BlueCross BlueShield of Kansas

Policy Memo

An Independent Licensee of the Blue Cross and Blue Shield Association.

No. 1 POLICIES AND PROCEDURES

The purpose of Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) Policies and Procedures is to provide specific explanations for provisions contained within the contracting provider agreements. This information is intended to supplement and further clarify the reciprocal rights and contractual obligations contained within the contract and the policies established by BCBSKS when services are provided in our service area (the state of Kansas not including Johnson and Wyandotte counties). All existing and future policies and procedures published within BCBSKS publications that are available via the BCBSKS Web site are considered part of this Policy Memo No. 1. These publications include newsletters, provider manuals, workshop materials, and periodic update communications.

Any dispute relating to or arising out of the contracting provider agreement and/or BCBSKS' policies and procedures applicable to such agreement, and that is not or cannot be resolved according to the appeal procedures of this Policy Memo, shall be resolved by binding arbitration. Such arbitration shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association. Arbitration shall be initiated by either party by making a written demand for arbitration upon the other party.

The arbitrator shall have the right to determine his or her own jurisdiction. The arbitration proceeding shall be conducted in Topeka, Kansas, unless both parties agree otherwise. The arbitrator may construe and interpret, but shall not delete from, add to, or modify the terms of the contracting provider agreement and/or BCBSKS' policies and procedures applicable to such agreement. The arbitrator shall have no authority to award extracontractual damages of any kind, including but not limited to consequential, punitive or exemplary damages, and shall be bound by controlling law. The arbitrator shall apply the substantive law of Kansas, without giving effect to any conflict-of-laws principles.

The parties acknowledge that because the contracting provider agreement affects interstate commerce, the Federal Arbitration Act also applies. The parties agree that the decision of the arbitrator shall be final, binding and non-appealable, and that judgment on the arbitration award may be entered by any court of competent jurisdiction. The parties shall share all expenses of the arbitration equally. However, each party shall bear the costs and expense of its own counsel, experts, witnesses, and preparation and submission of its claims and defenses to the arbitrator.

The arbitration process described above shall be available to providers only after exhaustion of all applicable review and/or appeal processes described within these policies and procedures. This exhaustion requirement shall apply to each claim or service in dispute.

MEDICAL REVIEW PROCESSES

The medical review processes are conducted by the staff of BCBSKS who seek the advice of qualified and practicing professionals related to medical necessity. A contracting provider agrees to accept review process decisions and to follow the established appeals procedures.

The entire review process itself includes the development of guidelines that relate to specific provisions of members' contracts; the processing of claims based on guidelines and medical records when indicated; the retrospective review of claim determinations; and the appeal process. BCBSKS seeks the advice of practicing professionals at appropriate points throughout the entire review process.

NOTE: All pertinent and complete medical records must be provided by the contracting provider when records are needed for the initial review of a claim or when records are requested for an audit. Additional documentation that is not a part of the medical record and that was not provided at the time of the initial request will not be accepted. Only records created contemporaneous with treatment will be considered pertinent. Services denied for failure to submit documentation are not eligible for provider appeal, and are a provider write-off.

Medical records are expected to contain all the elements required in order to file and substantiate a claim for the services as well as the appropriate level of care, i.e., evaluation and management service (see Policy Memo No. 2). Complete medical records are expected to contain all the elements required by Section XI. DOCUMENTATION below and by Kansas Administrative Regulation (K.A.R.) 100-24-1, as amended, which is hereby incorporated by reference and made a part of this policy.

Medical records are expected to support the medical necessity for all aspects of patient care, including ancillary services provided on the date of service for which a claim is filed. Each patient record must contain adequate documentation to justify the course of treatment ordered or provided, and reflect the patient's current status and progress during the course of treatment. The intensity of the service billed must be supported by the diagnosis code. Letters/checklists are not acceptable as documentation of medical necessity and do not replace what should be in the complete medical record. Abbreviations must be those that are generally accepted by your peers and clearly translated to be understandable to the reviewer.

If it is determined that the patient services provided by the contracting provider and documented as outlined above, are not medically necessary, the claim is denied and is a write-off to the provider. If the services are requested by the patient after being advised by the provider of the lack of medical necessity and the daily record or patient chart has been documented to that effect and a written waiver is obtained by the provider prior to the service being rendered, charges for the services will be the patient's responsibility.

I. CORRECTED CLAIM

A request made from a contracting provider to change a claim, (e.g., changing information on the service line, modifier addition, diagnosis correction, etc.) that has previously processed is considered a corrected claim. This excludes claims denied for additional information. The submission of a corrected claim must be received by BCBSKS within the 15-month timely filing deadline.

II. RETROSPECTIVE CLAIM REVIEWS

The contracting provider shall have the right to a retrospective review of any claim denied in whole or in part. The purpose of a retrospective review is for customer service to determine whether the original adjudication was correct.

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.

B. The provider will be given a written response to the written request for a retrospective review as soon as possible, but no later than 60 days from receipt date. In cases where claims are adjusted, the remittance advice will serve as the written response.

III. DENIED CLAIMS APPEALS PROCEDURE

Contracting providers may appeal certain pre and post-service claim denials. Only claims denied as not medically necessary may be appealed on the provider's own behalf as set forth in the policies and procedures. The provider may be designated as the member's authorized representative for appeal purposes according to the terms of the member's contract.

