2019 Annual Provider Summit

BlueCross BlueShield of South Carolina and
BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Welcome and Introductions

Provider Relations' mission is to serve as liaisons between BlueCross BlueShield of South Carolina, BlueChoice HealthPlan and the health care community to promote positive relationships through continued education and problem resolution.

Welcome and Introductions

2019 Benefit Update Meeting Acknowledgements

Cathryn Adair & Jennifer Winchester	Customer/Provider Experience
Tony Salvati & Kathy Wade	Magellan Healthcare
Kerri Fritsch & Team	Avalon Healthcare Solutions
Shay Looker & Team	Healthy Blue
Tiesha Williams & Team	Companion Benefit Alternatives (CBA)
Michele Polgar, Terry Whiteside, Greg Kline, & Michele Berg	CVS/Caremark/NovoLogix

NIA is an independent company that provides utilization management services on behalf of BlueCross.
CBA is a separate company that manages behavioral health and substance abuse benefits for BlueCross.
CVS/specialty is a division of CVS Health, an independent company that provides pharmacy benefit management and specialty pharmacy services on behalf of BlueCross.

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- *Benefits*
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- *Best Practices Towards Faster Claim Resolution*
- *Provider Enrollment*
- *The Provider Experience*

Benefits

Preferred Blue

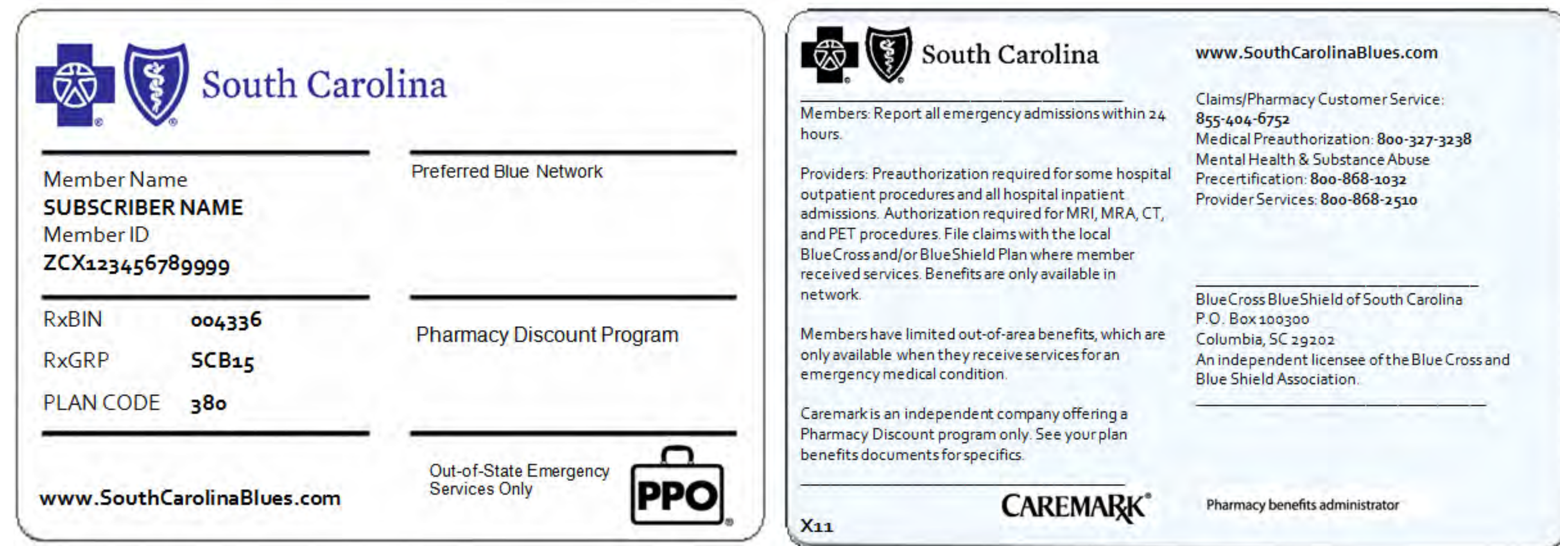
Large Commercial Business Plans: Effective Jan. 1, 2019

Group Name	Prefix
Red Ventures	BZS
Roechling Automotive	ZCW
The Regional Medical Center	ZCW

Preferred Blue

Short Term Healthcare

- Prefix is ZCX
- Network is Preferred Blue PPO
- Pre-existing medical conditions are **not** covered
- Medical benefits
- Pharmacy benefit is “Discount Only”

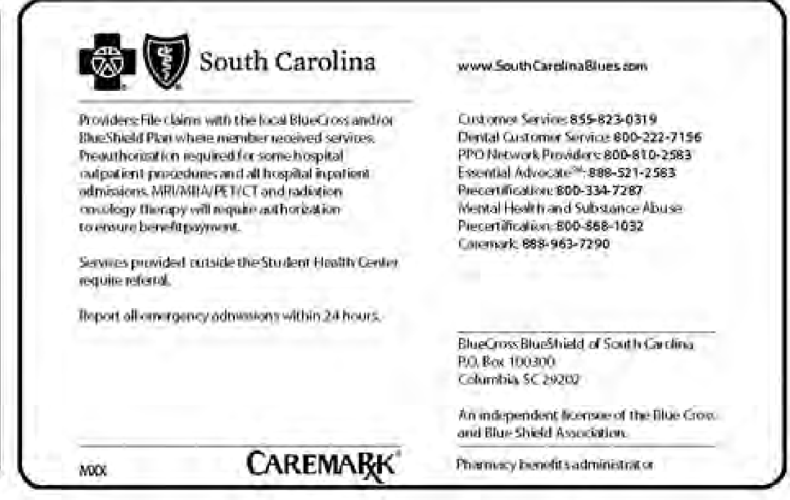


Important: Out-of-State Emergency Services Only

Preferred Blue

Student Health Plan

- Prefix is ZCW
- Preferred Blue Network
- Referrals are required for students of USC, MUSC and Clemson when care is provided **outside** onsite clinics.
- Cards for these members include the language, “Services provided outside the Student Health Center require referral.”

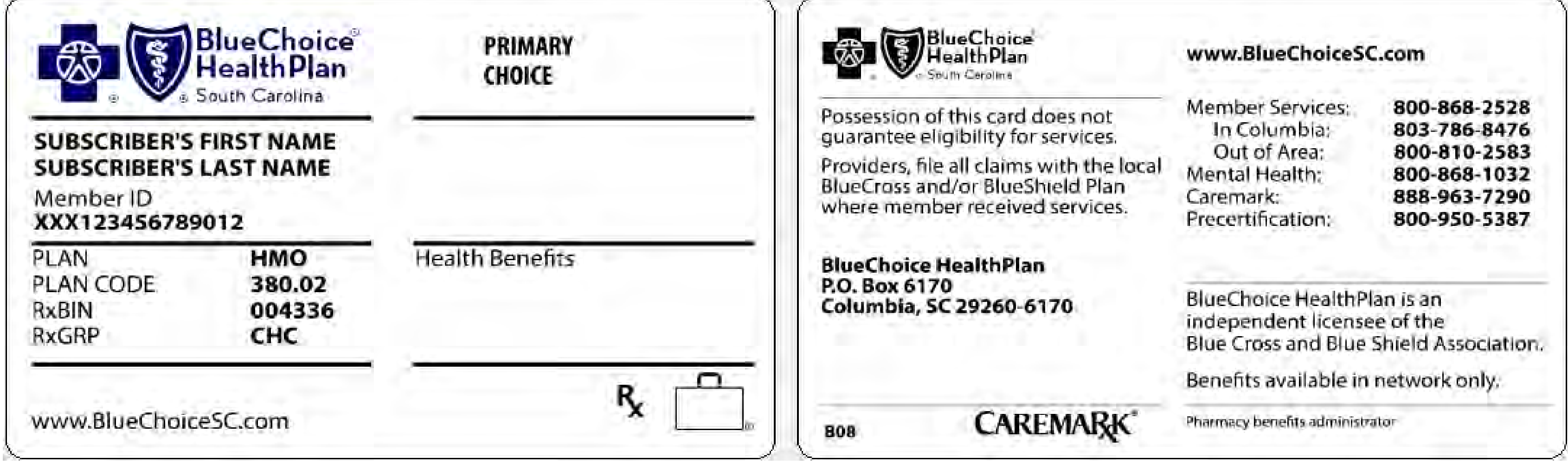


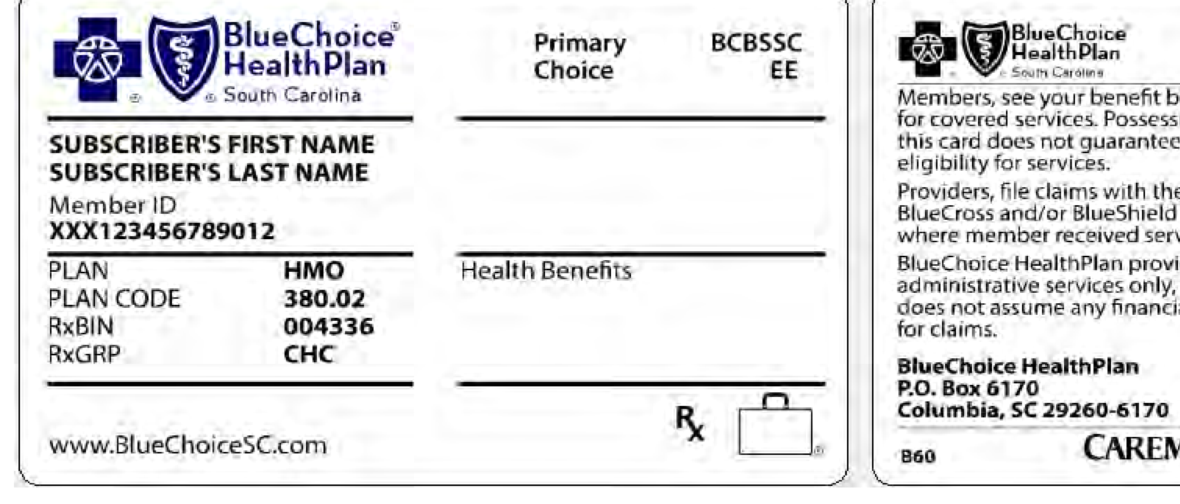
Offered to students at:

- University of South Carolina
- MUSC
- Clemson University
- Coastal Carolina
- Winthrop University and
- The Citadel

Primary Choice Large Group – HMO

Card Examples





BusinessADVANTAGE

Card Examples

BusinessADVANTAGE

SUBSCRIBER'S FIRST NAME
SUBSCRIBER'S LAST NAME
Member ID
XXX123456789012

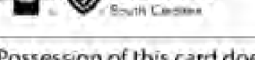
Advantage Network

PLAN	**PPO**
PLAN CODE	**380.04**
RxBIN	**004336**
RxGRP	**CHC**

Health Benefits
Pediatric Vision

www.BlueChoiceSC.com

Rx PPO B



www.BlueChoiceSC.com

Possession of this card does not guarantee eligibility for services.

Inpatient precertification required.

Providers, file all claims with the local BlueCross and/or BlueShield Plan where member received services.

File medical claims to:

BlueChoice HealthPlan
P.O. Box 6170
Columbia, SC 29260-6170

Member Services:	**800-868-2528**
In Columbia:	**803-786-8476**
Out of Area:	**800-810-2583**
Mental Health:	**800-868-1032**
Caremark:	**888-963-7290**
Precertification:	**800-950-5387**
PEN Vision:	**800-997-2736**

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

B10 CAREMARK

Pharmacy benefits administrator

BusinessADVANTAGE

SUBSCRIBER'S FIRST NAME
SUBSCRIBER'S LAST NAME
Member ID
XXX123614046483

Advantage Network

PLAN	**PPO**
PLAN CODE	**380.04**
RxBIN	**004336**
RxGRP	**CHC**

Health Benefits
Vision

www.BlueChoiceSC.com

Rx

www.BlueChoiceSC.com

Possession of this card does not guarantee eligibility for services.

Inpatient precertification required.

Providers, file all claims with the local BlueCross and/or BlueShield Plan where member received services.

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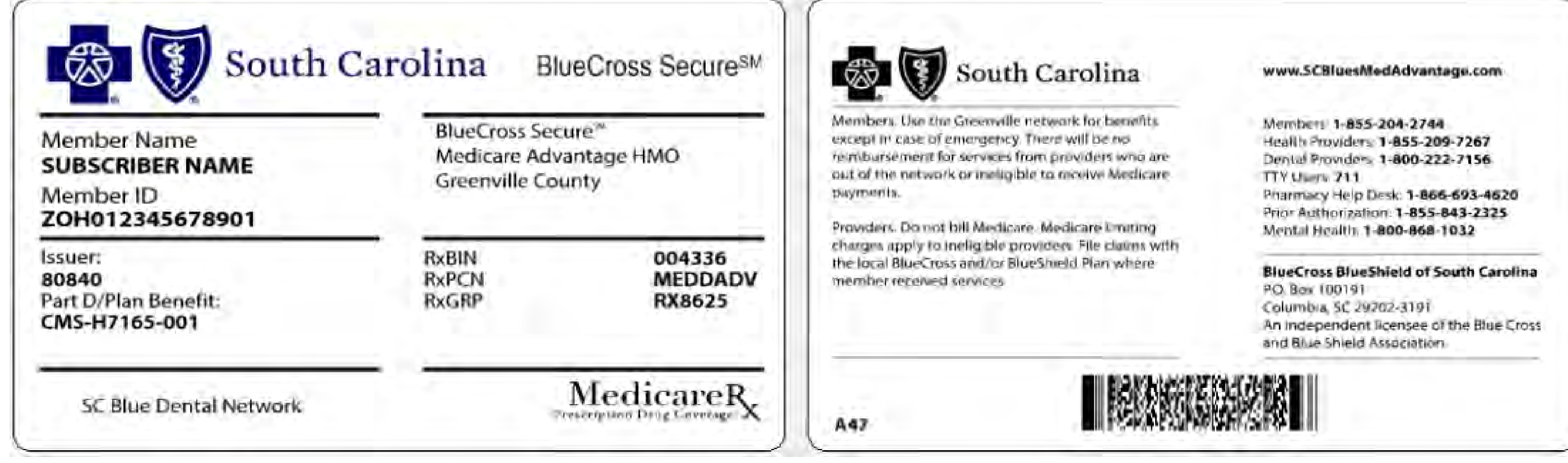
B12 CAREMARK

Pharmacy benefits administrator

Medicare Advantage: BlueCross Secure℠ HMO Greenville County

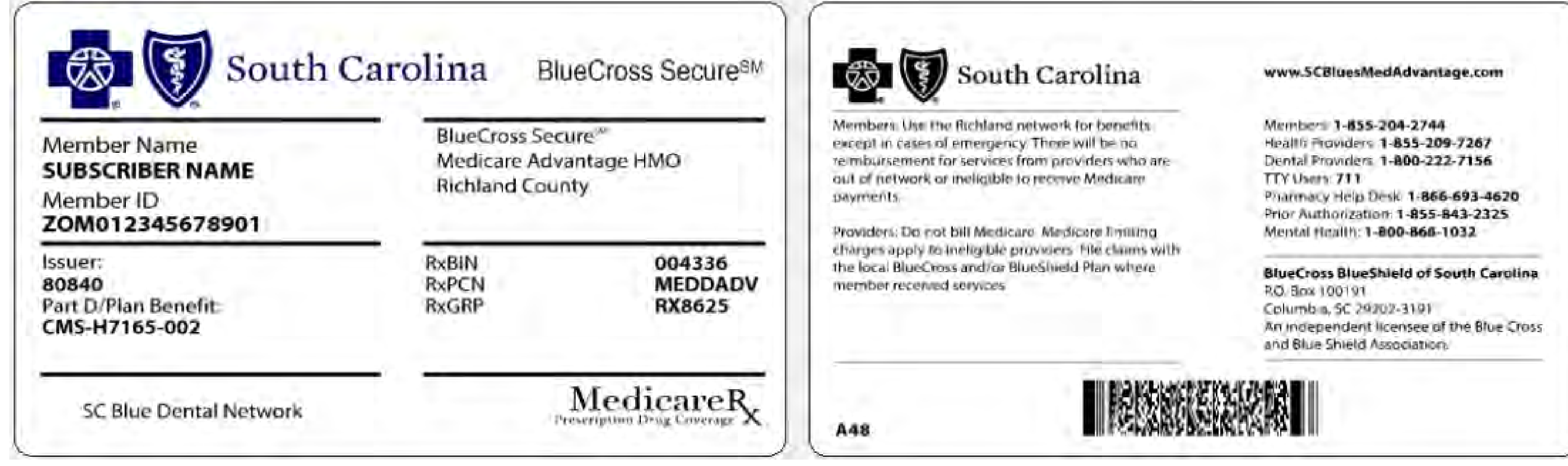
BlueCross Secure



- **Individual** products access the narrow **Medicare Advantage HMO Greenville County Network**.
- The prefix for this plan is ZOH.
- Cards reflect the plan name and network.
- Members must use the Greenville network for benefits except in cases of emergency.
- There will be no reimbursement for services from providers who are out of the network or ineligible to receive Medicare payments.
- Members have dental coverage beginning Jan. 1, 2019.

Medicare Advantage: BlueCross Secure^{SM} HMO Richland County

BlueCross Secure



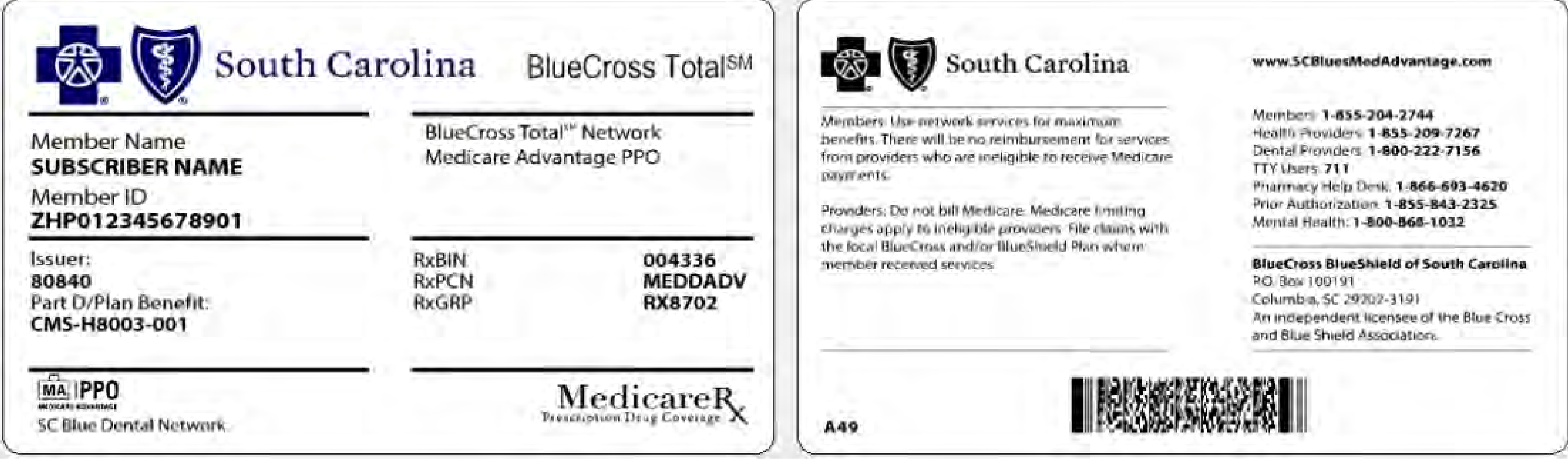
- **Individual** products access the narrow **Medicare Advantage HMO Richland County Network**.
- The prefix for this plan is ZOM.
- Cards reflect the plan name and network.
- Members must use the Richland network for benefits except in cases of emergency.
- There will be no reimbursement for services from providers who are out of the network or ineligible to receive Medicare payments.
- Members have dental coverage beginning Jan. 1, 2019.

Medicare Advantage: BlueCross Secure

	2018	2019
Maximum Out-of-Pocket Amount	$6,700	No change
Primary Care	$7 copay per visit	$15 copay per visit
Specialist	$45 copay per visit	No change
In-Patient Hospital Stays	$360 copay per day for days 1-5; $0 for days 6 and beyond	$400 copay per day for days 1-4; $0 for days 5 through 90
Part D Prescription Drug Coverage	Deductible - $200 on tiers 2, 3, 4 and 5. Tier 1 drugs are excluded	Deductible - $70 on tiers 3, 4 and 5. Tier 1 and 2 drugs are excluded

Medicare Advantage: BlueCross Total^{SM} PPO

BlueCross Total



- **Individual** products access the broad **BlueCross Total PPO Network**.
- The prefix for this plan is ZHP.
- Cards reflect the plan name and network.
- There will be no reimbursement for services from providers who are ineligible to receive Medicare payments.
- Members have dental coverage beginning Jan. 1, 2019.

Medicare Advantage: BlueCross Total PPO

	2018	2019
Deductible	In-network providers: $0 Out-of-network providers: $300	In-network providers: $0 Out-of-network providers: $0
Maximum Out-of-Pocket Amount	From in-network providers: $6,700 From in-network and out-of-network providers combined: $10,000	No Change
Doctor Office Visits		
Primary Care	In-network: $10 copay per visit Out-of-network: $30 per visit	No Change
Specialist	In-network: $40 copay per visit Out-of-network: $55 per visit	No Change
In-Patient Hospital Stays	In-network: $350 copay per day for days 1-5; $0 for days 6 and beyond Out-of-network, 20 % coinsurance	In-network: $400 copay per day for days 1-4; $0 for days 5 through 90 Out-of-network: No change

Medicare Advantage: BlueCross Secure & BlueCross Total

	2018	2019
Dental Services	• Preventive Dental: $150 maximum benefit every year. • Comprehensive dental is not covered. • Any licensed dental provider may provide services.	• Two preventive dental visits per year • Three restorative service visits per year, one extraction visit per year and one crown per year • In-network: $0 copay. Must use dental network for coverage • NOTE: If the PPO member goes out of network, we will cover 50% of the allowed amounts.
Health & Wellness	$0 copay for one Fitbit Alta per year	$0 copay for basic membership to a Silver & Fit participating fitness center
Hearing Services	• Routine non-Medicare covered hearing exam is not covered • Hearing aids are not covered	• $50 copay for one routine non-Medicare covered exam per year • $699 – $999 copay for hearing aids using the TruHearing Network for up to two hearing aids per year (one per ear, each year)
Meal Program	Not Covered	$0 copayment for meal program after a member’s inpatient hospital and/or skilled nursing facility/rehabilitation stay for five days (two meals per day) for up to four times per year

Medicare Advantage: Prior Authorizations

Methods for Requesting Prior Authorization

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

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

Companion Benefit Alternatives (CBA)

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

Medicare Advantage: Improve STAR Performance

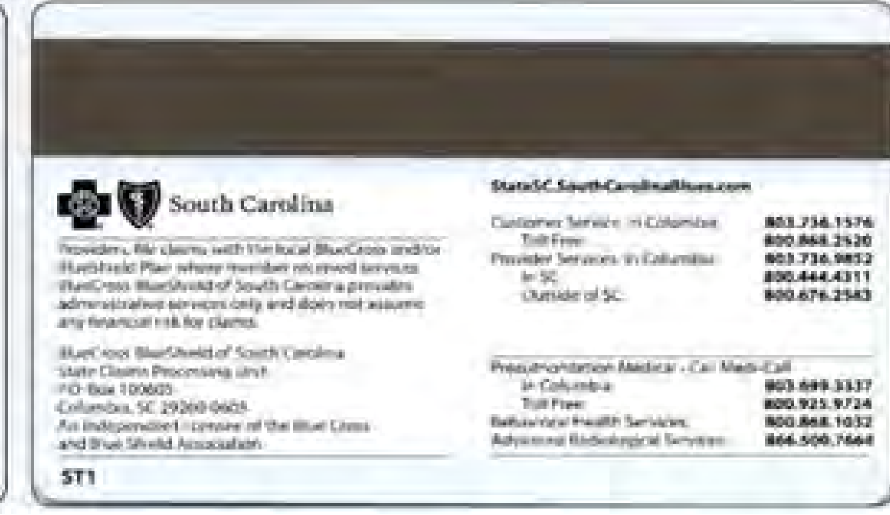
CMS uses the five-star rating system to monitor plans to ensure they meet Medicare's standards for quality of care and customer service.

- **Document** all care in the patient's medical record
- **Calculate** BMI at every visit
- **Code and bill** appropriately for services rendered
- **Promote** medication adherence
- **Recommend** formulary alternatives
- **Respond** to medical record requests (within five business days)
- **Recommend** participation in disease management programs
- **Schedule** patients requiring annual exams and periodic screenings
- **Contact** patients for follow up appointments and preventive exams

Medicare Advantage: Reminders

- Check the member's ID card to determine his/her plan.
- Know whether you are in the **BlueCross Total PPO** network or the **BlueCross Secure HMO** network.
- Refer members to in-network providers.
- Verify eligibility and benefits prior to rendering services.
- Follow Medicare guidelines for providing covered services.
- Review the Medicare Advantage Provider Manuals.

State Health Plan



State Health Plan: Standard Plan

Standard Plan	2018	2019
Deductibles		
Individual	$445	$490
Family	$890	$980
Copays		
Office Visits	$12	$14 (Waived for routine mammograms and well child visits)
Outpatient Facility Services	$95	$105
Emergency Room	$159	$175
Coinsurance Maximums		
Individual (Network)	$2,540	$2800
Family (Network)	$5,080	$5600
Individual (OON)	$5,080	$5600
Family (OON)	$10,160	$11,200

No cost-share changes for the Savings Plan

State Health Plan

What's New for 2019?

- **Standard Plan and Savings Plan**
  - **Site of Care**
    - Beginning Jan. 1, 2019, State Health Plan members who are receiving certain intravenous specialty drugs at a higher cost site of service (i.e., hospital outpatient setting) will be required to move to an equally appropriate, alternative site of service (infusion center or home).
    - Prior authorization (PA) is required through NovoLogix, CVS Caremark's medical PA software for drugs billed under the medical benefit.
    - Site of Care Drug List is available on www.SouthCarolinaBlues.com
  - **Patient-Centered Medical Home (PCMH)**
    - After members meet their deductible, they will pay **10 percent coinsurance**, rather than 20 percent, for care at a PCMH provider

CVS Caremark is a division of CVS Health, an independent company that administers prior authorization services on behalf of our health plans.

State Health Plan

What’s New for 2019?

- **Standard Plan**
  - Members who receive care at a BlueCross-affiliated PCMH provider will not be charged the $14 copayment for a physician office visit
  - $105 copayment for outpatient facility services is waived for physical therapy, speech therapy, occupational therapy, dialysis services, partial hospitalizations, intensive outpatient services, electroconvulsive therapy and psychiatric medication management
  - $175 copayment for emergency care is waived if admitted

State Health Plan

What's New for 2019?

- **Standard Plan: Adult Well Visits– Effective Jan. 1, 2019**
  - Eligible female members may use their well visit at their gynecologist or their primary care physician, but **not both**, in a covered year.
  - Adult well visits will be subject to copayments, deductibles and coinsurance.
  - Available to all non-Medicare primary adults:
    - Ages 19-39, one visit every three years
    - Ages 40-49, one visit every two years
    - Ages 50 and up, one visit per year
  - Benefits are available at network providers specializing in General Practice, Family Practice, Internal Medicine, Obstetrics and Gynecology and Pediatrics.

Services **not** included as part of the adult well visit are those **without** an A or B recommendation by the US Preventive Service Task Force (USPSTF).

State Health Plan

What's New for 2019?

Naturally Slim Weight Loss Program

- A clinical behavioral weight management program focusing on weight loss and diabetes prevention.
- Available to State Health Plan members, including spouses and dependent children age 18 and older, and Medicare-primary members.
- It is a 10-week, online program that uses weekly video lessons and interactive tools to teach the behavioral skills necessary to lose weight and keep it off long-term.

State Health Plan

Reminders

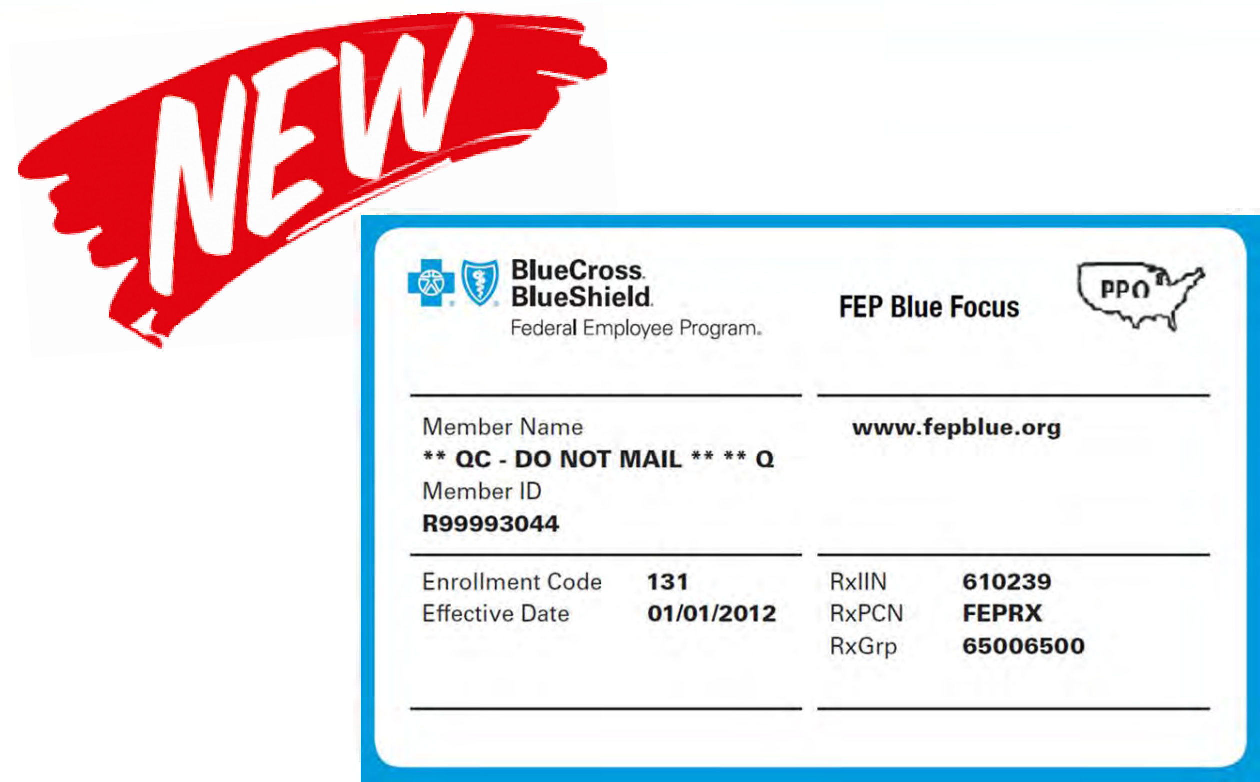
- Colonoscopy Benefit

  State Health Plan – 2018 Updated Colonoscopy Bulletin
  https://web.southcarolinablues.com/providers/providernews/2018providernews.aspx?article_id=1102

  - The State Health Plan will pay 100 percent of the allowed amount for **ONLY** the:
    - Pre-surgical consultation (medical benefit)
    - Generic prep kit (pharmacy benefit through Express Scripts)
    - Related anesthesia (medical benefit)
    - Colonoscopy procedure (medical benefit)

- Pre-Op Services
  - Pre-op services on the same inpatient claim will use a UB04 admission date vs. the date of service for precertification matching. Please make sure your date of service matches your precertification.

Federal Employee Program (FEP)



FEP Basic and FEP Blue Focus members do not have out-of-network benefits.

FEP Blue Focus

FEP Blue Focus	2019
Deductibles	
Individual	$500
Self-Plus One	$1,000
Family	$1,000
Catastrophic Out-of-Pocket Maximums	
Individual (Network)	$6,500
Self-Plus One (Network)	$13,000
Family (Network)	$13,000
Services	
Office Visits (Network) (including physical therapy, speech therapy, occupational therapy, cognitive therapy, vision services and foot care)	**Visits 1-10,** PCP or Specialist, $10 Copay

No cost-share changes for FEP Standard or FEP Basic

FEP Blue Focus

FEP Blue Focus	2019
Mental Health and Substance Abuse (professional services)	Visits 11+, PCP or specialist, 30 percent coinsurance after deductible
Urgent Care – Accidental (1st 72 hours)	$0 copay
Urgent Care – Medical	$25 copay
ER – Accidental (1st 72 hours)	$0 copay
ER – Medical	30% coinsurance after deductible
Physical, Occupational and Speech Therapy	$25 copay per visit, 25 visit limit combined
Cognitive Rehabilitation Therapy	30% coinsurance after deductible Limited to 200 hours
ABA Therapy Disorder/Autism Spectrum	30% coinsurance after deductible
Continuous Home Hospice Care	$25 copay per visit
Chiropractic/Osteopathic Care	$25 copay, limit of 10 manipulative/acupuncture benefits combined
Acupuncture by a healthcare provider who is licensed or certified to perform acupuncture by the state where service are provided	30% coinsurance after deductible, limited to 200 hours

FEP: Standard, Basic and FEP Blue Focus Updates

Adult, Preventive Care: Standard and Option, and FEP Blue Focus	2018 (Except FEP Blue Focus)	2019
Colorectal cancer tests, including: • Fecal occult blood test • Colonoscopy, with or without biopsy • Sigmoidoscopy • Double contrast barium enema • DNA analysis of stool samples • Prostate cancer tests – Prostate Specific Antigen (PSA) test • Cervical cancer tests (including Pap tests) • Screening mammograms, including mammography using digital technology	Preventive care benefits for each of the services listed above are limited to one per calendar year.	No Change
	We pay preventive care benefits on the first claim we process for each of the above tests you receive in the calendar year. Regular coverage criteria and benefit levels apply to subsequent claims for those types of tests if performed in the same year.	No Change
	Pathology for Sigmoidoscopy and Colonoscopy covered under diagnostic benefits.	Pathology for Sigmoidoscopy and Colonoscopy covered 100 percent under preventive benefits.

FEP: Standard, Basic and FEP Blue Focus Updates

Prior Approval Required (All Plans)
Gene therapy and cellular immunotherapy, for example CAR-T and T-Cell receptor therapy (new 2019)
Air Ambulance Transport (non-emergent) (new 2019)
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 –
Surgical services – The surgical services on the following list require prior approval for care performed by Preferred, Participating/Member, and Non-participating/Non-member professional and facility providers: • Outpatient surgery for morbid obesity; • Outpatient surgical correction of congenital anomalies; • Outpatient surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth; and • Gender reassignment surgery.

FEP: Standard, Basic and FEP Blue Focus Updates

Prior Approval Required (Additional for FEP Blue Focus)

Other services

- Outpatient intensity-modulated radiation therapy (IMRT) – Prior approval is required for all outpatient IMRT services except IMRT related to the treatment of head, neck, breast, prostate or anal cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer.
- Hospice care
- Organ/tissue transplants transplant.
- Clinical trials for certain blood or marrow stem cell transplants
- Prescription drugs and supplies – Certain prescription drugs and supplies require prior approval.

Surgical services

- Breast reduction or augmentation not related to treatment of cancer
- Oral maxillofacial surgeries/surgery on the jaw, cheeks, lips, tongue, floor and roof of the mouth, and related procedures
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ)
- Orthopedic procedures: hip, knee, ankle, spine, shoulder and all orthopedic procedures using computer-assisted musculoskeletal surgical navigation
- Reconstructive surgery for conditions other than breast cancer
- Rhinoplasty
- Septoplasty
- Varicose vein treatment

FEP: Standard, Basic and FEP Blue Focus Updates

Prior Approval Required (Additional for FEP Blue Focus)
Cardiac rehabilitation
Cochlear implants
Outpatient residential treatment center care for any condition
Prosthetic devices (external), including: microprocessor controlled limb prosthesis; electronic and externally powered prosthesis
Pulmonary rehabilitation
Radiology, high technology including: • Magnetic resonance imaging (MRI) • Computed tomography (CT) scan • Positron emission tomography (PET) scan • Note: High technology radiology related to immediate care of a medical emergency or accidental injury does not require prior approval.
Specialty durable medical equipment (DME), rental or purchase, to include: • Specialty hospital beds • Deluxe wheelchairs, power wheelchairs and mobility devices and related supplies

FEP: Other Information

- FEP Website – www.FepBlue.org
- FEP Provider Service Number – 888-930-2345
- Benefits and eligibility for FEP members is also available on My Insurance Manager[SM].
- 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.

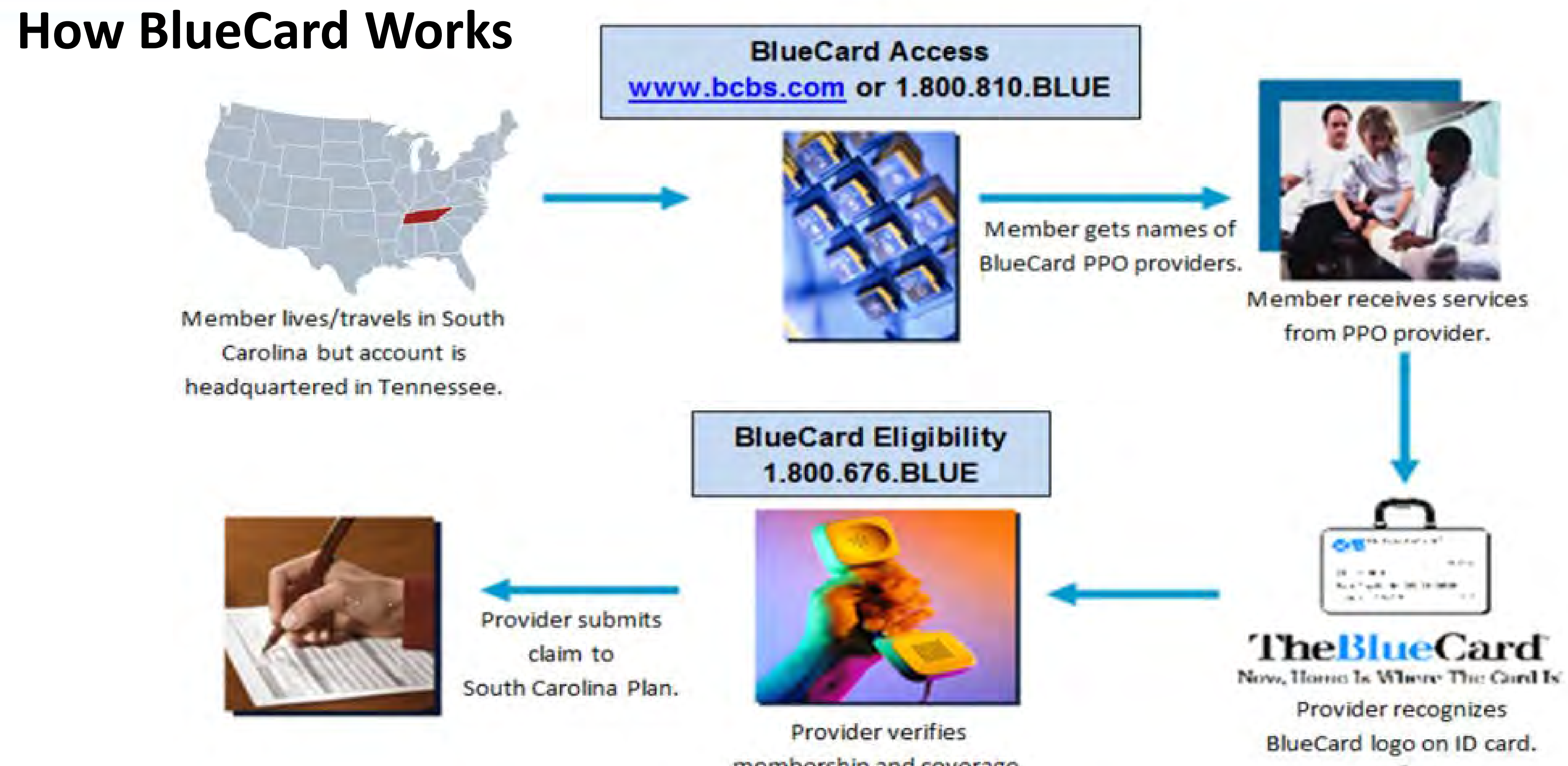
BlueCard Program

Overview

- 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 BlueShield of South Carolina Plan.
- We will be your point of contact for education, contracting, claims payment/adjustments and problem resolution.

BlueCard Program

How BlueCard Works



BlueCard Program

Home Plan

- The Plan that holds the patient's membership and benefits information.
- Responsibilities:
  - Enrollment process, issuing ID cards and Utilization Management.
  - Benefit, membership and eligibility determination.
  - All member interactions including member service calls and education.
  - Claim adjudication (benefit application) and creation of member EOBs.

Host Plan

- The Plan that is local for the provider that renders services.
- Responsibilities:
  - Perform provider contracting, rate negotiation, training and education.
  - Receive claims from local providers and price claims.
  - Route claim information with pricing data to the Control/Home Plan.
  - Send remittance notice and reimbursement to provider.
  - Handle ALL provider inquiries and provider service.

