CURAWISE
BILLING SOLUTIONS

CuraWise Newsletter

October 2025
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Welcome

At CuraWise, every newsletter is an opportunity to strengthen the bridge between providers and the insights that matter most. Since our launch, your engagement has been our greatest motivator—reminding us of our mission to simplify medical billing with transparency, clarity, and measurable results.

In September, we explored evolving payer policies, smarter denial management, and Q3 preparation strategies. The response underscored how essential these conversations are for provider success.

Now, as we step into October, our focus turns to year-end readiness, payer audits, and proactive revenue protection—all critical steps to help practices finish 2025 strong and enter 2026 with confidence.

Each edition reaffirms our commitment: not simply to process claims, but to empower providers with solutions that reduce risk, improve efficiency, and give back what matters most—time for patient care.

Together, we move forward—one solution, one success at a time.

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UnitedHealthcare to Continue Expanded Telehealth Benefits Through 2026

On **October 6, 2025**, UnitedHealthcare confirmed that its Medicare Advantage members will continue to have access to expanded in-home telehealth services for both medical and mental health care through 2026, even as certain Original Medicare telehealth flexibilities expired on September 30, 2025. Covered services include both audio-only and audio-video visits when delivered by in-network physicians, nurse practitioners, physician assistants, or mental health providers listed on the CMS Medicare Telehealth List. Notably, mental health services do not require in-person visits first. Plan rules differ slightly across Individual PPO, Group PPO, and PFFS plans, but all ensure that members retain convenient, flexible options to connect with providers remotely.

https://www.uhcprovider.com

DC Medicaid — DME Prior Authorization Update

Effective **October 1, 2025**, UnitedHealthcare Community Plan of the District of Columbia will align durable medical equipment (DME) prior authorization requirements with those of its Dual Complete® Special Needs Plan (DSNP) offerings. The update applies to several DME categories including hospital beds, patient lifts, power wheelchairs, and respiratory support devices. Providers must use the UnitedHealthcare Provider Portal to submit and manage prior authorizations.

https://www.uhcprovider.com

Texas Medicaid: New Clinical & Billing Rules

UnitedHealthcare has announced key updates affecting Texas Medicaid programs. Beginning **October 15, 2025,** revised clinical prior authorization criteria will apply to select medications under **CHIP, STAR, STAR Kids, and STAR+PLUS,** aligning with updated state mandates. Additionally, effective **September 1, 2025,** long-term care providers in the STAR+PLUS program must transition from the RUG-III billing methodology to the Patient-Driven Payment Model (PDPM) as members' Individual Service Plans (ISP) are renewed. Claims must now be submitted using updated HCPCS codes **(such as T2031 for assisted living and S5151 for respite care)** along with the correct state modifiers. Claims with outdated codes will be denied, making it critical for providers to review the new billing matrix, train staff, and manage prior authorizations through the Provider Portal or fax submission.

https://www.uhcprovider.com

Fidelis Care Expands Child Health Plus Eligibility

On **September 15, 2025,** Fidelis Care announced updated income eligibility guidelines for New York's Child Health Plus program, making coverage more accessible for children ages 0–18 across the state. Families with incomes under 2.2 times the federal poverty level now qualify for **no monthly premium**, while others will pay affordable premiums ranging from $15 to $60 depending on income and family size. The program covers essential services—including prescriptions, hospital care, dental, vision, and preventive care—without deductibles or copays, ensuring more children receive the comprehensive care they need.

www.fideliscare.org

Championing Mental Health: Early Intervention is Key

Patients often feel more comfortable sharing emotional challenges with their providers than with anyone else—but many won't do so without encouragement. A few thoughtful questions can open the door to vital conversations. According to the National Alliance on Mental Illness (NAMI), the average delay between the onset of a mental health condition and treatment is 11 years. By lowering barriers and offering timely support, providers can help individuals receive the care they need sooner. The New York State Office of Mental Health offers a range of resources for patients, families, and behavioral health providers, with additional support available through NAMI.

www.fideliscare.org

Horizon NJ Health Updates Reimbursement for Modifier 90 (Pass-Through Billing)

