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The Health Alliance
OF MIDAMERICA

PAYER PULSE

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Join the Alliance

Do you have colleagues in your organization who wants 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

Suggested Action Items From This Issue

- Consider reviewing your Aetna agreement for language defining inpatient status, and whether payment of inpatient hospitalizations is subject a review of severity using MCG criteria.
- Consider whether your contract permits communicating objections or concerns to Aetna if Aetna's policy for inpatient payments may be inconsistent with your contract
- If your facility or professional service agreements with Blue KC have a Medicare-based methodology, consider whether bundling telehealth originating site fees – a service Medicare pays for separately – is inconsistent with your agreement sufficient to warrant communicating an objection to Blue KC.
- If your Blue KC professional service agreement uses a Medicare-based reimbursement methodology, consider whether bundling G0545 – a service Medicare pays for separately – is inconsistent with your agreement sufficient to warrant communicating an objection to Blue KC.
- Consider contacting your Cigna provider representative to request a list of any professional providers who may be affected by Cigna's E/M downcoding policy. Consider emailing EMCodingAccuracy@CignaHealthcare.com to request an exemption from the policy.
- Evaluate the volume of Cigna admissions between 4 and 30 days of a prior stay, and Cigna reimbursement received from those stays. Consider communicating the financial impact of Cigna's policy to expand its readmission policy from 72 hours to 30 days.
- Assess potential financial impact of Blue KC bundling S2900, 0054T, 0055T, and 20985 into procedures.
- Evaluate usage of G0545 on professional and assess potential financial impact if the service is bundled into payment for evaluation and management services by Blue KC.
- Ensure professional billing systems are updated to record anesthesia modifiers (AA, AD, QK, QX, QY) on anesthesia CPT codes.
- Assess financial impact of Blue KC's policy to deny payment for G0463 Hospital outpatient clinics, and UHC's reduction in payment for off campus hospital departments, and whether any impact is sufficient to warrant communicating a concern to these carriers.
- Determine if facility claims systems have the capability to transmit itemized bills electronically if billed charges exceed $100,000.
- Ensure claims systems are updated to permit reporting telehealth originating site fee code Q3014 to Anthem Blue Cross.
- Quantify potential impact of UHC's anesthesia reimbursement policy changes and assess if impact is sufficient to warrant an objection to UHC.
- Distribute Anthem's readmission policy and Cigna's readmission policy to UM/CM/physician advisor teams so their appeals of Anthem denials of readmissions can focus on criteria outlined in Anthem's policy as exceptions that may qualify for separate payment.
- Distribute Cigna's relaxed coverage criteria for bariatric surgical procedures to surgeons' offices

3 Important Update on Telehealth

COVID-19 Telehealth Flexibilities Expired September 30

Prior to the COVID-19 Public Health Emergency, telehealth benefits under Medicare were much narrower than they have been in the last 5 years. With limited exception, telehealth would only be covered if a patient presented to an eligible originating site like an RHC, FQHC, hospital, or office for example. Those eligible originating sites had to either be located in a healthcare provider shortage area or outside Metropolitan Statistical areas.

During the PHE, flexibilities allowed telehealth to be delivered to patients located anywhere in the United States, by any provider type enrolled with Medicare.

What Ended September 30?

Originating Site Types. Ability to render telehealth to a patient located anywhere in the U.S. Now, pre-COVID rules are reinstated that limit the originating site to:

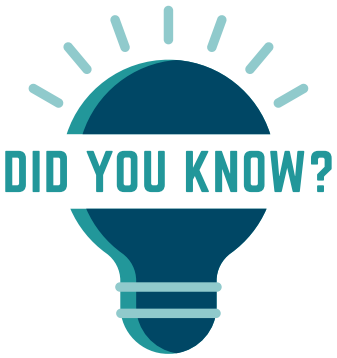
- The office of a physician or practitioner
- A critical access hospital
- A rural health clinic
- A Federally qualified health center
- A hospital
- A hospital-based or critical access hospital- based renal dialysis center
- A skilled nursing facility
- A community mental health center

Originating Site Locations. Eligible originating site types must be in a **healthcare provider shortage area** or outside a **Metropolitan Statistical Area**.

