2017 Year in Review

BlueNews℠

for Providers

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

Independent licensees of the Blue Cross and Blue Shield Association

Provider Relations and Education

Laboratory Medical Policy Edits

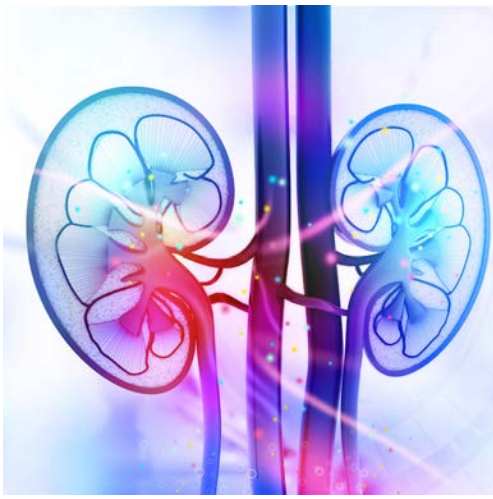
Avalon Healthcare Solutions administers laboratory benefits management services to promote patient access to affordable, high-quality health care. Avalon is an independent company that provides a comprehensive suite of laboratory benefit management services on behalf of BlueCross BlueShield of South Carolina and BlueChoice HealthPlan. As a reminder, as of Jan. 1, 2017, laboratory services done in a physician's office (place of service 11) that do not meet medical policy criteria may be denied.

Multiple education opportunities were offered to prepare for this initiative, including group meetings, news bulletins, webinars and presentations by Avalon at our year-end benefit update meetings. We recommend that you begin using the Avalon Trial Claim Tool to become familiar with the requirements for laboratory tests (example: frequency limitations, gender limitations, units, etc.) to avoid future denials. Log in to My Insurance Manager℠, select Resources, then under Tools, select Avalon Lab Benefit Management Trial Claim Tool. If your office requires additional training, please email Provider Relations and Education at **provider.education@bcbssc.com**.

Remember to send BlueCross and BlueChoice® members' testing to in-network laboratories only and to always check for preauthorization requirements on genetic testing, cytogenetic testing and molecular pathology codes. BlueCross and BlueChoice expect all providers to use in-network laboratory resources whenever possible.

You can find more communications about Avalon, the Trial Claim Tool and a list of participating laboratories by visiting our websites at **www.SouthCarolinaBlues.com** and **www.BlueChoiceSC.com**. You can also contact Avalon at **855-895-1676** or visit its website at **www.avalonhcs.com** for additional information.

Precertification for Dialysis

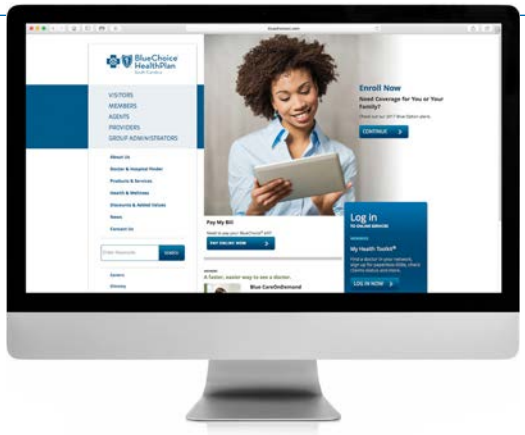


Beginning Jan. 1, 2017, BlueCross will require precertification (also known as prior authorization) for dialysis treatment. This requirement applies to Blue Essentials℠ Health Insurance Marketplace (Exchange) plans. This change will not impact BlueChoice products, as these plans already require precertification for dialysis treatment.

Precertification is required for patients beginning treatment on or after Jan. 1, 2017. Precertification is also required if a patient is currently in treatment and treatment will continue after Jan. 1, 2017. Use My Insurance Manager to initiate precertification requests to avoid payment interruption. We will provide a 90-day precertification for hemodialysis patients and a 30-day precertification for peritoneal dialysis patients.

Please keep in mind, these members do not have out-of-network benefits. Precertification requests will only be approved for contracting providers.

To read the full bulletin, visit the Provider News page of our websites. Use the **Provider Advocate Contact Form** to contact Provider Relations and Education with questions or concerns about this change.



No Paper Claims Filing to BlueChoice HealthPlan?

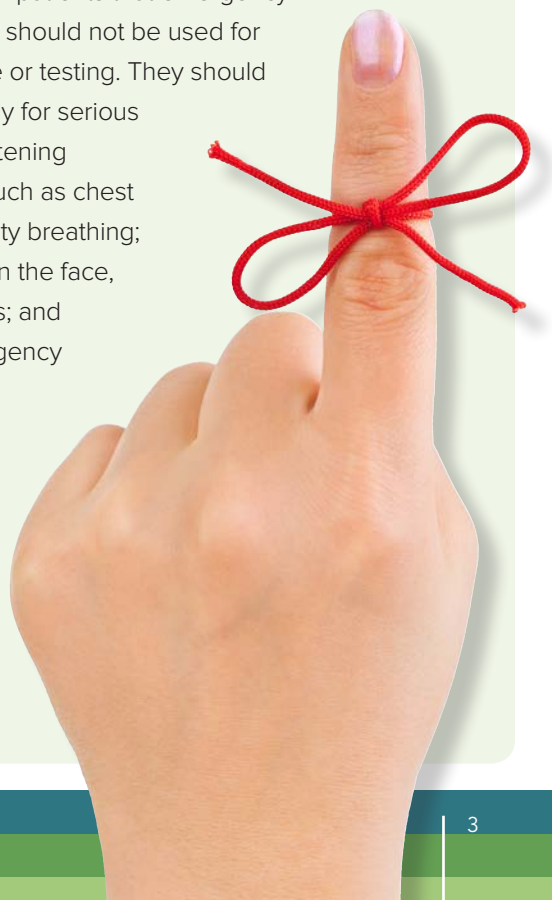
To further promote claims processing via electronic submission formats, BlueChoice is no longer accepting hard copy (paper) claims. Some providers have already received a response letter giving notice about this effort.

