REVENUE CYCLE MANAGEMENT

A UPA Billing Office Newsletter
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Telehealth for Traditional Medicare

For 2026, recently passed legislation has extended telehealth flexibilities through December 31, 2027.

This means there are no geographic restrictions on where a traditional Medicare patient can receive telehealth services and patients can continue to receive non-behavioral health related services in their home. Non-behavioral health telehealth services can also be delivered through audio-only communication platforms through this policy extension.

Additional policy details can be found at the links below:
Telehealth FAQs
Telehealth policy updates | Telehealth.HHS.gov

2026 CPT & HCPCS Updates

Effective January 1, 2026, there were 288 new CPT & HCPCS codes, 84 deletions and 46 revisions.

Highlights of changes can be found below. This is not an inclusive list of all the 2026 updates, that can be found at the link below for more details.

- New codes provided for Remote Monitoring & Digital Health including new CPT 99445 for 2–15 days of remote physiologic monitoring (CPT 99453 & 99454) within a 30-day period.
- Revised guidelines for reporting existing remote monitoring supply codes CPT 99453 & 99454.
- New CPT 99470 allows for billing RPM treatment management for 10–19 minutes, where existing codes were only for 20+ minutes.

-continued: 2026 CPT & HCPCS Updates

- Major revisions made to revascularization codes. 46 new codes categorized by 4 vascular regions will replace previous codes in this family. CPT range 37254-37299 are now described by iliac, femoral/popliteal, tibial/ peroneal, and inframalleolar, as well as lesion description of straightforward and complex.
- New time-based codes to report the evaluation of hearing aid candidacy. CPT 92628 is for the first 30 minutes with add-on code CPT 92629 to report for each additional 15 minutes with additional codes added for audiology services in relation to hearing aid selection & fitting services can be found in CPT code range 92631-92642.
- Radiology & Procedures: New codes for CT angiography of the head/neck, CT cerebral perfusion, prostate biopsy, and sacroiliac (SI) arthrodesis.
- Skin Substitutes: Specific skin substitutes in the office setting will be treated as "incident-to" supplies.
- Category III Codes: New technology codes for hemodynamic IVC monitoring, high-intensity focused ultrasound (HIFU) for prostate ablation, and laser ablation of breast tumors.
- Social Determinants of Health screening code G0136 description has changed to reflect a completely new description and guidelines for dates of service 1/1/2026 and after. “Administration of a standardized, evidence-based assessment of physical activity and nutrition, 5-15 minutes, not more often than every 6 months.”

Resources:
List of CPT/HCPCS Codes | CMS

University Physicians' Association, Inc.
upasolutions.com

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UHC Medicare Advantage Plans Referral Requirements for 2026:

United Healthcare Medicare Advantage Plans now require a PCP referral for certain outpatient, office or home specialists' services. This requirement went into effect January 1, 2026, however UHC will not deny claims lacking a referral until dates of service May 1, 2026, and after. Specialists within the same group/specialty under the same TIN do not require separate referrals. Mid-level providers are covered under the referral to the MD/DO when under the same TIN.

For billing purposes, the referral information can be added to Intergy Practice Management system within the charge detail screen.Please see the UPA RCM Office Resources SharePoint for detailed instructions.

Referral requirements will NOT apply to the following provider specialties:

- Primary care provider
- Mental health provider
- Obstetrician/gynecologist
- Chiropractor
- Audiologist
- Oncologist
- Hematologist
- Nuclear medicine
- Neonatology
- Emergency medicine
- Nutritionist
- Podiatrist
- Optometrist
- Ophthalmologist
- Optician
- Radiologist
- Therapeutic radiologist
- Infectious disease specialist
- Urgent Care

Referral requirements DO NOT apply to the following services:

