

# BLUE CROSS AND BLUE SHIELD OF KANSAS DENTAL PROVIDER POLICIES AND PROCEDURES SUMMARY OF CHANGES FOR 2021

Following is a summary of the changes to Dental Blue Shield Policies and Procedures for 2021. The policy memos in their entirety will be available in the provider publications section of [www.bcbsks.com](http://www.bcbsks.com) in December 2020.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2020 Policy Memos. Deleted wording is noted by strikethrough. New verbiage is identified in red.

## Dental Policy Memo SECTION V. Post-Payment Audits

- **Page 9:** Updated verbiage to reflect current practices.

### 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 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 within 30 days of receipt of the appeal. Submit the appeal as instructed in the determination letter.

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).

~~When findings reveal issues, which are presently specified in~~ **No appeals are available for post-pay audit findings and associated re-adjudications based on BCBSKS policy memos, billing guidelines or newsletters relating payment policies, including but not limited to content of service, multiple surgery guidelines, and or other billing and/or reimbursement guidelines.** ~~the terms of this appeal are not available.~~

## Dental Policy Memo

### SECTION XXIV. Reimbursement for New Procedure Codes

- **Page 21:** Added verbiage to reflect current practices.

#### **XXIV. Reimbursement for New Procedure Codes**

Periodically new American Dental Association (ADA) 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 established at any time. For those new codes replacing 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 codes, a new MAP will be established for such a 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 and relative value units if applicable** to establish the MAP.