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Electronic funds transfer

A toolkit for navigating the ins and outs of EFT

Introduction

Want to save over $2,000* per physician annually? Use this toolkit to learn how to use electronic funds transfer (EFT): “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.”** EFT is similar to direct deposit. Accepting EFT payments from health insurers and automating your claims process can:

- Speed up payment
- Save time spent on manual processes such as depositing paper checks and phone calls to health insurers
- Eliminate lost explanations of benefits (EOBs) and expedite filing to secondary payers
- Reduce the risk of lost or stolen checks
- Free time for revenue-enhancing functions such as ensuring correct payment

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** Source: NACHA, the Electronic Payments Association, ACH Primer for Healthcare*

*** Source: CAQH Committee on Operating Rules for Information Exchange (CORE) Phase III CORE EFT & ERA Operating Rule Set, June 2012*

Getting started: Accepting EFT payments in the physician practice

The Patient Protection and Affordable Care Act required the establishment of an electronic funds transfer (EFT) standard by July 1, 2012, which in turn, requires health insurers to offer EFT to physician practices by Jan. 1, 2014.

> Electronic funds transfers standard: The U.S. Department of Health and Human Services (HHS) adopted the NACHA CCD+Addenda as the Healthcare EFT Standard as a final rule July 10, 2012. Health plans must deliver the Healthcare EFT Standard if it is requested by physicians (45 CFR § 162.925). For physician practices, standardized EFT will greatly improve the claims payment process (Sec. 1104).
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> Operating rules for EFT and electronic remittance advice (ERA): HHS has adopted (August 10, 2012) a set of operating rules for electronic funds transfers (EFT) and the HIPAA transactions standards healthcare payment and remittance advice (allowing for automated reconciliation of the electronic payment with the remittance advice) (Sec. 1104). Visit www.caqh.org/ORMandate_EFT.php for more information.
>
> Both the healthcare EFT standard and operating rules are effective January 1, 2014.

EFT allows transfer of money between parties electronically. While payment by paper checks can be time-consuming and experience postal delays, EFT can be an efficient means of payment for physician practices. EFT can save your practice time by reducing manual administrative tasks, such as copying paper checks and traveling to the bank and waiting in line to make deposits.

Physician practices are now able to request that their claim payments are transferred through EFT to a bank account of their designation. Your practice should consider using EFT to further automate your claims management revenue cycle. Similarly, the health insurers you contract with might encourage you to both submit claims and receive payments electronically because these automated processes can result in significant administrative cost savings.

Steps for implementing EFT

The following are recommended steps for implementing EFT in your practice's claims management revenue cycle. Carefully reviewing these steps before you accept EFT payments in your practice can help you realize EFT efficiencies and avoid potential administrative headaches in the future.

Step 1: Determine which of your contracted health insurers offer EFT payments. If a current health insurer contract does not contain a provision authorizing EFT, you might have received an EFT authorization form from the health insurer in a separate mailing, or you might receive one after the contract is executed. You can also search the health insurer's website for EFT authorization forms or contact your health insurer representative. You might also consider accepting electronic remittance

advice (ERA). Visit the AMA payer policies website at www.ama-assn.org/go/payerpolicies for links to EFT and ERA information from many of the major health insurers.

Your practice should also review future or renewal contracts with health insurers for the addition of EFT provisions. If they do not offer EFT, you should ask why and when they plan to become compliant with any federal or state regulations.

Additional EFT resources

Consult the resource "Questions to ask a health insurer before signing an EFT agreement" for a checklist of questions to help you evaluate whether you should sign an EFT agreement with a health insurer.

Step 2: Determine how your practice will process EFT and ERA transactions. When a physician practice accepts EFT payments, the health insurer sends an explanation of benefits (EOB) or ERA to the physician practice via a HIPAA-compliant 835 electronic standard transaction or a paper EOB.

If your practice is unable to receive a HIPAA-compliant 835 payment/remittance advice, you should ask the health insurer whether there are alternative ways to access, download or view the remittance advice via the health insurer's website. We encourage you to determine how you will be able to access this information and incorporate it into your practice's work flow before signing an EFT agreement with a health insurer. Also, be sure to consult with your practice management software (PMS) vendor and/or clearinghouse to discuss accessing these electronic standard transactions.

Medicare Remit Easy Print (MREP) Software allows physicians and other health care providers to view and print an unlimited number of electronic remittance advices (ERA). This free software can help you save time resolving Medicare claim issues:

- Easily navigate and view your ERAs from your computer
- Print the ERA in the Medicare standard paper remittance advice format
- Easily search for claims information
- Print and export reports about ERAs including denied, adjusted and deductible-applied claims
- Archive, restore or delete imported ERAs

Visit the Medicare Remit Easy Print section of the Centers for Medicare and Medicaid Services' website to download the MREP software and find additional information.

Additional EFT resources

Consult the resource "Considerations for processing EFT transactions in the physician practice" to determine your practice's situation and how to best ensure that you are able to process EFT transactions.

Consult the resource "Questions to ask a billing service before signing an EFT agreement" and "Questions to ask a clearinghouse before signing an EFT agreement" to ensure that you are able to process EFT transactions if your practices uses either one or both of these kinds of vendors.

Step 3: Carefully review each health insurer's EFT agreement. Review these agreements closely, especially to make sure that the health insurer or a third-party administrator is not allowed to take advantage by debiting or off-setting payment transactions without notice and your consent. Also be sure to evaluate the agreement's termination notice requirements prior to signing the EFT agreement.

Step 4: Determine your preferred EFT format. You can explore your options with your bank. The most common EFT format for health care is the National Automated Clearing House Association's (NACHA) standard CCD+. Be sure to confirm with both the health insurer and the bank that they are using the CCD+ format.

Caution: EFT agreements your practice enters into with health insurers will supersede the protections your bank has put in place. You should pay close attention to the enrollment provision related to the health insurer's ability to debit your account. When in doubt, share your EFT agreement with your bank to determine whether your account protections will be waived as a result of the agreement.

Additional EFT resources

Consult NACHA's website under "Healthcare Industry" for additional details about EFT formats in NACHA's revised "ACH Primer for Healthcare Payments: A Guide to Understanding EFT Payment Processing."

Consult the resource "Questions to ask a bank before signing an EFT agreement" for additional information about issues you should discuss with your bank before signing an EFT agreement.

Step 5: Request information from the health insurer regarding the EFT format they use. The health insurer's EFT format should be compatible with your bank. The most common EFT format for health care (and the Healthcare EFT Standard) is the NACHA's standard CCD+ Addenda. We encourage you to contact each health insurer for its preferred enrollment process.

Step 6: Submit enrollment forms. The health insurer will provide guidance and an EFT and/or ERA enrollment form. You are encouraged to contact each health insurer for its preferred enrollment process because they may vary. If you are contracted with a billing service or collection service, be sure to contact them to determine how best to submit the required forms and documentation to the health insurer.

Step 7: Contact your bank. Determine with your bank how you will be notified when deposits are made to your account by health plans, and make sure that the notification will include the ERA reference information from the Addenda record of the CCD+ formatted EFT. This information allows you to tie the EFT directly to the ERA containing the claim detail related to the payment.

Terminating an EFT agreement or opting out

Before signing an EFT agreement, you should understand the EFT agreement's termination notice requirements. Health insurers' termination notice requirements and procedures may vary.

Some health insurers automatically consider contracted physicians as participants in the EFT program unless the physician opts out. Health insurers' opt-out processes may vary. For instance, one health insurer requires physicians to submit a letter by a given deadline. The letter must state that you do not wish to participate in the EFT program and your reason for not participating.

If the health insurer has not offered a clear opt-out procedure (and participation in an EFT program is not required in the health insurer's network agreement), you should notify the health insurer in writing immediately if you do not wish to participate in the EFT program.

Getting started: Considerations for processing electronic transactions in the physician practice

Sending and receiving electronic transactions can help reduce the time the staff in your practice spend on administrative tasks. For example, practice staff who currently open and file mail, match paper explanations of benefits (EOBs to paper checks) and complete manual bank deposit transactions might be able to perform more productive tasks, such as making appointment reminder phone calls, investigating overpayments and underpayments from health insurers, appealing denied claims, and reviewing aging reports more frequently. For a complete list of the electronic health care transactions that are available to you as a result of the mandate in the Health Insurance Portability and Accountability Act (HIPAA), access, "Understanding the HIPAA standard transactions: The HIPAA Transaction and Code Set rule."

