Q&A: Integrating SDOH documentation

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News & Insights

Q: What are the benefits of integrating social determinants of health (SDOH) documentation into behavioral health coding?

Leigh Poland, RHIA, CCS, CDIP, CIC: Over the last several years, there's been more and more emphasis on encouraging facilities and physicians to track, trend, and assess for SDOHs. We have very robust ICD-10-CM codes that can help us capture any SDOH factors: Z55-Z65.

These Z codes are not for diseases or injuries, but for circumstances, allowing for a more complete picture of the patient's health. The documentation can come from nonphysicians, such as clinicians, nurses, social workers, and case managers. They should document relevant SDOH information from their interactions or health risk assessment. We need to be able to capture this documentation in order to assign these particular codes. Ideally, we're integrating this assessment/documentation into the electronic health record so, in turn, we can capture the codes.

Why is this important? It paints a holistic picture of that patient. It gives a comprehensive understanding of the patient's overall health. It improves resource allocation. If we help to identify the social factors that are impacting that patient, we can link them with resources that will help support their social risk factor. This is beyond traditional medical services, and it enables better allocation of resources.

It allows for informed public health strategy because we have that aggregated data on SDOHs, and then it also allows payers and policymakers to better understand the impact of SDOHs on health outcomes and resource allocation.

Editor's note: *Poland provided this information in the HCPro webinar, "Mind the Gap: Strengthening Behavioral Health Coding and Documentation."*

Related Topics:
Coding, Documentation improvement

CMS issues CY 2027 OPPS proposed rule

July 8, 2026
News & Insights

CMS recently published the calendar year (CY) 2027 Outpatient Prospective Payment System (OPPS) proposed rule, outlining its plans to update Medicare outpatient payment rates and policies. Overall, CMS is proposing to update OPPS payment rates by 2.4% for CY 2027.

One of the key proposals in the rule is to pay for certain imaging services without contrast furnished in excepted off-campus provider-based departments at the Medicare Physician Fee Schedule-equivalent rate, rather than the higher OPPS rate. This policy is intended to expand site-neutral payments, but rural sole community hospitals would be exempt, according to CMS.

Based on data it collected during the Outpatient Drug Acquisition Cost Survey earlier this year, CMS is proposing to significantly reduce payments for 340B drugs. While the agency currently pays for 340B drugs at the average sales price (ASP) plus 6%, it is proposing to reimburse these drugs at ASP minus 33.4% starting in CY 2027. CMS has had its sights set on reducing 340B payment rates for years, but its previous controversial attempt was ultimately vacated by the Supreme Court. Similar to last time, the American Hospital Association and other industry stakeholders strongly oppose the proposal.

The proposed rule also calls for extensive cuts to the inpatient-only (IPO) list. In the CY 2026 OPPS final rule, CMS initiated a three-year elimination of the IPO list by removing 285 mostly musculoskeletal procedures. Now, it is proposing to cut 637 procedures in CY 2027, including certain digestive, endocrine, and maternity care services. If finalized, this proposal would leave roughly 800 procedures on the list ahead of the final transition year.

The CY 2027 OPPS proposed rule also details potential updates to quality programs, prior authorization, pass-through payments, and more. Comments on the rule are due by August 31, 2026. Revenue cycle staff can view CMS' fact sheet and press release for more information.

Related Topics:
Billing and reimbursement, Medicare news, OPPS

Highlights from the CY 2027 MPFS proposed rule

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News & Insights

CMS released a draft copy of the calendar year (CY) 2027 Medicare Physician Fee Schedule (MPFS) proposed rule this week, offering a first look at its plans to update physician reimbursement and related policies next year.

As required by statute, the proposed rule includes two separate conversion factors (CF) for qualifying and non-qualifying alternative payment model (APM) participants. For CY 2027, the proposed CFs are $33.17 for qualifying APM participants and $32.84 for non-qualifying APM participants, representing projected decreases of 1.19% and 1.68% from CY 2026.

CMS is proposing to reduce payment when a separately identifiable office/outpatient (O/O) evaluation and management (E/M) visit is furnished by the same physician or practice on the same date as a 0-, 10-, or 90-day global procedure. When a surgical procedure and separately identifiable E/M visit are furnished on the same day, CMS is proposing to pay the higher-valued service at 100%, while similar services furnished on the same day would be paid at 50%.

The proposed rule also calls for several changes related to the O/O E/M visit complexity add-on code, HCPCS code G2211. Notably, CMS is proposing to transition G2211 to a modifier that can be appended to the associated E/M base code.

“This modifier would increase the payment of the associated E/M code by 16%, instead of a flat rate, maintaining an equal percentage increase across all levels of E/M codes,” according to the CMS fact sheet.

The rule includes multiple provisions concerning remote physiologic monitoring (RPM) and remote therapy monitoring (RTM) services. Along with service valuation changes and other updates, CMS is proposing the following:

- Requiring RTM services to be furnished to only established patients
- Requiring practitioners who report RPM/RTM services to furnish a separately reportable initiating visit at the start of RPM or RTM services
- Allowing payment for RPM/RTM services only when clinical staff employed by the billing practice deliver them, rather than contractors

Other proposed updates include practice expense methodology changes, new HCPCS codes for advance care planning services, and more. Public comments on the CY 2027 MPFS proposed rule are due by September 14, 2026. Of note, CMS is seeking comments on code sets, primary care service valuation, and global surgery payment accuracy.

