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Administrative Simplification

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# HIPAA Administrative Simplification Frequently Asked Questions

July 14, 2022

## Guidance Letter 2022-04 - Health plans' payment of health care claims using Virtual Credit Cards (VCCs) and adopted Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards for Health Care Electronic Funds Transfers (EFT) and Electronic Remittance Advice (ERA) transactions; 45 Code of Federal Regulations (CFR) §§ 162.1601 and 162.1602(d) FAQs

### Question

Based on the clarifications in Guidance Letter 2022-04, regarding Health Care Electronic Funds Transfers (EFT) and Electronic Remittance Advice (ERA) transactions and Virtual Credit Cards (VCC), can the health care industry conclude that the act of charging fees, in and of itself, for EFT and ERA transactions is prohibited under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)?

### Answer

No. 45 CFR § 162.925(a)(2) provides that a health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction. Guidance Letter 2022-04 clarifies that if a health plan conditions sending EFT and ERA transactions using the adopted standards on a provider's acceptance of (which may include payment for) unwanted payment or reassociation services, this may be construed as adversely affecting the transaction or the provider because the transaction is a standard transaction. Therefore, while there may be circumstances in which a health plan, or its business associate, charging fees could be considered adversely affecting a transaction or entity because it is a standard transaction, the guidance letter does not speak to whether charging fees to conduct standard transactions is, in and of itself, a violation of the HIPAA requirements.

Should a provider believe that a health plan's actions or inactions are adversely affecting the provider or the transaction because the transaction is a standard transaction, the provider may file a complaint with the Centers for Medicare & Medicaid Services (CMS) National Standards Group (NSG) through the Administrative Simplification Enforcement Testing Tool (ASETT).

## Question

If a health plan pays providers via VCC payments, must the health plan comply with a provider's request to send health care payments via EFT through the Automated Clearing House (ACH) Network instead of VCC?

## Answer

Yes. If a provider requests that a health plan make payments for health care through the ACH Network using the adopted EFT standards, 45 CFR § 162.925(a)(1) requires the health plan to comply with the request. Note, however, that in order to receive EFT payments through the ACH Network and receive ERAs, a provider must enroll to conduct EFT and ERA transactions with each health plan that the provider bills.

## Question

If a provider requests that a health plan transmit remittance advice information using the adopted ASC X12 835 standard, must the health plan comply with the request?

## Answer

Yes. If a provider requests that a health plan transmit remittance advice information using the adopted ASC X12 835 standard, 45 CFR § 162.925(a)(1) requires the health plan to comply with the request. Note, however, that in order to receive EFT payments through the ACH Network and receive ERAs, a provider must enroll to conduct EFT and ERA transactions with each health plan that the provider bills.

## Question

What payment methods does the ASC X12 TR3 835 standard for ERA transmissions support?

## Answer

Version 5010 of the ACS X12 835 standard, as specified at 42 CFR § 162.1602, is the standard adopted for ERA transmissions. This standard requires health plans to identify a payment method for an ERA's corresponding payment by using a "Payment Method Code." Version 5010 includes Payment Method Codes that identify corresponding payments made through the ACH Network, by check, and by wire transfer,[1] but not by VCC.

## Question

If a provider requests that a health plan send health care payments via paper check, must the health plan comply with the request?

[1] The Accredited Standards Committee (ASC) X12 Standards for Electronic Data Interchange Technical Report Type 3, "Health Care Claim Payment/Advice (835), April 2006, Washington Publishing Company, 005010X221, Section 2.4

## Answer

HIPAA does not require a health plan to comply with a provider's request for health care payments via paper check. The only payment method that HIPAA regulations require health plans to provide, when requested by a provider to do so, is EFT through the ACH Network, which requires the use of the NACHA CCD+Addenda standard and the ASC X12 835 TRN Segment Specification identified in 42 CFR § 162.1602.

## Question

If a health plan, or its business associate, provides remittance advice by posting it to a web portal, must the health plan comply with a provider's request to deliver remittance advice, using the adopted ASC X12 835 standard, to the provider or a clearinghouse acting on behalf of the provider?

## Answer

Yes. If a provider requests that a health plan transmit remittance advice using the adopted ASC X12 835 standard, 45 CFR § 162.925(a)(1) requires the health plan to comply with the request. Compliance with the ASC X12 835 standard includes transmitting the data in the ASC X12 835 format to the requesting health care provider or a business associate that is acting on behalf of the health care provider, which may include a clearinghouse. Nothing prevents a health plan, or a business associate acting on behalf of the health plan, from offering to process the standard ASC X12 835 transaction into a nonstandard format on the provider's behalf by posting the transaction to a web portal for viewing, but the provider may choose to reject that service and request delivery in the standard format to a business associate of the provider's choice.

## Question

Will NSG collect financial penalties from a health plan for the purpose of reimbursing providers for any labor costs providers experience due to the health plan's noncompliance with the adopted EFT and ERA standards?

## Answer

No. NSG does not have the authority to reimburse health care providers for any labor costs a provider experiences related to a health plan's noncompliance with HIPAA requirements. NSG, on behalf of the Department of Health & Human Services (HHS), administers HIPAA requirements related to transactions, code sets, unique identifiers, and operating rules. Administration of these requirements includes an enforcement program. If you are aware of a health plan that has failed to comply with a request to send EFT and ERA transactions using the adopted standards, you may file a complaint through the Administrative Simplification and Enforcement Testing Tool (ASETT). Enforcement actions taken to address non-compliance are determined on a case-by-case basis in accordance with the applicable regulatory authority. Should NSG impose a Civil Money Penalty (CMP), collections from such CMPs must be deposited with the Treasury of the United States, in accordance with 42 U.S.C. 1320a–7a(f)(4).

## Question

Does a provider have to be affiliated with a health plan, or part of a health plan's network, in order to receive EFT and ERA transactions using the adopted standards?

## Answer

No. A provider does not have to be part of a health plan's network, or otherwise affiliated with a health plan, in order to receive EFT and ERA transactions using the adopted standards. The guidance letter clarifies that HIPAA does not provide for any exceptions to the requirement that health plans conduct a transaction as a standard transaction when requested to do so (42 C.F.R. § 162.925(a)(1)). Therefore, a health plan cannot deny a request for payment using the adopted EFT and ERA standards based on a provider's affiliation with the plan. Note, however, that in order to receive EFT payments through the ACH Network and receive ERAs, a provider must enroll to conduct EFT and ERA transactions with each health plan that the provider bills.