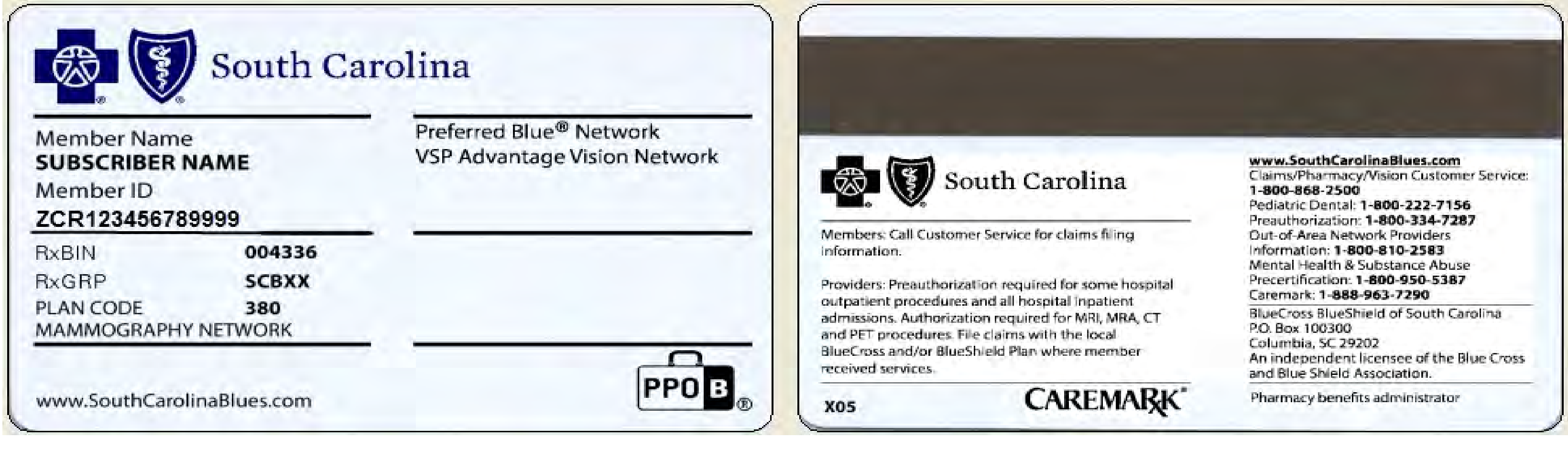
BlueCard Program

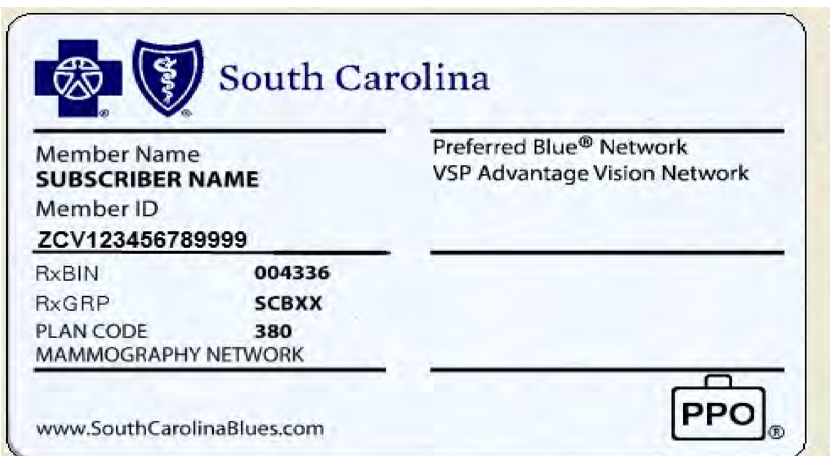
Ancillary Claim Filing Guidelines

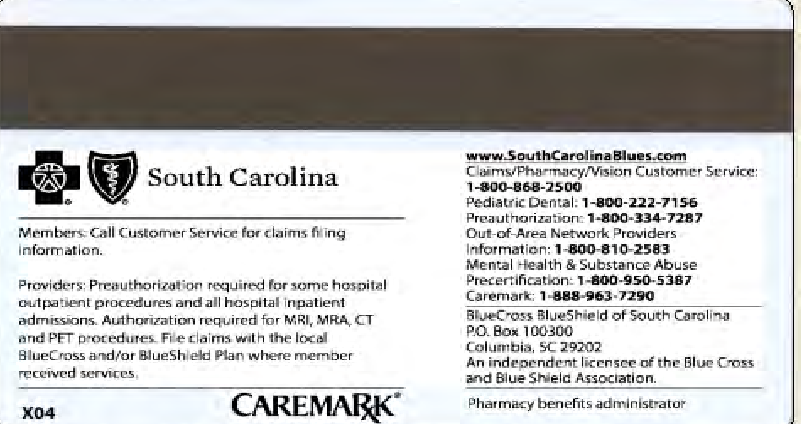
- **Durable Medical Equipment**
  - File to the plan whose state the equipment was received or purchased at a retail store.
- **Independent Clinical Laboratory (Lab)**
  - File to the plan whose state the where the referring physician is located.
- **Specialty Pharmacy**
  - File to the plan whose state the ordering physician is located.

ACA: BlueCross Small Group Plans

BlueCross offers plans to businesses with two to 50 employees. These plans use the **BlueCross Preferred Blue** Network.







Prefixes

ZCV Small Group Private
ZCR Small Group FFM

ACA: BlueChoice Small Group Plans

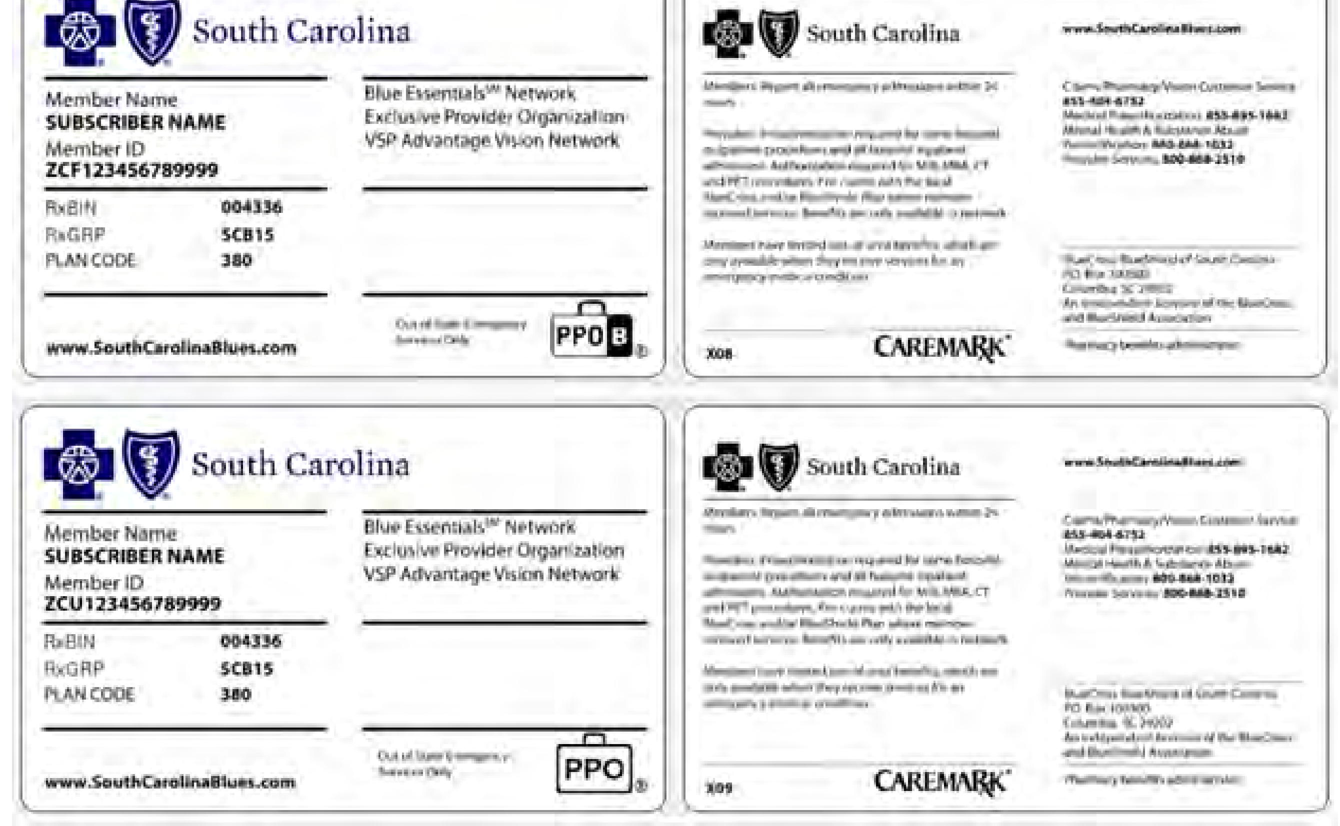
Business Advantage plans are a line of small group plans BlueChoice offers to businesses with two to 50 employees. These plans use the **BlueChoice Advantage Network**.

Prefixes

ZCL Small Group Private
ZCG Small Group FFM

ACA: BlueCross Individual Plans

BlueEssentialsSM is a line of individual plans BlueCross offers. The network name indicates that the **Blue Essentials Network** is being used. This network is unique to these plans.



Prefixes

ZCU Individual Private

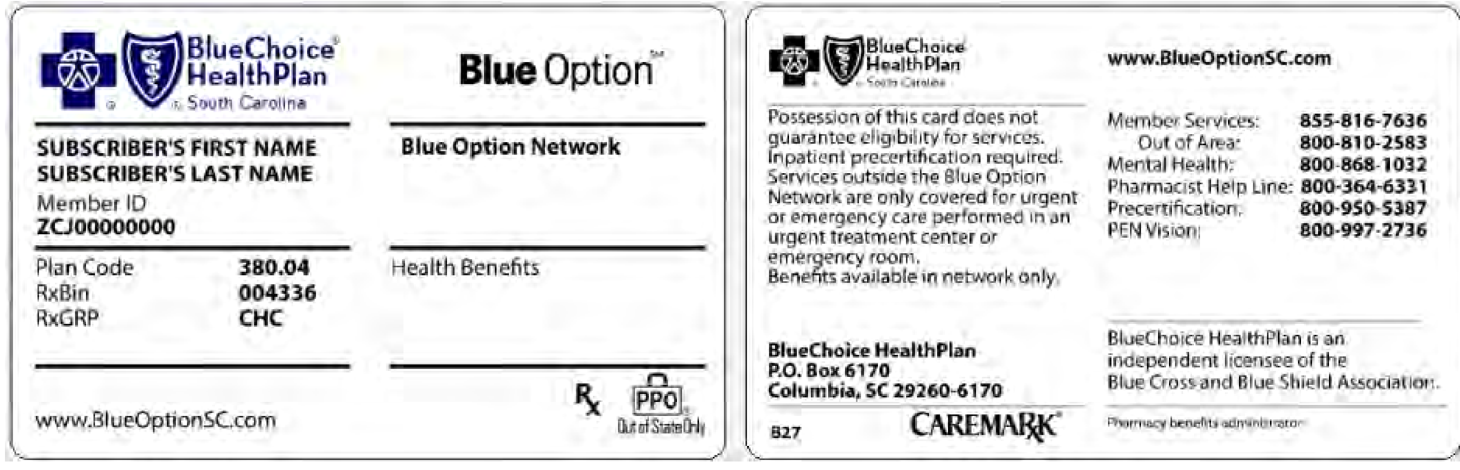
ZCF Individual FFM

Members **do not** have **out-of-network** or **out-of-state benefits**, except in the event of an emergency.

Services by providers in contiguous counties (bordering counties outside of South Carolina) that are contracted and participate in the BlueEssentials Network are considered in network.

ACA: BlueChoice HealthPlan Individual Plans

Blue Option℠ is a line of individual plans BlueChoice offers. The network name indicates that the **Blue Option Network** is being used.



Prefix

ZCJ Individual Private

Members **do not** have **out-of-network** or **out-of-state benefits**, except in the event of an emergency.

Services by providers in contiguous counties (bordering counties outside of South Carolina) that are contracted and participate in the Blue Option Network are considered in network.

ACA: Individual Plans

Premium Delinquencies

- Members without a federal subsidy are not allotted a delinquency grace period. Payment will not be made for members who are more than 30 days past due on their premiums.

- Members who have an FFM policy and receive a federal subsidy have a three-month grace period.

- We will notify you of a member's premium delinquency:
  - When verifying eligibility and benefits through My Insurance Manager and the VRU.
  - When verifying claim status through My Insurance Manager and the VRU.
  - When reviewing your remittance advice.

ACA: Transition of Care Form

Individual ACA members may receive treatment from out-of-network providers in two situations:

1. When services are for emergency care
2. To continue treatment with a provider whose network affiliation has changed

If a member wishes to receive ongoing treatment from an out-of-network provider, they must complete the Transition of Care Form.

- The member must complete the request prior to services and the request must be **approved** in order to be covered.
- Payment will be rendered to the member.
- The form is on our websites.

BlueCross BlueShield of South Carolina
Transition of Care/Continuation of Care
Request Form
(Please use a separate form for each condition)

Employee's Name ID #

Address City/State/ZIP

Effective Date

Phone: (Home) ____________ (Work) ____________

Patient's Name DOB ID #

Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Dependent

Health Condition: ____________

Physician/Provider(s) Involved

Name: ____________ Phone: ____________ Specialty: ____________

Name: ____________ Phone: ____________ Specialty: ____________

Name: ____________ Phone: ____________ Specialty: ____________

Date of First Treatment: ____________ Date of Last Visit: ____________

Current Treatment or Proposed Surgery: ____________

Expected Length of Treatment or Date of Surgery: ____________

Primary Care Physician

Provider's Name Member Health Plan ID #

Address

City/State/ZIP

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association TOC Auth (rev. 12.1.2017)

ACA: Other Information

Coordination of Benefits

- BlueEssentials and Blue Option will continue to coordinate benefits for members with Medicare primary coverage.

For more information about ACA plans, visit these websites:

- www.HealthCare.gov
- www.SouthCarolinaBlues.com
- www.BlueChoiceSC.com

Publix Members

Publix members now have coverage for applied behavior analysis (ABA) therapy. ABA therapy benefits require prior authorization through CBA. Amounts listed represent 2019 benefits.

Place of Service/Provider Type	In-network	Out-of-Network
Inpatient (facility and professional charges)	$450 deductible, 20 percent coinsurance	$900 deductible, 40 percent coinsurance
Outpatient (facility and professional charges)	$450 deductible, 20 percent coinsurance	
Partial and Intensive Outpatient	$450 deductible, 20 percent coinsurance	
Outpatient ER (facility charges)	$200 copay	
Outpatient ER (professional charges)	$450 deductible, 20 percent coinsurance	
Office	$25 copay (primary care), $50 (specialist)	

Healthy Blue

Healthy Blue – New name. Same benefits.

These will not change:

- Member ID cards – these will not change immediately. We will issue new cards to new members. Existing members will keep their current ID Cards.
- Member ID numbers
- EFT and ERA information
- Member Benefits
- Plan addresses and phone numbers
- Payer ID number for electronic claims submission

Healthy Blue Contact Information

Website: www.Healthybluesc.com

Provider Customer Care Center:
Phone: **866-757-8286**
TTY: **866-773-9634**
Fax: **912-233-4010** or **912-235-3246**
Hours: Monday–Friday from 8 a.m.–6 p.m.

Utilization Management (UM) department:
Phone: **1-866-902-1689**
Fax: **1-800-823-5520**
Hours: Monday–Friday from 8 a.m.–5 p.m.

24-hour Nurseline:
Phone: **1-866-577-9710**
TTY: **1-800-368-4424**

Case Management (CM) department:
Phone: **866-757-8286**
Hours: Monday–Friday from 8 a.m.–5 p.m.

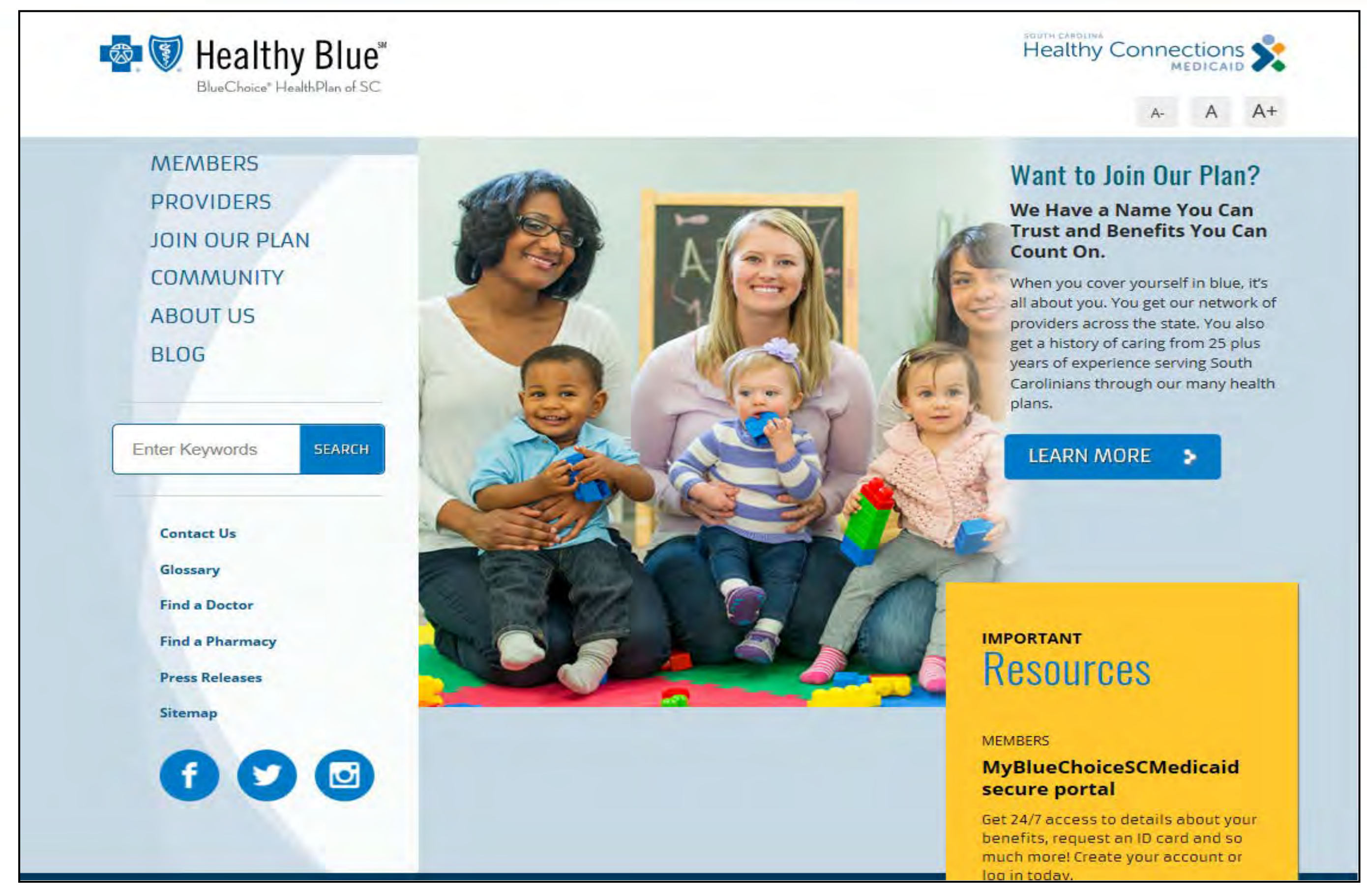
Disease Management (DM) department:
Phone: **888-830-4300**
TTY: **800-855-2880**

Vision Service Plan (VSP):
VSP is an independent company that offers a vision network on behalf of Healthy Blue.
Phone: **888-830-4300**
TTY: **800-855-2880**
Hours: Monday–Friday from 8 a.m.–10 p.m.

Express Scripts, Inc.:
Express Scripts is an independent company that provides pharmacy benefits on behalf of Healthy Blue.
Phone: **866-310-3666**
Hours: Monday–Friday from 8 a.m.–9 p.m.
Fax: **866-807-6241**
Hours: Saturday–Sunday from 8 a.m.–6 p.m.

https://www.healthybluesc.com

- Provider Directory
- Provider Operations Manual (POM)
- Forms
- Pharmacy Information
- Health Education
- **SBIRT** (Screening, Brief Intervention, Referral to Treatment)



Availity

Availity Access

- Go to https://www.availity.com/
- Click on Log In or Register
- Enter User ID and Password
- Click on "Payer Spaces" and choose BlueChoice Medicaid

Training for Availity:

- For training on Availity features click on "Help and Training"
- Click on "Get Trained"
- Choose the topic you need help with and click on "Enroll"

Covered Benefits

- Medicaid Managed Care Organization (MCO) plans are required to offer at a minimum the same benefits as Healthy Connections (FFS)
- Plans can choose to offer additional benefits

Need to know if a code is covered or what the reimbursement is for a code?

https://www.scdhhs.gov/resource/fee-schedules

If the code appears on the SCDHHS fee schedule, it is a covered code.

Need to know what the policy is for a certain service?

https://www.scdhhs.gov/provider-manual-list

*** Fee schedules and manuals are listed by provider specialty type*

Medicaid is always the payer of last resort

AIM

AIM Specialty Health handles authorization requests on behalf of Healthy Blue for the following **advanced imaging** and **cardiology services**.

- Computed tomography scans (including cardiac)
- Magnetic resonance imaging (including cardiac)
- Positron emission tomography scans (including cardiac)
- Nuclear cardiology
- Stress echocardiography
- Resting transthoracic echocardiography
- Transesophageal echocardiography
- Arterial ultrasound
- Cardiac catheterization
- Percutaneous coronary intervention (PCI)

We understand that the need for arterial duplex imaging or PCI procedures may not be identified until patients have undergone a physiologic study or cardiac catheterization. For these cases, please contact AIM to request clinical appropriateness review no later than 10 business days after you perform these procedures (and before you submit a claim). For all other cases, please contact AIM to obtain authorization before you perform the procedure.

AIM

AIM Specialty Health handles authorization requests on behalf of Healthy Blue for the following **radiation oncology** services.

- Brachytherapy
- Intensity modulated radiation therapy
- Proton beam radiation therapy
- Stereotactic radiosurgery/stereotactic body radiotherapy
- 3D conformal therapy1 (EBRT) for bone metastases and breast cancer
- Hypofractionation for bone metastases and breast cancer when requesting EBRT and intensity modulated radiation therapy (IMRT)
- Special procedures and consultations associated with a treatment plan (CPT codes 77370 and 77470)
- Image guided radiation therapy

Radiation oncology performed as part of an inpatient admission is **not** part of the AIM program.

Radiation oncology providers are strongly encouraged to verify that authorization has been obtained before initiating scheduling and performing services.

AIM

If AIM authorizes the service, AIM will provide an **order number** to the ordering provider.

AIM will send this approved authorization to Healthy Blue who will assign an actual **authorization number**.

Please file the authorization number on the claim and NOT the AIM order number.

Filing the AIM order number on the claim may result in a denial of the claim.

The ***Provider****Portal*[SM] is the fastest, easiest way to contact AIM. An online application, ***Provider****Portal* offers a convenient way to enter your authorization requests or check on the status of your previous authorizations. Go to **www.providerportal.com** to begin. Registration is required.

For questions regarding your online authorization, please contact the AIM ***Provider****Portal* Support team at **800-252-2021**.

Physicals

- Adult routine physicals are covered once every two years
- Sports physicals are covered under the following circumstances
  - Provided by an in-network primary care provider
  - Covered once per calendar year
  - Covered for members 6-18 years of age
  - Bill using CPT 99212 and diagnosis Z02.5
  - This can be billed in addition to a well child exam and the well child incentive
  - Reimbursement is $30.00

Behavioral Health Covered Services

- **Psychiatric Residential Treatment Facilities (PRTFs)**
  - All services require authorization
  - Ancillary services may require authorization depending on the number of services
  - Revenue codes 120, 124, 154
  - Therapeutic home time billed with revenue code 183
- **Autism Spectrum Disorder**
  - All ASD services require authorization
- **Rehabilitative Behavioral Health Services**
  - (RBHS) require prior authorization for most providers. Authorizations that are not resubmitted to and approved by Healthy Blue HealthPlan Medicaid may result in claims denials

Behavioral Health Covered Services

- **Clinical submission requirements for authorization requests** – Adult and child, RBHS:
  - Use of service codes: H2014, H2017, H2030, H2037, S9482 and H0038, which are defined as RBHS codes by Healthy Blue HealthPlan Medicaid
  - Prior authorization form (specific to your agency or the Rehabilitative Behavioral Health Services Treatment Review and Authorization Request Form found on the Healthy Blue HealthPlan Medicaid site)
  - Diagnostic assessment
  - Treatment plan of care, which includes services delivered
  - Any additional clinical information the provider feels supports the request, including treatment updates if the Diagnostic Assessment is more than three months old
- Services provided by licensed independent practitioners (LIPs), providers in the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) network, providers in the South Carolina Department of Mental Health (DMH), providers in the South Carolina Department of Education (DOE)
- ALL out of network providers require authorization for all services regardless of provider type.

Behavioral Health Covered Services

Service Codes that **DO NOT** require authorization for **Participating Providers**:

90785	90840	99366
90791	90846	99367
90792	90847	H0004
90832	90849	H0005
90833	90853	H0038
90834	H0002	H2017
90836	H0031	S9482
90837	H2000	H0034
90838	H2011	96372
90839	92201-99205 99211-99215	

Behavioral Health Credentialing

Companion Benefits 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 BlueShield of South Carolina and BlueChoice HealthPlan.

These forms are needed when submitting a provider for credentialing through CBA

- Completed application (The CBA application rather than the SC Uniform application)
- Completed W9 form or appropriate IRS documentation (Letter 147C, CP 575 E or tax coupon 8109-C)
- BlueChoice HealthPlan Medicaid/Healthy Blue MCO Agreement
  (MDs/Dos = physician agreement, all others = ancillary agreement)
- Disclosure of Ownership Statement
- Copy of state license
- Copy of Drug Enforcement Administration (DEA) license (if applicable)
- Medicaid number (required for network participation)
- Proof of current malpractice coverage†

Coverage minimums: Medical Doctors = JUA/PCF or $1,000,000/$3,000,000
All others = $1,000,000/$1,000,000

Prescription Authorizations

- Copayments are $3.40 per prescription/refill on brand-name and generic medications for members ages 19 and over.
- Members who are 21 years of age and older are limited to four prescriptions per-month. If medically necessary, more prescriptions may be added after PA.
- These are exempt from the monthly prescription limit:
  - Insulin syringes
  - Home-administered injectables
  - Aerosolized pentamidine
  - Clozapine therapy
  - Family planning drugs and devices
  - Diabetes strips

Prescription Authorizations

- All medications will be limited to a one-month (maximum **31-day**) supply at all retail pharmacies
- If a medical condition warrants a greater quantity than the defined one-month supply of medication, PA will ensure access to the prescribed quantity
- Members should refer to their **Evidence of Coverage (EOC)** for benefit details, exclusions and limitations

Express Scripts, Inc.
Prior Authorizations
Voice: 1-800-470-0933
Fax: 1-866-807-6241

Laboratory Services

- Healthy Blue has a preferred agreement with LabCorp for all labs
- Labs sent to LabCorp do not require precertification
- You can send anatomical pathology and cytology specimens to a local contracting pathology group or to LabCorp without precertification
- See website for a complete list of labs you can do **in your office and bill** to Healthy Blue
- You can send STAT labs to a contracting hospital

Claim Submission

Electronic Data Interchange (Payer ID 00403)

- Preferred and fastest way to submit your claims.
- You can also submit corrected claims electronically.
- For set-up and information, call 1-800-470-9630.

Correspondence

If you need to file an appeal or submit any type of correspondence, please mail to:

Healthy Blue
ATTN: Medicaid Claims
PO Box 100124
Columbia, SC 29202-3124

Overpayment Recovery Addresses

Overpayment Recovery

Healthy Blue
P.O. BOX Central – 73651
Cleveland, OH 44193-1177

Overpayment Recovery (for Overnight Delivery)

Healthy Blue – Central – 73651
4100 W 150th St.
Cleveland, OH 44135

EDI Gateway for Healthy Blue

This is to follow-up on recent communications regarding the designation of Availity as the exclusive EDI Gateway for Anthem, and to advise regarding the potential impact of this change on you. We believe that Availity's EDI Gateway will improve your experience, as well as the ultimate results for our customers.

Please note, some clearinghouses may take a position they will not connect to Anthem through Availity, which may impact your ability to send Anthem transactions through those clearinghouses. **You should immediately contact your current clearinghouse or service provider, to verify their ability and willingness to submit all of your Anthem transactions through Availity's EDI Gateway, or make other arrangements such as those described further below.**

If your current clearinghouse or service provider is unable or unwilling to submit transactions through Availity's EDI Gateway, and no other arrangements are made, potential impacts could include:

- **Connectivity** –Your clearinghouse may be unable or unwilling to transmit any EDI transactions to Anthem after **December 31st, 2018**.
- **Workflow –**Your clearinghouse may submit your claims via paper, which will delay claim processing, and impact availability of electronic remittance advice. Other electronic transactions like eligibility and claim status can also be affected.

Transactions that may be impacted include EDI submissions to Anthem, including 837 (Claims), 835 (ERA) and 27X (Claim Status and Eligibility) after **December 31st, 2018**.

EDI Gateway for Healthy Blue

Anthem and its affiliates are focused on continuity of service for your EDI transactions. If you are notified of any negative impact to your transactions, please know there are alternate submission options available.

- **If you wish to use a clearinghouse,** here is a list of EDI vendors that are transmitting EDI transactions to Availity EDI Gateway for Anthem transactions: www.availity.com/AnthemEDIVendors
- **If your current or desired clearinghouse is not on this list**, please contact them to confirm continuity of support for Anthem transactions.
- **If you wish to submit directly**, you can connect directly to the Availity Gateway at no cost for all Anthem and affiliate 837, 835 and 27X transactions. Please visit https://apps.availity.com/web/welcome/#/empower to learn more.

IT may take time to work with a clearinghouse or service provider, so please take action now to help ensure continuity of your EDI transactions.

Timely Filing, Re-submissions and Appeals

Claim Filing Limits

All providers are allowed 365 days to submit claims.

Claims Denied for Requests for Medical Records

We must receive medical records within **60** days of the request.

Corrected Claims

We must receive corrected claims within **90** days from the process date to consider them for payment. These include changes to coding, units, NPI, etc.

You must submit corrected claims hard copy with the Corrected *Claim* form.

BlueChoice HealthPlan of South Carolina
Medicaid

South Carolina Healthy Connections Medicaid

Corrected Claim Form

Provider information

Sent by — Date sent
Hospital/facility/physician — Phone number
NPI number — Provider tax ID number

Member information

Patient name — Date of service
Original claim number — Original date of claim
Member ID number — Medicaid ID number

INSTRUCTIONS: Please remember you have 90 days from the date of our request/denial to submit a corrected claim. Please attach the proper documentation, including a copy of any applicable correspondence received from BlueChoice HealthPlan Medicaid.

After completing this form, place it on top of all documentation and mail to:

BlueChoice HealthPlan Medicaid
Attn: Medicaid Claims
P.O. Box 100124
Columbia, SC 29202-3124

A copy of the claim should not be submitted with the documentation requested unless otherwise denoted by an asterisk (*).

For follow-up of a returned claim, check all that apply:

- ☐ *Coordination of Benefits*/Medicaid information
- ☐ Corrected billing*
- ☐ *Explanation of Medical Benefits/Explanation of Benefits* of primary insurance carrier
- ☐ Hard copy of itemized bill for a previously submitted claim
- ☐ Medical records
- ☐ Patient eligibility verified (through Customer Service, interactive voice response or provider access)
- ☐ Other:

To request a claim adjustment, check all that apply:

- ☐ Additional charges*
- ☐ Other action required:

www.BlueChoiceSCMedicaid.com

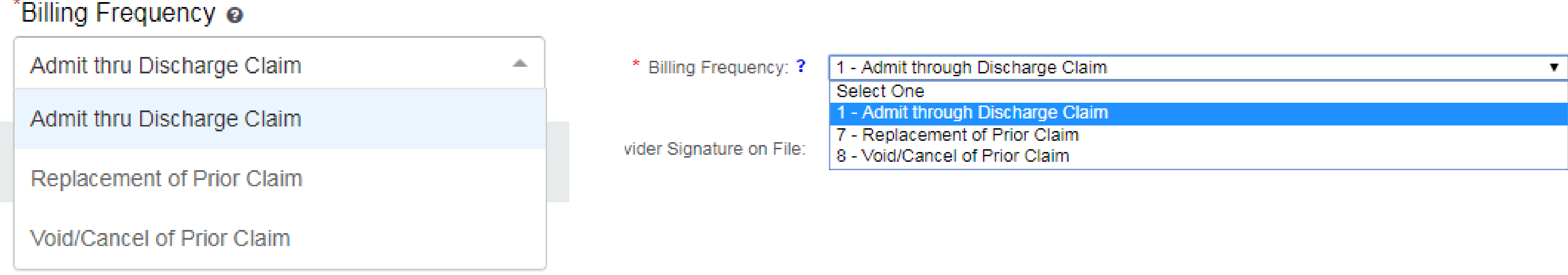
BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association. BlueChoice HealthPlan has contracted with Amerigroup Partnership Plan, LLC. an independent company, for services to support administration of Healthy Connections.

Corrected Claims

Corrected claims can be filed

- Electronically - Use loop 2300 & segment REF02 to indicate the original claim number.
  Use loop 2300 & segment CLM05-3 to indicate the claim frequency code.
  7 = replacement of a prior claim

- Availity – There is a field titled Billing Frequencies. To send a corrected claim, select Replacement of Prior Claim



- **Paper claims** - must be filed with the Claims Follow Up Form

Timely Filing, Re-submissions and Appeals

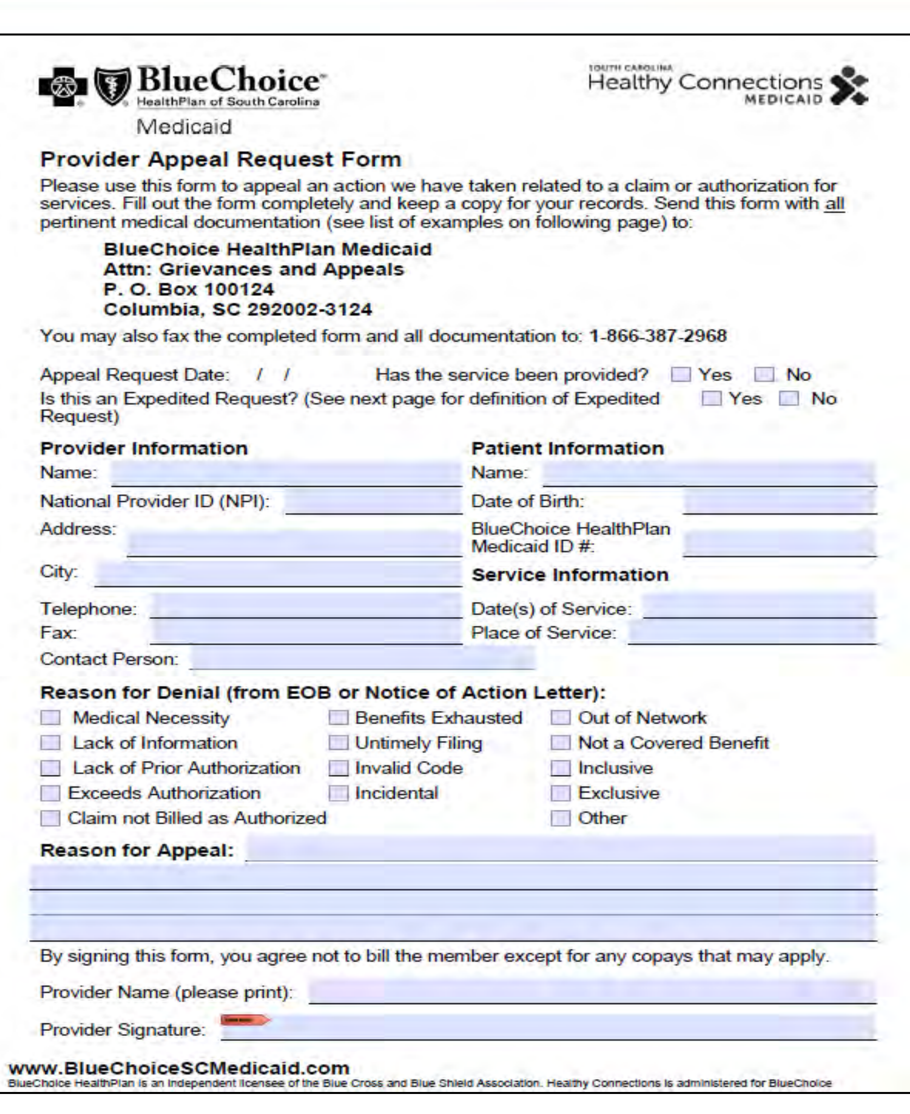
Appeals

We must receive appeals within **90** days from the process date to consider them for review.

Please include ALL pertinent clinical information along with the appeal.

You must submit appeals with the *Provider Appeal Request* form.

Correct address for appeals:
Healthy Blue – Appeals
P.O. Box 100124
Columbia, SC 29202



BlueChoice HealthPlan of South Carolina
Medicaid
South Carolina Healthy Connections Medicaid

Provider Appeal Request Form

Please use this form to appeal an action we have taken related to a claim or authorization for services. Fill out the form completely and keep a copy for your records. Send this form with all pertinent medical documentation (see list of examples on following page) to:

BlueChoice HealthPlan Medicaid
Attn: Grievances and Appeals
P. O. Box 100124
Columbia, SC 292002-3124

You may also fax the completed form and all documentation to: 1-866-387-2968

Appeal Request Date: / / Has the service been provided? ☐ Yes ☐ No
Is this an Expedited Request? (See next page for definition of Expedited Request) ☐ Yes ☐ No

Provider Information
Name:
National Provider ID (NPI):
Address:
City:
Telephone:
Fax:
Contact Person:

Patient Information
Name:
Date of Birth:
BlueChoice HealthPlan Medicaid ID #:

Service Information
Date(s) of Service:
Place of Service:

Reason for Denial (from EOB or Notice of Action Letter):

☐ Medical Necessity ☐ Benefits Exhausted ☐ Out of Network
☐ Lack of Information ☐ Untimely Filing ☐ Not a Covered Benefit
☐ Lack of Prior Authorization ☐ Invalid Code ☐ Inclusive
☐ Exceeds Authorization ☐ Incidental ☐ Exclusive
☐ Claim not Billed as Authorized ☐ Other

Reason for Appeal:

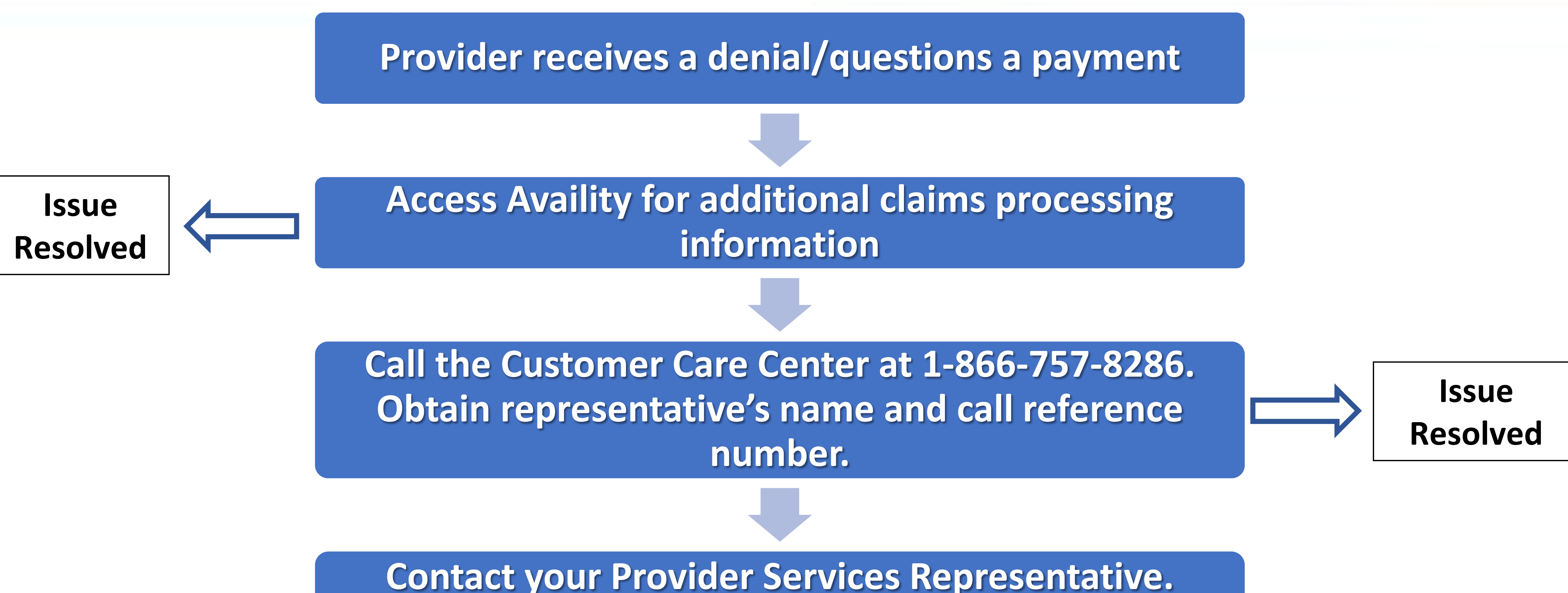
By signing this form, you agree not to bill the member except for any copays that may apply.

Provider Name (please print):

Provider Signature:

www.BlueChoiceSCMedicaid.com
BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association. Healthy Connections is administered for BlueChoice

Claims Work Flow



Verifying Eligibility

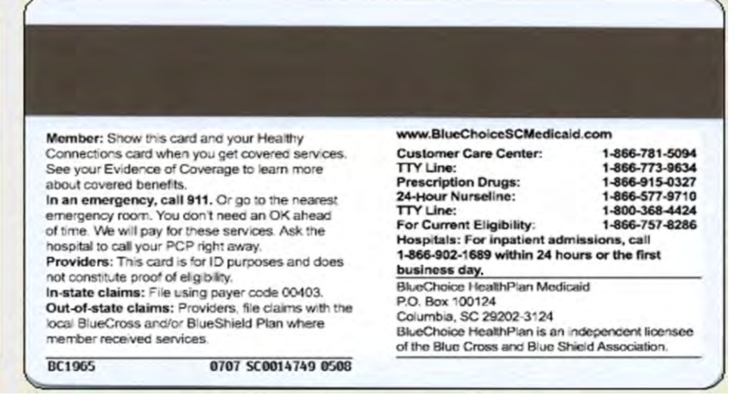
Providers must check member eligibility during each visit. Why?

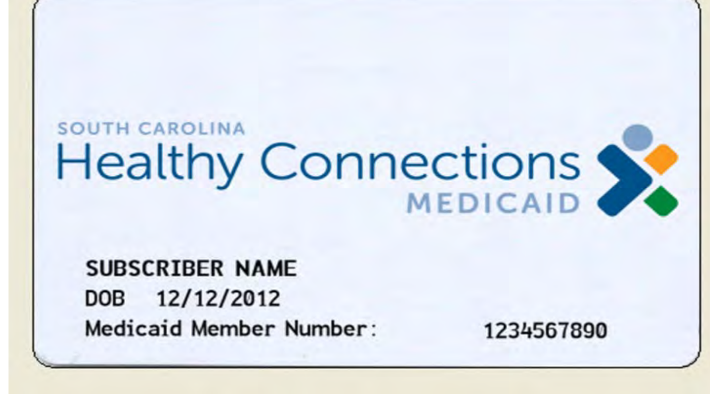
After being assigned to a health plan, a member can switch plans within his or her initial 90 days

Members can also lose their eligibility at any time or have a status change.

- Member ID card
- Customer Care Center: **1-866-757-8286**
- **www.Availity.com**
- SCDHHS Medicaid Provider Service Center at 1-888-289-0709
- SC **https://portal.scmedicaid.com/**

Identification Card





In addition to this BlueChoice HealthPlan Medicaid ID card, members are required to carry their South Carolina DHHS-issued Healthy Connections ID card.

Redetermination

- Members need to renew every year (specifically 12 months from the date of enrollment).
- Members need to update their addresses with Healthy Connections if they have moved
- To renew, members need to fill out the *Healthy Connections Annual Review Form* completely and accurately and send it back before the due date give on the form.
- We encourage members to visit **www.scchoices.com** to make sure their address is accurate.
- Members can visit their local Medicaid office for assistance

Extra Benefits

In addition to the core benefits offered, BlueChoice HealthPlan Medicaid also offers several extra benefits:

- **Free** headphones or earbuds, K-12th
- **Free** diaper bags for newborns
- **Free** cellphone w/ monthly minutes data & texts
- **Free** Girl Scouts memberships, K-8th
- **Free** Youth Explorer Program through Boy Scouts, 3rd-12th
- **Free** car seat
- **Free** circumcisions up to 1 year of age
- **Free** manual breast pump
- **Free** prenatal program
- **Discounts** on Boys & Girls Club fees
- **Free** Internet Essentials program/Free WiFi for 2 months
- **Free** Coupon booklet with discounts to local stores
- **Free** Sports Physicals, K-12th
- **No copays** for preventive/urgent care visits
- **No copays** for some OTC drugs with a prescription
- Healthy Rewards reloadable gift card
- The Blue Book Club℠
- Discounts for Jenny Craig®
- **Free** Med Sync program for same day medicine refills
- Community Resource Link resources for housing, etc.