Related Topics:
Billing and reimbursement, Coding, Medicare news

Get expert insights on denials at 2026 RIS

July 22, 2026
News & Insights

Join your most forward-thinking revenue integrity and revenue cycle peers for two days of empowering education and networking at the 2026 Revenue Integrity Symposium (RIS), to be held September 24-25 in Savannah, Georgia. 2026 RIS will cover essential education, updates, and thought leadership on topics that span the revenue cycle. Read the full agenda for more details on the sessions and speakers.

On day one of this year's event, **Monica E. Oas, CPC, CPMA,** enterprise denials program manager at UC Davis Health in Sacramento, California, will present a session on practical strategies for identifying the root causes of denials. Below, Oas provides a sneak peek of her session "Grab a Shovel: Digging for True Root Causes in Denial Data" and explains how her insights can help revenue cycle professionals.

Q: In what ways does your session challenge attendees to think outside the box?

Oas: This session challenges attendees to move beyond treating "root cause" as a buzzword and start thinking about what it actually requires in practice. In denial work, root causes are rarely obvious; they're often buried beneath layers of workflow, system behavior, and operational nuance. Getting to them means doing the digging, looking beyond the surface signal, and untangling what's really driving the outcome.

Q: What's the biggest challenge in revenue integrity and/or revenue cycle right now? How does your session help tackle this?

Oas: One of the biggest challenges in revenue cycle today is navigating a payer/provider dynamic that doesn't always operate on a level playing field. Denials can occur for valid reasons, but also for reasons that are unclear, inconsistent, or difficult to influence.

The real challenge is distinguishing what is within our control from what requires a different strategy, whether that's escalation, contract alignment, or payer engagement.

This session helps tackle that by focusing on how to accurately identify the true drivers behind denials. When you understand the core issue, you can apply the right solution, whether that's an internal process change or a more strategic payer-focused approach.

Q: What's one of the key pieces of information you would like people to take away from your session?

Oas: One of the key takeaways from this session is the importance of challenging assumptions, especially when working from incomplete information. In denial data, the first explanation is not always the right one. I want attendees to strengthen both their skill and their instinct to do the detective work: validate, test, and let their understanding of a problem evolve as clearer information emerges.

Q: What are you most excited about for this year's conference?

Oas: I'm especially excited to be a first-time presenter and to share real, practical experiences with others who are working through many of the same challenges. I'm also looking forward to the conversations that happen outside the sessions, hearing how others are approaching similar problems and exchanging ideas that we can all take back and apply in our own organizations. And on a personal note, I'm excited to experience Savannah for the first time. I've heard it's a beautiful city with a lot of character.

Q: What's a great piece of advice you've received regarding revenue integrity and/or revenue cycle? Or, what advice do you like to give people about revenue integrity and/or revenue cycle?

Oas: A great piece of advice I've received is to stay curious longer than you're comfortable. There's often pressure to quickly define a problem and move to solutioning, but in revenue cycle, the first answer is rarely the full story. Taking the time to ask a few more questions, test assumptions, and explore patterns more deeply often leads to much more accurate, and ultimately more impactful, solutions.

Editor's note: *Click here to learn more about 2026 RIS and register for the event. NAHRI and ACDIS members are eligible for a $100 discount on their registration. To receive your exclusive member savings or learn about group discounts, contact HCPro customer service at 800-650-6787 ext. 4111 or HCEvents@hcpro.com.*

Related Topics:
Auditing and monitoring, Denials and appeals

OIG issues Spring 2026 Semiannual Report to Congress

July 29, 2026
News & Insights

The Office of Inspector General (OIG) recently published the latest edition of its semiannual report to Congress, summarizing key oversight activities conducted between October 1, 2025, and March 31, 2026. The report informs HHS leadership and Congress about significant findings, recommendations, enforcement actions, and other oversight efforts.

Overall, the OIG's work generated $5.56 billion in investigative receivables, audit and evaluation receivables, and potential cost savings during this reporting period. The agency issued 78 audit reports and completed 881 investigations. It also issued 173 recommendations that identified roughly $958 million in questioned costs and funds that could be put to better use. Organizations implemented 182 of the OIG's recommendations, resulting in nearly $263 million in savings.

Revenue cycle professionals should take note of the OIG's recent oversight activities aimed at strengthening financial integrity. The report emphasizes findings from early 2026 that suggest Maine and Colorado may have made up to $123 million in improper fee-for-service Medicaid payments for certain autism therapy services. In October 2025, the OIG identified nearly $22.7 million in improper Medicare payments to suppliers for durable medical equipment furnished during inpatient stays.

The report also highlights the OIG's efforts to identify other cost-saving opportunities, including findings related to opioid use disorder treatment services, continuous glucose monitors and supplies, and Stelara biosimilar drugs used to treat certain autoimmune diseases.

Beyond payment integrity, the report outlines the OIG's ongoing efforts to combat healthcare fraud, protect patients from harm, address public health crises, safeguard grant and contract integrity, and strengthen cybersecurity. Revenue cycle professionals should read the report in full, as the findings could signal future oversight and enforcement priorities for both HHS and Congress.

Related Topics:
Auditing and monitoring, Billing and reimbursement, Compliance, Medicare news

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