



**BlueCross
BlueShield
of Kansas**

Policy Memo

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Blue Cross Blue Shield Association.

2018 Dental



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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 website are considered part of this Dental Policy Memo. These publications include newsletters, provider manuals, 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.

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 Agreement and BCBSKS may seek injunctive relief or specific performance in order to enforce its terms.

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. The submission of a corrected claim must be received by BCBSKS within the 15-month timely filing deadline. Claims denied requesting additional information (e.g. by letter or adjustment reason code) should never be marked "corrected claim" when resubmitted. Instead, providers should submit a new claim with the requested information.

When a claim denial or adjustment is made as a result of a BCBSKS audit, the provider may not submit a corrected claim to reverse the decision. The provider's next course of action is to enter into the appeal process.

II. 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 to allow the provider to contact customer service to determine whether the original adjudication was correct.

- A. All requests for retrospective review 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. To submit review online, go to: https://clyde.bcbsks.com/WebCom/Secure/forms/bcbsks_provider_claiminquiry.htm
- B. The provider will be given a 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 response.

III. DENIED CLAIMS APPEALS PROCEDURE

After completion of the retrospective review process (see Section II. Retrospective Claim Reviews), 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. When BCBSKS requests records to support a claim denial, but does not receive them within the 45-day time limit, the service will be denied not medically necessary and will be a provider write-off. 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 including Content of Service (COS) 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 III. DENIED CLAIMS APPEALS PROCEDURE. 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's Agreement

First Level: Written notification of disagreement highlighting specific points for reconsideration of a claim denied not medically necessary shall be provided to BCBSKS within 60 days from the date of the retrospective review determination. 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 files a second-level appeal within 60 days of notification of such decision.

Second Level: Forward a written request for the second-level appeal to BCBSKS customer service within 60 days following the first-level appeal denial notification. The second and final appeal determination shall be made by a dentist or clinical peer. The contracting provider agrees to abide by the second-level appeal determination.

All appeals 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.

A contracting provider agrees to accept the determination made at each level or to appeal the 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. However, a refund will be requested if the decision reverses a previous determination (either partially or totally).

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.

IV. UTILIZATION REVIEW AND MEDICAL NECESSITY

The contracting provider agreements require providers to cooperate in utilization review and medical necessity determinations. Utilization review is the process of determining the appropriateness of services rendered to and payments made on behalf of members. Appropriateness of service and payment determinations consist of the following activities.

A. MEDICAL NEED FOR SERVICES RENDERED

Medical necessity policy applies to all services rendered to BCBSKS members and includes any services or supplies used to diagnose and/or treat illness or injury. To be determined medically necessary, the service must be performed, referred, and/or prescribed by a duly licensed provider; provided in the most appropriate setting and consistent with the diagnosis and treatment of the condition; be in accordance with current generally accepted standards of medical practice in the United States based on credible scientific evidence; not primarily for the convenience of the patient, physician, or other health care provider; and not more costly than an alternative service or supply or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the illness, injury, or disease.. The following procedures would be subject to medical necessity and utilization review:

1. Established procedures of questionable current usefulness in the treatment of a specific condition(s).
2. Procedures which tend to be redundant when performed in combination with other procedures, or procedures that are unlikely to provide additional medical benefits, or are contradictory to one another.
3. Specific procedures or patterns of care, which vary significantly from a peer group.

B. TREATMENT PLAN PREDETERMINATION (REQUIRED BY CERTAIN MEMBER CONTRACTS)

Some BCBSKS members' contracts require benefit predetermination.

Failure to predetermine required benefits will result in the service being paid based upon the lesser procedure that restores function as indicated by the records submitted with the claim. If, from the record documentation, we cannot determine the appropriate level of service, payment will be based upon 50 percent of the maximum allowable payment (MAP) for the services actually rendered to the patient. The provider will then be responsible for the other half of the MAP in the form of a provider write-off. The member's contractual copayments or deductibles will be the responsibility of the patient.

The purpose of this requirement is to ensure compliance with the necessary predetermination procedures and serve as a reminder to providers of the importance of conducting this activity.

C. PRE-ADMISSION CERTIFICATION & CONCURRENT REVIEW

Before admitting a member to a hospital for elective (non-obstetrical, non-life threatening) inpatient care, medical information will need to be supplied to BCBSKS in order to certify medical necessity. A length of stay will be assigned at the time of pre-admission certification and will be subject to concurrent review as identified below. 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. For the most accurate and complete

information, all pre-admission certification should be validated through the BCBSKS provider portal (Availity®).

