Provider Reference Guide

Release Date: January 30, 2026

Kansas City

Provider Reference Guide

Each section is a clickable link.

Introduction

Blue Cross and Blue Shield of Kansas City's ("Blue KC") Provider Manual ("Manual") provides important information on Blue KC policies, procedures and administrative requirements.

Who This Guide Applies To

The information in this Guide applies to all entities and individuals that have executed an agreement with Blue KC and/or its affiliated health plans or delegates to participate in one or more Blue KC networks as an in-network provider (your "Agreement").

This includes, but is not limited to, facilities, hospitals, physicians and health care professionals, as well as ancillary, behavioral health and dental providers ("Contracted Providers").

How to Use This Guide

Please familiarize yourself with the contents of this Guide and keep the current version readily available as a reference.

Questions?

Visit the **Contact Us** page on the **Blue KC Provider Portal** for the most current contract options. For account-specific needs, you may also reach out to your **Provider Account Executive**.

Contractual Obligation

The contents of this Guide are contractually binding based on your Agreement(s) with Blue KC. Contracted Providers must follow all applicable Blue KC policies and procedures, as well as the applicable Member's Benefit Plan. Contracted Providers agree to communicate applicable requirements to their employees, agents and representatives.

Subcontractors

You are responsible for ensuring that any subcontractors, to the extent subcontractors are authorized under your agreement, comply with your Blue KC Agreement and all policies, procedures and administrative requirements, including, but not limited to this Guide, as well as all applicable federal and state statutes, laws, and regulations.

Conflicts With Your Agreement

If there is any conflict between language in this Guide and your Agreement, the Agreement controls. To the extent that this Guide supplements or clarifies the terms of the Agreement, this is not a conflict and both documents apply.

Updates

This Guide is subject to change and may be updated at any time. Deletions and additions are published periodically. If there is a material change to this Guide, Blue KC will make reasonable efforts to notify you in advance through **Provider Portal** notifications, our provider bulletins and newsletters, or email communications. **Always refer to the Provider Portal for the most current version.** The current published version supersedes all prior versions.

Important Disclaimer

This Guide is not intended to be a complete catalog of all Blue KC policies and procedures. Other policies and procedures not included in this Guide may be posted on the **Provider Portal** or communicated through targeted communications (e.g., bulletins and newsletters). **This Guide does not contain legal, tax or medical advice.** You should consult your professional advisors on those topics.

Accessing Policies

All provider policies and procedures are housed on the Blue KC Provider Portal. In addition to this Guide, you'll find links to:

- **Medical Policies**
- **BlueCard Medical Policies**
- **Payment/Reimbursement Policies**
- Other plan specific administrative guidelines, including behavioral health (Lucet).

BlueCard Program

BlueCard® is a national program that enables members of one BCBS Plan to obtain healthcare service benefits while traveling or living in another BCBS Plan's service area. The program links participating healthcare providers with the independent BCBS Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you submit claims for patients from other BCBS Plans, domestic and international, to Blue Cross and Blue Shield of Kansas City. Blue Cross and Blue Shield is your sole contact for claims payment, adjustments and issue resolution.

For information and guidance on the BlueCard Program, reference **The BlueCard Program Provider Manual**. Where applicable, the Blue KC Manual may summarize and link to the The BlueCard Program Provider Manual to promote consistency and currency. Always consult the current BlueCard Program Provider Manual on the **Provider Portal** for BlueCard specific processes and requirements.

Additional Resources

Our Provider Portal also includes resources such as:

- Benefit & Eligibility Verification
- Prior Authorization
- Claims Inquiry
- Clinical Guidelines
- Prescription Drug List (PDL)
- CAQH Quick Reference Guide
- Additional tools, forms and operational resources

Advertising Policy

With **prior approval** from Blue KC, Contracted Providers may mention their **Blue KC network affiliation(s)** in electronic or print advertising or promotional materials (e.g., websites, brochures, and directories).

- **Required approval:** all materials that reference Blue KC network affiliation must be reviewed and approved by Blue KC Corporate Communications before distribution or publication.
- **Symbols:** you are not permitted to use the Blue Cross or Blue Shield "cross and shield" symbols at any time.
- **How to Submit:** submit intent for use, along with all proposed copy and designs, for review and approval to your provider account executive who will route your request to Corporate Communications for review.

Tip: To avoid delays, include final copy, placements, audience, and distribution dates with your request. Blue KC may require revisions to ensure brand and license compliance.

Administrative

Member Rights and Responsibilities

The delivery of quality health care requires cooperation between members, their providers and facilities and their health care benefit plans. One of the first steps is for members, providers and facilities to understand member rights and responsibilities. Therefore, Blue KC has adopted a Members' Rights and Responsibilities statement, which can be accessed by going to the Blue KC website.

Member Rights

Blue KC members have certain rights and responsibilities, as outlined below.

- Receive considerate and courteous care with respect and recognition of personal privacy, dignity and confidentiality.
- Have a candid discussion of medically necessary and appropriate treatment options or services for member's condition from any Contracted Provider, regardless of cost or benefit.
- Receive medically necessary and appropriate care or services from any Contracted Provider listed in a member's managed care plan Directory or from any non-Contracted Provider or other healthcare provider.
- Receive information and diagnosis in clear and understandable terms and ask questions to ensure members understand what they are told by providers and other medical personnel.
- Participate with providers in making healthcare decisions, including accepting and refusing medical or surgical treatments.
- Give informed consent to treatment and make advance treatment directives, including the right to name a surrogate decision maker in the event members cannot participate in decision making.
- Discuss medical records with providers and expect that health records are kept confidential, except when disclosure is permitted by law consistent with our Notice of Privacy Practices.
- Be provided with information about a member's managed healthcare plan, its services and providers providing care, as well as have the opportunity to make recommendations about the rights and responsibilities of members.
- Communicate any concerns with a member's managed healthcare plan, regarding care or services, receive an answer to those concerns within a reasonable time and initiate the complaint and grievance procedure if members are not satisfied.
- Respect the dignity of other members and those who provide care and services through their managed healthcare plan.
- Ask questions about a treatment or health care service until members fully understand the care they are receiving and participate in developing mutually agreed upon treatment goals to the degree possible.

Member Responsibilities

- Follow the mutually agreed upon plans and instructions for care that members have discussed with their healthcare providers, including those regarding medications. Comply with all treatment follow-up plans and be aware of the medical consequences of not following instructions.
- Communicate openly and honestly with their treatment provider regarding a member's medical history, health conditions and care.
- Keep all scheduled healthcare appointments and provide advance notification to the appropriate provider if it is necessary to cancel an appointment.
- Know how to properly use the services from managed healthcare.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

Blue KC Plans & Networks

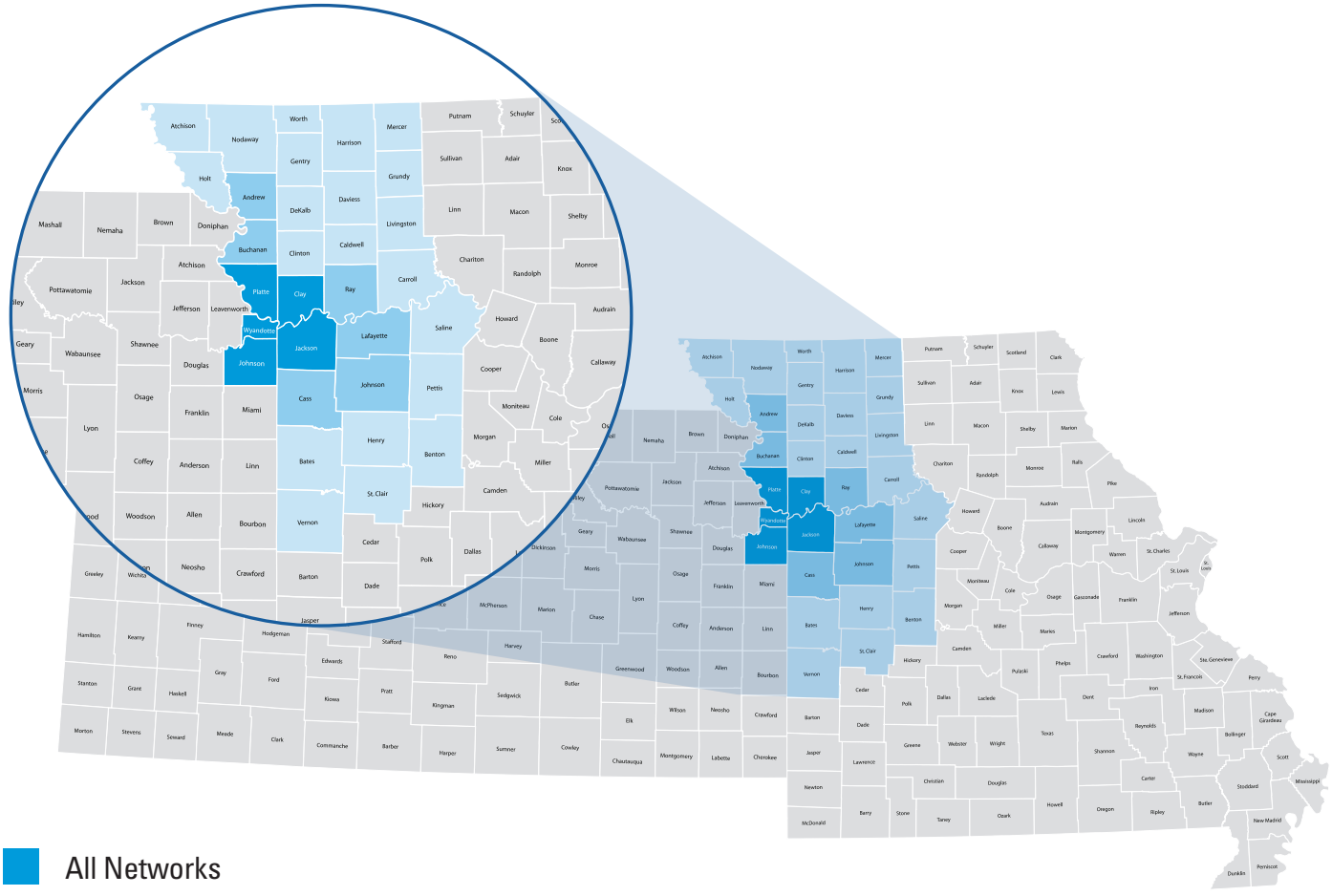
Counties Served

Kansas Counties

Johnson and Wyandotte

Missouri Counties

Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon and Worth



All Networks

Blue-Care, Preferred-Care, Preferred-Care Blue®, PHP/Freedom and Blue Access

Preferred-Care, Preferred-Care Blue®, PHP/Freedom and Blue Access

Service Area Table for Blue KC Networks

Commercial Service Area		
	Kansas	**Missouri**
Blue Access	Johnson and Wyandotte	Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, Saline, St. Clair, Vernon, and Worth
Blue-Care	Johnson and Wyandotte	Andrew, Buchanan, Cass, Clay, Jackson, Johnson, Lafayette, Platte, and Ray
BlueSelect Plus	Johnson and Wyandotte	Caldwell, Cass, Clay, Clinton, Dekalb, Jackson, Johnson, Lafayette, Platte, and Ray
High Performance Network	Johnson and Wyandotte	Clay, Jackson, and Platte
PHP/FREEDOM	Johnson and Wyandotte	Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, Saline, St. Clair, Vernon, and Worth
Preferred-Care	Johnson and Wyandotte	Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, Saline, St. Clair, Vernon, and Worth
Preferred-Care Blue	Johnson and Wyandotte	Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, Saline, St. Clair, Vernon, and Worth
ACA Service Area		
Blue Metro	Johnson and Wyandotte	Jackson
Blue Select	Johnson and Wyandotte	Clay, Jackson, Johnson, Lafayette, Platte, Ray
Blue Select Plus	Johnson and Wyandotte	Caldwell, Cass, Clay, Clinton, DeKalb, Jackson, Johnson, Lafayette, Platte, Ray
Preferred-Care Blue	Johnson and Wyandotte	Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, Saline, St. Clair, Vernon, and Worth

BlueAccess is a limited network that may or may not have any providers in the Blue KC counties. Network design is based on business and member needs.

Member Identification and Verification of Eligibility

Before any services are rendered, Contracted Provider must conduct a member verification under each benefit plan. Once verification is in place, Contracted Provider shall provide timely accessibility to members.

An individual's possession of a membership ID card is not a guarantee of eligibility or benefits. Always verify eligibility and benefits in advance of providing (non-urgent or non-emergent) services. Always verify another form of legal photo identification, such as a driver's license, passport or other government issued ID, to help prevent identity theft.

Member eligibility and benefits can be verified:

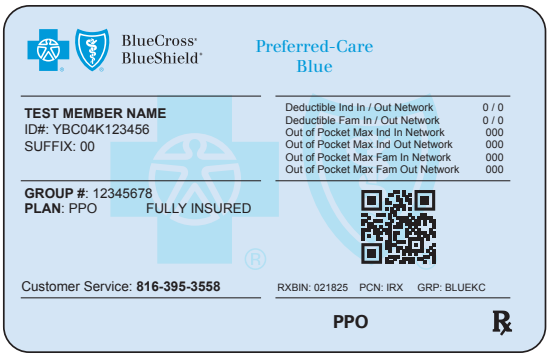
- Online at **Providers.BlueKC.com**
- By calling our **Provider Hotline** (see **Contact Resource Directory**)
  - Providers calling customer service must be able to verify their identity as well as the patient's identity:
    - Inquirer's name
    - Inquirer's telephone number
    - Provider Blue KC number or Tax ID number
    - Provider name
    - Member's Blue KC ID number or social security number

PPO, HMO and EPO Defined

A Contracted Provider's payment rate and related requirements within a network may vary based on whether the member's plan is a PPO, HMO, or EPO. All members participating in an HMO product must select a Primary Care Provider (PCP). PCP referrals are not required within the commercial HMO network. Members participating in a PPO or EPO are not required to select a PCP.

Preferred Provider Organization	Health Maintenance Organization	Exclusive Provider Organization
PPO Networks	**HMO Networks**	**EPO Networks**
Blue Access Commercial Blue Select Plus Preferred Care Commercial Preferred Care Blue	Blue Care	Blue Access Blue High Performance Network Blue Metro Commercial and ACA Blue Select Commercial and ACA Blue Select Plus Commercial and ACA Preferred Care Blue

Examples of Member Cards


BlueCross BlueShield
Preferred-Care Blue

TEST MEMBER NAME
ID#: YBC04K123456
SUFFIX: 00

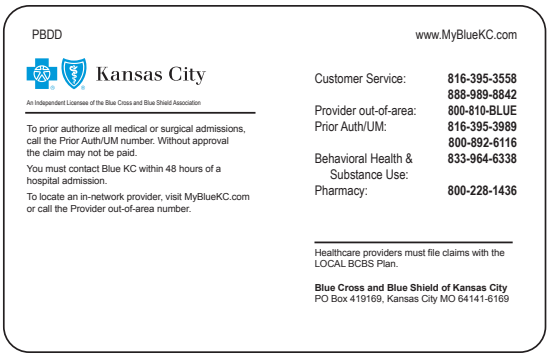
GROUP #: 12345678
PLAN: PPO FULLY INSURED

Customer Service: **816-395-3558**

Deductible Ind In / Out Network	0 / 0
Deductible Fam In / Out Network	0 / 0
Out of Pocket Max Ind In Network	000
Out of Pocket Max Ind Out Network	000
Out of Pocket Max Fam In Network	000
Out of Pocket Max Fam Out Network	000

RXBIN: 021825 PCN: IRX GRP: BLUEKC

PPO


PBDD

www.MyBlueKC.com

Kansas City
An Independent Licensee of the Blue Cross and Blue Shield Association

To prior authorize all medical or surgical admissions, call the Prior Auth/UM number. Without approval the claim may not be paid.

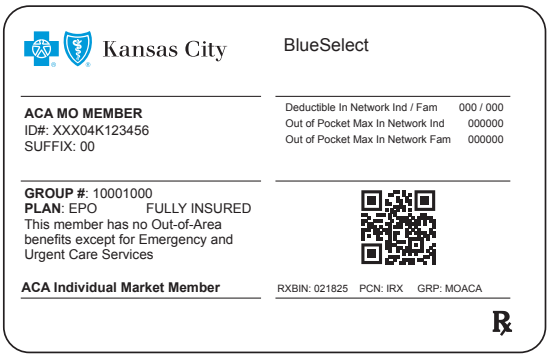
You must contact Blue KC within 48 hours of a hospital admission.

To locate an in-network provider, visit MyBlueKC.com or call the Provider out-of-area number.

Customer Service:	**816-395-3558** **888-989-8842**
Provider out-of-area:	**800-810-BLUE**
Prior Auth/UM:	**816-395-3989** **800-892-6116**
Behavioral Health & Substance Use:	**833-964-6338**
Pharmacy:	**800-228-1436**

Healthcare providers must file claims with the LOCAL BCBS Plan.

Blue Cross and Blue Shield of Kansas City
PO Box 419169, Kansas City MO 64141-6169


Kansas City
BlueSelect

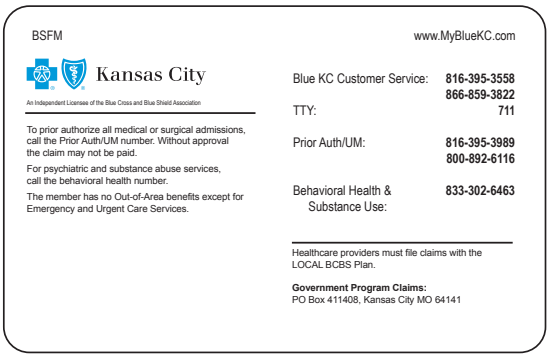
ACA MO MEMBER
ID#: XXX04K123456
SUFFIX: 00

GROUP #: 10001000
PLAN: EPO FULLY INSURED
This member has no Out-of-Area benefits except for Emergency and Urgent Care Services

ACA Individual Market Member

Deductible In Network Ind / Fam	000 / 000
Out of Pocket Max In Network Ind	000000
Out of Pocket Max In Network Fam	000000

RXBIN: 021825 PCN: IRX GRP: MOACA


BSFM

www.MyBlueKC.com

Kansas City
An Independent Licensee of the Blue Cross and Blue Shield Association

To prior authorize all medical or surgical admissions, call the Prior Auth/UM number. Without approval the claim may not be paid.

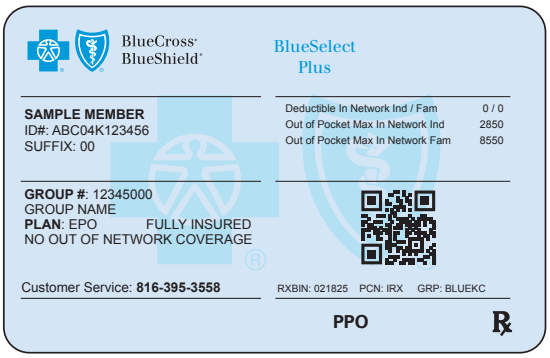
For psychiatric and substance abuse services, call the behavioral health number.

The member has no Out-of-Area benefits except for Emergency and Urgent Care Services.

Blue KC Customer Service:	**816-395-3558** **866-859-3822**
TTY:	**711**
Prior Auth/UM:	**816-395-3989** **800-892-6116**
Behavioral Health & Substance Use:	**833-302-6463**

Healthcare providers must file claims with the LOCAL BCBS Plan.

Government Program Claims:
PO Box 411408, Kansas City MO 64141


BlueCross BlueShield
BlueSelect Plus

SAMPLE MEMBER
ID#: ABC04K123456
SUFFIX: 00

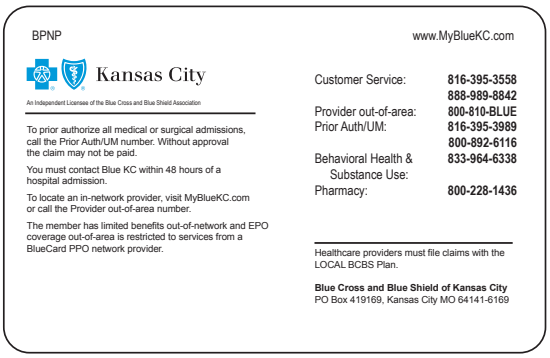
GROUP #: 12345000
GROUP NAME
PLAN: EPO FULLY INSURED
NO OUT OF NETWORK COVERAGE

Customer Service: **816-395-3558**

Deductible In Network Ind / Fam	0 / 0
Out of Pocket Max In Network Ind	2850
Out of Pocket Max In Network Fam	8550

RXBIN: 021825 PCN: IRX GRP: BLUEKC

PPO


BPNP

www.MyBlueKC.com

Kansas City
An Independent Licensee of the Blue Cross and Blue Shield Association

To prior authorize all medical or surgical admissions, call the Prior Auth/UM number. Without approval the claim may not be paid.

You must contact Blue KC within 48 hours of a hospital admission.

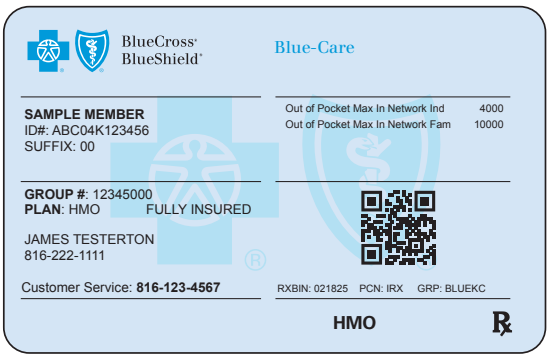
To locate an in-network provider, visit MyBlueKC.com or call the Provider out-of-area number.

