BLUESPEAK
WHAT'S NEW FROM BLUE
Kansas City

Prior Authorization Updates

OncoHealth to Assist Blue KC's Prior Authorization Process for Oncology Treatments

Blue Cross and Blue Shield of Kansas City (Blue KC) will partner with OncoHealth, a leading oncology organization, to administer prior authorization for oncology treatments for dates of service on or after **January 1, 2026**. This change is designed to streamline processes and deliver support for our members with cancer.

OncoHealth will assist Blue KC's prior authorization process for radiation therapy and oncology drugs that will require prior authorization for Commercial, ACA QHP for Individual/Family and Small Group ACA lines of business. **Note:** Blue KC will post new medical policies and updates to existing policies related to this partnership with OncoHealth. Click here for the Blue KC Medical Policies landing page, or you may visit our log-in page at Providers.BlueKC.com and click on *Go to Medical Policies*.

Look for communication in the October Provider Bulletin regarding the date when prior authorization requests will transition to OncoHealth.

For more details, including a webinar training schedule, impacted codes and resources, click here or log into the Blue KC Provider Portal at Providers.BlueKC.com and look under Recent News on the home page.

Payment Policy Updates

To find the complete versions 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.

Payment Policy Reminder

Blue KC Payment Policies provide coding and payment guidelines for claims submitted to Blue KC.

- When submitting claims, providers/facilities are required to follow Blue KC's Payment Policies and all applicable guidance for correct billing and coding to ensure accuracy of claims submitted for reimbursement.
- Pre- or post-payment edits may be implemented to ensure compliance with Payment Policies and correct coding guidelines.

- The presence or absence of such edits does not alleviate the obligation of contracted network providers/facilities to comply with Payment Policies and all applicable guidance for correct billing and coding.
- All Blue KC Payment Policies can be found at https://providers.bluekc.com/ContactUs/PaymentPolicies.

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Durable Medical Equipment Payment Policy

Policy Number	Policy Name	Effective Date for Policy	Effective Date for Enforcements	Full Policy Locations
POL-PP-195	Durable Medical Equipment	11/1/2020	10/1/2025	View our Durable Medical Equipment Payment Policy Visit our Payment Policies page Providers.BlueKC.com, click on "Go to Payment Policies"

Enforcements Added

- Durable Medical Equipment (DME) Rental
  - Effective October 1, 2025, Blue KC will implement editing that identifies claim lines submitted for the rental of a DME item in which the rental payment for the DME item exceeds the maximum number of rental payments, as defined by CMS. Source: CMS
- Durable Medical Equipment (DME) Owned

  - Effective October 1, 2025, Blue KC will implement editing that identifies claim lines for a DME item that has been submitted with an ownership modifier when the same DME item has been previously paid in history with another or the same ownership modifier. Source: CMS
- Durable Medical Equipment (DME) Replaced or Repaired
  - Effective October 1, 2025, Blue KC will implement editing that identifies claim lines submitted for replacement and repair of currently rented or owned DME items when reported within the warranty period or within the reasonable and useful lifetime of the DME item. Source: CMS
- CPAP Supply Frequency
  - Effective October 1, 2025, Medically Unlikely Edits (MUEs) will be applied to CPAP/BIPAP supplies. Units that exceed the allowed amount will be denied.
  - Supply codes submitted without modifier KX (Requirements specified in the medical policy have been met) will be denied. Source: CMS Local Coverage Policy for CPAP Supplies (CMS CPAP)

Inpatient Only Procedures Payment Policy

Policy Number	Policy Name	Effective Date for New Policy	Enforcement Date for New Policy	Full Policy Locations
POL-PP-257	Inpatient Only Procedures	10/1/2025	11/1/2025	View our Inpatient Only Procedures Payment Policy Visit our Payment Policies page Providers.BlueKC.com, click on "Go to Payment Policies"

New Policy Summary – as announced in the July 2025 Bulletin

- Blue KC will implement the CMS Inpatient-only list consisting of surgeries/procedures that will only be paid as an Inpatient procedure in an acute hospital setting.
- This policy will apply to all physicians and facilities, unless the provider's Blue KC network participation agreement contains a specific rate of reimbursement for the Inpatient-only procedure code performed outside of an acute hospital setting.
- If a surgery/procedure on the Inpatient-only list is performed as outpatient and reported on an outpatient claim, no payment will be made to the facility for the surgery/procedure or for any other services provided on the same date of service.

- The Inpatient-only surgery/procedure list is available at the site below:
  - https://www.cms.gov/license/ama?file=/files/zip/2025-nfrm-opps-addenda.zip
- This policy applies to all providers and facilities, unless the provider's Blue KC network participation agreement contains a specific rate of reimbursement for the in-patient only code.

