NHA Revenue Cycle Residency Program: Session 3

January 7, 2025

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Introductions

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Agenda

1. American Relief Act, 2025: What's In, What's Out, What's Next
2. Changes in Patient Status
3. Price Transparency: Compliance
4. 2026 Medicare Advantage Proposed Rule
5. Proposed Update to HIPAA Security Rule
6. Denials Management
7. May Meeting Presentations
8. Topics for March Meeting?

1. American Relief Act, 2025
What's In, What's Out, What's Next

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American Relief Act, 2025 – What's In

- Three-month extensions (through 3/31/2025)
  - Temporary changes to low volume hospital payment adjustment
  - Medicare Dependent Hospital program
  - Add-on payments for ambulance services
  - Work geographic practice cost index (GPCI) floor (physician payments)
  - Medicare telehealth flexibilities
    - Waiver of geographic and originating site requirements; expanded list of telehealth practitioners; FQHC/RHC telehealth services; delay in-person requirement for tele-behavioral health services; audio-only telehealth services
  - Acute hospital care at home waivers
  - $8B reduction in Medicaid disproportionate share

What's Out

- All of the above through end of 2025
- Reversal of 2.83% cut in Medicare payments to physicians (and other services reimbursed under Medicare Physician Fee Schedule, e.g., mammography, therapies)
- Advanced APM incentive payments for 2025
- Requiring separate NPI and attestation for off-campus hospital outpatient departments
- Site neutral payments
- Pharmacy benefit manager regulation

What's Next (??)

- Price transparency
- Medicare Advantage (expansion vs. regulation)
- 340B
- Reversal of Biden Administration regulations (e.g., Section 1554, nursing home minimum staffing requirements, HIPAA reproductive healthcare)
- Rural Emergency Hospital program
- ACA repeal (limited benefit insurance coverage)
- Make America Healthy Again
- Department of Government Efficiency (DOGE)

