2018 Annual Provider Summit

Provider Handbook

In the event of any inconsistency between information contained in this handbook and the agreement(s) between you and BlueCross BlueShield of South Carolina, the terms of those agreement(s) shall govern. The information included is general information and in no event should it 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 the preparation and editing of this publication.

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 — hosts this event for providers to learn about upcoming benefits and administrative changes in the new year.

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 handle the request most efficiently. 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 practice manager meetings.

If you have a training request or a question about topics such as compliance requirements, electronic claim filing updates, changes or problem identification/resolution, etc., 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 and www.BlueChoiceSC.com.

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

Provider Education Team			
Name	**Counties Served or Service Specialty**	**Telephone**	**Email**
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PROVIDER FUNDAMENTALS

OVERVIEW

A presentation designed for new network providers and established providers who need a refresher about the responsibilities of a network provider, the uses of the BlueCross self-service tools, and the roles Provider Relations and Education plays in advocating for providers.

My Insurance Manager User Guides

My Insurance Manager User Guides are available at www.SouthCarolinaBlues.com and www.BlueChoiceSC.com. You can also access the guides within My Insurance Manager by looking under Resources.

Web Resources

- BlueCard Provider Manual
- BlueCross Provider Office Administrative Manual
- BlueChoice Provider Office Administrative Manual
- Dental Provider Manual
- Member ID Card Guide
- My Insurance Manager User Guides
- BlueCard Basics
- Claim Attachments Guide

The Role of Provider Education

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.

Essentially, we help our network providers to work most effectively with our plans. We advocate on behalf of the providers, making sure not only to resolve an inquiry but that the resolution is ideal for both the provider and the Plan.

Our team is comprised of internal and external advocates. It is our external advocates who meet regularly with providers in their designated counties. Though we are all capable purveyors of information, it is the internal staff that is charged with developing educational materials that support the outreach of the external team.

How We Educate Our Providers

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 practice manager meetings.

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

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.

Education Delivery Methods

We provide education through the following avenues:

- **Webinars:** We offer online presentations of various education topics throughout the year. If you are not receiving emails from us regarding our trainings, and you would like to be notified, send an email to provider.education@bcbssc.com to be added to our list.
- **Newsletters and Bulletins:** BlueNews for Providers is a monthly newsletter that includes reminders, new information that can be beneficial to your office and a spotlight on a provider office for their great work as a network provider. We also post provider updates in the Provider News section of both websites.
- **Workshops:** We host meetings to discuss corporate initiatives, new benefits and changes for the upcoming year. We also host workshops onsite as needed.
- **Reports:** You receive reports of your progress as a network provider at each provider advocate visit or upon request.
- **Email Blasts:** Join our email list to receive emails announcing upcoming changes, training events and other exciting news.

You may request specialized training to be provided to your office on-site by completing the Provider Advocate Training Request Form, available on our websites.

Your Role as a Network Provider

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

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

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

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

Refunds: If you receive a payment that you need to return to us, you can use the Refund Form found on our website. This form ensures that we route your check to the appropriate department and process it properly.
If you have any questions about your fee schedule, please contact your contracting specialist.

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

- The provider will file all claims for all applicable members.
- We will reimburse the provider for covered services based on the member's contract. Fee allowances are the lower of the provider's charge for a procedure or the fee schedule of maximum allowances.
- The provider will accept payment plus any patient copayments, coinsurance and deductibles as full reimbursement. The provider will not bill the patient for more than his or her applicable patient liability amount not to exceed the fee allowance.
- The provider agrees to cooperate fully with the utilization review procedures in the Professional Agreement.
- The provider will use other network providers for a member's care unless medically necessary services, supplies or equipment are not available from a network provider, or in cases of medical emergencies or urgently needed services.
- The provider agrees to bill promptly and in a manner approved by BlueChoice for all services. Electronic claims submission (EMC) in the 837I or 837P HIPAA-compliant format is the preferred method of filing.

As a network provider you also agree to cooperate fully with the utilization review procedures. If medical records are needed for medical necessity review or for HEDIS reviews, you will submit these records and not charge a medical records fee.

Where Patients Should Go For Their Health Care Needs

Members can avoid needless worry, out-of-pocket costs and time sitting in the emergency room (ER) by knowing how to navigate the health care system and being familiar with other options for care. Here are some resources to use when health care needs are not a true emergency.

1. **Primary Care Physician (PCP)**
   A PCP should be the first choice for health care. A PCP addresses these common medical issues among others:
   - Illnesses such as colds, flu, earaches and sore throats
   - Minor injuries such as sprains, strains and back pain
   - Routine physical exams, vaccinations and screenings

   If your patient doesn't have a PCP, he or she can review provider directories online to get help finding a doctor to fit his or her needs.

2. **Network Urgent Care Clinics**
   Urgent Care clinics provide another option when a patient needs care and a PCP is not available. Urgent care clinics provide care for medical problems needing immediate attention but are not life threatening, or for problems that could get worse if the patient waits. An urgent care visit usually takes less time than a hospital ER and costs less.

3. **Blue CareOnDemand℠**
   Members can now visit with a doctor faster and easier than ever. With Blue CareOnDemand, members can visit with a doctor via smartphone, tablet or computer, rather than visiting an office or urgent care clinic. Doctors will diagnose illnesses and write prescriptions as appropriate for issues including but not limited to the following:
   - Colds
   - Pink eye
   - Flu
   - Ear infection
   - Fever
   - Migraines

   Members can download the app via the App Store or Google Play, or can sign up by visiting www.BlueCareOnDemandSC.com.

When should a patient go to the Emergency Room (ER)?

The ER is only for very serious or life-threatening problems such as

- Sudden or unexplained loss of consciousness
- Signs of a heart attack
- Signs of a stroke
- Severe shortness of breath
- Poisoning
- Medication/drug overdose or alcohol poisoning

The ER is not a substitute for a PCP visit. Going to the ER for something that is not a true emergency may result in longer wait times and increased patient cost.

How to Self-Service

The best places to locate educational materials we have created for providers are on our provider websites for BlueCross and BlueChoice.

In the Education Center, on both the BlueCross and BlueChoice websites, you can find useful resources to include the following information:

- Current and archived news bulletins and newsletters
- Provider tools pages for My Insurance Manager, My Remit Manager, STATchat and their associated user manuals
- Provider training offerings
- Medical policies and clinical guidelines
- Claims and remittance resources
- BlueCard resources
- Precertification information

Other important resources and information can be found on the Forms, Prescription Drug Information, Medicare Advantage, HIPAA Critical Center and Quality Initiatives pages.

My Insurance Manager

My Insurance Manager is a convenient and secure portal that allows providers to obtain patient benefit information, authorizations and claim status. It is easy to use for filing HIPAA-compliant professional, institutional and dental claims, viewing claims status and much more.

My Insurance Manager removes the need for practitioners to spend considerable time on a phone call with Provider Services representatives to get the status of a claim or initiate an authorization request.

My Insurance Manager allows you to do the following:

- Access eligibility and benefits
- Submit authorization requests
- Submit clinical documentation for pending authorization requests using the Clinical Attachments feature
- Submit claims (professional, institutional and dental), including new, corrected and voided claims
- View claim status
- Submit claims documentation using the Claim Attachments feature
- Use Ask Provider Services to submit claims inquiries
- Use STATchat to connect telephonically to a Provider Services Representative
- View your latest remittance advices

Each person in the facility can register under the same tax ID, but each person should create his or her own username and password, and complete other registration information.

The profile administrator for your group or practice will review your request; once approved, you will have access to use My Insurance Manager.

Once you go through the steps to create and approve a profile, you can sign onto My Insurance Manager with your new username and password.

My Remit Manager

My Remit Manager is a secure browser-based program that allows you to look up patients' claims and outstanding balances while maintaining compliance with HIPAA regulations.

In My Remit Manager, you are able to do the following:

- View Electronic Remittance Advice (ERA) information by file and see all details —Users have the option of viewing the specific details the payer sends or the standardized information in a conventional format.
- See patient errors and denials instantly— My Remit Manager highlights any claims which have errors or have been denied.
- View information categorized by check numbers or by patient — My Remit Manager clearly lists the name of each patient whose EOB is associated with an individual check or EFT.
- Print individual remits for a single patient — Eliminate the need to remove or blackout other patient information on the remit.
- Print remits for selected patients — Print individual or group remits.

If you need to register or if you have forgotten your username or password, complete our Provider Advocate Contact Form. We will email you the information you need to get started. The login requires that you have a user ID and a password. On the login page, simply enter your username and password and choose Log in.

Voice Response Unit (VRU)

The VRU requires you to use fully the automated system to check members' coverage and benefits, effective dates, group numbers, claim status and authorization information.

Do not forget about My Insurance Manager! You can still submit questions and talk to a service representative with reduced hold times through our STATchat function available online in My Insurance Manager. If you have not visited the website recently, please go to www.SouthCarolinaBlues.com or www.BlueChoiceSC.com, and sign into My Insurance Manager for the most efficient and user-friendly experience.

Support from Provider Services

Provider Relations and Education has a team of Provider Advocates that are available to assist you with educational needs and initiatives. The provider advocates travel several days a week. Provider Services Representatives are also available to assist you with the patient-specific benefit questions or complex claim inquiries.

BlueCross provides many tools for providers to use for eligibility, benefits and claims information and opportunities for you to speak with a representative:

- **Ask Provider Services**: A feature within My Insurance Manager that allows you to submit inquiries to Provider Services electronically.

- **STATchat℠**: Communicate directly with a Provider Services representative via web-based phone call.
    - Patient information from My Insurance Manager pre-populates onto the Provider Services representative's screens to assist in answering questions related to the member.
    - Keep in mind that the representative is restricted to only answering questions related to the member from your original inquiry; you are able to ask as many questions as you would like about that one member.

- **Provider Service Representatives:** Available for additional benefit details that are not available within My Insurance Manager or the Voice Response Unit.

Please allow representatives time to review and research your requests. They will respond to your claims inquiries either by letter with an explanation of the review outcome or by a remittance reflecting an adjustment.

LABORATORY BENEFITS MANAGEMENT PROGRAM

OVERVIEW

A presentation of the BlueCross and BlueChoice Laboratory Benefit Management Program including laboratory policy management, prior authorization requirements, common laboratory edits and details about the available provider resources.

Avalon Healthcare Solutions

Our Plan works with Avalon Healthcare Solutions 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

- Laboratory Medical Benefits Page
- Avalon Participating Laboratory List
- Preauthorization Matrix
- Medical Policies

Also Visit

- My Insurance Manager — Trial Claim Advice Tool
- Laboratory Quarterly Newsletter
- Provider News
- Avalon Medical Policy Video Library

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AVALON HEALTHCARE SOLUTIONS

Our Relationship with Avalon Healthcare Solutions

BlueCross and BlueChoice partnered with Avalon Healthcare Solutions in 2015. This partnership and program brings three key elements:

- **Network Management**
  - Member access to an expanded network of independent specialty laboratories.
- **Clinical Expertise in Laboratory Medicine**
  - Avalon's expertise in the laboratory industry and the direction of the Avalon Clinical Advisory Board (CAB) assist in maintaining medical policies grounded in evidence-based laboratory medicine.
- **Medical Policy Oversight**
  - Prior authorization requirements for certain laboratory tests.
  - Avalon Claims Editor technology provides consistency in the application of medical policies to evaluate claims better for appropriateness and medical necessity.

Who is Avalon?

Avalon is a clinical services and information technology company that provides comprehensive diagnostic laboratory management services to health plans. The Avalon program is a compliant and reliable extension of our current medical management program.

Avalon Network Labs

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 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.

The following are some of the key benefits for using in-network providers:

- 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.

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
Invitae Corporation Laboratories	
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	Kidney Stone Analysis
Medtox Laboratory	Toxicology
Monogram Biosciences	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

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

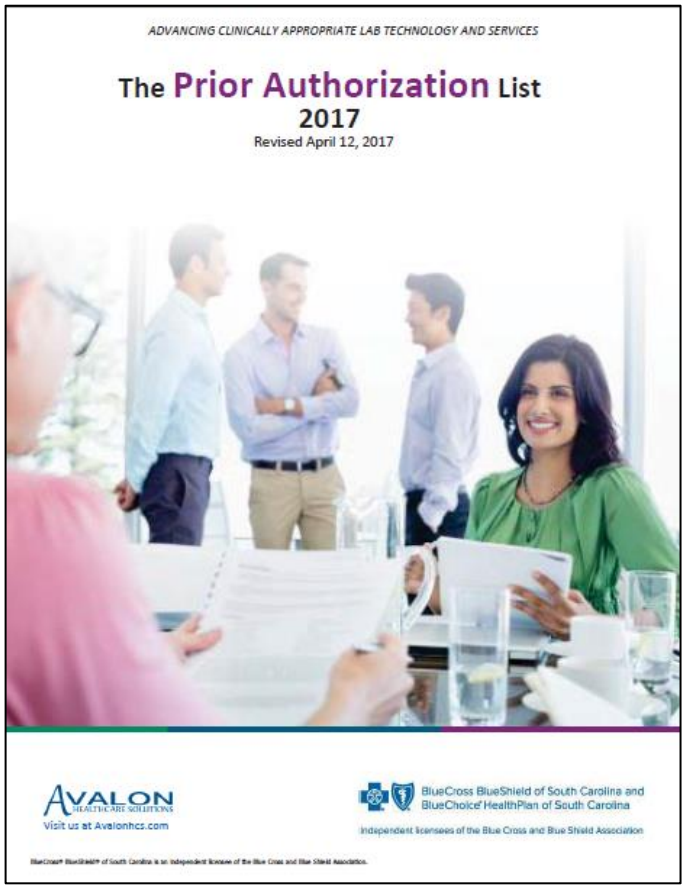
Check for authorization requirements on genetic testing, cytogenetic testing and molecular pathology codes on the BlueCross website in the Education Center. You can search the list of tests that require prior authorization by referring to the Avalon Lab Procedure Authorization Matrix.

You may submit prior authorization requests via phone or fax:

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

Avalon will review your request promptly 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.

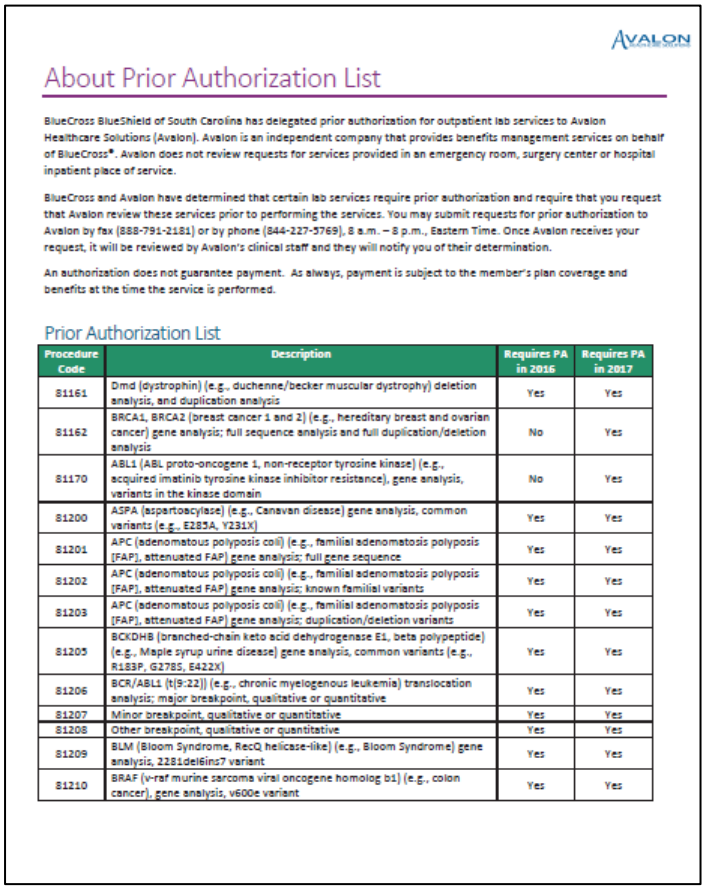
The **2017 and 2018 Lab Procedure Authorization Matrix** can be accessed by going to the Laboratory Medical Benefits page on the main menu, then Precertification within the Provider section of both websites.