NOTE: Medical policies including Content of Service (COS) as described in BCBSKS Policy Memos 1-12 or provider's obligations specified in their provider contracts are not considered eligible claims appeals as outlined in Section III. DENIED CLAIMS APPEALS PROCEDURE. Annually, BCBSKS outlines any changes to the Policy Memos and forwards them to providers for their review. Once providers accept these changes, they are part of the provider's contract and therefore not considered for claims appeals. Providers disagreeing with any policies should submit their position and supportive documentation to BCBSKS staff for future consideration.

Appeals as the Member's Authorized Representative: Appeals that you can make as the member's authorized representative according to the terms of the member's contract are claims for which the member is financially responsible. When you act as the member's authorized representative, you are not separately entitled to any appeals pursuant to this Contracting Provider Agreement.

Appeals Pursuant to Contracting Provider's Agreement: Before initiating the appeal procedures, verify through Section II. RETROSPECTIVE CLAIM REVIEWS inquiry procedures that the claim was correctly adjudicated. After verifying the claim adjudication you may appeal as follows:

First Level: Written notification of disagreement highlighting specific points for reconsideration of a claim denied not medically necessary shall be provided to BCBSKS within 180 days from the date of the remittance advice. This notice shall be considered an initial appeal and be forwarded with all pertinent medical records to BCBSKS Customer Service. Medical records submitted with the request for initial appeal will be referred to the appropriate consultant and a determination will be rendered. This decision will be binding unless the provider files a second level appeal within 60 days of notification of such decision.

Second Level: Forward a written request to customer service with your letter addressed to the Chief Medical Officer within 60 days following the first level appeal denial notification. The second and final appeal determination shall be made by the Chief Medical Officer. The contracting provider agrees to abide by the second level appeal determination.

All appeal decisions under this agreement must be provided within 60 days of receipt of the provider's request. Any appeals decision not provided within the aforementioned time frames shall be considered as decisions made in favor of the provider and claim payments will be adjusted accordingly.

Cases may only be appealed once at each step in the first or second levels. A contracting provider agrees to accept the determination made at each level or to appeal the claim at the next step of the appeals process. If throughout the appeals process the decision on the claim changes in the provider's favor, an additional payment will be made. If, however, the decision reverses a previous determination (either partially or totally), a refund will be requested.

The result of the appeals process shall be binding on the provider and BCBSKS subject only to the provision for binding arbitration previously stated herein.

IV. 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 cannot go back further than 15 months following the date of claim adjudication to initiate an audit. 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 and request refunds. If no documentation is received BCBSKS will deny for no documentation and request refunds. Denials will be a provider write-off.

Post-payment Audit Appeals:

A. First Level Appeal

Claims 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.

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 is to be submitted to the BCBSKS Chief Medical Officer. The second and final appeal determination will be made by the BCBSKS Chief Medical Officer within 30 days of receipt of the appeal.

When findings reveal issues, which are presently specified in BCBSKS policy memos, billing guidelines or newsletters relating to content of service, multiple surgery guidelines, and other billing and/or reimbursement guidelines, the terms of this appeal are not available.

V. UTILIZATION REVIEW AND MEDICAL NECESSITY

The contracting provider agreement requires providers to cooperate in utilization review and medical necessity determinations. Utilization review is the process of determining the appropriateness of

services rendered to and payments made on behalf of members. Appropriateness of service and payment determinations consist of the following activities:

A. MEDICAL NEED FOR SERVICES RENDERED

Medical necessity policy applies to all services rendered to BCBSKS members and includes any services or supplies used to diagnose and/or treat illness or injury. The service should be widely accepted by a peer group of practicing providers, based on scientific criteria and determined to be reasonably safe. Health care professionals should discuss all appropriate treatment alternatives available to patients regardless of benefit coverage limitations. To be determined medically necessary, the service must be consistent with the diagnosis and treatment of the condition; be in accordance with standards of good health care practice; and not be for the convenience of the patient or provider. The following procedures/equipment would be subject to medical necessity and utilization review:

1. Established procedures/equipment of questionable current usefulness in the treatment of a specific condition(s).

2. Procedures/equipment which tend to be redundant when performed/supplied in combination with other procedures/equipment; or procedures/equipment which are unlikely to provide additional medical benefits, or are contradicting to one another.

3. Specific procedures/equipment or patterns of care which vary significantly from a peer group.

B. PRE-ADMISSION CERTIFICATION & CONCURRENT REVIEW

Prior to admitting a member to a hospital for elective (non-obstetrical, non-life threatening) inpatient care, medical information will need to be supplied to BCBSKS in order to certify medical necessity. A length of stay will be assigned at the time of pre-certification and will be subject to concurrent review. Concurrent review is the process of obtaining current medical information to review for the medical necessity of a requested extension to the length of stay or course of treatment. Providers will be informed via the member's identification card of the groups involved in pre-admission certification and any specific procedures that are applicable through BCBSKS newsletters.

BCBSKS pre-admission certification and concurrent review activity are conducted in compliance with URAC guidelines. This includes the availability of either the expedited or standard appeal to services denied for medical necessity during the pre-admission certification and concurrent review processes. To initiate an appeal (phone or fax), you must have complete information since the time frame begins with the appeal request. These appeal options are only available prior to claim submission and are subject to time frames as established by BCBSKS, Department of Labor, and URAC. All pre-admission certification appeals for professional and hospital services will be reviewed concomitantly.