When you consider sending and receiving electronic or electronic data interchange (EDI) health care transactions with the health insurers with which you contract, remember to first take into account your practice's specific situation—especially the current claims revenue cycle you have established. The claims revenue cycle typically includes several intermediaries involved in processing the claims and related tasks. Your claims revenue cycle and its associated intermediaries will dictate the appropriate process you should follow when signing up for electronic transactions.

The threshold questions that must be answered are: 1) which electronic health care transactions you would like to integrate within your practice workflow, and 2) which health insurers you would like to send and receive these transactions. Consider your high-volume health insurers and the information you need to receive. For example, the HIPAA mandated Accredited Standards Committee (ASC) X12 270/271 electronic eligibility health care benefit inquiry and response transactions (eligibility request and response) and its associated operating rule requires all health insurers to respond to an electronic eligibility request with the patient specific co-payment, coinsurance, deductible and remaining deductible information[1]. By examining your high claim volume health insurers and the information you need to receive to determine your patients' personal financial responsibility for the services you provide, you can determine the impact the transition to electronic eligibility requests will have on your current calls to health insurers for eligibility information or time spent to access various Web portals.

Your practice management system (PMS) vendor is also a partner in your practice's claims revenue cycle process. Be sure to confirm with your PMS vendor that it provides the functionality, preferably combined with an integrated solution, necessary to update your patient's records for the eligibility request and response transactions, as well as the other electronic transactions you would like to implement. If the PMS does not offer an integrated solution, determine whether it may still be able to reduce administrative costs in your practice. For example, can it submit an explicit Service Type Code Eligibility Request, if you need that functionality? Be sure to ask if there are future plans to offer an integrated solution or associated functionality. A PMS that has electronic connections with your contracted payers and an integrated workflow can assist you with replacing your costly manual processes with time-efficient, automated solutions.

[1] Effective January 1, 2013.

Following are some common physician practice claims revenue cycle scenarios and the first steps for physician practices in those scenarios to take. Consider which of these scenarios most closely resembles your claims revenue cycle.

Scenario 1: Your practice has a PMS or electronic health record with an integrated PMS that sends and receives HIPAA-compliant electronic health care transactions, such as claims, eligibility and ERAs.

Your first step is to review the resources "Questions to ask a health insurer before enrolling in an electronic transactions program" to help obtain the information necessary to ensure a seamless transition to using electronic health care transactions.

Scenario 2: Your practice retains a health care billing service to compile and send claim submissions and monitor eligibility and ERAs.

Your first step is to review the resources "Questions to ask a billing service before enrolling in an electronic transactions program" to ensure that you obtain the information necessary for a seamless transition to using electronic health care transactions. Many billing services will assist you with electronic health care transaction enrollment, but be sure to also review your health insurer agreements carefully.

Scenario 3: Your practice has a PMS or hybrid electronic health record that sends and receives claims via a clearinghouse that translates the transactions into HIPAA-compliant transactions, such as claims, eligibility and ERAs, and sends the transactions to the health insurer or its intermediary.

Your first step is to review the resources "Questions to ask a clearinghouse before enrolling in an electronic transactions program" to ensure that you obtain the information necessary for a seamless transition to using electronic health care transactions. Many clearinghouses will assist you with enrollment, but be sure to also review your health insurer agreements carefully.

Physician practices that transition to sending and receiving electronic transactions, such as claims, eligibility and ERAs, typically experience increased efficiencies both in their own practices and for their billing services. Benefits include: quicker health insurer responses, fewer days in accounts receivable, less time spent on payment posting, reduced labor expenses, eliminating lost EOBs and missing checks, and fewer hassles that come with manual processes such as calling the health insurer and waiting on hold.

Getting started: Comparison of EFT payment options

The interim final rule with comment (IFC) [CMS-0024-IFC], " Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice," does not prohibit the use of other EFT payment options for healthcare claim payments, and health plans are not required to send health care EFTs through the Automated Clearing House (ACH) Network. Other options include wire transfer or virtual cards (not supported directly by the HIPAA administrative standards). However, health plans must certify they are compliant with the Healthcare EFT Standard and Operating Rules by January 1, 2014 and must deliver the Healthcare EFT Standard if it is requested by the provider [45 CFR 162.925]. As a physician practice, it is important that you have an understanding of each the most common EFT payment options, the features of each, and the costs to accept each payment option.

Cost comparison of EFT payment options

The costs used in the following chart are average costs based on publically available information. For actual costs to receive an ACH or Wire Transfer payment, please check with your financial institution. While the cost to accept virtual card payments is based on your agreement with your merchant processor, interchange fees between 1.9%-3+% of the payment amount typically apply, plus a per transaction fee.

	ACH	Virtual Card	Wire Transfer
Funds availability (as measured from the time that a plan initiates payment)	Next day	2-3 Business days depending on card type and agreement with Merchant Card Processing Provider (funds deposited to Bank Account via ACH Network)	Same day (funds irrevocable)
Average cost to receive $2,500 EFT payment	$0.34 (any payment value)[1]	Percentage of total payment plus a transaction fee [2] Example – 3% interchange fee on $2,500 payment and $0.10 transaction fee = $75.10	$10.73 (any payment value)[3]
Enrollment/acceptance	Must have a bank account One time with each health plan	Must have a bank account and agreement with a merchant card processing provider, and point of sale processing system/terminal	Must have a bank account One time with each health plan (account information must be provided to each health plan)
Risk	Very low risk with ACH credit payment; FI can support additional account monitoring tools such as debit filters or blocks	Higher risk with virtual cards; card numbers mailed or faxed have information that can be used by anyone with ability to accept card payments (Square, other options)	Very low risk with immediate payment
Manual processing for each payment	None – automatically deposited to bank account	Each payment must be manually entered into the POS terminal by office staff	None – automatically deposited to bank account
Reassociation with Electronic Remittance Information	Standardized inclusion of TRN Reassociation Data Segment in payment (called the addenda record) Delivered by financial institution after service is established (must be requested by the physician as part of the service)	Not included with payment Manual access to each EOB through web portal	No requirement to include TRN Reassociation Data Segment with payment If included, can be delivered by financial institution after service is established

[1] *The Blue Book of Bank Prices 2012-13 published by Phoenix-Hecht - https://www.phoenixhecht.com/treasuryresources/PDF/BBExecSumm.pdf*
[2] *MasterCard-* http://www.mastercard.com/us/merchant/pdf/MasterCard_Interchange_Rates_and_Criteria.pdf
[3] *The Blue Book of Bank Prices 2012-13*

Questions to ask a health insurer before signing an EFT agreement

Following are some important questions to discuss with your health insurer before signing an electronic funds transfer (EFT) agreement.

1. Will I get paid faster than I would with traditional paper explanations of benefits (EOB) and checks?

EFT is generally faster (as many as seven days in some cases) than mailed paper checks. Receiving EFT payments can reduce paperwork by automating manual processes, may also help to shorten your days in accounts receivable and reduce the risk of lost or stolen checks. Claims might be grouped by payee and sent weekly, while Medicare Advantage and HMO plans might be sent daily. Be sure to ask the health insurer what its payment cycle is when setting up your EFTs so you can anticipate the timing of the payment for each of your claims.

2. Does the health insurer offer alternative ways to access electronic remittance advice (ERA)?

If your practice is unable to receive the HIPAA-compliant 835 payment/remittance advice associated with your EFT payment, you should ask the health insurer whether there are alternative ways to access, download or view the ERA via the health insurer's Web site. Before signing an EFT agreement with a health insurer, determine how you will be able to access this information and make certain you set up a method of reconciling the EFTs to the ERAs received from the health insurer and your bank. Some health insurers will still send paper EOBs even if you are receiving the payments electronically. Whenever possible, it is a good idea to consider receiving ERAs instead of paper EOBs when you receive EFT payments. The health insurer enrollment process for ERAs may be a separate process from the EFT enrollment process.

3. Will the health insurer notify your practice or billing service (whomever processes the posting of your payments) prior to EFT deposits?

Some health insurers will send a free e-mail notification to the authorized party one day prior to the electronic payment being credited to your account.

