BLUESPEAK
WHAT'S NEW FROM BLUE
Kansas City

COVID-19 Updates

Blue Cross and Blue Shield of Kansas City (Blue KC) sincerely thanks all healthcare providers who are on the frontlines fighting the COVID-19 outbreak, protecting the health and well-being of our community and treating the sick.

Blue KC remains focused on ensuring your patients have access to the care they need. To stay up to date on COVID-19 policies, over-the-counter testing guidelines, coding and billing, see the "COVID-19 Information" section on the home page of Providers.BlueKC.com.

COVID-19 OTC TESTS

Every home in the U.S. is eligible to order free at-home COVID-19 tests at COVIDtests.gov. On January 10, 2022, the Biden Administration released new guidance requiring health plans to reimburse covered individuals for over-the counter (OTC) COVID-19 diagnostic tests. While this new guidance did not include Medicare, Blue Medicare Advantage has made the decision to offer free at-home COVID-19 tests for members. For details on how this guidance impacts all lines of business, visit the "COVID-19 Information" section on the home page of Providers.BlueKC.com.

TELEHEALTH UPDATE

The Centers for Medicare and Medicaid Services (CMS) revised the description of existing place of service (POS) code 02 and created new POS code 10 to meet the overall industry needs. POS 02 is for telehealth provided other than in the patient's home, while POS 10 is for telehealth provided in the patient's home.

Providers can file claims with POS 02 or POS 10 for telehealth, no matter the location, until further notice. If providers want to file a Blue Medicare Advantage claim with POS 10, they may do so beginning April 1, 2022. The effective date for providers to use POS 10 on non-Blue Medicare Advantage claims was Jan. 1, 2022.

For more details on Telehealth, visit the COVID-19 Information section on the home page of Providers.BlueKC.com.

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Community Investment

As providers, you show a lot of heart in how you care for your patients, and big hearts are now on display throughout our community.

Blue KC is honored to serve as a presenting sponsor for Parade of Hearts in the Kansas City metropolitan area. With a salute to our city's historic ties to heart imagery, the public art installation celebrates the Heart of America.

The hearts will be on display throughout the spring season and go up for auction in June. Members of the Kansas City area community will have the opportunity to bid on most of the hearts. The funds raised will be distributed to four area organizations: Alt-Cap – who will award minority-owned business grants, the Mid-America Regional Council – tasked with funding the reopening of childcare facilities and early childhood education digital needs, The University of Kansas Health System – to help support COVID-19 patients who have long-term lingering effects on the heart and the Visit KC Foundation – backing locally owned business grants in the hospitality and tourism industries. All the participating artists received a $2,000 stipend for their work.

Blue KC has elected to place eight hearts at community partner locations, including Union Station, Harvesters, Vibrant Health, Samuel U. Rodgers Health Center, Variety KC, Swope Health, KC Care Health Center and Veterans Community Project. To learn more and find out where you can view the 154 heart sculptures in the greater Kansas City region, click here.

"Celebrating regional unity through public art is something Union Station is thrilled to support. The fact that we're able to host the Blue Cross and Blue Shield of Kansas City heart is a further honor. Placed on our East Transit Plaza, this impressive creation will be enjoyed by tens of thousands of guests, as it sits between our two iconic buildings. This is a truly meaningful partnership and philanthropic project."

– George Guastello, President & CEO, Union Station

Behavioral Health

In response to our nation's mental health crisis, Blue KC recently trained school administrators and students in our area. The Blue KC Behavioral Health Initiatives team presented Youth Mental Health First Aid® earlier this month to Blue Valley School District administrators.

The skills-based training course taught participants how to reduce the stigma of mental health, recognize signs and symptoms of the most common mental health challenges and follow a five-step action plan for responding to the mental health needs of youth ages 6 to 18. Click here for a video highlighting the training.

One in five teens and young adults lives with a mental health condition, but many are reluctant to seek help.

In just 12 years, Mental Health First Aid® has become a widespread movement in the United States — more than 2.5 million people are certified Mental Health First Aiders®.

Blue Valley was the first school district our team has trained in Youth Mental Health First Aid®. We have conducted Mental Health First Aid® training with our employer groups and Blue KC employees.

