BLUESPEAK

PROVIDER NEWS AND UPDATES

Kansas City

March 2026 BlueSpeak

Welcome to the March 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.

Blue KC and Highmark Affiliation Approved

We are pleased to announce that Blue KC and Highmark Inc. (Highmark) have received regulatory approval from the Missouri Department of Commerce and Insurance and expect the affiliation to close on March 31, 2026.

This affiliation, initially announced on December 11, 2025, is aimed at accelerating innovation and improving health outcomes for Blue KC members across the Kansas City region.

Under this affiliation, Blue KC will be a locally governed, nonprofit company in Kansas City and gain access to new technology, capabilities and resources. Blue KC will also maintain its local leadership and strengthen its capacity to offer accessible and affordable healthcare for members and the community for years to come.

Nothing will change for our provider partners or members in the immediate future. Members will continue to access their health coverage and see their doctor just as they do today, and our provider partners will continue to file claims using the same system they do today.

Highmark's experience in pharmacy services, data and analytics solutions, payer and provider technologies, as well as its ownership of a large health system, Allegheny Health, will position Blue KC to better serve providers and patients, ensuring long-term sustainability for Blue KC members and customers.

We value your continued partnership and are committed to providing you with timely updates as more information becomes available. In the meantime, please reach out to your Blue KC Provider Account Executive with questions. Please reference our press release to learn more about the affiliation.

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Prior Authorization Updates

Coverage Change for Implanted Prosthetic Device

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**

Effective June 1, 2026, coverage for C1776 will be limited to one (1) unit per surgical encounter. The code applies only to the implanted prosthetic device used during joint replacement procedures (e.g., knee, hip, shoulder); hardware, screws, and other accessories are not separately reimbursable.

The device must be billed on the same claim as the corresponding surgical procedure. If an encounter requires more than one unit, medical records must be submitted to support medical necessity for review and determination. Documentation must clearly support the implanted joint device consistent with CMS and Coding Clinic guidance.

Code Additions

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

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The following codes will be added to our prior authorization list, effective **May 1, 2026:**

Code	Description	Effective Date	Lines of Business Impacted
G0277	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval	5/1/2026	Commercial, ACA
C1767	Generator, neurostimulator (implantable), nonrechargeable	5/1/2026	Commercial, ACA

64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	5/1/2026	Commercial, ACA

Medical Policy Updates

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

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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.

Effective date – 4/1/2026	ID: 7.01.76 Title: Treatment of Tarlov Cyst – New Policy • Treatment of Tarlov cysts (perineural cyst, sacral perineural cyst, sacral meningeal cyst) with surgical, percutaneous, and/or neuromodulation interventions is considered investigational.
Effective date – 4/1/2026	ID: 7.01.158 Title: Balloon Dilation of the Eustachian Tube – Bi-Annual Update • Balloon dilation of the eustachian tube (BDET) with a device approved by the U.S. Food and Drug Administration (FDA) for treatment of chronic obstructive eustachian tube dysfunction (ETD) may be considered medically necessary under the following conditions: ○ Removed “Adults (age 22 years and older)” ○ Changed from 12 months to 3 months or longer in 1 or both ears that significantly affects quality of life or functional health status

Effective date – 4/1/2026	ID: 7.01.101 Title: Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome – Interim Update • Medically necessary statement for HNS now specifically cites the Inspire device. • A new policy statement is added that HNS using other FDA-approved devices (e.g., Genio) is considered investigational for treating clinically significant OSA syndrome

Pharmacy Policy Updates

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

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Below are new Blue KC pharmacy policies effective **April 1, 2026,** for medications that already require prior authorization:

New Pharmacy Policies		
Policy Number	Policy Name	Summary
5.02.693	Inlexzo (gemcitabine intravesical system)	FDA approved for Bacillus Calmette-Guérin (BCG)-unresponsive non–muscleinvasive bladder cancer (NMIBC) with carcinoma in situ (CIS), with or without papillary tumors; Intravesical insert; Medical-Rx benefit
5.02.694	Papzimeos (zopapogene imadenovec-drba)	FDA approved for Recurrent Respiratory Papillomatosis (RRP); IV; Medical-Rx benefit

Below are Blue KC pharmacy policies with updates effective **April 1, 2026,** for medications that already require prior authorization:

Pharmacy Policies with Updates		
Policy Number	Policy Name	Summary
5.02.654	Elrexfio (elranatamab-bcmm)	Added criteria - Member has not experienced disease progression while on a bispecific B-cell maturation antigen (BCMA)- directed CD3 T-cell engager-containing regimen progression on BCMA target Added criteria – prescribed by or in consultation with an oncologist
5.02.678	Datroway (datopotamab deruxtecan-dlnk)	Added indication for EGFR mutated non–small cell lung cancer, locally advanced or metastatic
5.02.531	Blincyto (blinatumomab)	Added indication for ALL CD19+ Philadelphia chromosome negative in consolidation phase
5.02.549	Mylotarg (gemtuzumab ozogamicin)	Updated indications to expanded FDA approved ages

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.

Payment Policies Featured in this Section
Billing of Applied Behavior Analysis with Speech, Occupational and/or Physical Therapy
IOP, PHP, and Inpatient treatment Services for Substance Abuse and Psychiatric

Billing of Applied Behavior Analysis with Speech, Occupational and/or Physical Therapy Payment Policy

LINES OF BUSINESS IMPACTED						
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Policy Number	Policy Name	Effective Date for New Policy	Enforcement Date for New Policy	Full Policy Location
POL-PP-329	Billing of Applied Behavior Analysis with Speech, Occupational and/or Physical Therapy	4/1/2026	4/1/2026	View our Billing of Applied Behavior Analysis with Speech, Occupational and/or Physical Therapy Payment Policy Visit our Payment Policies page Go to Providers.BlueKC.com, click on "Go to Payment Policies"

New Policy Summary

- Below is a summary for new Blue KC Payment Policy, Billing of Applied Behavior Analysis with Speech, Occupational and/or Physical Therapy, that will be **effective for dates of service on or after April 1, 2026**. This new policy was announced in the January BlueSpeak Provider Newsletter.
- Concurrent care exists where more than one healthcare provider renders services during a period of time.
    - When Concurrent or Overlapping Billing is Allowed:
        - The following procedure codes, 97153 and 97155, may overlap, as long as the descriptors of each code have been met and different qualified health providers (QHPs) deliver the service.
        - A single provider may NOT bill these codes concurrently.

Modifier	Description
HM	Modifier HM indicates that a service was performed by a provider with less than a bachelor's degree. This modifier is most often used in the billing of behavioral health services, including Registered Behavior Technician
HO	Modifier HO Indicates a master's-level professional, such as a Board-Certified Behavior Analyst (BCBA) or licensed mental health provider

    - When Concurrent or Overlapping Billing is Not Allowed:
        - Billing applied behavior analysis (ABA) services when performed in the same block of time as speech, occupational and/or physical therapy, are not allowed.
        - Billing standards require only one service and one provider to be designated for a given time. For example:

- If a member receives ABA therapy with a registered behavior technician (RBT) and occupational therapy with an occupational therapist from noon to 1 p.m., this is considered overlapping time and is not allowed.
- If the member receives ABA therapy with an RBT from noon to 1 p.m. and occupational therapy from an occupational therapist from 1 p.m. to 2 p.m., these are not overlapping, and both services are billable. The billing of these services on the same day as ABA is allowed, but not during the same given time.

IOP, PHP, and Inpatient treatment Services for Substance Abuse and Psychiatric 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 Updates	Enforcement Date for Updates	Full Policy Location
POL-PP-238	IOP, PHP, and Inpatient treatment Services for Substance Abuse and Psychiatric	4/1/2026	4/1/2026	View our IOP, PHP, and Inpatient treatment Services for Substance Abuse and Psychiatric Payment Policy Visit our Payment Policies page Go to Providers.BlueKC.com, click on "Go to Payment Policies"

Updates Added

- As announced in the January 2026 BlueSpeak Provider Newsletter and **effective for dates of service on or after April 1, 2026**, the following condition codes will be required:
  - Partial Hospitalization claims will be required to use condition code 41 indicating Partial Hospitalization Program (PHP).
  - Intensive outpatient claims will be required to use condition code 92 indicating Intensive Outpatient Program (IOP) services.

