BlueChoice® HealthPlan
South Carolina

PROVIDER ADMINISTRATIVE OFFICE MANUAL

Published by Provider Relations and Education, Your Partners in Outstanding Quality, Satisfaction and Service

Revised: January 2023

INTRODUCTION

Founded in 1984, BlueChoice HealthPlan was one of the first health maintenance organizations (HMOs) in South Carolina. Originally known as Companion HealthCare, it was the first HMO offered by BlueCross BlueShield of South Carolina.

Throughout our history, we have stressed the need for preventive care. We created several programs to help our members stay healthy, including our Great Expectations® for health programs.

BlueChoice is nationally recognized for its wellness and disease management initiatives, including two dozen Great Expectations for health programs that help members stay well or learn to better manage their illnesses.

In January 2013, A.M. Best Company affirmed the A+ financial strength rating of BlueChoice as part of the group rating for the BlueCross BlueShield of South Carolina companies.

The American Association for Respiratory Care (AARC) invited BlueChoice to present the improved health outcomes of the health plan's asthma program members at the AARC national conference on Nov. 18, 2013.

BlueChoice participates in the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)

BlueChoice is committed to providing quality service, education and problem resolution to the health care community. This Provider Administrative Office Manual is part of that commitment. We developed this manual to guide you through claim filing and to help you deal more effectively with our company.

We have put great effort into making sure the information in these pages is accurate. If there is any conflict between the contents of this manual and a contract or member's certificate, the contract or certificate will prevail. Likewise, if a conflict exists between the contents of this manual and a provider's contract with BlueChoice, the contract will prevail.

We will make annual revisions and updates to this manual. We will also update provider information in the Education Center of our website at **www.BlueChoiceSC.com/providers** as needed.

In the event of any inconsistency between information contained in this manual and the agreement(s) between you and BlueChoice the terms of such agreement(s) shall govern. Also, please note BlueChoice and other Blue Cross and/or Blue Shield Plans may provide available information concerning an individual's status, eligibility for benefits and/or level of benefits. The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits. Further, presentation of BlueChoice identification cards in no way creates, nor serves to verify, an individual's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits.

TABLE OF CONTENTS

SECTION 1: GENERAL INFORMATION

1.1 Contacts

We direct all phone calls and emails to a central distribution center. We assign them to the provider advocate who can most efficiently handle the request. The provider advocate who responds to your inquiry may not be the one dedicated to your county but is available to respond to your inquiry.

1.1.1 Provider Advocates

Our Provider Relations and Education staff focuses on providing training and support to health care professionals. It serves as liaisons between BlueCross and the health care community to promote positive relationships through continued education and problem resolution. The staff is available for on-site office training and participation in regional practice manager meetings.

If you have a training request or question about a topic — such as compliance requirements, electronic claim filing updates and changes, or problem identification/resolution — please contact the Provider Education department by calling 803-264-4730, emailing your provider advocate or using the Provider Advocate Contact Form available at **www.BlueChoiceSC.com**.

Our provider advocates cover the state of South Carolina and contiguous counties in Georgia and North Carolina. We will route your inquiry to the appropriate staff member for resolution.

1.1.2 Contacting BlueChoice

BlueChoice is available to accept calls about utilization management (UM) issues. Members and providers can call our UM department with any questions about the UM process. Our website at **www.BlueChoiceSC.com** is available 24 hours a day.

Providers and members can contact BlueChoice at 800-868-2528. This is a 24-hour VRU that allows access to information, such as member eligibility, benefits, authorization status, claims status and other inquiries of a general nature. A Provider Service representative is available by telephone for more complex issues Monday through Friday, from 8:30 a.m. until 6 p.m.

Providers can contact BlueChoice's Health Care Services department at 800-950-5387 for authorizations and referrals or for general UM questions. This number can be accessed 24 hours a day.

Access via fax is available to providers 24 hours a day at 800-610-5685 or 803-714-6463, if local.

BlueChoice Provider Services Contacts

Name	Contact Description	Telephone	Website
BlueChoice and Blue Option	For claim status, benefits and eligibility	800-868-2528	**www.BlueChoiceSC.com** (My Insurance Manager)

1.1.3 Other Service Areas

Use this list of contact information for Companion Benefit Alternatives (CBA), National Imaging Associates (NIA) Magellan℠, prior authorizations and other helpful resources.

Other Service Area Contacts

Name	Contact Description	Telephone	Email/Web
Avalon Healthcare Solutions (Avalon) *Avalon is an independent company that provides laboratory benefit management services on behalf of BlueCross.*	Administers laboratory medical management and prior authorization	844-227-5769	**www.AvalonHCS.com***
Companion Benefit Alternatives (CBA) *CBA is a separate company that manages behavioral health and substance abuse benefits on behalf of BlueCross.*	Behavioral health credentialing and benefits	800-868-1032	**www.CompanionBenefitAlternatives.com***
Optum Rx® *Optum is an independent company that provides pharmacy services on behalf of BlueCross.*	Pharmacy benefit management and specialty pharmacy services	855-811-2218	**www.BlueChoiceSC.com** (My Insurance Manager) MBMNow
Find Care Tool	To verify provider network participation with Blue® Plans nationwide	N/A	**www.BlueChoiceSC.com** or **www.bcbs.com**
Electronic Data Interchange (EDI)	Problems submitting claims electronically	N/A	**EDI.Services@bcbssc.com**
Electronic Data Interchange Gateway (EDIG)	Enroll your practice or billing service as a recipient of electronic data or issues with transmissions	N/A	**EDIG.Support@PalmettoGBAServices.com**
NIA Magellan *NIA is an independent company that provides utilization management services on behalf of BlueCross.*	Prior authorization for advanced radiology, interventional pain management, lumbar surgery and radiation oncology procedures	888-642-9181	**www.RadMD.com***
Provider Enrollment	Credentialing, provider updates, network status	N/A	My Provider Enrollment Portal*
Technology Support Center	Technical issues with My Insurance Manager	855-229-5720	N/A
Health Care Services	Prior authorization	800-950-5387	**www.BlueChoiceSC.com** (My Insurance Manager)

1.2 News and Updates

1.2.1 Frequently Asked Questions

You can view frequently asked questions (FAQs) online. We create FAQs from questions we get from providers and those the plans develop in anticipation of provider questions.

1.2.2 Bulletins

View all the latest BlueChoice news announcements for providers online. Bulletins cover a range of important topics from all areas of our business. We may alert you of a recent news bulletin via email notification, through faxed responses and by call campaigns.

1.2.3 Newsletters

BlueNews℠ for Providers is a publication available online and emailed by request. It is for educational and research purposes only. While we often get the articles in the newsletter from sources we believe to be reliable, it is not professional health care advice.

1.3 Health Insurance Portability and Accountability Act (HIPAA) and Electronic Data Interchange (EDI) Services

HIPAA became law in 1996. HIPAA portability provisions ensure that insurance companies do not deny individuals health insurance coverage under preexisting conditions when the individual moves from one employer group health plan to another. HIPAA includes provisions for administrative simplification. The purpose of these provisions is to improve the efficiency and effectiveness of health care transactions by standardizing the electronic exchange of administrative and financial data and protecting the privacy and security of individual health information that insurance companies maintain or transmit electronically.

HIPAA administrative simplification imposes strict privacy and security requirements on health plans, health care providers and health care clearinghouses that maintain and/or transmit individual health information in electronic form. In addition, HIPAA mandates that EDI complies with the adoption of national uniform transaction standards and code sets and requires new unique provider identifiers.

1.3.1 HIPAA Transactions

The BlueChoice Gateway processes these HIPAA-required ASC X12N Version 4010A1 transactions:

- 270 (Health Care Eligibility/Benefit Inquiry)
- 271 (Health Care Eligibility/Benefit Response)
- 276 (Health Care Claim Status Request)
- 277 (Health Care Claim Status Response)
- 278 (Health Care Services Review)
- 834 (Benefit Enrollment and Maintenance)
- 835 (Health Care Payment/Advice)
- 837 (Health Care Claim — Professional)
- 837 I (Health Care Claim — Institutional)

1.3.2 Transaction Code Sets

The HIPAA Transactions and Code Sets regulation (45 CFR Parts 160 and 162) required the implementation of specific standards for transactions and code sets by Oct. 16, 2003. We met this deadline and are fully HIPAA-compliant.

Applicability. The regulation pertains to:

- All health plans, including Medicare, Medicaid, BlueChoice plans, employer-sponsored group health plans and other insurers.
- All vendors and clearinghouses, e.g., billing services, repricing companies and value-added networks that perform conversions between standard and nonstandard transactions.
- All providers, including physicians, hospitals and others, who conduct any of the HIPAA transactions electronically.

Purpose. The intent of HIPAA's Administrative Simplification regulation is to achieve a single standard for claims, eligibility verification, referral authorization, claims status, remittance advice (e.g., EOBs) and other transactions. Adoption of standard transactions should streamline billing, enhance eligibility inquiries and referral authorizations, permit receipt of standard payment formats that can post automatically to your accounts receivable system, and automate claims status inquiries.

Your Responsibility. HIPAA requirements affect most physicians and other providers, but not all. You should assign responsibility for ensuring compliance with the transactions and code sets to a specific person within your office who can work with the information systems vendors, payers and clearinghouses as applicable. Also, you should establish a process to monitor the status of new regulations and changes to comply with them as they become effective.

1.3.3 Trading Partner Agreements

Trading Partner Agreement. In general, a trading partner is any organization that enters a business arrangement with another organization and agrees to exchange information electronically. Typically, the two organizations develop a contract or agreement to describe this arrangement. BlueChoice requires providers or their vendors to complete a Trading Partner Agreement (TPA). You can find the TPA application at **www.HIPAACriticalCenter.com*** under Enrollments and Agreements.

Companion Guide. A companion guide clarifies the specifics about the data content a provider transmits electronically to a specified health plan. For example, it may clarify what identification number is needed for the Payer Identifier data element. We call our companion guides "Supplemental Implementation Guides" (SIGs) since they supplement the HIPAA Implementation Guides. These guides address the situational fields that HIPAA allows for and explain how we use these fields. You can find all our guides at **www.HIPAACriticalCenter.com***.

Supplemental Implementation Guide (SIG). There are data elements that we require in all cases. These are called "required." There are data elements we require only when the situation calls for them. These are called "situational.". Many situational data elements are related to the specialty of the physician. While you may choose to rely on your vendor to provide you with the necessary upgrade to capture applicable data, it may be wise to validate the vendor has supplied all the necessary data for two reasons:

- It is the provider's responsibility to be compliant. If you are not compliant, you risk having us return claims or fine you for noncompliance.
- Vendors are not covered entities under HIPAA. Most vendors will do the best they can to assist their clients in becoming HIPAA-compliant, but it is critical for you to ensure your software upgrade meets HIPAA requirements.

The capture of additional data usually means changes in business processes. You may need to change procedures or alter workflow. By understanding the new data you need to capture, you can plan where to make necessary changes in your office.

Understanding the data requirements, however, is not easy. You may want to consider getting expert help, especially if you are a multispecialty practice. If you decide to begin the task of validating your data requirements yourself, you should get a copy of the SIGs.

1.3.4 Electronic Funds Transfer (EFT)

Complete the electronic funds transfer form to participate in the EFT program. The authorized person who signs this form must also sign the EFT terms and conditions. You can fax completed forms to 803-870-8065, Attn: EFT Coordinator, or send an or email to **Provider.EFT@bcbssc.com**. The EFT form is available at **www.BlueChoiceSC.com**.

EFT deposits payments directly into your bank accounts, allowing you to receive funds before BlueCross mails checks.

1.3.5 Electronic Remittance Advice (ERA)

Providers with electronic file transfer capabilities can choose to receive the 835 ERA containing their Provider Payment Registers. Once you download the remittance files at your office, you can upload the files into an automated posting system. This eliminates several manual procedures. Complete the Clearinghouse ERA Enrollment form to receive ERAs. The ERA form is available at **www.BlueChoiceSC.com**.

If you are adding or changing billing services or clearinghouses, please complete the ERA Addendum-Billing Services and Clearinghouse or ERA Addendum — Corporate Headquarters found at **www.HIPAACriticalCenter.com***. You will not need the BlueCross EDIG Trading Partner Enrollment form when only requesting 835 transactions for existing trading partners.

Remittance advices are available in My Insurance Manager and My Remit Manager.

1.4 Website

Visit **www.BlueChoiceSC.com/providers** for educational information, news, updates, resources and forms.

To protect privacy and comply with HIPAA standards, we use the latest encryption technology to ensure no unauthorized person can access protected health information (PHI).

1.4.1 News and Updates

We have many informational publications for providers, including this manual. These publications are available on our website. By placing our publications on the website, we can provide you with important information quickly and accurately.

1.4.2 Resources

We've developed several resources to make your interactions with BlueChoice easy and efficient. Document types include instructional manuals, user guides, managed care magazines, quick reference guides and educational handouts. Resources are available to view online or to print. You can find these documents:

- Provider Office Administrative Manual
- BlueNews for Providers newsletter
- Provider news bulletins
- My Insurance Manager user guides
- Member Identification (ID) Card Guide
- FAQs

1.4.3 Forms

All forms are available to download and print at **www.BlueChoiceSC.com/find-form**. Be sure to select the Providers checkbox. Many are also available in a Spanish version. Some of the forms you may find most useful are explained here.

- **Other Health/Dental Insurance Questionnaire** — Ask your patients to update this information annually or when a change occurs in other health and/or dental coverage, including Medicare, that the subscriber or any covered dependent may have.

- **Electronic Funds Transfer (EFT) and Electronic Remit Advice (ERA) Enrollment Form** — Complete this form if you want to participate in the EFT program. The authorized person who signs this form must sign the EFT terms and conditions. You can fax completed forms to 803-870-8065, Attn: EFT Coordinator, or email them to Provider.EFT@bcbssc.com. An authorized person at your company must sign the form and the required EFT terms and conditions.
- **Refund Form** — Complete this form when sending BlueChoice unsolicited (voluntary) refund checks.
- **Provider Reconsideration (Appeal) Form** — Use this form to request review of a claim that has processed with an adverse determination. It ensures the medical information and supporting documentation you fax or mail gets to the right area at BlueChoice.

1.4.4 Registering for Trainings

As part of our service efforts, we host monthly webinars and annual workshops. These trainings educate new and experienced providers, along with their staff, on our business objectives and processes.

From the Provider page at **www.SouthCarolinaBlues.com**, select News and Events. Next, select Upcoming Trainings.

You will get a confirmation email that includes instructions for logging in for the selected webinar.

1.4.5 Provider Advocate Map and Contact Form

You can view the provider advocates according to county by viewing the territory map. It is located at **www.BlueChoiceSC.com**.

1.4.6 Locating Patients' Schedule of Benefits

You can access a patient's benefit booklet when viewing eligibility and benefits in My Insurance Manager. From the Patient Care tab, select Eligibility and Benefits for health from the drop-down menu. Enter the required data, and then select Continue. Choose eligibility view according to general, service type or procedure code, and then select Submit. Select See Member Benefit Booklet.

1.5 Electronic Solutions and Provider Self-Help

1.5.1 My Insurance Manager

My Insurance Manager is an online tool for providers to access:

- Benefits and eligibility information.
- Claims entry.
- Prior authorization request and status.
- Claims status.
- Remittance information.
- A mailbox.

It is a valuable provider tool that you can access after you have registered with a valid tax ID number on our system. Secure encryption technology ensures any information you send or receive is completely confidential. My Insurance Manager can provide you with eligibility information and general benefits for BlueChoice members.

My Insurance Manager is not available during weekly maintenance on Sunday evenings from 5 p.m. until midnight.

How To Register. Select the Log In button on the My Insurance Manager launchpad at **www.BlueChoiceSC.com/providers**. Choose Create a Profile, and then enter your Tax ID number for BlueChoice. Create a username and password. Your profile administrator and each authorized user must have a unique username and password registered in My Insurance Manager. Submit the information. You are now ready to access My Insurance Manager.

1.5.2 My Remit Manager

My Remit Manager is an online tool providers can use to search remittances by patient, account number and check number. It is free to all providers who receive EFT payments and electronic remittance advices. It accepts 835s from all commercial BlueChoice lines of business; and it works independently of your practice management system or clearinghouse.

Use My Remit Manager to:

- View ERA information by file and see all details. You have the option of viewing the specific American National Standard Institute (ANSI) details the payer sends or the standardized information in a conventional format.
- Instantly see patient errors and denials. The system highlights any claims that have errors or that BlueChoice has denied.
- View information categorized by check numbers or by patient. It clearly lists the name of each patient whose EOB is associated with an individual check or EFT.
- Print individual remits for a single patient. Eliminate the need to remove or blackout other patient information on the remit.
- Print remits for selected patients. Print individual or group remits.
- Generate and analyze reports. Analyze claim, payment, subscriber, CPT code, etc. and specific data over a specific time.

How To register. You can register to use My Remit Manager by completing the request form at **www.SouthCarolinaBlues.com/web/public/brands/sc/providers/tools-and-resources/my-remit-manager/**.

1.5.3 Electronic Data Interchange (EDI)

The BlueChoice EDI department facilitates electronic transfer of data services to health care providers and serves as a communication link between your office and BlueChoice.

There are three primary methods available for electronically submitting your claims:

1. Direct submission
2. Clearinghouse submission
3. Data entry on the web using My Insurance Manager

Some of the features and benefits of the electronic claim submission are:

- Shortened reimbursement cycle.
- Reduced office administrative costs.
- Decreased claim preparation costs.
- Verification of receipt of claim.
- Error identification for immediate correction.

For help or information about submitting electronic claims, contact the EDI Help Desk at 800-868-2505. We require all professional providers to submit electronic claims in the HIPAA X12 format. You can also view a list of vendors who are currently submitting HIPAA-compliant claims to us as certified vendors. You can view the list of vendors at **www.HIPAACriticalCenter.com***.

1.5.4 Voice Response Unit (VRU)

The VRU is available 24 /7. The VRU is a fully automated tool that provides quick and easy information to providers seeking benefits and eligibility information, routine claim status and refund statuses. If the requested information is available in the VRU, you will not receive the option to speak to a Provider Services representative.

For BlueChoice member information, call 800-868-2528.

1.5.5 VRU Fax Back

Our fax back option is also available through the VRU. Simply enter your fax number, and we will fax the member's benefits or claim status directly to you. You will usually receive the fax in less than five minutes, and you can keep it in the patient's file for future reference.

1.5.6 STATchat

STATchat is a communication tool that lets you speak with a Provider Services representative through your computer, using an internet connection. If you have questions about a claim you have researched in My Insurance Manager, use this tool. Simply select "Launch STATchat," and we will do the rest. To ensure quick service for all customers, please limit your call to the specific member claim you have researched.

System Requirements:

- Adobe Flash Player*
- A compatible web browser: EDGE*, Mozilla Firefox*, or Google Chrome*
- A headset (recommended) or stand-alone microphone and speakers connected to your computer

*Must be a version currently supported by the manufacturer.

Firewall Configuration:

Your firewall should allow outgoing user data protocol (UDP) to the public internet from the browsers that will be using STATchat and allow return traffic in response. If your router includes session initiation protocol (SIP) Application-Level Gateway (ALG) function or stateful packet inspection (SPI), disable both these functions for the *.twilio.com domain.

Bandwidth Requirements:

For each concurrent call, allow WebRTC: 8 KB/s. This does not scale based on bandwidth. On browsers using Flash, fallback bandwidth requirement is 6 KB/s.

Port Requirements:

Component	Address	Client-side Port Used	Server-side Port Used	Protocol
Signaling	*.twilio.com	Any (1,024 to 65,535)	443	TCP
RTP	54.172.60.0/23,34.203.250.0/23	Any (1,024 to 65,535)	10,000 – 20,000	UDP

If you experience problems, please call for technical help at 855-229-5720.

1.6 Enrollment and Contracting

BlueChoice credentials all physicians before adding them to the network according to the National Committee for Quality Assurance (NCQA) standards. This applies even when a new physician joins an established practice. To be considered for participation with BlueCross, you must complete the Provider Enrollment Application. All enrollment applications and communication go through My Provider Enrollment Portal, our new enrollment tool. The portal offers a web-based solution for providers who are credentialing or are interested in credentialing with BlueCross to complete the enrollment process.

1.6.1 Certifying Physicians

To apply for network participation, you must complete the application, include the required documentation, and submit it to BlueChoice through My Provider Enrollment Portal. We will notify you of any missing or incomplete information. The average processing time for enrollment is 90 business days from when we receive a completed package. Any missing or incomplete information will delay the enrollment process.

Until a physician has successfully completed the enrollment process, we cannot publish his or her name in the BlueChoice Network Directory, nor will members be able to select him or her as their physician. The effective date will be the date of approval by the credentialing committee. Effective dates are not retroactive.

Note: You only need to submit one Provider Enrollment Application, regardless of the number of networks for which you are applying.

1.6.2 Certifying Midlevel Practitioners

Physician Assistants. BlueChoice credentials PAs. PAs can choose to file claims for medical and laboratory services they provide in the office under their National Provider Identifier (NPI) once they have been credentialed with the plan, or they can bill under the supervising doctor's NPI. Our policies do not cover a physician assistant as an assistant at surgery. We only cover MDs as assistant surgeons, if medically necessary. If a physician assistant is assisting during surgery, he or she must bill as the rendering provider using an AS modifier.

Nurse Practitioners (NP). BlueChoice cannot credential NPs who are not under direct supervision of a doctor. NPs must submit claims under their NPI numbers. They cannot bill under the supervising doctor's NPI number.

BlueChoice does **not** credential these specialties:

- Associate counselor
- Massage therapist
- Dietitian
- Physical therapy assistant
- School psychologist
- Acupuncturist
- Diabetes educator
- Education specialist
- Homeopath
- Lay midwife
- Naturopath
- Psychology assistant
- Sports trainer
- Technician
- Christian science practitioner
- Occupational therapy assistant
- Recreational therapist

1.6.3 Provider File Updates

For us to maintain accurate participating provider directories and for reimbursement purposes, providers are contractually required to report all changes of address or other practice information electronically. Changes may include:

- Provider name.
- Federal tax ID number.
- NPI.
- Physical and billing addresses.
- Telephone number, including daytime and 24-hour numbers.
- Fax number.
- Email address.
- Hours of operation.
- Practice URL (website).
- Name changes, mergers or consolidations.
- Languages spoken.
- Accepting new patients.
- Age range and gender of patients accepted.
- Group affiliations.
- Practice management system.

