01 BEGINNER

» Administrative Simplification: OVERVIEW

The purpose of this fact sheet is to provide an overview of administrative simplification.

The Office of E-Health Standards & Services (OESS), an office within the Centers for Medicare & Medicaid Services (CMS), is responsible for the administrative simplification section of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). OESS:

- Develops the regulations that adopt administrative simplification standards, operating rules, identifiers, and code sets
- Communicates the administrative simplification requirements to industry
- Is charged with enforcement of the administrative simplification requirements

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01

BEGINNER

What Is Administrative Simplification and Why Is It Necessary?

The United States spends over $150 billion annually on health care administration. For the average physician, two-thirds of a full time employee is needed to carry out billing and insurance related tasks. By creating standards for the way information is exchanged and handled, administrative transactions can be made more efficient and less time consuming, which lowers costs across the health care system.

In the general sense, administrative simplification includes any commercial or government initiative to reduce health care administrative costs. More specifically, administrative simplification is Section 1171 Part C of the Social Security Act, established by the HIPAA and amended by the Affordable Care Act.

The Affordable Care Act builds upon HIPAA with new and expanded provisions, including requirements to adopt:

- Operating rules for each of the HIPAA covered transactions
- A unique, standard health plan identifier
- A standard for electronic funds transfers (EFT) and health care claims attachments

Who Is Required to Comply?

The administrative simplification standards and operating rules apply to HIPAA covered entities. Covered entities include:

- Health care providers that conduct certain transactions in electronic form
- Health care clearinghouses
- Health plans

The Affordable Care Act also requires that health plans certify their compliance with the standards and operating rules, and increases penalties for noncompliance.

What are Operating Rules?

Operating rules are defined as "the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications."

In simpler terms, the operating rules are guidelines that help improve interoperability by making certain transactions more uniform. Operating rules define and bring consistency to areas including:

- Rights and responsibilities of all parties
- Transmission standards and formats
- Response time standards
- Liabilities
- Exception processing
- Error resolution

To date, operating rules have been adopted for the eligibility for a health plan, the health claim status, and the health care electronic funds transfers (EFT) transactions. The Committee on Operating Rules for Information Exchange (CORE) is the authoring entity for these operating rules and has tools and educational resources to assist HIPAA-covered entities in their implementation.

01 BEGINNER

What Are the Health Plan Identifier (HPID) and the Other Entity Identifier (OEID) and How Are They Used?

Health Plan Identifier (HPID)

The **health plan identifier** (HPID) is a standard identifier for health plans that will be used to identify health plans in the standard transactions. It is required to be used in the standard transactions, and it may also be used for any other lawful purpose, for instance on a health plan identification card.

Other Entity Identifier (OEID)

The **other entity identifier** (OEID) is an identifier for an entity that needs to be identified in the standard transactions, but does not have or is not eligible to obtain a national provider identifier (NPI) or an HPID, and is not an individual. OESS has tools and educational materials to assist entities in applying for HPIDs or OEIDs.

The ICD-10 Transition

On October 1, 2015, the ICD-9 (International Classification of Diseases, 9th Edition) code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets.

ICD-10-CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification /Procedure Coding System) consists of two parts:

1. ICD-10-CM for diagnosis coding
2. ICD-10-PCS for inpatient procedure coding

The transition to ICD-10 is occurring because ICD-9 produces limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

01 BEGINNER

Deadlines and Key Dates

January 1, 2012	ASC X12N **Version 5010** Standards
January 1, 2012	**NCPDP Version D.O** Retail Pharmacy Standards
January 1, 2012	**NCPDP Version 3.0** Medicaid Pharmacy Subrogation
January 1, 2013	Effective date for operating rules for **eligibility for health plan** and **health claims status transactions**
December 31, 2013	**Certification, Part 1** – Health plan must certify data and information systems are in compliance with applicable standards and operating rules for: • Eligibility for a health plan • Health claim status
January 1, 2014	Effective date of operating rules for health care **Electronic Funds Transfers (EFT) and remittance advice**
January 1, 2014	Effective date of standards for: • Electronic Funds Transfers (EFT)
November 5, 2014	Health Plans (Controlling Health Plan or CHPs) must obtain **Health Plan Identifier (HPID)** - small health plans have until November 5, 2015
October 1, 2015	**ICD-10 CM** and **ICD-10 PCS**
November 5, 2015	Small Health Plans must obtain HPID
December 31, 2015	**Certification, Part 2** – Health plan must certify that its data and information systems are in compliance with applicable standards and operating rules for: • **Health claims or equivalent encounter information** • **Enrollment and disenrollment in a health plan** • **Health plan premium payments** • **Referral certification and authorization** • **Health claims attachments**
January 1, 2016	Effective Date of operating rules for: • **Health claims or equivalent encounter information** • **Enrollment and disenrollment in a health plan** • **Health plan premium payments** • **Referral certification and authorization** Effective Date of standard and operating rules for: • **Health claims attachments**
November 7, 2016	Covered Entities must use HPID to identify health plans in transactions