CURAWISE
BILLING SOLUTIONS

CURAWISE NEWSLETTER

The Official Newsletter of CuraWise Billing Solutions

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Welcome

At CuraWise, every newsletter is an opportunity to strengthen our connection with providers and share insights that truly matter. Since our July launch, your encouragement and feedback have been a powerful reminder of why we exist: to simplify the complex world of medical billing with transparency, clarity, and results.

Our August issue built momentum by diving into payer challenges and compliance essentials—topics that continue to resonate strongly. Now, with September, we're looking ahead: exploring evolving policies, smarter denial management, and strategies to help you finish Q3 with confidence and prepare for the year-end push.

Through every edition, our mission remains the same: not just billing claims, but empowering providers with strategies that protect revenue, reduce stress, and create space to focus on patient care.

"Progress is built one step at a time—keep moving forward."

Najma Un Nisa
Founder & CEO

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California Providers: Verify Data or Risk Removal from UHC Directories

UnitedHealthcare has announced an important reminder for California providers: under **Senate Bill 137** and contract terms, all demographic data must be **verified and updated quarterly** to remain in UHC's provider directories.

Providers who fail to update their information risk being removed from directories, which could also impact payments under California Health & Safety Code Section 1367.27(p)

Practices must review and confirm details such as office locations, phone numbers, hours of operation, and new-patient availability.

Multiple Update Options Available:

- **CAQH Provider Data** Portal for individuals and groups
- **My Practice Profile** via the UnitedHealthcare Provider Portal

Demographic Change Request Form for direct updates

https://www.uhcprovider.com

UHC Adds Prior Authorization for Therapy Services in KS, NC, and VA

UnitedHealthcare has announced that, beginning **November 1, 2025**, prior authorization will be required for all outpatient physical, occupational, and speech therapy services provided to Community Plan Medicaid members in **Kansas, North Carolina, and Virginia**. In North Carolina, this requirement will apply to members aged 21 and older, while in Kansas and Virginia it will apply to those aged 3 and older.

Under the new policy, the first six visits of a member's initial therapy plan will be covered if they take place within eight weeks of service initiation. However, an authorization request will still need to be submitted, and any care plan that extends beyond six visits or eight weeks will undergo a medical necessity review. Providers may begin submitting authorization requests as early as October 1, 2025, for services scheduled to start after the effective date.

This change reflects the ongoing shift by payers toward greater oversight of therapy utilization, with the stated aim of balancing patient access and cost efficiency. For providers, it highlights the importance of integrating authorization processes into daily operations to avoid reimbursement delays and disruptions in care.

https://www.uhcprovider.com

Important Update: AARP Medicare Supplement Claims Address Change

UnitedHealthcare has announced a new mailing address for AARP Medicare Supplement paper claim submissions:

UnitedHealthcare Claims Division
P.O. Box 1878
Southampton, PA 18966-9998

Please note: Some AARP Medicare Supplement ID cards may still show the old address. To avoid delays, providers must only use the new address going forward.

For faster and more efficient processing, claims should be submitted electronically using payer ID 36273.

Correctly submitted claims are typically processed within 10–14 days.

https://www.uhcprovider.com

UHC Requires Additional Documentation for Hip & Knee Surgery Authorization

As of **August 1, 2025**, UnitedHealthcare implemented new requirements affecting prior authorization requests for total joint replacements under Individual Exchange (IEX) or Individual & Family Plans (IFP). The update applies to procedures coded as CPT 27445, 27447, 27130, and 27132, exclusively for osteoarthritis treatment, and no additional CPT codes have been added to the authorization list. This applies nationwide to IEX/IFP plan members, and all requests are now subject to evaluation under the Surgery of the Hip and Surgery of the Knee policies.

For hip surgery, providers must include in the medical notes a full diagnostic interpretation of imaging, encompassing relevant clinical context, a detailed report of findings, the interpreting provider's impression, and their specialty. Providers might also be asked to submit the actual diagnostic images—MRI, CT, X-ray, or bone scan—to substantiate the findings, and consulting with the surgeon may help determine the best images to include

Similarly, knee surgeries require that documentation reflect a comprehensive imaging interpretation. The report must detail clinical information and clearly address aspects such as skeletal plate closure (for patients under 18), presence or absence of full-thickness cartilage defects, defect size and location, Outerbridge grade, joint

space and alignment, as well as any ligament tear locations and severity. As with hip cases, actual diagnostic images may be required upon request, and consultation with the surgeon can assist in selecting the most pertinent imaging.

