Administrative Simplification

ABOUT ADMINISTRATIVE SIMPLIFICATION

EFT and ERA: Electronic Funds Transfer and Electronic Remittance Advice Transactions Basics

What is a Health Care Transaction?

A health care transaction is an exchange of information between two parties to carry out financial or administrative activities. When electronic transactions are used effectively in health care, they:

- Increase efficiencies in operations
- Improve the quality and accuracy of information
- Reduce the overall costs to the health care system

Widespread use of Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA) adopted transactions—where everyone uses the same language, format, and code sets—can lead to substantial savings across the health care industry. To realize these benefits, however, all organizations need to be using the same adopted standards for their transactions.

Electronic Funds Transfer (EFT)

The process used to transmit health care payments from a health plan to a health care provider's bank is commonly called EFT.

Like the payroll direct deposit service that many businesses offer their employees, EFT uses the Automated Clearing House (ACH) Network, a processing and delivery system using nationwide telecommunications networks, to move the funds from the health plan's bank account to the health care provider's bank account.

Health plans can use a provider's banking information only to deposit funds, not to withdraw funds.

An EFT transaction contains payment processing information such as:

- Amount being paid
- Names and identification information of the payer and payee
- Bank account information for the payer and payee (including routing and account information)
- Date of payment

Electronic Remittance Advice (ERA)

The ERA transaction supplies information about the payment to the health care provider, including any adjustments to claims and other payments based on factors like:

- Contract agreements
- Secondary health plans
- Patient benefit coverage
- Expected copays and coinsurance
- Capitation payments
- Internal Revenue Service (IRS) withholding

The ERA helps providers link an EFT with the specific services covered, allowing providers and health plans to easily track transactions.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Administrative Simplification

CONTINUED

EFT and ERA Required for Health Plans

Health plans must conduct the EFT and ERA standard transactions with providers when asked to do so under **Administrative Simplification** rules.

Operating Rules

Operating rules for EFT and ERA, which are required by the Patient Protection and Affordable Care Act, became mandatory on January 1, 2014. **CAQH CORE Payment & Remittance** operating rules cover EFT and ERA infrastructure, **Claim Adjustment Reason Codes** (CARCs) and **Remittance Advice Remark Codes** (RARCs), reassociation, and provider enrollment for each of the processes, and can improve the use of and compliance with standards for these transactions. To learn more about these operating rules, visit the **CAQH CORE website**.

Adopted Standards

HHS has adopted two standards for EFT transactions:

- **CCD+Addenda**, the **NACHA** Corporate Credit or Deposit Entry (CCD) with Addenda. The EFT standards apply only to transmissions of data over the **Automated Clearing House (ACH) Network**.
- **Accredited Standards Committee (ASC) X12 Health Care Claim Payment/Remittance Advice (835), Version 005010X221** and its associated Errata Documents (here afterwards referred to as X12 835 V5010), the standard for data content of the CCD+Addenda Record.

The adopted standard for ERA transactions is **ASC X12 835 V5010**.

These standards apply to all HIPAA-covered entities.

CARCs and RARCs

All health plans are required to use CARCs and RARCs to explain payment adjustments. Health plans are not permitted to use proprietary codes in the ERA transaction to communicate adjustment information about the payment.

Individuals or organizations can request new codes and revisions to existing codes through the ASC X12 Code Committee. These requests can be submitted by using the "Maintenance Request Form" option on the web pages for **CARCs** or **RARCs**. This will add your request to the agenda of the code committee's next meeting.

Note to Health Plans

Health Plans are required to input the ASC X12 835 TRN Segment into Field 3 of the Addenda Record of the CCD+Addenda. The TRN Segment in the Addenda Record of the CCD+Addenda should be the same as the TRN Segment in the associated ERA that describes the payment.

Using the same TRN Segment helps to match the payment to the correct remittance advice, a process called reassociation. This enables a provider to auto post payments to accounts receivables.