Simplifying Administrative Requirements the Health Care System Imposes on Physicians - 2014

The Patient Protection and Affordable Care Act (ACA) includes numerous provisions in 2014 that aim to reduce administrative burdens on physicians, having built upon earlier administrative simplification provisions in 2013 and 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.

Reiterating what was stated earlier in this guide, 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 2014?

The ACA administrative simplification provisions that come into play for 2014 pertain to the administrative transaction of electronic payment of claims—through a transfer of funds—and transaction that entails a health plan communicating its payment decision related to a claim—known as remittance advice.

Specifically, by January 1, 2014, the Secretary must:

- Implement a standard for electronic funds transfer (EFT) and implement a set of operating rules for use of that EFT standard; and
- Implement a standard set of rules that pertain to claims remittance/payment.

In 2012, the Secretary finalized the Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set. This rule builds on current electronic communication standards that define operating rules that must be followed by all health plans (payers). This rule facilitates the ability of physician practices and other healthcare entities to receive claim payments electronically, and to automatically match explanations regarding any adjustments to these payments by the health plans with the correct claim. The rule also defines the maximum data set that a health plan can require a practice to submit to quality for electronic payment under these operating rules. These rules also standardize the format that a health plan must use for companion guides that explain the policies and requirements for practices and clearing houses to engage in these payment transactions. The rules apply to all payers. The EFT standard, and operating rules to facilitate standard EFT and claim remittance/payment, will increase the ability of physician practices to determine the precise payment determination for each claim submitted and to enhance their ability to collect payments.

Additional Resources

- *American College of Physicians information on HIPAA.*

  http://www.acponline.org/running_practice/practice_management/regulatory_compliance/hipaa/

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

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