CURAWISE
BILLING SOLUTIONS

CURAWISE NEWSLETTER

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Welcome

By February, the impact of early-year decisions becomes visible. Claims submitted under new payer rules begin to adjudicate, denial patterns emerge, and documentation quality is tested against real-world scrutiny. What felt aligned in January is now being measured by outcomes.

This is the month where revenue cycle performance reveals its strength—or exposes gaps that require immediate attention. Authorization workflows, coding accuracy, telehealth documentation, and front-end controls are no longer theoretical safeguards; they are actively influencing cash flow, appeal volumes, and operational strain.

February is also a critical window for course correction. Addressing denial trends, underpayments, and documentation inconsistencies now—while volumes remain manageable—prevents small issues from compounding into larger financial and compliance risks later in the year.

At CuraWise, our focus this month is helping providers interpret early signals and act decisively. By analyzing what February data is already showing and reinforcing disciplined workflows, practices can stabilize revenue, reduce rework, and move into Q2 with confidence rather than catch-up.

February is not a pause between planning and performance.
It is where strong strategies prove themselves.

Together, we turn early insight into sustained control—protecting revenue, compliance, and operational resilience as 2026 unfolds.

INDUSTRY INSIGHT

New Simplified Radiation Therapy Prior Authorization

UnitedHealthcare has introduced **simplified prior authorization requirements for radiation therapy services,** effective **January 1, 2026,** with the goal of reducing administrative burden for providers and medical billing companies. This update streamlines utilization management while continuing to support appropriate clinical oversight and timely patient access to care.

Under the revised process, **certain radiation oncology services will no longer require prior authorization,** helping practices reduce delays and minimize authorization-related claim denials. In addition, radiation therapy cases that were **authorized prior to January 1, 2026, will not require resubmission,** as existing authorizations will transition to align with the updated radiation therapy coding structure.

Providers and billing teams should ensure they are using the **correct, updated procedure codes for services rendered on or after the effective date** and adjust internal billing workflows accordingly. Verifying authorization status through the UnitedHealthcare Provider Portal remains essential to support clean claim submission and timely reimbursement.

www.uhcprovider.com

New York Medicaid: Dialysis Reimbursements Now Include Phosphate Binders

Effective **January 1, 2026, New York Medicaid** has updated its reimbursement policy for dialysis services so that the **cost of phosphate binders used during dialysis sessions is now included in the bundled Ambulatory Patient Group (APG)** payment rather than reimbursed separately.

Under this policy change, dialysis clinics should **submit one APG claim for dialysis services,** and it will automatically include the cost of phosphate binders provided during treatment. Separate claims for phosphate binder drugs will be **denied as non-covered services** if billed outside the bundled APG reimbursement.

This update aligns New York State Medicaid with federal changes under the Centers for Medicare & Medicaid Services (CMS) that incorporate oral phosphate binder costs into ESRD bundled payments. Providers and billing teams should adjust their claims workflows and internal billing systems accordingly to avoid denials and ensure accurate payment under the new bundled payment structure.

www.uhcprovider.com

Maryland Medicaid Covers Cell & Gene Therapy for Sickle Cell Disease

Starting **January 1, 2026, Maryland Medicaid** expanded its coverage to include **FDA-approved cell and gene therapies for sickle cell disease** under the federal Cell and Gene Therapy (CGT) Access Model. This means eligible Medicaid enrollees diagnosed with sickle cell disease can receive comprehensive care — including evaluation, apheresis, infusion, recovery, and long-term follow-up — at authorized treatment centers without facing additional cost barriers.

The therapies covered under this policy include **Casgevy and Lyfgenia**, two cutting-edge treatments that aim to address the underlying genetic cause of sickle cell disease rather than just manage symptoms. Maryland's participation in the CGT Access Model aligns with a broader federal initiative to improve access to potentially curative treatments while managing cost through outcomes-based agreements.

For providers and medical billing companies, this update underscores the importance of verifying **patient eligibility** and **treatment authorization criteria** for these therapies, coordinating care at **designated treatment centers,** and ensuring that reimbursements are submitted correctly under Maryland Medicaid's updated coverage framework.

www.uhcprovider.com

Idaho Medicaid: New Billing Changes for Diabetes Equipment and Supplies

Effective **April 1, 2026, Idaho Medicaid** is restructuring how diabetes equipment and supplies are billed for Medicaid members — shifting these items from the member's **medical benefit to the pharmacy benefit.** This policy change applies to a range of supplies commonly used in diabetes care, including syringes with needles, supplies for self-administered injections, alcohol wipes, and continuous glucose monitor (CGM) supplies and accessories.

For **dates of service from January 1 through March 31, 2026,** providers may submit claims under either the medical or pharmacy benefit, but claims submitted to both will be reviewed by the Medicaid Program Integrity Unit. **Beginning April 1, 2026,** any diabetes equipment or supply claims that are billed under the medical benefit

rather than the pharmacy benefit are subject to denial — meaning practices must ensure their billing systems route these HCPCS codes through the pharmacy benefit to receive payment.

Medical billing teams should update internal workflows, scrubber logic, and claim submission processes to reflect this shift. Confirming coverage and benefit type in advance and ensuring proper pharmacy routing can help avoid denials and streamline reimbursement under the updated Idaho Medicaid policy.

www.uhcprovider.com

United Healthcare

Hawaii Medicaid: New Guidelines for Early Childhood Mental Health Providers

Hawaii Department of Human Services has issued **new care and billing guidance for early childhood mental health providers** serving children under the **QUEST Integration (QI) Medicaid program,** aimed at improving access to developmental and behavioral health care for young children and supporting providers with practical billing tools. The updated guidance highlights best practices for using the **DC:0–5™ diagnostic tool**, a standardized framework designed specifically for **infants, toddlers, and preschool-aged children,** and includes a **crosswalk to existing billing codes** to help align clinical documentation with correct Medicaid coding.

This initiative encourages adoption of the DC:0-5™ diagnostic approach — which is tailored to the unique developmental and social-emotional needs of very young children — and provides **free training resources** to help behavioral health and pediatric providers implement these guidelines effectively. By integrating developmentally appropriate diagnostics and clearly linking them to Medicaid billing codes, Hawaii's new guidance supports more accurate documentation and reimbursement for early childhood mental health services.

For providers and medical billing teams, reviewing the updated guidance and adopting the recommended billing codes can help ensure that early intervention and behavioral health services for young children are billed correctly, enhancing care delivery and reducing administrative challenges under Hawaii Medicaid's managed care system.

www.uhcprovider.com

Anthem

Reminder on Corrected Claims Procedures

Anthem Blue Cross Blue Shield of New York has issued a reminder for providers regarding the **proper procedures for submitting corrected claims** to ensure accurate payment and avoid administrative delays. When a previously submitted claim contains errors, providers should follow the insurer's corrected claims process rather than submitting a new or replacement claim as if it were original. This typically involves **voiding or canceling the original claim and resubmitting the full corrected claim** according to Anthem's corrected claims guidelines.

