Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) serves 327,301 Kansans with dental coverage, as of May 31, 2014. 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 2015. 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 that 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 charges up to 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.
- Website [www.bcbsks.com](http://www.bcbsks.com) and self-service access through Availity 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. This increases 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: Non-contracting 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 non-contracting provider; subject to member benefits). In addition, BCBSKS does not recognize assignment of benefits to non-contracting providers.

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, 2014, 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 26, 2014, the BCBSKS Board of Directors met and approved policy memo changes and the dental MAPs that will be applicable in 2015. The reimbursement changes for 2015 include adjustments to our fee schedule to achieve better correlation between our MAPs for different services using dental relative value units. We are working to increase undervalued CDT codes while maintaining current allowances on overvalued CDT codes. We also are sensitive to the challenges experienced in rural Kansas related to access to dental care and recruitment of dentists. As such, in 2015, BCBSKS will increase reimbursement 5 percent for services performed by dentists in counties with a population of 13,000 or less (see attached listing of all applicable counties).

Charge comparisons reflecting reimbursement changes are available by contacting your professional relations representative or the provider network services personnel. The charge comparison is based on services billed by you during the first five months of 2014. Please note that the format of the charge comparison report has changed. The new format will actually provide the maximum allowable payment (the lesser of your charge or the MAP) for each procedure code. Your professional relations representative or our provider network services personnel can also help you with any questions you may have regarding information contained in this letter.

Contact Information

<table>
<thead>
<tr>
<th>Professional Relations Staff</th>
<th>Location</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doug Scott, Director</td>
<td>Topeka</td>
<td>800-432-0216 ext. 8831</td>
</tr>
<tr>
<td>Robyne Goates, Manager</td>
<td>Topeka</td>
<td>800-432-0216 ext. 8206</td>
</tr>
<tr>
<td>Christie Blenden</td>
<td>Topeka</td>
<td>800-432-0216 ext. 8651</td>
</tr>
<tr>
<td>Diana Evans</td>
<td>Topeka</td>
<td>800-432-0216 ext. 8716</td>
</tr>
<tr>
<td>Darin Fieger</td>
<td>Topeka</td>
<td>800-432-0216 ext. 8207</td>
</tr>
<tr>
<td>Vikki Lindemuth</td>
<td>Topeka</td>
<td>800-432-0216 ext. 7724</td>
</tr>
<tr>
<td>Professional Relations Provider Network Services</td>
<td>Topeka</td>
<td>800-432-3587, opt. 1 or 3</td>
</tr>
<tr>
<td>Kyle Abbott</td>
<td>Wichita</td>
<td>800-432-0216 ext. 1674</td>
</tr>
<tr>
<td>Velda Fresquez-Gray</td>
<td>Wichita</td>
<td>800-432-0216 ext. 1674</td>
</tr>
<tr>
<td>Debra Meisenheimer</td>
<td>Hutchinson</td>
<td>(620) 663-1313</td>
</tr>
<tr>
<td>Gwen Nelson</td>
<td>Dodge City</td>
<td>(620) 225-0884</td>
</tr>
</tbody>
</table>
Following is a summary of the changes to the Dental Blue Shield Policies and Procedures for 2015. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2014.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2014 Policy Memos. Deleted wording is noted in brackets [italicized]. New verbiage is identified in bold.

**Dental Policy Memo**

**INTRODUCTION**

- **Page 1:** Added verbiage after first paragraph to clarify confidentiality, sharing of information and protecting proprietary information.

  The effective delivery of health care requires communication and collaboration among providers, patients and payors. BCBSKS requires that all proprietary information be kept confidential. BCBSKS agrees to hold any and all information released to it in confidence unless otherwise instructed by the Contracting Provider or as otherwise required or permitted by law. The Contracting Provider may not disclose any terms of the Agreement to the third party except upon written consent of BCBSKS and as required by state or federal law, financial audits or quality of care investigations allowed by business arrangements and those additions are bound by confidentiality agreements. Failure to comply may result in penalties up to and including termination of the provider agreement. This requirement shall survive any termination or expiration of the Contracting Provider Agreement, and BCBSKS may seek injunctive relief or specific performance in order to enforce its terms.

