South Carolina

BlueCross BlueShield of South Carolina
is an independent licensee of the
Blue Cross Blue Shield Association.

Back To Basics

2024 ANNUAL PROVIDER SUMMIT

Provider Relations and Education – Mission Statement

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

Provider Relations and Education — Commercial Territory Map

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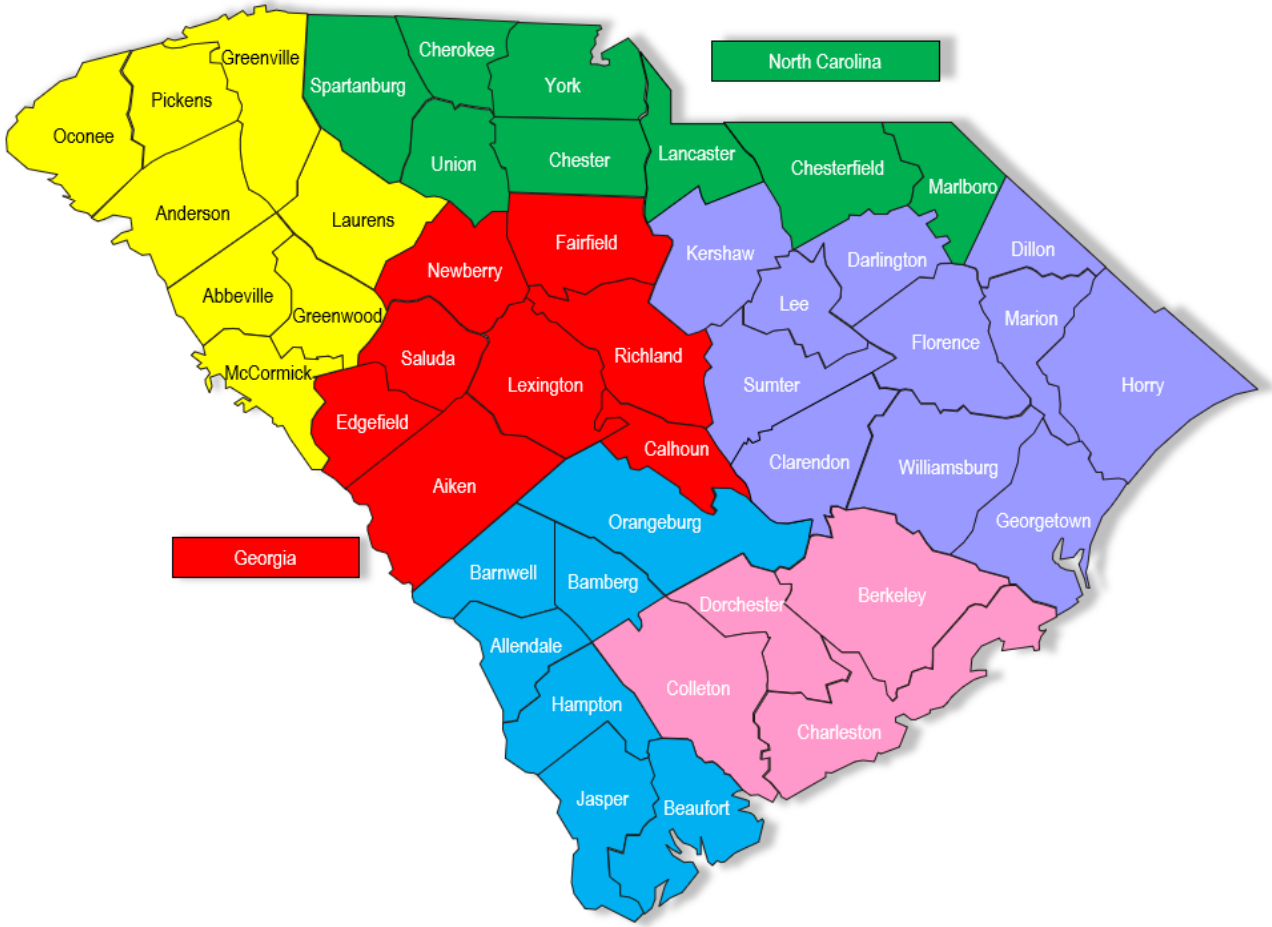

For the latest updates, always visit
www.SouthCarolinaBlues.com

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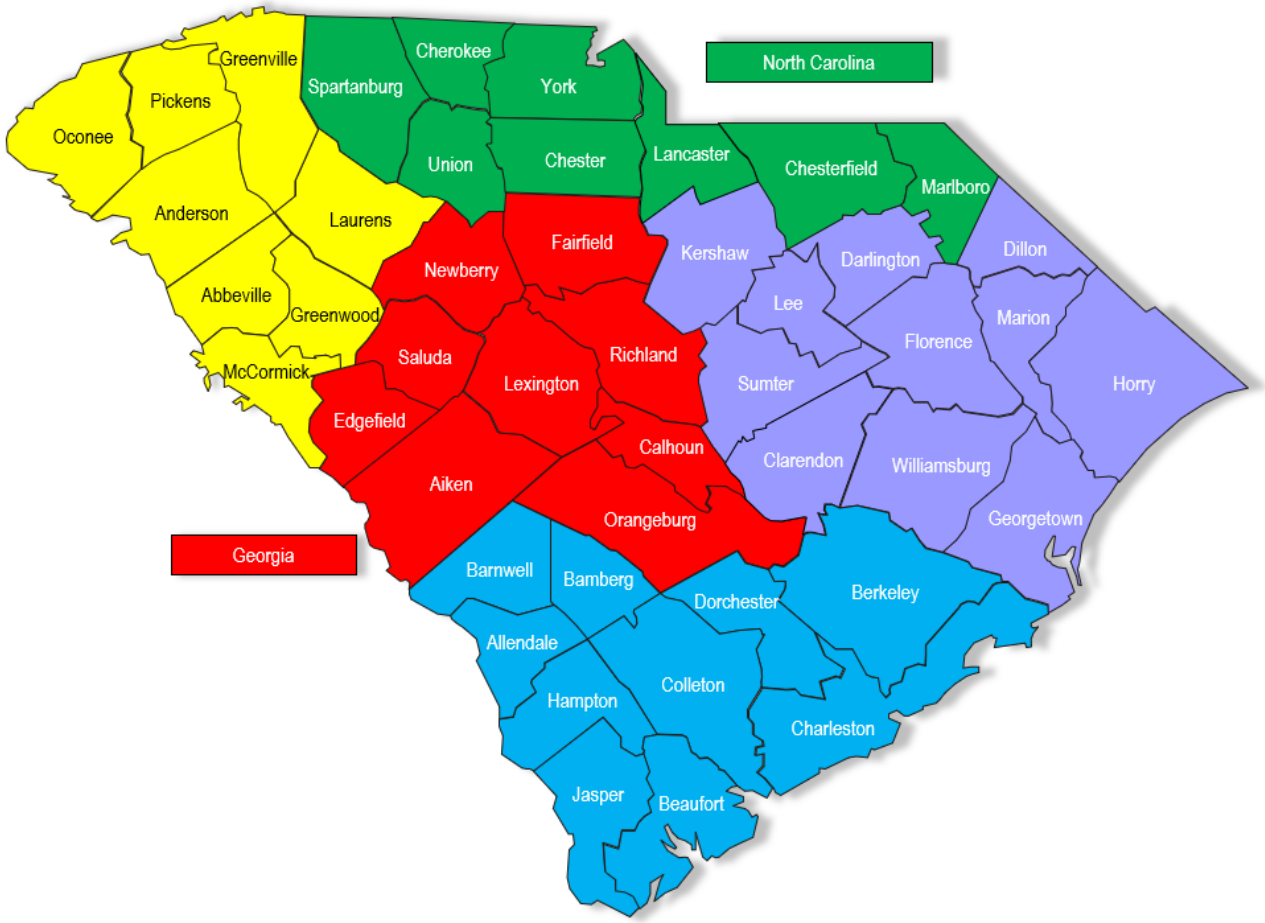


For the latest updates, always visit www.HealthyBlueSC.com.

Topics

- Authorizations
- Benefits
- Claims
- Dental
- Healthy Blue℠
- My Provider Enrollment Portal
- Pharmacy
- Provider Enrollment
- Quality
- Web Tools

Authorizations

Back To Basics

Agenda

- Authorizations 101
- Authorization Tools
- Special Programs
- Upcoming Changes
- Resources

Authorizations 101

Authorizations 101

Overview

The health plan uses authorizations to determine whether a service is medically necessary, or if it is a covered benefit for the member.

Other terms for authorization

- Prior approval
- Precertification (or precert)

Note: Authorizations are not a guarantee of payment and requirements may vary per plan.

Authorizations 101

Services Requiring Authorization

The following services require authorization for most plans:

- Elective inpatient services (including maternity)
- Skilled nursing facility admission
- Home health and hospice
- DME when the purchase price or rental is $XXX[1] or more
- Mental health and substance abuse
- High tech imaging[2] (MRIs, MRAs, CT Scans, PET Scans)
- Certain medications included under the medical benefit

Always check benefits and eligibility for authorization requirements

[1] *DME dollar thresholds vary per plan but are typically $500 or $1,000. Please note threshold amounts can be lower than $500.*

[2] *These services are typically handled by NIA Magellan.*

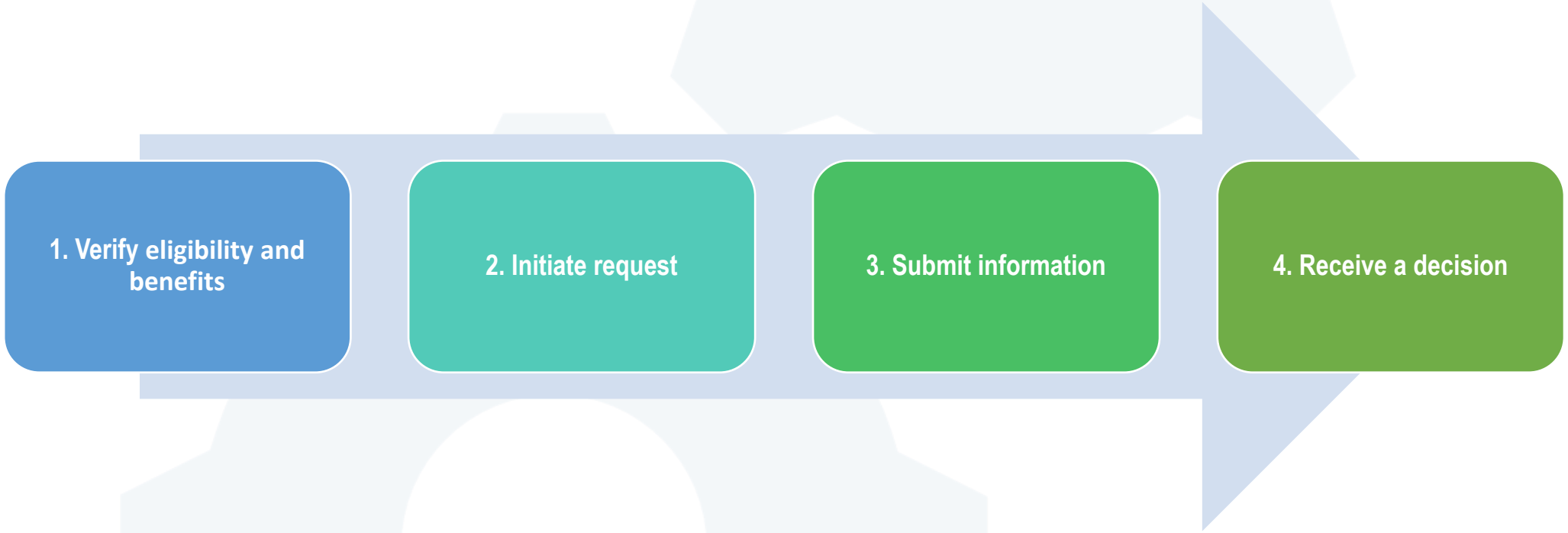
Authorizations 101

General Guidelines for Authorizations

- Submit elective requests prior to rendering services.
- Submit requests once and allow time for review.
- Services must be covered under the member's plan.
- Members must have active coverage at the time of request.
- Submit a notification of emergency admission within 24 – 48 hours of admission.
- Include the date of service on the appropriate forms.
- Mark requests as urgent **ONLY** when they are urgent.

Authorizations 101

Authorization Process



Authorizations 101

Authorization Methods

Authorizations can be requested using one of the following avenues:

- My Insurance Manager℠ - **Preferred**
  - Visit www.SouthCarolinaBlues.com or www.BlueChoiceSC.com.
- Medical Forms Resource Center (MFRC) - **Preferred**
  - Visit www.SouthCarolinaBlues.com, www.BlueChoiceSC.com, or www.FormsResource.Center.
- Fax
  - Numbers located on fax form
- Phone
  - Check the member's ID card.
  - Phone requests should include:
    - MD and nurse's name.
    - Therapist's name (if the member is receiving therapy within 15 days of start of care and after evaluations).
      - BlueCross requires a signed Plan of Care (POC/485) within 30 days of start of care, per CAM 222.

Note: All methods listed are for South Carolina members.

Authorizations 101

Required Information for Authorizations

Patient Details	• Name, ID number and date of birth
Service Details	• CPT/HCPCS codes with correct units, diagnosis codes and MD orders
Location Details	• Name of facility, address and tax ID/NPI • Name of rendering physician or office, address and tax ID/NPI
Contact Information	• Call back number and fax number
Date of Service	• Date when services are being rendered
Clinical Documentation	• How long the problem has been occurring, attempted treatments, conservative medications, studies (e.g., labs, imaging, assessments), etc.

Authorizations 101

Commonly Requested Authorizations

- Breast reductions
  - Clinicals should include height, weight, BMI and the number of grams to be removed.
- Hysterectomies
  - Clinicals should include recent imaging and conservative measures (or why they were not done).
- Surgeries
  - Clinicals should include attempted conservative therapies.
- Home Health
  - Clinicals should include:
    - MD/therapist name.
    - Treatment location.
    - Home health visit notes and homebound status.
    - Functional status for therapy.
    - Wound measurements, if applicable.

Authorization Tools

Authorization Tools

My Insurance Manager (MIM)

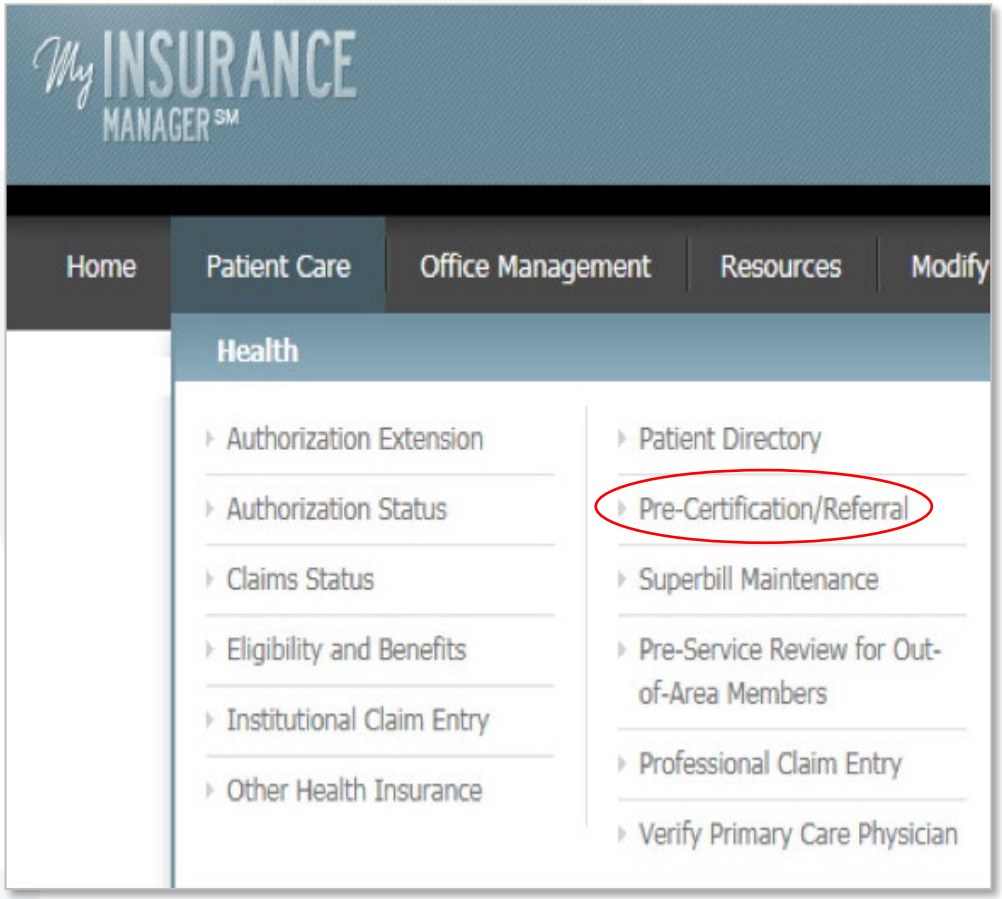
There are two options for obtaining authorizations through MIM:

Fast-Track

- Hundreds of available options
- Automated authorization number

Custom Request

- Allows specific details to be entered
- Authorization will pend for review; if approved, authorization number is provided



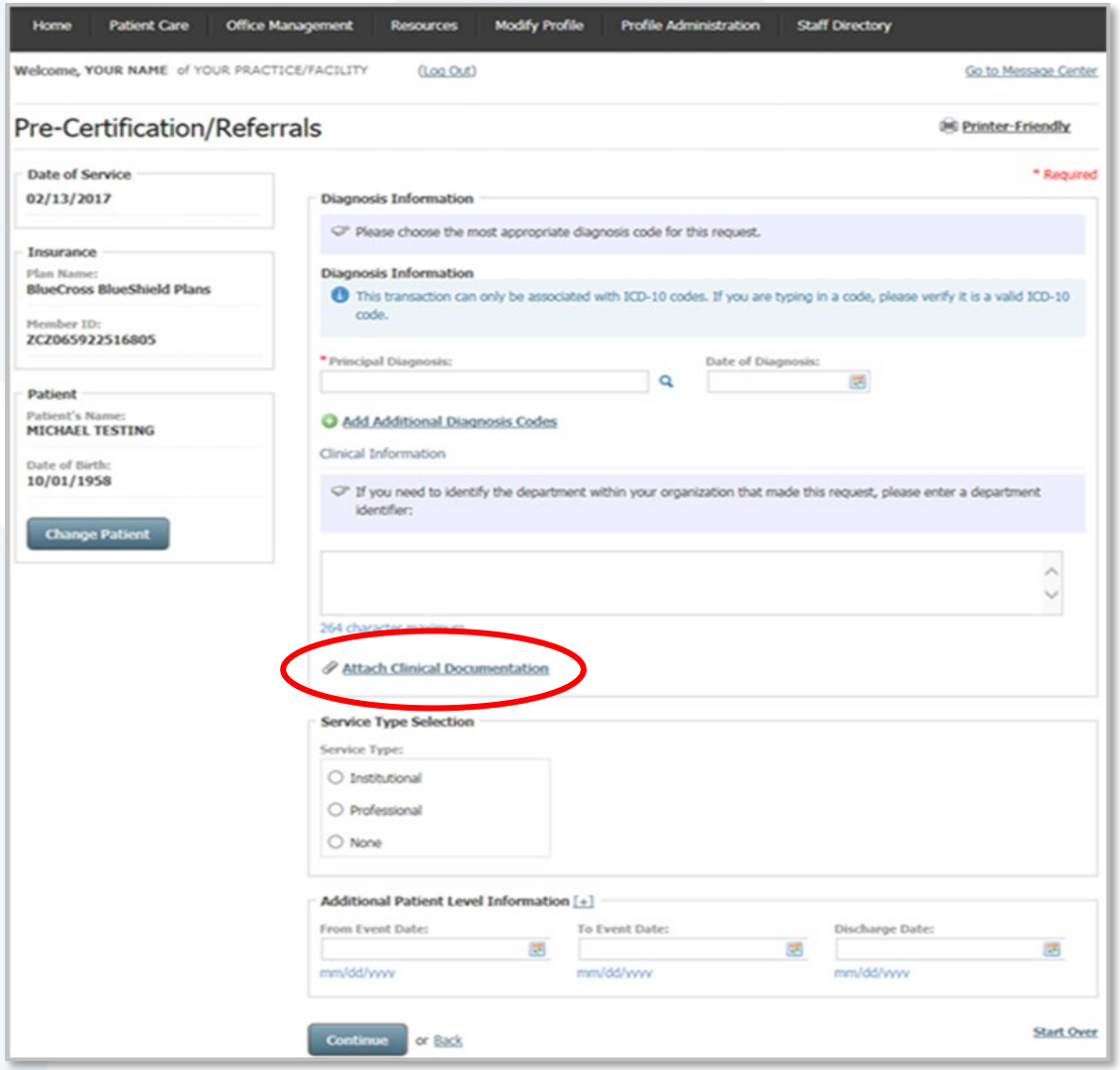
Note: MIM should be used for initial authorization requests. Please fax clinical documentation for updates or continued stay reviews.

Authorization Tools

My Insurance Manager (MIM) — Clinical Attachments

Clinicals are needed for authorization reviews. When prompted, be sure to:

- Select Attach Clinical Documentation.
- Upload file(s)
  - PDF format
  - 30 MB limit



Authorization Tools

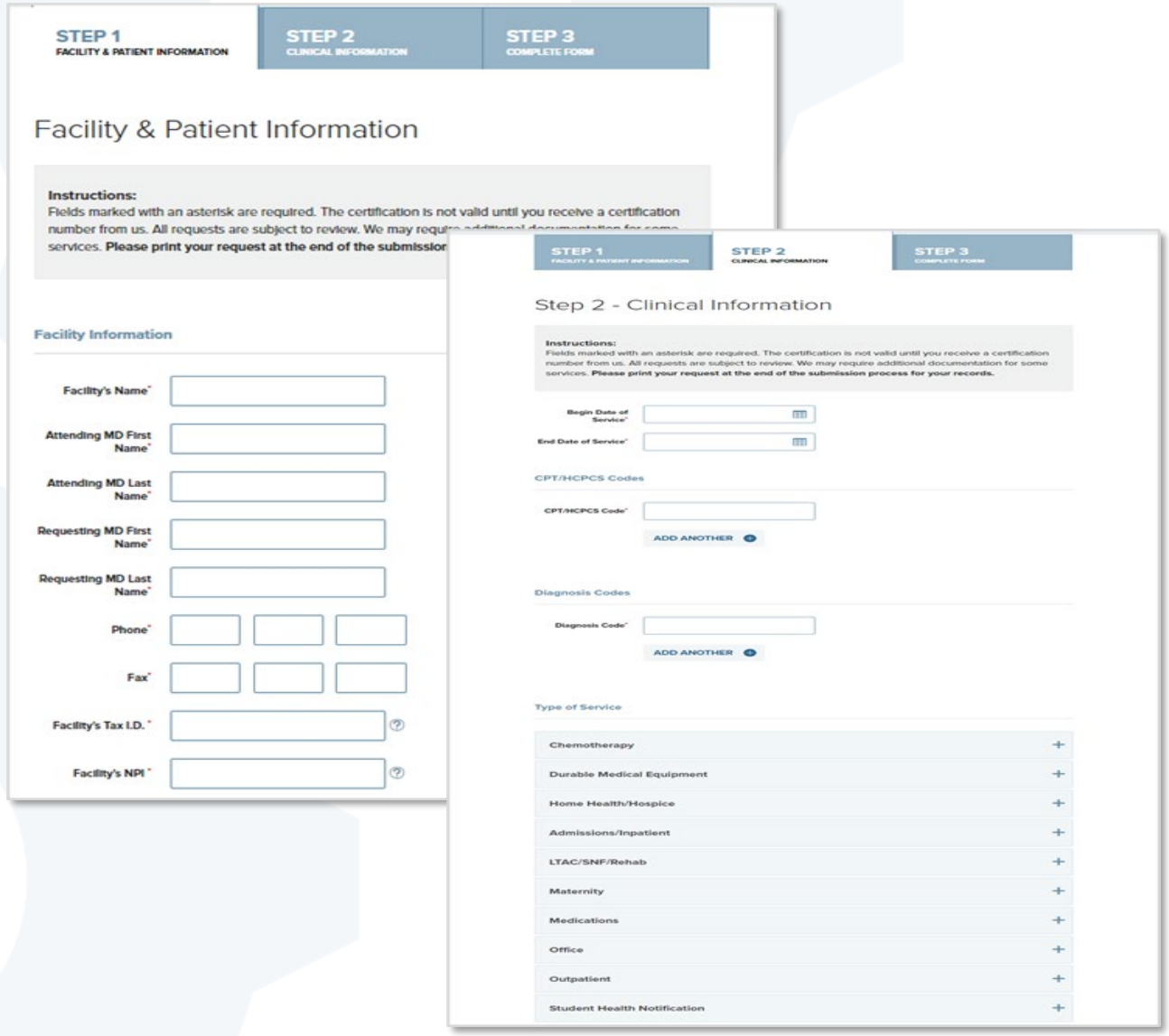
Medical Forms Resource Center (MFRC)

Complete requests in three easy steps:

1. Enter the facility and patient details.
2. Include all required clinicals.
3. Submit the request.

Benefits of using the MFRC:

- Offers various types of authorizations
- Guides you through the required documentation
- Receives priority processing



Authorization Tools

Medical Forms Resource Center (Continued)

Examples of MFRC request

>**********HYSTERECTOMY**********<

DIAGNOSIS:
PELVIC PAIN

COMPREHESIVE EVALUATION?
FALSE

COMPREHENSIVE EVAL DETAILS:

LAPROSCOPIC, ENDOSCOPIC, OR IMAGING STUDIES?
TRUE

DETAILS OF STUDIES:
TV US PERFORMED 10/14/19

HOW LONG AS PAIN BEEN PRESENT?
YEARS BUT WORSENING LATELY PT FEELS DUE TO ESSURE COILS

DETAILS OF UTERINE SPARING TX:

SIGNATURE:

>**********BREAST REDUCTION**********<

GENDER: FEMALE

HEIGHT: 5'4

WEIGHT: 187

BMI: 36.3

BRA SIZE: 42 H

R BREAST VOLUME: 2400

L BREAST VOLUME: 2400

GRAMS TO REMOVE RIGHT: 600 GRAMS

GRAMS TO REMOVE LEFT: 600 GRAMS

NIPPLE POSITION R: 36 CM

NIPPLE POSITION L: 36 CM

ASSOCIATED SYMPTOMS: RASHES CONSTANTLY BETWEEN AND UNDER BREASTS, NECK PAIN, SHOULDER PAIN, HEADACHES, BURNING SENSATIONS AND NUMBNESS TO CERVICAL AND THORACIC ARE

DURATION OF SYMPTOMS: 2 YEARS

TREATMENTS TRIED: MEDICATIONS, PHYSICAL THERAPY, SPECIAL SUPPORT BRAS

SUPPORT BRA DURATION: 2 YEARS

MEDICATIONS TRIED: IBUPROFEN FOR 2 YEARS

PHYSICAL THERAPY DURATION: 12 WEEKS

IS THE PATIENT IN PAIN? YES

PAIN SCALE: 8/10

SIGNATURE:

Authorization Tools

Fax Requests

When submitting requests via fax, include the Authorization Request Form or a coversheet with the following information:

- Patient details (name, ID card number, and date of birth)
- CPT/HCPCS and diagnosis codes
- Provider location and date of service
- Contact phone and fax number

To access this information:

Visit www.SouthCarolinaBlues.com and follow the path:

Providers>Prior Authorization>Precertification Request Form

For Mailing Images:

Focus Review/Health Care Services
I-20 @ Alpine Rd., AX-630
Columbia, SC 29219-0001

Authorization Tools

Fax Requests — Coversheet

Example of appropriate fax request coversheet

Required Information	Included?
Patient (Name, DOB and ID number)	Yes
Service (CPT and Diagnosis codes)	Yes
Location (Name, Address, Tax/NPI)	Yes
Contact (Phone and Fax number)	Yes
Date of Service	Yes

ABC Plastic Surgery
123 Alphabet St., Suite 150
Spartanburg, SC 29301
Phone 864-123-4567
Fax 864-987-6543

fax

TO: Authorizations FROM: Jimmy

FAX: 803-264-0183 PAGES: 3

PHONE: 800-334-7287 DATE: 1/24/2020

RE: Mighty Joe Young CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

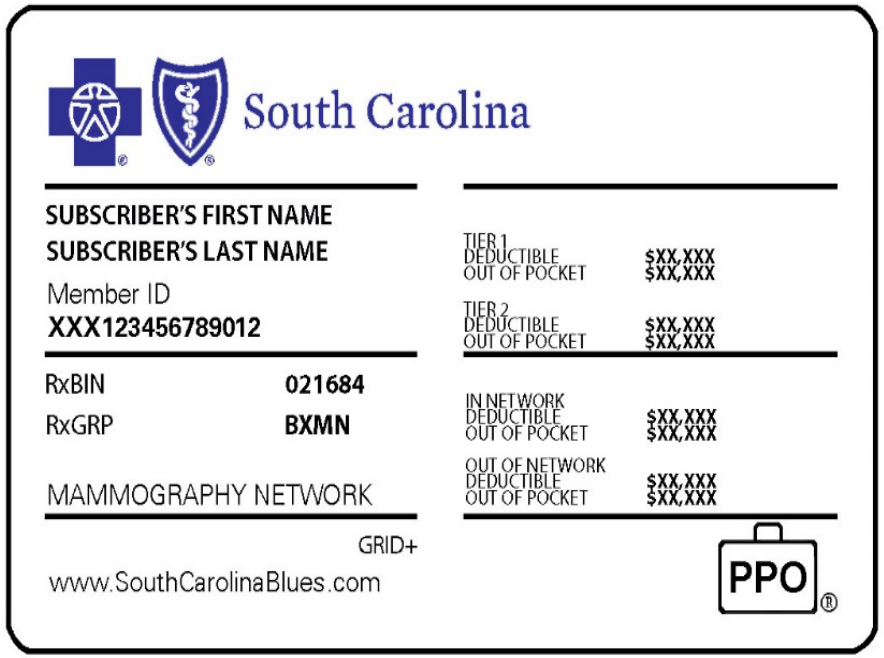
Comments:

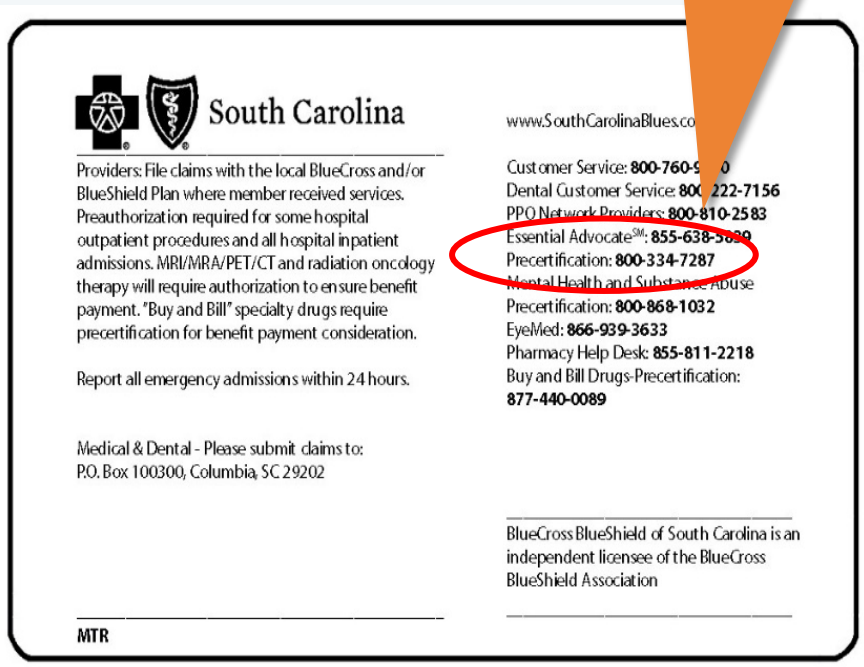
ID Number: ZYX0987654321
DOB: 11/14/2003
Outpatient Surgery, NPI 1472583690
Dr. Minnie Musketeer, NPI 3692581470
CPT Codes: 11446, 13152, 14060
DX Code: D23.22
DOS: 05/11/2020

Authorization Tools

Phone Requests

Contact the number on the back of the member's ID card.





Number will vary per plan.

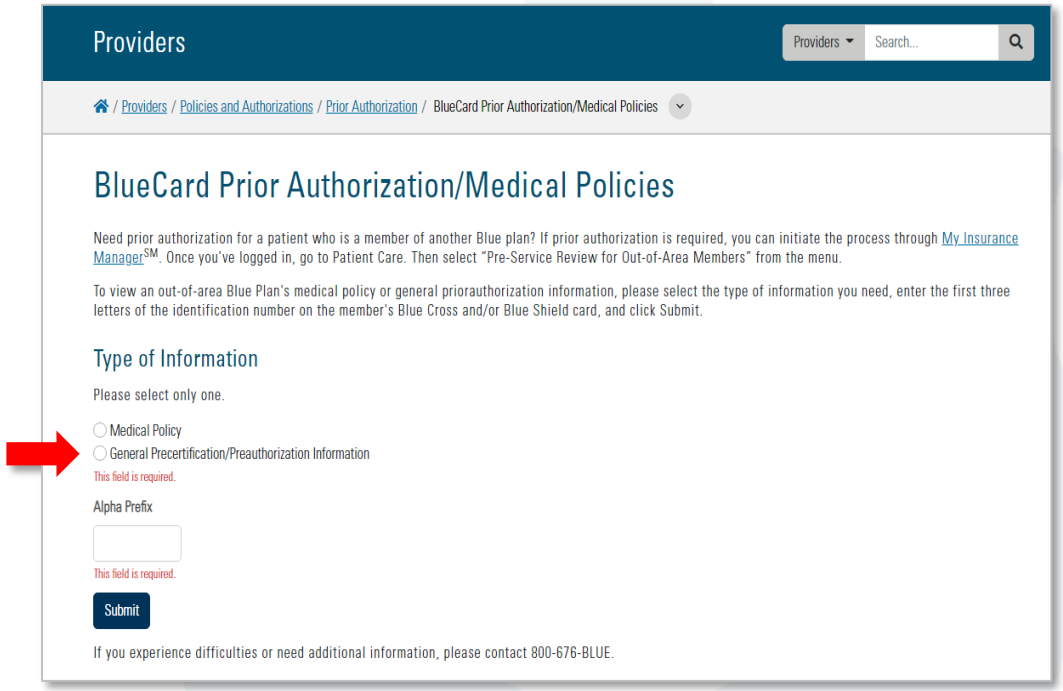
Note: Phone requests should include the MD and nurse's name. The therapist's name is needed if the member is receiving therapy within 15 days of start of care and after evaluations. BlueCross requires a signed Plan of Care (POC/485) within 30 days of start of care, per CAM 222.