ADVANCING CLINICALLY APPROPRIATE LAB TECHNOLOGY AND SERVICES

The Prior Authorization List
2017
Revised April 12, 2017

AVALON HEALTHCARE SOLUTIONS
Visit us at Avalonhcs.com

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


AVALON

About Prior Authorization List

BlueCross BlueShield of South Carolina has delegated prior authorization for outpatient lab services to Avalon Healthcare Solutions (Avalon). Avalon is an independent company that provides benefits management services on behalf of BlueCross®. Avalon does not review requests for services provided in an emergency room, surgery center or hospital inpatient place of service.

BlueCross and Avalon have determined that certain lab services require prior authorization and require that you request that Avalon review these services prior to performing the services. You may submit requests for prior authorization to Avalon by fax (888-791-2181) or by phone (844-227-5769), 8 a.m. – 8 p.m., Eastern Time. Once Avalon receives your request, it will be reviewed by Avalon's clinical staff and they will notify you of their determination.

An authorization does not guarantee payment. As always, payment is subject to the member's plan coverage and benefits at the time the service is performed.

Prior Authorization List

Procedure Code	Description	Requires PA in 2016	Requires PA in 2017
81161	Dmd (dystrophin) (e.g., duchenne/becker muscular dystrophy) deletion analysis, and duplication analysis	Yes	Yes
81162	BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis	No	Yes
81170	ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (e.g., acquired imatinib tyrosine kinase inhibitor resistance), gene analysis, variants in the kinase domain	No	Yes
81200	ASPA (aspartoacylase) (e.g., Canavan disease) gene analysis, common variants (e.g., E285A, Y231X)	Yes	Yes
81201	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	Yes	Yes
81202	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	Yes	Yes
81203	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	Yes	Yes
81205	BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (e.g., Maple syrup urine disease) gene analysis, common variants (e.g., R183P, G278S, E422X)	Yes	Yes
81206	BCR/ABL1 (t(9;22)) (e.g., chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	Yes	Yes
81207	Minor breakpoint, qualitative or quantitative	Yes	Yes
81208	Other breakpoint, qualitative or quantitative	Yes	Yes
81209	BLM (Bloom Syndrome, RecQ helicase-like) (e.g., Bloom Syndrome) gene analysis, 2281del6ins7 variant	Yes	Yes
81210	BRAF (v-raf murine sarcoma viral oncogene homolog b1) (e.g., colon cancer), gene analysis, v600e variant	Yes	Yes

How We Work Together

Laboratory procedures on the claim are evaluated for appropriateness for through a tool called the Claims Editor. Claims that do not meet the appropriate criteria may receive an edit for these reasons.

POLICY RULE	DEFINITION
Experimental and Investigational	Procedure is not covered under the member's benefit due to exclusion
Demographic Limitations	Limitations based on patient age
Excessive Procedure Units	Total units within and across claims for a single date of service more than necessary
Excessive Units per Period of Time	Maximum allowable units within a defined period of time has been exceeded
Insufficient Time Between Procedures	Minimum time required before a second procedure is warranted
Diagnosis Does Not Support Test Requested	Procedure was not appropriate for the clinical situation
Mutually Exclusive Codes	The procedure is not valid with other procedures is not valid with other procedures on the same date of service.

Laboratory Remit Code Descriptions

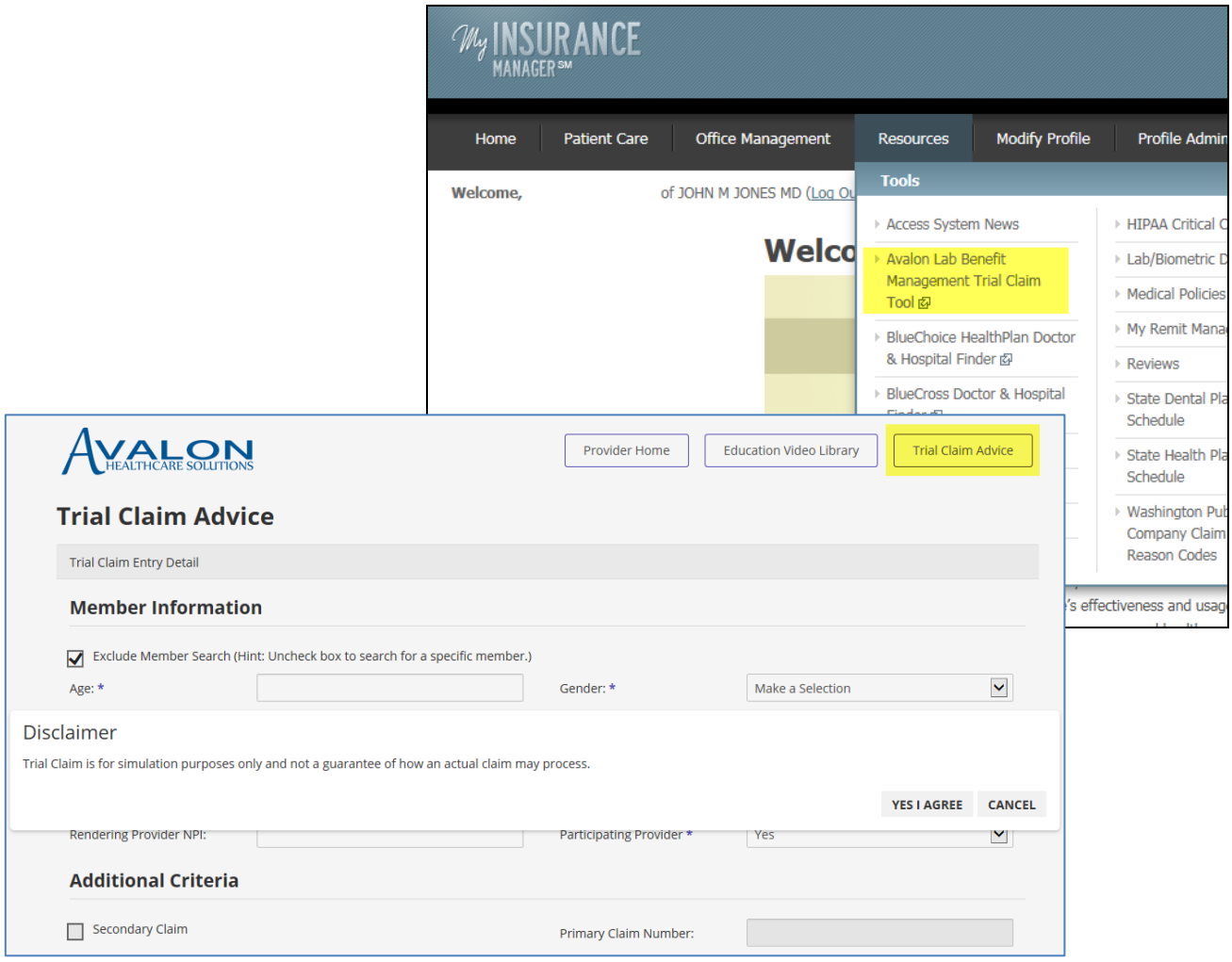
These codes are the laboratory edits used on the hardcopy and electronic remittances.

Remit	Description	CARC	RARC
077	SERVICES NOT CONSISTENT WITH DIAGNOSIS	11	N/A
319	INVESTIGATIONAL OR EXPERIMENTAL PROCEDURES ARE NOT COVERED	55	N/A
4058	AGE CRITERIA NOT MET.	6	N129
4071	PROCEDURE CODE NOT APPROPRIATE FOR PROVIDER AND OR PLACE OF SERVICE.	58	N/A
9067	FREQUENCY LIMITATIONS HAVE BEEN EXCEEDED.	119	N362
9357	THE PROCEDURE IS NOT VALID WITH OTHER PROCEDURES ON THE SAME DATE OF SERVICE.	231	N/A

Trial Claim Advice Tool

The Avalon Lab Benefit Management Trial Claim Advice Tool 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.



Laboratory Medical Benefits – Quick Tips

Read laboratory medical policies in their entirety to stay abreast of all medical policy changes.

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 laboratory medical policy to read the laboratory coverage criteria before rendering or requesting services.

Check for prior authorization requirements for certain tests such as Genetic Testing, Cytogenetic Testing, Molecular Pathology, etc.

View the Laboratory Medical Benefits 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.education@bcbssc.com or by calling 803-264-4730

Remember to send members to **in-network laboratories**. This information is subject to change. Please visit our websites for future updates.

AUTHORIZATIONS

OVERVIEW

Find out when and how to submit a prior authorization request for service to our plans, including those services managed by 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
- Medical Specialty Drug List
- NovoLogix Prior Authorization Provider Training Video
- Specialty Medical Benefit Management Presentation

Also Visit

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

Authorization Requirements

Authorization requirements vary by plan. Some services that usually require authorization include:

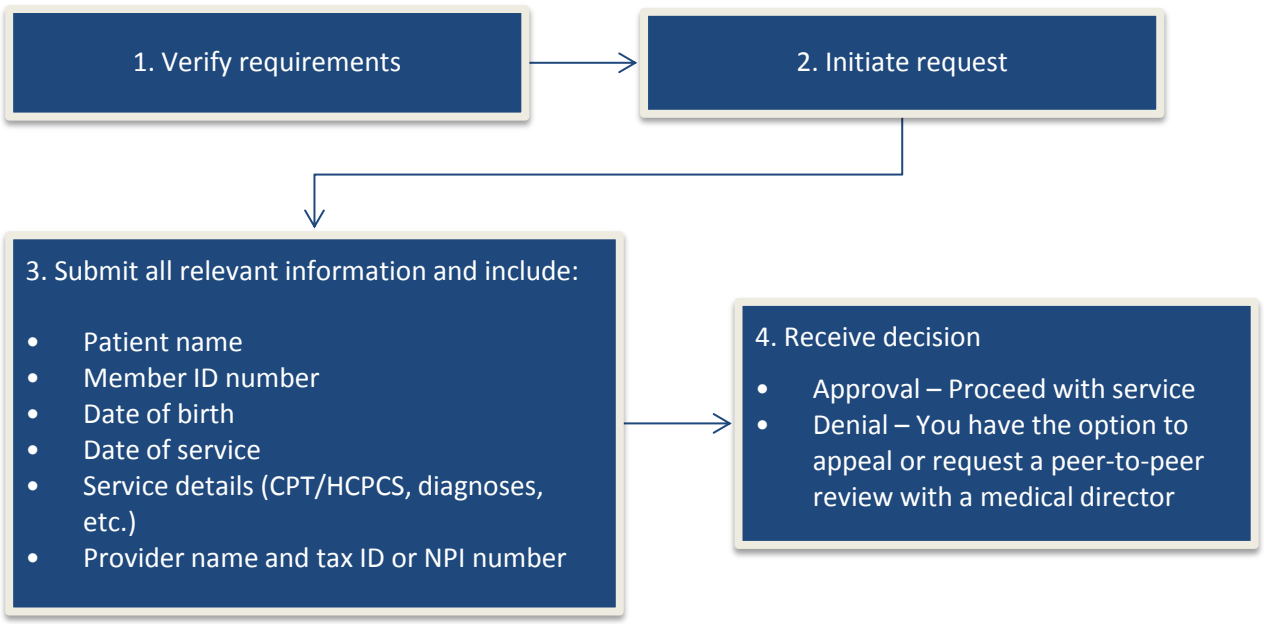
- Inpatient services
- Maternity notification
- Skilled nursing facility admission
- Home health and hospice
- DME when the purchase price or rental is $500 or more
- Transplants
- Mental health and substance use

Authorization Process

An authorization request answers three basic questions:

1. Who are you?
    - Provider information
2. What service/item does the patient need?
    - Service/item information
3. Who is the patient?
    - Patient information

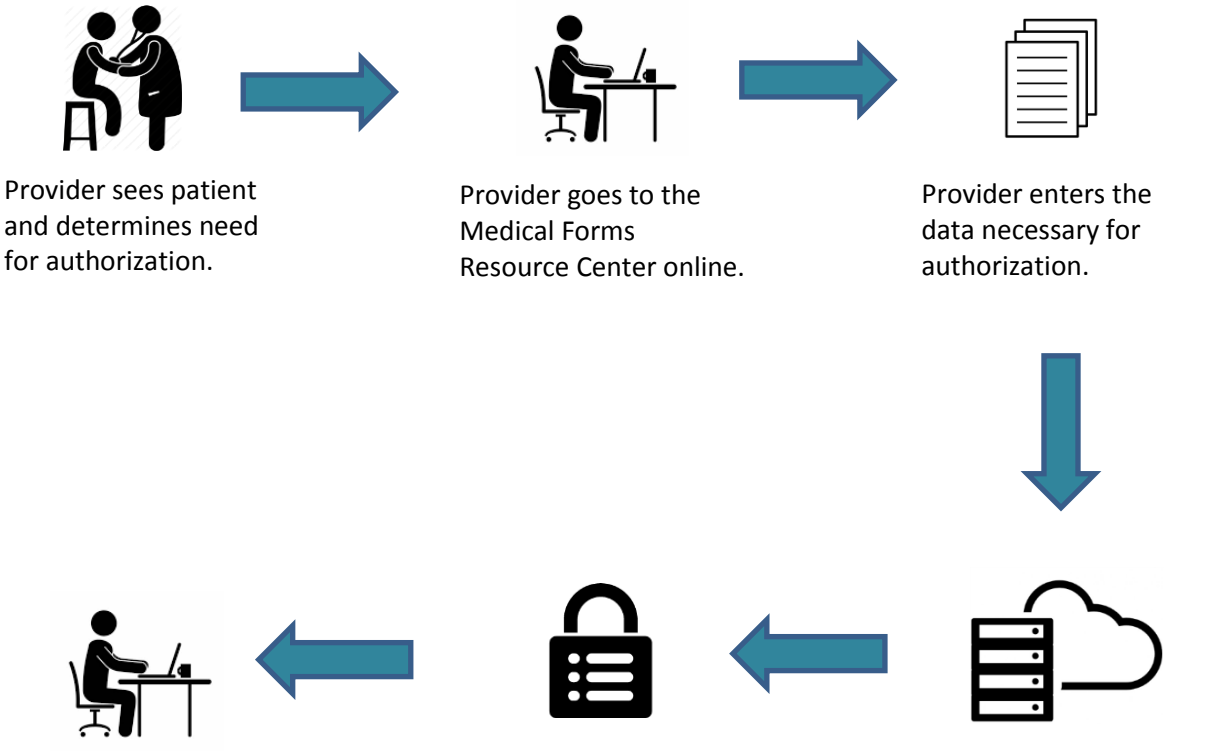
This information makes it easier and quicker to process authorization requests.



