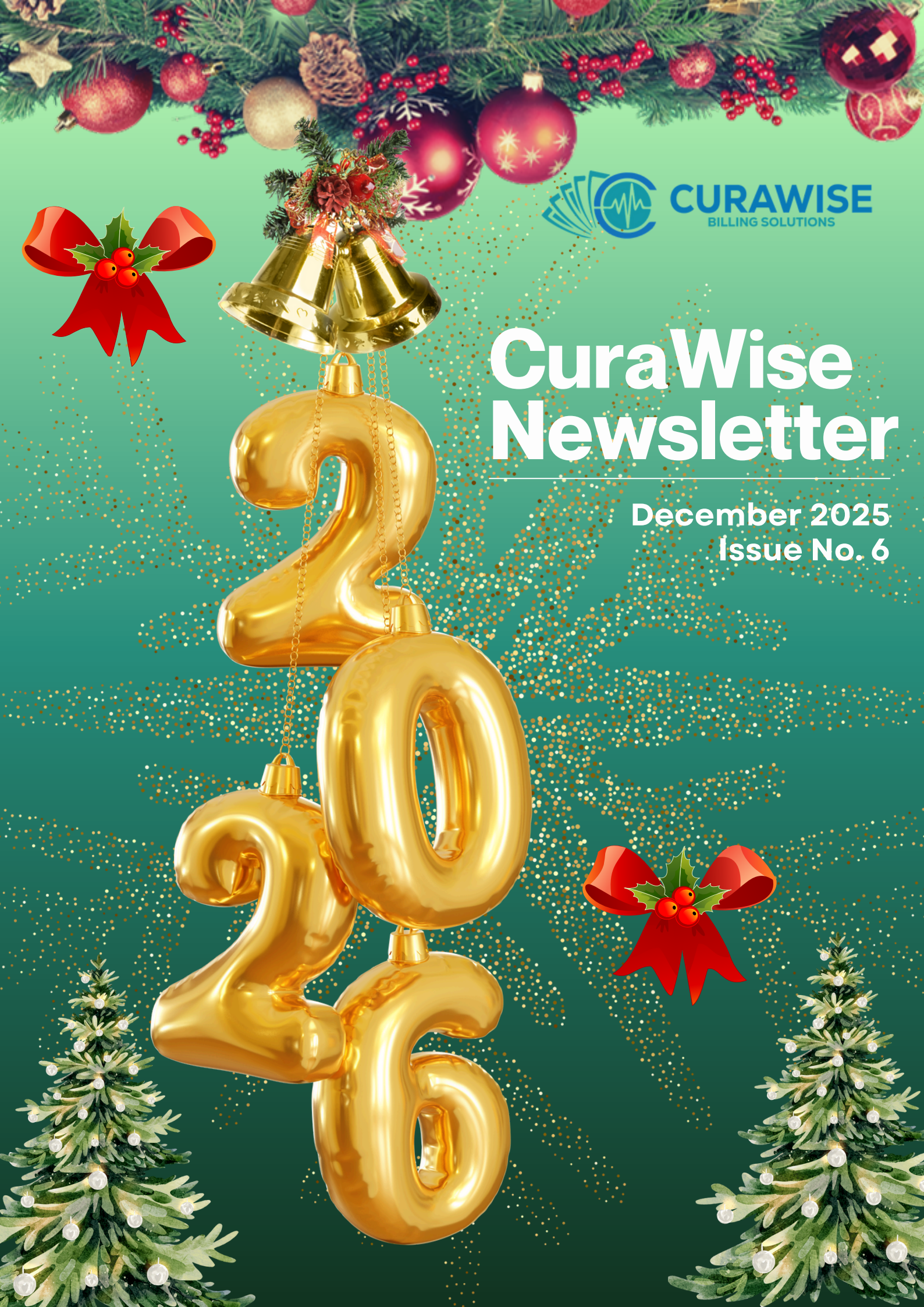
CURAWISE
BILLING SOLUTIONS

# CuraWise Newsletter

December 2025
Issue No. 6



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# Welcome

As we step into December, the focus shifts from precision to closure. This is the month where every correction made in November becomes stability — and every unresolved detail risks rolling into the new year.

December reminds us of pause — and preparation. Payers slow further, holiday schedules shorten operational windows, and year-end cutoffs limit movement across all stages of the revenue cycle. That makes December the definitive moment to finalize claims, clear A/R, verify documentation, and secure every dollar before 2025 officially closes.

Finishing the year strong isn't about adding pressure — it's about completing what matters most while there is still time.

At CuraWise, we remain committed to helping providers end the year with accuracy, confidence, and complete visibility. Our goal is simple: ensure January begins clean, stable, and free of inherited backlog.

*Together, we close 2025 with clarity — so 2026 begins without delay.*


INDUSTRY INSIGHT

## UnitedHealthcare Removes Prior Authorization for Select Imaging Services (Effective 2026)

UnitedHealthcare has announced that effective **January 1, 2026,** prior authorization requirements will be eliminated for select radiology and cardiology services, including certain **nuclear imaging procedures, obstetrical ultrasounds, and echocardiograms.** This change will apply across multiple UnitedHealthcare lines of business, including Commercial plans, Individual and ACA Exchange plans, Community Plans (Medicaid), Medicare Advantage plans (including D-SNPs), and Rocky Mountain Health Plan.

The update is part of UnitedHealthcare's broader initiative to simplify administrative processes and improve access to care by reducing authorization-related delays. Providers are advised to review the list of impacted procedures to ensure accurate scheduling and billing workflows ahead of the 2026 implementation date.

https://www.uhcprovider.com

## Discontinuation of Vyndaqel

On November 21, 2025, Pfizer confirmed that Vyndaqel® (tafamidis meglumine), the medication used to treat transthyretin amyloid cardiomyopathy (ATTR-CM), will be discontinued in the United States as of **December 31, 2025.**

For members of **UnitedHealthcare (UHC) Medicare Advantage plans—including non-SNP, D-SNP, C-SNP plans and Part D prescription drug plans**—this means Vyndaqel will no longer be available after year-end. As a replacement, UHC lists Vyndamax (tafamidis) as the covered alternative. Importantly, for members who already have an active prior authorization for Vyndaqel, there is **no requirement for a new authorization** to transition to Vyndamax; however, a **new prescription** must be submitted to the pharmacy to maintain continuity of therapy.

If you like, I can also draft a version of this for patients (in more everyday language) to include in your client-facing newsletter or patient-communication materials.

https://www.uhcprovider.com

## Texas Medicaid — Prior Authorization Updates for Medications

UnitedHealthcare Community Plan of Texas announced updates to prior-authorization criteria for certain medications effective **November 24, 2025.** The changes apply to **Wegovy® (semaglutide) and Zepbound® (tirzepatide)** for members enrolled in Texas Medicaid programs, including STAR, STAR Kids, STAR+PLUS, and CHIP. Updates include revised clinical criteria aligned with state DUR Board guidance, removal of prior-authorization checks related to gastroparesis and pancreatitis for Wegovy, updated lookback periods for medullary thyroid carcinoma (MTC) and MEN2, and inclusion of Zepbound in the GLP-1 agonist reference list. Providers prescribing these medications are advised to review the updated requirements to ensure timely approvals and avoid delays in patient care.

https://www.uhcprovider.com

## Important Update — Medicare Post-Acute Care Management Changing Jan. 1, 2026

UnitedHealthcare has announced that beginning January 1, 2026, it will assume responsibility for post-acute care utilization management for certain dual-eligible Medicare Advantage plans — specifically its "Highly Integrated Dual Eligible (HIDE)" and "Fully Integrated Dual Eligible (FIDE-AIP)" plans — in **Michigan, Texas and Indiana.** Previously, this portion of post-acute care management was administered by a third-party vendor (Care Transitions).