The member has limited benefits out-of-network and EPO coverage out-of-area is restricted to services from a BlueCard PPO network provider.

Customer Service:	**816-395-3558** **888-989-8842**
Provider out-of-area:	**800-810-BLUE**
Prior Auth/UM:	**816-395-3989** **800-892-6116**
Behavioral Health & Substance Use:	**833-964-6338**
Pharmacy:	**800-228-1436**

Healthcare providers must file claims with the LOCAL BCBS Plan.

Blue Cross and Blue Shield of Kansas City
PO Box 419169, Kansas City MO 64141-6169


BlueCross BlueShield
Blue-Care

SAMPLE MEMBER
ID#: ABC04K123456
SUFFIX: 00

GROUP #: 12345000
PLAN: HMO FULLY INSURED

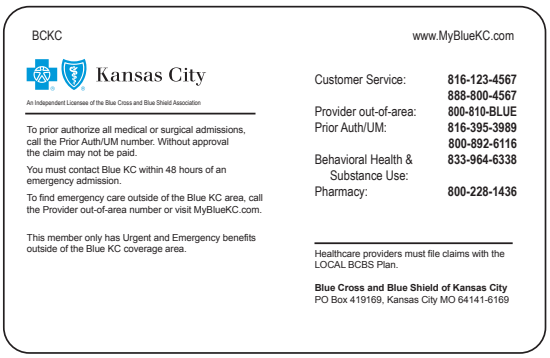
JAMES TESTERTON
816-222-1111

Customer Service: **816-123-4567**

Out of Pocket Max In Network Ind	4000
Out of Pocket Max In Network Fam	10000

RXBIN: 021825 PCN: IRX GRP: BLUEKC

HMO


BCKC

www.MyBlueKC.com

Kansas City
An Independent Licensee of the Blue Cross and Blue Shield Association

To prior authorize all medical or surgical admissions, call the Prior Auth/UM number. Without approval the claim may not be paid.

You must contact Blue KC within 48 hours of an emergency admission.

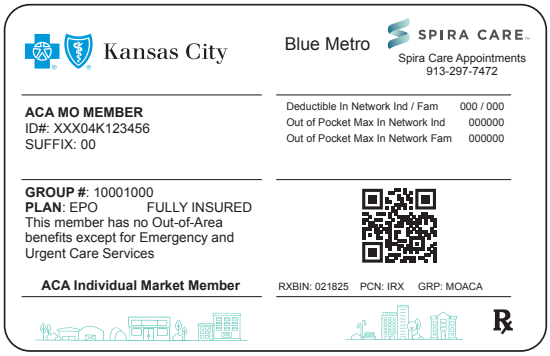
To find emergency care outside of the Blue KC area, call the Provider out-of-area number or visit MyBlueKC.com.

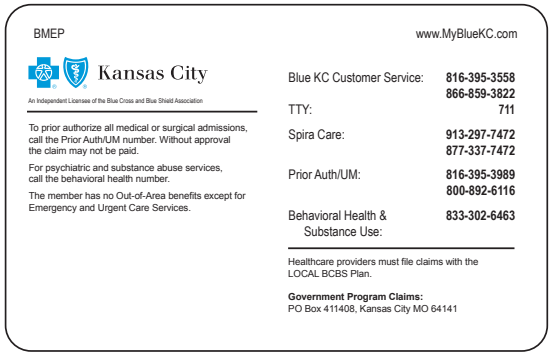
This member only has Urgent and Emergency benefits outside of the Blue KC coverage area.

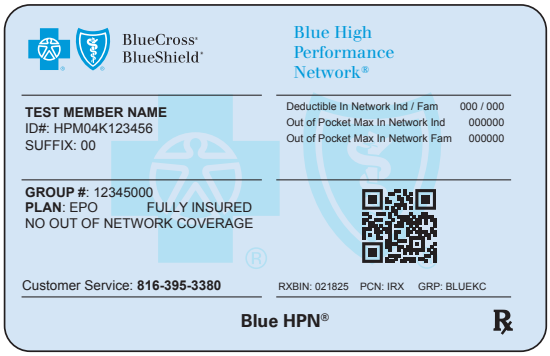
Customer Service:	**816-123-4567** **888-800-4567**
Provider out-of-area:	**800-810-BLUE**
Prior Auth/UM:	**816-395-3989** **800-892-6116**
Behavioral Health & Substance Use:	**833-964-6338**
Pharmacy:	**800-228-1436**

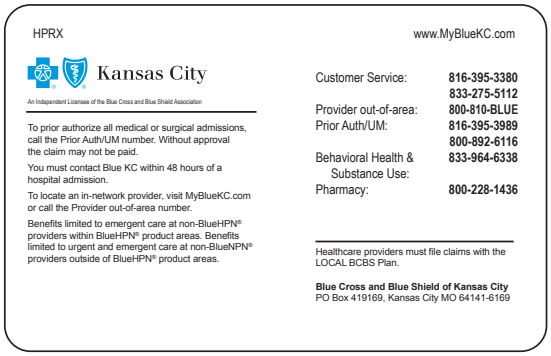
Healthcare providers must file claims with the LOCAL BCBS Plan.

Blue Cross and Blue Shield of Kansas City
PO Box 419169, Kansas City MO 64141-6169









Contracting & Credentialing

Network Interest

Providers interested in participating in the Blue KC Network need to take the following steps:

1. Register at the Council for Affordable Quality Healthcare (CAQH) website (see **Contact Resource Directory** for website). Please authorize Blue KC access to the providers' online credentialing information.
2. Ensure the provider's information is updated in the **National Plan & Provider Enumeration System** (NPPES).
3. If the provider is registered with CMS, ensure the provider information is updated in the **Medicare Provider Enrollment, Chain and Ownership System** (PECOS).
4. Submit Blue KC's Network Interest Form on the **Provider Portal** located here under the **Joining the Blue KC Network** section.
    i. Current Contracted Providers interested in adding networks should select **Current Providers Request** to **Add Network** button.

Blue KC's Network Interest Committee will evaluate the Network Interest Form and determine if there is a network need for the provider and if there is a need, a Credentialing form will be forwarded to the provider.

Credentialing

Credentialing is the initial verification that a provider's credentials meet the criteria established by Blue KC for education, training, licensure and experience. Blue KC performs credentialing on all Contracted Providers, unless delegated. Blue KC will not process credentialing applications older than 120 days.

Minimum Criteria for Credentialing

	Individual Licensed Health Care Practitioners	Licensed Health Care Facilities, Facility and Ancillary Providers
Initial Credentialing Application		X
W-9 Tax Form		X
Council for Affordable Quality Healthcare (CAQH) Current CAQH attestation within 60 days of credentialing/ recredentialing request	X	
Kansas State License	X	X
Missouri State License	X	X
CMS Medicare Certification		X
State Site Survey		X
Accreditation Certificate Ex. - JCAHO		X
Provider Transaction Access Number (PTAN)		X
Clinical Laboratory Improvement Amendments (CLIA)		X
DEA Certificate Exception for midlevel providers	X	
Bureau of Narcotics and Dangerous Drugs Certificate (BNDD) Missouri ONLY	X	
Medical School, Internship, Residency Physician ONLY	X	
Admitting Privileges at a Blue KC Participating Facility – or arrangements within practice, with hospitalists MD/DO ONLY	X	
Malpractice Insurance Providers must maintain professional liability insurance with minimum coverage limits of $1 million per claim with an aggregate limit of $3 million and in addition, providers must comply with any state insurance coverage requirements where the practice is located.	X	X
Advanced Practice Providers must include an In-Network Blue KC Provider as their Collaborating/Supervising Physician and submit a copy of the Collaboration Agreement. Missouri ONLY	X	
National Plan and Provider Enumeration System (NPPES) Providers' NPI must be registered with the matching taxonomy/ specialty as the licensure supports	X	X
Board Certification	**As Applicable	

- Laboratories, Durable Medical Equipment, Physical Therapists; Home Health Agencies; must provide at initial enrollment and recredentialing a "CMS Approval Letter" with a PTAN Number. The letter must reflect the current practice location and name must match as it appears on W-9 and NPPES.
- Groups in general should have at least one Affiliated Provider rendering services through the group.
- Physical therapy group providers must have NPIs that are site specific; and must have at least one Affiliated Provider at the site-specific location.
- CMS Facility Survey
- Certificate of Need for new facilities in Missouri

Attestation

Each Contracted Provider or Applicant to be a Contracted Provider is responsible for ensuring that all information required for credentialing is accurate and complete. Falsification, misrepresentation, or omission of information during the credentialing process may be grounds to reject or deny the credentialing application. As a part of the Council for Affordable Quality Healthcare (CAQH) registration process, the applicant is required to sign and date an attestation/authorization verifying the correctness and completeness of the application and indicating authorization for primary source verification.

The standard application includes a statement by the practitioner regarding the following:

- Any inability to perform the essential functions of the position
- Lack of impairment due to chemical dependency and/or substance abuse
- History of loss of license and /or felony convictions
- History of loss or limitation of privileges or disciplinary activity
- Current malpractice insurance coverage. Applicants must maintain professional liability insurance with minimum coverage limits of $1 million per claim with an aggregate limit of $3 million and in addition, Applicants must comply with any state insurance coverage requirements where the Contracted Provider is located.

Application Review

The Blue KC Credentialing department will make a reasonable effort to complete primary source verification within 45 to 60 days of receiving a completed/clean application (no missing data elements, attachments, or attestations) from the provider. The credentialing department may request additional information or supplemental documentation from a provider where necessary to evaluate inconsistent or adverse information in the provider's record.

In addition to the minimum criteria, credentialing department and Credentialing Committee will consider other factors relevant to the provider's qualification for inclusion in the network, including, but not limited to:

- History of professional liability claims
- Medicare/Medicaid sanction activity
- Sanctions or limitations on licensure
- Criminal history

- Past 5 years of work history with verification of gaps greater than 6 months (include month and year) (practitioners only).
- National Practitioner Data Bank query.
- Accreditation Certificate (facility only).
- State survey completed within the past 36 months (facility only).
- Sanctions or limitations on licensure from either a state board, hospital, or other network

A provider has the right to review information obtained by Blue KC to evaluate his/her credentialing application. This review may include information from any outside primary source (for example, malpractice insurance carriers or state-licensing boards). The provider has the right to correct erroneous information and, upon request, to be informed of the status of the credentialing or recredentialing application.

Corporate Credentials Committee

Completed applications are presented to the Blue KC Corporate Credentials Committee for review and final approval. The Corporate Credentials Committee meets on a monthly basis and as needed. Please contact the appropriate Account Executives (see **Contact Resource Directory**) for more information.

Credentials must be valid at the time of the Corporate Credentials Committee review and must be verified within the 180-day time limit. An applicant shall be evaluated in accordance with the process and criteria established by the Blue KC Corporate Credentials Committee. The Blue KC Corporate Credentials Committee is responsible for establishing the corporate credentialing Policies and Procedures and for initial credentialing and recredentialing decisions. These govern Contracted Provider participation in the networks and all subsidiaries and affiliates. Policies and Procedures are reviewed at least annually and revised and approved as needed. Such reviews or revisions are reported to the appropriate governing bodies.

Notification of Decision

Providers applying for initial credentialing will be notified by letter within 10 business days from the Corporate Credentials Committee's decision that their application has either been approved or denied. If approved, the provider may be offered Blue KC contracts for network participation as described in the Contracting section below. If the application is denied, the notification will include explanation of the reason for denial and any appeal rights available to the provider.

Recredentialing

All Blue KC Contracted Providers are recredentialed at a minimum of every 3 years or more often as needed. The recredentialing process is initiated by Blue KC. Contracted Providers must keep their Council for Affordable Quality Healthcare (CAQH) application up-to-date and reconfirm that the information profile is correct. A Contracted Provider may also be subject to additional credentialing review in the event the Contracted Provider notifies Blue KC of a change to the Contracted Provider's information under the Contracting section of this Guide.

For Contracted Providers who are due for recredentialing but have not provided all required documentation, Blue KC will perform outreach to gather the missing information. If there is no response from the Contracted Provider, a letter will be sent notifying the Contracted Provider of missing information. If the issue is not resolved within 30 days, the Contracted Provider's credentialing will be automatically terminated and contracting will be notified to terminate the Agreement.

The recredentialing process assures that the Blue KC Corporate Credentials Committee has access to all pertinent information from quality improvement and risk management. The Contracted Provider's recredentialing application will be reviewed by the Credentialing department and Corporate Credentials Committee, including minimum criteria and provider qualifications, similar to the process for new applications discussed above.

Blue KC monitors performance of all Contracted Providers on an ongoing basis as described in the Quality Improvement section of this Guide. Quality Improvement is the process that oversees the process and outcomes of member services to ensure care is efficacious current and consistent with generally accepted medical practices.

In addition to the review process for new applications, the Corporate Credentials Committee will be given additional quality information for consideration including, but not limited to:

- Member complaints and grievances
- Performance in Blue KC quality programs

Based on the Corporate Credentialing Committee's review of the recredentialing application, a Contracted Provider may be approved, placed on a corrective action plan or revoked. The Contracted Provider is considered to be recredentialed unless otherwise notified in writing. The Contracted Provider will be notified of any adverse decision within 30 business days of such decision, including the reason for the adverse decision and any appeal rights available to the Contracted Provider.

Revocation of Credentials

In reviewing a provider's credentialing or recredentialing application or additional information received between credentialing cycles, the Blue KC Corporate Credentials Committee may conduct such investigation as it deems necessary to make a decision and to determine whether the Applicant or Contracted Provider is qualified for network participation, as described above.

If, at any time, the Corporate Credentials Committee receives information on a Contracted Provider which results in a determination by the Corporate Credentials Committee that the Contracted Provider no longer meets the criteria to participate in Blue KC networks, the Corporate Credentials Committee may recommend corrective action, up to and including revocation of the Contracted Provider's credentials. In the event of an adverse decision by the Corporate Credentials Committee, the Contracted Provider will be notified of the decision in writing within 30 business days. Notification to the Contracted Provider will include explanation of the reason for the revocation and information regarding any appeal rights the Contracted Provider may have. In addition to Contracted Provider notification, Blue KC may provide notifications to members of the modification to or termination of a Contracted Provider's network participation.

Delegation and NCQA Accreditation

Blue KC may delegate credentialing of individually licensed practitioners to a Contracted Provider through whom those practitioners are Affiliated Providers. Any such delegation will occur through a written Delegation Agreement.

Blue KC is accredited by the National Committee for Quality Healthcare (NCQA), a nationally recognized accrediting agency known for the emphasis on highest quality of health plan services and clinical care. NCQA provides systems of standards, validated clinical and preventive service measures, and requirements to evaluate the member experiences with Blue KC and provider network services. Where delegated credentialing is permitted, The Contracted Practitioner must perform all such credentialing and provide supporting documentation to Blue KC as necessary for compliance with NCQA standards.

Contracting

Initial Contract

If an Agreement is not already in place for Contracted Provider that has completed credentialing, then contracts may be emailed to the Contracted Provider after the credentialing application has been approved by the Corporate Credentials Committee. The effective date of the Agreement will be the credentialing effective date as long as Blue KC receives e-signed contracts from the Contracted Provider within 30 days. Terms of the Agreement shall begin on the effective date and extend for the initial term, which will then automatically renew for successive one-year terms, unless terminated by either party as provided in the Agreement.

Even though the Contracted Providers' effective date is the date on which the Contracted Provider's application is complete and the Contracted Provider meets all licensure and certification requirements, the Contracted Provider will need to verify the Contracted Provider setup is complete in the Blue KC system before filing claims. Otherwise, they will process as an out of-network until the setup is completed.

The enrollment and contracting process is specific to the Contracted Provider's tax identification number(s) (EIN), National Provider Identification Number(s) (NPI), location(s), and scope of service(s) in place at the time of contracting. If the Contracted Provider desires to make changes to the Contracted Provider's EIN, NPI, locations, or scope of services, the Contracted Provider must provide notification to Blue KC, below. Additional EINs, NPIs, locations, or services are not included in the Agreement until they are approved in writing by Blue KC.

Reporting or Requesting Changes

If a Contracted Provider desires to add a service(s), location(s), EIN(s), or NPI(s) to the Agreement, Blue KC must be contacted to negotiate an Amendment to the Agreement. Depending on the service, location, EIN, or NPI being added, additional credentialing and configuration may be required. Where a Contracted Provider provides the services of physicians, advanced practice providers, or other licensed professionals as ("Affiliated Providers") under the Agreement, changes to the Affiliated Providers may be made through roster updates or credentialing, as determined by the Agreement. If an Affiliated Provider is approved by the Corporate Credentialing Committee as well as Contracting and they will participate in all of the same networks as the Contracted Provider, the Affiliated Provider will be added to the Contracted Provider's Agreement with an effective date that coincides with the credentialing approval date.

For the term of the Agreement, Contracted Providers must hold all licensure and accreditations required by local, state or federal laws to conduct business and perform obligations within the Agreement. Contracted Providers shall cooperate and provide all credentialing requirements in a timely manner. Any changes to credentialing information or adverse action against the Contracted Provider or an Affiliated Provider (e.g. licensing investigation, loss of accreditation, etc.) must be reported to Blue KC. If Blue KC delegates credentialing to the credentialing provider, the above information shall be reported as specified in the Delegation Agreement. Upon receipt of changes to credentialing information, the Contracted Provider or Affiliated Provider may be subject to additional review by the Corporate Credentials Committee, Peer Review Committee, or other quality committees as applicable.

Directory Updates

Blue KC provider directory includes Contracted Provider and/or Affiliated Provider's name, NPI, taxonomy, specialty, education, practice address, and other information as needed. Contracted Providers authorize Blue KC to use names and other relevant, current information in the network **Provider Directory** and other marketing material. Providers

must inform Blue KC of any changes, (including but not limited to address changes or services added or removed, new locations) to directory information at least 45 days prior to change taking effect.

Contracted Providers must attest to accuracy of directory information every 90 days, consistent with Blue KC Policy and requirements under the Consolidated Appropriations Act. Failure to timely attest to directory information or provide updated directory information may result in the removal of the applicable Contracted Provider or Affiliated Provider from the directory. If Blue KC is fined or penalized for any Directory inaccuracies based on Contracted Provider's failure to timely report changes or attest to directory information, Contracted Provider shall reimburse Blue KC for such fines or penalties.

For a large volume of directory updates, it may be more convenient to utilize a roster to submit changes:

1. The roster template is available on the **Provider Portal** for download;
2. Submit rosters to **Provider_Documentation@BlueKC.com**. Upload the roster.

To submit low volume changes:

1. Go to the **Provider Portal** and fill out the **Provider Update** form and submit online.

Updating information through this directory process should be limited to changes in the directory within the scope of the services and locations noted in the Agreement. This process is not acceptable to make changes to the Agreement, which requires negotiation and amendment to be effective.

Termination

Contracted Providers may be terminated or non-renewed by the Contracted Provider or Blue KC as specified in the applicable Agreement. Grounds for termination or non-renewal may be immediate (e.g. lapse in credentialing, loss of license, exclusion from federal health care programs etc.), for cause (e.g. violation of a term of the Agreement), or without cause. Termination may be for the entire Agreement, participation in a particular network, or inclusion of specific Affiliated Provider(s). Where required by law, the Contracted Provider will be notified of the reason for termination and any applicable appeal rights. Notification may also be made by Blue KC to members who may be affected by the termination. The parties may have ongoing obligations post-termination of the Agreement, such as transition of care or access to records, as specified in the Agreement.

Blue KC Provider Portal

Providers with Internet access can quickly find answers to questions about members, providers and benefit plans by visiting Blue KC's **Provider Portal** at **Providers.BlueKC.com**.

Overview

Blue KC's Provider Portal gives access to:

- Key insurance functions such as member eligibility, Plan benefits and coverage, claim status and inquiry, remittance advice, prior authorization, medical and payment policies, provider communications and more.
- A link to the Blue KC **Provider Directory** is available to look up names, addresses, and telephone numbers of Blue KC Contracted Providers. Contracted Providers can also use our **Provider Directory** to verify the accuracy of their own contact information.

Contracted Providers can log-in or create an account at **Providers.BlueKC.com**. The Contracted Provider's Organizational Administrator has the responsibility of adding and managing the Contracted Provider's users with access to the portal. HIPAA requires that each user have their own username, password and email address, so login information should not be shared. After login, click on "Account" in the main navigation to update your profile or manage other users..

- Users must sign in once every 30 days or the password will expire. With regular usage, passwords will expire every 120 days. Contact your Organizational Administrator or call 816-395-3700 for a password reset.

Visit the **Provider Portal login page** or resources section and click on "**How to Use the Provider Portal**" for an overview of key features and helpful video tutorials.

Request Access

Follow these steps to request access to the Blue KC Provider Portal:

1. From **Providers.BlueKC.com** click "Create Account".
2. Select one of the following options:
    i. I am a provider
    ii. I am a medical billing group working on behalf of one of more Blue KC providers
3. Complete the form
4. Click "Register"
5. You will receive an email with your login information.

Login

Follow these steps to login:

1. Go to **Providers.BlueKC.com**.
2. Type Username and Password, then click LOGIN.

Navigating the Portal

After login, the Home page will be displayed. From the Home page, you can access frequently used portal features and view important notifications and recent news.