(Pictured: Kristin Gernon, LCSW, LMSW, and Jacie Harris, LMLP, Behavioral Health Training and Development Specialists at Blue KC)

Provider Overpayment Tips

Have you ever received a remittance that wasn't for the correct amount?

Here are some scenarios and suggested steps to take if that occurs:

A reason for a remit not being for the proper amount could be due to a recoupment.
If you are seeing overpayments or adjustments on a remit, look at recent remits to find adjustment information and assist in reconciling the issue.
You can locate recent remits on the Provider Portal at Providers.BlueKC.com. Go to the Claims / Eligibility section and click on Provider Remittances.
We encourage providers to look at recent remits before calling the Provider Hotline.

Modifier Education

Assistant Surgeon Modifiers

Effective March 5, 2022, Blue KC is enforcing the Modifiers Payment Policy (POL-PP-108) to identify those procedures that are valid, invalid or require additional documentation for Assistant Surgeons based on the Status Indicator. Blue KC follows CMS status codes for validity of Assistant Surgeons.

Status 0	Payment restrictions for assistants at surgery apply to this procedure unless supporting documentation is submitted to establish medical necessity.
Status 1	Statutory payment restrictions for assistants at surgery apply to this procedure. Assistants at surgery may not be paid.
Status 2	Payment restrictions for assistants at surgery do not apply to this procedure. Assistants at surgery may be paid.
Status 9	Assistants at surgery concept does not apply.

The Blue KC Payment Integrity team is finding instances where providers have billed more than one assistant surgeon modifier on the same claim line. This billing practice results in unnecessary reductions to the provider reimbursement.

When billing for services as an assistant surgeon, bill only one assistant surgeon per CPT/procedure code.

Blue KC's Modifiers Payment Policy (POL-PP-108) provides guidance on the proper use of Modifier 80 and AS. Modifier AS represents that a Physician Assistant (PA) assists with a surgical procedure, as the PA is not a surgeon/physician. Modifier 80 represents that a Physician performs the surgical service. Providers should not apply Modifier 80 to a surgical procedure when a PA is assisting with the surgical procedure.

Modifier 80	A physician assists and performs the surgical service.
Modifier AS	Clinical nurse specialists, nurse practitioners and physician assistants may be reimbursed for serving as an assistant during surgery.

If you have questions around billing assistant surgeon modifiers on a claim, go to the log-in page at Providers.BlueKC.com and click on the *Go to Payment Policies* blue button. There you can find the payment policy for Modifiers (POL-PP-108) and follow correct coding guidelines.

Anesthesia Modifiers

When billing for anesthesia services, it is important to bill the modifiers affecting payment first, per coding guidelines.

Blue KC follows CMS guidelines for anesthesia modifiers QK, QS, QX, QY and QZ. These modifiers affect payment and should be the first listed modifiers on anesthesia services that require use of modifiers.

If you have questions around billing anesthesia modifiers on a claim, visit the log-in page at Providers.BlueKC.com and click on the *Go to Payment Policies* blue button. Once there, you can pull up the payment policy for Modifiers (POL-PP-108) and follow correct coding guidelines.

GAP Fee Schedule Available 24/7

Did you know you have access to the GAP Fee Schedule anytime you want?

Blue KC wants to remind providers the GAP Fee Schedule, which shows CPT and HCPCS codes, descriptions and their prices, is now available in the Resources section at Providers.BlueKC.com.

A GAP Fee is assigned to codes that either do not have a Medicare price assigned or are a carrier priced code where payment amounts are determined for a locality using information sources.

The schedule is updated on the first day of the month at the beginning of each quarter.

Payment Policy Updates

Timed Therapeutic Procedures: POL-PP-114

Blue KC would like to remind providers to review the Timed Therapeutic Procedures Payment Policy (POL-PP-114) and the documentation requirements outlined in the policy when billing for timed therapeutic procedure services.

