

February 17, 2011

The Honorable Kathleen Sebelius  
Secretary  
Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Dear Madam Secretary:

Re: Affordable Care Act (ACA), Administrative Simplification: Standard for Health Care Electronic Funds Transfers and Operating Rules for Electronic Funds Transfers and Health Care Payment and Remittance Advice

The National Committee on Vital and Health Statistics (NCVHS) is the statutory advisory committee with responsibility for providing recommendations on health information policy and standards to the Secretary of the Department of Health and Human Services (HHS). Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), NCVHS is to advise the Secretary on the adoption of standards and code sets for HIPAA transactions. The Patient Protection and Affordable Care Act (ACA) (Sec. 1104. (g)(3)), enacted on March 23, 2010, calls for NCVHS to assist in the achievement of administrative simplification to “reduce the clerical burden on patients, health care providers, and health plans.” by providing advice and recommendations to the Department of Health and Human Services (HHS) on the development of uniform operating rules for electronic exchange of information not defined by a standard or its implementation specification. Specifically ACA tasks NCVHS to:

- (A) Advise the Secretary whether a nonprofit entity meets the requirements for operating rules development;
- (B) Review the operating rules developed and recommended by such nonprofit entity;
- (C) Determine whether such operating rules represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards;
- (D) Evaluate whether such operating rules are consistent with electronic standards adopted for health information technology; and
- (E) Submit to the Secretary a recommendation as to whether the Secretary should adopt such operating rules.

Based on the above assignment, this letter is a third in a series addressing the ACA charges to the Committee, in concert with our existing responsibility to advise the Secretary on the adoption of standards. Our first two letters addressed 1. the health plan identifier (HPID) and 2. operating rules and their authoring entities for eligibility and claim status. This letter addresses the transactions for electronic funds transfers (EFT) specific to health care use and health care payment and remittance advice, commonly referred to as electronic remittance advice (ERA).

The problem addressed by this letter is the fact that, according to the U.S. Healthcare Efficiency Index (USHEI), the usage of the standard ERA transaction has doubled in the past year but is still only 46 percent, despite the fact that we are now seven years out from the first compliance date for standards. Furthermore, the electronic exchange is performed primarily via intermediary (third party) processing through health care clearinghouses, The rate of adoption of healthcare EFT, as reported by the USHEI, is only 10 percent.

To understand the specific issues associated with standards, operating rules and potential operating rule authoring entities for EFT and ERA, NCVHS contracted for an environmental scan to be conducted (see Appendix A) and held hearings on December 3, 2010. A wide range of stakeholders attended, including health plans, provider organizations, health care clearinghouses, retail pharmacy industry representatives, standards developers, professional associations, representatives of Federal and State health plans, WEDI, the banking industry, and entities proposing to serve as authoring entities --- including the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE), Accredited Standards Committee (ASC) X12, National Automated Clearing House Association (NACHA), and National Council for Prescription Drug Programs (NCPDP). See Appendix B: Agenda which includes testifiers.

Based on the testimony, NCVHS has developed the following observations and, as applicable, recommendations, as input to the Secretary with respect to: (1) overarching themes concerning the selection of operating rule authoring entities and the implementation of standards and operating rules, (2) standard and implementation specifications for a health care EFT and (3) candidates to serve as authoring entities for EFT and ERA operating rules.

### **Overarching Observations**

Following the testimony, several overarching observations were made by NCVHS:

- *There is value in establishing an active, open process that ensures communication among authoring entities and between authoring entities and standards development organizations.* Such a communication process has the potential to support more timely and accurate recognition of stakeholder needs and more specific enhancements to operating rules and standards. There is evidence that such communication has already started to occur -- ASC X12

incorporated items from the CAQH CORE Phase I and Phase II operating rules into the revised version of the adopted X12 HIPAA standard – version 5010 which will be required for use in January 2012. CAQH CORE then removed those items from the operating rules.

- *There is a transition path that needs to be recognized for health plans and providers to prioritize and plan for applicable investments in technologies and processes that will support new standards and their operating rules.* The degree of optionality in the standards has made it difficult for vendors to program their software. Improvement in the standards by reducing variability will enable better use of the standard transactions, but retooling of software and business processes will still be necessary and will take time.
- *There is value in ensuring consistency in certain aspects of operating rules across all transactions.* In particular, there are cross-cutting elements of business practices, such as connectivity, use of a standardized companion guide template, and work flows that need to be addressed irrespective of the transaction to which they are applied. In addition, there are differences in how standards and operating rules are viewed by standards development organizations and operating rules authoring entities as stakeholders in the financial and health care industries converge to address the health care EFT standard.

### **Specific Observations:**

#### **Identifying a Health Care EFT Standard**

In the generic sense, EFT is “any transfer of funds, other than a transaction originated by cash, check, or similar paper instrument that is initiated through an electronic [process] for the purpose of ordering, instructing, or authorizing a depository financial institution (DFI) to debit or credit an account.”<sup>1</sup> EFTs may be performed using an ATM, wire transfer, debit card, direct payroll deposit, or one of several NACHA-standard file formats (e.g., CCD+ and CTX) sent through the Automated Clearing House (ACH) Network. NACHA is recognized in the Treasury Department’s 31 CFR Part 210 as the author of the operating rules that apply to ACH payments.

Two of NACHA’s ACH formats and accompanying operating guidelines are designed for business-to-business (B2B) EFT transactions: CCD+ and CTX. These two formats differ significantly:

The CCD+ format includes addenda records of 80 characters in length to explain the payment being made. The CCD+ does not itself contain detailed remittance advice and therefore would not contain protected health information (PHI) when used in health care transactions; however, trace number segments may be included in the addenda so the payment can be re-associated with remittance advice that is sent separately.

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<sup>1</sup> Chapter 10 of the Debt Collection Improvement Act of 1996, Section 31001 (x)(1)(B)

The CTX format is a combination of remittance advice and EFT (i.e., ERA and EFT as would be used in health care), where “data and dollars” move together between the payer and the payee (health plan and provider as would be used in health care). Therefore, if CTX were used in health care, it would contain PHI. NACHA reports that, across industries, the CTX format is not in as widespread use as the CCD+, and there is no evidence of its use in health care. In testimony to the NCVHS on both September 15, 2010 and December 3, 2010, NACHA indicated that it is feasible to modify the CTX standard format for health care purposes, including creating a new standard entry class [SEC] code for health care transactions to ensure they are handled in a HIPAA-compliant manner as well as to potentially expand the remittance-carrying capacity. However, industry testimony did not support the sole use of CTX in health care at this time.

The ASC X12 835 Standard Implementation Guide describes EFT as “*the mechanism that payers use to instruct one DFI [depository financial institution] to move money from one account to another account at the same or at another DFI.*”<sup>2</sup> Table 1 of the ASC X12 835 Standard Implementation Guide states that the CCD+ may be used for EFT through the ACH Network, in which case a Trace Number must be included. However, neither the 835 nor any other standard is required to be used for health care EFT payments. Health plans are free to choose from a variety of formats and content to order, instruct, or authorize an EFT payment.

### **Recommendations for Identifying a Health Care EFT Standard** **NCVHS recommends that HHS:**

- 1.1 **Define health care EFT transaction** as the electronic message used by health plans to order, instruct or authorize a depository financial institution (DFI) to electronically transfer funds through the ACH network from one account to another.
- 1.2 **Define health care EFT standard** as the format and content required for health plans to perform an EFT transaction.
- 1.3 **Adopt as the standard *format*** for the health care EFT standard the NACHA CCD+ format, in conformance with the NACHA Operating Rules.
- 1.4 **Identify NACHA as the standards development organization** for maintenance of the health care EFT standard.

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<sup>2</sup> ASC X12 v4010 835 Health Care Claim Payment/Advice Standard Implementation Guide, Washington Publishing Company, May 2000, page 15.

1.5 **Adopt as the implementation specification for the *content*** for the addenda in the CCD+ the content requirements specified in the X12 835 TR3 REPORT (ASC X12N/005010X221) particular to the CCD+. <sup>3</sup>

1.6 Consider the implications of the fact that, as the result of the adoption of the healthcare EFT standard, some banks may become de facto healthcare clearinghouses as defined by HIPAA.

Note: Consistent with the HIPAA regulations, health plans will be required to use the standard transaction to perform EFT with their financial institutions. The health care EFT standard enables providers who request an electronic format of the remittance advice (ERA) to more easily and accurately reconcile a deposit and a claim payment. Note also that, because the health care EFT transaction would be a HIPAA transaction, any health care EFT standard will only apply to health plans that are making health care payments to providers. It does not apply to patients making payments to providers or payers making payments to patients. This standard would include both format and content requirements that would enable the payment initiated by a health plan to flow through the ACH Network to the provider's account and result in a provider being able to reconcile the deposit with the remittance advice.