Horizon NJ Health recently announced changes to its reimbursement policy relating to **Modifier 90 (Pass-Through Billing)**. Providers should pay close attention to the updated rules governing when and how modifier 90 can be used to pass through costs (e.g. for certain drugs or medical supplies). Incorrect use or submission of the modifier may lead to claim denials or payment delays. It's essential for providers and billing teams to review and update their billing practices accordingly.

https://www.horizonnjhealth.com/

Horizon NJ Health Updates Rules for Non-Participating Providers

Horizon NJ Health recently reinforced the obligations of **non-participating providers** (those not in-network). These providers must adhere to specific requirements—such as timely submission of claims, proper documentation, and compliance with billing standards—to be eligible for reimbursement. Failure to follow these rules may result in claim denials or reduced payments. Providers outside the network should review the updated guidelines carefully and ensure their billing and administrative workflows align with Horizon's non-participation policies.

https://www.horizonnjhealth.com/

Medicare Preferred Continuous Glucose Monitors

Anthem New York will transition to a **preferred list of continuous glucose monitors (CGMs)** for Medicare Advantage members. Providers should verify whether a patient's CGM is on the preferred list to ensure coverage and avoid reimbursement issues. It's also important to stay updated on any new criteria or documentation requirements associated with this change.

https://providernews.anthem.com

Outpatient Facility Claim Editing Update

Anthem New York will transition to a preferred list of continuous glucose monitors (CGMs) for Medicare Advantage members. Providers should verify whether a patient's CGM is on the preferred list to ensure coverage and avoid reimbursement issues. It's also important to stay updated on any new criteria or documentation requirements associated with this change.

https://providernews.anthem.com

New Pre-approval Requirements for Post-Acute & Home Health Services

Beginning **January 1, 2026**, Aetna will expand its **Enhanced Clinical Review** program for Medicare Advantage members in New Jersey, New York, Pennsylvania, and West Virginia (excluding NJ FIDE plans). Providers will be required to obtain **pre-approval for inpatient rehabilitation (revenue code 128), skilled nursing services (levels 1–4),** and a wide range of **home health services** billed under HCPCS codes **G0151–G0153, G0155–G0162, G0299–G0300, and G0493–G0496**. To avoid care delays or claim denials, authorization requests must be submitted **before services begin**, with urgent requests (needed within 48 hours) clearly flagged for expedited review.

www.aetna.com

Coding Changes for Compression Stockings

Effective **January 1, 2026,** new HCPCS codes will apply to **non-covered compression supplies** under Aetna's commercial plans. Compression stockings are considered a **disposable supply** and remain excluded as a standard benefit. The affected codes include **A6530–A6534, A6539, A6545, and A6549.** Providers in **Washington State** will receive their effective date after regulatory review, while for Texas, these changes apply only to fully insured plans if consistent with state requirements; all other plans will follow the outlined January 1, 2026 implementation.

www.aetna.com

CPAP Adherence Required for Reimbursement

Effective **December 1, 2025,** Aetna will require documented proof of adherence to positive airway pressure therapy in order to reimburse for **CPAP devices and related supplies**. Providers must submit one of the designated adherence codes — **G8851, G8854, or G8855 —** with claims. Claims without proper documentation will be denied, making accurate coding and patient adherence monitoring essential.

www.aetna.com

Medicare

CMS Issues Guidance to Strengthen Oversight of Medicaid State-Directed Payments

On **September 9, 2025,** CMS released preliminary guidance under Section **71116 of the One Big Beautiful Bill Act** to enhance oversight of medications by state-directed payments (SDPs) in Medicaid managed care. For rating periods beginning July 4, 2025 and beyond, SDPs for inpatient hospital, outpatient hospital, nursing facility, and qualified practitioner services may not exceed **100% of Medicare r**ates in Medicaid expansion states, or **110% of Medicare** rates in non-expansion states. ome existing SDP arrangements approved before July 4, 2025 may be **grandfathered until January 1, 2028**, after which a phased reduction is required. States must revise or submit compliant SDP plan documents, include quality evaluation measures, and ensure transparency and auditable methodologies for further review.