Use the main navigation menu across the top of the page to access portal features and resources:

Eligibility & Benefits	Claims	Prior Authorization	Resources	Medical Policies	Account

In the upper right, see Find a Doctor, Contact and the Log Off links.

Care Management

Care Management is defined as an integrated system that promotes cost-effective and appropriate interventions to improve the quality of health care services that are delivered to members. This enables Blue KC to achieve and monitor optimal outcomes in an equitable manner for all members across the network while managing care and cost.

Before any services are rendered, Contracted Providers must conduct a member verification under each benefit plan. The Blue KC staff verifies the member's eligibility or, if after business hours, will take the necessary information to verify eligibility the next business day. Answers to questions about specific benefits are available through **Providers.BlueKC.com** or the Provider Hotline during business hours. Once verification is complete, Contracted Provider shall provide timely accessibility of services to members.

Contracted Providers are responsible for providing clinically indicated medical care to members within the scope of the Contracted Provider's license. Nothing in the Agreement or this Guide is intended to prevent a Contracted Provider from recommending a treatment or service that the Contracted Provider believes is indicated for a member. However, recommendation by a Contracted Provider does not guarantee coverage for such service. Medical services provided by a Contracted Provider to an immediate family member of the Contracted Provider are not covered services.

Contracted Provider participation in all Blue KC coordinated care programs is mandatory. If external care is needed, Contracted Providers must first send member to another Contracted Provider. If not available, send to a qualified non-network provider, which may require prior authorization and out-of-network determination by Blue KC.

Blue KC Medical Policy

The medical policy is available at **Providers.BlueKC.com**. Blue KC has adopted Milliman Care Guidelines (MCG) for many of its medical policies as the MCG Guidelines are a compilation of best practices for treating common conditions in a variety of settings. Blue KC may also adopt its own medical policies. After acceptance of the disclaimer, Contracted Providers can search using a keyword, procedure code, alphabetic search or topic search. Medical Policies are also available via the **Blue KC Provider Portal (Contact/FAQs/Medical Policy)**.

All applicable Blue KC Policies and Procedures must be followed by Contracted Providers and all Affiliated Providers. Affiliated Providers must participate in the same network as identified by the Agreement. Blue KC is only held responsible for cost of covered services outlined in the Member's Benefit Plan.

Please remember that state and federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage. Although a service may be medically necessary, it may be excluded under a Member's Benefit Plan. Please submit an inquiry to medical policy through the contact tab at **Providers.BlueKC.com** with any questions.

In providing covered services under the Agreement, the Contracted Provider must comply with all local, state or federal laws to conduct business and perform obligations. Any provision set forth in the BAA, MA Addendum and State Law Addendum takes priority over conflicts in the Provider Agreement.

Prior Authorization

A complete list of services requiring prior authorization may be found at **Providers.BlueKC.com**. Blue KC performs a pre-review of selected services for all Blue KC programs, including lease and administrative services only (ASO) business. Any questions regarding prior authorization should be directed to the Prior Authorization/Clinical Operations Department. For Joint Administrative Accounts (JAA) not requiring a prior authorization, the team will advise the provider if prior authorization is not required. Contact resources are located in the **Contact Resource Directory**. Also, for providers answers to questions about specific benefits are available through **Providers.BlueKC.com** or the Provider Hotline during business hours.

For Federal Employee Plan (FEP), providers are advised not to use the Blue KC **Provider Portal** for prior authorization requirements. Instead, contact the FEP Customer Service Department. Contact resources are located in the **Contact Resource Directory**.

Prior authorization e-forms are available to help simplify and streamline the prior authorization process. The forms may be accessed on the website at **Providers.BlueKC.com**. These may be completed online and submitted to the Blue KC utilization management departments for processing. To access these forms, go to the Blue KC **Provider Portal**.

Contracted Providers will need the following member-specific information when submitting a prior authorization request through the Blue KC portal:

i. The requester's name and telephone number
ii. Admitting/service provider
iii. Member's name and birth date
iv. Blue KC identification number and group number
v. Proposed treatment plan: tests, diagnostic procedures, surgical procedures, treatment, etc.
vi. Date, place and type of admission or service
vii. Diagnosis primarily responsible for the admission or service
viii. Contracted Provider number and group number

Blue KC staff will verify that the treatment plan meets the criteria based on applicable MCG or Blue KC medical policy. If the admission or service is approved, the Blue KC nurse notifies the Contracted Provider and requester within the required timeframe for the applicable service type upon receipt of all necessary information. A letter will be generated following approval. For admissions, the nurse also assigns a length of stay. If the nurse is unable to approve the services(s) or elective admission, the case is referred to the medical director for review. The Blue KC Medical Director makes a determination based on the clinical information provided. If more information is necessary, the medical director or review nurse contacts the Contracted Provider to request the additional information before a determination is made. If the authorization is denied, the Contracted Provider may file a standard appeal to the appeals department or an expedited appeal by calling or in writing (see "Appeals Regarding Medical Necessity" in the **Contact Resource Directory** for details).

Inpatient and Outpatient

Blue KC registered nurses perform a review of all scheduled or acute medical and surgical inpatient admissions (except admissions for delivery and all scheduled rehab or skilled nursing facility admissions prior to the admission).

To satisfy this requirement, the admitting provider must submit clinical information to Blue KC to obtain the admission authorization. Blue KC must be notified of all urgent/emergent admissions within 48 hours of admission.

Information may be submitted via the **Provider Portal**, phone, or fax. The prior authorization list and forms are located at **Providers.BlueKC.com** (Find a Form).

To request a prior authorization, fax the request to the confidential fax number (816) 926-4253 with relevant clinical information or contact Blue KC's Utilization Management Department (see **Contact Resource Directory** for details).

Out-of-Network Services

For HMO and EPO members, prior authorization is required for any non-emergency service provided at or by a non-network facility and/or practitioner. For HMO members who desire out-of-network services, if such a service or procedure is available in the network, the request would be typically denied, unless unusual circumstances warrant an approval. **Preferred-Care PPO** and **Preferred-Care Blue® PPO** members may voluntarily elect to opt out of network. To those PPO members, out-of-network benefits would apply and an out of network prior authorization is not required or reviewed.

In certain situations where emergency care is received from an out-of-network practitioner or facility or where an out of-network practitioner renders services at an in-network Facility, the federal No Surprises Act or Missouri law may require the out-of network facility or practitioner to submit claims to Blue KC and require Blue KC to process the claims at the member's in-network cost share.

Radiology

Outpatient and elective MRI, MRA, CT, CTA, PET, spinal fusions, echocardiogram and nuclear cardiology studies will require prior authorization from eviCore. Imaging performed in conjunction with an inpatient stay, 23 hour observation or testing done in the emergency room is not subject to authorization requirements.

When imaging is required in less than 36 hours due to an urgent condition, call for authorization and tell eviCore that the imaging is urgent and ask for an expedited review.

eviCore is a radiology services organization specializing in the management of quality, cost-effective diagnostic services. To request an authorization, access their 24/7 web portal, call or fax (see **Contact Resource Directory** for information about eviCore).

Durable Medical Equipment

Services, durable medical equipment (DME) and prostheses that require prior authorization are listed at **Providers.BlueKC.com** in the forms section. The portal does not include Federal Employee Plan (FEP) or Joint Administrative Accounts (JAA) members. Please contact the customer service number on the back of the member's card for prior authorization requirements.

Medications

All prior authorization requests, including step therapy, specialty pharmacy, dose optimization/quantity limits are processed within 36 business hours. To check the status of a prior authorization, call pharmacy services.

Prescription drug lists are available on the Blue KC website by scrolling to the bottom of the home page, clicking FAQs, then Prior Authorizations for Medications (see **Contact Resource Directory** for details). Also, check online under pharmacy services for a current list of drugs requiring prior authorization. Please be aware that as new products are released and post-marketing information on existing therapies become available, changes in these lists may occur.

Changes to Services on a Prior Authorization

Effective January 1, 2026 for all lines of business including Commercial, Affordable Care Act (ACA) Qualified Health Plans, Joint Administrative Accounts (JAA), Federal Employee Program (FEP), and Medicare Advantage for other Blue Cross Blue Shield Association plans, prior authorization approval is given for a specific CPT code, but then the code changes at the time of service (based on the performance of a different procedure than originally planned), then the Contracted Provider must inform Blue KC of the change in CPT code prior to claim submission. Failure to report the change prior to submission of the claim will result in a denial of the claim.

Utilization Review

Providers need to understand all aspects of the Utilization Review and provide medical records requested in a timely manner:

- **Quality Improvement**: process that oversees the process and outcomes of member services to ensure care is efficacious and consistent with generally accepted medical practices.
- **Retrospective Review**: review after the patient has received healthcare to assess reimbursement levels, consistency and adjudication.

Blue KC Provider Advisory Pharmacy and Therapeutics Committee and medical director establish the specific Utilization Management activities to be conducted. Utilization Management reviews may be conducted by Blue KC or through a subcontractor.

Failure to timely produce requested medical records, or production of records that do not meet Blue KC medical policy, may result in denial of reimbursement for services.

In the event of a denial, a copy of the guideline, protocol, benefit provision or other similar criterion used to make the determination will be available upon request by calling or writing to the attention of the medical director (see **Contact Resource Directory** for details).

Concurrent Review

Concurrent Review is part of the Utilization Review process that enables Blue KC to evaluate continued hospital, rehabilitation or skilled nursing facility stays for medical necessity and appropriateness. Concurrent review takes place during a stay following prior authorization. In this process, the Blue KC nurse reviewers actively monitor the member's progress during inpatient care and communicate with members and Contracted Providers. These Blue KC nurses assist in managing members and facilitate discharge planning. As a result of this management, a member's length of stay may be adjusted or the member may be moved to a more appropriate level of care.

Upon authorization for admission, notification letters are sent to the Contracted Provider, attending physician, and member. The Blue KC nurse notifies the facility and provider of the number of days initially approved for the admission and schedules the first concurrent review at the time of initial stay approval.

Step 1: Contracted Provider's Review Nurse-Responsibilities

The Contracted Provider's review nurse is responsible for initiating all concurrent review calls to Blue KC on the scheduled next review date at those facilities which do not have a Blue KC Utilization Review (UR) nurse with remote access to the electronic medical record (EMR). For facilities with remote access to the EMR, Blue KC UR nurses will log in to review cases. The Contracted Provider's review nurse provides medical information that was collected since the initial stay approval. Blue KC must receive new clinical data from the hospital by 2 p.m. to verify the member's need for continued stay.

Step 2: Approval of Continued Stay

When the continued stay request is appropriate, according to Blue KC Medical Policy, the Blue KC nurse informs the hospital review nurse and provider of the number of additional days approved and the next date for concurrent review. Blue KC will send approval letters to the Contracted Provider, attending physician, and member.

Step 3: Referral to Medical Director

If the clinical information provided is not sufficient to approve a continued stay, the stay will be referred to the Blue KC medical director for further review. If the Blue KC medical director decides there is not sufficient data to approve the continuation of the stay, the Blue KC nurse will notify the Contracted Provider of the decision and the opportunity to provide additional information. If Contracted Provider submits additional information and that information is enough to approve, then step 2 is followed. If the information is not enough to approve under Blue KC Medical Policy, the request for continued stay will be denied.

Step 4: Denial of Continued Stay

When a continued stay is denied, the Blue KC review nurse will send a letter to the attending physician, Contracted Provider, and member that the service(s) or day(s) have been denied on the day the denial occurs or the next business day. If written notification cannot be provided by the next business day, verbal notification will be provided by the next business day and supplemented in writing as soon as possible. The letter of denial will provide instructions for reconsideration and appeal rights.

Step 5: Peer-to-Peer Conversation and Appeal of Denial

Blue KC provides the opportunity to discuss the denial decision with the Blue KC medical director making the initial determination; or with a different medical director, if the original medical director cannot be available. The request for peer-to-peer must be initiated within 2 business days of the denial and notification and completed within 7 business days.

If the peer-to-peer conversation upholds the original denial, the provider is informed of the right to initiate an appeal and the procedure to do so. If the medical director overturns the denial based on the peer-to-peer conversation, a letter of approval will be sent to the provider.

For continued stay denials, the Provider or facility may initiate an expedited appeal by calling the appeal department contact (see Appeals on **Contact Resource Directory**)

Medically Necessary

For Blue KC benefit plans, medical necessity denotes services and supplies that are essential to the health of the member for the diagnosis or care and treatment of a medical or surgical condition.

Services and supplies that are essential to the health of the member which, in the judgment of Blue KC meet all of the following requirements:

- Are reasonable and medically necessary for the diagnosis or treatment of illness or injury, to improve the function of a malformed body member, or to minimize the progression of disability and which could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered;
- In accordance with medical policies of Blue KC or those of a delegated entity that is performing services on behalf of Blue KC and in accordance with accepted standards of practice in the medical community of the area in which the health services are rendered and furnished in the most appropriate setting;
- Consistent with national Blue Cross and Blue Shield Association's reference medical policies, as amended from time to time;
- Not primarily for the convenience of the covered individual, nor the covered individual's family, provider or another provider;
- Consistent with the attainment of reasonably achievable outcomes; and
- Reasonably calculated to result in the improvement of the covered individual's physiological and psychological functioning.
- If more than one service or supply would meet the above requirements, such service or supply shall be furnished in the most cost-effective manner which may be provided safely and effectively to the covered individual. Services or supplies that are "not medically necessary" are not a covered benefit or services. Conversely, a service or supply may meet medical necessity criteria, but be specifically excluded from coverage by the terms of the benefit plan.

Failure to meet medical necessity will be determined by Blue KC reviewers or their authorized designee (at their discretion) and under the terms of the applicable benefit plan or as may be required by law. Medical necessity is subject to the appeals process.

Medical Claims Review

The Blue KC claims management system contains clinical edits which identify services that require review by a registered nurse for pre-existing conditions, medical necessity, appropriate billing and coding practices. These clinical edits are comprised of edits specific to a member's benefits and contract exclusions, as well as, specific diagnosis and procedure codes used by providers upon claim submission.

Registered nurses review these procedures to verify the member's available benefit for the procedure prior to assessing the medical necessity based on Blue KC medical policies. In the event a procedure does not meet medical necessity criteria, the nurse will forward the case for review by a medical director, pursuant to Blue KC procedures. Additional information may be required to complete their review.

Case Management

Members facing complex, catastrophic, high-risk, or high-cost health conditions may be referred to Blue KC's Case Management Program for personalized support. Through a comprehensive and integrated approach, the Case Management programs address holistic health needs of members including – medical, behavioral and social

determinants of health. There are various programs based on specific criteria and advanced analytics – See the list below. For more information about case management services or to make a referral, call Case Management (see **Contact Resource Directory** for details).

Case Manager

The case manager serves as an ongoing member advocate and oversees services for individuals to ensure they receive appropriate care and support. Care managers assess needs, develop care plans, coordinate services, monitor progress and advocate for members to maximize the member's medical outcome.

Disease Management (Chronic Condition Management)

As part of Blue KC's Population Health strategy, the Care Management Program offers a comprehensive suite of services to support members with chronic and complex conditions. These include diabetes, coronary artery disease (CAD), heart failure, chronic obstructive pulmonary disease (COPD), hypertension, asthma, metabolic syndrome, and depression.

The program is designed to complement the care members receive from their providers by offering personalized support, education, and resources that empower members to take an active role in managing their health. Care Managers, who may be nurses or licensed social workers, collaborate with members to develop individualized care plans, coordinate services, and address medical, behavioral, and social determinants of health.

Members are identified for outreach through advanced analytics and multiple data sources, including medical and pharmacy claims, lab results, and health risk assessments. Participation is based on an opt-out model, meaning eligible members are automatically considered unless they choose not to engage.

Blue KC Care Management App

Blue KC provides members with flexible options to engage in Care Management programs based on their individual preferences including telephonic, digital, and SMS communication. Through the **Blue KC Care Management app**, members can actively manage health conditions such as diabetes, asthma, and cancer, while staying connected to their personalized Care Team.

In addition to chronic condition support, members have access to a wide range of wellness resources, including:

- Maternal health support
- Weight loss programs
- Smoking cessation tools
- Pain management services

The Blue KC Care Management app is available to all members and offers convenient features to support health between doctor visits:

- Secure messaging with Care Team members for help coordinating care
- Personalized daily checklists to stay on track with health goals
- Clinically approved articles and videos tailored to individual needs
- Progress tracking for goals like daily steps and medication adherence
- Exclusive perks and discounts from trusted local and national brands

Case Management Referral Criteria

Blue KC members managing chronic or complex health conditions may be referred to various Care Management programs, including care coordination. Referrals are based on a range of clinical and utilization indications.

Below is a non-exhaustive list of common referral criteria:

- **High Utilization of Healthcare Services:** frequent use of multiple providers, facilities, and complex treatment plans.
- **Multiple Chronic Conditions:** examples include diabetes, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD).
- **Severe Trauma**: such as motor vehicle accidents involving multiple injuries.
- **Transplant Cases**
- **Oncology:** members undergoing active cancer treatment.
- **High-Cost Claims**
- **Neurological Injuries:**
  - Spinal cord injuries (e.g., quadriplegia, paraplegia)
  - Severe brain injuries (e.g., strokes, aneurysms)
- **Post-ICU/NICU Discharges:** adults or children transitioning home after intensive extensive hospital stays.
- **Complex Wound Care:** non-healing wounds requiring advanced interventions like wound vacs, IV antibiotics, LTAC placement, or hyperbaric oxygen therapy.
- **High-Risk Maternity**
- **Out-of-Area (OOA) or Out-of-Network (OON) Utilization:** especially for complex conditions such as cancer in active treatment.
- **Frequent Hospital Admissions:** multiple urgent or emergent admissions or readmissions within 30 days.
- **Significant Social Determinants of Health (SDOH):** including housing instability, food insecurity, or lack of transportation.
- **Extensive Durable Medical Equipment (DME) Needs:** requiring coordination of services and support.

How to Refer a Member to Blue KC Care Management Programs

Blue KC offers several convenient ways for members and providers to initiate a referral to Care Management services:

- **By Phone:** members or providers can contact the Blue KC Customer Service team directly for assistance.
- **Online Portal:** members can log into their MyBlueKC account and connect to Care Management app.
- **By Email:** providers and care partners may send referrals to the Care Management team at **Care_Management@BlueKC.com**.

For additional guidance or contact details, please refer to the **Contact Resource Directory**.

Physician Advisory Groups

Blue KC's mission statement declares that the company is committed to using its role as the area's leading health insurer to provide affordable access to healthcare and improve the health and wellness of our members.

To support this mission, Blue KC emphasizes the quality and safety of clinical care and services provided to our members. Physician advisory groups and committees are central to this effort, offering a collaborative platform for providers to share expertise and guide organizational decisions.

Our Commitment to Quality Improvement

Key to the success of our Quality Improvement Program is our commitment to continually enhance services for both members and providers. Each year, Blue KC conducts a comprehensive assessment of the quality of services provided, including clinical outcomes, and identifies barriers and opportunities for improvement.

Based on these findings, we update the Quality Improvement Description and Work Plan to ensure policies, procedures, and outcomes related to:

- Utilization management
- Member services
- Care management services
- Network management
- Quality and credentialing

These updates incorporate nationally recognized best practices and benchmarks. We continually analyze data from complaints, appeals, member surveys, and network operations functions, and maintain oversight of companies that provide clinical services on our behalf.

Purpose of Advisory Groups

These groups serve as a forum for physicians to:

- Review and influence clinical policies and guidelines
- Provide input on utilization management and appeals processes
- Identify opportunities for improvement and best practices across the network

Provider Advisory Committee (PAC)

The PAC is a collaborative forum where practicing clinicians partner with Blue KC to shape policies and programs that impact patient care.

What the PAC Does

- Reviews and advises on clinical guidelines, medical policies, and formulary updates
- Provides input on utilization management and quality initiatives
- Shares best practices and emerging trends in healthcare

Why It Matters

Your expertise helps ensure our programs reflect real-world clinical practice and promote high-quality, equitable care for our members.

How Providers Can Get Involved

Providers have multiple opportunities to participate:

- **Join Advisory Groups or Committees:** express interest in serving on standing committees such as the PAC
- **Provide Feedback:** participate in surveys, focus groups, and consultations to shape clinical guidelines and operational processes
- **Share Performance Data:** allow access to practice-level data for quality improvement projects and recognition programs

Next Steps

To learn more or indicate interest in joining an advisory group or committee please reach out to your Provider Relations Representative to express your interest.

Medical Records

Medical records include documentation the Contracted Provider maintains in its legal health record about a member. Well-documented medical records facilitate communication, coordination and continuity of care and they promote the efficiency and effectiveness of treatment. The medical record communicates the member's past medical treatment, past and current health status, and treatment for future healthcare. Medical records should be maintained in a manner that is current, detailed, organized and permits effective and confidential member care, along with quality review.

Contracted Providers must prepare, maintain, and protect all medical health record in accordance with the Provider Agreement. These records shall be preserved for the longer of 6 years after termination of the Agreement or following the completion of any audit.

Documentation Standards

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

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

The Contracted 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.

Patient Records

- Be legible in both readability and content.
- Contain only those terms and abbreviations that are or should be comprehensible to similar provider/peers.
- Contain patient-identifying information on each page to ensure pages are not lost or misfiled.
- Include all patient records received from other health care providers if those records formed the basis for treatment decision by the Contracted Provider.
- Indicate the date(s) any professional service was provided and date of each entry.