Billing teams should confirm that **corrected claims are clearly identified as such** in their submission (using appropriate frequency codes or EDI indicators) and that they include **all required supporting information** to justify the correction. Following Anthem's corrected claims procedures helps reduce denials, speeds up reimbursement, and ensures that financial records accurately reflect claim adjustments.

www.providernews.anthem.com

Anthem

Expanded Specialty Pharmacy Precertification List

Anthem Blue Cross Blue Shield of New York has announced an **expansion of its specialty pharmacy precertification list,** with new medications and drug categories requiring **prior authorization under the pharmacy benefit beginning April 1, 2026**. This change reflects Anthem's updated utilization management approach for high-cost and specialty medications, affecting both **Medicare Advantage and commercial plan members.**

Under the updated policy, additional specialty drugs — particularly those with significant cost or clinical complexity — will require **precertification before coverage is approved,** which means providers and billing teams must verify **authorization requirements before prescribing or dispensing these medications**. Failure to obtain the necessary precertification could result in **claim denials or delayed reimbursement** for the associated pharmacy charges.

Medical billing staff should update their **prior authorization checklists and adjudication workflows** to include the newly added specialty pharmacy agents. Reviewing Anthem's current precertification list and the list of affected drugs in advance can help ensure proper routing of pharmacy benefit claims, improve clean claim rates, and minimize administrative exceptions related to specialty drug coverage.

www.providernews.anthem.com

Anthem

Clinical Criteria Updates

Anthem Blue Cross Blue Shield of New York has published **updates to its Clinical Criteria, effective February 27, 2026,** which outline the clinical evidence and medical necessity requirements used to guide prior authorization and utilization review decisions. These criteria serve as key reference standards for both providers and medical billing teams when preparing documentation to support service approval and claims adjudication.

The updated documents include revisions to criteria for a range of services and therapies — for example, criteria governing the use of **colony stimulating factor agents** and other specialty treatment categories. Providers should review the full updated clinical criteria on the Anthem provider portal to understand the specific documentation expectations and any changes to threshold requirements that may impact prior authorization outcomes.

For medical billing operations, integrating these updated clinical criteria into internal workflows and clinical documentation checklists can help ensure that prior authorization requests are supported with appropriate evidence, reducing the risk of denials and administrative delays. Teams should also confirm that authorization submissions reference the current criteria version and that clinical documentation aligns with Anthem's updated medical necessity definitions.

www.providernews.anthem.com

Anthem

Carelon Medical Benefits Management & Radiology/Clinical CPT Code List Update

Anthem Blue Cross Blue Shield of New York advises providers that updates to the **Carelon Medical Benefits Management (formerly AIM Specialty Health)** clinical appropriateness guidelines — including **radiology and clinical CPT code lists — are in effect and should be referenced for prior authorization and utilization review requirements.** Carelon's guidelines are used by Anthem to determine medical necessity for advanced imaging, diagnostic testing, and other services where clinical appropriateness criteria apply.

The updated CPT code lists for radiology and clinical services include revisions that reflect changes to advanced imaging categories (such as abdomen, pelvis, and other modality guidelines) and should be used when determining whether a given service requires a precertification request to Carelon Medical Benefits Management. Providers and billing teams must **verify the correct CPT codes and corresponding guideline criteria before submitting prior authorization requests** to ensure compliant documentation and accurate utilization review.

Billing professionals should integrate these revised code lists into existing **prior authorization checklists and claims adjudication workflows,** review Carelon's guideline details via the Anthem or Carelon provider portals, and update internal systems so that claim submissions reflect current clinical appropriateness expectations and reduce the risk of denials due to guideline misalignment.

www.providernews.anthem.com

aetna®

National Precertification List (NPL) Updates — Effective April 1, 2026

Aetna has announced important updates to its **National Precertification List (NPL),** effective **April 1, 2026,** impacting both **commercial and Medicare plans.** These updates introduce new precertification requirements for several injectable and specialty medications as part of Aetna's ongoing utilization management and cost-containment strategy.

Under the updated NPL, multiple **denosumab-based products** will require precertification and are typically billed under **HCPCS miscellaneous codes J3490, J3590, and C9399.** Additional drugs added to the list include **Eydenzelt® (aflibercept-boav),** commonly billed under **J0178, HymovisOne®** billed under **J7322, and Poherdy® (pertuzumab-dpzb)** billed under **J9306 or Q-codes** where applicable, all of which will now require prior approval before administration.

The update also expands precertification requirements to several high-cost specialty therapies, including **Armlupeg® (pegfilgrastim-unne)** billed under **Q5126, Exdensur® (depemokimab)** reported under **J3590, Lunsumio Velo® (mosunetuzumab-axgb)** billed under **J9308, and Rybrevant Faspro® (amivantamab with hyaluronidase-lpuj)** billed under **J9332**. In addition, **Kyxata® (carboplatin)** has been added as a Medicare-only precertification requirement and is typically billed under **J9045.**

Providers are strongly encouraged to review these changes and align their clinical, scheduling, and billing workflows accordingly. **Precertification requests should be submitted at least two weeks prior to the date of service**, with accurate CPT/HCPCS coding, to avoid treatment delays, claim denials, or payment disruptions once the new NPL requirements take effect.

www.aetna.com

Additional Precertification Starting May 1, 2026

Effective May 1, 2026, Aetna is expanding its National Precertification List to include several **high-impact gene therapies and biologics** that will require prior authorization before services are rendered for both commercial and Medicare members.

Under the new requirements, **Papzimeos® (zopapogene imadenovec-drba)** — a gene therapy indicated for rare disease treatment — will need precertification before administration. Additionally, two formulations of **ustekinumab — ustekinumab-auub and ustekinumab-srlf** — are being added to the list and will require prior review to confirm medical necessity. These changes reflect Aetna's continued emphasis on clinical oversight and cost-effective care management for high-cost therapies.

Providers should begin updating their authorization and scheduling workflows now to account for these new requirements. As with other precertification policies, requests should be submitted **in advance of the service date** through the appropriate online portal or electronic medical record system to minimize delays and support timely reimbursement.

www.aetna.com

State Medicaid Oversight & Fraud Control

Minnesota's major Medicaid fraud crackdown continues as state officials launch a sweeping revalidation initiative to review thousands of enrolled providers identified as "high risk." Under the new **"Minnesota Revalidate"** program, the Department of Human Services has mobilized more than **160 additional staff** to conduct unannounced site visits and documentation reviews of nearly **5,800 Medicaid providers** across 13 service categories, with the goal of completing checks by this spring. This action comes amid federal threats to withhold up to **$2 billion in federal Medicaid matching funds** unless the state strengthens fraud prevention and oversight efforts. Audits of 14 high-risk programs have flagged over **$1 billion in potentially vulnerable claims,** and Minnesota has already paused provider enrollments in some services and paused payments to tighten program integrity.

