CMS issues NCD, expands T-TEER coverage

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News & Insights

CMS recently issued a final decision memo to formally expand Medicare coverage of transcatheter edge-to-edge repair (T-TEER) for the treatment of tricuspid regurgitation (TR).

The agency initiated a coverage analysis for T-TEER in late 2024 and set out to develop a National Coverage Determination (NCD) under coverage with evidence development (CED). The CED pathway allows Medicare to reimburse items and services furnished in the context of clinical studies or with the collection of additional clinical data.

T-TEER is covered when furnished according to an FDA market-authorized indication and certain patient, physician, and CED study criteria are met. First, despite optimal medical therapy, the patient must have symptomatic TR with tricuspid valve repair being considered as appropriate by a heart team. They must be under the care of this team in both pre-operative and post-operative settings.

At a minimum, the heart team must include the following specialists with experience in treating TR:

- Cardiac surgeon
- Interventional cardiologist
- Cardiologist with training and experience in heart failure management
- Interventional echocardiographer

CMS-approved T-TEER studies must include several elements, such as specific primary outcomes, an active comparator, and a care management plan that reflects the experience and role of each expert on the heart team.

Throughout its analysis, CMS received a total of 93 comments from physicians, organizations, professional associations, and other industry stakeholders during two public comment periods. Of note, many commenters raised concerns over CMS' proposal to require an electrophysiologist on the heart team. In response, the agency removed this criterion in its final decision.

T-TEER is not covered for patients outside of a CMS-approved study, and nothing in the NCD precludes T-TEER coverage through NCD 210.1 or the agency's Investigational Device Exemption policy.

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

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Coding SMEs needed

August 11, 2025
News & Insights

Are you passionate about sharing your knowledge and looking to make an impact in medical coding? Are you an experienced coding professional with inpatient, outpatient, pro-fee, specialty, or pediatrics knowledge? If so, we need you! HCPro is looking for subject matter experts to join our team on a contracted basis to design and/or review custom educational solutions for a variety of healthcare clients. This would include creating e-learning modules, presentations, and assessments to help teams stay up to date with industry best practices and compliance standards.

To learn more about this opportunity, contact Adrienne Trivers at Adrienne.Trivers@hcpro.com and include your professional resume/CV. We would love to hear from you!

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Case study: CDI education through audits

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News & Insights

For **Mariclare Hoffmann, RN, BSN, CCDS,** director of CDI at UC Health in Aurora, Colorado, audits—or, what her department refers to as "assessments"—are strictly intended to "focus on the education and individualized support of the CDI specialist."

"The goal," Hoffmann says, "is to make sure we can ensure a high level of competency, compliance, as well as quality. We're always focused on supporting the CDI specialist: Whether they're struggling to write their queries, providing enough clinical evidence, or just finding opportunities, we customize our education to whatever the needs of the specialist are."

At UC Health, conducting audits is the responsibility of the CDI educators. In Hoffmann's department, this task is split between one lead educator and three auditor/educators under the direction of one quality and education supervisor.

According to Hoffmann, UC Health has two audit types. The first is a "comprehensive audit," which is "top to bottom, including queries, clinical evidence, and missed review opportunities." For new hires, this audit occurs at six months and again at one year. After the first year, all CDI specialists are audited annually.

"Those [comprehensive audits] are the ones more focused on query compliance, making sure are practices are standardized, and making sure that our newly onboarded CDI specialists are moving at a good pace and acclimating to the UC Health workflow," Hoffmann explains.

With this type of audit, there is a score threshold that the CDI specialist must cross in order to pass (currently 85%). CDI specialists who fail to meet the threshold are given continuing education support until they are able to achieve a satisfactory score.

On the rare occasion when a CDI specialist is unable to demonstrate the desired improvements, they are placed on a performance improvement plan. But even this term, according to Hoffmann, is misleading.

"What it really means is that we will go back with them, review everything top to bottom, and do over-the-shoulder reviews with them. This way, they have real-time feedback. We would do this for several months before we would consider terminating an employee. We truly have assessments focused on the educational support and individual growth of the CDI," Hoffmann says.

The second type of audit is a "missed query" audit. These are, Hoffmann says, "purely educational" in orientation: "It's just for another opportunity for someone else to come up behind the CDI specialist and point out if they missed any query opportunities and provide some constructive feedback. There's not even a score associated with those."

Editor's note: *This is an excerpt from "'It's really not what you think': CDI education and audits," in the July/August 2025 edition of the* CDI Journal*.*

Related Topics:
Auditing and monitoring, Documentation improvement

Q&A: An interdepartmental approach to hospital mortality reviews

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Q: What is the purpose of hospital mortality reviews, and how are they calculated?

A: In simple terms, mortality reviews are a review of encounters where patients have expired while in the hospital. These reviews are done for anything related to risk factors, quality indicators, risk adjustment scoring, or financial purposes. Some of the benefits of doing these reviews are that they can most accurately reflect the acuity of patients and the care they are provided, which in turn will impact risk adjustment diagnoses, including mortality risk variables, reimbursement through the acute inpatient prospective payment system, and publicly related data such as CMS star ratings.