Provider Education

Tips for Independent Laboratory Claims

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Blue KC wants to inform providers that we are seeing an increase in clinical edit denials on independent laboratory claims. Blue KC is providing the information below to help resolve this issue for all providers who utilize independent laboratory vendors for testing.

Why is Blue KC seeing an increase in clinical edit denials on independent laboratory claims?	• The clinical edit denials on independent laboratory claims are occurring primarily for the following reasons:
	  ○ Incorrect or inappropriate modifiers submitted on the claim
	  ○ Diagnosis codes that do not support medical necessity
	• Independent laboratories cannot change or correct diagnosis codes. They rely entirely on the referring provider office to supply accurate and complete clinical information at the time of order entry.
	• When a claim denies due to missing, incorrect, or unsupported diagnoses, the laboratory is unable to resolve the denial without the referring provider's involvement. As a result, the lab may be unable to obtain reimbursement for the services rendered.

What policy do providers need to follow?	• Providers must follow Blue KC's Laboratory Medical Policies, which outline coverage criteria, medical necessity requirements and appropriate coding guidelines for laboratory testing. • Before submitting a laboratory order to an independent laboratory vendor, referring provider offices are responsible for ensuring that all tests include appropriate and accurate diagnosis codes. These codes must support medical necessity and align with applicable health insurance medical policy guidelines.

	• If a test is not covered based on the member's benefits or the applicable medical policy, the provider office is responsible for notifying and educating the member regarding any potential out-of-pocket costs.
For more information	• Providers may access additional information in the following ways: ○ Provider Portal: Review applicable medical policies under the Medical Policies section at Providers.BlueKC.com. ○ Provider Hotline: Contact the provider services hotline with questions regarding member benefits or coverage criteria at 816-395-3929 for our Commercial line of business or 866-859-3822 for the ACA Provider Hotline

Top Claim Denials for 2026 – What They Mean & How to Prevent Them

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The guide below explains five frequently issued claim denials and the most practical steps to avoid them. Note on how to use: Match the denial code on the remittance to the section below, then follow the prevention checklist and next steps.

Quick prevention checklist (use before resubmitting):

- Confirm member eligibility, subscriber ID, and effective dates for the date(s) of service.
- Check prior submissions to avoid duplicates; allow adequate processing time before rebilling.
- Validate CPT/HCPCS + modifier combinations against NCCI/CPT and payer guidance.
- Verify required claim fields are complete (provider identifiers, diagnosis pointers, units, dates, place of service, etc.).
- Confirm that the service is covered under the members' benefit plan (tier/coverage exclusions).

1. SHD – Definite Duplicate or X02-FKE – Duplicate Service
• **What it means:** Blue KC has already received and processed a claim for the same service.

- **Common causes:** Rebilled too soon; claim was corrected but submitted as a new claim; resubmission after a status check.
- **How to avoid:** Review your submission history before rebilling; submit as a **corrected claim** when changing information; allow adequate processing time before following up.
- **What to do if denied:** If the original claim is truly paid/denied, do not rebill. If you need to update the claim, submit a corrected claim with the required corrected claim indicators.
- **Provider Reference Guide takeaway:** Most clean claims process within about **30 days**. Check status on Providers.BlueKC.com or call the Provider Hotline. Avoid sending duplicate claim sooner than 30 days after the original submission—duplicates may require repayment or be deducted from future payments.

2. E06 – Procedure/Modifier Combination Disallowed

- **What it means:** A CPT/HCPCS code was billed with a modifier that is not allowed or not compatible with that service.
- **Common causes:** Modifier used incorrectly; modifier does not apply to the code; edits triggered by NCCI/CPT or payer-specific rules.
- **How to avoid:** Validate modifier rules before submission (NCCI edits, CPT guidance, and Blue KC payment policies); ensure documentation supports the modifier.
- **What to do if denied:** Correct the modifier (or remove it if not supported) and resubmit as a corrected claim when appropriate.
- **See also:** Blue KC Provider Payment Policies with modifier guidance (Bilateral Procedures; Increased Procedural Service Modifier 22; JW and JZ Modifiers; Modifiers; Modifier AS Assistant Surgeon; Modifier SU; Modifiers 59, XE, XP, XS & XU; National Correct Coding Initiative NCCI)

