



Regulations & Guidance – HIPAA Administrative Simplification Operating Rules

<https://questions.cms.gov/faq.php?id=5005&rtopic=1851&rsubtopic=8597>

1. How do I, as a provider, get my payments via Electronic Funds Transfer (EFT)?

Health plans are required to deliver your health care claim payments via EFT through the Automated Clearinghouse (ACH) Network upon your request, in accordance with 45 CFR 162.925. This provision states that if an entity requests a health plan to conduct a transaction as a standard transaction, the health plan must do so. The ACH Network, which is administered by NACHA – the Electronic Payments Association, is the network through which the transaction must be sent in accordance with the regulations at 45 CFR 162.1602. Providers are encouraged to contact their health plans to enroll in their individual EFT programs. Operating rules, which were adopted for the HIPAA EFT transaction at 45 CFR 162.1603, include specific rules to support the data elements for EFT enrollment. These operating rules were adopted to make the enrollment for conducting the EFT transaction consistent across all health plans, which was not the case prior to their adoption. To obtain a free copy of the Phase III operating rules, go to the CAQH CORE website at <http://www.CAQH.org> (FAQ22289)

2. What fees may apply to the HIPAA Electronic Funds Transfer (EFT) transaction?

Fees that may apply to a HIPAA EFT transaction for a provider include a banking transaction fee, which is the small charge applied by the provider's bank. According to NACHA – the Electronic Payments Association, the typical bank fee is around \$.34 nationally. If providers contract with vendors for additional "value-added services" such as reassociation with the electronic remittance advice (ERA), they should be aware that other fees may be charged by those vendors. However, providers are not required to contract for these additional services. Value added services may include customer service, 24-hour hotline numbers, consolidation of payments, prompt payments, special output of the remittance advice, and other similar services. Providers and their financial management staff are encouraged to review vendor contracts and agreements, including opt-in/opt-out clauses, and ensure they have a thorough understanding of the value of the additional services and additional costs of the fees that will be assessed. Health plans that function as or use clearinghouses are prohibited from charging fees or costs for normal telecommunications in excess of the fees they incur when they directly transmit or receive a standard transaction, in accordance with 45 CFR 162.925(a)(5). (FAQ22297)

3. Can a health plan require a provider to accept Virtual Credit Card payments?

No. A health plan cannot require a provider to accept virtual credit card payments. In addition, payment vendors contracted by a health plan to conduct payment activities on their behalf are business associates of the health plan and, as such, are also not permitted to require providers to accept virtual credit card payments. A provider has the right to request that a health plan use the Electronic Funds Transfer (EFT) transaction. If a provider makes the request, the health plan must comply, in accordance with 45 CFR 162.925(a). This provision states that if an entity requests a health plan to conduct a transaction as a standard transaction, the health plan must do so. If a provider is concerned that a health plan or its business associate has failed to meet the requirements of the HIPAA regulations, a complaint may be filed through the on-line complaint system at <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Enforcements/FileaComplaint.html> (FAQ22285)

4. Is the use of virtual credit cards for health care claim payments covered by HIPAA transactions requirements?

No. HHS adopted Electronic Funds Transfer (EFT) standards that apply only to health care claim payments made via EFT through the Automated Clearinghouse (ACH) Network. Virtual credit card payments are made outside of the ACH Network and therefore are not covered by the HIPAA EFT standards. The ACH Network, which is administered by the National Automated Clearing House Association (NACHA), is the processing and delivery system for many EFT. If a provider requests to receive health care claim payments via EFT through the ACH Network, a health plan must comply with that request. Health plans should not charge providers communications fees for the use of the HIPAA EFT transaction, nor should health plans' payment vendors, which are business associates of the health plans, do so. Any fees charged to a provider for an EFT transaction are banking transaction fees, which should be applied only by the provider's financial institution. According to [NACHA](#), these fees are typically around \$.034 per transaction nationally. This amount is current as of 2017 information. (FAQ22281)

5. What fees may apply to the HIPAA Electronic Funds Transfer (EFT) transaction?

Fees that may apply to a HIPAA EFT transaction for a provider include a banking transaction fee, which is the small charge applied by the provider's bank. According to NACHA – the Electronic Payments Association, the typical bank fee is around \$.34 nationally. If providers contract with vendors for additional "value-added services" such as reassociation with the electronic remittance advice (ERA), they should be aware that other fees may be charged by those vendors. However, providers are not required to contract for these additional services. Value added services may include customer service, 24-hour hotline numbers, consolidation of payments, prompt payments, special output of the remittance advice, and other similar services. Providers and their financial management staff are encouraged to review vendor contracts and agreements, including opt-in/opt-out clauses, and ensure they have a thorough understanding of the value of the additional services and additional costs of the fees that will be assessed. Health plans that function as or use clearinghouses are prohibited from charging fees or costs for normal telecommunications in excess of the fees they incur when they directly transmit or receive a standard transaction, in accordance with 45 CFR 162.925(a)(5). (FAQ22297)

6. Can a health plan require a provider to use the health plan's own proprietary Claims Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) combinations?

No. A health plan cannot require a provider to use the health plan's proprietary Claims Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) combinations. All covered entities must comply with the adopted Phase III operating rule requirements, which include specific CARC and RARC combinations to be used in EFT or ERA transactions. Payers are allowed to use (proprietary) combinations of CARCs and RARCs that are not in the CORE Operating rule as long as those combinations do not conflict with or fall within the 4 business scenarios and the combinations allowable under those scenarios.

Suggested changes and/or additional combinations for regular CARCs and RARCs outside of the CORE Rules may be submitted using [the Washington Publishing Company's \(WPC\) change request form](#). These CARC and RARC lists are updated 3 times a year at WPC. However, any change requests for new CARC/RARC combinations allowable under the CORE Rules should be submitted to CAQH-CORE via the yearly Market-Based Adjustment process. These change requests should not be submitted to WPC. (FAQ22301)

7. What should a provider be aware of when updating or reviewing contracts for the HIPAA Electronic Funds Transfer (EFT) transaction?

When updating, renewing, or signing contracts with health plans for any services, including enrolling for EFT transactions, providers should carefully read all of the provisions to identify any additional or unexplained costs associated with special services from health plans, their business associates and sub-contracted vendors. In 2016, the Workgroup for Electronic Data Interchange (WEDI) published a white paper titled [Electronic Payments: Guiding Principles](#) which provides helpful guidance for both health plans and providers regarding language, transparency, and terminology. This document may be useful to covered entities when implementing the HIPAA EFT transaction. (FAQ22385)