CURAWISE
BILLING SOLUTIONS

CuraWise Newsletter

The Official Newsletter of CuraWise Billing Solutions

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www.curawise-billing.com

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Welcome Message

From the Founder – Building on Momentum

Dear Readers,

Following the overwhelmingly positive response to our inaugural July newsletter, I want to extend my sincere thanks to everyone who reached out with words of encouragement and enthusiasm. Your feedback reinforces why CuraWise was founded—to be a transparent, insightful, and dependable partner in the complex world of medical billing.

Our July issue highlighted major regulatory changes, payer policy updates, and our commitment to smarter revenue cycle management. Since then, we've seen increased engagement from providers, and we're proud to be part of a growing conversation around billing innovation, compliance, and practice profitability.

At CuraWise, our mission is not only to bill claims—it's to empower providers through clarity, strategy, and responsive support. Whether you're a solo practitioner or managing a multispecialty group, our team is here to simplify your workflow and strengthen your bottom line.

Thank you again for trusting CuraWise as your revenue cycle ally. We look forward to navigating this evolving landscape—together.

Warm regards,

Najma Un Nisa

Founder & CEO

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United Healthcare

Arizona Medicaid Approves Self-Collected Cervical Cancer Screenings

In a significant development for preventive care access, UnitedHealthcare has announced that Arizona Medicaid now permits the use of FDA-approved self-collected hrHPV (high-risk human papillomavirus) tests for routine cervical cancer screening under specific clinical conditions. This decision follows the FDA's recent clearance allowing self-collected specimens to be used in a clinical setting when a provider is unable to obtain a traditional clinician-collected sample. However, this option is strictly limited to asymptomatic patients undergoing routine screening; it is not approved for evaluating symptoms or for follow-up after abnormal results.

Eligible individuals must be between the ages of 30 and 64, with no active symptoms, history of cervical cancer, or HIV infection. Patients must not have used any vaginal products or experienced abnormal bleeding within two days prior to collection. Providers are encouraged to confirm with their lab partners that self-collection kits are FDA-approved and supported. To ensure alignment with HEDIS quality measures, CPT codes **87624** or **87626** should be used when submitting claims. These screenings are valid for quality reporting if completed within the current measurement year or up to four years prior.

Based on results, patients testing negative for HPV can wait three years before retesting. Those testing positive for HPV-16 or HPV-18 should be referred for colposcopy. In cases where extended genotyping detects HPV types such as **56, 59, or 66**, providers may consider retesting in one year. All other positive findings should be followed up with a clinician-collected specimen for cytology or dual staining. This policy change supports UnitedHealthcare's broader goals of improving preventive screening rates and closing care gaps for Medicaid members in Arizona.

https://www.uhcprovider.com

United Healthcare

Rhode Island Medicaid Introduces Prior Authorization for Therapy Services Starting November 2025

UnitedHealthcare Community Plan has announced that, beginning **November 1, 2025,** prior authorization will be required for all outpatient **physical therapy, speech therapy, and occupational therapy** services provided to Rhode Island Medicaid members. While the i**nitial evaluation** for these services does **not require prior authorization**, it must still be submitted for tracking and claims processing purposes. Following the evaluation, the **first six visits** under a new treatment plan will be **automatically approved**, as long as they occur within **eight weeks** of the initial session. Providers must submit a prior authorization request for these visits to ensure proper claims handling and continuity of care.

If treatment continues beyond the initial six visits or extends past the eight-week window, UnitedHealthcare will review each additional visit for medical necessity before granting further approval. Prior authorization requests must be submitted **within two business days after the first therapy visit**, and approved authorizations will be backdated to the request date. To support authorization, providers should submit a signed referral, evaluation report, plan of care, and the most recent treatment or progress notes. The portal will open for submissions starting **October 1, 2025**, in preparation for the policy's effective date. These changes apply to both **new and existing therapy patients** and aim to improve documentation, service tracking, and medical oversight under the Rhode Island Medicaid program.

https://www.uhcprovider.com

FIDELIS CARE

Fidelis Launches 2025 Food Access Program for Healthcare Providers

Fidelis Care, which serves more than 2.4 million members across New York State, announced the launch of its 2025 grant program on July 16, 2025, aimed at addressing food insecurity through the expansion of Food Is Medicine (FIM) initiatives. Open to healthcare providers and community-based organizations statewide, the program will fund efforts that integrate access to nutritious food into healthcare delivery—an evidence-based approach shown to improve management of diet-related conditions, reduce healthcare costs, and promote better outcomes among vulnerable populations. With over 2.2 million New Yorkers—including more than 14 percent of the state's children—experiencing food insecurity, the grant initiative underscores Fidelis Care's ongoing commitment to health equity and the integration of social determinants into care models.

Applications must be submitted by **5:00 p.m. on August 6, 2025,** and grant recipients will be announced in September in honor of Hunger Action Month.