At the federal level, the U.S. House Committee on Energy and Commerce's Oversight and Investigations Subcommittee held a hearing on February 3, 2026, titled "Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid", highlighting how health care fraud — including in state Medicaid programs like Minnesota's — continues to drain taxpayer resources and harm vulnerable populations nationwide. Lawmakers emphasized the need for stronger controls, data sharing, and enforcement mechanisms to detect and prevent improper payments.

Provider-specific fraud cases are also emerging across other states. In **Connecticut,** authorities arrested individuals for posing as licensed medical professionals and fraudulently billing Medicaid for services they were not authorized to perform, illustrating ongoing risks at the clinic level and the importance of robust credentialing and billing practices for providers.

www.medicaid.gov

Medicaid Funding & Financial Pressures: North Carolina and Connectic

Medicaid programs across several states are facing intensified financial scrutiny as leaders work to balance rising administrative costs and ongoing service demands. In **North Carolina,** Medicaid officials are actively evaluating funding strategies to address budget challenges tied to increased administrative expenses and uncertainties around potential federal work requirements. Among the options under consideration are **higher hospital contributions and insurer tax adjustments** to stabilize the program's fiscal outlook while maintaining access to care.

Meanwhile in **Connecticut,** hospitals are pushing back against a **proposed provider tax plan** aimed at generating additional revenue for Medicaid. Hospital leaders warn that the tax — coupled with already **low reimbursement rates** — could exacerbate financial strains on facilities serving large Medicaid populations, further squeezing operating margins and jeopardizing care capacity. Both developments highlight growing tension between the need for sustainable Medicaid funding and the financial realities facing providers on the front lines of patient care.

www.medicaid.gov

www.medicaid.gov

Codes Removed to Simplify Prior Authorization — Effective January 26, 2026

Horizon Blue Cross Blue Shield of New Jersey implemented an important update to its prior authorization program effective **January 26, 2026,**

aimed at reducing administrative burden for participating providers. As part of this update, Horizon removed select procedure and service codes from its prior authorization requirements, streamlining the process for determining whether approval is needed before services are rendered.

The change means that providers will no longer be required to submit prior authorization requests for certain services that were previously flagged in the system. These removals are reflected directly in Horizon's online prior authorization and eligibility tools, ensuring that providers see only current and applicable requirements when checking coverage or planning care. This update is intended to improve efficiency, reduce delays in care, and minimize unnecessary back-and-forth related to authorizations.

Horizon advises providers to review their internal workflows and authorization checklists to align with the updated code list. Continuing to reference outdated requirements could result in unnecessary submissions or administrative delays, even though authorization is no longer required for the removed codes.

Providers are encouraged to rely on the most up-to-date information available through Horizon's provider portal and to routinely monitor provider alerts and news postings. Staying current with these changes will help ensure smoother claims processing, faster service delivery, and improved operational efficiency.

www.horizonblue.com

Site of Administration Update — Effective February 1, 2026

Horizon Blue Cross Blue Shield of New Jersey announced a **Site of Administration (SOA) policy update** that took effect on **February 1, 2026.** This update clarifies how certain **infusion and injectable medications** should be administered to qualify for coverage and reimbursement under Horizon plans. The goal is to ensure that therapies are delivered in **clinically appropriate settings** that support patient safety and optimal outcomes while aligning reimbursement with evidence-based standards of care.

Under the revised SOA guidance, services involving applicable infusion and injectable drugs will be reviewed against specific clinical site criteria when claims are submitted. Treatments administered in settings that do not meet those criteria may be subject to medical necessity review or payment adjustments. The update reflects Horizon's effort to balance access to care with appropriate utilization management, particularly for high-cost therapies where setting can significantly influence both costs and clinical effectiveness.

Providers are encouraged to familiarize themselves with the updated requirements and confirm, prior to administration, that the chosen site aligns with Horizon's clinical guidelines. Doing so can help avoid claim denials or reprocessing delays. As always, documentation that supports the medical necessity of the site choice remains critical for successful claims adjudication.

Because SOA policies can evolve, Horizon recommends regularly checking the provider news and policy sections of their portal and referencing the specific clinical criteria for each applicable medication or service. Staying up-to-date with these requirements will help practices streamline billing workflows and support timely reimbursement.

www.horizonblue.com

Horizon Casualty Services Joins MedRisk

Horizon Blue Cross Blue Shield of New Jersey announced a significant operational change in early **February 2026: Horizon Casualty Services (HCS)** has officially joined **MedRisk,** a national workers' compensation services organization. This transition is expected to affect how workers' compensation cases are managed, billed, and coordinated for providers who treat patients with work-related injuries covered under Horizon's casualty plans.

Under the update, administrative processes previously handled by HCS — including case coordination, utilization review, and certain billing support functions — will now be overseen through MedRisk's infrastructure. Providers should anticipate changes in how they submit workers' compensation claims, access case information, and interact with utilization management personnel. Horizon has indicated that this change aims to streamline services, improve response times, and leverage MedRisk's specialty expertise in workers' comp care delivery.

Providers participating in workers' compensation networks or who frequently treat injured workers are advised to review any **new claim submission instructions, contact points, and authorization workflows** associated with MedRisk integration. Ensuring accurate and timely communications with the new service partner will be essential for maintaining smooth operations and reimbursement continuity.

As with any administrative transition, Horizon encourages providers to monitor updates on its **provider portal and news center,** and to reach out proactively to MedRisk or Horizon support teams with questions about specific cases, billing procedures, or utilization review expectations under the new arrangement.

www.horizonblue.com

CMS Announces $600 Million Tech Pledge to Support Medicaid Modernization

The **Centers for Medicare & Medicaid Services (CMS)** has announced that **10 leading health technology companies** have voluntarily pledged more than **$600 million in no-cost and discounted technology products and services** to help **state Medicaid programs prepare for and implement work and community engagement requirements** under federal law. The commitments come from vendors that already support Medicaid eligibility and enrollment systems and are intended to assist states as they build out the systems and tools needed to comply with new federal requirements.

These technology resources are designed to support modernizing eligibility, enrollment, verification, and related administrative systems, which states must overhaul to meet the **Medicaid community engagement requirements** established by the **Working Families Tax Cut (WFTC) legislation (Public Law 119-21)** by **January 1, 2027.** CMS officials say the initiative could generate s**ignificant savings for states and taxpayers** while improving the beneficiary experience by streamlining processes and reducing administrative burden.

Participating companies include major vendors like **Accenture, Conduent, Deloitte, Gainwell, Maximus, Optum,** and others that provide eligibility and enrollment support to states. In addition to offering technology solutions, CMS is working with the **General Services Administration (GSA)** to help states procure these tools more efficiently through federal schedules, aiming to accelerate implementation and ensure transparency in purchasing.

