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The Health Alliance
OF MIDAMERICA

PAYER PULSE

INSIDE THIS ISSUE

Join the Payer Pulse

Do you have colleagues in your organization who want to be added to the Alliance's distribution list for this newsletter? We would love to have them!

Contact Brett Moorehouse at brett.moorehouse@allianceweb.org to be added to the distribution list.

Get the Most Out of Your Newsletter

Checkboxes depict action steps to help assess whether a policy impacts your organization

Important details or nuances may be emphasized with an exclamation mark to draw your attention to a key concept

Article titles will include hyperlinks to payer policies when they are publicly accessible

Look for alerts that highlight policies which may warrant consideration for communicating an objection to the health plan

2 Suggested Action Items From This Issue

- Monitor Blue KC claims' prompt payment on high dollar claims subject to prepayment review.
- Determine if you have claims with more than one unit of C1776 billed to Blue KC per claim that may be impacted by Blue KC's 1-unit per case limit. If so, determine if additional unit(s) should be reported with anchor, screw, or other device codes instead (e.g. C1713, C1741). Ensure implant is billed on the same claim as the procedure.
- Consider a claim edit to append medical records to a claim if payer is Blue KC and more than one unit of C1776 is reported.
- Ensure Blue KC dialysis claims billed with 90999 include the appropriate URR modifier to avoid denials and resubmission requirements beginning July 1, 2026. Consider adding edits when payer is Blue KC, code is 90999, and G1 - G6 are not on the line item.
- Blue KC laboratory ordering and claim submission practices to ensure modifiers and diagnosis codes support medical necessity and align with applicable laboratory medical policies, as inaccurate or incomplete information may result in claim denials and reimbursement delays.
- Consider implementing an edit when payer is Healthy Blue, and an E/M is on the claim with a procedure designated as an "XXX" global period, when the E/M doesn't have a modifier 25. Consider suspending claim submission for manual review for appropriate potential addition of modifier -25.
- Monitor Healthy Blue prompt payment on claims with an E/M and procedure designated as "XXX" global. Healthy Blue indicates it will will review claims billed with modifier 25, but those reviews should not obviate prompt payment obligations.
- Review MO HealthNet provider enrollment records and eMOMED account information to ensure revalidation notices are received and required off-cycle revalidation steps are completed within designated timelines to avoid administrative action or provider termination.
- Consider claim edits to capture Healthy Blue services exceeding identifed maximum units per day to auto-attach medical record documentation to claims.
- Consider claim edit to auto-attach medical records for inpatient claims with a sepsis diagnosis billed to Healthy Blue. Monitor prompt payment.
- Consider a claim edit to capture consultation codes billed to Missouri Medicaid. Develop crosswalk to non-consultation E/M codes for billing.
- Upon receipt of a UPIC audit, consider validating claims requested are within permitted lookback period and assessing volume of requested records. Look for applicable objections to audit type or scope to communicate early to reviewer.
- Ensure Medicare CAH Method II billing processes capture rendering NPIs at the line level for outpatient services by the June 29, 2026 effective date.
- Determine if Aetna's participation criteria create operational challenges for appointment times in urgent care, symptomatic visits, and preventive visits. Evaluate if new standards conflict with express terms in your contract. If so, consider a formal communication to Aetna under the policy objection provisions of your agreement.
- Review telehealth billing processes to ensure RHC and FQHC claims for dates of service on or after October 1, 2026 no longer use HCPCS code G2025 and instead report the appropriate individual CPT/HCPCS code.
- Review Kansas Medicaid maternity billing workflows to ensure pregnancies spanning 2026 and 2027 are appropriately unbundled, antepartum services are billed based on the number of prenatal visits, and delivery-only CPT codes are reported when postpartum care extends into 2027.
- Determine if you have any outstanding checks from Medicare. If they remain outstanding, contact WPS for a replacement check.

WPS, Aetna

Outstanding Citibank Checks

WPS announced that it changed banks from Citibank to U.S. Bank effective February 17, 2026. Providers should ensure that any checks issued from the previous Citibank account on or before February 17, 2026, are deposited before the Citibank account closes on June 30, 2026.

After that date, any outstanding Citibank-issued checks will become invalid. WPS stated replacement checks will be reissued from the U.S. Bank account during the week of July 13, 2026, and impacted providers will receive written notification cross-referencing the voided Citibank check number and replacement U.S. Bank check number.

