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CENTERS FOR MEDICARE & MEDICAID SERVICES

02 INTERMEDIATE

» Online Guide to:

ADMINISTRATIVE SIMPLIFICATION

CENTERS FOR MEDICARE & MEDICAID SERVICES

eHR INCENTIVE PROGRAM

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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ABOUT THIS GUIDE

This guide is intended to provide health care professionals with an overview of Administrative Simplification Hyperlinks to the CMS website are included in the guide to direct you to more information and resources

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PART 1:
ADMINISTRATIVE SIMPLIFICATION BASICS

About Administrative Simplification

What is Administrative Simplification?

- By standardizing the way information is exchanged electronically, Administrative Simplification can reduce the clerical burden on patients, health care providers, and health plans.
- Administrative Simplification is required through the **Health Insurance Portability and Accountability Act (HIPAA)**
- HIPAA standardizes transactions through:
  - Format and data content or "standards"
  - Operating rules
  - Standard Identifiers
  - Code sets

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.

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PART 1:
ADMINISTRATIVE SIMPLIFICATION BASICS

About Administrative Simplification

Administrative Simplification requirements through the original HIPAA:

- The Administrative Simplification provisions of HIPAA require the U.S. Department of Health & Human Services (HHS) to **adopt national standards for electronic health care transactions and national identifiers for providers, health plans, and employers.**
- The goal is to move industry to automated/electronic billing and payment processes.

Examples of HIPAA transactions:

- **Eligibility for a Health Plan Transaction**
- **Health Care Claim Transaction**
- **Claim Status Transaction**
- **Health Care Electronic Funds Transfers (EFT) and Remittance Advice Transaction**

PART 1:
ADMINISTRATIVE SIMPLIFICATION BASICS

About Administrative Simplification

New Administrative Simplification Provisions Under the Affordable Care Act (ACA)

- The Administrative Simplification provisions of the ACA **adopt new standards and "operating rules" for how electronic transactions are conducted between HIPAA-covered entities** (i.e., health plans, clearinghouses, and health care providers who conduct electronic health care transactions).
- The intent is to create **as much uniformity as possible** for implementing electronic standards.

The Administrative Simplification provisions of ACA aim to:

- **Create consistency**
- **Increase efficiency**
- **Lower administrative costs across the health care system.**

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PART 1:
ADMINISTRATIVE SIMPLIFICATION BASICS

Administrative Simplification: Benefits for Providers

Benefits of Administrative Simplification:

- **Allows providers to use uniform electronic formats for claims and eligibility information, regardless of the health plan.**
- **Allows providers to automate their billing and financial transactions with payers.**

Administrative Simplification will save time and speed up the payment process so that clinicians can spend more time seeing patients and less time filling out forms and calling health plans. For providers, this means:

- Faster payment
- Less rebilling
- More accurate processing
- Automation of manual processes
- Improved consistency across payers

PART 1:
ADMINISTRATIVE SIMPLIFICATION BASICS

HHS Administrative Simplification Initiatives

The following are HHS Administrative Simplification initiatives, which will be discussed in more detail throughout this guide:

- **Standards and Operating Rules for electronic transactions**
- **Health Plan Identifier (HPID)**
- **ICD-10**

Administrative Simplification Timeline

	2013	2014	2015	2016
Standards & Operating Rules	**1-Jan-13** Eligibility and Claim Status, Operating Rules (1)	**1-Jan-14** EFT Standards EFT & ERA Operating Rules (2)		**1-Jan-16** Claims Attachment Standard Operating Rules (2) for Claims, Enrollment and Disenrollment, Premium Payments, Claims Attachments, and Referral Certification and Authorization
HPID		**5-Nov-14** Large Health Plans must obtain HPID	**5-Nov-15** Small Health Plans must obtain HPID	**7-Nov-16** Covered entities must use HPID
ICD-10			**1-Oct-15** ICD-10 compliance	

This timeline shows all the Administrative Simplification initiatives. Health plans are required to implement these capabilities and certify they are compliant. Providers should focus on meeting the October 1, 2015, ICD-10 compliance date, since this requires the most significant preparation on their part.

