Compliance Review Program Reports

2019 Covered Entity Results to Date
July 31, 2020

Compliance Review Program Reports

Overview

The CMS National Standards Group (NSG), on behalf of the Department of Health and Human Services (HHS), administers the Compliance Review Program to ensure compliance with HIPAA Administrative Simplification rules for electronic health care transactions among covered entities. The following reports depict results of the 2019 Compliance Reviews.

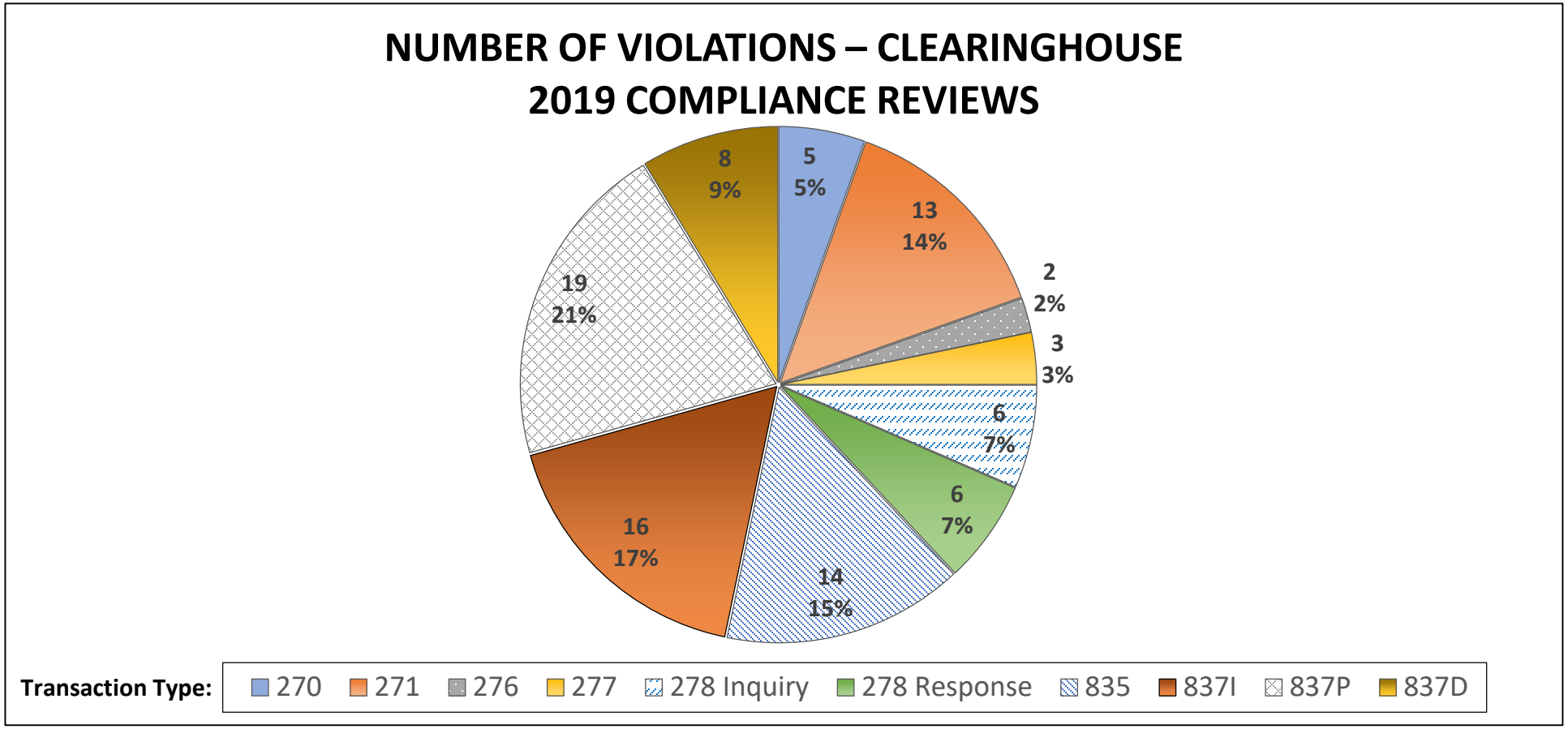
The first class of Compliance Review (CR) participants, was comprised of five health plans and four clearinghouses, randomly selected for participation.