- **Page 1:** Added verbiage after new paragraph to address provider disputes.

  Providers may dispute issues of concern through their Professional or Institutional Relations Representative. The representative will work with the provider to address the dispute. If the provider remains dissatisfied the dispute may be escalated to BCBSKS management. Disputes referred to BCBSKS management must be in writing and include the supporting documentation used to initially resolve the dispute and any additional information submitted by the provider that supports the issue. BCBSKS will provide a written response to the provider within 60 days of BCBSKS management receiving the written request.

- **Page 2:** Removed verbiage to clarify appeal process.

  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. Providers who choose to initiate arbitration must do so within 90 calendar days of the date of the second-level appeal determination[ described in Section III of this Policy Memo]. If a provider fails to initiate arbitration within this timeframe, the provider will be deemed to have waived his or her right to arbitration for all claims and services addressed in that second-level appeal determination.
Dental Policy Memo
SECTION II. RETROSPECTIVE CLAIM REVIEWS

- Page 2: Removed verbiage to clarify.

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

- Page 3: Added verbiage to clarify and help fix delays.

Second Level: Forward a written request for the second-level appeal to BCBSKS customer service [with your letter addressed to the Chief Medical Officer] within 60 days following the first-level appeal denial notification. The second and final appeal determination shall be made by [the Chief Medical Officer] a physician or clinical peer. The contracting provider agrees to abide by the second-level appeal determination.

- Page 3: Added verbiage to clarify and fix misleading text.

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] determination 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, a refund will be requested if the decision reverses a previous determination (either partially or totally), a refund will be requested].

Dental Policy Memo
SECTION IV. POST-PAYMENT AUDITS

- Page 4: Removed verbiage to clarify and help fix delays.

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] a physician or clinical peer within 30 days of receipt of the appeal.
Dental Policy Memo

SECTION V. UTILIZATION REVIEW AND MEDICAL NECESSITY

- **Page 5-6:** Added "Prior authorization" behind "pre-certification," changed 60 days to 30 days for notification to be consistent with other BCBSKS notification processes, then added/subtracted verbiage for clarity.

D. OUTPATIENT PRE-CERTIFICATION/PRIOR AUTHORIZATION
Under certain circumstances[ and upon specific notification], pre-certification/prior authorization may be required for outpatient services/procedures. BCBSKS will notify contracting providers [will be notified] at least [60] 30 days in advance of such requirement.[criteria to identify those situations for BCBSKS members falling within the scope of this provision.]
Pre-certification/prior authorization may also be required for other outpatient services such as home medical equipment and case management, including those services specified by employers, and outpatient procedures which necessitate a greater level of facility care than is usually needed.
Following provider notification, continued failure to complete pre-certification/prior authorization 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.

Dental Policy Memo

SECTION XI. [DOCUMENTATION] MEDICAL RECORDS

- **Pages 10-13:** Removed, replaced and rewrote section on Medical Records to Section XI. Renamed Documentation to Medical Records. Changes made to improve policy language and better address medical review processes.

A. Form of documentation in medical records

Documentation in the medical record must accurately reflect the healthcare services rendered to the patient and is an integral part of the reimbursement, audit, and review processes. [All pertinent and complete medical records must be provided or made available at no charge by the contracting provider upon request by BCBSKS or an entity acting on behalf of BCBSKS. Certain unusual circumstances as determined solely by BCBSKS require contracting providers to submit medical records to BCBSKS upon request and without advance notice. In these cases, a BCBSKS 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.]

1. **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). Each diagnosis submitted on the claim must be supported by the documentation in the patient’s medical record. The contracting provider agrees to submit claims only when appropriate documentation supporting said claims is present in the medical record(s) which shall be made available for audit and review at no charge.
   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.