BCBSKS pre-admission certification and concurrent review activity are conducted in compliance with URAC guidelines. This includes the availability of either the expedited or standard appeal to services denied for medical necessity during the pre-admission certification and concurrent review processes. To initiate an appeal (phone or fax), you must have complete information since the time frame begins with the appeal request. These appeal options are only available before claim submission and are subject to time frames as established by BCBSKS, Department of Labor, and URAC. All pre-admission certification appeals for professional and hospital services will be reviewed concomitantly.

D. OUTPATIENT PRE-CERTIFICATION/PRIOR AUTHORIZATION

Under certain circumstances, pre-certification/prior authorization may be required for outpatient services/procedures. BCBSKS will notify contracting providers at least 30 days in advance of such requirement.

Pre-certification/prior authorization may also be required for other outpatient services such as home medical equipment and case management, including 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.

E. PRE-PAYMENT AND DATA ANALYSIS

BCBSKS will identify any trends or patterns of patient care, i.e., through data analysis, which appear inconsistent with overall patterns or trends.

F. APPROPRIATE PLACE OF SERVICE

The provider agrees to use (to the extent possible) those inpatient, extended care, ancillary service and other health facilities and health professionals that have contracted with BCBSKS. Providers agree to render services to members in the most appropriate and economical setting consistent with the member's diagnosis, treatment needs, and medical condition. Actions taken for a provider's lack of compliance will range from provider education to financial assessments and finally requesting contract cancellation. 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.

G. RESOLUTION OF PROBLEMS

Providers agree to work with BCBSKS and other providers of care in the resolution of any utilization review problems that may be identified. Actions taken for a provider's lack of compliance will range from provider education to financial assessments and finally contract cancellation.

H. MEDICAL NECESSITY/UTILIZATION REVIEW DENIALS

Occasionally BCBSKS does not consider an item or service to be medically necessary. In such situations the item or service becomes a provider write-off. In the few situations where services are known to be denied as not medically necessary (including deluxe items) and the patient insists on the services, the provider must obtain a patient waiver in advance of services being rendered. (See X. WAIVER FORM.)

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.

NOTE: BCBSKS members are not to be billed for services determined to be unnecessary through the medical and utilization review process, per the Contracting Provider Agreements.

V. 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 and established standards of care. 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 will not initiate audits more than 15 months following the date of claim adjudication. Post-payment audits being performed to resolve an allegation of fraud or abuse are not subject to the 15-month limitation. 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, peer consultant medical opinion, and on-site visits.

If medical necessity is not supported by the medical record, BCBSKS will deny as not medically necessary. When BCBSKS requests medical records for an audit and no documentation is received within the 30-day time limit, BCBSKS will deny for no documentation. Services denied for failure to submit documentation are not eligible for provider appeal, and are a provider write-off. Please see Sections XVI. Refund Policy and XVII. Right of Offset for questions on notifications of overpayments.

Post-payment Audit Appeals:**A. First-Level Appeal**

Services 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. Submit the appeal as instructed in the determination letter.

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 determination will be made by a physician or clinical peer within 30 days of receipt of the appeal. Submit the appeal as instructed in the determination letter.

A contracting provider agrees to accept the determination made at each level or to appeal the determination through the appeals process. If through the appeals process the decision on the claim changes in the provider's favor, an additional payment will be made. However, a refund will be requested if the decision reverses a previous determination (either partially or totally).

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.

VI. CONTENT OF SERVICE

Content of service refers to specific services and/or procedures that are considered to be an integral part of previous or concomitant services or procedures to the extent that separate reimbursement is not recognized. Not all content of service issues are identified in the policy memo. BCBSKS staff may identify and classify specific coding and nomenclature issues as they arise. Listed below are some examples.