### **Observations Relating to Candidates for Operating Rules for the Health Care EFT and ERA Standard Transactions**

As a health care standard for EFT does not yet exist, there are, therefore, no operating rules specific to health care at this time. Further, it is our understanding that there are also no industry accepted operating rules for the ERA standard at this time. However, NCVHS heard considerable testimony surrounding drafts of operating rules for both transactions, and elements that should be addressed in operating rules for use when conducting a health care EFT standard transaction or an ERA standard transaction. These include examples such as: timelines for delivery of the EFT in relationship to delivery of the ERA; prohibition against use of paper checks or other forms of payment when the health care EFT standard is used; prohibition against adhesion contracts whereby providers are required to authorize debits which would not otherwise be permitted by law or require a provider to use a specific bank; a requirement for prior notification of any proposed debit so as to allow providers adequate time to ensure that sufficient funds are present; consistency in data content between the EFT and HIPAA transaction data content such as the claim submission transaction; and a standardized, secure online enrollment form and/or enrollment process for EFT.

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<sup>3</sup> It is acknowledged that there are other forms of EFT, including CTX, which are not widely used in health care. These may be considered in the future for the format and content of the health care EFT standard as the NCVHS has the responsibility for reviewing these standards and operating rules every three years.

NCVHS has formally requested potential operating rules authoring entities to develop and present their applications to be authoring entities for operating rules for the health care EFT standard and ERA standard. These will be reviewed by NCVHS after they are received, and further recommendations will be considered.

NCVHS remains available to answer any questions and will continue to support the Secretary's initiatives towards administrative simplification in every way possible.

Sincerely,

/s/

Justine M. Carr, M.D.  
Chairperson, National Committee  
On Vital and Health Statistics

Enclosures:

Appendix A: Environmental Scan  
Appendix B: Meeting Agenda

Cc: HHS Data Council Co-Chairs

**Environmental Scan:**

**Operating Rules for Health Care Claim Payment/Advice  
(a.k.a. Electronic Remittance Advice [ERA])  
and  
Standard and Operating Rules for Electronic Funds Transfer (EFT)**

November 24, 2010  
Updated December 7, 2010

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## 1.0 BACKGROUND

This Environmental Scan is a follow-on document to the “Environmental Scan on Unique Health Plan Identifier and Operating Rules for Health Information Transactions” provided to the National Committee on Vital and Health Statistics (NCVHS) on July 11, 2010.

The Affordable Care Act was signed into law on March 23, 2010. It includes a number of health-related topics including two sections related to administrative simplification (Sec. 1104) and standards for financial and administrative transactions (Sec. 10109). It calls for NCVHS to submit a recommendation to the Secretary of the U.S. Department of Health and Human Services (HHS) relative to adoption of a unique health plan identifier, operating rules for electronic exchange of information not defined by a standard or its implementation specifications, and standards for electronic funds transfer and health claims attachments. These structures will enhance the use of transactions required under Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Subtitle F – Administrative Simplification. (For a review of these transactions, see Appendix A.)

In September 2010, NCVHS advised the Secretary that the Committee on Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) met the Affordable Care Act’s requirements as a qualified authoring entity for operating rules, and recommended the adoption of CORE’s operating rules for non-retail pharmacy eligibility and claims status transactions. It also advised the Secretary that the National Council for Prescription Drug Programs (NCPDP) met the requirements as a qualified authoring entity for operating rules and recommended NCPDP operating rules for retail pharmacy eligibility transactions. Regulations for these operating rules must be adopted by July 1, 2011 and are expected to become effective by January 1, 2013.

In September 2010, NCVHS also recommended adoption of a unique health plan identifier (HPID) that would contain no embedded intelligence, and would be available for enumerating health plans as specified in the HIPAA regulations (45 CFR Part 160.103) and potentially intermediary entities that support health plans. An interim final rule for the HPID would carry an effective date of October 1, 2012.

## 2.0 INTRODUCTION

Two transactions are the subject of this Environmental Scan. The Affordable Care Act calls for the Secretary to adopt a standard and operating rules for **electronic funds transfers (EFT)** and operating rules for the **Health Care Claim Payment/Advice** transaction (often referred to as “electronic remittance advice” and abbreviated **ERA**). Together these should “allow for automated reconciliation of electronic payments with remittance advice” according to the Affordable Care Act. These standards and rules must be adopted by January 1, 2012 and July 1, 2012 respectively, to become effective by January 1, 2014 (industry compliance date).

### 2.1 Electronic Funds Transfer (EFT)

In general terms, an electronic funds transfer (EFT) is the transfer of money initiated through electronic means. EFT includes a variety of transactions or transfers, such as in direct deposits of payroll, debit card payments, electronic bill payment in online banking, and wire transfers.

Within the health care industry, the electronic message between a health plan and its designated financial institute (i.e., bank) authorizing the payment and transfer of funds to a provider’s financial institution is an electronic funds transfer transaction.

### 2.2 Health Care Claim Payment/Advice (ERA)

The ASC X12N 835 Health Care Claim Payment/Advice is the HIPAA-designated standard for health plans to notify providers of the amount being paid on claims that providers have filed with the health plan, and – if the payment does not equal the amount billed – to briefly explain the adjustments applied to the claims.

### 3.0 PURPOSE OF ENVIRONMENTAL SCAN

The purpose of this environmental scan is to establish baseline knowledge describing the need for standards and operating rules for EFT use in health care and for operating rules for the existing HIPAA ERA standard.

Please refer to the Environmental Scan on Unique Health Plan Identifier and Operating Rules for Health Information Transactions provided to the National Committee on Vital and Health Statistics (NCVHS) on July 11, 2010 for a summary of the legislative mandate and the full suite of administrative simplification requirements from Affordable Care Act.

This environmental scan is intended to be impartial and unbiased. Inclusion of information is based upon literature review and stakeholder communications. Exclusion of representative information is not intentional; but constrained by time or availability of information.

### 4.0 TERMINOLOGY ASSOCIATED WITH EFT AND ERA

**ASC X12 835 Health Care Claim Payment/Advice** is the official title of what is commonly referred to as the **Electronic Remittance Advice (ERA)** standard transaction and it is already an adopted standard under HIPAA.

The remittance advice is used by health plans to return information to providers, including retail pharmacies, about the amount of payment being made for each claim. **Claim Adjustment Reason Codes (CARCs)** in the remittance advice communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no CARC. There are approximately 300 such codes available per the Washington Publishing Company website. Reason codes range from items such as “the National Provider Identifier was not matched” to “Per regulatory or other agreement, the provider cannot collect this amount from the patient; however, this amount may be billed to subsequent payer. Refund to patient if collected.” In addition to CARCs, **Remittance Advice Remark Codes (RARC)** may be used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a CARC. There are over 800 RARCs.<sup>1</sup> Both CARCs and RARCs are external code sets; i.e., they are maintained by an entity that is not a standards development organization (not ASC X12 in this case).

There are two parts to the ERA:

**Health Care Claim Payment data** provide information about the payee, payer, amount, and identifying information of the payment (via a re-association trace number). This set of information can also authorize an EFT via the standard’s Table 1: “Header” level information.

**Remittance Advice data** describe the types of adjustments made when making payments against claims. There are two levels of adjustments: Table 2 “Detail” level information in the standard describes individual claim-specific adjustments, using a CARC and if necessary a RARC. (If there is no adjustment to a claim/line, then there is no CARC.) Table 3 “Provider Level Adjustment Segment (PLB)” or “Summary” in the standard describes adjustments specific to the provider.

Other terms often used synonymously with ERA are:

**Remittance Advice (RA)** is a term that may be used in one of two ways:

- One way “RA” is used is as a generic reference whether to a standard 835 or non-standard set of remittance information.

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<sup>1</sup> Washington Publishing Company, Claim Adjustment Reason Codes and Remittance Advice Remark Codes, 11/1/10. <http://www.wpc-edi.com/codes>

- Another way “RA” is used is to refer only to non-standard remittance information, hence distinguishing non-standard remittance information from the ASC X12 835 Health Care Claim Payment/Advice standard.

**Explanation of Payments (EOP)** is a term that may also be used to describe non-standard remittance information communicated by the payer to the payee.

**Explanation of Benefits (EOB)** is a written statement to a beneficiary from a third-party payer indicating the benefits and charges covered or not covered by the benefits plan. Although this is **NOT** a transaction for which a HIPAA standard has been established and is not further addressed in this Environmental Scan, it is defined here because some people use the terms ERA and EOB synonymously. In fact, the Preamble to the Transactions and Code Sets Final Rule (August 17, 2000) clarifies “that the ASC X12N 835 will be sent from a health plan to health care providers and/or health care clearinghouses. We are not regulating the explanations of benefits (EOBs) that health plans send to their subscribers.”