Distant Site Providers. FQHCs, RHCs, speech-language pathologists, physical therapists, and occupational therapists are no longer eligible distant site billers for telehealth.

In-Person Visit Requirements. If a mental/behavioral telehealth visit is delivered to a new patient at home or outside an eligible geographic location, the patient must be seen in-person in the 6-months prior to the telehealth visit. Patients who have been receiving these services via telehealth do not need an in-person visit in the preceding 6-months.

Can Payers Adopt Policies that Conflict with Coding Rules?



Federal HIPAA regulations establish ICD-10-CM and PCS as the standard medical data code sets for inpatient claims, and CPT as the standard medical data code set for outpatient procedures. This includes not only the codes themselves, but the official guidelines for coding and reporting created by the responsible code set maintenance organization.

All HIPAA Covered Entities, Including Health Plans, Must Use Standard Code Sets in Health Care Transactions

> The adoption of standard code sets and coding guidelines for medical data supports the regulatory goals of cost-effectiveness and the avoidance of duplication and burden. The code sets that are being proposed as initial HIPAA standards are already in use by most health plans, health care clearinghouses, and health care providers.
> *65 Fed Reg 50312, 50361 (Aug. 17, 2000)*

Submitting a Complaint

Question: How do I file a HIPAA complaint if my organization is concerned that another covered entity (health plan, health care clearinghouse, or covered health care provider) is not complying with the use of the standards, operating rules, or code sets?

Answer: You may file a complaint utilizing the **NSG ASETT tool**. To check on the status of a complaint, you can use ASETT, the HIPAA mailbox at HIPAAcomplaint@cms.hhs.gov or write to: Centers for Medicare & Medicaid Services National Standards Group: HIPAA Enforcement P. O. Box 8030, Mailstop D0-01-10, Baltimore, Maryland 21244-8030

Who Enforces Health Plan Code Set Compliance?

The Department of Health and Human Services National Standards Workgroup enforces Administrative Simplification provisions by investigating complaints alleging noncompliance. NSG will request and review documentation from entities to determine if a violation of a standard has occurred. Where it has been determined that a violation has occurred, NSG may request that the "filed against entity" (FAE) take corrective action to remediate the issue. Where an FAE fails to undertake required corrective action and a violation persists, NSG may impose a Civil Money Penalty.

Negotiator Notes

Q: When Can Payers Change a Contract Unilaterally?

A: It depends on each agreement's language. Usually, you will find a series of provisions at the end of the contract under a "General" or "Miscellaneous" heading. This area of the agreement often contains procedures for amending the agreement. Usually, amendments require a signature by both Parties. But, there may be language allowing unilateral changes by the contracting payer in certain situations.

Examples of Situations Contracts May Allow A Payer to Unilaterally Change a Contract

1. **None. All changes will be made by mutual agreement of the Parties through signed, written amendment.**
2. **Required by Law. Payer may amend the agreement to comply with changes to laws or regulations.**
3. **Any Time. Payer may change the agreement upon written notice, and change are accepted unless contract is terminated or provider objects.**

CAUTION

Examine whether a contract allows an amendment to be initiated when there is a change in law, or rather if the scope of the amendment is limited as necessary to comply with legal changes.

The Fine Print

Check every proposed amendment sent to your facility. Understand when your contract allows unilateral changes; understand your rights to give notice if you object to proposed terms. Compare **all language** in a proposed amendment – not just the terms the payer suggests are being updated.

Aetna Will Pay *Observation Rates* Unless / Until Hospitalization Meets MCG Criteria

Effective November 15, 2025, Aetna Medicare Advantage will adopt a new reimbursement approach for hospital stays of 1+ midnight in cases where a member is urgently or emergently admitted to a hospital and the provider has submitted an inpatient order.