C. OUTPATIENT PRE-CERTIFICATION

Under certain circumstances and upon specific notification, pre-certification may be required for outpatient services/procedures. Contracting providers will be notified 60 days in advance of criteria to identify those situations falling within the scope of this provision.

Pre-certification may also be required for other outpatient services such as home medical equipment and case management, including those services specified by employers, and outpatient procedures which necessitate a greater level of facility care than is usually needed.

Following provider notification, continued failure to complete pre-certification activities will result in a 50 percent Maximum Allowable Payment (MAP) reduction up to $200 with the member held harmless. Compliance audits will take place on a postpayment basis, which may result in refunds.

D. CASE MANAGEMENT

Case management is a process that identifies and coordinates alternative treatment plans to enhance care through effective administration of available health care resources in the most cost-efficient manner. The process is accomplished through the development of a treatment plan by the patient or legal representative, the physician, other health care providers, and the BCBSKS case manager.

E. PREPAYMENT AND DATA ANALYSIS

BCBSKS will identify any trends or patterns of patient care, i.e., through data analysis, which appear inconsistent with overall patterns or trends. Prepayment review will be implemented if attempts to work with the provider have failed to resolve the issue. Specific utilization guidelines may be applied to individual prepay members. Prepayment review means all claims will be reviewed prior to payment and records will be required.

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.

G. RESOLUTION OF PROBLEMS

Providers agree to work with BCBSKS and other providers of care in the resolution of any utilization or medical review problems that may be identified. Actions taken for providers' lack of compliance will range from provider education to financial assessments and finally contract cancellation.

H. MEDICAL NECESSITY/UTILIZATION REVIEW DENIALS

Occasionally BCBSKS does not consider an item or service to be medically necessary. In such situations the item or service becomes a provider write-off. In the few situations where services are known to be denied as not medically necessary (including deluxe items) and the patient insists on the services, the provider must obtain a patient waiver in advance of the services being rendered. (See Section X. WAIVER FORM)

Failure to discuss the above with the patient in advance, document this in the medical record, and obtain the waiver will result in a provider write-off.

NOTE: BCBSKS members are not to be billed for services determined to be unnecessary through the medical and utilization review process, per the Contracting Provider Agreements.

VI. CONTENT OF SERVICE

Content of service refers to specific services and/or procedures that are considered to be an integral part of previous or concomitant services or procedures to the extent that separate reimbursement is not recognized. Not all content of service issues are identified in the policies and procedures. BCBSKS staff may identify and classify specific coding and nomenclature issues as they arise. Examples of services that can be considered content of service are:

- Examination of the patient.
- History of illness and/or review of patient records.
- Evaluation of tests or studies (i.e., radiology or pathology).
- Any entries into the patient's records.
- Evaluation of reports of tests or studies earlier referred to another physician for an opinion and subsequently returned for use in the office visit being conducted.
- Advice or information provided during or in association with the visit.
- Case management.
- The prescription of any medicinals, home supplies or equipment during or as a result of the visit.
- The application or the re-application of any standard dressing during a visit.
- Therapeutic, prophylactic, or diagnostic injection administration provided on the same day as an office visit, home visit, or nursing home visit.
- Additional charges beyond the regular charge for services requested after office hours, holidays or in an emergency situation.
- Items of office overhead such as malpractice insurance, telephones, personnel, supplies, cleaning, disinfectants, photographs, equipment sterilization, etc.
- Telephone calls and Web-based correspondence are content of service when billed with another service on the same day. Such services are not covered if billed separately and the only service rendered on that day.

Some content of service issues related to specific services and/or procedures are identified throughout the policy and procedure documents.

NOTE: All-inclusive procedure codes must be used when appropriate.

A handling fee may be allowed under certain conditions. See Policy Memo No. 7, Radiology and Pathology.

VII. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

Any drug, device or medical treatment or procedure and related services that are experimental or investigational as defined by BCBSKS are non-covered services.

Experimental or investigational refers to the status of a drug, device or medical treatment or procedure:

A. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished and the drug or device is not Research-Urgent as defined except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or

B. if Credible Evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or

C. if Credible Evidence shows that the consensus among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or

D. if there is no Credible Evidence available that would support the use of the drug, device, medical treatment or procedure compared to the standard means of treatment or diagnosis except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Credible evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Research-Urgent shall mean a drug, device, medical treatment or procedure that may be covered (even though otherwise excluded by the contract as experimental or investigational) providing the specified criteria outlined in the contract is met.

Contracting providers shall notify the patient when services to be rendered are considered experimental or investigational and may not be covered under the member's contract. Any patient being billed for services considered experimental or investigational must have a signed waiver in his/her file. The provider must discuss this with the patient in advance, document this in the medical record, and include the GA modifier (waiver on file) on the claim form (electronic or paper). (See Section X. WAIVER FORM) Failure to discuss and obtain a signed waiver in advance of the service will result in provider write-off. Denied experimental or investigational services are not eligible for appeal.