**Re-association** is the term used to describe the fact that remittance information (in a standard ERA or non-standard remittance advice/EOP) must be reconciled (re-associated) with a payment. A **Re-association Trace Number** is used for this purpose. This number is described in the ASC X12 835 Implementation Guide. It must be unique within the sender/receiver relationship. The number is assigned by the sender. If payment is made by check, this must be the check number. If payment is made by EFT, this must be the EFT reference number. If this is a non-payment 835, this must be a unique remittance advice identification number.

**Electronic Funds Transfer (EFT)** in the generic sense is “any transfer of funds, other than a transaction originated by cash, check, or similar paper instrument that is initiated through an electronic terminal, telephone, computer, or magnetic tape, for the purpose of ordering, instructing, or authorizing a financial institution to debit or credit an account.”<sup>2</sup> A definition of EFT *specific to health care information transactions* is found in the ASC X12 835 Standard Implementation Guide, where EFT is described as “*the mechanism that payers use to instruct one DFI [depository financial institution] to move money from one account to another account at the same or at another DFI.*”<sup>3</sup> The EFT is also described in the Preamble to the HIPAA Privacy Rule as the transaction “used to *initiate* the transfer of funds between the accounts of two organizations, typically a payer to a provider...”<sup>4</sup> The difference between the EFT in the broader, financial sense and the standard called for under ACA is important in carrying out this mandate. See Section 7.

**Automated Clearing House (ACH) Network** is a processing and delivery system for EFTs utilizing nationwide telecommunications networks and any of the following protocols: FTP, HTTPS, frame relay, dial up, VPN, or Internet w/PGP. Entities that perform the processing and delivery between an originator and a receiver are **ACH Operators**. Today, there are two ACH Operators – **The Clearinghouse** and the **Federal Reserve Board**. ACH Operators may use third parties to aid in moving funds transfers between payment originators and payment receivers.

**Healthcare Clearinghouse** is a HIPAA covered entity and should not be confused with the ACH Network or the ACH Operator, The Clearinghouse. HIPAA’s Privacy Rule (at 45 CFR §160.103) defines healthcare clearinghouse as “a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and ‘value-added’ networks and switches, that ...processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.”

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<sup>2</sup> Chapter 10 of the Debt Collection Improvement Act of 1996, Section 31001 (x)(1)(B)

<sup>3</sup> ASC X12 v4010 835 Health Care Claim Payment/Advice Standard Implementation Guide, Washington Publishing Company, May 2000, page 15.

<sup>4</sup> Standards for Privacy of Individually Identifiable Health Information,” Final Rule, *Federal Register*, Vol. 65, No. 250, Thursday, December 28, 2000, page 82615.

**National Automated Clearing House Association (NACHA)** is the non-profit organization that was formed in 1974 for the purpose of administration, development, and enforcement of operating rules and management practices for the ACH Network. In creating operating rules, it utilizes a deliberative, transparent, and inclusive process similar to that used by Federal agencies under the Administrative Procedures Act. All proposals to amend the NACHA Operating Rules are overseen and initially reviewed by NACHA's Rules and Operations Committee, which is composed of a representative sample of financial institutions (by size, type, geography, etc.) as well as representatives of Regional Payments Associations, the Network Operators, the Federal Research Board of Governors, and the U.S. Treasury Department. When creating operating rules for electronic funds transfer, NACHA works in concert with the Electronic Fund Transfer Act (EFTA) and other laws and regulations.

**Operating Rules** are defined in the Affordable Care Act as the "necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes if this part."

Other organizations also provide descriptions for "operating rules:"

- **Committee on Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)** defines operating rules as the "rights and responsibilities of all parties [with respect to] security, transmission standards and formats, response time standards, liabilities, exception processing, and error resolution."<sup>5</sup>
- **NACHA** understands Operating Rules differently than Affordable Care Act or previous HIPAA regulations. NACHA indicates that "operating rules establish the roles, rights, and responsibilities of the parties exchanging data and/or value (and often prescribe formats for the process) to enable transaction initiation, processing and completion, error resolution, and liability apportionment."<sup>6</sup>

Companion Guide is another type of guidance document relating to the HIPAA standard transactions as used by the non-retail pharmacy component of the health care industry. It is estimated that there are over a thousand companion guides in use – varying by health plan.<sup>7</sup> The retail pharmacy community utilizes similar guidance documents, called "payer sheets." CMS provides the following description of companion guides and cites the HIPAA Administrative Simplification regulation text requirements for trading partner agreements (§162.915):

**Companion guides** are "health plan-specific versions of the HIPAA-adopted standard Implementation Guides that define the health plans' requirements for situational data elements, and provide special instructions and further guidance on how the health plan is interpreting the HIPAA Implementation Guides." While HIPAA adopted specific Implementation Guides (IGs), Companion Guides have been independently created by some health plans to supplement the IGs and are tailored to meet individual health plans' particular needs. Companion Guides are not required by HIPAA. Not all health plans publish Companion Guides.

[Per 45 CFR §162.915] Companion Guides cannot:

- (a) Change the definition, data condition, or use of a data element or segment in a standard.
- (b) Add any data elements or segments to the maximum defined data set.
- (c) Use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s).
- (d) Change the meaning or intent of the standard's implementation specification(s).

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<sup>5</sup> <http://www.caqh.org/pdf/COREfacts.pdf>

<sup>6</sup> Estep, Janet O., President and CEO NACHA, Private-Sector Operating Rules: A Payments Network Perspective, Testimony to NCVHS, July 20, 2010.

<sup>7</sup> Zubeldia, Kepa. "From HIPAA to Interoperability," HIPAA Transactions Convergence Project, presentation to NCVHS, April 6, 2005.

## 5.0 CURRENT INDUSTRY PRACTICES FOR REMITTANCE ADVICE AND PAYMENT

### 5.1 Paper vs. Electronic Remittance Advice

Figures from the U.S. Healthcare Efficiency Index suggest that by December 2009, 46% of remittance advice transactions were electronic as opposed to paper, double the adoption rate of what it was in December 2008.<sup>8</sup> However, these rates do not reflect the level of intermediary processing through healthcare clearinghouses (see 5.2 below).

### 5.2 Process of Transmitting Electronic Remittance Advice

It is known that many health plans/providers use one or more healthcare clearinghouses to send/receive remittance advice information. This process is described and illustrated on the following diagram:

A health plan may send a standard ERA

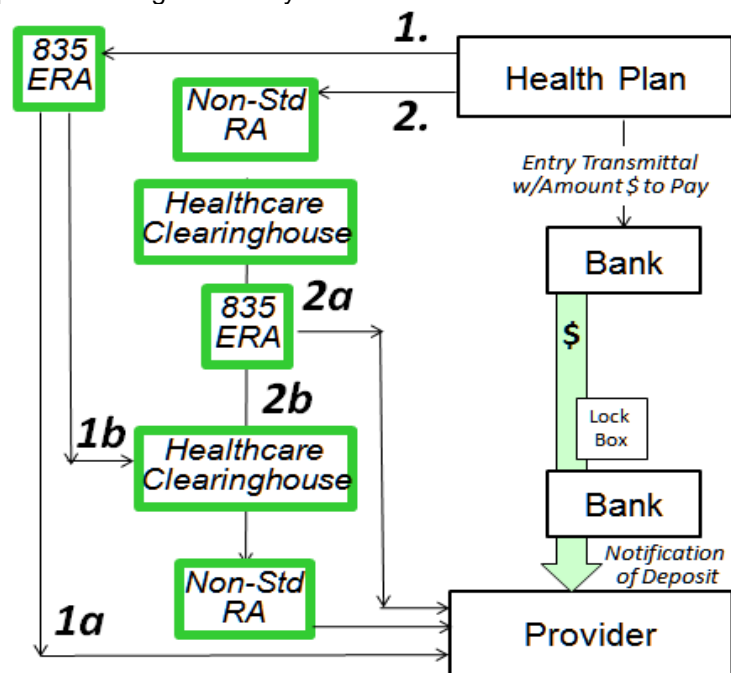
1a. directly to a provider who is able to receive it into its information system, or

1b. a health plan may be directed to send the standard ERA to a clearinghouse contracted by the provider to be converted to a non-standard remittance advice where the provider is unable to receive a standard 835 into its information system.

2. Health plans also may not be able to generate a standard ERA from their information systems, and so may send a non-standard remittance advice to a clearinghouse.

