EFT and ERA Standards and Operating Rules

Pam Grosze
Deb Strickland
Electronic Funds Transfer

- A health care EFT transaction - electronic message used by health plans to order, instruct or authorize a depository financial institution (DFI) to electronically transfer funds through the Automated Clearinghouse (ACH) network from one account to another
  - ACH network – the secure electronic network for the direct transfer of funds and data from one DFI account to another
EFT Payment Flow

Stage 1
Payer Initiates payment with their bank → Originating Bank (ODFI) Transfers funds to RDFI via ACH

Stage 2
Automated ClearingHouse (ACH)

Stage 3
Receiving Bank (RDFI) Receives funds for provider → Provider receives notification of deposit
Impact of the Affordable Care Act

- EFT mandated by 2014
  - Health Plans must support EFT
    - Standards Final Rule makes EFT a HIPAA transaction
    - If a provider asks for it the payer must be able to send it.
  - Providers are not required to accept (exception – for Medicare EFT is mandated)
    - Providers can have:
      - EFT and 835
      - EFT and paper RA
      - Paper check and 835
      - Paper check and paper RA
Impact of the Affordable Care Act

• EFT / ERA Standards Final Rule
  – Published July 2012
  – Requires the CCD+ format to be used for “Stage 1” payment initiation
    – Health plan sending info to their financial institution to initiate payment must be in the CCD+ format
  – Requires the TRN segment included in the CCD+ Addenda record to comply with the 835 TR3
  – Effective January 1, 2014
Impact of the Affordable Care Act

- EFT and ERA Operating Rules
  - Required by ACA
  - Operating Rules IFC published August 10, 2012
  - Compliance required by January 1, 2014
  - Health plans conducting EFT today may need updates to comply with the new requirements
ACH Formats

• File consists of a header record and trailing control record, one or more batches with a batch header and batch control record, and entry detail records containing the payment detail information.
• All records are 94 characters in length.
• Each record type is designated with an initial record type indicator value.
ACH Formats

• CCD – Corporate Credit or Debit Entry
  – Also known as Cash Concentration or Disbursement
  – As a debit, this is used by an originator to consolidate funds from its branches, franchises or agents.
  – As a Credit, CCD is used by an Originator to fund the accounts of its branches, franchises or agents.
ACH Formats

• CCD+ – Corporate Credit or Debit Entry plus Addenda
  – CCD+ is the same as CCD but with a single "7" addenda record attached.
    • The addenda must contain a copy of the TRN segment from the 835
      – Per the EFT Standards Final Rule, this must comply with the 835 TR3
    • Moves money and up to 80 characters of data, enough to reassociate dollars and data when the dollars are sent through the ACH and the data is sent on a separate path.
    • Must be sent by the payer to their financial institution to originate the payment
The CCD+ Addenda Record

• 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.
  – delimiters used are “*” for the element delimiter and “\” for the segment terminator.

• Additional information beyond the TRN segment must not be added to the Addenda record
  – Must comply with the 835 TR3
  – 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 (health plan) that is needed for reassociation of the EFT and 835.
835 TRN Segment

- **TRN01** – Trace Type Code
  - Value is always “1”
- **TRN02** – Reference Identification
  - EFT Trace Number (or Payment Reference # for paper)
- **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.
Addenda Record Example

• Field 3 in the Addenda record contains the TRN segment (Reassociation Trace Number segment) as it appears in the associated 835

Example: 705TRN*1*1234567896*1326549870\
• Operating rules support the adopted standards for health care transactions by fostering and enhancing uniform use of the standards across the health care industry.
  – encourages adoption of electronic transactions
Operating Rule Requirements

- Enrollments
- Reassociation / Timing and Delivery
- CARC/RARC combinations
- 835 Infrastructure
EFT and ERA Enrollment

- Signals intent to receive EFT and/or 835 for the provider and documents authorized signature to approve EFT transactions.
- Documents which providers (usually by NPI) are included in the approval and what bank routing and account numbers to be used to deposit the funds for EFT.
Enrollment Challenges Today

