BLUESPEAK

PROVIDER NEWS AND UPDATES

Kansas City

November 2026 BlueSpeak

Welcome to the November 2026 BlueSpeak Provider Newsletter from Blue Cross and Blue Shield of Kansas City (Blue KC). **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.

Integration updates for Blue KC-Highmark

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

Since the affiliation between Blue KC and Highmark became official on March 31, 2026, our organizations have been diligently working together to bring technology, resources and capabilities together in ways that strengthen how we serve members, providers and our community.

- While Blue KC remains a locally governed, not-for-profit company in Kansas City with local leadership, we connect into Highmark's scale, experience and capabilities, creating new opportunities to enhance the healthcare experience for our members and the providers who care for them.
- For providers, that includes opportunities to strengthen provider alignment, advance value-based care and make interactions with Blue KC simpler and more seamless.
- Blue KC and Highmark bring collective experience building value-based networks and programs designed to improve health outcomes and the member and provider experience.
- Highmark also brings experience using technology and other capabilities to streamline provider transactions and support providers in meeting quality measures that improve patient care.
- Over time, the affiliation will also create opportunities for Blue KC to expand the products, benefits, and services available to members and their families, drawing on Highmark's experience across all its markets.

As this work moves forward, we will continue to keep providers informed about changes and opportunities that affect how you work with Blue KC and care for our members.

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Prior authorization updates

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 **January 1, 2027.**

Code	Description	Effective Date	Lines of Business Impacted
66989	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	1/1/2027	ACA, Commercial
66991	Extracapsular cataract removal with insertion of intraocular	1/1/2027	Commercial

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	lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more		
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	1/1/2027	Commercial
J3490	Unclassified drugs (Lantidra)	1/1/2027	ACA, Commercial
0363U	Oncology (urothelial), mRNA, gene-expression profiling by real-time quantitative PCR of 5 genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm incorporates age, sex, smoking history, and macrohematuria frequency, reported as a risk score for having urothelial carcinoma Proprietary test: Cxbladder™ Triage Lab/Manufacturer: Pacific Edge Diagnostics USA, Ltd	1/1/2027	ACA, Commercial
0498U	Oncology (colorectal), next-generation sequencing for mutation detection in 43 genes	1/1/2027	ACA, Commercial

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	and methylation pattern in 45 genes, blood, and formalin-fixed paraffin-embedded (FFPE) tissue, report of variants and methylation pattern with interpretation Proprietary test: OptiSeq™ Colorectal Cancer NGS Panel Lab/Manufacturer: DiaCarta, Inc		
0560U	Oncology (minimal residual disease [MRD]), genomic sequence analysis, cell-free DNA, whole blood and tumor tissue, baseline assessment for design and construction of a personalized variant panel to evaluate current MRD and for comparison to subsequent MRD assessments Proprietary test: Haystack MRD™ Baseline Lab/Manufacturer: Quest Diagnostics ®	1/1/2027	ACA, Commercial
0561U	Oncology (minimal residual disease [MRD]), genomic sequence analysis, cell-free DNA, whole blood, subsequent assessment with comparison to initial assessment to evaluate for MRD Proprietary test: Haystack MRD™ Monitoring Lab/Manufacturer: Quest Diagnostics ®	1/1/2027	ACA, Commercial
81253	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26)	1/1/2027	ACA, Commercial

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	(eg, nonsyndromic hearing loss) gene analysis; known familial variants		
0569U	Oncology (solid tumor), next-generation sequencing analysis of tumor methylation markers (>20,000 differentially methylated regions) present in cell-free circulating tumor DNA (ctDNA), whole blood, algorithm reported as presence or absence of ctDNA with tumor fraction, if appropriate Proprietary test: Guardant Reveal™ Lab/Manufacturer: Guardant Health, Inc	1/1/2027	ACA, Commercial

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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 newsletter is intended to highlight new and updated policies but is not a comprehensive list of all policies or updates.