2a. The non-standard remittance advice may either be converted to a standard ERA which is then sent directly to the provider, or

2b. the non-standard remittance advice that has been converted to the standard ERA by the health plan's clearinghouse may be converted back to a non-standard format at the provider's direction.



It is estimated that 30 percent of all remittance advices do not include information about payment deposits, but rather explain encounters or address claims where a co-pay or deductible has already been paid to the provider.

<sup>8</sup> The U.S. Healthcare Efficiency Index<sup>®</sup> (USHEI) is a forum sponsored by Emdeon Business Services, LLC, for raising awareness and monitoring business efficiency in healthcare. The USHEI seeks to provide a national reference to track and measure the transition from a paper-based healthcare system to an electronic one. Measuring Business Efficiency in Healthcare, <http://www.ushealthcareindex.com/>

As shown in previous diagram, the submission of an Electronic Remittance Advice from a payer to a provider can be done separately from the submission of the Electronic Fund Transfer transaction from the payer to the bank. This is, by far, the most common way of submitting the transactions. The two transactions can also be done together in a single document that contains both the ERA information and the EFT information sent from the health plan to the health plan's bank and carried to the provider's bank and then to the provider.

In the case of sending the two transactions separately, one of the important elements is the time lapse between the submission of the EFT and the submission of the ERA by the health plan. While in most cases the standard practice is to have the two transactions be separated by no more than 5-8 days, in a number of instances the time lapse between the two transactions could be much longer, delaying the provider's process to reconcile the ERAs and EFTs.

### 5.3 Benefits of Electronic Funds Transfer

With respect to payments, the U.S. Healthcare Efficiency Index reports that only 10% of health care claims payments were made through electronic funds transfer (EFT) by the end of 2009. As illustrated above, checks are commonly sent either directly to a provider or to a provider's designated lock box (a local receiving address set up by a bank to collect payments and associated payment stubs or other accompanying invoice information for quick deposit). Some banks have health care lockbox operations where they receive checks and remittance advices, many of whom are recognizing that causes them to become a business associate under HIPAA.

The primary benefit of the EFT is cost reduction. According to the ACH, the cost to send a payment through a single check, including the check stock, staff time to process the check and payment reconciliation, postage, and bank fees, is \$1.68. The cost to send the payment through EFT is \$0.17.<sup>9</sup> However, these benefits do not accrue without many elements of the EFT and ERA being in place, including standardized operating rules that ensure consistent use of all applicable code sets and trace number assignment for re-association.

Two examples are described below of organizations realizing benefits from using EFT – as well as the systemic changes made to their business operations that were necessary to achieve those benefits.

**United Healthcare**, through its use of EFT (with 9 million ACH transactions issued in 2009), has found that there is significant reduction in administrative work, duplicate claims, and claim status inquiry telephone calls – benefits that accrue to both them as a health plan and to the providers to whom they send payments. United Healthcare also found that there was no chance of sending checks to the wrong provider address, stop payment and rework activity was reduced, and there were tighter internal controls over dollars and data sent, with no liabilities against claims paid through the EFT process.

However, initiating EFT did require information systems upgrades, provider registration, secure collection of banking information from providers, a solid authentication process, a delivery mechanism for the data to reach the provider, and proactive informing of providers when deposits are made to their accounts. They observed that “generating an EFT for claims paid is not enough if the two [ERA and EFT] are sent separately.”<sup>10</sup>

**Veterans Health Administration (VHA)** submits over 8 million claims electronically per year for health care not related to veterans' military service to 1,675 payers (200 payers account for majority of payments received). By 2004 after 18 months of implementation, the VHA had developed an ePayments system to replace paper checks and paper remittance advices. Latest reports as of April 2010 show that 84% of claims are being returned as ERAs, and of these, 36% of the payments come via EFT. VHA's ePayments system has resulted in 71% time reduction from claim submission to EFT receipt; and from 49 days in accounts

<sup>9</sup> ACH Cost Savings Analysis calculator, How Much Can Your Company Save by Converting Payroll to Direct Deposit? November 19, 2008 ([www.nacha.org/news/newsDetail.cfm//RecentBusinessNewsID/61](http://www.nacha.org/news/newsDetail.cfm//RecentBusinessNewsID/61))

<sup>10</sup> Troutman, Jeffrey W, PNC Healthcare; Lisi, Diana. United Healthcare; and Mayerick, Barbara C, Department of Veterans Affairs, E-Payment Cures for Healthcare, April 26, 2010

receivable to 14 days in accounts receivable with EFT. Automated data entry and report generation provide greater speed and accuracy and more efficiently manage exception processing.

VHA also observes, however, that there is still room for improvement – with standard use of the “claim adjustment reason codes” being at the top of their list. They also observe that payers need to improve their use of the ASC X12 835 by sending appropriate and balanced adjudication information for each line item payment before they move to EFT.<sup>11</sup>

#### **5.4 Discussion of Current Usage of Electronic Standard Transactions**

Based on studying the low adoption (estimated to be at 20%) of the ASC X12 820 Healthcare Premium Payment standard by employers in all industries, NACHA suggests that many health plans/providers may have information systems which vendors have not been able to program to the standard transaction because of the high degree of optionality in the standard, hence the continued generation and/or need to receive a non-standard remittance advice.<sup>12</sup> WEDI’s “Successful Practices for Implementation and Use of the 835 Transaction White Paper<sup>13</sup>” also observes that there is “inconsistent implementation and use of the 835 between trading partners.” This often occurs without trading partners willing to file compliance complaints against each other. The WEDI white paper concludes that, “By fixing some of these inconsistencies we can improve the ability of providers to automate the integration of the 835’s into their patient accounting system...”

### **6.0 OPERATING RULES FOR THE ERA TRANSACTION**

#### **6.1 Statutory Requirements**

With respect to operating rules for health information transactions in general, NCVHS was tasked in the Affordable Care Act (Sec. 1104. (g)(3)) to:

- (A) Advise the Secretary whether a nonprofit entity meets the requirements for operating rules development;
- (B) Review the operating rules developed and recommended by such nonprofit entity;
- (C) Determine whether such operating rules represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards;
- (D) Evaluate whether such operating rules are consistent with electronic standards adopted for health information technology; and
- (E) Submit to the Secretary a recommendation as to whether the Secretary should adopt such operating rules.

The purpose of adopting standards and associated operating rules was set forth in the Affordable Care Act, Sec. 1104 (b)(4)(A) as enabling determination of an individual’s eligibility and financial responsibility for services prior to or at the point of care, be comprehensive and requiring minimal augmentation by paper or other communications, support a transparent claims and denial management process, and describe all required data in unambiguous terms. The number and complexity of (paper and electronic) forms and data entry required by patients and providers should be reduced.

#### **6.2 Availability of Operating Rules for the ERA Transaction**

The **Committee on Affordable Quality Healthcare (CAQH)** created the **Committee on Operating Rules for Information Exchange (CORE)** as a nonprofit alliance of health plans and trade associations intended to support all payers.<sup>14</sup> CORE’s goal is to develop a set of voluntary business rules that build on

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<sup>11</sup> Ibid.

<sup>12</sup> Priscilla Holland, Senior Director, NACHA, private conversation with author, November 2, 2010

<sup>13</sup> WEDI, Successful Practices for Implementation and Use of the 835 Transaction White Paper, August 22, 2008, [www.wedi.org/snip](http://www.wedi.org/snip)

<sup>14</sup> CORE Facts: *Why can’t verifying patient eligibility and benefits and other administrative*

existing standards, such as HIPAA, to make electronic data transactions more predictable and consistent, regardless of the technology. CORE rules are modeled on business rules used daily in the banking sector for ATM transactions and airline industry for online reservations. CORE has stated that it is focused on creating operating rules and will not develop software solutions, a switch, a database or central repository of administrative information.

CAQH CORE has identified that operating rules for the ASC X12 835 Health Care Claim Payment/Advice are being written and reviewed as part of its Phase III set of operating rules. CORE's draft of the 835 operating rules indicates that the CORE infrastructure rules do not address the transaction data content needs of the industry, but rather establishes a "highway." It observes that the next phase of CORE rule-making will use the industry's experience and lessons learned from implementing the v5010 835 for developing such data content.

The draft of the operating rules applies to the v5010 of the ASC X12 835 standard. It requires that health plans:

- Make appropriate use of the ASC X12 standard acknowledgements (a transaction not currently required by HIPAA).
- Support two options for connectivity (SOAP v1.0 using the normative Web Services Definition Language [WSDL] Specification and MIME Multipart). (Health plans may also continue to provide connectivity through an already established means with a provider as a safe harbor.
- Use the CAQH/WEDI Best Practices Companion Guide template when publishing their 835 companion guides.
- Continue to provide dual delivery of their proprietary remittance advices along with the standard ERA for a period of time during which providers can ensure that their financial system can successfully use the standard ERA to post payments.

