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 updated its coverage policies after the renewal of the COVID-19 national public health emergency (PHE) declaration. We will again go beyond the PHE period and extend several COVID-19 policies through March 31, 2022. For more details, see the COVID-19 section on the home page at Providers.BlueKC.com.

COVID-19 INPATIENT HOSPITAL ADMISSIONS Blue KC's policy for certain Blue KC plans to waive all member cost sharing and copayments for inpatient hospital admissions due to the diagnosis of COVID-19 will expire on December 31, 2021. This impacts our Commercial line of business. Certain Employer Groups may have chosen to extend this waiver in 2022. **Note:** To find COVID-19 coverage information for patients with Blue Medicare Advantage plans, see the Medicare Advantage COVID-19 article on the home page at Providers.BlueKC.com.

RETURN TO WORK TESTING As employees head back to work, what kind of coverage is in place if a company wants to test for COVID-19? In accordance with federal guidance, COVID-19 tests will not be covered to screen for general workplace health and safety (such as employee return to work program(s) or for public health surveillance for SARS-CoV-2 or for any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19).

For documentation requirements related to COVID-19 testing and coding guidelines, please see the COVID-19 Billing and Coding Payment Policy, which became effective November 1, 2021. To find this policy, go to the log-in page at Providers.BlueKC.com and click on *Go To Payment Policies*.

COVID-19 VACCINE BILLING FOR MA Effective January 1, 2022, per the Centers for Medicare & Medicaid Services (CMS), Blue KC will be required to pay for the COVID-19 vaccine and its administration (including approved booster doses) without cost sharing for our Blue Medicare Advantage line of business. This will apply to beneficiaries enrolled in our plans. As of January 1, 2022, according to CMS, Blue KC will also be obligated to pay for claims if providers vaccinate or administer monoclonal antibody treatment for patients enrolled in our Blue Medicare Advantage plans.

We wanted to make our contracted providers aware of this billing change to prevent avoidable billing errors. For information about COVID-19 vaccine policies and guidance, see the toolkits by clicking here.

BLUESPEAK
WHAT'S NEW FROM BLUE
Kansas City

Community Investment

"It's not how much we give but how much love we put into giving." – Mother Teresa

Blue KC employees spread joy this year through the 2021 Blue KC Cares Giving Campaign.

Through our collective efforts, we raised a total of $294,625, exceeding last year's total by more than $12,000. Money raised will support more than 150 community organizations, including a focus on:

United Way of Greater Kansas City: Assembles service agencies, programs, volunteers and donors to provide the farthest-reaching network of support for those in need

The Caring Program for Children: Funded by Blue KC employees, this non-profit enhances the quality of life for children in our community by providing durable medical equipment and related items that otherwise could not be afforded by the child's family and are not covered by state or federal programs or by private insurance. To watch a video about the program, click here.

Well Stocked: This Blue KC initiative focuses on bringing local partners together to increase awareness of hunger issues and providing better access to healthy food in underserved areas in Kansas City.

Behavioral Health

MINDFUL MOMENTS Three minutes is all that is needed to help your patients take care of themselves and be intentional with their breath. Click here to watch one of Blue KC's Mindful Moments, a guided exercise to lessen the stress of the holiday season.

What if there was a way to reach someone on the phone 24/7 to address your patients' behavioral health issues, such as stress? Blue KC has a program that offers that type of service. We are thinking differently about care and coverage by enhancing services provided in member health plans. Mindful by Blue KC is a behavioral health initiative dedicated to addressing access and reducing stigma to support the behavioral health needs of our members.

Blue KC members have access to a variety of services and tools to address depression, anxiety, substance use and everyday challenges. By calling one number, 833-302-MIND (6463), members can get in-the-moment support and care navigation, help locating and referring to in-network providers or assistance connecting to expedited treatment options in crisis situations.

Kansas City
Mindful
By Blue KC

BLUESPEAK
WHAT'S NEW FROM BLUE
Kansas City

Saint Luke's, Blue KC Support Lung Cancer Survivor

Don Gallagher is a lung cancer survivor; a tie-dye-wearing Grandpa who loves his wife, his kids, his grandkids, eating vegan, driving trucks and his community; and he is a big-time advocate for advancing lung cancer awareness.