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PART 2:
STANDARDS

About Standards

- The Administrative Simplification standards **define uniform formats and data content** that must be used for any covered electronic transaction
- Instead of a variety of transaction formats across different health plans, providers can use these **standard formats** for the electronic transactions

PART 2:
STANDARDS

Standard Transactions

HIPAA aims to standardize basic administrative transactions

Basic Administrative Transactions

- (A) Health claims or equivalent encounter information
- (B) Health claims attachments
- (C) Enrollment and disenrollment in a health plan
- (D) Eligibility for a health plan
- (E) Health care electronic funds transfers (EFT) and remittance advice
- (F) Health plan premium payments
- (G) First report of injury
- (H) Health claim status
- (I) Referral certification and authorization

PART 2:
STANDARDS

Why Standardize?

The Need for Standardization (Administrative Simplification)

Higher Administrative Costs = Less Quality Care	
17% of U.S. Gross Domestic Product is spent on health care; this is expected to increase to 20% by 2020[1]	Up to 12% of a physician practice's annual revenue are billing and insurance-related costs[3]
An estimated one-third of all health care spending is on administrative costs ($315 billion by 2018)[2]	Per physician, two-thirds of an FTE (27 hours), is necessary for billing and insurance related tasks[3]

1. Health Spending Projections Through 2019: The Recession's Impact Continues, Health Affairs, March 2010

2. Health care administration in the United States and Canada: micromanagement, macro costs., International Journal of Health Services, 2004

3. Peering into the black box: billing and insurance activities in a medical group., Health Affairs, Jul-Aug 2009

PART 2:
STANDARDS

New Standards: EFT

Health care EFT standards:

- Adopt streamlined standards for:
  - Format and data content of the transmission a health plan sends to its bank to pay providers electronically (through an **electronic funds transfer**)
- Require the use of a tracking number that automatically matches the EFT payment with the remittance advice

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PART 3:
OPERATING RULES

About Operating Rules

What are Operating Rules?

- Operating rules are mandated by law and 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"

Why Operating Rules?

Operating Rules:

- Offer health care providers many benefits with very few requirements
- Improve interoperability by establishing uniformity in health care transactions, which helps close gaps created by the way different health plans operate
- Help cut red tape, save money, and allow doctors more time seeing patients and less time filling out forms
- Support the adopted standards for health care transactions

PART 3:
OPERATING RULES

Categories of Operating Rules

Operating Rules are the law

January 1, 2013 Compliance Date

- Eligibility for a health plan
- Health claim status

January 1, 2014 Compliance Date

- Health care electronic funds transfers (EFT) and remittance advice (EFT & ERA Operating Rule Set)

January 1, 2016 (To Be Adopted)

- Health care claims or equivalent encounter information
- Coordination of benefits
- Health plan enrollment/disenrollment
- Health plan premium payment
- Referral certification and authorization transactions

PART 3:
OPERATING RULES

Operating Rules: Eligibility and Claims Status

Operating Rules for Eligibility and Claims Status:

Rules put in place for two electronic health care transactions, making it easier for providers to determine:

- Whether a patient is eligible for coverage (transaction 270/271)
- The status of a health care claim submitted to a health insurer (transaction 276/277)

How Will Eligibility and Claims Status Operating Rules Affect Providers?

Eligibility and Claim Status

Benefits	Providers will have real-time access to:
• More accurate patient eligibility verification	• Health plan eligibility and benefit coverage before or at the time of service
• Improved point of service collections	• Key patient financials including year-to-date deductibles, co-pays, coinsurance, in/out of network variances via ASC X12v5010 270/271 transactions
• Decrease in claim denials	• Claim status data to ensure they are aware of status in billing process

PART 3:
OPERATING RULES

How Will Eligibility and Claims Status Operating Rules Affect Providers?

Other Advantages to Operating Rules:

- Health plans are now required to **include financial information**, such as deductible and co-insurance amounts. This means providers can know the patient's financial responsibility at the point of service.
- Health plans are required to **offer connectivity over the Internet with secure data transmission.**
- By standardizing the process for these electronic transactions with all health plans, it will be easier to **ensure patient eligibility information is readily accessible.**

PART 3:
OPERATING RULES

Eligibility & Claims Status Operating Rules: Benefits for Providers

The Operating Rules will:

Provide greater uniformity

Physicians and other health care providers can expect responses with the same eligibility data in the same format from all health plans.

Save physicians time and money

There will be reduced transaction costs - fewer phone calls between physicians and health plans, lower postage & paperwork costs, fewer denied claims, and a greater ability to automate administrative processes

Promote better patient care

Clinicians can spend more time treating patients and less time calling health plans

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What is Electronic Funds Transfer or "EFT"?

