BLUESPEAK
PROVIDER NEWS AND UPDATES

Kansas City

June 2026 BlueSpeak

Welcome to the June 2026 BlueSpeak Provider Newsletter. **If you have questions about these updates, call the Blue KC Provider Hotline at 816-395-3929 for our Commercial line of business or 866-859-3822 for the Affordable Care Act (ACA) Provider Hotline.** Thank you for your partnership in providing quality care to our members.

Obstetric Coding Changes

LINES OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP[1]	SMALL GROUP ACA	JAA[2]	FEP[3]	MEDICARE ADVANTAGE (BlueCard)[4]	Dental

BLUE highlighted boxes are the lines of business impacted by this update.

[1] ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family
[2] JAA: Joint Administrative Account
[3] FEP: Federal Employee Program
[4] Medicare Advantage (BlueCard): Medicare Advantage for other Blue Cross Blue Shield Association plans

Blue Cross and Blue Shield of Kansas City (Blue KC) is updating our maternity services billing processes to align with new American Medical Association (AMA) requirements. The AMA has revised coding for global maternity billing, with updates **effective January 1, 2027.**

- To support this transition, providers will need to begin making changes to the way maternity services are billed to support accurate reimbursement of services performed **on or after January 1, 2027**.
    - This includes providers making changes to the way they bill using E/M codes for prenatal visits starting **September 1, 2026**, for anyone set to deliver **on or after January 1, 2027.**
- Blue KC encourages providers to review guidance published by the American College of Obstetricians & Gynecologists (ACOG) and the AMA.
- Additional guidance and resources will be shared in upcoming editions of our monthly BlueSpeak Provider Newsletter.

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Payment Policy Updates

To find the complete version of Blue KC Payment Policies, click here or go to the login page at Providers.BlueKC.com and click on "Go to Payment Policies", which lists All Provider Payment and Coding Policies and Lab Payment Policies. **Note:** This is not a comprehensive list of updates.

Payment Policies Featured in this Section
Chiropractic and Osteopathic Manipulative Services
Hemodialysis, Home Hemodialysis and Peritoneal Dialysis Services
Joint Replacement C1776

Chiropractic and Osteopathic Manipulative Services Payment Policy

LINES OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP	SMALL GROUP ACA	JAA	FEP	Medicare Advantage (BlueCard)	Dental

BLUE highlighted boxes are the lines of business impacted by this update.

Policy Number	Policy Name	Full Policy Location
POL-PP-212	Chiropractic and Osteopathic Manipulative Services	View our Chiropractic and Osteopathic Manipulative Services Payment Policy Visit our Payment Policies page Go to Providers.BlueKC.com, click on "Go to Payment Policies"

Reminder

- As a reminder, per the 2024 update to Blue KC's Chiropractic and Osteopathic Manipulative Services Payment Policy, an edit was implemented requiring that each spinal region manipulated be supported by a corresponding diagnosis. While Blue KC previously enhanced this edit to include diagnosis pointers, submission of diagnosis pointers is no longer required. *However, providers must continue to ensure that the number of diagnoses reported supports the number of spinal regions manipulated.* Below is additional guidance from the policy to support accurate billing and coding.
- **Spinal Manipulative Procedures**
    - Chiropractic manipulative treatment (CMT) CPT codes 98940- 98942 are used to indicate the number of spinal areas manipulated.

- The problem/complaint addressed, and precise level of each subluxation treated, must be specified in the medical record.
- The level of the subluxation must be specified on the claim and must be listed as the primary diagnosis.
  - **Example:**
    - 98942 – Chiropractic manipulative treatment (CMT); spinal, 5 regions. Diagnosis should be specific to the location of the subluxation. CPT 98942 represents 5 different spinal regions; there must be a subluxation diagnosis to support each region.
    - Areas of treatment should be documented separately in spinal regions (e.g., cervical, thoracic, lumbar, sacrum and pelvic) and vertebral (C1-S5).
    - When billing, if providers are using the terms "all spinal regions", "upper and lower spinal regions" and "all affected regions", these terms do not support the service performed to the degree of specificity required.