As part of the Consolidated Appropriations Act (CAA), effective Jan. 1, 2022, providers must verify and/or update their demographic data at least every 90 days. Validations can be made within My Insurance Manager using M.D. Checkup and are determined based on the number of days since the last validation was made. If more than 90 days has passed since the provider's last validation, we must suppress them from our directories.

1.6.4 Change of Ownership

You must promptly notify BlueChoice if your organization changes ownership. Complete the Group Application located inside My Provider Enrollment Portal.

1.6.5 Recredentialing

BlueChoice requires all health care providers to go through recredentialing every three years. We will notify providers when it is time to begin the recredentialing process. We recredential through My Provider Enrollment Portal.

1.6.6 Enrollment Rights

We want to make sure the information we collect as part of the enrollment process is accurate and complete. We afford physicians these rights as they relate to their enrollment and recredentialing information:

- The right to review information submitted to support the enrollment or recredentialing application
- The right to correct erroneous information
- The right to be informed of the status of the enrollment or recredentialing application

If you have questions about the enrollment process or your enrollment rights, please contact Provider Enrollment using the support feature within My Provider Enrollment Portal. You can also contact Provider Education at **Provider.Education@bcbssc.com** or by calling at 803-264-4730.

1.6.7 Networks and Participation

BlueChoice supports several provider networks, including BlueChoice, Blue Option exclusive provider organization (EPO), HMO Blue and BlueChoice HMO.

1.6.8 Fee Allowances and Member Financial Responsibility

The Professional Agreement states that a provider will accept the fee allowance for covered services — defined as the provider's normal charge or the allowance, whichever is lower — as payment in full. Do not bill the member for any amount that exceeds the fee allowance.

Copayments. The copayment is a threshold amount that you should collect each time the member visits your office. The only exception is for obstetrical care, which has a one-time-only copayment, considered a global fee. It is your responsibility to collect copayments from members. The best time to do this is at the time of service.

Coinsurance and Deductibles. Some BlueChoice members have benefit plans with coinsurance and deductibles. The coinsurance is the percentage of the allowed amount that the member, not BlueChoice, is responsible for (e.g., we pay 80 percent, and the member pays 20 percent). Members may also have to meet a deductible before we will begin making payments.

Balance Billing. We base physician reimbursement on our "allowed amount." By signing the Professional Agreement and Hold Harmless Agreement, you have agreed not to bill members for any balance between the BlueChoice allowed amount and your charge for covered services.

Refunds. If you receive a payment that you need to return to us, you can use the Refund Form found on our website. This form ensures we route your check to the appropriate department and properly process it.

1.6.9 Language and Provisions

Each provider's agreement lists the contractual responsibilities of both BlueChoice and that preferred provider. Here is a general summary of the agreement:

- The provider will file all claims for all applicable members.
- The provider will accept BlueChoice's payment plus any patient copayments, coinsurance and deductibles as full reimbursement. The provider will not bill the patient for more than his or her applicable patient liability amount not to exceed the fee allowance.
- The provider agrees to cooperate fully with utilization review procedures.
- The provider will use other network providers for a member's care unless medically necessary services, supplies or equipment are not available from a network provider or in cases of medical emergencies or urgently needed services.
- The provider agrees to bill promptly and in a manner approved by BlueChoice for all services. Electronic claims submission in the 837I or 837P HIPAA-compliant format is the preferred method of filing.
- To the extent that a written agreement allows for subcontracting with participating providers, the written agreement specifies that all subcontracts will be subject to the terms of the written agreement.

If you have any questions about contracting, please submit a request by going to the Provider Advocates page on our website.

SECTION 2: PRODUCT (PLAN) INFORMATION

2.1 Product (Plan) Overview

2.1.1 Benefit Structure

Each BlueChoice insurance plan, whether group or individual, offers a variety of coverage. In addition, plans may also have different prior authorization and mental health requirements. Plans may also have separate insurance vendors for certain benefits, such as vision or dental.

2.1.2 How Members Access Physicians and Health Care Professionals

Members are encouraged to access care from an in-network doctor or other health care provider for Blue Cross and Blue Shield Plans nationwide. To determine whether you are in network for a particular member's plan, use the Find Care tool. This tool is available at **www.BlueChoiceSC.com** or **www.bcbs.com**.

2.2 Member Identification (ID) Cards Overview

2.2.1 How to Identify Members

When members arrive at your office, remember to ask to see their current member identification (ID) cards at each visit. This will help you identify the product the member has and get dental plan contact information. It will also help you with filing claims. Please note that all ID cards do not look the same and are for identification purposes only. They do not guarantee eligibility or payment of your claim.

Important facts about the ID card prefix:

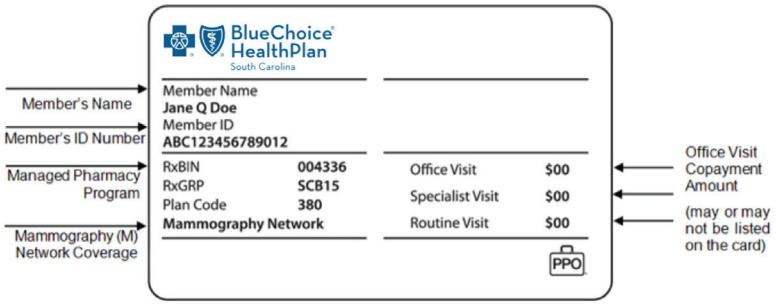
- Using the correct ID card prefix is critical for electronic routing of specific HIPAA transactions.
- It is important to capture all ID card data at the time of service.
- Do not assume that a member's ID card number is his or her benefits identification number.
- Be sure all your system upgrades accommodate the ID card prefix and all characters that follow it.
- Do not add, delete or change the sequence of characters or numbers in a member's ID card number.
- Make copies of the front and back of the ID card. Share this information with your billing staff.

Here is an explanation of each field on the ID card:

- ID — This is the member's BlueChoice identification number.
- EPO — This indicates the member is enrolled in an EPO plan. Members must stay in network to receive benefits for covered services.
- HMO — This indicates the member is enrolled in an HMO plan. Members must select a primary care physician, who is then responsible for providing or coordinating all their health care.
- PPO — This indicates the member is enrolled in an open access plan.
- HDHP — This indicates the member is enrolled in a high-deductible health plan (HDHP). Works the same as regular ADVANTAGE Plus and CarolinaADVANTAGE except the member must meet a high deductible amount that will be indicated on the card. Deductibles do not apply to preventive care.
- Rx — This indicates the member is enrolled in a pharmacy benefit plan.

Please refer to our Member Identification Card Reference Guide on **www.BlueChoiceSC.com** for more information about BlueChoice ID cards.

2.2.2 Sample ID Card



2.2.3 Verifying Eligibility and Benefits

Use My Insurance Manager to verify eligibility and benefits. Select the plan for which you want to review eligibility and benefits. Choose your eligibility view according to general benefits, service type or procedure code. Unless otherwise required by state law, the notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductible, may change as additional claims are processed.

For BlueChoice and Blue Option plan members, you can call the Provider Services VRU at 800-868-2528 (outside of Columbia).

2.3 BlueChoice Advantage Plus

2.3.1 Network

BlueChoice Advantage Plus is a line of small group preferred provider organization (PPO) health insurance plans we offer. The products use the BlueChoice Advantage Network. The product's benefit structure gives members financial incentives for seeking medical care from a network of preferred providers in South Carolina.

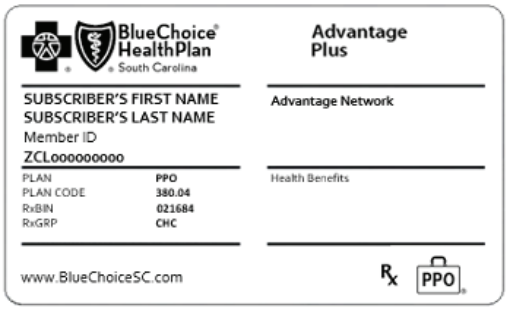
2.3.2 Requirement for Referral to Specialist

Members are not required to select a primary care physician. Members can see a specialist of choice without permission from this plan. Providers should always refer members to other in-network providers when necessary.

2.3.3 Prefix

The prefix for these plans is ZCL.

2.3.4 Sample ID Card



2.4 CarolinaADVANTAGE

2.4.1 Network

CarolinaADVANTAGE is a line of small group PPO health insurance plans we offer. The products use the BlueChoice Advantage network. The product's benefit structure gives members financial incentives for seeking medical care from a network of preferred providers in South Carolina.

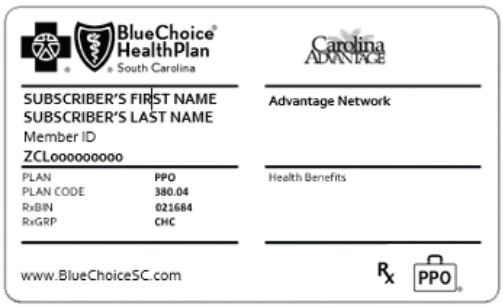
2.4.2 Requirement for Referral to Specialist

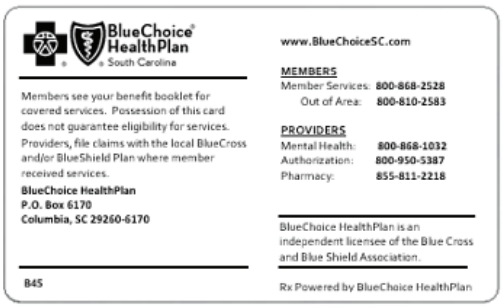
Members are not required to select a primary care physician. Members can see a specialist of choice without permission from this plan. Providers should always refer members to other in-network providers when necessary.

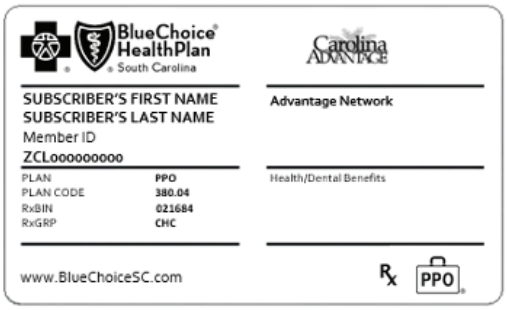
2.4.3 Prefix

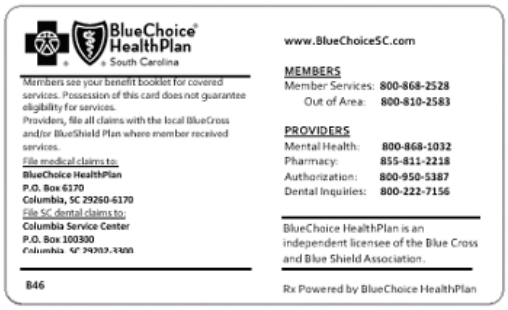
The prefix for these plans is ZCL.

2.4.4 Sample ID Cards









2.5 Primary Choice

2.5.1 Network

Primary Choice is a line of individual HMO health insurance plans we offer that use the BlueChoice HMO network. Members do not have out-of-network benefits.

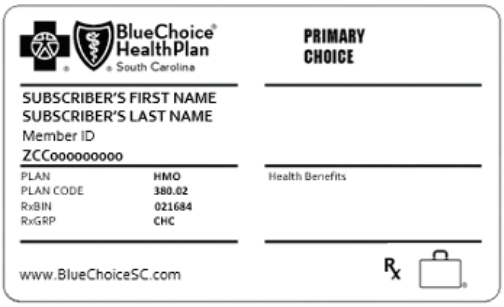
2.5.2 Requirement for Referral to Specialist

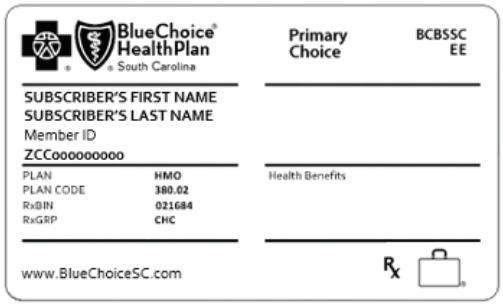
Members must select a primary cares physician. Members are required to have a referral to see specialists within the network.

2.5.3 Prefix

The prefix for these plans is ZCC.

2.5.4 Sample ID Cards





2.6 My Choice Individual

2.6.1 Network

My Choice is a line of individual PPO health insurance plans we offer. The products use the BlueChoice network. The product's benefit structure gives members financial incentives for seeking medical care from a network of preferred providers in South Carolina.

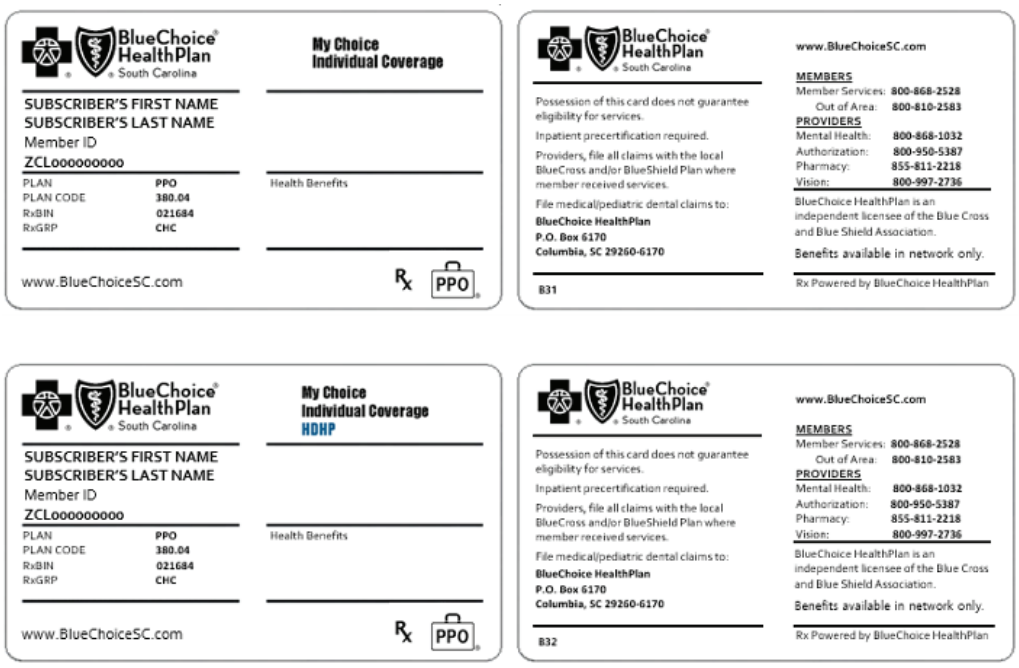
2.6.2 Requirement for Referral to Specialist

Members are not required to select a primary care physician. Members can see a specialist of choice without permission from this plan. Providers should always refer members to other in-network providers when necessary.

2.6.3 Prefix

The prefix for these plans is ZCL.

2.6.4 Sample ID Cards



2.7 BusinessADVANTAGE

2.7.1 Network

BusinessADVANTAGE is a line of small group PPO health insurance plans we offer. The products use the BlueChoice Advantage network. The product's benefit structure gives members financial incentives for seeking medical care from a network of preferred providers in South Carolina.

2.7.2 Requirement for Referral to Specialist

Members are not required to select a primary care physician. Members can see a specialist of choice without permission from this plan. Providers should always refer members to other in-network providers when necessary.

2.7.3 BusinessADVANTAGE Pharmacy

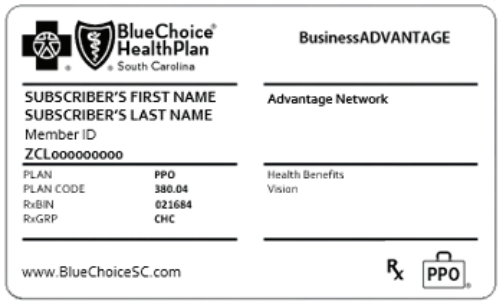
Optum Rx administers pharmacy benefits for members. Optum Specialty Pharmacy is our preferred specialty pharmacy. Members have a six-tier plan with either a drug card and/or mail-service benefits.

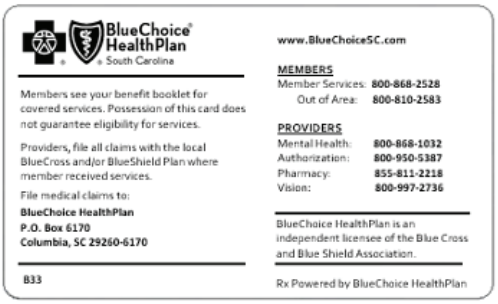
All compound drugs require prior authorization for BusinessADVANTAGE members. See Section 3 for additional information about pharmacy benefits.

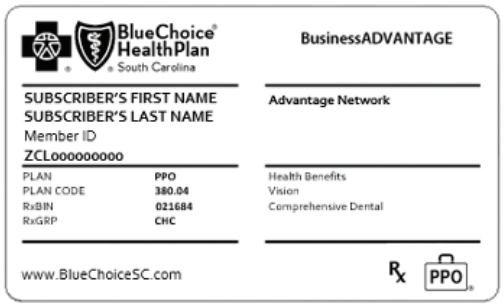
2.7.4 Prefixes

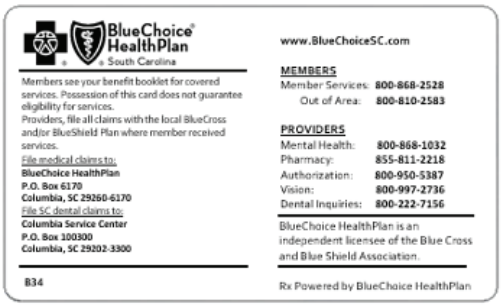
The prefixes for these plans are ZCL and ZCG.

2.7.5 Sample ID Cards









2.8 Affordable Care Act Plans: Blue Option

2.8.1 Network

Blue Option is a line of individual EPO health insurance plans we offer that use the Blue Option network. Members do not have out-of-network or out-of-state benefits, except in the event of a true emergency. This includes labs and DME. However, services from providers in bordering counties outside of South Carolina that are currently contracted and participate in the Blue Option networks are considered in network.

2.8.2 Requirement for Referral to Specialist and Prior Authorization

Members are not required to select a primary care physician. Members can see a specialist of choice without permission from this plan. Providers should always refer members to other in-network providers when necessary.

These services require prior authorization. This list is not all inclusive. Check My Insurance Manager for additional authorization requirements:

- Certain labs (through Avalon)
- Dialysis treatment
- Mental health and substance use disorders
- SNF admission
- Continuation of a hospital stay for a medical condition
- Hospital admission, including maternity notifications
- Radiation oncology (required through NIA Magellan)
- DME, when the purchase price or rental is $500 or more
- Certain drugs, all compound drugs and all specialty drugs billed under the medical benefit (required through MBMNow, Optum Rx's online prior authorization tool)
- Cosmetic procedures
- Home health care or hospice services
- Outpatient hysterectomy or septoplasty
- Treatment for hemophilia
- Advanced radiology (required through NIA Magellan)
- Nuclear cardiology (required through NIA Magellan)
- Admissions for habilitation, rehabilitation, and/or human organ and/or tissue transplants
- Musculoskeletal care, such as interventional spine management services and lumbar and cervical spine surgeries (required through NIA Magellan)

See Section 5 for additional information about prior authorization requirements.

2.8.3 Transition of Care

If a Blue Option member is under the care of a physician who is not in the network, he or she can request special consideration to have us apply benefits at in-network levels using the Transition of Care form. Upon review by our Utilization Management area, we may approve a member to continue care with the out-of-network provider for a specified time. The request must be submitted prior to rendering services. It is not necessary to have a Transition of Care form for emergency services. Members will be responsible for the difference between the amount the health plan pays for those services and what the provider charges. Please note, requests should only be made when there is not an in-network provider that can perform the services the patient requires.

2.8.4 Blue Option Pharmacy

Optum Rx administers pharmacy benefits for Blue Option members. Optum Specialty Pharmacy is our preferred specialty pharmacy. Blue Option members have a six-tier plan with either a drug card and/or mail-service benefits.

Members must use pharmacies in the Advanced Choice Network™. This network includes all CVS pharmacies, Walmart, Kroger, Publix, Longs Drugs, Bi-Lo, Rite Aid, and other grocers and independent pharmacies. Walgreens is not part of this network. If members fill prescriptions at a nonparticipating pharmacy, they will be required to pay the full retail price.

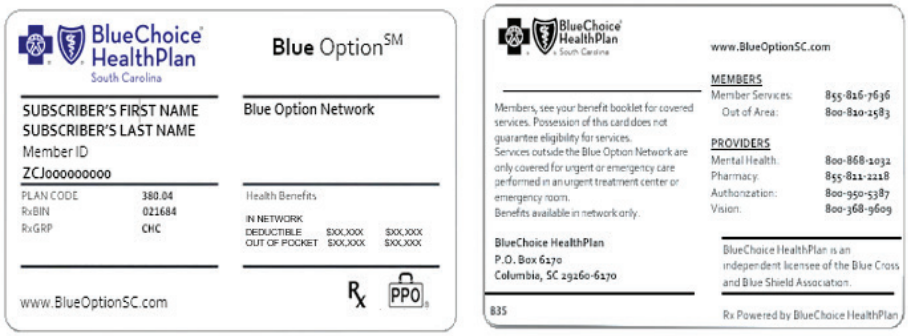
All compound drugs require prior authorization for Blue Option members.

The Covered Drug List for these members is different from the other BlueChoice plans. The Covered Drug List is available on our website, **www.BlueChoiceSC.com**. If you would like us to cover a drug that is not listed in the formulary, you or the member can fax a Formulary Exception Request form to 855-245-2134. The forms are available on our website. You can also call Provider Services at 800-868-2528. We will work with the prescribing physician to get any medical records or other necessary information to process the request.

2.8.5 Prefix

The prefix for these plans is ZCJ.

2.8.6 Sample ID Card



2.9 Other Benefits

2.9.1 Dental

Each BlueChoice plan offers a variety of coverage and differs by employer. Please verify eligibility and benefits before providing services.

On Jan. 1, 2017, BlueChoice launched Blue Dental℠ for both large and small group employers.

- All standard Blue Dental plans provide 100 percent coverage for preventive (Class 1) services. For larger groups, there are no deductibles, and preventive and diagnostic services do not accumulate toward the plan's annual maximum if services are received in network.
- Members can also use the national Dental Grid network.

