

September 2026 BlueSpeak

Welcome to the September 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.

Drug Waste Policy Edit Effective January 1, 2027

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 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

Prior Authorization Updates

Code additions

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

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

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

Code	Description	Effective Date	Lines of Business Impacted
L0999	Addition to spinal orthosis, not otherwise specified	11/1/2026	ACA, Commercial
E0676	Intermittent limb compression device (includes all accessories), not otherwise specified	11/1/2026	ACA, Commercial
L5999	Lower extremity prosthesis, not otherwise specified	11/1/2026	ACA, Commercial



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](#)

[Revenue Code 0710 Recovery Room](#)

Inpatient Readmissions Payment Policy

LINES OF BUSINESS IMPACTED

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

Revenue Code 0710 Recovery Room Payment Policy

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-330	Revenue Code 0710 Recovery Room	10/1/2026	10/1/2026	View our Revenue Code 0710 Recovery Room Payment Policy Visit our Payment Policies page Go to Providers.BlueKC.com , click on “Go to Payment Policies”

Updates added

- This policy applies to outpatient surgical procedures submitted by facilities not contracted to use CMS reimbursement methodology.
- The recovery room, also called the Post-Anesthesia Care Unit (PACU), is where a patient goes right after surgery to wake up from anesthesia and where specially trained nurses monitor vital signs (breathing, heart rate, blood pressure) as the patient stabilizes. They may receive pain or

nausea medication and gradually become alert before being moved to a hospital room or discharged home.

- Recovery Room time stops when a patient's vital signs are stable, they are fully alert and medically cleared to move to a regular hospital room or go home.
- Revenue code 0710 is only allowed on the day of surgery/procedure.
- Revenue code 0710 (Recovery Room) must be reported in conjunction with a valid anesthesia revenue code 037X. When revenue code 037X is not billed with revenue code 0710, the claim will be denied due to incomplete or incorrect data.

Medical Policy Updates

New policies

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](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.

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

Effective date – 10/1/2026	ID: 7.01.182 Title: Genicular Artery Embolization – New Policy • Genicular artery embolization (GAE), using any embolic agent (e.g., permanent microspheres, resorbable particles, or temporary liquid embolics), for the treatment of osteoarthritis of the knee is considered investigational.
Effective date – 10/1/2026	ID: 7.01.183 Title: Optilume Device for Urethral Stricture and Benign Prostatic Hyperplasia – New Policy

	- The Optilume Urethral drug-coated balloon may be considered medically necessary for the treatment of recurrent anterior (bulbar) urethral stricture in adult men when all of the following criteria are met: - The stricture is located in the anterior (bulbar) urethra; AND - The stricture is 3 cm or less in length; AND - The stricture is recurrent, having failed prior endoscopic treatment (direct visual internal urethrotomy or dilation). - The Optilume Urethral drug-coated balloon is considered investigational for the treatment of anterior urethral stricture in all other circumstances, including but not limited to penile urethral stricture, first-time (primary) treatment, and repeated use of the device. - The Optilume BPH Catheter System is considered investigational for the treatment of lower urinary tract symptoms secondary to benign prostatic hyperplasia.
Effective date – 10/1/2026	ID: 2.01.109 Title: Navigated repetitive Transcranial Magnetic Stimulation for Presurgical Mapping – New Policy Navigated transcranial magnetic stimulation (nTMS) of the brain using an FDA-cleared device and modality is considered investigational for preoperative motor or language mapping in individuals undergoing surgery for brain tumors or other intracranial lesions near eloquent cortex.
Effective date – 10/1/2026	ID: 3.03.08 Title: Digital Health Technologies: Eye-Tracking Diagnostic Device for Autism Spectrum Disorder – New Policy Eye-tracking–based diagnostic aids for autism spectrum disorder, including the EarliPoint Assessment, are considered investigational for the diagnosis and assessment of autism spectrum disorder.
Effective date – 10/1/2026	ID: 6.01.31 Title: Mammography-based AI (Image-only) Risk Prediction Models for Breast Cancer – New Policy Use of mammography-based AI risk prediction software for individuals undergoing bilateral screening mammography to estimate their 5-year risk of developing breast cancer is considered investigational.

Pharmacy Policy Updates

New effective date for specialty pharmacy change for two medications

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

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In our commitment to providing our members with the most effective therapies at the lowest possible cost, Blue KC will be **transitioning members to Lumicera Specialty Pharmacy as the exclusive dispensing pharmacy for the following medications, effective October 1, 2026**. Blue KC previously communicated an effective date of September 1, 2026, but has since moved the effective date to October 1, 2026, to ensure a smooth transition for providers and members.

Medication	Strength(s)
Fingolimod	0.5mg
Everolimus	2.5mg, 5mg, 7.5mg, 10mg

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

New pharmacy policy

Below is a new Blue KC pharmacy policy effective **October 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.

New Pharmacy Policy		
Policy Number	Policy Name	Summary
5.02.698	Loargys (pegzilarginase-nbln)	FDA approved for Arginase 1 Deficiency (ARG1-D); IV or SQ; Medical-Rx benefit

Provider Education

Post-payment clinical claim validation reviews

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

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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.



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.

- 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

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

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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

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

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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.

Coding requirements for annuals visits for Medicare Advantage

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

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

Blue KC wants to provide a helpful guide on the coding requirements for different types of annual visits, impacting the Medicare Advantage line of business used by other Blue Cross Blue Shield plans.

The purpose of the Initial Preventative Physical Examination (IPPE), the Initial Annual Wellness Visit (AWV) and the Subsequent Annual Wellness visit (AWV Sub) is to allow the provider to have a conversation with their patient to address current conditions and address any future healthcare needs. For complete CMS guidance, please refer to the Medicare Learning Network link below to the table.