The program inception, in April of 2019, had five participants begin their CRs; the remaining started in the subsequent months. To date, five have completed their CRs. The average to complete is just under ten months.

Violations of the Eligibility/Coverage/Beneficiary Information (271) transaction and the Health Care Claim Payment/Advice (835) transaction were discovered most often amongst the participants. There is one Request for Information (RFI) open with the X12 Committee for interpretation of the guides and potential violations discovered. However, with the open RFI aside, all completed reviews resulted in full compliance, without need for further enforcement action.

Number of Violations by Transaction and Covered Entity Type – Clearinghouses

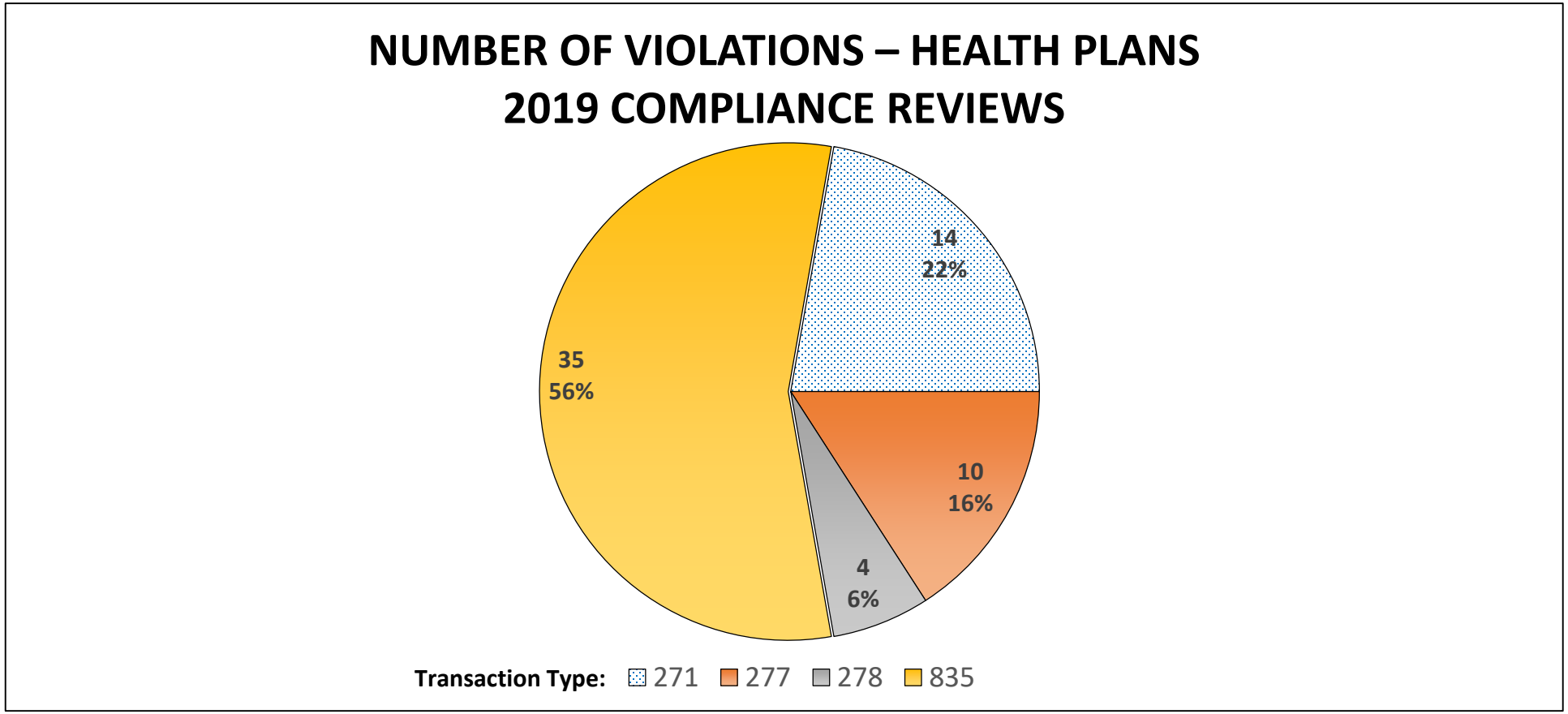
This chart shows the total number of unique violations, and percentage of the whole, discovered in the samples submitted by clearinghouses.