Payment Policies Featured in this Section
Chiropractic and Osteopathic Manipulation Services
JW and JZ Modifiers
Lactation Support Services
Pre- and Post-Service Claim Review

Chiropractic and Osteopathic Manipulation Services

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

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Policy Number	Policy Name	Effective Date for Updates	Enforcement Date for Updates	Full Policy Location
POL-PP-212	Chiropractic and Osteopathic Manipulation Services	2/1/2027	2/1/2027	View our Chiropractic and Osteopathic Manipulation Services Payment Policy Visit our Payment Policies page Go to Providers.BlueKC.com, click on "Go to Payment Policies"

Updates added

- **Effective February 1, 2027**, when CPT 98943 (extraspinal chiropractic manipulation) is billed on the same date of service, by the same provider, and in conjunction with spinal manipulative treatment codes 98940–98942, Blue KC applies a multiple procedure payment reduction.
- The spinal manipulation service (98940–98942) is considered the primary procedure and is reimbursed at 100% of the allowable amount. The extraspinal manipulation service (98943) is considered a secondary procedure and is reimbursed at 50% of the allowable amount.

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- This adjusted payment reflects Blue KC payment policy–based reimbursement methodology and does not indicate a denial, bundling edit, or determination of incorrect coding.

Drug waste policy edit effective January 1, 2027

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COMMERCIAL	**ACA QHP**	**SMALL GROUP ACA**	**JAA**	**FEP**	Medicare Advantage (BlueCard)	Dental

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Policy Number	Policy Name	Enforcement Date for Updates	Full Policy Location
POL-PP-234	JW and JZ Modifiers	1/1/2027	View our JW and JZ Modifiers Payment Policy Visit our Payment Policies page Go to Providers.BlueKC.com, click on "Go to Payment Policies"

Updates added

- **Effective January 1, 2027**, Blue KC will enhance our enforcement of the JW and JZ Modifiers POL-PP-234 Payment Policy by requiring that drug claims be billed in accordance with the policy.
- Blue KC allows reimbursement for single-dose vial (SDV) pharmaceutical waste reported by professional providers or outpatient facilities unless provider, state, federal contracts and/or mandates indicate otherwise.
- In addition, documentation in the member's medical record must include the amount of the drug/biologic administered to the member, the date, time, amount discarded, and the reason for the wasted amount.
- Blue KC requires that any reimbursable SDV drug dosage be calculated to minimize billed wastage based on available vial size combinations.
    - For example, when a drug/biologic is available in 20-unit vials and 100-unit vials and the member only requires 40 units, the expectation is the provider will use two 20-unit vials rather than using the 100-unit vial, administering only 40 units, and wasting the remaining 60 units.
- The number of units reported for the drug/biologic Healthcare Common Procedure Coding System Level II (HCPCS) code is based on the dosage indicated in the code description, not necessarily the number of milligrams actually given to the member.

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  - For example, J2506, pegfilgrastim (Neulasta) 0.5 mg – if a dose of 0.5 mg is administered to a member, 1 unit is reported since the descriptor text includes 0.5 mg.
- For wasted portions of drug products to be eligible for reimbursement, the provider must report the HCPCS code for the drug/biologic on one line with the actual units administered and the amount discarded/wasted reported on a separate line of the same claim with the modifier JW appended.
  - If an SDV contains 100 units, the HCPCS code indicates 1 unit, and 40 units are administered to a member, then the drug/ biologic should be reported on two lines with the first line indicating the 40 units administered and the second line with 60 units and modifier JW to indicate the wasted units and both lines will be eligible for reimbursement.
- The JZ modifier must be appended to a HCPCS code when the actual dose of a covered drug/biologic is administered from an SDV to the member with zero waste.
- Modifier JW is not permitted when the actual dose of a covered drug/biologic administered from a single dose vial is less than the billing unit defined by a specific HCPCS code. The provider may bill Blue KC for the drug/biologic administered with the JZ Modifier to be eligible for reimbursement and the remaining amount will be discarded.
  - For example, the descriptor text for HCPCS code J2175 is “injection, meperidine hydrochloride, per 100 mg.” If the administered dose of this drug is 97 mg and 3 mg are discarded, J2175 is reported with one unit on one line with the JZ modifier and the allowance for J2175 is eligible for reimbursement. Billing for one unit on a separate claim line with modifier JW for 3 mg of discarded drug would result in overpayment.
- **Note:** This policy does not apply to Multi-Dose Vials (MDV)

Related Coding

Modifier	Description	Comments
JW	Drug amount discarded/not administered to any patient.	Unused portion of the drug/biologic not administered may be eligible for reimbursement.
JZ	Zero drug amount discarded/not administered to any patient.	Unused portion of drug/biologic used is less than billing unit or zero drug/biologic is discarded.