Aetna will approve the inpatient stay without a medical necessity review and pay the claim at a lower level of severity rate that's comparable to your rate for observation services. If the inpatient stay meets MCG (Aetna Supplemental Guidelines for inpatient admissions), Aetna will pay the claim at your contracted inpatient rate. Aetna characterizes its use of MCG as a determination of whether the severity of an inpatient stay justifies your inpatient contracted rate and suggests MCG is not use dot make a medical necessity determination.

This policy doesn't apply to stays that are less than 1 midnight. Cases that are less than 1 midnight will still be subject to medical necessity reviews using Centers for Medicare & Medicaid Services (CMS) guidelines.

What is a 90-Day Notice?

Aetna's upcoming "Level of Severity Inpatient Payment Policy" was announced to providers in Aetna's monthly provider bulletin under a heading called "90-Day Notices". This refers to a contractual provision that may be used between a facility and payer requiring advance notice of policies that may have material impact to the facility. For example, the payer may commit to providing 90-days advance notice of material changes to policies and procedures.

Aetna Instructions for Lesion Removal Are Inconsistent with CPT Rules

Effective November 1, 2025: CPT® codes for benign and malignant integumentary lesion excisions (11400–11471 and 11600–11646) should be used for excision of cutaneous lesions as well as for superficial subcutaneous lesions. Following a complaint to CMS that this policy was inconsistent with CPT guidelines, Aetna's October bulletin clarifies this instruction applies "when the subcutaneous lesion has a cutaneous origin"

Blue KC Telehealth Policy Updates

Audio-only telephone services, CPT codes 99441-99443, have been deleted and replaced with 98008 – 98015. Blue KC will accept both the new telehealth codes 98000 – 98016 and office visit codes 99202-99215 for telehealth evaluation and management services. Please remember to use the correct telehealth place of service codes 2, or 10. Blue KC also indicates it follows the **Medicare list of covered telehealth services.**

Modifiers 95, GT, GQ and G0 are not required to identify Telehealth services but are accepted as informational only if reported on claims with eligible Telehealth services.

Blue KC's policy does not recognize speech, occupational, physical therapy as eligible telehealth providers.

Best practice suggests that documentation should also include a statement that the service was provided through telehealth, both the location of the patient and the provider and the names and roles of any other persons participating in the telehealth service.

HCPCS code Q3014 (Telehealth originating site), is considered mutually exclusive to other telehealth services and is not separately reimbursable for all lines of business.

Blue KC Prolonged Service and Visit Complexity Policy Makes CMS-Covered Add-on Code for Infectious Disease a Bundled Service with No Separate Payment

G0545 is a Medicare HCPCS code for visit complexity inherent to hospital inpatient or observation care associated with confirmed or suspected infectious diseases, specifically for use by infectious disease specialists.

Blue KC announced it will not make separate payment for this service, and believes compensation for this item is subsumed by the underlying evaluation and management code.

Blue KC Will Bundle Robotic Assistance

Blue KC will bundle robotic and computer assistance into the primary procedure reported. This includes codes S2900, 0054T, 0055T, and 20985. Reimbursement will be based on the standard code for the procedure. Blue KC considers robotic assist and computer assist a component (subset to) the primary procedure. This applies to both professional and facility claims.

Blue KC Will Not Pay Certain Prolonged Services

Blue KC will not separately reimburse HCPCS code G0545 and considers payment to be subsumed by the payment for services to which it is incident to. G0545 is an add-on code reported with evaluation and management services and describes visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious disease specialist. The code was created and is paid by Medicare.

Blue KC's Implant Policy

Effective September 1, 2025, Blue KC adds a reference to the FDA's definition of an implant to its Facility Billing - Implants policy.

Definition of Implant. Blue KC's policy states "The Food and Drug Administration (FDA) defines an implant as a device placed into a surgically or naturally formed cavity of the human body, intended to remain there for 30 days or more." Compare to the FDA regulatory definition, that can encompass other items placed for shorter durations. It is unclear if Blue KC intentionally omits those shorter-duration circumstances from its policy.

