HARRIS CareTracker

The 2026 Payer Policy & CMS Code Update Playbook

Your Expert Guide to CPT, ICD 10 CM, and Telehealth Changes

Effective January 1, 2026 (CPT)

855-528-4357

sales@harriscaretracker.com

Table of Contents

1. Overview of 2026 Code Set Updates

The 2026 coding cycle introduces substantial revisions to both the CPT and ICD 10 CM code sets, reflecting advances in digital health, procedural innovation, and clinical specificity. These changes affect virtually every healthcare organization, from large health systems to independent practices.

CPT 2026 **Effective January 1, 2026**	**ICD 10 CM FY2026** **Effective October 1, 2025**
288 New Codes **46** Revisions **84** Deletions	**487** New Codes **38** Revisions **28** Deletions
418 total changes spanning digital health, remote monitoring, lower extremity revascularization, hearing device services, and AI assisted diagnostics.	Major expansions in chronic conditions, non pressure ulcers (100+ new codes), social determinants of health, oncology specificity, and neurological disorders.

Sources: AMA CPT 2026 Code Set Release (September 2025); CMS FY 2026 ICD 10 CM Update (June 2025)

2. 2026 CPT Update: Key Areas of Change

The CPT 2026 code set, released by the American Medical Association in September 2025, includes 418 total changes effective January 1, 2026. The update reflects a significant shift toward digital health integration, procedural modernization, and more granular reporting of emerging clinical services.

Lower Extremity Revascularization

This represents one of the most comprehensive procedural restructurings in the 2026 cycle. Legacy codes 37220 through 37235 have been deleted and replaced with 46 new codes. The new structure reflects lesion complexity, multiple vascular territories (including inframalleolar interventions), and the shift toward outpatient settings. Surgical and interventional practices must review how their workflows map to the new structure, ensure accurate use of modifiers and lesion territory documentation, and update charge masters, encoder logic, and payer crosswalks.

Remote Patient Monitoring

New codes have been introduced for short duration remote monitoring (2 to 15 days within a 30 day period). These additions support flexible care delivery models outside traditional encounter based frameworks and acknowledge the growing role of continuous patient monitoring in chronic disease management.

Hearing Device Services

A comprehensive overhaul replaces legacy audiology codes with 12 new codes covering candidacy evaluation (92628), device selection with assessment of visual/dexterity limitations and psychosocial factors (92631/92632), fitting, follow up, electroacoustic verification, and behavioral support. The updated code descriptors remove outdated 'simple/intermediate/complex' terminology in favor of service level hierarchies that better reflect modern audiology practice.

Surgical and Interventional Updates

Notable additions include new Category I code 43889 for endoscopic sleeve gastroplasty (ESG), code 47384 for irreversible electroporation of the liver (replacing Category III code 0600T), and a comprehensive restructuring of thoracic endovascular aortic repair (TEVAR) coding. Catheter placement, radiologic supervision and interpretation, and all proximal extensions performed at the time of TEVAR are now bundled into the main procedure code.

Behavioral Health Telehealth Codes

Several existing behavioral health service codes have been added to CPT Appendices P and T, which list services recognized by the CPT Editorial Panel as correlating to in person services when delivered via audio video or audio only technologies. These additions increase flexibility in how behavioral health services are delivered, particularly in rural and underserved areas.

Proprietary Laboratory Analyses (PLA)

PLA codes account for approximately 27% of new codes in the 2026 cycle, representing the largest single category of additions. Practices that order or bill lab tests should confirm new PLA codes, ensure laboratories are aware of the changes, verify payer acceptance, and update ordering and billing workflows.

Sources: AMA CPT 2026 Code Set Release; American College of Surgeons Bulletin (January 2026); American College of Cardiology Coding Corner (December 2025); AAPC 2026 CPT Coding Updates

3. FY 2026 ICD 10 CM: 487 New Diagnosis Codes

The FY 2026 ICD 10 CM update, effective October 1, 2025, introduces 487 new diagnosis codes, 38 code revisions, and 28 code deletions. These changes reflect an ongoing effort to enhance coding specificity, improve clinical documentation, and align code structure with emerging healthcare trends and treatments.