Definitions	
Pharmaceutical Waste	The discarded amount not administered to any patient.

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Single-Dose Vial	A drug or biologic vial/ package that allows only one dose to be withdrawn for administration.

References and Research Materials
This policy has been developed through consideration of the following: • Centers for Disease Control and Prevention (CDC) • CMS • Optum EncoderPro 2025

Lactation Support Services

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

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Policy Number	Policy Name	Effective Date for Updates	Enforcement Date for Updates	Full Policy Location
POL-PP-326	Lactation Support Services	3/1/2027	3/1/2027	View our Lactation Support Services Payment Policy Visit our Payment Policies page Go to Providers.BlueKC.com, click on "Go to Payment Policies"

Updates added

- **Effective March 1, 2027**, CPT 99404 will be denied when billed with Z39.1.
- This requires lactation consultants to bill using 99401-99403, which will remain payable.
- HCPCS Code S9443 (lactation classes, non-physician provider, per session) will not be reimbursable.

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Pre- and Post-Service Claim Review

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COMMERCIAL	**ACA QHP**	**SMALL GROUP ACA**	**JAA**	**FEP**	Medicare Advantage (BlueCard)	Dental

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Policy Number	Policy Name	Effective Date for Updates	Enforcement Date for Updates	Full Policy Location
POL-PP-211	Pre- and Post-Service Claim Review	2/1/2027	2/1/2027	View our Pre- and Post-Service Claim Review Payment Policy Visit our Payment Policies page Go to Providers.BlueKC.com, click on "Go to Payment Policies"

Updates added

- **Effective February 1, 2027**, the following update will be added to the Pre- and Post-Service Claim Review Payment Policy:
  - When disputing a Payment Integrity audit finding, and all vendor disputes have been exhausted, you have the right to request an external review of that audit determination by an Independent Review Organization (IRO), which may be referred to as a certified review entity ("CRE"), to perform a review and conclusively resolve the dispute.
  - If the decision by the IRO is fully in favor of one party, the other party shall pay the entire fees and costs associated with the review and decision.
  - If the external review decision is partly in favor of each party, the parties shall share equally the cost of the review.
  - Invoices for the cost of external reviews will be billed quarterly.

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Medical policy updates

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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).

The Blue KC Medical Policy encompasses internally developed 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.

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Effective date – 12/1/2026	ID: 7.01.170 • Title: Laser Interstitial Thermal Therapy for Neurological Conditions – Interim Update ▪ Medically necessary criteria added to policy statement on radiation necrosis based on clinical practice guidelines, and drug-resistant epilepsy based on clinical input. ▪ Policy statement on primary and metastatic brain tumors remains investigational.
Effective date – 12/1/2026	ID: 8.01.61 • Title: Focal Treatments for Prostate Cancer – Interim Update ▪ New PICO and policy statement added for salvage ablative therapy using high-intensity focused ultrasound (HIFU) or cryoablation for locally recurrent, nonmetastatic prostate cancer after primary radiotherapy, covering focal, subtotal, and whole-gland ablation: HIFU or cryoablation may be considered medically necessary as salvage local therapy when specified criteria are met. ▪ Existing policy statement edited to clarify that the use of any focal therapy modality to treat primary localized prostate cancer is investigational.

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Effective date – 12/1/2026	ID: 8.01.68 • Title: Omidubicel as Adjunct Treatment for Hematologic Malignancies – Interim Update ▪ The policy was updated to add an evidence review for severe aplastic anemia and a new medically necessary statement: omidubicel is considered medically necessary in individuals 6 years or older with severe aplastic anemia who are planning allogeneic umbilical cord blood transplantation following reduced-intensity conditioning and for whom a compatible donor is not available.
Effective date – 12/1/2026	ID: OH- Tecvayli • Title: Tecvayli (teclistamab-cqyv) – OncoHealth Update ▪ Added information regarding teclistamab in combination with daratumumab. ▪ Added teclistamab should be prescribed by an oncologist or hematologist.

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Pharmacy policy updates

New effective date for specialty pharmacy change

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 medication, effective January 1, 2027.** Blue KC previously communicated an effective date of September 1, 2026, for this medication, but has since moved the effective date to January 1, 2027, to ensure a smooth transition for providers and members.

