

July 2011

CAP

Competitive Allowance Program

2012 KANSAS CITY DENTAL CONTRACT

Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) serves 328,481 Kansans with dental coverage, as of May 31, 2011. 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 2012. 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) 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 (i.e., there is a 20 percent penalty for members receiving services from a noncontracting provider) (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, 2011**, 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 July 1, 2011, the BCBSKS Board of Directors met and approved increases to most of the dental MAPs for the year 2012. 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
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

KANSAS CITY DENTAL PROVIDER POLICIES AND PROCEDURES

CHANGES FOR 2012

Following is a summary of the changes to Kansas City Dental Blue Shield Policies and Procedures for 2012. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2011.

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**.

Kansas City Dental Policy Memo

INTRODUCTION

- **Page 1:** A sentence was added at the end of the first paragraph to establish priority of documents in the event of a conflict.

The purpose of Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) Policies and Procedures is to provide specific explanations for provisions contained within the contracting provider agreements. This information is intended to supplement and further clarify the reciprocal rights and contractual obligations contained within the contract and the policies established by BCBSKS when services are provided in our service area (the state of Kansas not including Johnson and Wyandotte counties). All existing and future policies and procedures published within BCBSKS publications that are available via the BCBSKS Web site are considered part of this Kansas City Dental Policy Memo. These publications include newsletters, provider manuals, workshop materials, and periodic update communications. **In the event provisions of such BCBSKS publications, policy memos, and/or the provider agreement conflict, the most recently published provision controls.**

Kansas City Dental Policy Memo

MEDICAL REVIEW PROCESS

- **Page 2:** Wording was added in paragraphs 1 and 2 to clarify that a practicing professional is used whenever possible. In certain circumstances a practicing professional is not always available.

The medical review process is conducted by the staff of BCBSKS, who seek the advice of qualified **and, typically,** practicing professionals [related to medical necessity] **when necessary**. A contracting provider agrees to accept review process decisions and to follow the established appeals procedures.

The entire review process itself includes the development of guidelines that relate to specific provisions of members' contracts, the processing of claims based on guidelines and medical records when indicated, the retrospective review of claim determinations, and the appeal process. BCBSKS seeks the advice of [practicing] **clinical** professionals at appropriate points throughout the review process.

- **Page 2:** The third paragraph will be indented to more clearly delineate the NOTE section. A 30-day time frame is identified for submission of records when requested for purposes of an initial review or an audit. A sentence is added to outline the expectation of BCBSKS that the ordering/referring provider shall be responsible for providing medical records to the performing provider when requested for medical necessity review.

NOTE: All pertinent and complete medical records must be provided by the contracting provider **within thirty (30) days upon request** when records are needed for the initial review of a claim or when records are requested for an audit. **The ordering/referring provider shall also provide medical records to the performing provider when requested for the purpose of medical necessity review.** Additional documentation that is not a part of the medical record and that was not provided at the time of the initial request will not be accepted. 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.

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SECTION IV. POST PAYMENT AUDITS

- **Page 4:** In paragraph A, the word “claims” is replaced with the word “services.”

A. FIRST LEVEL APPEAL

[Claims] **Services** denied not medically necessary as a part of the postpay 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.

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SECTION X. WAIVER FORM

- **Page 10:** In paragraph B. 2, the words “and reason” were added to clarify that the reason for the waiver must be included on the waiver form.

B. THE WAIVER FORM MUST BE:

1. Signed prior to receipt of service.
2. Patient, [and] procedure, **and reason** specific.

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SECTION XI. DOCUMENTATION

- **Page 10:** On the fourth line of the first paragraph, a new paragraph will begin with “Information, when requested,” Wording is then added in that same second paragraph to clarify immediate procurement of a medical record when necessary.

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.

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. Rubber stamp signatures are not permissible; however, electronic signatures are. The signature must be legible and contain at least the first initial and full last name. This provision does not affect stamped signatures on claims, which remain permissible. 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 **as determined solely by BCBSKS** require [the immediate submission of] **contracting providers to submit medical records to BCBSKS upon request and without advance notice**. In these cases, a BCBSKS [will have a] representative **will** visit the **provider’s office during business hours** and secure **the** requested records **immediately and without giving prior notice to the provider**. 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.

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SECTION XIV. CLAIMS FILING

- **Page 12:** In paragraph 4 on this page, wording is streamlined to clarify the refund process to the member, increasing the timeframe to accomplish this.

[The provider may contact BCBSKS to verify the status of a patient's deductible.] If after BCBSKS makes its payment to the provider and a credit balance results from having collected payment from the member [prior to filing with BCBSKS], then the provider must refund the credit balance to the member within [thirty (30)] **sixty (60)** days from the [time the member requests the refund of the credit balance. Otherwise, the provider will make the refund within 60 days from notice from BCBSKS,] **date the overpayment is identified**, unless directed by the member to apply the credit balance to their account for future services.

- **Page 12:** A new 5th paragraph was added to address ICD-10-CM requirements.

Upon implementation of ICD-10-CM, non-specific diagnosis codes (including, but not limited to, Not Otherwise Classified (NOC) and Not Otherwise Specified (NOS) codes) will not be accepted.

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SECTION XV. REFUND POLICY

- **Page 12:** Removed last paragraph.

BCBSKS must request refunds from providers within 15 months from the date of adjudication. Failure to do so will result in the provider being held harmless. Refund requests for fraudulent claim payments and duplicate claim payments, including other party liability claims, are not subject to the 15-month limitation. Providers shall promptly notify BCBSKS upon becoming aware of an overpayment to initiate the refund process.

[Refunds as a result of an audit are due within 30 days from the date the audit is presented before exercising the right of offset.]