



Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule  
version 3.0.0 June 2012

**CAQH Committee on Operating Rules for Information Exchange (CORE)  
Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule  
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## **1 Background Summary**

In Phase III, CORE built on the Phase I and Phase II foundation by adding a range of operating rule requirements for both the HIPAA-adopted ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Technical Report Type 3 Implementation Guide and associated errata (hereafter v5010 X12 835) transaction, also known as the Electronic Remittance Advice (ERA), and the Electronic Funds Transfer (EFT) by addressing operating rules related to the NACHA ACH CCD plus Addenda Record (hereafter CCD+) and the X12 835 TR3 TRN Segment (hereafter the CCD+ and X12 835 TR3 TRN Segment together are the Healthcare EFT Standards<sup>1</sup>).

The Phase III CORE 350 Health Care Claim Payment/Advice Infrastructure (835) Rule Version 3.0.0 focused on improving the conduct and exchange of electronic claim advice data as these transactions can have a direct impact on a provider's revenue cycle management process. The Phase III CORE 350 Health Care Claim Payment/Advice Infrastructure (835) Rule Version 3.0.0 requires that health plans make appropriate use of the standard acknowledgements, support the CORE "safe harbor" connectivity requirement, use the CORE v5010 Master Companion Guide template when publishing their v5010 X12 835 companion guide, and continue to provide dual delivery of their proprietary claim remittance advices along with the v5010 X12 835 transaction for a period of time during which providers can ensure that their financial system can successfully use it to post payments. Both the Phase III CORE 380 EFT Enrollment Data Rule Version 3.0.0 and the Phase III CORE 382 ERA Enrollment Data Rule Version 3.0.0 ensure that the necessary data for reassociation is collected for reassociation.

Requiring the delivery and use of the Phase III CORE 350 Infrastructure Rule for the v5010 X12 835 continues to facilitate the industry's momentum to increase access to the HIPAA-adopted administrative transactions, and will encourage entities to use the infrastructure they have for eligibility and claim status, and apply this infrastructure to the health care claim payment/advice.

Currently, there is confusion throughout the healthcare industry in effectively using electronic funds transfer (EFT) for claim payments with ERA for remittance advice due to challenges and issues encountered by the provider in matching the payment to the remittance advice detail so that subsequent posting to the patient account is correct.

Consistent and uniform rules enabling providers to match and process both the EFT payment and the v5010 X12 835 will help to mitigate:

- Unnecessary manual provider follow-up
- Faulty electronic secondary billing
- Inappropriate write-offs of billable charges
- Incorrect billing of patients for co-pays and deductibles
- Posting delays

And provide for:

- Less staff time spent on phone calls and websites
- Increased ability to conduct targeted follow-up with health plans and/or patients
- More accurate and efficient payment of claims

### **1.1 Affordable Care Act Mandates**

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<sup>1</sup> The CCD+ and X12 835 TR3 TRN Segment are adopted together as the Federal Healthcare EFT Standards in [CMS-0024-IFC](#): Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

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This rule is part of a set of rules that addresses a request from the National Committee on Vital and Health Statistics (NCVHS) for fully vetted CAQH CORE Operating Rules for the EFT and ERA transactions; the NCVHS request was made in response to NCVHS' role in Section 1104 of the Affordable Care Act (ACA).

Section 1104 of the ACA contains an industry mandate for the use of operating rules to support implementation of the HIPAA standards. Using successful, yet voluntary, national industry efforts as a guide, Section 1104 defines operating rules as a tool that will build upon existing healthcare transaction standards. The legislation outlines three sets of healthcare industry operating rules to be approved by the Department of Health and Human Services (HHS) and then implemented by the industry; the second set of which are those for EFT and ERA.<sup>2</sup> The ACA requires HHS to adopt a set of operating rules for both of these transactions by July 2012. In a letter dated 03/23/11,<sup>3</sup> NCVHS recommended that the Secretary "name CAQH CORE in collaboration with NACHA – The Electronic Payments Association as the candidate authoring entity for operating rules for all health care EFT and ERA transactions..."

Section 1104 of the ACA also adds the EFT transaction to the list of electronic health care transactions for which the HHS Secretary must adopt a standard under HIPAA. The section requires the EFT transaction standard be adopted by 01/01/12, in a manner ensuring that it is effective by 01/01/14. In January 2012, HHS issued an Interim Final Rule with Comment (IFC)<sup>4</sup> adopting the CCD+ and the X12 835 TR3 TRN Segment<sup>5</sup> as the Healthcare EFT Standards. These standards must be used for electronic claims payment initiation by all health plans that conduct healthcare EFT.

As described in the IFC, the healthcare payment flow through the ACH Network occurs in three chronological stages, each of which includes a separate electronic transmission of information:

- *Stage 1 Payment Initiation:* The health plan (i.e., Originator) authorizes its financial institution (i.e., Originating Depository Financial Institution or ODFI) to make an EFT healthcare claims payment through the ACH Network on its behalf. (The Healthcare EFT Standards adopted in the IFC address only this stage.)
- *Stage 2 Transfer of Funds:* Funds from the payer's account at the ODFI are moved, through a series of interactions, into the payee's (i.e., Receiver's) account at the payee's financial institution (i.e., Receiving Depository Financial Institution or RDFI).
- *Stage 3 Deposit Notification:* The RDFI transmits information to the Receiver indicating the payment has been deposited into the Receiver's account.

## **1.2 Existing Standards and Operating Rules**

### **1.2.1 ASC X12 v5010 X12 835 Health Care Claim Payment/Advice**

The ERA is an electronic version of a payment explanation (remittance advice) submitted by a health plan to a provider that explains the payment a provider receives for a service claim. If a claim is denied or the payment adjusted, the ERA would contain the required explanations. The v5010 X12 835 provides the standardized data

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<sup>2</sup> The first set of operating rules under ACA Section 1104 applies to eligibility and claim status transactions with an adoption date of 07/01/11 and effective date of 01/01/13; the third set of operating rules applies to healthcare claims or equivalent encounter information transactions, enrollment and disenrollment in a health plan, health plan premium payments and referral, certification and authorization with an adoption date of 07/01/14 and effective date of 01/01/16.

<sup>3</sup> NCVHS [Letter to the Secretary](#) - Affordable Care Act (ACA), Administrative Simplification: Recommendation for entity to submit proposed operating rules to support the Standards for Health Care Electronic Funds Transfers and Health Care Payment and Remittance Advice 03/23/11.

