2026
VOLUME 2
EDITION 1

The Health Alliance
OF MIDAMERICA

PAYER PULSE

INSIDE THIS ISSUE

- Action Items 2
- Experimental/Investigational Status 3
- Aetna 4
- Blue Cross 5,6
- Cigna 7
- Humana 8
- United Healthcare 9
- WPS 10
- Medicaid 11

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

- Consider evaluating your claims denied for "experimental / investigational" or medical necessity-related reasons where your claim included a prior authorization number. This may indicate improper denials of authorized services.
- If you offer telehealth services to Medicare Advantage members, consider evaluating if you have received denials on or after October 1, 2025 which could pertain to Aetna telehealth policies that are more restrictive than Traditional Medicare
- Edit for Aetna claims with radiology, diagnostic, laboratory, or surgical services reported with ICD-10-CM codes Z53.01, Z53.09, Z53.1, Z53.20, Z53.21, Z53.29, Z53.8, and Z53.9, and without modifiers 52, 53, 73, or 74 to help avoid preventable denials.
- Consider evaluating whether your Blue KC contract requires payer compliance with coding guidelines and, if so, consider expressing concern with critical care coding policies that conflict with, and more restrictive than, CPT rules.
- Escalate denials of inpatient prior authorization for Blue KC inpatient-only procedures. Note that out of area Blue Plans may not follow the inpatient-only list.
- Review DME date of service billing for compliance with Blue KC policy.
- Ensure 90-day supplies of DME are billed monthly to Blue KC.
- Evaluate impact of Blue KC's policy to deny clinic visits billed by hospital, and consider if a communication expressing concern for adverse financial impact is warranted.
- Ensure charge capture of prolonged service code G2212 for Blue KC.
- For colorectal cancer screening, ensure Guardant Shield claims meet Humana's coverage criteria, and block all non-covered blood-based biomarker tests and FIT-DNA claims the required age/frequency limits.
- Update workflows to ensure use of HCPCS codes G8431 and G8510 for depression screening and follow-up, apply TH modifier appropriately for perinatal populations, and monitor annual unit limits to avoid denials prevent denials under Missouri Medicaid Managed Care.
- Consider notifying Aetna of concerns with a coding policy to bundle 15734 and 49659 with ventral hernia repair in the absence of coding rules supporting this approach.
- Ensure inpatient billing teams are using the updated MO HealthNet APR-DRG calculator effective December 3, 2025, including verification of out-of-state hospital listings, to prevent inpatient claim errors.
- Review claim edits to ensure ICD-10 codes B02.21–B02.29 and M54.16 are not billed for transforaminal injection procedures.
- Create edits for Medication Assisted Treatment codes G2067–G2075 to flag frequency > 1 per 7 days to avoid potentially preventable denials.
- Update E/M billing practices to reflect that Cigna allows separate reimbursement for CPT® 99459 when billed with office and outpatient E/M codes 99202–99205 and 99212–99215 effective October 11, 2025.
- Notify wound care providers of Cigna's newly covered products (Marigen Pacto, Grafix Duo) and update charge masters accordingly.
- For skin substitute products newly classified as experimental or investigational by Cigna, consider obtaining patient financial responsibility forms prior to product use.
- For chronic pain injections, review Humana's updated coverage criteria to ensure medical necessity, imaging guidance, repeat-injection requirements, and same-day injection restrictions are all met before billing.

Negotiator Notes

When Do Payers Designate Care as "Experimental/Investigational" and Why Does It Matter?

A: Payers designate items or services as “experimental” or “investigational” when they believe a procedure, item, or product lacks sufficient clinical evidence to meet the definition of a covered benefit under a health plan. Often, benefit plans only cover Medically Necessary services, to the exclusion of those that are Experimental or Investigational. Beware, though, each individual benefit plan may define Medical Necessity differently, while the carrier often applies one-size-fits-all policies in their administration of claims and benefits. Just as importantly, your contract with a carrier may not define or exclude experimental or investigational services from the carrier’s obligation to pay.

Examples of How Experimental/Investigational Designation Impacts Payment and Contracting

1. If your contract provides for payment of Medically Necessary services, and “Medical Necessity” does not exclude experimental/investigational items, you may be contractually entitled to payment despite payer’s designation of an item as experimental/investigational

2. If your contract defers to a covered individual’s specific benefit plan, a determination of whether an item or service is experimental / investigational and/or a covered benefit can only be determined by reviewing and applying the specific plan’s terms.

3. If you obtained predetermination or prior authorization for an item or service, so long as circumstances have not changed (e.g. patient’s condition is materially the same, service was rendered as authorized, patient has the same benefit plan), you cannot be denied payment for lack of medical necessity. Ensure the auth number is on the claim form.