2. **[Blue Cross and Blue Shield of Kansas] BCBSKS has adopted the following standards for documentation of medical services.**
Each patient’s health record shall meet these requirements:

a. Be legible in both readability and content;
b. Contain only those terms and abbreviations that are or should be comprehensible to similar providers/peers;
c. Contain patient-identifying information on each page to ensure pages are not lost or misfiled;
d. Indicate the dates any professional service was provided and date of each entry;
e. 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.
f. 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;
g. List start and stop times on all timed codes per CPT nomenclature;
h. Document the initial diagnosis and the patient’s initial reason for seeking the provider’s care;
i. Document the patient’s current status and progress during the course of treatment provided;
j. Indicate the medications prescribed, dispensed, or administered, and the quantity and strength of each;
k. Include all patient records received from other health care providers if those records formed the basis for treatment decision by the provider;
l. Each entry shall be authenticated by the person making the entry (see Signature Requirements) unless the entire patient record is maintained in the provider’s own handwriting;
m. 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.

3. Signature Requirements
In the content of health records, each entry must be authenticated by the author. Authentication is the process of providing proof of the authorship signifying knowledge, approval, acceptance or obligation of the documentation in the health record, whether maintained in a paper or electronic format accomplished with a handwritten or electronic signature. Individuals providing care for the patient are responsible for documenting the care. The documentation must reflect who performed the service.

a. The handwritten signature must be legible and contain at least the first initial and full last name along with credentials and date. A typed or printed name must be accompanied by a handwritten signature or initials with credentials and date.
b. An electronic signature is a unique personal identifier such as a unique code, biometric, or password entered by the author of the electronic medical record (EMR) or electronic health record (EHR) via electronic means, and is automatically and permanently attached to the document when created including the author’s first and last name, with credentials, with automatic dating and time stamping of the entry. After the entry is electronically signed, the text-editing feature should not be available for amending documentation. Example of an electronically signed signature: “Electronically signed by John Doe, M.D. on MM/DD/YYYY at XX:XX A.M.”
c. A digital signature is a digitized version of a handwritten signature on a pen pad and automatically converted to a digital signature that is affixed to the electronic document. The digital signature must be legible and contain the first and last name, credentials, and date.
d. Rubber stamp signatures are not permissible. This provision does not affect stamped signatures on claims, which remain permissible.

4. Corrections in the Medical Record
If the original entry in the medical record is incomplete, [please] contracting providers shall follow the guidelines below for making a correction, addendum, or amendment. Signature requirements as defined above apply to all corrections in the medical record.

a. Errors in paper-based records:
   To add an [A]addendum or [A]amendment to paper-based records, draw a single line in ink
through the incorrect entry, print the word "error" at the top of the entry, the reason for the change, the correct information, and authenticate the error by signing (including credentials) the notation with the date and time. Entries should not be antedated (assigned a date earlier than the current date). Errors must never be blocked out or erased.

b. Electronic medical records/Electronic health records:
   i. Addendum
      An addendum is new documentation used to add information to an original entry that has already been signed. Addenda should be timely with date and time of the addendum. Write “addendum” and state the reason for the addendum referring back to the original entry. Complete the addendum as soon after the original note as possible. Identify any sources of information used to support the addendum. Entries should not be antedated (assigned a date earlier than the current date).
   ii. Amendment
      An amendment is documentation meant to clarify or provide additional information within the medical record in conjunction with a previous entry. An amendment is made after the original documentation has been completed (and signed) by the provider. All amendments should be timely with the date and time of the amended documentation. Write “amendment” and document the clarifying information referring back to the original entry. Complete the amendment as soon after the original note as possible. Entries should not be antedated (assigned a date earlier than the current date).

5. Use of Medical Scribes
   Scribes are not permitted to make independent decisions or translations while capturing or entering information into the health record or EHR beyond what is directed by the provider. BCBSKS expects the signing and dating of all entries made by a scribe to be identifiable and distinguishable from that of a physician or licensed independent practitioner. All entries made by a scribe are ultimately the practitioner’s responsibility; therefore, review of the documentation and verification of its accuracy, including authentication by the practitioner, is required.

B. [MEDICAL REVIEW PROCESSES] BCBSKS requests for medical records

1. BCBSKS staff members conduct medical review of claims and seek the advice of qualified and, typically, practicing professionals when necessary. Contracting providers agree to accept the decisions made as a result of those reviews and to follow the appeals procedures established by this Policy Memo.