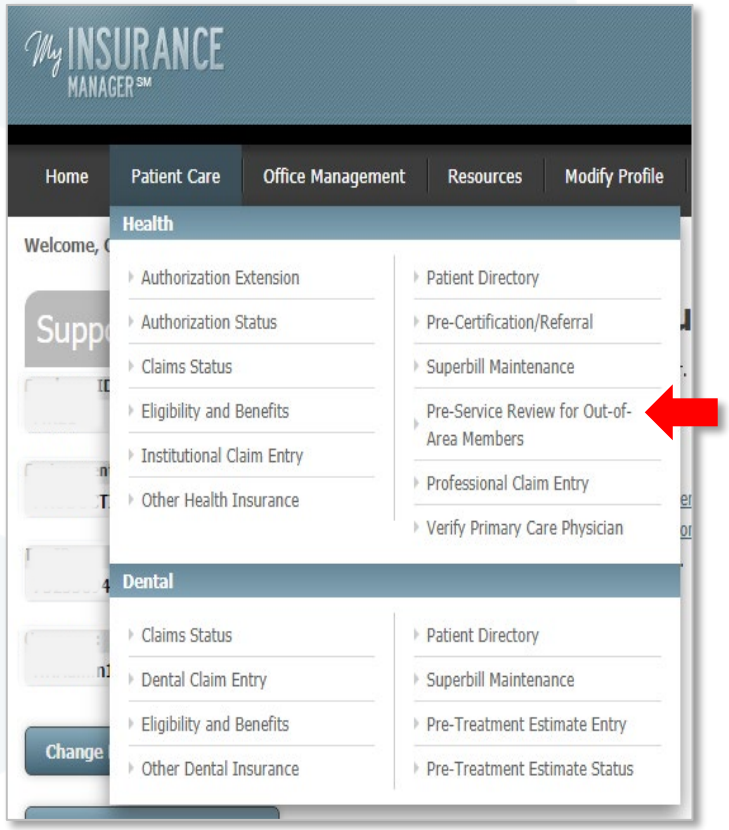
Authorization Tools

BlueCard Prior Authorization Lookup

Authorizations for **out-of-state members** can be verified and obtained in two steps:

1. Use the BlueCard Prior Authorization Tool.
2. Initiate the authorization through My Insurance Manager.





Special Programs

Special Programs

Third-party vendors that manage select authorizations for certain plans include:

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

Note: These are independent organizations that offer utilization management on behalf of BlueCross and BlueChoice.

Special Programs

NIA Magellan

Types of authorization for most plans:

- Radiation Oncology
- Advanced Radiology
- Musculoskeletal Care (MSK)

To request an authorization:

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

Special Programs

Avalon Healthcare Solutions

Authorizations for lab services in the following settings:

- Office
- Outpatient facility
- Independent laboratory

To request an authorization:

- Prior Authorization System (PAS) through My Insurance Manager
- Phone: 844-227-5769
- Fax: 813-751-3760

Note: Avalon does not review requests for services provided in an emergency room, ambulatory surgery center or hospital inpatient place of service.

Special Programs

avalon

Recording and slides are available at:

[Webinars — Avalon Healthcare Solutions (avalonhcs.com)]

Avalon hosted a panel of experts from the health insurance industry to discuss the management of chronic kidney disease (CKD) through lab values, which can provide early identification and intervention:

- How Lab Value Insights can help health plans achieve improved value-based outcomes and reduce costs
- The significance of using actionable insights to inform and enhance CKD care management programs
- Lessons learned and next steps for leveraging Lab Values Insights for CKD & and beyond

Special Programs

Avalon and Healthy Blue join forces to deliver quality care beginning Jan. 1, 2024

avalon

Special Programs

MBMNow

- Authorizations for specialty medications
- Medication lists are available online

To request an authorization:

- Access MBMNow through My Insurance Manager℠
- Phone: 877-440-0089
- Fax: 612-367-0742

OPTUM® BlueCross BlueShield of South Carolina

Special Programs

Companion Benefit Alternatives (CBA)

- Authorizations for behavioral health services.
- Examples of services that typically require authorization include:
  - Psychological testing.
  - Behavioral health program admissions.
  - Repetitive transcranial magnetic stimulation (rTMS).

To request an authorization:

- Visit www.CompanionBenefitsAlternatives.com and use the Forms Resource Center.
- Phone: 800-868-1032

Upcoming Changes

Upcoming Changes

Standardized Prior Authorization List

- In 2024, BlueCross will implement a standardized prior authorization list, which will include services that will require prior authorization regardless of the place of service.
- The list will include the highest volume and most common services or procedures requested by providers that could be deemed not medically necessary, investigational or cosmetic.

Plans that will be included are:

- Major Group (fully insured and administrative service only)
- Small Group and Individual
- National Alliance

Plans that will not be included are:

- BlueChoice® HealthPlan
- Exchange (Marketplace)
- Healthy Blue℠
- Medicare Advantage
- Federal Employee Program (FEP)

Upcoming Changes

Standardized Prior Authorization List (Continued)

Medical services that require prior authorization:

- Cardiac rehabilitation
- Cosmetic services
- DME (determined by dollar threshold of the plan)
- Enteral formula
- And more.

Behavioral health services that require prior authorization:

- Applied Behavioral Analysis (ABA therapy)
- Electroconvulsive Therapy (ECT)
- Intensive outpatient treatment
- Partial hospitalization
- Psychological testing

Note: These lists are not all inclusive.

Resources

Resources

Benefit Program	Authorization Service	Web-based Requests	Telephone Requests	Fax Requests
BlueCross	[various]	My Insurance Manager and MFRC	800-334-7287	803-264-0258 (Utilization Management) 803-264-0259 (Case Management)
BlueChoice	[various]	My Insurance Manager and MFRC	800-950-5387	800-610-5685
FEP	[various]	My Insurance Manager and MFRC	800-327-3238	N/A
Healthy Blue℠	[various]	My Insurance Manager and MFRC	866-757-8286	803-870-6500
State Health Plan (Medi-Call)	[various]	My Insurance Manager and MFRC	800-925-9724	803-264-0183
Avalon	Laboratory	Avalon PAS (inside My Insurance Manager)	844-227-5769	813-751-3760
CBA	Behavioral/Substance Abuse	www.CompanionBenefitAlternatives.com	800-868-1032	803-714-6456
NIA Magellan	• Advanced Radiology • Musculoskeletal Care • Radiation Oncology	www.RadMD.com	BlueCross: 866-500-7664 BlueChoice: 888-642-9181	888-656-1321
MBMNow	Specialty Medical Drug	My Insurance Manager	877-440-0089	612-367-0742

Resources

Peer-to-Peer Requests

Initiating Requests and Checking Statuses		
Medical Forms Resource Center	**South Carolina Website**	**Phone (for statuses and eligibility only)**
• Visit www.FormsResource.Center. • Select Request a Peer-to-Peer Discussion. • Enter all pertinent details. • Submit.	• Visit www.SouthCarolinaBlues.com. Providers>Forms>Other Forms>Peer-to-Peer Request • Enter all pertinent details (and save the document). • Email the form to Peer.Medical@bcbssc.com or fax to 803-264-9175.	• Call 803-264-8114 Available Monday - Friday 8:30 a.m. – 5:00 p.m. EST

Required Criteria

- Medical necessity adverse decision was received, along with health plan denial
- Requested within two business days of the denial for inpatient or continued stay requests or five business days for all other denials
- Requested prior to an appeal

Resources

Peer-to-Peer Requests (Continued)

Clinical Discussion

- Facilitated within one business day of receipt of request
- Our medical doctor makes two attempts to contact the rendering provider
- A decision is rendered at the end of the call

Resources

Utilization Management (UM) Courtesy Re-evaluations

UM courtesy re-evaluations are permitted for denials that are due to the following:

- No clinical information submitted
- Insufficient clinical information submitted

To request a UM courtesy review, you must:

- Specify the request is for a re-evaluation upon submission (via fax).
- Submit clinical documentation within five business days of the denial notice.

Benefits

Back To Basics

Agenda

- 2024 Benefits
- What's New?
- Benefit Reminders
- Resources

2024 Benefits

Preferred Blue

2024 Benefits

Preferred Blue

New Groups — Effective Jan. 1, 2024

Group Name	Prefixes
Spirax Sarco	• IIY
VELUX	• SJS
Vermeer	• SJS

Always verify benefits and eligibility prior to rendering services.
Use My Insurance Manager℠ (MIM) or call 800-868-2510.

State Health Plan

2024 Benefits

State Health Plan

Standard Plan	2023	2024
Deductibles		
Individual	$515	No change
Family	$1,030	No change
Coinsurance Maximum		
Individual (INN)	$3,000	No change
Family (INN)	$6,000	No change
Individual (OON)	$6,000	No change
Family (OON)	$12,000	No change
Services		
Office visits	$15 copay	No change
Outpatient facility	$115 copay	No change
Emergency room	$193 copay	No change
Cardiac and pulmonary rehabilitation	$15 copay	No change

2024 Benefits

State Health Plan

Savings Plan	2023	2024
Deductibles		
Individual	$4,000	No change
Family	$8,000	No change
Coinsurance Maximum		
Individual (INN)	$3,000	No change
Family (INN)	$6,000	No change
Individual (OON)	$6,000	No change
Family (OON)	$12,000	No change
Services		
Office visits	Full allowance until the deductible is met. Then, the coinsurance.	No change
Outpatient facility	Full allowance until the deductible is met. Then, the coinsurance.	No change
Emergency room	Full allowance until the deductible is met. Then, the coinsurance.	No change

2024 Benefits

State Health Plan

MUSC Plan	2023	2024
Deductibles		
Individual	$385	No change
Family	$770	No change
Coinsurance Maximum		
Individual (INN)	$2,200	No change
Family (INN)	$4,400	No change
Services		
Office visits	PCP: $25 copay Specialist: $45 copay	No change
Outpatient facility surgery	$290 copay	No change
Outpatient facility radiology (regular and advanced)	$85 copay	No change
Inpatient facility	$0	No change
Emergency room	$193 copay	No change
Urgent care	$85 copay	No change
Cardiac and pulmonary rehabilitation	$15 copay	No change

2024 Benefits

State Health Plan

Dependent Contraception

- Effective May 25, 2023: Standard, Savings and MUSC Plans
  - The State Health Plan began covering birth control at no member cost-share for primary members covered as child dependents.

Well Woman Visit

- Effective Jan. 1, 2024: Standard and Savings Plans
  - The State Health Plan will cover one well woman visit each year at no member cost-share for non-Medicare primary adults aged 19 and older who are covered under the Standard or Savings plan.
  - The well woman visit is in addition to the annual adult well visit.

2024 Benefits

State Health Plan

Reminders

- Routine and Diagnostic Colonoscopies
  - Covered at 100 percent for State Health Plan primary members, once every 10 years for aged 45 and older when rendered by an eligible in-network provider and follows the criteria listed in the United States Preventive Services Task Force (USPSTF)
- Cologuard
  - Covered at 100 percent, once every three years when rendered by an eligible in-network provider for aged 45 and older
    - Applies to the Savings, Standard, or MUSC plan (not Medicare as primary)
    - Must use in-network provider
    - Additional charges will apply for non-generic prep kit
- Patient Centered Medical Home (PCMH) for Standard and High Deductible Health Plan (HDHP)
  - Office visit copay is waived for PCMH in-person visits and subject to a 10 percent COINS after the deductible is met.
    - PCMH incentives do not apply to telehealth services

2024 Benefits

State Health Plan

Prior Authorizations

- Medical Services
  - Medi-Call: 800-925-9724
- Advanced Radiology
  - National Imaging Associates (NIA): 866-500-7664
- Behavioral Health Services
  - Companion Benefit Alternatives (CBA): 800-868-1032
- Pharmacy Specialty Drug
  - Express Scripts: 855-612-3128
- Medical Specialty Drug
  - MBMNow: 877-440-0089
- Laboratory Services
  - Avalon Healthcare Solutions: 844-227-5769

Always verify benefits and eligibility prior to rendering services.
Use My Insurance Manager℠ (MIM) or call 800-444-4311.

Federal Employee Program

2024 Benefits

Federal Employee Program

Blue Focus — No out of network benefits available	2023	2024
Deductibles		
Individual	$500	No change
Self — Plus One	$1,000	No change
Family	$1,000	No change
Out-of-Pocket Maximum		
Individual	$8,500	**$9,000**
Self — Plus One	$17,000	**$18,000**
Family	$17,000	**$18,000**
Services		
Office visits (Includes primary and/or specialty care combined)	$10 copay (first 10 visits)	No change
Telehealth	$0 copay (first two visits) $10 copay (all additional visits)	No change
Chiropractic care	$25 copay up to 10 visits	No change

2024 Benefits

Federal Employee Program

Blue Focus — No out of network benefits available.	2023	2024
Services (Continued)		
Urgent care	$25 copay	No change
Hospital care — Inpatient (prior authorization required)	30% COIN + BYD	No change
Hospital care — Outpatient	30% COIN + BYD	No change
ER — Accidental injury (within 72-hours)	$0 copay	No change
ER — Medical emergency	30% COIN + BYD	No change

Note: For a full list of benefits and updates, please visit https://www.fepblue.org/open-season/whats-new-2024.

2024 Benefits

Federal Employee Program

Standard	2023	2024
Deductibles		
Individual	$350	No change
Family	$700	No change
Out-of-Pocket Maximum		
Individual (INN)	$6,000	No change
Family (INN)	$12,000	No change
Services		
Physician care (INN)	$25 copay (PCP) $35 copay (specialist)	**$30 copay (PCP)** **$40 copay (specialist)**
Telehealth (INN)	$0 copay (first two visits) $10 copay (additional visits)	No change
Urgent care — Accidental injury	$0 copay	No change
Urgent care — Medical emergency	$30 copay	No change

2024 Benefits

Federal Employee Program

Standard	2023	2024
Services (Continued)		
Preventive care (INN)	$0 copay	No change
Chiropractic care (INN)	$25 copay up to 12 visits	**$30 copay up to 12 visits**
Hospital care — Inpatient (prior authorization required) (INN)	$350 copay Per admission	No change
Hospital care — Outpatient (INN)	15% COINS + BYD	No change
ER — Accidental injury (within 72-hours) (INN)	$0 copay	No change
ER — Medical emergency (INN)	15% COINS + BYD	No change

Note: For a full list of benefits and updates, please visit https://www.fepblue.org/open-season/whats-new-2024.

2024 Benefits

Federal Employee Program

Basic	2023	2024
Deductibles		
Individual	$0	No change
Family	$0	No change
Out-of-Pocket Maximum		
Individual (INN)	$6,500	No change
Family (INN)	$13,000	No change
Services		
Physician care	$30 copay (PCP) $40 copay (Specialist)	**$35 copay (PCP)** **$45 copay (Specialist)**
Telehealth	$0 copay (first two visits) $15 copay (additional visits)	No change
Chiropractic care	$30 copay up to 20 visits	**$35 copay up to 20 visits**
Urgent care	$35 copay	No change

2024 Benefits

Federal Employee Program

Basic	2023	2024
Services (Continued)		
Preventive care	$0 copay	No change
Hospital care — Inpatient (prior authorization required)	$250 copay, per day Up to $1,500 per admission	No change
Hospital care — Outpatient	$150 copay Per day, per facility	No change
ER — Accidental injury	$250 copay Per day, per facility	No change
ER — Medical emergency	$250 copay Per day, per facility	No change

Note: For a full list of benefits and updates, please visit https://www.fepblue.org/open-season/whats-new-2024.

2024 Benefits

Federal Employee Program

Blue Focus, Standard, and Basic	2023	2024
Adult Preventive Care		
• Colorectal cancer tests, including: – Fecal occult blood test – Colonoscopy, with or without biopsy Sigmoidoscopy – Double contrast barium enema – DNA analysis of stool samples • Prostate cancer tests — Prostate Specific Antigen (PSA) test • Cervical cancer tests (including pap tests) • Screening mammograms (including mammography using digital technology)	Preventive care benefits for each of the following services listed are limited to one per calendar year. Pathology for Sigmoidoscopy and colonoscopy covered at 100 percent under preventive benefits.	No change

BlueChoice

2024 Benefits

BlueChoice

Reminders

- Verify eligibility and benefits
  - Verify eligibility and benefits via My Insurance Manager℠ (MIM) or by calling Provider Services.
    - Should be completed prior to rendering services
  - Providers should not ask members to call in to check the costs of procedure codes
- Verify prior authorization (PA) requirements
  - Verify PA by checking the physician office manual or calling Health Care Services.
  - Providers should not ask members to verify PA requirements.
- Benefits for continuous glucose monitors
  - May fall under pharmacy or medical (durable medical equipment), depending on the member's plan

2024 Benefits

BlueChoice

Reminders (Continued)

- Check drug lists to ensure medications are covered
  - Submit clinical information (including any similar medications tried and the member's reaction) along with the authorization request to avoid processing delays.
- Obesity related services are not covered
  - Considered a contract exclusion
- Referral forms
  - Referral forms must be completed for patients and can be submitted by:
    - Faxing the referral form to 800-610-5685 or 803-714-6463
      - Form can be located on www.BlueChoiceSC.com
    - Completing the referral through MIM

2024 Benefits

BlueChoice

Reminders (Continued)

- Submit claims within a timely manner
  - Timely filing limit for original claims is 180 days from the date of service.
  - Timely filing limit for corrected claims is one year from the date of service.
- Balance billing
  - Network participating providers should not bill patients more than their liability.
  - Remittances can be located on MIM.

Medicare Advantage

2024 Benefits

Medicare Advantage

BlueCross Total	2023	2024
Deductibles		
In-network & Out-of-network	$0	No change
Out-of-Pocket Maximum		
From in-network providers:	$6,500	**$6,900**
From in-network and out-of-network providers combined	$10,000	No change
Services		
Outpatient office visits	INN — $0 copay (PCP) INN — $30-40 copay (Specialist) OON — $30 copay (PCP) OON — $55 copay (Specialist)	INN — No change (PCP) **INN — $25 (Specialist)** OON — No change (PCP) OON — No change (Specialist)
Inpatient hospital — acute	INN — $350 copay, per day (1-4) INN — $0 copay, per day (5-90) OON — 30% COINS for total stay	**INN — $300 copay, per day (1-4)** INN — No change (5-90) OON — No change
Inpatient hospital — psychiatric	INN — $624 copay, per day (1-4) INN — $0 copay, per day (5-90) OON — 40% COINS for total stay	**INN — $645 copay, per day (1-4)** INN — No change (5-90) OON — No change

2024 Benefits

Medicare Advantage

BlueCross Total	2023	2024
Services (Continued)		
Skilled nursing facility (SNF)	INN — $0 (days 1-20) INN — $196 copay (days 21-100) OON — 40% COINS for total stay	INN — No change (days 1-20) **INN — $203 copay (days 21-100)** OON — No change
Urgently needed services	INN & OON - $50 copay, per visit	**INN & OON - $55 copay, per visit**
Worldwide Emergency/Urgent Coverage	$250 service specific deductible, then 20% COINS for emergency care outside the United States	No change
Ambulance services (Ground or air)	INN & OON — $295 copay, per trip	No change
Hearing aids	$699-$999 using TruHearing Two per year (one per ear)	No change
Preventive dental (Fluoride treatment not covered)	INN — $0 copay (two, per year) OON — 50% COINS $3,000 maximum (combined)	No change **$3,500 maximum (combined)**
Comprehensive dental (Medicare covered services)	INN — $50 copay OON — 40% COINS $3,000 maximum (combined)	INN — No change OON — No change **$3,500 maximum (combined)**
Comprehensive dental (non-covered Medicare services)	INN & OON — 50% COINS $1,000 benefit maximum $3,000 maximum (combined)	No change **$3,500 maximum (combined)**

2024 Benefits

Medicare Advantage

BlueCross Total Value	2023	2024
Deductibles		
In-network & Out-of-network	$0	No change
Out-of-Pocket Maximum		
In-network	$6,900	**$7,900**
Out-of-network	$11,000 (Midlands/Coastal) $11,300 (Upstate/Lowcountry)	**$11,300**
Services		
Outpatient office visits	INN — $0 copay (PCP) INN — $30 copay (Specialist) OON — $40 copay (PCP) OON — $55 copay (Specialist)	No change
Inpatient hospital — acute	Midlands/Coastal INN $350 copay per days 1-5 Upstate/Lowcountry INN $375 copay per days 1-5 OON — 50% of total cost	**INN — $350 copay per day (1-4)** ***Midlands/Coastal/Upstate*** **OON — 20% COINS of total cost** ***Lowcountry*** **OON — 50% COINS of total cost**
Inpatient hospital — psychiatric	INN — $624 copay, per day (1-3) OON — 50% COINS for total stay	**INN — $645 copay per day (1-3)** ***Midlands/Coastal*** **OON — 20% COINS of total cost** ***Upstate/Lowcountry*** **OON — 50% COINS of total cost**

2024 Benefits

Medicare Advantage

BlueCross Total Value	2023	2024
Services (Continued)		
Skilled nursing facility (SNF) (100 benefit day max, per year)	INN — $0 (days 1-20) INN — $196 copay (days 21-100) OON — 50% COINS for total stay	INN — No change (days 1-20) **INN — $203 copay (days 21-100)** OON — No change
Emergency care	INN and OON — $95 copay, per visit	**INN and OON — $100 copay, per visit**
Worldwide emergency	$250 service specific deductible, then 20% COINS for emergency care outside the United States	No change
Urgent care	$50 copay	**$55 copay**
Ambulance services (Ground or air)	INN — $285 per one way trip OON — $295 per one way trip	**INN and OON — $295 per one way trip**
Hearing aids	$699-$999 using TruHearing Two per year (one per ear)	No change
Preventive dental	INN — $0 copay (two visits per year) OON — 50% COINS $2,000 maximum (combined)	No change
Comprehensive dental (Medicare covered services)	INN & OON — $50 copay $2,000 maximum (combined)	No change
Comprehensive dental (non-covered Medicare services)	INN & OON — 50% COINS $500 benefit maximum $2,000 maximum (combined)	No change

2024 Benefits

Medicare Advantage

BlueCross Secure — No out-of-network benefits.	2023	2024
Deductibles		
In-network	$0	No change
Out-of-Pocket Maximum		
In-network	$6,500	No change
Services		
Office visits	INN — $0 copay (PCP) INN — $30 copay (Specialist)	INN — No change (PCP) **INN — $35 copay (Specialist)**
Inpatient hospital — acute	INN — $325 copay, per day (1-6) INN - $0 copay (7-90)	No change
Inpatient hospital — psychiatric	INN — $624 copay, per day (1-3) INN — $0 copay (4-90)	**INN — $645 copay, per day (1-3)** INN — No change (4-90)
Skilled nursing facility (SNF)	INN — $0 copay (days 1-20) INN — $196 copay (days 21-100)	INN — No change (days 1-20) **INN — $203 copay (days 21-100)**
Urgently needed services	INN — $40 copay, per visit	**INN — $45 copay, per visit**
Emergency care	$95 copay, per visit (Waived if admitted within 24 hours)	No change

2024 Benefits

Medicare Advantage

BlueCross Secure — No out-of-network benefits.	2023	2024
Services (Continued)		
Worldwide Emergency/Urgent Coverage	$250 service specific deductible, then 35% COINS for emergency care outside the United States	No change
Ambulance services (ground or air)	INN — $285 per trip	No change
Hearing aids	$699-$999 using TruHearing Two per year (one per ear)	No change
Preventive dental	Not covered	**No COINS or Copay for:** **2 oral exams, per year** **2 cleanings, per year** **1 dental x-ray, per year**
Comprehensive dental (Medicare covered services)	INN — $50 copay	No change

2024 Benefits

Medicare Advantage

BlueCross Blue Basic	2023	2024
Deductibles		
In-network and Out-of-network	$0	No change
Out-of-Pocket Maximum		
In-network	$6,000	**$5,900**
Out-of-network	$10,000	**$9,550**
Services		
Outpatient office visits	INN — $0 copay (PCP) INN — $35 copay (Specialist) OON — $30 copay (PCP) OON — $45 copay (Specialist)	No change
Inpatient hospital — acute	INN — $325 copay, per day (1-6) INN — $0 copay, per day (7-90) OON — 30% COINS for total stay	INN — No change (1-6) INN — No change (7-90) **OON — 20% COINS for total stay**
Inpatient hospital — psychiatric	INN — $624 copay, per day (1-3) OON — 30% COINS for total stay	**INN — $645 copay, per day (1-3)** **OON — 20% COINS for total stay**

2024 Benefits

Medicare Advantage

BlueCross Blue Basic	2023	2024
Services (Continued)		
Skilled nursing facility (SNF)	INN — $0 copay (days 1-20) INN — $196 copay (days 21-100) OON — 30% COINS for total stay	INN — No change (days 1-20) INN — No change (days 21-100) **OON — 20% COINS for total stay**
Urgently needed services	INN and OON — $40 copay	No change
Emergency care	$90 copay, per visit (Waived if admitted within 24 hours)	No change
Worldwide Emergency/Urgent Coverage	$250 service specific deductible, then 20% COINS for emergency care outside the United States.	No change
Ambulance services (ground or air)	INN and OON — $275 per trip	No change

2024 Benefits

Medicare Advantage

BlueCross Blue Basic	2023	2024
Services (Continued)		
Hearing Aids	$699-$999 using TruHearing 2 per year (one per ear)	No change
Preventive Dental (fluoride treatment not covered)	INN and OON — $0 copay (Two per year) $1,000 maximum (combined)	INN and OON — No change (Two per year) **$2,000 maximum (combined)**
Comprehensive Dental (Medicare covered services)	INN — $50 copay OON — 30% COINS $1,000 maximum (combined)	INN — No change **OON — 20% COINS** **$2,000 maximum (combined)**
Comprehensive dental (non-covered Medicare services)	INN and OON — 50% COINS $1,000 benefit maximum	No change **$2,000 maximum (combined)**

2024 Benefits

Medicare Advantage

All Plans (Total, Total Value, Secure, & Blue Basic)	2023	2024
Services		
Annual wellness visit/annual physical	$0 Copay	No change
Lab work	$0 copay	No change
Preventive screenings: • Colorectal cancer screening • Breast cancer screening • Bone mineral density tests • Diabetic eye exam • Eyeglasses and frames • Glaucoma screening	$0 Copay	No change

2024 Benefits

Medicare Advantage

Value-added benefits

- FitOn Health
  - A flexible health and fitness benefit with monthly credits to use on a nationwide network of gyms, local fitness studios or community centers.
  - Credits can be used to cover a variety of options — monthly gym membership with unlimited visits, fitness studio classes, and at-home fitness accessories and equipment.
- Transportation (Only for Secure, Total and Blue Basic plans)
  - 24 one-way non-emergency rides to health-related locations such as in-patient facilities, health plan sponsored health events and other approved medical centers
  - Members must schedule rides at least 48 hours before pick-up time.
- Over the counter
  - $30-$150 credit per quarter (credit dependent on plan — Secure, Total, Total Value or Blue Basic)
  - Orders can be placed by phone, online or catalog
  - Members receive a Flex card for local pharmacies to purchase select items
- Post discharge meals
  - 10 free frozen meals after each inpatient discharge
  - Orders must be placed through the care management team.

2024 Benefits

Medicare Advantage

Value-added benefits (Continued)

- Annual wellness incentive
  - All members receive a $40 annual incentive after completing a wellness exam or physical
    - Received as additional money on the over-the-counter Flex card
- Concierge pharmacy services
  - For members that received a denial due to step therapy or prior authorization, or those who have difficulty obtaining medications
- Member health events
  - Members can attend local health events sponsored by BlueCross BlueShield of South Carolina.
    - Includes free services
    - Allows members to speak with a BlueCross representative for assistance
    - Has games for social interactions

2024 Benefits

Medicare Advantage

Prior Authorization — Important Notice: Integrated Home Care Services

- On July 5, 2023, our Medicare Advantage plans began requiring prior authorization through Integrated Home Care Services (IHCS) for all durable medical equipment (DME) used in the home setting, home health and home infusion services.
  - IHCS follows the Centers for Medicare and Medicaid Services guidelines to provide prior authorization for these services.
  - Services are covered when Medicare coverage criteria are met.
- The following places of service are included:
  - 4: Homeless shelter
  - 12: home
  - 13: Assisted living facility
  - 14: Group home
- Methods for requesting prior authorizations:
  - My Insurance Manager
  - Phone: 855-843-2325
  - Fax: 803-264-6552

Note: View the list of codes that will require prior authorization on www.SouthCarolinaBlues.com under Medicare Advantage.

IHCS is an independent company that provides utilization management on behalf of BlueCross BlueShield of South Carolina.

2024 Benefits

Medicare Advantage

Integrated Home Care Services 2024

- Beginning Jan. 1, 2024, BlueCross will use IHCS for the coordination and provision of DME, home health and home infusion services.
- IHCS has contracted directly with providers to be in the IHCS network.
- These providers will work with IHCS on new claims submission criteria.

2024 Benefits

Medicare Advantage

Inflation Reduction Act (For plans with Part D coverage)

- $35 limit for monthly insulin copay.
  - Shown as Tier 3 in formulary but special pricing.
- Part D vaccines (such as shingles) are covered at $0.
- Effective July 1, 2023 — "You pay a $35 copay in-network and out-of- network for a 1-month supply of Medicare Part B insulins for use in home infusion pumps."
- Members will pay 0 percent cost share in Catastrophic drug stage.

2024 Benefits

Medicare Advantage

CMS Stars Ratings

- **Schedule** patients for Medicare Annual Wellness Exams annually.
- **Document** all care in the patient's medical records.
- **Code and bill** appropriately for services rendered and conditions addressed.
- **Promote** medication adherence.
- **Recommend** formulary alternatives, when necessary.
- **Recommend** participation in disease management programs.
- **Respond** to medical record requests (within five business days).

Note: We have successfully reached a 4 Star Rating with out PPO plans, which includes Total, Total Value and Blue Basic. We have also added Newberry county to our PPO plan coverage.

2024 Benefits

Medicare Advantage

Network Sharing

- Allows Medicare Advantage (MA) PPO members from other Blue Plans to get in-network benefits
- Available in 48 states, District of Columbia and Puerto Rico
- Eligible members will have the following symbol on their ID cards: 

Tips for accuracy:

- Verify eligibility for out-of-area MA PPO members using the BlueCard Eligibility Line or through MIM.
- Submit claims for all BlueCross BlueShield members, regardless of state, to BlueCross BlueShield of South Carolina.
- Review member care gap reports and pay attention to open quality care gaps and patient health concerns.
- Ensure documentation of completed services while patients are visiting from other states.

2024 Benefits

Medicare Advantage

General Reminders

- Check the member's ID card to determine their plan type.
- Follow Medicare guidelines at www.cms.gov for covered services.
- Verify eligibility and benefits at each visit prior to rendering services.
- Prior authorization requirements may differ from other plans.
  - View the requirements and methods for obtaining authorization at www.SouthCarolinaBlues.com.
    - *Providers>**Medicare Advantage**>Prior Authorization*
- When possible, always refer members to network participating providers.
- Review the Medicare Advantage provider manuals for more information.
  - Update: Section 3.8: Confidentiality and Data Use.
    - Visit www.SouthCarolinaBlues.com .

Companion Benefit Alternatives

2024 Benefits

Companion Benefit Alternatives (CBA)

- CBA manages behavioral health enrollment.
- The CBA provider network services team offers support through
  - Email.
  - Phone.
  - In-person or virtual education.
  - Problem solving visits.
- Review the current CBA provider handbook located at www.CompanionBenefitAlternatives.com.

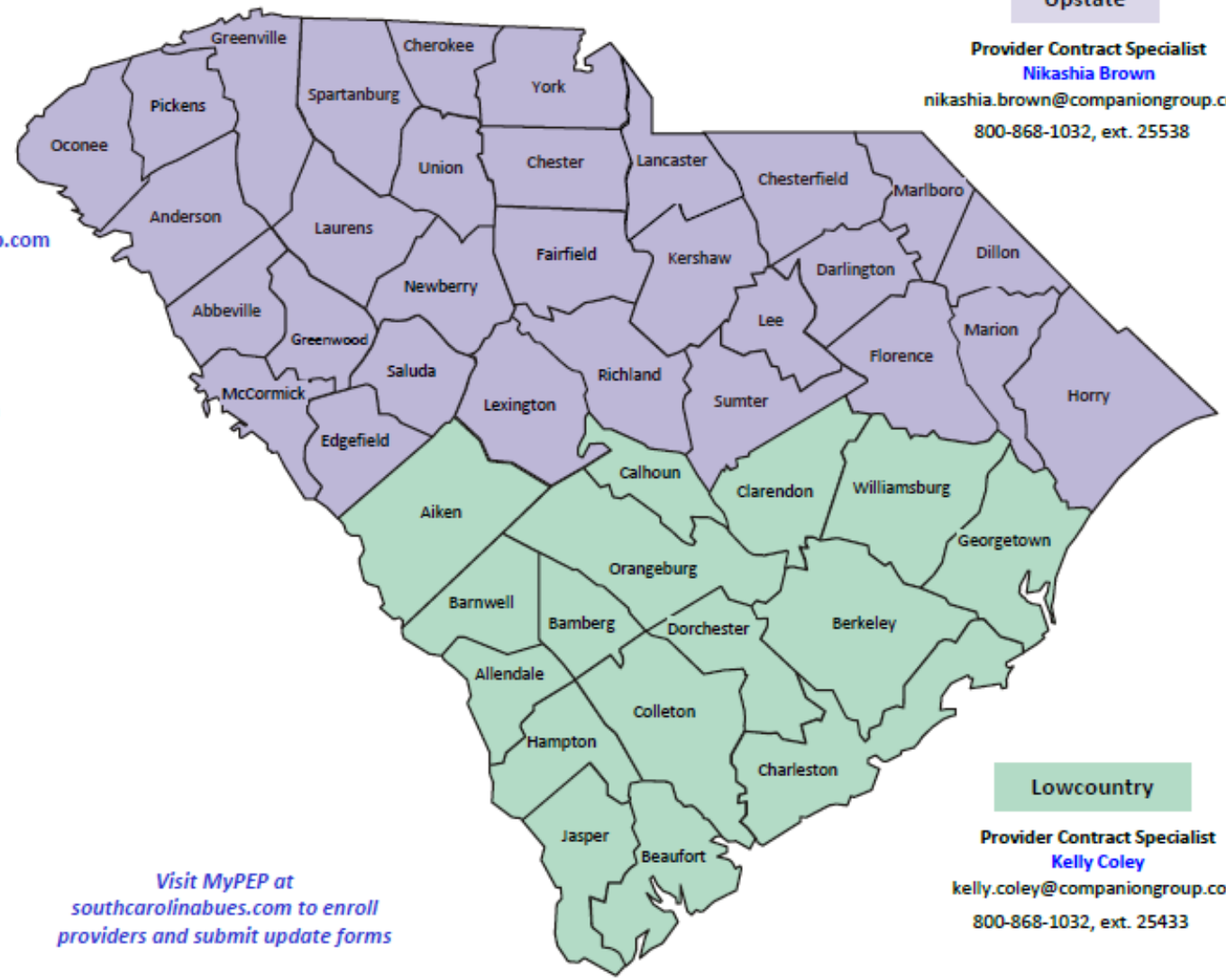
  Providers>Provider Login

  - Provider login password: cba123

Companion
BENEFIT ALTERNATIVES

Companion Benefit Alternatives
Provider Representative Territory Map

companionbenefitalternatives.com



Upstate

Provider Contract Specialist
Nikashia Brown
nikashia.brown@companiongroup.com
800-868-1032, ext. 25538

General Inquiries
cba.provrep@companiongroup.com
Call 800-868-1032 or
Fax 803-714-6456

Provider Network Coordinator
Alicia McKnight
alicia.mcknight@companiongroup.com
800-868-1032, ext. 25744

Provider Claims Support
Sandra Hall
sandra.h.hall@companiongroup.com
800-868-1032, ext. 25154

Value-Based Program Coordinator
Brandi Poole
brandi.poole@companiongroup.com
800-868-1032, ext. 25229

Provider Network Services Director
Shonda Ball
shonda.ball@companiongroup.com
800-868-1032, ext. 25560

My Provider Enrollment Portal

Visit MyPEP at southcarolinabues.com to enroll providers and submit update forms

Lowcountry

Provider Contract Specialist
Kelly Coley
kelly.coley@companiongroup.com
800-868-1032, ext. 25433

2024 Benefits

Companion Benefit Alternatives (CBA)

Reminders

- Providers requesting to change their contracting status with the Behavioral Health (BH) network must contact CBA directly.
  - Termination of a provider's affiliation to a location will not terminate their agreement with CBA.
- CBA network providers who change their practices must notify CBA of the change and confirm their credentialing status can be transferred.
  - Recredentialing notices may be missed when providers change groups between the recredentialing cycles.
- A provider's directory specialty is based on their professional licensure as confirmed during the credentialing process and cannot be changed.
  - If the provider directory does not reflect your current practice location, contact CBA immediately.

