



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

Independent licensees of the Blue Cross and Blue Shield Association

The BlueCard® Program

Provider Manual

Published by Provider Relations and Education
Your Partners in Outstanding Quality, Satisfaction and Service

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1. Introduction: The BlueCard Program Makes Filing Claims Easy

As a participating provider of BlueCross BlueShield of South Carolina, you may render services to patients who are National Account members of other Blue Plans and who travel or live in South Carolina.

This manual describes the advantages of the program and provides information to make filing claims easy. This manual offers helpful information about:

- Identifying members
- Verifying eligibility
- Getting pre-certifications/pre-authorizations
- Filing claims
- Who to contact with questions

2. What is the BlueCard Program?

2.1 Definition

BlueCard is a national program that 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 in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The BlueCard program lets you submit claims for other Blue Plan members directly to your local BlueCross BlueShield of South Carolina Plan.

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

2.2 BlueCard Program Advantages to Providers

The BlueCard Program lets you conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to BlueCross BlueShield of South Carolina. We will be your only point of contact for all your claims-related questions.

BlueCross BlueShield of South Carolina continues to experience growth in out-of-area membership because of our partnership with you. That is why we are committed to working with you to ensure your patients will have a positive experience at each visit.

2.3 Products Included in BlueCard

A variety of products and claim types are eligible for delivery via BlueCard, however, not all Blue Plans offer all of these products to their members. Currently, BlueCross BlueShield of South Carolina offers products in these categories:

- Traditional (Indemnity Insurance)
- Preferred Provider Organization (PPO)

- Exclusive Provider Organization (EPO)
- Health Maintenance Organization (HMO)

2.4 Products Excluded from the BlueCard Program

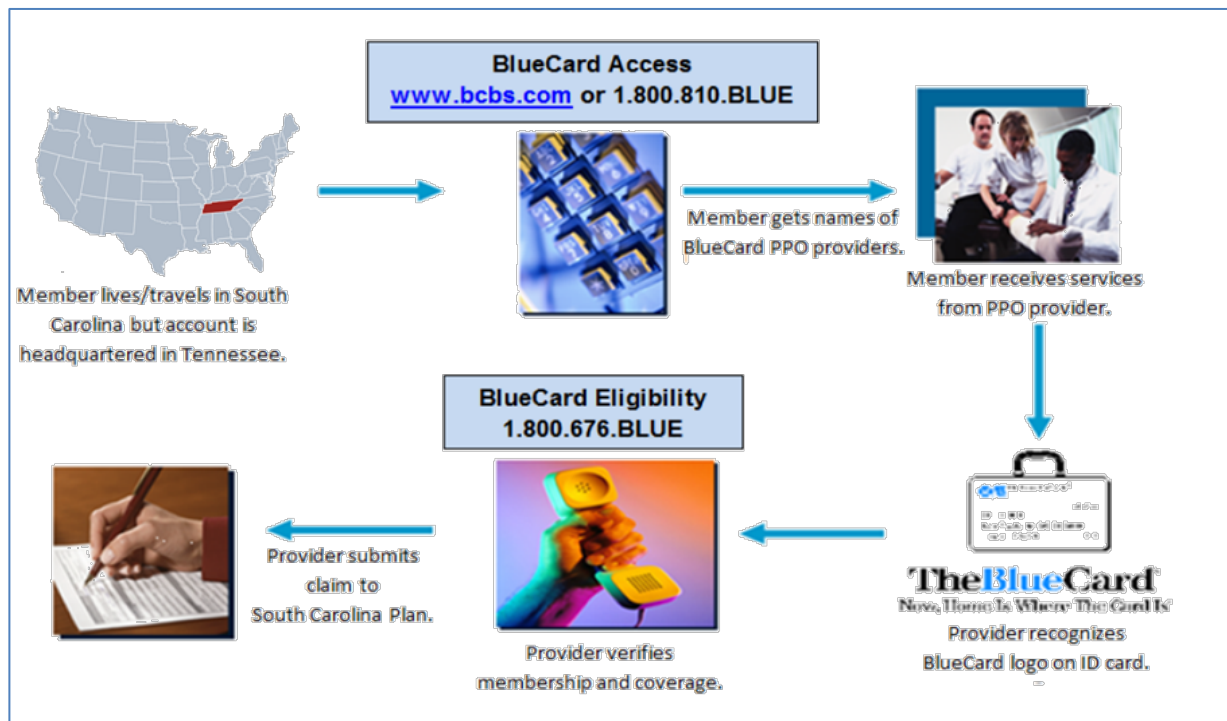
We exclude these claims from the BlueCard Program:

- Stand-alone dental
- Vision delivered through an intermediary model (using a vendor)
- Self-administered prescription drugs delivered through an intermediary model (using a vendor)
- The Federal Employee Program (FEP)
- Medicare Advantage (MA)*

Please follow the BlueCross BlueShield of South Carolina billing guidelines.

*MA is a separate program from BlueCard and delivered through its own centrally administered platform. Since you might see members of other Blue Plans who have MA coverage, there is a section about MA claims processing in this manual.

3. How the BlueCard Program Works



In this example, suppose a member has PPO coverage through BlueCross BlueShield of Tennessee. There are two scenarios for which the member might need to see a provider in another Plan's service area. In this example, it's South Carolina.

- 1) If the member was traveling in South Carolina or

- 2) If the member resided in South Carolina and had employer-provided coverage through BlueCross BlueShield of Tennessee.

In either scenario, providers and members can get the names and contact information for BlueCard PPO providers in South Carolina by calling the BlueCard Access[®] Line at 800-810-BLUE (2583) or on the internet by using the BlueCard National Doctor and Hospital Finder available at www.bcbs.com or at www.SouthCarolinaBlues.com. Simply key in the member's prefix and other required information to identify participating providers.

Note: You will receive a return message for members with no out-of-area benefits indicating that only in-area benefits are available, unless seeking urgent or emergent care.

As a South Carolina BlueCard PPO provider, when a member makes an appointment, you should verify the member's eligibility and coverage information via the BlueCard Eligibility[®] Line at 800-676-BLUE (2583). You can also get this information via a Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic eligibility transaction if you have established electronic connections for such transactions with us.

After rendering services, you will file the claim locally with BlueCross BlueShield of South Carolina. We will forward the claim to BlueCross BlueShield of Tennessee. The Tennessee Plan will adjudicate the claim according to the member's benefits and your provider arrangement with us. When the claim is finalized, the Tennessee Plan will issue an Explanation of Benefits (EOB) to the member. We will issue the explanation of payment or remittance advice and pay you.

3.1 How to Identify Members

3.1.1 Member ID Cards

When members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification cards.

The main identifier for out-of-area members is the prefix. The ID cards may also have

- PPO in a suitcase logo, for eligible EPO/PPO members
- PPOB in a suitcase logo, for eligible EPO/PPO members
- A blank suitcase logo
- An HPN in a suitcase logo with the Blue High Performance Network (HPN) name in the upper right or lower left corner, for Blue HPN EPO members.

Important facts concerning member IDs:

- A correct member ID number includes the prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between 6 and 14 numbers/letters following the prefix.
- Examples of prefix ID numbers:
 - ABC 1234567
 - ABC 1234H567
 - ABC 12345678901234
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the prefix.

- The prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate BCBS Plan.
- Members who are part of the FEP will have the letter "R" in front of their member ID number.

As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in the member's file.
- Make copies of the front and back of the member's ID card and pass this key information on to your billing staff.
- Remember that member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID numbers.

The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims between BCBS Plans. The prefix identifies the BCBS Plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with claim processing.

- Do not make up prefixes.
- Do not assume that the member's ID number is the social security number. All BCBS Plans replaced Social Security numbers on member ID cards with an alternate, unique identifier.

Sample ID Cards



BlueCard ID cards have a suitcase logo, it may be an empty suitcase, a PPO in a suitcase or an HPN in a suitcase.

The PPO in a suitcase logo indicates that the member is enrolled in either a PPO or exclusive provider organization (EPO) product. In either case, you will be reimbursed according to BlueCross BlueShield of South Carolina's PPO provider contract. Please note that EPO products may have limited out-of-area benefits. The potential for such benefit limitations are indicated on the reverse side of an EPO ID card.

The PPOB in a suitcase logo indicates the member has selected a PPO or EPO exchange product from a Blue Plan. The member has access to a PPO Network referred to as BlueCard PPO Basic. You will be reimbursed for covered services in accordance with your PPO contract with BlueCross BlueShield of South Carolina.

The Blue HPN EPO product includes an HPN in a suitcase logo on the ID card. Members must obtain services from Blue HPN providers to receive full benefits. If you are a Blue HPN provider, you will be reimbursed for covered services in accordance with your Blue HPN contract. If you are not a Blue HPN provider, it's important to note that benefits for services incurred with non-Blue HPN providers are limited to emergent care within

Blue HPN product areas, and to urgent and emergent care outside of Blue HPN product areas. For these limited benefits, if you are a PPO provider, you will be reimbursed according to your PPO provider contract, just like you are for other EPO products.

The empty suitcase logo indicates the member is enrolled in either a traditional or HMO or POS product. You will be reimbursed in accordance with the BlueCross BlueShield of South Carolina traditional or PPO contract for covered professional services and in accordance with the participating provider agreement (PAR) for hospital services.

Some Blue ID cards do not have a suitcase logo on them. Such ID cards include Medicaid, State Children’s Health Insurance Programs (SCHIP) (if administered as part of a state’s Medicaid program) and Medicare complementary and supplemental products, also known as Medigap. Government-determined reimbursement levels apply to these products. BlueCross BlueShield of South Carolina routes all of these claims for out-of-area members to the member’s Blue Plan. We also send most of the Medicare complementary or Medigap claims directly from the Medicare intermediary to the member’s Plan via the established electronic crossover process.