Hemodialysis, Home Hemodialysis and Peritoneal Dialysis Services Payment Policy

LINES OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP	SMALL GROUP ACA	JAA	FEP	Medicare Advantage (BlueCard)	Dental

BLUE highlighted boxes are the lines of business impacted by this update.

Policy Number	Policy Name	Enforcement Date	Full Policy Location
POL-PP-233	Hemodialysis, Home Hemodialysis and Peritoneal Dialysis Services	7/1/2026	View our Hemodialysis, Home Hemodialysis and Peritoneal Dialysis Services Payment Policy Visit our Payment Policies page Go to Providers.BlueKC.com, click on "Go to Payment Policies"

Reminder

- As a reminder, POL-PP-233 Hemodialysis, Home Hemodialysis and Peritoneal Dialysis Services Payment Policy requires that procedure code is billed with the most recent Urea Reduction Ratio (URR) for the dialysis patient. URR modifier goes with Code 90999.

- **Beginning July 1, 2026,** facility claims billed without a Urea Reduction Ratio modifier will be denied, and a corrected claim will need to be submitted.
- **Urea Reduction Ratio:** CPT 90999 (facility dialysis services) must be reported with the most recent Urea Reduction Ratio (URR) modifier for the patient. All hemodialysis facility claims require a URR modifier.
    - G1 Most recent URR of less than 60%
    - G2 Most recent URR of 60% to 64.9%
    - G3 Most recent URR of 65% to 69.9%
    - G4 Most recent URR of 70% to 74.9%
    - G5 Most recent URR of 75% or greater
    - G6 ESRD patient for whom less than seven dialysis sessions have been provided in a month

Joint Replacement C1776 Payment Policy

LINES OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP	SMALL GROUP ACA	JAA	FEP	Medicare Advantage (BlueCard)	Dental

BLUE highlighted boxes are the lines of business impacted by this update.

Policy Number	Policy Name	Effective Date for New Policy	Enforcement Date for New Policy	Full Policy Location
POL-PP-332	Joint Replacement C1776	7/1/2026	7/1/2026	View our Joint Replacement C1776 Payment Policy Visit our Payment Policies page Go to Providers.BlueKC.com, click on "Go to Payment Policies"

New Policy Summary

- **Effective July 1, 2026,** Blue KC's Joint Replacement C1776 Payment Policy POL-PP-332 clarifies coding and billing practices for implantable joint devices and components.
    - **Note:** Blue KC first communicated these changes in the March and April BlueSpeak Provider Newsletters.

- The American Hospital Association (AHA) Coding Clinic states that HCPCS code C1776 represents a joint device functioning as its natural counterpart, and Blue KC agrees that individual joint elements should not be reported separately since C1776 covers the entire joint component.
- The device must be billed on the same claim as the corresponding surgical procedure.
- The Centers for Medicare and Medicaid Services sets a Medically Unlikely Edit (MUE) of 10 units for HCPCS C1776, allowing multiple units for joints in feet and hands. One unit of C1776 is allowed for shoulder, knee or hip replacements, per the AHA Coding Clinic.
- If more than one unit of C1776 is submitted, the claim will be denied. If the provider feels the additional units submitted were medically necessary, supporting documentation may be sent for review. Documentation must provide the following:
    - Support of additional units as reasonable and necessary
    - Details supporting the additional units reported
    - The rationale and medical reasonableness for performing additional units
- Documentation must clearly support the implanted joint device consistent with CMS requirements and Coding Clinic guidance.
- Anchors and screws used for bone fixation or connecting bone-to-bone or soft tissue-to-bone may be billed separately with codes C1713 and C1741.

Coding	
HCPCS	Definition
C1776	Joint device (implantable)
C1741	Anchor/screw for bone fixation, absorbable, metallic (implantable)
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)

Medical policy updates

LINE OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP	SMALL GROUP ACA	JAA	FEP	Medicare Advantage (BlueCard)	Dental

The BLUE highlighted box is the line of business impacted by this update.