The following medical record standards (not all inclusive) are required; and if not met, may result in delay or denial of payment:

- Documented referral from appropriate referral source.
- Documented name (on each page of the record) and birth date of beneficiary.
- Legible handwriting (if it is not readable, it will be denied).
- Avoidance of abbreviations (use only standard abbreviations well known to your peers).
- Each CPT code submitted for payment must have the appropriate documentation to support the service rendered. Clearly document what you performed to differentiate between each service utilized.
- Time in and time out.
- Time for each CPT code billed.
- Activity completed for each CPT code including name of activity, repetitions, weights, resistance, etc.
- Modalities (parameters, period of time and specific location[s] treated).
- Manual therapy techniques (i.e., CPT 97140) when performed on the same date, and in the same region(s) as spinal manipulation (98941-98943) will not be paid separately.

To view the Timed Therapeutic Procedures Payment Policy (POL-PP-114), go to the log-in page at Providers.BlueKC.com and click on the *Go to Payment Policies* blue button.

Provider Reference Guide Documentation Standards

Medical records are expected to contain all elements required to file and substantiate a claim for services, as well as the appropriate level of care, i.e., evaluation and management services.

Each diagnosis submitted on the claim must be supported by the documentation in the patient's medical record.

The contracting Provider agrees to submit claims only when appropriate documentation supporting said claims is present in the medical record(s). Letters/checklists are not acceptable as documentation of medical

necessity and do not replace what should be in the complete medical record. Abbreviations must be those that are generally accepted and clearly translated to be uncontested by the reviewer.

Providers must submit a complete and accurate claim or encounter form in accordance with Blue KC's Policies and Procedures after providing services to a member. All submissions must adhere to all applicable medical coding guidelines and policy standards.

A link to the Provider Reference Guide can be found on the home page of the Provider Portal under Provider Service Quick Links.

Provider Reference Guide Additional Reminders

- Patient Records must be legible in both readability and content.
- Each entry shall be authenticated by the person making the entry unless the entire patient record is maintained in the Provider's own handwriting.
- Indicate the medications prescribed, dispensed or administered and the quantity and strength of each.
- Documentation of examination and treatment(s) performed or recommended (why it was done and for how long) and physical area(s) treated, vital signs obtained and tests (lab, x-ray, etc.) performed and the results of each.
- List start and stop times or total time for each CPT code/service performed on all timed codes per CPT nomenclature.

Member ID Cards for 2022

Updates

As you see patients in 2022, one thing has changed. They are equipped with new-look member ID cards!

In compliance with Consolidated Appropriations Act (CAA), Blue KC added the member's applicable in-network deductible and max out-of-pocket amounts to member ID cards and a Quick Response (QR) code, which links to a summary of the member's benefits. **Note:** The QR code is not featured on Blue Medicare Advantage or Medicare Supplement member ID cards at this time but will be in the future. Here's a sample new member ID card for Commercial and ACA QHP and a breakdown below:

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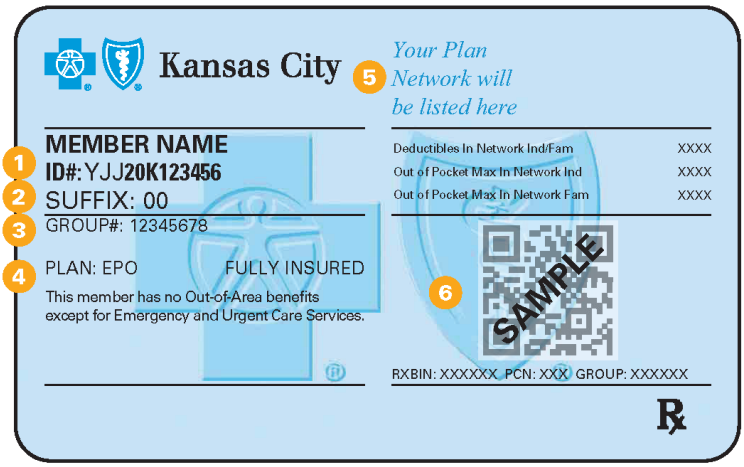

1. **Member ID Number** – Number we use to identify you and your policy. Contains a three-letter alpha prefix, followed by your ID number.
2. **Suffix** – This number is unique for each member covered on your policy.
3. **Group Number** – Number we use to classify our members into groups, usually by the employer they receive their plan from, or a direct pay group.
4. **Plan Type** – Identifies your plan type.
5. **Network Name** – This is the network of hospitals, doctors and other healthcare professionals that accepts your Blue KC policy. It's important that you see providers in this network to maximize the benefits of your policy.
6. **QR Code** – Use the camera on your mobile device to scan the QR code on your member ID card to view your benefit summary.

