2018 Contracting

Professional Relations

DENTAL CAP REPORT

INTRODUCTION

Blue Cross and Blue Shield of Kansas (BCBSKS) is the insurer Kansans trust with their health. Much of that status can be attributed to the high-quality care delivered by our network providers. This document outlines the details related to our 2018 Competitive Allowance Program (CAP) and Dental PPO offer, and includes the specifics of our Quality-Based Reimbursement Program (QBRP), which has been designed to reward efforts toward maintaining your high-quality standards.

BCBSKS continues to offer contracting providers top-notch services, including Professional Provider Representatives and provider network services.

If you need clarification or additional information related to any information included herein, contact your Professional Relations Representative or Provider Network Services.

Professional Relations Staff	Location	Phone Numbers	
Doug Scott, Director	Topeka	(800) 432-0216 ext. 8831	(785) 291-8831
Robyne Goates, Manager	Topeka	(800) 432-0216 ext. 8206	(785) 291-8206
Gwen Nelson	Topeka	(800) 432-0216 ext. 8716	(785) 291-8716
Darin Fieger	Topeka	(800) 432-0216 ext. 8207	(785) 291-8207
Christie Mugler	Topeka	(800) 432-0216 ext. 8651	(785) 291-8651
Vikki Lindemuth	Topeka	(800) 432-0216 ext. 7724	(785) 291-7724
Provider Network Services	Topeka	(800) 432-3587 option 1 or 3	(785) 291-4135 option 1 or 3
Kyle Abbott	Wichita	(800) 432-0216 ext. 1674	(316) 269-1674
Vickie Kloxin	Wichita	(800) 432-0216 ext. 1674	(316) 269-1674
Debra Meisenheimer	Hutchinson	(620) 663-1313	
Jennie Fellers-Morgan	Dodge City	(620) 225-0884	

BY THE NUMBERS

Blue Cross and Blue Shield of Kansas provides the best service in the industry and strives to be the health insurance company of choice for our members and providers.

#1 BCBSKS is top-ranked for Provider Satisfaction.

BCBSKS is 100 percent URAC accredited in health plan, case management and disease management. **100%**

313,120 BCBSKS and its subsidiaries serve 313,120 members with dental coverage, as of May 31, 2017.

BCBSKS spent 9.60 percent of annual premium income on administrative expenses for the year 2016. **9.60%**

90% BCBSKS contracts with 90 percent of all dentists in the Plan area for CAP and about 70 percent for the Dental PPO.

2018 REIMBURSEMENT AND POLICY MEMO CHANGES

On June 30, 2017, the BCBSKS Board of Directors met and approved policy memo changes and the dental MAPs that will be applicable for 2018. A summary of the policy memo changes is enclosed for your review.

Reimbursement for 2018 is aligned to promote the incentives available through the Quality-Based Reimbursement Program (QBRP) (see pages 5-7). All increases can be achieved through QBRP. BCBSKS continues to be sensitive to the challenges experienced in rural Kansas related to access to dental care and recruitment of dentists. As such, BCBSKS will continue to increase the base allowances 5 percent for services performed by dentists (CDT codes) in counties with a population of 13,000 or less (see page 8).

A charge comparison report reflecting reimbursement for 2018 is available by contacting your Professional Relations Representative or our Provider Network Services area. The charge comparison is based on services billed by you during the first five months of 2017. As a reminder, the format of the charge comparison report changed in 2016. The new format provides the lesser of your charge or the MAP for each procedure code you performed thus far in 2017. In addition, the new report shows whether each procedure code qualifies for QBRP.

THE VALUE IN CONTRACTING

BCBSKS provides business services that bridge the gap between the delivery and financing of health care. Services creating significant value for contracting providers include:

► **Local member contracts** structured to allow charges up to 100 percent of the MAP for participating CAP providers (subject to member benefits).

► **Direct payment from BCBSKS**, which minimizes your collection efforts and increases cash flow.

► **A dedicated field staff** available to visit your office to address any operational issues.

► **Access to professional relations** provider network services personnel to answer policy questions or obtain assistance with claim coding questions.

► **Website (bcbsks.com) and self-service** access through Availity, which improves your office efficiencies and maximizes your employee resources.

- Secured services include detailed claims payment information, member eligibility, remittance advice, and provider enrollment information.
- Other services include training modules, podcasts, newsletters, manuals, policy memos, and medical policies/ guidelines.

► **Opportunity to participate** in the BCBSKS Dental PPO network.

► **Opportunity to earn additional revenue** through the Quality-Based Reimbursement Program (QBRP).