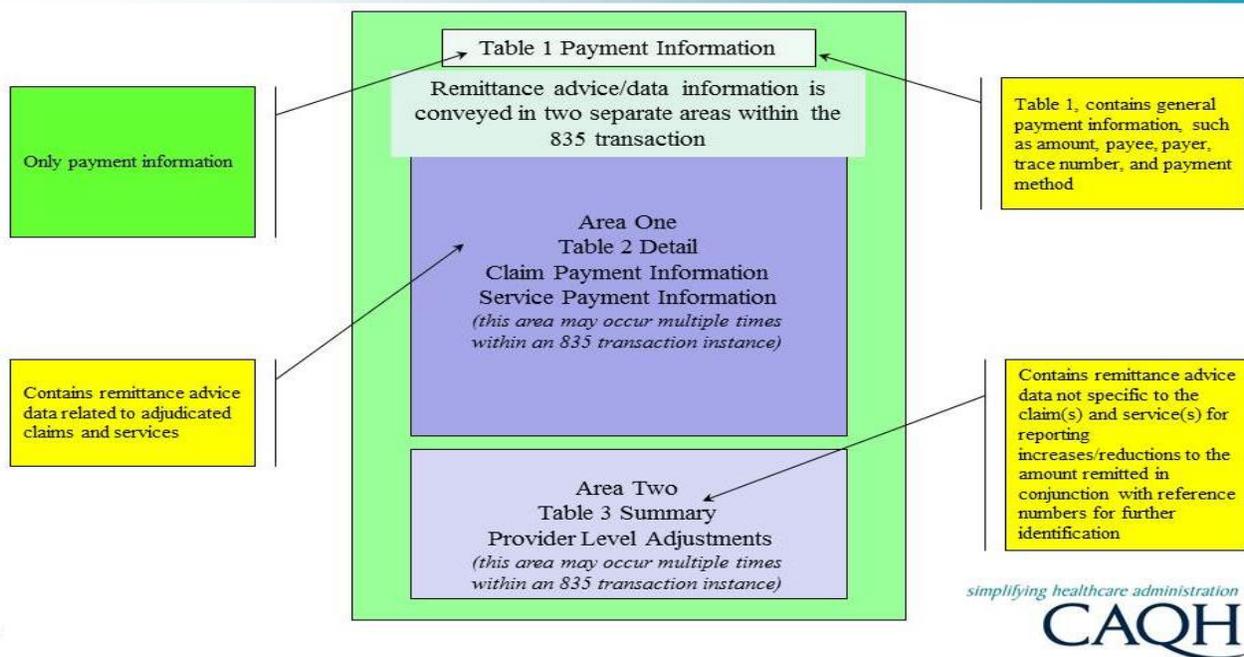
<sup>4</sup> [CMS-0024-IFC](#): Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

<sup>5</sup> The IFC requires health plans to input the X12 835 TR3 TRN Segment into the Addenda Record of the CCD+; specifically, the X12 835 TR3 TRN Segment must be placed in Field 3 of the Addenda Entry Record ("7 Record") of a CCD+.

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requirements to be implemented. The diagram below outlines the structure of the v5010 X12 835. Detailed information about the payment (the focus of this rule), is contained in Table 1 Payment Information.

## ASC X12 835 Health Care Claim Payment/Advice Transaction: Overall Structure



### 1.2.2 NACHA Operating Rules and the ACH EFT Standards

Today, many EFT payments throughout the United States are guided by the *NACHA Operating Rules*, which support the implementation of the existing ACH CCD+ and CTX EFT standards. These standards and their associated operating rules guide over 8 million EFTs each day, many of which are healthcare payments, via the ACH Network (a secure electronic network for the direct transfer of funds and data from one depository institution [e.g., bank] account to another). To date, healthcare-specific EFT operating rules for claim payments to providers have not been developed.

Within the financial industry, the data elements of the ACH CCD+ and CTX standards are fully described by the *NACHA Operating Rules*, which build upon the ACH standards. At a high level, the standards carry all necessary information for an EFT to be correctly processed, recorded, posted and identified by all parties to the EFT. The financial industry has made a focused effort to ensure data elements have clear, unambiguous terms that complement set values in other fields. NACHA continues to review these rules for updates and adjustments that speak to this goal. The current EFT standard, developed and maintained by NACHA, is being used successfully by some 14,000 banking institutions.

## 2 Issue to be Addressed and Business Requirement Justification

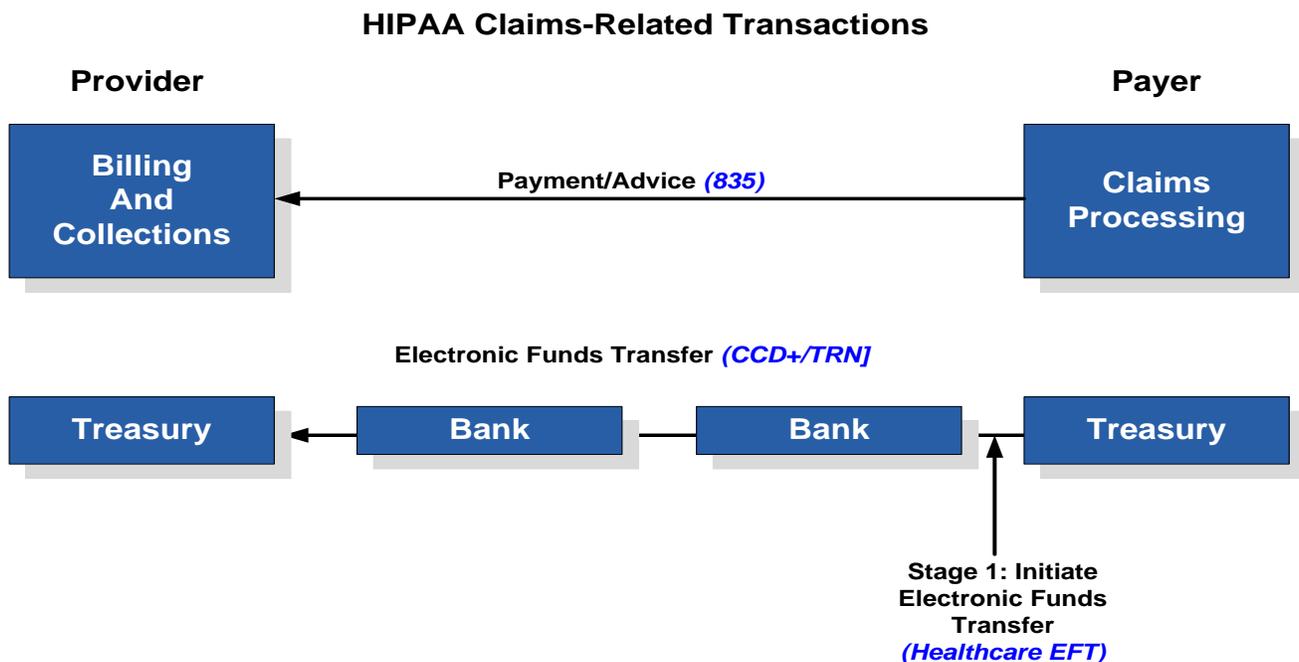
The v5010 X12 835 implementation guide provides a range of information to the provider regarding the details of the claim payment and whether the payment method is electronic using the Healthcare EFT Standards or paper check.

