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The Health Alliance
OF MIDAMERICA

PAYER PULSE

INSIDE THIS ISSUE

Welcome to the Inaugural Health Alliance Payer Policy Newsletter

This newsletter will share important updates on payer policy changes with Health Alliance of MidAmerica's hospital members. Our objective is to identify policies that may impact patient access, coverage for care, administrative burden, or reimbursement. Our goal is to equip hospitals with actionable takeaways to assess whether, and to what extent, the policies may impact their organization.

Meet the Editor

Richelle Marting

JD, MHSA, RHIA, CPC, CEMC, CPMA, CPC-I

Richelle Marting is an attorney focused on reimbursement issues impacting healthcare organizations and professionals. Her background in health information management and medical coding contributed to her experience as a coding compliance auditor, surgery center business office manager, and outpatient hospital coder before beginning her practice as a healthcare attorney. Since then, she has protected, recovered, and increased revenue exceeding tens of millions of dollars for clients by pursuing underpayments, appealing plan refund requests, negotiating contracts, and through audit defense. She has served as the director of managed care contracting for hospitals and medical practices and has supported attorneys during healthcare reimbursement litigation as a consulting or expert witness.

About Us

In February 1999, the Missouri Hospital Association and the Kansas Hospital Association formed an integrated limited liability company called The Health Alliance of MidAmerica. The Alliance enables healthcare-related organizations to strengthen efforts in the areas of policy development and federal representation and advocacy. Kansas City Metropolitan Healthcare Council is the regional office providing support for association activities.

Get the Most Out of Your Newsletter

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

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

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

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

What is a Payer Policy?

Most contracts between hospitals and health plans, insurers, or third-party administrators require the hospital to follow the plans' policies and procedures. These provisions can incorporate policies and procedures by reference into the contract. Unlike other changes to the contract, the incorporated policies and procedures can usually be modified by the plan without the hospital's specific agreement. This makes it particularly important to monitor policy and procedure updates to determine if they may have a material adverse impact or even contradict specifically negotiated terms of a contract.

Suggested Action Items From This Issue

- Inventory your plans' payer policy language. Identify how policies are defined, advance notice requirements, and procedures to communicate objections
- Consider whether billing systems can identify the lowest single dose vial size for the drug being billed, and if waste (modifier -JW) equals or exceeds this amount, self-edit for review before the claim is transmitted
- Review policies that may warrant an objection to the health plan to assess for your organization's response strategy
- Assess your organization's ability to electronically append medical records to claims when unlisted procedure codes are used, as well as its capability to manually highlight documentation before sending a claim
- Distribute Blue KC rules for billing clinical trial services
- Evaluate telehealth billing practices and determine if payer-specific logic to report new telehealth CPT codes for Blue KC are in effect
- Review Blue KC's new lab policies to assess their impact and develop a process to alert ordering providers of potentially non-covered labs
- Develop and distribute appeal template language if billing codes with bilateral procedure indicator "3", which permits payment at 100% for both sides, are performed bilaterally but only paid at 150% of the contract rate
- Consider the impact of payers declining to pay inherent complexity add-on codes on wRVU productivity in compensation arrangements and contract provisions that tie reimbursement to multiples of Medicare

Aetna Vitamin D Policy is More Restrictive Than Traditional Medicare

Aetna's annual update to its Vitamin D Laboratory Assay medical policy reflects coverage criteria that may not reflect current industry standards for coverage of vitamin D tests and is more limited in the list of covered diagnoses than Traditional Medicare's **Local Coverage Policy**.

Psychiatric Diagnostic Evaluations

For commercial members only, Aetna will begin limiting payment of psychiatric diagnostic evaluations to once every six months.

Labs Billed with -QW

Any lab codes that are not CLIA waived lab tests will be denied if -QW is appended for commercial claims.

Vitamin D Lab Limits

For commercial claims, Aetna will only cover Vitamin D tests once per year unless the patient has Vitamin D deficiency, sequealae of rickets, or osteomalacia, in which cases Vitamin D lab tests will be covered up to four times per year.

Aetna Drug Use and Waste Modifier Claim Edits

Aetna's expanded claim edit policy will edit and deny claims where modifier -JW is reported for drug waste that equals or exceeds the lowest single dose vial size for the drug. Modifiers -JW and -JZ are not to be reported on non-drug codes. Use on drug codes representing drugs only supplied in multi-dose formulations may also be denied when -JW or -JZ are appended. -JW and -JZ should not be reported on the same claim line.

