



**BlueCross
BlueShield
of Kansas**

1133 SW Topeka Boulevard
Topeka, Kansas 66629-0001

Web site: www.bcbsks.com

In Topeka – (785) 291-7000
In Kansas – (800) 432-0216

July 2008

CAP

Competitive Allowance Program 2009 DENTAL CONTRACT

Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) serves 356,961 Kansans with dental coverage, as of May 31, 2008. We appreciate your continued participation in serving our members as a contracting provider in the Competitive Allowance Program (CAP), and invite you to maintain your contracting status for 2009. Since your contract is perpetual, no action is necessary on your part for renewal.

As a contracting provider, you continue to receive excellent business services which bridge the gap between the delivery of health care services and the financing of prepaid health care benefits for your patients. Business services provided by BCBSKS creating the most significant value to you as a contracting provider include:

- Local member contracts structured to allow 100 percent of the maximum allowable payment (MAP) for participating CAP providers (subject to member benefits).
- Direct payment from BCBSKS, which minimizes your collection efforts and increases cash flow.
- Web site (www.bcbsks.com) available at your convenience, which improves your office efficiencies and maximizes your employee resources.
 - Secure services to include detailed claim payment information, member eligibility, remittance advice, and provider enrollment information.
 - Other services including training modules, newsletters, manuals, policy memos, and medical policies/guidelines.

- Detailed claim payment information provided to both you and the member explaining their financial responsibilities.
- Contracting providers' names made available to BCBSKS members through a number of sources, including the Internet, employer groups, and other contracting providers for referral purposes, increasing the potential for new patients.
- A dedicated field staff available to visit your office to address any operational issues.
- Training conducted by professional relations staff for new and experienced office staff to help update them on new administrative procedures to ensure timely claims payments.
- Providers and their staffs having access to professional relations hotline personnel to answer policy questions or obtain assistance with claim coding questions.

NOTE: Noncontracting providers' services are paid direct to the member at 80 percent of the MAP (subject to member benefits). In addition, assignment of benefits to noncontracting providers is not permissible.

Your continued contracting status is important to our members and many of your patients. If for any reason you feel unable to continue your contract, please phone me (Doug Scott, 785-291-8831) to discuss. Then, if you still feel you cannot accept this contract offering and choose to terminate your provider contract, you must send signed correspondence postmarked no later than midnight, **September 3, 2008**, to Doug Scott, Director of Professional Relations, cc480D2, 1133 SW Topeka Blvd., Topeka, KS 66629.

Reimbursement Changes

On June 26, 2008, the BCBSKS Board of Directors met and approved increases to most of the dental MAPs for the year 2009. Charge comparisons reflecting reimbursement changes are available by contacting your professional relations representative or the hotline. They can also help you with any questions you may have regarding information contained in this letter.

Contact Information

Professional Relations Staff	Location	Phone Numbers	
Doug Scott, Director	Topeka	1-800-432-0216 ext. 8831	(785) 291-8831
Robyne Goates, Manager	Topeka	1-800-432-0216 ext. 8206	(785) 291-8206
Sue Dunaway	Topeka	1-800-432-0216 ext. 8207	(785) 291-8207
Diana Evans	Topeka	1-800-432-0216 ext. 8716	(785) 291-8716
Cheri Iarossi	Topeka	1-800-432-0216 ext. 8651	(785) 291-8651
Professional Relations Hotline	Topeka	1-800-432-3587, option 1	(785) 291-4135, option 1
Velda Fresquez-Gray	Wichita	1-800-432-0216 ext. 1674	(316) 269-1674
Debra Meisenheimer	Hutchinson	(620) 663-1313	
Gwen Nelson	Dodge City	(620) 225-0884	

Policy Memo Changes

Following is a summary of the changes to the Blue Shield Dental Policy Memo for 2009. The policy memo in its entirety will be available in the provider publications section of www.bcbsks.com in December 2008.

Dental Policy Memo

Preface

The second sentence of the third paragraph was modified, as shown below, to state that arbitration proceedings are conducted in Topeka unless both parties agree otherwise.

The arbitrator shall have the right to determine his or her own jurisdiction. The arbitration proceeding shall be conducted in Topeka, Kansas, unless both parties agree otherwise. The arbitrator may construe and interpret, but shall not delete from, add to, or modify the terms of the contracting provider agreement and/or BCBSKS' policies and procedures applicable to such agreement. The arbitrator shall have no authority to award extracontractual damages of any kind, including but not limited to consequential, punitive or exemplary damages, and shall be bound by controlling law. The arbitrator shall apply the substantive law of Kansas, without giving effect to any conflict-of-laws principles.

The following paragraph was added explaining that the arbitration process is available to a provider only after all applicable review and/or appeal processes have been exhausted.