Medication	Strength(s)
Temozolomide	5mg, 20mg, 100mg, 140mg, 180mg, 250mg

- Blue KC will partner with prescribers and dispensing pharmacies to ensure this prescription is transferred to Lumicera Specialty Pharmacy, effective January 1, 2027.
- 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.

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Provider education

Prepare for electronic prior authorizations (ePA) before January 1, 2027

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

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As detailed in the October 2026 Blue Speak, we're getting ready to introduce electronic prior authorizations, making the process faster and easier for providers equipped to use this capability.

What you can do to connect to our ePA:

1. **Talk to your EHR vendor to confirm readiness.** Ask questions to help you understand their implementation roadmap, including:
    - What are our EHR system's API integration and electronic prior authorization capabilities and is our current EHR certified to support the functionality?
    - Will we need to upgrade our system or purchase additional modules?
    - Are you participating in pilot programs with payers?
2. **Upgrade your technology**, including EHR templates and workflows, if needed. Your vendor can give you information and support.
3. **Start testing**: We strongly encourage providers to take an active role in advancing electronic prior authorization by participating in Fast Healthcare Interoperability Resources® (FHIR) API testing with your EHR vendor and payer partners. Contact your EHR vendor to learn how and when you can begin testing to make sure your systems are ready for electronic prior authorization. Early testing and collaboration between your practice, EHR vendor, and payers is essential to ensure seamless, real-world implementation of electronic prior authorization workflows.

- Blue KC will provide more information in upcoming provider newsletters, including technical details to enable the new electronic workflows designed to streamline prior authorization and improve provider access to patient data for the members you treat.
- If your EHR is FIHR capable, please contact your Blue KC Provider Account Executive to learn about opportunities to be the first to utilize this new feature.

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Itemized bill requests for high-dollar claims

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

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To promote accurate billing and payment of high-dollar claims, Blue KC may request itemized bills when additional review is warranted for inpatient and outpatient claims reimbursed using a discounted charge methodology.

- Submitting Itemized Bills
  - Blue KC will request itemized bills as needed. Providers may also proactively submit itemized bills for inpatient and outpatient claims with total billed charges of $50,000 or more that will be reimbursed using a discounted charge methodology. Fax itemized bills to 816-995-1552.
  - If an itemized bill required for a high-dollar claim review is not submitted, Blue KC will deny the claim and request additional information.
  - A new or corrected claim is not required. Blue KC will reconsider the claim upon receipt of the itemized bill and additional information.
  - All claim submissions must comply with applicable medical coding guidelines and Blue KC medical and payment policies.

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Helpful tips for endoscopy reimbursement

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

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Blue KC wants to make providers aware of the following claims issue:

- Multiple endoscopic procedure discounting

Helpful Tips:

- Multiple endoscopic procedure discounting applies when:
  - Multiple endoscopic procedures from the same family are provided
    - By the same physician or physicians in the same group practice
    - On the same patient
    - On the same date of service
- Multiple endoscopic procedures
  - Same code with multiple units, or different codes, same family
- The Endoscopic procedure with the highest fee schedule rate is paid 100% plus the difference between the next highest fee schedule rate and the fee schedule rate for the base endoscopy procedure (for each subsequent endoscopic payable line)
- The total payment is added to the line with the highest fee schedule rate, and the other line is "bundled" and is not denied. While the line will show as $0.00, the total allowance paid should be reviewed.

Apixio rebrands as Machinify for post-payment reviews

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

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Blue KC wants to make sure you know that Apixio has rebranded under the Machinify name.

- You will see the name change on the Machinify provider portal and in letters requesting information or providing findings.
- Formerly known as Apixio, Machinify assists Blue KC with conducting post-payment reviews of medical records for services rendered to ensure billing and payment accuracy. Only acute care facilities are impacted.