Pharmacy Management

Medicare

Medicare Formularies 2019

MAPD (HMO & PPO)

- Medication adherence focus (i.e. 90 day scripts)
- Generic medications in lowest tiers
- Additional adherence generics covered

PDP

- Medication adherence focus (i.e. 90 day scripts)
- Generic medications placed in all tiers
- Adherence generics on tiers 1 and 2

Medicare

Drug Management Program…

…to help members safely use their opioid medications

- **Pharmacy and/or Prescriber Lock-Ins (based on prior utilization)**
  - All prescriptions for opioids or benzodiazepines from one pharmacy
  - All prescriptions for opioids or benzodiazepines from one prescriber
  - Limits the amount of opioids or benzodiazepines covered by plan

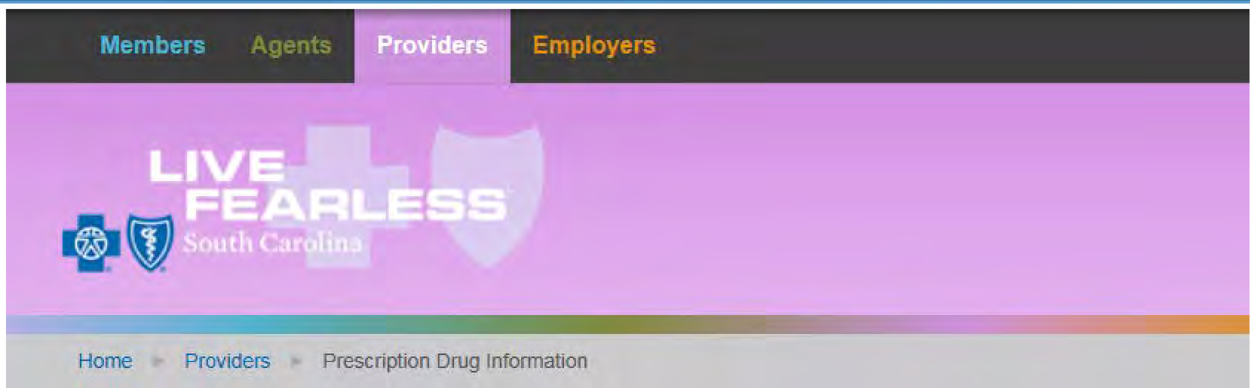
- **Cumulative Morphine Milligram Equivalent Edit Updates**
  - Soft edit for concurrent opioid and benzodiazepine use
  - Soft edit for duplicative long-acting (LA) opioid therapy
  - Care coordination edit at 90 morphine milligram equivalents (MME)
  - Hard edit at 200 MME or more
  - Hard edit 7 day supply limit for initial opioid fills (opioid naïve)

Affordable Care Act Plans (Marketplace/Exchanges)

ACA Formulary 2019

- **Will remain generic centric**
- **Some highlighted changes:**
  - **Buprenorphine products** moving to the ACA Preventive Tier 0 (member copay removed)
  - **Diabetes** – Removal of Humalog products (Novolin and Novolog remain preferred, Humulin remains non-preferred)
  - **Diabetes** – AccuChek will be the preferred diabetic supply brand (OneTouch products removed) Members may call **877-418-4746** to request a new AccuChek meter

Commercial



Prescription Drug Information

Drug Lists

- Drug Management
- Preferred Drug List
- Specialty Drug List
- Excluded Drug List
- Try Generics Drug List

Prescription Drug Programs

- Pharmacy Program Updates
- Specialty Drugs Under the Medical Benefit

No Major Changes in 2019

Commercial

Pharmacy Program Updates

The changes detailed here apply to all groups that use the BlueCross Preferred Drug List (PDL) and the Try Generics Drug List. They do NOT apply to groups using the Caremark Formulary/Performance Drug List.

Most changes to our pharmacy programs and lists are made quarterly. Any member who is using a drug that is affected by a pharmacy program change will receive a letter that describes the change and outlines any action required by the member and/or their doctor.

Changes that trigger a letter include:

- A drug being excluded from the formulary (drug list)
- A drug moving to a higher copay tier
- A drug being added to a pharmacy program, such as Prior Authorization, Quantity Management or Step Therapy.

- January 2019 Update

Commercial

Commercial Formulary 2019

- **Some additions:** Biktarvy, Cimduo, Descovy, Odefsey, Ozempic Symfi/Lo, Vraylar
- **Some deletions:** fenoprofen, Lazanda, Levorphanol, naprelan, Oxtellar XR brand, QudexyXR brand, Remodulin, Tasigna, Trokendi XR brand, Ventavis, Zolpimist
- **Some new preferred specialty drugs:** Bosulif, Erleada, Ibrance, Kevzara, Ksquali, Opsumit, Sprycel, Uptravi, Xeljanz/XR, Xtandi, Zytiga
- **One drug moving to non-preferred:** Cialis brand (due to generic availability)
- **New Prior Authorizations:** Novolin Relion, Kombiglyze XR, Onglyza, Bydureon/BCISE

Specialty Medical Benefit Management

Recent Updates:

- A majority of our self-funded clients added these programs in the spring. Several more to add for 1/1/19.
- State Health Plan: Added Medical PA through Novologix 1/1/18. Added Site of Care steerage – soft implementation 10/1/18; full implementation 1/1/19.

New Programs

Enhanced Safety & Monitoring

- 10/1/18 – implemented for all Exchange, fully insured and BlueChoice members
- PBM identifies and helps BlueCross target the most severe cases of fraud and abuse
- Prescriber and member outreach
- Few members; big impact

Pharmacy Advisor Counseling

- 10/1/18 – pilot program; all BlueChoice members and BlueCross employees
- A CVS-based program for members with certain chronic conditions when they receive an initial prescription for a chronic condition, are non-adherent or have gaps in their drug therapy
- Program includes mailings as well as face-to-face and telephonic encounters with a pharmacist

Navigating Medicare Advantage Members' Pharmacy Benefit

- E-scribe NCPDP Mail (0322038) Specialty (1466033)
- CVS Caremark Mail Fax: 1-800-378-0323
- CVS Caremark Mail Address
  PO Box 94467
  Palatine, IL 60094-4467
- Coverage Determinations & General Inquiries: 1-855-344-0930
- Coverage Determinations Fax: 1-855-633-7673
- Websites: www.caremark.com
  www.SCBluesMedadvantage.com

Navigating ACA Members' Pharmacy Benefit

- Websites
  - ✓ BlueCross: www.SouthCarolinaBlues.com
  - ✓ Blue Choice: www.BlueChoiceSC.com
- CVS Caremark **Mail Order Pharmacy**
  - ✓ Phone: 800-378-5697
  - ✓ Fax: 800-378-0323
- CVS Caremark **Prior Authorizations** & **Formulary Exceptions**
  - ✓ Phone: 855-582-2022
  - ✓ Fax: 855-245-2134
- CVS Caremark **Specialty Prior Authorizations**
  - ✓ Phone: 866-814-5506
- CVS Caremark **Appeals**
  - ✓ Phone: 855-582-2022
  - ✓ Fax: 855-245-8333

Navigating Commercial Members' Pharmacy Benefit

➢ **For lists of covered drugs, excluded drugs and drug management programs:**

- **BlueCross:** http://web.southcarolinablues.com/providers/prescriptiondruginformation/druglists.aspx
- **BlueChoice:** https://www.bluechoicesc.com/providers/specialty-drugs-and-pharmacy-drugs

To request a formulary exception: Requests go to Caremark or come in-house. See Excluded Drug List for more information.

➢ **To request a Prior Authorization or override for Step Therapy or Quantity Management*:**

For non-specialty: Use drug-specific fax form

- **BlueCross:** https://web.southcarolinablues.com/providers/forms/prescriptiondrugs/prescriptionplans.aspx
- **BlueChoice**: https://www.bluechoicesc.com/providers/oral-drug-step-prior-authorization-forms

For Specialty PAs: Contact CVS/specialty at 800-237-2767 (phone) or 866-249-6155 (fax).

*Some quantity management drug reviews come to BlueCross or BlueChoice to review. If you do not find a fax form, contact the precertification number on the back of the member's ID card.

Authorizations

What Is an Authorization?

Authorizations are necessary for certain services where a member's plan needs notification before treatment is administered. In these cases, the plan and providers work together to ensure the best care is offered to the member.

You may also see these terms used when referring to authorizations:

- Prior Authorization
- Prior approval
- Precertification

Note: Precertification requirements vary depending on each plan.

Authorization Requirements

Services that require authorization:

- 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 Abuse
- MRIs, MRAs, and CT Scans (required through NIA Magellan)

Check benefits and eligibility for authorization requirements!

***Some plans have exceptions to authorization requests.**

Benefits of Obtaining Authorizations

- Offers cost savings to patients
- Offers cost savings to providers
- Promotes in network participation
- Identifies additional programs and services to benefit patients

Preauthorizations allow for review of clinical information, inclusion in BlueVue, Caremark, NIA, etc., ensuring stop gaps are in place for contraindications, non-covered prescriptions, etc.

How to Efficiently Submit an Authorization

- Submit a request once and allow time to process…many requests are duplicates
- Submit all requests with specific and complete information
- Set up your documents as if they are going to someone the first time
- Request authorization training

When Do You Request?

- Prior to qualified services being rendered
- Within 24 hours of qualified emergent services

An Authorization Request Answers Three Basic Questions

1. Who are you?	Provider Information
2. What do you want to do?	Service Information
3. Who needs it?	Patient Information

Authorization Process

1. Verify requirements

2. Initiate request

3. Submit all relevant information and include:

- Patient name
- Member ID number
- Date of birth
- Date of service
- Service details (CPT/HCPCS, diagnoses, etc.)
- Provider name and tax ID or NPI number

4. Receive decision

- Approval – Proceed with service
- Denial – Review the information submitted to ensure it was submitted correctly. You can ask for peer to peer or appeal, when appropriate

Authorization Methods

My Insurance Manager

- Web based feature, includes **Fast Track options**, many auto approve

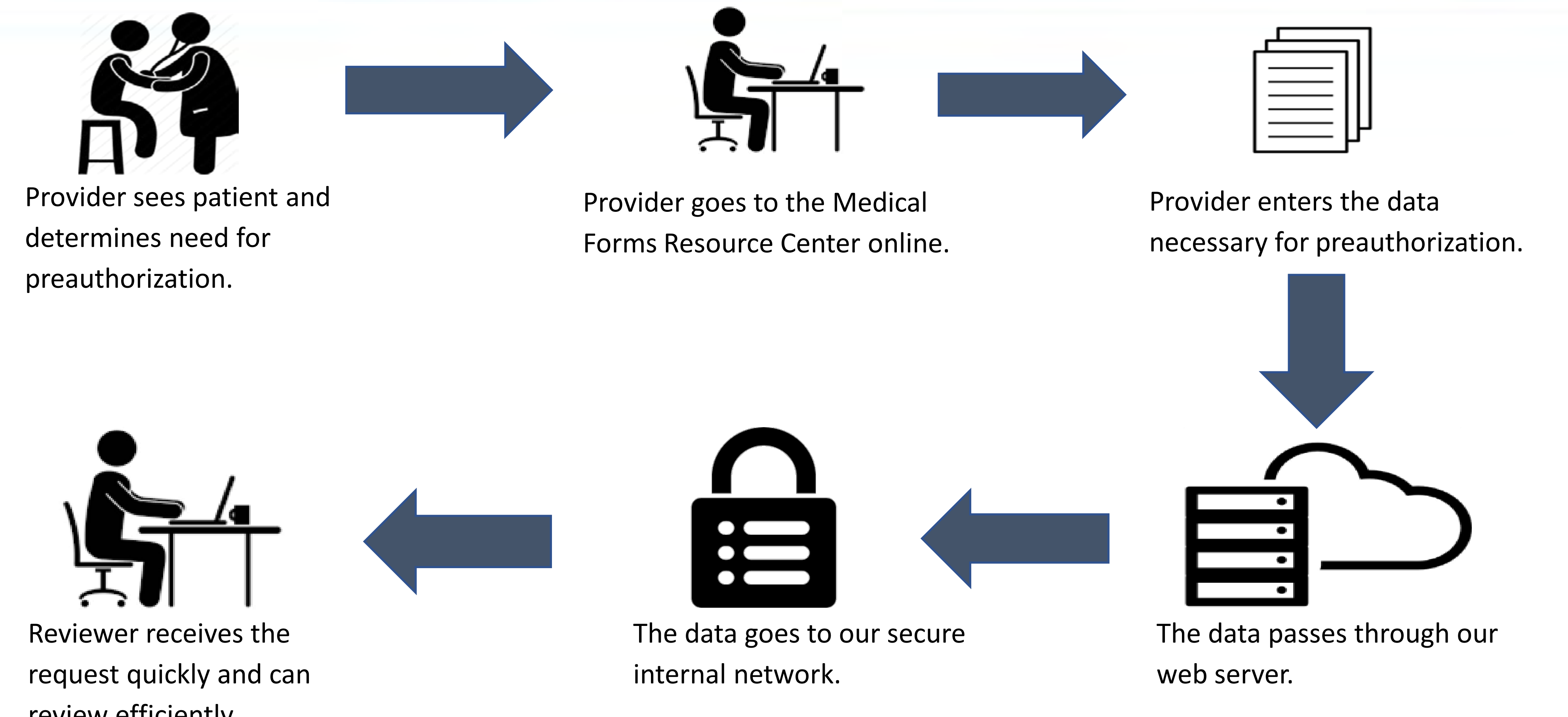
Medical Form Resource Center

- Web based method, requests pend for review

Fax

Phone

Medical Forms Resource Center (MFRC)



To use the MFRC, visit www.formsresource.center or visit the Providers page of our websites, www.SouthCarolinaBlues.com or www.BlueChoiceSC.com.

Types of Services Available

- ✓ To see the full list of the forms available, select **SEE A FULL LIST OF FORMS** on the home screen.
- ✓ You can use My Insurance Manager to check the status of your request.
- ✓ You will receive approval or denial using existing methods.
- ✓ MFRC requests pend for review.
- ✓ Both web-based methods, MFRC and My Insurance Manager, are expedited.

FULL LIST OF FORMS:

Chemotherapy
- Chemotherapy Notification

Durable Medical Equipment
- Continuous Glucose Monitoring
- Insulin Pump
- Lymphedema Pump
- Neuromuscular Stimulator
- Orthotics
- Prosthetics
- Wound Vac
- Miscellaneous

Home Health/Hospice
- Home Health
- Hospice

Admissions/Inpatient
- Breast Reduction
- Chemotherapy
- Excision of Lesion Tumor Mass
- General Precertification
- Hysterectomy
- Spinal Fusion Diskectomy Laminectomy

LTAC/SNF/Rehab
- LTAC
- SNF/IP Rehab

Maternity
- Maternity Notification

Medications
- General Medication Request

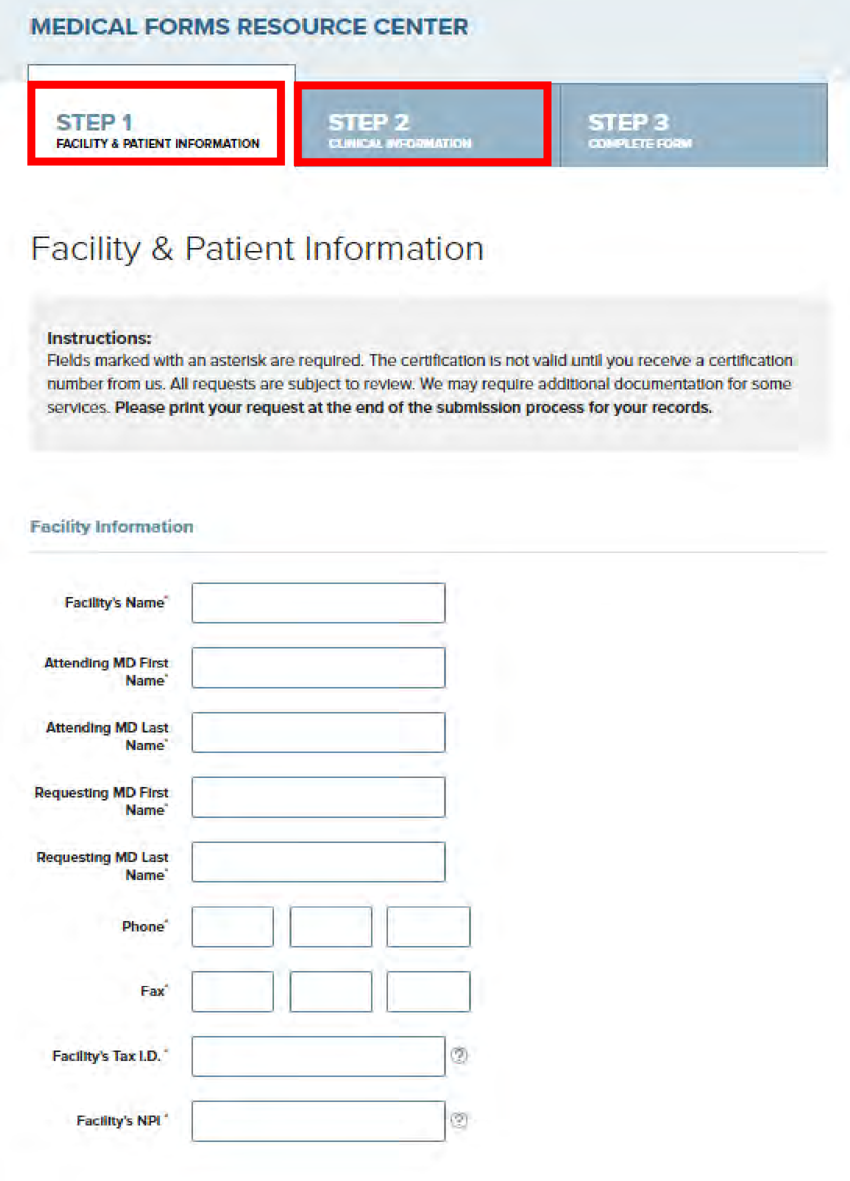
Office
- Breast Reduction
- Chemotherapy
- Excision of Lesion Tumor Mass
- General Precertification
- Radiofrequency Facet Ablation
- Septoplasty

Outpatient
- Breast Reduction
- Chemotherapy
- Excision of Lesion Tumor Mass
- General Precertification
- Hysterectomy
- Radiofrequency Facet Ablation
- Septoplasty
- Spinal Fusion Diskectomy Laminectomy

Three Easy Steps

Step 1

- ✓ Facility information
- ✓ Practitioner information
- ✓ Contact person's information
- ✓ Patient information



Step 2

- ✓ Date(s) of service
- ✓ CPT/HCPCS code(s)
- ✓ Diagnosis code(s)
- ✓ Select Type of Service

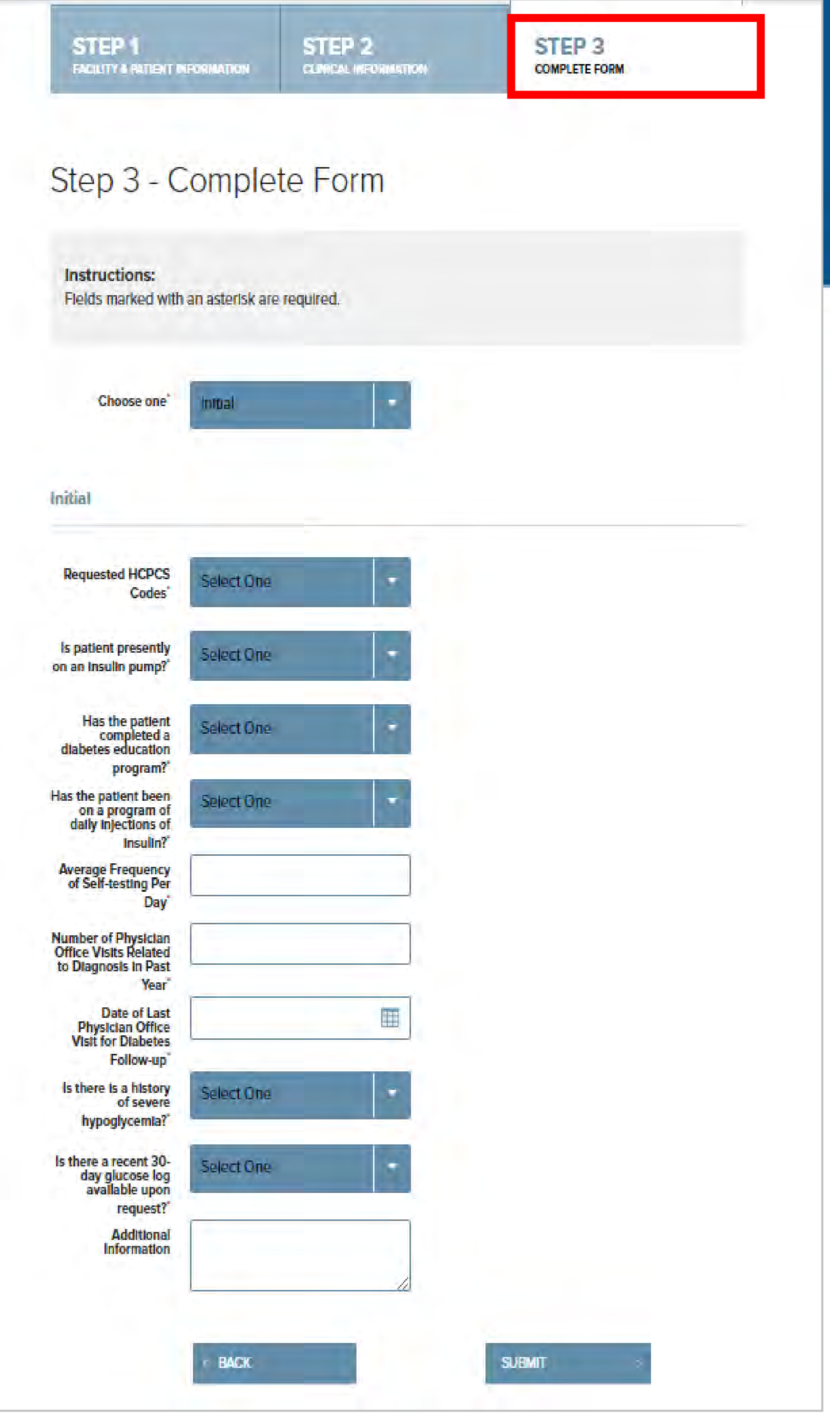
Three Easy Steps

Step 3

The last step will tell you exactly what information is needed to complete your request.

Use the "Print this submission" button to print or save a copy of the request.

Identifying user information will auto-populate for specific providers after initial use.



Coming Soon

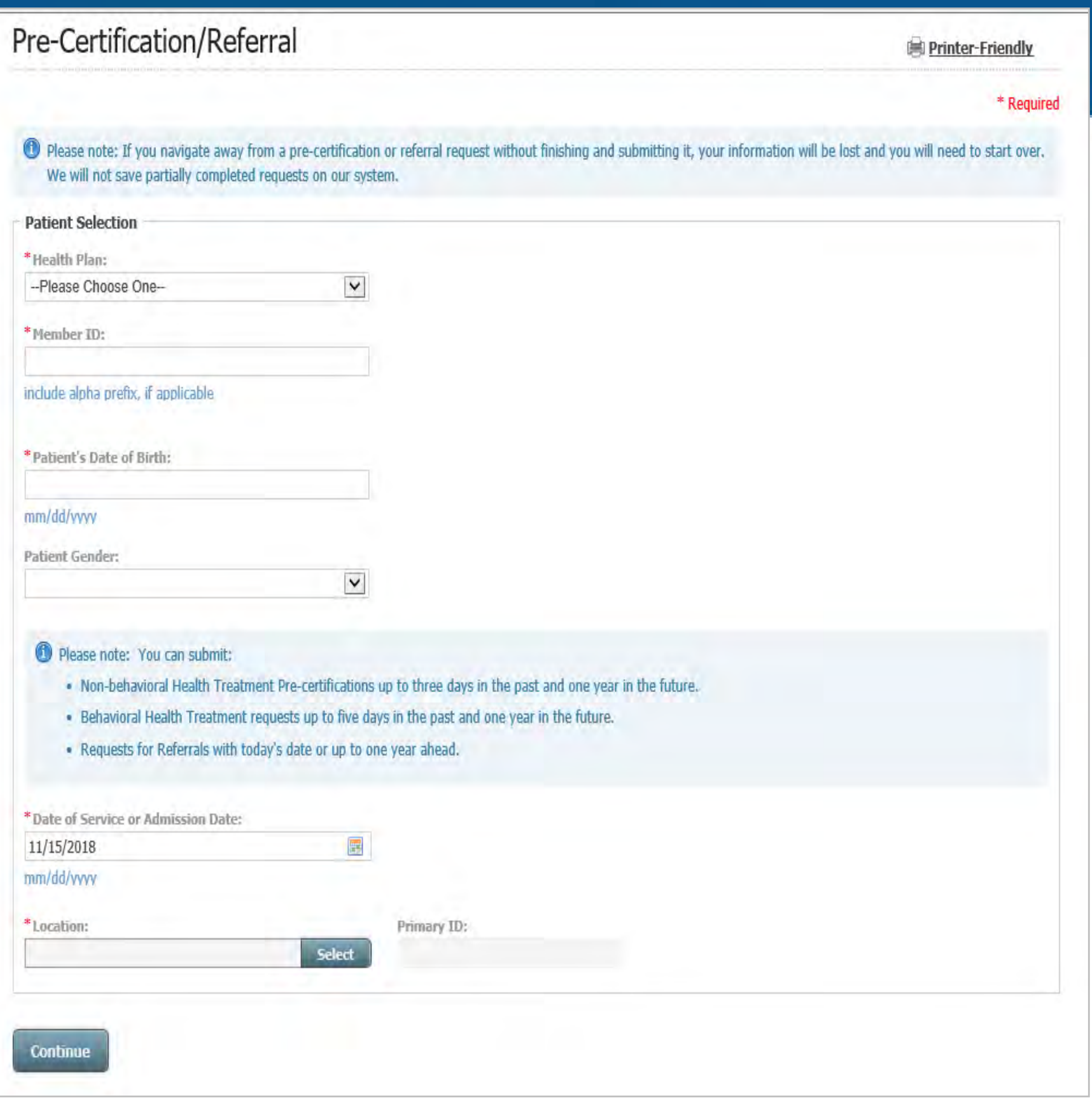
We are adding new forms to the MFRC!

- December 2018 — Peer to Peer Requests
- January 2019 — Student Health Forms
- First Quarter 2019 — Discharge Forms
- First Quarter 2019 — Continued Stay Reviews

My Insurance Manager

My Insurance Manager is the best option for Fast Track Requests. These are the services that typically do not require additional information and will give you an authorization number upon completion.

There are hundreds of Fast Track Requests available, many which automatically approve!

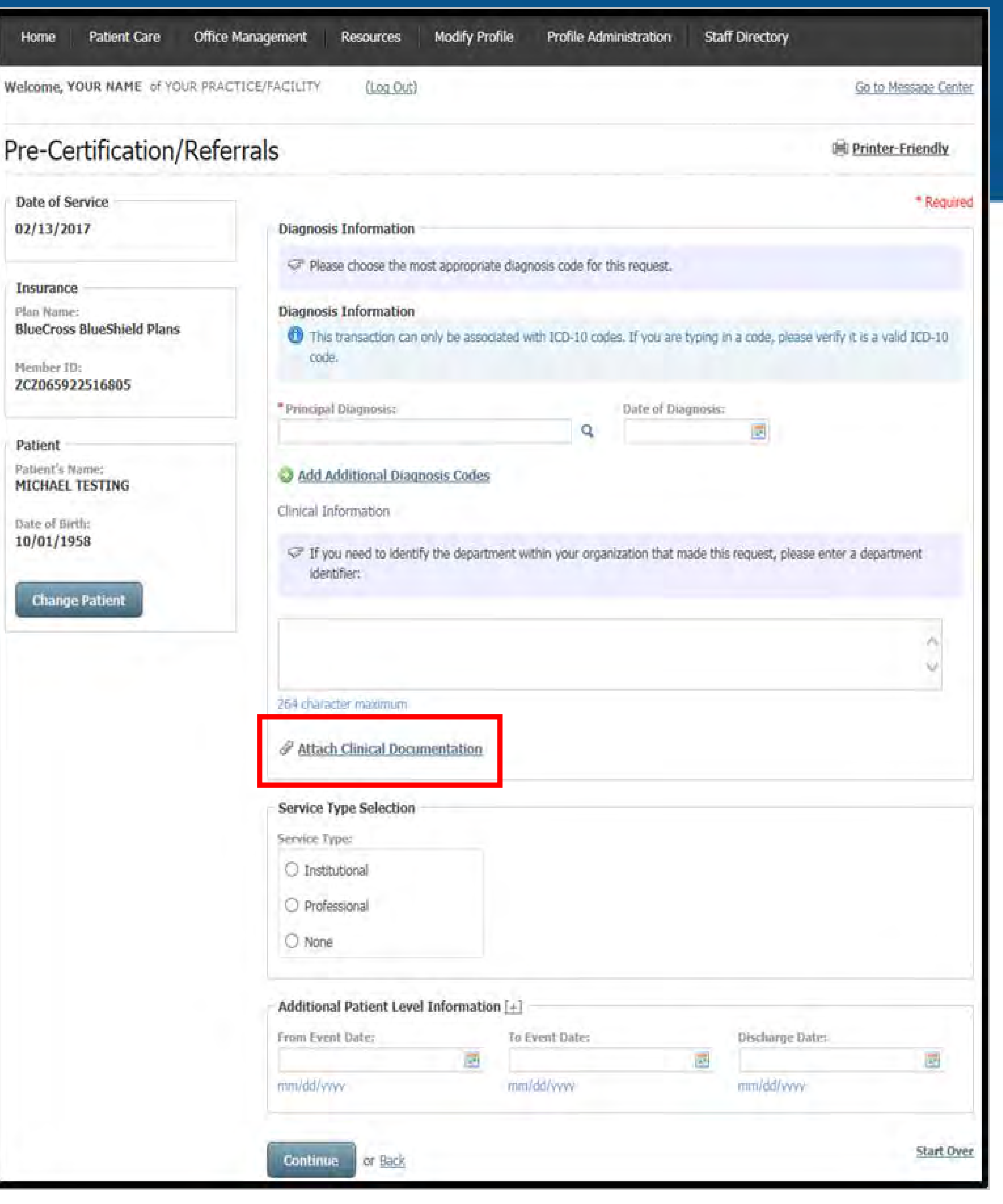


My Insurance Manager

Clinical Attachments

To attach clinical information for authorization requests that pend, follow these steps:

- Choose **Attach Clinical Documentation** from the Diagnosis Information page within the Precertification/Referral progression.
- **Attach a File** when prompted. Follow guidelines for acceptable file type and size.
- **Confirm** the attached document.
- Upload up to 10 attachments per request. Remove any document as needed.
- Select **Continue**.
- Complete required fields for Contact Name, Phone Number and Fax Number, then **Continue**.



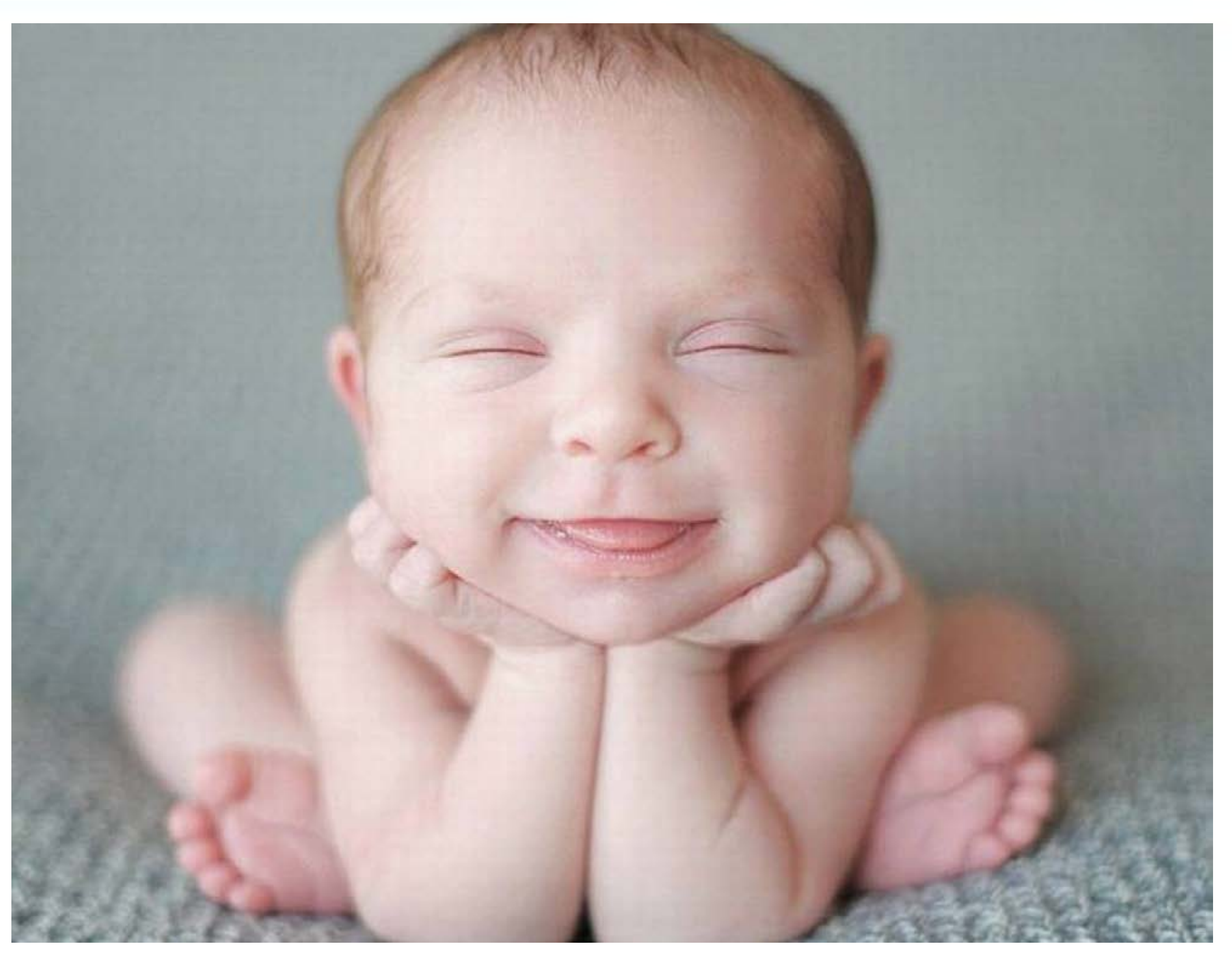
Fax Requests

When submitting fax requests, please include a coversheet which includes the following:

- Patient name
- DOB
- CPT code/DX code
- Fax number
- Contact number (with extension)
  - When using My Insurance Manager, include in "provider notes" section

Providing this information allows us to process your request quickly and reduces delays.

Obstetricians and Gynecologists Tips



- MFRC Forms Available
  - Hysterectomy
  - Maternity Notification
- Health Coaches
  - Initiated with notification
- Online pregnancy tool
  - Provides additional education for expectant moms, including post partum care tips

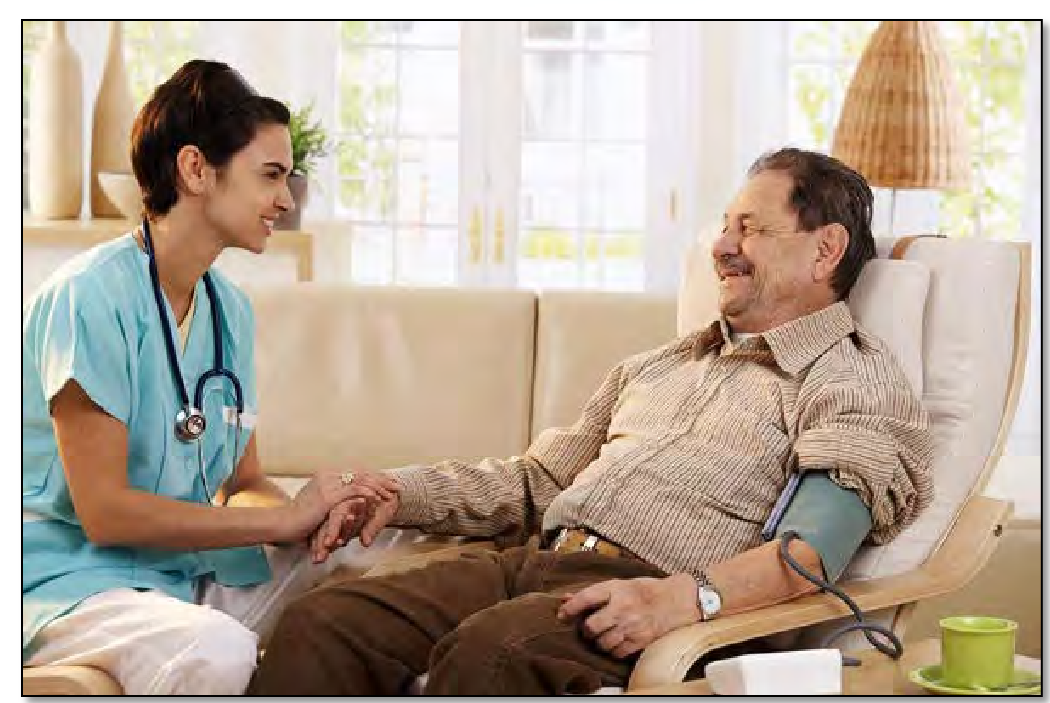
Durable Medical Equipment Tips

When initiating authorization requests for DME…

- Build requests as DME (instead of HOME) – even when being used at home.
- Include the estimated cost of the item – some plans have a ceiling. Below the ceiling? No preauthorization required.
- Include an UPDATED Letter of Medical Necessity with the UPDATED clinical notes to include diagnosis codes that support the member's diagnosis.
- Use MFRC for pre-formatted DME requests.
- Refer to medical policy CAM 115 Durable Medical Equipment for additional information and guidance.

Home Health Services Tips

- Approval is only for one month at a time. Avoid requesting all services at one time.
- Request specific services and be sure to include the rendering physician to avoid conflicting authorizations.
- Inform us when a patient hasn't used the complete date range of services. Our team will then update the authorization to reflect change(s).
- Communication is vital: Please respond to requests for additional information! It may be what is delaying approval.
- Too much information: when requesting additional days, give clinical update since last request, not entire history
- Do not request additional days before the dates of service end date.



Authorization and Benefit Management Partners

Other companies manage authorization for certain benefits.

- **NIA Magellan (NIA)**
  - Advanced radiology
  - Radiation oncology
  - Musculoskeletal treatment
  - Nuclear cardiology
- **Avalon Healthcare Solutions (Avalon)**
  - Laboratory services
- **NovoLogix and CVS/Caremark**
  - Drugs
  - Specialty drugs
- **Companion Benefit Alternatives (CBA)**
  - Mental health
  - Behavioral health
  - Substance abuse

Magellan Healthcare

Radiation Oncology

Once you successfully submit all required patient clinical information 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 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.

**NIA Magellan is an independent company that manages authorization for certain services on behalf of BlueCross and BlueChoice.*

Magellan Healthcare

Musculoskeletal Program

There are 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.
- Authorization for emergency spine surgery cases that are admitted through the emergency room or for spine surgery procedures outside the procedures listed on our websites should be requested through our Plans.
- Providers rendering these services should verify 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.

Magellan Healthcare

Visit www.RadMD.com for additional information about RadMD.

To request an authorization or review the status of an authorization:

- Visit www.RadMD.com or
- BlueCross members call 866-500-7664
- BlueChoice members call 888-642-9181

NovoLogix and CVS/Caremark

We require authorization for some specialty drugs through the CVS/Caremark* authorization tool, NovoLogix**.

This tool is available via My Insurance Manager with single-sign on access.

Three ways to get prior authorizations:

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

*CVS/Caremark is an independent company that provides pharmacy services on behalf of BlueCross and BlueChoice.
**NovoLogix is an industry-leading software system that assists in managing drugs reimbursed under the medical benefit.

Laboratory Benefit Management

We require some groups to obtain precertification for specific laboratory services through Avalon Healthcare Solutions*.

Genetic Testing

An authorization is applicable when services are provided in an office, outpatient or independent lab location.

**Avalon Healthcare Solutions (Avalon) is an independent company that manages authorization for lab services on behalf of BlueCross and BlueChoice.*

Laboratory Benefit Management

Other Information

- Always refer members to network participating labs
- **Avalon manages all laboratory services with the EXCEPTION of inpatient and emergency room services.** This does not alter the available member benefits, but using participating providers will result in lower out-of-pocket costs for your BlueCross and BlueChoice members.

Companion Benefits Alternative (CBA)

Some members are required to get authorization for mental health, behavioral health and substance abuse services through CBA*.

Determine authorization requirements when verifying eligibility and benefits for each member.

Examples of services that do require authorization:

- Psychological testing
- Repetitive transcranial magnetic stimulation (rTMS)
- Behavioral health program admissions

Many health plans no longer require authorization for routine office visits, including:

- Psychiatric evaluation
- Medication management
- Psychotherapy

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

General Guidelines for All Authorizations

- Submit preauthorization in advance of the service with complete information
- Elective surgeries have up to 15 days for review
- Emergency authorizations: submit within 24 hours, the next day at the latest
- Mark URGENT what is urgent
  - 80 percent of our workload is marked urgent
  - Decreases likelihood of truly urgent being handled

And Just a Reminder

The beginning of a new year brings about an increase in authorization requests. The highest volume of authorization requests are received in January.

Avoid long customer hold times.

Use the MFRC and My Insurance Manager!

Resources and Other Information

Benefit Program	Authorization Service	Web-based Requests	Fax Requests	Telephone Requests
BlueCross	Various	My Insurance Manager and MFRC	803-264-0258 (utilization management) 803-264-0259 (case management)	800-334-7287
BlueChoice			800-610-5685	800-950-5387
Federal Employee Program			N/A	800-327-3238
State Health Plan (Medi-Call)			803-264-0183	800-925-9724
Medicare Advantage			803-264-6552	855-843-2325
Avalon	Laboratory	N/A	888-791-2181	844-227-5769
CBA	Behavioral and substance abuse	www.CompanionBenefitAlternatives.com	803-714-6456	800-868-1032
NIA Magellan	Advanced Radiology	www.RadMD.com	888-656-1321	BlueCross: 866-500-7664 BlueChoice: 888-642-9181
	Musculoskeletal Care			
	Nuclear Cardiology			
	Radiation Oncology			
NovoLogix	Specialty Medical Drug	My Insurance Manager	844-851-0882	866-284-9229

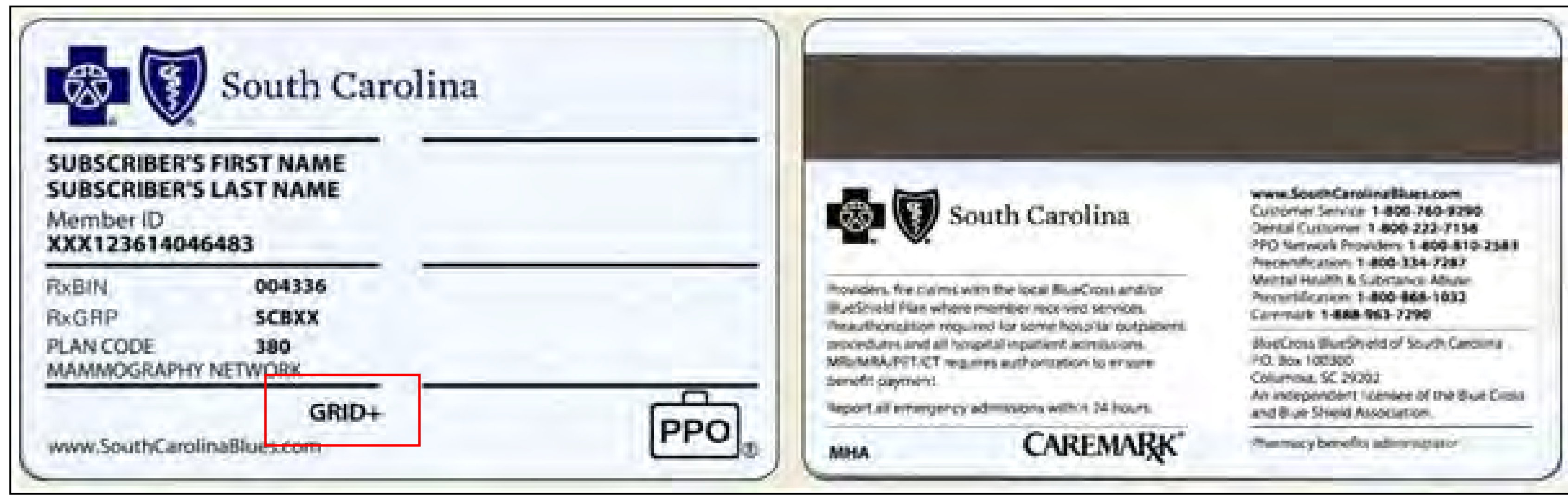
Dental Plans

Dental GRID

- Dental GRID allows dentists to see members from other participating BlueCross and BlueShield Plans at local Plan reimbursement levels.
- Our participating providers' reimbursement levels or provider agreements will not change when treating a GRID member.
- There are over 30 participating Plans, all independent licensees of the Blue Cross and Blue Shield Association.

