

October 2026 BlueSpeak

Welcome to the October 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.

Blue KC-Highmark integration underway

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

Following Blue KC and Highmark Inc. (Highmark) receiving regulatory approval for the affiliation and completing the transaction on March 31, 2026, Blue KC's leadership team and Board are working with Highmark's leaders and Board as the two organizations continue the integration process.

- Under this affiliation, Blue KC remains a local, not-for-profit company in Kansas City and gains access to new technology, capabilities and resources. Blue KC will maintain its local leadership, and, through this affiliation, will strengthen its capacity to offer accessible and affordable healthcare for members and the community for years to come.
- One benefit of the affiliation is the collective experience Highmark and Blue KC bring in deepening provider alignment and building value-based networks and programs that improve the member and provider experience while improving health outcomes. Highmark also has a history of helping providers improve technologies and capabilities for more seamless transactions and helping providers align with quality measures that improve patient health and outcomes.
- Blue KC has always believed in the power of collaboration, and this affiliation demonstrates its commitment to building a stronger future together through meaningful partnerships that build on our collective strengths and expand our impact.
- Nothing is changing immediately for members and partners of either organization. We will continue to share updates as the integration progresses.

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

[Inpatient Readmissions](#)

[JW and JZ Modifiers](#)

Inpatient Readmissions Payment Policy

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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-239	Inpatient Readmissions	11/1/2026	11/1/2026	View our Inpatient Readmissions Payment Policy Visit our Payment Policies page Go to Providers.BlueKC.com , click on “Go to Payment Policies”

Updates added

- **Effective November 1, 2026**, for the Inpatient Readmissions Payment Policy (formerly 30 Day Readmissions Payment Policy), Blue KC will not provide separate reimbursement to acute care hospitals when a patient is readmitted within 15 calendar days of discharge to the same health system for a related condition or admission.
- When a qualifying readmission occurs within 15 days of a prior inpatient discharge, the admissions will be combined and reimbursed as a single payment in accordance with the hospital's contractual agreement.
- Related readmissions include, but are not limited to:

- Readmissions for the same or a closely related condition, diagnosis, or procedure as the initial admission.
 - Readmissions resulting from an infection, complication, or adverse event associated with the original hospitalization or post-discharge care.
 - Readmissions involving a condition or procedure that indicates a failed surgical or medical intervention.
 - Acute exacerbations or decompensation of a coexisting chronic condition that may be related to care provided during the initial admission or the post-discharge period.
 - Readmissions associated with clinical instability at the time of discharge, including premature discharge, inadequate care coordination, or insufficient discharge planning and follow-up.
- This policy is intended to encourage effective care transitions, appropriate discharge planning, and high-quality patient outcomes while reducing avoidable readmissions.

Drug waste policy edit effective January 1, 2027

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

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

Medical policy updates

Updated policies

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The most up-to-date Medical Policy can be found by logging into [Providers.BlueKC.com](https://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 – 11/1/2026	ID: APEA – G2006 • Title: Diabetes Mellitus Testing – Avalon Update ▪ New CC6 allowing diabetes screening for those initiating or actively taking antipsychotic medications. ▪ Based on ADA guideline updates, CC9, frequency of allowed screening for adolescents changes from “three” to “two”.
Effective date – 11/1/2026	ID: APEA – G2035 • Title: Prenatal Screening (Nongenetic) – Avalon Update ▪ Removed the following sub-criteria from CC1: ▪ CC1a (HIV screening found in M2116) CC1.b., CC1.c., CC1.e. (STI screening found in G2157) CC1.d., CC1.f. (hepatitis



