

July 2006

CAP

Competitive Allowance Program 2007 DENTAL CONTRACT

Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) serves over 341,033 Kansans with dental coverage. 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 2007. 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 and 80 percent of the MAP to non-contracting providers.
- Direct payment from BCBSKS, which minimizes your collection efforts and increases cash flow. (Please note: Non-contracting providers do not receive direct payment, nor is assignment of benefits allowed.)
- Web site (www.bcbsks.com) available at your convenience, which improves your office efficiencies and maximizes your employee resources.
 - Secured services to include detailed claims payment information, member eligibility, remittance advice, and provider enrollment information.
 - Other services including training modules, newsletters, manuals, policy memos, and medical policies/guidelines.

- Detailed claims 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, which increases the potential for new patients.
- A dedicated field staff available to visit your office to address any operational issues.
- Periodic workshops held by professional relations staff, which deliver continuous training for new and experienced medical assistant 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.

If you have questions regarding any information contained in this letter, please contact your professional relations representative or the hotline at 1-800-432-3587 (in Topeka, 785-291-4135).

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 contact me directly (Fred Boston, 785-291-8831). If you feel you cannot accept this contract offering and choose to terminate your provider contract, you must forward your written correspondence postmarked no later than midnight, **September 1, 2006**. Please mail it to: Fred Boston, Director, Professional Relations, CC 480E1, 1133 S.W. Topeka Blvd., Topeka, KS 66629.

REIMBURSEMENT CHANGES

On June 22, 2006, the BCBSKS Board of Directors met and approved increases to the dental MAPs for the year 2007. Charge comparisons reflecting reimbursement changes are available by contacting your professional relations representative or the hotline at 1-800-432-3587 (in Topeka, 785-291-4135).

Contact Information

Professional Relations Staff	Location	Phone Number	
Fred Boston, Director	Topeka	1-800-432-0216 ext. 8831	(785) 291-8831
Rusty Doty, 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	(785) 291-4135
Debra Meisenheimer	Hutchinson	(620) 663-1313	
Velda Fresquez-Gray	Wichita	1-800-432-0216 ext. 1674	(316) 269-1674
Denny Hartman	Wichita	1-800-432-0216 ext. 1674	(316) 269-1674
Gwen Nelson	Dodge City	(620) 225-0884	

Important Information

We have summarized the changes to the Blue Shield Dental Policy Memo on the following pages. The policy memo in its entirety will be available on the Internet at www.bcbsks.com in December 2006.



Dental Policy Memo

Medical Review Processes

The third paragraph was reworded to include record requests for audits. The fifth paragraph was reworded specifying “complete” medical record. The last paragraph was reworded for clarity.

The medical review processes are conducted by the staff of BCBSKS who seek the advice of qualified and practicing professionals related to medical necessity. 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 professionals at appropriate points throughout the entire review process.

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 that is not a part of the medical record or information 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.

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.

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 need 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.

If it is determined that the patient services provided by the contracting provider and documented as outlined above, are not medically necessary, the claim is denied and is a write-off to the provider. If the services are requested by the patient after being advised by the provider of the lack of medical necessity and the daily record or patient chart has been documented to that effect and a written waiver is obtained by the provider prior to the service being rendered, charges for the services will be the patient's responsibility.

Sections I. & II. Retrospective Claim Reviews & Denied Claim Appeal Procedure

Using existing time frames, the entire review process can take up to one year and three months. Medical review staff felt this was too lengthy and shortened the time frames for BCBSKS to respond and for providers to initiate a retrospective claim review and claims being appealed.

I. RETROSPECTIVE CLAIM REVIEWS

The contracting provider shall have the right to a retrospective review of any claim denied in whole or in part. The purpose of a retrospective review is for customer service to determine whether the original adjudication was correct.

- A. All requests for retrospective review, including corrected claims, must be submitted in writing to and received by BCBSKS Customer Service within 120 days of the adjudication.
- B. The provider will be given a written response to the 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.

II. DENIED CLAIMS APPEALS PROCEDURE

Contracting providers may appeal certain pre and post-service claim denials. Only claims denied as not medically necessary may be appealed on the provider's own behalf as set forth in the policies and procedures. The provider may be designated as the member's authorized representative for appeal purposes according to the terms of the member's contract.

NOTE: Medical policies described in BCBSKS Dental Policy Memo or provider's obligations specified in their provider contracts are not considered

eligible claims appeals as outlined in Section II. DENIED CLAIMS APPEALS PROCEDURES. Annually, BCBSKS outlines any changes to the Policy Memo and forwards them to providers for their review. Once providers accept these changes, they are part of the provider's contract and therefore not considered for claims appeals. Providers disagreeing with any policies should submit their position and supportive documentation to BCBSKS staff for future consideration.

Appeals as the Member's Authorized Representative: Appeals that you can make as the member's authorized representative according to the terms of the member's contract are claims for which the member is financially responsible. When you act as the member's authorized representative, you are not separately entitled to any appeals pursuant to this Contracting Provider Agreement.