Dental GRID

- You can recognize a program member by noting the word “GRID” or “GRID+” on the member’s ID card.
- Contact Customer Service if you need to verify a member’s participation in the Dental GRID program in cases when it is not shown on the member’s ID card.

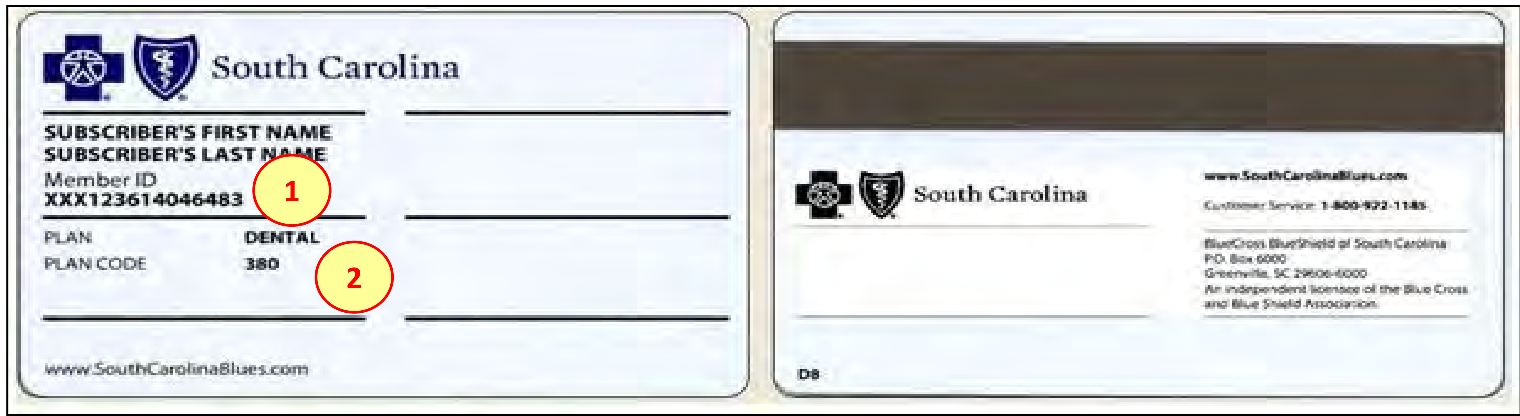


Sample Commercial-Medical and Dental ID Card

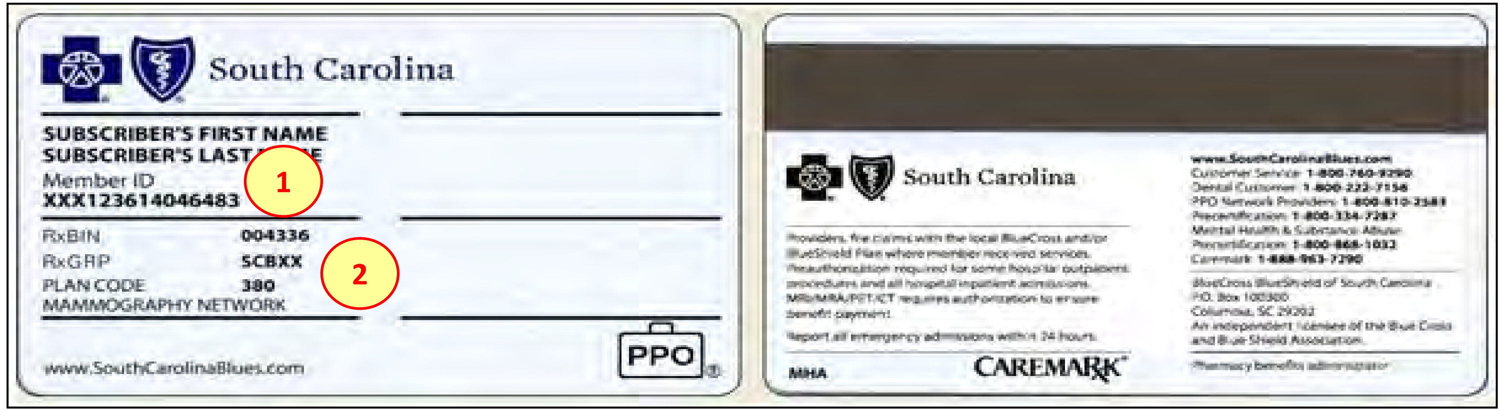
Commercial Dental Plans

- Some dental plans use a network of participating providers and other plans do not have a network.
  - We encourage members to choose in-network providers.
- Coverage levels include:
  - Preventive care
  - Restorative care
  - Major restorative care
  - Implant coverage (some plans may not offer this benefit)
  - Orthodontic care (some plans may not offer this benefit)

Commercial Dental Plans



Sample Commercial-Dental Only ID Card



Sample Commercial-Medical and Dental ID Card

Identify plan members by noting these important elements on their ID card:

1. Member ID number
2. Plan code

Commercial Dental Plans

Sample Commercial-Dental Only ID Card

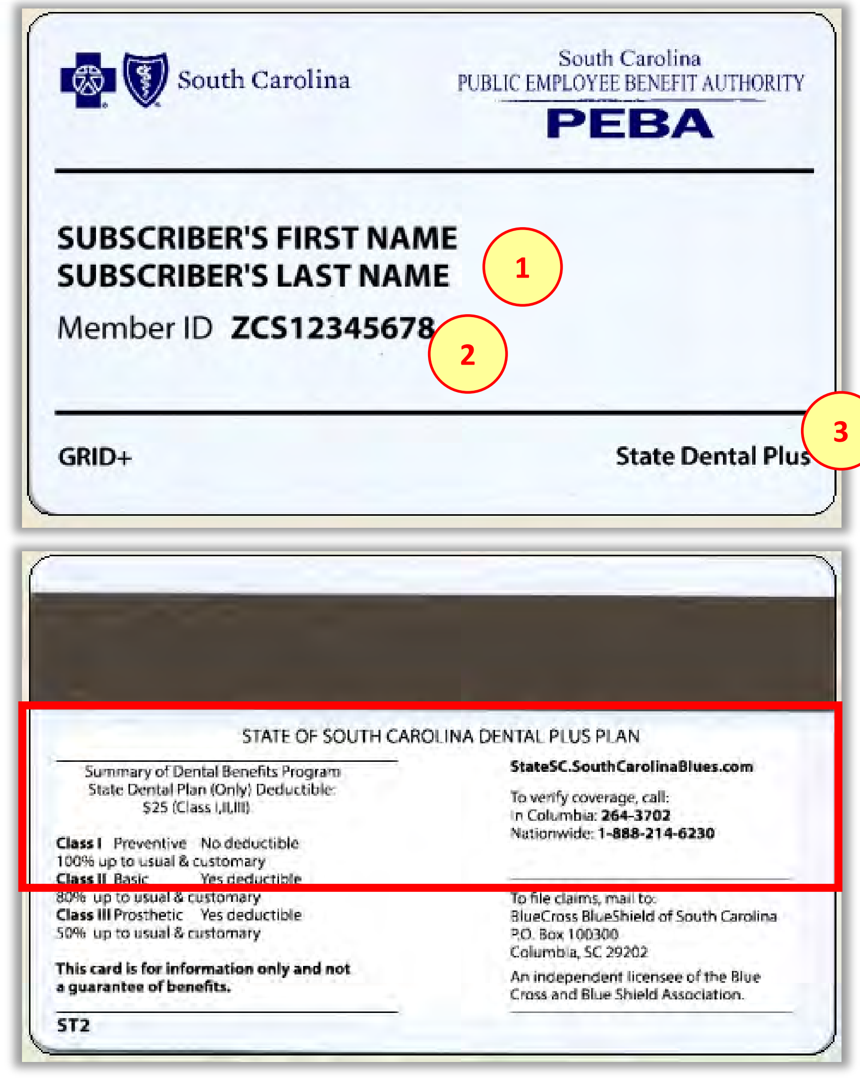
Sample Commercial-Medical and Dental ID Card

On the back of the member's ID card is a helpful customer service telephone number.

State Dental & Dental Plus Plans

- The Public Employee Benefit Association (PEBA) uses BlueCross BlueShield of South Carolina as an administrator for their dental plans.
- Dental Plus provides a higher reimbursement level for services the State Dental Plan covers.
  - Members pay the entire premium.
  - Dental Plus pays up to $1000 for covered services in addition to $1000 maximum payment under State Dental Plan.
  - Dental Plus members utilize the BlueCross BlueShield of South Carolina Participating Dental Network for network benefits.
- Dental Plus only covers services that the State Dental Plan covers.
- State Dental Plan Fee Schedule is available in My Insurance Manager.

State Dental & Dental Plus Plans



- Identify State Dental Plus plan members by noting these member ID card elements:
  1. Subscriber’s first and last name
  2. ID number
  3. Plan name
- On the back of the member’s ID card is a helpful customer service telephone number
- You can also find a brief summary of benefits

FEP: Standard Option (Medical) Routine Dental Benefits

- No deductibles, copayments or coinsurance.
- Member pays all charges in excess of the listed fee schedule amounts when using a non-preferred dentist.
- Member pays the difference between the fee schedule amount and the BlueCross Participating Dental Allowance when using a preferred dentist.

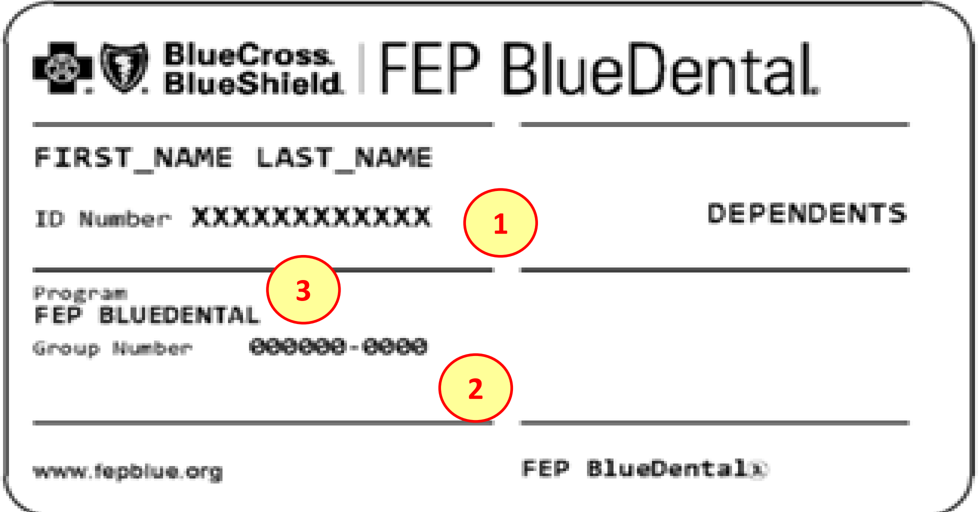
FEP: Basic Option (Medical) Routine Dental Benefits

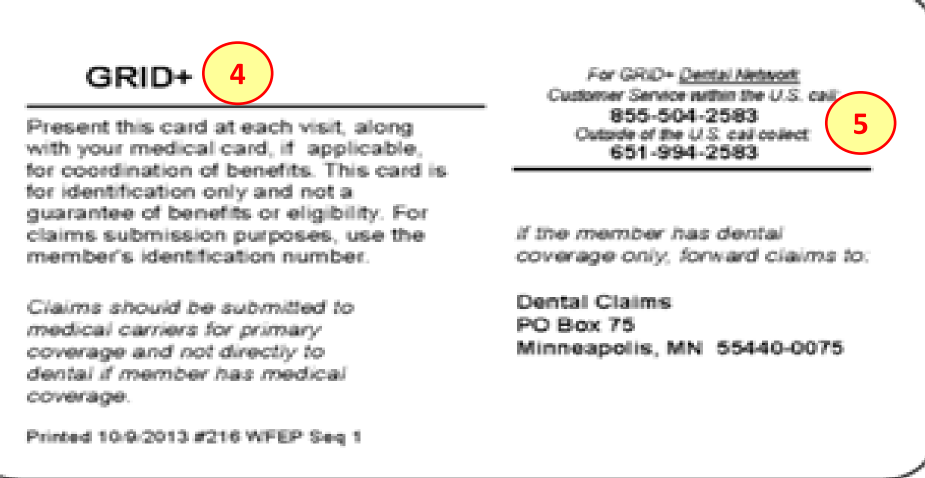
- Members pay $30 copay for evaluations; FEP pays any balances up to the BlueCross Preferred Blue Participating Dental Allowance.
- Basic members must use preferred dentists to receive benefits.

FEP BlueDental®

Identify FEP BlueDental Plan members by noting these elements on the member ID card:

1. Member ID number
2. Group number
3. Program name
4. Provider network
5. Customer Service telephone number and dental claims address





Sample FEP BlueDental ID Card

Other FEP Dental Information

- Members that are covered by FEP Basic Option medical plan and FEP BlueDental (High and Standard options), will not be responsible for the annual (calendar year) deductible when using an in-network provider.
- You should not collect copays or deductibles from these members.
  - If you collect, you are required to reimburse the member in full once the claim has processed under FEP BlueDental.
- **For the first time, TRICARE retirees are eligible to enroll and select their own dental coverage including FEP BlueDental.**

BlueCross Secure and Total Medicare Advantage Dental

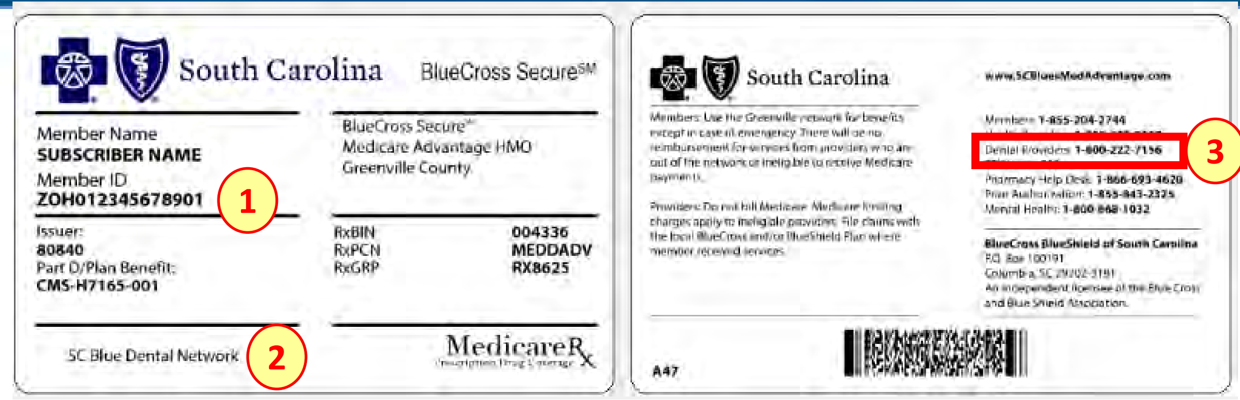
- Beginning January 1, 2019, the BlueCross Secure and Total health benefit plans will include dental and utilize the Participating Dental Network for the dental benefits.
- Letters were sent in mid-November to those Participating Dental Network providers sharing benefits and plan design information without an active Medicare Opt Out.
- Those providers, with an active Medicare Opt Out, received a separate letter advising that they were not eligible to see these members. Instructions for opting back in to Medicare were provided in that letter if the provider was eligible.

BlueCross Secure and Total Medicare Advantage Dental

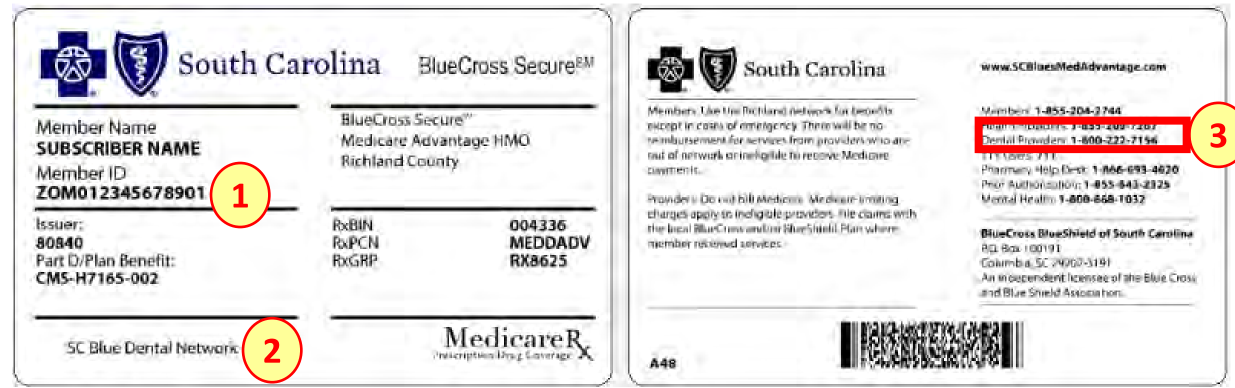
Covered services rendered by an in-network dental provider are covered at 100%. This plan has no deductible and no yearly maximum. Please note that any services not listed below will not be a covered benefit and will be 100% patient liability up to your submitted charge.

Services that are covered for the member	Frequency
Periodic Oral Exam	Two per calendar year, includes D0150
Comprehensive Oral Exam	Two per calendar year, includes D0150
Bitewing X-rays	One set per calendar year
Prophylaxis (Cleaning)	Two per calendar year
Amalgam Restoration (Fillings)	One per calendar year
Composite Restorations (Fillings)	Two per calendar year
Crowns	One crown per calendar year
Extraction, erupted tooth or exposed root	Limited to 5 teeth per calendar year
Reline complete denture, Upper and Lower	One per calendar year, each
Anesthesia-analgesia, anxiolysis	As needed

BlueCross Secure Medicare Advantage Dental



Sample BlueCross Secure ℠ ID Card



Sample BlueCross Secure ℠ ID Card

Important elements on ID card:

1. Member ID number
2. SC BlueDental Network
3. Customer service telephone number

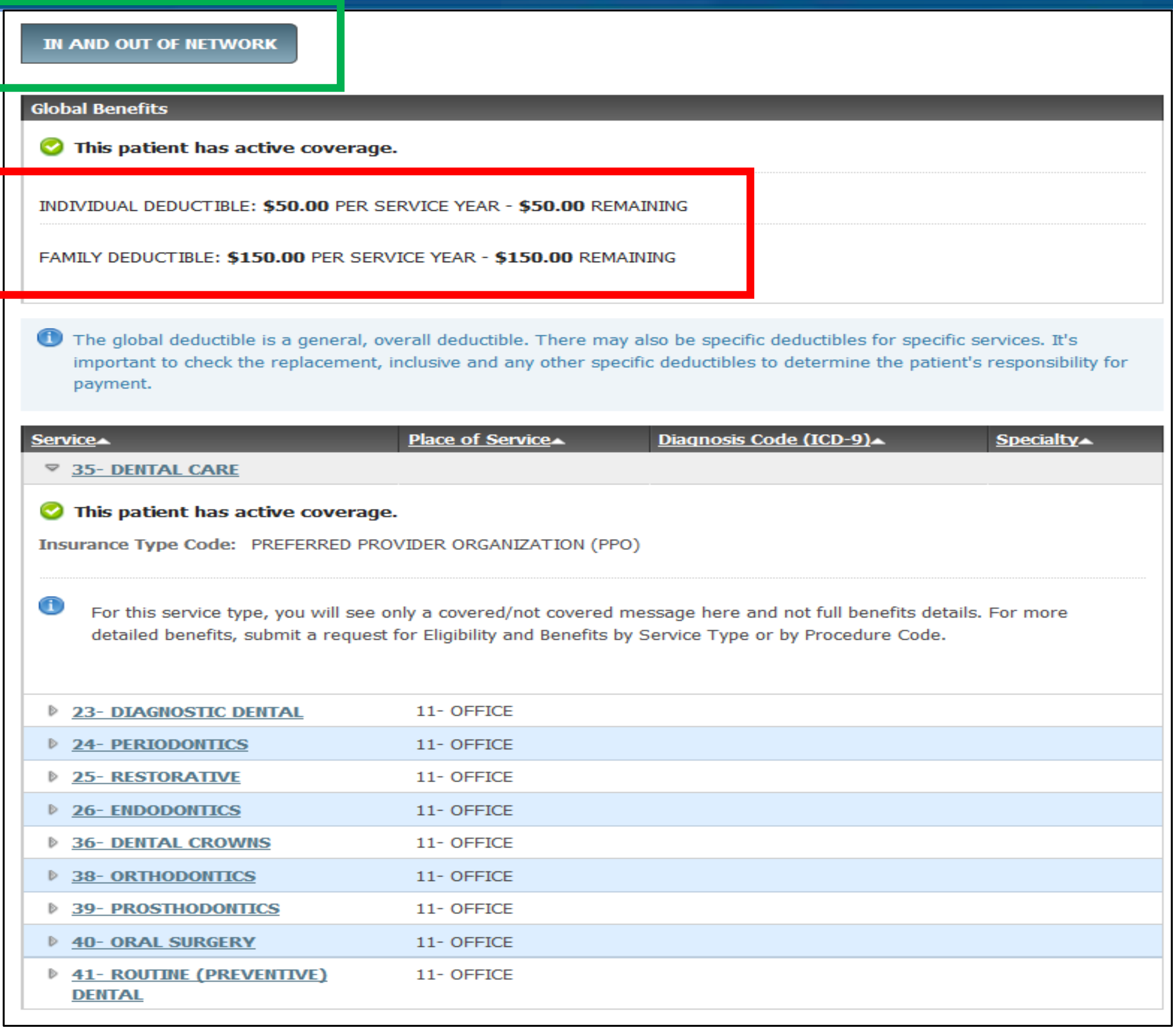
BlueCross Total Medicare Advantage Dental

Sample BlueCross Total ID Card

Important elements on ID card:

1. Member ID number
2. SC BlueDental Network
3. Customer service telephone number

Verifying Eligibility & Benefits



Use My Insurance Manager to verify eligibility and benefits.

This is not applicable to out-of-state or FEP BlueDental members.

Contact Service Centers

Verifying Eligibility & Benefits

Contact plan service centers for member benefits.

Plan	Provider Services Voice Response Unit (VRU)	Fax
Commercial Dental Plans	800-222-7156 (Columbia center) 800-922-1185 (Greenville center)	803-264-7629
State Dental and Dental Plus	888-214-6230 or 803-264-3702 (Columbia area)	803-264-7739
FEP BlueDental	855-504-2583	
FEP Dental (Medical)	800-444-4325	
BlueCross Secure and Total (MA Dental)	800-222-7156	803-264-7629

Filing Dental Claims

Contact plan service centers for member benefits.

Filing dental under medical benefits

- Use an 837P format with the accurate diagnosis code when rendering oral surgical services under State Dental and health plans.
- For FEP BlueDental, always file claims to the medical plan first.

Filing orthodontic claims electronically

- Submit one line with banding fee code (D8080-D8090) and the charge.
- Submit one line with the monthly adjustment code (D8670) and the total months of treatment and total charge.
- For a transfer case: Submit one line with the monthly adjustment code, total months of treatment remaining and total charge for the remaining monthly adjustments.

Filing Dental Claims

General guidelines

Dental Plan	Claims Filing Procedures
Commercial and BlueCross Secure and Total (MA Dental)	Submit claims electronically using HIPAA 837D format. Use carrier (payer) code 38520. If applicable, mail paper claims to the mailing address on the back of the member's ID card. Timely filing varies. Verify when checking eligibility and benefits.
Dental GRID	Send claims to the mailing address on the member's ID card.
FEP BlueDental	Submit all claims to the member's primary medical plan first. See the member's medical ID card for submission. Timely filing is December 31 of the year following the year of service.
State Dental and Dental Plus	Submit claims electronically using HIPAA 837D format. Use carrier (payer) code 38520. Timely filing is 24 months from date of service. Do not file a separate claim for Dental Plus members.
FEP Dental	Submit all claims to the member's primary medical plan first. See the member's medical ID card for submission. Timely filing is December 31 of the year following the year of service.

Other Important Information

BlueCross uses Dentistat Inc. (a credentialing verification organization) to credential and re-credential the Dental Provider Network.

- Dentistat performs all verifications according to the accepted industry standards as well as NCQA standards.
- Occasionally your office may be contacted by Dentistat Inc.

Medical Policies

Medical Policies

About Our Medical Policies

- Written to address procedures, treatments, devices and drugs proven to be safe and effective for a particular disease or condition.
- Continually reviewed for new medical advances and technology.
- Expert sources in relevant clinical areas are consulted in medical policy decision-making.
- Clinical situations and medical policies are reviewed and updated regularly.
- Accessible for members, physicians and providers.

Medical Policies

Where Are the Medical Policies?

- **www.SouthCarolinaBlues.com**
  - Education Center
- **www.BlueChoiceSC.com**
  - Resources
- **Other website pages**
  - Quality Initiatives
  - Laboratory Benefits Management
    - Laboratory Summary: Common Medical Policy Edits

Medical Policies

Disclaimer Page

- The inclusion of a medical guideline does not indicate that the referenced service or supply is necessarily available to all members.
  - Medical policies provide guidance and criteria for covered benefits.
  - Verify eligibility and benefits for all members prior to rendering services.
- The existence of a medical guideline is not an authorization.
  - Covered services where the patient meets the medical policy criteria may require authorization, per the member's benefit guidelines.
  - Verify authorization requirements when checking eligibility and benefits.
- Medical policies ARE NOT medical advice and DO NOT guarantee any results or outcomes.

You must accept the disclaimer to proceed with viewing medical policies.

Medical Policies

Finding a Specific Policy

- Alphabetical List
- Categorical List
- Medical Policy Search Bar
  - CPT Codes
  - Diagnosis Codes
- Advanced Options
  - All Words
  - Any Words
  - Exact Phrase
- Help With Search Option
  - Tips

Medical Policies

Policy Content

- Description
- Background
- Regulatory Status
- Policy Guidelines
- Rationale
- References
- Coding Section
- History

Important: Use of the CPT, HCPCS and ICD-10 codes listed in the medical policies **are not** a guarantee of payment. The codes are listed in the policy as a general reference tool and intended to describe the medical conditions for which services may be covered. It is **not an all inclusive** list.

Medical Policies

Contact Us

- Specific question
- How to interpret a policy
- Have a suggestion

Use My Insurance Manager to get information related to benefits, contract issues, authorization or claims.

Contact Us about a Medical Policy *Indicate required fields.

Complete the form below to send us a question about our Medical Policies. This form is NOT able to provide answers to questions regarding individual benefits, contract issues or precertification issues. For questions related to specific eligibility, coverage, or claims please utilize the secure Member or Provider My Insurance Manager or contact us via the contact information on the individual member's identification card.

This is not a secure form. Please do not include protected health information.

I am a:* --Select One--

Health Plan:*

First Name:*

Last Name:*

Practice/Group Name: (If applicable)

E-mail Address:*

Confirm E-mail Address:*

Daytime Area Code & Phone Number:* ( )

Fax: ( )

Policy Number:

Subject:* --Select One--

Supporting medical documentation may be requested.

Medical Policies

What's New for 2019

- **Laboratory Medical Policies – Effective Feb. 1, 2019**
  - Diagnostic Testing of Most Common Sexually Transmitted Diseases
  - B-Hemolytic Streptococcus Testing
  - Testing for Mosquito or Tick-Related Infections
- **Durable Medical Equipment – CAM 115**
  - Effective Jan. 1, 2019, life-sustaining equipment will no longer pay up to the purchase price., it will be paid on a rental basis only.
  - If the rental fee has been paid up to the purchase price before Jan. 1, 2019, it will be considered purchased and no further payment will be made.

"Payment is based on the monthly fee schedule amounts until medical necessity ends. No payment will be made for the purchase of equipment, maintenance and servicing, or for replacement of these items. Supplies and accessories are not allowed separately."

Medical Policies

What's New for 2019

Durable Medical Equipment – CAM 115

Codes	Description
E0424	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, cannula or mask and tubing
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, & tubing
E0433	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge
E0439	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing
E0465	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
E0466	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)
E1390	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1391	Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each
E1392	*Portable oxygen concentrator, rental*
K0738	*Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing*

Medical Policies

Website Resources

www.SouthCarolinaBlues.com or www.BlueChoiceSC.com

- Medical Policies and Clinical Guidelines
  - Anesthesia Guidelines
  - Clinical Practice Guidelines
  - Medical Policies
  - Preventive Guidelines
- Laboratory Medical Benefits
  - Avalon Lab Benefit Management Trial Claim Tool User Guide
- Provider News Page
  - Summary of Medical Policies

Medical Policies

Other Resources

- Bulletins
- Email Blasts
- Calls by provider specialty
- Laboratory Summary: Common Medical Policy Edits
- Avalon Lab Benefit Management Trial Claim Tool
  - My Insurance Manager

Avalon Healthcare Solutions

Laboratory Medical Policy Criteria

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.

Common Laboratory Services

Specific Policy Detail: Thyroid Disease Testing

Top Edit Noted	*Select* Policy Coverage Statements
Procedure not appropriate for clinical situation Other Edits: • Demographic Limitation • Diagnosis does not support test requested • Insufficient time between procedures	A. Individuals with symptoms consistent with hypothyroidism i. TSH to confirm or rule out primary hypothyroidism. ii. Free and/or total T4 as a follow-up to abnormal TSH findings iii. Free T4 as a follow-up in cases of suspected secondary hypothyroidism when TSH is normal iv. TSH, free T4 and total T4 for individuals every 6-12 weeks Repeat testing 12 weeks upon dosage change and annually in stable individuals. B. Individuals with symptoms consistent with hyperthyroidism. i. TSH to confirm or rule out primary hyperthyroidism. ii. Total or free T3 iii. TSH and free T4 first 3 months post-treatment; annual monitoring after first year even if asymptomatic for risk of relapse or late on-set hypothyroidism. C. Asymptomatic individuals 60 years of age and older, every 5 years; Individuals at high risk due to personal/family history; infertility, pregnancy, post-partum D. Investigational: Reverse T3; T3 uptake

Common Laboratory Services

Specific Policy Detail: Vitamin D Testing

Top Edit Noted	*Select* Policy Coverage Statements
Procedure not appropriate for clinical situation Other Edits: • Diagnosis does not support test requested • Insufficient time between procedures	A. 25 hydroxy vitamin D serum testing, including D2 and D3 fractions, when evaluating an underlying disease or condition specifically associated with vitamin D deficiency or decreased bone density i. Repeat testing 12 weeks after initiation vitamin D ii. Two testing to achieve goal, then annually B. 1,25 dihydroxy vitamin D serum testing, when evaluating vitamin D metabolism C. Not medically necessary i. General screening ii. 1,25 test when evaluating deficiency

Avalon Healthcare Solutions

Common Laboratory Services

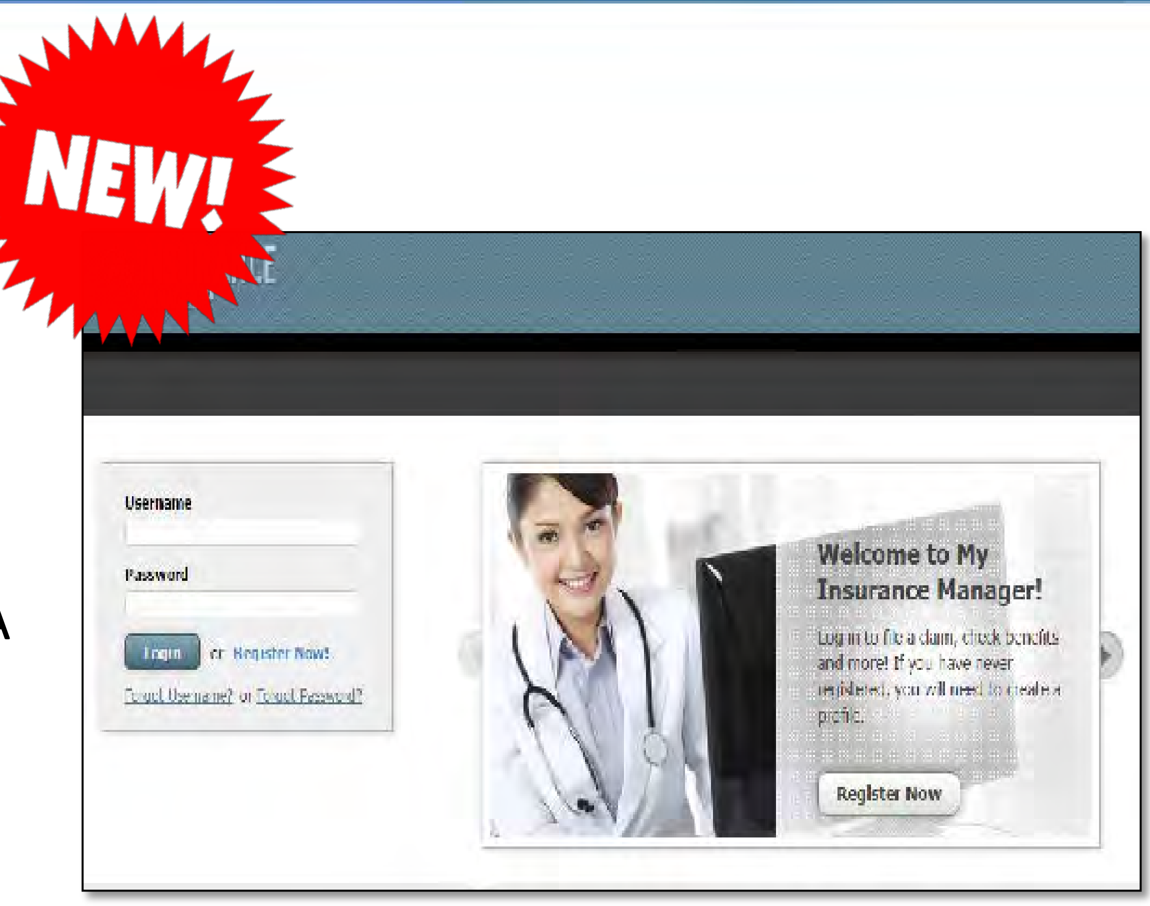
Specific Policy Detail: Hemoglobin A1c Testing

Top Edit Noted	*Select* Policy Coverage Statements
Procedure not appropriate for clinical situation Other Edits: • Diagnosis does not support test requested • Insufficient time between procedures	A. Measurement of hemoglobin A1c when a confirmed diagnosis of Type 1 or Type 2 diabetes: i. Upon initial diagnosis to establish a baseline value and to determine treatment goals ii. Twice a year (every 6 months) in individuals who are meeting treatment goals and who, based on daily glucose monitoring, appear to have stable glycemic control iii. Quarterly in individuals who are not meeting treatment goals for glycemic control iv. Quarterly in individuals whose pharmacologic therapy has changed B. Measurement of hemoglobin A1c when screening asymptomatic individuals with potential for increased risk, as defined by the ADA

Avalon Healthcare Solutions

Important Update

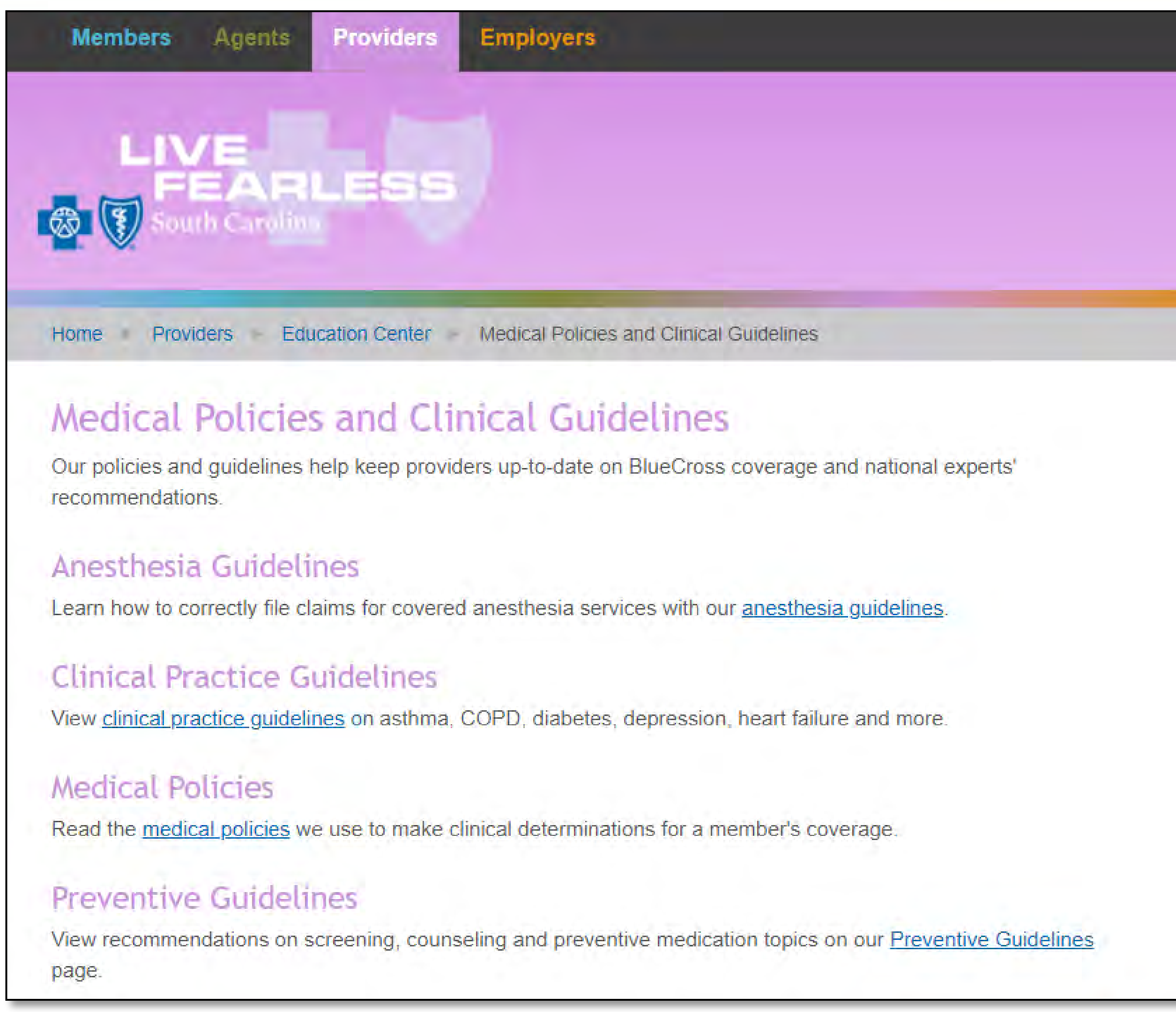
- In April 2019 you will be able to submit requests on-line
- BCBSSC Providers will access the Avalon PA application by Single Sign-On (SSO) through My Insurance Manager
- Avalon Laboratory Providers will access the new PA application through the Avalon Portal
  - Benefits:
    - Enables automatic verification of member eligibility and benefits coverage
    - Provides an automatic authorization for a subset of services that require a PA

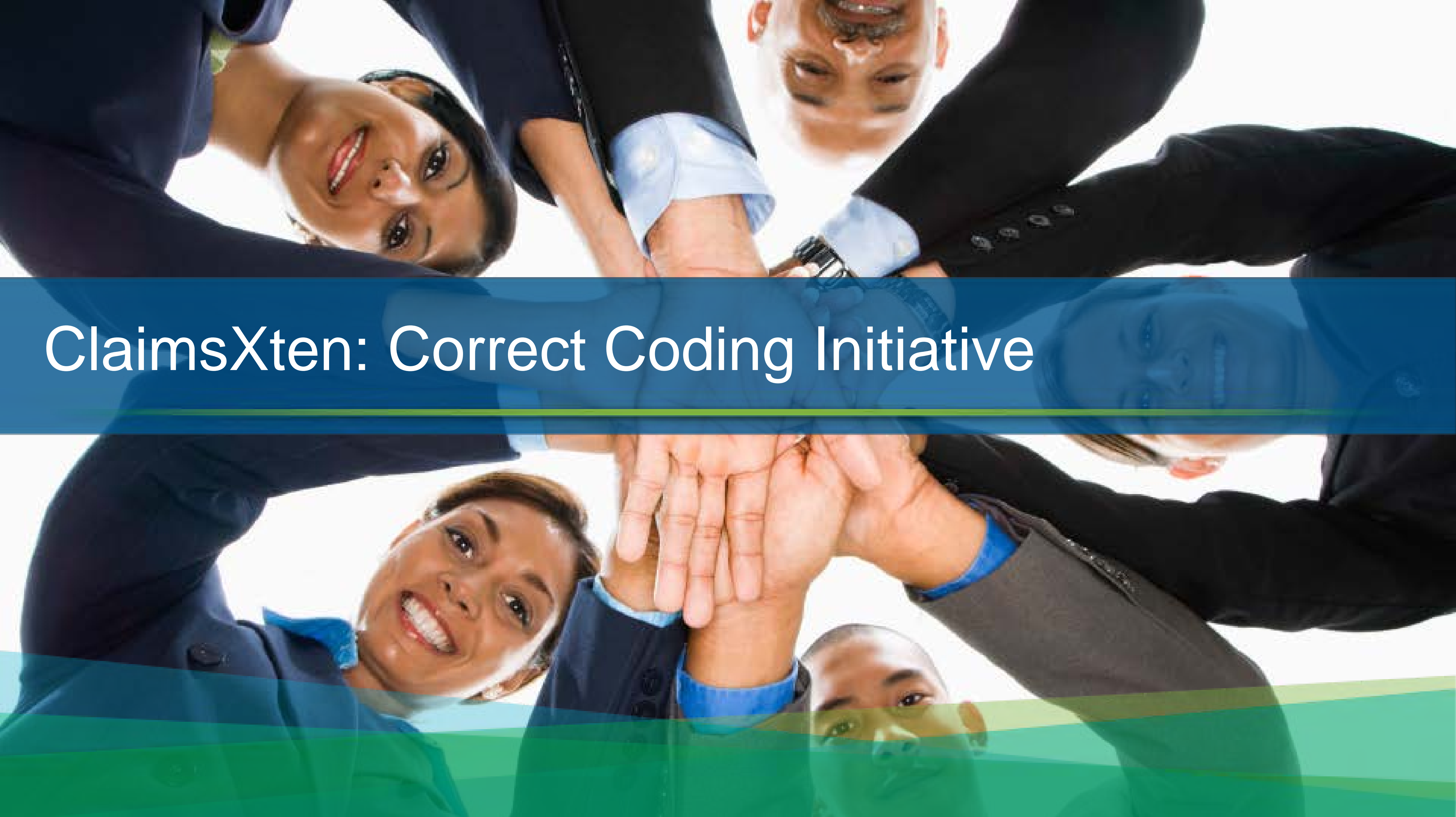


Avalon Healthcare Solutions

Medical Policies

- Review the appropriate medical policy prior to performing or requesting the test.
- Become familiar with the requirements for the tests.
- The three medical policies with the largest claim volume:
  - Thyroid Disease Testing
  - Hemoglobin A1c
  - Vitamin D




ClaimsXten: Correct Coding Initiative

Introduction

Coding claims completely and accurately is critical to ensure benefits and reimbursement are applied correctly.

