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.
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.
**STAGE 1**

**PAYMENT INITIATION**

Health plan authorizes its financial institution (sometimes through business associate) to send EFT payment through the ACH Network.

**HIPAA Standard:** NACHA CCD+ Addenda and for the addenda record the X12 835 TR5:TRN Segment Implementation Specification

**STAGE 2**

**TRANSFER OF FUNDS**

Health Plan’s Financial Institution sends payment, information about funds, and payment processing information to provider’s financial institution through the ACH Network.

Information includes TRN segment that matches the affiliated TRN segment used in the NACHA CCD+Addenda for Stage 1.

**Standard Required by NACHA**

**STAGE 3**

**DEPOSIT NOTIFICATION**

Provider’s Financial Institution sends notice to provider that funds have been deposited, along with information about transfer of funds and payment processing.

**No HIPAA/NACHA standard. Format to be agreed upon by the provider and its financial institution.**

Health plan sends explanation of benefits and/or remittance advice (sometimes through a business associate) to provider.

Information includes TRN segment that matches the affiliated TRN segment used in the NACHA CCD+Addenda for Stage 1.

**HIPAA Standard:** X12 835 TR3