2. Changes in Patient Status

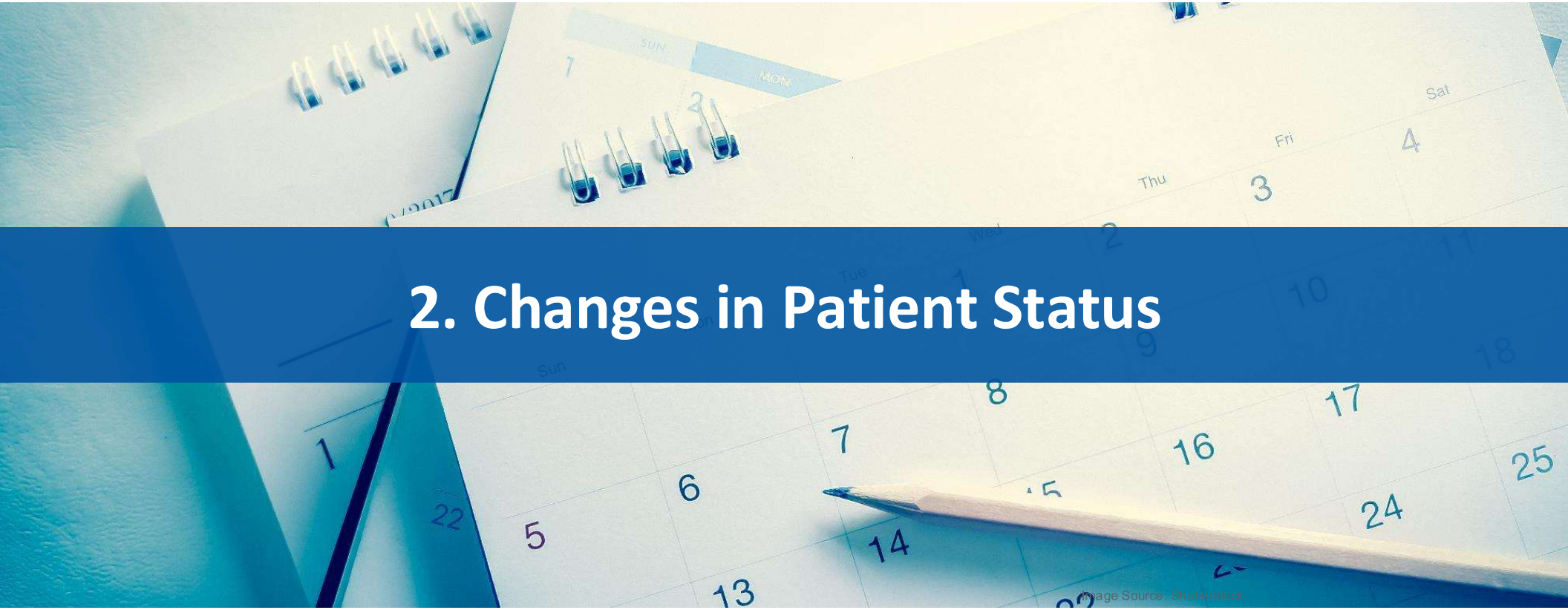

Image Source: Shutterstock

New Medicare Change of Status Notification

- Hospital must provide MCSN to patients while still in hospital
  - Intended to inform patient of status change, effect on Medicare coverage, appeal rights
  - Notice must be provided as soon as possible after status change, but no later than 4 hours prior to discharge
    - Eligible patients **with** Part B must reach 3rd day in hospital before receiving MCSN
  - Form available at *https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing/cms-10868* (multiple languages provided)

New Medicare Change of Status Notification

- Applies to Medicare fee-for-service patients only, not Medicare Advantage
- Applies to Medicare patients initially admitted as inpatients but then reclassified to outpatient observation *but not enrolled in Part B at time of stay*
- Applies to those staying at hospital for 3 or more consecutive days with less than 3 days as inpatient, but at least 1 inpatient day
  - Unless more than 30 days have passed between discharge from hospital and SNF admission
- Implementation date for MCSN is **February 14, 2025**

3. Price Transparency: Compliance

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TABLE 151A: Implementation Timeline for CMS Template Adoption and Encoding Data Elements

Requirement	Regulation cite	Implementation (Compliance) Date
MRF INFORMATION		
MRF Date	45 CFR 180.50(b)(2)(i)(B)	July 1, 2024
CMS Template Version	45 CFR 180.50(b)(2)(i)(B)	July 1, 2024
HOSPITAL INFORMATION		
Hospital Name	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Location(s)	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Address(es)	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Licensure Information	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
STANDARD CHARGES		
Gross Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024
Discounted Cash	45 CFR 180.50(b)(2)(ii)	July 1, 2024
Payer Name	45 CFR 180.50(b)(2)(ii)(A)	July 1, 2024
Plan Name	45 CFR 180.50(b)(2)(ii)(A)	July 1, 2024
Standard Charge Method	45 CFR 180.50(b)(2)(ii)(B)	July 1, 2024
Payer-Specific Negotiated Charge –Dollar Amount	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Payer-Specific Negotiated Charge – Percentage	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Payer-Specific Negotiated Charge – Algorithm	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Estimated Allowed Amount	45 CFR 180.50(b)(2)(ii)(C)	January 1, 2025
De-identified Minimum Negotiated Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024
De-identified Maximum Negotiated Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024
ITEM & SERVICE INFORMATION		
General Description	45 CFR 180.50(b)(2)(iii)(A)	July 1, 2024
Setting	45 CFR 180.50(b)(2)(iii)(B)	July 1, 2024
Drug Unit of Measurement	45 CFR 180.50(b)(2)(iii)(C)	January 1, 2025
Drug Type of Measurement	45 CFR 180.50 (b)(2)(iii)(C)	January 1, 2025
CODING INFORMATION		
Billing/Accounting Code	45 CFR 180.50(b)(2)(iv)(A)	July 1, 2024
Code Type	45 CFR 180.50(b)(2)(iv)(B)	July 1, 2024
Modifiers	45 CFR 180.50(b)(2)(iv)(C)	January 1, 2025

Estimated Allowed Amount

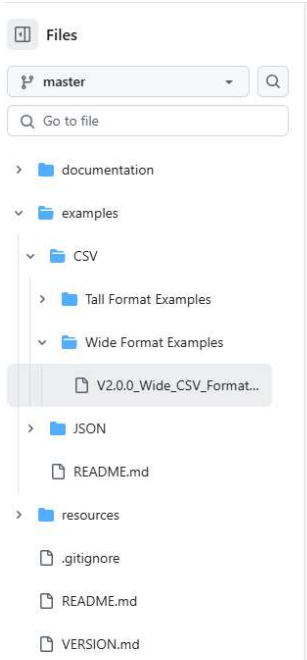
- Average dollar amount hospital has received from 3rd-party payer for item or service
  - Payer and plan specific
- Must encode a dollar value to reflect "estimated allowed amount"
  - CMS not prescriptive regarding source of the data
    - However, … *"One source hospitals may consider using is information from the EDI 835 electronic remittance advice (ERA) transaction, the electronic transaction that provides claim payment information, including any adjustments to the claim, such as denials, reductions, or increases in payment, would appear to meet this requirement as the data in the 835 form is used by hospitals to track and analyze their claims and reimbursement patterns."*
- CMS recommends encoding 999999999 (that's 9 nines) to indicate insufficient historic claims data to determine estimated allowed amount; update when sufficient data becomes available

