EFT and ERA Guide

Tired of dealing with paper checks and the arduous process of matching payment and remittances? Help has arrived in the form of new federal standards. As part of the Affordable Care Act of 2010 (ACA), health plans as of Jan. 1, 2014 are required to offer physician practices the option of receiving their payment via electronic funds transfer (EFT) using a national standard. This standard is combined with a set of ACA-mandated EFT business conventions known as “operating rules.” In concert with the existing HIPAA standard for electronic remittance advice (ERA) and new ERA operating rules, also required by the ACA, these important components of the practice revenue cycle have been significantly streamlined.

These operating rules build upon the industry-wide EFT standard adopted by the government. Once implemented, these operating rules are projected by the government to save between $2.7 billion and more than $9 billion in administrative costs over ten years by reducing inefficient manual administrative processes for physician practices, hospitals, and health plans.

EFT Standard

The Healthcare EFT Standard and Remittance rule identifies a HIPAA EFT standard format to be used for the claims reimbursement payment (ACH CCD+Addenda) and establishes a standard for the remittance information (the TRN Reassociation Trace Number) that must be included in the CCD+Addenda. All health plans do need to offer out the CCD+ to their providers.

While the government established the CCD+Addenda as the healthcare EFT standard, the rule does not prohibit the use of other EFT payment options including card and wire transfer. However, if a provider requests payments be sent to them using the healthcare EFT standard the health plan must deliver the payment using the CCD+Addenda format.

New EFT Enrollment Website

The Council for Affordable Quality Healthcare (CAQH) has developed a new EFT module for its Universal Provider Datasource, a widely-used credentialing database. Practices are now able to upload their EFT-related information one time and then grant access to their health plans. Although only a small number of health plans are currently participating, it is expected that many more will join this effort. The module is available at www.caqh.org
EFT/ERA Operating Rules

The ACA EFT and ERA operating rules will facilitate easier provider EFT/ERA enrollment and reassociation of EFTs and ERAs as well as speed up the payments themselves. Specifically, the ACA operating rules will help practices by:

- Requiring health plans to use a consistent format and form on EFT/ERA enrollment forms, ensuring that the enrollment process is similar across plans;
- Requiring health plans to offer an electronic method for provider EFT/ERA enrollment;
- Automating the reassociation of EFTs and ERAs;
- Requiring the health plan to release the EFT payment and ERA within a reasonable timeframe (e.g. 3 days or less) if the provider has enrolled for both transactions;
- Providing practice access to instructions from health plans on how to address late or missing EFTs and ERAs;
- Allowing practices to receive the key data elements (“trace numbers”) in the two transactions necessary for successful reassociation; and
- Requiring health plans to utilize a uniform set of code combinations for common business scenarios developed by CAQH CORE to convey details of the claim denial or payment adjustment (Claim Adjustment Reason Codes/Remittance Advice Remark Codes) to the practice. This Operating Rule establishes a maximum set of CARC and RARC code sets for use with four specific business scenarios (see below).

Benefits of Automation

Moving to a more automated payment and remittance process offers a number of benefits to the practice:

- Eliminates staff time to open mail, log the paper check, and make a bank deposit
- Minimizes the chance for improper cash management
- Payments generally are received faster from the health plan
- Reassociation of the payment and remittance is significantly improved
- More efficient identification and resolution of anomalies and issues requiring staff follow-up
<table>
<thead>
<tr>
<th>CAQH CORE-defined Claim Adjustment/Denial Business Scenario</th>
<th>CAQH CORE Business Scenario Description</th>
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</thead>
<tbody>
<tr>
<td>Scenario #1: Additional Information Required - Missing/Invalid/Incomplete Documentation</td>
<td>Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in CORE-required Code Combinations for CORE-defined Business Scenarios.doc</td>
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<tr>
<td>Scenario #2: Additional Information Required - Missing/Invalid/Incomplete Data from Submitted Claim</td>
<td>Refers to situations where additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in CORE-required Code Combinations for CORE-defined Business Scenarios.doc.</td>
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<tr>
<td>Scenario #3: Billed Service Not Covered by Health Plan</td>
<td>Refers to situations where the billed service is not covered by the health plan. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in CORE-required Code Combinations for CORE-defined Business Scenarios.doc</td>
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<tr>
<td>Scenario #4: Benefit for Billed Service Not Separately Payable</td>
<td>Refers to situations where the billed service or benefit is not separately payable by the health plan. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in CORE-required Code Combinations for CORE-defined Business Scenarios.doc</td>
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Action Steps: Take advantage of ACA Simplification

1. Complete an internal review of the payment and remittance processes your practice currently employs. Do you receive all these via paper checks and forms? Do you have a mixture of paper and electronic?

2. Establish if your practice is receiving some payments from health plans in the form of a credit card payment.

   Note: Some health plans have adopted this method of payment. The concern for practices is that every credit card transaction carries a fee for the payment recipient, usually 1.9% to 3% or more of the transaction amount. Should a health plan simply send the 16 digit number, these fees can escalate as credit card companies build in additional charges to offset fraud risk and other costs when numbers are entered manually. Under the law, however, health plans are required to send payments via EFT if the practice requests that mode of payment.

3. Determine if your practice is currently outsourcing EFT and/or paper check processing to a clearinghouse or other third party vendor; if so, you may want to review your contract to determine your options—including identifying those health plans that you will need to request EFT payments from.

4. Review the current functionalities of your practice management system (PM) software. You may be running software that does not have, for example, the capability to leverage the ERA transaction.

5. Determine what administrative simplification opportunities your practice wants to take advantage of. For example, if you would prefer not to upgrade your PM software, you can still request EFT payments from health plans. Some practices may wish to adopt an incremental approach by starting with EFT and moving to the other transactions at a later date.

   Note: In addition to reviewing your software’s capability of conducting EFT/ERA, you may want to take this opportunity to explore the other HIPAA transactions such as eligibility verification and claim status (standards and operating rules).

6. If your health plan is not participating in the CAQH EFT enrollment module, visit the health plans’ websites to enroll in EFT via the health plans’ websites.

7. If you are unable to find clear instructions for EFT enrollment on the health plan’s website, you can contact the health plan, either in writing (by customizing and sending the sample letter below (created by CAQH) email or via a phone conversation to request payment via EFT.

8. New! Members are reporting that some health plans or third-party vendors are charging fees for the EFT transaction. These fees typically range from 1% to 3% (of the total EFT payment), with some vendors contending that they are offering “value add” services for these fees. Action steps include first determining if your practice is incurring any fees for your EFT transactions and if your organization is receiving any true “value add.” Once you identify those entities that are unfairly charging you for EFT, contact them and
request the no cost version of the EFT transaction. Should they refuse, consider lodging an official complaint with CMS directly, or through MGMA government affairs (govaff@mgma.org). Some members have reported that simply requesting the no cost EFT option was sufficient.

Additional Resources
CMS EFT/ERA regulations and resources
CAQH EFT/ERA resources including EFT enrollment module
NACHA (The Electronic Payments Association) EFT resources