A paper claim may be considered only if specific conditions are met. BlueChoice Operations will review those instances where a provider waiver is requested for processing a paper claim.

For questions about this plan initiative, please contact your designated provider advocate or email Provider Relations and Education at **provider.education@bcbssc.com**.

Important Reminders ...

- For providers to obtain procedure-specific information on Health Insurance Marketplace (Exchanges) members, they must enter a specialty when verifying benefits and eligibility in My Insurance Manager.
- Remind your patients that emergency rooms (ERs) should not be used for routine care or testing. They should be used only for serious or life-threatening problems such as chest pain; difficulty breathing; numbness in the face, legs or arms; and other emergency situations.



2017 Behavioral Health Precertification Reminders

Companion Benefit Alternatives (CBA) requires precertification for certain services, such as psychological testing, repetitive transcranial magnetic stimulation (rTMS) and behavioral health program admissions. CBA is a separate company that manages behavioral health benefits on behalf of BlueCross and BlueChoice.

Many health plans no longer require preauthorization for routine office visits. Routine office visits include:

- Psychiatric evaluation
- Psychotherapy
- Medication management

A member's health plan benefits determine if you must get prior approval for services. You can determine precertification requirements when verifying eligibility and benefits for each member.

Please email **cba.provrep@companiongroup.com** if you have questions or concerns.

Inpatient Admission Date

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

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

The admission date on claims must match the precertification (prior authorization or preauthorization) in order to apply benefits accurately. If the admission date on the claim doesn't match the date of the precertification, services may be denied.

If you have questions about this bulletin, please contact Provider Education by using the **Provider Advocate Contact Form** or by calling **803-264-4730**.

Important Reminders ...

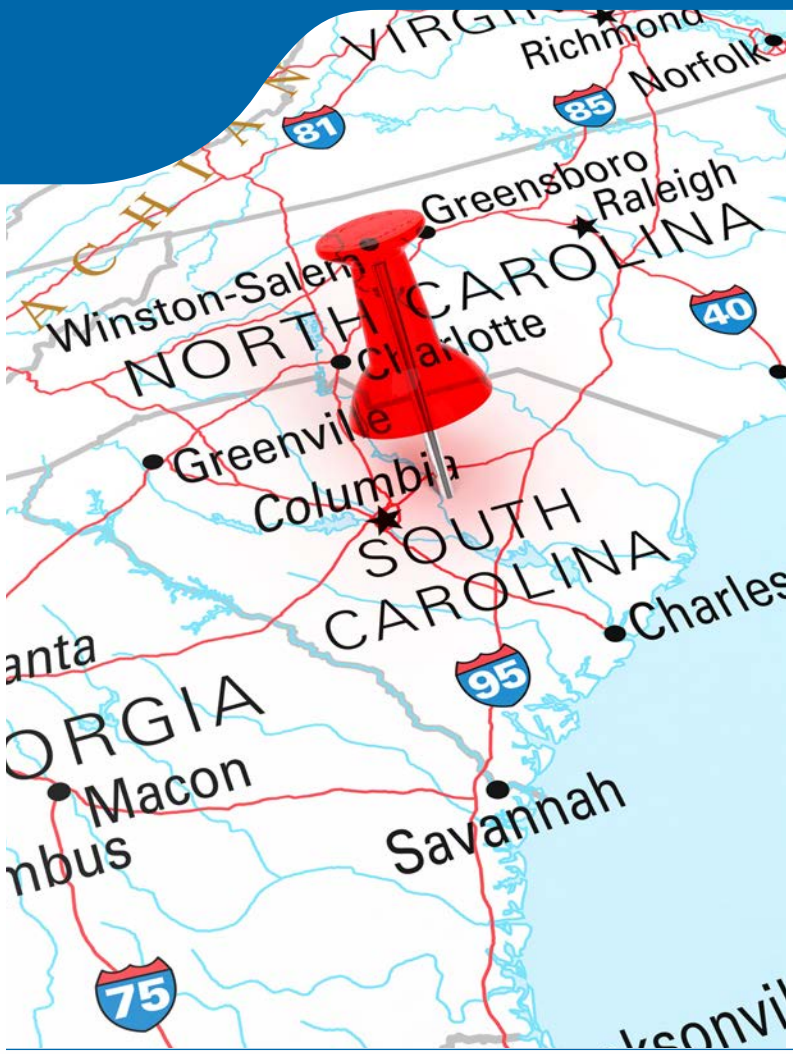
- State Health Plan does not require a prior authorization for IV infusion specialty drugs.
- Mental health providers: There are a few instances under the home-bound policy where services may be provided in the member's home. Clinical justification, review and approval by our senior clinical staff are required. Behavioral health providers are allowed to use their own home as an office when the location meets office criteria.
- Please send BlueCross and BlueChoice members' testing to in-network laboratories only and remember to always check for preauthorization requirements on genetic testing, cytogenetic testing and molecular pathology codes. BlueCross and BlueChoice expect all providers to use in-network laboratory resources whenever possible. Look for the complete list of participating labs when you visit the Provider page of **www.SouthCarolinaBlues.com** and **www.BlueChoiceSC.com**.
- To review the Excluded Drug List, visit the Prescription Drug Information page on the provider websites. This list shows drugs that are excluded from coverage, as well as how to request a formulary exception.