Aetna

Payment for Aetna Medicare Advantage (MA) Telehealth services

The expanded Centers for Medicare & Medicaid Services (CMS) telehealth flexibilities that were in place during the COVID-19 public health emergency technically expired briefly before being extended by Congress through January 30, 2026. **Aetna reinstated Medicare telehealth payment restrictions as of October 1, 2025.**

Reduced/Discontinued Services Billing Requirement

Effective April 1, 2026 (commercial and Medicare Advantage), Aetna will require modifiers 52, 53, 73, or 74 when billing radiology, diagnostic, laboratory, or surgical services reported with ICD-10-CM codes Z53.01, Z53.09, Z53.1, Z53.20, Z53.21, Z53.29, Z53.8, and Z53.9. Claims submitted without the applicable modifier will be denied.

Transforaminal Epidural Injections Medical Policy Update

Effective April 4, 2026, Aetna will designate several services as Experimental, Investigational, or Unproven.

- Combined pulsed radiofrequency and transforaminal epidural steroid injection for treatment of herpes zoster (HZ)–related pain
- Combined pulsed radiofrequency and transforaminal epidural steroid injection for treatment of lumbar radiculopathy

ICD-10 Codes Not Covered for These Indications:

- B02.21 – B02.29: Zoster with other nervous system involvement (Herpes zoster pain)
- M54.16: Radiculopathy, lumbar region

Medication-Assisted Treatment Services

Effective April 1, 2026 (Commercial and Medicare Advantage)

Aetna will bundle weekly Medication-Assisted Treatment (MAT) service codes G2067–G2075 when billed within seven days of each other. This is a minor deviation from **Medicare's billing instruction, which recognizes** there may be "limited situations such as a beneficiary starting treatment at the OTP in the middle of the OTP's standard weekly billing cycle"

Ventral Hernia Coding Update

Effective April 1, 2026 (commercial and Medicare Advantage)

Aetna will deny CPT® codes 15734 and 49659 as incidental when billed with repair of ventral hernia repairs up to 10 centimeters. There are no CPT® guidelines nor CMS Correct Coding Initiative language indicating the policy would be consistent with industry standards.

Emergency Care Reimbursement & Billing

Blue KC added new requirements to support medical necessity for critical care professional services. In addition to CPT® definitions, Blue KC now requires providers to meet two added medical review criteria, which may increase documentation burden and create risk of denied or downgraded claims:

- **Clinical condition criterion:** The patient must present a "tremendous likelihood" of sudden, clinically significant, or life-threatening deterioration requiring the highest level of physician preparedness to intervene urgently
- **Treatment criterion:** Critical care services must involve direct physician management using life- or organ-supporting interventions (e.g., mechanical ventilation, vasopressors, dialysis) that require frequent personal assessment and manipulation by the physician. Blue KC notes that failure to initiate these urgently would most likely result in rapid deterioration.

Blue KC Updates DME Billing and Documentation Rules

- Certain DME items now require a face-to-face visit with the ordering provider within six months before the order date.
- The date of service should be the date the item is delivered, not the date ordered. If a delivery or shipping service is used, the supplier may report the shipping date as the date of service. These instructions align with Medicare.
- Submit claims for 90-day supplies monthly

Blue KC Will Implement CMS's Inpatient-Only List

Blue KC will implement CMS's inpatient-only list consisting of surgeries/procedures that will only be paid as an inpatient procedure in an acute hospital setting. Although announced before CMS finalized elimination of the inpatient-only list over the next three years, Blue KC has not yet clarified whether it will follow CMS or retain the current inpatient-only list.

Blue KC Will Not Recognize Facility Clinic Visit Charges

Blue KC continues to deny payment for facility clinic visit charges, treating these services as non-covered. Providers should be aware that these claims are being systematically denied even when billed with valid CPT®/HCPCS codes and supporting documentation.

Medical Policies Removed From Website

Blue KC has removed several medical policies from its public provider website, including:

- Catheter Ablation as Treatment for Atrial Fibrillation (Commercial, Medicare)
- Kidney Transplant (Commercial, Medicare)
- Myoelectric Prosthetic and Orthotic Components for the Upper Limb (Commercial, Medicare Advantage)
- Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers (Commercial, Medicare)
- Transcatheter Mitral Valve Repair (Commercial, Medicare)

Providers who rely on these policies should be aware that these documents are no longer available online and may need to reference external sources for clinical criteria and coverage requirements.

Prolonged Services Billing

Blue KC updated its Prolonged Services – Reimbursement & Billing policy to once again recognize CPT® code G2212, which had been removed in 2022.

