CY 2025 Complaint Enforcement/Compliance Review Analysis Report

The Centers for Medicare & Medicaid Services (CMS) National Standards Group (NSG), acting on behalf of the U.S. Department of Health and Human Services (HHS), administers the Enforcement and Compliance Review Program to promote adherence to the Health Insurance Portability Accountability Act (HIPAA) standards for electronic health care transactions. These standards are intended to reduce administrative burden, improve operational efficiency, and support nationwide interoperability.

Complaint Annual Findings:

During calendar year 2025, we received 140 complaints against various entities for investigation.

The top complaints submitted during CY 2025 include the following:

1. 835 Health Care Claim Payment/Advice: Complaints submitted regarded delayed delivery of Electronic Remittance Advice. In some cases, providers were given paper remittance advice or asked to log into a portal to view payment details.
   Tip: Failure to provide timely standard remittance advice is inconsistent with HIPAA requirements and the intent to streamline electronic health care transactions and reduce administrative burden.
2. 837 Health Care Claim (Professional): Health plans required providers to submit information that is not part of the standard electronic claim format. As a result, providers experienced incorrect denials and delays in payment.
   Tip: Under HIPAA Administrative Simplification requirements, health plans must accept and process the standard 837 transaction and cannot require additional data elements that are not part of the adopted standard.
3. 270 Eligibility, Coverage, or Benefit Inquiry: Trading partner refuses to conduct HIPAA-standard transactions.
   Tip: Under HIPAA Administrative Simplficiation provisions, if a covered entity requests a standard transaction, the health plan is required to accept and process it using the adopted standard format.

Compliance Review Annual Findings:

Across CY 2025 reviews, the most frequently identified areas of noncompliance involved the following electronic transaction types:

1. **835** – Health Care Claim Payment/Advice : Compliance reviews identified that some health plans are not meeting the requirements of the X12 835 Implementation Guide

(TR3) 005010X221A1. Specifically, certain plans failed to include the National Provider Identifier (NPI) in the 1000B NM1 Payee Identification segment when required.

Tip: Ensure the payee's NPI is included in the 1000B NM1 segment when required, in accordance with TR3 005010X221A1.

2. **278** – Health Care Services Review – Request for Review and Response: Under HIPAA and the NPI Final Rule, health plans must use NPIs as the standard identifier for health care providers in administrative and financial transactions. The TR3 requires the 1000B N103 element to contain the qualifier **"XX"** to indicate an NPI, and the N104 element to contain the payee's actual NPI. When an NPI is missing or incorrect, the Administrative Simplification Enforcement and Testing Tool (ASETT) flag(s) the transaction as non-compliant. These errors can lead to payment delays, reconciliation problems, and potential compliance actions.

   Tip: Use qualifier "XX" in N103 to identify the NPI and report the correct NPI in N104 for the provider.

3. **271** – Health Plan Eligibility and Benefit Response: Compliance reviews identified that some health plans are not utilizing the standard format for submitting transactions. Under Administrative Simplification requirements, health plans must use the adopted standard format correctly so that eligibility and benefit information can be processed electronically and consistently. Under Administrative Simplification provisions, health plans are required to use the adopted standard transaction format(s) (such as the X12 270/271 for eligibility and benefits) correctly. This ensures eligibility and benefit information can be processed electronically, consistently, and efficiently across the healthcare system.

   Tip: Submit transactions using the adopted standard format to ensure eligibility and benefit data can be processed consistently.

Helpful Tips:

- Validate that NPIs are accurate, complete, and in the correct fields prior to submission.
- Implement automated system edits to detect missing or invalid NPIs and format errors.
- Provide training to staff and trading partners on NPI usage and transaction standards to prevent recurring compliance issues.

Reminder: The ASETT tool is a free web-based tool that allows users to test their own electronic health care transactions and their trading partners' transactions for compliance with X12 or the National Council for Prescription Drug Programs' (NCPDP) implementation guides adopted as transaction standards under HIPAA.