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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

- Evaluate potential financial impact on reimbursement from changes to OB coding. Consider wRVU and professional compensation impact.
- Ensure billing teams include Condition Code A6 on institutional claims when reporting vaccines with diagnosis code Z23, consistent with National Uniform Billing Committee guidance, to avoid RTPs.
- Update workflows to comply with new VA precertification requirements, including use of VAPP and tracking enforcement deadlines to prevent denials.
- Evaluate impact of Aetna's ventral hernia policy and consider raising concerns where CPT-supported services (e.g., CPT 15734) are denied as incidental. **CMS's complaint portal is here.**
- Consider reviewing RPM utilization and billing practices for CPT 99453–99458 to ensure alignment with Aetna's limited list of covered chronic conditions and policy requirements, as services outside of these criteria may no longer be reimbursed.
- Review billing practices for Aetna treatment room services to ensure compliance with bundling rules and avoid non-reimbursed charges when billed with other services. Notify managed care and inquire if an objection/complaint surruonding decrease to reimbursement is appropriate.
- Consider an objection to Aetna's RPM policy limitations, at least with respect to Medicare Advantage members. CMS contacts for complaints/concerns about Aetna MA policies that are more restrictive than Traditional Medicare include CMS Medicare Part CD Questions: MedicarePartCDQuestions@cms.hhs.gov.
- Review Blue KC prompt pay provisions and confirm whether contract terms or statutory requirements apply to ensure timely payment and identify potential interest eligibility.
- Ensure charge capture for CPT 99459 for pelvic exams rendered to individuals covered by a Cigna plan.
- Assess capabilities to modify, if applicable, recovery room unit billing to per-minute units for Blue KC. Configure systems to report a HCPCS code on the line for recovery room services. Consider system capability to report recovery room end time based upon Blue KC's definition.
- Assess any circumstances Humana requires paper claim filing where admin fees may be imposed.
- Ensure pharmacy billing systems are configured to submit valid ICD-10 diagnosis codes in NCPDP field 492-DO without decimals for MO HealthNet claims, and coordinate with prescribers to obtain required codes, as manual overrides will no longer be permitted beginning June 1, 2026.
- Review SMBP eligibility screening and documentation processes to confirm required risk factors are captured prior to billing under MO HealthNet, as noncompliant services may be denied.
- Ensure PCP referrals are obtained prior to specialist visits for UnitedHealthcare Medicare Advantage HMO/HMO-POS members, particularly for services scheduled on or after January 1, 2026, as missing referrals may result in claim denials.
- Ensure use of the updated CMS Advance Beneficiary Notice (ABN) form by May 12, 2026, as use of outdated forms after this date may result in inability to charge the patient for the service.
- Evaluate claims reporting CPT 99459 with E/M services and confirm compliance with updated payer reimbursement policies, as certain payers (e.g., Cigna) no longer reimburse this code when billed with office or outpatient E/M visits.
- Ensure contract management systems, encoders, and billing tools are updated to reflect MS-DRG version 43.1 for Kansas Medicaid effective April 1, 2026.

CPT Coding Update

OB Global Billing Changes (2027)

Significant obstetric coding changes will take effect January 1, 2027, including elimination of the global maternity care model. Key updates include:

- Elimination of 16 global maternity care codes, including global vaginal delivery (59400), cesarean delivery (59510), VBAC (59610), as well as antepartum bundles and postpartum-only codes.
- Prenatal and postpartum visits billed separately using Evaluation and Management (E/M) codes (99202-99499) with the -TH modifier.
- Delivery services billed separately using delivery-only CPT codes
- Labor management over multiple days will be billed using inpatient E/M codes.
- Twins and multiples will be billed with multiple delivery units.

What We Don't Know

- Exact new CPT codes
- RVU values and payment rates
- How Medicaid and commercial will price the codes
- If insurers require prior authorizations
- Documentation and frequency requirements
- Payer-specific billing rules

How to Prepare

- Document prenatal and postpartum visits like traditional E/M visits
- Update EHR templates
- Train clinical and billing staff
- Review payer contracts ahead of 2027
- Start financial modeling based on visit volume

General Billing Updates

National Uniform Billing Committee Condition Code A6 Update

The National Uniform Billing Committee approved a revision to Condition Code A6 at its February meeting. The code, which currently applies to pneumococcal pneumonia and influenza vaccines, will be revised to reflect broader Medicare vaccine coverage without beneficiary cost sharing.

The updated description will be effective July 1, 2026, and will be incorporated into the next publication of the UB-04 Manual.