Network Participation Criteria Updates

Aetna revised its Network Participation Criteria. Key changes include:

- Urgent care appointments changed from immediately to same day or within 24 hours
- Symptomatic appointments reduced from 7 days to 3 days
- Routine/preventive appointments reduced from 30 days to 7 days
- Follow-up appointments now expected within 2 weeks instead of "as needed"
- Removal of the requirement that hospitals maintain an RN or master's-level behavioral health professional on staff 24/7

Blue Cross

Enhanced Prepay Review for High-Dollar Claims

Effective July 1, 2026, Blue KC implemented additional audit steps as part of its in-depth prepay review process for claims with allowed amounts of $1 million or more.

To support this review, Blue KC will require submission of medical records and/or itemized bills for these high-dollar claims.

Implanted Prosthetic Device Billing Update

Effective June 1, 2026, Blue KC updated billing requirements for CPT/HCPCS code C1776, limiting coverage to one (1) unit per surgical encounter. This code applies only to the implanted prosthetic device used during joint replacement procedures.

Blue KC also clarified that anchors and screws used for bone fixation or soft tissue attachment may be billed separately using C1713 and C1741. The implanted device must be billed on the same claim as the related surgical procedure.

If more than one unit of C1776 is reported, medical records must be submitted to support medical necessity for review and determination. Documentation must clearly support the implanted device and be consistent with CMS and Coding Clinic guidance.

GAP Fill Fee Schedule Improvements

Blue KC announced updates to the format of its GAP Fill Fee Schedule available through the provider portal. Recent improvements include:

- Addition of a column identifying Facility vs. Non-Facility allowable pricing
- Inclusion of the effective date in the downloaded file name

Blue KC stated these changes were implemented in response to provider feedback.

Tips for Independent Laboratory Claims

Why is Blue KC seeing an increase in laboratory claim denials?
Blue KC stated denials on independent laboratory claims are primarily related to:

- Missing, invalid, incorrect, or inappropriate modifiers
- Diagnosis codes that do not support medical necessity

Blue KC also noted that independent laboratories cannot change or correct diagnosis codes and rely entirely on the referring provider office to provide complete and accurate clinical information at the time of order entry. Without provider involvement, the laboratory may be unable to resolve the denial or obtain reimbursement for services rendered.

What are provider responsibilities?
Referring provider offices are responsible for ensuring laboratory orders include accurate diagnosis codes that support medical necessity and align with applicable Blue KC Laboratory Medical Policies, coverage criteria, and coding guidelines. Providers are also responsible for notifying patients when a test may not be covered under member benefits or applicable medical policy requirements.

Hemodialysis Modifier Requirement Reminder

Under POL-PP-233 Hemodialysis, Home Hemodialysis and Peritoneal Dialysis Services Payment Policy, procedure code 90999 must be billed with the patient's most recent Urea Reduction Ratio (URR) modifier.

Beginning July 1, 2026, facility claims submitted with a missing, incorrect, or invalid URR modifier will be denied and must be corrected and resubmitted for payment consideration.

Applicable modifiers include:

- G1 Most recent URR of less than 60%
- G2 Most recent URR of 60% to 64.9%
- G3 Most recent URR of 65% to 69.9%
- G4 Most recent URR of 70% to 74.9%
- G5 Most recent URR of 75% or greater
- G6 ESRD patient for whom less than seven dialysis sessions have been provided in a month

Applies To:

- Commercial
- ACA QHP
- Small Group ACA
- JAA
- FEP
- Medicare Advantage (BlueCard)
- Dental

Medicare Advantage Referral Requirements Update

UnitedHealthcare announced it will continue to defer adverse payment decisions related to Medicare Advantage referral requirements, extending the grace period that was previously scheduled to end on April 30, 2026. UHC stated it will provide advance notice before referral-related payment edits are implemented.

Providers should continue obtaining and submitting referrals for services scheduled on or after January 1, 2026.

Chemotherapy Observation or Inpatient Hospitalization

UnitedHealthcare Community Plan (Medicaid) issued a Chemotherapy Observation or Inpatient Hospitalization policy stating that inpatient hospitalization is medically necessary for drug regimens requiring inpatient monitoring or complex administration over multiple days.