We're upgrading our claims-auditing system in 2019 to better align our claims adjudication with:

- Benefit plans
- Medical policies
- Centers for Medicare & Medicaid Services' (CMS') National Correct Coding Initiatives (NCCI)

Our current code-auditing system, ClaimCheck®, will be replaced with ClaimsXten™.

ClaimsXten is produced by Change Healthcare.

This upgrade will take place during the first quarter of 2019.

What is NCCI?

Three Major Types of Edits:

Procedure-to-Procedure (PTP) Edits

- PTP edits ensures appropriate payment of services that should be reported together.
- If a provider reports two codes for the same beneficiary, on the same date of service, the second code is only payable when a clinically appropriate NCCI-associated modifier is also reported.

Medically Unlikely Edits (MUEs)

- MUEs prevent payment for an inappropriate number/quantity of the same service on a single day.
- The MUE for a HCPCS/CPT code is the maximum number of units of service.

Add-on Code Edits

- Add-on code edits consist of a listing of HCPCS and CPT add-on codes with their respective **primary** codes.
- An add-on code is eligible for payment if, and only if, one of its primary codes is also eligible for payment.

What is ClaimsXten?

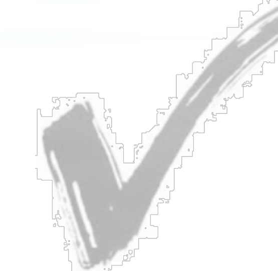
ClaimsXten is robust code auditing software that:

- Ensures correct coding
- Aligns logic closely with NCCI
- Audits in context to the member's claims' history

Benefits of Upgrading:

- Streamlined claims adjudication
- Clinically supported rules and logic
- Enhances processing accuracy and consistency
- Reduces manual reviews

Edits and Implementation



Many of the edits within the ClaimsXten system are enhancements of edits that our current ClaimCheck system looks for today.

These enhancements make the interpretation and application of the edits more effective.

ClaimsXten Rules/Edits

	Rule	Description	Example
1.	**CMS Correct Coding Initiative**	Recommends the denial of claim lines for which the submitted procedure is not recommended for reimbursement when submitted with another procedure as defined by a code pair found in the National Correct Coding Initiative (NCCI).	When procedure code 0213T (injection with ultrasound guidance) is submitted with 19304 (mastectomy), procedure code 0213T is recommended for denial.
2.	**Unbundling**	Recommends the denial of claim lines where a procedure is submitted with another procedure that is one of the following: A more comprehensive procedure, a procedure that results in overlap of services, or procedures that are medically impossible or improbable to be performed together on the same date of service.	Procedure code 49000 (exploratory laparotomy) is recommended for denial when submitted with procedure code 44010 (duodenotomy, exploration biopsy).
3.	**Allowed Once Per Date of Service**	Recommends the denial of claim lines containing procedure codes that should only be performed once per date of service.	Bilateral tenotomy procedure 27392 is recommended for denial if submitted more than once on the same date of service.

ClaimsXten Rules/Edits

	Rule	Description	Example
4.	**Medicare Medically Unlikely Edit (MUE) – DME**	This rule checks for the line quantity billed on a claim line and recommends denial if the line quantity exceeds the MUE for the HCPCS/CPT code with MAI of 1, 2 or 3 reported by the same provider or across providers (depending on the provider setting configuration), for the same member, on the same date of service. This rule will evaluate date ranges to determine if the MUE has been met or not.	A claim is submitted for A4235 (replacement battery, for use with home blood glucose monitor) with seven units, across three days. The line quantity is spread across the three days to determine the quantity per day: 7 units / 3 days = 2.33 per day. The total is rounded to the nearest whole number, 2. The MUE for A4235 is 2 and the MAI is 1. Only this line is considered and the daily value is equal to the MUE allotted, therefore, the line will be allowed.
5.	**Allowed Multiple Times Per Date of Service**	Recommends the denial of claim lines when the quantity billed for the procedure code exceeds the maximum allowed per date of service per site.	Procedure 29125 (for short arm splint application), has a maximum allowance of twice per date of service. If the submission of the procedure is three times, the third occurrence is recommended for denial.

ClaimsXten Rules/Edits

	Rule	Description	Example
6.	**CMS Always Bundled Procedures**	Recommends the denial of claim containing lines with procedure codes indicated by CMS as always bundled when billed with any other procedure not indicated as always bundled for the same member for the same provider ID for the same date of service.	Procedure code 36416 (collection of blood specimen) is identified by CMS as a bundled service. When this procedure is submitted with another procedure that is not considered a bundled service (for example, 33510, coronary artery bypass), 36416 is recommended for denial.
7.	**Base Code Quantity**	Recommends the denial of claim lines containing base codes billed with a quantity greater than one per date of service.	When procedure code 63102 (vertebral body resection) is submitted more than once for the same date of service, and no other line on same claim or in history, the line is recommended for denial and replaces procedure code 63102 with a quantity of 1.
8.	**New Patient Code for Established Patient**	Recommends the denial of claim lines containing a new patient E&M code for established patients.	New patient code 99204 is recommended for denial when submitted within three years (by the same provider or provider group/specialty) of another E&M code. It is replaced with the appropriate established patient code as indicated in the new patient crosswalk.

ClaimsXten Rules/Edits

	Rule	Description	Example
9.	**Same Day Visit**	Recommends the denial of claim lines with E&M codes billed on the same date of service as a procedure code within a global period.	E&M procedure code 99213 is recommended for denial when submitted on the same date of service as procedure code 49000.
10.	**Bilateral**	Identifies the same code billed twice for the same date of service where the first code has the bilateral -50 modifier appended. The rule recommends the denial of the second submission regardless if submitted with or without a bilateral modifier.	When myringotomy procedure code 69420 is submitted twice and at least one of the lines has modifier -50, the line without the modifier -50 (or the second line with modifier -50) is recommended for denial.
11.	**Post-Operative Visit**	Recommends the denial of claim lines containing E&M codes billed within the post-operative period.	E&M procedure code 99213 is recommended for denial when submitted within the 90-day post-op period of procedure code 49000.
12.	**Co-Surgeon**	Identifies claim lines containing procedure codes billed with the co-surgery modifier (62) that have not met the criteria for submitting a procedure for co-surgery payment according to CMS.	Procedure A4890-62 (repair and maintenance of hemodialysis equipment) is recommended for denial as this procedure does not warrant co-surgeons according to CMS.

ClaimsXten Rules/Edits

	Rule	Description	Example
13.	**Pre-Operative Visit**	Recommends the denial of claim lines containing E&M codes billed within the pre-operative period.	E&M procedure code 99213 is recommended for denial when submitted within the one-day pre-op period of procedure code 49000.
14.	**Medicare Medically Unlikely Edit (MUE) – Practitioner**	Recommends the denial of claim lines where the MUE for a CPT/HCPCS code is exceeded by the same provider, for the same member, on the same date of service. Procedure codes with an MUE adjudication indicator (MAI) of 1 will edit as a single line edit. Procedure codes with an MAI of 2 or 3 will consider frequency from other claim lines to determine if the MUE is met or exceeded. This rule will evaluate date ranges to determine if the MUE has been met or not.	1. A claim is submitted with procedure code 26110 (arthrotomy with biopsy; interphalangeal joint), modifier 55 and line quantity = 2. This procedure code MUE allowed value is 3 and the MAI = 1. The line will be allowed , since the MUE value has not been not exceeded. 2. A claim is submitted with procedure code 11771 (excision of pilonidal cyst or sinus), line quantity = 2 and 2-days' time interval. This procedure code daily MUE allowed value is 1 and the MAI = 2. The calculated individual line quantity is 1 so the current claim line will be allowed.

ClaimsXten Rules/Edits

	Rule	Description	Example
15.	**Add On Without Base Code**	There are CPT and HCPCS defined add-on codes for which the AMA has assigned specific base code(s). This rule audits those codes, and recommends the denial of claim lines containing the add-on codes when the defined base code cannot be found by the same member for the same date of service. This rule also audits that vaccine supply and immune globulin supply codes are submitted with their associated administration procedure code as is required according to CPT Guidelines.	CPT add-on procedure code 15787 (abrasion; each additional 4 lesions or less) is submitted without the base procedure code 15786 (abrasion; single lesion) present on the claim or in any history lines. Procedure code 15787 is recommended for denial.
16.	**Assistant Surgeon**	Recommends the denial of claim lines containing procedure codes inappropriately submitted with an assistant surgeon modifier 80, 81, 82, or AS in any of the four modifier positions.	When procedure code 10021 (fine needle aspiration) is submitted with modifier -80, the line is recommended for denial.
17.	**Modifier To Procedure Validation – Payment Modifiers**	Recommends the denial of procedure codes when billed with any payment-affecting modifier that is not likely or appropriate for the procedure code billed.	Anesthesia procedure 00560 is recommended for denial when submitted with modifier -50.

ClaimsXten Rules/Edits

	Rule	Description	Example
18.	**Multiple Code Rebundling**	Recommends the denial of claim lines when another more comprehensive procedure exists. If the more comprehensive code is also submitted for this member by the same provider, for the same date of service, the component codes will be denied and the comprehensive code will be recommended for reimbursement. If the more comprehensive code is not submitted for this member by the same provider for the same date of service, it will be added to the claim.	When laboratory procedures 82465 (cholesterol), 83718 (HDL cholesterol) and 84478 (triglycerides) are submitted together for the same date of service, all are recommended for denial and replaced with the panel code 80061 (lipid panel).
19.	**Global Component**	Identifies instances where the sum of all payments (total, professional, technical) for a procedure across multiple providers exceeds the amount that would have been paid for the total procedure. This rule audits for the same member ID, the same date of service, ***across*** providers.	When procedure code 51725-26 (simple cystometrogram) is submitted and 51725 was previously submitted by a different provider on the same date of service, 51725-26 is recommended for denial.
20.	**CMS Modifier to Procedure Validation**	Recommends the denial of claim lines containing invalid procedure code and modifier combinations based on the CMS Physician Fee Schedule (and select DME modifiers) and the date of service.	Procedure code 51784-50 (electromyography studies of anal or urethral sphincter, other than needle) is recommended for denial, as this procedure is not valid with modifier -50.

ClaimsXten Rules/Edits

	Rule	Description	Example
21.	**Modifier To Procedure Validation – Non-Payment Modifiers**	Recommends the denial of procedure codes when billed with any non-payment-affecting modifier that is not likely or appropriate for the procedure code billed.	Hysterectomy procedure 58150 is recommended for denial when submitted with modifier –LT.
22.	**Duplicate Component Billing**	Recommends the denial of claim lines containing procedure codes billed with a professional or technical modifier when the procedure code was previously submitted as a global procedure for the ***same*** provider ID for the same member for the same date of service.	When procedure code 51725–26 is submitted and 51725 was previously submitted for the same provider, same date of service, 51725–26 is recommended for denial.
23.	**Age Code Replacement**	Identifies claim lines containing procedure codes that are inconsistent with the patient's age, and replaces the line with the age-appropriate code.	Procedure code 42825 (tonsillectomy, younger than age 12) is replaced with procedure code 42826 (tonsillectomy, age 12 or over) when submitted for a 20-year-old patient.
24.	**Age**	Recommends the denial of claim lines containing procedure codes inconsistent with the patient's age.	Maternity procedure code 59400 is recommended for denial when submitted for a 9-year-old patient.

Modifier System Enhancements

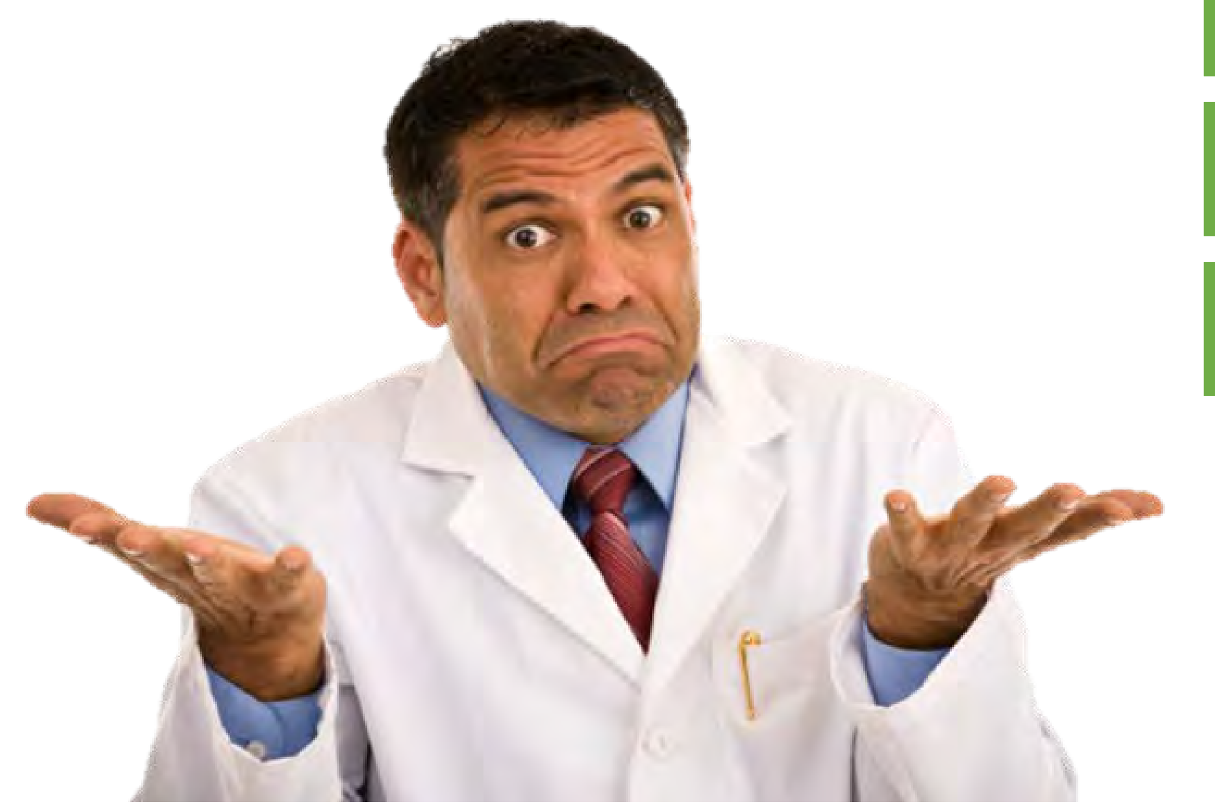
In December 2018, we implemented a project to strengthen the way we recognize modifiers you file on claims and verify that the modifier is appropriate for the service.

This project will:

1. Recognize any valid HIPAA modifier filed in any of the 4 modifier claim fields.
2. Recognize modifiers you use to identify certain programs or services in order to process your claims more effectively.

Modifier System Enhancements

A sample of claims across all business lines for 2018 were evaluated and revealed this suite of invalid modifiers:



V9	H	1	10	R
W3	SZ	AL	J	30
L1	G	0	OO	21
-	16	L	G0	60

Claims submitted with invalid modifiers will now be stopped at the gateway.

Provider Outreach

We encourage providers to:

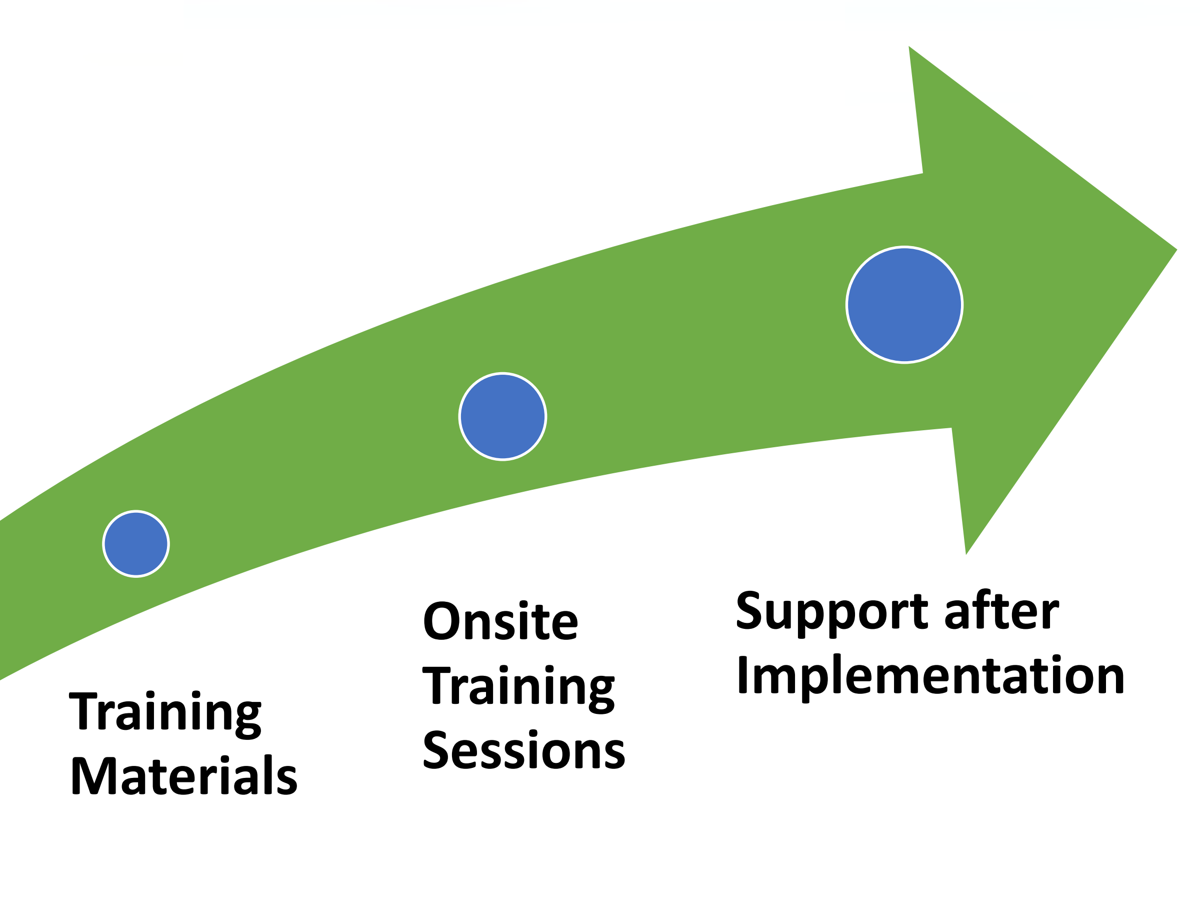
- Review your current coding practices
- Consult with all business partners (billers, clearinghouses) who may code and bill on your behalf
- Ensure all appropriate staff are refreshed on correct coding guidelines
- Review our training materials and share it with appropriate staff members
- Identify potential impacts and make changes now to avoid them
- Monitor your organization's coding behavior to always follow correct coding guidelines
- File modifiers that are valid and appropriately related to the services performed

Provider Outreach

Provider Relations and Education is here to guide you through this transition.

Upon implementation, monitor your remittances and contact Provider Relations and Education if you notice any trends.

We will work directly with you to determine resolution.



Resources

CMS: www.cms.gov

National Correct Coding Initiative Edits:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

NCCI Policy Manual Archive (downloads):
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Manual-Archive.html

Medically Unlikely Edits:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

Modifiers:
https://search.cms.gov/search?utf8=%E2%9C%93&affiliate=cms-new&dc=&query=modifier+coding

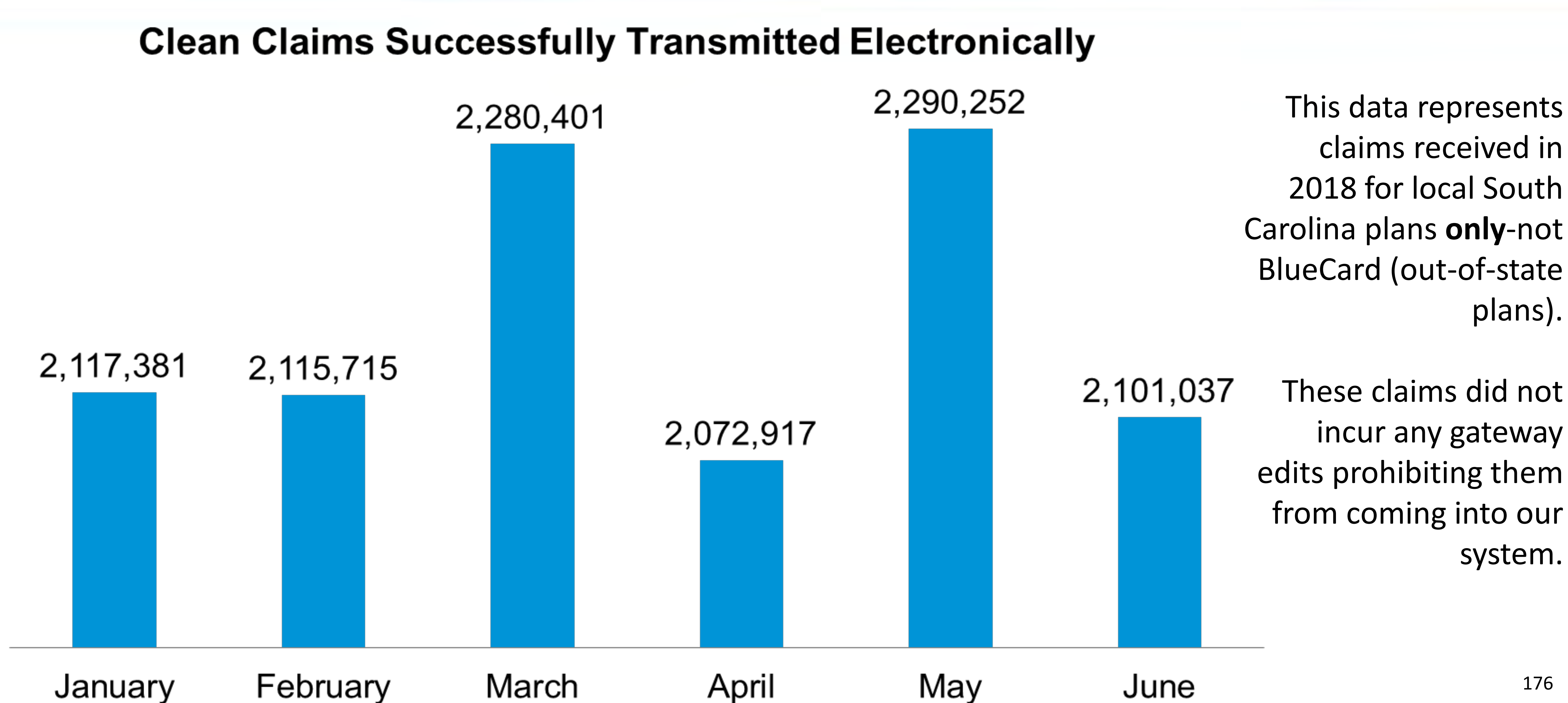
BlueCross BlueShield of South Carolina Provider Relations and Education:
https://web.southcarolinablues.com/providers/contactus/provideradvocates.aspx

Best Practices Towards Faster Claim Resolution

Disclaimer

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

Ever Wonder How Many Claims We Process?



This data represents claims received in 2018 for local South Carolina plans **only**-not BlueCard (out-of-state plans).

These claims did not incur any gateway edits prohibiting them from coming into our system.

And During First Half of 2018…

12,977,703

- Commercial Claims processed

Over $ 3 Billion

- Paid on commercial claims

Front End Edits During the First Half of 2018

SUBSCRIBER ID NOT ON FILE AS ENTERED

$53.2 million dollars	139,350 total claims

$22.8 million dollars	62,771 total claims

$29.9 million dollars	44,645 total claims

$29 million dollars	36,013 total claims

- These claims did not make past the gateway and were returned because of the errors listed.
- These errored claim submissions can be found on a front end rejection report.
- Work with vendors to ensure these claims are refiled appropriately.

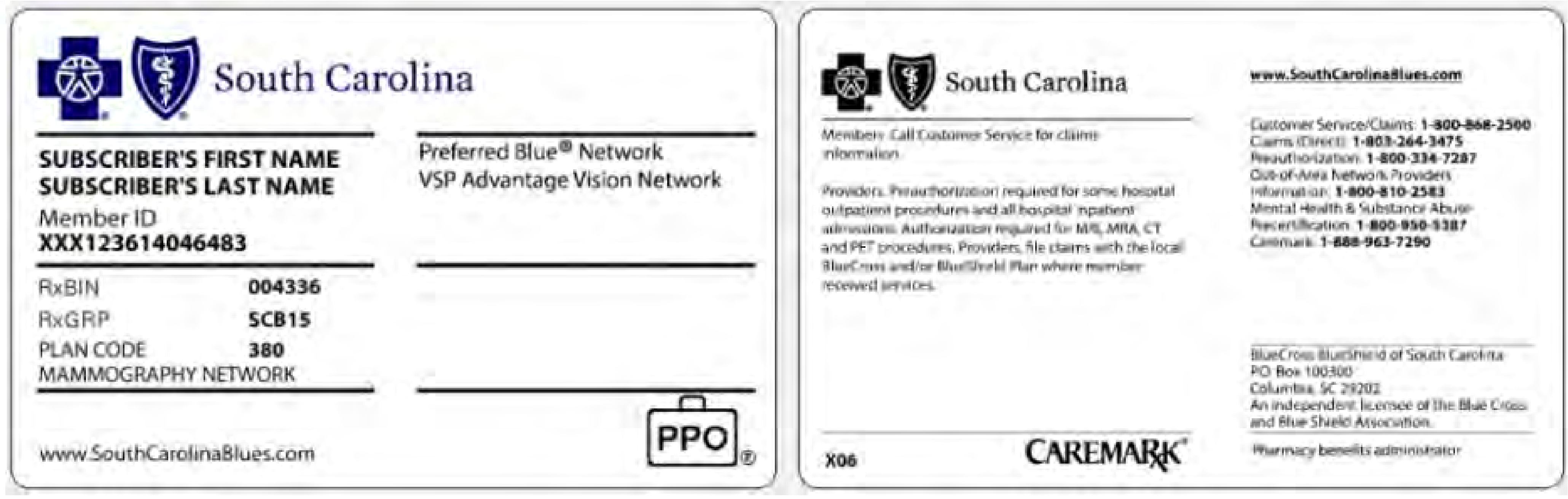
Front End Edit: Subscriber ID Not on File as Entered

139,350 total claims worth $53.2 million dollars

Possible Cause(s):

- Submitted to the wrong plan
- Member policy cancelled
- Member ID number transcribed incorrectly
- Subscriber/Member information entered incorrectly

Front End Edit: Subscriber ID Not on File as Entered



Avoid this error by:

1. Asking for the most current ID card at every visit. Members have access to Digital ID cards now.
2. Checking benefits and eligibility at every visit.
3. Verifying the patient and subscriber prefix information for claim entry/submissions.
4. Confirming Payer ID and Plan ID where applicable.

Front End Edit: Billing Provider Number Not on File

62,771 total claims worth $22.8 million dollars

Possible Cause(s):

- Provider ID Number Transcribed Incorrectly
- Inactive Provider ID Number
- Re-credentialing Past Due
- Claims Filed Before Enrollment Completed

Front End Edit: Billing Provider Number Not on File

62,771 total claims worth $22.8 million dollars

Avoid this error by:

1. Enrolling new practices and new practice locations.
2. Enrolling new practitioners. **Is the referring physician enrolled?**
3. Re-credentialing timely and appropriately.
4. Confirming provider ID information with clearinghouses and payers.
5. Updating practice information as it happens!

Claim Denials During the First Half of 2018

1,603,671 total claim lines worth
$816 million dollars

OTHER HEALTH INSURANCE/ACCIDENT QUESTIONNAIRES
185,111 total claim lines

DUPLICATE CLAIM SUBMISSIONS
228,193 total claim lines

SUBSCRIBER NOT COVERED FOR DATE OF SERVICE
152,240 total claim lines

MEDICARE SECONDARY
32,268 total claim lines

SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER
36,194 total claim lines

Other Health Insurance/Accident Questionnaires

131,287 claim lines

Possible Cause(s):

- Accident Diagnosis Filed on Claim
- Certain Group Requirements
- Dollar Amount of Claim

Other Health Insurance/Accident Questionnaires

131,287 claim lines

Actual Remittance/Explanation of Benefit Verbiage:

Other Health Insurance: We need to know if you have any other health or dental insurance before we can process this claim. You can update this information by completing the questionnaire you received or by contacting customer care.

Accident Questionnaires: These services may be the result of an accident. If so, they could be the responsibility of a third party or work related. You will receive an accident questionnaire to complete and return to us as soon as possible. We cannot determine benefits without your response. If you have questions. Please call us toll free at 1-800-288-2227 extension 43060. Please refer to the section in your benefits booklets on worker's compensation or subrogation (third party liability).

Other Health Insurance/Accident Questionnaires

131,287 claim lines

Subrogation / Workers' Compensation
I-20 at Alpine Road
Columbia, SC 29219-0001
1-800-288-2227, extension 43060
Fax: 1-803-865-0654

South Carolina

ACCIDENT QUESTIONNAIRE

Subscriber: ____________
Address: ____________
Address: ____________

Patient: ____________
Identification No.: ____________
Provider: ____________
Date of Service: ____________
Group Number: ____________
Claim Number: ____________
Claim Amount: ____________

Dear Member:

Our review process indicates this patient may have received healthcare services related to an accident. So we may evaluate our responsibility, please complete, sign and return this form within five days of receipt. If we do not receive this information, we may have to deny your claims. **If you have previously completed a form for this accident, please check here ____ and update.**

Was the injury or illness: **Auto/Motorcycle Accident**____ **Work Related**____ **Other Accident**____ **No Accident** ____
Date of the injury or illness: ____________ City/County and State of Injury: ____________
Describe the injury or illness and how it happened: ____________
Names of other family members injured: ____________

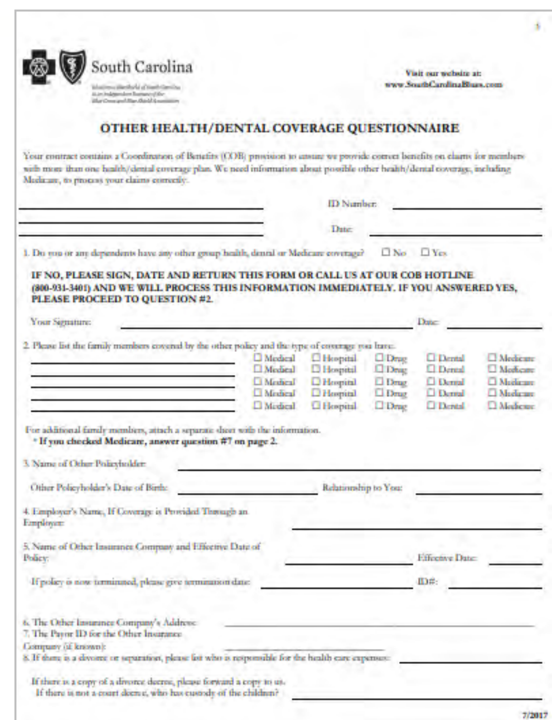
If you checked "Auto/Motorcycle Accident" or "Other Accident," please answer the following:
Did another person cause this accident? YES / NO
If yes, name and address of person causing injury: ____________
Insurance Company of person causing injury: ____________ Policy/Claim #: ____________
Address and Phone #: ____________ Adjuster's Name: ____________
If auto or motorcycle related, was the patient wearing a seatbelt? YES / NO a helmet? YES / NO
If auto or motorcycle related, was the patient the driver ______ or a passenger ______?
Auto Insurance Company of Patient: ____________ Policy/Claim #: ____________
Address and Phone #: ____________ Adjuster's Name: ____________

If you checked "Work Related," please answer the following:
Name and address of patient's employer at the time of injury: ____________
Have you filed a Workers' Compensation claim? YES / NO
If yes, name of Workers' Compensation carrier: ____________
Policy/Claim #: ____________ Adjuster's Name: ____________
Address and Phone #: ____________
Has the employer or the workers' compensation carrier accepted or denied liability? ACCEPTED / DENIED

Name, address, and telephone number of your attorney (if applicable): ____________

I agree that the above information is correct, and I will not settle a claim before contacting the Subrogation / Workers' Compensation Department of Blue Cross and Blue Shield.

Signature Date Telephone Number



South Carolina

Visit our website at:
www.SouthCarolinaBlues.com

OTHER HEALTH/DENTAL COVERAGE QUESTIONNAIRE

Your contract contains a Coordination of Benefits (COB) provision to ensure we provide correct benefits on claims for members with more than one health/dental coverage plan. We need information about possible other health/dental coverage, including Medicare, to process your claims correctly.

ID Number: ____________
Date: ____________

1. Do you or any dependents have any other group health, dental or Medicare coverage? ☐ No ☐ Yes

IF NO, PLEASE SIGN, DATE AND RETURN THIS FORM OR CALL US AT OUR COB HOTLINE (800-931-3401) AND WE WILL PROCESS THIS INFORMATION IMMEDIATELY. IF YOU ANSWERED YES, PLEASE PROCEED TO QUESTION #2.

Your Signature: ____________ Date: ____________

2. Please list the family members covered by the other policy and the type of coverage you have:

Family member					
____________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
____________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
____________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
____________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
____________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare

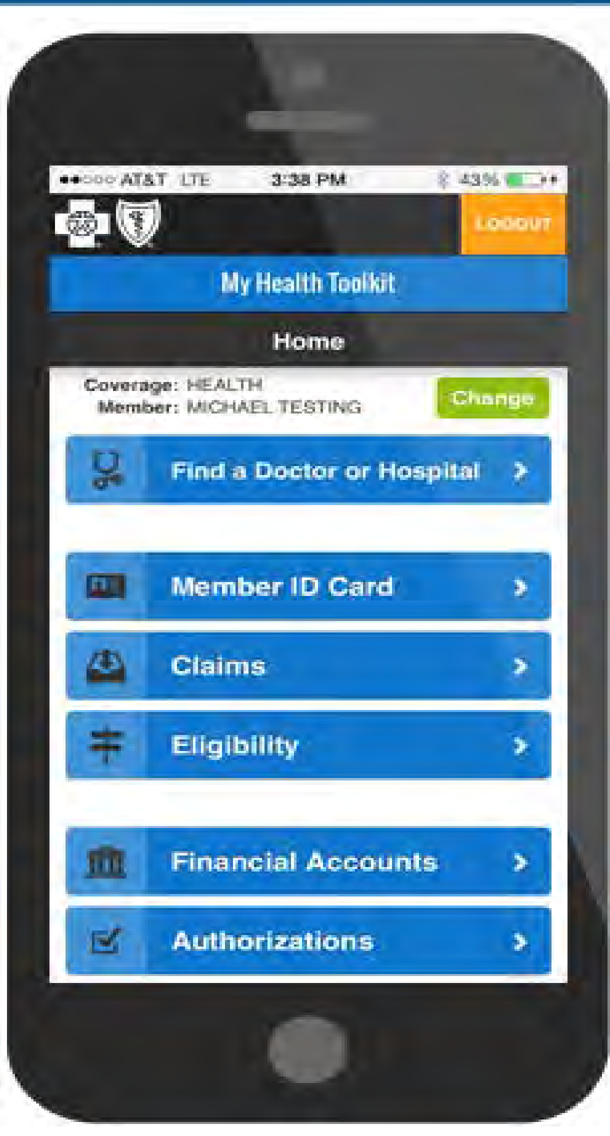
For additional family members, attach a separate sheet with the information.
* **If you checked Medicare, answer question #7 on page 2.**

3. Name of Other Policyholder: ____________
Other Policyholder's Date of Birth: ____________ Relationship to You: ____________
4. Employer's Name, If Coverage is Provided Through an Employer: ____________
5. Name of Other Insurance Company and Effective Date of Policy: ____________ Effective Date: ____________
If policy is now terminated, please give termination date: ____________ ID#: ____________
6. The Other Insurance Company's Address: ____________
7. The Payor ID for the Other Insurance Company (if known): ____________
8. If there is a divorce or separation, please list who is responsible for the health care expenses: ____________
If there is a copy of a divorce decree, please forward a copy to us.
If there is not a court decree, who has custody of the children? ____________

7/2017

Avoid this error by:

1. Encourage members to update information online or by phone. Members can even use the My Health Toolkit app.
2. Incorporate forms into patient in-take packet. Submit **IF** requested.



Duplicate Claim Submissions

403,270 claims

Possible Cause(s):

- Submitting Corrected Claims without the Appropriate Bill Type
- Incorrect Posting of Original Claim Outcome
- *Thinking* it is a Corrected Claim
- Claim Status Delays
- Submission Uncertainty

Explanation of Benefit Verbiage: We have already received a claim for this service(s). We processed that claim and sent you an explanation of benefits.

Duplicate Claim Submissions

403,270 claims

Avoid this error by:

1. Submitting modifiers appropriately.
2. Verifying the place of service, date of service, procedure codes, modifiers, diagnoses, etc. are accurate **before** submission.
3. Verifying claim status before submitting claims a second or third time.
4. Ensure corrected claims include the appropriate corrected claim bill type or other indicators.

Subscriber Not Covered for Date of Service

408,971 claim lines

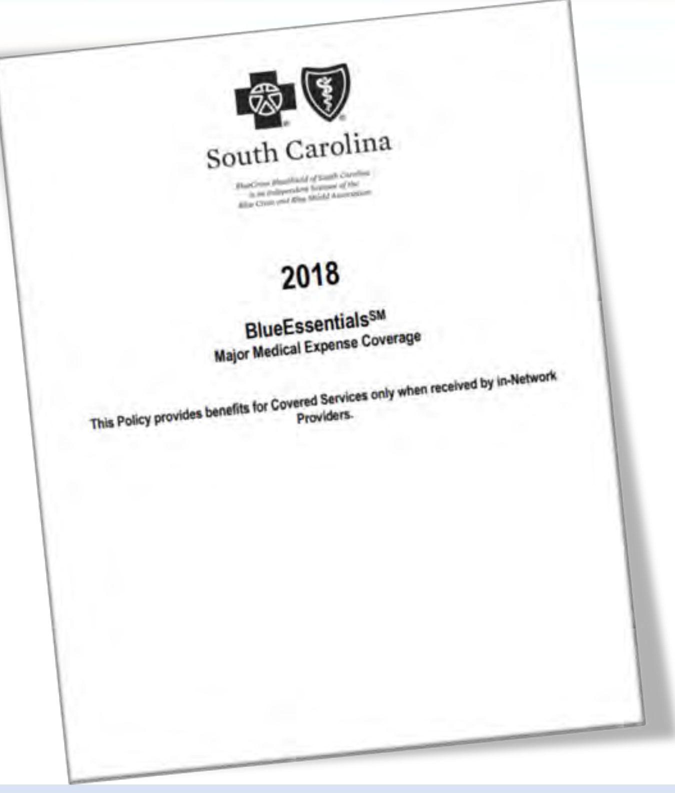
Possible Cause(s):

- Member Not Covered on the Date of Service
- Non-covered Service Based on Benefit Plan
- Ineligible Family Member (single coverage only)
- Unpaid Premiums

Explanation of Benefit Verbiage: Our records show this person was not covered at the time of service. If you feel this is incorrect and your coverage is through your employer, please contact your employer benefits representative. Otherwise, please contact customer service. For more information, please refer to the eligibility section of your benefits booklet.

Subscriber Not Covered for Date of Service

408,971 claim lines



Avoid this error by:

1. Verifying eligibility and benefits **before** rendering service.
2. Verifying coverage requirements, limitations or coverage criteria.
3. Reviewing medical policies.

Medicare Secondary Claims

84,767 claim lines

Possible Cause(s):

- Not Waiting for Claims to Crossover
- Excluding the Primary Payment Information

Explanation of Benefit Verbiage: Since Medicare is your primary insurance, we need a copy of the Medicare summary notice to process this claim. Please attach a copy of it to this form and send it to us. We cannot determine benefits on this claim until we receive this information. Please refer to the Medicare coordination of benefits section of your benefit booklet for specific details.

Medicare Secondary Claims

84,767 claim lines

Avoid this error by:

1. Verifying the Medicare member information for the patient.
2. Submitting the primary payment information as necessary to all secondary payers.
3. Waiting at least 30 days for claims to “cross over” from Medicare.
4. Ensuring that the patient’s ID number is accurate

Services Provided by Out-of-Network Provider

534,557 claim lines

Possible Cause(s):

Member has in-network coverage only and services were provided by an out-of-network provider

Explanation of Benefit Verbiage: Your benefit plan does not cover these service from an out-of-network provider. Please refer to the exclusions or schedule or benefits section of your benefits booklet for specific details.

Services Provided by Out-of-Network Provider

534,557 claim lines

Avoid this error by:

1. Referring to other in network specialists and providers.
2. Checking provider directories when needed.
3. Checking benefits and eligibility at every visit.
4. Talking to members about plan restrictions when appropriate.

Other Common Remittance Notifications

No Authorization on File

Non-compliant NDC Codes

Non-compliant Medical Policy Adherence

Tips For Clean Claim Processing

Tips For Clean Claim Processing

Carrier Codes

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 Federal Employee Program (FEP)
- 403 Healthy Blue (BlueChoice Medicaid)
- 922 BlueChoice HealthPlan 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
- 886 PAI

Use these carrier codes for dental claim submission.

- 38520 BlueCross BlueShield of South Carolina
- 77828 Companion Life

Provider Reconsiderations

If you disagree with how your claim processed…

Independent licensees of the Blue Cross and Blue Shield Association

South Carolina Provider Reconsideration Form

This form is intended for use by physicians and other health care professionals in South Carolina. If you are located outside of South Carolina and have claims questions, reviews or appeals, please direct them to your local Blue® plan. To request a claim review, please complete this form for BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan members. Use this form as the cover transmittal sheet for all supporting documentation. Forms submitted without supporting documentation will not be considered. Be sure to complete each section.

You may wish to seek reconsideration of a claim:

- If you have additional documentation that supports a reversal of the claim determination.
- If you want a reconsideration of the claim adjudication.

Provider Information

Provider's Name: ______________________ NPI or Tax ID: ______________

Phone Number: ______________ Ext: ________ Fax Number: ______________

Contact Person: ______________________ Email: ______________

Authorized Signature: ______________________ Date: ______________

Patient and Claim Information

Patient's Name: ______________ Member ID: ______________ Date of Birth: ______________

Claim Number *(Do not attach claim)*: ______________ Date of Service: ______________

Reconsideration

Check the appropriate box to indicate whether this is the first or second reconsideration request.