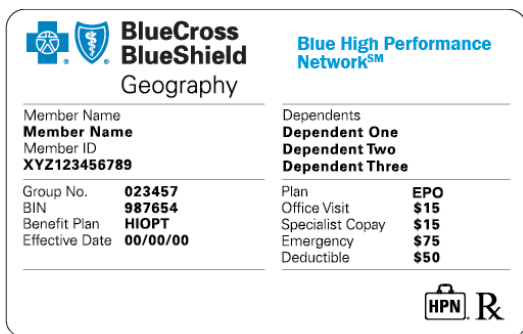
3.2 How to Identify BlueCard Blue HPN Members

Blue High Performance Network (Blue HPN) is a narrow network that is available to members that live in key metropolitan areas. Blue HPN members must access Blue HPN providers in order to receive full benefits. If you are not a Blue HPN provider, it is important to note that benefits for services incurred with non-Blue HPN providers are limited to emergent care within Blue HPN product areas, and to urgent and emergent care outside of Blue HPN product areas.

You can recognize Blue HPN members by the following:

- The Blue High Performance Network name on the front of the member ID card
- The HPN in a suitcase logo in the bottom right hand corner of the member ID card

Language regarding benefit limitations is also included on the back of the Blue HPN EPO member ID card. For these limited benefits, if you not a Blue HPN provider but are a PPO provider, you will be reimbursed according to BlueCross BlueShield of South Carolina PPO provider contract, just like you are for other EPO products.



3.3 How to Identify and File Claims International Members

Occasionally, you may see identification cards that are from members of International Licensees or that are for international-based products. Currently, those Licensees include Blue Cross Blue Shield of the U.S. Virgin Islands, BlueCross & BlueShield of Uruguay, Blue Cross and Blue Shield of Panama, and Blue Cross Blue Shield of Costa Rica, and those products include those provided through GeoBlue and the Blue Cross Blue Shield

Global™ portfolio; however, if in doubt, always check with BlueCross BlueShield of South Carolina as the list of International Licensees and products may change. ID cards from these Licensees and for these products will also contain three-character prefixes and may or may not have one of the benefit product logos referenced in the following sections. Please treat these members the same as you would domestic BCBS Plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance and co-payment) and file their claims to BlueCross BlueShield of South Carolina. See below for sample ID cards for international members and products.

Example of an ID card from an International Licensee:

		BlueCross & BlueShield de Uruguay	
MEMBER NAME	Plan	www.bcbs.com.uy	
Member Name	1400	Uruguay Atención al Cliente: (598-2) 707-7575	
MEMBER ID	RPA PREMIUM	United States (E.E.U.U.) Customer Service: (598-2) 707-7575 Provider Finder: 1-800-810-2583 Eligibility: 1-800-876-2583	
XYZ 0123456789	Expiration Date: May. 31, 2011	Proveedores en Uruguay: Para verificar elegibilidad y beneficios, por favor llamar a nuestras oficinas. Déjele facturas por servicios médicos a nuestra dirección.	
Plan	PPO	Providers in the United States: To verify membership eligibility, please call Eligibility line. Providers should file all claims to the local BlueCross and/or BlueShield Plan in whose Service Area the member received services.	
GROUP	URU038	BlueCross & BlueShield de Uruguay Lord Pensonby 2456 11600 Montevideo, Uruguay An Independent Licensee of the BlueCross and BlueShield Association.	
BC/BS Plan Codes: 154/654			
CREDENCIAL PARA USO EXCLUSIVO FUERA DE URUGUAY			

Examples of ID cards for International Products

Illustration A - GeoBlue:

		Xplorer Premier	
		XP-5000-NRX	
Jane E Demo QHF999999999H		Members: See benefit booklet for services covered by your plan. Possession of this card does not guarantee eligibility for benefits.	
Group No. 99990483	Copay in Network, Inside U.S. \$30	24/7 Member Services Outside the U.S. +1.610.254.5850 Toll Free Within the U.S. 1.855.481.6647 customerservice@geo-blue.com	
BIN 610020	Copay in Network, Outside U.S. \$0	24/7 Medical Assistance Including Evacuation Collect Calls Accepted +1.610.254.8771 globalhealth@geo-blue.com	
Coverage Dates 15-Apr-2016 - 14-Apr-2017	Copay Out of Network, Outside U.S. \$10	Prescription/Pharmacy Information Pharmacy Help Desk 1.800.788.2910	
Medical claims incurred Inside the U.S., Puerto Rico, and U.S. Virgin Islands Hospitals or Physicians: file claims with local Blue Cross and/or Blue Shield Plan Members: See benefit booklet for claims filing procedures or visit www.geobluetravelinsurance.com .		GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association.	
Claims incurred Outside the U.S., Puerto Rico, and U.S. Virgin Islands and all Dental and Rx claims File all claims with GeoBlue, Claims Department P.O. Box 1748, Southeastern, PA 19399-1748, USA. Visit www.geobluetravelinsurance.com for instructions.		Pharmacy benefits administrator.	

Illustration B – Blue Cross Blue Shield Global portfolio:

		BlueCross BlueShield Global	
		www.bupaglobalaccess.com	
Member Name:	Employer Group Name:	U.S. Customer Service +1786-257-4741 U.S. Customer Service Toll Free +1844-369-3797 Providers Inquiries & Precertification +1844-369-3099	
Member ID.	Employer Group No.	Evacuation/Repatriation (if included): +44 1273 333911 Prescription/Pharmacy Information and Pharmacy Help Desk +1855-767-1864	
Rx Group No.		Underwritten and/or administered by Bupa or its Designated Affiliate, independent licensees of the Blue Cross Blue Shield Association.	
BIN		Process claims through Pharmacy Data Management (PDMI)	
PCN:		U.S. Service Center Palmetto Bay Village Center 17901 Old Cutter Road, Suite#400 Palmetto Bay, FL 33157 Email: info@bupaglobalaccess.com	
Blue Cross Blue Shield Global is a brand owned by the Blue Cross and Blue Shield Association.		Pharmacy benefits administrator.	
		BIN-BCBS-CARD-PRINT-1803Y1	


Illustration C – Shield-only ID Card:

Please note that in certain territories, including Hong Kong and the United Arab Emirates, Blue Cross branded products are not available. The ID cards of members in these territories will display the Blue Shield Global logo (see example below):



Member Name:	Employer Group Name:
Member ID:	Employer Group No.:
Rx Group No.:	
BIN:	
PCN:	

U.S. ONLY 



www.bupaglobalaccess.com


U.S. Customer Service **+1 786-257-4741**
 U.S. Customer Service Toll Free **+1 844-369-3797**
 Providers Inquiries & Precertification **+1 844-369-3099**

Evacuation/Repatriation (if included): **+44 1273 333911**
 Prescription/Pharmacy Information and Pharmacy Help Desk **+1 855-767-1864**

Underwritten by Bupa or its Designated Affiliate, independent licensees of the Blue Cross Blue Shield Association.

Blue Shield Global is a brand owned by BCBSA.

U.S. Service Center
 Palmetto Bay Village Center
 17901 Old Cutler Road, Suite #400
 Palmetto Bay, FL 33157
 Email: info@bupaglobalaccess.com

 Pharmacy benefits administrator.

Please note that the Canadian Association of Blue Cross plans and its member plans are separate and distinct from the Blue Cross and Blue Shield Association (BCBSA) and its member Plans in the United States.

You may occasionally see ID cards for people with Canadian Blue Cross Plan coverage. Claims for Canadian Blue Cross Plan members are not processed through the BlueCard Program.

Please follow the instructions of the Blue Cross Plans in Canada on the ID cards when servicing their members. The Blue Cross Plans in Canada are:

- | | | |
|---------------------|--------------------|-------------------------|
| Alberta Blue Cross | Ontario Blue Cross | Quebec Blue Cross |
| Manitoba Blue Cross | Pacific Blue Cross | Saskatchewan Blue Cross |
| Medavie Blue Cross | | |

Source: <http://www.bluecross.ca/en/contact.html>

3.4 Consumer-Directed Health Care and Health Care Debit Cards

Consumer Directed Healthcare (CDHC) is a term that refers to a movement in the healthcare industry to empower Members, reduce employer costs and change consumer healthcare purchasing behavior.

Health plans that offer CDHC provide the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information and financial incentives.

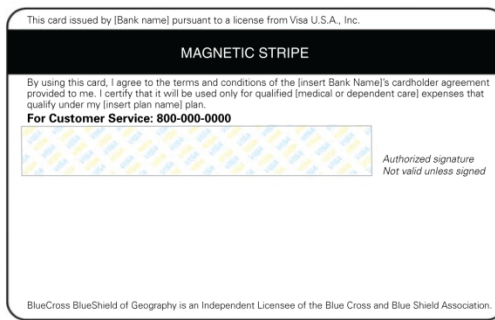
Members who have Consumer-Directed Healthcare (CDHC) plans often have healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). All three are types of tax favored accounts offered by the member’s employer to pay for eligible expenses not covered by the health plan.

Some cards are “standalone” debit cards that cover eligible out-of-pocket costs, while others also serve as a health plan member ID card. These debit cards can help you simplify your administration process and can potentially help:

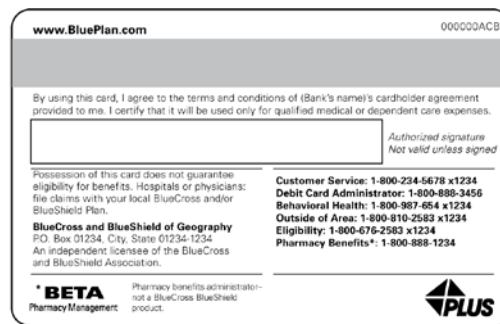
- Reduce bad debt
- Reduce paperwork for billing statements
- Minimize bookkeeping and patient account functions for handling cash and checks
- Avoid unnecessary claim payment delays

In some cases, the card will display the Blue Cross and Blue Shield trademarks, along with the logo from a major debit card such as MasterCard® or Visa®.

Below is a sample stand-alone healthcare debit card:



Below is a sample combined healthcare debit card and member ID card:



The cards include a magnetic strip allowing you to swipe the card to collect the member’s cost-sharing amount (i.e., copayment). With health care debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card through any debit card swipe terminal. The funds will be deducted automatically from the member’s appropriate HRA, HSA or FSA account.

