2017 Benefit Update Meeting

Columbia, South Carolina

BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Meeting Handbook for Providers

In the event of any inconsistency between information contained in this handbook and the agreement(s) between you and BlueCross 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.

It is with pleasure that we welcome you to the 2017 Benefit Update Meeting. It is our desire to make this workshop educational, informative, and fun for you. We have changed our format to create break-out sessions on topics that mean the most to you. Exceptional guest speakers, vendors, and business partners have all gathered here in Columbia to present a diverse range of topics that you will find most useful in your line of business.

For years we have enjoyed the strong relationships developed between our company and the provider community. Our members are healthier, more active, informed, and involved because of your commitment to offering quality care. That's why we appreciate you and look forward to continued partnerships to improve the lives of the people of South Carolina.

Please enjoy all that we have planned for this day. While this day is about education, it is also about appreciation. We hope that you recognize that intent in the sessions you attend and the staff you meet. Thank you for spending your day with us. Have a wonderful Holiday Season and happy New Year!

Sincerely,

Brian Butler
Senior Director, Provider Outreach
BlueCross BlueShield of South Carolina

Martha Owens Perry
Vice President, Health Care Services
BlueCross BlueShield of South Carolina

CONTENTS

BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

PURPOSE

Each year, the Provider Relations and Education team of BlueCross BlueShield of South Carolina and BlueChoice HealthPlan — along with many of our business partners and support areas — host this event for providers to learn about upcoming benefits and administrative changes in the new year.

We're changing the format for our conference to fully engage our audience and give participants more chances to interact with hosts and visit our vendor exhibits.

MISSION

Our mission is to serve as liaisons between BlueCross, BlueChoice® and the health care community to promote positive relationships through continued education and problem resolution.

Provider Relations and Education Team

Contacts

We direct all phone calls and emails to a central distribution center and 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.

Provider Advocates

Our Provider Relations and Education staff focuses on providing training and support to health care professionals. We serve 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 on www.SouthCarolinaBlues.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.

Provider Education Team			
Name	**Counties Served or Service Specialty**	**Telephone**	**Email**
Mary Ann Shipley	Berkeley, Chesterfield, Darlington, Dillon, Dorchester, Florence, Georgetown, Horry, Marion, Marlboro, Williamsburg	Toll free 800-288-2227, ext.4730	mary.ann.shipley@bcbssc.com
Ashlie Graves	Cherokee, Chester, Fairfield, Greenwood, Lancaster, Laurens, Lexington, Newberry, North Carolina (Charlotte area), Orangeburg, Saluda, Spartanburg, Union, York		ashlie.graves@bcbssc.com
Ashley Jones	Allendale, Bamberg, Barnwell, Beaufort, Charleston, Colleton, Hampton, Jasper		ashley.jones@bcbssc.com
Sandy Sullivan	Calhoun, Clarendon, Kershaw, Lee, Richland, Sumter		sandy.sullivan@bcbssc.com
Bunny Temple	Abbeville, Aiken, Anderson, Edgefield, Georgia (Augusta area), Greenville, McCormick, Oconee, Pickens		bunny.temple@bcbssc.com
Shamia Gadsden	Medicare Advantage and Quality Education		shamia.gadsden@bcbssc.com
Contessa Struckman	Quality Education		contessa.struckman@bcbssc.com
Sharman Williams	BlueCard® Program and Ancillary Education		sharman.williams@bcbssc.com
Noelle Jacobs	Internal Education		noelle.jacobs@bcbssc.com
Jamie Pringle	Internal Education		jamie.pringle@bcbssc.com
Joseph Pineda	Reporting and Internal Support		joseph.pineda@bcbssc.com
Teosha Harrison	Manager		teosha.harrison@bcbssc.com

Table of Contents

OVERVIEW

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 claims information in full to ensure you receive accurate payment without delay. You can also file both professional and institutional claims (primary, secondary and corrected claims) in My Insurance Manager.

Medical Policies and Clinical Guidelines

Our policies and guidelines help keep providers up to date on BlueCross and BlueChoice coverages and national experts' recommendations. Please visit the Education Center of www.SouthCarolinaBlues.com and www.BlueChoiceSC.com frequently to stay abreast of policy changes and to read any policy in its entirety.

Web Resources

- 2016 BlueCard Provider Manual
- 2016 BlueCross Provider Office Administrative Manual
- 2016 BlueChoice Provider Office Administrative Manual
- BlueCard Basics
- Claims Entry Guides
- Claim Attachments Guide

Also Visit

- Education Center
- News Bulletins

Rendering National Provider Identifier (NPI)

We require you to report the rendering provider NPI on all claims. Any claim we receive without the required rendering provider's information will be denied. We will accept corrected claims if your office inadvertently omits the rendering provider information.

Modifiers

Use modifiers to report that 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 very important to know how to use modifiers correctly.

National Drug Code (NDC)

BlueCross and BlueChoice require you to file the appropriate NDC with the unit of measure and quantity for all outpatient-administered drug claims. This applies to institutional outpatient and professional services billed.

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) and International Unit (F2)]

Be sure to report the NDC with the appropriate corresponding J-codes.

You can find additional information about NDC requirements in the Provider News section of our websites at www.SouthCarolinaBlues.com and www.BlueChoiceSC.com. You can also find additional NDC information, as well as an NDC to HCPCS crosswalk, on the website of the Centers for Medicare & Medicaid Services (CMS).

Work with your billing companies to avoid unnecessary denials.

Rehabilitative and Habilitative Services

BlueCross and BlueChoice will begin applying separate and distinct benefit limits for habilitative and rehabilitative services for dates of service on and after Jan. 1, 2017. This change is in compliance with the Notice of Benefit and Payment Parameters for 2016 rule issued in accordance with Affordable Care Act (ACA) guidelines. This means that beginning with dates of service on and after Jan. 1, 2017, we will no longer have a combined visit limit for habilitative and rehabilitative services. Each of these services will now be counted separately. For example, today, a patient may have 60 visits allowed in his or her benefit plan. After the first of the year, he or she may now have 30 habilitative services and 30 rehabilitative services available under an ACA-compliant health plan. It is important to identify which service is being rendered when billing to correctly count visits and ensure the patient's benefits are applied appropriately.

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 with modifier SZ when billing habilitative services for the codes listed in the tables. The SZ modifier distinguishes between habilitative and rehabilitative services. Appropriate use of the modifier will help reduce claims issues and adjustments related to habilitative services.
- Review your current coding practice as it relates to the use of modifier SZ and the billing of habilitative and rehabilitative services.

Physical and Occupational Therapy Codes					
97001 -97006	97024	97116	97537	97750	G0152
97010	97026	97124	97542	97755	G0157 - G0160
97012	97028	97139 - 97140	97545 - 97546	97760 - 97762	G8990 - G8995
97014	97032 - 97036	97150	97597 - 97598	97799	S9129
97016	97039	97530	97602	4018F	
97018	97110	97532 - 97533	97605 - 97608	G0129	
97022	97112 - 97113	97535	97610	G0151 - G0152	

Speech Therapy Codes					
92507 - 92508	92571	96105	G0161	G9174 - G9176	V5362
92521 - 92524	92577	96111	G8999	G9186	V5363
92526	92597	96116	G9158	S9128	4552F
92555 - 92557	96110	G0153	G9159 - G9164	S9152	

Carrier (Payer) Codes

BlueCross 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 these carrier codes for direct electronic claim submission to BlueCross.

- 400 State Health Plan
- 401 Preferred Blue℠ and BlueEssentials℠ (also includes all out-of-state BlueCard claims)
- 402 FEP
- 403 BlueChoice HealthPlan Medicaid
- 922 BlueChoice and Blue Option

Use these carrier codes for third party administrators (TPAs) that use the Preferred Blue network and are accepted electronically.

- 315 TCC, a separate company that administers third party administration services on behalf of BlueCross and BlueChoice.
- 886 Planned Administrators, Inc. (PAI), a separate company that administers third party administration services on behalf of BlueCross and BlueChoice.

Use these carrier codes for dental claim submission.

- 38520 BlueCross.
- 77828 Companion Life. Life insurance is offered by Companion Life. Because Companion Life is a separate company from BlueCross and BlueChoice, Companion Life will be responsible for all services related to life insurance.

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.

Here are examples of and solutions to common edits that apply to loops and segments for professional claims, institutional claims and dental claims. Visit www.HIPAACriticalCenter.com for more information.

- **837 Professional Edit 251 – Subscriber ID Not On File As Entered**

  Loop(s) and Segments (s) Impacted:

  2010BA | NM109

  Corrective action: Validate the subscriber identification number on the insurance card. Confirm with the patient/subscriber for the most recent insurance card. If the subscriber ID is valid, verify the correct payer code is being used.

- **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 BlueCross to validate whether additional paperwork is needed to update the provider identification number in the database.

- **837 Institutional Edit PS7 – Invalid Alpha-Prefix On Subscriber ID**

  Loop(s) and Segment (s) Impacted:

  2010BA | NM109

  Corrective action: Call the Technical Support Center (TSC) at 800-868-2505 to validate the alpha prefix at the beginning of the subscriber identification number.

- **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.

Medicare Crossover Claims

The claims you submit to the Medicare intermediary will cross over to the Blue Plan only after the Medicare intermediary processes them. This process takes 14 business days. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. Please allow 30 days for processing.

Submit services covered by Medicare directly to Medicare. The claim will be crossed over by Medicare. This allows the crossover process to occur and the member's benefit policy to be applied. We will reject Medicare primary claims, including those with Medicare-exhausted services and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date.

The Blue Plan will issue the remittance once the claim has completed processing. Always check claim status before submitting a Medicare secondary claim to the Blue Plan to avoid unnecessary denials.

Subrogation

A BlueCross member's health contract contains an important clause called "subrogation" or "reimbursement." This means when BlueCross 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.

BlueCross' staff of physicians has established a list of diagnosis codes that indicate an injury or illness may be accident-related or work-related. When claims are processed through our system, a questionnaire is generated if the patient has received treatment for an injury or illness that has one of these "accident-type" diagnosis codes.

You should have members complete our Subrogation (Accident) Questionnaire available on the Forms page of the Provider section at www.SouthCarolinaBlues.com. A Spanish version of this form is also available. The answers will help us properly administer claims and determine if we need to seek reimbursement from a third party or an insurance company for these claims. If the questionnaire is not returned, we may withhold payment on medical claims.

BlueCard Program

The BlueCard program enables Blue Plan members to get health care service benefits and savings while traveling or living in another Blue Plan's service area. The program links participating health care providers across the country and internationally through a single electronic network for claims processing and reimbursement.

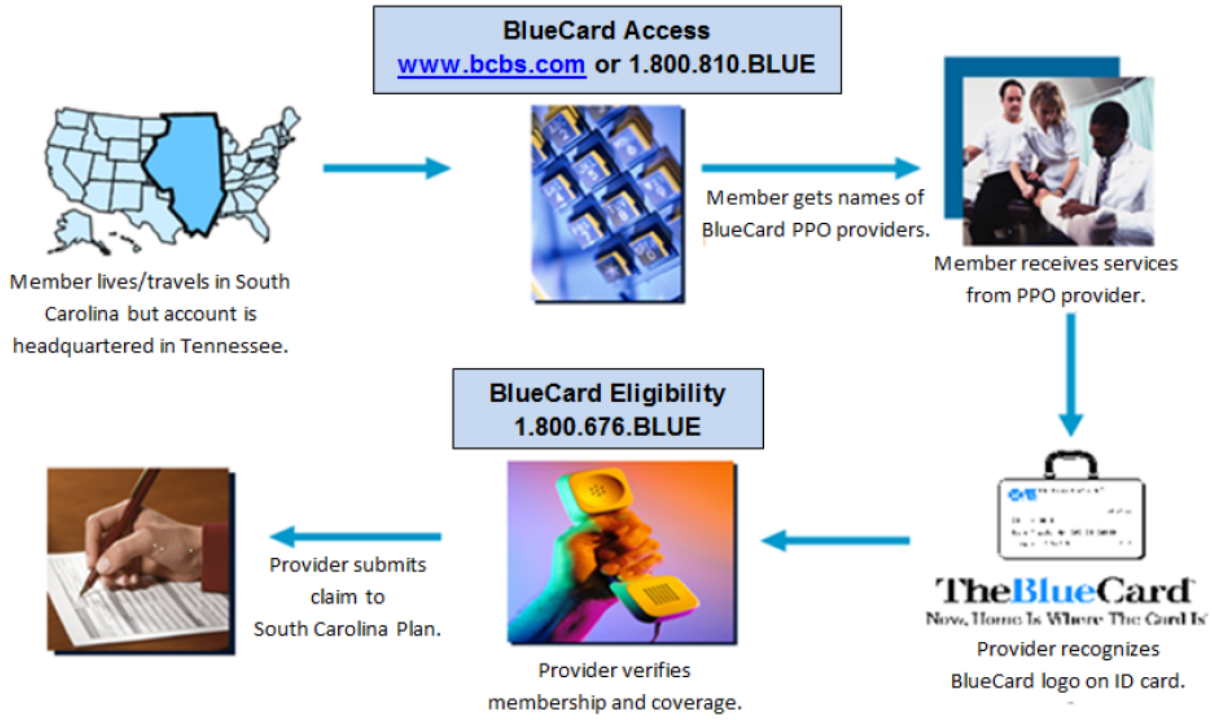
The BlueCard program lets you submit claims for Blue Plan members directly to your local BlueCross.

We will be your point of contact for education, contracting, claims payment/adjustments and problem resolution.

Products Included in the BlueCard Program	Products Excluded from the BlueCard Program
Traditional (indemnity insurance)	Stand-alone dental
Preferred Provider Organization (PPO)	
Health Maintenance Organization (HMO)	FEP
Medicare Advantage*	

*Medicare Advantage is a separate program from BlueCard.

How the BlueCard Program Works



BlueCard Program

Ancillary Filing Guidelines

Ancillary providers are independent clinical laboratories, providers of durable/home medical equipment and supplies and specialty pharmacy providers. You should file claims for your Blue Plan patients to BlueCross BlueShield 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.

- **Durable Medical Equipment (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 or where the referring physician is located.
- **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.

*Please note, BlueEssentials and Blue Option members do not have benefits for services provided by out-of-state providers, except in the event of an emergency. This also includes labs and durable medical equipment services. Members only have benefits within South Carolina when the provider is in the BlueEssentials or Blue Option network.

Most Common Denials

1. **Service (or member) is not covered**
   Some benefits that may not be covered include smoking cessation, certain routine benefits, infertility, obesity and dependent maternity.
   How to avoid these denials:
   a. Verify eligibility and benefits before rendering services using My Insurance Manager or by contacting the appropriate plan.
   b. Verify coverage requirements, limitations or coverage criteria by referring to any applicable medical policies.

2. **Duplicate charges**
   How to avoid these denials:
   a. Submit modifiers as appropriate
   b. Verify the place of service, date of service, procedure codes, modifiers, diagnoses, etc. are accurate before submitting
   c. Verify claim status before submitting claims a second time

3. **The primary payer information is needed**
   How to avoid these denials:
   a. Verify if the member has other insurance that may be primary
   b. Submit the primary payment information as necessary

4. **Filing errors**
   Some filing error denials occur due to an incorrect ID number, incorrect alpha prefix, the claim was filed to the incorrect plan or carrier, the rendering or referring provider NPI is missing, the NDC is missing, the diagnosis or procedure are inconsistent with the patient's age or gender and conflicting diagnosis/procedure combination was reported.
   How to avoid these denials:
   a. Always ask for the member's most current ID card.
   b. Verify if services are covered by an intermediary or other carrier.
   c. File claims to your local Blue Plan.
   d. Follow the ancillary filing guidelines, as appropriate for your specialty.
   e. Include the rendering or referring NPI.
   f. Submit the NDC along with the quantity and unit of measure for all drugs administered in the office or outpatient setting.
   g. Verify procedures and diagnoses before submitting claims.

5. **No authorization**
   A prior authorization is required but was not received.
   How to avoid these denials:
   a. Confirm authorization requirements before rendering services.
   b. Contact the appropriate benefits manager to complete prior authorization requests.
   c. Update authorizations when changes are needed (procedure, date of service, rendering physician, etc.).

If you have questions about claims, log in to My Insurance Manager. My Insurance Manager allows you to check claim status, connect to Provider Services using STATchat, submit your claims questions electronically using Ask Provider Services and attach documents electronically to claims for review.

You may also use the Provider Services VRU to check claim status.

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 a number of manual procedures.

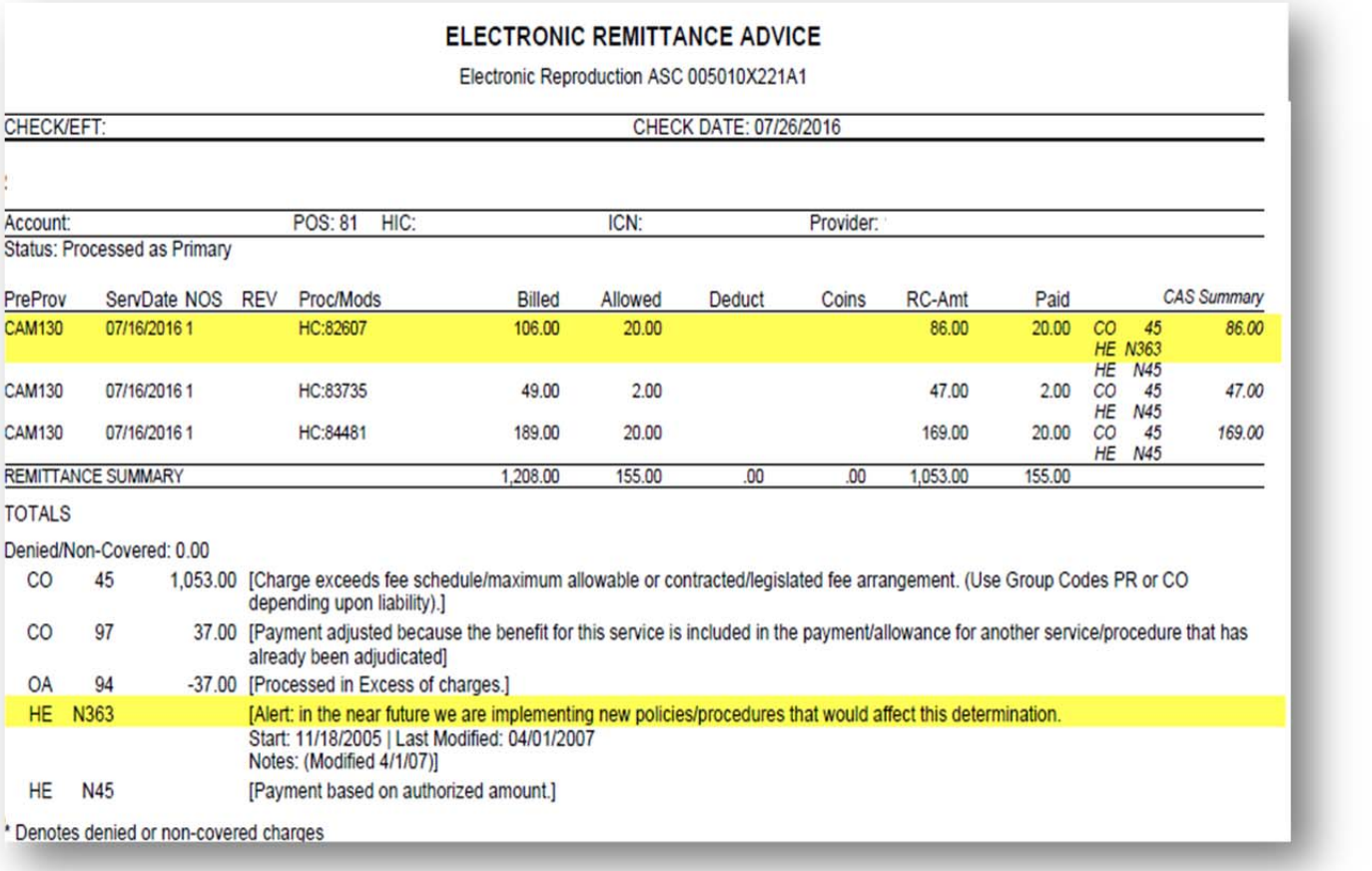
If you are adding or changing billing services or clearinghouses, please complete the ERA Addendum-Billing Services and Clearinghouse or ERA Addendum-Corporate Headquarters found on www.HIPAACriticalCenter.com. You will not need the BlueCross EDIG Trading Partner Enrollment form when only requesting 835 transactions for existing trading partners. Remittance advices are available in My Insurance Manager and My Remit Manager.