The most up-to-date Medical Policy can be found by logging into Providers.BlueKC.com and clicking on the Medical Policies section. While on that web page, you can also find a link to view Milliman Care Guidelines (MCG), which complement our Blue KC policies.

The Blue KC Medical Policy encompasses internal Blue KC Medical Policy, Blue Cross Blue Shield Association derived Medical Policy, and policies adopted from our vendor partners, such as Avalon, MCG and eviCore.

Note: This is not a comprehensive list of updates.

Effective date	Policy

Effective date – 7/1/2026	ID: 10.01.543
	
	Title: Radiology Site of Care – New Policy
	• When policy topic is covered
	  ○ Coverage for advanced diagnostic imaging services performed in a **hospital-based outpatient imaging facility** may be limited when the imaging service can be safely and effectively performed in a freestanding outpatient imaging facility and applicable site-of-care criteria are met.
	• When policy topic is not covered
	  ○ Advanced diagnostic imaging services are not covered when performed at a **hospital-based facility**, when the member meets the selected site of care criteria to have the service performed at a freestanding outpatient imaging center.

Effective date – 7/1/2026	ID: 2.01.107 Title: Fractional Carbon Dioxide (CO2) Laser Ablation Treatment of Hypertrophic Scars or Keloids for Functional Improvement – Interim Update • Fractional ablative carbon dioxide (C02) laser fenestration of a burn scar or traumatic scar may be considered **medically necessary** when there is documented evidence of all the following:

	○ Significant functional impairment related to the scar; defined as a significantly limited, impaired, or delayed capacity to move, coordinate actions or perform physical activities and is exhibited by difficulties in one or more of the following areas ○ The treatment can be reasonably expected to improve the functional impairment, including: ▪ physical and motor tasks ▪ independent movement ▪ performing activities of daily living (e.g., eating, bathing, dressing) ○ At least two or more other scar treatment has been trialed, including but not limited to: ▪ intralesional corticosteroids ▪ pressure garments ▪ silicone gel or sheeting • Carbon dioxide (CO2) fractional laser ablation treatment of hypertrophic scars or keloids is considered **investigational** in the absence of functional improvement when the criteria above have not been met because the evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Pharmacy policy updates

Commercial Formulary Updates – Premium

LINE OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP	Small Group ACA	JAA	FEP	Medicare Advantage (BlueCard)	Dental

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We want to let our contracted providers know of updates to the Blue KC Commercial Prescription Drug Lists that will go into effect on July 1, 2026.

Below are the **Premium** Prescription Drug List updates that will be effective July 1, 2026:

Please Note: These changes ONLY apply to members on the Premium Formulary. Group-specific benefit exceptions may apply.

New Prior Authorization Requirements

Drug Class	Drugs Requiring Prior Authorization
Antihypertensive Agents	Arbli suspension 10 mg/mL
Chelating Agents	Depen tablet 250 mg

New Excluded Medications with Alternatives

Drug Class	Excluded Medications	Covered Alternative(s)
Antidepressants	sertraline capsule 150 mg, 200 mg	sertraline tablet
Antiemetic Agents	ondansetron tab 16mg ODT	ondansetron ODT 4 mg, 8 mg
Antihypertensive Agents	valsartan solution 20mg/5mL	valsartan tablet
Antiparkinson Agents	Vyalev Injection	carbidopa-levodopa ER/IR tablet, entacapone, pramipexole, rasagiline, ropinirole, selegiline, tolcapone
Cancer Agents	abiraterone tab 500 mg	abiraterone tablet 250 mg
Dermatological Agents	Twyneo cream	Epiduo Forte, Onexton, Retin-A-Micro gel 0.06%, 0.08%
Diuretic Agents	triamterene cap	amiloride tablet, eplerenone tablet, spironolactone tablet
Gastrointestinal Agents	glycerol phe liq 1.1gm/mL	sodium phenylbutyrate powder
Glycemic Agents	Zegalogue Injection	Baqsimi, Glucagon Emergency Kit (made by Fresenius Kabi)
Hormonal Agents	Premarin tablet	conjugated estrogen tablet, Duavee
Muscle relaxants	baclofen sol 5mg/5mL	baclofen tablet
	baclofen sol 10mg/5mL	
Otic antibiotic	ciprofloxacin-hydrocortisone suspension	ciprofloxacin-dexamethasone otic suspension, [ciprofloxaxin otic] together with [fluocinolone otic]