Should You Use My Insurance Manager℠ or the Voice Response Unit (VRU)?

When certain provider specialties attempt to get member eligibility information using the VRU, the system may be limited in the response it provides. These specialty providers should instead use My Insurance Manager to determine benefits.

- Pastoral Counselor
- Dietician
- Education Specialist
- Physician Assistant
- Christian Science
- Hospice
- Optician
- Ambulance Service
- Pharmacy
- Mail Order Pharmacy

Choose **Service Type** eligibility request when using My Insurance Manager. For further explanation about the requested benefits, providers should use the Ask Provider Services feature within the provider portal.



For Our Contracted Providers in Bordering States

Providers contracted with BlueCross BlueShield of South Carolina to participate in the Blue Essentials℠ network, who have offices located in North Carolina and Georgia, should file all claims for those members directly to the South Carolina plan, not to your local (Home) plan.

Work with your clearinghouse to determine the correct payer (carrier) ID to use for South Carolina when filing claims electronically.

Blue Essentials members can be identified by these alpha prefixes: **ZCF**, **ZCU** or **ZCQ**. Please refer to the 2017 Member ID Card Guide to see examples of the ID cards. This guide can be found on the Resources pages of our provider websites. We appreciate you sharing this information with appropriate staff in your practice.

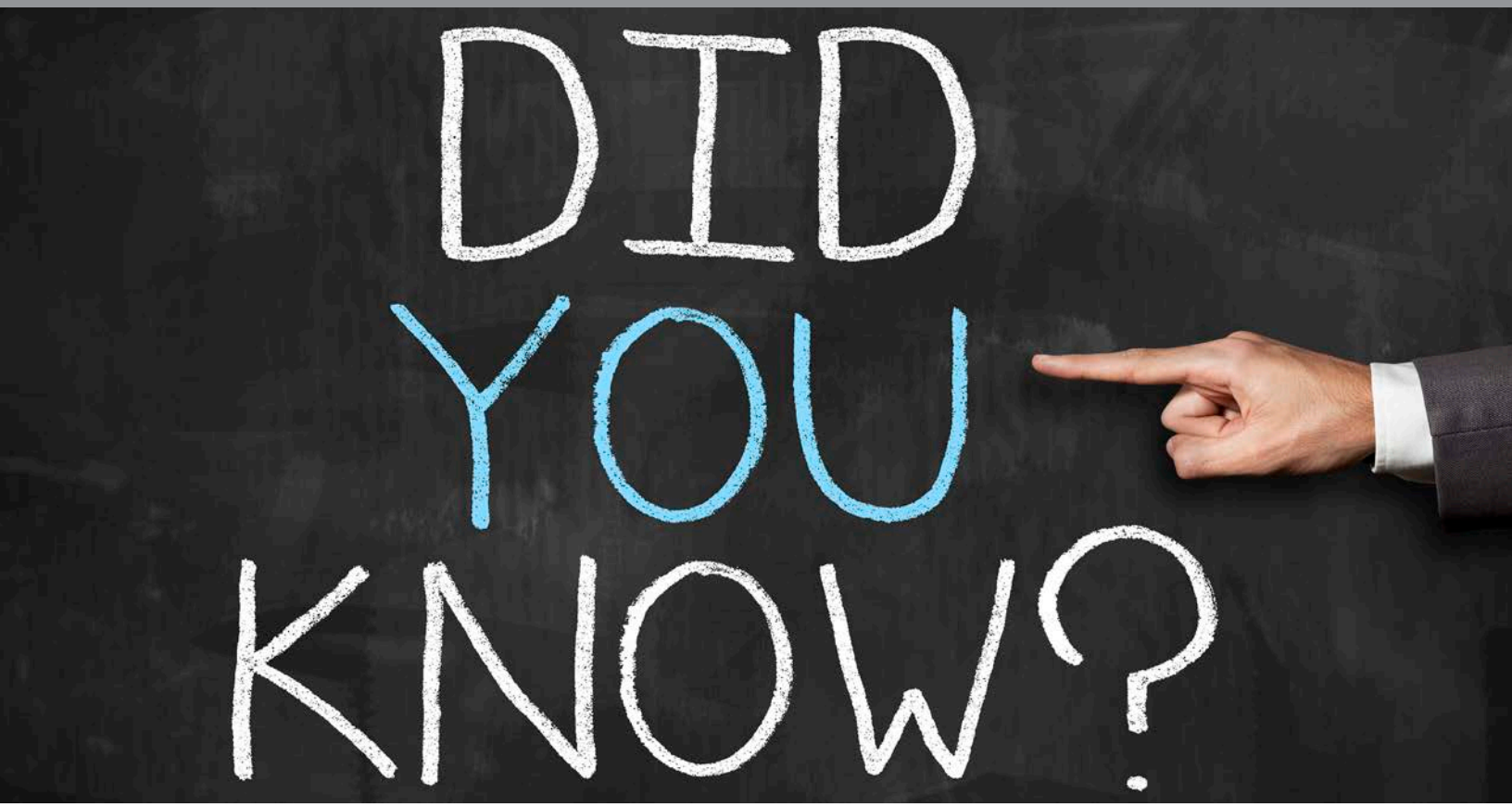
Employee Prescription Drug Program

On Jan. 1, 2017, BlueCross BlueShield of South Carolina and BlueChoice HealthPlan implemented a new prescription drug program for their employees called Maintenance Choice. The program requires employees and their dependents to receive a 90-day prescription for any long-term (maintenance) medication for a chronic condition. They may also choose to receive their medication by mail or pick up their prescription at a CVS pharmacy. CVS is a division of CVS/caremark, an independent company that provides specialty pharmacy services on behalf of BlueCross and BlueChoice®.

What you should do:

At the time of refill, most members will need a new prescription instructing the pharmacy to dispense a 90-day supply. If a member chooses to continue to fill his or her maintenance prescription at a pharmacy other than CVS, the plan will not pay for it.

To view the notice that our employees received regarding this pharmacy benefit change, find this article in the Provider News sections of **www.SouthCarolinaBlues.com** and **www.BlueChoiceSC.com**.



Important Reminders ...

- When you receive a notice to send member records for medical review, please return those medical records to the Plan or department that requests them, in order to avoid delays.
- Be advised of a new denial code, UM902 – Procedure/Service/Item, is non-covered based on the medical guidelines found under CAM 50128.
- Please respond in a timely manner to medical record requests in support of our HEDIS® outreach. Remember that BlueCross and BlueChoice do not reimburse our providers for release of member health information. Work with your medical record vendors to release this information as a "non-billable event" to our plans.

Medical Record Requests for CMS Validation Program Returns