The Dental GRID allows dentists to see members from other participating Blue Cross and Blue Shield Plans at local plan reimbursement levels.

Your reimbursement levels or provider agreements will not change. GRID is a separate company that offers a dental network on behalf of BlueChoice.

2.9.2 Mental Health

Mental health benefits vary among each plan. Please verify eligibility and benefits before providing services.

2.9.3 Pharmacy

Many BlueChoice plans use Optum Rx for prescription drug benefits. Pharmacy benefits vary between plans. Verify eligibility and benefits for each member.

See Section 3 for additional information about pharmacy benefits.

2.9.4 Vision

Many BlueChoice plans offer vision benefits. Vision benefits vary between plans. Some of our vision benefit business partners include EyeMed® and Physicians Eyecare Network (PEN). These are independent organizations that provide vision benefits on behalf of BlueChoice. Verify eligibility and benefits for each member.

SECTION 3: PHARMACY BENEFITS

3.1 Pharmacy Benefits

BlueChoice members who have a non-ACA plan use one of two different formularies: Most members use the Tiered Prescription Drug List, while some members still use the Prescription Drug List (legacy version). Both are based on tiers, which are copayment (or coinsurance) levels, depending on the member's benefit plan. Optum Rx administers the BlueChoice drug lists. The drug lists include information about what copayment level a drug is on and any relevant utilization management requirements and other pertinent details about BlueChoice pharmacy benefits. You can find the forms on the Provider page of our website. See tier descriptions here for both drug lists.

3.1.1 Tiered Prescription Drug List

- Tier 1 — Lowest-cost prescription generic and some over the counter (OTC) drugs
- Tier 2 — Prescription generic and some OTC drugs
- Tier 3 — Brand-name drugs that don't have a generic available; may include higher-priced generics that have more cost-effective options at lower tiers
- Tier 4 — Brand-name drugs that have brand-name or generic options at lower tiers; may include higher-priced generics that have more cost-effective options at lower tiers
- Tier 5 — Specialty drugs that are more effective and cost less than other specialty drugs that treat the same conditions; may include some nonspecialty brand-name or generic drugs that have more cost-effective options at lower tiers
- Tier 6 — Specialty drugs that have more cost-effective alternatives at Tier 5; may include some nonspecialty brand-name or generic drugs that have more cost-effective options at lower tiers

3.1.2 Prescription Drug Lists

- Generic (Tier 1) — Most prescription generic drugs and select over-the-counter (OTC) agents
- Most members now have a pharmacy benefit that includes a two-level generic category:
  - Value Generics (generic drugs that cost less than $15 per month and covered OTC drugs)
  - Standard Generics (most other generic drugs that cost more than $15 per month)
- Preferred (Tier 2) — Select prescription brand-name drugs on the Prescription Drug List
- Nonpreferred (Tier 3) — Prescription brand-name drugs and occasionally high-priced generic drugs

You can find the prescription drug lists on our website at **www.BlueChoiceSC.com/providers/specialty-drugs-and-pharmacy-drugs**. Please note, these lists are subject to change at any time without advance notice to members or physicians.

3.1.3 Pharmacy Drug Prior Authorization

BlueChoice requires physicians to get prior authorization before prescribing certain medications to members. Prior authorization drugs are subject to medical necessity review and may require the submission of additional details or medical records for approval. All our prior authorization criteria are developed and based on the most current U.S. Food and Drug Administration (FDA) prescriber labeling and clinical recommendations from the BlueChoice and BlueCross Pharmacy and Therapeutics Committee (P&T Committee). We list drugs that require prior authorization on the Tiered Prescription Drug List and the Prescription Drug List with the notation "PA." Drugs that require medical necessity prior authorization are notated with "MN."

To initiate the prior authorization process, please contact the Optum Rx prior authorization center toll free at

855-811-2218 before giving the member the prescription. You will be asked to provide member-specific information via phone or fax, including the diagnosis and the member's previous medication use. You can also print a copy of each individual prior authorization request form from our website at **www.BlueChoiceSC.com/providers/oral-drug-step-prior-authorization-forms**.

3.2 Specialty Drug Benefits

The specialty pharmaceuticals benefit covers medications that treat complex clinical conditions, often with complex drug delivery systems and routes of administration. We cover specialty pharmaceuticals according to each member's group health plan. These medications include, but are not limited to, infusible medications for chronic disease, injectable and self-injectable medications for acute and chronic diseases, and other oral specialty medications. You can find a copy of the Specialty Drug List on the provider page of our website, as indicated previously. BlueChoice provides coverage for specialty drugs under both the pharmacy and medical benefit. The pharmacy benefit covers specialty oral and self-injectable medications through our preferred specialty pharmacy. Briova is a division of Optum Rx, an independent company that provides specialty pharmacy services on behalf of BlueChoice. Certain self-administered drugs are not covered under the medical benefit. You can contact Optum Specialty Pharmacy by phone at 855-811-2218.

For drugs billed under the pharmacy benefit (oral and self-injectable drugs), the member has a monthly specialty pharmacy copayment. The specialty pharmacy will collect the copayment for drugs it dispenses. For drugs billed under the medical benefit, the member has a specialty pharmacy copayment for every dose you administer in your office. Please collect the copayment directly from the member. This copayment differs from plan to plan. Please contact our Provider Services department at 800-868-2528 or visit our website at **www.BlueChoiceSC.com** to determine specific benefits and copayments for your patient.

3.2.1 Specialty Medical Benefit Drug Prior Authorization and Site-of-Care Steerage

Many specialty drugs billed under the medical benefit require prior authorization. These prior authorizations are requested through MBMNow, Optum Rx's online prior authorization tool. MBMNow is a web-based application available with single sign-on access through My Insurance Manager. If you administer a drug in your office that needs prior authorization and you bill for it under your tax ID number, you can request prior authorization in one of three ways:

1. Call MBMNow at 877-440-0089.
2. Fax MBMNow at 612-367-0742.
3. Online through My Insurance Manager.

My Insurance Manager is our preferred method for you to get authorizations. Go to **www.BlueChoiceSC.com/providers,** and then select the Log In button on the My Insurance Manager launchpad at the top of the page. Enter the required information to go to the MBMNow system.

Site-of-Care Steerage: All BlueChoice members have a benefit that requires certain infused drugs to be administered at an appropriate, cost-effective site of care. This may be the member's home or an in-network infusion suite rather than an outpatient hospital setting. Site-of-care steerage is incorporated into the MBMNow prior authorizations for drugs on the Site of Care list.

For the most updated Specialty Medical Management Drug lists, please go to **https://www.bluechoicesc.com/providers/specialty-drugs-and-pharmacy-drugs** and select either Specialty Medical Drugs or Specialty Pharmacy Drugs.

3.3 Excluded Drugs/Formulary Exceptions

Some drugs are excluded from coverage. A current list of excluded drugs is available in the Provider section of our website. If you would like us to cover a drug that is not on the formulary, you or the member can request a formulary exception. We will work with the prescribing physician to get medical records or other necessary information to process the request. Formulary exception requests are routed to one of two destinations, depending on the drug.

For exception requests reviewed by BlueChoice, please call 877-440-0089.

To determine where the formulary exception goes for review, please see the most updated version of the Excluded Drug List at **www.BlueChoiceSC.com/providers/specialty-drugs-and-pharmacy-drugs**. Select Prescription Drugs, and then select the Excluded Drug List link.

3.4 Mail-Service Pharmacy

Some BlueChoice members have a mail-service benefit available as a part of their prescription benefit. These members can get a 90-day supply of certain medications for a specified copayment as outlined in their benefit plan. Members interested in using their mail-service benefit can contact BlueChoice Customer Service at 800-868-2528 to request an Optum Rx mail-service order form, or they can find one in the Forms section on the Member page of our website.

If members choose to use their mail-service benefit, please provide a 90-day prescription in one of these ways:

- Send an e-prescription to the Optum Rx mail-service pharmacy.
- Phone in a prescription to the Optum Rx mail-service pharmacy at 855-828-9834.
- Give your patient a written prescription to send with an Optum Rx order form.

3.5 Step Therapy

BlueChoice requires certain medications we cover under the prescription benefit satisfy specific step therapy criteria. The notation “ST” throughout the text of the prescription drug lists identifies medications that currently require step therapy. Step therapy criteria simply means before BlueChoice members can fill medications on the Step Therapy Drug List, they must first have tried one or more prerequisite medications to treat their conditions, to be covered through their benefits. All step therapy criteria are based on current FDA prescriber labeling and clinical decisions made by the BlueChoice P&T Committee.

Our pharmacy benefits manager handles most step therapy requests. You can reach Optum Rx by calling 855-811-2218. There may also be a form for the request on our website. See the directions in the Prior Authorization section to find these forms. If there is not a form for the drug you are seeking approval for, please call Health Care Services toll free at 800-950-5387, option 6, to determine if we approve the medication based on the step therapy criteria.

3.6 Quantity Management

Some drugs on the Prescription Drug List have quantity limits, typically for a one-month supply. The P&T Committee approved these limits. They are based on FDA prescriber labeling and treatment/prescribing guidelines developed by nationally accepted medical organizations. Medications that currently have a quantity limit are identified by the notation “QL” throughout the text of the prescription drug lists.

If you deem it necessary for your patient to have more than the quantity limit allows, you can request an exception. Our pharmacy benefits manager handles some quantity limit requests. You can reach Optum Rx by calling 855-811-2218. For other quantity limit requests, please call Health Care Services toll free at 800-950-5387, option 6.

SECTION 4: CLAIMS AND BILLING GUIDELINES

4.1 Claims Filing

For prompt payment, we encourage electronic claims submission. Transmit claims in the HIPAA 837 format under the appropriate carrier codes. You should complete all applicable claim information in full to ensure you get accurate payment without delay. You can also file both professional and institutional claims (primary, secondary and corrected claims) in My Insurance Manager.

4.1.1 Using the Correct Provider Identifier

Tax Identification Number (TIN). Each participating provider should use his or her nine-digit TIN or NPI when filing claims. This will ensure accurate and timely payment. An exception to this occurs if you do not have a TIN and use your Social Security number to report income.

Place your provider number in the appropriate form indicator for the 837 (I and P) when filing claims. Follow these same instructions for entering the rendering provider's NPI number.

If you have changed your TIN, complete only the Request To Change Tax ID form. You will need to submit a copy of your TIN confirmation before we will update your profile. The IRS will send this confirmation to you. If you have any questions about your TIN, you can visit the IRS website at **www.irs.gov**.

NPI. The NPI is a 10-digit, all numeric identifier. NPIs are only issued to providers of health services and supplies. As a provision of HIPAA, the NPI is intended to improve efficiency and reduce fraud and abuse.

There are several advantages to using the provider NPI for claims and billing:

- It allows providers to bill with only one number.
- It simplifies the billing process since it is no longer necessary to maintain and use legacy identifiers for each health care plan.
- It simplifies making changes to addresses or locations

NPIs are divided into two types:

- Type One: Individual providers, which includes but is not limited to physicians, dentists and chiropractors
- Type Two: Hospitals and medical groups, which includes but is not limited to hospitals, residential treatment centers, laboratories and group practices

For billing purposes, claims must be filed with the appropriate NPI for billing, rendering and referring providers. Providers can apply for an NPI online at the NPPES website at **nppes.cms.hhs.gov**.

Rendering Provider Number. We require you to report the rendering provider NPI on all claims. Any claim we receive that is missing the required rendering provider's information will result in a claim denial. We will accept corrected claims if your office inadvertently omits the rendering provider information.

4.1.2 Diagnosis Codes, Procedure Codes and Modifiers

Claims filed with BlueChoice are subject to these procedures:

1. Verification that all required fields are completed on the claim

2. Verification that all diagnosis codes, modifiers and procedure codes are valid for the date of service

Diagnosis Codes. All claims must include the proper ICD-10-CM diagnostic code. Using deleted or incorrect codes will result in an inability to process your claim or payment delays. These are guidelines the Centers for Medicare & Medicaid Services (CMS) established for use of diagnosis codes:

- Code the primary diagnosis first, followed by the secondary, tertiary and so on.
- Code any coexisting conditions that affect the treatment of the patient for that visit or procedure as supplementary information.
- Do not code a diagnosis that is no longer applicable.
- Code to the highest degree of specificity.
- Code a chronic diagnosis, when it is applicable to the patient's treatment or when follow-up on the condition is requested during the visit.

Procedure Codes. Common Procedure Technology (CPT®) is a standardized system of five-digit codes and descriptive terms used to report the medical services and procedures performed by physicians or health care professionals. Accurate CPT coding is crucial for proper reimbursement and compliance with government regulations.

All physicians and health care professionals must use the appropriate procedure codes from the most recent Healthcare Common Procedure Coding System (HCPCS) and CPT coding manuals or quarterly updates. Claim processing cannot be completed without accurate procedure codes, which reflect the services provided to members.

Consult the American Medical Association for annual revisions and publications to the CPT Book.

Modifiers. Use modifiers to report the procedure has been altered by a specific circumstance. Modifiers provide valuable information about the actual services rendered, reimbursement and payment data. Modifiers also provide for coding consistency and editing for Level I (CPT codes) and Level II (HCPCS). Because the use of modifiers is frequently the only way to alter the meaning of a CPT code, it is important to know how to use modifiers correctly.

4.2 Electronic Claim Submission

As a participating network provider, you agree to submit claims for BlueChoice members electronically. You should complete all applicable claim information in full to ensure you receive accurate payment without delay. SIGs are available in the HIPAA Critical Center at **www.HIPAACriticalCenter.com***. These will help you with the electronic claim filing process. You can also file both professional and institutional claims (primary, secondary and corrected claims) by using My Insurance Manager.

We currently accept these claim submission formats:

- CMS-1500 claims filed via My Insurance Manager
- CMS UB-04 claims filed via My Insurance Manager
- HIPAA 4010A1 electronic format claims (professional and institutional)

BlueChoice no longer accepts paper claims. We may consider a paper claim only if specific conditions are met. BlueChoice Operations will review those instances where a provider waiver is requested for processing a paper claim.

4.2.1 Electronic Medical Claim (EMC)

Submit claims electronically to BlueChoice using the HIPAA-compliant 837 (I or P), X12 format. This is more efficient because it allows hospitals and physicians to receive payment five to seven days faster than for claims they file hardcopy. EMC filing also ensures claims accuracy through system edits.

You can file both CMS-1500 and CMS UB-04 claims to BlueChoice via the Web using My Insurance Manager. You can also submit CMS-1500 claims to BlueChoice using the Superbill tool within My Insurance Manager. This tool is ideal for providers who want to submit primary claims for one date of service only.

You can submit primary, secondary and corrected claims for both professional and institutional providers. File online and most claims with amounts due will process in three to five days.

If you file your claims electronically and need help with a technical problem, please contact your computer system vendor or our Technology Support Center at 800-868-2505.

4.2.2 Carrier Codes

BlueChoice uses carrier codes (payer ID) to route electronic transactions to the appropriate line of business once the gateway accepts the claim. Failure to use the correct electronic carrier code will result in misrouted claims or delayed payments. If you transmit through a clearinghouse, check with the clearinghouse to see if it requires a different carrier code for claim submission.

Use carrier code 922 for direct electronic claim submission for BlueChoice and Blue Option members.

4.2.3 Electronic Loops and Data Segments

Each individual loop on an electronic claim has a segment component where the data is entered. The loops and segments contain the readable information that provides the clearinghouse the identifying information for the claim that was filed. The loops on an electronic claim are organized by categories of information that match data elements on the CMS-1500 claim form.

Below are examples and solutions of common edits that apply to loops and segments for professional claims, institutional claims and dental claims.

- 837 Professional Edit HA9 — Invalid Rendering Physician ID Number

  Loop(s) and Segment (s) Impacted:

  2310B | NM109

  – Corrective action: Validate the rendering physician provider identification number is sent. Call the appropriate provider service area for BlueChoice to validate the rendering provider identification number needs any additional paperwork to update the provider database.

- 837 Institutional Edit QAC — Medicare COB amounts from Medicare remit was entered incorrectly

  Loop(s) and Segment(s) Impacted:

  2320 | AMT 2320 | CAS 2430 | SVD 2430 | CAS

  – Corrective action: Sum of CAS Segments and Medicare payment must equal the total charges.
- 837 Dental Edit L25 — Missing or invalid tooth number submitted on claim

  Loop(s) and Segment(s) Impacted:

  2400 | TOO

  – Corrective action: Submit a valid tooth number for the service given on the claim.

Visit the **www.HIPAACriticalCenter.com*** for more information.

4.2.4 Most Common Electronic Submission Denials

- Authorization or referral number invalid or missing
  – Confirm authorization requirements prior to rendering services.
  – Contact the appropriate benefits manager to complete prior authorization requests.
- Billed charges missing or incomplete
- Rendering NPI not listed on claim
  – Include the rendering physician NPI for all claims.
- NDC/NDC unit of measure not listed on claim
  – Include the NDC, unit of measure and quantity.
- Diagnosis, procedure or modifier codes invalid or missing
- Diagnosis-related group (DRG) codes missing or invalid
- Duplicate claims
  – Submit modifiers as appropriate.
  – Verify claim status prior to submitting claims a second time.
- COB information missing or incomplete
  – Verify if the member has other insurance which may be primary.
- Early and periodic screening, diagnostic and treatment (EPSDT) information missing or incomplete
- Eligibility/enrollment not valid on date of service (DOS)
- EOB missing or incomplete
  – Submit the primary payment information as necessary.
- Spanning dates of service do not match the listed days/units

4.3 Claims Management

4.3.1 National Drug Code (NDC) Requirements

BlueChoice requires the reporting of the NDC, NDC unit of measure and NDC quantity for all outpatient-administered drug claims.

When submitting NDCs on professional electronic and paper (CMS-1500) claims, you must include this related information:

- 11-digit NDC
- NDC qualifier (N4)
- NDC quantity
- NDC unit of measure [Unit (UN), Milliliter (ML), Gram (GR), International Unit (F2)]

You can find additional information about the NDC requirements at **www.BlueChoiceSC.com**. You can also find additional NDC information, and an NDC to HCPCS crosswalk, on the CMS website.

4.3.2 Timely Filing

Generally, providers must file claims within 180 days from the date of service. Some policies, however, require you to file claims within 90 days. Since timely filing limits vary, we encourage you to file your claims as soon as possible. BlueChoice will deny claims it receives after the timely filing period. The member and BlueChoice should be held harmless for these amounts.

4.3.3 Claim Status

You can view claim status by visiting **www.BlueChoiceSC.com/providers** and logging in to My Insurance Manager. You can also access claim status through the VRU by calling the appropriate plan.

4.3.4 Corrected Claims

File corrected claims electronically via the HIPAA X12N format or via My Insurance Manager at no charge. You can submit hard copy corrected claims that include the rendering provider NPI as well by filing to the address on the back of the member's ID card. Corrected claims require manual intervention and may increase your claim adjudication times. Corrected claims for BlueChoice plans must be submitted within one year from the original claim receipt date.

You can log in to My Insurance Manager to submit a corrected claim. From the Patient Care menu, choose Professional Claim Entry. The Plan Information page will list your profile information first. Select a plan and indicate whether the plan is the primary payer. Select the billing location, rendering provider and/or referring provider when prompted. You can opt to choose a patient or manually enter the patient's information on the Patient Information page.

On the Claim Information page, select Replacement of Prior Claim from the Claim Type menu. Enter the prior claim number in the required field. Enter the information from the line of your claim. When you are done, select Continue. Confirm the claim information you entered. After reviewing your claim, select Submit.

If you file through a clearinghouse, please contact your vendor for additional information about submitting corrected claims.

If you don't know where the 2300 loop or 2300 NTE ADD fields are in the form you use, contact your software vendor. If your software vendor has additional questions, direct them to call the EDI Helpline.

a. Enter Claim Frequency Type code (billing code) 7 for a replacement/correction, or 8 to void a prior claim, in the 2300 loop in the CLM*05 03.

b. To ensure we process the claim accurately, add a note explaining the reason for the resubmission in loop 2300 NTE (segment) ADD (Qualifier). For example: NTE*ADD* (changed CPT).

c. Enter the original claim number in the 2300 loop in the REF*F8*.

d. 7 — Replace (replacement/correction of prior claim)

e. 8 — Void (void/cancel of prior claim)

4.3.5 Duplicate Claims

BlueChoice will deny any claims you submit after the originals as duplicates. If you have not received payment for a claim, do not resubmit the claim. You should check claim status through My Insurance Manager or VRU.

Our EDI department can work with your clearinghouse if there is a problem with us not getting your claims submissions. Contact EDI by email at **EDI.Services@bcbssc.com** or by phone at 800-868-2505.

4.3.6 Facts About Resubmitting Claims

Before you resubmit a claim because you have not received payment or a response regarding payment, stop and think. By sending another claim, you are adversely affecting the claims payment process and potentially creating confusion for the member.

a. By resubmitting your service(s) a second time, we must conduct an additional investigative step, which lengthens the claim processing time.

b. If you resubmit a claim, we will ultimately deny the claim as a duplicate.

c. The member will receive multiple EOBs for the same service, often resulting in a call to your office and/or ours.

d. Most claims submitted to BlueChoice are processed before 30 days.

e. In fact, most electronically submitted claims are processed within 14 days.

4.3.7 Balance Billing

Participating hospitals, physicians or health care professionals may not bill BlueChoice members for balances above our allowable fees. In your contract with us, it states you shall not look to BlueChoice members for payment for covered services:

"[Provider] agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, or have any recourse against a Member or persons acting on behalf of a Member, except to the extent that the applicable Plan specifies a copayment, coinsurance or deductible."

If the service is not covered, there must be prior written agreement to bill the member for these noncovered services.

You may collect only the applicable cost sharing (i.e., copayment) amounts from the member at the time of service and may not otherwise charge or balance bill the member. Reimbursement is made directly by Blue Choice.

Providers are responsible for getting prior authorization for inpatient facility services for out-of-area members. The member will not be responsible when prior authorization is required but not received for inpatient services. Failure to get necessary prior authorizations will result in claim penalties or denials. Here's what you should know:

- We base the amount of the penalty on your contract and applicable pricing methods.
- The member's plan will continue to determine which services require prior authorization.
- The member will not be responsible and cannot be balance billed unless the member has signed a written consent to be billed prior to rendering the service. Members are liable for services denied as not medically necessary.

Out-of-network providers may balance bill for the difference in BlueChoice's allowable and actual charges.