If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as what you pay to swipe any other signature debit card.

Helpful tips:

- Using the member’s current member ID number, including prefix, carefully determine the member’s financial responsibility before processing payment. Check eligibility and benefits electronically through BlueCross BlueShield of South Carolina or by calling 1.800.676.BLUE (2583).
- All services, regardless of whether or not you’ve collected the member responsibility at the time of service, must be billed to BlueCross BlueShield of South Carolina for proper benefit determination, and to update the member’s claim history.
- Please do not use the card to process full payment up front. If you have any questions about the member’s benefits, please contact 1.800.676.BLUE (2583) or, for questions about the healthcare debit card processing instructions or payment issues, please contact the toll-free debit card administrator’s number on the back of the card.

3.5 Limited Benefits Products

Verifying BCBS patients’ benefits and eligibility is important, now more than ever since new products and benefit types entered the market. Patients who have traditional, PPO, HMO, POS or other coverage, typically with high lifetime coverage limits (i.e., \$1 million or more), may have annual benefits limited to \$50,000 or less.

Currently BlueCross BlueShield of South Carolina doesn't offer such limited benefit plans to our members, however you may see patients with limited benefits who are covered by another BCBS Plan.

How to recognize members with limited benefits products?

Members with limited benefits coverage (that is, annual benefits limited to \$50,000 or less) carry ID cards that may have one or more of the following indicators:

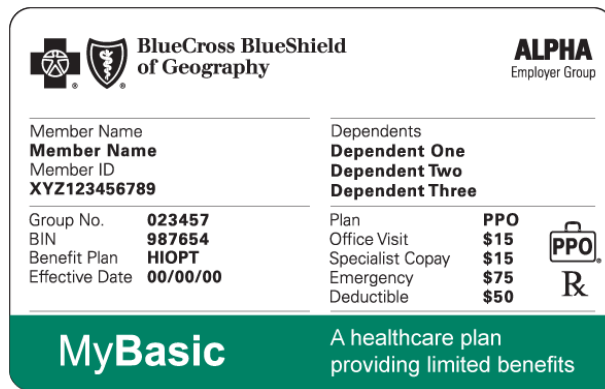
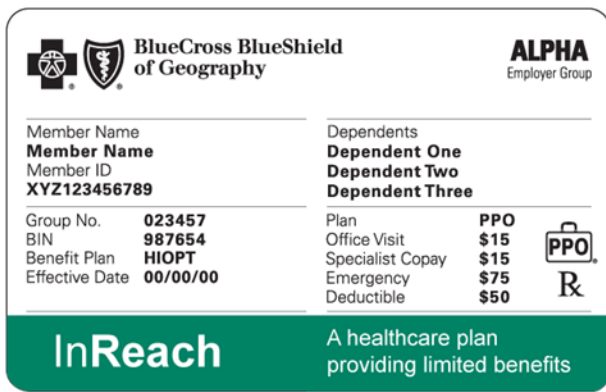
Product name will be listed such as **InReach** or **MyBasic**

A **green stripe** at the bottom of the card

A statement either on the front or the back of the ID card stating this is a limited benefits product

A **black cross and/or shield** to help differentiate it from other identification cards

These ID cards may look like this:



3.6 Coverage and Eligibility Verification

For BlueCross BlueShield of South Carolina members, verify the patient's eligibility and coverage at My Insurance ManagerSM or by calling 800-868-2510.

For other Blue Plan members, submit an electronic inquiry or call BlueCard Eligibility at 800-676-BLUE (2583) to verify the patient's eligibility and coverage:

- Electronic — Submit a HIPAA 270 transaction (eligibility) via www.SouthCarolinaBlues.com. You can receive real-time responses to your eligibility requests for out-of-area members between 6 a.m. and midnight, Central Time, Monday through Saturday.
- Phone — Call BlueCard Eligibility at 800-676-BLUE (2583).
- English- and Spanish-speaking phone operators are available to assist you.
- Blue Plans are located throughout the country and may operate on a different time schedule than BlueCross BlueShield of South Carolina. You may be transferred to a voice response system linked to customer enrollment and benefits outside that Plan's regular business hours.
- The BlueCard Eligibility line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for claim status.

Electronic Health ID Cards

- Some Blue Plans have implemented electronic health ID cards to facilitate a seamless coverage and eligibility verification process.

- Electronic health ID cards enable electronic transfer of core subscriber/member data from the ID card to the provider's system.
- An electronic health ID card has a magnetic stripe on the back of the ID card, similar to what you can find on the back of a credit or debit card. The subscriber/member electronic data is embedded on the third track of the three-track magnetic stripe.
- Core subscriber/member data elements embedded on the third track of the magnetic stripe include the subscriber's/member's name, ID, date of birth and Plan ID.
- The Plan ID data element identifies the health Plan that issued the ID card. Plan ID will help you facilitate health transactions among various payers in the marketplace.
- You will need a track 3 card reader in order for the data on track 3 of the magnetic stripe to be read (the majority of card readers in provider offices only read tracks 1 & 2 of the magnetic stripe; tracks 1 & 2 are proprietary to the financial industry).

3.7 Utilization Review

You should remind patients that they are responsible for obtaining pre-certification/preauthorization for outpatient services from their BCBS Plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (Provider Financial Responsibility, see section 3.10). In addition, members are held harmless when pre-service review is required and not received for inpatient facility services (unless an account receives an approved exception).

Providers must also follow specified timeframes for pre-service review notifications:

1. 48 hours to notify the member's Plan of change in pre-service review; and
2. 72 hours for emergency/urgent pre-service review notification.

General information on pre-certification/preauthorization information can be found on the out-of-area member Medical Policy and Pre-Authorization/Pre-Certification Router on our websites utilizing the three-letter prefix found on the member ID card.

You may also contact the member's Plan on the member's behalf. You can do so by:

- For BlueCross BlueShield of South Carolina members, contact the number on the back of the ID card or use My Insurance Manager.
- For other BCBS Plans members:
 - Call BlueCard Eligibility 1.800.676.BLUE (2583) — ask to be transferred to the utilization review area.
 - When pre-certification/preauthorization for a specific member is handled separately from eligibility verifications at the member's BCBS Plan, your call will be routed directly to the area that handles pre-certification/pre-authorization. You will choose from four options depending on the type of service for which you are calling:
 - Medical/Surgical
 - Behavioral Health
 - Diagnostic Imaging/Radiology
 - Durable/Home Medical Equipment (D/HME)

If you are inquiring about both, eligibility and pre-certification/pre-authorization, through 1.800.676.BLUE (2583), your eligibility inquiry will be addressed first. Then you will be transferred, as appropriate, to the pre-certification/preauthorization area.

- Submit an electronic HIPAA 278 transaction (referral/authorization) to BlueCross BlueShield of South Carolina.
- The member’s BCBS Plan may contact you directly regarding clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

When obtaining pre-certification/preauthorization, please provide as much information as possible, to minimize potential claims issues. Providers are encouraged to follow-up immediately with a member’s BCBS Plan to communicate any changes in treatment or setting to ensure existing authorization is modified or a new one is obtained, if needed. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

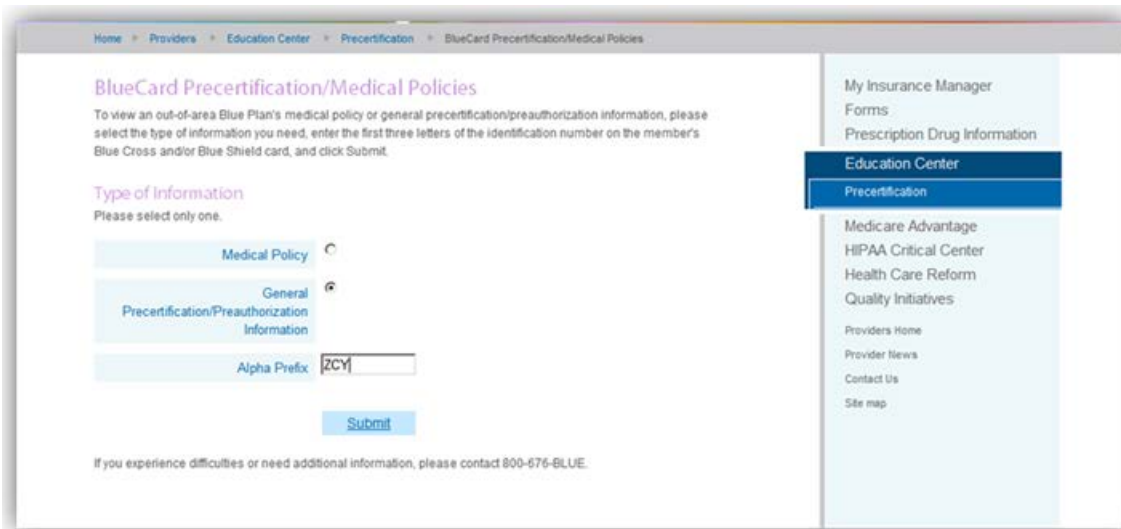
3.8 Electronic Provider Access

Electronic Provider Access (EPA) gives you the ability to access an out-of-area member’s BCBS Plan provider portals to conduct electronic pre-service review. The term pre-service review is used to refer to pre-notification, pre-certification, pre-authorization and prior approval, amongst other pre-claim processes. EPA enables providers to use their local BCBS Plan’s provider portal to gain access to an out-of-area member’s BCBS Plan provider portal, through a secure routing mechanism. Once in the member’s BCBS Plan provider portal, the out-of-area provider has the same access to electronic pre-service review capabilities as the Plan’s local providers.

The availability of EPA varies depending on the capabilities of each BCBS Plan. Some Plans have electronic pre-service review for many services, while others do not. The following describes how to use EPA and what to expect when attempting to contact BCBS Plans.