Last fall, BlueCross and BlueChoice® sent medical record requests to selected providers for Risk Adjustment Data Validation (RADV). Our plans will again conduct outreach in support of this federally mandated program. The Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health & Human Services validate the accuracy of risk adjustment data submitted by health plans in the Individual and Small Group markets.

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

Look for more information from our plans for this outreach in our June newsletter.

Claims and Billing Minute: Filing a Professional Claim Adjustment

If you need to adjust or correct a previously paid claim, the adjustment must contain these three items:

1. Frequency Code "7" (Adjustment) in CMS-1500 Box 22 (Resubmission Code).

This corresponds to the CLM05-3 segment in the 2300 Loop of the electronic claim file.

22. RESUBMISSION CODE	ORIGINAL REF. NO.
7	6D208455800005

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

2. The BlueCross claim number ("ICN" or "DCN") of the previously paid claim in CMS-1500 Box 22 (Original Ref. No.).

This corresponds to an REF segment with an F8 qualifier in the 2300 Loop of the electronic claim file.

22. RESUBMISSION CODE	ORIGINAL REF. NO.
7	6D2084558005

REF*F8*6D2084558005~

3. A brief description of the reason for the adjustment (new service line, different tooth number, etc.) in CMS-1500 Box 19 (Additional Claim Information).

19. ADDITIONAL CLAIM INFORMATION (Designed by NUCC)
SERVICE LINE 1 - CHANGE PROCEDURE CODE TO 99211

This corresponds to an NTE segment in the 2300 Loop of the electronic claim file.

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

You're Doing What to Alpha-Prefixes?!

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

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

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

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

Remember: ID cards are for identification purposes only. They do not guarantee eligibility or payment of the claim. You should always verify patient eligibility by calling **800-676-BLUE (2583)**.

Important Reminders ...

- Medical claims clearinghouses have their own proprietary payer ID list. Check with your clearinghouse for the payer ID you should use for BlueCross BlueShield of South Carolina plans.
- When billing with a code for an unclassified drug or procedure, providers should include the additional information in the SV 101-7 field of the claim line. This corresponds to Box 24 on the CMS-1500 Claim Form.

There's A New Way to Contact Provider Relations and Education

We've recently implemented the **Provider Advocate Training Request Form** for providers to request training. The form asks the requestor about what topic(s) will be covered during training; who will be in attendance (e.g., billers or clinicians); how the training will be delivered (e.g., in-person or conference call); and when the training is to be given.

The Provider Advocate Training Request Form differs from the recently updated and renamed **Provider Education Contact Form**. Use the former to request training from us. Use the latter for questions you may have for us that are not related to specific claims only or patients. You can no longer use the Provider Education Contact Form to request training.

Find these forms on the Contact Us/Provider Advocates page of **www.SouthCarolinaBlues.com**. Stay tuned for the Provider Advocate Training Request Form to be added also to **www.BlueChoiceSC.com**.

