# BLUE CROSS AND BLUE SHIELD OF KANSAS
# DENTAL PROVIDER POLICIES AND PROCEDURES
# SUMMARY OF CHANGES FOR 2022

Following is a summary of the changes to Dental Blue Shield Policies and Procedures for 2022. The policy memos in their entirety will be available in the provider publications section of www.bcbsks.com in December 2021.

NOTE: Changes in numbering because of insertion or deletion of sections are not identified. All items herein are identified by the numbering assigned in 2021 Policy Memos. Deleted wording is noted by strikethrough. New verbiage is identified in red.

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

- **Page 4:** Updated broken link.

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://secure.bcbsks.com/bcbsks-provider/facelets/allUsers/form/ProviderClaimEnrollmentInquiry.faces. ~~https://clyde.bcbsks.com/WebCom/Secure/forms/bcbsks_provider_claiminquiry.htm~~

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

- **Page 8:** Updated verbiage for clarity of who reviews the post payment audit appeals.

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. ~~Submit the appeal as instructed in the determination letter~~.

## Dental Policy Memo
## SECTION X. Waiver Form

- **Page 11:** Updated link to go directly to Availity

G. 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 web at Availity.com ~~www.bcbsks.com~~) for further guidelines.

## Dental Policy Memo
## SECTION X. Waiver Form

- **Page 13:** Added link to our electronic waiver form.

C. WAIVER FORM (see last page of Policy Memo No. 1)

## Dental Policy Memo
## SECTION XII. Uniform Provider Charging Practices

- **Page 16:** Updated verbiage to add clarity for no charge.

B. If a discount or lower charge is given to every patient without insurance or person paying at the time of the service, then BCBSKS would consider the "discounted price" to be the usual charge and would expect the provider to bill us that same amount. Professional provider services where the provider would normally make no charge, a claim should not be submitted.

## Dental Policy Memo
## SECTION XIV. Professional Services Coordinated with a Non-Contracting Provider

- **Page 17:** Updated verbiage to add clarity regarding new providers within a group.

  When a contracting provider uses a non-contracting provider (either in or out-of-state) to perform ~~a portion of a~~ one or more professional service~~s~~ (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 ~~hold~~ 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.

  ~~However,~~ 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.

## Dental Policy memo
## SECTION XIX. Contracting Status Determination

- **Page 19:** Added verbiage regarding assignment in the event of sale, consolidation, or merger of a contracting provider.

  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.