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

Independent licensees of the Blue Cross and Blue Shield Association

2020 Annual Provider Summit

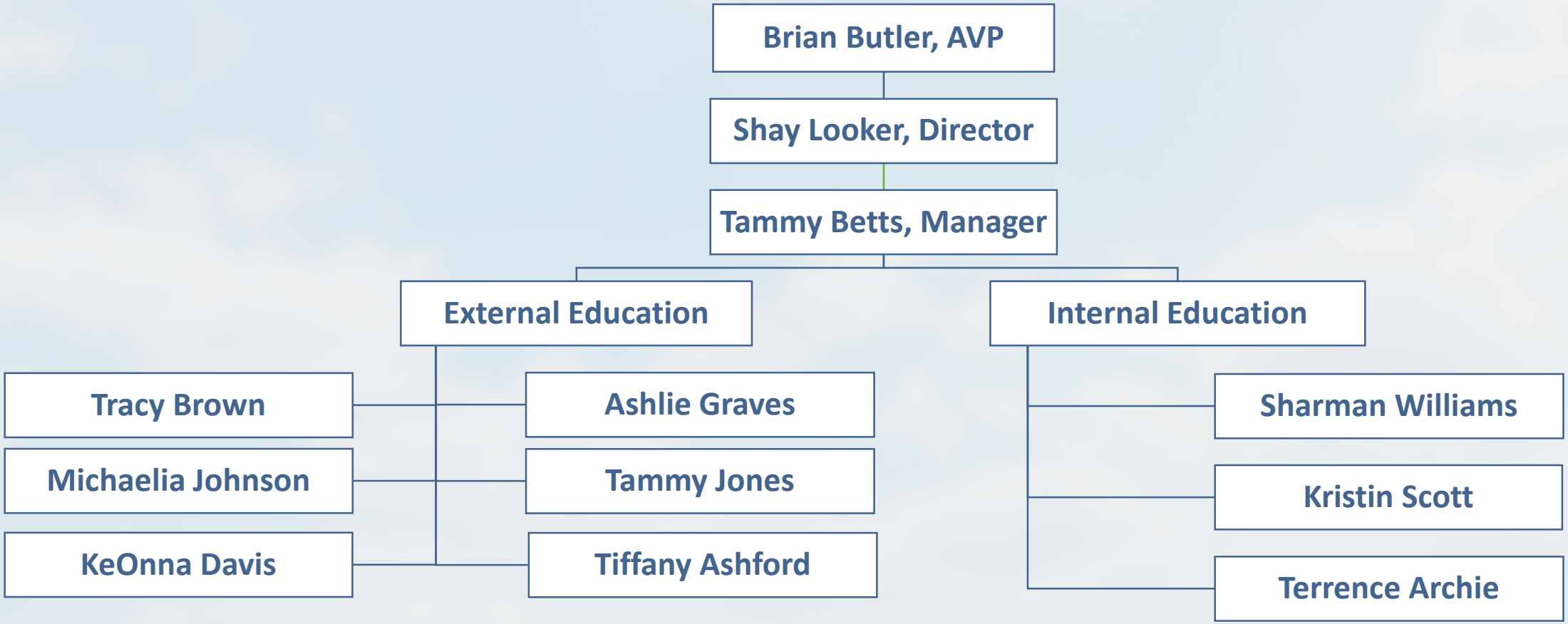
Presented by Provider Relations and Education

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

The Provider Relations teams are here for you!
Contact your county's designated consultant for training requests.



Be in the kNOW
A Palmetto Provider University Event

Pharmacy Benefit Management

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

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PBM Transition Announcement

IMPORTANT ANNOUNCEMENT

- Effective January 1, 2020, *OptumRx* will replace CVS Caremark as the Pharmacy Benefit Manager (PBM) for the following lines of business:
  - BlueCross BlueShield of South Carolina, BlueChoice HealthPlan of South Carolina, Inc., Planned Administrators, Inc. (PAI); Thomas Cooper Insurance Company (TCC)
    - All Fully Insured
    - Self-Funded groups where BlueCross manages the medical and pharmacy benefit
  - Medicare Advantage Plans
    - Prescription Drug Plan (PDP)
    - Medicare Advantage Drug Plan (MAPD)
  - Affordable Care Act (ACA) Plans
    - Federally-facilitated Exchange (FFE)
    - Private

This change in PBM does not impact State Health Plan and FEP members.

Value of the New Partnership

- **PARTNERSHIP**
  Dedicated center of excellence in South Carolina
- **AFFORDABILITY**
  Expanded network options
- **PHILOSOPHY**
  Supporting our lowest net cost strategy and total cost of care value
- **CLINICAL INNOVATION**
  First in market to introduce electronic medical record integration tool, PreCheck MyScript
- **OPERATIONAL EXCELLENCE**
  Industry leading and owned operating platform, RxClaim
- **CUSTOMER SERVICE**
  First contact resolution with live chat, proactive outreach to members with denied prior authorizations

What will be different?

IMPORTANT ANNOUNCEMENT

- Members will receive new ID cards
- New mail order pharmacy:
  - OptumRx Home Delivery
- New specialty pharmacy:
  - BriovaRx (Excludes State Health Plan and FEP)
- New medical management tool
- New contact information for Prior Authorizations (PAs):
  - See *Navigating the Commercial Member's Pharmacy Benefit* slide
  - Please note: All active PAs will be transferred!

New PBM Contacts

General OptumRx Information for Commercial and ACA Plans

- OptumRx Home Delivery Mail Service
  - E-scribe National Council for Prescription Drug Programs (NCPDP)
    - Mail NCPDP ID = 0556540
    - Specialty NCPDP ID = 5732676
- OptumRx Home Delivery
  - Call 855-811-2218
  - Fax 800-491-7997
  - Mailing Address
    - P.O. Box 2975
      Shawnee Mission, KS 66201-1375

New PBM Contacts

General OptumRx Information for Commercial and ACA Plans (cont'd)

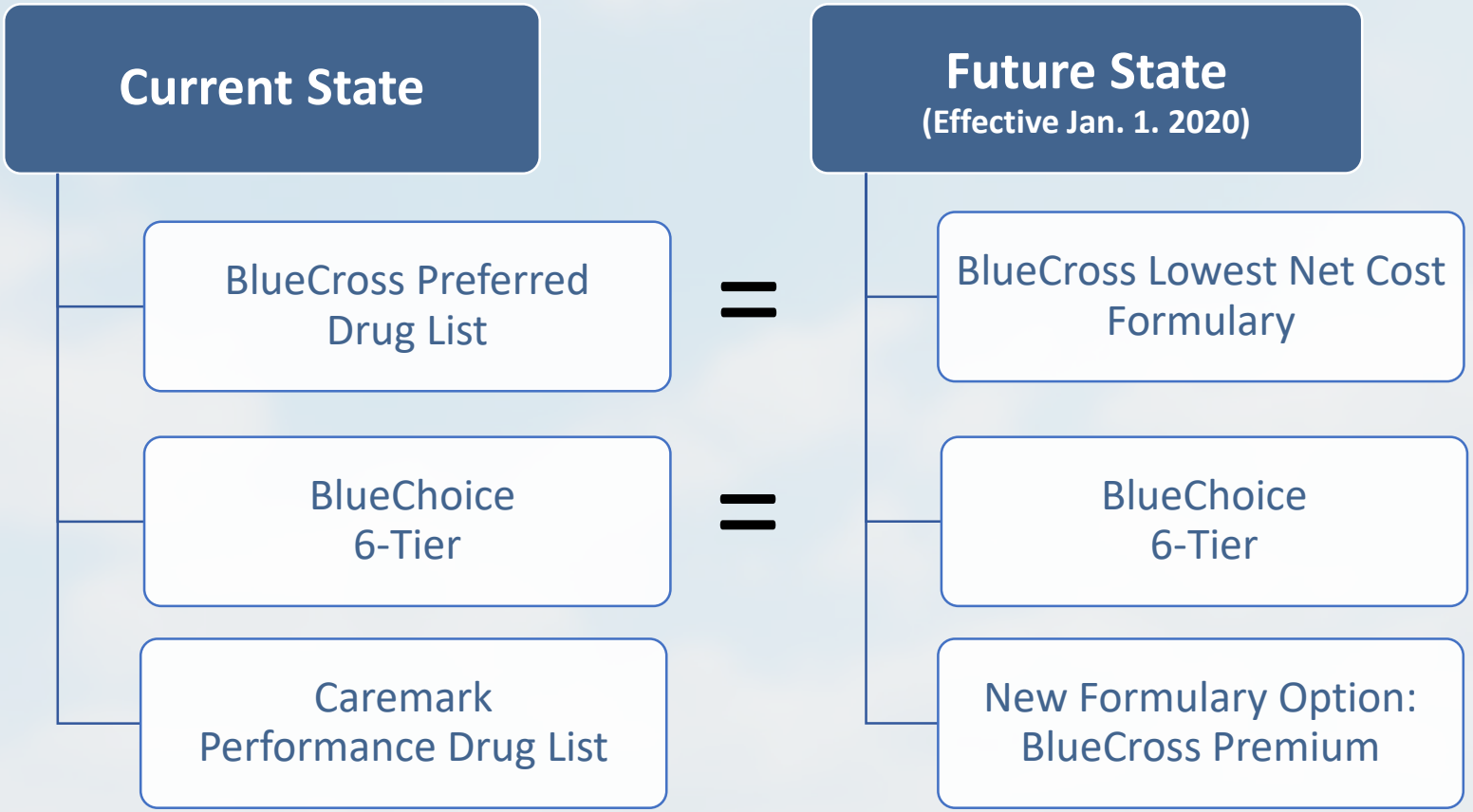
- Briova Specialty Pharmacy
  - Call 877-259-9428
  - Fax 800-218-3221
- Specialty Medical Benefit Management
  - Call 877-440-0089
  - Fax 612-367-0742

Commercial Plans

Commercial Formulary

Good News for 2020!

No substantial changes to the BlueCross or BlueChoice Formularies



Commercial Members

Navigating the Commercial Member's Pharmacy Benefit

- View list of covered drugs, excluded drugs and drug management programs
  - www.SouthCarolinaBlues.com
  - www.BlueChoiceSC.com
- Member and Provider plan contacts, use the number on the back of the member's ID card.
- Prior Authorization, Formulary Exceptions and General Inquiries
  - Call 855-811-2218

Affordable Care Act Plans

Affordable Care Act

2020 Formulary Covered Products With Lower Tier (Cost) Alternatives

BRAND NAME	FORMULARY ALTERNATIVE(S)
AMITIZA	TIER 2: LINZESS
BIKTARVY	TIER 1: ABACAVIR/LAMIVUDINE-ZIDOVUDINE TIER 2: SYMFI, SYMFI LO, COMPLERA, TRIUMEQ
DESCOVY	TIER 1: ABACAVIR/LAMIVUDINE, LAMIVUDINE-ZIDOVUDINE TIER 2 EVOTZ, PREZCOBIX, JULUCA, TRUVADA, CIMDUO, KALETRA
GENVOYA	TIER 1: ABACAVIR/LAMIVUDINE-ZIDOVUDINE TIER 2: SYMFI, SYMFI LO, COMPLERA, TRIUMEQ
LATUDA	TIER 1: ZIPRASIDONE
NOVOLIN	TIER 2: HUMULIN
NOVOLOG	TIER 2: HUMALOG
NOXAFIL	TIER 1: ITRACONAZOLE, VORICONAZOLE
ODEFSEY	TIER 1: ABACAVIR/LAMIVUDINE-ZIDOVUDINE TIER 2: SYMFI, SYMFI LO, COMPLERA, TRIUMEQ
STRIBILD	TIER 1: ABACAVIR/LAMIVUDINE-ZIDOVUDINE TIER 2: SYMFI, SYMFI LO, COMPLERA, TRIUMEQ
TOVIAZ	TIER 1: DARIFENACIN, OXYBUTYNIN, SOLIFENACIN, TOLTERODINE, TROSPIUM
TRESIBA FLEXTOUCH	TIER 2: LEVEMIR FLEXTOUCH, LANTUS SOLOSTAR, TOUJEO SOLOSTAR, TOUJEO MAX

Affordable Care Act

2020 Non-Formulary Products and Alternatives

BRAND NAME	2020 EHB FORMULARY ALTERNATIVE(S)
ALBUTEROL SULFATE HFA	VENTOLIN HFA, PROAIR HFA, PROAIR RESPI
ALOGLIPTIN	TRADJENTA, JANUVIA
ASMANEX	BUDESONIDE, FLOVENT DISKUS/HFA, PULMICORT
BASAGLAR KWIKPEN	LANTUS
BEVESPI AEROSPHERE	SYMBICORT AER, ADVAIR HFA, FLUTICASONE/SALMETEROL INH, WIXELA INHUB AER, BREO ELLIPTA INH
CLIMARA PRO	PREMPRO, PREMPHASE, COMBIPATCH, JINTELI
CORLANOR	ENTRESTO, GENERIC BETA BLOCKERS, ACE INHIBITORS, ARB, DIURETICS
ESOMEPRAZOLE	LANSOPRAZOLE, OMEPRAZOLE, PANTOPRAZOLE, RABEPRAZOLE
FARXIGA	INVOKANA, JARDIANCE
FIASP FLEXTOUCH	NOVOLOG FLEXPEN, HUMALOG KWIKPEN
HYOSCYAMINE SULFATE ER	HYOSCYAMINE TAB/SUB/ELX, OSCIMIN SUB, NULEV TAB
LEVALBUTEROL TARTRATE HFA	LEVALBUTEROL NEB
PREMARIN	ESTRADIOL CREAM 0.01%, ESTRADIOL
QVAR REDIHALER	BUDESONIDE, FLOVENT DISKUS/HFA, PULMICORT, SYMBICORT
SOLIQUA 100/33	VICTOZA OR BYETTA AND LANTUS OR TOUJEO
VASCEPA	OMEGA-3-ACID, COLESTIPOL, GENERIC STATINS
XIGDUO XR	INVOKANA, INVOKAMET, INVOKAMET XR, SYNJARDY

Affordable Care Act

Member and Provider Plan Contact Information

- BlueCross
  - ACA Individual Plan Members
    - Call 855-823-0387
  - Small Group ACA Plan Members
    - Call 855-819-0955
  - www.SouthCarolinaBlues.com
- BlueChoice
  - ACA Plan Members
    - Call 855-816-7636
  - www.blueoptionsc.com

Medicare Advantage Plans

Medicare Advantage

MAPD Formulary

- 5-Tier Formulary
- Standard Utilization Management
- Adherence Drugs on Lowest Tiers
- Dual Insulin Strategy
- Part D Formulary Designed Specifically for MAPD Part D

Tier Composition (Drug Type Labels)

Tier 1: Preferred Generic
Tier 2: Generic
Tier 3: Preferred Brand
Tier 4: Non-Preferred Drug
Tier 5: Specialty Tier

Star Adherence Strategy

Generic STAR Adherence Drugs: Tier 1 low to moderate cost, Tier 2 if high cost generics <$670/month

Formulary Rules

Tier 1: Very Low-cost generics
Tier 2: Low to moderate cost generics
Tier 3: Preferred Brand Tier
Tier 4: Non-Preferred Brand Tier and high cost generics
Tier 5: Specialty >$670/month (Brands, Generics)

Tier Assignment may also be impacted by:

- P&T Compliance review (Risk to Benefit, Essential Drug)
- CMS Category/class review concerns (representation, preferred product)
- Actuarial considerations

High-Risk Medication Strategy

HRM's: Tier 4 with PA or QL, or Tier 2 with PA or QL if the drug is both a STARS and an HRM. Exception for digoxin: Tier 2 with PA/QL

Medicare Advantage

PDP Formulary

- 5-Tier Formulary
- Standard Utilization Management
- Adherence Drugs on Lowest Tiers
- Solo Insulin Strategy
- Part D Formulary Designed Specifically for PDP

Tier Composition (Drug Type Labels)

Tier 1: Preferred Generic
Tier 2: Generic
Tier 3: Preferred Brand
Tier 4: Non-Preferred Drug
Tier 5: Specialty Tier

Star Adherence Strategy

Generic STAR Adherence Drugs: Tier 1 if low cost; Tier 2 if moderate, Tier 4 high cost generics <$670/month

Formulary Rules

Tier 1: Low cost maintenance generics (including most STAR adherence drugs)

Tier 2: Low to moderate cost generics including acute use products

Tier 3: Preferred Brand and moderate cost generics

Tier 4: Non-Preferred Brand Tier and higher cost generics

Tier 5: Specialty >$670/month (Brands, Generics)

Tier Assignment may also be impacted by:

- P&T Compliance review (Risk to Benefit, Essential Drug)
- CMS Category/class review concerns (representation, preferred product)
- Actuarial considerations

High-Risk Medication Strategy

Generally Tier 4 with PA and/or QL or Tier 2 with PA or QL if the drug is both a STAR adherence drug and an HRM. Some HRM's will be NF based on clinical review and volume of utilizations.

Medicare Advantage

Navigating the Medicare Advantage Member's Pharmacy Benefits

- E-scribe National Council for Prescription Drug Programs (NCPDP) Mail and Specialty
    - Mail NCPDP ID = 0556540, Specialty NCPDP ID = 5732676
- OptumRx Home Delivery Phone
    - Call 855-540-5951
- OptumRx Mail Address
    - P.O. Box 2975
      Shawnee Mission, KS 66201-1375
- Coverage Determinations and General Inquiries
    - Call 888-645-6025
    - Fax 844-403-1028
- Websites
    - www.optumrx.com
    - www.SCBluesMedadvantage.com

Communications

Communications

Members

- Each line of business is using its own strategy that may include postcards, letters and/or enrollment packets beginning in October and throughout the rest of 2019. We will send all members a letter about mail and specialty pharmacies changing, as well as routine lettering about formulary and drug management programs.
  - Transition letters focusing on new ID card and changes in mail and specialty pharmacies
  - Mail Service change letters to current utilizers
  - Specialty Pharmacy change letters to current utilizers
  - Letter about any change or new requirement that will require action on the member's part. Members will be told about any "grandfathering" of requirements.

Communications

Providers

- Email Blasts
- News Bulletin
  - www.SouthCarolinaBlues.com
  - www.BlueChoiceSC.com
- Provider Education Visits

Pharmacists

- OptumRx has been sending fax blasts to pharmacies since mid-October. This information contains information on the new bin, when to start using it, etc.

Specialty Drug Medical Benefit Management

Specialty Drug Medical Benefit Management

What's New for 2020

- MBMNow will replace Novologix as the tool to submit prior authorizations for drugs billed under the medical benefit
- Drug lists for the Specialty Medical Benefit Management programs remain the same and can be found on the Precertification and Pharmacy pages of the websites:
  - www.SouthCarolinaBlues.com
  - www.BlueChoiceSC.com
- Access MBMNow via My Insurance Manager℠ when you check member benefits
- Contact info for medical specialty drug authorizations
  - Call 877-440-0089
  - Fax 612-367-0742

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A Palmetto Provider University Event

New Pharmacy Benefit Management Tools

BlueCross BlueShield of South Carolina and
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Comparison Chart

PreCheck MyScript and SMBM

Attribute	PreCheck MyScript	SMBM
Description	• Capability that shows prescription coverage and cost information, prior authorization requirements, clinically appropriate medication alternatives, and clinical alerts	• A web-based guidance platform that suggests treatments for specialty conditions (including for cancer and non-cancer patients) for which BCBS requires a Prior Authorization
Benefits	• Clarity on drug cost and coverage, enabling an informed conversation at the point of care • Lowers the cost of medications for the patient and plan • Saves physicians time by minimizing drug rejects and prior authorizations	• Provides faster, more efficient, and more accurate processing of Prior Authorizations for cancer and specialty treatments

Comparison Chart

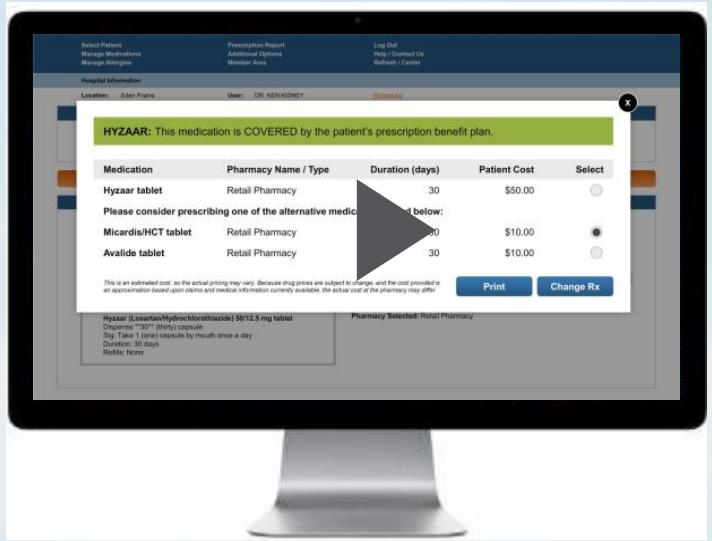
PreCheck MyScript and SMBM

Attribute	PreCheck MyScript	SMBM
Users	• Providers who write prescriptions	• Providers who must request an authorization for a specialty drug treatment
When Used	• During the e-prescribing process	• Before administering the treatment to the patient
Access Point	• Primarily in the Provider's EMR within the ePrescribing Workflow • PCMS cannot be accessed through the SMBM prior authorization portal	• In My Insurance Manager (MIM) • SMBM prior authorization portal cannot be accessed from PCMS

PreCheck MyScript

PreCheck MyScript

Visibility at the point of care ▶ Cost share | Formulary placement | Clinical alerts



>20% of physicians switched to an alternative drug[1]

>30% Prior authorizations were avoided or initiated[1]

Streamlining prior authorizations

Finding lower cost alternatives

Improving plan performance

Source: 1.Third party analysis of OptumRx internal claims data. November 2018

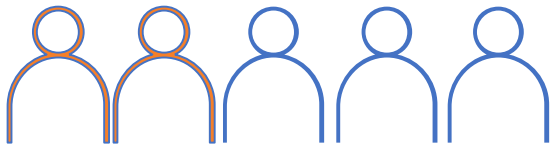
1. 2017 PreCheck MyScript program results

PreCheck MyScript

Know when a PA is required and the patient price at the point of care

Today, many patients don't know which pharmacies are preferred, or which medications are covered and are most affordable

2 out of **5** consumers abandon their prescription[1]



70% of medication related ER visits are due to non-adherence[2]

74% of physicians want real-time data access to better support their patients[3]

1.PharmaExec. Nov. 2018.
2. Am Heart J. Medication Adherence: A Call for Action. ncbi.nlm.nih.gov/pmc/articles/PMC3947508. Available in PMC 2014 March 9. Published in final edited form as: Am Heart J. 2011 Sep; 162(3): 412–424. doi: 10.1016/ahj.2011.06.007. Accessed July 3, 2018.
3. 2016 PBMI Research Report, Pharmacy Trends in Accountable Care Organizations.

PreCheck MyScript

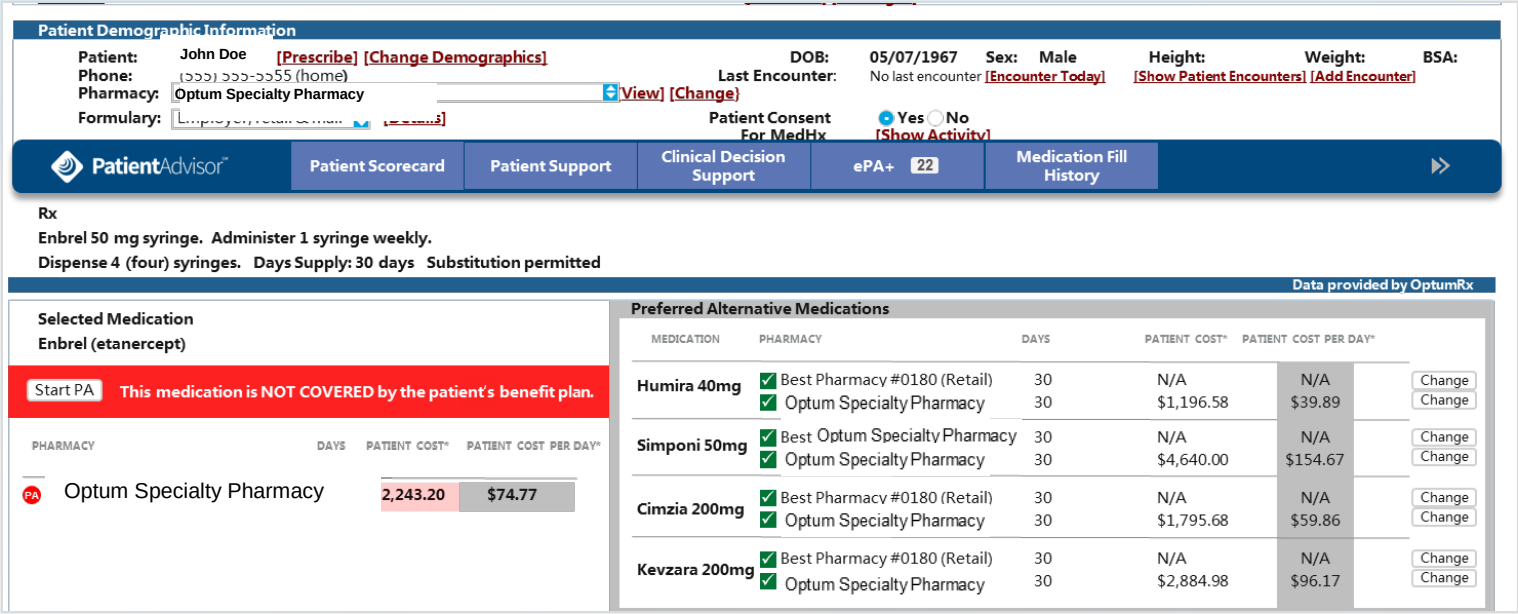
Provides real time alternative medications in seconds

Offers benefit-specific, clinically appropriate, alternative medications

Actively displays savings opportunities at OptumRx and Optum Specialty Pharmacy

Members have access to the same information via the OptumRx digital tools

If a Target Medication is not covered….



1. BriovaRx pharmacies are proactively displayed in Link Dashboard, EMR integration planned for 2019.

PreCheck MyScript

Options for different drugs and pharmacies are presented

Offers benefit-specific, clinically appropriate, alternative medications

Actively displays savings opportunities at OptumRx and Optum Specialty Pharmacy

Members have access to the same information via the OptumRx digital tools

…alternatives are suggested

Preferred Alternative Medications

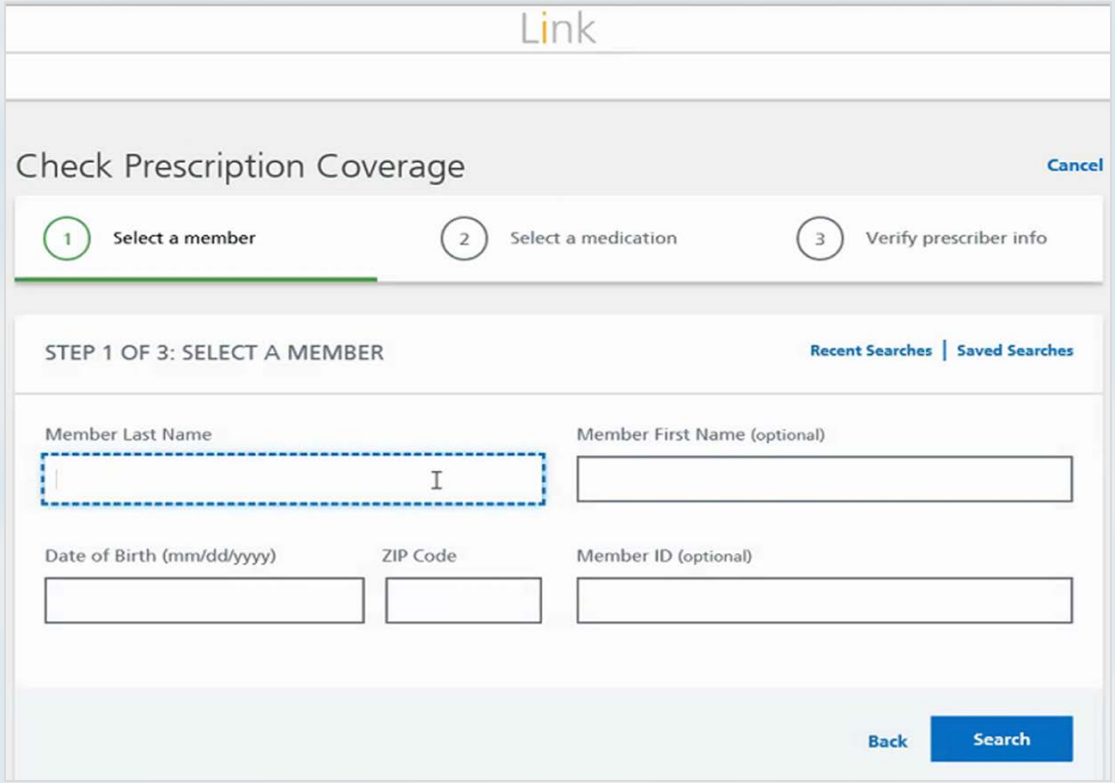
MEDICATION	PHARMACY	DAYS	PATIENT COST*	PATIENT COST PER DAY*	
Humira 40mg	✓ Best Pharmacy #0180 (Retail)	30	N/A	N/A	Change
	✓ Optum Specialty Pharmacy	30	$1,196.58	$39.89	Change
Simponi 50mg	✓ Best Pharmacy #0180 (Retail)	30	N/A	N/A	Change
	✓ Optum Specialty Pharmacy	30	$4,640.00	$154.67	Change
Cimzia 200mg	✓ Best Pharmacy #0180 (Retail)	30	N/A	N/A	Change
	✓ Optum Specialty Pharmacy	30	$1,795.68	$59.86	Change
Kevzara 200mg	✓ Best Pharmacy #0180 (Retail)	30	N/A	N/A	Change
	✓ Optum Specialty Pharmacy	30	$2,884.98	$96.17	Change

1. BriovaRx pharmacies are proactively displayed in Link Dashboard, EMR integration planned for 2019.

PreCheck MyScript

Integration with EMR systems is on-going

Any Provider can have web-based access after registering with Optum…



…and PCMS is live with several EMRs and ePrescribing solutions

Epic Integrator	Live
DrFirst	Live
AthenaHealth	Live
NewCrop	Live
AllScripts	Live
Cerner Integrator	Live

Link to PCMS: PreCheck MyScript

PreCheck MyScript

Saves patients money and provides visibility to authorization requirements

Better clinical decisions which leads to lower costs for patients, better adherence, and health outcomes

Patient

- $135 per script savings[1]
- Up to 4% higher medication adherence[1]
- 80% shift from tier 3 medications to lower tier[1]

Physician

- 19% decrease in cost[1]
- $24.49 savings per PA for physician/office staff[1]
- Within EMR work stream
- 80% access in 2020[1]

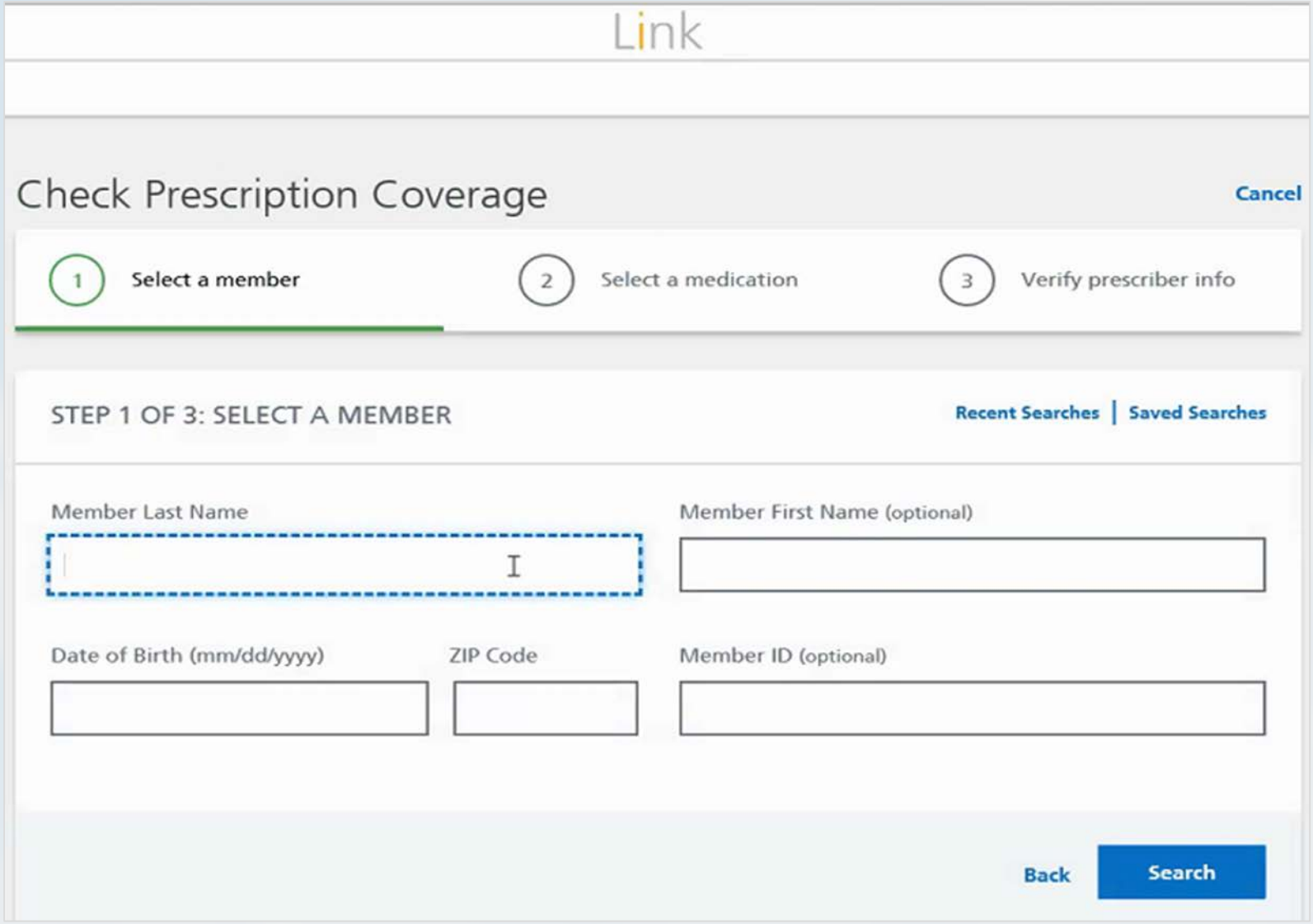
2019 Performance[2]

160K+	Providers Utilizing
4M	Patients Impacted
22.6M	Transactions Generated
<2 sec	Application response time

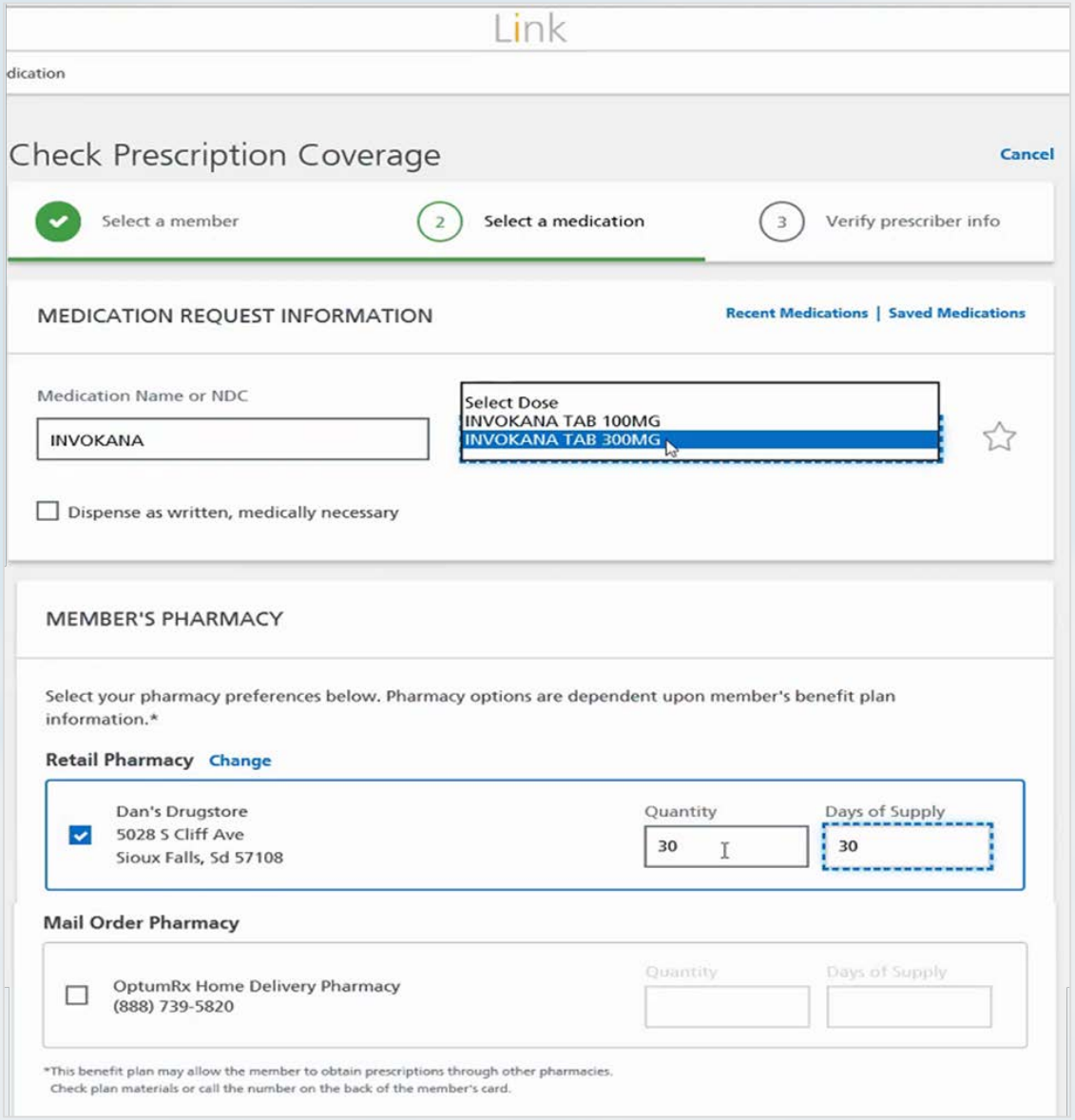
~20% of all transactions with an alternative resulted in a **drug change**[2]

Sources: 1.Third party analysis of OptumRx internal claims data. November 2018
2. OptumRx HD vs. Retail Adherence Study based on paid claims from Jan – Dec 2018 for Direct Commercial in 3 classes.

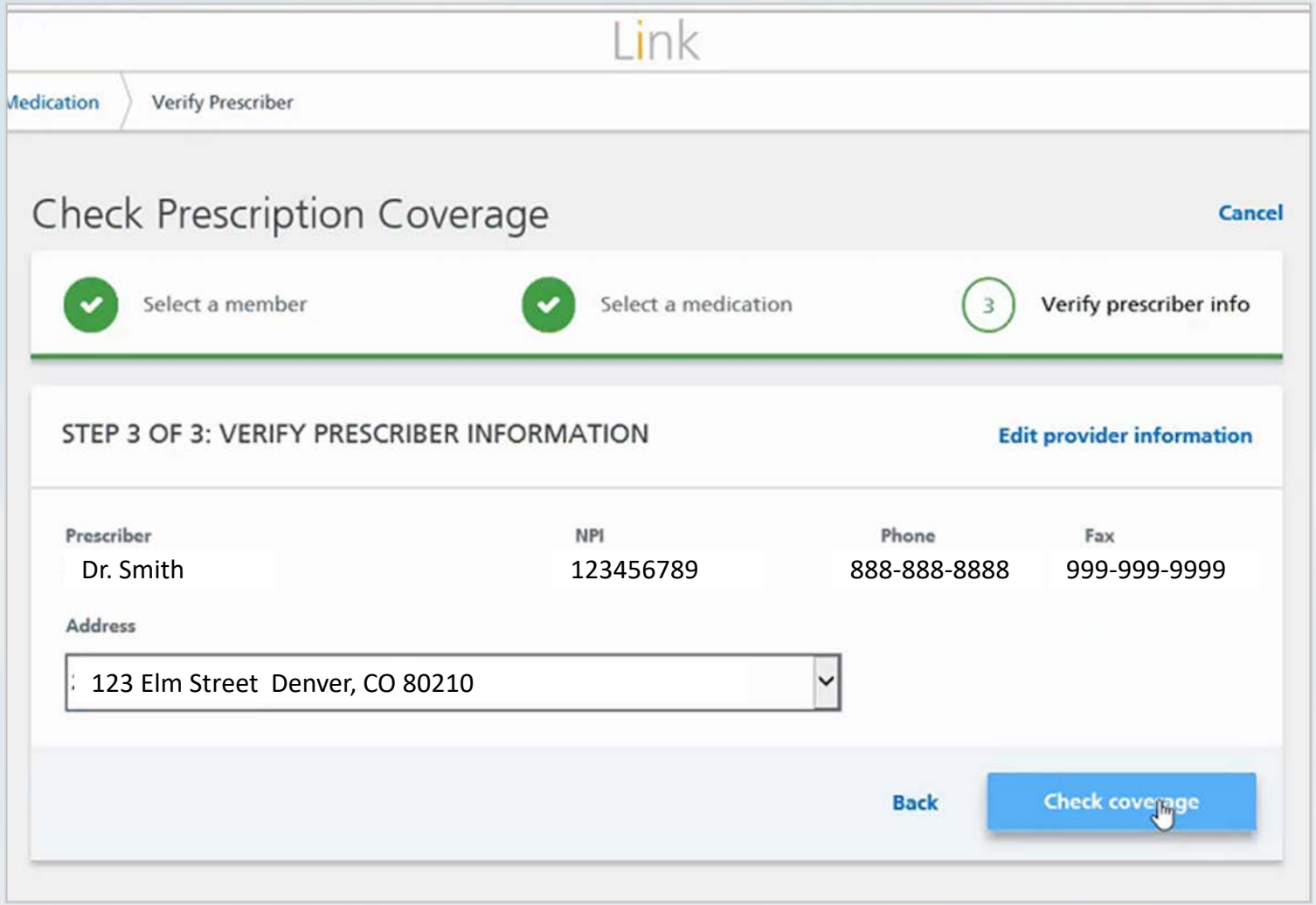
Patient Search



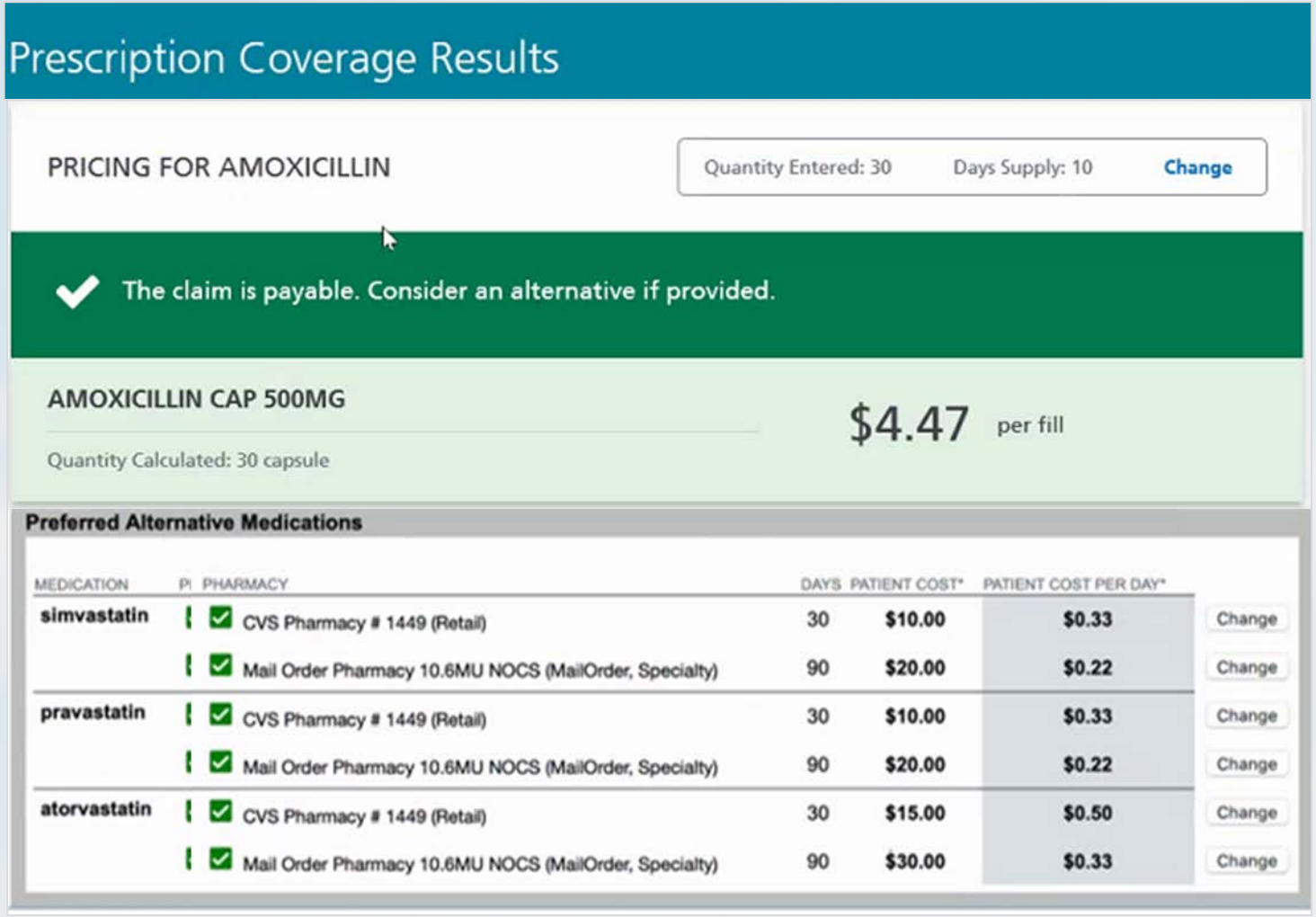
Drug Search and Medication Detail Info Entered



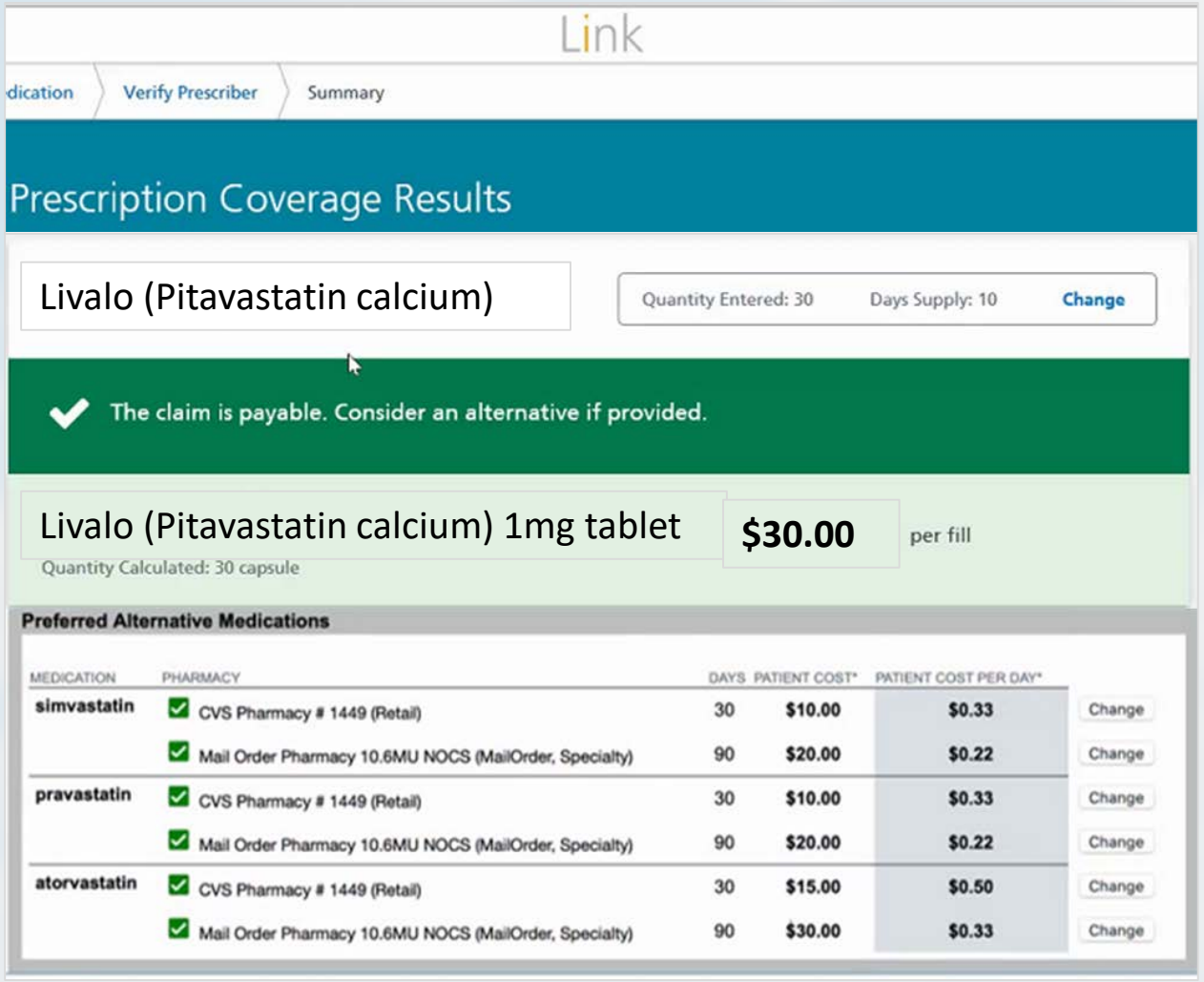
Verification of Prescriber Information



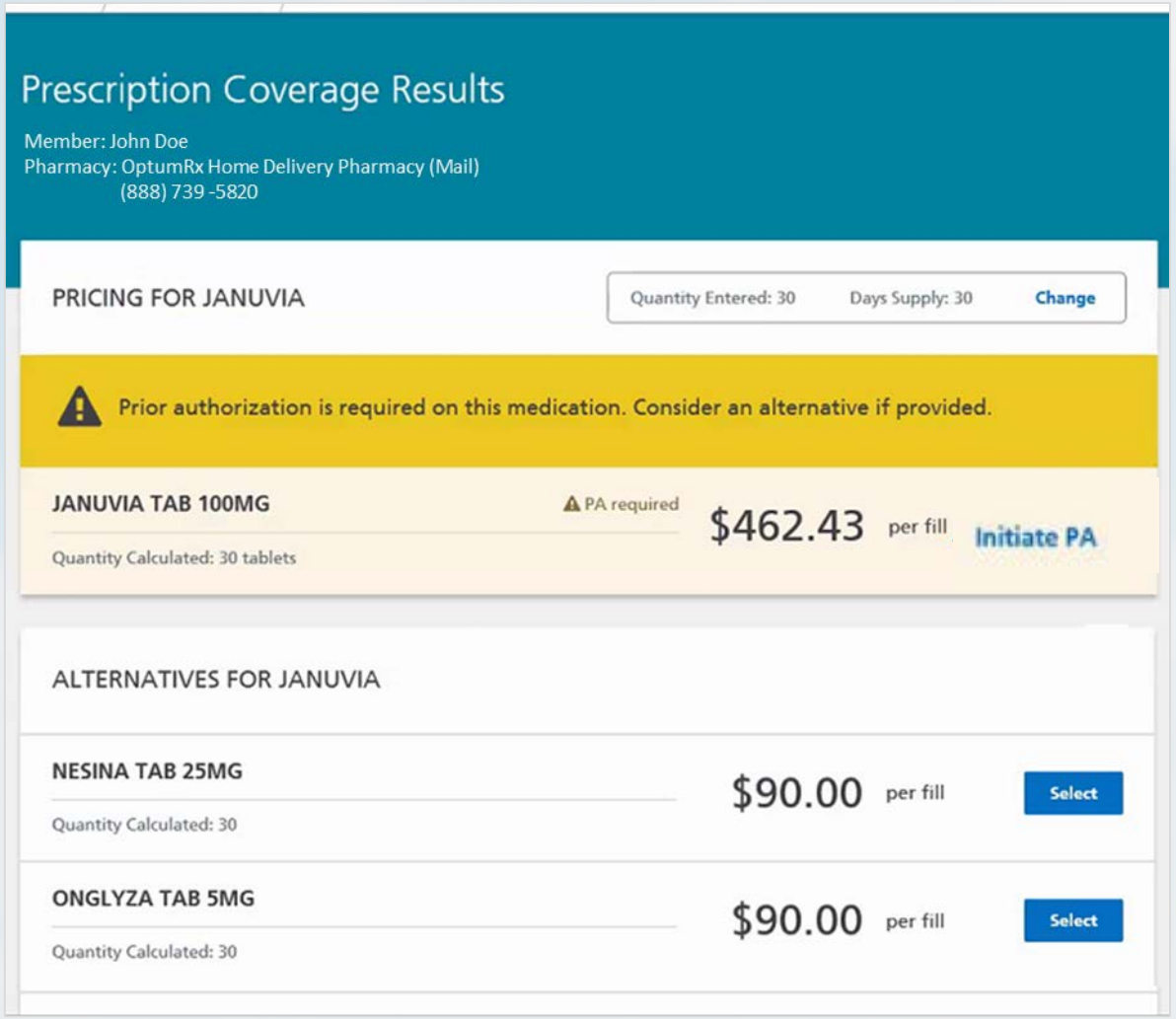
Member Benefit Check and Submit to Pharmacy



Switch Medications and Submit to the Pharmacy



View Prior Authorizations at the Point of Care



Specialty Medical Benefit Management

Specialty Medical Benefit Management Program

MBMNow is the SMBM program's online tool to process prior authorizations

SPECIALTY MEDICAL BENEFIT MANAGEMENT PROGRAM
SMBM

Cancer Guidance Program
CGP

CANCER FOCUS

Evidence-based prior authorization program (includes 100% of NCCN-compliant regimens for 60+ cancers) that allows health plans to reduce medical expenses associated with oncology medical drugs that are administered under the medical benefit and oral chemotherapy.

Specialty Guidance Program
SGP

ALL OTHER SPECIALTY CONDITIONS

Evidence-based prior authorization program that allows health plans to reduce medical expenses associated with specialty medical drugs (non-oncology) that are administered under the medical benefit for specialty categories such as inflammatory, IVIG, MS.