How to Identify ACA QHP Cards in 2022

We have received calls from providers wondering how to identify patients enrolled in ACA QHP, since ACA does not appear on the ID cards. You will know if your patient has an ACA QHP plan if the member ID number on the 2022 card begins with the following alpha pre-fixes:

On Exchange Alpha Pre-Fixes	Off Exchange Alpha Pre-Fixes
YJT	YBM
YJJ	YBT
YBS	YBX
YBG	YJV
YBD	YJW

Burns & McDonnell Partners with National Alliance

We want to make sure you have the right number to call to get your questions answered about your patients. If one of your patients works for a company listed in the table at the end of this article, contact National Alliance instead of Blue KC.

Effective January 1, 2022, Burns & McDonnell switched from using Blue KC to our partner National Alliance for its administrative services. In a partnership with Blue KC and Blue Cross and Blue Shield of South Carolina, National Alliance services more than 25 Administrative Services Only (ASO) groups based within the Blue KC territory.

See the following table for the updated names of our ASO groups using National Alliance in 2022, along with the Customer Service Number and Group Prefix:

Group Name	Service Center Phone	Prefix
American Century Services	1-833-468-3384	AFK
Archdiocese of Kansas City	1-888-495-9340	KDC
Black & Veach	1-833-644-1298	KAF, KGJ, KJC, KPM
Bothwell Regional Medical Center	1-855-215-0280	BGT
Burns & McDonnell	1-833-578-1131	KPM
Commerce Bancshares, Inc.	1-888-495-9340	GXV
Community Hospital of Fairfax	1-888-495-9340	KUS
Daily's Premium Meats	1-888-495-9340	DMG
Dairy Farmers of America	1-833-644-1302	KBM, KCP, KFL, KGB, KJS, KWB

Family Guidance Center	1-888-495-9340	FGX
Ferrellgas	1-888-495-9340	FLG
Hillyard Industries, Inc.	1-888-495-9340	HLJ
Hillyard, Inc.	1-888-495-9340	HIL
JE Dunn Construction Group, Inc.	1-855-212-4661	DUX
Kansas City Southern	1-888-495-9340	KDW, KSJ
Murphy-Hoffman Company	1-888-495-9340	MHA, MUP
Netsmart Technologies	1-888-468-3601	NAT
News - Press & Gazette Company	1-888-495-9340	KUS
North Kansas City Hospital	1-888-495-9340	NHW
Saint Luke's Health System	1-855-229-5717	BAD
Seaboard Corporation	1-888-495-9340	EAB, SBY
Seaboard Triumph Foods	1-888-495-9340	IDS
Searles Valley Minerals, Inc.	1-888-495-9340	SVG
The University of Kansas Health System	1-833-468-3590	USK, USY
Triumph Foods, LLC	1-888-495-9340	UVF
University Health (Formerly	1-888-495-9340	FTR, IYJ

Truman Medical Center)		
ValueHealth (NueHealth)	1-888-495-9340	NUE
WellSky	1-888-495-9340	KBU, KHF, KUS
Western Missouri Medical Center	1-855-215-0280	WSN

Blue KC Teams with Advance Care Planning Vendor

Effective Advance Care Planning (ACP) is a valuable part of patient care and, as you know, it can be very time consuming. To support your team and give our members an opportunity to complete comprehensive ACP, Blue KC is partnering with Iris Healthcare, a specially trained ACP healthcare organization.

We wanted to make you aware that Iris Healthcare has begun to reach out to some Blue KC members whom we have identified would benefit from this FREE service.

The Iris Healthcare ACP experts facilitate the discussions and generate Advance Directive documents with the patient. Clinicians may utilize completed documents from Iris for ACP consultation with our members, and submit the following ACP CPT codes for your time and service reviewing the signed Advance Directives:

CPT 99497 (base code) – $86	Time-based code for initial 30-minutes of ACP discussions during a face-to-face encounter with patient and/or family member(s) / surrogate
CPT 99498 (add on) – $75	Time-based code for each additional 30-minutes of APC discussions during a face-to-face encounter with patient and/or family member(s) / surrogate

What Iris Healthcare Does:

- Completes ACP conversations on behalf of care teams.
- Defers all specific treatment detail and patient questions to you.
- Coordinates family discussions and resolves family conflict or care disagreements.
- Meets quality measures and helps improve patient experience.
- Distributes ACP documents to you for your input and/or signature where appropriate, such as medical order for life-sustaining treatments.