**ASC X12** is an ANSI-Accredited Standards Committee that develops electronic data interchange (EDI) standards for a number of industries, including the HIPAA financial and administrative transactions (see Environmental Scan of July 11, 2010 and Appendix A). It has requested to be officially named as an operating rule authoring entity for the ASC X12 Health Care Claim Payment/Advice standard transaction. It is currently in the process of updating instructional guidance in its TR3 (Technical Reports, also known as Implementation Guides [IGs]).

**National Council for Prescription Drug Programs (NCPDP)** is a not-for-profit ANSI-Accredited standards development organization representing virtually every sector of the pharmacy services industry. NCPDP creates and promotes standards for the transfer of data related to medications, supplies, and services. Its Telecommunications and Batch standards 5.1 and D.0 for claims, eligibility, and authorization and 3.0 for Medicaid pharmacy subrogation are HIPAA transaction standards for the retail pharmacy industry.

NCPDP utilizes the ASC X12 835 transaction for its remittance advices. It maintains an "835 Mapping Document" that provides guidance to bridge the gap between medical and retail pharmacy terminology.<sup>15</sup> It includes provision of claim adjustment reason codes (also called "reject codes") specific to the retail pharmacy industry and instructions for use of data fields as needed for retail pharmacy usage.<sup>16</sup>

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*data in provider offices be as easy as making an ATM withdrawal?* <http://www.caqh.org/pdf/COREfacts.pdf>

<sup>15</sup> Lynne Gilbertson, Vice President, Standards Development, NCPDP, Personal communication November 12, 2010

<sup>16</sup> Michele Davidson, Walgreens, Personal communication November 12, 2010



### 6.3 Benefits of Operating Rules for the ERA Transaction

The following benefits of operating rules for ERA have been summarized from CAQH CORE<sup>17</sup>:

- Reduce staff time spent on phone calls and websites to reconcile payments with remittance advices.
- Increase ability to conduct targeted follow-up on payments that do not match claims.
- More accurate and efficient claim payment processing – potentially including more accurate future claims when associated with both enhanced use of the eligibility transactions (ASC X12 270/271) and better understanding of reasons for claims adjustments from ASC X12 835 history.
- Facilitate the health care industry’s momentum to increase use of the HIPAA-adopted administrative transactions, especially where the operating rules infrastructure for other transactions can be leveraged.

## 7.0 STANDARDS AND OPERATING RULES FOR THE HIPAA ELECTRONIC FUNDS TRANSFER TRANSACTION

### 7.1 Statutory Requirements

Affordable Care Act calls for adoption of standards and operating rules for electronic funds transfer (EFT): Sec. 1104. Administrative Simplification, (2) *ELECTRONIC FUNDS TRANSFER*.—*The Secretary shall promulgate a final rule to establish a standard for electronic funds transfers (as described in section 1173(a)(2)(J) of the Social Security Act, as added by subsection (b)(2)(A))...*

In general terms, a technical standard is an established norm or requirement. It is usually a formal document that establishes uniform engineering or technical criteria, methods, processes, and practices. HIPAA’s Administrative Simplification regulation text provides specific definitions:

**Standard** has been defined within HIPAA (45 CFR §160.103) as “a rule, condition, or requirement:

- (1) Describing the following information products, systems, services or practices:
  - (i) Classification of components.
  - (ii) Specification of materials, performance, or operations; or
  - (iii) Delineation of procedures; or
- (2) With respect to the privacy of individually identifiable health information.”

**Standard transaction** (45 CFR §162.103) means a transaction that complies with an applicable standard adopted [under HIPAA].

**Implementation specification** (45 CFR §160.103) is defined as “specific requirements or instructions for implementing a standard.” As applicable to the standard transactions, the ASC X12 standards for electronic transactions are embodied within ASC X12 Implementation Guides (IGs). It is noted that data elements within the IGs have been described as “required,” “not used,” and “situational,” as defined below. The term “**conditional**” with respect to data elements is in ASC X12, but has not applied to HIPAA. However, the Affordable Care Act includes in Sec. 1104 (b) Operating Rules for Health Information Transactions (4)(A)(iv) the requirement that the Standards and Operating Rules (italics added for emphasis) “describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be *required or conditional* upon set values in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse).”

**Required** means the item must be used to be compliant with the IG.

**Not used** means the item should not be used when complying with the IG.

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<sup>17</sup> CORE, Phase III Core Claim Payment/Advice (835) Rule, Certification/Testing Subgroup Draft – 03-20-10

**Situational** means the item should be used whenever the situation defined in the note is true; otherwise, the item should not be used. The defining rule is generally documented in a syntax or usage note attached to the item. If no rule appears in the notes, the item should be sent if the data is available to the sender. Use of this item varies, depending on data content and business context.

Under the HIPAA Standards for Electronic Transactions Final Rule, published August 17, 2000, **Designated Standard Maintenance Organizations** (DSMOs) were described as a category of organization that the Secretary may designate to organizations that agree to maintain standards. These provisions also establish criteria for the processes to be used in such maintenance. Several Data Content Committees (DCCs) and Standard Setting Organizations (SSOs) have agreed to maintain those standards designated as national standards in the final rule "Standards for Electronic Transactions" according to the criteria established by the Secretary.

HIPAA also provides a process for adoption of new standards at 45 CFR §162.910(c):

(c) *Process for modification of existing standards and adoption of new standards.* The Secretary considers a recommendation for a proposed modification to an existing standard, or a proposed new standard, only if the recommendation is developed through a process that provides for the following:

- (1) Open public access.
- (2) Coordination with other DSMOs.
- (3) An appeals process for each of the following, if dissatisfied with the decision on the request:
  - (i) The requestor of the proposed modification.
  - (ii) A DSMO that participated in the review and analysis of the request for the proposed modification, or the proposed new standard.
- (4) Expedited process to address content needs identified within the industry, if appropriate.
- (5) Submission of the recommendation to the National Committee on Vital and Health Statistics (NCVHS).

In its September 30, 2010 letter of recommendations to the Secretary of HHS, NCVHS recommended that CAQH CORE, as the recommended authoring entity for the eligibility and claims status operating rules, be included in the DSMO Committee and that CMS be designated a non-voting participant in the DSMO Committee.

## 7.2 Availability of an EFT Standard for Transmitting Health Care Information

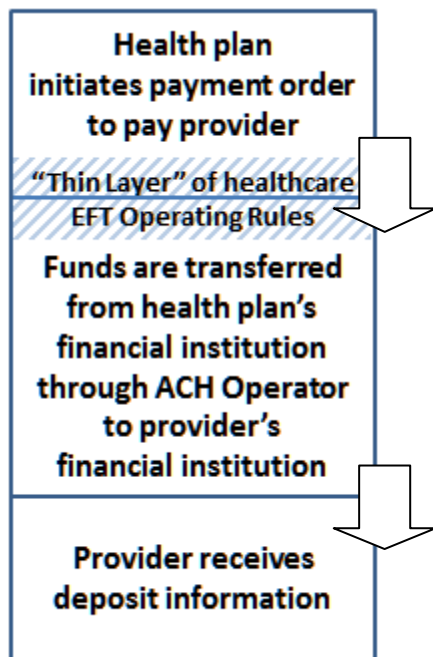
In Section 4.0 it was noted that understanding the difference between the generic definition of EFT and a standard for EFT to be adopted for health care is very important.

In health care, EFT is described as "*the mechanism that payers use to instruct one DFI [depository financial institution] to move money from one account to another account at the same or at another DFI.*"<sup>18</sup>

There is also a difference between the fact that an EFT transaction may carry only payment information and a trace number to associate the payment information with a remittance advice, or may carry both payment information and remittance advice information. This is illustrated below, where the shaded area has been described by NACHA as a "thin layer" of information that may be unique to a specific industry's needs. Although this "thin layer" is shown as information content supplied by the health plan as part of its construction of the EFT or sent to a bank or intermediary to create the ACH EFT, the information is used throughout the entire process of transferring funds and sending deposit information to the provider – and includes information that would associate the 835 with the payment.

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<sup>18</sup> ASC X12 v4010 835 Health Care Claim Payment/Advice Standard Implementation Guide, Washington Publishing Company, May 2000, page 15.



Today, many health plans create the ACH EFT transaction themselves to avoid bank fees for creating the transaction. Some small banks are unable to create the ACH EFT transaction and would require either the health plan or an intermediary to do so. There is no health care standard that specifies the content and format of the information necessary to accompany payment from a health plan to a provider. Currently, health plans may use a number of different formats with varied data content to provide this information, including two forms of the NACHA standard EFT formats.