Apply here via **fideliscare.org/food-grant**.

www.fideliscare.org

Horizon NJ Health Eliminates 1,000 More Prior Authorization Codes to Reduce Administrative Burden

As part of its ongoing effort to simplify the utilization management process, Horizon NJ Health announced that it will eliminate p**rior authorization (PA) requirements for an additional 1,000 service codes** effective **July 1, 2025.** This move follows a similar action in June 2025, where 1,000 codes were previously removed. In total, Horizon is now eliminating prior authorization for over **30% of all outpatient services** that once required approval—marking a significant shift toward administrative streamlining.

This change is designed to reduce the volume of follow-up requests and paperwork faced by physicians and their staff, allowing them to focus more directly on patient care. Horizon also emphasized its commitment to **automating and digitizing the PA process,** incorporating tools like Availity Essentials to enable providers to verify PA requirements or submit requests 24/7. Starting July 1, 2025, the impacted codes will be removed from Horizon's online tools and clearly marked as **no longer requiring authorization**.

This initiative aligns with national trends aimed at improving efficiency in healthcare delivery by minimizing unnecessary administrative steps—particularly in managed Medicaid and D-SNP programs. Providers are encouraged to use Horizon's **Prior Authorization Procedure Search Tool and Utilization Management Request Tool** for real-time updates and streamlined authorization workflows.

https://www.horizonnjhealth.com/

Horizon NJ Health Encourages Use of ICD-10 Z-Codes to Address Social Determinants of Health

On **July 28, 2025**, Horizon NJ Health released new guidance urging providers to more routinely utilize **ICD-10 Z-codes** to document patients' non-medical needs such as housing instability, food insecurity, transportation issues, and other barriers to care.

These codes—part of the **Z55–Z65** classification—help clinicians systematically record social determinants of health, enabling more comprehensive care planning, enhanced care coordination, and improved communication around patient needs. Documenting these Z-codes supports better tracking and referral workflows for social services and aligns with broader efforts across Medicaid and managed care programs to integrate nonclinical data into value-based care models. Horizon emphasized that these codes are essential in helping eliminate barriers to care and ensuring holistic support for vulnerable populations.

https://www.horizonnjhealth.com/

Cigna Exceeds Earnings Expectations in Q2 2025; Confirms Strong Outlook for the Year

On **July 31, 2025**, The Cigna Group reported robust second-quarter results, with total revenues rising 11% year-over-year to **$67.2 billion, and adjusted income from operations of $1.9 billion, or $7.20 per share**—up from $6.72 in the prior year. Fueled by a 17% increase in performance from its Evernorth Health Services unit—including strong growth in its pharmacy benefit management and specialty care lines—the result exceeded analyst expectations. Net income attributable to shareholders remained stable at approximately **$5.71 per share.**

Cigna reaffirmed its full-year **2025 adjusted EPS outlook of at least $29.60,** supported by continued momentum across strategic business segments and despite elevated stop-loss medical costs in its insurance arm, which slightly raised its medical care ratio to **83.2%**—a metric broadly in line with industry expectations.

Despite strong fundamentals, investors showed caution—shares slipped following the release amid broader concerns over rising medical cost trends. Still, Cigna's relative insulation from government-backed insurance volatility, particularly after the divestiture of its Medicare business, positions it favorably compared to peers. CEO David Cordani attributed the quarter's strength to disciplined execution and a balanced, growth-oriented business mix.

https://newsroom.thecignagroup.com/

aetna

Level of severity inpatient payment policy

Effective N**ovember 15, 2025**, Aetna will implement a revised inpatient reimbursement policy for **Medicare Advantage and Special Needs Plan (SNP)** members, aimed at expediting payments and reducing administrative burden. Under this new approach, hospital stays of **one or more midnights** that are urgently or emergently admitted with a valid inpatient order will be **automatically approved**—even if they do not meet traditional MCG (Milliman Care Guidelines) criteria.

Instead of denying the claim for insufficient medical necessity, Aetna will **reimburse the stay at a lower severity inpatient rate**, similar to what's paid for observation services. If the provider believes the inpatient stay justifies full payment, they retain the right to **appeal for higher-level reimbursement** using MCG criteria. This eliminates the need to re-bill as outpatient or observation in many borderline cases and accelerates the payment timeline.

Importantly, this policy applies only to stays **exceeding one midnight**. Shorter stays will continue to undergo standard **medical necessity review** using CMS guidelines. Aetna emphasizes that this change is intended to simplify provider workflows and promote faster reimbursement, while preserving fair audit and appeals rights.

The official payment policy will be published on the Aetna provider portal via Availity in October 2025.

www.aetna.com

aetna

Aetna Clarifies Lesion Excision Coding for Deeper Tissue Procedures

Starting **November 1, 2025**, Aetna will require providers to use **specific CPT® codes for soft tissue tumor excisions** when reporting removal of lesions located in **deep subfascial or submuscular tissue**, rather than standard integumentary lesion codes. This update applies to both **commercial** and **Medicare plans**.