Drug Unit of Measurement

- If the hospital has established a standard charge for a drug, required to encode the file with a description of the drug, including the applicable drug unit and type of measurement as a separate and distinct data element from the description
- The measurement type that corresponds to the established standard charge for drugs as defined by either the National Drug Code (NDC) or the National Council for Prescription Drug Programs (NCPDP)

Standard Name	*Valid Value*
Grams	GR
Milligrams	ME
Milliliters	ML
Unit	UN
International Unit	F2
Each	EA
Gram	GM

Drug Unit of Measurement

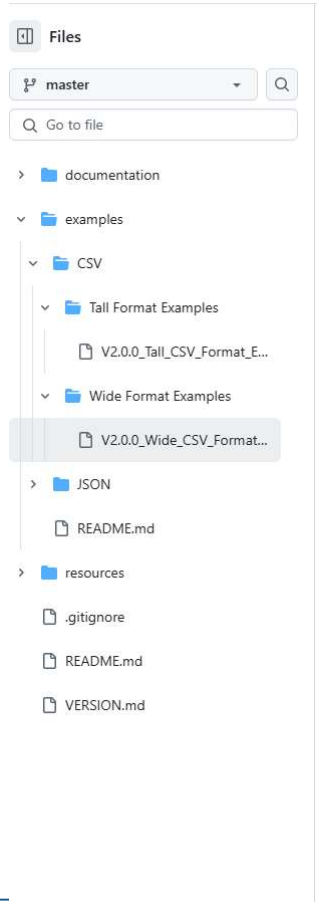


hospital-price-transparency / examples / CSV / Wide Format Examples / **V2.0.0_Wide_CSV_Format_Example.csv** ↑ Top

Preview | Code | Blame | 23 lines (23 loc) · 5.87 KB | Raw

	hospital_name	last_updated_on	version	hospital_location	hospital_address
2	West Mercy Hospital	2024-07-01	2.0.0	West Mercy Hospital|West Mercy Surgical Center	12 Main Street, Fullerton, CA 92832|23 Ocean Ave, San Jose, (
3	description	code|1	code|1|type	code|2	code|2|type
4	Major hip and knee joint replacement or reattachment of lower extremity without mcc	470	MS-DRG	175869	LOCAL
5	Major hip and knee joint replacement or reattachment of lower extremity without mcc	470	MS-DRG	175869	LOCAL
6	Major hip and knee joint replacement or reattachment of lower extremity without mcc	470	MS-DRG	175869	LOCAL
7	Evaluation of hearing function to determine candidacy for, or postoperative status of, surgically implanted hearing device; first hour	92626	CPT		
8	Behavioral health; residential (hospital residential treatment program), without room and board, per diem	H0017	HCPCS		
9	Behavioral health; residential (hospital residential treatment program), without room and board, per diem, days 1-3	H0017	HCPCS		
10	Behavioral health; residential (hospital residential treatment program), without room and board, per diem, days 4-5	H0017	HCPCS		
11	Behavioral health; residential (hospital residential treatment program), without room and board, per diem, days 6+	H0017	HCPCS		
12	Treatment or observation room — observation room	762	RC		
13	Treatment or observation room — observation room	762	RC		
14	Bilateral procedure				
15	Co-surgeon				
16	Bilateral procedure with co-surgeon				
17	Aspirin 81 milligram chewable tablet	10135-0729-62	NDC		
18	Mexiletine hydrochloride 150 milligram capsule	0093-8739-01	NDC		
19	Mexiletine hydrochloride 150 milligram capsules, 100 capsules per bottle, 1 bottle	0093-8739-01	NDC		
20	Fluconazole 2 milligrams/milliliter	J1450	HCPCS	25021-0184-82	NDC
21	Kit for preparation of tc-99m tetrosfomin injection, 100 millicurie	17156-0026-30	NDC		
22	Permethrin 5% cream	45802-0269-37	NDC		
23	Cyanocobalamin 1000 micrograms/milliliter injection solution	J3420	HCPCS	63323-0044-01	NDC

