

2026 Policy Memo 1

Policies and Procedures



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Please note: any timeframe listed in days refers to calendar days unless otherwise specified.

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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 the applicable 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. All provisions within policy memos are subject to changes in State or Federal laws and regulations. In the event any changes in laws or regulations preclude or prevent compliance with any portion of the policy memos, such portion of the policy memo shall be severable. Any changes in laws or regulations not addressed in policy memo at the time, will be automatically updated to comply.

I. Confidentiality

The effective delivery of health care requires communication and collaboration among providers, patients and payers. 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.

Use of Confidential Information by Provider must be strictly for the purpose for which it was disclosed and may not be sold to any third party. Confidential Information, including claims data, obtained by provider may neither be de-aggregated in any manner to identify BCBSKS, other BCBS entities, and/or member information, nor may it be comingled in any manner. Any disclosure of Confidential Information shall be limited to the minimum necessary to fulfill the purpose for which it was disclosed. Confidential Information must be returned or securely destroyed by the Provider upon conclusion of the purposes for which it was disclosed. In the event Provider cannot immediately return or destroy Confidential Information due to legal, license, or other requirements, Provider agrees to maintain the confidentiality of such information until the expiration of said requirements. BCBSKS maintains the right to audit Provider to ensure compliance with these provisions.

These requirements shall survive any termination or expiration of the Agreement and BCBSKS may seek injunctive relief or specific performance in order to enforce its terms.

Nothing in this section shall be construed to limit the disclosure of confidential information to the extent required by law.

II. Retrospective Claim Reviews/Corrected Claim

The contracting provider shall have the right to one 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://provider.bcbsks.com/bcbsks-provider/facelets/allUsers/form/ProviderClaimEnrollmentInquiry.faces>
- 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.
- C. 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.
- D. Corrected claims, regardless of reason for the correction, must be submitted within timely filing limits as a new claim with box 22 completed. A corrected claim for services initially denied in whole or in part counts as the provider's retrospective review.

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) as described in BCBSKS Policy Memos 1-12 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 Memos 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 physician or clinical peer. The contracting provider agrees to abide by the second-level appeal determination.

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

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 agreement requires 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. Health care professionals should discuss all appropriate treatment alternatives available to patients regardless of benefit coverage limitations. 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/equipment would be subject to medical necessity and utilization review:
 - 1. Established procedures/equipment of questionable current usefulness in the treatment of a specific condition(s).

2. Procedures/equipment which tend to be redundant when performed/supplied in combination with other procedures/equipment; or procedures/equipment which are unlikely to provide additional medical benefits, or are contradicting to one another.
 3. Specific procedures/equipment or patterns of care which vary significantly from a peer group.
- B. 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-certification and will be subject to concurrent review. 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 (via 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 prior to 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.

- C. 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 those services specified by employers, and outpatient procedures which necessitate a greater level of facility care than is usually needed.

Following provider notification, continued failure to complete pre-certification/prior authorization activities will result in a 50 percent Maximum Allowable Payment (MAP) reduction up to \$200 with the member held harmless. Compliance audits will take place on a post-payment basis, which may result in refunds.

- D. CASE MANAGEMENT – Case management is a process that identifies and coordinates alternative treatment plans to enhance care through effective administration of available health care resources in the most cost-efficient manner. The process is accomplished through the development of a treatment plan by the patient or legal representative, the physician, other health care providers, and the BCBSKS case manager.
- E. PREPAYMENT 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. Prepayment review will be implemented if attempts to work with the provider have failed to

resolve the issue. Specific utilization guidelines may be applied to individual prepay members. Prepayment review means all claims will be reviewed before payment and records will be required.

- F. APPROPRIATE PLACE OF SERVICE –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 providers' lack of compliance will range from provider education to financial assessments and finally requesting contract cancellation.
- G. RESOLUTION OF PROBLEMS – Providers agree to work with BCBSKS and other providers of care in the resolution of any utilization or medical review problems that may be identified. Actions taken for providers' 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 the services being rendered. (See Section 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.

