# Revenue Cycle Current Hot Topics and Challenges

Montana Health Research & Education Foundation

Eide Bailly

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# Denials

# DENIALS

- Why are denials a hot topic?
  - Rising healthcare costs make denials a financial risk.
  - Denial rates are increasing.
  - Impact cash flow, patient satisfaction, and administrative burden.

# The Cost of Denials

- Financial Implications:
  - Revenue Loss: Direct impact on the organization's revenue stream.
  - Increased Operational Costs: Additional resources required for rework and appeals.
  - Impact on Patient Care: Potential reduction in resources available for patient care.
- Importance of Proactive Denial Management:
  - Mitigating Financial Risks: Proactive measures reduce the risks associated with denials.
  - Optimizing Revenue Streams: Focusing on prevention and resolution for optimal revenue generation.

**DENIALS AFFECT THE BOTTOM LINE!**

# Understanding Denials

### Common Types of denials:

- *Coding Errors*: Examples include incorrect codes leading to claim rejections.
- *Lack of Medical Necessity*: Denials due to insufficient documentation of medical necessity.
- *Timely Filing Issues*: Claims rejected for not meeting timely filing requirements.

### Common Types of denials:

- *Incomplete Documentation*: Insufficient medical records leading to claim denials.
- *Billing Errors*: Errors in billing information causing claim rejection.
- *Eligibility Issues*: Denials arising from patient eligibility-related discrepancies.

### Impact on revenue integrity:

- *Revenue Leakage*: Unresolved denials result in revenue leakage.
- *Operational Inefficiency*: Denials disrupt operational efficiency and workflow.
- *Patient Care Impact*: Can affect the quality of patient care due to financial constraints.

# Clinical Denials

Level of Care – Inpatient downgrade to Observation or even Outpatient

Medicare and Medicare Advantage:

- **Two Midnight Presumption**
  - The provider documenting an estimated need for the two midnights plus a plan that will take the two midnights.
  - "Under the 2-midnight presumption, inpatient hospital claims with lengths of stay greater than 2 midnights after formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care.
- **Two Midnight Benchmark**
  - The provider documenting the need for a second medically appropriate midnight after the first midnight as an outpatient with the plan of care for the second midnight.
  - "The decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpatient service. In other words, if the physician makes the decision to admit after the pt arrived at the hospital and began receiving services, he or she should consider the time already spent receiving those services in estimating the pt's total expected LOS.

Commercials:

- **May use InterQual or MCG**



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# Clinical Denials

Medical Necessity

- **Covered Diagnosis Code**
- **Lack of documentation detailing care and interventions prior to surgical/interventional procedures**
- **Noridian will consider total hip replacement surgery medically necessary in the following circumstances. Advanced joint disease demonstrated by:**
  - Radiographic supported evidence or when conventional radiography is not adequate, magnetic resonance imaging (MRI) and/or computed tomography (CT) (in situations when MRI is non-diagnostic or not able to be performed) supported evidence (subchondral cysts, subchondral sclerosis, periarticular osteophytes, joint subluxation, severe joint space narrowing, avascular necrosis); **AND**
  - Pain that cannot be adequately controlled despite optimal conservative treatment or functional disability from injury due to trauma or arthritis of the joint; **AND**
  - If appropriate, history of unsuccessful conservative therapy (non-surgical medical management) that is clearly addressed in the pre-procedure medical record. (If conservative therapy is not appropriate, the medical record must clearly document the rationale for why such approach is not reasonable). Non-surgical medical management is usually but not always implemented prior to scheduling total joint surgery. Non-surgical treatment as clinically appropriate for the patient's current episode of care typically includes one or more of the following: anti-inflammatory medications or analgesics, or flexibility and muscle strengthening exercises, or supervised physical therapy [Activities of daily living (ADLs) diminished despite completing a plan of care], or assistive device use, or weight reduction as appropriate, or therapeutic injections into the hip as appropriate.

# Clinical Denials

Medical Necessity

- **Commercial Payors have their own policies:**
  - **BC MT** – Blue Cross and Blue Shield of Montana (BCBSMT) has incorporated Carelon (formerly AIM Specialty Health) Medical Benefits Management clinical appropriateness guideline review criteria into its medical policies. Carelon is contracted with BCBSMT to provide prior authorization and medical necessity review of tests and services for members enrolled in certain plans as of Jan. 1, 2021. To access the most current Carelon Medical Benefits Management clinical appropriateness guidelines, go to: Carelon Medical Benefits Management at <https://www.guidelines.carelonmedicalbenefitsmanagement.com>. (All rights reserved.)
  - **United Health Care** – United Healthcare has several policies including policy for “Facet Joint and Medial Branch Block Injections for Spinal Pain”.