Non Pressure Chronic Ulcers (Chapter 12)

This chapter features one of the most substantial updates, introducing over 100 new codes for non pressure chronic ulcers. These codes are now classified by anatomical site and depth/severity, requiring documentation of laterality, precise wound location, and ulcer depth for every encounter.

Abdominal, Pelvic, and Perineal Pain

FY 2026 introduces 16 new R codes designed to provide better specificity when reporting pain in these areas. R10.2 (Pelvic and perineal pain) has been converted into a parent code to support more granular reporting. Additionally, a new code R11.16 captures Cannabis Hyperemesis Syndrome, a condition marked by cyclic vomiting in chronic cannabis users.

Social Determinants of Health (Z Codes)

Reflecting CMS emphasis on social determinants of health, the FY 2026 update enhances the Z code family. Z59.86 becomes a parent code with new child codes related to financial insecurity. New Z77.3 series codes help identify patient exposure to war or conflict zones. Food allergy codes become more granular, with Z91.011 (Allergy to milk products) and Z91.012 (Allergy to eggs) expanding into parent codes with more detailed sub options.

Oncology Specificity

C50.A (Malignant inflammatory neoplasm of breast) becomes a parent code with specific options for inflammatory breast cancer. D71 expands to accommodate functional disorders of polymorphonuclear neutrophils. A new family of codes under Z15.06 now allows documentation of genetic susceptibility to malignant neoplasms of the digestive system, including colorectal cancers.

Neurology and Behavioral Health

New codes have been added for primary progressive apraxia of speech, multiple sclerosis subtypes, and muscular dystrophy variants, increasing diagnostic granularity for neurological conditions. Guideline revisions also clarify sequencing for hypertension with heart disease and chronic kidney disease.

Infectious Diseases: Chapter 1 of the ICD 10 CM Classification System

New codes address Demodex mite infestation with corresponding blepharitis codes. Updated guidelines also provide enhanced clarification for HIV sequencing, one of the most significant guideline changes in

the FY2026 cycle.

Injury and External Causes

The update includes a dozen codes to capture injuries to military personnel and civilians caused by war, civil insurrection, and peacekeeping missions, including codes for low level and high level blast overpressure injuries.

Sources: CMS FY 2026 ICD 10 CM Update (June 2025); CDC FY 2026 Official ICD 10 CM Coding Guidelines; Oncology Practice Management (September 2025); ACDIS (July 2025)

4. Critical Code Spotlight

The following code changes and guideline updates represent areas of heightened audit risk and revenue impact. Each requires targeted education, documentation updates, and workflow adjustments.

CPT 92137: Optical Coherence Tomography Angiography (OCTA)

Effective: January 1, 2025

CPT code 92137 was introduced in the 2025 code set to describe computerized ophthalmic diagnostic imaging of the retina, including OCT angiography (OCT A), with interpretation and report. This code replaced the previous practice of billing OCTA procedures under the standard OCT code (92134).

- The code requires both traditional OCT of the retina and OCT A to be performed and interpreted on the same day.
- 92137 cannot be billed at the same patient encounter as 92133 (OCT of the posterior segment) or 92134 (OCT of the retina).
- 92137 may be billed in combination with 92235 (Fluorescein angiography), 92240 (Indocyanine green angiography), or 92242 (Combined FA/ICG angiography).
- OCTA provides noninvasive, dye free imaging of retinal and choroidal vasculature. The code carries a higher reimbursement rate than standard OCT (92134).
- Because this code is relatively new, few Medicare Administrative Contractors have published detailed coverage policies. Practices should document medical necessity thoroughly and monitor payer acceptance closely.

Sources: AMA CPT 2025 Code Set; AAO FAQ on CPT 92137 (October 2025); Retinal Physician (December 2025)

ICD 10 CM E11.A: Type 2 Diabetes Mellitus in Remission

Effective: October 1, 2025

The FY 2026 update introduces code E11.A for Type 2 diabetes mellitus without complications, in remission. Prior to this update, no distinct code existed to capture diabetes remission status.