Intraoperative Neurophysiology Monitoring (IONM) Services Payment Policy

Policy Number	Policy Name	Effective Date for New Policy	Enforcement Date for New Policy	Full Policy Locations
POL-PP-260	Intraoperative Neurophysiology Monitoring (IONM) Services	10/1/2025	11/1/2025	View our Intraoperative Neurophysiology Monitoring (IONM) Services Payment Policy Visit our Payment Policies page Providers.BlueKC.com, click on "Go to Payment Policies"

New Policy Summary

- Intraoperative Neuromonitoring (IONM) is the use of electrophysiological methods to monitor the functional integrity of certain neural structures during surgery.
- IONM codes are reported based upon the time spent monitoring only, and not the number of baseline tests performed, or parameters monitored. In addition, time spent monitoring excludes time to set up, record, and interpret the baseline studies, and to remove electrodes at the end of the procedure. Time spent performing or interpreting the baseline neurophysiologic study should not be counted as intraoperative monitoring, as it represents separately reportable procedures.
- 95940 - Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)
- 95941 - Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)
- G0453 - Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)
- The monitoring professional must be solely dedicated to performing the intraoperative neurophysiologic monitoring and must be available to intervene at all times during the service as

necessary, for the reported time period(s). For any given period of time spent providing these services, the service receives full attention and, therefore, other clinical activities beyond providing and interpreting of monitoring cannot be provided during the same period of time.

- The American Academy of Neurology states IONM services should be performed in Place of Service (POS) 19, 21, 22 or 24. Therefore, Blue KC will only reimburse 95940, 95941, and G0453 services when these codes are reported with POS 19, 21, 22 and 24.

Modifiers Payment Policy

Policy Number	Policy Name	Effective Date for Policy	Effective Date for Enforcements	Full Policy Locations
POL-PP-108	Modifiers	8/25/2020	10/1/2025	View our Modifiers Payment Policy Visit our Payment Policies page Providers.BlueKC.com, click on "Go to Payment Policies"

Enforcements Added

- Effective October 1, 2025, Blue KC will enforce the following for POL-PP-108 Modifiers Payment Policy:
  - The appropriate anesthesia modifier (AA, AD,QK, QX, QY) must be added to all anesthesia services to indicate who performed the service and if the service was medically directed.
  - Claims without an appropriate anesthesia modifier will be denied.

Office Facility Fees Payment Policy

Policy Number	Policy Name	Effective Date for Policy	Effective Date for Enforcements	Full Policy Locations
POL-PP-127	Office Facility Fees	3/1/2020	12/1/2025 (For G0463)	View our Office Facility Fees Payment Policy Visit our Payment Policies page Providers.BlueKC.com, click on "Go to Payment Policies"

Reminder

- Blue KC does not recognize ownership of a professional provider/private practice by a hospital or facility or use of a hospital or facility's tax identification number for claims submission on behalf of the provider/private practice as a hospital or facility provider when the setting is office based.
- Therefore, when this type of relationship exists, the place of service where services are provided is not considered by Blue KC to be a hospital or facility.
- In addition, Blue KC defines an office setting as one that is located within a hospital or facility, a professional building attached to and owned by a hospital or facility, or an offsite professional building owned by a hospital or facility.
- All procedures and/or services performed by a private professional provider/private practice group in an office POS as defined in this policy will only be eligible for reimbursement when reported on a Form CMS-1500 with an office place of service (POS code 11).
- Revenue codes considered as not eligible for reimbursement are:
    - 051X Clinic
    - 0510 General Classification
    - 0511 Chronic Pain Center
    - 0512 Dental Clinic
    - 0513 Psychiatric Clinic
    - 0514 OB/GYN Clinic
    - 0515 Pediatric Clinic
    - 0516 Urgent Care Clinic
    - 0517 Family Practice Clinic
    - 0519 Other Clinic
    - 052X Freestanding Clinic
    - 0520 General Classification
    - 0523 Family Practice Clinic
    - 0526 Urgent Care Clinic (a)
    - 0527 Visiting Nurse Service(s) to a member's home when in a Home Health Shortage Area
    - 0529 Other Free-Standing Clinic
- Claims received on or after December 1, 2025, with HCPCS code G0463 Hospital Outpatient Clinic Visit for Assessment and Management of a Patient will be denied as non-covered and provider responsibility.

Psychological and Neuropsychological Testing Payment Policy

Policy Number	Policy Name	Effective Date for New Policy	Enforcement Date for New Policy	Full Policy Locations
POL-PP-261	Psychological and Neuropsychological Testing	11/1/2025	11/1/2025	View our Psychological and Neuropsychological Testing Payment Policy Visit our Payment Policies page Providers.BlueKC.com, click on "Go to Payment Policies"

New Policy Summary

- Psychological and neuropsychological testing are complex activities that necessitate extensive knowledge and training, as articulated in several professional psychology guidelines and standards.
- Claims submitted for psychological and neuropsychological testing for disorders, other than for learning disabilities, are covered when submitted by one of the following physician or other qualified healthcare provider specialties:
    - Neuropsychologist, or
    - Psychologist, or
    - Pediatric neurodevelopmental specialist
- CPT codes for psychological and neuropsychological testing (96130, 96131, 96132) should not be used to screen for attention deficit disorder and/or attention deficit hyperactive disorder.
- Screening for attention deficit disorder and attention deficit hyperactive disorder should be submitted with CPT 96127 Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD]).

Revenue Codes Requiring HCPCS Codes Payment Policy

Policy Number	Policy Name	Effective Date for Policy	Effective Date for Enforcements	Full Policy Locations
POL-PP-229	Revenue Codes Requiring HCPCS Codes	2/1/2022	10/1/2025	View our Revenue Codes Requiring HCPCS Codes Payment Policy Visit our Payment Policies page Providers.BlueKC.com, click on "Go to Payment Policies"

Enforcements Added

- Effective October 1, 2025, Blue KC will enforce the following for POL-PP-229 Revenue Codes Requiring HCPCS Codes Payment Policy: Evaluation and Management services (99202-99499, G0380-G0384, G0463, and G2212) will be denied when billed in a treatment room (revenue codes 0760, 0761, and 0769).
- For claims received on or after October 1, 2025, Blue KC will deny services when a CPT/HCPCS code is missing from a revenue code that requires it based on CMS, the Uniform Billing Editor, and the UB-04 manual that requires certain revenue codes to be submitted with the appropriate CPT/HCPCs code. For a complete list of revenue codes requiring CPT/HCPCS, please see the full policy for POL-PP-229 Revenue Codes Requiring HCPCS Codes Payment Policy.