VIII. NON-COVERED SERVICES

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, procedures, equipment and/or pharmaceuticals that may be considered non-covered services when designated by the member's contract. These denials are billable to the member. (See Section XV. CLAIMS FILING)

IX. PATIENT-DEMANDED SERVICES

A. If a provider prescribes services that he knows will not be covered because of a lack of medical necessity or the procedure being considered is experimental or investigational and he alerts the patient of the non-coverage, yet the patient still insists on the services, the provider may bill the patient if the request is properly documented and signed by the member. (See Section X. WAIVER FORM)

B. Providers must obtain a waiver on any mental health consultation, testing, or evaluation that is performed by agreement or at the direction of a court for the purpose of assessing custody, visitation, parental rights, or to determine damages of any kind of personal injury action and if the service is not otherwise medically necessary. To enable the provider to bill a patient for such services, BCBSKS will deny benefits for such services as lacking medical necessity.

X. WAIVER FORM

NOTE: The waiver cannot be utilized for services considered to be content of another service provided.

A. SITUATIONS REQUIRING A WAIVER

1. Medical necessity denials
2. Utilization denials
3. Deluxe features (Applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract)
4. Patient demanded services
5. Experimental/investigational procedures

B. THE WAIVER FORM MUST BE

1. Signed **prior** to receipt of service.
2. Patient and service specific.
3. Date of service and dollar amount specific.
4. Retained in the patient's file at the provider's place of business. (The waiver form is no longer required with claims submission. Use the GA modifier for all electronic and paper claims.)

5. Presented on an individual basis to the patients. It may not be a blanket statement signed by all patients.

6. Acknowledged by patient that he or she will be personally responsible for the amount of the charge, to include an approximate amount of the charge at issue.

   NOTE: If the waiver is not signed **prior** to the service being rendered, the service is considered a contracting provider write-off, unless there are extenuating circumstances.

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

XI. DOCUMENTATION

Appropriate documentation of services is an integral part of the payment and/or review process. The contracting provider agrees to keep sufficient records to support claims for reimbursement, documents the medical necessity for the service, and agrees to make available all information necessary to carry out the terms of his/her contracting provider agreement at no charge.

Information, when requested, should be submitted to BCBSKS within 30 days of the request. In the case of typed or electronic medical records, the entry must be authenticated (signed) by the provider at the time of submission. Rubber stamp signatures are not permissible; however, electronic signatures are. The signature must be legible and contain at least the first initial and full last name. This provision does not affect stamped signatures on claims, which remain permissible. Time extensions may be granted on a case-by-case basis; however, any extension must be approved by BCBSKS and will allow BCBSKS additional time for review activities. Certain unusual circumstances require the immediate submission of medical records. In these cases, BCBSKS will have a representative visit the office and secure requested records. The provider agrees to provide these records at the time of request. The member contract gives us the ability to obtain this information without a signed patient release.

Failure to send the requested documentation within the time frame above or providing insufficient or no documentation to determine medical necessity will result in claim denial, and accordingly a provider write-off.

Medical records are expected to contain all the elements required in order to file and substantiate a claim for the services as well as the appropriate level of care, i.e., evaluation and management service (see Policy Memo No. 2). Complete medical records are also expected to contain all the elements required herein and by K.A.R. 100-24-1, as amended, which is hereby incorporated by reference and made a part of this policy.

Medical records are expected to support the medical necessity for all aspects of patient care, including ancillary services provided on the date of service for which a claim is filed. Each patient record must contain adequate documentation to justify the course of treatment provided and reflect the patient's current status and progress during the course of treatment. The intensity of the service billed must be supported by the diagnosis code. Letters/checklists are not acceptable as documentation of medical necessity and do not replace what should be in the complete medical record. Abbreviations must be those that are generally accepted by your peers and clearly translated to be understandable to the reviewer.

XII. UNIFORM PROVIDER CHARGING PRACTICES

Occasionally BCBSKS receives questions about what constitutes a provider's usual charge when a provider offers cash customers a discount and what amount to bill BCBSKS. The term "usual charge" is defined in our Contracting Provider Agreements, but to specifically address this question, our policy is as follows:

A. Provider discounts or charging practices based upon individual patients' situations (for example: patient hardship or professional courtesy) are acceptable and are not considered the provider's usual charge. If a provider gives a patient a discount for cash, they must bill BCBSKS the same amount.

B. If a provider gives a lower charge to every patient who does not have health insurance, we consider that lower charge to be the "usual charge."

   Because a contracting provider agrees to not bill a BCBSKS member at the time of service, there should never be a circumstance in which a BCBSKS member pays anything other than a deductible, copayment, coinsurance, or non-covered procedure at the time of service. As an additional matter in regard to this point, our payments are timely enough that they are essentially cash for all practical purposes. If we are in fact late with payments, then the remedy is stated under the Prompt Payment law.

C. Agencies such as community mental health centers and county health departments would be allowed to use a sliding scale for charging practices due to agency regulations.

XIII. PURCHASED SERVICES

When providers bill for PET, CT, or MRI services that were purchased from another provider, they must bill BCBSKS the amount for which the service was purchased.

XIV. PROFESSIONAL SERVICES COORDINATED WITH A NON-CONTRACTING PROVIDER

When a contracting provider uses a non-contracting provider (either in or out-of-state) to perform a portion of a professional service (e.g., professional component, technical component or other technology utilized in the performance of a service), the contracting provider must bill BCBSKS for all services. If the non-contracting provider bills the member or BCBSKS, the contracting provider will be required to hold the member harmless.

