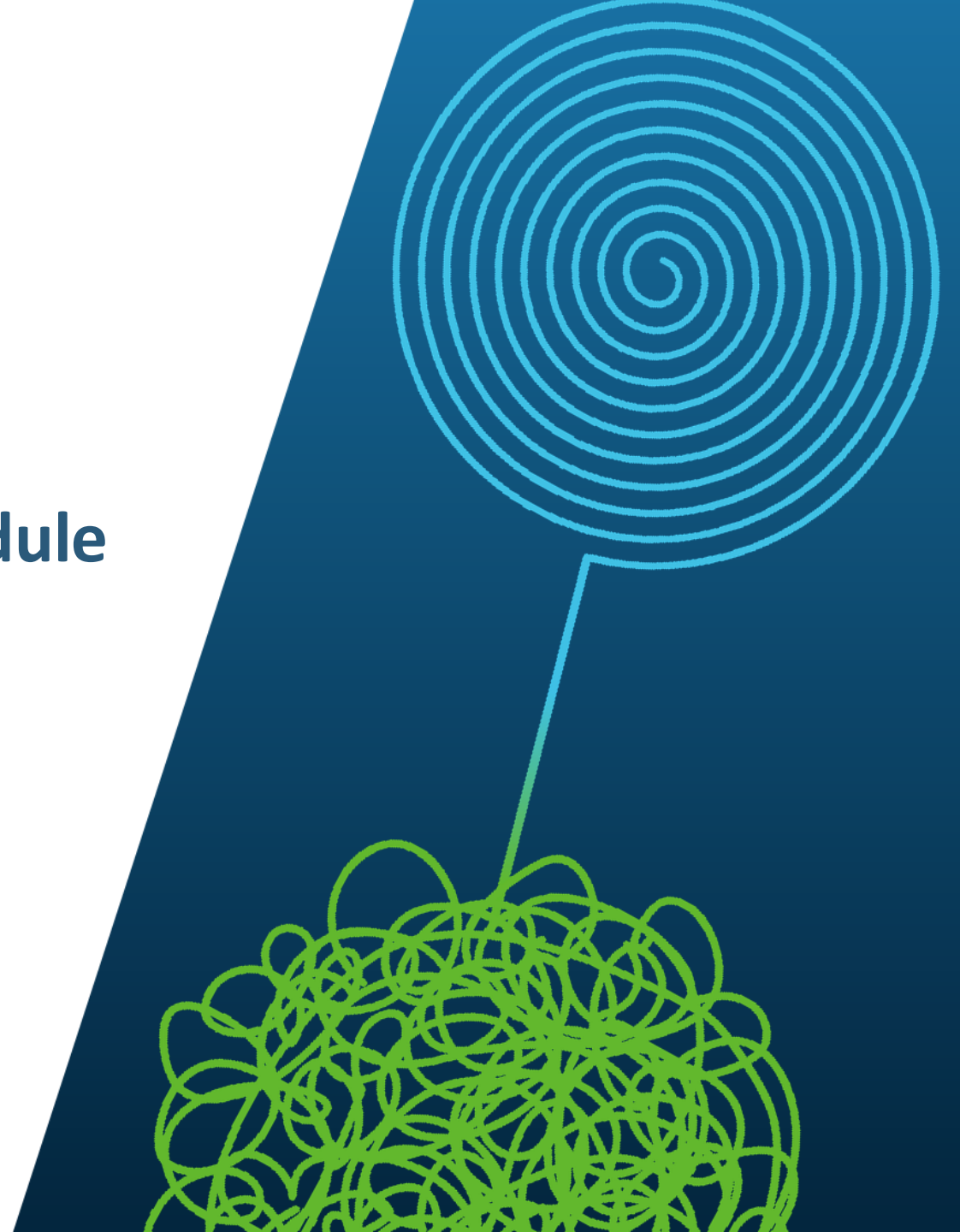
Healthcare Regulatory Roundup #106

2026 Medicare Physician Fee Schedule Final Rule – *Part 2*

December 10, 2025



Introductions

Martie Ross

Principal

mross@pyapc.com

Valerie Rock

Principal

vrock@pyapc.com

PYA

pyapc.com

800.270.9629

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Agenda

2026 Medicare Physician Fee Schedule Final Rule
Parts 1 and 2

Today – Part 2

1. Telehealth Changes
2. Global Payments Reforms
3. Skin Substitutes
4. Care Management
5. Prevention and Wellness

Part 1 (December 3)