4. Will I be able to easily match and post payments to accounts?

A trace number is required in the EFT addenda record. This trace number is used to link the ERA and EFT so you can match and post payments easily. Confirm that the health insurer includes the trace number in the EFT payment.

5. Will I be able to access and view my transactions electronically?

Ask whether the health insurer offers online access to your claims transactions so you can view the ERAs online, view and print EOBs if necessary, and monitor claims for follow up.

6. Will I receive separate EFT/ERAs for each National Provider Identifier (NPI) that I bill under?

Some health insurers will issue a separate EFT/ERA for each billing or pay-to NPI number. Physicians billing with multiple NPIs may receive a separate EFT/ERA for each NPI. Ask the health insurer whether it has an "override" value to use on all your ERAs to reduce the number of payments generated. If you are using a billing service, make certain to check with them before designating any

overrides because you will want to ensure the posting protocol is manageable within the billing software. If you bill internally, make certain to check with your practice management software vendor.

7. How will the health insurer recover overpayments?

Be sure that the health insurer will only reverse an EFT under the circumstance of a duplicate or erroneous EFT. Ask the health insurer to clarify its policy on when it would debit your account.

8. Will the health insurer apply service fees or other account debits?

It is extremely important that you review the EFT agreement closely to determine whether it allows the health insurer to unilaterally apply service fees, refund requests or adjusting entries, or otherwise debit funds from your account. We encourage you to know up front how your bank will record these credit and debit entries to your account and whether your bank will charge you a fee for such entries or for debits that exceed the balance of your bank account. An EFT agreement that permits the health insurer to take adjusting entries, service fees or offsets out of your bank account may prevail over applicable regulatory requirements. However, the Medicare program does not allow Medicare carriers to take offsets from physicians' bank accounts.

For instance, Aetna's standard EFT agreement states:

> "EFT and overpayment recovery—for example—Aetna's overpayment recovery process does not change once you enroll in EFT. We will only reverse an EFT deposit from your account in the instance of a duplicate or erroneous EFT. IF an electronic debit is unsuccessful, or for deposit only accounts, Aetna will pursue settlement via alternate measures."

The Centers for Medicare and Medicaid Services (CMS) states the following in their EFT agreement:

> "I hereby authorize the Centers for Medicare and Medicaid Services (CMS) to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any duplicate or erroneous entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account."

9. How timely will payments be?

You should ask the health insurer how timely EFT payments will be compared to check payments that are mailed to you. You can contact your state medical association and national medical specialty society for more information on your state's prompt payment laws, which may have differing payment time frames from the health insurer's EFT agreement, depending on whether claims are submitted electronically. AMA members can also easily look up their state's prompt pay laws in the National Managed Care Contract Database.

10. How are reprocessed claims handled?

Ask how the health insurer reports reprocessed claims. Health insurers should report a reversal of the incorrect claim adjudication followed by the corrected adjudication. Be aware that sometimes these will show up in different ERA files (or on different paper EOBs).

11. What is the health insurer's process for terminating an EFT agreement or opting out?

Before signing an EFT agreement, you should understand an EFT agreement's termination notice requirements. Health insurers' termination notice requirements and procedures may vary.

Questions to ask a bank before signing an EFT agreement

Following are some important questions to discuss with your bank before signing an electronic funds transfer (EFT) agreement with a health insurer or trading partner.

Credit: An entry to the record of an account that represents the transfer or placement of funds into an account. Credits are associated with receiving revenue or payments.
Debit: An entry to the record of an account that represents a transfer or removal of funds from an account. Debits are associated with reduction of revenue.

1. Will I need to change my bank account?

To participate in EFT, you can continue using your current bank account or create a new bank account. Whichever option you choose, you will need to provide the payer with your preferred bank account information as instructed in the EFT enrollment form and request fees, if any, associated with receiving the EFT transactions.

2. What is a TRN— Reassociation Trace Number?

The TRN— Reassociation Trace Number is an electronic data interchange (EDI) segment that the payer includes both the ERA and the ACH CCD+ (HIPAA mandated EFT format) Addenda Record that is forwarded to the bank. The EDI data segment used is the TRN – Reassociation Trace Number is designed to be a machine-readable number; the TRN Reassociation Trace Number is a series of numbers and asterisks, similar to what you see below:

TRN*1*12345*1512345678*999999999\

The TRN— Reassociation Trace Number on the ACH CCD+ Addenda Record should match the TRN number supplied on the corresponding ERA.

3. How do I obtain the TRN— Reassociation Trace Number from my EFT to match my electronic remittance advice (ERA)?

The TRN— Reassociation Trace Number is passed from the payer to the payer's bank and then to the physician practice's bank. The Healthcare EFT Standard requires that the TRN Reassociation Trace Number be included in the Healthcare EFT Standard Addenda Record. The payer is required to include the TRN data segment in the ERA 835 Transaction Set and the Addenda of the CCD+. Physician practices should contact their bank and request delivery of the ACH CCD+ Addenda Record information.

When choosing to participate in EFT, advise your bank where to send the ACH CCD+ Addenda record (record 7) information that includes the TRN— Reassociation Trace Number key and discuss options, and if any, associated fees.

4. What safeguards does the bank offer for commercial and personal accounts receiving EFTs?

Your bank should have detailed policies and procedures in place that protect the EFTs it receives. Make sure to get a copy of these policies and procedures and discuss them with your bank. Note that commercial and personal accounts are governed by different rules and regulations. The National Automated Clearing House Association's (NACHA) Operating Rules govern all EFTs that are sent over the Automated Clearing House (ACH) Network. Many financial institutions offer treasury or cash management services to prevent unauthorized or fraudulent debit transactions. Ask to speak to a cash or treasury management officer at your financial institution about services available to manage and protect your account.

5. Are there options to protect against unauthorized ACH transactions?

Most banks make provisions to protect your account from unauthorized debit transactions. Some common protections include:

ACH debit "filter": With this service, the bank automatically returns all ACH items to a designated account, except transactions that are pre-authorized by the customer. Some banks allow their customers to fine-tune their payment criteria based on maximum dollar amounts, exact dollar amounts and maximum number of occurrences. No customer intervention or review is necessary once this service is established.

ACH debit block: With this service, your bank blocks all debits from withdrawing monies and posting to your account. Be sure to ask your bank about fees for the debit blocking protection, which could be monthly or per transaction.

ACH transaction review: With this service, you are able to review and confirm ACH debit and credit transactions online. This type of service requires your practice to monitor these transactions daily, which can be more time consuming. However, it can be an excellent safeguard.

ACH positive pay: With this service, your practice can review ACH debits before they are posted. Your practice makes the decision to accept or return each individual debit. This requires vigilance on the part of your practice and same-day review. Ask your bank which of these services it offers.

Caution: Agreements between the payer and your practice can supersede the protections your bank has put in place. Pay close attention to the enrollment provisions related to a payer's ability to debit your account. When in doubt, share the payer EFT agreement with your bank to determine whether your account protections will be waived through the agreement. If you are concerned that a particular payer can retrieve what they consider to be overpayments by simply debiting your bank account as stated above, share the agreement with the bank.

6. Can I review detailed information on specific transactions online?

Your bank should offer your account balance and transaction history online. Check to see whether you will receive e-mail notifications and online alerts when there is activity on your account, including the types of features for each specific transaction. For example, one highly beneficial online feature is the ability to initiate stop-payment instructions and receive real-time confirmation.

7. What options does the bank offer or recommend for a zero-balance account (ZBA)?

With a ZBA, no balance is left in the account. A balance of zero is maintained by automatically transferring funds from a master account in order to cover checks when presented. Physician practices that choose to use a ZBA can write checks from the ZBA account, and the monies are removed from an associated funding “savings” account. In the past, these accounts were used for payroll transactions, since payroll companies have come into the financial market, they are not commonly used. ZBA accounts do not offer protection from unauthorized ACH debit transactions. Funds will be pulled from the master account to cover all debits (check or ACH) presented on the ZBA account.

8. What options does the bank offer or recommend for a sweep account?

A sweep account is one with a balance that earns interest. With this kind of bank or brokerage account, the available cash balance is routinely transferred into an investment that bears interest. Sweep accounts are generally used for large balances that earn enough interest to off-set associated flat fees for account maintenance, which can range between $150 and $200 per month. They are called “sweep” accounts because the balance is swept into investment instruments such as Eurodollar investments, money market accounts and mutual fund accounts. Sweep accounts do not offer protection from unauthorized debit transactions. All debits (check or ACH) presented on the sweep account will be funded before the excess funds are transferred or “swept” into the overnight investment account.

