2022 Compliance Review Program Findings

The CMS National Standards Group, on behalf of HHS, administers the Compliance Review Program. The program aims to promote compliance with HIPAA Administrative Simplification rules for electronic health care transactions. Our nation's health care system could save an estimated $25 billion[1] a year if all covered entities complied with required standards and operating rules for electronic transactions.

Since the program launched in April 2019, NSG has initiated 63 compliance reviews with 53 health plans, 4 clearinghouses, and 6 providers. As of May 2023, 40 of the 63 participants have successfully completed their compliance reviews. In May 2022, NSG released a Compliance Review Findings report summarizing common violations identified in the 18 compliance reviews that completed the assessment process between April 2021 and March 2022. An additional 24 compliance reviews completed the assessment process between April 2022 and March 2023. The updated insights in this report reflect the violation findings discovered within those 24 compliance reviews.

The transaction types experiencing the most violations during the 2020 and 2021 compliance reviews were specific to 835, 271, and 277 transactions. This changed slightly in 2022 as the most common transaction types experiencing violations are now 835, 271, and 834 transactions. CMS is sharing updated 2022 violation findings insights to inform and educate the industry, encourage widespread compliance, and assist covered entities with preparing for compliance reviews.

1 https://www.caqh.org/sites/default/files/2022-caqh-index-report%20FINAL%20SPREAD%20VERSION.pdf

Common Violations of Standards

1. 835 Electronic Remittance Advice (ERA) — 67 total violations requiring corrective action

Most common 2022 violations involved:

- The 2100 NM1 Corrected Patient/Insured Name segment. Covered entities should not include this information when it is the same as the information included in the Patient/Insured Name segment.
- The LQ segment in Loop 2110. Covered entities failed to include an appropriate Remark code in segment LQ when using a Claim Adjustment Reason Code (CARC).
- The 2100 Claim Payment Information loop, CLP Claim Payment Information, and CAS Claim Adjustment segments Covered entities failed to supply claim and service level adjustments to support patient responsibility amounts.

More information is available in 005010X221A1 X12 implementation guides (TR3 Report) for the 835 transaction. See guidance related to:

- Loop 2100, CLP05 Patient Responsibility Amount, CLP05 Industry Note, Front Matter Section 1.10.2.4 Claim Adjustment and Service Adjustment Segment Theory.

- Loop 2100, NM1 Corrected Patient/Insured NM103/04/05/09.
- Loop 2100, MIA/MOA Inpatient/Outpatient Adjudication Information segments, Situational Rule.
- Loop 2110, CAS Service Adjustment segment, Situational Rule, TR3 Note #2, Front Matter Section 1.10.2.4 Claim Adjustment and Service Adjustment Segment Theory.
- Loop 2110, LQ Health Care Remark Codes, Situational Rule.

Why it matters: 22% of all 835 transaction violations were due to covered entities providing unnecessary information or failing to include appropriate CARC/RARC codes when required. Sending redundant information is costly, inefficient, and increases the potential for error by the receiver. Including appropriate explanations for financial adjustments to convey information about remittance processing decreases inefficiencies and time spent processing transactions by minimizing the need for additional back and forth between providers and health plans and supports automated patient billing processes.

2. 271 Eligibility for a Health Plan Response — 36 total violations requiring corrective action

Most common 2022 violations involved:

- The 2110C/D Subscriber/Dependent Eligibility or Benefit Information loop. Covered Entities reported duplicate subscriber/dependent eligibility benefit information in the EB segment.
- The 2110/C/D Subscriber/Dependent Eligibility or Benefit Information loop. Covered entities used an improper structure for Subscriber/Dependent Eligibility or Benefit Information in the EB segment.
- The 2110C Subscriber Eligibility or Benefit Information loop. Covered Entities did not provide the minimum compliant responses as specified in Front Matter Section 1.4.7.1.

More information is available in 005010X279A1 X12 implementation guide (TR3 Report) for the 270/271 transactions. See guidance related to:

- 2110C/D, EB segment, TR3 Notes #3 & #4. X12 RFI numbers 2267, 2201, and 1422.
- Front Matter Section 1.4.7.1 #2, and X12 RFI numbers 1123 and 1718

Why it matters: 42% of all 271 transaction violations occurred in the 2110C/D loops and were due to covered entities reporting duplicate and/or improperly structured subscriber/dependent eligibility benefit information and failing to send the minimum compliant response. It is important to convey subscriber and dependent benefit information in a consistent and concise manner so that it can be efficiently received and interpreted. Returning a minimally compliant response communicates the financial liability and other benefit information with clarity for subscribers and dependents in a standardized way.

3. 834 Enrollment and Disenrollment in a Health Plan — 21 total violations requiring corrective action

Most common 2022 violations involved:

- Loop 2100A, LUI Member Language segment. Covered entities unnecessarily reported English as the member's primary language.
- Loop 2100C, NM1 Member Mailing Address segment. Covered entities reported the member mailing address in loop 2100C when it was the same as the residential address reported in loop 2100A.
- Loop 2000 INS Member Level Detail segment and Loop 2300 HD Health Coverage segment. Covered Entities used an incorrect Maintenance Type Code based on the Action Code reported in the BGN segment of the header record.

More information is available in 005010X220A1 X12 implementation guide (TR3 Report) for 834 transactions. See guidance related to:

- 2100A, LUI segment, Situational Rule.
- 2100C, NM1 segment, Situational Rule.
- 2000, INS Member Level Detail, INS03, Industry Note for Code value 030 (Audit or Compare). Front matter section 1.4.5 Updates, Versus Full File Audits, Versus Full File Replacements.
- 2300, HD Health Coverage, HD01, Code value 030 (Audit or Compare). Front matter section 1.4.5 Updates, Versus Full File Audits, Versus Full File Replacements.

Why it matters: 33% of all 834 transaction violations occurred in the 2100A/2100C loops and were due to covered entities unnecessarily reporting redundant information. Including redundant information decreases the efficiency of the transaction.

Common Violations of Operating Rules

Out of a total of 26 operating rules violations requiring corrective action in 2022, 9 (42%) were related to sections 4.1, 4.2, and 4.3 of Rule 370. These sections of the rule require that health plans and clearinghouses:

- Inform providers during Electronic Funds Transfers (EFT) and Electronic Remittance Advice (ERA) enrollment that they will need to contact their financial institution to arrange for the delivery of the minimum CCD+/835 data elements for reassociation.
- Track the elapsed time between when the 835 and EFT are issued.
- Have a written procedure for late or missing EFT/ERA transactions.

Preparing for a Compliance Review

Find out how to prepare for a compliance review. Visit the Administrative Simplification Enforcement website and check out the What to Expect Q&A and Prep Steps resources.