Robotic and Computer Assisted Surgery Payment Policy

Policy Number	Policy Name	Effective Date for Policy	Effective Date for Enforcements	Full Policy Locations
POL-PP-232	Robotic and Computer Assisted Surgery	3/1/2022	10/1/2025	View our Robotic and Computer Assisted Surgery Payment Policy Visit our Payment Policies page Providers.BlueKC.com, click on "Go to Payment Policies"

Enforcements Added

- Effective October 1, 2025, Blue KC will enforce the following for POL-PP-232 Robotic and Computer Assisted Surgery Payment Policy:
    - Robotic and computer assisted surgery(s) are considered integral to the primary procedure and will not be separately reimbursed.
    - Professional and facility claims will not receive additional payment for these services.

SBRT, SRS and FSRT Payment Policy

Policy Number	Policy Name	Effective Date for Update	Effective Date for Enforcements	Full Policy Locations
POL-PP-250	SBRT, SRS and FSRT	11/1/2021	10/1/2025	View our SBRT, SRS and FSRT Payment Policy Visit our Payment Policy page Providers.BlueKC.com, click on "Go to Payment Policies"

Enforcements Added

- Effective October 1, 2025, Blue KC will enforce the following for POL-PP-250 SBRT, SRS, and FSRT Payment Policy:
    - The services listed below will be denied when billed within 30 days of IMRT, as is included in the payment of CPT 77301.
        - Intensity – Modulated Radiation Therapy (IMRT CPT 77301) plan-related radiation therapy services include CT imaging for treatment planning (77014), treatment simulations (77280-77290), external beam isodose planning (77295, 77306, and 77307), special teletherapy port plan (77321), special dosimetry (77331) and medical physics consultation (77370).

Transcranial Magnetic Stimulation Payment Policy

Policy Number	Policy Name	Effective Date for New Policy	Enforcement Date for New Policy	Full Policy Locations
POL-PP-259	Transcranial Magnetic Stimulation	11/1/2025	11/1/2025	View our Transcranial Magnetic Stimulation Payment Policy Visit our Payment Policies page Providers.BlueKC.com, click on "Go to Payment Policies"

New Policy Summary

- Transcranial magnetic stimulation (TMS) is a non-invasive procedure that is performed without any anesthesia. An alternating current is used to perform stimulation of the cortex of the brain to help the release of certain neurotransmitters like dopamine, serotonin, and norepinephrine.
- The following healthcare professional are authorized to perform TMS.
  - Psychiatrists
  - Neurologists
  - Clinical Psychologists
- 90867 - Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery, and management
- 90868 - Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session
- 90869 - Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management
- CPT 90868 (TMS subsequent delivery and management) will be denied without CPT 90867 (initial treatment TMS) billed first on a previous date of service.
- CPT 90689 (subsequent motor threshold redetermination) will be denied without CPT 90868 billed first on a previous date of service.
- (Do not report 90867, 90868 or 90869 in conjunction with 95860-95870, 95928, 95929, 95939, 0889T, 0890T, 0891T, 0892T, TMS codes include E/M services, psychotherapy, and psychiatric diagnostic evaluation related to TMS therapy).
- For other possible National Correct Coding Initiative Conflicts please see NCCI Procedure to Procedure edits.

Lifetime Event

- Effective October 1, 2025, Blue KC will implement editing that will audit claims to determine if a procedure code(s) has been submitted more than once or twice on the same date of service or across dates of service when it can only be performed once or twice in a lifetime. Source: AMA/CMS
- Lifetime Procedure codes specific to an anatomic site (leg, arm, toe, eye) will need to be billed with the appropriate anatomic modifier (LT, RT, F1, F2, etc.).

Medical Policy Updates

The most up-to-date Medical Policy can be found by logging into Providers.BlueKC.com and clicking on the Medical Policies section. While on that web page, you can also find a link to view Milliman Care Guidelines (MCG), 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, MCG and eviCore.

New Blue KC Medical Policies

Effective date – 10/1/2025	ID: 5.01.52 Title: Gene Therapies for Aromatic L-amino Acid Decarboxylase Deficiency Eladocagene exuparvovec-tneq is considered medically necessary for individuals if they meet criteria 1 through 7: 1. Meets any 1 of the 3 diagnostic criteria for aromatic L-amino acid decarboxylase deficiency a. Biallelic pathogenic/likely pathogenic variants in *dopa decarboxylase (DDC)* gene OR b. One pathogenic/likely pathogenic variant plus a variant of uncertain significance AND aromatic L-amino acid decarboxylase enzyme activity in plasma < 5% OR cerebrospinal fluid or plasma neurotransmitter profile consistent with aromatic L-amino acid decarboxylase deficiency (see Policy Guidelines) OR c. Two variants of uncertain significance AND aromatic L-amino acid decarboxylase enzyme activity in plasma < 5%