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**2.1 Problem Space**

NACHA and CAQH CORE research, as well as CORE EFT and ERA Subgroup surveys and discussion have identified that providers report reassociation of the remittance data to the payment data as a significant problem. This problem often occurs because the necessary data required by the provider are incorrect, missing, or not available, or have not been requested in a way that is meaningful to the provider’s financial institution. Providers are at a great disadvantage when attempting to reassociate their payment with the remittance advice as a result of the frequency of these types of errors and the confusion and misunderstanding of the existing standards and operating rules or lack of operating rules that govern them.

EFT and ERA operating rules represent the convergence of financial services and health care as outlined in the diagram below. With the HHS-adopted Healthcare EFT Standards the EFT and ERA travel separately to the provider. The v5010 X12 835 travels from the payer to the provider either directly or through a clearinghouse or other intermediary, whereas the CCD+ is initiated by the payer or a third party processor but then must travel through the ACH Network from the Originating Depository Financial Institution (the payer’s bank) to the Receiving Depository Financial Institution (the provider’s bank). The provider must then reassociate the EFT and ERA using a reassociation trace number.



When a provider receives payment via EFT and an ERA, payment and remittance advice processing are typically much faster than when a paper check and corresponding paper remittance advice are received. Providers save considerable time and expense from not sorting mail, opening envelopes, posting the checks, depositing the checks, and ultimately reconciling the paper remittance advice with the patient accounts. Currently, however, payers still reimburse providers via paper checks and explain the payment with an attached paper remittance advice. Statistically, it is difficult to determine how extensively EFTs and ERAs are used in the industry today. According to the US Healthcare Efficiency Index, currently only ten percent of all healthcare payments are made electronically.<sup>6</sup> Other industry research estimates this percentage at around thirty percent.<sup>7</sup> These low rates of

<sup>6</sup> Source: US Healthcare Efficiency Index, 2007: <http://ushealthcareindex.com>

<sup>7</sup> Source: Overhauling the US Healthcare Payment System, McKinsey Quarterly, June 2007

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adoption may be due to the many unique complexities related to ERA and EFT that serve as difficult barriers to broader adoption. These key business issues are outlined below.

**2.1.1 Matching Payment to Remittance Data**

When the correct ASC X12 835 EFT Reassociation Trace Number is sent in the CCD+, providers are able to “reassociate” funds that are sent separately from the ERA with the remittance advice information in the v5010 X12 835.<sup>8</sup> Currently, there are many problems in the industry that result in the lack of a correct ASC X12 EFT Reassociation Trace Number being included in the EFT payment. Frequently, health plans simply do not include the ASC X12 EFT Reassociation Trace Number from the v5010 X12 835 with the EFT payment. When the reassociation trace number is included, it may be incorrectly placed in the ACH Trace Number field and not in the CCD+ Addenda Record Payment Related Information field. (See §2.1.1.1 for a more detailed explanation of this issue.) If the reassociation trace number is placed in the ACH trace number field, it will be replaced by the Originating Depository Financial Institution (ODFI), which is the financial institution originating the EFT payment into the ACH Network – as required by the *NACHA Operating Rules*. The ODFI is responsible for populating the ACH Trace Number field. Even if the health plan or a third-party populates the field it will be replaced by the ODFI. It is also possible for the EFT data received by the provider to include a trace number that has been altered during the transaction process or an incorrect trace number that is different from the ASC X12 EFT Reassociation Trace Number the health plan placed in the ERA. Additionally, although the *NACHA Operating Rules* require the financial institution to deliver the reassociation trace number to the provider, the provider must first request such delivery. Most providers are unaware of this *NACHA Operating Rule* requirement.

**2.1.1.1 ASC X12 EFT Reassociation Trace Number and ACH Trace Number**

The table below describes the two trace numbers that often are confused with each other. Both trace numbers are required data in the Healthcare EFT Standards; however, each trace number is specific either to the CCD+ or the v5010 X12 835 transaction. The ASC X12 EFT Reassociation Trace Number is the only trace number that is used to match the EFT to the corresponding ERA.

	ACH Trace Number	ASC X12 EFT Reassociation Trace Number
<b>Creator</b>	<ul style="list-style-type: none"> <li>• ODFI</li> </ul>	<ul style="list-style-type: none"> <li>• Health Plan/Payer</li> </ul>
<b>Source</b>	<ul style="list-style-type: none"> <li>• NACHA CCD+ Field 11 of Entry Detail Record</li> <li>• The ACH Trace number is assigned by the ODFI as specified in the <i>NACHA Operating Rules</i></li> </ul>	<ul style="list-style-type: none"> <li>• HIPAA-adopted ASC X12N 005010X221A1 835, Table 1 TRN Reassociation Trace Number Segment (<i>see Note 1 below</i>) TRN02-127 Trace Number</li> <li>• ASC X12 EFT Trace number is placed in the Payment Related Information field of the CCD+ Addenda Record as part of the entire TRN Reassociation Trace Number Segment (<i>this number is assigned by the payer</i>)</li> </ul>
<b>Primary Function</b>	<ul style="list-style-type: none"> <li>• Uniquely identifies each Entry within a batch in an ACH input File</li> </ul>	<ul style="list-style-type: none"> <li>• Uniquely identifies the transaction set and aids in reassociating payments and remittance advices that have been separated</li> <li>• Source: HIPAA-adopted ASC X12N 005010X221A1 835</li> </ul>
<b>Delivery to Provider</b>	<ul style="list-style-type: none"> <li>• Flows unchanged from the ODFI to the RDFI through the ACH Network</li> </ul>	<ul style="list-style-type: none"> <li>• ASC X12 EFT Trace Number as part of the entire TRN Reassociation Trace Number Segment is placed in the CCD+ Addenda Record Payment Related Information field and flows through the ACH Network unchanged</li> <li>• Flows unchanged from the payer to the ODFI and then through ACH Network to the RDFI and then to the provider</li> </ul>

<sup>8</sup> In addition to trace number confusion, sometimes the ‘Company Name’ field in the CCD+ is often used incorrectly to identify the third party sender or intermediary rather than the health plan making the payment. The *NACHA Operating Rules* require the ‘Company Name’ field to identify the ‘originator’ (i.e., health plan) of the CCD+ to identify itself in the EFT by the name that it is known and recognized by the ‘Receiver’ (i.e., provider).

