THOMAS D. BIXBY
LAW OFFICE LLC

LEGAL ADVICE FOR HEALTH PLANS

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CMS Issues HIPAA Transactions Rule Compliance Review Program Findings

Violations of Electronic Remittance Advice Standards are Most Common

Last week, the Centers for Medicare and Medicaid Services (CMS) posted updated findings of its HIPAA Transactions Rule Compliance Review Program. The Program is intended to "to promote compliance with HIPAA Administrative Simplification rules for electronic health care transactions" that health plans conduct with health care providers (and other covered entities—clearinghouses and other health plans). CMS "has initiated 39 compliance reviews with 35 health plans and four clearinghouses." The findings relate to 15 completed Compliance Reviews, in which CMS reported over 180 violations.

Violations related to Electronic Remittance Advice (ASC X12 835 transactions) that health plans send to health care providers made up at least 54% of these violations, including violations of related Operating Rules. The most common 835 transaction violations CMS found include health plans' failure to use valid National Provider Identifiers (NPIs), appropriate Remittance Advice Remark Codes (RARCs), and valid HCPCS codes in the transactions. In addition, health plans failed to comply with Operating Rules that require that the health plan:

- Notify a provider that it will need to contact its bank to arrange for the delivery of information to allow the provider to "reassociate" an electronic funds transfer (EFT) payment with electronic remittance advice. This notice must be provided when the provider enrolls in the health plan's process for receiving electronic remittance advice, EFTs, or both.

- Track the time between sending an electronic remittance advice (835 transaction) and making payment by electronic funds transfer (EFT).

- Have a written procedure for addressing a provider's report of a late or missing electronic funds transfer (835) transaction or EFT payment. These procedures "must

be delivered to the healthcare provider during its EFT and [electronic remittance advice] enrollment with the health plan."

The Operating Rules also require health plans to pay providers by electronic funds transfer (EFT) upon request. This requirement applies to out-of-network providers, as well as in-network providers (but does not require payment that is not otherwise due).

Violations of several of these requirements are easy to fix—adding language to an already-existing website page or form, for example. Health plans may want to evaluate compliance with these requirements in order to minimize the likelihood of regulatory scrutiny. Click here for the CMS findings.

Background on the HIPAA Transactions Rule

The HIPAA Transactions Rule (45 C.F.R. Part 162), which went into effect in 2003, is not as well-known as the HIPAA Privacy, Security, and Breach Notification Rules. Nevertheless, violations of the Transactions Rule are subject to the same penalty provisions that apply to the other HIPAA Rules. (Click here for a table showing current Civil Money Penalty amounts.)

The Transactions Rule adopts standards for nine transactions (see list below). The Rule also adopts "Operating Rules" for several of the standard transactions. When a health plan electronically conducts with a health care provider (or, in some cases, with another party) a transaction that qualifies as one of the transactions listed below (based on the regulatory definition of the applicable transaction), the health plan must use the standardized format to do so. Moreover, if a provider (or another party) requests the health plan to conduct a transaction using the standard format (rather than on paper, for example), the health plan is required to do so.

The transactions that are subject to the Rule (and the standards adopted for those transactions) are:

1. **Health Care Claims or Equivalent Encounter** transactions (ASC X12N/005010X222, 223, and 224 (837), which are separate standards for, respectively, (a) Professional claims; (b) Institutional claims; and (c) Dental claims);
2. **Eligibility for a Health Plan** transactions (ASC X12N/005010X279 (270/271);
3. **Referral Certification and Authorization** transactions (ASC X12N/005010X217 (278);
4. **Health Care Claim Status** transactions (ASC X12N/005010X212 (276/277);
5. **Enrollment and Disenrollment in a Health Plan** transactions (ASC X12N/005010X220 (834);

6. **Health Care Electronic Funds Transfers (EFT) and Remittance Advice** transactions (ASC X12N/005010X221 (835);

7. **Health Plan Premium Payments** transactions (ASC X12N/005010X218 (820); and

8. **Coordination of Benefits** transactions (ASC X12N/005010X222, 223, and 224 (837), which are separate standards for, respectively, (a) Professional claims; (b) Institutional claims; and (c) Dental claims);

9. **Medicaid Pharmacy Subrogation** transactions (the Batch Standard Medicaid Subrogation Implementation Guide, Version 3, Release 0 (Version 3.0), July 2007, National Council for Prescription Drug Programs).

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For more information, please contact Tom Bixby at (608) 661-4310 or TBixby@tbixbylaw.com

Thomas D. Bixby Law Office LLC
(608) 661-4310 | www.tbixbylaw.com