Medical Forms Resource Center (MFRC)

BlueCross and BlueChoice recently implemented the Medical Forms Resource Center (MFRC). The MFRC is an online tool created to allow you to submit your authorization requests for some services electronically. The system is fast and easy to use, and it ensures accuracy. It also cuts down on follow-up calls as all the required information is outlined on the form.

How Does it Work?



To use the MFRC, visit www.formsresource.center or visit the Provider page of our websites, www.SouthCarolinaBlues.com or www.BlueChoiceSC.com, select Education Center and choose Precertification.

Types of Services Available Through MFRC

MFRC allows you to initiate authorization requests for many services:

- Breast reduction
- Chemotherapy
- Excision of lesion tumor mass
- General medication request
- General precertification
- Durable medical equipment (DME)
    - Continuous glucose monitoring
    - Insulin pump
    - Lymphedema pump
    - Miscellaneous
    - Neuromuscular stimulator
    - Orthotics
    - Prosthetics
    - Wound vac
- Home health
- Hospice
- Hysterectomy
- Long term acute care (LTAC)
- Notifications
    - Maternity
    - Discharge
- Radiofrequency facet ablation
- Septoplasty
- Skilled nursing facility (SNF)/inpatient rehab
- Spinal fusion discectomy laminectomy

You can select General Precertification for services not listed or continue to use My Insurance Manager. More services will be added in the future.

Please note: if a plan requires authorization for any of these services through another benefit management partner or program (e.g., Magellan, Avalon Healthcare Solutions, NovoLogix, etc.), you will need to obtain authorization through the appropriate benefit management partner.

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, it is clearly legible. This helps to prevent follow-up calls for faxes that did not 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.

Other Information:

- MFRC authorization requests are given first priority.
- MFRC is one-way communication, meaning information comes in but not out. MFRC does not provide a status of your request.
- Once you have filled out the first screen, your facility information will automatically fill the form the next time you visit, if your organization allows cookies.
- Once you have completed your submission, it takes about 10 – 15 minutes for the information to load into our authorization system.
- MFRC requests pend for review to ensure we have all the information needed to complete the request.
- You will receive approval or denial using existing processes.
- Use the Print this submission button to print or save a copy of the request.

My Insurance Manager

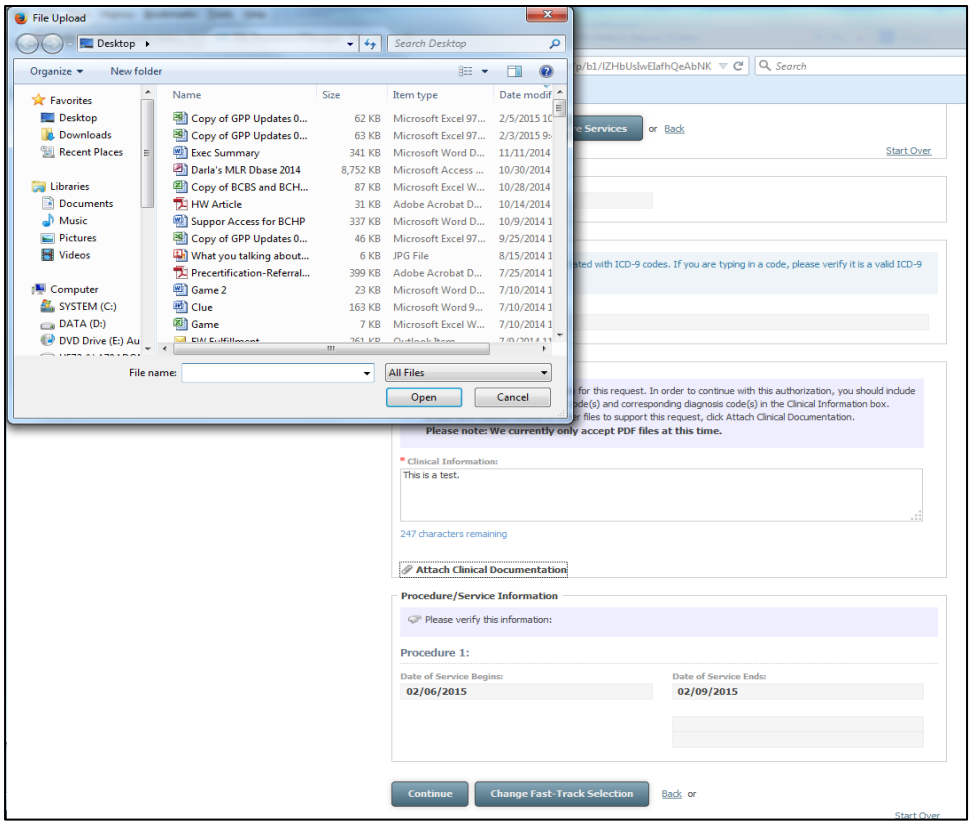
My Insurance Manager features an automated authorization and referral tool that allows you to request authorizations for many patient services online. You can also check the status of an existing request. Select “Precertification/Referral” from the drop-down menu under the Patient Care tab in My Insurance 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 the review of information from the authorization 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 authorization processing.

Adding Clinical Attachments to an Existing Pended Authorization

You can attach clinical attachments to an existing, pended authorization by logging in to **My Insurance Manger** and under **Patient Care**, selecting the **Authorization Status** option. After completing the **Patient Selection** fields, proceed to the **Authorization Status** screen. Here you will find all pended authorizations, select the pended authorization you want to add a clinical document by selecting **View Authorization** and then selecting **Attach Clinical Documentation**.



Verify the document you want to attach is the associated with the authorization request

Press select to display it in the **Attach Clinical Documentation** screen

Remember to review the document you have uploaded in Attach Clinical Documentation screen

By confirming, you acknowledge the document is accurate and formatted correctly

You will receive a message indicating “Files were successfully attached.”

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Magellan Healthcare*

Many plans require prior authorization for procedures through Magellan Healthcare.

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 Magellan Healthcare has not properly authorized.

BlueChoice will not reimburse claims for the following services if authorization is not received:

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

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

Musculoskeletal Program

This program includes 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 authorization for all interventional spine pain management procedures and spine surgeries outlined.
- Magellan Healthcare does not manage 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 authorization requirements before providing services. Please note: some services require authorization directly through our plans.

*National Imaging Associates, Inc. is a subsidiary of Magellan Healthcare, Inc.

Magellan Healthcare

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 are 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 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 submit all required patient clinical information successfully to Magellan Healthcare 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 that 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 authorization determination.

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

Verify authorization requirements before providing services. Please note: some services require authorization directly through our plans.

Specialty Medical Drug Benefit and NovoLogix

BlueCross and BlueChoice manage certain specialty drugs (injectable/infusible) under the medical benefit and require providers to obtain authorizations through NovoLogix, CVS/Caremark's online 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.

If authorization is required but not obtained, you will receive the following edit on your remittance:

Remittance Type	Code	Description
Electronic	197	Precertification/Authorization/Notification absent
Hardcopy	9331	This service requires prior authorization: Please contact NovoLogix at 1-800-284-9229

If you file self-administered drugs under the medical benefit when they should be filed under the pharmacy benefit, you will receive these edits on your remittance:

Remittance Type	Code	Description
Electronic	204	This service/equipment/drug is not covered under the patient's current benefit plan
Hardcopy	9381	This service requires prior authorization: Please contact NovoLogix at 1-800-284-9229

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

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

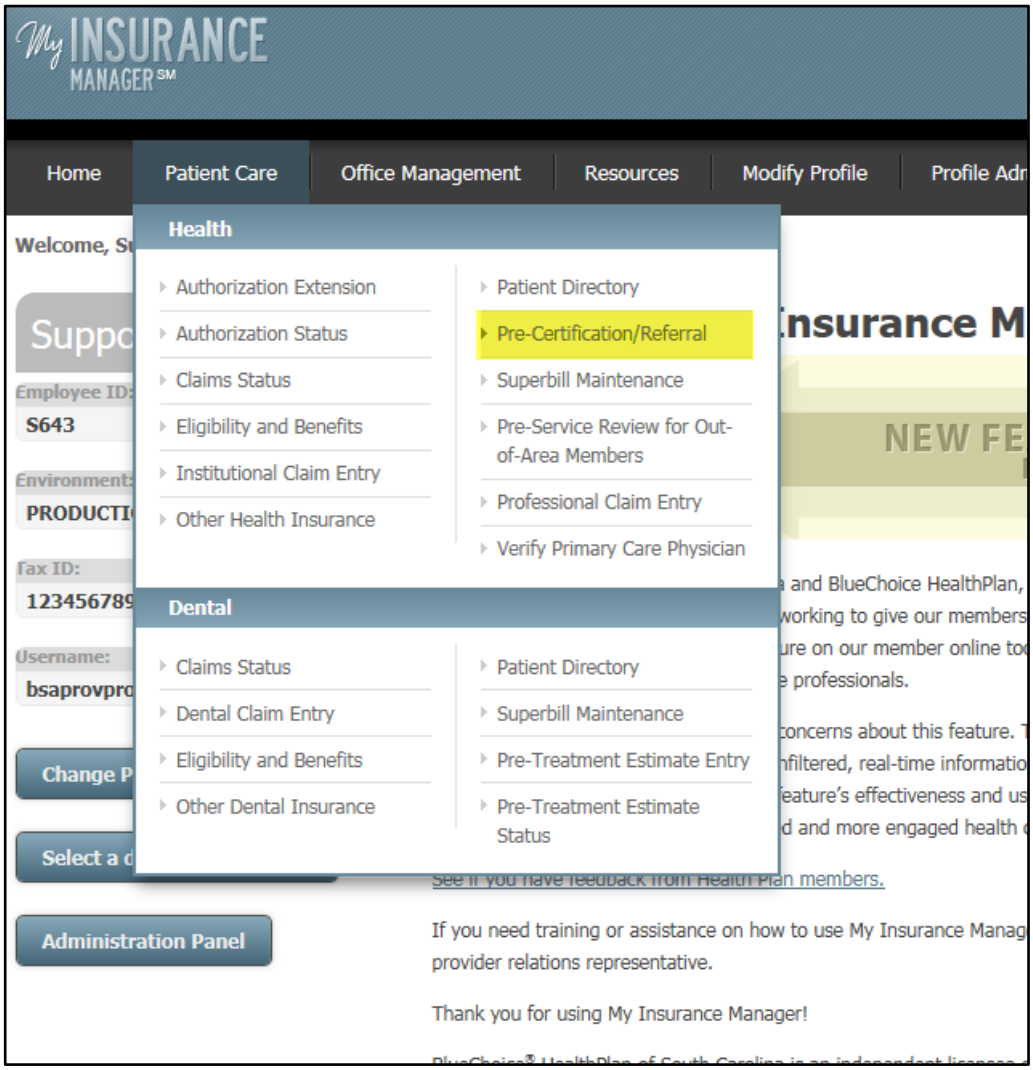
My Insurance Manager is our preferred method for you to get authorizations. Go to our websites, www.SouthCarolinaBlues.com or www.BlueChoiceSC.com, then to My Insurance Manager. Enter the required information to go to the NovoLogix system.

Beginning Jan. 1, 2018, the State Health Plan requires authorization for medical specialty drugs through NovoLogix. If an authorization is not received, the member will be responsible for the full cost of the drug and any associated administration charges.

Specialty Medical Drug Benefit and NovoLogix: Using My Insurance Manager

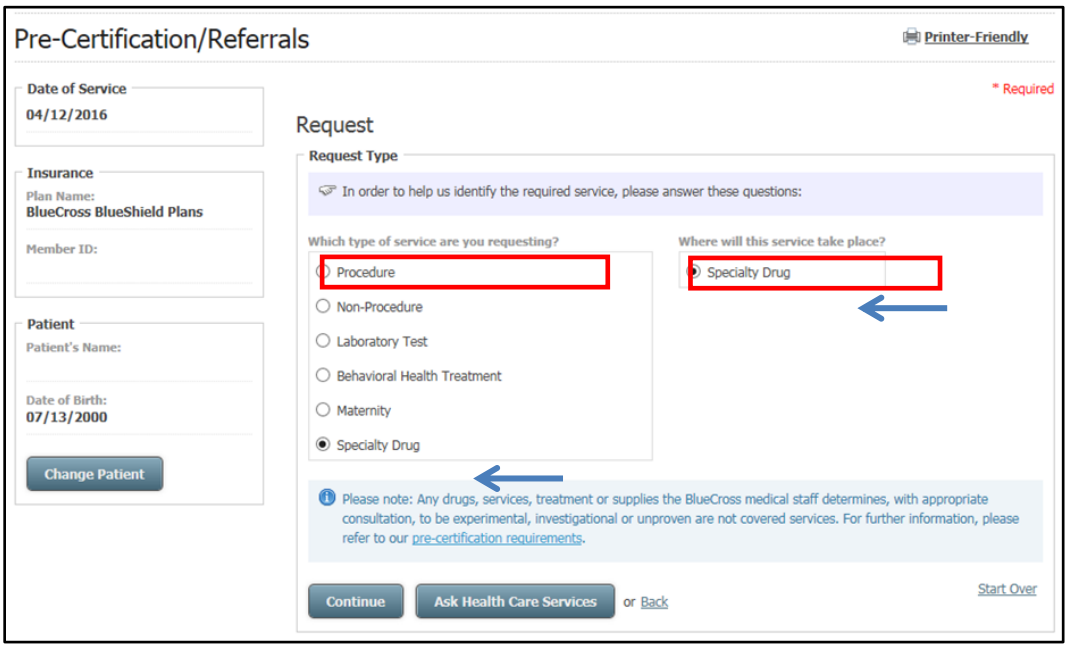
Providers will create an authorization request using the **Pre-Certification/Referral** option through My Insurance Manager.