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	ACH Trace Number	ASC X12 EFT Reassociation Trace Number
<b>Issues</b>	<ul style="list-style-type: none"> <li>The ACH Trace Number is not used to reassociate the EFT and ERA; it is used primarily for customer service and transaction research, and to aid in identifying returned transactions</li> <li>If a health plan creates an ACH Trace Number it will be modified or overwritten by the ODFI to conform with NACHA rule requirements and the ODFI's numbering system</li> </ul>	<ul style="list-style-type: none"> <li>When CCD does not include the Addenda Record containing the Payment Related Information field the CCD cannot carry the ASC X12 EFT Trace Number</li> <li><i>NACHA Operating Rules</i> require the RDFI to provide the ASC X12 EFT Trace Number as part of the entire TRN Reassociation Trace Number Segment in the CCD+ Payment Related Information field to the Provider by opening of business on the 2<sup>nd</sup> banking day – <b><u>if it has been requested by the Provider</u></b></li> <li>The <i>NACHA Operating Rules</i> are silent on how this information is provided - providers should contact their banks to arrange for the method and timing of delivery.</li> <li>Matching the ASC X12 EFT Trace Number as part of the entire TRN Reassociation Trace Number Segment from the CCD+ Addenda Record with the TRN02-127 EFT Trace Number in the v5010 835</li> </ul>
<b>SDO</b>	NACHA	ASC X12
<i>Explanatory Note 1</i>		TRN Reassociation Trace Number <i>Segment (composed of 4 data elements)</i> is sometimes referred to as: <ul style="list-style-type: none"> <li>TRN 02 Reference ID Segment</li> <li>X12 TRN Segment</li> <li>Reassociation segment</li> <li>ERA TRN Trace Segment</li> <li>TRN segment</li> </ul>
<i>Explanatory Note 2</i>		The trace number in the TRN Reassociation Trace Number <i>Segment described in Note 1 (TRN02-127 Trace Number)</i> is sometimes referred to as: <ul style="list-style-type: none"> <li>EFT Reference number</li> <li>The Trace Number</li> </ul>
<i>Explanatory Note 3</i>	<b><u>The ACH Trace Number and the X12 EFT Trace Number are NOT the same number.</u></b>	

**2.1.2 Timely Receipt of Correct Matching Data**

Providers frequently report a lengthy duration of time between the receipt of the ERA and the availability of funds for use in their bank accounts via EFT. This delay does not occur in the paper world if the check and paper remittance advice arrive together in the same envelope. Some health plans indicated that contractual requirements are the cause of the EFT payment delay. Some providers perceive that the banks are holding onto their EFT deposits, but the date on which funds are made available by the financial institution to the provider is controlled by the ACH Originator (the payer). The delay in receipt between the ERA and the EFT by more than two or three days presents providers with significant reassociation and reconciliation management issues. When an EFT is received more than two or three days after an ERA, the provider is forced to take one of two possible actions: post the payment information from the ERA and conduct follow-up revenue cycle activity (e.g., billing secondary insurance, billing patients, and issuing refunds to patients) without knowing that the ERA will be correctly reconciled to the EFT, or hold the ERA and not post the payments until the EFT arrives. The first option can cause significant rework and compromise the integrity of the provider's financial statements. Alternatively, holding the ERA until the EFT arrives results in increased accounts receivable outstanding and perhaps providing incorrect information to patients about the amount that they owe or that their insurance has paid.

To address these problems CORE Participants developed this rule by achieving substantial consensus that a CAQH CORE rule should address reassociation by establishing the minimum data needs of a provider to reassociate the EFT with the ERA and defining the maximum elapsed time between the receipt of the v5010 X12 835 and the corresponding Healthcare EFT Standards.

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**3 Scope**

**3.1 What the Rule Applies To**

This CORE rule conforms with and builds upon the:

- HIPAA-adopted ASC X12 005010X221A1 Health Care Claim Payment/Advice (835) Technical Report Type 3 implementation guide

And

- NACHA 2011 ACH File Specifications for the CCD+

**3.2 Applicable Data Elements**

This rule addresses the following specified records and fields in the CCD+(Table 3.2-1a) and loops, segments and data elements in the v5010 X12 835 (Table 3.2-1b):

<b>Table 3.2-1a</b>		
<b>CCD+ Data Elements</b>		
<b>CCD+ Record #</b>	<b>Field #</b>	<b>Field Name</b> <small>(See §6 Glossary for Definition of these Terms)</small>
<b>5</b>	9	Effective Entry Date <sup>9</sup>
<b>6</b>	6	Amount
<b>7</b>	3	Payment Related Information

<b>Table 3.2-1b</b>
<b>v5010 X12 835 Data Elements</b>
<b>Data Element Segment Position, Number &amp; Name</b>
BPR Financial Information
BPR16-373 EFT Effective Date
TRN Reassociation Trace Number Segment
TRN02-127 Reference Identification (EFT Trace Number)
TRN03-509 Originating Company Identifier (Payer Identifier)

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<sup>9</sup> The date the payer intends to provide good funds to the payee via EFT as specified in the Healthcare EFT Standards in Field #9 of the Company Batch Header Record 5.

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**3.3 CORE-required Minimum CCD+ Data Elements for Successful Reassociation**

This rule addresses two standards: the CCD+ and the v5010 X12 835. The data elements identified in the column titled “Focus of this Rule” in Table 3.3-1 below are the CORE-required Minimum Data Elements from the CCD+ necessary for successful reassociation of the EFT payment with the corresponding v5010 X12 835.

Table 3.3-1			
Focus of this Rule			Informational Only
CORE-required Minimum CCD+ Reassociation Data Elements <sup>10</sup>			Corresponding v5010 X12 835 Data Elements
CCD+ Record #	Field #	Field Name <small>(See §6 Glossary for Definition of these Terms)</small>	Data Element Segment Position, Number & Name
5	9	Effective Entry Date	BPR16-373 Date ( <i>EFT Effective Date</i> )
6	6	Amount	BPR02-782 Monetary Amount ( <i>Total Actual Provider Payment Amount</i> )
7	3	Payment Related Information	TRN Reassociation Trace Number Segment, specifically data elements: <ul style="list-style-type: none"> <li>• TRN01-481 Trace Type Code                      Required</li> <li>• TRN02-127 Reference Identification <i>(EFT Trace Number)</i>                      Required</li> <li>• TRN03-509 Originating Company Identifier <i>(Payer Identifier)</i>                      Required</li> <li>• TRN04-127 Reference Identification <i>(Originating Company Supplemental Code)</i>                      Situational</li> </ul>

**3.4 When the Rule Applies**

This rule applies when an entity uses, conducts, or processes the v5010 X12 835 and the Healthcare EFT Standards.

**3.5 What the Rule Does Not Require**

This rule does not require any entity to conduct either the v5010 X12 835 or the Healthcare EFT Standards.

**3.6 Outside the Scope of This Rule**

This rule does not address any business relationship between a health plan and a healthcare provider or their respective financial institutions.

**3.7 How the Rule Relates to Phase I and II CORE**

As with other Phase I and Phase II CORE Rules, general CORE policies also apply to Phase III CORE Rules and will be outlined in the Phase III CORE Rule Set.

