the Effective Entry Dates in the two files (along with other information required in the ERA, for example account numbers).

External Communication

In order to prevent Provider calls regarding missing ERA or EFT files, it is important to communicate with Providers regarding the bank holiday schedule and payment processing schedules. It is imperative that the Provider understand these schedules so that it is clear when they can expect to receive their files and when bank holidays impact receipt of files.

b. Processes around obtaining the Effective Entry Date

The Health Plan must assign the Effective Entry Date that appears in both the CCD+ (EFT) and the ERA (835) file, and these dates must be the same date. The Effective Entry Date is assigned based upon the payment cycle of the Health Plan and the date upon which the funds will become available to the Provider.

When the EFT file goes through the ACH Network, the ACH Operator will read the Effective Entry Date and settle according to that date. If the ACH Operator is not able to settle on the Effective Entry Date due to a stale date (in the past) or non-banking day, the ACH Operator will insert the next banking day into the Effective Entry Date field reflecting that settlement will occur on that date, and notifies the ODFI via an indicator in the advice returned by the operator. The Health Plan may be notified of the change via an 824 or other notification, or may receive no notification, based on arrangements that have been made with their bank (ODFI). The RDFI is then responsible for posting entries and providing funds availability on the settlement date.

Because the ACH Operator will correct the date to a valid banking day if it is incorrect, this may cause the Effective Entry Date in the EFT and ERA to vary and therefore impact reassociation. This is why it is <u>critical</u> to ensure that the date inserted by the Health Plan is a valid banking day. If the 835 corresponding to that EFT had already been released by the Health Plan, then the Health Plan would be unable to correct the Effective Entry Date within the 835 to correspond to the EFT, so the Provider would experience a discrepancy in the dates of the two files, and may be unable to reassociate the files. This will result in the Provider calling the payer.

It is strongly advised that the Health Plan include edits in their system to ensure that the Effective Entry Dates within the 835 and the EFT match. The Health Plan should also develop a process to notify Providers if they receive a notification that the Effective Entry Date was changed in the EFT and the 835 has already been released and cannot be updated. In addition, Health Plans should review their internal processes to determine what caused the incorrect Effective Entry Date, and remediate to prevent the situation in the future. If the issue with the date occurred due to a system problem that caused a delay in file delivery, it is important to have processes in place to notify Providers of the issue with the date and the impact to reassociation.

Note – the CAQH CORE Rule 370 requirement around the timing of the EFT and ERA file delivery is focused on the date the files are **released** by the Health Plan and specify that the ERA file must be **released** within 3

business days before or after the Effective Entry Date in the EFT file. Other factors that may impact when the Provider actually receives the ERA file (e.g. multiple clearinghouses in the delivery path) have no effect on the Health Plan's compliance with the Operating Rule. Providers must communicate with their trading partners to clearly understand the timeframes in which they will receive each of their files.

c. How to identify the bank holidays

Each bank should publish their holiday schedule on their website for public access. In general, bank holidays should follow the calendar put forth by the Federal Reserve, which can be found on the Federal Reserve website, at www.federalreserve.gov/aboutthefed/k8.htm.

Whether the Health Plan works directly with their financial institution or through a vendor, they should receive a list of all banking holidays, parameters and timeframes for ACH file submissions when establishing the process for ACH Origination.

d. Where is the date in the 835

The Effective Entry Date in the 835 is located in the BPR16 element.

e. Where is the date in the EFT CCD+

In the CCD+ (EFT) file, the Effective Entry Date is located in the Batch Header, Record Type 5, Field Number 9, positions 70-75.

f. What are returns and when would they happen in relation to the date?

A Return is a credit or debit Entry initiated by an RDFI or ACH Operator that returns a previously originated credit or debit Entry to the ODFI within the timeframes established by the *NACHA Operating Rules.*

If originated more than the proscribed number of days (2 days prior for credits, 1 day prior for debits), the entry will be returned to the ODFI and re-originated in the correct timeframe. If the Health Plan sends the file to their ODFI outside these timeframes, the file may be held by the ODFI until the right date, then the ODFI will send.