Document

- Each entry shall be authenticated by the person making the entry.
- Each patient record shall include any writing intended to be a final record, but shall not require the maintenance of rough drafts, notes other writings or recordings once this information is converted to final form; the final form shall accurately reflect the care and services rendered to the patient.
- Any amendments, additions, or late documentation should be documented in a manner that tracks the date and author of each component of the record.

Medication Details

- Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- Indicate the medications prescribed, dispensed or administered, and the quantity and strength of each.

Treatment and Diagnosis Details

- Contain pertinent information concerning the patient's condition and justify the course of treatment. The record must document the medical necessity and appropriateness of each service.
- Indicate significant illnesses and medical conditions on the problem list.
- 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.
- Document the initial diagnosis and the patient's initial reason for seeking the provider's care.
- Document the patient's current status and progress during the course of treatment provided.

Maintenance, Audit and Access

Blue KC is authorized to access, inspect, audit, and review all claims and records obtained by Contracted Providers. All medical records must be provided to Blue KC without additional charge and in the timeline specified in the request letter, unless otherwise specified in the Agreement.

Failure to provide or release records, information or data as required under the Agreement or Blue KC Policy constitutes a material breach of the Agreement and, in Blue KC's sole discretion, may result in termination of this Agreement. Further, where records are requested for an audit or other review by Blue KC, failure to provide the medical records may result in a denial of payment for the service and/or recoupment of prior payment.

Sending Medical Records to Blue KC

For all medical records requests, please attach the request letter to all medical records and fax or mail to the Medical Records address in the **Contact Resource Directory** or FAX as indicated in the request letter.

Medical Records should be provided in an organized, legible manner. For large volume medical records or multiple dates of service, Contracted Providers may provide a table of contents or index. Incomplete, disorganized, or illegible records may result in a denial of payment for the service and/or recoupment of prior payment if Blue KC cannot confirm that applicable coverage requirements were met. It is the responsibility of the provider to ensure accurate and appropriate documentation consistent with industry standards.

Electronic Medical Record (EMR) Data Feeds

Blue KC offers the option for Contracted Providers to submit medical record data through secure EMR data feeds. This approach helps reduce manual requests and supports timely, accurate data exchange for quality programs such as HEDIS®.

Benefits of EMR Feeds:

- Streamlined submission process, reducing the need to fax or mail large volumes of records
- Improved accuracy and timeliness for quality reporting and care management
- Reduced administrative burden for provider offices

Getting Started:

- Providers interested in establishing an EMR feed should contact Blue KC Provider Relations or their designated network representative.
- Blue KC will collaborate with you to set up a secure connection using industry-standard protocols.
- Data shared through EMR feeds must comply with HIPAA, contractual requirements, and NCQA Primary Source Verification (PSV) standards.

Important:

Even with EMR feeds, providers remain responsible for ensuring complete and accurate documentation. Incomplete or missing data may still require supplemental record requests.

HEDIS®

HEDIS is administered by the National Committee for Quality Assurance (NCQA). NCQA has expanded the size and scope of HEDIS to include measures for providers, PPOs and other organizations.

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.

Member Medical Records

The quality components of the Blue KC process for HEDIS measurement requires that we access and copy information from member medical records. Contracted Providers, under the Agreement, are required to provide medical record documentation in response to a HEDIS request. Unless otherwise specified, Medical Records must be provided under the Agreement without charge, even when a copy service is involved in the production of the medical records.

The HEDIS medical record data abstraction process begins in late January and finishes in late April.

To minimize office disruption, we ask providers with 15 or less records to pull their records and submit to Blue KC via our secure Kiteworks system, fax-mail or U.S. mail. See HEDIS in **Contact Resource Directory** for details.

Please make the data available consistent with the timeline in the request letter. The use of a copy service often involves delays in obtaining necessary information. Please be sure these requests are forwarded promptly and followed-up on to ensure timely delivery.

Failure to provide or release records, information or data as required under the Agreement constitutes a material breach of the Agreement and, in Blue KC's sole discretion, may result in termination of this Agreement.

On-site Review

In Blue KC's discretion, Blue KC may obtain information for a HEDIS review through an on-site review. Prior to conducting an on-site review, our abstractors will contact Contracting Providers' office to determine who will be coordinating the HEDIS record requests, location of medical records and information regarding EMR (Electronic Medical Record) vendor, if applicable.

Risk Adjustment Process

Risk adjustment, a CMS required component of the Affordable Care Act (ACA), helps align payments to health plans with the risk characteristics of people enrolled in each plan.

Accurate risk adjustment relies on comprehensive, face-to-face health assessments of patients. These assessments result in appropriate medical record documentation and diagnosis coding. The diagnosis codes are then submitted to the health plan on a claim and used to determine the level of risk associated with the patient.

Blue KC has risk adjustment programs in place that align with our commitment to ensuring that quality of care is maintained through the provider-patient relationship. These programs help identify care and coding opportunities that can help prevent and/or detect conditions and encourage members to schedule health screenings, tests and vaccines. Contracted Providers are responsible for complete documentation of member's medical conditions and coding of related diagnosis on claims consistent with ICD-10 or other applicable coding guidelines.

Claims, Billing & Remittance

Contracted Providers must submit a complete and accurate claim or encounter form in accordance with Blue KC's Policies and Procedures after providing services or supplies to a member. This includes claims for all Blue KC members as well as other plans utilizing Blue KC's networks. If a Contracted Provider is rendering service in a contiguous county to Blue KC's service area and is separately contracted with another Blue Cross and Blue Shield plan ("Blue Plan") for that county, the claim should be submitted to the other Blue Plan.

Claims should be submitted electronically in a HIPAA standard or otherwise on a **UB-04 or CMS 1500** standard form. Providers should follow National Correct Coding Initiatives (NCCI) while assigning the appropriate CPT®, HCPCS, ICD-10, and revenue codes. Always include the alphanumeric prefix portion of the member identification number on all claim forms.

Process and Timely Filing

Contracted Providers must submit completed and accurate claims of covered services for members to Blue KC within 180 days after date of service or 90 days from payment from primary insurance to receive payment from Blue KC. If not submitted within this period, claims will be denied based on timely filing and the Contracted Provider will not bill members for services associated with such claims. Contracted Provider must obtain a signed release of information and assignment of benefit form from all members.

We emphasize that a key step in the claims payment process is for a Contracted Provider's accounts receivable department to do complete remit reconciliation and then perform any necessary follow-up. A remit reconciliation confirms that the claim has been received.

Timing	Overview
Primary	In the Blue KC Agreement, we ask that claims be filed within 30 days of the date of service but no later than 180 days in order to be considered for payment.
Secondary	Claims should be filed within 180 days of the date of service or 90 days from the primary carrier's payment date with the Primary payer remittance. Blue KC accepts secondary claims electronically.
Claim Verification (Follow-Up at 30 days if no remittance)	Visit **Providers.BlueKC.com** or call the provider hotline. See the **Contact Resource Directory** for claims related information.

What to Include

- Always remember to include the alphanumeric prefix portion of the member identification number on all claim forms.
- Services billed on the **837P (CMS-1500)** should include the name and NPI of the performing provider on each line item.

- Use Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and International Classification of Diseases (ICD-10) codes. Please use the current codes reflective of the date of service of the claim.

Where to File

Claims filing information is printed on the back of a member's ID card. If a provider is unsure where to file a claim, please call the Provider Hotline (see **Contact Resource Directory** for details).

Electronic Claim Submission

Claims Acknowledgement (277CA)

It is important to familiarize yourself with procedures within the Administrative Services of Kansas (ASK) clearinghouse. It is a Contracted Provider's responsibility to become familiar with the processes and procedures of the clearinghouse in regard to their handling and distribution of the 277CA, so please initiate this discussion whenever there is a change with software vendors and/or clearinghouses. Failure to reconcile the 277CA can result in Blue KC not receiving all the initial electronic claims that were intended to be submitted.

The 277CA provides detailed information on all electronic claims that have been accepted or rejected. This information is vital since it represents the actual accepted claims that will be forwarded to Blue KC for processing as well as rejected claims that must be corrected and resubmitted.

ASK delivers a 277CA back to the original submitter (trading partner) of the electronic claim file. Some trading partners, such as clearinghouses, may reformat, repackage or bundle the information in the 277CA into other various printed and electronic reports.

See the ASK website for more information about:

- Electronic claim processes and the 277CA with training examples
- Register for ASK email notifications

Please contact ASK (see **Contact Resource Directory** for details) with any questions related to electronic claim submission.

- Send Type I and/or Type II NPI(s) depending how the Contracted Provider is set up with Blue KC.
- ASK accepts electronic claims directly or through a clearinghouse.
- After a claim file has been submitted to ASK, a Claims Acknowledgement (277CA) is produced which indicates the status of each claim: rejected, or accepted. ASK will provide a 277CA to whomever submits the claim(s).
- If claim was rejected, it must be corrected and resubmitted within 180 days of the date of service to meet timely filing requirements.
- Accepted claims are transmitted to Blue KC for processing.
- If no payment or response is received within 30 days, check **Providers.BlueKC.com** or call Provider Hotline for status.
- Electronic claim submissions is the preferred method and saves providers time and money.

Blue KC expects the original claim submission to be accurate and fully reflect all information gathered during the patient encounter. However, when a corrected claim is necessary, please note the requirements and information listed below.

Resubmitting Claims

The majority of "clean" claims received by Blue KC are processed rapidly and, therefore, payment or denial can be anticipated within 30 days. To verify claim status please check **Providers.BlueKC.com** or call the Provider Hotline (see **Contact Resource Directory** for details). For adequate processing time, allow at least 30 days from the date of claim submission before following up. Contracted Providers should avoid sending duplicate bills to Blue KC sooner than 30 days after original submission. If bill and the related payment are duplicated, the Contracted Provider may be required to repay amounts or it may be deducted from subsequent amounts due.

Claims Data Elements - Electronic Corrected Claims

Name of Data Element	837P or 837I Loop and Data Element	Data Element Information
Claim Frequency Type Code	2300 I CLM05 – 3	**7** (Replacement of a Prior Claim) **8** (Void of a Prior Claim)
Payer Claim Control Number Qualifier Original Reference Number Qualifier	2300/ REF0I	**F8**
Payer Claim Control Number Original Claim Number	2300/ REF02	The original Blue KC assigned **claim number.**
Claim Note Reference Code	2300 I NTE0I	**ADD** (Additional Information)
Claim Note Text	12300 I NTE02	**Free-form text field** (80 characters) to provide a description of correction.

Submitting Corrected Claims

Submit a Corrected Electronic Claim	Do not Submit a Corrected Electronic Claim*
Original claim was denied for other carrier information. Send a corrected claim with the necessary COB data elements.	Claims that have been denied for medical necessity.
Changes related to date of service, CPT, HCPCS, DX code, modifiers, revenue code, type of bill or units. These are just some examples of changes that could be made.	Claims that have been denied for investigational or experimental services.
Original claim was denied for additional information, such as: NOC code, CPT or HCPCS description (NOC code). Send corrected claim with full code description in the claim note text.	Claims with services that have been bundled or denied inclusive of another service.
Original claim for DME, Clinical Lab or Specialty Pharmacy denied for no referring physician. Send corrected claim with the referring physician information.	Claims that have been denied for lack of information request for additional clinical documentation (office notes, surgical notes, reports, etc.).

*Use a claim inquiry via **Providers.BlueKC.com**

Claim corrections submitted without the appropriate data elements will be denied and the original claim will not be adjusted.

We will no longer accept corrected paper claims. As of February 1, 2019, Blue KC only accepts corrected claims electronically. Providers should send a Corrected Electronic Professional Claims (837P) or Corrected Electronic Institutional Claims (837I). Providers may also submit a corrected claim at **Providers.BlueKC.com**.

A corrected claim will not be accepted after an official overpayment notice has been sent to the provider outlining the reason for the recoupment and dispute process. To dispute an overpayment notice, see the Request for Reconsideration in the Appeals and Disputes section, below.

How will Blue KC handle my corrected electronic claim (837P or 8371)?

Regular (local) Business and Federal Employee (FEP)

- Original claim will be voided.
- The corrected claim will be processed and paid, if applicable, on the same remittance advice.

BlueCard (ITS)

- Original claim will be voided.
- The corrected claim will be reprocessed and paid, if applicable, on the different remittance advices.
- Because these claims are going to the members' home plan, please allow 30 days for the corrected claim to process.

What if a claim is returned or rejected?

- Rejected claims should not be submitted as corrected claims.
- Only claims that have completed adjudication should be submitted as corrected.
- When sending a corrected electronic claim, providers must re-send the claim in its entirety including the corrections.

How will Blue KC handle paper corrected claim inquiries?

- Paper corrected claim inquiries will be returned to the provider with a handout directing the provider to file an electronic adjustment.

What happens when a corrected claim is completed on the Blue KC Provider Portal?

- Corrected claim inquiries completed at **Providers.BlueKC.com** are imaged and processed. The corrected claim will then follow the same steps as indicated above.

Payments of Claims

Blue KC will process or transmit complete and accurate claims for payment:

- In accordance with the member's benefit plan, Blue KC policies and procedures, and the Contracted payment rate
- The net of amounts recoverable from other third-party payors through Coordination of Benefits
- The net of any applicable copayments, coinsurance, cost share, or deductibles

Complete, accurate and clean claims shall contain all information required to allow Blue KC to adjudicate and pay the claim without further investigation. This information includes identification of member and Contracted Provider, correct Blue KC billing numbers, services provided and appropriate standard diagnosis and procedure codes.

Blue KC will either process and pay claims without returning claim to Contracted Provider, or return in a timely manner to request further information.

Payments should be made within 30 days after the claim is made final. Payor shall pay Contracted Provider for services or notify Contracted Provider of delay or denial. For claims subject to provisions of RSMo 376.383, claims not paid within 45 days shall be subject to interest charges. Blue KC will notify Contracted Provider of incomplete claims in a timely manner.

Claims Payment and Remittance

Blue KC sends a weekly remittance advice statement to Contracted Providers. This statement provides detailed information for any claim processed (paid or denied) during that week. The Blue KC remittance advice shows the amount a Contracted Provider may bill the member and the amount the provider agrees to write-off, pursuant to contract terms.

Interest on Claims

If a claim received by Blue KC is not paid within the guidelines established by the states of Missouri or Kansas,

Blue KC will pay interest to the Contracted Provider if required by law. If additional information is required by Blue KC to process the claim, the claim must be paid within a specified period from the receipt of this new information to avoid interest charges paid to the provider.

Interest is reported on the remittance advice in two areas:

- At the claim level
- At the summary level by line of business

Claims related to Administrative Services Only (ASO) business, Medicare Advantage, certain rental/lease business and FEP groups are exempt from state interest statutes. No interest will be paid on these claims.

Refunds to Covered Individuals

Within 30 days of receiving payment from Blue KC or the payor, the Contracted Provider agrees to remit any credit balances due to a member for covered services. If Blue KC has been required by statute to pay the Contracted Provider any interest, as a part of its claims payment process, the Contracted Provider is required to reimburse a pro rata share of that interest payment to the member.

Electronic Remittance (835)

The 835 will allow automatic accounts receivable posting and is one of the major cost savings of the HIPAA implementation. If a Contracted Provider is interested in implementing the benefits of an electronic remittance advice, please contact your practice management system vendor or clearinghouse. If a Contracted Provider elects to receive EFT and 835, Blue KC will continue to mail paper remits for 60 days after the EFT and 835 election or the last change in provider data. After that time, paper remits will be discontinued. Contracted Providers will always be able to access remits at **Providers.BlueKC.com**.

Either the vendor, clearinghouse or the provider will need to contact Administrative Services of Kansas (ASK) (see **Contact Resource Directory**) for set up.

Electronic Funds Transfer (EFT)

If a Contracted Provider is not already set up for EFT, please complete the Provider Electronic Funds Transfer Application in the Forms section at **Providers.BlueKC.com**. Providers will receive faster payments when deposited directly into a bank account.

Provider Payments

Contracted Providers may receive up to eight payments with each weekly remittance advice. One payment is issued for each of the following Blue KC lines of business:

- BlueCard
- Blue-Care HMO
- Blue Cross and Blue Shield
- Federal Employee Program (FEP)-Standard
- Federal Employee Program (FEP)-Basic
- Federal Employee Program (FEP)-Blue Focus

Each line of business may include several products. For example, a Blue Cross and Blue Shield check may include Preferred-Care Blue®PPO, Preferred-Care PPO, Medicare Supplemental or Traditional.

Format and Examples

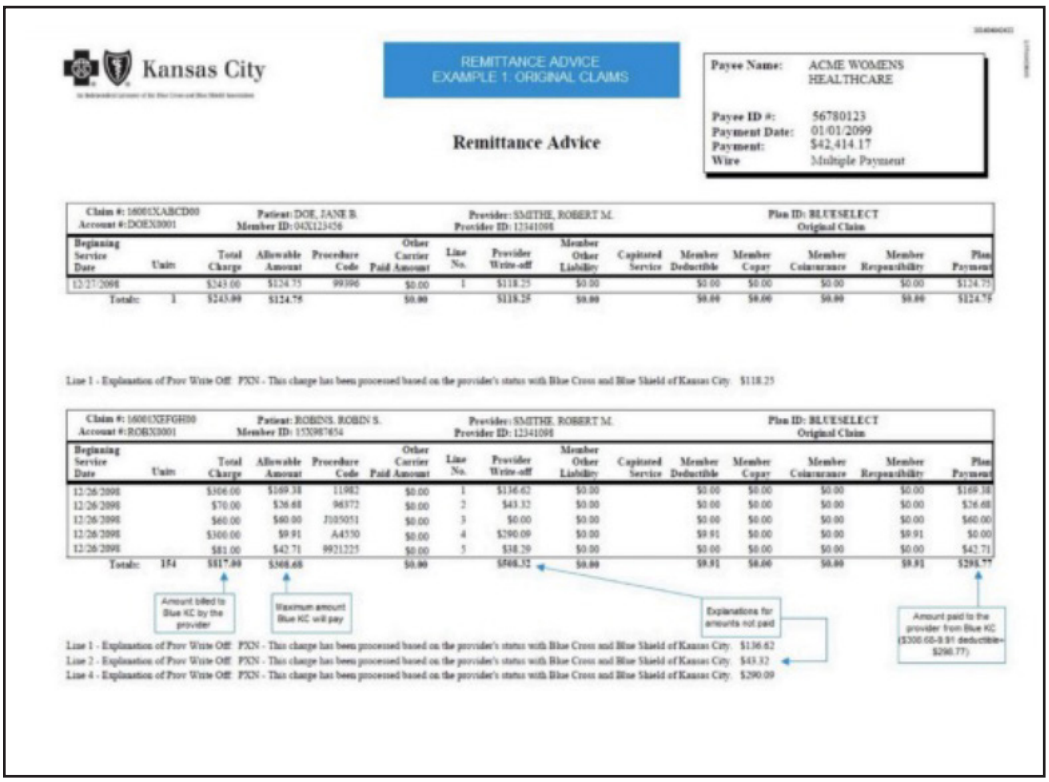
The format of the remittance advice is divided into three parts for every check or payment made to a Provider. The parts are as follows:

- Original Claims (example 1)
- Adjusted Claims (examples 2 void, 3 supplemental and 4 overpayment)
- Payment Summary (example 5)

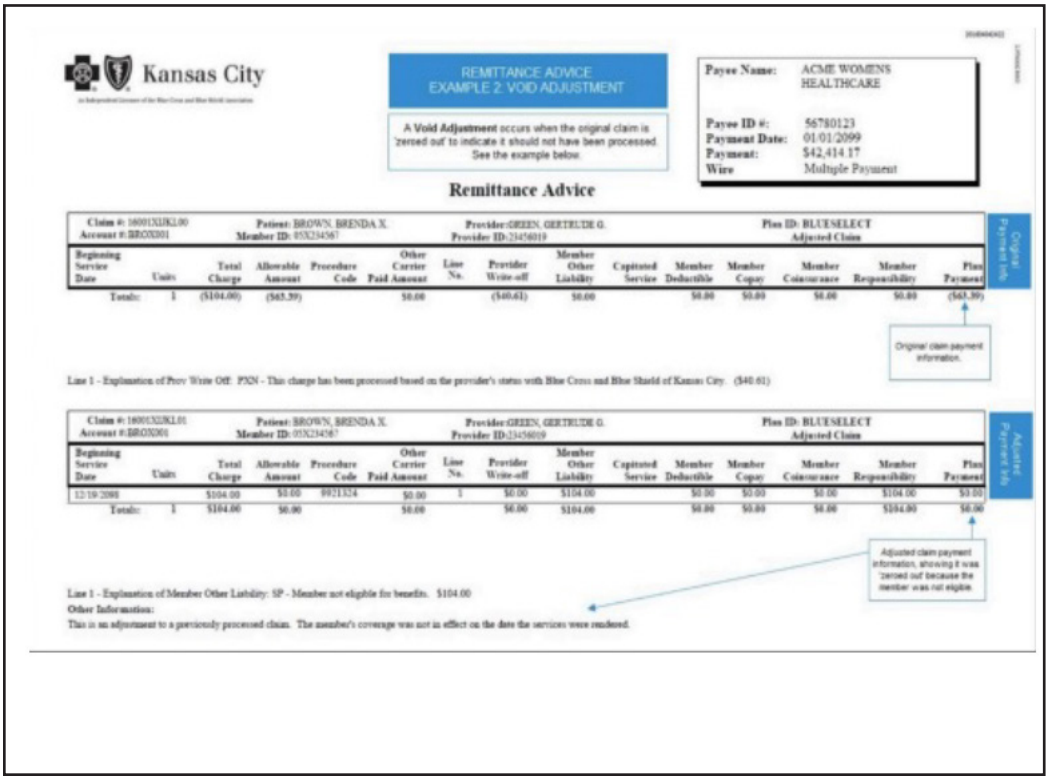
A summary line is presented for each Contracted Provider of service per product.

