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 $16 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 conducted 20 compliance reviews with a mix of clearinghouses and health plans. As of March 2021, 8 of the 20 participants have completed their reviews.

To help covered entities prepare for compliance reviews, CMS is releasing the following lists of the most common issues and violations found during reviews.

1 https://www.caqh.org/sites/default/files/explorations/index/2020-caqh-index.pdf

Common Violations of Standards

1. Health Care Claim Payment/Advice — 43 total violations requiring corrective action

- **Most common violation involved** the NM1 Corrected Patient/Insured segment in Loop 2100. Covered entities unnecessarily included either a first, middle, or last name, or organization name or ID number in the segment.
- **More information** is available in 005010X221A1 X12 implementation guides (TR3 Report) for the 835 transaction. See guidance related to Loop 2100, NM1 Corrected Patient/Insured, NM103/04/05, and the NM109 Situational Rule.
- **Why it matters:** 28% of all 835 violations were due to covered entities including unnecessary information in their transactions. Removing unnecessary data reduces the chance for errors and can help transactions be completed more quickly.

Common Violations of Standards (continued)

2. Health Care Eligibility Verification Response — 17 total violations requiring corrective action

- **Most common violation involved** the EB segment of Loops 2110C/D. Covered entities used an improper structure for Subscriber/Dependent Eligibility or Benefit Information.
- **More information** is available in 005010X279A1 guides (TR3 Report) for the 271 transaction. See guidance related to Loops 2110C/D in the EB segment, along with TR3 Note #3 and X12 RFI #2267.
- **Why it matters:** 35% of all 271 violations were due to covered entities inefficiently reporting benefit information. Streamlining data reporting can speed transactions and reduce the chance for errors.

3. Health Care Claim Status Response — 7 total violations requiring corrective action

- **Most common violation involved** the incorrect use of external Revenue and Facility Type codes.
- **More information** is available in 005010X212 guides (TR3 Report) for the 277 transaction regarding external code source rules.
- **Why it matters:** 28% of all 277 violations were due to covered entities incorrectly using standardized industry code sets. When responding to a claim status inquiry with the 277, invalid codes can lead to inaccurate claim status information.

Common Violations of Operating Rules

Out of a total of 30 operating rules violations requiring corrective action, 9 were related to the Payment Remittance Reassociation CCD+/835 Rule. This rule requires that health plans and clearinghouses:

- Inform providers 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.