This rule supports the CORE Guiding Principles that CORE rules will not be based on the least common denominator but rather will encourage feasible progress, and that CORE rules are a floor and not a ceiling, e.g., entities can go beyond the Phase III CORE Rules.

<sup>10</sup> NOTE: The [01/10/12 HHS IFC](#) adopts the CCD+ and the X12 835 TR3 TRN Segment together as the Healthcare EFT Standards.

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**3.8 Assumptions**

A goal of this rule is to establish a foundation for the successful and timely reassociation of the Healthcare EFT Standards transaction being exchanged between a health plan and a healthcare provider through the ACH Network and the corresponding v5010 X12 835 being exchanged by a separate mechanism.

The following assumptions apply to this rule:

- This rule is a component of the larger set of Phase III CORE Rules; as such, all the CORE Guiding Principles apply to this rule and all other rules
- This rule is not a comprehensive implementation guide for the Healthcare EFT Standards

The v5010 X12 835 states in §1.10.2.2 that “there is a one to one relationship between any specific 835<sup>11</sup> [sic] and the related payment mechanism (check or EFT). One 835 [sic] must only relate to a single payment mechanism and one payment mechanism must only relate to a single 835 [sic].”

**4 Rule Requirements**

**4.1 Receipt of the CORE-required Minimum CCD+<sup>12</sup> Data Required for Reassociation**

A health plan must proactively inform the healthcare provider during EFT (Healthcare EFT Standards) and ERA (v5010 X12 835) enrollment that it will need to contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation of the EFT payment with the ERA remittance advice as defined in §3.3 Table 3.3-1.

A healthcare provider must proactively contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation of the EFT payment with the ERA remittance advice as defined in §3.3 Tables 3.3-1.

The CORE-required Minimum CCD+ Data are defined in Table 4.1-1 below and in Table 3.3-1 above. This rule does not prohibit a healthcare provider and its financial institution from mutually agreeing to exchange more Healthcare EFT Standards data in addition to the required minimum data.

<b>Table 4.1-1</b>		
<b>CORE-required Minimum CCD+<sup>13</sup> Reassociation Data Elements</b>		
<b>CCD+ Record #</b>	<b>Field #</b>	<b>Field Name</b> <b>(See §6 Glossary for Definition of these Terms)</b>
5	9	Effective Entry Date
6	6	Amount
7	3	Payment Related Information

<sup>11</sup> See Section 6.1 Glossary

<sup>12</sup> **NOTE:** The [01/10/12 HHS IFC](#) adopts the CCD+ and the X12 835 TR3 TRN Segment together as the Healthcare EFT Standards.

<sup>13</sup> Ibid.

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#### **4.2 *Elapsed Time between Sending the v5010 X12 835 and the CCD+ Transactions***<sup>14</sup>

A health plan must release for transmission to the healthcare provider the v5010 X12 835 corresponding to the Healthcare EFT Standards:

- No sooner than three business days<sup>15</sup> based on the time zone of the health plan prior to the CCD+ Effective Entry Date<sup>16</sup>

And

- No later than three business days after the CCD+ Effective Entry Date.

A health plan must ensure that the CCD+ Effective Entry Date is a valid banking day and that the corresponding v5010 X12 835 BPR16 date is the same valid banking day.<sup>17</sup>

##### **4.2.1 Retail Pharmacy Coordination**

For retail pharmacy, the health plan may release for transmission the v5010 X12 835 any time prior to the CCD+ Effective Entry Date of the corresponding EFT; and no later than three days after the CCD+ Effective Entry Date. Such a release shall not be considered out of conformance with §4.2 above.

##### **4.2.2 Elapsed Time Auditing Requirements**

A health plan must ensure the v5010 X12 835 and corresponding Healthcare EFT Standards meet the elapsed time requirements specified in §4.2 ninety percent (90%) of the time as measured within a calendar month. A health plan is required to have the capability to track and audit this elapsed time requirement.

#### **4.3 *Resolving Late/Missing EFT and ERA Transactions***

A health plan must establish written Late/Missing EFT and ERA Transactions Resolution Procedures defining the process a healthcare provider must use when researching and resolving a late or missing Healthcare EFT Standards payment and/or the corresponding late or missing v5010 X12 835. Late or missing is defined as a maximum elapsed time of four business days following the receipt of either the Healthcare EFT Standards or v5010 X12 835.

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<sup>14</sup> Issue still exists on how to address the situation when a public or private health plan has no funds available to initiate the Healthcare EFT Standards.

During the development of this rule CORE Participants discussed the situation where a public or private health plan may not have funds available to initiate an EFT, and whether this rule should address such situations by including rule language regarding allowing an exception to the requirement to release the v5010 X12 835 in relationship to the Effective Entry Date specified in the Healthcare EFT Standards. In reality, no Healthcare EFT Standards can be initiated since there are no funds available to the health plan to transfer to a healthcare provider. When there are no funds being transferred to the healthcare provider, the health plan has no payment date on which to base the release of the corresponding v5010 X12 835. The concept of the Doctrine of Constructive Receipt (See Appendix 6.1 Glossary) as defined by the IRS was discussed as that Doctrine may apply to a potential requirement set forth in this rule. At issue is whether or when a health plan should be required to release a v5010 X12 835 for transmission to the healthcare provider in this situation. Some healthcare providers want to receive the v5010 X12 835 regardless of when funds may become available to fund the EFT while others do not want to receive the v5010 X12 835 until the actual funds are transferred into their bank account. CORE is requesting further examination of this issue by NCVHS and CMS.

<sup>15</sup> A business day consists of the 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 actual calendar day(s) constituting business days are defined by and at the discretion of each health plan. See Phase I CORE 155 Eligibility and Benefits Batch Response Time Rule version 1.1.0 March 2011 and CORE Phase I Glossary. A business day is not required to also be a valid Banking Day. See §6.1 Glossary for definition of Banking Day.

<sup>16</sup> Effective Entry Date is the date the payer intends to provide good funds to the payee via EFT which date must also be a valid Banking Day (see Section 6.1 Glossary.) A valid Banking Day is not required to also be a business day for entities that are not financial institutions.

<sup>17</sup> See §6.1 Glossary for definition.

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For retail pharmacy, a late or missing v5010 X12 835 is defined as a minimum elapsed time of four business days following the receipt of the Healthcare EFT Standards.

The Late/Missing EFT and ERA Resolution Procedures must be delivered to the healthcare provider during its EFT and ERA enrollment with the health plan.

**4.4 Cross-Industry Needs: Role of NACHA Operating Rules for the Financial Institutions to Support Health Care**

Section 1104 of the ACA requires use of the Healthcare EFT Standards for all electronic healthcare claims payments. CORE addresses operating rules for health plans, healthcare providers, clearinghouses/vendors/PMS and large providers. CORE recognizes that to comprehensively solve the issue of reassociation health care must coordinate with the financial services industry given financial institutions are another key stakeholder in the reassociation process.