For providers, this development signals upcoming changes in how **eligibility and enrollment data** may be processed and verified, potentially affecting how patients are screened for Medicaid coverage and how providers verify eligibility and benefits. Providers should stay informed on system changes that may impact billing workflows, beneficiary eligibility checks, and administrative processes as states begin implementing these updated systems over the coming months.

www.cms.gov

CMS Closes Medicaid Provider Tax Loophole to Protect Federal Funds

The **Centers for Medicare & Medicaid Services** has finalized a major rule aimed at **closing a longstanding Medicaid tax loophole** that allowed some states to shift their Medicaid financing responsibilities onto federal taxpayers. Under the new "**Preserving Medicaid Funding for Vulnerable Populations — Closing a Health Care-Related Tax Loophole" Final Rule,** CMS will enforce stricter limits on how states can use health care-related provider taxes to draw federal matching dollars—ensuring that state contributions remain equitable and in line with statutory financing requirements.

Historically, certain state tax structures — particularly **higher tax rates on Medicaid business compared with non-Medicaid business** — enabled states to generate revenues used to claim additional federal Medicaid funds, sometimes totaling **more than $24 billion annually.** CMS has determined that these arrangements effectively shifted state costs to the federal government and undermined the intended **Federal-State Medicaid partnership.** The new rule prohibits such tax differentials and eliminates indirect, opaque mechanisms that previously allowed states to exploit the financing system. CMS estimates that closing this loophole will **save federal taxpayers more than $78 billion over the next decade.**

To help states adjust, the rule establishes **phased compliance timelines:** states with managed care organization (MCO) taxes recently approved will have until the end of 2026 to comply; other older MCO tax waivers have until the end of their 2027 fiscal year; and non-MCO provider taxes (e.g., hospital or nursing home taxes) will have until fiscal year 2028 to align with the new standards. Providers should be aware that these changes may influence state **Medicaid financing strategies,** with downstream implications for program support, reimbursement rates, and budgeting decisions at the state level.

www.cms.gov

Medicare ACO Growth Signals Strong Provider Engagement in Value-Based Care

The **Centers for Medicare & Medicaid Services (CMS)** recently highlighted continued expansion in **Medicare Accountable Care Organizations (ACOs)** — underscoring strong provider participation in value-based care models designed to improve quality while controlling costs. According to CMS data, more clinicians, health systems, and provider groups are joining **ACO arrangements through key programs such as the ACO Realizing Equity, Access, and Community Health (REACH) Model and the Medicare Shared Savings Program (MSSP).** These initiatives incentivize care coordination, preventive care, and efficient resource use by offering shared savings opportunities tied to quality and cost performance.

The growth in ACO participation reflects broader momentum toward **value-based payment models** in Medicare. Providers in ACOs assume accountability for the total cost and quality of care for attributed beneficiaries and can earn additional payments when they achieve savings while meeting quality benchmarks. The trend toward ACOs also aligns with CMS's goals of reducing fragmentation in care delivery, improving chronic disease management, and enhancing health equity by rewarding outcomes rather than service volume.

For providers, this expansion offers multiple opportunities:

- **Increased participation in value-based contracts** that reward quality and efficiency.
- **Enhanced care coordination infrastructure,** which can support better patient outcomes.
- **Potential financial upside** through shared savings and performance-based incentives.

Physicians, hospitals, and care groups interested in joining an ACO or expanding their role within existing arrangements should engage with CMS and Medicare ACO resources to understand program requirements, performance metrics, and accountability standards. Monitoring ongoing ACO developments remains important as CMS continues to refine these models to drive system-wide improvements in care delivery.

www.cms.gov

Maine Medicaid Audit — Improper Payments Identified

HHS Office of Inspector General (OIG) has released an audit identifying **approximately $45.6 million in improper Medicaid payments** made by **Maine Medicaid** for rehabilitative and community support services provided to children diagnosed with autism. The review found that a significant portion of the payments did not comply with federal Medicaid requirements, raising concerns about program oversight and claims integrity.

The audit highlighted several contributing factors, including **insufficient or missing documentation,** services that did not meet Medicaid coverage criteria, and weaknesses in state-level monitoring and provider compliance controls. In some cases, services were billed without adequate proof that they were medically necessary, properly authorized, or delivered in accordance with approved care plans.

As a result of these findings, OIG recommended that Maine strengthen its claims review processes, enhance provider oversight, and pursue recovery of unallowable payments. The report also emphasized the need for clearer guidance and more consistent enforcement to reduce the risk of future improper payments in high-risk service categories.

For Medicaid providers nationwide, this audit serves as an important compliance reminder. Providers should ensure that **clinical documentation is complete, services meet program requirements, and billing accurately reflects care delivered,** particularly for behavioral health and community-based services that are subject to heightened federal scrutiny. Strengthening internal compliance and audit readiness can help mitigate financial and regulatory risk.

www.oig.hhs.gov

OIG Fall 2025 Semiannual Report to Congress

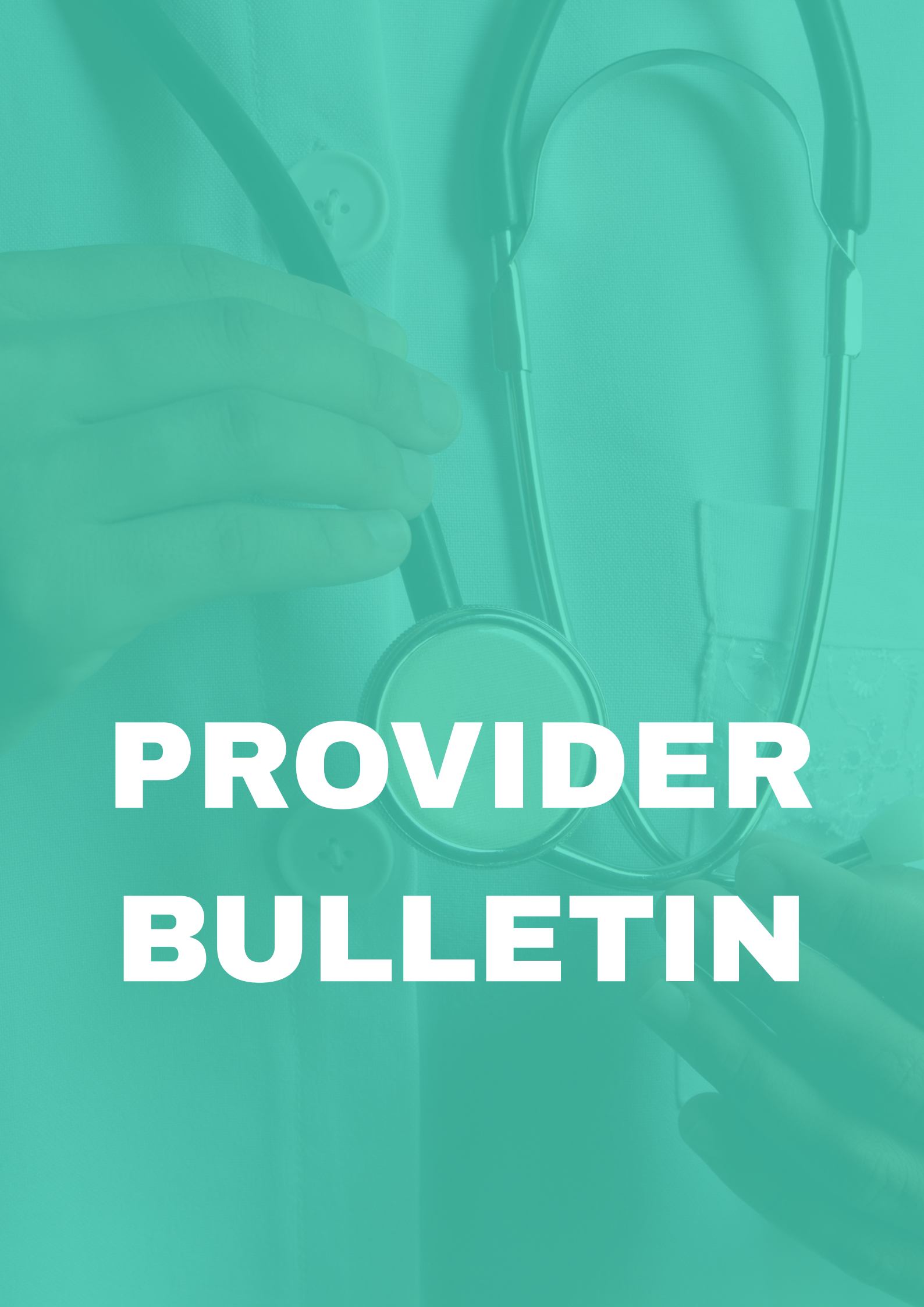
The **HHS Office of Inspector General** released its **Fall 2025 Semiannual Report to Congress,** outlining major audit findings, enforcement outcomes, and priorities for combating fraud, waste, and abuse in federal health programs — including **Medicare and Medicaid.** The report underscores OIG's continued commitment to protecting program integrity and safeguarding taxpayer dollars across health care services.