☐ Initial Request
☐ Subsequent Request (attach copy of initial decision and new or additional documentation)*

**Please note: Subsequent requests must include new or additional information in order to be re-reviewed.*

Brief description of request/desired action you want us to take as result of this claim review:

____

Description of attachments included (office records, lab reports, physician orders, etc.):

____

Please Fax or Mail to (send to only one):

Plan	Reconsideration Time Limits	Fax Number	Mailing Address
BlueChoice HealthPlan	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
BlueEssentials℠ & Blue Option℠	60 days from process date	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Preferred Blue® & BlueCard®	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Group & Individual	180 days from process date	803-264-4172	AX-F25, I-20 @ Alpine Road, Columbia, SC 29219
State Health Plan	6 months from process date	803-264-4204	AX-B10, P.O. Box 100605, Columbia, SC 29260
Federal Employee Program	90 days from process date	803-264-8104	AX-B05, P.O. Box 600601, Columbia, SC 29260

Updated 5/30/18 (CS)

Want to Know More?

Sources

- BlueCross/BlueChoice Provider Administrative Manual
- https://web.southcarolinablues.com/providers/laboratorymedicalbenefits.aspx
- https://med.noridianmedicare.com/documents/10542/2840524/Duplicate+Claims+Presentation
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Fast-Facts/2017-01-05-Duplicate-Claims.html
- https://revcycleintelligence.com/news/8-tips-for-avoiding-denials-improving-claims-reimbursement
- https://cdn2.hubspot.net/hubfs/207376/docs/eBooks/Manage_Medical_Claim_Denials.pdf?t=1494330988446

Provider Enrollment

New Provider Enrollment Process

- New Staff
- Updated/helpful web content
- Clearer communication
- New all-inclusive checklists
- VRU
- Expedited process
- More outreach

Checklist

To ensure you are submitting a complete provider enrollment packet, please visit our website:

www.SouthCarolinaBlues.com

Here you will find checklists specific to each provider type, forms and the Provider Enrollment Application.

The enrollment process will begin when ALL items are received and complete.

Provider Enrollment Checklist for Initial Provider Enrollment

Submit all documentation to Provider.Blue.Enroll@bcbssc.com.

Use this checklist to determine which forms you need based on your specialty type. **Each checklist item is hyper-linked with forms or examples for your reference.** Note: Mid-levels include NP, PA, CRNA, CNM, CNS and hospital-based physicians. Ancillary includes speech, physical, occupational and audiology therapists.

	Checklist Items	Mid-Level	M.D.	DDS	DMD	Ancillary	Chiro
A	Provider Enrollment Application	1					
B	Registration Form for Mid-Level and Hospital-Based Providers						
C	SC Dental Credentialing Application[2]						
D	Copy of SC Medical/Practice License						
E	DEA Certification[3]			4	4		
F	Current Copy of Malpractice Insurance (Minimum $1M/3M)						
G	Authorization for Clinic/Group to Bill for Services						
H	Clinical Lab Improvement Amendments (CLIA) form						
I	NP Preceptor Form						
J	Network Contracts (send in a request)						
	Additional Items for Medicaid						
K	Medicaid ID Number[5]						
L	Disclosure of Ownership Form 1514						
M	Nurse Protocols						

[1]If you are a mid-level provider who wants to be enrolled in our Medicaid network, fill out the Provider Enrollment Application.
[2]If the provider performs any routine dental services, the Dental Credentialing application is needed.
[3]Required for M.D.s, DOs, ODs, NPs and PAs.
[4]If applicable
[5]On the Provider Enrollment Application

Healthy Blue
BlueChoice HealthPlan of SC

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the Blue Cross and Blue Shield Association. BlueChoice HealthPlan has contracted with Amerigroup Partnership Plan, LLC, an independent company, for services to support administration of Healthy Connections.

184890 11-2018

Individual Provider Enrollment Documentation

Only fully completed applications can be reviewed:

- Complete Provider Enrollment Application (all pages initialed and dated) *
- DEA Certification
- Proof of malpractice coverage, including supplemental coverage (Must be $1M/$3M or more) *
- Authorization to Bill
- CLIA Form
- Contract pages for networks signed with wet signatures
- Medicaid ID Number
- Disclosure of Ownership

Most incomplete packets are missing initials or dates on the application and proof of malpractice.

Completed Applications

Send completed documentation to:

- ✓ **PREFERRED** Initial Enrollment Applications: Provider.Blue.Enroll@bcbssc.com
  - **Fax Initial Credentialing:** 803-870-8919
- ✓ **PREFERRED** Provider Updates (demographics): Provider.Blue.Updates@bcbssc.com
  - **Fax Provider Updates (demographics):** 803-264-4795
- ✓ **PREFERRED** Recredentialing: Recred.App@bcbssc.com
  - **Fax Recredentialing:** 803-870-9997
- ✓ **Fax EFT:** 803-870-8065

In order to expedite the processing of your application, **all required information** must be submitted. Please do not submit an incomplete application, as the process cannot begin until all of the required information is received.

Contract signatures must be wet signatures.
E-signatures and stamped signatures are not accepted.

Please use these new email addresses to correspond with us.

Do not send emails to Provider.Cert any longer.

The Review Process

We received your application … What happens next?

- We confirm receipt of your application
- We review your application to ensure all requested documentation is included and current
- We request missing or incomplete information for a **60-day maximum**.
- We primary-source verify this information:

Licensure

Education

Board Certifications

DEA License

The Review Process

Completed Applications

Are sent to the Enrollment Committee to be reviewed.

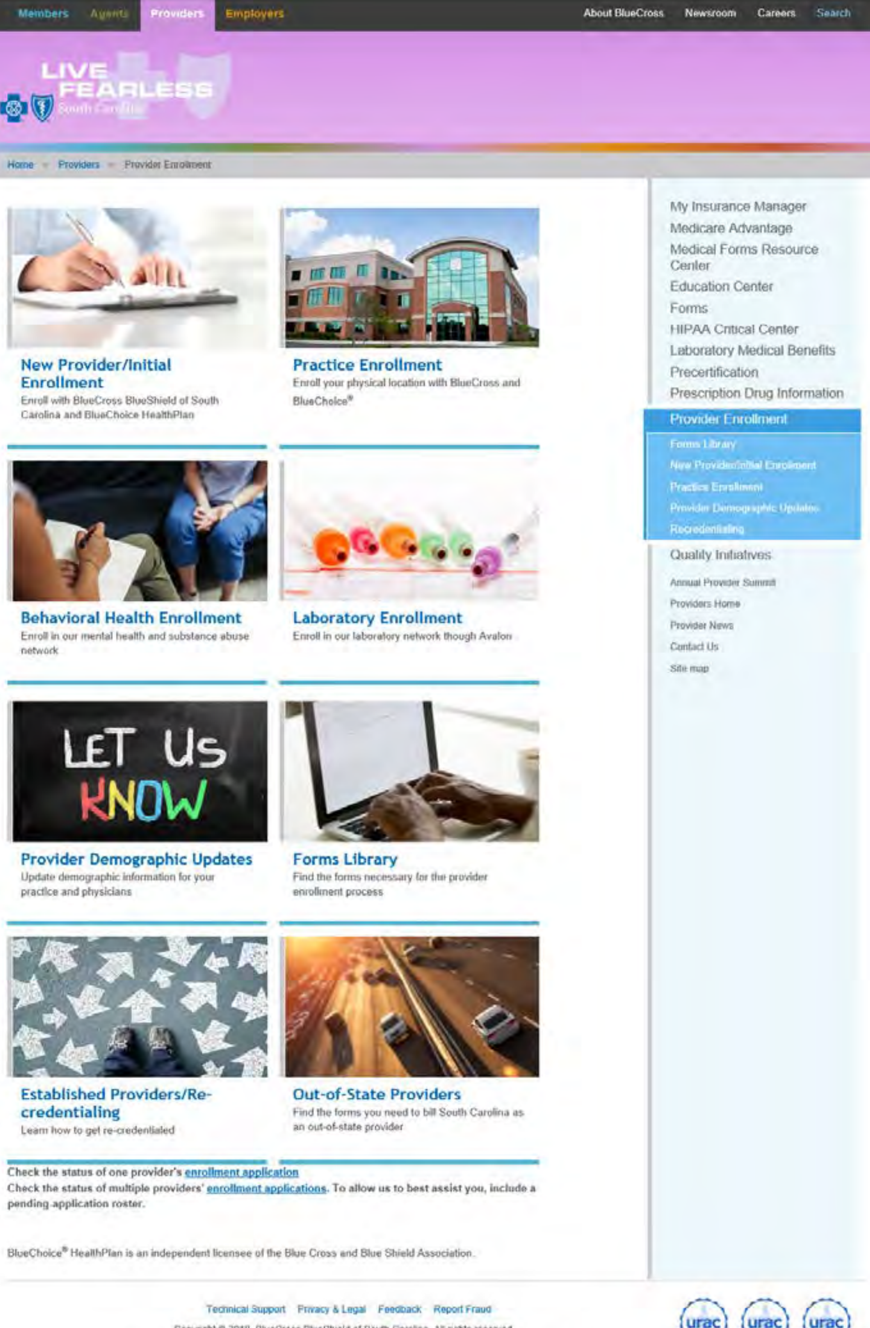
The effective date is the date the Enrollment Committee approves the application. Regulations prevent us from backdating effective dates.

The review period begins after all required documentation is received.

Provider Enrollment Webpage

Four Easy Steps:

1. Use the checklist to find the forms you need based on your specialty.
2. Fill out the appropriate forms, and collect the required documentation.
3. Request the appropriate network contracts. Sign and include with your application.
4. Submit a Complete Application with all required signatures and documentation to Provider.Blue.Enroll@bcbssc.com.



Recredentialing

Re-credentialing is required every **three** years.

Our credentialing staff will contact you to let you know when it is time for you to complete this update.

The Re-credentialing Form can be found in the Existing Providers/Recredentialing section of www.SouthCarolinaBlues.com.

Once completed, please return the form and all required documentation via email to Recred.App@bcbssc.com, or by fax at 803-870-9997.

Being Proactive

You can recredential providers up to six months before their recredentialing dates.

Ask your Education Representative for a provider roster that includes your providers' effective dates. Use the Provider Education Contact Form to contact us.

The re-credentialing form and required documentation can be found in the Existing Providers/Recredentialing section of www.SouthCarolinaBlues.com.

Once completed, please return the form and all required documentation via email to Recred.App@bcbssc.com, or by fax at 803-870-9997.

Recredentialing

This process consists of a **five-page Managed Care Practitioner Credentials Update Form**. It is an abbreviated version of the Provider Enrollment Application, so the same guidelines apply:

- Office/credentialing contact , phone number and email address is needed.
- Hospital admitting information is required. If the provider does not admit, an admitting plan must be submitted.
- Providers will need to submit a copy of their malpractice coverage that will not expire within 30 days.
- If the provider answers **Yes** to any question on **page 2,** a detailed explanation is required.

Signature dates on page 2, 3 and 5 must be less than 180 days old.

Dental Credentialing

Dental credentialing is for the Participating Dental and State Dental Plus networks.

Other plans that use the Participating Dental Network include:

- BlueCross Federal Employee Program (FEP)
- BlueDental^{SM}
- FEP Basic and Standard
- GRID members

For **Initial and Recredentialing** use the South Carolina Dental Credentialing Application.

Fax completed applications, documentation and contract signature page(s) to 803-870-8919.

DENTAL ENROLLMENT APPLICATION

We cannot process this Credentialing Application until you complete it in full.
Please maintain a copy of this Credentialing Application for your records.

Please note that your individual dentist contract is portable and we will apply it to all current locations where you are practicing as identified in this application.

The information contained in this application will be used by the contracting entity of each participation agreement and for each network you wish to participate in, including those of affiliates.

The Enrollment Application is complete when:

- ☐ You have signed and dated it
- ☐ You have attached current copies of these:
  - ☐ Dental license (provide copies for EVERY state in which you are licensed)
  - ☐ Federal DEA registration for EVERY ENTITY in which the DDS is prescribing controlled substances (or documentation that DEA registration is pending).
  - ☐ American Board/Specialty Certificate (if applicable)
  - ☐ Professional Liability Insurance Declaration Page for each state in which you practice, showing policy limits, dentist's name, policy number, effective and expiration dates. If expiration date is within weeks of this application, submit updated documentation.
  - ☐ Authorization to Bill
- ☐ For multiple practice locations, please attach a separate sheet with the practice information.
- ☐ A signed contract signature page for the Participating Dental Network. Request a copy.

Email the application and required documentation to Provider.Blue.Enroll@bcbssc.com or fax 803-870-8919.

Notice of Applicant's Right

You may review or request the status of your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable state laws. If there are discrepancies in the information received during the credentialing process, we will notify and allow you an opportunity to correct erroneous information submitted by another party within 30 days of submitting your application. This includes information submitted by an outside primary source, such as a professional insurance carrier, state-licensed board and/or the National Practitioner Data Bank and the Healthcare Integrity Protection Data Bank.

Confidentiality Statement

Information gathered as part of the credentialing or re-credentialing process is maintained in a confidential manner and will not be communicated or reproduced.
The provision is designed to safeguard information and ensure confidentiality.

Behavioral Health Credentialing

Companion Benefit Alternatives (CBA) coordinates credentialing for mental health practitioners.

Please contact CBA at 800-868-1032, ext. 25744.

Return completed applications by **mail** or **fax**.

CBA is a separate company that administers mental health and substance abuse benefits on behalf of BlueCross and BlueChoice HealthPlan.

BEHAVIORAL HEALTH
PROVIDER CREDENTIALING APPLICATION

APPLICATION CHECKLIST:

[ ] Completed application.
[ ] If this is a new office location, completed W9 form or appropriate IRS documentation *(Letter 147C, CP 575 E or tax coupon 8109-C).*
[ ] A signed network agreement for each network you wish to apply.
The agreement may have more than one signature page. Be sure to sign all signature pages. If you need an agreement for Companion Benefit Alternatives (CBA), Medicare Advantage or Medicaid MCO, please email your request to: CBA.provrep@companiongroup.com.
[ ] Copy of state license.
[ ] Copy of DEA license (if applicable).
[ ] Copy of board certification (if applicable).
[ ] Copy of protocol (advanced practice registered nurses).
[ ] Proof of current malpractice coverage.*
[ ] Completed disclosure of ownership and control interest statement (required for Medicaid MCO network).

*Coverage limits vary: MD = JUA/PCF[1] or $1,000,000/$3,000,000
All others = $1,000,000/$1,000,000

Our health plan partners no longer use paper remittances. This includes paper remittance advices and paper checks. All payments and remittance advices will only be provided electronically. If your group or practice is not currently a Palmetto Paperless Provider, be sure to complete both the Terms and Conditions for Electronic Payment and the Electronic Funds Transfer Authorization Form and return them with your application.

Please enclose all information and allow at least 30 days for processing before checking on the application status. We cannot process applications until we receive all information. Retain a copy of all application materials for your records.

RETURN APPLICATION TO:
Companion Benefit Alternatives, Inc.
ATTN: Provider Network Coordinator AX-315
PO Box 100185
Columbia, SC 29202
Fax Number: 803-714-6456

[1] JUA = Joint Underwriting Association; PCF = Patient Compensation Fund
G/CBA/Form/Behavioral Health Network Services
FPN042-Credentialing Application

Behavioral Health Credentialing

In late spring 2019, behavioral health providers will be able to apply via an online application at www.companionbenefitalternatives.com.

General Inquiries: cba.provrep@companiongroup.com

Credentialing for Telemedicine

What is Telemedicine?
A consultation between referring and consulting physicians for specific specialties through interactive audio and video telecommunication systems that permit two-way communication.

Which providers are eligible for Telemedicine?
Providers who meet the contracting requirements and are currently in-network are eligible to submit claims for telemedicine and 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?
The medical policy **CAM 032 Telemedicine** gives complete information about our telemedicine program.

Telemedicine Services Application

South Carolina

TELEMEDICINE SERVICES APPLICATION

Facility, Clinic or Practice Name: ______________________________

Taxpayer Identification Number (TIN): ____________________

National Provider Identifier (NPI) Number: ________________

Physical Address: ______________________________

City, State and ZIP: ______________________________

Are you able to comply with these requirements?

Yes	No	Requirement
Yes	No	Provide medically necessary services via an interactive audio and video telecommunications system which permits two-way communication between the referring physician's site and the consulting physician's site.
Yes	No	Provide telemedicine services that comply with the American Telemedicine Association (ATA) standards, and conduct these services in accordance with the terms and conditions expressed in the BlueCross BlueShield of South Carolina or associate plan telemedicine policy and all other federal and state laws and regulations.
Yes	No	Provide technically sufficient telemedicine equipment, transmission speed and image resolution at the referring physician's and consulting physician's sites, and allow the consulting physician to appropriately evaluate, diagnose or treat the patient for services billed.
Yes	No	Confirm all telecommunication services use an acceptable method of encryption that is secure and HIPAA compliant to protect the confidentiality and integrity of the information transmitted.

Please email each of these to provider.blue.enroll@bcbssc.com:

- ☐ Written quality of care protocols for telemedicine services
- ☐ Patient confidentiality protocols for telemedicine services
- ☐ A sample copy of the informed consent form for telemedicine services

Please list the provider(s) of telemedicine services at this site:

Provider's Name:	Provider's NPI:	Services Provided:

Authorized Contact Person for This Site: ________________

Telephone Number for This Site: ________________

By selecting "Yes," you understand that the performance of this service must be appropriately documented in medical records, and is subject to audit by BlueCross BlueShield of South Carolina or associate plan, federal and state agency representatives.

Name: ____________________ Title: ____________

Telephone: ____________

Please submit your application to Provider.Blue.Enroll@bcbssc.com.

Telemedicine Services

Acceptable Services

- Consultation for high-risk pregnancy
- Consultation for acute stroke treatment
- Pharmacologic management, and psychiatric diagnostic interview examinations and testing
- Emergency Room-to-Emergency Room consultations
- Specialty consultations provided to hospitalized inpatients

Unacceptable Services

- Telephone conversations
- Email messages
- Video cell phone interactions
- Facsimile transmissions
- Services provided by allied health professionals that are neither allopathic or osteopathic physicians
- Internet-based audio-video communication that is not secure and HIPAA compliant (e.g., Skype)

Telehealth is the interaction between patient and clinician via the Blue CareOnDemand application. Visit www.BlueCareOnDemandSC.com for more information.

Provider Validation: M.D. Checkup

- The M.D. Checkup process unites providers and members by allowing you to validate your information and making it available to BlueCross members worldwide through provider directories, accessible online anywhere at any time.
- You'll receive a questionnaire by email from Provider Enrollment. Review and validate key demographic information for your practice such as your office hours, telephone number and address and we'll do the rest!
- Be proactive! Visit the Provider Validation tool to perform M.D. Checkup online in My Insurance Manager.

Notification of any changes to your office demographics should be updated immediately to avoid directory and billing errors. This includes terminated providers.

M.D. Checkup

Provider Name	Hours of Operation
Physical and Billing Addresses	EHR
Phone Numbers (Daytime and 24 Hour)	Practice Management System
Fax Number	Website, if applicable
* **Accepting New Patients?**	Group Affiliations
Age/Gender Restrictions?	NPI/ TIN
Email Address	Name Changes/Merger
Admitting Privileges	Languages Spoken
* **Validating Physicians in the Practice**	

M.D. Checkup

The **Location Details** screen shows the practice details:

- Address
- Telephone
- Fax
- Email
- Website
- Hours of operation
- Affiliated practitioners

The **Edit** function allows users to modify the information shown.

Provider Data Validation - Location Details

Need help? Ask Provider Services

Verify Locations > **Location Details**

PROVIDER 1

Requires Verification

Back | Remove Location | Edit | Verify

803-555-1234 info@email.com
803-555-1235 www.example.com

Instructions: Please verify that all of the the information associated with this location as well as the Practitioner information is correct.

Provider Location Information	
DBA Name	NORTH PROVIDER 1
Specialty	NEUROSURGERY
Billing Name	PROVIDER
Billing NPI	0123456789
Physical Address	Address, Columbia, SC
Billing Address	Address, Columbia, SC

Hours of Operation	
Monday	8:00 AM - 5:00 PM
Tuesday	8:00 AM - 5:00 PM
Wednesday	8:00 AM - 5:00 PM
Thursday	8:00 AM - 5:00 PM
Friday	8:00 AM - 4:00 PM
Saturday	10:00 AM - 6:00 PM
Sunday	Closed

Affiliated Practitioners - Provider 1

Search...

You can search by Practitioner Name, NPI or Specialty

Add Practitioner

M.D. Checkup

Home | Patient Care | Office Management | Resources | Modify Profile | Profile Administration | Staff Directory | Provider Update

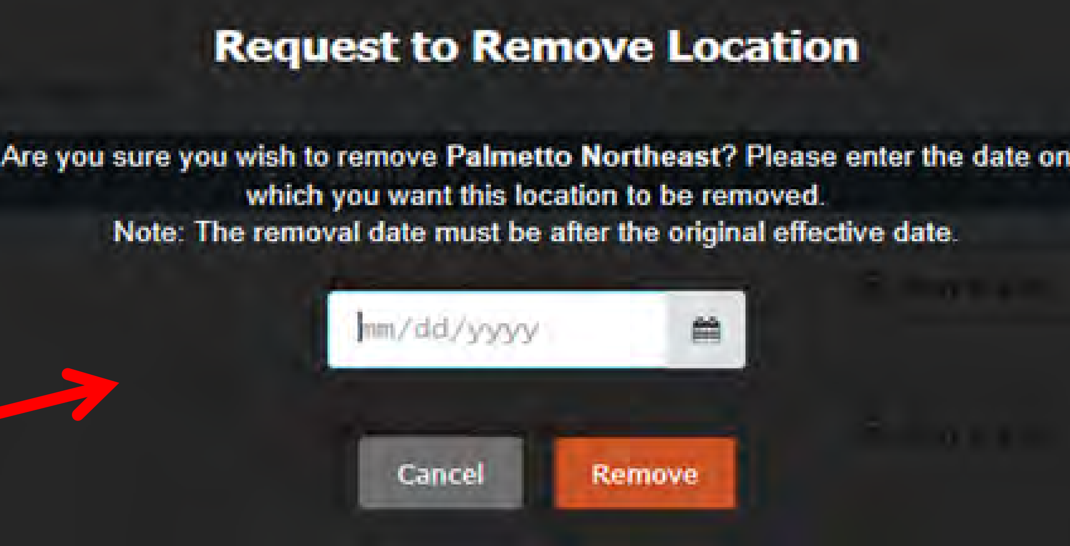
Provider Data Validation - Locations List

Instructions: Please verify that every location in this list is associated with your practice and that all of the information is correct.

Search locations...

Location	Status	
Provider 1 Main Street	Requires Verification	View & Edit / Remove Location
Provider 2 Pine Road	Requires Verification	View & Edit / Remove Location
Provider 3 Davis Avenue	Requires Verification	View & Edit / Remove Location

View & Edit | Remove Location

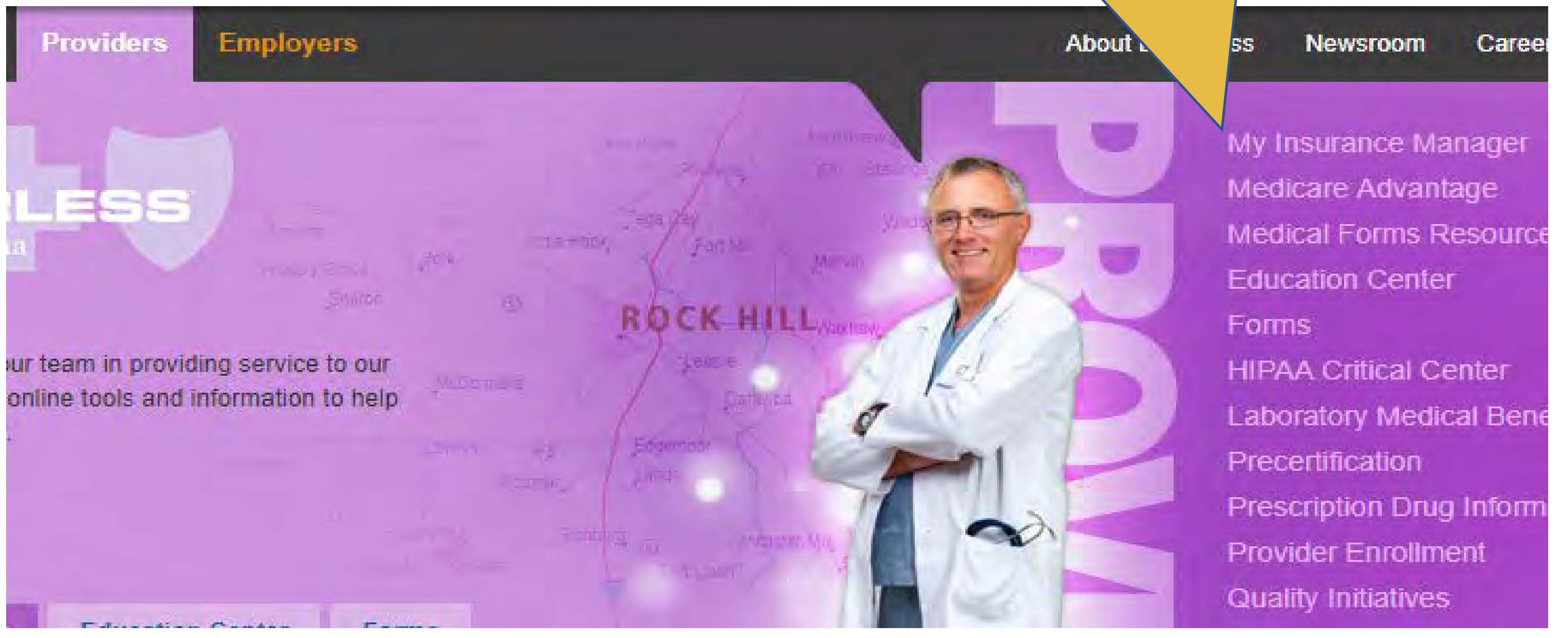


The Provider Experience

My Insurance Manager: Access

- ✓ www.SouthCarolinaBlues.com
- ✓ www.BlueChoiceSC.com

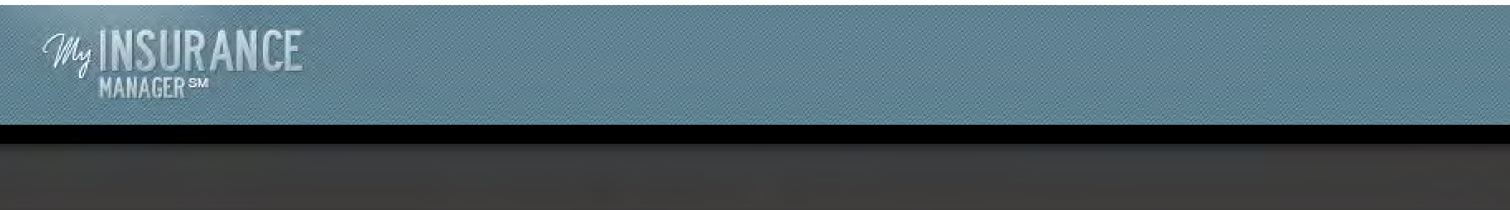
Click Provider to access My Insurance Manager.

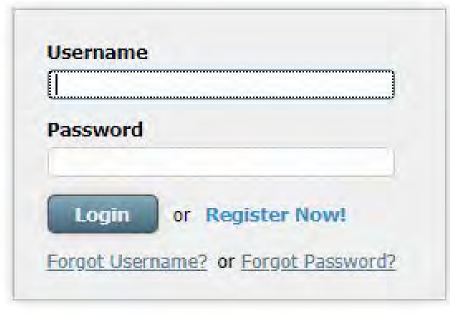


My Insurance Manager: Features

What you can do…

- ✓ Access Eligibility and Benefits
- ✓ Submit Precertification Requests
- ✓ View Claims Status
- ✓ View Remittance Advice
- ✓ Much, much more!

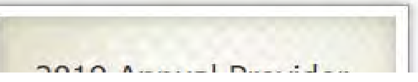


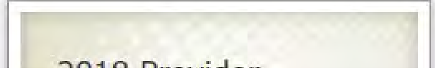


Browser Requirements

For predictable, reliable performance, we recommend viewing My Insurance Manager using one of these browsers:

Latest Features

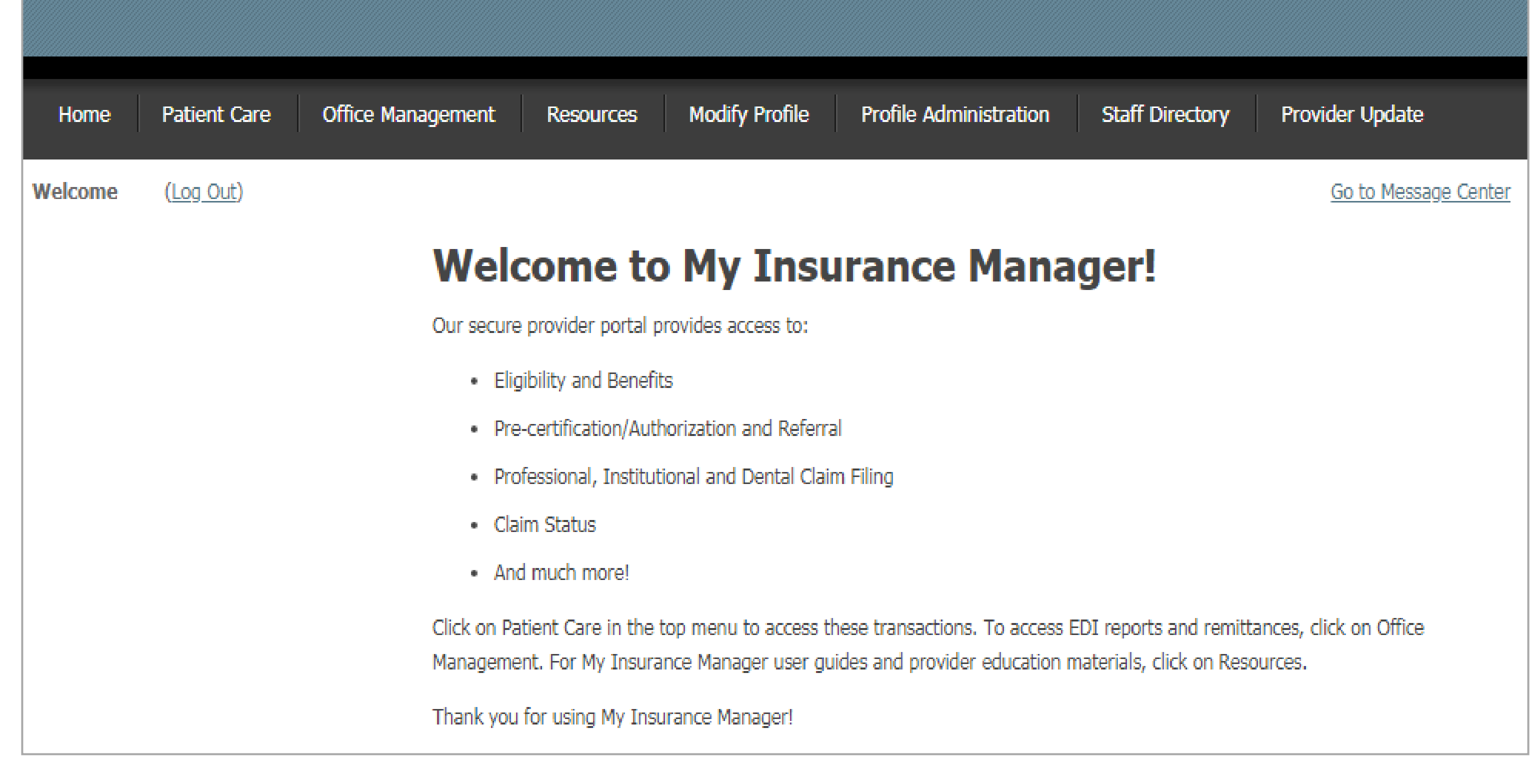




My Insurance Manager: Administrative Tab

Administrative Tab

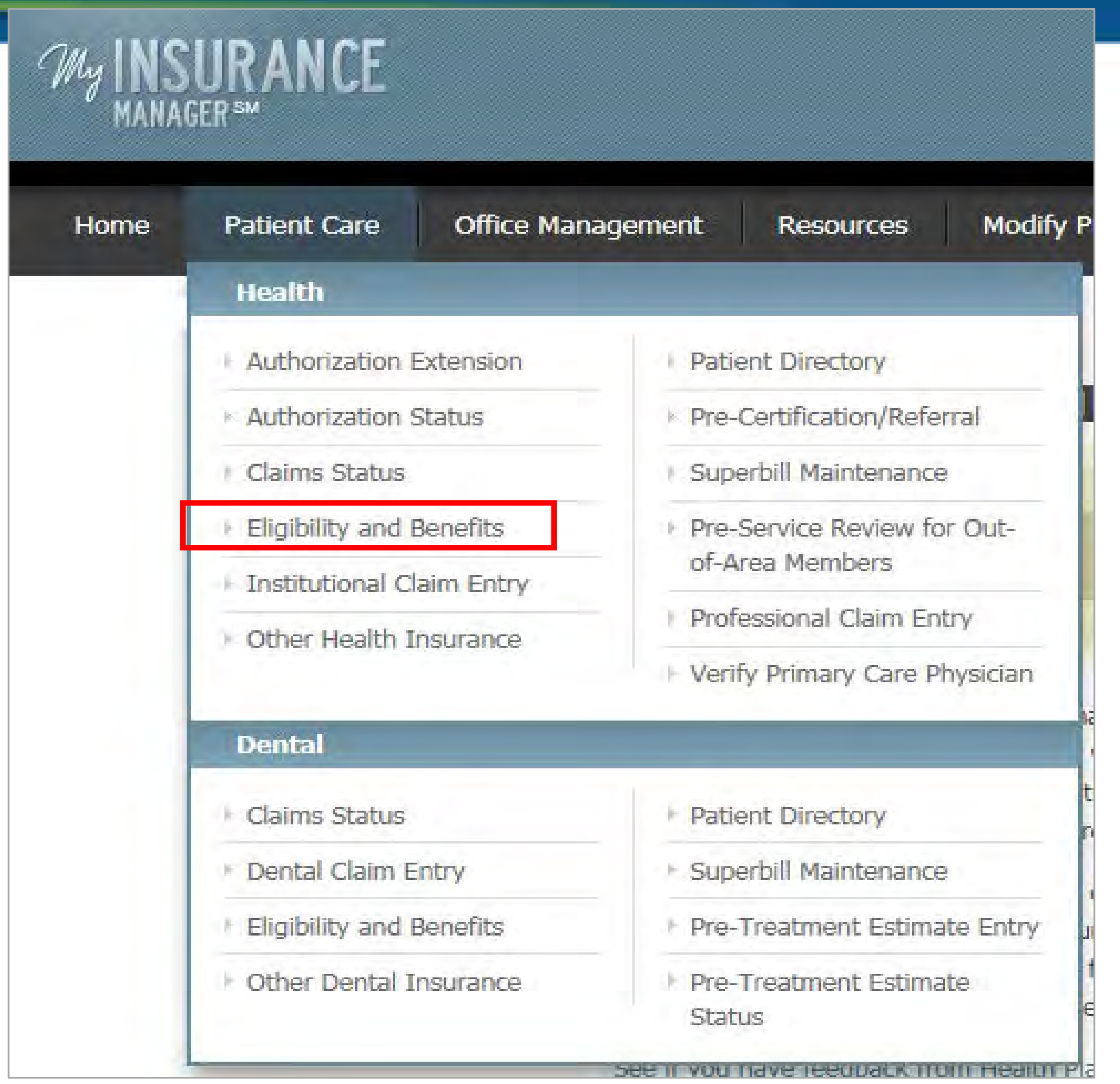
- ✓ Patient Care
- ✓ Office Management
- ✓ Resources
- ✓ Modify Profile
- ✓ Profile Administration
- ✓ Staff Directory



My Insurance Manager: Eligibility and Benefits

There are three Eligibility and Benefits search options:

- ✓ General
- ✓ Service Type
- ✓ Procedure Code



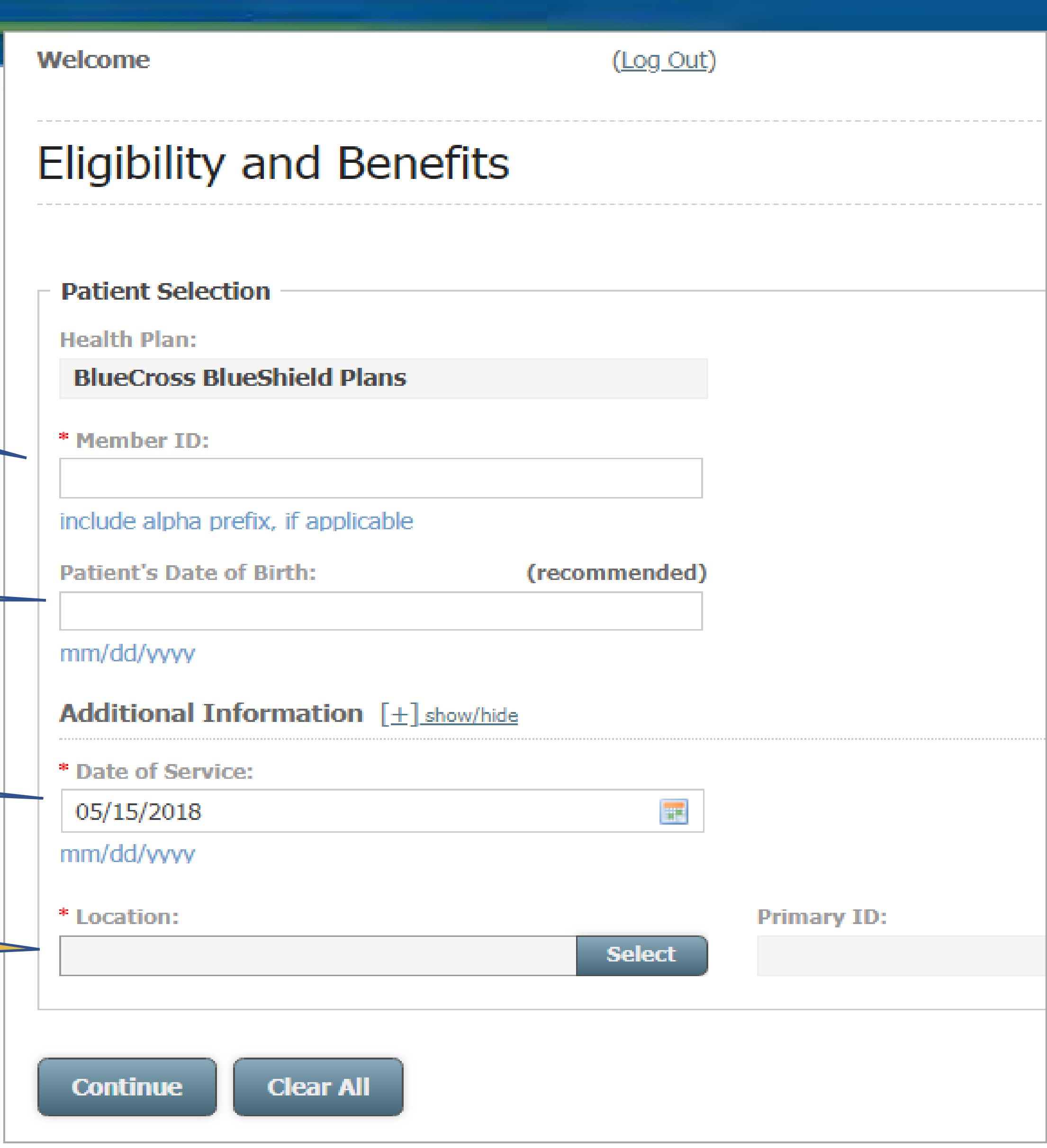
My Insurance Manager: Eligibility and Benefits

Enter the patient's Member ID including the prefix .

Enter the patient's date of birth.

Enter the date of service.

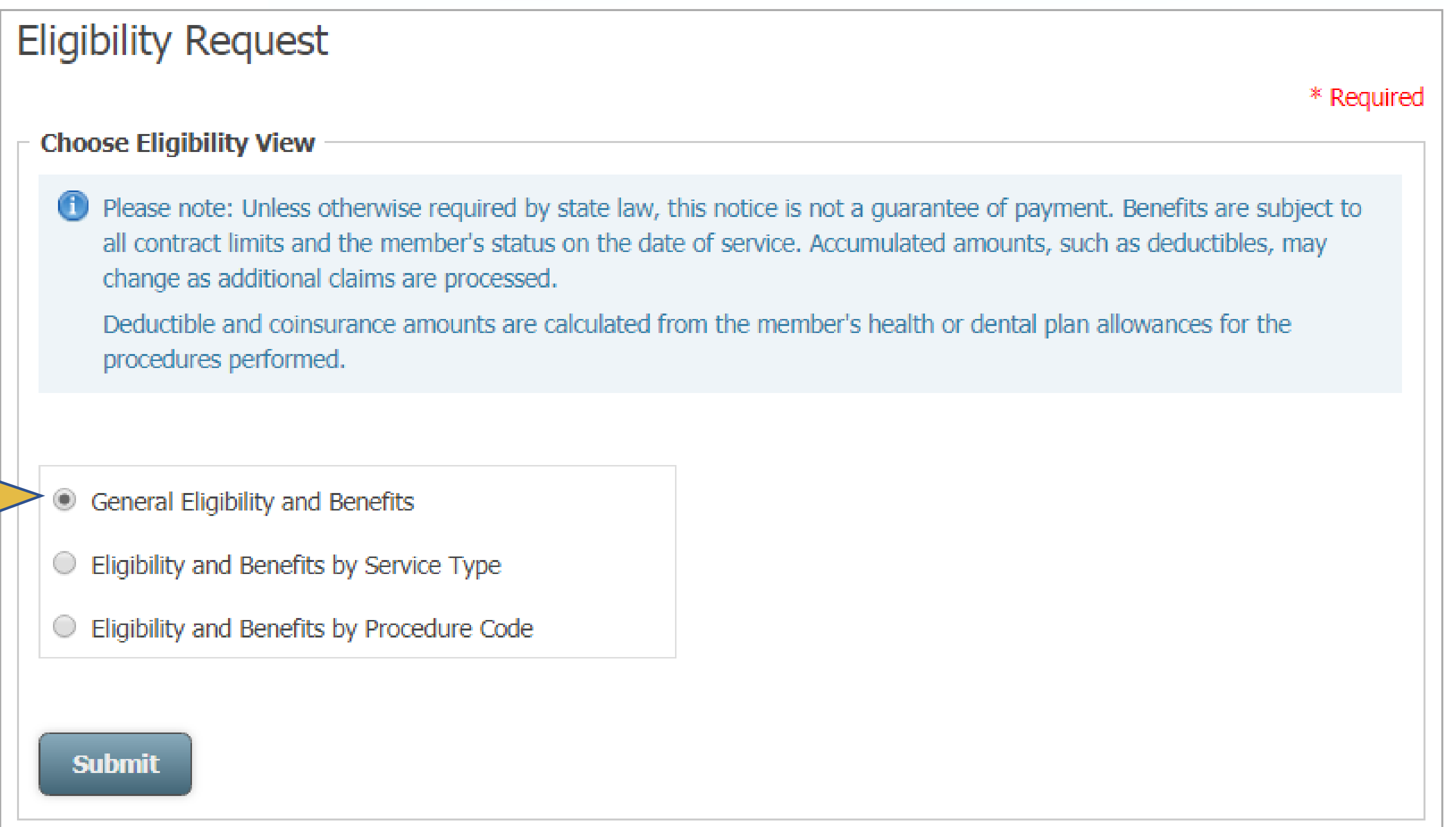
Click Select to choose a location. A list of locations associated with your tax ID will appear, then click Continue.