When the EFT file goes through the ACH Network, the ACH Operator will read the Effective Entry Date and settle according to that date. If the ACH Operator is not able to settle on the Effective Entry Date due to a stale date (in the past) or non-business day, the ACH Operator will insert the next business day into the Effective Entry Date field reflecting that settlement will occur on that date. The RDFI is then responsible for posting entries and providing funds availability on the settlement date.

g. How is the date used by the Provider

The Effective Entry Date is one of the fields used by the Provider to reassociate the EFT and ERA files. Because both are required to have the same date, this provides one of the unique values that Providers will use for reassociation. If either the 835 or the EFT file is received, but not the corresponding one, then this date is needed when working between Provider and payer to locate the missing file.

B. Guidance for Payers using a Third Party for creating EFT or ERA files

Some payers use a third party, who is considered a Business Associate, to create either their ERA or their EFT files. This can create challenges in meeting the requirements of CAQH CORE Rule 370; however, because these third parties are bound by Business Associate Agreements, they are required to meet the requirements outlined in the Standards and Operating Rules just like the Health Plan. When the files are created by different entities, then ensuring the release within 3 business days of the Effective Entry Date may be extremely difficult, but must be accomplished. It may also be challenging ensuring that the Effective Entry Date contained in the 835 matches the date in the EFT. Additional communication measures may be necessary to ensure that appropriate information flows between all parties to meet these requirements. Failure to include Effective Entry Dates and EFT Trace Numbers that match the EFT transaction result in a non-compliant 835, which could subject the Health Plan and the Business Associate to complaints and fines.

C. Issues and Challenges for Health Plans

The EFT Standards Final Rule for EFT transactions make the EFT transaction a HIPAA transaction, requiring Health Plans to provide the payment with an EFT via the ACH Network if requested by the Provider. Like the 835 transaction for the remittance advice, Health Plans must support the HIPAA standard transaction, and provide it at the request of the Provider. However, there may be Providers that still prefer paper in some situations, so the Health Plan may need to support a mixture of formats for the transactions.

D. Paper Payment and Paper EOB / Remittance Advice

When Providers receive payment by paper check and remittance information by paper EOB, the cost to the Health Plan is high. Forms must be purchased and then printed and mailed. Mail delivery takes a long time, and can result in lost or misdirected checks and EOBs. It can even result in theft of these

items. Any of these situations then result in resources manually researching on both the Health Plan and Provider side, and phone calls to resolve the issue. All the paper items must then be re-issued, resulting in additional cost.

E. Paper Payment and Electronic Remittance Advice (ERA)

When the remittance advice becomes electronic, the cost for the Health Plan is greatly reduced. Typically these are very large documents, and the cost for printing and mailing is high. With a paper check payment, there is still cost incurred with printing and mailing these, along with the aforementioned risks of loss or theft. The manual process of reassociating these documents is difficult, which can ultimately result in high support costs.

F. Electronic Payment (EFT) and Paper EOB / Remittance Advice

Printing the remittance advice comes with a high cost to the health plan in paper, printing, and mailing. For the Provider, dealing with the paper remittance is also costly in resource cost for manually posting the information (usually multiple copies of the remittance are made for use by multiple resources, so there are copying costs as well). Receiving the payment electronically gets the funds in the financial institution sooner, but they may not be able to be posted to the system or utilized until the remittance advice is received and manually posted.

G. Electronic Payment (EFT) and Electronic Remittance Advice (ERA)

When both the payment and remittance advice are received electronically, costs are low for both Provider and Health Plan. Because reassociating and processing the files can be automated, processes are much more efficient, and the need for support by the Health Plan is reduced. It is important for the Health Plan to ensure quality in the files produced, along with compliance to the Standards and Operating Rules to ensure optimal ability for automation. The Health Plan must also ensure proper security measures are in place to comply with HIPAA requirements regarding PHI.

H. Electronic Payment (EFT) and Changes in Bank Account Information

There are times when the Provider changes their bank or changes their bank account within the same bank. When that occurs, the Health Plan must modify the information in their EFT transaction to include the new bank account information so that the EFT transaction will not be rejected.