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Maternity billing services updates

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

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

- The AMA has revised maternity coding and eliminated the use of traditional global maternity billing codes, **effective January 1, 2027.**
- This is an industry-wide AMA coding change that affects the way maternity services are reported.
- The transition will result in providers submitting claims throughout the pregnancy rather than waiting until delivery to submit a global maternity claim.
    - This change is viewed as a back-end change in how providers submit claims to Blue KC; moving away from one bundled claim to individual claims for the services performed.
- To support this transition, we encourage providers 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 expected to deliver **on or after January 1, 2027.** This is intended to support the transition away from global maternity billing and toward encounter-based billing
        - Antepartum care in 2026
            - If the patient had 4–6 antepartum visits in 2026, use CPT 59425.
            - If the patient had 7 or more antepartum visits in 2026, use CPT 59426.
            - If the patient had 3 or fewer antepartum visits in 2026, report each visit individually using the appropriate E/M code (e.g., 99202–99499)
            - The AMA clarifies that these 2026-specific antepartum codes remain in effect for services provided in 2026, even if delivery occurs in 2027
            - A single pregnancy that spans both calendar years may therefore include a 2026 antepartum-only code (59425 or 59426) and 2027 E/M and delivery reporting. So, providers do not need to rebill any visits prior to 9/1/26.
            - Providers should be using the TH modifier with the unbundled E/M codes before and after 1/1/27.

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- There will be no changes to the current process for collecting copays.
    - Only one office visit copayment will apply for OB services per pregnancy.
    - The copayment will be assessed at the time of delivery and will be in addition to the IP hospital services cost sharing if indicated.
    - A Blue KC member will pay an office visit copayment for each visit to a physician for complication of pregnancy appointments.
- Providers should evaluate their clinical, billing and EHR workflows now to prepare for a transition from global maternity billing to encounter-based billing.
- Blue KC encourages providers to review guidance published by the American College of Obstetricians & Gynecologists (ACOG) and the AMA.

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Annual wellness visits: An opportunity for accurate chronic condition recapture

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

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The Medicare Annual Wellness Visit (AWV) is covered once every 12 months for eligible beneficiaries and centers on a health risk assessment and personalized prevention plan. Patients with chronic conditions often see several providers, and no single office may have the full picture. Because the AWV includes a review of medical history, medications, and the providers involved in a patient's care, it is a practical point to identify chronic conditions that need current assessment and documentation. (CMS, 2026; Bain et al., 2019/2024.)

For Medicare Advantage risk adjustment, diagnoses must be supported and reported within the annual data collection period; they do not carry forward automatically. "Recapture" means confirming and reporting conditions that are still present, not copying last year's list. A chronic condition managed mainly by a specialist can still be missed in the primary care record if no one addresses it during the year. Using the AWV to review chronic conditions, including those managed by other providers, can help reduce these omissions and keep the record current. (CMS, 2014; AAPC, n.d.)

To make the visit effective, consider the following steps:

- Prepare: Reconcile the problem list, medication list, and available specialist and hospital records before the visit so that likely chronic conditions are on the clinician's radar.
- Assess and document: Confirm which conditions remain current and document each condition's status along with any assessment, monitoring, treatment, or care coordination.
- Report only what is supported: A problem-list entry or outside record alone is not sufficient, and resolved conditions should not be reported as active. Reporting should rest on the clinician's own documentation from a face-to-face encounter. (AAPC, n.d.; CMS, 2026.)
- Follow up as needed: The AWV does not replace medically necessary chronic disease care. Schedule follow-up when a condition needs further evaluation, bill separately identifiable problem-oriented services appropriately (for example, modifier 25 when applicable), and discuss possible cost-sharing with the patient. (Pryor, 2021.)

The goal of the AWV is a complete, accurate annual picture of the patient's health, not additional diagnoses. Documentation and coding should follow the ICD-10-CM Official Guidelines, CMS and payer requirements, and the clinician's independent medical judgment, and should never be driven by payment or risk score impact. Unsupported diagnoses can lead to overpayment recovery and Risk Adjustment

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Diagnosis Validation findings, so work with your compliance office to apply this guidance within your organization's policies. This article is educational and is not coding, billing, or legal advice. (CMS, 2026.)

