Simplifying Administrative Requirements the Health Care System Imposes on Physicians - 2013

The Patient Protection and Affordable Care Act (ACA) includes numerous provisions in 2013 that aim to reduce administrative burdens on physicians. These provisions in 2013 build on other administrative simplification provisions that became effective in 2012. The ACA generally assigns the responsibility for implementation of the administrative simplification provisions to the Secretary of the Department of Health and Human Services (HHS), often referred to as "the Secretary." Many implementation activities will be handled by the Centers for Medicare and Medicaid Services (CMS), an agency component of HHS.

How significant are administrative burdens on physicians?

The health system, and its multiple payers, imposes significant burdens on physician practices. A typical physician practice has a contract with 12 or more health plans in addition to participating in Medicare and Medicaid and must follow each payer's requirements for contracting, credentialing, preauthorizing, coding, billing, and reimbursing. It is estimated that nearly 14 percent of physician practice revenue is consumed by billing and insurance-related functions. Further, studies by the Medical Group Management Association calculate the annual cost of administrative tasks, many of which are of dubious value, at around $25,000 per year per physician. In addition to being costly and frustrating to physicians, administrative burdens are unnecessarily limiting physicians' ability to provide patient care.

What health reform law-mandated efforts to streamline administrative requirements take effect in 2013?

<u>Standard Process for Verifying Patient Insurance Eligibility and Checking on Status of Claim for Payment</u>

By January 1, 2013, the Secretary must implement a standard set of rules that facilitate electronic transactions that enable physician practices to verify patient health insurance coverage eligibility and obtain the status of claims submitted to bill for services. The Secretary must establish these operating rules by July 1, 2011, allowing stakeholders time to prepare for the January 2013 effective date. The Secretary released these operating rules as an Interim Final Rule with Comment on June 30, 2011. The rules as they pertain to patient eligibility are to facilitate the ability of a physician to determine: the insurance product that covers the patient, whether a specific service is covered, and any patient financial responsibility. The physician practice is to be able to access this information prior to or at the time of the patient encounter. The rules that pertain to claim status are to facilitate timely practice access to whether the insurer received the claim submitted and the status of an accepted claim in the processing cycle. The rules are also to promote physician access to insurer claims processing cycle details, including how a determination is made whether to pay a claim and how to appeal adverse determinations. The provision states that these rules allow for use of a machine readable identification card.

The Secretary must develop the operating rules in consultation with a broad range of health care stakeholders, including physicians. The Secretary is to use a rigorous process by which health plans demonstrate their compliance with the rules, with financial penalties imposed on plans that fail to comply. The rules apply to all payers.

This provision aims to expand on the concept promoted through an initiative led by an organization established by large private payers to simplify administrative requirements imposed on physicians. This organization, the Council for Affordable Quality Healthcare, is working with ACP and a wide range of other stakeholders to provide physician practices with real-time access to patient eligibility and benefits information through a single electronic portal that contains information on patients covered by all participating payers. While this still-evolving effort is helpful, its overall impact is limited as it does not include all private payers nor does it include

Medicare. That the rules will apply to all payers should maximize the benefit derived from this provision.

On July 8, 2011, the Secretary published a regulation that adopted electronic health care transaction standards that fulfilled the above requirements --- they facilitate the ability of health care providers to determine whether a patient is eligible for coverage and the status of a health care claim submitted to a health insurer.

Standard Mapping of International Classification of Diseases, Clinical Modification, Ninth Revision (ICD-9), Diagnosis Codes to those in More Expansive ICD-10 Code Set

The ACA requires HHS to maintain a crosswalk that translates how current ICD-9 diagnosis codes map to the ICD-10 diagnosis code set that physicians are required to use October 1, 2014. Diagnosis codes are included on the claim form to indicate the reason the physician preformed the service for which he/she billed. These codes are also used to track morbidity and mortality.

The ICD-10 code set, which is more granular, contains roughly five times the number of diagnosis codes maintained in ICD-9. The law requires HHS to solicit stakeholder comment on its initial ICD-9 to ICD-10 crosswalk effort and make changes prior to the October 2014 effective date. The revised crosswalk will be considered a standard mapping that facilitates the adoption of ICD-10 by enabling physician practices to update their systems and promoting health plan standardization in the diagnosis requirements that trigger payment of claims.

The College provides a substantial amount of information regarding ICD-10 on its *Running a Practice: Coding* page available at: http://www.acponline.org/running_practice/practice_management/payment_coding/coding/.

Additional Resources

- *CMS website on "Operating Rules for HIPAA Transactions*."

  http://ww.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/OperatingRulesforHIPAATransactions.html