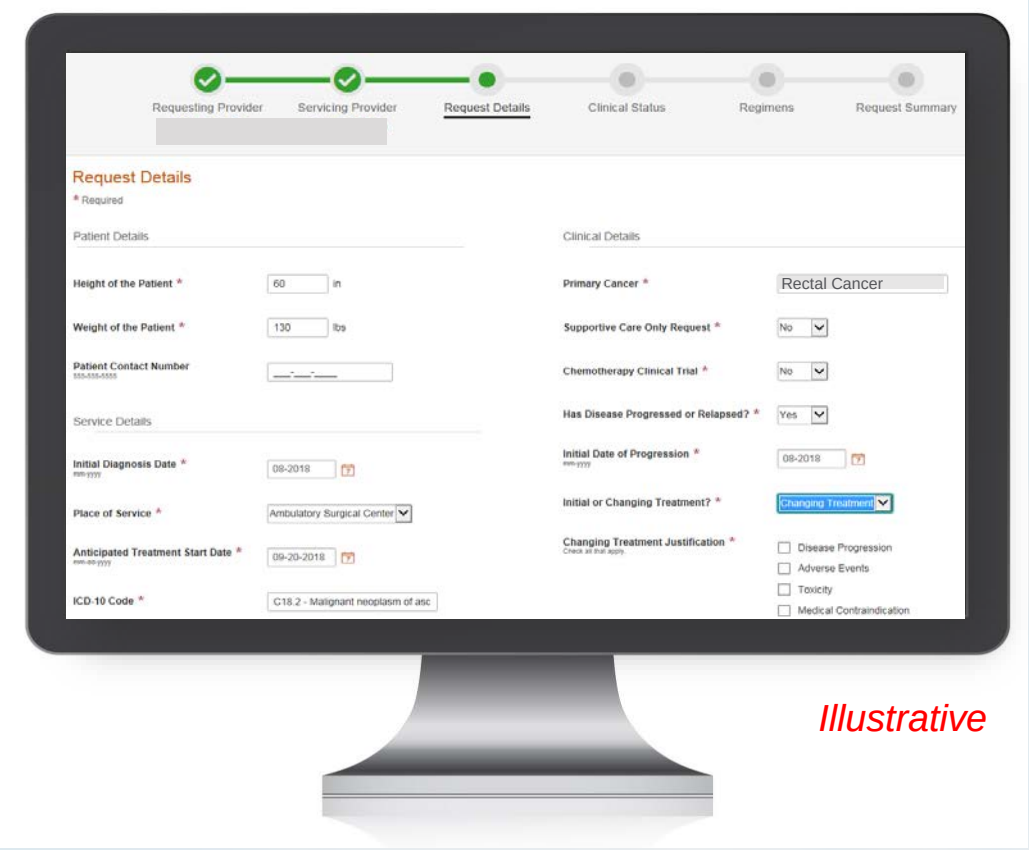
Specialty Medical Benefit Management Program

Developed in coordination with providers

- Developed with insights from a team of 10+ board-certified oncologists, hematologists, and internal medicine medical directors; five specialty pharmacists; 60+ registered nurses with experience as complex case managers, oncology care, or specialty drug administration
- Already contracted to support authorizations for 23M+ members
- Utilization management expertise in specialty drug management (15+ years in oncology)

Specialty Medical Benefit Management Program

Access the tool via My Insurance Manager



Illustrative

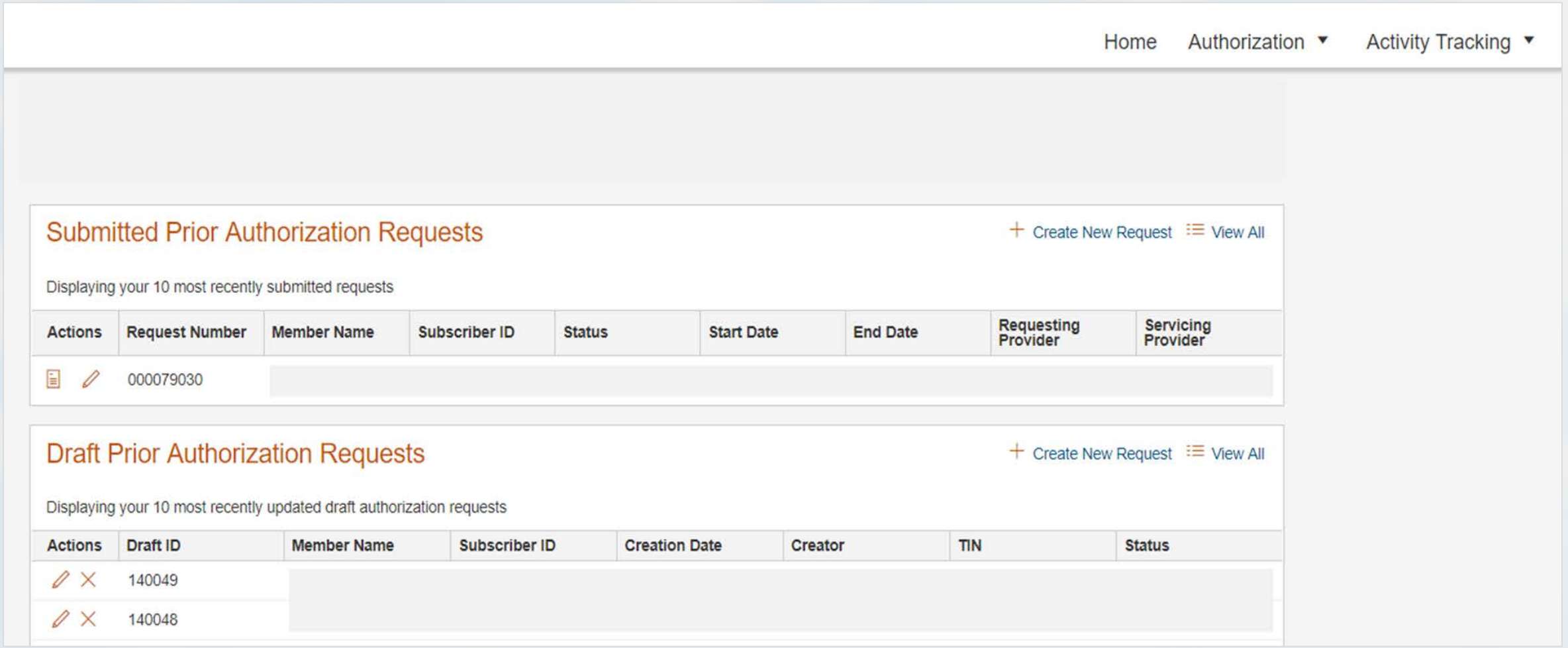
- No need to get a new Prior Authorization on 1/1 if a previous Novologix PA is still active
- Easy, single sign-on portal in MIM
- Regimen-level PA approval across medical and Rx benefits (for oral / topical chemotherapy)
- Oncology decision support based on NCCN guidelines
- Better medication and dosage controls
- Clone an existing Prior Authorization to append a new drug to an existing authorization or create a new PA

<1% adverse determination rate for oncology

7%-9% adverse determination rate for other specialty

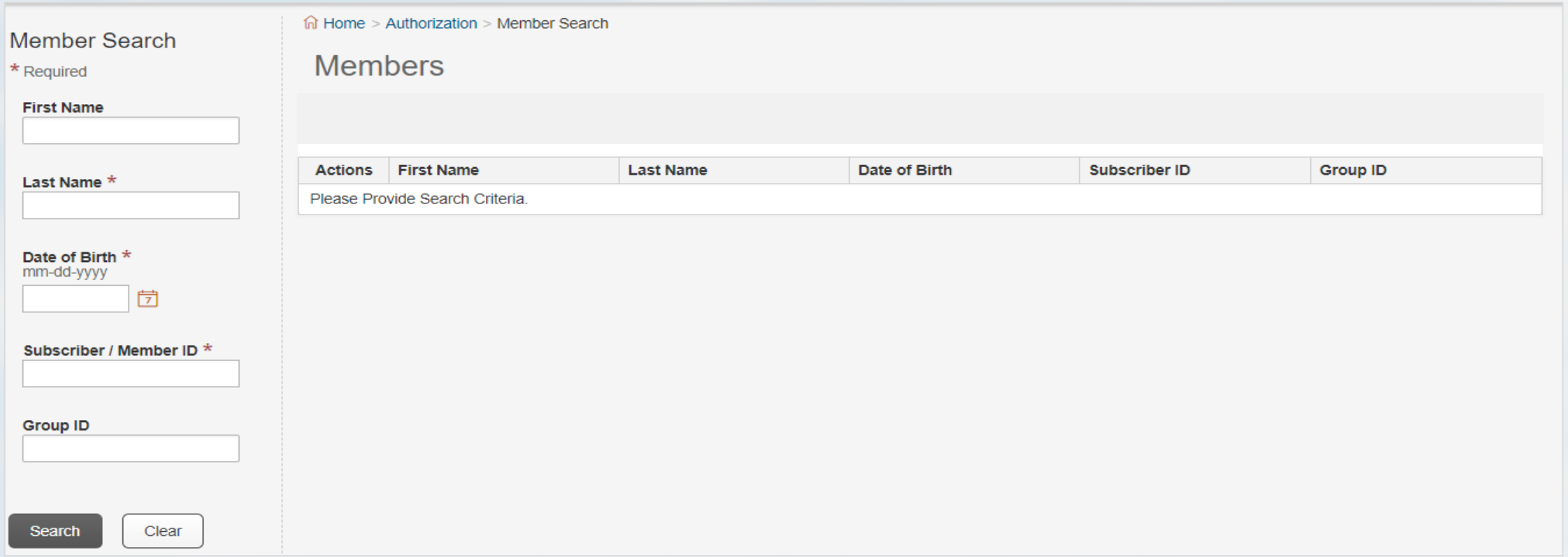
Specialty Medical Benefit Management Dashboard

The dashboard is the first screen and shows submitted prior authorizations drafts and submitted prior authorizations



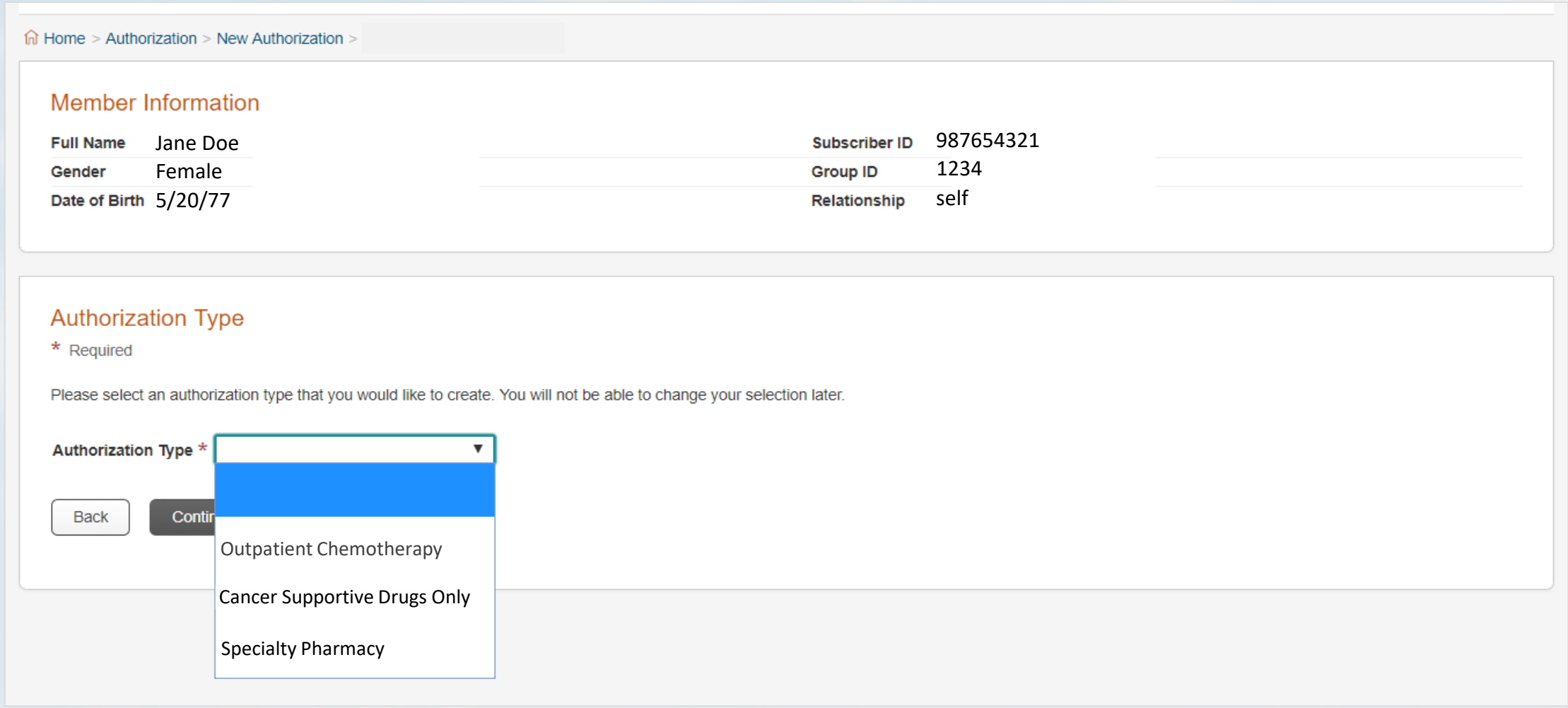
Member Search

Search for a patient to initiate the process



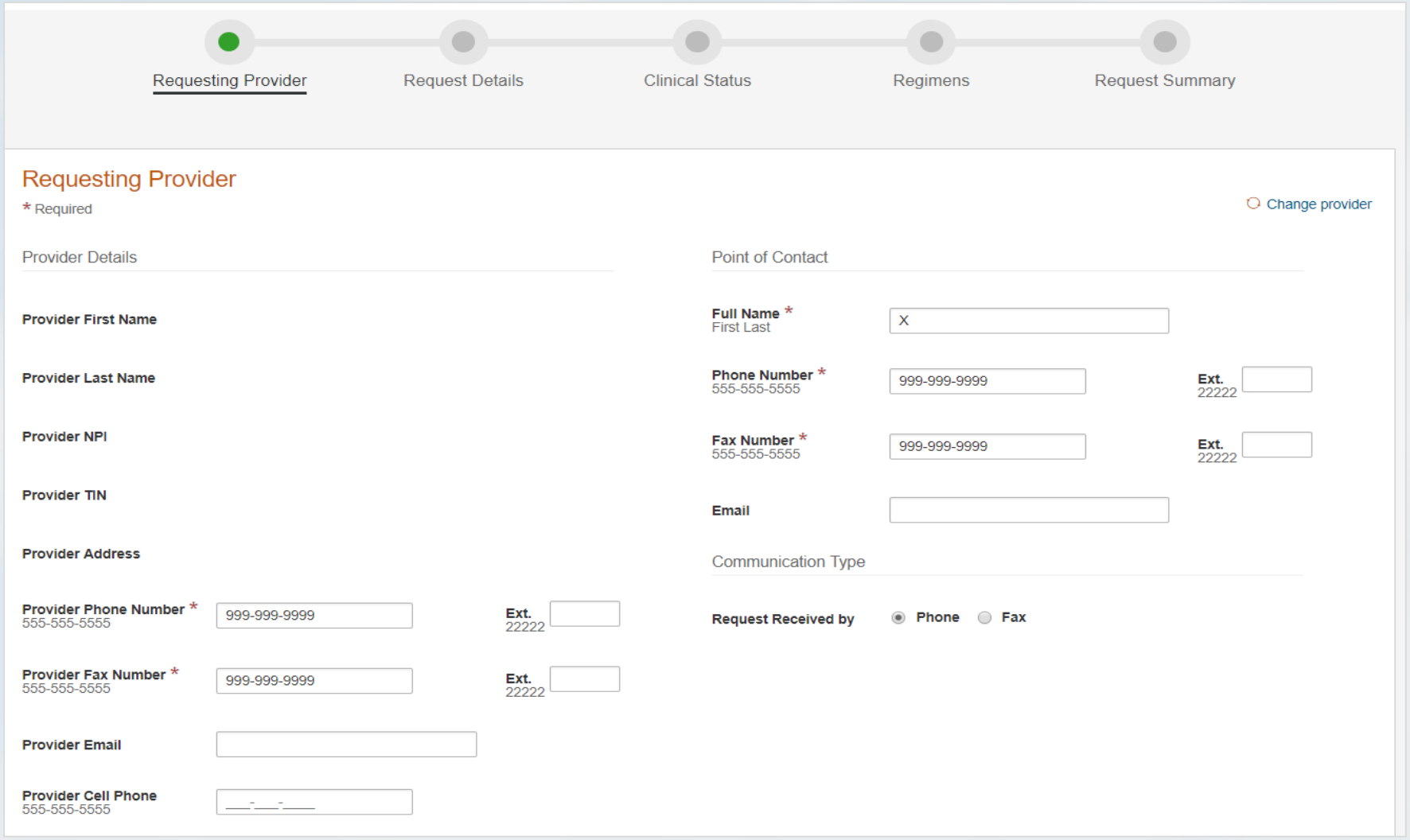
Authorization Type

Select whether the authorization will be for oncology or specialty



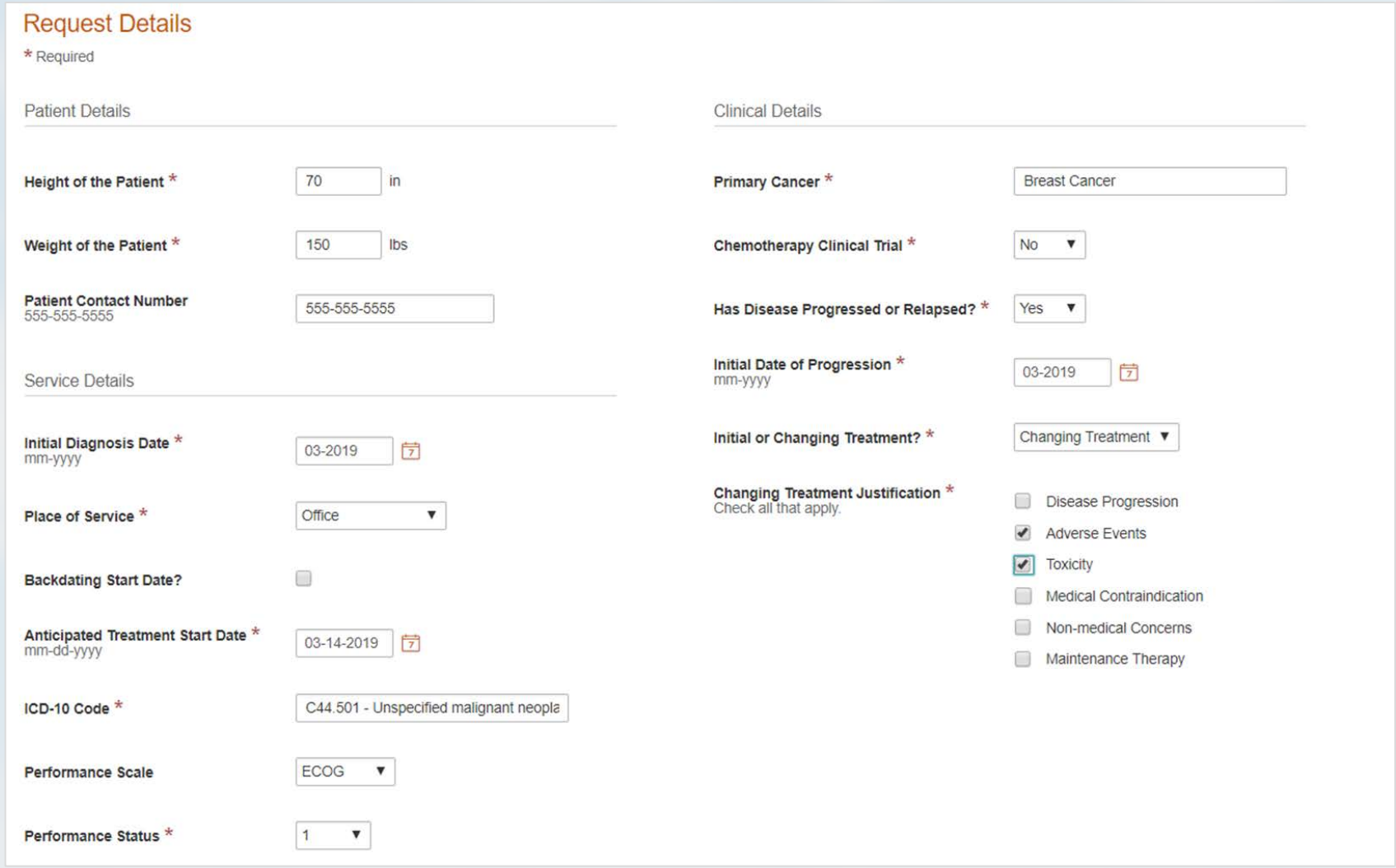
Requesting Provider

Complete requesting provider information



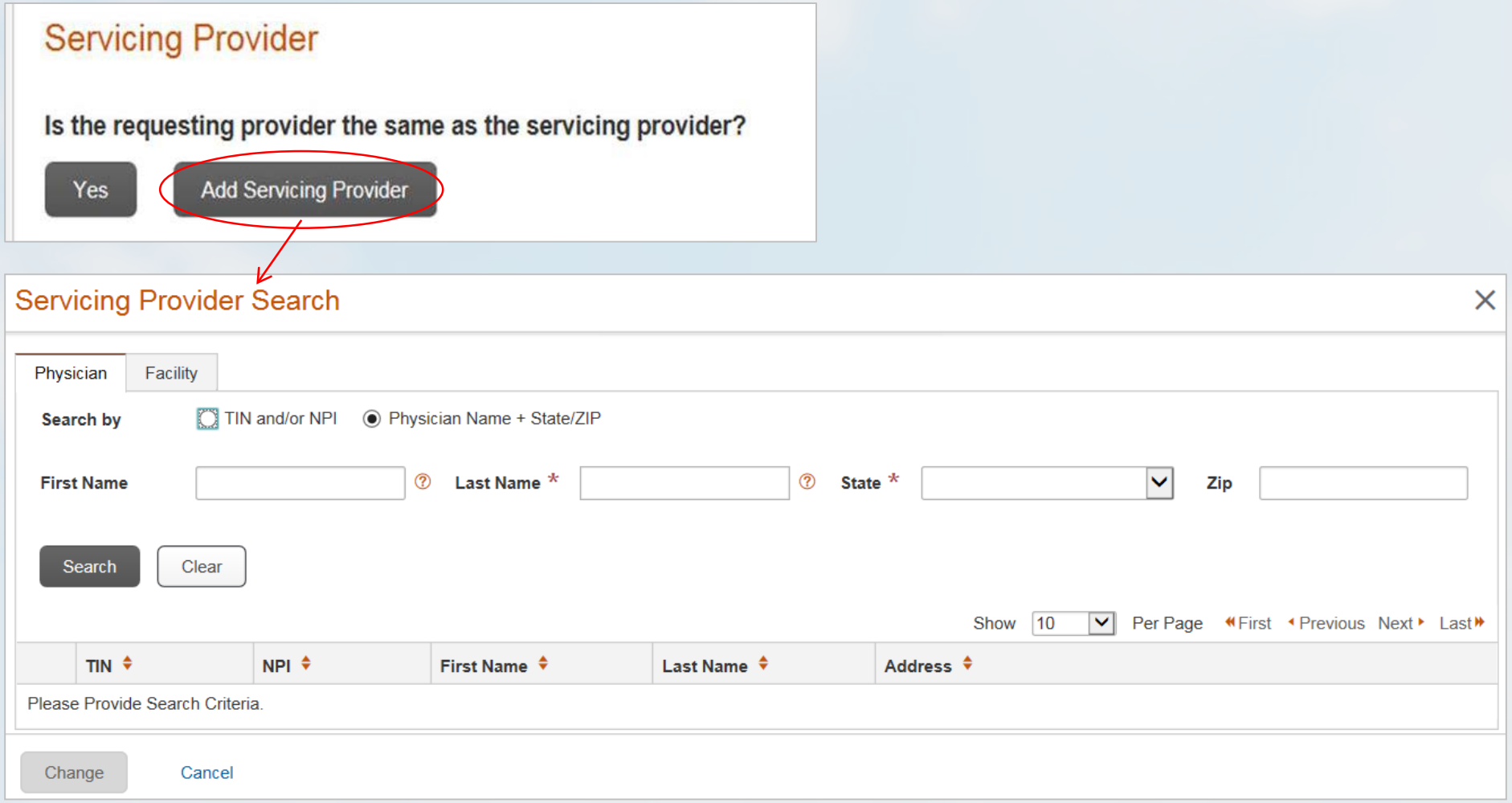
Request Details

Complete information related to the patient



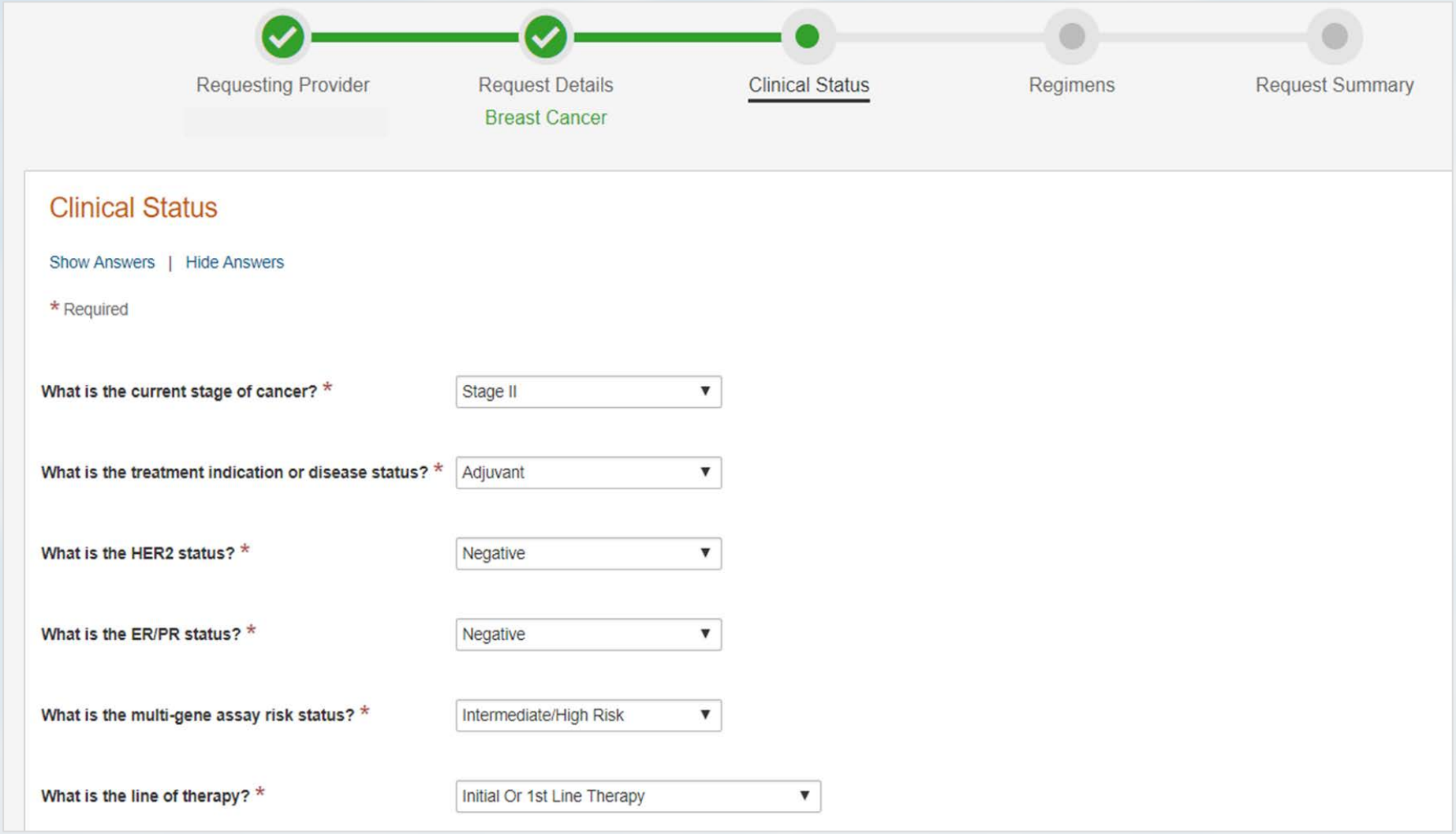
Add a Servicing Provider

An out of network check will be in place for certain providers (check payer's provider portal for more details)

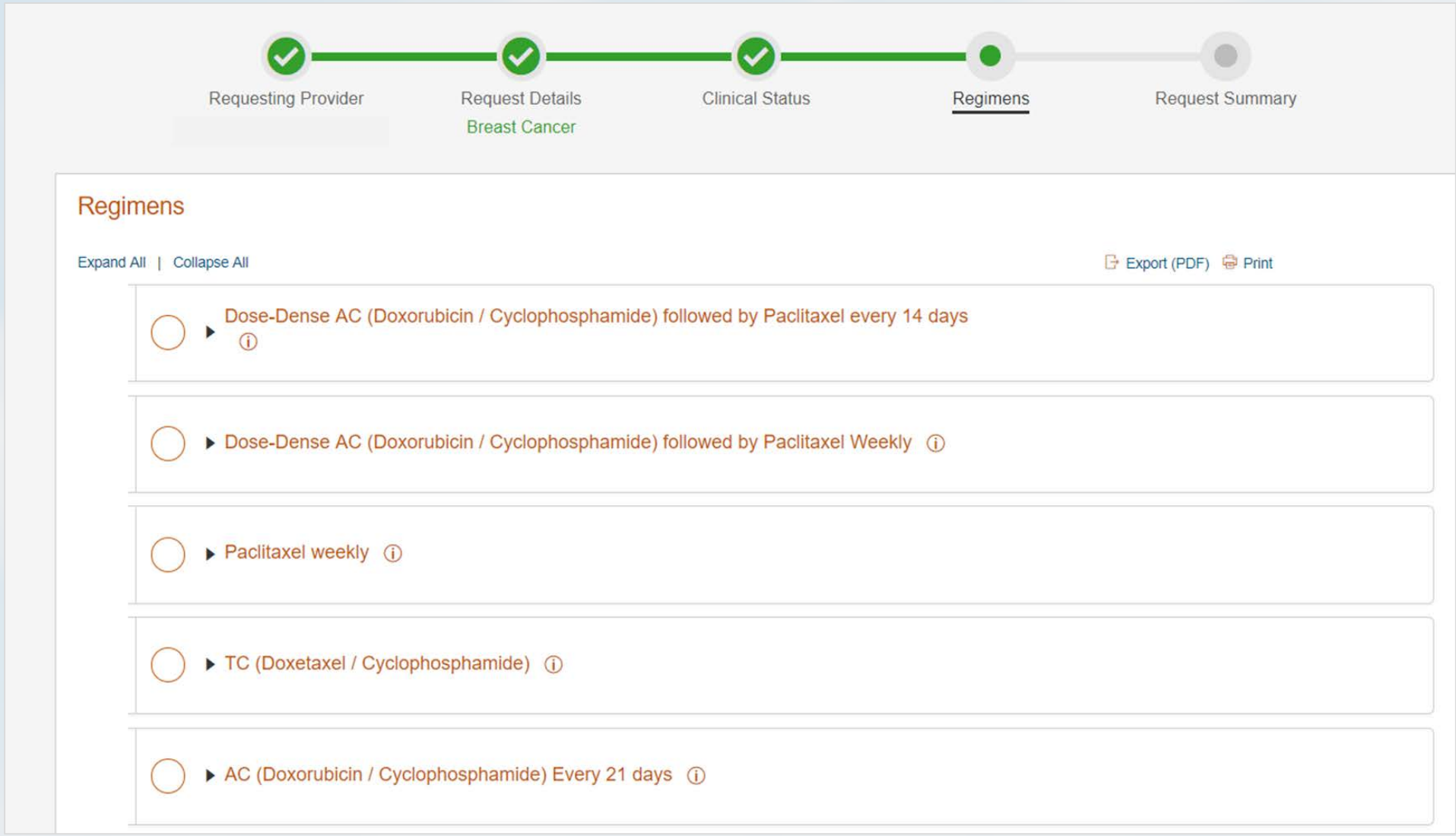


Clinical Status

Complete information related to the specific patient condition

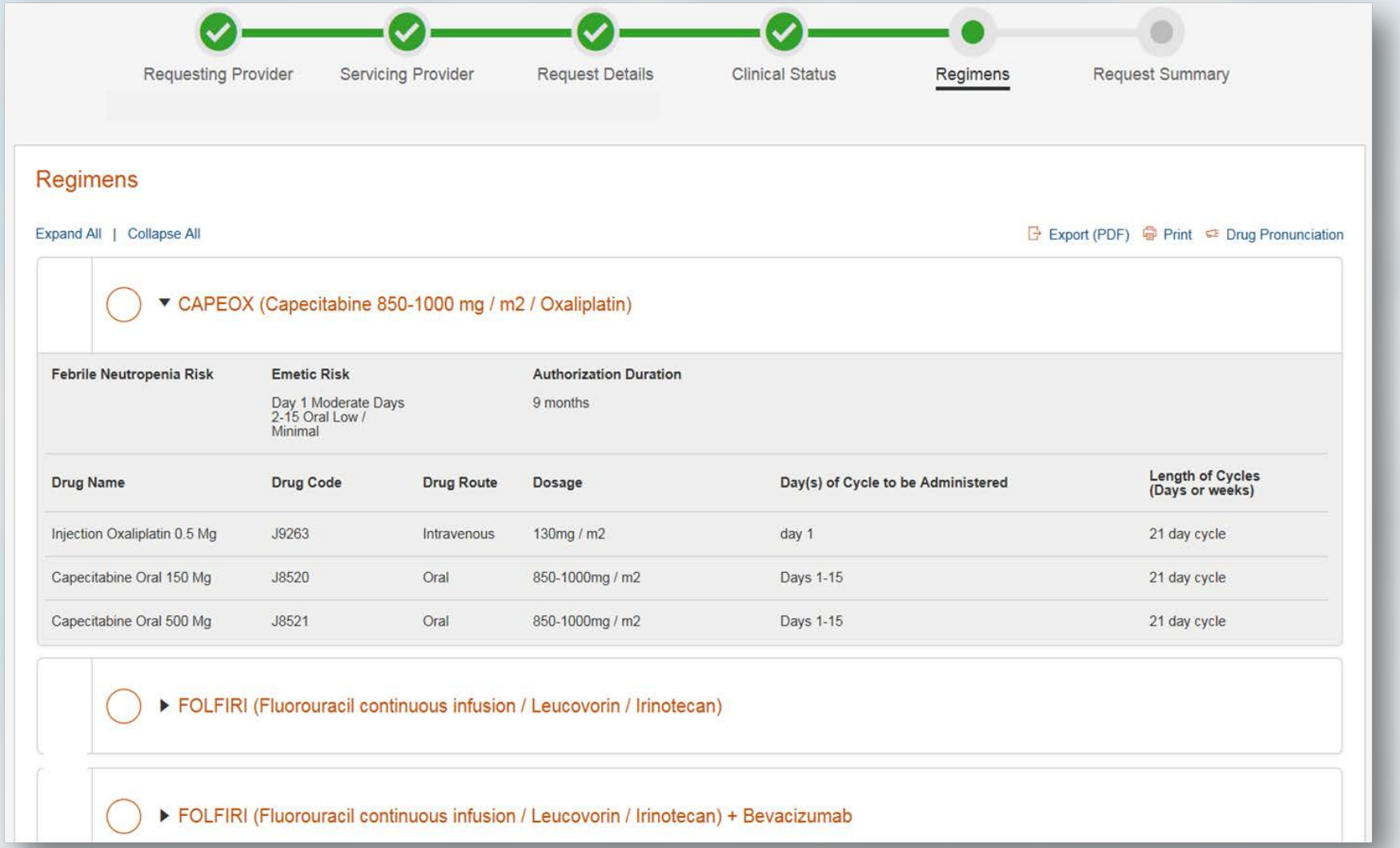


Regimen


Requesting Provider
Request Details
Breast Cancer
Clinical Status
Regimens
Request Summary
Regimens
Expand All | Collapse All
Export (PDF)
Print
Dose-Dense AC (Doxorubicin / Cyclophosphamide) followed by Paclitaxel every 14 days
Dose-Dense AC (Doxorubicin / Cyclophosphamide) followed by Paclitaxel Weekly
Paclitaxel weekly
TC (Doxetaxel / Cyclophosphamide)
AC (Doxorubicin / Cyclophosphamide) Every 21 days

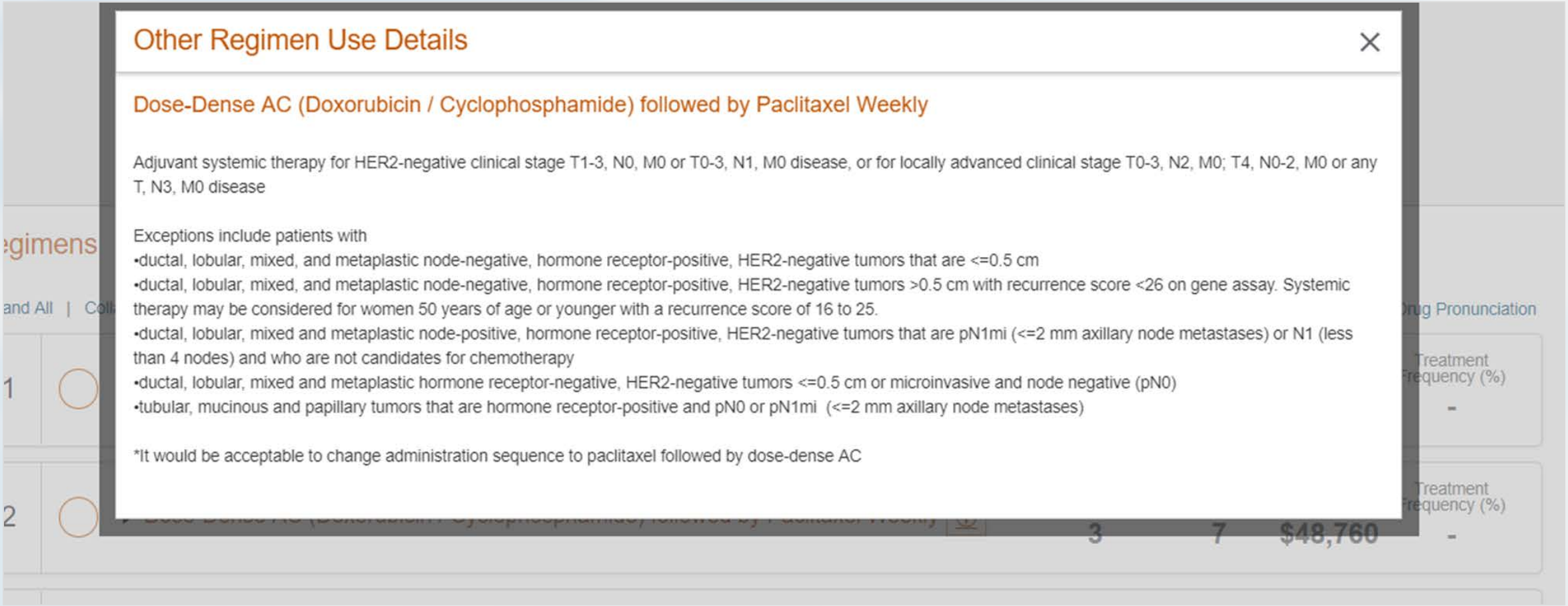
Regimen

Expand regimen to view detail



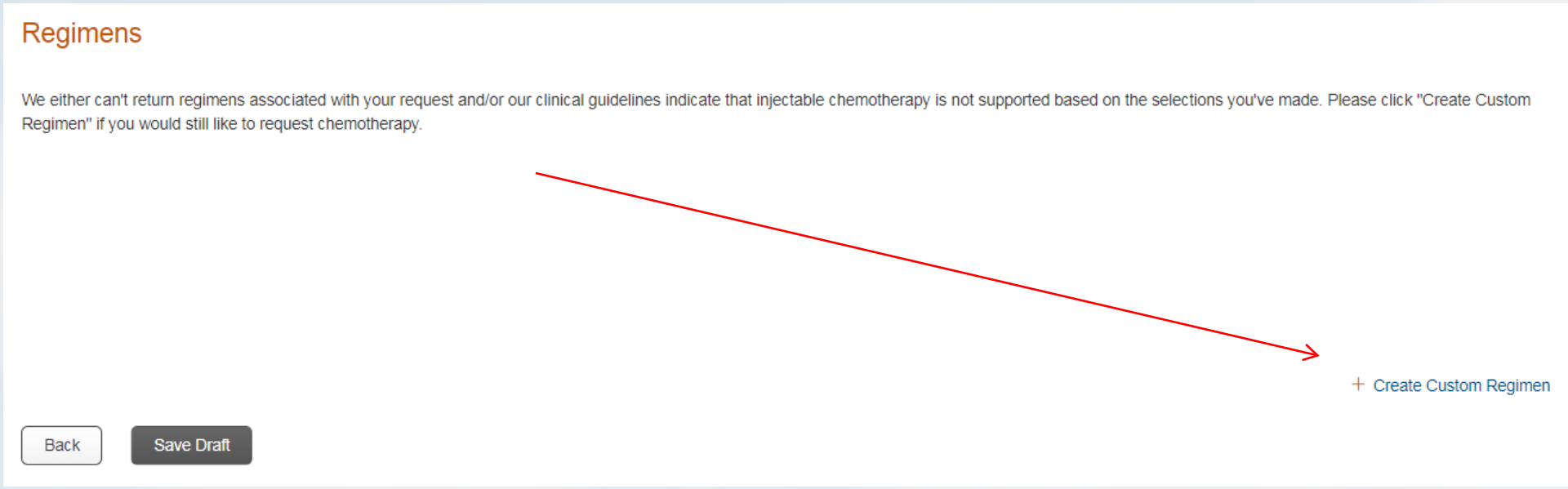
Regimen

Additional regimen details are available



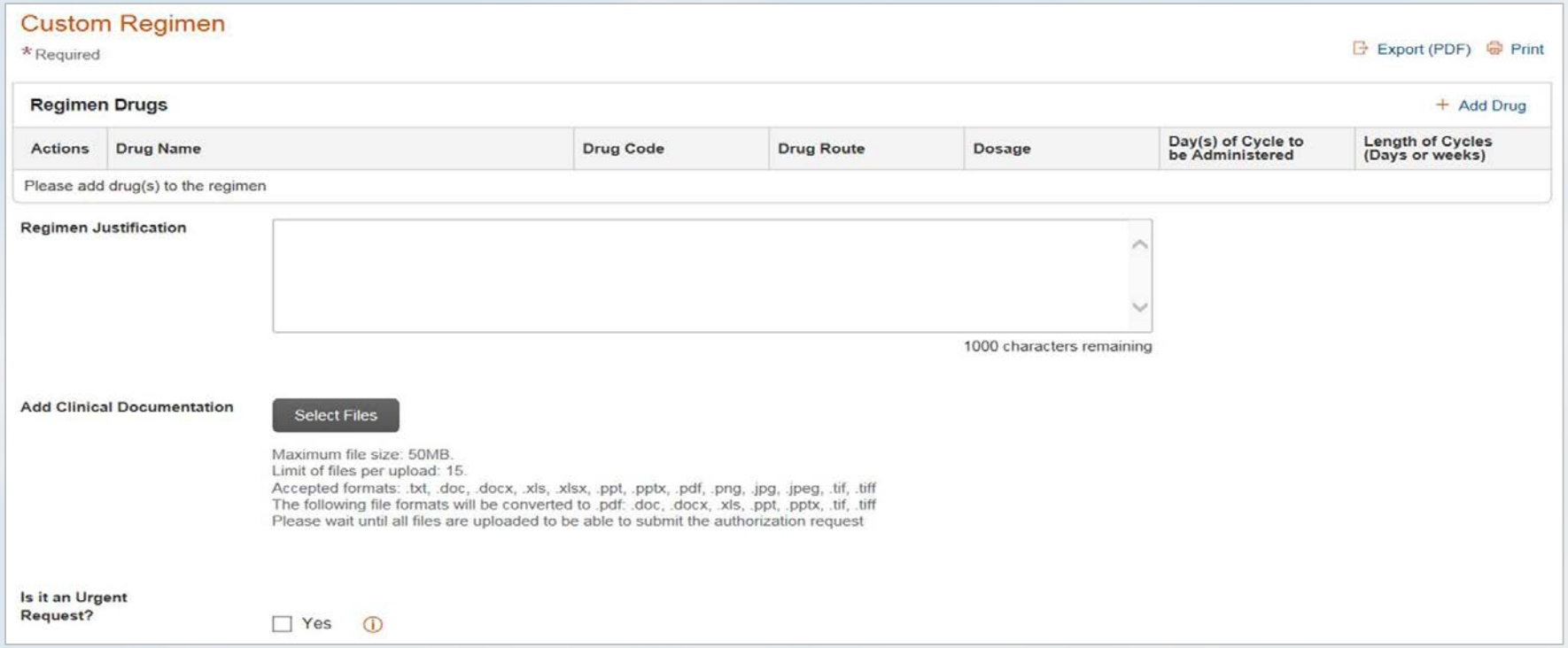
Create a Custom Request

If the answers on the Clinical Status page indicate chemotherapy isn't supported, the user will be required to submit a custom request



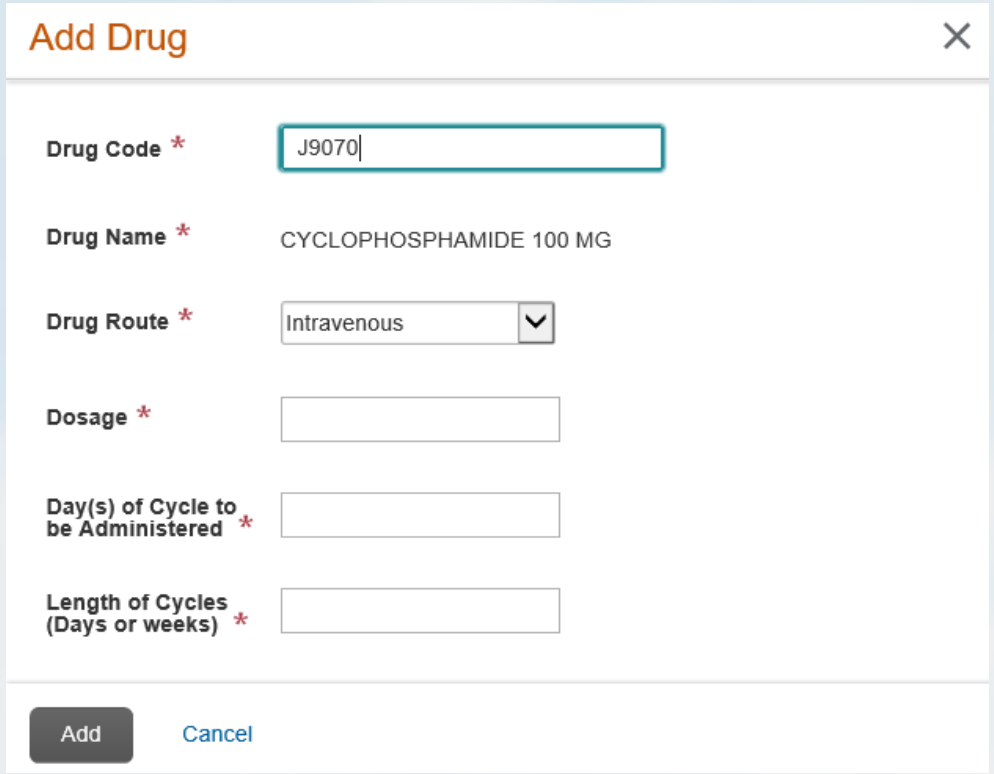
Create a Custom Regimen

A provider choosing to create a custom regimen will add drugs requested

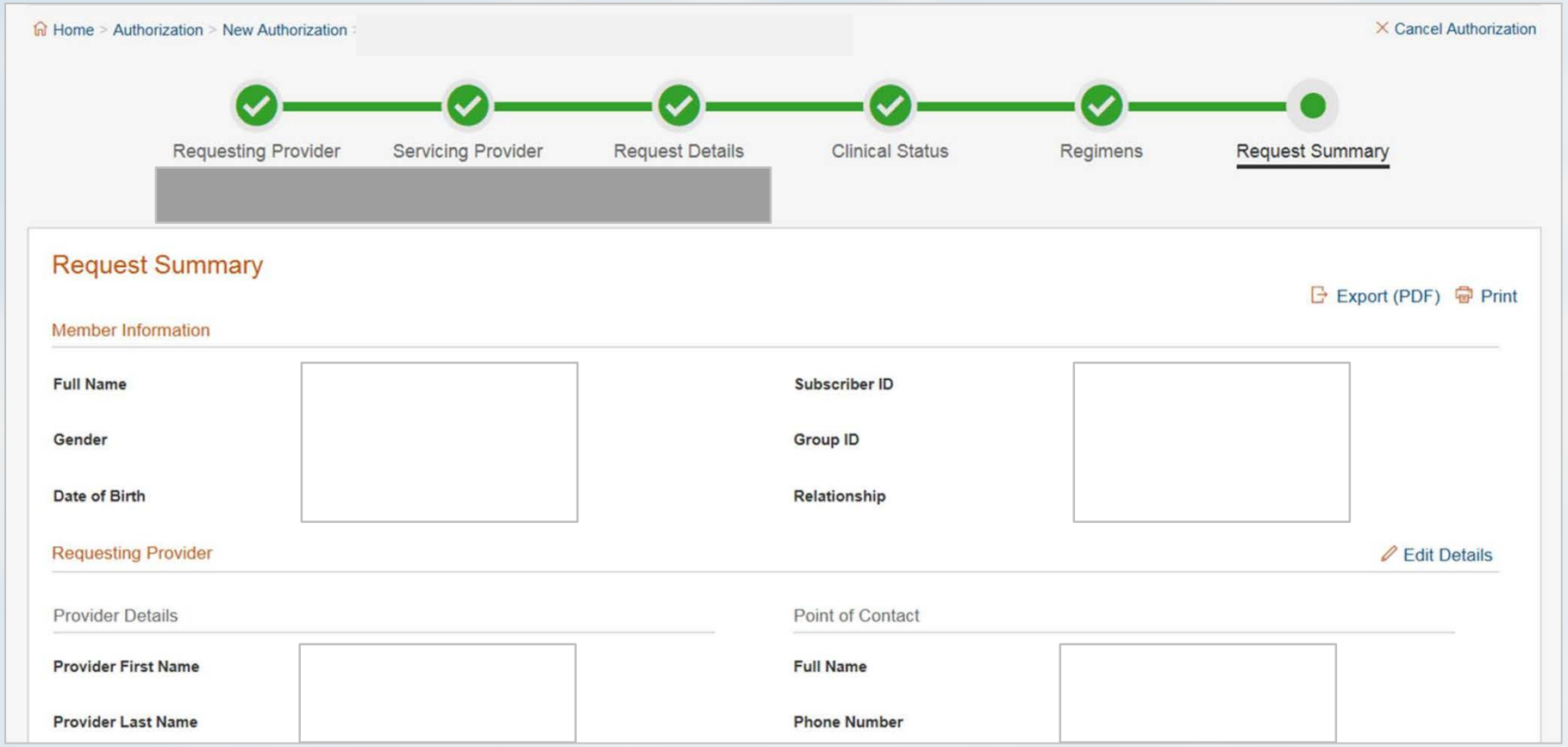


Create a Custom Regimen (cont'd)…

A provider choosing to create a custom regimen will add drugs requested

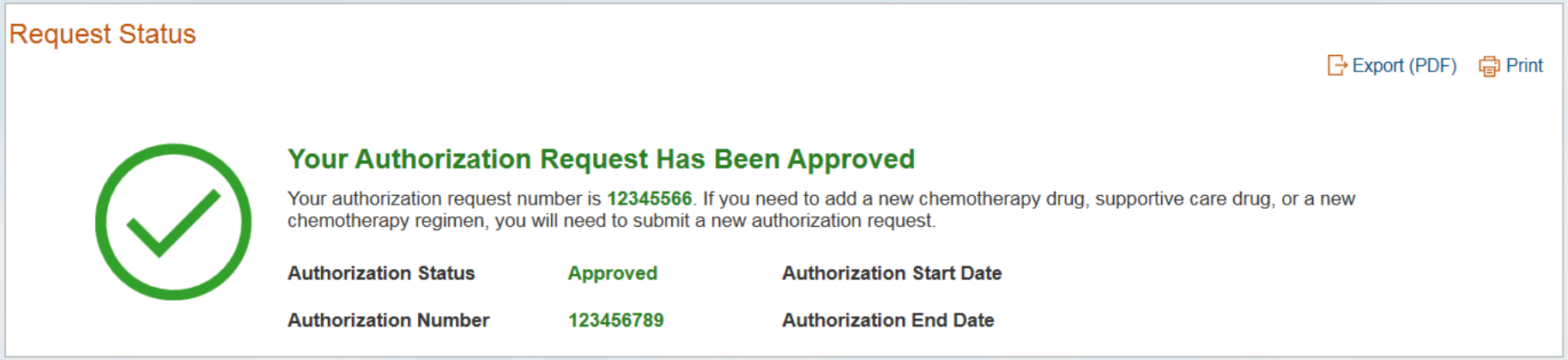


Request Summary for Custom Regimen



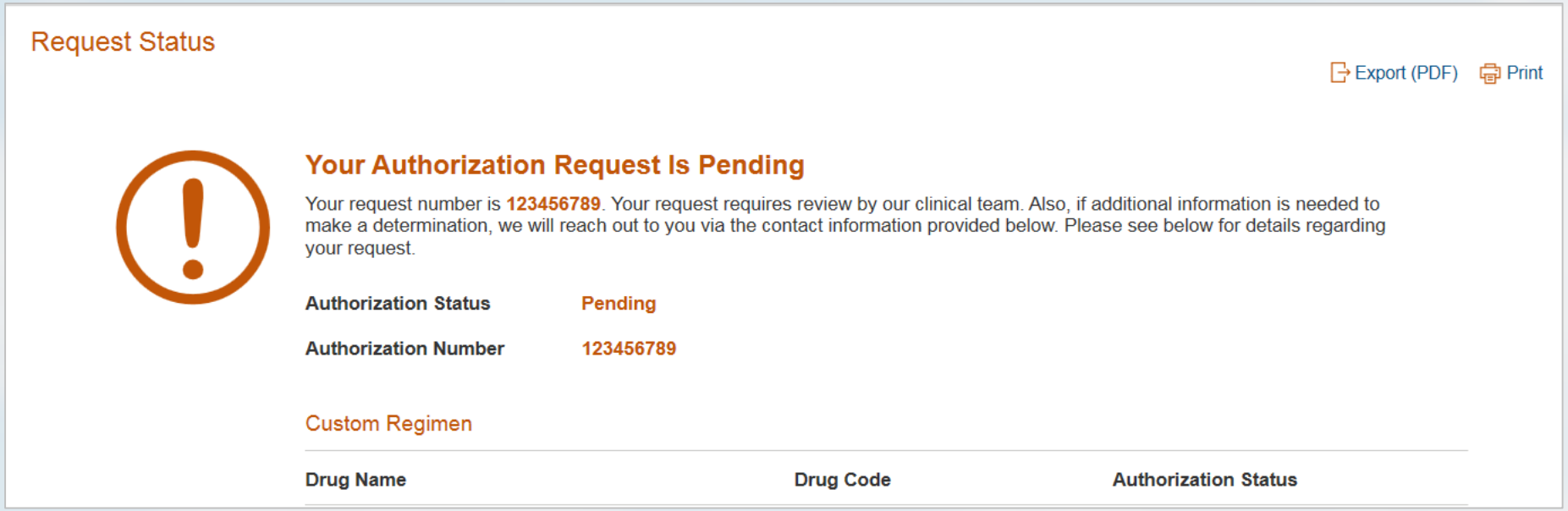
Authorization Approved

Providers having selected an NCCN-compliant treatment will receive an auto-approved authorization confirmation