What Iris Healthcare Does Not Do:

- Provide medical or nursing care.
- Suggest or advise a patient or family on care choices.
- Submit CPT codes or invoice the patient.

Next Steps:

- Staff Notification – In the event a patient calls to confirm partnership with Iris Healthcare, please make sure your staff is aware that Iris Healthcare is a new partner.
- Patient Support – Please encourage your patients and their families to work with the Iris Healthcare team.

Partnership to Support Patients with Diabetes

Livongo by Teladoc Health® Kansas City

Blue KC has partnered with Livongo by Teladoc Health with one goal: To make living with diabetes easier.

The partnership allows us to keep quality care available to our members with diabetes, whether at home or in the clinical setting. Here are a few more facts:

- The comprehensive diabetes management program is for members and their dependents ages 13 and older with a diagnosis of type 1 or type 2 diabetes – **all at no cost to the member**.
- The program offers a cellular-connected blood glucose meter, unlimited supplies, robust analytics and digital and human coaching that is available any time of the day.

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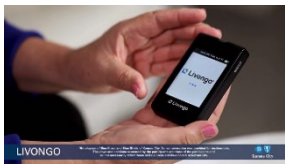
Click on the image below to watch a video to learn more.



Your patients can register online using code BlueKC or by calling (800) 945-4355 and using Blue KC as the registration. If you have questions, please call 816-395-2222, ext. 8283.

Start Spreading the News: Member Experience Survey

This is one survey you want your patients to take!

Starting in March, a random sample of members will receive a survey regarding their experience with Blue KC and their healthcare providers. The surveys will come from either the Centers for Medicare and Medicaid Services (CMS) or from SPH Analytics and Blue KC.

This impacts Blue KC members who have plans with our Commercial, Small Group ACA, ACA QHP for Individual/Family and Blue Medicare Advantage lines of business. The survey is also known as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Please encourage your patients to fill out the survey and stress its importance for several reasons:

- Tells regulatory bodies how well providers and health insurance plans collaborate.
- Gives your patients a chance to give an opinion on their perception of care.
- Honest feedback helps providers and health plans improve the healthcare experience and benefits your patients receive.

The survey will not ask for personal identification information.

Blue Medicare Advantage Information

Annual Wellness Visits

The annual wellness visit is a good opportunity for Medicare Advantage members to touch base with their Primary Care Providers. They can review their health status and all their existing illnesses as well as a

strategy to mitigate them. Medication regimens, diet and exercise modifications and preventive screenings can aid members in optimizing their health throughout the year.

Preplanning for these visits can aid in documenting existing conditions, which CMS requires each year, as well as assessing for and completing those quality measures such as colorectal and breast cancer screenings. For those with diabetes diagnoses, an annual retinal exam, as well as the latest A1c and blood pressure readings of the year continue as incentivized measures. This is especially important considering that as of 2019, one in four Americans over the age of 65 have diabetes. Reviewing the importance of this statistic with your patients may encourage them to improve their health by knowing their risks.

Blue KC has several benefits that may help motivate members to sign up for their annual wellness visits. Our members may qualify for up to two twenty-five-dollar gift certificates for completing their preventive screenings. In addition, there is transportation assistance and Diabetic Care Management that includes personalized glucose monitoring assistance and a glucometer with strips. Lastly, the Silver Sneakers program provides access to fitness amenities in the community, along with others who are like-minded in their pursuit of optimal fitness.

Blue Medicare Advantage Plan Changes for 2022

This year brings some exciting updates for our Blue Medicare Advantage plans. Here is a summary of the primary changes that became effective Jan. 1, 2022:

Consolidation of Plans • Blue Medicare Advantage Complete (HMO) and Blue Medicare Advantage Plus (HMO) are now Blue Secure (HMO). • The Blue Medicare Advantage Access (PPO) plan is now Blue Medicare Advantage Essential (PPO).
Two New Plans • Simply Blue (PPO) and a $75/month Part B Give-back plan called Simply Blue Advantage (PPO) are newly created plans.

