

July 2010

# CAP

## Competitive Allowance Program

### 2011 DENTAL CONTRACT

Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) serves 344,180 Kansans with dental coverage, as of May 31, 2010. 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 2011. Since your contract is perpetual, no action is necessary on your part for renewal.

We continue to strive toward providing you, our contracting provider, with 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.
- Electronic remittance advice and payment capabilities.
- Web site ([www.bcbsks.com](http://www.bcbsks.com)) available at your convenience, which improves your office efficiencies and maximizes your employee resources.
  - Secured services to include detailed claim payment information, member eligibility, remittance advice, and provider enrollment information.
  - Other services including training modules, podcasts, 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 staff 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 charge up to 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 your concerns. 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, 2010**, to Doug Scott, Director of Professional Relations, cc480D2, 1133 SW Topeka Blvd., Topeka, KS 66629.

Thank you for your continued willingness to partner with Blue Cross and Blue Shield of Kansas to bring the highest quality health care to our members at the lowest possible cost.

Sincerely,



Douglas R. Scott  
Director, Professional Relations

## Reimbursement Changes

On June 25, 2010, the BCBSKS Board of Directors met and approved increases to most of the dental MAPs for the year 2011. 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

<b>Professional Relations Staff</b>	<b>Location</b>	<b>Phone Numbers</b>	
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
Diana Evans	Topeka	1-800-432-0216 ext. 8716	(785) 291-8716
Darin Fieger	Topeka	1-800-432-0216 ext. 8207	(785) 291-8207
Cheri Iarossi	Topeka	1-800-432-0216 ext. 8651	(785) 291-8651
Professional Relations Hotline	Topeka	1-800-432-3587, opt. 1 or 3	(785) 291-4135, opt. 1 or 3
Kyle Abbott	Wichita	1-800-432-0216 ext. 1674	(316) 269-1674
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	

# BLUE CROSS AND BLUE SHIELD OF KANSAS

## DENTAL PROVIDER POLICIES AND PROCEDURES

### CHANGES FOR 2011

Following is a summary of the changes to Dental Blue Shield Policies and Procedures for 2011. The policy memos in their entirety will be available in the provider publications section of [www.bcbsks.com](http://www.bcbsks.com) in December 2010.

NOTE: Changes in numbering due to insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2011 Policy Memos. Deleted wording is noted in brackets [ ]. New language is identified in **bold**.

#### Dental Policy Memo

#### MEDICAL REVIEW PROCESSES

- **Page 2:** Wording in the third paragraph was changed and a sentence added to make the process more clear: in sentence 2 "information" was changed to "documentation," and the phrases, "or information" and "after the review has been completed," were deleted. A sentence was added at the end of the paragraph.

**NOTE:** All pertinent and complete medical records must be provided by the contracting provider when records are needed for the initial review of a claim or when records are requested for an audit. Additional [information] **documentation** that is not a part of the medical record [or information] **and** that was not provided at the time of the initial request will not be accepted [after the review has been completed]. Only records created contemporaneous with treatment will be considered pertinent. **Services denied for failure to submit documentation are not eligible for provider appeal, and are a provider write-off.**

- **Page 2:** In paragraph 4, added wording to identify the initials, K.A.R.

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

- **Page 2:** In paragraph 5, added the words "ordered or" to signify the ordering physician is responsible for documenting the medical necessity of any services ordered.

Each patient record must contain adequate documentation to justify the course of treatment **ordered or** provided, and reflect the patient's current status and progress during the course of treatment.

## Dental Policy Memo

### SECTION I. CORRECTED CLAIM

- **Page 2:** Added Section I. CORRECTED CLAIM to define the difference between a corrected claim and retrospective claim reviews.

#### I. CORRECTED CLAIM

A request made from a contracting provider to change a claim, (e.g., changing information on the service line, modifier addition, diagnosis correction, etc.) that has previously processed is considered a corrected claim. This excludes claims denied for additional information. The submission of a corrected claim must be received by BCBSKS within the 15-month timely filing deadline.

## Dental Policy Memo

### SECTION II. RETROSPECTIVE CLAIM REVIEWS

(previously Section I.)

- **Page 3:** In Section A., first sentence, deleted the words "including corrected claims" as that information now appears in the new Section I.

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.

- **Page 3:** In Section B., the word "written" was added before "request" for greater clarification.

B. The provider will be given a written response to the **written** request for a retrospective review as soon as possible, but no later than 60 days from receipt date. In cases where claims are adjusted, the remittance advice will serve as the written response.

## Dental Policy Memo

### SECTION III. DENIED CLAIMS APPEALS PROCEDURE

(previously Section II.)