For providers, this means that prior-authorization and discharge-planning requests for post-acute care — including stays in skilled nursing facilities, inpatient rehabilitation facilities, and long-term acute care — must now be submitted through the UnitedHealthcare Provider Portal starting 2026, under the revised HIDE/FIDE-AIP authorization workflow. Existing prior authorizations for inpatient services remain valid until expiration; Care Transitions will close them and UHC will reopen them under the new policy structure as of **Jan. 1, 2026.**

https://www.uhcprovider.com

## New Referral Requirement for Specialist Services under UHC Medicare Advantage

As of January 1, 2026, most members enrolled in UHC Medicare Advantage HMO and HMO-POS plans will need a formal referral from their Primary Care Provider (PCP) before seeing specialists for services in outpatient, office, or home settings.

If a referral is not on file (or submitted before the visit), claims may be denied beginning May 1, 2026 — although UHC has stated that for services scheduled between January 1 and April 30, 2026, claims missing referrals may still be processed (as a transition period).

https://www.uhcprovider.com

## Stay Compliant: Access & Availability Standards for Providers

Fidelis Care reminds providers that access to quality care is a critical requirement under standards set by the **New York State Department of Health (NYSDOH) and CMS**. Primary Care Providers, OB/GYNs, specialists, and behavioral health providers are required to meet defined **Access and Availability Standards** to ensure timely, reliable care for all Fidelis Care members. To confirm compliance, Fidelis Care conducts regular Access & Availability surveys that evaluate appointment timeliness, accuracy of provider directory information, and the responsiveness of office phone systems and staff.

Common compliance issues identified through surveys include appointment wait times that do not meet state guidelines, closed provider panels, inaccurate contact details, and offices being unreachable during normal business hours. To remain compliant, providers must keep their contact information up to date, ensure appointment availability aligns with state-mandated standards, and maintain consistent patient access procedures. To support provider readiness, Fidelis Care has released new General Medical and **Behavioral Health Access & Availability Tip Sheets.** Providers with questions or needing assistance are encouraged to contact their assigned Fidelis Care Provider Engagement Account Manager.

www.fideliscare.org

## CLIA Certification and Provider Laboratory Services Reimbursement Guidelines

Fidelis Care reminds providers that the **Clinical Laboratory Improvement Amendments (CLIA) of 1988** are federal requirements designed to ensure the quality of laboratory testing and apply to any facility or individual provider performing laboratory services billed to **Medicare or Medicaid.** To remain eligible for reimbursement, providers must comply with both **federal and New York State regulations,** including maintaining a **valid and active CLIA certificate** appropriate for the type of laboratory tests performed at each service location. Applicable exceptions are determined in accordance with NYS and CMS rules.

To ensure accurate processing of laboratory claims, providers are required to include their **CLIA number on all applicable claims.** For electronic claims, the CLIA number must be reported in **Loop 2300 (REF01 = X4, REF02),** while paper claims (CMS-1500) must list the CLIA number in **Box 23,** using a hyphen or semicolon if multiple entries are included. Providers are encouraged to refer to CMS CLIA resources and Fidelis Care's CLIA Tip Sheet for additional guidance and compliance support.

www.fideliscare.org

## Fidelis Care Updates Authorization Requirements Effective January 1, 2026

Fidelis Care has announced updates to its **Medicaid and Medicare Authorization Grids** effective **January 1, 2026,** introducing new prior-authorization and review requirements for select behavioral health and outpatient surgical services. Under Medicaid, prior authorization will now apply to **Family Psychotherapy (CPT 90847)** and **Group Psychotherapy (CPT 90853),** with notification and concurrent review required for **mental health group psychoeducation services exceeding 30 visits per calendar year;** substance use disorder (SUD) group and family therapy services remain exempt. For Medicare members, **CPT code 20610** will require prior authorization when performed in **freestanding ambulatory surgery centers.** Providers are encouraged to review the updated authorization grids to ensure timely approvals and compliance with Fidelis Care guidelines.

www.fideliscare.org

Anthem

## Partial Hospitalization & Outpatient Programs Now Billed as "All-Inclusive"

Anthem now requires that services under the **Partial Hospitalization Program (PHP)** and **Intensive Outpatient Program (IOP)** — when billed for facility-based care — must be billed as a single "all-inclusive" unit per date of service. Any additional or itemized billing for services included under PHP/IOP will be denied. Providers must ensure claims use the correct revenue/HCPCS codes for PHP/IOP on the UB-04 form to avoid denial

https://providernews.anthem.com

Anthem

## COVID-19 Vaccines Remain Fully Covered Through 2026

Anthem has confirmed that **COVID-19 vaccinations continue to be covered as preventive services through 2026,** with **no member out-of-pocket cost.** This applies when vaccines are administered in accordance with applicable clinical and coverage guidelines. Providers are encouraged to continue offering COVID-19 immunizations and ensure correct coding to support preventive-care reimbursement.

https://providernews.anthem.com

Anthem

## Specialty Pharmacy & Clinical Policy Updates Released

Recent updates include changes and clarifications related to **specialty pharmacy**, prior authorization requirements, and other **clinical and reimbursement policies**. These updates may impact how certain medications and services are approved and reimbursed. Providers should review the latest Anthem communications to stay compliant with evolving coverage and documentation requirements

https://providernews.anthem.com

Anthem

## Reminder: ABA Service Guidelines & Claims Submission for Providers

Providers offering Applied Behavior Analysis (ABA) services under Anthem in New York should note key reminders on referrals, documentation, and claims submission to ensure correct processing and continuity of care. The recent "ABA Reminders" bulletin emphasizes that all ABA service referrals must be properly authorized, and that treatment plans and claims should adhere to Anthem's coding, billing, and resource-allocation guidelines to maintain the integrity of individualized care plans.

https://providernews.anthem.com

aetna

## Infertility Prior-Authorizations Now Include Associated Medications

As of the December 2025 OfficeLink Updates, infertility prior-authorizations (PAs) under Aetna now automatically cover associated medications — meaning a single PA request will cover both the procedure and related drugs. If the request is approved, providers only need to submit the prescription to the pharmacy, simplifying the process for infertility treatments.

www.aetna.com

aetna

## Updates to Claim Edits — New "Claim and Code Review Program (CCRP)" Coming March 1, 2026

Aetna's updated CCRP will begin applying new claim edits from March 1, 2026 for commercial, Medicare, and Student Health members. This includes increased scrutiny for high-dollar claims, bundled services, anesthesia, implants — and other specified claim types — to ensure coding accuracy. Providers should verify all coding carefully, especially for complex or bundled services, and may be asked to supply medical records.

www.aetna.com

## Changes to Vision Coverage for Aetna Medicare Individual Members — EyeMed Requirement

Starting January (year following 2025), members under Aetna's Medicare Individual plan seeking routine vision benefits must see an EyeMed provider to access their vision coverage (routine eye exams, eyewear, etc.). Providers should check eligibility and verify whether they are EyeMed-participating before delivering vision services to ensure proper coverage

www.aetna.com

## Important Changes to Precertification, Coverage & Drug Lists — Check 2026 Formularies & Policies

Aetna will update many components — including its National Precertification List (NPL), pharmacy drug lists, step-therapy/quantity-limit rules, and other coverage requirements. For example, certain procedures (e.g. hip osteotomy) will now require precertification, effective as indicated in the December 2025 bulletin. Providers are advised to review the new formularies and coverage policies carefully before treatment and prescribing.

www.aetna.com

## Reminder: Pre-Approval Requirements for Inpatient Rehab, Skilled Nursing & Home Health Care

Aetna has announced **new pre-approval (prior authorization) requirements for inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF), and home health care services.** These requirements will apply to **certain Medicare Advantage plans** and are **effective starting January 2026.**

Providers must ensure required authorizations are obtained before services are rendered to avoid claim denials and reimbursement delays. CuraWise advises providers to review updated authorization workflows and plan-specific requirements in advance.

**Applicable States: New Jersey, New York, Pennsylvania, West Virginia**

www.aetna.com

## Behavioral Health – Intensive Outpatient Treatment Services

**Molina Healthcare of Ohio** announced an updated policy for Intensive Outpatient Treatment Services billed under **HCPCS code H0015**, as outlined in its November 2025 Provider Bulletin. The update clarifies coverage and reimbursement requirements for structured outpatient behavioral health and substance use disorder treatment programs, including allowable service components when medical necessity criteria are met.