Appeals Pursuant to Contracting Provider Agreement: Before initiating the appeal procedures, verify through I. Retrospective Claim Reviews inquiry procedures that the claim was correctly adjudicated. After verifying the claim adjudication you may appeal as follows:

First Level: Written notification of disagreement highlighting specific points for reconsideration of a claim denied not medically necessary shall be provided to BCBSKS within 180 days from the original claim adjudication date. This notice shall be considered an initial appeal and be forwarded with all pertinent medical records to BCBSKS Customer Service. Medical records submitted with the request for initial appeal will be referred to the appropriate consultant and a determination will be rendered. This decision will be binding unless the provider re-appeals the decision within 60 days of notification.

Second Level: Forward a written request to customer service, with your letter addressed to the vice president of medical affairs. The final appeal determination shall be provided by the vice president of medical affairs. The contracting provider agrees to abide by the final determination in the appeals process.

All appeal decisions under this agreement must be provided within 60 days of receipt of the provider's request. Any appeals decision not provided within the aforementioned time frames shall be considered as decisions made in favor of the provider and claim payments will be adjusted accordingly.

Cases may only be appealed once at each step in the first or second levels. A contracting provider agrees to accept the determination made at each level or to appeal the claim at the next step of the appeals process. If throughout the appeals process the decision on the claim changes in the provider's favor, an additional payment will be made. If, however, the decision reverses a previous determination (either partially or totally), a refund will be requested.

The result of the appeals process shall be binding on the provider and BCBSKS subject only to the provision for binding arbitration previously stated herein.

Section V. Content of Service

Reference was made to the Web site for the dental manual.

Appropriate all-inclusive procedure codes must be used when available. **Please refer to the BCBSKS Dental Manual (available on the Web at www.bcbsks.com) for further guidelines.**

Section IX. Waiver Form

Wording was added clarifying deluxe waivers are applicable to deluxe orthopedic and prosthetic appliances as specified in the member contract.

IX. WAIVER FORM

NOTE: The waiver cannot be utilized for services considered to be content of another service provided.

A. SITUATIONS REQUIRING A WAIVER

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

Section X. Documentation

Language was added clarifying that failure to send requested records to determine medical necessity will result in claim denials.

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 need 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. The member's contract gives us the ability to obtain this information without a signed patient release. If there is insufficient information to determine medical necessity, claims will ultimately be a provider write-off or refund. Failure to send the requested documentation within the time frame will also result in claim denials for lack of medical necessity.

Section XIII. Claims Filing

The fifth paragraph was reworded, removing crowns and bridges, because BCBSKS allows crowns and bridges to be billed prior to placement in the patient's mouth.

XIII. CLAIMS FILING

Dental prosthetics/appliances, except for crowns and bridges must be billed when the prosthetic/appliance is placed in the patient's mouth.

Section XX. Application of Contract

The existing paragraph A was removed and reworded for consistency between the Dental Policy Memo and Medical Policy Memo No. 1. The intent of paragraph A is essentially the same.

XX. APPLICATION OF CONTRACT

- 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. For indemnity plans the difference between payment and the CAP allowance can be billed to the patient. There are circumstances in which another Blue Cross and Blue Shield Plan applies its pricing and medical and administrative policies to a claim. While the provider must submit the claim to BCBSKS, and must hold the insured harmless for amounts in excess of such Plan's allowed charge and for services such other Plan determines not to be medically necessary or experimental or investigational, the conditions of these policies and procedures relating to amounts of reimbursement, content of service, and appeals procedures apply only if specifically indicated.

The conditions of these policies and procedures also apply to other entities when services (including services covered by workers compensation) are received within the company service area and Blue Cross and Blue Shield of Kansas, Inc. is involved in the processing of the claim and payment is issued either by Blue Cross and Blue Shield of Kansas, Inc. other Blue Cross and Blue Shield companies/plans or other entities such as insurers or administrators of welfare benefit plans or workers compensation plans.

The conditions of these policies and procedures DO NOT apply to the programs insured and/or administered by Blue Cross Blue Shield companies/plans when such programs rely upon providers who contract with an entity other than Blue Cross and Blue Shield of Kansas, Inc. for the purpose of establishing reimbursement levels in the company service area. And, in the event the provider is required to submit claims direct to a Blue Cross and Blue Shield company/plan outside the company service

area that is adjudicating the claim, the provisions of these policies and procedures do not apply.

Section XXX. Medicare Advantage Claims

Language was added clarifying Medicare Advantage programs offered by other Blue Plans.

XXX. MEDICARE ADVANTAGE CLAIMS

Medicare Advantage (MA) claims should be submitted directly to BCBSKS, who will report the status of such claims on its remittance advices. However, MA claims cannot and will not be processed or appealed pursuant to BCBSKS policies and procedures. For MA claims occurring under a form of coverage offered by a Blue Cross and Blue Shield Plan other than BCBSKS, such other Blue Plan is solely responsible for determining pricing and medical policy (as required by the Centers for Medicare & Medicaid Services [CMS]). A provider's contracting status with CMS determines MA payment allowances. The provider may appeal MA claims only to the Blue Plan providing the MA coverage regardless of whether BCBSKS or another Blue Cross and Blue Shield Plan issued payment. The provider agrees to abide by the final determination resulting from the MA appeals process, which is established by CMS. The appeals policies and procedures of such other Blue Plans should be obtained from those Blue Plans directly.

Last Page, Waiver Form

Wording was added clarifying deluxe waivers are applicable to deluxe orthopedic and prosthetic appliances as specified in the member contract.