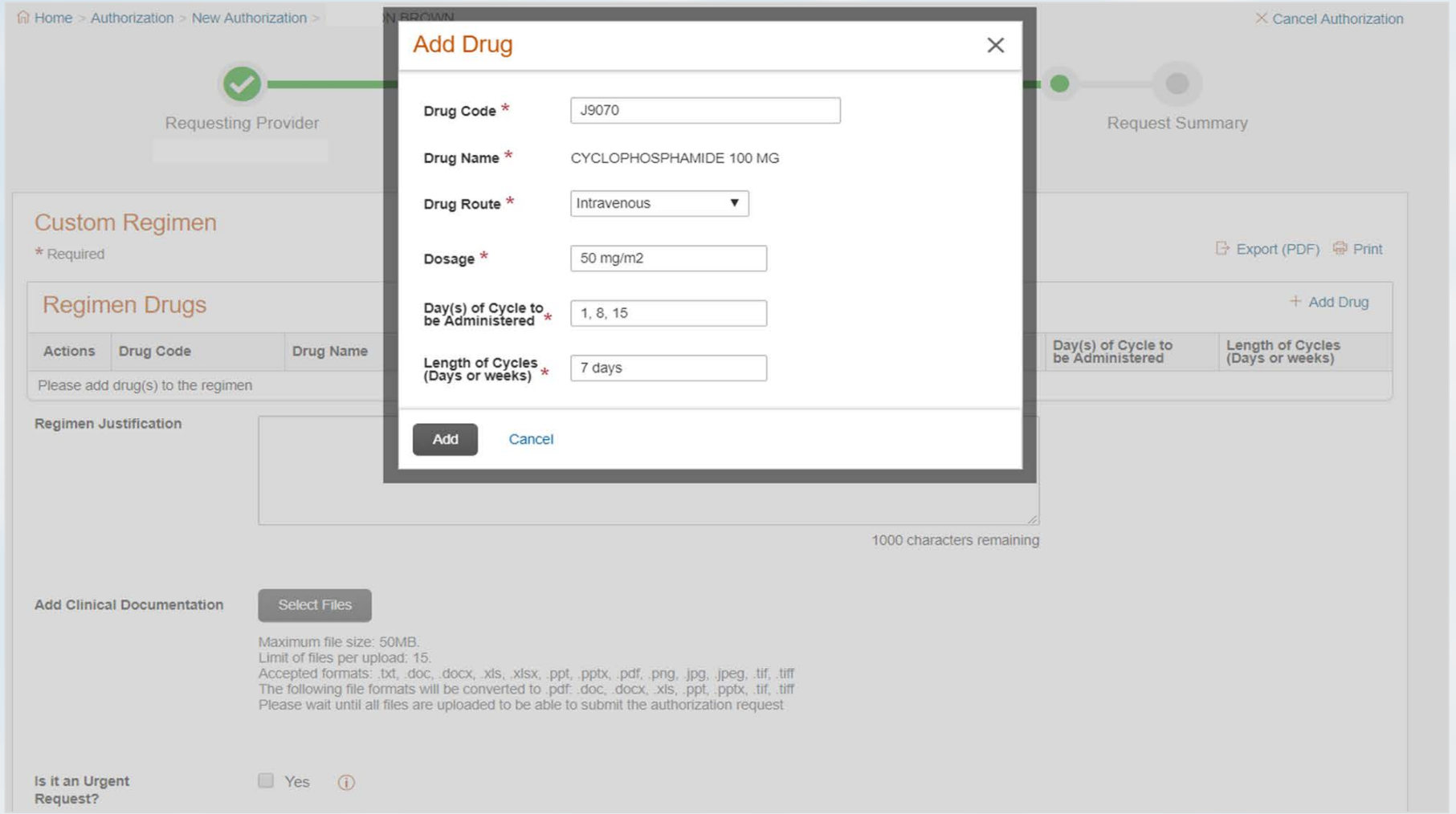
Authorization Pending

Providers submitting a custom request will receive a Pending Review confirmation screen



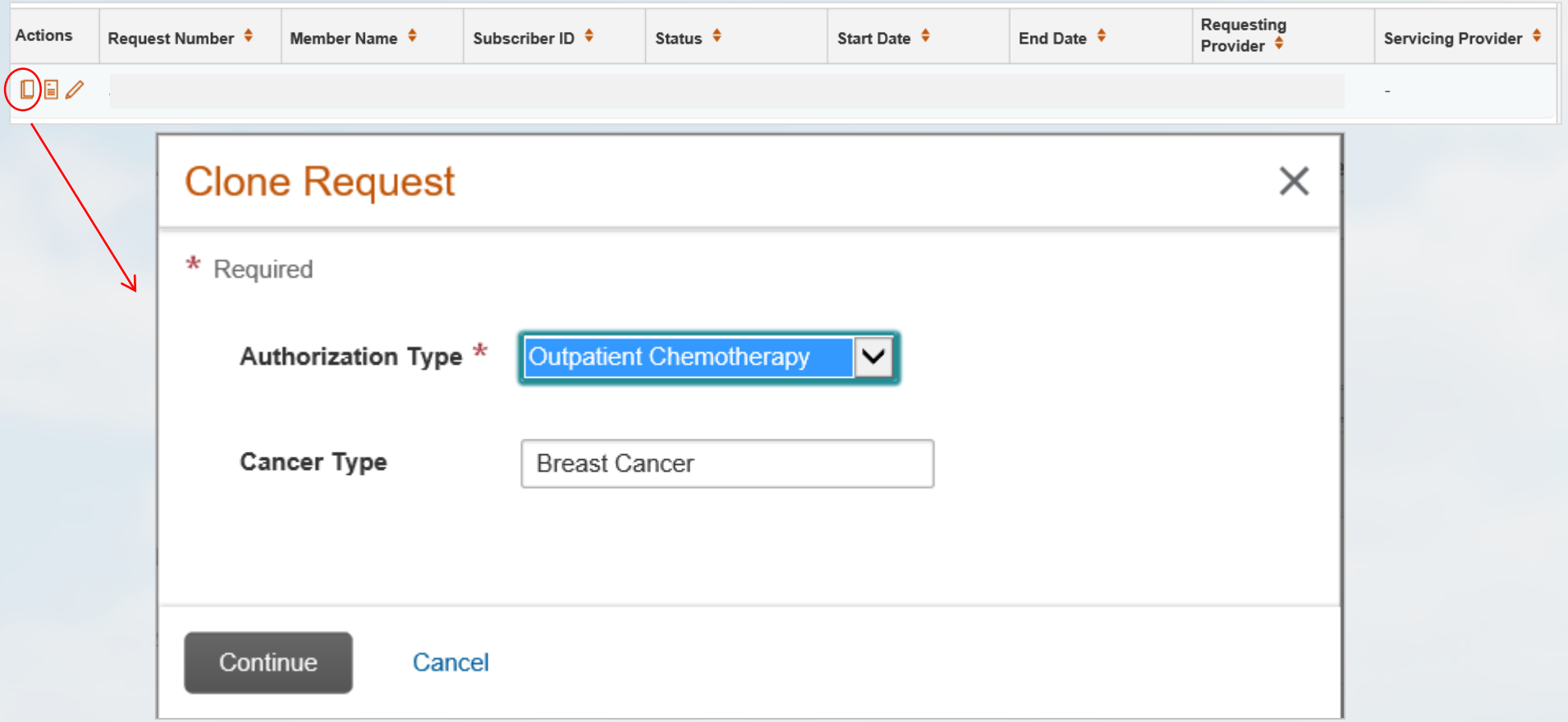
Drug Selection

Submit a custom request if clinically necessary



Cloning an Authorization

Providers can clone an existing authorization by searching for the authorization to be cloned and clicking the “clone” button in the upper left corner

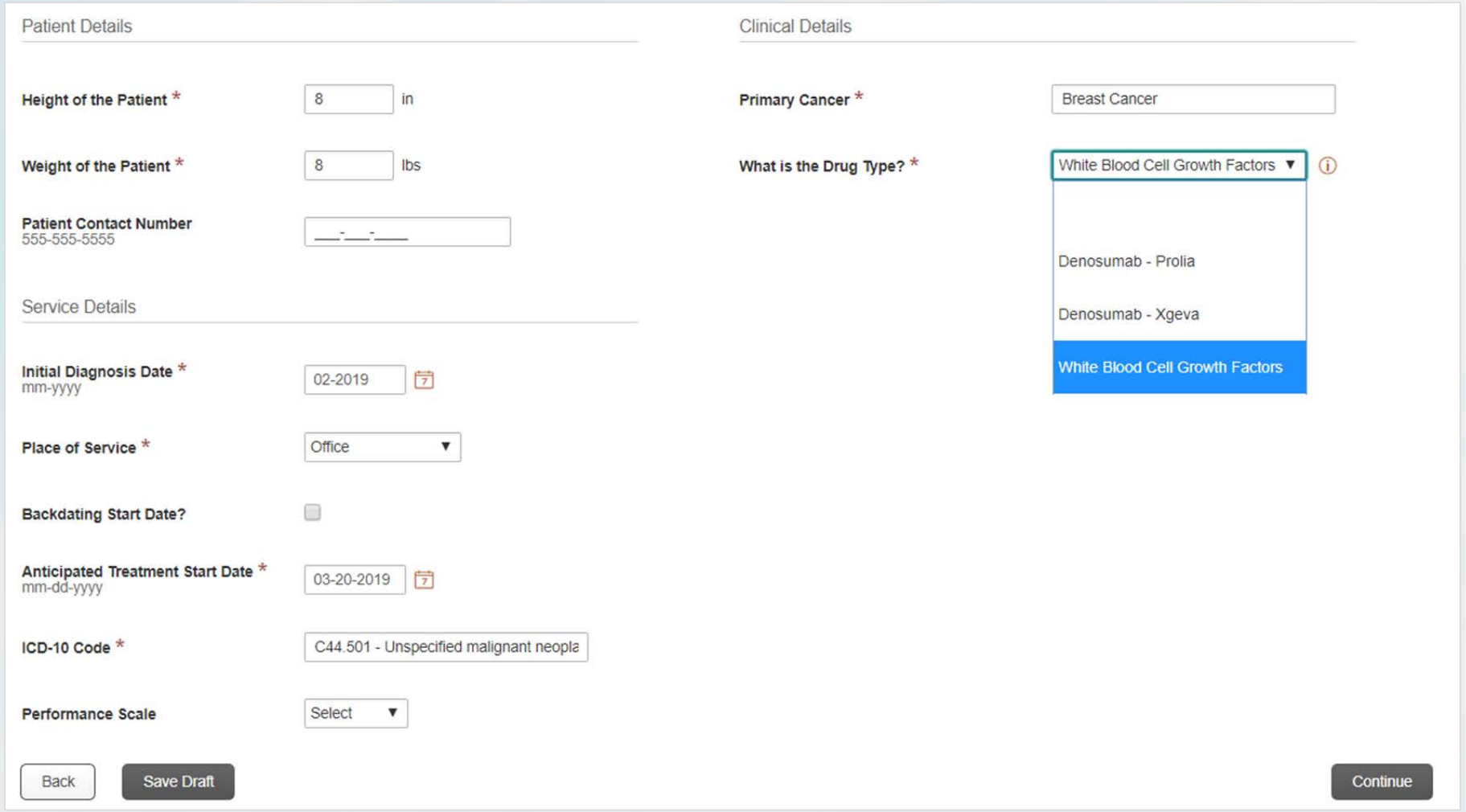


Patient Information

Providers can also submit requests for standalone drugs

Examples:

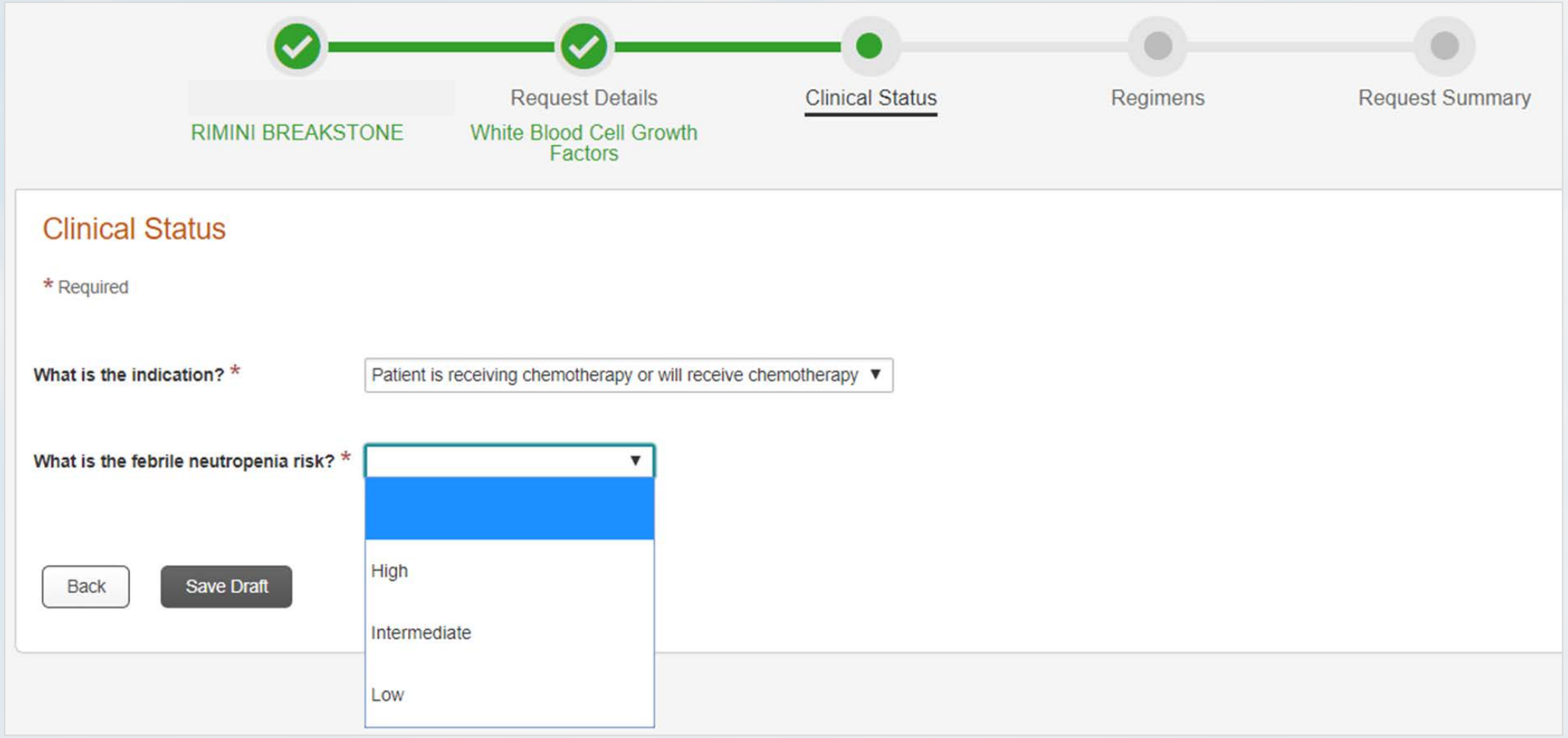
Specialty non-cancer, cancer supportive drugs



Clinical Status

Providers can also submit requests for standalone drugs

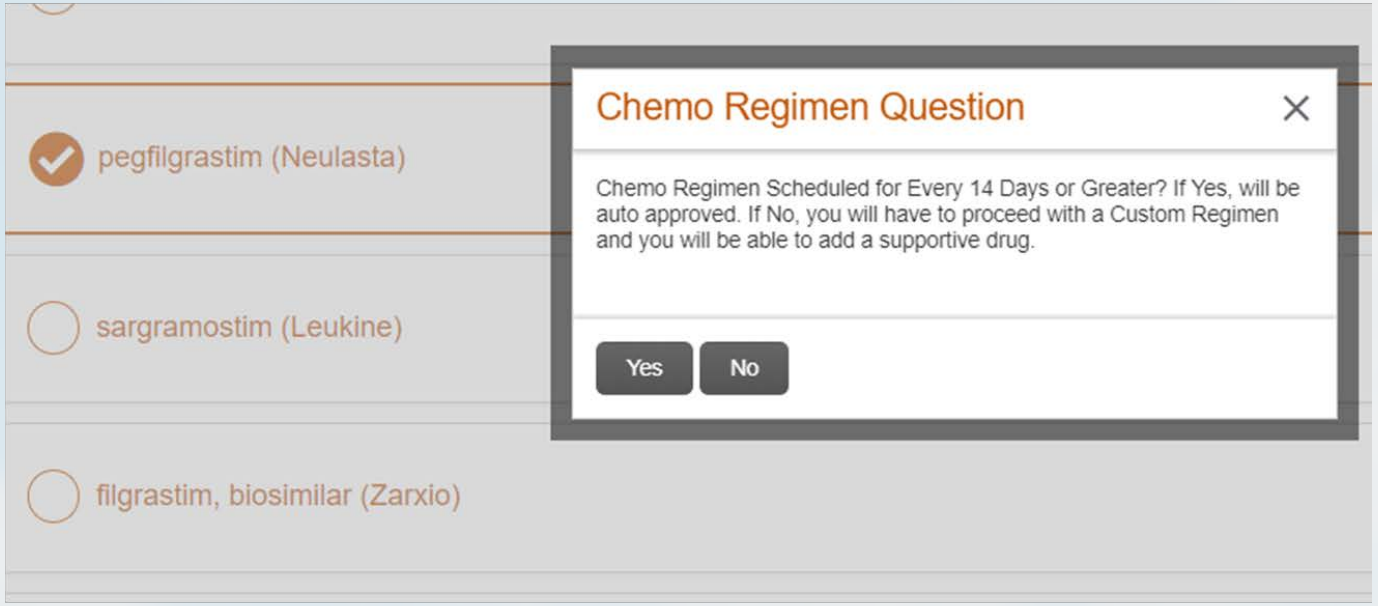
Examples: Specialty non-cancer, cancer supportive drugs



Regimen

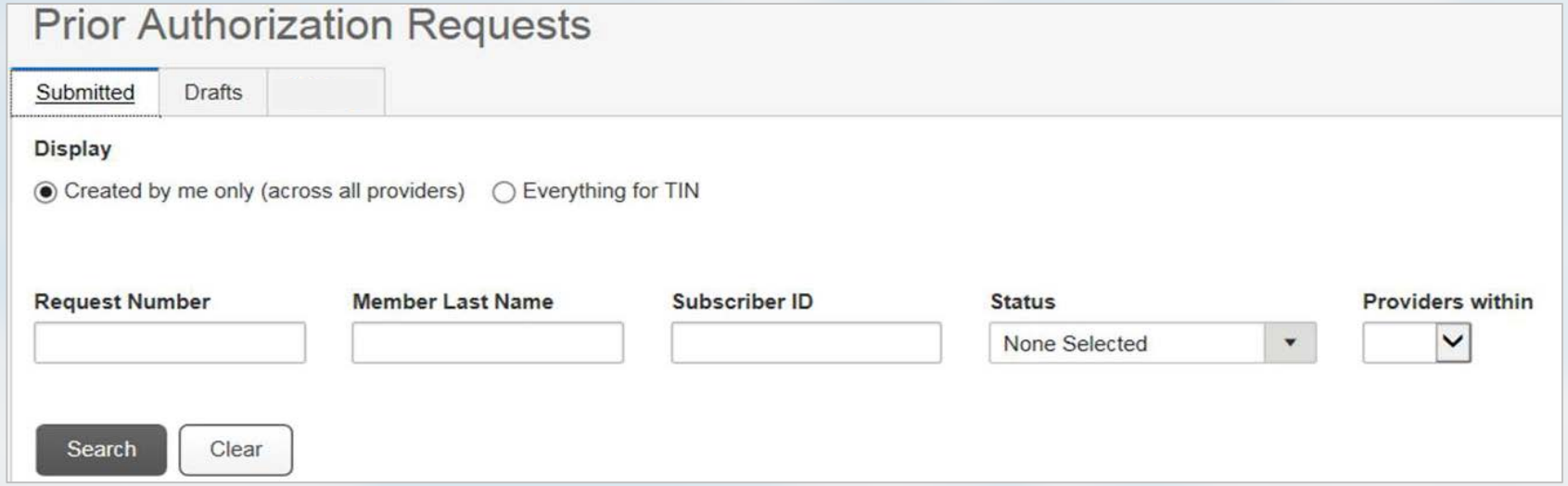
Providers are shown treatments which meet evidence for their request

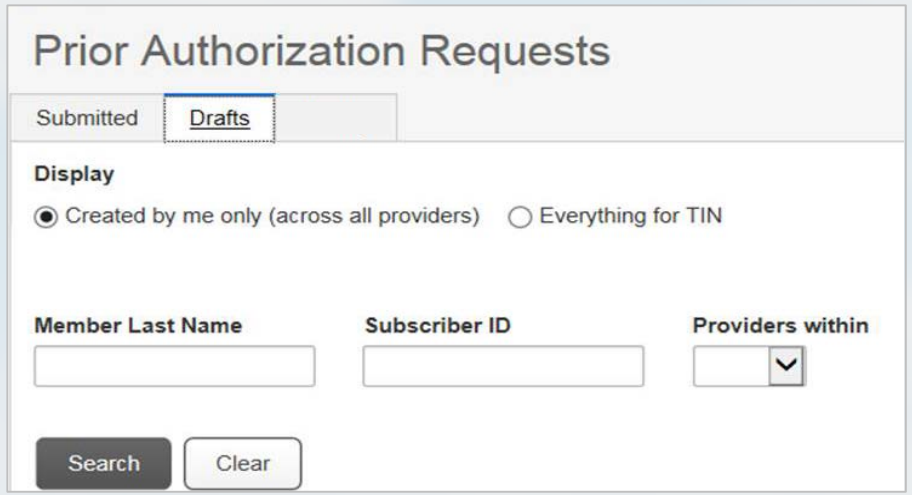
- filgrastim (Neupogen)
- tbo-filgrastim (Granix)
- pegfilgrastim (Neulasta)
- sargramostim (Leukine)
- filgrastim, biosimilar (Zarxio)
- filgrastim, biosimilar (Nivestym)
- pegfilgrastim, biosimilar (Fulphila)
- pegfilgrastm-CBQV biosmlr 0.5 MG (Udenyca)



Member Search

Search for previously submitted authorization requests, draft requests and requests previously entered on a different platform





Member Search

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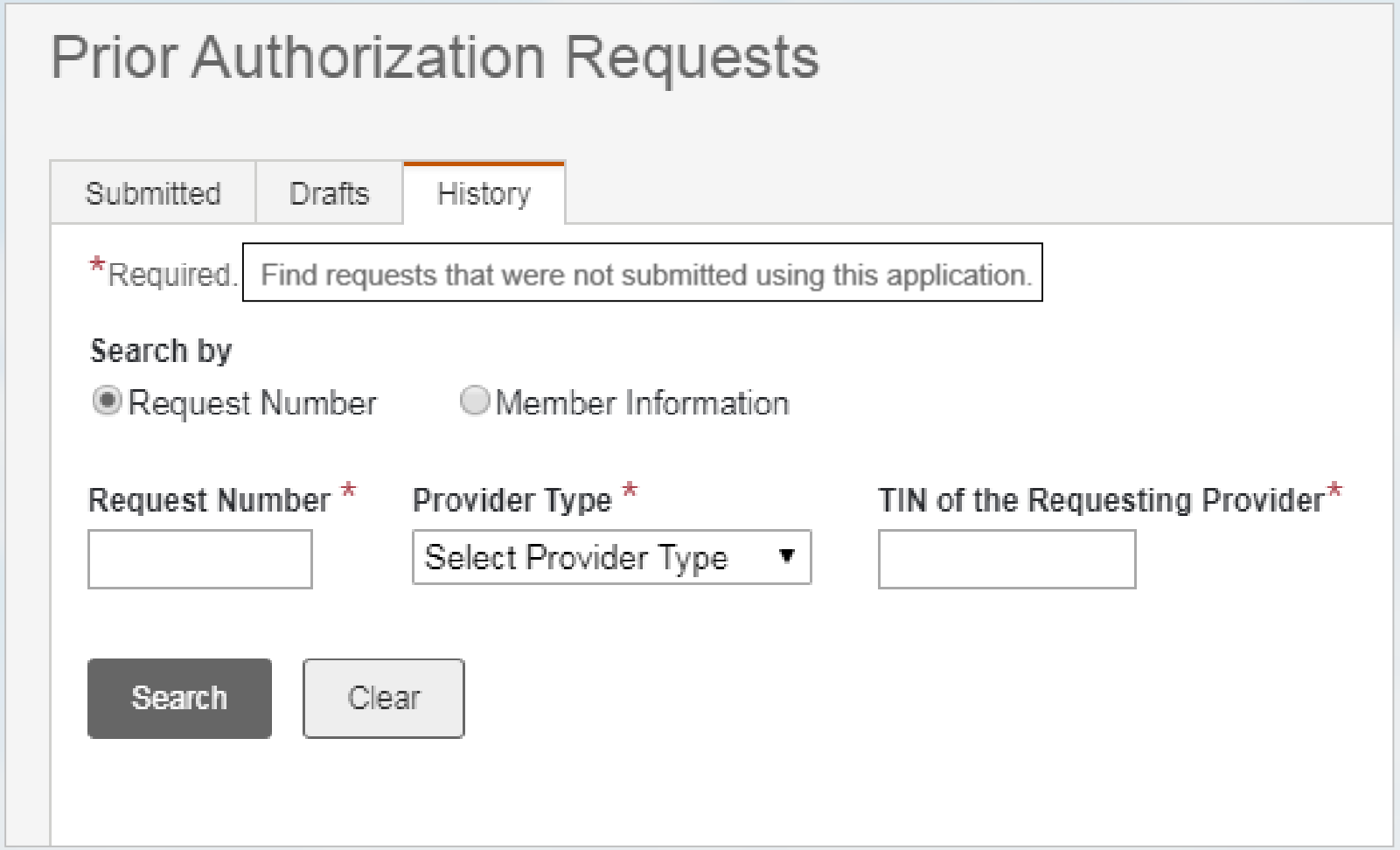


Home Delivery

Home Delivery

Improves patient outcomes and the patient experience is simple

1. 24/7 Access to Pharmacist by Phone
2. Free Shipping
3. 16 Safety Checks
4. 97% Ship Within Three Days
5. Overnight Shipping Available via FedEx

Home Delivery

Optum's process is simple

Step 1

Home Delivery pharmacy receives prescription

- Physician sends ePrescription to OptumRx

Step 2

Order processed

- First time members receive a call to verify ship to address and credit card information
- Payment options: ACH, credit and debit or check

Step 3

Prescription dispensed

- Prescription is reviewed by pharmacist
- Medication is filled and checked for accuracy, including 16 safety checks

Step 4

Order shipped

- Free, first-class 2-day shipping on all orders (USPS)
- Overnight urgent delivery needs (FedEx)
- Shipped in temperature-controlled, tamper-proof packaging
- 24/7 access to a pharmacist

*OptumRx analysis of 2018 home delivery claims.
† If the client is Union/Trust, then USPS or UPS will be used for express shipping.

Home Delivery

Available tools for providers, staff, and patients

Home Delivery Brochure

Here are some common questions about **OptumRx home delivery.**

Who is OptumRx?

As one of the top 3 pharmacies in the U.S., we serve millions of people every day through our state-of-the-art home delivery pharmacy and a national network of community pharmacies.

Visit us at optumrx.com to learn more.

Shipping

How long does it take to get my home delivery order?
Your prescriptions generally arrive within 3-5 business days after we receive your order.

Will I be notified when my prescription ships?
Yes, you can sign up for shipping notifications at **optumrx.com** or call at **1-855-828-9834**.

Who is sending the medications?
OptumRx is the pharmacy that sends your medications to you. We have medication fulfillment centers throughout the United States to ensure we can fill your prescriptions as efficiently as possible.

Can I get refill reminders?
Refill reminders are available by email, phone, or text.

Get Started Today:

1. Your doctor sends your prescription electronically to OptumRx.
2. OptumRx processes your prescription.
   - OptumRx will also call Medicare patients to obtain consent to ship the prescription.
   - OptumRx will call patients for billing information if a copay is required.
3. OptumRx delivers your prescriptions to you.

Benefits of Home Delivery

Convenience and peace of mind.

- 24/7 access to pharmacists.
- Lower out-of-pocket costs for most benefit plans
- Free standard shipping
- Automatic refills
- Multiple quality checks for safety and accuracy
- Easier to take your medications as prescribed (and fewer chances to forget to refill)

More Questions?

Call us **1-800-526-3477, TTY 711** and we will be happy to help you.

Or set up an online account at **optumrx.com**.

OPTUMRx® | Home Delivery

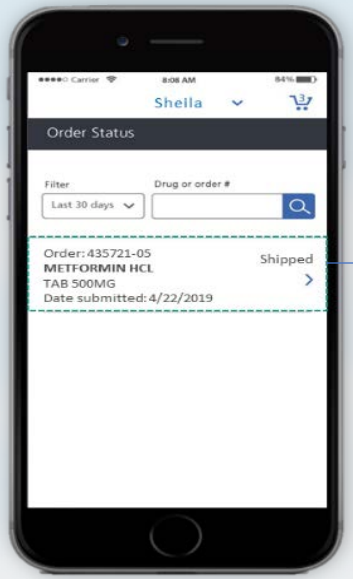
Your prescriptions delivered right to you

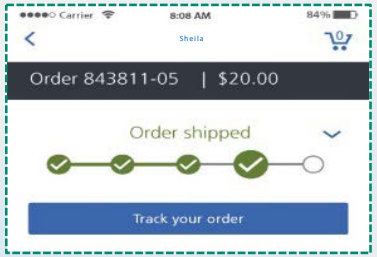
OPTUM® Spotlight

optumrx.com

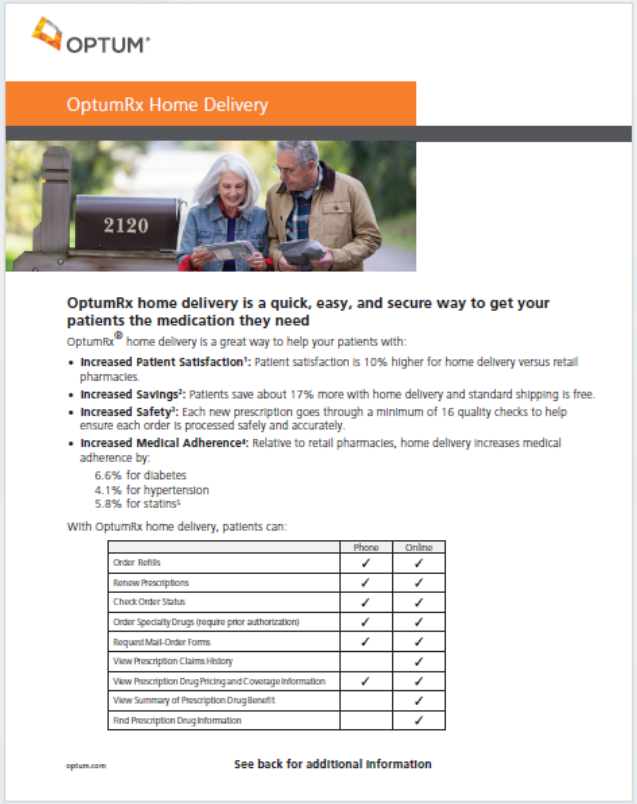
OptumRx is a pharmacy care services company helping clients and more than 65 million members achieve better health outcomes and lower overall costs through innovative prescription drug benefits services.

Order Delivery Status and Tracking





Education



OPTUM®

OptumRx Home Delivery

OptumRx home delivery is a quick, easy, and secure way to get your patients the medication they need

OptumRx® home delivery is a great way to help your patients with:

- **Increased Patient Satisfaction[1]:** Patient satisfaction is 10% higher for home delivery versus retail pharmacies.
- **Increased Savings[2]:** Patients save about 17% more with home delivery and standard shipping is free.
- **Increased Safety[3]:** Each new prescription goes through a minimum of 16 quality checks to help ensure each order is processed safely and accurately.
- **Increased Medical Adherence[4]:** Relative to retail pharmacies, home delivery increases medical adherence by:
  - 6.6% for diabetes
  - 4.1% for hypertension
  - 5.8% for statins[5]

With OptumRx home delivery, patients can:

	Phone	Online
Order Refills	✓	✓
Renew Prescriptions	✓	✓
Check Order Status	✓	✓
Order Specialty Drugs (require prior authorization)	✓	✓
Request Mail-Order Forms	✓	✓
View Prescription Claims History		✓
View Prescription Drug Pricing and Coverage Information	✓	✓
View Summary of Prescription Drug Benefit		✓
Find Prescription Drug Information		✓

optum.com

See back for additional information

CoverMyMeds

CoverMyMeds

Electronic prior authorization (ePA) solutions are used to streamline the prior authorization process for all stakeholders

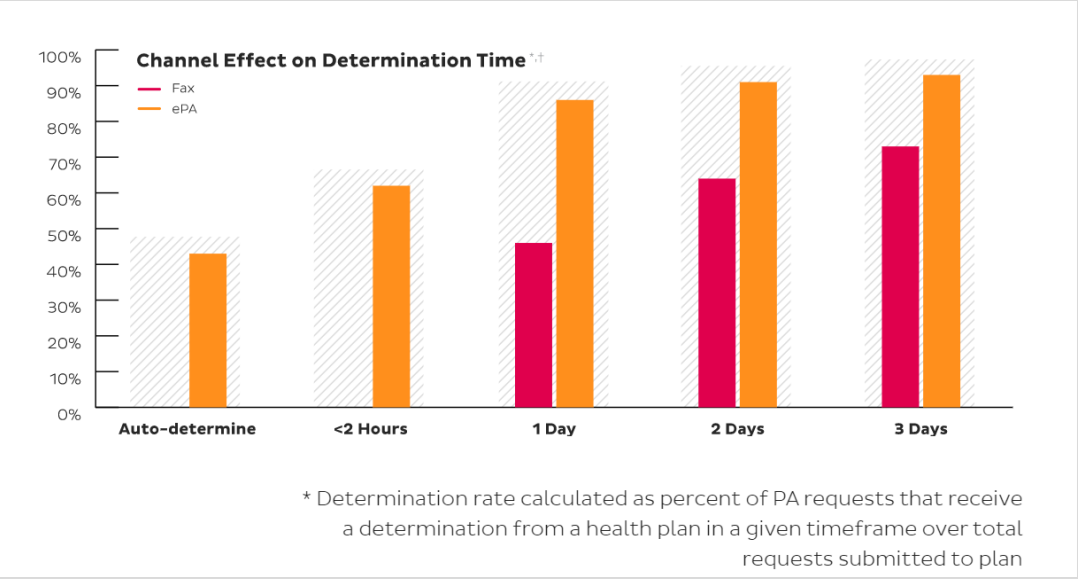
- **Manual Prior Authorizations create pain points**
  - Approximately 11 percent of prescription claims are rejected at the pharmacy, and, on average, 66 percent of those prescriptions require PA
  - Manual PA processes lead to patients abandoning their prescriptions 37% of the time
- **Electronic Prior Authorizations are efficient and effective**
  - Allows an automated process of exchanging patient health and medication information
  - Allows providers to initiate prior authorization requests after a rejection at the pharmacy or proactively in their e-prescribing workflow

Source: https://www.covermymeds.com/main/insights/scorecard/impact/

CoverMyMeds ePA Benefits

Partners with electronic health records, payers, pharmacies and providers to:

- Initiate, transmit and track the status of a prior authorization
- Help patients quickly get their medication
- Ensure secure and HIPAA-compliant PA submissions
- OptumRx is partnered with CoverMyMeds to offer free electronic prior authorization (ePA) services to all providers and their staff



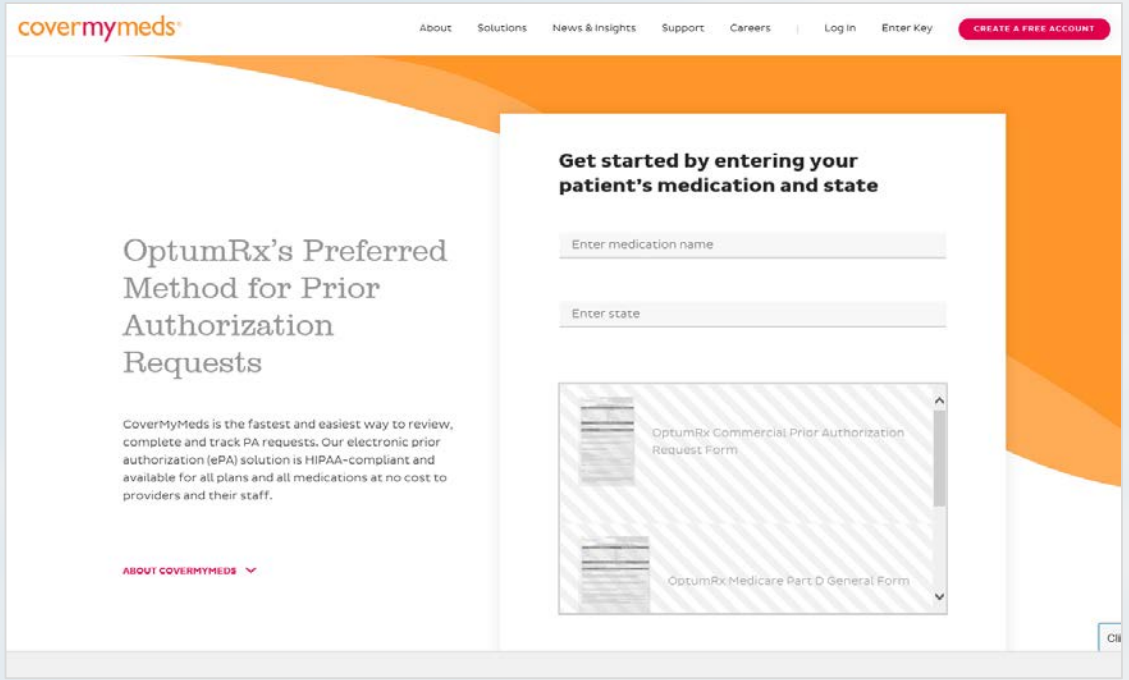
* Determination rate calculated as percent of PA requests that receive a determination from a health plan in a given timeframe over total requests submitted to plan

Source: https://www.covermymeds.com/main/insights/scorecard/impact/

Getting Started Is Easy

To Get Started: All you need to do is register for a free account at **go.covermymeds.com/ORX** or log into your existing CoverMyMeds account or create an account by:

- Click on the “Get Started” red button
- Fill out required basic account information:
  - Full Name
  - Email Address
  - Office type
  - Create user/pass



Demo: https://video.covermymeds.com/prescriber-demo

Summary

BlueCross BlueShield of South Carolina now offers providers new tools:

- **PreCheck MyScript:** See the drug price a patient will pay and lower cost alternatives if they are available
- **Specialty Medical Benefit Management Program**: Submit PAs for cancer and specialty regimens
- **Home Delivery:** Save patients money and increase med adherence
- **CoverMyMeds:** Convenient and accurate way to submit non-specialty PAs

Be in the kNOW
A Palmetto Provider University Event

Authorizations

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

Independent licensees of the Blue Cross and Blue Shield Association

Authorizations 101

Authorizations

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: An authorization is not a guarantee of payment and authorization requirements may vary per plan.

Authorization Requirements

Services requiring authorization for most plans:

- Inpatient services
- Maternity
- Skilled nursing facility admission
- Home health and hospice
- DME when the purchase price or rental is $XXX* or more
- Transplants
- Mental health and substance abuse services
- MRIs, MRAs, and CT Scans (required through NIA Magellan)

Always check benefits and eligibility for authorization requirements!

Some plans do have exceptions to authorization requests.

***DME purchase maximums vary by plan.**
Check eligibility and benefits for the purchase or rental price that requires authorization.

How to Efficiently Request Authorizations

When do you need to request an authorization?

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

Authorization Submission Tips

- Submit a request once and allow time to process
- **Submit all requests with specific and complete information**

Request training through your provider advocate if needed.

Authorization Process

1. Verify requirements

2. Initiate request

3. Submit all relevant information to include:

- Patient's name, ID number and date of birth
- Date of service
- Service details (CPT/HCPCS, diagnoses, clinical data, etc.
- Provider name and Tax ID or NPI

4. Receive a decision

- Approval – proceed with service
- Denial – review the information provided to ensure it was submitted correctly
  - You can request a Peer-to-Peer review or appeal, when appropriate.

Authorization Methods

Preferred Method: My Insurance Manager℠ (MIM)

- From www.SouthCarolinaBlues.com and www.BlueChoiceSC.com

Preferred Method: Medical Form Resource Center (MFRC)

- From www.SouthCarolinaBlues.com and www.BlueChoiceSC.com

Fax

- Check the member's ID card

Phone

- Check the member's ID card

General Guidelines for All Authorizations

- Submit authorization in advance of the service with complete information.
- Submit emergency authorizations within 24 hours or the next business day.
- Mark URGENT what is truly urgent.
  - 80 percent of our workload is marked urgent
  - Decreases likelihood of truly urgent being handled

Durable Medical Equipment Tips

- Build requests as durable medical equipment (DME) (instead of HOME) in MIM – even when being used at home.
- Include the estimated cost of the item – some plans have a threshold. 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 CAM 115.

Home Health Services Tips

- Approvals are for one month at a time.
- Request specific services and be sure to include the rendering physician to avoid conflicting authorizations.
- Notify us when a patient has not used the requested date range of services.
- Respond to requests for additional information with the specifically requested information.
- When requesting additional days, give clinical update since last request, entire history is not required.
- You can also use MFRC for forms dedicated to home health services.

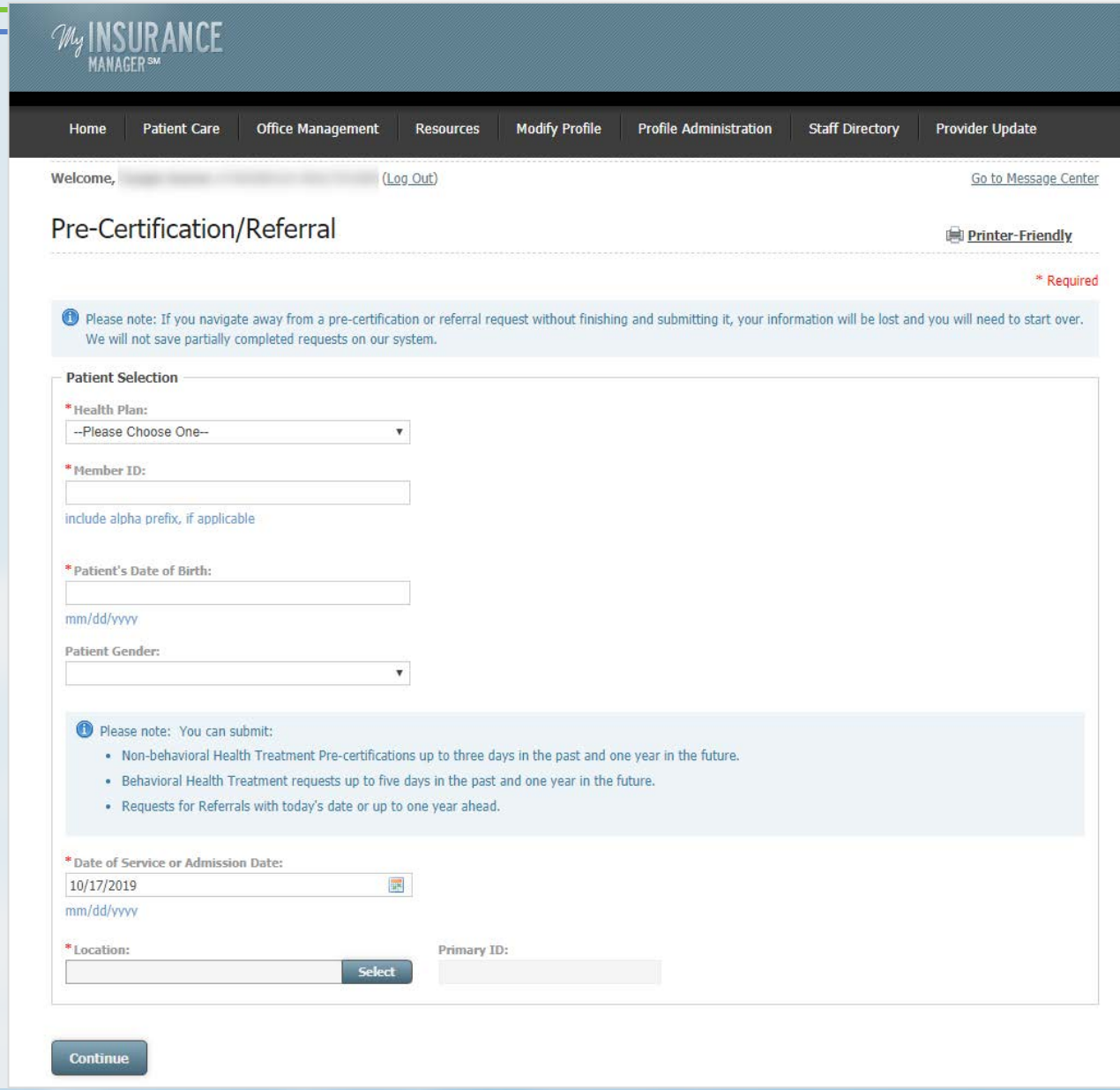
Authorization Tools

My Insurance Manager

MIM is always the best option.

Fast Track Requests in MIM typically do not require additional information and will give you an authorization number upon completion.

There are hundreds of Fast Track Requests available.

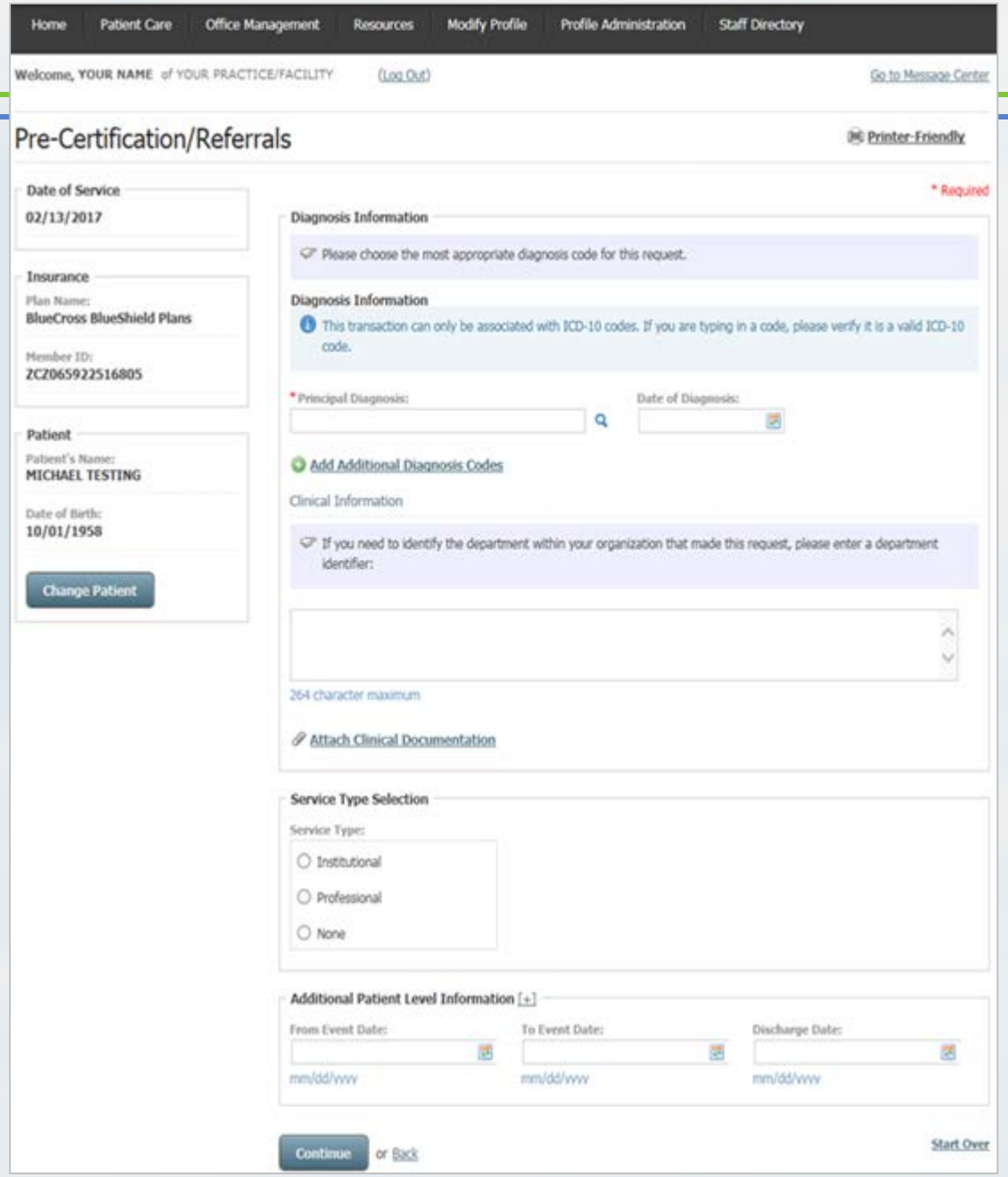


My Insurance Manager

Clinical Attachments

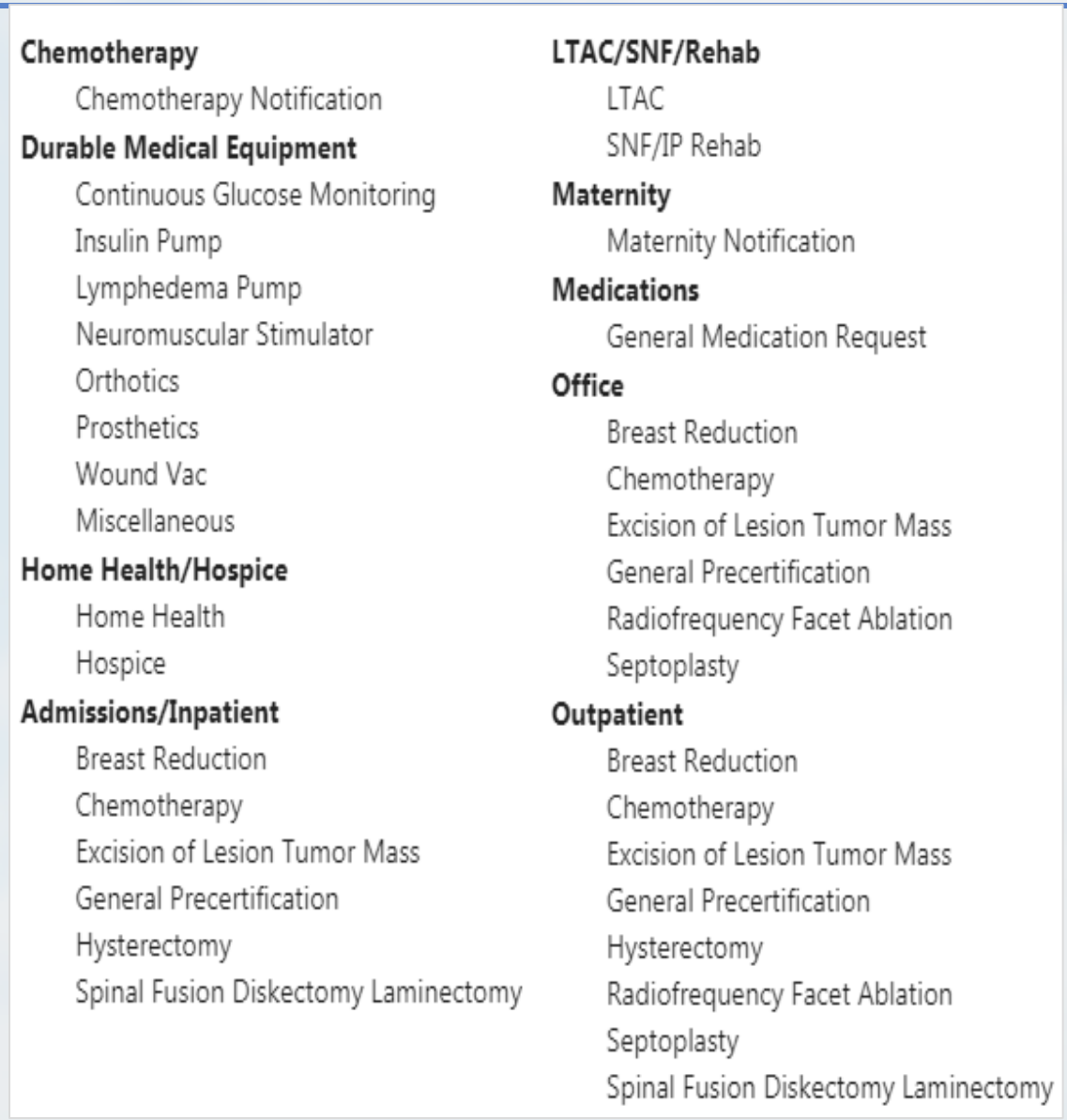
To attach clinical information for authorization requests that pend, follow these steps:

- 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.
- Complete required fields for Contact Name, Phone Number and Fax Number, then **Continue**.



Medical Forms Resource Center

- Approvals are for one month at a time.
- Medical Forms Resource Center (MFRC) authorizations jump ahead of faxes.
- Form fields ask for all information needed to complete the authorization.
- Select **SEE A FULL LIST OF FORMS** on the home screen.
- Use MIM to check the status of your request.
- Receive approval or denial using existing methods.