3. 385 – Provider Billing Error

- **What it means:** The claim is missing required information and/or contains a submission or billing error.
- **Common causes:** Missing/invalid provider identifiers; incomplete patient/subscriber details; missing/incorrect diagnosis pointers; invalid dates of service; missing units; mismatched place of service; incomplete rendering/billing provider information.
- **How to avoid:** Use a claim scrubber or internal checklist; confirm all required fields are present and consistent across the claim.
- **What to do if denied:** Correct the missing/incorrect fields and resubmit as a corrected claim.
- **See also:** General Coding and Billing Payment Policy

4. ST – Termination (Coverage Ended)

- **What it means:** The member's coverage was terminated for the date(s) of service billed.
- **Common causes:** Eligibility changed; incorrect subscriber number; date of service outside the coverage period.
- **How to avoid:** Verify eligibility, subscriber number, and effective/termination dates before the visit and before billing.
- **What to do if denied:** If coverage is active per verification, confirm the correct member/subscriber ID and resubmit with corrected information (or contact support if the eligibility response conflicts with the denial).

5. TR0 – Tier Not Found / Service Not Covered

- **What it means:** The billed service is excluded or not covered under the member's benefit plan/tier.
- **Common causes:** Benefit exclusions; non-covered service category; plan limitations.
- **Examples often seen:** Acupuncture, massage therapy, and some laboratory services (coverage varies by plan).
- **How to avoid:** Verify benefits/coverage for the specific service (and authorization requirements, if applicable) before performing or billing.
- **What to do if denied:** Confirm coverage details; if the service is truly non-covered, bill the member per your policies and applicable rules. If coverage exists, resubmit corrected information or supporting documentation as required.
- **See also:** Unlisted and Miscellaneous Codes Payment Policy

The Importance of Coding Accuracy in Risk Adjustment

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

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Risk adjustment uses a statistical methodology to account for the baseline health status and expected health costs of a patient. Medicare Advantage and other risk-based programs require accurate coding to ensure the degree of illness and patient complexity are appropriately reflected as it exerts a direct influence on patient care, institutional reimbursement, and quality metrics.

What Coding Accuracy effects	• Appropriate Reimbursement: Health plans and providers are remunerated according to the health status of their patient populations. Inaccurate or incomplete coding can result in either underpayment or overpayment, both of which carry substantial financial implications. • Quality Measurement: Numerous quality and performance indicators are dependent upon accurate coding. Thorough documentation of diagnoses allows for proper representation of patient complexity, thereby facilitating fair and meaningful comparisons. • Regulatory Compliance: Payers and regulatory authorities routinely conduct audits of coding practices. Inaccuracies may result in penalties, financial repayment obligations, and heightened scrutiny, all of which can adversely affect the reputation of providers and organizations. • Patient Care Continuity: Precise coding portrays the authentic clinical scenario, thereby supporting care coordination, suitable interventions, and improved health outcomes. It also ensures that all members of a patient's care team have access to comprehensive and current information.
The Burden for Physicians in Ensuring Coding Accuracy	• Physicians and other health care providers occupy a pivotal role in patient care and documentation. Their clinical records constitute the fundamental basis for coders to assign accurate diagnostic codes. Providers may enhance risk adjustment and coding accuracy by: ○ Documenting all pertinent diagnoses and conditions during every patient encounter. ○ Accurately documenting the active diagnosis, the current status of the condition, and the corresponding plan of care within the Assessment and Plan. ○ Providing specificity in clinical documentation (for example, noting “Type 2 diabetes with chronic kidney disease” rather than simply “diabetes”). ○ Regularly updating the problem list and rectifying any discrepancies. ○ Collaborating proactively with coding professionals to clarify documentation and respond promptly to queries.
Conclusion	• Accurate coding in risk adjustment is more than just following billing requirements; it is an indispensable part of high-quality, patient-focused care. • Physicians and healthcare providers bear a heavy responsibility in ensuring that documentation accurately reflects the complexity of their patients. • By prioritizing coding accuracy, providers not only ensure appropriate reimbursement and compliance, but also advance the quality and continuity of care delivered to their patients.