Blue KC's new Benefit Extras for 2022 are:
• A new way for our members to communicate with us
  ○ Text Blue KC: You may skip the wait and text the word: #BKC4HELP to the number 543210. This holds your place in line, and the next available Customer Service representative will call you.
  ○ Check Benefits: You may access benefits via interactive text by texting the word: #BMA22 to the number 543210. You receive brief highlights of all your benefit extra via text message.

    - Get Quote: You may skip the wait and text the word #BKC4MA to 543210. This holds your place in line, and the next available representative will call you.
- Blue Benefit Bucks (BBB) – BBB works like a debit card, so it is simple to use. BBB is loaded with flexible benefits depending on the plan. Members have the power to spend it based on what is most important to them. Depending on a member's plan, his or her BBB combined yearly benefit allowance, over-the-counter (OTC) allowance and member rewards can be on one single card.
- Some plans provide hearing benefits and hearing aids with our new partner NationsHearing®
    - To find a NationsHearing® provider, call (877) 208-2596 (TTY:711) or go online at NationsHearing.com/BlueKC.
- Routine eye exams and eyewear, when covered, are offered through the Blue Medicare Advantage network of optometrists and ophthalmologists.
- New Balance & Cognitive Training available through our partners Nymbl and NationsHearing® bring our members a "No Sweat" workout. This 20-minute combined session focuses on balance and building strength over time by downloading an app on a smartphone or tablet.
- In-home foot care for members with chronic conditions through our partner Belle Cares.

Details to aid in capturing existing chronic conditions

CMS requires an annual submission of Hierarchical Condition Category (HCC) codes. These are categories for disease groups organized into body systems or similar disease processes. With the HCC payment model, providers should report all chronic conditions and co-morbidities annually at the highest level of specificity. The following criteria are required for all submissions:

- All diagnosis codes submitted must be documented in the record and must be a result of a face-to-face visit.
- Acceptable data sources are hospital inpatient facilities, hospital outpatient facilities and physician offices.
- Must have a legible signature with credentials by an approved CMS provider type (see www.cms.gov) for a complete list.

Questions to help determine whether to document a chronic condition

- Is the condition being treated on an ongoing basis?
- Does the condition co-exist at the time of the encounter and require or affect patient care, treatment or management?
- Does the condition impact your medical decision making?

Medical Policy Updates

The most up-to-date Medical Policy can be found here. While on that web page, you can also find a link to view Milliman Care Guidelines (MCG), which complement our Blue KC policies.

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

New Blue KC Medical Policies	
Effective date – 3/1/2022	7.01.170 Laser Interstitial Thermal Therapy for Neurological Conditions
Effective date – 3/1/2022	7.01.516 Implantable Peripheral Nerve Stimulation (PNS) Devices
Effective date – 3/1/2022	9.03.501 Bimatoprost Implant (Durysta)

Don't Forget about MCG

When reviewing Blue KC Medical Policies for a procedure, we want to remind providers to make sure you also check Milliman Care Guidelines (MCG), which are additional policies we use in conjunction with Blue KC polices.

While there might not be a medical policy on certain procedures or services, our MCG Guidelines could still contain a medical necessity review. For example, most of our surgical procedures are in the MCG Guidelines.

To access MCG Guidelines, log in to Providers.BlueKC.com, select the "Medical Policies" section and click on the "Review MCG Guidelines" button. Let's take a closer look at questions you might have regarding MCG Guidelines:

Why is Blue KC using MCG?

- MCG provides criteria for review based on current evidence from scientific research. MCG is nationally recognized and widely utilized in the industry.

What is the content difference between Blue KC policies and MCG guidelines?

- Most content resides within the MCG guidelines. If you are looking for criteria for acute in-patient care, Skilled Nursing Facility (SNF), IP rehab or LTACH, please search within the MCG guidelines. Most prior authorization subjects can also be found within MCG Guidelines. However, some subject matter resides in Blue KC policy (e.g. genetic testing, high tech radiology).

Can you search the policies and guidelines?