A. ALL CROWNS, ABUTMENT AND/OR RESTORATIVE, INCLUDE:

1. Impression
2. Tooth preparation
3. Temporary crown
4. Try-in
5. Seating and cementing
6. Materials/supplies
7. Patient instruction
8. Patient records
9. Follow-up care

B. SURGICAL REMOVAL OF AN ERUPTED TOOTH INCLUDES:

1. Local anesthesia
2. Elevation of flap
3. Removal of tooth
4. Removal of bone
5. Alveoplasty
6. Suturing
7. Postoperative care
8. Suture removal
9. Materials/supplies
10. Patient instruction
11. Patient records

C. AMALGAM/COMPOSITE RESTORATIONS INCLUDE:

1. Local anesthesia
2. Moisture control (rubber dental dam)
3. Tooth preparation
4. Cavity liner
5. Acid etching (for composite restorations)
6. Restorative material
7. Finishing procedures (carving, polishing, etc.)
8. Postoperative procedures
9. Patient instruction and records

D. ROOT CANAL THERAPY – ONE OR MORE CANALS

1. Local anesthesia
2. Moisture control (rubber dental dam)
3. Opening and drainage of canal(s)
4. Removal of pulp
5. Interim medicated treatment (if necessary)
6. Placement of canal filling material
7. Preparation for placement of pre-formed pin(s)
8. Follow-up care
9. Patient instruction and records

E. DENTURES – FULL OR PARTIAL

1. Impression and all materials
2. Bite registration
3. Face bow
4. Establishment of correct occlusion
5. Wax models
6. Try-ins
7. Seating/delivery
8. Patient records and instruction
9. Six-month follow-up care, including but not limited to relief of sore spots, base adjustments, re-balancing occlusion.

F. Services such as local anesthesia, impressions for prosthetics, materials/supplies, suture removal by performing provider, and postoperative care will always be content of service. Depending on the procedure performed, various other procedures may become content of the complete services. Additional charges beyond the regular charge for services requested after office hours, or holidays also will be content of service.

G. SEDATIVE BASE

A sedative base provided as a layer of medicated material (usually calcium hydroxide or a similar preparation) for protection of the pulp chamber is considered content of service of the amalgam or composite restoration.

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.

VII. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

Any drug, device, medical treatment or procedure and related services that are Experimental or Investigational as defined by BCBSKS are non-covered services.

Experimental or Investigational refers to the status of a drug, device, medical treatment or procedure:

- A. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished and the drug or device is not Research-Urgent as defined except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or

- B. if Credible Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or
- C. if Credible Evidence shows that the consensus among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or
- D. if there is no Credible Evidence available that would support the use of the drug, device, medical treatment or procedure compared to the standard means of treatment or diagnosis except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Credible evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Research-Urgent shall mean a drug, device, medical treatment or procedure that may be covered (even though otherwise excluded by the contract as experimental or investigational) providing the specified criteria outlined in the contract is met.

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 billed for services considered experimental or investigational must have a signed waiver in 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). (See Section X. WAIVER FORM.) Failure to discuss and obtain a signed waiver in advance of the service will result in provider write-off.

VIII. NON-COVERED SERVICES

Providers are not reimbursed for professional services they provide to an immediate family member ("immediate family member" means the husband or wife, children, parents, brother, sister, or legal guardian of the person who received the service) or themselves as specified in the member contract.

There are several categories of services and procedures that may be considered non-covered services for various reasons. These denials are billable to the member. (See Section XV. CLAIMS FILING.)

IX. PATIENT-DEMANDED SERVICES

If a provider prescribes services that he knows will not be covered because of a lack of medical

necessity or the procedure being considered is experimental or investigational and he alerts the patient of the non-coverage, yet the patient still insists on the services, the provider may bill the patient if the request is properly documented and signed by the member. (See X. WAIVER FORM.)

X. WAIVER FORM

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

A. SITUATIONS WHEN A WAIVER SHOULD BE OBTAINED:

1. Medical necessity denials
2. Utilization denials
3. Patient demanded services
4. Experimental/investigational procedures

B. THE WAIVER FORM MUST BE:

1. Signed **before** receipt of service.
2. Patient and procedure specific.
3. Date of service and dollar amount specific.
4. Retained in the patient's file at the provider's place of business. (The waiver form is no longer required with claims submission. Use the GA modifier for all electronic and paper claims.)
5. Presented on an individual basis to the patients. It may not be a blanket statement signed by all patients.
6. Acknowledged by patient that he or she will be personally responsible for the amount of the charge, to include an approximate amount of the charge at issue.

NOTE: If the waiver is not signed **before** the service being rendered, the service is considered a contracting provider write-off, unless there are extenuating circumstances.

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

XI. MEDICAL RECORDS

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.