New Excluded Drugs with Covered Generic Equivalents

Complera tablet	Dificid tablet	Dyrenium capsule	Iressa 250 mg
Korlym tablet	Lovenox injection	Motegrity tablet	Nexavar tablet 200 mg
NuvaRing	Pradaxa capsule	Promacta powder, tablet	Purixan suspension
Rytary capsule	Tasigna capsule	Thalitone tablet	

Commercial Formulary Updates – Select

LINE OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP	Small Group ACA	JAA	FEP	Medicare Advantage (BlueCard)	Dental

The BLUE highlighted box is the line of business impacted by this update.

Below are the **Select** Prescription Drug List updates that will be effective July 1, 2026:

Please Note: These changes ONLY apply to members on the Select Formulary. Group-specific benefit exceptions may apply.

New Step Therapy Requirements

Members must try the generic equivalent before listed drug(s) will be covered.

NuvaRing

New Prior Authorization Requirements

Drug Class	Drugs Requiring Prior Authorization
Antihypertensive Agents	Arbli suspension 10 mg/mL
Chelating Agents	Depen tablet 250 mg

New Excluded Medications with Alternatives

Drug Class	Excluded Medications	Covered Alternative(s)
Antidepressants	sertraline capsule 150 mg, 200 mg	sertraline tablet

Antidiabetic Agents	Exenatide injection	liraglutide injection, Bydureon BCise, Byetta
Antiemetic Agents	ondansetron tab 16mg ODT	ondansetron ODT 4 mg, 8 mg
Antimigraine Agents	Trudhesa nasal spray	dihydroergotamine nasal spray
Antiparkinsons Agents	Vyalev injection	carbidopa-levodopa ER/IR tablet, entacapone, pramipexole, rasagiline, ropinirole, selegiline, tolcapone
Dermatological Agents	Twyneo cream	adapalene-benzoyl peroxide gel, Epiduo Forte, Onexton, Retin-A Micro gel 0.06%,0.08%
Diuretic Agents	Dyrenium capsule	amiloride tablet, eplerenone tablet, spironolactone tablet
	triamterene capsule	
Glycemic Agents	Zegalogue injection 0.6/0.6	Baqsimi, Glucagon Emergency Kit (made by Fresenius Kabi)
Growth Hormones	Genotropin injection	Omnitrope, Norditropin
Hormonal Agents	Premarin tablet	conjugated estrogen tablet, Duavee
Phosphate Binders	Velphoro chew	calcium carbonate, calcium acetate, sevelamer

New Excluded Drugs with Covered Generic Equivalents

Aptiom tablet	Brilinta tablet	Complera tablet	Entresto tablet
Imitrex injectable	Iressa tablet	Korlym tablet	Lovenox injectable
Lyrica solution 20mg/mL	Motegrity tablet	Nexavar tablet	Pradaxa capsule
Promacta tablet	Purixan suspension 20 mg/mL	Rytary capsule	Spiriva HandiHaler
Tasigna capsule	Thalitone tablet	Tikosyn capsule	Victoza inj 18 mg/3 mL

Commercial Formulary Updates – Essential Health Benefits

LINES OF BUSINESS IMPACTED						
Commercial	**ACA QHP**	**SMALL GROUP ACA**	JAA	FEP	Medicare Advantage (BlueCard)	Dental

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Below are the **Essential Health Benefits (EHBs)** Prescription Drug List updates that will be effective July 1, 2026:

Please Note: These changes ONLY apply to members on the EHB Formulary. Group-specific benefit exceptions may apply.

