PAYER POLICY PLAYBOOK

Appeals & Policy Changes

Q2 2026 Issue

Hold on Modifier 25:
BCBS Michigan Delays Rollout

- **Blue Cross Blue Shield of Michigan (BCBSM)** has **paused implementation** of its Modifier 25 reimbursement policy, originally scheduled to take effect May 1, 2026, following provider feedback and engagement with the Michigan State Medical Society (MSMS). No new effective date has been announced.
- The proposed policy would reduce reimbursement by **50% for non-preventive evaluation and management (E/M) services billed with Modifier 25** when reported on the same day as a procedure by the same provider for the same patient. BCBSM clarified that the policy applies **only to minor procedures with 0- or 10-day global periods**; prior inclusion of 90-day global procedures was an error, as those encounters should be reported with **Modifier 57**.
- The policy targets office/outpatient E/M codes **99202–99205 and 99212–99215**. Preventive, administrative, and emergency department E/M services (99281–99285) are excluded, along with **office visits within one calendar day of an ED visit** (when the ED claim processes first) and **procedures with no global period (global "XXX")**. The minor procedure itself would continue to be reimbursed at the full contracted rate.
- The change is expected to affect BCBSM commercial plans, Blue Care Network, Medicare Plus Blue, BCN Advantage (participating providers), and the Federal Employee Program. BCBSM has stated the intent is to **avoid duplicative payment of practice expense for same-day services**, though provider organizations continue to raise concerns regarding access, documentation burden, and reimbursement reductions.

Appeals Perspective: Modifier 25 Delay Doesn't Mean Relief

While recent Blue Cross Blue Shield (BCBS) updates have delayed broader changes to Modifier 25 reimbursement, this should not be interpreted as a pause in risk. For Appeals teams, the message is clear: today's rules remain in place—but tomorrow's scrutiny is already forming.

No Immediate Change—But No True Stability

At present, Modifier 25 billing and reimbursement guidelines remain unchanged. However, many BCBS plans have already increased review activity, signaling that enforcement behaviors often begin before formal policy rollout.

Why This Still Matters for Appeals

Even without a finalized change, Appeals teams should anticipate increased scrutiny of E/M services billed with procedures. Expect more frequent determinations that the E/M service was not separately identifiable, along with a heavier reliance on documentation specificity to support appeals.

RCM Action:

Model financial exposure immediately—this is a margin compression risk rather than a coding issue, as payers are increasingly reducing or denying Modifier 25 E/M reimbursement even when billing is appropriate.

Key Updates
Medical Mutual Criteria Changes

Medical Mutual Is Transitioning from MCG to InterQual for Medical Necessity Review Criteria

Medical Mutual announced that effective **April 13, 2026**, it has transitioned its medical necessity review criteria from **MCG to InterQual**. While this may initially appear to be a straightforward vendor change, it carries important downstream implications for **utilization review (UR), case management workflows, and denial trends** across inpatient and observation status determinations.

From an operational standpoint, this transition requires teams to shift from MCG's symptom-severity and response-to-treatment framework to InterQual's more prescriptive, criteria-driven structure. InterQual often emphasizes **objective clinical thresholds, episode-specific criteria, and clearer progression pathways**, which may impact how cases are reviewed, documented, and defended. As a result, cases that previously met under MCG may not automatically translate to InterQual without stronger documentation of clinical intensity and failed outpatient or lower-level care.

For utilization review and case management teams, this change necessitates **adjustment of review strategies and recalibration of medical necessity narratives**. Documentation will need to be more tightly aligned with InterQual's expectations, particularly around **clinical indicators, timing of interventions, and physician intent**. Teams may also need to collaborate more closely with providers to ensure that the medical record supports inpatient level of care under the new criteria set.

From a denials management perspective, organizations should anticipate **potential shifts in denial patterns**, particularly in the early phases of implementation. There may be an increase in **medical necessity denials** as providers and reviewers adapt to InterQual's criteria, especially in borderline or short-stay cases. However, over time, organizations that proactively align workflows and education with InterQual requirements may see **improved consistency in determinations and stronger defensibility on appeal**.

Overall, this transition underscores the importance of **education, auditing, and proactive communication** across UR, case management, and physician teams. Understanding the nuances between MCG and InterQual will be critical to maintaining compliance, minimizing denials, and ensuring appropriate level-of-care determinations moving forward.

This is not just a vendor change—this is a shift in how medical necessity is evaluated.

Post-Service Inpatient Validation:

Why This Matters for Denials Teams

Post-service inpatient validation is quickly becoming one of the most important—and challenging—drivers of denials in today's revenue cycle environment. While many organizations focus heavily on front-end authorization and concurrent review, payers are increasingly shifting their scrutiny to retrospective validation of inpatient stays after discharge.