- Code assignment is based on provider documentation that diabetes mellitus is in remission.
- Documentation must align with clinical definitions for remission status, as recognized by the American Diabetes Association.
- This code allows practices to distinguish between active Type 2 diabetes management and patients whose diabetes has entered remission, improving clinical data accuracy and care tracking.
- Practices should update EHR templates to include remission status prompts for diabetic patients.

Sources: CMS FY 2026 ICD 10 CM Official Guidelines for Coding and Reporting; CDC FY 2026 Coding Guidelines

HIV Sequencing: Updated FY2026 Guidelines

Effective: October 1, 2025

The FY2026 ICD 10 CM guidelines include significant changes to HIV coding, particularly regarding how to sequence codes when HIV related conditions or comorbidities are present.

- Updated guidelines clarify when to use code B20 (HIV disease) versus code Z21 (asymptomatic HIV infection status).
- Proper sequencing of HIV related conditions and comorbidities is essential for accurate claims processing.
- Documentation errors in HIV sequencing are a known driver of claim rejections. Coders should review the updated guidelines carefully and update coding workflows.
- Training on the revised sequencing rules should be prioritized, particularly for practices with significant HIV patient populations.

Sources: CMS FY 2026 ICD 10 CM Official Guidelines for Coding and Reporting; CDC (July 2025)

5. Clinical Specificity: What Changed and Why It Matters

The FY 2026 ICD 10 CM update significantly increases specificity requirements across multiple clinical categories. Practices that fail to adapt their documentation will face increased denials and audit exposure.

Clinical Area	What Changed	Documentation Impact
Non Pressure Chronic Ulcers	100+ new codes classified by anatomical site and depth/severity	Must document laterality, precise wound location, and ulcer depth for every encounter
Abdominal / Pelvic Pain	16 new R codes; R10.2 converted to parent code for more granular reporting	Pain location, character, and associated symptoms must be explicitly documented
Hypertension with Heart Disease / CKD	Guideline revision clarifies sequencing for hypertension with heart disease and chronic kidney disease	Providers must clearly document causal relationships between conditions
Multiple Anatomical Sites	New guidelines define 'multiple' as 2 or more sites; must follow chapter specific instructions	Assign codes for each specified site individually when documented
Infectious Diseases	New codes for Demodex mite infestation with corresponding blepharitis codes	Specify organism and site for new infectious disease categories
HIV Coding	Enhanced guidelines for sequencing HIV with comorbidities; B20 vs Z21 clarification	Clear documentation of HIV status, related conditions, and treatment context required

Sources: CMS FY 2026 ICD 10 CM Code Updates; CDC FY 2026 Official Coding Guidelines

6. Telehealth and Digital Health: Permanent Policy Changes

CMS has transitioned COVID era telehealth flexibilities into permanent policy effective January 1, 2026, as finalized in the Calendar Year 2026 Medicare Physician Fee Schedule Final Rule, published October 31, 2025. The Consolidated Appropriations Act, 2026 (signed February 3, 2026) extended and permanently implemented additional Medicare telehealth flexibilities.

Virtual Direct Supervision: Now Permanent

Beginning January 1, 2026, supervising physicians and non physician practitioners (NPPs) may permanently meet the 'presence' and 'immediate availability' requirements of direct supervision through real time, two way audio and video communication technology. This policy permanently replaces the temporary COVID era flexibility that had been extended through December 31, 2025.

- Applies to incident to services covered under 42 CFR 410.26, diagnostic tests under 42 CFR 410.32, cardiac rehabilitation, intensive cardiac rehabilitation, and pulmonary rehabilitation services.
- The CY 2026 Hospital Outpatient Prospective Payment System Final Rule (November 21, 2025) also made virtual supervision permanent for Level 2 diagnostic tests in hospital outpatient settings.
- Services with a 010 or 090 global surgery indicator are excluded. These services continue to require in person supervision.
- The technology used for supervision must include both real time audio and real time video. Audio only communication does not satisfy the direct supervision requirement.
- Teaching physicians may now use real time two way audio and video to satisfy the presence requirement for resident furnished telehealth services from all training locations, not limited to rural areas.

