CURAWISE
BILLING SOLUTIONS

CURAWISE NEWSLETTER

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Welcome

As we step into November, the focus shifts from planning to precision. This is the month where small gaps become big outcomes – where every missed correction today becomes a December consequence.

Thanksgiving reminds us of appreciation – and alignment. Payer turnaround slows, offices move into holiday rhythm, and staffing naturally tightens. That makes November the most strategic point of the year to clean A/R, tighten documentation, finalize coding accuracy, and secure year-end cash flow before the holidays freeze movement.

Finishing 2025 strong isn't about doing more – it's about correcting smarter, earlier.

At CuraWise, we are here to help providers protect revenue with structure, clarity, and timely action – so December becomes a month of closure... not crisis.

Together, we correct, align, and move into the year's final stretch with confidence.

Together, we correct early — so success isn't delayed

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United Healthcare

Prior Authorization for Outpatient Therapy & Chiropractic Services

UnitedHealthcare has announced that effective **February 1, 2026**, certain Medicare Advantage members in **Arizona and California** will now require **prior authorization** for outpatient physical therapy, occupational therapy, speech therapy, and Medicare-covered chiropractic services. The initial evaluation visit will not require authorization, however the **plan of care** — including number of visits, duration, and frequency — must be submitted for authorization before treatment continues. In some situations, up to six visits for new patients or new conditions within an eight-week period may be allowed without clinical review, but the prior authorization request still must be submitted. Services delivered in outpatient office or outpatient hospital settings are included, while home-based therapy is excluded.

This change is important for providers because failure to obtain authorization before services begin could result in **claim denials** — and members cannot be billed for these denied services. Providers and billing teams should update workflows immediately, especially for patients in these two states, to ensure authorization is requested in advance. Proper documentation of the initial evaluation, detailed plan of care, and timely submission through the UnitedHealthcare Provider Portal will be crucial to prevent revenue loss and avoid delayed payments.

https://www.uhcprovider.com

United Healthcare

New Referral Requirement for Medicare Advantage Specialist Visits

Starting **January 1, 2026,** most of the UnitedHealthcare Medicare Advantage HMO and HMO-POS plans will require a **referral from a primary care physician (PCP)** before a member can be seen by a specialist. This means that specialist visits will need to be pre-authorized via the PCP's referral to avoid claim denials or delays.

Providers and billing teams should proactively update their referral management workflows and educate staff and patients about this upcoming change. It's critical to verify the patient's plan type and referral status ahead of scheduling the specialist visit to ensure smooth processing and avoid member liability or unpaid services.

https://www.uhcprovider.com

United Healthcare

Telehealth Benefit Maintained through 2026

Starting with the 2026 plan year, UnitedHealthcare's Medicare Advantage (MA) plans will **continue to provide expanded telehealth coverage** for both medical and mental-health services that members receive from home. The coverage includes **in-home telehealth visits** with in-network physicians, nurse practitioners, physician assistants, and mental-health providers, delivered via **either audio-only or audio-video technology**, as long as the service is on the approved Medicare Telehealth List. Mental-health telehealth visits do **not** require a prior in-person visit when provided by an in-network mental-health professional. For MA PPO plans, telehealth coverage from home is available when the provider is in-network; for MA PFFS plans, members may access telehealth from any Medicare-eligible provider. (Source: UHC Provider website)

https://www.uhcprovider.com

United Healthcare

Documentation Updates for Hip & Knee Total Joint Replacements

Starting **October 1, 2025,** additional medical documentation will be required when submitting prior-authorization requests for total knee and hip replacement surgeries **(CPT 27447, 27130, 27132)** for UnitedHealthcare Community Plan members in Arizona, Ohio and Tennessee. This requirement expands on December 1, 2025 to include **Florida, Georgia and North Carolina,** and then further expands again on **January 1, 2026** for Indiana, Kentucky and Virginia. Providers must ensure that the required clinical information (including imaging, conservative treatment history, and medical necessity evidence) is submitted as part of the authorization package to avoid delays or denials.

https://www.uhcprovider.com

FIDELIS CARE

Important Reminders About HIV Prevention and Testing

Fidelis Care highlights the ongoing need for providers to actively incorporate HIV screening and prevention services, including offering PrEP (pre-exposure prophylaxis) to eligible patients, within primary and specialty care workflows. By integrating HIV prevention

into routine practice—particularly for high-risk populations—the bulletin notes this can improve patient outcomes, reduce transmission rates, and support broader public health goals.

www.fideliscare.org

Anthem

Prior-authorization & step-therapy updates for medical-benefit drugs

Effective immediately, Anthem's New York plans have updated prior authorization and step therapy requirements for medications billed under the medical benefit (rather than pharmacy benefit). Providers should review the updated medical-policy criteria to ensure that units, diagnosis codes, and trial-failure documentation meet the new thresholds before initiating treatment. Failure to comply may result in claim delays or service denials.