We've Made It Easier to Locate Laboratory Medical Policies

Our medical policies and clinical guidelines can be viewed online when visiting the Provider page of **www.SouthCarolinaBlues.com** and **www.BlueChoiceSC.com**. To make it easier for our laboratory providers to locate relevant policies, we've added this service type to the Categorical List of medical policies we use to make clinical determinations for a member's coverage. The search (by code) capability works even better when entering a code while inside this category. Please visit the Medical Policies and Clinical Guidelines page frequently to stay abreast of policy changes and to read any policy in its entirety.

Diabetic Test Strips

Beginning July 1, 2017, diabetic test strips for Blue Essentials members will only be covered under the pharmacy benefit. Members will be limited to a supply of 204 strips per month.

Members received notification of this change in May 2017.

Test strips will no longer be covered under the member's medical benefit. So if you currently supply test strips to these members, please begin writing prescriptions. If you believe a member requires more than 204 test strips a month, you can request an exception by calling **855-582-2022**. Please note that exceptions will be made based on medical necessity.

If you have questions about this bulletin, please contact Provider Education at **803-264-4730** or submit your question using the **Provider Education Contact Form**.

Uniting Providers and Patients

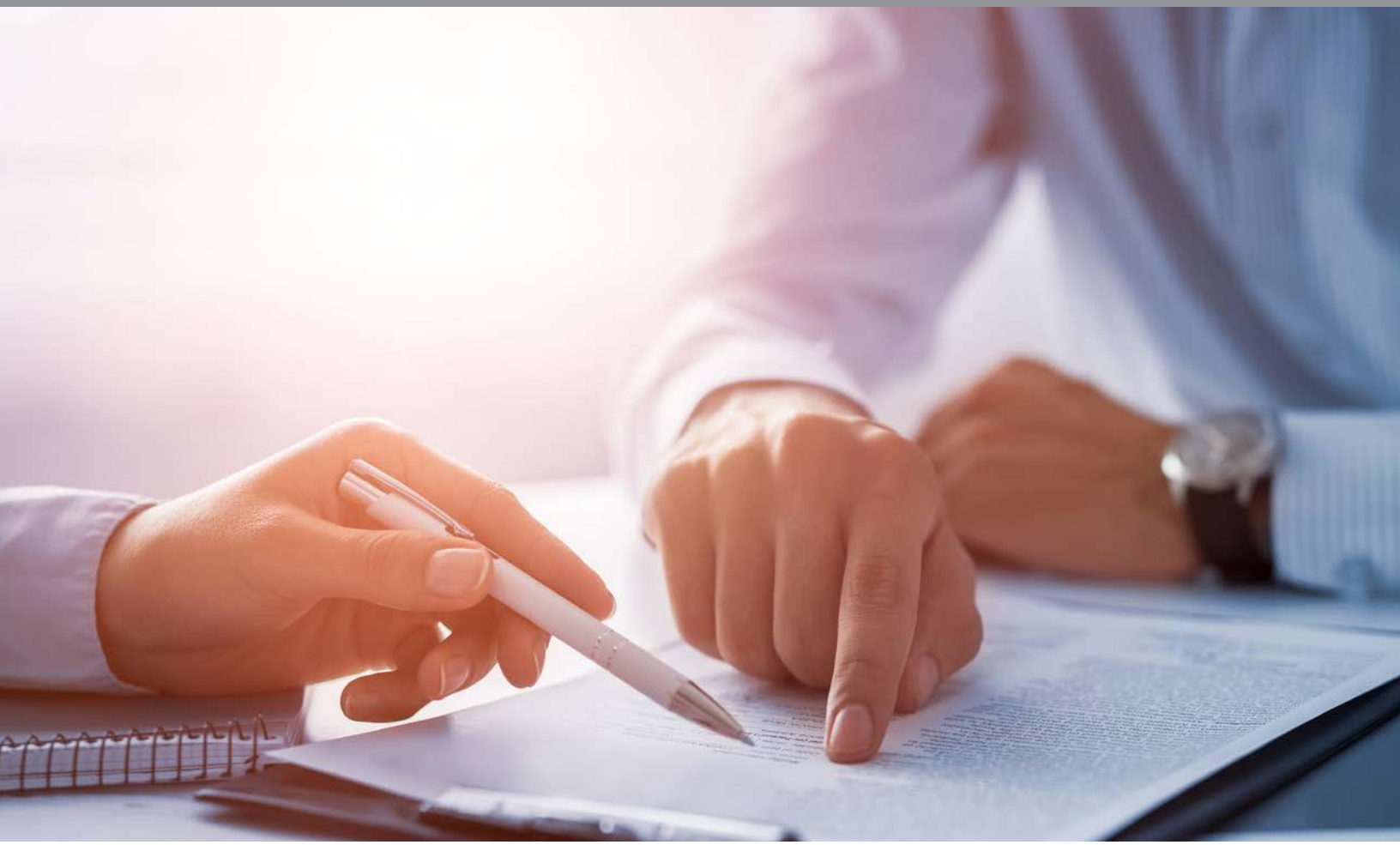
BlueCross® BlueShield® of South Carolina and BlueChoice HealthPlan members are looking for you — our valued health care providers. Help members in their search for network-participating primary care physicians, specialists, hospitals and medical suppliers by updating your information with M.D. CheckUp.

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

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

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

If you have questions about this program, please contact Provider Education at **803-264-4730**, or submit your question using the **Provider Education Contact Form**.