Transaction Types: 270 = Healthcare Coverage inquiry; 271 = Healthcare Coverage Response. 276 = Claim Status Inquiry; 277 = Claim Status Response. 835 = Healthcare Insurance Payment or Explanation of Benefits. 837D = Healthcare Dental Claim. 837I = Healthcare Institutional Claim. 837P = Healthcare Professional Claim.

Number of Violations by Transaction and Covered Entity Type – Health Plans

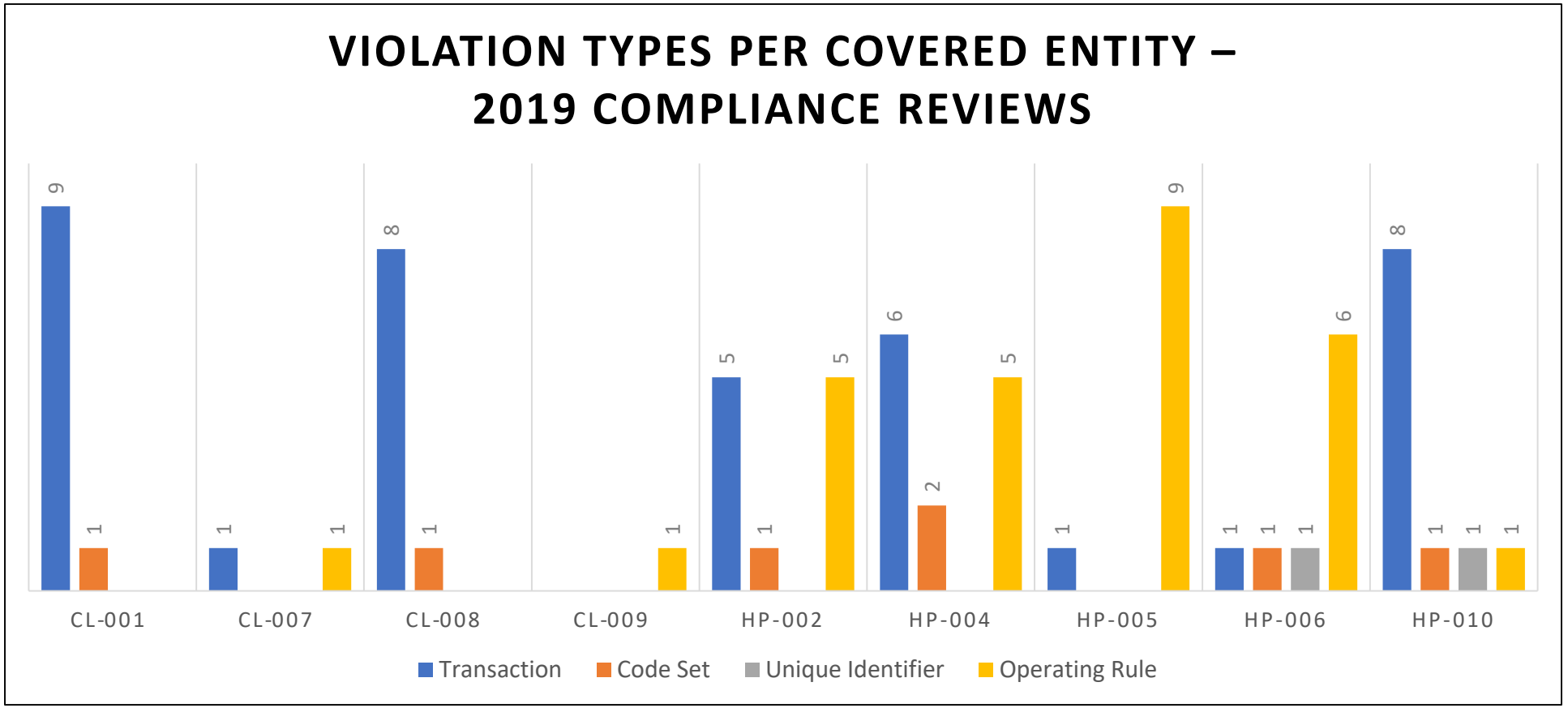
This chart shows the total number of unique violations, and percentage of the whole, discovered in the samples submitted by health plans.