XV. CLAIMS FILING

The contracting provider agrees to submit claims to BCBSKS for covered services (excluding "self pay" requests made by the patient as defined within the Health Information Technology for Economic and Clinical Health (HITECH) Act, Section 13405(a)) rendered to members at the usual charge (normal retail charge for HME suppliers) in the BCBSKS designated format, and to look to BCBSKS for payment except for amounts identified as patient responsibility: copays, coinsurance, deductible, indemnified payment balances and non-covered amounts. The contracting provider agrees to accept payment allowances in all cases once notified of payment determination. Claims must be filed within 15 months of the service date or discharge from the hospital. Failure to do so will result in claims being rejected with members held harmless.

All contracting providers (except as provided in Section XXV.), who are defined as eligible providers under the member's BCBSKS contract and who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own National Provider Identifier (NPI) or specific performing provider number, if applicable. The name of the ordering provider, when applicable, (including NPI or specific performing provider number, except when exempt by law) must appear on every claim. When applicable, the contracting provider agrees to conduct claim transactions with BCBSKS as standard transactions in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

BCBSKS may encounter a claim that has been submitted using one procedure code which, in the opinion of BCBSKS, is not an appropriate description of the service provided under the circumstances. In such a case, BCBSKS will assign a procedure code which, in its opinion, is appropriate for the service under the circumstance, and will adjudicate the claim based upon such alternative procedure code. BCBSKS may either report payment of the claim under the revised procedure code or under the originally submitted procedure code; in either case, the maximum allowable payment applicable to the revised procedure code shall be the one that applies.

BCBSKS requires providers to report procedures according to American Medical Association Current Procedural Terminology (CPT) and the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) guidelines. However, the proper submission of codes and/or modifiers according to these guidelines shall not imply or create entitlement to health care coverage or reimbursement by BCBSKS for all reported procedures. BCBSKS has sole discretion to determine the applicability of codes and modifiers for reimbursement decisions. Specifically, this discretion includes, but is not limited to, determinations concerning content of service and consideration of modified or add-on codes for additional reimbursement.

For primary procedures, providers should submit the code that most accurately describes the service provided. Add-on codes (as defined by CPT) should not be reported as stand-alone procedures and must be submitted with the primary service in order to be considered for reimbursement. A list of additive codes BCBSKS recognizes for reimbursement is available from your provider representative or the BCBSKS Web site.

The provider may contact BCBSKS to verify the status of a patient's deductible. If after BCBSKS makes its payment to the provider and a credit balance results from having collected payment from the member prior to filing with BCBSKS then the provider must refund the credit balance to the member within thirty (30) days from the time the member requests the refund of the credit balance. Otherwise, the provider will make the refund within 60 days from notice from BCBSKS unless directed by the member to apply the credit balance to their account for future services.

XVI. REFUND POLICY

BCBSKS must request refunds from providers within 15 months from the date of adjudication. Failure to do so will result in the provider being held harmless. Refund requests for fraudulent claim payments and duplicate claim payments, including other party liability claims, are not subject to the 15-month limitation. Providers shall promptly notify BCBSKS upon becoming aware of an overpayment to initiate the refund process.

Refunds as a result of an audit are due within 30 days from the date the audit is presented before exercising the right of offset.

XVII. RIGHT OF OFFSET

BCBSKS will, through auto deduction processes, exercise the right of offset for claims previously paid. This right includes offset against any subsequent claim(s) submitted by the provider, including those involving other members. To accomplish this, BCBSKS will supply providers detailed individual claims information on the remittance advice so amounts can be reconciled efficiently.

XVIII. SERVICES PROVIDED BY NON-PHYSICIANS AND RESIDENT PHYSICIANS

A. All non-physicians, who are defined as eligible providers under the member's BCBSKS contract and who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own National Provider Identifier (NPI) or specific performing provider number, if applicable. The name of the ordering provider, when applicable, (including NPI, except when exempt by law) must appear on every claim.

B. A physician may bill for the services of a nurse, other than an ARNP, if there is an employer/employee relationship and the services are supervised by the physician (supervision means the patient recognizes the supervising physician as his/her physician and there is a periodic review of the records by the physician). These services must be an integral part of the physician's professional service, included in the physician's bill, and be of the type that are commonly furnished in the physician's office or clinic.

C. Independently practicing Advanced Registered Nurse Practitioners (ARNPs) who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own NPI or specific performing provider number. The name of the ordering provider, when applicable, (including NPI, except when exempt by law) must appear on every claim.

D. Services of a Resident Physician are billed under the attending Faculty Physician's NPI or specific performing provider number if done in connection with the Residency Program.

E. If the Resident Physician is providing services outside of the Residency Program, all Blue Shield Policy Memos apply and services shall be billed under his/her own NPI or specific performing provider number.

F. BCBSKS will not pay for any services performed and billed by an independent provider who does not meet applicable state or national licensure registration or certification requirements to perform that service or who is not defined as an eligible provider in the member's contract.

G. BCBSKS will not pay for outpatient services connected with a nervous and mental diagnosis when provided by an unlicensed provider, or a licensed provider with a licensure other than designated in the member's contract as eligible to provide nervous and mental benefits. Supervision of an unlicensed provider, a licensed counselor, or one not designated as eligible in the member's contract does not constitute a service being rendered by an eligible provider. The exception to this would be if the service was rendered through a state licensed alcohol or drug abuse treatment facility, a hospital, psychiatric hospital, or a community mental health center. Eligible non-physician psychiatric providers include ARNPs, certified psychologists, and licensed specialist clinical social workers.