The commonly used CPT® codes **11400–11471** (benign) and **11600–11646** (malignant) should now be reported **only for cutaneous and superficial subcutaneous lesions**. For **deeper excisions**, providers must use the more appropriate soft tissue excision codes such as:

- **21011–21014, 21552–21556, 21930–21933, 23071–23076, 24071–24076, 25071–25076**, and additional codes in the **27000–28000** ranges.

Improper coding of deeper lesion excisions may lead to **denials, recoding, or delays in reimbursement**. Aetna recommends providers carefully document the anatomical depth of lesions and select codes accordingly.

Note: For providers in Maine and Vermont, these changes will follow the next applicable quarterly effective date (**January 1, April 1, July 1, or October 1)**. In **Washington**, changes will be implemented upon regulatory approval.

www.aetna.com

aetna

Changes to our National Precertification List (NPL)

Effective **August 1, 2025,** Aetna requires precertification for several specialty injectable drugs under both **commercial** and **Medicare** plans. In addition to confirming medical necessity, these requests must also specify the **site of care** where the drug will be administered. This change aims to enhance utilization oversight and ensure appropriate clinical use of high-cost biologics and biosimilars.

The following medications and their associated billing codes now require precertification:

- **Conexxence™** (denosumab-bnht)
  Codes: **J3490, J3590, C9399**
- **Bomyntra™** (denosumab-bnht)
  Codes: **J3490, J3590, C9399**
- **Denosumab-bnht** (biosimilar to Prolia® and Xgeva®)
  Codes: **J3490, J3590, C9399**
- **Omlyclo™** (omalizumab-igec)
  Codes: **J3490, J3590, C9399**
  Site of care precertification required
- **Penpulimab-kcqx**
  Codes: **J3490, J3590, C9399**
  Site of care precertification required
- **Ustekinumab-stba** (biosimilar)
  Codes: **J3490, J3590, C9399**
- **Ustekinumab** (reference product)
  Codes: **J3490, J3590, C9399**
- **Starjemza™** (ustekinumab-hmny)
  Codes: **J3490, J3590, C9399**

Submission Guidelines:

- Submit requests at least two weeks before the planned date of service
- Use Aetna's Availity® portal or integrated EMR system to submit precertification requests
- For specialty pharmacy drugs, use Novologix® (available through Availity)

- Use Aetna's Precertification Lists Search Tool to confirm requirements by CPT®/HCPCS code

State-Specific Notes:

- **Texas:** Applies only to fully insured plans, pending regulatory approval
- **Maine & Vermont:** Effective at the next quarterly cycle (Jan 1, Apr 1, Jul 1, Oct 1) after August 1
- **Washington:** Effective upon regulatory clearance

www.aetna.com

Anthem

Anthem Reminds Providers: Flu Vaccination Reimbursement Covered for NY Members

Anthem Blue Cross Blue Shield of New York recently reaffirmed its reimbursement policy for flu vaccine services for both capitated and fee-for-service contracted providers. Effective immediately, Anthem will reimburse standardized **CPT flu vaccine codes**—such as **90630, 90656, 90672, 90673, 90685, 90686, 90756,** and others—when submitted as part of vaccination services for covered members. This aligns their policy with guidelines set by the New York State Department of Health and ensures providers receive proper credit for administering flu vaccines to eligible patients.

Anthem emphasizes that if providers previously administered flu vaccines for Anthem members but did not include the appropriate CPT code on the claim, they should submit a correct claim—not a new one—to receive reimbursement and quality measure recognition. This ensures both financial compensation and alignment with preventive care reporting requirements.

https://providernews.anthem.com

Anthem

Anthem Releases Comprehensive ABA Provider Resource Guide

Anthem Blue Cross Blue Shield of New York has unveiled a new **Applied Behavior Analysis (ABA) Provider Resource Guide** aimed at supporting providers offering behavioral health services under commercial plans. Developed in alignment with the August 2025 provider update, the guide delivers clear direction on **billing, documentation, and operational standards** for both C**ategory I CPT® codes (97151–97158)** and **Category III codes (0362T, 0373T).** It helps clinicians accurately navigate supervision requirements, group billing, telehealth services, consent documentation, and the structure of treatment and progress notes.

The guide places emphasis on correctly completing CMS-1500 forms (especially field 31), using appropriate modifiers, listing rendering provider NPIs, and documenting treatment planning that aligns with Anthem's criteria—such as individualized interventions, clinical justification, and periodic progress evaluations. It highlights common denial reasons, including unsupported service durations, missing treatment plans, and insufficient provider credentials, and offers actionable tips to avoid these pitfalls by ensuring all encounter documentation supports claim coding.

Anthem encourages credentialed ABA providers in New York to thoroughly review and integrate this resource into their workflows to help improve **claim accuracy, reduce administrative burden,** and elevate continuity of care for patients with autism and behavioral health needs. A full copy of the guide is available via Anthem's provider portal.

https://providernews.anthem.com

Medicare

CMS Issues Emergency Flexibilities for Texas

In response to the ongoing Public Health Emergency (PHE) in the State of Texas, CMS has announced a set of regulatory waivers, flexibilities, and resources to help healthcare providers continue delivering care amid emergency conditions.

