LEGAL ADVICE FOR HEALTH PLANS

HEALTH LAW ALERT
March 25, 2019

CMS Increases Scrutiny of Electronic Transactions

Agency Launches "Compliance Review Program"

Today, the Centers for Medicare and Medicaid Services[1] published an Information Bulletin announcing a "Compliance Review Program," under which CMS "will conduct periodic reviews [of] randomly selected [health plans and health care clearinghouses] to assess their compliance" with the standards for electronic transactions, associated code sets, and applicable Operating Rules. The agency plans to select nine (9) entities for Compliance Reviews next month.

The standards for electronic transactions are established under the HIPAA Transactions Rule (45 C.F.R. Part 162). Health plans, health care providers, and health care clearinghouses are subject to these requirements when they exchange claims, eligibility, remittance advice, and other transactions using electronic media (*i.e.*, transactions not conducted on paper). Although the Rules have been in effect since 2003, they have previously been enforced only through complaints filed by an interested party.

A description of the Compliance Review Program is published on the CMS website and is available here. CMS provides information about the Transactions Rule and applicable standards on its website (click here).

Requirements for Electronic Transactions

Under the HIPAA Transactions Rule, health insurers and other health plans are required to conduct transactions in a standard electronic format if they conduct the transaction in paper (or another) form. The requirement applies to all transactions a health plan conducts with any trading partner. Thus, for example, if a health plan accepts paper claims from a provider, the health plan ***must*** accept standard electronic claims from the provider on request. Similarly, if a health plan pays a provider by check, the health plan ***must*** allow the provider to

[1] The Centers of Medicare and Medicaid Services within the Department of Health and Human Services (and, specifically, the Division of National Standards within CMS) is responsible for enforcing the HIPAA Transactions Rule.

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obtain payment through electronic funds transfer (EFT)—even if the provider is ***not*** in the health plan's network.

The transactions subject to the requirements include:

- **Health care claims** or equivalent encounter transactions (the standard is the ASC X12N 837 transaction);

- **Eligibility for a health plan** transaction (the standard is the ASC X12N 270/271 transaction);

- **Remittance advice** transactions (the standard is the ASC X12N 835 transaction);

- **Electronic Funds Transfer (EFT)** transactions (pursuant to NACHA Operating Rules and tied to the ASC X12N 835 transaction);

- **Health care claim status** transactions (the standard is the ASC X12N 276/277 transaction); and

- **Referral Certification and Authorization** transaction (the standard is the ASC X12N 278 transaction).

Health plans must also comply with "Operating Rules" adopted by CMS that apply to four of the transactions listed above. For example, the Operating Rules for electronic remittance advice (ERA) and Electronic Funds Transfer (EFT) require health plans to use specified standards in creating applications for providers to register to conduct ERA and EFT transactions. Moreover, health plans must make these applications available in electronic form. The Operating Rules for eligibility inquiries mandate that a health plan's response to the provider making an inquiry include (among other things) the member's "financial responsibility for co-insurance, co-payment and deductibles" (including the balance of the member's remaining deductible) as well as the dates of a member's eligibility. And health plans that publish "Companion Guides" for their trading partners must use a standardized format for these documents.

Web-Based Transactions (Direct-Data Entry)

The CMS bulletin does not address whether the Compliance Reviews will include evaluation of health plans' web-based systems for exchanging eligibility, claims, claim status, and other transactions with providers—referred to by the Transactions Rule as "Direct Data Entry" or "DDE" transactions. The Transactions Rule requires these web-based DDE systems to "use the applicable data content and data condition requirements" that are used in the standard transactions. Thus, a web-based system for submitting claims (for example) must collect all of the same data elements that are submitted in a standard ASC X12N 837 claims transaction.

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