Latest Medical Policy Updates

We frequently revise the medical policies we use to make clinical determinations for a member's coverage. Here are recent medical policies that have been reviewed, updated or newly added. Please visit the Medical Policies and Clinical Guidelines pages of **www.SouthCarolinaBlues.com** and **www.BlueChoiceSC.com** regularly to stay informed of these changes and to read any policy in its entirety.

- **CAM Policy 60118 – Scintimammography and Gamma Imaging of the Breast and Axilla**
  Medical necessity statement included with regard to localization of sentinel lymph nodes.
- **CAM Policy 132 – Lipid Panels**
  Medical necessity criteria has been expanded to clarify risk factors.
- **CAM Policy 204122 – Chromosomal Microarray Analysis for the Evaluation of Pregnancy Loss**
  Investigational statement related to testing that does not meet criteria specified was added.
- **CAM Policy 70178 – Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions**
  Policy verbiage has been expanded for clarification of the use of allograft plugs and discs to be investigational.
- **CAM Policy 80113 – Accelerated Breast Irradiation and Brachytherapy Boost After Breast-Conserving Surgery for Early-State Breast Cancer**
  Policy verbiage updated for breast width criterion removed from first policy statement; bullet point on age of at least 50 years added to AWBI statement; and clarification of technically clear surgical margins for AWBI.
- **CAM Policy 80127 – Hematopoietic Cell Transplantation for Breast Cancer**
  Policy updated to remove the word "stem" as it relates to transplant in accordance with NCCN terminology.

Claims and Billing Minute: Filing a Professional Claim Void

If you need to void a previously paid claim, the void must contain these items:

1. Frequency Code "8" (Void) in CMS-1500 Box 22 (Resubmission Code).

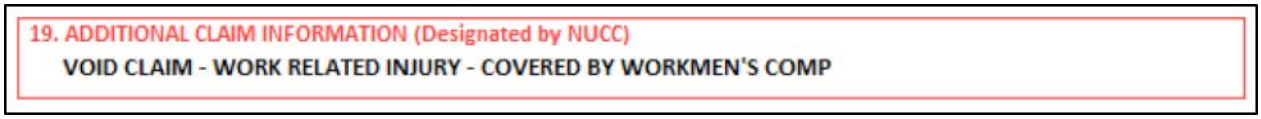
This corresponds to the CLM05-3 segment in the 2300 Loop of the electronic claim file.
CLM*436944*271*11:B:8*Y*A*Y*Y~**

2. The BlueCross or BlueChoice claim number ("ICN" or "DCN") of the previously paid claim in CMS-1500 Box 22 (Original Ref. No.).

This corresponds to an REF segment with an F8 qualifier in the 2300 Loop of the electronic claim file.

REF*F8*6D208455800005~

3. A brief description of the reason for the void (OPL claim, workman's comp, etc.) in CMS-1500 Box 19 (Additional Claim Information).



This corresponds to an NTE segment in the 2300 Loop of the electronic claim file.
NTE*ADD*VOID CLAIM – WORK RELATED INJURY – COVERED BY WORKMAN'S COMP~

Understanding Telemedicine vs. Blue CareOnDemand℠*

Both telemedicine and Blue CareOnDemand are services aimed at providing convenience in caring for a patient. Yet there is a slight difference in how these services are delivered to BlueCross and BlueChoice members. One service allows consultation between a physician and a patient and the other allows consultation between physicians only. Here is a look at these two approaches to health care delivery.

BlueCross and BlueChoice cover consultations between referring and consulting physicians via telemedicine for certain specialties: high-risk pregnancies (maternal-fetal medicine); strokes (vascular neurology); and mental health (psychiatry). To participate in telemedicine services for the health plans, providers must comply with these requirements:

1. Provide medically necessary services via an interactive audio and video telecommunications system that permits two-way communication.
2. Provide telemedicine services that comply with the American Telemedicine Association standards; and meet the terms and conditions of BlueCross and BlueChoice.
3. Provide technically sufficient telemedicine equipment.
4. Use an acceptable method of encryption that is secure and HIPAA-compliant for all telecommunication services.

When conducting telemedicine services, it is deemed non-covered if the physicians communicate using solely or a combination of the following: telephone conversations; email messages; video cellphone interactions; facsimile transmissions; non-secured and non-HIPAA-compliant web-based audio-video communications; and services provided by allied health professionals that are neither allopathic nor osteopathic physicians.

Blue CareOnDemand differs somewhat. It is a service that allows members to see a doctor via video visit, using a computer or mobile device. Members are securely connected with a physician to handle consultations for common illnesses — such as cold/flu symptoms, pinkeye, urinary tract infections and more — when the practice is closed or when minor acute illnesses make it difficult to leave their home. The provider can then ask and answer questions, diagnose symptoms and, if appropriate, call in a prescription to the member's pharmacy. Blue CareOnDemand is not included in all BlueCross and BlueChoice health plans.

*AmericanWell. (26 June 2017). SC BlueCross, SC BlueChoice Members Can See a Doctor Without Going to the Doctor's Office. Retrieved from https://www.americanwell.com/press-release/sc-bluecross-sc-bluechoice-members-can-see-a-doctor-without-going-to-the-doctors-office/.