www.cms.gov

Medicare

CMS Launches Landmark $50 Billion Rural Health Transformation Program

On **September 15, 2025,** CMS unveiled the Rural Health Transformation (RHT) Program, a historic $50 billion federal investment over five years designed to modernize and strengthen rural health care nationwide. Under the Working Families Tax Cuts Act, states are invited to apply by **November 5, 2025,** with awards to be announced by December 31, 2025. The funding will support state-driven plans to expand access, improve quality, recruit and retain health workforce, foster innovation, and build digital health infrastructure. Half of the funds will be distributed equally among approved states; the remainder will be awarded based on state performance metrics and impact potential.

www.cms.gov

Medicare

Medicare Advantage & Part D Expected to Be Stable in 2026

CMS projects that for 2026, the Medicare Advantage and Medicare Prescription Drug (Part D) programs will remain largely stable, with limited disruptions to benefits and plan availability. The 2026 Rate Announcement finalizes payment policies and modestly increases government payments to MA plans (an average increase of 5.06%) to support program sustainability. CMS also exercised its authority over Part D plan bids, rejecting those with excessive premium hikes or reduced benefits, and continues to apply the Part D Premium Stabilization Demonstration (albeit in a scaled form) to help maintain affordability.

www.cms.gov

Medicare

CMS Releases Final Guidance for Initial Price Applicability Year 2028

On **September 30, 2025**, CMS issued final guidance for the third cycle of **Medicare Drug Price Negotiation**, covering drugs payable under Part B. The guidance refines earlier drafts and adds protections for orphan drugs, while improving transparency and aligning negotiation criteria. ey features include:

- **Negotiation Timeline:** The third cycle of drug negotiations begins in 2026, with **maximum fair prices (MFPs)** taking effect January 1, 2028.
- **Inclusion of Medicare Advantage Data:** Total expenditure calculations will include both Fee-for-Service (FFS) Part B claims and Medicare Advantage encounter data, bringing more balance and accuracy to negotiation decisions.
- **Enhanced Orphan Drug Protections:** Drugs designated for rare diseases (orphan drugs) may be excluded from negotiations when their entire approved use is for rare conditions, preserving incentives for innovation.

www.cms.gov

Medicare

Telehealth Policy Cliff — Effective October 1, 2025

With the lapse of emergency telehealth flexibilities on October 1, 2025, longstanding Medicare rules will return—impacting home-based visits, geographic restrictions, and eligible provider types. The policy change may eliminate reimbursement for many in-home telehealth services (outside of behavioral health, substance use disorder, and ESRD dialysis care). Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) will also lose broad telehealth privileges for medical visits post-December 31, affecting claims under the G2025 code. Providers should audit current telehealth operations, prepare patient communications, and develop contingency plans for transitioning affected visits to in-person settings.

www.cms.gov

GAO

GAO Report on Healthcare Consolidation

The U.S. Government Accountability Office (GAO) released a new report in September 2025 highlighting the rapid rise in physician practice consolidation. By 2024, nearly

half of physicians (47%) were employed by or affiliated with hospital systems, up from less than 30% in 2012. The report also found that private equity ownership of practices—while smaller—has grown to about 6.5% of physicians. Evidence shows consolidation is linked to higher spending and prices, particularly as services shift to hospital outpatient billing, but offers little proof of improved quality or access. GAO cautions providers to watch for market impacts such as reduced competition and reimbursement pressures.

www.gao.gov

September 2025 Pharma Highlights

The pace is accelerating across pharma: AI in patient care is facing scrutiny as a study flagged risks in patients using ChatGPT for medical advice, while GLP-1 therapies continue to expand beyond diabetes into broader cardiometabolic indications—real-world data shows about one in four GLP-1 users lack a type 2 diabetes diagnosis. Tariff policy took a sharp turn with a newly announced **100 % duty on imported branded medicines** effective October 1, 2025, unless manufacturers have U.S. production underway. In dealmaking, MSD acquired Verona Pharma ($10 bn), Roche picked up 89bio ($3.5 bn), and Pfizer reentered obesity therapeutics by acquiring Metsera ($4.9 bn). These moves underscore growing consolidation and strategic bets in high-growth therapeutic areas.

www.emjreviews.com

PROVIDER BULLETIN

Q4 2025 ICD-10 Coding Updates

As of **October 1, 2025**, the annual ICD-10 revision cycle went into effect—with meaningful changes across **cardiovascular, respiratory, and oncology domains.** These updates are designed to reflect evolving clinical practices, improve specificity in diagnosis coding, and align documentation with reimbursement expectations.