Behavioral health providers should carefully review the revised policy, including documentation standards and authorization requirements, to ensure compliance and avoid billing delays or claim denials.

www.molinahealthcare.com

## Durable Medical Equipment (DME) - Enclosed Bed Systems & PA Requirements

Molina Healthcare reiterated its **Durable Medical Equipment (DME)** requirements for Ohio Medicaid providers, emphasizing that **prior authorization** remains mandatory for certain DME items, including **enclosed bed systems**. Molina continues to work with national DME vendors such as **Apria and Byram** to support covered equipment services.

Providers must submit complete and accurate supporting documentation with DME authorization requests. Required materials may include home evaluation reports, clinical justification supporting medical necessity, and evidence of caregiver education to support safe and appropriate use of the equipment.

www.molinahealthcare.com

## Prior Authorization (PA) – Digital-Only Submission via Portal Starting Jan 1, 2026

In order to streamline Utilization Management and reduce administrative burden, Molina is transitioning to a digital-only PA submission model. As of December 31, 2025, Molina will no longer accept PA requests

submitted by fax. Beginning January 1, 2026, all PA requests must be submitted through the Availity Essentials portal.

Molina notes this change will bring several benefits: faster turnaround times, fewer administrative denials or delays, and greater transparency — with real-time status updates and improved tracking of authorizations. Providers who have not yet registered for Availity Essentials are strongly encouraged to do so as soon as possible to avoid any interruptions in PA processing.

www.molinahealthcare.com

Medicaid.gov
Keeping America Healthy

## CMS Issues New Guidance on State-Directed Payments and Medicaid Reform

CMS recently released official guidance tightening limits on "state-directed payments" (SDPs) under Medicaid managed care. As of rating periods beginning July 4, 2025, SDPs for inpatient hospital services, outpatient care, nursing facilities, and certain qualified providers are capped at 100% of the comparable Medicare rate in states that expanded Medicaid — or at 110% in non-expansion states.

The guidance also establishes a "grandfathering" period for some SDP arrangements submitted before July 4, 2025; these may continue temporarily, but will gradually be brought into compliance with the new rate caps by January 1, 2028. This change aims to curb excessive supplemental payments, promote fiscal responsibility, and maintain program integrity across state Medicaid systems.

www.medicaid.gov

Medicaid.gov
Keeping America Healthy

## Enrollment & Unwinding Trends: What to Watch

Under the new federal legislation affecting Medicaid financing and rules, states are being encouraged — or required — to adopt eligibility and "community engagement" requirements for certain able-bodied, working-age adults.

These reforms could significantly shift enrollment patterns as states reassess who qualifies and how benefits are maintained. For providers and care networks, the implications are substantial: patient populations may fluctuate, reimbursement dynamics may change, and continuity of care could be affected during the transition period.

States now have a window — until January 1, 2027 — to implement these requirements, though some may act sooner, making it essential for providers to monitor state-level Medicaid policy updates closely.

www.medicaid.gov

Medicaid.gov
Keeping America Healthy

## Legal & Policy Challenges — Federal Cuts, Tax Restrictions, and Program Risks

Alongside payment-model reforms, CMS issued guidance to enforce new limits on "health care-related taxes" (provider taxes) under Medicaid financing. The guidance generally prohibits states from creating new provider taxes or increasing existing ones, and disallows certain financing practices previously used to draw down federal matching funds — measures estimated to save taxpayers over $200 billion over the next decade.

These sweeping changes — including caps on SDPs, restrictions on provider taxes, and eligibility reforms — introduce fiscal pressure across many state Medicaid programs. For some states and providers, this may result in reduced payments, service limitations, or reconsideration of benefit scopes. The risk is that such policy shifts could challenge access to care, especially in underserved or safety-net dependent communities.

www.medicaid.gov

Medicaid.gov
Keeping America Healthy

## Court Ruling Protects Funding for Key Providers in 22 States

**On December 2, 2025,** a federal judge issued a preliminary injunction blocking enforcement of a provision in the 2025 domestic-policy bill that would have stripped Medicaid funding from certain reproductive-health providers — including affiliates of Planned Parenthood — across 22 states. The court found the provision unconstitutionally vague and retroactive.

The ruling preserves Medicaid funding for these clinics, ensuring continued access to non-abortion preventive, reproductive, and general health services for low-income and vulnerable populations. Observers warn, however, that legal uncertainty remains — the ruling could be appealed — making the stability of future Medicaid support for such providers precarious.

www.medicaid.gov

## OIG Identifies Improper DMEPOS Payments During Inpatient Stays

The OIG reported that **Medicare improperly paid more than $22 million** to DME suppliers for equipment provided while beneficiaries were **hospital inpatients,** where such costs should have been bundled under **Part A** payments.

OIG recommended aggressive **recoupment actions**, r**efunding beneficiary cost-sharing**, and strengthening claim edits. DME suppliers and hospital billing teams were urged to review inpatient vs. outpatient billing controls to mitigate audit risk.

www.oig.hhs.gov

## OIG Reinforces Oversight on SNF & Home Health Billing

OIG reiterated its focus on **SNF and home health billing** accuracy, emphasizing risks related to overlapping services, documentation gaps, and medical-necessity concerns. Providers were reminded that improper billing patterns may trigger audits or payment recoveries.

Facilities were encouraged to conduct internal compliance reviews and strengthen staff training on coverage criteria.

www.oig.hhs.gov

## Horizon BCBS New Jersey – Utilization & DME Documentation Focus

Horizon BCBSNJ emphasized stricter **DME and post-acute documentation standards,** reinforcing medical-necessity criteria and authorization rules for home-based and outpatient services.

DME suppliers and nursing providers were reminded that missing clinical documentation can lead to recoupments or delayed payments.

www.horizonblue.com

## Empire BCBS (New York) Provider Policy & Authorization Updates

Empire BlueCross BlueShield issued late-2025 provider communications reminding facilities and clinicians of **prior authorization requirements,** utilization management updates, and documentation expectations for hospital outpatient and ancillary services.

Hospitals and outpatient providers were advised to validate pre-service approvals to avoid denials or post-service audits.

www.anthembluecross.com

## AMA Warns 2026 Medicare Payments Remain Financially Unsustainable

Following CMS's final rule, the AMA issued multiple provider alerts highlighting that **temporary payment relief does not address structural weaknesses** in Medicare physician reimbursement, including inflationary pressures and budget-neutral redistribution.

The AMA urged practices and hospital systems to engage in congressional advocacy to support long-term Medicare payment reform.

www.ama-assn.org

## FDA Issues Safety Update on Unauthorized Medical Devices Used in Care Settings

In **November 2025,** the FDA updated safety communications related to **unauthorized medical and emergency devices** being marketed for use in healthcare and long-term care settings. The agency reiterated that **unapproved devices** may pose patient-safety and liability risks.

Hospitals, nursing homes, and home-care agencies were advised to verify device approval status and reinforce adherence to evidence-based clinical protocols.

www.fda.gov

FDA

## FDA Reinforces Oversight of Medical Equipment Distribution

FDA enforcement actions during this period highlighted the agency's continued scrutiny of device marketing, imports, and labeling—particularly for equipment used in patient care environments.

Facilities were reminded to work only with authorized vendors and maintain documented equipment validation processes.

www.fda.gov

Medicare

## Update on Processing of Telehealth and Acute Hospital Care at Home Claims

In the **November 7, 2025**, the Centers for Medicare & Medicaid Services (CMS) issued important guidance regarding **Medicare telehealth and hospital-at-home claims processing** following the expiration of certain COVID-19 public health emergency flexibilities. CMS clarified that for dates of service on or after **October 1, 2025,** telehealth claims will only be paid if they meet current statutory requirements under Medicare.