If the new account is within the same bank, the bank will send a Notification of Change (NOC) to the sender (Health Plan) so that the Health Plan can update their information, and the bank will post the funds to the new account. Because the *NACHA Operating Rules* require the Originator (Health Plan) to act upon the Notification of Change, if the Health Plan continues to send to the old account after 6 banking days, this could be considered a NACHA rules violation (see section 2.11.1 of the *NACHA Operating Rules*). During this transition, the account information contained in the 835 could contain the outdated account information for some time, and should be monitored.

If the change is to a new financial institution, the item will be returned to the Sender (Health Plan) as "account closed". The Health Plan will need to gather information from the Provider to update the account information in their EFT transaction, and may need to provide paper checks until the account information can be updated.

The written instructions given to the Provider during the enrollment process should include what will occur during the "lag period" from notification of the change to the implementation of the new account information, and whether a new pre-note is included in this process.

Any changes made by the Health Plan or the financial institution to the banking information should be communicated to the Provider to ensure no disruption in the delivery of the EFT transactions.

I. Zero Payments and Remittance Advices

When the payment amount for the Provider for the adjudication cycle is zero, a payment device (check or EFT) is typically not created. A remittance advice is still needed, however, to provide the adjudication detail for the claims finalized in the adjudication cycle. Per the requirements of the ASC X12 835 TR3, the 835 must include a unique remittance advice identification number in TRN02. The 835 will include BPR values indicating a "NON" payment and $0 payment amount, which gives the Provider the indication that a check or EFT will not be accompanying the 835.

XI. Successful Implementation of a Reassociation Process by a Provider

Matching the payment to the corresponding remittance advice can be a challenging process. Developing effective operational and technical processes for this can help

Providers reduce resources, reducing cost as well, and also allow for more timely secondary billing, reducing A/R days.

A. Managing the Receipt of Payments and Remittance Advices

CAQH CORE Rule 370 requires that both the ERA and EFT files be released for transmission to the Provider within 3 business days of the Effective Entry Date in the EFT file. It also requires that the Effective Entry Date contained in the ERA match that in the EFT. If either the ERA or EFT file is received and the accompanying file is not received within 3 business days of that Effective Entry Date, then the accompanying file is considered late.

CAQH CORE Rule 370 also requires that Health Plans supply written procedures for how to research and resolve files that fall into this "late" category, and that these procedures be delivered during the EDI Enrollment process. Providers should establish processes for tracking file receipt and monitoring for late or missing files, so that they know when to deploy these procedures with the Health Plan.

It is important to track the payments and remittance advices that are received to ensure that all proper reassociation takes place. The Provider's system may have capabilities to handle this in an automated fashion, tracking all files received, and performing the reassociation as additional files are received. If an automated solution is not available, a more manual tracking tool, for example a spreadsheet, is advised to manage the documentation of files that are received.

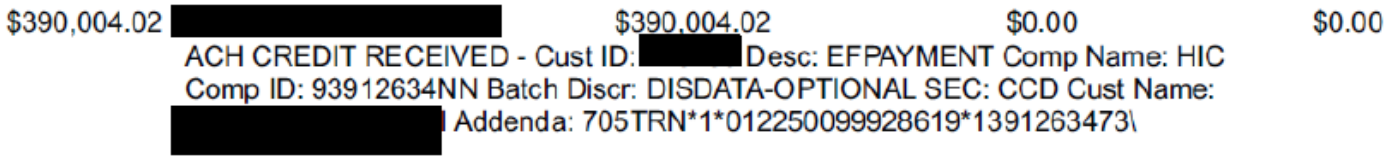
B. How to talk to your financial institution

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

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

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

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



C. Communication

In addition to communicating with their financial institution, Providers will need to communicate with their Health Plan to ensure they understand the Health Plan’s schedules for when the EFT and ERA files will be released so that they understand the timeframes involved in receiving their payments and remittance advices. Providers must also understand the Health Plan’s business day schedule to be clear on the impact of holidays and other days the Health Plan is closed.