- Blue KC policies can be searched using the search button on the policy page by CPT, key word, HCPCS, policy or guideline number if known.

- MCG Guidelines can be searched under each category of care by using Ctrl F and entering a key word.

New MCG Guidelines	
Effective date – 3/1/2022	BKC-M-333 Left Atrial Appendage Closure, Percutaneous, 25th Edition BKC-M-333-RRG Left Atrial Appendage Closure, Percutaneous – Rapid Recovery Guideline, 25th Edition o Replacing 2.02.26 Percutaneous Left-Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation o CPT code added – 33267, 33268, 33269

Pharmacy Policy Updates

Reminders for Blue Medicare Advantage Prior Authorization

- The most efficient way to submit a prior authorization request is through the Provider Portal at Providers.BlueKC.com. On the log-in page, click on "FORMS" and then proceed to the Prior Authorization section.

- When calling in a verbal request for prior authorization, please ensure that you are sending clinical documentation directly after calling in the request by faxing it to 877-549-1744 or 877-549-1745. Without the necessary clinical documentation, prior authorization approvals will be delayed. Please ensure you include the member's name and member ID number on the clinical documentation, so it can be matched up with the prior authorization request.

- We have recently seen a large influx of providers marking both Medical and Pharmacy requests as expedited that do not meet the CMS definition. To ensure timely review of all requests, only submit your request as expedited if it meets the criteria. The CMS definition of Expedited is:
    - *That applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.*

- As a reminder, all Part B Medication standard requests are processed within 72 hours.

- There may be instances when you switch medication products for a member. Please be aware that different brands and biosimilars of medications can have different J-Codes associated for billing purposes. If you switch products and do not submit a prior authorization for related J-Code, you risk denial of your claim.
    - Example – J0885 – Epogen; Procrit; Q5106- Retacrit

Fax Numbers for Clinical Documentation

Part B Medication Requests: (816) 398-6547

Members Medical Service, Procedure or Equipment Requests: (877) 549-1744

Medicare Part B Step Therapy Drug List

The following list of Non-Preferred Part B drugs will be subject to step therapy pursuant to CMS sub-regulatory guidance provided in the HPMS memo dated August 7, 2018. The allowance of step therapy practices for Part B drugs will help achieve the goal of lower drug prices while maintaining access to covered services and drugs for members.

Step therapy requirements will apply to "new starts" only and will not apply to members who are currently and actively receiving therapy with a Non-Preferred product (members with a paid claim within the past 365 days) on the list. For dates of service on or after January 1, 2022, we will require step therapy for the following Part B medications that are listed as Non-Preferred products.

Drug Class	Drug Name	Status	Billing Code
VEGF Inhibitors	**Lucentis**	**Preferred**	J2778
	Eylea	Non-Preferred	J0178
	Beovu	Non-Preferred	J0179
	Macugen	Non-Preferred	J2503
Hyaluronan Injections	**Orthovisc**	**Preferred**	J7324
	Synvisc; Synvisc-One	**Preferred**	J7325
	Monovisc	**Preferred**	J7327

	Durolane	Non-Preferred	J7318
	Genvisc	Non-Preferred	J7320
	Hyalgan; Supartz	Non-Preferred	J7321
	Hymovis	Non-Preferred	J7322
	Euflexxa	Non-Preferred	J7323
	Gel-One	Non-Preferred	J7326
	Gelsyn-3	Non-Preferred	J7328
	Trivisc	Non-Preferred	J7329
	Visco-3	Non-Preferred	J7333
Bevacizumab (Oncology)	**Mvasi**	**Preferred**	Q5107
	Zirabev	**Preferred**	Q5118
	Avastin*	Non-Preferred	J9035
Rituximab and Biosimilars	Truxima	**Preferred**	Q5115
	Ruxience	**Preferred**	Q5119
	Riabni	Non-Preferred	Q5123
	Rituxan	Non-Preferred	J9312

*Oncology indications only

Drug Class	Drug Name	Status	Billing Code
Herceptin and Biosimilars	**Kanjinti**	**Preferred**	Q5117
	Ogivri	**Preferred**	Q5114
	Trazimera	**Preferred**	Q5116
	Herceptin	Non-Preferred	J9355
	Herzuma	Non-Preferred	Q5113
	Ontruzant	Non-Preferred	Q5112
	Herceptin Hylecta	Non-Preferred	J9356

Commercial Formulary Updates

We want to let our contracted providers know of updates to the Blue KC Commercial Prescription Drug Lists that will go into effect on April 1, 2022.