	OR cerebrospinal fluid or plasma neurotransmitter profile consistent with aromatic L-amino acid decarboxylase deficiency (see Policy Guidelines) 2. Has persistent neurological defects (e.g., autonomic dysfunction, hypotonia, dystonia and other movement disorders, etc.) 3. Has anti-AAV2 antibody titer <1:1,200 4. Achieved skull maturity assessed by neuroimaging to allow placement of the stereotactic head frame for surgery 5. Does not have any contraindications that would preclude the surgical intraputaminal administration 6. Medication is being administered at United States Food and Drug Administration approved dosing by a healthcare professional (see Policy Guidelines) 7. Medication is planned to be administered in a medical center which specializes in stereotactic neurosurgery. Eladocagene exuparvovec is considered investigational when the above criteria are not met. Eladocagene exuparvovec-tneq is considered investigational for all other indications. Repeat treatment with Eladocagene exuparvovec-tneq is considered investigational.
Effective date – 10/1/2025	ID: 8.01.57 Title: Baroreflex Stimulation Devices Baroreflex stimulation therapy with a device approved by the U.S. FDA is considered investigational for individuals with heart failure despite the use of maximally tolerated guideline-directed medical and device therapy. Baroreflex stimulation therapy is investigational for all other indications.

Amniotic Membrane and Amniotic Fluid Medical Policy Reminder

Blue KC will provide coverage for Amniotic Membrane and Amniotic Fluid when it is determined to be medically necessary provided specific criteria is met and appropriate amniotic membrane or fluid products for the following diagnoses are used:

- Treatment of nonhealing diabetic lower-extremity ulcers.
- Treatment of the following ophthalmic indications, with or without suture:
    - Neurotrophic keratitis with ocular surface damage and inflammation that does not respond to conservative therapy;
    - Corneal ulcers and melts that do not respond to initial conservative therapy;
    - Corneal perforation when there is active inflammation after corneal transplant requiring adjunctive treatment;
    - Bullous keratopathy as a palliative measure in patients who are not candidates for curative treatment (eg, endothelial or penetrating keratoplasty);
    - Partial limbal stem cell deficiency with extensive diseased tissue where selective removal alone is not sufficient;
    - Moderate or severe Stevens-Johnson syndrome;
    - Persistent epithelial defects that do not respond within 2 days to conservative therapy;
    - Severe dry eye (DEWS 3 or 4) with ocular surface damage and inflammation that remains symptomatic after Steps 1, 2, and 3 of the dry eye disease management algorithm (see Considerations); or
    - Moderate or severe acute ocular chemical burn.
- Treatment of the following ophthalmic indications, with suture or glue:
    - Corneal perforation when corneal tissue is not immediately available; or
    - Pterygium repair when there is insufficient healthy tissue to create a conjunctival autograft.

Human amniotic membrane grafts with or without suture are considered investigational for all ophthalmic indications not outlined above.

Injection of micronized or particulated human amniotic membrane is considered investigational for all indications, including but not limited to treatment of osteoarthritis and plantar fasciitis.

Injection of human amniotic fluid is considered investigational for all indications.

All other uses of the human amniotic products not listed above are considered investigational.

All other human amniotic products for indications not listed above are considered investigational, including but not limited to treatment of lower-extremity ulcers due to venous insufficiency and repair following Mohs micrographic surgery.

For a comprehensive list of criteria and approved products, please refer to the Blue KC Amniotic Membrane and Amniotic Fluid Medical Policy (7.01.149).

Bio-Engineered Skin and Soft Tissue Substitutes Medical Policy Reminder

Blue KC will provide coverage for bio-engineered skin and soft tissue substitutes when it is determined to be medically necessary provided specific criteria is met and appropriate skin substitute products for the following diagnoses are used:

- Breast reconstructive surgery using allogeneic acellular dermal matrix products.
- Treatment of chronic, non-infected, full-thickness diabetic lower extremity ulcers.
- Treatment of chronic, non-infected, partial or full-thickness lower extremity skin ulcers due to venous insufficiency, which have not adequately responded following a one month period of conventional ulcer therapy.
- Treatment of dystrophic epidermolysis bullosa.
- Treatment of second and third degree burns.
- Interpositional barrier following parotidectomy.
- Implant for reconstruction following removal of a malignant neoplasm.

All other uses reviewed of the bioengineered skin and soft tissue substitutes are considered investigational.

For a comprehensive list of criteria and approved products, please refer to the Blue KC Bio-Engineered Skin and Soft Tissue Substitutes Medical Policy (7.01.113).

Pharmacy Policy Updates

New Pharmacy Policies

Here is a new Blue KC pharmacy policy for a drug that will require prior authorization effective **October 1, 2025:**

New Pharmacy Policy		
Policy Number		
5.02.681	Alhemo (concizumab-mtci)	FDA Approved for Hemophilia A or B with inhibitors; SQ; Medical-Rx benefit

Here are new Blue KC pharmacy policies for drugs that require prior authorization and became effective on **September 1, 2025:**

New Pharmacy Policies		
Policy Number	Policy Name	Summary
5.02.679	Bizengri (zenocutuzumab-zbco)	FDA approved for Non–small cell lung cancer (NSCLC) and Pancreatic adenocarcinoma that are NRG1 fusion positive; IV; Medical-Rx Benefit
5.02.680	Niktimvo (axatilimab)	FDA approved for Chronic graft-versus-host disease (cGVHD); IV; Medical-Rx benefit

Provider Education

Provider Data Transformation: Driving Accuracy and Efficiency

Our provider data management transformation with **Symplr** is almost here!