NACHA – The Electronic Payments Association is the organization responsible for the development and maintenance of operating rules governing the ACH Network, through which all financial institutions conduct EFTs. NACHA also writes the ACH standards for the payment transactions that flow over the ACH Network. Only financial institutions are able to vote on *NACHA Operating Rules*. Therefore, to address the role of financial institutions in healthcare payments related to the ACH Network, the healthcare industry must look to the *NACHA Operating Rules* to address reassociation challenges in health care that are essential and applicable to financial institutions.

With regard to the ACA, the 01/10/12 HHS IFC has adopted the CCD+ and X12 835 TR3 TRN Segment as the Healthcare EFT Standards. The CCD+ standard is used by many industries, and due to the ACA, the use of the CCD+ payment transaction will now play a formal role in improving the EFT process in health care for both health plans and healthcare providers.

During the development of this CORE reassociation rule, the CORE Participants reaffirmed that close coordination between CORE healthcare operating rules and *NACHA Operating Rules* is essential to achieving the goals of administrative simplification as envisioned by the ACA legislation. The CORE Participants identified key areas where enhancements to the *NACHA Operating Rules* could address current issues in using the NACHA CCD+ when doing EFT healthcare payments. The combination of healthcare operating rules and enhanced *NACHA Operating Rules* have the potential to offer substantial benefit for reducing costs and enabling a more effective future use of the ACH Network for the billions of healthcare claim payments that will be exchanged over the ACH Network due to the ACA. To assist with promoting cross-industry needs, CORE communicated to NACHA areas to be considered for *NACHA Operating Rules* enhancements in order to have substantial healthcare improvements. Highlights of these key areas are below; additional enhancements to *NACHA Operating Rules* unique to health care will be coordinated with the healthcare operating rules effort.

<b>Identified NACHA Operating Rule Enhancement</b>	<b>Goal of Identified Recommended Enhancement</b>
Establish a standard format for the electronic delivery of the CORE-required Minimum CCD+ Reassociation Data Elements between the provider and the financial institutions; include relation to CCD+	A standard format used by <i>all parties</i> encourages the market to have the information needed to create tools that will enable effective and efficient processing of billions of healthcare CCD+ payment transactions
Require all financial institutions to deliver the CORE-required Minimum CCD+ Reassociation Data Elements to healthcare providers	Consistent provider receipt from financial institutions of the CORE-required Minimum CCD+ Reassociation Data Elements is needed by the provider so that the provider can successfully match the CCD+ payments from health plans with the corresponding v5010 X12 835

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<b>Identified <i>NACHA Operating Rule</i> Enhancement</b>	<b>Goal of Identified Recommended Enhancement</b>
Establish a standard connectivity “safe harbor” for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements to providers that aligns with current healthcare industry efforts	Financial services alignment with the healthcare industry’s movement towards a common, reliable and secure method to exchange both administrative and clinical information

## **5 Conformance Requirements**

Separate from any HHS certification/compliance program to demonstrate conformance as mandated under ACA Section 1104, CAQH CORE offers *voluntary* CORE Certification for all Phases of the CAQH CORE Operating Rules. CORE Certification is completely optional. Pursuing *voluntary* CORE Certification offers an entity a mechanism to test its ability to exchange EFT and ERA transaction data with its trading partners. A CORE-certified Seal is awarded to an entity or vendor product that voluntarily completes CORE certification testing with a CAQH CORE-authorized testing vendor. Key benefits of *voluntary* CORE Certification include:

- Demonstrates to the industry adoption of the Phase III CORE EFT & ERA Operating Rules via a recognized industry “Seal”
- Encourages trading partners to work together on transaction data content, infrastructure and connectivity needs
- Reduces the work necessary for successful trading partner testing as a result of independent testing of the operating rules implementation
- Promotes maximum ROI when all stakeholders in the information exchange are known to conform to the CORE Operating Rules

For more information on achieving *voluntary* CORE Certification for the CAQH CORE EFT & ERA Operating Rules, refer to the Phase III CORE EFT & ERA Operating Rules Voluntary Certification Master Test Suite Version 3.0.0 or contact [CORE@caqh.org](mailto:CORE@caqh.org).

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## 6 Appendix

### 6.1 Glossary of Terms and Definitions

Term	Definition
835	See entry for the ASC X12 Health Care Claim Payment/Advice Transaction Set
ABA Routing Number (also ABA Transit Routing Number)	<p>The ABA Routing Number serves to identify the specific financial institution responsible for the payment of a negotiable instrument. Originally designed to identify only check processing endpoints, the ABA Routing Number has evolved to designate participants in automated clearinghouses, electronic funds transfer, and on-line banking. The ABA Routing Number has changed over the years to accommodate the Federal Reserve System, the advent of MICR, the implementation of the Expedited Funds Availability Act (EFAA), and, most recently, Check 21. An ABA Routing Number will only be issued to a Federal or State chartered financial institution which is eligible to maintain an account at a Federal Reserve Bank.<sup>18</sup></p> <p>The ABA transit number appears on a standard check in the <u>MICR</u> (magnetic ink character recognition) form, consists of nine digits, is printed in magnetic ink, is machine-readable and appears at the bottom left of a check. The MICR number is of the form:</p> <p>XXXXXXXXYC</p> <p>where XXXX is Federal Reserve Routing Symbol, YYYY is ABA Institution Identifier, and C is the Check Digit.<sup>19</sup></p>
ACH (Automated Clearing House)	<p>The ACH Network is a batch processing, electronic payments system governed by <i>The NACHA Operating Rules</i>,<sup>20</sup> which provide for the interbank clearing of electronic payments for participating depository financial institutions. Transactions received by the financial institution during the day are stored and processed later in a batch mode. This provides faster processing than paper checks.</p> <p>ACH payments include:</p> <ul style="list-style-type: none"> <li>• Direct Deposit of payroll, Social Security and other government benefits, and tax refunds</li> <li>• Direct Payment of such consumer bills as mortgages, loans, utility bills and insurance premiums</li> <li>• Business-to-business payments</li> <li>• e-Commerce payments</li> <li>• Federal, state and local government payments</li> </ul> <p>The number of ACH payments in 2010 exceeded 19.4 billion transactions.</p>
ACH Operator	An entity that acts as a central facility for the clearing, delivery, and settlement of Entries between or among Participating DFIs <sup>21</sup>
ACH Payment Acknowledgement	A rarely used non-monetary entry initiated by the RDFI to provide the payee an acknowledgement of a payment.
Addenda Record	A record that contains supplemental data related to an Entry (See CCD+ [Entry]) <sup>22</sup>

<sup>18</sup> American Bankers Association [http://www.aba.com/products/ps98\\_routing.htm](http://www.aba.com/products/ps98_routing.htm)

<sup>19</sup> [http://en.wikipedia.org/wiki/Routing\\_transit\\_number#Routing\\_number\\_format](http://en.wikipedia.org/wiki/Routing_transit_number#Routing_number_format)

<sup>20</sup> NACHA Operating Rules & Guidelines 2011

<sup>21</sup> Ibid.