Understanding "Pay and Educate" Alerts

The pay and educate process allows providers to understand the impact on claim adjudication and payment when services they are providing have not complied with BlueCross medical policies. An alert on the remittance advice will notify a provider of the impacted service, advising that in the near future the Plan will implement new policies/procedures that would affect this determination. Claim adjudication and payment will continue with the alert for several weeks so providers have time to adapt the services they are providing to comply with Blue Plan medical policies and guidelines.

Electronic Remittance Example

- **Electronic Remit Alert Message: N363 – Alert:** In the near future we are implementing new policies/procedures that would affect this determination.



ELECTRONIC REMITTANCE ADVICE

Electronic Reproduction ASC 005010X221A1

CHECK/EFT: CHECK DATE: 07/26/2016

Account: POS: 81 HIC: ICN: Provider:

Status: Processed as Primary

PreProv	ServDate	NOS	REV	Proc/Mods	Billed	Allowed	Deduct	Coins	RC-Amt	Paid	CAS Summary	
CAM130	07/16/2016	1		HC:82607	106.00	20.00			86.00	20.00	CO 45 HE N363 HE N45	86.00
CAM130	07/16/2016	1		HC:83735	49.00	2.00			47.00	2.00	CO 45 HE N45	47.00
CAM130	07/16/2016	1		HC:84481	189.00	20.00			169.00	20.00	CO 45 HE N45	169.00
REMITTANCE SUMMARY					1,208.00	155.00	.00	.00	1,053.00	155.00		

TOTALS

Denied/Non-Covered: 0.00

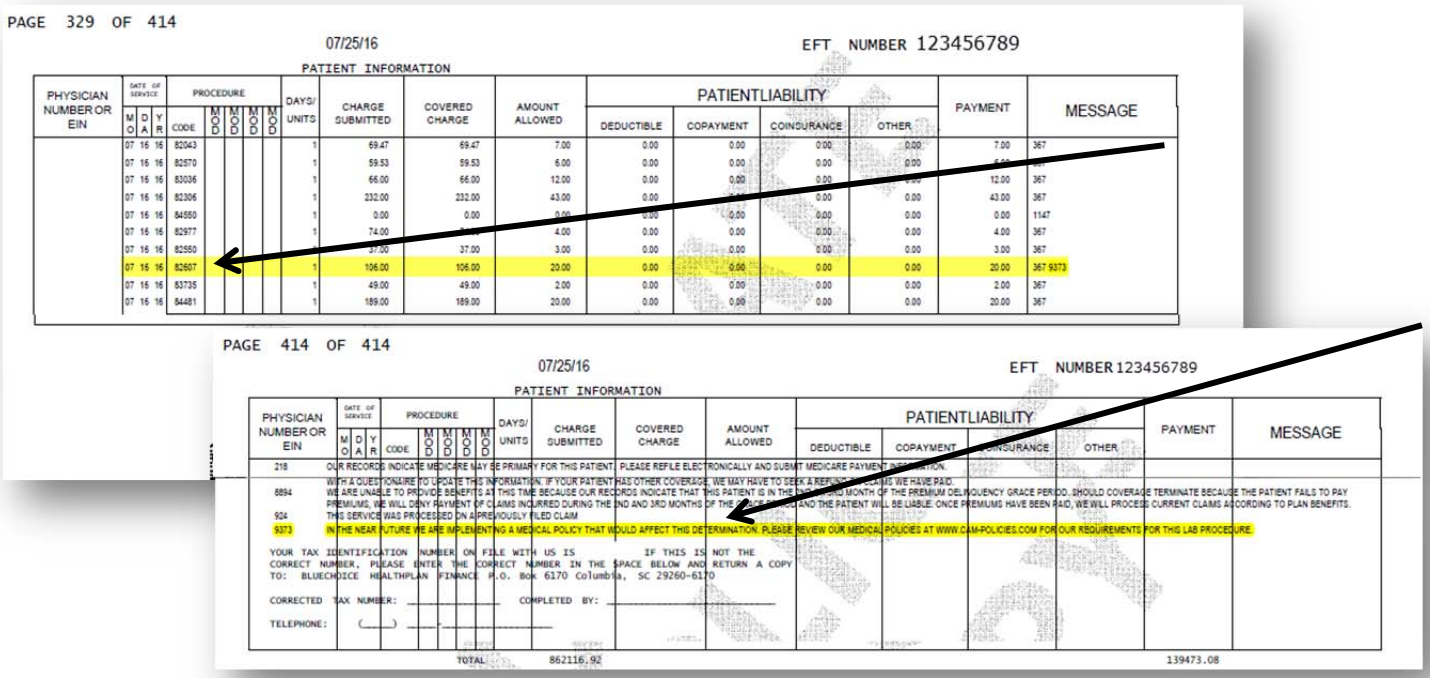
CO	45	1,053.00	[Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).]
CO	97	37.00	[Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated]
OA	94	-37.00	[Processed in Excess of charges.]
HE	N363		[Alert: in the near future we are implementing new policies/procedures that would affect this determination. Start: 11/18/2005 | Last Modified: 04/01/2007 Notes: (Modified 4/1/07)]
HE	N45		[Payment based on authorized amount.]

* Denotes denied or non-covered charges

Understanding "Pay and Educate" Alerts (continued)

Paper Remittance Example

- **Paper Remit Message: 9373** – In the near future, we are implementing a medical policy that would affect this determination. Please review our medical policies at WWW.CAM-POLICIES.COM for our requirements for this lab procedure.



PAGE 329 OF 414

07/25/16 EFT NUMBER 123456789

PATIENT INFORMATION

PHYSICIAN NUMBER OR EIN	DATE OF SERVICE M O	D A	Y R	PROCEDURE CODE	MOD	MOD	MOD	MOD	DAYS/ UNITS	CHARGE SUBMITTED	COVERED CHARGE	AMOUNT ALLOWED	PATIENT LIABILITY DEDUCTIBLE	COPAYMENT	COINSURANCE	OTHER	PAYMENT	MESSAGE
	07	16	16	82043					1	69.47	69.47	7.00	0.00	0.00	0.00	0.00	7.00	367
	07	16	16	82570					1	59.53	59.53	6.00	0.00	0.00	0.00	0.00		
	07	16	16	83036					1	66.00	66.00	12.00	0.00	0.00	0.00	0.00	12.00	367
	07	16	16	82306					1	232.00	232.00	43.00	0.00	0.00	0.00	0.00	43.00	367
	07	16	16	84550					1	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1147
	07	16	16	82977					1	74.00	74.00	4.00	0.00	0.00	0.00	0.00	4.00	367
	07	16	16	82550					1	37.00	37.00	3.00	0.00	0.00	0.00	0.00	3.00	367
	07	16	16	82607					1	106.00	106.00	20.00	0.00	0.00	0.00	0.00	20.00	367 9373
	07	16	16	83735					1	49.00	49.00	2.00	0.00	0.00	0.00	0.00	2.00	367
	07	16	16	84481					1	189.00	189.00	20.00	0.00	0.00	0.00	0.00	20.00	367

PAGE 414 OF 414

07/25/16 EFT NUMBER 123456789

PATIENT INFORMATION

PHYSICIAN NUMBER OR EIN	DATE OF SERVICE M O	D A	Y R	PROCEDURE CODE	MOD	MOD	MOD	MOD	DAYS/ UNITS	CHARGE SUBMITTED	COVERED CHARGE	AMOUNT ALLOWED	PATIENT LIABILITY DEDUCTIBLE	COPAYMENT	COINSURANCE	OTHER	PAYMENT	MESSAGE
218	OUR RECORDS INDICATE MEDICARE MAY BE PRIMARY FOR THIS PATIENT. PLEASE REFILE ELECTRONICALLY AND SUBMIT MEDICARE PAYMENT INFORMATION.																	
8894	WITH A QUESTIONAIRE TO UPDATE THIS INFORMATION. IF YOUR PATIENT HAS OTHER COVERAGE, WE MAY HAVE TO SEEK A REFUND FOR CLAIMS WE HAVE PAID. WE ARE UNABLE TO PROVIDE BENEFITS AT THIS TIME BECAUSE OUR RECORDS INDICATE THAT THIS PATIENT IS IN THE [illegible] MONTH OF THE PREMIUM DELINQUENCY GRACE PERIOD. SHOULD COVERAGE TERMINATE BECAUSE THE PATIENT FAILS TO PAY PREMIUMS, WE WILL DENY PAYMENT OF CLAIMS INCURRED DURING THE 2ND AND 3RD MONTHS OF THE [illegible] AND THE PATIENT WILL BE LIABLE. ONCE PREMIUMS HAVE BEEN PAID, WE WILL PROCESS CURRENT CLAIMS ACCORDING TO PLAN BENEFITS.															
924	THIS SERVICE WAS PROCESSED ON A PREVIOUSLY FILED CLAIM																	
9373	IN THE NEAR FUTURE WE ARE IMPLEMENTING A MEDICAL POLICY THAT WOULD AFFECT THIS DETERMINATION. PLEASE REVIEW OUR MEDICAL POLICIES AT WWW.CAM-POLICIES.COM FOR OUR REQUIREMENTS FOR THIS LAB PROCEDURE.																	
YOUR TAX IDENTIFICATION NUMBER ON FILE WITH US IS IF THIS IS NOT THE CORRECT NUMBER, PLEASE ENTER THE CORRECT NUMBER IN THE SPACE BELOW AND RETURN A COPY TO: BLUECHOICE HEALTHPLAN FINANCE P.O. Box 6170 Columbia, SC 29260-6170																		
CORRECTED TAX NUMBER: _____ COMPLETED BY: _____																		
TELEPHONE: (___) ___-_____																		
TOTAL										862116.92							139473.08	

Provider Reconsiderations

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. Please be sure to complete the form in its entirety and attach all supporting documentation.

Provider reconsideration requests should include an explanation of the issue(s) to be reconsidered, such as seeking additional benefits, or why we should reconsider the service. We require you to include any supporting documentation, such as member's history and physical, any operative reports, office notes, pathology reports, hospital progress notes, radiology reports and/or laboratory reports. We are unable to review requests that are submitted without supporting documentation.

Send the Provider Reconsideration Form to the appropriate fax number or address as provided on the form. You can also send Provider Reconsideration requests using the Claim Attachments feature within My Insurance Manager.

The table includes some reasons you may or may not want to request provider reconsideration. Please note this is not a comprehensive list of reasons to submit a provider reconsideration form for claim denial.

Reasons You May Request Provider Reconsideration	**Reasons You May Not Request Provider Reconsideration**
Medical necessity determination	Deductible/coinsurance issues
Cosmetic services	Benefit limitations
Investigational/experimental services*	Benefit exclusions
No authorization for inpatient stay	Membership issues
Multiple surgery and/or medical care a patient receives on the same day	Claims that include a primary insurer Explanation of Benefits (EOB)

It generally takes BlueCross and 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.

*Your documentation must support that the service in question is medically necessary and not experimental or investigational.

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.

This feature can be used for these plans:

- BlueCross
- BlueChoice
- FEP
- State Health Plan
- BlueEssentials
- Blue Option
- Out-of-State (BlueCard)

Please include the medical records cover sheet that was sent with the initial request for documentation for BlueCard claims. This ensures timely routing and processing of your attachments to the other Blue Plan.

Do You Know How to Use STATchat℠?

STATchat is a fast, free and simple way to talk with a Provider Services representative after you've searched online for the answer to a claims status or eligibility question. You can also use STATchat to get or to check the status of precertifications. To use STATchat, log in to My Insurance Manager.

If you still have a question after viewing claims status, eligibility and benefits, just click "Ask Provider Services" at the bottom of the page. Then click "Connect" at the top of the page.

If you have questions after checking the status of your authorization, or if you have begun the online precertification process, just click the "Ask Health Care Services" button at the bottom of the page.

Click the "Connect" button at the top of the page, and you will soon be speaking to a representative online. In fact, you will receive priority service and be connected to the next available agent. All you need is a headset with a microphone or a speaker and a microphone.

Colonoscopies: Preventive Billing vs. Diagnostic Billing

The American Gastroenterological Association (AGA) gives guidance on how to determine if a patient is referred for a screening colonoscopy or a diagnostic colonoscopy. The AGA is an independent company that offers colonoscopy guidelines on behalf of BlueCross and BlueChoice. Whether a patient has gastrointestinal (GI) symptoms or not before the procedure governs how you will bill for the service.

Refer the patient with no GI symptoms for a screening colonoscopy for these reasons:

- Patient is age 50 with no high-risk factors.
- Patient has a personal history of colon cancer or colon polyps.
- Patient has a family history (first-degree relative) of colon cancer or colon polyps.

Refer the patient for a diagnostic colonoscopy because of these symptoms:

- Blood in stool/hemopositive stool
- Bleeding from rectum
- Iron deficiency anemia of unknown cause
- Change in bowel habits
- Persistent abdominal pain

Colonoscopies: Preventive Billing vs. Diagnostic Billing (continued)

Screening or Early Detection Colonoscopy

If the initial, preprocedure intent is to perform a routine screening colonoscopy on an individual without GI symptoms:

- Use the preventive diagnosis code Z1211 (encounter for screening for malignant neoplasm of colon) or Z1212 (encounter for screening for malignant neoplasm of rectum) for the primary diagnosis. (This is because the initial intent of the procedure was screening or early detection.)
- Use secondary diagnosis codes for any conditions identified during the screening colonoscopy (for example, to remove a polyp).
- To whatever colonoscopy code most accurately describes the services performed, append modifier -33 (preventive or screening service).

If a patient who has a personal or family history of colon cancer or colon polyps returns for a follow-up screening and is without GI symptoms:

- Use the preventive diagnosis code Z1211 or Z1212 for the primary diagnosis code, as the intent of the procedure was screening.
- File the history of disease as the secondary diagnosis code (for example, Z85038 or Z85048, personal history of malignant neoplasm; Z800, family history of malignant neoplasm; or Z86010, personal history of colonic polyps).

Be sure to use the appropriate diagnosis code for screening colonoscopy claims and add modifier -33 to the accurate CPT code that describes the service you performed. Remember, screening and/or early detection colonoscopy is correctly coded only for individuals without GI symptoms, as is identified by the AGA.

Diagnostic Colonoscopy

If you perform a colonoscopy because the patient presents with GI symptoms:

- File the claim with the diagnosis that is the reason for the colonoscopy as the primary diagnosis. Do not append modifier -33 to the code that most accurately describes the service provided.

Mammogram Codes

The CPT codes currently used for diagnostic and screening mammograms will be deleted and replaced in 2017. These codes are being replaced with new codes that include computer aided detection (CAD) when performed.

The existing diagnostic and screening mammogram codes which will be deleted are 77055, 77056 and 77057. The existing CAD codes, 77051 and 77052, will also be deleted in 2017 to accommodate the new codes.

The new codes are 77065, 77066 and 77067. The code G0202 will also include CAD beginning Jan. 1, 2017. Please begin using the new codes for services on or after Jan. 1, 2017 to avoid claim denials.

Other information and important updates for 2017:

- Be mindful of age-specific CPT codes for well visits and file appropriately, e.g.:
  - 99395 – ages 18-39 years
  - 99396 – ages 40-64 years
  - 99397 – ages 65 years-older
  - Please remember, not all plans cover well visits
- Timely filing
  - Timely filing limits vary between different benefit plans.
  - To ensure you don't encounter timely filing issues we recommend that you file all claims within 90 days of the date of service.
- Patient Protection and Affordable Care ACT (PPACA)
  - Preventive benefits are payable for non-grandfathered plans when the specific criteria is met (age, gender, frequency, etc.) and when the designated procedure and diagnosis codes are submitted.
  - Services that are submitted with non-routine diagnosis codes will be processed as diagnostic and will apply member cost share, per the members' benefits.

Frequently Asked Questions

Our health care system has several locations that use the same tax identification number (TIN) when submitting claims. How do we get our claims to process under the correct NPI and not under the TIN so that payments are received to the correct location?
When filling your claims you should use the NPI for the location where the services are rendered.

What type of documents can I submit using the Claim Attachments feature in My Insurance Manager?
The type of document you can submit is based on the status of the claim you are reviewing. You are able to see what information is needed or accepted once you are on the Claim Status Detail page. The possible document types are:

- Accident Questionnaire
- Certificate of Medical Necessity for Durable Medical Equipment
- Medical Record
- Other Health Insurance
- Primary Carrier EOB
- Provider Reconsideration

What can I do about an issue with electronic claims and modifiers not transmitting through our clearinghouse?
Our EDI department can work with your clearing house if there is a problem with us not getting your claim submissions. Contact EDI by email at edi.services@bcbssc.com or by phone at 800-868-2505.

Where can I view the medical policies?
To access medical policies:

1. From the BlueCross homepage, select “Provider” at the top of the page.
    a. Select “Education Center” on the right side of the page.
    b. Under “Medical Policies and Clinical Guidelines” in the center of the page, select “Medical Policies.”

2. From the BlueChoice homepage, select “Provider” on the left side of the page.
    a. Select “Resources” on the right side of the page.
    b. Select “Medical Policies” on the right side of the page and then select “Medical Policies” in the center of the page.

3. This takes you to the Medical Policies Disclaimer page. Read and accept the disclaimer to get to the listing of medical policies.

4. You can then search topics by alphabet or category as well as search by keywords. If you have questions about medical policies, contact Medical Affairs by choosing “Contact Us” at the top of the screen. Our clinical staff will review your question and contact you.

OVERVIEW

A presentation of the Avalon Lab benefit management program including precertification requirements, claim editor description, details about the Trial Claim Advice Tool and medical policy video library.

Avalon Healthcare Solutions

Our Plans work with Avalon to administer a comprehensive suite of laboratory benefit management services. Avalon is an independent company that provides benefit management services on behalf of BlueCross and BlueChoice.

Web Resources

- Avalon Participating Laboratory List
- Preauthorization Matrix
- Trial Claim Advice Tool
- Avalon Medical Policy Video Library
- Medical Policies

Also Visit

- Education Center
- Provider News
- www.Avalonhcs.com

AVALON HEALTHCARE SOLUTIONS

BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Avalon Healthcare Solutions

Who we are

- Avalon is a clinical services and information technology company providing comprehensive diagnostic laboratory management services to health plans.
- Avalon uses the latest evidence-based medicine to support robust laboratory-related medical policies.
- Avalon's program is a compliant and reliable extension of BlueCross' medical management program.

What we bring and how we are different

- Medical Policy - Continuing evaluation of industry developments resulting in creation of new medical policies or revisions to existing policies
- Network - Dedicated to ensuring that patients receive high quality, cost-effective laboratory testing
- Technology - Complex claims editor for adherence to policies
- Analytics - Supported by lab values that enhance member quality of care
- Member Focus – Access to high quality, cost effective laboratory services

Network

The Avalon contracted network of labs is designed to meet the access and clinical needs of the South Carolina market's physicians and the patients that they serve. BlueCross, BlueChoice and Avalon are dedicated to ensuring that your patients receive the highest quality laboratory testing at the most reasonable cost.

It is imperative to use the services of in-network laboratory service providers.

Some of the key benefits for using in-network providers are:

- The costs of lab services are aligned to the patient's benefit design to ensure the lowest out-of-pocket cost for patients.
- In-network labs are monitored to provide high standards for quality, science and service. Out-of-network lab services are not held to the same high standards, which may result in variances in the quality of results, science and service.
- Coordination of benefits and patient care work best through the use of an in-network lab provider.

You can verify which laboratories are participating in our networks by accessing our Provider Directories on our provider websites.