9. Does the bank offer account analysis?

Account analysis is a statement or invoice for services that a financial institution provides to its commercial customers, specifying services provided, volumes of transactions processed, and charges assessed or compensating balances required to offset the fees owed.

10. What other services may a bank offer that could assist with my cash management?

EFT is a part of a broader sound cash management process. If your practice does not accept ERAs and EFT, a bank may offer services to streamline your cash management process, such as lock box services for all payments, converting paper payments from patients through the mail to ERAs, converting paper EOBs to ERAs and balancing activities for the files your practice sends. EFTs and lock box services minimize employee theft, are often less expensive than the historical manual processes and lower days in accounts receivables. You will also need a business associate agreement if the bank is processing personal health information in the lock box.

Questions to ask a billing service before signing an EFT agreement

If you have an agreement with a billing service to perform your practice's accounts receivable function, you will need to coordinate your participation in a health insurer's electronic funds transfer (EFT) program with your billing service. Following are some important questions to clarify with your billing service before signing an EFT agreement with a health insurer.

1. Will my billing service help me receive EFT payments and electronic remittance advices (ERA)?

Physician practices that transition to sending and receiving electronic transactions, such as EFTs and ERAs, typically experience increased efficiencies not only for their own practice but also for their billing services. These benefits include:

- Fewer days in accounts receivable
- Less time spent on payment posting
- Decreased labor expense
- Elimination of lost EOBs and paper checks
- Fewer headaches associated with manual processes
- Less time to put the money in your account
- Reduced risk of lost or stolen checks
- Quicker turnaround time for filing to secondary payers

2. How do I initiate the EFT process with each of my contracted health insurers?

Your contracted billing service should be able to assist you in the EFT enrollment process for your contracted health insurers.

Caution: Agreements entered into with health insurers can supersede the protections your bank has put in place. When in doubt, share your EFT agreement with your bank to determine whether your bank account protections will be waived through the agreement with the health insurer.

If you are concerned that a particular health insurer may be able to retrieve what they consider overpayments by simply debiting your bank account as stated above, share the agreement with your bank to determine what protections, if any, are available.

Keep in mind that a health insurer that previously reduced your next claim payment by an amount it believed was an overpayment without advanced notice when you received payments by paper check could similarly reduce the next claim payment arriving by EFT. Several states offer protection against auto take-backs without appropriate notice. Contact your state medical association for your state laws and provisions. AMA members can also visit www.ama-assn.org/go/nationalcontract to access the National Managed Care Contract Database to look up relevant state laws and provisions.

Additional EFT resources

Consult the resource "Questions to ask a bank before signing an EFT agreement" before enrolling in a health insurer's EFT program.

3. How do I make sure the health insurer submits the ERAs for EFT payments through my billing service?

Once your practice decides to send and receive ERAs and EFTs, then you are required to complete a new set of electronic data interchange (EDI) enrollment forms for each governmental payer and private health insurer. Your billing service has a unique "submitter identifier" that must be linked to your provider billing numbers in order to submit claims electronically and receive ERAs on your behalf. This will indicate to the various health insurers and clearinghouses that the ERAs should be redirected to the identified billing service. In some cases, you might choose to receive the ERAs and EFT payments directly and then forward the information to your billing service.

If you currently receive payments to your practice location and you are not sure you want your billing service to be able to access payments, you do not need to change this process. Some physician practices are concerned about billing service "stability" and like receiving both the ERAs and payments directly and then providing that information to the billing service so they can post payments.

Some physician practices use a lock box to accept payer check payments. A lock box is typically an address with your bank to which payments are sent, and the bank then posts these payments to your account. If your practice currently uses a lock box, you should discuss with both your bank and your billing service the most optimal way to continue as you move to EFTs. However, you may choose to retain your lock box for patient payments, especially if your practice is located in a crime-prone area and you do not want checks mailed to your office.

4. How will I be able to access the ERAs from the health insurer?

Talk with both your billing service and the health insurer to determine all the available ways they can provide access to the ERAs. Make sure you know how your practice will be able to access this information and integrate it into your practice work flow before signing an EFT agreement with a health insurer.

5. Will the billing service charge any additional costs or fees?

Many billing services include this service as part of their standard billing fee. However, some companies may charge a small administrative fee for handling the application process. The most common fee structures billing services use is a percentage of gross collections, a flat per-claim fee or a combination of the two. Additional administrative or accounting services are often offered at a flat hourly rate or monthly retainer.

- If charging a percentage of collections, the billing service would probably only charge a percentage for claims that the billing service directly assisted in collecting payment.
- If the billing service charges a percentage of total practice collections, it is a percentage of not only what the billing service collects but also of co-pays, deductibles and other monies collected at your practice.
- Be sure to ask your billing service up front whether there are any additional fees for EFT/ERA set up and understand the turnaround time for setting up each of the applications.
- Make certain that a reconciliation process is in place between you and your billing service to ensure that what is receive in your bank account is received at the billing service in the form of an ERA.

Questions to ask a clearinghouse before signing an EFT agreement

If you have an agreement with a clearinghouse to submit and receive your practice's electronic transactions, you will need to coordinate with that entity if you desire to participate in a health insurer's electronic remittance advice (ERA) and electronic funds transfer (EFT) program. Following are some important questions to clarify with your clearinghouse before signing an EFT agreement with a health insurer.

1. How do I initiate the ERA/EFT process with each of my contracted health insurers?

Your practice's contracted clearinghouse will be able to assist you with the ERA enrollment process with your contracted health insurers. Some clearinghouses will be able to assist you with your EFT enrollment process as well, regardless of whether they will be directly receiving the EFT payment. If your clearinghouse is unable to assist you with EFT enrollment, you will need to contact the health insurer directly for its preferred EFT enrollment process. If you also contract with a billing service, it is best to contact the billing service for assistance as well.

Caution: Agreements entered into with health insurers can supersede the protections your bank has put in place. When in doubt, share your EFT agreement with your bank to determine whether your bank account protections will be waived through the agreement with the health insurer.

If you are concerned that a particular health insurer may be able to retrieve what they consider overpayments by simply debiting your bank account as stated above, share the agreement with the bank to determine what protections, if any, are available.

Keep in mind that a health insurer that previously reduced your next claim payment by an amount it believed was an overpayment without advanced notice when you received payments by paper check could similarly reduce the next claim payment arriving by EFT. Several states offer protection against auto take-backs without appropriate notice. Contact your state medical association for your state laws and provisions. AMA members can also visit www.ama-assn.org/go/nationalcontract to access the National Managed Care Contract Database to look up relevant state laws and provisions.

Additional EFT resources

Consult the resources "Questions to ask a bank before signing an EFT agreement" and "Questions to ask a billing service before signing an EFT agreement" for additional information you should discuss with your bank and billing service.

2. How do I make sure the health insurer submits the electronic remittance advices (ERAs) for EFT payments through my clearinghouse?

Once your practice decides to send and receive ERAs and EFTs, then you are required to complete a new set of electronic data interchange (EDI) enrollment forms for each governmental payer and private health insurer. Your clearinghouse has a unique "submitter identifier" that must be linked to your provider billing numbers in order to submit claims electronically and receive ERAs on your behalf. This will indicate to the various payers and clearinghouses that the ERAs should be redirected to the identified clearinghouse.

3. How will I be able to access the ERAs from the health insurer?

First you must understand how receiving EFTs and ERAs will affect your work flow. Then you should determine how and who should receive the HIPAA-compliant 835 payment/remittance advice transactions from the health insurer. Talk to your clearinghouse and the health insurer to determine all the available ways they can provide access to the ERAs. Make sure you know your practice will be able to access this information and integrate it into your practice work flow before signing an EFT agreement with a health insurer.

4. Will the clearinghouse charge any additional costs or fees?

Typically, clearinghouses charge physician practices for their services. General fees can include a start-up fee, monthly flat fee and/or per-claim transaction fee based on the volume of your claims. The clearinghouse might introduce new features, so you should confirm which services—such as EFT transactions—are included in the contracted fees. New features could include inquiries for eligibility and claims status as well as secondary billing services. Ask whether the clearinghouse offers a "trial period." In addition, be aware that clearinghouses generally charge payers a monthly flat fee and/or a claim transaction fee based on volume. Be sure to consider any associated costs for support services.