### 7.3 EFT Formats

The three generic formats for providing information for an electronic transference of funds include:

- **Proprietary Format** – Health plans may provide payment information using a proprietary format agreed upon between the health plan and the health plan's bank. The data content requirements of this "input file," or EFT authorization, would be part of that agreement, and may not necessarily include a re-association trace number. A proprietary input file then is converted to a NACHA format for transference of funds.
- **ASC X12 835 or 820** - Table 1 of the X12 835 is an available means for a health plan to authorize its bank to send an electronic payment. Table 1 is not a required element of the standard. However, if the 835 is used to initiate an EFT, then the health plan must follow the standard's data content requirements, including the trace number segment in the addenda record that allows for re-association.
- **NACHA Formats (CCD+ or CTX)** - There are two NACHA formats (CCD+ and CTX – to be further illustrated and explained in 7.3.1 and 7.3.2) that can be used between a payer and the payer's bank (These formats are also used to transmit funds between financial institutions). These are not specific to health care payments by a health plan that is making payment against a claim filed by a provider. However, both formats are listed as optional methods of transmitting health care payment and remittance advice in the current implementation guide for ASC X12 835 Health Care Claim Payment/Advice versions 4010 and 5010.<sup>19</sup>

<sup>19</sup> Op Cit. Healthcare Reform: Administrative Simplification and Healthcare Payments

The primary difference between the two formats is that in the CCD+, the remittance advice is separate from the payment; while in the CTX format, the remittance advice is combined with the payment in a single transaction. In both transactions, however, payment can be made for multiple invoices/claims.

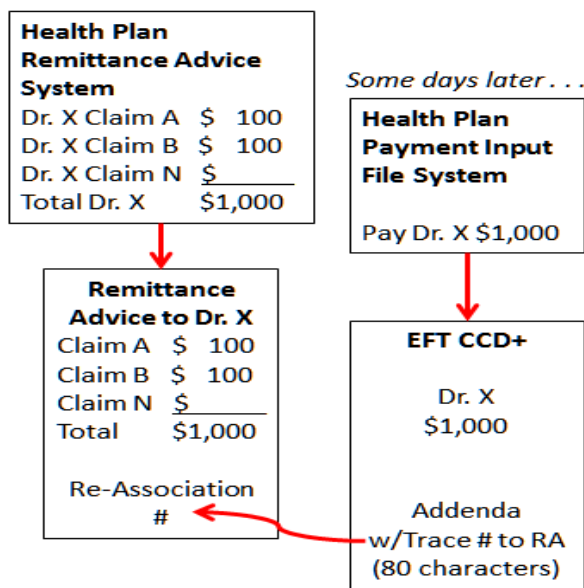
According to the current, generic NACHA operating rules, a payment issuer (e.g., health plan) may include addenda records containing trace number segments for re-association in these formats, but the payment issuer is not required to do so. Medicare currently requires that the standard ACH format CCD+ be used by its contractors when authorizing their banks to pay providers through EFT. Medicare requires the trace number segment be included the addenda record to allow for re-association.<sup>20</sup>

### 7.3.1 EFT CCD+ Format

**Cash Concentration or Disbursement (a.k.a. Corporate Credit or Debit)<sup>21</sup> (CCD)** is the ACH Network SEC Code for a credit or debit entry (payment) transaction initiated by an organization to consolidate funds of that organization or to fund outlying accounts.

The **CCD+** format is applicable to EFT for health care electronic remittance advice (as illustrated on the left below) because its addenda record may supply a “re-association key” to link to the remittance advice sent to providers in the existing manner. (This addenda record is limited to 80 characters of information.)

One issue associated with the CCD+ is that health plans often adjudicate claims in one system (creating the remittance advice) and then use a different system to direct disbursement of funds (creating the EFT). This may result in remittance advice and EFT being delivered a day or more apart from one another. As a result, the “re-association keys” may not always synchronize. Other issues include that there is no obligation to include a re-association trace number in the standard. In addition, a financial institution may move or drop the trace number en route.

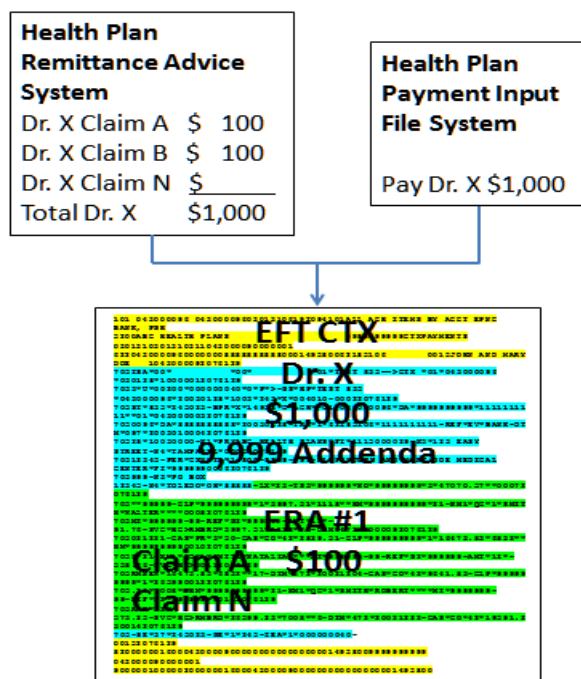


<sup>20</sup> Medicare requires the CCD+ format when the EFT travels separately from the remittance advice. Medicare allows the CTX format, but it is rarely, if ever, used. “Chapter 24 Update and EFT Format Standardization,” CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 1284, Date July 9, 2007.

<sup>21</sup> NACHA Healthcare Glossary, Version 1, April 7, 2010

### 7.3.2 EFT CTX Format

**Corporate Trade Exchange (CTX)** is the ACH Network SEC Code for the transaction that supports the transfer of funds (debit or credit) within a trading partner relationship in which a full ASC X12 message or payment-related UN/EDIFACT information is sent with the fund transfer. It enables there to be up to 9,999 addenda records of 80 characters each associated with a single EFT CTX transaction. The EFT in the CTX format may be considered an envelope (with formatting for the NACHA represented in the illustration in yellow) which contains a message – in other words, the funds (represented in the illustration in aqua) and the remittance advice (represented in the illustration in green) move together.<sup>22</sup>



The CTX is not as widely used today as the CCD+. One issue associated with its use is that technical changes to information systems generating the information for the CTX need to be made so that two separate systems generating remittance advice and payment information are more tightly integrated, or a single system used. Technical changes are also required in information systems that will receive the information – to decode the transactions carried by the CTX, which are typically in Web page or comma-delimited (CSV) format.<sup>23</sup> Although it is feasible for the CTX to carry 9,999 addenda records (with 800,000 characters), this has been described by some as insufficient. On the other hand, the size of the CTX has also been described as a processing limitation factor for some software applications, when large numbers of EFTs are submitted in a single batch. Another reason for the low use of CTX is the privacy implications of submitting protected health information embedded in a banking transaction (see Section 7.5 below). A non-technical issue is associated with time frame differences when a dispute concerning a transaction can result in loss to the financial institution if the return expires before the consumer's 60-day protection window under Regulation E. Finally, as with the CCD+, the CTX is not specific to health care.

### 7.4 Operating Rules for EFT

Just as there is no health care standard for EFT, there are no health care operating rules for EFT. The need for and nature of the operating rules needed for a health care standard EFT probably need to be determined after the standard is selected.

<sup>22</sup> NACHA and the ACH Network, PowerPoint slides supplied to CMS, October 21, 2010

<sup>23</sup> National Association of Insurance Commissioners, EFT Implementation Guide, September 13, 2010.

## 7.5 EFT Privacy and Security

In addition to the format and content for a health care EFT standard, operating rules also need to address privacy and security – for both protected health information (PHI), especially with respect to the CTX format of EFT, and provider financial information. It is clear from HIPAA that electronic remittance advice contains protected health information and must be rendered secure for it to be transmitted in a manner that would consider the transmission process to be a courier. There are also specific provider concerns relating to health plan access to providers' financial information:

### 7.5.1 HIPAA Administrative Simplification (P.L. 104-191) Sec. 1179

The Sec. 1179 provision within HIPAA relates to processing payment transactions by financial institutions. Specifically, Sec. 1179 states “To the extent that an entity is engaged in activities of a financial institution ..., or is engaged in authorizing, processing, clearing, settling, billing, transferring, reconciling, or collecting payments, for a financial institution, this part, and any standard adopted under this part, shall not apply to the entity with respect to such activities...” This initially suggested that an EFT standard for health care could not be adopted, or that financial institutions/the ACH Network – by processing ERAs – would be considered business associates.