	screening found in G2036) CC1.g., CC1.h (diabetes screening found in G2006) CC1.i. (bacteriuria screening found in G2156) CC1.o. (TB screening found in G2063) - Removed CC2, as STI screening is found in G2157 Former CC5, now CC4, edited for clarity. - Now reads: “4) Testing of salivary hormone levels to assess risk of preterm labor is considered investigational.”
Effective date – 11/1/2026	ID: APEA – G2113 - Title: Oral Cancer Screening and Testing – Avalon Update - For clarity, mRNA CancerDetect and Omnipathology were moved from former CC2 into new CC2 to make it explicitly clear that these tests never meet coverage criteria. - New CC2: “2) Noninvasive tests designed to screen for, detect, or diagnose oral cancer (e.g., mRNA CancerDetect™, OmniPathology Oropharyngeal HPV PCR Test) are considered investigational.”
Effective date – 11/1/2026	ID: APEA – G2149 - Title: Pathogen Panel Testing – Avalon Update - New CC10: “10) Molecular-based panel testing to screen for or diagnose joint infections (e.g., BIOFIRE® Joint Infection (JI) Panel, Synovasure® Comprehensive PJI Test Panel with SynTuition™) is considered investigational.”
Effective date – 11/1/2026	ID: AHS – G2054 - Title: Liquid Biopsy – Avalon Update - CC2: Based on NCCN guideline updates, removed “and unresectable (local or regional)”, added “1/2/3” to “NTRK1/2/3” to align with current naming conventions - CC3 edited to align with updated NCCN guidelines. “castration-resistant” changed to “metastatic”. Removed former CC3.a., added new CC3.a. and CC3.c., - CC3.b. edited for clarity. Now reads: “3) For individuals diagnosed with metastatic prostate cancer, cfDNA/ctDNA testing of the following biomarkers is considered medically necessary: a) Multigene panel testing for homologous recombination repair (HRR) genes (see Note 2) when metastatic biopsy is unsafe or unfeasible for individuals with metastatic prostate cancer.

- b)BRCA1 and BRCA2 for individuals being considered for rucaparib treatment.
- c)BRCA1, BRCA2, ATM, BARD1, BRIP1, CDK12, CHEK1, CHEK2, FANCL, PALB2, RAD51B, RAD51C, RAD51D, and RAD54L for individuals being considered for olaparib treatment.”
- In CC6 added “Urine Assay” to “PredicineCARE™ Urine Assay” to align with more specific name for the version run on urine now that a PLA has been released.

Pharmacy Policy Updates

New pharmacy policy

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Below is a new Blue KC pharmacy policy effective **November 1, 2026**, for a medication that already require prior authorization. **Note:** This newsletter is intended to highlight new and updated policies but is not a comprehensive list of all policies or updates.

New Pharmacy Policy		
Policy Number	Policy Name	Summary
5.02.700	Tregzi (Allogeneic Regulatory T cell Immunotherapy with HSPC and T cells-vldq)	FDA approved for Hematological malignancies; IV; Medical benefit

Pharmacy policies with changes

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Below are Blue KC pharmacy policies with changes effective **November 1, 2026**, for medications that already require prior authorization. **Note:** This newsletter is intended to highlight new and updated policies but is not a comprehensive list of all policies or updates.

Pharmacy Policies with Changes		
Policy Number	Policy Name	Summary of Changes
5.02.527	Elaprase (idursulfase) and Avlayah (tividenufusp alfa-eknm)	Added new drug Avlayah to current Elaprase policy; Avlayah is FDA approved for Mucopolysaccharidosis type II (MPS II, Hunter syndrome); IV; Medical benefit
5.02.683	Imaavy (nipocalimab-aahu)	Updated to add new indication for warm autoimmune hemolytic anemia
5.02.665	Anktiva (Nogapendekin Alfa)	Policies were updated to maintain evidence-based coverage standards.
5.02.543	Brineura (cerliponase alfa)	
5.02.564	Evenity (romosozumab-aqqg)	
5.02.625	Korsuva (difelikefalin)	
5.02.609	Nulibry (fosdenopterin)	
5.02.666	Parenteral Iron	
5.02.682	Qfitlia (fitusiran)	
5.02.544	Radicava (edaravone)	
5.02.576	Trodelvy (sacituzumab govitecan-hziy)	

Provider education

Itemized bill requests for high-dollar claims

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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, even when billed charges are below the established \$100,000 threshold.

- 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.

CMS Interoperability requirements effective January 1, 2027

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Effective January 1, 2027, a federal rule (CMS-0057 – Interoperability and Prior Authorization Final Rule) will require certain health plans to enhance electronic interoperability and prior authorization processes for Medicare plans.

- As part of a broader Blue Cross Blue Shield Association initiative, Blue KC is applying these enhancements across **all lines of business, including commercial plans**.
- Utilizing Blue KC's electronic PA process will reduce administrative effort, improve prior authorization turnaround times and provide more efficient access to patient data.
- Providers will be able to use electronic prior authorization (ePA) workflows to determine if prior authorization is required, submit required documentation electronically and receive decisions more quickly, often within seconds.
- In-network providers will also be able to securely retrieve patient data, supporting timelier and coordinated care.
- 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 FHIR capable, please contact your Blue KC Provider Account Executive to learn about opportunities to be the first to utilize this new feature.