https://providernews.anthem.com

Anthem

Claims Filing Policy Reminders — Correct Coding Required Before Submission

Anthem reminds providers to ensure claims are submitted with complete and accurate coding the first time — including correct modifiers, diagnosis linkage and medical-necessity documentation. The plan notes that incomplete or inaccurate claims continue to be a leading cause of payment delays. Anthem specifically encourages practices to review coding edits, policy updates and NCCI bundling restrictions prior to claim submission to reduce denials and rework.

https://providernews.anthem.com

Anthem

Availity Portal Enhancements for Authorization & Documentation Uploads

Anthem has updated the Availity portal to improve workflow for prior-authorization requests and supporting-document uploads. Providers are encouraged to submit clinical documentation electronically through Availity at the time of request — instead of faxing — to help reduce turnaround times and avoid missing documentation errors. Anthem notes that electronic submissions allow faster review, status tracking and fewer pended cases.

https://providernews.anthem.com

aetna

Upcoming Medical-Plan Drug-List Changes

Effective **January 1, 2026,** Aetna will update its medical-plan drug lists (for commercial & Medicare plans). The changes will be announced beginning November 1, 2025 so affected patients can be notified. Providers are encouraged to review current patient medications and consider prescribing preferred alternatives if appropriate. Patented medications moving to non-preferred status can generally remain under the current prior authorization until expiration without patient disruption.

www.aetna.com

aetna

Revised Precertification Requirements & Telehealth Update

Aetna has announced several key utilization management and billing updates. Effective **November 1, 2025**, additional specialty medications — including **Leqembi®** for Medicare — are being added to the National **Precertification List (NPL),** meaning prior authorization will now be required before coverage. In addition, beginning February 1, 2026, behavioral-health services billed under revenue codes **86x and 89x** will require valid CPT/HCPCS codes to align documentation and billing standards. Finally, while Original Medicare reinstated originating-site and geographic restrictions for telehealth as of **October 1, 2025,** Aetna confirms that its Medicare **Advantage plans will continue offering broader telehealth coverage** beyond the Original Medicare limits.

www.aetna.com

Ohio Department of Medicaid

Next Generation MyCare Program Launch — Key Provider Resources

Starting **January 1, 2026,** Ohio will implement the Next Generation MyCare program. Providers should review and share the newly released resources including: an Overview One-Pager, a Provider Help Desk One-Pager (with contact info), a FAQ document, and a Member ID Card One-Pager. These materials are designed to help providers understand the program, identify eligible members, and prepare for the rollout.

www.medicaid.ohio.gov

MOLINA HEALTHCARE

Medicaid Provider Rate Adjustment — Idaho

The Idaho Department of Health & Welfare has announced a **4% reduction** in Medicaid fee-for-service provider payment rates for dates of service from **September 1, 2025 onward.** Providers will be auto-reprocessed; no action required. Claims impacted include non-exempt FFS claims. Note that certain provider types are exempt (including pharmacy ingredient cost, school-based services, tribal providers, state-owned facilities, and specified HCBS services). Authorized services under waivers will be updated to reflect the new rates. Providers participating in managed care should consult individual MCO fee schedules for corresponding adjustments. (Source: Molina Provider Bulletin MA25-19)

www.molinahealthcare.com

MOLINA HEALTHCARE

Benefits of Submitting Claims Electronically

Molina reminds providers that switching from paper to electronic claim submission (EDI via a clearinghouse or the Availity portal) brings several advantages: better HIPAA compliance, lower operational cost (less printing/postage), improved data accuracy, faster information delivery, fewer claim rejections due to mail or format delays.

www.molinahealthcare.com

MOLINA HEALTHCARE

Update Provider Directory Data Accuracy & Validation

Providers must validate and maintain accurate practice information (address, NPI/TIN, specialties, contact details, whether accepting new patients) at least every 90 days. Inaccurate directory data can impact member access, referrals and timely claims processing. Failure to update may risk removal from the directory.

www.molinahealthcare.com

Humana

Contract Negotiations with Centra Health (Virginia)

Humana is actively engaged in negotiations with Centra Health in Virginia to renew their provider agreement, with the current contract set to expire on **January 1, 2026** unless renewed. They emphasize that they are working in good faith to maintain network access and continuity of care for Medicare Advantage members. Providers should monitor this situation, as changes could impact network status and referrals.

www.humana.com

Humana

New Value-Based Care Partnerships for Musculoskeletal Conditions

Humana announced new strategic partnerships with Vori Health and HOPCo, expanding its musculoskeletal-care program for Medicare Advantage members. Beginning November 2025 (Dallas) and January 2026 (Denver), members will have access to care-navigation teams integrated with their primary-care clinicians—aimed at improved outcomes for musculoskeletal conditions such as arthritis, osteoporosis and joint disorders. Providers in those regions should be aware of the expanded care-navigation model and coordinate accordingly.