Drug Unit of Measurement



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Preview | Code | Blame | 23 lines (23 loc) · 5.87 KB | Raw

rate that would otherwise apply.					
	drug_type_of_measurement	standard_charge|gross	standard_charge|discounted_cash	standard_charge|Platform_Health_Insurance|PPO|negotiated_dollar	standard_charge|Platform_Health_Insurance|PPO|negotiated_percentage
				20000	
				20000	
				20000	
		150	125	98.98	
		2500	2250	1500	
		2500	2250		
		2500	2250		
		2500	2250		
		13000	12000	8000	
		13000	12000	10000	
					150
					62.5
					93.75
	UN	2	1.5	0.75	
	UN	5	4	3	
	EA	500	400		
	ML	75	45	35	
	EA	515	450	265	
	GM	120	75	70	
	ML	30	25	8	

Modifiers

- Include any modifier that may change standard charge that corresponds to hospital item or service
  - Include description of modifier and how it changes the standard charge

description	modifiers	setting	standard_charge|Platform_Health|PPO|negotiated_percentage	additional_payer_notes|Platform_Health|PPO
Bilateral procedure	**50**	both	150	150% payment adjustment for the item or service to which the modifier is appended
Co-surgeon	**62**	both	62.5	62.5% of the amount for the item or service to which this modifier is appended for each co-surgeon
Bilateral procedure with co-surgeon	**50|62**	both	93.75	93.75% of the amount for the item or service to which this combination of modifiers is appended for each co-surgeon

Requirement to Certify Completeness and Accuracy of MRF

Compliance Statement

To the best of its knowledge and belief, this hospital has included all applicable standard charge information in accordance with the requirements of 45 C.F.R. §180.50 and the information encoded in this machine-readable file is true, accurate and complete as of the date indicated in this file.

Effective **July 1, 2024**

Hospital enters value of "true" or "false"

OIG Report on Transparency Compliance

- Issued in November 2024
- OIG reviewed 100 hospitals in stratified random sample
  - 63 were compliant, 37 were not
  - Of those that were non-compliant, 34 did not comply with requirements for the machine-readable file, 14 were non-compliant with shoppable services requirement
- OIG recommendations to CMS
  - Review non-compliant hospitals to confirm OIG findings and proceed with enforcement
  - Work with hospitals to implement changes to requirements (provide written guidance clarifying definition of “shoppable services” and develop training program tailored to smaller hospitals)
  - Continue to strengthen internal controls

4. Medicare Advantage 2026 Proposed Changes

Image Source: Shutterstock

January 2024 Prior Authorization Final Rule

- By 1/1/2026, plan must send PA decisions within 72 hours (urgent) and 7 calendar days (standard)
  - For MA plans, current rule is 14 calendar days for standard requests
  - For MA plans, shorter time periods for Part B drugs (24/72 hours) will remain
- By 1/1/2026, plan must furnish provider with written explanation for PA decision
  - For MA plans, current rule requires for post-claim audits
- By 3/31/2026, plan must post PA metrics on website
  - Percent of PA requests approved, denied, approved after appeal
  - Average time between submission and decision
- By 1/1/2027, plans must implement APIs to facilitate electronic PA process
  - Identify items or services requiring PA (excluding drugs)
  - Specify documentation requirements for items and services requiring PA