Updates affecting both the Preferred and Premium Formularies

Please Note: These changes only apply to Groups on the Preferred and Premium formularies (this does NOT impact Small Group ACA). Group-specific benefit exceptions may apply.

Tier Changes Increasing Member Copayment

Members will now be required to pay Tier 3 cost sharing for the following medications.

Medications moving from $0 cost share to Tier 3
Non-Arkray brand needles and syringes

Updates affecting only the Preferred Formulary

Please Note: These changes only apply to Groups on the standard Blue KC formulary (this does NOT impact Small Group ACA or members on the Premium formulary). Group-specific benefit exceptions may apply.

New Prior Authorization Requirements

New Prior Authorization Requirements	
Drug Class	**Drugs Requiring Prior Authorization**
*Anti-Obesity Medications	Contrave, Lomaira, Qsymia, Saxenda, Wegovy

**Please note: These medications are only available for a prior authorization and potential coverage if a member's plan covers obesity drugs.*

New Edits for Inpatient Billing

We counted you down to this new policy change, and it is now live!

Effective March 1, 2022, new data elements are required on inpatient institutional claims (837I). All institutional claims (837I) with an inpatient bill type of 11x (Loop 2300/CLM05) that contain a patient status code (Loop 2300/CL103) equal to one of the following: 02, 03, 05, 50, 51, 61, 62, 63, 65, 66, 70, and have an admit date (Loop 2300/DTP03) that is the same as the statement through date (Loop 2300/DTP03), must contain a valid condition code (Loop 2300/HI01:2) to avoid a claim rejection.

Claims without a valid condition code will receive a 277CA rejection of A6:460. Please use the following chart for reference to the new required data elements and edit:

Name of Data Element	837I Loop and Data Element	Data Element Information
Inpatient Bill Type	Loop 2300 CLM05	11x

Patient Status Code	Loop 2300 CL103	02, 03, 05, 50, 51, 61, 62, 63, 65, 66, 70
Admit Date	Loop 2300 DTP03	Same as statement through date
Statement Through Date	Loop 2300 DTP03	Same as admit date
Code List Qualifier	Loop 2300 HI01:1	BG
Condition Code	Loop 2300 HI01:2	Applicable Condition Code

All institutional claims (837I) with an inpatient bill type of 11x (Loop 2300/CLM05) and an operating room revenue code equal to 036x (Loop 2400/SV201) will require a valid principal procedure code (Loop 2300/HI01:2). Claims without a valid principal procedure code will receive a 277CA rejection of A6:465. Please use the following chart for reference to the new required data elements and edit:

Name of Data Element	837I Loop and Data Element	Data Element Information
Inpatient Bill Type	Loop 2300 CLM05	11x
Revenue Code	Loop 2400 SV201	036x
Code List Qualifier	Loop 2300 HI01:1	BBR
Principal Procedure Code	Loop 2300 HI01:2	Applicable ICD-10 Principal Procedure Code

For more information on electronic claims or questions, please call the Blue KC provider hotline at 816-395-3929.

Portal Power

Blue KC's powerful digital tool for providers can be accessed 24/7 with a click of a button! Experience our Provider Portal at **Providers.BlueKC.com**	**Provider Portal Features Include:** • Search and review claims • Submit and view electronic prior authorizations • Look up member eligibility • Access Medical and Payment Policies • See provider remittances • View Provider Reference Guides • Check out recent news updates • Find provider forms • And so much more!

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Contact Us

Your comments are welcome and can be sent to BlueSpeak@BlueKC.com. We would love to hear from you!

Anyone can join the BlueSpeak email distribution list by signing into the Provider Portal and then selecting "Register for BlueSpeak eNewsletter" under "Provider Service Quick Links" on the home page.

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, 866-508-7140 for Blue Medicare Advantage line of business or 866-859-3822 for the ACA Provider Hotline. We value and appreciate you as our partner in providing quality care.