2024 Benefits

Companion Benefit Alternatives (CBA)

Reminders (Continued)

- CBA does not credential or reimburse interns or anyone under the supervision of a licensed practitioner.
  - CBA credentials providers who are fully licensed and can independently work in a clinical setting.
  - Supervisors should not submit their information on claims to seek reimbursement for the supervisee.
- To assist CBA in enhancing the quality of care for our members, inform them of your availability for extended office hours or quick access appointment availability.
  - Information can be sent to CBA.Provrep@bcbssc.com.

2024 Benefits

Companion Benefit Alternatives (CBA)

Telehealth

- Providers must apply for telehealth approval.
  - Applications can be submitted through My Provider Enrollment Portal.
  - Approval applies to commercial health plans.
- Approved telehealth providers must notify the virtual care team (VirtualCare@bcbssc.com) of:
  - Any change in Tax ID or NPI, or additional locations.
  - Addition or removal of individual providers (each rendering BH provider requires approval).
  - A change of telehealth vendors.
  - No longer providing telehealth services.
- Telehealth services must comply with our medical policy, CAM 176.
  - www.SouthCarolinaBlues.com: *Providers>Medical Policies>Commercial and Contracted Plans*
- CBA telehealth participation is subject to continued CBA network status and active credentialing.
- The modifier 95 is required on all CPT codes when services are delivered via telehealth.
- Verify member eligibility and benefits for telehealth coverage.
  - Call the number of the back of the member's ID card.

2024 Benefits

Behavioral Health and Autism Applications

- CBA cannot accept the Individual Application in My Provider Enrollment Portal for enrollment.
  - The Behavioral Health Application and/or the Autism Panel Application must be submitted.
- Case comments can be submitted to verify the status of the application or submit a support case.
- Send an email to CBA.Provrep@bcbssc.com to verify if the provider is already enrolled in the network before completing an application.
- To be considered for the Healthy Blue network, providers must have their Medicaid ID number. Submit this using one of the following:
  - Entering the Medicaid ID number on the application.
  - Uploading the award letter from the South Carolina Department of Health and Human Services, which includes the Medicaid ID number.
  - Uploading a notice on letterhead with the providers name, NPI, case number and Medicaid ID number.

2024 Benefits

Behavioral Health and Autism Applications (Continued)

- Be sure to include the following:
  - Social security number
  - Tax ID number
  - NPI number
  - Medicaid ID number
  - Current copy of malpractice insurance policy
    - Practitioner's name must be included on the policy or listed on an attached roster.
  - Undergraduate and graduate information
  - Five years of continuous wok history (provide explanation for any gaps)
  - Cultural Competency course completion date
    - This is required when applying for the Healthy Blue network.
  - Current copy of provider's license
    - A SC LLR* license verification is also acceptable.
  - Clearly name uploaded documents (i.e., license, malpractice, etc.)

*Labor, Licensing and Regulation

2024 Benefits

Nurse Practitioner Required Certification — APRNs and NPs

- As of Sept. 1, 2023, APRNs and NPs must have a behavioral health certification or accreditation at the time of initial credentialing to be considered for the CBA network.
- All established APRNs and NPs in the CBA network will be required to have a behavioral health certification or accreditation by Sept. 1, 2026, to maintain their network status.
- APRNs and NPs that do not have a behavioral health certification or accreditation should apply to one of the medical networks with BlueCross as they are not eligible for the CBA network.
  - Once credentialed, they can be affiliated to a predominately behavioral health practice.

2024 Benefits

Claims Support — Forms Resource Center

- All behavioral health providers have access to the Forms Resource Center (FRC) to submit clinical information for authorizations.
  - This has been expanded to allow network providers to submit a claim support inquiry for any claims that have been processed.
- As of Oct. 1, 2023, all claims request must be entered using the FRC form.
  - Visit www.CompanionBenefitAlternatives.com.
  - Select Provider (password: cba123).
  - Scroll down and select the Claims Support link.
- This form is used to request review of up to nine claims for possible adjustment.
  - For 10 or more claims, select the option to receive a template via secure email.
- All claims must be initialed through the FRC for proper handling and routing.

2024 Benefits

Upcoming Network Changes

- Upon completion of CMS certification, providers (including Licensed Professional Counselors and Licensed Marriage and Family Therapists) may be eligible to join the Medicare Advantage network.
  - Pre-registration begins Nov. 30, 2023, for Medicare Advantage.
    - Includes verification of demographics, credentialing status and contract status.
  - Pre-registration does not guarantee participation.
  - Providers must have an active Medicare number to participate in the Medicare Advantage network.
- Effective Jan. 1, 2024, Licensed Psycho-Educational Specialists will be eligible to join the Autism Panel in addition to the Healthy Blue network.
  - There is no change to the CBA network.
  - Reach out to CBA.Provrep@bcbssc.com for enrollment information.

What's New?

What's New?

ProgenyHealth

- **Oct. 9, 2023**, BlueCross began working with ProgenyHealth®.
- ProgenyHealth specializes in neonatal care management services, and their program enhances services for our members.
- With this program, ProgenyHealth's neonatologists, pediatricians and neonatal nurse care managers collaborate closely with our members, as well as attending physicians and nurses. This approach promotes healthy outcomes for BlueCross's premature and medically complex newborns.

Which plans are included:

- This program applies to:
  - BlueChoice HealthPlan.
  - Fully insured businesses (major group, small group and individual plans).
  - Some self-insured plans.

Note: Review the "New Assistance for Providers From ProgenyHealth" bulletin on www.SouthCarolinaBlues.com for more information.

Benefit Reminders

Benefit Reminders

BlueCard Program

- The BlueCard Program enables Blue Plan members to get health care service benefits and savings while traveling or living in another Blue Plan's service area.
- The program links participating health care providers across the country and internationally through a single electronic network for claims processing and reimbursement.

Benefit Reminders

BlueCard Program

Ancillary Filing Guidelines

Durable Medical Equipment (DME)

- File to the Plan whose state the equipment was purchases at a retail store; or
- File to the Plan whose state the equipment was shipped

Independent Clinical Laboratory

- File to the Plan where the specimen was drawn; or
- File to the Plan where the referring physician is located

Specialty Pharmacy

- File to the Plan whose state the ordering physician is located

Benefit Reminders

Medical Records

- Submit medical records upon request.
- Medical records could be requested to support medical necessity for claims adjudication or to close gaps in care for HEDIS®.
- The submission of medical records is a **non-billable event.**
  - Share this information with any outside vendors used to submit medical records on your behalf (e.g., Ciox, ScanSTAT, etc.).

Benefit Reminders

National Drug Code (NDC)

- NDCs must have 11 digits following the 5-4-2 format upon submission.
  - If the package lists an NDC with 10 digits, it must be converted to an 11-digit NDC.
    - First determine the format of your 10-digit NDC by closely examining the package information and counting the numbers separated by dashes.
- Once you have identified the format as either 4-4-2, 5-3-2 or 5-4-1, insert a zero according to the following table:

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

Benefit Reminders

Laboratory Services

- Use network participating laboratories to ensure low member cost shares.
- Access the current list of participating laboratories at www.SouthCarolinaBlues.com.

  Providers>Policies and Authorizations>Prior Authorization>Laboratory Medical Benefits

- All lab tests must be supported by the available medical policies located on our website.

  Providers>Medical Policies>Commercial and Contracted Plan Policies

Benefits of reviewing medical policies:

- Prevents delays in claims processing
- Ensures proper and timely payment
- Reduces the need for reconsiderations

avalon

Reminders

Appointment Availability

Primary Care Physicians

- New and established patient visits
  - Scheduled within 15 days
- Urgent appointments
  - Scheduled within 48 hours

Specialists

- New and established patient visits
  - Scheduled within 30 days
- Urgent appointments
  - Scheduled within 48 hours

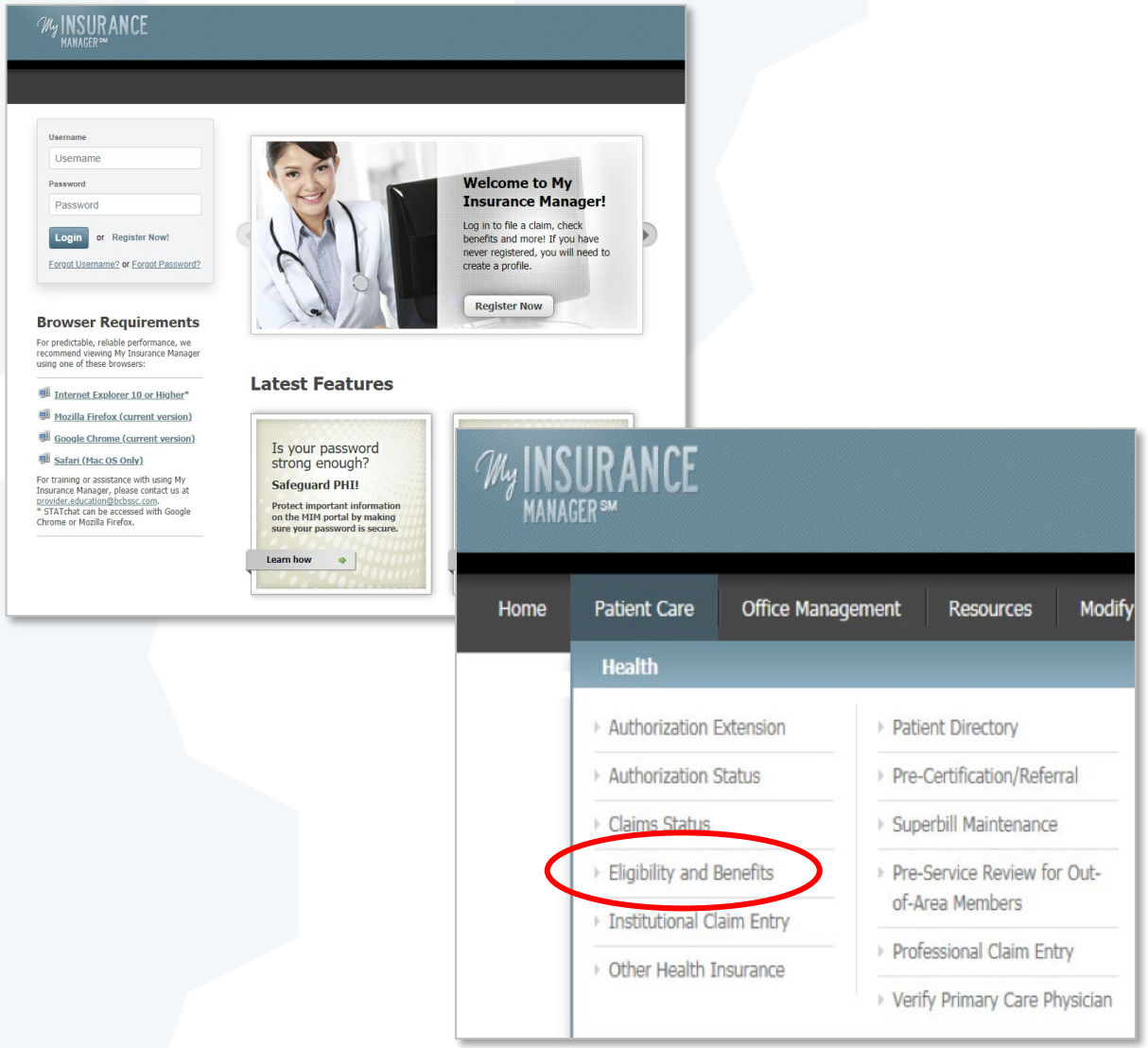
Resources

Resources

My Insurance Manager

Online portal giving access to check eligibility and benefits with the following options:

- General
- Service type
- Procedure code (recommended)



Resources

Voice Response Unit (VRU)

- The voice response unit (VRU) provides options to obtain eligibility, benefits and much more 24/7.
- The VRU is fully automated and offers quick and easy information over the phone without the need of speaking with a representative.

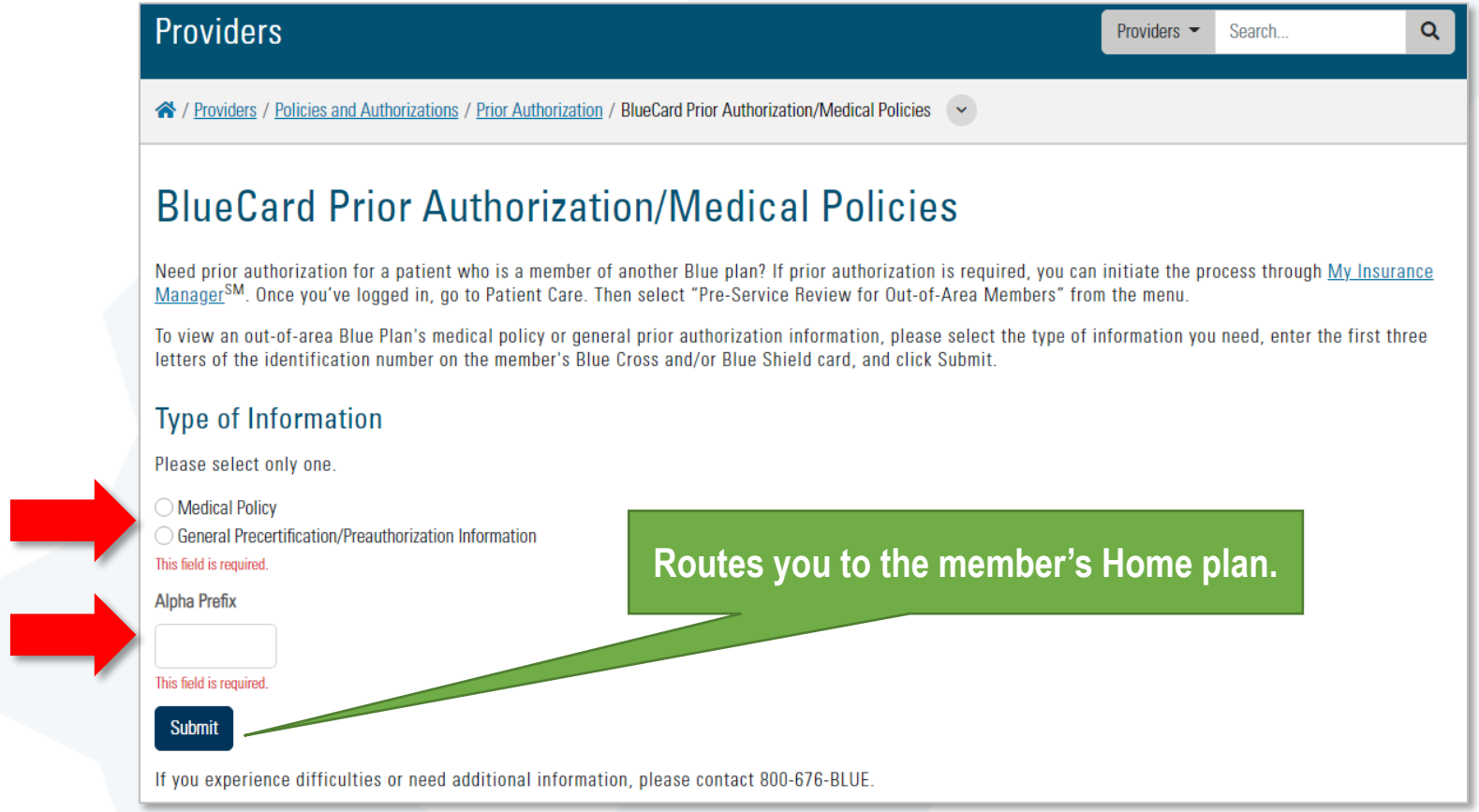
How to Access the VRU

- For BlueCross BlueShield of South Carolina members:
  - In South Carolina, call 800-868-2510.
  - In Columbia/Lexington, call 803-788-8562.
  - If out-of-state, call 800-334-2583.
- For BlueCard® members, call 800-676-BLUE (2583).
- For Federal Employee Program (FEP) members, call 888-930-2345.
- For State Health Plan members, call 800-444-4311.

Resources

BlueCard Out-of-State Member Authorizations and Medical Policies

You can verify authorization requirements and medical policies for out-of-state members using the BlueCard Authorization/Medical Policy tool.

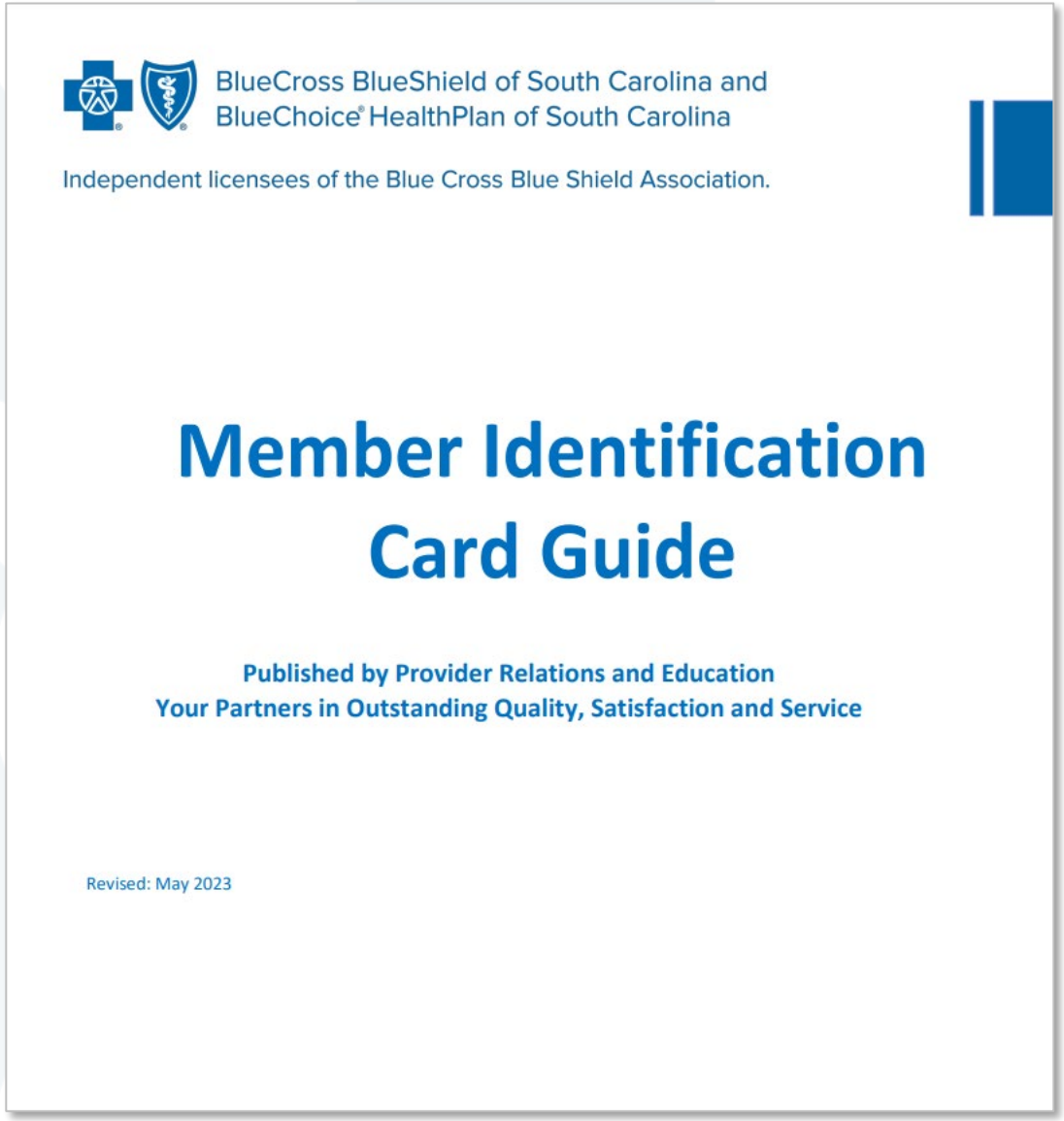


Resources

Member ID Card Guide

- You can get an overview of our various plans, associated networks and an example of the ID card you may see.
- Visit www.SouthCarolinaBlues.com and use the path:

Providers>Tools and Resources>Guides



Claims

Back To Basics

Claims Disclaimer

The information included is general and in no event should be deemed as a promise or guarantee of payment. We do not assume and hereby disclaim any liability for loss caused by errors or omissions in preparation and editing of this publication.

Agenda

- Claim Reminders
- Claim Tips
- Available Resources

Claim Reminders

Claim Reminders

High Dollar Pre-payment Reviews

What is a high dollar pre-payment review (HDPR)?

- The process of reviewing high dollar inpatient hospital claims to ensure providers are billing in accordance with services rendered.

What happens during the HDPR process?

- Charges on the claim are reduced based on audit findings of the claim with the highest charges.
  - The audit threshold is determined by the admission date.
- A claim line with revenue code 0249 is added to the claim.
  - Line will deny with CARC 216, RARC N183
  - Determined by the *Inpatient Non-Reimbursable Charge/Unbundling* policy
    - www.SouthCarolinaBlues.com

      Providers>Tools and Resources>Guides>Inpatient Non-Reimbursable Charge/Unbundling Policy

Claim Reminders

High Dollar Pre-payment Reviews (Continued)

Criteria for high dollar pre-payment reviews (HDPR).

- A HDPR takes place when the following criteria are met:
  - Inpatient institutional (acute care) claims; and
  - Claims with an allowed amount of **$100,000 or more**; and
  - Any pricing methodologies except for the following pricing models that do not incorporate individual charges due to global pricing
    - Per-diem
    - Flat-fee case rate
    - DRG rate (except those in which a portion of the claim is charge-sensitive)

What is needed for the HDPR?

- Itemized bills
  - Submit, when requested, using the claims attachment feature in My Insurance Manager℠.
    - **If medical records are needed, a separate request will be sent.**

Claim Reminders

Itemized Bills

Example of an acceptable itemized bill:

42 Rev. Co.	43 Description	44 HCPCS/Rate/HPPS Code	45 Serv. Date	46 Serv. Units	47 Total Charges
0250	Dicyclomine 10 MG		010322	1	27.00
0250	Nitroglycerin 0.4 MG		010322	1	28.73
0250	Midazolam 10 MG	J2250	010322	2	29.09
0250	Atorvastatin 40 MG		010322	2	76.93
0272	Catheter Angiographic		010322	1	226.00

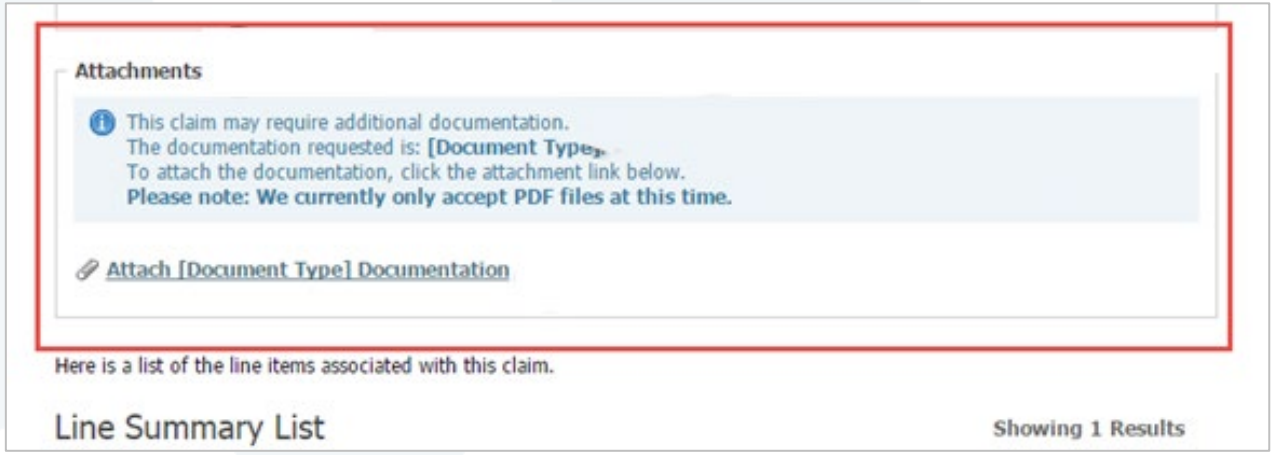
Example of an unacceptable itemized bill:

42 Rev. Co.	43 Description	44 HCPCS/Rate/HPPS Code	45 Serv. Date	46 Serv. Units	47 Total Charges
0250	Pharmacy			336	7780.81
0272	Sterile supplies			8	7680.40
0278	Supply/implant		010322	2	6385.00

Claim Reminders

Claim Attachments

- Feature in My Insurance Manager that lets you upload requested information directly into the portal for a claim.
- The feature cannot be used for claims that have not been finalized.
- Types of documentation that can be uploaded include:
  - Accident questionnaires.
  - Certificate of medical necessity (for durable medical equipment).
  - Medical records.
  - Other health insurance.
  - Primary carrier explanation of benefits.
  - Provider reconsideration.
  - Itemized bills.



Note: Review the "What You Need to Know About Claim Attachment" guide on www.SouthCarolinaBlues.com for more information.

Providers>Tools and Resources>Guides

Claim Reminders

Laboratory Services

- Avalon Healthcare Solutions manages the laboratory benefits on behalf of BlueCross BlueShield of South Carolina and BlueChoice HealthPlan.
- Access the current list of participating laboratories at www.SouthCarolinaBlues.com.

  Providers>Policies and Authorizations>Prior Authorization>Laboratory Medical Benefits

- Before rendering lab services, review the Medical Policies pages to view the complete medical policy for specific labs to ensure the criteria is followed for coverage.

Benefits of reviewing medical policies:

- Prevents delays in claims processing
- Ensures proper and timely payment
- Reduces the need for reconsiderations

avalon

Claim Reminders

Laboratory Services — Medical Policies

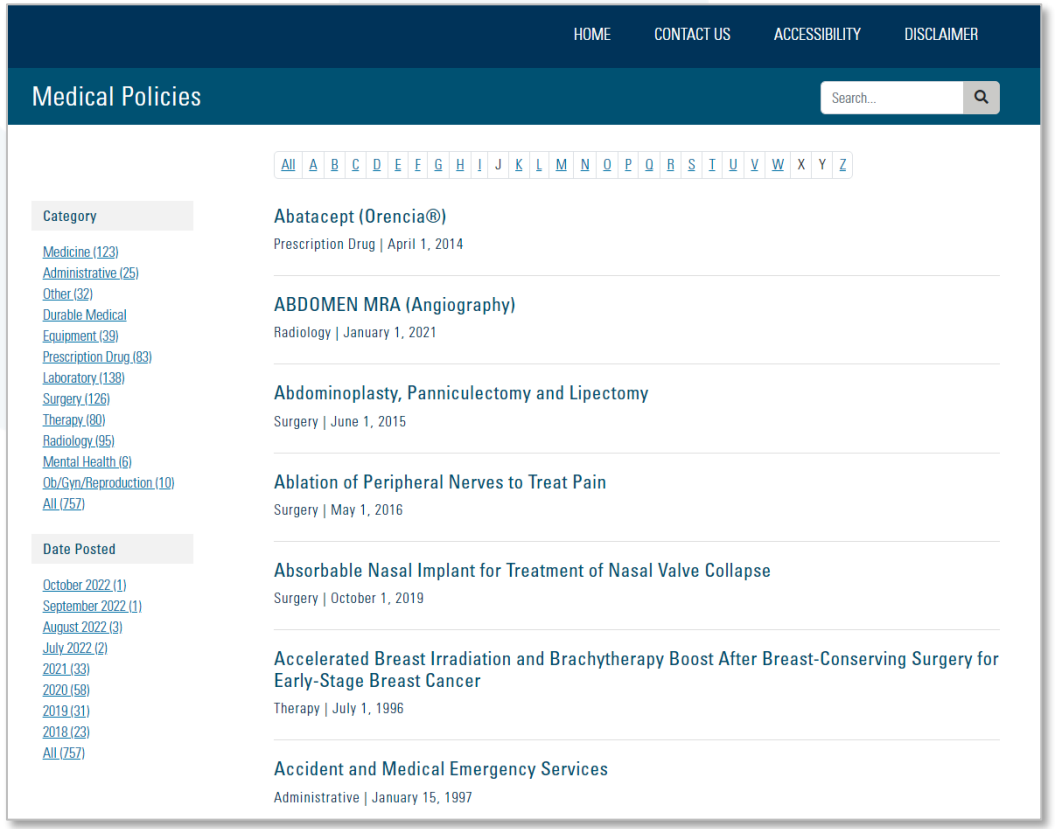
The Medical Policies pages can be found on one of the following:

- www.SouthCarolinaBlues.com

Providers>Medical Policies>Commercial and Contracted Plan Policies

- www.BlueChoiceSC.com

Providers>Medical Policies (under Resources)>Medical Policies



Note: CPT and diagnosis codes listed on each medical policy are not a guarantee of payment but are included only as a general reference tool. They may not be all-inclusive.

Claim Reminders

Laboratory Services — Medical Policy Criteria

The following are the policy rule criteria used to determine coverage for laboratory services:

Policy Rule	Definition
Experimental and investigational	Procedure is not covered under the member's benefit due to exclusion
Demographic limitations	Limitations based on the member's age/sex
Excessive procedure units	Total units within and across claims for a single date of service more than necessary
Excessive units per period of time	Maximum allowable units within a defined period of time has been exceeded
Insufficient time between procedures	Minimum time required before a second procedure is warranted
Rendering provider limitations	Providers/procedures not permitted in combination
Diagnosis does not support test requested	Procedure was not appropriate for the clinical situation
Mutually exclusive codes	The procedure is not valid with other procedures on the same date of service

Examples

Laboratory Test	Example	Rejection Applied
Vitamin D	Testing rendered two weeks after initiation of Vitamin D therapy	Insufficient time between procedures
Thyroid Disease	Testing of reverse T3, T3 uptake	Experimental and investigational
Testosterone	Testing saliva for testosterone	Experimental and investigational

Claim Reminders

Provider Reconsiderations

What is a provider reconsideration?

- A request to investigate the outcome of a finalized claim.

What are the guidelines for a provider reconsideration?

Reasons that would require a reconsideration…	[1] Reasons that would not require a reconsideration…
Medical necessity determination	Membership, eligibility or benefit issues
Lack of authorization for non-emergent services when the member does not present themselves as a BlueCross BlueShield of South Carolina member	Lack of authorization for non-emergent services when the member presents themselves as a BlueCross BlueShield of South Carolina member

[1]For reasons listed in this column, contact the appropriate Provider Services department using Ask Provider Services, STATchat℠ or call the phone number on the back of the member's ID card.