XIX. LOCUM TENENS PROVIDER

In situations in which the regular physician is unavailable, a locum tenens can be used to provide a visit/service. The locum tenens must not provide services over a continuous period of longer than 60 days. For situations extending beyond 60 days, BCBSKS must be contacted to discuss billing arrangements.

In billing for services provided by a locum tenens, the claim must be filed using the NPI or specific performing 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.

XX. CONTRACTING STATUS DETERMINATION

A. Any entity which provides and/or bills members and/or BCBSKS for health care services which advertises or represents itself to the general public as being owned, controlled, managed, affiliated with, or operated by a contracting provider must also be contracting with BCBSKS unless otherwise permitted by BCBSKS. Failure of such providers to contract with BCBSKS shall be considered cause for termination of the Contracting Provider Agreement in accordance with the Contracting Provider Agreement. This provision is applicable to entities serving members in the same general locale as those served by the contracting provider.

B. A provider who practices in multiple locations in the same locale must be contracting or non-contracting in all locations.

C. If the name of the provider set forth in the first paragraph of the contracting provider agreement is a professional association or other legal entity, rather than that of an individual, then the contracting provider agreement applies to all persons within the professional association. Any new providers who join the professional association will be understood to be bound by the contracting provider agreement. The party signing the contracting provider agreement on behalf of the professional association warrants to BCBSKS that such party: (1) has the authority to sign such agreement on behalf of the professional association; (2) shall make the terms of the agreement known to members of the professional association; and (3) shall inform new members of the professional association of the terms of the agreement upon entry into the professional association.

NOTE: Certain contracts offered by BCBSKS may offer individual physician options on contract status. Such options are specified by contract language and are offered solely at the discretion of BCBSKS.

The foregoing warranties apply to any person defined as an eligible provider in BCBSKS contracts employed by the individual, professional association or other entity signing the contracting provider agreement. If such eligible provider is among those identified in Section XXV. TIERED REIMBURSEMENT AND PROVIDER NUMBER REQUIREMENTS hereof, the MAPs applicable to such eligible providers will apply to any services provided by them. If such persons are contracting separately with BCBSKS, until such contract is terminated, then it shall apply rather than these provisions, but if such separate contract terminates, then nonetheless these provisions shall apply with regard to the contracting status of such person. It is the responsibility of the contracting provider or a representative to notify BCBSKS of any changes in practice information, e.g., license

status, address, tax ID number, NPI, ownership, individual provider leaving/joining group practice, death of provider, closure of office, etc.

XXI. NEW TECHNIQUES AND TECHNOLOGY

Maximum allowable payments (MAPs) for new techniques, technology, home medical equipment and/or supplies will be based, when possible, on existing procedures/services and comparable value and result. Additional allowances for new techniques, technology, home medical equipment and/or supplies will be considered if there is documented significant improvement in safety or efficacy of patient care.

XXII. REIMBURSEMENT AND POLICY CHANGES

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 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, 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.
>
> 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.

XXIII. AMENDMENTS TO POLICIES AND PROCEDURES; RIGHT TO TERMINATE CONTRACT

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 U.S. Mail or hand delivery of all changes to its Policies and Procedures and Maximum Allowable Payment schedules at least 150 days prior to 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 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). If the provider finds the amendment(s) 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).

XXIV. ESTABLISHING AND AMENDING MEDICAL POLICY

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 Blue Cross and Blue Shield of Kansas members and providers,
>
> BE IT RESOLVED, that the Blue Cross and Blue Shield of Kansas 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, Blue Cross and Blue Shield of Kansas 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.

XXV. TIERED REIMBURSEMENT AND PROVIDER NUMBER REQUIREMENTS

BCBSKS has established different MAPs for the same service for the following specialties: Advanced Registered Nurse Practitioners, Physician Assistants, Clinical Psychologists, Licensed Clinical Social Workers, Community Mental Health Centers, Outpatient Substance Abuse Facilities, Chiropractors, Physical Therapists, Certified Physical Therapist Assistants, Occupational Therapists, Certified Occupational Therapy Assistants, Speech Language Pathologists, Licensed

Clinical Marriage and Family Therapists, Licensed Clinical Professional Counselors, and Licensed Clinical Psychotherapists. Please review your charge comparison (refer to Section XXXV. CHARGE COMPARISON REPORTS) to determine any write-off amounts.

Eligible providers listed above must obtain an NPI and assure it is included as the performing 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 performing provider NPI.

XXVI. REIMBURSEMENT FOR NEW PROCEDURE CODES

Periodically new American Medical Association Current Procedural Terminology (CPT) 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 added at any time. For those new codes that replace existing codes, BCBSKS will crosswalk the existing MAP to the 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 to establish the MAP.

XXVII. REIMBURSEMENT FOR PHARMACEUTICALS

Covered pharmaceuticals are reimbursed based on a formula as determined by BCBSKS that utilizes the published average sales price (ASP) 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 or AWP. A charge comparison report is available upon request.

XXVIII. REIMBURSEMENT FOR SLEEP STUDY TESTING

The allowance for sleep testing procedures as outlined by CPT is 100 percent of the MAP for providers board certified in sleep medicine. All other eligible providers receive 60 percent of the MAP.