- EFT is the electronic message used by health plans to order, instruct, or authorize a depository financial institution to electronically transfer funds to a provider's account for health care.
- The EFT includes information about the transfer of funds such as the amount being paid, the name and identification of the payer and payee, bank accounts of the payer and payee, routing numbers, and the date of the payment.

PART 3:
OPERATING RULES

What is a Remittance Advice or "ERA"?

- An ERA is an explanation from the health plan to the provider about the claim payment.
- A health plan adjusts the claim charges based on contract agreements, secondary payers, benefit coverage, expected copays and coinsurance, etc. These adjustments are described in the ERA.

PART 3:
OPERATING RULES

EFT and ERA Operating Rules: Benefits for Providers

For Providers:

- Operating rules have **made it easier to enroll in EFT and ERA across different health plans** by requiring a standard enrollment form.
- The requirement that a trace number to the ERA be included in the EFT will **eliminate costly manual reconciliation** that must currently be done.

PART 3:
OPERATING RULES

EFT and ERA Operating Rules: Benefits for Providers

Before Operating Rules…	After Operating Rules…
• To sign up for EFT for from the 100+ health plans a provider may work with, the provider would have to fill out 100 different forms	• Providers fill out a **standardized form** for EFT for all their health plans and providers can use electronic forms
• Only large organizations have the infrastructure for Electronic Data Interchange (EDI); EDI systems are expensive	• Providers can receive the ERA through the public internet
• It is difficult to match up the payment in the EFT with the corresponding ERA that describes the payment	• A trace number makes it possible for a provider's system to automatically match the EFT payment and ERA

PART 3:
OPERATING RULES

EFT Payments Information for Providers

- Health care EFT payment through the Automated Clearing House (ACH) Network is the adopted standard for EFT.
- Other methods of EFT are not prohibited; however, a health plan **must transmit health care payments through the ACH Network (as Medicare does) if requested by the provider.**
- In general, a health plan cannot incentivize a provider to use an alternate transaction method (such as payments through credit cards or FedWire) other than the adopted standard, or dis-incentivize a provider from using a standard transaction.

PART 3:
OPERATING RULES

Technical Information on Operating Rules

- CAQH CORE is the authoring entity of the operating rules.
- CAQH CORE provides information on the technical aspects of complying with the operating rules.
- CAQH CORE is a nonprofit alliance of health plans and trade associations that aims to be the catalyst for industry collaboration on initiatives that simplify health care administration for health plans and providers, resulting in a better care experience for patients and caregivers.

Visit the CAQH CORE website to learn more:

http://www.caqh.org/

PART 4:
STANDARD IDENTIFIERS

About Identifiers

HIPAA requires that HHS adopt standard unique identifiers to be used when referring to entities named in HIPAA electronic transactions To date, HHS has implemented identifiers for two types of entities:

- Employer Identification Number (EIN)
- National Provider Identifier (NPI)

HHS is now implementing unique identifiers for two additional types of entities for electronic transactions:

- Health Plan Identifier (HPID)
- Other Entity Identifier (OEID)

PART 4:
STANDARD IDENTIFIERS

Overview of Health Plan Identifier

What is Health Plan Identifier?

- The HPID standardizes how health plans are identified in standard transactions.

When must an HPID be used?

- Required to be used in the standard transactions to identify a health plan
- Does not require that health plans now be identified in the standard transactions if they were not identified before this rule
- May be used for any other lawful purpose

PART 4:
STANDARD IDENTIFIERS

What Is the Other Entity Identifier?

There is no statutory requirement to use Other Entity Identifier (OEID); it is available for voluntary use.

- Who may obtain an OEID? Entities that:
  - Need to be identified in a standard transaction
  - Are NOT eligible to obtain an NPI
  - Are NOT eligible to obtain an HPID
  - Are NOT an individual

PART 4:
STANDARD IDENTIFIERS

Health Plan and Other Entity Enumeration System

- HPID and OEID applications are available through the Health Plan and Other Entity Enumeration System (HPOES)
- HPOES is housed within CMS's Health Insurance Oversight System (HIOS)
- To access HIOS, users will need to go to the CMS Enterprise Portal at **https://portal.cms.gov**

PART 4:
STANDARD IDENTIFIERS

HPID and OEID Registration and Application Process

- For additional information on policy and requirements for the HPID and OEID OR an overview of the HPID and OEID registration and application process, go to the CMS HPID website:

  http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html

PART 5:
CODE SETS: ICD-10

Overview of ICD-10

- On **October 1, 2015,** a key element of the data foundation of the United States' health care system will undergo a major transformation.
- We will transition from the decades-old Ninth Edition of the International Classification of Diseases (ICD-9) set of diagnosis and inpatient procedure codes, to the far more contemporary Tenth Edition of those code sets—or ICD-10—used by most developed countries throughout the world.