# Coding and NCCI Edits

- Coding
  - Unspecified codes
  - Codes come from provider notes which list diagnoses with ICD 10 codes. Providers often include multiple codes for one condition for which only one should be reported as it is all inclusive.
- NCCI Edits
  - Bundling of services. Determining if a modifier is appropriate or if services should not be reported together. In some circumstances no modifier is allowed.
  - Medically Unlikely Edits (MUE). Determine if appropriate clinically and if Medicare adjudication indicator will allow an appeal. To overturn MUE edits, requires an appeal.

# Pharmacy Units Incorrect

- Pharmacy
  - Pharmacy multiplier is not accurate
  - The dosage for pharmacy items with HCPCS codes must correspond with the HCPCS code description to ensure appropriate billing. The description in the chargemaster should reflect the value of the HCPCS J code assigned. This is an area Pharmacy, Chargemaster coordinator, Nursing, and Coding all need to be involved.
  - Monitoring how information flows between the pharmacy system, medication administration record (MAR), chargemaster, and final claim are critical to assure the correct J code and units are reported on the claim.
- Within the EMR is a Quantity field (Cerner QCF – Quantity Conversion Factor EPIC Charge Unit Multiplier). This is the field that needs to contain the conversion factor for the dispensed drug to the J code unit.

# Timely Filing

- Timely Filing Issues
  - Submitting claims past the payer’s deadline.
  - Misunderstanding payer-specific deadlines.
- Avoid denial by
  - Track submission deadlines for all payers.
  - Implement an automated claims management system.
  - Appeal denied claims promptly if within the allowable timeframe.

# Steps for Management and Prevention

- Track, trend, and reporting denials.
- Identify root cause.
- Standardize appeals process.
- Training and education.
- Communication.
- Create a denials management workgroup.

# Root Cause

- **Understanding why claims are denied helps in preventing similar issues in the future.** (Common reasons include missing information, coding errors, or eligibility problems.)
- ***Action Steps:***
  - Categorize denials (e.g., coding errors, missing documentation, authorization issues).
  - Analyze denial trends by payer, type, or department.
  - Investigate high-frequency denials.


# Training and Education

- **Keeping staff informed about payer policies, coding standards, and documentation requirements is key to reducing errors.**
- ***Action Steps:***
  - Conduct regular training sessions on updated payer rules, ICD/CPT codes, and common denial reasons.
  - Provide refresher courses to billing and coding staff to minimize preventable errors.
  - Encourage cross-functional training to improve collaboration between departments involved in the claims process.

# Communication

- **Open communication can help resolve issues quicker and even prevent future denials.**
- ***Action Steps:***
  - Set up regular meetings with payers to address denial trends and discuss ways to streamline processes.
  - Maintain open communication with providers to ensure documentation accuracy and completeness.
  - Create a feedback loop with clinical staff to improve the quality of submitted claims, especially in areas like coding and medical necessity documentation.

# Denial Management Workgroup

- Denial Management is an essential part of revenue cycle management. By using it, healthcare providers can investigate every unpaid claim, spot trends, and appeal the rejection of a claim. Through this process, healthcare providers can improve their processes to avoid payment issues for future claims.
- Suggested responsibilities of the Denials Management Workgroup:
  - Identify denial trends.
  - Note opportunities for process improvement.
  - Locate potential root causes or root cause deficiencies.
  - Recommend tasks to eliminate and/or prevent future denials.
  - Determine a method to monitor and sustain improvements.
  - Meet consistently; monthly and quarterly.

# Updates from 2026 Final Rule

# Practice Expense Methodology Changes

- CMS updated how indirect practice expenses are calculated, shifting resources towards non facility settings. They state the change is designed to better reflect current practice patterns.
- Reduction in indirect practice expense RVUs for facility-based services.
- Facility-based payments decrease by 7%; non-facility-based increase by 4%.
    - Significant impact to procedures performed by providers in hospital
    - Provider based clinic professional services payment significantly cut

# Medicare Out of Pockets Costs Increase in 2026

- Part A deductible and co-insurance:
  - Hospital: The deductible is increasing from $1,676 to $1,736 (1st 60 days); daily co-insurance paid after 60 days increasing from $419/day to $434/day in a benefit period and from $838/day to $868/day for lifetime reserve days.
  - SNF: daily co-insurance for days 21-100 increasing from $209.50/day to $217/day.
- Part B:
  - Standard monthly premium paid by all Medicare beneficiaries increasing from $185 to $202.90.
  - CMS: Would have been $11 more per month absent changes to skin substitute coverage.
  - Income-related monthly adjustment amounts for Part B premium also increasing by 10%.
  - Annual deductible also increasing by 10%, from $259/year to $283/year.
  - Likely to see increases in Medicare supplemental insurance rate.