Prior Authorizations

Avalon leverages technology to minimize prior authorization and increase physician satisfaction. The complexity of some testing requires accumulation of additional clinical information. Prior authorization guidelines are developed to manage:

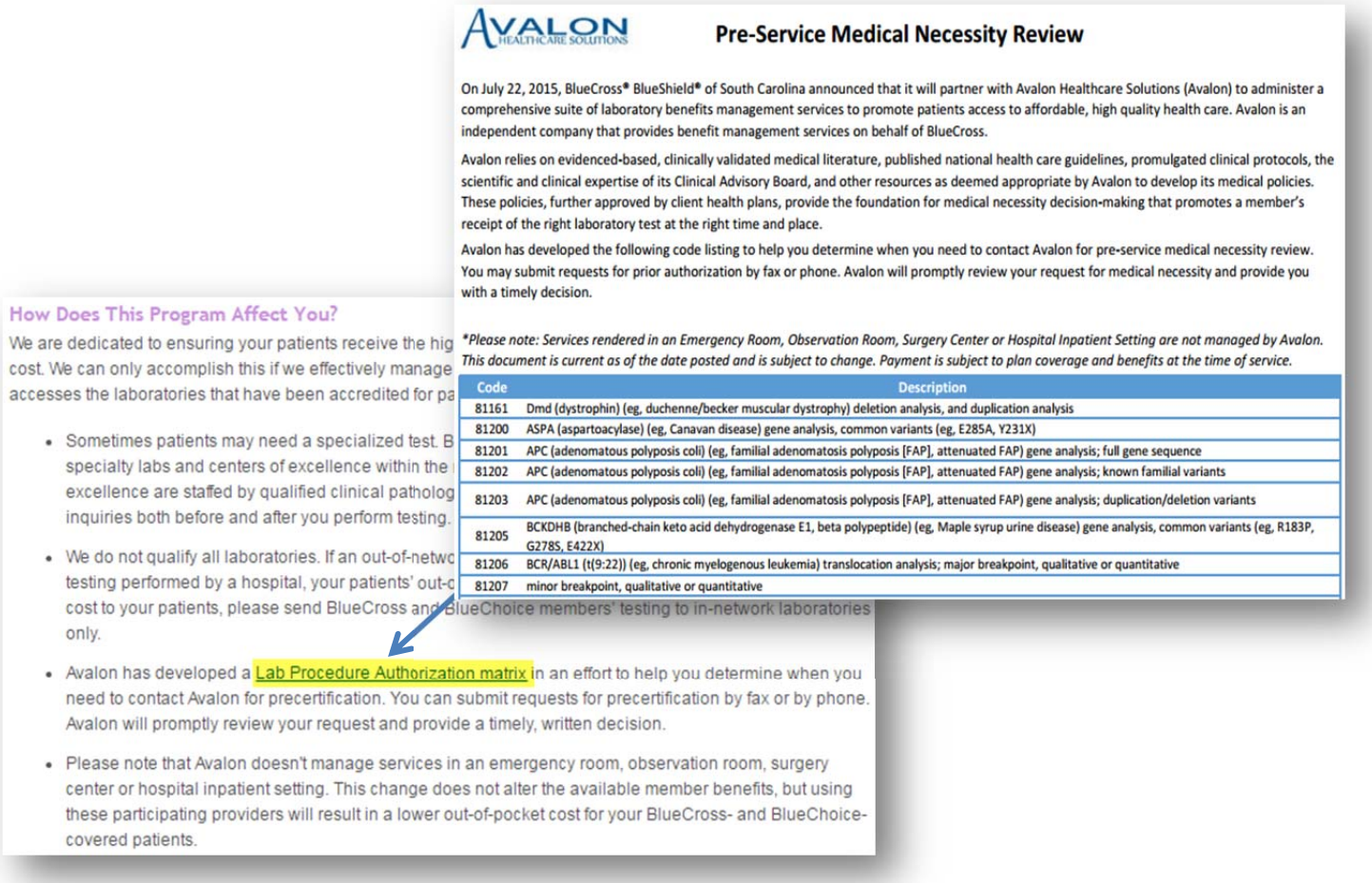
- Clinical complexities
- New technology
- Fraud, waste and abuse prevention

Check for preauthorization requirements on genetic testing, cytogenetic testing and molecular pathology codes on the BlueCross website in the Education Center. You can search the list of tests that require prior authorization by referring to the Avalon Lab Procedure Authorization Matrix.
You may submit prior authorization requests via phone or fax:

- **Phone: 844-227-5769**
- **Fax: 888-791-2181**

Avalon will promptly review you request for medical necessity and provide you with a timely, written decision.
It is the responsibility of the referring physician to obtain the authorization; however, the lab may do so if it has the necessary clinical information.

The 2017 Lab Procedure Authorization Matrix can be accessed by first going to the Education Center, then Lab Precertification within the Provider section of both websites.



AVALON HEALTHCARE SOLUTIONS

Pre-Service Medical Necessity Review

On July 22, 2015, BlueCross® BlueShield® of South Carolina announced that it will partner with Avalon Healthcare Solutions (Avalon) to administer a comprehensive suite of laboratory benefits management services to promote patients access to affordable, high quality health care. Avalon is an independent company that provides benefit management services on behalf of BlueCross.

Avalon relies on evidenced-based, clinically validated medical literature, published national health care guidelines, promulgated clinical protocols, the scientific and clinical expertise of its Clinical Advisory Board, and other resources as deemed appropriate by Avalon to develop its medical policies. These policies, further approved by client health plans, provide the foundation for medical necessity decision-making that promotes a member's receipt of the right laboratory test at the right time and place.

Avalon has developed the following code listing to help you determine when you need to contact Avalon for pre-service medical necessity review. You may submit requests for prior authorization by fax or phone. Avalon will promptly review your request for medical necessity and provide you with a timely decision.

**Please note: Services rendered in an Emergency Room, Observation Room, Surgery Center or Hospital Inpatient Setting are not managed by Avalon. This document is current as of the date posted and is subject to change. Payment is subject to plan coverage and benefits at the time of service.*

Code	Description
81161	Dmd (dystrophin) (eg, duchenne/becker muscular dystrophy) deletion analysis, and duplication analysis
81200	ASPA (aspartoacylase) (eg, Canavan disease) gene analysis, common variants (eg, E285A, Y231X)
81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence
81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants
81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants
81205	BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, Maple syrup urine disease) gene analysis, common variants (eg, R183P, G278S, E422X)
81206	BCR/ABL1 (t(9:22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative
81207	minor breakpoint, qualitative or quantitative

How Does This Program Affect You?

We are dedicated to ensuring your patients receive the hig
cost. We can only accomplish this if we effectively manage
accesses the laboratories that have been accredited for pa

- Sometimes patients may need a specialized test. B
specialty labs and centers of excellence within the
excellence are staffed by qualified clinical patholog
inquiries both before and after you perform testing.
- We do not qualify all laboratories. If an out-of-netwo
testing performed by a hospital, your patients' out-o
cost to your patients, please send BlueCross and BlueChoice members' testing to in-network laboratories only.
- Avalon has developed a Lab Procedure Authorization matrix in an effort to help you determine when you need to contact Avalon for precertification. You can submit requests for precertification by fax or by phone. Avalon will promptly review your request and provide a timely, written decision.
- Please note that Avalon doesn't manage services in an emergency room, observation room, surgery center or hospital inpatient setting. This change does not alter the available member benefits, but using these participating providers will result in a lower out-of-pocket cost for your BlueCross- and BlueChoice-covered patients.

Claim Editor Tool

Avalon has implemented the Avalon Claim Editor, which is designed to provide consistent application of our medical policies to laboratory services during the claims adjudication process. The Claim Editor automates claim adjudication based on sound scientific, clinically based policies for laboratory tests.

Claim Editor evaluates laboratory procedures on the claim for appropriateness:

- Patient medical conditions
- Patient demographics
- Frequency between laboratory procedures
- Threshold of allowable units
- Experimental and investigational procedures

Rule	Definition
Experimental and Investigational	Procedure is not covered under the member's benefit due to the experimental and investigational exclusion
Demographics	Limitations based on patient age or gender
Procedure Units	Within and across claim for a date of service
Units/Period of Time	Maximum allowable units within a defined period of time
Time Between Procedures	Minimum time required before a second procedure is medically necessary
Rendering Provider Limitations	Providers/procedures not permitted in combination
Diagnosis Constraints and Allowances	Procedure and diagnosis required or prohibited combination

Beginning with dates of service on or after July 1, 2016, the Avalon Claim Editor has been configured to process laboratory claims.

Edits have been phased in with alerts to notify you when lab tests have not met our medical policy criteria as well as which medical policy (e.g., CAM 130) was used. The pay and educate time period allows providers time to evaluate practice patterns and does not impact claim payment. Please see the pay and educate alert codes:

- **Electronic Remit Alert Message: N363 – Alert: In the near future we are implementing new policies/procedures that would affect this determination.**
- **Paper Remit Message: 9373 – In the near future, we are implementing a medical policy that would affect this determination. Please review our medical policies at WWW.CAM-POLICIES.COM for our requirements for this lab procedure.**

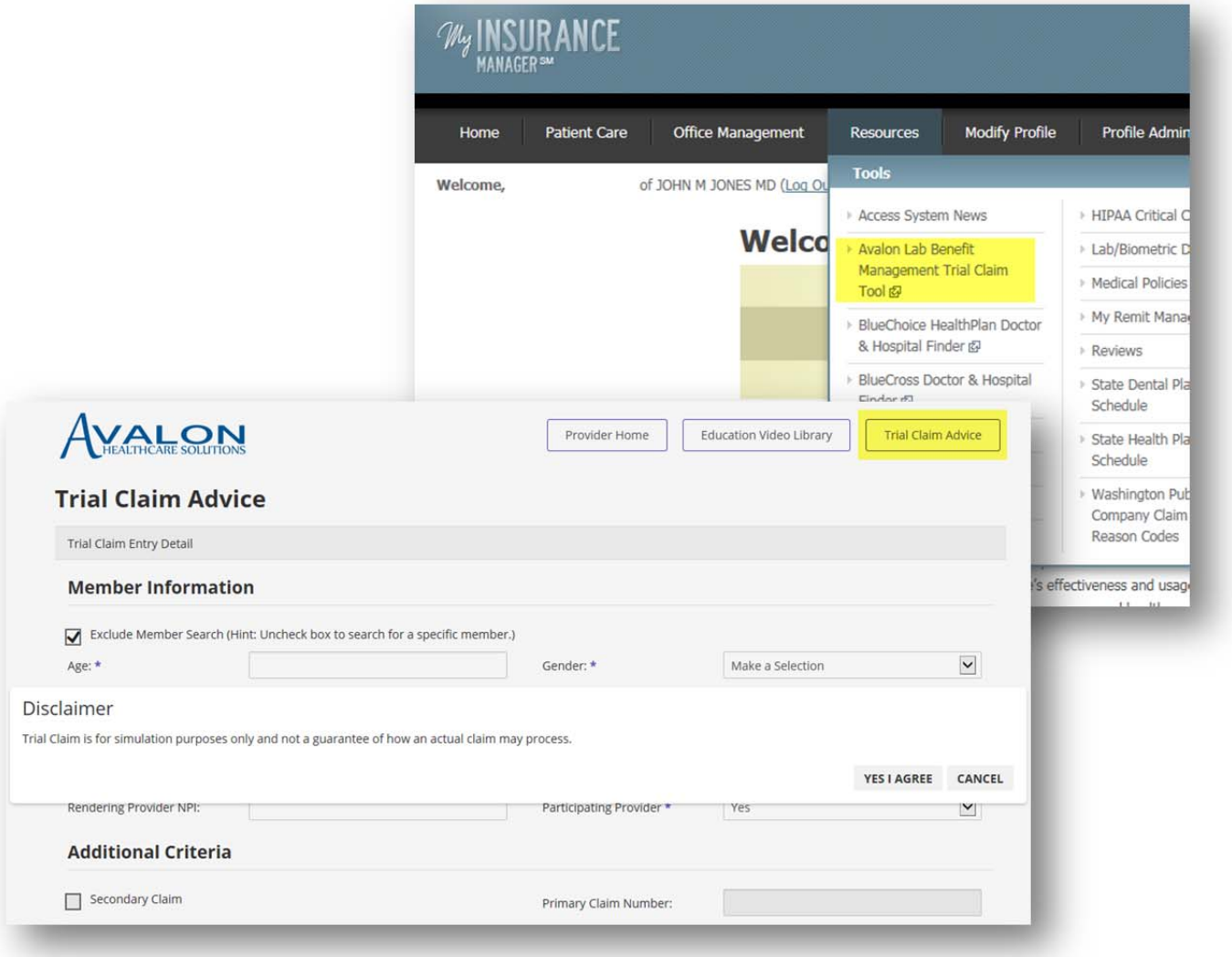
The laboratory medical policy edits go live:

- **Nov. 1, 2016 - Independent laboratories (POS 81)**
- **Jan. 1, 2017 - Hospitals (POS 19 and 22) and Physician offices (POS 11)**

Trial Claim Advice Tool

Avalon developed the Lab Benefit Management Trial Claim Advice Tool, which allows you to input specific information to determine how the Claim Editor will review claims for lab services. The tool can be accessed in My Insurance Manager in the Resources section.

The Trial Claim Advice Tool allows the user to simulate the Claim Editor processing of specific procedure codes and diagnoses:



Policy Education Library

Avalon's Clinical Advisory Board Chair, Dr. Geoffrey Baird hosts a video library of policy rationale and guidance on the Avalon portal that can be accessed via My Insurance Manager in the Resources section using the "Avalon Lab Benefit Management Trial Claim Tool" link to sign in to the Avalon provider portal.

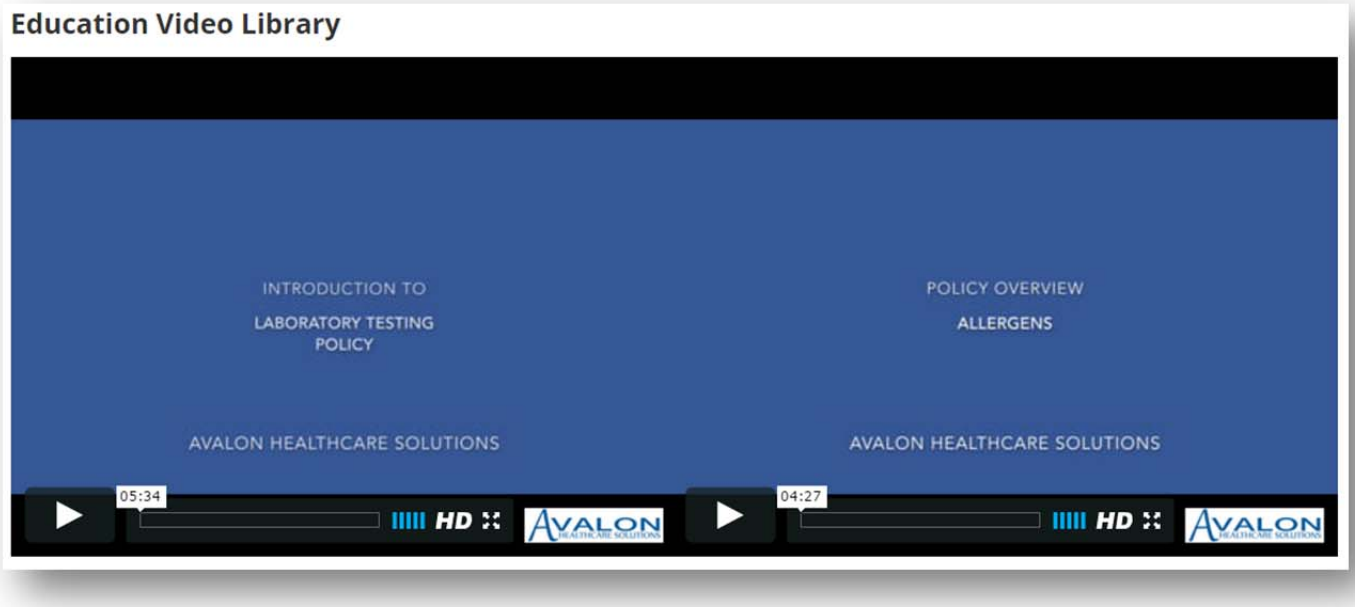
NEW – Policy Education Video Library

Avalon's Clinical Advisory Board Chair, Dr. Geoffrey Baird, provides an understanding of the rationale for policies. The "**Introduction to Laboratory Testing Policy**" video provides the fundamentals of our policy development. The following policies are also included in our education video library:

- Allergens
- Cardiovascular and Lipid
- Cervical Cancer Screening

These policies are part of the video library:

- Allergens
- Cardiovascular and Lipid
- Cervical Cancer Screening
- Hemoglobin A1c
- Rapid Influenza
- Vitamin B12
- Vitamin D



Avalon Healthcare Solutions – Quick Tips

Access the Avalon Trial Claim Advice Tool from within My Insurance Manager to see how the Claim Editor will review codes and what medical policies may apply. Also view:

- Frequently Asked Questions
- Claim Editor Advice Tool User Training Guide

Visit the Lab Precertification pages on both websites for bulletins, guides, presentations and other resources.

For additional questions please contact:

- Avalon Provider Services at 855-895-1676
- BlueCross Provider Education at provider.eduction@bcbssc.com or by calling 803-264-4730

Remember to send members to **in-network laboratories**. Here is the list of participating laboratories, as of **Nov. 1, 2016**. This information is subject to change. Please visit our websites for future updates.

Laboratories and Lab Specialty	
Aegis Sciences Corporation	Toxicology
American Institute of Toxicology	Toxicology
Ameritox, Ltd.	Toxicology
Bako Pathology	SPC Pathology
BioReference	All
GeneDx, Inc.	Genetics
Boston Heart Diagnostics	Cardiovascular Diagnostics
American Forensic Toxicology Services, LLC	Toxicology
Regional Toxicology Services, LLC	Toxicology
Rocky Mountain Toxicology, LLC	Toxicology
Secon of New England, LLC	Toxicology
Technical Resource Management, LLC	Toxicology
Counsyl, Inc.	Genetics
Diatherix Laboratories, LLC	SPC Micro
Genomic Health	Oncology
Genoptix	Oncology
Greenwood Genetic Center	Genetics
Laboratory Corporation of America	All

Laboratories and Lab Specialty	
Accupath Diagnostics	General
Esoterix Genetic Laboratory	Genetics
Esoterix Inc (Genzyme)	Genetics
Genzyme Genetics (Integrated Genetics)	Genetics
Dianon Systems	Pathology
Liposcience	Heart Disease
Litholink Corporation	Stone Analysis
Medtox Laboratory	Toxicology
Monogram Bisosciences	Pathology
Viro-Med Laboratories Inc.	Infectious Disease
LabSource, LLC	Toxicology
Labtech Diagnostics	All
Medical Diagnostic Laboratories, LLC	SPC Micro
Millennium Health, LLC	Toxicology
Myriad Genetic Laboratories	Genetics
Premier Medical Inc.	Toxicology/Routine
Quest	All
Select Laboratories	Regional Lab
Solstas Laboratory Partners	All

OVERVIEW

Find out when and how to submit a prior authorization request for service to our plans, including those services managed by NIA Magellan and others.

Preauthorization, Precertification and Prior Authorization

These terms are used interchangeably to note a process used to determine if services will be covered by the Plan. Some services routinely require precertification or admission certification for our Plans. Other services require precertification due to the member's contract benefits, type of service, etc.

Web Resources

- Precertification Request Forms.
- Lab Procedure Authorization Matrix.
- Group Prefixes Requiring NovoLogix Prior Authorizations. Novologix is a product of CVS/caremark, a division of CVS Health, an independent company that provides pharmacy services on behalf of BlueCross and BlueChoice.
- Guide: What You Need to Know About Medical Specialty Drug Prior Authorizations.
- Specialty Medical Benefit Management Frequently Asked Questions.
- My Insurance Manager Training Guides.
- Lab Procedure Authorization Matrix.
- Medical Specialty Drug List.
- NovoLogix Prior Authorization Provider Training Video.
- Specialty Medical Benefit Management Presentation.

Also Visit

- www.RadMD.com (NIA Magellan)
- www.Avalonhcs.com (Avalon)
- Education Center

My Insurance Manager

My Insurance Manager features an automated authorization, precertification and referrals tool that allows you to request authorizations for many patient services online. You can also check the status of an existing request. Select Precertification/Referral from the drop-down menu under the Patient Care tab in My Insurance Manager. Choose the appropriate member health plan, enter member information in all required data fields and then select the type of service. For certain services, the authorization request may automatically approve or be placed in a pending status for further review. A pended authorization is review of information from the precertification request, along with any supporting documentation to determine medical necessity of the treatment.

Use the clinical attachments feature in My Insurance Manager to upload supporting documentation for services that do not automatically approve. Our system will accept up to 10 PDF documents per request created in Adobe Acrobat version 1.3 or higher. There is a maximum file size of 30 MB per document.

Quick Tip:
Please submit detailed specifics related only to the requests you wish to authorize. Submitting additional information not requested by our clinicians may delay precertification processing.

BlueCard Electronic Provider Access (EPA)

Use EPA to request precertification for out-of-area (BlueCard) members. Go to www.SouthCarolinaBlues.com. Select the menu options Education Center, Precertification and then the BlueCard precertification tool.

Next, enter the alpha prefix from the member's ID card. The alpha prefix is the first three alpha characters that precede the member ID. You can first check whether the Blue Plan requires precertification by either:

- Sending a service-specific request through BlueExchange®.
- Accessing the Blue Plan's precertification requirements pages by using the medical policy router. Go to www.SouthCarolinaBlues.com. You will then select Providers, Education Center, Precertification and then BlueCard Precertification Medical Policies Tool.

Once in the Blue Plan's provider portal, you will have the same access to electronic preservice review capabilities as the Blue Plan's local providers. The Blue Plan landing page will look similar across Blue Plans, but will be customized to the particular Blue Plan based on the electronic preservice review services it offers.

The availability of EPA will vary depending on the capabilities of each Blue Plan. Some Blue Plans will be fully implemented and have electronic preservice review for many services. Others will not yet have implemented electronic preservice review capabilities. This section describes how to use EPA and what to expect when attempting to contact Blue Plans at different stages of implementation.

Medical Forms Resource Center (MFRC) Benefits & Security

BlueCross is dedicated to working together with our network providers. We want to continue to provide you with information that is helpful to your practice.