The examples on the pages that follow represent the format of the Professional Remittance Advice. The Facility Remittance Advice is slightly different.

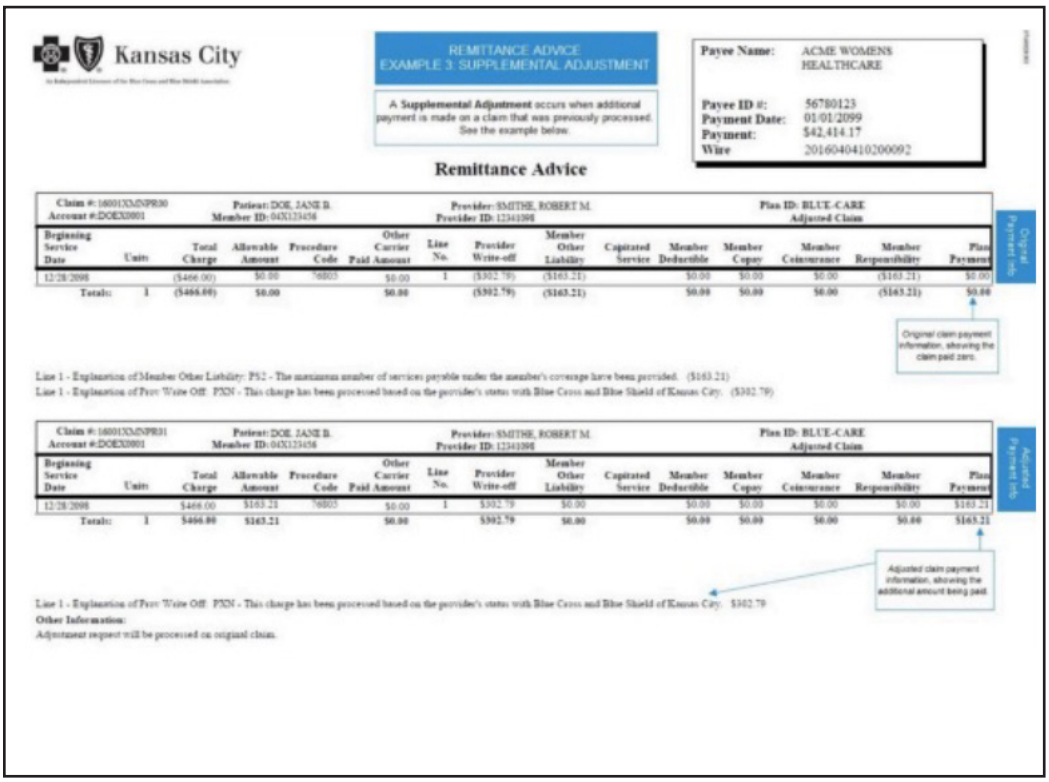
Example 1: Original Claims



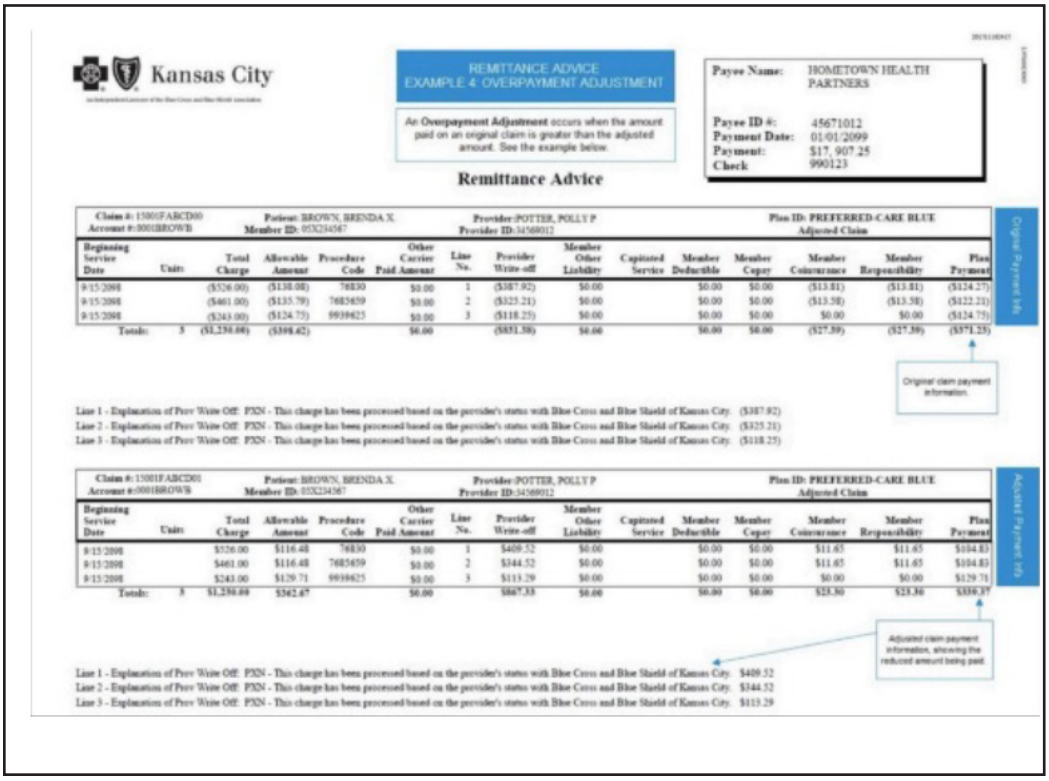
Example 2: Void Adjustment



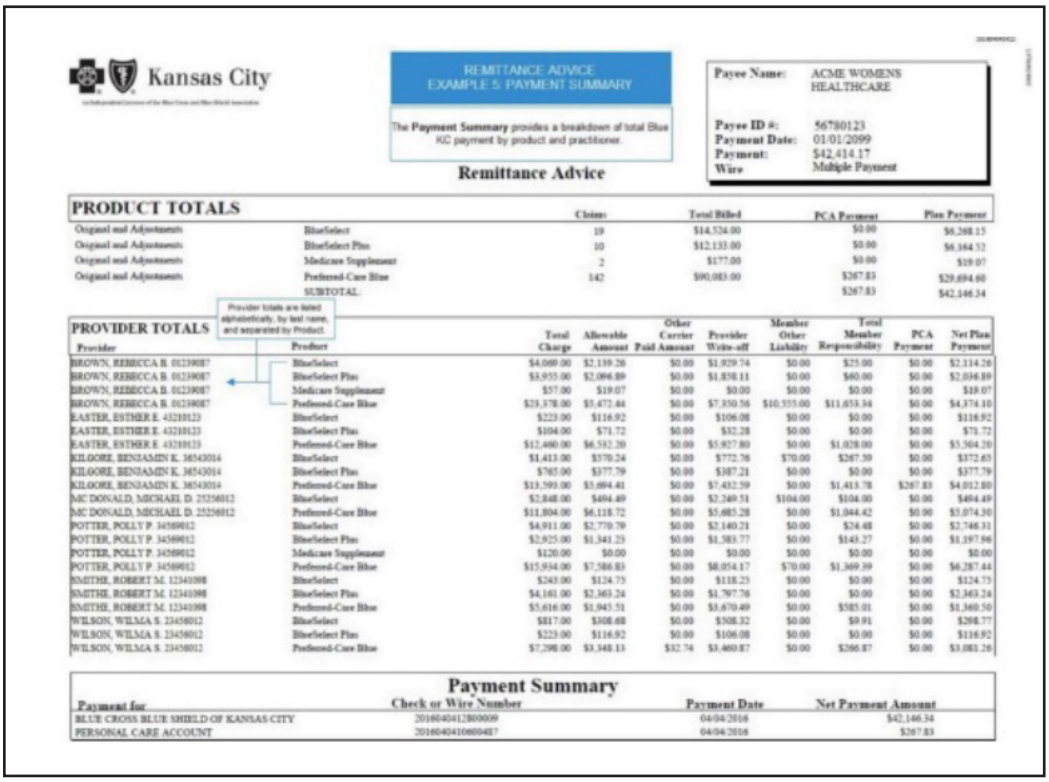
Example 3: Supplemental Adjustment



Example 4: Overpayment Adjustment



Example 5: Payment Summary



Kansas City

REMITTANCE ADVICE
EXAMPLE 5: PAYMENT SUMMARY

The **Payment Summary** provides a breakdown of total Blue KC payment by product and practitioner.

Remittance Advice

Payee Name:	ACME WOMENS HEALTHCARE
Payee ID #:	56780123
Payment Date:	01/01/2099
Payment:	$42,414.17
Wire	Multiple Payment

PRODUCT TOTALS

		Claims	Total Billed	PCA Payment	Plan Payment
Original and Adjustments	BlueSelect	19	$14,524.00	$0.00	$6,268.15
Original and Adjustments	BlueSelect Plus	10	$12,133.00	$0.00	$6,164.52
Original and Adjustments	Medicare Supplement	2	$177.00	$0.00	$29.07
Original and Adjustments	Preferred-Care Blue	142	$90,083.00	$267.83	$29,694.60
SUBTOTAL:				$267.83	$42,146.34

Provider totals are listed alphabetically, by last name, and separated by Product.

PROVIDER TOTALS

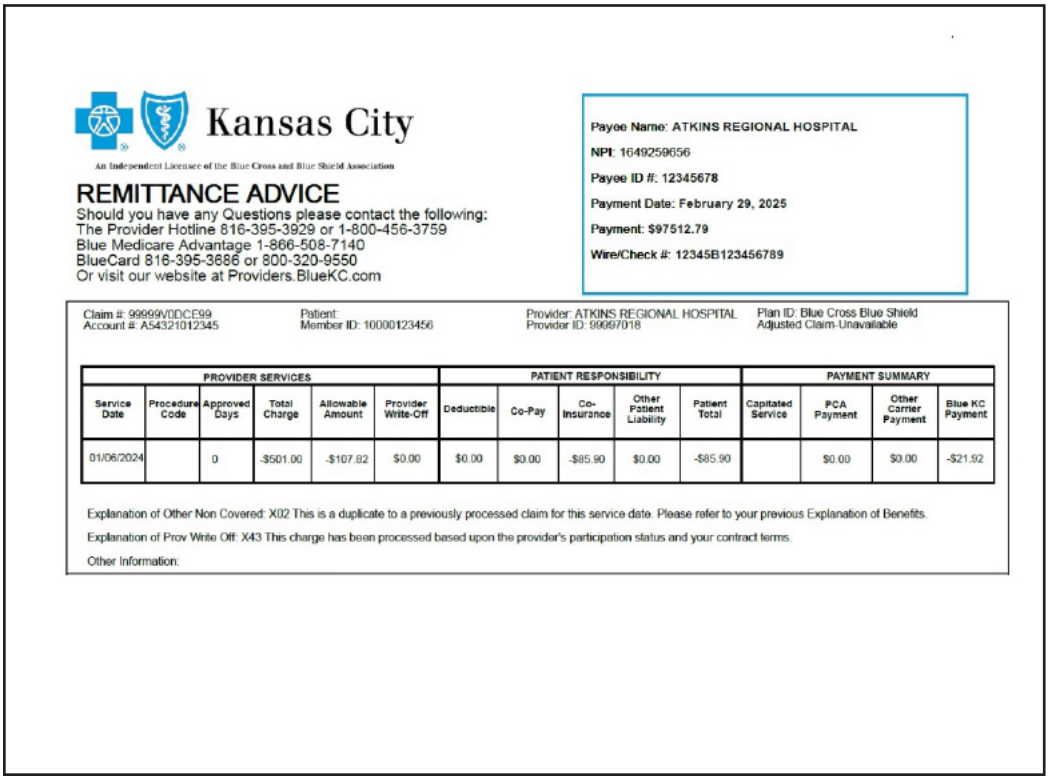
Provider	Product	Total Charge	Allowable Amount	Other Carrier Paid Amount	Provider Write-off	Member Other Liability	Total Member Responsibility	PCA Payment	Net Plan Payment
BROWN, REBECCA B. 0123087	BlueSelect	$4,069.00	$2,139.26	$0.00	$1,929.74	$0.00	$25.00	$0.00	$2,114.26
BROWN, REBECCA B. 0123087	BlueSelect Plus	$3,955.00	$2,096.89	$0.00	$1,858.11	$0.00	$60.00	$0.00	$2,036.89
BROWN, REBECCA B. 0123087	Medicare Supplement	$57.00	$19.07	$0.00	$0.00	$0.00	$0.00	$0.00	$19.07
BROWN, REBECCA B. 0123087	Preferred-Care Blue	$23,378.00	$5,472.44	$0.00	$7,350.56	$10,555.00	$11,653.44	$0.00	$4,374.10
EASTER, ESTHER E. 43210123	BlueSelect	$223.00	$116.92	$0.00	$106.08	$0.00	$0.00	$0.00	$116.92
EASTER, ESTHER E. 43210123	BlueSelect Plus	$104.00	$71.72	$0.00	$32.28	$0.00	$0.00	$0.00	$71.72
EASTER, ESTHER E. 43210123	Preferred-Care Blue	$12,460.00	$6,532.20	$0.00	$5,927.80	$0.00	$1,028.00	$0.00	$5,504.20
KILGORE, BENJAMIN K. 36543014	BlueSelect	$1,413.00	$570.24	$0.00	$772.76	$70.00	$267.59	$0.00	$372.65
KILGORE, BENJAMIN K. 36543014	BlueSelect Plus	$765.00	$377.79	$0.00	$387.21	$0.00	$0.00	$0.00	$377.79
KILGORE, BENJAMIN K. 36543014	Preferred-Care Blue	$13,593.00	$5,694.41	$0.00	$7,432.59	$0.00	$1,413.78	$267.83	$4,012.80
MC DONALD, MICHAEL D. 23256012	BlueSelect	$2,848.00	$494.49	$0.00	$2,249.51	$104.00	$104.00	$0.00	$494.49
MC DONALD, MICHAEL D. 23256012	Preferred-Care Blue	$11,804.00	$6,118.72	$0.00	$5,685.28	$0.00	$1,044.42	$0.00	$5,074.30
POTTER, POLLY P. 34589012	BlueSelect	$4,911.00	$2,770.79	$0.00	$2,140.21	$0.00	$24.48	$0.00	$2,746.31
POTTER, POLLY P. 34589012	BlueSelect Plus	$2,925.00	$1,341.23	$0.00	$1,583.77	$0.00	$143.27	$0.00	$1,197.96
POTTER, POLLY P. 34589012	Medicare Supplement	$120.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
POTTER, POLLY P. 34589012	Preferred-Care Blue	$15,934.00	$7,586.83	$0.00	$8,054.17	$70.00	$1,369.39	$0.00	$6,287.44
SMITH, ROBERT M. 12340398	BlueSelect	$243.00	$124.75	$0.00	$118.25	$0.00	$0.00	$0.00	$124.75
SMITH, ROBERT M. 12340398	BlueSelect Plus	$4,161.00	$2,363.24	$0.00	$1,797.76	$0.00	$0.00	$0.00	$2,363.24
SMITH, ROBERT M. 12340398	Preferred-Care Blue	$5,616.00	$1,945.51	$0.00	$3,670.49	$0.00	$585.01	$0.00	$1,360.50
WILSON, WILMA S. 23456012	BlueSelect	$817.00	$308.68	$0.00	$508.32	$0.00	$9.91	$0.00	$298.77
WILSON, WILMA S. 23456012	BlueSelect Plus	$223.00	$116.92	$0.00	$106.08	$0.00	$0.00	$0.00	$116.92
WILSON, WILMA S. 23456012	Preferred-Care Blue	$7,298.00	$3,348.13	$32.74	$3,460.87	$0.00	$286.87	$0.00	$3,081.26

Payment Summary

Payment for	Check or Wire Number	Payment Date	Net Payment Amount
BLUE CROSS BLUE SHIELD OF KANSAS CITY	20160404128000039	04/04/2016	$42,146.34
PERSONAL CARE ACCOUNT	20160404106000487	04/04/2016	$267.83

The examples on the previous pages represent the format of the Professional Remittance Advice. The Facility Remittance Advice is slightly different. An example is included below.

Example 6: Facility Remittance Advice



Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

REMITTANCE ADVICE

Should you have any Questions please contact the following:
The Provider Hotline 816-395-3929 or 1-800-456-3759
Blue Medicare Advantage 1-866-508-7140
BlueCard 816-395-3686 or 800-320-9550
Or visit our website at Providers.BlueKC.com

Payee Name: ATKINS REGIONAL HOSPITAL
NPI: 1649259656
Payee ID #: 12345678
Payment Date: February 29, 2025
Payment: $97512.79
Wire/Check #: 12345B123456789

Claim #: 99999V0DCE99
Account #: A54321012345

Patient:
Member ID: 10000123456

Provider: ATKINS REGIONAL HOSPITAL
Provider ID: 99997018

Plan ID: Blue Cross Blue Shield
Adjusted Claim-Unavailable

PROVIDER SERVICES						PATIENT RESPONSIBILITY					PAYMENT SUMMARY			
Service Date	Procedure Code	Approved Days	Total Charge	Allowable Amount	Provider Write-Off	Deductible	Co-Pay	Co-Insurance	Other Patient Liability	Patient Total	Capitated Service	PCA Payment	Other Carrier Payment	Blue KC Payment
01/06/2024		0	-$501.00	-$107.82	$0.00	$0.00	$0.00	-$85.90	$0.00	-$85.90		$0.00	$0.00	-$21.92

Explanation of Other Non Covered: X02 This is a duplicate to a previously processed claim for this service date. Please refer to your previous Explanation of Benefits.

Explanation of Prov Write Off: X43 This charge has been processed based upon the provider's participation status and your contract terms.

Other Information:

Member Billing

The Agreement between the Contracted Provider and Blue KC is proprietary and confidential information. Notwithstanding the confidential nature of this information, Blue KC and Contracted Provider may disclose confidential information, including, but not limited to payment rates, quality metrics, and cost of care information, to members, referring providers, payors, plan sponsors, or as otherwise required by law to provide transparency regarding the potential or actual cost or quality of health care services.

Collection of Member Copayment, Coinsurance, Cost Share or Deductible

Contracted Provider shall collect all member copayments at the time of service. Coinsurance, cost share or deductible amounts are collected after services are rendered. Contracted Providers shall not waive amounts due from the member outside of provider's hardship and/or bad debt policies. Blue KC shall make remaining payments directly to Contracted Provider for covered services. Contracted Provider cannot bill member for the difference between full charges and payment rate. The Contracted Provider accepts the payment rate as payment in full for services provided to members. Contracted Provider cannot advance or otherwise provide funds to members directly or indirectly for copayment, coinsurance, cost share, deductible, or premium payment.

Blue KC will not reimburse for physician/nurse/provider phone calls for prescriptions. Members should not be billed for physician/nurse/provider phone calls for prescriptions.

Contracted Provider can negotiate arrangements with the member for payment of copayment, coinsurance, cost share or deductible, but providers shall not accept payments from any third parties.

For Chiropractic Services, a health benefit plan or health carrier, as defined in section 376.1350, including but not limited to Preferred Provider Organizations (PPO), independent physician associations, third-party administrators or any entity that contracts with licensed health care providers shall not impose any copayment that exceeds fifty (50) percent of the total cost of providing any single chiropractic service to its enrollees. (L. 2009 H.B. 577).

Payment collection from a member after Blue KC has processed the claim and issued a remittance advice:

- **Deductible:** a specific amount the member pays toward covered services before Blue KC begins to make payments.
- **Coinsurance:** a percentage of Blue KC reimbursement allowed for a covered service that the member is required to pay after they have met their deductible.

Payment collection from a member at the time of a visit:

- **Copayment:** a specified dollar amount which the member is responsible for paying at the time of an office visit.
- **Non-covered service amounts:** services that are not eligible for payment under the member's policy or benefit plan.

The Blue KC remittance advice shows the amount a Contracted Provider may bill the member and the amount the Contracted Provider agrees to write-off, pursuant to the Agreement.

Non-Covered Services

Contracted Providers may only collect payment from a member for a non-covered service if the member signs a written consent confirming that the member agrees to be responsible for payment of the service(s) prior to the service(s) being rendered.

The written consent must include the following:

- The specific service(s) to be provided
- A statement that the service(s) is or are not covered by Blue KC
- The estimated cost of the service(s)
- A statement that the member has agreed, in advance, to receive and pay for the specific service(s)
- A statement that the member will not be obligated to pay for the service(s), other than copayment, deductible, or coinsurance, if it is later determined that the service(s) are covered by Blue KC

It is important that Contracted Providers retain a copy of the member's signed consent and provide it to Blue KC in the event of a dispute regarding financial responsibility.

For further assistance, providers may call the Provider Hotline (see **Contact Resource Directory** for details).

Routine Examinations and Screenings

It is important that Contracted Providers be familiar with how to bill correctly for services that may be part of routine physical examinations. It is critical that these services be reported with the appropriate type of services, procedures, and diagnosis codes.

While Blue KC provides wellness benefits that are mandated by Kansas and Missouri state and federal laws, most Blue KC benefit plans provide coverage for routine preventive screenings that are not wellness benefits, based on recommendations from the Blue Cross and Blue Shield Association and guidelines set forth by the American College of Physicians.