On-demand at pyapc.com

1. 2026 Payment Rate/Conversion Factor
2. Efficiency Adjustment
3. Practice Expense Methodology
4. Merit-Based Incentive Payment System (MIPS)
5. Ambulatory Specialty Model
6. Medicare Shared Savings Program (MSSP)

1. Telehealth Changes

Medicare Telehealth Coverage: January 30 Cliff

- Medicare covers tele-behavioral health services furnished to beneficiary at home on permanent basis
  - May be billed by physicians, practitioners, Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs)
  - Effective 1/31/2026 must have:
    - Face-to-face visit within 6 months of initiating telehealth services, and (2); ***and***
    - Face-to-face visit once every 12 months following initiation of tele-behavioral health services (with certain exceptions).
- Effective 1/31/2026:
  - Medical telehealth services covered only if patient physically present at facility in rural area at time of service
  - PTs, OTs, and SPLs cannot bill Medicare for telehealth services furnished in any setting
- Through 1/30/2026:
  - Those medical telehealth services CMS previously identified as covered when using audio-only platform will be covered (except CPT 99441-99443)
- Going forward, any telehealth service will be covered when furnished audio-only if:
  - Beneficiary is at home when service provided;
  - Practitioner is capable of audio-video connection; ***and***
  - Beneficiary cannot or does not want to connect by video.

Streamlined Review Process for Telehealth Services

- Simplifying the process for adding services to the **Medicare Telehealth Services List**:
  - Reduces the evaluation from 5 steps to 3 and focuses on whether services are separately payable, subject to telehealth provisions, and feasible via interactive technology
    - Is the service separately payable under PFS?
    - Is the service subject to 1834(m)?
      - Meets the definition of telehealth; a substitute for an in-person encounter as opposed to a remote service
      - Involves the services of the physician or APP
    - Are one or more of the elements of the HCPCS code descriptions capable of being provided via interactive telecommunication per 42 CFR § 410.78(a)(3)?
  - Eliminates the "provisional" status—approved codes will be **considered permanent**, though CMS retains removal authority
  - **Submit codes for consideration for 2027 by February 10, 2026.**

Code Changes

- **Added** to Telehealth List:
  - 90849 (Multiple family group psychotherapy)
  - G0473 (Group behavioral counseling)
  - G0545 (Inherent complexity, inpatient/obs visit, confirmed infectious disease by ID specialist)
  - 92622 & 92623 (Auditory osseointegrated sound processor programming)

- **Not Added**:
  - Dialysis codes (90935–90947), INR monitoring code G0248, AMA's Telemedicine E/M codes (98000–98015) due to the code's clinical feasibility of providing the entire service via telehealth, is a technical code, or is not covered, respectively.
  - **UPDATE:** CMS **did not delete** HCPCS code **G0136** (SDOH risk assessment) **nor did they remove it from the list**; considers the services accounted for in current codes.

Removal of Frequency Limitations

- Finalized proposal to **permanently removing frequency limits** for:

Subsequent inpatient visits (**99231–99233**)	Subsequent nursing facility visits (**99307–99310**)	Critical care consults (**G0508 & G0509**)

Expansion of Virtual Direct Supervision

- **Permanent allowance** of real-time audio-video supervision for incident to services, adopting the definition of "immediate availability" to include using A/V real-time communication (audio-only is excluded)
- **Excluding** those with global surgery indicators **010** and **090**
- **Includes:**
  - Incident-to services (§ 410.26)
  - Diagnostic tests (§ 410.32)
  - Pulmonary rehabilitation services (§ 410.47)
  - Cardiac rehabilitation and intensive cardiac rehabilitation services (§ 410.49)
  - Certain hospital outpatient services as provided at § 410.27(a)(1)(iv)