Blue KC ED Coding Tip Sheet Contains Multiple CPT Inaccuracies

Blue KC's emergency department coding tip sheet contains several discrepancies from CPT® guidance:

- Blue KC omits required CPT® phrasing for 99285, removing "or side effects of treatment" from the number and complexity of diagnoses element.
- Blue KC substitutes "severe… progression of adverse effect," which is not consistent with CPT® and misrepresents disease progression vs. adverse effects of treatment.
- Blue KC instructs providers to review prior external records "from a unique source," while CPT® requires review from each unique source, which impacts medical decision-making credit.
- Blue KC's Independent Interpretation definition excludes "other qualified health care professionals," although CPT® includes them.
- Blue KC defines major surgery based on "complexity and risk," inconsistent with CMS guidance and Blue KC's own policies, which classify major surgery as procedures with a 90-day global period.
- Blue KC adds high-risk criteria not supported by CPT®, including decisions regarding parenteral controlled substances (opioids, barbiturates, amphetamine drugs) and "other high-risk testing or treatment." CPT® does not assign high-risk MDM based solely on drug class involvement.
- Blue KC provides incorrect lesion excision guidance, instructing providers to "add the size of two lesions together" to determine code selection. CPT® requires reporting the total excised diameter for each lesion individually, not the combined lesion sizes.

Pelvic Exam Reimbursement Clarification

Effective **October 11, 2025**, Cigna will no longer deny CPT® code 99459 for pelvic examinations when reported with office or outpatient evaluation and management codes 99202–99205 and 99212–99215.

Cigna Expands List of Experimental and Investigational Products

Several products are now classified as experimental, investigational, and unproven, including:

- Acelagraft
- Acesso
- TrifACA
- AminoPlast Double
- Apollo FT
- Axolotl Graft Ultra
- InnovaMatrix FD
- Natalin
- NeoThelium FT
- NeoThelium 4L
- NeoThelium 4L+
- Summit AAA
- SurGraft AC
- SurGraft ACA

This update expands treatment options for diabetic foot and venous stasis ulcers but maintains restrictions on newer or less-studied products.

EviCore Lab Management Code List Update

Cigna and eviCore issued a new version of the Lab Management Code List, which outlines laboratory procedure codes that are "under management" and require prior authorization through eviCore rather than directly through Cigna. This document can assist patient access teams in verifying whether prior authorization is needed, ensuring requests are submitted to the correct entity and obtained in a timely manner.

Cigna Modifier 22 Increased Procedural Services Update

Cigna updated its Modifier 22 Increased Procedural Services reimbursement policy. The policy states that Cigna may reimburse up to 120% of the applicable fee schedule when modifier 22 is used, provided documentation supports substantially greater work, time, or complexity than usual. Cigna notes that modifier 22 should be used only in limited situations and requires supporting documentation such as operative reports or office notes. The policy also reiterates that modifier 22 should not be used with E/M services.

Behavioral Health Coaching and Peer Support Services

Cigna Healthcare has published a new Commercial Medical Policy establishing coverage for Behavioral Health Coaching and Peer Support Services. The policy provides coverage for these services under Cigna's commercial plans, reflecting an expansion of covered behavioral health support options.

Clean Claim and Pass-Through Billing

Humana's Provider Manual defines a clean claim differently than the Medicare Advantage regulatory definition of a clean claim at 42 C.F.R. § 422.500. Humana's definition indicates a clean claim is not one that is "pended for review", which allows otherwise clean and complete claims to be pended for prepayment review of medical records without creating an obligation to pay interest.

While not new, the manual reiterates Humana's prohibition on pass-through billing, defined as billing for services not performed by the billing provider or an individual under the provider's direct employment. Services identified as pass-through billing are not eligible for reimbursement, and providers may not bill, charge, or seek payment from Humana or members for such services.

Telehealth and Virtual Services Billing Guidance

Applies to All Lines of Business

A professional provider billing as the distant site for a telehealth service is not eligible to receive reimbursement for an originating site fee in addition to the professional telehealth service. Consider, for example, a professional rendering a telehealth visit from clinic location A to a patient physically located in Clinic B.

Humana recognizes telehealth place of service billing codes 02 and 10.

Humana Inpatient Admission Criteria Update

Humana suggests its inpatient admission criteria are based on 42 CFR 412.3 (CMS inpatient admission criteria). Humana uses MCG guidelines to interpret the reasonableness of the admitting physician's expectation of a two-midnight or longer stay. MCG guidelines do not identify the expected duration of a length of stay, and the sources they rely upon do not identify expected lengths of stay either.