VA Community Care Precertification Requirements Update

The VA is implementing a new precertification requirement for certain services under the Community Care program. In addition to obtaining VA authorization, providers may also be required to submit precertification through the VA Precertification Portal (VAPP) for select services. The VA confirmed that a master list of services requiring precertification is available through its Precertification Storefront and portal tools.

A transition period is currently in place, during which claims will continue to be paid even if precertification is not obtained. However, **beginning September 26, 2026, for TriWest regions**, precertification must be submitted electronically through VAPP and approved prior to the date of service, or the applicable claim line will be denied.

5 Aetna

Ventral Hernia Coding Policy Conflicts with CPT Guidance

Aetna's **April 1, 2026,** policy update would continue to deny CPT 15734 and 49659 as incidental when billed with certain ventral hernia repair codes, including hernias less than 3 cm and 3–10 cm.

This policy conflicts with CPT Assistant (July 2023), which states that CPT 15734 (myocutaneous flap) is reported when a flap is created to reconstruct the abdominal wall following hernia repair, representing additional reconstructive work performed by the surgeon rather than an inherent part of the hernia repair.

Aetna and the CMS division that manages payer compliance with standardized code sets have been notified. Recall last year, a similar Aetna policy for lesion code was corrected after CMS investigated and confirmed Aetna's policy conflicted with CPT rules.

Aetna Prenatal Care Policy

Aetna Clinical Policy Bulletin 0047 outlines expectations for primary care providers who elect to furnish prenatal care to members.

When a primary care provider manages prenatal care, Aetna assigns the following responsibilities to the rendering provider:

- Enroll the patient in Aetna's maternity program (Beginning Right Maternity Program)
- Coordinate genetic testing through Aetna-designated programs
- Ensure the patient selects a participating obstetrician for co-management
- Refer the patient to the obstetrician for an initial educational visit in the first trimester
- Refer the patient for ultrasounds and fetal non-stress testing
- Transfer care to the obstetrician for delivery no later than 28 weeks gestation
- Maintain and transfer complete prenatal records to the obstetrician within required timeframes
- Present and facilitate first trimester fetal aneuploidy screening consent
- Bill antepartum care using CPT 59425 (4–6 visits) or 59426 (7+ visits) (until 2027), as applicable

Primary care providers delivering prenatal care, but who do not perform deliveries, should ensure their workflows align with Aetna's procedures.

6 Aetna

Treatment Room Services Policy Change

Aetna announced a reimbursement policy change effective **June 1, 2026**, under which treatment room services (revenue codes 760, 761, and 769) will no longer be separately reimbursed when billed with the following:

- Inpatient stay
- Outpatient minor surgical or medical procedure
- Outpatient observation stay
- Emergency room visit
- Urgent care visit
- Laboratory and/or radiology services

Aetna also states that Evaluation and Management (E&M) services will not be reimbursed when billed with revenue codes 760, 761, or 769.

Remote Patient Monitoring (RPM) Policy Update

Aetna implemented a new Remote Patient Monitoring (RPM) clinical policy **effective March 1, 2026**, applicable to both commercial **and Medicare Advantage plans**, for CPT codes 99453–99458. The policy limits coverage to specific chronic conditions, including heart failure, hypertension, and diabetes, and will not cover RPM for conditions outside of this list. Coverage also requires use of an FDA-approved or cleared device capable of automatic data transmission, that the service is ordered and supervised by a qualified provider, and that collected data is used to inform and adjust the patient's treatment plan, with documented patient consent.

Members who were actively receiving RPM within the 90 days prior to March 1, 2026, may continue services through August 31, 2026, with full policy enforcement beginning September 1, 2026.

UHC attempted to implement a similar policy for MA plans January 1, 2026, that was postponed.

Blue Cross

Prompt Payment and Interest Guidance

Blue KC's 2026 Provider Guide addresses prompt payment requirements for claims subject to Missouri's prompt pay statute.

The guide states that payment should be made within 30 days after a claim is finalized. Blue KC will either issue payment or notify the contracted provider of a delay or denial. For claims subject to RSMo § 376.383, claims not paid within 45 days may be subject to interest charges.

The manual also indicates that when the terms of a provider contract conflict with the Provider Guide, the contract governs.

Facilities whose agreements include broader prompt payment or interest provisions should review their contracts to determine whether those terms apply and evaluate prompt payment and interest obligations under the most protective language.

Recovery Room Billing Policy (Rev Code 0710)

Blue KC implemented a Recovery Room Billing Policy (Rev Code 0710) applicable to outpatient surgical procedures, with **requirements effective February 1, 2026, and additional updates effective April 1, 2026.**

The policy requires recovery room services to be reported in **time-based units (1 minute = 1 unit)** and **defines the end of recovery room time** based on when a patient is stable, fully alert, and medically cleared for transfer or discharge. **Beginning April 1, 2026, claims must also include a CPT/HCPCS code in addition to revenue code 0710**, or the claim will be returned as incomplete.