In October 2019, Don received a diagnosis of stage 3B lung cancer. He was not, nor had he ever been, a smoker. Yet, there he was, an otherwise hale and hearty 62-year-old man living his best life. In an instant, life as he knew it changed.

With an amazing team of doctors and caregivers from Saint Luke's Hospital, a treatment plan was put into action. Though it was not easy by anyone's definition, Don attacked his cancer and approached this new reality with strength and purpose, determined to spread the word that anyone with lungs can get lung cancer and to end the stigma the disease carries.

Though Don was fortunate to have an amazing, intelligent and effective community in place, he credits Blue KC Case Manager Stacey Aumock as one of his *chief listeners*. Don said, "What she did for me was bigger than one specific thing; the regular conversations, her constancy, the checking in and especially the listening made a great difference to me."

To read more about Don's story, click here. Tell us about a patient who inspires you by emailing BlueSpeak@BlueKC.com, so we can share your story in an upcoming issue of Blue Speak.


Stacey Aumock, Don's Blue KC Case Manager

BLUESPEAK
WHAT'S NEW FROM BLUE
Kansas City

Member ID Cards for 2022

Updates

The goal of the Consolidated Appropriations Act (CAA) is to break down barriers in the nation's health system to provide members with improved access to their health information and to prevent situations where members might incur unexpected costs.

In compliance with CAA requirements, Blue KC is making updates to member ID cards. We will be adding the member's in-network major medical deductible and applicable medical out of pocket maximums to member ID cards. A Quick Response (QR) code will also be added to member ID cards. When scanned, it will link to the member's benefit summary document, providing them access to their plan's deductible, their ER copay, their specialty copay and more, all at their fingertips. The mandate also requires member ID cards to include a telephone number and website address, which ours currently do.

You can view an updated sample member ID card image here. These member ID card updates impact our Commercial line of business and Affordable Care Act (ACA) Qualified Health Plans (QHP).

How to Identify ACA QHPCards in 2022

It might be challenging to know whether a Blue KC Member is enrolled in an ACA QHP Plan since ACA does not appear on an ID card. But not to worry! You'll 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

BLUESPEAK
WHAT'S NEW FROM BLUE
Kansas City

Provider Directory Requirements for CAA 2022

Effective January 1, 2022, the Consolidated Appropriations Act (CAA) requires group health plans and issuers to establish a verification process to confirm Provider Directory information at least every 90 days.

- Delegated Providers will attest through monthly file and quarterly roster submission.
- Non-Delegated Providers must attest quarterly through CAQH Proview.
- **Note:** We take great care in verifying your information, and we also want to remind you of your obligation to ensure you submit the most accurate information possible, either via the roster submission or CAQH Proview.

Additionally, the CAA requires an update of Directory information within two business days of a plan or issuer receiving information from a provider or facility. Digital contact information (e.g., website URL) is also required for the Provider Directory:

- It is recommended that it points the user back to a health system or group / provider address where the user can obtain appointment information
- CAQH will be requesting this information as part of the attestation process
- CAQH will be moving the attestation cycle from 120 days to 90 days
- **Lack of quarterly attestation will result in provider being suppressed from Directory**

Value-Based Programs Evolve for 2022

Ask Kelly Hubka why she's so passionate about her role as Blue KC Director of Value-Based Programs, she turns to her past as a hospice nurse.

"I found there was often reason for the patient's diagnosis beyond genetics or bad luck," Hubka said. "All too often it was a lack of preventive screenings that led to cancer diagnoses caught too late, a lack of follow-up care that caused unnecessary complications or just a lack of routine medical care. I was interested in how to change the course for patients and started studying novel approaches to changing outcomes in healthcare. I learned about Value-Based Care and a lightbulb went off that this was a big part of the answer."

Value-Based programs have been a part of Blue KC for more than a decade with successful results.

"Blue KC's Value-Based Care initiatives help reorient how care is being delivered with a stronger focus on preventing disease and improving overall health and well-being," said Matt Edwards, Blue KC Department Vice President of Healthcare Transformation. "When our provider partners are actively engaged with the Blue KC population in this manner, we see reduced medical cost trend, a higher percentage of members

receiving important preventive screenings, better medication adherence and fewer members end up hospitalized or in the emergency room compared to provider groups that do not participate in our Value-Based programs."