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

2. 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 clinical professionals at appropriate points throughout the entire review process.

3. Contracting providers must submit [all pertinent and complete medical records [must be provided by the contracting provider] to BCBSKS within [30 days] the time frame specified by BCBSKS [upon request] when records are needed for the initial review of a claim or when records are requested for an audit. In most instances, BCBSKS will allow 30 calendar days for the production of the requested records. In certain unusual circumstances as determined solely by BCBSKS, BCBSKS will require providers to submit medical records without advance notice. In such cases, a BCBSKS representative will visit the provider’s office during business hours and secure the requested records immediately. The provider agrees to provide the requested records immediately. Members’ contracts permit BCBSKS to obtain medical records without a signed patient release.
4. 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.

5. If it is BCBSKS determines that the patient services provided by the contracting provider 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 before the service being rendered, charges for the services will be the patient's responsibility.

Dental Policy Memo
SECTION XIV. PROFESSIONAL SERVICES COORDINATED WITH A NON-CONTRACTING PROVIDER

- Page 14: Verbiage added to clarify non-contracting referrals.

When a contracting provider uses a non-contracting provider (either in or out-of-state) to perform a portion of a professional service (e.g., professional component, technical component or other technology utilized in the performance of a service), the contracting provider must bill BCBSKS for all services. If the non-contracting provider bills the member or BCBSKS, the contracting provider will be required to hold the member harmless. However, 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.

Dental Policy Memo
SECTION XVIII. LOCUM TENENS PROVIDER

- Page 15: Inserted verbiage to include parallel substitutions.

In situations in which the regular [physician] provider is unavailable, a locum tenens can be used to provide a visit/service. The locum tenens must be the same type of provider as for whom the locum is substituting (for example, a dentist can only authorize another dentist as a locum tenens) and the locum tenens must be licensed in Kansas and only perform within his/her scope of license. The locum tenens must not provide services [over] during a continuous period of longer than 60 days. For situations extending beyond 60 days, BCBSKS must be contacted to discuss billing arrangements.
Dental Policy Memo

SECTION XXV. APPLICATION OF CONTRACT

- **Page 18:** Included verbiage to include BCBSKS subsidiaries

  The conditions of these policies and procedures and the contracting provider agreement apply to all benefit programs, indemnity and to self-insured plans administered by Blue Cross and Blue Shield of Kansas, Inc. or its subsidiaries, including those with deductibles, coinsurance and shared payments. For indemnity plans the difference between payment and the MAP allowance can be billed to the patient.

  The conditions of these policies and procedures and the contracting provider agreement 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., or its subsidiaries, is involved in the pricing and/or processing of the claim and payment is issued either by Blue Cross and Blue Shield of Kansas, Inc., its subsidiaries, other Blue Cross and Blue Shield companies/plans or other entities such as insurers or administrators of welfare benefit plans or workers compensation plans. **In the event there is need for substantive differences between the terms and conditions of these Policies and Procedures and those applicable to a subsidiary of BCBSKS, a separate contract would govern the subsidiary network.**

  The conditions of these policies and procedures and the contracting provider agreement DO NOT apply to the programs insured and/or administered by Blue Cross and 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.

Dental Policy Memo

SECTION XXXII. CAP PROVIDER DIRECTORIES

- **Page 20:** Added verbiage regarding suppressing providers when current information is not provided.

  BCBSKS makes CAP provider information, including contracting providers’ names, available to members on our website: [www.bcbsks.com](http://www.bcbsks.com), and to BCBSA for national doctor locator directories. **BCBSKS reserves the right to suppress a provider from the directory when current information is not provided upon request.**

Dental Policy Memo

SECTION XXXVIII. CONTRACT AMENDMENT

- **Page 21-22:** Added verbiage to amend Contracting Provider Agreement.

  The Contracting Provider Agreement is hereby amended to delete Section IV.B, paragraphs 1 through 5 (see below), which references certain circumstances under which BCBSKS could make adjustments to the maximum allowable payment (MAP) for services.