What's Changing & Why It Matters

- **Cardiovascular:** New refinements cover heart failure subtypes, acute coronary syndrome variants, and post-interventional complications (e.g. stent thrombosis, graft failures). The finer granularity helps distinguish severity and guide care, but missing the specificity may affect claims eligibility or reimbursement adjudication.
- **Respiratory:** Enhanced codes now address chronic respiratory failure, ventilator dependency, and occupational or environmental lung disease exposures. For patients with overlapping pulmonary conditions, the new subcodes make differentiation clearer—essential for correct billing.
- **Oncology:** Revisions include site-specific malignancy codes, more granular staging/behavior modifiers, and categories for therapy-induced complications (e.g. adverse effects of chemotherapy, radiation pneumonitis). This allows more accurate tracking of disease progression, response to treatment, and secondary health events.

Provider & Office Actions

- **Update EHR / Coding Systems:** Ensure your electronic health record system, coding software, and billing modules incorporate the new ICD-10 codes to prevent mismatches or system errors.
- **Staff Training & Awareness:** Host training sessions for clinicians, coders, and billing staff to familiarize them with the new codes in their specialty. Use case scenarios to test understanding of the updated granularity.
- **Review Payer Policies:** Some payers may adopt the new codes for prior authorization, medical necessity, or claim review criteria. Confirm that your contracts or payer guidelines reflect acceptance of the updated codes.
- **Monitor Claims & Denials:** During transition, closely monitor denials or rejections to identify patterns tied to outdated codes. Address issues quickly with corrected resubmissions and updated coding.
- **Communicate with Referring Providers:** If you receive referrals or documentation from outside providers (e.g. consultants, hospitals), be sure they also adopt the new codes to prevent downstream errors or mismatches.

These changes offer deeper specificity and clinical alignment—helping payers and reviewers better understand patient complexity and treatment needs. If your practice adapts early, you reduce the risk of claim denials, maintain smoother workflows, and position your team for better compliance and reimbursement accuracy.

www.cms.gov

OIG Report: Behavioral Health Networks Found to Be Limited and Inaccurate

The Office of Inspector General (OIG) released a comprehensive evaluation in October 2025 examining the adequacy and accuracy of behavioral health provider networks within Medicare Advantage (MA) and Medicaid managed care plans. The findings revealed significant gaps that limit patient access to mental health and substance use disorder care at a time when demand is growing nationwide.

- **Narrow Networks:** Nearly **three-quarters of Medicare Advantage plans** and almost half of Medicaid managed care plans had networks that included **fewer than 25%** of available behavioral health providers in their service areas. This raises major concerns about whether enrollees can realistically find timely care.

- **Inactive or "Ghost" Providers:** On average, **55% of providers listed in MA directories** and **28% in Medicaid directories were inactive**—meaning they did not provide a single covered behavioral health service to plan members in 2023. In some rural plans, inactivity rates reached as high as 63%, further compounding access barriers.

- **Causes of Inactivity:** Many inactive providers were no longer at the listed locations, did not accept the plan's insurance, or were not practicing clinically (e.g., working in administrative roles). Providers cited **low reimbursement rates** and **administrative burdens** as major reasons for not actively participating in these networks.

OIG Recommendations:

The report urges CMS and state partners to:

1. **Leverage encounter data** to track whether listed providers are actively seeing patients.
2. **Correct directory inaccuracies**—including outdated addresses, phone numbers, and participation status.
3. Collaborate with states to strengthen oversight of **Medicaid provider directories.**
4. Explore the development of a **nationwide provider directory** to centralize, standardize, and improve accuracy across all health plans.