5. Will I need to change my bank account?

To participate in EFT, you can continuing using your current bank account or create a new bank account. Whichever option you choose, you will need to provide the health insurer with your preferred bank account information as instructed in the EFT enrollment form.

6. How are overpayments addressed with EFT?

If you are concerned that a particular health insurer may be able to retrieve what they consider overpayments by simply debiting your bank account as stated above, share the agreement with the bank to determine what protections, if any, are available.

Keep in mind that a health insurer that previously reduced your next claim payment by an amount it believed was an overpayment without advanced notice when you received payments by paper check could similarly reduce the next claim payment arriving by EFT. Several states offer protection against auto take-backs without appropriate notice. Contact your state medical association for your state laws and provisions.

AMA members can also visit www.ama-assn.org/go/nationalcontract to access the National Managed Care Contract Database to look up relevant state laws and provisions.

7. What is the average time lag between the receipt of an ERA and the posting of the EFT payment to my bank account?

The average time between the receipt of an ERA and the posting of the EFT into your bank account can vary depending on each payer's and your bank's business practices. Your practice's contracted clearinghouse will be able to assist you in understanding the typical EFT delivery processing timelines by payer. This information may be available in the clearinghouse's enrollment information. Otherwise, be sure to discuss directly with the clearinghouse and/or payer to determine how this average time lag will affect your practice work flow.

Information technology solutions: Consider the potential savings

The potential elimination of manual processes with the introduction of information technology (IT) solutions could allow physician practice staff to increase their focus on auditing, appeals, and collection of claim payments from health insurers. By streamlining the manual processes, you can ensure that practice staff can perform revenue-enhancing functions, such as making sure the appropriate payment for providing medical services and procedures is received from patients and health insurer.

Potential savings for the physician practice

A Milliman USA study projected potential savings per electronic transaction for a typical physician practice. The breakdown of this estimated savings is shown in Figure 1. Several factors will affect the actual savings versus the potential savings for a physician practice, including the number of electronic claims submissions and number of electronic transactions.

Figure 1: Potential savings for the physician practice

Transaction	Savings per transaction	Transactions per year	Estimate annual savings
Claims	$ 3.73	6,200	$ 23,126
Eligibility	$ 2.96	1,250	$ 3,700
Referrals	$ 6.23	1,000	$ 6,230
Pre-authorizations	$ 8.71	200	$ 1,742
Payment posting	$ 1.48	6,200	$ 9,176
Claim status	$ 3.33	620	$ 2,064.50

Source: *Electronic Transaction Savings Opportunities for Physician Practices*, Milliman USA, revised Jan. 2006.

Potential savings for the health insurer

Health insurers may also realize savings from conducting electronic transactions. Figure 2 reveals the potential savings for a typical health insurer from every transaction that is electronically submitted, processed and adjudicated by the health insurer. The actual savings a health insurer realizes will vary.

Practice management systems, billing services, clearinghouses and other intermediaries may have the capabilities to conduct electronic standard transactions. The use of electronic connectivity may translate into real-time claim auto-adjudication, eligibility verification, referrals, and pre-authorizations, as well as other important transactions that occur between the physician practice and the health insurer. The American Medical Association (AMA) encourages electronic connectivity for claims transactions and fully supports the development, adaptation and implementation of national health technology standards.

Figure 2: Potential savings for the health insurer

Transaction	Average cost per claim		
	Paper	Electronic	Savings
Claims	$ 2.20	$ 1.14	$ 1.06
Eligibility verification	$ 3.19	$ 0.75	$ 2.44
Referrals/preauthorization	$ 2.54	$ 1.04	$ 1.50
Remittance advice/explanation of benefits	$ 0.81	$ 0.38	$ 0.43
Claim status	$ 3.19	$ 0.38	$ 2.81

Source: “Electronic Transactions between Payors and Providers: Pathways to Administrative Cost Reductions in Health Insurance,” John. L. Phelan, PhD., Milliman, Inc., May 2010

Information technology solutions

Following is a sample of some of the IT solutions currently available to help physician practices streamline their manual processes. The costs associated with implementing IT solutions can range from a few thousand to several thousand dollars. We encourage your practice to establish an IT solutions assessment team to analyze your practice’s current work flow and gather recommendations from other physician practices to begin the process of requesting proposals from vendors that meet your practice specifications. After completing these steps, you should determine whether the time is right to begin automation of some or all of your practice’s manual processes.

Appointment reminder

- Patient reminders of upcoming appointments

Appointment scheduling

- Schedule patient appointments electronically
- Schedule recurring appointments electronically

Credentialing

- Enter physician information electronically into one centralized system for quick and easy retrieval for health insurer credentialing requests

E-prescribing

- Write prescriptions digitally and send the orders electronically to a pharmacy

Electronic claims

- Audit claims automatically for potential coding errors
- Receive quicker claim payment from health insurers
- Track accounts receivable electronically
- Transmit claims electronically through a claims submission clearinghouse or billing service, or submit them directly to the health insurer

Electronic health records

- Access detailed patient demographic and clinical information before, during and after the patient visit, including:
    - detailed medical history
    - diagnosis
    - hospitalizations
    - immunization records
    - injuries
    - medication lists
    - patient demographics
    - X-rays and other images
    - progress notes
    - surgeries
- Decrease the cost per-patient chart
- Reduce storage space for paper medical records
- Reduce staff time devoted to locate, store and transport the patients' medical records and related documentation
- Improve documentation and reporting of diagnosis and treatment

Eligibility and benefits verification

- Review patient eligibility and verify benefits online before submission of the patient's claim

Managed care tracking

- Electronically track:

  - claim approvals and denials
  - pre-certification requests
  - referrals and patient cost-sharing responsibilities
- Alert practice staff to unauthorized visits or services

Handheld electronics

- "Communicate" with a medical record via a wireless connection to a handheld, pocket-sized device such as a smartphone.

Health insurer websites are a great resource for physicians and their practices often allowing:

- Access to patient information, including benefits and eligibility
- Submission of referrals
- Access to fee schedules or rates
- Access to the health insurer's medical payment policy
- Electronic claim submission, claim status and payment information
- Electronic claim confirmation receipt
- Online re-credentialing

Case study

Case study: How can your practice realize significant cost savings by using the integrated Health Insurance Portability and Accountability Act (HIPAA) electronic health care transactions?

The suite of HIPAA-mandated electronic or electronic data interchange (EDI) health care transactions, including electronic claims, eligibility request and response, and electronic remittance advice, are designed to work together to create greater efficiencies for both the health care provider and the health insurer. By adopting an integrated approach to using the HIPAA EDI transactions, information gained from one transaction becomes useful information in the next transaction.

Did you know that the increased use of practice automation tools, such as electronic eligibility verification, has the potential to save physicians and health insurers nearly $30 billion per year?[1]

The below case study offers some typical scenarios that show how the use of the HIPAA EDI transactions save time and reduce administrative waste.

Example Case

A 50-year-old male arrives at his primary care provider (PCP) complaining of a persistent cough. The front office staff has the patient complete all the necessary paper work and sends an Accredited Standards Committee **ASC X12 270 health care eligibility benefit inquiry** transaction (eligibility request) to the patient's health insurer with Service Type Code 30 (Health Benefit Plan Coverage).

Below is the information returned to the practice from the **ASC X12 271 health care eligibility benefit response (eligibility response):**

- Subscriber/Patient Name, Member Identification (ID) Number, Date of Birth (DOB), Gender, Address (and any other demographic info needed for other EDI transactions);
- Health insurer coverage is active, also includes the beginning date of coverage in the plan and name of the plan.
- PCP Name (confirms that the provider is the patient's PCP)
- Plan includes active coverage for Medical Care, Hospital, Emergency Services, Pharmacy, Professional (Physician) Visit – Office and Urgent Care.

[1] U.S. Healthcare Efficiency Index, **www.ushealthcareindex.com**

- The patient's insurance plan covers 80% of his medical services, leaving his patient financial liability at 20%.

- The patient has a $5,000 In Network Deductible, with $4,000 remaining to be met and a $10,000 Out of Network Deductible with $10,000 remaining to be met.