  **SECTION IV. MAXIMUM ALLOWABLE PAYMENT SYSTEM**

  B. The physician agrees to fully and promptly inform BCBSKS of the existence of agreements under which such physician agrees to accept an amount for any and or all services as payment in full which is less than the amount such physician accepts from BCBSKS as payment in full for such services. BCBSKS staff is authorized to adjust
maximum allowable payments for the physician in light of such agreements, under the following terms:

1. The BCBSKS staff may adjust the maximum allowable payment only in circumstances in which the staff becomes aware through independent investigation or as a result of information provided by a contracting provider, that a contracting provider has a payment agreement with another payor or offers a discount or other financial arrangement, the effect of which is that such contracting provider accepts from another payor as payment in full an amount less than such contracting provider would accept from this corporation as payment in full;

2. Such adjustment shall be approved in writing by the executive vice president or by the president of this corporation.

3. Such adjustment shall be communicated in writing to the contracting provider. Such communication shall be considered a change in policy adopted by the board of directors, and the contracting provider shall have such advance notice of the change and such rights to cancel the Contracting Provider Agreement rather than abide by the change as are afforded for other amendments to policies and procedures under Section III.A.2. of this agreement.

4. The board of directors or executive committee of BCBSKS shall be informed by the staff of any such adjustments to MAPs so made, at the next meeting of the board of directors or executive committee immediately following such adjustment.

5. The board of directors or executive committee of this corporation shall have the ability to make subsequent changes in adjustments to MAPs so made, which changes shall be prospective only and shall be effective as any other amendment to policies and procedures after communication. If a change in such adjustments would have the effect of inducing a party which terminated its Contracting Provider Agreement as a result of the staff adjustment to MAPs to wish to contract anew with BCBSKS, a contract shall be tendered to such party and shall become effective on the date of execution by such party.

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Dental Policy Memo

SECTION XXXIX. GLOSSARY

- Page 22: Added glossary link to Policy Memo.

A list of definitions for some of the language used in these Policy Memos can be found at the Blue Cross and Blue Shield of Kansas website.

http://bcbsks.com/help/glossary.htm
Following is a summary of the changes to Blue Shield Policies and Procedures for 2015. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2014.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2014 Policy Memos. Deleted wording is noted in brackets [italicized]. New verbiage is identified in bold.

Policy Memo No. 4
SECTION VII. CREDENTIALING

- **Page 3:** Changed verbiage to better address the credentialing process.

  BCBSKS has a credentialing program that consists of the initial full review of the provider's credentialing application and recredentialing at a minimum of every 36 months. Monitoring of all network providers for continual compliance with established criteria will occur as needed, but not less than monthly.

  If a provider ceases to comply with criteria or has actions taken by the licensing board (e.g. any agreement entered into with the appropriate licensing board), credentialing staff will review all adverse action and report to the Corporate Credentials Committee. If a provider's license has been suspended or revoked, action will be taken immediately to cancel their contract.

  [This process consists of an initial full review of the provider's credentials at the time of application and at the time of recredentialing which occurs at least every 36 months.] Credentialing criteria are available on the BCBSKS website at: http://www.bcbsks.com/CustomerService/Providers/Publications/professional/PolicyMemos/credentialing-criteria.htm

- **Page 4:** Added verbiage to address member safety and timeframes for appeals.

  C. **Suspension for Member Safety**

  BCBSKS will review any action taken against a contracting provider where there is unacceptable conduct, competency concerns or where there is concern for the safety of BCBSKS members. The contracting provider will be offered appeal rights if his/her contracting status has been suspended for further investigation.

  D. **First-Level Appeal Panel**

  All appealed disputes are referred to a first-level appeal panel consisting of at least three qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute. **BCBSKS will have 60 days from the receipt of the first-level appeal request to organize a first-level appeal panel.**
E. Second-Level Appeal Panel

If the first-level appeal panel upholds the denial or restriction, the provider may submit a written request for a second-level appeal. This provides consideration to a second-level appeal panel consisting of at least three individuals as defined in the first-level appeal panel and that were not involved with the first-level appeal panel. **BCBSKS will have 60 days from the receipt of the second-level appeal request to organize a second-level appeal panel.**