Implications for Providers:

Providers should be proactive in ensuring that their directory listings are accurate and current, as incorrect data may lead to compliance issues, loss of patient trust, or increased administrative audits. Participation in network reviews and prompt updates to practice information can also help improve overall access to behavioral health care.

www.oig.hhs.gov

HHS Announces Information Blocking Enforcement Crackdown

On **September 3, 2025,** the U.S. Department of Health and Human Services (HHS) announced a major shift in regulatory posture, signaling that it will now actively enforce the **information blocking rules** established under the **21st Century Cures Act**. The following day, the **HHS Office of Inspector General (OIG)** and the **Office of the National Coordinator for Health IT (ONC/ASTP)** jointly issued an **enforcement alert,** emphasizing that providers, certified health IT developers, and health information networks are all subject to compliance reviews.

Under the Cures Act, information blocking refers to any practice that **unreasonably interferes** with the **access, exchange, or use of electronic health information (EHI).**

- Refusing or delaying patient record sharing without valid exceptions
- Configuring EHRs or portals to limit data exports or external connections
- Failing to provide timely access to other providers or payers

P**enalties & Enforcement Measures**

- The OIG can impose **civil monetary penalties up to $1 million per violation** (subject to inflation adjustments).
- The ONC may **revoke certification** for health IT developers that fail to comply, impacting their ability to market and support certified EHR products.
- Providers may face reputational risk, audit exposure, and possible contract challenges with payers if found non-compliant.

Until now, federal agencies have primarily focused on **education and guidance.** The September 2025 announcement signals a transition to **active enforcement,** with OIG investigations and penalties expected in 2026. This shift underscores the government's intent to ensure that patients and providers have seamless access to their health data.

To avoid violations and prepare for enforcement, providers should:

1. **Review and update policies** on patient record access, data sharing, and release of information.
2. **Ensure EHR systems and APIs** are configured to support the full range of required data exchange.
3. **Document exceptions carefully** (e.g., patient safety, privacy risks, infeasibility) to justify any restrictions on data sharing.
4. **Train staff and clinicians** to understand what constitutes information blocking versus permissible exceptions.
5. **Audit and monitor workflows** regularly to confirm compliance.

HHS has made clear: organizations that do not align with these rules may face significant financial and operational consequences. Now is the time for providers to tighten internal practices, strengthen IT capabilities, and ensure compliance is a top organizational priority.

www.hhs.gov

FEATURE FOCUS

OIG Tightens Scrutiny: Remote Patient Monitoring Audits Coming in 2026

Remote Patient Monitoring (RPM) has become one of Medicare's fastest-growing programs, expanding from about **55,000 beneficiaries in 2019** to over **570,000 by 2022.** While this growth has transformed chronic care management, it has also triggered new federal oversight. The Office of Inspector General (OIG) has added RPM to its 2026 audit Work Plan, signaling that providers should prepare for intensive compliance reviews.

Why RPM Is Under Review

A recent OIG report revealed that 43% of RPM patients did not receive all required components of the service. These include device setup and education, data transmission on at least 16 out of 30 days, and ongoing clinician monitoring. Missing documentation, incomplete logs, and unclear ordering provider records were common compliance gaps.

What Providers Can Expect

Starting in 2026, OIG audits will examine:

- **Billing accuracy** – Did claims include all three required service components?
- **Medical necessity** – Was RPM appropriate and justified for the patient?
- **Documentation quality** – Are device logs, monitoring notes, and provider actions fully recorded?
- Adherence requirements – Did patients meet the 16-day transmission threshold?

To reduce audit risk, practices should:

1. **Conduct internal RPM audits** to confirm all billed claims are fully compliant.
2. **Ensure ordering providers are documented** in both claims and medical records.
3. **Verify device data logs** meet the minimum submission requirement.
4. **Train staff and clinicians** on correct RPM coding, billing, and monitoring standards.
5. **Stay updated** on CMS and OIG guidance as new rules or enforcement measures are introduced.

www.oig.hhs.gov

Prior Authorization Reform: AMA and Insurers Pledge to Reduce Burden

Prior authorization (PA) has long been cited by physicians as one of the most significant sources of administrative burden in U.S. healthcare. According to surveys by the American Medical Association (AMA), more than 90% of physicians report that prior auth requirements delay patient care, while nearly one-third say the process has led to serious adverse events for their patients.