4.3.8 Overpayment and Refunds

There may be times when we must request refunds of payments previously made to you. When refunds are necessary, we notify you of the claim in question 30 days before any adjustment. The notification letter explains that we will deduct the amount owed from future payments unless you contact us within 21 days.

If you identify we made an overpayment and have not received a notice from us, you can return the overpayment with the Overpayment Refund Form on our website. Provide documentation supporting the refund and include a check for the appropriate amount.

Solicited Refunds. We request solicited refunds when we determine there is a claims overpayment, or we made a payment in error.

Please send the refund to us within the requested 30 days from the date of the letter. You must include a copy of the refund request letter for accurate and timely processing. Send your refund to:

BlueChoice HealthPlan
Attn: Lockbox, AX-A30
4101 Percival Road
Columbia, SC 29223

It is critical that you return the refund within the specified timeframe. If we do not receive the refund within 30 days of the date of the refund request letter, we will systematically offset the amount on a future remittance. The systematic offset is the preferred method for many providers to reconcile refunds. This approach reduces the administrative costs associated with paper processing and minimizes the potential for duplicate refunds.

If you still need more information about a refund, please log into My Insurance Manager and submit your question using Ask Provider Services.

Unsolicited Refunds. Unsolicited refunds are those you voluntarily submit as the result of a possible claims overpayment or a payment made due to a billing and/or processing error.

Please complete all the information on the Overpayment Refund form.

We will review the information to determine the validity of the unsolicited refund request. We'll then determine if we will either adjust the claim to process the unsolicited request or return the request and check with a written explanation of our findings.

4.3.9 Split Billing Preoperative Charges

If lab work is performed within 72 hours of an inpatient surgery, the charges can be billed on the patient claim. They do not have to be split unless the 72-hour time frame has passed.

4.4 Release of Medical Records

In some instances, we may require medical records to process a claim. Please note we do not pay for fees for supplying medical records. Please send the requested information so we can expedite the processing of your claim(s).

We may also need medical records when an admission review is performed or for appeals.

4.4.1 When Medical Records Are Required

If we need records from your office for a member with BlueChoice insurance through another Blue Cross and/or Blue Shield Plan, you will receive a letter from Inovalon® ordering the records. Inovalon is an independent company that coordinates medical records retrieval on behalf of BlueChoice. Having a single records vendor among all Blue Plans streamlines the records request process. It helps eliminate multiple requests from various Plans.

We also collect medical records to gather data to measure our performance, develop quality initiatives such as member outreach programs, and enhance educational programs for providers and members.

You should only receive requests for records from BlueChoice or Inovalon.

- Records requests will only come from Inovalon for nonclaim related requests for out-of-state BlueChoice members.
- You will continue to receive requests from your local BlueChoice for claims-related issues.
- You may receive requests from us or one of our business partners to review medical charts for one or several of your patients in support of HEDIS activities.
- Forward all requested medical records within 10 calendar days.

4.4.2 Claim Attachments

My Insurance Manager has expanded the clinical attachments feature to allow providers to upload medical records and documentation for claims using the Claim Status function.

Select the claim that requires additional documentation. Then choose the Attach Documentation option. Select the PDF file you wish to upload to My Insurance Manager. Once you upload the document, it will encrypt automatically. The claim and documentation will be routed to the appropriate area for review.

Our system will accept up to three PDF documents per request created in Adobe® Acrobat version 1.4 or higher. There is a maximum file size of 30 MB per document.

Refer to the user guide, "What You Need To Know About Claim Attachments," for additional information at **www.BlueChoiceSC.com**.

4.4.3 Nonpayment for Medical Record Requests

You or any entity designated for such responsibilities should not charge BlueChoice for the creation or submission of medical records. As a participating provider, your contract states you agree to permit BlueChoice or one of our business partners to inspect, review and acquire copies of records upon request at no charge. We appreciate you working with your vendors to ensure they understand this contractual arrangement to submit the requested records (on your behalf) without delay or request for payment.

4.5 Guidance for Physician Office

Physicians should file claims electronically to BlueChoice in the HIPAA-compliant 837P (CMS HCFA 1500) format. File with the appropriate place of service codes, procedure codes, modifiers, NDCs, diagnoses, referring physician and rendering physician.

4.5.1 Assistant Surgeon and Co-Surgeon Claims Filing

You should file claims for assistant surgeon services with modifier 80 to indicate you used a surgical assistant.

You should file claims for co-surgeon services with modifier 62. We will review these claims post-procedure to ensure appropriate reimbursement. You should get prior authorizations for requests for assistant surgeons and co-surgeons whenever possible.

4.5.2 Bilateral Procedure Claim Filing

You should file claims for bilateral procedures on one line with the 50 modifier and one unit.

4.5.3 Multiple Procedure Claim Filing

You should file claims for multiple procedures filed on the same date of service on the same line with the appropriate number of units.

4.5.4 Anesthesia Claim Filing

Time Units — You must submit anesthesia claims with the number of minutes in the quantity field. We reimburse all physician and certified registered nurse anesthetist (CRNA) services in 15-minute increments (one-time unit = 15 minutes). We will round units to the nearest tenth.

Modifiers — Anesthesia claims with CPT codes 00100 – 01999 must include one of these modifiers:

Anesthesiologist Modifiers

- AA — Anesthesia services the anesthesiologist personally performed
  - Pricing Formula = (RVU + Time Units) x Conversion Factor
- AD — Supervision of five or more concurrent anesthesia services — BlueChoice does not pay.
- QK — Medical direction by anesthesiologist — two, three or four concurrent procedures
  - Pricing Formula = (RVU + Time Units) x Conversion Factor x 65 percent

- QS — Monitored Anesthesia Care — you must bill with modifier AA
  - Pricing Formula = (RVU + Time Units) x Conversion Factor
- QY — Supervision of one procedure
  - Pricing Formula = (RVU + Time Units) x Conversion Factor x 65 percent

CRNA Modifiers

- QX — Medically directed anesthesia services
  - Pricing Formula = (RVU + Time Units) x Conversion Factor x 50 percent
- QZ — Anesthetist services not medically directed
  - Pricing Formula = (RVU + Time Units) x Conversion Factor x 80 percent

We don't allow additional benefits for other anesthesia services on the same day as services with modifier QZ.

Please note: BlueChoice uses Medicare RVUs to price anesthesia claims.

Risk Factor Modifiers — We only allow risk factor modifiers for anesthesia services when you file the services with the AA modifier. Here are the valid risk modifiers:

- P3 — A patient with severe systemic disease (add one RVU)
- P4 — A patient with severe systemic disease that is a constant threat to life (add two RVUs)
- P5 — A moribund patient who is not expected to survive without the operation (add three RVUs)

Anesthesia Procedures Reimbursed by Fee Schedule

We reimburse for these procedure codes by fee schedule:

- 01967 — Anesthesia for planned vaginal delivery
- 01968 — Anesthesia for cesarean delivery
- 01969 — Anesthesia for cesarean hysterectomy following neuraxial labor anesthesia

We may reimburse CRNAs for epidurals. The CRNA should file with the QX modifier, and the physician should file with the QK modifier. If the physician solely performs the epidural, then use the AA modifier.

4.5.5 Filing Claims for Maternity Services

BlueChoice pays claims for prenatal office visits (routine and nonroutine), delivery and postpartum visits under a global reimbursement arrangement. You should file these claims after the member delivers. Use these CPT codes for global maternity charges:

- 59400 — Routine OB care, including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
- 59510 — Routine OB care, including antepartum care, cesarean delivery and postpartum care
- 59610 — Routine OB care, including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery
- 59618 — Routine obstetric care, including antepartum care, cesarean delivery and postpartum care following attempted vaginal delivery after previous cesarean delivery

You can file claims individually for prenatal visits, delivery and postpartum visits only when the member miscarries, changes physicians, disenrolls, delivers before her 26th week, or if the member is received by her obstetrician or enrolls with BlueChoice after her 34th week. You should use these CPT codes when filing individually for maternity services:

- 59409 — Vaginal delivery only (with or without episiotomy and/or forceps)
- 59410 — Vaginal delivery, including postpartum care
- 59514 — Cesarean delivery only
- 59515 — Cesarean delivery, including postpartum care
- 59612 — Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
- 59614 — Vaginal delivery including postpartum care, after previous cesarean (with or without episiotomy and/or forceps)
- 59620 — Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
- 59622 — Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care

- 99201 to 99215 — Prenatal office visits
- 59425 — Antepartum care only; four to six visits
- 59426 — Antepartum care only; seven or more visits

Special Considerations

- Fetal nonstress test for multifetal gestation is not eligible for additional reimbursement.
- Delivery of multiple babies is not eligible for additional delivery reimbursement through the same opening (vaginal or cesarean).
- Prenatal or childbirth education classes are noncovered services.

Breast Pumps

BlueChoice covers ONE breast pump at no cost for pregnant members, with nongrandfathered coverage, per 12-month period. To receive this benefit, eligible members must use contracted, in-network providers. Members can choose one of two pumps:

- Ameda Finesse electric pump
- Ameda One Hand manual pump

If a member uses a nonparticipating provider or chooses another type of breast pump, the pump may be subject to cost sharing, such as deductibles, copayments or coinsurance.

The Ameda breast pumps are also available for members to order from Ameda Direct online at **www.insured.AmedaDirect.com*** or from Better Living Now at **www.BetterLivingNow.com***.

Members with grandfathered plans may also have benefits for breast pumps. Please be sure to verify eligibility and benefits to determine if your members have this benefit.

4.5.6 Rehabilitative and Habilitative Services

BlueChoice applies separate and distinct benefit limits for habilitative and rehabilitative services for dates of service on and after Jan. 1, 2017, for non-grandfathered plans. This change follows the Notice of Benefit and Payment Parameters for 2016 rule issued in accordance with the ACA.

Habilitative and rehabilitative services defined:

- Habilitative services help a person keep, learn or improve skills and functioning for daily living that have not developed.
- Rehabilitative services help a person keep, restore or improve skills and functioning for daily living that have been lost or impaired after an illness or injury, such as a car accident or stroke.

What you should do:

- File the appropriate modifier for dates of service on or after Jan. 1, 2018.
  - Use modifier 96 for habilitative services.
  - Use modifier 97 for rehabilitative services.
- Review your current coding practice as it relates to the use of these modifiers and the billing of habilitative and rehabilitative services.

This also applies to hospitals and facilities providing habilitative and rehabilitative care.

4.6 Guidance for Hospitals and Facilities

4.6.1 Ambulatory Surgery Center (ASC)

Ambulatory surgery centers should file claims electronically to BlueChoice according to your contract. Prior authorization follows each specific group requirement.

4.6.2 Home Health

Home health providers should file claims electronically to BlueChoice in the HIPAA-compliant 837I (UB-04) format. File with the appropriate bill type and revenue code for the type of treatment as a single line item. You must get prior authorization for all home health services.

Revenue Code	Type of Home Health
551	Skilled Nursing
421	Physical Therapy
441	Speech Therapy
561	Medical Social Worker

Revenue Code	Type of Home Health
571	Home Health Aide
431	Occupational Therapy
279	Wound Care

4.6.3 Hospice

Bill hospice care electronically to BlueChoice in the HIPAA-compliant 837I (UB-04) format using revenue code 651, 655 or 656. You must get prior authorization and reauthorization for all hospice services.

Revenue Code	Type of Home Health
651	Home Hospice Care
655	Respite Care
656	General Inpatient Care

4.6.4 Long-Term Acute Care (LTAC)

LTAC facilities should submit claims electronically to BlueChoice in the HIPAA-compliant 837I (UB-04) format using the appropriate revenue codes. You must get prior authorization for all LTAC services.

4.6.5 Skilled Nursing Facility (SNF)

Skilled nursing providers should file claims electronically to BlueChoice in the HIPAA-compliant 837I (UB-04) format. File with the appropriate bill type and revenue code for the type of treatment as a single line item. You must get prior authorization for all skilled nursing services.

We may consider skilled nursing coverage medically necessary when all these criteria are met:

- Services require a SNF level of care (LOC) and cannot be provided in a less intensive setting.
- Services require the skills of qualified technical or professional health personnel, such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, speech language pathologists or audiologists.
- These skilled nursing or skilled rehabilitation personnel directly provide or generally supervise services to assure the safety of the patient and to achieve the medically desired result.
- You provide services under a plan of care a physician establishes and periodically reviews.

4.6.6 Dialysis

Dialysis providers should file claims electronically to BlueChoice in the HIPAA-compliant 837I (UB04) format.

When filing secondary to Medicare, please be sure to use the appropriate revenue code to ensure secondary processing. Please refer to Exhibit A of your contract for additional billing guidelines.

4.6.7 Inpatient Nonreimbursable Charge/Unbundling Policy

BlueChoice implemented a policy Oct. 1, 2018, to address charges considered to be nonreimbursable, unbundled or are otherwise not allowed to be billed separately. This policy is applicable only to inpatient charges and is not intended to impact care decisions. You can view this policy at **www.BlueChoiceSC.com/providers/provider-self-service-tools-and-payment-resources**.

4.7 Guidance for Ancillary Providers

Ancillary providers are independent clinical laboratory, durable/home medical equipment and supplies and specialty pharmacy providers. You should file claims for your Blue Plan patients to BlueChoice of South Carolina as your local Plan. There are unique circumstances, however, when claims filing directions will differ based on the type of provider and service.

- DME — File to the Plan in whose state the equipment was shipped to or purchased at a retail store. You must file all DME claims with the referring provider NPI number. If you do not include this information, it will delay the accurate processing of your claim.
- Independent Clinical Laboratory (Lab) — File to the Plan in whose state the specimen was drawn.
- Specialty Pharmacy — File to the Plan in whose state the ordering physician is located.

If you contract with more than one Plan in a state for the same product type (i.e., PPO or traditional), you can file the claim with either Plan.

SECTION 5: REFERRALS AND PRIOR AUTHORIZATIONS

5.1 Referrals

5.1.1 Initial Referrals to Specialists

Primary Choice members must have a referral from their primary care physicians before seeking the services of specialists. Once the primary care physician determines a member needs the services of a specialist, the primary care physician is responsible for notifying our Health Care Services department before sending the member to the specialist. To make a referral, the primary care physician's office can either visit our website at **www.BlueChoiceSC.com** or use the Referral Partner Authorization form by visiting the Forms page of **www.BlueChoiceSC.com/find-form**.

We do not accept requests for referrals retroactively. Specialists are responsible for making certain they have valid referrals before seeing members. Therefore, we recommend you use the web to ensure BlueChoice has received the referral.

5.1.2 Web Referrals

The best way for primary care physicians to make referrals to specialists is through our website at **www.BlueChoiceSC.com**. Referrals made through our website are loaded instantly and immediately assigned an authorization number. Just follow these simple steps:

1. Go to **www.BlueChoiceSC.com/providers**.
2. Select Log In on the My Insurance Manager launchpad at the top of the page.
3. Enter your username and password (or select Create New Profile if this is your first visit to our website).
4. Select Authorization/Pre-Certification/Referral.

Please be prepared to enter the member's identification number and date of birth. You will also need to know the specialist's last name and specialty type. Once the referral is complete, you should print a copy of the referral confirmation and fax it to the specialist's office.

5.1.3 Referral Partner Authorization Form

If your office does not have access to the internet, you can use the Referral Partner Authorization form instead. The member's primary care physician's office should complete the form. Once the form is completed, the primary care physician's office should fax a copy to BlueChoice and the specialist's office the same day you make the referral.

Referrals made by the primary care physician only include office visits and office-based procedures that do not require prior authorization. Referrals do not include approval for procedures/services that require separate authorization.

You cannot use web referrals and the referral Partner Authorization form to request authorization for these services:

- Referrals to noncontracting specialists
- Referrals for routine vision care
- Referrals for mental health and substance abuse services
- DME and home care services
- Referrals with diagnosis of obesity, infertility, impotence, or for cosmetic surgery (or any other possible contract exclusion)
- Inpatient or outpatient facility services
- Procedures or services that require prior authorization

If you would like to request any of these services, please contact our Health Care Services department at 800-950-5387 to get prior authorization.

5.1.4 Follow-Up Visits to Specialists

The initial referral from the primary care physician is the approval for all medically necessary follow-up visits and office-based services that do not require prior authorization. It is the specialist's responsibility to keep track of the expiration date of the referral. If the specialist needs to see the member after the initial referral has expired, the specialist must contact the primary care physician's office directly to get a new referral.

5.1.5 Specialist Referral Extensions on the Web

Primary care physicians and specialists can request specialist referral extensions on the Web. The Authorization/Pre-Certification/Referral screen in My Insurance Manager includes additional options. You can request a referral extension through the Request Extension button or by going through the Check Status button. Only approved office visit referrals are available for extension (CPT 99201 – 99255), and specialists may only extend their own referrals.

Please note: If it has been longer than six months since the date the referral expired, the specialist must contact the primary care physician for a new referral.

5.1.6 Expiration Dates for Referrals

Referrals to specialists are valid for six months from the date the primary care physician made the referral and include all medically necessary follow-up visits.

5.1.7 Specialist Referrals to Other Specialists

Typically, only the member's primary care physician initiates referrals. Here, however, are instances when the specialist may need to contact BlueChoice directly to initiate a referral to another specialist:

- Obstetricians — If a member is pregnant, her obstetrician can refer her to other specialists for conditions related to pregnancy. Please use the Maternity Referral Form found on our website or call Health Care Services at 800-950-5387 for approval. Find the applicable form by visiting the Forms page of **www.BlueChoiceSC.com/find-form**.
- Gynecologists — Gynecologists can make referrals to urologists and infertility specialists. (Please note: Not all members have infertility benefits.) Please call Health Care Services at 800-950-5387 for approval.
- All specialists — All specialists can make referrals to oncologists and pain management specialists. Please call Health Care Services at 800-950-5387 for approval.
- Oncologists — Oncologists can refer members to other specialists for services related to their treatment. Please call Health Care Services at 800-950-5387 for approval.
- Nephrologists — Nephrologists can refer members to other specialists for services related to their treatment. Please call Health Care Services at 800-950-5387 for approval.

5.1.8 Exceptions to the Standard Referral Process

- **Initial Maternity Care Visit** — Once a woman discovers or suspects she is pregnant, she can go to her primary care physician or self-refer to her obstetrician. The physician who verifies the member is pregnant should complete the **Pregnancy Notification Form** and fax it to BlueChoice. Find the applicable form by visiting the Forms page of **www.BlueChoiceSC.com/find-form**. For more details, refer to Obstetrical Authorization Procedures in Section 5 of this manual.
- **Vision Screenings** — No primary care physician referral is necessary for routine vision care. The Physicians Eyecare Network (PEN) is an independent company that administers vision benefits on behalf of BlueChoice. Members with vision benefits can go directly to any PEN specialist. Members can call our Customer Service department if they need a listing of the PEN specialists. If a member has a medical problem related to the eye, however, the primary care physician must contact BlueChoice to make a referral to a participating specialist for nonroutine vision care.
- **Mental Health and Substance Abuse Referrals** — Please contact CBA by calling 800-868-1032 or by submitting the appropriate form found in CBA's online Form Resource Center (**forms.CompanionBenefitAlternatives.com***) to get authorization for mental health and substance abuse services. Some members may have a different managed behavioral health organization for mental health referrals. If this is the case, the number will be listed on the back of the member's ID card.
- **Chiropractic Referrals** — Many BlueChoice members have coverage for chiropractic services included in their benefits. If the member has chiropractic benefits, he or she can self-refer directly to any contracting chiropractor. No referral from the primary care physician or prior authorization from BlueChoice is necessary. At the time of the first visit, however, we recommend contacting our Provider Services department at 800-868-2528 or visiting our website to verify individual coverage. Chiropractic benefits may vary. Once the member has exhausted benefits, BlueChoice will no longer cover services. For prior authorization requirements, verify benefits and eligibility through My Insurance Manager.
- **Physical therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)** — PT, OT and ST do not require prior authorization for up to the yearly benefit limits unless they are provided at home. At the member's first visit, we recommend contacting our Provider Services department at 800-868-2528 or visiting our website to review the member's benefits and to make sure he or she has not exhausted his or her benefits. Once the member exhausts his or her benefits, we will no longer cover services. For prior authorization requirements, verify benefits and eligibility through My Insurance Manager.

5.2 Prior Authorizations

5.2.1 Requesting Prior Authorizations

There are some services that routinely require prior authorization or admission certification for BlueChoice. Other services require prior authorization due to the member's contract benefits, type of service or other criteria.

We require you to submit initial prior authorization requests for certain services. To improve the efficiency and quality of processing initial prior authorization requests, we must have you submit, at minimum, this information with your request:

- Member's name
- Database number/subscriber ID
- Date of birth
- ICD-10 diagnosis
- Service: CPT, HCPCS and/or Notification of Emergent Admission
- Provider's name and tax ID or NPI number

Incomplete or missing patient information can prolong the response time to your prior authorization request. The health plan will send a response to the requester that notifies you of missing data.

In the table below are the business partners that provide care management services on behalf of BlueChoice.

Business Partner	Description	Contact Information
Avalon	Prior authorization of certain lab services	Call 844-227-5769 or fax 813-751-3760.
CBA	Prior authorization for mental health services	Call 800-868-1032 or visit **www.CompanionBenefitAlternatives.com***.
Optum Rx	Prior authorization for some medical (injectable/infusible) specialty drugs through MBMNow	**www.BlueChoiceSC.com** (My Insurance Manager) MBMNow
NIA Magellan	Prior authorization for certain advanced radiological procedure, radiation oncology, musculoskeletal interventional pain management/spine surgery, and nuclear cardiology	Visit **www.RadMD.com*** or call 888-642-9181.

Verify prior authorization requirements before providing services. Please note, some services require prior authorization directly through BlueChoice.

Prior authorization is the responsibility of the rendering (or ordering) primary care physician or specialist physician. Once the primary care physician has referred a member to a specialist, it becomes the specialist's responsibility to get prior authorization for services or procedures that require a separate authorization.