- I. DENTAL 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.

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 first level appeal determination will be made by a physician or clinical peer who was not involved with the audit determination. 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 who was not involved with the audit determination. The BCBSKS determination will be made within 30 days of receipt of the appeal.

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).

No appeals are available for post-pay audit findings and associated re-adjudications based on published BCBSKS payment policies, including but not limited to content of service, multiple surgery guidelines, or other billing guidelines.

VI. Content of Service

A. Medical 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 policies and procedures. BCBSKS staff may identify and classify specific coding and nomenclature issues as they arise. Examples of services that can be considered content of service are:

- Examination of the patient.
- History of illness and/or review of patient records.

- Evaluation of tests or studies (i.e., radiology or pathology).
- Hearing and vision screenings.
- Any entries into the patient's records.
- Evaluation of reports of tests or studies earlier referred to another physician for an opinion and subsequently returned for use in the office visit being conducted.
- Advice or information provided during or in association with the visit.
- Case management.
- The prescription of any medicinals, home supplies or equipment during or as a result of the visit.
- The application or the re-application of any standard dressing during a visit.
- Therapeutic, prophylactic, or diagnostic injection administration provided on the same day as an office visit, home visit, or nursing home visit.
- Additional charges beyond the regular charge for services requested after office hours, holidays or in an emergency situation.
- Examination and/or treatment room.
- Items of office overhead such as malpractice insurance, telephones, computer equipment, software, personnel, supplies, cleaning, disinfectants, photographs, equipment sterilization, etc.
- Telephone calls and web-based correspondence are content of service when billed with another service on the same day.
- Anesthesia provided in an office setting is considered content of service and not reimbursed separately. The provider cannot require the patient to sign a waiver or bill the patient for this service.
- For services that include assessment and evaluation of that assessment, the date of the assessment shall be the date of service.
- Mileage (except for ambulance)

Some content of service issues related to specific services and/or procedures are identified throughout the policy and procedure documents.

NOTE – All-inclusive procedure codes must be used when available.

A handling fee may be allowed under certain conditions. See Policy Memo No. 7, Radiology and Pathology.

B. Dental Content of Service

- 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

- SURGICAL REMOVAL OF AN ERUPTED TOOTH INCLUDES:

10. Local anesthesia
 11. Elevation of flap
 12. Removal of tooth
 13. Removal of bone
 14. Alveoloplasty
 15. Suturing
 16. Postoperative care
 17. Suture removal
 18. Materials/supplies
 19. Patient instruction
 20. Patient records

- AMALGAM/COMPOSITE RESTORATIONS INCLUDE:

21. Local anesthesia
 22. Moisture control (rubber dental dam)
 23. Tooth preparation
 24. Cavity liner
 25. Acid etching (for composite restorations)
 26. Restorative material
 27. Finishing procedures (carving, polishing, etc.)
 28. Postoperative procedures
 29. Patient instruction and records

- ROOT CANAL THERAPY – ONE OR MORE CANALS

30. Local anesthesia
 31. Moisture control (rubber dental dam)
 32. Opening and drainage of canal(s)
 33. Removal of pulp
 34. Interim medicated treatment (if necessary)
 35. Placement of canal filling material
 36. Preparation for placement of pre-formed pin(s)
 37. Follow-up care
 38. Patient instruction and records

- DENTURES – FULL OR PARTIAL

39. Impression and all materials
 40. Bite registration
 41. Face bow
 42. Establishment of correct occlusion
 43. Wax models
 44. Try-ins
 45. Seating/delivery
 46. Patient records and instruction

47. Six-month follow-up care, including but not limited to relief of sore spots, base adjustments, re-balancing occlusion.

- Services such as local anesthesia, impressions for prosthetics, materials/supplies, suture removal by rendering 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.
- 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 BCBSKS Secure Section [BlueAccess] via [Availity.com](https://www.availity.com)) for further guidelines.