The allowance for sleep testing procedures performed in Freestanding Sleep Laboratories or Centers is 100 percent of the MAP for those facilities accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC). All other eligible facilities receive 60 percent of the MAP when services are provided in a Freestanding Sleep Laboratory or Center. Services provided in a setting other than a Freestanding Sleep Laboratory or Center will be limited to 50 percent of the applicable MAP for facilities.

XXIX. REIMBURSEMENT FOR LESSER SERVICES

When a service performed is considered a lesser service and billed with a "52" modifier, reimbursement may be reduced to an allowance reflective of the service performed.

XXX. ADVERSE EVENTS

The Blue Cross and Blue Shield 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 BCBS 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

B. SURGERY PERFORMED ON THE WRONG PATIENT

C. WRONG SURGICAL PROCEDURE ON A PATIENT

When one of these three adverse events occurs, no payment will be made to the provider for that error or correction of that error. The patient shall be held harmless and may not be billed for any adverse event. The provider shall refund payments to BCBSKS made for an adverse event if a claim is filed in error. If the surgical error is corrected by a different provider, payment for that procedure will be made.

D. RETENTION OF FOREIGN OBJECT IN SURGICAL PATIENT

In cases where a foreign object is mistakenly left in the patient during a surgical procedure the following applies:

1. If the same provider also removes the object then no payment for the correcting surgery will be made and the patient will be held harmless.

2. If a provider other than the original provider removes the foreign object, that provider shall receive payment.

The Provider shall cooperate with BCBSKS in initiatives designed to help prevent or reduce such events and ensure that appropriate payments are made with no additional charges incurred for any condition which was not present on admission.

XXXI. APPLICATION OF CONTRACT

A. The conditions of these policies and procedures apply to service benefit programs, indemnity and to self-insured plans administered by Blue Cross and Blue Shield of Kansas, Inc., including those with deductibles, coinsurance and shared payments. For indemnity plans the difference between payment and the MAP allowance can be billed to the patient.

The conditions of these policies and procedures also apply to other entities when services (including services covered by workers compensation) are received within the company service area and Blue Cross and Blue Shield of Kansas, Inc. is involved in the processing of the claim and payment is issued either by Blue Cross and Blue Shield of Kansas, Inc., other Blue Cross and Blue Shield companies/plans or other entities such as insurers or administrators of welfare benefit plans or workers compensation plans.

The conditions of these policies and procedures DO NOT apply to the programs insured and/or administered by Blue Cross and Blue Shield companies/plans when such programs rely upon providers who contract with an entity other than Blue Cross and Blue Shield of Kansas, Inc. for the purpose of establishing reimbursement levels in the company service area. And, in the event the provider is required to submit claims direct to a Blue Cross and Blue Shield company/plan outside the company service area that is adjudicating the claim, the provisions of these policies and procedures do not apply.

B. When BCBSKS receives and prices a claim which is paid by another entity, such other entity may make payments at variances with those which would be made by BCBSKS if it were adjudicating and paying the claim. In such a case, the provider must bring any such difference to the attention of BCBSKS within 15 months of payment to have such payment corrected.

C. BCBSKS may review charge/payment records of non-BCBSKS patients to determine contract compliance. The patients' anonymity can be protected by providing information specific to the contract compliance review.

D. Obligations under the contract with respect to services rendered while contract was in force survive termination of the contract.

E. When BCBSKS is the secondary insurance payer and the contracting provider has entered into an agreement with the insurance carrier who is the primary payer to accept an allowance which is less than the allowable charge under this contract, then the allowance of the primary insurer shall be considered the allowable charge under this contract for the purpose of that claim. When the allowance of the primary payer is greater than the allowable charge under this contract, the provisions of this contract are applicable.

F. In circumstances in which a party other than BCBSKS is entitled to the benefits of the Contracting Provider Agreement and these Policies and Procedures, such party may, at its discretion, honor assignments of benefits to providers not contracting with BCBSKS.

XXXII. ACKNOWLEDGMENT OF INDEPENDENT STATUS OF PLAN

The provider hereby expressly acknowledges its understanding that the agreement to which these policies and procedures apply constitutes a contract between the provider and BCBSKS that the Plan is an independent corporation operating under a license with the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield Plans, the Association permitting the Plan to use the Blue Cross and Blue Shield Service Mark, and that the Plan is not contracting as the agent of the Association.

The provider further acknowledges and agrees that he/she has not entered into such agreement based upon representations by any person other than the Plan and that no person, entity, or organization other than the Plan shall be held accountable or liable to the provider for any of the Plan's obligations to the provider created under such agreement. This section shall not create any additional obligations whatsoever on the part of the Plan other than those obligations created under other provisions of such agreement.

XXXIII. ACKNOWLEDGMENT OF BALANCED BUDGET ACT OF 1997

This contract will terminate if the provider is excluded from participation in any federal health care program, as defined under 42 U.S.C. 1320a-7b(f). Provider agrees to inform BCBSKS of the commencement of any proposed exclusion within seven (7) business days of first learning of it, and to inform BCBSKS immediately upon any such exclusion becoming effective with respect to provider.

XXXIV. CONTRACT SCOPE OF SERVICES

When a provider contracts with BCBSKS, all covered services provided by that provider will be subject to the contract. This means that for covered services, the BCBSKS allowance for that

service must be accepted as payment in full, e.g., medical equipment or supplies furnished by the provider.