We have introduced an online MFRC to allow providers to submit clinical information for review. This feature became available in the first quarter of 2017. Using the MFRC is fast and efficient and can result in a quicker decision for the member.

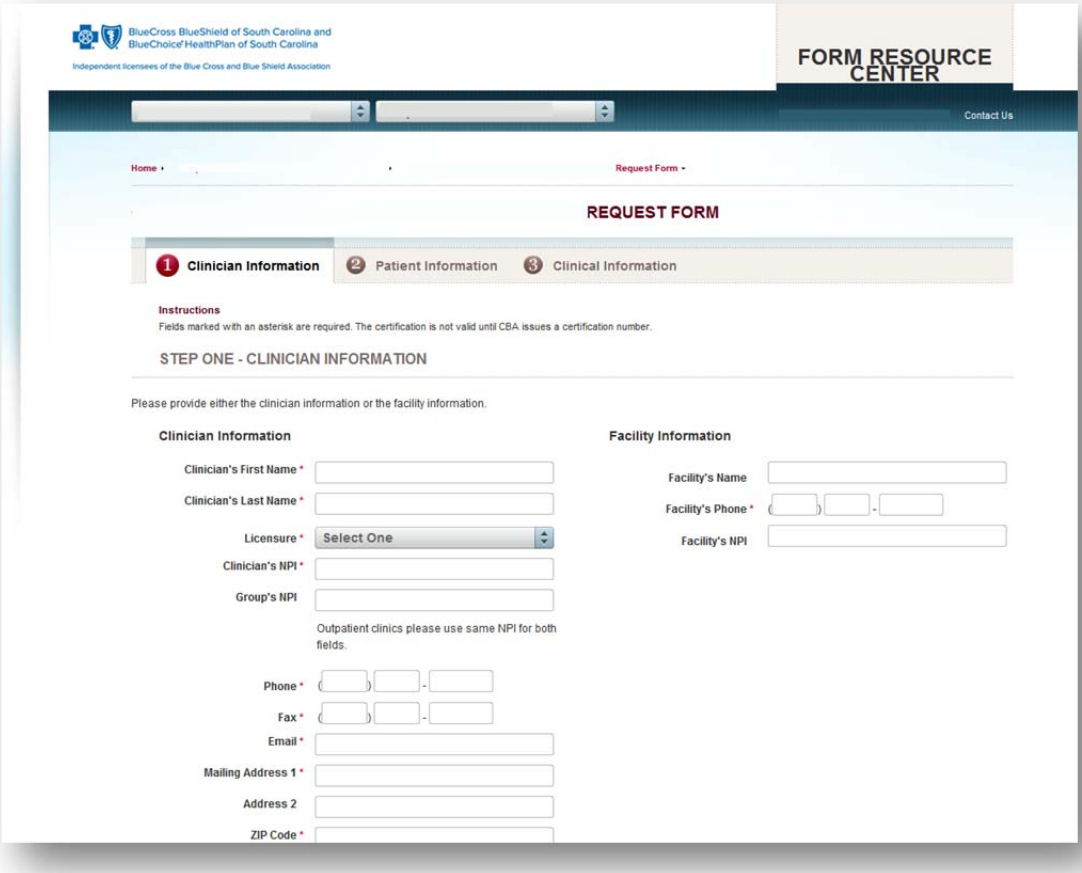
MFRC Accuracy

When you complete an MFRC request, you will be prompted to provide the specific administrative and clinical information to support your request. 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 that it is clearly legible. This helps to prevent follow-up calls for faxes that didn't transmit or print properly.

MFRC Security

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.



NIA Magellan

Many plans require prior authorization for procedures through NIA Magellan.

Advanced Imaging Services

BlueCross will not reimburse claims for computerized tomography/computed tomography angiography (CT/CTA) scans, magnetic resonance imaging (MRI), magnetic resonance angiography (MRA) and positron emission tomography (PET) scans that NIA has not properly authorized.

BlueChoice will not reimburse claims for these services if precertification is not received:

- CT/CTA
- CT Colonography
- Coronary CTA
- MRCP
- MRI/MRA
- PET Scans
- Nuclear Cardiology Studies
- Stress Echocardiology

Verify prior authorization requirements before providing services. Please note: Some services require prior authorization directly through our Plans. Visit www.RadMD.com to request prior authorization or find out the status of a precertification request.

NIA Magellan

Radiation Oncology

The purpose of this program is to ensure that members receive the most appropriate radiation therapy treatment consistent with our medical policies, evidence-based clinical guidelines and standards of care followed for treatment. These clinical guidelines are aligned with national standards and peer-reviewed literature. They will be totally transparent and available to the provider community.

The radiation oncologist determining the treatment plan and providing the radiation therapy is responsible for submitting the prior authorization and medical necessity review request on behalf of our members. The radiation oncologist is responsible for getting the authorization number before initiating treatment.

Once you successfully submit all required patient clinical information to NIA Magellan for review, it will make a medical necessity determination within two to three business days. For the most expedient turnaround time, use www.RadMD.com to submit requests.

Please be sure to supply all requested information at the time of the request to ensure medical necessity can be confirmed quickly for your physicians and patients.

For requests deemed medically necessary, you will receive written (via fax) and verbal notification of the prior authorization determination.

For requests not deemed medically necessary, you will receive written (via U.S. mail) and verbal notification of the prior authorization determination.

Verify prior authorization requirements before providing services. Please note: Some services require prior authorization directly through our Plans.

Musculoskeletal Program

This program includes prior authorization for two components of non-emergent musculoskeletal care: outpatient, interventional spine pain management services; and inpatient and outpatient lumbar and cervical spine surgeries. BlueCross and BlueChoice plans not participating in the program include FEP, State Health Plan, self-funded plans and out-of-state members (BlueCard).

- It is the responsibility of the ordering physician to get prior authorization for all interventional spine pain management procedures and spine surgeries outlined.
- Magellan Healthcare 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 non-payment of the claim.

Verify prior authorization requirements before providing services. Please note: Some services require prior authorization directly through our Plans.

Specialty Medical Drug Benefit and NovoLogix

On June 1, 2016, BlueCross BlueShield of South Carolina and BlueChoice HealthPlan began managing certain specialty drugs (injectable/infusible) under the medical benefit and requiring providers to get prior authorizations through NovoLogix, CVS/caremark's online prior authorization tool, for those drugs. NovoLogix is an industry-leading software system that assists in managing drugs reimbursed under the medical benefit and is a web-based application available with single sign-on access through My Insurance Manager.

Getting Medical Pharmacy Prior Authorizations

There are three ways to get prior authorizations for medical specialty drugs:

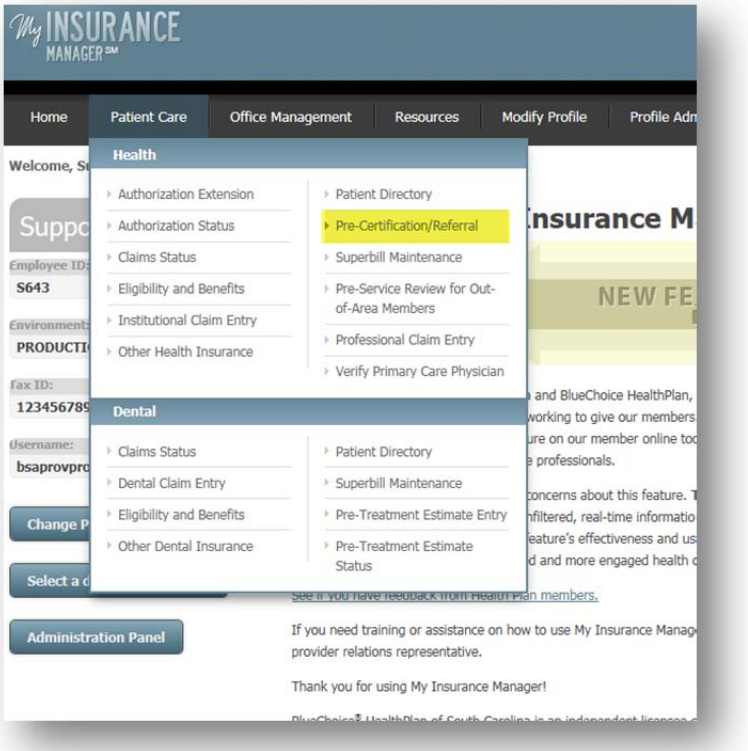
1. Call NovoLogix at 866-284-9229.
2. Fax NovoLogix at 844-851-0882.
3. Online through My Insurance Manager.

My Insurance Manager is our preferred method for you to get authorizations. Go to our websites, www.SouthCarolinaBlues.com or www.BlueChoiceSC.com, then to My Insurance Manager. Enter the required information to go to the NovoLogix system.

Using My Insurance Manager

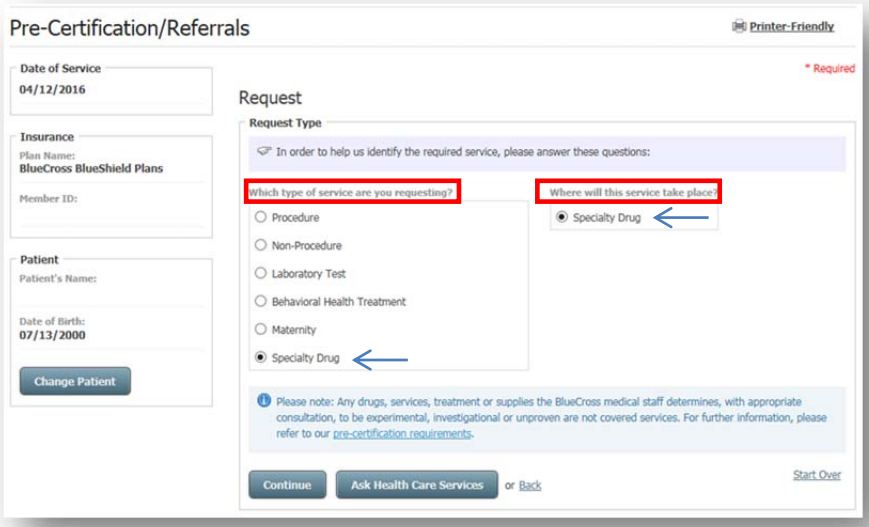
Providers will generate a prior authorization request as they do today using the **Pre-certification/Referral** option through My Insurance Manager.

After completing the **Patient Selection** and **Request Type** fields, continue to either the **Fast Track Reques**t or submit a **Customized Precertification Request**.

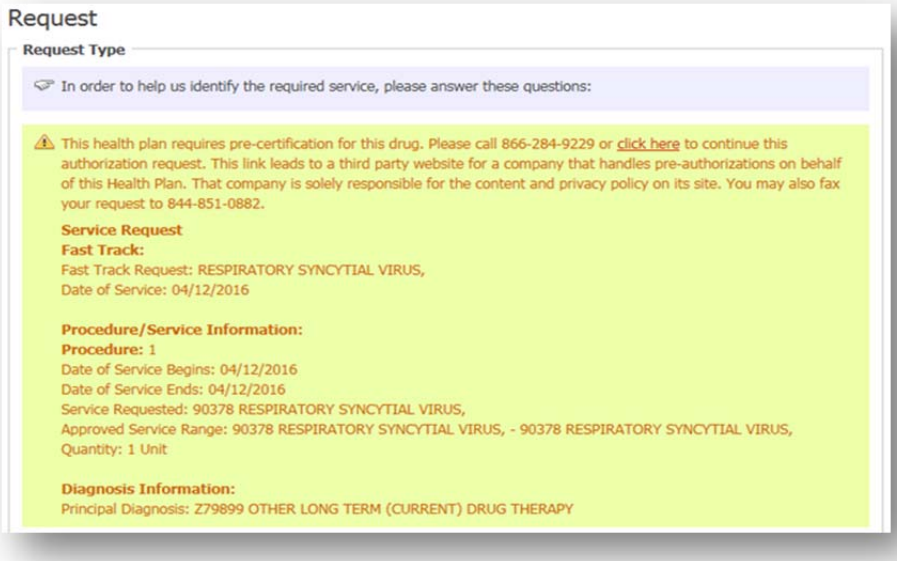


Using My Insurance Manager (continued)

You must specify **Specialty Drug** as the type of service you are requesting and where the service will take place in the **Request Type** section on the **Request** page, and then select **Continue**.



A pop-up box will appear telling you that precertification is required for the drug.



Frequently Asked Questions

How can I verify if a patient's insurance plan requires prior authorization?
We encourage providers to use My Insurance Manager to verify benefits, eligibility and if a prior authorization is required at each patient visit.

How will I receive a confirmation for a prior authorization request I submitted electronically through the NovoLogix system? How can I check the status of pending requests?
Prior authorization requests will either be auto approved or released to the next party for review. The status will be displayed at the top screen of the NovoLogix portal. You can view the approved or denied status of all pending requests on the NovoLogix landing page through My Insurance Manager.

Do I have to submit all prior authorizations for specialty drugs and additional clinical information online or can I fax them to NovoLogix?
The preferred method of submitting prior authorizations to NovoLogix is via My Insurance Manager. Providers may also fax authorization requests to 844-851-0882 or call 866-284-9229. You can submit additional clinical information electronically through the NovoLogix portal or by calling NovoLogix with the requested information, if applicable.

Will the pharmacy benefits prior authorizations process move to NovoLogix in the future?
NovoLogix is an industry-leading software system that assists in managing drugs reimbursed under the medical benefit. Providers prescribing specialty drugs billed under the member's pharmacy benefit will continue to request prior authorizations as usual through CVS/caremark.

Is there a crosswalk to convert J-codes to the required NDCs when creating a prior authorization request?
There is no crosswalk to convert J-codes to NDCs. When creating a prior authorization request on the NovoLogix system, input the drug name, and a drop-down list of NDCs associated with that drug will populate for selection. You can find NDCs on the drug packaging and online by searching the drug name.

Sometimes the NDC of the medication that will be given to the patient is unknown until the patient is present and ready for treatment. How can we provide an NDC number for Irinotecan, Gemcitabine, etc., at the time we are requesting authorization?
When requesting a prior authorization, enter the most accurate information about the drug, to include NDCs and quantity. BlueCross and BlueChoice will be monitoring provider-filing practices to assist in avoiding possible claim denials.

Will CVS/caremark implement new medical policies for prior authorizations, or will the current BlueCross medical policies be used?
The NovoLogix system will use policies that BlueCross has reviewed and approved. They may use the same criteria as the current BlueCross medical policies, or they may be somewhat different.

What should I do if my prior authorization request is denied?
You can request a reconsideration if you have additional clinical information to support medical necessity.

OVERVIEW

Learn about program benefits, the health coaching process and important plan tools.

CBA

CBA is a separate company that manages behavioral health and substance abuse benefits on behalf of BlueCross and BlueChoice.

Web Resources (CBA website)

- Best Practices
- Claims 101
- Clinical Forms
- Join the Network
- Precertification 101
- Request Precertification

Companion
BENEFIT ALTERNATIVES

BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina
Independent licensees of the Blue Cross and Blue Shield Association

Companion Benefit Alternatives (CBA)

CBA is a behavioral health managed care company. Since 1992, CBA has managed behavioral health care services on behalf of several health plans, including BlueCross, BlueChoice, PAI and FEP.

CBA's clinical staff has diverse educational and professional backgrounds. Its staff is made up of psychiatrists, psychiatric nurses, licensed master's level social workers, licensed professional counselors and certified addiction counselors.

CBA has an extensive network of providers who specialize in behavioral health care and substance use treatment. Before joining the CBA network, a provider must meet stringent credentialing requirements. The CBA provider contract specialist is available to conduct educational and training visits about the precertification process, filing claims, checking benefits and using the online filing tool. Please call 800-868-1032, or email a specialist if you have any questions or to arrange a visit. CBA provider network representative contact information is included on the last page of this section.

CBA Website: www.CompanionBenefitAlternatives.com

You can access numerous tools and resources in one easy-to-use section of the website. Just follow these simple steps:

- Click on "Providers."
- Click on "Resources."
- Enter the password: cba123.

Providers and their office staff can access this information 24 hours a day, seven days a week.

- Network updates
- Protocols
- Administrative forms
- Utilization management information
- Clinical practice guidelines
- Form Resource Center
- Link to the online claims filing tool

Remember, the website will be your source for the latest manual updates and provider bulletins. So please take a mo¬ment to explore the website. If you are interested in a demonstration of the website or the online claims-filing tool, please call 800-868-1032.

Eligibility and Benefits

The member's health plan provides eligibility and benefit information, as well as claims processing. CBA certifications are subject to the member's current benefit and eligibility status at the time the service is rendered.

To verify benefits, please contact the Provider Services area for the patient's health plan. CBA does not give out benefit information.

Plan	Web Tool	Telephone Number
BlueCross (PPO plans)	My Insurance Manager	Provider Services: 800-868-2510
State Health Plan	My Insurance Manager	Provider Services: 800-444-4311
Medicare Advantage Plans	My Insurance Manager	Provider Services: 800-605-3256
BlueChoice	My Insurance Manager	Provider Services: 800-868-2528
BlueChoice HealthPlan Medicaid	www.BlueChoiceSCMedicaid.com	Customer Care Center: 866-757-8286
FEP	www.fepblue.org	Provider Services: 888-930-2345
PAI	www.paisc.com	Provider Services: 800-768-4387

Precertification

Precertification is the process in which the provider, member or primary care physician requests authorization for services before rendering services. We may require precertification of some or all services. We may deny any claim that is not precertified partially or in full. Do not rely on the referring physician or patient to get precertification. A service that is not precertified is the financial liability of the provider, not the patient.

- To request precertification online, access the Form Resource Center.
- To request precertification for psychological testing, please contact CBA to request the appropriate form.
- If you need further instructions, please contact the CBA provider contract specialist at 800-868-1032, ext. 25538.

To request precertification by phone, please contact CBA at 800-868-1032. To avoid delays, please have the member's health plan information available and select the appropriate prompts.

- Psychological testing requires review before administering the test. Please complete the Psychological Testing form and fax it to CBA, along with clinical justification for the test. Please note that many policies exclude testing for the treatment of learning disabilities.
- CBA approves one initial evaluation (90791 or 90792) per provider per course of treatment.
- You should file subsequent visits with appropriate therapy and/or evaluation and management codes.
- Precertifications are specific to the rendering provider. If another provider in your practice sees the patient, we require a separate authorization.
- A patient may request or may have a clinical need for a service his or her health plan does not cover. If the member chooses to have the service after being notified that his or her health plan will not pay for it, the member is responsible for any charges incurred. Per your CBA Professional Agreement, make sure you get written acknowledgement from the member that he or she is responsible for the charges.

STATchat

STATchat is a fast, free and simple way to talk with a Provider Services representative after you've searched online for the answer to a claims status or eligibility question. You can also use STATchat to get or to check the status of precertifications. To use STATchat, log in to My Insurance Manager.

If you still have a question after viewing claims status, eligibility and benefits, just click "Ask Provider Services" at the bottom of the page. Then click "Connect" at the top of the page.

If you have questions after checking the status of your authorization, or if you have begun the online precertification process, just click the "Ask Health Care Services" button at the bottom of the page. Click the "Connect" button at the top of the page, and you will soon be speaking to a representative online. In fact, you will receive priority service and be connected to the next available agent. All you need is a headset with a microphone or a speaker and a microphone. To learn more about STATchat, please contact the CBA provider contract specialist at 800-868-1032, ext. 25538.

My Insurance Manager and STATchat are products of BlueCross

Quality Improvement Program

CBA maintains an active quality improvement program. The purpose of this program is to:

- Monitor behavioral health care provided by the CBA Behavioral Health Network.
- Evaluate network and member satisfaction with CBA services.
- Identify areas for improvement.
- Develop or participate in corrective action plans, as appropriate.

Here are some of the quality improvement activities that make up CBA's quality improvement program.

Quality Case Review

We provide ongoing identification, review and follow-up for:

- Any quality of care concern.
- Any quality of service concern.
- All member-initiated grievances.

In some instances, we may have to intervene. We base this on how severe the actions deviate from acceptable medical care standards. Interventions may include:

- Notification.
- Education.
- Sanction.
- Termination from our network.

We will notify the provider and/or facility in writing of any actions taken. If there is a grievance, we will also notify the member or authorized representative. We will confirm we received the grievance. Then we will advise him or her of the grievance process.

Discharge Coordination

We want patients to receive timely outpatient and ambulatory care after an inpatient discharge. Recently, we have improved this number.

After a mental health admission, seven days is standard for outpatient follow-up with a behavioral health provider. Mental Health providers should conduct outpatient follow-up coordination seven days after discharge to prevent relapses and readmissions.