1. Documentation of Medical Services

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. 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 CDT/CPT nomenclature or total time each CDT/CPT code/service is performed;
 - 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, 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 addendum or 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 dentist 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. 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.
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 to BCBSKS within the time frame specified by BCBSKS when records are needed for the initial review of a claim or when records are requested for an audit. Medical records shall include all versions, whether handwritten or EMR/EHR-generated. Any applicable audit log documentation must be provided. In most instances, BCBSKS will allow 30 calendar days for the production of the requested records. Failure to send the requested documentation or providing insufficient documentation to determine medical necessity may result in a claim denial and accordingly a provider write-off. 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.
 5. If 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.

XII. UNIFORM PROVIDER CHARGING PRACTICES

Occasionally BCBSKS receives questions about what constitutes a provider's usual charge when a provider offers cash customers a discount and what amount to bill BCBSKS. The term "usual charge" is defined in our Contracting Provider Agreements, but to specifically address this question, our policy is as follows:

- A. Provider discounts or charging practices based upon individual patient situations (for example: patient hardship or professional courtesy) are acceptable and are not considered the provider's usual charge. If a provider gives a patient a discount for cash, they must bill BCBSKS the same amount.
- B. If a discount or lower charge is given to every patient without insurance or person paying at the time of the service, then BCBSKS would consider the "discounted price" to be the usual charge and would expect the provider to bill us that same amount.

XIII. PURCHASED SERVICES

When providers bill for PET, CT, or MRI services that were purchased from another provider, they must bill BCBSKS the amount for which the service was purchased.

XIV. PROFESSIONAL SERVICES COORDINATED WITH A NON-CONTRACTING PROVIDER

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.

XV. CLAIMS FILING

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 Act (HIPAA) (when applicable), and to look to BCBSKS for payment except for amounts identified as patient responsibility: copays, coinsurance, deductible, member contract indemnified payment limitation balances and non-covered amounts. The contracting provider agrees to accept payment allowances in all cases once notified of payment determination. Claims must be filed within 15 months of the service date or discharge from the hospital. Failure to do so will result in claims being rejected with members held harmless. When BCBSKS becomes aware, BCBSKS will notify contracting providers when employee groups impose alternate timely filing requirements.

All contracting providers 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. When applicable, the contracting provider agrees to conduct claims transactions with BCBSKS as standard transactions in compliance with HIPAA.

All services performed on the same date by the same provider should be billed as one claim. In cases where multiple paper claim forms are required, a total for all procedures should be reported only on the last claim form to prevent the claim from being split during processing.

BCBSKS may encounter a claim that has been submitted using one procedure code which, in the opinion of BCBSKS, is not an appropriate description of the service provided under the circumstances. In such a case, BCBSKS will assign a procedure code which, in its opinion, is appropriate for the service under the circumstance, and will adjudicate the claim based upon such alternative procedure code. BCBSKS may either report payment of the claim under the revised procedure code or under the originally submitted procedure code; in either case, the maximum allowable payment applicable to the revised procedure code shall be the one that applies.

If after BCBSKS makes its payment to the provider and a credit balance results from having collected payment from the member, then the provider must refund the credit balance to the member within sixty (60) days from the date the overpayment is identified, unless directed by the member to apply the credit balance to their account for future services.

With implementation of ICD-10-CM, coding to the highest level of specificity will be required for proper adjudication of benefits. Therefore, non-specific diagnosis codes will not be accepted when a more specific code is available.

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

XVI. REFUND POLICY

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. Initiation of the arbitration process described in Section XXXVIII will not delay or otherwise impact BCBSKS' determination of refunds for overpayments owed from the provider to BCBSKS through the offset process.

XVII. 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 providers detailed individual claims information on the remittance advice so amounts can be reconciled efficiently. Initiation of the arbitration process described in Section XXXVIII will not delay or otherwise impact BCBSKS' right to collect refunds of overpayments owed from the provider to BCBSKS through the offset process.

XVIII. LOCUM TENENS PROVIDER

In situations in which the regular 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 during a continuous period of longer than 60 days. For situations extending beyond 60 days, BCBSKS must be contacted to discuss billing arrangements.

In billing for services provided by a locum tenens, the claim must be filed using the NPI or specific performing provider number of the provider for whom the locum tenens is substituting and a Q6 modifier must be used. In addition, the medical record must indicate the services were provided by a locum tenens. Locum tenens can be utilized in certain situations. However, covering for a deceased provider and billing under that deceased provider's NPI does not meet the criteria for locum tenens and is not permissible.