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

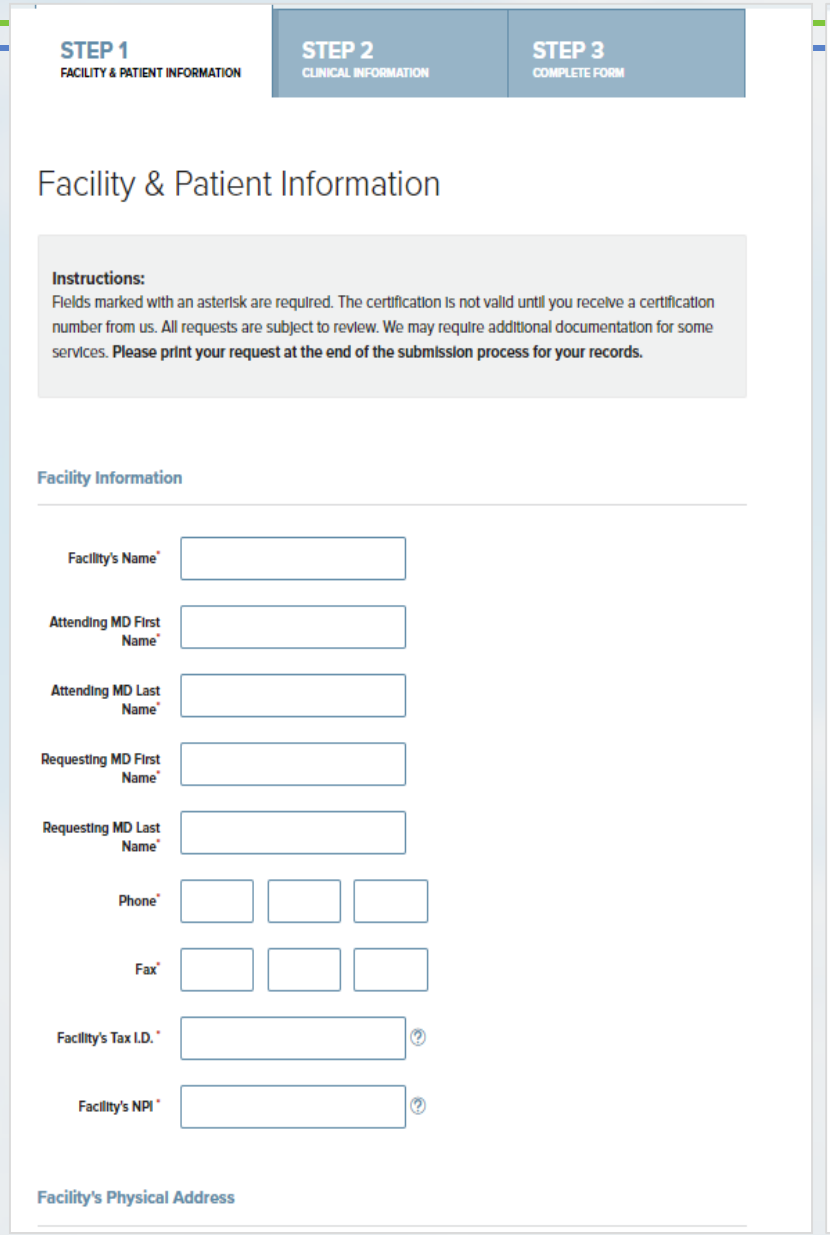
Medications
- General Medication Request

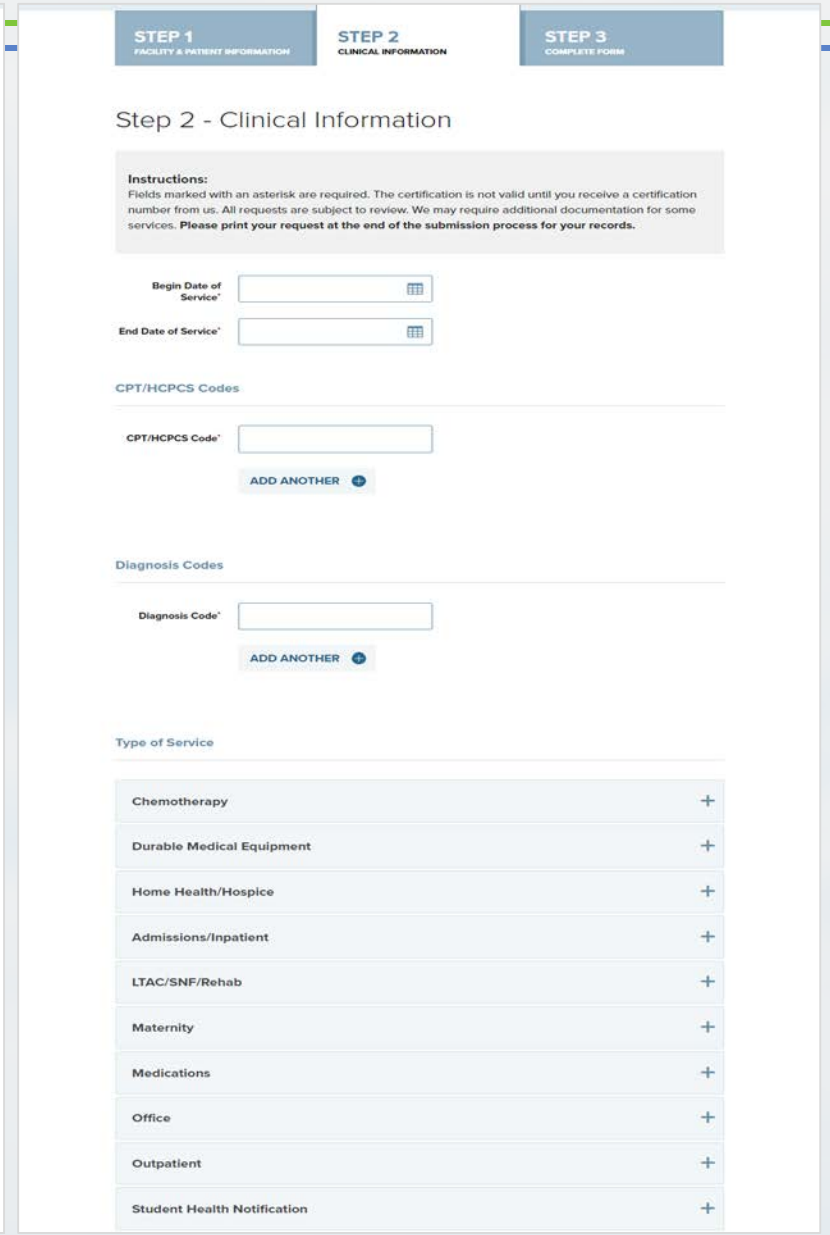
Office
- Breast Reduction
- Chemotherapy
- Excision of Lesion Tumor Mass
- General Precertification
- Radiofrequency Facet Ablation
- Septoplasty

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

MFRC in Three Easy Steps

1. Complete facility and patient information
2. Add clinical information in step 2
3. Complete request





Fax Requests

When submitting fax requests, please include the Authorization Request Form or a coversheet or fax form which includes the following:

- Patient name
- Date of birth
- CPT code/DX code
- **Fax number**
- Contact number (with extension)

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

Peer-to-Peer Requests

Peer-to-Peer Criteria

Peer-to-Peer Discussions must meet the following criteria:

- Received a medical necessity adverse decision
- Received a health plan authorization denial
- Requested within five business days of initial **denial** notification
- Requested prior to an appeal

Requesting a Peer-to-Peer Discussion

Peer-to-Peer Request Form and Resources

Medical Forms Resource Center

- Access www.FormsResource.Ccenter
- Select “Request a Peer-to-Peer Discussion”
- Type all pertinent information
- Submit

SouthCarolinaBlues.com

- Access www.SouthCarolinaBlues.com Providers > Forms > Specialties/Other > Peer-to-Peer Request Form
- Type & save all pertinent information
- Send via E-mail: Peer.Medical@bcbssc.com or Fax: 803-264-9175

Phone

- Complete status checks and receive Peer-to-Peer education by calling: 803-264-8114
- Monday – Friday
- 8:30 a.m. – 5 p.m. EST

Peer-to-Peer Clinical Discussion

- Peer-to-peer discussions are typically facilitated within one business day of receipt of the completed Peer-to-Peer Request Form.
- Our MD will make two attempts to call the rendering provider within the scheduled three-hour window to reach the provider.
- A decision is rendered at the end of the call and the health care provider is made aware of the rationale.
  - If approved the authorization will be updated and a formal notification will be faxed and mailed.
  - If the authorization is still denied there is still an option to utilize remaining appeal rights.

Special Programs

Authorization and Benefit Management Partners

Third-party vendors manage authorizations for certain benefits.

- NIA Magellan (NIA)
- Avalon Healthcare Solutions (Avalon)
- Specialty Pharmacy Manager
- Companion Benefit Alternatives (CBA)

These are independent organizations that provide prior authorization administration on behalf of BlueCross and BlueChoice.

Magellan Healthcare

Check the member's ID card and eligibility and benefits to determine if authorization through NIA Magellan is required.

- Advanced radiology
- Radiation oncology
- Musculoskeletal care
- Nuclear cardiology

Magellan HEALTH SM

Magellan Healthcare

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

- Visit RadMD.com
- Call 866-500-7664 for BlueCross members
- Call 888-642-9181 for BlueChoice members

Magellan Healthcare

Radiation Oncology

- Submit all required patient clinical information to Magellan for review. You will get a medical necessity determination within two to three business days. For the fastest turnaround time, use RadMD.com to submit requests.
- Supply all requested information at the time of the request to ensure medical necessity can be confirmed quickly for your physicians and patients.

Magellan Healthcare

Musculoskeletal Program

- Components of non-emergent musculoskeletal care:
  - Outpatient, interventional spine pain management services
  - Inpatient and outpatient lumbar and cervical spine surgeries.
- BlueCross and BlueChoice plans not participating in the program include:
  - FEP
  - State Health Plan
  - Some self-funded plans

Check benefits via MIM or the VRU to determine where to get an authorization if needed.

Magellan Healthcare

Musculoskeletal Program

- Ordering physician must get authorization for all interventional spine pain management procedures and spine surgeries.
- Rendering physicians should verify they have the necessary authorization.

Note: You must request authorization for emergency spine surgery cases admitted through the emergency room (ER) or spine surgery procedures outside the procedures listed on our websites through our plans.

Magellan Healthcare

Advanced Radiology

- Beginning Jan. 1, 2020, NIA will begin managing these CPT codes for **all groups** that currently have the Radiology program.

Authorized CPT Code	Description	Allowable Billed Groupings
78472	MUGA Scan	78472, 78473, 78494, 78496
78451	Myocardial Perfusion Imaging – Nuclear Cardiology Study	78451, 78452, 78453, 78454, 78466, 78468, 78469, 78481, 78483, 78499

Specialty Drug Authorizations

Beginning Jan. 1, 2020, we require authorization for some specialty drugs through our Specialty Pharmacy Manager.

This tool is available via MIM.

Three ways to get prior authorizations:

- Online through My Insurance Manager (fastest option)
- Fax Specialty Pharmacy Manager at 612-367-0742
- Call Specialty Pharmacy Manager at 877-440-0089

Specialty Drug Authorizations

Non-Authorization Remittance Remark Codes

- You will receive an adverse determination if you file self-administered drugs under the medical benefit that should be filed under the pharmacy benefits.

Remittance Type	Code	Description
Electronic	197	Precertification/Authorization/Notification absent
Hardcopy	9331	This service requires prior authorization: Please contact Specialty Pharmacy Manager at 877-440-0089

Companion Benefits Alternative (CBA)

- Some groups require 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 requiring authorization:
    - Psychological testing
    - Repetitive transcranial magnetic stimulation (rTMS)
    - Behavioral health program admissions
- Get authorization through the Forms Resource Center on www.CompanionBenefitAlternatives.com

Laboratory Benefit Management

We require some groups to get authorization for specific laboratory services through Avalon, our laboratory benefit manager.

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

Laboratory Benefit Management

- Always refer members to network participating laboratories.
- **Avalon manages all laboratory services EXCEPT inpatient and emergency room services.**
- A list of participating laboratories is available in the Policies and Authorizations section of www.SouthCarolinaBlues.com

Laboratory Benefit Management

There are three ways to submit prior authorization requests:

- **Online** - On April 1, 2019 Avalon's online Prior Authorization System (PAS) was launched and is now available to both ordering and rendering Providers.
- **Fax**
- **Phone**

Resources and Other Information

Benefit Program	Authorization Service	Web-based Requests	Telephone Requests	Fax Requests
BlueCross	[various]	My Insurance Manager and MFRC	800-334-7287	803-264-0258 (utilization management) 803-264-0259 (case management)
BlueChoice	[various]	My Insurance Manager and MFRC	800-950-5387	800-610-5685
Federal Employee Program	[various]	My Insurance Manager and MFRC	800-327-3238	N/A
State Health Plan (Medi-Call)	[various]	My Insurance Manager and MFRC	800-925-9724	803-264-0183
Avalon	Laboratory	Avalon PAS	844-227-5769	888-791-2181
CBA	Behavioral and Substance Abuse	www.CompanionBenefitAlternatives.com	800-868-1032	803-714-6456
NIA Magellan	Advanced Radiology	www.RadMD.com	BlueCross: 866-500-7664 BlueChoice: 888-642-9181	888-656-1321
NIA Magellan	Musculoskeletal Care	www.RadMD.com		888-656-1321
NIA Magellan	Nuclear Cardiology	www.RadMD.com		888-656-1321
NIA Magellan	Radiation Oncology	www.RadMD.com		888-656-1321
Specialty Pharmacy Manager	Specialty Medical Drug	My Insurance Manager	877-440-0089	612-367-0742

Be in the kNOW
A Palmetto Provider University Event

Claims Resolution

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

Independent licensees of the Blue Cross and Blue Shield Association

Disclaimer

In the event of any inconsistency between information contained in this presentation and the agreement(s) between you and BlueCross BlueShield, the terms of such agreement(s) shall govern. The information included is general information and in no event should be deemed as 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.

Claim Totals

Claim Totals

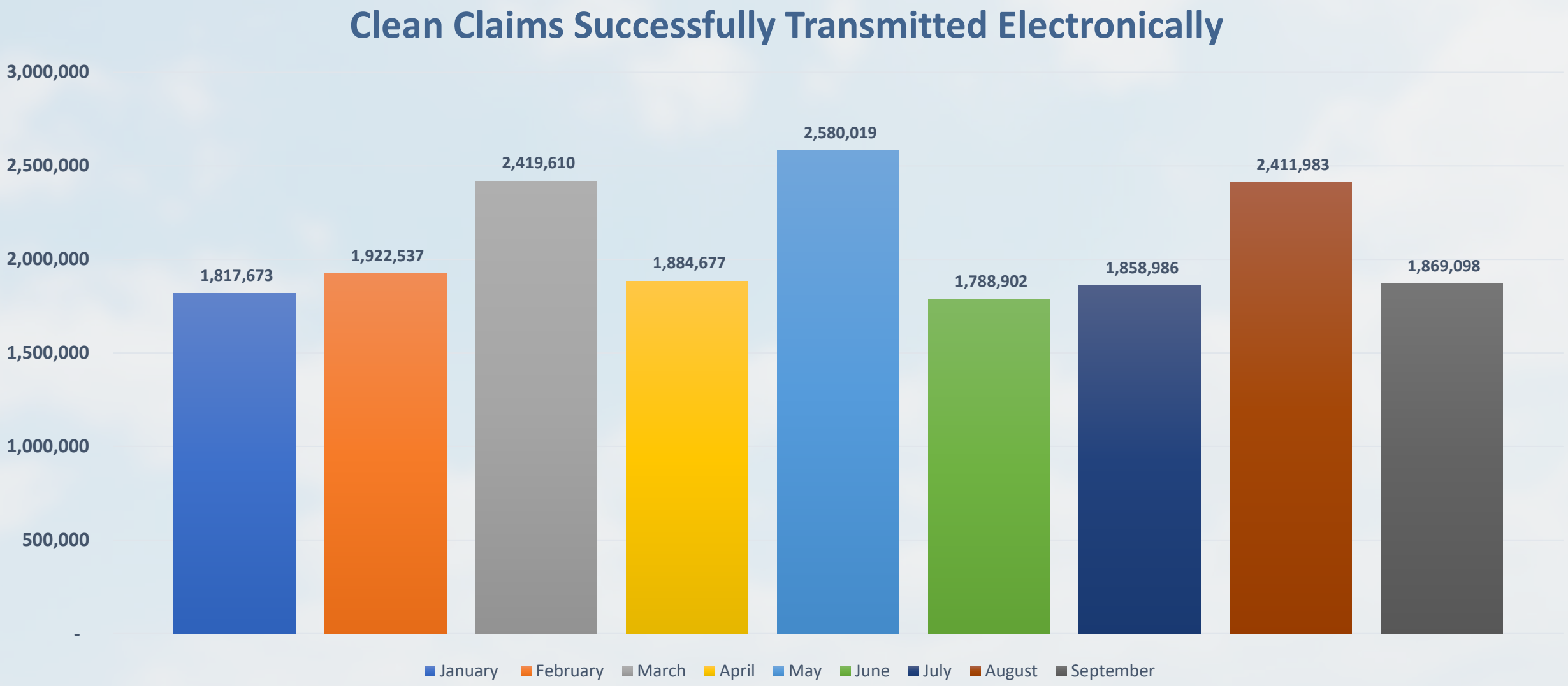
18,553,485

- Commercial claims processed from January – September 2019

Over $7 Billion

- Commercial claims paid from January – September 2019

Claim Totals



Top Edits

Top Edits

2019 Front End Edits

EDI Reject Code: 251 & EAA

SUBSCRIBER ID NOT ON FILE AS ENTERED

- Total Claims: 180,987
- Total Charges: $73.7M

EDI Reject Code: HA9

INVALID RENDERING PHYSICIAN ID NUMBER

- Total Claims: 91,317
- Total Charges: $46.2M

EDI Reject Code: 560

BILLING PROVIDER NUMBER NOT ON FILE

- Total Claims: 56,855
- Total Charges: $26.5M

EDI Reject Code: PS7

INVALID PREFIX ON SUBSCRIBER ID

- Total Claims: 49,298
- Total Charges: $40.1M

Top Edits

Subscriber ID Not on File as Entered

Total Claims: 180,987 | Total Charges: $73.7M

EDI Reject Code: 251 & EAA (Institutional)

POSSIBLE CAUSES

- Member's ID number transcribed incorrectly
- Member's information entered incorrectly
- Member's plan was cancelled
- Submitted to the wrong plan

HOW TO AVOID

- Ask for the most current ID card at each visit
- Check benefits and eligibility at each visit
- Verify the patient and subscriber prefix
- Confirm the Payer ID and Plan ID

Top Edits

Invalid Rendering Physician Number

Total Claims: 91,317 | Total Charges: $46.2M

EDI Reject Code: HA9

POSSIBLE CAUSES

- Provider’s ID number transcribed incorrectly
- Provider’s credentials need updating
- Provider’s ID number is inactive

HOW TO AVOID

- Confirm provider information with BlueCross
- Re-credential timely and appropriately
- Update information as it happens

Top Edits

Billing Provider Number Not on File

Total Claims: 56,855 | Total Charges: $26.5M

EDI Reject Code: 560

POSSIBLE CAUSES

- Provider's ID number transcribed incorrectly
- Provider's credentials need updating
- Provider's ID number is inactive

HOW TO AVOID

- Confirm provider information with BlueCross
- Re-credential timely and appropriately
- Update information as it happens

Top Edits

Invalid Prefix on Subscriber ID

Total Claims: 49,298 | Total Charges: $40.1M

EDI Reject Code: PS7

POSSIBLE CAUSES

- Member’s ID number changed during benefit year
- Member’s plan changed during benefit year
- Member’s information entered incorrectly
- Claim submitted to the wrong plan

HOW TO AVOID

- Ask for the most current ID card at each visit
- Check benefits and eligibility at each visit
- Verify the patient and subscriber prefix
- Confirm the Payer ID and Plan ID

Top Edits

2019 Common Claim Edits

CARC: 252 | RARC: N686

ACCIDENT/SUBROGATION QUESTIONNAIRE

Total Claims: 806,794

CARC: 252 | RARC: N686/MA92

OTHER HEALTH INSURANCE QUESTIONNAIRE

Total Claims: 675,920

CARC: 18 | RARC: N522

DUPLICATE CLAIM SUBMISSION

Total Claims: 597,408

CARC: 252 | RARC: N4

OTHER HEALTH INSURANCE ON FILE

Total Claims: 231,403

Top Edits

Accident/Subrogation Questionnaire

Total Number of Claims: 806,794

CARC: 252 | RARC: N686

POSSIBLE CAUSES	HOW TO AVOID
• Accident diagnosis filed on the claim • Claim submitted incorrectly	• Encourage members to update their information • Incorporate form into initial paperwork

NOTE: The form is located on SouthCarolinaBlues.com

Top Edits

Other Health Insurance Questionnaire

Total Number of Claims: 675,920

CARC: 252 | RARC: N686/MA92

POSSIBLE CAUSES	HOW TO AVOID
• Certain group requirements • Dollar amount of the claim	• Encourage members to update their information • Incorporate form into initial paperwork

NOTE: The form is located on SouthCarolinaBlues.com

Top Edits

Duplicate Claim Submission

Total Number of Claims: 597,408

CARC: 18 | RARC: N522

POSSIBLE CAUSES	HOW TO AVOID
• Not submitted corrected claims appropriately	• Submit corrected claims in the proper manner
• Uncertain if a claim was submitted	• Verify claim status before resubmitting
• Misunderstanding the claim edit	• Contact customer service for clarity

Top Edits

Other Health Insurance on File

Total Number of Claims: 231,403

CARC: 252 | RARC: N4

POSSIBLE CAUSES	HOW TO AVOID
• Member did not provide other health information • Member did not update their information	• Verify the member's eligibility details at each visit • Encourage members to update their information

ClaimsXten™

ClaimsXten™

ClaimsXten is a comprehensive code auditing software.

WHAT CLAIMSXTEN DOES

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

BENEFITS OF CLAIMSXTEN

- Streamlined claims adjudication
- Clinically supported rules and logic
- Improved processing accuracy and consistency

ClaimsXten™

Bilateral Rule

835 Remittance Code: N182

RULE LOGIC

- Identifies the same code billed twice for the same date of service, where the first code has the bilateral modifier (50) appended
- Denies the second submission of the code, regardless if it is submitted with or without the bilateral modifier

ClaimsXten™

MUE/DUT Rule

835 Remittance Code: N362

RULE LOGIC

- Identifies claim lines where the MUE has been exceeded for the procedure code reported by the same provider, for the same member, on the same date of service

ClaimsXten™

Modifier Rule

835 Remittance Code: N657

RULE LOGIC

- Denies procedure codes when billed with payment and non-payment modifiers that are not likely or appropriate for the procedure code billed

Claim Tips

Claim Tips

Providers are encouraged to:

- Review your organization’s current coding practices
- Ensure all staff members are refreshed on correct coding guidelines
- Identify any potential impacts and make the necessary changes to avoid them
- Monitor your organization’s coding behavior to always follow correct coding guidelines

Claim Tips

For clean claim processing:

- Submit claims electronically
- Stay on top of changes
- Review all edits
- Know timely filing deadlines
- Verify your work

Reminders

Reminders

Carrier/Payer ID Codes

Use these carrier codes for direct electronic claim submission to BlueCross:

- 00400 – State Health Plan
- 00401 – Preferred Blue℠, BlueEssentials℠ and out-of-state BlueCard® claims
- 00402 – Federal Employee Program (FEP)
- 00403 – Healthy Blue℠
- 00922 – BlueChoice HealthPlan and Blue Option℠
- 00C63 – Medicare Advantage

Use these carrier codes for Third Party Administrators (TPAs) that use the Preferred Blue network and are accepted electronically:

- 00315 – Thomas Cooper Company (TCC)
- 00886 – Planned Administrators, Inc. (PAI)

Use these carrier codes for dental claim submission:

- 38520 – BlueCross BlueShield of South Carolina
- 77828 – Companion Life

Reminders

Claim Reconsiderations

Reasons that would require a provider reconsideration

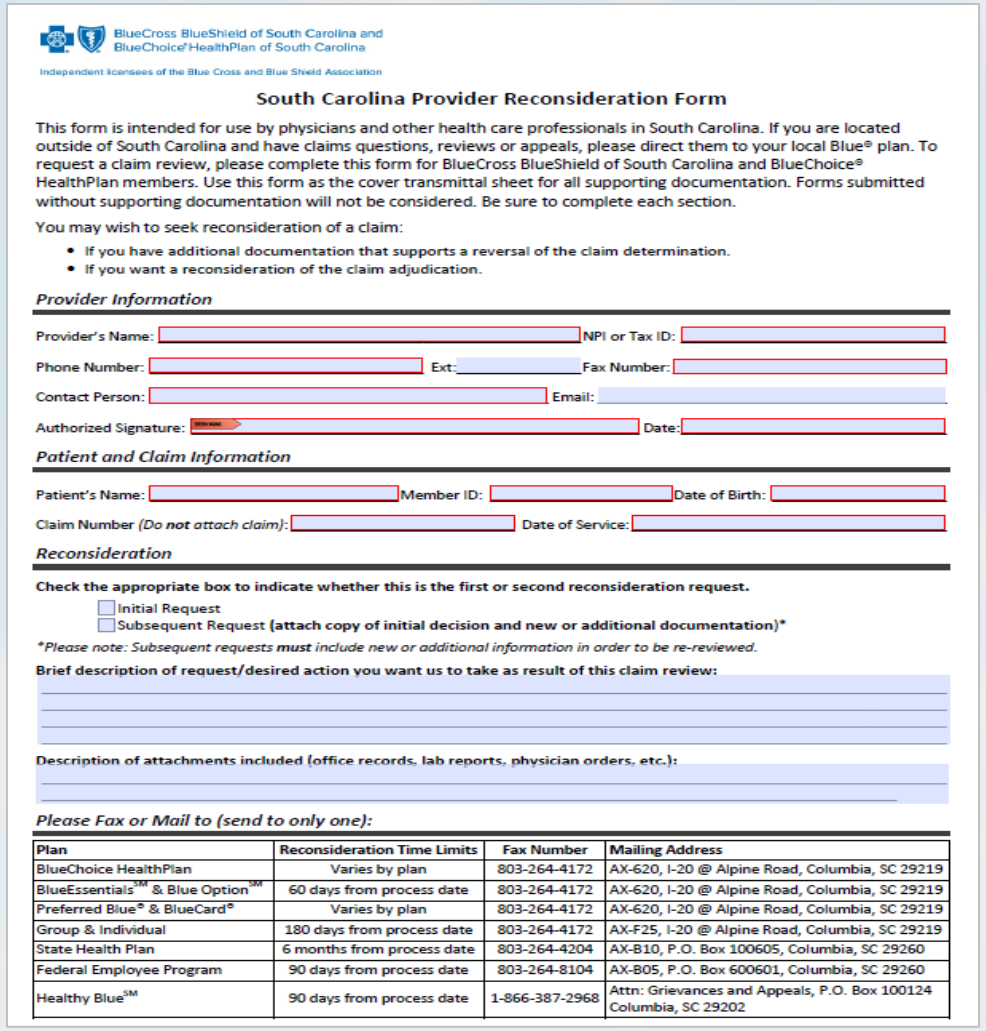
- Medical necessity determination
- Lack of authorization for non-emergent services when the member **does not** present themselves as a BlueCross BlueShield South Carolina member

Reasons that would not require a provider reconsideration

- Membership, eligibility and benefit issues
- Lack of authorization for non-emergent services when the member presents themselves as a BlueCross BlueShield South Carolina member

Reminders

Claim Reconsiderations (cont'd)



BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina

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
Healthy Blue℠	90 days from process date	1-866-387-2968	Attn: Grievances and Appeals, P.O. Box 100124 Columbia, SC 29202

Reminders

High Dollar Prepayment Review (HDPR)

New dollar threshold:

- Reduced to $200,000, effective Jan. 1, 2020
- Applies to inpatient claims
- Non DRG
- Itemized bills will be requested

Note: Any claim that is paid in whole or in part based on charges is included in the prepayment review process.

Reminders

Part 2 Program Providers

Behavioral Health Disclaimer Statement

Disclaimer to include on claims:

- "42 CFR Part 2 prohibits unauthorized disclosure of these records."

Where to include the disclaimer:

- **Professional Claim Forms**
  - For 837 Professional: Report in the Loop 2300 Claim Note NTE
  - For CMS 1500: Report in Item 19, Additional Claim Information
- **Institutional Claim Forms**
  - For 837 Institutional: Report in the Loop 2300 Billing Note NTE
  - For CMS 1450: Report in Form Locator (FL) 80 ("Remarks" field)

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A Palmetto Provider University Event

Provider Enrollment

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

Independent licensees of the Blue Cross and Blue Shield Association

Missing Documentation

Missing Documentation

- The provider enrollment and recredentialing processes will only begin once **all** required documentation has been received.
- We contact the office and/or credentialing contact listed on the Provider Enrollment Application if we receive an application that is incomplete or missing documentation via email and phone.
- Outreach will be made to the provider for 60 days in an attempt to collect the missing items. If missing items are not received within that 60 days the application will be returned, the enrollment process closed for that provider and a new enrollment form will be required to re-start the enrollment process.

Missing Documentation

- 60 percent of enrollment applications are received incomplete!
- The enrollment process will **NOT** begin until all enrollment items have been received.
  - Even if just **one** item is missing, the process will not begin until that **one** item is received.
- Signature pages as well as effective dates for certain documents can expire while the application is waiting on missing items.

Missing Documentation

Five Common Missing or Incorrect Items

Include:

1. Current application
    I. Previous versions of the application will no longer be accepted
2. Five-year work history, including current employer
    I. Gaps longer than six months explained
    II. Include schooling if work history is less than six months
3. Malpractice roster and/or coversheet with provider's name included
4. CLIA Form with ALL applications
    I. Form must be filled out even if the provider does not have a CLIA certificate.
5. Contract pages with wet signatures

The Provider Enrollment Process

Why this process?

The enrollment process is performed to:

- Confirm accurate directories so members can find you.
- Ensure we have accurate and complete information on providers as well as the practice they are joining.
- Verify providers are in good standing.
- Confirm providers meet requirements.
- Validate practitioners' qualifications.

To begin the provider enrollment process, each provider must complete the Provider Enrollment Application and submit required documentation.

Provider Enrollment Process

- To ensure that you are submitting a complete provider enrollment packet, please visit the Provider Enrollment section of www.SouthCarolinaBlues.com
- Here you will find instructions on how to enroll a new medical or dental provider, a behavioral health provider, laboratory or patient-centered medical home (PCMH).
- You will also find instructions on updating demographic information, how to recredential an existing provider along with the forms required for these updates.

Clean Application Enrollment Process

Clean Application Enrollment Process

Clean Apps Received Dec. 2018 – Oct. 2019

Month Received	Clean App	Missing Items	Grand Total	Percent Received Clean
Dec-2018	165	257	422	39.10%
Jan-2019	295	456	751	39.28%
Feb-2019	314	444	758	41.42%
Mar-2019	241	456	697	34.58%
Apr-2019	286	434	720	39.72%
May-2019	276	465	741	37.25%
Jun-2019	292	439	731	39.95%
Jul-2019	342	517	859	39.81%
Aug-2019	315	438	753	41.83%
Sep-2019	346	396	742	46.63%
Oct-2019	307	469	776	39.56%
Grand Total	3179	4771	7950	**39.99%**

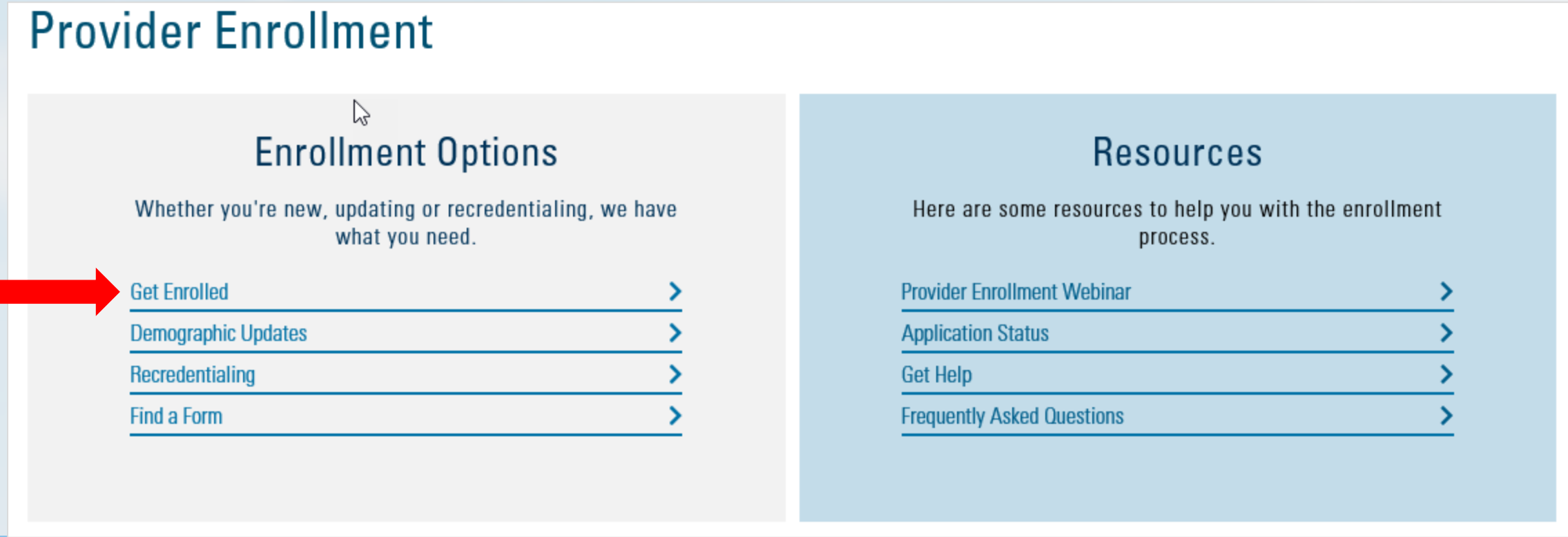
Provider Enrollment Processing

- The effective date is the date the credentialing committee approves the application per Utilization Review Accreditation Commission (URAC) requirements.
- Back dating of network dates set by committee are not allowed.
- You receive a notification email within a couple of days of the Credentialing Committee approval. The provider receives a welcome packet.
- The credentialing committee reviews all enrollment packets to ensure providers meet credentialing criteria, including URAC, the National Committee for Quality Assurance (NCQA) or South Carolina's Department of Health and Human Services (SCDHHS)-required items.

Provider Enrollment Process

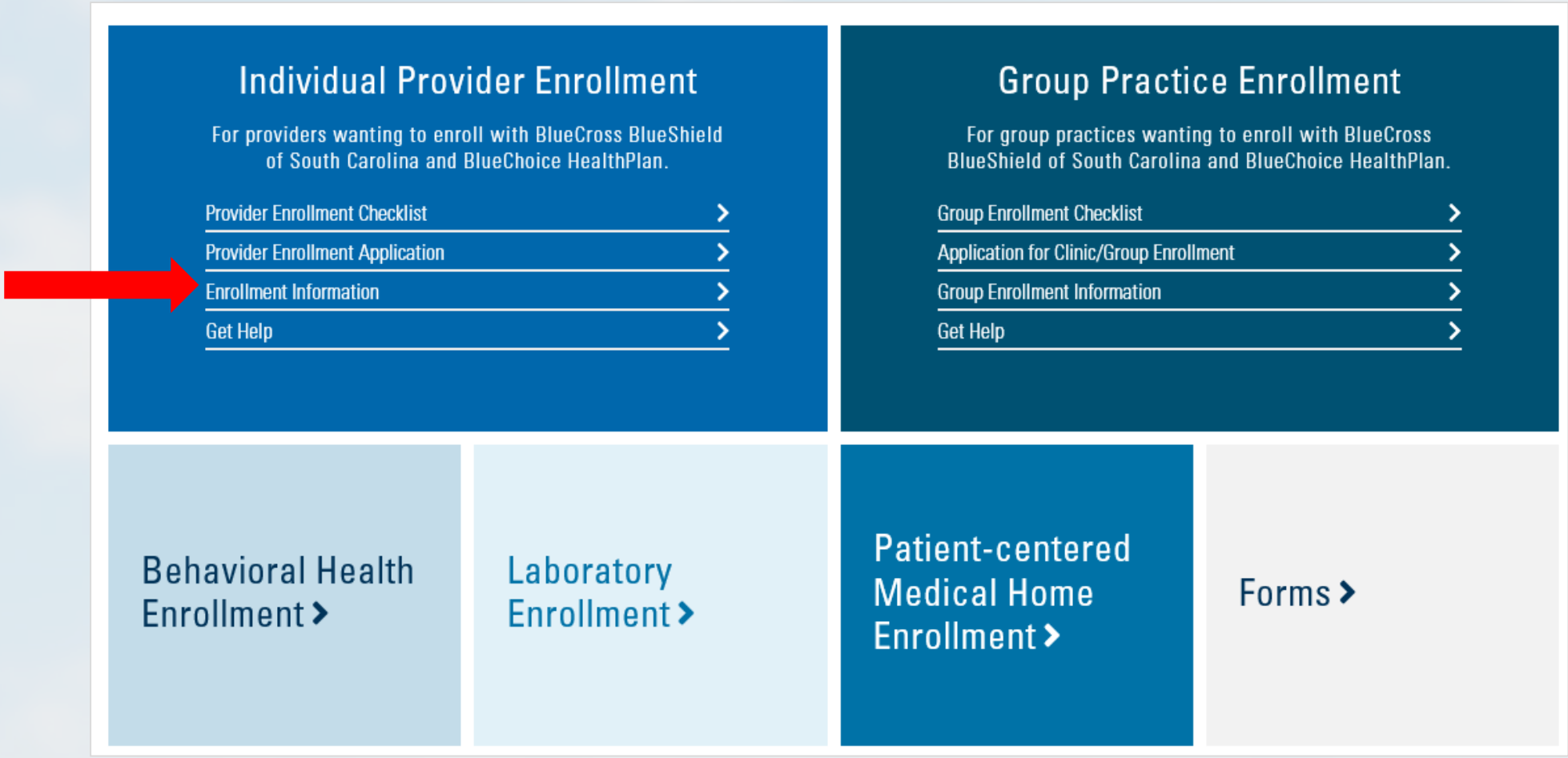
The Provider Enrollment page gives you options to enroll in our networks, update your information or recredential. You also have access to valuable resources.

Click **Get Enrolled** to start a new enrollment.



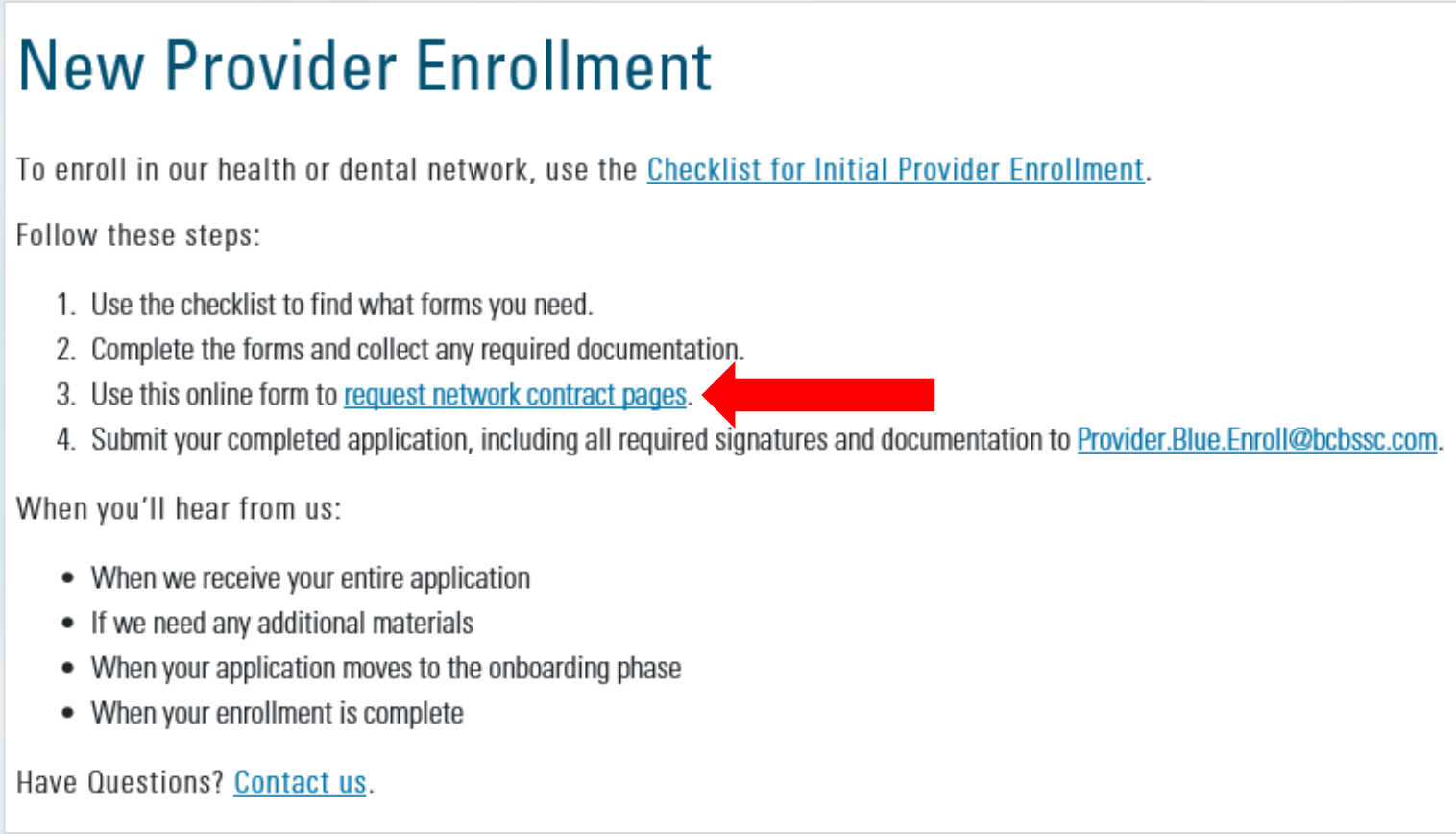
Provider Enrollment Process

Click **Enrollment Information** to learn how to add a new provider to your practice.



Provider Enrollment Process

1. Open the Checklist.
2. Complete and collect all necessary forms.
3. You will need network contract pages. Click here to request the contract pages.
4. Submit **completed** enrollment applications to Provider.Blue.Enroll@bcbssc.com



New Provider Enrollment

To enroll in our health or dental network, use the Checklist for Initial Provider Enrollment.

Follow these steps:

1. Use the checklist to find what forms you need.
2. Complete the forms and collect any required documentation.
3. Use this online form to request network contract pages.
4. Submit your completed application, including all required signatures and documentation to Provider.Blue.Enroll@bcbssc.com.

When you'll hear from us:

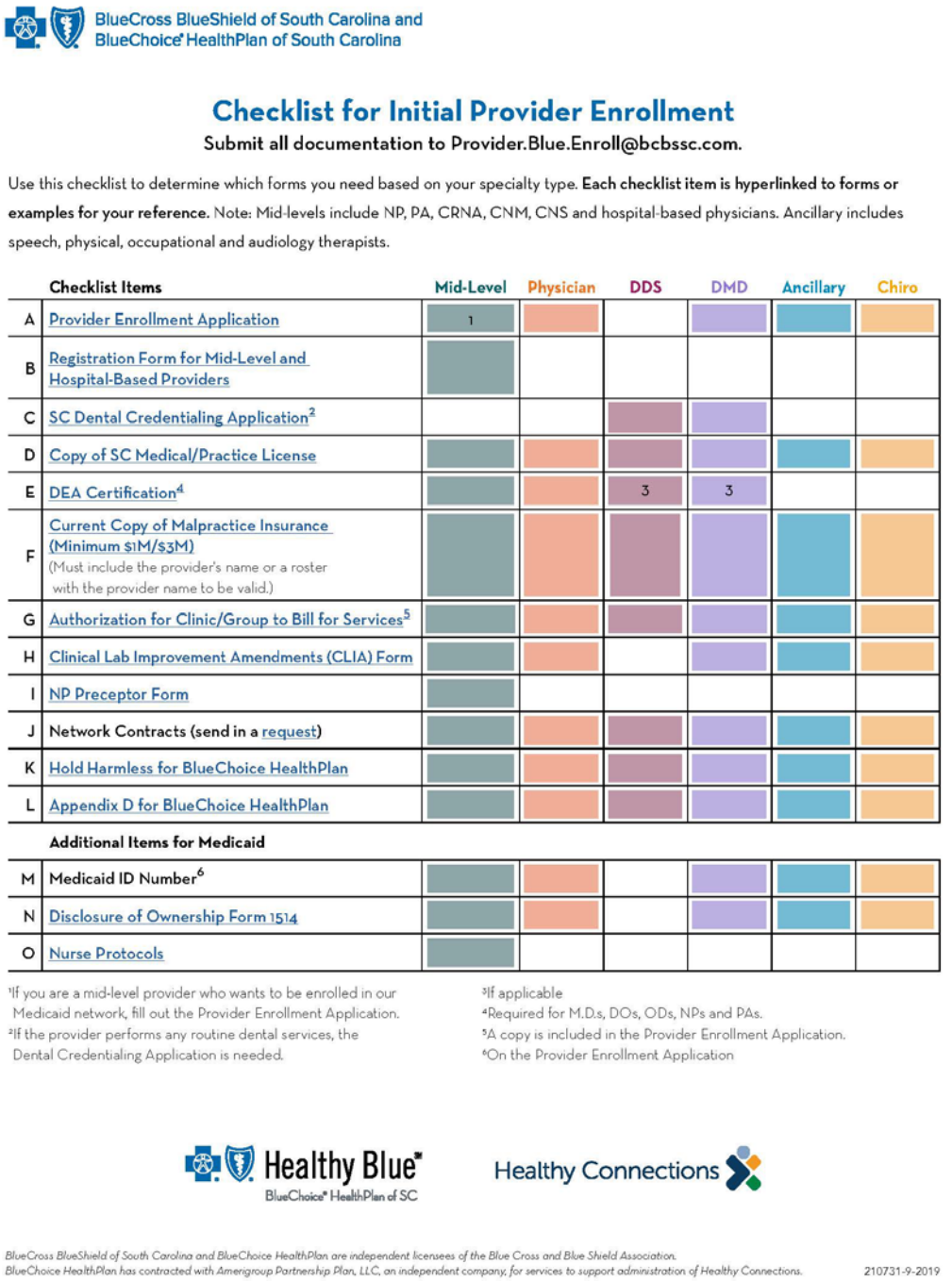
- When we receive your entire application
- If we need any additional materials
- When your application moves to the onboarding phase
- When your enrollment is complete

Have Questions? Contact us.

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

Provider Enrollment Checklist

- We have included an interactive Provider Enrollment Checklist in the application.
- Each requirement is linked with a form or example.
- This checklist outlines each form that is required for each provider type.
- Mid-levels are required to complete the full application for Healthy Blue (Medicaid). An abbreviated two-page application is required for commercial networks.



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

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 hyperlinked to 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	Physician	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[4]			3	3		
F	Current Copy of Malpractice Insurance (Minimum $1M/$3M) (Must include the provider's name or a roster with the provider name to be valid.)						
G	Authorization for Clinic/Group to Bill for Services[5]						
H	Clinical Lab Improvement Amendments (CLIA) Form						
I	NP Preceptor Form						
J	Network Contracts (send in a request)						
K	Hold Harmless for BlueChoice HealthPlan						
L	Appendix D for BlueChoice HealthPlan						
	Additional Items for Medicaid						
M	Medicaid ID Number[6]						
N	Disclosure of Ownership Form 1514						
O	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]If applicable
[4]Required for M.D.s, DOs, ODs, NPs and PAs.
[5]A copy is included in the Provider Enrollment Application.
[6]On the Provider Enrollment Application

Healthy Blue® BlueChoice® HealthPlan of SC

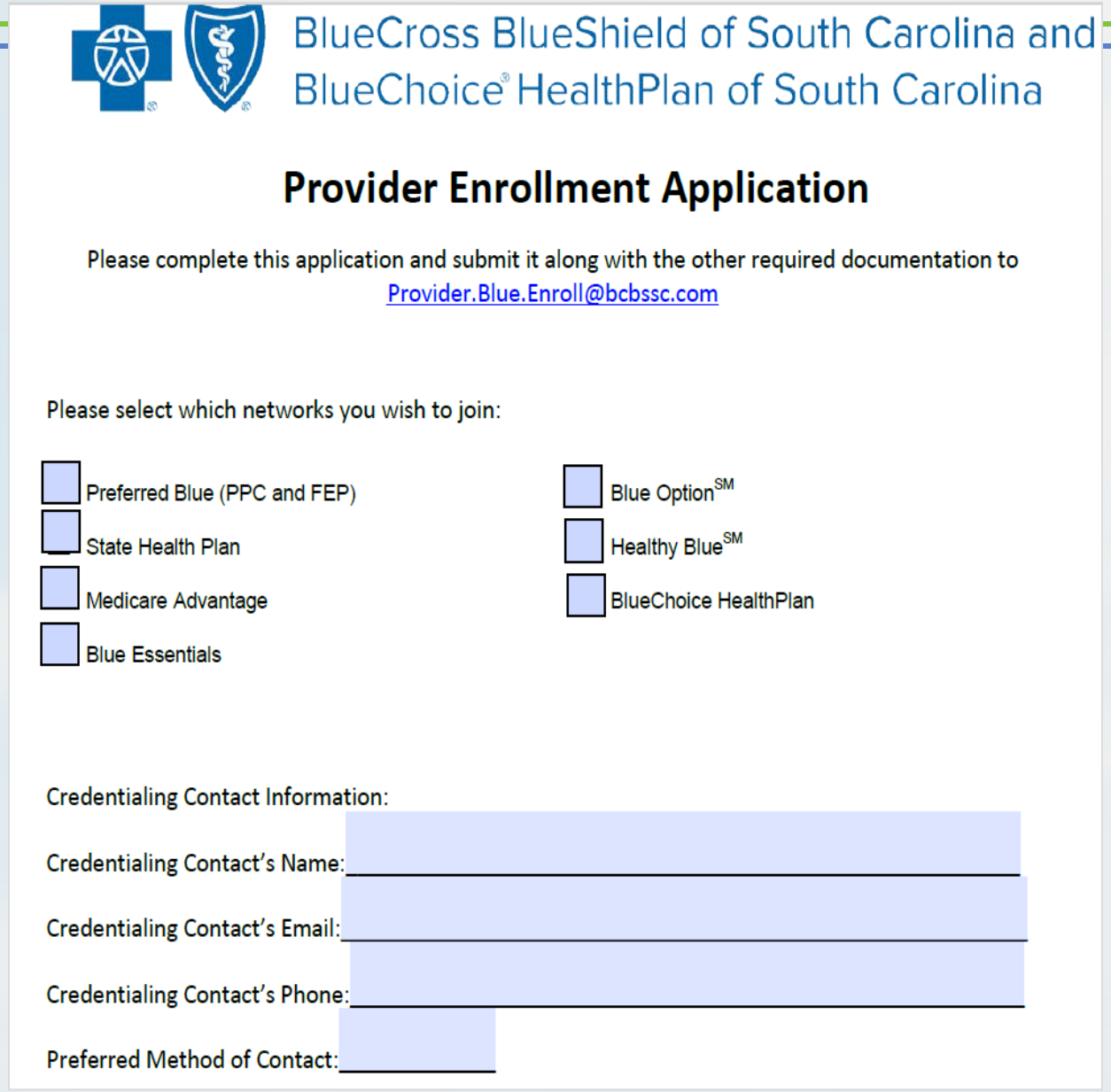
Healthy Connections

210731-9-2019

Provider Enrollment Application

- This is the Provider Enrollment Application.
- Check all networks that you wish the provider to join.
- **Completed** applications should be faxed to 803-870-8919 or emailed to: Provider.Blue.Enroll@bcbssc.com

Note: Send the application one time.



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

Provider Enrollment Application

Please complete this application and submit it along with the other required documentation to Provider.Blue.Enroll@bcbssc.com

Please select which networks you wish to join:

- ☐ Preferred Blue (PPC and FEP)
- ☐ State Health Plan
- ☐ Medicare Advantage
- ☐ Blue Essentials
- ☐ Blue Option℠
- ☐ Healthy Blue℠
- ☐ BlueChoice HealthPlan

Credentialing Contact Information:

Credentialing Contact's Name: _____

Credentialing Contact's Email: _____

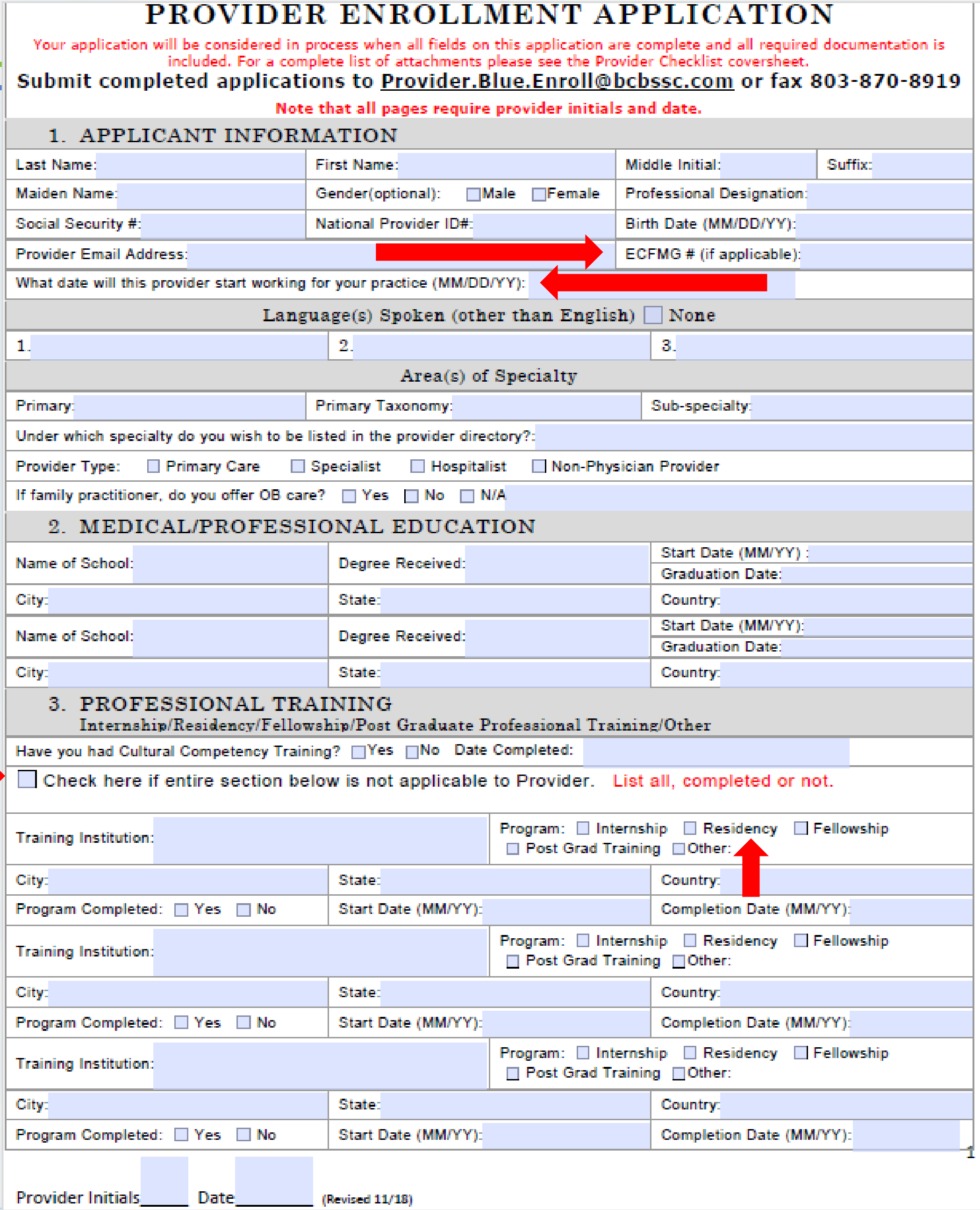
Credentialing Contact's Phone: _____

Preferred Method of Contact: _____

Provider Enrollment Application

This page requests information regarding the practitioner's personal information, medical/professional education and professional training.

- Section 1 –
  - The Education Commission for Foreign Medical Graduates (ECFMG) # is the number assigned to foreign medical graduates.
  - The date the provider will start working for your practice is required.
- Section 3 –
  - If this section is not applicable, you must check the box.
  - Must include the MD or OD residency



PROVIDER ENROLLMENT APPLICATION

Your application will be considered in process when all fields on this application are complete and all required documentation is included. For a complete list of attachments please see the Provider Checklist coversheet.

Submit completed applications to Provider.Blue.Enroll@bcbssc.com or fax 803-870-8919

Note that all pages require provider initials and date.

1. APPLICANT INFORMATION

Last Name:	First Name:	Middle Initial:	Suffix:
Maiden Name:	Gender(optional): ☐Male ☐Female	Professional Designation:	
Social Security #:	National Provider ID#:	Birth Date (MM/DD/YY):	
Provider Email Address:		ECFMG # (if applicable):	
What date will this provider start working for your practice (MM/DD/YY):			

Language(s) Spoken (other than English) ☐ None

1.	2.	3.

Area(s) of Specialty

Primary:	Primary Taxonomy:	Sub-specialty:

Under which specialty do you wish to be listed in the provider directory?:

Provider Type: ☐ Primary Care ☐ Specialist ☐ Hospitalist ☐ Non-Physician Provider

If family practitioner, do you offer OB care? ☐ Yes ☐ No ☐ N/A

2. MEDICAL/PROFESSIONAL EDUCATION

Name of School:	Degree Received:	Start Date (MM/YY) : Graduation Date:
City:	State:	Country:
Name of School:	Degree Received:	Start Date (MM/YY): Graduation Date:
City:	State:	Country:

3. PROFESSIONAL TRAINING
Internship/Residency/Fellowship/Post Graduate Professional Training/Other

Have you had Cultural Competency Training? ☐Yes ☐No Date Completed:

☐ Check here if entire section below is not applicable to Provider. List all, completed or not.

