Administrative Simplification

ADMINISTRATIVE SIMPLIFICATION

EFT and ERA: Payment Remittance Reassociation Basics

What is Payment Remittance Reassociation?

When health plans initiate payment of a health care claim through the Automated Clearing House (ACH) Network, they generally send the health care electronic funds transfer (EFT) and the electronic remittance advice (ERA) transmission in different electronic formats. Thus, health care providers often receive the EFT and its corresponding ERA at different times. After both the EFT and ERA arrive at the health care provider, the provider must "reassociate" the ERA with the payment that it describes to reconcile the amount paid, post the payment to its accounts receivable system, and update patient accounts.

How Adopted Standards Facilitate Reassociation

As depicted in the illustration on page 3, health care EFTs through the ACH Network involve three stages. In Stage 1, a health plan authorizes its financial institution to transfer funds to a provider's financial institution. ***The adopted HIPAA standards require health plans to include a unique Reassociation Trace Number (TRN) in their Stage 1 transmissions and to include a matching TRN in each corresponding ERA transmission.*** While HHS has not adopted standards to govern transmission of the EFT from a health plan's financial institution to a provider's financial institution or the transmission of a deposit notification from the provider's financial institution to the provider (Stage 2 and Stage 3), by mandating consistent format and data elements for health plans to use in Stage 1 payment initiation transmissions, health care providers should receive a TRN in the Stage 3 deposit notification from their financial institution.

When a provider receives EFT and ERA transmissions containing matching TRNs, they're able to reduce administrative burden by automating the reassociation process. When reassociation information is missing, delayed, or incorrect, providers must use considerable time and resources to track down and identify payments.

How Adopted Operating Rules Support Successful Reassociation

To further support EFT and ERA reassociation, HHS adopted the Council for Affordable Quality Healthcare (CAQH) Phase III Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule. Sections 4.1 through 4.3 of the rule require health plans to take affirmative actions aimed at supporting the reassociation process and reducing burden caused by missing, delayed, or incorrect reassociation information.

4.1. Receipt of the CORE-Required Minimum CCD+ Data Required for Reassociation

CAQH CORE identified a set of data elements within the NACHA CCD+Addenda standard that providers must receive, including the TRN segment, to properly reassociate an EFT payment with its corresponding ERA.

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These data elements are collectively referred to as the CORE-required Minimum CCD+ Data Elements. While health plans are required to include these data elements in their Stage 1 payment initiation transmissions, HIPAA rules do not mandate that financial institutions deliver this information in their Stage 3 deposit notification transmissions to providers.

Therefore, ***section 4.1 requires health plans to proactively inform health care providers that they will need to contact their financial institutions to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements***, when providers are enrolling[1] for EFT and ERA transactions.

After arranging for the delivery of the CORE-required Minimum CCD+ Data Elements with Stage 3 deposit notification transmissions, providers should have all the information necessary to conduct reassociation.

4.2: Elapsed Time between Sending the v5010 X12 835 and the CCD+ Transactions

To address burden associated with delays between receipt of an EFT and an ERA, section 4.2 requires health plans to release the ERA for transmission to the health care provider:

- No sooner than three business days prior to the date identified in the Stage 1 payment initiation transmission as the date the health plan intends to provide funds to the payee via EFT (the Effective Entry Date).
- No later than three business days after the Effective Entry Date identified in the Stage 1 payment initiation.

The rule defines a business day as "24 hours commencing with 12:00 am (Midnight or 00:00 hours) of each designated day through 11:59 pm (23:59 hours) of that same designated day."

The rule varies slightly for retail pharmacy transactions, allowing health plans to release the ERA for transmission any time prior to the Effective Entry Date identified in the Stage 1 payment initiation transmission, but no later than three days after that date.

To be compliant with the rule, a health plan must track and audit all EFT and ERA transactions it transmits to ensure that 90% of all transactions within each calendar month are compliant with these timing requirements.

4.3: Resolving Late/Missing EFT and ERA Transactions

To assist providers with resolving late or missing EFT or ERA transmissions, section 4.3 requires that health plans must establish and deliver to each provider enrolling for EFT and ERA, written Late/Missing EFT and ERA Transactions Resolution Procedures. The procedures must define the process a provider can follow with the health plan when researching and resolving a late or missing EFT payment and/or the corresponding late or missing ERA. Late or missing is defined as a maximum elapsed time of four business days following the receipt of either the EFT or ERA.