We're excited about the benefits this change will bring to you and your teams. While we're not ready to share the official launch date just yet, we want to keep you informed and engaged as we get close.

Why this matters:	• **Greater data accuracy** to reduce errors and improve trust • **Shorter credentialing cycles** to help onboard providers faster • **Simplified tools** for updating and maintaining your information

These enhancements are designed to make it easier for you to focus more on patient care. We do anticipate a brief learning curve for our providers, and we'll be sharing more details, training opportunities and resources soon to help you prepare for the transition.

High-Cost Claims Process Update

Effective September 1, 2025, Blue KC is expanding the scope of high dollar claim reviews with our facility providers to ensure billing and payment accuracy. Facility providers were notified in June 2025 of this change.

Blue KC will begin the Prepayment DRG and Clinical Chart Validation Review Audit for dates of service on or after January 1, 2026. This will allow additional time for providers to make any necessary process changes to submit itemized bills and medical records to Blue KC. However, we encourage providers to submit itemized bills prior to the effective date of the audit.

- In addition to Blue KC's existing itemized bill review process for discounted charge claims, Blue KC will expand the scope of these reviews to include coding and clinical validation review of facility claims with a DRG payment methodology. This review is not based on medical necessity. Clinical validation is a distinct and separate process from coding validation.
- Blue KC requires submission of itemized bills *with all facility claims with a billed charge of $100,000* or more with a reimbursement methodology of DRG, DRG outlier or discounted charges for inpatient and outpatient claims. Medical records and/or itemized bills may also be requested as needed to support Blue KC payment integrity audits.
- When a medical record and/or itemized bill is required for these high-cost claims and is not submitted, the claim will be denied, and a letter will be generated requesting additional information. A new or corrected claim does not need to be submitted because the claim will be reconsidered upon receipt of the additional information from the provider.

- As a reminder, all claim submissions must adhere to all applicable medical coding guidelines and Blue KC medical and payment policies.
- Please continue to fax the itemized bill to 816-995-1552 for *both inpatient and outpatient claims.*
- Beginning September 1, 2025, medical records should be faxed to 816-926-4258.
    - Include the patient's Subscriber ID number.
    - At this time, the attachments cannot be submitted electronically with the claim.
    - The claim may not be faxed to the number above, but it can be submitted electronically.
- Criteria for this process is:
    - Payment methodology for the claim is based on percentage of billed charge or DRG/DRG Outlier for inpatient or outpatient claims.
    - Interim claims are included for non-Blue KC Members.
    - Transplant claims are excluded.
    - Claims in which Blue KC is the secondary payer are excluded.
    - Interim claims are excluded for Blue KC members until the final billing is submitted. At that time, the itemized bill should also be submitted.

If you have any questions or require additional information, please feel free to contact your Blue KC Provider Account Executive. We would like to thank you in advance for your cooperation and assistance related to this matter.

Diagnosis Pointers for CMS-1500 Claims

- Blue KC's Payment Integrity program performs routine analytics of claims utilization to identify potentially inappropriate patterns of billing.
    - After a review of overall utilization patterns, we are expanding our editing practices of coding medical services to ensure that the appropriate diagnosis codes are used and pointed to the correct services. This must also be reflected in the medical record.
    - These additional enforcements support and enforce appropriate coding and billing based on CMS Billing guidelines, which require you to use field 24e for DX pointers on the CMS-1500 Claim Form.
    - Please see the following guidance from CMS: https://www.cgsmedicare.com/pdf/5010_jobaid.pdf.
    - Blue KC's adoption of National Correct Coding Initiative (NCCI), along with CMS guidance for the use of appropriate diagnosis pointers, ensures that claims are paid appropriately, and denials for incorrect coding can be avoided.
- Diagnosis pointers/references are necessary to accurately reference which services apply to specific medical conditions.

  - Diagnosis pointers are an essential component of medical billing. The primary purpose of using diagnosis pointers is to specify the medical condition(s) that led to the services or procedures being performed. This is important information to determine the medical necessity of the services.
  - Diagnosis pointers are used to understand why a particular test, treatment or procedure was performed, thereby facilitating the approval and reimbursement process.
  - Incorrect use of diagnosis pointers can lead to claim denials and rejections. Each line on the claim allows for up to four diagnosis pointers to indicate the relevant regions. If necessary, providers may need to use a diagnosis code that encompasses two conditions and/or regions to ensure all areas are properly represented with a diagnosis code, if applicable.
  - When billing for preventative services in conjunction with acute care, the diagnosis pointer helps clarify the rationale behind each service and its relationship to the patient's overall health picture.
  - Preventive and diagnostic lab services differ primarily in their purpose and the context in which they are ordered and can be distinguished by appropriate use of diagnosis pointers.
  - Example: Consider a patient visiting a healthcare provider for type II diabetes. The patient also complains of intermittent chest pain. The provider performs an EKG and orders an A1C blood test. The claim form would list the CPT codes for the EKG and blood test. The diagnosis of chest pain would point to the EKG, and the diagnosis of type II diabetes would point to the A1C blood test.
- For additional information about properly completing the CMS-1500 Claim Form, view the CMS-1500 instructions at https://www.nucc.org/.
- Please be advised that all claim submissions must adhere to all applicable medical coding guidelines, Blue KC Provider Reference Guide, Payment and Medical Policies, as well as all CMS standards.