Some services and procedures that require prior authorization:

- Inpatient hospital services
  - All inpatient hospital admissions require prior authorization.
  - Prior authorization for most direct emergency admissions is available online.
- Outpatient facility services
  - Infusions and transfusions
  - Surgical procedures
  - Advanced radiology
  - Radiation oncology
  - Some lab services
- Office-based services
  - Colonoscopy (not required if at an ambulatory surgical center [ASC] or facility)
  - Complex pulmonary function tests (except when rendered by pulmonologist or allergist)
  - EGD (not required if at ASC or facility)
  - Nerve conduction studies/EMGs (except when rendered by neurologist, neurosurgeon or physiatrist)
- DME, home health, hospice, orthotics, prosthetics and other medical supplies
- Mental health and substance use disorder services
- Advanced radiology imaging services
- Radiation oncology services

- Laboratory services
- Pharmacy drugs
- Other services

5.2.2 Inpatient Care Prior Authorization

All inpatient hospital admissions require prior authorization. The admitting physician is responsible for getting prior authorization for all elective procedures prior to admission by contacting our Health Care Services department at 800-950-5387. For emergency admissions that occur after hours or on weekends, including antepartum maternity and all deliveries, the facility must notify us on the first business day following the admission or delivery.

We approve benefits for the initial length of stay based on the member's eligibility, admitting diagnosis and medical necessity. One of our RN care management coordinators conducts a concurrent review. The RN care management coordinators receive clinical information directly from the facility by phone, fax or My Insurance Manager. We use Milliman Care Guidelines to assist in medical necessity determinations. A BlueChoice medical director also evaluates these reviews. If we need additional clinical information to determine medical necessity, the RN care management coordinator will contact the facility and/or the physician. During the concurrent review process, the RN care management coordinators will also facilitate discharge planning.

Inpatient hospital prior authorizations include coverage for services of the attending physicians and surgeons, including anesthesiology, pathology and radiology services. The authorization will also cover labs for preadmission testing.

5.2.3 Pulmonary Function Tests

These complex pulmonary function tests require prior authorization except when rendered in a contracting pulmonology/allergy office or a contracting outpatient facility:

- 94011 – 94016
- 94070
- 94150
- 94200
- 94240
- 94250
- 94260
- 94350
- 94360
- 94370
- 94375
- 94400 – 94621
- 94640
- 94642
- 94660
- 94662
- 94667 – 94750
- 94760 – 94779

5.2.4 Durable Medical Equipment (DME), Home Health, Hospice, Orthotics, Prosthetics and Other Medical Supplies

BlueChoice directly manages prior authorizations, claims and network management processes for DME and home care services. BlueChoice will coordinate the delivery and authorization for home care services. BlueChoice directly manages prior authorizations for these services:

- DME (for charges $500.00 or more)
- Hemophilia management
- Home health services
- Home infusion therapy (includes enteral and parental feeding)
- Home occupational therapy
- Home physical therapy
- Home speech therapy
- Hospice care
- Orthotics and prosthetics
- Oxygen and respiratory equipment
- Private duty nursing

You can supply DME under $500 in the physician's office and file it under the physician's tax ID number without prior authorization.

Most services do not require prior authorization. Verify eligibility and prior authorization requirements and use network providers. Please use the Request for Preauthorization of Benefits for Ancillary Services form to request all ancillary services requiring prior authorization. Print, complete and fax the form as indicated. Find the applicable form by visiting the Forms page of **www.BlueChoiceSC.com/find-form**. We only authorize ancillary services via fax.

5.2.5 Mental Health and Substance Use Disorder Services

Many routine mental health and substance use disorder services no longer require authorization. Services, such as admissions, psychological testing and procedures, may require prior authorization. Confirm prior authorization requirements when you verify eligibility and benefits prior to rendering services.

Please contact CBA for prior authorization by calling 800-868-1032 or by using the CBA Initial Outpatient Mental Health Treatment Request Form available at CBA's online Form Resource Center (**forms.CompanionBenefitAlternatives.com***).

It is during the initial evaluation of the member that the type of treatment and number of visits is determined. CBA will encourage the behavioral health specialist to communicate the treatment plan to the member's primary care physician. We consider member benefits and medical necessity during the approval process.

5.2.6 Advanced Radiology Imaging Services

Advanced radiology requires prior authorization through National Imaging Associates (NIA).

Some advanced radiology services included in this requirement are:

- CT and CTA scans.
- CT colonography (CPT 74261 & 74263).
- Coronary CTA.
- MRCP.
- MRI and MRA scans.
- Outpatient interventional radiology services.
- PET scans.
- Stress echocardiology.
- Nuclear cardiology studies, including stress thallium and Lexiscan stress tests.

You can contact NIA online for prior authorizations at its website, **www.RadMD.com***, or by choosing the RadMD link on the BlueChoice website under Providers and then Resources. To get started, simply go to www.RadMD.com* and select the New User button on the right side of the home page. Fill out the application and select the Submit button. The NIA webmaster will respond with your NIA-approved username and password. On subsequent visits to the site, just select the Login button to proceed. You can also contact NIA directly at 888-642-9181.

For more information about advanced radiology services that require prior authorization, please visit **www.BlueChoiceSC.com/providers/precertification**.

5.2.7 Radiation Oncology Services

Radiation oncology requires prior authorization through NIA when performed and billed in an outpatient or office setting.

Some examples of radiation therapy treatment plans that require authorization are:

- Low-dose-rate (LDR) brachytherapy.
- High-dose-rate (HDR) brachytherapy.
- Two-dimensional conventional radiation therapy (2D).
- Three-dimensional conformal radiation therapy (3D-CRT).
- Intensity-modulated radiation therapy (IMRT).
- Image-guided radiation therapy (IGRT).
- Stereotactic body radiation therapy (SBRT).
- Proton beam radiation therapy (PBT).
- Intraoperative radiation therapy (IORT).
- Neutron beam therapy.
- Hyperthermia.

You can initiate prior authorization for these services using **www.RadMD.com*** or by calling NIA at 888-642-9181.

5.2.8 Musculoskeletal Care (MSK)

BlueChoice requires prior authorization through NIA Magellan for interventional pain management spine services when performed and billed in an outpatient or office location. We also require prior authorization for lumbar and cervical spine surgery in an inpatient and/or outpatient location.

- It is the responsibility of the ordering physician to get prior authorization for all interventional spine pain management procedures and spine surgeries outlined.
- NIA Magellan does not manage prior authorization for emergency spine surgery cases that are admitted through the emergency room or for spine surgery procedures outside the procedures listed.
- Providers rendering these services should verify that they have the necessary authorization. Failure to do so may result in nonpayment of the claim.
- Verify prior authorization requirements before providing services. Please note: Some services require prior authorization directly through our Plans.

You can initiate prior authorization for these services using **www.RadMD.com*** or by calling NIA at 888-642-9181.

5.2.9 Nuclear Cardiology

BlueChoice requires prior authorization for nuclear cardiology services through NIA Magellan.

You can initiate prior authorization for these services using **www.RadMD.com*** or by calling NIA at 888-642-9181.

5.2.10 Laboratory Services

BlueChoice requires prior authorization for certain specialized lab procedures when performed in an office or outpatient setting or at an independent lab location. These services must be authorized through Avalon Healthcare Solutions.

Providers must use BlueChoice contracting labs to ensure the highest level of benefits and the lowest cost to patients. Labs are not required to participate in the Avalon network. The Avalon network is a new network of labs, which supplements the existing BlueChoice network.

Some examples of lab procedures that require authorization through Avalon include the following:

- 81223 — Full gene sequence
- 81161 — DMD (dystrophin) (e.g., Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis if performed
- 87901 — HIV-1 reverse transcriptase and protease regions
- 81420 — Fetal chromosomal aneuploidy (e.g., trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18 and 21
- 88245 — Chromosome analysis

You can initiate prior authorization requests with Avalon by calling 844-227-5769 or by faxing 813-751-3760. For more information about this program and a list of applicable lab tests that require prior authorization, please visit the Education Center at **www.BlueChoiceSC.com/providers**.

5.2.11 Genetic Labs and Pathology Testing

Please direct genetic and pathology testing services for BlueChoice members to network participating labs. Labs may require prior authorization through Avalon. You can initiate prior authorization requests with Avalon by calling 844-227-5769 or by faxing 813-751-3760. For more information about this program and a list of applicable lab tests that require prior authorization, please visit the Education Center at **www.BlueChoiceSC.com/providers**.

You have the option of sending cytopathology and surgical pathology specimens to network participating pathology groups. For a listing of the pathology groups contracting with BlueChoice, please refer to the Network Directory on the website.

5.2.12 Other Services That Require Prior Authorization

These procedures require prior authorization regardless of the place of service.

- 24-hour ambulatory blood pressure monitors
- Biofeedback
- Cardiac rehabilitation
- Injectable/infusible chemotherapy
- Neurostimulators (bone, muscle, TENS)
- Pregen
- Radiation therapy (including IMRT)
- Refractive surgeries/services
- Tilt table testing
- Cholesterol subparticle testing (e.g., Berkeley HeartLab, Health Diagnostics Lab)
- Diabetic teaching programs (except at approved facilities — call 800-327-3183, ext. 25305 for list)
- Guided imagery — except when rendered by neurosurgeon
- Pharmacy drugs — certain pharmacy drugs require prior authorization
- Specialty drugs — certain injectable and infusion drugs require prior authorization
- Ultrasound, CT or radiographic bone mineral density studies (CPT 76977, 77078 and 77079 only)
- Varicose vein procedures, including endovenous radiofrequency and laser ablation, ligation and sclerotherapy
- Aquatic therapy
- Capsule endoscopy (CPT 91110)
- Erectile dysfunction or infertility treatment
- Investigational procedures/services
- Other possible contract exclusions
- Pulmonary rehabilitation
- Referrals to noncontracting providers
- Sleep studies
- UPPP/LAUP
- Cosmetic procedures (those without a functional impairment)
- Extracorporeal shock wave lithotripsy of the foot (ESWL)
- Pain management services and/or multidisciplinary programs
- Routine foot care (CPT 11055 – 11057 and 11719 – 11721) and corrective shoes
- Therapeutic blood therapies, including transfusions and dialysis
- Pediatric developmental testing (CPT 96110 and 96111) only available for developmental pediatricians

5.3 Prior Authorization Not Required

BlueChoice does not require you to get prior authorization for certain services when you provide them in a contracting office. Members with an HMO or point-of-service (POS) plan must have a valid referral for office visits on file for high benefits.

5.3.1 Services That Do Not Require Prior Authorization

- Arthrocentesis
- Barium swallow
- Bone scans
- Cardiac event/holter monitor
- CT/MR guidance
- Dilation of anal sphincter
- EKG
- EMG (neurologist and physiatrist only)
- Endometrial biopsy
- Fluoroscopic guidance for needle placement
- Gastric emptying study
- Hemorrhoidectomy
- Hida scan (hepatobiliary scan)
- Ingestion challenge test
- Mammograms (screening or diagnostic)
- Plain film X-rays
- Routine stress test (nonnuclear)
- Sigmoidoscopy
- Urodynamics
- Visual field examination
- Laser treatment for inflammatory skin disease (psoriasis)
- PUVA (does not require authorization if a valid dermatology referral is on file)
- Ultrasounds (abdominal, pelvic, renal, carotid, transcranial doppler, ophthalmic)
- VCUG (If urinalysis is requested, an authorization will need to be loaded to the facility for the UA.)
- Barium enema
- Bone density scans
- Breast biopsies
- Colposcopy
- Cystoscopy
- EEG (neurologist office only)
- Electroretinography with interpretation and report
- Endometrial ablation without hysteroscopic guidance
- Fluoroscopic guidance and localization
- Fundus photography
- Hemorrhoid ligation
- Hemorrhoidopexy
- Hysterosalpingogram (HSG)
- KUB
- Methylprednisolone acetate, injection
- PT/OT/ST
- Scanning laser
- Surgical tray
- Vasectomy in a urologist office (check exclusions)
- Cardiovascular stress test (does not include nuclear echo, i.e., Sestamibi, Thallium, etc.)
- Pulmonary function tests — Simple (See URG under Pulmonary Function Test for specific providers.)
- Retinopathy, treatment or extensive or progressive retinopathy
- UVA and UVB (do not require authorization if a valid dermatology referral is on file)

5.3.2 Primary Care Physician Services

These services and procedures do not require prior authorization when performed by a primary care physician:

- Colonoscopy (45378 – 45392)
- Continuous overnight pulse oximetry (94762)
- Excision of nail (11720 – 11755)
- Flexible sigmoidoscopy (45300, 45330 – 45335, 45338 – 45340)
- Iron injection* (J1750)
- Paring or cutting of benign lesions (11055 – 11057)
- Removal of skin tags (11200 – 11201)
- Spirometry (94010, 94014-94016, 94060, 94070, 94375, 94620)
- U/S bone density measurement (76977), peripheral

*Not covered for ACA plans

5.4 Online Prior Authorization

We are always looking for ways to streamline our prior authorization procedures. Physicians can request prior authorizations online for all inpatient and outpatient services and procedures.

Getting prior authorization online is easy. Just follow these simple instructions:

- Go to **www.BlueChoiceSC.com/providers**.
- Select Log In on the My Insurance Manager launchpad at the top of the page.
- Enter your username and password (or select Create New Profile if this is your first visit to our website).
- Select Authorization/Precertification/Referral.

You can use My Insurance Manager to request prior authorization and submit referrals for all services. We listed these procedures in the Fast Track option for quick and easy access to initiate requests. These lists are not inclusive. We add services and procedures periodically. Please refer to the online guide, "What You Need to Know About Precertifications and Referrals," at **www.BlueChoiceSC.com** for updates and additions.

5.4.1 Clinical Attachments

Use the clinical attachments feature in My Insurance Manager to upload supporting documentation for services that do not automatically approve. Using this upload feature expedites prior authorization requests, since the clinical information is automatically attached to the case and forwarded to our clinicians for review. Other information to keep in mind:

1. This feature only accepts PDF documents that have been created in Adobe Acrobat version 1.3 or higher.
2. Each document can be up to 30 MB in size.
3. You can upload up to 10 attachments per request. You can attach more if necessary when you check the authorization status.

Refer to the user guide, "What You Need To Know About Clinical Attachments," for additional information at **www.BlueChoiceSC.com**.

5.4.2. Medical Forms Resource Center (MFRC)

The MFRC is an online tool which allows you to submit prior authorization requests for some services electronically for BlueChoice members.

When you submit an MFRC request, it goes through a server that has the highest security certificate available for secure communications. The information is transferred to our private network where it is inaccessible from the Internet.

The MFRC's one-way data transfer ensures the safety and privacy of the clinical information you submit to us. The MFRC can help you save time, cut down on miscommunication, prevent omissions, and ensure safe and accurate communication of your clinical data.

When you complete an MFRC request, you'll be prompted to provide clinical information specific to the selected service. This ensures we receive the minimum necessary information to process your request quickly and accurately.

The electronic format ensures that when we receive your data, it is clearly legible. This helps prevent follow-up calls for faxes that didn't transmit or print properly.

Prior authorization requests submitted through the MFRC additionally receive priority processing.

To use the MFRC, visit **www.FormsResource.center** or **www.BlueChoiceSC.com/providers/precertification**. Select General Precertification.

5.5 Obstetrical Authorization Procedures

5.5.1 Great Expectations Maternity

BlueChoice members can enroll in our maternity program at any point during their pregnancy. Great Expectations

Maternity provides educational materials and ongoing support and monitoring by our nurses and health educators throughout the pregnancy and postpartum period. If you would like to talk with someone about this program, please call us at 855-838-5897.

See Section 6 for additional information about this program.

5.5.2 Global Maternity Authorization

Once a member discovers or suspects she is pregnant, she can go to either her primary care physician or self-refer to her obstetrician. The physician who verifies the member is pregnant should immediately initiate the maternity authorization by completing the Pregnancy Notification form and faxing it to BlueChoice. Visit the Forms page of **www.BlueChoiceSC.com/find-form**. We developed this form as a mechanism for the physician and BlueChoice to monitor members who are at risk for delivering low birth weight or otherwise high-risk infants.

Once we receive the form, our Maternity Services department will authorize global maternity care. We will send a confirmation letter to the obstetrician, primary care physician and member.

5.5.3 Services Included in the Maternity Authorization

The global fee, which is to be billed after delivery, includes all prenatal visits (routine or nonroutine), delivery and postpartum care. Once you get the initial maternity authorization, you can perform these services in the obstetrician's office and bill them separately without additional authorization:

- Ultrasounds
- Amniocentesis
- Nonstress tests
- Biophysical profiles
- RhoGAM injections

Please note: BlueChoice will pay for these services without a separate authorization if they are medically necessary. We may request medical records to confirm medical necessity. We do not consider ultrasounds performed solely to determine sex to be medically necessary. Should we identify a service as not medically necessary, we will deny coverage of the service or request a refund from your office. In these circumstances, the member is not liable for the charges.

5.5.4 Services Provided in the Obstetrics Office That Require Prior Authorization

BlueChoice only needs to separately authorize services that are not related to maternity care. We will not cover nonmaternity services provided without authorization.

Several maternity services rendered outside the obstetrician's office require prior authorization. You can request BlueChoice prior authorize these services by calling BlueChoice at 800-950-5387 or by faxing the Maternity Referral form found on our website to 800-610-5685. You may be held responsible for these services if received by the member without prior authorization.

Examples of services that require prior authorization:

- Referrals for outpatient services, including amniocentesis, nonstress tests and biophysical profiles (no separate authorization for outpatient fetal nonstress test [59025] is required if filed with one of these diagnostic codes: 643.91 – 645.20, 648.84 – 648.94.)
- Referrals to other specialists (maternity or nonmaternity related)
- Labs, pathology and genetic testing sent to a noncontracting facility
- External cephalic version
- Referrals for inpatient services, including all deliveries

In accordance with federal guidelines, we will authorize a minimum four-day inpatient length of stay for a vaginal delivery, and we will authorize a minimum three-day inpatient length of stay for a cesarean section delivery. Hospital-affiliated birthing centers (or birthing centers a hospital owns) are a covered benefit for some groups. A maternity authorization must be on file for the hospital-affiliated birthing center.

5.5.5 Referrals to Specialists During Pregnancy

While the member is pregnant, her obstetrician can serve as her primary care physician and refer her to other specialists when necessary. These referrals can be maternity or nonmaternity related. Once it is determined that you need to refer the member to a specialist, it is the obstetrician's responsibility to get authorization from BlueChoice. If her primary care physician has treated the member for the condition, or if it is something that the primary care

physician can treat, we may request that you send the member to her primary care physician. You can get authorization for referrals by calling BlueChoice at 800-950-5387 or by faxing the Maternity Referral form found on our website to 800-610-5685.

5.5.6 Genetic Labs and Pathology Testing

Please direct genetic and pathology testing services for BlueChoice members to network participating labs. Labs may require prior authorization through Avalon. You can initiate prior authorization requests with Avalon by calling 844-227-5769 or by faxing 813-751-3760. For more information about this program and a list of applicable lab tests that require prior authorization, please visit the Education Center at **www.BlueChoiceSC.com/providers**.

You have the option of sending cytopathology and surgical pathology specimens to network participating pathology groups. For a listing of the pathology groups contracting with BlueChoice, please refer to the Network Directory on the website.

5.6 Other Services

5.6.1 Diabetes Education, Insulin Pumps and Supplies

Diabetes education does not require prior authorization when provided at an approved center. Members with diabetes and prediabetes can attend an education program at one of our contracting centers with no copayment, deductible or coinsurance. Members can contact Customer Service for more information.

We provide glucose monitors free of charge to our members with diabetes. Our preferred monitor is OneTouch® (product of Lifescan Inc.*). Using the preferred model reduces the member's copayment for testing strips. Also, all other glucose test strips require prior authorization for medical necessity. Members on insulin pumps who need to use another glucose monitor/test strip may be granted a lifetime override for that test strip upon request by the member or physician.

To order a glucose monitor, the patient or physician's office can call us at 855-838-5897. We will send the patient a free monitor in three to five business days.

Note: Please do not give the member a prescription for the monitor. The member's pharmacy benefit does not cover monitors. We do, however, cover strips under the pharmacy benefit, so the member will need a prescription for the strips indicating how often you want him or her to test. Requests for more than 200 test strips per month require prior authorization.

We cover insulin pumps and continuous glucose monitor systems after the member meets medical necessity criteria up to the limits of his or her DME benefit maximum. The physician's office that is managing the pump therapy must complete the Precertification for Medical Necessity External Insulin Infusion Pump form found on our website. You can only request continuous glucose monitoring systems by completion of the Precertification for Medical Necessity Continuous Glucose Monitoring System form.

We cover diabetic shoes (one pair per year) and inserts (two pairs per year) if medically necessary. Please be prepared to provide clinical information. The member's financial responsibility will depend on his or her individual coverage.

Members with diabetes may receive a diabetic care voucher. The purpose of the voucher is to encourage the member to schedule a visit with his or her physician to get recommended screening tests and review his or her diabetes care plan.

BlueChoice members who present this voucher are entitled to a maximum of one 30-minute physician visit at no charge to the member in a calendar year. Additional visits during the calendar year are subject to applicable copayments, deductibles and coinsurance.

When you submit a claim using either of the codes and diagnoses listed, we will reimburse you at 100 percent of allowable charges by BlueChoice. You can submit evaluation and management codes with your claim. The additional codes will be subject to deductible and coinsurance. You should not charge members a copayment for this visit. As this voucher is for a diabetes care visit to review the member's diabetes care plan and make appropriate adjustments, we ask that you consider these tests as supported by the American Diabetes Association during the visit:

- HbA1C test (send to network participating laboratories)
- LDL cholesterol (send to network participating laboratories)
- Urine microalbumin test (performed in office or send to network participating laboratories)
- Blood pressure measurement
- Encourage your patient to get an eye exam

Submit your claim using one of these CPT codes for this benefit:

- 99401 — Preventive Medicine Counseling, Individual, 15 minutes
- 99402 — Preventive Medicine Counseling, Individual, 30 minutes
- Allowable primary diagnosis codes: E10.9, E11.9, E10.65, E11.65, E11.69

Microalbumin tests (CPT codes 82043 and 82044) are recommended by the American Diabetes Association at least once a year for patients with diabetes. These tests can be performed in the physician's office or sent to network participating laboratories without authorization. The American Diabetes Association is an independent organization that provides health education information on behalf of BlueChoice.

We cover diabetic eye exams for all our members with diabetes at no cost. If the member has routine vision benefits, he or she can self-refer directly to any PEN participating provider. If the member does not have routine vision benefits, he or she can still receive a free exam by contacting the Great Expectations Diabetes program at 855-838-5897 for details.

5.6.2 Asthma Supplies

Peak flow meters are provided free of charge to BlueChoice members with asthma, upon request, if supplies are available. The member or physician can call 855-838-5897 and select option 2 to order.