Frequency Limits Permanently Removed

CMS permanently removed telehealth frequency limits on subsequent inpatient visits, nursing facility visits, and critical care consultations effective January 1, 2026. Practices can now bill these services via telehealth without encounter count restrictions.

Documentation Requirements for 2026 Audits

- Claims must document the consultation duration, modality utilized (audio only versus audio/video), and patient consent.
- Virtual supervision must be documented with evidence of real time, two way audio and video availability throughout the service.
- Teaching physicians must document virtual presence for resident supervised telehealth encounters.
- Incident to billing and split/shared services remain among the top audit targets by the Office of Inspector General (OIG).

Billing Location Changes

CMS is ending the temporary flexibility that allowed clinicians to bill using their enrolled practice address when delivering care from home or another alternate location. As clarified in the CMS Telehealth FAQ updated February 4, 2026, virtual only telehealth practitioners whose only physical practice location is their home address will need to enroll that home address as a practice location.

Sources: CY 2026 Medicare Physician Fee Schedule Final Rule (October 31, 2025); CY 2026 OPPS Final Rule (November 21, 2025); CMS Telehealth FAQ (February 26, 2026); Consolidated Appropriations Act, 2026

7. Behavioral Health and Telehealth Expansion

CPT Appendix Updates for Behavioral Health

Several existing behavioral health service codes have been added to CPT Appendices P and T, which list services recognized by the CPT Editorial Panel as correlating to in person services when delivered via audio video or audio only technologies. This increases flexibility in how behavioral health services are delivered, helping to overcome access barriers in rural, underserved, and geographically limited areas.

Digital Mental Health Treatment (DMHT) devices classified under 21 CFR 882.5801 and 882.5803 are supported with HCPCS codes G0552, G0553, and G0554 for device supply, onboarding, and treatment of individual symptoms as an adjunct to clinician supervised treatment.

In Person Visit Requirements

- Under Section 1834(m) of the Act, an in person, non telehealth visit is required within 12 months of each mental health telehealth service.
- The initial in person requirement of six months prior to the first mental health telehealth service becomes effective after December 31, 2027.
- These visits may be performed by a physician or practitioner of the same specialty within the same group practice if the telehealth furnishing clinician is not available.
- Beneficiaries who began receiving mental health telehealth services on or before December 31, 2027 are not subject to the six month prior in person requirement.

Sources: CY 2026 Medicare Physician Fee Schedule Final Rule; CMS Telehealth FAQ (February 26, 2026)

8. The "Gold Standard" Role Based Training Framework

To bridge the gap between clinical care and administrative billing, this playbook outlines an 8 step structured onboarding and training cycle designed to reduce ramp time from the typical 30 to 90 day window. Each step builds on the previous one, creating a progressive competency model that ensures staff are productive, compliant, and accurate.

01

Compliance Education

Pre training on HIPAA regulations, OIG exclusion list screening, and the legal implications of 'knowing' submissions under the False Claims Act. This step establishes the compliance foundation before any billing work begins, ensuring every team member understands the regulatory environment in which they operate.

02

Medical Terminology

Foundational instruction on body systems, anatomical terminology, and specialty specific language. This ensures new staff can accurately interpret clinical documentation and map it to appropriate code sets. Coverage includes common abbreviations, diagnostic terminology, and procedure naming conventions.

03

Software Proficiency

Hands on training for EHR data mapping, practice management system navigation, and charge capture workflows. Staff learn how clinical documentation flows into the billing pipeline, where errors commonly occur, and how to use system tools to prevent them.

04

Role Specific Training

Tailored modules based on functional responsibility: charge capture, claim generation, payment posting, accounts receivable follow up, or denial management. Each role receives instruction specific to its place in the revenue cycle, with measurable competency benchmarks.

05

Practice Scenarios

Simulated exercises including eligibility verification, claim scrubbing, denial resolution, and payer specific requirements in a sandbox environment. Staff learn to identify and correct errors before they reach production workflows, building pattern recognition and decision making skills.

06

Shadowing

Supervised observation of experienced staff during live billing operations. New team members witness real time decision making, payer interactions, and the application of coding guidelines in actual practice settings. This bridges the gap between theoretical knowledge and practical application.