C. Durable Medical Equipment (DME) Content of Service

Content of service refers to specific services and/or procedures that are considered to be an integral part of the total price of the equipment or supply to the extent that separate reimbursement is not recognized. Examples of services which can be considered content of service are:

- Any entries into the patient's records.
- Evaluation of reports on tests or studies.
- Advice, counseling or information provided during or in association with the service.
- Containers and labeling.
- Shipping or delivery within normal trade area or practice.
- Setup of equipment.
- Repair and maintenance of normal wear on rental equipment.
- Billing fees.
- Taxes.
- Fittings, adjustments and video monitoring.
- Items of office overhead such as malpractice insurance, telephones, personnel, etc.

Note: Appropriate all-inclusive HCPCS codes must be used when available.

VII. Experimental or Investigational Procedures

Any drug, device or medical treatment or procedure and related services that are experimental or investigational as defined by BCBSKS are considered a provider write-off unless a Limited Patient Waiver is obtained prior to services being rendered.

Experimental or investigational refers to the status of a drug, device or 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 or 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 or 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(s) 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 notify 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 their 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

There are several categories of services, procedures, equipment and/or pharmaceuticals that may be considered non-covered services when designated by the member's contract. These denials are billable to the member. (See Section XV. CLAIMS FILING)

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.

IX. Patient-Requested Services

- A. 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 Section X. WAIVER FORM)
- B. Providers must obtain a waiver on any mental health consultation, testing, or evaluation that is performed by agreement or at the direction of a court for the purpose of assessing custody, visitation, parental rights, or to determine damages of any kind of personal injury action and if the service is not otherwise medically necessary. To enable the provider to bill a patient for such services, BCBSKS will deny benefits for such services as lacking medical necessity.

X. Waiver Form

NOTE – The waiver cannot be utilized for services considered to be content of another service provided, nor can it be used to bill the patient the difference between the provider charge and the allowed amount.

A. SITUATIONS REQUIRING A WAIVER

- 1. Medical necessity denials
- 2. Utilization denials
- 3. Deluxe features (Applicable to deluxe orthopedic, prosthetic and dental appliances as specified in the member contract)
- 4. Patient-requested services
- 5. Experimental/investigational procedures

B. THE WAIVER FORM MUST BE

- 1. Signed before receipt of service.
- 2. Patient, service, and reason 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 Policy Memo No. 1)

XI. 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.
 3. 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 or total time for each CPT/CDT code/service performed on all timed codes per CPT/CDT nomenclature.
 - h. Document the initial diagnosis and the patient's initial reason for seeking the provider's care.
 - i. Document the patient's current status and progress during the course of treatment provided.
 - j. Indicate the medications prescribed, dispensed, or administered, and the quantity and strength of each.

- k. Include all patient records received from other health care providers if those records formed the basis for treatment decision by the provider.
 - l. Each entry shall be authenticated by the person making the entry (see Signature Requirements) unless the entire patient record is maintained in the provider's own handwriting.
 - m. Each patient record shall include any writing intended to be a final record, but shall not require the maintenance of rough drafts, notes, other writings, or recordings once this information is converted to final form; the final form shall accurately reflect the care and services rendered to the patient.
4. 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.
 - b. A typed or printed name must be accompanied by a handwritten signature or initials with credentials and date.
 - c. 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."
 - d. 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.
 - e. Rubber stamp signatures are not permissible. This provision does not affect stamped signatures on claims, which remain permissible.
5. 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).

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

B. BCBSKS requests for medical records

1. Contracting providers must provide complete medical records at no charge in a format that can be utilized by BCBSKS or an entity acting on behalf of BCBSKS.
2. 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.
3. 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.
4. 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 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.

5. The ordering/referring provider shall also provide medical records to the rendering 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.
6. 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 patients' 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 provider gives a lower charge to every patient who does not have health insurance, we consider that lower charge to be the "usual charge." Professional provider services where the provider would normally make no charge, a claim should not be submitted.