www.humana.com

Humana

Humana Q3 2025 Results & Full-Year 2025 Guidance Affirmed

Humana reported adjusted diluted earnings per share (EPS) of **$3.24** for the third quarter of 2025, beating Wall Street estimates. The company reaffirmed its full-year 2025 adjusted EPS guidance at approximately **$17.00 per share** — even while revising its GAAP EPS outlook downward. Additionally, Humana now expects a member decline in its individual Medicare Advantage segment of about **425,000** for 2025, an improvement from earlier projections of up to 500,000. The insurer's medical-expense ratio for the quarter came in at 91.1 %, aligning with expectations. These results underline Humana's stabilising membership trends and its ongoing focus on cost-management and high-value benefits.

www.humana.com

Medicare

2026 Marketplace Preview — Premiums & Subsidies

CMS reports that for plan year 2026, the average monthly premium for the lowest-cost individual Marketplace plan (after tax credits) is projected at around **$50 per month** for eligible enrollees. CMS also highlights major shifts ahead in enrollee cost burdens, due to rising underlying plan prices and the scheduled expiration of enhanced premium tax credits. These changes mean that both provider-clients and patients should begin preparing for higher uninsured/underinsured risk and greater financial liability.

www.cms.gov

Medicare

Major Medicare Payment Rule Updates — Focus on Accuracy & Waste Reduction

CMS has finalized the Calendar Year 2026 Physician Fee Schedule (PFS) rule, which includes a -2.5% efficiency adjustment for select technical services, improved data sources for relative value calculations, and a major shift in how "skin substitute" wound-care products are reimbursed (moving them under the PFS as "incident-to" supplies). These changes aim to modernize payment accuracy, reduce high-value waste (Medicare spending on skin substitutes grew from $256 million in 2019 to over $10 billion in 2024), and advance chronic-disease management and preventive care. The skin substitute policy alone is projected to reduce Medicare fee-for-service spending by about $19.6 billion in 2026.

www.cms.gov

Medicare

CMS Claims Hold Update — Status Change for October 2025 Dates of Service

CMS initially instructed Medicare Administrative Contractors (MACs) to **temporarily hold claims** for dates of service **October 1, 2025 and forward,** due to the expiration of certain legislative payment provisions affecting the Medicare Physician Fee Schedule, ground ambulance services, and FQHC services. CMS has now updated this direction: MACs have been authorized to **lift the hold and begin processing most claims** with DOS October 1, 2025+, including Medicare PFS services, ground ambulance claims, and FQHC claims. However, claims for telehealth services **that cannot be clearly identified as behavioral-health/mental-health**, and **Hospital-at-Home services,** will remain on hold pending further CMS guidance. Practices should monitor claim status and pay careful attention to telehealth coding specificity, as behavioral-health telehealth is being released, but other telehealth categories may continue to pend.

www.cms.gov

Medicare

NCCI Edit Revision for COVID-19 Vaccine Administration

A specific Procedure-to-Procedure edit involving CPT 90480 in combination with G0008/G0009/G0010 was revised by CMS on October 14, 2025. MACs will **automatically reprocess** claims with dates of service July 1, 2025 to October 15, 2025 that were denied due to this edit — no action required by providers. Alternatively, providers may appeal or wait to submit claims after the change is fully implemented.

www.cms.gov

Medicare

CMS 2026: Early Star Rating Pressure Indicators

CMS has signaled early performance pressure for the 2026 Star Ratings cycle, with emphasis on medication adherence, timely preventive screenings and documentation accuracy for chronic-condition management. Providers should proactively optimize HEDIS reporting, patient outreach, and coding completeness now — because year-over-year scoring shifts are tightening and quality measures will have a direct impact on MA plan reimbursement and bonus revenue.

www.cms.gov

United Healthcare

UHC Expands 2026 Electronic Prior Authorization Pilot

UnitedHealthcare is expanding its electronic prior authorization (ePA) pilot for 2026 to additional specialties and provider types, with the goal of reducing administrative delays and creating more consistency in automated approvals. Providers participating in eligible markets can expect faster determinations when submitting PA requests through approved electronic platforms — and UHC notes this will help minimize avoidable denials tied to incomplete documentation.

https://www.uhcprovider.com

Medicaid BH Network Adequacy Enforcement Updates

States continue to tighten behavioral-health network adequacy enforcement across Medicaid managed care. Plans will face increased oversight related to time-and-distance standards, appointment availability, and access to BH specialists. For providers, this may result in new outreach from MCOs to increase network participation, faster credentialing requests, and expanded behavioral-health referral volume — especially for underserved counties.

www.dhcs.ca.gov

OIG Audit – Indiana HCBS Non-Compliance Findings

The U.S. Office of Inspector General (OIG) released an audit showing **246 separate non-compliance issues** across 30 residential settings serving Medicaid Home and Community Based Services (HCBS) waiver members in Indiana. Deficiencies included missing or incomplete care documentation, failure to meet health and safety requirements, lack of required residential monitoring, staff training gaps, and incomplete administrative records. Out of 20 residential providers reviewed, **15 providers** had at least one administrative deficiency, and **29 of the 30 residential settings** had at least one health or safety-related non-compliance finding. OIG recommended focused corrective action, stronger state oversight, and improved internal provider controls. This audit reinforces that Medicaid HCBS programs remain a top priority for federal audit scrutiny — and providers should proactively verify documentation, compliance protocols, and record-keeping to avoid recoupment or enforcement risk.

