

2021 Compliance Review Program Findings

The [CMS](#) National Standards Group (NSG), 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 \$20 billion¹ 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 39 compliance reviews with 35 health plans and four clearinghouses. As of April 2022, 19 of the 39 participants have successfully completed their reviews. In July 2021, NSG released a [Compliance Review Findings](#) report summarizing common violations identified in the 15 compliance reviews that completed the assessment process between April 2019 and March 2021. An additional 19 compliance reviews completed the assessment process between April 2021 and March 2022. The updated insights in this report reflect the violation findings discovered within those 19 compliance reviews.

While the specific violations identified in this report vary slightly from those identified in the 2020 report, the three most common transaction types experiencing violations (835, 271, 277) remained constant. CMS is sharing updated 2021 violation findings insights with the purpose of informing and educating the industry, encouraging widespread compliance, and assisting covered entities with preparing for compliance reviews.

¹ <https://www.caqh.org/sites/default/files/explorations/index/2021-caqh-index.pdf>

Common Violations of Standards



1. **835 Electronic Remittance Advice (ERA) – 83 total violations requiring corrective action**

Most common 2021 violations involved:

- The N1 Payee Identification segment in Loop 1000B and the NM1 Service Provider Name segment in Loop 2100. Covered entities used an invalid National Provider Identifier (NPI) number.
- 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 SVC Service Payment Information segment in Loop 2110. Covered entities used invalid Healthcare Common Procedures Coding System (HCPCS) codes and modifiers in sub elements SVC01-02 and SVC01-03.

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

- Loop 1000B, N1 Payee Identification, N103/04 XX Code Note.
- Loop 2100, NM1 Service Provider Name, NM108/09 XX Code Note.
- Loop 2110, LQ Health Care Remark Codes, Situational Rule.
- Loop 2110, SVC, Service Payment Information, SVC01-01 through SVC01-07, and External Code Source 130.

Common Violations of Standards (continued)

Why it matters: 27% of all 835 violations were due to covered entities using invalid NPI numbers or HCPCS codes/modifiers or failing to include appropriate CARC/RARC codes when required. Following NPI guidelines, using correct HCPCS codes, and correctly using adjustment reason codes to convey information about remittance processing decrease inefficiencies and time spent processing transactions by minimizing the need for additional back and forth between providers and health plans, and increase the support for automated patient billing processes.



2. 271 Eligibility for a Health plan Response — 22 total violations requiring corrective action

Most common 2021 violations involved:

- The N3 Subscriber Address and N4 Subscriber City, State, Zip Code segments in Loop 2100C. Covered entities did not include N3 and N4 segments when the subscriber was the patient.
- The ISA Interchange Control Header. Covered entities used invalid information in the ISA06 Interchange Sender and ISA08 Interchange Receiver ID segments when the U.S. Federal Tax Identification Number (30) qualifier was used in ISA05 and/or ISA07.

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

- Loop 2100C, N3 Subscriber Address, N4 Subscriber City, State Zip Code, and X12 RFI #1934.
- EDI Control Directory, Control Segments, ISA - Interchange Control Header, ISA05/06, and ISA07/08.

Why it matters: 32% of all 271 violations were due to covered entities excluding required information or citing values unrelated to qualifiers used within the previous element. Accurately identifying the subscriber within the eligibility/verification transaction is a key to streamlining business processes since many EDI transactions rely on the verification of eligibility provided here as a prerequisite for conducting subsequent transactions, such as the health care claim.



3. 277 Health Care Claim Status Response — 14 total violations requiring corrective action

Most common 2021 violations involved:

- The Loop 2000C HL Service Provider Level and Loop 2000D HL Subscriber Level segments. Covered Entities used a value of 0 in the HL04 Hierarchical Child Code segment of Loop 2000B and should not have included subordinate HL segments in Loops 2000C/D.

Common Violations of Standards (continued)

More information is available in 005010X212 X12 implementation guides (TR3 Report) for the 276/277 transactions. See guidance related to:

- Loop 2000B/C/D, HLO2 Hierarchical Parent ID Number
- HL04 Industry Note

Why it matters: 14% of all 277 violations were due to covered entities improperly structuring the 277 rejection response. Using properly structured 277 responses eliminates unnecessary information and supports Administrative Simplification through reducing inefficiencies and time spent processing transactions by minimizing the need for additional back and forth between providers and health plans.

Common Violations of Operating Rules

Out of a total of 63 operating rules violations requiring corrective action in 2021, 15 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 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.

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