# Inpatient Only List

- CMS finalized its proposal to phase out the IPO list beginning in CY 2026 with a three-year transitional period:
  - In 2026, 285 codes will be removed from the IPO list, most of which are musculoskeletal procedures.
- CMS has indicated they will exempt procedures that are removed from the IPO list from certain medical review activities related to the “two midnights” policy:
  - CMS will allow IP admission for procedures on the IPO list.
  - CMS will allow IP admission for procedure which have been removed from the IPO list if they meet applicable inpatient criteria.
- The why – CMS indicated will enable physicians to use their clinical judgement as to the most appropriate setting to receive care.
- Services not on the IPO list can still be performed in the outpatient setting.
- The concern – is outpatient payment comparable to inpatient payment.



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# Promoting Interoperability Program

- This includes the programs we referred to:
  - Meaningful Use
  - EHR Incentive Programs
- Established by the HITECH Act 2009.
- Incentives to encourage healthcare providers to adopt and demonstrate meaningful use of electronic health records.
- In 2018 name was changed to promoting interoperability to emphasize exchange of health information between health care entities and patients.
- Moved from an incentive program to a penalty program.
  - For the PPS hospitals, those that fail to report are subject to a 75% reduction in market basket update.
  - For the CAH's, their reimbursement is reduced from 101% to 100% of reasonable cost.
    - This is the one program that impacts reimbursement to the CAHs.



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# TEAM – Transforming Episode Accountability Model

- TEAM is a new mandatory payment model that will bundle payment to acute care hospitals for five types of surgical episodes. There is a five year episodic payment model beginning 1-1-26 through 12-31-30.
  - Coronary Artery Bypass Grafts
  - Lower Extremity Joint Replacements
  - Major Bowel Procedures
  - Surgical Hip/Femur Fracture Treatment
  - Spinal Fusion
- It applies to inpatient PPS hospitals in 188 core-based statistical areas.
- TEAM expands upon previous episode-based payment models like the Comprehensive Care for Joint Replacement (CJR) and the Bundled Payments for Care Improvement Advanced (BPCI-A) models.



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# TEAM – Transforming Episode Accountability Model

- The hospitals that have been selected will be responsible for the cost and quality of care furnished starting with surgery through 30 days after beneficiary leaves the hospital.
- CMS has calculated a standardized spending (target) by episode using the MS-DRGs assigned, and the CPT codes assigned.
  - This episode payment model includes Part A costs (hospital and swing bed) and all professional services (surgeon, anesthesiologist or CRNA).
- If total spending for all services is below the target price and quality standards are met, the hospital/providers in the sharing arrangement may receive a reconciliation payment.
- If total spending for all services is above the target price, the hospital/providers may owe a repayment to CMS.
- There is a phase in approach to this upside and downside of payment. Quality composite scores also factor into this model and payment.

# TEAM – Transforming Episode Accountability Model

- Under TEAM, CMS will allow beneficiaries to receive SNF services without meeting the 3-day Inpatient requirement, facilitating payment of claims for SNF services delivered to beneficiaries at eligible sites.
  - This will be effective for episodes starting on or after January 1, 2026.
- The beneficiary must have been discharged from the TEAM participant hospital for one of the TEAM episode MS-DRGs or HCPCS codes. The SNF stay must be within 30 days after the beneficiary is discharged from the hospital or hospital outpatient department.
- The beneficiary must meet the following eligibility criteria for TEAM upon admission for a hospital inpatient stay or hospital outpatient procedure:
  - Are enrolled in Medicare Parts A and B
  - Are not eligible for Medicare on the basis of having end-stage renal disease
  - Are not enrolled in any managed care plan (for example, Medicare Advantage, healthcare prepayment plans, or cost-based health maintenance organizations)

# TEAM – Transforming Episode Accountability Model

- The beneficiary must meet the following eligibility criteria for TEAM upon admission for a hospital inpatient stay or hospital outpatient procedure (continued):
  - The waiver applies only if the SNF is qualified to admit beneficiaries under TEAM.
    - CMS determines the qualified SNFs for each calendar quarter based on a review of the most recent rolling 12 months of overall star ratings on the Five-Star Quality Rating System for SNFs on the Nursing Home Compare website. Qualified SNFs are rated an overall of 3 stars or better for at least 7 of the 12 months.
    - CMS will post a list of qualified SNFs on the TEAM website. https://www.cms.gov/priorities/innovation/innovation-models/team-model
    - Providers furnishing SNF services under swing bed agreements will not be subject to the star ratings requirement.
    - The SNF must include the appropriate demonstration code (A9) in the Treatment Authorization field on claims that qualify for the waiver under TEAM. The waiver, and more specifically the SNF 3-day Rule waiver, **will also apply to swing bed providers (Type of Bill 18X), including Critical Access Hospital (CAH) swing beds**.

# TEAM – Transforming Episode Accountability Model

- One interesting add on to this TEAM is a requirement for a primary care referral by hospital discharge planning.
- If a patient has a primary care provider already identified, the referral is made to that provider.
- If a patient does not have a primary care provider – the provider must still make a referral to a primary care provider, basing on patient preference.
  - TEAM hospital will draw patients from many communities and will need contacts to make the referrals.