These requirements differ from common billing practices, where recovery room time is determined based on a physician or anesthesia order for transfer and billed as a single unit without time-based increments or additional HCPCS coding, consistent with Medicare packaging methodology. The policy also does not clearly address coordination of benefits scenarios when Medicare is primary or secondary, which may create inconsistencies in billing and reimbursement.

Humana, Cigna

Humana Paper Claim Administrative Fee

Humana implemented a paper claim administrative fee for Medicare Advantage claims to encourage electronic claim submission. Humana will assess a $5.00 fee for each claim submitted on a CMS-1500 or UB-04 paper claim form when the reimbursement amount is $10.00 or greater. Humana states that electronic claim submission reduces administrative costs, improves processing, and provides quicker access to payment.

Pelvic Exam Code 99459 Reimbursement Update

Effective October 11, 2025, Cigna will no longer deny CPT® code 99459 when reported with office or outpatient E/M codes 99202–99205 and 99212–99215, as reflected in Cigna's Evaluation and Management Services reimbursement policy.

ICD-10-CM Excludes1 Coding Edits

UnitedHealthcare announced updates to its Diagnosis Code Requirement Policy reinforcing compliance with ICD-10-CM Excludes1 conventions.

Excludes1 notes indicate diagnoses that generally should not be reported together because the conditions are considered mutually exclusive. UnitedHealthcare states that claims submitted with diagnosis codes that conflict with Excludes1 edits may be subject to claim edits or denials.

The Official ICD-10-CM Guidelines note that Excludes1 edits may have limited exceptions when the two conditions are unrelated. In those circumstances, both diagnoses may be reported if supported by documentation.

Hospitals and coding teams may wish to review coding practices and documentation to ensure appropriate application of Excludes1 conventions when reporting diagnoses on claims.

Professional/Technical Component Policy Update

Effective April 1, 2026, UnitedHealthcare will update its policy for reimbursement of imaging professional components when reported on the same date of service as an Evaluation and Management (E/M) service by the same individual provider.

Under the revised policy:

- When a radiology service is billed on the same date of service as an E/M service for the same patient by the same provider, reimbursement for the professional component is considered included in the E/M service when **only a review is performed rather than a full written interpretation and report.** This applies whether the radiology service is billed globally or with modifier 26.
- When a global radiology code is billed on the same date of service as an E/M service by the same individual provider, **the professional component will not be considered for separate reimbursement unless a copy of the full interpretation report is submitted.**
- UnitedHealthcare will implement a Smart Edit to provide additional details regarding submission of full interpretation reports.

Policy Rescissions

UnitedHealthcare announced that implementation of the following policies has been postponed until further notice:

- Remote Physiologic Monitoring (RPM)
- Computer-Assisted Surgical Navigation for Musculoskeletal Procedures

Spinal Fusion and Decompression Policy Update

UnitedHealthcare updated its Spinal Fusion and Decompression Policy to identify additional spine procedures as unproven and not medically necessary due to insufficient evidence of efficacy, including dynamic stabilization systems, facet joint replacement, isolated facet joint fusion, and vertebral joint implants (e.g., MOTUS).

The policy also states that multiple serial or staged spine procedures are not supported when all services could be performed in a single session, citing insufficient evidence of efficacy. These updates may increase denial risk for newer spine technologies and staged procedures.

Vitamin D Testing Policy Discrepancy

UnitedHealthcare's Vitamin D testing policy references a superseded WPS Medicare KS/MO LCD and identifies CPT 82652 as the applicable test code. However, the current WPS LCD also includes CPT 82306, creating uncertainty as to whether UnitedHealthcare Medicare Advantage applies diagnosis restrictions to 82306 or considers it non-covered under this policy.

Pharmacy Diagnosis Code Requirement Update

MO HealthNet announced that **effective June 1, 2026**, it will eliminate manual overrides for pharmacy claims rejected due to missing or incorrectly formatted ICD-10 diagnosis codes under the Diagnosis Code Required Policy Edit. Claims for applicable medications must include a valid, billable ICD-10 code submitted in accordance with the NCPDP Telecommunication Standard (field 492-DO, no decimal point) to be processed successfully.

Self-Measured Blood Pressure (SMBP) Monitoring

Self-Measured Blood Pressure (SMBP) monitoring for dates of service on or after February 1, 2025, are covered when prescribed by a physician or other qualified provider. Devices must be obtained through participating Durable Medical Equipment (DME) providers, include an appropriately sized cuff, and are limited to one device every three years, with upper-arm cuffs required unless not clinically appropriate.