- The patient has a $10 Co-payment for each Professional (Physician) visit in the office.

This information is electronically stored into the practice management software system (PMS) which also updates the patient's record.

The patient is diagnosed with pneumonia and the PCP would like to have the patient admitted to the hospital. Knowing that the patient's health insurer requires a prior authorization for this type of admission, the office sends an **ASC X12 278 health care services review – Request for review** prior authorization transaction directly to the health insurer. This request will contain the Subscriber/Patient Name, Member ID number, DOB, Gender and address received from the health insurer's **ASC X12 271 health care eligibility benefit response.**

The health insurer returns an **ASC X12 278 health care services review – Response** which approves the admission to the in-network hospital requested by the physician or other health care provider.

The office then sends an **ASC X12 837 health care professional claim** for the office visit directly to the health insurer, once again using the Subscriber/Patient Name, Member ID Number, DOB, Gender and Address received from the health plan **ASC X12 271 health care eligibility benefit response.** Included in that claim is a unique Patient Control Number assigned by the physician's PMS.

After a week, the practice submits an **ASC X12 276 health care claim status request** to determine claim status using the Subscriber/Patient Name and Member ID number received from the health insurer **ASC X12 271 health care eligibility benefit response** and used in **the ASC X12 837 health care professional claim** as well as the Patient Control Number used in the **ASC X12 837 health care professional claim**. The health insurer returns an **ASC X12 277 health care claim status response** acknowledging that the claim was received and is currently in process.

Fourteen days after sending the **ASC X12 837 health care professional claim**, the practice receives an **ASC X12 835 health care claim payment/advice** transaction containing the adjudication information for the office visit, including the Subscriber/Patient Name, Member ID Number and the Patient Control Number used in the **ASC X12 837 health care professional** allowing the practice to upload or post the adjudicated claim information into its PMS as well as the electronic remittance advice (ERA) reconciliation information indicating the payment for the claim was included in an electronic funds transfer (EFT) payment to the physician practice's bank account.

Understanding the HIPAA standard transactions: The HIPAA Transactions and Code Set rule

Many physician practices recognize the Health Information Portability and Accountability Act (HIPAA) as both a patient information *privacy* law and electronic patient information *security* law. However, HIPAA actually encompasses a number of regulations. As such, the federal government has published several "rules" that instruct the health care industry on how to comply with the law. HIPAA began as a bipartisan effort to provide portability of health insurance benefits to individuals who left the employment of a company that provided group health insurance (that is why HIPAA is the "Health Information Portability and Accountability Act").

In response to this initiative and the additional expense of billing individuals for continuation of coverage, the health insurance industry requested standardization and promotion of electronic health care transactions. The health insurance industry argued that electronic health care transactions would reduce administrative cost and justify the new costs associated with premium billing and administration that portability would create. The health insurance industry's request became the "administrative simplification" component, called "Health Insurance Reform: Standards for Electronic Transactions." These standards include the form and format of electronic transactions as well as their content—such as the Current Procedural Terminology (CPT®)* and the International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) codes. This document refers to this part of HIPAA as the "Transaction and Code Set rule" (HIPAA TCS rule).

Note: The Department of Health and Human Services (HHS) published two HIPAA final rules on January 16, 2009. One of these rules adopted version 005010. See the section "Upgrading to newer standards" for more information.

*CPT is a registered trademark of the American Medical Association.

The HIPAA standard transactions are designed to improve your claims management revenue cycle

The push for administrative simplification originated in the health insurance industry as a way to standardize the claims processing and payment cycle, the eligibility and enrollment cycle, and even health insurers' premium payment. However, use of the HIPAA standard transactions holds tremendous promise for physicians as a way to reduce their costs and overhead expenses associated with billing, collections, referral authorization, eligibility and other related components of the claims management revenue cycle. Physician practices that use the HIPAA standard electronic transactions are saving **thousands of dollars annually** by using the standard transactions. Access the resource "Follow that Claim" for more information on these savings.

How is the HIPAA TCS rule related to the HIPAA Privacy and Security rules?

At the time HIPAA was enacted, the Internet was fast becoming a standard method of commerce and communication in its own right. Many people were concerned that promoting electronic health care transactions, especially over the Internet, would expose sensitive and confidential patient information to hackers and other entities that did not have authorized access. Thus, the HIPAA Privacy rule was developed as an attempt to establish a federal standard for protecting individually identifiable health information. During the development of the HIPAA Privacy rule, it became apparent that patient information was created, maintained and stored in electronic formats on computers and not just as paper records or oral communications. This realization resulted in the HIPAA Security rule, which deals with the administrative, physical and technical requirements that safeguard electronic protected health information that is maintained on computers and similar devices.

It is important to note that HIPAA does not require physicians to conduct transactions electronically, but if a physician practice conducts any of the transactions named under HIPAA, the physician practice must submit these transactions according to the HIPAA standards. Furthermore, under a separate but related law known as the Administrative Simplification Compliance Act (ASCA), most physician practices are required to submit their claims to Medicare electronically and in accordance with the HIPAA standards (physician practices that contain fewer than 10 full-time equivalents are exempt).

What are the standard transactions?

Table 1: Electronic transactions considered standard under HIPAA: Between a physician practice and health insurer

Common name of transaction	Formal name of transaction	Transaction function
Claims	ASC* X12 837 Health Care Claim: Professional	Submitting claims to the health insurer
EOB/RA	ASC X12 835 Health Care Claim Payment/Remittance Advice	Receiving payment and/or remittance information from the health insurer for claims
Claim status request	ASC X12 276 Heath Care Claim Status Request	Contacting the health insurer about the status of a claim
Claim status response	ASC X12 277 Health Care Claim Status Response	Receiving information about the status of a claim from the health insurer
Patient eligibility request	ASC X12 270 Health Care Eligibility Benefit Inquiry	Contacting the health insurer about the eligibility and benefits of a patient
Patient eligibility response	ASC X12 271 Response	Receiving information from the health insurer about the eligibility and benefits of a patient
Authorization request	ASC X12 278 Health Care Services Review Information - Review	Sending a request for referral authorization or prior authorization for services for a patient
Authorization response	ASC X12 278 Health Care Services Review Information - Response	Receiving the response to a referral authorization or prior authorization request
Coordination of benefits	ASC X12 837 Health Care Claim: Professional	Determining payment responsibilities of the health insurer
Claims attachments†	ASC X12 275 Additional Information to Support a Health Care Claim or Encounter	Submitting claims attachments to the health insurer
First report of injury†	ASC X12 148 First Report of Injury, Illness or Incident	First report of injury to the health insurer

* Accredited Standards Committee

† Note: Standards for claims attachments and first report of injury have not yet been adopted.

Table 2: Electronic transactions considered standard under HIPAA: Between an insurance purchaser and a health insurer or between health insurers		
Common name of transaction	**Formal name of transaction**	**Transaction function**
Membership enrollment	ASC X12 834 Benefit Enrollment and Maintenance	Enrolling members in the health plan
Premium payments	ASC X12 820 Payment Order and Remittance Advice	Making premium payments for the health insurance coverage
Coordination of benefits	ASC X12 837 Health Care Claim: Professional	Coordination of benefits

What is ASC X12?

Health care industry groups develop standards, which the government then adopts. The HIPAA TCS rule adopts the standards for the transactions included in Table 1: Electronic transactions considered standard under HIPAA: Between a physician practice and a health insurer and Table 2: Electronic transactions considered standard under HIPAA: Between an insurance purchaser and a health insurer or between health insurers, as defined by the Accredited Standards Committee (ASC) X12. Recognized by the Department of Health and Human Services (HHS), ASC X12 is a standards development organization, accredited by the American National Standards Institute (ANSI) that focuses on developing standards for electronic information exchanges. ASC X12 has subcommittees that focus on different industries, such as finance, government, transportation and insurance. The AMA is a member of ASC X12 and participates on the Insurance Subcommittee (X12N). X12N develops and maintains standards related to the insurance and health care industries, such as the standards in Table 1 and Table 2.

What is an implementation guide?