Claim Reminders

Provider Reconsiderations — Requirements

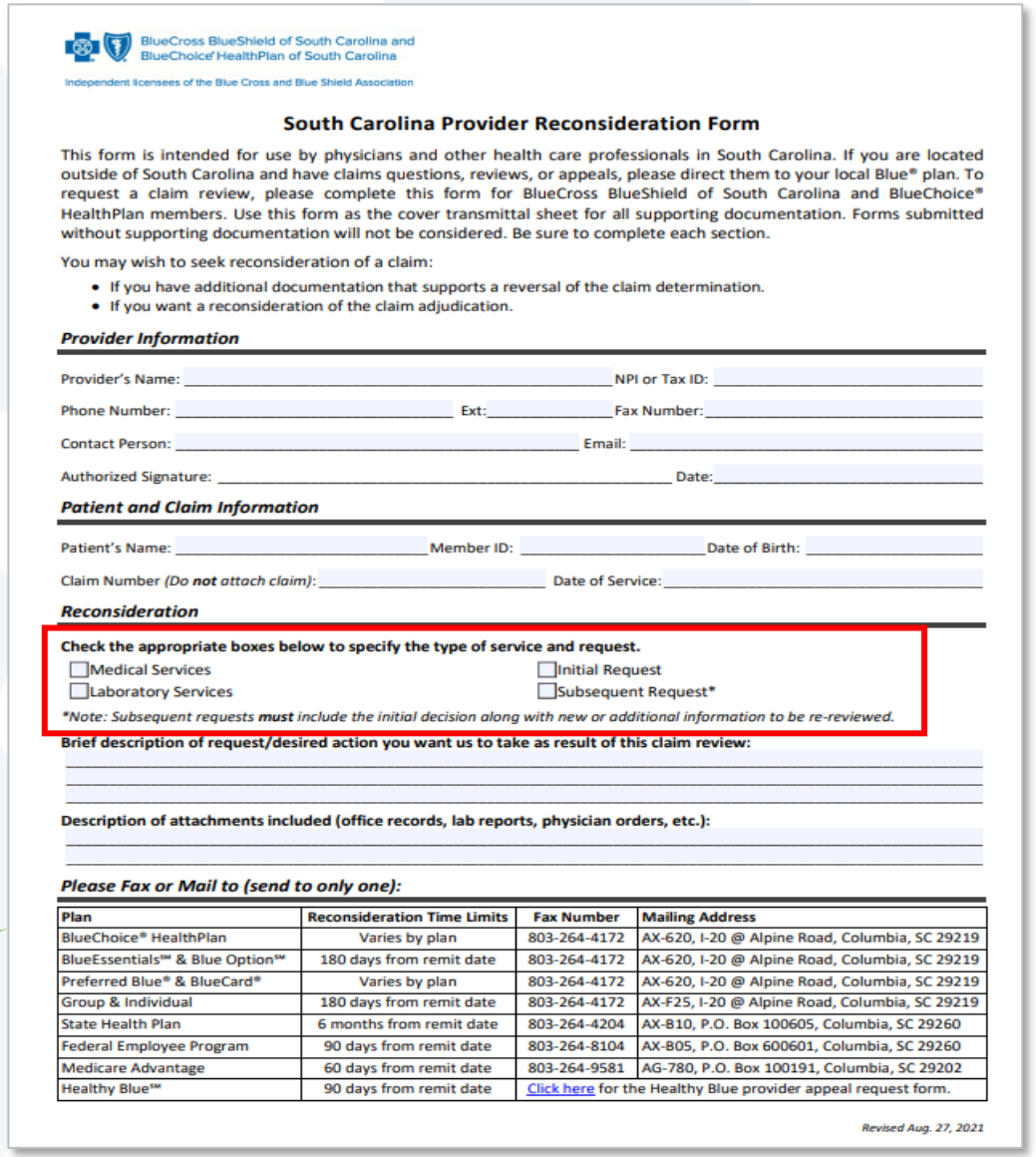
Provider Reconsideration Form

- www.SouthCarolinaBlues.com
  - *Providers>Claims & Payment>Appeals & Reconsiderations*
- www.BlueChoiceSC.com
  - *Providers>Find a Form>Provider Reconsideration Form*

Supporting Documentation

- Supporting document must be included, such as:
  - History and physical records
  - Operative reports
  - Office notes
  - Progressive notes
- **Reconsiderations cannot be reviewed without support.**

Be mindful of the filing guidelines.



BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

South Carolina Provider Reconsideration Form

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

You may wish to seek reconsideration of a claim:

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

Provider Information

Provider's Name: _____ NPI or Tax ID: _____

Phone Number: _____ Ext: _____ Fax Number: _____

Contact Person: _____ Email: _____

Authorized Signature: _____ Date: _____

Patient and Claim Information

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

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

Reconsideration

Check the appropriate boxes below to specify the type of service and request.

☐ Medical Services ☐ Initial Request

☐ Laboratory Services ☐ Subsequent Request*

Note: Subsequent requests **must include the initial decision along with new or additional information to be re-reviewed.*

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

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

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

Plan	Reconsideration Time Limits	Fax Number	Mailing Address
BlueChoice® HealthPlan	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
BlueEssentials℠ & Blue Option℠	180 days from remit date	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Preferred Blue® & BlueCard®	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Group & Individual	180 days from remit date	803-264-4172	AX-F25, I-20 @ Alpine Road, Columbia, SC 29219
State Health Plan	6 months from remit date	803-264-4204	AX-B10, P.O. Box 100605, Columbia, SC 29260
Federal Employee Program	90 days from remit date	803-264-8104	AX-B05, P.O. Box 600601, Columbia, SC 29260
Medicare Advantage	60 days from remit date	803-264-9581	AG-780, P.O. Box 100191, Columbia, SC 29202
Healthy Blue℠	90 days from remit date	Click here for the Healthy Blue provider appeal request form.	

Revised Aug. 27, 2021

Claim Reminders

Provider Reconsiderations vs. Corrected Claims

Knowing when to submit a provider reconsideration versus a corrected claim is important.

Examples of when a provider reconsideration can be submitted.

Provider reconsideration
A claim is rejected because the medical necessity could not be determined
A claim is rejected for lack of authorization, but the member was comatose when they arrived at the hospital

Examples of when a corrected claim should be submitted.

Corrected claim
An anesthesia claim is submitted with the incorrect modifier and rejects as a duplicate
A provider only performs the Cesarean delivery, but submits their claim with the procedure 59515 (which includes postpartum care), causing the claim to process globally

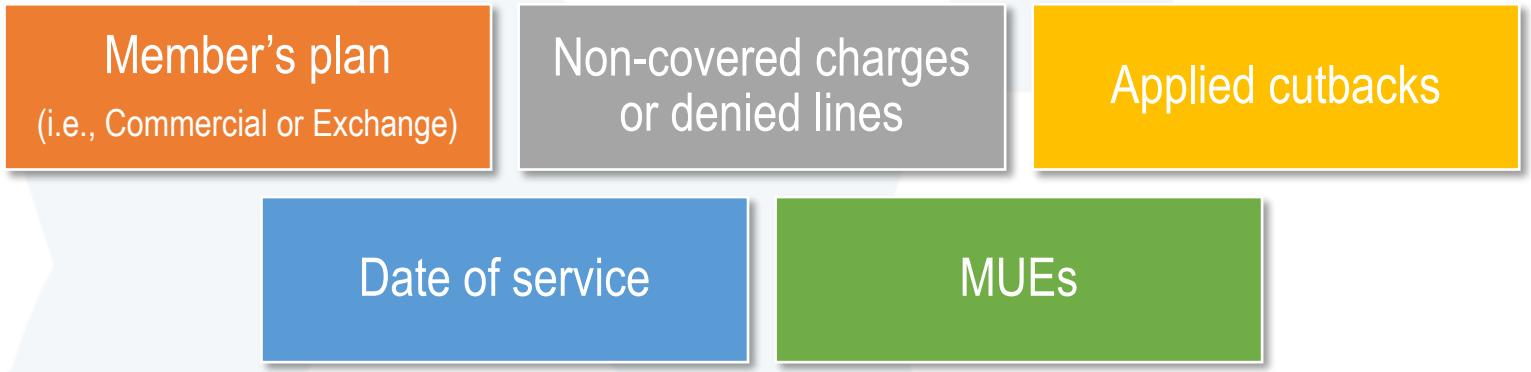
Claim Reminders

Pricing Inquiries

What is a pricing inquiry?

- An investigation of the reimbursement applied to a claim.

Before submitting pricing inquiries, verify the following:



Note: If using a third-party vendor, be sure to relay this information to them.

Claim Reminders

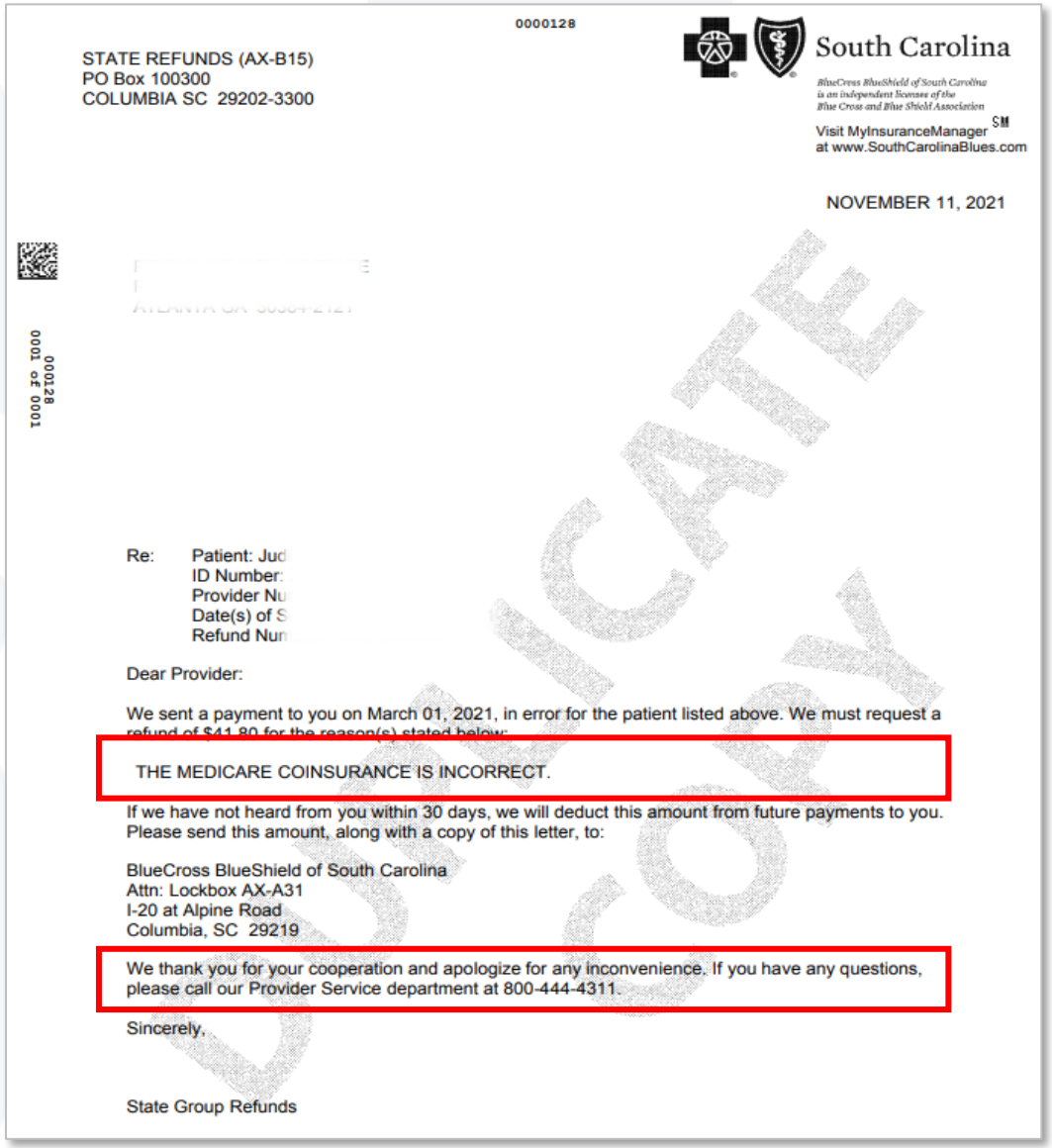
Refunds

For assistance with refunds:

- Access My Insurance Manager.
- Contact the number on the back of the member's ID card.

If you do not have the refund letter:

- Call Provider Services: 800-868-2510, opt. 4
  - Used for the following lines of business:
    - BlueCard
    - BlueEssentials℠
    - Major Group
    - National Alliance
    - Small Group & Individual



0000128

STATE REFUNDS (AX-B15)
PO Box 100300
COLUMBIA SC 29202-3300

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Visit MyInsuranceManager℠ at www.SouthCarolinaBlues.com

NOVEMBER 11, 2021

0001 of 0001 000128

Re: Patient: Jud
ID Number:
Provider Nu
Date(s) of S
Refund Nur

Dear Provider:

We sent a payment to you on March 01, 2021, in error for the patient listed above. We must request a refund of $41.80 for the reason(s) stated below:

THE MEDICARE COINSURANCE IS INCORRECT.

If we have not heard from you within 30 days, we will deduct this amount from future payments to you. Please send this amount, along with a copy of this letter, to:

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

We thank you for your cooperation and apologize for any inconvenience. If you have any questions, please call our Provider Service department at 800-444-4311.

Sincerely,

State Group Refunds

DUPLICATE COPY

Claim Reminders

Network Participating Providers

Network participating providers should always use or refer members to other network participating providers, when necessary, including laboratories.

By using or referring other network participating providers:

- Members will not have to bear the burden of higher out-of-pocket costs.
- Members will not be subject to balance billing.

Claim Reminders

Claim Submissions

Claims can be submitted using the following:

- Electronically (through your clearinghouse)
  - Preferred method
  - See the payer IDs
- My Insurance Manager (MIM)
- Mail (hard copy)
  - Use the address located on the back of the member's ID card

For more information, visit www.SouthCarolinaBlues.com:

Providers>Claims & Payments>Claims Submission

Medical Plans	
State Health Plan	00400
BlueCross BlueShield of South Carolina	00401
Federal Employee Plan (FEP)	00402
Healthy Blue℠	00403
Planned Administrators, Inc. (PAI)	00886
BlueChoice® HealthPlan	00922
Medicare Advantage	00C63

Dental Plans	
BlueCross BlueShield of South Carolina	38520

Claim Reminders

Claim Submissions — Corrected Claims

- Corrected claims can be submitted using one of the following avenues:
  - Electronically (the preferred method)
    - Enter frequency code 7 (which indicates an adjustment) in Box 22 of the CMS-1500.
    - Enter the original claim number in Box 22 of the CMS-1500.
    - Include a brief description for the reason of the adjustment in Box 19 of the CMS-1500.
  - My Insurance Manager (MIM)
    - Select Replacement of Prior Claim on the Claim Information page.
  - Mail (hard copy)
    - Ensure “Corrected Claim” is labeled on the claim.
- For all avenues, be sure to include **all lines** from the original claim along with the correction(s) that should be made.
- Guidance on submitting corrected claims can be located on www.SouthCarolinaBlues.com.

  Providers>News and Events>News Archive>2021 News>Reminder: Corrected Claims

Claim Tips

Claim Tips

Claims Requiring Questionnaire Responses

- Accident or subrogation
  - Generated based on trauma related diagnoses on a claim
  - Allow members at least 60 days to respond and for the review to be completed
- Other health insurance (OHI)
  - Generated based on the member's age, if they have more that one policy on file, etc.
  - Must be completed by the member or the member can contact customer service to verify or update

Encourage members to return the questionnaire as soon as possible to avoid processing delays.

Incorporate the forms in the onboarding paperwork.
Only submit the documentation if requested.

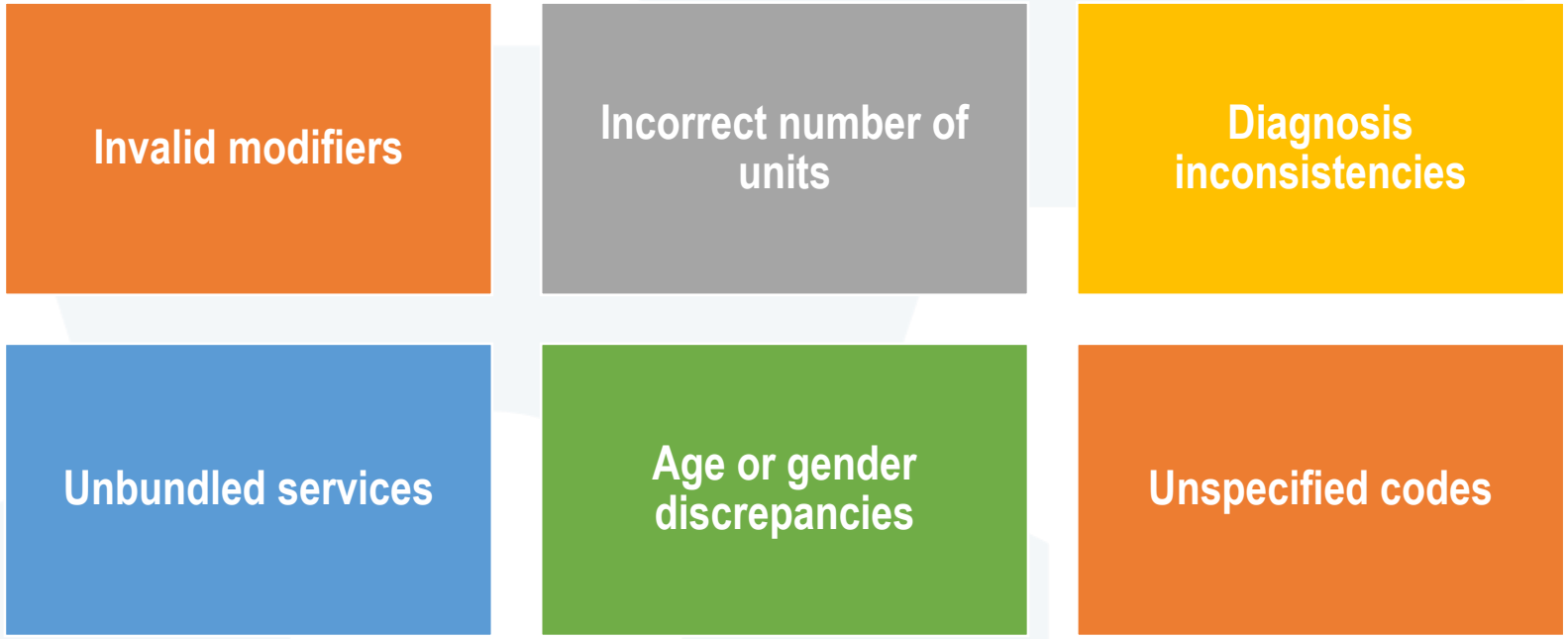
Note: Both forms are on www.SouthCarolinaBlues.com.

Providers>Forms>Other Forms

Claim Tips

Correct Coding

- Accurate coding and reporting of services on medical claims is critical in assuring proper payment to providers.
- Common coding issues include:



Available Resources

Available Resources

Voice Response Unit (VRU)

If we processed and paid a claim or applied patient liability, the VRU will provide:

- Processed date.
- Remittance date.
- Check number.
- Amount paid.
- Amount applied to the patient's liability (copay, deductible or coinsurance).

If we processed and denied a claim, the VRU will provide:

- Denial reason.
- Remittance date.

Note: If a claim is processed to the member, please contact them for the details. Submitting a HIPAA transaction (276/277) will advise if the claim was processed to the member.

Available Resources

My Insurance Manager℠

My Insurance Manager (MIM) is the quickest way to obtain claims information. With MIM, you can:

- Submit claims.
- Check claims status.
- View refund letters.
- Get assistance with claims.
  - Ask Provider Services
  - STATchat℠

Additional information included in MIM:

- Eligibility and benefits
- Prior authorizations
- Provider updates

Note: Review the available MIM guides on www.SouthCarolinaBlues.com for more information.

Providers>Tools and Resources>My Insurance Manager

Available Resources

Ask Provider Services (Web inquiries)

- Ask Provider Services is a feature inside My Insurance Manager that allows you to submit secured web inquiries for help with claims.
- To get the most effective and accurate responses, ask specific, probing questions.
  - This feature should not be used for general claim status.

Examples of appropriate questions to ask…	Examples of inappropriate questions to ask…
Why was line one of the claim denied as noncovered?	What is the status of the claim?
Why were services applied to the member's deductible?	Have medical records been received?
Has the member returned the coordination of benefits questionnaire?	Has the claim been processed?

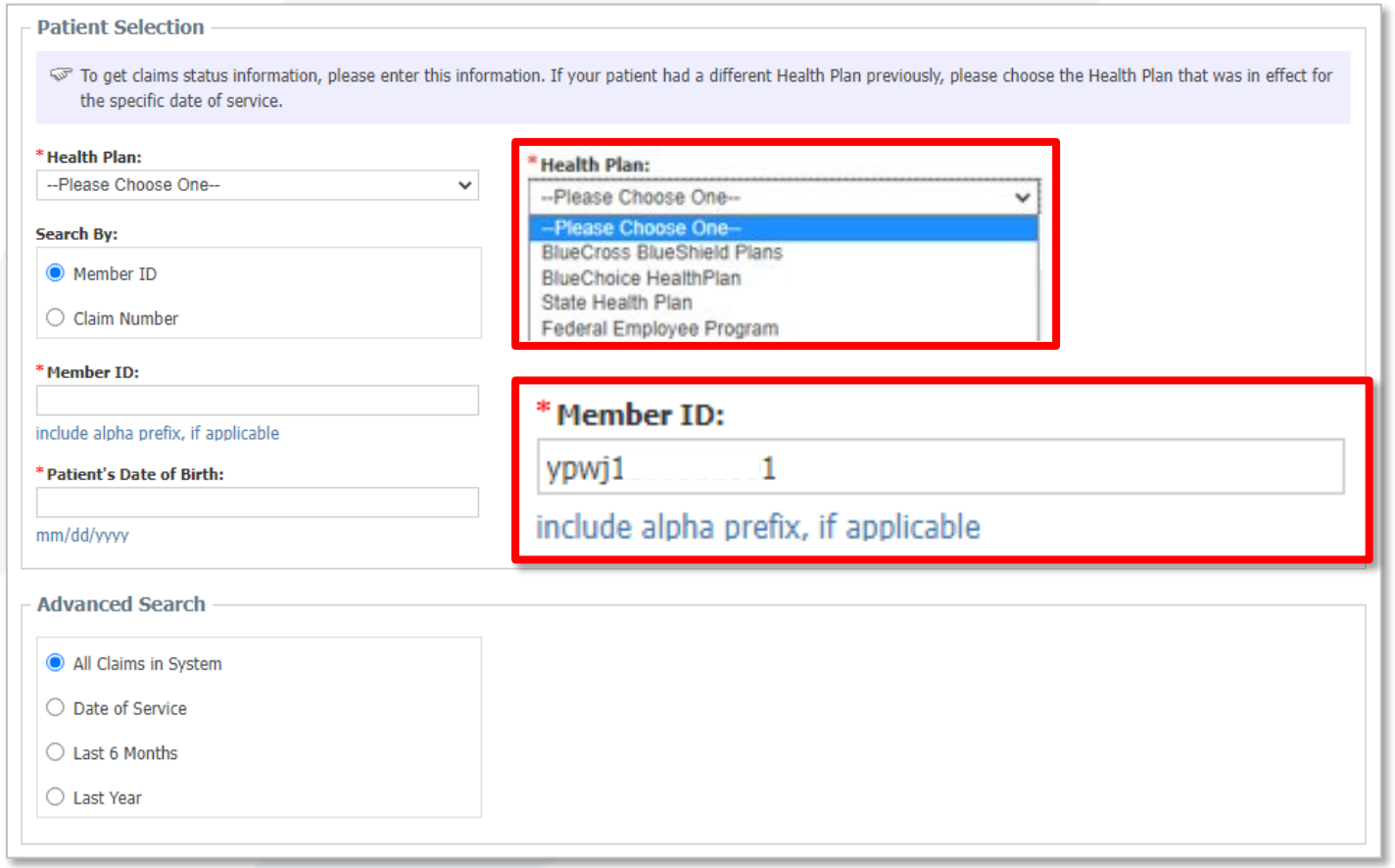
Available Resources

Ask Provider Services — Submitting Web Inquiries

Searching by Member ID (Recommended Option)

Be sure to:

- Select the appropriate Health Plan.
- Enter the **FULL** Member ID, including the prefix and any additional letters.
- Enter the date of birth.
- Select one of the advanced options.



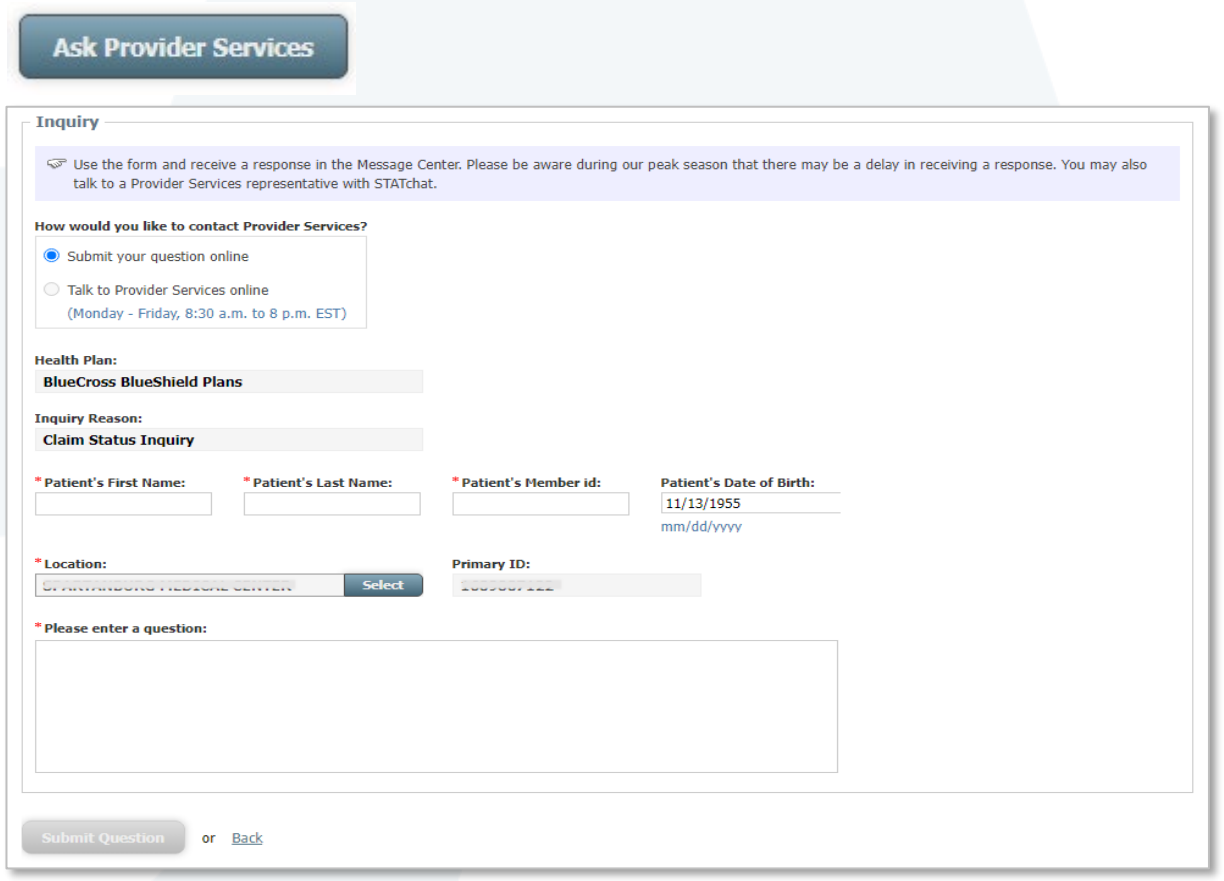
Available Resources

Ask Provider Services — Submitting Web Inquiries

Searching by Member ID (Continued)

Be sure to:

- Enter the patient's first and last name.
- Enter the **FULL** Member ID, including the prefix and any additional letters.
- The date of birth and location will auto-populate from the selected claim.
- Enter your question (be specific as possible).



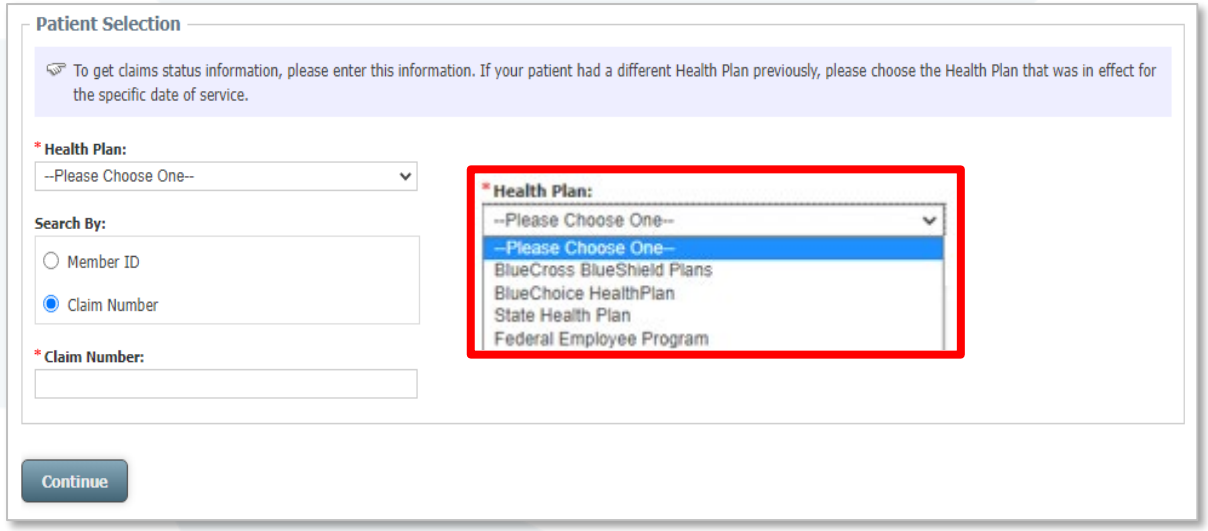
Available Resources

Ask Provider Services — Submitting Web Inquiries

Searching by Claim Number

Be sure to:

- Select the appropriate Health Plan.
- Enter the claim number.



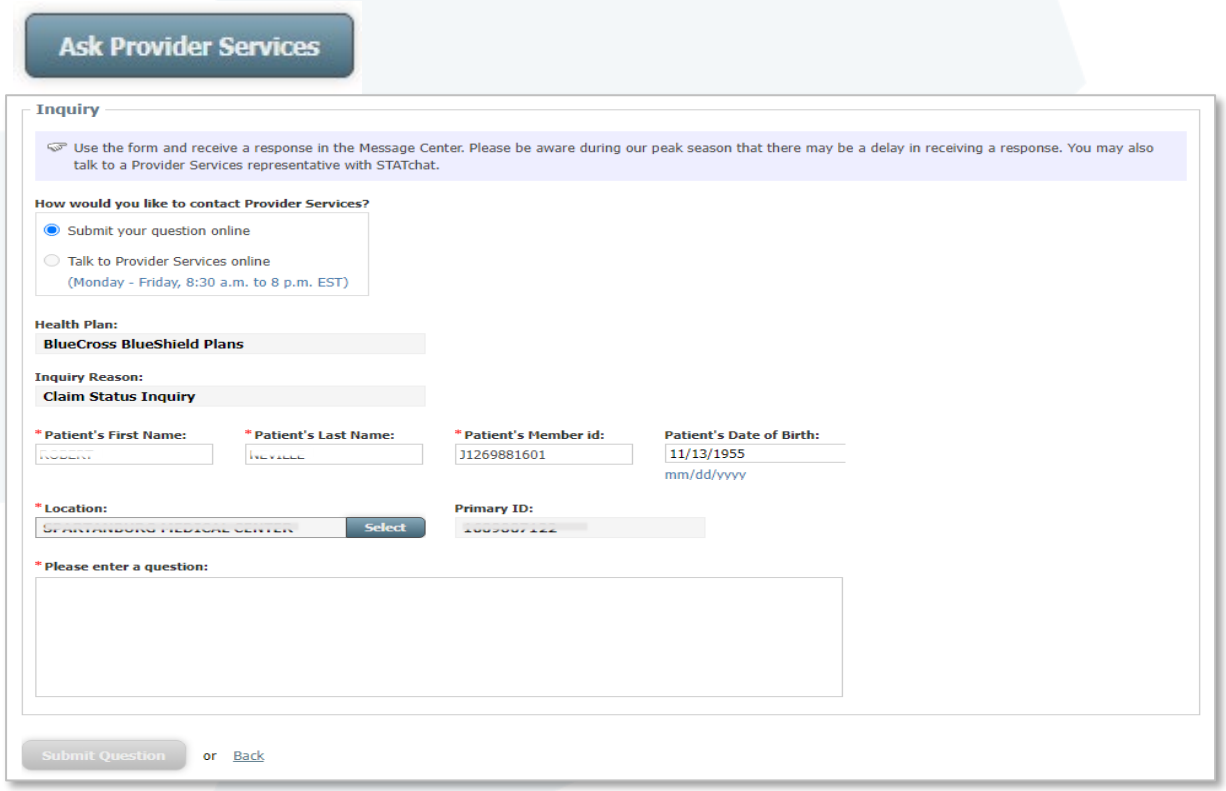
Available Resources

Ask Provider Services — Submitting Web Inquiries

Searching by Claim Number (Continued)

Be sure to:

- Enter the patient's name, ID number, date of birth and location will auto-populate from the entered claim.
- Enter your question (be specific as possible).

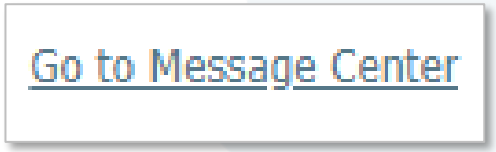


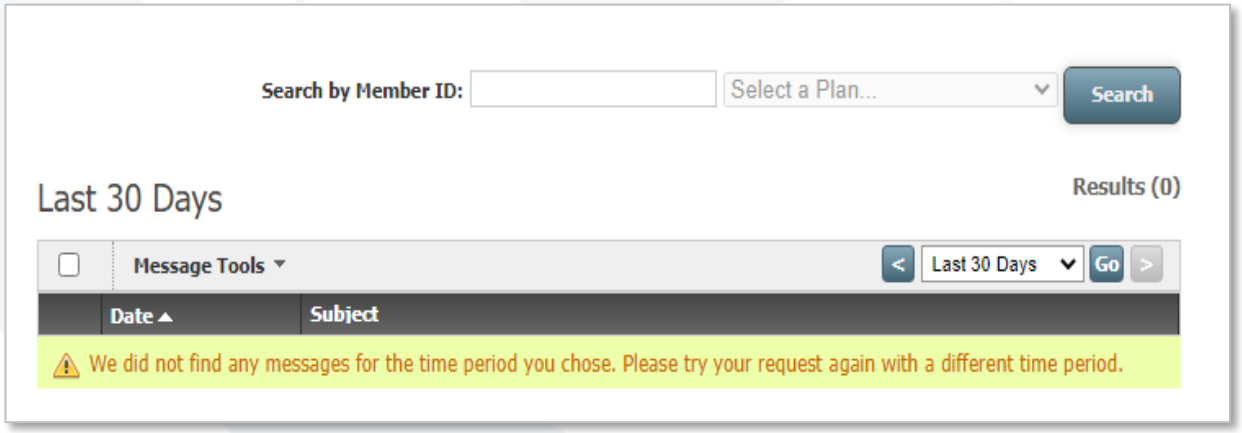
Available Resources

Ask Provider Services — Viewing Web Inquiry Responses

Be sure to:

- Select Go to Message Center.
- To narrow the results, you can:
  - Enter the ID number and select the Health Plan.
  - Select specific months.





Note: If you submit an inquiry in one month and do not see a response, search by the member's ID number. The response may be listed under a different month.