We cover spacers under the member's pharmacy benefit. They are available at the middle tier, preferred copayment. We only cover Aerochamber® spacers, with or without a mask. We limit this benefit to one per year. To get a spacer, the member must take a prescription for the Aerochamber to a contracting pharmacy.

Nebulizers are a 10-month, rent-to-purchase item for our members with asthma, reactive airway disease or COPD.

5.6.3 Emergency Medical Care

BlueChoice members are instructed to contact their treating physicians, if possible, before seeking medical services in an emergency department (ED). If the treating physician sends the member to the ED, the physician should contact us the next business day so we can provide an authorization. This will eliminate the need for the claim to meet medical necessity criteria. If the member goes to the ED without a referral from his or her physician, we will process the claim according to "prudent layperson" criteria. If the member self-refers to the ED and the claim does not meet prudent layperson criteria, payment of the claim will be the member's responsibility.

Definition of "prudent layperson criteria" — a medical condition manifesting itself by acute symptoms of enough severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

5.6.4 Using Ask Health Care Services

If you have a question for the Health Care Services department, you can use the Ask Health Care Services button located in My Insurance Manager. This button takes you to a screen where you can ask a question or opt out to STATchat to speak with a representative.

If you ask the question via the web, we will provide a response within one business day via the Your Mailbox feature. Enter the question in the box indicated. Note the ID number and date of birth of the patient you are referencing. Also include the authorization number if applicable. Be sure you select Submit after entering your information.

To retrieve your response, go to Your Mailbox in My Insurance Manager. Choose BlueChoice HealthPlan, type in the member ID number and select Continue. You will see the response. Select Response to get the answer to your question.

SECTION 6: UTILIZATION MANAGEMENT, DISEASE MANAGEMENT AND MANAGED CARE PROGRAMS

6.1 Utilization Management

UM is the evaluation of the appropriateness and medical need of health care services procedures and facilities according to evidence-based criteria or guidelines, and under the provisions of an applicable health benefits plan. Typically, UM addresses new clinical activities or inpatient admissions based on the analysis of a case, but may relate to ongoing provision of care, especially in an inpatient setting.

UM describes proactive procedures, including discharge planning, concurrent planning, prior authorization and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews and appeals introduced by the provider, payer or patient. An UM program comprises roles, policies, processes and criteria.

UM roles may include UM reviewers (often an registered nurse with UM training), an UM program manager and a physician advisor. UM policies may include the frequency of reviews, priorities, and balance of internal and external responsibilities.

UM processes may include escalation processes when a clinician and the UM reviewer are unable to resolve a case, dispute processes to allow patients, caregivers, or patient advocates to challenge a point of care decision, and processes for evaluating inter-rater reliability amongst UM reviewers.

6.2 Great Expectations for Health and Disease Management Programs

As a managed care organization, BlueChoice understands the importance of integrating chronic condition management and preventive services with other components of the health care delivery system to support the health of our members. As a result, we offer Great Expectations for Health, a set of health management programs that addresses a variety of health issues. Unless otherwise noted, we offer these programs free of charge to our members. Enrollment in these programs occurs when we identify members internally through claims or clinical data, or when physicians refer them. Physicians should call the phone numbers listed with each program described here to refer a member to the respective program. Members can also self-refer to these programs by telephone or via web enrollment. Membership is voluntary and in no way affects a member's benefit plan. Individual employer groups, not the health plan, establish any benefit design incentives for participating in programs.

6.2.1 Adult Attention-Deficit Hyperactivity Disorder (ADHD)

CBA offers the Health Coaching for Adult ADHD program. The program helps members understand ADHD and the best ways to manage it through personalized coaching. Services include guidance and support during three scheduled phone calls, identifying outpatient providers and community resources, help with setting long-term and short-term goals, and providing tools to help manage medications and appointments. For more information, please contact CBA at 800-868-1032, ext. 25835.

6.2.2 Alcohol

CBA offers the Health Coaching for Substance Use (Recovery Support) program. The program helps members prevent relapses and maintain sobriety through personalized coaching. Members can use this support program along with other forms of treatment to help coordinate their steps to recovery. Services include guidance and support during scheduled phone calls, assistance with developing a plan of care, help with setting long-term and short-term goals, and educational and community resources. For more information, please contact CBA at 800-868-1032, ext. 25835.

6.2.3 Asthma

The Great Expectations Asthma program helps members learn how to manage their asthma and improve their quality of life. Through educational outreach and phone calls, experienced respiratory therapists provide education about asthma and support for complying with each member's physician's plan of care. Members can also request a free peak flow meter. For more information, please contact us at 855-838-5897, option 2.

6.2.4 Back Care

The Great Expectations Back Care program helps members learn to take care of their backs. Participants receive information on how to effectively communicate with their health care provider(s), questions to ask your doctor, and options for pain management, including physical and behavioral therapies, self-care, and building an action plan to prevent future problems. Members with severe, chronic back pain will be considered for case management. For more information, please contact us at 855-838-5897, option 3.

6.2.5 Bipolar Disorder

CBA offers the Health Coaching for Bipolar Disorder program. Services include guidance and support during scheduled phone calls, help with setting long-term and short-term goals, and educational and community resources. For more information, please contact CBA at 800-868-1032, ext. 25835.

6.2.6 Case Management

The Great Expectations Case Management program is for members with the need for extraordinary health care. Experienced nurse case managers work with members, their families and caregivers, and the members' medical team to help coordinate services to meet the physician's treatment plan. Physicians can refer members for case management evaluation by calling 800-327-3183, ext. 25370.

6.2.7 Childhood Obesity

The Great Expectations Healthy and Active Kids program identifies children who are overweight or obese and offers their families education and interactive tools and incentives for adopting healthy habits. For more information, please contact us at 855-838-5897, option 3.

6.2.8 Chronic Kidney Disease

Great Expectations Chronic Kidney Disease program helps members with stages 1 – 3 kidney disease learn how to manage their condition and reduce the risk of developing complications. The program consists of educational materials, individualized health coaching, access to interactive online resources, newsletters and important health reminders. For more information, please contact us at 855-838-5897, option 2.

6.2.9 Chronic Obstructive Pulmonary Disease (COPD)

Great Expectations COPD is an individualized program that helps members learn how to manage their disease and minimize complications. Our goal is to support members in practicing recommended self-care behaviors and following their physician's plan of care. Members may receive educational materials, telephonic coaching, access to online resources and newsletters as appropriate. For more information, contact us at 855-838-5897, option 2.

6.2.10 Depression

CBA offers the Health Coaching for Depression program. The program educates members about depression, antidepressant medications and the importance of following their physicians' recommendations for care. Members receive educational materials and phone calls from registered nurses and social workers who offer an initial assessment and follow-up coaching sessions. For more information, please contact CBA at 800-868-1032, ext. 25835.

6.2.11 Diabetes

The Great Expectations Diabetes program helps members learn how to manage their diabetes and reduce the risk of developing complications from their disease. Members may receive educational materials, telephonic coaching, access to online resources and newsletters as appropriate. For more information, please contact us at 855-838-5897, option 2.

6.2.12 Heart Disease

Great Expectations Heart Disease program is for members with coronary artery or ischemic heart disease. The program educates members about lifestyle modifications and evidence-based guidelines for the monitoring and control of cardiac risk factors, such as hyperlipidemia and hypertension. Members may receive educational materials, newsletters, reminder phone calls and case management services, as appropriate. For more information, please contact us at 855-838-5897, option 2.

6.2.13 Heart Failure

The Great Expectations Heart Failure program educates members with heart failure about appropriate self-care strategies to minimize exacerbation of their condition, prevent complications and maintain their quality of life. Members may receive educational materials, newsletters, reminder phone calls and case management services, as appropriate. For more information, please contact us at 855-838-5897, option 2.

6.2.14 High Blood Pressure

The Great Expectations High Blood Pressure program is designed to help members learn more about managing their blood pressure. The program educates members about lifestyle modifications and evidence-based guidelines for the monitoring and control of cardiac risk factors, such as hypertension. Members may receive educational materials, telephonic coaching, access to online resources and newsletters, as appropriate. For more information, please contact us at 855-838-5897, option 2.

6.2.15 High Cholesterol

The Great Expectations High Cholesterol program is an educational program for members who want to learn more about managing their cholesterol. The program educates members about lifestyle modifications and evidence-based guidelines for the monitoring and control of cardiac risk factors, such as high cholesterol. Members may receive educational materials, newsletters, reminder phone calls and case management services, as appropriate. For more information, please call us at 855-838-5897, option 2.

6.2.16 Maternity

The Great Expectations Maternity program provides tailored, comprehensive education, tools and support to help members take steps toward having a healthy baby. We provide support and monitoring throughout the members' pregnancy and postpartum period. Women are invited to enroll in the program at no charge when a primary care physician or obstetrician sends in a maternity authorization form or notification of pregnancy. Members may also self-refer. For more information, please contact us at 855-838-5897.

6.2.17 Metabolic Health

The Great Expectations Metabolic Health program helps members learn how to manage prediabetes and/or metabolic syndrome, reducing the risk of developing complications such as Type 2 diabetes and heart disease. Metabolic syndrome is the name of a group of conditions linked to being overweight or obese. Members may receive educational materials, telephonic coaching, access to online resources and newsletters, as appropriate. For more information, please contact us at 855-838-5897, option 2.

6.2.18 Migraine

The Great Expectations Migraine program is for adults who suffer from severe, recurrent headaches. We provide information about the importance of having a personal physician to guide headache management. Members may receive educational materials about pertinent migraine-related topics, telephonic coaching, access to online resources and newsletters, as appropriate. For more information, please contact us at 855-838-5897, option 2.

6.2.19 NICU Case Management

NICU Case Management offers services to infants who have certain conditions. These conditions include but aren't limited to complications associated with premature birth, congenital birth defects, hydrocephalus, seizures, cystic fibrosis and genetic disorders. Clinically experienced certified nurse case managers work closely with the caregiver and the member's providers to ensure ongoing communication and coordination of care. For more information, please contact us at 855-838-5897.

6.2.20 Stress Management

Great Expectations Stress Management program is an early intervention program designed to help members develop a personalized plan to deal with stressors in a way that does not adversely affect their health. For more information, contact CBA at 800-868-1032, ext. 25835.

6.2.21 Tobacco Cessation

Great Expectations Tobacco Cessation program is for members ages 18 and above and provides support and resources to help members become tobacco-free. This program guides members through deciding to quit, identifying triggers and overcoming the challenges of giving up tobacco. For more information, please contact us at 855-838-5897, option 3.

6.2.22 Weight Management

Great Expectations Weight Management is a program designed to educate members about healthy eating, exercise, and other behavior modification strategies to reach and maintain a healthy weight. Members may receive educational materials, telephonic coaching, access to online resources and newsletters as appropriate. For more information, please contact us at 855-838-5897, option 3.

6.3 Prescription Monitoring Program

The South Carolina Reporting & Identification Prescription Tracking System (SCRIPTS) is required for use by all providers that prescribe opioids to BlueChoice members from category II – IV controlled substances. It is recommended that use of this program should be a part of every patient's care. It is intended to improve the state's ability to identify and stop diversion of prescription drugs in an efficient and cost-effective manner that will not impede the appropriate medical use of licit controlled substances where there is a valid prescriber-patient or pharmacist-patient relationship.

If you receive a letter from us that indicates your patient has been identified as overusing/abusing a prescription drug you can review SCRIPTS to gauge prescribing patterns for that patient. Talk with your patients about any adverse findings found on their SCRIPTS report. Let them know that you can lawfully monitor his or her prescriptions in accordance with SC Code Ann. Section 44-53-1610 et. seq. (Prescription Monitoring Act).

SCRIPTS is a free service designed to help physicians monitor patient behavior. Create an account to use SCRIPTS at **SouthCarolina.PMPAware.net**.

6.4 Health Care Services

Illness or injury can impact anyone. The complexity of the health care system is often confusing to patients. Our Health Care Services team is available to help you ensure that patients receive the services they need.

Case Management — A physician can contact Health Care Services to request evaluation for case management services or to discuss a member's treatment. A registered nurse case manager will then review information from the physician, member and other appropriate sources to determine if the member is a candidate for case management. Once we have reviewed a referral, we either accept or decline the case. If we accept the case, the case manager will contact the member, identify problems, develop a care plan, develop primary goals and establish interventions, all in coordination with the physician's treatment plan for the member.

Medical Management — BlueChoice's clinical staff represents multiple specialties. Our goal is to help patients move through the health care system and assist them in receiving needed care.

To contact a registered nurse care management coordinator on the Inpatient team, please call 800-950-5387 and select option 6.

SECTION 7: PROVIDER POLICIES

7.1 Medical Policies

Medical policies consist of medical guidelines that are used when making clinical determinations in connection with a member's coverage under a health plan. The medical policies and associated medical guidelines are interpreted and applied at the sole discretion of the health plan fiduciary and may be subject to state or federal laws.

These guidelines are accessible to you on our provider websites. You can also contact our Medical Affairs department if you have questions about our medical policies.

Medical guidelines are based on medical research that provides evidence of scientific merit (or the lack of scientific merit) for medical services as related to medical conditions. Medical guidelines are based on appropriate and available medical research available at the time they are written. Because of the changing nature of medical science, medical guidelines are reviewed and updated periodically. Accordingly, the information on the web is provided for information only and may not reflect a recent policy change or all the applicable medical guidelines.

The inclusion of a medical guideline on the website does not indicate that the referenced service (or supply) is necessarily available to a member. For a determination of the benefits that a member is entitled to receive under his or her health plan, such member's health plan must be reviewed. In the event of a conflict between the medical policy and any health plan, the express terms of the health plan will govern. The existence of a medical guideline is not an authorization, certification, explanation of benefits, or a contract for the service or supply that is referenced in the medical guideline.

Medical guidelines are written to address frequently occurring clinical situations. However, because of the variety of clinical circumstances, some services or supplies or conditions addressed in the medical guidelines may be appropriate for additional, individualized review.

Medical Policies are not medical advice and do not guarantee any results or outcomes.

7.2 Medical Review

If a provider submits an appeal without written consent from the member, this is referred to as provider reconsideration. Physicians and physician groups may file provider reconsideration if they disagree with the adjudication of a claim.

Provider reconsiderations are forwarded to and handled by the Provider Services team. Member appeals are forwarded to and handled by the Appeals team.

7.2.1 Medical Necessity Criteria

BlueChoice uses Milliman Care Guidelines criteria for determining appropriateness of benefit application. In situations where Milliman does not have criteria, we use the Blue Cross and Blue Shield Association Uniform Medical Policy Manual, Technology Evaluation Center assessments, or criteria developed by our Policy and Procedure Committee. For information on how to receive a copy of any criteria we use in our decision making, please call Health Care Services at 800-950-5387. Many of our medical policies are also available on our website at **www.BlueChoiceSC.com/providers/medical-policies**.

7.2.2 Member Appeals

BlueChoice members have the right to submit an appeal if a claim has processed with an adverse determination. An adverse determination is a denial or penalty that unfavorably affects the member, such as increased liability. Members can give written authorization for a physician or physician group to appeal on their behalf. Use of the Designation of Authorized Representative to Appeal Form is optional for use by any individual or physician to appeal on behalf of a member. This form is located at **www.BlueChoiceSC.com/find-form**. Be sure to select the Providers check box.

7.2.3 Expedited Appeals

If you or a member believes a denial of coverage of pending medical services warrants immediate appeal due to the medical urgency of requested services, you or the member can request an expedited appeal. An expedited appeal related to preservice medical necessity must indicate that a delay in decision making might seriously jeopardize the life or health of the member; or if a member's physician certifies that the member has a serious condition that requires immediate medical attention to avoid serious impairment to bodily functions, serious harm to an organ or body part, that would place the member's health in serious jeopardy; or if in the opinion of a provider with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. If BlueChoice determines that the appeal qualifies for expedited status, we will process the appeal and notify all involved of our decision within 24 to 72 hours of the receipt of all information necessary to complete the appeal, dependent upon the plan's nongrandfathered versus grandfathered status.

7.2.4 Preservice Appeals

Members can request internal appeals of adverse determinations related to medical necessity or the experimental or investigational nature of any proposed health care service or supply. Physicians shall have the right to file an appeal of an adverse determination prior to rendering the service (preservice appeal) if they are appealing on behalf of the BlueChoice member. If you are appealing on the member's behalf, you must get authorization from the member in writing. If you file a preservice appeal on behalf of the member, we will handle it under the appeal process available to its plan member based on the terms of that plan member's plan and the applicable state and federal laws and regulations.

7.2.5 Independent Review Organization Requests

Certain medical necessity appeals may qualify for review by an independent review organization (IRO). These requests are the member's second and final level of appeal. Requests must be in writing, initiated by the member or legally authorized member representative, and must meet these criteria in accordance with the SC Department of Insurance (SCDOI) Guide to External Review, Bulletin Number 2001-4(A):

- The service or payment for service was denied, reduced or terminated because either:
  - The service does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.
  - The service was experimental or investigational and involves a life-threatening or seriously disabling condition.
- The amount payable for covered benefits is at least $500 for grandfathered plans. Nongrandfathered plans do not have a required minimum dollar amount.
- The BlueChoice internal appeals process has been completed.

To qualify for this type of appeal, you must exhaust the internal BlueChoice appeal process and you must request the external appeal process within 90 days of the original appeal. Additionally, the disputed service amount must be more than $500 for grandfathered plans. Nongrandfathered plans do not have a required minimum dollar amount.

7.2.6 Medical Director Access

If a physician disagrees with a clinical decision BlueChoice makes about the denial of coverage of services, the physician can discuss the case with our medical director. Please dial 800-950-5387 and select option 5 to leave a message for the medical director. Include the member's name and identification number along with the clinical service in question. The medical director will then return your call, generally within one business day.

7.2.7 Provider Reconsiderations

Providers have no appeal rights. Contracting providers, however, can request a reconsideration. Provider reconsideration is a provider's written request for review of a prior benefit decision. This is a voluntary process we offer to ensure the benefit decision was correct.

A provider can pursue provider reconsideration by using the Provider Reconsideration Form. This form is intended for use by physicians and other health care professionals in South Carolina only. It is at **www.BlueChoiceSC.com/find-form**. Be sure to select the Providers check box. Complete the form in its entirety and use it as a cover for all supporting documentation. A request must be submitted within 90 calendar days of the earliest adverse determination notification. You must include pertinent clinical or other documentation necessary to support the reconsideration. Physicians have only one level of reconsideration.

Send the Provider Reconsideration Form to the appropriate Plan fax number or address as provided on the form.

If a provider is found to consistently file provider reconsideration requests for inappropriate reviews, an education specialist may initiate a training session to discuss proper procedure.

7.2.8 Determinations

It generally takes BlueChoice 30 days to complete provider reconsideration reviews. After the review is complete, the appropriate service area will initiate claim adjustments or generate letters of denial to providers.

7.3 Coverage for Appropriate Services

BlueChoice is committed to providing a comprehensive plan of services and benefits to our members. As a part of this commitment, BlueChoice:

- Makes decisions about the coverage of services based on appropriateness of care and services and whether they are provided in accordance with the member's plan of benefits.
- Does not compensate any decision-makers for denying coverage of care or services.
- Does not offer any incentives to encourage denials.
- Monitors utilization of services to identify potential problems of underutilization.

BlueChoice encourages open physician-patient communication about appropriate treatment alternatives. This includes medication treatment options and does not penalize, discourage or in any way create disincentives for physicians to discuss medically necessary or appropriate care for the patient regardless of coverage.

7.4 Our Privacy Practices

BlueChoice knows it is important to protect the privacy of our members' confidential medical information. Here are some of the steps we have taken to protect the privacy of confidential information:

- We require all staff, consultants and business associates to keep confidential any personal health information they learn in performing their jobs. We require all physicians and other health care providers to maintain the confidentiality of this information. They must guard against unauthorized or inadvertent disclosure of confidential information. Practice staff must receive periodic training in member information confidentiality. BlueChoice will review this as part of our general medical record review process.
- We require any entity with which we contract for clinical or administrative services to maintain such confidentiality and to have a privacy policy in place that protects against unauthorized use or disclosure of confidential information. All such entities must sign an agreement attesting that they are compliant with federal privacy regulations.
- We have advanced security systems to limit unauthorized access to information in our computer files.
- We keep any medical information we get from physicians and other health care providers in a secure area, and we limit access to authorized staff. We also require physicians and other health care providers to keep medical records in a secure area, and we monitor this through on-site visits to their offices.

Please go to our website to review our Notice of Privacy Practices.

7.5 Communication Between Physicians

Communication between primary care physicians and specialists is very important for the continuity and coordination of care. BlueChoice has evaluated physicians' satisfaction with the communication they receive and have found that both primary care physicians and specialists have some level of dissatisfaction. You can use the Physician Communication Summary Visit Report for any communication between primary care physicians and specialists about a patient. Using this form can minimize the need to send dictated letters, and thus minimize the administrative burden of communication with other physicians. We encourage you to consider using this form which can be found on our website in the Providers' section under Forms.

7.6 Subrogation, Worker's Compensation

7.6.1 Subrogation

A BlueChoice member's health contract contains an important clause called "subrogation" or "reimbursement." This means when BlueChoice pays medical bills for an injury or illness that has been caused by a third party, we have a right to seek reimbursement of those medical bills from the third party, the third party's insurance company and/or the member's insurance company.

BlueChoice' staff of physicians has established a list of diagnosis codes that indicate an injury or illness may be accident related or work related. When a BlueChoice member is involved in a subrogation case, you should treat the patient as any other BlueChoice member. We will pay benefits directly to your office. If the court deposes you, or requests that you file certain forms or render care over and above what is considered medically necessary, you should collect any related fees from the other insurance carrier or the attorney representing the carrier.

7.6.2 Workers' Compensation

BlueChoice does not cover treatment of an occupational illness or injury that workers' compensation covers. You should treat the member and follow the normal procedures for filing workers' compensation claims. If there is any question whether workers' compensation covers the treatment, please follow all normal BlueChoice referral and authorization procedures.

7.7 Coordination of Benefits (COB)

Member contracts contain a COB provision to ensure we provide correct benefits on claims for members with more than one health/dental coverage plan.

Have your patient complete the Online Other Health/Dental Insurance Questionnaire form to give BlueChoice information about possible other health/dental coverage, including Medicare, to process your claims correctly. Download a form at **www.BlueChoiceSC.com/find-form**. Be sure to select the Providers check box.

7.7.1 Filing COB Claims

Please file your secondary claims along with a copy of the primary carrier's EOB. Secondary claims can be filed electronically and through My Insurance Manager.