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

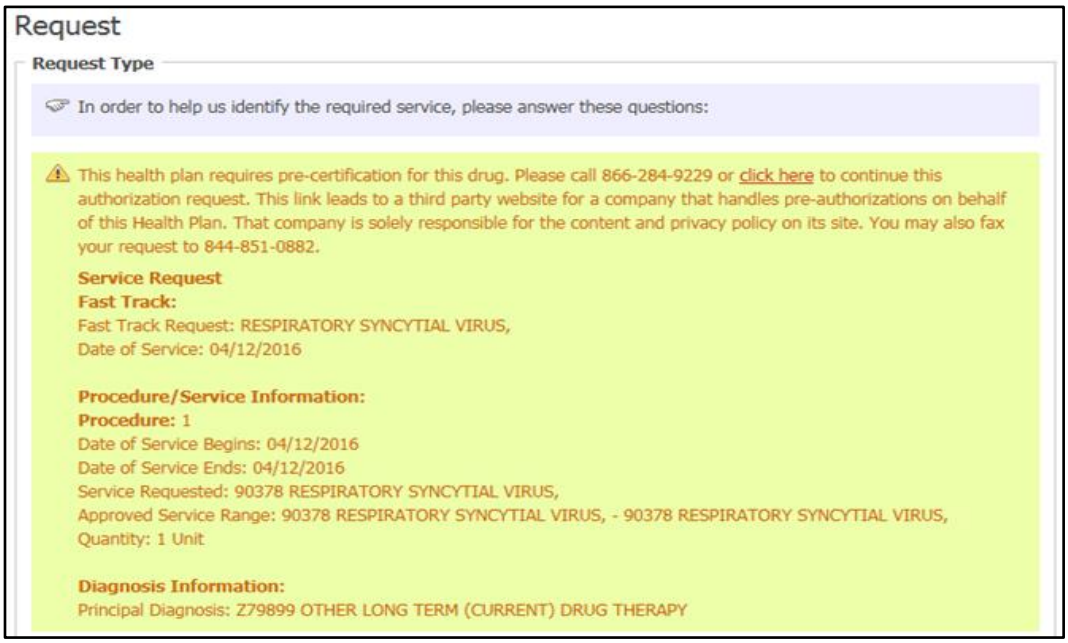


Specialty Medical Drug Benefit and NovoLogix: Using My Insurance Manager (continued)

You must specify **Specialty Drug** as the type of service you are requesting, 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.



Lab 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

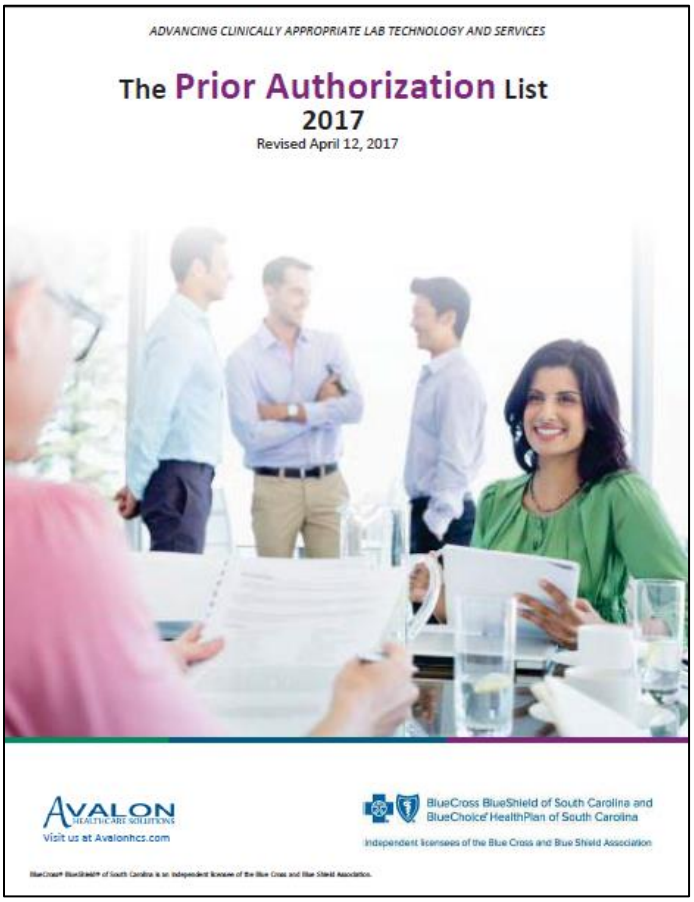
Check for authorization requirements on genetic testing, cytogenetic testing and molecular pathology codes on the BlueCross website in the Education Center. You can search the list of tests that require prior authorization by referring to the Avalon Lab Procedure Authorization Matrix.

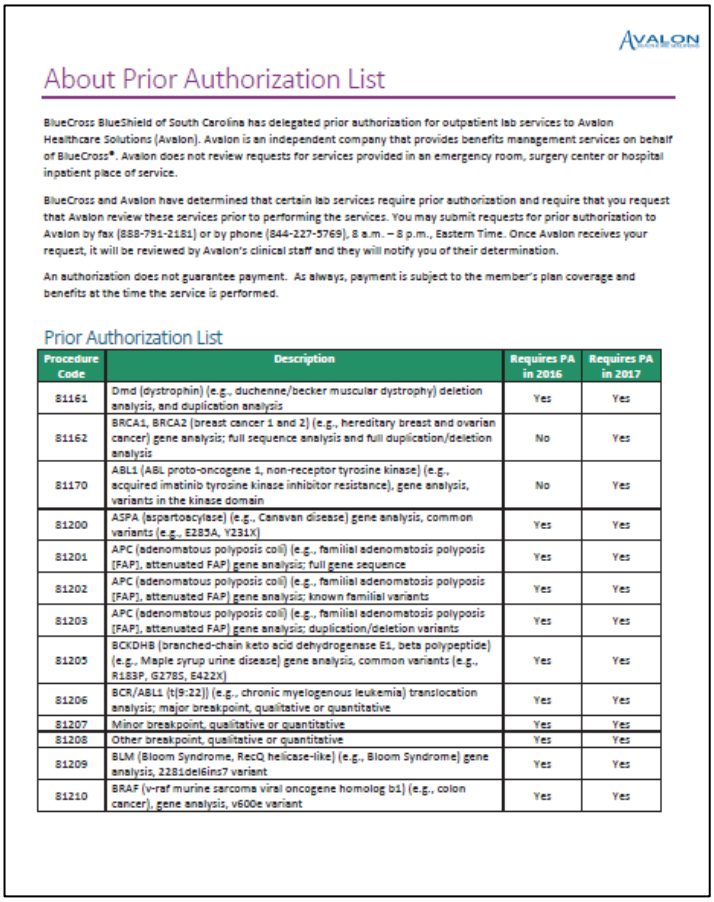
You may submit prior authorization requests via phone or fax:

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

Avalon will review your request promptly 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 and 2018 Lab Procedure Authorization Matrix** can be accessed by going to the Laboratory Medical Benefits page on the main menu, then Precertification within the Provider section of both websites.





AVALON

About Prior Authorization List

BlueCross BlueShield of South Carolina has delegated prior authorization for outpatient lab services to Avalon Healthcare Solutions (Avalon). Avalon is an independent company that provides benefits management services on behalf of BlueCross®. Avalon does not review requests for services provided in an emergency room, surgery center or hospital inpatient place of service.

BlueCross and Avalon have determined that certain lab services require prior authorization and require that you request that Avalon review these services prior to performing the services. You may submit requests for prior authorization to Avalon by fax (888-791-2181) or by phone (844-227-5769), 8 a.m. – 8 p.m., Eastern Time. Once Avalon receives your request, it will be reviewed by Avalon's clinical staff and they will notify you of their determination.

An authorization does not guarantee payment. As always, payment is subject to the member's plan coverage and benefits at the time the service is performed.

Prior Authorization List

Procedure Code	Description	Requires PA in 2016	Requires PA in 2017
81161	Dmd (dystrophin) (e.g., duchenne/becker muscular dystrophy) deletion analysis, and duplication analysis	Yes	Yes
81162	BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis	No	Yes
81170	ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (e.g., acquired imatinib tyrosine kinase inhibitor resistance), gene analysis, variants in the kinase domain	No	Yes
81200	ASPA (aspartoacylase) (e.g., Canavan disease) gene analysis, common variants (e.g., E285A, Y231X)	Yes	Yes
81201	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	Yes	Yes
81202	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	Yes	Yes
81203	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	Yes	Yes
81205	BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (e.g., Maple syrup urine disease) gene analysis, common variants (e.g., R183P, G278S, E422X)	Yes	Yes
81206	BCR/ABL1 (t(9;22)) (e.g., chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	Yes	Yes
81207	Minor breakpoint, qualitative or quantitative	Yes	Yes
81208	Other breakpoint, qualitative or quantitative	Yes	Yes
81209	BLM (Bloom Syndrome, RecQ helicase-like) (e.g., Bloom Syndrome) gene analysis, 2281del6ins7 variant	Yes	Yes
81210	BRAF (v-raf murine sarcoma viral oncogene homolog b1) (e.g., colon cancer), gene analysis, v600e variant	Yes	Yes

MENTAL HEALTH

OVERVIEW

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

Companion Benefit Alternatives (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

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

Independent licensees of the Blue Cross and Blue Shield Association

Companion BENEFIT ALTERNATIVES

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 navigating 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:

- Choose Providers.
- Choose 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
- Medical Forms 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 moment 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 they are rendered. 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 have searched online for the answer to a claims status or eligibility question. You can also use STATchat 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 choose Ask Provider Services at the bottom of the page. Then choose 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 choose the Ask Health Care Services button at the bottom of the page. Choose the Connect button at the top of the page to speak with a representative online. 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

Below 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.

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 does not 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 administrative services only (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 communicating proactively 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. 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)

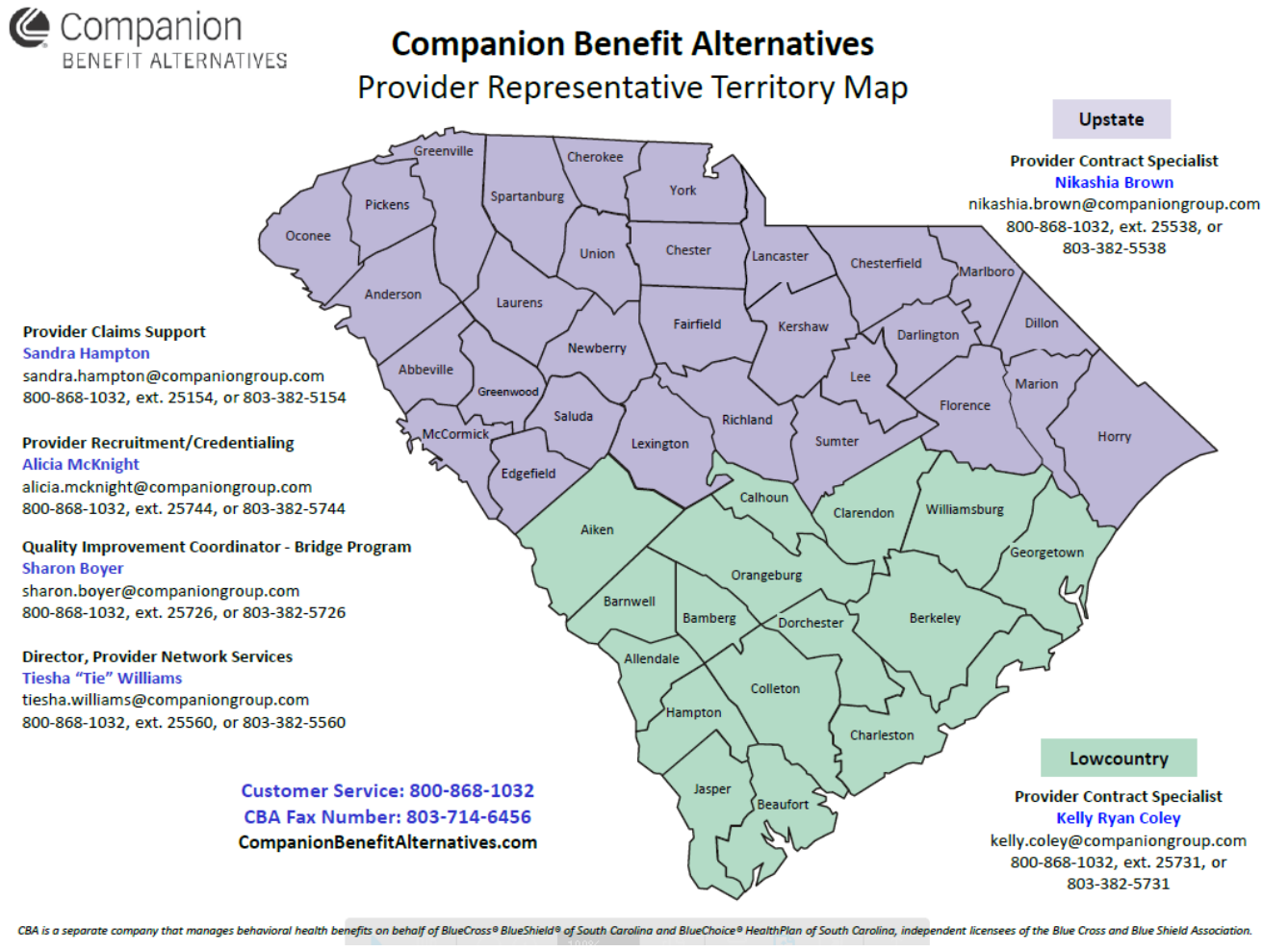
Points to remember:

- 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 Request

You may receive a request asking you to validate key provider information. We request this information to maintain complete and accurate files as the Centers for Medicare and Medicaid (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.



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.

BLUECROSS DENTAL

OVERVIEW

A summary of our dental networks and plans.

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

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.

- Anthem Blue Cross and Blue Shield of Colorado
- Anthem Blue Cross and Blue Shield of Connecticut
- Anthem Blue Cross and Blue Shield of Indiana
- Anthem Blue Cross and Blue Shield of Kentucky
- Anthem Blue Cross and Blue Shield of Maine
- Anthem Blue Cross and Blue Shield of Missouri
- Anthem Blue Cross Blue Shield of Nevada
- Anthem Blue Cross and Blue Shield of New Hampshire
- Anthem Blue Cross and Blue Shield of Ohio
- Anthem Blue Cross and Blue Shield of Virginia
- Anthem Blue Cross and Blue Shield of Wisconsin
- Anthem Blue Cross of California
- Blue Cross Blue Shield of Arizona
- Blue Cross and Blue Shield of Arkansas
- Blue Cross and Blue Shield of Florida
- Blue Cross Blue Shield of Georgia
- Blue Cross and Blue Shield of Kansas
- Blue Cross and Blue Shield of Kansas City
- Blue Cross Blue Shield of Massachusetts **(effective 1/1/18)**
- Blue Cross Blue Shield of North Dakota
- Blue Cross & Blue Shield of Rhode Island
- Blue Cross and Blue Shield of Vermont (CBA Blue)
- Blue Cross Blue Shield of Wyoming
- Blue Cross Blue Shield of Hawaii
- Blue Cross and Blue Shield of North Carolina
- BlueCross BlueShield of South Carolina
- BlueCross BlueShield of Tennessee
- Blue Cross of Idaho
- BlueCross & BlueShield of Western/BlueShield of Northeastern New York (no providers posted currently)
- Blue Cross and Blue Shield of Nebraska
- Capital Blue Cross (Central PA)
- CareFirst Blue Cross and Blue Shield (Maryland/District of Columbia)
- Empire Blue Cross Blue Shield of New York
- Excellus BlueCross BlueShield (Rochester NY)
- Horizon Blue Cross Blue Shield of New Jersey
- Wellmark Blue Cross and Blue Shield of Iowa

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 charges and actual charges.

Levels of dental coverage for these plans include:

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

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 that 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	2017 FEP Pays		2018 FEP Pays	
Clinical oral evaluations	To age 13	Age 13 and over	To age 13	Age 13 and over
Periodic oral evaluation (up to two per person per calendar year)	$12	$8	No change	
Limited oral evaluation	$14	$9		
Comprehensive oral evaluation	$14	$9		
Detailed and extensive oral evaluation	$14	$9		
Diagnostic imaging				
Intraoral complete series	$36	$22	No change	
Intraoral periapical first image	$7	$5		
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	No change	
Protective restoration	$24	$15		
Preventive				
Prophylaxis – adult (up to two per person per calendar year)	---	$16	No change	
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		

In Network
The member pays the difference between the amounts listed and the BlueCross Participating Dental Allowance.