Value-Based programs at Blue KC have evolved over the years. Here's a look at what's in store for 2022:

- **Primary Care First (PCF):** Prioritizes the doctor-patient relationship and enhances care for patients with complex, chronic or serious needs. PCF reduces administrative burden and focuses financial rewards on improved health outcomes.

- **Accountable Care Organizations (ACO):** A local high value network of doctors and hospitals that takes on financial and medical responsibility for providing coordinated care to members to reduce duplication of services and wasteful spending.

- **Health System Performance Program (HSPP):** Released last year, this program focuses on trend management, enhanced quality of care and appropriate resource management.

Click here for more information.

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.

iris healthcare

Kansas City

We wanted to make you aware that Iris Healthcare has begun to reach out to some Blue KC members who 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. Once the process is complete, you will receive signed Advance Directives to review with your patients. Submit the following CPT codes for your time and service reviewing the signed Advance Directives with your patients:

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.

Blue Medicare Advantage Information

Properly Documenting and Coding COPD/Bronchitis/Emphysema/Asthma

COPD is described as any disorder characterized by persisting or recurring obstruction of bronchial airflow.

COPD is often used to describe the following conditions:

- Chronic bronchitis
- Emphysema
- Obstructive asthma

Smoking is the primary risk factor for COPD. Other risk factors include secondhand smoke, a history of childhood respiratory infections, heredity and air pollution. Occupational exposure to certain industrial pollutants also may increase the odds for developing COPD.

When documenting COPD, chronic bronchitis and obstructive asthma, it is also important to document the patient's exposure to tobacco smoke where applicable using the following smoking statuses:

- History of tobacco use
- Tobacco dependence
- Current tobacco use

Documentation and Coding Tip

When both COPD and one of the conditions it is comprised of, such as emphysema, are documented throughout the same encounter, emphysema (or any of the other conditions comprising COPD) should be addressed in the assessment as it is a more specific type of COPD.

Example: 76-year-old patient following up with COPD, history of tobacco use, continuing home oxygen treatments. PMH: Emphysema, IBS, GERD.

Assessment: J43.9- unspecified emphysema, Z87.891- history of tobacco use

Correct code to capture: *J43.9- unspecified emphysema*

Transition of Care Medication Reconciliation Post-Discharge

Medication reconciliation, one component of CMS Transition of Care star measure, clarifies that primary care providers, who know their patient's health history best, should review medication regimens after a hospital admission with their patients, our members, to ensure safety and optimize health outcomes as changes in health status are occurring.

Medication reconciliation can be performed by a prescribing practitioner, clinical pharmacist or registered nurse within 30 days following discharge date. Documentation of a transitional care management visit will also meet the measure requirements (members in hospice are excluded).

Required outpatient medical record documentation should include evidence of medication reconciliation post-discharge (time-stamped) provided on the day of discharge through 30 days (total of 31 days) (an outpatient visit is NOT required). Any of the following meet criteria:

- Documentation of the current medications with a notation that the provider reconciled the current and discharge medications
- Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Documentation of the member's current medications with a notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge.
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient record.
- Include credentials for those completing the medication reconciliation.

The current Total Care Insights dashboard that is accessed for the Commercial Blue KC population is now available for Medicare Advantage and members with ACA QHP as well. Notifications can be set to alert your offices to any new admissions, to allow for a more proactive approach to managing these care gaps and completing a transition of care (TCM) visit. If the requirements for a TCM visit cannot be met, then use of the CPTII 1111F code to complete a medication reconciliation within 30 days will close the gap. More information is coming out regarding the transition to the MA Total Care Insights dashboard. This will include a user guide.

CMS Star Ratings Gap Closure for Medication Reconciliation

Measure	Office Visit/ Medical Claim	CPT II Codes	Supplemental Records through Pulse8 or Kiteworks	HEDIS Hybrid
Medication Reconciliation Post-Discharge	99495 99496	1111F	X	X

HEDIS data is collected in three ways:

- Administrative data from our claims database.
- Survey data from member and provider surveys.
- Hybrid data from a combination of our administrative data and medical record reviews.

HEDIS Hybrid means there is more than one way to close that gap. This is typically from administrative data (claims) and from medical records. Every year at Blue KC, we have team members working to collect submitted data from these different sources to close these quality gaps.