Because a contracting provider agrees to not bill a BCBSKS member at the time of service, there should never be a circumstance in which a BCBSKS member pays anything other than a deductible, copayment, coinsurance, or non-covered procedure at the time of service. As an additional matter in regard to this point, our payments are timely enough that they are essentially cash for all practical purposes. If we are in fact late with payments, then the remedy is stated under the Prompt Payment law.

- C. Agencies such as community mental health centers, federally qualified health centers and county health departments would be allowed to use a sliding scale for charging practices due to agency regulations.
- D. 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.

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 one or more professional services (e.g., professional component, technical component or other technology utilized in the performance of a service), the contracting provider who ordered the service(s) must bill BCBSKS for all services rendered by the non-contracting provider. If the non-contracting provider bills the member or BCBSKS, the contracting provider will be required to ensure the member is held harmless.

In the same manner, if a contracting group allows providers who have not yet received credentialing approval from BCBSKS to see members, the contracting group and non-contracting provider must hold the member harmless.

In the event members request referrals to non-contracting providers, referring 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 (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.

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 billing National Provider Identifier (NPI) if applicable. The name of the ordering provider, when applicable, (including NPI or specific rendering provider number, except when exempt by law) must appear on the claim. The contracting provider agrees to conduct claim transactions with BCBSKS as standard transactions in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

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.

BCBSKS requires providers to report procedures according to American Medical Association Current Procedural Terminology (CPT) or Current Dental Terminology (CDT) and the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) guidelines. However, the proper submission of codes and/or modifiers according to these guidelines shall not imply or create entitlement to health care coverage or reimbursement by BCBSKS for all reported procedures. BCBSKS has sole discretion to determine the applicability of codes and modifiers for reimbursement decisions. Specifically, this discretion includes, but is not limited to, determinations concerning content of service and consideration of modified or add-on codes for additional reimbursement.

For primary procedures, providers should submit the code that most accurately describes the service provided. Add-on codes (as defined by CPT/CDT) should not be reported as stand-alone procedures and must be submitted with the primary service in order to be considered for reimbursement.

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.

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.

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.

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 XLVI 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 XLVI will not delay or otherwise impact

BCBSKS' right to collect refunds of overpayments owed from the provider to BCBSKS through the offset process.

XVIII. Services Provided by Non-Physicians and Resident Physicians

- A. All non-physicians, 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 rendering provider number, if applicable. The name of the ordering provider, when applicable, (including NPI, except when exempt by law) must appear on every claim. BCBSKS does not recognize incident-to billing.
- B. A physician may bill for the services of a licensed nurse, other than an APRN, if there is an employer/employee relationship and the services are supervised by the physician (supervision means the patient recognizes the supervising physician as their physician and there is a periodic review of the records by the physician). These services must be an integral part of the physician's professional service, included in the physician's bill, and be of the type that are commonly furnished in the physician's office or clinic.
- C. Independently practicing Advanced Practice Registered Nurses (APRNs) or Physician Assistants (PAs) who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own NPI or specific rendering provider number. The name of the ordering provider, when applicable, (including NPI, except when exempt by law) must appear on every claim.
- D. Services of a Resident Physician are billed under the attending Faculty Physician's NPI or specific rendering provider number if done in connection with the Residency Program.
- E. If the Resident Physician is providing services outside of the Residency Program, all Blue Shield Policy Memos apply and services shall be billed under their own NPI or specific rendering provider number.
- F. BCBSKS will not pay for any services performed and billed by an independent provider who does not meet applicable state or national licensure registration or certification requirements to perform that service or who is not defined as an eligible provider in the member's contract.
- G. BCBSKS will not pay for outpatient services connected with a nervous and mental diagnosis when provided by an unlicensed provider, or a licensed provider with a licensure other than designated in the member's contract as eligible to provide nervous and mental benefits. Supervision of an unlicensed provider, a licensed counselor, or one not designated as eligible in the member's contract does not constitute a service being rendered by an eligible provider. The exception to this would be if the service was rendered through a state licensed alcohol or drug abuse treatment facility, a hospital, or a psychiatric hospital. Eligible non-physician psychiatric providers include APRNs, certified psychologists, licensed specialist clinical social workers, licensed clinical marriage and family therapists, licensed clinical professional counselors, and licensed clinical psychotherapists.