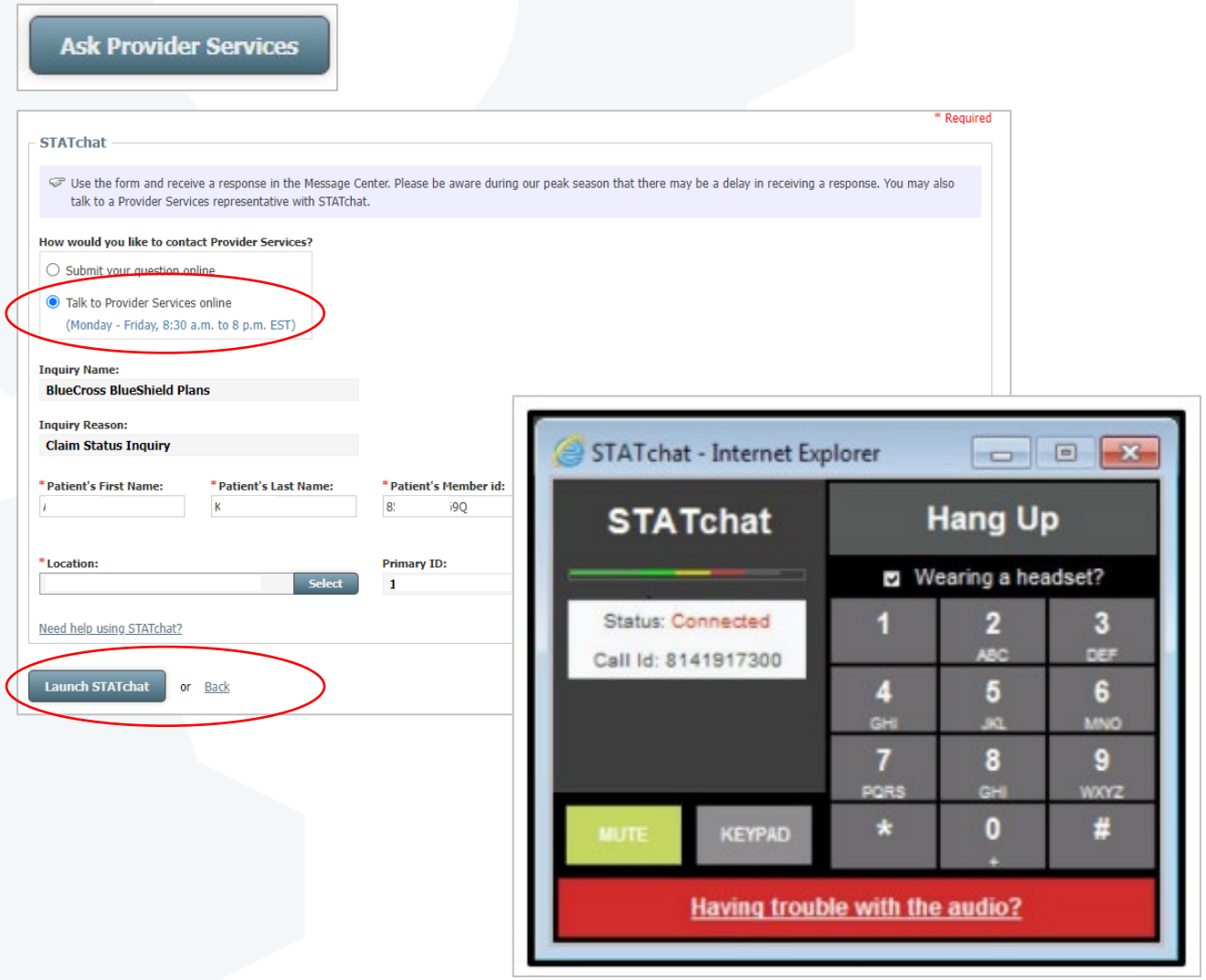
Available Resources

STATchat

- STATchat is a fast and simple way to speak with a provider services representative.
- The feature is available through My Insurance Manager.

System Requirements

- A current version of Adobe Flash Player
- A compatible web browser, such as Microsoft Internet Explorer 10 or EDGE® or Google Chrome®
- A headset (recommended) or standalone microphone and speakers connected to your computer



Dental Network

Back To Basics

Agenda

- Provider Enrollment
- Dental Plans
- Dental GRID
- Eligibility, Benefits and Claims
- 2024 Coding Updates

Dental Provider Enrollment

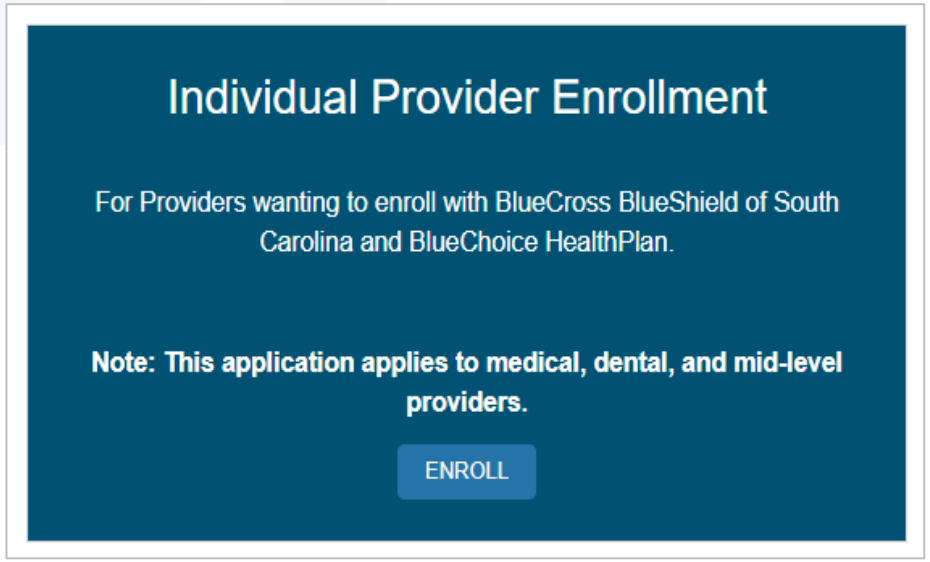
Dental Provider Enrollment

Participating Dental Network

- Plans that use the Participating Dental Network include:
  - Commercial plans.
  - Medicare Advantage plans.
  - State Dental Plus.
  - Companion Life Dental.
  - FEP Basic, Standard and BCBS FEP Dental.
  - GRID members.
- Visit www.SouthCarolinaBlues.com.

  Providers>Provider Enrollment>My Provider Enrollment Portal

My Provider Enrollment Portal



Dental Provider Enrollment

Updates to Dental Enrollment Application

- Since implementing My Provider Enrollment Portal, we have made updates to improve efficiency. The latest update is with the dental application.
- To streamline the process, all individual providers will use the same application.
- From the entry page, you will still select DDS or DMD as the provider type.

Note: The fields will be the same, but the application may look different.

Dental Provider Enrollment

What to Include with Initial Individual Enrollment

Checklist Items	Doctor of Dental Surgery (DDS)	Doctor of Dental Medicine (DMD)
Provider Enrollment Application		
Copy of SC Medical/Practice License		
DEA Certification	**Note 1**	
Current Copy of Malpractice (Min. $1M/$3M)		
Authorization to Bill for Services		
Clinical Lab Improvement Amendments		**Note 2**
Nurse Practitioner Preceptor Form		
Signed Contracts		
Hold Harmless – BlueChoice HealthPlan		
Appendix D – BlueChoice HealthPlan		
Additional Items for Medicaid		
Medicaid ID Number		**Note 2**
Nurse Protocols		
Physician Assistant Protocols		

1. **Only needed if applicable.**
2. **Only needed if the DMD is applying for medical networks.**

Note: Shaded fields are required.

Dental Provider Enrollment

What to Include with Initial Group Practice Enrollment

Checklist Items	Dental
Group Practice Application	
IRS Verification of Tax ID (No W-9s)	
Electronic Funds Transfer Enrollment	
Application for Satellite Location	
Clinical Lab Improvement Amendments	
Signed Contracts	
Copy of CMS Letter	
Copy of Medicare PTAN Letter	
Copy of Business License	
Copy of DHEC License	
Additional Items for Medicaid	
Medicaid ID Number	

Note: Shaded fields are required.

Dental Provider Enrollment

What to Include for In-State, Out-of-Network

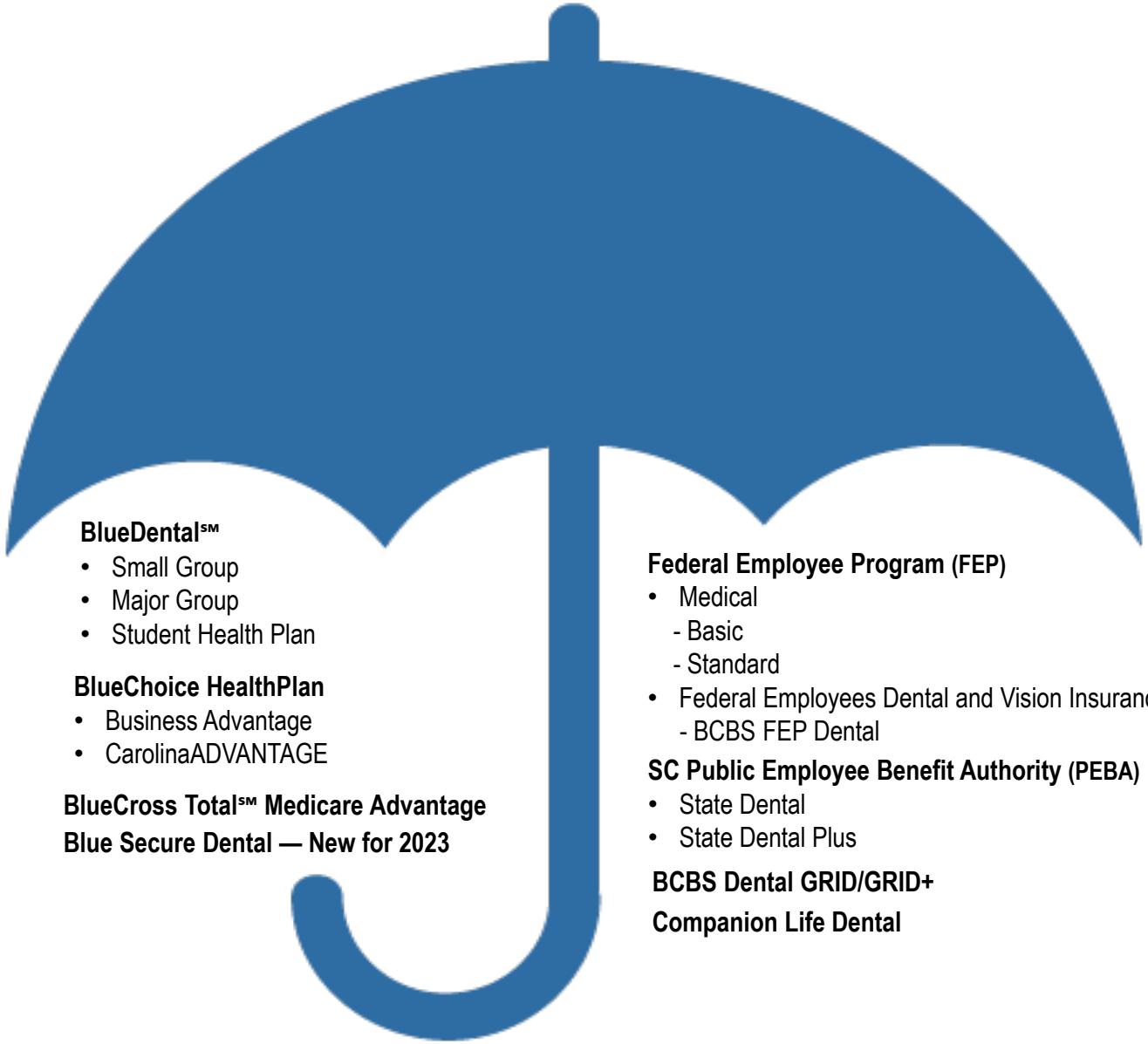
Checklist Items
[1]Health Professional Application
[1]Authorization to Bill for Services
[2]Group Practice Application
[2]IRS Verification of Tax ID (No W-9s)
[2]Electronic Funds Transfer Enrollment

Note: This checklist applies to individual practitioners. Group practices that wish to remain out-of-network would complete the Group Enrollment application and select No for the network participation question.

1. **Needed for each individual being linked to the practice.**
2. **Needed if the group is not on file.**

Dental Plans

BlueCross BlueShield of South Carolina
Dental Umbrella



BlueDental℠
- Small Group
- Major Group
- Student Health Plan

BlueChoice HealthPlan
- Business Advantage
- CarolinaADVANTAGE

BlueCross Total℠ Medicare Advantage

Blue Secure Dental — New for 2023

Federal Employee Program (FEP)
- Medical
  - Basic
  - Standard
- Federal Employees Dental and Vision Insurance Program (FEDVIP)
  - BCBS FEP Dental

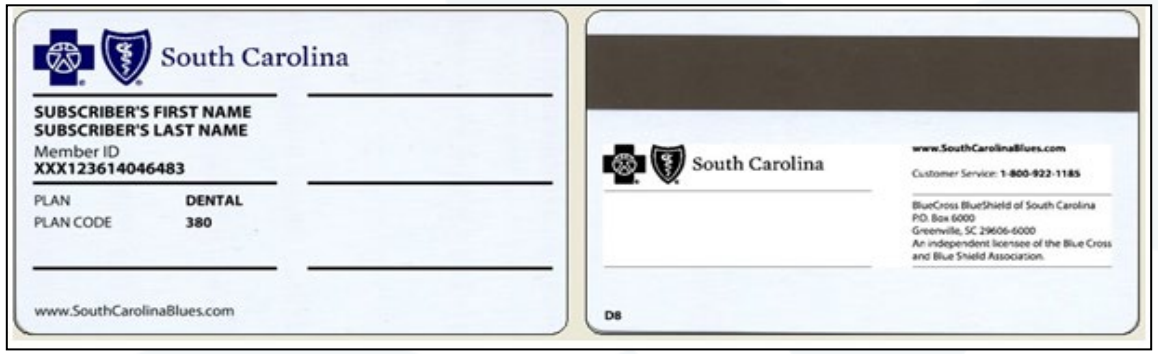
SC Public Employee Benefit Authority (PEBA)
- State Dental
- State Dental Plus

BCBS Dental GRID/GRID+

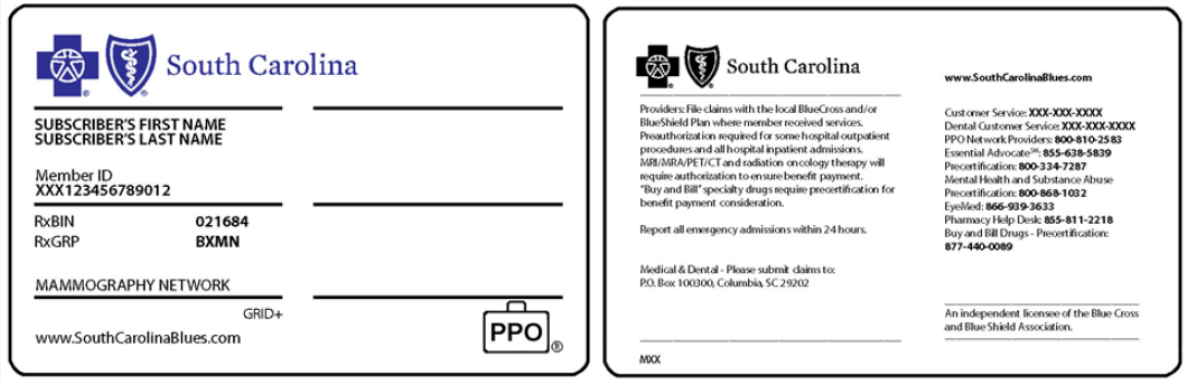
Companion Life Dental

Dental Plans

Commercial Plans



Sample Commercial — Dental Only ID Card



Sample Commercial — Medical and Dental ID Card

Dental Plans

Commercial Plans (Continued)

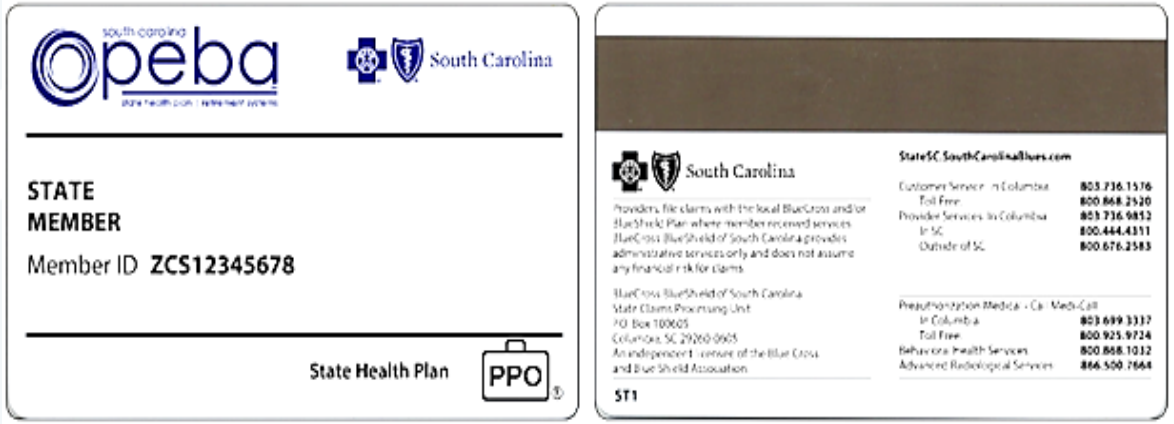
- There are some dental plans that use a network of participating providers, while other plans do not.
  - Members are always encouraged to select in-network providers.
    - Members that use out-of-network providers will be responsible for all charges exceeding the schedule of dental allowances
- Coverage levels include:
  - Preventive care.
  - Restorative care.
  - Major restorative care.
  - Implant services (coverage varies per plan).
  - Orthodontic care (coverage varies per plan).

Dental Plans

State Plan: Basic Dental

- SC Public Employee Benefit Association (PEBA) uses BlueCross BlueShield of South Carolina as an administrator for their dental plans.
- Benefits are divided into four classes:
    1. Diagnostic and preventive services.
    2. Basic dental services.
    3. Prosthodontics.
    4. Orthodontics.

Note: A $1,000 benefit period maximum applies to classes 1-3.

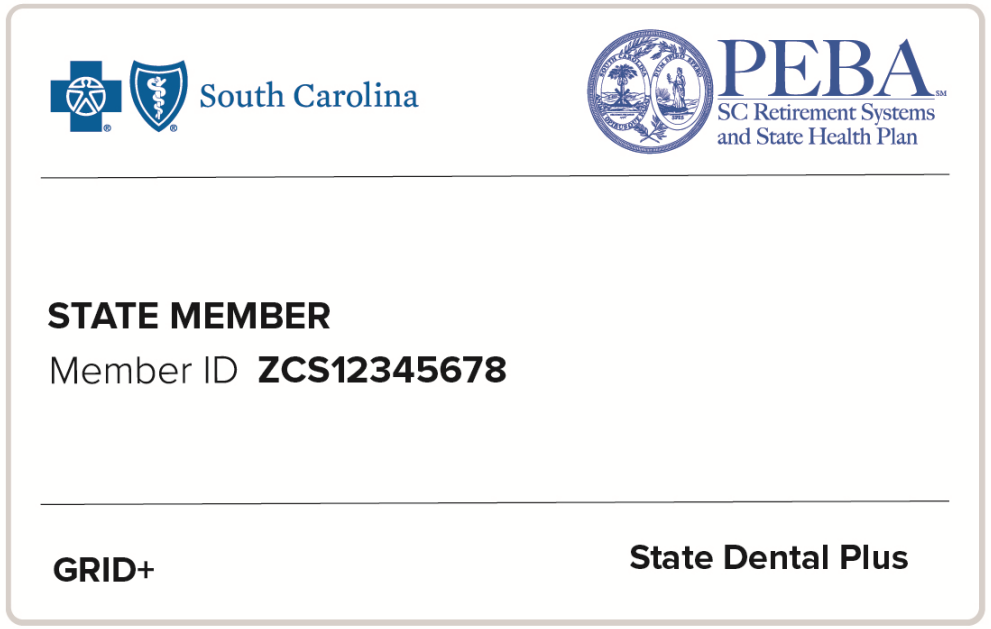


- Covered services are paid based on its schedule of dental procedures and allowable charges.
- Beginning Jan. 1, 2024, State Dental and Dental Plus will no longer apply the alternate benefit for codes D2391 – D2394.

Dental Plans

State Plan: Dental Plus

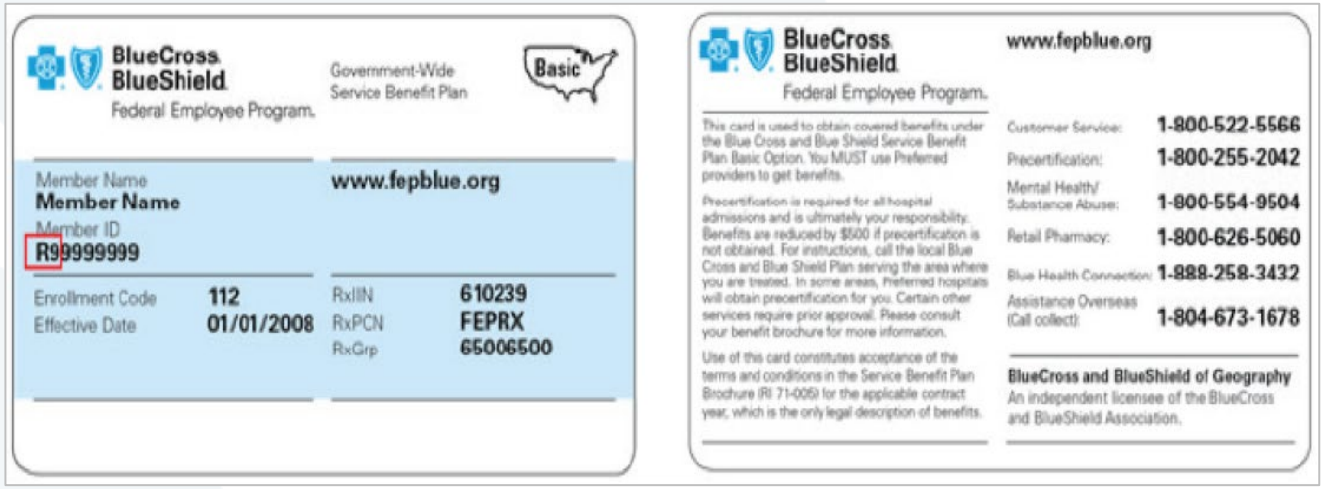
- Members with the Dental Plus plan with have **State Dental Plus** on their ID card.
- Dental Plus is a supplement to the Basic Dental plan and provides an additional $1,000 benefit period maximum for classes 1-3.
- Dental Plus provides a higher level of reimbursement for services that the Basic Dental plan covers.
  - Reimbursement is based on the commercial negotiated rate with BlueCross BlueShield of South Carolina.
- Dental Plus members utilize the BlueCross BlueShield of South Carolina Network for in-network benefits.



Dental Plans

Federal Employee Program (FEP): Basic Option

- Members have a $35 copay for evaluations. If members have Medicare Part B or a FEDVIP plan, the FEDVIP plan pays the $35 copay.
- FEP pays any balance up to the BlueCross Preferred Blue Participating Dental allowance.
- Basic members must use preferred dentists to receive benefits.
- If a service is not covered by FEP Basic, in-network providers can charge their usual and customary charge.



Dental Plans

Federal Employee Program (FEP): Basic Option

Covered Service	FEP Pays	Member Pays
Clinical Oral Evaluations	Preferred: All charges in excess of member's $35 copayment Participating/Non-participating: Nothing	Preferred: $35 copayment per evaluation Participating/Non-participating: Member pays all charges
Periodic oral evaluation*		
Limited oral evaluation		
Comprehensive oral evaluation*		
*Benefits are limited to a combined total of two evaluations per person per calendar year		
Diagnostic Imaging		
Intraoral – complete series including bitewings (limited to one complete series every three years)		
Preventive		
Prophylaxis – adult (up to two per calendar year)		
Prophylaxis – child (up to two per calendar year)		
Topical application of fluoride or fluoride varnish – for children only (up to two per calendar year)		
Sealant – per tooth, first and second molars only (once per tooth for children up to age 16 only)		
Not covered: Any service not specifically listed above	Nothing	All charges

Dental Plans

Federal Employee Program (FEP): Standard Option

- Members have no deductibles, copays or coinsurance.
- Members pay the difference between the fee schedule amount and the BlueCross Participating Dental allowance while using preferred dentists.
  - When using non-preferred dentists, members pay all charges in excess of the listed fee schedule.
- If a service is not covered by FEP Standard, both in and out-of-network providers can charge their usual and customary charge.

Dental Plans

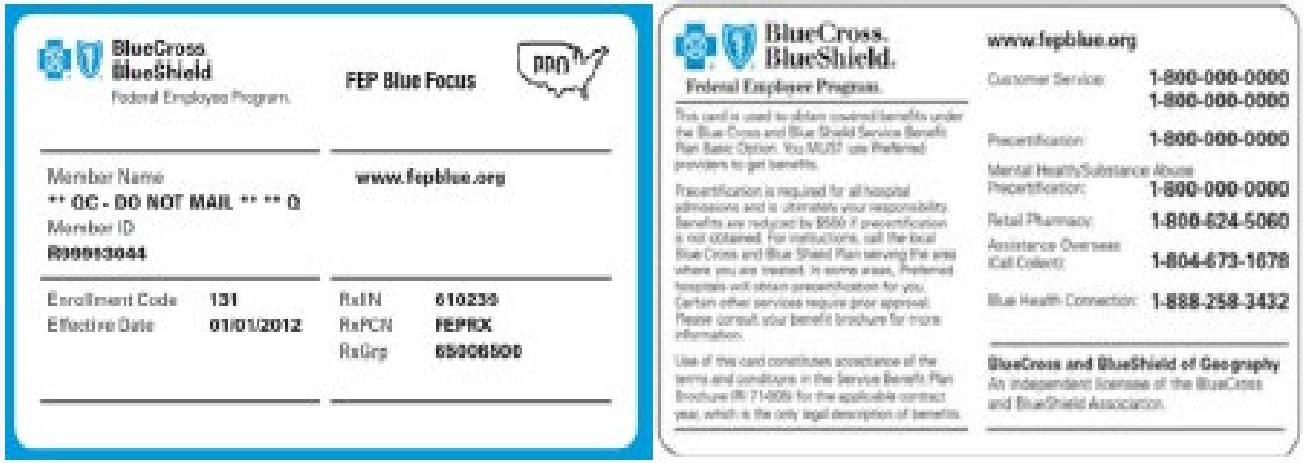
Federal Employee Program (FEP): Standard Option

Covered Service	FEP Pays		Member Pays
Clinical Oral Evaluations	To Age 13	Age 13 and Over	In Network The difference between the amounts listed to the left and the BlueCross Participating Dental Allowance Out of Network All charges in excess of the scheduled amounts listed to the left.
Periodic oral evaluation (up to two per person per calendar year)	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
Diagnostic Imaging			
Intraoral complete series	$36	$22	
Palliative Treatment			
Palliative treatment of dental pain – minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive			
Prophylaxis – adult (up to 2 per person per calendar year)	---	$16	
Prophylaxis – child (up to 2 per person per calendar year)	$22	$14	
Topical application of fluoride or fluoride varnish (up to two per person per calendar year)	$13	$8	
Not covered: Any service not specifically listed above	Nothing	Nothing	All charges

Dental Plans

Federal Employee Program (FEP): Blue Focus

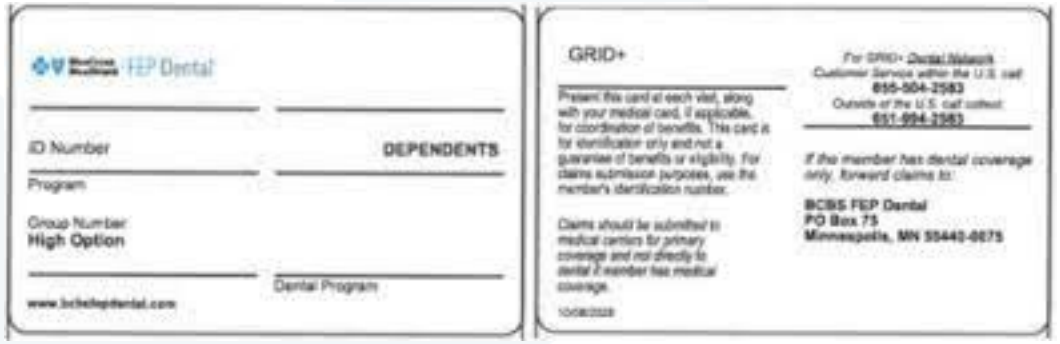
- Members with a Blue Focus plan do not have dental benefits directly with their plan.
- Members would need BCBS FEP Dental or another Federal Employees Dental and Vision Insurance Program (FEDVIP) for dental benefits.
- Claims would need to be filed directly to the FEDVIP plan.



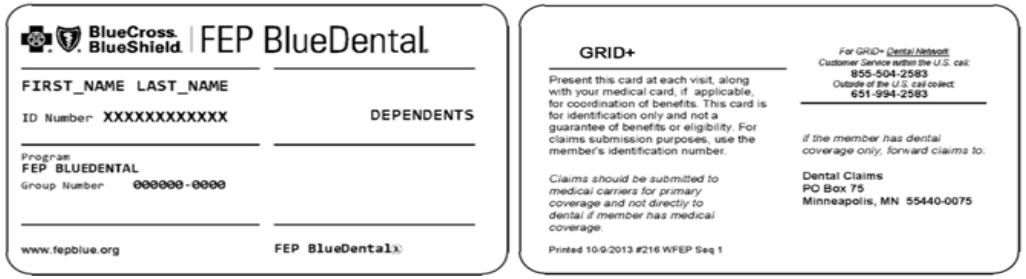
Dental Plans

Federal Employee Program (FEP): BCBS FEP Dental

- Members covered by FEP Basic Option medical plan and BCBS FEP Dental will not be responsible for the annual deductible when using an in-network provider.
- In accordance with Federal law, always file medical first if the member has dental benefits under their medical plan.
- Beginning Jan. 1, 2024, FEP Dental will cover:
  - Two routine oral exams and one additional exam if a problem occurs between check ups.
  - Nitrous oxide for children aged 5 and under, and other individuals with medical conditions that may require it.



Sample of new BCBS FEP Dental ID Card



Sample of old FEP BlueDental ID Card

Note: Existing members may have an ID card with the previous name, FEP BlueDental listed (as seen in the samples). New ID cards are not being issued to all existing members.