A Better GAP Fill Fee Schedule

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Blue KC is pleased to have recently improved the format of the GAP Fill Fee Schedule, which you can access by logging into Providers.BlueKC.com and selecting the GAP Fill Fee Schedule tab under Resources. Here are some of the recent improvements we made following your feedback:

- Added a column to designate Facility or Non-Facility allowable pricing.
- When the file is downloaded, the effective date is now reflected in the file name.

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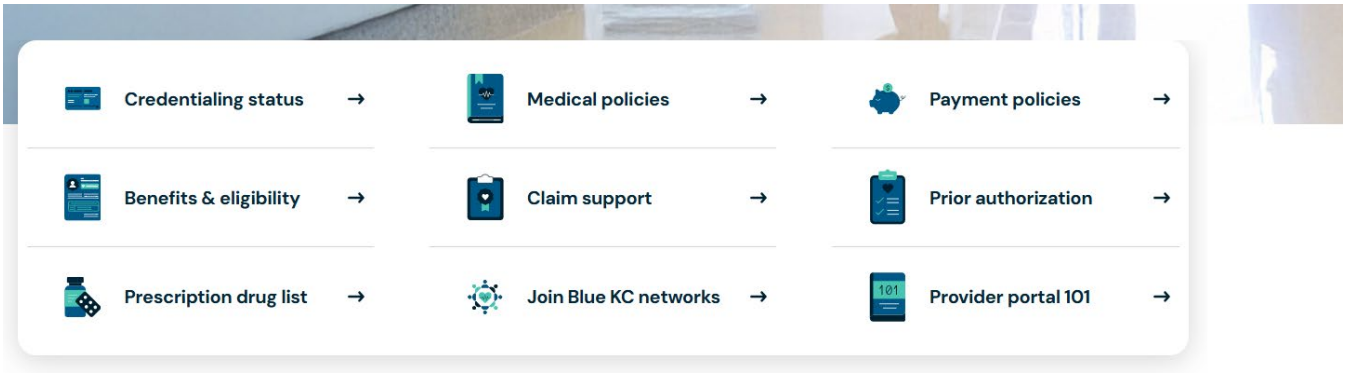
Have you noticed our new-look Blue KC Provider Portal login page at Providers.BlueKC.com?

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:

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.

Recently Enhanced Blue KC Provider Reference Guide Now Available

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

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- The recently enhanced Provider Reference Guide (PRG) can be found by logging into Providers.BlueKC.com and clicking on Resources.

• Multiple documents have been consolidated into a single primary PRG with a supporting BlueCard manual and Federal Employee Program (FEP) manual, which can also be found on the Resources page.
• Various policies and procedures have been updated and/or revised.
• The Blue KC Provider Reference Guide includes information about administrative areas, including policies, programs, quality standards, appeals, and more.

Blue KC Care Management Team – A partner in health

LINES OF BUSINESS IMPACTED						
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The Blue KC Care Management Team includes clinical nurses, social workers and Community Health Workers. They can help your patients by offering resources for a healthy pregnancy, managing chronic health conditions, offering support and encouragement after a diagnosis, providing assistance with transitions of care, assisting patients in achieving their wellness goals and answering questions about benefits. The team personalizes a plan based on each patient's unique care needs.

The Care Management Team continuously monitors a dashboard, which surfaces insights about preventive health needs, such as flu shots or annual eye exams, and flags patient survey responses related to their health, wellness and nutrition. Our team then works with your patients to schedule care and navigate resources.

One of the best ways to connect with the Care Management Team is through the Blue KC Care Management app. With this health resource, users can also view articles and videos personalized to them, set appointment and medication reminders, and access exclusive perks from local and national brands, including offers on groceries, health and wellness, and more.

You can encourage patients to download the Blue KC Care Management App from the App Store or Google Play. They should use access code **kcnews** when prompted. They can also learn more about the Blue KC Care Management app and Care Team on this page. For more information about case management services or to make a referral, call the Management Referral Line at 816-395-2060 or 1-866-859-3811.

April Free Documentation & Coding Webinar

LINES OF BUSINESS IMPACTED						
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Join us for the April 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:

April 28 & 30 7:30 a.m. & 11:30 a.m. CT	**From Blockages to Breakthroughs:** Navigating Vascular Codes	Avoid the blockage of improper coding and documentation for vascular disorders including DVT's – Acute and Chronic, etc.

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.