► **Detailed claim-payment information** provided to both you and the member explaining their financial responsibilities.

► **Electronic remittance advice** and payment capabilities.

► **Opportunity to participate on Dental Advisory Committees** and provide direct input in the development of dental policies and emerging issues.

► **Contracting providers' names made available to BCBSKS members** through a number of sources, including the internet, employer groups, and other contracting providers for referral purposes, which increases the potential for new patients.

► **Periodic workshops** conducted by professional relations staff that delivers continuous training for new and experienced dental assistant staff, helping update your staff on new administrative procedures to ensure timely claim payments.

NOTE — In 2018, for the majority of our business, non-contracting providers' services will be paid direct to the member at a 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, assignment of benefits to non-contracting providers is not allowed.

2018 DENTAL PROVIDERS QBRP

The BCBSKS Quality-Based Reimbursement Program (QBRP) is designed to promote efficient administration, improved quality, and better patient care and outcomes. Contracting BCBSKS providers have an opportunity to earn additional revenue through add-ons to allowances for meeting the defined quality metrics. BCBSKS claims data is used to determine qualification for any applicable metric requiring data.

The 2018 QBRP program is effective for services performed January 1, 2018 through December 31, 2018. Since the 2018 CAP letter is sent out in July 2017, providers have several months to prepare to meet the various QBRP metrics and qualify for incentives effective January 1, 2018, in accordance with the metric review schedule (see page 7). Please read the requirements and metrics for the 2018 QBRP program so you are prepared to maximize the available incentives. Any subsequent pertinent information or clarification will be communicated accordingly.

Criteria for 2018
In accordance with the 2018 Dental Policy Memo, Section XXV. Reimbursement for Quality, this document describes the components of our QBRP effective January 1, 2018 through December 31, 2018. This program applies to all BCBSKS CAP, Dental PPO, and BlueCross BlueShield of Kansas Solutions, Inc. (a wholly owned subsidiary of BCBSKS) dental providers and services except for clinical lab (using codes on the Medicare clinical lab fee schedule) pharmacies, and pharmaceuticals. This program will offer an opportunity for eligible providers to earn increased reimbursement based on meeting the metrics in Groups 1 and 2 described on page 6. This reimbursement will be in addition to the respective base MAPs for CAP, Dental PPO, and Solutions for 2018. **Please note —** Changes in CDT and CPT codes (added/deleted) will be effective prospectively, including QBRP.

The quality-based incentives will be earned at the individual provider level unless otherwise specified.

An eligible provider may independently qualify for each metric, except when measured on a group basis. The QBRP metrics are multiplied individually by the applicable MAP, then totaled with the applicable MAP to determine the total reimbursement “QBRP MAP.” BCBSKS will allow the lesser of the provider’s charge or the “QBRP MAP.”

In order for incentive payments to begin January 1, 2018, BCBSKS will use information on file or available from outside sources to determine which incentives providers qualify for based on unique provider individual NPI numbers, billing NPI numbers or tax ID, whichever is applicable. Confirmation notices with the qualifying incentive category, amount, and effective date will be generated for each individual provider and sent by email to the address on file. Email delivery of the confirmation notices for 2018 QBRP incentives effective January 1, 2018 will be sent mid-December 2017.

Please note — BCBSKS is working on enhancements to the provider information portal to include self-service QBRP information. Once this portal is available, it may replace the email confirmation process. More information and instructions will be communicated when the QBRP portal is available.

2018 DENTAL PROVIDER QBRP

(NEW) All metrics will be reviewed on a semi-annual basis and any incentives earned will be effective either January 1, 2018 or July 1, 2018 as applicable. We will continue monthly reviews for 2018 to identify providers who did not qualify for incentive(s) beginning January 1, 2018 because of not meeting prerequisites, or new providers/groups after January 1, 2018, but may subsequently qualify for incentive(s). If/when one of these two situations occur, the incentive(s) will be effective the first of the following month. A confirmation notice will be emailed to the provider to include the new incentive category and effective date. Any corrections will be effective the first of the following month unless otherwise specified.

We will conduct a QBRP refresh in the first and second quarters (depending on the metric) of 2018 for an effective date of July 1, 2018 to determine if providers are continuing to meet the performance standards for the metric(s) earned for the incentive payments effective January 1, 2018. If the refreshed data indicates a provider is no longer meeting the performance standards for the metric(s), then the associated QBRP incentive(s) will cease beginning July 1, 2018 for the remainder of the year. If a provider no longer meets the performance standards for the metric(s), a new communication advising of the change in QBRP incentive(s) qualifications will be sent.