7.7.2 Determining Primary vs. Secondary

To determine which policy is primary, we apply these COB rules in this order:

1. Nondependent/Dependent — The group plan provided where an employee works is primary for the employee. If the same employee also has coverage as a dependent under a spouse's plan, the spouse's plan is secondary.
2. Dependent Child: Parents Not Separated or Divorced — When the same child is covered as a dependent of different persons, called "parents":
   a. The plan of the parent whose birthday falls earlier in a year is primary to the plan of the parent whose birthday falls later in that year.
   b. If both parents have the same birth date, the plan that has been in effect longer is primary. The reference to "birth date" means only the month and day. It does not refer to the year of birth.
3. Dependent Child: Parents Separated or Divorced — When a child has coverage as a dependent under two or more plans of divorced or separated parents, we determine coverage responsibility in this order:
   a. First, the plan of the parent with custody of the child
   b. Then, the plan of the spouse of the parent with custody of the child
   c. Then, the plan of the parent not having custody of the child

If the court has determined that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of the parent has actual knowledge of those terms, however, the benefits of that plan are primary. The plan of the other parent is considered secondary.

4. Joint Custody — If a court has determined that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the primary plan will be determined according to Rule 2.
5. Active/Inactive Employee — The plan that covers a person as an employee who is neither laid off nor retired (or that employee's dependent) is primary to the plan that covers that person as a laid off or retired employee (or that employee's dependent).
6. Longer/Shorter Length of Coverage — If none of the rules applies, the plan the member has been covered under the longest is primary.
7. Medicare — BlueChoice is secondary to Medicare except when federal law mandates BlueChoice to be the primary plan. Note: The laws governing Medicare are complex and change frequently. The two most common examples of our plan paying primary are listed here. If you have more questions, please contact our Provider Services department.
   a. This plan is primary to Medicare for employer group health plans of 20 or more employees for working members over age 65 and their spouses.
   b. This plan is primary to Medicare for employer group health plans for employees, retirees and dependents who are entitled to Medicare solely based on end-stage renal disease (ESRD) for up to 30 months.

7.7.3 Methods for Calculating COB

Each employer group decides what type of COB it would like to purchase for its employees. Each method calculates payments differently and may not provide for payment of the entire remaining balance after the primary carrier has paid. Here are three methods for calculating COB payment:

- Standard COB — The secondary policy subtracts the primary policy's payment from the total charges to calculate the remaining liability. The secondary policy will either pay the remaining liability or the secondary policy's "primary liability," whichever is less.
- Maintenance of Benefits — The secondary policy subtracts the primary policy's payment from its allowed amount to calculate the remaining liability. The secondary policy will either pay the remaining liability up to its allowed amount or the secondary policy's "primary liability," whichever is less.
- Nonduplication of Benefits — The secondary policy subtracts the primary policy's payment from the secondary policy's primary liability to calculate the remaining liability. The secondary policy will pay either its primary liability or its primary liability minus the primary policy's payment, whichever is less.

The secondary "primary liability" is the amount that the secondary policy would have paid if it had been the primary policy.

7.7.4 Medicare and COB

These guidelines will assist you in handling Medicare beneficiaries who also have BlueChoice coverage:

1. When Medicare is primary and the provider has accepted assignment:
   a. Do not charge the patient.
   b. File the claim to Medicare.
   c. Receive the Medicare Summary Notice (MSN).
   d. File the claim to BlueChoice and include a copy of the MSN. Indicate in the "other coverage" field that Medicare is primary.
2. When Medicare is primary and the provider has not accepted assignment:
   a. Charge the member in full, up to the Medicare-allowed amount.
   b. File the claim to Medicare.
   c. File the claim to BlueChoice indicating in the "other coverage" field that the member has Medicare and has "paid in full."
   d. After Medicare has processed the claim, have the member file a copy of the MSN to BlueChoice.
3. When Medicare is secondary:
   a. Collect the BlueChoice copayment from the member.
   b. File the claim to BlueChoice and indicate in the "other coverage" field that Medicare is secondary.
   c. BlueChoice will pay the claim according to our current fee schedule.
   d. The member can then file to Medicare for reimbursement for the BlueChoice copayment.

SECTION 8: QUALITY IMPROVEMENT

8.1 Quality Improvement Program and Report

BlueChoice maintains an active quality improvement program. This program oversees various monitoring functions, such as quality assurance (QA) studies, member satisfaction surveys and a review of patient grievances. BlueChoice continuously monitors clinical and service quality issues. We document this process in our annual Quality Improvement Evaluation and Action Plan. If you would like to get information about our quality improvement program or the annual evaluation, please call our Quality Improvement department at 803-786-8466. You can also find selected results of our annual HEDIS and CAHPS surveys on our website under About Us/Performance.

8.1.1 Practitioner/Provider Performance Data

Practitioner/provider performance data refers to compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual health care practitioner, such as a physician, or a health care organization, such as a hospital. Common examples of performance data would include the HEDIS quality of care measures maintained by the NCQA and the comprehensive set of measures maintained by the National Quality Forum. We can use practitioner/provider performance data for multiple plan programs and initiatives, including but not limited to:

- Reward Programs — Pay-for-performance, pay-for-value and other results-based reimbursement programs that tie provider or facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.
- Recognition Programs — Programs designed to transparently identify high-value providers and facilities and make that information available to consumers, employers, peer practitioners and other health care stakeholders.

8.1.2 Practice Guidelines

BlueChoice has adopted best-practice guidelines for several areas of clinical care. We select national practice guidelines and then monitor compliance with these standards through medical chart review and claims analysis. Please refer to the appendix for a listing of the web addresses for the national guidelines we have adopted. Or you can visit our website at **www.BlueChoiceSC.com** for direct links to these practice guidelines. If you would prefer to get a hard copy of these guidelines, please call the Quality Improvement department at 803-786-8466.

8.1.3 Physician Office Accessibility Standards

For primary care services, BlueChoice has developed recommendations for accessibility to the primary care physician office. We measure physician compliance with the access standards through member satisfaction surveys, on-site office assessments and monitoring of member complaints. You can find a list of these goals in the appendix.

8.1.4 Improving Patient Satisfaction by Decreasing Wait Time

Results of previous member satisfaction surveys indicate that wait time in BlueChoice network offices continues to be longer than wait times in other parts of the country. We always strive to provide information to our physicians that can improve office efficiencies. If you would like suggestions on decreasing wait time and improving your patients' satisfaction, we have a resource for you. We have researched the literature related to improving satisfaction by decreasing wait time in the office and have summarized our findings in an article in the appendix.

8.1.5 Preventive Health Services

BlueChoice has adopted preventive health guidelines for adults and children. The objective of the Health Management department is to provide ongoing education to members and physicians to ensure they are aware of these guidelines. We take steps to develop appropriate programs to assist our members and physicians in following the preventive health guidelines. You can find a description of these guidelines and associated websites in the appendix, or you can find them on our website at **www.BlueChoiceSC.com**.

8.2 Medical Office Site Review Criteria

8.2.1 Office Physical Environment

The office is accessible to members, including those with handicaps. There is a ramp or wheelchair- or walker-accessible entrance and a bathroom that is wheelchair accessible. The office gets full credit for both the ramp and a bathroom. The office receives no credit for only one of these items.

The waiting room has ample seating for all patients/guests waiting for an appointment.

Waiting rooms, exam rooms and offices are clean, uncluttered, organized and neat.

Office is free of hazards like electrical shock, fire, poisoning, burns and items that may cause slips or falls. Halls and rooms should be free of items that can be of threat to patient or guest safety, corridors or exits should not be blocked for full credit. The office gets no credit for any hazard identified, i.e., less than 3 feet of clearance in corridors or no electrical outlet safety plugs in patient areas for pediatric and family practice offices.

Exam/dressing rooms and restrooms maintain the patient's right to privacy. Practices that maintain privacy using doors or other types of barriers get full credit. If the dressing rooms or restrooms do not have doors, the practice gets no credit.

Practices do not store medications in public areas. Practices inventory and lock narcotics. Sample medications are not stored in patient areas.

Educational materials are available to patients. These materials may be available in the waiting room or exam room or may be provided to the individual patient based on the diagnosis.

8.2.2 Medical/Emergency Preparedness

The office maintains adequate and proper emergency supplies (i.e., IV fluids, ambu bag, airway, emergency drugs) with scheduled periodic inspections. Medical offices can choose to store supplies on a cart, on a shelf or in an emergency case.

The office gets no credit if there are no inspections of the emergency cart supplies, if drugs are expired or if the emergency supplies are inadequate (i.e., an ambu, an airway and emergency drugs without an airway, etc.).

Offices always maintain oxygen. Clinical staff should know the location of the oxygen. Oxygen should be easily accessible within the office for full credit. The office gets no credit if the staff is unaware of the location of the oxygen or if the oxygen is not easily accessible.

Clinical office staff (nurses, technicians, medical office assistants) has current, certified training in CPR and can respond to other emergencies. Offices get full credit for current clinical staff certification. An office will get no credit if certification is not current for all clinical staff.

Written emergency procedures are available. Written protocols on how to manage emergency situations (i.e., cardiac arrest, fire evacuation and natural disaster evacuation) are easily accessible. Offices get full credit for written protocols for both medical emergencies and a fire/natural disaster plan. Offices get no credit if they have a fire evacuation map without a written protocol.

Either fire extinguishers are available and maintained or a sprinkler system is present. Offices with either method get full credit.

Offices have an occurrence reporting system to document all in-office accidents and follow-up when necessary on all accidents, injuries and safety hazards that occur within the office. Offices with a handwritten log, an incident report, documentation sent to the insurance company, or other emergency care documentation for the injured person get full credit.

Offices store and dispose of hazardous wastes in a timely manner and in an acceptable manner to minimize the risk of infection or contamination (i.e., containers for the disposal of needles and other hazardous wastes). Offices should use standard (HIV) precautions to get full credit.

8.2.3 Appointments/Scheduling

Practices schedule appointments and document them in an appointment book or track them on a computer system, not to exceed six per hour. Each physician, certified physician assistant or primary care nurse practitioner should schedule no more than six appointments per hour for full credit.

Schedule allows for same-day scheduling of urgent/emergent appointments. Patients should be able to schedule a same-day sick visit for full credit.

An answering mechanism is available 24 /7. Answering services with whom the physician checks regularly or who can contact the physician directly receive full credit. Physicians who allow patients to call the doctor directly 24 hours per day get full credit. An answering machine that instructs the patient to call the local hospital switchboard to page or beep the doctor gets full credit. An answering machine that provides instructions for beeping the doctor directly gets full credit. An answering machine that instructs the patient to go to or call the local emergency room for triage gets no credit.

8.2.4 Medical Record Maintenance

The practice uses a system for the collecting, processing, maintaining, storing, retrieving and distributing of medical records.

The practice has a policy for retention of active medical records.

The practice has a policy for the retirement of inactive medical records. For full credit, you should purge medical records as often as every two years. You can routinely purge deceased/inactive files but should purge them at least every two years. We do not require this policy for new practices less than two years old but encourage new practices to begin planning for future purging. Practices without a purging and storage plan for inactive/deceased records receive no credit.

The practice has a written policy for the release of medical information. This policy may consist of a medical record release form as acceptable documentation for full credit.

There is a consent form for surgical procedures you perform in the office. A surgical form the patient signed receives full credit. All invasive procedures require a consent form. Practices who perform no invasive surgical procedures receive N/A (not applicable). Practices with a generic medical treatment consent form only receive no credit.

The practice has a written patient confidentiality policy, either in the employee handbook or as a separate statement you give to each employee. The form does not need the employee's signature to receive full credit.

You record progress notes for each patient encounter. Please make sure:

- All entries are dated.
- The record is legible.
- There is a date for a return visit or other follow-up plan for each encounter.
- You provide written information to the patient about his or her follow-up plan.
- You addressed problems from previous visits.
- There is evidence of continuity and coordination of care between primary and specialty physicians.

8.2.5 Medical Office Site and Records Review

We conduct the general office review for all physician offices that have received a member complaint in one of these categories: physical accessibility, physical appearance, and adequacy of waiting and examining room space. BlueChoice has 60 days after a complaint to conduct an office review. Multiple complaints about the same provider within the same complaint category does not generate the need for additional office reviews. If a provider receives a complaint in a different category, however, we must conduct an additional office review whether we have already conducted a prior office review. The purpose of this review is to verify that the physician provides care in an appropriate environment that can adequately serve our members.

BlueChoice will continue to conduct precontracting general office reviews for Medicare and Medicaid. We review providers who perform outside our standard every six months until they reach a passing score. The purpose of this review is to verify the physician provides care in an appropriate environment that can adequately serve our members. The review covers areas including medical record-keeping practices, office physical environment, medical emergency preparedness, appointments/scheduling, laboratory facilities and radiology services.

It is the primary care physician's responsibility to ensure the continuity and coordination of care. The medical records should include documentation of all services you provide, including ancillary and diagnostic tests the primary care physician ordered, and all diagnostic, consultation and therapeutic services for which the primary care physician referred the member.

We have established standards for medical record documentation and on-site medical office reviews. Please refer to the appendix for a copy of our medical record documentation criteria and our medical office review criteria. For copy-ready model chart forms, you can contact the Quality Management department or visit our website at **www.BlueChoiceSC.com**.

8.3 Medical Records and Member Surveys

8.3.1 Medical Record Review Criteria

The performance goal is an overall score of 80 percent. We resurvey offices that do not meet every two years until they meet the goal.

Each medical record is retrievable for review. The medical record must be available for review to get full credit.

Practices should maintain medical records in an organized, uniform manner. Computerized medical records are acceptable. To receive full credit, each patient should have an individual and organized medical record. Family charts should maintain an organized and individual record for each member of the family to get full credit. Unorganized records get no credit. Partially organized records get partial credit.

Each medical record contains a completed patient history, which consists of patient and family medical history, along with documentation of tobacco, alcohol and substance abuse history. Each item counts 20 percent of the overall score. All items must be present to receive (100 percent). Histories may appear in the progress notes, on a printed medical form or in hospital dictations the physician prepares. Transferred records with documentation that the current primary care physician has reviewed and noted the history are also acceptable. For pediatric patients, patient history consists of patient and family medical history only, and each part counts 50 percent. Both items must be present to get full credit (100 percent).

The medical record has documentation of, and prominently displays, allergies or drug reactions. Documentation of allergy information, including the absence of known allergies, should be in a consistent location for all charts (i.e., chart folder, progress note, medication form, diagnostic summary, history form) to get full credit. Because consistency enables staff to readily identify allergies, medical records with a consistent location of allergy information are crucial to get full credit.

Each medical record has a diagnostic summary/problem list, including medical-surgical conditions, medications and preventive services/risk assessment in a consistent place in the chart. Each item counts for one-third of the overall score. All items must be present to get full credit (100 percent). Medical records with a current problem list in a consistent place that documents acute and chronic problems, medications, and preventive services/risk assessment get full credit. Medical records that only include a medication list or only record medical-surgical conditions and/or have no information related to preventive services/risk assessment get partial credit. If the problem list is not current or not in a consistent place within the chart, then it earns partial credit. Medical records with no diagnostic summary, no problem list and no preventive services/risk assessment get no credit. For pediatric patients, we only score the diagnostic summary/ problem list if there is evidence of chronic illness in the patient's chart. Otherwise, we record this as N/A.

Therefore, the preventive services/risk assessment would count for 100 percent of this section. An example of preventive services for pediatrics would be documentation of immunizations, assessing home environment, car safety, etc.

We record progress notes for each patient encounter and include these for full credit:

- Working diagnosis(es) consistent with findings. Each encounter should have documentation of an appropriate diagnosis based on the findings for full credit.
- Treatment plan consistent with diagnosis(es). Encounters should include documentation of an appropriate treatment plan for the diagnosis(es) that includes follow-up plans. The care should be medically appropriate for full credit. Medical records with diagnosis-specific conditions and no treatment plan will receive no credit. An incomplete treatment plan will get partial credit.

Other items we assess but do not calculate into the overall primary care physician's medical record review score:

- Communication from facilities and specialists to the primary care physician (continuity and coordination of care)
- Availability/access and security of the patient's medical record
- Annual training on patients' privacy with staff
- Advance directives

8.3.2 Solicited Records Requests

There are times when BlueChoice may request medical records from you for a patient. We may request records to determine medical necessity or apply benefits to a claim, or we may request records for risk adjustment or HEDIS review. When you get a request for records, please respond to the appropriate mailing address or fax number provided with the request.

You or any entity designated for such responsibilities should not charge BlueChoice for the creation or submission of medical records. As a participating provider, your contract states you agree to permit BlueChoice or one of our business partners to inspect, review and acquire copies of records upon request at no charge. We appreciate you working with your vendors to ensure they understand this contractual arrangement to submit the requested records (on your behalf) without delay or request for payment.

8.3.3 Member Satisfaction Surveys

BlueChoice conducts a survey to assess members' satisfaction with the care and services they receive. We share the results of these surveys with physicians annually. For information on the results of the most recent survey, please visit our website at **www.BlueChoiceSC.com** or contact Provider Education at 803-264-4730 or **Provider.Education@bcbssc.com**.

8.3.4 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

BlueChoice conducts surveys to assess members' satisfaction with the care and services they receive. CAHPS is a standardized national survey that measures members' experiences with health plan services and the care and services that network professionals offer. Each year, we send the CAHPS to a random sample of members. We ask for feedback on issues related to getting the care they need, getting timely care, the quality of care received, customer service and claims processing.

We share the results of these surveys with physicians each year. For information on the results of the most recent survey, please contact Provider Education at 803-264-4730 or **Provider.Education@bcbssc.com**.

8.3.5 Quality Health Plan Enrollee Experience Survey (QHPEES)

QHPEES is a consumer survey that assesses enrollee experience with qualified health plans (QHPs) offered through the Health Insurance Marketplace (Exchanges). This survey was designed to capture accurate and reliable information from consumers about their experiences with health care services during the previous six months. CMS-approved survey vendors administer the distribution and evaluation of the survey.

For information about this survey, please contact Provider Education at 803-264-4730 or **Provider.Education@bcbssc.com.**

8.4 Maternity Quality Initiatives

BlueChoice has partnered with the South Carolina Department of Health and Human Services and implemented programs to improve birth outcomes. These programs include:

- Birth Outcomes Initiative (BOI).
- Screening, Brief Intervention and Referral to Treatment (SBIRT).
- Centering Pregnancy.

8.4.1 Birth Outcomes Initiative (BOI)

Within the BOI program BlueChoice uses specific filing requirements to identify at what point during gestation deliveries are occurring and why. Append these modifiers to the CPT C-section or delivery procedure code for claims. If the appropriate modifier is not filed with the CPT, we may deny the services.

Modifiers	Uses
GB — 39 weeks gestation or more	For all deliveries at 39 weeks gestation or more regardless of method (induction, C-section or spontaneous labor).
CG — Less than 39 weeks gestation	• For deliveries resulting from patients presenting in labor or at risk of labor, and subsequently delivering before 39 weeks •. For inductions of C-sections that meet the ACOG or approved BOI medically necessary guidelines, please complete the appropriate ACOG Patient Safety Checklist. Keep the documents in the patient's file. • For inductions of C-sections that do not meet the ACOG or approved BOI guidelines, please complete the appropriate ACOG Patient Safety Checklist. Also, you must get approval from the regional perinatal center's maternal fetal medicine physician. Then keep these documents in the patient's file.
No Modifier — Elective nonmedically necessary deliveries less than 39 weeks	For deliveries less than 39 weeks gestation that do not meet ACOG or approved BOI guidelines or are not approved by the designated regional perinatal center's fetal medicine physician.
UA — Prolonged labor when a vaginal delivery fails to progress and converts to a C-section	• Document the time of admission to the hospital and the start time of the C-section in the patient's record. • Prolonged labor is defined as at least six hours of documented labor.

8.4.2 Screening, Brief Intervention and Referral to Treatment (SBIRT)

The SBIRT program allows obstetricians and gynecologists to identify, intervene and refer at-risk patients to treatment by using the universal SBIRT Integrated Screening Tool (the SBIRT referral). Providers that screen patients using this form can also receive additional reimbursement by using specific coding.

The primary diagnosis should be pregnancy related or postpartum related (based upon when the screening or intervention takes place). The secondary diagnosis should either be V82.9 (ICD-9) or Z139 (ICD-10).

- H0002: Behavioral health screening — $24.00 reimbursement
  - Completion of the SBIRT referral for the screening
  - Screening, can be billed once per 12-month period
  - Append the HD modifier for positive screenings only
- H0004: Behavioral health intervention — $48.00 reimbursement
  - Intervention and referral to treatment, documented within the SBIRT referral
  - Brief intervention, can be billed twice per 12-month period
  - Defined as a brief intervention or session in which a referral is made or attempted

The SBIRT initiative applies to all BlueChoice plans except out-of-state (BlueCard) members, State Children's Health Insurance Program (SCHIP) and plans that do not have maternity benefits.

8.4.3 Centering Pregnancy

The Centering Pregnancy program model gathers eight to 12 women with similar due dates to meet as a group with their physician for a total of 10 sessions. The sessions occur throughout their pregnancies and early postpartum care. Approved practices receive additional reimbursement for conducting centering sessions.

Participating providers will receive reimbursement for providing these services:

- 99078 with TH modifier — reimbursement is $30.00 per visit, up to 10 visits total
- 0502F — reimbursement is $175.00 as a one-time retention incentive on or after the fifth visit

You should bill for Centering Pregnancy visits separately from global maternity benefits and file the appropriate pregnancy-related diagnosis code.

To participate as a Centering Pregnancy provider, practices must have Centering® Healthcare Institute membership and be in the process of achieving or have already achieved Site Approval status. Providers must maintain accreditation/licensure with Centering Healthcare Institute to maintain participation

in our Centering Pregnancy program. Complete the Centering Pregnancy Application Form located at **www.BlueChoiceSC.com/find-form**. Be sure to select the Providers check box.

The Centering Healthcare Institute is a separate company that provides wellness education on behalf of BlueChoice. For additional information about these programs, please visit the Providers section of **www.BlueChoiceSC.com**.

8.5 Other Quality Information

8.5.1 Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a tool developed by NCQA that measures performance in the delivery of medical care and preventive health services. It provides a consistent way to evaluate the quality of care you provide to our members. BlueChoice uses HEDIS to identify and acknowledge areas of excellence and opportunities for improvement. We also use HEDIS to develop quality initiatives and educational programs for members and providers.