PART 5:
CODE SETS: ICD-10

About ICD-10

- In 1990, the World Health Organization (WHO) approved the 10th Revision of the International Classification of Diseases (ICD), which is known as ICD-10.

What is ICD-10?	Basic Requirement?	Dates

• A method of coding:
  • The patient's state of health and Institutional procedures
• Diagnosis Codes - ICD-10 CM : Patient Diagnosis, maintained by National Center for Health Statistics (NCHS)
• Procedure Codes- ICD-10 PCS: Procedures delivered in the Inpatient Settings (replaces Volume 3, maintained by CMS)
	• 5010 is a prerequisite to ICD-10 and is an update to the Electronic Data Interchange Version 4010
	• ICD-10 codes completely replace ICD-9 codes
	• All HIPAA-covered entities must use ICD-10 codes for information transmitted electronically
	• Does not impact other medical coding sets (CPT-4, HCPCS, NDC)
		• Published Final Regulation (45 CFR 162.1002): January 16, 2009
		• Effective Date: March 17, 2009
		• **Compliance Date: October 1, 2015**
		  • Professional and outpatient services are based on the Date of Service
		  • Inpatient services are based on the Date of Discharge
		• Code Freeze Date: October 1, 2011

PART 5:
CODE SETS: ICD-10

Why Transition to ICD-10?

- ICD-10 better reflects current medical practice and provides more specific data than ICD-9
  - ICD-10-CM: Describes left vs. right, initial vs. subsequent encounter, routine vs. delayed healing, and nonunion vs. malunion
  - ICD-10-PCS: Provides detailed information on procedures and distinct codes for all types of devices
- Structure accommodates addition of new codes
  - The current coding system is running out of capacity and cannot accommodate future state of health care

PART 5:
CODE SETS: ICD-10

ICD-10 Compliance Date

ICD-10 COMPLIANCE DATE OCTOBER 1, 2015

All organizations covered by HIPAA must use ICD-10 to code health care services provided on or after **October 1, 2015**

PART 5:
CODE SETS: ICD-10

ICD-10 and Administrative Simplification

- ICD-10, combined with other Administrative Simplification initiatives, will increase the efficiency and the quality of electronic information that providers exchange with each other, Medicare, and other payers. ICD-10 preserves important clinical detail from provider documentation that is not captured under ICD-9.

PART 5:
CODE SETS: ICD-10

Key ICD-10 Resources

- See the **CMS ICD-10 Introduction Guide** for additional information about ICD-10
- For detailed information on transitioning to ICD-10, visit the Road to 10 Tool on the **ICD-10 website**
- For the latest resources and news, visit the **CMS ICD-10 website**

PART 6:
ENFORCEMENT

Administrative Simplification Enforcement

- The CMS Office of E-Health Standards & Services (OESS) is responsible for the HIPAA Administrative Simplification complaint and enforcement activities related to HIPAA Transactions, including compliance with Standards, Operating Rules, Code Sets, and Unique Identifiers (Health Plan, Employer, and Provider Identifiers)

PART 6:
ENFORCEMENT

How to File a Complaint

- Administrative Simplification Enforcement Tool (ASET): **https://htct.hhs.gov/aset**
- ASET is a web-based application where individuals or organizations can file a HIPAA complaint against a health care provider, health plan, or clearinghouse for potential non-compliance with the non-Privacy/Security provisions of HIPAA
- Registered users can log on to this site to file a complaint. New users can register here: **https://htct.hhs.gov/aset/newUserRegistration.jsp**

PART 6:
ENFORCEMENT

- The Administrative Simplification provisions in ACA require health plans to file a statement with HHS certifying that their data and information systems are in compliance with the standards and operating rules
- For information on the certification schedule, visit: **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/ComplianceCertificationandPenalties.html**

ENFORCEMENT

- Visit the CMS Administrative Simplification website at: **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/index.html?redirect=/Affordable-Care-Act/**
- Here you can learn more about:
  - **Administrative Simplification**
  - **Health Plan Identifier**
  - **Operating Rules – EFT/ERA**
  - **Operating Rules – Eligibility and Claims Status**
  - **ICD-10**