CMS instructed Medicare Administrative Contractors (MACs) to process and pay eligible telehealth claims, including specific **behavioral health services, ESRD-related assessments, and services furnished by eligible Accountable Care Organizations (ACOs).** Claims that were previously held or returned due to non-payable status may be resubmitted if they meet coverage criteria, as CMS directed MACs to return affected claims with appropriate remark codes to allow for correction and resubmission.

Providers, hospitals, and home-based care organizations are encouraged to **review telehealth and hospital-at-home claims submitted on or after October 1, 2025,** verify documentation accuracy, and confirm that billing codes and place-of-service indicators comply with current Medicare rules. Taking these steps can help reduce claim denials, prevent payment delays, and ensure continued compliance with Medicare billing requirements.

www.cms.gov

Medicare

## Medicare Participation Announcement for CY 2026: Decide by December 31

CMS issued a clear reminder that **all physicians, practitioners, and suppliers** must decide whether to **participate in Medicare for calendar year 2026 by December 31, 2025.** Providers who elect to participate will continue to receive **full payment under the Medicare Physician Fee Schedule,** while **non-participating providers will receive 5% less**. Providers wishing to maintain their current participation status (participating or non-participating) **do not need to take action,** but those intending to change their status must submit the required documentation by the deadline.

In addition, CMS emphasized the importance of ensuring that **provider records in the National Plan and Provider Enumeration System (NPPES) a**re accurate and up to date, particularly **taxonomy codes and practice address information.** Providers with incorrect or outdated NPPES data may experience **enrollment delays, credentialing issues, or payment disruptions,** which could have a significant impact on **DME suppliers, nursing-care agencies, and any organization billing Medicare directly.**

www.cms.gov

Medicare

## CMS Issues Claims-Processing Update — Returned Telehealth & Hospital-at-Home Claims Now Payable; New 2026 ESRD Payment Rule

On November 21, 2025, CMS announced a key "Claims Processing Update" covering Medicare claims that were impacted during the recent federal government shutdown. Specifically, certain telehealth and "Acute Hospital Care at Home" claims, submitted with dates of service on or after October 1, 2025 and previously returned (often with CARC 16 / RARC M77), are now considered payable — provided they meet all applicable Medicare requirements. CMS has directed Medicare Administrative Contractors (MACs) to resume processing these claims, and providers are encouraged to **resubmit denied or returned claims** accordingly.

For hospitals, home-care and nursing agencies, DME suppliers, and outpatient/clinic practices, this means there's immediate potential to recover revenue from services rendered during the shutdown-affected period. Organizations should review any claims submitted since October 1 that may have been held or denied, check remittance advices, and if eligible, resubmit those claims. In addition, providers who charged

beneficiaries out-of-pocket during the shutdown may need to refund overpayments after successful resubmission of claims.

In the same newsletter, CMS also issued the 2026 ESRD Prospective Payment System Final Rule, updating payment rates for renal dialysis services for beneficiaries on or after January 1, 2026. Under the rule, the **ESRD PPS base rate will increase to $281.71**, which CMS expects will increase total payments to End-Stage Renal Disease (ESRD) facilities — both freestanding and hospital-based — by approximately 2.2%. The update also revises payment methodology for acute kidney injury (AKI) dialysis and updates quality-incentive program requirements.

www.cms.gov

Medicare

## CMS Announces Key 2026-Era Updates for Home Health, DME Suppliers & Hospice Providers

CMS highlighted several important updates for **providers, DME suppliers, and home-health and hospice care agencies** in its November 26, 2025 MLN Connects newsletter. CMS first reminded providers that the **Medicare Participating Physician or Supplier Agreement (Form CMS-460) —** which allows providers and suppliers to bill Medicare as participating entities — **expires on November 30, 2025.** Although CMS continues to accept the current version of the form, providers are encouraged to monitor for updates and confirm that their Medicare enrollment records remain accurate. Failure to maintain valid participation documentation could result in billing delays or disruptions in Medicare reimbursement.

In addition, CMS opened a **public comment period** regarding proposed revisions to the **DMEPOS supplier enrollment application (Form CMS-855S),** with comments due by **December 22, 2025.** These proposed updates may impact how DME suppliers initially enroll in Medicare or complete revalidation and re-enrollment processes. CMS noted that the changes are intended to strengthen program integrity and improve enrollment accuracy. DME suppliers, billing teams, and compliance staff are strongly encouraged to review the proposed revisions and submit feedback, as future enrollment requirements may directly affect supplier eligibility and reimbursement.

CMS also announced the Calendar Year (CY) 2026 furnishing fee for clotting-factor products, setting the per-unit reimbursement rate used in billing for these therapies under Medicare. This update is particularly relevant for providers, home-care agencies, and pharmacies involved in managing patients with hemophilia and other bleeding disorders. Finally, the newsletter included updated educational resources for home-health and hospice providers, aimed at helping agencies clearly explain Medicare-covered services, eligibility requirements, and patient rights to beneficiaries and their families — supporting compliance while improving patient communication and understanding.

www.cms.gov

Medicare

## CMS Finalizes 2026 Home-Health Payment Rule — Expect Lower Aggregate Medicare Payments to HHAs

CMS announced the final rule for the 2026 Home Health (HH) Prospective Payment System (PPS). CMS While the base payment update reflects a 2.4% increase in Home Health Agency (HHA) rates, the combined impact of rate adjustments, temporary and permanent payment changes, and outlier payment formula updates means CMS estimates an overall reduction in total Medicare payments to home-health agencies by about **1.3% (approx. US$220 million)** compared to 2025.

For home-health and hospice providers, this means a tighter reimbursement environment in 2026. Agencies should review and optimize billing practices, assess budgets, and plan operationally to accommodate lower aggregate funding. Given that reimbursements will be more constrained, careful documentation, efficient care delivery, and cost controls will become even more important to sustain margins and service quality under the new payment paradigm.

www.cms.gov

Medicare

## CMS Reaffirms Commitment to Reducing Administrative Burden & Promoting Outcome-Based, Whole-Person Care in 2026

Alongside the payment-rule announcement, CMS emphasized its broader strategy for 2026: reducing administrative and regulatory burdens, giving clinicians more flexibility in where and how they deliver care, improving program integrity, aligning payments with outcomes rather than volume, and increasing use of technology to support whole-person care.

For providers, nursing-care agencies, and DME/home-care suppliers, this signals a shift toward more streamlined operations and potential uptake of innovative care models (e.g., remote monitoring, telehealth, home-based care). It may bring opportunities to restructure service models, adopt technology-assisted care, and collaborate more closely with Medicare in delivering value-based services — especially for chronic care, home-health, and long-term care populations.

www.cms.gov

Medicare

## Therapy Code List: 2026 Annual Update

CMS released **Medicare Learning Network (MLN) Matters Article MM14250,** announcing the **2026 Annual Therapy Code List Update,** which becomes effective **January 1, 2026.** This update revises the list of CPT and HCPCS codes that **"sometimes" or "always" describe therapy services** under Medicare, including physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP). The therapy code list is a critical compliance reference because it determines which services are subject to Medicare therapy billing requirements, such as plan-of-care rules, therapy modifiers (GP, GO, GN), assistant modifiers (CQ, CO), and applicable coverage and documentation standards.

A major focus of the 2026 update is the **expansion and clarification of Remote Therapeutic Monitoring (RTM) codes.** CMS added new RTM device supply and data transmission codes for shorter monitoring periods, including **98984 (respiratory system, 2–15 days) and 98985 (musculoskeletal system, 2–15 days)** within a 30-day period. CMS also added **98979,** a new RTM treatment-management code that covers the first 10 minutes of clinician time per calendar month when at least one interactive communication occurs. These additions provide greater flexibility for therapy providers, DME suppliers, and home-based care organizations to bill Medicare for remote monitoring services that do not meet the traditional 16–30 day minimum threshold.