Providers must also communicate with any other trading partners involved in their receipt of ERA files (e.g. clearinghouses) to understand the impact of these trading partners on the receipt times of their ERA files. CAQH CORE Rule 370 includes requirements for the Health Plans’ release of the files, but does not include requirements on any other trading partners in the “delivery chain” of the ERA file. Additional trading partners involved in the delivery of the ERA files can increase the delivery time of the file and must be accounted for before initiating the research processes provided by the Health Plan.

D. Month-End Processing

End of month is often a critical time for the Provider’s business office. Financial accounts must be balanced, and all remittance information must be posted so that everything balances, and all patient accounts are updated in

preparation for monthly statements. Receipt of accurate payment and remittance information is critical to these processes.

If an EFT or ERA file has not been received within the defined “late” period, the Provider should follow the procedures that were provided by the Health Plan during the enrollment process for researching late files. Depending on the disposition of the missing file, the Provider may need to make decisions to perform manual processing to get all accounts closed by the deadlines.

E. The Reassociation Process - Paper Payment and Paper EOB / Remittance Advice

When both the payment and EOB are received on paper, they generally arrive at the Provider in the same physical package in the mail, with the check attached to the front of the EOB. Reassociation in this situation is simplistic – it is obvious that the corresponding payment and EOB have been received since they are attached.

There are challenges, however, in working in an entirely paper system. Once received, all subsequent work must be done manually. A person must take action to deposit the check, like physically going to the financial institution to deposit the check, or using functionality like “remote deposit capture” on a mobile device. Resources are required to key the remittance information into the accounts receivable system to update all accounts with the payment information. This is very resource-intensive, as well as prone to human error.

F. The Reassociation Process - Paper Payment and Electronic Remittance Advice (ERA)

When payment is received via check, there is an inherent delay due to the time taken with mail delivery. It is very likely that the ERA will be received prior to the check. In that situation, the ERA would be held (not posted) until the check (or checks if multiple transaction sets are included in the 835) is received to ensure that the two balance (contain the same payment amount) and that the funds are actually received before accounts are updated to reduce the risk of accounts being updated incorrectly, and incorrect patient statements being sent.

Information from the paper check – check number, check date, and payment amount, are used to compare to the ERAs being held to determine which ERA matches to the specific check. This information should be documented from the paper check before depositing into the financial institution.

The paper check number is compared to the TRN02 in the 835. The check date is compared to the BPR16. The payment amount should match to the BPR02.

Once the correct match is made, the ERA posting process can be completed.

G. The Reassociation Process - Electronic Payment (EFT) and Paper EOB / Remittance Advice

When the payment is received electronically, the funds will be available in the Provider's financial institution account on the Settlement Date in the EFT file. The Provider will receive the Payment Related Information from their financial institution via paper statement, electronic file, or web portal. This information will most likely be available prior to receipt of the paper EOB because of the delay due to mail.

Once the EOB is received, the Payment Related Information should be compared to the paper EOB to determine which payment matches to this EOB. The Payment Related Information will contain an identifier that is available on the paper EOB, for example an RA Number, that can be matched. The Effective Entry Date in the EFT should match to the RA date on the paper, and the payment amount in the EFT should match to the total payment amount reflected on the EOB.

Once the correct match is made, resources can begin keying the remittance information into the accounts receivable system.

H. The Reassociation Process - Electronic Payment (EFT) and Electronic Remittance Advice (ERA)

When both payment and remittance are electronic, the opportunity arises to automate the reassociation process. Software tools are available to track all EFT payments received (along with the associated Payment Related Information) and ERAs received, and automatically do the comparison to determine a match.

In addition to comparing the Effective Entry Date in the EFT file to the BPR16 in the 835 and the payment amount from the EFT to the BPR02 in the 835, the Payment Related Information is used. The information starting at the 4th character in this record can be used to match directly to the TRN segment in the 835 (note that if the health plan uses an element delimiter other than "*", then additional work will have to be done to compare the information element by element rather than comparing the entire segment).

Once the correct match is made, the posting process for the ERA can be completed.