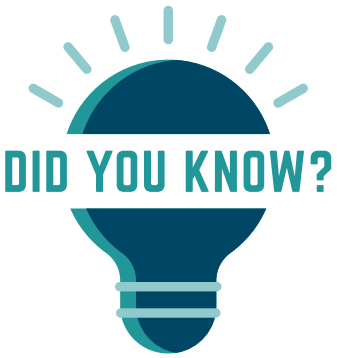
Aetna Neuropsych Testing Policy is More Restrictive Than Traditional Medicare

Aetna's neuropsych testing medical policy does not include CPT 96105, which is covered by WPS Medicare. Aetna's policy includes a list of covered and non-covered diagnoses, whereas **Medicare's LCD** is not limited by diagnoses.

Aetna Rescinds Planned APRN, Midwife Incident-To Payment Policy

In Aetna's January 2025 provider newsletter, it announced a policy change to take effect April 1, 2025, in which payment for modifiers SA and SB would be reduced by 15%. Modifier SA indicates that a nurse practitioner is providing a service in collaboration with a physician, while modifier SB is used for services provided by a nurse midwife. The policy was set to apply to both Aetna's commercial and Medicare members; however, **Aetna announced** it would not move forward with this policy change.

Medicare Advantage Readmission Policies



Medicare Advantage plans are required by federal law and federal regulations to provide their members all benefits of the Traditional Medicare program in a manner that is no more restrictive than Traditional Medicare. Medicare Advantage plans provide those benefits by:

1. furnishing the benefits directly;
2. arranging for the benefits; or
3. paying for the benefits.

Most Medicare Advantage plans authorize hospitalization concurrent with admission

Prior Authorization for Medicare Advantage, Defined

A process through which the physician or other healthcare provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee.

CMS Longstanding Policy

> If the plan approved the furnishing of a service through advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity
> *IOM 100-16 Chapter 3*

2024 Regulations Codify CMS Longstanding Policy

> Regardless of the rationale the MA organization ultimately used to deny services during a review (e.g., medical necessity or payment policy), effective January 1, 2024, "If the MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity and **may not reopen such a decision for any reason except for good cause**. . . ." *42 C.F.R. 422.138(c).*

Blue KC to Deny Pediatric, Neonatal Critical Care When Not Reported with a Supporting Diagnosis

Blue KC's Newborn and Neonatal Critical Care policy will deny claims involving neonatal critical care codes (99468-99469) and neonatal initial intensive care (99477, 99478, 99479, 99480) if submitted with a diagnosis that does not support critical care. The policy does not identify a list of diagnoses that would cause a claim to deny as not supported.

Blue KC's policy outlines certain services that bundle into the payment for neonatal and pediatric critical care that generally align with CPT, with the exception of also bundling hydration service codes 96360 and 96361 for intravenous infusion into critical care. 96360 and 96361 do not bundle into critical care per CPT.

Blue KC Observation Services Policy Limits Obs to 48 Hours

Blue KC's Observation Room Services policy limits observation stays to 48 hours, while at the same time, its **two-midnight rule policy** does not necessarily cover stays spanning > 48 hours as inpatient. The discrepancy between the two policies may impact professional claims' place of service reporting.

Laparoscopic Gastric Band Adjustment

Blue KC's new laparoscopic adjustable gastric banding payment policy applies to professional and commercial claims.

Routine gastric band adjustments with saline injection or aspiration are part of the global surgical package of CPT 43770 for 90 days following the placement procedure. After 90 days, band adjustments may be billed separately using S2083. Blue KC will not pay for an evaluation and management service on the same day as S2083 if the sole purpose of the encounter is for gastric band adjustment.

Blue KC's policy will not cover fluoroscopic guidance (76000) if needed to perform band adjustment. However, other industry coding guidance suggests in the uncommon scenario fluoroscopic guidance is used, it could be billed. See **AAPC General Surgery Coding Alert**.

Blue KC Unlisted Code Policy Requires Manual Highlighting to Identify Procedure

When unlisted procedure codes are reported, Blue KC will require supporting documentation to determine appropriate payment. In addition to providing records, Blue KC asks providers to manually "identify the portion of the report (such as underlining or highlighting the entry) that identifies the test or procedure associated with the procedure code in question."

Healthy Blue Follows Suit with Anthem; Retracts Anesthesia Maximum Unit Policy

Anthem Blue Cross and Blue Shield made national news after publishing a policy which would have limited payment for anesthesia services to certain undisclosed maximum time increments. Missouri was one of a handful of states in which the policy would have been implemented, until Anthem ultimately announced it would withdraw its policy out of concern for lack of clarity on its impact to patient care. Following suit, Healthy Blue of Missouri has announced a similar retraction to its proposed policy which would have taken effect for Missouri Medicaid Healthy Blue claims.