The X12N subcommittee has documented the specific details of each HIPAA standard transaction in an implementation guide. The implementation guide is a very detailed document that defines:

- The electronic format of the transaction
- The details of the necessary data and where to place them in the electronic file
- The details of the various code sets that are used and how to use them
- The kind of electronic “envelopes” each transaction requires (these are sometimes known as the headers and control documents)
- References for the different code sets used in that transaction

The implementation guides are complex documents. For example, the current ASC X12 837 professional version for health care claims is 704 pages in length. The primary entities that use these

guides are: (1) health insurers (to program their software to process claims); (2) clearinghouses (to ensure that claims conform to the implementation guides); and (3) physician practice management software vendors (to program their software to capture information and transmit a compliant standard transaction or receive and process a standard transaction). The first version of the guides that the government adopted is known as version 004010.

HIPAA mandated standard transactions and operating rules

The current HIPAA mandated standard transactions for health care are the 005010 version of the ASC X12 standard transactions found in Table 1. All HIPAA-covered entities (health insurers, physicians and clearinghouses) were required to adopt and comply with the 005010 version of these standard transactions by January 1, 2012.

Additionally, HIPAA requires all covered entities to support requirements of the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Operating Rules that include:

- Connectivity rules
- Eligibility and Claim Status Operating Rules: Phase I and Phase II (Federally mandated via Final Rule)
- EFT & ERA Operating Rules: Phase III (Federally mandated via Final Rule); and
- Uniform reporting of CARC and RARC Operating Rules Phase III (Federally mandated via Final Rule).

Visit CAQH CORE website and access the Nationally Mandated Operating Rules Timeline with Associated Resources web page for more information about upcoming operating rules.

Implementing the updated version of the standard transactions and operating rules requires changes to practice management systems, changes to some data reporting requirements, potential changes to work flow processes and staff training.

Another recent regulation will also require the replacement of the ICD-9-CM code sets with International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) on October 1, 2014.

What are companion guides?

The health care industry has provided a method of communicating how an individual "trading partner" will implement an ASC X12 standard; the collection of this implementation information is known as a "companion guide." (A trading partner is a vendor with which a physician practice exchanges patient data or protected health information electronically in the course of its operations.) The ASC X12 implementation guides provide some flexibility in terms of data elements that can be used, although version 005010 drastically reduces the flexibility. The complexity of these transactions also sometimes requires health insurers to implement these transactions in phases as they update their internal software or business processes.

Health insurers publish companion guides that provide detailed information about their specific implementation of a HIPAA standard transaction and any pertinent requirements. These guides are usually available for review on health insurers' websites. Health insurers may change and modify their companion guides whenever they make a change to their implementation of a HIPAA standard transaction. For example, a health insurer might begin to use situational codes (many health insurers did not require situational codes when they first implemented HIPAA standard transactions). The materials in the implementation and health insurers' companion guides contain important information

for physician practices' software vendors. These vendors are frequently the ones that ensure physician practices are able to send their claims and other transactions according to the X12N standards and the health insurer requirements.

Companion guides in real life

When a health insurer changes its companion guide, a change is reflected in its implementation of the HIPAA standard transactions. Some of these changes could result in claims processing delays or denials. For example, if your practice management system does not currently use some of the HIPAA-required designated situational information (such as birth weight), and a health insurer decides to place a claim edit on this field, the claim will be denied.

How will you know whether a companion guide change is going to affect you and suddenly result in a claim rejection? It is virtually impossible for most physician practices to audit the companion guides of each contracted health insurer and then remain on top of the constant changes. There are more than 1200 companion guides.

A practical solution is to choose a practice management software, billing service or a clearinghouse that can assure you it can perform this function. You may also need to continue to update and modify your practice management software to ensure compliance with the health insurers' claim submission requirements.

Determine whether your vendor will be staying up to date on health insurer claim submission requirements. If not, or if you are a small physician practice, consider a claims clearinghouse approach, in which the clearinghouse commits to remaining current. You can also implement a system of routine review of companion guides, at least for the health insurers with which you submit the most claims.

How is the HIPAA TCS rule enforced?

October 16, 2003 was the deadline for HIPAA-covered entities (health insurers, physicians and clearinghouses) to comply with HIPAA's electronic transaction and code set provisions, and January 1, 2012 was the adoption date for use of the updated transactions, version 005010. However, some health insurers still have not adopted all of the standard transactions or implemented the code set edits and rules. For example, some health insurers may accept an electronic claim (ASC X12 837) but do not create an electronic remittance advice (ASC X12 835) or do not provide an electronic claims status transaction (ASC X12 276/277). This inconsistency creates a burden for physician practices.

As a best practice, you should be able to check eligibility electronically (ASC X12 270/271) with every health insurer. By implementing this best practice, you will receive electronic documentation of patient eligibility and avoid excessive telephone wait times. Consider how using these electronic transactions would improve your practice efficiency.

The AMA strongly encourages health insurers to use the HIPAA standard transactions. The HIPAA regulation states, "If an entity requests a health plan to conduct a transaction as a standard transaction the health plan must do so." 45 CFR §162.925

Non-compliance by a health insurer

Health insurers and self-insured employer-sponsored health insurers are covered entities under HIPAA. As such, they must comply with all applicable HIPAA regulations, including the HIPAA TCS rule. A health insurer that does not accept a standard transaction or produce one of the transactions for which it is responsible (such as the electronic remittance advice) is in violation of the law.

The AMA urges physicians to ask health insurers with which they work to comply with HIPAA. If the health insurers do not comply, you can file a complaint with the Centers for Medicare & Medicaid Services (CME).

CMS has stated it will focus on voluntary and complaint-driven enforcement. If you are ready to use the standard transactions and you have a health insurer that is not cooperating, consider filing a complaint.

What are the typical areas in which health insurers are not compliant, and how does this non-compliance increase physician practice costs?

The health insurer does not accept ASC X12 837 Health Care Claim. As a result, your practice's clearinghouse must convert your electronic claim to paper and send that paper claim to the health insurer. Both of these steps cost you time and money in getting the claim paid.

The health insurer does not offer Health Care Claim Payment/Remittance Advice ASC X12 835. If your practice management software supports this feature, the health insurer's non-compliance will prevent you from automatically posting the payment. It will also prevent you from using electronic denial management and other electronic payment reconciliation tools that dramatically improve payment recovery.

The health insurer does not accept the Health Care Eligibility Verification Benefit Inquiry ASC X12 270 or provide the Response ASC X12 271. When the only option is the health insurer's Web portal, your practice will not realize the full cost savings of direct electronic transactions and will incur additional expense by manually re-entering eligibility request information on multiple health insurers' websites and verifying eligibility through phone calls.

The health insurer does not accept Health Care Services Review Information (referral authorization) ASC X12 278. If your practice performs these two functions manually by phone or fax or through the health insurer's Web portal, your practice will not achieve the cost savings possible through performing these functions electronically.

The health insurer does not accept the Health Care Claims Status Request ASC X12 276 or provide the Response ASC X12 277. Avoiding the follow-up time of manually tracking claims will reduce administrative time and expense for your practice.

The health insurer does send the Health Care Claim Payment/Advice ASC X12 835, but the information in the transaction is inaccurate or doesn't follow the business rules of the standard. This results in added costs for custom programming by your vendor for that health insurer, or prevents you from automated posting, and prevents you from using tools for denial management.

Health insurer Web portals

Using health insurer Web portals is not as cost efficient as using the HIPAA standard transactions. Using a Web portal requires your practice to re-key data that is already in your practice management system and visit different Web portals for each health insurer. In addition, you have to re-key the response data received from the Web portal, such as referral authorization numbers, which could otherwise be posted electronically in your practice management system.

Your state may mandate the use of HIPAA standard transactions

States have begun to help in the enforcement effort by mandating that any health insurer doing business in their state use the HIPAA standard transactions. For example, Minnesota passed legislation that became effective in 2009 that requires health insurers and health care providers to use the standard transactions. This law requires the exchange of eligibility, claim, and payment and remittance advice information electronically. Other states are considering similar legislation. The push at the state level for adoption of the HIPAA standard transactions is aimed at reducing administrative costs associated with the claims management revenue cycle.

What are the HIPAA Transaction Code Sets?

The HIPAA TCS are a major component of each standard transaction. In many cases, the code sets are familiar to most physician practices (for example, CPT codes or ICD-9-CM codes). Code sets may also be ones that you do not actively choose during a patient encounter but are instead behind the scenes. Two examples of such code sets are Place of Service codes and relationship codes (the relationship of the patient to the insurance guarantor).