Medicare Annual Wellness Exam Requirements ^{1,2}				
Element	Included	IPPE G0402	AWV G0438	AWV Sub G0439
Health Risk Assessment (provider or patient completed)	Demographic data, health status self-assessment, psychosocial risks, behavioral risks, ADLs, and instrumental ADLs		X	X
Past Medical, Family and Social History	Past medical and surgical history, current medications and supplements, family history, diet, physical and social activities, alcohol, tobacco, and illegal drug use history	X	X	X
Current Providers and Suppliers	Current providers and suppliers providing medical care for patient		X	X
Potential Depression Risk Factors	Current or past experiences with depression, other mood disorders and completed standardized screening tool	X	X	
Functional Ability and Safety Level	ADL's, fall risk, hearing impairment, home and community safety	X	X	
Examination	Height, weight, BMI, blood pressure, balance and gait, visual acuity screen, other factors deemed appropriate based on clinical standards	X		
Measurements	Height, weight, BMI, blood pressure, other routine measurements as appropriate		X	X

Cognitive Impairment Screening	Direct observation or reported observations from patient or others to assess cognitive function		X	X
Establish/Update Preventive Screening Schedule	Schedule based on checklist for the next 5-10 years, clinical recommendations, and results of wellness visit		X	X
Establish/Update List of Risk Factors and Conditions	Include recommendation for primary, secondary, or tertiary interventions, mental health conditions and cognitive impairments, IPPE risk factors or identified conditions, treatment options and associated risks and benefits		X	X
End-of-Life Planning (patient's discretion)	Discussion includes their ability to prepare an advance directive, agreement on following the advance directive, psychiatric advance directives	X	X	X
Current Opioid Prescriptions (if applicable)	Potential opioid use disorder risk factors, pain severity and treatment plan, non-opioid treatment options, specialist referral as appropriate	X	X	X
Substance Use Disorder Screening	Review potential SUD risk factors and make referrals as appropriate	X	X	X
Educate, Counsel, and Refer	Based on results of visit or necessary preventive services, provide education, counseling and referrals	X	X	X
Physical Activity and Nutrition Risk Assessment	Optional standardized physical activity and nutrition risk assessment		X	X

¹ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html#IPPE>

¹ When these codes are billed in conjunction with an evaluation and management (E/M) service, append modifier 25 to the E/M service code.

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.

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

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

Why are denials increasing?	- Clinical edit denials are primarily occurring due to: Missing, invalid, or incorrect modifiers submitted on claims Primary diagnosis codes that do not support medical necessity Important: - Independent laboratories cannot change or correct diagnosis codes. - They depend entirely on the referring provider to submit complete and accurate clinical information when the test is ordered. Because of this: - Labs cannot resolve denials without provider involvement - Claims may go unpaid for services already performed
What providers must do	- To prevent denials, referring providers must follow these steps: Follow Blue KC Laboratory Medical Policies - Adhere to all coverage criteria, medical necessity requirements, and coding guidelines for lab services Submit Accurate Diagnosis Codes - Before ordering lab tests: - Ensure diagnosis codes are complete and accurate - Confirm codes support medical necessity



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

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All are invited to the Blue KC Value-Based Programs Virtual Fall Forum. Register in advance through Microsoft Teams at the following link: [Blue KC's Value-Based Programs Virtual Fall Forum: "GLP-1 Success at Blue KC: Benefits, Best Practices & Adherence Support"](#)

Once registered, you will receive a confirmation email with your webinar access information

Date	• Wednesday, October 14, 2026; 12:00 – 1:00 p.m. CT
Title	• GLP-1 Success at Blue KC: Benefits, Best Practices & Adherence Support
Presenter	• Ashley Smith, PharmD, Pharmacy Operations, Blue KC, and Rebecca Anderson, LMSW, Director, Community Health, Blue KC.
Description	• Ashley will share an overview of Blue KC's GLP-1 Coverage & Benefits, with a focus on best practices to support patient adherence to GLP-1 medications, mitigate side effects, reduce treatment discontinuation, and increase long-term success.

- Rebecca will share how Blue KC's Community Health Workers (CHWs) are supporting members' treatment adherence on high-cost medications (including GLP-1s) by connecting them with co-pay and drug company assistance programs to reduce discontinuation and treatment gaps.

October Free Documentation & Coding Webinar

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Join us for the October 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:

October 27 & 29 7:30 a.m. & 11:30 a.m. CT	Use Your Head: Sharpen Your Neurology Coding Skills	Make the connections to properly document and code for Neurological disorders commonly managed in primary care.
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Caring for our Community

Blue KC joins 700 volunteers to help end food insecurity in honor of September 11



To mark the 25th anniversary of the 9/11 terrorist attacks, a dozen Blue KC employees joined more than 700 volunteers from Kansas City in a massive nationwide movement to "Honor Through Action."

As part of the largest annual day of service in U.S. history, organized and led by the nonprofit [9/11 Day](#), the volunteers packed nearly 200,000 healthy, non-perishable meals for local families in need throughout Missouri and Kansas. Volunteers packed ingredients, including lentils and rice, into a meal in an assembly-line fashion.

It was all to help support the event's main beneficiary and Blue KC's longtime partner, [Kanbe's Markets](#). According to Feeding America statistics from 2023, 1 in 7 people and 1 in 5 kids, including 128,000 children, are at risk of hunger in the Kansas City region.

In 2016, 9/11 Day held its inaugural large scale meal pack event in New York City. The event expanded to 18 cities in 2023, and this was the first year 9/11 Day brought the meal pack to Kansas City, joining 50 large-scale 9/11 Day service projects nationwide. This 25th anniversary effort mobilized 50,000 volunteers from across the country who packed more than 17 million meals. Click [here](#) to learn more.

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.