- **Page 3:** In paragraph 5, First Level, wording was added to the last sentence to clarify the process.

This decision will be binding unless the provider [re-appeals the decision] **files a second level appeal** within 60 days of notification **of such decision.**

- **Page 3:** In paragraph 6, Second Level, wording was added to clarify the process.

Forward a written request to customer service with your letter addressed to the Chief Medical Officer **within 60 days following the first level appeal denial notification.**

## Dental Policy Memo

### SECTION IV. POST-PAYMENT AUDITS

(previously Section III.)

- **Page 4:** Additional wording clarifies audit verification factors in sentence 1 of paragraph 1. In the last sentence of the same paragraph, another avenue of education is identified.

BCBSKS conducts periodic post-payment audits of patient records and adjudicated claims to verify congruence with BCBSKS medical and payment policies, including medical necessity **and established standards of care.**

BCBSKS provides education through policy memos, medical policy, newsletters, workshops, direct correspondence, **peer consultant medical opinion**, and on-site visits.

## Dental Policy Memo

### SECTION V. UTILIZATION REVIEW AND MEDICAL NECESSITY

(previously Section IV.)

- **Page 5:** Under C. PRE-ADMISSION CERTIFICATION & CONCURRENT REVIEW, Paragraph 1. After sentence 2, a sentence was inserted to define concurrent review.

**Concurrent review is the process of obtaining current medical information to review for the medical necessity of a requested extension to the length of stay or course of treatment.**

- **Page 6:** Under F. APPROPRIATE PLACE OF SERVICE, two sentences were added to the end of the paragraph regarding referrals to non-contracting providers.

**In the event members request referrals to non-contracting providers, providers should have patients sign a statement acknowledging full understanding of the non-contracting referral and the patient's financial responsibilities. The statement should be filed in the patient's chart.**

- **Page 7:** On the first line of the page (under H. MEDICAL NECESSITY/UTILIZATION REVIEW DENIALS—section begins on page 6), a phrase was inserted to call attention to a documentation requirement.

Failure to discuss the above with the patient in advance, **document this in the medical record**, and obtain the waiver will result in a provider write-off.

## Dental Policy Memo

### SECTION VII. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

(previously Section VI.)

- **Page 9:** In the last paragraph after section D., verbiage was added to outline documentation requirements for use of the waiver form. The requirement that a copy of the waiver must accompany the claim has been deleted.

Contracting providers shall inform the patient when services to be rendered are considered experimental or investigational and may not be covered under the member's contract. Any **patient being** [services] billed [to the patient as] **for services considered** experimental or investigational must have a signed waiver in [their] **his/her** file. **The provider must discuss this with the patient in advance, document this in the medical record, and include the GA modifier (waiver on file) on the claim form (electronic or paper).** [A copy of the waiver must accompany the claim.] (See Section X. WAIVER FORM) **Failure to discuss and obtain a signed waiver in advance of the service will result in provider write-off. Denied experimental or investigational services are not eligible for appeal.**

## Dental Policy Memo

### SECTION VIII. NON-COVERED SERVICES

(previously Section VII.)

- **Page 9:** Removed "Please note:" on the first line.

[Please note:] Providers are not reimbursed . .

## Dental Policy Memo

### SECTION X. WAIVER FORM

(previously Section IX.)

- **Page 10:** Under Section A. SITUATIONS WHEN A WAIVER SHOULD BE OBTAINED, number 3 was removed.

3. [Deluxe features (Applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract)]

- **Page 10:** Under Section C., removed the word "SAMPLE."

C. [SAMPLE] WAIVER FORM (see last page of Dental Policy Memo)

## Dental Policy Memo

### SECTION XI. DOCUMENTATION

(previously Section X.)

- **Page 11:** After the third paragraph, two paragraphs were added defining requirements of medical records.

Medical records are expected to contain all the elements required in order to file and substantiate a claim for the services as well as the appropriate level of care, i.e., evaluation and management service (see Policy Memo No. 2). Complete medical records are also expected to contain all the elements required herein and by K.A.R. 71-1-15, as amended, which is hereby incorporated by reference and made a part of this policy.

Medical records are expected to support the medical necessity for all aspects of patient care, including ancillary services provided on the date of service for which a claim is filed. Each patient record must contain adequate documentation to justify the course of treatment provided and reflect the patient's current status and progress during the course of treatment. The intensity of the service billed must be supported by the diagnosis code. Letters/checklists are not acceptable as documentation of medical necessity and do not replace what should be in the complete medical record. Abbreviations must be those that are generally accepted by your peers and clearly translated to be understandable to the reviewer.

