BLUE CROSS AND BLUE SHIELD OF KANSAS
PROVIDER POLICIES AND PROCEDURES
SUMMARY OF CHANGES FOR 2027

Following is a summary of the changes to Blue Shield Policies and Procedures for 2027. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com by December 2026.

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.

NOTE: To ensure alignment with corporate branding and document consistency standards, the numbering format within the Policy Memo documents has been updated. These modifications are limited to formatting only and do not alter the content, except as expressly identified in the Summary of Changes outlined below.

Policy Memo No. 1
SECTION 2. (Formerly II.) Retrospective Claim Reviews/Corrected Claim

- **Page 6:** Added verbiage for clarification.

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 from a medical policy edit or medical review determination counts as the provider's retrospective review.

Policy Memo No. 1
SECTION 5. (Formerly V.) Post-payment Audits

- **Page 10:** Added verbiage for clarification.

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. BCBSKS may use the process of claim history extrapolation to determine the overpayment amount. Please see Sections ~~XVI~~ 16. Refund Policy and ~~XVII~~ 17. Right of Offset for questions on notifications of overpayments.

Policy Memo No. 1
SECTION 6. (Formerly VI.) Content of Service

- **Page 12/13:** Updated verbiage for clarity regarding dental content of service.

6.3. Dental Content of Service

Examples of dental services that can be considered content of service are:

A. All crowns, abutment and/or restorative, include:
- Impression
- Tooth preparation
- Temporary crown
- Try-in
- Seating and cementing
- Materials/supplies
- Patient instruction and chart
- ~~Patient records~~
- Follow-up care

B. Surgical removal of an erupted tooth includes:
- Local anesthesia
- Elevation of flap
- Removal of tooth
- Removal of bone
- Alveoloplasty
- Suture and ~~S~~suturing
- Postoperative care
- Suture removal
- Materials/supplies (i.e. saline, IV syringes, tray set up, etc.)
- Patient instruction and chart
- ~~Patient records~~

C. Amalgam/composite restorations include:
- Local anesthesia
- Moisture control (rubber dental dam)
- Tooth preparation
- Cavity liner
- Acid etching (for composite restorations)
- Restorative material
- Finishing procedures (carving, polishing, etc.)
- Postoperative procedures
- Patient instruction and ~~records~~chart

D. Root canal therapy – one or more canals
- Local anesthesia
- Opening and drainage of canal(s)
- Removal of pulp
- Interim medicated treatment (if necessary)

- Placement of canal filling material
- Preparation for placement of pre-formed ~~pin(s)~~posts
- Follow-up care
- Patient instruction and ~~records~~chart

E. Dentures – full or partial
- Impression and all materials
- Bite registration
- Face bow
- Establishment of correct occlusion
- Wax models
- Try-ins
- Seating/delivery
- Patient ~~records and~~ instruction and chart
- Six-month follow-up care, including but not limited to relief of sore spots, base adjustments, re-balancing occlusion.

Policy Memo No. 1
SECTION 10. (Formerly X.) Waiver Form

- **Page 16:** Adding the whole title of form to the section header for clarity.

10. **Limited Patient Waiver From**

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.

Policy Memo No. 1
SECTION 22. (Formerly XXII.) Reimbursement and Policy Changes

- **Page 25:** Updated verbiage for the frequency of policy updates.

22. 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 mid-year 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. Amendments that are the result of payment integrity initiatives shall not constitute a material change to the terms of the agreement. Amendments that are not the result of payment integrity initiatives, such as changes to the Maximum Allowable Payment schedules, shall constitute a material change to the terms of the agreement. For amendment(s) that materially change the terms of the agreement, such as changes to the MAP schedules, ~~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. For amendment(s) that do not materially change the terms of the agreement, the provider may, within 30 days of the amendment becoming effective, notify BCBSKS that such amendment(s) pose an undue hardship on the provider. The parties shall then negotiate in good faith to find an acceptable resolution. BCBSKS does not guarantee that such negotiation will result in BCBSKS withdrawing the amendment(s), especially when such amendment(s) are mandatory obligations imposed by other entities such as the Blue Cross and Blue Shield Association.

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.

Policy Memo No. 1

SECTION 23. (Formerly XXIII.) Amendments to Policies and Procedures; Right to Terminate Contract.

- **Page 26:** Updated verbiage for the frequency of policy updates.

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 may need to institute certain Payment Integrity initiatives to ensure that claims are paid accurately. ~~Occasionally,~~Up to four times per year, 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). Amendments that are the result of payment integrity initiatives shall not constitute a material change to the terms of the agreement. Amendments that are not the result of payment integrity initiatives, such as changes to the Maximum Allowable Payment schedules, shall constitute a material change to the terms of the agreement.

If the provider finds ~~the~~ amendment(s) that materially change the terms of the agreement to be 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).