The updated therapy code list reinforces that when RTM services are furnished **under a therapy plan of care,** they are subject to therapy billing rules, including the use of appropriate therapy modifiers and documentation supporting medical necessity. Payment methodology varies by setting: RTM services billed by hospital outpatient departments may be paid under the **Outpatient Prospective Payment System (OPPS),** while services billed in non-facility settings are paid under the **Physician Fee Schedule (PFS).** CMS emphasized that failure to the updated code list beginning January 1, 2026 may result in claim denials, incorrect reimbursement, or compliance risk, particularly for therapy practices, hospital outpatient departments, DME suppliers involved in RTM, and home-care organizations offering therapy-related services.

www.cms.gov

# PROVIDER BULLETIN

# Professional Providers — CMS Final Rule 2026

The Centers for Medicare & Medicaid Services (CMS) has released the **final rule for the CY 2026 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP).** Issued on **October 31, 2025,** the rule includes:

- Final payment and policy changes under the **2026 Medicare Physician Fee Schedule (MPFS)**
- Final policies for the **Quality Payment Program (QPP), including MIPS and MIPS Value Pathways (MVPs)**

Most provisions are effective January 1, 2026, unless otherwise specified.

## The Medicare Physician Fee Schedule (PFS) – Background

Medicare has paid physicians and other billing professionals under the Physician Fee Schedule since 1992. Services covered include those furnished in:

- Physician offices and clinics
- Hospital inpatient and outpatient settings
- Ambulatory surgical centers
- Skilled nursing facilities and other post-acute care settings
- Hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes

Many technical services in these environments are also paid under the PFS, especially when no separate institutional payment applies. For most office-based services, Medicare pays a single non-facility rate that reflects the full range of resources required (physician work, practice expense, malpractice).

## Highlights of the 2026 Final Rule

## 1. Dual Conversion Factors & Overall Payment Changes

For the first time, CMS is using two separate conversion factors (CFs) in 2026 — one for clinicians who qualify under Advanced APMs and one for all other clinicians:

- **Qualifying APM Participants (QPs):**
  - CF = $33.5675
  - Approx. +3.77% increase over 2025
- **Non-QPs:**
  - CF = $33.4009
  - Approx. +3.26% increase over 2025

These increases reflect:

- A **0.75% statutory update** for QPs and 0.25% for non-QPs under MACRA
- A **+0.49% positive budget-neutrality adjustment**
- A **one-time +2.5% payment bump** mandated by recent legislation (the "One Big Beautiful Bill Act")

**–2.5% "Efficiency Adjustment" to Non–Time-Based Services**

- To partially offset the higher CFs, CMS finalized a **–2.5% efficiency adjustment** applied to **most non–time-based services** starting in 2026.
- Exempt from this –2.5% cut:
  - Time-based codes (e.g., many E/M visits, therapy, care management, psychotherapy)
  - Services on the telehealth list
  - New 2026 codes and maternity global packages

Analysis suggests that many specialties will still see an overall ~1% payment reduction on affected services, once the efficiency adjustment is fully incorporated.

2. Practice Expense & Site-of-Service Shift (Facility vs Office)

Beginning January 1, 2026, CMS is changing how indirect practice expense (PE) RVUs are allocated:

- For facility-based services, the portion of indirect PE tied to work RVUs is cut in half compared with non-facility (office) settings.
- Practical effect:
  - Office-based services: modest upward pressure on PE and payments

Hospital/facility-based professional services: downward pressure on payments

Examples CMS and specialty groups have highlighted:

- **Cardiology:** approx. +5% for non-facility services vs −7% for facility services (overall ~+1% for cardiology, on average).
- **Otolaryngology:** −12% impact in facility settings vs +3% in non-facility settings.
- **Radiology / Interventional Radiology** (see details below): office-based imaging gains vs hospital-based professional components losing ground.

This is a **strategic shift:** CMS is deliberately rebalancing payment **away from facilities** and toward **office-based care**, though **modifier -26 professional-component** billing is partially protected.

## 3. Supervision, Incident-To, and Diagnostic Testing

The final rule continues or formalizes several supervision flexibilities first introduced during the COVID-19 PHE:

- **Direct supervision via real-time audio-video** remains permissible for certain diagnostic tests in physician offices and IDTFs (both audio and video are required).
- CMS reiterates the **incident-to** requirements and clarifies that auxiliary personnel may continue to furnish certain services under appropriate supervision.

For many practices, this means that **virtual presence** (audio-video) can still support supervision requirements for diagnostic testing and some technical components, reducing the need for physical co-location.

## 4. Telehealth Policies – 2026 Updates

CMS largely **maintains and extends** the telehealth expansions implemented during the PHE, with some refinements:

- The **Medicare Telehealth Services List** has been updated using a more formal, stepwise review process; several **behavioral health and group therapy codes** remain on the permanent list.

CMS **declined** to remove **G0136** (Social Determinants of Health Risk Assessment) from the telehealth list after stakeholder pushback — it remains covered when furnished via telehealth.

- **RHCs and FQHCs** can continue to bill for medical services delivered via telecommunication technologies through December 31, 2026, regardless of broader waiver status.

CMS continues to distinguish **telehealth vs communication-technology-based services (CTBS)** and emphasizes that some brief virtual services (e.g., check-ins) remain CTBS, not full telehealth encounters.

**5. Remote Physiologic / Therapeutic Monitoring and Time-Based Services**

In parallel with PFS changes, CMS finalized a set of **new and revised Remote Therapeutic Monitoring (RTM) and Remote Physiologic Monitoring (RPM)** codes to support:

- **Shorter-duration monitoring periods** (e.g., 2–15 days of data)
- Updated **treatment-management codes** with refined time thresholds

These **time-based monitoring codes are exempt** from the −2.5% efficiency adjustment, making them relatively more attractive compared with non-time-based procedural services.

## Payment Impact by Specialty – Illustrative % Changes

Because the final rule is budget-neutral overall, individual specialties and practices see different outcomes depending on service mix, site of service, and use of time-based codes. Selected published estimates:

- **Radiology (overall):**
  - Imaging center / global: +1%
  - Hospital professional component: −3%
  - Combined estimated impact: −2%
- **Interventional Radiology:**
  - Office / imaging center: +7%
  - Hospital professional: −7%
  - Combined estimated impact: +2%
- **Nuclear Medicine:** approx. +1% non-facility vs −3% facility (combined −1%).
- **Cardiology:** estimated overall +1%, with +5% non-facility and −7% facility services.
- **Neurology:** CMS projects about +1% overall impact.
- **Otolaryngology (ENT):** around −12% in facility settings and +3% in non-facility settings, reflecting the practice-expense shift.

- **Primary Care / Family Medicine**: benefits from:
  - Higher CF
  - More appropriate valuation of primary-care services
  - → Overall **meaningful positive shift** in payment levels, particularly for E/M-heavy practices.

**Important:** These are **national averages.** Actual impact on a given practice will depend heavily on:

- Facility vs office site of service
- Mix of time-based vs procedural code
- Participation in **APMs (QPs)** vs standard PFS
- Local GPCI adjustments

## MIPS Changes 2026

## Participation & Risk

For 2026, eligible professionals continue to participate in the Merit-based Incentive Payment System (MIPS) under the QPP. If they are MIPS-eligible and do not participate, they face up to a –9% penalty on 2028 Medicare Part B payments (payment adjustments lag performance by two years).

- Maximum negative adjustment (2028 for 2026 performance): –9%
- Positive adjustments remain budget-neutral and are scaled based on overall program performance.
-

2026 MIPS Thresholds & Category Weights

For the 2026 performance year (2028 payment year), CMS finalized:

- Performance threshold (to avoid a penalty): 75 points
- Score/payment impact ranges:
  - **0.00 – 18.75 points** → –9% payment adjustment
  - **18.76 – 74.99 points** → sliding negative adjustment (between –9% and 0%)
  - **75.00 points → neutral (0%)**
  - **75.01 – 100 points** → positive adjustment (scaled upward)
- Category weights (Traditional MIPS, 2026 performance year):
  - **Quality – 30%**
  - **Cost – 30%**
  - **Improvement Activities (IA) – 15%**
  - **Promoting Interoperability (PI) – 25%**

The **"exceptional performance"** bonus that existed in earlier years has expired; there is **no separate extra pool** beyond the standard positive adjustment.