On September 4, 2025, this guidance was updated to include more detailed information in the "Summary of changes" sections pertaining to both hip and knee surgeries, reinforcing the imaging and documentation expectations outlined above.

https://www.uhcprovider.com

FIDELIS CARE®

New York State School Vaccinations & Well-Child Visits

With the new school year approaching, providers have an important opportunity to help families keep their children healthy, protected, and ready for the classroom. New York State requires that all students be up to date on specific immunizations in order to attend school. These include vaccines such as measles, mumps, rubella, polio, hepatitis B, diphtheria, tetanus, pertussis, varicella, and meningococcal for adolescents. Providers are also reminded that all immunizations for patients under the age of 19 must be reported through the New York State Immunization Information System (NYSIIS).

Well-child visits are equally essential. These visits go beyond basic checkups, providing growth and developmental assessments, vision and hearing screenings, behavioral and mental health evaluations, preventive counseling on healthy habits, and the administration of vaccines. They ensure children are meeting milestones, address concerns early, and prepare them for success in school and beyond.

Encouraging families to schedule these visits not only helps children meet state requirements but also supports early intervention, improves long-term health outcomes, and strengthens the bond between providers and patients.For Fidelis Care members, all recommended well-child visits and immunizations are fully covered with no copays, coinsurance, or deductibles when provided in-network.

Now is the perfect time to reach out to families, schedule appointments, and make sure students are ready for a healthy start to the school year.

www.fideliscare.org

FIDELIS CARE®

Availity Essentials – Expanded Features for Providers

Fidelis Care has enhanced its partnership with Availity Essentials, giving providers access to a comprehensive digital hub that simplifies everyday administrative tasks. Through the upgraded platform, providers can now verify member eligibility and benefits in real time, submit and track claims, correct denials quickly, and review electronic remittances with greater ease. Prior authorization requests can also be submitted and monitored directly through the portal, and providers have immediate access to payer resources and support, eliminating the need to navigate multiple systems or spend extra time on calls.

These improvements are designed to reduce administrative burden, speed up claims processing, and strengthen revenue cycle management. By consolidating essential functions into a single portal, Availity Essentials allows providers to focus more on patient care and less on paperwork. Providers who have not yet taken advantage of these features are encouraged to register their practice and ensure staff are trained to make the most of the platform. For additional guidance, Fidelis Care Provider Relations Specialists are available to provide support.

www.fideliscare.org

Horizon

Important Update: Supply and Implant Billing Requirements

Horizon NJ Health has announced a new reimbursement policy on Supply and Implant Billing Requirements, effective September 9, 2025. Under this policy, certain supplies, surgical instruments, implants, and their components will no longer be reimbursed separately and must be billed as part of the associated procedure or service. Providers are encouraged to review their current billing practices and update claims submission processes

to ensure compliance with the new guidelines. Additional details and the full policy can be accessed through the Horizon NJ Health provider portal or by contacting a Provider Relations representative.

https://www.horizonnjhealth.com/

Anthem

RSV Immunization: A Crucial Step to Safeguard Infant Health

As RSV season approaches, Anthem is highlighting the critical role of maternal RSV immunization for fetal protection. Administered between 32 and 36 weeks of pregnancy, Pfizer's Abrysvo allows pregnant individuals to pass protective antibodies to their newborns, offering up to six months of defense against severe RSV illness

This approach aligns with CDC recommendations, which emphasize that it takes about two weeks post-vaccination for sufficient antibodies to develop and transfer to the baby, providing vital early immunological support.