CAHPS Member Experience Survey – Why It Matters

The Medicare population Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey includes reasonably valid indicators about chronic conditions, health history and self-reported health status. In fact, due to broader questioning, the CAHPS may be more informative than claims-based data collection to understand population health and patient experience in the American healthcare system. (Brault, Landon, & Zaslavsky, 2019). The CAHPS key patient experience measures, such as provider communication, correlate with patient trust, understanding and compliance with healthcare provider recommendations (Anhang-Price et al., 2014).

The CAHPS Improvement Guide was developed to support health plans, medical groups and physician practices with the goal to provide resources to support improved patient experience and outcomes. Blue KC welcomes feedback on wins and challenges, so we may partner to improve our Medicare population health in the greater Kansas City area.

For the CAHPS Ambulatory Improvement Guide, click here.

Update on Blue KC's Chronic Condition Improvement Plan – COPD and Depression

Major Depressive Disorder is currently estimated to affect 120 million people worldwide and around 16% of the U.S. population. It is among the top reasons people seek care (Gilbody & et al., 2006). Evidence suggests increased prevalence of Depression in those with COPD (Wilson, 2006). In a sampling of 2013 Blue KC members over the age of 40 with COPD, a majority, 73%, were between 60 and 80 years old and 55% were women. Moreover 37% had an opportunity to still complete their annual wellness visit and incorporate Depression screening and treatment initiation as needed.

A multidisciplinary team using a multifaceted treatment plan is recommended to effectively treat Depression. Evidence-based practice includes primary care providers, case managers and mental health experts working in tandem to screen, assess treatment adherence and patient outcomes and consult, with possible referral, a psychiatrist as indicated. (HEDIS Measures and Technical Resources, n.d.; Von Korff &

Goldberg, 2001; Gilbody & et al., 2006). Additionally the APA clinical practice guideline gives further guidance on therapy and pharmacotherapy (APA, 2019).

APA CPG Depression: Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts (apa.org)

Highlight: The PHQ-9 is a validated and widely used tool to screen for Depression in the primary care setting (Beard et al., 2016). PHQ-9 recommended assessment frequency: monthly until remission or first six months following diagnosis; quarterly while on active treatment, and at least annually otherwise.

PHQ-9 Codes	PHQ-9 Codes Descriptions	Code System
3725F	Screening for depression performed	C4
G8431	+ Screen and f/u documented	HCPCS
G0444	CMS sampling only- annual depression screening, 15 minutes	HCPCS
G8510	- Screen and f/u not required	HCPCS

Medicare Supplement Changes

The new year ahead brings some exciting updates for our Medicare Supplement Products. Here is a summary of the primary changes that are effective Jan. 1, 2022:

New A, F, G & N Plans under MVLH entity

- Existing members may stay in their old A, F, G and N plans, but they will not have the new services

New G & N Plans will include the following benefits

- Vision (using our network)
- Hearing (Nations Benefit – using their network)
- SilverSneakers (offered through Tivity)
- PERS (Personal Emergency Response System) (Offered through Best Buy)
- Digital Balance Training Program (Offered through Nymbl)

ACA QHP Updates

Updates are on the way for your patients with ACA QHP for Individual, Family and Small Group. Here are highlights for changes effective January 1, 2022:

Network disruption in rural areas: Moving from RxPremier to RxSelect
Gold and Silver Plans will now have Co-Pays for Network Visit, Urgent Care and Specialist Visit instead of deductible/co-insurance.
Three Blue KC Choice Exclusive Provider Organization (EPO) Plans have been introduced with lower deductibles for your patients meeting Income Thresholds.
BlueSelect and Blue Select Plus will now be available in Caldwell, Cass, Clay, Clinton, DeKalb, Jackson, Johnson, Johnson (KS), Lafayette, Platte, Ray and Wyandotte (KS) counties.

Modifier Education

Therapy Modifiers

Blue KC wants to educate our providers about therapy modifiers after experiencing a significant increase in the number of therapy claims (chiropractor and physical therapy) that have been denied because they did not have the correct modifier.