Transaction Types: 271 = Healthcare Coverage Response. 277 = Claim Status Response. 278 Response = Payment Authorization Response. 835 = Healthcare Insurance Payment or Explanation of Benefits.

Number of Violations Per Compliance Review

This chart shows the number of violations by type the Covered Entity was charged with and submitted a Corrective Action Plan to resolve. A clearinghouse entity is designated with CL prior to the compliance review number; a health plan is designated HP.



Code Set – Code Set violations are those found where missing or invalid medical or non-medical codes are used in all transactions

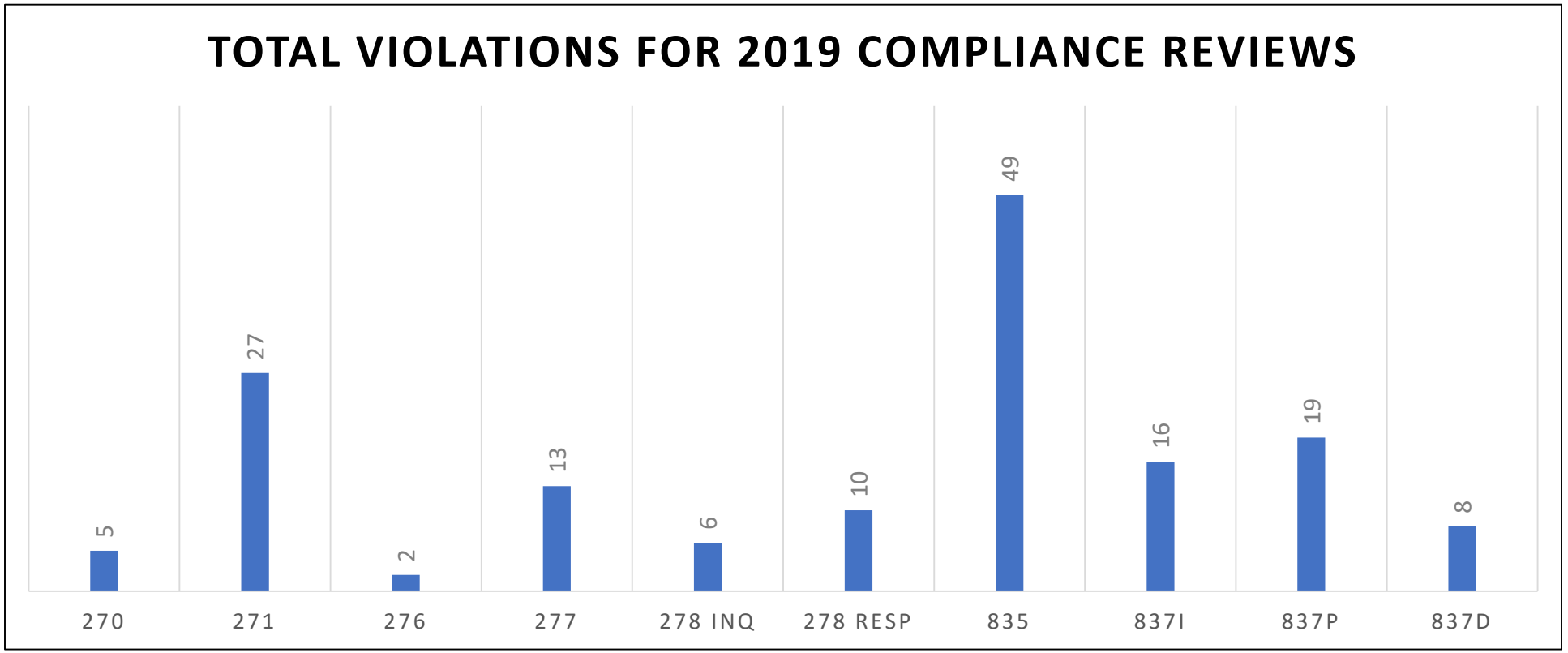
Transaction – Transaction set (e.g., 835, 834, 837) violations are those found where the entity does not follow the published Implementation Guides (TR3s) constructing the electronic file

Operating Rule – Operating Rule violations are identified when an entity attests or demonstrates that they are not complying with the specific business rules or guidelines defined by a specific operating rule

Unique Identifier – Unique Identifier violations are those found with invalid EIN or NPI used in healthcare transactions

Total Violations by Transaction Type

This chart displays the number of violations for all Compliance Reviews by ASC X12 5010 Transaction type.