# TEAM Hospitals in MT, ID, OR, WA

| Mandatory or Voluntary Participant | Hospital CCN | Hospital Name | CBSA | CBSA Name | CBSA State | Participation Start Date | Participation End Date | Newly Identified TEAM Participant Relative to Previous List |
|---|---|---|---|---|---|---|---|---|
| Mandatory | 130002 | ST LUKE'S MAGIC VALLEY RMC | 46300 | Twin Falls, ID | ID | 01/01/2026 | 12/31/2030 | N |
| Voluntary | 270057 | BOZEMAN HEALTH DEACONESS REGIONAL MEDICAL CEN | 14580 | Bozeman, MT | MT | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380004 | PROVIDENCE ST VINCENT MEDICAL CENTER | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380007 | LEGACY EMANUEL MEDICAL CENTER | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380009 | OHSU HOSPITAL AND CLINICS | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380017 | LEGACY GOOD SAMARITAN MEDICAL CENTER | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380021 | HILLSBORO MEDICAL CENTER | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380025 | LEGACY MOUNT HOOD MEDICAL CENTER | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380037 | PROVIDENCE NEWBERG MEDICAL CENTER | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380038 | PROVIDENCE WILLAMETTE FALLS MEDICAL CENTER | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380047 | ST CHARLES BEND CAMPUS | 13460 | Bend, OR | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380050 | SKY LAKES MEDICAL CENTER | 28900 | Klamath Falls, OR | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380060 | ADVENTIST HEALTH PORTLAND | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380061 | PROVIDENCE PORTLAND MEDICAL CENTER | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380071 | WILLAMETTE VALLEY MEDICAL CENTER | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380082 | PROVIDENCE MILWAUKIE HOSPITAL | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380089 | LEGACY MERIDIAN PARK MEDICAL CENTER | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380091 | KAISER SUNNYSIDE MEDICAL CENTER | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 380103 | KAISER FOUNDATION HOSPITAL WESTSIDE | 38900 | Portland-Vancouver-Hillsboro, OR-WA | OR | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 500050 | PEACEHEALTH SOUTHWEST MEDICAL CENTE | 38900 | Portland-Vancouver-Hillsboro, OR-WA | WA | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 500053 | TRIOS | 28420 | Kennewick-Richland, WA | WA | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 500058 | KADLEC REGIONAL MEDICAL CENTER | 28420 | Kennewick-Richland, WA | WA | 01/01/2026 | 12/31/2030 | N |
| Voluntary | 500077 | PROVIDENCE HOLY FAMILY HOSPITAL | 44060 | Spokane-Spokane Valley, WA | WA | 01/01/2026 | 12/31/2030 | N |
| Mandatory | 500150 | LEGACY SALMON CREEK MEDICAL CENTER | 38900 | Portland-Vancouver-Hillsboro, OR-WA | WA | 01/01/2026 | 12/31/2030 | N |