Recent research reinforces the importance of timing: studies suggest that administering the vaccine **around five weeks before delivery**—i.e., nearer to 32 weeks gestation within the recommended window—optimizes the transfer of antibodies to newborns, offering better protection during their most vulnerable early months.

https://providernews.anthem.com

Anthem

Anthem Expands Specialty Pharmacy Precertification Requirements

Anthem New York is updating its precertification requirements for specialty medications across commercial and Medicare Advantage plans. Beginning December 1, 2025, an expanded list of drugs will require prior authorization. Providers should review the updated list in the Anthem provider portal to ensure timely submissions and avoid claim delays or denials.

https://providernews.anthem.com

cigna healthcare

Evernorth Invests $3.5 Billion in Shields Health Solutions

On **September 2, 2025**, Evernorth Health Services, the health services division of The Cigna Group, announced a $3.5 billion investment in Shields Health Solutions, a leading specialty pharmacy management company. Shields partners with more than 80 health systems across nearly all 50 states, helping hospitals and clinics build and manage in-house specialty pharmacies that support patients with complex and chronic conditions.

This investment strengthens Evernorth's specialty pharmacy capabilities and expands opportunities for collaboration with health systems to improve continuity of care. While the move enhances long-term specialty care infrastructure, Cigna confirmed it will not affect its 2025 earnings guidance.

For providers, this signals a continued focus on improving access to specialty medications, supporting patients who require high-cost therapies, and better integrating care across hospital, clinic, and home settings.

https://newsroom.thecignagroup.com/

aetna®

Correct Billing for HIV PrEP in New York

Aetna is reminding providers in New York that proper billing practices are essential when submitting claims for HIV pre-exposure prophylaxis (PrEP) related services. Instead of using the general administrative injection code **96372**, providers must bill with the specific **CPT or HCPCS codes** that accurately describe the service rendered, along with the appropriate **ICD-10 diagnosis codes.**

This clarification is intended to reduce claim errors, prevent delays in reimbursement, and ensure PrEP services are covered in accordance with benefit policies. Providers can access detailed coding guidance through the Aetna provider portal on Availity. By following the updated billing requirements, practices can streamline claim processing and help members receive uninterrupted access to critical preventive HIV services.

www.aetna.com

aetna®

Claim & Code Review Program (CCRP) Expands

Aetna is expanding its Claim and Code Review Program (CCRP), with new edits taking effect on December 1, 2025. The CCRP is designed to improve claim accuracy by ensuring that billing practices align with current coding standards and payment policies. These updates will apply across Commercial, Medicare, and Student Health plans.

Providers are encouraged to review the updated claim edits in advance through Availity to avoid potential denials or reimbursement delays Staying ahead of these changes will help streamline billing processes, improve

accuracy, and support faster payment turnaround.

www.aetna.com

Medicare

CMS Launches Nationwide Push to Remove Ineligible Medicaid Enrollees

CMS announced on **August 19, 2025,** a nationwide initiative to strengthen Medicaid and CHIP eligibility oversight by removing individuals who are not legally entitled to benefits. As part of this effort, CMS will send states monthly enrollment reports highlighting enrollees whose citizenship or immigration status could not be verified through federal databases, such as the Department of Homeland Security's SAVE system. States must then review these cases, request additional documentation where necessary, and take action to ensure only eligible individuals remain enrolled. This push is designed to reinforce program integrity and protect taxpayer resources, though it may also lead to coverage disruptions for some patients if eligibility cannot be confirmed.

www.cms.gov

Medicare

HHS Expands Access to Affordable Health Insurance

On **September 4, 2025**, the U.S. Department of Health and Human Services announced new hardship exemption guidance that widens access to catastrophic health plans for consumers who don't qualify for premium subsidies or cost-sharing reductions. Beginning November 1, these individuals can apply—either through HealthCare.gov or via mail submission—for a hardship exemption that will allow them to enroll in lower monthly premium catastrophic plans. These plans offer essential health benefits, including three primary care visits before the deductible, and serve as a valuable safety net for those facing potentially devastating medical costs or affordability challenges. This move aims to make insurance more accessible, especially amid rising healthcare costs, while ensuring program integrity and supporting financial stability for patients.

www.cms.gov

Medicare

CMS News: Digital Updates for Laboratories

In its August 7, 2025, MLN Connects® Newsletter, CMS announced important updates for clinical laboratories. To modernize workflows and reduce reliance on paper processes, laboratories will transition to electronic fee coupons and digital Clinical Laboratory Improvement Amendments (CLIA) certificates. This change is designed to streamline compliance, improve record-keeping, and make essential documents more accessible for providers and regulators alike.