Out-of-Network
The member pays all charges in excess of the scheduled amounts listed.

Non-Covered Services
The member pays all charges for any service not specifically listed above.

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	2017 FEP Pays	2017 Member Pays	2018 FEP Pays & Member Pays
Clinical oral evaluations			
Periodic oral evaluation*	**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	No change
Limited oral evaluation			
Comprehensive oral evaluation*			
Diagnostic imaging			
Intraoral – complete series including bitewings *(limited to one complete series every three years)*	**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	No change
Bitewing – single image**			
Bitewings – two images**			
Bitewings – four images**			
Preventive			
Prophylaxis – adult *(up to two per calendar year)*	**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	No change
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	

*Benefits are limited to a combined total of two evaluations per person per calendar year
**Benefits are limited to a combined total of four images per person per calendar year

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 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.

The mailing address for FEP dental correspondence changed Oct. 17, 2017.

The new address is

4400 Leeds Ave.
Suite 100
North Charleston, SC 29405

Filing Dental under Medical Benefits

In general, dental providers are exempt from billing with diagnosis codes. If billing for medical services, however, dental providers should file an electronic health claim using the 837P format or online using My Insurance Manager and include a diagnosis. 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:

- BlueCross uses Dentistat Inc., an independent company, to credential and recredential our dental provider network. Dentistat performs all verifications according to accepted industry standards as well as NCQA standards. 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.
- Beginning Jan. 1, 2018, Planned Administrators, Inc. (PAI) will use the BlueCross Participating Dental Network.

PHARMACY MANAGEMENT

OVERVIEW

A summary of pharmacy management changes for 2018 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

CVS/Caremark will continue to serve as the Pharmacy Benefit Manager (PBM) in 2018. In addition, we have added new HMO and PPO plans with drug coverage effective Jan. 1, 2018. CVS/Caremark is an independent company that manages pharmacy benefits on behalf of BlueCross.

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 for stand-alone PDP plans: 888-645-6025
- Coverage determinations and general inquiries for HMO and PPO plans: 855-204-2744
- Coverage determinations fax: 855-633-7673
- Websites: www.Caremark.com or www.SCBluesMedadvantage.com

Affordable Care Act (ACA) Plans

Advanced Choice Network (ACN) Pharmacy will remain for 2018:

- ACN includes all CVS pharmacies, Walmart, Kroger, Publix, Longs Drugs, BI-LO, Rite Aid plus various other grocers and independent pharmacies.
- Caremark Specialty Pharmacy is the network pharmacy for specialty medications.
- Walgreens is currently out of network.

Retail pharmacy 31 day supply maximum will remain for 2018:

- Retail pharmacy: maximum 31 day supply
- Mail order pharmacy: maximum 90 day supply
- Specialty pharmacy: maximum 31 day supply

CVS/Caremark will continue to serve as the Pharmacy Benefit Manager in 2018:

- To locate the formulary for a list of covered drugs, visit www.SouthCarolinaBlues.com and www.BlueChoiceSC.com.
- To send a prescription to Caremark Mail Order Pharmacy, call 800-378-5697 or fax to 800-378-0323.
- To request a prior authorization, an override for step therapy or quantity management or a formulary exception, contact CVS/Caremark at 855-582-2022 (phone) or 855-245-2134 (fax).
- For specialty prior authorizations, contact CVS/specialty at 866-814-5506 (phone).

Commercial

CVS/Caremark will continue to serve as the PBM in 2018:

- To locate the formulary for a list of covered drugs, excluded drugs and drug management 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, an 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 Drugs: Medical Benefit Management

Authorization may be required for some specialty drugs under the medical benefit through CVS/Caremark's online tool, NovoLogix.

Beginning Jan. 1, 2018, State Health Plan requires authorization for medical specialty drugs through NovoLogix. If an authorization is not received, the member will be responsible for the full cost of the drug and any associated administration charges.

More information about our Specialty Drug Medical Benefit Management program is available in the Authorizations section of this handbook or our website, www.SouthCarolinaBlues.com.

PROVIDER CERTIFICATION & CREDENTIALING

OVERVIEW

A presentation about provider credentialing 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

M.D. CHECKUP
MEDICAL DIRECTORY CHECKUP

Uniting Providers and Patients

BlueCross and BlueChoice members are looking for you — our valued health care providers. Help members in their search for network participating primary care physicians, specialists, hospitals and medical suppliers by updating your information with M.D. CHECKUP.

This process unites providers and members by validating your information and making it available to BlueCross and BlueChoice members worldwide through provider directories, accessible online anywhere at any time.

Grow your practice and make yourself known by responding to M.D. CHECKUP requests each quarter. You will receive a questionnaire by email from Provider.Directory@bcbssc.com. Review key demographic information for your practice such as your office hours, telephone number and address, and we will do the rest! Each quarter, providers that respond will be entered into a drawing to win fabulous prizes for the whole office!

Look for M.D. CHECKUP online in My Insurance Manager in 2018!

Your participation in this program is vital to maintaining current and accurate information for your practice or facility. Get in front of new patients with M.D. CHECKUP.

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. This form is found in the Forms section of our websites, www.SouthCarolinaBlues.com and www.BlueChoiceSC.com.

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.

Make sure you include ALL REQUESTED documentation. We will not process applications that are missing required information.

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 under 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 the following 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)

BlueChoice HealthPlan Medicaid Documentation

If applying for participation in the BlueChoice HealthPlan Medicaid network, a disclosure of ownership form and a Clinical Laboratory Improvement Amendments (CLIA) certificate for each location doing labs are also required. Please note that for BlueChoice HealthPlan Medicaid, your Medicaid ID number must be provided prior to credentialing; failure to do so will delay your application.

Applications Missing Documentation

If your application is incomplete or missing any documentation, we will attempt to contact you once per week, for three weeks.

As soon as we receive the outstanding information, the application will be sent to the next Credentialing Committee meeting. The effective date will be the date the Credentialing Committee approves the application. We do not backdate effective dates.

Once your application has been approved, a notification email is sent to you within a couple of days of the Credentialing Committee approval.

Applications Requiring a Focused Review

There are some instances where an application must go through a focused review by the Credentialing Committee. Focused reviews are conducted every two months, beginning in February of each year.

Focused reviews are required:

- If the physician has had any malpractice occurrences and/or sanctions.
- If the physician answered "No" to any of the Health and History Questions in the application.

During focused reviews, the committee discusses any malpractice events or sanctions, and then it votes on whether or not to accept or approve the application.

Denial of an Application

An application is denied when providers do not meet credentialing criteria, which includes a long list of items that need to be satisfied according to the Utilization Review Accreditation Commission (URAC), the National Committee for Quality Assurance (NCQA), or South Carolina's Department of Health and Human Services (SCDHHS). There are also state requirements that must be met, as well. For example, having inadequate malpractice coverage would be a reason for denial of an application.

The Credentialing Committee votes to deny after a focused review.

Re-credentialing

Re-credentialing is required every three years. Our credentialing staff will contact you when it is time for you to complete this update. The South Carolina Uniform Credentials Update Form can be found in the Forms section of our websites. Once completed, please return the form and all required documentation via email to recredentialing.app@bcbssc.com, or by fax at 803-870-9997.

Companion Benefit Alternatives

Companion Benefit Alternatives (CBA) coordinates credentialing for mental health practitioners. CBA is a separate company that administers mental health and substance abuse benefits on behalf of BlueCross and BlueChoice.

Telemedicine

What is telemedicine?
A consultation between referring and consulting physicians for specific specialties through interactive audio and video telecommunications system that permits two-way communication.

What providers are eligible for telemedicine?
Providers who meet the contracting requirements and are currently in-network are eligible to submit claims for telemedicine when the service is within the scope of their practice. Those specialties are maternal-fetal medicine, vascular neurology, and psychiatry.

What is the Medical Policy associated with telemedicine?
CAM Policy 032 gives complete information about our telemedicine program.

Services are deemed non-covered if the physicians communicate using solely or a combination of the following:

- Telephone conversations
- Email messages
- Video cellphone interactions
- Facsimile transmissions
- Non-secured and non-HIPAA-compliant web based audio-video communications
- Services provided by allied health professionals that are neither allopathic nor osteopathic physicians

The Telemedicine Services Application Form is located in the Forms section on our websites. The application must be completed and submitted prior to rendering services. Submit the application via email to Provider.Cert@bcbssc.com. Your Provider Education Advocate will schedule an on-site visit to evaluate and photograph your telemedicine equipment. The photos will be added to your application. Your completed application will be reviewed and you will receive notification via mail or email once a determination has been made.

QUALITY INITIATIVES

OVERVIEW

Become more familiar with programs aimed at improving birth outcomes, care opportunities 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 Presentation
- Centering Pregnancy Application Form
- Maternity Screening Referral Tool (SBIRT)
- Quality Initiatives Presentation
- HEDIS Compliance Companion Forms

Also Visit

- Education Center
- Provider News
- Quality Initiatives

Maternity Initiatives

BlueCross has partnered with the SCDHHS and implemented programs to improve birth outcomes. These programs include

- Birth Outcomes Initiative (BOI)
- Screening, Brief Intervention, and Referral to Treatment
- 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

SBIRT is an evidenced-based, integrated and comprehensive approach to the identification, intervention and treatment of drug and alcohol usage, domestic violence, depression and tobacco usage. The SBIRT program in South Carolina is specific to pregnant women up to 12 months postpartum.

Providers use the universal SBIRT Integrated Screening Tool (the SBIRT referral) to identify at-risk patients, intervene and refer them to treatment. The referral tool is a questionnaire comprised of eight questions. Program participation is available to obstetricians/gynecologists and midwifery practices. Clinicians, not administrative staff, should administer the referral tool. Providers who screen patients using this form can also receive additional reimbursement by using specific coding.

These services pay separately from global maternity benefits. Members do not have any cost-share responsibility:

- **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

In addition, specific diagnoses must be billed:

- **During pregnancy** – the primary diagnosis code must be pregnancy related and the secondary diagnosis must be Z13.9
- **Postpartum visit** – the primary diagnosis must be postpartum related and the secondary diagnosis must be Z13.9

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.

Maternity Initiatives

Centering Pregnancy

Centering Pregnancy is a model of group care developed by the Centering® Healthcare Institute. The Centering Healthcare Institute is a separate company that provides wellness education on behalf of BlueCross and BlueChoice.

Women learn care skills, participate in facilitated discussions and develop a support network. The group model consists of 8–12 women with similar due dates who meet as a group for a total of 10 sessions throughout pregnancy and early postpartum. Participants receive increased time with providers, have increased satisfaction with their care and experience better outcomes.

Program participation is available to obstetricians/gynecologists and midwifery practices who are under contract with the Centering Healthcare Institute. Providers must use the Centering Pregnancy Application Form to apply for participation with BlueCross and BlueChoice. This form must be completed and submitted prior to rendering services to members. If services are billed but the form has not been completed, claims will not pay accordingly.

These services pay separately from global maternity benefits and should ***not*** be billed with an office visit (members do not have any cost-share responsibility):

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

In addition, specific diagnoses must be billed:

- **Sessions conducted during pregnancy** – the primary diagnosis code must be pregnancy related
- **Sessions conducted during the postpartum visit** – the primary diagnosis must be postpartum related

Any other appropriate diagnoses can be filed as secondary.

The Centering Pregnancy program is available 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.

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

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a tool that measures performance in the delivery of medical care and preventive health services. The National Committee for Quality Assurance (NCQA) coordinates and administers HEDIS yearly, and the Center for Medicare and Medicaid Services (CMS) uses it for monitoring the performance of health plans. The tool evaluates both physical and behavioral health clinical practice guidelines (CPG) adherence.

HEDIS provides a consistent way to evaluate the quality of care you provide to our members. This allows employers, consumers and consultants a means of comparing health plans on an "apples-to-apples" basis. We use 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.

The NCQA develops measures around conditions of services that impact a large portion of the population. Data is collected throughout the year through retrospective review of services via claims information and medical records. When you submit claims using complete and appropriate codes for these services, we are less likely to request medical records.

By honing in on key dimensions of care and services, HEDIS assists you in streamlining comprehensive, quality care that generates better health outcomes. Improving HEDIS scores is a win-win situation for all involved, therefore, we are offering our support by outlining the details of specific measures, identifying critical administrative steps and pointing you to valuable resources.

HEDIS covers 81 measures across five domains of care:

- Effectiveness of Care
- Access and Availability of Care
- Patient Experience
- Utilization and Relative Resource Use
- Health Plan Descriptive Information

Our goal is to ensure our patients' care opportunities are met. You can use our Provider Reference Matrix to get an overview of HEDIS measures. The matrix provides measure-specific information on what services are needed and how you can help meet our members' care opportunities.

If you have relevant information indicating that the member has already received the service or that the member has a condition that excludes him or her from the measure, you can:

- File a claim (you can submit up to 25 procedure codes with any claim to help transmit this information to us).
- Supply the medical record.
- Share the Electronic Medical Record Data.
- Complete a Compliance Companion Form.

The Compliance Companion Forms are available within the Provider Reference Matrix. These forms help to improve our awareness of the preventive services you provide. It also reduces the number of record requests you receive during annual audits that our quality improvement nurses perform.

We are less likely to request medical records when you submit claims with all appropriate procedure and diagnosis codes. Please respond to these requests using the appropriate mailing address or fax number provided in the request.

Care Opportunities and Quality Navigators

In support of HEDIS, we have developed the Quality Navigator Program. Our Plans collect and share care opportunity 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 work with providers to reveal care opportunities such as skipped prescriptions or missed disease screenings.

As a participating provider, your contract states that 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.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)/Qualified Health Plan Enrollee Experience Survey (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 timely care, the quality of care received and customer service.

QHP EES is a consumer survey that assesses enrollee experience with the Qualified Health Plans (QHPs) offered by the Affordable Care Act. 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.

Patient-Centered Medical Home (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.

Medical Record Requests for CMS Risk Adjustment Validation Program

Earlier this year, BlueCross and BlueChoice sent medical record requests to selected providers for Risk Adjustment Data Validation (RADV). Our plans are conducting outreach in support of this federally-mandated program. CMS and the U.S. Department of Health & Human Services validate the accuracy of risk adjustment data submitted by health plans in the Individual and Small Group markets.

We require participating providers to respond timely to medical record requests for members identified as part of the random sample audit. We review those members' progress notes, hospital notes and correspondences from services provided during calendar year 2016.

All providers are not required to participate in this audit process. For those providers that were chosen, you would have received this notice beginning June 1.

If your practice contracts with a vendor that manages the release of patient information on your behalf, please work with your vendor to forward the data to us as a non-billable event. Ensure your vendor understands that you permit our health plans or our designated business partner to inspect, review and acquire copies of records upon request at no charge.

Providers that have not sent the requested patient information timely — or send an invoice for payment — will be contacted by a Provider Advocate to facilitate release of medical records.

BLUE CROSS MEDICARE ADVANTAGE

OVERVIEW

Learn about our new Medicare Advantage plans.