Post-payment clinical claim validation reviews

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Blue KC will introduce Post-Payment Clinical Claim Validation (CCV) reviews with Cotiviti. Clinical Chart Validations with Cotiviti will begin **November 1, 2026**.

- CCV reviews are conducted to ensure proper billing. These reviews will require a copy of the medical records and will be requested by Cotiviti via U.S. mail, if Blue KC has not already received the medical records.
- Cotiviti's staff includes registered nurses and medical and claims experts with varying expertise, including, but not limited to:
 - Coding
 - Claims operations
 - Quality
- Cotiviti works with health plans across the United States to conduct payment accuracy and claim validation reviews.
- The reviews are based on documentation and coding accuracy and are not based on medical necessity review.

Apixio rebrands as Machinify for post-payment reviews

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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.

Maternity billing services updates

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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.

- 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](#).

Provider concierge services

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Blue KC has seen an increase in calls from members noting that providers were requiring them to engage in their concierge programs or monthly membership services in order to receive care.

We want to remind providers that Blue KC members cannot be denied or discouraged from receiving covered services solely because they choose not to participate in or pay for optional concierge services. Contracted providers are expected to provide services to all members, in accordance with their provider agreement. We appreciate your cooperation.

Flu vaccine awareness for high-risk members

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As we enter the Flu season, please consider the importance administering the flu vaccine to high-risk members. According to the [CDC](#), flu vaccination decreases the chance of infection, lessens the severity of infection and can reduce the chance of hospitalization.

People who are at [higher risk](#) of developing serious complications from the flu, include:

- People with chronic lung disease (such as chronic obstructive pulmonary disease [COPD] and cystic fibrosis)
- People with heart disease (such as congenital heart disease, congestive heart failure and coronary artery disease)
- People with asthma
- People with diabetes
- People with hypertension (high blood pressure)
- People with a [body mass index \(BMI\) of 40 kg/m² or higher](#)
- Adults 65 years and older

The CDC also recommends [antiviral drugs](#) for people who are at increased risk of serious flu complications based on their age or underlying health conditions, if they develop flu symptoms.

CPT Code 96379 added for 837P and 837I claims

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Blue KC requires the use of National Drug Codes (NDCs) and NDC units on all Professional (837P) and Outpatient Institutional (837I) claims.

- Effective **November 1, 2026**, for **Therapeutic, Prophylactic or Diagnostic injection or infusion (96379)**, claims must be submitted with NDC and NDC units of measure in the 2410 loop of the 837P and the 837I.
- All drug-related J-codes, as well as Synagis (90378) and Lutathera (A9513), are already in effect, which was announced in a previous communication.
- The NDC submitted must be the actual NDC noted on the drug package or container.
- The appropriate HCPCS code and units are also required.
- The NDC is usually found on the drug label or medication's outer packaging.
- When the NDC appears on both, it is recommended to use the NDC on the individual product being dispensed.
- For unclassified J codes and other HCPCS/CPT codes that do not describe the dosage per HCPCS/CPT code unit, include the NDC, number of NDC units and HIPAA standard NDC unit of measure qualifier. The NDC units and NDC units qualifier must represent the dosage for the charge.
- The data elements below must be provided on the electronic claim.
- Claims that do not comply with the parameters stated below will be rejected by Blue KC's clearinghouse.

Name of Data Element	837P or 837I Loop /Data Element	Data Element Information
Product/Service ID Qualifier	2410 / LIN02	N4
Product/Service ID	2410 / LIN03	NDC (11 digit with no hyphens)
Quantity	2410 / CTP04	NDC Unit Count



Unit or Basis of Measure Code	2410 / CTP05	Unit of Measure Examples: • F2 – International Unit • GR – Gram • ME – Milligram • ML – Milliliter • UN – Unit
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Why maintaining accurate taxonomy in NPPES matters

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Maintaining an accurate taxonomy code within the **National Plan and Provider Enumeration System (NPPES)** is critical to ensuring proper claim processing, payment accuracy, and provider alignment within the network.