Teaching Physician Virtual Supervision

- Clarified there are no changes to supervision requirements, including E/M – requires presence during the portion of the service that determines the level of service billed (telehealth or in person)
- CMS Finalized – 180 from proposed:
  - Allowing teaching physicians to have a virtual presence for purposes of billing for virtual services furnished involving residents in all teaching settings when it is a 3-way telehealth visit
    - Patient, resident, and teaching physician in different locations
    - Document whether the teaching physician was physically present or present via AV technology for the telehealth service; include which portion of the visit

Telehealth: FQHCs and RHCs

- **Reminder**: CMS permanently allows FQHCs/RHCs to provide mental health visits via telehealth (2022 PFS).
  - Telehealth eligibility requires prior and subsequent in-person visits.
  - 2025 PFS delayed in-person visit requirements through end of 2025.
  - Future changes will align with federal waivers, currently effective through January 30, 2026.
- **One-year extension** to bill for **non-behavioral health visits (or medical visit services)** via telehealth (including audio-only).
  - Continue using **G2025** through **December 31, 2026**.
  - CMS solicited feedback on paying at PPS/AIR rates.
  - However, it will maintain the use of the G2025 paid at the weighted average of all services on the telehealth list.

Telehealth: Enrollment

- **No extension** for allowing distant site providers to use their enrolled practice address instead of home address when providing services from their home.
  - See FAQ for suppression of street address details:
    - "A doctor or clinician may need to enroll their home address as a practice location but prefer their personal contact information not be publicly reported. Doctors and clinicians can either mark the address as a "Home office for administrative/telehealth use only" location in the Provider Enrollment, Chain, and Ownership System (PECOS), which will suppress street address details, or email the QPP Service Center to suppress the street address and/or phone number. In such cases, CMS maintains city, state, and zip code information so that doctors and clinicians can still be included in searches and have their performance information reported.
    - CMS may also suppress street addresses when there's a safety concern related to a clinician's practice location information being publicly available."

https://www.cms.gov/medicare/quality/physician-compare-initiative

2. Global Payments Reforms

Global Surgical Package

- No immediate changes:
  - CMS did not finalize changes to the valuation of global surgical packages for CY 2026
- **Request for public input:**
  - What next steps can CMS take to improve the accuracy of payment for global surgical packages?
  - Should or how should CMS revise the portion of the global surgery package relative value unit (RVU) attributed to the surgical procedure?
  - What should the procedure shares be based on when the transfer of care modifier(s) are applied for the 90-day global packages?
  - What are the current practice standards related to the division of work between surgeons and providers of post-operative care?

Reminder: 2025 Changes

- **Modifier -54** (surgical care only) reporting expanded in **CY 2025 PFS Final Rule**.
  - Now required whenever surgeon does not intend to provide post-op care, formal and informal agreements.
- **New add-on code G0559** finalized for CY 2025.
  - Used when post-op care is provided by a different practitioner/group.
  - Added to the E/M code performed and billed.
- **Improving global package valuation**
  - CMS views expanded use of **transfer of care modifiers** as a first step in refining global surgical payment accuracy.
  - Exploring ways to **allocate payment shares** when care is split between providers.

Three Proposed Approaches

Approach 1

Subtract Assumed Post-Op Work RVUs

- Uses Physician Time File to subtract wRVUs for assumed post-op visits from total global package RVUs.

Approach 2

Claims-Based Post-Op Visit Counts

- Uses **actual post-op visits** reported via CPT code **99024**.
- Multiplies median visit count by average valuation per visit.
- **CMS prefers this approach** for its accuracy and transparency.

Approach 3

Time-Based Ratio

- Calculates procedure RVUs using **physician time** data.
- Uses ratio of time spent in post-operative visits to total physician time.