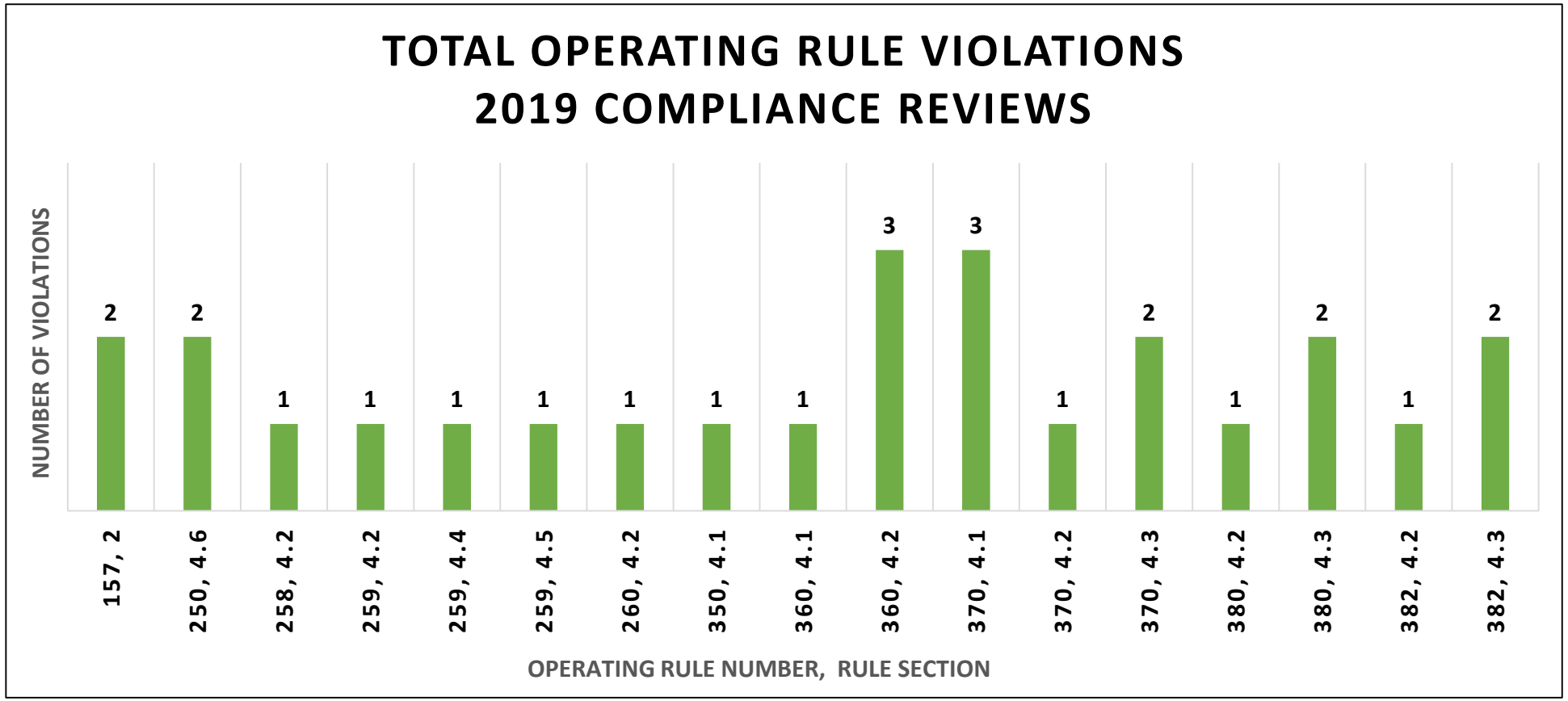
During the 2019 Compliance Reviews, hundreds of transactions were reviewed and tested. The transactions listed (270, 271, 276, 277, 278-Inquiry, 278-Response, 835, 837-Institutional, 837-Provider, and 837-Dental) displayed errors when tested with Edifecs' XEngine Testing Tool. The total number of unique violations that warranted corrective action are identified by transaction type.