Member Eligibility

To determine if a member is eligible for preventive care benefits under his/her Benefit Plan, a Contracted Provider may check **Providers.BlueKC.com** or call the Provider Hotline (see **Contact Resource Directory** for details).

Care Guidelines

The guidelines set forth to determine what services are considered preventive are updated periodically. Refer to **CDC.gov/vaccines** to access the most up-to-date immunization schedules. Blue KC's current Preventive Healthcare Guide is located at **BlueKC.com**, click Living Healthy then select Preventive Guidelines.

Payments to Hospitals

The reimbursement in the Agreement Fee Schedule is the only payment required for services, subject to Coordination of Benefits and other sources of payment provisions. The member is responsible for any member cost share amount and Blue KC is responsible to pay other amounts. If Contracted Provider is a hospital, the Blue KC Policies and Procedures and following payment conditions shall apply: days of hospital service, changes in hospital charges, bundling of services, unbundling of services and Hospital Acquired Conditions (HACs).

Days of Hospital Service

The day of admission shall be counted, but not the day of discharge when calculating days of inpatient hospital service payments. No charge shall be made to payor or member for part of a day of hospital service, except when an extended stay is elected by member after a Contracted Provider has recommended a hospital discharge. If member is absent from hospital at census-taking hour, daily service charge may be billed to member but not the payor. If member is required to leave for a short period of time, but is present during census-taking hour, no reduction in payment rate or normal daily service charge will be applied.

Changes in Contracted Provider Charges

If a Agreement includes a payment rate that is calculated as a percentage of the Contracted Provider's charge, Contracted Provider shall notify Blue KC to all changes of provider's chargemaster at least 60 days in advance. Written notice should include the effective date and percentage increase of Chargemaster for inpatient charges, outpatient charges and all other charges (i.e., the aggregate percentage increase for inpatient and outpatient charges) and calculations to demonstrate compliance with Agreement terms related to the increase. If the hospital has failed to provide require notice or the adjusted increase was not implemented, Blue KC may retroactively adjust payments or recoup as overpayments. All relevant information shall be provided by the Contracted Provider at Blue KC's request and within seven (7) calendar days.

The combined Chargemaster Increase for each consecutive 12-month period shall not exceed the limit specified in the Agreement. When the limit is exceeded, the formula provided in the Agreement will instead be used to determine payment for services.

Blue KC will give notice to the Contracted Provider for any payment adjustments with supporting calculations. These adjustments will be effective as of the effective date of the Chargemaster Increase that exceeded the Chargemaster Limit.

Bundling of Services

Contracted Providers may be reimbursed for services under DRG, APC, per diem or other bundled rate as determined in the Agreement. Contracted Providers shall follow all applicable bundling rules and **Blue KC Payment Policies** when submitting claims for services. Improperly unbundled services are not reimbursable. When a discounted charge payment methodology reimbursement is applied, all lines are reviewed per Blue KC payment polices for determination of reimbursement.

Final payment is subject to the application of claims adjudication and edits common to the industry.

Hospital Acquired Conditions (HACs) and Serious Adverse Events

Contracted Providers shall comply with all Blue KC requirements relating to HACs including Present on Admission indicators (POA)on claim forms for all diagnoses per Blue KC Payment Policy Payment Policy.

Blue KC will not reimburse Contracted Providers for serious adverse events including CMS-defined Hospital acquired conditions. Present on Admission (POA) is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered POA. A POA Indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes.

Contracted Providers shall not receive reimbursement for inpatient services related solely to HACs and shall hold Blue KC and the member harmless for charges for any inpatient services related solely to HACs.

The list below may be updated from time to time.

HACs means any one or more of the following:

- Pressure ulcers stages III & IV
- Catheter-associated urinary tract infections
- Vascular catheter-associated infection
- Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG)
- Air embolism
- Blood incompatibility
- Foreign object retained after surgery
- Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
- Surgical-site infections following:
  - Bariatric Surgery
  - Laparoscopic Gastric Bypass
  - Gastroenterostomy
  - Laparoscopic Gastric Restrictive Surgery
  - Orthopedic Procedures
    - Spine
    - Neck
    - Shoulder
    - Elbow
  - Cardiac implantable electronic device (CIED)
- Manifestations of poor glycemic control
  - Diabetic Ketoacidosis
  - Nonketotic Hyperosmolar Coma
  - Hypoglycemic Coma
  - Secondary Diabetes with Ketoacidosis
  - Secondary Diabetes with Hyperosmolarity
- Deep vein thrombosis and pulmonary embolism following orthopedic procedures:
  - Total Knee Replacement
  - Hip Replacement
- Iatrogenic Pneumothorax with venous catheterization
- Other conditions subsequently identified as HACs by the Centers for Medicare and Medicaid. (Blue KC will use the CMS effective date as the effective date for any addition to this list.)

Coordination of Benefits

Coordination of Benefits (COB) is a cost-containment provision of group contracts which helps to avoid duplicate payment of covered services. COB is applied when a member is enrolled with Blue KC and another insurance plan. COB assures that services are not reimbursed at more than 100 percent of Contracted Provider's total charges or the Blue KC contracted rate, whichever is less.

Please note that Blue KC accepts electronic claims (837) with COB data.

Blue KC and Contracted Provider shall coordinate benefits with the non-duplication provisions of the Member's Benefit Plan and applicable law. Third-party payment collection must also follow identification procedures for proper Coordination of Benefits.

The Contracted Providers must ask members for duplicate or COB coverage information, and shall notify Blue KC of any potential or actual duplicate COB coverage through Blue KC's claims filing practices.

Any payment incorrectly collected for services of a third-party responsibility should be returned to Blue KC by Contracted Provider. Contracted Provider shall not withhold services nor require member to pay for services pending determination of primary responsibility.

Participating providers may not collect from a member any amount above the established Blue KC allowable for a corresponding covered service.

Blue KC's liability for members with additional health insurance coverage will be governed by the Member's Benefit Plan.

Coordination with Medicare

Employer group insurance is frequently primary to Medicare benefits for the working aged, and beneficiaries with renal and other disabling conditions. Blue KC may pay secondary for members enrolled in an individual plan who are eligible for or enrolled in Medicare.

If Medicare is primary, the Contracted Provider must accept Medicare as form of payment. Blue KC will make payment only for Medicare cost sharing amounts.

Multiple Insurance Plans

If members have more than one insurance plan, always include the following information in the appropriate box on the claim form:

- Name of other insurance company
- Policyholder's name
- Identification number

No-fault Automobile Insurance

State insurance commissions regulate whether insurance companies can coordinate benefits with no-fault automobile insurance coverage.

- **Kansas:** benefits are coordinated with the no-fault insurer. Please check the Auto Accident box on the CMS 1500 claim form.
- **Missouri:** there is no Coordination of Benefits with no-fault carriers for Missouri residents.

Workers' Compensation

Work-related accidents are not covered under most Blue KC Benefit Plans. All reimbursement should be sought from the worker's compensation insurance.

If services provided by the Contracted Provider are the result of a member's on-the-job injury, specific information regarding the accident or condition is always needed on the claim:

- An indication that the injury was work-related (CMS 1500 employment box)
- Related diagnoses in appropriate fields on the claim form

Secondary Coverage Guidelines

The determination of which insurance carrier's allowable applies and which plan pays primary is determined in accordance with the member's health plan and the National Association of Insurance Commissioners (NAIC) guidelines. The Blue KC Agreement does not govern these determinations.

The following guidelines apply when Blue KC is a member's secondary health plan, except when the application of such guidelines could cause either party to violate any federal or state law.

When an individual is covered by two or more health plans, Blue KC's secondary payment will vary based on the rules governing a member's health plan. The Contracted Provider must "write off" any amount that exceeds the applicable allowable described below. Once the appropriate allowable is determined, the Contracted Provider should expect to receive payment from multiple health plans and/or the member that equals the allowable.

For purposes of Secondary Coverage Guidelines, allowable means the amount the Contracted Provider has agreed to accept as payment for the service or supply.

Missouri Group Insured Health Plans

When determining the secondary payment under these programs, Blue KC applies the primary carrier's allowable. However, Blue KC's secondary payment will never exceed the amount of the member's responsibility determined by the primary program.

The group purchaser is located in Missouri.

Kansas Group Insured Health Plans

When determining the secondary payment under these programs, Blue KC applies the highest of the allowables between the two or more programs.

The group purchaser is located in Kansas.

Self-Insured or ASO Plans

When determining the secondary payment under these programs, Blue KC applies the allowable as required in the plan sponsor's plan documents.

Federal Employee Plan

When determining the secondary payment under this program, FEP applies the lower of the allowables between the two or more programs.

BlueCard (Other Blue Cross and Blue Shield Plans)

When determining the secondary payment under these plans, the home plan determines what allowable applies in accordance with state law and plan documents.

Due to the variety of ways that an allowable may be determined, providers should not expect that claims will be processed under the same rule on each claim that is processed. Your allowable may be determined in several ways and thus the amount of the secondary payment will differ.

Medicare

Medicare Part A refers to inpatient institutional services, and Part B refers to outpatient and professional services.

When Blue KC is secondary to Medicare, the following guidelines apply:

Provider Filing with Medicare

Please DO NOT file with Blue KC and Medicare simultaneously. The Contracted Provider must wait until receipt of the Medicare remittance advice. After receipt of the Medicare remittance advice, please determine if the claim was automatically crossed-over to the member's supplemental insurance.

Crossed-over Claims

If the claim was crossed-over, the paper and electronic (835) remittance advice should have Remark Code MA 18, which states, "The claim information is also being forwarded to the member's supplemental insurer. **Send any questions regarding supplemental benefits to them:**

If the claim was crossed-over, please DO NOT file the claim with Blue KC unless it has been 30 days and the cross-over claim has not been received.

Claims not Crossed-over

If the remittance advice does not indicate the claim was crossed-over, please file the claim to Blue KC. Go to **Providers.BlueKC.com** or call the Provider Hotline (see **Contact Resource Directory** for details), with questions regarding COB or Medicare supplemental reimbursement.

Regulatory Requirements

Anti-Discrimination

The Contracted Provider shall not discriminate against a member on the basis of his or her source, method or rate of payment, his or her coverage under a benefit plan, age, sex or gender, sexual orientation or preference, marital status, race color, ancestry, ethnicity, national origin, religion, veteran status, disability, handicap, health status or medical condition (including mental as well as physical), genetic condition, claims experience, evidence of insurability (including conditions arising from domestic violence), utilization of medical or mental health services or supplies, or other unlawful basis including, without limitation, the member's filing of any complaint, grievance or legal action against the Contracted Provider. If Contracted Provider suspects frauds, abuse or misconduct, Contracted Provider shall report this information immediately to Blue KC.

HIPAA®

Blue KC and Contracted Providers are each separate covered entities for purposes of the Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing regulations found at 45 C.F.R. Parts 160 and 164 (collectively HIPAA). Blue KC and Contracted Providers are permitted to exchange protected health information for treatment, payment, and health care operations. Contracted Providers are responsible for ensuring compliance with HIPAA when entering, transmitting or accessing information to submit a claim or exchange other information with Blue KC. Where state law is more restrictive than HIPAA, Contracted Providers must comply with the applicable state law. Contracted Providers are responsible to assess whether they have legal authority (including written authorization, where required) to use or disclose such information. Contracted Providers are responsible for obtaining all authorizations that may be required to submit claims and obtain reimbursement under the Agreement.

The provider must comply with all HIPAA requirements for electronic transactions including transactions through a clearinghouse, intermediary, subcontractor or other agent.

Substance Use Disorder Claims

Contracted Providers that provide substance use disorder diagnosis, treatment or referral services and receive funds from certain federal programs are subject to additional privacy restrictions under 42 C.F.R Part 2 (Part 2 Rule). All providers who are a Part 2 Program or who operate a subpart that is a Part 2 Program must notify Blue KC.

Examples include:

- **Standalone SUD facilities:** community-based clinics, residential centers, Opioid Treatment Programs (OTPs)
- **Identified units:** special SUD units in general hospitals or Federally Qualified Health Centers (FQHCs)
- **Identified personnel:** specific providers (like buprenorphine prescribers) within general facilities, if primarily providing SUD care

For purposes of this section, all capitalized terms not defined in this section shall have the meanings provided in the Part 2 Rules.

A Part 2 Program is prohibited by the Part 2 Rule from disclosing Patient Identifying Information to Blue KC through the submission of a claim without first obtaining the patient's written consent. A Contracted Provider that is a Part 2 Program may obtain one consent from the patient to allow disclosure, including re-disclosure of information for treatment, payment and health care operations. This consent must notify the patient that the information may be redisclosed in accordance with HIPAA, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient. Contracted Providers are responsible for ensuring that all consents obtained comply with the requirements of the Part 2 Rule, including, but not limited to elements required by 42 C.F.R 2.31.

By submitting any claim (or other record) that contains Patient Identifying Information to Blue KC, a Contracted Provider that is a Part 2 Program represents and warrants that the Contracted Provider has first obtained patient consent in compliance with 42 C.F.R Part 2 to allow disclosure to Blue KC and Blue KC's use of the information for treatment, payment and health care operations. Blue KC reserves the right to deny payment of claims (and the right to refuse to process other information) in the event that Contracted Provider fails to obtain such consent.

Where provider has already notified Blue KC that it is a Part 2 Program or has a subpart that is a Part 2 Program, Blue KC does not require that provider further designate the claim information as subject to the Part 2 Rule. **However, if provider desires to communicate application of the Part 2 Rule as part of the claim submission, the following information should be added to the 837:**

2300/NTE 01 = ADD

2300/NTE 02 = 42 CFR Part 2 prohibits unauthorized disclosure of these records.

Provision of Part 2 Records and Information

Contracted Providers periodically submit records or other information to Blue KC as requested by Blue KC, as required by the Agreement or to support a claim. If the records or other information submitted to Blue KC includes Patient Identifying Information subject to the Part 2 Rule, either because Contracted Provider is a Part 2 Program or the Contracted Provider received such information from a Part 2 Program, the Contracted Provider may only provide the records or information to Blue KC if Contracted Provider has obtained patient consent for such disclosure. Where the records or information relate to a claim previously submitted to Blue KC, the original consent for the claim submission or for treatment, payment and health care operations may satisfy this requirement.

Provider is also required to notify Blue KC that the information is subject to the Part 2 Rule through inclusion of specific notice (the "Part 2 Disclaimer"). Accordingly, provider shall include the Part 2 Disclaimer with any record or information that contains Patient Identifying Information when submitting the record or information to Blue KC.

The Part 2 Disclaimer is:

"42 CFR Part 2 prohibits unauthorized disclosure of these records"

Confidentiality Proprietary Rights

Blue KC and the Contracted Provider shall maintain the confidentiality of information contained in the medical records of members in accordance with federal and state laws and regulations as documented in the Agreement including any Amendments, Attachments and/or Addendums.

Through the Agreement, each party may receive or become aware of confidential information of the other. Each party must agree to hold such information confidential and shall not reveal information to any third party except as otherwise permitted. Both parties reserve the right to control the use of their respective names, symbols, trademarks and service makes. Parties cannot use each other's marks without prior written consent, which can be ceased if a withdrawal from consent or termination of Agreement occurs.

- Contracted Provider shall limit the exposure of confidential information to necessary employees, while also educating staff on protocol and importance of maintaining confidentiality. Do not disclose information to any person outside of the organization except as needed to comply with the Agreement.
- Contracted Providers shall ensure that any payment rate or other confidential information disclosed to billing company, attorneys, etc. is not disclosed to any other Contracted Provider or organization.
- Contracted Providers must promptly return or destroy all Blue KC's confidential information upon termination or request of Blue KC unless otherwise allowed by the Agreement.
- Blue KC may disclose provider information consistent with confidentiality provisions in the Agreement. The Agreement shall not restrict any disclosure required by law. If responding to a formal disclosure request by

law, party must give advance notice to other party involved and take all action to not disclose unnecessary confidential information.

Notwithstanding the above confidentiality rights, Blue KC and provider may disclose confidential information, including, but not limited to payment rates, quality metrics, and cost of care information, to members, referring providers, payors, plan sponsors, or any other individual or entity as required by law to provide transparency regarding the potential or actual cost or quality of health care services.

Payment Compliance, Fraud, Waste & Abuse

What Constitutes Fraud, Waste and Abuse?

Fraud, Waste and Abuse (FWA) programs encompass a wide range of improper billing practices. Blue KC is committed to identifying, investigating, correcting; and if necessary, referring to law enforcement officials, cases of suspected fraud, waste and abuse by either providers, pharmacies or members.

The definitions of Fraud, Waste and Abuse herein are for reference only and may be subject to change depending upon applicable contract requirements and/or law, including without limitation, case law, statutes, regulations or administrative determinations.

If Contracted Provider suspects fraud, abuse or misconduct, Contracted Provider shall report this information immediately to Blue KC. See the **Contact Resource Directory** for information on reporting suspected fraud, waste or abuse or **click here to report a fraud concern**. Contracted Providers may also use these contact options to report suspicions or allegations anonymously.

Definitions of Fraud, Waste and Abuse

- **Fraud:** in general, means knowing and willful deception, misrepresentation or a reckless disregard of the facts with the intent to receive an unauthorized benefit.
- **Waste:** the expenditure, consumption, mismanagement, use of resources, practice of inefficient or ineffective procedures, systems and/or controls to the detriment or potential detriment of entities.
- **Abuse:** practices, which, while not necessarily meeting the legal definition of "fraud;' conflicted with or take advantage of legally sanctioned standards or contract provisions.

Blue KC has implemented payment compliance and payment integrity programs including coding edits to prevent fraud, waste and abuse.

Fraud generally involves a willful act. Waste is generally not considered criminally negligent action but rather a misuse of resources. Abuse involves actions that are inconsistent with acceptable fiscal, business or medical practices.

Fraudulent or abusive practices include, but are not limited to, the following:

- Billing for services not actually performed
- Falsifying a patient's diagnosis to justify tests, surgeries or procedures that aren't medically necessary
- Misrepresenting procedures performed to obtain payment for non-covered services, such as cosmetic surgery

- Upcoding - billing for a more expensive service than the one actually performed
- Unbundling - billing separately for services that are typically billed together
- Offering, soliciting, paying or accepting kickbacks for patient referrals
- Waiving patient co-pays or deductibles and over-billing the insurance carrier or benefit plan
- Billing a patient more than the deductible, co-pay and coinsurance amounts for services
- Some examples of consumer healthcare fraud are:
  - Visiting numerous doctors ("doctor shopping") to get multiple prescriptions for the same drug
  - Filing claims for services or medications not received
  - Forging or altering bills or receipts
  - Using someone else's coverage or insurance card
  - Allowing someone else to use a member's insurance card

Applicable Laws

In providing covered services under the Agreement, Contracted Provider must comply with all local, state or federal laws to conduct business and perform obligations.

The following information provides an overview of certain laws that apply to providers. This is not an exhaustive list.

The Federal Healthcare Fraud Statute

Prohibits

Knowingly and willfully executing, or attempting to execute, a scheme or artifice.

1. To defraud any health care benefit program; or
2. To obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,

Penalties

In connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in the 18 U.S. Code Section 1365), such person shall be fined under 18 U.S. Code Section 1347 or imposed not more than 20 years, or both; and if the violation results in death, such person shall be fined under 18 U.S. Code Section 1347, or imprisoned for any term of years or for life, or both.

18 United States Code§ 1347

The Civil False Claims Act

Prohibits

- Knowingly presenting, or causing to be presented, a false claim for payment or approval.
- Knowingly making, using, or causing a false record or statement in support of a false claim.
- Conspiring to violate the False Claims Act.
- Having possession or control of property or money and knowingly delivering, or causing to be delivered, less than all of the property or money to be used by the Government.

- Certifying receipt of property used, or to be used by the Government, without knowing if the information on the receipt is true, with an intent to defraud the Government. .
- Knowingly buying or receiving public property from an unauthorized Government officer or employee.
- Knowingly making, using or causing a false record or statement material to an obligation or pay or transfer money or property to the Government or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

31 United States Code§ 3729-3733

Penalties

Civil Money Penalties, adjusted for inflation, as well as up to three (3) times the amount of damages which the Government sustained per claim submitted in violation of the False Claim Act.

The Anti-Kickback Statute

Prohibits

Knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind, for referrals, for items or for services, that are paid in whole or in part under a federal healthcare program (which includes the Medicare program).

Penalties

Shall be guilty of a felony and upon criminal conviction, fined up to $100,000 and imprisoned for up to 10 years. In addition to criminal penalties, civil penalties include exclusion from participation in federal healthcare programs, and fines up to $50,000 per kickback plus 3 times the amount of remuneration.

42 United States Code §1320a-7b{b)

The Stark Statute (Physician Self-Referral Law)

Prohibits

A Physician from making a referral for certain designated health services to an entity in which the physician (or an immediate member of the provider's family) has an ownership/investment interest, or with which the physician (or an immediate member of the physician's family) has a compensation arrangement. The entity in which the physician (or an immediate member of the physician's family) has an ownership/investment interest, or with which the physician (or an immediate member of the physician's family) has a compensation arrangement shall not present or cause to be presented a claim or bill to any individual, third-party payor, or other entity for which services were rendered pursuant to a prohibited referral (exceptions apply).

Penalties

Denial of payment for the designated health services, refund/repayment of the amounts impermissibly collected up to a $15,000 fine for each service provided. Up to a $100,000 fine for entering into an arrangement or scheme.