New Excluded Medications with Alternatives

Drug Class	Excluded Medications	Covered Alternative
Monoclonal Antibody	Prolia injection	Enoby
	Xgeva injection	Xtrenbo

New Excluded Drugs with Covered Generic Equivalents

Brilinta tablet	Complera tablet	Entresto tablet	Fycompa tablet
Pradaxa capsule	Premarin tablet	Promacta tablet	Tasigna capsule
Tracleer tablet	Xarelto suspension	Xarelto tablet	

Specialty pharmacy change for three medications

LINE OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP	SMALL GROUP ACA	JAA	FEP	Medicare Advantage (BlueCard)	Dental

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In our commitment to providing our members with the most effective therapies at the lowest possible cost, Blue KC **will be transitioning members to Lumicera Specialty Pharmacy as the exclusive dispensing pharmacy for the following medications, effective July 1, 2026.**

Medication	Strength(s)
Temozolomide	5mg, 20mg, 100mg, 140mg, 180mg, 250mg
Fingolimod	0.5mg
Everolimus	2.5mg, 5mg, 7.5mg, 10mg

- Blue KC will partner with prescribers and dispensing pharmacies to ensure these prescriptions are transferred to Lumicera Specialty Pharmacy, effective July 1, 2026.
- Members impacted by this change will receive a letter explaining what to expect and how to reach Lumicera Specialty Pharmacy to confirm their contact and shipping information.
- As a reminder, specialty medications require prior authorization (PA). Any existing or active PAs for these medications will remain in place and continue through the remainder of their approved timeframe.

Provider Education

Primary payer Explanation of Benefits requirement

LINES OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP	SMALL GROUP ACA	JAA	FEP	MEDICARE ADVANTAGE (BlueCard)	Dental

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As a reminder, the Blue Cross Blue Shield Association requires that providers submit to Blue KC an Explanation of Benefits (EOB) for all services when another insurance carrier is the primary payer, including Medicare. The EOB is necessary to support claim processing, as it documents the primary payer payment or denial information.

Even if the other insurance carrier does not cover the service (ex. hearing aids), Blue KC still requires providers to submit an EOB to process the claim.

We appreciate your assistance in helping ensure a smooth and efficient claims process.

Risk adjustment 101: The basics of risk adjustment

LINES OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP	SMALL GROUP ACA	JAA	FEP	MEDICARE ADVANTAGE (BlueCard)	Dental

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What is risk adjustment?

- Risk adjustment is a CMS (Centers for Medicare & Medicaid Services) and HHS (Health and Human Services) process that reflects the relative health status and expected care needs of a patient by assigning a risk score (RAF); accurate documentation and ICD-10-CM coding ensure this complexity is captured to support appropriate care planning, quality reporting and continuity of care.

What do providers need to know about risk adjustment?

- For providers, risk adjustment depends on documenting the conditions you evaluate, monitor and treat during routine care. Specific, complete ICD-10-CM documentation shows patient complexity and supports accurate risk capture without adding unnecessary detail. The goal is not to document more – it is to document precisely what you evaluate, manage and treat.

What are some best practices for documentation and coding?

- ***Document all conditions that impact care***
  - **Document what you addressed today;** List the condition chiefly responsible for the visit first, then include other conditions you evaluated, managed, or that affected treatment decisions.
  - **Include relevant chronic conditions;** If a chronic disease is being treated on an ongoing basis or it affects today's care, document it and code it. At minimum, reassess major chronic conditions annually.
  - **Document signs and symptoms when a diagnosis is not yet confirmed;** Document the signs, symptoms, workup, and clinical impression clearly so the encounter still reflects your medical decision-making.
  - **Review and update problem lists regularly**; don't pull lists into notes without current supporting assessment.
- ***Documentation Specificity matters***

- **Choose precise clinical language**; Document the type, severity, stage, acuity, and manifestations that are supported by your assessment. Avoid vague labels when a more specific diagnosis is clinically appropriate.
- **Show the relationship between conditions;** Use phrases such as "due to," "with," "secondary to," or condition-specific descriptors like "diabetic" when clinically accurate (for example, diabetic CKD, hypertensive CKD, or heart failure due to hypertension when supported).