However, the following information from the Preamble to the HIPAA Privacy Rule appears to preclude these concerns:

“We note that a covered entity may conduct the electronic funds transfer portion of the two payment standard transactions with a financial institution without restriction, because it contains no protected health information. The protected health information contained in the electronic remittance advice or the premium payment enrollee data parts of the transactions is not necessary either to conduct the funds transfer or to forward the transactions. Therefore, a covered entity may not disclose the protected health information to a financial institution for these purposes. A covered entity may transmit the portions of the transactions containing protected health information through a financial institution if the protected health information is encrypted so it can be read only by the intended recipient. In such cases no protected health information is disclosed and the financial institution is acting solely as a conduit for the individually identifiable data.”<sup>24</sup>

This information in the Preamble to the original HIPAA Privacy Rule also appears to be consistent with the more recently issued guidance on unsecured PHI that would render PHI unusable, unreadable, or indecipherable to unauthorized individuals for purposes of the breach notification requirements under Section 13402 of Title XIII (HITECH).<sup>25</sup> This guidance indicates that electronic PHI that has been encrypted by “the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key” and “such process or key has not been breached” is therefore not “unsecured” PHI. Valid encryption processes for data at rest are those consistent with NIST SP800-111. Valid encryption process for data in motion are those that comply with FIPS 140-2 (including NIST SP800-52, SP800-77, or SP800-113).<sup>26</sup>

In addition to the encryption process, NACHA operating rules require that financial institutions using the ACH Network adhere to the security requirements of the Gramm-Leach-Bliley Act. Because security encompasses confidentiality, data integrity, and data availability, it is also important to note that the ACH Network is

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<sup>24</sup> *Standards for Privacy of Individually Identifiable Health Information, Final Rule, Federal Register*, Vol. 65, No. 250, Thursday, December 28, 2000, page 82496

<sup>25</sup> 45 CFR Parts 160 and 164, Notification in the Case of Breach of Unsecure Protected Health Information, Interim Final Rule, August 24, 2009, effective September 23, 2009.

<sup>26</sup> 45 CFR Parts 160 and 164. Guidance Specifying the Technologies and Methodologies That Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements Under Section 13402 of Title XIII (HITECH) of ARRA 2009; Request for Information, applicable upon issuance (April 17, 2009)

ubiquitous, providing availability to virtually every FDIC-insured depository financial institution (8,246) and credit union (7,905) in the country. Nearly all financial institutions process inbound ACH credits, with a few currently receiving only government payments.<sup>27</sup>

Information is needed to determine whether the content of the EFT message (i.e., the protected health information) should be encrypted (and if so, is encrypted). As an analogy, it is observed that the network that facilitates the exchange of electronic prescriptions, which is considered a business associate under HIPAA per Section 13408 of the HITECH Act, utilizes Secure Sockets Layer (SSL) to encrypt the virtual private network (VPN) through which prescriptions are routed. However, in testimony before the NCVHS on December 8, 2004 concerning e-prescribing,<sup>28</sup> it was noted that encrypting the prescription itself would not be useful, as the network service often is required to reconcile differences in versions of the prescription standard between providers and retail pharmacies.

Similar decisions concerning encryption need to be considered for the remittance advice portion of the EFT. By way of background, prior to 2003, most EFT transactions were exchanged over value-added networks (VANs). In September 2002, Wal-Mart spearheaded the use of the Applicability Statement 2 (AS2) that supported encryption for the network through which the EFT is transmitted. The AS2 is a specification standard of the Internet Engineering Task Force (IETF RFC 4130) that allows applications to communicate EFT data in real-time over the Internet using the Multipurpose Internet Mail Extensions (MIME) and HyperText Transport Protocol (HTTP). The AS2 standard provides security by using HTTP encryption mechanisms (HTTPS or SSL), authentication, synchronous and asynchronous receipt, and repudiation of message origin and receiving. Products may be certified as conforming to the AS2 by an industry-neutral software testing program under joint partnership of the Uniform Code Council, Inc. (UCC) and Drummond Group Inc. (DGI) (which is also an ONC-ATCB for certifying electronic health record technology). Information is needed to determine how widely the AS2 is used and whether that would suffice for encryption of the ERA.

### **7.5.2 Provider Confidentiality**

There is also the concern of providers in supplying health plans with banking information that enables payment by EFT credits. Providers do not want to provide health plans with information that may enable debits as well – for example, to debit the provider's account if there has been an overpayment. This could be addressed by mandating that EFT only applies to credit transactions only. Alternatively, there could be a mandate that any debit must be preceded with a specified period of notification to the provider, with information on how to inquire about, delay, or prevent the debit, pending resolution.<sup>29</sup>

### **7.6 Benefits of an EFT Standard and Operating Rules for Health Care**

While it may seem feasible to simply adopt the generic standard and operating rules for EFTs for health care – after all, EFT is being used today in health care; there are very specific issues that must be addressed to achieve the full benefits of EFT as outlined in Section 5.3. In addition to these generic benefits, improvements for health care would support enhanced use of the ERA and EFT, would relieve financial institutions from the potentiality of being considered HIPAA business associates, and would provide assurances to providers that their financial information would be used only for express purposes of claims remittance and no other purposes without notification.

## **8.0 OTHER ACTIVITIES ASSOCIATED WITH ERA AND EFT**

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<sup>27</sup> Healthcare Reform: Administrative Simplification and Healthcare Payments, NACHA, August 19, 2009 (<https://admin.nacha.org/userfiles/File/Healthcare%20Resource/Healthcare%20Payments%20--%20August%2019%202009%20final.pdf>)

<sup>28</sup> NCVHS Letter to Secretary Leavitt on Electronic Signatures in E-Prescribing, March 4, 2005.

<sup>29</sup> Healthcare Reform: Administrative Simplification and Healthcare Payments, NACHA, August 19, 2009 (<https://admin.nacha.org/userfiles/File/Healthcare%20Resource/Healthcare%20Payments%20--%20August%2019%202009%20final.pdf>)

## **8.1 Medical Banking Project**

“Medical banking” is a term that was coined in 1996. It conveys a vision for a new “bank intermediary” that would “integrate high value tools that reduce costs, optimize the reach of care services, and engender more investment and focus on transparency and quality in healthcare.” The Medical Banking Project, now a component of the Healthcare Information Management and Systems Society (HIMSS), was established to research, document, and facilitate medical banking convergence. A major focus is to assist banks develop “medical banking inter-organizational systems” (MBIOS) that link healthcare and banking information technology. Through the creation of Focus Groups and Institutes, interested parties address industry challenges. The result has been adoption, in 2008, of a “Common Standards Guide.” This Guide offers best thinking on standards and best practices in medical banking. One of its deliverables is a Gold Seal Standard recognition program for customers that recognize use of appropriate controls for confidentiality, privacy, and security, including compliance with HIPAA. Another is a “Deductible Engine” program that advances the idea of real time adjudication in the marketplace.<sup>30</sup>

## **8.2 Minnesota Uniform Companion Guide for the 835 Health Care Claim Payment/Advice**

The Minnesota Administrative Uniformity Committee (AUC) has worked for over 15 years to streamline billing activities across Minnesota. In 2007, Minnesota state law (“Minnesota E3 Initiative”) called for standardized, electronic health care billing transactions and identified the AUC to work with the Minnesota Department of Health to streamline three major components of the billing process: eligibility, claims, and payment and remittance advice. – all of which have been implemented in 2009.

Minnesota’s Uniform Companion Guide for the 835 Health Care Claim Payment and Remittance Advice Transaction addresses code set issues, bringing group purchasers and providers to agree on consistent usage for Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC). The Companion Guide also correlates the provider information on the 835 to the 837 Claim.<sup>31</sup>

## **8.3 Linxus Version 1.0 HIPAA Transactions and Code Sets Standard Implementation**

Linxus is a group of health plans and providers in the New York metropolitan area that came together in 2004 to explore the possibilities of utilizing information technology to alleviate the high costs of health care administration. It created what it terms “single implementation specifications of HIPAA transactions” for health care eligibility benefit inquiry and response (270/271), claim status request and response (276/277), and claim payment/advice (835). Similar to Minnesota’s Companion Guide, Linxus’ Implementation Guide has a single specification that adopts consistent use of CARC and RARC to provide comprehensive explanations of the most frequent payment scenarios. The Linxus Implementation Guide also includes connectivity requirements for the 835.<sup>32</sup>

## **9.0 SUMMARY**

The Affordable Care Act calls for NCVHS to recommend operating rules and operating rules authoring entities as well as standards and associated operating rules to improve utilization of the HIPAA transactions and code sets. It is clear that work on improving utilization of the ERA and adopting EFT is occurring already – but the industry has important key steps to take to fully adopt these operating rules and standards in a consistent manner.