See https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Transactions/TransactionsOverview for further information on **HIPAA Transaction Types**.

Note: The same error may occur multiple times during a compliance review for the covered entity, but only the first instance of a unique error is recorded for compliance review purposes.

Total Violations by Operating Rule

This chart displays the number of Operating Rule violations for all Compliance Reviews by CAQH CORE operating rule.

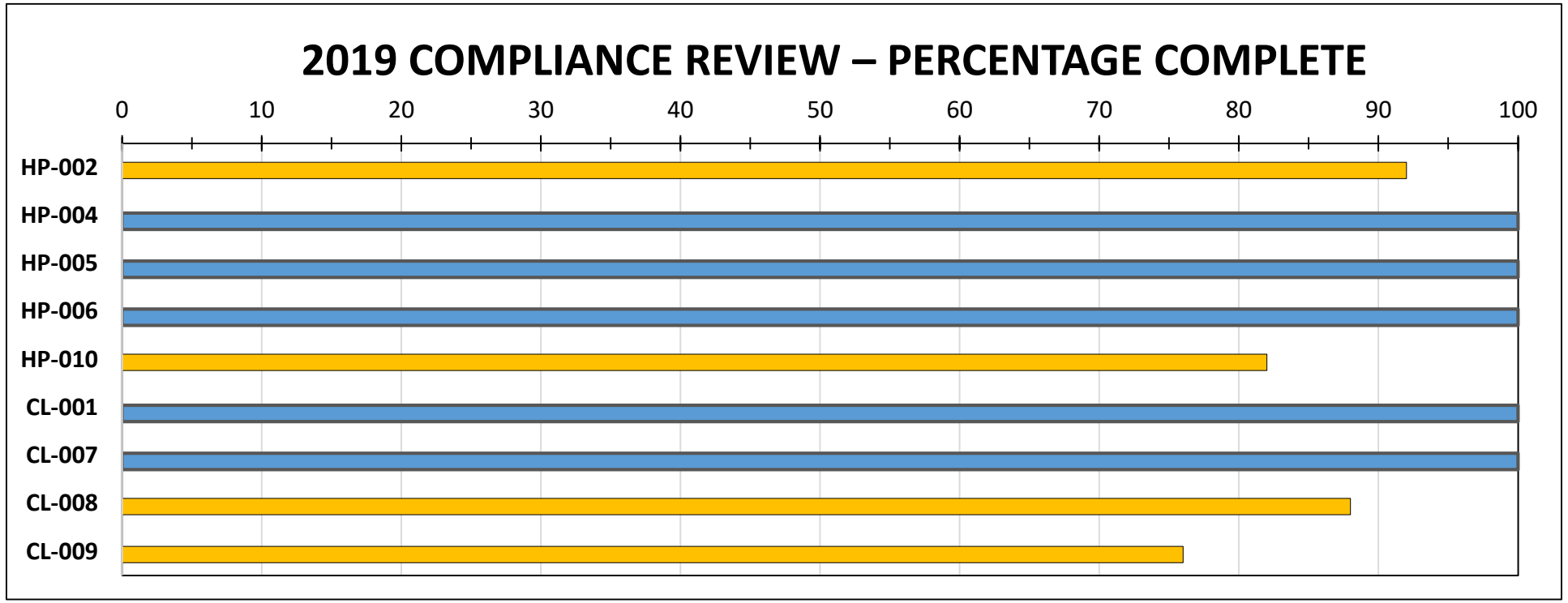


During the 2019 Compliance Reviews, each entity provided an Operating Rules Attestation and Verification that indicates their compliance with mandated operating rules. The total number of operating rule violations that warranted corrective action are identified by operating rule number and section.

See https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Operating-Rules/OperatingRulesOverview and https://www.caqh.org/core/operating-rules for more information on **Operating Rule compliance.**

Covered Entity by Compliance Review Phase

This chart displays how far each covered entity has progressed through the compliance review process.
A clearinghouse entity is designated with CL; a health plan is designated HP.