Current Procedure Share Assumptions

- Modifier -54 assigns surgeons a **fixed share** of global package valuation:
  - ~79–81% for about half of the 90-day globals
  - ~90% for most of the 10-day globals
- Key findings from 2023 data:
  - Current assumptions **underestimate** surgeon workload:
    - Only **28% of 90-day** and **2% of 10-day** assumed post-op visits were actually provided.
  - **Claims-based approach (Approach 2)** yields higher, more accurate procedure shares:
    - Average share would rise from **82% to 91%**.
    - 85% of procedures would see increased shares.
- Findings support revising procedure shares to reflect **real-world care patterns**.

3. Skin Substitutes

Skin Substitutes Overview

- **CPT Codes 15271–15278:**
  - Describe application based on **wound size** and **anatomical location**.
  - Normally supplies in the non-facility setting are bundled; however, most of these products have been considered biologicals and paid separately under the ASP plus 6% payment methodology, historically.
- National standardized payment methodology for skin substitutes, replacing the current product-specific approach.
  - CMS cites explosive growth in spending—from **$250 million to over $10 billion** in five years—while the number of patients only doubled.
  - Skin substitutes are already on the OIG Work Plan.

Proposed Local Coverage Determination (LCD)

- Released April 25, 2024
- Collaboratively developed by the MACs
- L36377, titled: Skin Substitute Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers[1]
- All MACs have delayed implementation to January 1, 2026

1. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=36377&ver=19

Skin Substitute Payment Overhaul

- Single Rate Across Settings: **A uniform rate of approximately $127.14 per cm^2 will apply to all designated HCPCS supply codes paid across physician offices and outpatient departments**
  - Estimated savings: $9.4 billion
  - Rates to be based on the latest quarter hospital outpatient rates and utilization patterns
  - Proposed fee is a volume-weighted average of one of the FDA categories: 361 HCT/P
  - **See corrections of final rule here: https://public-inspection.federalregister.gov/2025-21458.pdf?utm_campaign=pi+subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov**

FDA-Based Grouping

- Covered sheet products are grouped into three categories based on FDA regulatory pathways:
  - Premarket-approved (PMA)
  - 510(k)-cleared or De Novo pathway devices
  - 361 HCT/Ps (Human Cell, Tissue, and Cellular/Tissue-Based Products)
- Products (biologicals) licensed under **Section 351** will continue to be reimbursed under the **ASP methodology**.
- Products not in sheet form to be paid as incident-to supplies; priced by MACs.

Skin Substitutes to Be Paid as Incident-To Supplies

- These three categories of covered sheet skin substitutes are no longer be paid under section 1847A.
- ASP reporting for skin substitute manufacturers now **voluntary**
- CPT codes 15271 through 15278 would be billed with the current HCPCS supply code and paid as incident-to supplies in the non-facility setting
- The skin substitute product codes are being converted to add-on codes (with indicator ZZZ)

Action Steps

1. Assess the products utilized and their FDA category.
2. Evaluate supplier contracts, financial impact, and adjust clinical protocols.
3. Review charges to determine if any changes need to be made.
4. Educate staff on documentation requirements for coverage and billing changes.

4. Care Management

Advanced Primary Care Management Services (APCM)

- APCM includes current codes:
  - **G0556** – APCM for patients with one or no chronic conditions
  - **G0557** – APCM for patients with two or more chronic conditions
  - **G0558** – APCM for patients with two or more chronic conditions and who are QMBs
- Behavioral Health Integration (BHI) add-on codes for APCM:
  - **GPCM1** – Initial psychiatric collaborative care management (CoCM)
  - **GPCM2** – Subsequent psychiatric collaborative care management (CoCM)
  - **GPCM3** – Care management for behavioral health conditions (BHI)
- Neither APCM nor add-on codes have minimum time requirements.
- Services can be delivered by billing practitioner or clinical staff under general supervision of billing practitioner.
- Separate consent is required for APCM and for BHI services.