What Is Post-Service Inpatient Validation?

Post-service inpatient validation occurs when a payer reviews a completed hospitalization and determines whether the **inpatient level of care was medically necessary** based on documentation, clinical criteria, and regulatory standards.

Unlike prior authorization or concurrent review, these denials happen **after the care has already been delivered**, making them inherently more difficult to prevent and recover.

Why Denials Are Increasing

Several trends are driving growth in post-service inpatient denials:

- Stricter application of InterQual/MCG criteria & Expansion of payer audit programs and AI-driven reviews
- Increased focus on cost containment for inpatient admissions. Greater enforcement of observation vs. inpatient status distinctions

As a result, even medically appropriate admissions are being challenged if documentation does not clearly support inpatient-level care.

Take Note

Post-service inpatient validation is not going away—it is expanding.

For denials teams, this represents a shift from transactional denial management to clinical advocacy and strategy. Organizations that invest in stronger documentation, tighter front-end alignment, and more sophisticated appeal approaches will be best positioned to protect revenue in this evolving landscape.

Post-service inpatient validation reflects a broader payer strategy: Moving denials later in the process, where **recovery is harder** and provider leverage is reduced.

This means denial prevention can no longer live only at the front end. Success requires **alignment across UR, CDI, case management, and denials teams**.

Q2 2026 Payer Updates:
What Your Team Needs to Know

BCBS MA Sepsis 3 Criteria Updates

BCBS Massachusetts has updated its approach to its Sepsis-3 clinical criteria for Q2 2026, reinforcing a continued shift toward objective, organ dysfunction–driven definitions of sepsis. These updates further align with national Sepsis-3 standards, emphasizing clinical specificity, measurable organ dysfunction, and clear linkage between infection and physiologic impact.

While sepsis remains a high-risk, high-cost diagnosis, BCBS MA is signaling increased scrutiny around cases that rely primarily on SIRS criteria or non-specific clinical indicators without clear evidence of organ dysfunction.

Teams should expect a higher denial risk for sepsis cases lacking definitive organ dysfunction, along with increased payer focus on clinical progression and response to treatment. There will also be a need for tighter alignment between physician documentation, coding specificity, and UM criteria support to ensure consistency and defensibility.

Risk areas include early sepsis diagnoses without sustained abnormalities, cases involving rapid clinical improvement without inpatient-level interventions, and documentation that continues to rely on legacy SIRS terminology without clear correlation to Sepsis-3 criteria.

Key Takeaways

Sepsis Must Be Clinically Demonstrable

BCBS MA continues to reinforce that a sepsis diagnosis alone is insufficient—documented organ dysfunction and clear infection linkage are required to support medical necessity.

SIRS Alone No Longer Supports Sepsis

Reliance on SIRS criteria without Sepsis-3–aligned indicators (e.g., SOFA/qSOFA, organ dysfunction) places cases at high risk for denial.

Be On The Lookout

Diagnosis alone is not sufficient for a strong appeal—clinical severity must be clearly demonstrated and consistently documented.

UnitedHealthcare

UnitedHealthcare's 2026 updates continue to emphasize site-of-service management and medical necessity scrutiny—changes that are expected to increase inpatient downgrades and require stronger admission-level justification in appeals.

More Site-of-Service Denials | UHC continues to emphasize site-of-service management and observation vs. inpatient determinations, increasing scrutiny of whether services can be safely delivered in lower-acuity settings.

Heightened "Why Not Outpatient" Scrutiny | Denials increasingly cite lack of documentation supporting why services could not be safely performed in an outpatient or observation setting, driving the need for clear contraindications and risk-based admission rationale.

Key Takeaways

UHC denials are increasingly driven by site-of-service assumptions, making it critical that documentation clearly supports why inpatient care was necessary at the time of admission—not just that criteria were met.

Aetna

Aetna's 2026 changes reflect a shift toward internal clinical policy enforcement beyond standard criteria—creating additional barriers even when InterQual or MCG benchmarks are met.

Proprietary Clinical Policy Overrides Increasing | Appeals teams continue to encounter Aetna denials that reflect payer-specific medical necessity interpretations beyond standard InterQual or MCG criteria, particularly in respiratory, sepsis, and cardiac cases.

Key Takeaways

Aetna denials increasingly hinge on payer-specific medical necessity definitions, making it essential for appeals to go beyond criteria and clearly articulate the clinical severity, risk, and need for inpatient care in narrative form—not just guideline alignment.

Humana

Humana's 2026 updates expand prepayment review activity and clinical validation audits—shifting denial risk upstream and increasing documentation expectations before claims are finalized.