One of the key themes in the report is the persistence of **improper payments and compliance gaps** in both fee-for-service and managed care settings. Audits identified ongoing issues with documentation deficiencies, billing that did not meet coverage criteria, and inadequate state oversight in several Medicaid programs. These findings reinforce the importance of robust provider documentation, precise coding, and adherence to federal and state policy requirements to avoid payment recoupments or enforcement actions.

The report also highlights **strengthened enforcement activity** during the reporting period, including civil and criminal actions against entities involved in fraudulent billing schemes. Cases involving false claims, kickbacks, and medically unnecessary services remain a focus of OIG investigations — signaling continued risk for providers who lack strong compliance programs or fail to monitor billing accuracy. The Semiannual Report encourages provider organizations to continuously improve internal controls, staff training, and risk-based auditing efforts.

Additionally, OIG emphasized oversight of emerging program areas, such as **Medicaid managed care**, behavioral health services, and prescription drug costs — especially where growth in service utilization has outpaced monitoring capabilities. These priorities can influence future audits and enforcement actions, making it essential for providers to stay informed about areas of heightened scrutiny and to align operations with federal expectations.

www.oig.hhs.gov



PROVIDER BULLETIN

The Hidden Cost of “Almost Right” Billing in Q1

At the start of every year, healthcare organizations reset goals, budgets, and operational priorities. January brings new CPT/HCPCS updates, revised payer policies, benefit resets, and renewed pressure to improve margins. Yet, despite best intentions, many providers enter Q1 with billing that is not fully accurate—but almost right. This “almost right” billing is rarely dramatic enough to trigger immediate alarms, but over the course of Q1, it quietly erodes revenue, strains staff, and distorts financial performance.

Unlike blatant billing errors that result in outright denials, “almost right” billing refers to claims that are technically submitted but fail to meet payer-specific expectations. Examples include missing or incorrect modifiers, slightly mismatched diagnosis-to-procedure relationships, outdated authorization rules, incomplete documentation, or incorrect place-of-service selection. These claims may still be processed—but often at reduced rates, delayed timelines, or with increased rework. The financial impact accumulates slowly, making it harder to detect until the quarter is already lost.

Why Q1 Is the Most Vulnerable Quarter

Q1 carries unique risk because it combines change and volume. Annual code updates take effect January 1, payer edits are refreshed, and medical policies are revised. Even experienced billing teams can struggle to adapt quickly—especially when payer changes are not clearly communicated or differ by plan. At the same time, patient benefits reset, prior authorizations expire, and eligibility rules shift, increasing the likelihood of technical claim issues.

For hospitals, SNFs, and DME providers, Q1 also brings heightened scrutiny around medical necessity and documentation. New utilization benchmarks and evolving value-based models mean that payers are actively reviewing patterns early in the year. Claims that might have passed in Q4 may now be flagged for review, downcoding, or post-payment audit. The result is a growing backlog of reworked claims and delayed reimbursements—often without a clear explanation at first glance.

The Financial Impact You Don’t See on the Surface

The most dangerous aspect of “almost right” billing is that it often does not show up as denials. Instead, it appears as:

- Underpayments compared to contracted rates
- Longer payment cycles
- Increased manual follow-up
- Higher days in Accounts Receivable (A/R)
- Silent write-offs at month-end

Because these issues don’t always trigger denial codes, leadership may assume performance is stable. However, when Q1 closes, finance teams often discover revenue shortfalls that cannot be fully explained by patient volume alone. In reality, the losses stem from hundreds or thousands of small billing inefficiencies that compounded over the quarter.

For SNFs and DME providers, the impact can be even more severe. Small errors in modifiers, rental vs. purchase indicators, or documentation timing can lead to partial payments or extended holds. Each delayed claim affects cash flow, payroll planning, and vendor obligations—creating operational stress far beyond the billing department.

The Operational Cost: Staff Burnout and Rework

Beyond lost revenue, “almost right” billing places a heavy burden on staff. Billing teams spend Q1 reacting instead of optimizing—correcting claims, resubmitting documentation, responding to payer inquiries, and chasing explanations of benefits (EOBs). This reactive environment increases overtime, reduces morale, and limits the team’s ability to focus on prevention.

Clinical teams also feel the impact. Documentation requests, retroactive clarifications, and audit support pull providers away from patient care. Over time, this cycle reinforces inefficiency: clinicians document defensively, billers compensate manually, and leadership loses visibility into true performance drivers.

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Why Technology Alone Isn’t Enough

Many organizations assume that billing software or clearinghouse edits will catch most issues. While technology is essential, it cannot replace payer-specific intelligence and human expertise. Clearinghouse edits validate formatting—but they do not account for nuanced payer rules, local coverage determinations, or evolving medical necessity standards.

“Almost right” billing persists when organizations rely solely on automated processes without regular audits, payer trend analysis, and proactive rule updates. Without this layered approach, errors repeat quarter after quarter—especially in high-volume environments like hospitals and DME operations.