My Insurance Manager: Eligibility and Benefits

Click the radio button to view:

- General Eligibility and Benefits
- By Service Type
- By Procedure Code



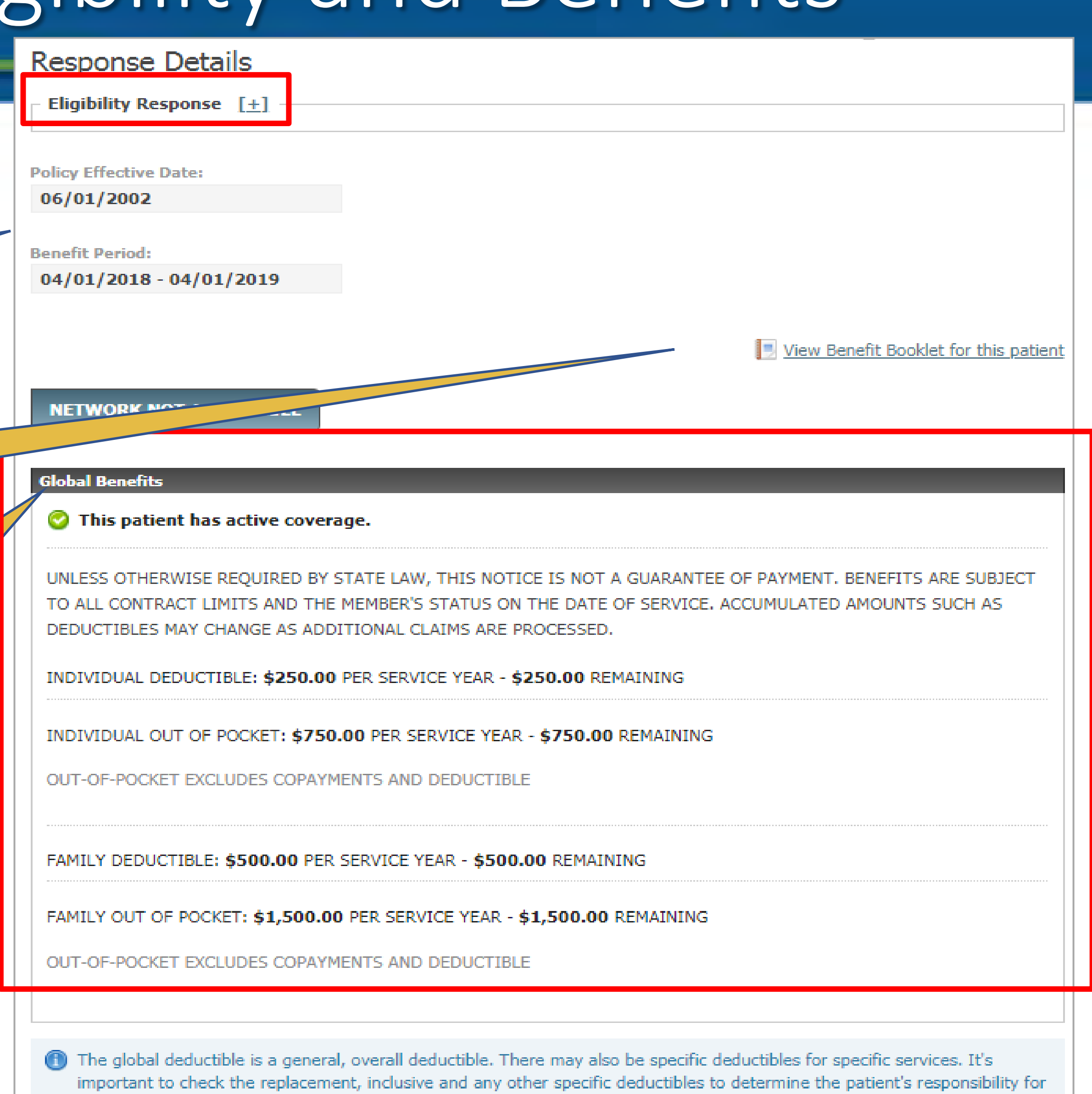
My Insurance Manager: Eligibility and Benefits

General Benefits

Policy Effective Date and Benefit Period.

Follow the link to view or download a pdf. of the member's benefit booklet.

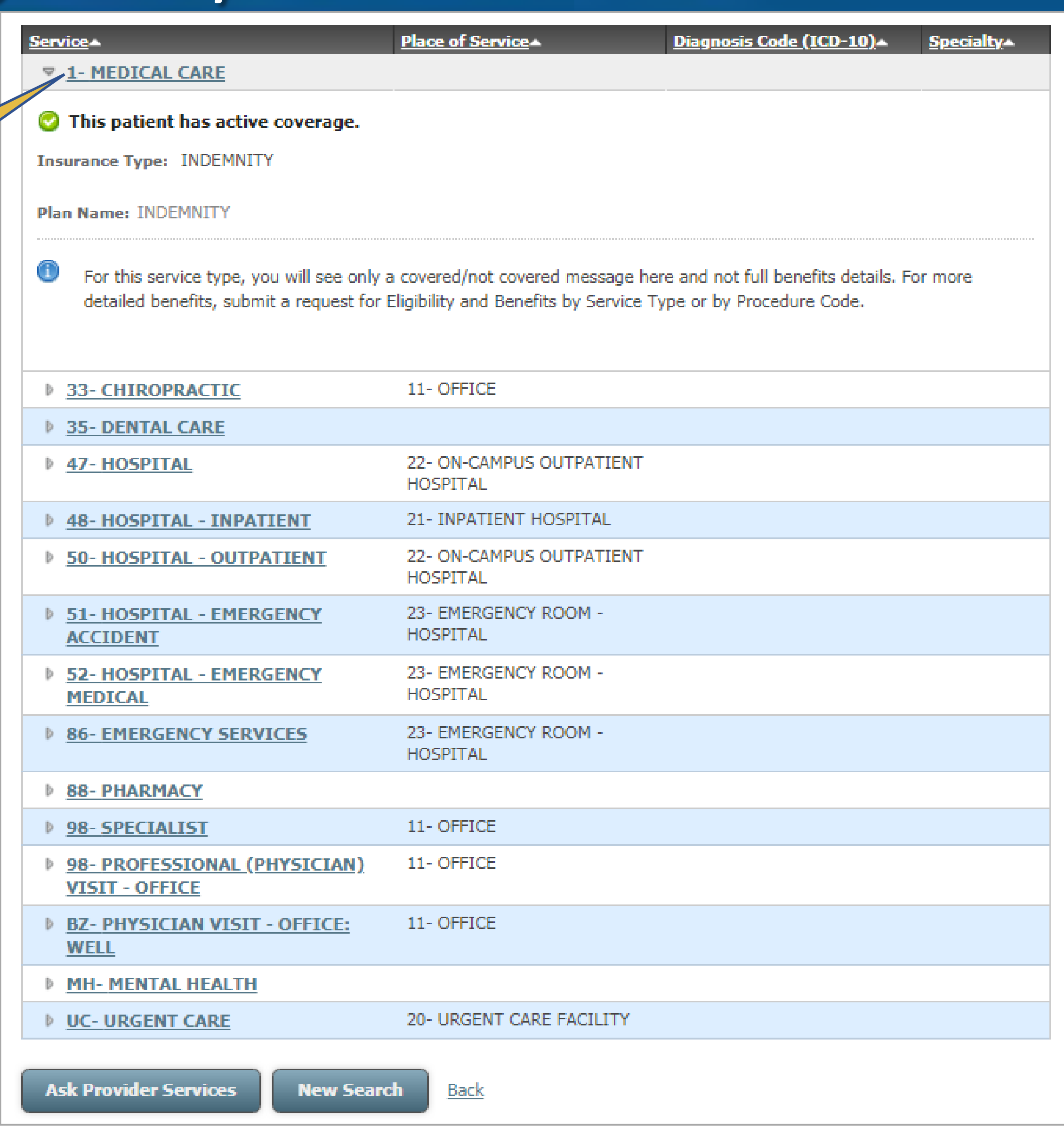
Global Benefits section shows if the patient has active coverage and deductible or coinsurance information.



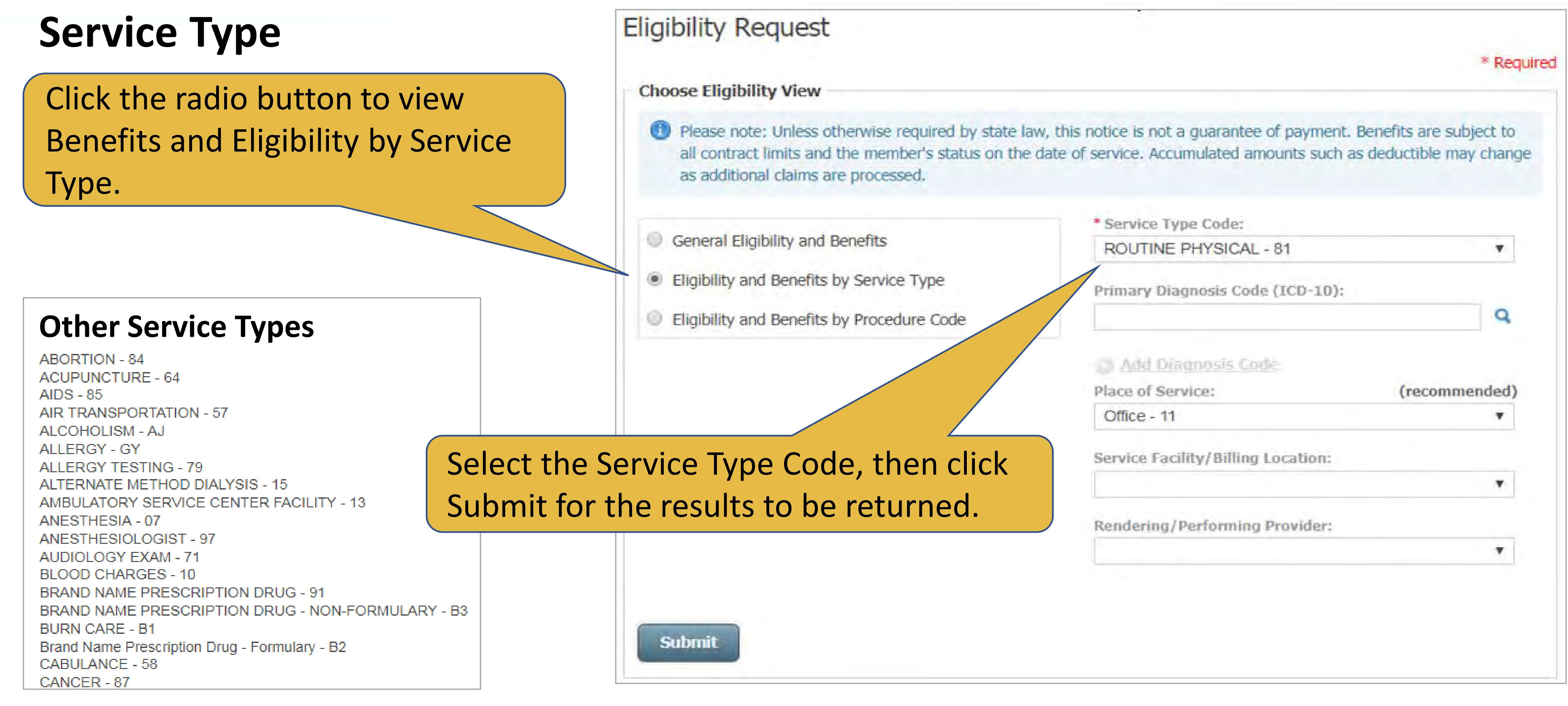
My Insurance Manager: Eligibility and Benefits

General Benefits

Expand the Service types listed to find if the patient has active coverage for that specific benefit.



My Insurance Manager: Eligibility and Benefits

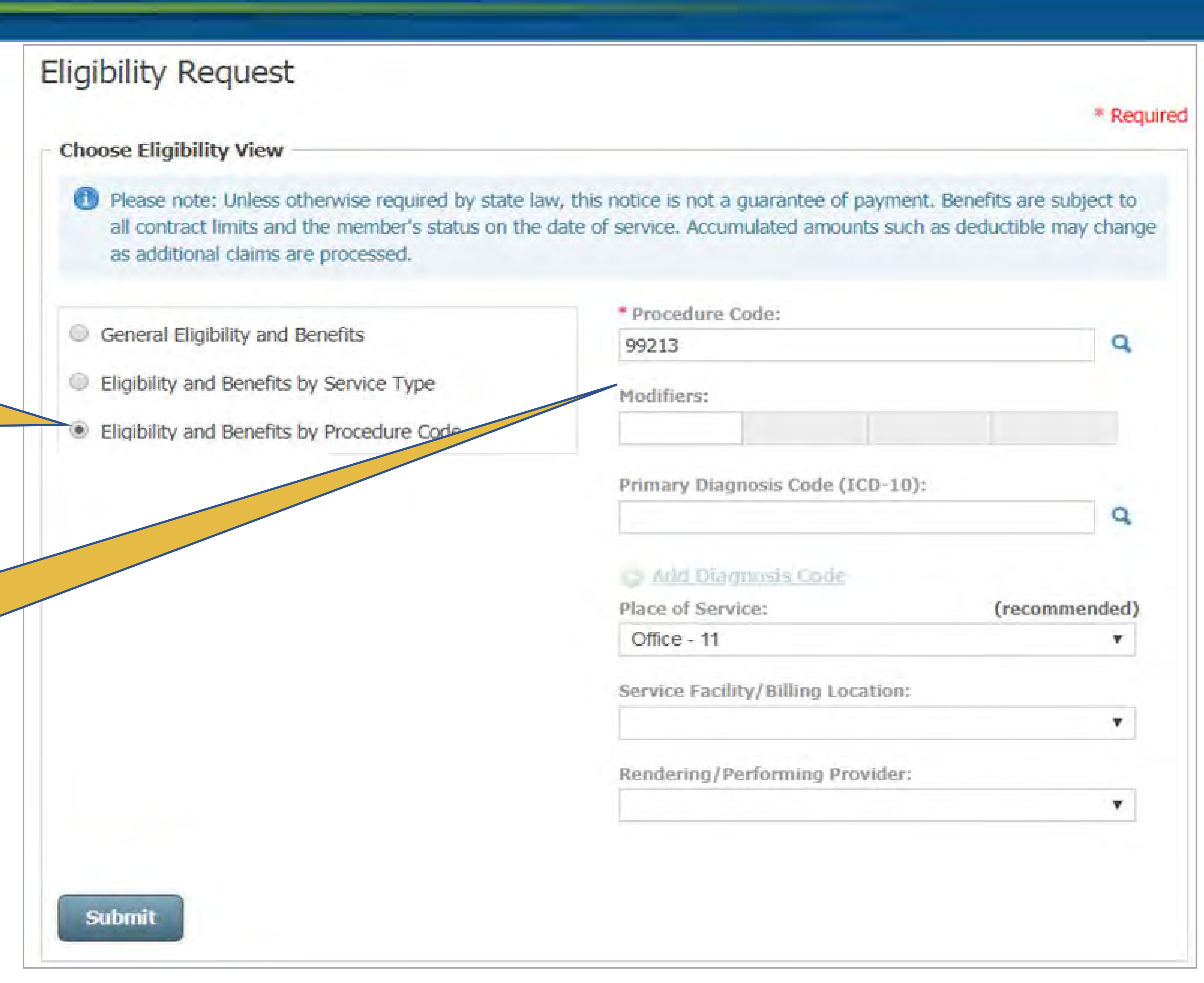


My Insurance Manager: Eligibility and Benefits

Procedure Code

Click the radio button to view Benefits and Eligibility by Procedure Code.

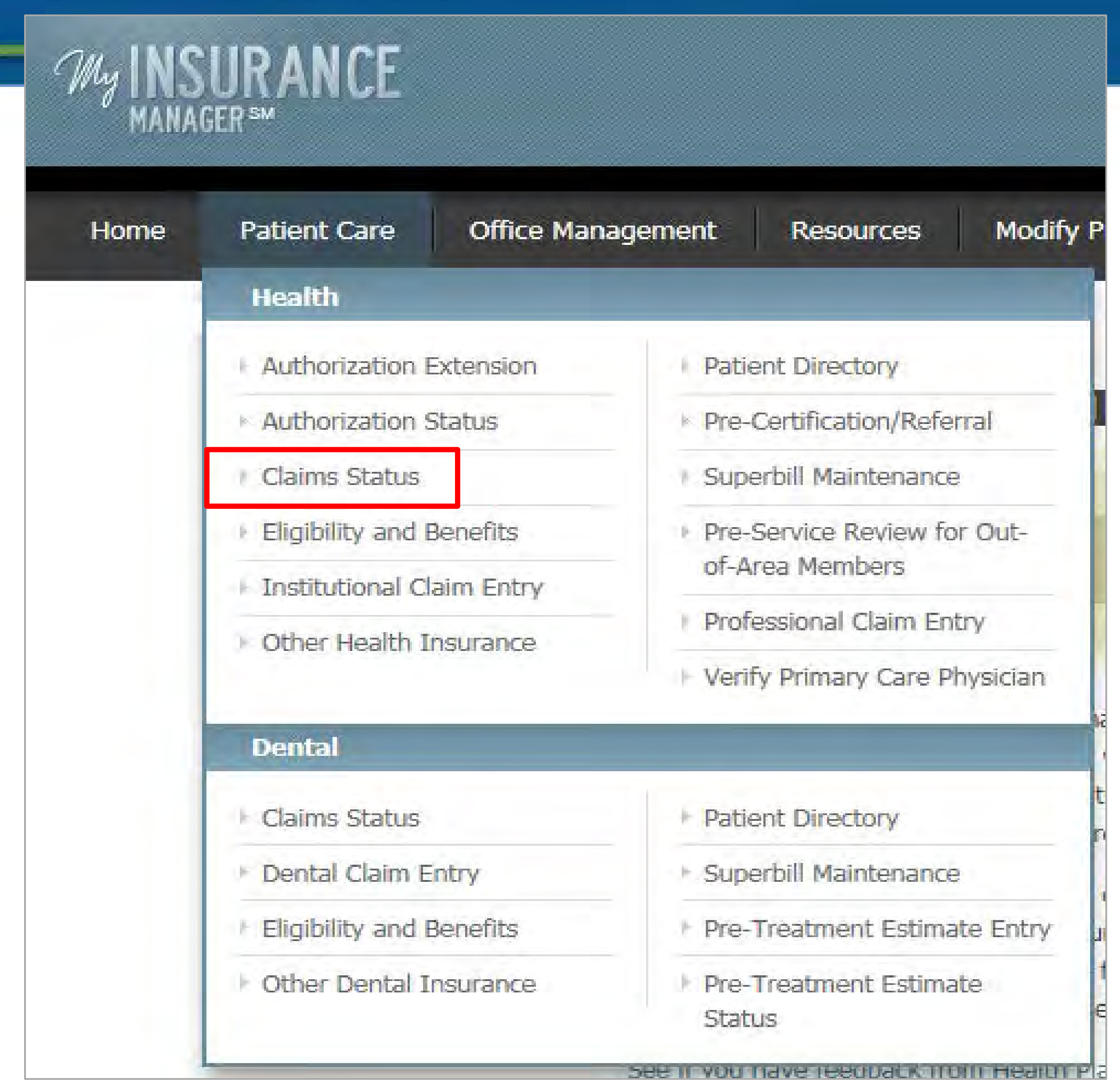
Enter the HCPCS code in the Procedure Code field. Then click Submit for the results to be returned.



My Insurance Manager: Claim Status

There are two ways to check Claims Status:

- ✓ Member ID (Recommended)
- ✓ Claim Number



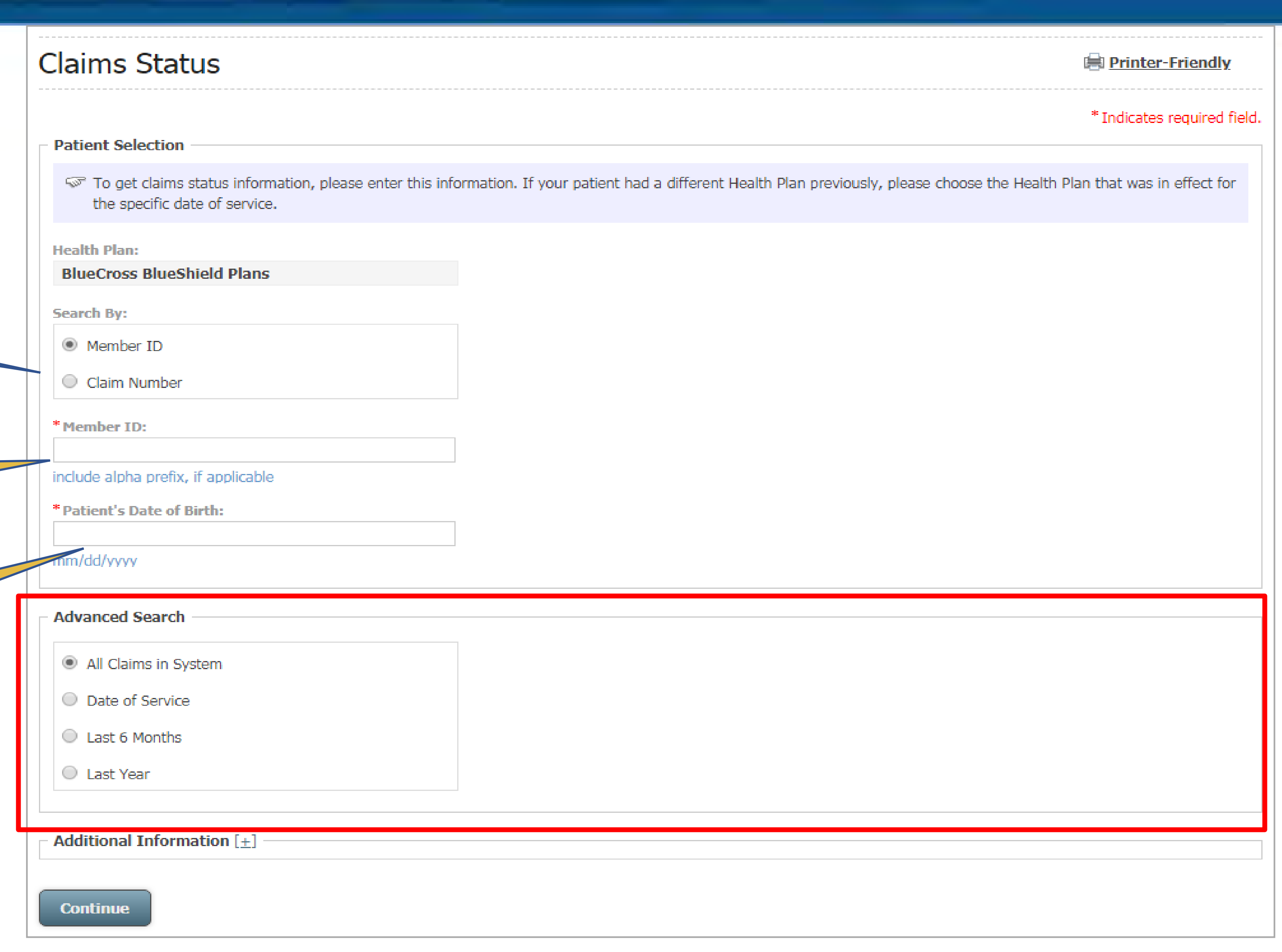
My Insurance Manager: Claim Status

Search by Member ID

Search by Member ID.

Enter the patient's Member ID including the prefix.

Enter the patient's Date of Birth, then click Continue for the search results .



My Insurance Manager: Claim Status

Claim Summary List

Claims Summary List *(click a column title to sort)*

Claim Number		Claim Status	Primary ID	Beginning Date of Service	Process Date	Total Charges
7335	0000	PROCESSED		11/17/2017	12/11/2017	$262.00
7349	0000	PROCESSED		11/03/2017	12/28/2017	$1,680.00
7321	0000	PROCESSED		10/03/2017	11/29/2017	$1,848.00
7285	0000	PROCESSED		09/05/2017	10/24/2017	$2,184.00
7262	0000	PROCESSED		08/01/2017	10/05/2017	$2,688.02
7263	0000	DENIED		08/01/2017	10/05/2017	$2,016.02
7E20	0000	DENIED		07/18/2017	08/21/2017	$336.00
7E22	0001	PROCESSED		07/06/2017	09/14/2017	$1,176.00
7D88	0002	PROCESSED		06/02/2017	10/09/2017	$2,754.00
7D58	0000	DENIED		05/31/2017	07/06/2017	$271.02
7D44	0000	PROCESSED		05/17/2017	05/25/2017	$271.02

Click any column to sort.

Click the Claim Number for the Claim Status Details.

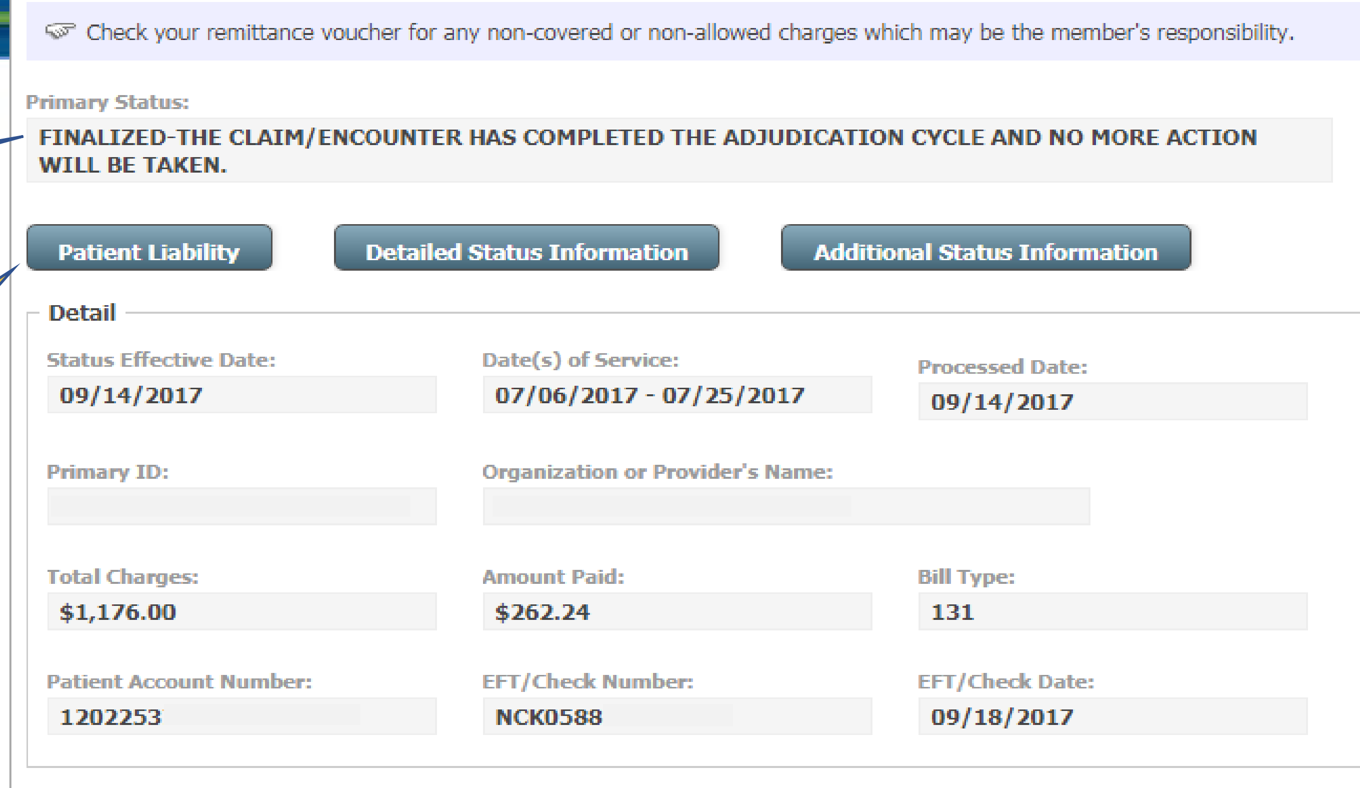
My Insurance Manager: Claim Status

Claim Status Detail

Primary Status field will show the claim as Pending or Processed.

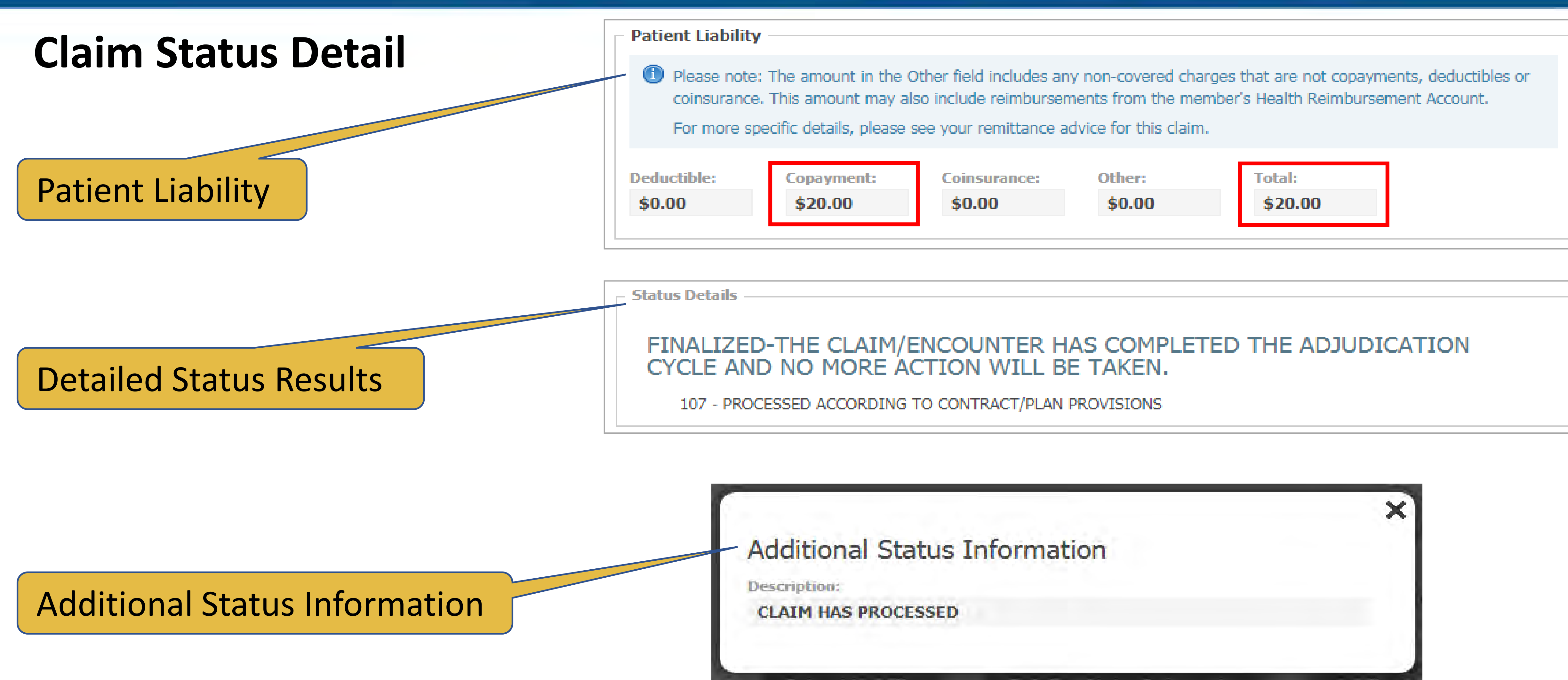
Click Patient Liability, Detailed Status Information or Additional Status Information for more claim details.

Click the Line Item number for more information about the line(s).



My Insurance Manager: Claim Status

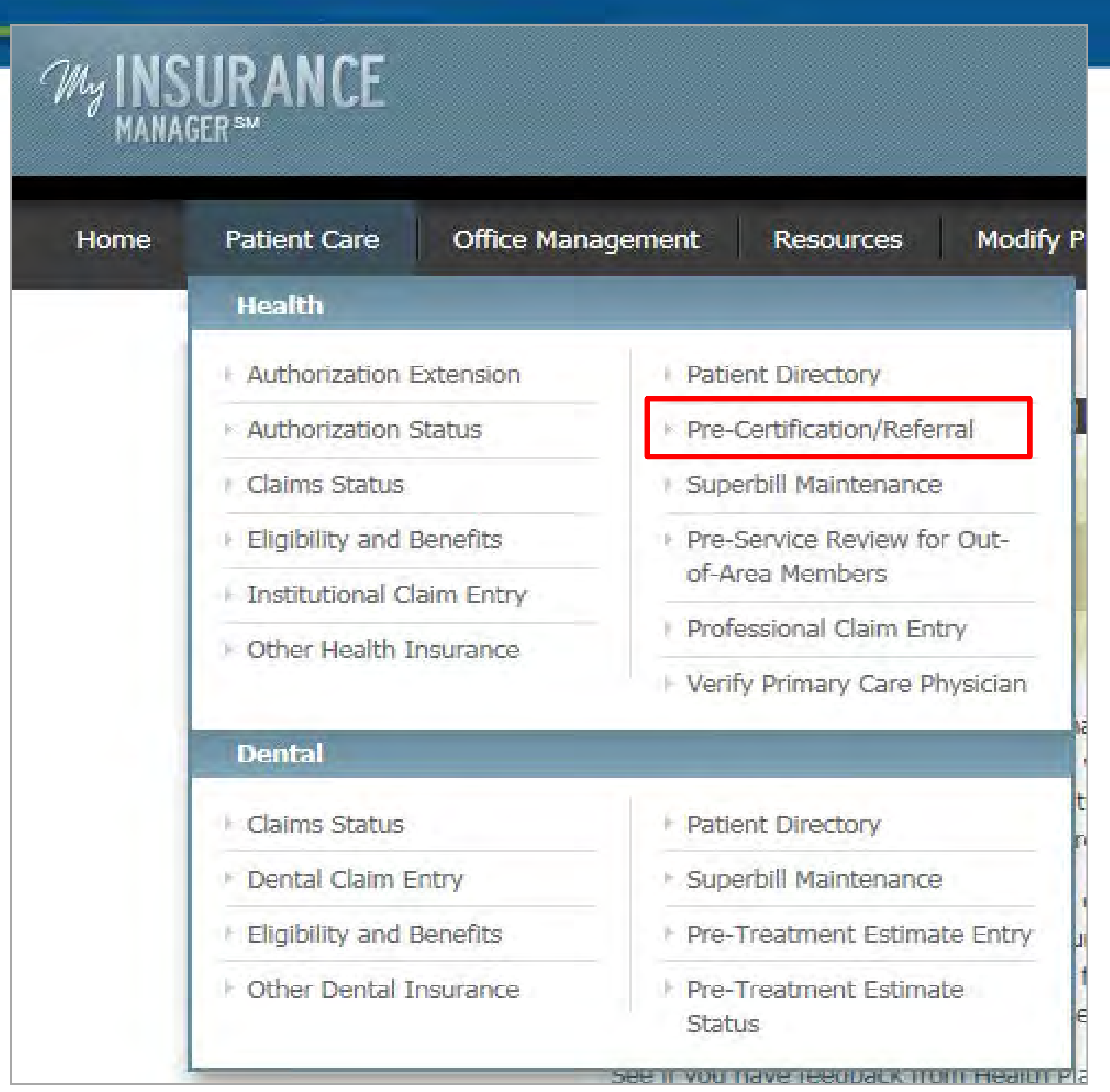
Claim Status Detail



My Insurance Manager: Precertification / Referral

Precertification/Referral

- ✓ Fast-Track
- ✓ Customize
- ✓ Attach Clinical Documentation



My Insurance Manager: Precertification / Referral

Enter the patient's Member ID including the prefix.

Enter the patient's Date of Birth.

Enter the Date of Service or Admission Date.

Enter the Location, then click Continue.

Pre-Certification/Referral

Printer-Friendly

* Required

Please note: If you navigate away from a pre-certification or referral request without finishing and submitting it, your information will be lost and you will need to start over. We will not save partially completed requests on our system.

Patient Selection

Health Plan:
BlueCross BlueShield Plans

* Member ID:

include alpha prefix, if applicable

* Patient's Date of Birth:

mm/dd/yyyy

Patient Gender:

Please note: You can submit:

- Non-behavioral Health Treatment Pre-certifications up to three days in the past and one year in the future.
- Behavioral Health Treatment requests up to five days in the past and one year in the future.
- Requests for Referrals with today's date or up to one year ahead.

* Date of Service or Admission Date:
05/15/2018
mm/dd/yyyy

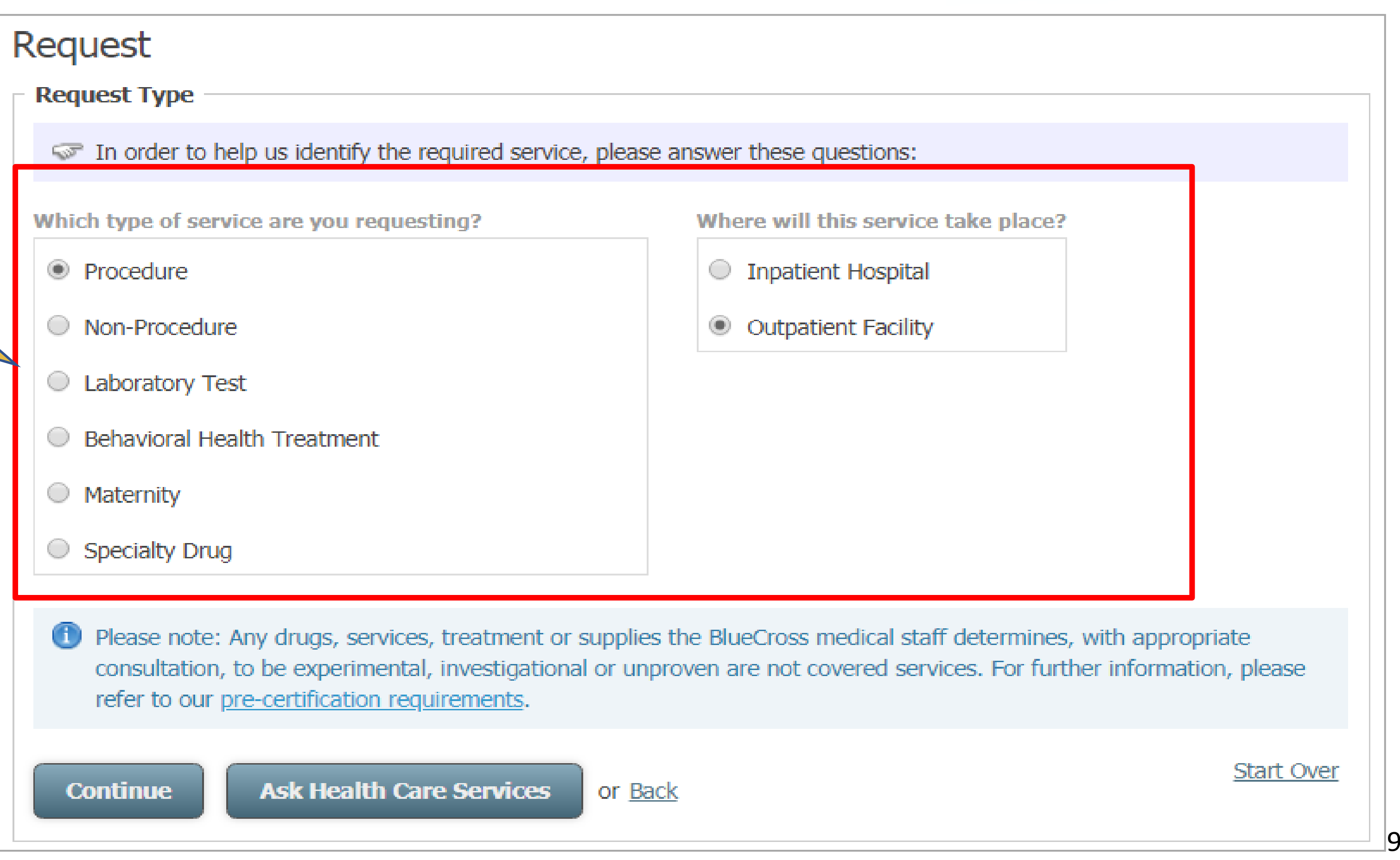
* Location: Select

Primary ID:

Continue

My Insurance Manager: Precertification / Referral

Select the type of service and where the service will take place, then click Continue.

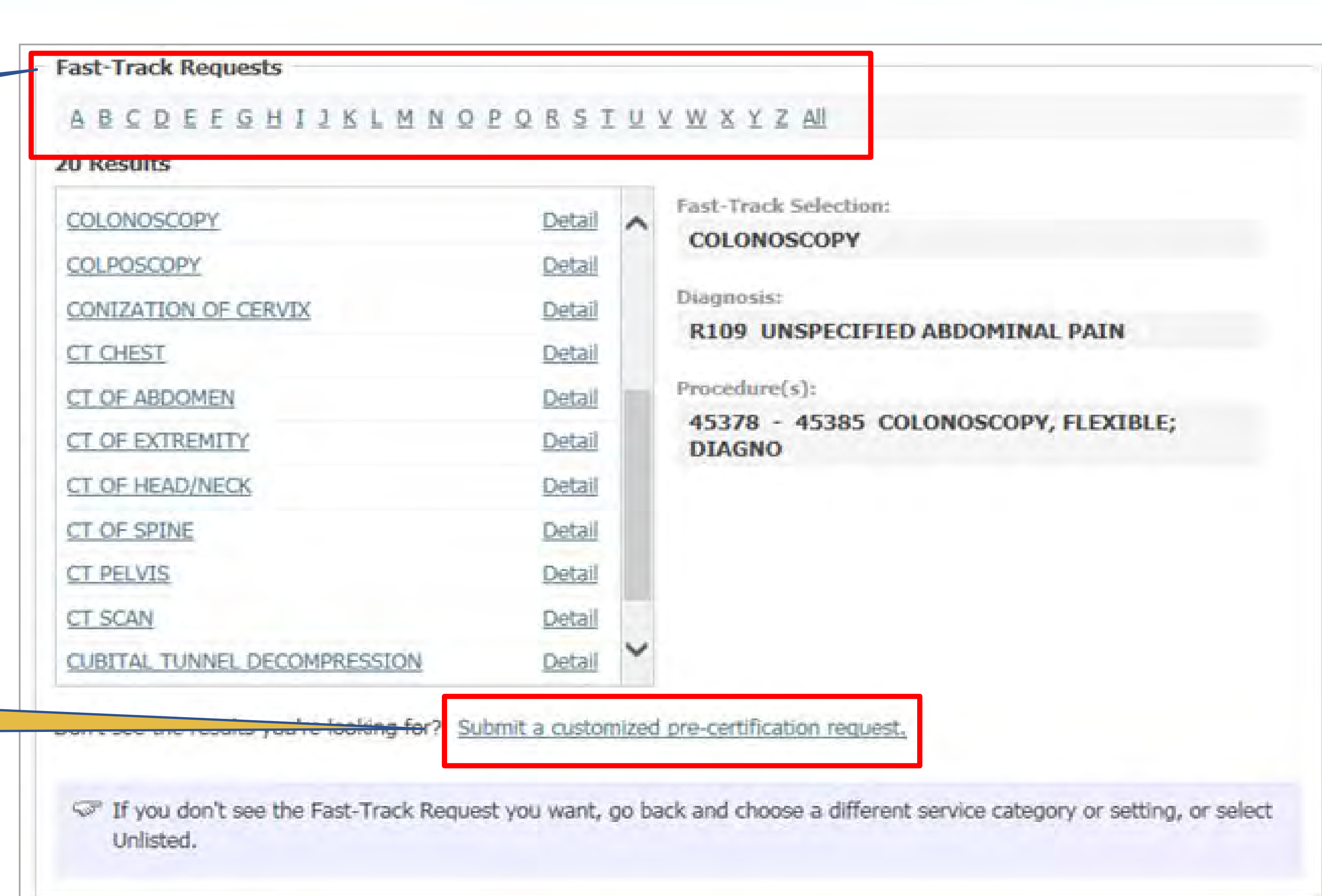


My Insurance Manager: Precertification / Referral

Fast-Track Requests

Many Fast-Track services automatically approve.