## 2026 MIPS Policy Updates (High Level)

Key finalized changes that matter for practices:

- **MIPS Value Pathways (MVPs)**
  - CMS is expanding MVPs, adding six new specialty-focused MVPs for:
    - Diagnostic Radiology
    - Interventional Radiology
    - Neuropsychology
    - Pathology
    - Podiatry
    - Vascular Surgery
- **Existing MVPs** are updated to align with revised measure inventories.
- **Improvement Activities**
  - 3 new activities added, 7 modified, 8 removed.
  - The "Achieving Health Equity" sub-category is replaced with a broader "Advancing Health and Wellness" focus.
- **Quality & Cost**
  - CMS adjusts attribution rules for Total Per Capita Cost (TPCC) to better reflect appropriate accountable clinicians.
  - New cost measures in future years will be introduced with a 2-year "feedback-only" period before affecting scores.
- **Promoting Interoperability (PI)**
  - PI weight remains 25%, but technical updates strengthen data security and add flexibility:
  - Additional HIPAA Security Rule attestation requirements
  - Use of updated 2025 SAFER Guides
  - New optional TEFCA-based bonus measure for public health reporting.
- **Overall MIPS Landscape**

CMS estimates that ~84% of clinicians will receive positive adjustments based on 2026 performance, but solo and small practices remain at higher risk for penalties.

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# MIPS 2026: Higher Stakes for Medicare Providers

## December 2025 Provider Update

As providers close out the **2025 performance year,** now is a critical time to prepare for **MIPS Performance Year 2026**. Early planning is essential to protect future Medicare reimbursement and avoid potential penalties under the **Merit-Based Incentive Payment System (MIPS).**

CuraWise supports Medicare providers with structured MIPS consulting and reporting services designed to improve performance outcomes, strengthen compliance, and position practices for long-term success under CMS's value-based care framework.

## Why MIPS Preparation Matters Now

Under CMS rules, a **MIPS-eligible professional who does not participate** or submits incomplete data during **2026** will automatically receive a **zero performance score.** This results in a **negative payment adjustment of up to 9%**, applied to **Medicare Part B payments in 2028.**

With CMS maintaining strict enforcement of MIPS participation requirements, advance preparation is the most effective way to reduce compliance risk and protect revenue.

## What Providers Must Achieve in MIPS 2026

To avoid penalties and qualify for a **neutral or positive payment adjustment,** providers must meet the **MIPS performance threshold of 75 points** by reporting successfully in the following categories:

- **Quality**
- **Promoting Interoperability**
- **Improvement Activities**
- **Cost** (automatically calculated by CMS using claims data)

## MIPS Impacts More Than Reimbursement

MIPS performance affects not only Medicare payments, but also **public quality reporting, payer evaluations, and practice reputation.** Low scores or penalties may influence patient trust, referral patterns, and overall practice sustainability.

Consistent MIPS performance supports both **financial stability** and **competitive positioning** in an increasingly outcomes-driven healthcare environment.

## How CuraWise Supports Providers for MIPS 2026

CuraWise offers comprehensive, end-to-end MIPS services, including:

- Eligibility and readiness assessment
- Specialty-aligned measure selection
- Quality & Promoting Interoperability optimization
- Ongoing performance monitoring
- Submission support and compliance review
- Strategic guidance for value-based care readiness

Our experience with CMS reporting requirements allows providers to approach MIPS with confidence—well before reporting deadlines arrive.

Prepare Now for MIPS 2026 Success

- Protect future Medicare revenue
- Reduce compliance risk
- Strengthen performance transparency
- Plan proactively for value-based care

Start your MIPS 2026 planning with CuraWise

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# Historic Changes to Stark Law and Anti-Kickback Statute Regulations (2025–2026)

The **Centers for Medicare & Medicaid Services (CMS)** and the **Office of Inspector General (OIG)** have finalized sweeping reforms to long-standing federal fraud and abuse regulations, commonly known as the **Stark Law** and the **Anti-Kickback Statute (AKS).** These changes aim to reduce unnecessary administrative burden, modernize outdated compliance frameworks, and better support the healthcare system's transition toward **value-based reimbursement and coordinated care.**

These reforms represent some of the **most significant updates in decades,** directly impacting physicians, hospitals, post-acute providers, and healthcare organizations entering collaborative or value-based arrangements.

## Background: Understanding the Stark Law

The Physician Self-Referral Law (Stark Law) prohibits physicians from referring Medicare patients for certain designated health services to entities with which they (or their immediate family members) have a financial relationship, unless an exception applies.
When Stark was enacted in 1989, healthcare reimbursement operated primarily under a fee-for-service model. The law was designed to prevent financial incentives from influencing clinical decision-making. While effective in reducing abuse, Stark's rigid framework increasingly conflicted with modern care models emphasizing coordination, quality outcomes, and shared accountability.
Violations of Stark carry severe consequences, including:

- Prohibition on Medicare payment for services resulting from improper referrals
- Mandatory refund of payments received
- Potential civil penalties

## CMS Stark Law Final Rule: Key Objectives

Through its final rule, CMS sought to modernize and clarify Stark regulations to better align with today's healthcare environment. The changes largely adopt proposals first introduced in the **October 2019 Notice of Proposed Rulemaking** and focus on the following goals:

- **Reducing administrative complexity** that drives compliance costs and limits patient-care investment
- **Protecting non-abusive, beneficial arrangements,** regardless of whether parties operate under fee-for-service or value-based models
- **Clarifying core regulatory concepts,** such as commercial reasonableness and compensation requirements
- **Creating permanent Stark exceptions for value-based arrangements,** allowing providers to collaborate on care coordination, quality improvement, and cost reduction without fear of violating self-referral laws

These reforms acknowledge that legitimate, patient-centered arrangements should not be treated as inherently suspect simply due to financial relationships.

## Value-Based Care: Practical Examples Now Permitted

Under the finalized Stark and OIG rules—provided all regulatory requirements are met—providers may more easily engage in arrangements such as:

- **Care-transition support**
  Hospitals may furnish physician offices with care coordinators who provide individualized case-management
  services for patients transitioning to post-acute care.
- **Outcome-based collaboration with post-acute providers**
  Hospitals may support or reward post-acute providers for meeting outcome measures that reduce readmissions
  and improve care continuity.
- **Patient engagement technologies**
  Providers may furnish patients with tools such as smart tablets that enable real-time, two-way communication to
  support telehealth and in-home services.
- **Cybersecurity support**
  Health systems may donate cybersecurity technology and services to physician practices to protect data integrity
  and reduce system-wide cyber risk.

## Anti-Kickback Statute (AKS) Final Rule: Expanded Safe Harbors

In parallel, the OIG finalized major AKS reforms that:

- Create seven new safe harbors
- Modify four existing safe harbors
- Codify one new exception under the Beneficiary Inducements Civil Monetary Penalty (CMP)

Key Safe Harbors and Modifications Include:

**1. Value-Based Arrangements**
Three new safe harbors protect certain remuneration exchanged among participants in qualifying value-based arrangements, depending on the level of financial risk assumed:

- Care coordination arrangements to improve quality and efficiency
- Value-based arrangements with substantial downside financial risk

- Value-based arrangements with full financial risk

**2. Patient Engagement and Support**
A new safe harbor permits tools and supports furnished directly to patients to enhance quality, outcomes, and care efficiency.

**3. CMS-Sponsored Models**
A new safe harbor protects remuneration associated with participation in CMS-sponsored payment and service delivery models.

**4. Cybersecurity Technology and Services**
A new safe harbor allows donations of cybersecurity technology and services to safeguard healthcare infrastructure.

**5. Electronic Health Records (EHR)**
Updates to the existing EHR safe harbor:
- Expand protections to include certain cybersecurity technologies
- Strengthen interoperability requirements
- Eliminate the prior sunset date

**6. Local Transportation**
Modifications expand mileage limits for rural areas and extend protections for transportation following inpatient discharge or extended observation stays.

**7. ACO Beneficiary Incentive Programs**
Codification of a statutory AKS exception for beneficiary incentive programs under the Medicare Shared Savings Program.