Training Institution:	Program: ☐ Internship ☐ Residency ☐ Fellowship ☐ Post Grad Training ☐Other:	
City:	State:	Country:
Program Completed: ☐ Yes ☐ No	Start Date (MM/YY):	Completion Date (MM/YY):
Training Institution:	Program: ☐ Internship ☐ Residency ☐ Fellowship ☐ Post Grad Training ☐Other:	
City:	State:	Country:
Program Completed: ☐ Yes ☐ No	Start Date (MM/YY):	Completion Date (MM/YY):
Training Institution:	Program: ☐ Internship ☐ Residency ☐ Fellowship ☐ Post Grad Training ☐Other:	
City:	State:	Country:
Program Completed: ☐ Yes ☐ No	Start Date (MM/YY):	Completion Date (MM/YY):

1

Provider Initials_____ Date_______ (Revised 11/18)

Please note that ALL pages now require provider initials and date.

Provider Enrollment Application

This page asks for the practitioner's state license, board certifications and hospital privileges.

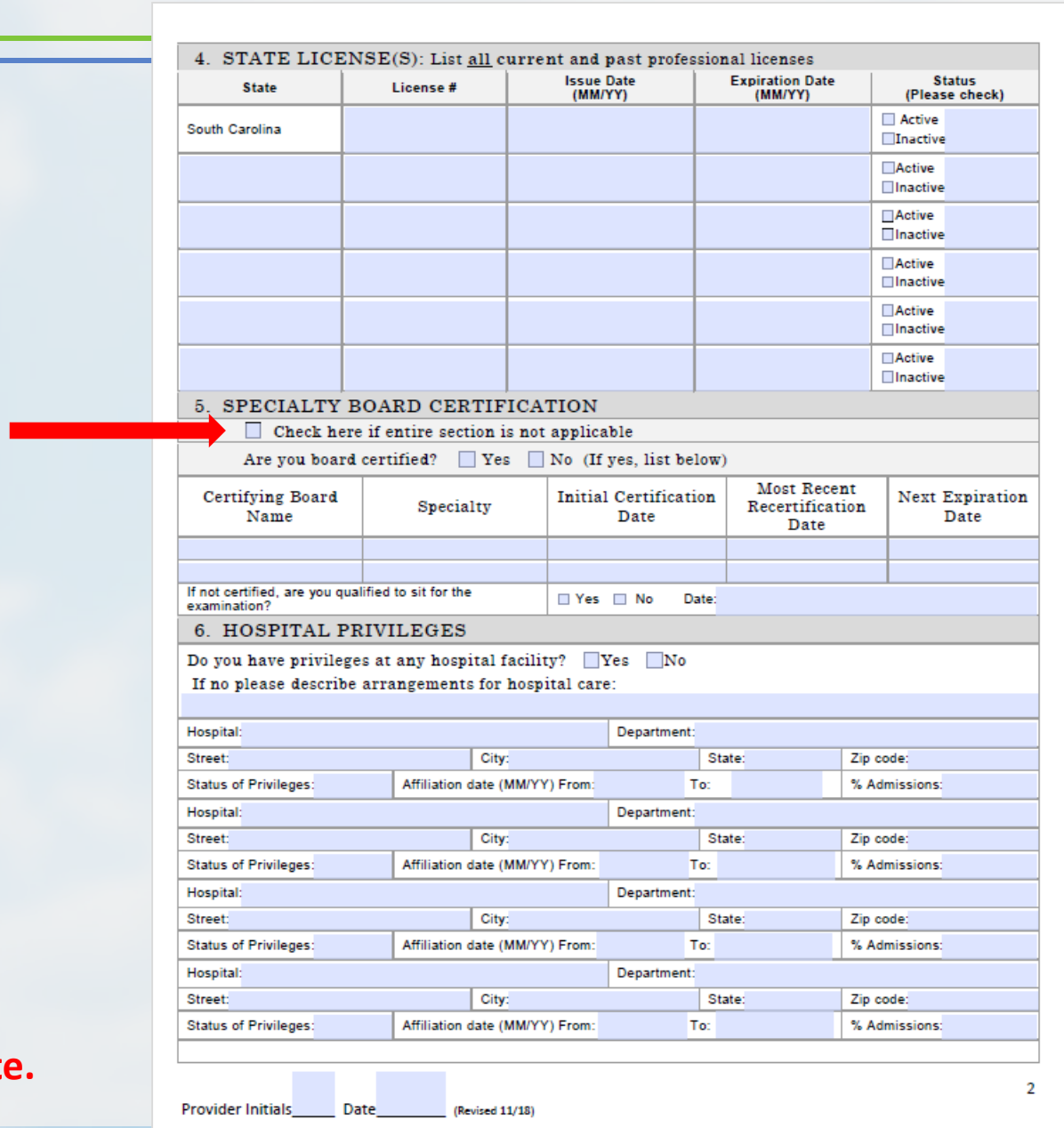
Section 5

- If this section is not applicable you must check the box.
- Education and specialty must match.

Section 6

- This must be a **written** description of the hospital admitting arrangement.
- Include a **Do Not Admit Plan** (if applicable).

Please note that ALL pages now require provider initials and date.



4. STATE LICENSE(S): List all current and past professional licenses

State	License #	Issue Date (MM/YY)	Expiration Date (MM/YY)	Status (Please check)
South Carolina				☐ Active ☐ Inactive
				☐ Active ☐ Inactive
				☐ Active ☐ Inactive
				☐ Active ☐ Inactive
				☐ Active ☐ Inactive
				☐ Active ☐ Inactive

5. SPECIALTY BOARD CERTIFICATION

☐ Check here if entire section is not applicable

Are you board certified? ☐ Yes ☐ No (If yes, list below)

Certifying Board Name	Specialty	Initial Certification Date	Most Recent Recertification Date	Next Expiration Date

If not certified, are you qualified to sit for the examination? ☐ Yes ☐ No Date:

6. HOSPITAL PRIVILEGES

Do you have privileges at any hospital facility? ☐ Yes ☐ No

If no please describe arrangements for hospital care:

Hospital: Department:
Street: City: State: Zip code:
Status of Privileges: Affiliation date (MM/YY) From: To: % Admissions:

Hospital: Department:
Street: City: State: Zip code:
Status of Privileges: Affiliation date (MM/YY) From: To: % Admissions:

Hospital: Department:
Street: City: State: Zip code:
Status of Privileges: Affiliation date (MM/YY) From: To: % Admissions:

Hospital: Department:
Street: City: State: Zip code:
Status of Privileges: Affiliation date (MM/YY) From: To: % Admissions:

Hospital: Department:
Street: City: State: Zip code:
Status of Privileges: Affiliation date (MM/YY) From: To: % Admissions:

Provider Initials____ Date_____ (Revised 11/18)

2

Provider Enrollment Application

These specialties do not need to disclose hospital privileges (Section 6).

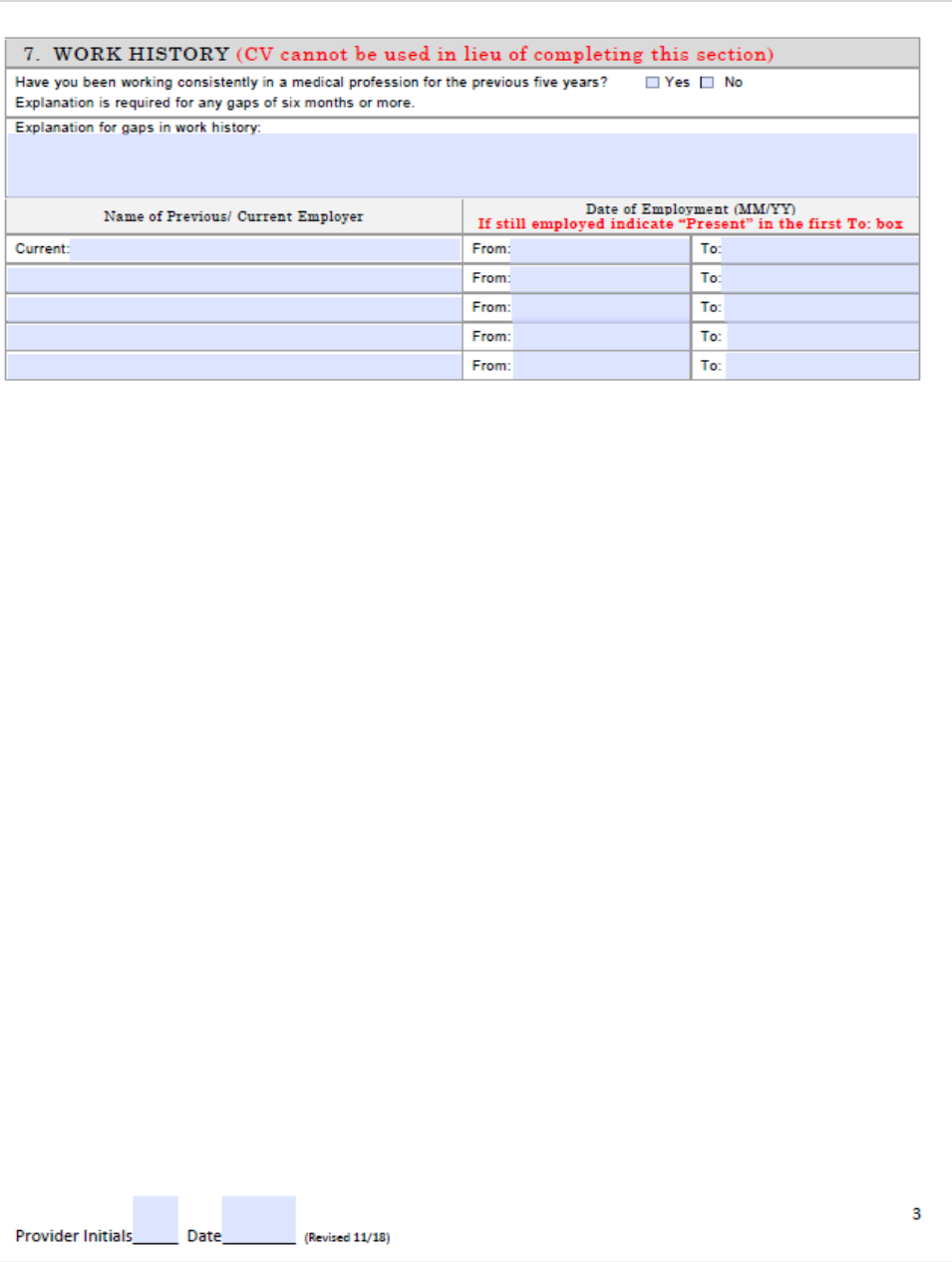
1. Nurse Practitioner
2. Physician Assistant
3. Certified Registered Nurse Anesthetist
4. Anesthesia Assistant
5. Certified Nursing Midwife
6. Dietician
7. Chiropractor
8. Physical Therapist
9. Occupational Therapist
10. Speech Language Pathologist
11. Audiologist

Provider Enrollment Application

This page asks for the practitioner's work history.

- **Five Year Work History** must be in "month/year to month/year" format.
- Do not include the day. If no end date, indicate "to present."
- Must include the current employer or school status.
- An explanation of gaps longer than six months is required.
- A curriculum vitae (CV) cannot be used in place of this section.

Please note that ALL pages now require provider initials and date.



7. WORK HISTORY (CV cannot be used in lieu of completing this section)

Have you been working consistently in a medical profession for the previous five years? ☐ Yes ☐ No
Explanation is required for any gaps of six months or more.

Explanation for gaps in work history:

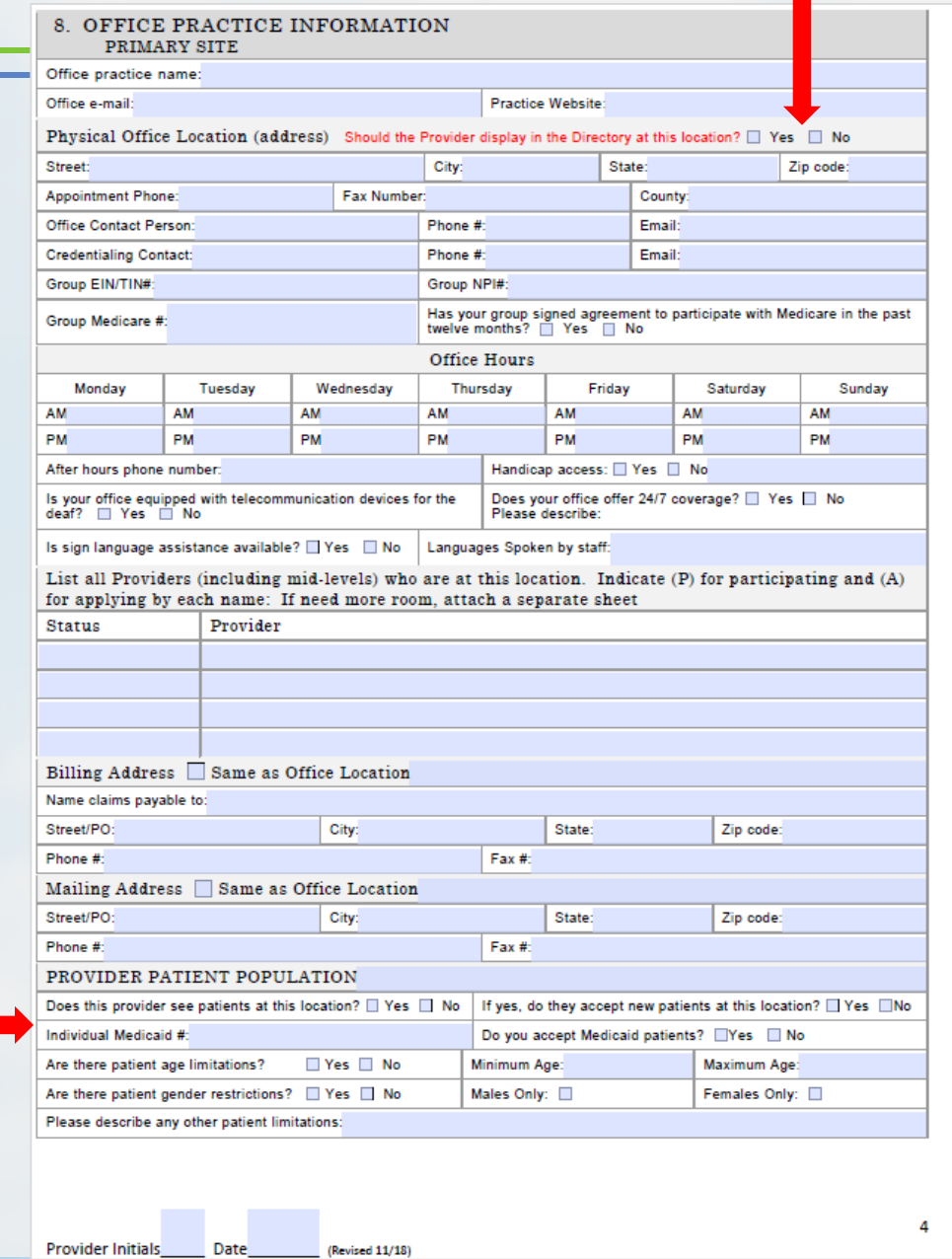
Name of Previous/ Current Employer	Date of Employment (MM/YY) If still employed indicate "Present" in the first To: box	
Current:	From:	To:
	From:	To:
	From:	To:
	From:	To:
	From:	To:

Provider Initials____ Date_____ (Revised 11/18)

3

Provider Enrollment Application

- This page asks for the practitioner's primary practice location, office hours, billing address and patient population demographics.
- Section 8 - Please indicate if you would like the provider to display at this location in our directory.
- Please include the practitioner's Medicaid ID number if they are applying for the Medicaid network.



8. OFFICE PRACTICE INFORMATION
PRIMARY SITE

Office practice name:

Office e-mail: | Practice Website:

Physical Office Location (address) Should the Provider display in the Directory at this location? ☐ Yes ☐ No

Street: | City: | State: | Zip code:

Appointment Phone: | Fax Number: | County:

Office Contact Person: | Phone #: | Email:

Credentialing Contact: | Phone #: | Email:

Group EIN/TIN#: | Group NPI#:

Group Medicare #: | Has your group signed agreement to participate with Medicare in the past twelve months? ☐ Yes ☐ No

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM

After hours phone number: | Handicap access: ☐ Yes ☐ No

Is your office equipped with telecommunication devices for the deaf? ☐ Yes ☐ No | Does your office offer 24/7 coverage? ☐ Yes ☐ No Please describe:

Is sign language assistance available? ☐ Yes ☐ No | Languages Spoken by staff:

List all Providers (including mid-levels) who are at this location. Indicate (P) for participating and (A) for applying by each name: If need more room, attach a separate sheet

Status	Provider

Billing Address ☐ Same as Office Location

Name claims payable to:

Street/PO: | City: | State: | Zip code:

Phone #: | Fax #:

Mailing Address ☐ Same as Office Location

Street/PO: | City: | State: | Zip code:

Phone #: | Fax #:

PROVIDER PATIENT POPULATION

Does this provider see patients at this location? ☐ Yes ☐ No | If yes, do they accept new patients at this location? ☐ Yes ☐ No

Individual Medicaid #: | Do you accept Medicaid patients? ☐ Yes ☐ No

Are there patient age limitations? ☐ Yes ☐ No | Minimum Age: | Maximum Age:

Are there patient gender restrictions? ☐ Yes ☐ No | Males Only: ☐ | Females Only: ☐

Please describe any other patient limitations:

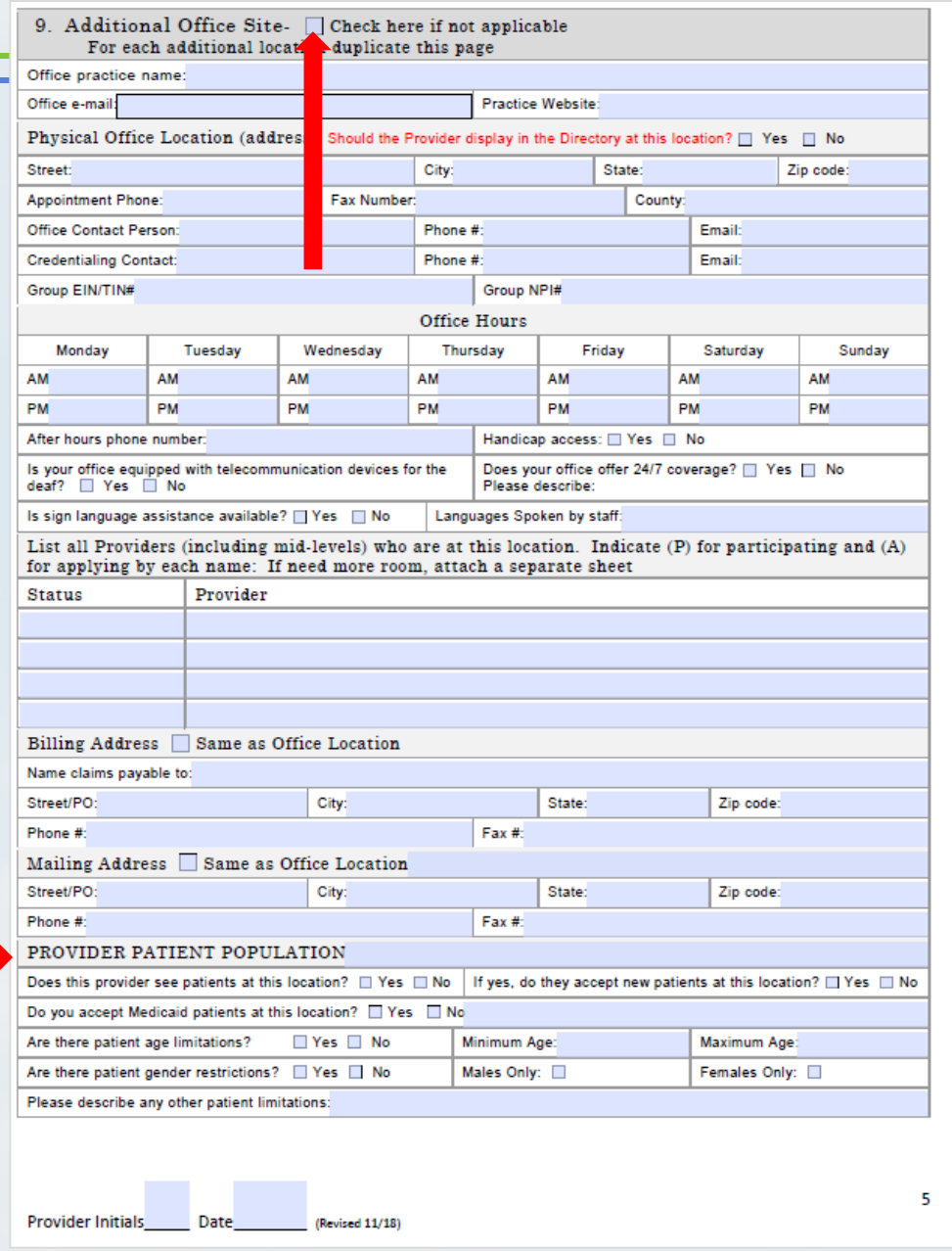
Provider Initials____ Date_____ (Revised 11/18)

4

Please note that ALL pages now require provider initials and date.

Provider Enrollment Application

- This page asks for the practitioner's **additional** practice locations, office hours, billing address and patient population demographics.
- If the practitioner has no additional locations, please check the box at the top of the page.
- If the practitioner has several additional locations, make copies of this page and complete for each site.



9. Additional Office Site- ☐ Check here if not applicable
For each additional locat… duplicate this page

Office practice name:

Office e-mail: | Practice Website:

Physical Office Location (addres… | Should the Provider display in the Directory at this location? ☐ Yes ☐ No

Street: | City: | State: | Zip code:

Appointment Phone: | Fax Number: | County:

Office Contact Person: | Phone #: | Email:

Credentialing Contact: | Phone #: | Email:

Group EIN/TIN# | Group NPI#

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM

After hours phone number: | Handicap access: ☐ Yes ☐ No

Is your office equipped with telecommunication devices for the deaf? ☐ Yes ☐ No | Does your office offer 24/7 coverage? ☐ Yes ☐ No Please describe:

Is sign language assistance available? ☐ Yes ☐ No | Languages Spoken by staff:

List all Providers (including mid-levels) who are at this location. Indicate (P) for participating and (A) for applying by each name: If need more room, attach a separate sheet

Status	Provider

Billing Address ☐ Same as Office Location

Name claims payable to:

Street/PO: | City: | State: | Zip code:

Phone #: | Fax #:

Mailing Address ☐ Same as Office Location

Street/PO: | City: | State: | Zip code:

Phone #: | Fax #:

PROVIDER PATIENT POPULATION

Does this provider see patients at this location? ☐ Yes ☐ No | If yes, do they accept new patients at this location? ☐ Yes ☐ No

Do you accept Medicaid patients at this location? ☐ Yes ☐ No

Are there patient age limitations? ☐ Yes ☐ No | Minimum Age: | Maximum Age:

Are there patient gender restrictions? ☐ Yes ☐ No | Males Only: ☐ | Females Only: ☐

Please describe any other patient limitations:

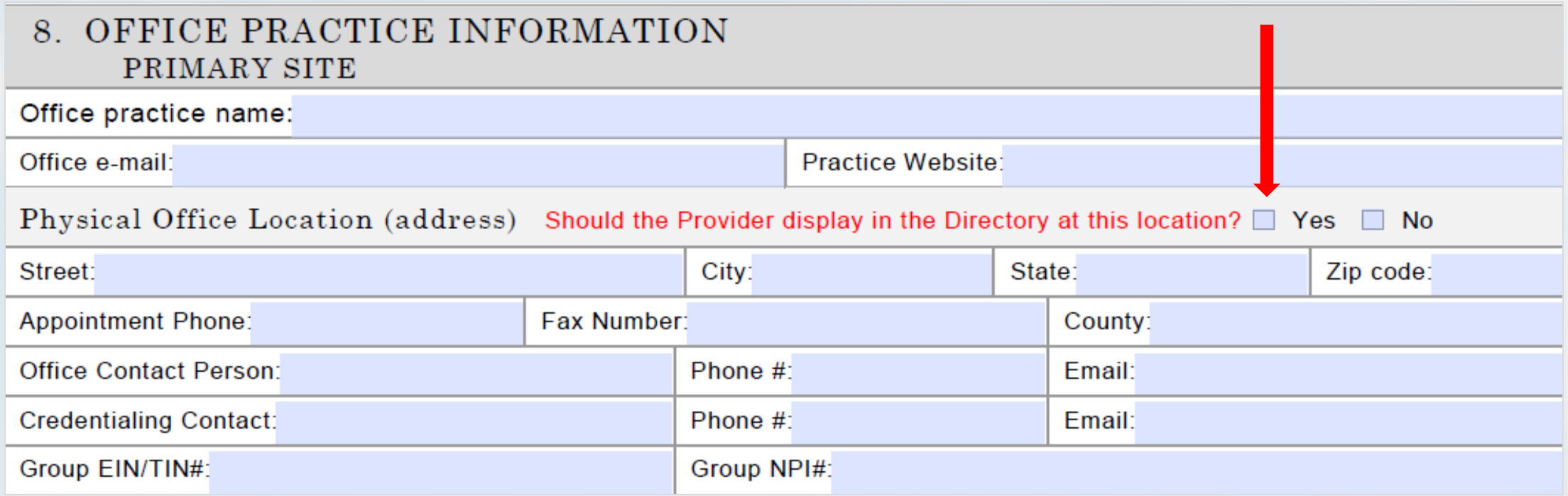
Provider Initials____ Date_____ (Revised 11/18)

5

Please note that ALL pages now require provider initials and date.

Provider Enrollment Application

- Pages 4 and 5 ensure your practitioners are listed accurately in our provider directory.
- A practitioner can be affiliated to multiple locations. Only check this box if the practitioner is actively taking appointments at a location. If this box is checked, this practitioner will display at this location in our directory.



8. OFFICE PRACTICE INFORMATION

PRIMARY SITE

Office practice name:			
Office e-mail:		Practice Website:	
Physical Office Location (address)	Should the Provider display in the Directory at this location? ☐ Yes ☐ No		
Street:	City:	State:	Zip code:
Appointment Phone:	Fax Number:	County:	
Office Contact Person:	Phone #:	Email:	
Credentialing Contact:	Phone #:	Email:	
Group EIN/TIN#:	Group NPI#:		

Provider Enrollment Application

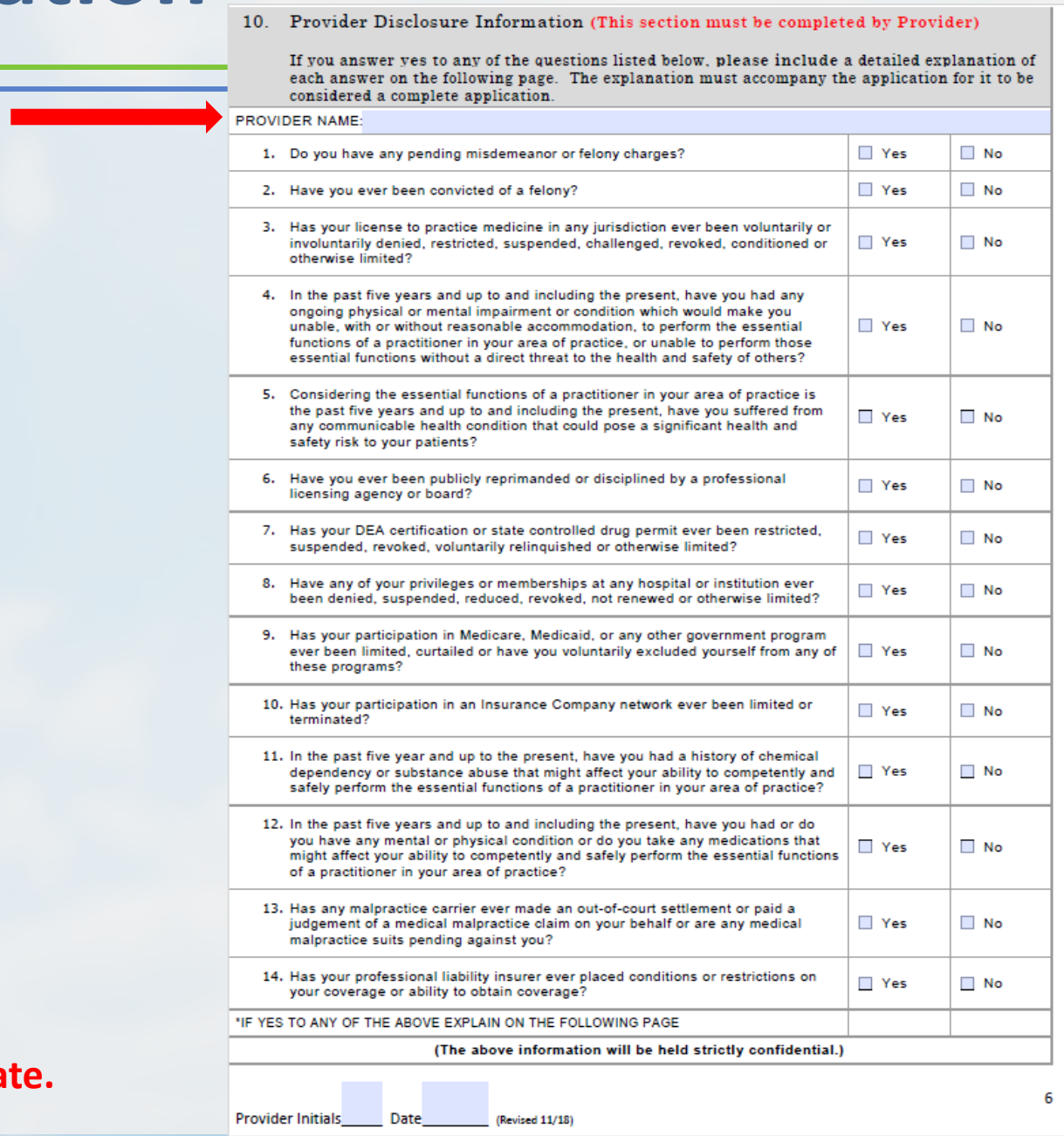
- Pages 4 and 5 ensure your practitioners are listed accurately in our provider directory.
- Patient population information is also displayed in the provider directory. Please make sure this information is accurate.

PROVIDER PATIENT POPULATION		
Does this provider see patients at this location? ☐ Yes ☐ No	If yes, do they accept new patients at this location? ☐ Yes ☐ No	
Individual Medicaid #:	Do you accept Medicaid patients? ☐ Yes ☐ No	
Are there patient age limitations? ☐ Yes ☐ No	Minimum Age:	Maximum Age:
Are there patient gender restrictions? ☐ Yes ☐ No	Males Only: ☐	Females Only: ☐
Please describe any other patient limitations:		

Provider Enrollment Application

- The provider must complete this page and include his or her name.
- **In order for the enrollment process to begin** any box checked "Yes" must be accompanied by a detailed **written** explanation.
- Attachments can be included, but a written explanation is also required. We cannot accept any legal document in lieu of the provider statement.
- All answers will be validated, confirmed and reviewed.

Please note that ALL pages now require provider initials and date.



10. **Provider Disclosure Information** (This section must be completed by Provider)

If you answer yes to any of the questions listed below, please include a detailed explanation of each answer on the following page. The explanation must accompany the application for it to be considered a complete application.

PROVIDER NAME:

1. Do you have any pending misdemeanor or felony charges?	☐ Yes	☐ No
2. Have you ever been convicted of a felony?	☐ Yes	☐ No
3. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited?	☐ Yes	☐ No
4. In the past five years and up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	☐ Yes	☐ No
5. Considering the essential functions of a practitioner in your area of practice is the past five years and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients?	☐ Yes	☐ No
6. Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board?	☐ Yes	☐ No
7. Has your DEA certification or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?	☐ Yes	☐ No
8. Have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, not renewed or otherwise limited?	☐ Yes	☐ No
9. Has your participation in Medicare, Medicaid, or any other government program ever been limited, curtailed or have you voluntarily excluded yourself from any of these programs?	☐ Yes	☐ No
10. Has your participation in an Insurance Company network ever been limited or terminated?	☐ Yes	☐ No
11. In the past five year and up to the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	☐ Yes	☐ No
12. In the past five years and up to and including the present, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	☐ Yes	☐ No
13. Has any malpractice carrier ever made an out-of-court settlement or paid a judgement of a medical malpractice claim on your behalf or are any medical malpractice suits pending against you?	☐ Yes	☐ No
14. Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to obtain coverage?	☐ Yes	☐ No
*IF YES TO ANY OF THE ABOVE EXPLAIN ON THE FOLLOWING PAGE		

(The above information will be held strictly confidential.)

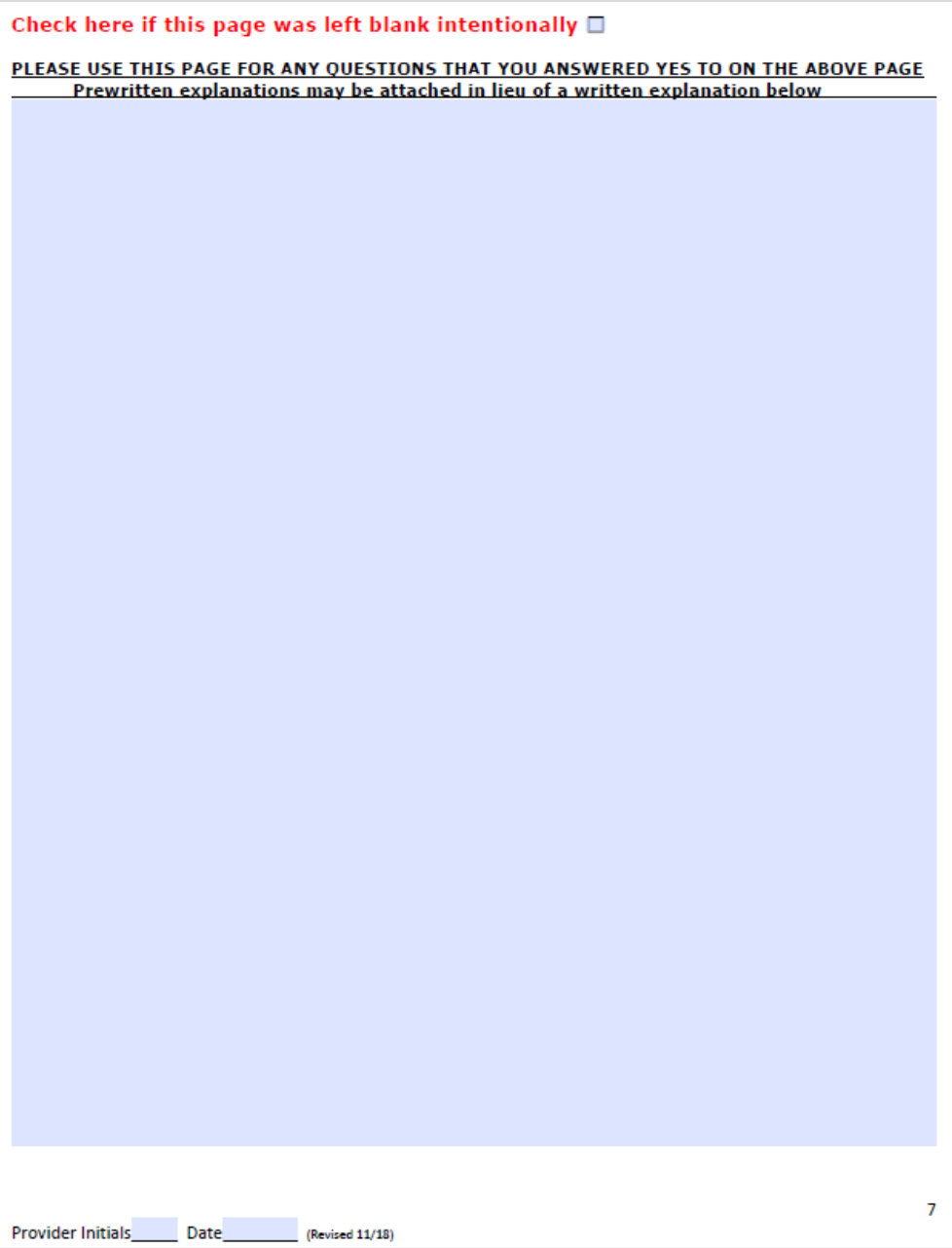
Provider Initials____ Date_____ (Revised 11/18)

6

Provider Enrollment Application

- The provider must complete this page.
- Use this page to respond to any questions answered “yes” to on the previous page.
- Prewritten explanations may be attached in place of this page being completed.

Please note that ALL pages now require provider initials and date.



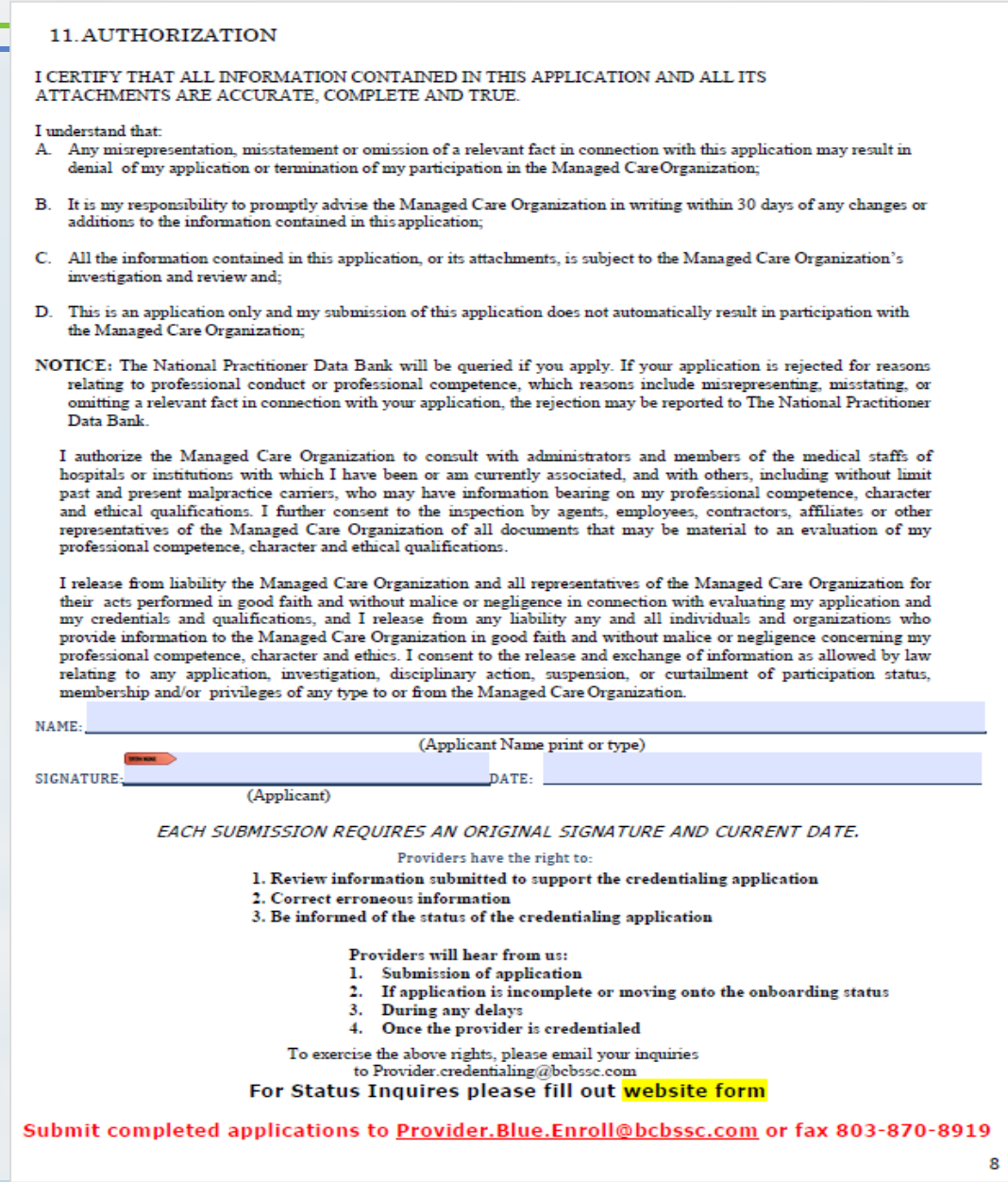
Check here if this page was left blank intentionally ☐

PLEASE USE THIS PAGE FOR ANY QUESTIONS THAT YOU ANSWERED YES TO ON THE ABOVE PAGE
Prewritten explanations may be attached in lieu of a written explanation below

Provider Initials_____ Date_____ (Revised 11/18)

Provider Enrollment Application

- This page must be signed and dated.
- Electronic signatures are acceptable for this page.
- Signature date must be within 150 days of the date of submission.
- Submit completed application along with required forms to **Provider.Blue.Enroll@bcbssc.com** or fax them to 803-870-8919



11. AUTHORIZATION

I CERTIFY THAT ALL INFORMATION CONTAINED IN THIS APPLICATION AND ALL ITS ATTACHMENTS ARE ACCURATE, COMPLETE AND TRUE.

I understand that:

A. Any misrepresentation, misstatement or omission of a relevant fact in connection with this application may result in denial of my application or termination of my participation in the Managed Care Organization;

B. It is my responsibility to promptly advise the Managed Care Organization in writing within 30 days of any changes or additions to the information contained in this application;

C. All the information contained in this application, or its attachments, is subject to the Managed Care Organization's investigation and review and;

D. This is an application only and my submission of this application does not automatically result in participation with the Managed Care Organization;

NOTICE: The National Practitioner Data Bank will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating, or omitting a relevant fact in connection with your application, the rejection may be reported to The National Practitioner Data Bank.

I authorize the Managed Care Organization to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been or am currently associated, and with others, including without limit past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the inspection by agents, employees, contractors, affiliates or other representatives of the Managed Care Organization of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications.

I release from liability the Managed Care Organization and all representatives of the Managed Care Organization for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations who provide information to the Managed Care Organization in good faith and without malice or negligence concerning my professional competence, character and ethics. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension, or curtailment of participation status, membership and/or privileges of any type to or from the Managed Care Organization.

NAME: _____

(Applicant Name print or type)

SIGNATURE: _____ DATE: _____

(Applicant)

EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE.

Providers have the right to:

1. **Review information submitted to support the credentialing application**
2. **Correct erroneous information**
3. **Be informed of the status of the credentialing application**

Providers will hear from us:

1. **Submission of application**
2. **If application is incomplete or moving onto the onboarding status**
3. **During any delays**
4. **Once the provider is credentialed**

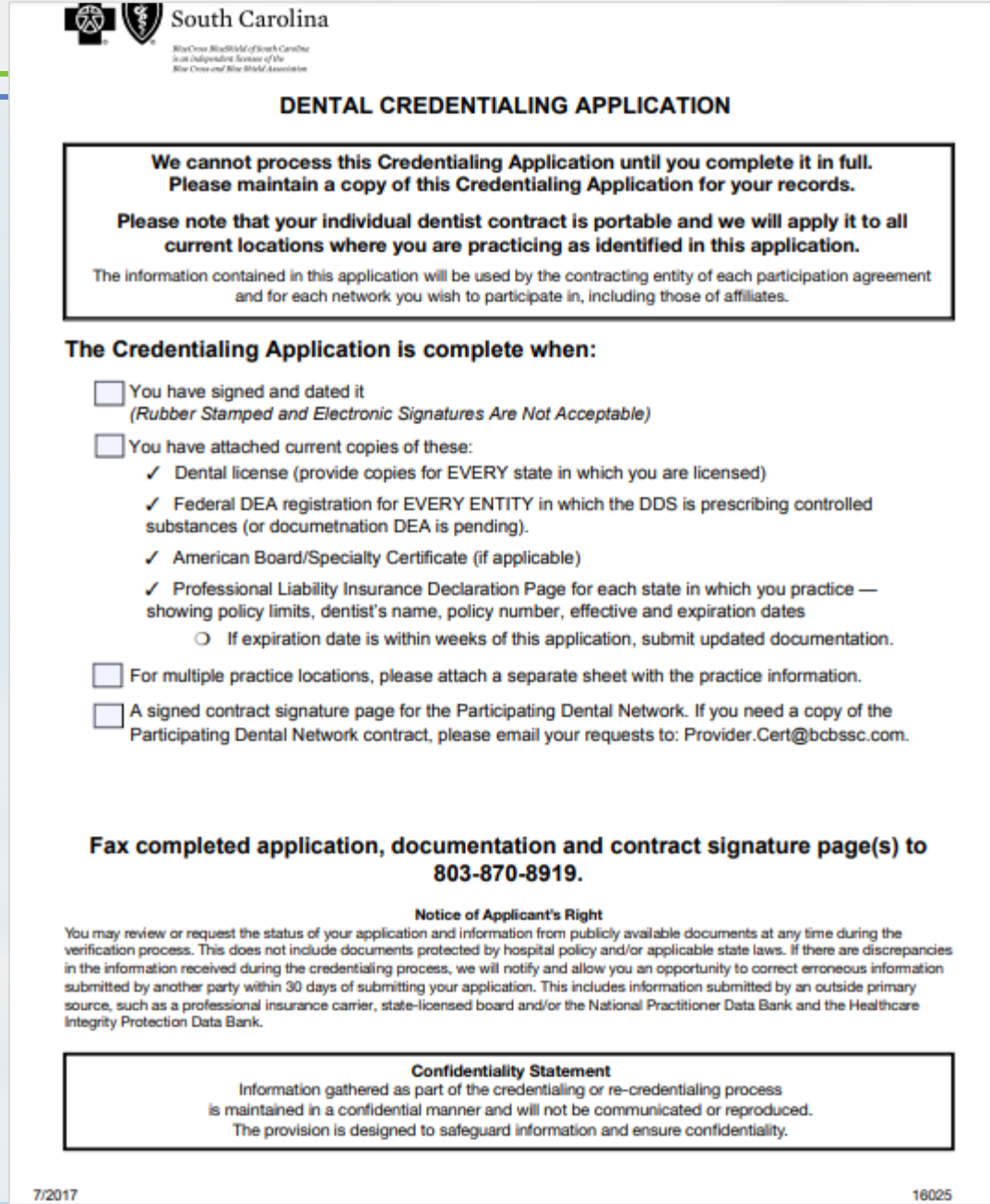
To exercise the above rights, please email your inquiries to Provider.credentialing@bcbssc.com

For Status Inquires please fill out website form

Submit completed applications to Provider.Blue.Enroll@bcbssc.com or fax 803-870-8919

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℠
  - FEP Basic and Standard
  - GRID members
- For **Initial Credentialing** use the South Carolina Dental Credentialing Application.



South Carolina

BlueCross BlueShield of South Carolina is an Independent Licensee of the Blue Cross and Blue Shield Association

DENTAL CREDENTIALING 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 Credentialing Application is complete when:

☐ You have signed and dated it
(Rubber Stamped and Electronic Signatures Are Not Acceptable)

☐ 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 documetnation DEA 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.

☐ For multiple practice locations, please attach a separate sheet with the practice information.

☐ A signed contract signature page for the Participating Dental Network. If you need a copy of the Participating Dental Network contract, please email your requests to: Provider.Cert@bcbssc.com.

Fax completed application, documentation and contract signature page(s) to 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.

7/2017 16025

Behavioral Health Credentialing

- Companion Benefit Alternatives (CBA) coordinates credentialing for mental health practitioners.
- Complete these steps to enroll with CBA.

Behavioral Health

Companion Benefit Alternatives, Inc. (CBA) manages our behavioral health network. CBA is a separate company that administers behavioral health benefits on behalf of BlueCross BlueShield of South Carolina.

Want to join this network? You'll need to do the following:

1. Complete and sign the CBA Practitioner Credentialing Application.
2. Complete and sign the CBA Professional Agreement. Please email CBA.ProvRep@companiongroup.com to request this document.
3. Sign the Hold Harmless Agreement (HMA) (Appendix C of the CBA Professional Agreement).
4. Include:
    1. A copy of your South Carolina state license
    2. A copy of your DEA license, if applicable
    3. A copy of the protocol (nurse practitioners only)
    4. Proof of current malpractice coverage

You can submit these items via mail or fax to:

- Companion Benefit Alternatives, Inc.
  ATTN: Network Coordinator AX-315
  P.O. Box 100185
  Columbia, SC 29202
- Fax: 803-714-6456

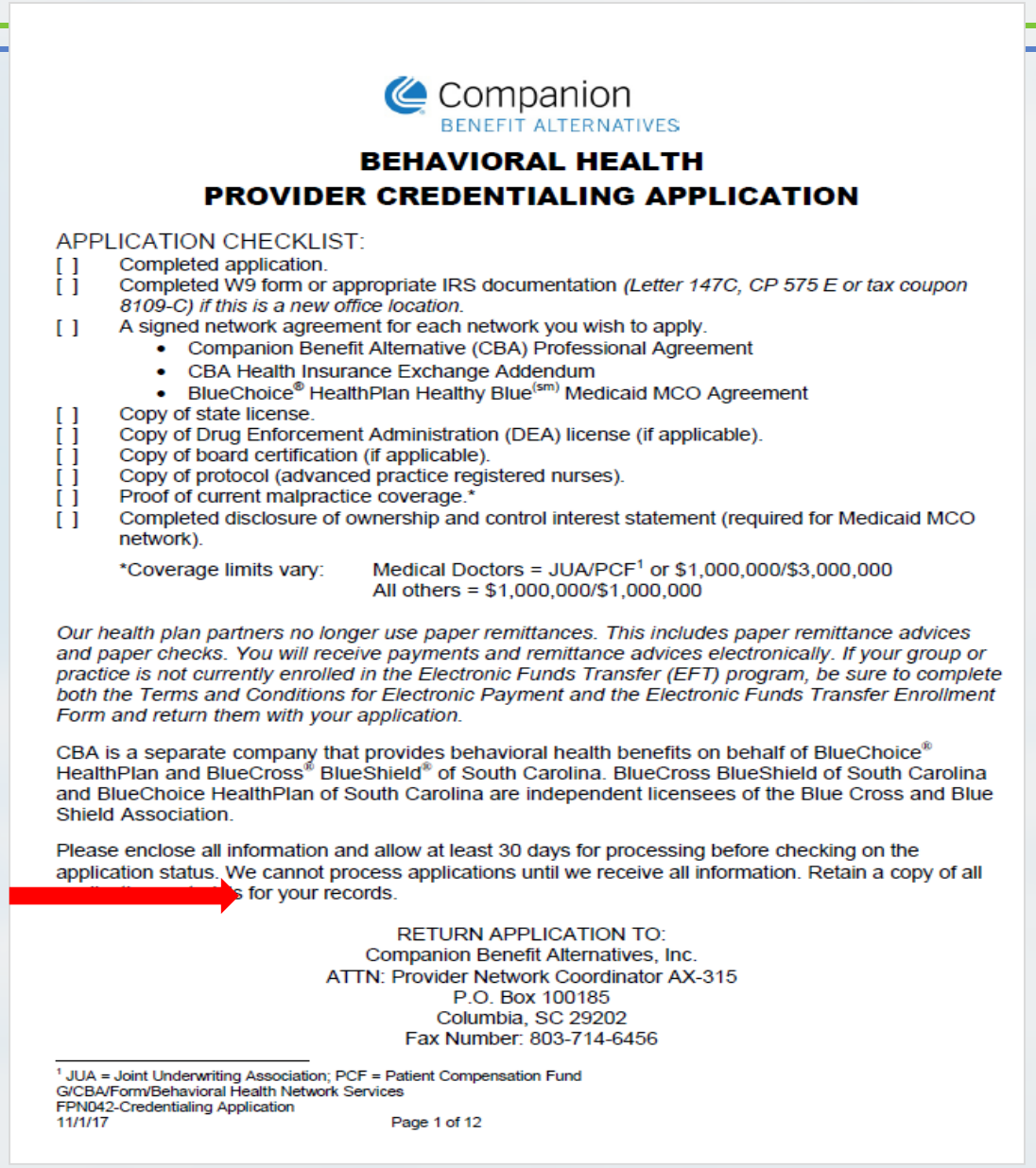
CBA is a separate company that administers mental health and substance abuse benefits on behalf of BlueCross and BlueChoice HealthPlan.

Behavioral Health Credentialing

Now Available

Behavioral health providers can now apply for network enrollment via an online application at www.CompanionBenefitAlternatives.com.

- Send general inquiries to cba.provrep@companiongroup.com
- If you have enrollment questions, please contact CBA at 800-868-1032, ext. 25744.



Companion
BENEFIT ALTERNATIVES

BEHAVIORAL HEALTH
PROVIDER CREDENTIALING APPLICATION

APPLICATION CHECKLIST:

[ ] Completed application.
[ ] Completed W9 form or appropriate IRS documentation *(Letter 147C, CP 575 E or tax coupon 8109-C) if this is a new office location.*
[ ] A signed network agreement for each network you wish to apply.
- Companion Benefit Alternative (CBA) Professional Agreement
- CBA Health Insurance Exchange Addendum
- BlueChoice® HealthPlan Healthy Blue(sm) Medicaid MCO Agreement

[ ] Copy of state license.
[ ] Copy of Drug Enforcement Administration (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: Medical Doctors = 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. You will receive payments and remittance advices electronically. If your group or practice is not currently enrolled in the Electronic Funds Transfer (EFT) program, be sure to complete both the Terms and Conditions for Electronic Payment and the Electronic Funds Transfer Enrollment Form and return them with your application.

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

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 [illegible] for your records.

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

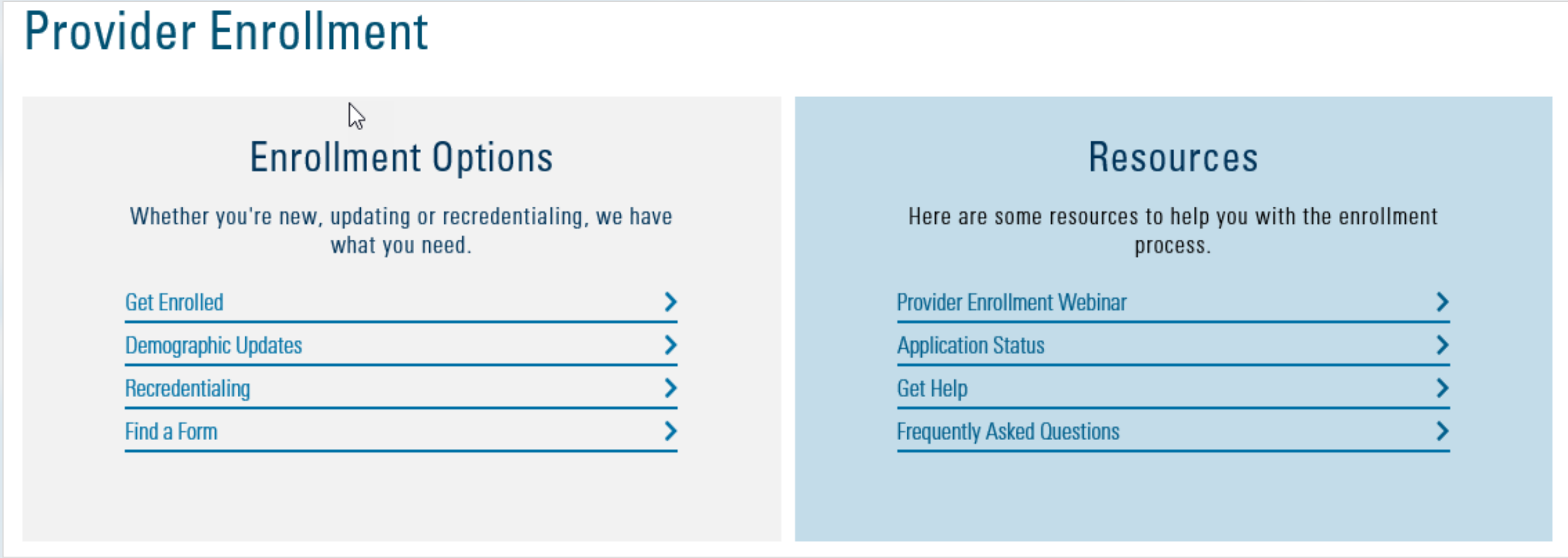
[1] JUA = Joint Underwriting Association; PCF = Patient Compensation Fund

G/CBA/Form/Behavioral Health Network Services
FPN042-Credentialing Application
11/1/17 Page 1 of 12

Demographic Updates

Demographic Updates

You can make updates easily through Medical Directory Check Up (M.D. CheckUp).
Click on **Demographic Updates** to update your information.