www.oig.hhs.gov

OIG Enforcement – Seven Medicaid-Fraud Arrests in Arkansas

On **October 20, 2025,** the Arkansas Medicaid Fraud Control Unit (MFCU) under the state Attorney General announced the arrest of **seven individuals** for alleged Medicaid fraud. Among the cases: on October 3, 39-year-old Kimberly Rios of West Memphis was charged with a Class B felony for billing Medicaid for in-home services she did not provide. On October 9, Latonya Jackson of Fort Smith pleaded guilty to a Class A misdemeanor, admitting to billing for care provided while the patient was hospitalized and she was not working at the hospital. On October 10, Tanzania Terrell of Gould was charged with similar misuse of billing while working elsewhere. Additional arrests included Brandi Davis (charged with both Class A and B felonies for creating false employee profiles and splitting illicit proceeds), and Crystal Garcia (charged with Class A felony for arranging kickbacks in exchange for fraudulent home-care billing). The cases highlight the ongoing increased enforcement of Medicaid fraud, particularly around home-care and in-home services — and send a clear message to providers: billing accuracy, documentation, time-tracking, and service verification must be rigorous. Providers and their billing partners (such as your firm) should review internal compliance protocols, ensure time-clock and verification systems are secure, and verify that billed services were delivered as documented.

www.oig.hhs.gov

PROVIDER BULLETIN

Telehealth Sunset Billing Pitfalls — Effective December 1, 2025

Beginning **December 1, 2025,** temporary COVID-era telehealth coverage flexibilities will expire. After this date, many of the telehealth codes that were allowed during the PHE period — especially certain audio-only E/M codes, psychotherapy telehealth services without an in-person re-establishment, and virtual check-in type codes — will no longer be payable unless they meet **permanent Medicare telehealth coverage rules.** Providers should expect payers to resume stricter criteria tied to modality, originating-site, and face-to-face comparability.

This means that visits billed as telehealth must now clearly meet the permanent code-level requirements. Claims that use a code which used to be allowed temporarily, but is not allowed under the permanent rules, will deny. Importantly, denied telehealth services **cannot be balance-billed to the patient,** so the revenue loss will fall 100% on the provider/organization. Clinicians should not assume that "virtual" = automatically payable after December 1.

Clinics that frequently deliver virtual care — primary care, behavioral health, chronic condition check-ins — are at highest risk. Organizations should immediately review their telehealth code lists, remove codes tied to temporary flexibilities, and verify which CPT/HCPCS codes have permanent status. It is essential that documentation clearly supports the modality used (audio-video vs audio-only) and reflects all required elements of medical necessity.

Providers are also advised to confirm that place-of-service (POS) mapping, GT / 95 modifiers, and telehealth billing rules within their EHR/EMR match the permanent rules — not the temporary PHE rules. Some systems still auto-apply PHE modifiers, and this can trigger denials. Testing sample telehealth claims before December 1 can help confirm that payer edits are behaving as expected.

Most importantly — clinicians must be aware that certain visit types may need to convert back to in-person for payment. A brief provider meeting, updated telehealth code reference sheet, and reminder communication before December 1 can prevent losses. Ensuring that care teams understand which visit types must be onsite post-sunset will protect reimbursement and help maintain uninterrupted patient care access.

At **CuraWise Billing Solutions**, we actively support providers during regulatory transitions like this. Our team monitors payer bulletins, CMS updates, audit trends, and reimbursement rule changes — and we convert them into actionable billing alignment steps for the clinics we serve. As part of our telehealth-sunset readiness support, we can assist with reviewing telehealth code lists, updating templates, validating CPT/HCPCS alignment, and identifying which services must convert back to in-person to remain payable. This ensures providers remain compliant, protected from preventable denials, and positioned to maintain stable cash flow as the **December 1, 2025** changes take effect.

E/M Documentation Scrutiny Tightens in January, 2026

Beginning **January 2026,** payers and audit contractors will increase scrutiny on Evaluation & Management (E/M) documentation — especially for Level 4 (99204 / 99214) and Level 5 (99205 / 99215) encounters. Payers are signaling tighter review of medical-decision making (MDM) elements, time-based billing justification, and supporting documentation for complexity scoring. Providers should not assume that historic documentation patterns will continue to pass payer validation at higher E/M levels.

One of the main areas of investigation will be whether the provider's documentation clearly demonstrates that the **complexity of problems addressed, data reviewed,** and/or **risk of managemen**t truly meet the level billed. Generic templates or insufficiently specific MDM statements will no longer be considered adequate. E/M claims that do not have clear, specific, measurable support will be at increased risk for down-coding or retrospective audit recoupment.