BHI Add-On Codes for APCM

HCPCS Code	CPT Code (time required)	Description	Primary Care Team	Service Components
GPCM1	99492 (*70 min*) 99494 (*30 add'l min*)	Initial Psychiatric CoCM, in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional	• Treating provider • BH Care Manager • Patient • Psychiatric Consultant	• Initial assessment • Joint care planning • Ongoing follow-up • Weekly systemic case review
GPCM2	99493 (*60 min*) 99494 (*30 add'l min*)	Subsequent Psychiatric CoCM, in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional		
GPCM3	99484 (*at least 20 min*)	Care management services for behavioral health conditions, directed by a physician or other qualified health care professional, per calendar month	Same as above but **excludes** the psychiatric consultant	same as above but **excludes** weekly systemic case review

Remote Physiological Monitoring (RPM)

CPT Code	Short Description	Proposed Fee Structure
99453	Patient education and device set-up	No changes in work or PE RVU for CY 2026
99445 (NEW)	Data transmission – remote monitoring of physiologic parameters; **2-15 days in a 30-day period**	CY2026 OPPS GMC for 99454 divided by CY 2026 PFS conversion factor (non-qualifying) 1.42 RVUs (currently 1.33)
99454	Data transmission – remote monitoring of physiologic parameters; **16-30 days in a 30-day period**	
99091	Collection and interpretation of physiologic data by the physician and/or other QHP, minimum of 30 minutes each 30 days	No changes in work or PE RVU for CY 2026
99470 (NEW)	RPM treatment management services by clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; **first 10 minutes**	50% of 99457 RVU
99457	RPM treatment management services by clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; **first 20 minutes**	No changes in work or PE RVU for CY 2026
99458	RPM treatment management services by clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; **each additional 20 minutes**	No changes in work or PE RVU for CY 2026

Remote Therapeutic Monitoring (RTM)

CPT Code	Short Description	Proposed Payment Structure
98975	Patient education and device set-up	No changes for CY 2026
98984 (NEW)	Data transmission – RTM of respiratory system; **2-15 days in a 30-day period**	Contractor priced – an approach used for 98978 in 2025
98976	Data transmission – RTM of respiratory system; **16-30 days in a 30-day period**	Contractor priced – an approach used for 98978 in 2025
98985 (NEW)	Data transmission – RTM of musculoskeletal system; **2-15 days in a 30-day period**	CY2026 OPPS GMC for 99454 divided by CY 2026 MPFS conversion factor (non-qualifying) 1.2 RVUs (currently 1.33)
98977	Data transmission – RTM of musculoskeletal system; **16-30 days in a 30-day period**	
98986 (NEW)	Data transmission – RTM of cognitive behavioral therapy; **2-15 days in a 30-day period**	Contractor priced
98978	Data transmission – RTM of cognitive behavioral therapy; **16-30 days in a 30-day period**	Contractor priced

RTM (*cont.*)

CPT Code	Short Description	Proposed Payment Structure
98979 (NEW)	RTM treatment services, physician or other qualified healthcare professional time in a calendar month requiring at least one real-time interactive communication with the patient or caregiver during the calendar month; **first 10 minutes**	50% of 98980 RVU
98980	RPM treatment management services by clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; **first 20 minutes**	No changes for CY 2026
98981	RPM treatment management services by clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; **each additional 20 minutes**	No changes for CY 2026

FQHC/RHC Billing

- Effective 1/1/2026, FQHCs and RHCs no longer bill G0512 for CoCM services; bill individual CPT codes that comprise G0512
  - **99492** – Initial psychiatric CoCM (first month, 70 minutes)
  - **99493** – Subsequent psychiatric CoCM (60 minutes)
  - **99494** – Add-on code for additional 30 minutes
- Effective 1/1/2026, FQHCs and RHCs no longer bill G0071 for communication technology-based services; bill individual CPT codes that comprise G0071
  - **G2010/G2250** – Remote evaluation of recorded video and/or images submitted by established patient (store-and-forward), including interpretation with follow-up within 24 business hours
  - **98016** – Brief, patient-initiated audio-only communication (5–10 minutes) between qualified healthcare provider and established patient