Codes Inclusive to Imaging Services

Policy Number: POL-PP-254
Effective: March 10, 2025
Applicability: Commercial

Blue KC defines certain items or services as integral to the provision of other services. In those instances, the items considered integral are not separately reimbursed from that service. Blue KC's updated policy describes bundling for the following:

- Contrast agents billed in conjunction with an MRI
- Radiopharmaceuticals billed in conjunction with a PET scan
- Materials billed with a CT or other radiographic study
- Non-ionic contrasts or low osmolar contrast material
- High osmolar contrast material
- Isotopes for therapeutic purposes

Trigger Point Injection Policy Assessment

Blue KC has a medical (CAM 201103) and a payment (POL-PP-112) policy covering trigger point injections. Blue KC's payment policy limits TPIs to 4 injections in a 12-month period. But, WPS Medicare's LCD describes the frequency limit as 4 sets/series (as opposed to individual injections) in a 12-month period. Ensure documentation includes muscle(s) injected (not just number), medication and amount, and needle size.

Blue KC's medical coverage policy contains language that conflicts with its payment policy. The medical policy indicates injection of saline and Botox are covered, in addition to anesthetic and steroid. The payment policy only addresses anesthetics and corticosteroid (not Botox or saline). Blue KC's medical policy also indicates "Trigger point and tender point injections are investigational/ unproven therefore considered NOT MEDICALLY NECESSARY for all indications, including the treatment of myofascial pain syndrome, complex regional pain syndrome, abdominal wall pain, and fibromyalgia.

Billing Clinical Trials

All services provided as part of a clinical trial, such as S9988, S9990, S9991, S9992, S9994, S9996, G0293 and G0294 must be billed with the modifier Q0 or Q1. Additionally, the service must be billed with ICD-10 diagnosis code Z00.6 in either the primary or secondary position of the diagnosis codes on the claim. Report a clinical trial number on claims for items/services provided in clinical trials/studies/registries.

Blue KC MUE Edits Will Consider Medically Necessary Exceptions

Blue KC uses CMS National Correct Coding Initiative Medically Unlikely Edits. Some edits are based on the maximum likely units in a day, but may not be absolute maximum values. These are identified by MUE edit indicator '3'. Line items denied for exceeding an MUE where the edit indicator is '3' may be appealed with documentation to demonstrate actual units performed or administered and the medical necessity of the units provided. Blue KC also reports that MUE limits are the third highest reason for denials.

Laboratory Billing

When laboratory procedures are performed by a party other than the treating or reporting physician to other qualified healthcare professional, the procedure must be identified by adding modifier -90 to the claim line. Blue KC would require modifier -QW on all CLIA waived tests, but not all CLIA waived tests require a -QW modifier under CMS policy. The policy also vaguely describes incorrect diagnosis, age mismatch, place of service, and maximum unit edits.

Blue KC Recognizes New Telehealth Codes

Policy Number: POL-PP-109
Effective Date: 4/25/25

Audio-only telephone services CPT codes 99441-99443, have been deleted from the CPT book in 2025. These codes were replaced with 98008-98015. Medicare has chosen not to adopt these new telehealth codes, but as of January 1, 2025, Blue KC **will require** 98000-98016 for outpatient telehealth E/M services and will no longer accept 99202-99215 to report telehealth services. Otherwise, Blue KC follows the Medicare List of Approved Telehealth Services. Modifiers -95, -GT, -GQ, and -G0 are not required to identify telehealth services but are accepted as informational.

However, Blue KC considers HCPCS code Q3014 (Telehealth originating site) to be mutually exclusive to other telehealth services and not separately reimbursable for all lines of business.

Blue KC Experimental and Investigational Services Policy

Policy Number: 10.01.528
Effective: January 1, 2025
Applicability: All Plan Types

Blue KC reviewed its Miscellaneous Investigational Procedures policy in January 2025, and will review again in July 2025. The policy outlines CPT and HCPCS codes Blue KC considers experimental or investigational. Of the approximately 1,670 codes listed, more than 240 (14%) of the codes are covered - at least in some circumstances - even by the Medicare program.

Blue KC Fracture Care Policy Contradicts CPT Billing Rules

Policy Number: POL-PP-244
Effective Date: 4/01/25

Blue KC's fracture care policy states "Subsequent replacement of cast, splint or strapping during the global period is not separately reimbursable." CPT guidelines provide that "[s]ubsequent replacement of cast, splint, or strapping (2900-29750) and/or traction device (20690, 20692) **during** or after the global period [of initial restorative treatment] **may be reported separately**."