# Excerpt of TEAM Qualified SNF & CAH List

**TEAM Qualified SNF List for Q2 2026**

| CCN | Name | Facility Type | Address | City | State | Phone Number |
|---|---|---|---|---|---|---|
| 275129 | IMMANUEL SKILLED CARE CENTER | SNF | 185 CRESTLINE AVE | KALISPELL | MT | 4067529622 |
| 275133 | BLACKFEET CARE CENTER | SNF | 728 S GOVERNMENT SQ | BROWNING | MT | 4063382686 |
| 275135 | DISCOVERY CARE CENTRE LTD | SNF | 601 N 10TH ST | HAMILTON | MT | 4063632273 |
| 275136 | MADISON VALLEY MANOR | SNF | 211 N MAIN ST | ENNIS | MT | 4066827271 |
| 275147 | TOBACCO ROOT MOUNTAINS CARE CENTER | SNF | 326 MADISON ST | SHERIDAN | MT | 4068425600 |
| 275156 | SOUTHWEST MONTANA VETERANS HOME | SNF | 65 VETERANS CIRCLE | BUTTE | MT | 4067923100 |
| 27Z300 | POPLAR HOSPITAL SWING BED | CAH with Swing-bed Designation | 211 H ST | POPLAR | MT | 4067686100 |
| 27Z301 | FALLON MEDICAL COMPLEX INC | CAH with Swing-bed Designation | 202 S 4TH ST W | BAKER | MT | 4067783331 |
| 27Z302 | DAHL MEMORIAL HEALTHCARE ASSOCIATIO | CAH with Swing-bed Designation | 106 E PARK ST | EKALAKA | MT | 4067758730 |
| 27Z303 | GRANITE COUNTY MEDICAL CENTER | CAH with Swing-bed Designation | 310 SOUTH SANSOME STREET | PHILIPSBURG | MT | 4068593271 |
| 27Z304 | BENEFIS MISSOURI RIVER MEDICAL CTR | CAH with Swing-bed Designation | 1501 SAINT CHARLES ST | FORT BENTON | MT | 4066223331 |
| 27Z305 | MCCONE COUNTY HEALTH CENTER INC | CAH with Swing-bed Designation | 605 SULLIVAN AVE | CIRCLE | MT | 4064853381 |
| 27Z306 | MOUNTAINVIEW MEDICAL CENTER | CAH with Swing-bed Designation | 16 W MAIN ST | WHITE SULPHUR | MT | 4065473321 |
| 27Z307 | BENEFIS TETON MEDICAL CENTER | CAH with Swing-bed Designation | 915 4TH ST NW | CHOTEAU | MT | 4064665763 |
| 27Z308 | ROOSEVELT MEDICAL CENTER | CAH with Swing-bed Designation | 818 2ND AVE E | CULBERTSON | MT | 4067876401 |
| 27Z309 | PRAIRIE COUNTY HOSPITAL DISTRICT | CAH with Swing-bed Designation | 312 SOUTH ADAMS AVENUE | TERRY | MT | 4066355511 |
| 27Z310 | GARFIELD COUNTY HEALTH CENTER | CAH with Swing-bed Designation | 332 LEAVITT AVE | JORDAN | MT | 4065572500 |
| 27Z311 | BIG SANDY MEDICAL CENTER INC | CAH with Swing-bed Designation | 166 MONTANA AVE E | BIG SANDY | MT | 4063782188 |
| 27Z312 | PHILLIPS COUNTY HOSPITAL | CAH with Swing-bed Designation | 311 S 8TH AVE E | MALTA | MT | 4066541100 |
| 27Z313 | PIONEER MEDICAL CENTER | CAH with Swing-bed Designation | 301 W 7TH AVE | BIG TIMBER | MT | 4069324603 |
| 27Z314 | DEER LODGE MEDICAL CENTER | CAH with Swing-bed Designation | 1100 HOLLENBECK LANE | DEER LODGE | MT | 4068462212 |
| 27Z316 | FRANCES MAHON DEACONESS HOSPITAL | CAH with Swing-bed Designation | 621 3RD ST S | GLASGOW | MT | 4062283500 |
| 27Z317 | LIVINGSTON HEALTHCARE | CAH with Swing-bed Designation | 320 ALPENGLOW LN | LIVINGSTON | MT | 4062223541 |
| 27Z318 | BARRETT HOSPITAL DEVELOPMENT CORPOR | CAH with Swing-bed Designation | 600 MT HIGHWAY 91 S | DILLON | MT | 4066833000 |
| 27Z319 | RUBY VALLEY MEDICAL CENTER | CAH with Swing-bed Designation | 321 MADISON ST | SHERIDAN | MT | 4068425453 |
| 27Z320 | CABINET PEAKS MEDICAL CENTER | CAH with Swing-bed Designation | 209 HEALTH PARK DR | LIBBY | MT | 4062837000 |
| 27Z321 | WHEATLAND MEMORIAL HEALTHCARE | CAH with Swing-bed Designation | 530 3RD ST NW | HARLOWTON | MT | 4066324351 |
| 27Z322 | SHERIDAN MEMORIAL HOSPITAL ASSOC | CAH with Swing-bed Designation | 440 W LAUREL AVE | PLENTYWOOD | MT | 4067653700 |
| 27Z323 | CLARK FORK VALLEY HOSPITAL | CAH with Swing-bed Designation | 10 KRUGER RD | PLAINS | MT | 4068264800 |
| 27Z324 | LOGAN HEALTH - CONRAD | CAH with Swing-bed Designation | 805 SUNSET BLVD | CONRAD | MT | 4062713211 |
| 27Z325 | ST LUKES COMMUNITY HOSPITAL | CAH with Swing-bed Designation | 107 6TH AVE SW | RONAN | MT | 4066764441 |
| 27Z326 | BEARTOOTH BILLINGS CLINIC | CAH with Swing-bed Designation | 2525 N BROADWAY AVE | RED LODGE | MT | 4064460667 |
| 27Z327 | ROSEBUD HEALTH CARE CENTER | CAH with Swing-bed Designation | 383 N 17TH AVE | FORSYTH | MT | 4063462161 |
| 27Z328 | LOGAN HEALTH - SHELBY | CAH with Swing-bed Designation | 640 PARK AVE | SHELBY | MT | 4064343200 |
| 27Z329 | MADISON VALLEY MEDICAL CENTER | CAH with Swing-bed Designation | 305 N MAIN ST | ENNIS | MT | 4066826862 |
| 27Z330 | STILLWATER BILLINGS CLINIC | CAH with Swing-bed Designation | 710 11TH ST N | COLUMBUS | MT | 4063221000 |