XIX. 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 physician can only authorize another physician as a locum tenens, an APRN/PA can only authorize another APRN/PA, etc.) and the locum tenens must be licensed in Kansas and only perform within their 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 rendering 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. Situations when Locum Tenens is not permitted:

- A. Deceased provider
- B. Replace a provider who has permanently left the practice/group
- C. Locum tenens provider has a temporary license
- D. Provider is pending completion of credentialing

XX. 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 or other legal entity, 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. If such eligible provider is among those

identified in Section XXV. TIERED REIMBURSEMENT AND PROVIDER NUMBER REQUIREMENTS hereof, the MAPs applicable to such eligible providers will apply to any services provided by them. If such persons are contracting separately with BCBSKS, until such contract is terminated, then it shall apply rather than these provisions, but if such separate contract terminates, then nonetheless these provisions shall apply with regard to the contracting status of such person.

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 their BCBSKS participating agreement in jeopardy (subject to termination for cause). Certain contracts offered by BCBSKS may offer individual physician 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.
- E. In the event of sale, consolidation or merger of a contracting provider, the contracting provider must notify BCBSKS within 30 days of the sale, consolidation or merger being finalized. All rights, duties, obligations, and responsibilities of any provider contracts in place before the sale, consolidation or merger will be assigned to the new entity.

XXI. New Techniques and Technology

Maximum allowable payments (MAPs) for new techniques, technology, home medical equipment and/or supplies will be based, when possible, on existing procedures/services and comparable value and result. Additional allowances for new techniques, technology, home medical equipment and/or supplies will be considered if there is documented significant improvement in safety or efficacy of patient care.

XXII. 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.

XXIII. 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, BCBSKS notifies providers via hand delivery or electronically 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 prior to 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).

XXIV. 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.

XXV. Tiered Reimbursement and Provider Number Requirements

BCBSKS has established different MAPs for the same service for the following specialties: Advanced Practice Registered Nurses/Advanced Registered Nurse Practitioners, Physician Assistants, Clinical Psychologists, Licensed Clinical Social Workers, Community Mental Health Centers, Outpatient Substance Abuse Facilities, Autism Specialists, Individual Intensive Support providers, Registered Behavioral Technician, Chiropractors, Physical Therapists, Certified Physical Therapist Assistants, Licensed Athletic Trainers, Licensed Dietitians, Occupational Therapists, Certified Occupational Therapist Assistants, Speech Language Pathologists, Licensed Clinical Marriage and Family Therapists, Licensed Clinical Professional Counselors, Licensed Clinical Psychotherapists, Licensed marriage and Family Therapist, Licensed Master level Psychologist, Licensed Master Level Social Worker, Licensed Master Addiction Counselor, and Licensed Professional Counselor. Please review your charge comparison (refer to Section XXXVI. CHARGE COMPARISON REPORTS) to determine any write-off amounts.

Eligible providers listed above must obtain an NPI and assure it is included as the rendering provider number on all claims submitted before any payment for such claims will be made by BCBSKS. Members may not be billed for services when a claim has not been paid because of the lack of the rendering provider NPI. Clinical laboratory, radiology, and drug MAPS are excluded from tiered reimbursement and will apply base MAP.

XXVI. Reimbursement for New Procedure Codes

Periodically new American Medical Association Current Procedural Terminology (CPT) or Current Dental Terminology (CDT) 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 added at any time. For those new codes that replace existing codes, BCBSKS will crosswalk the existing maximum allowable payment (MAP) to the new code. In the event a new code is established which combines two or more existing codes, a new MAP will be established for such new code. For those brand new codes or codes without a Relative Value Unit (RVU), BCBSKS will consider a number of sources, for example: the RVU when applicable, consultants, and input from providers to establish the MAP.