You can use our provider reference matrix guides to get an overview of HEDIS measures that BlueChoice focuses on. These matrixes provide measure-specific information on what services are needed and how you can help prevent or close our members' gaps in care. If you have relevant information indicating the member has already received the service or has a condition that excludes him or her from the measure, you can close the gap by:

- Filing a claim.
- Supplying the medical record.
- Completing a Compliance Companion Form.
- Sharing the electronic medical record data.

You can submit up to 25 codes with any claim to help transmit this information to us.

It is important to note that we are less likely to request medical records when you submit claims with all appropriate procedure and diagnosis codes. When you get a request for records, please respond to the appropriate mailing address or fax number provided with the request. You, or any entity designated for such responsibilities, should not charge BlueCross for the creation or submission of medical records.

According to HIPAA, a health care provider is permitted to disclose a patient's PHI to a health plan for purposes of the plan's health care operations, which include quality assessment and improvement activities. Therefore, HIPAA allows providers to disclose a patient's PHI to a health plan for HEDIS data collection purposes without authorization when both the provider and health plan have or had a relationship with the patient and the information disclosed pertains to that relationship (45 CFR 164. 501 and 506[c][4]).

8.5.2 Patient-Centered Medical Home (PCMH)

PCMHs are primary care practices that use a team-based approach to health care. Its compensation model is a blended payment methodology that recognizes infrastructure changes and enhanced patient services:

1. Fee-for-service payment, including payments for some nontraditional services (e.g., electronic visits, pharmacist consultations)
2. Per-member, per-month care coordination fee
3. Bonus adjustments to care coordination fee for quality outcomes

8.6 Provider Reviews and Audits

8.6.1 Fraud, Waste and Abuse (FWA)

Providers participating in BlueCross' MA and PDP plans must complete CMS annual compliance training for "Medicare Parts C and D Fraud, Waste, and Abuse" and "Medicare Parts C and D General Compliance." Go to the **Medicare Learning System** at **www.CMS.gov** to access training and get certificates of completion once finished. BlueChoice requires attestations and/or copy of the certificate of completion for our MA and PDP plans from contracted network providers. You must complete FWA compliance training and submission of the attestation by April 1 each year.

8.6.2 Provider Report Cards

Many provider report cards are made available to you during site visits from your designated provider education representative and upon request. Use these reports to gauge and improve performance in your practice:

- Gaps In Care Provider Report (Detail and/or Summary) Card — Lists patient data and practice information in relation to quality measurements; also displays provider rating for Rewarding Excellence Program
- OB/GYN Report Card — Shows how your patient care impacts our maternity quality initiatives
- Provider Report Card — Encompasses an overview of the provider's EMC percentage, duplicate filing rates, self-service usage, rendering provider on claim

8.6.3 Responding to Patient Reviews

Patient reviews provide insight into their experiences with your medical office and their interaction with your practitioners. These reviews — submitted by our members via My Health Toolkit® — can also attract new patients to your practice. My Health Toolkit is an online resource for your patients to manage their benefits, locate an in-network doctor and use many other tools to take charge of their health care.

You should log in to My Insurance Manager to respond to each patient review. By making it a priority to respond to online reviews in a way that reflects a high level of personal care, you can build rapport with current patients. This increases your practice's appeal and credibility with potential patients.

8.7 Member Rights and Responsibilities

8.7.1 Member Rights

- Members have the right to be treated with respect and recognition of their dignity and right to privacy.
- Members have the right to choose their own personal doctors from our list of health care professionals. If members are not happy with their first choice, they have the right to choose another primary care physician from our network.
- Members have the right to expect their primary care physicians and their teams to coordinate all the care they need.
- Members have the right to participate with their doctors in decision making to help take charge of their own health.
- Members have the right to get the information they need to make thoughtful choices before they take any treatment their doctors suggest. BlueChoice HealthPlan does not direct practitioners to restrict information about treatment options.
- Members have the right to learn about their conditions and treatment in words they understand and to be a part of decisions about their own care.
- Members have the right to share their opinions, concerns or complaints constructively.
- Members have the right to receive information about BlueChoice HealthPlan, our services, practitioners, providers, and members' rights and responsibilities.
- Members have the right to complain or make appeals about BlueChoice HealthPlan or the care they receive.
- Members have the right to make recommendations about BlueChoice HealthPlan's rights and responsibilities policy.

8.7.2 Member Responsibilities

- Members have the responsibility to treat all medical staff with respect and courtesy as their partners in good health.
- Members have the responsibility to work with their doctors to form good relationships based on trust and teamwork.
- Members have the main responsibility of keeping up their good health and preventing illness.
- Members have the responsibility to ask questions and make sure they understand the information they receive.
- Members have the responsibility to give BlueChoice HealthPlan and their doctors as much information as they can so it can be used to help them get well.
- Members have the responsibility to work with their primary care physicians to form a treatment plan and to follow the directions agreed upon.
- Members have the responsibility to think about what might happen if they don't follow their doctors' treatment plan or suggestions.
- Members have the responsibility to keep appointments they schedule. In cases where they may have to cancel or may be running late, members have the responsibility to call the office and let it know.
- Members have the responsibility to read all our materials carefully as soon as they sign up for BlueChoice HealthPlan. Members have the responsibility to follow the rules of their membership.

8.8 Our Privacy Practices

BlueChoice knows it is important to protect the privacy of our members' confidential medical information. Here are some of the steps we have taken to protect the privacy of confidential information:

- We require all staff, consultants and business associates to keep confidential any personal health information they learn in performing their jobs. We require all physicians and other health care providers to maintain the confidentiality of this information. They must guard against unauthorized or inadvertent disclosure of confidential information. Practice staff must receive periodic training in member information confidentiality. BlueChoice will review this as part of our general medical record review process.
- We require any entity with which we contract for clinical or administrative services to maintain such confidentiality and to have a privacy policy in place that protects against unauthorized use or disclosure of confidential information. All such entities must sign an agreement attesting that they are compliant with federal privacy regulations.
- We have advanced security systems to limit unauthorized access to information in our computer files.
- We keep any medical information we get from physicians and other health care providers in a secure area, and we limit access to authorized staff. We also require physicians and other health care providers to keep medical records in a secure area. We monitor this through on-site visits to their offices.

APPENDICES

Appendix 1 Practice Guidelines

We have adopted the recommendations of the following organizations as our practice guidelines. With permission from these organizations, BlueChoice has created direct links from our website to these guidelines.

While we review the guidelines annually, you should not construe them as a legal or required standard of care or as an indication they will always apply in every medical situation. These are recommendations only. They do not guarantee any medical results or indicate coverage for such services by any given plan or policy.

We hope these guidelines will be a convenient resource in helping you care for your patients. These are independent companies that offer clinical guideline information on behalf of BlueChoice.

- **Asthma**
  - National Institutes of Health: National Heart, Lung, and Blood Institute
    - Guidelines for the Diagnosis and Management of Asthma (EPR-3 Report 2007)
    - HLBI Guidelines Asthma Care Quick Reference Guide (2012)
- **Back Pain**
  - American College of Physicians
    - Noninvasive Treatments for Acute, Subacute and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians (2017)
- **Behavioral Health**

  Attention-Deficit Hyperactivity Disorder
  - American Academy of Pediatrics
    - Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment of Attention-Deficit Hyperactivity Disorder in Children and Adolescents (2011)
    - Clinical Practice Guideline: Diagnosis and Evaluation of the Child With Attention-Deficit Hyperactivity Disorder (PEDIATRICS Vol. 105 No. 5 May 2000, pp. 1158 – 1170)
    - Clinical Practice Guideline: Treatment of the School-Aged Child With Attention-Deficit Hyperactivity Disorder (PEDIATRICS Vol. 108 No. 4 October 2001, pp. 1033 – 1044)
  - Bright Futures at Georgetown
    - Bright Futures in Practice: Mental Health
    - Bright Futures in Practice: Mental Health — Volume II, Tool Kit

  Depression
  - U.S. Preventive Services Task Force
    - Screening for Depression in Adults (2016)
  - American Psychiatric Association
    - Practice Guideline for the Treatment of Patients With Major Depressive Disorder (2010)
    - Treating Major Depressive Disorder: A Quick Reference Guide (2010)
- **Chronic Kidney Disease**
  - National Kidney Foundation
    - Kidney Disease Quality Outcomes Initiative (KDQOI) Clinical Practice Guidelines

- **Chronic Obstructive Pulmonary Disease (COPD)**
  - The Global Initiative for Chronic Obstructive Pulmonary Disease
    - Pocket Guide to COPD Diagnosis, Management and Prevention: A Guide for Health Care Professionals
    - Global Strategy for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease
- **Congestive Heart Failure (CHF)**
  - American College of Cardiology Foundation and American Heart Association
    - 2013 ACCF/AHA Guideline for the Management of Heart Failure (2013)
    - 2016 ACC/AHA/HFSA Focused Update on New Pharmacological Therapy for Heart Failure: An Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure
- **Coronary Artery Disease (CAD)**
  - American College of Cardiology Foundation and American Heart Association
    - 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol To Reduce Atherosclerotic Cardiovascular Risk in Adults (2013)
    - 2012 ACCF/AHA Focused Update of the Guideline for the Management of Patients With Unstable Angina/Non — ST-Elevation Myocardial Infarction (Updating the 2007 Guideline and Replacing the 2011 Focused Update) (2012)
  - American Heart Association®
    - Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women — 2011 Update: A Guideline From the American Heart Association (2011)
  - American Heart Association/American College of Cardiology
    - AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update: A Guideline From the American Heart Association and the American College of Cardiology Foundation (2011)
- **Diabetes**
  - American Diabetes Association
    - Standards of Medical Care in Diabetes (2018)
- **Epilepsy**
  - American Academy of Neurology
    - Epilepsy Practice Guidelines
- **High Blood Cholesterol**
  - American College of Cardiology Foundation and American Heart Association
    - 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol To Reduce Atherosclerotic Cardiovascular Risk in Adults (2013)
  - National Institutes of Health: National Heart, Lung, and Blood Institute
    - Third Report of the Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) (updated 2004)
- **Hypertension (High Blood Pressure)**
  - American College of Cardiology/American Heart Association
    - 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults — National Institutes of Health: National Heart, Lung, and Blood Institute
    - 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC8) (2014)
  - American Heart Association
    - Treatment of Hypertension in the Prevention and Management of Ischemic Heart Disease: A Scientific Statement From the American Heart Association Council for High Blood Pressure Research and the Councils on Clinical Cardiology and Epidemiology and Prevention (2007)

- **Immunization Guidelines**
  - Centers for Disease Control and Prevention
    - Immunization Schedules
- **Inflammatory Bowel Disease**
  - American College of Gastroenterology
    - Management of Crohn's Disease in Adults (2008)
    - Ulcerative Colitis in Adults (2010)
- **Maternity/Perinatal Guidelines**
  - United States Preventive Services Task Force (USPSTF)
    - Screening for Depression in Adults (2016)
  - American Congress of Obstetricians and Gynecologists
    - Guidelines for Perinatal Care, Seventh Edition (2012)
- **Metabolic Syndrome**
  - American Heart Association and National Institutes of Health: National Heart, Lung, and Blood Institute
    - Diagnosis and Management of the Metabolic Syndrome (2005)
- **Migraine**
  - American Academy of Neurology
    - Clinical Practice Guidelines
    - Practice Parameter: Evidence-Based Guidelines for Migraine Headache (2000)
  - International Headache Society
    - International Classification of Headache Disorders, Third Edition (ICHD-3) (2013)
- **Multiple Sclerosis**
  - American Academy of Neurology
    - Multiple Sclerosis Practice Guidelines
- O**besity and Overweight: Adults**
  - Office of Disease Prevention and Health Promotion
    - 2015 – 2020 Dietary Guidelines for Americans (2016)
  - American Heart Association and American College of Cardiology Foundation
    - Guideline for the Management of Overweight and Obesity in Adults (2013)
  - National Institutes of Health: National Heart, Lung, and Blood Institute
    - The Practical Guide: Identification, Evaluation and Treatment of Overweight and Obesity in Adults (2000)
    - Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults (1998)
- **Obesity and Overweight: Pediatric**
  - Endocrine Society
    - Pediatric Obesity Assessment, Treatment, and Prevention: An Endocrine Society Clinical Practice Guideline
  - Office of Disease Prevention and Health Promotion
    - 2015 – 2020 Dietary Guidelines for Americans (2016)
  - National Institutes of Health: National Heart, Lung, and Blood Institute
    - Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents (Summary Report) (2012)

  - American Academy of Pediatrics
    - AAP Publications Retired or Reaffirmed, October (2006)
    - Active Healthy Living: Prevention of Childhood Obesity Through Increased Physical Activity (2006)
    - Dietary Recommendations for Children and Adolescents: A Guide for Practitioners (2006)
- **Parkinson's Disease**
  - American Academy of Family Physicians
    - Parkinson's Disease: Diagnosis and Treatment (2006)
  - American Academy of Neurology
    - Clinical Practice Guidelines for Movement Disorders
- **Physical Activity Guidelines**
  - United States Department of Health and Human Services
    - 2008 Physical Activity Guidelines for Americans (2008)
    - Physical Activity Guidelines for Americans Midcourse Report: Strategies To Increase Physical Activity Among Youth (2012)
- **Prediabetes**
  - American Diabetes Association
    - Standards of Medical Care in Diabetes (2018)
- P**reventive Guidelines**
  - United States Preventive Services Task Force (USPSTF)
    - The Guide to Clinical Preventive Services (2014)
    - USPSTF A – Z Topic Guide (2013)
  - American Academy of Family Physicians
    - Summary of Recommendations for Clinical Preventive Services (2017)
- **Rheumatoid Arthritis**
  - American College of Rheumatology
    - 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis
    - 2012 Update of the 2008 Recommendations for the Use of DMARDS and Biologics in the Treatment of RA (2012)
- **Stress Management Guidelines**
  - World Health Organization
    - World Health Organization Guidelines for Management of Acute Stress, PTSD and Bereavement: Key Challenges on the Road Ahead
- **Tobacco Cessation Guidelines**
  - Agency for Healthcare Research and Quality (AHRQ)
    - Clinical Guidelines for Prescribing Pharmacotherapy for Smoking Cessation

Appendix 2 Physician Office Accessibility Standards

1. Wait time for health maintenance/preventive care
   a. To meet criteria, routine complete physical exam appointments should be scheduled within eight weeks of request.
2. Wait time for routine care appointments
   a. To meet criteria, routine care appointments should be scheduled within four weeks.
3. Wait time for episodic care appointments
   a. To meet criteria, episodic care appointments should be scheduled within three days, with 24/7 triage availability.
4. Wait time for urgent care
   a. To meet criteria, urgent care appointments should be scheduled within 24 hours.
5. Wait time for emergency
   a. To meet criteria, emergency care patients should be seen immediately or referred to an emergency room or urgent care center.
6. Appointment scheduling per hour
   a. To meet criteria, each physician should schedule no more than five to six appointments per hour.
7. Wait time in waiting room
   a. To meet criteria, the provider should see patients within 15 minutes of arrival.
8. After-hours access
   a. To meet criteria, physicians should have an after-hours answering mechanism in place 24/7.

BlueChoice HealthPlan®

Decreasing Wait Time

Improving Patient Satisfaction & Decreasing Wait Time in the Office

Each year BlueChoice HealthPlan conducts a survey of patients to monitor various aspects of satisfaction. As a part of the survey, we monitor the length of time patients have to wait to see their physicians. The results of this survey indicate that our patients have to wait much longer than patients of health plans in other parts of the country.

In an effort to provide resources to physician offices that are interested in improving patient satisfaction and decreasing their wait times, we reviewed the literature to identify articles related to wait time in the office. Here is a summary of what we found.

Simple Suggestions for Improving Patient Satisfaction

Communicate wait time to patients at the onset of their visits and periodically throughout a patient's wait. Research confirms this will impact patients' satisfaction. If the physician is running more than 15 minutes behind, communicate the delay to waiting patients. When taking a patient back to the exam area, communicate how long the patient may have to wait, or at least communicate how many patients the physician has to see before coming to this room. When physicians are running 45 minutes or more behind, office staff should contact patients at home or work to notify them of the delay and offer to reschedule the appointment.

Don't follow the "hurry up and wait" method. Patients who are hurried out of the waiting room area and into an exam room may have a high expectation of a quick visit. Most patients expect to have some wait time in the exam room, but an excessive wait in the exam room contributes to high dissatisfaction.

Improve the waiting room conditions. Most importantly, make sure there is a variety of ways patients can occupy themselves. A television, wide selection of recent magazines, ample seating room and toys for children are a must. Access to coffee, vending machines and telephones can help, too. Make sure exam rooms also have magazines and health-related educational materials to occupy time in the exam room.

Recognize the inconvenience to the patient. Physicians should apologize for any delays. A sincere apology and brief explanation of the cause of the delay works wonders. Simply saying "we value your time and try to avoid delays; sometimes they are inevitable" can diffuse a patient's pent up anger.

Appendix 4 Preventive Health Guidelines

We have adopted the recommendations of the U.S. Department of Health and Human Services through the Public Health Service, the Office of Public Health and Science, and the Office of Disease Prevention and Health Promotion as our preventive health guidelines for adults, children and adolescents. With permission from these organizations, BlueChoice created direct links from our website to these guidelines.

While we review the guidelines annually, you should not construe them as a legal or required standard of care, or as an indication they will always apply in every medical situation. These are recommendations only. They do not guarantee any medical results or indicate coverage for such services by any given plan or policy.

We hope these guidelines will be a convenient resource in helping you care for your patients.

- Preventive Health Guidelines for Adults
  - Clinician's Handbook of Preventive Services, Second Edition (1998)
- Preventive Health Guidelines for Children and Adolescents
  - Clinician's Handbook of Preventive Services, Second Edition (1998)
  - American Academy of Pediatrics Immunization Information for Clinicians
  - Centers for Disease Control and Prevention, Vaccines and Immunizations Information

The Clinician's Handbook of Preventive Services is part of Put Prevention Into Practice, an Agency for Healthcare Research and Quality (AHRQ) national program to improve delivery of appropriate clinical preventive services. You can order a copy of the book from the AHRQ Publications Clearinghouse at P.O. Box 8547, Silver Spring, MD 20907, or by calling 800-358-9295. You can also order a free information packet of Put Prevention Into Practice materials.

Appendix 5 Glossary

Adjustment — The reprocessing of a claim to make changes to information submitted on the original claim

Affordable Care Act — Legislation passed on March 23, 2010, that requires quality and affordable health care and/or health insurance; plans are required to cover certain preventive services termed as essential health benefits

Ancillary — Professional diagnostic or therapeutic services, such as DME, laboratory and specialty pharmacy provided on an outpatient basis as part of basic medical or surgical services

Appeal — A member's request to reconsider a decision about a disallowed claim for payment

Balance bill — The practice of billing a patient for the difference between what the Plan pays and what the provider charges

Benefit — Services and supplies the Plan pays for; it also refers to the amount a health plan will pay

Clearinghouse — Companies that function as intermediaries who forward claims information from the provider to the Plan

Commercial — Plans that are offered individually or collectively as a group

Compliance — An understanding and willingness to meet the terms of all applicable federal and state regulations as pertaining to health care

Contiguous county — Sharing a common border with the state of South Carolina

Data segment — An intermediate unit of information in a transaction. The data segment comprises several data elements.

Date of service — The day in which a patient was seen or given treatment by a health care provider

DME — Durable medical equipment; any equipment that provides therapeutic benefits to a patient in need because of certain medical conditions and/or illnesses

EDI — Electronic Data Interchange; standardized format that allows providers to send information to the Plan electronically rather than with paper

EFT — Electronic funds transfer; any transfer of funds, other than a transaction originated by cash, check or similar paper instruments, that is initiated through an electronic terminal, telephone, computer or magnetic tape, for the purpose of ordering, instructing or authorizing a financial institution to debit or credit an account

Electronic loop — A group of related data segments; all data segments related to claim information may be one loop; this loop may be repeated several times to provide several sets of claim information

Eligibility — Able to receive services based on enrollment in a Plan

EMC — Electronic media claims; the process of transmitting medical claims electronically to a Plan

ERA (remit) — Electronic remittance advice; a statement to the provider that explains how and why benefit calculations were determined

Federally Facilitated Marketplace — An organized marketplace for health insurance plans that operate under the ACA

Fraud — The act of deliberate deception performed to gain an unlawful benefit, such as improper coding of health services on a claim for payment

Grandfathered — A plan or policy in place before March 23, 2010, when the ACA became effective; these plans can offer the coverage they did before the ACA

In-network — Providers or health care facilities that are part of a Plan's network of contracted providers

Member — Any person entitled to receive benefits under a Plan

Network — Group of physician, hospitals and other clinical providers that a specific Plan has contracted to deliver services to its members

Nongrandfathered — A plan that did not take effect until after the ACA took effect on March 23, 2010, or has had certain plan changes made to it

NPI — National Provider Identifier; a unique 10-digit identification number CMS issues to providers in the United States

Opioids — Any synthetic narcotic that has opiate-like activities but is not derived from opium

Out-of-Network — Providers or health care facilities that are not part of a Plan's network

Participating provider — A contracted health care professional who accepts assignment and is paid directly by the Plan

Prior authorization (preauthorization, precertification) — A process used to determine if services will be covered by the Plan

PHI — Any information about health status, provision of health care or payment for health care that is collected by a Plan

Provider reconsideration — A provider's written request for review of a prior benefit

Referring provider — The physician who directs a patient for care to a specialist for service

Rendering provider — The individual who provided the care to the patient

Specialist — A health care professional whose practice is limited to a particular area, such as a branch of medicine, surgery or nursing

TIN — A unique provider identifier conferred by the Social Security Administration or the IRS; referred to interchangeably as provider number

UB-04 — The standard paper claim form to bill hospital claims

Vendor (business partner) — A company or individual that has some involvement with the Plan's management and/or administration of a service

*These links lead to third party websites. Those companies are solely responsible for the contents and privacy policy on their sites.

BlueChoice HealthPlan is an independent licensee of the Blue Cross Blue Shield Association.

In the event of any inconsistency between information contained in this handbook and the agreement(s) between you and BlueCross BlueShield of South Carolina, the terms of such agreement(s) shall govern. The information included is general information and in no event should be deemed to be a promise or guarantee of payment. We do not assume and hereby disclaim any liability for loss caused by errors or omissions in preparation and editing of this publication.

216514-7-2023