# Updates from 2026 Final Rule on Skin Substitutes

# Skin Substitutes

- CMS has seen significant growth in spending under Medicare Part B for skin substitutes in NON-Facility setting.
- Prior to 2026, skin substitute paid under Average Sales Price (ASP) based methodology. Final Rule- Single rate- approximately $127.14 per square cm. - Weighted Average.
  - Apply to all designated HCPCS supply codes paid across physician offices and OP departments in PPS facilities.
  - Each skin substitute product has a unique billing code and payment limitations.
- CY 2026-payment will be incident-to supplies when utilized as part of covered application procedure paid under MPFS in non-facility setting or under the OPPS in HOPD setting.
- Re-categorization to promote consistency. Grouping and paying based on product characteristics, more aligned with FDA status, to incentivize competition to create “more innovative products”, while also resulting in savings to Medicare Trust Fund.
  - Estimated savings of 9.4 billion.
  - Three categories applicable:
    - Pre Market approved (PMA)
    - 510K cleared or De Novo.
    - 361 HCT/Ps (Human Cell, Tissue, Cellular/Tissue Based.

# Skin Substitutes Payment Prior in OPPS ASC

- CY 2014 OPPS/ASC final rule packaged skin substitute products furnished in the hospital outpatient setting into their associated application procedures as part of a broader policy to package all drugs and biologicals that function as supplies when used in a surgical procedure.
- As part of the policy to package skin substitutes, we also finalized a methodology that divides the skin substitutes into a high-cost group and a low-cost group, to ensure adequate resource homogeneity among Ambulatory Payment Classification (APC) assignments for the skin substitute application procedure.
- Prior to 2026 PPS hospitals reported a procedure based on the type of skin substitute:
  - 1527X – high cost skin grafts - $1829 - $3660
  - C5271 – low cost skin grafts - $ 612 - $1829

# Skin Substitutes 2026 OPPS Rule

- CMS will unpackage skin substitutes and pay for them separately as incident-to supplies to align with the final payment policy change in the Medicare PFS.
- CMS will treat skin substitute products (excluding those licensed under Section 351 of the Public Health Service Act) as “incident-to supplies” when used as part of a covered application procedure in the physician office or hospital outpatient department.
- CMS will categorize products into three groupings. All skin substitutes will be assigned new payment status indicator “S1” and assigned to one of three new APCs based on their Food and Drug Administration (FDA) regulatory category:
  - APC 6000 (PMA skin substitute products).
  - AAPC 6002 (361 HCT/P skin substitute products).
  - PC 6001 (510(k) skin substitute products) (which includes 510(k) and De Novo).
- For CY 2026, will apply a single national payment rate of $127.14 per $cm^2$ for all three of them:
  - This was a 1.5% increase over the proposed rate.
  - Expected to reduce spending by around $19 billion in CY 2026.

# Skin Substitutes

- 2026 – Example of Change to APC payment based on unbundling graft material:

| HCPCS Application Code | CY 2025 OPPS/ASC Final Rule GMC | CY 2025 OPPS/ASC Final Rule APC | Percent Decrease | CY 2026 OPPS/ASC Proposed Rule GMC | CY 2026 OPPS/ASC Proposed Rule APC |
|---|---|---|---|---|---|
| 15271 | $1806.82 | APC 5054 | 49% | $914.97 | APC 5053 |
| 15273 | $4,194.23 | APC 5055 | 50% | $2,068.02 | APC 5054 |
| 15275 | $1,723.70 | APC 5054 | 47% | $905.87 | APC 5053 |
| 15277 | $3,102.43 | APC 5054 | 53% | $1,451.28 | APC 5054 |

- For 2026 separate payment for the graft material:
  - For CY 2026, will apply a single national payment rate of $127.28 per cm.

# Skin Substitutes

- Consolidated Appropriations Act of 2021 referred to skin graft products as ‘‘drugs and biologicals,’’ signaling that the Congress considers them as such for payment purposes.
  - Commenters stated that for decades CMS has appropriately classified and paid for CTPs/skin substitutes as drugs or biologicals under section 1847A of the Act. They state the proposal to abruptly reclassify them is an unexplained reversal of this longstanding policy and is therefore ‘‘arbitrary and capricious.’
- The Consolidated Appropriations Act, 2021, Public Law 116–260, division CC, section 401(c), **amended section** 1847A(f)(A) to state that, manufacturers of drugs or biologicals including items, services, supplies, and products that are payable under Medicare Part B as a drug or biological, that have not entered into a National Medicaid Drug Rebate Agreement are required to report ASP (and WAC) data to CMS.
  - Under this policy, as finalized, skin substitute products (other than those approved via BLA under section 351 of the PHS Act) will no longer be paid as biologicals and will no longer be required to report ASP to us.

# Skin Substitutes

- We clarify that skin substitute products that are not regulated as biological products under section 351 of the PHS Act and that are paid as incident to supplies are not subject to the Medicare discarded drug policy.
- This change impacts how skin graft substitutes are reported:
  - Revenue code 278

    Vs.