With regards to amendments that do not materially change the terms of the agreement, the provider may, within 30 days of the amendment becoming effective, notify BCBSKS that such amendment(s) pose an undue hardship on the provider. The parties shall then negotiate in good faith to find an acceptable resolution. BCBSKS does not guarantee that such negotiation will result in BCBSKS withdrawing the amendment(s), especially when such amendment(s) are mandatory obligations imposed by other entities such as the Blue Cross and Blue Shield Association.

Policy Memo No. 1
SECTION 24. (Formerly XXIV.) Establishing and Amending Medical Policy

- **Page 26:** Removing reference to charge comparisons, adding fee schedule language and ABA exclusion of tiered reimbursement.

The BCBSKS Medical Policy Governance and Implementation Committee (MPGIC) serves as the governing body responsible for the approval and implementation of all medical and dental policies (hereafter referred to as medical policies). All medical policies must undergo a standardized development, clinical review, and governance approval process prior to implementation.

Medical policies are developed using current evidence, established best practices, and the prevailing standard of care. The Medical Policy Department is responsible for creating and

maintaining these policies, with oversight from board certified Medical Directors. After the team completes its initial clinical review, all new and updated medical policies are presented to the MPGIC for feedback, refinement, and approval to ensure alignment with the local provider network and care delivery system.

Provider Network Solutions is responsible for ensuring that all new and updated medical policies are communicated via mail or electronic mail to providers at least 30 days prior to the effective date of the amendment(s) for review, input and feedback. The Medical Advisory Committee serves as a forum for providers to offer input on the development and ongoing review of medical policies. While the committee's feedback is a valuable part of the process, BCBSKS is ultimately responsible for creating, evaluating, and implementing new or revised policies.

~~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.~~

Policy Memo No. 1
SECTION 25. (Formerly XXV.) Tiered Reimbursement and Provider Number Requirements

- **Page 26:** Removing reference to charge comparisons, adding fee schedule language and ABA exclusion of tiered reimbursement.

  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 Dieticians, 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~~. Please review your MAP schedule (refer to section 36. Fee Schedules) to determine any write-off amount.

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.

Effective January 1, 2027, certain Recognized Applied Behavioral Analysis ("ABA") MAPs are also excluded from tiered reimbursement and will apply base MAP. Reimbursement allowances for the ABA codes will be reflected on the MAP schedules that become effective on January 1, 2027.

Policy Memo No. 1
SECTION 27. (Formerly XXVII.) Reimbursement for Pharmaceuticals

- **Page 27:** Updated verbiage to reflect current reimbursement practices.

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~~.

Policy Memo No. 1
SECTION 36. (Formerly XXXVI.) Fee Schedules

- **Page 30:** Updated verbiage to clarify fee schedules.

Fee Schedules will be made available through the provider portal, replacing charge comparison reports. The fee schedule provided in the provider portal became effective on January 1 of this year. However, new codes can be added at any time (refer to Section 26. Reimbursement for New Procedure Codes). When a MAP is established for a brand-new code at any point after January1, the reimbursement allowance will not be reflected on the fee schedule in the provider portal. The provider may contact their provider representative to request an updated fee schedule that includes brand new codes that have been added this year. The manual provision of an updated fee schedule shall not constitute a "change" to the MAP schedule as described in Section 23. Amendments to Policies and Procedures; Right to Terminate Contract, A.

Policy Memo No. 2
SECTION 6. (Formerly VI.) Telemedicine

- **Page 5:** Updated verbiage to reflect current non-covered services.

  Telemedicine does not include communication between:

  A. Health care providers that consist solely of a telephone voice-only conversation, email, text, or facsimile transmission; or

  B. Health care providers and a patient that consists solely of an email, text, or facsimile transmission.

  Physical therapy, ~~Speech therapy,~~ occupational therapy, and audiology services are not covered as telehealth services.

Policy Memo No. 8
SECTION 1. (Formerly I.) OB Services – Non-Surgical Content of Services

- **Page 3:** Updated verbiage to reflect current non-surgical content of service.

  1. OB Services – Non-Surgical Content of Services
     - ~~Total OB care includes normal antepartum care, delivery (with or without low forceps and/or episiotomy), local anesthesia, and normal postpartum care.~~
     - Antepartum care includes office visits, routine urinalyses, fetal heart tone monitoring, non-stress testing, stress testing and internal fetal monitoring. Proper E/M coding rules will apply. (See Section ~~IV.~~ ~~A~~4. Additional Policy Clarification)
     - Delivery only includes delivery (with or without low forceps and/or episiotomy) and normal postpartum care. New delivery codes will apply.
     - Postpartum care ~~includes hospital care and office visits following delivery. In cases where the delivering physician provides antepartum care and postpartum care in addition to the delivery, total OB care is to be billed as an all-inclusive charge under the appropriate code.~~ will follow proper E/M coding rules.