BLUE CROSS AND BLUE SHIELD OF KANSAS
DENTAL PROVIDER POLICIES AND PROCEDURES
SUMMARY OF CHANGES FOR 2024

Following is a summary of the changes to Dental Blue Shield Policies and Procedures for 2024. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com by December 2023.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2023 Policy Memos. Deleted wording is noted by strikethrough. New verbiage is identified in red.

Dental Policy Memo
Introduction paragraph

- **Page 4:** Added verbiage to cover any changes in laws and regulations that we must abide by.

  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.

Dental Policy Memo
SECTION II. Retrospective Claim Reviews/Corrected Claim

- **Page 4:** Updated verbiage to add clarity and consistency on number of retrospective reviews allowed.

  The contracting provider shall have the right to one~~a~~ retrospective review of any claim denied in whole or in part.

Dental Policy Memo
SECTION II. Retrospective Claim Reviews/Corrected Claim

- **Page 5:** Added part D. to add clarity that a corrected claim is part of their retrospective review.

  D. Corrected claims, regardless of reason for the correction, must be submitted 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.

Dental Policy Memo
SECTION IV. Utilization Review and Medical Necessity

- **Page 7:** Updated verbiage to add clarity on where pre-admission precertification is done.

  For the most accurate and complete information, all pre-admission certification should be validated through the BCBSKS provider portal (via Availity®).

Dental Policy Memo
SECTION V. Post-Payment Audits

- **Page 8:** Updated verbiage for clarity regarding timeframe we are following.

  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 business day time limit, BCBSKS will deny for no documentation.

Dental Policy Memo
SECTION VI. Content of Service

- **Page 11:** Updated verbiage to add clarity on where to find the dental manual.

  Please refer to the BCBSKS Dental Manual (available on the BCBSKS Secure Section [BlueAccess] via~~web at~~ Availity.com) for further guidelines.

Dental Policy Memo
SECTION VII. Experimental or Investigational Procedures

- **Page 11:** Updated verbiage for clarity of non-covered services and what that means for the provider.

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

Dental Policy Memo
SECTION VII. Experimental or Investigational Procedures

- **Page 12:** Updated verbiage to reflect gender neutral pronouns for more sensitivity to DEI.

Any patient being billed for services considered experimental or investigational must have a signed waiver in ~~his/her~~their file.

Note – we have updated this reference throughout the entire dental policy memo document but have not redlined them in this document.

Dental Policy Memo
SECTION VIII. Non-Covered Services

- **Page 12:** Updated order of verbiage for clarity and better flow.

There are several categories of services and procedures that may be considered non-covered services for various reasons. 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.

~~There are several categories of services and procedures that may be considered non-covered services for various reasons. These denials are billable to the member. (See Section XV. CLAIMS FILING.)~~

Dental Policy Memo
SECTION X. Waiver Form

- **Page 12:** Updated verbiage for clarity on situations when a waiver should be obtained.

A. SITUATIONS WHEN A WAIVER SHOULD BE OBTAINED:

1. Medical necessity denials
2. Utilization denials
3. Patient-requested services
4. Deluxe features (see Dental Manual)
5. Experimental/investigational procedures

Dental Policy Memo
SECTION XI. Medical Records

- **Page 15:** Updated verbiage to clarify providers providing medical records.

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

Dental Policy Memo
SECTION XVIII. Locum Tenens Provider

- **Page 19:** Updated verbiage for clarity and better flow.

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. ~~Locum tenens can be utilized in certain situations. However, covering for a deceased provider and billing under that deceased provider's NPI does not meet the criteria for locum tenens and is not permissible.~~ 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

Dental Policy Memo
SECTION XXII. Amendments to Policies and Procedures; Right to Terminate Contract

- **Page 20:** Updated verbiage to follow current practices of notifications sent to providers.

  A. Annual Contract Renewal – As part of its annual provider contract renewal process, BCBSKS notifies providers via ~~U.S Mail~~, 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.

Dental Policy Memo
SECTION XXXVI. Medicare Advantage Programs

- **Page 25:** Updated verbiage to reflect all provider specialties.

  Medicare Advantage (MA) claims should be submitted directly to BCBSKS, or its designee, 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.