XXXV. CHARGE COMPARISON REPORTS

The provider may request one annual charge comparison report for procedures billed to BCBSKS on behalf of our members. Information included in the annual charge comparison will include services billed and allowed from January to May 31st each year.

XXXVI. PATHOLOGY OR LABORATORY SERVICES

Anatomical lab must be billed by the provider who renders the service. Clinical lab can be billed by providers in those circumstances where they are sending the specimen outside their office for analysis.

XXXVII. SPECIAL PROVISION PERTAINING TO PENDED CLAIMS

The provider contract considers a person a member until such time as there is an indication they are no longer a member. This means that while a member's coverage is in a pending status for lack of payment of premium or notice of change of status, the provider contract continues to apply.

XXXVIII. LIMITED PROVIDER NETWORKS

The overall business climate or some large employer groups may require a reimbursement level lower than that available under the ordinary MAP from BCBSKS. To meet these market needs, BCBSKS may offer an amendment to the Contracting Provider Agreement, or an additional agreement, providing for such lower level of reimbursement. While nothing in these policies will require a provider to accept this additional discount, if a contracting provider fails to accept such addendum or agreement, a contracting provider shall nevertheless accept as payment in full from a member covered under such a program the amounts established as the MAP under the contracting provider agreement. Such provider may collect from such member the deductible, co-insurance, and additional copayments which apply when such person obtains services from providers who have not signed such amendment or additional agreement.

XXXIX. CAP PROVIDER DIRECTORIES

BCBSKS makes CAP provider information, including contracting providers' names, available to members on our Web site: www.bcbsks.com, and to BCBSA for national doctor locator directories.

XL. ACKNOWLEDGMENT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY REGULATIONS

Although BCBSKS does not guarantee the availability of a Web site, if and when a Web site may be made available to contracting providers, the contracting provider shall access such Web site and the information available through it only for the purpose of payment, treatment, and operations as these terms are defined in HIPAA at 42CFR, part 164.

XLI. ACKNOWLEDGMENT OF K.S.A. 44-1030

As a provider of services to the State of Kansas and to counties, municipalities and other state governmental units, Blue Cross and Blue Shield of Kansas is required by K.S.A. 44-1030 to

observe the provisions of the Kansas Act Against Discrimination, not to discriminate against any person in the performance of work because of race, religion, color, sex, disability, national origin or ancestry, to include the phrase "equal opportunity employer" or a similar phrase in advertisements for employees, and to require in any contracts Blue Cross and Blue Shield of Kansas has with others that such others shall also abide by such provisions, and that if such contractors are found guilty of a violation of the Kansas Act Against Discrimination, such contractors shall be deemed to have breached their contracts with Blue Cross and Blue Shield of Kansas and the contract may be canceled, terminated or suspended in whole or in part. The contracting provider agrees that it shall abide by the foregoing provisions.

XLII. MEDICARE ADVANTAGE CLAIMS

Medicare Advantage (MA) claims should be submitted directly to BCBSKS, who will report the status of such claims on its remittance advices. However, MA claims cannot and will not be processed or appealed pursuant to BCBSKS policies and procedures. For MA claims occurring under a form of coverage offered by a Blue Cross and Blue Shield Plan other than BCBSKS, such other Blue Plan is solely responsible for determining pricing and medical policy (as required by the Centers for Medicare & Medicaid Services (CMS)). A provider's contracting status with CMS determines MA payment allowances. The provider may appeal Medicare Advantage claims only to the Blue Plan providing the MA coverage regardless of whether BCBSKS or another Blue Cross and Blue Shield Plan issued payment. The provider agrees to abide by the final determination resulting from the MA appeals process, which is established by CMS. The appeals policies and procedures of such other Blue Plans should be obtained from those Blue Plans directly.

BlueCross BlueShield of Kansas

An Independent Licensee of the Blue Cross and Blue Shield Association.

LIMITED PATIENT WAIVER

Patient's Name: _____ Provider Name: _____

Identification Number: _____ Provider Address: _____

_____

Provider Number: _____

The provider must document in the patient record the discussion with the patient regarding the following service(s).

NOTICE OF PERSONAL FINANCIAL OBLIGATION
Read Before Signing

I have been informed and do understand that the charge(s) for _____
(nomenclature/procedure code/appliance)

provided to me on _____ (date) will not be covered because Blue Cross and Blue Shield of Kansas (BCBSKS) considers this service(s) to be:

- ☐ Not medically necessary
- ☐ Utilization denials
- ☐ Deluxe features (Applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract) [the allowance for a standard item(s) will be applied to the deluxe item(s)]
- ☐ Patient demanded services
- ☐ Experimental or investigational

It is my wish to have this service(s) performed even though it will not be paid by BCBSKS.

I UNDERSTAND THAT I WILL BE HELD PERSONALLY RESPONSIBLE FOR APPROXIMATELY $ _____. This amount is an approximation only, based on the service(s) scheduled to be provided.

Acknowledgment of personal financial obligation applies to charge(s) for service(s) specified above when performed by this or another provider(s).

I further understand any additional service(s) could affect the amount of my financial responsibility.

_____ _____

Patient/Parent/Guardian Signature Date

I, _____(witness name), did personally observe and do certify the person who signed above did read this notice and did affix their signature in my presence.

_____ _____

Witness Signature Date