XXVII. Reimbursement for Pharmaceuticals

Covered pharmaceuticals are reimbursed based on a formula as determined by BCBSKS that utilizes the published average sales price (ASP), wholesale acquisition cost (WAC), or the average wholesale price (AWP). Reimbursement for pharmaceuticals will be reviewed periodically and may be adjusted during the year to reflect changes in the ASP, WAC or AWP. Individual drug pricing is available upon request.

XXVIII. Reimbursement for Lesser Services

When a service performed is considered a lesser service and billed with a "52" modifier, reimbursement may be reduced to an allowance reflective of the service performed.

XXIX. 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.

XXX. Reimbursement for Site of Service

BCBSKS may apply a site of service differential when services which could be performed in an office are performed outside of the office setting. Reimbursement for overhead/supplies is included in the MAP for such services. When performed outside the office setting, the rendering provider should not incur overhead expense. That expense is incurred and billed by the facility where the procedure is performed. Therefore, reimbursement up to the MAP, or the provider's charge (whichever is less) is made for those procedures performed in the office setting. The reimbursement is less when services are performed elsewhere.

XXXI. Adverse Events

The BCBSKS list of "Adverse Events" shall automatically include all future CMS adopted "Never Events" that pertain to physicians. The updates become effective immediately upon adoption even if the addition occurs mid-year. The CMS "Never Events" updates do not constitute a change in policy and neither the patient nor BCBSKS shall pay for the medical errors.

Adverse events A, B, and C are not billable to BCBSKS.

- A. SURGERY PERFORMED ON THE WRONG BODY PART
- B. SURGERY PERFORMED ON THE WRONG PATIENT
- C. WRONG SURGICAL PROCEDURE ON A PATIENT

When one of these three adverse events occurs, no payment will be made to the provider for that error or correction of that error. The patient shall be held harmless and may not be billed for any adverse event. The provider shall refund payments to BCBSKS made for an adverse event if a claim is filed in error. If the surgical error is corrected by a different provider, payment for that procedure will be made.

- D. RETENTION OF FOREIGN OBJECT IN SURGICAL PATIENT – In cases where a foreign object is mistakenly left in the patient during a surgical procedure the following applies:
 - 1. If the same provider also removes the object, then no payment for the correcting surgery will be made and the patient will be held harmless.
 - 2. If a provider other than the original provider removes the foreign object, that provider shall receive payment.

The Provider shall cooperate with BCBSKS in initiatives designed to help prevent or reduce such events and ensure that appropriate payments are made with no additional charges incurred for any condition which was not present on admission.

XXXII. Application of Contract

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

The conditions of these policies and procedures and the contracting provider agreement also apply to other entities when services (including services covered by workers compensation) are received within the company service area and 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 BCBS companies/plans or other entities such as insurers or administrators of welfare benefit plans or workers compensation plans. In the event there is need for substantive differences between the terms and conditions of these Policies and Procedures and those applicable to a subsidiary of BCBSKS, a separate contract would govern the subsidiary network.

The conditions of these policies and procedures and the contracting provider agreement DO NOT apply to the programs insured and/or administered by BCBS 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. And, in the event the provider is required to submit claims direct to a BCBS company/plan outside the company service area that is adjudicating the claim, the provisions of these policies and procedures do not apply.

- 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 payer and the contracting provider has entered into an agreement with the insurance carrier who is the primary payer 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 payer is greater than the allowable charge under this contract, the provisions of this contract are applicable.
- F. In circumstances in which a party other than BCBSKS is entitled to the benefits of the Contracting Provider Agreement and these Policies and Procedures, such party may, at its discretion, honor assignments of benefits to providers not contracting with BCBSKS.