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

- ID Card Guide
- BlueCross Total℠ PPO Provider Office Administrative Manual
- BlueCross Secure℠ HMO Provider Office Administrative Manual

Also Visit

- www.SouthCarolinaBlues.com
- www.SCBluesMedAdvantage.com
- www.cms.gov

Medicare Advantage Products

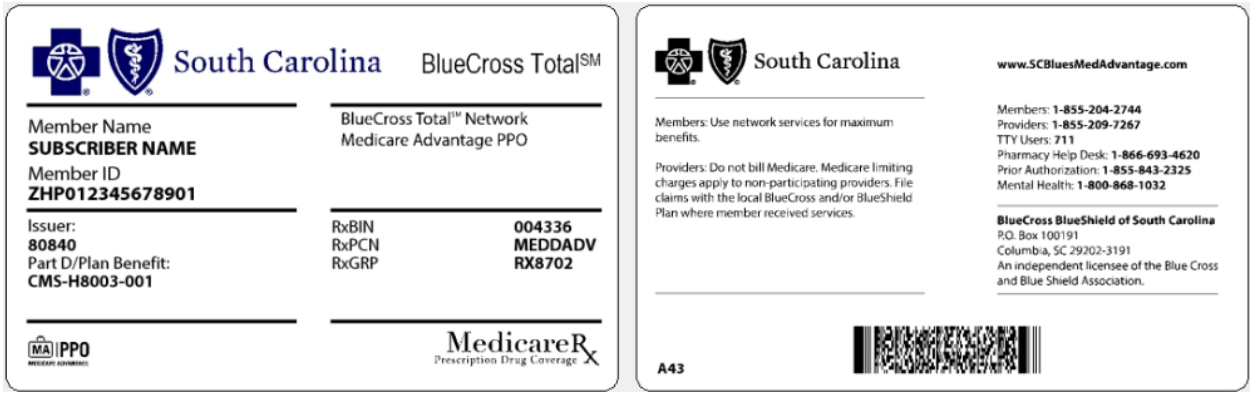
BlueCross now offers Medicare Advantage products for eligible consumers effective Jan. 1, 2018. We offer two lines of products: BlueCross Total℠ and BlueCross Secure℠. Both product types combine the benefits of traditional Medicare with Medicare Part D prescription drug coverage.

BlueCross Total

BlueCross Total is a Medicare Advantage PPO plan that allows members to go to any network doctor, specialist or hospital for in-network benefits. A member can choose an out-of-network provider, but he or she may have to pay more for services. This plan is supported by the Medicare Advantage PPO network of providers.

Plans available:

1. BlueCross Total Upstate:
    - Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg, York
2. BlueCross Total Midlands/Coastal:
    - Aiken, Calhoun, Fairfield, Florence, Horry, Kershaw, Lexington, Orangeburg, Richland, Saluda, Sumter
3. BlueCross Total Lowcountry:
    - Beaufort, Berkeley, Charleston, Dorchester, Georgetown



- The prefix is ZHP.
- The member's personal identification number follows the prefix. The ID number sequence must be included with each claim submission.
- The suitcase on the front of the card indicates the network.
- The plan name (BlueCross Total Upstate, BlueCross Total Midlands/Coastal, BlueCross Total Lowcountry) is located on the front of the card in the upper right quadrant.

If a BlueCross Total member chooses to seek out-of-network services when in-network services are available, higher out-of-network cost sharing will apply.

BlueCross Secure

BlueCross Secure is a Medicare Advantage HMO where members must go to any network doctor, specialist or hospital for in-network benefits. Out of network services are NOT covered.

- The prefix is ZOH (Greenville County) or ZOM (Richland County).
- The member's personal identification number follows the alpha prefix. The ID number sequence must be included with each claim submission.
- The plan name (BlueCross Secure HMO Greenville or BlueCross Secure HMO Richland) is located on the front of the card in the lower right quadrant.

Please note: BlueCross Secure HMO members do not access the Medicare Advantage PPO network. These members only have benefits when using the Medicare Advantage HMO Greenville and Medicare Advantage HMO Richland network of providers. Services provided out of network are not covered unless the member has a medical emergency or is determined to urgently need medical services. Members should refer to their Evidence of Coverage for these exceptions.

Medicare Advantage Participating Provider Agreement

The Provider Agreement and the Medicare Advantage Office Administrative Manual outline the contractual responsibilities of both BlueCross and the network provider regarding the CMS requirements. Here is a general summary of these requirements:

- The provider will file all claims for members to the plan.
- BlueCross will reimburse the provider for covered services based on the member's contract and Original Medicare allowance.
- The provider will accept BlueCross' payment plus any patient copays, coinsurance and deductibles as full reimbursement. The preferred provider will not bill the patient for more than his or her applicable patient liability amount not to exceed the fee allowance.
- The provider agrees to cooperate fully with the Utilization Review Procedures in the Professional Agreement.
- The provider will use other network providers for a member's care unless medically necessary services, supplies or equipment are not available from a network provider or in cases of medical emergencies or urgently needed services.
- The provider agrees to bill promptly and in a manner approved by BlueCross for all services. Electronic Claims Submission (EMC) in the 837I or 837P HIPAA-compliant format is the required method of filing unless the provider has an exemption from Original Medicare (IOM 100-04, Chapter 24, Sections 90-90.6).

Benefits

CMS has established requirements applicable to BlueCross Medicare Advantage benefit plans. Find details on specific benefits and cost sharing included in the BlueCross plans by visiting the Providers page of www.SouthCarolinaBlues.com.

All BlueCross Medicare Advantage benefit plans offer benefits that

- Provide beneficiaries with all Part A (except hospice care) and Part B services under Original Medicare if the beneficiary is entitled to benefits under both parts, and Part B services if the beneficiary is a grandfathered "Part B only" enrollee (CMS Internet-Only Manual (IOM) 100-16, Chapter 4, Section 10.2).
- Cannot impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in Original Medicare (IOM 100-16, Chapter 4, Section 10.2).
- Cover ambulance services dispatched through 911 or a local equivalent for which other means of transportation would endanger the member's health (IOM 100-16, Chapter 4, Section 20.1).
- Offer all Medicare preventive services performed at a network provider without copay. A copay will apply, however, if a beneficiary is being treated or monitored for an existing medical condition during the preventive visit.
- Provide maintenance and post-stabilization care services. Benefits include covered services related to an emergency medical condition and which are provided after the member is stabilized either to maintain the member's stabilized condition or, under certain circumstances, to improve or resolve the member's condition.
- Cover renal dialysis services for members temporarily outside of the plan's service area.
- Offer a network of providers that allows sufficient access to covered services, according to CMS standards.
- Provide benefits in a manner consistent with professionally recognized standards of health care.
- Make covered services available to members through office hours or telephone service, 24 hours a day, seven days a week.

Enhanced Benefits

These benefits are provided to our Medicare Advantage members. Patients must meet certain criteria for coverage. Verify eligibility and benefits prior to rendering services.

- Members may request one Fitbit Alta from our plan once per year.
- Vision care
    - One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)
    - In addition to Medicare-covered services, our plan also covers non- Medicare covered eyewear including contact lenses and eyeglasses (lenses and frames), up to $100 every year.
- Dental services
  Preventive dental services covered include oral exam, cleaning, x-ray and fluoride treatment:
    - $150 benefit maximum every year for preventive dental services.
    - Any licensed dental provider may provide services.
    - Members are responsible for any amount over the dental coverage limit.
    - We cover Medicare-covered dental benefits, which include non-routine dental care.

Prior Authorization List

Services that require prior authorization and/or notification:

- Durable medical equipment (DME)
    - Non-standard wheelchairs and
    - Non-standard beds
- All inpatient admissions
    - Rehabilitation facility admissions
    - Long term acute care (LTAC) and
    - Skilled nursing facilities (SNF)
- Dialysis treatment
    - Notification is required for members initiating dialysis treatment
- Non-emergent transportation
    - Non-emergent air ambulance and
    - Non-emergent water transportation
- Behavioral health services
    - Inpatient admissions
    - Rehabilitation facility admissions and
    - Residential treatment centers

Behavioral health, mental health and substance abuse benefits are managed by Companion Benefit Alternatives (CBA), an independent company that manages these benefits on behalf of BlueCross.

Inpatient admissions also require a review if a continued stay is necessary.

Methods for Requesting Prior Authorization

You can request prior authorization for these services using any of these methods:

- **Medical Forms Resource Center (MFRC)** – A new, secure online tool available at www.formsresource.center
- **My Insurance Manager** – The secure online provider portal available at www.SouthCarolinaBlues.com
- **Telephone** – Call 1-855-843-2325
- **Fax** – Fax requests to 803-264-6552

Contact Companion Benefit Alternatives (CBA):

- **Online** – www.CompanionBenefitAlternatives.com
- **Telephone** – Call 1-800-868-1032

Medicare Advantage Pharmacy Benefits

CVS/Caremark will continue to serve as the PBM in 2018.

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 for stand-alone PDP plans: 888-645-6025
- Coverage determinations and general inquiries for HMO and PPO plans: 855-204-2744
- Coverage determinations fax: 855-633-7673
- Websites: www.Caremark.com or www.SCBluesMedadvantage.com

CMS STAR Rating System and Measures

The BlueCross Quality Improvement program improves the performance of the plan based on the results of our CMS STAR Rating. The rating process utilizes a five-star quality rating system to measure Medicare Advantage beneficiaries' experience with their health plans and the care they receive. BlueCross is rated on 48 unique quality and performance measures. Each year, CMS conducts a comprehensive review of these measures.

The current STAR ratings criteria are based on these categories:

- **Outcomes:** measures reflecting improvements in members' health
- **Intermediate Outcomes:** measures reflecting actions taken which can assist in improving a member's health status
- **Patient Experience:** measures members' perspectives of the care received
- **Access:** measures reflecting processes and issues that could create barriers to receiving needed care.
- **Process:** measures capturing the health care services provided to members that can assist in maintaining, monitoring, or improving their health status

The STAR ratings benefit providers and members in many ways.

Benefits to Providers

- Improved patient relations
- Increased awareness of patient safety issues
- Greater focus on preventive medicine and early disease detection
- Strong benefits to support chronic condition management

Benefits to Members

- Improved relations with their doctors
- Greater focus on preventive services for peace of mind, early detection and health care that matches their individual needs
- Medicare uses information from member satisfaction surveys, plans and health care providers to give overall performance star ratings to Medicare health plans.

Your involvement with patients greatly impacts STAR performance. You can influence STAR measures by:

- Documenting all care in the patient's medical record.
- Calculating BMI at every visit.
- Coding and billing appropriately for services rendered.
- Promoting medication adherence.
- Recommending formulary alternatives.
- Responding to medical record requests (within five business days).
- Recommending participation in disease management programs.
- Scheduling patients requiring annual exams and periodic screenings.
- Reaching out to patients for follow up appointments and preventive exams.

Medicare Advantage Provider Resources

Information for providers is available on the Provider page of www.SouthCarolinaBlues.com. You'll have access to various guides and documents:

- Provider Office Administrative Manuals
- BlueNews℠ for Providers newsletter
- Provider News Bulletins
- My Insurance Manager User Guide
- Identification (ID) Card Guide
- Reference Guide for Provider Information and Contacts
- Prior Authorization List

Visit the website to view forms, register for Palmetto Provider University training opportunities and to contact Provider Education.

Self-Help Tools

Providers also have access to use our self-help tools:

- **My Insurance Manager** — Access benefits, eligibility, claims entry, claim status, remittance information and contact the Medicare Advantage Provider Services unit by using STATchat.
- **My Remit Manager** — View remittances, create reports, search and reconcile patient accounts.
- **Voice Response Unit (VRU)** — The VRU is available 24 hours a day, seven days a week and provides eligibility, benefits, claim status and refund status.

CLAIMS & BLUECARD

OVERVIEW

General information and guidance to assist you with frequently occurring claims issues.

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

- BlueCard Provider Manual
- BlueCross Provider Office Administrative Manual
- BlueChoice Provider Office Administrative Manual
- My Insurance Manager User Guides
- BlueCard Basics
- Claim Attachments Guide

Also Visit

- Education Center
- News Bulletins

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
- C63 Medicare Advantage

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 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 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.

Corrected Claims

If you need to correct a previously submitted professional claim, the corrected claim needs to contain the following:

1. The frequency code "7," indicating the claim is an adjusted claim
    - 1a. 2300 Loop, CLM05-3 segment = 7 (meaning adjustment)

      CLM*436944*271*11:B:7*Y*A*Y*Y~**

    - CMS-1500 Box 22 (Resubmission Code)

2. The previous claim number (ICN or DCN)
    - 1b. 2300 Loop, REF Segment = F8 (followed by the Original Ref. claim No.)

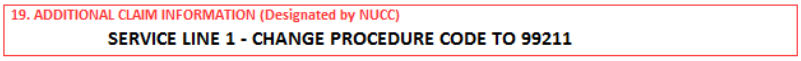
      REF*F8*6F11111110005~

    - CMS-1500 Box 22 (Original Ref. No.)

3. A description of the reason for the adjusted claim (additional line, change in units, etc.)
    - 2. 2300 Loop, NTE segment = free form text up to 80 characters

      NTE*ADD*SERVICE LINE 1 – CHANGE PROCEDURE CODE TO 99211~

    - CMS-1500 Box 19 (Additional Claim Information)



These prevent claims from processing incorrectly and ensure the corrections being submitted are considered.

ICD-10 Codes

The 2018 ICD-10 diagnosis and procedure codes became effective Oct. 1, 2017. Additional codes have been added and some existing codes have been deleted or revised.

Here are some examples of code changes:

- **New** - C9620, malignant mast cell neoplasm, unspecified
- **Deleted** - H5412, Blindness, left eye, low vision right eye
- **Revised** - S04042D, injury of visual cortex, left side, subsequent encounter

Always refer to and file correct codes according to the date of service.

Updated Injection Codes

Earlier this year, several generic HCPCS codes used for certain injectable drugs were replaced. Please be sure you are using the appropriate codes:

Drug Name	Old HCPCS	Current HCPCS
Adynovate	C9137	J7207
Bendeka	J9033	J9034
Coagadex	J3490	J7175
Darzalex	C9476	J9145
Empliciti	C9477	J9176

Drug Name	Old HCPCS	Current HCPCS
Kanuma	C9478	J2840
Nucala	J3590	J2182
Onivyde	C9474	J9205
Yondelis	C9480	J9352

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. Claim edits were implemented Oct. 1, 2017, for claims that are been submitted without the corresponding NDC.

When submitting NDCs on electronic 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)]

Always 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).

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 edit until we receive this information. We will accept corrected claims if your office 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.

To differentiate between different types of therapy, use the following modifiers:

- GN – Speech therapy
- GO – Occupational therapy
- GP – Physical therapy

Rehabilitative and Habilitative Services

BlueCross and BlueChoice apply separate and distinct benefit limits for habilitative and rehabilitative services for dates of service on and after Jan. 1, 2017, for Affordable Care Act (ACA) plans. This change is in compliance with the Notice of Benefit and Payment Parameters for 2016 rule issued in accordance with the Affordable Care Act (ACA). Dates of service on and after Jan. 1, 2017, no longer have a combined visit limit for habilitative and rehabilitative services. Each of these services is now counted separately. Members have 15 habilitative services and 15 rehabilitative services available under their ACA-compliant health plan.