Blue KC's policy states: "Liquids or materials that are absorbed or incorporated by the surrounding tissue will not be reimbursed if billed as an implant." *See NUBC definition that includes liquids.*

Degraded or resorbable material. As written, it is also not clear if Blue KC's policy also encompasses implants that are "intended to degrade or resorb over time". See *FDA Guide, **Here***.

✔ **Revenue code 0274.** Blue KC's policy says "Revenue codes 0270 – 0274 are for medical and surgical supplies and devices. Items that fall under these codes are not considered implants. This differs from NUBC, which includes revenue code 0274 as an identifier of implants.

✔ **Revenue codes 0275, 0276.** Blue KC's policy does not consider cardioverter-defibrillators, pacemakers, or lenses to be implants.

Shipping and storage. Blue KC's policy states "provider or vendor administrative storage and delivery costs will not be reimbursed."

Blue KC Will Not Pay Telehealth Originating Site Fees

Effective September 1, 2025, revenue code 0780, Telehealth general classification, will be used to bill facility fees associated with the telehealth originating site. This code will be considered mutually exclusive to other telehealth services and is not separately reimbursable.

Chemo Drug Brexanolone Classified as Experimental by Blue KC

Effective July 1, 2025, Blue KC's Miscellaneous Investigational Procedure policy identifies HCPCS J1632, Brexanolone, often used for depression, as experimental. This medication is considered for coverage by most other plans such as Aetna, Molina, and many regional Blue Cross plans.

Blue KC Will Generally Follow CMS's Inpatient-Only List

CMS publishes **an annual list** of CPT codes that are only paid under the Medicare ❗ program in the inpatient setting. Blue KC will generally follow this list, except if "the provider's Blue KC network participation agreement contains a specific rate of reimbursement for the Inpatient-only procedure code performed outside of an acute hospital setting".

Blue KC Updates Anesthesia Modifier Requirements

Effective October 1, 2025, Blue KC will require the appropriate anesthesia modifier (AA, AD, QK, QX, QY) to be added to all anesthesia services to indicate who performed the service and if the service was medically directed.

Claims without an appropriate anesthesia modifier will be denied.

Blue KC to No Longer Recognize Hospital Outpatient Departments' Clinics

Claims received on or after December 1, 2025, with HCPCS code G0463 Hospital Outpatient Clinic Visit for Assessment and Management of a Patient will be denied as non-covered and provider responsibility.

Additionally, under its **Revenue Codes Requiring HCPCS Codes Policy**, Blue KC now states Evaluation and Management services (99202-99499, G0380-G0384, G0463, and G2212) will be denied when billed in a treatment room (revenue codes 0760, 0761, and 0769).

For claims received on or after October 1, 2025, Blue KC will deny services when a CPT/HCPCS code is missing from a revenue code that requires it based on CMS, the Uniform Billing Editor, and the UB-04 manual that requires certain revenue codes to be submitted with the appropriate CPT/HCPCs code. For a complete list of revenue codes requiring CPT/HCPCS, **see the full policy for POL-PP-229 Revenue Codes Requiring HCPCS Codes Payment Policy**.

High Cost Claims Update

Blue KC will begin the Prepayment DRG and Clinical Chart Validation Review Audit for dates of service on or after January 1, 2026. This will allow additional time for providers to make any necessary process changes to submit itemized bills and medical records to Blue KC. However, Blue KC encourages providers to submit itemized bills prior to the effective date of the audit.

Blue KC requires submission of itemized bills with all facility claims with a billed charge of $100,000 or more with a reimbursement methodology of DRG, DRG outlier or discounted charges for inpatient and outpatient claims. Medical records and/or itemized bills may also be requested as needed to support Blue KC payment integrity audits.