QBRP PREREQUISITES AND GROUPS FOR PROVIDERS	
QBRP Participation Prerequisites	Providers must conduct business with BCBSKS electronically (i.e. turn off paper). Providers must submit all eligible claims electronically, accept electronic remittance advice documents (ERAs: either through receiving the ANSI 835 transaction or by downloading the RA from the BCBSKS website (and turn off printed RAs), and receive all communications (newsletters, etc.) electronically.
Group 1	Applies to all eligible contracting dental providers and to all eligible/ covered CDT and CPT codes (excludes Clinical Lab, Pharmacy, and Pharmaceuticals).
Group 2	Applies to all eligible contracting dental providers and to all eligible/covered CDT codes (excludes Clinical Lab, Pharmacy, and Pharmaceuticals).

2018 DENTAL PROVIDERS QBRP

Metric	%	Group	Description	Qualifying Period
Electronic Self-Service (ES3, ES2)	**2.5 (ES3)** *(96% or >)* **1.5 (ES2)** *(86-95%)*	1	Must use Availity portal or ANSI 270/271 & 276/277 transactions to electronically obtain BCBSKS patient eligibility, benefit, and claims status information. Electronic access must meet one of the percentages at left compared to the provider's total number of queries to BCBSKS, regardless of the mode of inquiry to receive the corresponding incentive. Providers billing under a single tax ID number will have their inquiries combined for determining the percent.	Semi-annual
Provider Information Portal (PRD)	2.0	2	Must verify provider information twice a year according to the qualifying schedule below. Each individual provider within a group must verify information. Verification must be completed within the BCBSKS provider information portal.	Semi-annual

QUALIFYING FOR ELECTRONIC SELF-SERVICE INCENTIVES (ES3, ES2)

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period:	Incentive begins:
August 1 - October 31, 2017	January 1, 2018
February 1 - April 30, 2018	July 1, 2018

QUALIFYING FOR PROVIDER INFORMATION PORTAL INCENTIVES (PRD)

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period:	Incentive begins:
June 1 - November 30, 2017	January 1, 2018
December 1, 2017 - May 31, 2018	July 1, 2018

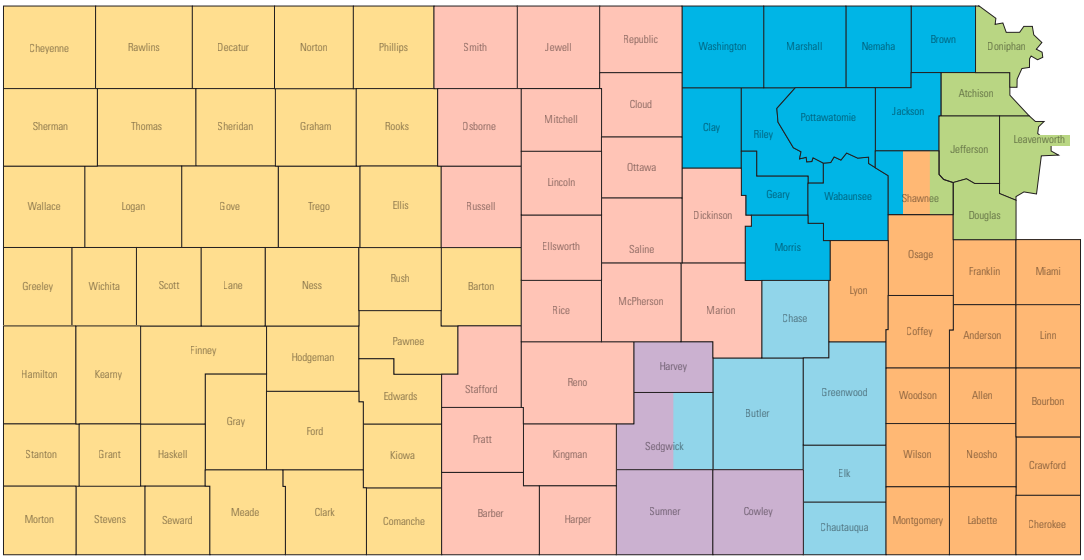
QBRP CHANGES FOR 2018		
Metric	**Change**	**Reason**
Electronic Self-Service	Changed from three to two incentive categories, raised thresholds, and changed incentive weighting.	To increase self-service.
Provider Information Portal	Increased incentive from 0.5 to 2.0 percent.	To increase provider data validation adherence.