42 United States Code §1395nn

The Whistleblower Protection Act

- Allows employees to stop, report or testify about employer actions that are illegal, unhealthy or violate specific public policies. Protects those who report illegal activity from retaliation. Retaliation includes such actions as firing or laying off, demoting, denying overtime or promotion, or reducing pay or hours.

Revisor of Statutes State of Missouri

Fraudulent insurance act, committed, when - powers and duties of department - penalties:

1. As use in sections **375.991 to 375.99** the term "statement" means any communication, notice statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of damages, bills for services, diagnosis, prescription, hospital or doctor records, x-rays, test results or other evidence of loss, injury or expense.
2. For the purposes of sections **375.991 to 375.99** a person commits a "fraudulent insurance act" if such person knowingly presents, causes to be presented or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker or any agent thereof, any oral or written statement including computer generated documents as part of or in support of, an application for the issuance of or the rating of, an insurance policy for commercial or personal insurance or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance, which such person knows to contain materially false information
3. concerning any fact material thereto or if such person conceals, for the purpose of misleading another, information concerning any fact material thereto.
4. A "fraudulent insurance act" shall also include but not be limited to knowingly filing false insurance claims with an insurer, health services corporation or health maintenance organization by engaging in any one or more of the following false billing practices:
    i. "**Unbundling**'; an insurance claim by claiming a number of medical procedures were performed instead of a single comprehensive procedure;
    ii. "**Upcoding**'; an insurance claim by claiming that a more serious or extensive procedure was performed than was actually performed;
    iii. "**Exploding**'; an insurance claim by claiming a series of tests was performed on a single sample of blood, urine or other bodily fluid, when actually the series of tests was part of one battery of tests; or
    iv. "**Duplicating**'; a medical, hospital or rehabilitative insurance claim made by a healthcare provider by resubmitting the claim through another healthcare provider in which the original healthcare provider has an ownership interest.

Penalties

A fraudulent insurance act for a first offense is a class E felony. Any person who is found guilty of a fraudulent insurance act who has previously been found guilty of a fraudulent insurance act shall be guilty of a class D felony. Any person who pleads guilty or is found guilty of a fraudulent insurance act shall make restitution to any person or insurer for any financial loss sustained as a result or the violation.

Missouri Statute 375.991 RSMo.

Kansas Office of Revisor of Statutes

40-2,118. Fraudulent insurance act defined; penalty; notification of commissioner, when; antifraud plan. For purposes of this act a "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented

to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic oral or telephonic communication or statement as part of or in support of, an application for the issuance of or the rating of an insurance policy for personal or commercial insurance or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

40-2, 118 - Revisor of Statutes

Penalties

A fraudulent insurance act shall constitute a severity level 6, nonperson felony if the amount involved is $25,000 or more; a severity level 7, nonperson felony if the amount involved is at least $5,000 but less than $25,000; a severity level 8, nonperson felony if the amount involved is at least $1,000 but less than $5,000; and a class C nonperson misdemeanor if the amount involved is less than $1,000. Any combination of fraudulent acts that occur in a period of six consecutive months and that involve $25,000 or more shall have a presumptive sentence of imprisonment regardless of its location on the sentencing grid block. In addition, any person who violates K.S.A. 40- 2,118 shall make restitution to the insurer or any other person or entity for any financial loss sustained as a result of the violation.

K.S.A. 40-2, 118 - Revisor of Statutes

Surveillance, Audit and Payment Integrity

Blue KC Right to Audit

Blue KC is authorized to access, inspect, audit and review all claims and related member medical records required to be created and maintained by Contracted Providers under the Agreement.

These audits may consist of, but shall not necessarily be limited to, verification of services reported to Blue KC and medical necessity of services and quality of care provided. Blue KC may recover or offset any amount related to billing or coding errors. There is no time limitation on recovery or offset in instances of fraud or misrepresentation by the Contracted Provider and the right to recover or offset shall not be affected by termination of this Agreement.

Procedures and mechanisms employed in the detection of possible fraud and abuse include, but are not limited to:

- Review of member profiles of use of services and payment made for such, including pharmacy utilization
- Review of Contracted Provider claims and payment history for patterns indicating need for closer scrutiny
- Software decision support services and detection including but not limited to duplicate payments, conflicting dates of service, over-utilization
- Field auditing activities
- The use of third-party audit vendors for claim overpayment recovery
- Internal payment integrity and coding compliance reviews on such items as claims pricing, procedures, quantity, duration, deductibles, coinsurance, provider eligibility, member eligibility, etc.
- Medical staff review and application for established medical service parameters
- Pre-payment and post-payment audits to identify FWA and for overpayment recovery through the use of internal or third-party audit vendors

Payment Integrity Program and Special Investigations Unit

The Payment Integrity Program at Blue KC is a holistic process that helps safeguard healthcare expenditures from accidental and intentional billing and coding errors. Payment Integrity programs, including, but limited to, contract compliance, itemized bill review, credit balance review, DRG review, clinical chart review. Payment Integrity program activities may occur pre-payment or post-payment.

Blue KC's Special Investigations Unit (SIU) is responsible for identifying, investigating, and resolving potential instances of fraud, waste, and abuse within healthcare claims and provider billing practices. The program ensures compliance with regulatory standards and internal policies by conducting thorough reviews, audits, and data analysis. When necessary, the SIU works with regulatory agencies and recovers overpayments based on confirmed findings. SIU also oversees the dispute process, giving providers the opportunity to challenge findings through a structured first-level and second-level review, discussed below in Payment Integrity Dispute Process and SIU Investigation Dispute Process.

Through proactive monitoring and collaborative efforts, the Payment Integrity Program and SIU promote integrity, accountability, and financial stewardship across the organization's healthcare operations.

Payment Policies

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies and documentation requirements as they pertain to submitted claims.

These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology (CPT)
- Centers for Medicare and Medicaid (CMS)
- American Medical Association (AMA)
- National Correct Coding Initiative (NCCI)
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary or investigational. In the event of a conflict between any policies, the member's coverage document will govern.

For the most current Blue KC payment policies, visit the Blue KC **Provider Portal**.

Pre-Payment Edits, Post-Payment Audits, and SIU Investigations

The Special Investigations Unit (SIU) and Blue KC Payment Integrity department utilize pre-payment edits, pre-payment and post-payment audits, and SIU investigations to verify compliance with:

- Blue KC medical and payment policies,
- American Medical Association (AMA) Guidelines,

- Centers for Medicare and Medicaid Services (CMS) regulations and guidance,
- Medical necessity, established standards of care, in cooperation with medical management,
- Appropriate coding practices including Current Procedural Terminology (CPT), CMS, AMA, National Correct Coding Initiative (NCCI) guidelines,
- Member benefit certificates, and
- Other professional organizations and societies.

Pre-payment edits, Pre- and Post-payment audits, and SIU investigations can range from a basic encounter edit to determine if the level of care is accurately billed, to a complete audit which thoroughly examines all aspects of the medical record and medical practice to determine if the services billed are supported.

Pre-payment audits and edits can request medical records prior to the initial payment to the provider. Medical records or itemized bills will need to be submitted before the final payment can be determined.

Post-payment audits are performed after the service(s) is billed and payments have been received by the provider. If the service is not supported by the medical record and correct coding and documentation guidelines, Blue KC will deny as Contracted Provider responsibility and the member cannot be billed.

Medical Record Documentation Requirements

Documentation in the medical record must reflect the healthcare services rendered to the patient. The Contracted Provider shall maintain medical, financial, accounting and other records and will:

- Provide complete records upon request in accordance with the timeframe provided in the request
- Utilize the Blue KC standards for documentation of medical services as required by national coding standards, this Guide or Blue KC Policies or Procedures
- The Contracted Provider shall maintain, in accordance with standard and accepted practices and Blue KC standards, such medical, financial, accounting and other records, in an organized record-keeping system.
- The records requested by Blue KC, its authorized representatives or agents or any governmental agency shall be provided by the Contracted Provider at no cost to the requesting party unless otherwise specified in the Agreement.
- Records or copies of records requested by Blue KC or our vendor partners shall be provided within the timeframe outlined from the date such request is made; however, records shall be provided on an expedited basis where necessary for Blue KC to conduct a medical records review on an expedited basis, or in the case of an audit or site visit by Blue KC, such records or copies of records shall be provided at the time of the audit or site visit. Site visits, audits or any other inspection of books and records shall occur during regular business hours.

Medical records are expected to contain all elements required in order to file and substantiate a claim for services as well as the appropriate level of care, i.e. evaluation and management services. Documentation must support the procedure code, diagnosis code and the appended modifier, as outlined by the American Medical Association (AMA) and ICD-10-CM Guidelines.

Letters/checklist 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 by your peers and clearly translated to be untestable to the reviewer.

Elements of a complete medical record include but are not limited to:

- Physician orders and/or certifications of medical necessity
- Patient questionnaires associated with physician services
- Progress notes of another provider that are referenced in the note
- Treatment logs
- Related professional consultation reports
- Procedure, lab, x-ray and diagnostic reports
- Contracted Provider notes for billed date of service

If the records are not received within the timeline indicated by Blue KC per the payment policy, the audit findings letter or specific Blue KC communication from the SIU Department:

- An administrative or technical denial of the claim may be issued, and the overpayment recovery process is initiated. For a post-payment audit or SIU Investigation, the Contracted Provider may not submit a corrected claim once notification of overpayment has been received. Blue KC will process the appropriate adjustment to recoup the identified overpayment.
- Blue KC post-payment audit programs and SIU Investigations include specific dispute resolution guidelines that must be followed to prevent an administrative or technical denial.
- During an SIU Investigation or a post payment audit additional documentation that is not a part of the medical record and that was not provided at the time of the initial request for the will not be accepted. Only medical records that were created contemporaneously with treatment will be considered.
- The provider must hold harmless and may not bill Blue KC, the Payor or the covered individual for any administrative or technical denial.
- The provider may be placed on pre-payment review status at any time.
- Blue KC may take additional actions as described in the Provider Agreement.

Blue KC will accept Amended Medical Records in the following instances:

Late Entry: A late entry supplies additional information that was omitted for the original entry. The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information and signs the late entry.

Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical records and be signed by the person making the addendum.

Correction: When making a correction to a medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign or initial and date the deletion, stating the reason for the correction. Document the correct information on the next line or space with the current date and time, referring back to the original entry.

Contracted Providers are reminded that deliberate falsification of medical records and prior authorization requests is a felony offense and is viewed seriously when encountered.

Examples of falsifying records include:

1. Creation of new records when records are requested
2. Back-dating entries
3. Post-dating entries
4. Pre-dating entries
5. Writing over, or
6. Adding to existing documentation (except as described in late entries, addendums and corrections)

Incorrect Payments, Appeals & Disputes

Blue KC maintains a number of administrative processes by which a Contracted Provider can notify Blue KC of a payment error, appeal a denial, or dispute an audit finding. These processes vary depending on whether the dispute relates to a payment error, denial of coverage or claim, or a payment integrity or SIU finding. Contracted Providers must complete the applicable administrative process prior to initiating any dispute under the Agreement. However, all claim adjustments must be made within 12 months of the original paid date. If a member has primary coverage with another carrier, a claim must be submitted within 90 days of the primary carrier's payment to be considered timely. If another carrier paid primary in error and then later recouped their payment, those claims must also be filed within 90 days of notification from the other carrier.

Claims Inquiry

Claims Inquiries must be submitted within 90 days of the original payment or the original timely filing period, whichever is longer.

If a Contracted Provider receives an incorrect payment (e.g. duplicate payment, a payment to an incorrect provider, or wrong payment rate), or a remittance advice does not balance to the payment received, please deposit the check. Do not return Blue KC's check.

The Contracted Provider should submit the payment error to Blue KC as a Claims Inquiry using one of the following methods:

i. Submit questions via Contact Us at **Providers.BlueKC.com**. Use **Claims** as the type of inquiry. Check claim status or review paid claims (plus eligibility and benefits) or view BlueCard responses and inquiries; click Claims/Eligibility

ii. Submit a claim inquiry eForm through the **Provider Portal** at **Providers.BlueKC.com**

iii. Call the **Provider Hotline** (see **Contact Resource Directory**)

Include all necessary information on the form in order for the claim to be properly researched:

- Claim number
- Date of service
- The Blue KC 8-digit provider/group number
- The policy holder's/insured's name (if different from the member) and ID number

The inquiry will be routed to the appropriate area for correction, and every effort will be made to resolve the problem quickly.

An adjustment will be made to a future remittance advice to account for (or balance) the reported problem. If appropriate, incorrect payments will be deducted at that time.

Overpayments

If a provider receives an aggregate overpayment due to excess reimbursement from multiple group insurance carriers, please do not refund the overpayment to the member. Call the Provider Hotline (see **Contact Resource Directory**) on where the overpayment should be sent.

Overpayments that are a result of a payment error (e.g. duplicate payment) should be resolved through submission of a Claims Inquiry, above. Overpayments that were created as a result of a Contracted Provider billing error should be corrected through submission of a corrected claim or submission of a Claims Inquiry, above. The overpayment amount will be recouped through the remittance advice. Blue KC will accept inquiries for provider identified overpayments with no time limit.

Blue KC will recover any overpayments, payments related to billing code errors, or incorrect payments by credit transactions on the remittance advice. Blue KC may offset the full amount of any incorrect payment and reissue payment for the correct amount. Should the Contracted Provider not receive an overpayment letter outlining the reason for recovery, the provider may submit a claim inquiry within 12 months of the date of the recovery.

There is no time limit for overpayments that are voluntarily returned by the Contracted Provider.

For claims subject to RSMo 376.384, Blue KC will not request a refund or offset against a claim more than 12 months after Blue KC's payment of the claim except in cases of fraud or misrepresentation by the provider.

Unsolicited Refunds

To help reduce the administrative cost for Contracted Providers, Blue KC will no longer accept unsolicited checks effective January 1, 2025. If you have identified a potential overpayment, you can submit a request for review of possible overpayment and check "Overpayment" on our Claim Inquiry form. Any unsolicited check received will be returned to the provider requesting a claim inquiry for review of potential overpayment.

In filling out the details on the form, providers can include the claim information and reasons they feel the claim is overpaid. If the potential overpayment is valid, Blue KC will offset the claim to recoup the overpayment. If a provider does not receive frequent payments (two or more monthly payments in a three-month time span), Blue KC will respond to the claim inquiry form and advise an overpayment letter will be sent to you and should be attached to the overpayment when returned to Blue KC.

Member Overpayments

Upon receipt of a remittance advice for insured Blue KC local business, if a Contracted Provider collected more than the amount indicated as member responsibility on the remittance advice, it must be refunded to the member no later than 30 days after receipt of the remittance advice. A refund is not required if the member owes for previous services rendered and the overpayment is applied to the outstanding balance.

Claim Payment Dispute Process and Appeals

For Medical Necessity and Coverage Determinations

After a prior authorization, concurrent review or retrospective review for a service denied as not medically necessary, providers have the opportunity to discuss the case with the Blue KC medical director, who made the denial determination, if the request is made by the end of the next business day after denial notification. Please call and fax additional clinical information. See **Contact Resource Directory** for details.

Standard Appeal is a regular review for coverage denials or reductions, taking up to 30 days, while an Expedited Appeal is for urgent situations where a delay threatens life, health, or maximum function, requiring a decision within 72 hours or less, often involving immediate care needs like continuing hospital stays or urgent mental health services.

	Standard Appeal	Expedited Appeal
When to File	A standard appeal for a denial of medical necessity is available within 180 days after notification of the denial or when waiting 30 days for a response does not jeopardize the member's health.	An expedited appeal is available during care or pre care, when the standard time frame for a response (30 days) could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.
Initiation	To initiate a standard appeal the provider should submit additional information to Blue KC by calling, faxing or written correspondence (see Appeals in **Contact Resource Directory** for details).	For expedited reconsideration of a denial, a provider may phone or fax additional clinical information to Blue KC to the attention of the medical director. A medical director will also be available within 24 hours to discuss the case with the provider. (see Appeals in **Contact Resource Directory** for details).
Review	The appeal review will be conducted by a medical director who has no previous involvement in the case, is in the same or similar specialty and is not a subordinate of the medical director who made the original decision. If the medical director is unable to reverse the decision, then the case is sent to an independent peer review organization.	The Blue KC medical director will review any medical records and additional documentation submitted by the hospital or provider.The review will be performed by a medical director with no previous involvement in the case. If the medical director is unable to reverse the determination, then the case is referred to an independent peer review organization.
Response	Blue KC will make its best effort to issue a written decision to the provider and member within 30 days.	The Blue KC medical director will issue a decision promptly within 72 hours or two business days, whichever is less. Blue KC will notify the provider, member and hospital in writing of the Blue KC medical director's decision. Expedited appeals, on behalf of the member, which do not resolve a difference of opinion may be resubmitted through the standard appeals process and will be reviewed by a medical director who did not participate in the prior review.

All Other Purposes

If a Contracted Provider disagrees with the denial of a service on a claim or a request for an overpayment that is unrelated to a Payment Integrity or SIU Investigation, the Contracted Provider may request reconsideration of the adjudicated claim. Blue KC may adjust an adjudicated claim if it is determined that the claim was incorrectly paid or denied.

Providers must give Blue KC written notice of a request for reconsideration within 90 days of the disallowance, payment, or other notice of adjudication. If the provider fails to request reimbursement in a timely manner, the provider cannot bill or seek reimbursement from a member that was denied.

Payment Integrity Dispute Process

First-Level Dispute

Services denied as a part of the pre-payment edit, pre- or post-payment audit process, may be disputed in writing within 30 days of notification of the findings or the receipt of the remittance advice.

Written notification of disagreement highlighting specific points for reconsideration should be provided with the dispute.

- Submit a written inquiry to Blue KC using the form found on Blue KC's website along with supporting documentation unless you have received a findings letter from a Blue KC payment integrity vendor. For vendor supported audit programs, submit the supporting documentation per the contact information provided on the audit findings letter.
- Additional information may be found in Blue KC's Pre and Post Service Claim Review payment policy, POL-PP-212.

Second-Level Dispute

For some audit programs, a second-level dispute may be offered per the audit findings letter. A Contracted Provider may request a second dispute in writing within 30 days of notification of the first-level dispute determination. Submit the dispute as instructed in the letter containing the determination of the first-level dispute.

Once the full dispute process has been completed, Blue KC will consider it to be the final payment of the claim.

Selected Audit programs include a payment integrity third-level dispute process as noted in the provider findings letter.

SIU Audit or Investigation Dispute Process

SIU First-Level Dispute

Services denied as a part of the pre- or post-payment audit process may be disputed in writing within 30 days of notification of the findings. Written notification of disagreement highlighting specific points for reconsideration should be provided with the dispute. Submit the dispute as instructed in the findings letter containing the determination or outcome of the Pre- or Post-Payment Audit.

SIU Second-Level Dispute

A Contracted Provider may request a second and final dispute in writing within 30 days of notification of the first-level dispute determination. Submit the dispute as instructed in the letter containing the determination of the first-level dispute. Once the full dispute process has been completed, Blue KC will consider it to be the final payment of the claim.

SIU Dispute Timeframes and Overpayment Recovery

Failure to submit a first-level or second-level dispute within 30 days from the date of notification of the findings will result in the initiation of recovery for the identified overpayment, either through offset or collections.

Identified overpayments that are upheld following a second-level dispute determination will be initiated for recovery—either through offset or collections.

Contracted Providers may request to remit payment for the identified overpayment by check, as an alternative to recovery through offset or collections.

Special Service Arrangements

Blue KC may contract for Special Service Arrangements with network providers so members can receive maximum benefits. The Special Service Arrangements may be developed for any designated area of health benefits coverage.

The purpose of these descriptive Policies and Procedures is to provide specific explanations of provisions contained within a supplier's contract and is intended to clarify contractual obligations and supplier's rights.

The provider agrees that when any such Special Service Arrangements are made, the provider will admit or direct covered members to other network providers that participate in the Special Service Arrangement. A notice will be provided to all network providers in advance regarding all new arrangements.

These select networks must be used by members. If services are subject to a Special Service Arrangement and a provider is not participating in such arrangement, Blue KC will not pay for such service, and the provider must hold the member harmless.

Prescription Drugs

Members are supplied with a listing of participating pharmacies. Members are responsible for notifying their providers of the correct pharmacy to use.

Home Health Agencies (HHA)

Utilization Review and Medical Necessity

Provider agreements require providers to cooperate in utilization review and medical necessity determinations. Utilization review is a process to understand all aspects provider services including: prior authorization, quality improvement, concurrent review, case management and respective review.

Prior Authorization

Prior authorization is the process used to determine the appropriateness of services provided to members and payments made on behalf of members. For BlueCard members please check with the member's home plan for authorization requirements. See **Contact Resource Directory** or visit **Providers.BlueKC.com** for details.

Appeals and Grievances

If a provider believes a claim has been processed incorrectly, please review the Claims module for and follow the appropriate procedures. See **Contact Resource Directory** the claims inquiry online form or if you have any further questions call the **Provider Hotline**.

Infusion Certification Process

Infusion providers are no longer required to submit a Certificate of Medical Necessity (CMN) documents with claims. This applies to all Blue KC networks.

Pharmacy

Clinical Pharmacy Department

The Clinical Pharmacy Department is part of Blue KC. All pharmacy benefit management operations are coordinated internally, with the exception of claims processing. Blue KC has a pharmacy network available for claims processing through Optum Rx that started January 1, 2020.