- Blue KC relies on the taxonomy associated with each provider's NPI in NPPES as **the primary source of truth** when determining provider specialty and validating claims.
- When a provider's taxonomy is outdated or does not reflect their current scope of practice, it can result in:
 - **Claim rejections or denials** due to NPI/taxonomy mismatches
 - **Payment delays** while discrepancies are investigated and resolved
 - **Inaccurate reimbursement** based on inaccurate specialty classification
- Additionally, taxonomy drives how providers are configured in payer systems, including whether they are recognized as primary care or specialty providers.
- When this information is inaccurate, it can impact claim processing, provider program eligibility, member attribution for value-based programs, reporting, and other administrative processes.
- Provider Action
 - Providers should routinely review their taxonomy information in NPPES and update it whenever there is a change in specialty, subspecialty, role, or scope of practice. Maintaining accurate information helps support efficient claim processing, appropriate reimbursement, and accurate provider records.
- FAQ: Taxonomy Updates
 - **Q: Where do I update my taxonomy?**
 - A: Taxonomy updates must be made directly in the NPPES system associated with your NPI. <https://npiregistry.cms.hhs.gov/search>
 - **Q: How often should taxonomy be reviewed?**
 - A: Providers should review their taxonomy anytime there is a change in specialty, role, or practice setting, and periodically to ensure accuracy.
 - **Q: How does taxonomy impact claims?**
 - A: Blue KC uses taxonomy to validate provider specialty. Mismatches between claim submission and NPPES can result in claim rejection or delays.
 - **Q: Does updating taxonomy in NPPES automatically update payer systems?**

- A: Providers should update their taxonomy directly in NPPES and notify Blue KC of any specialty or scope-of-practice changes to help ensure provider records remain accurate across administrative and operational processes.
- **Q: What happens if my taxonomy is incorrect?**
 - A: Incorrect taxonomy can lead to claim denials, delayed payment, or incorrect reimbursement until the discrepancy is resolved.

Blue KC earns 4 out of 5-star rating in NCQA's 2026 Health Plan Ratings

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The NCQA's¹ annual Health Plan Ratings are out, and Blue KC stood out not only in Kansas and Missouri, but also in the 10-state region by achieving a 4 out of 5-star rating.

- Blue KC was awarded:
 - 4 Stars for its commercial PPO plan
 - 4 Stars for its commercial HMO plan
- The ratings make Blue KC:
 - The **only** 4-star rated commercial product in Missouri and Kansas
 - The 3rd highest rating for commercial HMO plans in the 10-state region²
 - Tied for 1st in commercial PPO plans in the 10-state region²
- Additionally, Blue KC is the **only** commercial PPO plan in the 10-state region² and one of only three commercial plans (out of 111 nationwide) to receive Health Outcomes Accreditation³.
- While many factors led to the 2026 ratings, Blue KC outperformed other plans in NCQA's Prevention and Population domain for:
 - Smarter clinical data capture
 - Earlier, targeted intervention
 - More ways to contact members about gaps in care
 - Provider and value-based enablement
 - Continuous feedback and execution

¹National Committee for Quality Assurance

²10-state region includes: Arkansas, Colorado, Illinois, Iowa, Kansas, Kentucky, Missouri, Nebraska, Oklahoma, Tennessee

³The Health Outcomes Accreditation is awarded to plans for identifying and addressing barriers that prevent members from accessing high-quality care.

November Free Documentation & Coding Webinar

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Join us for the November 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](#) or details:

November 17 & 19 7:30 a.m. & 11:30 a.m. CT	Staging the Story: Cancer Coding with Clarity and Confidence	Uncover the skills necessary to overcome the challenges of correctly documenting and coding the most common Cancers and Hematological conditions.
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Caring for our community

Blue KC kicks off Splitlog Farm renovation in KCK to improve food insecurity



Blue KC, Cornerstones of Care and Build Wyco joined leaders from M.E. Pearson Elementary School at a groundbreaking and volunteer event to announce the rebirth of the Splitlog Farm in Kansas City, KS. Build Trybe, a Cornerstones of Care vocational program, began teaming up with volunteers from Blue KC to clear brush and fill dumpsters as work begins to restore the farm to its former glory.

The farm sits across the street from M.E. Pearson Elementary School, part of Kansas City, Kansas Public Schools. This new project will help the Splitlog Farm provide access to healthy food for the school and the surrounding neighborhood, as well as an outdoor classroom for the school and eating space for the neighborhood to enjoy.

The initiative will help address food insecurity, as one in seven people (15.1%) and one in five children (20%) in the Kansas City region are at risk of hunger. The county with the highest rate of food insecurity in the Kansas City region is Wyandotte, (18.8% overall, 26% for children). Click [here](#) to learn more about the project.



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](tel:816-395-3929) for Commercial line of business or [866-859-3822](tel:866-859-3822) for the ACA Provider Hotline. We value and appreciate you as our partner in providing quality care.