Additionally, time-based reporting — which is widely used post-2021 — must have direct time attribution. The expectation is shifting from "total time spent" to clear breakdown of time components (clinical review vs ordering vs results analysis vs counseling etc.) that reflect what Medicare considers billable time. If time is used, it must be defensible.

Providers are encouraged to re-review their E/M templates and ensure that problem severity, differential evaluation, risk statements, and data review are explicitly documented within the note — not implied. A higher billed code without visible evidence of higher clinical complexity will not survive audit review in 2026. Clinicians should avoid over-generalized phrases like "multiple chronic conditions reviewed" without specifying which conditions and which changes were assessed.

This tightening will be especially impactful for primary care, internal medicine, cardiology, endocrinology, rheumatology, oncology, psychiatry, and other specialties that frequently manage multiple chronic conditions in a single encounter. These are the categories that payers are flagging as "high-exposure" for 2026 audit targeting.

CuraWise Billing Solutions actively tracks payer audit focus patterns and identifies risk areas before they turn into denials or recoupments. We can help providers refine documentation structure for higher-level E/M visits, review note templates, validate MDM alignment with billed levels, and flag documentation gaps that could trigger down-codes or post-payment audits. Our focus is to protect provider revenue integrity while maintaining compliance — especially during periods of increased payer scrutiny like this upcoming January transition.

RPM Under Federal Audit Focus — Prepare Compliance Logs Now

Remote Patient Monitoring (RPM) services are now appearing more frequently in federal audit targeting because of rapid utilization growth and widespread inconsistency in documentation patterns. CMS and oversight teams have stated that RPM claims lacking verifiable clinical use will face higher denial and recoupment risk — especially for CPT 99457 / 99458 time-based codes where medical necessity must be clearly demonstrated in the record.

For RPM to be payable, clinicians must show that remote physiologic data was actually **reviewed, interpreted, and acted upon** — not just transmitted. RPM supply codes such as **99454** (device supply / data transmission) cannot be billed if the patient is not actively engaged. Auditors are also flagging enrollment with no ongoing clinical rationale. RPM documentation must connect the remote readings to treatment adjustments, counseling, risk assessment, or care plan decisions.

Time-based RPM codes such as **99457 (first 20 minutes)** and **99458 (each additional 20 minutes)** require validated time documentation. Federal audit standards state that passive data receipt is not billable time — only clinical review + patient interaction. Providers must ensure that time logs reflect minute-based timestamps and that those minutes directly support the CPT code billed.

Additionally, **99453** (initial device setup + patient education) remains a one-time event per episode and cannot be repeatedly billed if the patient is restarted or re-activated without a justified new episode of care. Auditors are reviewing **9909**1 as well — this code still exists, but it requires 30 minutes of physician/NP time specifically reviewing physiologic data.

Because RPM adoption became mainstream quickly, many practices are unaware that these codes now carry audit sensitivity similar to the early days of Chronic Care Management. Federal enforcement is increasing — and RPM claims without defensible logs are now considered high-exposure.

Our specialized billing compliance team can assist by reviewing RPM workflows, validating correct use of CPT codes (99453, 99454, 99457, 99458, 99091), and ensuring documentation clearly supports medical necessity, minutes billed, and true clinical interaction — not just passive data transmission. This support helps prevent avoidable denials before they occur, strengthens audit defense posture, and protects RPM revenue stability. Proactive coding reviews, documentation refinement, and periodic internal chart audits are strongly recommended — especially during this period of heightened OIG and CMS oversight.

Many practices are also unaware that RPM eligibility must be periodically re-validated. If a patient becomes non-engaged, stable, or no longer meets clinical necessity for continuous remote physiologic monitoring, payers expect RPM to be paused — not auto-continued. This is one of the exact patterns auditors are targeting. A structured periodic eligibility check prevents overbilling and reduces retroactive recoupment risk.

Our team can also help implement standardized RPM compliance templates — including data review note language, time-tracking structure, audit-ready log formatting, and documentation checklists for clinical teams. This allows clinicians to remain focused on patient care while ensuring every billed unit of RPM service — especially 99457 and 99458 — has traceable, defensible justification.

FEATURE FOCUS

The Silent Q4 Claims Leak: Why November Generates the Highest Denial Exposure of the Year

Most healthcare organizations assume January is the beginning of denial risk — but the truth is the opposite. November is the hidden peak.

This is the month where payer behavior quietly pivots, and unless a practice is actively watching adjudication movement in real time, the losses go undetected until the next calendar year. In fact, national trend analyses show that November denial acceleration is one of the most consistent unspoken patterns in revenue cycle performance — yet almost no one prepares for it.

Why does November matter so much? Because while the industry is focused on finishing the year, payers are already preparing for the next one. This is the month when insurers begin injecting next-year edit logic into their systems — well before public messaging, policy bulletins, or CPT update notices are released. What worked in September may suddenly fail mid-November, even with identical codes, identical documentation, and identical patient profiles.