These flexibilities include:

- Expedited provider enrollment and claims processing
- Waivers for certain prior authorization requirements
- Temporary adjustments to billing and documentation rules under Medicare, Medicaid, and CHIP

Providers in affected areas should monitor CMS communications for updated guidance and work with their MACs (Medicare Administrative Contractors) for specific billing instructions.

www.cms.gov

Medicare

CMS Proposes and Finalizes Sweeping 2026 Reforms Across Medicare Programs

In a landmark series of updates released in July and August 2025, the Centers for Medicare & Medicaid Services (CMS) has proposed and finalized one of the

the most comprehensive reform packages in recent years—reshaping how providers are reimbursed, how patients access care, and how value is delivered across the healthcare system.

Physician Fee Schedule: Dual Rates & RVU Realignment

The proposed **CY 2026 Medicare Physician Fee Schedule (PFS)** introduces two separate conversion factors—$33.59 for Advanced APM participants and $33.42 for non-APM providers. This dual structure incentivizes participation in value-based care models and reflects CMS's shift toward rewarding performance, not just volume.

Notably, CMS has proposed a 2.5% reduction in **non–time-based work RVUs**, which could impact procedural specialties. However, time-based codes such as E/M, maternity, and telehealth are exempt—creating opportunities for optimized coding strategies and team-based care planning

Telehealth & Virtual Supervision: Permanent Expansion

In recognition of virtual care's essential role post-pandemic, CMS intends to make **virtual direct supervision permanent** and expand the **Medicare Telehealth Services List.** This ensures continued access for patients and reinforces the need for billing teams to maintain robust telehealth documentation and workflow compliance.

Chronic Care Innovation Ahead

CMS has also announced development of a new **Ambulatory Specialty Model** set for 2027, aimed at chronic conditions such as heart failure and low back pain. This signals increased support for team-based, coordinated care—and new billing pathways likely to emerge in the coming year

Facility-Based Payment Increases Finalized

Under finalized FY 2026 rules, several facility types will see payment increases:

- **Skilled Nursing Facilities (SNFs)** receive a 2.7% increase, with case-mix updates and equity-based QRP expansions.
- **Inpatient Hospitals** gain a 3.0% increase under IPPS, with new social determinants of health (SDoH) reporting requirements.
- **Inpatient Rehabilitation Facilities (IRFs)** receive a 2.6% increase, while CMS retires outdated COVID-19 metrics and seeks public input on reducing documentation burden.
- **Inpatient Psychiatric Facilities (IPFs)** and **Hospice providers** each receive a 2.6% increase, alongside expanded quality reporting metrics and the rollout of the HOPE tool.

Home Health & Dialysis Proposals

CMS proposes a 2.5% rate increase under the Home Health PPS, coupled with refinements to value-based scoring and behavioral adjustments. For ESRD providers, CMS proposes raising the base rate to $281.06, with regional adjustments to reflect non-contiguous service costs.

Shared Savings Program & Site-Neutral Reforms

CMS also aims to strengthen the **Medicare Shared Savings Program (MSSP)** by expanding participation support for new ACOs and refining rural benchmarks. Simultaneously, proposed **OPPS/ASC reforms** include enhanced hospital price transparency, expanded prior authorization tracking, and **site-neutral payment alignment** to eliminate disparities across care settings

www.cms.gov

Medicare

CMS Expands Access to Gene Therapies Through Innovative State Agreements

The Centers for Medicare & Medicaid Services (CMS) has announced new agreements with select state Medicaid programs to broaden access to **lifesaving gene therapies** for rare and severe conditions. These high-cost treatments, which can exceed $2 million per patient, are now being made more affordable through value-based payment arrangements.

The initiative allows states to **negotiate outcomes-based contracts** with manufacturers—meaning payment is tied to the therapy's effectiveness. It also introduces **subscription-based models,** giving states predictable annual costs in exchange for broad population access.

The first wave of participating states will implement these agreements for therapies treating conditions like **spinal muscular atrophy (SMA)** and **sickle cell disease**, with more states expected to follow by 2026.

www.cms.gov

Medicare

CMS Flags 2.8 Million Americans for Potential Dual Enrollment in Medicaid and ACA Plans

In a recent data analysis, the Centers for Medicare & Medicaid Services (CMS) identified approximately **2.8 million individuals** who may be simultaneously enrolled in both **Medicaid** and **ACA Marketplace coverage**—raising concerns about duplication of benefits and improper payments.

This overlap is especially problematic during **Medicaid**

redeterminations, where lags in coverage updates may result in enrollees retaining both types of plans without realizing it. CMS is now working with state agencies to resolve these discrepancies, prevent coverage gaps, and recover potential overpayments.