Turning Q1 into a Strategic Advantage

The organizations that perform best financially treat Q1 not as a recovery period, but as a stabilization and calibration phase. They conduct early-quarter audits, review denial and underpayment trends weekly, and update workflows before issues scale. They ensure that documentation standards, coding updates, and authorization rules are aligned across clinical and billing teams.

Precision—not volume—is the key. Clean claims submitted correctly the first time protect cash flow, reduce A/R days, and set a strong financial baseline for the rest of the year. When “almost right” becomes right the first time, Q1 transforms from a silent revenue leak into a foundation for sustainable growth.

Final Thought

In healthcare billing, accuracy is not binary. Claims are rarely just right or wrong—they exist on a spectrum. Q1 exposes the cost of operating too close to the edge of that spectrum. Identifying and fixing “almost right” billing early is not just a compliance exercise—it is a strategic financial decision that determines how strong the rest of the year will be.

Credentialing Gaps: The Silent Revenue Stopper in Q1

At the start of every year, healthcare organizations focus on revenue goals, patient volumes, and operational efficiency. Yet one of the most damaging revenue risks in Q1 often goes unnoticed—not because it is rare, but because it is silent.

Credentialing gaps do not always generate denials. They do not always trigger alerts. In many cases, claims continue to submit, process, and even appear “accepted.” The impact is only discovered weeks or months later—when payments are missing, reduced, or permanently unrecoverable.

By the time the issue is identified, the revenue is often already lost.

Why Credentialing Issues Peak in Q1

The first quarter of the year is uniquely vulnerable to credentialing-related revenue disruptions due to several overlapping factors:

- Annual payer revalidations
- Medicare and commercial payer enrollment updates
- Provider changes effective January 1
- Practice relocations, ownership changes, or tax updates
- New providers added at year-end or early Q1

Even when practices believe their credentialing is “up to date,” small changes—such as an address update, new suite number, or ownership adjustment—can trigger a payer to suspend or alter payment eligibility.

In many cases, these changes are administrative, not clinical—yet the financial consequences are significant.

The Most Dangerous Part: Claims May Still Submit

One of the biggest misconceptions among providers is that credentialing issues always result in clear denials. In reality, credentialing gaps often cause:

- Claims to process at out-of-network rates
- Payments to be reduced or held
- Claims to pay $0 without a clear denial reason
- Retroactive recoupments months later

Because the claims pipeline appears active, leadership may assume revenue delays are related to payer backlogs, billing volume, or normal A/R timing. This false sense of stability allows the problem to compound quietly.

Common Credentialing Gaps That Stop Revenue

Credentialing issues in Q1 typically stem from overlooked or underestimated changes, including:

- Expired or incomplete payer revalidations
- New providers seeing patients before full enrollment approval
- Changes in practice address, ownership, or tax ID
- Provider status mismatches between Medicare and commercial payers
- Missing linkage between providers and service locations
- Failure to update payer portals after EHR or operational changes

Individually, these issues may seem minor. Collectively, they can halt or reduce revenue across entire service lines.

Why These Losses Are Often Not Recoverable

Unlike typical denials, credentialing-related payment issues are often not appealable once services are rendered outside of active enrollment.

Payers may classify affected claims as:
- Non-covered due to enrollment status
- Out-of-network by default
- Invalid for retroactive correction

This means that even perfectly documented, medically necessary services may never be reimbursed—simply because the credentialing status was incomplete at the time of service.

The Operational Ripple Effect

Credentialing gaps do not only affect revenue. They place strain across the organization:

- Billing teams spend time investigating missing payments instead of optimizing workflows
- A/R days increase without clear root causes
- Providers question billing performance despite accurate claims
- Leadership loses confidence in financial forecasting
- Staff morale declines as issues appear “unfixable”

Because credentialing problems originate outside daily billing operations, they are often misattributed—leading to delayed resolution.

Why Technology Alone Doesn’t Catch This Early

Most practice management systems and clearinghouses focus on claim format and submission rules, not real-time payer enrollment status.

Clearinghouse acceptance confirms that a claim can be transmitted—not that the payer considers the provider fully eligible for payment.

Without proactive credentialing audits and payer portal monitoring, practices may not realize there is a problem until payment trends are already impacted.

Turning Credentialing Into a Q1 Advantage

Practices that perform well financially in Q1 treat credentialing as a revenue control function, not an administrative task. Best practices include:

- Conducting early-year credentialing audits
- Verifying provider enrollment status across all active payers
- Confirming revalidation timelines and confirmations
- Aligning credentialing data with billing and scheduling systems
- Reviewing January payment trends for anomalies tied to enrollment

When addressed early, credentialing gaps can be resolved before they cause permanent revenue loss.

Final Thought

Credentialing gaps rarely announce themselves. They do not create obvious errors, urgent alerts, or immediate denials. Instead, they quietly reduce or stop payments while operations continue as usual.

In Q1—when financial patterns for the year are being established—these silent gaps can determine whether a practice starts strong or spends months trying to recover lost ground.

Proactive credentialing oversight is not just a compliance function. It is a revenue protection strategy.

FEATURE FOCUS

Downcoding: The Revenue Loss Most Practices Don’t Track

Downcoding is one of the most invisible yet costly revenue leaks in healthcare billing—and in 2026, it is happening more frequently than many practices realize.

Unlike denials, downcoded claims are paid, just at a lower level than submitted. Because payment still arrives, downcoding often escapes attention—quietly eroding revenue month after month.

Why Downcoding Increases After January

Each year, January marks a reset in payer behavior. New E/M guidelines, refreshed payer algorithms, updated telehealth policies, and recalibrated utilization thresholds all come into effect.

As a result:
- Payers apply stricter automated review logic
- Historical billing patterns are re-benchmarked
- Providers experience a spike in silent reimbursement reductions

For many practices, the financial impact isn’t visible until Q2 or Q3—after thousands in revenue have already been lost.

How Payers Apply Automated E/M Leveling Logic

Modern payers rely heavily on automated E/M leveling engines that evaluate claims using:
- Visit frequency and intensity
- Diagnosis-procedure pairing logic
- Documentation consistency trends
- Provider-specific historical benchmarks

If a payer’s system determines that a billed E/M level “exceeds expected norms,” it may downcode automatically—without issuing a denial or requesting documentation.

This is not a clinical judgment. It is a statistical one.

Telehealth-Specific Downcoding Risks

Telehealth claims remain under heightened scrutiny in 2026.

Common telehealth downcoding triggers include:
- Time-based documentation not aligning with billed levels
- Overuse of higher-level E/M codes in virtual visits
- Inconsistent modifier and place-of-service application
- Behavioral health visit frequency exceeding payer thresholds

Even when services are medically necessary and properly documented, payer algorithms often default to conservative reimbursement levels.

Facility vs. Professional Fee Vulnerabilities

Downcoding affects facility and professional claims differently:
- Professional fees are often downcoded at the E/M level due to perceived over-complexity.
- Facility fees may be adjusted based on visit intensity, diagnosis mix, or utilization frequency.