Internally, November also disrupts clinical rhythm. Clinic schedules tighten. Providers push more follow-ups before December holiday closures. Chronic disease management visits spike. Annual preventive metrics accelerate. With higher visit volume and compressed time, documentation naturally shrinks — the narrative becomes shorter, more templated, more "checkbox lean." This is exactly the type of documentation that payer algorithms punish — especially in Q4.

Another silent force: benefit structure. By November, many commercial patients have met their deductibles — meaning the payer now holds more financial liability per claim. When the payer is paying more — the payer defends more. Denial engines become stricter not because coding competency changed — but because risk exposure shifted back toward the payer.

Then add clearinghouse behavior. Clearinghouses begin implementing January-effective edit packages in November. They need 30–45 days of live claims to test rule stability before the new year. So the harsh truth is: **many January rules are already active by Thanksgiving** — even though they are not technically "effective" yet.

This is why November denials are so deceptive.
They don't look like mistakes.
They look like normal claims — until they don't process.

If a practice waits until January to analyze, confirm, or request remediation — the money is already lost. The most destructive revenue leaks are the ones that are silent, slow, and unnoticed — because no one is looking during the period where the shift begins. November is that period.

This is why Q4 needs defensive posture — not autopilot. The organizations who protect margin in November are the ones who actively track payer behavior in-month, identify denial pattern shifts as they form, and adjust documentation and modifier logic before denials lock in.

Curawise can monitor live denial signals during this period, detect pre-January behavior change within payer systems, and help you adjust coding + documentation alignment in real time — not weeks after the loss is already baked in. Preventing November leakage is not about coding knowledge — it's about timing intelligence.

BUSINESS BEAT

When November Becomes a Cash Trap: Why Q4 Claims Don't Come Back Once They Slip Into December

Every revenue cycle leader knows denial rates spike in Q4 — but most misdiagnose the reason. November is where the breakdown actually begins. It's not a coding seasonality problem — it is a calendar problem that compounds into financial damage. Claims that are not cleared by the third week of November begin sliding into processing windows that collide with year-end payer capacity compression. Once a claim moves into December, it is statistically far less likely to surface again at full reimbursement value, even if everything was coded correctly.

December is not a normal adjudication month. It is a month where payers shift internal priorities away from throughput and toward balance sheet positioning. Year-end actuarial reporting, loss ratio optimization, and internal cash containment behaviors override operational fairness. Payers have no incentive to accelerate disbursements in late Q4 — but they have strong incentive to delay them. Once an encounter lands in that timing zone, the claim is not "delayed" — it is functionally demoted.

This is why November denials do not behave like April denials. Appeals filed in January are technically "processed," but yield recovery is weakened because payer workplan priority in Q1 centers on new benefit year resets, not reconciliation of legacy claims. Payer systems prioritize new eligibility, new deductible logic, new cohorts, and new utilization management rules. Q1 is not retroactive — it is forward-facing. That means unresolved November friction doesn't get fixed — it gets overwritten by new-year processing logic.

Most clinics assume they can "circle back" in January and fix whatever got messy at year-end. But January is when the payer algorithm resets, and new benefit structures erase the ability to attach the same logic to the same patient cohort. So when a November claim fails in December, the clinic has essentially already lost the fair recovery window. The denial can be appealed, yes — but the probability of full-value restoration is materially lower because the payer no longer has year-consistent reference frames for that encounter.

Operationally — this means that denial prevention in November is not denial management. It is denial avoidance. The real strategic action isn't "better appeals later" — it is "prevent the claim from falling into December at all." The goal is not to respond to denials — the goal is to prevent claims from reaching the month when claims become decoupled from normal adjudication flow.
The most financially disciplined practices treat the first two weeks of November like the last four

days of a quarter — a clearing zone — not a business-as-usual zone. They review open claims daily, not weekly. They accelerate encounter finalization cycles. They freeze non-critical operational distractions. November work must be prosecuted aggressively before Thanksgiving — because once the calendar flips into late-month, the payers are already operationally shifting into financial closure posture.

And this is the unspoken truth: November is not the month to do "year-end projects." November is the month to protect liquidity. Practices that treat November as a clean-up window often enter January under water — not because they made strategic mistakes — but because they underestimated the financial power of calendar math.

3 Contract Clauses to Re-Negotiate BEFORE January

Revenue compression from payer contracts rarely comes from headline fee schedule percentages — it comes from technical language buried in the operational clauses. The mistake most clinics make is believing that negotiation is purely about rate adjustments. In reality, the true revenue protection power lies in redefining constraints — the small condition lines that determine how the rules are applied during the year. November is the last viable window to adjust these before auto-renewal triggers. Once January hits — the door closes.

Downstream repricing tolerances are one of the biggest silent killers. A difference between a 5% tolerance and an 8% tolerance does not read as dramatic in contract language — but in practical real-world adjudication, it allows payers and delegated pricing vendors to pull thousands of dollars down across high-volume code sets. Many providers bleed margin through tolerated discount windows they never scrutinized because the percentage looked "small." Small tolerances, at scale, cause silent multi-quarter yield erosion.

