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Administrative Simplification

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HIPAA Administrative Simplification Information Bulletin

June 10, 2022

Correction: Common Error Revealed by the Compliance Review Program

This information bulletin amends and replaces the one released under the same title on June 2, 2022 by removing an inadvertent reference to "priority payer" and revising language accordingly.

The National Standards Group (NSG), on behalf of the Department of Health and Human Services (HHS), conducts a Compliance Review Program as a proactive approach to achieving industry compliance with HIPAA adopted transactions, code sets, unique identifiers, and operating rules. HIPAA covered entities are randomly selected and the entity's transactions are tested for compliance with the adopted HIPAA standards. Based on recent findings from the Compliance Review Program, NSG found a number of violations related to the Health Care Claim Payment/Advice (835) document. To help covered entities avoid this error in the future, NSG is highlighting the correct way to utilize the **NM1 - Corrected Patient/Insured** segment on the **2100 Loop** of the **ASC X12N Version 5010 X 221 Health Care Claim Payment/Advice (835)** (from this point forward referred to simply as "835").

The 835 is intended to meet the particular needs of the health care industry for the payment of claims and transfer of remittance information. The 835 can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice from a payer to a payee, either directly or through a Depository Financial Institution (DFI) for electronic funds transfer (EFT).

One of the more common errors NSG identified involves the inclusion of unnecessary information in the 835 transaction. Several payers supply data in the **NM1 - Corrected Patient/Insured Name** segment unnecessarily, populating data such as a first, middle, or last name; organization name; or ID number that is no different than the data provided in the **NM1 – Patient Name or NM1 – Insured Name** segments.

The X12 TR3 Report, Implementation Guide (IG) states that the usage of the NM1 - CORRECTED PATIENT/INSURED NAME segment is for situational purposes. The IG states that the **NM1- Corrected Patient/Insured Name** segment is "required when needed to provide corrected information about the patient or insured. If not required by this implementation guide, *do not send*." (emphasis added).[1] In accordance with the IG this field should ***only*** be populated when the adjudicated patient/insured name or ID information is different than what was submitted on the claim in order to supply ***corrected*** information. If there is no correction being made, the IG explicitly states that data may not be populated in this segment.

[1] The Accredited Standards Committee (ASC) X12 Standards for Electronic Data Interchange Technical Report Type 3 - Health Care Claim Payment/Advice (835), April 2006, Washington Publishing Company, ASC X12N/005010X221, Section 2.4, pp. 143-145.

This error can be eliminated by adhering to the requirements of the adopted TR3 Report. We hope you find this information useful, and that it results in more efficient electronic health care transactions.

Should you have questions about this information bulletin, send inquiries to AdministrativeSimplification@cms.hhs.gov with the subject line: 2100 Loop Information Bulletin.