Blue KC Gap Fill Fee Schedule

- POL-PP-108 Modifiers Payment Policy will be enforced on October 1, 2025, to include codes on the Gap Fill Fee Schedule. This update will apply to providers who have reimbursement agreements that are based on CMS reimbursement methodology and will allow for better consistency with Blue KC's Modifiers Payment Policy.
- To find the current Blue KC Gap Fill Fee Schedule, log into Providers.BlueKC.com, click on Resources on the home page and select the Gap Fill Fee Schedule tab. The rates posted on the schedule are the base rates (without payment modifier adjustments).

- To see how a modifier will affect a code in the Gap Fill Fee Schedule, please reference the Modifiers Payment Policy by clicking here or going to https://providers.bluekc.com/MedicalPolicy/PaymentPolicies.

Reminder: Benefit Verification Required for FEP Members (Member IDs beginning with "R")

As a reminder for our Federal Employee Program (FEP) population, providers must call to verify benefits for member IDs beginning with the letter "R".

- The provider portal does ***not*** display complete benefit information for this line of business.
- To avoid delays in care or payment issues, please ensure you verify eligibility and benefits by phone prior to providing services.
- We are actively working to improve this process and close the gap in portal access for FEP benefit details.

Blue KC Continues to Cover the COVID-19 and RSV Vaccines

We want to make sure providers know Blue KC's coverage policies for vaccines, including the COVID-19 and RSV vaccines.

Blue KC is committed to ensuring access to vaccines that protect individuals and communities from serious illness. The decision to receive a vaccine is made between patients and their healthcare providers, and we remain committed to maintaining rigorous, evidence-based processes to evaluate coverage policies.

Blue KC will continue covering all immunizations that were recommended by the Advisory Committee on Immunization Practices (ACIP) on January 1, 2025, with no cost-sharing through 2026, while operating within federal and state laws and meeting program and customer requirements.

For the COVID-19 Vaccine:

- Blue KC's coverage of the COVID-19 vaccine will not change through 2026. The vaccine is available to most Blue KC members for $0 at in-network providers.
- View our COVID 19 Billing and Coding Payment Policy.

For the RSV Vaccine:

- Blue KC's coverage of the RSV vaccine will also not change through 2026. The vaccine is available to most Blue KC members who meet the recommendations for $0 at in-network providers.

- Please note that the CDC now recommends adults ages 50-74 who are at increased risk of severe RSV disease get an RSV vaccine, which is a change from previous guidance that only included those 60 and older.

Flu Vaccine Awareness for High-Risk Members

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/m^2 or higher**
- Adults 65 years and older

Learn more about the flu by clicking **here**.

New Blue KC High-Risk Diagnoses Audits

- The Blue KC Risk Adjustment Department has developed a new program to provide education to our providers.
- Blue KC began audits based on high-risk diagnosis codes that were submitted on claim(s) and impact the ACA QHP for Individual/Family and Small Group ACA lines of business.
- The audit will focus on high-risk diagnosis codes, such as Cancer, Myocardial Infarction, Ventilation Dependence, Pulmonary Embolism and Deep Vein Thrombosis.
- Once the audit process is complete, Blue KC will send educational information to the provider's office.
- Please share the educational information with your providers and coding department for a comprehensive reflection of your patient's disease burden.

Coding Guidance for Preoperative Evaluations and Follow-Up Encounters

Blue KC is reiterating coding guidance from the 2025 ICD-10 Manual with regards to preoperative evaluations and follow-up encounters. The contents of the article can be found in their entirety in the 2025 ICD-10 Manual Chapter 21: Section 8 Follow Up Codes and Section 12 Routine and Administrative Examinations, along with additional guidance in the ICD-10 Manual.

For patients receiving preoperative evaluations only:

- Sequence first a code from subcategory Z01.81, Encounter for pre-procedural examinations, to describe the pre-op consultations.
- Assign a code for the condition to describe the reason for the surgery as an additional diagnosis.
- Code also any findings related to the pre-op evaluation. These codes include:
    - Z01.810-Encounter for preprocedural cardiovascular examination
    - Z01.811-Encounter for preprocedural respiratory examination
    - Z01.812-Encounter for preprocedural laboratory examination
    - Z01.818-Encounter for other preprocedural examination

The follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury.

- They imply that the condition has been fully treated and no longer exists.
- They should not be confused with aftercare codes or injury codes with a 7th character for subsequent encounter that explain ongoing care of a healing condition or its sequelae.
- Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment.
- The follow-up code is sequenced first, followed by the history code.
- A follow-up code may be used to explain multiple visits. Should a condition be found to have recurred on the follow-up visit, then the diagnosis code for the condition should be assigned in place of the follow-up code.
- The follow-up Z codes/categories are:
    - Z08 Encounter for follow-up examination after completed treatment for malignant neoplasm
    - Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

Codes Z08-Encounter for follow-up examination after completed treatment for malignant neoplasm, and Z09-Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm may be assigned following any type of completed treatment modality (including both medical and surgical treatments).

Source: 2025 ICD-10 Manual Chapter 21: Section 8 Follow-up Codes and Section 12 Routine and Administrative Examinations

Centers for Medicare & Medicaid Services' Guidelines for Appointment Wait Time Standards

Ensure timely access to medical care for our members by following CMS guidelines for Qualified Health Plan (QHP) appointment wait time standards for routine primary care, non-urgent specialty care and behavioral health.