Clinical review turnaround windows are another structural risk. The wording often sounds harmless — but a response window over 48 hours introduces automatic non-compliance vulnerability. Most practices cannot operationally respond to documentation requests within narrow windows when volume is high — especially in Q1 and Q4. This means payers gain "technical denial toolkits" simply because the clinic never reviewed timing language. One line in a contract can convert an entire E/M category into an auto-deniable class — not because documentation is bad — but because the clock is impossible.

Retro-recoupment limits are the third high-risk zone. A 90-day lookback is manageable. A 12-month lookback is catastrophic. A one-year recoup window converts a single audit into a full-year clawback threat. Practices who agree to long lookbacks essentially authorize payers to reopen their entire prior operational year — with zero symmetry — because providers cannot reopen old cost structure to recapture the loss.

The reason this must be renegotiated before January is because once the calendar turns — legal frameworks are commanded not to amend active clauses mid-year. Even small language modifications must go through legal and finance reviews — which pushes decisions into mid-year cycles when clinical leverage is weakest. This means January signatures become a year-long trap — even if rates look fair.

Smart organizations understand that contract power is not in the rate — it is in the clause. The most sophisticated groups renegotiate clause architecture in Q4, not rates. They shape the

container that controls revenue all year. If the clauses lock in unchallenged, the entire next twelve months of financial outcomes are pre-decided before the first encounter of the year is even billed.

Revenue Margin Compression Forecast — MA & Medicaid 2026

Most clinics are preparing for 2026 by asking what "the new fee schedule cuts" will look like. But the most damaging revenue suppression next year will not show up in bold in official reimbursement tables. It will show up inside adjudication behavior — through micro-compression of high-volume CPT categories. MA and Medicaid do not need large across-the-board fee cuts to reduce provider profitability — they simply need to trim 1–3% on the CPT codes that produce the most billable encounters. High-volume × small shave = big annual impact. That is the real financial architecture of 2026.

Simultaneously, payers will tighten the documentation specificity scoring that determines whether an E/M is reimbursed at the level submitted. They will not deny most encounters entirely — they will down-level them. Providers will receive remits that show "paid," but paid lower. That means denial rates may appear stable, but paid dollars per encounter will decline. The damage becomes invisible if practices only track denial counts and not reimbursement yield per CPT grouping.

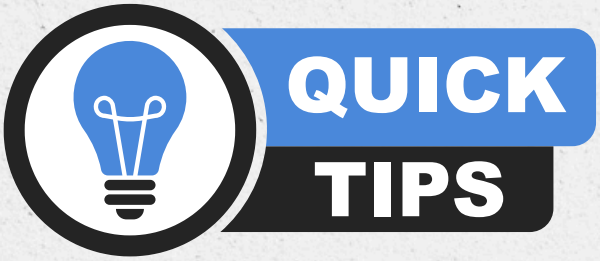
This is how loss becomes normalized quietly. Practices will assume things are "fine" because claims aren't being rejected. But yield suppression is more financially destructive than denials — because it bypasses appeals, bypasses escalation, bypasses coding departments — and directly exits cash.

This compression pattern is already telegraphed through payer predictive modeling and actuarial positioning. MA plans need to offset rising medical cost inflation without creating headline-level policy backlash. Medicaid programs need to control state budget leakage under political visibility. Micro-compression is the perfect strategy — silent, non-headline, uncontroversial on paper, but devastating in aggregate.

The practices that will survive this are not the ones with better billers — they are the ones with better documentation infrastructure. Documentation is not a compliance act in 2026 — it is the defensive weapon against compression. Level justification must be proactively embedded — not reactionarily defended.

Groups that rely only on coder intervention will fall behind. Coders cannot fix what the provider never justified. The root correction point moves upstream — the note. Providers must treat note quality as a revenue lever — as strategically valuable as contract negotiation.

The biggest blind spot for 2026 is that most groups think fee schedules predict revenue. They don't. The adjudication engine predicts revenue. And in 2026, the adjudication engine is programmed for silent suppression — not visible denial. Only organizations who understand where yield is silently extracted will avoid being financially blindsided.



- Don’t File Prior Auth on Fridays — roll-over lag creates weekend queue inflation and pushes approvals deeper into next-week cycles.
- Confirm Modifier Usage Weekly — small modifier drift (esp. 25, 59, 95, XE) becomes huge denial drivers if checked monthly instead of weekly.
- Pull “Pending Documentation” Claims Every 7 Days — if these sit longer than one week, they convert from “pending” to “stale” and payers reclassify them into low-priority queues.

EVENT SCHEDULE NOV 2025

07-08
NOV, 2025

TELEHEALTH SUNSET COMPLIANCE VIRTUAL SUMMIT

National virtual briefing preparing providers for the December 1, 2025 telehealth rule rollback. POS mapping clarity + modifier transitions.