CMS emphasizes that **billing teams and enrollment offices** should review eligibility and insurance coordination protocols, particularly for patients transitioning between Medicaid and subsidized exchange coverage.

www.cms.gov

U.S. Department of Health and Human Services
Enhancing the health and well-being of all Americans

HIPAA Enforcement Spotlight: $290K Settlement for Email Breach

In July 2025, the U.S. Department of Health and Human Services (HHS) announced a Resolution Agreement with Deer Oaks Behavioral Health Organization following a breach that exposed electronic Protected Health Information (ePHI) of more than 16,000 individuals. The breach occurred when an employee's email account was compromised, allowing unauthorized access to sensitive patient data.

An investigation by the HHS Office for Civil Rights (OCR) revealed that Deer Oaks failed to conduct a comprehensive, enterprise-wide risk analysis. The organization also lacked adequate security measures for email access, failed to implement sufficient audit controls, and did not properly train its workforce or monitor vendors in line with HIPAA Security Rule requirements.

As part of the resolution, Deer Oaks agreed to pay $290,000 and implement a two-year Corrective Action Plan. This plan requires the organization to conduct a full risk analysis, develop and implement a formal risk management strategy, update its HIPAA policies and procedures, and provide regular workforce training. Deer Oaks will also be subject to direct monitoring by OCR throughout the two-year period.

This case highlights the importance of proactive compliance. All covered entities and business associates should ensure they regularly assess security risks, encrypt email systems and mobile devices used to access PHI, maintain current Business Associate Agreements, monitor access to sensitive data, and train staff to recognize and respond to phishing attempts. The cost of noncompliance—both financial and reputational—continues to rise.

www.hhs.gov

Medicare

CMS Defeats Humana in Medicare Advantage Star Ratings Lawsuit

A federal court has ruled in favor of the **Centers for Medicare & Medicaid Services (CMS),** dismissing a lawsuit brought by Humana over changes to the **Medicare Advantage Star Ratings system**. The case marks a significant legal victory for CMS and may have lasting implications for payers, providers, and billing organizations involved in value-based care.

Humana challenged CMS's revised methodology for the 2024 Star Ratings, specifically the agency's expanded use of the **Tukey outlier deletion method**, which excluded extreme data points in calculating plan scores. Humana alleged that the change was applied retroactively and without sufficient notice, leading to a lower star rating for its flagship contracts—and the potential loss of hundreds of millions in bonus payments. However, the court sided with CMS, ruling that the agency acted within its legal authority to adjust quality measurement policies in pursuit of more accurate and equitable evaluations. The decision affirms CMS's discretion to refine performance metrics under the Star Ratings program, a cornerstone of the Medicare Advantage quality incentive structure.

For providers and billing partners, the ruling signals that Star Ratings will continue to evolve—and that **documentation, coding accuracy, patient satisfaction, and timely care coordination** will remain critical components of performance. Health plans may adopt more aggressive internal review processes to ensure that quality metrics align with CMS expectations. As the 2026 plan year approaches, stakeholders should monitor further CMS updates to the methodology and prepare for downstream effects on reimbursement and reporting.

www.cms.gov

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PROVIDER BULLETIN

Compliance Alert – OIG 2025 Work Plan Update

The **HHS Office of Inspector General (OIG)** has expanded its 2025 Work Plan to target high-risk billing practices, focusing on **telehealth services, modifier 25 misuse, and duplicate billing.** Providers and billing teams should take note and act promptly to reinforce documentation protocols and audit procedures.

Telehealth billing compliance: OIG's program integrity review of telehealth services has identified risks including **upcoding** (billing for higher levels of service than medically necessary), duplicate billing, and billing for services not rendered or inappropriate for telehealth delivery. – OIG reports show that some providers billed the highest level of telehealth service on nearly every visit, and duplicated claims across Medicare fee-for-service and MA or VA systems. – Overly frequent telehealth billing without adequate documentation is a red flag.

Modifier 25 misuse: OIG audited E/M claims billed with modifier 25 on the same date as intravitreal injections and found that **42% of such claims** did not meet Medicare requirements. In sample reviews, **22 out of 24 claims lacked documentation** to support a separate E/M service. Medicare paid approximately **$124 million** for these at-risk claims during the audit period. OIG has recommended CMS update billing guidance and conduct medical reviews to recover improper payments.

Duplicate billing concerns: OIG flagged instances where providers billed the same telehealth service twice —for example, both through Medicare fee-for-service and a Medicare Advantage plan—or multiple times for the same procedure. These duplications may indicate billing system errors or improper submission practices.

www.oig.hhs.gov

Medicare

CMS Proposes Physician Payment Rule: Cut Waste, Enhance Quality, Strengthen Chronic Care

On July 14, 2025, the Centers for Medicare & Medicaid Services (CMS) published its CY 2026 Medicare Physician Fee Schedule (PFS) proposed rule (CMS-1832-P). The rule aims to significantly reduce unnecessary spending, elevate quality measures, and improve chronic disease management for Medicare beneficiaries.