- **In accordance with CMS guidelines as of January 1, 2025**, please ensure that our members can schedule an appointment within the time frames listed below at least 90% of the time:

Provider Specialty Type	Appointments Must Be Available Within
Primary Care (Routine)	15 business days
Specialty Care (Non-urgent)	30 business days
Behavioral Health	10 business days

- While CMS applies these wait time standards to QHPs, Blue KC generally evaluates the same wait time standards across all of our lines of business.

Eligibility and Claim Status Inquiry Guidelines – Helpful Reminders and Hints

To ensure that providers receive timely responses to eligibility and claim status inquiries utilizing the 27x process, we kindly ask that you follow these guidelines:

270 – Eligibility and Benefits Requests

- Eligibility & Benefit requests should only be submitted for members with scheduled services based on the applicable service type code.
- Requests should not be submitted for your full patient load or for all available service types.
- A minimum of 30 seconds should be allowed prior to resubmitting a request.

- Member data should be validated using the member ID card prior to submission to ensure the request is accurate and to avoid rejections.

276 – Claim Status Requests

- Claim Status requests should not be submitted until a claim has aged a minimum of 7 days.
- Refer to the claim acknowledgment provided by the corresponding electronic claim submission to confirm acceptance prior to submitting a claim status request.
- Claim Status requests must be submitted under the appropriate billing provider NPI to receive a response.

If you have any questions, please don't hesitate to contact your Blue KC Provider Account Executive or the ASK-EDI help desk by phone or email at 1(800) 472-6481 or askedi@ask-edi.com.

Blue KC Care Management Team – A partner in health

The Blue KC Care Management Team includes clinical nurses, social workers and Community Health Workers. They can help your patients navigate cancer, offer resources for a healthy pregnancy, manage chronic health conditions, offer support and encouragement after a diagnosis, provide assistance with transitions of care, assist patients in achieving their wellness goals and answer questions about benefits. The team personalizes a plan based on each patient's unique care needs.

The Care Management Team continuously monitors a dashboard, which surfaces insights about preventive health needs, such as flu shots or annual eye exams, and flags patient survey responses related to their health, wellness and nutrition. Our team then works with your patients to schedule care and navigate resources.

One of the best ways to connect with the Care Management Team is through the Blue KC Care Management app. With this health resource, users can also view articles and videos personalized to them, set appointment and medication reminders, and access exclusive perks from local and national brands, including offers on groceries, health and wellness, and more.

You can encourage patients to download the Blue KC Care Management App from the App Store or Google Play. They should use access code **kcnews** when prompted. They can also learn more about the Blue KC Care Management app and Care Team on this page. For more information about case management services or to make a referral, call the Management Referral Line at 816-395-2060 or 1-866-859-3811.

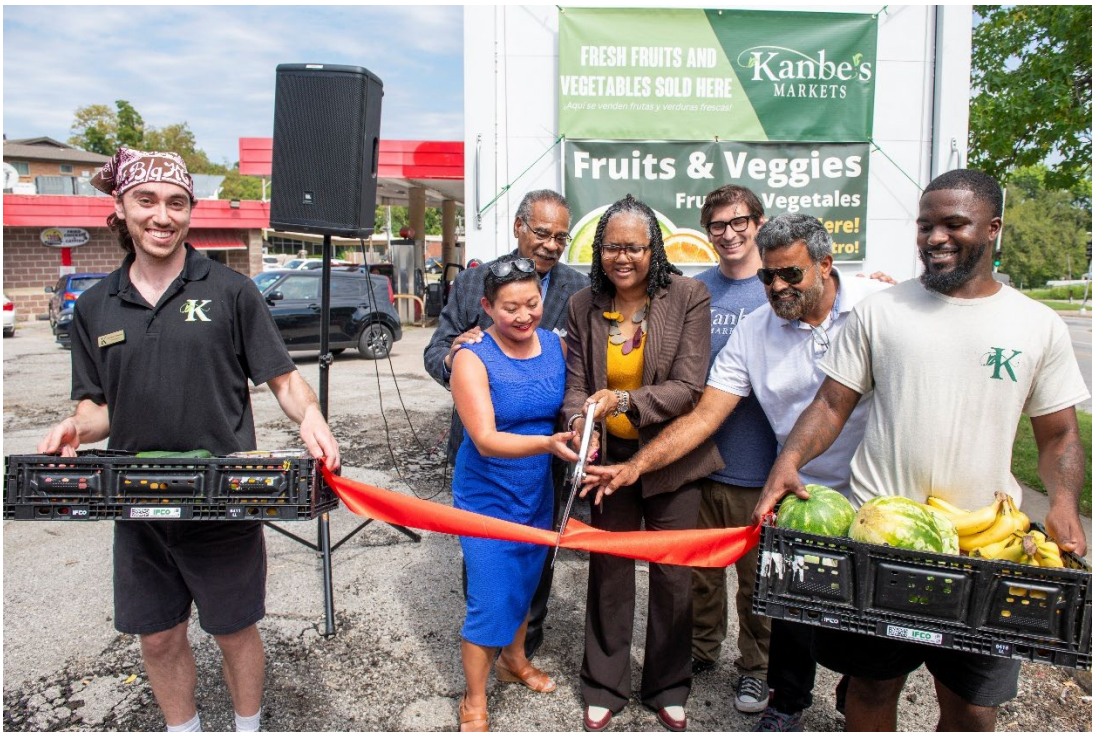
October Free Documentation & Coding Webinar

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 October webinar, click here for details:

October 28 & 30 7:30 a.m. & 11:30 a.m. CT	Arm Yourself: Battling Through Coding and Documentation for Cancer	Join us as we discuss skills necessary to overcome the challenges of correctly documenting and coding the most common Cancers and Hematological Conditions.