Anthem Relaxes Bundled Services Policy for Telehealth

Effective 10/1/2025, Anthem removed from its bundles services policy: Telehealth originating site facility fee (Q3014) when reported with an E&M code in place of service 11 this is included in the Virtual Visits (C08002).

Anthem Readmissions Policy

Anthem does not allow separate reimbursement for claims that have been identified as an unplanned readmission. Clinical coding criteria and/or licensed clinical medical review will be used to determine if the subsequent admission is for:

- The same or closely related condition or procedure as the prior discharge.
- An infection or other complication of care.
- A condition or procedure indicative of a failed surgical intervention.
- An acute decompensation of a coexisting chronic disease.
- A need that could have reasonably been prevented by the provision of appropriate care.
- An issue caused by a premature discharge from the same facility.

Negotiator Notes

What is an Implant?

Understanding how to define an implant has important contracting and revenue implications. Often, managed care contracts carve out payment for implantable items from other reimbursement methodologies like surgical groupers. To receive the carve-out payment, there must be an implant involved, and it must be reported on the claim in a manner that qualifies for carve-out payment. For example, using revenue code 0278.

A frequent facility - payer dispute surrounds whether certain items qualify for carve-out implant payments. To avoid those disputes, it's important to understand how your agreement or payer policy defines an implant. There are several industry definitions for implants to consider.

- **Food and Drug Administration.** "Implant means a device that is placed into a surgically or naturally formed cavity of the human body if it is intended to remain there for a period of 30 days or more. FDA may, in order to protect public health, determine that devices placed in subjects for shorter periods are also "implants" for purposes of this part." 21 CFR 812.3(d).

- **National Uniform Billing Committee.** Billing under revenue 0274, 0275, 0276, and 0278 requires compliance with the NUBC definitions for these revenue codes. NUBC defines an implant as "that which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, a tube or needle containing a radioactive substance, a graft or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas surgically or artificially removed, stents, artificial joints, shunts, pins, plates, screws, and anchors.

> "There is no permanency requirement absent a contractual provision to the contrary"

Watch Payer Policies. Monitor your major carriers' policies that discuss how implants are defined and will be reimbursed. Compare those policies to your contract to understand if those policies are consistent with your negotiated terms and expectations.

Monitor Refund Requests. Many carriers leverage contractors to audit claims containing revenue codes for implants. These contractors may not always have the language for your specific agreement to use in reviewing claims and corresponding records.

Cigna May Auto-Downcode Evaluation and Management Services

Effective October 1, 2025, Cigna will begin periodic reviews of CPT® codes 99204- 99205, 99214-99215, 99244-99245 and "services may be adjusted by one level to reflect the appropriate reimbursement when the AMA guidelines are not met."

If Cigna determines, based on claims, data that "established guidelines were not followed", it will request supporting documentation. Providers who believe their medical record documentation supports reimbursement for the originally submitted level for the E/M service should follow the reconsideration and appeals processes.

Cigna Hospital Site of Care Policy May Affect Access to Hospital Outpatient PT/OT

Beginning October 1, 2025, A Cigna contractor American Specialty Health (ASH) will begin reviewing medical necessity reviews for hospital outpatient physical and occupational therapy for Cigna commercial plans. ASH will follow Cigna's Site of Care policy to approve initiation or continuation of hospital based PT or OT. Cigna's Site of Care policy expects hospital-based therapy to be reserved for situations that require specialized equipment, specialized personnel (e.g., Board Certified Cardiovascular and Pulmonary Clinical Specialist, wound care certified), or when a freestanding facility is not available within a reasonable distance. Alternatively, hospital outpatient PT/OT may be approved if patients meet a list of certain medical circumstances. The source of supporting medical literature for Cigna's policy is unclear.

Cigna Expands its Readmission Policy

Effective July 1, 2025, Cigna's readmission policy considers hospital stays within 30 days (formerly 72 hours) to be readmissions if the admitting diagnosis is the same or similar as a prior hospitalization, regardless of the final diagnosis. There are no exclusions for unavoidable admissions or instances Cigna declined to authorize the level of post-acute care hospital requested. **July 24, 2025**, Cigna announced a correction to clarify planned readmissions are excluded from the policy.