- ***Use DSP to keep the Assessment and Plan concise and complete***
  - **D — Diagnosis:** Document the most specific diagnosis supported at the encounter.
  - **S — Status:** Note whether the condition is stable, improving, worsening, or uncontrolled.
  - **P — Plan:** State the treatment, monitoring, referrals, or follow-up. Avoid vague phrases such as "continue current treatment."

Sources:
https://journal.ahima.org/Portals/0/archives/AHIMA%20files/Documentation%20and%20Coding%20Practices%20for%20Risk%20Adjustment%20and%20Hierarchical%20Condition%20Categories.pdf
https://www.aapc.com/codes/coding-newsletters/my-urology-coding-alert/audits-handle-common-audit-issues-by-developing-robust-audit-program-170439-article?srsltid=AfmBOoqEfl1OgzagF-CKpoC3ZmelcUuBeLXcYdoJWymH5Nb6vz7wfvGB

Top 5 miscoded conditions and how to fix them

LINES OF BUSINESS IMPACTED						
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Based on Insights from the 2025 High-Risk Diagnosis Validation Audit Findings, these are the most common drivers of miscoded conditions – and what to do differently:

1. Diagnosis Not Supported in the Note

- **Issue:**
  - Diagnosis submitted on the claim is **not documented or clearly supported** in the encounter note.
- **Fix:**
  - Ensure every diagnosis is **explicitly stated in the note**
  - Tie the diagnosis to **clinical findings or rationale**

2. Missing Diagnosis, Status, and Plan

- **Issue:**

- Documentation lacks a clear **diagnosis, current status, or treatment plan**, preventing validation.
- **Fix:**
    - Include **status (stable, worsening, resolved)**
    - Document **assessment and treatment/management**
    - Ensure the condition is **actively addressed during the visit**

3. Condition Only Listed in Past Medical History (PMH)

- **Issue:**
    - Condition appears only in PMH and is **not addressed in the current encounter**, making it non-codable.
- **Fix:**
    - Move relevant conditions into the **assessment/plan** when applicable
    - Document **how the condition impacts care today**

4. Unclear or Uncertain Diagnoses

- **Issue:**
    - Documentation includes terms like **"possible" or "suspected,"** which do not support coding in outpatient settings.
- **Fix:**
    - Confirm and document **definitive diagnoses when appropriate**
    - Avoid coding **uncertain or rule-out conditions**

5. Condition Status Not Clearly Defined (Active vs. History)

- **Issue:**
    - Lack of clarity on whether a condition is **active, resolved, or historical** (e.g., cancer, stroke).
- **Fix:**
    - Clearly state **"active," "history of," or "resolved"**
    - Include **ongoing monitoring or treatment** if active

✅ **Bottom Line**

- Clear, encounter-specific documentation—diagnosis + status + clinical relevance—is the key to reducing miscoding and improving audit accuracy.

Closing gaps in care

LINES OF BUSINESS IMPACTED						
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A key focus remains on ensuring members are actively engaged in their healthcare – particularly in attending follow-up appointments and completing recommended preventive services. Early identification of health needs is critical to effectively closing care gaps and improving overall outcomes.

- Closing HEDIS care gaps helps ensure patients receive timely preventive care and proactive chronic disease management, supporting better health outcomes and reducing the risk of disease progression.
- This approach supports better health outcomes, reduces complications and ensures members receive the right care at the right time.
- An essential component of this effort is encouraging medication adherence. Ensuring members take prescribed medications as directed plays a vital role in managing conditions, preventing disease progression and supporting long-term wellness.
- Together, through collaboration with providers and member engagement, Blue KC can drive meaningful improvements in care quality and patient health.