Blue Policy Will Check for Diagnosis Matching on Claims with J9271 Keytruda

Commercial and exchange plan claims will be checked for matching the diagnosis billed on the claim with J9271. If the diagnosis is an FDA-approved diagnosis for the use of Keytruda, the claim will pay. If the diagnosis is not an FDA-approved diagnosis, the claim will not pay, as it will be considered investigational.

Neither Blue KC nor the FDA list specific diagnoses that would be covered or approved. Blue KC also suggests claims with a diagnosis code identifying an encounter for chemotherapy would cause a claim to deny. Usually, patients receiving Keytrude will be presenting for chemotherapy where coding guidelines would direct Z51.11 (Encounter for chemotherapy) be reported as the first-listed diagnosis, creating concern for denials of properly coded claims.

Blue KC to Implement 62 New Lab Coverage Policies

Effective June 1, 2025*, Blue KC will implement 62 new lab coverage policies covering coverage of tests including cardiovascular disease risk assessments, cervical cancer screening, colorectal cancer screening, COVID tests, influenza tests, PSA tests, and Vitamins B and D tests. Blue KC does not list hypertension as a risk factor for cardiovascular disease to support annual lipid profiles. PSA tests may be paid annually for men at increased risk of prostate cancer. Patients with documented Vitamin D deficiency can be monitored twice a year for effectiveness of supplementation therapy.

*Blue KC's Provider Bulletin lists a June 1, 2025 effective date while its website lists July 1, 2025.

Facility Observation Services

Payment Policy: POL-PP-258
Effective Date: August 1, 2025

Facility Observation Services G0378, G0379 are submitted with bill type 13X, 78X, or 85X. Report HCPCS code G0378 (hospital observation service, per hour) under the appropriate revenue code (0762) with units that represent the hours in observation care (rounded to the nearest hour).

! Observation service code G0378 will only be considered for reimbursement when the observation period meets or exceeds 8 hours, but not more than 48 hours.

Blue Cross Will Not Reimburse Inherent Complexity Codes

On January 1, 2024, CMS implemented new inherent complexity add-on codes to be appended to evaluation and management services in certain circumstances. When CMS estimated the frequency at which these services would be billed and paid, its estimates contributed to its budget neutrality analysis that in turned affected reductions for all other services. **G2211 (0.33 wRVUs)** describes Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed healthcare services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. **G0545 (0.89 wRVUs)** describes Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious disease specialist, including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and complex antimicrobial therapy counseling and treatment.

After initially recognizing and paying for both codes, in March 2024, Blue KC announced it would not separately reimburse G2211 or G0545. Blue KC considers payment for these codes to be subsumed by the payment for services to which it is incident to codes 99202-99205, 99212-99215.

Cigna Bilateral Procedure Policy Will Reduce Payment by 50% in Instances Medicare Pays Full Allowables

Cigna's Bilateral Procedure policy will cause claims billed with modifier -50 to be paid at 150% of the contracted rate for all services with a "1" or a "3" indicator in CMS's Medicare Physician Fee Schedule Resource Based Relative Value System.

However, CMS's RBRVS file indicates bilateral procedure reductions **do not apply** to codes with an indicator of "3".

Configure systems to edit if modifier -50 is reported to Cigna with any code that has an RBRVS bilateral procedure indicator of 0, 2, or 9.

Cigna Will Implement New Coding and Billing Accuracy Policy

Cigna's policy identifies several coding and billing practices Cigna would consider erroneous, including the omission of documented diagnoses and cloned records or documentation. Cigna consider these examples "not deemed to be reimbursable". Among the at-risk documentation is cloned documentation, which Cigna defines as taking medical record documentation, copying, then transferring word for word to another date of service for the same patient or applying to a different patient's record instead of documenting specifics related to each encounter (also referred to as "copy and paste").

A policy or practice that permits copy and paste documentation, even with appropriate safeguards, may place records at risk for denial by Cigna.

Cigna Virtual Care Policy

Cigna's Virtual Care Reimbursement Policy excludes reimbursement for inpatient and observation services (99221–99223, 99231–99233) when billed with Place of Service (POS) 02 for medical services. This policy conflicts with Missouri's telehealth parity laws and limits access to necessary telehealth services in inpatient settings. Missouri Revised Statutes § 376.1900 mandates that a health carrier may not exclude an otherwise covered healthcare service from coverage solely because the service is provided through telehealth rather than face-to-face consultation or contact between a healthcare provider and a patient.