Medical Forms Resource Center: A Better Way to Request Precertification

We are excited to announce a new tool that will make initiating prior authorization requests more efficient. The Medical Forms Resource Center (MFRC) will be available online at **www.SouthCarolinaBlues.com** and **www.BlueChoiceSC.com** for providers to use beginning Sept. 19, 2017.

The MFRC is a web-based tool created to allow you to electronically submit your precertification requests for some services. The system is fast, secure and accurate. It also cuts down on follow-up calls, as all the required information is outlined on the form. It's a perfect alternative to using My Insurance Manager for precertification requests for services that pend approval. Take a look at some of its key features:

- Information is transmitted to our private network through a server that has the highest security certificate available for secure communications.
- The electronic format ensures we receive your data and that it is clearly legible, eliminating the need for faxes that don't transmit or print properly.
- Requests submitted using the MFRC receive priority processing.

Read the full announcement about this new way of requesting prior authorization online by visiting the Provider News pages of our websites. For a demonstration of how to use the MFRC, go to the Provider Training page to register.

National Drug Code (NDC) Claim Edits Effective Oct. 1, 2017

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan require providers to file a valid NDC with the unit of measure and quantity for all professional and outpatient administered drug claims. This applies to institutional outpatient and professional services billed.

This requirement has been in place since March 2015. We will begin applying claim edits effective Oct. 1, 2017, to applicable services that have been filed without the corresponding NDC.

What does this mean for you?

Beginning Oct. 1, 2017, the NDC must be submitted for all professional and outpatient administered drug claims. If the NDC is missing, incomplete or invalid, the charges will be denied.

What is the NDC?

The NDC is a universal number that identifies a drug. The NDC consists of 11 digits in a 5-4-2 format. The Food and Drug Administration (FDA) assigns the first five digits, which identify the manufacturer of the drug. The manufacturer assigns the remaining digits, which identify the specific product and package size. Some packages will display 10 digits for the NDC. This needs to be converted to an 11-digit NDC. Refer to the "How do I bill the NDC?" section to determine how to convert a 10-byte NDC to an 11-byte NDC.

You'll find the NDC on the drug container (vial, bottle or tube). The NDC you submit to us must be the actual NDC number on the container from which you administered the medication. If a drug is administered from a vial, for example, you should use the NDC on the vial. Do not bill for one manufacturer's product and dispense another. Do not bill using invalid or obsolete NDC numbers.

How do I bill the NDC?

Submitted NDCs must be valid and have 11 digits following the 5-4-2 format. If the package or container list an NDC with 10 digits, this must be converted to an 11-digit NDC. To do this, first determine the format of your 10-digit NDC by examining the package information and counting the numbers separated by dashes. Once you have identified the format as either 4-4-2, 5-3-2 or 5-4-1, insert a zero according to this table:

10-Digit Format		Add a zero in …		Report NDC as …
4-4-2	*####-####-##	1st position	0####-####-##	0##########
5-3-2	#####-*##-##	6th position	#####-0##-###	#####0#####
5-4-1	#####-####-*#	10th position	#####-####-0##	#########0##

Note: Asterisk (*) denotes missing digit in 11-digit (5-4-2) format.

Frequently Asked Questions from the Field

Topic	Question	Our Response
Dental	Is the submission of a pretreatment estimate similar to a prior authorization request?	A pretreatment estimate is a real-time snapshot of the benefits that are payable at the time the pretreatment processes. It is considered a prior authorization. For Commercial dental plans, it is recommended but not required to request a pretreatment estimate for services over $300.
	What is a non-duplicate policy?	Non-duplication refers to coordination of benefits. This means that we coordinate up to our payment. We will not pay anything as secondary if the primary plan's payment is equal to or greater than our primary payment. For example, if a dentist charges $62 for a filling (D2140) and the allowed amount is $60, we will pay $0 if the other coverage pays $60. Another example, if the dentist is charging $70 for a perio-cleaning (D4910) and the allowed amount is $65, if the other carrier pays $45, then we will pay $20 ($65-$45=$20).
	What is a missing tooth clause?	Services related to teeth missing before the member's effective date of coverage with our dental plan are not covered.
	Are there waiting periods applied to certain services?	For Commercial dental plans, yes, some services apply a waiting period. This is dependent on the group's benefits. Some may have no waiting period; and others may have waiting periods of 6-12 months applicable to basic and major or just major.
Precertification	How can I complete a precertification request for two or more procedures – such as a colonoscopy and endoscopy – via My Insurance Manager℠?	Currently, you are unable to complete a precertification request for more than one service on a single entry using My Insurance Manager. Once you have chosen your request type and select one service, you will continue through the remaining precertification request screens to completion. At that time, you may begin a second request.
	How can I have diagnoses added to the Fast-Track Request Option in My Insurance Manager?	Presently, you cannot go directly to the Novologix portal. You can access Novologix through the single sign-on access from My Insurance Manager using the member's ID.
	Can I go directly to Novologix to complete a precertification request?	Presently, you cannot go directly to the Novologix portal. You can access Novologix through the single sign-on access from My Insurance Manager using the member's ID.
General	Are there specific guidelines for preadmission testing (e.g., EKG) when performed in a physician's office?	If you perform preadmission testing, such as an EKG, in your office, you should file it like any other procedure through an office visit. If the place of service is at the office, you bill as an office claim. When you do the preadmission testing at the hospital within 72 hours of admission, then you should bill it on the UB with the occurrence code 41.
	How do I get a copy of our practice's 1099 tax form?	Please call the 1099 Tax Line at **800-991-2701** to request form copies for BlueCross, BlueChoice, TRICARE and other plans.
	Who should I contact if I have a question about the status of my provider credentialing application?	For BlueCross and BlueChoice provider credentialing questions, please email **provider.cert@bcbssc.com**. Email CBA at **cba.provrep@companiongroup.com** for questions about mental health provider credentialing.
	What can I do about an issue with electronic claims and modifiers not transmitting through our clearinghouse?	Our EDI department can work with your clearinghouse if there is a problem with us not getting your claims submissions. Contact EDI by email at **edi.services@bcbssc.com** or by phone at **800-868-2505**.