- PT/OT/ST, cardiac therapy or pulmonary therapy
- Provision of anesthesiology (pain management services rendered by an anesthesiologist do require a referral)
- Home health agency services
- Services performed in an observation setting
- Any services from a pathologist or inpatient consulting physician, including hospitalists
- Emergency room, ambulance or urgent care services
- Telehealth services
- Medicare-covered preventive services, kidney disease education or diabetes self- management training
- Routine annual physical exams, routine vision exams or hearing exams
- Dialysis services
- Any lab services, radiological or non-radiological testing services, or radiation therapy
- Durable medical equipment, home health, prosthetic/orthotic devices, medical supplies, diabetic testing supplies, Medicare Part B drugs or allergens
- Additional coverage that may be included by some Medicare Advantage plans but are not covered by Medicare, such as hearing aids, routine eyewear, dental care, fitness memberships or outpatient prescription drugs

Resources:
Referral requirements for Medicare Advantage HMO/HMO-POS plans Jan. 1, 2026, | UHCprovider.com

E/M Downcoding Payer Trend Reminders

Over the last year, an increasing number of insurance carriers have implemented algorithm based downcoding reimbursement programs. Downcoding is the process of paying a claim for a lower level of service than what was billed. Algorithms, like "bell curve" statistics, are used to identify high-level E/M visits with low complexity diagnosis codes for a reduced reimbursing without notification to the provider through a denial or medical record review process. Providers and practice administrators need to be aware of this major payer trend and the impacts on reimbursement and the requirement for proper documentation standards. To dispute downcoded claims, formal appeals must be filed with the payer to provide supporting documentation of the services performed.

Payers with Downcoding Processes:

- Aetna
- BlueCross
- Cigna
- Humana
- United Healthcare

E/M Documentation Reminders Recommended to Support Level of E/M service:

- Medical necessity is the prevailing requirement. Was the level of service performed and billed medically necessary?
- When coding by medical decision making, ensure that at least 2 or 3 elements of complexity are documented to support straightforward, low, moderate, and high complexity including the number of possible diagnoses, the amount of data reviewed and analyzed, and the number of diagnostic services ordered, past records reviewed, any applicable physician interpretations or review of labs, tests, imaging, etc.
- When coding by time, ensure that total time spent on the date of service performing any of the following, is documented to support the total time for the encounter.
  - Reviewing patient medical history
  - Time spent face-to-face on exam or evaluation
  - Counseling and education for patient/family/caregivers
  - Documenting clinical information
  - Interpreting test results, when not separately reported with another service
  - Care Coordination & Communication with other healthcare providers and/or making referrals

Resources:
Payer evaluation and management (E/M) downcoding programs: What you need to know

Reminders for "Excludes1" Coding Edits:

Excludes1 is an ICD-10-CM coding guideline that states two or more conditions cannot exist together, or they are mutually exclusive to each other. For UPA RCM clients, you may receive tasking communication stating that two diagnosis codes reported together have an Excludes1 edit. This means that if both ICD-10 codes are reported on the claim, payers may deny the claim. The practice/provider should then review the encounter documentation to determine which is the most appropriate diagnosis to report when these edits exist. In exceptionally rare cases where the two conditions are unrelated to each other, you may appeal a denial, however most payers are not overturning denials related to Excludes1. It is recommended that practices closely monitor tasking trends to educate providers on commonly denied diagnosis combinations for their practice specialty. Common scenarios of Excludes1 edits include:

- Congenital vs. Acquired conditions for the same body part/system
- Specific vs. Unspecified Diagnosis codes for the same or similar conditions
- Conflicting or Clinical Contradicting Diagnosis codes, such as coding both with and without descriptions, or normal + high-risk.
- Signs and symptoms of a confirmed diagnosis should also not be reported.

As of 2026, the following payers are applying Excludes1 edits to their claim processing and will commonly deny claims.

- BCBS of TN
- Humana
- United Healthcare

Resources:
1/1/2026 – UnitedHealthcare Commercial Reimbursement Policy
Update Bulletin: January 2026