Alongside these updates, CMS shared new search optimization tips for clinicians navigating CMS.gov. These tools are meant to help providers more efficiently find policy guidance, billing updates, and educational resources on the CMS website. Together, these initiatives reflect CMS's broader effort to improve digital access, enhance compliance processes, and support providers with more user-friendly resources.

www.cms.gov

Medicare

CMS Launches "Crushing Fraud" Campaign to Strengthen Medicare Integrity

The Centers for Medicare & Medicaid Services (CMS) is intensifying its fight against fraudulent activity with the launch of its "Crushing Fraud" campaign, as highlighted in the MLN Connects® Newsletter on August 7, 2025. This initiative reflects CMS's ongoing commitment to protect taxpayer dollars, safeguard Medicare resources, and ensure that funds are used appropriately to support patients who genuinely rely on the program.

Medicare fraud remains a costly challenge, often involving false claims, overbilling, or misrepresentation of services. Through Crushing Fraud, CMS is working closely with providers, health systems, and law enforcement to identify and stop these abuses early. The campaign emphasizes the importance of accurate documentation, proper billing practices, and provider accountability, while also encouraging healthcare professionals to report suspicious activity.

For providers, this initiative is not only about compliance but also about preserving the trust of patients and maintaining the long-term sustainability of Medicare. By following CMS guidance, staying vigilant, and fostering a culture of integrity, providers play a critical role in ensuring Medicare dollars are directed to legitimate patient care.

As CMS expands its oversight and enforcement efforts, the Crushing Fraud campaign serves as both a reminder and a call to action: safeguarding Medicare is a shared responsibility, and together, the healthcare community can reduce waste, strengthen compliance, and protect the integrity of the nation's most vital health program.

www.cms.gov

Medicare

Flu Vaccine Pricing for the 2025–26 Season

CMS has released the updated payment allowances and effective dates for the 2025–26 influenza season. The new pricing applies to Medicare payment for flu vaccines administered to beneficiaries during the upcoming season and reflects adjustments based on current cost data.

Providers should review the published payment allowance tables to confirm the correct rates for each flu vaccine product. These allowances apply when vaccines are furnished free of charge by the manufacturer under a government distribution program or purchased by the provider for administration.

Accurate use of the updated rates is essential for proper reimbursement and to avoid claim denials. CMS reminds providers that Medicare covers one flu shot per season for all beneficiaries, with no copayment or deductible, and allows additional doses if medically necessary.

With the new rates in effect, now is the time to verify that billing systems and staff are updated to ensure smooth claims processing and timely payment during the fall vaccination push.

www.cms.gov

Medicare

Nursing Home Care Compare Updates Temporarily Paused

CMS has announced that updates to Nursing Home Care Compare will be temporarily paused as the system transitions to a new cloud-based platform. Beginning July 30, 2025, no new data will be posted, with updates expected to resume in October 2025 once the transition is complete.

During this pause, the publicly available quality and performance data for nursing homes will not reflect the most recent reporting period. Providers should be aware that families, caregivers, and other stakeholders may see a gap in updated information until the October refresh.

CMS emphasizes that this change is technical in nature and does not affect providers' ongoing quality reporting requirements. Facilities must continue submitting data as usual to ensure that their performance is accurately reflected when the system comes back online.

www.cms.gov

PROVIDER BULLETIN

OIG Audit: Novitas Corrects $9.4M in Cost Report Errors

The HHS Office of Inspector General (OIG) released an audit (Report No. A-06-24-05003) on August 28, 2025, highlighting serious errors by Medicare Administrative Contractor Novitas Solutions, Inc. in finalizing cost report settlements. Novitas had settled 118 cost reports (122 reopenings in total) based solely on desk reviews and later reopened them to correct obvious errors.

Key Findings & Financial Impacts

- Every desk review contained obvious errors or inconsistencies with Medicare requirements.
- These reopenings resulted in $9.4 million in payment corrections—specifically $5.0 million in overpayments recovered and $4.4 million in underpayments restored to providers.

Root Causes & OIG Recommendations

The errors were attributed to inadequate training and insufficient supervisory review processes—supervisors failed to detect errors made by auditors. The OIG recommended:

1. **Enhanced training** for desk reviewers and supervisors on Medicare cost report criteria.
2. **Stronger supervisory** procedures to better catch audit inaccuracies during desk reviews.

Novitas agreed with these recommendations and has committed to implementing corrective actions.