Enhanced Quality Measures & Chronic Disease Focus

CMS plans to eliminate ten low-yield quality measures and introduce five new outcome-based metrics—such as diabetes prescreening and preventive services—to better support care for chronic conditions and bolster long-term health outcomes.

New Ambulatory Specialty Model (ASM)

Starting in January 2027, specialists treating conditions like heart failure and lower back pain would participate in a mandatory payment model. ASM emphasizes early identification, care coordination, and payment tied to outcomes rather than volume.

Reducing Waste Around Skin Substitutes

Medicare spending on wound care materials skyrocketed from $256 million in 2019 to over $10 billion in 2024. CMS proposes paying for skin substitutes as incident-to supplies, potentially slashing reimbursement by nearly 90% while preserving access.

Telehealth & Digital Health Expansion

The proposal simplifies telehealth inclusion on the Medicare list and proposes making COVID-era flexibilities permanent. It would also broaden reimbursement for digital behavioral health treatment devices (DMHT) and enable tele-supervision for certain services like cardiac rehab.

Payment Conversion Factors Raise Reimbursements

The agency proposes two separate conversion factors beginning in 2026: Qualifying APM Participants (QPs) would receive a 3.83% increase, while non-QP clinicians would get 3.62%, resulting in base rates of approximately $33.59 and $33.42, respectively.

Implications for Stakeholders

Providers

Expect heightened emphasis on documentation of preventive care, outcome-based metrics, and coding precision in chronic disease pathways. Specialist practices should prepare for ASM participation starting in 2027.

Payers

Plan sponsors and private payers aligned with Medicare may preemptively reshape metrics and value-based programs to mirror CMS priorities.

Billing Partners

Prepare billing systems for new conversion factors and code updates. Ensure compliance with skin substitute reimbursable policies and documentation standards for DMHT billing.

CMS's CY 2026 Physician Fee Schedule proposal marks a major shift toward outcome and prevention, with new quality metrics, a mandatory chronic care model (ASM), and significant payment reductions for high-cost supplies like skin substitutes. Telehealth and digital health are receiving stronger support while move toward value-based care accelerates. Physicians operating under qualifying alternative payment models (QPs) may see higher reimbursement growth compared to non-participants. Key actions include preparing for upcoming changes in documentation, billing workflows, and care coordination programs. CMS is accepting comments on the proposal until September 12, 2025.

www.cms.gov

Medicare

ICD-10-CM Code Set Updates – Effective October 1, 2025

The Centers for Medicare & Medicaid Services (CMS) has released the finalized ICD-10-CM diagnosis code set for fiscal year 2026, effective for services and inpatient discharges occurring from October 1, 2025, through September 30, 2026. This annual update includes 395 new diagnosis codes, 25 deletions, and 13 revisions, along with significant structural and guideline adjustments that impact clinical documentation, coding accuracy, and reimbursement workflows.

A primary focus of the FY 2026 update is improved specificity for long COVID cases. The coding structure under U09.9 has been expanded to reflect persistent post-COVID symptoms such as cognitive impairment, chronic fatigue, pulmonary complications, and cardiovascular sequelae. This change supports more accurate clinical tracking and resource allocation for long-term COVID-related care.

Behavioral and mental health classifications have also been refined. New diagnosis codes provide granularity for conditions like generalized anxiety, mixed depressive states, sleep disorders linked to psychiatric diagnoses, and self-injurious behaviors. These additions will enhance clinical documentation, coding clarity, and value-based care reporting.

In alignment with CMS's health equity goals, the FY 2026 update includes new Z codes related to social determinants of health (SDoH). These codes capture important non-clinical factors such as housing instability, food insecurity, lack of transportation, literacy barriers, and inadequate social or family support systems. Accurate use of these codes will help quantify patient risk profiles and support health equity data strategies.

The code set also includes updates to musculoskeletal and neurological diagnoses. These involve refined terminology for cervical disc disorders, classification of hereditary myopathies, and expanded subtypes of migraines and headaches—supporting improved specificity in clinical documentation and risk adjustment.

Healthcare organizations are expected to complete all system updates to electronic health records (EHRs), billing platforms, and encoder tools prior to the October 1 implementation date. Coders, providers, and clinical documentation specialists should undergo training on the updated guidelines and revised code groupings. Clinical templates, encounter forms, and provider education materials must be revised to ensure alignment with the new diagnosis structure and definitions.

Failure to implement the FY 2026 code set on time may result in billing denials, claim rejections, audit findings, or compliance risk due to the use of invalid or outdated codes. Clinical documentation improvement (CDI) programs should work closely with coding departments to identify documentation gaps and ensure that providers are capturing the level of detail required to support the new codes.

For more information and access to the full update, providers may refer to the CMS ICD-10-CM resource page at cms.gov, and review AAPC's summary analysis at AAPC FY 2026 ICD-10-CM Update.

www.cms.gov

AI in Medical Billing: Enhancing Denial Prevention and Prior Authorization

Artificial intelligence (AI) is transforming medical billing by providing predictive denial management and smarter prior authorization workflows. AI-driven tools analyze historical claims and payer behavior to predict which submissions are likely to be denied before they are sent, enabling corrections upfront and greatly reducing error rates. Such systems help identify coding inconsistencies, missing authorizations, or eligibility gaps that commonly lead to denials.