Coverage includes CPT 99473, which may be billed once per year, and CPT 99474, which may be billed once per calendar month. Covered equipment includes A4670 (automatic blood pressure monitor).

Pregnant or postpartum participants (up to 12 months) must have at least one of the following risk factors:

- Diagnosis of hypertension
- History of preeclampsia, eclampsia, hypertension, or gestational hypertension
- Family history of preeclampsia, eclampsia, hypertension, or gestational hypertension
- Obesity (BMI ≥ 30)
- Advanced maternal age (≥ 35 years)
- Autoimmune disorder(s)
- Elevated blood pressure during a previous visit or screening
- Population-level risk factors (e.g., race or geographic location)

Other MO HealthNet participants (non-pregnant/postpartum) must have at least one of the following:

- Newly diagnosed hypertension within the last 6 months
- Uncontrolled hypertension or multiple comorbidities (e.g., diabetes, obesity, hypercholesterolemia)
- History of conditions affecting blood pressure (e.g., heart disease, heart failure, stroke, congenital heart disease, or renal disease)

Updated Advance Beneficiary Notice (ABN) Form

CMS has released an updated Advance Beneficiary Notice (ABN) form, with a required implementation deadline of May 12, 2026. Providers must discontinue use of prior versions by this date. Use of an expired form after May 12, 2026, means providers cannot charge the patient for the service.

Vaccine Billing Clarification

CMS has posted Transmittal 13677 updating Pub. 100-04, Chapter 18, Preventive and Screening Services, Section 10.2.1 to clarify vaccine billing instructions. Issued on March 12, 2026, the update explains that Condition Code A6, which indicates Vaccine/Medicare 100% Payment, must be reported on institutional claims when ICD-10-CM diagnosis code Z23 (Encounter for Immunization) is required for a vaccination.

R13677CP

Medicare Advantage Referral Requirement Update

Beginning January 1, 2026, most members enrolled in UnitedHealthcare Medicare Advantage HMO and HMO-POS plans will be required to obtain a primary care provider (PCP) referral before receiving certain specialist services in outpatient, office, or home settings. Referrals must be submitted by the PCP to UnitedHealthcare prior to the specialist visit and take effect immediately.

This requirement does not apply to many specialties and services, including primary care, OB/GYN, mental health, oncology, radiology, emergency and urgent care, preventive services, lab and diagnostic testing, PT/OT/ST, telehealth, and several others. UHC has also clarified that separate referrals are not required for providers within the same specialty under the same tax ID (TIN).

Although UHC has announced a temporary grace period and will not deny claims for missing referrals until May 1, 2026, referral requirements remain in place. Providers are encouraged to continue obtaining and documenting referrals now to avoid claim denials and payment issues once full enforcement resumes.

Full details:
Referral requirements for Medicare Advantage HMO/HMO-POS plans January 1, 2026

Anesthesia Conversion Factor Update

Kansas Medicaid issued a bulletin updating the anesthesia conversion factor used for anesthesia services. Effective for dates of service on and after January 1, 2026, the conversion factor applied to anesthesia codes will be $19.54. As with other KMAP policy updates, implementation by KanCare managed care organizations may vary from the effective date identified in the bulletin.

Healthy Blue Inpatient Status Criteria MCG 30th Edition

Healthy Blue, a Medicaid managed care organization operating in Kansas and Missouri, announced it will implement the 30th edition of MCG criteria for inpatient status determinations.

Federal Medicaid regulations define inpatient status based on an expectation that the patient will require at least 24 hours of hospital care, and this standard is not dependent on proprietary criteria.

If Healthy Blue applies MCG criteria in a way that is more restrictive than the 24-hour benchmark, it may result in inappropriate denials of inpatient status. Hospitals should monitor denials and ensure determinations are based on the federal standard rather than solely MCG guidelines.

Kansas Medicaid MS-DRG Version 43.1 Update

Kansas Medicaid announced that MS-DRG Grouper version 43.1 will be used for inpatient claims with discharge dates on and after April 1, 2026. Hospitals should ensure contract management systems, encoders, and billing tools are updated to reflect MS-DRG version 43.1 for Kansas Medicaid effective April 1, 2026.

Monkeypox Vaccine Reimbursement Update

Kansas Medicaid issued a bulletin updating reimbursement for the monkeypox vaccine effective April 1, 2026. The policy confirms reimbursement for vaccine code 90611 and administration codes 90460, 90471, and 90472.

Notably, CPT 90461, which reports additional vaccine administration for patients age 18 or younger, does not appear to have a published fee schedule rate on the KMAP website, while similar administration code 90472 does. If CPT 90461 is not reimbursed, providers administering additional vaccine components during pediatric encounters may not receive payment for that administration service.

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.