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<sup>30</sup> Facilitating the Medical Banking Industry, HIMSS MB Project, [www.mbproject.org/aboutus-emerging.php](http://www.mbproject.org/aboutus-emerging.php)

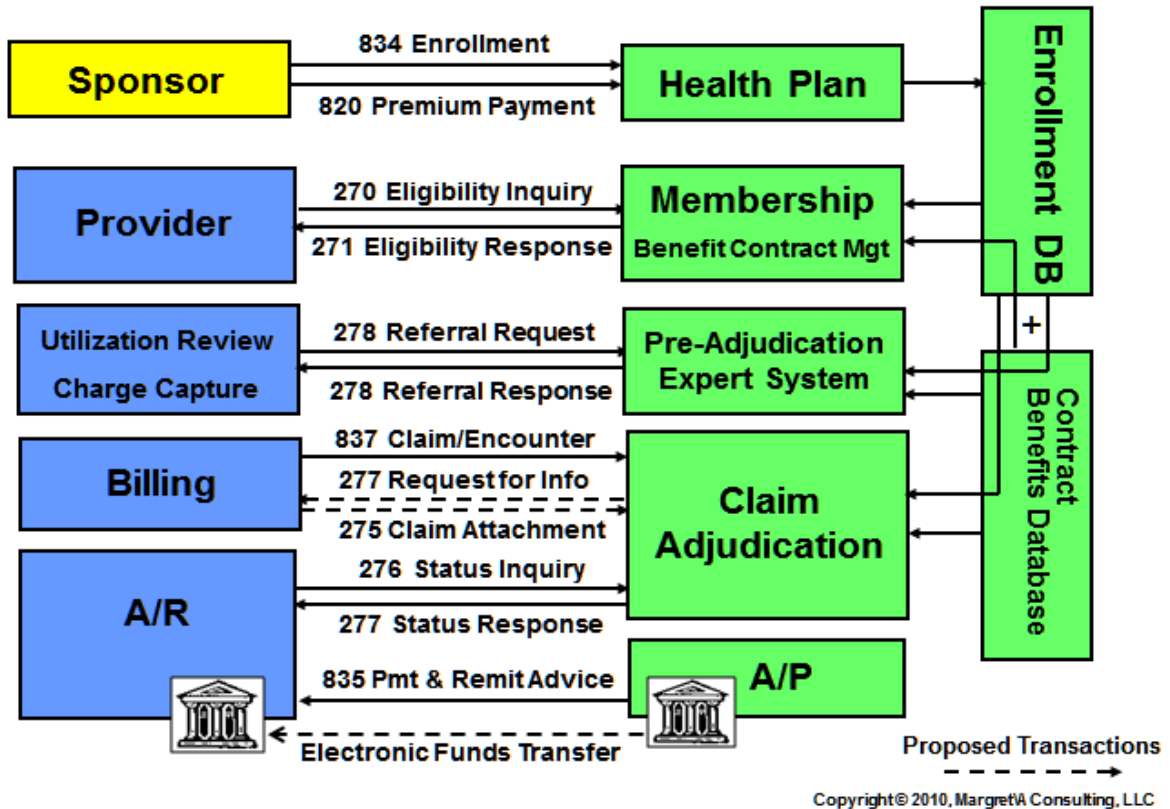
<sup>31</sup> About the AUC at <http://www.health.state.mn.us/auc/about.htm>

<sup>32</sup> Linxus HIPAA Transactions and Code Sets Standard Implementation Specification, Version 1.0, Approved as of 3/28/08.



**Appendix A HIPAA Transactions and Code Sets**

**HIPAA Administrative Simplification (P.L. 104-191) Sec. 1173** included requirements for the adoption of standard transactions and code sets to enable health information to be exchanged electronically for specific financial and administrative information. A final rule adopting standards for seven ASC X12 standard transactions and code sets, as illustrated below, was issued on August 17, 2000, with a final compliance date of October 2003. (In addition telecommunication and batch standards for retail pharmacy claims, eligibility, and authorizations from NCPDP were also adopted.) Affordable Care Act is now requiring adoption of associated operating rules for the standard transactions and the adoption of the health claims attachments standards. (It is noted that one other transactions was called for under HIPAA, first report of injury, which has yet to be adopted.)



National Committee on Vital and Health Statistics (NCVHS)  
Subcommittee on Standards

Administrative Simplification under the  
Patient Protection and Affordable Care Act  
Standards and Operating Rules for Electronic Funds Transfer (EFT) and Remittance Advice (RA)

Marriott Washington Hotel, 1221 22<sup>nd</sup> Street, NW, Washington, DC  
(Between M and N Streets)  
December 3, 2010

AGENDA

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|--------------------|--|--|
| 8:30-8:45 a.m.     | <b>Call to order and Welcome/Introductions</b>                                     | Judith Warren, Co-Chair<br>Walter Suarez, Co-Chair<br>Karen Trudel, <i>CMS</i>   |
| 8:45 – 10:15 a.m.  | <b>Update on enhancements to Operating Rules for Eligibility and Claims Status</b> |  |
|                    | Update from CAQH<br>Update from NCPDP<br>Questions from committee                  | Gwen Lohse, <i>CAQH CORE</i><br>Lynne Gilbertson, <i>NCPDP</i><br>Committee members  |
| 10:20 – 10:30 a.m. | <b>Break</b>   |  |
| 10:30 – 11:30 a.m. | <b>OVERVIEW OF THE PAYMENT PROCESS (BIG PICTURE)</b>                               |  |
|                    |  | Jan Estep, <i>NACHA</i><br>Russ Waterhouse, <i>The Clearinghouse</i><br>Jim Ribelin, <i>HERAE</i>                            |
| 11:30 – 12:15 p.m. | <b>HOW THE PAYMENT AND REMITTANCE ADVICE PROCESS WORKS IN HEALTH CARE</b>          |  |
|                    | <b>Banks</b>   | Stuart Hanson, <i>FifthThird Bank</i><br>Steve Stone, <i>PNC Bank</i><br>John Casillas, <i>HIMSS Medical Banking Project</i> |
| 12:30 – 1:20 p.m.  | <b>BREAK for LUNCH</b>   |  |

National Committee on Vital and Health Statistics (NCVHS)  
 Subcommittee on Standards

1:20 – 5:00 p.m.	<b>STANDARDS AND OPERATING RULES FOR ELECTRONIC FUNDS TRANSFER AND CLAIMS PAYMENT/REMITTANCE ADVICE</b>	
1:20 – 2:45 p.m.	<b>Standards and Operating Rule Authors</b>	Margaret Weiker and Deb Strickland, <i>X12</i> Gwen Lohse, <i>CAQH CORE</i> Jan Estep, <i>NACHA</i>
2:45 – 3:30 p.m.	<b>Health Plans</b>	Jay Eisenstock, <i>Aetna</i> Bob Schleichert, <i>AultCare</i> Angie Casey, <i>HP</i> Annette Gabel, <i>Medco</i>
3:30 – 3:45 p.m.	<b>BREAK</b>	
3:45 – 4:25 p.m.	<b>Health Care Providers</b>	Barbara Mayerick, <i>VA</i> Laurie Darst, <i>Mayo</i> Jim Whicker, <i>Kaiser</i> Larrie Dawkins, <i>MGMA, provider group</i>
4:25 – 5:00 p.m.	<b>Health Care Clearinghouses/Vendors</b>	Sean Kilpatrick and Russ Anderson, <i>Availity/RealMed</i> Susanne Powell, <i>Emdeon</i>
5:00 – 5:15 p.m.	<b>Closing Remarks</b>	Judith Warren, Co-Chair Walter Suarez, Co-Chair
5:15 p.m.	<b>Adjourn</b>	

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This meeting will be broadcast live on the Internet, with the help of the Department of Veterans Affairs. To listen to an audio broadcast, you need RealAudio Player software, which is available free from the Department of Veterans Affairs website at <http://www.va.gov/virtconf.htm>. The link to the live broadcast will be available from the NCVHS home page on the meeting date. Recordings of broadcasts from the past six months are available from the VA Virtual Conference Archive at <http://www.va.gov/virtconf.htm>

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**National Committee on Vital and Health Statistics (NCVHS)  
Subcommittee on Standards**

*Times, topics, and speakers are subject to change. For final agenda, please call 301-458-4200 at NCHS or visit the NCVHS Home Page at <http://www.ncvhs.hhs.gov/>*