07

Gradual Independence

Independent throughput with structured quality spot checks and performance reviews. Supervisors monitor accuracy rates, turnaround times, and compliance adherence while progressively reducing oversight as competency is demonstrated through measurable outcomes.

08

Continuous Development

Quarterly deep dives on payer bulletins, CMS updates, and coding guideline changes. Annual recertification ensures staff remain current with evolving standards. This step also includes review of denial trends, root cause analysis, and process improvement cycles.

9. Compliance and Audit Readiness for 2026

The 2026 code updates carry direct implications for compliance. Outdated codes, missing documentation, and improper sequencing will trigger denials, payment retractions, and potential audit penalties. The following actions should be completed before each effective date.

Update Encoder and EHR Systems

Import all new, revised, and deleted codes for both CPT 2026 and ICD 10 CM FY2026. Verify that claims editing rules reflect the updated definitions before processing any 2026 encounters. Confirm that deleted codes trigger system alerts to prevent accidental use.

Validate Payer Fee Schedules

Confirm that major payers recognize and reimburse new codes. Payer acceptance may lag behind CMS publication. Contact payers directly to clarify documentation requirements, particularly for new remote monitoring, hearing device, and AI related codes.

Audit High Volume Services

Perform internal audits of high volume services impacted by 2026 updates. Use denial trend analysis to identify coding patterns that need correction and focus education efforts where errors concentrate. Priority areas include non pressure ulcers, abdominal pain, HIV sequencing, and lower extremity revascularization.

Update Charge Masters and Crosswalks

Review charge masters to replace deleted CPT codes with their 2026 successors. Update internal crosswalks so that legacy code references are eliminated from all billing workflows. Pay particular attention to the 46 new lower extremity revascularization codes and the 12 new hearing device service codes.

Train Providers on Documentation

Ensure clinicians understand the increased specificity requirements. Priority training topics include non pressure ulcer documentation (laterality, depth, site), diabetes remission (E11.A), HIV sequencing rules, abdominal/pelvic pain granularity, and telehealth documentation (modality, duration, consent).

Monitor Early Billing Data

After implementation, review early claims data to identify trends tied to new codes. Share common documentation issues with coding teams and refine EHR templates accordingly. Conduct follow up audits within 60 days of each effective date.

10. Implementation Checklist

Use this checklist to track your organization's readiness for the 2026 code cycle. Each item should be assigned an owner and a completion deadline.

- [ ] Import FY 2026 ICD 10 CM code files (effective October 1, 2025) into all billing and EHR systems
- [ ] Import CPT 2026 code files (effective January 1, 2026) and update encoder logic and charge masters
- [ ] Identify and retire all deleted CPT codes (84 deletions) and ICD 10 CM codes (28 deletions) from active workflows
- [ ] Map legacy lower extremity revascularization codes (37220 through 37235) to the 46 new replacement codes
- [ ] Update telehealth documentation templates to include modality, duration, patient consent, and supervision method
- [ ] Enroll any virtual only practitioner home addresses as practice locations per updated CMS requirements
- [ ] Conduct provider education sessions on diabetes remission (E11.A), HIV sequencing, and non pressure ulcer specificity
- [ ] Validate payer acceptance of new CPT codes, especially remote monitoring and hearing device service codes
- [ ] Schedule internal audits of high volume services within 60 days of each effective date
- [ ] Implement quarterly training cadence aligned with payer bulletin releases and CMS guideline updates
- [ ] Review and update compliance policies to reflect permanent virtual direct supervision rules
- [ ] Update EHR templates with remission status prompts, pain specificity fields, and ulcer documentation requirements
- [ ] Brief clinical leadership on the Consolidated Appropriations Act, 2026 telehealth provisions
- [ ] Establish a monitoring dashboard for denial rates on new and revised codes during the first 90 days

Navigate 2026 with Confidence

Harris CareTracker equips your practice with the tools, training, and compliance framework to thrive through every code cycle update.

Contact your Harris CareTracker representative to schedule a personalized walkthrough.

855-528-4357 | sales@harriscaretracker.com