Bariatric Surgery Will Be Covered for Lower BMIs Than Previously Covered, Expanding Access

Cigna lowered BMI requirements for bariatric surgery. Effective August 1, 2025, bariatric surgery will be covered by Cigna for patients with a BMI of ≥35 kg/m2 regardless of the presence, absence, or severity of obesity-associated medical problems (BMI ≥27.5 kg/m2 in Asian population). BMI of 30–34.9 kg/m2 is covered for individuals with type 2 diabetes mellitus and/or other obesity-associated medical problems (BMI ≥25 kg/m2 in Asian population).

Humana Payment for Originating Site Requires Corresponding Distant Site Charges

Humana does not reimburse charges for HCPCS code Q3014 if billed by a facility, unless an eligible telehealth service has been reported for the same date of service.

HCPCS code Q3014 is defined as: telehealth originating site facility fee.

Post-operative follow-up visit complexity inherent to evaluation and management – HCPCS code G0559

Notification number: 8048
Effective date: 7/3/2025
Notification date: 3/5/2025

Humana does not reimburse charges for HCPCS code G0559 if:

- Billed without an evaluation and management (E/M) services code
- Billed more than once in 90 days during the global period of the same surgical procedure
- The surgery code in history is billed with the same tax identification number as HCPCS code G0559, unless modifier 54 is present

Humana will Pay G2211 Inherent Complexity Add-On: Claims Edits Can Help Ensure Prompt Processing

Humana does not reimburse charges for HCPCS G2211 if:

- Reported without one of the following evaluation and management (E/M) CPT codes: 99202–99205 and 99211–99215
- Reported more than once per date of service. (Same provider, same member, same date of service)
- G2211 is reported with modifier 25.

HCPCS G2211 is defined as: 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 (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established).

Humana Edits Deny Payment for Esketamine if Reported for Wrong Dosage

Notification number: 7739
Effective date: 3/6/2025
Notification date: 12/6/2024

Humana does not reimburse charges for HCPCS code G2082 if billed with an national drug code (NDC) for an 84 mg dose of esketamine nasal spray. G2082 is and office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation. According to the HCPCS code descriptor and the drug manufacturer instructions, HCPCS code G2082 is only used for the provision of the 56 mg dose of esketamine nasal spray.

UHC Implements *Medicare* Edits on *Medicaid* Claims

UHC's Medicaid plan in Texas announced implementing edits that bundle payment for a range for shoulder surgery procedures based upon National Correct Coding Initiative Edits. The edits referenced in UHC's policy apply to the Medicare program, though, and do not exist in CMS's Medicaid NCCI edits. While the policy only applies in Texas at this time, we will monitor for expansion of the policy into Kansas and Missouri.

UHC Medicare Advantage Policy for Cardiovascular Diagnostic and Therapeutic Procedures

UHC 's coverage policy for Lower Extremity Stenting, Atherectomy, and/or Angioplasty defers to WPS Medicare's **local coverage determination**. However, UHC Medicare Advantage's policy states: "compliance with these policies is required". ❗ If this statement reflects UHC MA's intent to enforce LCDs as mandatory policies for coverage, the result may be unnecessary or inappropriate denials of coverage and payment for care. LCDs guide, but do not dictate, coverage and payment and are not binding on Medicare program adjudicators.

UHC Reduces Payment for Off Campus Departments

Effective September 1, 2025, UHC will implement payment reductions on commercial claims when services are rendered at an off-campus, provider based department and modifier -PO is appended. Modifier -PO was developed by CMS to identify services rendered at excepted off-campus hospital outpatient departments. **"Excepted" departments are those** off-campus hospital departments within 35-miles of the main campus that was furnishing services billed under OPPS prior to November 2, 2015. CMS will reduce payment for G0463 hospital outpatient clinic visits **by 60%**. The policy does not apply to the following facility types:

- Services rendered in the Emergency Department
- Critical Access Hospitals
- Psychiatric, Rehabilitation, or Long-Term Care Hospitals or Hospital Units
- Hospitals located in Maryland, Puerto Rico or the U.S. territories
- Rural Sole Community Hospitals
- Indian Health Service hospitals

The policy to reduce payment will apply to any contracted allowable for commercial plans - not just those based upon Medicare methodologies.