All claims containing a procedure code from the list of applicable "Therapy Code List and Dispositions" should contain a therapy modifier. The modifier will distinguish the discipline of the plan of care:

- Modifier GN – Services delivered under an outpatient speech-language pathology plan of care
- Modifier GO – Services delivered under an outpatient occupational therapy plan of care
- Modifier GP – Services delivered under an outpatient physical therapy plan of care

Providers/suppliers must continue to report one of these modifiers for any therapy code on the list of applicable therapy codes, except as noted above. This applies to all claims from the following provider types:

- Physicians
- Non-physician practitioners (NPPs)
- Physical therapists in private practice (PTPPs)
- Occupational therapists in private practice (OTPPs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Outpatient physical therapy providers (OPTs)
- Hospitals
- Skilled Nursing Facilities (SNFs)
- Any others billing for physical therapy, speech-language pathology or occupational therapy services (as noted on the applicable code list below)

Therapy codes can be found at:
https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.

Modifier 90 on Gastroenterology Claims

Blue KC wants to help educate our providers regarding the use of modifier 90. We have received gastroenterology claims that list the procedure, as well as modifier 90 for the biopsy lab work. It is our policy not to pay for a modifier 90 lab code if the provider does not have a laboratory or is not a pathologist with a Clinical Laboratory Improvement Amendments (CLIA) number. We also do not pay the surgeon for both the procedure and pathology work since the specimen collection is included in the procedure code.

Labs reported with modifier 90 would not be payable under our Pass-Thru Billing Payment Policy. Modifier 90 is used by a physician or clinic when the laboratory tests performed for a patient are performed by an outside or reference laboratory.

This modifier is used to indicate that although the physician is reporting the performance of a laboratory test, the actual testing component was a service from a laboratory.

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 Policies	
Effective date – 12/1/2021	7.01.168 Cryoablation for Chronic Rhinitis – NEW Assn Policy New Policy – Considered Investigational
Effective date – 12/1/2021	7.01.168 Liposuction for Lipedema and Lymphedema – NEW Assn Policy New Policy – Considered Investigational
New MCG Guideline	
Effective date – 12/1/2021	BKC-A-0341 Oral Appliances (Mandibular Advancement Devices) New Policy – Includes Medically Necessary Indications

Pharmacy Policy Updates

Intra-articular Hyaluronic Acid Injections

On June 1, 2021, Blue KC changed its medical policy to allow coverage of the hyaluronic acid knee injections if members meet certain criteria. Three preferred products within this class became effective November 1, 2021:

Synvisc/Synvisc-One	Orthovisc	Monovisc

All products will continue to require prior authorization. However, to obtain prior authorization for one of the non-preferred products, such as Euflexxa or Gel-One, members need to meet medical policy criteria AND step through all three of the preferred products first. Members with a current authorization for a non-preferred product need to change to a preferred product upon authorization renewal.

This update impacts our Commercial and Joint Administrative Account (JAA) lines of business.

Colony Stimulating Factors for Oncology

Effective November 1, 2021, Blue KC updated its policy to require prior authorization for the filgrastim and pegfilgrastim products with preferred products in each category.

The preferred filgrastim product is Zarxio. The other products, Neupogen, Granix and Nivestym are non-preferred. Members need to step through preferred Zarxio before Neupogen, Granix or Nivestym are covered.

The preferred pegfilgrstim products are Neulasta/Neulasta OnPro and Udenyca. Members need to step through BOTH Neulasta and Udenyca before receiving coverage for Fulphila, Nyvepria or Ziextenzo. This update impacts our Commercial and (JAA) lines of business.

Filgrastim		**Pegfilgrastim**	
Zarxio	Q5101	Neulasta/Onpro	J2505
Nivestym	Q5110	Udenyca	Q5111
Granix	J1447	Fulphila	Q1508
Neupogen	J1442	Nyvepria	Q5122
		Ziextenzo	Q5120

Medicare Formulary Enhancements

The calendar will soon turn to a new year, and Blue KC is pleased to announce Medicare Formulary Enhancements for your patients starting in January 2022.

- Part D Senior Savings Model
    - This program makes the cost of insulin more affordable and predictable for our members by providing all covered insulins for a $35 copay per one month supply during the initial and gap coverage phases. Blue KC will also offer all pre-diabetic and diabetic members a reward incentive for completing a comprehensive medication review and for demonstrating adherence to their diabetic medications.
- Tier 1 and Tier 2 drugs will allow for 100-day supply at $0 cost to the member. These two tiers are composed of most of the adherence medications.
- Shingrix vaccine is moving from Tier 3 to Tier 2 to allow the member a lower cost share.