Why It Matters to Providers

- **Financial Uncertainty:** Reopened settlements may lead to unexpected adjustments—either recoupments or payments owed—affecting practice finances.

- **Internal Oversight:** Providers must ensure upstream compliance and rigor in cost reporting, as downstream corrections reflect audit gaps.
- **Operational Vigilance:** This audit underscores the need for strong documentation and internal review, even when audits have seemingly concluded.

www.oig.hhs.gov

Expanding Telehealth Flexibilities Through September 2025—Behavioral Health Goes Permanent

CMS has extended several Medicare telehealth flexibilities that were introduced during the COVID-19 public health emergency—now, lasting through September 30, 2025—thanks to the Full-Year Continuing Appropriations and Extensions Act of 2025.

What's Extended Through September 30, 2025:

- **Home-based access:** Medicare patients may receive **non-behavioral and non-mental health telehealth services** from **anywhere**—including their homes—with **no geographic restrictions.**
- **Audio-only options:** These services remain reimbursable via two-way, real-time **audio-only communication,** provided the provider is capable of video but the patient opts out
- **Expanded provider types:** Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can continue to act as **distant-site providers** for telehealth billing purposes.
- **In-person visit requirement delayed:** For behavioral health via telehealth, the previously required initial and annual in-person visits remain waived—but only **through September 30, 2025**

What's Here to Stay (Permanent Flexibility):

CMS has made several important telehealth provisions **permanent,** ensuring continued access beyond 2025 for behavioral health services:

- **Behavioral and mental health telehealth in the home** is permanently covered—**with no originating site or geographic restrictions**
- Services furnished by **marriage and family therapists and mental health counselors** via telehealth are also now **permanently permitted distant-site providers.**

What This Means for Providers

- Continue using telehealth—especially audio-only options—for non-behavioral care through September 2025, from anywhere, even home**.**

- Behavioral and mental health telehealth can continue indefinitely, so keep leveraging virtual platforms to expand access and continuity of care.
- FQHCs and RHCs can maintain their telehealth offerings for behavioral health without time or setting restrictions.
- Keep an eye out after September 30—restrictions will return for non-behavioral telehealth unless Congress extends these flexibilities again.

www.hhs.gov

FEATURE FOCUS

Duplicate Enrollment Under Scrutiny: CMS Rolls Out New Safeguards

The Centers for Medicare & Medicaid Services (CMS) has intensified its efforts to safeguard Medicaid and CHIP program integrity by launching a nationwide crackdown on duplicate enrollments. The issue came to light in July 2025, when CMS reported that nearly **2.8 million** individuals were enrolled in coverage more than once—either across multiple state Medicaid/CHIP programs or by holding concurrent enrollment in both Medicaid/CHIP and subsidized Affordable Care Act (ACA) marketplace plans. This duplication is estimated to cost the federal government approximately **$14 billion** annually, underscoring the urgency of corrective measures.

In **August 2025,** CMS began implementing stronger safeguards to resolve these costly inefficiencies. States now receive **monthly enrollment reports** identifying individuals whose citizenship or immigration status could not be verified through federal data sources. These reports are intended to help states act quickly, ensuring enrollees either provide the necessary documentation or have their records corrected. Additionally, CMS provided states with new **data-matching tools** to better reconcile duplicate enrollments, authority that was reinforced by the **One Big Beautiful Bill Act**, which expanded CMS's ability to intervene directly in these cases.

Another major step was the r**estart of the Periodic Data Matching (PDM)** process in **July 2025**, which had been paused during the COVID-19 public health emergency. PDM allows CMS to identify individuals who are simultaneously

enrolled in Medicaid/CHIP and ACA marketplace plans. When such cases are flagged, individuals are notified and given 30 days to resolve the discrepancy. If no action is taken, their ACA subsidies are terminated to prevent overlapping benefits.

For providers, these new safeguards may create immediate challenges. Patients undergoing eligibility reviews could face temporary coverage disruptions, leading to uncertainty in claims processing and potential delays in reimbursement. Administrative staff may need to invest more time helping patients respond to notices and gather documentation to prove eligibility. Providers should also prepare billing teams for more frequent eligibility verification and the possibility of claim denials tied to shifting coverage status.