In real-world applications, community health networks using predictive analytics have seen prior-authorization denials from commercial payers drop by 22%, as AI flags problematic claims before submission and reduces manual appeals burden by 30–35 hours weekly. AI also accelerates cash flow by reducing days in accounts receivable and enabling smarter denial follow-up prioritization based on risk scores and patterns derived from previous payer behavior.

AI is also streamlining prior authorization. Systems now auto-identify services requiring authorization, pull pertinent clinical information directly from EHRs, fill out authorization requests, and even predict approval likelihood based on payer criteria. This automation significantly reduces front-end workload and accelerates decision cycles.

One provider network success story illustrates this shift: by using AI to automate document processing and claim filtering, manual tasks were reduced by half, turnaround times halved, documentation time dropped by 40%, and over 15,000 labor hours were saved each month—delivering a 30% return on investment.

However, not all outcomes are positive. Physician associations warn that payer-side AI tools may increase denial rates for prior authorization, sometimes denying necessary care without sufficient human oversight. In a recent survey, 61% of physicians expressed concern that AI is increasing denials and disrupting care.

AI-based denial prediction and prior authorization automation dramatically reduce manual workloads, improve first-pass clean claims acceptance, and speed revenue cycle operations—all while allowing staff to focus on higher-value tasks. These solutions also provide real-time denial insights and workflow improvements, which reduce turnaround time and improve claim accuracy.

While AI on the billing side offers great efficiencies, provider teams should monitor reliance on payer-side AI denial systems to ensure patient care is not hindered. Ensuring human review for prior authorization denials remains essential to prevent inappropriate denials and patient harm.

www.ama-assn.org

Optimizing Patient Collections: Enhancing Point-of-Service Payments, Card-on-File, and Flexible Plans

Improving patient collections begins by offering transparent cost estimates prior to service, empowering patients to understand and manage their financial responsibility. Sending estimates ahead of appointments and confirming eligibility shortly before visits significantly increases the likelihood of collecting co-pays and deductibles at the point of service. Collection rates decline steeply when balances are left uncollected until after the visit. This practice considerably improves payment clarity and avoids surprises during billing cycles.

Collecting payments at the point of service—including co-pays, incidental charges, and pre-service balances—minimizes days in accounts receivable, reduces bad debt, and boosts practice profitability. Studies indicate that balances not collected at check-in have a far lower chance of being paid at all, with point-of-service collections proving far more effective in cash flow recovery.

Maintaining a secure credit card-on-file system offers flexibility to charge payments for outstanding balances or incidental charges immediately and efficiently. When permissions are managed appropriately and security standards are met, practices benefit from faster payment turnaround and increased collections consistency.

Offering flexible, interest-free or low-interest payment plans helps patients manage larger balances over time, leading to higher overall payment rates and reduced reliance on collections agencies. Practices that implement internal or outsourced payment plan programs often strike a balance between affordability for patients and revenue integrity for the provider.

Successful collection strategies also depend on clear financial communication and patient engagement. Staff training on how to explain patient responsibility, using templates for statements and reminders, and leveraging patient portals or text messaging helps maintain transparency and prompt payments. Automated follow-up sequences and digital patient portals further streamline the process, making it easier for patients to pay at their convenience.

www.nexhealth.com

How to Scale a Medical Billing Business Without Sacrificing Compliance or Quality

As more practices seek specialized billing partners and reimbursement rules grow more complex, medical billing companies have a massive opportunity to expand. But with that growth comes risk—particularly around quality control and compliance. The question isn't just how to grow, but how to scale sustainably without compromising the standards that keep your clients—and regulators—satisfied.

Growth vs. Risk: Why Scaling Carefully Matters

Rapid expansion can lead to increased denials, coding inconsistencies, missed filing deadlines, and even HIPAA violations if quality assurance doesn't scale in parallel. While it's tempting to onboard more clients quickly, doing so without solid systems in place can create long-term damage to your brand and relationships.

1. Invest in Process Before Headcount

Before hiring more billers or taking on additional accounts, map out standardized workflows that apply across specialties—eligibility verification, charge entry, coding review, AR follow-up, and reporting. Documented SOPs allow for smoother onboarding, training, and consistency, regardless of team size.

2. Automate Intelligently

Scaling doesn't mean hiring endlessly. Invest in RCM platforms, clearinghouse integrations, and claim scrubbers that reduce manual labor and increase throughput. AI-based denial prediction tools, automated eligibility checks, and batch EDI claim management can streamline operations without increasing error rates.

3. Maintain Quality Through Internal Audits

As client volume grows, build a system of internal QA reviews for coding accuracy, charge integrity, and documentation compliance. Random audits, pre-submission reviews, and monthly scorecards help catch issues early and preserve client trust.