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	Nonpreferred	J0178
	Beovu	Nonpreferred	J0179
	Macugen	Nonpreferred	J2503
Hyaluronan Injections	**Orthovisc**	**Preferred**	J7324
	Synvisc; Synvisc-One	**Preferred**	J7325
	Monovisc	**Preferred**	J7327
	Durolane	Nonpreferred	J7318
	Genvisc	Nonpreferred	J7320
	Hyalgan; Supartz	Nonpreferred	J7321
	Hymovis	Nonpreferred	J7322
	Euflexxa	Nonpreferred	J7323

	Gel-One	Nonpreferred	J7326
	Gelsyn-3	Nonpreferred	J7328
	Trivisc	Nonpreferred	J7329
	Visco-3	Nonpreferred	J7333
Bevacizumab (Oncology)	**Mvasi**	**Preferred**	Q5107
	Zirabev	**Preferred**	Q5118
	Avastin*	Nonpreferred	J9035
Rituximab and Biosimilars	Truxima	**Preferred**	Q5115
	Ruxience	**Preferred**	Q5119
	Riabni	Nonpreferred	Q5123
	Rituxan	Nonpreferred	J9312

*Oncology indications only

Drug Class	Drug Name	Status	Billing Code
Herceptin and Biosimilars	**Kanjinti**	**Preferred**	Q5117
	Ogivri	**Preferred**	Q5114
	Trazimera	**Preferred**	Q5116
	Herceptin	Nonpreferred	J9355
	Herzuma	Nonpreferred	Q5113
	Ontruzant	Nonpreferred	Q5112
	Herceptin Hylecta	Nonpreferred	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 January 1, 2022.

The Blue KC Medical and Pharmacy Management Committee reviews and maintains the Prescription Drug List. The Committee, consisting of practicing physicians and pharmacists in the Kansas City area, holds quarterly meetings to evaluate new drug therapies and review drug utilization issues. Medications are evaluated based on drug safety and costs. Click here for our consumer website for prescription drug lists.

These updates only impact our Commercial line of business. Group-specific benefit exceptions may apply. Formulary changes to Blue Medicare Advantage (MA) and ACA QHP are not listed here. Blue KC offers two Commercial formularies: Preferred and Premium. Updates to these PDLs are listed separately below.

Below are the **Preferred** Prescription Drug List updates that are effective January 1, 2022:

New Step Therapy Requirements

- Members must try preferred alternative(s) before other drugs will be covered.
- Exceptions can be requested through the prior authorization process.

New Step Therapy Requirements		
Drug Class	Drugs Requiring a Trial of Alternative(s)	Preferred Alternative(s) (Try First)
Narcolepsy	Xyrem	Sunosi
Injectable Methotrexate	Reditrex	Otrexup
Beta-Blockers	Bystolic	Nebivolol (generic Bystolic)
Short-Acting Bronchodilators	ProAir, ProAir Respiclick, Ventolin	Generic version
High Cholesterol	Praluent	Repatha

Tier Changes Increasing Member Copayment

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

Medications moving from Tier 2 to Tier 3	
Bystolic	Divigel
Otrexup	Praluent
ProAir, ProAir Respiclick	Ventolin
Xyrem	

Excluded Drugs with Over-the-Counter Availability

The following drugs are now excluded but are available for members to purchase out of pocket, over the counter.

AMMONIUM LAC LOT/CRE 12%	BENZEPRO MIS 6%	CALC ACETATE TAB 667MG	CLOTRIMAZOLE CRE/SOL 1%	DICLOFENAC GEL 1%
ESOMEPRA MAG CAP 20MG DR	FAMOTIDINE TAB 20MG	FLUTICASONE SPR 50MCG	HYDROCORT OIN 1%	IBUPROFEN SUS 100/5ML
LANSOPRAZOLE TAB/CAP 15MG/DR	LEVOCETIRIZI TAB 5MG	LOPERAMIDE CAP 2MG	MECLIZINE TAB 12.5MG, 25MG	OLOPATADINE DRO/SOL 0.1%, 0.2%

OMEPRAZOLE CAP 20MG/DR	PAZEO DRO 0.7%			

Below are the **Premium** Prescription Drug List updates that are effective January 1, 2022:

New Step Therapy Requirements

- Members must try preferred alternative(s) before other drugs will be covered.
- Exceptions can be requested through the prior authorization process.