Because these reductions appear as “paid claims,” they rarely trigger internal alerts unless actively monitored.

Real-World Scenarios We See Often

- A Level 4 E/M consistently paid as Level 3—without denial notices
- Telehealth behavioral health sessions reimbursed below expected rates
- High-performing providers flagged due to volume-based benchmarking
- Facility claims reduced based on visit pattern algorithms

In all cases, appeals alone do not solve the problem.

Operational Controls That Detect Downcoding

Preventing downcoding requires operational visibility, not reactive follow-ups.

Effective controls include:
- Expected-vs-actual reimbursement analysis
- E/M level trend monitoring by payer and provider
- Telehealth reimbursement benchmarking
- Provider-specific variance reporting
- Payer behavior tracking over time

Without these controls, downcoding remains invisible.

Why Data—not Appeals—Stops Downcoding

Appealing individual claims may recover dollars temporarily—but it does not stop systemic payer behavior.

What works instead:
- Identifying payer-specific downcoding patterns
- Adjusting documentation and coding alignment strategically
- Modifying visit distribution trends where appropriate
- Using data to defend billing patterns proactively

At CuraWise, we focus on preventing revenue erosion at scale, not chasing underpayments one claim at a time.

The CuraWise Approach

CuraWise helps healthcare practices uncover and address silent revenue loss caused by downcoding through data-driven analysis and payer trend monitoring. By identifying payer-driven reimbursement patterns and aligning documentation and coding in a defensible, compliant manner, we help protect revenue without increasing audit exposure. Because revenue you never see is often the hardest revenue to recover, our approach focuses on prevention, visibility, and long-term financial stability rather than reactive appeals.

Underpayments: When ‘Paid’ Doesn’t Mean ‘Paid Correctly

Introduction: The Most Overlooked Revenue Leak

In 2026, one of the most damaging revenue issues facing healthcare practices is not denials, rejected claims, or unpaid balances—it is underpayments. These occur when claims are processed and reimbursed, but not at the correct contracted rate. Because payment is received, underpayments often escape attention, silently reducing revenue without triggering alarms or follow-up workflows.

Unlike denials, which are visible and disruptive, underpayments are subtle. They do not stop cash flow; they weaken it gradually. Over time, these small discrepancies compound into significant financial loss, particularly for practices operating on thin margins or high volume.

Why Underpayments Are Increasing in 2026

Underpayments are becoming more common as payer reimbursement systems grow more automated and complex. Payers now rely heavily on adjudication engines that apply internal pricing logic, utilization thresholds, and bundled payment rules—often without transparency or notification to providers.

Frequent updates to fee schedules, policy revisions, and telehealth reimbursement adjustments further increase risk. In many cases, payer systems fail to apply updated contract terms consistently across all claim scenarios. As a result, practices assume accuracy while payers apply outdated or incomplete pricing logic.

The shift toward automation has made reimbursement faster—but not necessarily more accurate.

“Paid” Does Not Mean “Correct”

A claim marked as “paid” is often treated as closed. Most billing teams are trained to focus on denials, rejections, and unpaid balances, not on validating whether the amount paid matches contractual expectations. This operational reality is exactly why underpayments persist.

Because underpayments do not interrupt workflows, they are rarely flagged unless practices actively compare expected reimbursement versus actual payment at the line-item level. Without that comparison, errors remain invisible.

This creates a dangerous assumption: if the payer paid, the payer paid correctly.

Common Causes of Underpayments

Underpayments typically stem from payer-side issues rather than provider billing errors. One of the most common causes is the application of incorrect or outdated fee schedules. When payers fail to update internal systems after contract renewals or amendments, claims may continue to be paid at older, lower rates.

Another frequent cause is inconsistent modifier pricing. Even when modifiers are correctly applied, payer systems may discount or reprice services based on internal logic that does not align with contractual terms. Bundled payment logic, multiple procedure reductions, and utilization-based adjustments can also reduce reimbursement without clear explanation.
In telehealth and behavioral health services, normalization trends have introduced additional complexity. Services that were previously reimbursed at parity may now be partially reduced or capped, often without explicit denial notices.

The Cumulative Impact of Small Variances

Underpayments are rarely dramatic on a single claim. A difference of $15, $30, or $50 may not seem material in isolation. However, when applied across hundreds or thousands of encounters, the financial impact becomes substantial.

Because underpayments are distributed across time and volume, they distort financial performance quietly. Practices may believe their revenue cycle is stable while actual earnings fall short of contractual potential. This hidden erosion makes forecasting less accurate and masks true operational performance.

Over time, underpayments can affect staffing decisions, growth plans, and overall financial confidence—without any obvious trigger event.

Why Appeals Alone Are Not the Answer

Appeals are often seen as the solution to reimbursement issues, but they are rarely effective for systemic underpayments. Appealing individual claims may recover small amounts temporarily, but it does not address the underlying cause of repeated pricing errors.

Many underpayments are technically “allowed” by payer systems, even when they contradict contract intent. In these cases, appeals are denied or ignored because the issue is not claim-specific—it is structural.

Sustainable correction requires identifying patterns, not chasing exceptions.

The Role of Data in Stopping Underpayments

Preventing underpayments requires data-driven visibility into payer behavior. This means analyzing reimbursement trends over time, comparing expected contract rates against actual payments, and identifying payer-specific pricing inconsistencies.

When practices understand which payers, codes, modifiers, or service types are consistently underpaid, they gain leverage. Data allows organizations to escalate issues at the contract or payer-relation level, rather than through repetitive appeals.
More importantly, data enables proactive decision-making. Practices can adjust workflows, documentation emphasis, and payer strategies based on real reimbursement behavior—not assumptions.

Telehealth and Behavioral Health: High-Risk Areas

Telehealth and behavioral health services remain among the most vulnerable areas for underpayments in 2026. As utilization stabilizes post-pandemic, many payers are applying tighter reimbursement controls, often without clear communication.

Time-based services, high-frequency encounters, and virtual visit patterns are frequently repriced or partially reduced. Even when documentation is compliant and services are medically necessary, reimbursement may not reflect contracted expectations.

Without targeted monitoring, these reductions are easily missed because claims are still processed and paid.

Facility vs. Professional Fee Underpayments

Underpayments affect facility and professional claims differently. Professional fees are often reduced through E/M leveling compression or modifier adjustments, while facility fees may be impacted by visit intensity logic, diagnosis grouping, or bundled payment thresholds.

Because these mechanisms differ, practices must evaluate reimbursement performance separately across claim types. A single global metric will not reveal where revenue is being lost.

The CuraWise Approach to Underpayments

CuraWise helps healthcare practices uncover and address underpayments through structured revenue integrity analysis. We focus on identifying payer-driven reimbursement trends, validating payments against contractual expectations, and detecting systemic pricing discrepancies that traditional billing workflows overlook.