Demographic Updates

- M.D. Checkup allows you to view information for all associated locations and affiliated practitioners for each location.
- You can update information at any time.
- We require verification for each location on a quarterly basis.
  - January 1 – March 31
  - April 1 – June 30
  - July 1 – September 30
  - October 1 – December 31

Demographic Updates

Has your information changed? It's important for us to know. You can easily make updates with MD Checkup. Access MD Checkup through My Insurance Manager℠ to:

- Update your practice address.
- Change or add where an already-enrolled physician practices within your group. The tax ID number must be the same.
- Terminate a provider.
- Update your office/directory information.

To learn more, access the MD Checkup User Guide.

Other Provider Updates

- Authorization to Bill - Affiliate a practitioner to a new group
- Change of Address Form - Update billing address(es)
- Doing Business As (DBA) Name Change Form - (In order to update the Legal Business Name for a provider group, we require a copy of the most current official IRS letter for the entity. Examples include an IRS LTR 147C, CP267, CP 575 A, CP 575 E, CP-224 or tax coupon 8109-C. Send to Provider.Blue.Updates@bcbssc.com) W-9s are not accepted.
- Electronic Funds Transfer (EFT) and Electronic Remittance Advise (ERA) Enrollment Form/EFT Terms and Conditions
- Request to Add or Terminate Practitioner Affiliation - Add, terminate or change practitioner affiliation
- Satellite Location Application - Add a new location to file claims to an existing group or change your tax identification number.

Demographic Updates

- MD Checkup is available within My Insurance Manager[SM].
- **Verify** – Confirm information shown is current and accurate.
- **Update** – Once a change has been made, Update must be selected to confirm and accept the change.
- **Remove Location** – Enter or select a date to indicate that a location shown in the Location List is no longer active or part of the organization.
- **Remove Practitioner** – Enter or select a date to indicate that a practitioner is no longer participating with the specific location.
- **Add Practitioner** – Add a practitioner to the specific location by using the Add Practitioner's search function.
- **View & Edit** – Access and edit location information (addresses, telephone number, fax number, hours of operation, etc.).

Demographic Updates

Why are these updates so critical? You could be losing patients!

- Keeping the provider directory accurate and up to date is essential to the health plan and to the providers.
- If you receive the notice to update your demographic information, please do not just click accept without fully reviewing the information.
- If you are not the correct person that should be reviewing this data, please send this to the appropriate person who can accurately validate.

Demographic Updates

Common Errors Found During Secret Shopper

- **Appointment phone numbers are incorrect** – A patient calls and cannot reach the office to make an appointment. Patients will choose to call another practice.
- **Practitioners are listing at a location where they do not practice** – A patient calls to schedule an appointment with a certain practitioner. They are told he is not at this location. Patients get frustrated and may choose another practice.
- **Practitioners listed as accepting new patients** – Patients call to make a new patient appointment and are told that physician's panel is closed. Patients get frustrated and may choose a another practice.
- **Staff unaware of updates** – Sometimes updates are made but the staff is not aware. Be sure staff knows about all demographic updates

How can you avoid these errors?

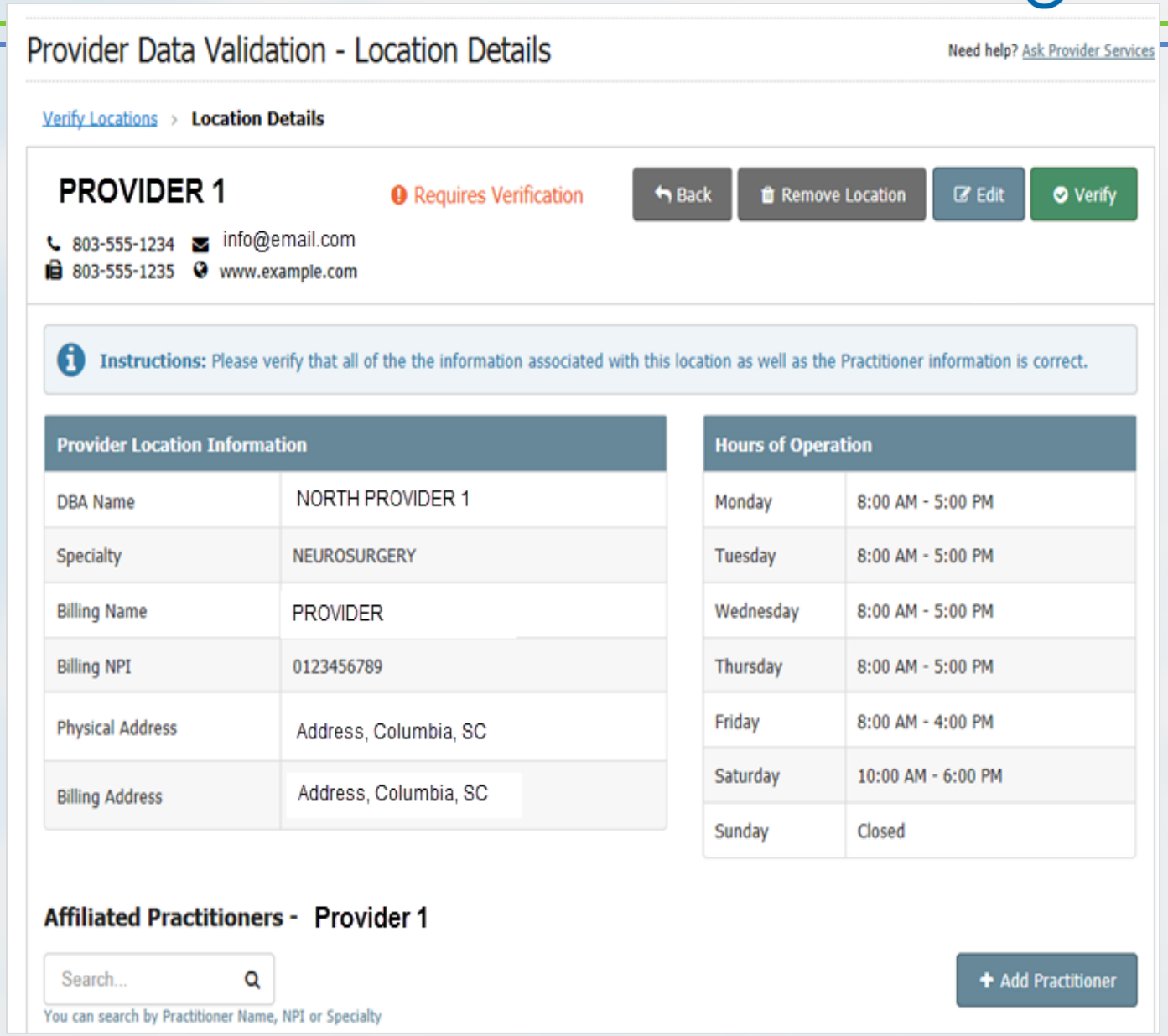
Update often! The process is easy and can be done at any time. You can update as soon as you learn of a change in your practice.

Demographic Updates

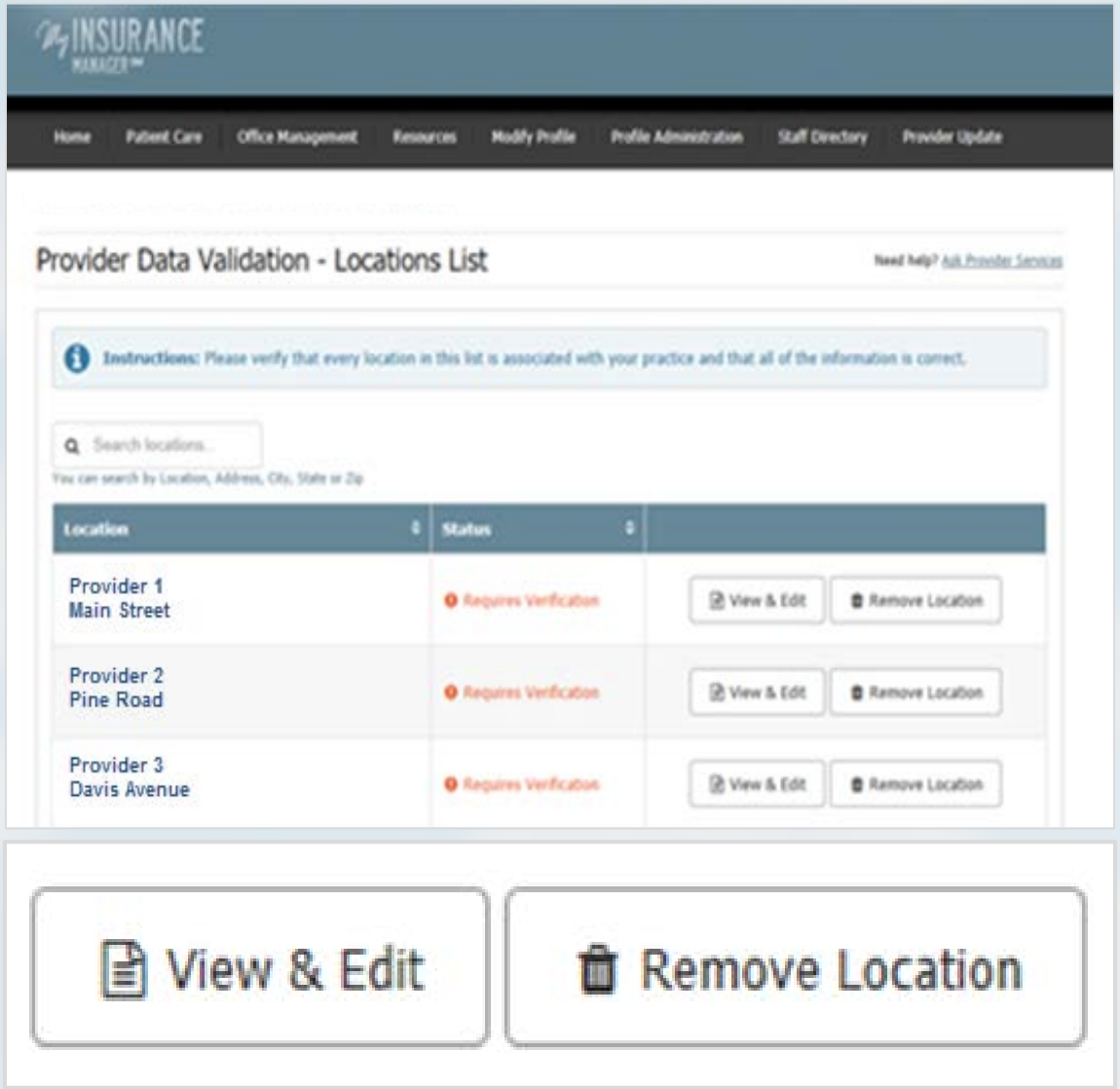
The Location Details screen shows the practice details:

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

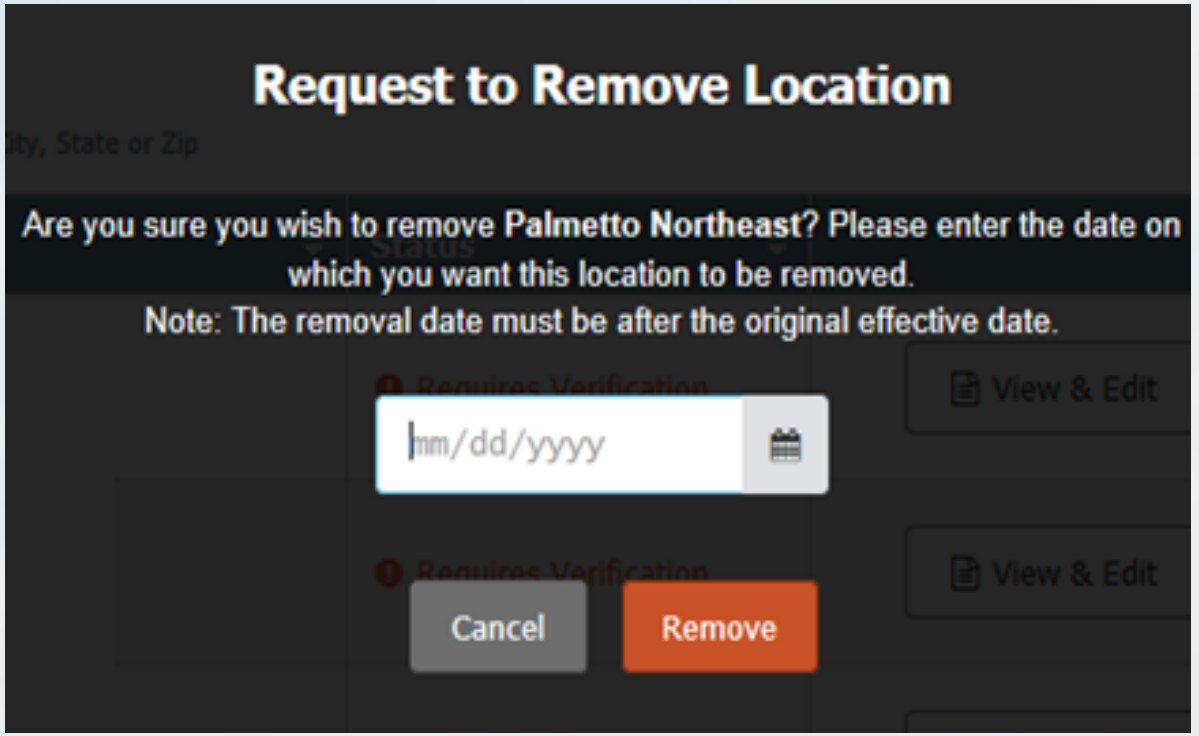
The Edit function allows users to modify the information shown.



Demographic Updates



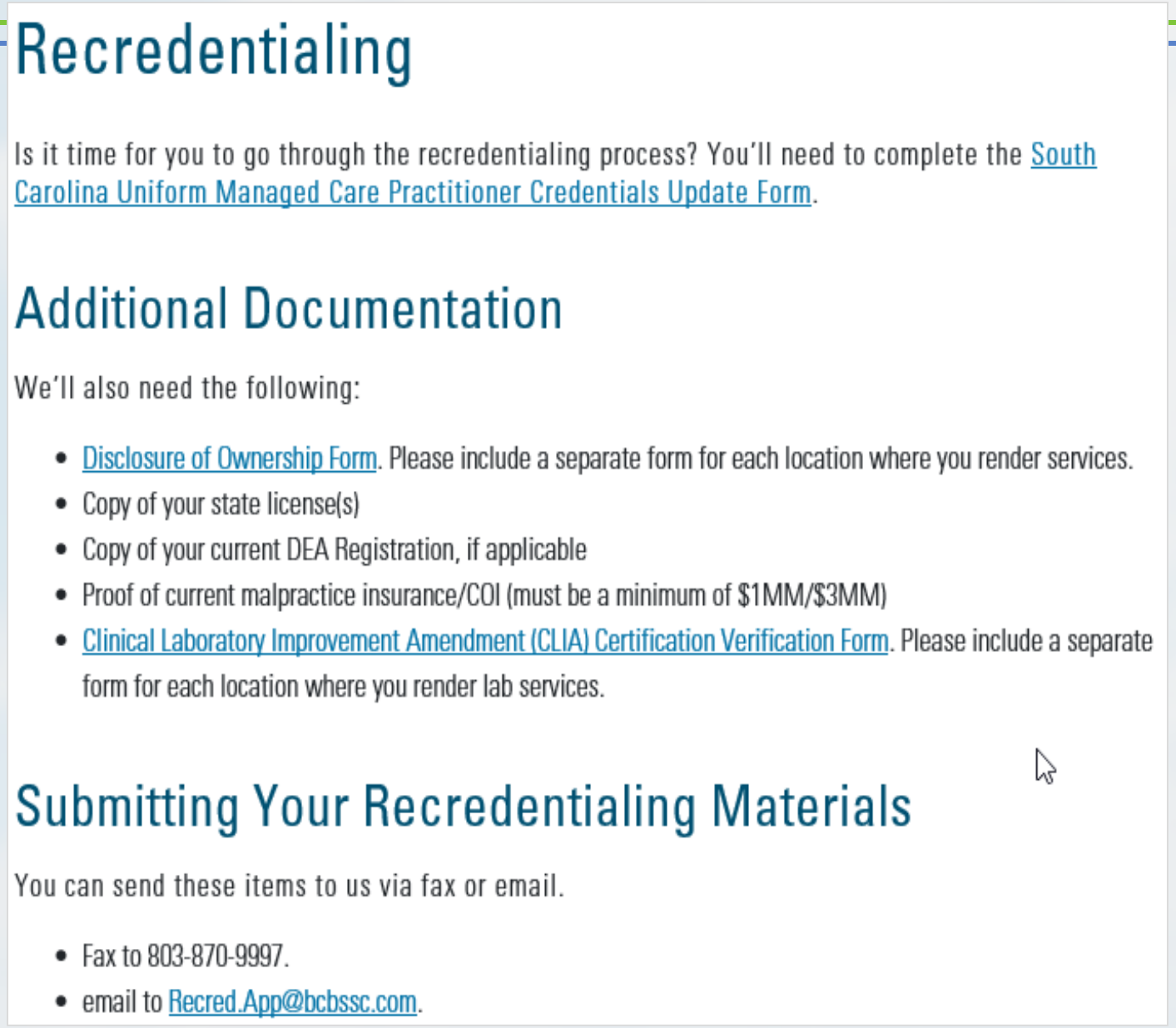
If you click on Remove Location, you are closing out that location in our system as well as removing it from the directory.



Recredentialing

Recredentialing

- Established providers are required to recredential every three years.
- You can access the forms necessary to recredential by clicking on **Recredentialing**.
- If the provider is three months or longer past the recredentialing date, the provider must re-enroll.



Recredentialing

Is it time for you to go through the recredentialing process? You'll need to complete the South Carolina Uniform Managed Care Practitioner Credentials Update Form.

Additional Documentation

We'll also need the following:

- Disclosure of Ownership Form. Please include a separate form for each location where you render services.
- Copy of your state license(s)
- Copy of your current DEA Registration, if applicable
- Proof of current malpractice insurance/COI (must be a minimum of $1MM/$3MM)
- Clinical Laboratory Improvement Amendment (CLIA) Certification Verification Form. Please include a separate form for each location where you render lab services.

Submitting Your Recredentialing Materials

You can send these items to us via fax or email.

- Fax to 803-870-9997.
- email to Recred.App@bcbssc.com.

Recredentialing

Our credentialing staff will notify you when it is time for you to complete this update.

The recredentialing process consists of a **5 page South Carolina Uniform Managed Care Practitioner Credentials Update Form**. This 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 150 days old.**

Contact Us

Contact Us

BlueCross BlueShield of South Carolina, BlueChoice HealthPlan and Healthy Blue℠ have streamlined the Provider Enrollment Process to improve the enrollment experience.

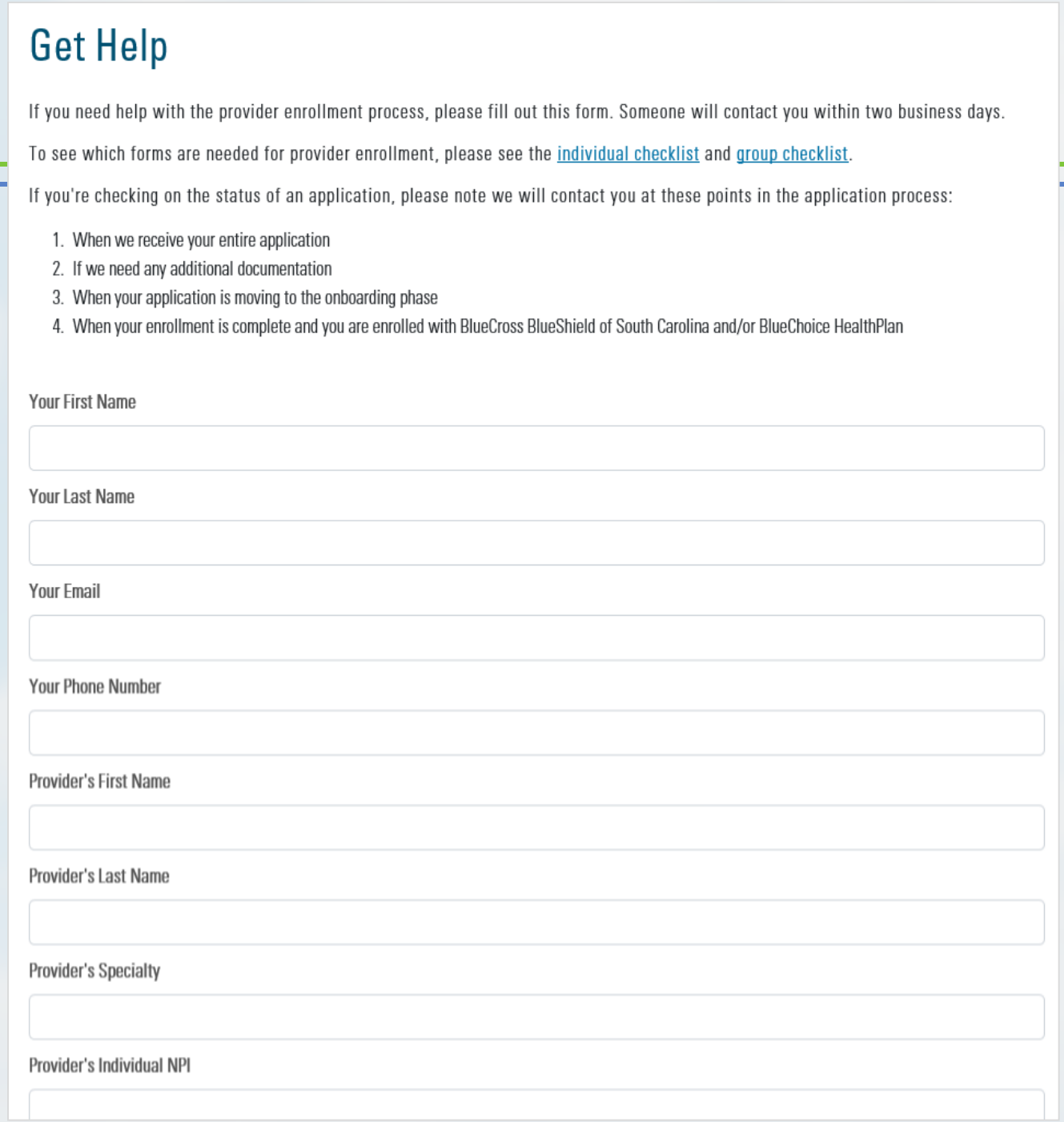
- Initial Enrollment Applications – Provider.Blue.Enroll@bcbssc.com
- Returning Documentation – Provider.Requested.Info@bcbssc.com
- Provider Demographic Updates – Provider.Blue.Updates@bcbssc.com
- Recredentialing – Recred.App@bcbssc.com

Do not email Provider.Cert@bcbssc.com – This email address is no longer monitored.

Note: Do not send your email to multiple addresses.

Contact Us

- BlueCross BlueShield of South Carolina, BlueChoice HealthPlan and Healthy Blue℠ streamlined the Provider Enrollment Process to improve the enrollment experience.
- Fill out the online form to ask questions via email. Do not email directly.
- This form contains all the information needed to respond to inquiries quickly and accurately.



Get Help

If you need help with the provider enrollment process, please fill out this form. Someone will contact you within two business days.

To see which forms are needed for provider enrollment, please see the individual checklist and group checklist.

If you're checking on the status of an application, please note we will contact you at these points in the application process:

1. When we receive your entire application
2. If we need any additional documentation
3. When your application is moving to the onboarding phase
4. When your enrollment is complete and you are enrolled with BlueCross BlueShield of South Carolina and/or BlueChoice HealthPlan

Your First Name

Your Last Name

Your Email

Your Phone Number

Provider's First Name

Provider's Last Name

Provider's Specialty

Provider's Individual NPI

Contact Us

- Use the VRU to check status of a submitted application or ask questions.
- Call Provider Services at 1-800-868-2510 and select option 5.
  - Press 1 to check the status of an application.
- The phone lines will be available Monday through Friday from 8 a.m. to 5 p.m.
- There will not be a voicemail option.
- **This line is for credentialing questions only.**

Be in the kNOW
A Palmetto Provider University Event

Quality

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

Independent licensees of the Blue Cross and Blue Shield Association

National Committee for Quality Assurance (NCQA)

What is National Committee for Quality Assurance?

- NCQA is a private organization dedicated to improving health care quality by developing quality standards and performance measures.
- Healthcare Effectiveness Data and Information Set (HEDIS®) coordination.
- Provider Involvement.
- **Patient safety**

Healthcare Effectiveness Data and Information Set

What is Healthcare Effectiveness Data and Information Set (HEDIS®)

- Used to track trends in population health

What entities use HEDIS data?

- NCQA
- Centers for Medicare and Medicaid Services (CMS)
- Federal Employee Program (FEP)
- Members

What HEDIS Means to You

- Members from your practice will be chosen by NCQA
- All member documentation that is requested is needed for the HEDIS audit

HEDIS “Season” Retrospective

- A look back at the care given or due in the year prior
- January to May of the year AFTER

Quality Navigator Program

What is the Quality Navigator Program?

- Participation is based on provider attribution within the primary care specialty
- Auto-Enroll
- No cost to providers
- Multiple tools and offerings to support providers

Understanding Your Care Opportunity Reports

- Care Opportunities can be broken into two categories
  - A true “gap” in care
  - A “gap” in data
- The Quality Navigator program will supply your practice tools
  - Location- or organization-level goals for compliance.
  - A 2020 quick reference guide with measure education and coding guidance.

Quality Navigator Program

The Quality Navigator Program Incentives for 2020

- Based on NCQA-approved CPT II codes closing current care opportunities.
- Shifts compliance verification from medical record requests and reviews to claims verification.
- Based on code submissions via claims.

Incentives for 2020

- General CPT II codes available for incentive are available today upon request
- Request individual line of business CPT II codes with incentive values from your quality navigator.
    - Each line of business sets the incentive rates, method and frequency of incentive payments.

Requests for Information and Gaining Compliance

Requests for Information:

- Sent via email, fax, or mail by practice preference
- Providers need to send back only the requested documentation or indicate that it is not available
- Requests are based on claims

Compliance:

- Elements of Year-Round Compliance
- Elements of Compliance during HEDIS Season
- There are changes for 2020

South Carolina

Request For Medical Records - Cover Letter

To : PROVIDER NAME PROVIDER ADDRESS Phone:###-###-####/ Fax: ###-###-####	From : BlueChoice HealthPlan BlueCross BlueShield of South Carolina Fax: 803-419-8191 Requested Date:11/05/2019

Greetings:

BlueChoice HealthPlan and BlueCross BlueShield of South Carolina are collecting medical records for quality improvement and to help identify true care opportunities for our members. If the member has not had the service requested within the required time frame, please schedule the member for a visit to address these care opportunities. This Care Gap Report contains:

- Measure List Description
- List of Members and Measure Care Gaps
- Standard Guidelines for all administrative measures specific to Members

Please provide the requested member information specified on the attached document(s) within seven business days from the requested date above.

We appreciate your cooperation and ask that you return the attached form and requested medical records for each member by fax to **803-419-8191** or by email at **HEDIS.Records@BCBSSC.com**.

If you are required to mail records, please send them to:

BlueCross BlueShield of South Carolina
Attn: Quality Management Department
4101 Percival Road, AX-310
Columbia, SC 29229

If you have questions or concerns, please email the Quality Department at Navigator@BCBSSC.com.

Thank you,
Shannon F. Montgomery, RN, BSN
Manager, Quality Management
BlueCross BlueShield of South Carolina

South Carolina

To: PROVIDER NAME Date: 11/05/2019	From: BlueChoice HealthPlan BlueCross BlueShield of South Carolina Fax: 803-419-8191

Clinical Measure = (ABA) Adult BMI Assessment

Member: MEMBER NAME DOBMEMBER DOB ID#: MEMBER ID CARD

In order for us to conduct a review, please send a copy of the following:

Members age **20-74** on the date of service: the most recent BMI **value** and weight recorded in the measurement year or year prior.
Members age **18 and 19** on the date of service: the most recent BMI percentile plus height and weight recorded in the measurement year or year prior.

Please check the appropriate box:

[ ] Documentation of requested information. ***Medical Record Attached***

[ ] No medical records with requested information during the time frame specified.

[ ] This is not my patient.

Key Takeaways

Impacts HEDIS and Quality Ratings

Schedule patients for annual exams

- Include periodic screenings and preventive services
- Follow up on missed appointments
- Refer members whose biometric data is out of range to our Case Management programs

Utilize CPTII codes wherever possible per coding guidelines

Code all the valid/ current diagnosis codes (active treatment)

Promote medication adherence

Explore direct EHR data feeds to plans

Be in the kNOW
A Palmetto Provider University Event

Contact: Navigator@bcbssc.com

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

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Be in the kNOW
A Palmetto Provider University Event

Self Service Web Tools

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

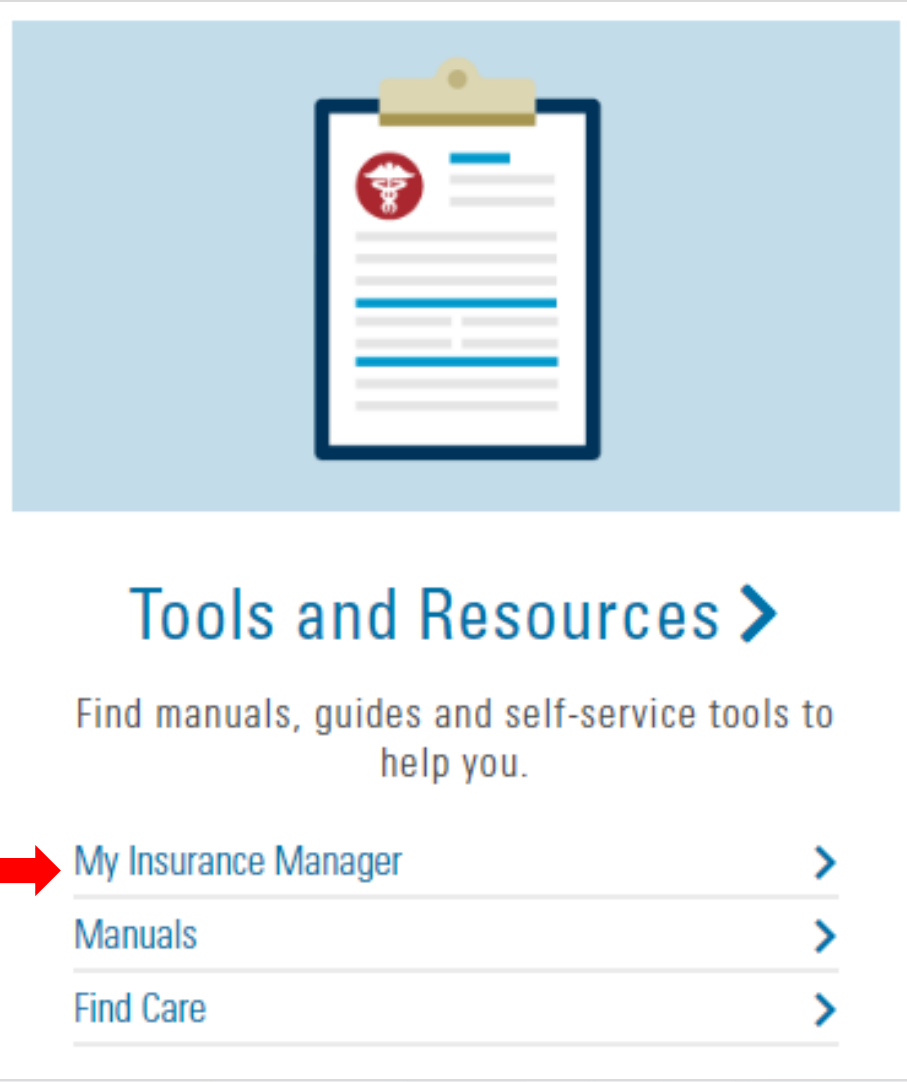
Independent licensees of the Blue Cross and Blue Shield Association

My Insurance Manager

My Insurance Manager

You can access MIM through:

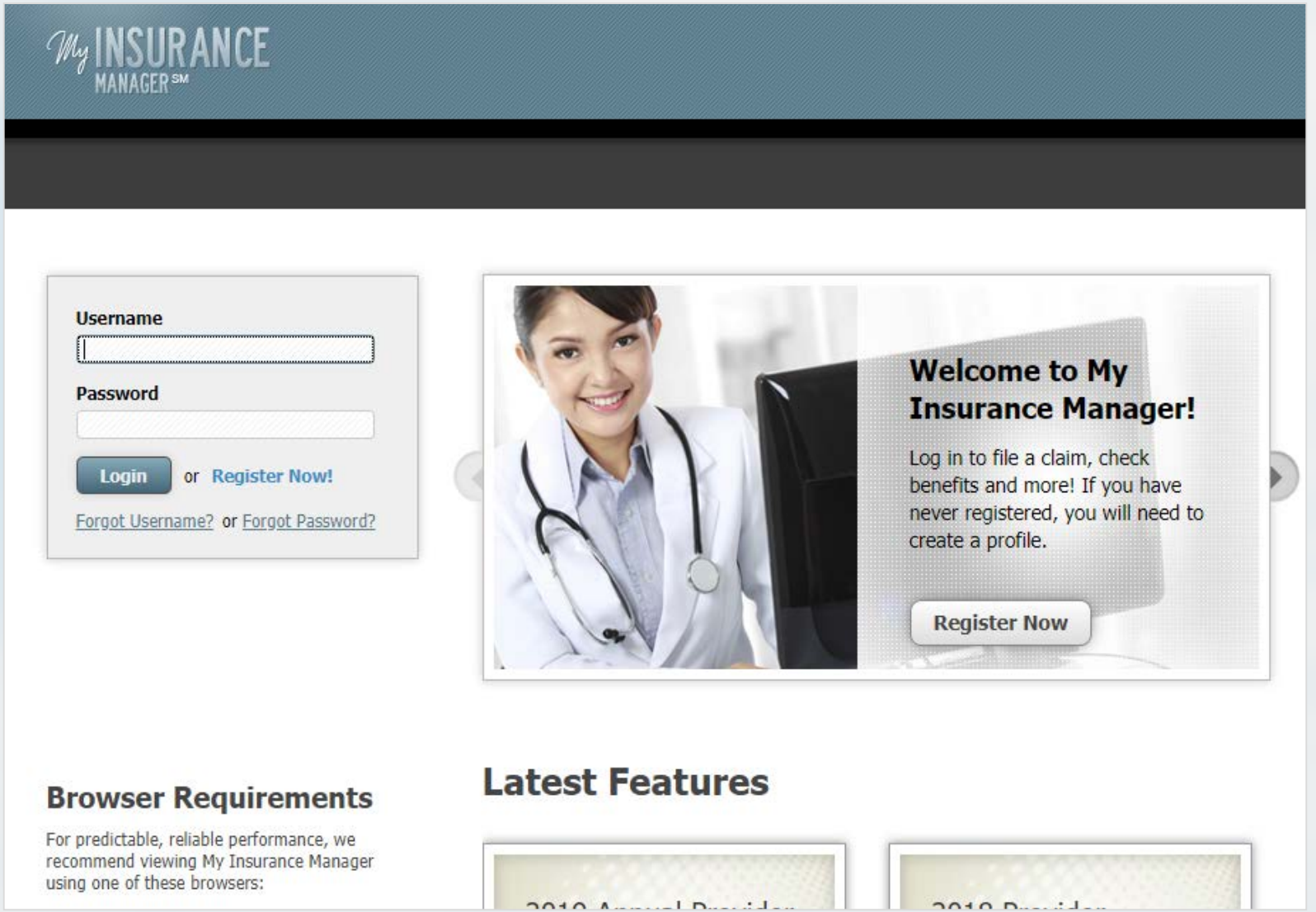
- www.SouthCarolinaBlues.com
- www.BlueChoiceSC.com



My Insurance Manager

What You Can Do

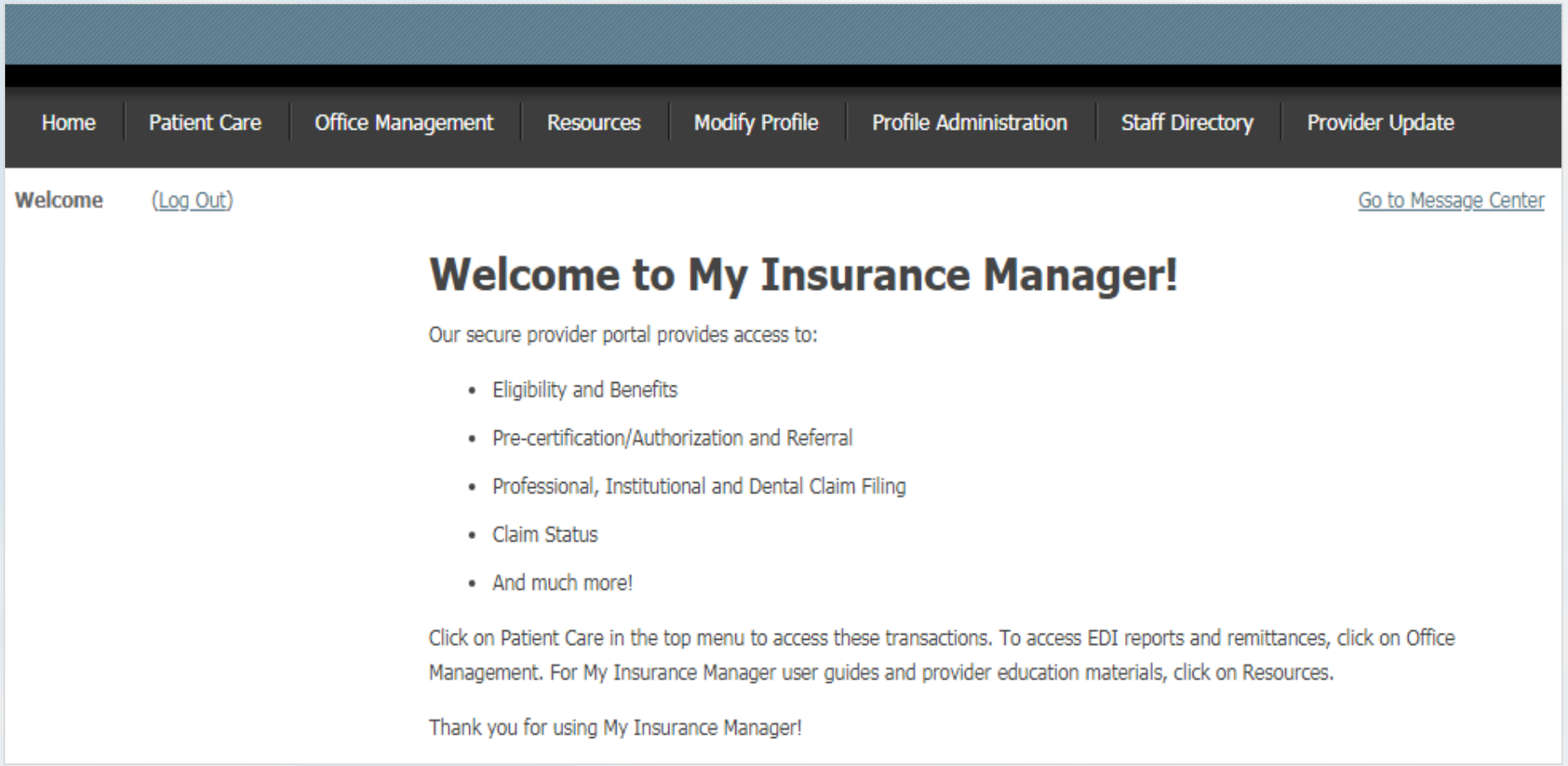
- Access Eligibility and Benefits
- Submit Precertification Requests
- View Claims Status
- View Remittance Advice
- Much, much more!



My Insurance Manager

Administrative Tab

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

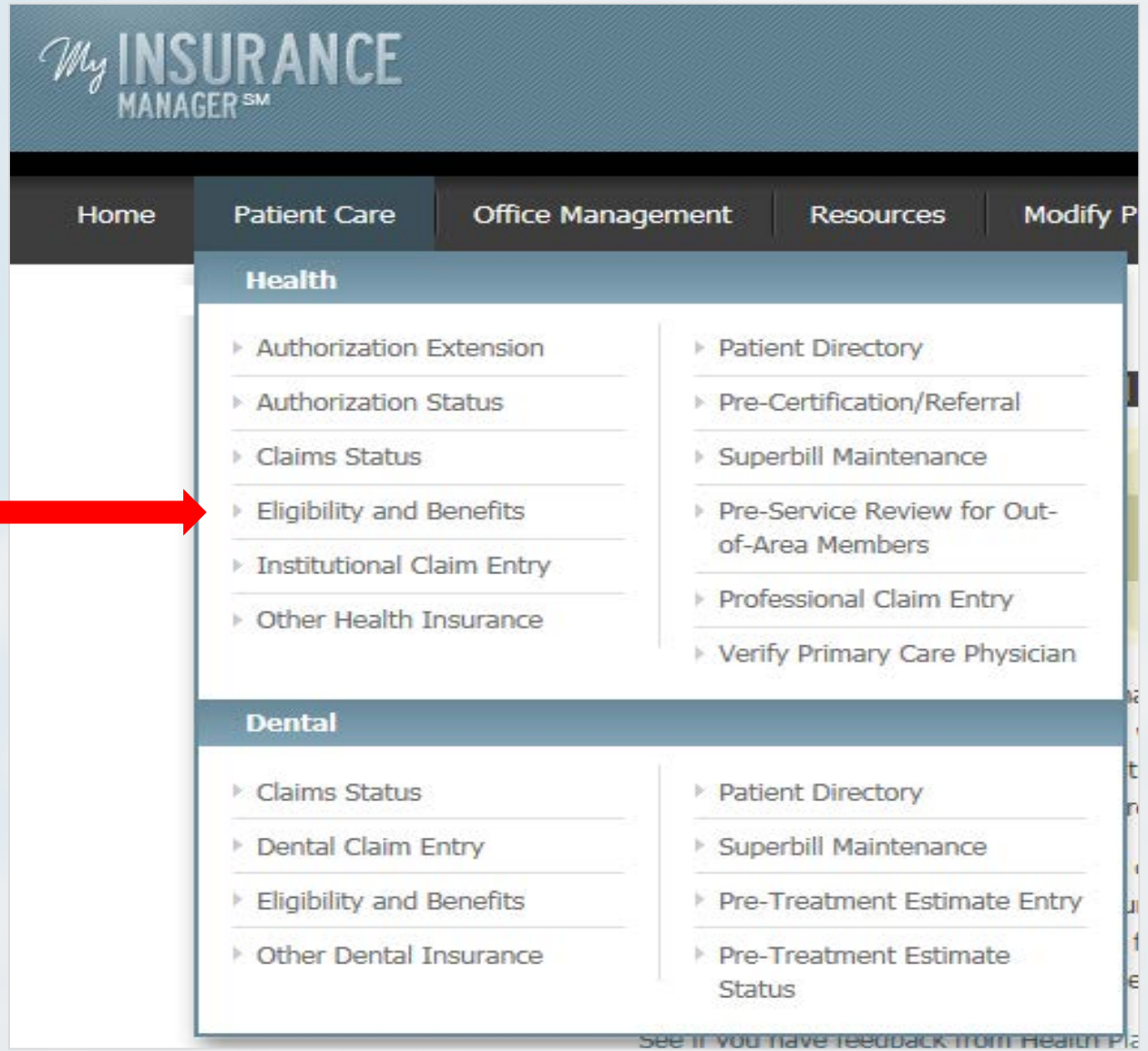


My Insurance Manager

Eligibility and Benefits

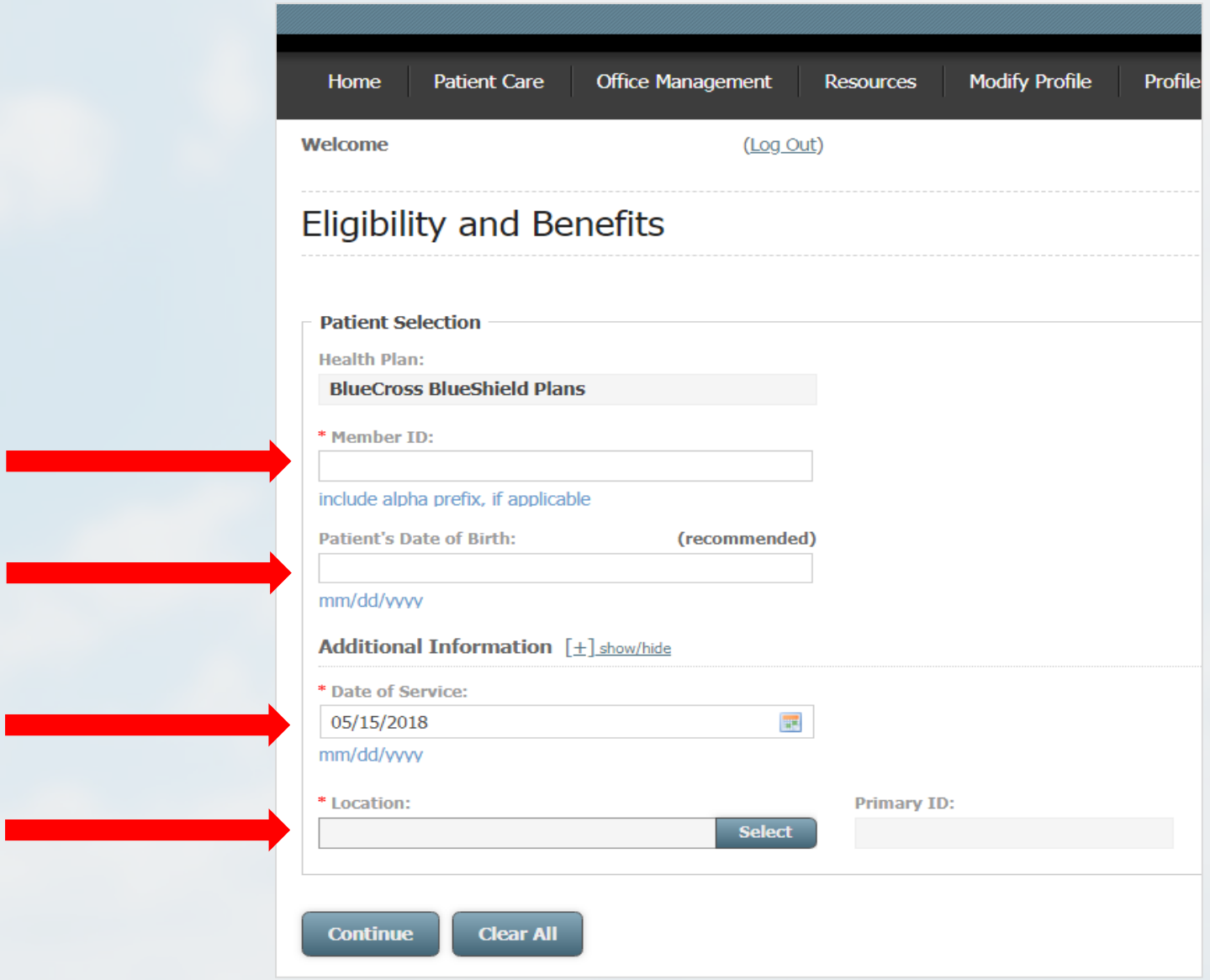
There are three Eligibility and Benefits search options:

- General
- Service Type
- Procedure Code



My Insurance Manager

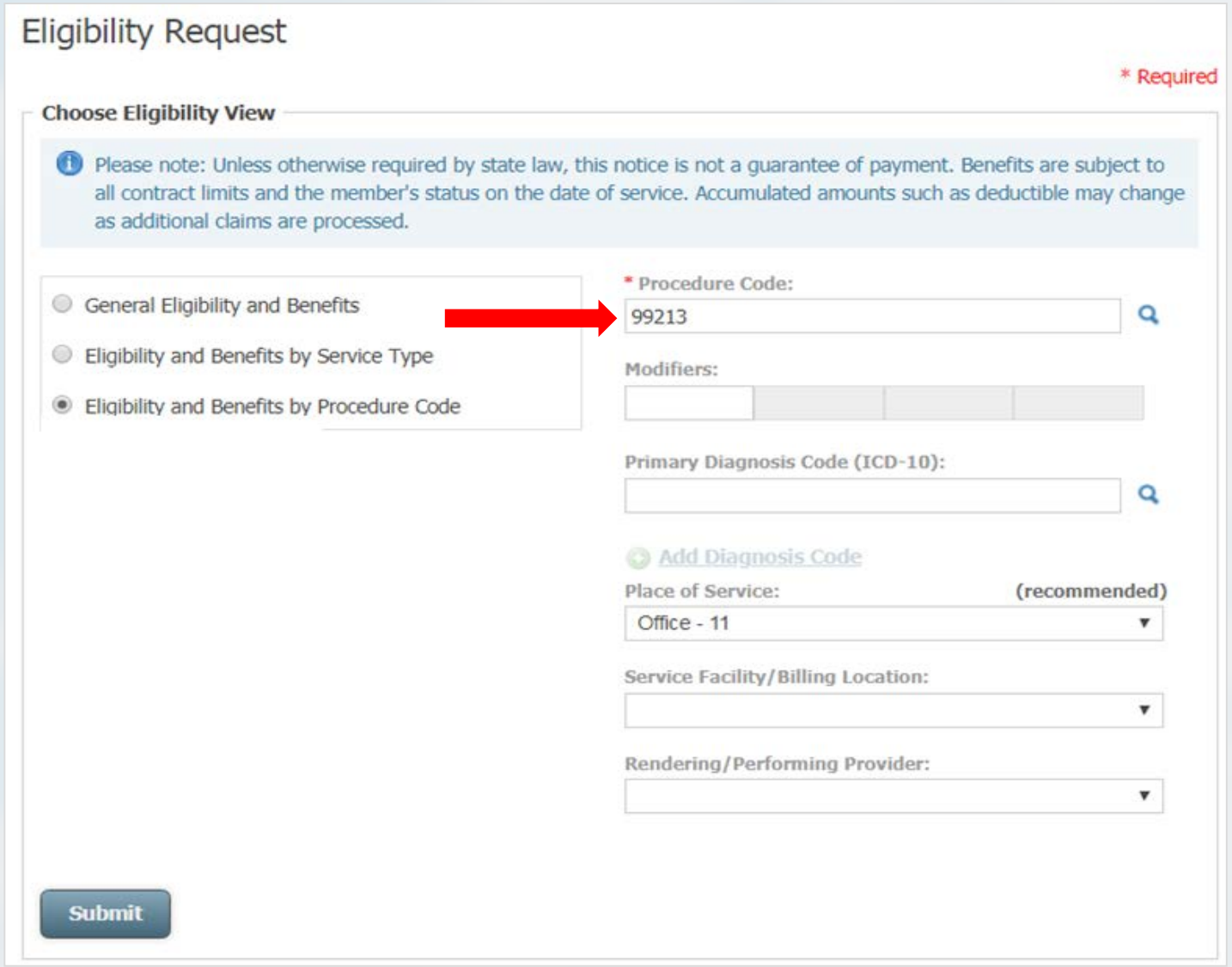
Eligibility and Benefits



My Insurance Manager

Eligibility and Benefits

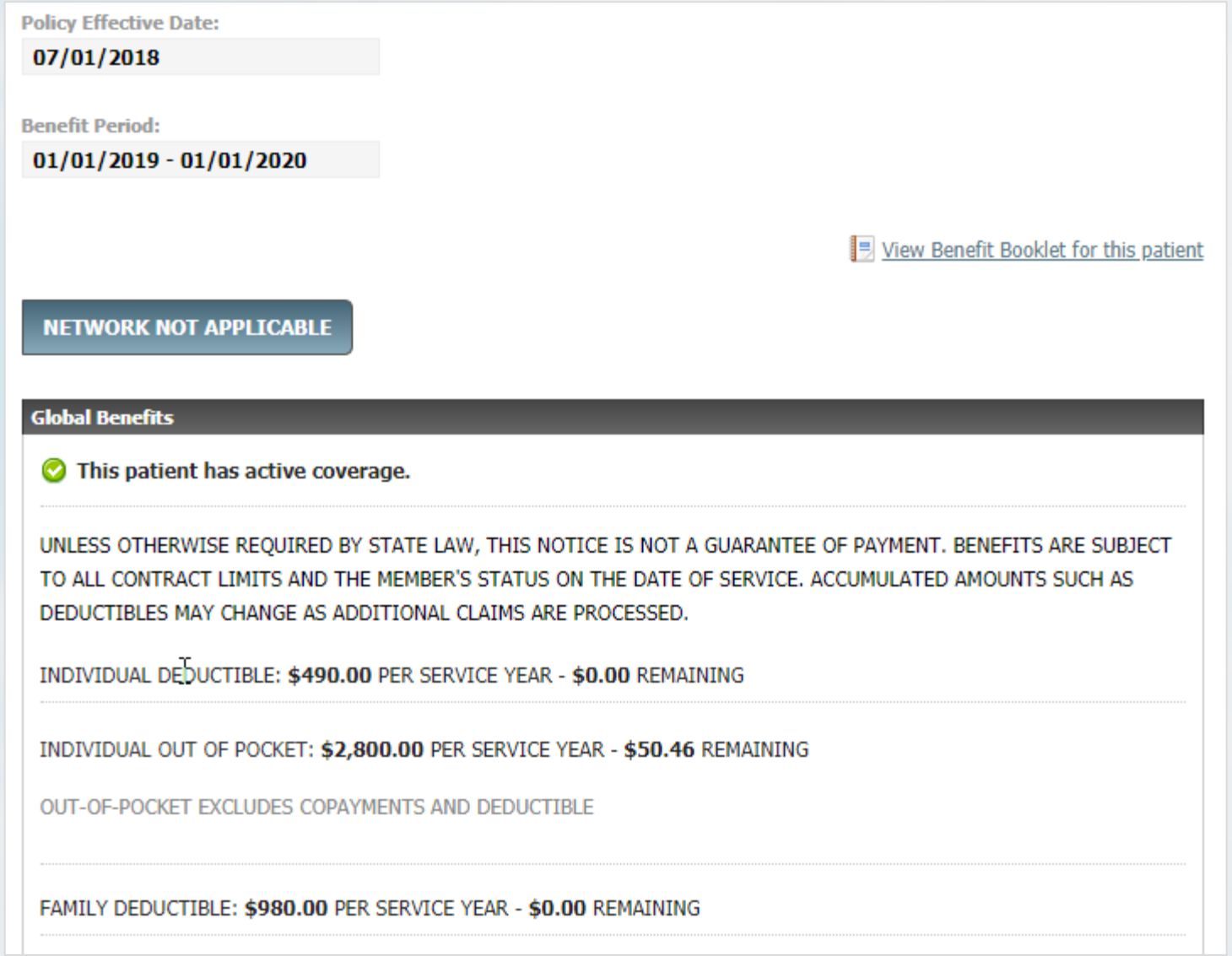
Procedure Code



My Insurance Manager

Eligibility and Benefits

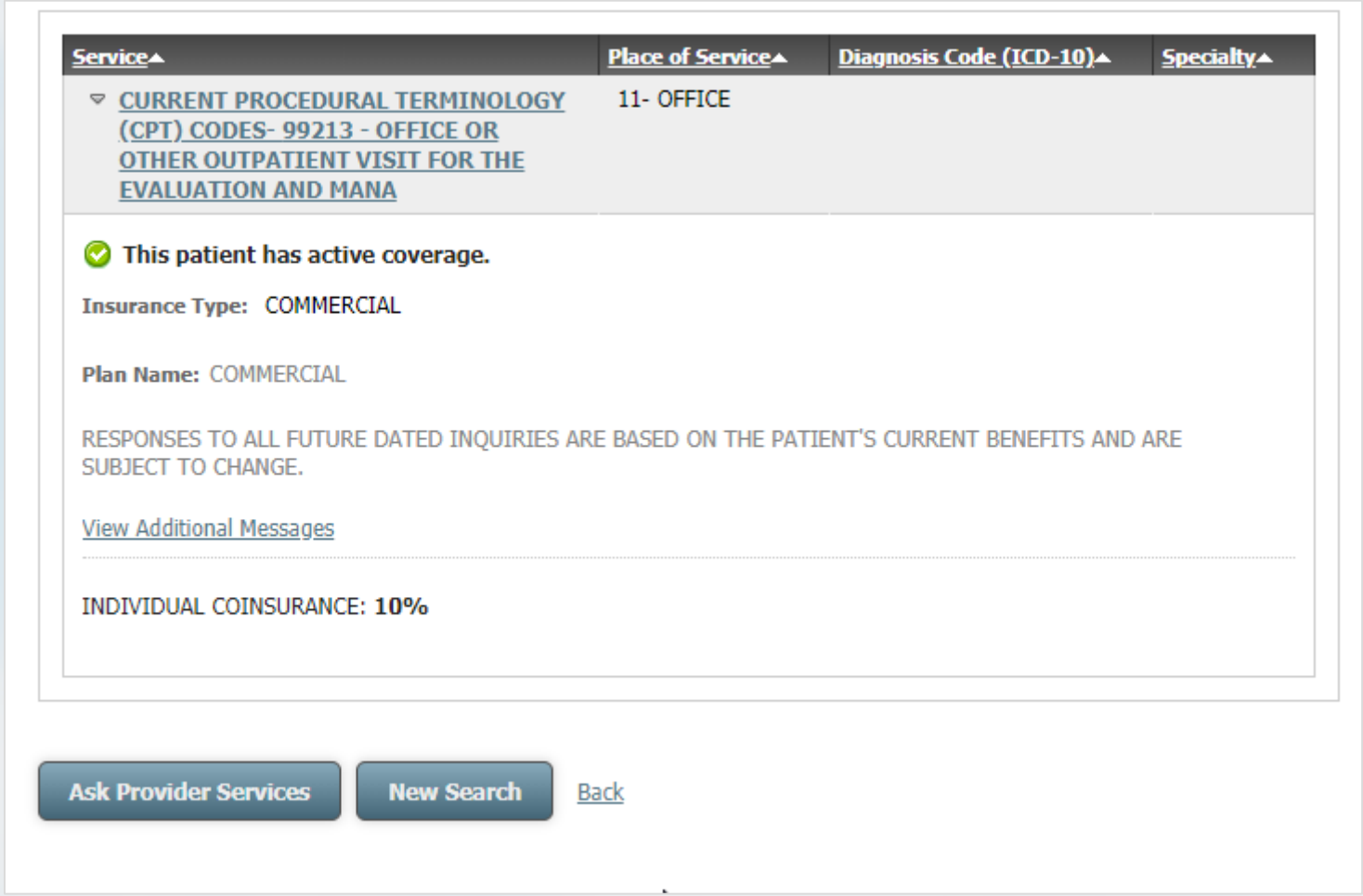
Procedure Code



My Insurance Manager

Eligibility and Benefits

Procedure Code

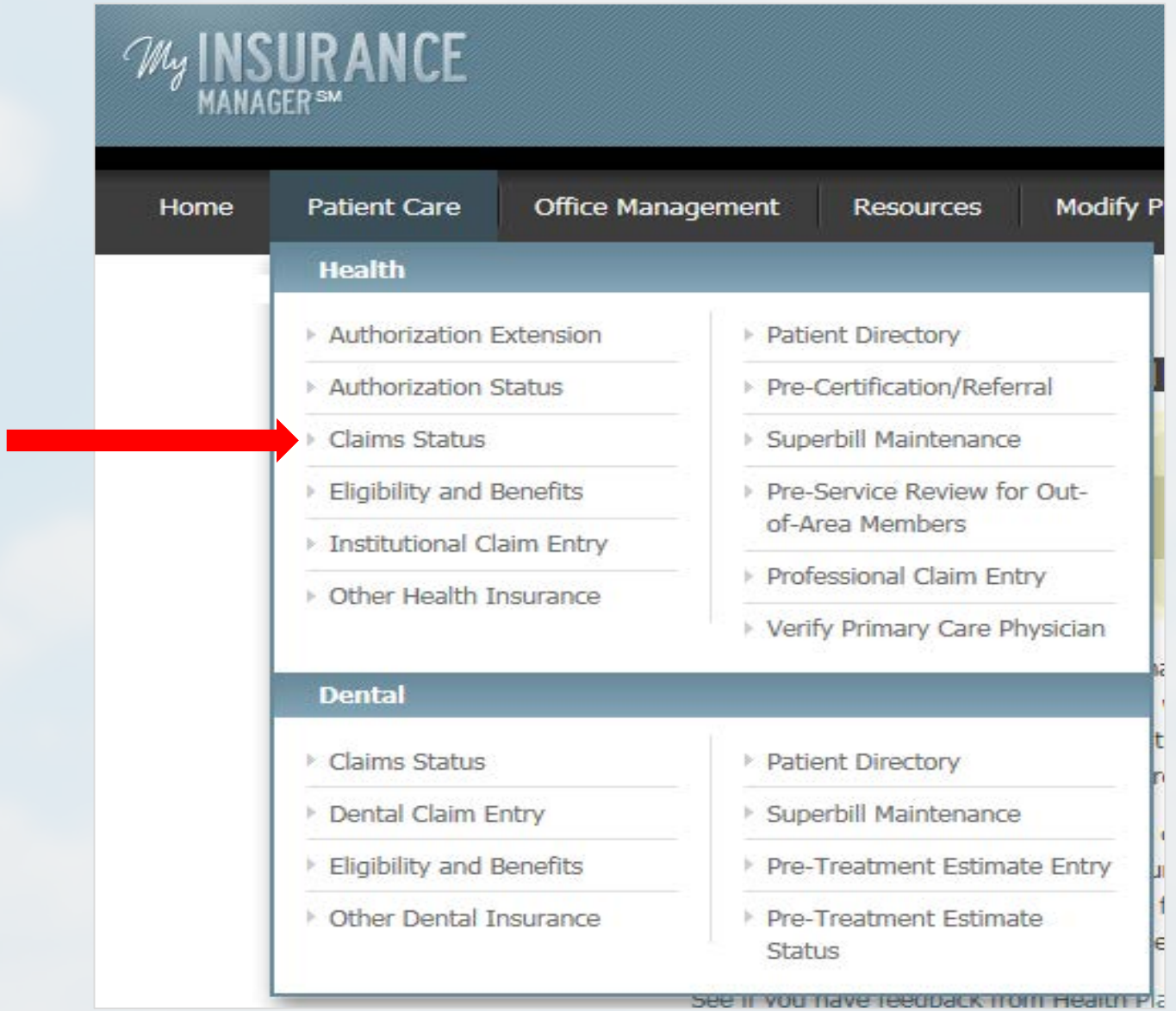


My Insurance Manager

Claim Status

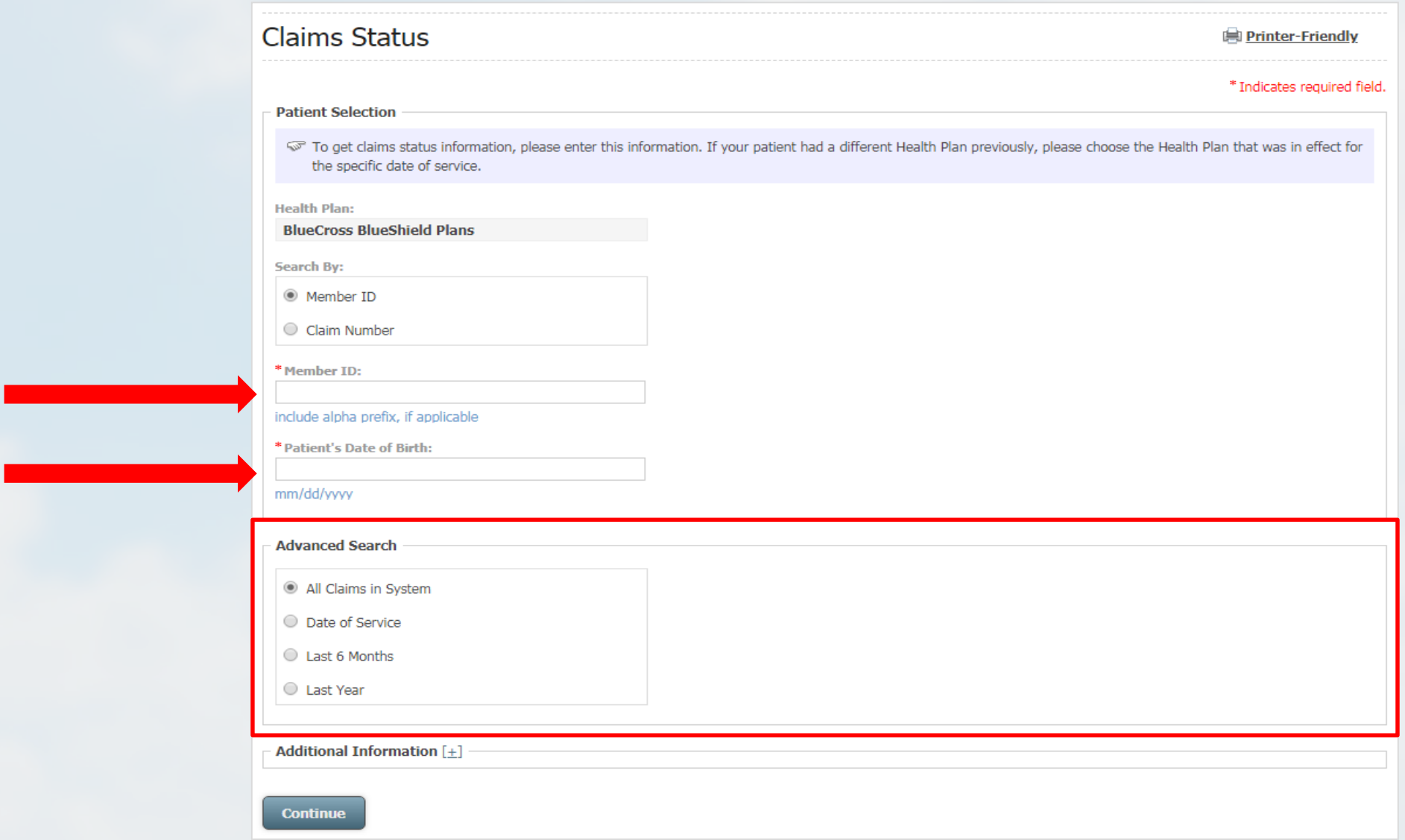
There are two ways to get a claim's status:

- Member ID
- Claim Number



My Insurance Manager

Claim Status



My Insurance Manager

Claim Status

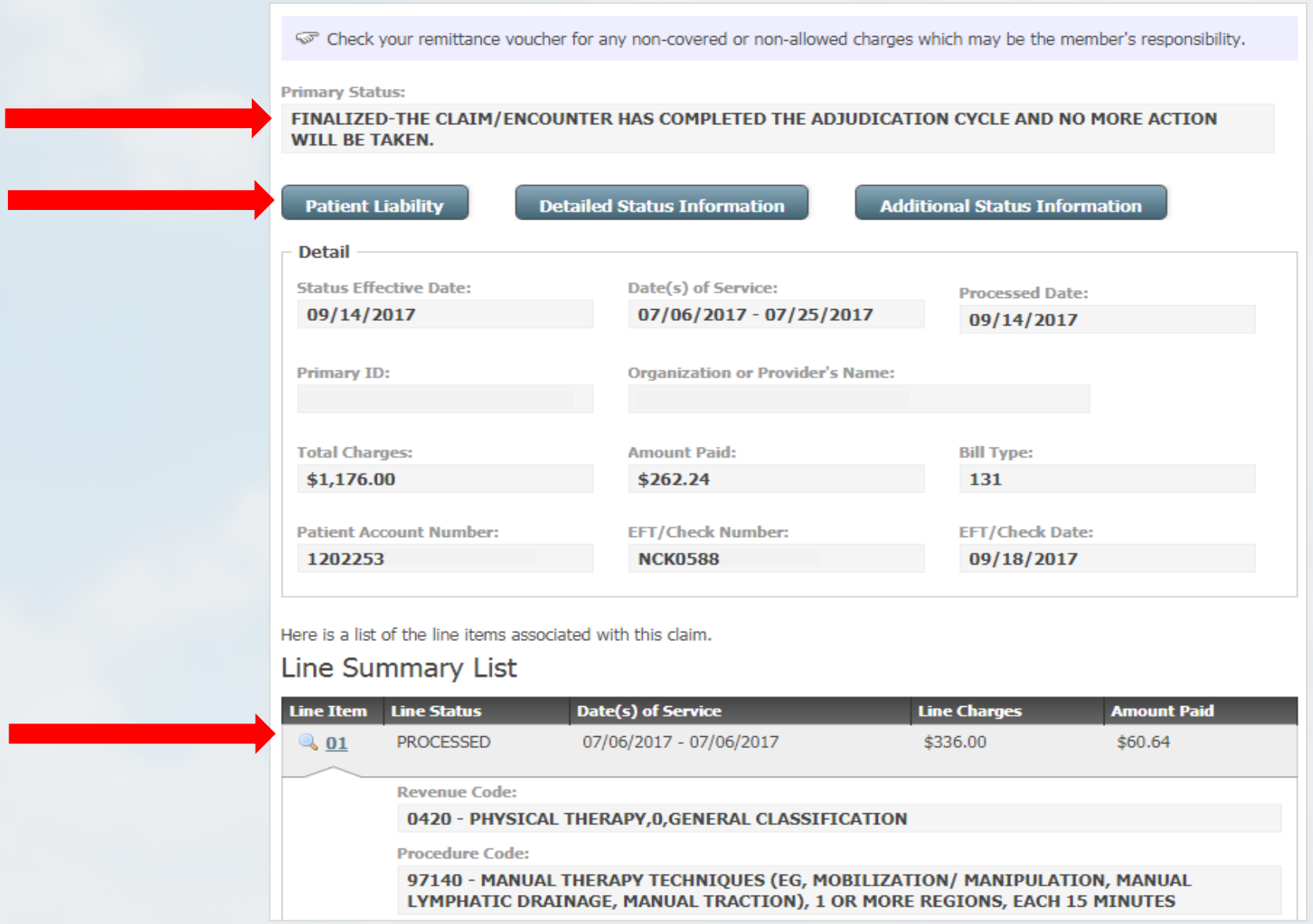
Claims Summary List *(click a column title to sort)*

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

My Insurance Manager

Claim Status

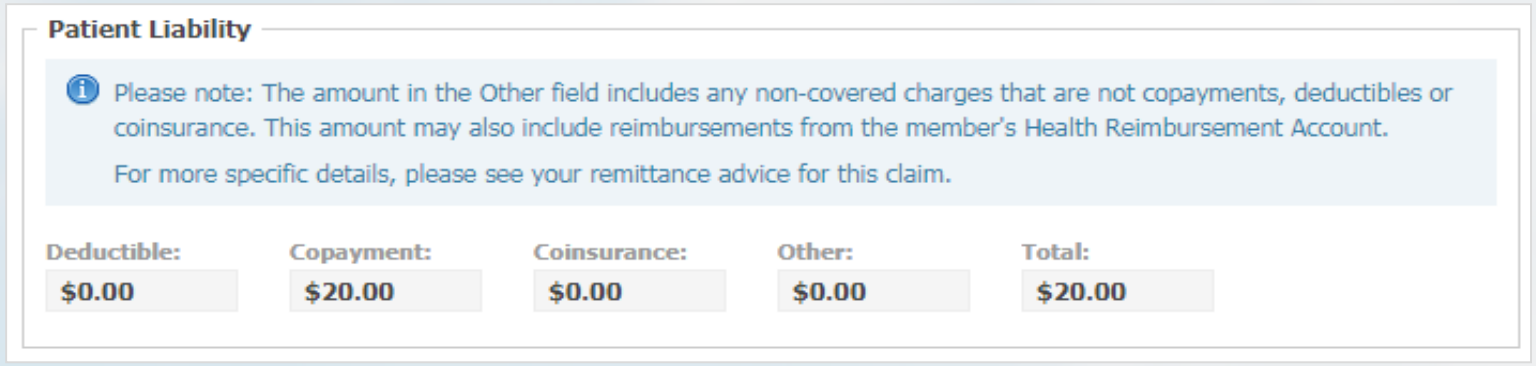
Detail

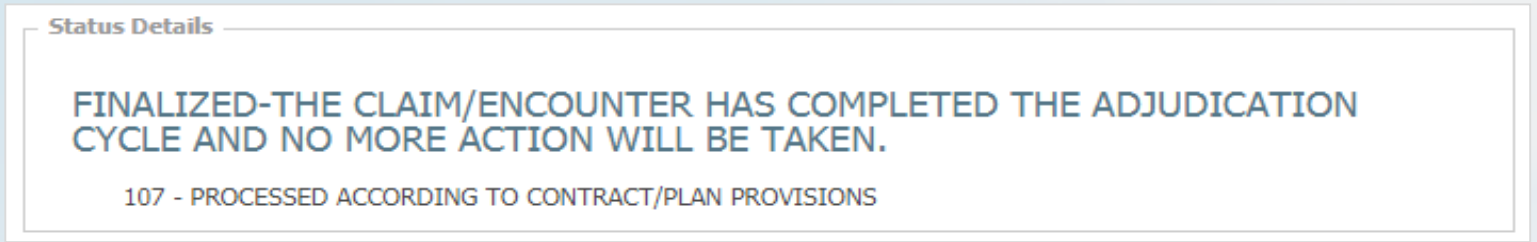


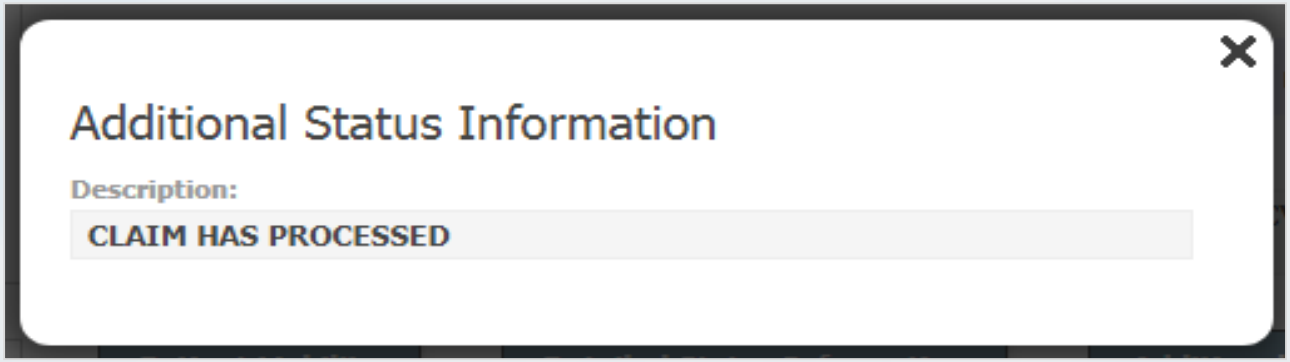
My Insurance Manager

Claim Status

Detail



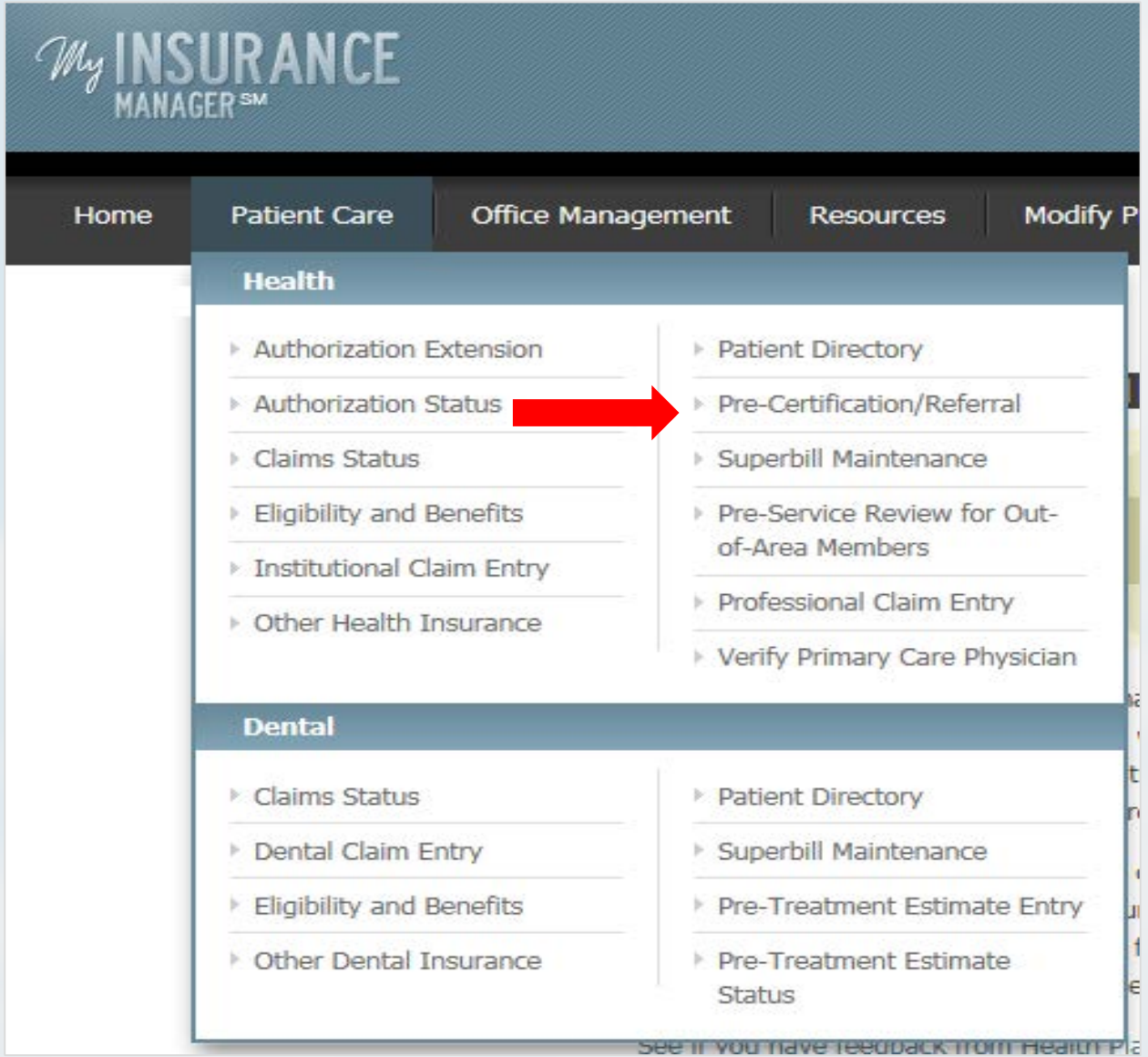




My Insurance Manager

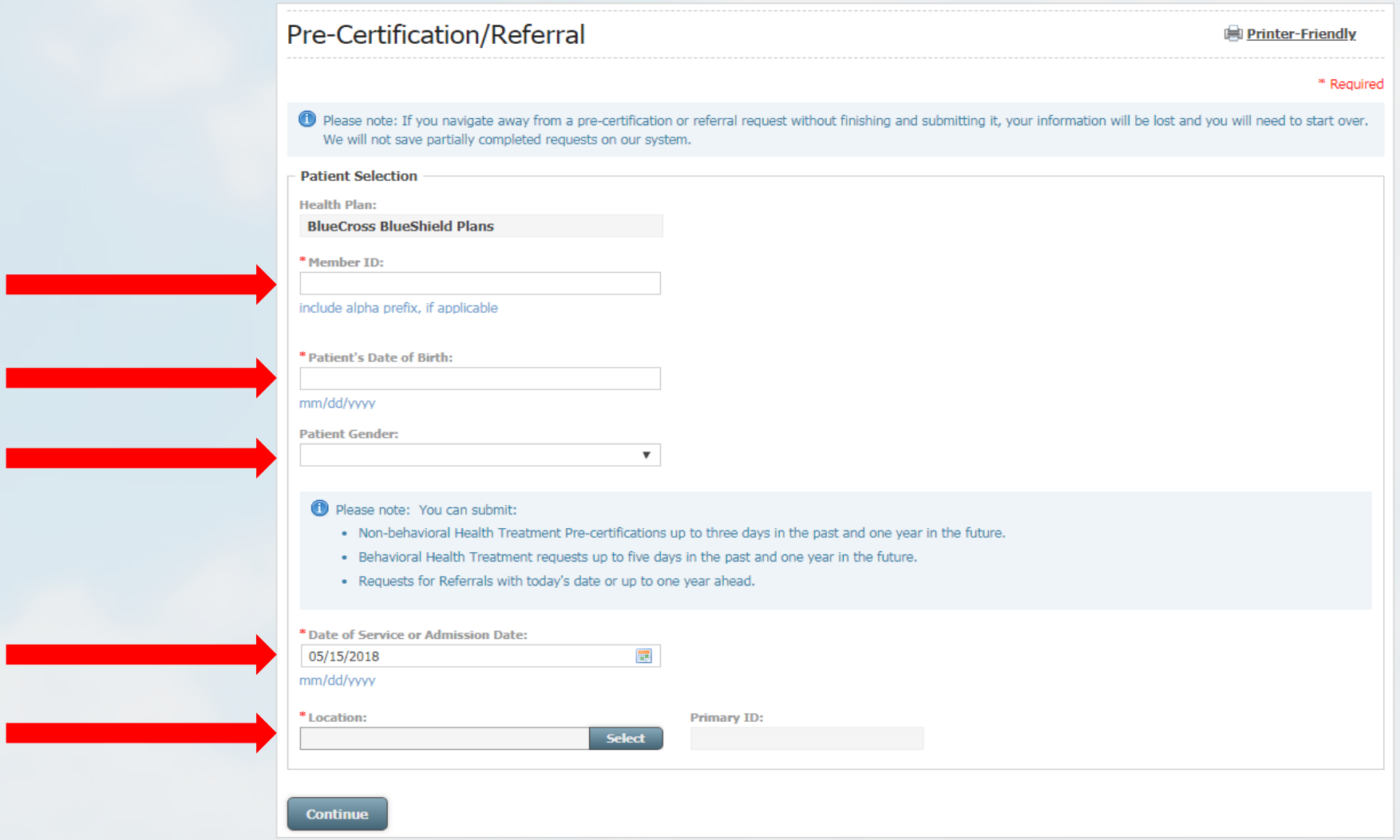
Precertification/Referral

- Fast-Track
- Customize
- Attach Clinical Documentation



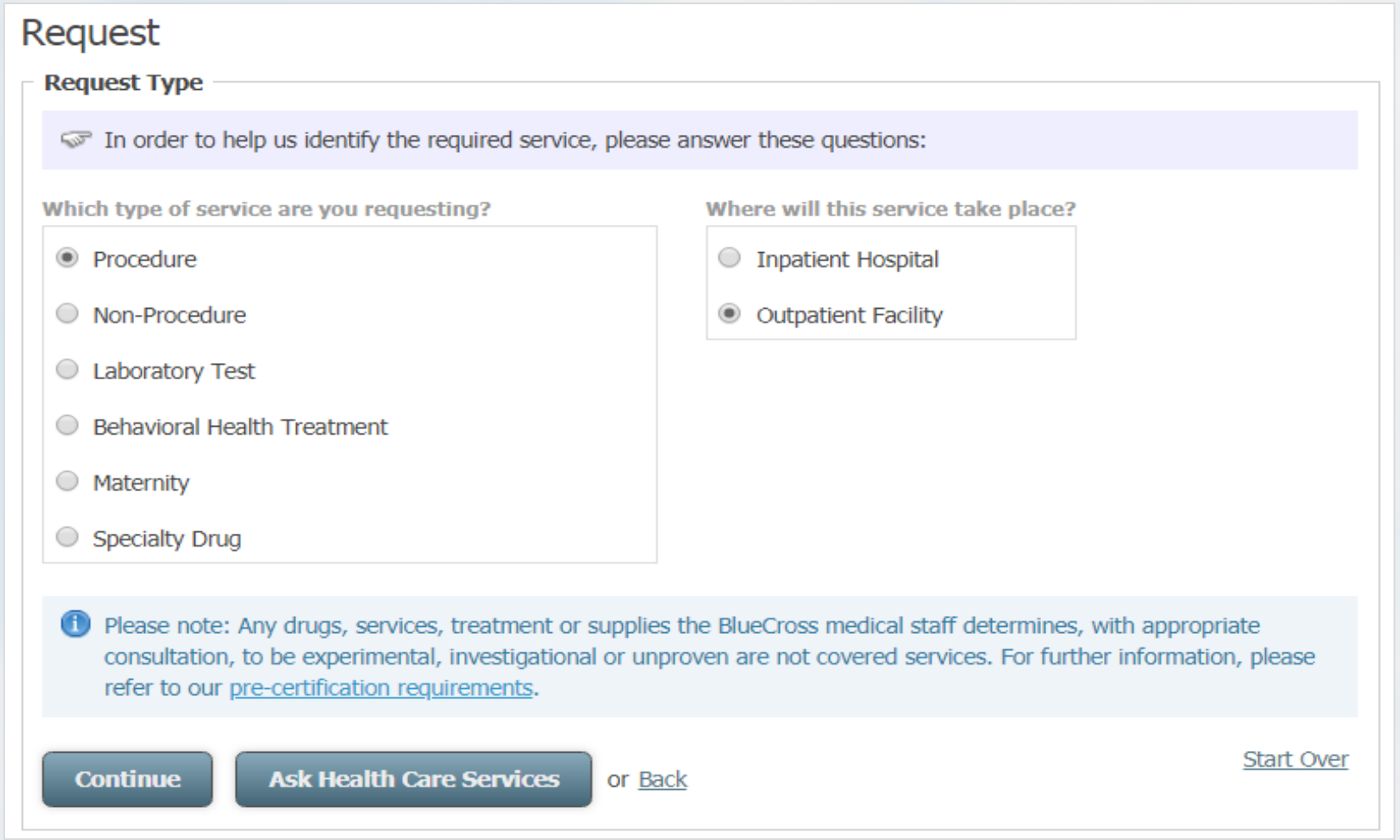
My Insurance Manager

Precertification/Referral



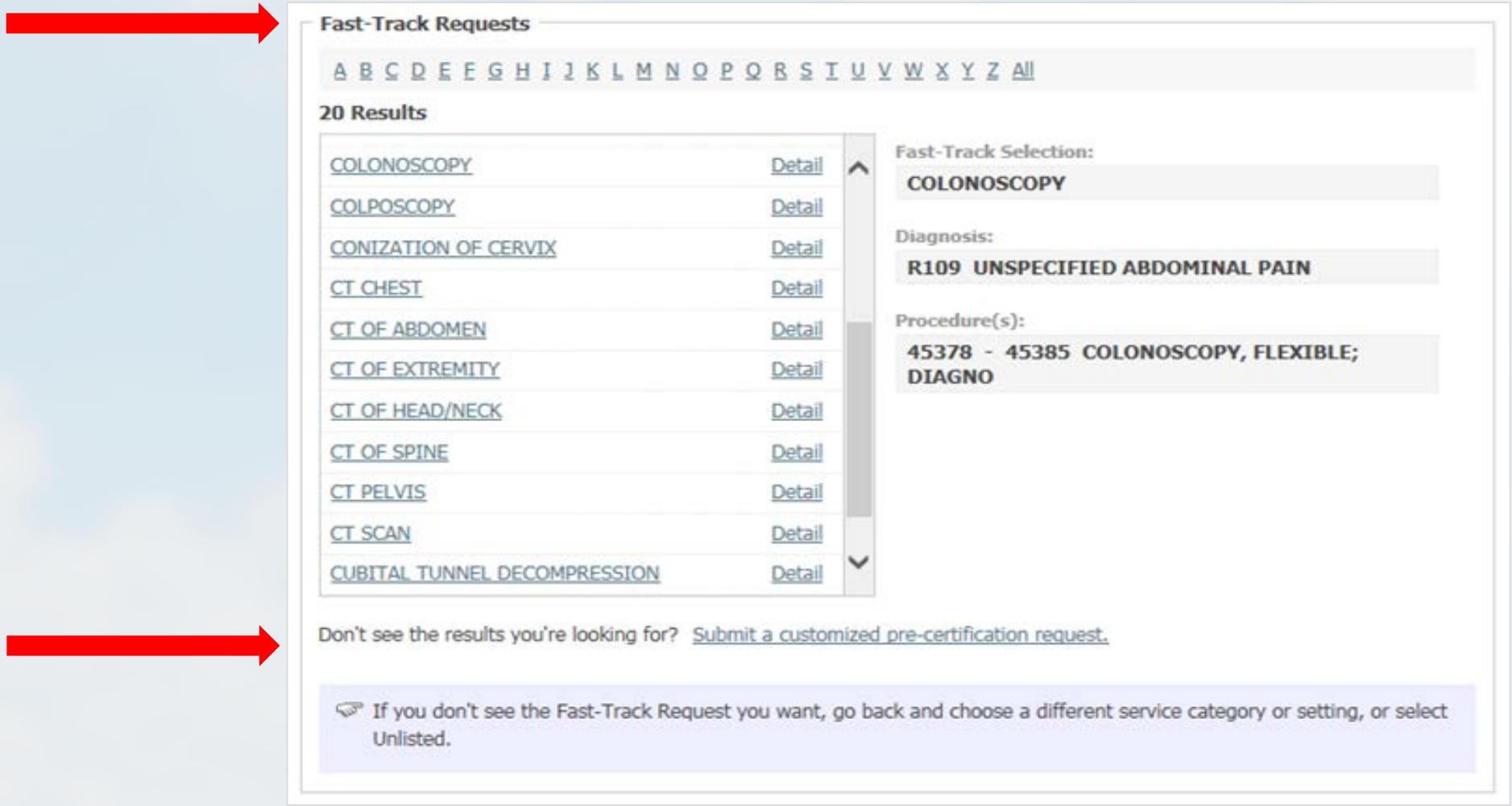
My Insurance Manager

Precertification/Referral



My Insurance Manager

Precertification/Referral



My Insurance Manager

Authorization Status

Authorization Status

Patient Selection

Please note: The Health Plan you choose must have your National Provider Identifier (NPI) registered on certification or referral process.

We will display behavioral health authorizations only to the rendering provider.

* **Health Plan:**
BlueCross BlueShield Plans

* **Member ID:**

include alpha prefix, if applicable

* **Patient's Date of Birth:**

mm/dd/yyyy

* **Location:** Select

Primary ID:

Continue

Advanced Search

All Authorizations

- (•) All Available Dates
- ( ) Specific Beginning Date ...
- ( ) Date Range ...

Update Results | Show All Authorizations | or New Search

Our records show these authorizations for the period you chose:

Partial Authorization Status List *(click a column title to sort)* Showing 3 Result(s)

Authorization Number	Status	Authorization Period	Healthcare Provider	Place of Service
1709431	APPROVED	04/03/2017 - 04/03/2017		OUTPATIENT HOSPITAL
1706731	APPROVED	03/08/2017 - 03/08/2017		OUTPATIENT HOSPITAL

We list authorization status records according to health plans. If your patient had a different health plan and you would like to see those records, please search under the previous health plan.

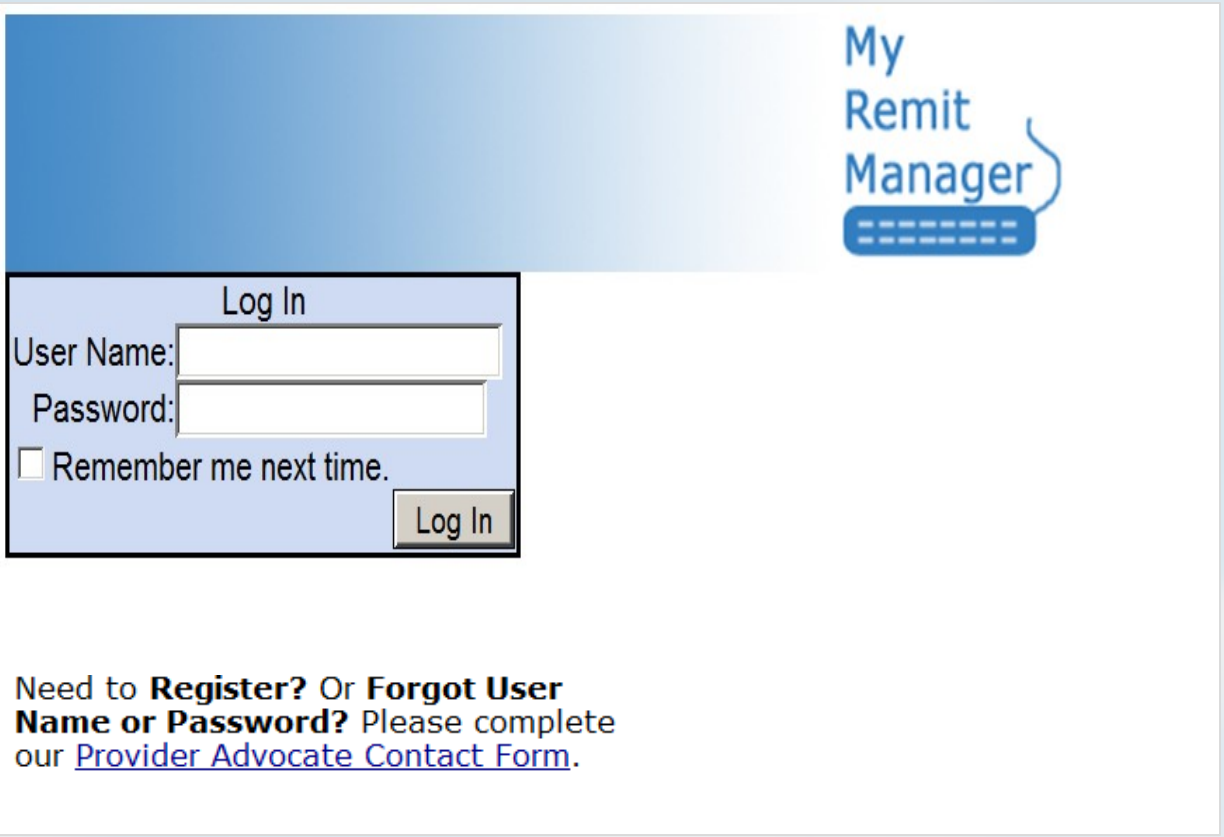
My Remit Manager

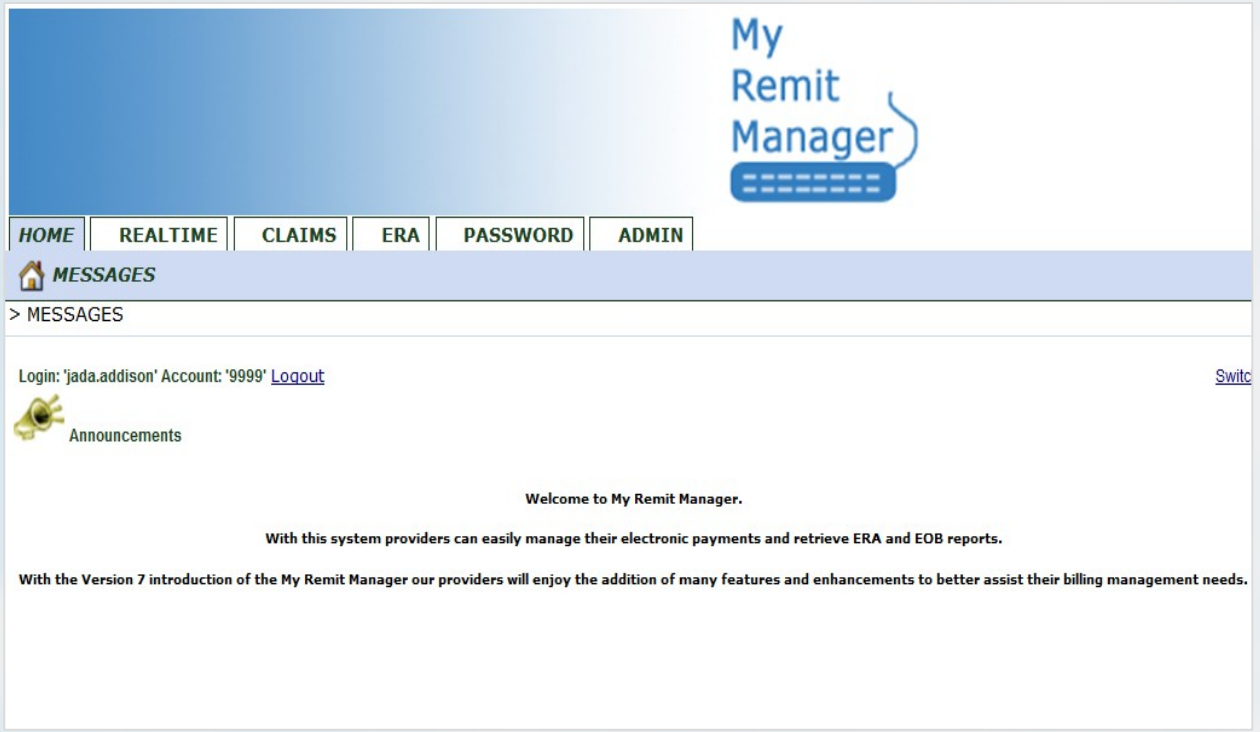
My Remit Manager

What You Can Do

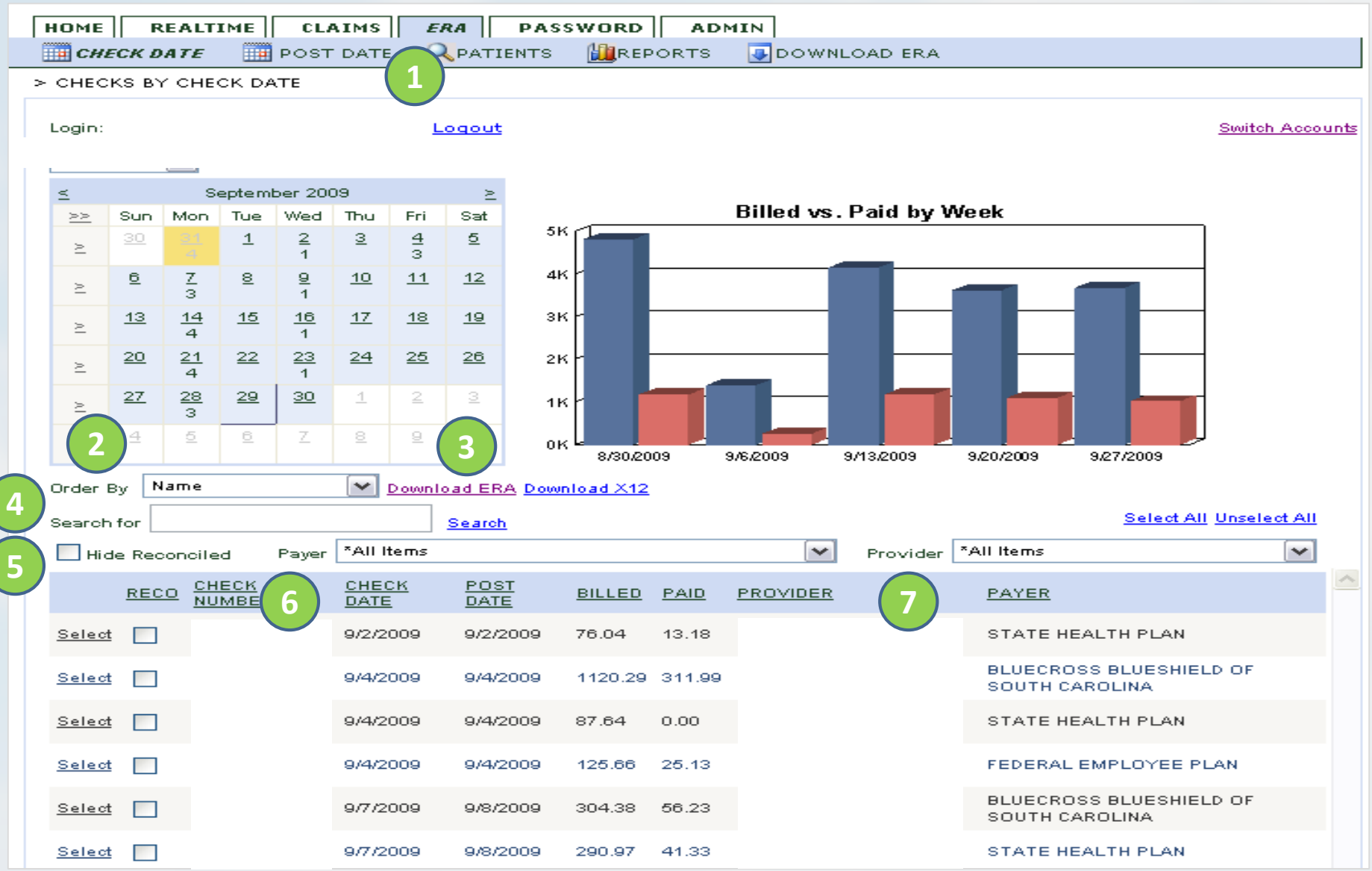
- Review electronic remittances in a HIPAA-compliant format
- Search remittances by patient, account number or check number
- Available to providers who receive payments electronically
- For access to My Remit Manager, please email provider.education@bcbssc.com or call our Provider Education voicemail line at 803-264-4730

My Remit Manager





My Remit Manager



My Remit Manager

ERA Patient Listing

CHECK/EFT: 000123 **CHECK DATE: 06/02/2008**

Account: POS: 22 HIC: ZC INC: 8D4945 Provider: 1598

Status: Processed as Primary

PreProv	ServDate	NOS	REV	Proc/Mods	Billed	Allowed	Deduct	Coins	RC-Amt	Paid		CAS Summary	
233	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

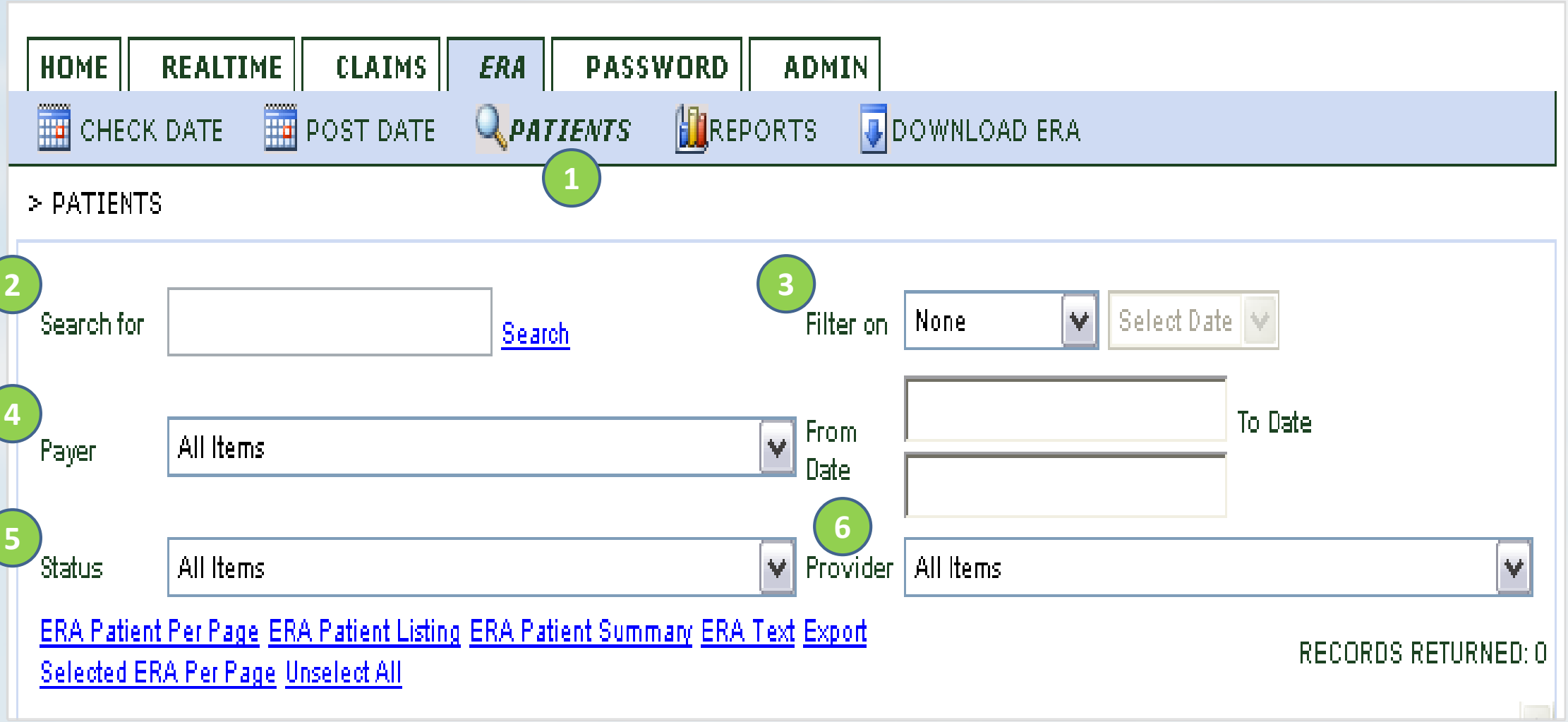
Denied/Non-Covered: 0.00

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).]