Social Determinants of Health (SDOH) Screenings

- Use term **upstream drivers** of health in place of SDOH
  - Upstream drivers, e.g., smoking, low physical activity, substance misuse, in addition to environmental drivers
- Revise HCPCS code G0136 from administration of a standardized, evidence-based ***social determinants of health risk assessment tool*** to administration of a standardized, evidence-based ***assessment of physical activity and nutrition***
  - Time remains 5-15 minutes, not more often than every 6 months
  - CMS had proposed deleting code because resource costs already accounted for in existing codes
  - "return to more clinically salient areas of risk assessment"
  - Evidence-based tools
    - Nutrition: Mini-EAT tool, Starting the Conversation: Diet tool, Short Dietary Assessment Instruments,
    - Physical activity: Physical Activity Vital Sign tool, CHAMPS Physician Activity Questionnaire for Older Adults, Rapid Assessment of Physical Activity (RAPA), Telephone Assessment of Physical Activity (TAPA)

Community Health Integration and Principal Illness Navigation

- May be personally performed and billed by clinical social workers, marriage and family therapists, and mental health counselors enrolled in Medicare program
  - May also be furnished by auxiliary staff under general supervision of billing practitioner
    - Clinical staff, e.g., RNs and social workers
    - Non-clinical staff (e.g., community health worker, patient navigator, peer specialist), but only if meet applicable state certification requirements or receive appropriate training
- CPT 90791 (psychiatric diagnostic evaluation) and CPT 96156, 96158, 96159, 96164, 96165, 96167, and 96168 (health behavior assessment and intervention services) may serve as initiating visit for provider that cannot bill E/M codes

Advancing Chronic Care with Effective, Scalable Solutions

- CMS Innovation Center announced **new voluntary alternative payment model** on December 1.
- ACCESS tests Outcome-Aligned Payments (OAPs), recurring payments made to Part B-enrolled entity for managing patients' qualifying conditions, with full payment tied to achieving measurable health outcomes:
  - Clinicians who co-manage ACCESS beneficiaries with ACCESS participant may bill new ACCESS Model Co-Management service for documented review of ACCESS updates and care coordination activities
  - Waivers of co-payments and deductibles

- Four tracks:
  1. Early cardio-kidney-metabolic conditions: hypertension, dyslipidemia, obesity or overweight with marker of central obesity, and prediabetes
  2. Cardio-kidney-metabolic conditions: diabetes, chronic kidney disease, and atherosclerotic cardiovascular disease (including heart disease)
  3. Musculoskeletal conditions: chronic musculoskeletal pain
  4. Behavioral health conditions: depression and anxiety
- **Apply by April 1, 2026 for July 1, 2026 start date.**

5. Prevention and Wellness

Medicare Diabetes Prevention Program (MDPP)

- Eligibility limited to beneficiaries at risk of developing Type 2 diabetes.
  - One of the following within 12 months before attending first core session:
    - Hemoglobin A1c test result between 5.7% and 6.4%
    - Fasting plasma glucose of 110-125mg/dL
    - 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerant test)
  - BMI of 25 or more (BMI of 23 or more for Asian beneficiares).
  - Never been diagnosed with ESRD or type 1 or type 2 diabetes
  - No prior MDPP participation
- MDPP suppliers must separately enroll in Medicare + have CDC preliminary/full recognition.
- 1-hour group sessions furnished by trained lifestyle coach using CDC-approved curriculum.
  - 16 weekly core sessions
  - 6 monthly follow-up sessions

https://www.cdc.gov/diabetes-prevention/php/program-provider/program-requirements.html

MDPP Limited Participation

- As of March 2025, only 331 Medicare-enrolled MDPP suppliers
- Over 8 years, only 9,000 participants (split evenly between traditional Medicare and MA)
  - Per AMA, about 50% of all Medicare beneficiaries have prediabetes (in addition to about 27% having diabetes).
- Recent efforts to expand participation:
  - During COVID-19, permit live, virtual delivery in compliance with CDC requirements for *distance learning* sessions:
    - Now extended through 2027.
    - May use remote monitoring or date-stamped photo(s) showing weight on digital scale + beneficiary present in home to meet baseline and performance achievement weight measurement requirements.
    - Supplier must maintain capability to deliver in-person services.
  - In 2024, simplified payment structure:
    - Fee-for-service reimbursement for beneficiary attendance at sessions.
    - Performance-based payments tied to beneficiary weight loss.