Dental Plans

Federal Employee Program (FEP): BCBS FEP Dental

	High Option		Standard Option	
	In-network	Out-of-network	In-network	Out-of-network
Class A (Basic) services (e.g., exams, cleanings, x-rays, sealants)	$0	10% COINS	$0	40% COINS
Class B (Intermediate) services (e.g., oral surgery, fillings, gum scaling)	30% COINS	40% COINS	45% COINS	60% COINS
Class C (Major) services (e.g., crowns, bridges, root canals, dentures)	50% COINS	60% COINS	65% COINS	80% COINS
Class D (Orthodontics) services (Adults and children)	50% COINS up to $3,500 lifetime maximum per person	50% COINS up to $3,500 lifetime maximum per person	50% COINS up to $2,500 lifetime maximum per person	50% COINS up to $2,500 lifetime maximum per person
Annual Deductible **Class A, B and C services** (Does not include Class D services)	$0	$50 per person	$0	$75 per person
Annual Maximum **Class A, B and C services** (Does not include Class D services)	No benefit limit	$3,000 per person	$1,500 per person	$750 per person

Dental Plans

Medicare Advantage: BlueCross Total℠, Blue Basic℠, Total Value℠ and Secure (HMO)

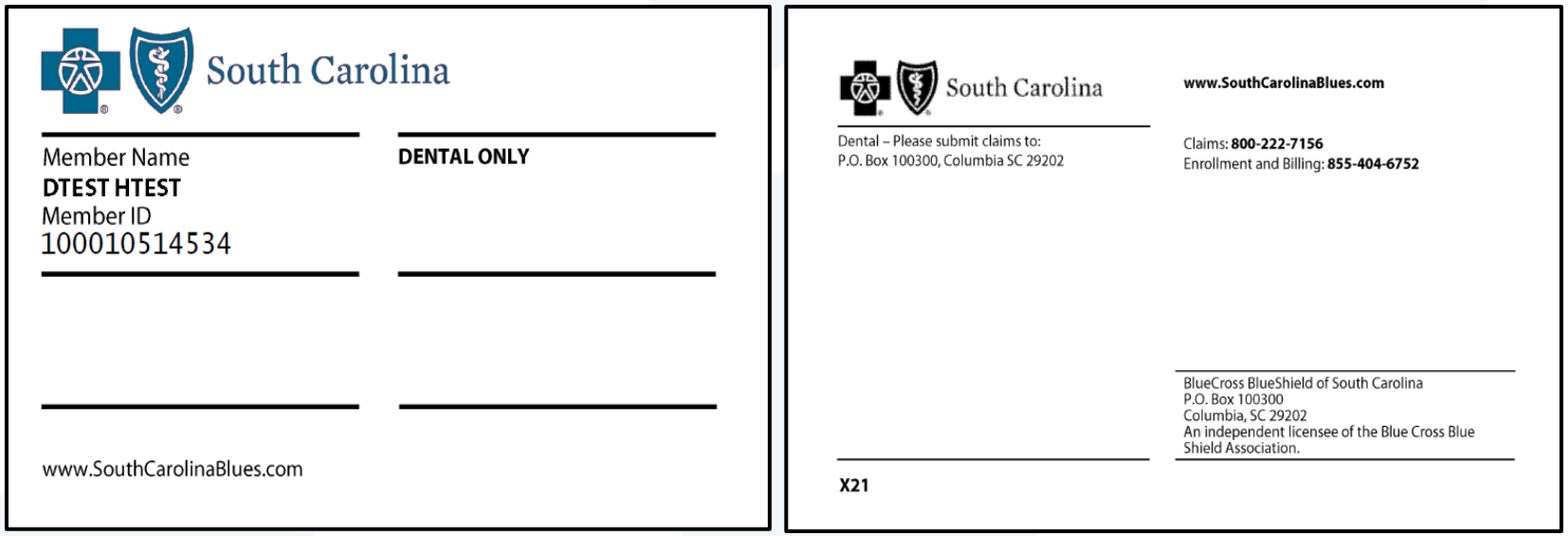
	BlueCross PPO Dental Benefit Highlights				HMO
	Service	**In-Network**	**Visits (per year)**	**Out-of-Network**	**In-Network ONLY**
Preventive Dental	**Oral exams Cleanings**	$0	2	50% COINS	$0
	Dental x-rays	$0	1	50% COINS	$0
Comprehensive Dental* **(Non-Medicare covered services)**	Restorative Endodontics Extractions Prosthodontics ***Note: Implants are not covered.***	Anesthesia Other oral/maxillofacial surgery Other services (e.g., deep cleanings, fillings, crowns, root canal, dentures, bridges)		50% COINS (INN and OON)	N/A
Annual Maximum **(Per member, per year)**	**BlueCross Total: $3,500** **(Comprehensive and preventive combined)** **Total Value: $2,000** **(Comprehensive and preventive combined)** **Blue Basic: $2,000** **(Comprehensive and preventive combined)**				N/A

***SC Blue Dental Network**

Dental Plans

Blue Secure (Continued)

- Became effective on Jan. 1, 2023.
- Sample ID card:



Dental Plans

Blue Secure (Continued)

	Blue Secure Dental Gold 1		Blue Secure Dental Silver 1	
Member Age	**19 or older**			
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	$50 Individual and $150 Family		$50 Individual and $150 Family	
Annual Maximum (Coverage limit)	$1,500		$1,000	
Class I – Preventive Procedures and Exams	0% COINS	20% COINS	0% COINS	30% COINS
Class II – Basic and Restorative*	30% COINS (after six months)	50% COINS (after six months)	50% COINS (after six months)	70% COINS (after six months)
Class III – Major Procedures**	50% COINS (after 12 months)	70% COINS (after 12 months)	70% COINS (after 12 months)	Not covered
Class IV – Orthodontia Services	**Not covered**			
Maximum Out-of-Pocket	**N/A**			

*** 6 month waiting period | ** 12 month waiting period**

Dental Plans

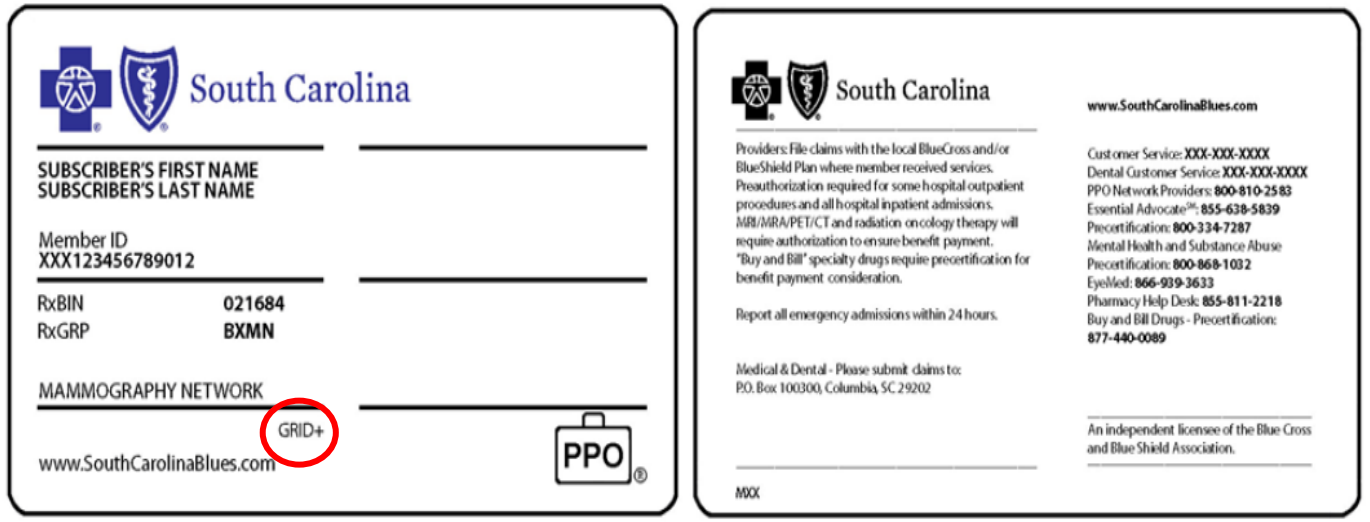
Blue Secure (Continued)

	Blue Secure Dental Gold 1		Blue Secure Dental Silver 1	
Member Age	**Under 19 years old**			
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	$50 per child	$100 per child	$50 per child	$100 per child
Annual Maximum (Coverage limit)	**No limit**			
Class I – Preventive Procedures and Exams	0% COINS	20% COINS	0% COINS	30% COINS
Class II – Basic and Restorative	30% COINS	50% COINS	40% COINS	60% COINS
Class III – Major Procedures	50% COINS	60% COINS	50% COINS	60% COINS
Class IV – Orthodontia Services (Prior authorization required)	50% COINS		50% COINS	
Maximum Out-of-Pocket Per Child	**$400**	**$800**	**$400**	**$800**
Maximum Out-of-Pocket Total (All children)	**$800**	**$1,600**	**$800**	**$1,600**

Dental GRID

Dental GRID

- Dental GRID allows dentists to see members from other participating BlueCross plans at the local plan's reimbursement levels.
- Our participating providers' reimbursement levels or provider agreements will not change when treating GRID members.
- Members in this program can be recognized by the work **GRID** or **GRID+** on their ID card.



Sample Commercial - Medical and Dental ID Card

Dental GRID

Participating Plans

Anthem Insurance Companies, Inc.		
Anthem Blue Cross of California	Anthem Blue Cross and Blue Shield of Colorado	Anthem Blue Cross and Blue Shield of Connecticut
Blue Cross and Blue Shield of Georgia	Anthem Blue Cross and Blue Shield of Indiana	Anthem Blue Cross and Blue Shield of Kentucky
Anthem Blue Cross and Blue Shield of Maine	Anthem Blue Cross and Blue Shield of Missouri	Anthem Blue Cross and Blue Shield of Nevada
Anthem Blue Cross and Blue Shield of New Hampshire	Empire Blue Cross and Blue Shield of New York	Anthem Blue Cross and Blue Shield of Ohio
Anthem Blue Cross and Blue Shield of Virginia	Anthem Blue Cross and Blue Shield of Wisconsin	
Health Care Service Corporation (HCSC)		
Blue Cross and Blue Shield Illinois	Blue Cross and Blue Shield Montana	Blue Cross and Blue Shield New Mexico
Blue Cross and Blue Shield Oklahoma	Blue Cross and Blue Shield Texas	
Other		
Blue Cross and Blue Shield of Arizona	Blue Cross and Blue Shield of Kansas	Blue Cross and Blue Shield of Kansas City
Blue Cross and Blue Shield of Massachusetts	Blue Cross and Blue Shield of Nebraska	Blue Cross and Blue Shield of Vermont (CBA Blue)
BlueCross BlueShield of North Carolina	BlueCross BlueShield of Tennessee	BlueCross of Idaho
BlueCross & BlueShield of Western/ BlueShield of Northeastern New York	Capital Blue Cross (Central PA)	CareFirst Blue Cross and Blue Shield (Maryland/District of Columbia)
Excellus BlueCross BlueShield (Rochester NY)	Horizon Blue Cross and Blue Shield of New Jersey	Wellmark Blue Cross and Blue Shield of Iowa

Eligibility, Benefits and Claims

Eligibility, Benefits and Claims

Verifying Eligibility and Benefits

Use My Insurance Manager℠ to verify eligibility and benefits or contact customer service.

Plan	Provider Services Voice Response Unit (VRU)	Fax
Commercial Dental Plans	800-222-7156 (Columbia center) 800-922-1185 (Greenville center)	803-264-7629
State Basic Dental and Dental Plus	888-214-6230 803-264-3702 (Columbia area)	803-264-7739
BCBS FEP Dental	855-504-2583	803-264-8104
FEP Dental (Medical)	800-444-4325	
BlueCross Total℠, Total Value℠ and Blue Basic℠ (MA Dental)	800-222-7156	803-264-7629
Companion Life Dental	800-765-9603 or 800-753-0404, ext. 45921	

Eligibility, Benefits and Claims

Filing Dental Claims Under Medical Benefits

- Use an 837P format with the accurate diagnosis code when rendering oral surgical services under State Dental and health plans.
- The following codes should always be filed to State Medical first:
  - Impacted teeth
    - D7220-D7251
  - Other surgical procedures
    - D7260, D7261, D7285, D7286
  - Excision or lesions
    - D7410-D7415
  - Remove of tumors, cysts, and neoplasms
    - D7440-D7465
  - Excision of bone tissue
    - D7471-D7490
- For BCBS FEP Dental, always file claims to the medical plan first if the member has dental benefits under their medical plan.

Eligibility, Benefits and Claims

Filing Orthodontic Claims Electronically

- Submit one line with banding fee code (D8080-D8090) and the charge.
- Submit one line with the monthly adjustment code (D8670), the total months of treatment, and the total charge.
  - Do not file the claim each month
    - Payments are automatically sent until one or more of the following apply:
      - The patient exhausts his or her lifetime benefit maximum.
      - The patient's dental coverage is terminated.
      - The patient reaches the maximum age allowed for services under his or her policy.
  - **For a transfer care**, submit one line with the monthly adjustment code, total months of the remaining treatment, and the total remaining charge.

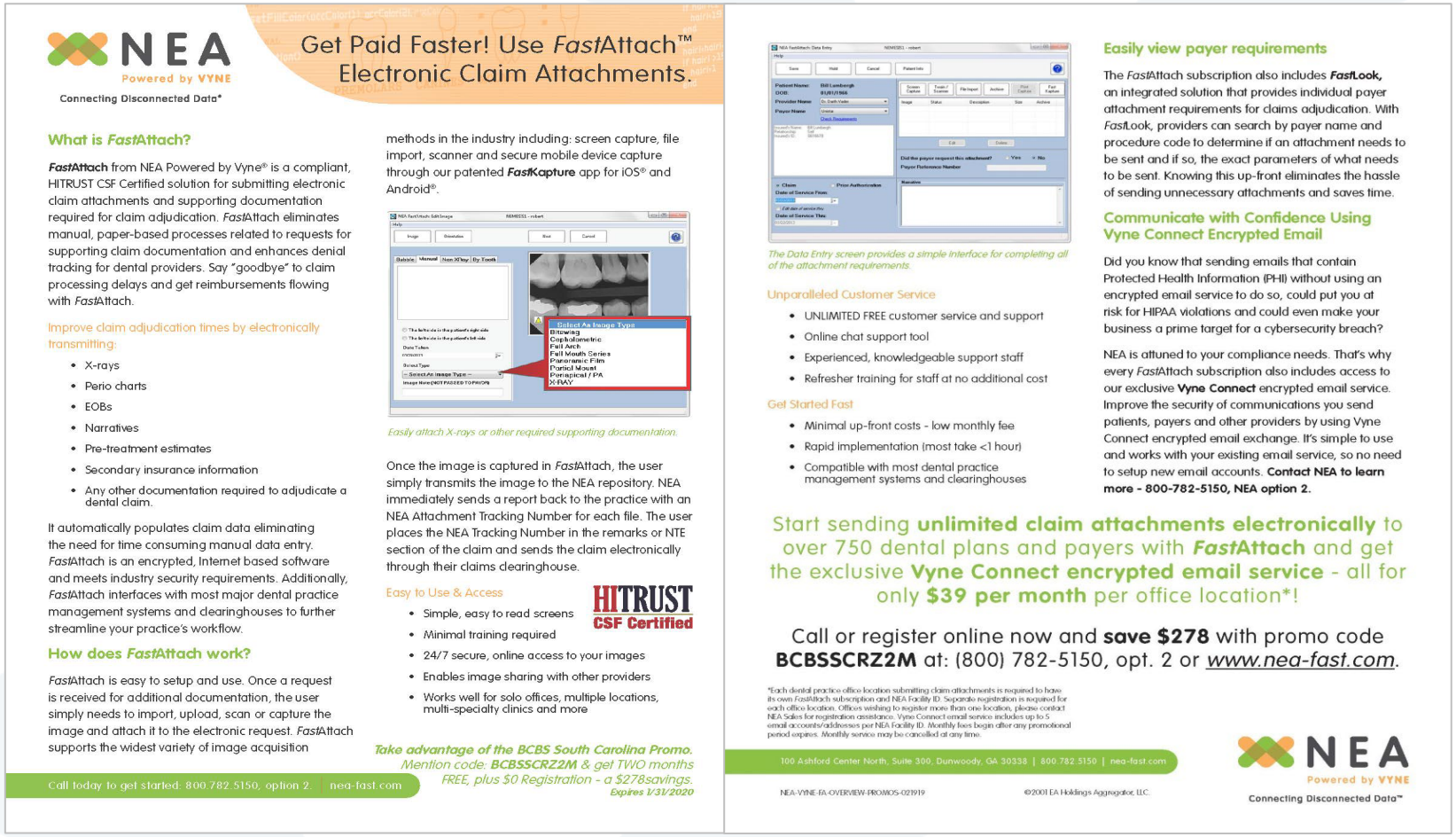
Eligibility, Benefits and Claims

General Guidelines for Filing Dental Claims

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

Eligibility, Benefits and Claims

National Electronic Attachment (NEA)



NEA
Powered by VYNE
Connecting Disconnected Data®

Get Paid Faster! Use *Fast*Attach™ Electronic Claim Attachments.

What is *Fast*Attach?

***Fast*Attach** from NEA Powered by Vyne® is a compliant, HITRUST CSF Certified solution for submitting electronic claim attachments and supporting documentation required for claim adjudication. *Fast*Attach eliminates manual, paper-based processes related to requests for supporting claim documentation and enhances denial tracking for dental providers. Say "goodbye" to claim processing delays and get reimbursements flowing with *Fast*Attach.

Improve claim adjudication times by electronically transmitting:

- X-rays
- Perio charts
- EOBs
- Narratives
- Pre-treatment estimates
- Secondary insurance information
- Any other documentation required to adjudicate a dental claim.

It automatically populates claim data eliminating the need for time consuming manual data entry. *Fast*Attach is an encrypted, Internet based software and meets industry security requirements. Additionally, *Fast*Attach interfaces with most major dental practice management systems and clearinghouses to further streamline your practice's workflow.

How does *Fast*Attach work?

*Fast*Attach is easy to setup and use. Once a request is received for additional documentation, the user simply needs to import, upload, scan or capture the image and attach it to the electronic request. *Fast*Attach supports the widest variety of image acquisition methods in the industry including: screen capture, file import, scanner and secure mobile device capture through our patented ***Fast*Kapture** app for iOS® and Android®.

Easily attach X-rays or other required supporting documentation.

Once the image is captured in *Fast*Attach, the user simply transmits the image to the NEA repository. NEA immediately sends a report back to the practice with an NEA Attachment Tracking Number for each file. The user places the NEA Tracking Number in the remarks or NTE section of the claim and sends the claim electronically through their claims clearinghouse.

Easy to Use & Access

- Simple, easy to read screens
- Minimal training required
- 24/7 secure, online access to your images
- Enables image sharing with other providers
- Works well for solo offices, multiple locations, multi-specialty clinics and more

HITRUST CSF Certified

Take advantage of the BCBS South Carolina Promo.
*Mention code: **BCBSSCRZ2M** & get TWO months FREE, plus $0 Registration - a $278savings.*
Expires 1/31/2020

Call today to get started: 800.782.5150, option 2. | nea-fast.com

The Data Entry screen provides a simple interface for completing all of the attachment requirements.

Unparalleled Customer Service

- UNLIMITED FREE customer service and support
- Online chat support tool
- Experienced, knowledgeable support staff
- Refresher training for staff at no additional cost

Get Started Fast

- Minimal up-front costs - low monthly fee
- Rapid implementation (most take <1 hour)
- Compatible with most dental practice management systems and clearinghouses

Easily view payer requirements

The *Fast*Attach subscription also includes ***Fast*Look,** an integrated solution that provides individual payer attachment requirements for claims adjudication. With *Fast*Look, providers can search by payer name and procedure code to determine if an attachment needs to be sent and if so, the exact parameters of what needs to be sent. Knowing this up-front eliminates the hassle of sending unnecessary attachments and saves time.

Communicate with Confidence Using Vyne Connect Encrypted Email

Did you know that sending emails that contain Protected Health Information (PHI) without using an encrypted email service to do so, could put you at risk for HIPAA violations and could even make your business a prime target for a cybersecurity breach?

NEA is attuned to your compliance needs. That's why every *Fast*Attach subscription also includes access to our exclusive **Vyne Connect** encrypted email service. Improve the security of communications you send patients, payers and other providers by using Vyne Connect encrypted email exchange. It's simple to use and works with your existing email service, so no need to setup new email accounts. **Contact NEA to learn more - 800-782-5150, NEA option 2.**

Start sending **unlimited claim attachments electronically** to over 750 dental plans and payers with ***Fast*Attach** and get the exclusive **Vyne Connect encrypted email service** - all for only **$39 per month** per office location*!

Call or register online now and **save $278** with promo code **BCBSSCRZ2M** at: (800) 782-5150, opt. 2 or *www.nea-fast.com*.

*Each dental practice office location submitting claim attachments is required to have its own *Fast*Attach subscription and NEA Facility ID. Separate registration is required for each office location. Offices wishing to register more than one location, please contact NEA Sales for registration assistance. Vyne Connect email service includes up to 5 email accounts/addresses per NEA Facility ID. Monthly fees begin after any promotional period expires. Monthly service may be cancelled at any time.

100 Ashford Center North, Suite 300, Dunwoody, GA 30338 | 800.782.5150 | nea-fast.com

NEA-VYNE-FA-OVERVIEW-PROMOS-021919

NEA
Powered by VYNE
Connecting Disconnected Data™

Note: All dental insurance plans utilizes NEA, except for Federal Employee Program (FEP).

2024 Coding Updates

2024 Dental Coding Updates

New CDT Codes for 2024

Code	Description
D0396	3D printing of a 3D dental surface scan
D1301	immunization counseling
D2976	band stabilization — per tooth
D2989	excavation of a tooth resulting in the determination of non-restorability
D2991	application of hydroxyapatite regeneration medicament — per tooth
D6089	accessing and retorquing loose implant screw — per screw
D7284	excisional biopsy of minor salivary glands
D7939	indexing for osteotomy using dynamic robotic assisted or dynamic navigation
D9938	fabrication of a custom removable clear plastic temporary aesthetic appliance
D9939	placement of a custom removable clear plastic temporary aesthetic appliance
D9954	fabrication and delivery of oral appliance therapy (OAT) morning repositioning device
D9955	oral appliance therapy (OAT) titration visit
D9956	administration of home sleep apnea test
D9957	screening for sleep related breathing disorders

Note the following:

- ***Verify eligibility and benefits prior to rendering services.***
- ***No deleted dental codes for 2024.***

Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

Healthy Blue

Back To Basics

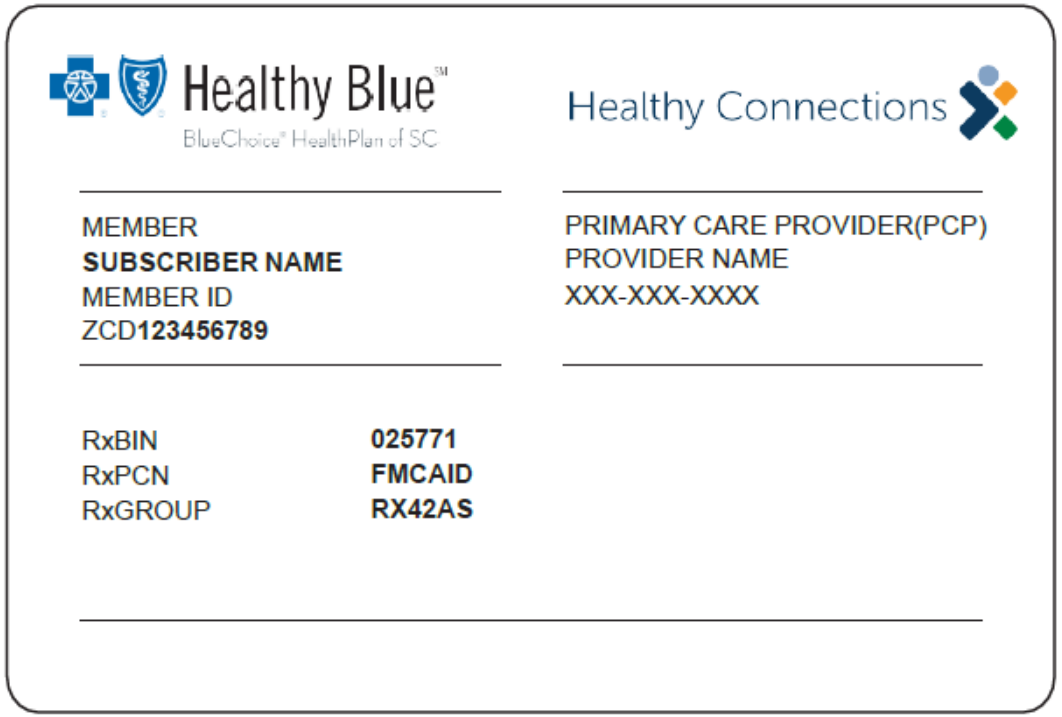
Agenda

- New Changes for 2024
- Contacts and Resources
- Benefits
- Authorizations
- Claims
- Reminders
- Community Services

New Changes for 2024

New Changes for 2024

New ID Cards for Members



Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

MEMBER
SUBSCRIBER NAME
MEMBER ID
ZCD**123456789**

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

RxBIN	**025771**
RxPCN	**FMCAID**
RxGROUP	**RX42AS**

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

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

Providers: This card is for ID purposes and does not constitute proof of eligibility. This member has limited benefits outside of South Carolina. Providers should request eligibility information.

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

www.HealthyBlueSC.com

Members

Customer Service:	**866-781-5094**
TTY Line:	**866-773-9634**
24-Hour Nurse line:	**800-830-1525**
Pharmacy Customer Service:	**866-781-5094**

Providers

Help for Pharmacists:	**833-253-4711**
Provider Service Call Center:	**866-757-8286**

Healthy Blue
P.O. Box 100317
Columbia, SC 29202-3317

Healthy Blue is offered by BlueChoice HealthPlan, an independent licensee of the Blue Cross Blue Shield Association.

B99

New Changes for 2024

New Mailing Address

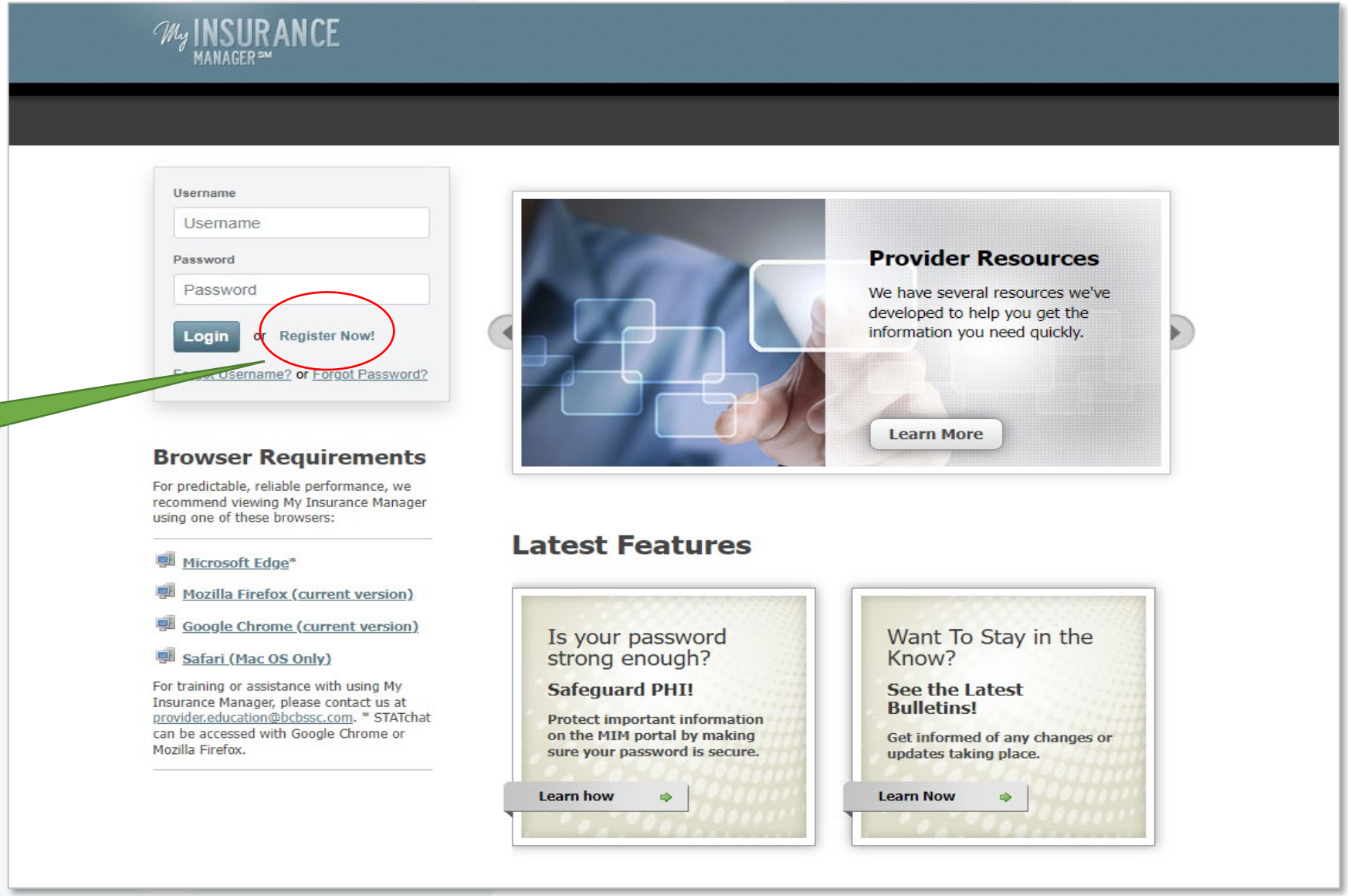
Address	Used for…
P.O. Box 100317 Columbia, SC 29202-3317	• Claims • Return mail • Member grievances • Provider disputes • Member and provider written correspondence (excluding appeals)

New Changes for 2024

New Provider Portals

My Insurance Manager

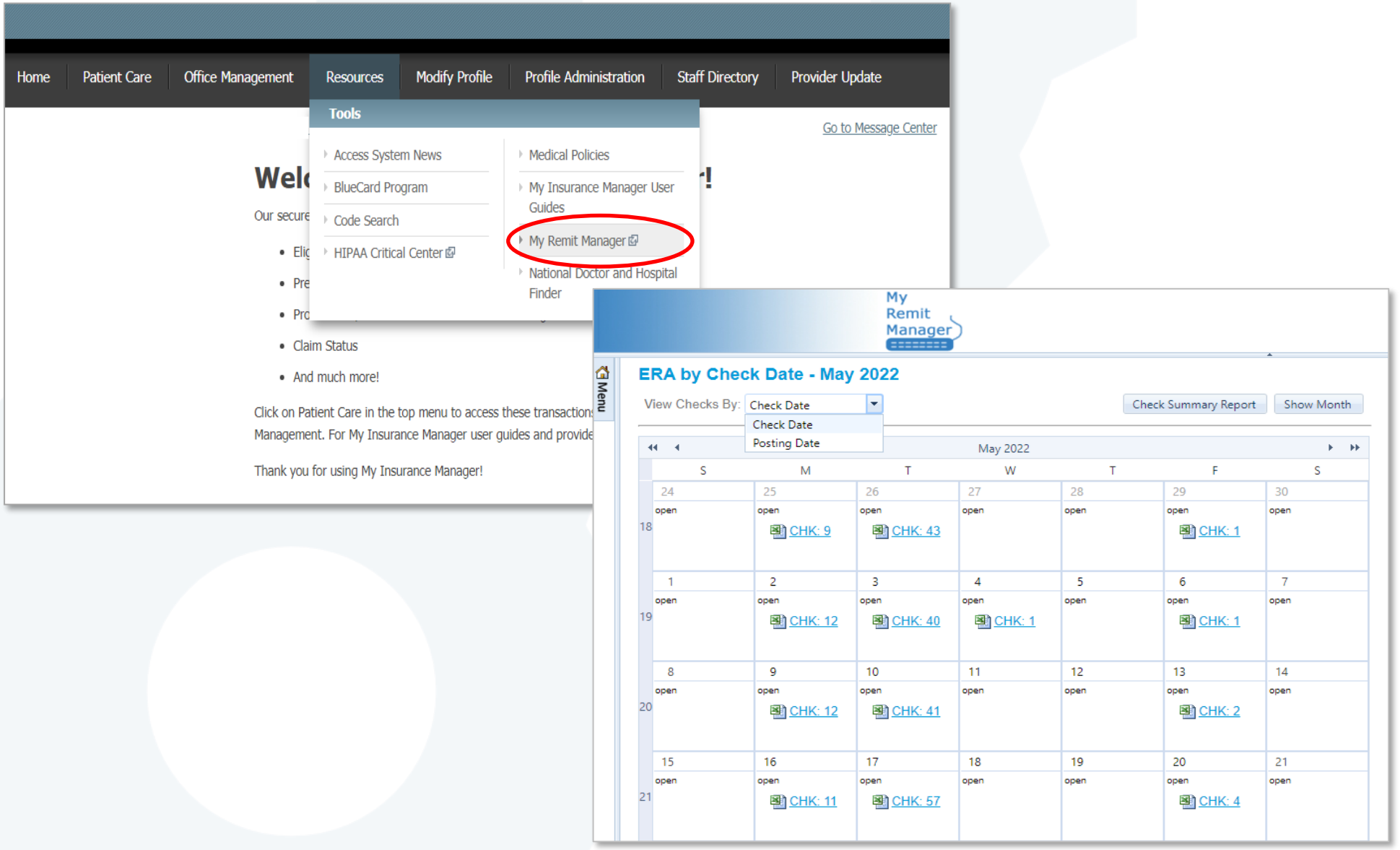
Start here if you've never signed up for the portal.



New Changes for 2024

New Provider Portals

My Remit Manager



New Changes for 2024

New Vendors

Avalon Healthcare Solutions*	National Imaging Associates* (NIA)	Novologix*
Manages utilization reviews for laboratory services.	Manages utilization reviews for high tech imaging and radiology services.	Manages utilization reviews for certain specialty drugs.
PAS Portal (In My Insurance Manager) Phone: 844-227-5769 Fax: 813-751-3760	www.RadMD.com Phone: 888-642-9181	My Insurance Manager

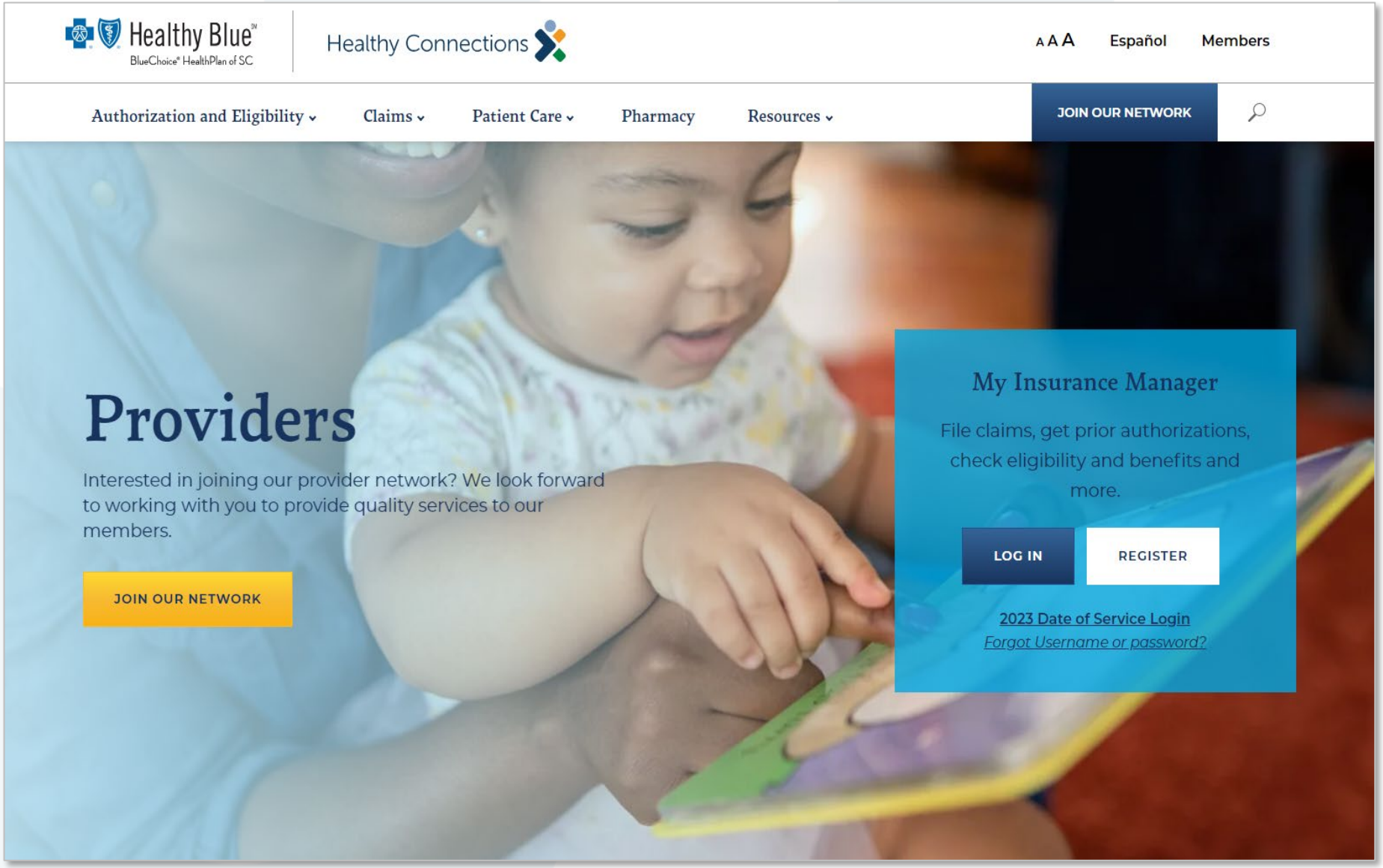
** These are independent companies that manage services on behalf of BlueChoice HealthPlan.*

New Changes for 2024

Updated Website

www.HealthyBlueSC.com

Same URL — just a different look!