Using the EPA Tool

The first step is to go to www.SouthCarolinaBlues.com. You will then select the Prior Authorization menu option. Education Center, Precertification and then the BlueCard precertification tool.



Next, enter the prefix from the member’s ID card. The prefix is the first three characters that precede the member ID.

You can first check whether the Home Plan requires pre-certification by either:

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

Entering the member's prefix from the ID card automatically routes you to the BCBS Plan's EPA landing page. This page welcomes you to the Plan's portal and indicates that you have left BlueCross BlueShield of South Carolina's portal. The landing page allows you to connect to the available electronic pre-service review processes. Because the screens and functionality of Plans' pre-service review processes vary widely, Plans may include instructional documents or e-learning tools on the landing page to provide instruction on how to conduct an electronic pre-service review. The page also includes instructions for conducting pre-service review for services where the electronic function is not available.

The BCBS Plan landing page looks similar across Plans, but will be customized to the particular Plan based on the electronic pre-service review services offered.

3.9 Provider Financial Responsibility for Pre-Service Review for BlueCard Members

As a participating provider, you are responsible for obtaining pre-service review for inpatient facility services for BlueCard members and holding the member harmless when pre-service review is required by the account or member contract and not received for inpatient services. Participating providers must also:

- Notify the member's BCBS Plan within 48 hours when a change or modifications to the original pre-service review occurs.
- Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

Failure to contact the member's BCBS Plan for pre-service review or for a change or modification of the pre-service review will result in claim penalties or denials for inpatient facility services. The member must be held harmless and cannot be balance-billed if pre-service review has not occurred*.

Pre-service review contact information for a member's BCBS Plan is provided on the member's identification card. Pre-service review requirements can also be determined by:

- Using the Electronic Provider Access (EPA) tool available at www.SouthCarolinaBlues.com or the provider portal at My Insurance Manager. Note that the availability of EPA will vary depending on the capabilities of each member's BCBS Plan.
- Submitting an ANSI 278 electronic transaction to BlueCross BlueShield of South Carolina or calling 1.800.676.BLUE (2583).

Services that deny as not medically necessary remain member liability.

Who do I contact if I have additional questions about Provider Financial Responsibility for Pre-Service Review?

If you have any questions on Provider Financial Responsibility or general questions, please contact BlueCross BlueShield of South Carolina.

Who do I contact if I have additional questions about Electronic Provider Access?

If you have any questions on how to use the EPA tool, please contact your Provider Education Representative

3.10 Updating Your Provider Information

Maintaining accurate provider information is critically important to ensure that consumers have timely access to care. Updated information helps us maintain accurate provider directories and also ensures that providers are more easily accessible to members. Additionally, Plans are required by Centers for Medicare & Medicaid Services (CMS) to include accurate information in provider directories for certain key provider data elements and accuracy of directories are routinely reviewed/audited by CMS.

Since it is the responsibility of each provider to inform Plans when there are changes, you are reminded to notify us of any changes to your demographic information or other key pieces of information, such as a change in ability to accept new patients, street address, phone number or any other change that affects patient access to care. For BlueCross BlueShield of South Carolina to remain compliant with federal and state requirements, changes must be communicated quarterly so that members have access to the most current information in our Provider Directory.

Key Data Elements

The data elements required by CMS and crucial for member access to care are as follows:

Physician Name

Location (i.e., Address, Suite, City/State, Zip Code)

Phone Number

Accepting New Patient Status

Hospital Affiliations

Medical Group Affiliations

Plans are also encouraged (and in some cases required by certain regulatory/accrediting entities) to include accurate information for the following provider data elements:

Physician Gender

Languages Spoken

Office Hours

Specialties

Physical Disabilities Accommodations (e.g., wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, other accessible equipment)

Indian Health Service Status

Licensing information (i.e., Medical License Number, License State, National Provider Identifier NPI)

Provider Credentials (i.e., Board Certification, Place of Residency, Internship, Medical School, Year of Graduation)

Email and website address

Hospital has an emergency department, if applicable

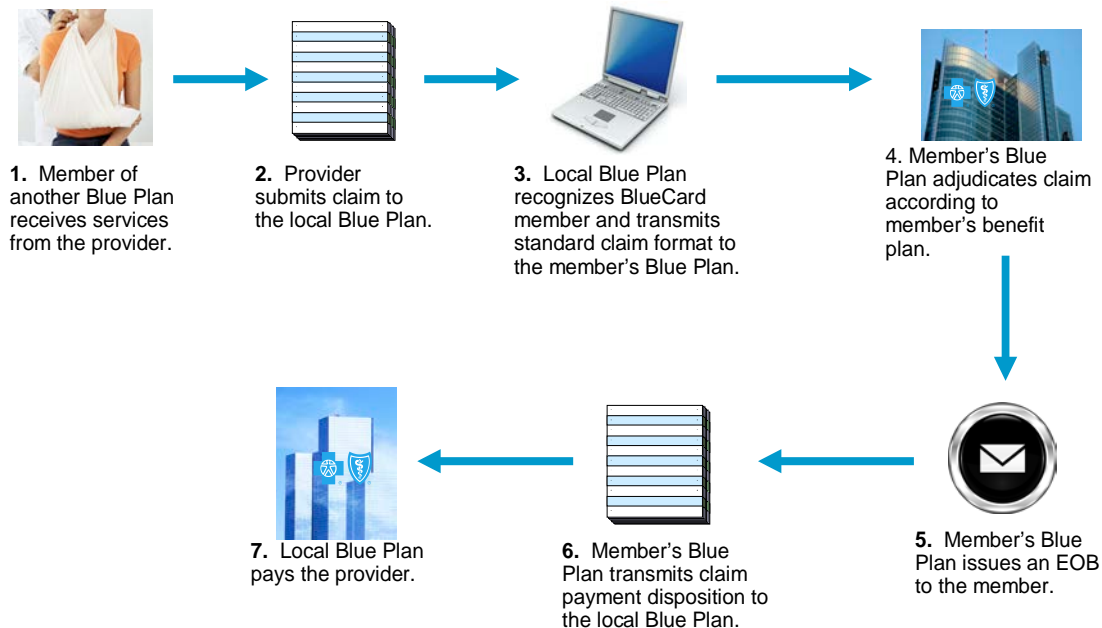
How to Update Your Information

You should routinely check your current practice information in our provider directory on our website. If your information is not current and updates are needed, please provide the correct information as soon as possible by visiting the Credentialing/Provider Updates page on www.SouthCarolinaBlues.com. As an additional opportunity to confirm your information, you may also receive an email from Provider.Directory@bcssc.com.

4. Claim Filing

4.1 How Claims Flow through BlueCard

Below is an example of how claims flow through BlueCard.



After the member of another Blue Plan receives services from you, you should file the claim with BlueCross BlueShield of South Carolina. We will work with the member's plan to process the claim and the member's Plan will send an EOB to the member. We will send you an explanation of payment or the remittance advice and issue the payment to you under the terms of our contract with you and based on the member's benefits and coverage.

You should always submit your claims to BlueCross BlueShield of South Carolina.

Following these helpful tips will improve your claims experience:

- Ask members for their current member ID cards and regularly get new photocopies of them (front and back). Having the current card enables you to submit claims with the appropriate member information (including the prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically by calling 800-676-BLUE (2583). Be sure to provide the member's prefix.
- Verify the member's benefit cost-sharing amount before accepting full payment upfront.
- Indicate any payment you collected from the patient on the claim. (On the 837 electronic claim submission form, check field AMT01=F5 patient paid amount; on the CMS1500 locator **29** amount paid; on UB04 locator **54** prior payment; on UB04 locator **53** prior payment.)

- Submit all Blue claims to BlueCross BlueShield of South Carolina. Be sure to include the member's complete identification number when you submit the claim. This includes the three-character prefix. Submit claims with only valid prefixes. We cannot process claims with incorrect or missing prefixes and member identification numbers.
- In cases in which there is more than one payer, and a Blue Plan is a primary payer, submit other party liability (OPL) information with the claim. Upon receipt, we will electronically route the claim to the member's Blue Plan. The member's plan then processes the claim and approves payment. BlueCross BlueShield of South Carolina will reimburse you for services.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.
- Check claims status via My Insurance Manager at www.SouthCarolinaBlues.com.

4.2 Medicare Advantage Claims

4.2.1 Medicare Advantage Overview

Medicare Advantage (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as "traditional Medicare".

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

In addition to these products, Medicare Advantage Organizations may also offer a Special Needs Plan (SNP), which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Medicare Advantage plans may allow in and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage by calling 1.800.676.BLUE (2583) or submitting an electronic inquiry, for all Medicare Advantage members prior to providing service since the level of benefits, and coverage rules, may vary depending on the Medicare Advantage plan.

Types of Medicare Advantage Plans

Medicare Advantage HMO

A Medicare Advantage HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally (except in urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits, and the coverage rules, may vary by Medicare Advantage plan.

Medicare Advantage POS

A Medicare Advantage POS program is an option available through some Medicare HMO programs. It allows members to determine — at the point of service — whether they want to receive certain designated services within the HMO system, or seek such services outside the HMO's provider network (usually at greater cost to the member). The Medicare Advantage POS plan may specify which services will be available outside of the HMO's provider network.

Medicare Advantage PPO

A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Blue Medicare Advantage PPO members have in-network access to Blue MA PPO providers.

Medicare Advantage PFFS

A Medicare Advantage PFFS plan is a plan in which the member may go to any Medicare-approved doctor or hospital that accepts the plan's terms and conditions of participation. Acceptance is "deemed" to occur where the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The Medicare Advantage Organization, rather than the Medicare program, pays for services rendered to such members. Members are responsible for cost-sharing, as specified in the plan, and balance billing may be permitted in limited instance where the provider is a network provider and the plan expressly allows for balance billing.