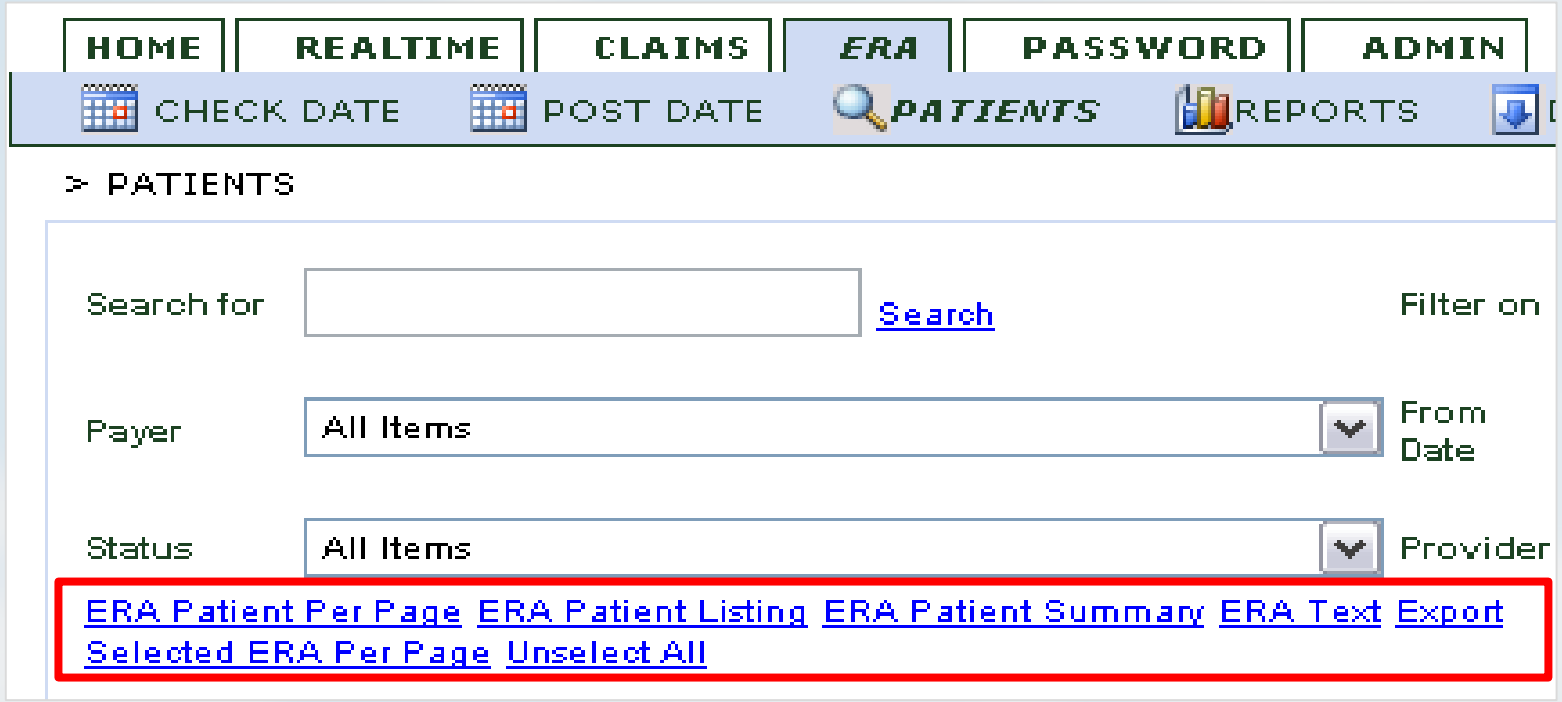
PR 2 32.38 [Coinsurance Amount]

* Denotes Denied Or Non-covered Charges

My Remit Manager



My Remit Manager



ERA Patient Per Page
Allows you to view each patient result on a separate page

ERA Patient Listing
Displays multiple patients on one page just like traditional remits

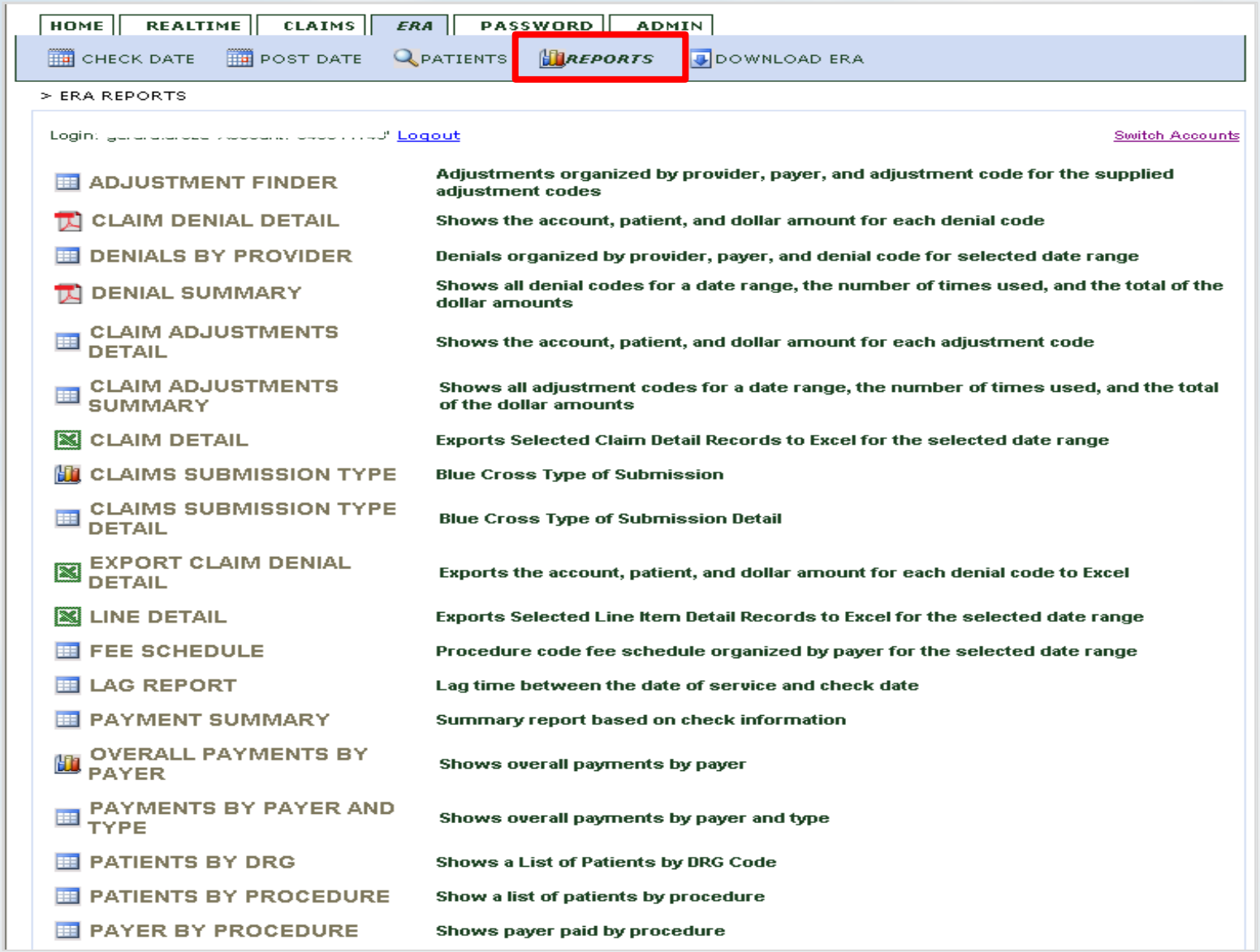
ERA Patient Summary
Displays payment information only without reason codes

ERA Text
Exports remit information into a text file instead of a PDF

Export Selected ERA Per Page
Exports only the patients that you have checked

Unselect All
Allows you to unselect all patients you have checked

My Remit Manager



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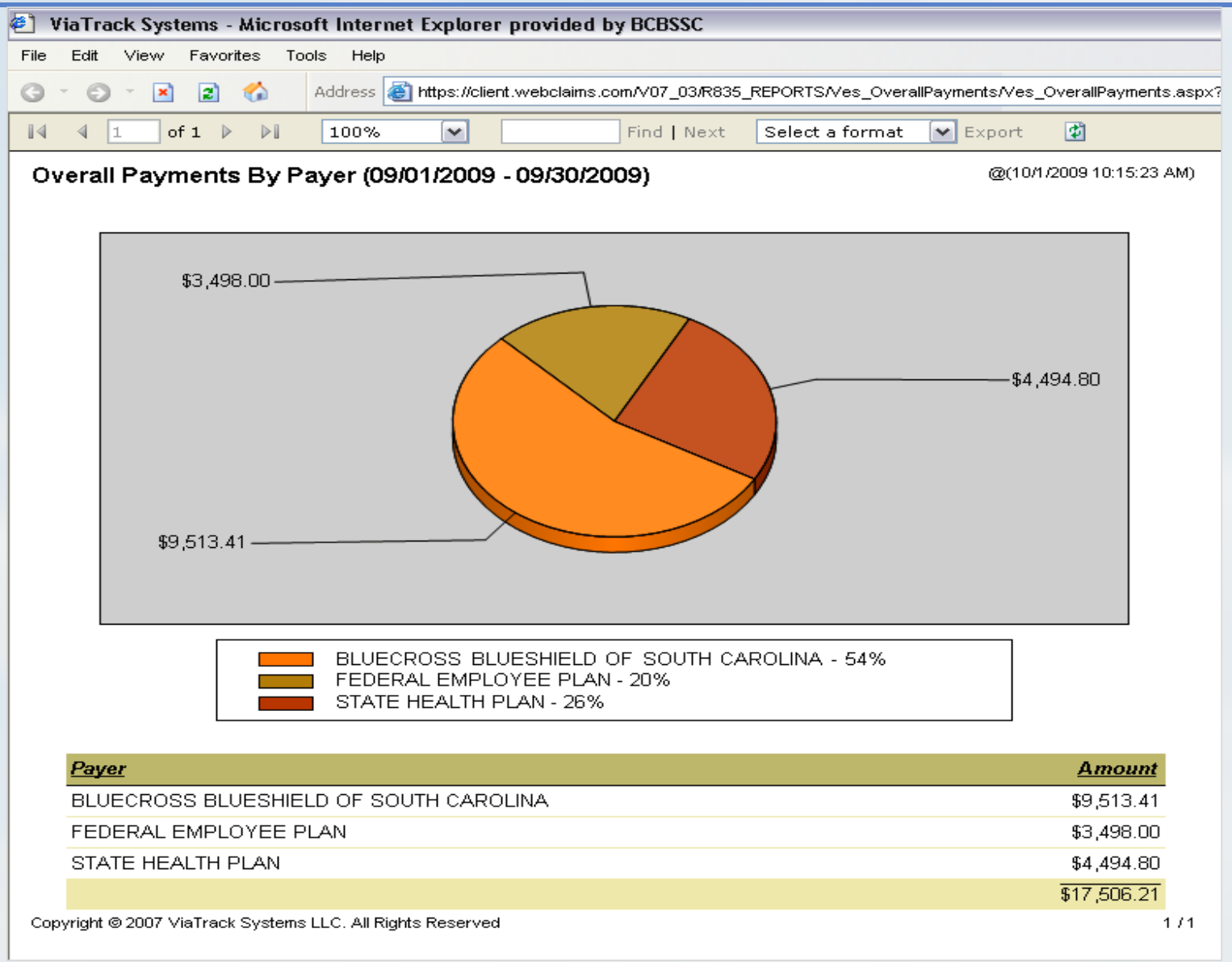

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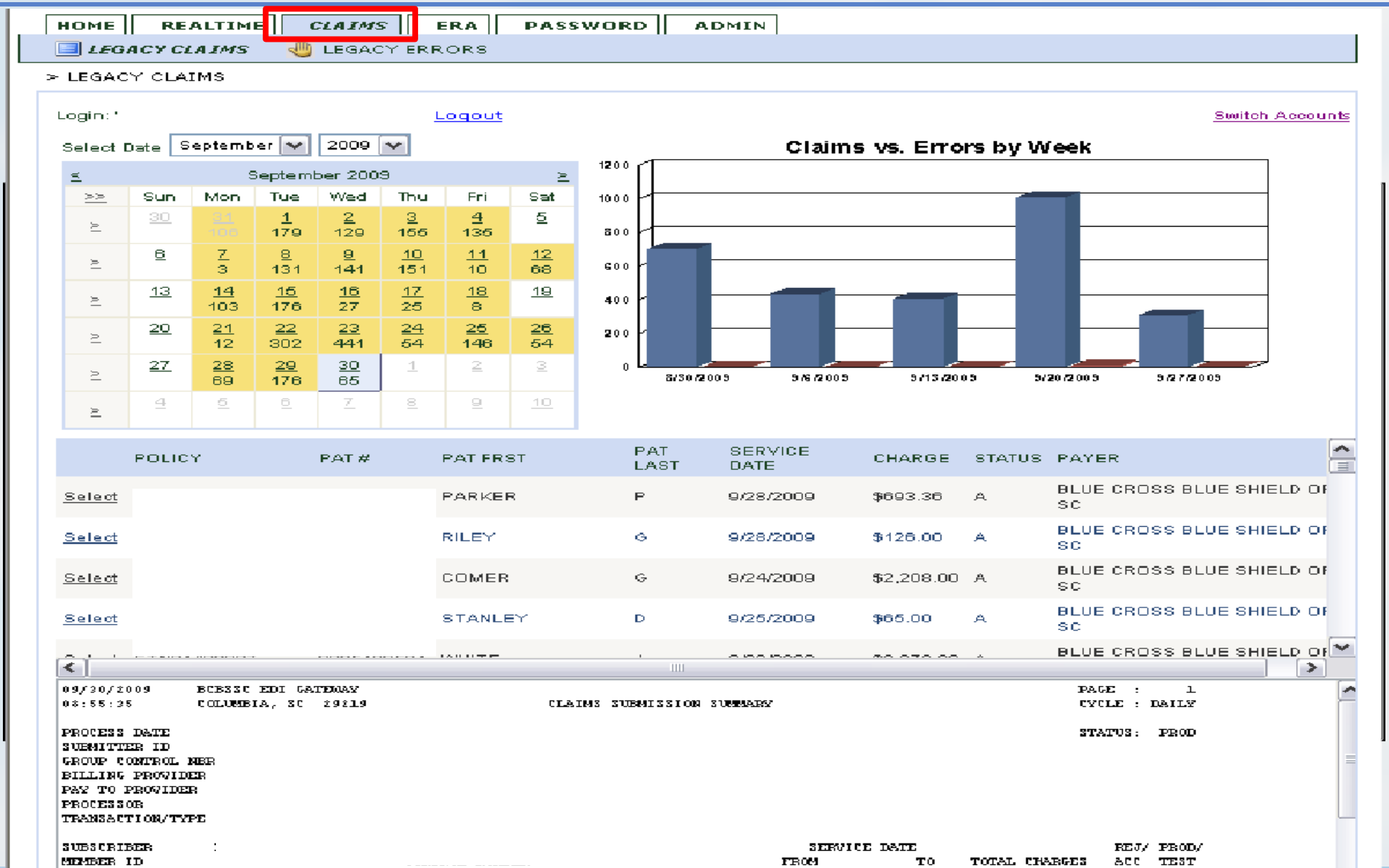
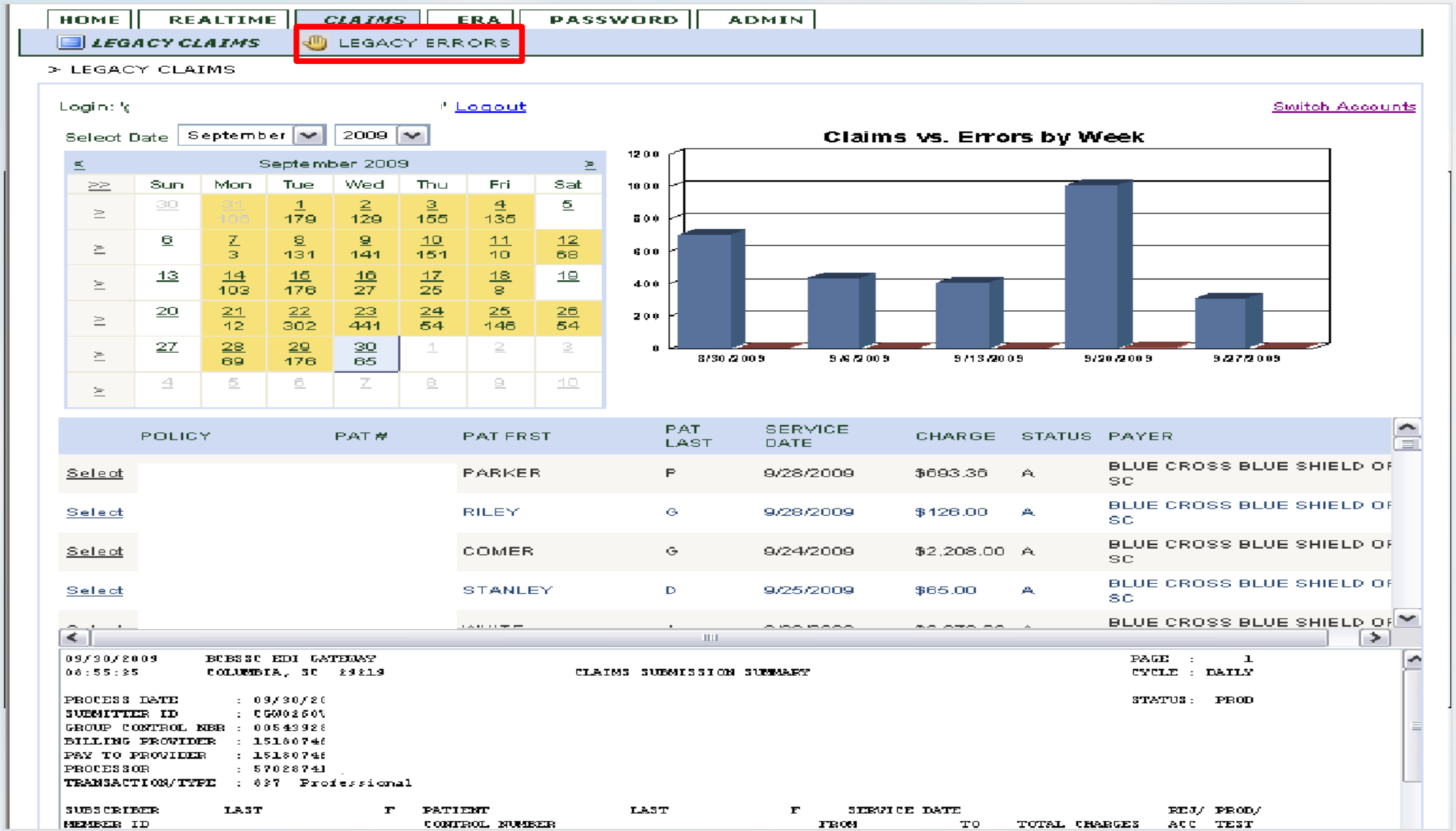


My Remit Manager



Additional Resources

Inquiry	Contact
Problems submitting claims electronically	EDI EDI.Services@bcbssc.com
Enroll practice or billing services as a recipient of electronic data	Electronic Data Interchange Gateway (EDIG) Edig.services@bcbssc.com
Receive EFT and ERA	Provider EFT Provider.eft@bcbssc.com
Reset password for encrypted emails, problems with StatChat functionality	Technology Support Center 855-229-5720
Technical problems with My Insurance Manager	Web Technology Support Center 800-868-2505
User Guides and Manuals	Tools and Resources www.SouthCarolinaBlues.com

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Benefits

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

Independent licensees of the Blue Cross and Blue Shield Association

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BlueChoice HealthPlan

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

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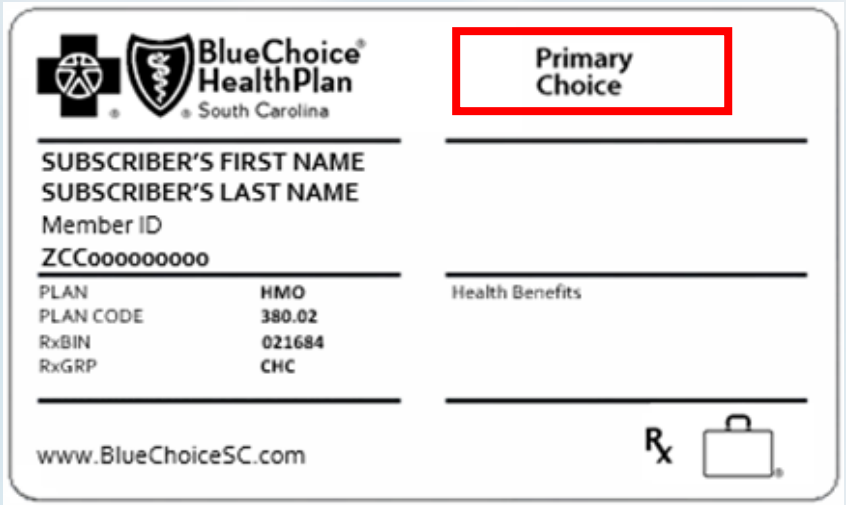
BlueChoice HealthPlan

Primary Choice – Prefix ZCC

BlueChoice HMO Network

Large Group HMO

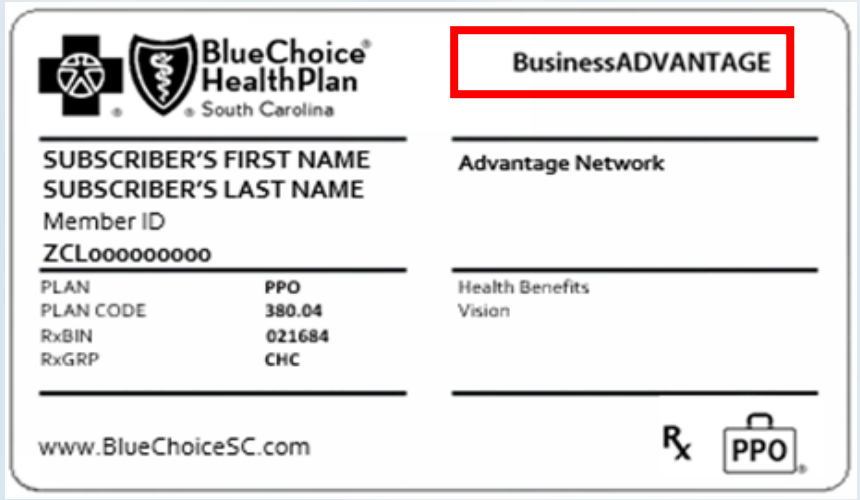


BlueChoice HealthPlan

BusinessADVANTAGE – Prefix ZCL

Advantage Network

Small Group


BlueChoice HealthPlan
South Carolina

BusinessADVANTAGE

SUBSCRIBER'S FIRST NAME
SUBSCRIBER'S LAST NAME
Member ID
ZCL000000000

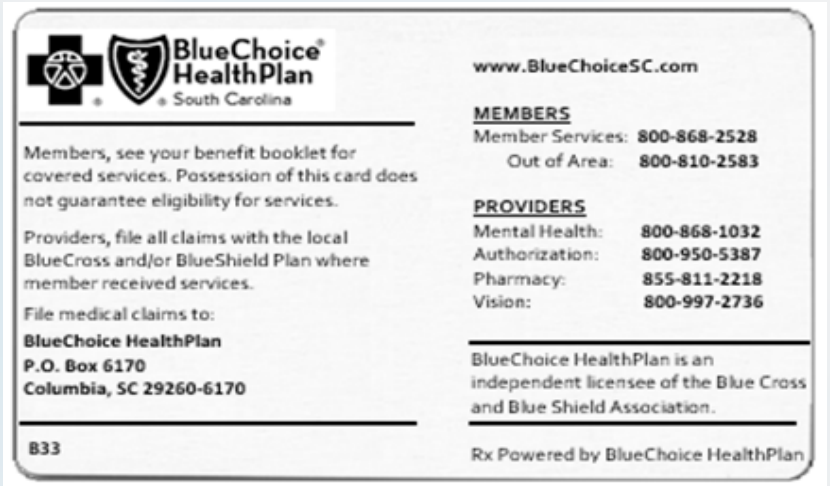
PLAN	PPO
PLAN CODE	380.04
RxBIN	021684
RxGRP	CHC

Advantage Network

Health Benefits
Vision

www.BlueChoiceSC.com

Rx PPO


BlueChoice HealthPlan
South Carolina

www.BlueChoiceSC.com

Members, see your benefit booklet for covered services. Possession of this card does not guarantee eligibility for services.

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

B33

MEMBERS
Member Services: 800-868-2528
Out of Area: 800-810-2583

PROVIDERS
Mental Health: 800-868-1032
Authorization: 800-950-5387
Pharmacy: 855-811-2218
Vision: 800-997-2736

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

Rx Powered by BlueChoice HealthPlan


BlueChoice HealthPlan
South Carolina

BusinessADVANTAGE

SUBSCRIBER'S FIRST NAME
SUBSCRIBER'S LAST NAME
Member ID
ZCL000000000

PLAN	PPO
PLAN CODE	380.04
RxBIN	021684
RxGRP	CHC

Advantage Network

Health Benefits
Vision
Comprehensive Dental

www.BlueChoiceSC.com

Rx PPO


BlueChoice HealthPlan
South Carolina

www.BlueChoiceSC.com

Members, see your benefit booklet for covered services. Possession of this card does not guarantee eligibility for services.
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

File SC dental claims to:
Columbia Service Center
P.O. Box 100300
Columbia, SC 29202-3300

B34

MEMBERS
Member Services: 800-868-2528
Out of Area: 800-810-2583

PROVIDERS
Mental Health: 800-868-1032
Pharmacy: 855-811-2218
Authorization: 800-950-5387
Vision: 800-997-2736
Dental Inquiries: 800-222-7156

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

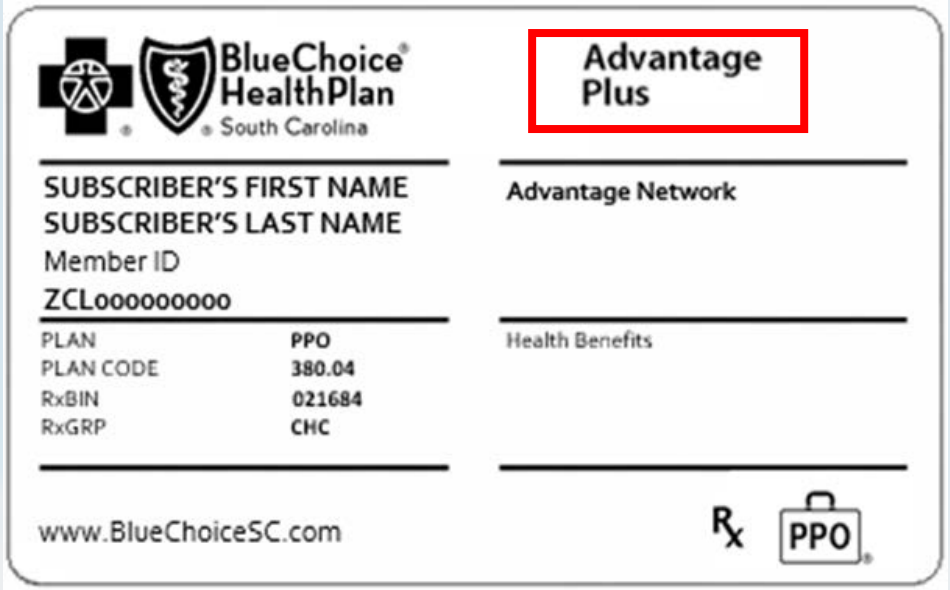
Rx Powered by BlueChoice HealthPlan

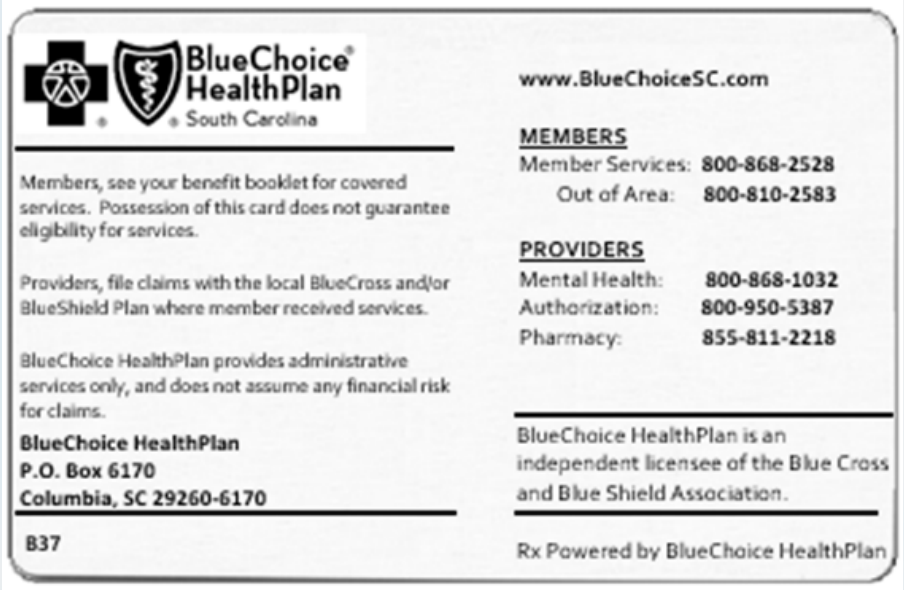
BlueChoice HealthPlan

Advantage Plus – Prefix ZCL

Advantage Network

Large Group

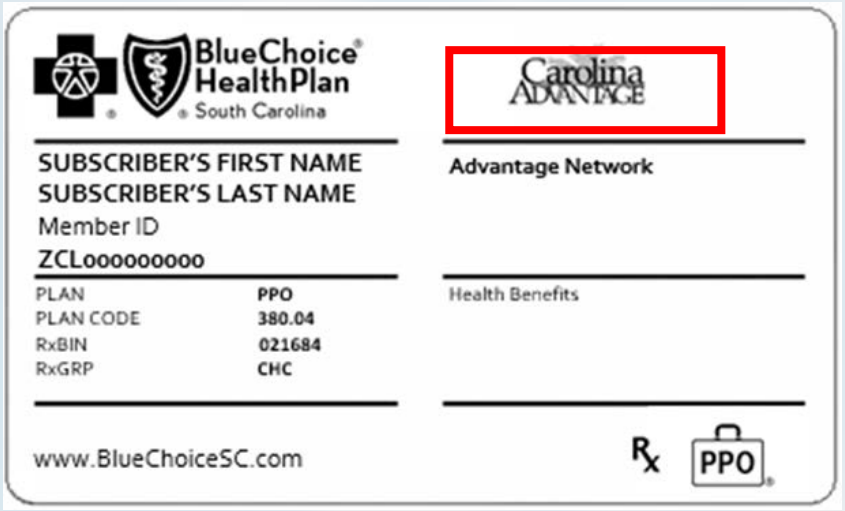


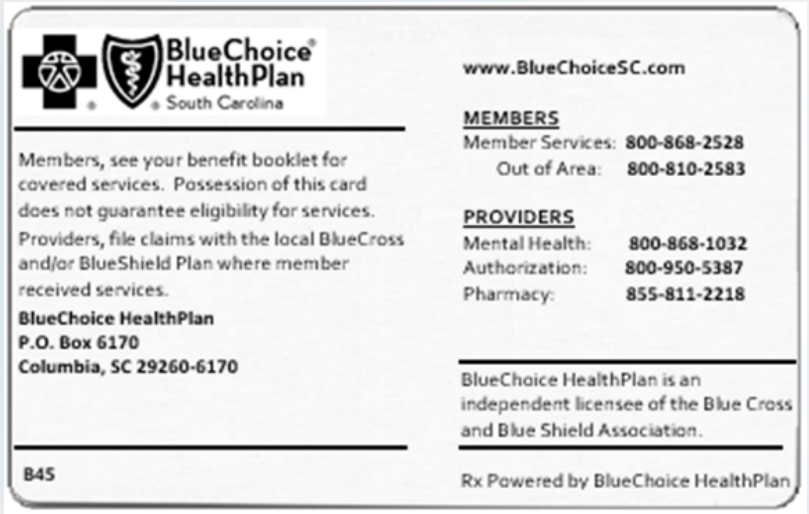


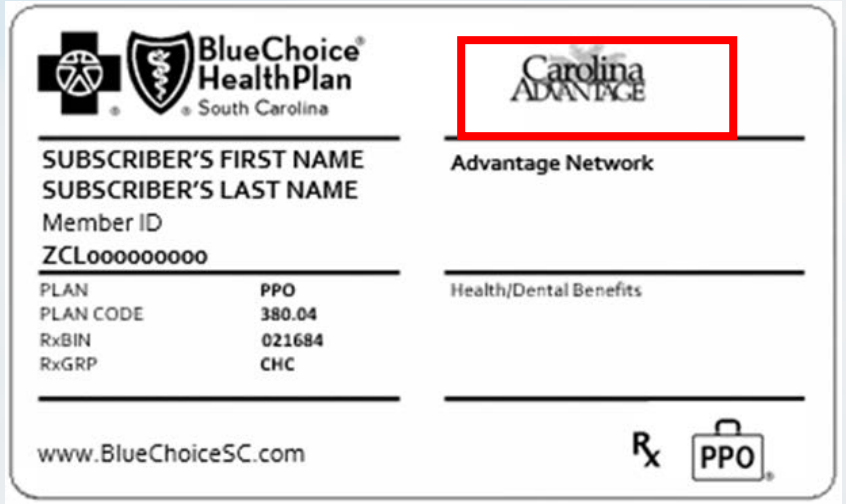
BlueChoice HealthPlan

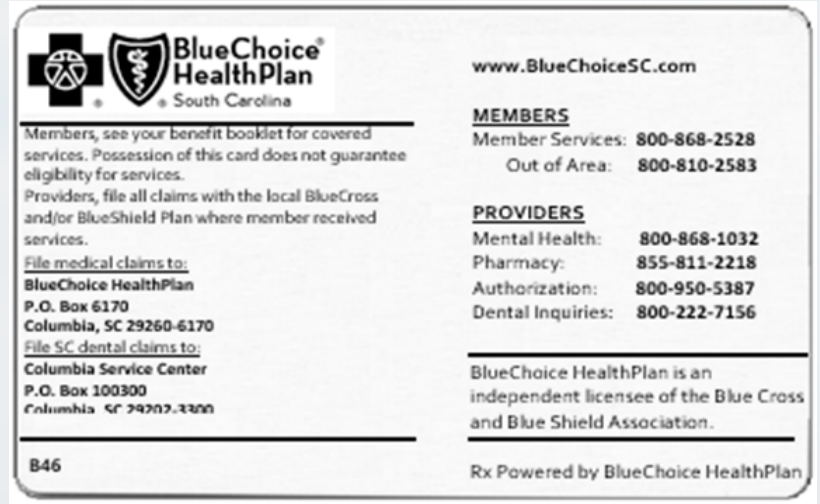
CarolinaADVANTAGE – Prefix ZCL

BlueChoice Network







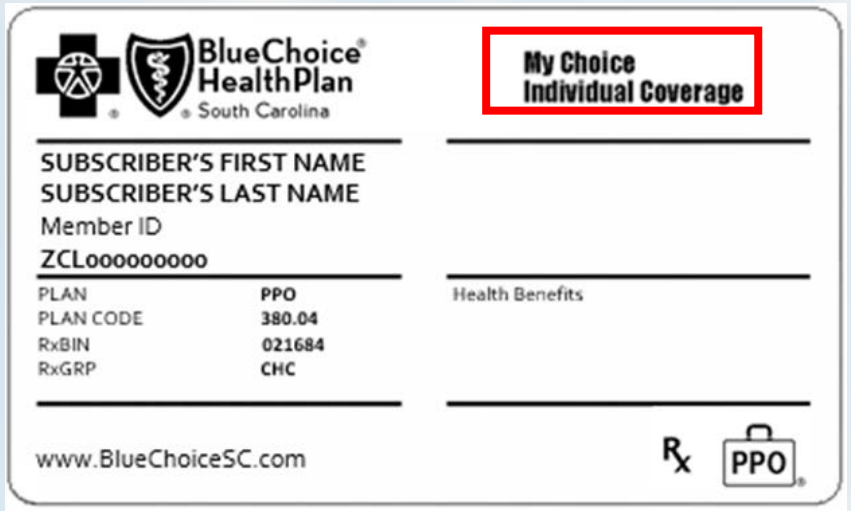


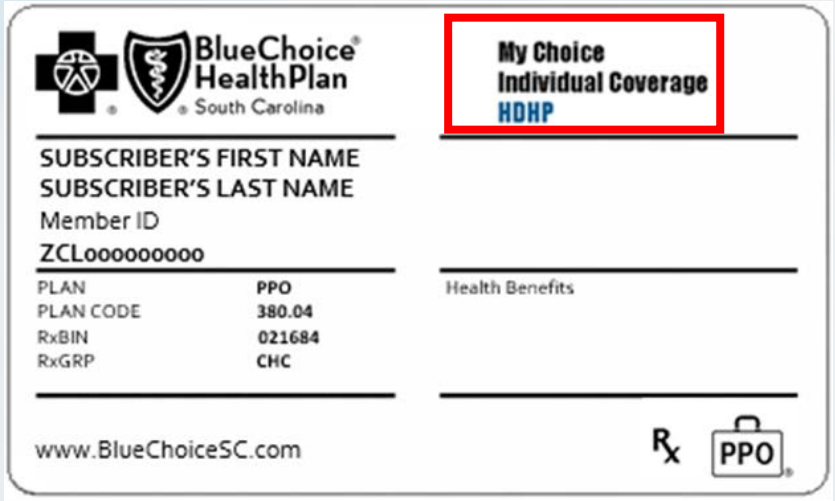
BlueChoice HealthPlan

My Choice Individual/HDHP – Prefix ZCL

Advantage Network

Small Group

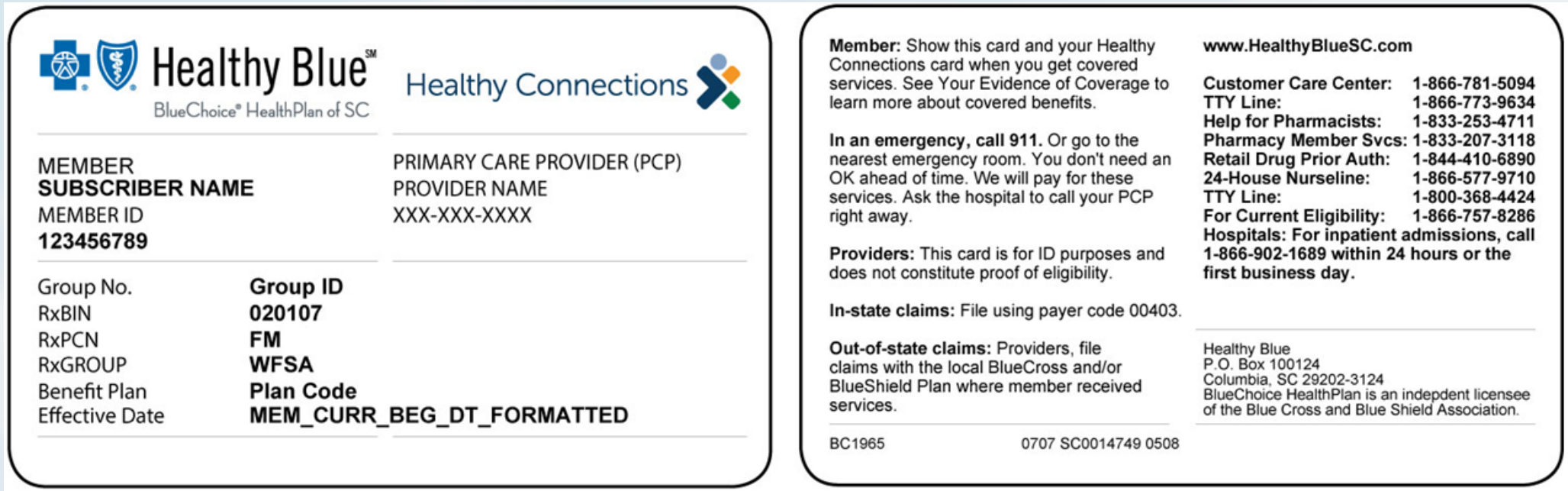




BlueChoice HealthPlan

Healthy Blue℠ – Prefix ZCD

Medicaid Network



Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

MEMBER
SUBSCRIBER NAME
MEMBER ID
123456789

PRIMARY CARE PROVIDER (PCP)
PROVIDER NAME
XXX-XXX-XXXX

Group No.	**Group ID**
RxBIN	**020107**
RxPCN	**FM**
RxGROUP	**WFSA**
Benefit Plan	**Plan Code**
Effective Date	**MEM_CURR_BEG_DT_FORMATTED**

Member: Show this card and your Healthy Connections card when you get covered services. See Your Evidence of Coverage to learn more about covered benefits.

In an emergency, call 911. Or go to the nearest emergency room. You don't need an OK ahead of time. We will pay for these services. Ask the hospital to call your PCP right away.

Providers: This card is for ID purposes and does not constitute proof of eligibility.

In-state claims: File using payer code 00403.

Out-of-state claims: Providers, file claims with the local BlueCross and/or BlueShield Plan where member received services.

BC1965 0707 SC0014749 0508

www.HealthyBlueSC.com

Customer Care Center:	**1-866-781-5094**
TTY Line:	**1-866-773-9634**
Help for Pharmacists:	**1-833-253-4711**
Pharmacy Member Svcs:	**1-833-207-3118**
Retail Drug Prior Auth:	**1-844-410-6890**
24-House Nurseline:	**1-866-577-9710**
TTY Line:	**1-800-368-4424**
For Current Eligibility:	**1-866-757-8286**

Hospitals: For inpatient admissions, call 1-866-902-1689 within 24 hours or the first business day.

Healthy Blue
P.O. Box 100124
Columbia, SC 29202-3124
BlueChoice HealthPlan is an indepdent licensee of the Blue Cross and Blue Shield Association.

Visit www.HealthyBlueSC.com.

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BlueCard® Program

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

Independent licensees of the Blue Cross and Blue Shield Association

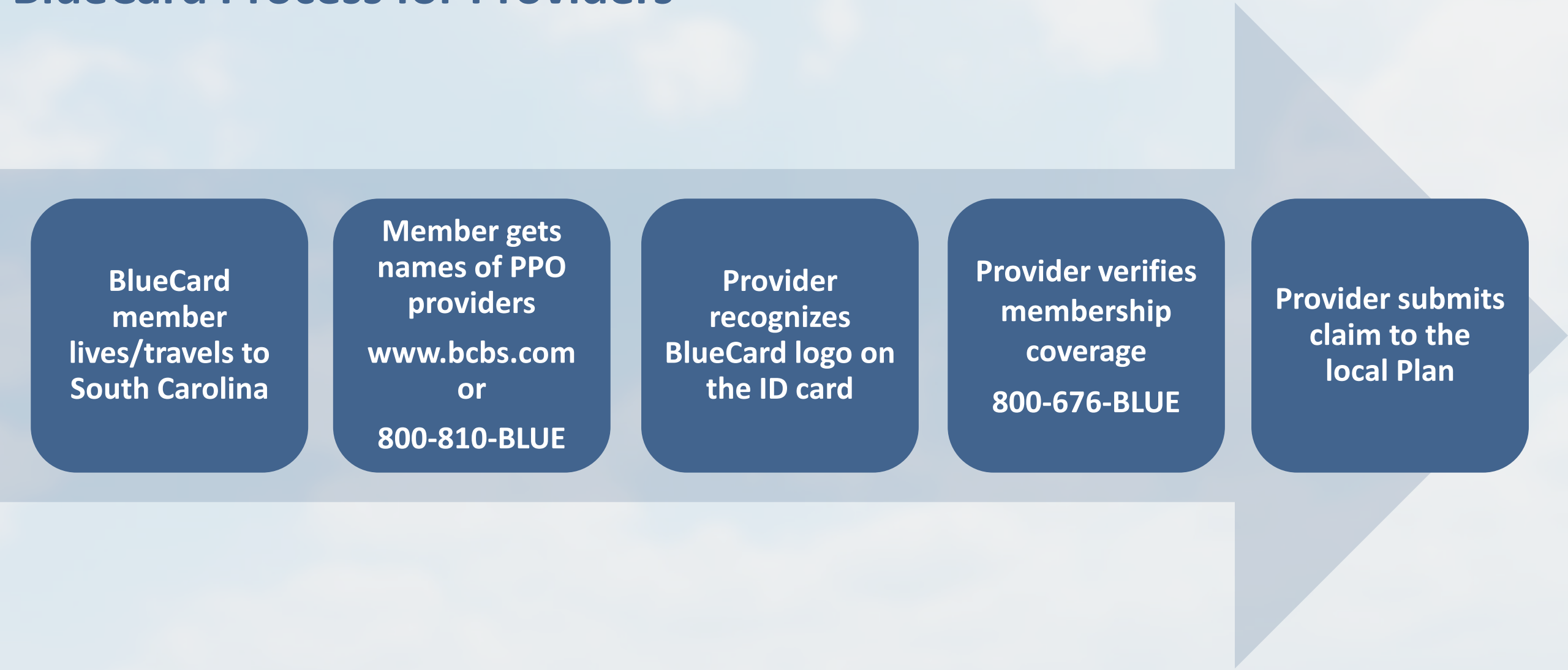
BlueCard Program

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 providers submit claims for other Blue Plan members directly to BlueCross BlueShield of South Carolina Plan for processing.
- BlueCross is your point of contact for education, contracting, claims payment/adjustments and problem resolution.

BlueCard Program

BlueCard Process for Providers



BlueCard Program

Home Plan

- Responsibilities to member:
  - Adjudicate claims based on member eligibility and contractual benefits
  - Utilization Review
  - Member inquiries and education
  - Send member explanation of benefits

Host Plan

- Responsibilities to provider:
  - Point of contact for claims inquiries and education
  - Forward clean claims to the Home Plan for processing
  - Apply pricing and reimbursement to claims
  - Send provider remittances

BlueCard Program

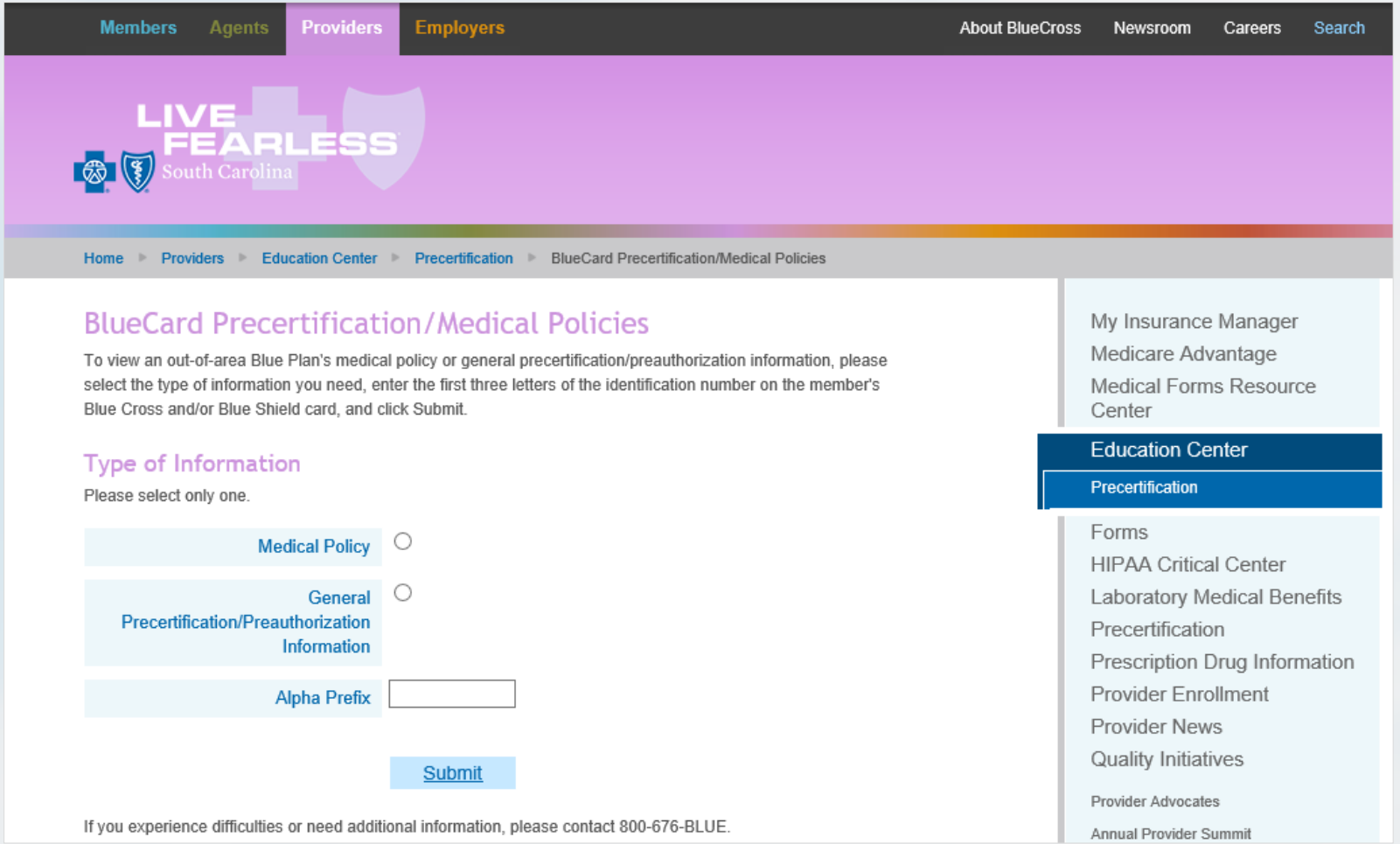
Ancillary Filing Guidelines

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

BlueCard Program

Electronic Provider Access

- Access out-of-area Blue Plan's provider portals to view:
  - Prior authorization information
  - Medical policies
- Enter the member's prefix from the member ID card



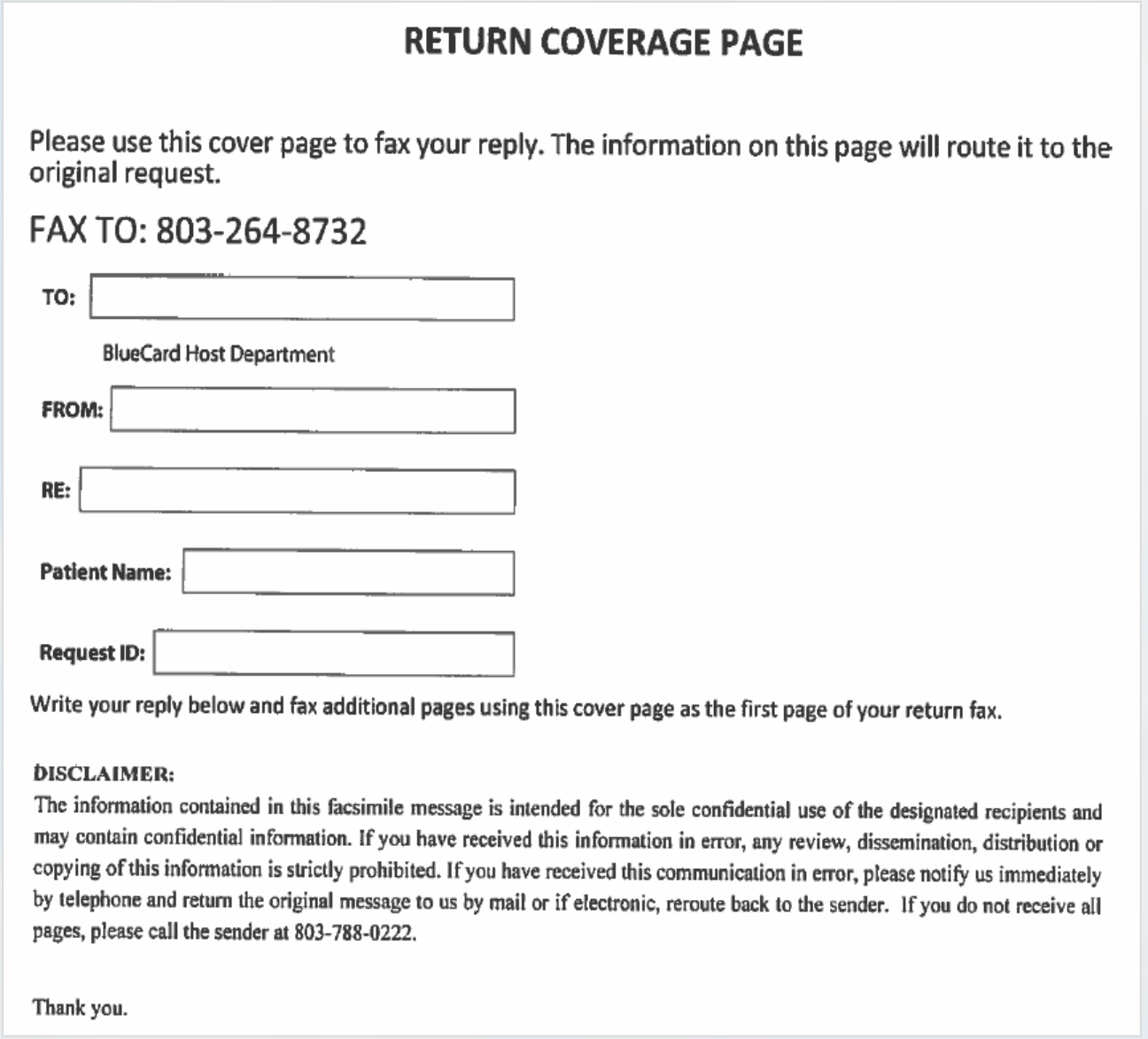
www.SouthCarolinaBlues.com and www.BlueChoiceSC.com

BlueCard Program

Medical Record Requests

- Submit the Return Coverage page with the medical records.
- Forward all medical records within 20 days from the receipt date of the request.
- Send the specified requested records or the name of the provider that may have the records.

Important: Submission of medical records is a non-billable event.



RETURN COVERAGE PAGE

Please use this cover page to fax your reply. The information on this page will route it to the original request.

FAX TO: 803-264-8732

TO: _____

BlueCard Host Department

FROM: _____

RE: _____

Patient Name: _____

Request ID: _____

Write your reply below and fax additional pages using this cover page as the first page of your return fax.

DISCLAIMER:

The information contained in this facsimile message is intended for the sole confidential use of the designated recipients and may contain confidential information. If you have received this information in error, any review, dissemination, distribution or copying of this information is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us by mail or if electronic, reroute back to the sender. If you do not receive all pages, please call the sender at 803-788-0222.

Thank you.

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South Carolina Plan Reminders

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

Independent licensees of the Blue Cross and Blue Shield Association

SC Plan Reminders

Rendering National Provider Identifier (NPI)

- Report the rendering provider NPI on all claims.

Prefix Changes

- As of April 15, 2018, all Blue Plans and providers must be able to accept a prefix that includes a combination of alpha and numeric characters.
- ID cards are for identification purposes only; they do not guarantee eligibility or payment of the claim.

Medical Records

- Submission of medical records is a non-billable event.

SC Plan Reminders

National Drug Code (NDC)

- Use the appropriate NDC for all administered drug claims with the corresponding J-codes on institutional outpatient and professional claim.
- When submitting NDCs on professional electronic and paper (CMS-1500) claims include:

11-digit NDC	NDC Qualifier (N4)	NDC Quantity	NDC Unit of Measure

Colonoscopies

- Routine procedure and diagnosis codes
  - The following claims must be filed as preventive to pay appropriately:
    - Anesthesia
    - Facility
    - Professional
  - Use the modifier 33 with specific surgical codes to identify the procedure as preventive
    - See CAM 089 for more information

SC Plan Reminders

Mid-level Practitioners

- 2019 Provider Office Administrative Manual: 1.6.2 Certifying Mid-Level Practitioners
  - Physician Assistants (PAs): BlueCross credentials PAs. PAs can choose to file claims for services they provide in the office under their NPI once they have credentialed with the plan; **OR** they can bill under the supervising doctor's NPI.
  - Nurse Practitioners (NPs): If an NP has not been credentialed by BlueCross, they must bill under the supervising doctor's NPI. If an NP has been credentialed with BlueCross, they can bill for services under their NPI; **OR** under the supervising doctor's NPI.

SC Plan Reminders

Care Management Program

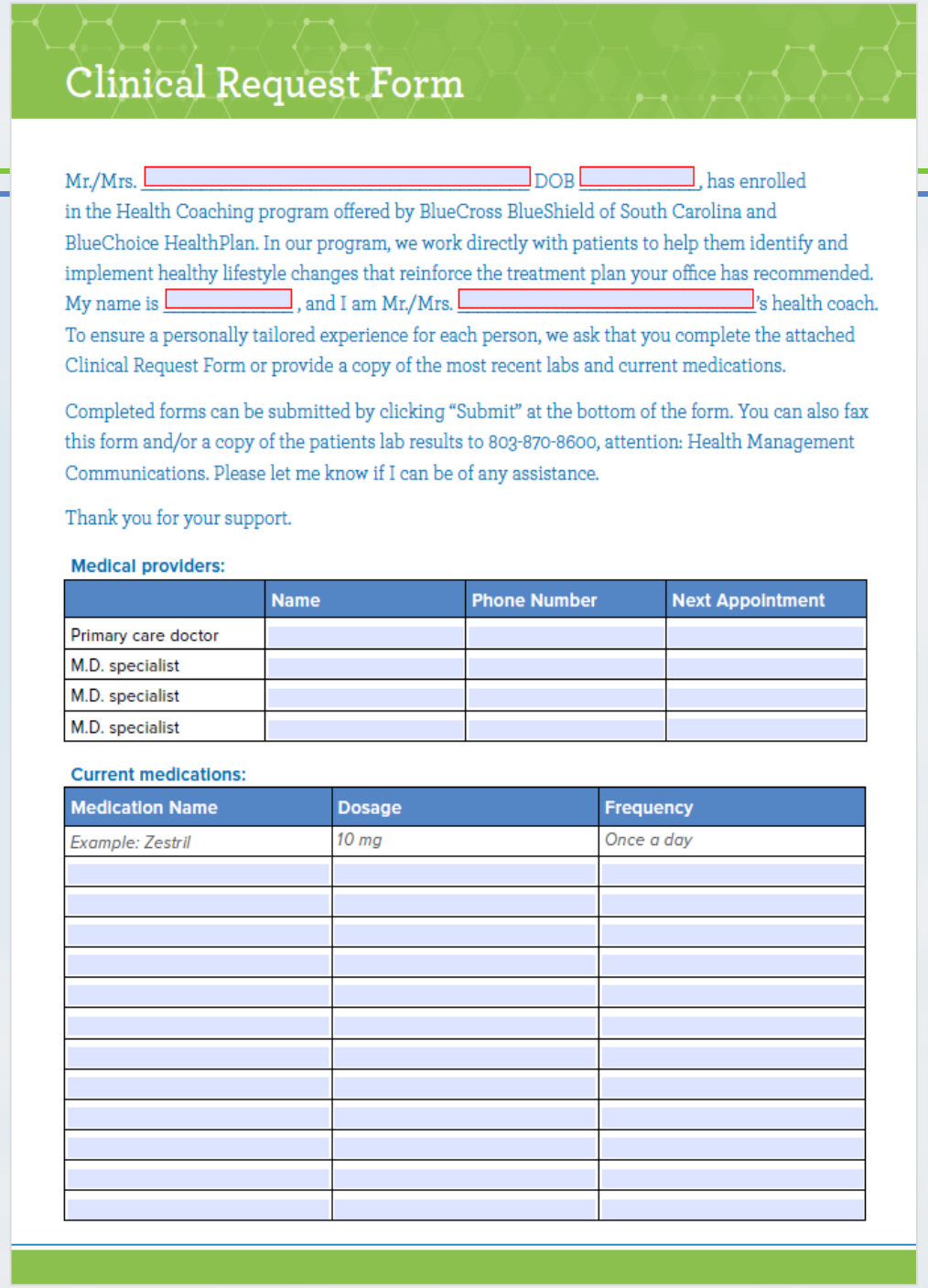
- Collaborate with providers to collect information to provide comprehensive coaching
- Coaching is offered for:
  - Disease Management
  - Behavioral Health
  - Healthy Lifestyles

SC Plan Reminders

Care Management Program (cont'd)

- Health coaches use this form to:
  - Reinforce importance of medication adherence and lab results
  - Tailor coaching to initial baseline and future updates
  - Recognize improvement over time
- Let's work together:
  - Complete the form and provide a copy of the most recent labs and medications
  - Fax form to 803-870-8600

Releasing this information to insurance companies is protected by HIPAA through Treatment, Payment and Healthcare Operations (TPO) provision.



Clinical Request Form

Mr./Mrs. _____ DOB _____, has enrolled in the Health Coaching program offered by BlueCross BlueShield of South Carolina and BlueChoice HealthPlan. In our program, we work directly with patients to help them identify and implement healthy lifestyle changes that reinforce the treatment plan your office has recommended. My name is _____, and I am Mr./Mrs. _____'s health coach. To ensure a personally tailored experience for each person, we ask that you complete the attached Clinical Request Form or provide a copy of the most recent labs and current medications.

Completed forms can be submitted by clicking "Submit" at the bottom of the form. You can also fax this form and/or a copy of the patients lab results to 803-870-8600, attention: Health Management Communications. Please let me know if I can be of any assistance.

Thank you for your support.

Medical providers:

	Name	Phone Number	Next Appointment
Primary care doctor			
M.D. specialist			
M.D. specialist			
M.D. specialist			

Current medications:

Medication Name	Dosage	Frequency
Example: Zestril	*10 mg*	*Once a day*

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THANK YOU

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