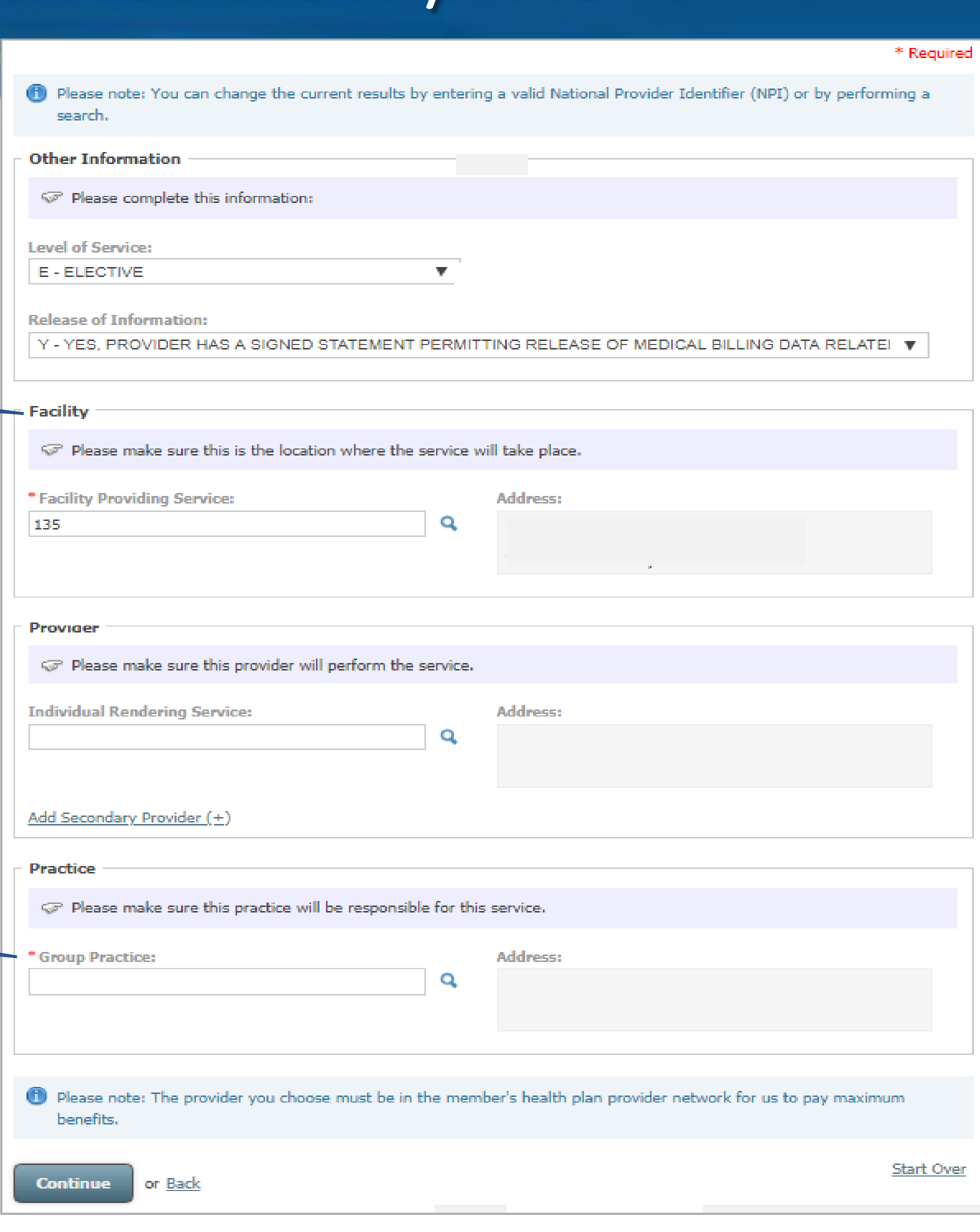
Click here to create a customized request.



My Insurance Manager: Precertification / Referral

Enter the facility providing the service.

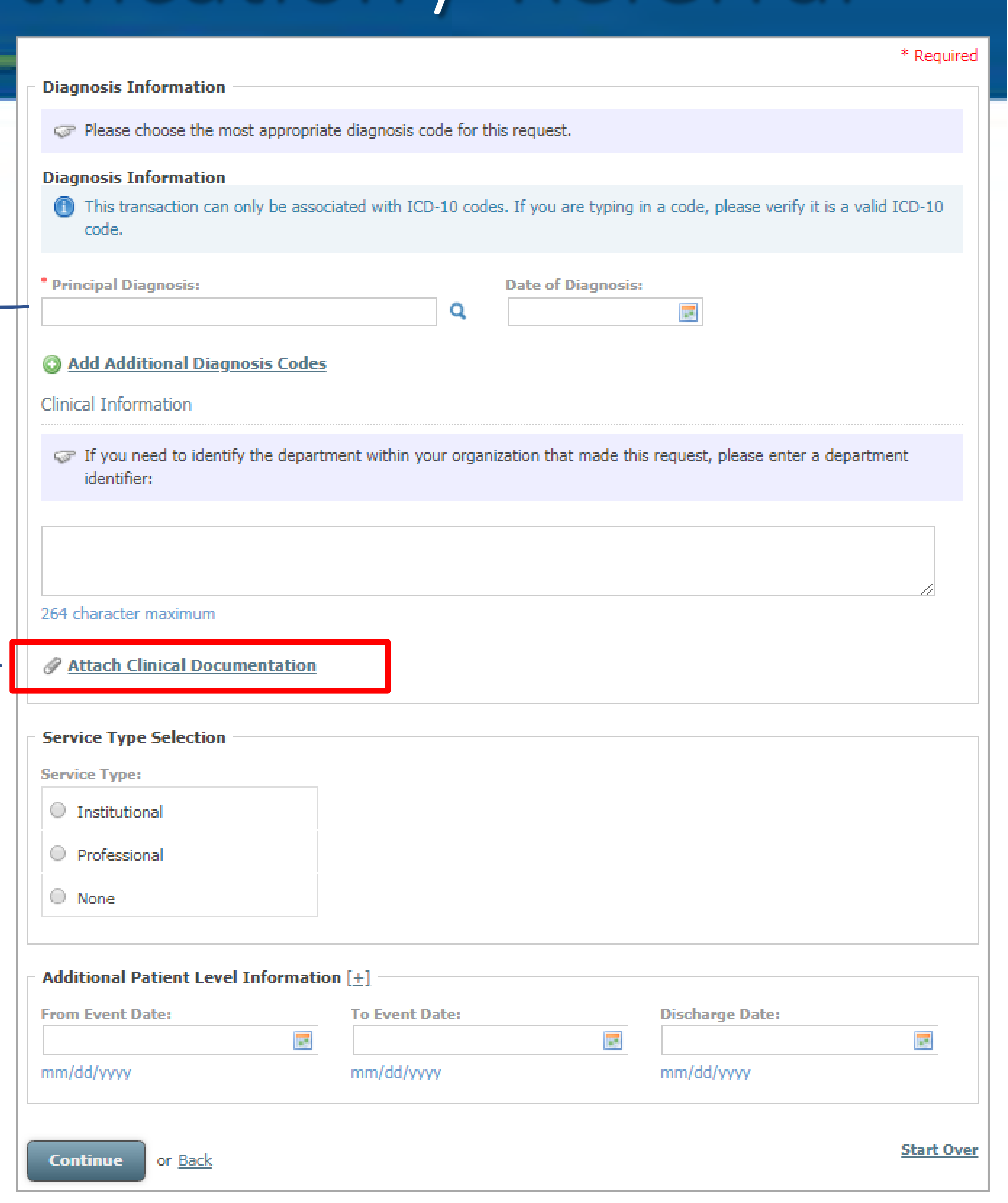
Enter the Group Practice name, then click Continue.



My Insurance Manager: Precertification / Referral

Enter the Principal Diagnosis.

Click here to add up to 10 documents. The file must be in PDF format with a maximum of 30 MB.



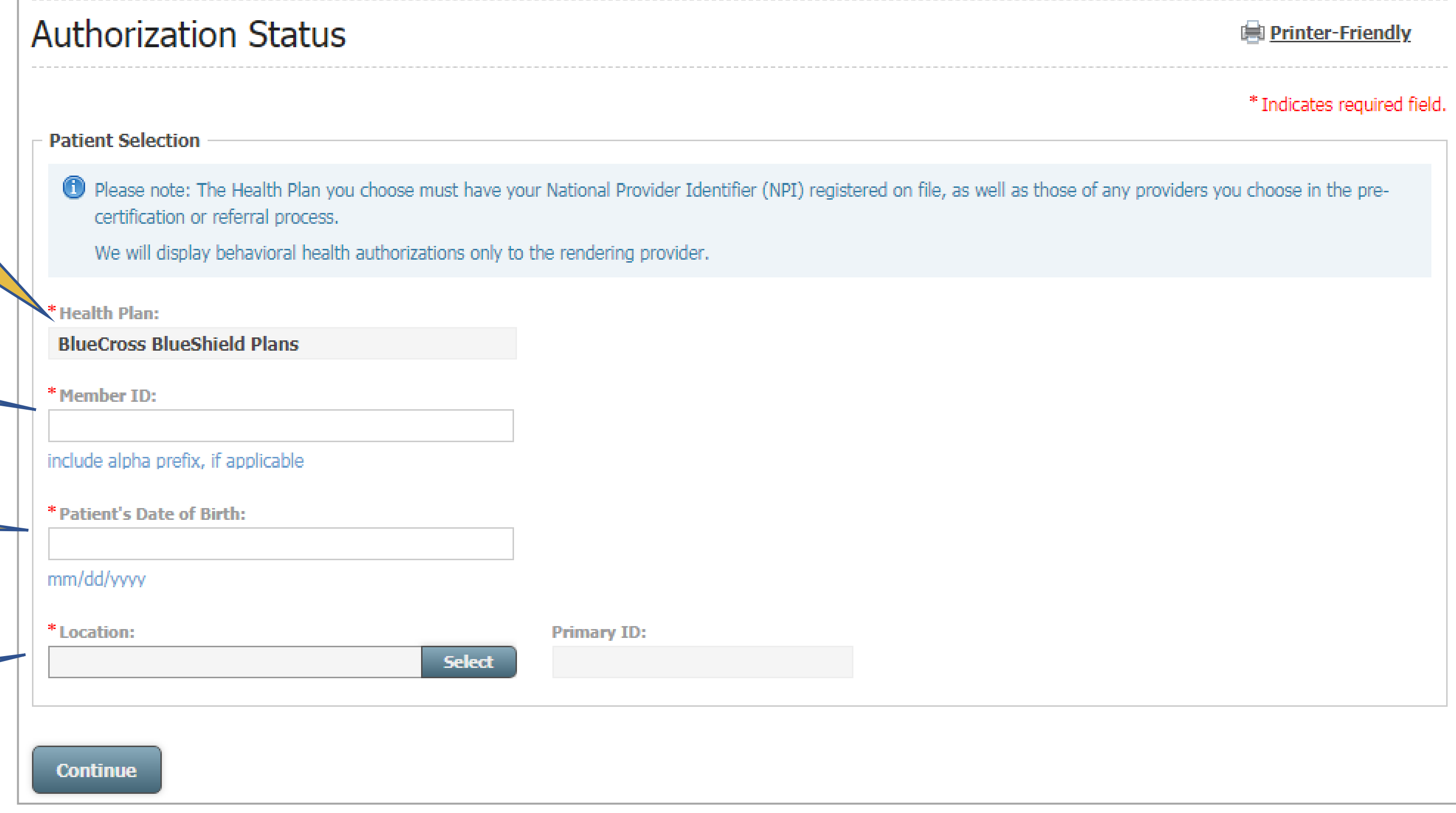
My Insurance Manager: Authorization Status

Select the patient's Health Plan.

Enter the patient's Member ID including the prefix.

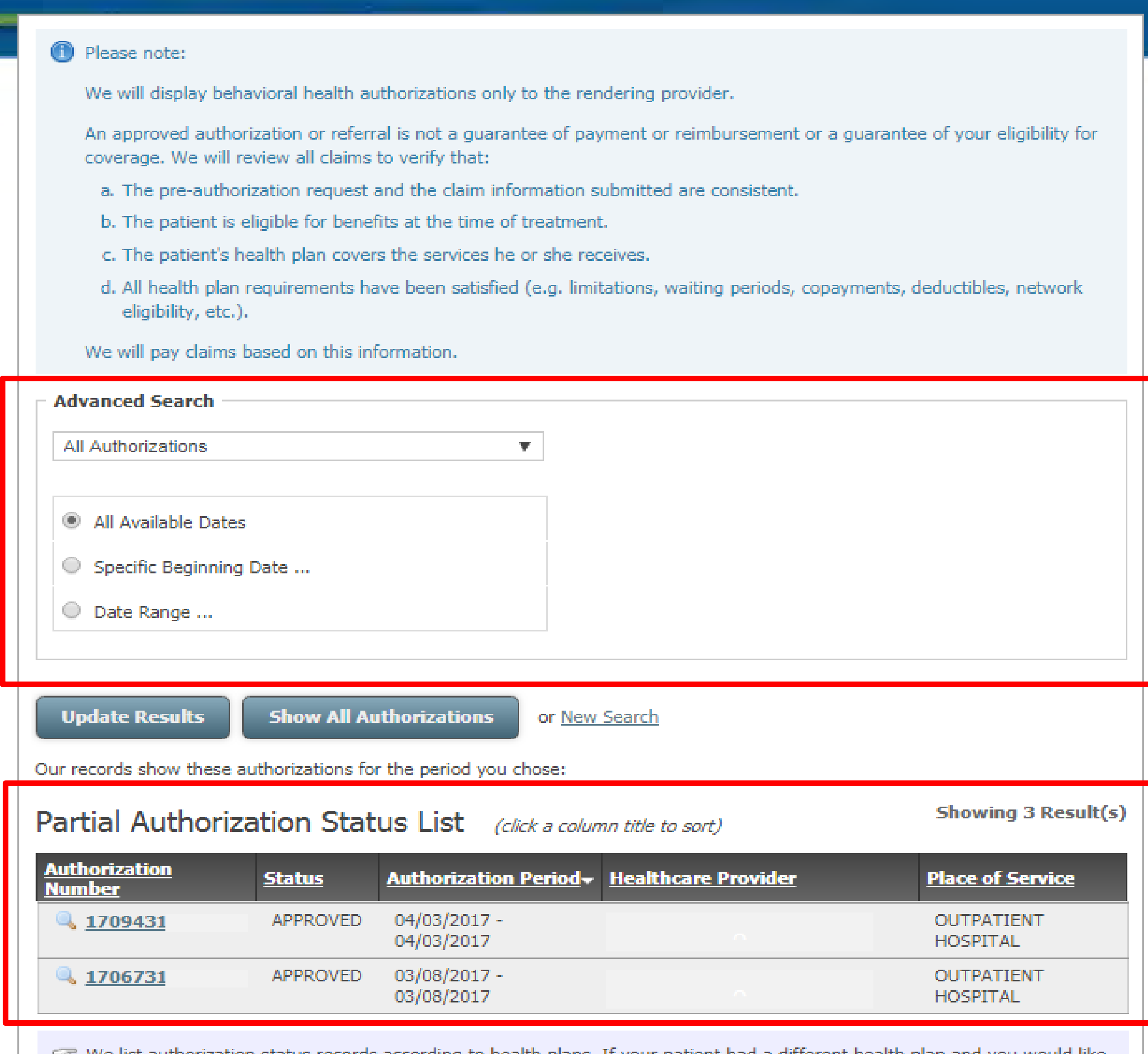
Enter the patient's date of birth.

Enter the service location, then click Continue.



My Insurance Manager: Authorization Status

Click to view the Authorization Number.

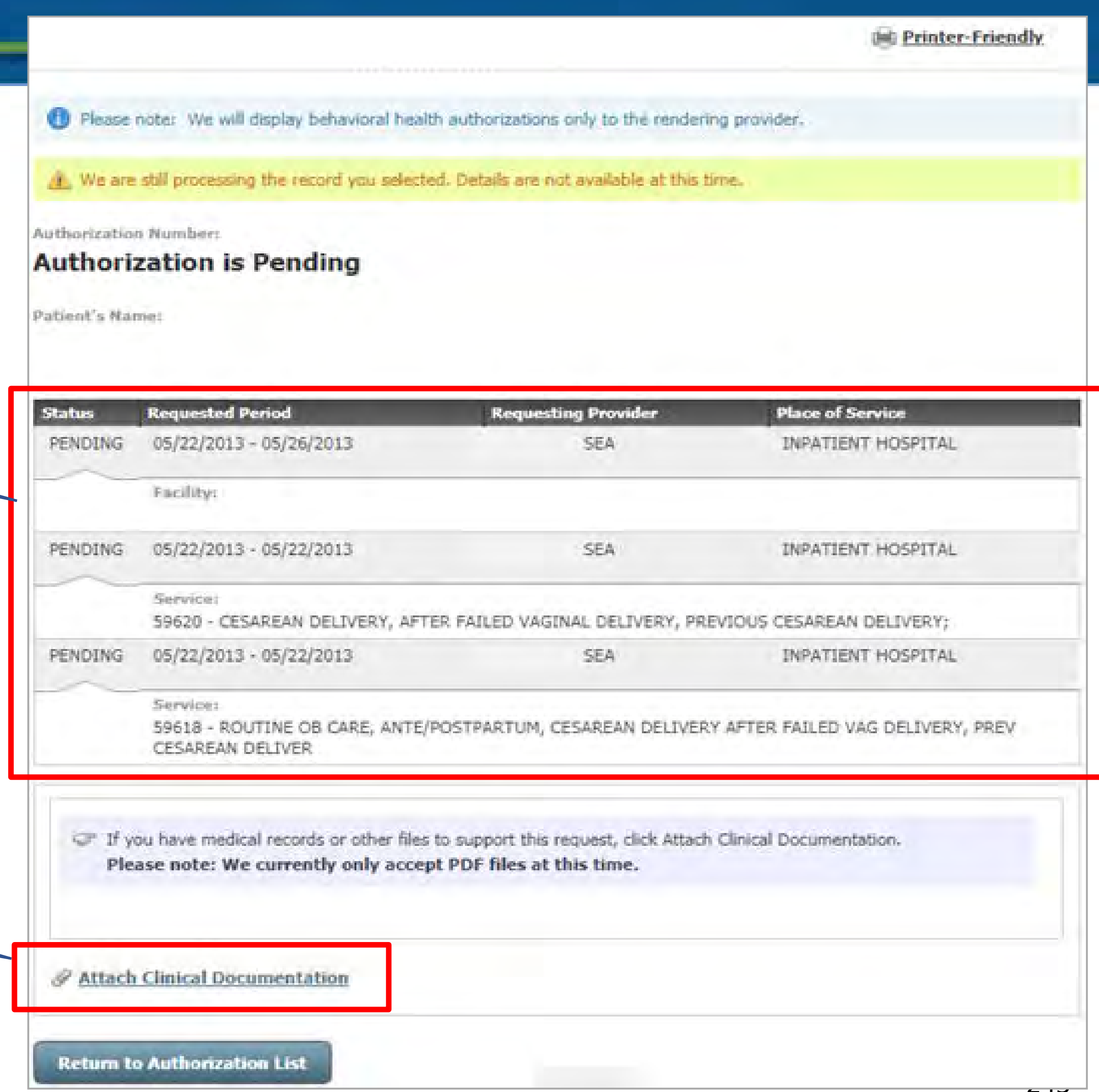


My Insurance Manager: Authorization Status

Pending Authorization

Pending authorization detail

Click to submit additional clinical documentation.



My Insurance Manager

Troubleshooting Tips

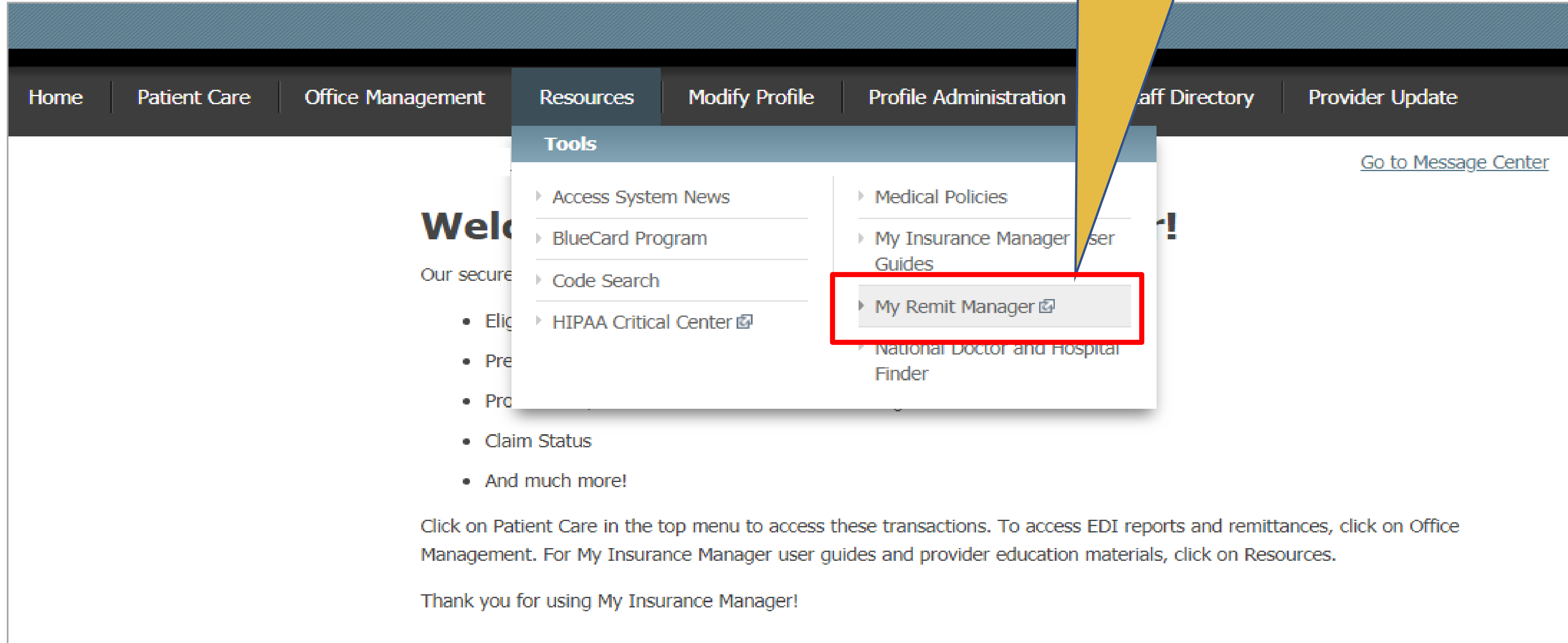
- Be sure complete the My Insurance Manager registration process to avoid limited access to the My Insurance Manager features.
- If you are having trouble viewing My Insurance Manager, be sure you are using a recommended browser — such as Internet Explorer 10 or higher, Mozilla Firefox, Google Chrome or Safari.
- On Sundays from 5 p.m. to midnight Eastern Standard Time, My Insurance Manager is unavailable for maintenance.

My Remit Manager: Access

There are two ways to access My Remit Manager:

- ✓ Go to www.MyRemitManager.com
- ✓ Access within My Insurance Manager, under Resources

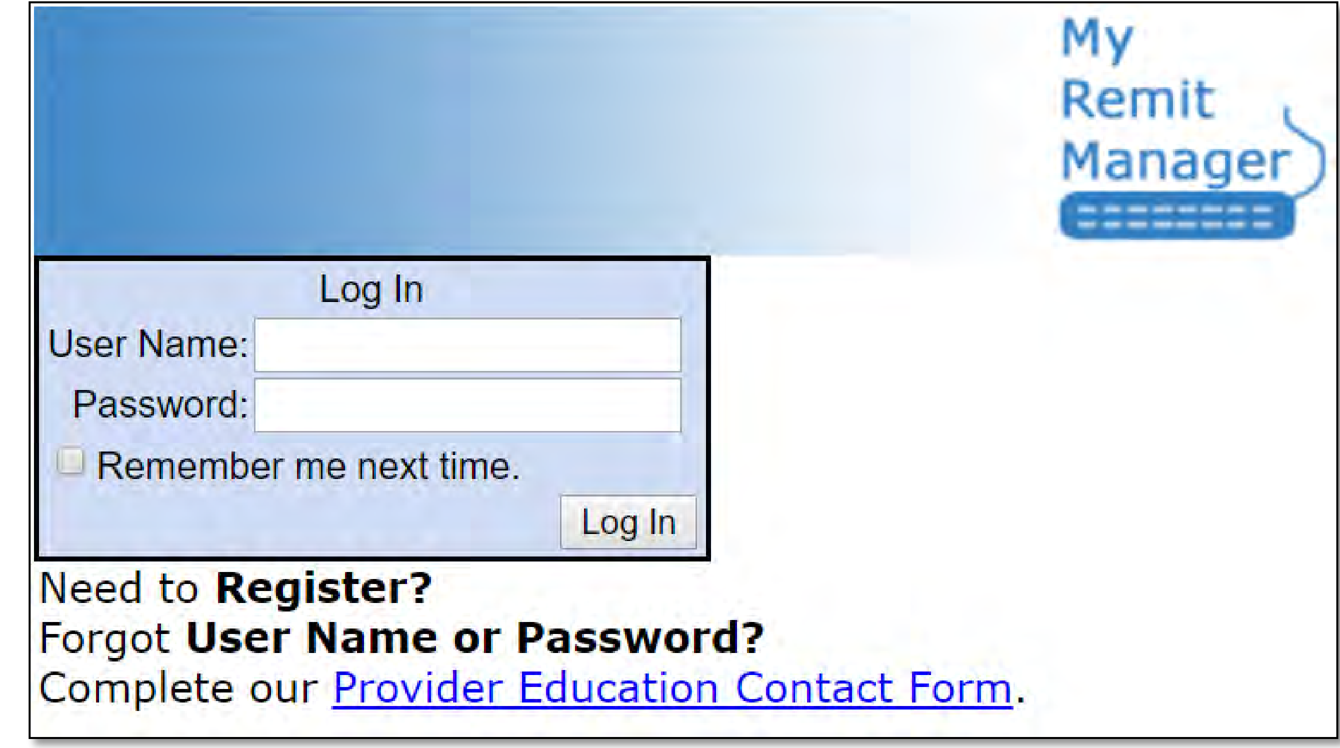
Click My Remit Manager.



My Remit Manager: Features

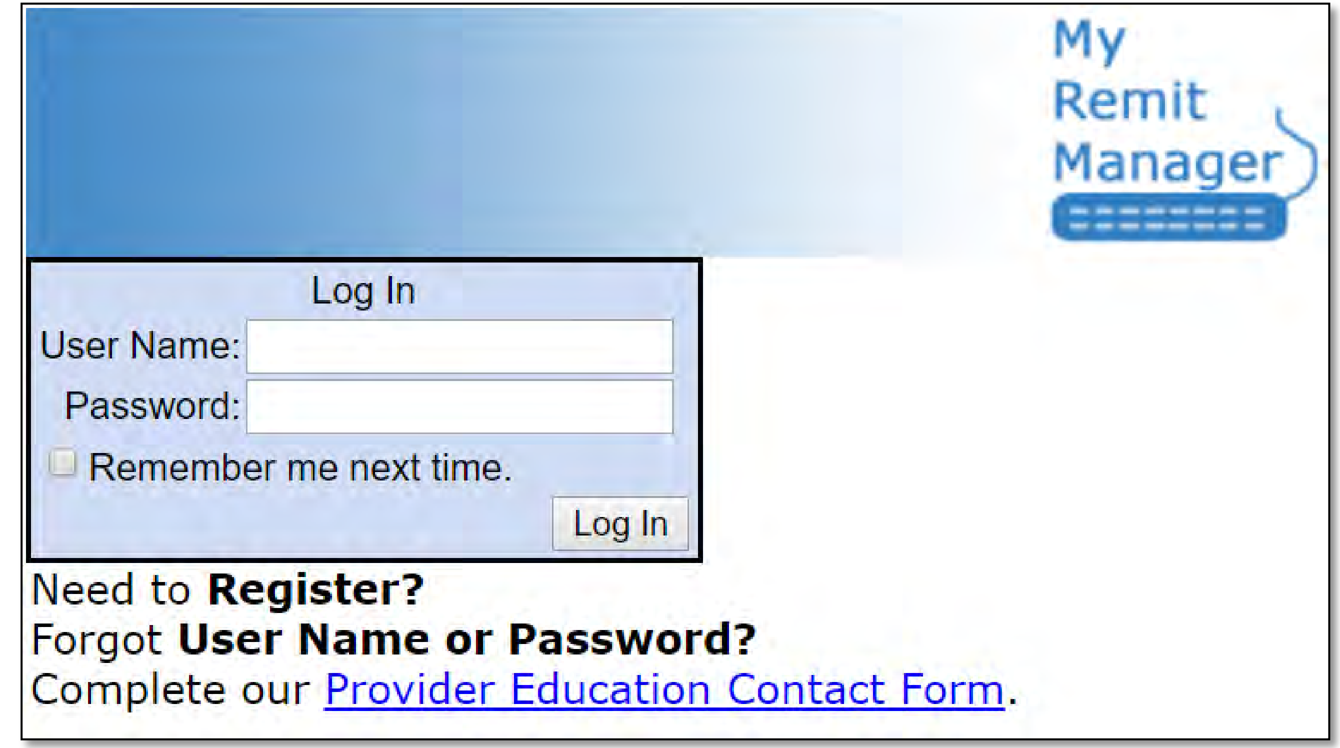
What you can do…

- ✓ Review electronic remittances in HIPAA-compliant format
- ✓ Search remittances by patient account number or check number
- ✓ Available to providers who receive remittances electronically
- ✓ Create reports

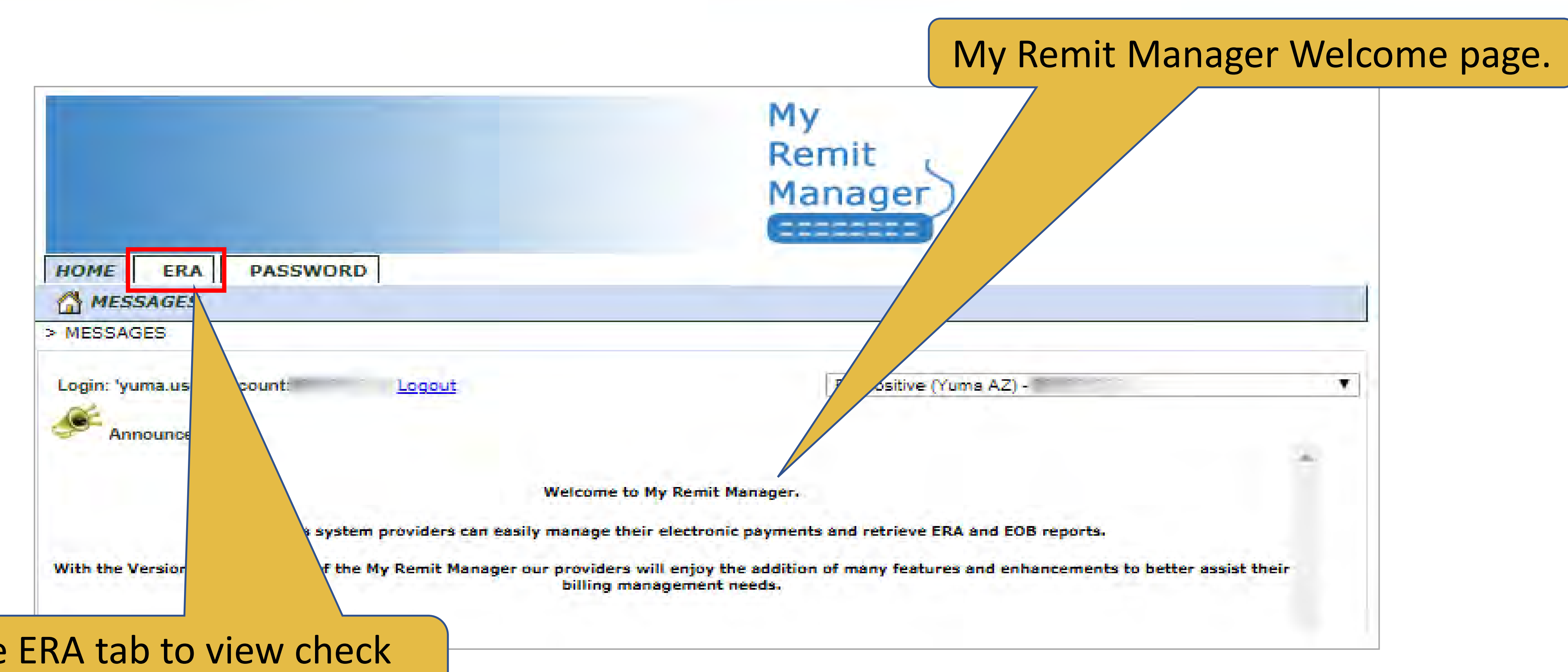


My Remit Manager: Log In

- ✓Submit the Provider Education Contact Form or EDI Services
  - ✓EDI.Services@bcbssc.com
- ✓Provide Name, Tax ID, NPI and email address
- ✓User name, temporary password and instructions will be emailed



My Remit Manager: Getting Started



My Remit Manager Welcome page.

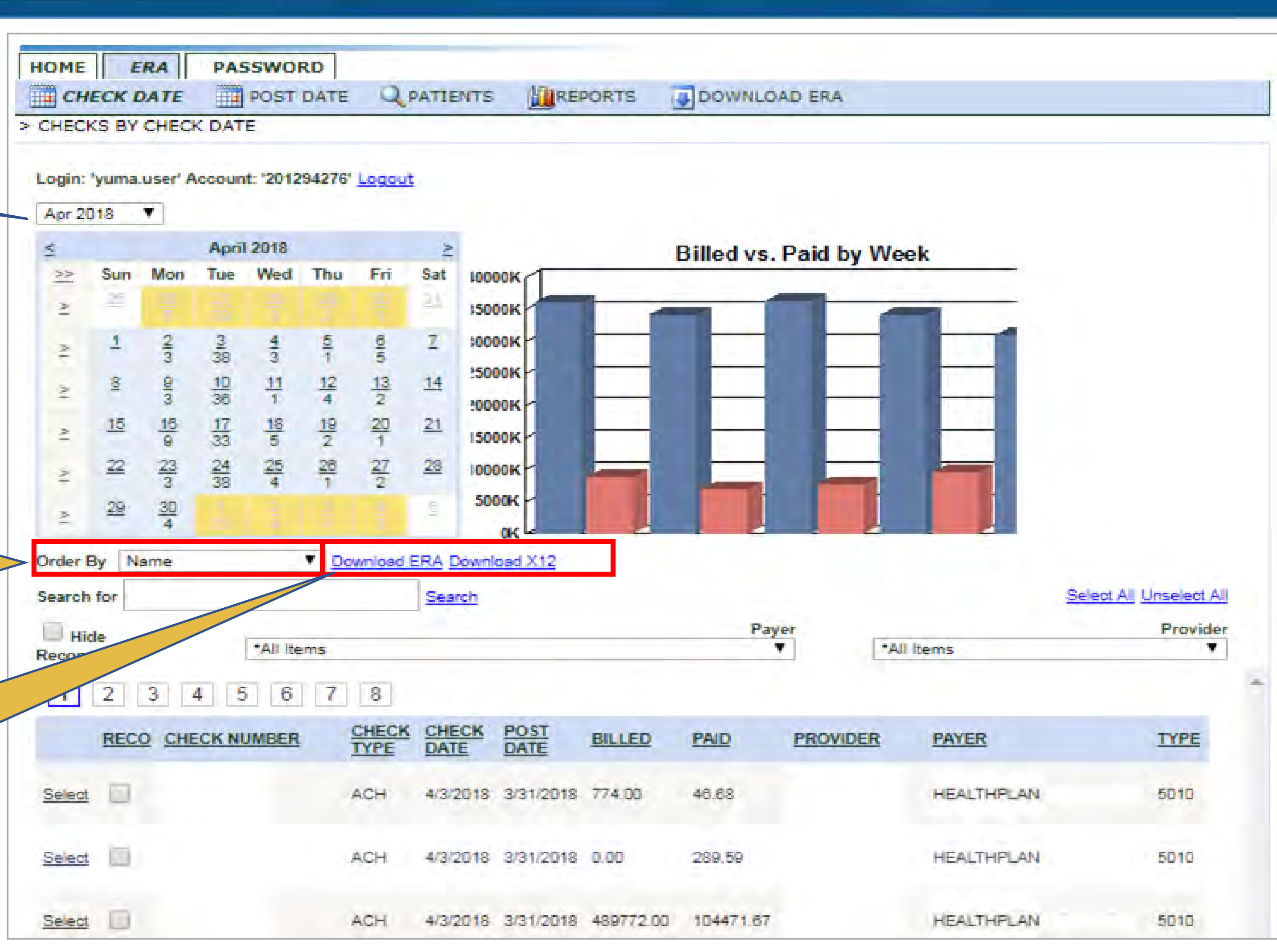
Select the ERA tab to view check and remittance information.

My Remit Manager: Viewing Electronic Remittance Advices (ERAs)

Select a month or year.

Use the drop down menu to select how to sort the patients on the remit:
- Name
- Account
- Provider then Name
- Provider then Account

Select Download ERA to view the remit.



My Remit Manager: Viewing ERAs

Sample remittance advice.

ERA Patient Listing

Electronic Reproduction ASC 004010X091

CHECK/EFT: **CHECK DATE: 06/02/2008**

Account: POS: 22 HIC: INC: Provider:

Status: Processed as Primary

PreProv	ServDate	NOS	REV	Proc/Mods	Billed	Allowed	Deduct	Coins	RC-Amt	Paid	*CAS Summary*		
	01/16/2008	2		HC:00940:QK	408.00	161.92		32.38	246.08	129.54	*CO*	*45*	*246.08*
											PR	*2*	*32.38*
REMITTANCE SUMMARY					408.00	161.92	.00	32.38	246.08	129.54			

TOTALS

Denied/Non-Covered: 0.00

CO 45 246.08 [Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).]

PR 2 32.38 [Coinsurance Amount]

* Denotes Denied Or Non-covered Charges

My Remit Manager: Receiving ERAs

To Receive ERAs…

ERA Received from BlueCross

- Complete the ERA and Electronic Funds Transfer (EFT) Enrollment Form to receive ERAs.
- Complete the Financial Institutional information on the form if you choose to receive EFT (direct deposit), optional.
- Submit both forms via email to Provider.EFT@bcbssc.com.

ERA Received from Clearinghouse

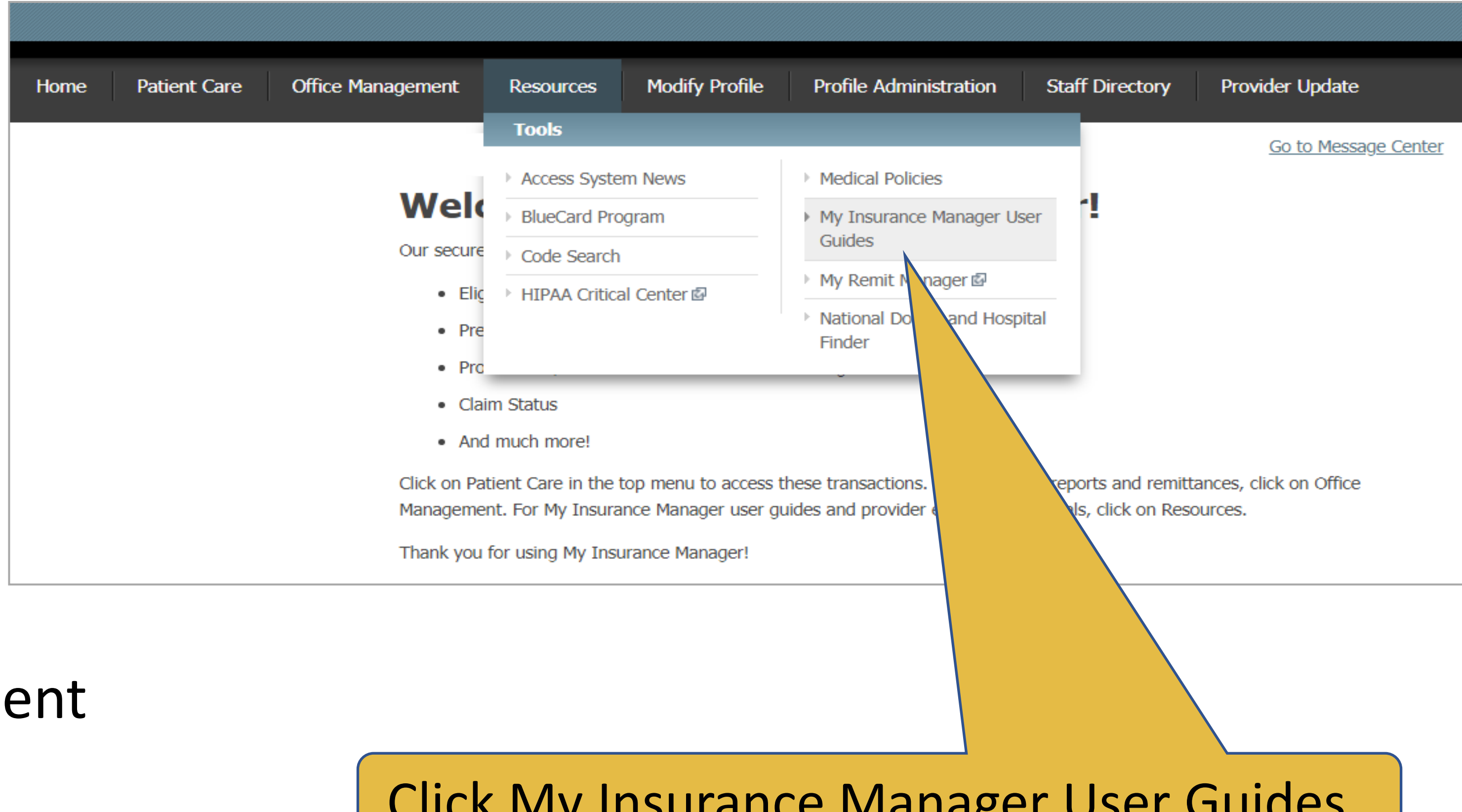
- Complete the EDI Gateway ERA Enrollment Form.
- Submit via email to EDI.Services@bcbssc.com.

NOTE: If you have any change in your financial status, e.g., new Tax ID, bank, account, or pay-to address, contact via email Provider.Cert@bcbssc.com.

Resources

My Insurance Manager User Guides

- Authorization Status
- Claim Status
- Eligibility and Benefits
- Patient Directory
- Precertification/Referral
- Profile Admin



My Remit Manager

- Send remittance advise or payment inquiries via email to EDI.Services@BCBSSC.com.

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