Discharge planning activities include:

- Providing facility utilization review staff with referrals to network providers, when requested.
- Authorizing outpatient visits, where benefits are available, before discharge, when requested.
    - Giving the member a list of community resources. We do this when:
        - A member's benefits are exhausted for a benefit year.
        - The member's health plan doesn't cover requested services.

The community resource list does not preclude the provider's services with the client. The list aims to provide the member with low- or no-cost treatment alternatives.

Recommended Follow-Up Care Guidelines

We use the HEDIS standardized performance measures. These measures evaluate and enhance the quality of mental health and substance use care our members receive. More than 90 percent of America's health plans use the HEDIS tool. The tool measures performance on important dimensions of care and service.

Continuity of Care

The primary care physician plays an important role in a patient's overall health care. Communication with the primary care physician is essential to the overall continuity and coordination of care for patients. This is especially important when a primary care physician refers a patient to you.

CBA asks for your assistance in improving the continuity and coordination of your patients' health care. Please review your system for communicating with primary care physicians and try to identify ways to improve the process. Information to communicate between you and the primary care physician includes diagnosis, number of visits, progress updates and discharge care plans.

Case and Disease Management

We administer a behavioral health case management program for these accounts:

- FEP
- BlueChoice
- The State Health Plan
- All fully insured and some ASO Plans (refer to member's ID card)

Case management aims to develop a patient-specific care plan. An ideal plan encourages patients to comply with their providers' outpatient treatment plans.

Our case managers attempt to develop a continuum of care. They do this by remaining actively involved with patients, family members and providers as needed. Case managers also offer:

- Education about behavioral health issues.
- Community referrals and resources.
- Advocacy within the insurance environment.

We encourage you to assist case managers by proactively communicating about the patient's treatment.
We also offer disease management programs. These programs are for members with depression and alcohol problems. When we identify and enroll members in depression management, they receive regularly scheduled telephone assessments to monitor:

- Side effects.
- Symptoms.
- Adherence to treatment plans.

After each call, we generate a report for the member. And with the patient's consent, we generate a report for the prescribing physician. Members referred to alcohol management also complete the core assessment. This assessment helps identify and separate responsible drinking from at-risk drinking. For patients with at-risk drinking behaviors, we can conduct a brief alcohol intervention and three monthly follow-up assessments.

Annual Surveys

1. Provider Survey: CBA conducts an annual provider survey to assess provider accessibility to members and satisfaction with CBA services. We develop and implement an action plan in response to any communicated need for improvement.
2. Member Survey: CBA conducts an annual member survey to assess members' access to CBA network providers and administrative services provided by CBA. We develop and implement an action plan in response to any communicated need for improvement.

Access Standards

These guidelines reflect the CBA Medical Advisory Committee's recommendations for patient access to your office. We evaluate compliance with these access standards each year via a provider survey, member survey and on-site reviews. Please refer to these guidelines as a reference regarding access expectations.

Provider Access Category	Access Standard	Measurement Methodology
Routine office visit (i.e., medication refill or supportive therapy)	Within **10** working days	Office Site Visit CBA Provider Survey CBA Member Survey
Urgent care (i.e., patient unable to perform some day-to-day duties involving work, school, caring for family or taking care of basic needs)	Within **48** hours	Office Site Visit CBA Provider Survey CBA Member Survey
Non-life-threatening emergency (i.e., patient unable to perform many day-to-day duties involving work, school, caring for family or taking care of basic needs)	Within **six** hours or referral to ER	Office Site Visit CBA Provider Survey CBA Member Survey
Life-threatening emergency	Immediate or referral to ER	Office Site Visit
After-hours access	After-hours procedure to include 24-hours-a-day/seven-days-a-week on-call licensed provider	Office Site Visit Credentialing Screen
Maximum appointments scheduled per hour	Four	Office Site Visit
Number of behavioral health providers per number of members	One provider per 3,000 members or within 50 miles	Member Count Report by Health Plan

CBA Credentialing Committee

The Credentialing Committee is a subcommittee of our Medical Advisory Committee. It meets monthly and:

- Reviews the credentials of provider applicants for inclusion or exclusion from the CBA network.
- Reviews the credentials of any facilities for inclusion or exclusion from the CBA network.
- Provides input on credentialing policies and procedures.

The committee includes both internal and external members. Internal members include:

- CBA's executive director.
- CBA's medical director.
- The director of Provider Network Services.
- Network services staff.

External members include:

- A provider from each discipline within our network.

Credentialing and Recredentialing

Credentialing is the process of verifying pertinent provider information in order to accept the provider into the CBA network. Recredentialing is the process of reverifying that information. It occurs every three years.

We will contact you by fax, email or regular mail when it is time for your recredentialing. Please remember to update your contact information with us so that you will receive your notification in a timely manner.

These criteria establish your legal authority to practice, along with relevant experience and necessary training. We verify them during the credentialing and recredentialing processes.

- Current license approved by the state
- Attestation of clinical privileges in good standing (if applicable)
- Valid DEA/CDS certificate (if applicable)
- Board certification (if applicable)
- Verification of highest level of training
- Five-year work history
- 24-hour availability (to include pager, cell phone, live answering service or backup clinician) with a 30-minute response time. Backup clinicians should meet CBA standards for credentialing (i.e., licensure, malpractice insurance) as well as certification that equals or exceeds the primary provider's certification.
- Current and adequate malpractice insurance:
    - $1,000,000/$3,000,000 for M.D.s
    - $1,000,000/$1,000,000 for non-M.D.s

We keep a confidential file on each provider with his or her current information, along with any member complaints or quality issues that are brought to our attention.

Change in Status Information

Please notify CBA any time you have a change in your practice. We process precertifications and claims from the provider information we have on file. Therefore, it is very important that you provide any updates in a timely manner. We request at least 30 days' advance notice, if possible.

Please send the appropriate documentation in writing to:

Companion Benefit Alternatives, Inc.
Attn: Provider Network Coordinator
P.O. Box 100185, AX-315 | Columbia, SC 29202
Fax: 803-714-6456 or email: alicia.mcknight@companiongroup.com

Here are some examples of changes we need to know about:

- Change of name, address, telephone or TIN
- New satellite office locations
- New provider joining a practice
- Provider leaving a practice
- Change of office manager or other contact person
- Change of ownership (practice purchased by a hospital, etc.)

Change in Status Information (continued)

Points to remember:

- Please submit all requests for changes in writing.
- Any time you change your TIN, you will need to create a new user profile(s) for the online claims-filing tool under the new TIN.
- If you change your TIN, you should also contact our precertification staff to have your current authorizations properly transferred to the new TIN.
- If you terminate from the CBA network for any reason, you should notify the affected members before the effective date of the termination. Please refer to your CBA Professional Agreement.

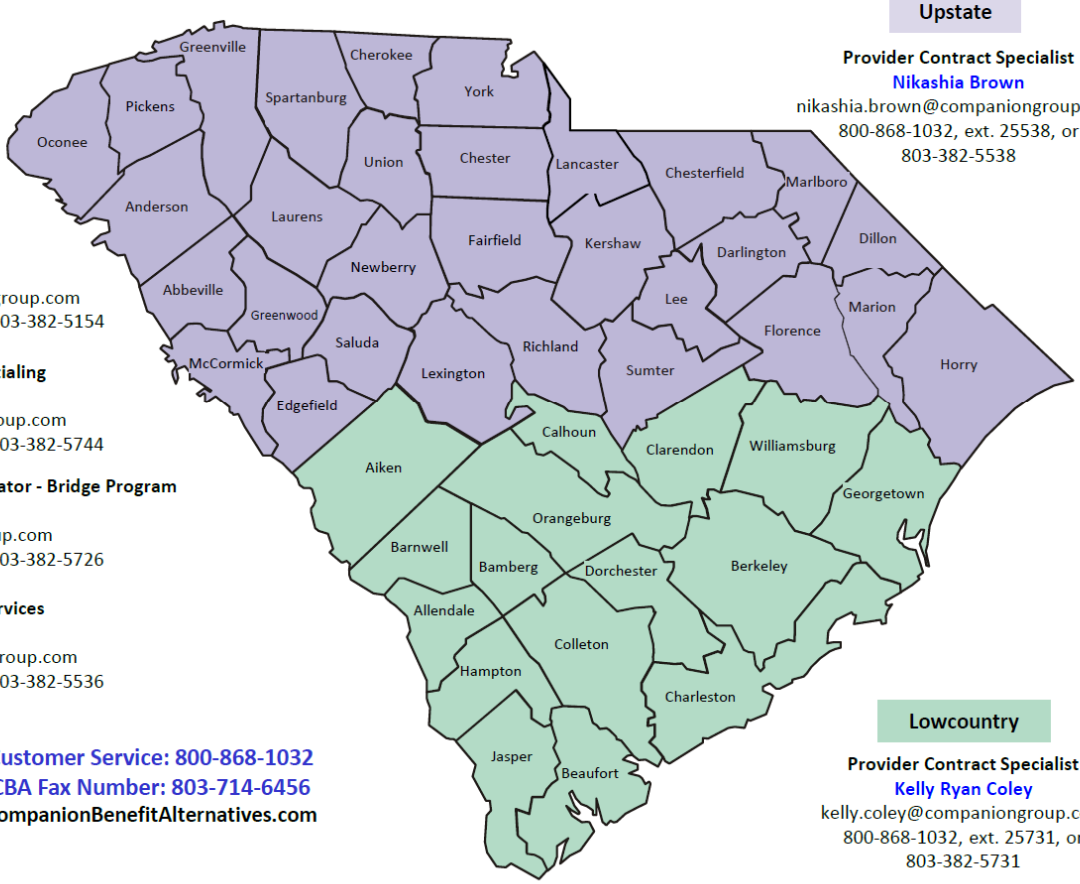
Provider Validation Requests

You may receive a request asking you to validate key provider information. We request this information to maintain complete and accurate files as CMS requires.

As a participating provider, we require you to validate your information with us periodically to ensure your files are current. This information gives you an opportunity to tell us important facts about your office management, location and practicing physicians. Your participation in this effort will improve how we display all provider offices and facilities in our different provider directories, as well as our internal systems to ensure your claims process as they should.
If you receive a phone call or email from us requesting this information, please respond.

Companion
BENEFIT ALTERNATIVES

Companion Benefit Alternatives
Provider Representative Territory Map



Upstate

Provider Contract Specialist
Nikashia Brown
nikashia.brown@companiongroup.com
800-868-1032, ext. 25538, or
803-382-5538

Provider Claims Support
Sandra Hampton
sandra.hampton@companiongroup.com
800-868-1032, ext. 25154, or 803-382-5154

Provider Recruitment/Credentialing
Alicia McKnight
alicia.mcknight@companiongroup.com
800-868-1032, ext. 25744, or 803-382-5744

Quality Improvement Coordinator - Bridge Program
Sharon Boyer
sharon.boyer@companiongroup.com
800-868-1032, ext. 25726, or 803-382-5726

Director, Provider Network Services
Natalie Johnston
natalie.johnston@companiongroup.com
800-868-1032, ext. 25536, or 803-382-5536

Customer Service: 800-868-1032
CBA Fax Number: 803-714-6456
CompanionBenefitAlternatives.com

Lowcountry

Provider Contract Specialist
Kelly Ryan Coley
kelly.coley@companiongroup.com
800-868-1032, ext. 25731, or
803-382-5731

CBA is a separate company that manages behavioral health benefits on behalf of BlueCross® BlueShield® of South Carolina and BlueChoice® HealthPlan of South Carolina, independent licensees of the Blue Cross and Blue Shield Association.

OVERVIEW

A summary of our dental networks and essential plan will be shared.

Web Resources

- Administrative Office Manual for Dental Providers
- South Carolina Dental Credentialing Application
- Dental Provider Reconsideration Form
- Other Health/Dental Insurance Questionnaire
- BlueCross Dental Presentation
- My Insurance Manager User Guides
- My Remit Manager User Guide

Commercial Dental Plans

Some commercial dental plans use a network of participating providers, and other plans do not. Members can visit any dental provider. An out-of-network provider, however, can balance bill for the difference in BlueCross' allowable and actual charges.

Levels of dental coverage for these plans include:

- Preventive care.
- Restorative care.
- Major restorative care.
- Orthodontic care (optional).

Dental GRID

Dental GRID allows dentists to see members from other participating Blue Cross and Blue Shield Plans at local plan reimbursement levels. We will consider you as an in-network dental provider for members that have out-of-state plans. Your reimbursement levels or provider agreements will not change. GRID is a separate company that offers a dental network on behalf of BlueCross.

These participating plans are all independent licensees of the Blue Cross and Blue Shield Association.

- BlueCross BlueShield of South Carolina
- Blue Cross of California
- Blue Cross of Idaho
- Blue Cross Blue Shield of Nevada
- Blue Cross Blue Shield of Arizona
- Blue Cross Blue Shield of Colorado
- Blue Cross Blue Shield of Wyoming
- Blue Cross Blue Shield of North Dakota
- Blue Cross Blue Shield of Nebraska
- Blue Cross and Blue Shield of Kansas
- Blue Cross Blue Shield of Missouri
- Blue Cross Blue Shield of Wisconsin
- BlueCross BlueShield of Tennessee
- Blue Cross Blue Shield of Indiana
- Blue Cross Blue Shield of Kentucky
- Blue Cross Blue Shield of Ohio
- Blue Cross Blue Shield of Virginia
- Blue Cross and Blue Shield of North Carolina
- Blue Cross Blue Shield of Georgia
- Blue Cross Blue Shield of Maine
- Blue Cross Blue Shield of New Hampshire
- Blue Cross Blue Shield of Connecticut
- Empire Blue Cross Blue Shield
- Horizon Blue Cross Blue Shield
- CareFirst BlueCross BlueShield
- Capital Blue Cross
- CBA Blue
- Wellmark
- Excellus BlueCross BlueShield
- HealthNow New York
- BlueCross BlueShield of Kansas City*
- BlueCross BlueShield of Rhode Island*

*These plans are new to the Dental Grid for 2017.

State Dental and Dental Plus Plans

BlueCross administers the State Dental and Dental Plus Plans. The dental benefits have four classes: diagnostic and preventive services; basic dental services; prosthodontics; and orthodontics. We pay covered services under the State Dental Plan based on its Schedule of Dental Procedures and Allowable Charges.

Dental Plus is a supplement to the State Dental Plan that provides a higher level of reimbursement for dental services the State Dental Plan covers. Members pay the entire premium with no contribution from the state. Dental Plus pays up to $1,000 for covered services in each benefit period for each covered member, in addition to the $1,000 maximum payment under the State Dental Plan.

Dental Plus does not cover services that are not covered under the State Dental Plan. Instead, it covers the same procedures and services (except orthodontics) at the same percentage of coverage as the State Dental Plan. The allowances are based on whether the provider participates in the BlueCross dental provider network.

Use the State Dental Plan fee schedule to determine if a service applies to dental or health benefits. You can find this fee schedule when you log in to My Insurance Manager and accept the State Dental Plan Fee Schedule Agreement.

FEP Standard Option Dental Benefits

Under Standard Option, FEP pays for the following services up to the amounts shown per service as listed in the Schedule of Dental Allowances. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments or coinsurance. A member pays all charges in excess of the listed fee schedule amounts when using a non-preferred dentist. The member pays the difference between the fee schedule amount and the BlueCross Participating Dental Allowance when using a preferred dentist.

Covered Service	**FEP Pays**		**Member Pays**
Clinical oral evaluations	To age 13	Age 13 and over	**In Network** The difference between the amounts listed to the left and the BlueCross Participating Dental Allowance.
Periodic oral evaluation (up to two per person per calendar year)	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
Diagnostic imaging			
Intraoral complete series	$36	$22	
Intraoral periapical first image	$7	$5	**Out-of-Network** All charges in excess of the scheduled amounts listed to the left
Intraoral periapical each additional image	$4	$3	
Intraoral occlusal image	$12	$7	
Extraoral images	$16	$10	
Bitewing – single image	$9	$6	
Bitewings – two images	$14	$9	
Bitewings – four images	$19	$12	
Vertical bitewings	$12	$7	
Posterior-anterior or lateral skull and facial bone survey image	$45	$28	
Panoramic image	$36	$23	
Palliative treatment			
Palliative treatment of dental pain – minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive			
Prophylaxis – adult (up to two per person per calendar year)	---	$16	
Prophylaxis – child (up to two per person per calendar year)	$22	$14	
Topical application of fluoride or fluoride varnish (up to two per person per calendar year)	$13	$8	
Not covered: Any service not specifically listed above	Nothing	Nothing	All charges

Federal Employee Program (FEP) Basic Option Dental Benefits

Under Basic Option, FEP provides benefits for the services listed. Members pay a $30 copayment for each evaluation, and FEP pays any balances up to the BlueCross Preferred Blue Participating Dental Allowance.

Basic members must use preferred dentists to receive benefits.

Covered Service	FEP Pays	Member Pays
Clinical oral evaluations	**Preferred:** All charges in excess of member's $30 copayment **Participating/ Non-participating:** Nothing	**Preferred:** $30 copayment per evaluation **Participating/ Non-participating:** Member pays all charges
Periodic oral evaluation*		
Limited oral evaluation		
Comprehensive oral evaluation*		
*Benefits are limited to a combined total of two evaluations per person per calendar year		
Diagnostic imaging		
Intraoral – complete series including bitewings (limited to one complete series every three years)		
Bitewing – single image**		
Bitewings – two images**		
Bitewings – four images**		
**Benefits are limited to a combined total of four images per person per calendar year		
Preventive		
Prophylaxis – adult (up to two per calendar year)		
Prophylaxis – child (up to two per calendar year)		
Topical application of fluoride or fluoride varnish – for children only (up to two per calendar year)		
Sealant – per tooth, first and second molars only (once per tooth for children up to age 16 only)		
Not covered: Any service not specifically listed	Nothing	All charges

FEP BlueDental

GRID Dental Corporation (GDC) is a separate company that administers FEP BlueDental on behalf of BlueCross. FEP BlueDental members use the GRID+ network as an in-network provider source. Participating providers now have access to FEP BlueDental members. This is a supplementary dental program to the FEP medical plans.

Other FEP Dental Information

When a member is covered by an FEP medical plan with dental benefits and a separate FEP dental plan, those two policies will coordinate to pay benefits on dental claims. We recommend that the dentist not charge the patient for any copay or coinsurance associated with the medical plan benefits at the time of their office visit because, in most cases, these amounts will be addressed by the dental plan.

In the case of the members covered by an FEP medical Basic Plan and an FEP BlueDental policy, a $30 copay will be considered patient responsibility by the medical plan, but will be picked up by the FEP BlueDental policy if the claim is submitted for covered procedures. The medical and dental plans each maintain separate provider networks with separate schedules of allowances. So the dental plan may generate a check to make up the $30 copay. If the dental network allowances are lower than the medical allowances however, the greater network discount on the dental plan can result in no additional payment. In other words, the $30 copay not paid by the medical plan may not result in a $30 payment from the dental plan. If the dental plan allowances are lower than the medical plan allowances, a portion of that $30 or all of that $30 may be applied to the network provider write-off. In these cases, the provider has contractually agreed to accept the dental plan allowances as payment in full for services performed. Therefore, the patient would not be responsible for any payment over the dental network allowances.

Filing Dental Under Medical Benefits

Dental providers are exempt from billing with diagnosis codes, in general. If billing for medical services however, dental providers should file an electronic health claim using My Insurance Manager or use a CMS-1500 claim form. An example of a dental service that is covered under a member's medical benefit is the extraction of an impacted tooth. If a dental provider chooses to bill with a diagnosis code, use of International Classification of Diseases, 10th revision (ICD-10) coding is required.

For FEP BlueDental, claims should be submitted to the member's primary medical plan first. Primary payment will be sent to you, and FEP medical will forward the claim —along with the primary payment amount — to FEP BlueDental. The primary benefit will be coordinated on the claim received from the medical carrier and upon completion of coordination of benefits, FEP BlueDental will send the secondary payment to you.

Filing Orthodontic Claims Electronically

- Filing a claim for the initial banding and monthly adjustments:
    - Submit one line with the banding fee code (D8080-D8090) and the charge for the banding.
    - Submit one line with the monthly adjustment code (D8670) and the **total months** of treatment and the **total charge** for the monthly adjustments. The total months of treatment should be filed in the DN1 segment of Loop 2300. We will calculate the monthly charge by dividing the total charge of the monthly adjustments by the total months of treatment.
- Filing a claim for a transfer case:
    - Submit one line with the monthly adjustment code (D8670), the **total months** of treatment **remaining**, and the **total charge** for the **remaining** monthly adjustments. In this case, the total months of treatment **remaining** should be filed in the DN1 segment of Loop 2300.

When you file one of the claims, you do not need to file any more orthodontic claims to us for the patient. In either instance, we will automatically send you payment for the monthly adjustments on or around the first day of each month until:

- The patient exhausts his or her lifetime orthodontic benefits, or
- The patient's dental coverage terminates under his or her current policy, or
- The patient reaches the maximum age allowed for orthodontic coverage under his or her policy.