Sources: Centers for Medicare & Medicaid Services. (2026, February 11). Annual wellness visits. Coverage frequency and preventive purpose. CMS coverage guidance; Bain, P. A., Lazaroff, A., Jin, J., & Brown, M. (2019, December 19; renewed 2024, March 5). Medicare annual wellness visit (AWV): Streamline workflow to perform a thorough AWV. AMA STEPS Forward. Team-based workflow, visit scope, and patient expectations. AMA toolkit; Centers for Medicare & Medicaid Services. (2014). Medicare Managed Care Manual, Chapter 7: Risk adjustment. Annual risk-adjustment process and diagnosis data collection; see sections 60 and 120.1. CMS manual; AAPC. (n.d.). What is HCC coding? Supported diagnosis abstraction and risk-adjustment coding principles. AAPC HCC coding overview; Centers for Medicare & Medicaid Services. (2026, March 4). Medicare Advantage Risk Adjustment Data Validation program. Medical-record support for submitted diagnoses. CMS RADV guidance; Pryor, J. (2021, July 7). What's included in an AWV? AAPC Knowledge Center. Wellness-service scope and additional problem-oriented care. AAPC AWV article

Keeping the problem list current

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Maintaining an accurate up-to-date problem list is an important part of clinical documentation. Reviewing and updating the problem list helps ensure that active conditions are accurately documented, and the patient's current health status is properly reflected in the medical record. An accurate problem list supports continuity of care and promotes complete documentation.

- Problem list vs. Past medical history:
  - The problem list should reflect conditions that are active, chronic, recurrent, or otherwise affect current care. Personal medical history should include prior conditions, surgeries, or illnesses that are resolved or no longer actively treated but still matter for screening, surveillance, risk assessment, or treatment decisions.
- Coding and risk adjustment reminder:
  - A diagnosis appearing on the problem list does not automatically support coding or risk adjustment reporting. The encounter documentation should show that the condition is current and clinically relevant, including how it was monitored, evaluated, assessed, treated, or otherwise considered in the patient's care.
- Best practices for Maintaining an Accurate Problem List
  - Review regularly. Confirm whether listed conditions are active, resolved, duplicated, or entered in error.
  - Clarify status. Use terms such as active, stable, resolved, history of, in remission, or no evidence of disease when clinically appropriate.

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  - Move resolved conditions to past medical history. Conditions such as cancer, stroke, or DVT that are no longer active should be documented in the past medical history when appropriate.
  - Avoid copy-forward errors. Review conditions to ensure historical or resolved conditions are not carried forward to an active problem list.
- Bottom line: The problem list should reflect what matters now. Past medical history should reflect what mattered before but may still influence care today. Keeping both areas accurate improves patient care, documentation integrity, coding accuracy, and risk adjustment support.

References: American Medical Association. (2025). Is updating the problem list a physician-only task? https://www.ama-assn.org/system/files/regulatory-myth-updating-problem-list.pdf; American Health Information Management Association. (2011, August 31). Problem list guidance in the EHR. https://journal.ahima.org/Portals/0/archives/AHIMA%20files/Problem%20List%20Guidance%20in%20the%20EHR.pdf; American Health Information Management Association. (2011). Problem list guidance in the EHR: Appendix A: Sample policy and procedure template. https://www.ahima.org/media/u3ink5ud/problem-list-guidance-in-the-ehr-appendix-a-sample-policy-and-procedure-template-9-11.pdf; Warner, M. (2019, April 1). Take the problem out of problem lists. AAPC. https://www.aapc.com/blog/46377-take-the-problem-out-of-problem-lists/; Dick, M. (2018, March 5). Include MEAT in your risk adjustment documentation. AAPC. https://www.aapc.com/blog/41212-include-meat-in-your-risk-adjustment-documentation/; Centers for Medicare & Medicaid Services, National Center for Health Statistics, American Hospital Association, & American Health Information Management Association. (2025, July 10). ICD-10-CM official guidelines for coding and reporting: FY 2026—Updated October 1, 2025 (October 1, 2025–September 30, 2026). https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf; Centers for Medicare & Medicaid Services. (n.d.). ICD-10. https://www.cms.gov/medicare/coding-billing/icd-10-codes

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Coding accuracy starts with documentation: What providers need to know about the 2027 ICD-10-CM updates

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.

The FY2027 ICD-10-CM code set became effective on October 1, 2026. While the number of changes is moderate, the theme is clear: specificity. Many new and expanded codes depend on details only you can document—anatomical site, laterality, disease type, severity, and whether a condition is related to a procedure. Familiar problem list entries and EHR favorites may no longer be enough.