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.

Two new modifiers will become effective Jan. 1, 2018, which will differentiate between habilitative and rehabilitative services.

What you should do:
File the appropriate modifier for dates of service on or after Jan. 1, 2018:

- 96: Habilitative
- 97: Rehabilitative

Patient Responsibility

You may collect patient cost shares as appropriate for the care being provided at the time of service, such as copays, coinsurance and deductibles. Participating providers should not bill patients up front for total charges.

Inpatient Admission Date

BlueCross and BlueChoice require you to file the first day of an inpatient stay as the true admission date. This requirement is in accordance with the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI).

The admission date is considered to be the date the patient was admitted as inpatient to the facility. This date should be reported on the UB-04 in the Admission Date field (Form Locator 12). Preoperative and preadmission services associated with the inpatient stay should be reported in the Statement Covers Period field ("From" and "Through" dates in Form Locator 6).

The admission date on claims must match the authorization (precertification, prior authorization or preauthorization) in order to apply benefits accurately.

Electronic Remittance Advice (ERA)

Providers with electronic file transfer capabilities can choose to receive the 835 ERA. 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 Form or ERA Addendum-Corporate Headquarters Form 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.

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. The Medicare intermediary will be releasing the claim to the Blue Plan for processing around the same time you receive the Medicare remittance advice. Please allow 30 days from the Medicare remittance advice date for the Blue Plan to complete 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.

Medicare Beneficiary Identifier (MBI)

The existing Social Security-based Health Insurance Claim Number (HICN) will be replaced beginning April 2018. The replacement number is referred to as the Medicare Beneficiary Identifier (MBI). The MBI will be uniquely generated and contain 11 characters, consisting of uppercase alpha and numeric characters.

New Medicare cards will be mailed to beneficiaries beginning April 2018. All existing Medicare cards will be replaced by April 2019. Providers will be able to use either the MBI or the HICN during the transition period, from April 2018 through Dec. 2019.

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 administer claims properly and determine if we need to seek reimbursement from a third party or an insurance company for these claims.

BlueCard Program

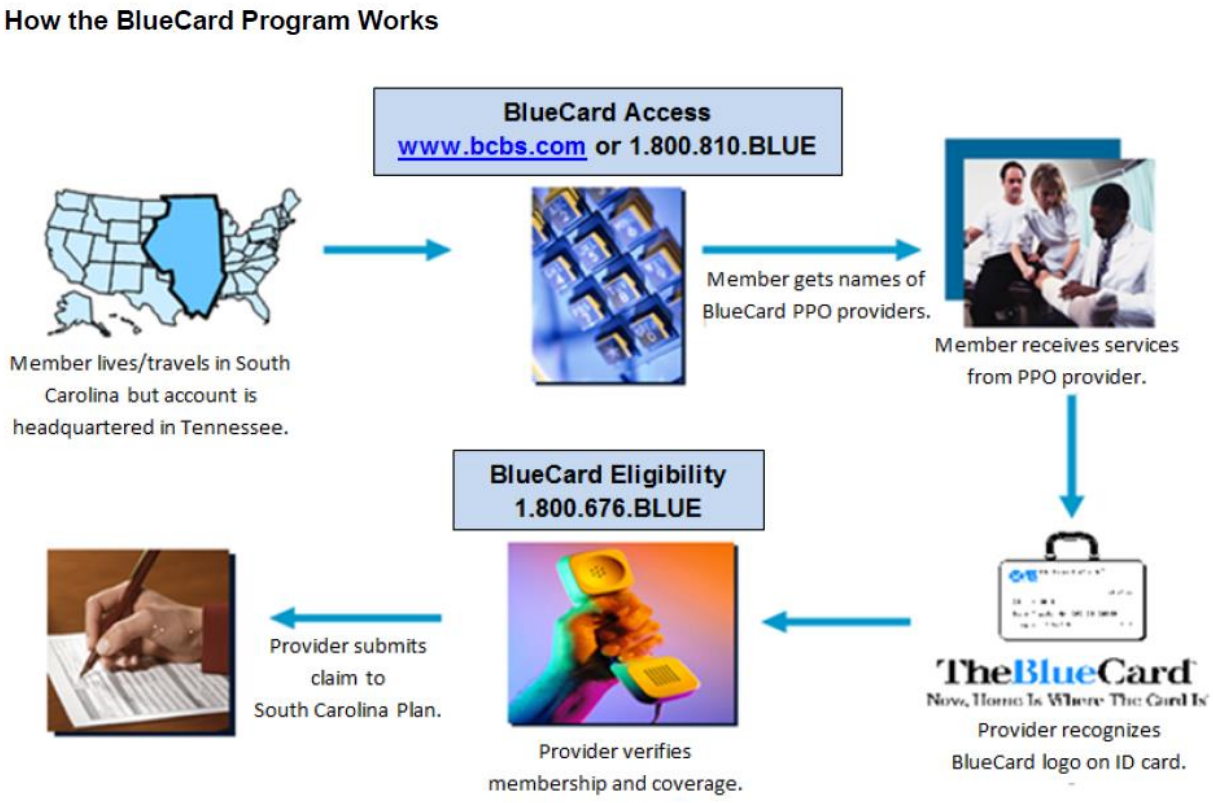
The BlueCard program enables Blue Plan members to get health care service benefits and savings while traveling or living in another Blue Plan's service area. The program links participating health care providers across the country and internationally through a single electronic network for claims processing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



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 whose state the equipment was received 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 whose state the specimen was drawn or where the referring physician is located.
- **Specialty Pharmacy**. File to the plan whose state the ordering physician is located.

*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.

Ancillary filing guidelines for FEP members are:

- **Durable Medical Equipment (DME) –** File to the plan servicing the provider location SHIPPING the equipment or supplies.
- **Independent Clinical Laboratory (Lab) –** File to the plan where the laboratory processing the specimen is located.
- **Specialty Pharmacy –** File to the CVS Specialty Pharmacy program.

Arkansas Blue Cross Blue Shield: Affordable Care Act Plans

- Beginning in Jan. 2018, some Arkansas plans, including Arkansas Works, will not have Out of Area benefits.
- Any elective service outside of the state of Arkansas will not be covered by the member's policy.
- The prefixes are EXX, AEE and AXC.
- There will not be a "suitcase" on the ID cards.
- Check the True-Blue PPO Provider Directory and refer members to participating providers in the True-Blue PPO network.
- If the service is not available in network, you may request a prior approval and may request a referral to an out of state BlueCard provider or other provider as appropriate.
- Note this does not apply if the service is an emergency.

Most Common Edits

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 edits:
   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 edits:
   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 edits:
   a. Verify if the member has other insurance that may be primary
   b. Submit the primary payment information as necessary

4. **No authorization**
   An authorization is required but was not received.

   How to avoid these edits:
   a. Complete authorizations as required by the members' benefit contract.
   b. 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.

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.

Once you view Claim Status for the claim and see what information is needed, choose the Attach Documentation option. Select the PDF file you wish to upload to My Insurance Manager. Once the attachment has been submitted, you will receive this message, **"You have successfully submitted the requested documentation."** You can print the Claim Status Detail page for your records. 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.

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. Below are the possible document types:

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

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.

Provider Reconsiderations

A provider can pursue provider reconsideration by using the Provider Reconsideration Form. 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) and why we should reconsider the service. We require you to include any supporting documentation, such as the 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.

It is not necessary to send the Provider Reconsideration Form when using the Claim Attachments feature unless the claim is BlueCard. You only need to attach the documentation relevant to the claim and submit.

It generally takes 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.

If you disagree with the outcome of the initial reconsideration request, you may request a second request. Second requests must include new or additional information. If you do not submit new or additional documentation, we will uphold the previous decision.

Other Information:

- Timely filing
  - Timely filing limits vary between different benefit plans.
  - To avoid 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 to member cost share, per the members' benefits.

BENEFIT UPDATES FOR COMMERCIAL & AFFORDABLE CARE ACT PLANS

OVERVIEW

Learn about upcoming benefits and administrative changes.

Network Participation

Members access different networks based on their plans. Some members do not 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

- ID Card Guide
- BlueCross Provider Office Administrative Manual
- BlueChoice Provider Office Administrative Manual

Also Visit

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

Prefix Changes

The three character prefix is a foundational component of the BlueCard Program. The information the prefix contains defines the service relationships and arrangements between the Blue plan and its subscribers.

Based on the current growth rate of BlueCross and its affiliates, the number of available alpha prefix combinations will be exhausted in 2018. To accommodate this growth, we will increase the prefix pool by incorporating numbers into the prefix for new groups. Effective Apr. 15, 2018, all Blue plans and providers must be able to accept a prefix that includes a combination of alpha and numeric characters.

When BlueCross members arrive at your office or facility, continue to ask to see their current member identification cards (ID cards) at each visit. Doing so will help you

- Identify the member's product.
- Obtain health plan contact information.
- Speed claims processing.

Remember: ID cards are for identification purposes only; they do not guarantee eligibility or payment of the claim. Verify eligibility for BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina members by using My Insurance Manager, our secure online tool. Verify eligibility for out-of-state members by calling 800-676-BLUE (2583).

1. **How does this impact me?**
   Any time after Apr. 15, 2018, you may begin to see prefixes on member ID cards that contain numeric characters. You will continue to submit the member prefix to conduct everyday transactions and to check eligibility and benefits in the same manner as you do today. Current prefixes will remain active unless cancelled by an account.

   If you have implemented system changes to limit the prefix to a three digit alpha only prefix, you will need to make system modifications to allow for numeric characters effective April 15, 2018.

2. **Will the alpha numeric prefix still be three positions?**
   Yes, the change to alpha numeric allows us to keep the current three position prefix to which most are accustomed.

3. **Will any of the prefixes be all numeric?**
   No, a prefix cannot be all numeric. The system edits will be modified to allow for numeric positions.

4. **With the change to numeric, will this still be referred to as "alpha prefix?"**
   No, "alpha prefix" will now be referred to as "prefix."

5. **With the move to numeric, is there an impact to FEP?**
   No. FEP ID numbers start with an R, which has been taken into consideration and will be accounted for in the requirements and design process.

6. **Are there any restrictions on the numeric character?**
   Yes, zero and one will not be used. The numeric character will be two through nine.

7. **What are the new prefix combinations?**
   There are six combinations that will be released once the current set is exhausted. For example, prefixes may look like any of the following:

   - A2A
   - 2AA
   - 22A
   - AA2
   - 2A2
   - A22

Digital ID Cards

BlueCross and BlueChoice launched a feature in My Health Toolkit® for members to access digital copies of their ID card. Members can now access their digital ID cards anytime, anywhere from their computers or mobile devices. They will also be able to order cards online, print copies, download images of the cards and also email the images securely from My Health Toolkit.

How members can access their digital ID cards

If members are at your office and don't have their plastic ID card, advise them to:

- Go to www.SouthCarolinaBlues.com or www.BlueChoiceSC.com on their mobile device, and log in to My Health Toolkit.
- Select Insurance Card from the main menu.

Advantages for providers

The digital ID card:

- Provides real-time information. The digital ID card is always current.
- Is readily accessible.
- Provides a new way to capture insurance information. If your office accepts patient emails, you can encourage members to email their cards. It can also expedite check-ins and annual updates.

Digital ID card emails will come from either noreply@southcarolinablues.com or noreply@bluechoicesc.com with the subject Insurance Card.

As always, we encourage you to verify eligibility and benefits when a member presents you with a copy of the ID card.

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.

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 requires 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.

These services may require precertification (This list is not all inclusive. Other services may require authorization.):

- 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 Magellan)
- Musculoskeletal care such as interventional spine management services and lumbar and cervical spine surgeries (required through Magellan)
- Radiation oncology (required through Magellan)
- Certain labs (through Avalon)
- Specialty medical specialty drugs (required through NovoLogix, CVS/Caremark's online authorization tool)

Some PPO groups may have authorization requirements that differ from the previous list (e.g., some groups require prior notification for physical, speech and occupational therapies). Check for group-specific authorization requirements before providing services. You can get authorization using the Medical Forms Resource Center online at www.formsresource.center or by using the Authorization/Precertification/Referral link in My Insurance Manager. This feature also includes the Referral and Authorization Status functions.

Note: 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

2018 New Groups

Group Names and Prefix(es)	
Hudson Automotive Group (effective 8/1/2017) – FUV	**JM Smith Corporation** – IEY
Self Regional Medical Center (effective 10/1/2017) – ZCZ	**McLeod Hospital** – IDY (new prefix)

BlueChoice Commercial

There are multiple group product lines that access the broad commercial BlueChoice network. Plan benefits vary. Some BlueChoice products are 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 requires 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 Magellan)
- Musculoskeletal care such as interventional spine management services and lumbar and cervical spine surgeries (required through Magellan)
- Radiation oncology (required through Magellan)
- Certain labs (through Avalon)
- Specialty medical specialty drugs (required through NovoLogix, CVS/Caremark's online prior authorization tool)

Some groups may have authorization requirements that differ from the previous list (e.g., some groups require prior notification for physical, speech and occupational therapies). Check for group-specific authorization requirements before providing services. You can get authorization using the Medical Forms Resource Center online at www.formsresource.center or by using the Authorization/Precertification/Referral link in My Insurance Manager. This feature also includes the Referral and Authorization Status functions.

Note: 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.

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 by 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 authorization for State Health Plan members. You can request authorization 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 authorization and case management services for the State Health Plan.

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

- 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 authorization (This list is not all inclusive. Other services may require 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 authorization to Medi-Call seven days before the scheduled procedure.
- MRIs, MRAs and CT scans (required through Magellan)
- Chemotherapy/radiation therapy (one-time notification)*
- Synagis®

Members are not liable for denied charges if authorization 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 prefix is ZCS. Newer cards reflect the PEBA logo.

State Health Plan

2018 Benefit Changes: Savings Plan

Savings Plan	2017	2018
Deductibles		
Individual	$3,600	No change
Family	$7,200	No change
Copays		
Office Visits	No copay	No change
Outpatient Facility Services	No copay	No change
Emergency Room	No copay	No change
Coinsurance Maximums		
Individual (Network)	$2,400	No change
Family (Network)	$4,800	No change
Individual (OON)	$4,800	No change
Family (OON)	$9,600	No change

2018 Benefit Changes: Standard Plan

Standard Plan	2017	2018
Deductibles		
Individual	$445	No change
Family	$890	No change
Copays		
Office Visits	$12	No change
Outpatient Facility Services	$95	No change
Emergency Room	$159	No change
Coinsurance Maximums		
Individual (Network)	$2,540	No change
Family (Network)	$5,080	No change
Individual (OON)	$5,080	No change
Family (OON)	$10,160	No change

Other Information

- Use of the South Carolina Reporting & Identification Prescription Tracking System (SCRIPTS) database is required for State Health Plan members. SCRIPTS is used by dispensing practitioners and pharmacies to collect and report dispensing activity of all CII-CIV controlled substances.
- Beginning Jan. 1, 2018, members who fill prescriptions for specialty medications must use the Plan's custom credentialed specialty network. The network will include Accredo, Express Scripts' specialty pharmacy, and accredited locally-owned pharmacies. Patients seeking specialty medication should contact Express Scripts at 855-612-3128 for more information.
- Beginning Jan. 1, 2018, State Health Plan requires authorization for medical specialty drugs through NovoLogix. If an authorization is not received, the member will be responsible for the full cost of the drug and any associated administration charges.
- **EyeMed: Vision care program**
  The eyeglass frame benefit will change from every 24 months to every 12 months.