Additional audit requirements for $1M claims

LINE OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP	SMALL GROUP ACA	JAA	FEP	Medicare Advantage (BlueCard)	Dental

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Effective July 1, 2026, Blue KC will be performing an in-depth prepay review on any claim that will allow $1M or more. To ensure Blue KC can continue to perform this prepay review, medical records and/or itemized bills will be required for these claims.

As a part of the Blue Cross Blue Shield Association requirements, host plans like Blue KC are required to review the following activities prepay:

- Itemized Bill Review
- DRG Review
- Claim Data and Financial Accuracy review including:
    - Pricing Review

- Payment Policy review
- Provider contract review
- Line by Line review
- Never Event Review and Hospital Acquired Condition Review

- Core Clinical Editing
- Advanced editing / Secondary Editing

In order for Blue KC to conduct these reviews on a prepay basis, medical records and/or an itemized statement may be required.

Please use the following fax number for these specific records: 816-926-4258.

Use Claim Inquiry Form to help avoid delays

LINES OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP	SMALL GROUP ACA	JAA	FEP	MEDICARE ADVANTAGE (BlueCard)	DENTAL

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Blue KC wants to remind providers that we are seeing an increase in written correspondence inquiries that providers are sending via fax without a claim inquiry form, which could cause delays. Blue KC is providing information to help resolve this issue.

- It is important to submit our claim inquiry e-form to take advantage of our automated process and help ensure we can handle your inquiry as quickly as possible.
- Please allow up to 30 days for a response.
- As a reminder, providers should submit our claim inquiry e-form for any of the following reasons:
    - Allowable Questions
    - Billed in Error / Void
    - Complete Medical Records Request
    - Corrected Claim
    - Lab Service Denial
    - Overpayment
    - Prior Authorization Denial
    - Other
- To find this recently enhanced e-form, go to the log in page at Providers.BlueKC.com, select the forms option and click on “Claim Inquiry Form” in the Claim Forms section.

Attention referring providers: How to submit lab orders to avoid denials

LINES OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP	SMALL GROUP ACA	JAA	FEP	MEDICARE ADVANTAGE (BlueCard)	Dental

BLUE highlighted boxes are the lines of business impacted by this update.

Blue KC is experiencing an increase in clinical edit denials for independent laboratory claims. This guidance outlines the causes and provides clear steps for referring providers to prevent denials and ensure proper reimbursement.

Why are denials increasing?	• Clinical edit denials are primarily occurring due to:
	  ○ **Missing, invalid, or incorrect modifiers** submitted on claims
	  ○ **Primary diagnosis codes that do not support medical necessity**
	• **Important:**
	  ○ Independent laboratories **cannot change or correct diagnosis codes**.
	  ○ They depend entirely on the referring provider to submit complete and accurate clinical information when the test is ordered. Because of this:
	    ▪ Labs **cannot resolve denials without provider involvement**
	    ▪ Claims may go **unpaid for services already performed**

What providers must do	• To prevent denials, referring providers must follow these steps:
	1. **Follow Blue KC Laboratory Medical Policies**
	  a. Adhere to all **coverage criteria**, **medical necessity requirements**, and **coding guidelines** for lab services
	2. **Submit Accurate Diagnosis Codes**
	  a. Before ordering lab tests:
	    i. Ensure **diagnosis codes are complete and accurate**
	    ii. Confirm codes **support medical necessity**

	iii. Verify alignment with **Blue KC medical policies** 3. **Educate Members on Coverage** a. If a test is **not covered**: i. Inform the member **before services are performed** ii. Explain any **potential out-of-pocket costs** • **Key Reminder** ○ Independent laboratories rely entirely on referring providers for correct clinical and coding information. ○ Errors at the time of order entry can lead to denials that **only the provider can resolve**.

Free documentation & coding webinar in July

LINES OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP	SMALL GROUP ACA	JAA	FEP	MEDICARE ADVANTAGE (BlueCard)	Dental

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Join us for the July monthly webinar hosted by our partner, Veradigm! This is a free documentation and coding education webinar. Each 1-hour webinar is approved for one AAPC CEU when you achieve a 70% or higher on the post-test. To register for the webinar, click here for details:

July 28 & 30 7:30 a.m. & 11:30 a.m. CT	Heart to Chart: Document and Code Confidently for Cardiovascular Conditions	Strengthen your cardiovascular coding skills with practical guidance, to ensure accuracy.