When one of the above occurs, we will notify you via your remittance and stop our automatic claim spin-off process. There is no need for you to submit future claims to us only to get a rejection, as this is not a good use of your administrative time or money.

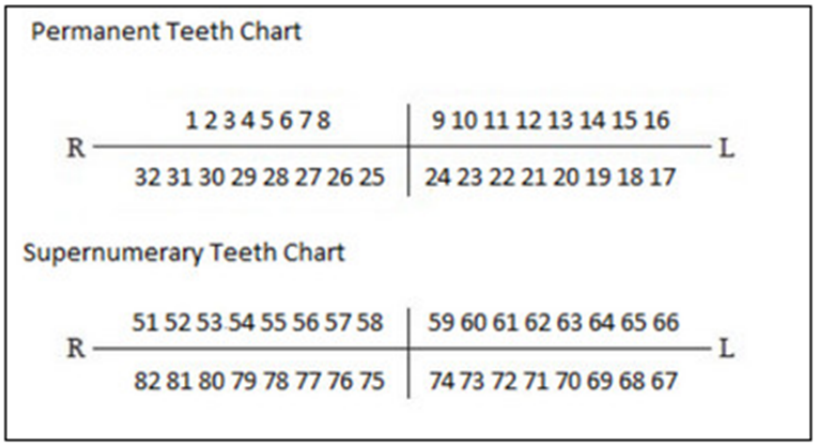
Other information and important updates for 2017:

- Beginning Jan. 1, 2017, BlueCross and BlueChoice are launching 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 — as long as services are received in network.
    - Members can also use the national Dental Grid network.
- BlueCross uses Dentistat Inc., an independent company, to handle certain elements of our dental network provider credentialing and re-credentialing processes. Occasionally your office may be contacted, either by telephone or through written correspondence, by Dentistat. It is important that you respond to Dentistat to ensure your continued relationship with our plans.

Frequently Asked Questions

Is there a designated provider advocate for dental services?
No, there is not a specific Provider Advocate who works only with dental providers. Provider Advocates can be contacted according to the county where your office is located.

How are supernumerary teeth indicated on the patient's tooth chart in My Insurance Manager?
Supernumerary teeth are not indicated on the patient's tooth chart in My Insurance Manager because the likelihood of someone having supernumerary teeth is so rare (< 20 percent of the population). Refer to the chart for the standard numbering scheme when reporting services rendered on supernumerary teeth in the permanent dentition. Add an "S" to the letter of the primary tooth corresponding to a supernumerary tooth in the primary dentition. Contact the appropriate service center if you have questions related to a member's benefits for services involving supernumerary teeth.



When filing claims for an FEP BlueDental member on an American Dental Association (ADA) claim form, should it go to BlueCross FEP Medical first?
Yes, submit all claims to the member's primary medical plan first. Primary payment will be sent to you, and then FEP Medical will forward the claim, along with the primary payment amount, to FEP BlueDental. The primary benefit will be coordinated on the claim received from the medical carrier and upon completion of coordination of benefits. FEP BlueDental will send the secondary payment to you.

OVERVIEW

A summary of pharmacy management changes for 2017 will be shared.

Web Resources

- Coverage Determinations and Redeterminations (Medicare Advantage/Medicare Part D Plans)
- Prior Authorization/Step Therapy Criteria (Medicare Advantage/Medicare Part D Plans)
- Prescription Drug Lists (BlueCross and BlueChoice)
- Caremark Pharmacy Locator
- Caremark National Pharmacy Network Participating Independent Retail Pharmacies
- South Carolina Network Pharmacies
- Participating Retail 90 Pharmacies
- Preferred Drug List
- Specialty Drug List
- Excluded Drug List
- Try Generics Drug List
- Prior Authorization Drug List
- Quantity Management Program Drug List and Fax Forms
- Step Therapy Program Drug List and Fax Forms
- Drug Management Programs
- Generic Program Exception Form
- Non-Specialty Drug Prior Authorization Program and Fax Forms

Also Visit

- Education Center
- Provider News

Medicare Advantage

Effective Jan. 1, 2017, CVS/Caremark will replace Prime Therapeutics as the pharmacy benefit manager (PBM) for Medicare Advantage. Members will receive new pharmacy ID cards.

Important numbers:

- E-scribe NCPDP Mail (0322038) Specialty (3431397)
- CVS/caremark mail fax: 800-378-0323
- CVS/caremark mail address:
  PO Box 94467
  Palatine, IL 60094-4467
- Coverage determinations and general inquiries: 855-344-0930
- Coverage determinations fax: 855-633-7673
- Websites: www.caremark.com or www.SCBluesMedadvantage.com

Health Insurance Marketplace (Exchange)

BlueChoice to BlueCross Transition

- BlueChoice will no longer offer Blue Option plans through the Federally Facilitated Marketplace (FFM) beginning Jan. 1, 2017
- BlueChoice members with alpha prefix ZCX and some ZCJ will have new ID cards
- Best practice to request all members' new ID cards
- New prior authorizations will be requested if applicable

Advanced Choice Network (ACN) Pharmacy

- As of Oct. 1, 2016, ACN includes all CVS pharmacies, Walmart, Kroger, Publix, Longs Drugs, Bi-Lo, plus various other grocers and independent pharmacies
- Beginning Jan. 1, 2017, Rite Aid will join the ACN network
- Walgreens is currently out of network

Retail pharmacy 31 day supply maximum

- Retail pharmacy: maximum 31 day supply
- Mail order pharmacy: maximum 90 day supply
- Best practice to continue to write 90 day supply prescriptions where applicable
- For list of covered drugs and drug management programs visit www.SouthCarolinaBlues.com and www.BlueChoiceSC.com.
- To request a prior authorization or a formulary exception, call 855-582-2022

Commercial

CVS/Caremark will continue to serve as the PBM in 2017

- To locate the formulary for a list of covered drugs, excluded drugs and drug management programs, programs visit www.SouthCarolinaBlues.com and www.BlueChoiceSC.com.
- To request a formulary exception, see instructions on the Excluded Drug List. Some requests are reviewed by CVS/Caremark and others are reviewed by BlueCross.
- To request a prior authorization or override for step therapy or quantity management visit www.SouthCarolinaBlues.com and www.BlueChoiceSC.com.
- For specialty prior authorizations, contact CVS/specialty at 800-237-2767 (phone) or 866-249-6155 (fax).

Specialty Medical Management

Effective June 1, 2016, certain drugs administered by a provider to a commercial BlueCross or BlueChoice member and billed through the medical benefit:

- May require prior authorization
- May not be covered (i.e., self-administered drugs)
- May not be covered when billed as an outpatient claim

Effective Jan. 1, 2017, certain drugs administered by a provider to an ***Exchange*** member and billed through the medical benefit:

- Will require prior authorization
- Will not be covered if the drug is considered self-administered
- Will not be covered when billed as an outpatient claim

To find more information about our Specialty Medical Management program visit www.SouthCarolinaBlues.com.

OVERVIEW

A presentation about provider updates and requirements for network participation.

The Importance of Credentialing

BlueCross, BlueChoice and BlueChoice HealthPlan Medicaid use the credentialing process to validate practitioners' qualifications.

BlueCross and BlueChoice credential physicians and mid-level providers applying for participation in our networks.

Web Resources

- South Carolina Uniform Credentialing Application
- South Carolina Dental Credentialing Application
- South Carolina Uniform Credentials Update Form
- File Application Packet
- Request to Add or Terminate Practitioner Affiliation Form
- Change of Address Form
- Authorization for Clinic/Group to Bill for Services Form
- Application for Satellite Location to File Claims or to Change EIN
- NPI Provider Notification Form
- The Credentialing Process presentation

Provider Certification

BlueCross gives potential network applicants the South Carolina Uniform Credentialing Application (SCUCA), specific network contracts and professional agreements for network participation. The South Carolina Uniform Credentialing Application is available in the Providers' area of the website. Select Forms and then select Credentialing/Provider Updates and Credentialing. For contract or professional agreements, email provider.cert@bcbssc.com with your name, mailing address and the specific network contracts you need. You only need to submit one SCUCA application, regardless of the number of networks for which you are applying.

BlueCross credentials physician assistants (PAs) and nurse practitioners (NPs). PAs can choose to file claims for medical and laboratory services they provide in the office under their legacy identifiers or rendering National Provider Identifiers (NPIs). They can also bill under the supervising doctor's legacy identification number or NPI. Our policies do not cover a PA as an assistant at surgery. We only cover M.D.s as assistant surgeons, if medically necessary. If a PA is assisting during surgery, the PA must bill as the rendering provider, using an AS modifier.

An NP who is not under direct supervision of a doctor can be credentialed by BlueCross. NPs must submit claims with their own NPI numbers in the rendering provider field. The group or practice NPI should be submitted as the billing provider.

BlueCross requires all health care providers to go through recredentialing every three years. We email or fax credentialing packages to health care practices. You must return the packages to us within the allotted time, or you could lose your network participation.

Please email your completed application and documentation to provider.cert@bcbssc.com or fax to 803-264-4795. Make sure you include ALL REQUESTED documentation, as we will not process applications that are missing required information.

Provider File Updates

To maintain accurate participating provider directories and for reimbursement purposes, we require providers 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.
- EHR

These changes can be updated any time by using the appropriate form found on our websites. We'll also continue to reach out to you to verify that your office information is complete and accurate each quarter. Be sure you respond to requests from provider.directory@bcbssc.com, provider.cert@bcbssc.com or your Provider Advocate when contacted about this matter.

The Credentialing Process

Once Provider Certification receives an application, it is reviewed for completeness of the information submitted. If it is a "clean" application, meaning that everything is included and current, it is sent to the Credentialing Committee. If the Credentialing Committee approves the application, a notification is sent by email along with a welcome package to the provider. If the Credentialing Committee does not approve the application, then we send it to the Provider Disciplinary Committee to review further. The Committee will approve or deny the application, and we will send notification to the provider.

To improve our communication with providers, BlueCross' and BlueChoice's Provider Certification teams will now send auto-generated emails that advise the status of your credentialing applications. Providers will receive an initial email upon receipt of a complete application that is in review. A second email will be sent to providers when the application is sent to Provider Contracting for network review. A final auto-generated email is sent to the provider upon completion of the entire credentialing process. Please do not send inquiries or responses to the auto-generated email. Providers should continue to contact provider.cert@bcbssc.com for questions about the status of a credentialing application.

This credentialing status process does not apply to mental health practitioners who CBA credential. Email CBA at cba.provrep@companiongroup.com for questions about mental health provider credentialing.

The credentialing application must include this documentation to be considered complete. The credentialing process begins only after all dated, initialed and signed documents have been received. Applications will not be accepted if any information is missing or incomplete, including proof of malpractice coverage.

- Current DEA certificate or license copy
- Proof of malpractice coverage, including supplemental coverage
- Electronic Claims Filing Requirement form
- NPI/National Plan and Provider Enumeration System (NPPES) confirmation letter or email
- A signed contract signature page for each network in which you wish to participate
- Copy of IRS document validating the Employer Identification Number for a new location (Letter 147C, CP 575 E or tax coupon 8109 C)
- Medicare Certification Letter
- Authorization For Clinic/Group to Bill For Services form (if applicable)
- EFT and ERA Enrollment form (for a new location)
- EFT Terms and Conditions form (for a new location)

Provider Certification Response Times

Use the table to determine the estimated response time according to your Provider Credentialing request type.

Request Type	Credentialing Form	Review Period[1]
Initial Credentialing	South Carolina Uniform Credentialing Application	45 days or less for clean (complete) files
	South Carolina Dental Credentialing Application	
	Registration Form for Midlevel and Hospital-Based Providers	
Re-credentialing	South Carolina Uniform Credentials Update Form	30 days, once every three years
Update Provider Information	File Application Packet	10-14 days
	Request to Add or Terminate Practitioner Affiliation Form[2]	10-14 days
	Change of Address Form (online)	48 hours
	Authorization for Clinic/Group to Bill for Services Form[2]	10-14 days
	Application for Satellite Location to File Claims or to Change Employer Identification Number (EIN) Form[3]	10-14 days
	National Provider Identifier (NPI) Provider Notification Form	10-14 days

[1] *Typical review periods shown. Response times are an estimate and can vary based on provider response and/or an elevated volume of requests to Provider Certification.*

[2] *BlueChoice participating providers must include the Hold Harmless Agreement and Appendix D document. Request these documents by contacting Provider Certification at provider.cert@bcbssc.com.*

[3] *Include the EFT Authorization Form.*

QUALITY INITIATIVES

OVERVIEW

Become more familiar with programs aimed at improving birth outcomes, closing gaps in care and complying with HEDIS quality measure guidelines.

Quality Initiatives Pages

Visit the Quality Initiatives section of our websites to read more about quality programs including PCMH, recognition programs and HEDIS.

Web Resources

- Maternity Initiatives Webinar Presentation
- Centering Pregnancy Application Form
- Maternity Screening Referral Tool (SBIRT)
- Quality Initiatives Webinar Presentation
- HEDIS Provider Reference Matrix for Adults
- HEDIS Pediatric Provider Reference Matrix
- HEDIS Compliance Companion Forms

Also Visit

- Education Center
- Provider News
- Quality Initiatives

Maternity Initiatives

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

- Birth Outcomes Initiative (BOI).
- SBIRT.
- Centering Pregnancy.

BOI

Within the BOI program, BlueCross 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 American College of Obstetricians and Gynecologists (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 non-medically 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.

Maternity Initiatives

SBIRT

The SBIRT program allows physicians to identify, intervene and refer at-risk patients to treatment by using the universal SBIRT Integrated Screening Tool (the SBIRT referral). Providers who 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 be Z139 (encounter for screening, unspecified).

- H0002: Behavioral health screening — $24 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 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 BlueCross and BlueChoice plans except FEP, out-of-state (BlueCard) members, State Children's Health Insurance Program (SCHIP) and plans that do not have maternity benefits.

Centering Pregnancy

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

Participating providers will receive reimbursement for providing these services:

- 98078 with TH modifier — Reimbursement is $30 per visit, up to 10 visits total
- 0502F — Reimbursement is $175 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 diagnosis code.

To participate as a centering pregnancy provider, practices must have Centering® Healthcare Institute membership and also be in the process of achieving (or have already achieved) site approval status. The Centering Healthcare Institute is a separate company that provides wellness education on behalf of BlueCross. Providers must maintain accreditation/licensure with Centering Healthcare Institute in order to maintain participation in our centering pregnancy program. Complete the Centering Pregnancy Application Form located at www.SouthCarolinaBlues.com to seek approval to receive reimbursement for centering pregnancy services.

For additional information about these programs, please visit the Provider sections of www.SouthCarolinaBlues.com and www.BlueChoiceSC.com.

HEDIS

HEDIS is a tool developed by the 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. BlueCross 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 BlueCross focuses on. These matrices provide measure-specific information on what services are needed and how you can help meet our members' care opportunities. 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:

- Submitting a claim for the service.
- Submitting the medical record.
- Submitting the appropriate Compliance Companion Form.
- Submitting electronic medical record data transmission.

Use of a Compliance Companion Form helps to improve our awareness of the preventive services you provide. It also reduces the number of record requests you receive during annual audits our quality improvement nurses perform.

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

Care Opportunities

Our goal is to ensure our patients' care opportunities are met. A gap in care occurs when a member has not received preventive health services. Our Plans collect and share this data with our providers so you can reach out to your patients to receive those missed and/or undocumented preventive health services.

You will receive Care Opportunity Detail and Summary Reports from your assigned Navigator. Your Navigator will provide support in understanding this quality initiative. Our Quality Navigators will meet with you to assist with techniques in such topics as meeting care opportunities and to closing care gaps. The Navigators work with providers to reveal and close gaps in care such as skipped prescriptions or missed disease screenings that may lead to preventable medical care at places such as emergency rooms.

Your practice or facility may have relevant information indicating the member has already received the service or has a condition that excludes him or her from the HEDIS measure. When this happens, you can close the gap by:

- Filing a claim.
- Supplying the medical record.
- Completing a Compliance Companion Form.
- Sharing the Electronic Medical Record Data.

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 receive 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.

As a participating provider, your contract states you agree to permit BlueCross, 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.

CAHPS/QHP EES

BlueCross and BlueChoice conduct 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 the CAHPS surveys with physicians annually.

QHP EES is a consumer survey that assesses enrollee experience with the 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.

PCMH

Patient-centered medical homes are nationally recognized primary care practices that use physician-led care teams to deliver care that is patient-centered, proactive, coordinated and evidence-based. PCMH practices in the BlueCross PCMH network are supported by a value-based reimbursement methodology that includes per-member-per-month (PMPMs) care coordination fees and annual bonus opportunities based on performance on established clinical quality measures. PCMH value-based reimbursement is provided on top of traditional fee-for-service payments.

If you would like more information about becoming a PCMH, please contact Michelle Davis at michelle.davis@bcbssc.com or 803-382-5250.

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.

- 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 and the rendering provider on the claim.

OVERVIEW

Learn about upcoming benefits and administrative changes in the new year.

Network Participation

Members access different networks based on their plans. Some members don't have out-of-network benefits and others have higher patient liability.

Verify which network applies when you check eligibility and benefits. Avoid denials and higher patient liability.

Web Resources

- 2016 and 2017 ID Card Guide
- 2016 BlueCross Provider Office Administrative Manual
- 2016 BlueChoice Provider Office Administrative Manual

Also Visit

- www.SouthCarolinaBlues.com
- www.BlueChoiceSC.com
- www.FEPBlue.org
- www.statesc.SouthCarolinaBlues.com

Preferred Blue

There are multiple group product lines that access the broad commercial Preferred Blue network. Plan benefits vary. Some Preferred Blue products are grandfathered, while others are non-grandfathered.

Preferred Blue is a line of PPO health insurance plans we offer. The products' benefit structure gives members financial incentives for seeking medical care from a network of preferred providers in South Carolina.

Generally, members can see a specialist of choice without permission from these Plans. Providers should always refer members to other in-network providers when necessary.

BlueCross requests notification for any admission to a hospital or skilled nursing facility (SNF). This notification enables the member to access optional benefits, such as case management and disease management programs, along with discharge planning. The preferred method for submitting precertification requests for Preferred Blue members is through My Insurance Manager on our website, www.SouthCarolinaBlues.com.

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

- Septoplasty
- Sclerotherapy performed in an outpatient or office setting
- Chemotherapy/radiation therapy (one-time notification)*
- Hysterectomy
- Procedures that may be cosmetic in nature [You must submit these for review, in writing, five to seven days before the scheduled procedure. Include pictures if appropriate (blepharoplasty, reduction mammoplasty, TMJ surgery, etc.)]
- MRIs, MRAs and CT scans (required through NIA Magellan)
- Musculoskeletal care such as interventional spine management services and lumbar and cervical spine surgeries (required through NIA Magellan)
- Radiation oncology (required through NIA Magellan)
- Certain labs (through Avalon)
- Specialty medical specialty drugs (required through NovoLogix, CVS/caremark's online prior authorization tool)

Some PPO groups may have precertification requirements that differ from the previous list (i.e., some groups require prior notification for physical, speech and occupational therapies). Check for group-specific precertification requirements before providing services, and request a precertification via My Insurance Manager. The system will let you know if the group does not require a precertification. The precertification requirements are on our website in the Education Center.

You can get prior authorization using the Authorization/Precertification/Referral link in My Insurance Manager. This feature also includes the Referral and Authorization Status functions.

Note: Prior authorizations do not guarantee payment of benefits. Claim payments are subject to the rules of the plan.

*BlueCross has added special programs for patients undergoing chemotherapy and radiation therapy. Please notify us of any patients receiving these treatments. You will only need to notify us once for a patient's course of treatment

2017 New Groups:

Group Name	Alpha Prefix(es)
Oliver Rubber Company, LLC	ORI
Volvo Car	VCI
World Acceptance	DKQ and DKO

BlueChoice

There are multiple group product lines that access the broad commercial BlueChoice network. Plan benefits vary. Some BlueChoice products are grandfathered, while others are non-grandfathered.

BlueChoice offers a line of PPO (and some HMO) health insurance plans. The products' benefit structures give members financial incentives for seeking medical care from a network of preferred providers in South Carolina.

Most BlueChoice plans do not require members to get a referral to see a specialist. Providers should verify benefits and referral requirements before providing services or sending a member to a specialist. Providers should always refer members to other in-network providers when necessary.

BlueChoice requests notification for any admission to a hospital or SNF. This notification enables the member to access optional benefits, such as case management and disease management programs, along with discharge planning. The preferred method for submitting precertification requests for BlueChoice members is through My Insurance Manager on our website, www.BlueChoiceSC.com.