**8. Telehealth for In-Home Dialysis**
A new CMP exception permits telehealth technologies furnished to certain in-home dialysis patients.

**9. Outcomes-Based Payments and Part-Time Arrangements**
The personal services and management contracts safe harbor is revised to:
- Allow greater flexibility for outcomes-based compensation
- Accommodate part-time arrangements

**10. Warranties**
Updated protections allow bundled warranties covering multiple items and related services.

The **2025–2026 Stark Law and Anti-Kickback Statute** reforms represent a historic modernization of federal healthcare regulations. For providers prepared to implement compliant, value-driven arrangements, these changes offer meaningful opportunities to support better outcomes while reducing unnecessary administrative barriers.

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# FEATURE FOCUS


## 2026 CPT® CODE UPDATE

# 2026 CPT® CODE UPDATE

## Implications for Providers, Billing Teams, and Compliance Leaders

## Introduction: Why CPT® 2026 Deserves Provider Attention

The CPT® 2026 Code Set, released by the American Medical Association (AMA), reflects a continued transition in healthcare reimbursement toward precision, accountability, and technology-aligned reporting. Unlike earlier years that introduced sweeping structural changes—most notably the 2021 Evaluation & Management (E/M) overhaul—CPT® 2026 focuses on refinement rather than reinvention.

Effective January 1, 2026, providers must apply the updated code set across Medicare, Medicaid, and most commercial payers. While the changes may appear incremental, their operational and financial impact is significant, particularly as payers expand automated claim review, prepayment edits, and post-payment audits.

For providers, hospitals, DME suppliers, and nursing-care organizations, CPT® 2026 reinforces a central theme:

*Accurate coding and defensible documentation are no longer administrative best practices—they are essential safeguards for revenue integrity.*

## The Strategic Direction of CPT® 2026

CPT® 2026 continues the AMA's multi-year effort to modernize clinical reporting by ensuring CPT codes accurately reflect:

- How care is delivered today
- The growing role of technology and data
- Increased coordination across care settings
- Risk-based reimbursement and oversight

The 2026 update includes:

- Hundreds of new, revised, and deleted codes
- Clearer descriptors for services historically misreported
- Expanded guidance for technology-enabled care
- Cleanup of legacy codes that no longer reflect clinical practice

Rather than simplifying documentation requirements, CPT® 2026 raises expectations—placing greater responsibility on providers to demonstrate medical necessity, data review, and clinical rationale through the medical record.

## Change in CPT® 2026

## 1. Digital Health and Virtual Services

CPT® 2026 further integrates digital health services into mainstream reporting. Codes related to virtual care, remote services, and technology-assisted evaluation continue to evolve as these services move from novelty to standard practice.

Areas of emphasis include:

- Remote physiologic monitoring (RPM)
- Remote therapeutic monitoring (RTM)
- Digital interpretation of patient data
- Technology-assisted clinical decision-making

While many of these services already exist in CPT, 2**026 refines descriptors, thresholds, and reporting clarity,** leaving less room for subjective interpretation.

**Provider Consideration:**

Billing these services accurately requires:

- Clear tracking of qualifying days or intervals
- Documentation of provider involvement (not just device data)
- Alignment with payer-specific coverage rules

## 2. Increased Focus on Data Review and Interpretation

One consistent theme across CPT® 2026 is the expectation that **data review and interpretation be explicit and supported.** Codes increasingly distinguish between:

- Passive receipt of results
- Active professional interpretation
- Independent diagnostic analysis

This distinction is especially relevant for:

- Imaging-related services
- Diagnostic tests with professional components
- Digital diagnostics supported by software or algorithms
-

Generic documentation such as “results reviewed” may no longer be sufficient for many services.

## 3. Specialty-Specific Code Refinements

Several clinical specialties saw structural cleanup or clarification in 2026. These refinements:

- Reduce overlap between bundled and separately reportable services
- Clarify when professional vs technical components apply
- Align CPT language with contemporary standards of care

Specialties affected include (but are not limited to):

- Diagnostic and interventional services
- Technology-driven procedures
- Select device-related workflows

Providers should review CPT® 2026 updates specifically related to the services they perform most frequently, rather than relying on general summaries.

## Documentation Standards: The Hidden Centerpiece of CPT® 2026

While CPT® 2026 does not introduce an explicit documentation overhaul, it operates on an underlying assumption: documentation must clearly support why a service was provided, how it was performed, and what professional work occurred.

Key documentation expectations in 2026 include:

- Clear linkage between diagnosis and procedure
- Evidence of clinical decision-making or interpretation
- Accurate reflection of time, data, or complexity where required
- Avoidance of copy-forward or boilerplate language

As payer analytics become more sophisticated, documentation quality often determines whether a claim is paid, delayed, or reviewed.

## Operational Risks of Ignoring CPT® 2026 Updates

Organizations that fail to align with CPT® 2026 face multiple downstream risks:

- Claim denials due to use of deleted or revised codes
- Underpayment from misreported services
- Increased audit exposure due to documentation mismatch
- Revenue leakage from conservative or inconsistent coding
- Delays in cash flow during Q1 2026

These risks are magnified for organizations with high volumes, complex care models, or multi-provider workflows.

## Sample Reference Table & Analysis
## CPT® 2026 Impact Areas for Providers

### High-Impact CPT® 2026 Areas Providers Must Review

### 1. Digital Health Services

| Area | 2026 CPT Focus | Common CPT Code Families Affected | Operational Impact |
|---|---|---|---|
| Digital & Virtual Care | Expanded and refined service descriptors | 98970–98972, 99421–99423, applicable Category I digital codes | Documentation precision required |

**What's changing:**
CPT® 2026 continues refining how digital interactions, virtual communication, and technology-facilitated care are described. While many of these codes already exist, descriptors have become more explicit, requiring clearer differentiation between clinical services and administrative communication.

**Provider risk:**
Using digital service codes without documenting clinical intent, decision-making, and provider time may result in denials or downcoding.

### 2. Remote Physiologic & Therapeutic Monitoring

| Area | 2026 CPT Focus | Common CPT Code Families Affected | Operational Impact |
|---|---|---|---|
| Remote Monitoring (RPM / RTM) | Clarified thresholds and reporting rules | 99453–99458, 98975–98981 | Accurate day/time tracking critical |

**What's changing:**
CPT® 2026 reinforces established requirements around:
- Qualifying data collection periods
- Provider review and management time
- Separation of technical device data from professional services

**Provider risk:**
Billing RPM or RTM services without meeting minimum data or time thresholds exposes claims to audit risk, especially as CMS and payers apply automated validation.

### 3. Diagnostic & Interpretation-Based Services

| Area | 2026 CPT Focus | Common CPT Code Families Affected | Operational Impact |
|---|---|---|---|
| Diagnostic Services | Interpretation vs. review clarified | Radiology professional components (e.g., modifier -26), select diagnostic CPT ranges | Stronger clinical notes required |

### What's changing:

CPT® 2026 emphasizes the distinction between:

- Reviewing results
- Independently interpreting diagnostic data

In many services, only interpretation qualifies for professional reporting.

### Provider risk:

Documentation that simply states "results reviewed" may not support reporting of professional diagnostic components.

## 4. Procedural Codes & Bundling Clean-Up

| Area | 2026 CPT Focus | Common CPT Code Families Affected | Operational Impact |
|---|---|---|---|
| Procedural Services | Bundling logic and descriptor clean-up | Specialty-specific procedure families (varies by discipline) | Charge master updates essential |

### What's changing:

CPT® 2026 continues removing ambiguity around:

- When procedures are bundled
- When separate reporting is appropriate
- Overlapping services frequently misreported together

### Provider risk:

Outdated charge masters and legacy billing habits may result in overbilling or missed revenue, depending on how codes are applied.

## 5. Deleted or Retired CPT Codes

| Area | 2026 CPT Focus | Common CPT Code Families Affected | Operational Impact |
|---|---|---|---|
| Deleted Codes | Removal of obsolete services | Legacy or redundant CPT codes (varies annually) | EHR & code library cleanup required |

### What's changing:

Each CPT update removes codes that no longer reflect current clinical practice. CPT® 2026 continues this process.

