

BlueNewsSM for Providers



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

Springing Into Action

Upcoming Webinars

Provider Scope[®]

Continued Stay Reviews

90-Day Validation

Refunds Reminder

Medical Policy Updates



SPRINGING INTO ACTION

April showers bring fresh updates. We're bringing you timely news and helpful resources to support you and your practice. We value our partnership and look forward to continuing our relationship with you as our providers.

UPCOMING WEBINARS AND TRAINING

Would you or someone in your office like to become more knowledgeable about topics concerning authorizations, finding remittances or updating your provider information? You can learn more about these topics and much more by joining our Provider Relations team for these upcoming webinars:

- ▶ **Authorizations** **May 13, 2026** **Noon to 1 p.m.**
- ▶ **My Remit Manager** **May 14, 2026** **1 p.m. to 2 p.m.**
- ▶ **Provider Enrollment** **June 10, 2026** **Noon to 1 p.m.**

You can register for the events [here](#).



NEW PROVIDER CODING EDUCATION PROGRAM: PROVIDER SCOPE®

BlueCross BlueShield of South Carolina will soon work with Codoxo to launch the Provider Scope education solution. Provider Scope reviews provider coding patterns using both artificial intelligence and rules based methods.

This program is designed to provide transparency, educational resources and coding pattern insights to the provider community to support compliance with documentation and coding standards. This will have no operational effect on you or your practice.

Upon receiving a letter, you will be able to log in to Codoxo's provider portal to review your billing activity in comparison to your specialty or peer group. We encourage you to use this portal as an educational resource, as it offers insight into specific billing patterns. If not addressed, these patterns may result in future prepayment or postpayment audits.

In addition, this education program may involve Codoxo reaching out to you directly via letters, emails or phone calls to discuss billing patterns. Codoxo has experienced coding, clinical and billing staff that can help answer any questions around identified billing patterns and provide relevant guidance.

For accurate communication and efficiency, [preregister here](#)*

The following information will be required:

- ▶ Billing provider name or rendering practitioner's full name
- ▶ Tax ID
- ▶ Mailing address
- ▶ Billing provider's NPI or rendering practitioner's NPI
- ▶ Phone number
- ▶ Fax number
- ▶ Email address

Should you have any questions regarding this program, please contact Codoxo at 470-223-3591.

Codoxo is an independent company that provides insight on billing and coding patterns on behalf of BlueCross.

**This link leads to a third-party website. Codoxo is responsible for the content and privacy policy on its site.*



IMPORTANCE OF SUBMITTING CONTINUED STAY REVIEWS PROPERLY IN COHERE HEALTH

To ensure patients continue to receive uninterrupted care, continued stay reviews (CSRs) must be submitted within seven days of the initial request. This requirement applies to inpatient hospitals, rehabilitation facilities, long-term acute care hospitals and skilled nursing facilities.

When submitting a CSR, uploading clinical documentation alone is not sufficient. You must also select the Start Continuation button. Failing to do so can lead to significant downstream impacts. For example:

- ▶ The request may not be identified as a CSR in our system.
- ▶ Our team might not see that you are awaiting a response.
- ▶ Review responses might be delayed and may escalate unnecessarily.
- ▶ The request may not be submitted successfully.

Correct Submission Process

When providing additional documentation, please follow these steps in order:

1. Select the Start Continuation button first.
2. Upload and complete all required clinical documentation.

Why This Matters

Following the correct process helps to:

- ▶ Ensure your request is routed properly and reviewed promptly.
- ▶ Reduce unnecessary escalations.
- ▶ Support accurate, timely responses and prevent delays in patient care.

Next Steps

Please review the related tip sheet available in the Learning Center. After reviewing, share this reminder with your teams and ensure that all staff responsible for submissions understand the importance of selecting the Start Continuation button. This step is essential for accurate processing and successful submission.

If you have questions or need assistance, please contact your provider relations consultant.



90-DAY VALIDATION REQUIREMENTS

Your demographic data can change within your practice and within our networks. To ensure our members know how to find the right physicians or facilities for the care they need, we must validate the accuracy of our provider directories.

As a reminder, on Jan. 1, 2022, the Consolidated Appropriations Act required providers to verify or update their demographic data at least every 90 days. If more than 90 days have passed since the provider's last validation, we must suppress them from our directories.

You can use M.D. Checkup in My Insurance Manager™ (MIM), to validate your demographic data. Validations are determined based on the number of days since the provider's last validation. To perform the validation, do the following:

1. Log in to MIM.
2. In the purple box labeled "Provider Validation," select Validate Now.
3. For each location with a status of "Verification Required," select View & Edit.
4. Review and edit (if needed) the information, and then select Verify.

To update suppressed locations due to missing the 90-day validation period, do the following:

1. Log in to MIM.
2. In the purple box labeled "Provider Validation," select Validate Now.
3. For each location with a status of "Suppressed from Directories," select View & Edit.
4. Review and edit (if needed) the information, and then select Verify.

We receive your data automatically once validated in MIM and update our directories within two business days.

IMPORTANT REMINDER REGARDING REFUNDS

If an overpayment is made, we may ask you to return the extra amount. You may also notice the overpayment in your own accounting and choose to repay it on your own. Solicited Refunds.

If you received an overpayment refund request letter from us, we ask that you return payment to us within 30 days of the date of the letter. Please include a copy of the refund request letter for accurate and timely processing. You can send a check and a copy of the letter to us by mail to the following address:

BlueCross BlueShield of South Carolina
Attn: Lockbox AX-A31
I-20 East at Alpine Road
Columbia, SC 29219-0001

Please note that if the requested refund is not received within 30 days, we'll systematically offset the amount from future payments. This offset may be the preferred method for some providers to resolve refund issues.

If you receive a solicited refund request from another Blue® Plan, the refund must be sent to that Plan. We are unable to process refund requests from other Plans.

Unsolicited Refunds

If you did not receive a letter from us but wish to refund an overpayment to us voluntarily, please complete and submit the Overpayment Refund Form along with your check.

We'll review the information and will process the refund if our records also reflect an overpayment was made. If our records indicate otherwise, we'll return your check along with an explanation for the returned payment.

Have questions about potential overpayment? If you need further information about whether you may owe us a refund, please log in to My Insurance Manager and submit your question using the Ask Provider Services feature.

If you receive payment from another Blue Plan and feel it is incorrect, you must send the unsolicited refund to that Plan. As with solicited refunds, we are unable to process refund requests from other Plans.

MEDICAL POLICY UPDATES

BlueCross BlueShield of South Carolina regularly revises the medical policies used to make clinical determinations for a member's coverage.

We encourage you to review the Current News section of the website for the latest updates and to visit the [Medical Policies and Clinical Guidelines page](#) regularly to stay informed of any changes. Providers are strongly encouraged to review each medical policy in its entirety. As a reminder, procedure and diagnosis codes listed within medical policies are provided for general guidance only and do not guarantee payment. Clinical determinations are based on the medical necessity criteria outlined in the policy.



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

Independent licensees of the Blue Cross Blue Shield Association.

Benefits Disclaimer: The information listed is general information and does not guarantee payment. Benefits are always subject to the terms and limitations of specific plans. No employee of BlueCross BlueShield of South Carolina or BlueChoice HealthPlan of South Carolina has authority to enlarge or expand the terms of the plan. The availability of benefits depends on the patient's coverage and the existence of a contract for plan benefits as of the date of service. A loss of coverage, as well as contract termination, can occur automatically under certain circumstances. There will be no benefits available if such circumstances occur.

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