I. Electronic Payment (EFT) and Changes in Bank Account Information

If the Provider's bank and/or bank account changes, communication with the Health Plan and the bank will be crucial to ensure no disruption in the EFT transaction. Advance coordination is needed whenever possible to avoid the payments being dropped back to paper checks. The Provider will need to notify all their Health Plans of the account information change, and will need to carefully watch all 835s and EFTs to confirm the account information included, as during the "transition" period, the account information in the 835 may be the outdated account information.

Changes made by the Health Plan may require the Provider to complete enrollments again. In this situation, the Provider should closely monitor receipt of the payment and remittance information to ensure no issues were introduced during the process.

J. What to do when dealing with a Third Party Administrator (TPA) or Pharmacy Benefit Manager (PBM)?

Challenges can arise when dealing with entities like TPAs or PBMs. Roles and responsibilities may be unclear or difficult to identify. TPAs or PBMs may be Business Associates of the Health Plans, conducting transactions on behalf of the Health Plans, or they may actually act as the payer. Entities that are Business Associates, like Health Plans or Payers, must comply with the HIPAA requirements like other covered entities[16], including the regulations outlined in this document. In order to overcome these challenges, in situations where these entities are involved, it is important to clearly understand and document the roles, responsibilities, and processes around dealing with them.

K. Practice Management Systems (PMS)

When receiving both payment and remittance advice electronically, Providers lean heavily on their practice management system vendors to effectively utilize the electronic files and automate the processes of reassociation and

[16] 45 CFR 162.923(c): Use of a business associate: A covered entity may use a business associate, including a health care clearinghouse, to conduct a transaction covered by this part. If a covered entity chooses to use a business associate to conduct all or part of a transaction on behalf of the covered entity, the covered entity must require the business associate to do the following: 1) Comply with all applicable requirements of this part [HIPAA standards, operating rules, code sets, identifiers, other HIPAA admin sim requirements]; 2) Require any agent or subcontractor to comply with all applicable requirement s of this part.

posting. PMS systems should be able to perform the reassociation process without requiring human intervention the majority of the time, only requiring human review for exceptions.

When beginning the process of implementing electronic transactions, the PMS vendor should be engaged to ensure all systems are prepared for receipt and processing of the electronic files. It is important to ensure a production-ready status for managing the electronic files; otherwise, it may still be necessary to create human-readable versions of the files to handle manually until the PMS system can automate the process.

XII. Summary

With increased focus in the healthcare industry on electronic payments, one of the key elements to ensure the success of the utilization of EFT transaction is the ability of the Provider to be able to reconcile the payment with the ERA or paper RA. Unlike other EDI transactions, the EFT and ERA or paper RA can be received at different times through different transport mechanisms. Because of the challenge of trying to reconcile the payment with the RA information, it is key that the Provider and/or their software vendor understand how the reassociation process works in order to reconcile the payments with the RA information they receive.

It is also imperative that other healthcare entities (payers, clearinghouses, etc.) are abiding by the CAQH CORE EFT & ERA Operating Rules. There needs to be a consistent process to ensure that all EFT payments are delivered to the Providers in a consistent manner that allows the Provider to apply the same processes to all EFT payments in order to complete the reassociation process.

By all participating healthcare entities adhering to a common set of processes, the Provider will be able to successfully complete the reassociation process and take full advantage of the benefits of utilizing the EFT transaction to receive their payments.

XIII. Acknowledgements

WEDI EFT SWG Co-Chairs
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Deb Strickland, Xerox
Ron Meier, HealthNet

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XIV. Resources

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

> "*NACHA Operating Rules* Healthcare Updates and their Impact to Providers and Health Plans"
>
> "Enrollment Process for Healthcare Claim Electronic Funds Transfer (EFT) Payments and Healthcare Electronic Remittance Advices (ERA)"
>
> "Implementing a Healthcare Payment EFT Process to Accompany a Healthcare Claim Payment Remittance Advice"
>
> "NPI Utilization in Healthcare EFT Transactions"
>
> "EFT Addenda Record for Paper Remittance Advices"
>
> "Best Practices – Reassociation" at www.x12.org

2014 NACHA Operating Rules at www.nacha.org

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

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