  - Revenue code 636

# Skin Substitutes

- Reporting of wound care with skin substitutes:
  - Procedure code will be reported for the skin grafting:
    - Often in the code range of 15271-15278.
    - Professional service reported by MD, NP, PA.
    - Procedure reported for the technical and professional service when done in outpatient hospital.
    - Revenue code for technical dependent on where done: Potential revenue codes include 360, 361 (Operating Room) 761 (Treatment Room or Special Procedure room for wound care).
  - Charges reported for the skin grafting material:
    - Often assigned a Q code from the HCPCS book.
    - Before purchasing a skin graft material, check the graft is a covered graft. There are grafts which are non covered which results in neither the grafting material or the procedure to be covered by insurance.
    - Billing reference manuals will list both revenue code 278 or 636 reportable for Q codes for skin graft material.
    - New updated in 2026 need to incorporate – some grafts under 278 and some under 636.
    - Units, units, units! Most errors occur here. Many of the products are per sq cm and units should be reported accordingly.

# Wound Care

# Wound Care

- Wound care is under scrutiny from Medicare and other payors due to the large increase in payments occurring for this service.
- Risks occur in organizations for a variety of reasons:
  - Lack of documentation:
    - Documentation of initial size of wound with **documentation of healing process** at each encounter.
    - Medical necessity for frequency of wound care.
    - Specific site of wound(s).
    - Diagnoses:
      - Unspecified or nonspecific diagnoses.
      - Diagnoses inconsistent from one treatment to the next.
      - Not capturing cause – i.e., Diabetes, Peripheral Vascular Disease.
  - Disorganized medical record:
    - Unable to follow progression of treatment of wound(s).
    - Multiple pages of medical records with little documentation specific to the treatment of the wound.



Eide Bailly

# Wound Care

- Skin substitute application requires attention to documentation of the procedure performed and the type and amount of product applied.
- Considerations for documentation of skin substitutes:
  - Specific name and type of skin substitute product.
  - The specific anatomical location of the wound.
  - The size of the wound treated.
  - The amount (size) of skin substitute product applied, and the amount (size) wasted.
    - If there is wastage, the units and charge should be on a separate charge line with the JW modifier.
    - Reason for the wastage (including the reason for using a package size larger than was necessary for the size of the ulcer, if applicable).
  - Clinical rationale for selecting the specific product applied (i.e., non-healing wound, type of wound, depth, other comorbid conditions the patient has).
  - When performing multiple grafting procedures over a period of time, documentation needs to reflect the response to treatment.
  - Manufacturer's serial/lot/batch or other unit identification number of grafts/CTP material. When the manufacturer does not supply unit identification, the record must document such.

# Vaccine Updates for RHC

# Medicare Part B Vaccine Coverage

**COVERED:**

1. Influenza
2. Pneumococcal/pneumonia
3. Hepatis B
4. Tetanus/Tdap
   - When provided due to injury/illness not for routine booster
5. COVID administration

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- All other vaccines covered under Medicare Part D.
- Recommend ABN but not required as statutorily excluded from Medicare Part B coverage.
- Bill with GY modifier as non-covered.
  - Modifier charge line is not rolled into a CG line

# INFLUENZA, PNEUMOCOCCAL COVID & HEP B VACCINES

**<u>Covered under the RHC Program</u>**
**<u>TRADITIONAL MEDICARE</u>**

1/1 – 6/30/25

- Report cost associated with vaccine & administration on Cost Report.

Effective 7/1/25 bill on TOB 0711.

- Traditional Medicare billed on the RHC claim with or without an E/M on the same date of service.

# Telehealth

# Medicare and Telehealth

- With recent legislation, CMS updated coverage of telehealth services and allows the following through December 31, 2027.
  - Extension allows for telehealth services to be provided with no geographic restrictions and allows for services to be provided in patients home.
  - Extended range of practitioners (physical therapist, occupational therapist, speech language pathologist, and audiologist) can provide Medicare telehealth services.
  - Beneficiaries may continue to receive audio only telehealth services in their homes.
  - RHCs and FQHCs continue to bill for non-behavioral telehealth services by reporting HCPCS code G2025.
  - In person visit requirements (6- and 12-month requirements) continue to be waived.
- Commercial coverage for telehealth is now permanent for many commercial plans.
  - Recommend reviewing each plan's coverage policies for specific details regarding telehealth benefits.

# Telehealth RHC/FQHC

- CMS finalizing policies:
  - Non-behavioral health visits furnished via telecommunication technology that allow RHCs and FQHCs to bill for RHC and FQHC services furnished using telecommunication technology by reporting HCPCS code G2025 on the claim, including services furnished using audio-only communications technology through December 31, 2026.