XXXIII. Acknowledgment of Independent Status of Plan

The provider hereby expressly acknowledges its 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 BCBS Plans, the Association permitting the Plan to use the BCBS Service Marks, and that the Plan is not contracting as the agent of the Association. BCBSKS serves an operating area of 103 counties in Kansas (all counties except Johnson and Wyandotte).

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.

XXXIV. Acknowledgement 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 BCBSKS of the commencement of any proposed exclusion within seven (7) business days of first learning of it, and to inform BCBSKS immediately upon any such exclusion becoming effective with respect to provider.

XXXV. 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.

XXXVI. Fee Schedules

Fee Schedules will be made available through the provider portal, replacing charge comparison reports.

XXXVII. Pathology or Laboratory Services

Anatomical lab must be billed by the provider who renders the service. Clinical lab can be billed by providers in those circumstances where they are sending the specimen outside their office for analysis.

XXXVIII. Special Provision Pertaining to Pended Claims

The provider contract considers a person a member until such time as there is an indication they are 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.

XXXIX. 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 addendum 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, co-insurance, and additional copayments which apply when such person obtains services from providers who have not signed such amendment or additional agreement.

XL. CAP Provider Directories

BCBSKS makes CAP provider information, including contracting providers' names, available to members on the BCBSKS 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, change in ownership, EIN, TIN, NPI, legal name, address, adding or removing a provider) within 10 business days.

XLI. 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.

The Contracting Provider shall not, in connection with any functions, activities, or services directly or indirectly contract with any person or entity that undertakes any functions, activities, or services, including without limitation storage of member information outside of the United States of America or its territories without prior written consent from BCBSKS.

XLII. Acknowledgment of Non-Discrimination Laws and Equitable Access Requirements

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.

Providers agree to ensure that all services are provided in a culturally competent manner to all enrollees and to promote equitable access to all enrollees, including but not limited to the following:

- People with limited English proficiency or reading skills.
- People of ethnic, cultural, racial, or religious minorities.
- People with disabilities.
- People who identify as lesbian, gay, bisexual, or other diverse sexual orientations.
- People who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex.
- People living in rural areas and other areas with high levels of deprivation.
- People otherwise adversely affected by persistent poverty or inequality.

XLIII. Medicare Advantage Claims

Medicare Advantage (MA) claims should be submitted directly to BCBSKS (or its designee for dental), which will report the status of such claims on its remittance advices. MA claims will be processed pursuant to BCBSKS policies and procedures specific to MA and are subject to applicable MA appeal rights. For MA claims occurring under a form of coverage offered by a BCBS Plan other than BCBSKS, the provider in the BCBSKS MA provider network will be reimbursed for covered services at the BCBSKS MA reimbursement rate. The other BCBS Plan is solely responsible for determining medical policy. BCBSKS providers not participating in the BCBSKS MA provider network who provide services to an MA member of either BCBSKS or another BCBS Plan will be reimbursed at the amount applicable in Original Medicare (as required by the Centers for Medicare & Medicaid Services (CMS)). BCBSKS contracting MA providers, see the Medicare Advantage Manual for MA-specific policies, procedures, and guidelines.

XLIV. 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.

XLV. Provider Dispute Resolution

- 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.

- 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 Policy Memo No. 1. 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 extra-contractual 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 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.

XLVI. Right of Delegation

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

XLVII. 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. B. The physician agrees to fully and promptly inform BCBSKS of the existence of agreements under which such physician agrees to accept an amount for any and or all services as payment in full which is less than the amount such physician accepts from BCBSKS as payment in full for such services. BCBSKS staff is authorized to adjust MAP for the physician 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 payer or offers a discount or other financial arrangement, the effect of which is that such contracting provider accepts from another payer 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.

XLVIII. Glossary

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

<https://www.bcbsks.com/help/glossary.shtml>

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:

- | | |
|--|--|
| ☐ Not medically necessary | ☐ Patient-requested services |
| ☐ 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) | ☐ 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 _____

Visit us at bcbsks.com



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