- Processes vary from payer to payer – some electronic and some paper
- Some payers will allow “bulk” enrollment for all numbers, some require one form per NPI
- Paperwork often lost or misdirected at payer, difficult to understand requirements on forms which may require multiple resubmissions
- ERA and/or EFT files may not be grouped at the level (TIN / NPI) needed by the provider for their reconciliation and posting
Enrollment Key Items

• Key requirements:
  – 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

• payer needs to validate:
  – The provider is a valid provider
  – The bank account information is accurate
  – They have the proper authorization from the provider organization to send the claim payments using EFT
Enrollment Operating Rules

• Rules include a controlled vocabulary and a maximum set of allowable fields that can be included on an EFT and ERA enrollment
  – Provider specifies TIN or NPI grouping of files
    • Other groupings, e.g. billing address, not allowed
• Master template (names and order of fields) for paper and electronic-based enrollments
• Written instructions must be provided
  – Submitting the required data elements
  – Changing or canceling enrollments
• Electronic enrollment method must be offered
EFT and ERA Payment Flow
Reassociation

• Reassociation is the process of matching an Electronic Remittance Advice (ERA) in the ASC X12 835 format to the associated Electronic Funds Transfer (EFT).
• The 835 may have traveled through a clearinghouse, a bank, or via direct transmission from the payer to the provider.
• The EFT always travels through the banking system (ACH).
• Files may arrive at different times or on different days.
## Key Information for Reassociation

<table>
<thead>
<tr>
<th><strong>X12 835 ERA Data</strong></th>
<th><strong>ACH – CCD+</strong></th>
</tr>
</thead>
</table>
| **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*20120131~  
AND  
TRN*1*0057940746*1133557799~ | **Company ID**  
• Batch Header, Record Type 5, Field Number 5, positions 41-50  
5200HEALTHPLAN . . . 1133557799CCDEFTP. |
| **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~ | **Identification Number / ID**  
• Record Type 6, Field Number 7, positions 40-54 (Optional)  
62212345689012 . . . 2244668800 . . . |
| **Trace Number Segment**  
• The TRN02 (trace number) is used for reconciliation as well as the payer tax ID TRN03  
TRN*1*0033557799*1133557799~ | **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|
Reassociation Challenges

• 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.
Reassociation Operating Rules

- Rule establishes minimum required data that must be present in the CCD+ file
  - Effective Entry Date (Record 5 Field 9) = BPR16
    - Must be a valid Banking Day
  - Amount (Record 6 Field 6) = BPR02
  - Payment Related Information (Record 7 Field 3)
    - Addenda Record
    - Contains copy of the TRN segment from the 835

- 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 provider must contact the financial institution to arrange for delivery of the reassociation data
Reassociation Operating Rules - EFT/ERA Timing

- 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 health plan must be able to track and audit this requirement

- The health plan must have written procedures for the provider to use for researching and resolving a late or missing EFT or ERA file
  - Late = 4 business days after the receipt of the EFT or 835

- Procedures must be delivered to the provider during the enrollment process
Claim Adjustment Codes and their Challenges

Codes are used in the ERA to provide information on why the originally billed charges were not paid in full.

<table>
<thead>
<tr>
<th>The Codes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Adjustment Reason Code (CARC)</td>
<td>Reason code</td>
</tr>
<tr>
<td>Remittance Advice Remark Code (RARC)</td>
<td>Detail and clarification note</td>
</tr>
<tr>
<td>Claim Adjustment Group Code (CAGC)</td>
<td>Identifies party responsible for adjustment amount</td>
</tr>
<tr>
<td>NCPDP Reject Code</td>
<td>Pharmacy claim rejection reason</td>
</tr>
</tbody>
</table>

Challenges Today

- Different payers use different CARCs/RARCs for the same situations
- Not all payers use RARCs
- Subjectivity in interpretation of CARCs/RARCs and in the combinations
- Codes are updated several times per year
  - Modified or deactivated codes often used incorrectly
  - New codes not requested, so proprietary paper codes provide more benefit for providers
Uniform Use of CARC/RARC Operating Rules