Contact Information

The State Health Plan Provider Services telephone number is 800-444-4311.

Federal Employee Program (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 BlueShield of South Carolina administers contracts and services 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 no 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 authorization and for other services as prior approval. A pre-service 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 pre-service claim for benefits may require authorization and prior approval.

The penalty for lack of authorization 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.

Authorization 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 pre-certified, 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, authorization must be received within two business days. Please include this information when requesting authorization from FEP:

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

FEP

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 for the retail and mail order drug program, 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.
    - Contact AllianceRx Walgreens Prime, our Pharmacy Program administrator for specialty drug program, 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.

Authorization 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 authorization and/or prior approval for services rendered in South Carolina.

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

Authorization and/or prior approval for mental health/substance abuse (MHSA) is processed through Companion Benefit Alternatives (CBA) at 888-346-3731.

FEP

Predeterminations

For services not requiring prior approval, a predetermination may be submitted to the FEP medical review nurse. The cover letter should include the 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 FEP is the primary payer, a Certificate of Medical Necessity (CMN) stating what equipment is needed, why the equipment is needed, and for how long the equipment will be used is required prior to processing claims for payment. 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 retail and mail order pharmacy vendor for FEP.

- Retail Pharmacy: 800-624-5060
- Mail-Order Pharmacy: 800-262-7890

Beginning in 2018, AllianceRx Walgreens Prime administers the Specialty Drug Pharmacy Program.

Specialty Drug Pharmacy Program
AllianceRx Walgreens Prime
P.O. Box 692169
Orlando, FL 32869
1-888-346-3731

FEP

2018 Benefit Changes: Standard Option

The Standard Option offers medical, hospitalization, mental health and prescription drug benefits in and out of network.

Standard Option	2017	2018
Deductibles		
Individual	$350	No change
Self-Plus One	$700	No change
Family	$700	No change
Catastrophic Out-of-Pocket Maximums		
Individual (Network)	$5,000	No change
Self-Plus One (Network)	$10,000	No change
Family (Network)	$10,000	No change
Individual (OON)	$7,000	No change
Self-Plus One (OON)	$14,000	No change
Family (OON)	$14,000	No change
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 change
Mental Health and Substance Abuse (Network) ***(professional services)***	$25 copay	No change
Outpatient Facility Services (Network)	15 percent coinsurance	No change
Emergency Room (Network)	15 percent coinsurance	No change
Manipulative Treatment (Network)	$25 copay	No change
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)	No change
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)	No change
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)	No change
Topical application of fluoride or fluoride varnish	Limited to two per calendar year	No change
Extra-oral images	Allowance is the same for each image	No change

FEP

2018 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	2017	2018
Deductibles		
Individual	$0	No change
Self-Plus One	$0	No change
Family	$0	No change
Catastrophic Out-of-Pocket Maximums		
Individual (Network)	$5,500	No change
Self-Plus One (Network)	$11,000	No change
Family (Network)	$11,000	No change
Services		
Office Visits ***(including physical therapy, speech therapy, occupational therapy, cognitive therapy, vision services and foot care)***	$30 PCP copay $40 specialist copay	No change*
Mental Health and Substance Abuse ***(professional services)***	$30 copay	No change
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 change*
Labs, Pathology, EKGs	$0	No change
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 change*
Diagnostic bone density tests, CT scans, MRIs, PET scans, angiographies and genetic testing, nuclear medicine and sleep studies	$100 copay at professional office $150 copay at outpatient hospital or ASC	No change*
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 change*
Emergency Room	$125 copay per visit	No change
Manipulative Treatment	$30 copay	No change
Inpatient Admission (Network)	$175 per day copay, up to $875	No change
Outpatient Observation (Network)	$175 per day copay, up to $875	No change
Continuous Home Hospice Care (Network)	$150 per day copay, up to $750	No change

*Members are responsible for 30 percent coinsurance for agents, drugs, and supplies administered or obtained in connection with the member's care. Agents are defined as medicines and other substances or products given by mouth, inhaled, placed on you, or injected in you to diagnose, evaluate, and/or treat your condition. Agents include medicines and other substances or products necessary to perform tests such as bone scans, cardiac stress tests, CT Scans, MRIs, PET Scans, lung scans, and X-rays, as well as those injected into the joint.

FEP

2018 Benefit Changes: Standard Option and Basic Option

Standard Option and Basic Option	2017	2018
Skilled Nursing Facility (SNF)	**If the member does not have Medicare Part A, no benefits are available for SNF.** **If the member does have Medicare Part A, Medicare is primary and the Standard Option pays the Medicare Part A copayments for the first through the 30th day. Basic Option pays nothing.**	**Standard Option (PPC)** **No Medicare A:** 30 days Annually, $175 per admission **Standard Option (Non-PPC)** **No Medicare A:** 30 days Annually, $275 per admission, 35% of plan allowance, difference between allowance and billed amount **Basic Option:** No benefits Criteria: • Member is enrolled in case management prior to admission to the SNF (signed consent required), and actively participates in case management both prior to and during admission to the SNF • Precertification is obtained prior to admission (including overseas care). • We approve the preliminary treatment plan prior to admission (plan must include proposed therapies and document the need for inpatient care). • Member participates in all treatment and care planning activities, including discharge planning/transition to home.
DNA Analysis of Stool Samples	**Genetic (diagnostic):** **Standard (PPC) –** 15% coinsurance plus deductible **Basic (PPC) –** $100 copay	**Adult, Preventive (PPC):** Paid at 100% of plan allowance
Latent Tuberculosis Infection Test	**Standard (PPC) –** 15% coins plus deductible **Basic (PPC) –** Paid at 100% of plan allowance	**Adult, Preventive (PPC):** Paid at 100% of plan allowance **Child, Preventive (PPC):** Paid at 100% of plan allowance (ages 18-21)
Telehealth Services	No Benefits	**Standard (PPC)-** $10 copay, no out-of-network benefits **Basic (PPC)-** $15 Copay, no out-of-network benefits Member must use fepblue.org/telehealth or call 855-636-1579 for services.
Vasectomy	**Outpatient:** **Standard (PPC) –** 15% coinsurance plus deductible **Basic (PPC) –** $150 in-office or $200 ASC/outpatient per surgeon;$100 per facility per day; 30% coinsurance for agents, drugs, supplies	**Family planning:** Paid at 100% of plan allowance at a preferred provider. • Limited to one per lifetime. • Includes the semen analysis following a vasectomy. • Reversal is not covered.

FEP

2018 Benefit Changes: Standard Option and Basic Option

Standard Option and Basic Option	2017	2018
Oral Medical Foods	**Under the medical benefit:** **Standard (PPC) –** 15% coins plus deductible **Basic (PPC) –** 30% coinsurance	Paid under pharmacy (retail/mail) Prior Approval Required
Manipulative Treatment	Only professional claims applied to a member's annual visit maximum.	Professional and facility claims apply to a member's annual visit maximum.
Gonadotropin-Releasing Hormone (GnRH)	Benefits limited to members age 16 and over.	Benefits provided regardless of age.
Stem Cell Transplants **(Autoimmune Diagnoses)**	Listed diagnoses were presented as examples of covered diagnoses.	Listed diagnoses serve as the complete list of covered diagnoses. Limited to: • Multiple sclerosis • Scleroderma • Systemic lupus erythematosus • Chronic inflammatory demyelinating polyneuropathy)
Allogeneic Stem Cell Transplants **(Inherited Metabolic Disorders)**	Listed diagnoses were presented as examples of covered diagnoses.	We now limit the coverage of allogeneic blood or marrow stem cells to the following inherited metabolic disorders: • Gaucher's disease • Metachromatic leukodystrophy • Adrenoleukodystrophy • Hurler's syndrome • Maroteaux-Lamy syndrome variants.
Autologous Stem Cell Transplants **(Clinical Trials)**	**Covered autologous blood or marrow stem cell:** • Breast cancer • Epithelial ovarian cancer	We now provide coverage limited to the following diagnoses for autologous blood or marrow stem cell transplants, only when performed as part of a clinical trial: • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Chronic myelogenous leukemia • Glial tumors • Retinoblastoma • Rhabdomyosarcoma • Wilm's tumor • Other childhood kidney cancers.

Other Information

- FEP Provider Service Number – 888-930-2345
- Benefits and eligibility for FEP members is also available on My Insurance Manager.
- 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.

Affordable Care Act (ACA): Small Group Plans

Health plans in the individual and small group markets are offered through the Federally Facilitated Marketplace (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 ACA plans to businesses with 2 to 50 employees. The BlueCross small group ACA plans are called Business BlueEssentials and the BlueChoice small group ACA 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 (BlueCross) and the Covered Drug List (BlueChoice) through our websites, www.SouthCarolinaBlues.com or www.BlueChoiceSC.com.

Vaccination Network

Certain seasonal and non-seasonal vaccinations are available under small group ACA 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.

Affordable Care Act (ACA): Small Group Plans

Requirement for Referral to Specialist

Small group ACA 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 authorization. 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 Magellan)
- Musculoskeletal care such as interventional spine management services and lumbar and cervical spine surgeries (required through Magellan)
- Radiation oncology (required through Magellan)
- Nuclear cardiology (required through Magellan)
- Certain labs (through Avalon)
- Specialty medical specialty drugs (required through NovoLogix, CVS/Caremark's online authorization tool)

Other Information:

BlueCross and BlueChoice ACA members' flu vaccines are now covered under the pharmacy benefit at no cost through the CVS/Caremark® Vaccine Network. The Vaccine Network is limited to CVS pharmacies and applies to all ACA members.

Members must use a CVS pharmacy in order to receive the vaccine with no cost share. Flu vaccines administered in pharmacies other than CVS will be subject to an administrative fee that will be the member's responsibility.

Members can also continue to receive flu vaccines at no cost under the medical preventive benefit from network participating medical providers.

The following are vaccines covered under the program this year:

- Injectable Seasonal Influenza Vaccine
- Injectable Seasonal Influenza Vaccine-High Dose (Fluzone)

Affordable Care Act (ACA): BlueEssentials and Blue Option Individual Plans

Product Name(s)

The individual ACA products BlueCross offers are called BlueEssentials, and the BlueChoice products offered are called Blue Option. These are all non-grandfathered products. Non-grandfathered ACA plans 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, Rite Aid and Safeway locations, plus various grocers and independent pharmacies.

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 ACA 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 ACA 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.

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.**

Affordable Care Act (ACA): BlueEssentials and Blue Option Individual Plans

Requirement for Referral to Specialist

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

Authorization

Certain categories of benefits require authorization. Failure to get authorization can result in us denying benefits. Authorization is not a guarantee that we will cover the service. For authorization requirements, verify benefits and eligibility through My Insurance Manager. Once you have verified authorization requirements, you can initiate the authorization request using the Medical Forms Resource Center or in My Insurance Manager.

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

These services may require authorization (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
- Dialysis treatment
- MRIs, MRAs and CT scans (required through Magellan)
- Musculoskeletal care such as interventional spine management services and lumbar and cervical spine surgeries (required through Magellan)
- Radiation oncology (required through Magellan)
- Nuclear cardiology (required through Magellan)
- Certain labs (through Avalon)
- Specialty medical specialty drugs (required through NovoLogix, CVS/Caremark's online authorization tool)

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)

Affordable Care Act (ACA): BlueEssentials and Blue Option Individual Plans

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.

Other Information

- Beginning Jan. 1, 2018, BlueEssentials and Blue Option will coordinate benefits for members when other coverage is primary.
- BlueEssentials and Blue Option members **do not have out-of-network** benefits or benefits when services are provided outside of South Carolina.
  - Members only have out-of-network benefits in the event of a true emergency.
  - Members only have benefits within South Carolina when the provider is in the BlueEssentials or Blue Option network.
- BlueEssentials and Blue Option members **do not have benefits** for services provided outside of South Carolina.
  - This also includes labs and durable medical equipment services.
  - Members only have out-of-state benefits in the event of a true emergency.
  - 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: Diabetic test strips are covered under the pharmacy benefits
  - Members will be limited to a supply of 204 strips per month.
  - If you believe a member requires more than 204 test strips a month, you may request an exception by calling 855-582-2022. Please note that exceptions will be made based on medical necessity.
- Pharmacy coverage for flu vaccines
  - ACA members' flu vaccines are now covered under the pharmacy benefit at no cost through the CVS/ Caremark Vaccine Network. The Vaccine Network is limited to CVS pharmacies and applies to all ACA members.
  - Members must use a CVS pharmacy in order to receive the vaccine with no cost share. Flu vaccines administered in pharmacies other than CVS will be subject to an administrative fee that will be the member's responsibility.
  - Members can also continue to receive flu vaccines at no cost under the medical preventive benefit from network participating medical providers.
  - The following vaccines are covered under the program this year:
    - Injectable Seasonal Influenza Vaccine
    - Injectable Seasonal Influenza Vaccine-High Dose (Fluzone)

Publix

Beginning Jan. 1, 2018, copays are increasing for Publix members. The new copays will be:

- $30 – family doctor office visit (family or general practice, internal medicine or pediatrics)
- $30 – mental health specialist office visit
- $50 – specialist office visit
- $50 – urgent care visit
- $250 – emergency room visit

These members are identified by the prefixes PXN, PWA and PBB.

APPENDIX

Contact Information

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

Area	Websites	Contact Numbers	
BlueCross (including BlueEssentials)	www.SouthCarolinaBlues.com	Provider Services: 800-868-2510	Authorizations: 800-334-7287
BlueChoice (including Blue Option)	www.BlueChoiceSC.com	Provider Services: 800-868-2528	Authorizations: 800-950-5387
Medicare Advantage	www.SCBluesMedAdvantage.com www.SouthCarolinaBlues.com	Provider Services: 855-209-7267	Authorizations: 855-843-2325
BlueChoice HealthPlan Medicaid	www.BlueChoiceSCMedicaid.com	Customer Care Center: 866-757-8286	
FEP	www.FEPBlue.org	Provider Services: 888-930-2345	Authorizations: 800-327-3238
State Health Plan	www.StateSC.SouthCarolinaBlues.com	Provider Services: 800-444-4311	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
Magellan	www.RadMD.com	BlueCross: 866-500-7664	BlueChoice: 888-642-9181
NovoLogix (CVS/Caremark)	Accessible through My Insurance Manager	Phone: 866-284-9229	Fax: 844-851-0882

Electronic Solutions	Purpose	Websites
My Insurance Manager	Access benefits, eligibility, claim status and submit questions to Provider Services. Upload documentation for pending authorizations and processed claims.	Accessbile through www.SouthCarolinaBlues.com or www.BlueChoiceSC.com.
My Remit Manager	View electronic remittances, download reports, search patient accounts.	Accessbile through www.SouthCarolinaBlues.com or www.BlueChoiceSC.com.
Medical Forms Resource Center	Initiate authorization requests.	www.formsresource.center

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