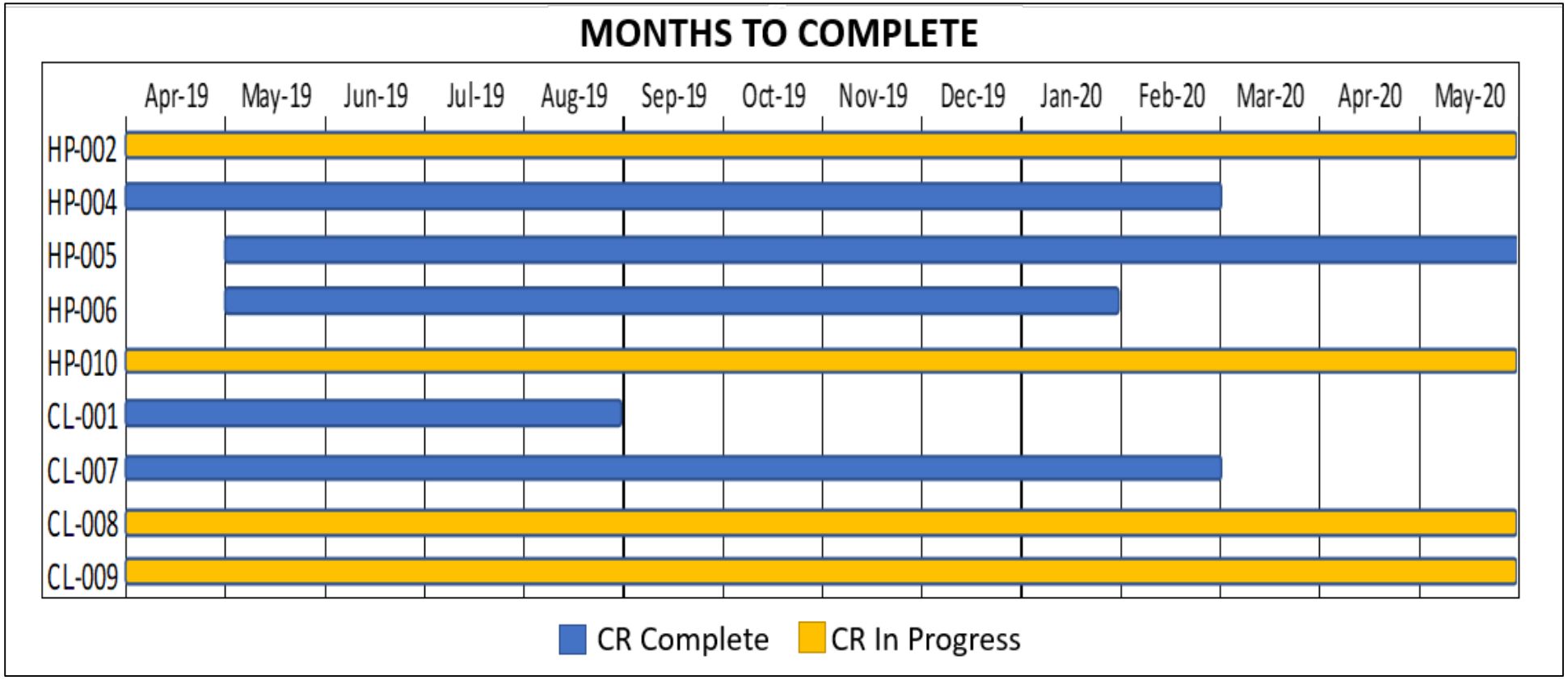


Phase	Percentage Complete	Description
I	0-15%	Select and train the Covered Entity (CE)
II	16-25%	Send the introductory package and receive CE's artifacts
III	26-50%	Conduct Assessment, prepare Draft Findings Report, send and review CE response upon receipt
IV	51-95%	Send Notice of Corrective Action, review and monitor CAP
V	96-100%	Verify violations are resolved; send Compliance Review Closure Notice

Months to Completion

This chart displays how long each covered entity took to complete their compliance review. The completion date is shown for all complete Compliance Reviews.

A clearinghouse entity is designated by CL; a health plan is designated HP.



Compliance Review start dates are staggered to provide the covered entities any assistance needed as they complete the Compliance Review package and submit the required artifacts.