New Provider Portal login page

LINES OF BUSINESS IMPACTED						
COMMERCIAL	ACA QHP	SMALL GROUP ACA	JAA	FEP	MEDICARE ADVANTAGE (BlueCard)	DENTAL

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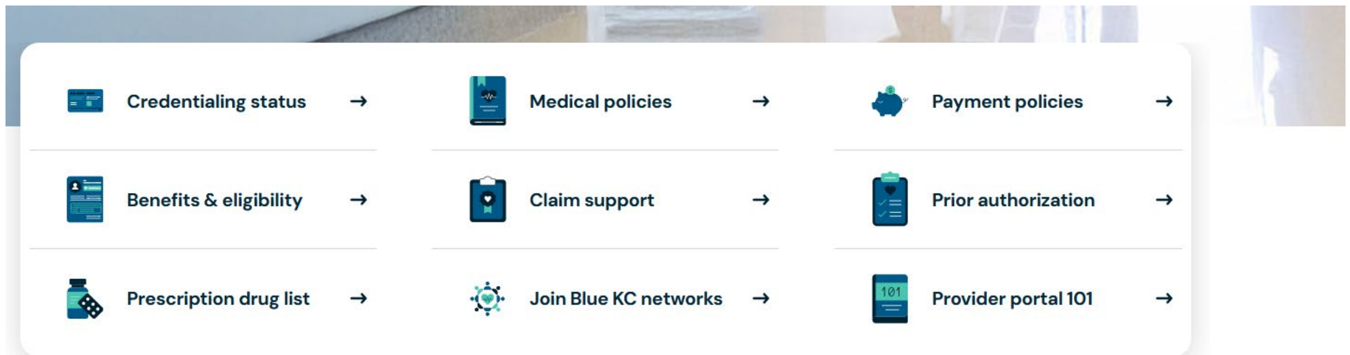
Have you noticed our new-look Blue KC Provider Portal login page at Providers.BlueKC.com?

Blue KC is making it easier for you to get the information you need by providing additional quick access link options that take you directly to the section of the portal you are interested in seeing.

Here's how this new section appears on the login page:



Make sure to log in to take advantage of all the Blue KC Provider Portal functions, including submitting a new or viewing an existing prior authorization and our provider data forms. Here are some helpful forms on our Portal:

- General Inquiry Form
  - For a faster way to answer your questions.
- Provider Updates Form
  - For updates in between initial credentialing and re-credentialing cycles
- Initial Credentialing Forms
  - For solo/rendering practitioners and ancillary/facility providers new to Blue KC.
- Revalidation Credentialing Forms
  - For existing solo/rendering practitioners and ancillary/facility providers.

For non-contracted provider groups, ancillaries and facilities interested in joining Blue KC's networks, select "Join Blue KC Networks" on our login page at Providers.BlueKC.com.

For claims related inquiries, please use the Claim Inquiry Form (Providers.BlueKC.com/eForms/Form/ClaimInquiry), which provides the following category options:

Select the most accurate reason for this inquiry

- ○ Allowable Questions
- ○ Billed in Error / Void
- ○ Complete Medical Records Request
- ○ Corrected Claim
- ○ Lab Service Denial
- ○ Overpayment
- ○ Prior Authorization Denial
- ○ Other

You are also able to use this Claim Inquiry form to request the status of a previous inquiry if a response has not been received within 30 days.

Contact us

Please join the BlueSpeak email distribution list by sending a request to BlueSpeak@BlueKC.com. You can also use this email address to give us any feedback about BlueSpeak. We would love to hear from you!

If you have questions about any of these updates, please call the Blue KC Provider Hotline at 816-395-3929 for Commercial line of business or 866-859-3822 for the ACA Provider Hotline. We value and appreciate you as our partner in providing quality care.