There are also many new codes that have been developed for the X12 transactions. For example, the X12 835 remittance now has standardized claims adjustment reason and remark codes. Using standardized codes for X12 835 remittance advice may provide a practice management system with the logic it needs to automatically and correctly post a payment.

When the code set is part of a transaction you submit, such as the electronic claim, eligibility request or claim status, it is important that you understand how the codes within the code set are used, and you should also have a way of entering these codes into your practice management software. When a code is contained in a transaction you receive, such as the electronic remittance advice, being familiar with the meaning of the code is helpful. But not every health insurer uses the code sets the same way. Some health insurers will use a very specific adjustment reason code and related remark code for each line item they adjudicate, while other health insurers may use more generalized codes. Some health insurers use codes that have been removed from the list and are no longer valid. This inconsistency makes your efforts to process an electronic remittance advice and determine the accuracy of the payment more difficult.

AMA tip

Visit www.ama-assn.org/go/reportcard to learn more about the inconsistency in use of the reason and remark codes with the AMA's National Health Insurer Report Card.

A number of different organizations maintain the code sets. The various X12 subcommittees maintain some of these code sets, and other organizations maintain other code sets. For example, the AMA maintains the CPT® codes, the National Uniform Claim Committee maintains the Health Care Provider Taxonomy code set and CMS maintains the Place of Service code set.

How can physicians improve practice efficiencies by using HIPAA standard transactions?

Steps you can take to improve practice efficiency

Using the HIPAA standard transactions can bring efficiency and cost savings to physician practices. If you are not sure how these transactions will help your practice or what you may need to do in preparation, a good place to start is conducting a brief internal assessment.

The **first step** of an internal assessment is to determine whether you are currently submitting or receiving any of the following transactions:

- ASC X12 837 Electronic Claims
- ASC X12 835 Remittance Advice
- ASC X12 270/271 Eligibility Benefit Inquiry and Response
- ASC X12 276/277 Claim Status Inquiry and Response

The requirement for the claims attachment standard transaction has not yet been adopted, but you should keep this future standard transaction in mind when evaluating your practice management system.

The **second step** of an internal assessment is to understand some basic information about your claims management revenue cycle process by answering the following questions:

- Do you use a billing service?
- Do you maintain your own billing software?
- If you create electronic claims, are they HIPAA-compliant standard transactions? Many older versions of practice management software that physician practices and billing services use do not create a standard transaction but instead rely on a clearinghouse to take the paper claims' print image or other format and convert those to electronic claims. This method is only a temporary solution.
- Do you use a clearinghouse? Does the clearinghouse offer any other transactions in addition to claims?
- Are you a specialty physician practice that might be impacted by the situational fields and new code sets?
- How much time and cost does your practice spend to manually verify eligibility, check claims status or manage referral authorizations?
- How much time does your practice spend posting manual remittance advice?

The **third step** of an internal assessment is to understand how well your practice management system vendor, billing service and/or clearinghouse supports the HIPAA standard transactions.

Practice management software and billing service vendor readiness

It is imperative to understand how your practice management software and billing vendors are complying with the HIPAA TCS rule. First, determine how many vendors are involved. For example, you might have one vendor for your billing and claims generation and another vendor for electronic eligibility or referral authorizations. Survey each vendor by asking them to complete the AMA vendor survey tool (available to AMA members)**.**

Clearinghouse readiness

If you currently use a clearinghouse, you should determine the clearinghouse's ability to provide standard transactions and the costs associated with providing those transactions. For example, some clearinghouses charge per physician and others per transaction. You should know how the clearinghouse(s) you are considering will charge your practice for services prior to selecting a clearinghouse as a solution. You should be aware that some clearinghouses that perform HIPAA standard transactions may also convert to paper any electronic claims that they cannot process. In some cases, the clearinghouse performs this conversion because it has not tested its HIPAA standard transactions with the health insurer. Sometimes it is more efficient to use the clearinghouse as a portal for standard transactions other than claims. Competent clearinghouses should provide a mechanism to receive the electronic remittance advice, submit an eligibility and benefits verification request, receive a response, and review the claim's status.

Glossary

Automated clearing house (ACH): An electronic funds transfer system governed by the National Automated Clearing House Association (NACHA) operating rules.

Accounts receivable: Money your patients, health insurers or others owe to your practice for services provided.

Adjusting entries: Entries usually made at the end of an accounting period to allocate income and expenditure to the period in which they actually occurred.

Cause: An action, event or force that produces or contributes to an effect or result. Also called causation.

CCD+ corporate credit or debit: This application can either be a credit or debit application in which funds are transferred between unrelated corporate entities or transmitted as intra-company cash concentration and disbursement transactions. This application can serve as a stand-alone payment, or it can support a limited amount of payment-related data. The CCD+ application is a HIPAA-compliant application.

Claims management revenue cycle: This process includes functionality of the following: reimbursement, fees and credentialing; registration, coding and charge capture; claims transmission and payment posting; insurance follow-up and patient follow-up; patient collections; and reporting.

Clearinghouse: An entity that serves as a data broker between the physician practice and the health insurer. The physician practice submits claims through the clearinghouse, and the clearinghouse is responsible for routing the claim to the health insurer.

CMS: The Centers for Medicare and Medicaid Services.

Code of Federal Regulations (CFR): The codification (organizing laws, rules or principles) of the general and permanent rules and regulations published in the Federal Register by departments and agencies of the federal government.

Credit: An entry to the record of an account that represents the transfer or placement of funds into an account.

Debit: An entry to the record of an account that represents a transfer or removal of funds from an account.

Debit block: A bank service that blocks unauthorized debits that would automatically withdraw monies and post to a designated account.

Debit filter: A bank service that automatically returns all ACH items for a designated account, except those that are pre-authorized.

Electronic data interchange (EDI): The structured transmission of data between organizations by electronic means.

Electronic funds transfer (EFT): The electronic transfer of funds into an account (credit) or from an account (debit).

Explanation of benefits (EOB): A paper explanation of benefits, usually received by mail with a paper check payment attached.

Electronic remittance advice (ERA): The electronic delivery of explanation of benefits information.

Federal Register (FR): The official journal of the United States government.

Health Insurance Portability and Accountability Act (HIPAA): Title II of HIPAA, known as the Administrative Simplification provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for physicians and other health care providers, health insurers and employers.

Internal control: A process usually set up by an organization's governing body, management or other staff to reasonably ensure objectives are achieved in operations, financial reporting and compliance. Typically this includes separation of duties for functions such as mail, payment posting, deposit and reconciliation.

National Automated Clearing House Association (NACHA): The Electronic Payments Association, a not-for-profit trade association that manages and enforces the rules for the ACH Network. NACHA maintains the NACHA operating rules.

NACHA Operating Rules: The body of work defining the requirements for all EFT transactions processed through the ACH Network. Any financial institution using the ACH Network agrees to be bound to these rules.

Offset: The ability of a bank to "offset" a debt from one account holder using funds from a separate account that might be shared by that holder. (Offsetting allows for counterbalancing and compensating.)

Positive pay: A banking feature that allows review of ACH debits before they are posted. The customer makes the decision to accept or return each individual debit. This feature requires vigilance on the part of the customer and same-day review.

Patient Protection and Affordable Care Act (ACA): Federal statute signed into law on Mar. 23, 2010. The law focuses on reform of the private health insurance market, providing better coverage for patients with pre-existing conditions, improving prescription drug coverage in Medicare and extending the life of the Medicare Trust fund by at least 12 years.

Practice management system (PMS): An electronic system generally used for patient scheduling and billing by electronic means.

Provider billing number: A unique identifier for physicians and other health care providers for use in the health care system. The National Provider Identifier (NPI) is the standard.

Regulatory compliance: The process by which business entities follow the laws of the state and/or regulator.

Service fees: A monetary charge added to a customer's bill or account for a service that has been provided by a business such as a bank.

Sweep account: A bank or brokerage account with balance earning interest, in which the available cash balance is automatically and regularly transferred into an investment that bears interest.

Transaction review: A bank service that allows online review and confirmation of ACH debit and credit transactions.

Zero balance account: A bank account in which a balance of zero is maintained by automatically transferring funds from a master account in an amount only large enough to cover checks when presented.