### Provider risk:

Submitting claims with deleted CPT codes after January 1, 2026 may lead to automatic rejections.

## Why CPT® 2026 Signals a Larger Shift

While many of the CPT® 2026 updates may appear incremental when viewed in isolation, together they point to a clear industry direction. Payers are no longer tolerant of loosely applied codes or generic documentation. Instead, reimbursement is increasingly tied to precise representation of clinical work, supported by records that clearly demonstrate medical necessity, professional judgment, and adherence to CPT definitions.

As automated claim review and data analytics expand across Medicare and commercial payers, even small inconsistencies can have outsized consequences—particularly when they appear at scale across multiple claims or providers.

## The Cost of Delayed Alignment

Organizations that postpone updating coding and documentation workflows often feel the impact early in the year. Common challenges include:

- First-quarter billing slowdowns as claims are rejected or suspended
- Variable payer responses, creating unpredictability in reimbursement
- Heightened audit vulnerability, especially for digital, monitoring, or interpretation-based services

These issues are rarely isolated incidents; they tend to repeat until workflows are formally corrected.

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## Operational Strategies for Providers in 2026

To maintain billing stability and reduce compliance exposure, providers should approach CPT® 2026 planning as an operational priority rather than a technical update. Key actions include:

- Reviewing CPT® 2026 changes by service category and clinical specialty
- Eliminating deleted or retired codes from charge masters and EHR libraries
- Confirming that digital health and monitoring services meet all CPT thresholds
- Aligning clinical, coding, and billing teams through joint training sessions
- Performing early-year claim reviews to identify denial or variance patterns

Early action helps ensure smoother reimbursement cycles and stronger audit defensibility.

**CuraWise** supports providers through annual CPT transitions with a comprehensive approach that includes charge-master validation, documentation and coding audits, and ongoing compliance guidance. By aligning coding practices with current CPT standards and payer expectations, CuraWise helps organizations protect revenue, reduce risk, and adapt confidently to regulatory change.

www.ama-assn.org www.cms.gov

**NOTE:**

**CPT® is a registered trademark of the American Medical Association. Code descriptions and guidelines are maintained by the AMA. Providers should consult official AMA publications and applicable payer guidance for definitive coding instructions.**

# BUSINESS BEAT

# Compliance Is Now a Business Risk — Not Just a Regulatory One

For years, compliance in healthcare was often treated as a regulatory obligation—important, but largely separate from day-to-day business strategy. In 2026, that mindset no longer holds. Today, compliance has become a core business risk that directly impacts cash flow, growth planning, staffing decisions, and long-term stability.

As payers lean heavily on automation, analytics, and targeted audits, even minor compliance gaps can disrupt operations at scale. What was once a documentation issue can now translate into delayed payments, inconsistent reimbursements, or unexpected revenue loss.

## The Business Impact of Compliance Gaps

Modern enforcement is no longer reactive. Medicare, Medicaid, and commercial payers increasingly identify risk through data patterns—flagging unusual billing trends, vague documentation, or inconsistent code usage. When issues surface, the consequences are felt operationally:

- Claims are delayed or denied, affecting cash flow
- Rework increases administrative cost
- Audit activity diverts leadership and staff attention
- Revenue projections become less reliable

Over time, these disruptions erode margins and strain resources, particularly for organizations operating on tight budgets.

## Why Compliance Now Lives in the C-Suite

Compliance issues are no longer confined to coders or billing teams. They influence broader business outcomes—from payer negotiations to expansion plans. Leadership teams increasingly recognize that strong compliance processes support:

- Predictable revenue cycles
- Accurate financial forecasting
- Stronger payer relationships
- Reduced exposure during audits and reviews

In this environment, organizations that embed compliance into business strategy are better positioned to adapt and grow.

## From Cost Center to Strategic Safeguard

The most successful provider organizations no longer view compliance as a cost of doing business. Instead, they treat it as a safeguard for revenue integrity. This includes proactive reviews of coding practices, regular documentation audits, and tight alignment between clinical, billing, and administrative teams.
Early investment in compliance infrastructure often prevents much larger financial disruptions down the road.

## Business Takeaway

In 2026 and beyond, compliance failures don’t just create regulatory consequences—they create business instability. Providers that acknowledge this shift and act early will be better equipped to maintain financial health in an increasingly scrutinized reimbursement environment.

## CuraWise Perspective

CuraWise helps healthcare organizations manage compliance as a business priority—supporting providers with documentation reviews, coding audits, and revenue protection strategies designed to reduce risk and strengthen financial performance.

# Quick Tips

## 1. CONFIRM ALL CHARGES ARE ENTERED BEFORE YEAR-END

Review encounter logs, late documentation, and hospital or facility feeds to ensure all December services are captured. Missing charges at year-end often result in lost revenue, especially when charts are finalized in January.

## 2. CLEAR HIGH-DOLLAR CLAIMS BEFORE PAYER CUTOFFS


Prioritize high-value and aging claims before payer year-end processing slowdowns. Many payers experience December backlogs, and unresolved issues can delay payments into Q1.

## 3. VERIFY CPT & MODIFIER ACCURACY

December is the best time to identify outdated CPT codes, missing or invalid modifiers, and payer-specific billing errors. Fixing issues early helps reduce denials when new CPT and policy updates take effect in January.

# CALENDAR & EVENTS

## DECEMBER 2025

**DECEMBER 22, 2025**

### CMS DMEPOS ENROLLMENT COMMENT DEADLINE

The Centers for Medicare & Medicaid Services (CMS) closes the public comment period on proposed updates to DMEPOS supplier enrollment application (CMS-855S) requirements. DME suppliers and billing leaders should monitor potential compliance and enrollment changes that may affect 2026 participation.

### MEDICARE PARTICIPATION STATUS DEADLINE

**DECEMBER 31, 2025**

Physicians, non-physician practitioners, and suppliers must finalize their Medicare participating or non-participating election for Calendar Year 2026 by this date. Providers continuing under the same status do not need to take action; however, any changes must be submitted before year-end. Inaccurate or outdated PECOS and NPPES data may result in payment delays.

**DECEMBER 15–31, 2025**

### YEAR-END BILLING & CLAIMS SUBMISSION WINDOW

Final window for resolving high-dollar claims, pending documentation, and prior authorization discrepancies before payer year-end processing slowdowns. Claims unresolved during this period frequently roll into Q1 processing, impacting cash flow.

### CPT® 2026 & MEDICARE PAYMENT UPDATES GO LIVE

**JANUARY 1, 2026**

The CPT® 2026 code set, updated ICD-10-CM coding, and multiple CMS payment rule changes take effect for services rendered on or after January 1, 2026. Billing systems, charge masters, and EHR configurations must be updated to avoid denials tied to deleted or revised codes.

# DECEMBER HEALTH AWARENESS FOCUS

## INFLUENZA & RESPIRATORY ILLNESS PREVENTION MONTH

December highlights the peak of influenza and seasonal respiratory illness activity, reinforcing the importance of prevention, vaccination, and early intervention across healthcare settings. As patient volumes rise during the winter months, providers play a critical role in reducing preventable complications through timely screening, immunization, and risk-based care coordination.

For providers, this is also a key period to ensure accurate vaccine documentation, diagnosis coding, and care-plan records, especially for high-risk populations such as older adults, patients with chronic conditions, and residents of long-term care facilities. Consistent documentation supports both quality reporting and compliant reimbursement.

December's focus on respiratory health serves as a transition into the new year—prompting providers to review preventive care workflows, reinforce patient education, and prepare clinical and billing teams for January 1 coding, coverage, and payment updates.

# GET IN TOUCH WITH US

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As the year comes to a close, December offers a moment to reflect on what's been accomplished and prepare for what lies ahead. Thank you for the dedication you bring to patient care and operational excellence—may the new year begin with clarity, balance, and renewed confidence.

# Thank You