To learn more about these operating rules, visit the CAQH CORE website.

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1 In order to receive EFT payments through the ACH network and receive ERAs, a provider must enroll with each health plan that it bills to conduct EFT and ERA transactions. All EFT and ERA enrollment processes must comply with the adopted operating rules, the Phase III CORE 380 EFT Enrollment Data Rule and the Phase III CORE 283 ERA Enrollment Data Rule; 45 CFR § 162.1603.

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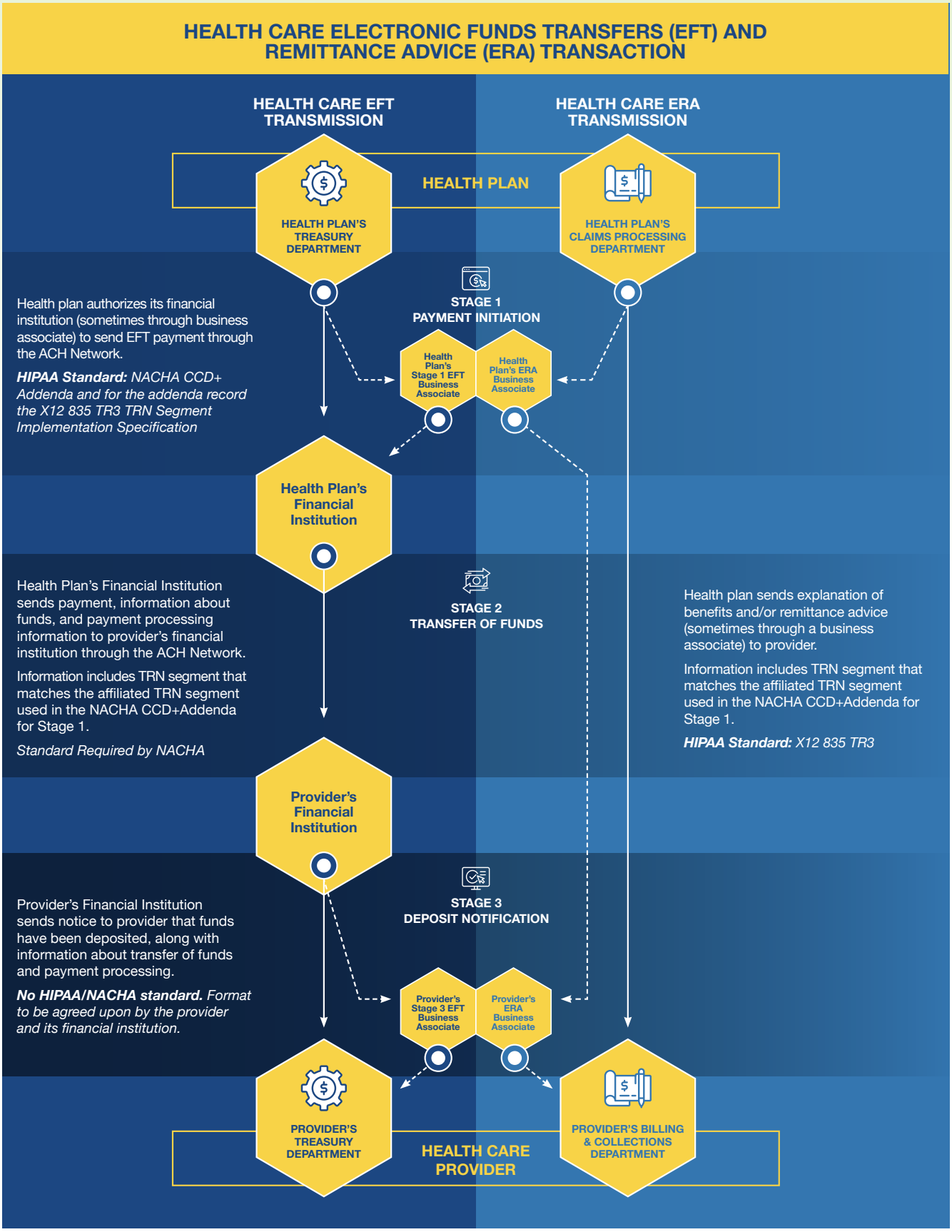
Illustration



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