XIX. CONTRACTING STATUS DETERMINATION

- A. Any entity which provides and/or bills members and/or BCBSKS for health care services which advertises or represents itself to the general public as being owned/owning,

controlled/controlling, managed/managing, affiliated with, or operated by a contracting provider must also be contracting with BCBSKS, unless otherwise permitted by BCBSKS. Failure of such providers to contract with BCBSKS shall be considered cause for termination of the Contracting Provider Agreement in accordance with the Contracting Provider Agreement. This provision is applicable to entities serving members in the BCBSKS operating area. Contracting providers shall not subcontract other providers using their BCBSKS contracting agreement without the written consent of BCBSKS.

- B. A provider who practices in multiple locations in the BCBSKS operating area must be contracting or non-contracting in all locations.
- C. If the name of the provider set forth in the first paragraph of the contracting provider agreement is a professional association, rather than that of an individual, then the contracting provider agreement applies to all persons within the professional association. Any new providers who join the professional association will be understood to be bound by the contracting provider agreement. The party signing the contracting provider agreement on behalf of the professional association warrants to BCBSKS that such party (1) has the authority to sign such agreement on behalf of the professional association, (2) shall make the terms of the agreement known to members of the professional association, and (3) shall inform new members of the professional association of the terms of the agreement upon entry into the professional association. The foregoing warranties apply to any person defined as an eligible provider in BCBSKS contracts employed by the individual, professional association or other entity signing the contracting provider agreement.

NOTE: In the event a provider has been terminated by BCBSKS from the network and subsequently joins a participating provider's practice, such participating provider will place his/her BCBSKS participating agreement in jeopardy (subject to termination for cause). Certain contracts offered by BCBSKS may offer individual dentists options on contract status. Such options are specified by contract language and are offered solely at the discretion of BCBSKS.

- 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.

XX. NEW TECHNIQUES AND TECHNOLOGY

Maximum Allowable Payments (MAPs) for new techniques and technology will be based, when possible, on existing procedures of comparable value and result. Additional allowances for new techniques or technologies will be considered if there is documented significant improvement in safety or efficacy of patient care.

XXI. REIMBURSEMENT AND POLICY CHANGES

The BCBSKS Board of Directors authorized the following resolution regarding reimbursement changes and staff's authority.

BE IT RESOLVED, that the Board of Directors of BCBSKS hereby adopts as a policy the delegation of the authority to establish MAPs and to create or change policies and procedures under its contracts with providers of health care services to the executive staff of BCBSKS.

BE IT FURTHER RESOLVED, that the Board of Directors of BCBSKS hereby adopts as a policy of the corporation the understanding that any requirements for notifying annually each contracting provider at least 150 days in advance of the end of the calendar year of adjustments to the MAP shall not be construed to (1) require adjustments on the first day of a year, (2) to limit the ability of the corporation, through the authority delegated to staff above, to change MAPs with less notice than 150 days, or (3) to prevent the corporation from changing MAPs, through the authority delegated to staff, more frequently than annually.

BE IT FURTHER RESOLVED, that in making changes in MAP or in creating or changing policies and procedures staff shall provide notice to providers affected thereby at least 30 days in advance of the proposed effective date of such change in MAP or policies and procedures, and such affected providers shall have the ability to terminate their contracts with BCBSKS effective on the proposed effective date of such change rather than abide by such changes in MAP or such policies and procedures.

BE IT FURTHER RESOLVED, that staff shall report to BCBSKS Board of Directors at the same time providers receive notification of changes in MAPs or policies and procedures which staff makes and the nature of such changes. The failure of staff to notify the Board of Directors shall not invalidate such changes to MAPs or policies and procedures.

BE IT FURTHER RESOLVED, that this resolution shall be published as a policy and procedure of the corporation to all contracting providers.

XXII. AMENDMENTS TO POLICIES AND PROCEDURES; RIGHT TO TERMINATE CONTRACT

This provision is intended to supersede and nullify Sections III.A.2. and V.A. of the contracting provider agreement to the extent this provision conflicts with those sections.

A. Annual Contract Renewal

As part of its annual provider contract renewal process, Blue Cross and Blue Shield of Kansas notifies providers via U.S. Mail or hand delivery of all changes to its Policies and Procedures and Maximum Allowable Payment schedules at least 150 days before the amendments' effective date, which shall be January 1 of the following year. Such amendments must be accepted or rejected in their entirety; acceptance requires no affirmative act by the provider. If the provider finds the amendments unacceptable, the provider agreement may be terminated only by providing BCBSKS written notice of nonrenewal postmarked on or before September 3 of that same year. Such termination shall be effective January 1 of the following year.