MDPP Current Reimbursement

HCPCS G-Code	Payment Description	Payment
G9886*	Behavioral counseling for diabetes prevention, in-person, group, 60 minutes	$26
G9887*	Behavioral counseling for diabetes prevention, distance learning, 60 minutes	$26
	Subtotal Maximum Attendance-Based Payment (22 Sessions)	**$572**
G9880	5 percent weight loss (WL) achieved from baseline weight	$149
G9881	9 percent WL achieved from baseline weight	$26
G9888**	Maintenance 5 percent WL from baseline in months 7-12	$8
	Total Maximum Payment	**$755**

- MDPP supplier may offer in-kind incentives with reasonable connection to approved curriculum during MDPP services period.
- Cost of incentives cannot be shifted to beneficiary or another Federal health care program.
- Must maintain documentation of incentives that individually exceed $25 in retail value; incentives involving technology may not, in aggregate, exceed $1,000 in retail value for any one beneficiary.

MDPP Changes

- Extend virtual option through 2029
  - Eliminate requirement that supplier must have capacity to deliver in-person services
- Add asynchronous delivery modality (online sessions) through 2029
  - MDPP supplier requirements
    - Obtain online organization code from CDC prior to delivering online sessions
    - Adhere to CDC standards regarding program format, coach interaction, program intensity and duration
      - Live (not AI) coach-beneficiary interaction for each session (includes bi-directional emails and texts)
    - Ensure beneficiaries engage with content (documented completion of sessions, knowledge checks, contribution to discussion boards)
  - G9871 pays $18/session (vs. $26 for in-person and distance learning); same performance achievement payments
  - Cannot combine asynchronous with live sessions (in-person or distance learning)
    - Except permitted make-up sessions for in-person/distance learning patients may be delivered asynchronous
- Expand options for recording weight measurements
  - Permit photos from home + other reasonable locations outside in-person delivery site (maintain date-stamp requirement)
  - As alternative to photos, submit medical record documentation of weight taken within 5 business days of session

MDPP Payment Structure

TABLE B-E1: MEDICARE DIABETES PREVENTION PROGRAM (MDPP) EXPANDED MODEL CALENDAR YEAR (CY) 2026 ONLINE PAYMENT STRUCTURE

HCPCS G-Code	Payment Description*	CY 2026
G9871	Behavioral counseling for diabetes prevention, online, 60 minutes	$18
G9880	5 percent WL Achieved from baseline weight	$153
G9881	9 percent WL Achieved from baseline weight	$ 27
G9888	Maintenance 5 percent WL from baseline in months 7-12	$8

Note: Medicare pays up to 22 sessions. Online sessions billed with code G9871cannot be combined with G9886 or G9887, in a 12-month period:
Months 1-6: one Online session every week (up to 16)
Months 7-12: one Online session every month (up to 6)
Months 7-12, once participant achieves 5 percent WL, suppliers delivering the Set of MDPP services Online may submit Maintenance of 5 percent WL claim with attendance claim (G9888 + G9871). Medicare will pay for Maintenance 5 percent WL up to 6 times in months 7-12.

Digital Mental Health Treatment (DMHT)

- New reimbursement in 2025 for physicians + practitioners authorized to deliver services for diagnosis and treatment of behavioral health conditions:
  - **G0552** – supply of DMHT device + onboarding and education to augment behavioral health treatment plan (contractor priced)
  - **G0553** – first 20 minutes of monthly treatment management services directly related to use of device, requiring at least one interactive communication with beneficiary/caregiver
  - **G0554** – additional 20 minutes
- Current conditions of payment:
  - Furnished incident to billing practitioner's plan of care for behavioral health treatment
  - Billing practitioner must incur cost of device furnished to beneficiary
  - Device must have been cleared under FD&C Act section 510(k) or granted De Novo authorization by FDA + classified at 882.5801 (psychiatric disorders)
- Expand coverage to include devices classified at 882.5803 (ADHD)

Our Next Healthcare Regulatory Roundup Webinar

January 14, 2026; 11 am – 12 pm ET

Healthcare Regulatory Roundup #107:

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