<sup>22</sup> Ibid.

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Term	Definition
Agent	One who agrees and is authorized to act on behalf of another, a principal, to legally bind an individual in particular business transactions with third parties pursuant to an agency relationship. <sup>23</sup>  Also  A party authorized to act on behalf of another and to give the other an account of such actions. <sup>24</sup>
ASC X12 835 (ASC X12 Health Care Claim Payment/Advice) Transaction Set	An electronic transaction based on the ASC X12 standards implemented in accordance with either the ASC X12N 835 004010X091A1 or the ASC X12N 835 Health Care Claim Payment/Advice implementation guides as defined in 005010X221A1.
ASC X12 835 Implementation Guide	Implementation guides provide a detailed explanation of the transaction set by defining data content, identifying valid code tables, and specifying values that are applicable for electronic claims payment. <sup>25</sup>
Banking Day	Pursuant to U.C.C. § 4-104, a banking day means a day on which a bank is open to the public for carrying on substantially all of its banking functions. Banking day is the business day of a bank. Banking days include all the days when offices of a bank are open for business to the public. Business includes all banking functions. Usually a banking day is any day except Saturday, Sunday and legally defined holidays. Regulations D and CC of Federal Reserve Regulations deal with public holidays. <sup>26</sup>
Business Day	A business day consists of the 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 actual calendar day(s) constituting business days are defined by and at the discretion of each health plan. See Phase I CORE 155 Eligibility and Benefits Batch Response Time Rule Version 1.1.0 March 2011 and CORE Phase I Glossary.
CARC (Claims Adjustment Reason Code)	A Claims Adjustment Reason Code provides an overall explanation for the financial adjustment to the amount submitted on a healthcare claim. <sup>27</sup>
CCD+ [Entry]	The Corporate Credit or Debit is an ACH standard for EFT which is used to make/collect payments to/from other corporate entities. The CCD+ ACH Standard can include one record of payment-related information of up to 80 characters. Health plans use the CCD+ to send payments via EFT, with a reassociation number that matches the EFT to its associated ERA. (See also CTX ACH Standard.) <sup>28</sup>
CTX	The Corporate Trade Exchange is an ACH standard for EFT which supports the transfer of funds (debit or credit) with another entity for which there is an existing trading relationship. This standard includes ASC X12 835 payment related information, which can be placed in multiple (up to 9,999) addenda records. <sup>29</sup>
Company Descriptive Date	A date established by the Originator as the date it would like displayed to the Receiver for descriptive purposes. <sup>30</sup>
Company Entry Description	Established by the Originator to provide the Receiver with a description of the purpose of the Entry. <sup>31</sup>

<sup>23</sup> West's Encyclopedia of American Law, edition 2. © 2008 The Gale Group, Inc. All rights reserved.

<sup>24</sup> Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier.

<sup>25</sup> ASC X12N 004010A1 Implementation Guide dated May 2000 and ASC X12N 005010X221A1 Implementation Guide dated April 2006.

<sup>26</sup> NACHA Operating Rules & Guidelines 2011

<sup>27</sup> <http://www.wpc-edi.com/content/view/711/401/>

<sup>28</sup> NACHA Operating Rules & Guidelines 2011

<sup>29</sup> Ibid.

<sup>30</sup> Ibid.

<sup>31</sup> Ibid.

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Term	Definition
Company Identification	An alphanumeric code used to identify the Originator of an ACH transaction. <sup>32</sup>
Company Name	Identifies the source of the Entry and is used for descriptive purposes for the Receiver and is the name by which the Originator is known to and readily recognized by the Receiver of the Entry. In an ACH transaction in which the Originator of a credit Entry is not the payer of the transaction (the party from which payment is ultimately being directed), the Company Name must be the name by which the payer is known to and readily recognized by the Receiver of the Entry. <sup>33</sup>
Constructive Receipt, Doctrine of <sup>34</sup>	For Federal income tax purposes, the doctrine of constructive receipt is used to determine when a cash-basis taxpayer has received gross income. A taxpayer is subject to tax in the current year if he or she has unfettered control in determining when items of income will or should be paid. Unlike actual receipt, constructive receipt does not require physical possession of the item of income in question.  The full text of the IRS regulation defining constructive receipt states as follows:  <i>“Income although not actually reduced to a taxpayer's possession is constructively received by him in the taxable year during which it is credited to his account, set apart for him, or otherwise made available so that he may draw upon it at any time, or so that he could have drawn upon it during the taxable year if notice of intention to withdraw had been given. However, income is not constructively received if the taxpayer's control of its receipt is subject to substantial limitations or restrictions.”</i>
Corporate Credit or Debit	See CCD+
Corporate Trade Exchange	See CTX
DFI Account Number	The RDFI's customer's account number (Receiver/Payee/Provider). <sup>35</sup>
Discretionary Data	A field in the Entry Detail Record of an ACH transaction allowing ODFIs to use code of significance to them to enable specialized handling of the Entry. There is no standardized interpretation of this data. <sup>36</sup>
Effective Entry Date	The date the payer intends to provide good funds to the payee via EFT as specified in the ACH CCD+ Standard in Field #9 of the Company Batch Header Record 5. <sup>37</sup>
EFT (Electronic Funds Transfer)	The electronic exchange or transfer of money from one account to another, either within a single financial institution or across multiple institutions, through computer-based systems. <sup>38</sup>
Entry	An order or request for the transfer of money from one account to another, e.g., a CCD+ is a type of Entry. A non-monetary transaction is also an Entry.
EOB (Explanation of Benefits)	A document from an insurance company giving details regarding how the insurance company processed medical insurance claims. Although EOBs often look like a medical bill, the EOB tells the patient what portion of a claim was paid to the healthcare provider and what portion of the payment, if any, the individual is responsible for.
ERA (Electronic Remittance Advice)	An electronic version of a payment explanation which provides details about providers' claims payment. ERAs are provided by health plans to providers. The industry standard for sending ERA data is the HIPAA-adopted ASC X12 835 standard. If the claims are denied, the ERA would contain the required explanations.

<sup>32</sup> Ibid.

<sup>33</sup> NACHA Operating Rules & Guidelines 2011

<sup>34</sup> [http://en.wikipedia.org/wiki/Constructive\\_receipt](http://en.wikipedia.org/wiki/Constructive_receipt)

<sup>35</sup> NACHA Operating Rules & Guidelines 2011

<sup>36</sup> Ibid.

<sup>37</sup> Ibid.