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

- Septoplasty
- Sclerotherapy performed in an outpatient or office setting
- Chemotherapy/radiation therapy (one-time notification)*
- Hysterectomy
- Procedures that may be cosmetic in nature [You must submit these for review in writing five to seven days before the scheduled procedure. Include pictures if appropriate (blepharoplasty, reduction mammoplasty, TMJ surgery, etc.)]
- MRIs, MRAs and CT scans (required through NIA Magellan)
- Musculoskeletal care such as interventional spine management services and lumbar and cervical spine surgeries (required through NIA Magellan)
- Radiation oncology (required through NIA Magellan)
- Certain labs (through Avalon)
- Specialty medical specialty drugs (required through NovoLogix, CVS/caremark's online prior authorization tool)

You can get prior authorization using the Authorization/Precertification/Referral link in My Insurance Manager. This feature also includes the Referral and Authorization Status functions.

Some groups may have precertification requirements that differ from the previous list (i.e., some groups require prior notification for physical, speech and occupational therapies). Check for group-specific precertification requirements before providing services and request a precertification via My Insurance Manager. The system will let you know if the group does not require a precertification. The precertification requirements are on our website in the Education Center.

Note: Prior authorizations do not guarantee payment of benefits. Claim payments are subject to the rules of the plan.

*BlueChoice has added special programs for patients undergoing chemotherapy and radiation therapy. Please notify us of any patients receiving these treatments. You will only need to notify us once for a patient's course of treatments.

2017 New Groups:

Group Name	Alpha Prefix(es)
Landrum Professional Employee Services	ZCL
Prysmian Group	ZCL

State Health Plan

The State Health Plan consists of two separate plans: the Savings Plan and the Standard Plan. You can view a member's State Health Plan benefit booklet by logging in to My Insurance Manager on our website or on the State Health Plan employee website at https://StateSC.SouthCarolinaBlues.com/web/public/statesc/.

State Health Plan is a self-insured grandfathered medical plan available for state of South Carolina employees and their families. It offers valuable medical coverage if a member becomes sick or injured. It also offers some limited services for routine care.

The South Carolina Public Employee Benefit Authority (PEBA) determines the benefits, develops reimbursements and governs the State Health Plan. BlueCross administers the State Health Plan, providing claims management; customer and provider services; and medical management. You may contact the State Health Plan Provider services by logging into My Insurance Manager or calling provider services at 800-444-4311.

State Health Plan members do not need a referral to see a specialist. Many services require precertification for State Health Plan members. You can request precertification at www.SouthCarolinaBlues.com by logging into My Insurance Manager or by calling Medi-Call at 800-925-9724. Medi-Call is a division of BlueCross that handles the medical precertification and case management services for the State Health Plan.

All State Health Plan inpatient procedures and admissions require precertification. The State Health Plan Standard Plan has a copayment for each emergency room visit that is waived if the hospital admits the patient. Some examples that require precertification:

- Admissions for obstetrical care and sick newborn services.
- Hospitalizations that are longer than the length of stay that Medi-Call previously authorized.

These outpatient services may require precertification. This list is not all inclusive. Other services may require prior authorization. Check My Insurance Manager for additional authorization requirements.

- Pregnancy (must call within 12 weeks or there will be an additional $200 penalty).
- Any non-emergency surgery (e.g., septoplasty, hysterectomy or sclerotherapy).
- Chemotherapy or radiation therapy.
- In vitro fertilization for the member or spouse.
- Extended care services, such as hospice, home health care, SNF or DME.
- Any medical treatment involving inpatient rehabilitative services and extended care.
- Organ transplant, bone marrow transplant or other stem cell rescue or tissue transplant.
- Any procedure that may potentially be considered cosmetic in nature (e.g., blepharoplasty, reduction mammoplasty, TMJ or other jaw surgery, etc.), requires written precertification to Medi-Call seven days before the scheduled procedure.
- MRIs, MRAs and CT scans (required through NIA Magellan).
- Chemotherapy/radiation therapy (one-time notification)*.
- Synagis®.

Members are not liable for denied charges if precertification is not received.

*BlueCross has added special programs for patients undergoing chemotherapy and radiation therapy. Please notify us of any patients receiving these treatments. You will only need to notify us once for a patient's course of treatment.

The Standard Plan and State Savings Plan alpha prefix is ZCS. Newer cards reflect the PEBA logo.

State Health Plan

2017 Benefit Changes: Savings Plan

Savings Plan	2016	2017
Deductibles		
Individual	$3,600	No changes
Family	$7,200	No changes
Copays		
Office Visits	No copay	No changes
Outpatient Facility Services	No copay	No changes
Emergency Room	No copay	No changes
Coinsurance Maximums		
Individual (Network)	$2,400	No changes
Family (Network)	$4,800	No changes
Individual (OON)	$4,800	No changes
Family (OON)	$9,600	No changes

2017 Benefit Changes: Standard Plan

Standard Plan	2016	2017
Deductibles		
Individual	$445	No changes
Family	$890	No changes
Copays		
Office Visits	$12	No changes
Outpatient Facility Services	$95	No changes
Emergency Room	$159	No changes
Coinsurance Maximums		
Individual (Network)	$2,540	No changes
Family (Network)	$5,080	No changes
Individual (OON)	$5,080	No changes
Family (OON)	$10,160	No changes

State Health Plan

Pharmacy Updates

- **Effective Jan. 1, 2017, the pharmacy formulary will transition to Express Scripts' National Preferred Formulary.**
    - This change in formulary does not impact Medicare primary members enrolled in the Medicare Part D plan offered by PEBA. Express Scripts will notify members, in-network providers and pharmacies of this upcoming transition. Express Scripts is an independent company that contracts directly with the State Health Plan. State Health Plan members impacted by this transition will receive personalized information from Express Scripts that will include a list of their current prescriptions that will no longer be covered, as well as covered alternatives. The State Health Plan will also participate in Express Scripts' specialty pharmacy programs for Hepatitis C therapy and PCSK9 therapy.
    - The formulary list is available at www.express-scripts.com.
    - Excludes some branded products in highly interchangeable categories.
    - Exception process in place for situations when there are clinical reasons to use excluded products.
    - Free manufacturer offering of the preferred diabetes glucose meter for members who are impacted by test strip coverage changes.
    - Members and physicians will be notified of changes before Jan. 1, 2017.
- Hepatitis C Cure Value Program and Cholesterol Care Value Plan
    - Requires all Hepatitis C and PCSK9 cholesterol medications to be filled through Accredo, Express Scripts' specialty medication pharmacy
    - Ensures medication adherence and assistance from specialty pharmacist for these high-cost medications
    - Existing members as of Jan. 1, 2017, taking a Hepatitis C therapy will be grandfathered and not required to move to Accredo
    - Continue to require clinical review for Hepatitis C and PCSK9 medications
- Shingles vaccinations are covered for individuals age 60 and over. Services received at a network pharmacy should be submitted to Express Scripts, the State's pharmacy benefit manager. Services received at a network provider's office should be submitted by the provider to State Health Plan. The State Health Plan will cover the shingles vaccination as primary for Medicare supplemental members. File directly to State Health Plan.

State Health Plan

Other information and important updates for 2017:

- Effective Jan. 1, 2017, the State Health Plan will remain a grandfathered health plan.
- The State Health Plan will also increase the lifetime limit for hospice services to $7,500.
- Members are encouraged to join these health management programs
    - Coming Attractions: maternity management program
    - Stress management program
    - More details about PEBA Perks, other value-based benefits and health management programs available online at www.peba.sc.gov/healthwellness.html.
- No member cost share for:
    - The Ameda Purely Yours electric breast pump and the Ameda One Hand manual pumps are covered at no cost for covered mothers with maternity benefits. Covered members can order pumps from Better Living Now at www.betterlivingnow.com or Ameda Direct at www.insured.amedadirect.com. **Breast pumps will not be covered when received from other providers.**
    - Routine and diagnostic colonoscopies (and consultations) are covered, as allowed by USPSTF when performed by a participating provider. Specific codes must be used in order to allow this benefit.
    - Diabetes education performed by a participating provider. Specific codes must be used in order to allow this benefit.
    - Contraceptives to subscribers and covered spouses. Specific codes must be used in order to allow this benefit.
- Routine HPV laboratory screening services are allowed once every five years with no member cost share when filed in conjunction with the covered routine Pap smear.
- Newborns must be added to the policy within 31 days of the date of birth.
- Members who have services rendered at PCMHs are not subject to the office copay. The member's coinsurance will be allowed at 10 percent after the deductible has been met.

EyeMed: Vision care program

Contact Information

Website is www.statesc.SouthCarolinaBlues.com
Telephone number is 800-444-4311

FEP

The BlueCross BlueShield Service Benefit Plan, more commonly known as FEP, is part of the Federal Employee Health Benefits Program established by Congress and regulated by the Office of Personnel Management to offer benefits to federal employees, retirees and dependents. It is a national Plan established by the Blue Cross and Blue Shield Association. Each of the 36 member companies is responsible for the claims-processing, customer service, network development, provider contracting, auditing activities and provider reimbursement for services received in its exclusive geographic territory. BlueCross is responsible for the state of South Carolina. The plan is fully funded and qualifies as minimum essential coverage (MEC) and satisfies the PPACA's individual shared responsibility requirement.

Currently, FEP offers two enrollment options for members. The Standard Option offers medical, hospitalization, mental health, dental and prescription drug benefits with benefits for in-network and out-of-network services. The Basic Option offers medical, hospitalization, mental health and prescription drug benefits for in-network service only, except in certain emergency or other extenuating circumstances. Providers should always contact FEP before providing services under the Basic Option as a non-network provider on a non-emergent basis. For medical services, FEP uses the commercial Preferred Blue network and the commercial Dental Participating Network for dental services. Providers participating in these networks automatically participate with FEP.

Under Standard and Basic Options, FEP limits the annual out-of-pocket expenses for the covered services the member receives to protect them from unexpected health care costs. When the eligible out-of-pocket expense reaches the catastrophic protection maximum, the member longer has to pay the associated cost-sharing amounts for the rest of the calendar year. For Self Plus One and Self and Family enrollments, once any individual family member reaches the Self Only catastrophic protection out-of-pocket maximum during the calendar year, that member's claims will no longer be subject to associated cost-sharing amounts for the rest of the year. All other family members will be required to meet the balance of the catastrophic protection out-of-pocket maximum.

FEP members do not need a referral to see a specialist.

FEP refers to the pre-service claim approval process for inpatient hospital admissions as precertification and for other services as prior approval. A preservice claim is any claim, in whole or in part, that requires approval from us before you receive medical care or services. In other words, a preservice claim for benefits may require precertification and prior approval.

The penalty for lack of precertification for inpatient admissions is $500. Even if you obtain a retro approval, the $500 penalty will not be waived. If the stay is not medically necessary, we will not provide benefits for inpatient hospital room and board or inpatient physician care; we will only pay for covered medical services and supplies that are otherwise payable on an outpatient basis.

Precertification is required for all inpatient hospitalizations when FEP is the primary payer. When the inpatient services are related to gender reassignment services, FEP requires all inpatient services be precertified, even if FEP is a secondary payer. We must receive inpatient admission authorizations 24 to 48 hours before services, unless the services are related to an emergency admission. In the case of an emergency admission, precertification must be received within two business days. Please include this information when requesting precertification from FEP:

- Patient's name
- ID number
- Call-back number

Federal Employee Program

Prior approval is required for these services under both Standard and Basic Option:

- Outpatient sleep studies performed outside the home
- Applied behavior analysis (ABA)
- Gender reassignment surgery
- BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes
    - Members must receive genetic counseling and evaluation services before preventive BRCA testing is performed.
    - First-degree relatives are living or deceased biological parents, siblings and children of the member being tested. Second-degree relatives are living or deceased biological grandparents, aunts, uncles, nieces, nephews, grandchildren and half-siblings (siblings with one shared biological parent) of the member being tested.
- Surgical services
    - Outpatient surgery for morbid obesity
    - Outpatient surgical correction of congenital anomalies
    - Outpatient surgery needed to correct accidental injuries (see Definitions) to jaws, cheeks, lips, tongue, roof and floor of mouth
    - Gender reassignment surgery
- Outpatient intensity-modulated radiation therapy (IMRT)
- Hospice care
- Organ/tissue transplants
- Prescription drugs and supplies – Certain prescription drugs and supplies require prior approval.
    - Contact CVS/caremark, our Pharmacy Program administrator, at 800-624-5060 (TTY: 800-624-5077 for the hearing impaired) to request prior approval, or to get a list of drugs and supplies that require prior approval.

Precertification and/or prior approval must be received from the state where the services will be performed. For example, if the lab for the BRCA test is in Utah, the provider must contact the Blue Plan in Utah for prior approval. BlueCross' FEP can only provide precertification and/or prior approval for services received in South Carolina.

Precertification and/or prior approval for medical services is processed through the BlueCross' precertification department at 800-327-3238.

Precertification and/or prior approval for mental health/substance abuse (MHSA) is processed through CBA at 800-868-1032.

FEP

Predeterminations

For services not requiring prior approval, a predetermination may be submitted to the FEP medical review nurse. The cover letter should include contact name and phone number, referring and rendering provider name and address, patient name and ID number, date of service, place of service, diagnosis codes and description, and CPT codes with description. The supporting records and documentation should include history and physical, current office records related to the desired service, vital signs (including height and weight), medical examination and findings and functional Issues related to the desired service. ALL PHOTOS MUST BE MAILED! FEP has 30 days from the date of receipt to respond to a request. A pre-determination is NOT a guarantee of payment for services. Benefits and payment will be determined when the claim is filed. The information should be submitted via fax or mail.

FEP Fax: Provider Services
Attn: Medical Review
803-264-8104

FEP Mail: FEP Provider Services
Attn: Medical Review, AX-B05
P.O. Box 600601
Columbia, SC 29260-0601

DME

DME benefits are based on medical necessity and do not require prior approval. When the FEP is the primary payer however, FEP requires a Certificate of Medical Necessity (CMN) stating what equipment is needed, why the equipment is needed and for how long the equipment will be needed. FEP covers DME rentals or purchases at our option, including repair and adjustment. When the DME is under a rental agreement, supplies and accessories are considered part of the agreement. Certain benefits limits do apply to DME supplies. DME is defined by FEP as equipment and supplies that:

1. Are prescribed by the attending physician (i.e., the physician who is treating the illness or injury)
2. Are medically necessary
3. Are primarily and customarily used only for a medical purpose
4. Are generally useful only to a person with an illness or injury
5. Are designed for prolonged use
6. Serve a specific therapeutic purpose in the treatment of an illness or injury

Pharmacy

CVS/caremark is the pharmacy vendor for FEP.

- Retail Pharmacy: 800-624-5060
- Mail-Order Pharmacy: 800-262-7890
- Specialty Pharmacy Program: 888-346-3731

FEP

2017 Benefit Changes: Standard Option

Standard Option	2016	2017
Deductibles		
Individual	$350	No changes
Self-Plus One	$700	
Family	$700	
Catastrophic Out-of-Pocket Maximums		
Individual (Network)	$5,000	No changes
Self-Plus One (Network)	$10,000	
Family (Network)	$10,000	
Individual (OON)	$7,000	
Self-Plus One (OON)	$14,000	
Family (OON)	$14,000	
Services		
Office Visits (Network) ***(including physical therapy, speech therapy, occupational therapy, cognitive therapy, vision services and foot care)***	$25 primary care physician (PCP) copay $35 specialist copay	No changes
Mental Health and Substance Abuse (Network) ***(professional services)***	$25 copay	
Outpatient Facility Services (Network)	15 percent coinsurance	
Emergency Room (Network)	15 percent coinsurance	
Manipulative Treatment (Network)	$25 copay	
Inpatient Admission	$350 copay for unlimited days (network) $450 copay for duration of services, plus 35 percent of the allowance and any remaining balance after our payment (OON)	
Outpatient Observation	$350 copay for the duration of services (network) $450 copay for duration of services, plus 35 percent of the allowance and any remaining balance after our payment (OON)	
Continuous Home Hospice Care	$350 copay per episode (network) $450 copay per episode; member is responsible for 35 percent of the plan allowance, plus any remaining balance after payment (OON)	
Topical application of fluoride or fluoride varnish	No limit	Limited to two per calendar year
Extra-oral images	Pay higher allowance for the first image, reduced amount for each extra	Allowance is the same for each image

Federal Employee Program

2017 Benefit Changes: Basic Option

The Basic Option offers medical, hospitalization, mental health and prescription drug benefits for in-network service only except in certain emergency or other extenuating circumstances. Benefits are given for in-network services.

Basic Option	2016	2017
Deductibles		
Individual	$0	No changes
Self-Plus One	$0	
Family	$0	
Catastrophic Out-of-Pocket Maximums		
Individual (Network)	$5,500	No changes
Self-Plus One (Network)	$11,000	
Family (Network)	$11,000	
Individual (OON)	No coverage out of network	
Self-Plus One (OON)		
Family (OON)		
Services		
Office Visits ***(including physical therapy, speech therapy, occupational therapy, cognitive therapy, vision services and foot care)***	$30 PCP copay $40 specialist copay	No changes
Mental Health and Substance Abuse ***(professional services)***	$30 copay	No changes
Outpatient Surgical Facility	$100 copay per day per facility plus 30 percent of the allowance for agents, drugs, and/or supplies administered or obtained in connection with care	No changes
Labs, Pathology, EKGs	$0	No changes
Cardiovascular Monitoring, EEGs, Neurological Testing, Ultrasounds, X-rays, Home Sleep Studies	$100 copay per day per facility plus 30 percent of the allowance for agents, drugs and/or supplies administered or received in connection with care	No changes
Diagnostic bone density tests, CT scans, MRIs, PET scans, angiographies and genetic testing, nuclear medicine and sleep studies	$30 copay per day per facility plus 30 percent of the allowance for agents, drugs and/or supplies administered or received in connection with care	$100 copay at professional office $150 copay at outpatient hospital or ASC
Outpatient treatment services by a facility, cardiac rehabilitation, cognitive rehabilitation therapy, pulmonary rehabilitation, rehabilitative (physical, occupational and speech therapy) and ABA	$30 copay per day per facility plus 30 percent of the allowance for agents, drugs and/or supplies administered or received in connection with care	No changes
Emergency Room	$125 copay per visit	No changes
Manipulative Treatment	$30 copay	No changes
Inpatient Admission (Network)	$350 copay for unlimited days	$175 per day copay, up to $875
Outpatient Observation (Network)	$175 per day copay, up to $875	No changes
Continuous Home Hospice Care (Network)	$150 per day copay, up to $750	No changes

Federal Employee Program

2017 Benefit Changes: Standard Option and Basic Option

Standard Option and Basic Option	2016	2017
***BRCA testing**	• BRCA1 and BRCA2 testing available for individuals 18 and over who are from a family with known BRCA1/BRCA2 mutation. • Includes testing for members who have a personal history of breast, ovarian, fallopian tube, peritoneal, pancreatic and/or prostate cancer who have not received testing, when genetic counseling and evaluation supports BRCA testing. • Includes testing for large genomic rearrangements in BRCA1 and BRCA2 genes. • Prior approval is required for preventive and diagnostic testing, and members have to receive genetic counseling. *Additional requirements apply.	Adult preventive benefits for BRCA-related testing are expanded to cover members with a family history of pancreatic or prostate cancer diagnosed in a first- or second-degree relative. Genetic counseling and prior approval by the plan in the state where the lab is located is still required.
Applied Behavioral Analysis	Non-covered.	Beginning in 2017, FEP will provide benefits for ABA in relation to Autism Spectrum Disorder to include assessments, evaluations, and treatment. The services require prior approval for both inpatient and outpatient services.
Nonsurgical Treatment of Amblyopia and Strabismus	The nonsurgical treatment of amblyopia and strabismus for a child is covered until age 18.	The nonsurgical treatment of amblyopia and strabismus for a child is covered until age 21.
Sleep Studies	Do not require prior approval.	Sleep studies performed in a professional office or an outpatient facility will require a prior approval. If it is performed at home, no prior approval is required.
Pharmacy Benefits	Standard Option uses an open formulary. Basic Option uses a managed formulary. Some drugs and supplies are excluded from coverage.	Certain costly FDA-approved drugs having multiple generic equivalents or alternative options may be excluded from the Standard Option and/or Basic Option formulary.
Self-Injectable Drugs	Benefits are available for members to receive certain self-injectable medications through their medical provider using the medical benefits.	Only the first dose will be paid through the medical benefits. The member will then need to fill the prescription through the appropriate pharmacy program.