The arbitration process described above shall be available to providers only after exhaustion of all applicable review and/or appeal processes described within these policies and procedures. This exhaustion requirement shall apply to each claim or service in dispute.

Medical Review Processes

The following language was added to the fourth paragraph to more clearly explain the elements required for in medical records to support medical necessity of services:

Complete medical records are expected to contain all the elements required by Section X. below and by K.A.R. 71-1-15, as amended, which is hereby incorporated by reference and made a part of this policy.

Section I. Retrospective Claim Reviews

Wording was added to paragraph A. allowing providers to contact customer service by telephone, in addition to writing, to request retrospective claim reviews. Language was also modified stating that requests for retrospective review be submitted within 120 days from the date of the remittance advice, rather than within 120 days of adjudication.

- A. All requests for retrospective review, including corrected claims, must be submitted (in writing or by phone) to and received by BCBSKS Customer Service within 120 days from the date of the remittance advice.

Section II. Denied Claims Appeals Procedure, Second Level

The title vice president of medical affairs was changed to chief medical officer. Language regarding final determination was modified for clarity.

Second Level: Forward a written request to customer service, with your letter addressed to the Chief Medical Officer. The second and final appeal determination shall be made by the Chief Medical Officer. The contracting provider agrees to abide by the second level appeal determination.

Section III. Post-Payment Audit Appeals

The title of this section changed to Post-Payment Audits and language was modified throughout to clarify both post-payment audits and post-payment audit appeals. The title vice president of medical affairs was changed to chief medical officer.

The entire section, as modified, appears below:

III. POST-PAYMENT AUDITS

BCBSKS conducts periodic post-payment audits of patient records and adjudicated claims to verify congruence with BCBSKS medical and payment policies, including medical necessity. Post-payment audits can range from a basic encounter audit 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. Post-payment audits are performed after the service(s) is billed to BCBSKS and payments have been received by the provider. BCBSKS cannot go back further than 15 months following the date of claim adjudication to initiate an audit. Due to additional time allowed for provider appeals, as outlined in this policy memo, refunds would be applicable after the provider appeals have been exhausted, regardless of the time frame involved. BCBSKS provides education through policy memos, medical policy, newsletters, workshops, direct correspondence, and on-site visits.

If medical necessity is not supported by the medical record, BCBSKS will deny as not medically necessary and request refunds. If no documentation is received, BCBSKS will deny for no documentation and request refunds. Denials will be a provider write-off.

Post-payment Audit Appeals:

A. First Level Appeal

Claims denied not medically necessary as a part of the post-pay audit process may be appealed in writing within 30 days of notification of the findings. Written notification of disagreement highlighting specific points for reconsideration should be provided with the appeal. The BCBSKS determination will be made within 30 days of receipt of the appeal.

B. Second Level Appeal

A provider may request a second and final appeal in writing within 30 days of notification of the first level appeal determination. The second and final appeal is to be submitted to the BCBSKS Chief Medical Officer. The second and final appeal determination will be made by the BCBSKS Chief Medical Officer within 30 days of receipt of the appeal.

When findings reveal issues, which are presently specified in BCBSKS policy memos, billing guidelines or newsletters relating to content of service, multiple surgery guidelines, and other billing and/or reimbursement guidelines, the terms of this appeal are not available.

Section IV. Utilization Review and Medical Necessity

The following language was added to paragraph D. Outpatient Pre-Certification to be consistent with Policy Memo No. 1.

Following provider notification, continued failure to complete pre-certification activities will result in a 50 percent Maximum Allowable Payment (MAP) reduction up to \$200 with the member held harmless. Compliance audits will take place on a post-payment basis, which may result in refunds.

Section X. Documentation

A statement was added requiring typed or electronic medical records be signed by the provider at the time of submission. Wording was modified to remove "for lack of medical necessity" and clarify provider write-off. These changes were necessary because without receiving documentation from the provider, BCBSKS is unable to determine medical necessity.

X. DOCUMENTATION

Appropriate documentation of services is an integral part of the payment and/or review process. The contracting provider agrees to keep sufficient records to support claims for reimbursement, documents the medical necessity for the service, and agrees to make available all information necessary to carry out the terms of his/her contracting provider agreement at no charge. Information, when requested, should be submitted to BCBSKS within 30 days of the request. In the case of typed or electronic medical records, the entry must be authenticated (signed) by the provider at the time of submission.

Time extensions may be granted on a case-by-case basis; however, any extension must be approved by BCBSKS and will allow BCBSKS additional time for review activities. Certain unusual circumstances require the immediate submission of medical records. In these cases, BCBSKS will have a representative visit the office and secure requested records. The provider agrees to provide these records at the time of request. The member contract gives us the ability to obtain this information without a signed patient release.

Failure to send the requested documentation within the time frame above or providing insufficient or no documentation to determine medical necessity will result in claim denial, and accordingly a provider write-off.