Medicare Advantage PFFS varies from the other Blue products you might currently participate in:

- You can see and treat any Medicare Advantage PFFS member without having a contract with BlueCross BlueShield of South Carolina.
- If you do provide services, you will do so under the Terms and Conditions of that member's Blue Plan.
- MA PFFS Terms and Conditions might vary for each Blue Plan and we advise that you review them before servicing MA PFFS members.
- Please refer to the back of the member's ID card for information on accessing the Plan's Terms and Conditions. You may choose to render services to a MA PFFS member on an episode of care (claim-by-claim) basis.
- Submit your MA PFFS claims to BlueCross BlueShield of South Carolina.

Medicare Advantage Medical Savings Account (MSA)

Medicare Advantage Medical Savings Account (MSA) is a Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.

4.2.2 Medicare Advantage PPO Network Sharing

What is BCBS Medicare Advantage PPO Network Sharing?

All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing allows all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted MA PPO provider.

What does the BCBS Medicare Advantage (MA) PPO Network Sharing mean to me?

If you are a contracted MA PPO provider with BlueCross BlueShield of South Carolina and you see MA PPO members from other BCBS Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with BlueCross BlueShield of South Carolina. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted MA PPO provider with BlueCross BlueShield of South Carolina and you provide services for any BCBS MA members, you will receive the Medicare allowed amount for covered services. For

urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How do I recognize an out-of-area member from one of these Plans participating in the BCBS MA PPO network sharing?

You can recognize a MA PPO member when their member ID card has the following logo.



The "MA" in the suitcase indicates a member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID.

Do I have to provide services to Medicare Advantage PPO members from other Blue Cross Blue Shield Plans?

If you are a contracted Medicare Advantage PPO provider with BlueCross BlueShield of South Carolina, you must provide the same access to care as you do for BlueCross BlueShield of South Carolina BCBS MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a Medicare Advantage PPO contracted provider, you may see Medicare Advantage members from other BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local Blue Cross Blue Shield Medicare Advantage PPO members?

If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local MA PPO members.

What will I be paid for providing services to these out-of-area Medicare Advantage PPO network sharing members?

If you are a MA PPO contracted provider with BlueCross BlueShield of South Carolina, benefits will be based on your contracted MA PPO rate for providing covered services to MA PPO members from any MA PPO Plan. Once you submit the MA claim, BlueCross BlueShield of South Carolina will work with the other Plan to determine benefits and send you the payment.

What will I be paid for providing services to Medicare Advantage out-of-area members not participating in the Medicare Advantage PPO Network Sharing?

When you provide covered services to other BCBS MA out-of-area members, benefits will be based on the Medicare allowed amount. Once you submit the claim, BlueCross BlueShield of South Carolina will send you the payment. However, these services will be paid under the member's out-of-network benefits unless for urgent or emergency care.

May I request payment upfront?

Generally, once the member receives care, you should not ask for full payment up front other than out-of-pocket expenses (deductible, co-payment, coinsurance and non-covered services).

Under certain circumstances when the member has been notified in advance that a service will not be covered, you may request payment from the member before services are rendered or billed to the member. The member should sign an Advance Benefit Notification (ABN) form before services are rendered in these situations.

What is the member cost sharing level and co-payments?

Member cost sharing level and co-payment is based on the member’s health plan. You may collect the co-payment amounts from the member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 1.800.676.BLUE (2583).

May I balance bill the member the difference in my charge and the allowance?

No, you may not balance bill the member for this difference. Members may be billed for any deductibles, co-insurance, and/or co-pays.

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact your local Plan at BlueCross BlueShield of South Carolina.

Who do I contact if I have a question about MA PPO network sharing?

If you have any questions regarding the MA program or products, contact BlueCross BlueShield of South Carolina.

What is BCBS Medicare Advantage PPO Network Sharing?

Network sharing allows MA PPO members from MA PPO BCBS Plans to obtain in-network benefits when traveling or living in the service areas of the MA PPO Plans as long as the member sees a contracted MA PPO provider. MA PPO shared networks are available in 39 states and one territory:

Alabama	Kentucky	Nebraska	Puerto Rico
California	Kansas	Nevada	Rhode Island
Colorado	Louisiana	New Hampshire	South Carolina
Connecticut	Maine	New Jersey	Tennessee
Florida	Massachusetts	New Mexico	Texas
Georgia	Michigan	New York	Utah
Hawaii	Minnesota	Ohio	Virginia
Idaho	Missouri	Oklahoma	Washington
Illinois	Montana	Oregon	Wisconsin
Indiana	North Carolina	Pennsylvania	West Virginia

4.2.3 Eligibility Verification

- You can verify eligibility by contacting the BlueCard Eligibility Line at 1.800.676.BLUE (2583) and provide the member’s three-digit prefix located on the ID card. Be sure to ask if Medicare Advantage benefits apply.

You may also submit electronic eligibility requests or use My Insurance Manager. If you experience difficulty obtaining eligibility information, please record the prefix and report it to BlueCross BlueShield of South Carolina. *See section 3.9, Electronic Provider Access.*

4.2.4 Medicare Advantage Claims Submission

- Submit all Medicare Advantage claims to BlueCross BlueShield of South Carolina.
- Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

- Payment will be made directly by a Blue Cross Blue Shield Plan.

4.2.5 Reimbursement for Medicare Advantage PPO, HMO, POS, PFFS

Note: The reimbursement information below applies when a provider treats a Blue Cross Blue Shield Medicare Advantage member to whom the provider's contract does not apply.

Examples:

- A provider that is contracted for Medicare Advantage PPO business treats a Medicare Advantage HMO member.
- A provider that is contracted for commercial business only treats a MA PPO member.
- A provider that is contracted for Medicare Advantage HMO business treats any MA PPO member.
- A provider that is contracted for local Medicare Advantage HMO business treats an out-of-area MA HMO member.
- A provider that is not contracted with the local Plan treats a MA HMO member.

Based upon the Centers for Medicare and Medicaid Services (CMS) regulations, if you are a provider who accepts Medicare assignment and you render services to a Medicare Advantage member for whom you have no obligation to provide services under your contract, you will generally be considered a non-contracted provider and be reimbursed the equivalent of the current Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).

Special payment rules apply to hospitals and certain other entities (e.g., skilled nursing facilities) that are non-contracted providers.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Providers that are paid on a reasonable cost basis under original Medicare should send their CMS Interim Payment Rate letter with their Medicare Advantage claim. This letter will be needed by the Plan to calculate the Medicare Allowed amount.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Cross Blue Shield Plan or its branded affiliate. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Note: Enrollee payment responsibilities can include more than copayments (e.g., deductibles).

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

Medicare Advantage Private-Fee-For-Service (PFFS) Claim Reimbursement

If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member, but are not obligated to provide services to such member under a contract, you will generally be reimbursed the Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare). Providers should make sure they understand the applicable Medicare Advantage reimbursement rules by reviewing the Terms & Conditions under the member's Blue Plan. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Cross Blue Shield Plan. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

Note: The reimbursement information below applies when a provider treats a Blue Cross Blue Shield Medicare Advantage member to whom the provider's contract applies.

Examples:

- A provider that is contracted for Medicare Advantage PPO business treats an out-of-area Medicare Advantage PPO member.
- A provider that is contracted for Medicare Advantage HMO business treats an MA HMO member from the local Plan.

If you are a provider who accepts Medicare assignment and you render services to any Blue Cross Blue Shield Medicare Advantage member for whom you have an obligation to provide services under your contract, you will be considered a contracted provider and be reimbursed per the contractual agreement.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Cross Blue Shield Plan. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

4.2.6 Medicare Advantage Coordination of Care Program

A new national Coordination of Care program to support Blue MA members was launched on January 1, 2020. The program aims to increase the quality of members' care by enabling Blue MA PPO group members to receive appropriate care, wherever they access care.

To better support all Blue MA PPO group members residing in South Carolina, BlueCross is working with providers to improve these members' care through:

- Supporting providers with additional information about open gaps in care
- Requesting medical records to give Plans a complete understanding of member health status

MA PPO group members participating into this program can be identified as having a member address in South Carolina and based on the following logo included on their Blue Cross and/or Blue Shield ID Cards:



4.3 Medicaid Claims

Blue Plans currently administer Medicaid programs in various states across the U.S. as Managed Care Organizations (MCO), providing comprehensive Medicaid benefits to the eligible population. Because Medicaid is a state-run program, requirements vary for each state, and thus each BCBS Plan. Medicaid members have limited out-of-state benefits, generally covering only emergent situations. In some cases, such as continuity of care, children attending college out-of-state, or a lack of specialists in the member's home state, a Medicaid member may receive care in another state, and generally the care requires prior authorization.

4.3.1 Identifying Medicaid Members to Determine Eligibility and Benefits

BCBS ID cards do not always indicate that a member has a Medicaid product. ID cards for Medicaid members do not include the suitcase logo that you may have seen on most ID cards, but they do include a disclaimer on the back providing information on benefit limitations. For members with such ID cards, you should obtain eligibility and benefit information and prior authorization for services using the same tools as you would for other BCBS members.

- Submit an eligibility inquiry by calling the BlueCard Eligibility Line at 1.800.676.BLUE (2583)
- Submit an eligibility inquiry using BlueExchange.
- Obtain preservice review using the Electronic Provider Access (EPA) tool

4.3.2 Medicaid Reimbursement and Billing

Claims for all BCBS Medicaid members should be submitted to your local BCBS Plan. If you are contracted with your local BCBS Plan for Medicaid, your local Medicaid rates will only apply for BlueCross BlueShield of South Carolina members; they do not apply to out-of-state Medicaid members. When you see a Medicaid member from another state and submit the claim, you must accept the Medicaid fee schedule that applies in the member's home state.

Please remember that billing out-of-state Medicaid members for the amount between the Medicaid-allowed amount and charges for Medicaid-covered services is prohibited by Federal regulations ([42 CFR 447.15](#)).

If you provide services that are not covered by Medicaid to a Medicaid member, you will not be reimbursed. You may only bill a Medicaid member for services not covered by Medicaid if you have obtained written approval from the member in advance of the services being rendered.

In some circumstances, a state Medicaid program will have an applicable copayment, deductible or coinsurance applied to the member's plan. You may collect this amount from the member as applicable. Note that the coinsurance amount is based on the Medicaid fee schedule for that service.