- Business Scenarios Defined
  - Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation
  - Scenario #2: Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim
  - Scenario #3: Billed Service Not Covered by Health Plan
  - Scenario #4: Benefit for Billed Service Not Separately Payable

For each Business Scenario, specific combinations of CAGC, CARC, RARC/NCPDP Reject Codes are allowed

- Defined set is the *maximum* allowed, combinations outside the set are not allowed
- Additional Business Scenarios can be developed by a payer if needed, but for the defined scenarios, only the defined code set is allowed
- Any product extracting the 835 data (non-pharmacy) must provide to the end user text describing the CAGC/CARC/RARC or NCPDP Reject Codes used in the 835
  - It must also provide text describing the Business Scenario this falls under
  - Does not apply to an entity that is forwarding the 835 on to another system for processing
## Code Combinations for Business Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation

<table>
<thead>
<tr>
<th>CARC</th>
<th>CARC Description</th>
<th>RARC</th>
<th>RARC Description</th>
<th>ASC X12 CAGC</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).</td>
<td><strong>M1</strong></td>
<td>X-ray not taken within the past 12 months or near enough to the start of treatment.</td>
<td>CO or PI</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>M19</strong></td>
<td>Missing oxygen certification/re-certification.</td>
<td>CO or PI</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>M21</strong></td>
<td>Missing/incomplete/invalid place of residence for this service/item provided in a home.</td>
<td>CO or PI</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>M23</strong></td>
<td>Missing invoice.</td>
<td>CO or PI</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>M29</strong></td>
<td>Missing operative note/report.</td>
<td>CO or PI</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>M30</strong></td>
<td>Missing pathology report.</td>
<td>CO or PI</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>M31</strong></td>
<td>Missing radiology report.</td>
<td>CO or PI</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>M42</strong></td>
<td>The medical necessity form must be personally signed by the attending physician.</td>
<td>CO or PI</td>
</tr>
</tbody>
</table>
Uniform Use of CARC/RARC Operating Rules

- Note that the process for maintaining the Code Combination list is to be defined
  - CARCs / RARCs are updated 3 times per year, so since the time the Code Combination list was developed it is already outdated
  - Internal code combinations means that new operating rule must be published to incorporate changes
- Some code combinations appear in multiple Scenarios
- Some recommended CAGC conflict with those required by the TR3 or the codes list
835 Infrastructure Operating Rules

• The rule requires minimum connectivity requirements ("safe-harbor") for non-pharmacy 835s.

• Continue delivery of paper remittance for a minimum of 31 calendar days or 3 payment cycles, whichever is more
  – Timeframe can be extended or shortened based upon mutual agreement

• 835 Companion Guides must conform to the CORE Master Companion Guide Template

• The 999 Acknowledgement requirements were excluded from the IFC
WEDI EFT Subworkgroup

• Just completed:
  – Education Paper for creating the Addenda record when using paper remittances
  – Issues Brief on customization of the Addenda Record
  – White Paper on EFT process for providers and payers

• Currently working on:
  – Issues Brief on Enrollment Operating Rules from both Payer and Provider perspective

• Conference Calls
  – 1st and 3rd Monday of each month
  – 11:00 AM ET

• Listserv - wedi-eft@lists.wedi.org

• We welcome your input!
Where to go for more information

- WEDI
  - [www.wedi.org](http://www.wedi.org)
- WEDI Operating Rules Database
  - [www.wedionline.org/oprules/](http://www.wedionline.org/oprules/)
- NACHA
  - [www.nacha.org](http://www.nacha.org)
  - [www.electronicpayments.org](http://www.electronicpayments.org)
- CAQH CORE
  - [www.caqh.org](http://www.caqh.org)
- X12
  - [www.X12.org](http://www.X12.org)
Questions?

Pam Grosze
PNC Healthcare
972-275-7010
Pamela.grosze@pnc.com

Deb Strickland
TIBCO
203-269-9075
dstrickl@tibco.com