12
NOV, 2025

CMS MLN CONNECTS — MA 2026 PAYMENT PREVIEW (VIRTUAL)

CMS analysts outline 2026 MA payment scoring changes + micro-compression forecast.

20
NOV, 2025

OIG RPM AUDIT TARGET WEBINAR

OIG session on RPM audit triggers + time-defensibility documentation standards.

26
NOV, 2025

DENIAL AVOIDANCE BEFORE DECEMBER FREEZE – VIRTUAL CLINIC

RCM strategists present November denial salvage cut-off logic & December freeze risk.

#world diabetes day

NATIONAL DIABETES AWARENESS MONTH

This month recognizes the 537 million people worldwide living with diabetes and emphasizes early detection, consistent monitoring, and proactive chronic care management. For providers, this is also a timely reminder to reinforce patient education, strengthen care-plan documentation, and leverage care-coordination pathways — especially for populations with recurrent metabolic risk.

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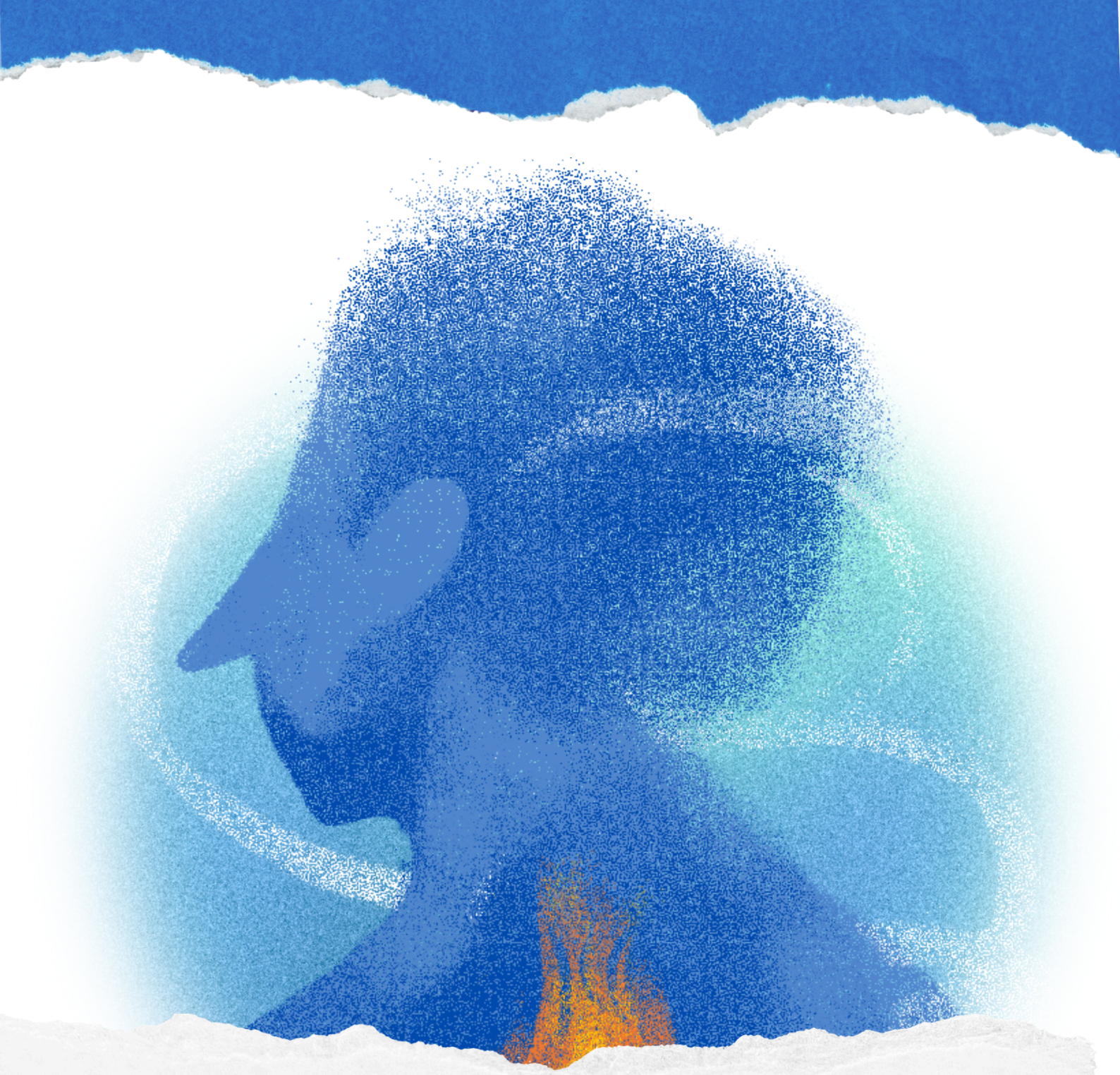

Healing begins with noticing — in our patients, and in ourselves.