B. Mid-year Amendments

Occasionally, BCBSKS will amend its Policies and Procedures or Maximum Allowable Payment schedules with mid-year effective dates. When this is necessary, notice of such amendment(s) shall be provided via mail or electronic mail to affected providers at least 30 days before the effective date of the amendment(s). If the provider finds the amendment(s) unacceptable, the provider may subsequently terminate their contracting provider agreement by providing BCBSKS with written notification of termination postmarked on or before the effective date of the amendment(s). Termination shall be effective on the effective date of the amendment(s).

XXIII. ESTABLISHING AND AMENDING MEDICAL POLICY

The BCBSKS Board of Directors authorized the following resolution regarding establishing and amending medical policy changes and staff's authority.

WHEREAS, the Provider Relations and Medical Affairs Division has identified a need for the ability to establish and amend corporate medical policy in a more expeditious and efficient manner, and

WHEREAS, this division has developed new procedures to establish and amend medical policies more efficiently to better serve BCBSKS members and providers,

BE IT RESOLVED, that the BCBSKS Board of Directors hereby affirms as policy, that when a proposed medical policy does not originate in a Liaison Committee or does not rise to a level of concern requiring review by Liaison, Medical or Dental Advisory Committees, the Provider Relations and Medical Affairs Division is authorized to establish or amend corporate medical policy; and

BE IT FURTHER RESOLVED, that except for non-substantive operational changes, BCBSKS staff shall report all such new policies or amendments to the Board of Directors in a timely fashion. However, failure to do so shall not invalidate any new or amended medical policy.

XXIV. REIMBURSEMENT FOR NEW PROCEDURE CODES

Periodically new American Dental Association (ADA) and the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) codes are published and finalized, usually each December with a January 1 effective date; however, new codes can be established at any time. For those new codes replacing existing codes, BCBSKS will crosswalk the existing MAP to the new code. For those brand new codes, BCBSKS will consider a number of sources; for example, consultants' input from providers and relative value units if applicable to establish the MAP.

XXV. REIMBURSEMENT FOR QUALITY

In addition to, or in lieu of, the maximum allowable payment (MAP) as referenced elsewhere in any BCBSKS Policy Memo, BCBSKS may establish reimbursement criteria based on quality components to reward providers for meeting specified performance levels. Such criteria and corresponding reimbursement changes will be communicated in advance of the effective date.

XXVI. APPLICATION OF CONTRACT

- A. The conditions of these policies and procedures and the contracting provider agreement apply to all benefit programs, indemnity and self-insured plans administered by BCBSKS or its subsidiaries, including those with deductibles, coinsurance and shared payments, including services that process under the medical benefit. 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 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 BCBSKS, or its subsidiaries, is involved in the pricing and/or processing of the claim and payment is issued either by BCBSKS, 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. For programs in which 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 and in which BCBSKS allowances are applicable, the provisions of these policies and procedures shall apply.

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 BCBSKS for the purpose of establishing reimbursement levels in the company service area.

- B. When BCBSKS receives and prices a claim which is paid by another entity, such other entity may make payments at variances with those which would be made by BCBSKS if it were adjudicating and paying the claim. In such a case, the provider must bring any such difference to the attention of BCBSKS within 15 months of payment to have such payment corrected.
- C. BCBSKS may review charge/payment records of non-BCBSKS patients to determine contract compliance. The patients' anonymity can be protected by providing information specific to the contract compliance review.
- D. Obligations under the contract with respect to services rendered while contract was in force survive termination of the contract.
- E. When BCBSKS is the secondary insurance payor and the contracting provider has entered into an agreement with the insurance carrier who is the primary payor to accept an allowance which is less than the allowable charge under this contract, then the allowance of the primary insurer shall be considered the allowable charge under this contract for the purpose of that claim. When the allowance of the primary payor is greater than the allowable charge under this contract, the provisions of this contract are applicable.

XXVII. ACKNOWLEDGMENT OF INDEPENDENT STATUS OF PLAN

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 Blue Shield Association (Association), 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.

The provider further acknowledges and agrees that he/she has not entered into such agreement based upon representations by any person other than the Plan and that no person, entity, or organization other than the Plan shall be held accountable or liable to the provider for any of the Plan's obligations to the provider created under such agreement. This section shall not create any additional obligations whatsoever on the part of the Plan other than those obligations created under other provisions of such agreement.