2026 MA & Part D Proposed Rule

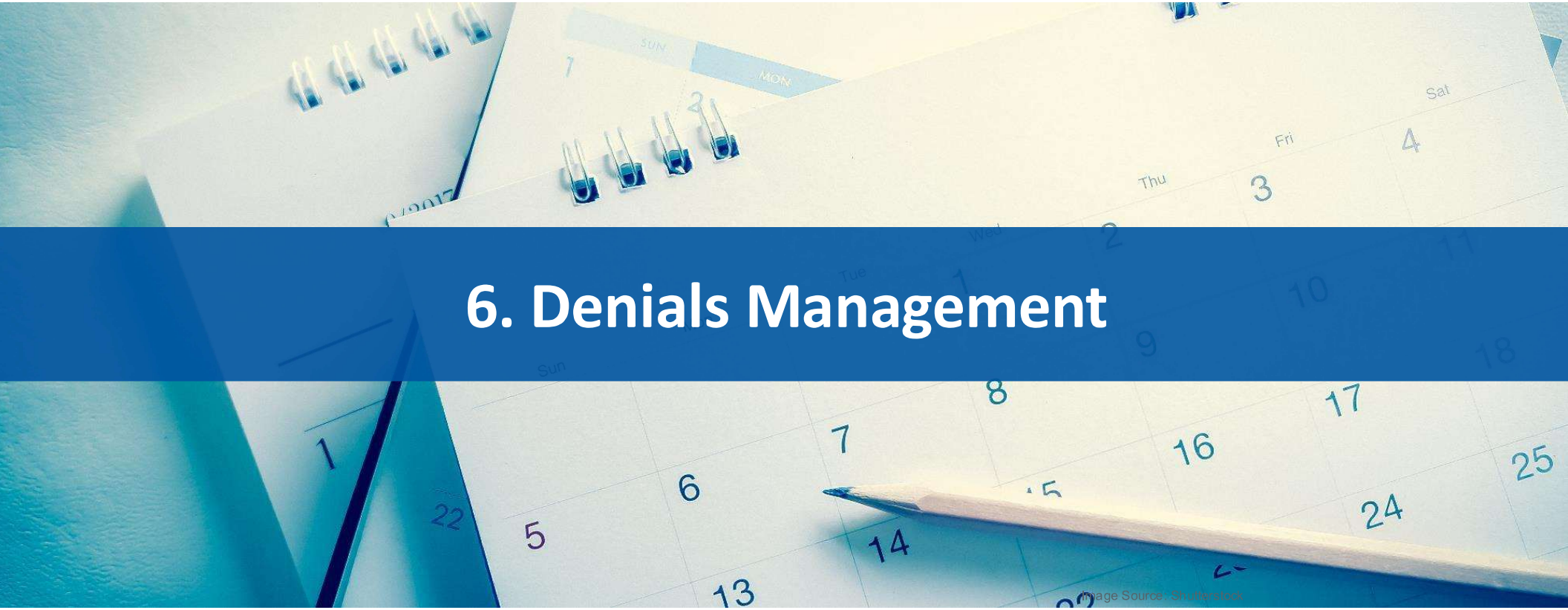
- Prior authorization
  - Prohibit plans from refusing payment on inpatient admission for which prior authorization was given
  - Tighter standards for internal coverage criteria
  - Requirements regarding enrollee notification of appeal rights
  - Reporting requirements relating to initial coverage decisions and appeals
- Marketing
  - Pre-approval of 'generic' MA advertisements
  - New broker disclosure requirements (including higher cost of supplemental plan if return to traditional Medicare)
- Changes to expenses included in medical loss ratio
- Part D coverage for GLP-1s

5. Proposed Updates to HIPAA Security Rule

Image Source: Shutterstock

Proposed HIPAA Security Rule Changes

- Released December 27
- Rule would require providers to –
  - Encrypt ePHI (with limited exceptions)
  - Employ multifactor authentication (also with limited exceptions)
  - Deploy anti-malware software
  - Adopt written procedures for system restoration within 72 hours of cyberattack
  - Complete annual inventory and network map of EHR data as it moves through organization's system
- Comments due by March 7



6. Denials Management

Image Source: Shutterstock

Common Reasons for Denials

- Missing or incorrect data
- Duplicate submissions
- Late submission of claims
- Improper coding
- Lack of prior authorization
- Incomplete or missing documentation
- Dual coverage

Using Strategy in Denials Management

- Denials management is key to your hospital's financial stability
- Take steps to examine, correct, and prevent claim denials
  - Include incorrect payments as well as denials
  - Track by payer and plan
  - Track by preventability – internal error vs. or payer problem
- Prevention of internal errors is vital
  - Is discussion needed with clinical staff – including physicians?
- Develop KPIs
  - Denial rate – by reason
  - Denial adjustments
  - Percentage of clean claims

Denials Management

- Convene Denials Committee
  - Include representative from each phase of revenue cycle (including clinical staff)
  - Meet at least bi-weekly
  - Maintain complete list of unresolved denials categorized by payer and type
  - Identify specific reason for each denial (root cause analysis)
  - Pursue appeals when appropriate, take appropriate action to prevent future denials
  - Track and report internally on denials and appeals
  - Focus on root causes of initial denials (versus final denial write-offs)
    - Creates more transparency into specific staff, physicians, or departments causing the denials
    - Creates higher staff and department accountability
- Establish regular, ongoing communication with payer representatives
  - Standing list of issues to be addressed

7. May Meeting Presentations

Image Source: Shutterstock

10-15 Minute Presentation (One Per Facility)

- How did you identify, define, and quantify issue to be addressed?
- What solutions did you consider?
- What solution did you elect to pursue?
- Who will be impacted?
- What resources will you require? (e.g., IT solution, staff training, physician buy-in)
- What challenges have you encountered and how will you address them?
- What is your implementation timeline?
- What are your key performance indicators (measures of success)?

8. March Meeting Topics?

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A national healthcare advisory services firm
providing consulting, audit, and tax services