Contacts and Resources

Contacts and Resources

Website
www.HealthyBlueSC.com

Provider Service
Phone: 866-757-8286 or TTY: 866-773-9634
Fax: 803-870-6511
Hours: Monday – Friday, 8:30 a.m. to 5 p.m. EST

Disease Management (DM) Department
Phone: 866-757-8286 or TTY: 866-773-9634
Fax: 803-870-6502
Hours: Monday – Friday, 8:30 a.m. to 5 p.m. EST

Utilization Management (UM) Department
Phone: 866-757-8286 or TTY: 866-773-9634
Fax: 803-870-6500
Hours: Monday – Friday, 8:30 a.m. to 5 p.m. EST

Quick Reference Guide
Use this guide to identify the most efficient method to obtain benefit information and get preauthorization for certain services.

Vision Service Plan* (VSP)
Phone: 800-615-1883
Hours: Monday – Friday, 8 a.m. to 5 p.m. EST
Saturday, 10 a.m. to 3 p.m. EST
Sunday, 10 a.m. to 4 p.m. EST

24/7 Nurse line
Phone: 800-830-1525

Case Management (CM) Department
Phone: 866-757-8286 or TTY: 866-773-9634
Fax: 803-870-6501
Hours: Monday – Friday, 8:30 a.m. to 5 p.m. EST

Companion Benefit Alternatives (CBA)
Phone: 866-757-8286 or TTY: 866-773-9634
Fax: 803-870-6506
Hours: Monday – Friday, 8:30 a.m. to 5 p.m. EST

National Imaging Associates* (NIA)
Phone: 888-642-9181
Hours: Monday – Friday, 8 a.m. to 5 p.m. EST
Website: www.RadMD.com

** These are independent companies that manage services on behalf of BlueChoice HealthPlan.*

Contacts and Resources

CarelonRx – Prior Authorizations

Retail

Phone: 844-410-6890
Fax: 844-512-9005
Hours: Monday- Friday 8 a.m. to 8 p.m. EST
Saturday 10 a.m. to 2 p.m. EST

Home Delivery/Mail Order

Phone (24/7): 833-203-1737
Fax: 800-207-3118

Medical Injectables

Phone: 833-988-1264
Fax: 844-512-7027
Hours: 7 a.m. to 7 p.m. EST

Specialty Pharmacy

Phone (24/7): 833-255-0646
Fax: 833-263-2871

Contacts and Resources

BlueBlast

Monthly provider focused newsletter including:

- Important health plan updates
- Healthy Connections updates
- Announcements
- Billing and claims information
- And more

Visit www.HealthyBlueSC.com to sign up.

Provider communications

Stay current on **Healthy Blue** policies and processes, updates to clinical guidelines, state and federal regulatory changes, and other issues affecting your practice and patients.

Subscribe to News Updates

Benefits

Benefits

Checking Covered Services

- Fee schedules
  - Visit www.scdhhs.gov/resource/fee-schedules*.
    - Information is listed by provider specialty
    - If the code appears on the fee schedule, it is covered
    - Medicaid Manage Care Organization (MCO) plans are required to offer at a minimum, the same benefits as Healthy Connections Fee for Service (FFS)
- Manuals
  - Visit www.scdhhs.gov/provider-manual-list*.
    - Information is listed by service type
    - Includes general information, billing details, claims guidelines and more

These links lead to a third-party site. Their organization is solely responsible for the content and privacy policies on the site.

Benefits

Copays

Service	2023	2024
Primary care visits, RHCs*, and FQHCs*	$3.30	**$0**
Specialist visits (including optometrists)	$3.30	**$0**
Durable medical equipment (DME)	$3.40	**$0**
Chiropractic care	$1.15	**$0**
Home health (limited to 50 visits)	$3.30	**$0**
Outpatient hospital	$3.40	**$0**
Inpatient hospital	$25.00	**$0**

* Rural Health Clinics and Federally Qualified Health Clinics

Authorizations

Authorizations

Requesting Prior Authorizations

Prior authorizations can be requested through the below avenues:

- My Insurance Manager (preferred)
  - www.HealthyBlueSC.com
    - Providers>My Insurance Manager
- Medical Forms Resource Center (preferred)
  - www.HealthyBlueSC.com
    - Providers>Authorizations>Medical Forms Resource Center
- Phone (Utilization Management)
  - 866-757-8286
- Fax (Utilization Management)
  - 803-870-6500 (general requests)

Authorizations

Requesting Prior Authorizations — My Insurance Manager

There are two options for obtaining authorizations through MIM:

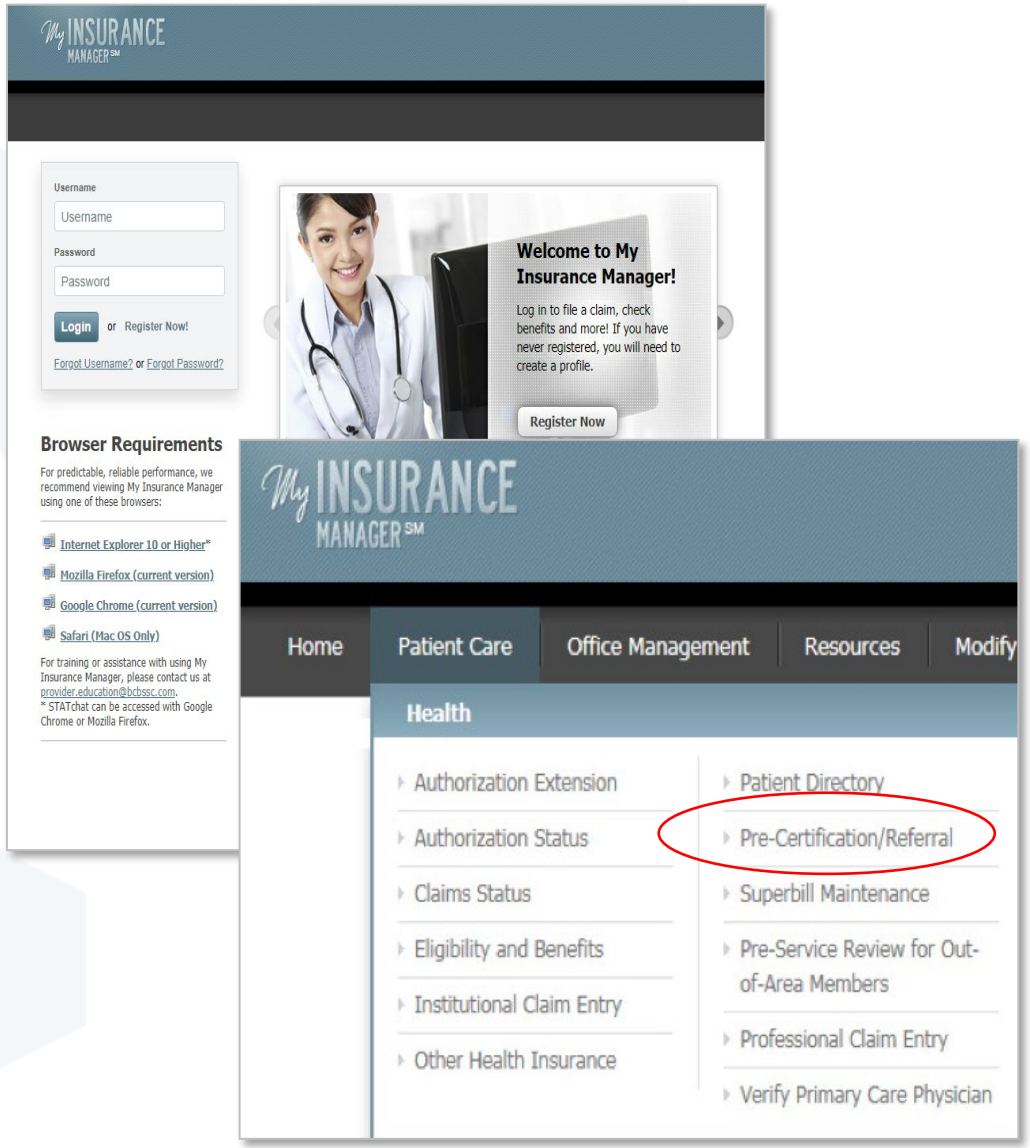
Fast-Track

- Hundreds of available options
- Automated authorization number

Custom Request

- Allows specific details to be entered
- Authorization will pend for review; if approved, authorization number is provided

Note: MIM should be used for initial authorization requests. Please fax clinical documentation for updates or continued stay reviews.



Authorizations

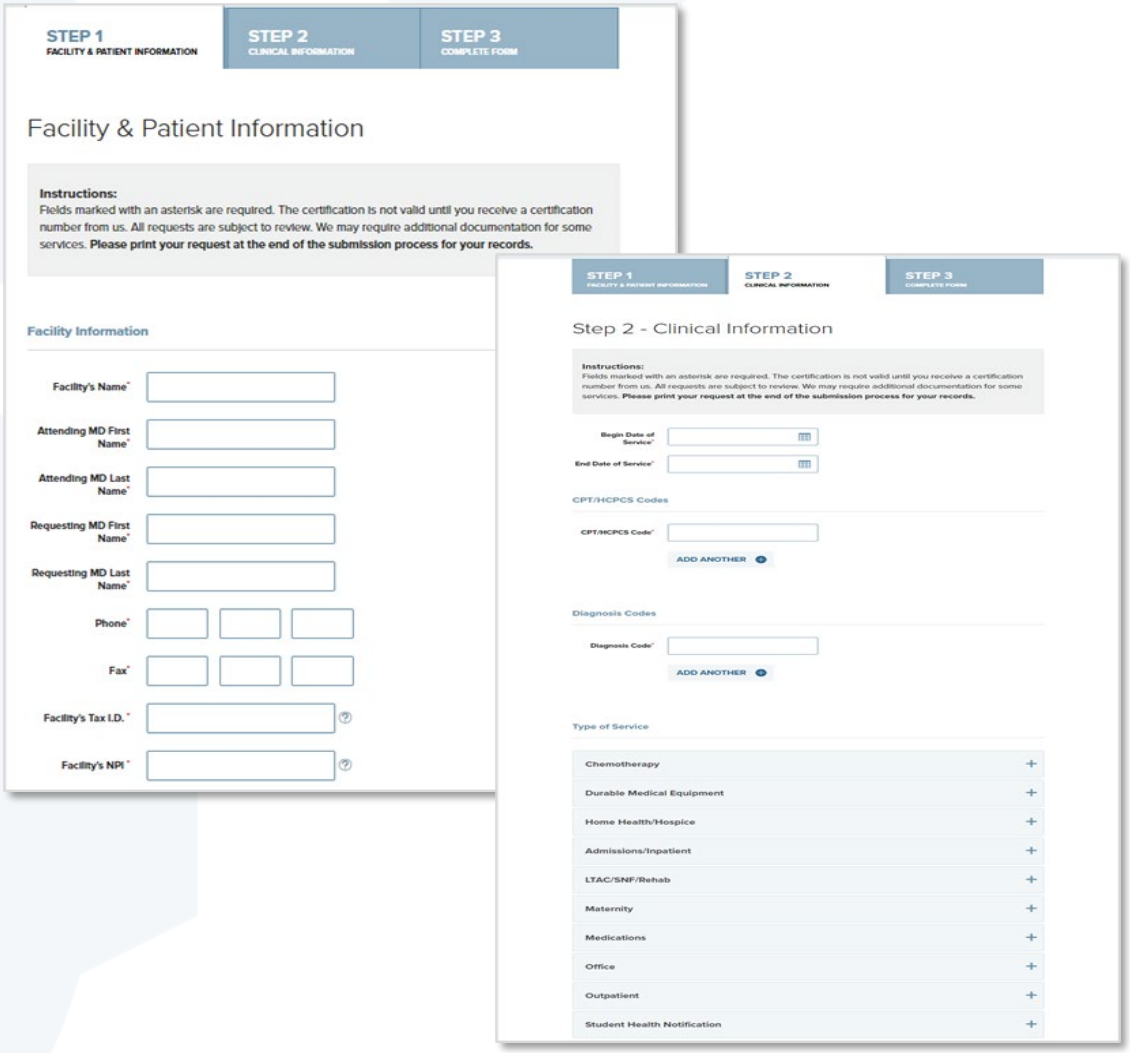
Requesting Prior Authorizations — Medical Forms Resource Center

Complete requests in three easy steps:

1. Enter the facility and patient details
2. Include all required clinicals
3. Submit the request

Benefits of using the MFRC

- Offers various types of authorizations
- Guides you through the required documentation
- Receives priority processing



Authorizations

Requesting Prior Authorizations – Phone

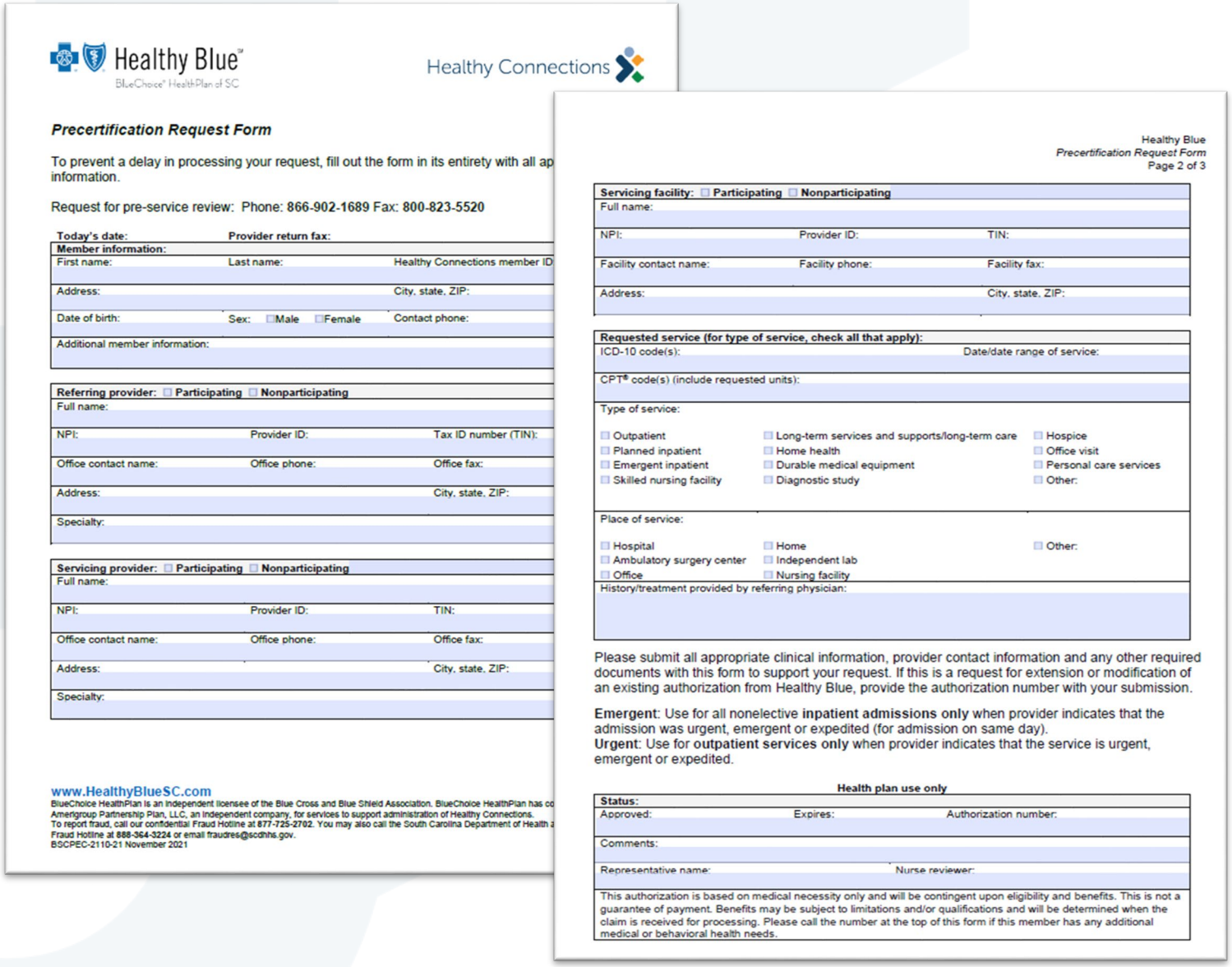
- Contact the utilization management (UM) team at 866-757-8286.
- The following information is required:
  - Member's name, date of birth, Medicaid number and address
  - ICD-10 codes
  - CPT/HCPCS codes and units or visit amounts where appropriate
  - Date(s) of service
  - Level of care as appropriate
  - Requesting or servicing provider's Tax ID/NPI, address, phone and fax number
  - Servicing facility's Tax ID/NPI, address, phone and fax number
  - For neonatal intensive care unit (NICU) admission, all the above plus the mother's name, date of birth and Medicaid number

Authorizations

Requesting Prior Authorizations — Fax

Types of fax request forms include:

- Inpatient
- Psychological testing
- MCO — BabyNet
- MCO — Makena
- Universal Newborn — Pediatric offices
- Universal Synagis®



Healthy Blue
BlueChoice® HealthPlan of SC

Healthy Connections

Precertification Request Form

To prevent a delay in processing your request, fill out the form in its entirety with all ap
information.

Request for pre-service review: Phone: 866-902-1689 Fax: 800-823-5520

Today's date: **Provider return fax:**

Member information:
First name: | Last name: | Healthy Connections member ID
Address: | City, state, ZIP:
Date of birth: | Sex: ☐ Male ☐ Female | Contact phone:
Additional member information:

Referring provider: ☐ **Participating** ☐ **Nonparticipating**
Full name:
NPI: | Provider ID: | Tax ID number (TIN):
Office contact name: | Office phone: | Office fax:
Address: | City, state, ZIP:
Specialty:

Servicing provider: ☐ **Participating** ☐ **Nonparticipating**
Full name:
NPI: | Provider ID: | TIN:
Office contact name: | Office phone: | Office fax:
Address: | City, state, ZIP:
Specialty:

www.HealthyBlueSC.com
BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association. BlueChoice HealthPlan has co
Amerigroup Partnership Plan, LLC, an independent company, for services to support administration of Healthy Connections.
To report fraud, call our confidential Fraud Hotline at 877-725-2702. You may also call the South Carolina Department of Health a
Fraud Hotline at 888-364-3224 or email fraudres@scdhhs.gov.
BSCPEC-2110-21 November 2021

Healthy Blue
Precertification Request Form
Page 2 of 3

Servicing facility: ☐ **Participating** ☐ **Nonparticipating**
Full name:
NPI: | Provider ID: | TIN:
Facility contact name: | Facility phone: | Facility fax:
Address: | City, state, ZIP:

Requested service (for type of service, check all that apply):
ICD-10 code(s): | Date/date range of service:
CPT® code(s) (include requested units):
Type of service:
☐ Outpatient ☐ Long-term services and supports/long-term care ☐ Hospice
☐ Planned inpatient ☐ Home health ☐ Office visit
☐ Emergent inpatient ☐ Durable medical equipment ☐ Personal care services
☐ Skilled nursing facility ☐ Diagnostic study ☐ Other:
Place of service:
☐ Hospital ☐ Home ☐ Other:
☐ Ambulatory surgery center ☐ Independent lab
☐ Office ☐ Nursing facility
History/treatment provided by referring physician:

Please submit all appropriate clinical information, provider contact information and any other required documents with this form to support your request. If this is a request for extension or modification of an existing authorization from Healthy Blue, provide the authorization number with your submission.

Emergent: Use for all nonelective **inpatient admissions only** when provider indicates that the admission was urgent, emergent or expedited (for admission on same day).
Urgent: Use for **outpatient services only** when provider indicates that the service is urgent, emergent or expedited.

Health plan use only
Status:
Approved: | Expires: | Authorization number:
Comments:
Representative name: | Nurse reviewer:
This authorization is based on medical necessity only and will be contingent upon eligibility and benefits. This is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. Please call the number at the top of this form if this member has any additional medical or behavioral health needs.

Claims

Claims

Submitting Claims — Dates of Service on or before Dec. 31, 2023

The timely filing limit for original and corrected claims is 365 days and the following avenues can be used:

- **Electronically through your clearinghouse (preferred)**
  - Contact your clearinghouse for the appropriate payor ID.
- **Electronically directly to payer**
  - Use payor ID 00403.
  - For set up and information, contact E-Solutions at 800-470-9630.
- **Provider Portal**
  - Use Availity.
- **Mail (hard copy)**

  Healthy Blue
  P.O. Box 100124
  Columbia, SC 29202-3124

Claims

Submitting Claims — Dates of Service on or after Jan. 1, 2024

The timely filing limit for original and corrected claims is 365 days and the following avenues can be used:

- **Electronically through your clearinghouse (preferred)**
  - Contact your clearinghouse for the appropriate payor ID.
- **Electronically directly to payer**
  - Use payor ID 00403.
  - For set up and information, contact Electronic Data Interchange Gateway at EDIG.Support@palmettogba.com.
- **Provider Portal**
  - My Insurance Manager
- **Mail (hard copy)**

  Healthy Blue
  P.O. Box 100317
  Columbia, SC 29202-3317

Claims

Claim Payment Disputes — What is a claim payment dispute?

- Disagreement with the outcome of a claim
- Includes two steps:
  1. Claim payment reconsideration
  2. Claim payment appeal (only with member's consent)
- Common reasons for a claim payment dispute include issues related to, but not limited to:
  - Contractual payment
  - Disagreements over reduced or zero-paid claims
  - Post-service authorization
  - Other health insurance denial
  - Claim code editing
  - Duplicate claim
  - Retro-eligibility
  - Experimental/investigation procedures
  - Claim data
  - Timely filing

Claims

Claim Payment Disputes — Claim Payment Reconsiderations

- Initial request to investigate the outcome of a finalized claim
- Must be submitted within **90 calendar days** from the date of the explanation of payment
- Must include as much information as possible to explain why you feel the claim was processed incorrectly

How to submit:

- **Online**
  - My Insurance Manager
- **Verbally**
  - Provider Service: 866-757-8286
- **Mail (written)**
  - Healthy Blue
    P.O. Box 100317
    Columbia, SC 29202-3317

Claims

Claim Payment Disputes — Claim Payment Appeals (Only with member consent)

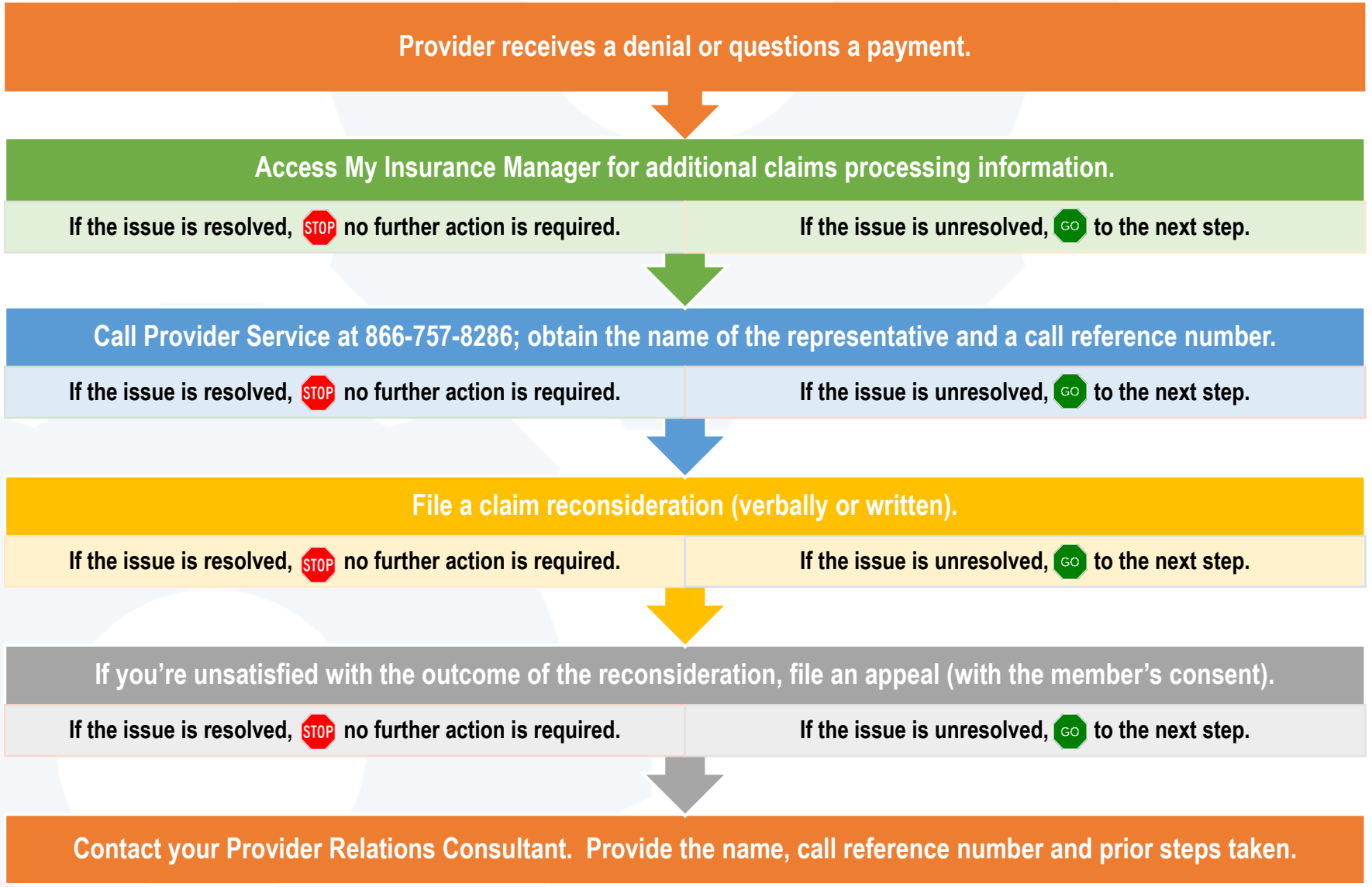
- Request submitted when there is a disagreement with the outcome of the claim payment reconsideration
- Must be submitted within **30 calendar days** from the explanation of payment or the claims payment reconsideration determination letter
- Must include as much information as possible to explain why you feel the claim was processed incorrectly

How to submit:

- **Mail (written)**
  - Healthy Blue
    P.O. Box 100317
    Columbia, SC 29202-3317

Claims

Claims Assistance Workflow



Claims

Balance Billing

Balance billing is sending a member a bill for an amount that Healthy Blue did not reimburse on the submitted claim.

Per your Healthy Blue contract, **you are not permitted to balance bill for any portion of the services that the health plan does not pay**.

The member should be held harmless and not financially responsible for any amounts not paid for the contracted service(s) unless otherwise specified in the evidence of coverage (EOC).

Reminders

Reminders

Member Annual Eligibility

Ways for the member to apply or renew:

- Website: apply.scdhhs.gov
  - Select Apply for Medicaid or Submit Annual Review
- Fax: 888-820-1204
- Email: 8888201204@faxschdds.gov
- Mail:

  SCDHHS Central Mail
  P.O. Box 100101
  Columbia, SC 29202
- In person: local eligibility office

Reminders

Cultural Competency

- Cultural competency is a set of congruent behaviors, attitudes and policies that enable effective work in cross-cultural situations.
- Cultural awareness is the ability to recognize the cultural factors, values, communications and more that shape personal and professional behavior.

Skills include:

- Listening to others in an unbiased manner
- Using appropriate methods of interaction
- Recognizing the importance of cultural, social and behavioral factors in public health
- And more

Learn more about cultural competency:

- www.thinkculturalhealth.hhs.gov/education *

This link leads to a third-party site. Their organization is solely responsible for the content and privacy policies on the site.

Reminders

Fraud, Waste and Abuse

- Providers are required to:
  - Comply with all applicable statutory, regulatory and other Medicaid managed care requirements in South Carolina.
  - Report any law violations and follow their organization's code of conduct that expresses their commitment to standards of conduct and ethical rules of behavior.

How to report:

- Call 800-763-0703.
- Complete the form at: https://www.southcarolinablues.com/web/public/brands/sc/assistance/report-fraud/
- Call the South Carolina Department of Health and Human Services (SCDHHS) at 888-364-3224 or email fraudres@scdhhs.gov.

Reminders

Access and Availability

- Primary care

Type of visit	Availability standard
Routine	Within four to six weeks
Urgent, non-emergent	Within 48 hours
Emergent	Immediately upon presentation at a service delivery site

- Specialist care

Type of visit	Availability standard
Routine	Within four weeks; 12 week maximum for unique specialists
Urgent medical condition appointment	Within 48 hours of referral or notification from PCP
Emergent	Immediately upon referral

Note: Wait times should not exceed 45 minutes for a scheduled appointment of a routine nature.

Community Service

Community Service

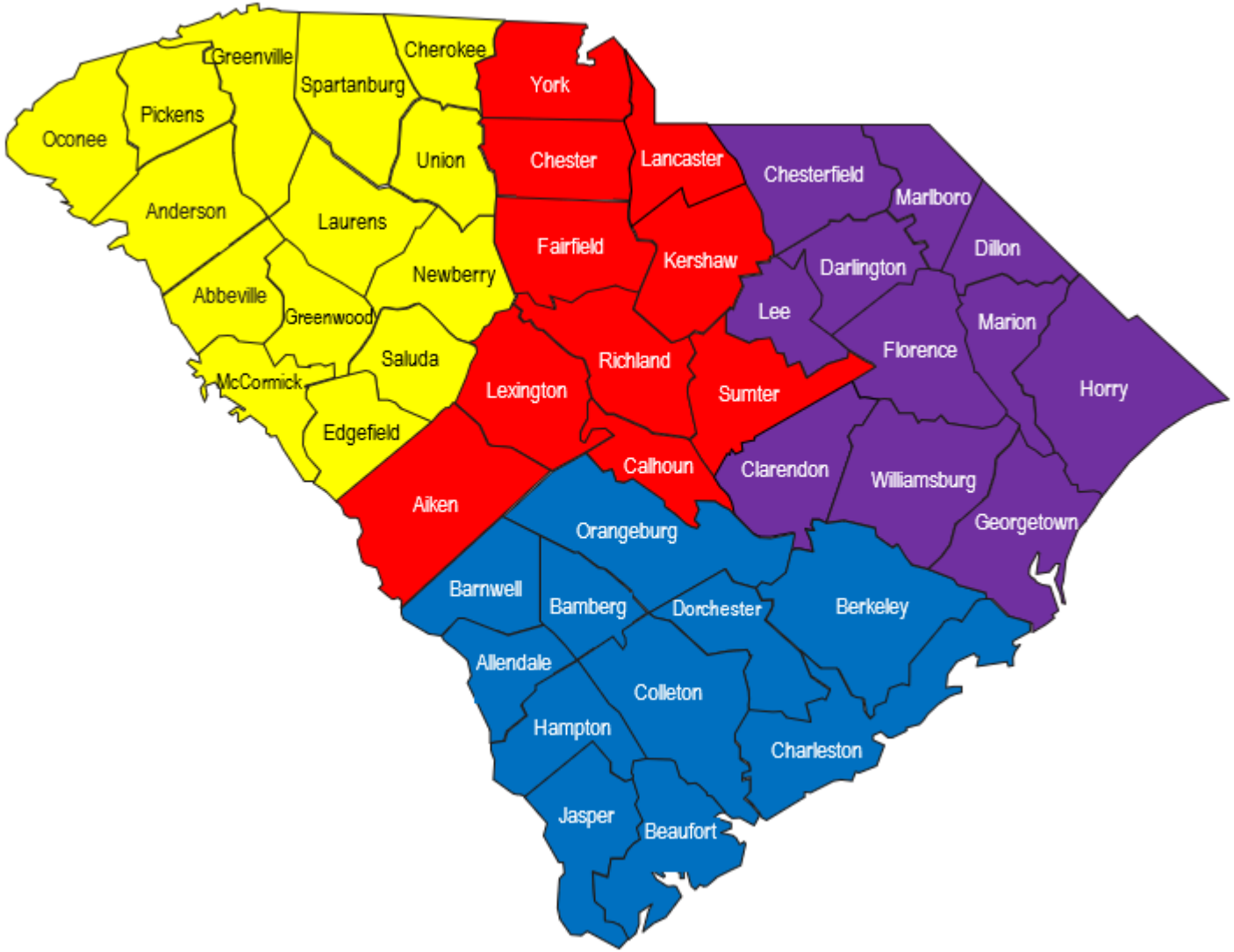
Community Outreach Specialists

Nathan Cox
Nathan.Cox@bluechoicesc.com
(704) 941-7490

Marcell Barnes
Marcell.BarnesJR@bluechoicesc.com
(803) 467-6011

Jessica Barnett
Jessica.Barnett@bluechoicesc.com
(843) 693-0359

Leslie Bruton
Leslie.Bruton@bluechoicesc.com
(864) 887-1127



Community Service

Social Media Platforms

 @HealthyBlueSC

 @HealthyBlueSC

 @HealthyBlueSC

#HealthyBlueSC

Community Service

Value Added Benefits

Free cell phone with monthly minutes, data and texts

Free food delivery for qualifying members (up to $40)

- Eligibility requirements apply

Free fruit and vegetables

- Eligibility requirements apply

Free adult vision

- Ages 21 & up
- Annual exam
- Glasses and frames every two years

$35 Barnes & Noble Gift Card

- Babies 0 – 24 months

Free diapers and car seats

- Up to 15 months of age
- Case of diapers (200 count)
- Limited to no more than six, after well-child visits
- Car seat — eligibility requirements apply

$100 Gift Card for GED Testing

- Ages 17 and up

Free tutoring services for grades K — 8th

Free Sports Physicals

- Ages 6 — 18

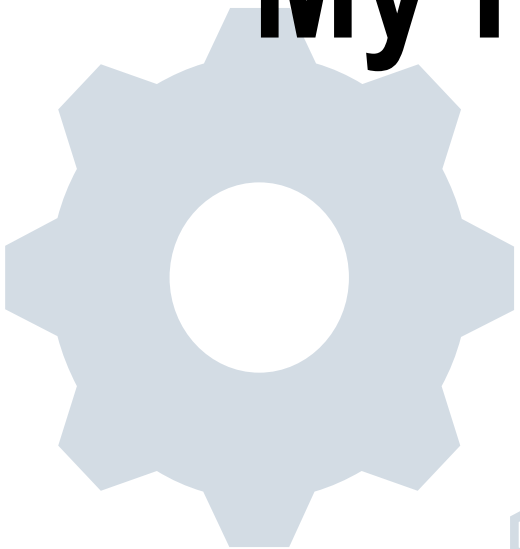
and MUCH, MUCH MORE!