Prepayment Clinical Reviews Expanding | Humana continues to focus prepayment review activity on high-cost and high-variance DRGs, including sepsis, respiratory failure, and malnutrition, delaying reimbursement and increasing initial denial rates.

Clinical Validation Denials Increasing | More cases are being denied based on insufficient clinical support for billed diagnoses, requiring stronger alignment between provider documentation and objective clinical indicators.

Key Takeaways

Humana denials are increasingly driven by prepayment and clinical validation scrutiny, making it essential that documentation clearly demonstrates diagnostic credibility with objective clinical evidence aligned to the record—not just provider labeling.

Cigna

Cigna's 2026 changes focus on tighter utilization management and observation-level pathways—driving more frequent challenges to inpatient admissions.

Observation-First Pathways Expanding | Cigna is broadening conditions expected to be managed under observation (e.g., chest pain, syncope, mild CHF), increasing inpatient-to-observation downgrades.

Short-Stay Inpatient Denials Rising | Admissions under two midnights are facing increased scrutiny, with denials often citing lack of documentation supporting expected length of stay or risk of clinical deterioration.

Key Takeaways

Cigna denials are increasingly tied to observation-first expectations and short-stay scrutiny, making it essential to clearly document anticipated length of stay and the clinical risk supporting inpatient admission at the point of decision.

Resources & Links

Aetna – 2026

Aetna Commercial Supplemental Criteria (MCG)
https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/healthcare-professionals/supplemental-criteria-for-transparency-2024.pdf

Aetna Better Health Clinical Guidelines and Policy Bulletins
https://www.aetnabetterhealth.com/clinical-guidelines-policy-bulletins.html

Clinical Guidelines & Policy Bulletins – Aetna Medicaid
https://www.aetnabetterhealth.com/florida/providers/clinical-guidelines-policy-bulletins.html

Blue Cross Blue Shield – 2026

BCBS Modifier 25 pause information|
https://providerinfo.bcbsm.com/documents/alerts/2026/202604/alert-20260413-new-modifier-25-policy-postponed.pdf

MSMS: BCBSM Clarifies Modifier 25 Policy But Reduction Remains
https://www.msms.org/news/update-bcbsm-clarifies-modifier-25-policy-reduction-remains

BCBSM Policy Clarification on Modifier 25
https://providerinfo.bcbsm.com/documents/alerts/2026/202602/alert-20260226-clarification-policy-update-em-codes-modifier-25.pdf

BCBS Massachusetts Sepsis-3 Criteria and Resources
https://provider.bluecrossma.com/ProviderHome/wcm/connect/91a3e206-5abd-4f37-90e4-a7dbc113452e/MPC_041626-1S-2-PFS+Sepsis-3+fact+sheet.pdf?MOD=AJPERES

Centers for Medicare & Medicaid Services (CMS) – 2026

CMS Inpatient Hospital Reviews
https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/hospital-patient-status-reviews

CMS Hospital Patient Status Review Frequently Asked Questions
https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-education/inpatient-hospital-reviews-faqs

CMS Two-Midnight Rule Fact Sheet
https://www.cms.gov/files/document/two-midnight-rule-fact-sheet.pdf

Resources & Links (cont'd)

Humana – 2026

Humana Provider Payment Integrity (PPI) Prepayment Review Policy
https://provider.humana.com/coverage-claims/payment-integrity/prepayment-review

Humana Provider Payment Integrity Medical Record Review Resources
https://provider.humana.com/coverage-claims/payment-integrity/medical-record-review-resources

Humana 2026 Provider Manual
https://assets.humana.com/is/content/humana/FINAL_773902ALL0725-B_2026_ProviderManual-NonDelegated_formattedpdf

Medical Mutual – 2026

Medical Mutual Transitioning from MCG to InterQual for Medical Necessity Review Criteria
https://www.medmutual.com/-/media/MedMutual/Files/Providers/In-the-News/2026/Medical-Mutual-Transitioning-from-MCG-to-InterQual-for-Medical-Necessity-Review-Criteria-on-April-13.pdf

Medical Mutual Medical Necessity Criteria and Clinical Review Guidelines
https://www.medmutual.com/For-Providers/Medical-Necessity-Criteria-and-Clinical-Review-Guidelines

UnitedHealthcare – 2026

UnitedHealthcare Outpatient Surgical Procedures – Site of Service Policy
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/outpatient-surg-procedures-site-service.pdf

UnitedHealthcare Office-Based Procedures – Site of Service Policy
https://uhg1-prod.adobecqms.net/content/dam/provider/docs/public/policies/comm-medical-drug/office-based-procedures-site-service.pdf

UnitedHealthcare Hospital Services: Observation and Inpatient Policy
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/hospital-services-observation-inpatient.pdf