4. Protect Compliance at Every Layer

Scaling means more PHI, more endpoints, and more staff handling sensitive data. Ensure all systems remain HIPAA-compliant, enforce role-based access controls, and use BAAs with every vendor. Train new hires on security awareness and keep documentation ready for OCR or payer audits.

5. Don't Rush Onboarding

Taking on new clients quickly can feel like success—but improper onboarding is one of the top causes of denial spikes. Use a structured onboarding checklist: gather payer IDs, coding templates, fee schedules, NPI/TIN validation, and access credentials before claims start flowing. A 10-day delay upfront is better than a 90-day AR nightmare.

6. Monitor Metrics—And Share Them

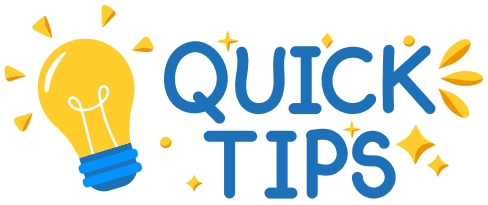
Tracking days in AR, first-pass clean claim rates, denial percentages, and collection ratios is key to spotting scaling stress. Share performance reports with clients monthly. Transparent communication builds loyalty and shows you're managing growth responsibly.

7. Build a Scalable Team Culture

As you expand, ensure your team is aligned around quality, accountability, and communication. Use centralized ticketing tools, define escalation protocols, and empower billing leads to train and manage others. A strong internal culture is the best defense against client churn and operational chaos.

Final Word

Scaling a billing business isn't just about size—it's about systematizing excellence. Companies that grow without sacrificing compliance or quality earn more than revenue—they earn long-term trust. That's what separates a billing vendor from a billing partner.



- **Credentialing delays** continue to be a leading cause of claim rejections and delayed payments. To stay ahead, practices should begin the credentialing process at least 90 to 120 days before the intended start date. This ensures timely payer enrollment, especially for new providers or location expansions, and avoids reimbursement gaps once services begin.
- **Modifier 25** is frequently misused, leading to payer audits and recoupments. Remember: it should only be used when a significant, separately identifiable E/M service is performed on the same day as a procedure. Accurate usage requires clear documentation in the clinical notes, detailing how the E/M service went beyond the pre-procedural assessment.
- To speed up **payment posting** and reduce human error, practices should automate Electronic Remittance Advice (ERA) processing wherever possible. At the same time, it's crucial to train billing staff to understand and interpret denial reason codes and remark codes. Recognizing trends in denials allows teams to respond proactively, correct root causes, and improve clean claim rates over time.

Calendar & Events

Compliance Deadlines – Fall 2025

September 30, 2025 – Sunset of HCPCS Code G0511

CMS will officially discontinue the use of code G0511 for general care management services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) after this date. Providers should review CMS's updated billing guidance for transitioning to alternative care management codes or models.

October 1, 2025 – ICD-10-CM FY 2026 Code Set Becomes Effective

The FY 2026 ICD-10-CM updates go into effect for all discharges and patient encounters from October 1, 2025, through September 30, 2026. These updates include 395 new diagnosis codes, and revisions with significant implications for long COVID, behavioral health, and SDoH documentation. All billing and EHR systems must be updated by this date.

National Webinars – Upcoming Learning Opportunity

CMS will host a national **MLN Connects webinar on August 28, 2025**, offering a comprehensive overview of the **Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule.** This session will cover key changes related to physician payment rates, telehealth services, quality measure updates, and the proposed Ambulatory Specialty Model (ASM) aimed at improving chronic care management.

The webinar is open to providers, billing professionals, compliance officers, and practice administrators interested in understanding how the proposed rule could impact reimbursement and reporting in the upcoming year.

Date: Wednesday, August 28, 2025
Time: 1:00 PM–2:30 PM ET
Registration & Details: CMS MLN Connects – CY 2026 PFS Webinar

Conferences – Late Summer & Fall 2025 Highlights

AAPC Compliance Summit

In-person professional education opportunities this fall include the **AAPC DOCUCON event,** a virtual conference delivering up to **12 CEUs** and focusing on coding, documentation best practices, and compliance strategies. Scheduled for **September 9–10, 2025,** DOCUCON provides essential updates for medical coding teams and compliance officers.

www.aapc.com

MGMA Leaders Conference 2025

For operational leadership and healthcare practice executives, the **MGMA Leaders Conference** will take place from **September 28–October 1, 2025,** at the Orange County Convention Center in Orlando, FL. This flagship conference addresses trends in practice leadership, financial planning, patient experience, and scaling operations across ambulatory care settings. It convenes over 1,300 industry decision-makers and includes continuing education credits (ACMPE, ACHE, CME) for attendees.

www.mgma.com

Have questions, need support, or want to explore how to optimize your billing and compliance operations? We're here to help.

Whether you're looking for AR recovery, coding audits, credentialing support, or a trusted full-service RCM partner, our team is ready to assist. Reach out today—we'd love to connect with you.

Contact us :

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Thank You