The New Reform Effort

In **September 2025,** the AMA announced that it has reached a **collaborative agreement with major health** insurers to simplify and streamline PA processes. The goal is to reduce **paperwork, wait times, and unnecessary medical reviews,** aligning with the Biden Administration's broader push for administrative simplification in healthcare.

The reforms include:

- **Electronic Prior Authorization (ePA):** Expanding automation and real-time approvals via provider portals and EHR integration.
- **Gold Carding Programs:** Exempting providers with a strong track record from repeated PAs for common services.
- **Shortened Review Timelines:** Ensuring urgent requests are reviewed within 24–48 hours.
- **Transparency & Reporting:** Insurers will publish PA approval and denial rates, creating accountability.

For practices, these reforms could reduce delays, prevent denials, and free up staff from time-consuming appeals. Providers will also benefit from expanded real-time electronic approvals, cutting down on fax-based submissions and phone calls. However, implementation will vary by payer and state, meaning providers must closely monitor insurer bulletins to track adoption timelines.

The AMA and insurers' pledge marks a turning point in tackling prior authorization burdens. While not eliminating PA entirely, these reforms aim to reduce delays, increase transparency, and improve patient access to care. For providers, preparing now by integrating electronic solutions and monitoring payer rollouts will be key to benefiting from the new system.

www.ama-assn

BUSINESS BEAT

Medicare 2026 Stability Outlook

CMS Projects Stability for 2026

The Centers for Medicare & Medicaid Services (CMS) recently announced that premiums and benefits under Medicare Advantage (MA) and Medicare Part D prescription drug plans are expected to remain largely stable into 2026. This projection signals continuity for seniors and providers alike, following several years of cost pressures and policy adjustments. For practices, this means fewer sudden shifts in reimbursement tied to patient enrollment patterns.

Stable premiums and benefits mean seniors are less likely to switch plans, which can reduce administrative burdens for providers tied to re-enrollment, eligibility verification, and payer coordination each January. For medical groups and billing teams, fewer patient churns translate into steadier revenue cycles and reduced claim resubmissions due to plan changes.

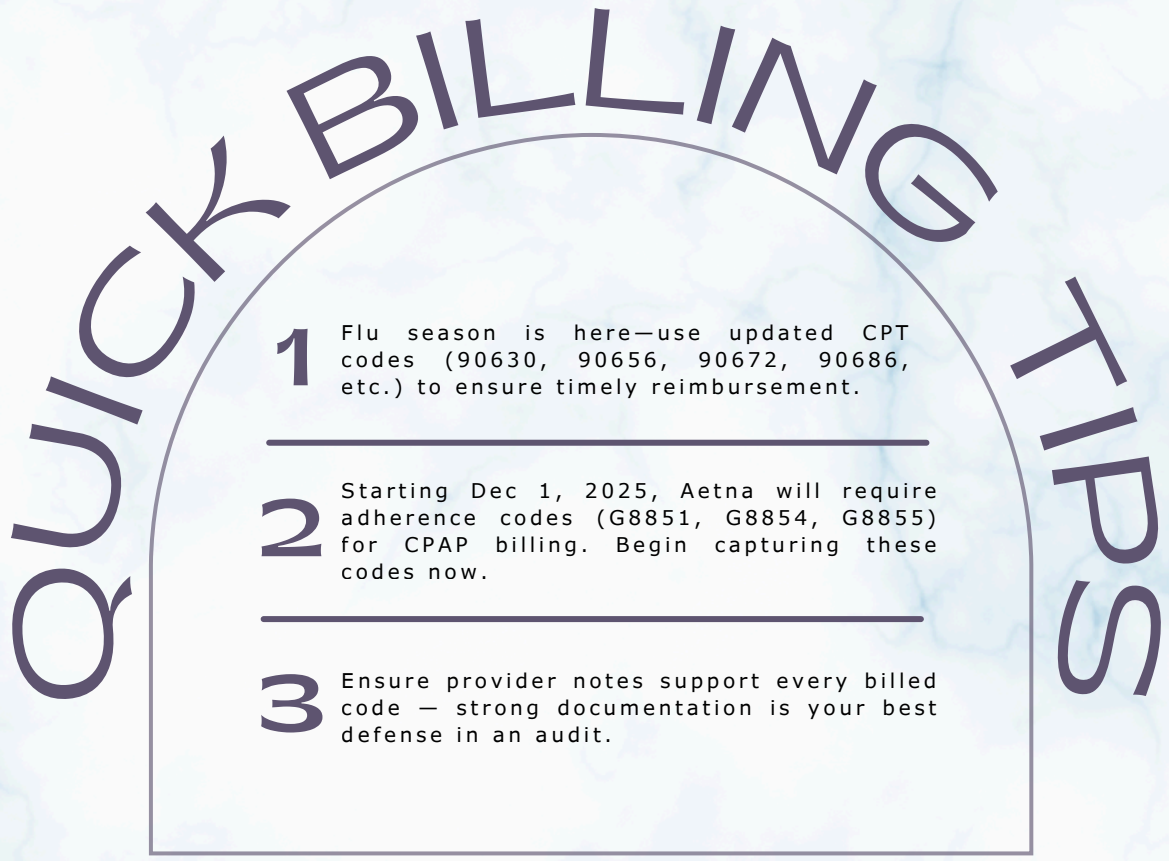
- **Predictable Cash Flow:** Practices can forecast revenue with greater confidence, especially those serving a high proportion of Medicare Advantage patients.
- **Medication Access:** Stability in Part D plans reduces disruptions in prescription coverage, improving adherence and limiting appeals for formulary exceptions.
- **Payer Relationships:** Insurers face fewer premium increases to justify, which may encourage focus on quality performance metrics and value-based care programs.