This language may contradict the federal Medicaid inpatient definition at 42 C.F.R. § 440.2, which defines inpatient status under the Medicaid program based on whether the patient is expected to require hospital care for 24 hours or longer.

If you are seeing inpatient status denials for reasons other than the 24-hour benchmark, contact us for a copy of the Medicaid provider complaint form.

Modifier 25 Requirement for "XXX" Procedures

Healthy Blue announced that, effective for claims processed on and after May 1, 2026, claims for XXX procedures billed with an Evaluation and Management (E&M) service must include modifier 25 for Medicare Advantage products. Healthy Blue states that modifier 25 should be used only when the E&M service is significant and separately identifiable from the procedure.

Beginning July 1, 2026, Healthy Blue will review claims billed with modifier 25 to confirm documentation supports a distinct E&M service beyond the usual work of the procedure. Healthy Blue clarified that the separate E&M service may relate to the same condition as the procedure, but must not include work that is part of the procedure, staff supervision, or interpretation of results.

Claims may be denied or reviewed after payment when documentation does not support a separately identifiable E&M service.

Maximum Units Per Day Policy Update

Healthy Blue updated its Maximum Units Per Day reimbursement policy (G-15003) effective August 1, 2026. The policy states reimbursement is limited to the maximum number of units allowed per day for a procedure or service billed for the same member, date of service, and provider or provider group. Units billed above the daily maximum will not be eligible for reimbursement unless supporting documentation is submitted for review.

Healthy Blue noted that maximum unit edits are based on claims data analysis and clarified that these edits do not replace or override National Correct Coding Initiative (NCCI) edits. The policy also states claims may be denied, adjusted, or recouped when billing guidelines or reimbursement policies are not followed.

Sepsis and Newborn DRG Documentation Requirement

Effective August 1, 2026, Healthy Blue will require full medical record submission with certain inpatient sepsis and newborn claims for Medicaid providers reimbursed under the diagnosis-related group (DRG) methodology. Healthy Blue stated the requirement is intended to support accurate payment and claim review.

Healthy Blue noted that normal newborn MS-DRG 795 and APR DRG 640-1 are excluded from the requirement. The documentation request is supported by the existing Claims Requiring Additional Documentation reimbursement policy, and claims and medical records may be reviewed prior to payment or audited after payment.

MO Health Net

✔ Consultation Codes

Effective for dates of service on or after July 1, 2026, the MO HealthNet Division (MHD) will no longer reimburse consultation CPT codes 99242–99245 and 99252–99255. Providers should instead report the appropriate Evaluation and Management (E&M) code based on the location of the visit and the complexity of the service performed.

Escalating Unresolved Managed Care Issues

MO HealthNet reminded providers that if an issue remains unresolved after contacting a Managed Care (MC) health plan directly, providers may submit an MC Request for Information to MHD.MCCommunications@dss.mo.gov for assistance. An MHD MC Liaison will review the request and coordinate with the appropriate health plan to help resolve the issue.

MHD stated that responses will generally be provided within 72 hours for inquiries affecting a managed care member's services and within 10 working days for standard inquiries, unless otherwise advised.

Medicaid Integrity Audit Notice

The Missouri Medicaid Audit and Compliance Unit (MMAC) notified providers that CMS contractor CoventBridge (USA) Inc., the Midwest Region Unified Program Integrity Contractor (UPIC), may randomly select providers for a Medicaid integrity audit conducted in coordination with MO HealthNet.

As part of the audit process, selected providers may be required to submit medical records for claims billed between October 1, 2023, and September 30, 2025 to verify compliance with applicable federal and state Medicaid requirements, including MO HealthNet policies applicable to Managed Care Organization (MCO) providers.

MO HealthNet Reminders to Providers:

- Medical record requests from CoventBridge require timely response
- Records may be disclosed under HIPAA for authorized health oversight activities under 45 CFR 164.512(d)
- Failure to comply may result in administrative action under 13 CSR 70-3.030

Providers were also encouraged to ensure administrative staff recognize CoventBridge correspondence as official and requiring prompt attention.

Off-Cycle Revalidation Initiative

The Missouri Medicaid Audit & Compliance (MMAC) Unit announced a two-phase off-cycle provider revalidation initiative in partnership with CMS and MO HealthNet to strengthen program integrity and accelerate revalidation of selected provider types outside of the standard revalidation cycle. Providers selected for revalidation will receive 120-, 90-, 60-, and 30-day notices through the email address associated with their eMOMED account and must complete revalidation requirements by the deadline identified in the notice. Failure to timely complete revalidation may result in administrative action, including termination from the MO HealthNet program.