Topic	Question	Our Response
BlueCross Provider 101	Can you submit a corrected claim electronically?	Yes, you can submit a corrected (replacement) claim using your clearinghouse or via My Insurance Manager. Within My Insurance Manager, choose the Replacement of Prior Claim option when progressing through the Claims Entry menu.
	Who should I contact if my claims are not getting to BlueCross through our clearinghouse?	Our EDI department can work with your clearinghouse if there is a problem with us not getting your claim submissions. Contact EDI by emailing **edi.services@bcbssc.com** or by calling **800-868-2505**.
	Our organization is not allowed to submit records or any protected health information (PHI) online, so we use traditional mail to send supporting medical documentation. What steps should be taken if, after 30-45 days, the provider reconsideration status is not available to view in My Insurance Manager℠?	When documentation is received by the plans via mail, it can take time to send it to the appropriate area for review. It may take 30+ days from the date it is mailed to review completion. After the review is complete, the appropriate service area will initiate claim adjustments – viewable in My Insurance Manager – or generate letters of denial to providers.
	How do I find out what the contracted rates are for various codes on various plans?	Only State Health Plan and State Dental Plan fee schedules can be accessed via My Insurance Manager. For other plans' rates, please contact your Provider Contracting Manager. If you are not sure of whom you should contact, please send an inquiry to **provider.education@bcbssc.com** or submit the **Provider Education Contact Form**.
	How long should a claim remain in "Pending" status within My Insurance Manager?	It can take up to 30 days for a claim to complete the process from receipt to adjudication. If you see that claims are consistently taking longer than 30 days to process, please contact your Provider Education Advocate.
Affordable Care Act (ACA) or Exchange Plans	How do I determine if a prescription contraceptive requires authorization?	It depends on the procedure code. Verify the CPT/HCPCS code precertification requirements within My Insurance Manager. The Preventive Care Guide gives a list of contraceptives that are covered as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).
	What is the time frame to add a newborn to an ACA/Exchange policy?	Parents generally have 30 days to add newborns to their policies. If you have an ongoing or repeated issue with this, please contact Provider Relations and Education for assistance.
	Why is the PPO suitcase logo included on the member ID card if there aren't out-of-network or out-of-state benefits available for an ACA plan? What does the PPO-B designation on the card mean?	The PPO is there to indicate that when the member seeks emergency care out of state, the plan uses the PPO network. The PPO-B indicates the plan was purchased through the Federally Facilitated Marketplace (FFM).
	Does a Transition of Care form need to be completed for service and each provider?	The Transition of Care form should be completed for each out-of-network provider a member is seeing. The form is not necessary for each individual service — only to request approval to see the out-of-network provider. The form must be completed by the member before rendering services, as coverage is dependent on approval from the plan.
	Which plans require a referral to see a specialist?	The ACA/Exchange plans do not require a referral to see a specialist. Some other plans do, so be sure to verify eligibility and benefits before rendering services.

Topic	Question	Our Response
Telemedicine	Is telemedicine the same as telehealth? What's the difference?	Although the terms have been used interchangeably, telemedicine is generally considered the clinical application of technology. Telehealth encompasses a broader definition — it's a collection of means of methods, not a specific clinical service, to enhance care delivery and education.
	Do all BlueCross and BlueChoice® plans cover both telemedicine and telehealth?	BlueCross and BlueChoice cover consultations between referring and consulting physicians via telemedicine. Blue CareOnDemand℠ — a telehealth service that allows members to see a doctor by video via computer or mobile device — is not included in all BlueCross and BlueChoice health plans.
	What are some examples of eligible telemedicine services?	• Consultation for acute stroke treatment • Pharmacologic management and psychiatric diagnostic • interview examination and testing • Emergency room to emergency room consultations • Specialty consultations provided to hospitalized inpatients
	What is the medical policy associated with telemedicine?	CAM Policy 032 gives complete information about our telemedicine program.
	How are telemedicine claims processed?	Reimbursement to the consulting physician delivering the medical service is the same as the current fee schedule amount for the service provided. Consulting physicians will submit claims for telemedicine or telepsychiatry services using the appropriate CPT code for the professional service along with the telemedicine modifier GT, via interactive audio and video telecommunications systems (e.g., 99243 GT). By coding and billing the "GT" modifier with a covered telemedicine procedure code, the consulting physician is certifying that the member/beneficiary was present at the referring physician site when the telemedicine service was furnished. Telemedicine services are subject to any coinsurance or copayment requirements.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