Community Investment

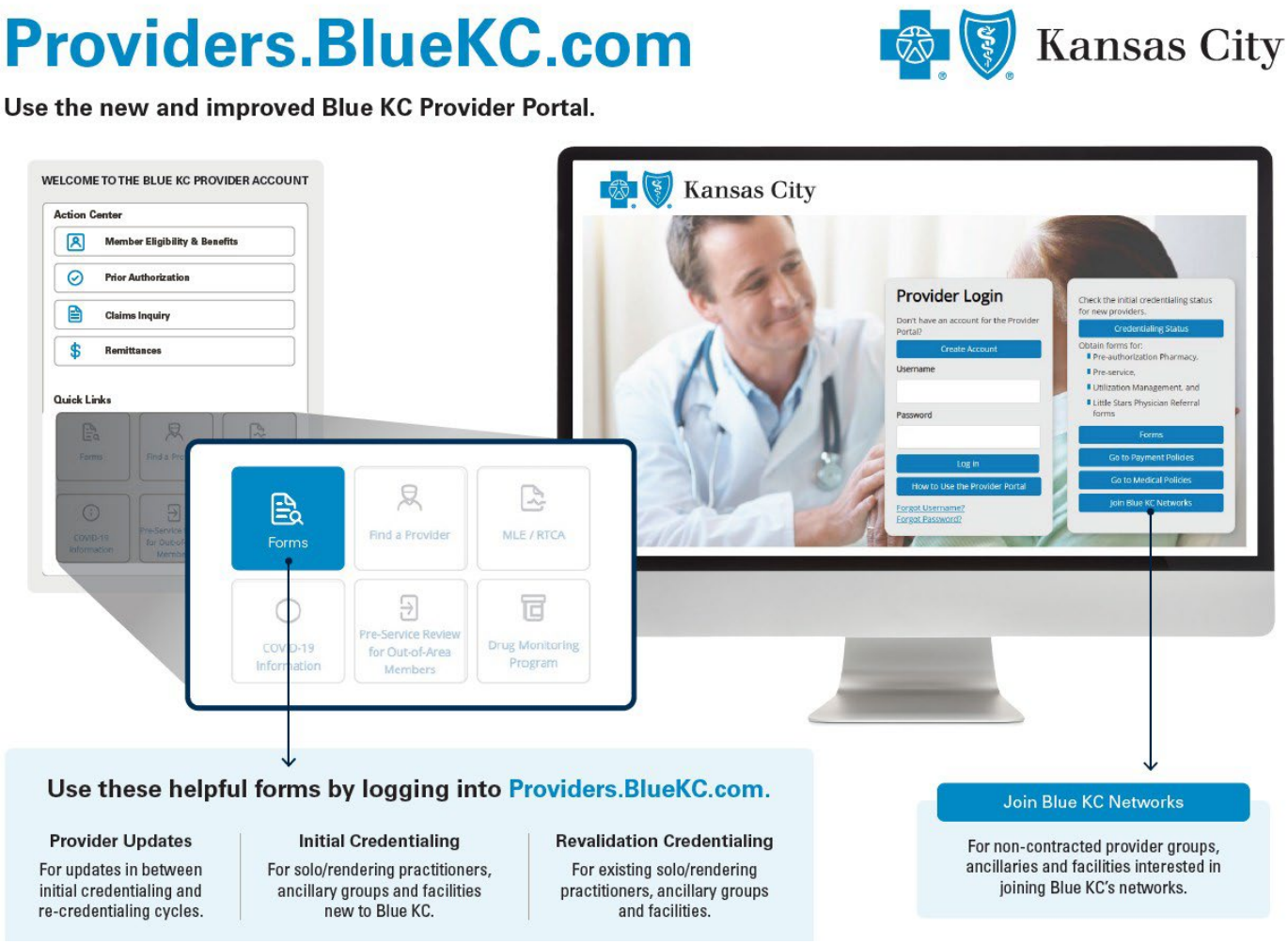
Blue KC, Kanbe's Celebrate Milestone of Access to Affordable Produce



From one pilot location in 2016 to 100 locations in 2025, Kanbe's Markets reached the century mark milestone with its Fresh Food Access Partners program that brings fruits and vegetables to neighborhood stores, thanks in part to local partners like Blue KC. As one of Kanbe's original partners, Blue KC funded the first location for Kanbe's Fresh Food Access partners program and recently funded their 100th location inside Food Express at 3740 E. Gregory Blvd., Kansas City, Mo.

To learn more about Blue KC's partnership with Kanbe's, click here. For additional information about Kanbe's, visit kanbesmarkets.org.

Helpful Forms on Provider Portal



Contact Us

Please join the BlueSpeak email distribution list by sending a request to BlueSpeak@BlueKC.com. You can also use this email address to give us any feedback about BlueSpeak. We would love to hear from you!

If you have questions about any of these updates, please call the Blue KC Provider Hotline at 816-395-3929 for Commercial line of business, 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.