4.3.3 Medicaid Billing Data Requirements

When billing for a Medicaid member, please remember to check the Medicaid website of the state where the member resides for information on Medicaid billing requirements.

Providers should always include their National Provider Identifier (NPI) on Medicaid claims, unless the provider is considered atypical. Providers should also bill using National Drug Codes (NDC) on applicable claims.

4.3.4 Provider Enrollment Requirements

Some states require that out-of-state providers enroll in their state's Medicaid program in order to be reimbursed. Some of these states may accept a provider's Medicaid enrollment in the state where they practice to fulfill this requirement.

If you are required to enroll in another state's Medicaid program, you should receive notification upon submitting an eligibility or benefit inquiry. You should enroll in that state's Medicaid program before submitting the claim. To view provider enrollment requirements for BCBS Medicaid states, please visit www.SouthCarolinaBlues.com.

4.3.5 Medicaid Questions

How do I submit Medicaid claims?

Medicaid claims should be submitted to your local BCBS Plan in the same manner as you submit claims for other BCBS members. You will also receive your payment in the same manner, although the payment amount will likely be different from your contracted rate, or different from the Medicaid rate in the state in which you practice.

How do I know that I am seeing a Medicaid member?

Members enrolled in a BCBS Medicaid product are issued BCBS ID cards. Medicaid ID cards do not always indicate that a member is enrolled in a Medicaid product. Medicaid ID cards:

- Will not include a suitcase logo.
- Will contain disclaimer language on the back of the ID card indicating benefit limitations for provider awareness.

Providers should always submit an eligibility inquiry if the ID card has no suitcase logo and includes a disclaimer with benefit limitations, using the same tools available for BlueCard:

- BlueCard Eligibility Line
- BlueExchange

Because ID cards will not always indicate that the member is enrolled in a Medicaid product, you should always obtain eligibility and benefit information. With an eligibility response, you should receive information on Medicaid coverage.

What amount should I expect to receive for members that reside outside of BlueCross BlueShield of South Carolina's service area?

When billing for services rendered to an out-of-state Medicaid member, you will be reimbursed according to the member's home state Medicaid fee schedule, which may or may not be equal to what you are accustomed to receiving for the same service in your state.

My state does not require me to include an NPI or NDC code and many of the other data elements listed above on a Medicaid claim. Why do I have to include these codes?

Most state Medicaid programs require NPI and NDC codes and the additional data elements (when applicable) to be populated on claims submitted for Medicaid members for encounter data reporting purposes. To ensure compliance with state Medicaid requirements, providers who bill for Medicaid members should include these data elements on applicable BCBS Medicaid claims or the claims may be pended or denied.

I do not often see Medicaid members from another state. Why must I enroll as a Medicaid provider outside of my own state when billing for some Medicaid members in other states?

Many state Medicaid programs require providers to enroll before reimbursement may be provided by the Plan. If you do not enroll with the state where required, the claim could be denied.

Whom do I contact if I have questions?

If you have questions, please call BlueCross BlueShield of South Carolina.

4.4 Claims Coding

Code claims as you would for BlueCross BlueShield of South Carolina claims.

4.5 Ancillary Claims

Ancillary providers include Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies and Specialty Pharmacy providers. File claims for these providers as follows:

- Independent Clinical Laboratory (Lab)
 - File to the BCBS Plan in whose service area the referring provider is located.
- Durable/Home Medical Equipment and Supplies (D/HME)
 - File to the Plan in whose service area the equipment was shipped to or purchased at a retail store.
- Specialty Pharmacy
 - File to the Plan in whose service area the ordering physician is located.

*If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.

Provider Type	How to File (Required Fields)	Where to File	Example
<p>Independent Clinical Laboratory (any type of non-hospital based laboratory)</p> <p>Types of Service include, but are not limited to: blood, urine, samples, analysis, etc.</p>	<p>Referring Provider:</p> <ul style="list-style-type: none"> - Field 17B on CMS 1500 Health Insurance Claim Form or - Loop 2310A (claim level) on the 837 Professional Electronic 	<p>File the claim to the Plan in whose service area the referring provider is located.</p> <p>Note:</p> <ul style="list-style-type: none"> • Claim must be processed based on information submitted on the claim. • The referring provider NPI, as submitted on the claim, must be used to determine where service was rendered. • Claims for the analysis of a lab must be filed to the Plan in whose service area the referring provider is located. • BlueCard rules for claims incurred in an overlapping service area and contiguous county apply. 	<p>Blood is drawn in lab or office setting at the request of a referring provider located in Alabama.</p> <p>Blood analysis is done in South Carolina.</p> <p><i>File both portions of the claim to: BlueCross BlueShield of Alabama.</i></p>
<p>Durable/Home Medical Equipment and Supplies (D/HME)</p> <p>Types of Service include, but are not limited to: Hospital beds, oxygen tanks, crutches, etc.</p>	<p>Patient's Address:</p> <ul style="list-style-type: none"> - Field 5 on CMS 1500 Health Insurance Claim Form or - Loop 2010CA on the 837 Professional Electronic Submission. <p>Ordering Provider:</p> <ul style="list-style-type: none"> - Field 17B on CMS 1500 Health Insurance Claim Form or - Loop 2420E (line level) on the 837 Professional Electronic Submission. <p>Place of Service:</p>	<p>File the claim to the Plan in whose service area the equipment was shipped to or purchased in a retail store.</p> <p>Note:</p> <ul style="list-style-type: none"> • Claim must be processed based on information submitted on the claim. • The Place of Service code, as submitted on the claim, must be used to determine where service was rendered (e.g. member home/equivalent setting, retail, office, etc.). 	<p>A. Wheelchair is purchased at a retail store in South Carolina.</p> <p><i>File to: BlueCross BlueShield of South Carolina</i></p> <p>B. Wheelchair is purchased on the internet from an online retail supplier in Alabama and shipped to South Carolina.</p> <p><i>File to: BlueCross BlueShield of South Carolina</i></p> <p>C. Wheelchair is purchased at a retail store in South Carolina and shipped to Alabama.</p>

Provider Type	How to File (Required Fields)	Where to File	Example
	<ul style="list-style-type: none"> - Field 24B on the CMS 1500 Health Insurance Claim Form or - Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions. <p>Service Facility Location Information:</p> <ul style="list-style-type: none"> - Field 32 on CMS 1500 Health Insurance Form or - Loop 2310C (claim level) on the 837 Professional Electronic Submission. 	<ul style="list-style-type: none"> • BlueCard rules for claims incurred in an overlapping service area and contiguous county apply. 	<p><i>File to:</i> BlueCross BlueShield of Alabama</p>
<p>Specialty Pharmacy</p> <p>Types of Service: Non-routine, biological therapeutics ordered by a healthcare professional as a covered medical benefit as defined by the member's Plan's Specialty Pharmacy formulary. Include, but are not limited to: injectable, infusion therapies, etc.</p>	<p>Referring Provider:</p> <ul style="list-style-type: none"> - Field 17B on CMS 1500 Health Insurance Claim Form or - Loop 2310A (claim level) on the 837 Professional Electronic Submission. 	<p>File the claim to the Plan whose state the Ordering Physician is located.</p> <p>Note:</p> <ul style="list-style-type: none"> • Claim must be processed based on information submitted on the claim. • The ordering physician NPI, as submitted on the claim, must be used to determine where service was rendered. • BlueCard rules for claims incurred in an overlapping service area and contiguous county apply. 	<p>Patient is seen by a physician in Alabama who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in South Carolina where the member lives for 6 months of the year.</p> <p><i>File to:</i> BlueCross BlueShield of Alabama</p>

- The ancillary claim filing rules apply regardless of the provider's contracting status with the BCBS Plan where the claim is filed.
- Providers are encouraged to verify member Eligibility and Benefits by contacting the phone number on the back of the member ID card or call 1.800.676.BLUE (2583), prior to providing any ancillary service.
- Providers that use outside vendors to provide services (example: sending blood specimen for special analysis that cannot be done by the Lab where the specimen was drawn) should utilize in-network participating Ancillary Providers to reduce the risk of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting BlueCross BlueShield of South Carolina.
- Members are financially liable for ancillary services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.
- Providers who wish to establish Trading Partner Agreements with other Plans should contact BlueCross BlueShield of South Carolina to obtain additional contact information.
- If you have any questions about where to file your claim, please contact BlueCross BlueShield of South Carolina.

4.6 Air Ambulance Claims

Claims for air ambulance services must be filed to the BCBS Plan in whose service area the point of pickup ZIP code is located.

Note: If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.

Service Rendered	How to File (Required Fields)	Where to File	Example
Air Ambulance Services	<p>Point of Pickup ZIP Code:</p> <ul style="list-style-type: none"> – Populate item 23 on CMS 1500 Health Insurance Claim Form, with the 5-digit ZIP code of the point of pickup <ul style="list-style-type: none"> – For electronic billers, populate the origin information (ZIP code of the point of pick-up), in the Ambulance Pick-Up Location Loop in the ASC X12N Health Care Claim (837) Professional. – Where Form CMS-1450 (UB-04) is used for air ambulance service not included with local hospital charges, populate Form Locators 39-41, with the 5-digit ZIP code of the point of pickup. The Form Locator must be populated with the approved Code and Value specified by the National Uniform Billing Committee in the UB-04 Data Specifications Manual. <ul style="list-style-type: none"> – Form Locators (FL) 39-41 – Code: A0 (Special ZIP code reporting), or its successor code specified by the National Uniform Billing Committee. – Value: Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance. – For electronic claims, populate the origin information (ZIP code of the point of pick-up) in the Value Information Segment in the ASC X12N Health Care Claim (837) Institutional. 	<p>File the claim to the Plan in whose service area the point of pickup ZIP code is located*.</p> <p>*BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.</p>	<ul style="list-style-type: none"> • The point of pick up ZIP code is in Plan A service area. • The claim must be filed to Plan A, based on the point of pickup ZIP code.