XXVIII. ACKNOWLEDGMENT OF BALANCED BUDGET ACT OF 1997

This contract will terminate if the [provider] is excluded from participation in any federal health care program, as defined under 42 U.S.C. 1320a-7b(f). Provider agrees to inform Blue Cross and Blue Shield of the commencement of any proposed exclusion within seven (7) business days of first learning of it, and to inform Blue Cross and Blue Shield immediately upon any such exclusion becoming effective with respect to [provider].

XXIX. CONTRACT SCOPE OF SERVICES

When a provider contracts with BCBSKS all covered services provided by that provider will be subject to the contract. This means that for covered services, the BCBSKS allowance for that service must be accepted as payment in full, e.g., medical equipment or supplies furnished by the provider, as well as prescription drugs supplied through the Stand Alone Drug Program.

XXX. CHARGE COMPARISON REPORTS

The provider may request one annual charge comparison report for procedures billed to BCBSKS on behalf of our members. Information included in the annual charge comparison will include services billed and allowed from January 1 to May 31 each year.

XXXI. SPECIAL PROVISION PERTAINING TO PENDED CLAIMS

The provider contract considers a person a member until such time as there is an indication he/she is no longer a member. This means that while a member's coverage is in a pending status for lack of payment of premium or notice of change of status, the provider contract continues to apply.

XXXII. LIMITED PROVIDER NETWORKS

The overall business climate or some large employer groups may require a reimbursement level lower than that available under the ordinary MAP from BCBSKS. To meet these market needs, BCBSKS may offer an amendment to the Contracting Provider Agreement, or an additional agreement, providing for such lower level of reimbursement. While nothing in these policies will require a provider to accept this additional discount, if a contracting provider fails to accept such amendment or agreement, a contracting provider shall nevertheless accept as payment in full from a member covered under such a program the amounts established as the MAP under the contracting provider agreement. Such provider may collect from such member the deductible, copayments, and additional copayments that apply when such person obtains services from providers who have not signed such amendment or additional agreement.

NOTE: This section does not apply to the Federal Employee Program (FEP) Preferred Dental Network.

XXXIII. CAP PROVIDER DIRECTORIES

BCBSKS makes CAP provider information, including contracting providers' names, available to members on our website: www.bcbsks.com, and to the Association for national doctor locator directories. BCBSKS reserves the right to suppress a provider from the directory when current information is not provided upon request.

Providers must notify BCBSKS of changes to provider data (including, but not limited to, EIN, TIN, NPI, legal name, address, adding or removing a provider) within 10 business days.

XXXIV. ACKNOWLEDGMENT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY REGULATIONS

Although BCBSKS does not guarantee the availability of a website, if and when a website may be made available to contracting providers, the contracting provider shall access such website and the information available through it only for the purpose of payment, treatment, and operations as these terms are defined in HIPAA at 42CFR, part 164.

XXXV. ACKNOWLEDGMENT OF NON-DISCRIMINATION LAWS

As a provider of services to the State of Kansas and to counties, municipalities and other state governmental units, BCBSKS is required by K.S.A. 44-1030 to observe the provisions of the Kansas Act Against Discrimination, not to discriminate against any person in the performance of work because of race, religion, color, sex, disability, national origin or ancestry, to include the phrase "equal opportunity employer" or a similar phrase in advertisements for employees, and to require in any contracts BCBSKS has with others that such others shall also abide by such provisions, and that if such contractors are found guilty of a violation of the Kansas Act Against Discrimination, such contractors shall be deemed to have breached their contracts with BCBSKS and the contract may be canceled, terminated or suspended in whole or in part. The contracting provider agrees that it shall abide by the foregoing provisions.

As a provider of services for qualified health plans, any entity that operates a health program or activity, any part that receives Federal financial assistance is required by Section 1557 of the Patient Protection and Affordable Care Act, and its implementing regulations published by the Office of Civil Rights, to not discriminate against any person on the basis of race, color, national origin, sex, gender identity, age, or disability, to accommodate individuals with limited English proficiency. Any entities that are found to have discriminated in violation of section 1557, and its implementing regulations, can be subject to a private right of action. The contracting provider agrees that it shall abide by the foregoing provisions.

XXXVI. MEDICARE ADVANTAGE PROGRAMS

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 and 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.