There are many types of data that can be reported from mortality reviews. For example, mortality reviews can start with mostly reporting on changes to the severity of illnesses and risks of mortality that were seen in reported diagnosis-related groups (DRG), but then be built out to also calculate risk adjustment changes. Additional information on observed-to-expected mortality rates can be provided as well, helping to identify the DRGs that are most commonly related to mortalities.

Diving more deeply into some of the calculators and methodologies used for mortality reviews and reporting, the mortality index is a standardized way of reporting inpatient mortality and is calculated by dividing the observed mortality by the expected mortality. The observed mortality is the actual number of mortalities within a specific time frame: the goal is to decrease the observed mortality, which is done by increasing the number of patients that are discharged alive. The expected mortality—sometimes referred to as relative expected mortality—is a predicted number of deaths based on patients' level of illness, age, gender, diagnoses, and various other factors. The goal for expected mortality is to appropriately document and code all of the conditions that are contributing to a patient's severity of illness and their risk of mortality. In terms of the score itself, an optimal mortality index score would be less than one, indicating that the actual mortality rate is lower than the expected mortality rate.

The general goal is to decrease observed deaths and then appropriately document the acuity, the severity of illness, and the risk of mortality for all patients in order to improve the expected mortality. It is helpful to understand that the expected mortality is determined by both the patients who expire and the patients who are discharged alive. It's a really important point to remember that the entire population helps determine the expected mortality.

The mortality index can also be utilized to help hospitals understand how their actual mortality rate stacks up against what is statistically expected. Many mortality index methodologies highlight mortality predictors, and those are factors that can increase the expected mortality. Examples of these factors include fluid and electrolyte imbalances, acute and chronic kidney disease, organ failures, malnutrition, cachexia, and neoplasms. Most of those variables have to be present on admission to count towards that relative expected mortality. Generally, inpatient hospice deaths get excluded from the mortality index.

Many mortality cases do have a short length of stay, so it is important to ensure that all of the diagnoses are being documented with supporting clinical indicators, as the principal diagnosis will impact the DRG that is assigned for a particular admission. The DRG can then determine the risk model in which a patient falls into while the risk model is used for the expected mortality within that mortality index. The principal diagnosis selection and DRG really play a large role in the calculation of the mortality index.

Mortality reviews are best approached as a team effort that involves quality review specialists, coders, CDI professionals, providers, and additional stakeholders. To impact the mortality index, there needs to be a collaborative approach, and it has to be a balance between retrospective analysis and proactive improvement.

Editor's note: Sydni Johnson, BSN, RN, CCDS, *director of education for clinical documentation and denials at Banner Health in Arizona, and* ***Beth Simms, BSN, RN, CCDS,*** *CDI and acute care coding program manager at Banner Health, answered this question on the* ACDIS Podcast*. This Q&A originally appeared on JustCoding.*

Related Topics:
Auditing and monitoring, Billing and reimbursement, Coding, Documentation improvement, Patient status

Common errors in skin substitute claims

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News & Insights

One of the most common errors seen in skin substitute claims is the inappropriate application of drug waste modifiers, which are as follows:

- -JW (Drug amount discarded/not administered to any patient)
- -JZ (Zero drug amount discarded/not administered to any patient)

Organizations should train coders on CMS' drug waste modifier policy and consider implementing claim scrubbers to flag missing or incorrect modifiers before submission, says **Betty A. Hovey, BSHAM, CCS-P, CDIP, CPC, COC, CPMA, CPCD, CPB, CPC-I,** senior consultant and owner of Compliant Health Care Solutions in Port Charlotte, Florida.

Organizations need to validate that the amount of units billed corresponds with the amount of units applied, says **Christine Hall, CHC, CDEO, CPC, CPB, CPMA, CRC, CEMA, CPC-I,** CEO and senior consultant for Stirling Global Solutions, LLC, in Port St. Lucie, Florida.

"Encourage coders to cross-reference operative reports and supply logs to confirm that product usage aligns with the code reported," she says.

Hovey recommends working with IT teams to develop an EHR prompt to ensure precise measurements get captured, as many facilities misreport the number of applied or discarded units. For example, they may bill for the entire product size when only a portion was used, or fail to adjust to payer-specific unit calculations.

"Train staff to document exact square centimeters applied and discarded, and verify units against payers' billing rules," she says.

Revenue integrity professionals should understand proper Healthcare Common Procedure Coding System (HCPCS) code selection for skin substitute claims. Hovey recommends maintaining an updated product-code crosswalk that is verified against the HCPCS Level II code list. In addition, she suggests training coders to confirm the product's National Drug Code and brand name in the documentation before coding.

There can be a lot of variation in payers' coverage criteria for skin substitute products, and organizations run the risk of billing for off-label applications not supported by local coverage determinations (LCD) if they aren't aware of the differences. It's important to review LCDs and payers' policies before the product application, notes Hovey.

Skin substitute claims must also include the appropriate Current Procedural Terminology (CPT®) code to reflect the graft application. CPT code selection for skin substitute grafts is based on the location and size of the defect; codes 15271–13274 are used to report application on the arms, legs, or trunk, and codes 15275–15278 are for other locations on the body.

***Editor's note**: This is an excerpt from, "Ensuring appropriate coding and documentation for skin substitute claims," in the July 2025 issue of the* NAHRI Journal*.*

Related Topics:
Billing and reimbursement, Coding, Documentation improvement

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