- The air ambulance claims filing rules apply regardless of the provider’s contracting status with the BCBS Plan where the claim is filed.
- Where possible, providers are encouraged to verify Member Eligibility and Benefits by contacting the phone number on the back of the Member ID card or calling 1.800.676.BLUE (2583).
- Providers are encouraged to utilize in-network participating air ambulance providers to reduce the risk of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting BlueCross BlueShield of South Carolina.
- Members are financially liable for air ambulance services not covered under their benefit plan. It is the provider’s responsibility to request payment directly from the member for non-covered services.

- Providers who wish to establish Trading Partner Agreements with other Plans should contact BlueCross BlueShield of South Carolina to obtain additional contact information.
- If you have any questions about where to file your claim, please contact BlueCross BlueShield of South Carolina.

4.7 Contiguous Counties/Overlapping Service Areas

4.7.1 Contiguous Counties

Claims may be filed directly to the member's BCBS Plan by contiguous area providers based on the permitted terms of the provider contract, which may include:

- Provider location (i.e. which Plan service area is the providers office located)
- Provider contract with the two contiguous counties (i.e., is the provider contracted with only one or both service areas).
- The member's BCBS Plan (i.e., is the member's BCBS Plan in a county contiguous to the provider location).
- The member's location (i.e., does the member live or work in the service area covered by his/her BCBS Plan).
- The location of where the services were received (i.e., did the member receive service from a provider located in a county contiguous to the member's BCBS Plan).

4.7.2 Overlapping Service Areas

Submission of claims in an overlapping service area is dependent on which Plan(s) the provider contracts within that service area, the type of contract the provider has (I.e., PPO, Traditional) and the type of contract the member has with their BCBS Plan.

- If you contract with all local BCBS Plans in your state for the same product type (i.e., PPO or Traditional), you may file an out-of-area member's claim with either Plan.
- If you have a PPO contract with one BCBS Plan, but a Traditional contract with another BCBS Plan, file the out-of-area member's claim by product type.
- For example, if it's a PPO member, file the claim with the Plan that has your PPO contract.
- If you contract with one BCBS Plan but not the other, file all out-of-area claims with your contracted Plan.

4.8 Medical Records

Medical Records

BCBS Plans have made many improvements to the medical records process to make it more efficient and are able to send and receive medical records electronically with other BCBS Plans. This method significantly reduces the time it takes to transmit supporting documentation for our out-of-area claims, reduces the need to request records multiple times and significantly reduces lost or misrouted records.

Under what circumstances may the provider get requests for medical records for out-of-area members?

1. As part of the pre-authorization process — If you receive requests for medical records from other BCBS Plans prior to rendering services, as part of the pre-authorization process, you will be

instructed to submit the records directly to the member's Plan that requested them. This is the only circumstance where you would not submit them to BlueCross BlueShield of South Carolina.

2. As part of claim review and adjudication — these requests will come from BlueCross BlueShield of South Carolina in the form of a letter, fax, email, or electronic communication requesting specific medical records and including instructions for submission.

BlueCard Medical Record Process for Claim Review

1. An initial communication, generally in the form of a letter, should be received by your office requesting the needed information.
2. A remittance may be received by your office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is not a duplicate request for medical records. If you previously submitted medical records but received a remittance advice indicating records were still needed, please contact BlueCross BlueShield of South Carolina to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.
3. If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact BlueCross BlueShield of South Carolina to determine if the records are needed from your office.
4. Upon receipt of the information, the claim will be reviewed to determine the benefits.

Helpful Ways You Can Assist in Timely Processing of Medical Records

1. If the records are requested following submission of the claim, forward all requested medical records to BlueCross BlueShield of South Carolina.
2. Follow the submission instructions given on the request, using the specified physical or email address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.
3. Include the cover letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by BlueCross BlueShield of South Carolina.
4. Please submit the information to BlueCross BlueShield of South Carolina as soon as possible to avoid further delay.
5. Only send the information specifically requested. Frequently, complete medical records are not necessary.
6. Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

4.9 Adjustments

Contact BlueCross BlueShield of South Carolina if an adjustment is required. We will work with the member's BCBS Plan for adjustments; however, your workflow should not be different.

4.10 Appeals

Appeals for all claims are handled through BlueCross BlueShield of South Carolina. We will coordinate the appeal process with the member's BCBS Plan, if needed.

4.11 Coordination of Benefits (COB) Claims

Coordination of benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

If you discover the member is covered by more than one health plan, and:

- BlueCross BlueShield of South Carolina or any other BCBS Plan is the primary payor, submit other carrier's name and address with the claim to BlueCross BlueShield of South Carolina. If you do not include the COB information with the claim, the member's BCBS Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your administrative burden.
- Other non-BCBS health plan is primary and BlueCross BlueShield of South Carolina or any other BCBS Plan is secondary, submit the claim to BlueCross BlueShield of South Carolina only after receiving payment from the primary payor, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's BCBS Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your administrative burden.

Carefully review the payment information from all payers involved on the remittance advice (RA) before balance billing the patient for any potential liability. The information listed on the BlueCross BlueShield of South Carolina remittance advice as "patient liability" might be different from the actual amount the patient owes you, due to the combination of the primary insurer payment and your negotiated amount with BlueCross BlueShield of South Carolina.

For Professional claims if the member does not have other insurance, it is imperative on the electronic HIPAA 837 claims submission transaction or CMS 1500 claim form, in box 11D, either "YES" or "NO" be checked. Leaving the box unmarked can cause the member's Plan to stop the claim to investigate for COB.

Coordination of Benefits Questionnaire

To streamline our claims processing and reduce the number of denials related to Coordination of Benefits, a Coordination of Benefits (COB) questionnaire is available to you at www.SouthCarolinaBlues.com that will help you and your patients avoid potential claim issues.

When you see any Blue members and you are aware that they might have other health insurance coverage, give a copy of the questionnaire to them during their visit. Providers should ensure that the form is completely filled out and at a minimum, includes your name and tax identification or NPI number, the policy holder's name, group number and identification number including the three character prefix and the member's signature. Once the form is complete, send it to your local BCBS Plan as soon as possible. Your local BCBS Plan will work with the member's Plan to get the COB information updated. Collecting COB information from members before you file their claim eliminates the need to gather this information later, thereby reducing processing and payment delays.

4.12 Claim Payments

- If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This will cause member confusion because of multiple Explanations of Benefits (EOBs).
- If you do not receive your payment or a response regarding your payment, please use My Insurance ManagerSM to check the status of your claim.
- In some cases, a member's BCBS Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, BlueCross BlueShield of South Carolina may ask you for the information.

4.13 Claim Status Inquiry

BlueCross BlueShield of South Carolina is your single point of contact for all claim inquiries.

Claim status inquiries can be done by:

- My Insurance ManagerSM
- Electronically — send a HIPAA transaction 276 (claim status inquiry).

4.14 Calls from Members and Others with Claim Questions

If BCBS Plan members contact you, advise them to contact their BCBS Plan and refer them to their ID card for a customer service number.

The member's BCBS Plan should not contact you directly regarding claims issues. If the member's BCBS Plan contacts you directly and asks you to submit the claim to them, refer them to BlueCross BlueShield of South Carolina.

4.15 Value Based Provider Arrangements

Plans have value-based care delivery arrangements in place with their providers. Each Plan has created their own arrangement with their provider(s), including reimbursement arrangements. Due to the unique nature of each Plan/provider arrangement, there is no common provider education template for value-based care delivery arrangements that can be created and distributed for use by all Plans.

4.16 Key Contacts

For more information:

- Visit the www.SouthCarolinaBlues.com
- My Insurance Manager
- Call BlueCross BlueShield of South Carolina at 800.868.2510
- Contact Provider Education at Provider.Education@bcbssc.com

5. Frequently Asked Questions

5.1 BlueCard Basics

1. What Is the BlueCard Program?

BlueCard is a national program that enables members of one BCBS Plan to obtain healthcare service benefits while traveling or living in another BCBS Plan's service area. The program links participating healthcare providers with the independent BCBS Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you conveniently submit claims for patients from other BCBS Plans, domestic and international, to your local BCBS Plan.

Your local BCBS Plan is your sole contact for claims payment, adjustments and issue resolution.

2. What products are included in the BlueCard Program?

The following products/claims are included in the BlueCard Program:

- Traditional (indemnity insurance)
- PPO (Preferred Provider Organization)
- EPO (Exclusive Provider Organization), including Blue High Performance Network (Blue HPN)
- POS (Point of Service)
- Standalone vision
- Standalone prescription drugs

Note: Standalone vision and standalone self-administered prescription drugs programs are eligible to be processed through BlueCard when such products are not delivered using a vendor. Consult claim filing instructions on the back of the ID cards.

3. What products are excluded from the BlueCard Program?

The following products/claims are excluded from the BlueCard Program:

- Stand-alone dental
- The Federal Employee Program (FEP)

5.2 Identifying members and ID Cards

1. How do I identify members?

When members from BCBS Plans arrive at your office or facility, be sure to ask them for their current ID card. The main identifier for out-of-area members is the prefix. The ID cards may also have:

- PPO in a suitcase logo
- PPOB in a suitcase logo
- Blank suitcase logo
- An HPN in a suitcase logo with the Blue High Performance Network (HPN) name in the upper right or lower left corner, for Blue HPN EPO members

2. What is a "prefix?"

The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the BCBS Plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.

3. What do I do if a member has an identification card without a prefix?

Some members may carry outdated identification cards that may not have a prefix. Please request a current ID card from the member.

4. How do I identify Medicare Advantage members?

Members will not have a standard Medicare card; instead, a BCBS logo will be visible on the ID card. The following examples illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:

<i>Member ID cards for Medicare Advantage products will display one of the benefit product logos shown here:</i>		Health Maintenance Organization
		Medical Savings Account
		Private Fee-For-Service
		Point of Service
		Network Sharing Preferred Provider Organization.

5. How do I identify international members?

Occasionally, you may see identification cards from members residing abroad or foreign BCBS Plan members. These ID cards will contain three-character prefixes. Please treat these members the same as domestic Blue Plan members.