RURAL ACCESS COUNTIES

The following is a list of counties with a population of 13,000 or less that qualify for a Rural Access incentive. (Source: U.S. County 2012 Estimated Census)

County	Population	County	Population
Anderson	7,917	Marion	12,347
Barber	4,861	Marshall	10,022
Brown	9,881	Meade	4,396
Chase	2,757	Mitchell	6,355
Chautauqua	3,571	Morris	5,854
Cheyenne	2,678	Morton	3,169
Clark	2,181	Nemaha	10,132
Clay	8,531	Ness	3,068
Cloud	9,397	Norton	5,612
Coffey	8,502	Osborne	3,806
Comanche	1,913	Ottawa	6,072
Decatur	2,871	Pawnee	6,928
Doniphan	7,864	Phillips	5,519
Edwards	2,979	Pratt	9,728
Elk	2,720	Rawlins	2,560
Ellsworth	6,494	Republic	4,858
Gove	2,729	Rice	9,985
Graham	2,578	Rooks	5,223
Grant	7,923	Rush	3,220
Gray	6,030	Russell	6,946
Greeley	1,298	Scott	4,937
Greenwood	6,454	Sheridan	2,538
Hamilton	2,639	Sherman	6,113
Harper	5,911	Smith	3,765
Haskell	4,256	Stafford	4,358
Hodgeman	1,963	Stanton	2,175
Jewell	3,046	Stevens	5,756
Kearny	3,968	Thomas	7,941
Kingman	7,863	Trego	2,986
Kiowa	2,496	Wabaunsee	7,039
Lane	1,704	Wallace	1,517
Lincoln	3,174	Washington	5,758
Linn	9,441	Wichita	2,256
Logan	2,784	Wilson	9,105
		Woodson	3,278

Professional Relations Dental Field Representative Territorial Map



DDS

- Gwen Nelson – Topeka – Rep. Code C
- Vickie Kloxin – Wichita – Rep. Code M
- Kyle Abbott – Wichita – Rep. Code P
- Jennie Fellers-Morgan – Dodge City – Rep. Code R
- Debra Meisenheimer – Hutchinson – Rep. Code K
- Christie Mugler – Topeka – Rep. Code Z
- Darin Fieger – Topeka – Rep. Code D

BlueCross BlueShield of Kansas

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PRD FRTM02 06/17

BlueCross BlueShield of Kansas

BLUE CROSS AND BLUE SHIELD OF KANSAS
DENTAL PROVIDER POLICIES AND PROCEDURES
SUMMARY OF CHANGES FOR 2018

Following is a summary of the changes to Dental Blue Shield Policies and Procedures for 2018. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2017.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2017 Policy Memos. Deleted wording is noted in brackets [*italicized*]. New verbiage is identified in **bold.**

Dental Policy Memo
SECTION V. POST-PAYMENT AUDITS

- **Page 8:** Changed verbiage for clarity.

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 cannot go back further than 15 months following the date of claim adjudication to initiate an audit.*] **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.

Dental Policy Memo
SECTION XI. MEDICAL RECORDS

- **Page 15:** Updated verbiage for clarity.

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. [*Services denied for failure to submit documentation are not eligible for provider appeal, and are a provider write-off.*]

Dental Policy Memo
SECTION XV. CLAIMS FILING

- **Page 16:** Added verbiage as notification that employee groups may impose alternate timely filing requirements.

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 (normal retail charge for HME suppliers) in the BCBSKS designated format, and to look to BCBSKS for payment except for amounts identified as patient responsibility: copays, coinsurance, deductible, indemnified payment 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.**

Dental Policy Memo
SECTION XVIII. LOCUM TENENS PROVIDER

- **Page 17:** Added verbiage for clarity.

  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.**

Dental Policy Memo
SECTION XIX. CONTRACTING STATUS DETERMINATION

- **Page 17:** Updated verbiage for clarity.

  ### 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.**

Dental Policy Memo
NEW SECTION. REIMBURSEMENT FOR QUALITY

- **Page 20:** Created new section to reflect current practice.

  ### 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.

Dental Policy Memo
SECTION XXXIV. ACKNOWLEDGEMENT OF K.S.A. 44-1030

- **Pages 22-23:** Updated verbiage to reflect current laws.

XXXV. ACKNOWLEDGMENT OF [*K.S.A. 44-1030*]**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.

Dental Policy Memo
LIMITED PATIENT WAIVER

- **End of Dental Policy Memo:** Updated Limited Patient Waiver to match other BCBSKS forms (esthetic only).

*Please see page 5 of this summary for updated form.

Limited Patient Waiver

BlueCross BlueShield of Kansas

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:

- ☐ Not medically necessary
- ☐ 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)
- ☐ Patient demanded services
- ☐ Utilization denials
- ☐ 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.

- ☐ **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.
- ☐ **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