<sup>38</sup> [http://en.wikipedia.org/wiki/Electronic\\_funds\\_transfer](http://en.wikipedia.org/wiki/Electronic_funds_transfer)

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Term	Definition
Healthcare EFT Standards	The combined use of the ACH CCD+ Standard and the X12 835 TR3 TRN Segment to originate/initiate an electronic healthcare claim payment. These standards must be used for claims payment initiation by all health plans that conduct healthcare EFT. <sup>39</sup>
Health Plan	Title 45, Code of Federal Regulations. Section 160.103— (1) Health plan includes the following, singly or in combination: <ul style="list-style-type: none"> <li>(i) A group health plan, as defined in this section.</li> <li>(ii) A health insurance issuer, as defined in this section.</li> <li>(iii) An HMO, as defined in this section.</li> <li>(iv) Part A or Part B of the Medicare program under title XVIII of the Act.</li> <li>(v) The Medicaid program under title XIX of the Act, 42 U.S.C. 1396, et seq.</li> <li>(vi) An issuer of a Medicare supplemental policy (as defined in section 1882(g)(1) of the Act, 42 U.S.C. 1395ss(g)(1)).</li> <li>(vii) An issuer of a long-term care policy, excluding a nursing home fixed- indemnity policy.</li> <li>(viii) An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.</li> <li>(ix) The healthcare program for active military personnel under title 10 of the United States Code.</li> <li>(x) The veterans' healthcare program under 38 U.S.C. chapter 17.</li> <li>(xi) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)(as defined in 10 U.S.C. 1072(4)).</li> <li>(xii) The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq.</li> <li>(xiii) The Federal Employees Health Benefits Program under 5 U.S.C. 8902, et seq.</li> <li>(xiv) An approved State child health plan under title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, et seq.</li> <li>(xv) The Medicare + Choice program under Part C of title XVIII of the Act, 42 U.S.C. 1395w-21 through 1395w-28.</li> <li>(xvi) A high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.</li> <li>(xvii) Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).</li> </ul>
Individual ID Number	The accounting number by which the Receiver (Payee) is known to the Originator (Payer). <sup>40</sup>
Intermediary	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 or provides other services that facilitate the exchange, delivery or transfer of electronic health information between organizations.

<sup>39</sup> [CMS-0024-IFC](#): Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

<sup>40</sup> NACHA Operating Rules & Guidelines 2011

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Term	Definition
	Used interchangeably with the terms “SWITCH” and “CLEARINGHOUSE” in the context of CORE rules. <sup>41</sup>
NPI (National Provider Identifier)	A unique 10-digit identification number issued to healthcare providers by the Centers for Medicare and Medicaid Services.
ODFI (Originating Depository Financial Institution)	A NACHA participating financial institution that originates ACH payments at the request of and by (ODFI) agreement with its customers. ODFIs must abide by the provisions of <i>The NACHA Operating Rules</i> . <sup>42</sup>
Originator	The entity that authorizes the ODFI to send on its behalf EFT transactions to a Receiver’s (payee’s) account. The Originator may also authorize a Third Party Sender to initiate EFT transactions on its behalf to a Receiver’s (payee’s) account. <sup>43</sup>
Payee (Healthcare Provider)	The Receiver of an EFT payment. See Receiver.
Payer	The entity that pays a healthcare claim submitted by a Healthcare Provider for reimbursement of healthcare services delivered to a health plan beneficiary.
Payment Related Information	A field in the CCD+ Addenda Record containing payment-related ASC X12 data segments. <sup>44</sup>
Posting (See Reconciliation)	Applying remittance advice data to open patient accounts in order to relieve the open account receivable.
Remittance (Remit)	The sending of money to someone at a distance. The sum of money sent. To transmit (money) in payment.
RA (Remittance Advice)	A document that describes payments that are being made. The person or company that is making the payment will sometimes include a remittance advice, which is like a receipt of payment. A remittance advice is usually used by companies either processing a purchase or a filed claim. <sup>45</sup>
RARC (Remittance Advice Remark Code)	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjust Reason Code. <sup>46</sup>
Reassociation	Matching a payment to the remittance advice data received.
RDFI (Receiving Depository Financial Institution)	Any financial institution qualified to receive ACH payments that agrees to abide by the <i>NACHA Operating Rules</i> . <sup>47</sup>
Receiver	An entity that has authorized an Originator of an EFT transactions to initiate EFT transactions to its deposit account. <sup>48</sup>
Receiving Company Name	Established by Originator to provide additional identification of the Receiver (Payee). <sup>49</sup>
Reconciliation (See Posting)	Balancing information from two or more sources, like a payment and a remittance advice or a remittance advice and a posting report, to ensure that the amount(s) reported on one source are equivalent to the amount(s) reported on the other(s).
Sending Point	An organization that transmits Entries to an ACH Operator on behalf of an ODFI. A Sending Point may be an ODFI acting on its own behalf or a participating DFI, or Third-Party Service provider acting on behalf of one or more ODFIs. <sup>50</sup>

<sup>41</sup> CORE™ Phase I Rules and Policies Glossary of Terms

<sup>42</sup> <http://www.nacha.org/c/Intro2ACH.cfm>, NACHA, Intro to the ACH Network

<sup>43</sup> NACHA Operating Rules & Guidelines 2011

<sup>44</sup> Ibid.

<sup>45</sup> [http://www.investorwords.com/6904/remittance\\_advice.html](http://www.investorwords.com/6904/remittance_advice.html)

<sup>46</sup> <http://www.wpc-edi.com/content/view/711/401/>

<sup>47</sup> <http://www.nacha.org/c/Intro2ACH.cfm>, NACHA, Intro to the ACH Network

<sup>48</sup> NACHA Operating Rules & Guidelines 2011

<sup>49</sup> Ibid.

<sup>50</sup> Ibid.

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Term	Definition
Standard Entry Class Code	A code identifying an Entry initiated to an organization to transfer funds to or from an account of that organization to another organization. <sup>51</sup>
Third Party Sender (also Third Party Service Provider, Third Party Payment Vendor)	An entity authorized by the Originator to initiate EFT transactions on its behalf to a Receiver's (payee's) account. <sup>52</sup>
Unsecured Electronic Network	A public or private network not entirely located within a single, contiguous facility not dedicated to communication between two end-points. From the <i>NACHA Operating Rules</i> perspective the Internet is considered to be an unsecured network even though secure transmissions may be made over that otherwise unsecure network. <sup>53</sup>

## 6.2 References

- ASC X12 005010X221A1 Health Care Claim Payment/Advice Professional Technical Report Type 3 (835) and associated errata
- NACHA 2011 Operating Rules & Guidelines, A Complete Guide to the Rules Governing the ACH Network
- CAQH CORE/NACHA White Paper: [Adoption of EFT and ERA by Health Plans and Providers: A White Paper Identifying Business Issues and Recommendations for Operating Rules](#) (2011)
- [CMS-0024-IFC](#): Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 01/10/12.

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<sup>51</sup>Ibid.

<sup>52</sup> NACHA Operating Rules & Guidelines 2011

<sup>53</sup> Ibid.