# Virtual Direct Supervision

- In both OPPS and PFS rule, CMS finalized to permanently adopt a definition of direct supervision that would allow “immediate availability” of a supervising practitioner using audio/video real-time communications technology (excluding audio-only) for all services described as incident-to a physician’s professional services, except for select global surgery codes.
- This allows direct supervision of most cardiac rehabilitation, intensive cardiac rehabilitation, pulmonary rehabilitation services, and diagnostic services to be available via audio/video real-time communications technology (excluding audio-only).
- This flexibility allows providers to use their clinical judgment to determine the mode of supervision on a case-by-case basis.

# Teaching Physician

Teaching Physician Requirements Related to Telehealth 2026

- CMS made permanent its policy permitting teaching physicians to use real-time two-way audio video to satisfy the presence requirement for resident furnished telehealth services. Rather than requiring the resident and the teaching physician to be in the same location during a telehealth visit, these services can be delivered via a three-way audio video conference.
  - While Medicare covers some audio only telehealth services, reimbursement for such services when furnished by a resident requires audio plus visual.

# Enrollment

# Transmittal 13041
# Change Request 13900
# issued: January 10, 2025
# https://www.cms.gov/files/document/r13041otn.pdf

# Method II Billing

**SUBJECT: Editing for Duplicate Processing for Practitioner Professional Services and Critical Access Hospital (CAH) Professional Services**

I. **SUMMARY OF CHANGES**: The purpose of this Change Request (CR) is to prevent duplicate billing of professional claims from CAHs and professional physicians that were identified in Office of Inspector General (OIG) Report: Duplicate Medicare Professional Fee Billing by Both the Critical Access Hospital (CAH) and Health Care Practitioner to Medicare Part B (A-06-21-05003).

**EFFECTIVE DATE: July 1, 2025**

**Unless otherwise specified, the effective date is the date of service.*

**IMPLEMENTATION DATE: July 7, 2025**

# Purpose

*Editing for Duplicate Processing of Practitioner Professional Services and CAH Professional Services*

- Prevent duplicate billing of professional services from CAHS under Method II option of billing on UB-04 and Medicare Part B billing on the CMS-1500 form.
- **Effective date**: July 1, 2025 (original implementation date: July 7, 2025). This was moved to January 1, 2026, for implementation.
- Edit will detect:
  - CMS-1500 submitted by practitioner that has reassigned their billing rights to CAH based on place of service reporting and location of services at CAH.
  - UB-04 submitted for professional services without a reassignment to the CAH.

# New Edits – CAH Claims UB-04

Will apply only to Revenue Codes for Professional Services (096X, 096X or 098X):

- The Attending NPI is not associated with the CAH Method II on the new PECOS reassigned benefits screen OR the Line Level Date of Service on the claim does not fall within the Effective and Term dates of reassignment to the CAH Method II for the "Attending Physician".
  - Denial Codes with Group Code CO (Contractual Obligation):
    - CARC 16 – Claim/service lacks information or has submission/billing errors need to adjudicate.
    - RARC N253 – Missing/incomplete/invalid attending provider primary identifier.
    - MSN 9.4 – This item or service was denied because information required to make payment was incorrect.
- The Rendering NPI (at line level) is not associated with the CAH Method II on the new PECOS reassigned benefits screen OR the Line Level Date of Service on the claim does not fall within the Effective and Term dates of reassignment to the CAH Method II for the "Rendering Physician".
  - Denial Codes with Group Code CO (Contractual Obligation):
    - CARC 16 – Claim/service lacks information or has submission/billing errors need to adjudicate.
    - RARC N290 – Missing/incomplete/invalid rendering provider primary identifier.
    - MSN 9.4 – This item or service was denied because information required to make payment was incorrect.

*CARC – Claim Adjustment Reason Code *RARC – Remittance Advice Remark Code *MSN – Medicare Summary Notice

# Updated Medicare Beneficiary Notices

# Updates to Medicare Beneficiary Notices

- Both Medicare beneficiaries and providers have certain rights and protections related to financial liability and appeals under the Fee-for-Service (FFS) Medicare and the Medicare Advantage (MA) Programs.
- These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers.
- Notices included are:
  - MOON (Medicare Outpatient Observation Notice) notice - updated and expires February 28, 2029. Providers have until April 20,2026 to transition to the new form.
  - Advanced Beneficiary Notice (ABN)
  - Important Message to Medicare (IMM) – expired December 31, 2025. No new form published with new OMB number
  - Detailed Notice of Discharge (DND) – expired Dember 31, 2025. No new form published with new OMB number
  - All of these forms mentioned have expired. The MOON was just updated the week of February 23, 2026, and providers have sixty days to implement the new form. As of the 23rd the ABN, IMM, and DND were not updated.

Recommendations

  - Update to the new MOON form.
  - Continue to check for Medicare updates for other forms. Typically have 60 days to implement new forms.
  - Need the OMB number on the document – Form CMS 10065-IM (Exp. 12/31/2025) OMB approval 0938-1019

- https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative

# Questions?

# Thank you

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