XXXVII. MODERATE (CONSCIOUS) 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.

XXXVIII. COLLECTION OF PAYMENT

The provider shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement, or have any recourse against Member, enrollee or persons other than BCBSKS acting on their behalf for services provided pursuant to the contracting provider agreement, including but not limited to, nonpayment by BCBSKS, BCBSKS insolvency, inability to continue operations or breach of this Agreement. This provision shall not prohibit collection of supplemental charges or copayments or reasonable deductibles, or charges for non-covered services where applicable made in accordance with the terms of the member's contract.

XXXIX. PROVIDER DISPUTE RESOLUTION

- A. Providers may dispute issues of concern through their Professional 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.
- B. Any dispute relating to or arising out of the contracting provider agreement and/or BCBSKS' policies and procedures applicable to such agreement, and that is not or cannot be resolved according to the appeal procedures of this Policy Memo, shall be resolved by binding arbitration. Arbitration is the process of resolving disputes between BCBSKS and a contracting provider separate and distinct from any appeal procedures described in this Dental Policy Memo. Once such appeal procedures are completed, BCBSKS may begin recoupment measures of any refunds due from the audited provider as described in Sections XVI and XVII, and initiation of the arbitration process will not delay or otherwise impact the recoupment process set out therein. Such arbitration shall be conducted in accordance with the Healthcare Payor Provider Arbitration Rules of the American Arbitration Association. Arbitration shall be initiated by either party filing a written demand for arbitration with the American Arbitration Association and payment of all requisite fees.

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 parties acknowledge that because the contracting provider agreement affects interstate commerce, the Federal Arbitration Act also applies. The parties agree that the decision of the arbitrator shall be final, binding and non-appealable, and that judgment on the arbitration award may be entered by any court of competent jurisdiction. The parties shall share all expenses of the arbitration equally. However, each party shall bear the costs and expense of its own counsel, experts, witnesses, and preparation and submission of its claims and defenses to the arbitrator.

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. 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.

XL. RIGHT OF DELEGATION

BCBSKS has the right to delegate any and all aspects of the audit and appeal processes to any qualified entity.

XLI. CONTRACT AMENDMENT

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

XLII. GLOSSARY

A list of definitions for some of the language used in these Policy Memos can be found at the BCBSKS website.

<http://bcbsks.com/help/glossary.htm>

Limited Patient Waiver



Section 1 – Patient Information

| | | |
|-----------------------------|--------------|-------------------------|
| First Name _____ | MI _____ | Provider Name _____ |
| Last Name _____ | Suffix _____ | Provider Address _____ |
| Identification Number _____ | City _____ | |
| Provider NPI _____ | State _____ | ZIP Code _____ +4 _____ |

The provider must document in the patient record the discussion with the patient regarding the following service(s):

Section 2 – Notice of Personal Financial Obligation (Please read before signing)

I have been informed and do understand that the charge(s) for _____
Nomenclature/Procedure Code/Appliance
provided to me on _____ **will not be covered** because Blue Cross and Blue Shield of Kansas (BCBSKS) considers this service to be:

- | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Not medically necessary | <input type="checkbox"/> Patient demanded services |
| <input type="checkbox"/> Deluxe features (applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract) – the allowance for standard item(s) will be applied to the deluxe item(s) | <input type="checkbox"/> Utilization denials |
| | <input type="checkbox"/> Experimental or investigational |

It is my wish to have this service(s) performed even though it will not be paid by BCBSKS.

I understand that I will be held personally responsible for approximately \$_____. This amount is an approximation only, based on the service(s) scheduled to be provided.

Options: Check only one box. We cannot choose for you.

- | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Option 1: I want the service listed above. I also want the provider to bill my insurance for the service provided so that a determination of coverage can be made by my carrier. |
| <input type="checkbox"/> Option 2: I want the service listed above, but do not want the provider to bill my insurance. I understand that I am responsible for the charge and have no appeal rights if the claim is not processed through my insurance. |

Acknowledgment of personal financial obligation applies to charge(s) for service(s) specified above when performed by this or another provider(s).

I further understand any additional service(s) could affect the amount of my financial responsibility.

Your signature required

Patient (Signature of parent/guardian if other than patient) _____ Date Signed _____

I, _____ (witness name), did personally observe and do certify the person who signed above did read this notice and did affix their signature in my presence.

Your signature required

Witness _____ Date Signed _____

