CMS requests updated billing information from qualifying APM participants

September 2, 2026
News & Insights

CMS released an advisory for certain clinicians who are qualifying alternative payment model (APM) participants and are eligible to receive APM incentive payments, notifying them that their current billing information must be updated to receive funds for the 2026 payment year.

Under the Medicare Quality Payment Program, an eligible clinician who participates in an APM and meets or exceeds the applicable payment amount or patient count thresholds for a performance period is a qualifying APM participant (QP) for that year. CMS identified eligible clinicians who attained QP status in the 2024 performance period and earned a 1.88% APM incentive payment for the 2026 payment year based on aggregate paid amounts for the covered professional services they furnished in the calendar year 2025 base period.

When the agency processed the 2026 APM incentive payments, CMS reported it was unable to identify taxpayer identification numbers associated with some QPs and was therefore unable to disburse the payment. To successfully issue the APM incentive payment for the 2026 payment year, CMS is requesting assistance identifying current Medicare billing information for these QPs.

The agency said that all information must be received by October 13, 2026. Following that date, CMS said any claim to an APM incentive payment for the 2026 payment period based on an eligible clinician's qualifying APM participant status for the 2024 performance period will be forfeited.

Editor's note: *This article originally appeared in* CDI Strategies*, ACDIS' weekly e-newsletter.*

Related Topics:
Billing and reimbursement, Medicare news

UnitedHealthcare to cut prior authorization requirements for 1,700 services

September 9, 2026
News & Insights

UnitedHealthcare is fulfilling its pledge to reduce prior authorization requirements by 30% by the end of the year. Starting October 1, 2026, the insurer will no longer require approval for more than 1,700 procedure codes across various plans.

The impacted codes span a broad range of specialties and services, including cardiology and diagnostic imaging, genetic and laboratory testing, outpatient surgery, home health services, and orthopedic and musculoskeletal procedures. UnitedHealthcare provided lists of Current Procedural Terminology (CPT®) codes that will no longer require prior authorization for the following plan types:

- Commercial
- Medicare Advantage and dual special needs
- Community
- Individual exchange
- Oxford

UnitedHealthcare was one of the many commercial payers that signed a 2025 pledge to work with CMS to improve their authorization processes. The insurer said this initiative is designed to reduce administrative burden and remove barriers to care, which should give healthcare organizations more time to focus on patients.

UnitedHealthcare also recently enhanced its prior authorization and notification tool, which should prove helpful for organizations as they navigate the changes. Available through the payer's provider portal, the tool now offers better visibility into authorization requirements, more targeted existing case searches, and other improvements.

Editor's note: *This article originally appeared in* Revenue Integrity Insider*, NAHRI's weekly e-newsletter.*

Related Topics:
Billing and reimbursement, Denials and appeals

CDC survey finds continued decline in HAIs

September 16, 2026
News & Insights

The prevalence of healthcare-associated infections (HAI) in U.S. hospitals declined between 2015 and 2023, according to a CDC survey recently published in *The New England Journal of Medicine*. The findings show continued progress in reducing infections acquired during hospital care, although researchers noted that the overall burden of HAIs persist.

Researchers reviewed medical records of 12,299 hospitalized patients in 199 hospitals during the 2015 survey period and found a total of 394, or 3.2%, had an HAI. In comparison, 355 of 13,653 hospitalized patients in 218 hospitals, or 2.6%, had an HAI in 2023. Among the 151 hospitals that participated in both the 2015 and 2023 surveys, patients were 27% less likely to have an HAI in 2023 than in 2015.

Pneumonia, surgical-site infections, and gastrointestinal infections were among the most common HAIs identified in 2023. Additionally, the survey showed significant reductions in several specific infections, including central line-associated bloodstream infections, catheter-associated urinary tract infections, and Clostridioides difficile infections, reflecting progress in hospital infection prevention efforts. However, the national burden remains high, as researchers estimated that approximately 518,000 HAIs occurred in U.S. hospitals in 2023.