Federal Employee Program

2017 Benefit Changes: Standard Option and Basic Option

Standard Option and Basic Option	2016	2017
Gender Reassignment Surgery	In 2016, FEP began providing prescription drug benefits for the treatment of gender identity/gender dysphoria.	Benefits are extended to cover specific surgical procedures for gender reassignment surgery for members age 18 and older. ALL surgical procedures for gender reassignment require prior approval including inpatient, outpatient, and overseas services. This is a once-per-lifetime benefit. The member must have a diagnosis and supporting documentation from a qualified healthcare professional. The supporting documentation must show the new gender identity has been present for at least 24 continuous months. The member must have a strong desire to rid himself or herself of primary and/or secondary sex characteristics due to a significant inconsistency with his or her gender identity. The gender dysphoria cannot be a symptom of another mental disorder or chromosomal abnormality. The gender dysphoria must cause clinical distress or impairment in the regular area of social, occupational and other functional areas. The member must live full time for 12 continuous months in the desired gender and have life experience functioning in the desired gender in his or her place of employment, family, social and community activities. Furthermore, he or she must complete 12 months of continuous hormone therapy. Two referral letters are required from qualified mental health professionals. One of the letters must be from the psychotherapist who has treated the member for gender dysphoria for at least 12 continuous months. The letters must document a diagnosis of persistent and chronic gender dysphoria, that any comorbidities (diabetes, hypertension, etc.) are stable, that the member is prepared to undergo surgery and that all aspects of the planned surgery are understood. Finally, if other medical or mental health concerns are present, the conditions must be documented as optimally managed and reasonably under control. The surgical benefits for female to male surgery are limited to mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidiolplasty, phalloplasty, urethroplasty, scrotoplasty, and placement of testicular and erectile prosthesis. The surgical benefits for male to female surgery are limited to penectomy, orchiectomy, vaginoplasty, clitoroplasty and labiaplasty. The gender reassignment surgery benefits are once-per-lifetime benefits. Reversal and revisions of procedures will not be covered.

Federal Employee Program

Other Information and Important Updates

- FEP Website – www.FepBlue.org
- FEP Provider Service Number – 888-930-2345
- Benefits and eligibility for FEP members is also available on My Insurance Manager.
- Beginning in 2016, FEP began accepting electronic submission of claim attachments through My Insurance Manager by attached the information to the appropriate link next to the claim information.
- FEP considers one month as 30 days. Therefore, any benefits with requirements or limits expressed in months must be multiplied by 30. For example, gastric bypass surgery requires nutritional counseling for at least three months prior to surgery. Three months is equal to 90 days.

Exchange Plans: Small Group Plans

Health plans in the individual and small group markets are offered through the FFM and private marketplaces. The federal government manages the FFM, and insurance companies manage private marketplaces. Plans are available to both individuals who may be uninsured, underinsured or otherwise eligible for federal subsidies and small businesses.

Product Name(s)

BlueCross and BlueChoice offer small group Exchange plans to businesses with two to 50 employees. The BlueCross small group Exchange plans are called Business BlueEssentials, and the BlueChoice small group Exchange plans are called BusinessADVANTAGE℠.

Network

Business BlueEssentials plans use the BlueCross Preferred Blue Network. BusinessADVANTAGE plans use the Advantage Network.

Prescription Drug Plan

Members have drug coverage through Caremark. Business BlueEssentials members have a **four-tier** plan with either a drug card and/or mail-service benefits. BusinessADVANTAGE members have a **six-tier plan** with either a drug card and/or mail-service benefits.

You can download the Preferred Drug List through our websites, www.SouthCarolinaBlues.com or www.BlueChoiceSC.com.

Vaccination Network

Certain seasonal and non-seasonal vaccinations are available under small group Exchange members' pharmacy benefit at no cost to the member through the Vaccination Network only. As of Aug. 1, 2016, this network was limited to CVS Retail pharmacies. Vaccinations are available under members' medical benefit, as well.

Exchange Plans: Small Group Plans

Requirement for Referral to Specialist

Small group Exchange plan members do not need a referral to see a specialist.

When the Treating Physician and/or Facility is Required to Give Notice for Certain Services

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

- Hospital admission, including maternity notifications
- SNF admission
- Continuation of a hospital stay (remaining in the hospital or SNF for a period longer than was originally approved) for a medical condition
- Outpatient hysterectomy or septoplasty
- Home health care or hospice services
- DME, when the purchase price or rental is $500 or more
- Admissions for habilitation, rehabilitation and/or human organ and/or tissue transplants
- Treatment for hemophilia
- Mental health and substance use disorders
- Certain prescription drugs and specialty drugs
- Cosmetic procedures
- MRIs, MRAs and CT scans (required through NIA Magellan)
- Musculoskeletal care such as interventional spine management services and lumbar and cervical spine surgeries (required through NIA Magellan)
- Radiation oncology (required through NIA Magellan)
- Nuclear cardiology (required through NIA Magellan)
- Certain labs (through Avalon)
- Specialty medical specialty drugs (required through NovoLogix, CVS/caremark's online prior authorization tool)

Other information and important updates for 2017:

- All compound drugs will require a prior authorization beginning Jan. 1, 2017.

BlueEssentials and Blue Option Individual Plans

Product Name(s)

The individual exchange products BlueCross offers are called BlueEssentials, and the BlueChoice products offered are called Blue Option. These are all non-grandfathered products. Non-grandfathered health plans within the Exchanges must offer a core package of items and services (essential health benefits).

Network

BlueEssentials and Blue Option individual plans operate under an EPO, which means they use a network of participating doctors, hospitals and other health care providers. Members access benefits only through an in-network provider. If a provider is not in the BlueEssentials or Blue Option EPO network, we will cover services only in the event of an emergency.

Pharmacy Network

BlueEssentials and Blue Option individual plans use the Advanced Choice Network (ACN). It includes all CVS pharmacies, Walmart, Kroger and Safeway locations, plus various grocers and independent pharmacies. Beginning Jan. 1, 2017, all Rite Aid pharmacies are to join the ACN.

Prescription Drug Plan

Members have drug coverage through Caremark. BlueEssentials members have a **four-tier** plan with either a drug card and/or mail-service benefits. Blue Option members have a **six-tier** plan with either a drug card and/or mail-service benefits. As of Oct. 1, 2016, members must use pharmacies in the Advanced Choice Network™. This network is exclusive for all BlueCross and BlueChoice Exchange plans. If members fill prescriptions at a non-participating pharmacy, they will be required to pay the full retail price.

You can download the Preferred Drug List and view the list of Advanced Choice Network pharmacies through our websites, www.SouthCarolinaBlues.com or www.BlueChoiceSC.com.

Vaccination Network

Certain seasonal and non-seasonal vaccinations are available under Individual Exchange members' pharmacy benefit at no cost to the member through the Vaccination Network only. As of Aug. 1, 2016, this network was limited to CVS Retail pharmacies. Vaccinations are available under members' medical benefit, as well.

Benefits and Eligibility

Always verify coverage for members, as eligibility may change based on premium status or Medicare entitlement. You can quickly get the most current member eligibility and benefit information by using My Insurance Manager on our websites. You can also call the Provider Services VRU at 800-868-2510.

BlueEssentials and Blue Option Individual Plans

Transition of Care

If a BlueEssentials or 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. 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 be only be made when there is not an in-network provider that can perform the services the patient requires.**

Requirement for Referral to Specialist

BlueEssentials and Blue Option members do not need a referral to see a specialist.

Precertification

Certain categories of benefits require precertification. Failure to get preauthorization can result in us denying benefits. Precertification is not a guarantee that we will cover the service. For precertification requirements, verify benefits and eligibility through My Insurance Manager. Once you have verified precertification requirements, you can initiate the precertification request in My Insurance Manager.

When the Treating Physician and/or Facility is Required to Give Notice for Certain Services

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

- Hospital admission, including maternity notifications
- SNF admission
- Continuation of a hospital stay (remaining in the hospital or SNF for a period longer than was originally approved) for a medical condition
- Outpatient hysterectomy or septoplasty
- Home health care or hospice services
- DME, when the purchase price or rental is $500 or more
- Admissions for habilitation, rehabilitation and/or human organ and/or tissue transplants
- Treatment for hemophilia
- Mental health and substance use disorders
- Certain prescription drugs and specialty drugs
- Cosmetic procedures
- MRIs, MRAs and CT scans (required through NIA Magellan)
- Musculoskeletal care such as interventional spine management services and lumbar and cervical spine surgeries (required through NIA Magellan)
- Radiation oncology (required through NIA Magellan)
- Nuclear cardiology (required through NIA Magellan)
- Certain labs (through Avalon)
- Specialty medical specialty drugs (required through NovoLogix, CVS/caremark's online prior authorization tool)

BlueEssentials and Blue Option Individual Plans

Mental Health

You should get treatment plans through CBA. You can visit www.CompanionBenefitAlternatives.com or call one of these numbers:

- 803-699-7308
- 800-868-1032 (outside Columbia)

Premium Delinquencies

Members who do not have a federal subsidy do not have a delinquency grace period. We will deny claims immediately upon delinquency.

Members who have an FFM policy and receive a federal subsidy have a three-month grace period. During the first month of delinquency, we will process all claims and apply benefits accordingly. During the second and third months of delinquency, claims will pend until the member pays the premiums. If the premium is not current at the end of the third month (90 days), we will deny claims. We will notify you of a member's premium delinquency:

1. When verifying eligibility and benefits through My Insurance Manager and the VRU.
2. When verifying claim status through My Insurance Manager and the VRU.
3. When reviewing your remittance advice.

Medicare Entitlement

If an individual is entitled to Medicare, then BlueEssentials plan benefits for medical or prescription coverage are excluded. As stated in the BlueEssentials contract, we will not pay claims for "services or supplies for which you are entitled to benefits under Medicare. ..." Examples of individuals entitled to Medicare would be those 65 years of age and older, and patients with end-stage renal disease (ESRD).

Other information and important updates for 2017:

- BlueChoice will no longer offer Blue Option plans through the FFM beginning Jan. 1, 2017. Members whose ID number begins with the alpha prefix ZCX have the option of selecting a comparable BlueEssentials plan on the FFM or shopping for an off-exchange plan through the BlueCross or BlueChoice private exchanges.
- BlueEssentials and Blue Option members do not have out-of-network or out-of-state benefits, except in the event of a true emergency. However, services from providers in contiguous counties (bordering counties outside of South Carolina) that are currently contracted and participate in the BlueEssentials and Blue Option networks are considered in-network.
- BlueEssentials and Blue Option members do not have benefits for services provided by out-of-state providers, except in the event of an emergency. This also includes labs and durable medical equipment services. Members only have benefits within South Carolina when the provider is in the BlueEssentials or Blue Option network.
- Effective Oct. 1, 2016, MUSC health services are available through BlueEssentials, Blue Option and BlueChoice HealthPlan Medicaid. This includes all MUSC facilities and providers, thus providing access to MUSC specialty services not found in other facilities throughout the state.
- All Exchange Plans will require a prior authorization for compound drugs and dialysis treatment beginning Jan. 1, 2017.

Contact Information

My Insurance Manager is our preferred method for you to access benefits and eligibility, get claim status, initiate prior authorizations and submit documentation related to pending prior authorizations and claims. Please visit www.SouthCarolinaBlues.com or www.BlueChoiceSC.com to log into My Insurance Manager.

Area	Websites	Contact Numbers	
BlueCross (including BlueEssentials)	www.SouthCarolinaBlues.com	Provider Services: 800-868-2510	Prior Authorizations: 800-334-7287
BlueChoice (including Blue Option)	www.BlueChoiceSC.com	Provider Services: 800-868-2528	Prior Authorizations: 800-950-5387
BlueChoice HealthPlan Medicaid	www.BlueChoiceSCMedicaid.com	Customer Care Center: 866-757-8286	
FEP	www.FEPBlue.org	Provider Services: 888-930-2345	Prior Authorizations: 800-327-3238
State Health Plan	www.statesc.SouthCarolinaBlues.com	Provider Services: 800-444-4311	Prior Authorizations: 800-925-9724
CBA	www.CompanionBenefitAlternatives.com	800-868-1032	
Avalon Healthcare Solutions	www.AvalonHCS.com	Phone: 844-227-5769	Fax: 888-791-2181
NIA Magellan	www.RadMD.com	866-500-7664	
NovoLogix (CVS/caremark)	Accessible through My Insurance Manager	Phone: 866-284-9229	Fax: 844-851-0882

BlueCross and BlueChoice Support	Email Addresses	Contact Numbers
Electronic Data Interchange (EDI)	edi.services@bcbssc.com	Phone: 800-868-2505
Electronic Data Interchange Gateway (EDIG)	edig.services@bcbssc.com	
EFT and ERA	provider.eft@bcbssc.com	
Provider Certification	provider.cert@bcbssc.com	Fax: 803-264-4795 or 803-870-8919
Provider Relations and Education	provider.education@bcbssc.com	Phone: 800-288-2227, ext. 44730
Technology Support Center		Phone: 855-229-5720
Web Technology Support		Phone: 800-868-2505
BlueCross		Phone: 800-763-0703 Fax: 803-264-4050

Provider Resources

Provider Advocate Contact Form

- www.southcarolinablues.com > Providers > Contact Us
- www.bluechoicesc.com > Providers > Education Center > Education Specialist

Designation of Authorized Representative to Appeal

- www.southcarolinablues.com > Providers > Forms > Specialties/Other Forms > Other Forms
- www.bluechoicesc.com > Providers > Forms

Provider Reconsideration Form

- www.southcarolinablues.com > Providers > Forms > Financial and Appeals > Appeals
- www.bluechoicesc.com > Providers > Forms > Physician Appeal Request Form

Dental Provider Reconsideration Form

- www.southcarolinablues.com > Providers > Forms > Financial and Appeals > Appeals

Authorization to Disclose Protected Health Information (PHI) to a Third Party

- www.southcarolinablues.com > Providers > Forms > Specialties/Other Forms > Other Forms

Other Health/Dental Insurance Questionnaire

- www.southcarolinablues.com > Providers > Forms > Other Forms
- www.bluechoicesc.com > Providers > Forms > Online Other Health Coverage Questionnaire

Request to Add or Terminate Practitioner Affiliation Form

- www.southcarolinablues.com > Providers > Forms > Credentialing/Provider Updates > Update Provider Information
- www.bluechoicesc.com > Providers > Forms

Change of Address Form

- www.southcarolinablues.com > Providers > Forms > Credentialing/Provider Updates > Update Provider Information
- www.bluechoicesc.com > Providers > Forms

Authorization for Clinic/Group to Bill for Services Form

- www.southcarolinablues.com > Providers > Forms > Credentialing/Provider Updates > Update Provider Information
- www.bluechoicesc.com > Providers > Forms

Application for Satellite Location to File Claims or to Change EIN

- www.southcarolinablues.com > Providers > Forms > Credentialing/Provider Updates > Update Provider Information
- www.bluechoicesc.com > Providers > Forms

Centering Pregnancy Application Form

- www.southcarolinablues.com > Providers > Forms > Specialties/Other Forms > Specialty Forms
- www.bluechoicesc.com > Providers > Forms

Provider Resources

Maternity Screening Referral Tool (MSRT)

- www.southcarolinablues.com > Providers > Forms > Specialties/Other Forms > Specialty Forms
- www.bluechoicesc.com > Providers > Forms

Pregnancy Notification Form

- www.southcarolinablues.com > Providers > Forms > Specialties/Other Forms > Specialty Forms
- www.bluechoicesc.com > Providers > Forms

HEDIS Compliance Companion Forms (varied)

- www.southcarolinablues.com > Providers > Forms > Specialties/Other Forms > Quality Forms
- www.bluechoicesc.com > Providers > Forms

Radiation Therapy Treatment Form

- www.southcarolinablues.com > Providers > Forms > Specialties/Other Forms > Specialty Forms
- www.bluechoicesc.com > Providers > Resources > Radiation Oncology Program

Report Fraud

- www.southcarolinablues.com > Providers > Contact Us
- www.bluechoicesc.com > Providers > Report Fraud

Subrogation Questionnaire

- www.southcarolinablues.com > Providers > Forms > Specialties/Other Forms > Other Forms

BlueCross Provider Office Administrative Manual

- www.southcarolinablues.com > Providers > Education Center > Resources

BlueChoice Provider Office Administrative Manual

- www.bluechoicesc.com > Providers > Education Center > Provider Resources > Manuals & Guides

BlueCard Program Provider Manual

- www.southcarolinablues.com > Providers > Education Center > Resources
- www.bluechoicesc.com > Providers > Education Center > Provider Resources > Manual & Guides

Member Identification Card Guide

- www.southcarolinablues.com > Providers > Education Center > Resources
- www.bluechoicesc.com > Providers > Education Center > Provider Resources > Manual & Guides

Preventive Care Guide

- www.southcarolinablues.com > Providers > Education Center > Resources
- www.bluechoicesc.com > Providers > Education Center > Provider Resources > Manuals & Guides

Reference Guide for Information & Contacts

- www.southcarolinablues.com > Providers > Education Center > Resources
- www.bluechoicesc.com > Providers > Education Center > Provider Resources > Manuals & Guides

Provider Resources

Quick Reference Card

- www.southcarolinablues.com > Providers > Education Center > Resources
- www.bluechoicesc.com > Providers > Education Center > Provider Resources > Manuals & Guides

Palmetto Provider University Presentations (varied)

- www.southcarolinablues.com > Providers > Education Center > Provider Training > Presentations
- www.bluechoicesc.com > Providers > Education Center > Provider Resources > Presentations

Frequently Asked Questions (varied)

- www.southcarolinablues.com > Providers > Education Center > Resources > Frequently Asked Questions
- www.bluechoicesc.com > Providers > Resources > FAQs

Doctor & Hospital Finder

- www.southcarolinablues.com > Member > Find a Doctor
- www.bluechoicesc.com > Doctor & Hospital Finder

My Insurance Manager portal

- www.southcarolinablues.com > Providers > My Insurance Manager
- www.bluechoicesc.com > Providers > My Insurance Manager

My Insurance Manager information

- www.southcarolinablues.com > Providers > Education Center > Provider Tools
- www.bluechoicesc.com > Providers > Resources

My Remit Manager portal

- www.southcarolinablues.com > Providers > Education Center > Provider Tools > My Remit Manager
- www.bluechoicesc.com > Providers > Resources > Claims and Payment Resources > My Remit Manager

My Remit Manager information

- www.southcarolinablues.com > Providers > Education Center > Provider Tools
- www.bluechoicesc.com > Providers > Resources > Claims and Payment Resources

Voice Response Unit information

- www.southcarolinablues.com > Providers > Education Center > Provider Tools

Ancillary Claims Filing Reminders

- www.southcarolinablues.com > Providers > Education Center > Resources
- www.bluechoicesc.com > Providers > Resources > Ancillary Services

How to Determine if You Are a Network Provider

- www.southcarolinablues.com > Providers > Education Center > Resources

Drug Lists

- www.southcarolinablues.com > Providers > Prescription Drug Information > Drug Lists
- www.bluechoicesc.com > Providers > Resources > Prescription Drug Information

Provider Resources

What You Need to Know About Skilled Nursing Facilities

- www.southcarolinablues.com > Providers > Education Center > Resources
- www.bluechoicesc.com > Providers > Education Center > Provider Resources > Manuals & Guides

Provider Reference Matrix Guides (Adult & Pediatric)

- www.southcarolinablues.com > Providers > Quality Initiatives > Healthcare Effectiveness Data and Information Set (HEDIS)
- www.bluechoicesc.com > Providers > Resources > HEDIS

HEDIS Charts (Adult & Pediatric)

- www.southcarolinablues.com > Providers > Quality Initiatives > Healthcare Effectiveness Data and Information Set (HEDIS)
- www.bluechoicesc.com > Providers > Resources > HEDIS

Improving Patient Satisfaction for Providers

- www.southcarolinablues.com > Providers > Education Center > Resources
- www.bluechoicesc.com > Providers > Education Center > Provider Resources > Manuals & Guides

Healthier Moms and Babies

- www.southcarolinablues.com > Providers > Education Center > Resources
- www.bluechoicesc.com > Providers > Education Center > Provider Resources > Manuals & Guides

Avalon Healthcare Solutions (Avalon)

- www.southcarolinablues.com > Providers > Education Center > Precertification > Lab Precertification
- www.bluechoicesc.com > Providers > Education Center > Provider Resources > Lab Precertification

Avalon Preauthorization Request Form

- www.southcarolinablues.com > Providers > Forms > Specialties/Other Forms > Other Forms
- www.bluechoicesc.com > Providers > Education Center > Provider Resources > Lab Precertification

CVS/caremark/Novologix client portal

- www.southcarolinablues.com > Providers > Education Center > Precertification > Specialty Medical Drugs
- www.bluechoicesc.com > Providers > Education Center > Provider Resources > Specialty Medical Drugs

National Imaging Associates (NIA) Magellan

- www.southcarolinablues.com > Providers > Education Center > Precertification > Radiology Precertification
- www.bluechoicesc.com > Providers > Resources > Office and Facility Resources > Radiology Services

Transition of Care Form (BlueEssentials and BlueOption)

- www.southcarolinablues.com > Member > Insurance Basics > Forms > Transition of Care Form
- www.bluechoicesc.com > Members > Forms > Transition of Care Form