Cigna MA's Coverage and Payment for Chronic Care, Advanced Primary Care May be More Restrictive than CMS

Cigna announces that effective June 1, 2025, Cigna Healthcare Medicare Advantage will not reimburse for advanced primary care management services or chronic care management. This new policy encompasses CPT codes 99490, 99491, 99439, 99437, 99487, 99489, G0556, G0557, and G0558. These are services covered under Traditional Medicare benefits.

Cigna's Readmission Policy Expands from 72 Hours to 30 Days

Effective July 1, 2025, Cigna will expand its commercial plan readmission policy to look at hospitalizations within 30 days of a prior admission, up from its prior timeframe of only 72 hours. Cigna authorizes hospitalizations concurrent with admission, and its policy may have the effect of disregarding its authorization.

New Radiation Oncology Unit Limits

Effective February 1, 2025, UHC will place limits on the number of certain radiation oncology codes billable in a 90-day episode of care. Units in excess of established limits will not be considered for reimbursement. A new episode of care begins again if a radiology treatment planning code is submitted before the previous 90-day episode of care ends. **The policy also applies to Medicare Advantage**. Traditional Medicare has per-day unit of service limits but does not have limits for 90-day episodes of care.

UHC Adopts GA Modifier; January 1, 2025

UHC will begin requiring use of the -GA modifier for commercial claims if the provider believes the member's benefits will not cover a service. -GA will be required to adjudicate as member responsibility to pass balance to the patient or secondary. When used on UHC commercial claims, -GA modifier identifies when the enhanced content requirements of the consent were met. UHC policy requires consents be signed, dated, and maintained in the medical record. To be valid, consents should include: an estimate of the charges for that service; the provider's statement of the reason the provider believes the service may not be covered; a statement that the service has been determined not to be covered; and that the member knows of this determination and agrees to be responsible for the charges.

For MA members, in addition to obtaining the member's written consent before the service is done, providers must request a pre-service determination; make sure the member has received the Integrated Denial Notice (IDN).

To submit an advance notification request using the UnitedHealthcare Provider Portal, go to UHCprovider.com > Sign In > Prior Authorizations.

Drug Waste Modifiers for UHC Community Plan

Effective October 1, 2024, for both facilities and professional billing, UnitedHealthcare will align with CMS's requirement for reporting the -JZ modifier for a claim to be considered for reimbursement.

Report the -JZ modifier to attest that no amount of drug or biological from a single-dose container or a single-use package was unused or discarded. The use of the JW modifier will continue to be required when submitting claims for any waste from a single-dose container or single-use package.

UHC Community Plan Bundling G2211

Missouri Providers: Effective with dates of service on or after September 1, 2024, HCPCS code G2211 will be included within the UnitedHealthcare Community Plan Rebundling Policy, Professional. The update **has not** yet been made for Kansas professional billing, but Kansas professionals may consider assessing the impact as the policy is likely to be extended to Kansas in the future.

UHC Policy Deems Respiratory Viral Panel Testing Experimental

Policy Number: 2025T0661A
Applicable Plan Types: Commercial, Exchange
Effective Date: June 1, 2025

Respiratory pathogen panel testing of six or more targets in an outpatient setting is unproven and not medically necessary due to insufficient evidence of efficacy for all indications. This affects HCPCS codes 0115U; 0202U, 0223U, 0225U, 87632, and 87633.

Note that Missouri and Kansas Medicaid pay for these tests. While a Medicaid MCO can develop coverage criteria to decide when services are medically necessary under a benefit plan, they cannot refuse to cover and pay for a test that is a covered benefit under the State Medicaid plan.

Definition of Hospital Inpatient Care

Policy Number: MMP046.10
Effective Date: May 1, 2025
Applicability: Medicare Advantage

UHC MA's Hospital Services policy correctly adopts the two-midnight benchmark, case-by-case exception, and inpatient only list from Traditional Medicare's criteria for inpatient status.

But, the policy also states: "As described in the commercial policies referenced above, UnitedHealthcare uses InterQual® as a source of medical evidence to support medical necessity and level of care decisions. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider."

> MA plans may not use InterQual or MCG criteria, or similar products, to change coverage or payment criteria already established under Traditional Medicare laws

Source: 88 Fed. Reg. 22194 (April 12, 2023)

Discontinued Procedures Modifier

UHC Community Plan - Kansas creates a policy to deny the claim line reported with modifier -53 on outpatient facility claims. Facilities use modifiers -73 and -74 to describe procedures discontinued prior to or after the induction of anesthesia.