## Dental Policy Memo

### SECTION XIV: CLAIMS FILING

(previously Section XIII.)

- **Page 12:** The exclusion defined by HITECH was added to the first sentence of the first paragraph.

The contracting provider agrees to submit claims to BCBSKS for covered services (**excluding "self pay" requests made by the patient as defined within the Health Information Technology for Economic and Clinical Health (HITECH) Act, Section 13405(a)**) rendered to members at the usual charge in the BCBSKS designated format which complies with state and federal laws such as Health Insurance Portability and Accountability (HIPAA) (when applicable), and to look to BCBSKS for payment except for amounts identified as patient responsibility:

- **Page 12:** A sentence was inserted at the beginning of the second paragraph stating that contracting providers shall submit claims using their NPI or specific performing provider number, if applicable.

All contracting providers (except as provided in Section XXV. of Policy Memo No. 1), who are defined as eligible providers under the member's BCBSKS contract and who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own National Provider Identifier (NPI) or specific performing provider number, if applicable. The name of the ordering provider, when applicable, (including NPI or specific performing provider number, except when exempt by law) must appear on every claim.

## Dental Policy Memo

### SECTION XV. REFUND POLICY

(previously Section XIV.)

- **Page 12:** In the first paragraph, a final sentence was added to state that providers should notify BCBSKS upon discovery of an overpayment.

**Providers shall promptly notify BCBSKS upon becoming aware of an overpayment to initiate the refund process.**

## Dental Policy Memo

### SECTION XVI. RIGHT OF OFFSET

(previously Section XV.)

- **Page 13:** A sentence was inserted after sentence 1 to further clarify the right of offset.

BCBSKS will, through auto deduction processes, exercise the right of offset for claims previously paid. **This right includes offset against any subsequent claim(s) submitted by the provider, including those involving other members.** To accomplish this, BCBSKS will supply [the] providers detailed individual claims information on the remittance advice so amounts can be reconciled efficiently.

## Dental Policy Memo

### SECTION XVII. CONTRACTING STATUS DETERMINATION

(previously Section XVI.)

- **Page 13:** Section D. was added stating it is the responsibility of the provider to notify BCBSKS of status changes.

**D. It is the responsibility of the contracting provider or a representative to notify BCBSKS of any changes in practice information, e.g., license status, address, tax ID number, NPI, ownership, individual provider leaving/joining group practice, death of provider, closure of office, etc.**

## Dental Policy Memo

### SECTION XXIII. APPLICATION OF CONTRACT

(previously Section XXII.)

- **Pages 15:** Under A., the phrase "including services that process under the medical benefit" was added to the end of the first sentence.

- A. The conditions of these policies and procedures apply to service benefit programs, indemnity and self-insured plans administered by Blue Cross and Blue Shield of Kansas, Inc., including those with deductibles, coinsurance and shared payments, **including services that process under the medical benefit.**

## Dental Policy Memo

### SECTION XXIV. ACKNOWLEDGMENT OF INDEPENDENT STATUS OF PLAN

(previously Section XXIII.)

- **Page 16:** The acronym "BCBSA" was added for any future reference to the Association.

The provider hereby expressly acknowledges his/her understanding that the agreement to which these policies and procedures apply constitutes a contract between the provider and BCBSKS that the Plan is an independent corporation operating under a license with the Blue Cross and Blue Shield Association (**BCBSA**), an association of independent Blue Cross and Blue Shield Plans, the Association permitting the Plan to use the Blue Cross and Blue Shield Service Mark, and that the Plan is not contracting as the agent of the Association.

## Dental Policy Memo

### SECTION XXX. CAP PROVIDER DIRECTORIES

(previously Section XXIX.)

- **Page 17:** Wording was added to send provider information for national doctor locator directories.

BCBSKS makes CAP provider information, including contracting providers' names, available to members on our Web site: [www.bcbsks.com](http://www.bcbsks.com), and to BCBSA for national doctor locator directories.

## Dental Policy Memo

### SECTION XXXIV. MODERATE (CONSCIOUS) SEDATION

- **Page 18:** A new section was added to define the use of medically necessary moderate sedation.

**Section I.B. MODERATE (CONSCIOUS) SEDATION of Policy Memo No. 9 is not applicable to dental and oral surgery procedures. Medically necessary moderate sedation, when performed by a trained observer and directed by the dentist, will be allowed when performed in an office setting when the dental service is covered under a medical benefit. Moderate (conscious) sedation, even when medically necessary, is a non-covered service under the dental contract, and is a member responsibility if requested by the member.**