5.3 Verifying Eligibility and Coverage

How do I verify membership and coverage?

For BlueCross BlueShield of South Carolina members, go to My Insurance manager.

For other BCBS Plan members, electronically or call BlueCard Eligibility at 800-676-BLUE by phone to verify the patient's eligibility and coverage:

Electronic — Submit a HIPAA 270 transaction (eligibility) to BlueCross BlueShield of South Carolina.

5.4 Utilization Review

1. How do I obtain utilization review?

You should remind patients that they are responsible for obtaining pre-certification/authorization for outpatient services from their BCBS Plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (Provider Financial Responsibility).

You may also contact the member's Plan on the member's behalf. You can do so by:

- Phone — Call the utilization management/pre-certification number on the back of the member’s card. If the utilization management number is not listed on the back of the member’s card, call BlueCard Eligibility 1.800.676.BLUE (2583) and ask to be transferred to the utilization review area.
- Electronic — Submit a HIPAA 278 transaction (referral/authorization) to BlueCross BlueShield of South Carolina.

5.5 Claims

1. Where and how do I submit claims?

You should always submit claims to BlueCross BlueShield of South Carolina. Be sure to include the member’s complete identification number when you submit the claim. The complete identification number includes the three-character prefix. Do not make up prefixes. Claims with incorrect or missing prefixes and/or member identification numbers cannot be processed.

2. How do I submit claims for international Blue members?

The claim submission process for international BCBS Plan members is the same for domestic BCBS Plan members. You should submit the claim directly to BlueCross BlueShield of South Carolina.

3. How do I handle COB claims?

If after calling 1.800.676.BLUE (2583) or through other means you discover the member has a COB provision in their benefit plan and BlueCross BlueShield of South Carolina is the primary payer, submit the claim with information regarding COB to BlueCross BlueShield of South Carolina.

If you do not include the COB information with the claim, the member’s BCBS Plan or the insurance carrier will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

4. How do I handle Medicare Advantage claims?

Submit claims to BlueCross BlueShield of South Carolina. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by a BCBS Plan.

5. How do I handle traditional Medicare-related claims?

- When Medicare is the primary payor, submit claims to your local Medicare intermediary.
- All BCBS claims are set up to automatically cross over (or forward) to the member’s BCBS Plan after being adjudicated by the Medicare intermediary.

6. How do I submit Medicare primary/BCBS Plan secondary claims?

- For members with Medicare primary coverage and BCBS Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.
- When submitting the claim, it is essential that you enter the correct BCBS Plan name as the secondary carrier. This may be different from the local BCBS Plan. Check the member’s ID card for additional verification.
- Be certain to include the prefix as part of the member identification number. The member’s ID will include the prefix in the first three positions. The prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.
- When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the BCBS Plan:

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate BCBS Plan and the claim is in process. Do not resubmit the claim to BlueCross BlueShield of South Carolina, duplicate claims will result in processing and payment delays.
- If the remittance advice indicates that the claim was not crossed over, submit the claim to BlueCross BlueShield of South Carolina with the Medicare remittance advice.
- In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on your claim.
- For claim status inquiries, contact BlueCross BlueShield of South Carolina.

5.6 Contacts

1. Who do I contact with claims questions?

Use My Insurance Manager to check claims status.

2. How do I handle calls from members and others with claims questions?

If members contact you, advise them to contact their BCBS Plan. Refer them to the front or back of their ID card for a customer service number.

3. Where can I find more information?

For more information:

- Visit the www.SouthCarolinaBlues.com
- My Insurance Manager
- Call BlueCross BlueShield of South Carolina at 800.868.2510
- Contact Provider Education at Provider.Education@bcbssc.com

6. Glossary of BlueCard Program Terms

Administrative Services Only (ASO)

ASO accounts are self-funded, where the local plan administers claims on behalf of the account but does not fully underwrite the claims. ASO accounts may have benefit or claims processing requirements that may differ from non-ASO accounts. There may be specific requirements that affect; medical benefits, submission of medical records, Coordination of Benefits or timely filing limitations.

BlueCross BlueShield of South Carolina receives and prices all local claims, handles all interactions with providers, with the exception of Utilization Management interactions, and makes payment to the local provider.

Affordable Care Act

The comprehensive healthcare reform law was enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

bcbs.com

The Blue Cross Blue Shield Association's Web site.

BlueCard Access® 1.800.810.BLUE (2583)

A toll-free 800 number for you and members to use to locate healthcare providers in another BCBS Plan's area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.

BlueCard Eligibility® 1.800.676.BLUE (2583)

A toll-free 800 number for you to verify membership and coverage information and obtain pre-certification on patients from other BCBS Plans.

Blue High Performance Network (Blue HPN)

A national network of providers offered in key geographies that provides national accounts enhanced quality and cost savings.

National Doctor & Hospital Finder Website

A website you can use to locate healthcare providers in another BCBS Plan's area <http://www.bcbs.com/healthtravel/finder.html>. This is useful when you need to refer the patient to a physician or healthcare facility in another location. If you find that any information about you, as a provider, is incorrect on the website, please contact BlueCross BlueShield of South Carolina.

Blue Cross Blue Shield Global® Core

A medical assistance program that provides BCBS members traveling or living outside the United States, Puerto Rico and U. S. Virgin Islands with access to doctors and hospitals around the world.

Consumer Directed Healthcare/Health Plans (CDHC/CDHP)

Consumer Directed Healthcare (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs, and change consumer healthcare purchasing behavior. CDHC provides the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information, and financial incentives.

Coinsurance

A provision in a member's coverage that limits the amount of coverage by the benefit plan to a certain percentage. The member pays any additional costs out-of-pocket.

Coordination of Benefits (COB)

Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Co-payment

A specified charge that a member incurs for a specified service at the time the service is rendered.

Deductible

A flat amount the member incurs before the insurer will make any benefit payments.

Essential Community Providers

Healthcare providers that serve predominately low-income, high-risk, special needs and medically underserved individuals. The Department of Health and Human Services (HHS) proposes to define essential community providers as including only those groups suggested in the ACA, namely those named in section 340B(a)(4) of the Public Health Service Act and in section 197(c)(1)(D)(i)(IV) of the Social Security Act.

Exclusive Provider Organization (EPO)

A health benefits program in which the member receives no benefits for care obtained outside the PPO network except emergency care and does not include a Primary Care Physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.

FEP

The Federal Employee Program.

Hold Harmless

An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed on with a BCBS Plan as full payment for these services.

Marketplace/Exchange

For purposes of this document, the term Marketplace/Exchange refers to the public exchange as established pursuant to the Affordable Care Act (ACA): A transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Marketplaces will offer a choice of health plans that meet certain benefits and cost standards.

The ACA allows the opportunity for each state to establish a State-based Marketplace. Recognizing that not all states may elect to establish a State-based Marketplace, the ACA directs the Secretary of HHS to establish and operate a Federally-facilitated Marketplace in any state that does not do so, or will not have an operable Marketplace for the 2014 coverage year, as determined in 2013.

Medicaid

A program designed to assist low-income families in providing healthcare for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age six and low-income pregnant women. Medicaid is governed by Federal guidelines in terms of eligibility, procedures, payment level etc., but states have a broad range of options within those guidelines to customize the program to their needs and/or can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the State Department of Health (or similar state agency).

Medicare Advantage

The program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as “traditional Medicare.”

Medicare Advantage offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

Medicare Crossover

A program established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare’s supplemental insurance company.

Medicare Supplemental (Medigap)

Pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the “gaps” in original Medicare Plan coverage. Medigap policies help pay some of the healthcare costs that the original Medicare Plan doesn’t cover.

Medigap policies are regulated under federal and state laws and are “standardized.” There may be up to 12 different standardized Medigap policies (Medigap Plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap Plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell. Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member’s BCBS Plan via the Medicare Crossover process.

Medigap does not include Medicare Advantage products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have a Medicare Advantage Plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments or other cost-sharing.

National Account

An employer group with employee and/or retiree locations in more than one BCBS Plan’s service area.

Other Party Liability (OPL)

Cost containment programs that ensure that BCBS Plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, Workers’ Compensation, subrogation, and no-fault auto insurance.

Plan

Refers to any BCBS Plan.

Point of Service (POS)

A health benefit program in which the highest level of benefits is received when the member obtains services from his/her primary care provider/group and/or complies with referral authorization requirements for care. Benefits are still provided when the member obtains care from any eligible provider without referral authorization, according to the terms of the contract.

Preferred Provider Organization (PPO)

A health benefit program that provides a significant incentive to members when they obtain services from a designated PPO provider. The benefit program does not require a gatekeeper (primary care physician) or referral to access PPO providers.

Prefix

Three characters preceding the subscriber identification number on BCBS ID cards that identify the member’s BCBS Plan or National Account.

Qualified Health Plan (QHP)

Under the Affordable Care Act, which started in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Small Business Health Options Program (SHOP)

Program designed to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The program allows employers to choose the level of coverage and offer choices among health insurance plans. SHOP insurance is generally available to employers with 1-50 employees, but in some states SHOP is available to employers with 1-100 employees.

State Children's Health Insurance Program (SCHIP)

SCHIP is a public program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.

Traditional Coverage

Provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost sharing features, such as deductibles, coinsurance or copayments.

7. BlueCard Program Quick Tips

The BlueCard Program provides a valuable service that lets you file all claims for members from other BCBS Plans with your local Plan.

Here are some key points to remember:

- Make a copy of the front and back of the member's ID card.
- Look for the three-character prefix that precedes the member's ID number on the ID card.
- Call BlueCard Eligibility at 1.800.676.BLUE (2583) to verify the patient's membership and coverage or submit an electronic HIPAA 270 transaction (eligibility) to the local Plan.
- Submit the claim to BlueCross BlueShield of South Carolina. Always include the patient's complete identification number, which includes the three-character prefix.
- For claims inquiries, contact BlueCross BlueShield of South Carolina.