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HEALTH LAW ALERT
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HHS Adopts Electronic Funds Transfer "Operating Rules"

Rules Estimated to Cost Health Plans $1.3 Billion

Today, the Department of Health and Human Services (HHS) published an interim final rule amending the HIPAA Transactions Rule to adopt "operating rules" for electronic funds transfers and electronic remittance advice transactions. The Affordable Care Act, which requires HHS to adopt "operating rules" to supplement the implementation guides for each type of standard transaction, defines operating rules as "the necessary business rules and guidelines for the electronic exchange of information." HHS estimates that these rules will save health care providers $3.1 billion in administrative costs over ten years, but that implementation of the rules will cost health plans a net of $1.3 billion over that time.

The interim final rule adopts six operating rules drafted by the Committee on Operating Rules for Information Exchange (CORE) that apply to electronic funds transfers and electronic remittance advice transactions. The operating rules establish:

- The data elements and format a health plan must use to permit a provider to sign up for electronic remittance advice and electronic funds transfers;
- The specific "reason" and "remark" codes health plans must use in remittance advice to explain denials of or adjustments to claims in certain "business scenarios";
- Standards for linking an electronic funds transfer transaction to the applicable electronic remittance advice transaction; and
- Certain "infrastructure" requirements, such as a "connectivity safe harbor" and requirements for health plan companion guides.

The compliance date for the operating rules is January 1, 2014—the same date on which a health plan must begin to use standard electronic funds transfers to pay providers that request electronic payment.

The interim final rule is published at 77 *Federal Register* 48007 (click here). Comments on the adoption of the operating rules are due on or before October 9, 2012. Click here for my compilation of the HIPAA Administrative Simplification Rules incorporating the interim final rule (*see* second line under "Compiled Rules") (or see the "Resources" page at tbixbylaw.com). Click here to see the operating rules (see the six bullets below "Links to individual rules are available below").

EFT and ERA "Enrollment"

When a provider wishes to sign up for electronic payment or remittance advice from a health plan, the health plan must collect the provider's "enrollment" information in accordance with the operating rules. The health plan is required to collect specific information in a specific sequence, using a "controlled vocabulary"—specific terms each of which has a precise meaning.[1] Thus, a health plan cannot request the "Routing Number" of a provider's bank or the "Bank Routing Number." Rather, it must request the "Financial Institution Routing Number." Although health plans are not required to request all data elements listed in the operating rule, they will be prohibited from requesting data elements not provided for in the operating rule. Thus, "all health plan enrollment forms will be similar, and a provider will be able to identify and collect all the required data for . . . multiple health plan forms simultaneously."

A health plan will be required to make its enrollment process for electronic funds transfers and remittance advice available through an electronic mechanism that will be available to any trading partner—referred to as an "electronic safe harbor" for enrollment applications. The operating rules make clear that health plans may continue to offer paper enrollment applications and may offer other electronic alternatives than the "safe harbor." Health plans will also be required to "develop and make available . . . specific written instructions and guidance for the healthcare provider" submitting an enrollment application.

Reason and Remark Codes for Certain Business Scenarios

In electronic remittance advice, health plans currently may select among hundreds of combinations of "reason" and "remark" codes to explain adjustments to or denials of claims. As the operating rules explain, "[t]here is a high level of subjectivity to . . . the interpretation of the codes[, which] leads to a wide variety of code combinations used to address similar business situations." The operating rules therefore establish four common "business scenarios" (see box on next page) and limit the codes (and the combinations of the codes) that health plans will be permitted to use in electronic remittance advice. The operating rules do not, however, impose restrictions on the use of reason and remark codes in other "business scenarios."

Although the operating rules will impose significant limitations on the choice of codes health plans may use to describe a claim denial or adjustment, the operating rules will continue to allow flexibility in some cases. For example, when providing remittance advice indicating that additional information is necessary to adjudicate a claim due to missing, invalid, or incomplete documentation, a health plan must choose one of only eight "reason codes." But, the health plan may select among approximately 150 "remark codes" to provide detail to one of those reason codes—the code that indicates a "[claim] lacks

[1] The operating rules explain that the "controlled vocabulary reduces ambiguity inherent in normal human languages[,] ensures consistency[,] and is potentially a crucial enabler of semantic interoperability."

information [that] is needed for adjudication." On the other hand, the other seven "reason code" choices give plans no options for related "remark codes."

Linking EFT and ERA—"Reassociation Trace Numbers"

In adopting the Electronic Funds Transfer Rule, HHS determined that health plans must include a "reassociation trace number" in EFT transactions to enable health care providers to easily link the actual payment with the associated remittance advice (click here for my Health Law Alert on the subject). The operating rule requires health plans to include additional data elements to further facilitate the reassociation process. Health plans will also be required to "proactively inform the healthcare provider" during the provider's enrollment in the electronic funds transfer process that the provider must ask its financial institution to provide the "reassociation trace number" when reporting an electronic payment. Moreover, health plans will be required to send electronic remittance advice between three days before and three days after the date on which funds are electronically deposited in the provider's account.

Infrastructure Requirements

The operating rules address several "infrastructure" issues, designed to ease the industry's transition to increased use of electronic funds transfers. First, the rules will require health plans to provide a connectivity "safe harbor" to ensure all providers (and their clearinghouses) have the ability to conduct electronic remittance advice transactions with the health plan. Although HHS decided not to adopt a proposed operating rule that would require health care providers to send (and health plans to receive) "Acknowledgment" transactions, the agency nevertheless "strongly encourag[es] the industry to implement the acknowledgment requirements in the [proposed operating rules]."

Third, in order to ensure providers have sufficient time to transition to reconciliation of electronic remittance advice with electronic payments, health plans will be required to continue sending paper remittance advice for a minimum of 31 calendar days (or three payments) after a provider's

"Business Scenarios" to Which Operating Rules Apply

The operating rules restrict the use of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Reason Codes (RARCs) in four business scenarios. Those scenarios are:

- **Additional Information Required—Missing/Invalid/Incomplete Documentation** (Refers to situations where additional documentation is needed from the billing provider or an [electronic remittance advice] from a prior payer).
- **Additional Information Required—Missing/Invalid/Incomplete Data from Submitted Claim** (Refers to situations where additional data are needed from the billing provider for missing or invalid data on the submitted claim).
- **Billed Service Not Covered by Health Plan**.
- **Benefit for Billed Services Not Separately Payable**.

implementation of the electronic process. Finally, health plans will be required to use the CORE standardized template for companion guides when publishing a companion guide for electronic funds transfer transactions.

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