UHC Policy Eliminates Numerous Anesthesia Unit Payments

Effective October 1, 2025, UHC will:
1) no longer recognize physical status modifiers P3, P4, or P5 for additional anesthesia units;
2) decrease CRNA reimbursement by 15% on lines with a -QZ modifier describing personally performed CRNA services; and
3) no longer recognize CPT codes describing qualifying circumstances that complicate anesthesia as eligible for additional anesthesia units.

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)

Policy Number: CS356.D **(Missouri)** CS356KS.01 **(Kansas)**
Effective Date: December 1, 2025
Applicability: Medicaid

UHC will use Interqual to make inpatient status determinations. "If the individual's condition does not improve within 48 hours, additional clinical information should be submitted to support an inpatient level of care."

Under **42 CFR 440.2**, an inpatient under the Medicaid program is one who is expected to remain in the facility more than 24 hours.

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.

Missouri Medicaid Increases Anesthesia Rates

Pending Centers for Medicare & Medicaid Services (CMS) approval, effective for dates of service on and after July 1, 2025, the MO HealthNet Division (MHD) will increase the conversion factor for anesthesia services. Upon CMS's approval of the State Plan Amendment, MHD will update the claims processing system with the indicated conversion factors and reprocess claims paid for dates of service on or after July 1, 2025.

Modifier	Modifier Description	Current Conversion Factor	Conversion Factor Effective July 1, 2025
AA	Anesthesia service performed personally by anesthesiologist	$10.29	$12.98
QK	Medical direction of two (2), three (3), or four (4) concurrent anesthesia procedures involving qualified individuals	$3.14	$3.89
QX	Certified Registered Nurse Anesthetist (CRNA)/Anesthegiologist Assistant (AA) service; with medical direction by a physician	$7.15	$9.09
QZ	CRNA service; without medical direction by a physician	$7.15	$9.09

Healthy Blue Missouri Respiratory Virus Testing Policy

Missouri Medicaid pays for respiratory virus testing, codes 87631 - 87633. Healthy Blue's policy CG-LAB-14 identifies codes 87632, 87633 as not medically necessary.

Effective January 1, 2026, "respiratory viral panel testing in the outpatient setting is considered not medically necessary and will no longer be reimbursed when testing average-risk individuals or when large panels involving six or more targets are used."

It is unclear how this changes prior policy language, under which there were no circumstances when codes 87632, 87633 would be covered.

Healthy Blue does not define "average risk" or above-average risk that may warrant coverage for testing against a greater number of respiratory viruses.

UHC Medicaid Plan Limits Coverage of Remote Physiologic Monitoring

Effective January 1, 2026, UHC's Medicaid Community Plan will only cover remote physiologic monitoring for heart failure and hypertensive disorders of pregnancy. In Missouri, RSMo 208.686 requires the Department of Health and Social Services cover remote monitoring services for pregnancy; diabetes; heart disease; cancer; chronic obstructive pulmonary disease; hypertension; congestive heart failure; mental illness or serious emotional disturbance; asthma; myocardial infarction; or stroke if the patient has two or more risk factors. Risk factors include: (a) two or more hospitalizations in the prior twelve-month period; (b) frequent or recurrent emergency department admissions; (c) a documented history of poor adherence to ordered medication regimens; (d) a documented history of falls in the prior six-month period; (e) limited or absent informal support systems; (f) living alone or being home alone for extended periods of time; (g) a documented history of care access challenges; or (h) documented history of consistently missed appointments with health care providers.