Cigna, UHC

Respiratory Viral Testing Policy Update

UnitedHealthcare Community Plan announced an implementation delay for its medical policy addressing Respiratory Pathogen Nucleic Acid Detection Testing. The policy, which had been scheduled to take effect on January 1, 2026, will now be implemented on February 1, 2026. As written, the policy applies coverage parameters more restrictive than those currently in place under Kansas and Missouri Medicaid fee-for-service programs.

Cigna Medicare Advantage Facility Clinic Visit Payment Update

Effective January 1, 2026, Cigna Healthcare Medicare Advantage updated its facility claims payment policy for hospital outpatient clinic visits. Under the updated policy, Cigna will:

- No longer deny facility claims billed with HCPCS code G0463 (hospital outpatient clinic visit) and revenue code 0510 (hospital-based outpatient clinics) for both participating and nonparticipating providers.
- Pay facility claims for both participating and nonparticipating providers when billed with any CPT®/HCPCS codes and revenue codes 0510–0519 or 0520–0529. A primary care provider or specialist cost share will apply based on the member's benefit plan.
- Continue to pay professional claims billed with CPT® codes 99202–99215 and place of service (POS) 19 or 22, with no member cost share when POS 19 or 22 is reported.

Prior Authorization Submission Update

UnitedHealthcare no longer accepts prior authorization requests submitted by fax. Providers must submit prior authorization requests through UnitedHealthcare's designated electronic submission channels in accordance with current plan requirements.

Prior Authorization and Notification

Medical Policy & Coding Updates – Wound Care

Wound Care – ICD-10-CM Codes Added to Medical Necessity Criteria

Effective October 1, 2025, wound care medical necessity criteria have been updated to reflect the 2026 ICD-10-CM annual code revisions. The list of Group 1 ICD-10-CM codes supporting medical necessity has been expanded to include L98.431; L98.A111–L98.A118; L98.A121–L98.A128; L98.A211–L98.A218; L98.A221–L98.A228; L98.A311–L98.A318; and L98.A321–L98.A328, broadening the range of covered skin and ulcer-related conditions that may support reimbursement for wound care services.

Telehealth Policy Extensions

Recent federal action extended several Medicare telehealth flexibilities, through the end of 2027.

For behavioral and mental health services, Medicare continues to allow telehealth visits without requiring an in-person visit within six months of the initial service or annually thereafter. The in-person visit requirement also remains waived for mental health services furnished via telehealth by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to beneficiaries located in their homes. Additional extensions allow Medicare telehealth services to continue without geographic or originating-site restrictions, maintain expanded eligibility for telehealth providers, permit audio-only telehealth services, and allow FQHCs and RHCs to continue serving as Medicare distant-site providers for non-behavioral and non-mental health services.

Billing and Coding Policy Updates

WPS has published updates to several Medicare billing and coding articles with a January 1, 2026 effective date. This includes:

- Billing and Coding: Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea
- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemaker.

APR-DRG Calculator Update

The MO HealthNet Division released a revised All Patient Refined Diagnosis Related Group (APR-DRG) calculator, effective December 3, 2025, applicable to all hospitals submitting inpatient claims. The update includes revisions to the directory of out-of-state hospitals, and providers are encouraged to confirm that they are using the most current version of the APR-DRG calculator when preparing inpatient claims. Additional guidance is available through MO HealthNet Bulletins 48-01 and 48-33.

Telehealth Billing for Behavioral Health Services

Missouri Medicaid requires specific billing rules when behavioral health services are delivered via telemedicine. For fee-for-service participants located in a residential or inpatient setting (POS 14, 21, 33, 51, 55, 56, or 61) and where prior authorization is required, providers must bill using the GT modifier and the place of service where the participant is physically located; POS 02 may not be used in these circumstances. Telemedicine services provided on school grounds must be billed with POS 03 and the GT modifier. The originating site is eligible only for a facility fee, billed using HCPCS Q3014, to reflect use of the facility during telemedicine services.

Missouri Medicaid Managed Care – Depression Screening and Follow-Up

Effective October 1, 2025, Missouri Medicaid Managed Care plans will cover standardized depression screening and follow-up for members ages 12 and older. Accepted HCPCS codes include G8431 (positive screen with documented follow-up plan) and G8510 (negative screen), each reimbursed at $13.55. Screening is limited to one unit per calendar year for the general population; however, use of the TH modifier allows up to four screenings per year for pregnant or postpartum members, consistent with perinatal screening guidance.

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.

Kansas Hospital Association

KCMHC Kansas City Metropolitan Healthcare Council
an affiliation of Kansas and Missouri Hospital Associations

MHA Missouri Hospital Association

7015 College Blvd., Suite 150 • Overland Park, KS 66211-1579 • Phone: 913/327-7200 • Fax: 913/327-7210