Despite these hurdles, the initiative represents a significant step toward reducing fraud, waste, and abuse in federal health programs. By tightening oversight and enhancing state collaboration, CMS aims to ensure that taxpayer dollars are directed only to individuals who qualify, while reinforcing trust in the system. For providers, staying proactive—through strong eligibility monitoring, patient communication, and close coordination with payers—will be essential to maintaining continuity of care and financial stability during this transition.

www.cms.gov

BUSINESS BEAT

Cybersecurity and HIPAA: Protecting PHI in the Billing Workflow

In today's healthcare landscape, billing companies manage massive volumes of **protected health information (PHI)**—from patient demographics to insurance details. While this data is critical for ensuring timely reimbursement, it also makes billing operations a prime target for cybercriminals. At the same time, federal enforcement of **HIPAA Security and Privacy Rules** is intensifying, with record fines being issued in 2025 for breaches tied to poor safeguards. For billing providers, the challenge is clear: protect patient data while keeping workflows efficient.

The Growing Risk Environment

Healthcare remains one of the most attacked industries, with ransomware, phishing schemes, and unauthorized system access driving most reported breaches. Billing companies, in particular, often work across multiple provider networks, making them vulnerable entry points if security controls are weak. A single breach can expose thousands of patient records, resulting not only in financial penalties but also reputational damage and loss of client trust.

Core Safeguards Every Billing Workflow Needs

- **Encryption:** Both at rest and in transit, PHI should be encrypted using industry standards (AES-256 or equivalent).
- **Access Controls:** Role-based permissions ensure staff access only the data they need, minimizing exposure.
- **Multi-Factor Authentication (MFA):** Required for all remote access, VPNs, and cloud platforms handling PHI.
- **Audit Logs:** Continuous monitoring of logins, file access, and data transfers to detect suspicious activity early.
- **Vendor Management:** Business Associate Agreements (BAAs) with clearinghouses, EHR vendors, and cloud providers must clearly outline responsibilities for PHI protection.

Balancing Security and Workflow Efficiency

Strong cybersecurity doesn’t have to slow down billing operations. Automating claim submission, denial tracking, and eligibility checks through secure platforms reduces manual handling of PHI and minimizes risk. Regular staff training on phishing awareness and HIPAA compliance ensures human error doesn’t undermine technical safeguards.

The Compliance Advantage

Investing in cybersecurity not only avoids fines but also strengthens client relationships. Providers increasingly ask billing partners to demonstrate HIPAA readiness, and companies that proactively highlight their safeguards gain a competitive edge. In an environment where compliance, trust, and efficiency are equally important, robust cybersecurity has become a hallmark of a successful billing company.

Always verify eligibility before submitting claims.

With CMS's duplicate enrollee audits now underway, even small eligibility errors can trigger denials or repayment demands. A simple eligibility pre-check at each visit helps prevent costly mistakes and protects your revenue cycle.

Use modifiers carefully.

Incorrect use of modifiers—especially 25, 59, and 95—is one of the most common reasons for claim denials. Reviewing payer-specific rules before submission ensures your claims get paid the first time.

Submit claims promptly

Delays in submission increase the risk of denials and cash flow gaps. Aim to send claims within 24–48 hours of service to keep reimbursements on track and accounts receivable days low.

EVENTS AND CALENDER

16 Sep

Compliance Deadlines

CMS Quarterly HCPCS Application Deadline

Providers and billing companies should note CMS's deadline for submitting applications for new HCPCS codes or modifications for the January 2026 cycle.

20 Sep

Compliance Deadlines

Medicaid/CHIP Redetermination Updates

As CMS continues its crackdown on duplicate enrollees, states will begin releasing updated eligibility reports around mid-September. Providers should prepare for patient eligibility shifts that could affect claims.

Mid Sep

National Updates

Mid-September 2025 – Flu Vaccination Season Launch

CMS will release reminders and updated guidance for Medicare-covered flu vaccinations for the 2025–26 season. Practices should verify coding and payment allowances to ensure accurate reimbursement as the new rates take effect.

25 Sep

Conferences & Learning Opportunities

AAPC Local Chapter Meetings

AAPC local chapters nationwide will host coding and compliance workshops, offering CEUs and practical training. These meetings provide valuable peer-to-peer networking and education for coding teams.

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