BLUE CROSS AND BLUE SHIELD OF KANSAS
PROVIDER POLICIES AND PROCEDURES
SUMMARY OF CHANGES FOR 2026

Following is a summary of the changes to Blue Shield Policies and Procedures for 2026. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com by December 2025.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2025 Policy Memos. Combined language is identified in blue. Deleted wording is noted by strikethrough. New verbiage is identified in red.

Policy Memo No. 1
Table of Contents

- **Page 3:** Added CPT copyright disclaimer. *Note: this disclaimer has been added to the beginning of each Policy Memo that references CPT.*

  CPT Copyright 2017 American Medical Association. All rights reserved. CPT® is a registered trademark of the American medical Association.

Policy Memo No. 1
SECTION II. Retrospective Claim Reviews/Corrected Claim

- **Page 5:** Updated verbiage for clarity regarding corrected claims.

  Corrected claims, regardless of reason for the correction, must be submitted within timely filing limits as a new claim with box 22 completed ~~to and received by BCBSKS Customer Service within 120 days from the date of the remittance advice and include the original claim number.~~ A corrected claim for services initially denied in whole or in part counts as the provider's retrospective review.

Policy Memo No. 1
SECTION IV. Utilization Review and Medical Necessity

- **Page 8:** Removed verbiage that was duplicate to other sections.

F. APPROPRIATE PLACE OF SERVICE – ~~The provider agrees to use (to the extent possible) those inpatient, extended care, ancillary services and other health facilities and health professionals which have contracted with BCBSKS.~~ Providers agree to render services to members in the most appropriate and economical setting consistent with the member's diagnosis, treatment needs, and medical condition. Actions taken for providers' lack of compliance will range from provider education to financial assessments and finally requesting contract cancellation~~. In the event members request referrals to non-contracting providers, providers should have patients sign a statement acknowledging full understanding of the non-contracting referral and the patient's financial responsibilities. The statement should be filed in the patient's chart.~~

Policy Memo No. 1
SECTION IV. Utilization Review and Medical Necessity

- **Page 8:** Added subsection *I.* from the Dental CAP policy memo document for combining policy memo documents into one.

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.

Policy Memo No. 1
SECTION VI. Content of Service

- **Page 10:** Created subsections B and C from Dental CAP and HME CAP policy memo documents for combining all policy memo documents into one.

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) 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.

Policy Memo No. 1
SECTION X. Waiver Form

- **Page 14:** Updated verbiage to reflect dental deluxe features for combining all policy memo documents into one document.

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

Policy Memo No. 1
SECTION XI. Medical Records

- **Page 16:** Updated verbiage to include CDT codes for combining policy memo documents into one document.

g. List start and stop times or total time for each CPT/CDT code/service performed on all timed codes per CPT/CDT nomenclature.

Policy Memo No. 1
SECTION XII. Uniform Provider Charging Practices

- **Page 19:** Updated verbiage to reflect all agencies.

  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.

Policy Memo No. 9
SECTION X. Adverse Events

- **Page 7:** Updated verbiage to reflect dental adverse events for combining all policy memo documents into one document.

  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 or tooth.
  B. Surgery performed on the wrong patient.
  C. Wrong surgical procedure on a patient.

Policy Memo No. 12
SECTION VII. Anesthesia Modifiers

- **Page 5:** Added section to include information regarding billing for anesthesia modifiers.

  VII. Anesthesia Modifiers

  All general anesthesia claims must include the appropriate modifiers – AA, AD, QK, QX, QY or QZ. To ensure proper billing, all anesthesia claims must specify the correct anesthesia modifier in the first modifier position, clearly identifying the provider of anesthesia services.