Specialty Pharmacy Program

A specialty pharmacy is one that provides specialized care for patients with complex chronic health conditions such as rheumatoid arthritis, multiple sclerosis, psoriasis and others. These pharmacies do everything from dispense the specialty medication to help patients manage their health condition.

The following is a list of other services provided by the specialty pharmacies at no additional cost:

- Assigns a member care coordinator who serves as a personal advocate and point of contact
- Provides the necessary supplies to administer the medications
- Provides patients with refill reminders (calls, text or e-mail)
- Works directly with patients to arrange a convenient shipment date

- Coordinates with Blue KC to take care of billing issues
- Offers access to a dedicated clinical staff of nurses and pharmacists who are knowledgeable about the medications and conditions
- Offers care management programs to help patients get the most from their medication
- Allows the medications to be delivered to either the provider's office or member's home
- Ships all medications overnight

Prescriptions for a specialty medication must be filled by a designated specialty pharmacy.

Many specialty medications require prior authorization and must also be obtained from one of our specialty pharmacies. They will provide the injectable medications to either the prescriber's office or the patient's home and will bill Blue KC directly.

Most specialty medications are covered under the pharmacy benefit.

Prescription Drug List (PDL)

The Provider Advisory Committee (PAC) of Blue KC develops and maintains the Prescription Drug List (PDL). The committee is composed of practicing providers and pharmacists within the Kansas City area. Quarterly meetings are held to evaluate new drug therapies and review drug utilization issues. Medications are evaluated on the basis of safety, effectiveness, adverse events, cost and proven advantages over existing agents. You can access the Prescription Drug Lists (PDL) on the **Providers.BlueKC.com**.

The member's Blue KC identification card reflects the pharmacy network a member may access.

Closed Formulary

Some employer groups may have selected a closed formulary option to better control utilization and cost. In this situation, most drugs categorized in the top tier will not be covered. If a member has failed or is intolerant to a formulary medication (1st or 2nd tier), the prescribing provider can submit documentation to request coverage of a non-formulary medication.

For a list of specialty medications including those covered under the medical benefit, please refer to the Prescription Drug List (PDL)

For details please review the **Providers.BlueKC.com** forms section and the **Contact Resource Directory**.

New Products

Any new branded medication will automatically be assigned to the top cost sharing tier and will require prior authorization until reviewed by the Committee. Please be aware that as new products are released and post-marketing information on existing therapies becomes available, changes in the PDL status may occur. Providers will be notified of any such changes through newsletters and direct mailings.

Prior Authorization for Medication

Prior authorization is a prior review of all services including inpatient stays that are medically necessary as well as services and supplies covered under the Provider Agreement of the Member's Benefit Plan. Blue KC may implement prior authorization processes as deemed necessary.

Member Information

All prior authorizations should be submitted via the Blue KC Provider Portal. When requesting prior authorization, the provider will need the following member information on the prior authorization form:

- Member name
- Blue KC member ID number
- Medication and the intended length of therapy
- Date of birth
- Relevant clinical information
- If necessary, medical office notes may be required to complete the review

Medications Requiring Prior Authorization

Please be aware that as new products are released and post-marketing information on existing therapies becomes available, changes in this list may occur. Provider and pharmacy providers will be notified of any such changes via newsletters and direct mailings.

Prior authorization forms are available (if the **Provider Portal** is unavailable) to help simplify and streamline the prior authorization process. The forms may be accessed at **Providers.BlueKC.com**. These must be completed and submitted online to the Clinical Pharmacy Department for processing.

- All prior authorization requests are processed within 36 business hours (1 business day from date of receipt of all necessary information).
- All patient information is strictly confidential. Incomplete forms may result in a denial.

Required Prior Authorization

- Where there are safety concerns and significant risk of drug interactions.
- To ensure that the manufacturer's recommended dosing guidelines are followed.

Utilization Management of Medication

The Provider Advisory Committee (PAC) may implement utilization management processes as deemed necessary.

Utilization management edits (such as quantity limits, length of therapy limits, prior drug therapy requirements or preclusive therapy) are used when the following exists:

- Safety concerns
- Significant risk of drug interactions
- Potential deviation from the manufacturer's recommended dosing guidelines

Behavioral Health & Substance Use

If a member requires behavioral health, psychiatric and/or substance use services, a PCP referral is not necessary.

Call the **Provider Helpline** at 1-800-528-5763 or use the WebPass system to refer patients with behavioral health needs to Blue KC's behavioral health care management services provided by Lucet. Blue KC members have 24/7 access to Mindful Advocates, licensed behavioral health clinicians who can provide in-the-moment support, help members understand their benefits, and connect them with care options based on their unique needs. Mindful Advocates can assist with finding in-network providers and with scheduling appointments for more urgent needs by calling 833-302-MIND (6463) or the number on the back of the member ID card.

Consultations

If a provider treating a member on a medical/surgical unit requires a psychiatric consultation or evaluation, please contact an expert in behavioral health and substance use to provide a psychiatrist to evaluate the member.

Additional Services

- Telephone consultation 24 hours a day, seven days a week by a licensed behavioral health professional
- Consultation with a psychiatrist to consider treatment options for members with behavioral health concerns
- Referrals for urgent and emergency services needed on the same day or next day
- Prevention services for at-risk members including telephone support
- Educational materials provided for members with depression, attention deficit hyperactivity disorder and bipolar disorder
- **Provider Helpline** at 1-800-528-5763 for immediate consultation and referrals when a provider's office calls
- Online educational resources at **LucetHealth.com**

Claims

For any correspondence or information, see the **Contact Resource Directory** for the claims address for behavioral health and substance use.

Medical Necessity Guidelines

Lucet Health (Lucet) utilizes medical necessity criteria to make medical necessity determination. The medical necessity criteria set applied varies according to the behavioral health service being requested. To determine which criteria set will be used, please go to **lucethealth.com/providers/resources/mnc**.

Refer to the list below:

- **Level of Care Utilization System (LOCUS):** used to evaluate behavioral health treatment requests for adults age 19+ years.
- **Child and Adolescent Level of Care Utilization System (CALOCUS):** used to evaluate mental health treatment requests for children and adolescents ages 6-18 years.

- **Early Childhood Service Intensity Instrument (ECSII):** used to evaluate mental health treatment requests for infants, toddlers and children ages birth through 5 years.
- **American Society of Addiction Medicine criteria (ASAM):** used to evaluate substance use disorder service and treatment requests.

Prior Authorization

Prior authorization is a prior review of all services including inpatient stays that are medically necessary as well as services and supplies covered under the Agreement of the Member's Benefit Plan. Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements. To prior authorize mental health or substance use treatment services, please call Lucet.

Member's Plan	Prior Authorization Requirements
Blue-Care HMO **Preferred-Care PPO** **Preferred-Care Blue® PPO**	• No authorization is required for outpatient services. • Required for all inpatient and residential services. • Applied Behavior Analysis (ABA) requires prior authorization from first visit. A reference number will then be assigned. (For autism services, please refer to the Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder Medical Policy located under the Policies & Manuals section of **LucetHealth.com**.) Refer to the member's plan for specific benefits and authorization requirements for psychological/neuropsychological testing. To prior authorize mental health or substance abuse services, please **call Lucet**. (Prior authorization requirements were removed for psych and neuropsych testing with the exception of JAA groups)

Provider Designation Programs

Blue Distinction

The **Blue Distinction Specialty Care** Program is a national designation program that recognizes healthcare facilities that demonstrate expertise in delivering quality specialty care-safely, effectively and cost efficiently-through two levels of designation across seven areas of specialty care.

2 Levels		
Blue Distinction Center	Healthcare facilities recognized for their **expertise** in delivering specialty care.	1. Bariatric Surgery 2. Cardiac Care 3. Knee and Hip Replacement 4. Maternity Care 5. Spine Surgery 6. Transplants 7. Fertility Care 8. Substance Use Treatment and Recovery
Blue Distinction Center+	Healthcare facilities recognized for their **expertise and efficiency** in delivering specialty care.	

Only those facilities that first meet nationally established, objective quality measures for Blue Distinction Centers will be considered for designation as a Blue Distinction Center+. See **Contact Resource Directory**.

Total Care

Total Care (TC) is a delivery model designed to improve specific aspects of the healthcare delivery system. The Primary Care Providers (PCP) engaged in this delivery model will play a key role in the transformation of the delivery system.

The Advanced Primary Care (APC) Program is one of Blue KC's programs designed to align with the BDTC model. The APC Program is based on foundational medical home concepts as well as APC principles designed to improve aspects of the healthcare delivery system, such as:

- Person- and family-centered care
- Care that meets population needs while ensuring it is continuous, comprehensive and equitable
- Care that is team-based and collaborative
- Care that is coordinated and integrated with the medical neighborhood and community-based services
- Care that is accessible and of high value
- A well-developed infrastructure that supports movement from fee-for-service to value-driven, population-based care and payment
- Effective use of Health Information Technology (HIT) to include electronic records, data analytics and population health tools
- Measurement and active improvement in quality, experience and cost/utilization outcomes

To find out more about the APC program and how to participate, please email **_Medical_Home@BlueKC.com** and request more information.

Contact Resource Directory

Contact Resource Directory

Main Contacts and Resources

Provider Portal	
Web address	Providers.BlueKC.com
The Blue KC Provider Portal has an eligibility search/information, forms, medical policies, archived issues of Blue KC's BlueSpeak and reference documentation/resources.	
Provider Hotline	
Toll Free	1-800-456-3759
Phone	816-395-3929
TODY	816-842-5607
Fax	816-395-3959
Available Monday- Friday 8:00 a.m. to 6:00 p.m. Central Time	

Blue KC

Main Contact Number and Address		
Toll Free Number	1-800-822-BLUE (2583)	1-888-989-8842
Phone Number	816-395-2222	
Web address	BlueKC.com	Providers.BlueKC.com
Correspondence Address	Blue KC, PO Box 419169, Kansas City, MO 64141	
Location Address	1400 Baltimore, Kansas City, MO 64105	
Available Monday - Friday 8:00 a.m. to 6:00 p.m. Central Time		
Appeals (regarding Medical Necessity)		
Toll Free Number	1-800-892-6116 ext. 2214 (expedited)	
Phone Number	816-395-3929 (standard)	816-395-2214 (expedited)
Fax Number	816-817-2486 (standard)	816-395-2073 (expedited)
Correspondence Address (standard)	Blue KC, Appeals Department PO Box 417005, Kansas City, MO 64141-7005	
Correspondence Address (expedited)	Blue KC, Attention Medical Director PO Box 419169, Kansas City, MO, 64141-6169	
For continued stay denials and expedited appeals, call the Blue KC Medical Director at 816-395-2214 or toll-free at 1-800-892-6116 ext. 224.		

Away From Home Care	
Toll Free Number	1-800-348-2421
Phone Number	816-395-3791
Away From Home Care is an out-of-area program sponsored by the BCBS Association that is available to select HMO members.	

Blue Distinction
The Blue Distinction Specialty Care Program is a national designation program that recognizes healthcare facilities that demonstrate expertise in delivering quality specialty care safely, effectively and cost efficiently through two levels of designation - Blue Distinction Center and Blue Distinction Center+. For more information, please visit **bcbs.com/about-us/programs-initiatives/blue-distinction-specialty-care/centers-and-physicians-search.** Total Care (TC) is a delivery model designed to improve specific aspects of the healthcare delivery system. Blue KC has designed compensation methodologies that reward providers for managing the care of their patients giving attention to cost, quality and patient satisfaction. For information about TC, see the Provider Reference Guide at **Providers.BlueKC.com**.

Blue Medicare Advantage - Blue-Advantage Plus of Kansas City, Inc.	
Web address	**Providers.BlueKC.com**
Blue-Advantage Plus of Kansas City, Inc. is a wholly owned subsidiary of Blue Cross and Blue Shield of Kansas City offering Medicare Advantage (HMO) plans. See the separate Provider Administrative Manual located at the web address above.	

Management Referral Line		
Toll Free Number	1-800-822-2583 ext. 2060	1-866-859-3811
Phone Number	816-395-2060	
Members with chronic, catastrophic, high-risk or high cost conditions are referred to the Case Management Program for assistance. This program goes beyond short-term discharge planning.		

Claims Inquiry	
Web address	**Providers.BlueKC.com**
Electronic Submission	All providers should submit claims inquiry by using the Claims Inquiry eForm.

Clinical Operations	
Phone Number	816-395-2214
Fax Number	816-395-2073
Correspondence Address	Blue KC, Attention Medical Director PO Box 419169, Kansas City, MO 64141-6169
For policy information go to **Providers.BlueKC.com**, access Medical Policies then search for the policy name, number, CPT code, keyword or phrase.	

Customer Service	
Toll Free Number	1-888-989-8842
Phone Number	816-395-3558
TODY	816-842-5607
Available Monday - Friday 8:00 a.m. to 8:00 p.m. Central Time.	
Credentialing	
Toll Free Number	1-800-822-2583
Phone Number	816-395-3929
Fax Number	816-395-3185
EDI Help Desk	
Toll Free Number	1-800-472-6481
Federal Employee Program (FEP)	
Toll Free Number	1-800-221-2362
Phone Number	816-395-3678
Fax Number	816-395-3811
Web address	**FEPBlue.org**
Correspondence Address	Blue KC, PO Box 419071, Kansas City, MO 64179-0288
Available Monday-Friday 8:00 a.m. to 5:00 p.m. Central Time.	
Find Blue KC Doctors, Hospitals, and Pharmacies	
Web address	**BlueKC.com/Find-Care/Doctors-Hospitals**
In addition to looking up any provider, a provider may use this site to verify the accuracy of their own contact information.	
Fraud, Waste, and Abuse Hotline for Federal Employees Program (FEP)	
Toll Free Number	1-800-337-8440
National Federal Employee Program (FEP) Anti-Fraud Hotline	
Phone Number	816-395-2870
Fax Number	816-502-0182
Web address	**BlueKC.com** (in the footer, click Anti-Fraud) or at **FEPBlue.org**
Email Address	**_SIU@BlueKC.com**
Correspondence Address	Blue KC, PO Box 419169, Kansas City, MO 64141
Providers may also use these contact options to report suspicions or allegations of Fraud or Abuse anonymously.	

Fraud, Waste, and Abuse Hotline for Blue KC Local		
Toll Free Number	1-800-340-0119	
Phone Number	816-395-3151	
Fax Number	816-502-0182	
Web address	**BlueKC.com** (in the footer, click Anti-Fraud)	
Email Address	_SIU@BlueKC.com	
Correspondence Address	Blue KC, PO Box 419169, Kansas City, MO 64141	
Providers may also use these contact options to report suspicions or allegations of fraud or abuse anonymously.		
Fraud, Waste, and Abuse Hotline for Blue KC Pharmacy		
Phone Number	816-395-3778	
Fax Number	816-502-0182	
Web address	**BlueKC.com** (in the footer, click Anti-Fraud)	
Email Address	**_SIU@BlueKC.com**	
Correspondence Address	Blue KC, PO Box 419169, Kansas City, MO 64141	
Providers may also use these contact options to report suspicions or allegations of fraud or abuse anonymously.		
Health Companion™ Program (Disease Management)		
Toll Free Number	1-866-859-3813	
Phone Number	816-395-2076	
Email Address	**HealthyCompanion@BlueKC.com**	
Disease Management Program benefit to Blue KC members. Physicians may refer members via phone or confidential email for nurse outreach.		
HEDIS®		
Fax Number	816-995-1593	
Correspondence Address	Blue KC, Quality Management Department, 1400 Baltimore, Kansas City, MO 64105	
The HEDIS medical record data abstraction process begins in late January and finishes in late April. To minimize office disruption, we ask providers, with 15 or less records, to pull their records and submit to Blue KC via our secure Kiteworks system, fax-mail or U.S. mail. Kiteworks is at Blue KC Secure File Sharing. If providers need assistance accessing Kiteworks, call 816-395-313 . If providers have questions or concerns regarding the medical record abstraction process, please contact Rudy Bremen N., Quality Nurse Liaison, at 816-395-252		
HIPAA Privacy and Security		
Toll Free Number	1-800-932-1114	
Phone Number	816-395-3784 (privacy)	
Email Address	**Privacy@BlueKC.com**	**IS_Security@BlueKC.com**
Correspondence Address	Blue KC, PO Box 417012, Kansas City, MO 64141-7012	

Sending Medical Records	
Fax Number	Per request letter
For HMO and PPO Federal Employees Program Motors members	Blue KC, PO Box 411878, Kansas City, MO 64141-1878
For ITS Host members (BlueCard) Blue KC	PO Box 419016, Kansas City, MO 64141-6016
Medical records may be mailed to the address above or can be faxed to the number indicated on the request letter.	
Pharmacy Services	
Toll Free Number	1-800-228-1436
Phone Number	816-395-2176
Web address	**Providers.BlueKC.com**
Correspondence Address	Blue KC Pharmacy Services, attention Teresa Haile, PO Box 419169, Kansas City, MO 64141-2735
A list of medications or classes of medications requiring prior authorization, step therapy, specialty pharmacy and/or having dose optimization/quantity limits are listed at **BlueKC.com** (contact, FAQs, medical policies, review our medical poli prescription drugs or search by drug name) or at **Providers.BlueKC.com** (login, medical poli review our medical poli agree to terms, prescription drugs or search by drug name). Calls are answered 24n (outside of Monday-Friday 8:00 a.m. to 5:00 p.m. calls are answered by Optum Rx). In an effort to make sure the new-to-market prescription drugs covered are safe, effective and affordable, coverage of many new drug products will be delayed until the plan's Provider Advisory Committee (PAC) has reviewed them. This review process is usually completed within six months after a drug becomes available.	
Prior Authorization (Utilization Management)	
Toll Free Number	1-800-892-6116 ext. 3989
Phone Number	816-395-3989
TODY	816-842-5607
Fax Number	816-926-4253
Web address	**Providers.BlueKC.com**
A list of services or medications requiring prior authorization, step therapy, specialty pharmacy and/or having dose optimization/quantity limits are listed at **BlueKC.com** (Contact, FAQs, Medications) or (Contact, Find a Form).	
Provider Data	
Toll Free Number	1-800-822-2583 ext. 3929
Phone Number	816-395-3929
Fax Number	816-395-3387
Web address	**Providers.BlueKC.com**
Email Address	**Provider_Data@BlueKC.com**
To update provider data, please download a Provider Demographic Change Request form from the web address above, complete and email the form, with any required supporting documents, to the email address above.	

Blue KC Provider Portal	
Toll Free Number	1-800-822-2583 ext. 3700
Phone Number	816-395-3700
Web address	Providers.BlueKC.com
To get a login ID, register from Providers.BlueKC.com	
Utilization Management/Concurrent Review	
Toll Free Number	1-800-892-6116 ext. 2388
Phone Number	816-395-2388
TODY	816-842-5607
Fax Number	816-995-1556
Web address	Providers.BlueKC.com
Clinical Information can be faxed to the number above.	

BlueCard

BlueCard Access	
Toll Free Number	1-800-810-2583
365/24/7; Use to find providers in another Blue Plan's area	
BlueCard Eligibility	
Toll Free Number	1-800-676-2583
365/24/7; Eligibility, benefits and prior authorization from the Provider Portal.	
BlueCard Provider Hotline (Customer Service)	
Toll Free Number	1-800-320-9550
Phone Number	816-395-3686
Fax Number	816-527-0432
Web address	Providers.BlueKC.com
Correspondence Address	Blue KC, PO Box 419016, Kansas City, MO 64141-6016
Toll free and local phone numbers are staffed 8:00 a.m. to 8:00 p.m. CT, Monday - Friday.	

Vendors/Delegates

Optum Specialty Pharmacy	
Phone Number	1-855-427-4682
Fax Number	1-877-342-4596

ASK-Administrative Services of Kansas (EDI HelpDesk)		
Toll Free Number	1-800-472-6481	
Fax Number	785-290-0720	
Web address	**ask-edi.com**	
Email Address	**askedi@ask-edi.com**	
Electronic claim assistance		
CAQH Solutions - Council for Affordable Quality Healthcare		
Web address	**Proview.CAQH.org/PR**	
Used to obtain a CAQH number and maintain a provider's credentialing information.		
EDI Help Desk		
Toll Free Number	1-800-472-6481	
eviCore (formerly MedSolutions Imaging)		
Toll Free Number	1-888-693-3211	
Phone Number	1-888-693-3210	
Web address	**eviCore.com**	
Radiology Prior Authorization		
Behavioral Health and Substance Use		
Toll Free Number **Physician Helpline**	1-800-528-5763 (member and provider)	1-888-611-6285 (provider relations)
Phone Number	816-237-2354 (member and provider)	
Web address	**LucetHealth.com**	
For Local	Blue KC, Attention Written Correspondence PO Box 419169, Kansas City, MO, 64141-6169	
For FEP	Blue KC, Attention Written Correspondence PO Box 419071, Kansas City, MO, 64179-0288	
For BlueCard	Blue KC, Attention Written Correspondence PO Box 419016, Kansas City, MO, 64141-6016	
Blue KC contracts with Lucet for coordination of all behavioral health, psychiatric and/or substance abuse services for members. To prior authorize mental health or substance abuse services, call the number above. Staff can call the **Physician Helpline** for immediate assistance if patients have an urgent need or to discuss a case with a clinician.		
Preferred Health Professionals (PHP)		
Toll Free Number	1-800-544-3014	
Phone Number	816-823-6700	
Fax Number	1-800-874-9179	

Kansas City

BLUE KC NETWORK PROVIDER REFERENCE GUIDE

A reference guide for all Blue KC contracted network providers.

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