Looking Ahead to 2026

While premiums may remain stable, CMS has signaled continued **emphasis on audits, risk adjustment accuracy, and quality measures** under the Star Ratings system. Providers should anticipate **greater scrutiny of documentation and coding,** even as patient cost-sharing remains steady.

For billing teams and practices, the business opportunity lies in leveraging this stability to **tighten revenue cycle processes, improve HEDIS quality reporting, and reduce denials.** CuraWise is closely monitoring CMS updates to ensure providers remain well-positioned for financial and compliance success heading into 2026.

www.cms.gov



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EVENTS AND CALENDER

15-18 OCT

HFMA Annual Conference

The Healthcare Financial Management Association's premier annual meeting brings together CFOs, revenue cycle leaders, and compliance experts. Sessions will cover Medicare/Medicaid payment updates, revenue cycle optimization, technology in billing, and policy trends shaping 2026.

27-29 OCT

MGMA Leaders Conference

The Medical Group Management Association's flagship conference focuses on practice management, billing operations, payer relations, and leadership strategies. Attendees will gain insights on denial management, staffing models, and value-based care readiness.

19-22 OCT

HLTH 2025 – Healthcare Innovation Conference

One of the largest global healthcare innovation gatherings, featuring leaders across payers, providers, and tech.

Breast CANCER AWARENESS MONTH

Quick Billing Tips: Breast Cancer Screening

1. **Use Correct Screening Codes:**
- 77067 – Screening mammography, bilateral (2-view study of each breast).
- 77063 – Screening digital breast tomosynthesis (3D mammogram), bilateral (list separately in addition to code 77067).
2. **Annual Screening Covered:** Medicare and most commercial payers cover one screening mammogram every 12 months for women age 40 and older (no copay or deductible under ACA).
3. **Document Appropriately:** Clearly note “screening” vs. “diagnostic” mammogram in provider documentation — this ensures correct claim submission and avoids denials.
4. **Modifier Reminder:** If both screening and diagnostic mammograms are performed on the same date, apply modifier -GG (screening mammography converted to diagnostic mammography).
5. **Patient Education:** Encourage eligible patients to schedule their annual screening. Preventive services reduce long-term costs and improve outcomes.

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Thank You

As we wrap up this month’s insights, take a moment to pause, breathe, and reset. Caring for yourself is just as important as caring for others.