By aligning documentation, coding, and reimbursement data defensibly, we help practices protect revenue without increasing audit exposure. Our approach prioritizes prevention, visibility, and long-term revenue stability rather than reactive appeals.

Because revenue you never see is often the hardest revenue to recover.

Closing Thought: Visibility Is the New Advantage

In an era of automated payments and complex payer logic, revenue accuracy can no longer be assumed. Practices that rely solely on claim status reports will continue to lose revenue quietly, while those that invest in reimbursement visibility will protect their financial future.

Underpayments may be silent—but they are not inevitable.

BUSINESS BEAT

Why Revenue Stability Matters More Than Revenue Growth in 2026

Executive Summary: A New Financial Priority

For many years, healthcare practices measured success almost exclusively through revenue growth. Higher visit volumes, expanded service lines, and increasing patient demand were viewed as indicators of financial health. In 2026, however, this metric alone is no longer sufficient. Practices are discovering that growth without stability can introduce greater financial risk, operational strain, and uncertainty.

Revenue stability—predictable, defensible, and accurate reimbursement—has become the more critical benchmark. As payer behavior grows more automated and reimbursement models become increasingly complex, stability provides the foundation for sustainable success.

The Changing Nature of Healthcare Revenue

Healthcare revenue has fundamentally changed. Payers now rely heavily on automated adjudication systems, utilization algorithms, and internal pricing logic. These systems evaluate claims based not only on accuracy but also on historical patterns, volume trends, and payer-specific benchmarks.

As a result, revenue is no longer determined solely by services rendered. It is shaped by how payers interpret those services within increasingly opaque systems. This shift means that practices can experience revenue erosion even as volumes increase and claims are technically “clean.”

Why Growth Alone Can Mask Financial Risk

Growth often feels reassuring. More encounters, more claims, and higher gross charges create the appearance of success. However, without stable reimbursement, growth can hide underlying financial problems.

Downcoding, underpayments, delayed reimbursements, and utilization-based adjustments frequently occur without denials or alerts. These silent reductions reduce effective revenue while practices continue to expand workload and overhead. Over time, this imbalance leads to staff burnout, strained cash flow, and unpredictable financial performance.

In 2026, growth without visibility can be more dangerous than stagnation.

Revenue Stability as a Strategic Advantage

Revenue stability provides clarity. When reimbursement is predictable, practices can forecast cash flow accurately, plan staffing levels responsibly, and make informed investments in technology and expansion. Stability reduces reliance on short-term fixes and minimizes financial surprises.

Stable revenue also strengthens compliance posture. Practices with controlled billing operations are better positioned to withstand audits, respond to payer inquiries, and defend billing patterns. Stability is not just a financial benefit—it is a risk-management tool.

The Operational Cost of Revenue Volatility

Revenue volatility creates operational friction. When payments fluctuate unpredictably, practices are forced into reactive decision-making. Staffing adjustments, delayed investments, and emergency cash-flow measures become common.

This volatility also places pressure on billing teams. Instead of focusing on optimization and prevention, teams spend time reacting to discrepancies after revenue has already been lost. Over time, this reactive posture reduces efficiency and increases error risk.

The Role of Data in Achieving Stability

Stability is not achieved through volume—it is achieved through insight. Practices that understand how payers actually reimburse, rather than how they expect them to reimburse, gain control over their financial outcomes.

Data-driven analysis allows practices to identify reimbursement trends, detect payer-specific behaviors, and recognize patterns of silent revenue loss. When practices monitor expected versus actual reimbursement over time, they move from

assumption to certainty.

This visibility transforms billing from a transactional function into a strategic asset.

Why Stability Comes Before Growth

Growth built on unstable revenue magnifies risk. Every new provider, location, or service line increases exposure to payer behavior and reimbursement variability. Without stable foundations, expansion can accelerate revenue leakage rather than profitability.

In contrast, practices that prioritize stability first create scalable systems. Once reimbursement is predictable and defensible, growth becomes more sustainable, measurable, and profitable.

In 2026, stability is not a constraint on growth—it is a prerequisite.

The CuraWise Perspective on Revenue Stability

At CuraWise, we view revenue stability as the cornerstone of strong financial performance. Our approach focuses on visibility, control, and prevention—helping practices understand how revenue is generated, adjusted, and sustained over time.

By identifying payer-driven reimbursement trends, aligning documentation and coding defensibly, and monitoring revenue behavior holistically, we help practices protect what they earn before pursuing expansion. Stability allows growth to be intentional rather than reactive.

Closing Thought: Control Is the New Growth Metric

In an environment defined by automation, payer complexity, and silent revenue erosion, growth alone is no longer the clearest sign of success. Practices that thrive in 2026 will be those that prioritize stability, transparency, and control.

Revenue stability is not about slowing down—it is about building a financial foundation strong enough to support long-term growth with confidence.

QUICK BILLING TIPS

Track paid-at-less-than-expected claims—not just denials.

Claims that are paid but reimbursed below contracted or expected levels often go unnoticed. Reviewing paid amounts against expected reimbursement helps identify silent revenue loss before it compounds.

Validate telehealth modifier usage across payers.

Telehealth reimbursement rules vary by payer. Ensuring modifiers and place-of-service codes align with each payer's current policy reduces payment reductions and unexpected repricing.

Audit your top five CPT codes by reimbursement variance.

Focus on high-volume CPTs where small payment differences create significant financial impact. Comparing expected versus actual reimbursement on these codes often uncovers consistent payer adjustments.

EVENT SCHEDULE

FEBRUARY-2026

13 FEBRUARY

AAPC WEBINAR: E/M LEVELING & DOWNCODING RISK IN 2026 (VIRTUAL)

Educational session from the American Academy of Professional Coders (AAPC) focusing on E/M distribution trends, automated payer downcoding logic, documentation alignment, and audit risk mitigation.

20 FEBRUARY

HFMA WEBINAR: UNDERPAYMENTS & REVENUE INTEGRITY STRATEGIES (VIRTUAL)

Presented by the Healthcare Financial Management Association (HFMA), this webinar explores underpayment detection, contract variance analysis, payer behavior trends, and revenue integrity best practices.

24 FEBRUARY

AMA EDUCATION: CPT® UPDATES & REIMBURSEMENT IMPACT FOR 2026 (VIRTUAL)

Hosted by the American Medical Association (AMA), this session reviews CPT® coding updates, reimbursement implications, and payer adoption trends impacting billing accuracy and revenue performance in 2026.

27 FEBRUARY

MGMA INSIGHTS: TELEHEALTH BILLING & COMPLIANCE UPDATE (VIRTUAL)

Session hosted by the Medical Group Management Association (MGMA) addressing telehealth reimbursement updates, modifier usage, payer policy variations, and operational risks for medical practices in 2026.

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Thank you for reading. As we move further into 2026, we wish you continued clarity, stability, and success in your billing and revenue operations. We look forward to sharing more insights to support your practice throughout the year.