Phase I:

- The following Provider Types shall revalidate prior to Oct. 1, 2026:
  - Adult Day Care providers (Provider ID beginning with “29”)
  - Durable Medical Equipment Suppliers (Provider ID beginning with “62”)
  - Providers without NPIs,
  - Any other provider identified as “high-risk” by CMS or MMAC.
    - Includes Clinics (Provider ID beginning with “50”) with an Autism Center (Specialty code of “AC”)
- **Timeline of events for Phase I:**
  - May 4 – May 30, 2026: Public Notice and educational campaign
  - June 1 – Sept. 1, 2026: Monthly 120, 90, 60, 30-day revalidation notices sent to providers.
  - October 1, 2026: Initiation of Administrative Action, including termination, for non-compliant providers.

Phase II:

- The following Provider Types shall revalidate prior to March 2, 2027:
  - Home Health Agencies (Provider Type #s beginning with “58”)
  - Private Duty Nursing (Provider Type #s beginning with “94”)
  - Applied Behavioral Analysts (Provider Type #s beginning with “73”)
  - Hospice (Provider Type #s beginning with “82”)
  - Substance Abuse (Provider Type #s beginning with “86”)
- **Timeline of events for Phase II:**
  - Oct. 1 – Oct. 31, 2026: Public Notice and educational campaign
  - Nov. 1, 2026 – Feb. 1, 2027: Monthly 120, 90, 60, 30-day revalidation notices sent to providers.
  - March 3, 2027: Initiation of Administrative Action, including termination, for non-compliant providers.

CAH Method II Billing Guidance

CMS released new guidance for Critical Access Hospital (CAH) Method II billing, effective June 29, 2026. Under the updated guidance, CAHs must bill professional services with rendering NPIs reported at the line level, enabling Medicare to identify the rendering professional for each outpatient service on a combined billing claim.

RHC/FQHC Telehealth Billing Changes

Effective for dates of service on or after October 1, 2026, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) must bill the individual CPT or HCPCS code that describes the distant site telehealth service furnished, rather than HCPCS code G2025. CMS will publish the applicable codes annually with the Physician Fee Schedule rulemaking.

Pregnancy Billing Transition Guidance

Effective July 1, 2026, KMAP issued transition billing guidance in anticipation of the American Medical Association's (AMA) 2027 revisions to the maternity code set, including the deletion of all global pregnancy and delivery codes. No changes are required when all components of the global maternity package, including antepartum, delivery, and postpartum care, are completed on or before December 31, 2026. In those cases, providers may continue billing the appropriate global maternity code.

For pregnancies that span 2026 and 2027, global billing is not permitted. Antepartum, delivery, and postpartum services must be unbundled and billed by component.

Antepartum care must be billed based on the total number of visits performed by a single provider or provider group. This applies when:

- Delivery occurs on or before December 31, 2026, but postpartum care occurs in 2027.
- Delivery occurs on or after January 1, 2027, and prenatal care began in 2026.

Antepartum billing requirements:

- 7 or more visits: CPT 59426
- 4 to 6 visits: CPT 59425
- 1 to 3 visits: Appropriate Evaluation and Management (E/M) codes

For deliveries occurring on or before December 31, 2026, when postpartum care will occur in 2027, providers must use the applicable delivery-only CPT codes:

- 59409: Vaginal delivery only
- 59514: Cesarean delivery only
- 59612: Vaginal delivery after previous cesarean delivery
- 59620: Cesarean delivery following an attempted vaginal delivery after a previous cesarean delivery

Note: Delivery with postpartum care codes must not be billed when postpartum services occur in 2027. In those circumstances, the appropriate delivery-only code must be reported.

All delivery and postpartum services furnished in 2027 must follow the 2027 coding guidance. KMAP also noted that implementation by the KanCare Managed Care Organizations (MCOs) may vary from the policy's effective date and directed providers to review the KanCare Open Claims Resolution Log for implementation and reprocessing status

The Health Alliance of MidAmerica

The Health Alliance of Mid America creates a corporate affiliation between the Kansas Hospital Association and Missouri Hospital Association that benefits members through the realization of efficiencies and economies of scale in the provision of products and services for member hospitals.