New Step Therapy Requirements		
Drug Class	Drugs Requiring a Trial of Alternative(s)	Preferred Alternative(s) (Try First)
Contraceptives	Taytulla	Any **ONE** of the following generics: Gemmily, Merzee, norethindrone-ethinyl estradiol-ferrous fumarate
Urinary Antispasmodics	Gelnique, Oxytrol	Any **TWO** of the following generics or preferred brands: oxybutynin IR/ER, tolterodine IR/ER, trospium IR/ER, solifenacin, darifenacin ER, Myrbetriq

New Prior Authorization Requirements	
Drug Class	Drugs Requiring Prior Authorization
Antifungals	Cresemba, Vfend
Continuous Glucose Monitors	Dexcom
Lidoderm	Lidoderm
Migraine Agents	Cafergot, Ergomar, Migergot
Tolvaptan	Jynarque, Samsca

New Excluded Medications with Alternatives

New Excluded Medication with Alternatives

Drug Class	Excluded Medications	Covered Alternative
Antilipemic Agents	Praluent	Repatha

New Excluded Drugs with Covered Generic Equivalents

Absorica	Azopt	Lyrica CR	Travatan Z

Payment Policy Updates

Blue KC has instituted coding and billing guidelines for Stereotactic Body Radiation Therapy (SBRT) and Stereotactic Radiosurgery (SRS) procedures, effective November 1, 2021. For a list of the main codes that should be used for coding/billing these procedures and additional codes that may be used under specific circumstances, view the Payment Policy by going go the log-in page at Providers.BlueKC.com and clicking on *Go To Payment Policies*. The codes follow eviCore Radiation Therapy guidelines.

We also have a payment policy update for Mohs Micrographic Surgery (MMS), which is a technique that treats skin cancer by gradually removing thin layers of skin from a skin cancer site until a patient is cancer free. Effective January 1, 2022, Blue KC will only reimburse for MMS, repairs, and related services under one place of service and should be submitted on the same claim. Services submitted under multiple places of service sites will be denied payment. For the updated policy, visit the log-in page at Providers.BlueKC.com and click on *Go To Payment Policies*.

Claims for MMS services are payable under the following places of service:

- Office – 11
- Inpatient hospital – 21
- Outpatient hospital – 22
- Ambulatory Surgery Center – 24
- Independent clinic – 49
- Federally Qualified Health Center – 50
- State or local public health clinic – 71
- Rural health clinic – 72

Advanced Practice Provider Credentialing

In order to comply with CMS guidance, Blue KC wants to remind you we have updated our provider credentialing policies for all lines of business. **All Advanced Practice Providers (APPs), which were previously called Mid-Level Practitioners,** must be credentialed with Blue KC by January 1, 2022. APPs include, but are not limited to:

Nurse Practitioners	Clinical Nurse Specialists
Nurse Midwives	Physician Assistants
Nurse Anesthetists	Anesthesiologist Assistants

To meet the January 1, 2022, deadline, APPs should apply for credentialing as soon as possible. For credentialing instructions and other details, refer to the Advanced Practice Provider Credentialing and Provider Directory Requirements article, which can be found in the Recent News Updates section on the home page of the Provider Portal at Providers.BlueKC.com.

New Edits for Inpatient Billing

Beginning March 1, 2022, Blue KC will have new data elements 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.

Thank You Provider Partners

Blue KC thanks you for being a provider of service to our members. We know you work hard to ensure that each member receives quality healthcare.

Being a partner in the healthcare industry, we want to make sure members stay up to date on preventive services, such as immunizations, labs, breast cancer screenings and colorectal cancer screenings to name a few.

The information we receive from providers is a key component in identifying members who may have gaps in their healthcare. Providing the members' healthcare data in a timely manner will help us close the gaps in care and reduce healthcare costs. Our goal is to improve the health of each member. Thank you for all you are doing.

Through the Blue KC interventions, we outreach to members to educate them on the importance of scheduling preventive services with their providers.

BLUESPEAK
WHAT'S NEW FROM BLUE

Kansas City

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!
NOT REGISTERED FOR THE PROVIDER PORTAL? CLICK ON "REGISTER NOW" ON THE LOG-IN PAGE!	

Contact Us

Your comments are welcome and can be sent to BlueSpeak@BlueKC.com.

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.