- Why your documentation matters in risk adjustment
  - Every diagnosis code starts with your documentation. In risk adjustment, those codes map to Hierarchical Condition Categories (HCCs)—groups of similar diagnoses used in payment models. Each HCC carries a risk adjustment factor (RAF), which CMS (Medicare Advantage) and HHS (commercial) use to calculate health plan payments. When a note is vague or a condition isn't fully described, your patient's true health status may not be reflected, affecting payment accuracy, audit outcomes, and patients' access to the right programs and resources.

Key 2017 Updates at a Glance		
Clinical Area	What Changed	What to Document
Neoplasms	More specific metastatic codes (C78.-, C79.-); revised C50.-/D05.- relationship	Metastatic site; in situ vs. invasive; laterality
Cardiomyopathy	I42.0 expands to I42.00, I42.01 (familial-genetic), and I42.09	Type, cause, and familial/genetic status
Postprocedural hypoglycemia	New E89.830 (post-bariatric) and E89.838 (other)	Link to the procedure and timing
Liver disease	New K74.0A (moderate hepatic fibrosis)	Fibrosis stage (e.g., F2)
Musculoskeletal	Expanded M86.8X- osteomyelitis; new M67.A plantar fasciitis/fibromatosis codes	Site, laterality, and 7th character

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- Documentation in action
    - A few examples show how a small detail in your note can change the code assigned:
        - Cardiomyopathy: Note whether dilated cardiomyopathy is familial or genetic. A confirmed familial genetic mutation now supports I42.01 rather than the former parent code I42.0.
        - Hepatic fibrosis: Document the stage. "Moderate hepatic fibrosis (Stage F2)" supports the new K74.0A code; "hepatic fibrosis" alone does not.
        - Breast cancer: State clearly whether disease is in situ or invasive. An operative report titled "breast cancer resection" does not support an invasive C50.- code when pathology confirms carcinoma in situ.
- Common documentation gaps to avoid
    - Selecting outdated or deleted codes from EHR favorites, templates, or the problem list
    - Using unspecified diagnoses when more detail is known
    - Leaving out laterality or anatomical site
    - Problem list entries that conflict with the encounter note
- Tips for your practice
    - Refresh your shortcuts: Work with your EHR team to remove deleted codes and update favorites and templates.
    - Document the details: Include anatomical site, laterality, type or subtype, stage or severity, and genetic or familial status when applicable.
    - Link conditions to procedures: State clearly when a condition, such as hypoglycemia after bariatric surgery, is related to a prior procedure.
- The bottom line
    - The 2027 updates depend on documentation. Clear, specific notes help claims process correctly, reduce audit risk, and give a complete picture of each patient's health. Thank you for your continued partnership in caring for the members we serve.

Sources: AAPC webinar, "Overview of the ICD-10 Updates for 2027: Small Count, Big Impact," presented by Dawn Carter; *AAPC, "What Is HCC Coding?"* – https://www.aapc.com/resources/what-is-hierarchical-condition-category

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December free documentation & coding webinar

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.

Join us for the December 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:

December 15th & 17th 7:30 a.m. & 11:30 a.m. CT	**Gut Instincts:** Coding for Accuracy and Impact	Fill up on documentation and coding guidance for the most common Gastrointestinal disorders.

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BLUESPEAK
PROVIDER NEWS AND UPDATES
Kansas City

Customer experience recognition

Blue KC wins global award for companywide customer experience transformation



Blue KC found the winner's circle at the world's largest celebration of customer experience.

Last month, the world's most customer centric companies were crowned at the Customer Centricity World Series Awards, and Blue KC was named a winner in the Customer Centric Transformation category. The award recognizes Blue KC's holistic customer experience transformation.

The event, organized by ARCET Global, is a leading international customer experience awards program that recognizes organizations that excel in customer experience best practices. In 2026, ARCET Global introduced a new honors category designed to spotlight organizations delivering outstanding customer experiences.

This year had more than 158 entries spanning across 24 countries, continuing its standing as a global gathering of customer experience best practice. Award recipients are selected by an independent panel of more than 150 judges who evaluate written case studies using a framework endorsed by the University of Dundee Business School. The program recognizes organizations at both the regional level (North America, Europe, MENA, LATAM, and APAC) and the global level.

To learn more about Blue KC's commitment to member satisfaction, please visit BlueKC.com/consumer/blue-kc/about.

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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.

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