BLUE CROSS AND BLUE SHIELD OF KANSAS
DENTAL PROVIDER POLICIES AND PROCEDURES
SUMMARY OF CHANGES FOR 2019

Following is a summary of the changes to Dental Blue Shield Policies and Procedures for 2019. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2018.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2018 Policy Memos. Deleted wording is noted in brackets [*italicized*]. New verbiage is identified in **bold.**

Dental Policy Memo
SECTION XI. Medical Records

- **Page 13:** Added language regarding cloning of medical records.

A. Form of documentation in medical records – Documentation in the medical record must accurately reflect the health care 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. **Cloned Medical Record Documentation – BCBSKS expects providers to submit documentation specific to the patient and specific to the individual encounter. Documentation should support the individualized care each BCBSKS member received.**
   Documentation identified as cloned, copied and pasted, pulled forward, or inserted via template without identifiable and appropriate updates specific to the current visit will not be considered for the purposes of determining services provided for that visit.

Dental Policy Memo
SECTION XI. Medical Records

- **Page 14:** Added verbiage for clarity.

  B. BCBSKS requests for medical records

  1. **Contracting providers must provide or make available complete medical records at no charge in a format that can be utilized by BCBSKS or an entity acting on behalf of BCBSKS.**

Dental Policy Memo
SECTION XV. Claims Filing

- **Page 16:** Added verbiage for clarity.

  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. **Provider may not charge a Blue Cross and Blue Shield (BCBS) member or employer policy holder any enrollment and/or maintenance fees associated with membership into a concierge, direct primary care, or any other similar model practice**. 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 XXXIX. Provider Dispute Resolution

- **Page 24:** Updated verbiage for clarity.

  A. Providers may dispute issues of concern through their Professional or Institutional Relations Representative. **A provider representative will respond to the provider in writing within 30 days of the request to advise of the status of the dispute or the outcome.** 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.