It is also noted that approximately 60% of the HAIs were not associated with a medical device or procedure. This statistic highlights that although device-associated infections remain an important focus of hospital infection prevention programs, a majority of HAIs identified in the survey occurred outside the categories traditionally associated with devices or procedures.

These latest findings continue a trend observed in previous CDC prevalence surveys. In 2011, approximately one in 25 hospitalized patients had an HAI on a given day. That figure declined to one in 31 in 2015 and one in 38 in 2023.

The researchers concluded that the lower prevalence of HAIs in 2023 represents meaningful progress, but the number of infections occurring in U.S. hospitals remains high. The fact that most identified HAIs were not associated with a device or procedure also suggests that continued prevention efforts will need to address a broad range of infections beyond traditional device-associated categories.

Editor's note: *A version of this article originally appeared on JustCoding.*

Related Topics:
Auditing and monitoring, Compliance, HIM/HIPAA, Patient status

CMS updates COVID-19 vaccine pricing for 2026–2027 season

September 23, 2026
News & Insights

CMS recently released its 2026–2027 seasonal influenza and COVID-19 vaccine pricing file, providing updated Part B payment allowances for several COVID-19 vaccine products.

The file now includes the following Current Procedural Terminology (CPT®) product codes and payment allowances for COVID-19 vaccines, effective August 27, 2026:

- 91304 (Novavax): $232.218
- 91319 (Pfizer): $103.330
- 91320 (Pfizer): $230.405
- 91321 (Moderna): $172.967
- 91322 (Moderna): $172.967
- 91323 (Moderna): $252.225

COVID-19 vaccines are covered as preventive vaccines under Part B. When billing these claims, code selection should be based on the vaccine product, formulation, dose, patient age, and date of service.

COVID-19 vaccine claims should also include the appropriate administration code(s). CPT code 90480 is used to report the administration of a single-dose COVID-19 vaccine via intramuscular injection, and its payment allowance for the 2026–2027 season remains at $44.95.

When a COVID-19 vaccine is administered in a patient's home, and applicable requirements are met, both CPT code 90480 and Healthcare Common Procedure Coding System (HCPCS) code M0201 should be reported on the claim. HCPCS code M0201 can only be reported once per Medicare patient per date of service, even if the provider administers more than one Part B preventive vaccine in the same visit. The payment allowance for HCPCS code M0201 remains at $39.90.

Revenue cycle teams should continue to monitor CMS' vaccine pricing web page, as the agency stated it will update the file periodically as more pricing information becomes available. CMS also posted a crosswalk with updated National Drug Codes for the 2026–2027 season.

Editor's note: *This article originally appeared in* Revenue Integrity Insider, *NAHRI's weekly e-newsletter.*

Related Topics:
Billing and reimbursement, Coding, Medicare news

2027 CPT code set: Updates for maternity care, hernia repairs, and more

September 30, 2026
News & Insights

The American Medical Association (AMA) released the 2027 Current Procedural Terminology (CPT®) code set, detailing 299 additions, 74 revisions, and 80 deletions set to take effect next year.

The most significant change for 2027 is a new CPT coding framework for maternal healthcare, which will fully replace the current global bundle. The AMA released this portion of the code set in July to give organizations ample time to prepare for implementation. Under the new granular framework, services for antepartum care, labor management, delivery, and postpartum care will be coded separately. The update consists of 12 new codes, 17 deleted codes, and six revised codes. It also includes significant revisions to subsection guidelines and relocates some existing codes.

Along with the updates for obstetric care, the 2027 code set includes three new codes for ventricular assist device procedures, nine for traumatic and non-traumatic diaphragmatic hernia repairs, and six for unattended sleep studies. The AMA updated prostate biopsy codes and guidelines to better reflect current techniques and improve data specificity. There are also new and revised radiology codes, as well as 10 new codes to describe artificial intelligence-related services.

The 2027 CPT code set takes effect on January 1, 2027. Click here for additional AMA guidance and resources on the new maternity care coding conventions.

Related Topics:
Auditing and monitoring, Coding, Documentation improvement

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