Executive order directs HHS to focus on price transparency

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News & Insights

President Donald Trump recently signed an executive order that directs HHS and other federal departments to update price transparency guidance and enforcement efforts. The executive order signals the current administration's intent to prioritize price transparency policies stemming from Trump's first term.

The executive order directs HHS to take actionable steps on the following within 90 days:

- Require the disclosure of the actual prices of items and services, not estimates
- Issue updated guidance or proposed regulatory action ensuring pricing information is standardized and easily comparable across hospitals and health plans
- Issue guidance or proposed regulatory action updating enforcement policies designed to ensure compliance with the transparent reporting of complete, accurate, and meaningful data

The Hospital Price Transparency final rule, which took effect on January 1, 2021, requires hospitals to list all prices online in a machine-readable file (MRF) and a consumer-friendly display or tool for the 300 most common shoppable services.

Since the rule's publication, HHS has continued to take steps to ensure transparent healthcare pricing and boost hospitals' compliance with the regulations. In 2023, CMS updated its enforcement processes and began requiring corrective action plan completion deadlines, imposing civil monetary penalties earlier and automatically, and streamlining the compliance process.

In the 2024 Outpatient Prospective Payment System final rule, CMS strengthened its enforcement capabilities and finalized a slew of new price transparency requirements with staggered implementation timelines. In recent years, hospitals have had to standardize files, incorporate new data elements, and improve accessibility to maintain compliance.

PatientRightsAdvocate.org recently released its latest semi-annual report on hospital price transparency compliance, finding that hospitals are still struggling to comply with price transparency requirements nearly four years after the rule took effect. The nonprofit analyzed 2,000 publicly available hospital websites between July 1 and November 13, 2024, and determined that only 421 (21.1%) were in full compliance. The 1,579 noncompliant hospitals failed to meet at least one price transparency requirement. The report also details how policy rollbacks may be causing low compliance rates and impacting consumers' experiences.

Revenue cycle professionals can read the report for more information on recent price transparency compliance trends.

Related Topics:
Compliance, Medicare news, OPPS

Ensuring proper payment for CPAP devices and accessories

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CMS determined the improper payment rate for continuous positive airway pressure (CPAP) devices and accessories was 15% in 2023, with a projected improper payment amount of $157.5 million. For this reporting period, approximately 73.5% of CPAP improper payments were caused by insufficient documentation.

Organizations can view CMS' provider compliance tip on CPAP devices and accessories for information on proper billing codes, coverage criteria, and documentation tips.

To qualify for CPAP coverage, a patient must have an in-person clinical evaluation by the treating practitioner before the sleep test to assess them for obstructive sleep apnea (OSA). CMS defines "apnea" as a cessation of airflow for at least 10 seconds. It defines "hypopnea" as an abnormal respiratory event lasting at least 10 seconds with at least 30% reduction in the thoracoabdominal movement or airflow and at least 4% oxygen desaturation.

The patient must have an approved sleep test for one of the following:

- Polysomnogram attended by a qualifying practitioner and conducted in a sleep lab
- Unattended home sleep test (HST) with a Type II or III home sleep monitoring device
- Unattended HST with a Type IV home sleep monitoring device that measures at least three channels

An initial 12-week period of CPAP is covered in adult patients with OSA if either of the following criteria are met during the sleep test:

- Apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) greater than or equal to 15 events per hour, with at least 30 events taking place
- AHI or RDI greater than or equal to five, and less than or equal to 14, events per hour, with at least 10 events taking place and documentation of the following:
  - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia
  - Hypertension, ischemic heart disease, or history of stroke

Following this 12-week period, coverage depends on the practitioner's reassessment and documentation of the patient's symptoms and therapy regimen adherence.

CMS covers CPAP devices under the durable medical equipment (DME) benefit. DME suppliers and treating practitioners who prescribe CPAP devices and accessories must meet the provisions outlined in National Coverage Determination 240.4. They can find the most up-to-date list of Healthcare Common Procedure Coding System and Current Procedural Terminology (CPT®) codes in Local Coverage Determination L33718.

Editor's note: This article originally appeared in Revenue Integrity Insider*, NAHRI's weekly e-newsletter.*

Study: Improvements needed in adverse SDOH screening, documentation

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News & Insights

A new study has revealed some of the greatest barriers and facilitators to screening, documenting, and addressing social determinants of health (SDOH) across United States' emergency departments (ED).

The *JAMA Network Open* study examined a sample of 280 academic and nonacademic EDs across the country. In particular, this study focused on reporting policies that screen for housing instability, difficulty paying for utilities or transportation, or food insecurity.

The study aimed to identify the most common impediments in SDOH screening, such as the following:

- Social need questions were often addressed during triage with the social workers on-hand; however, social workers are often only available during business hours
- Many clinicians expressed reservations about the utility of such screenings; additionally, ED patients themselves often do not wish to divulge personal social needs information
- Lack of resources, staffing, and time often impaired successful screening and subsequent linkages to social needs services

Accordingly, and based upon the testimonies of the 280 emergency departments, the authors concluded that the following solutions are necessary:

- Address electronic health record system limitations
- Include ED leadership and staff in adverse SDOH screening implementation efforts
- Increase the availability of social workers, navigators, and case managers to address identified needs
- Reduce documentation burdens for an already overburdened ED staff

Editor's note: *A version of this article originally appeared in* CDI Strategies*, ACDIS' weekly e-newsletter.*

Related Topics:
Documentation improvement, Medicare news

Tips for coding critical care scenarios

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News & Insights

Critical care coding can be confusing for both coders and providers because of the complexity of time-based codes and multiple bundled procedures. When defining this type of service, the differences between coding for adults, pediatrics, and neonates have similar yet different guidelines.

What is critical care? The *CPT Manual* defines critical care as follows:

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition. Critical care involves high complexity decision-making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or prevent further life-threatening deterioration of the patient's condition.

Remember the following points when coding critical care scenarios:

- Providers can render critical care during life-threatening situations in any area of the hospital.
- Providers can render critical care to adults, children, and neonates.
- Providers most often (but not always) render critical care in the coronary care unit, ICU, pediatric intensive care unit, respiratory care unit, neonatal care unit, or emergency care facility.
- Providers can perform critical care over the course of multiple days.
- Critical care usually involves treatment for one or more vital organ/system failure(s), such as the central nervous system, circulatory system, renal, hepatic, and metabolic/respiratory systems, and shock.
- Many procedures and services are bundled into the application of critical care.
- Critical care and other evaluation and management (E/M) services may be provided to the same patient on the same date by the same physician.
- The *CPT Manual* divides codes for critical care according to patient age and total duration time that the patient spends in critical care.
- Inpatient medical necessity is defined by a severity of illness and intensity of services that can be provided safely and effectively only to an inpatient.
- Industry-standard medical necessity guidelines provide screening criteria for inpatient care, but physician judgment and decision-making take precedence if they are consistent with accepted professional practice guidelines.

***Editor's note**: This article is an excerpt from "The Complete Guide to Medical Necessity: JustCoding's Training and Education Toolkit" by Lori-Lynne A. Webb, CPC, CCS-P, CCP, CHDA, CDIP, COBGC.*

Related Topics:
Coding, Documentation improvement

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