Community Service

Member Incentives

Activity	2023 Current Reward Value	2024 Proposed Reward Value
Prenatal Care Visit	$25	$25
Postpartum Care Visit	$50	$50
Well Child Visits (ages 1 – 6) Later Well Child Visits (ages 7 – 8)	Max of $80	Max of $80
Annual Checkups (ages 3 – 21)	$25	$25
Pap Test	$50	**$25**
Breast Cancer Screen	$50	**$25**
Chlamydia Screening	$25	$25
Diabetes Eye Exam	$25	$25
Diabetes Blood Test	$25	$25
Flu Shot	$10	**$20**
HPV Shots	N/A	**$20**
Colorectal Cancer Screening	N/A	**$10**
Personal Health Assessment (Non-HEDIS)	N/A	**$20**
My Health Toolkit (Non-HEDIS)	N/A	**$20**

My Provider Enrollment Portal



Back To Basics

Agenda

- My Provider Enrollment Portal Overview
- Completing Clean Applications
- Making Corrections to Applications
- Resources and Helpful Tips

My Provider Enrollment Portal Overview

My Provider Enrollment Portal Overview

Use the portal to:

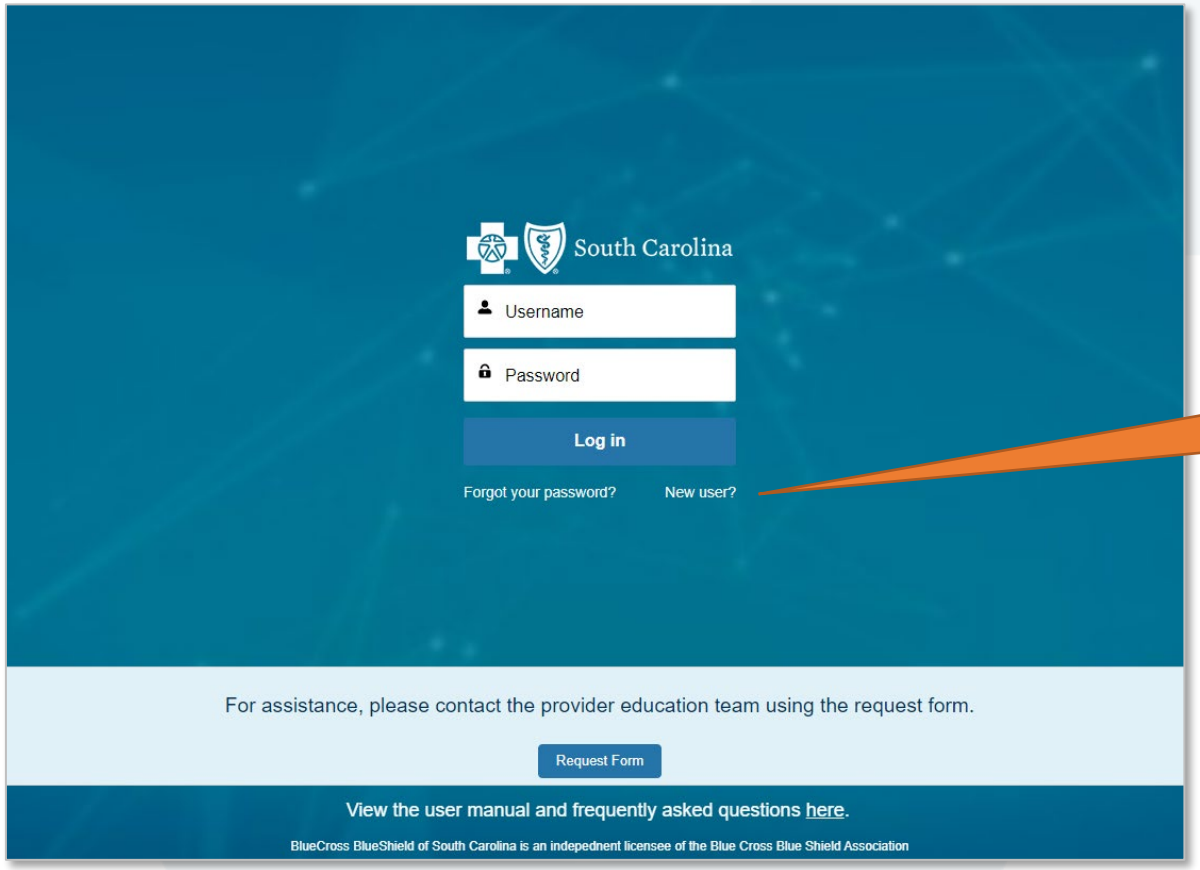
- Become a network provider.
- Receive automated status updates.
- Make certain updates for the physician or practice.
- Receive notifications when additional information is needed.

My Provider Enrollment Portal Overview

Sign Up for Access to the Portal

Visit www.SouthCarolinaBlues.com.

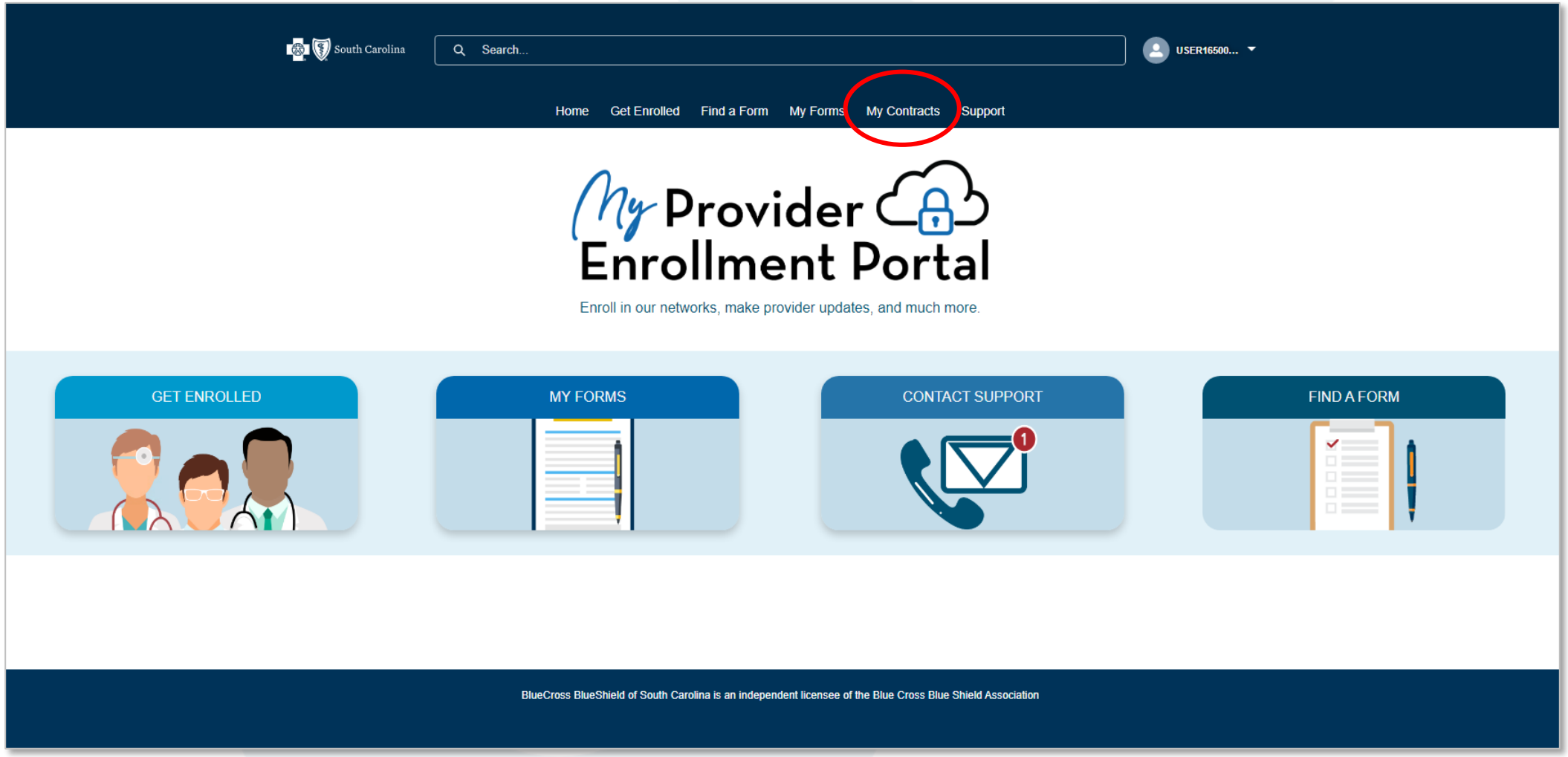
Providers>Provider Enrollment>My Provider Enrollment Portal



Select New user if you've never signed up!

My Provider Enrollment Portal Overview

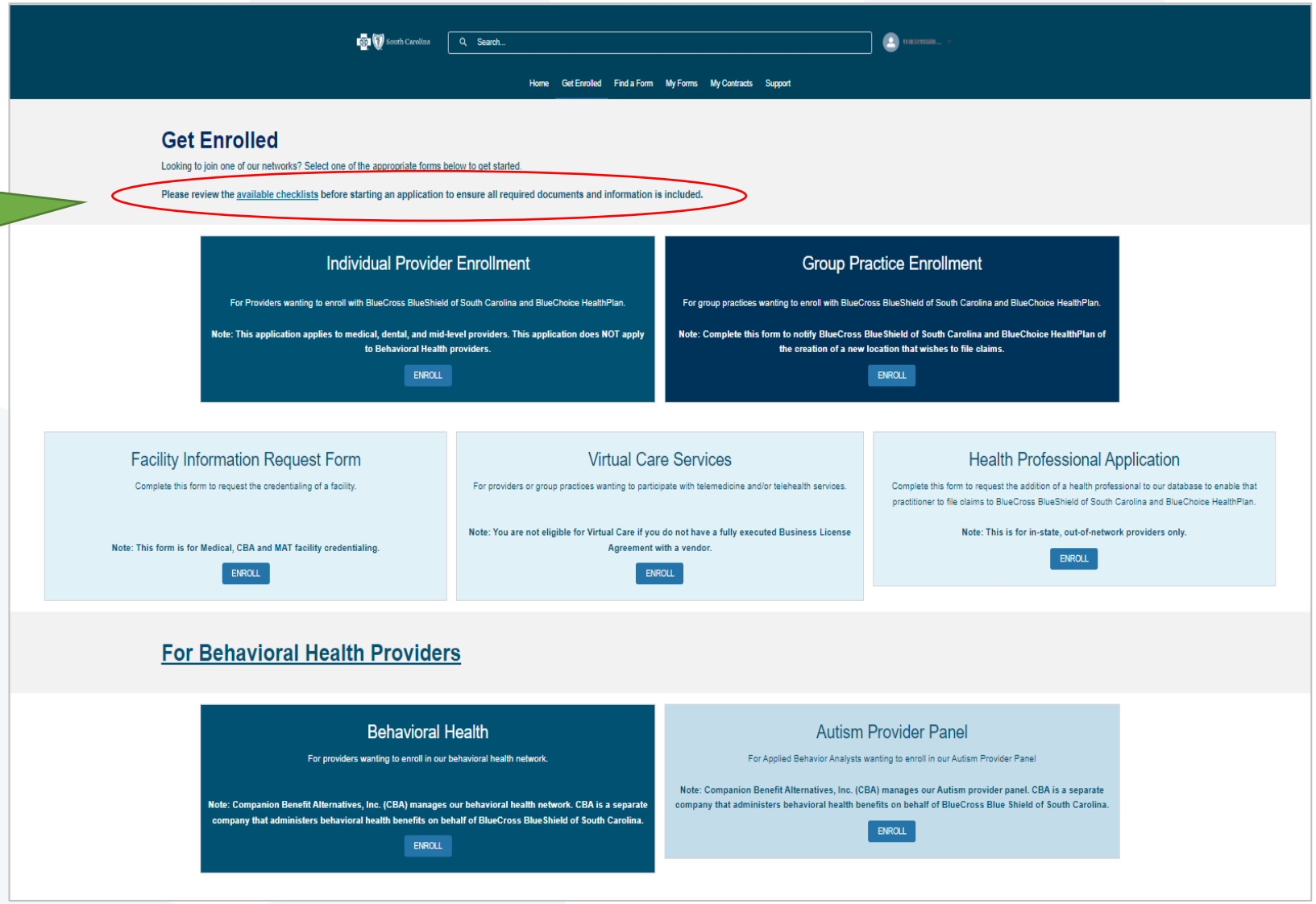
Home Page



My Provider Enrollment Portal Overview

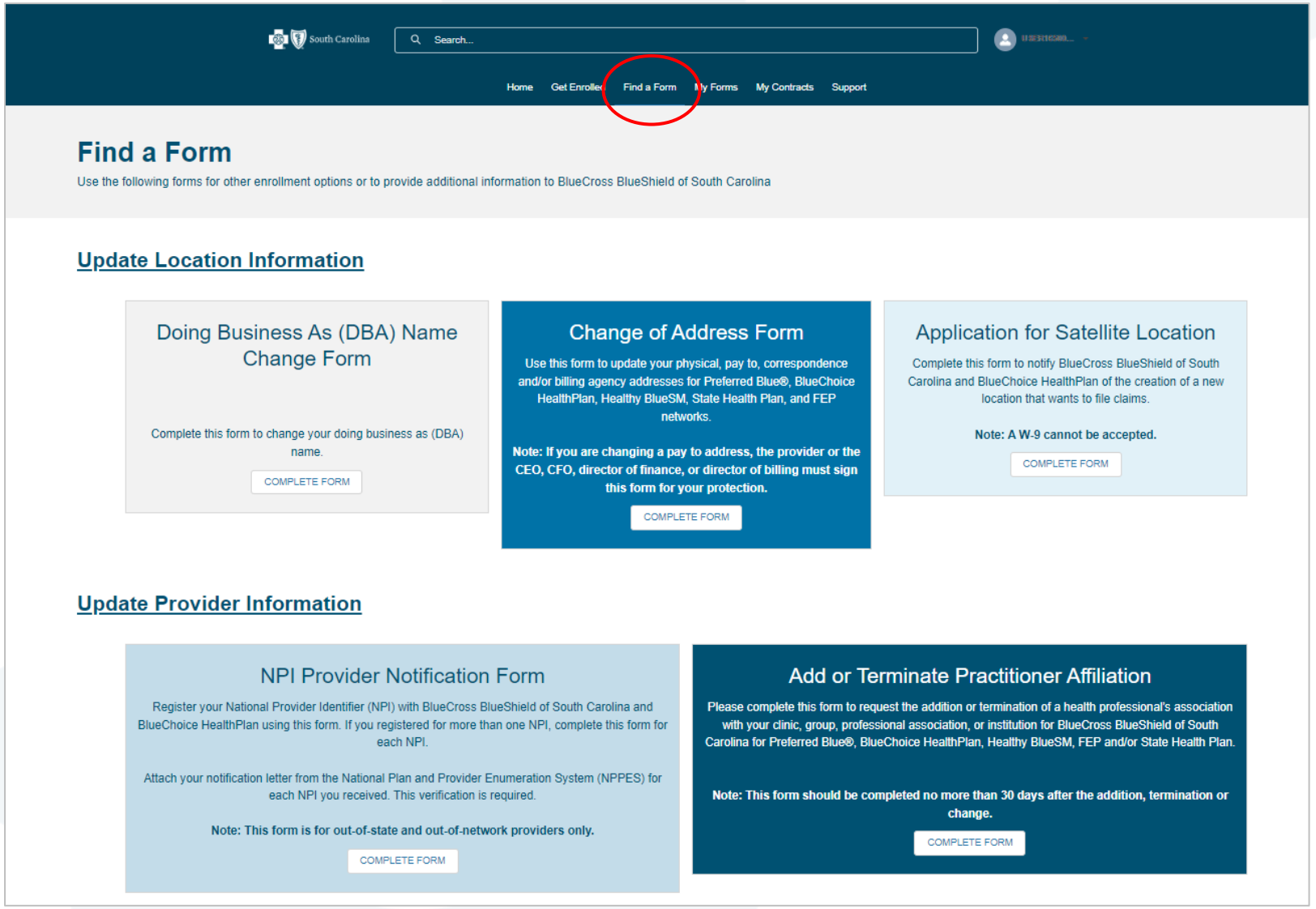
Get Enrolled

Review the available checklists before starting an application.



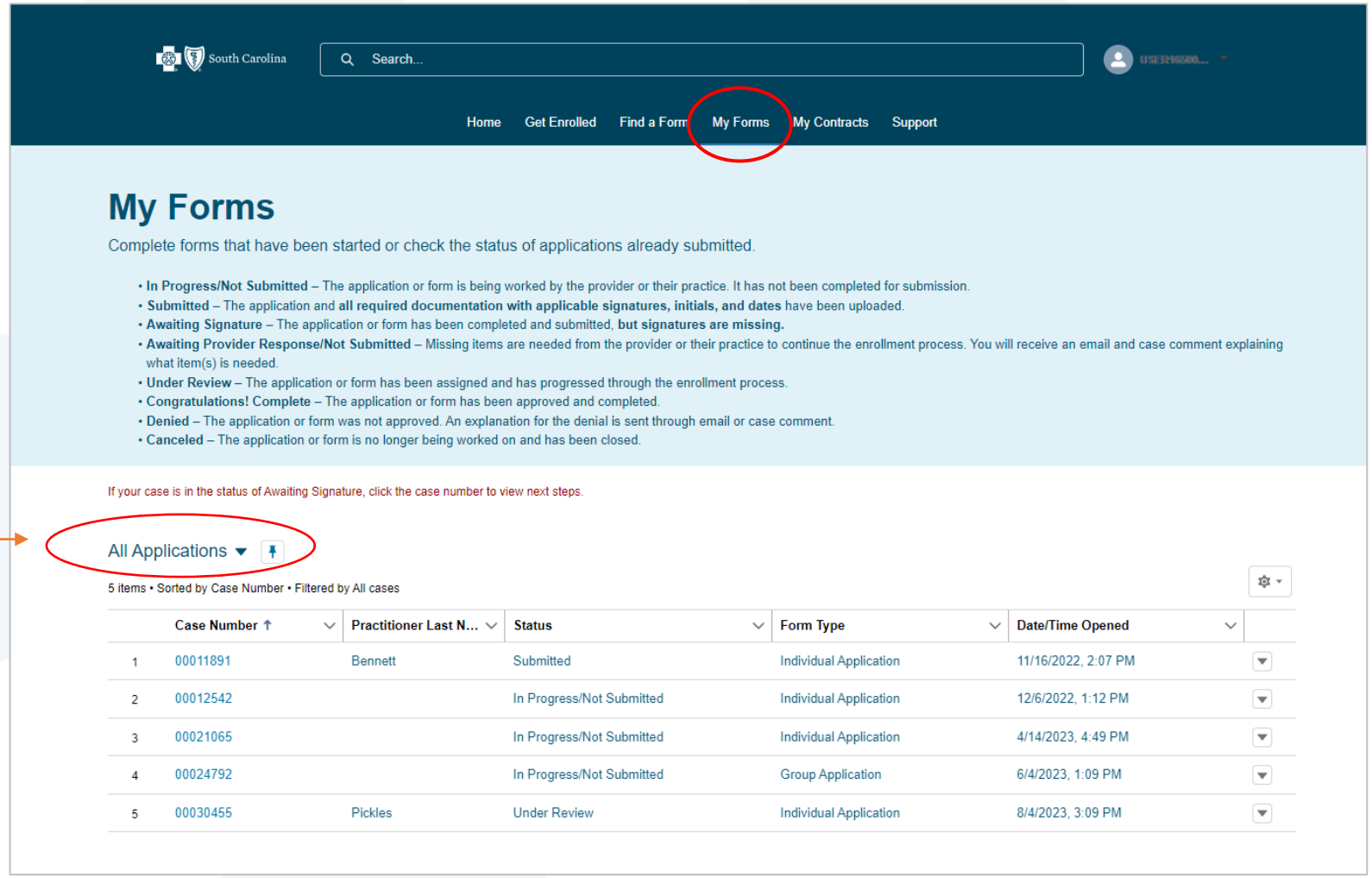
My Provider Enrollment Portal Overview

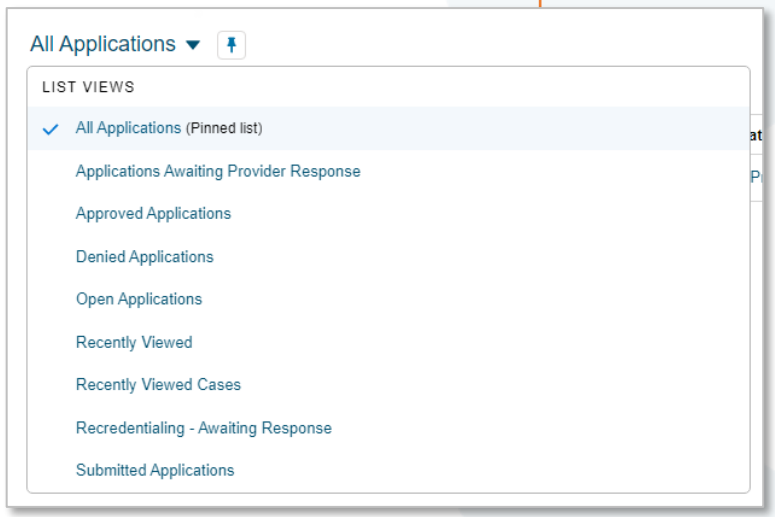
Find a Form



My Provider Enrollment Portal Overview

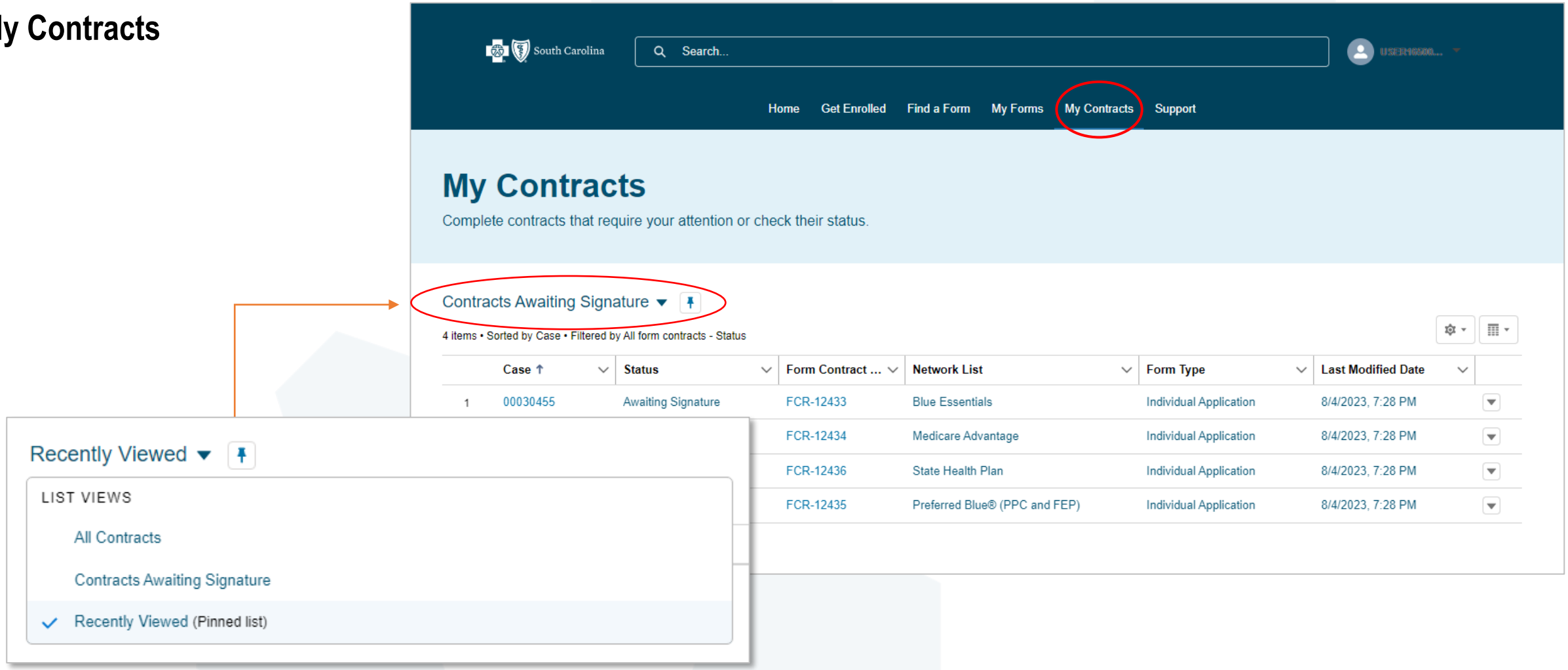
My Forms





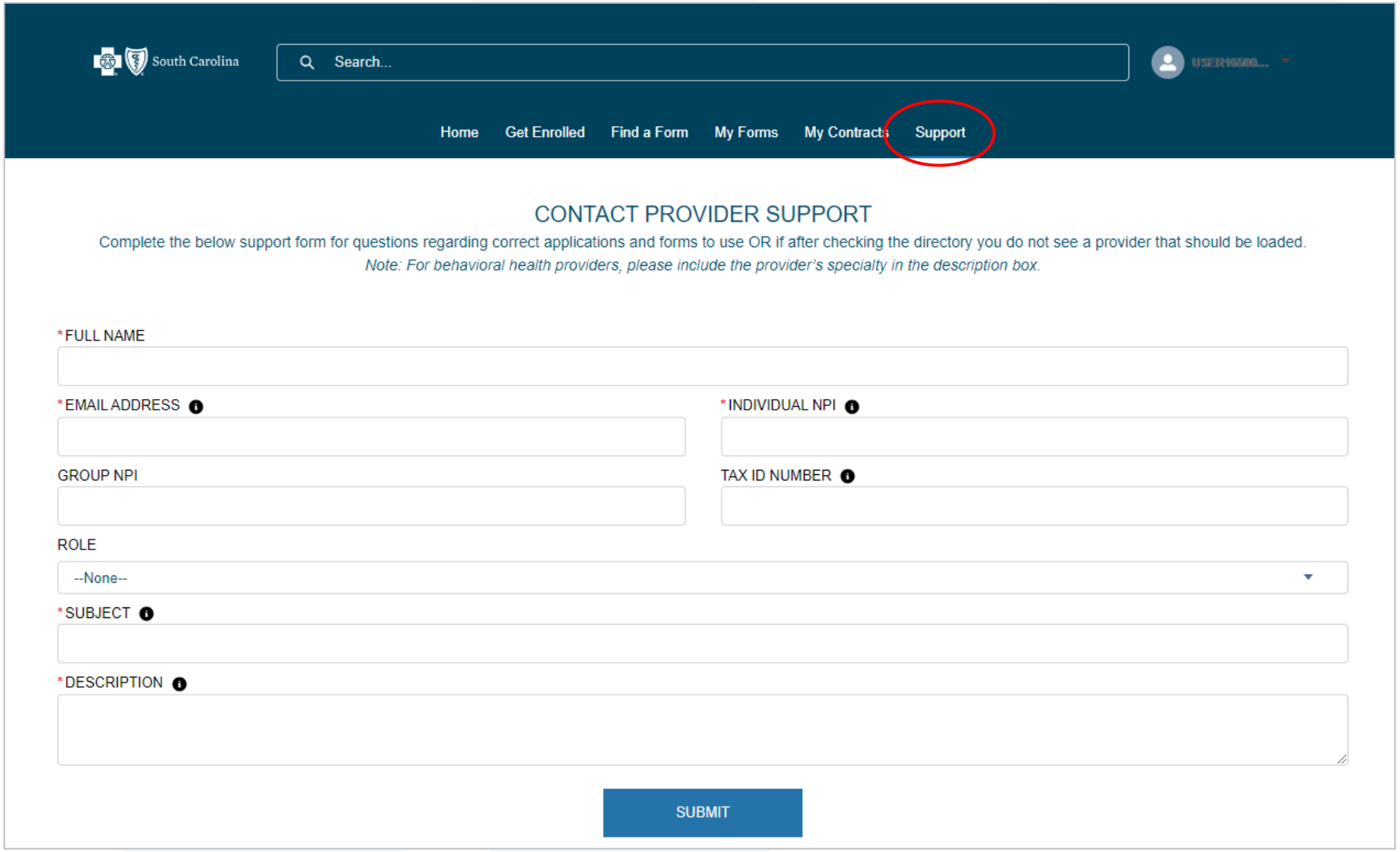
My Provider Enrollment Portal Overview

My Contracts



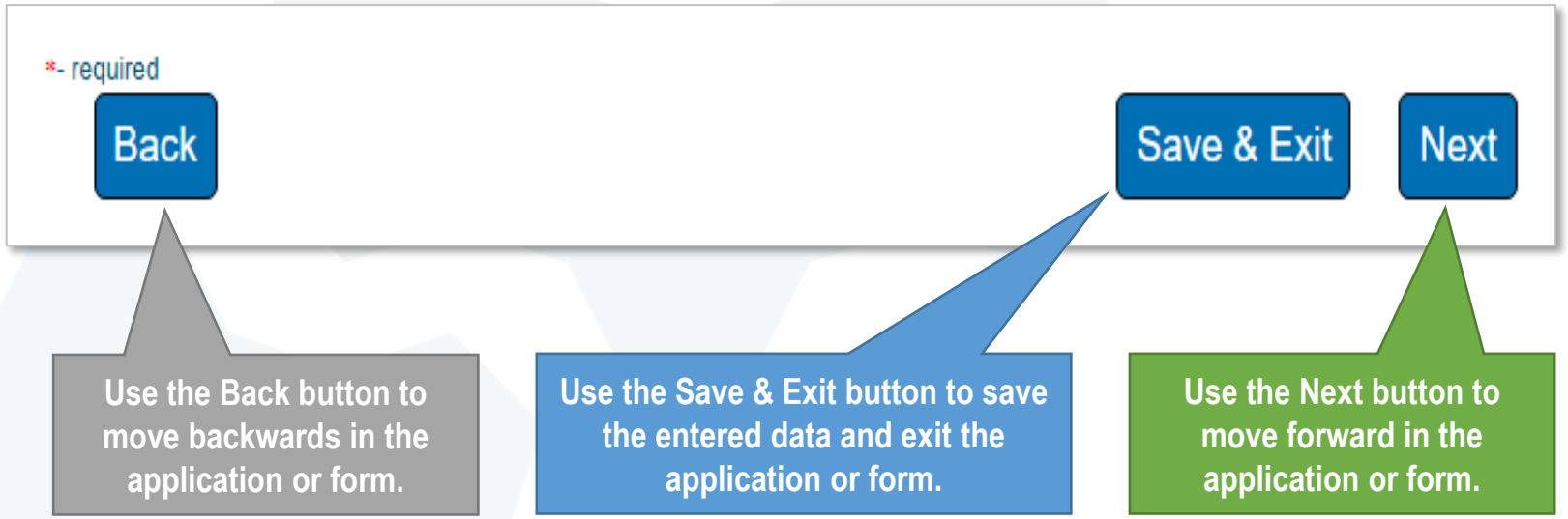
My Provider Enrollment Portal Overview

Support

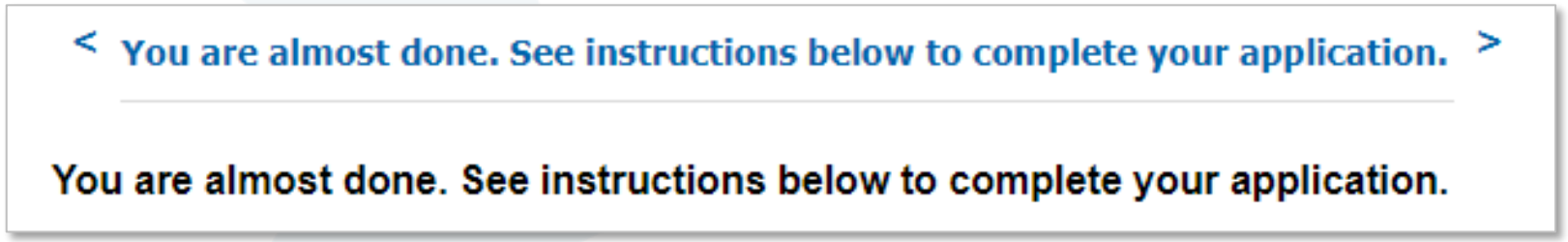


My Provider Enrollment Portal Overview

Navigational Buttons



When you get here, you MUST select Next to submit the application.



My Provider Enrollment Portal Overview

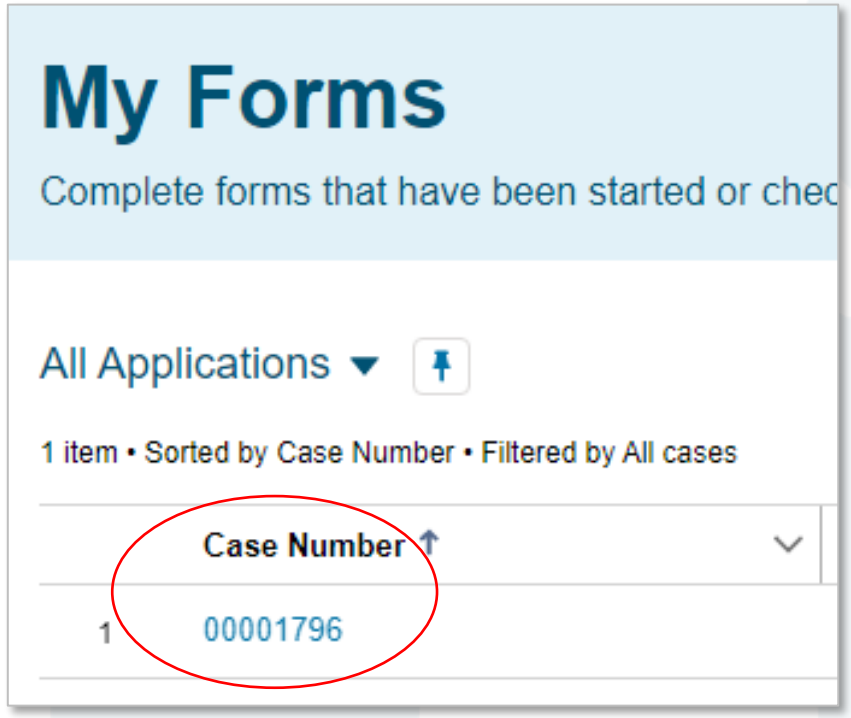
Important Items in the Portal

Be mindful of the following items in the portal:

- Case numbers
- Statuses
- Contracts
- Case comments

My Provider Enrollment Portal Overview

Case Numbers — Generated with each application, form and support case.

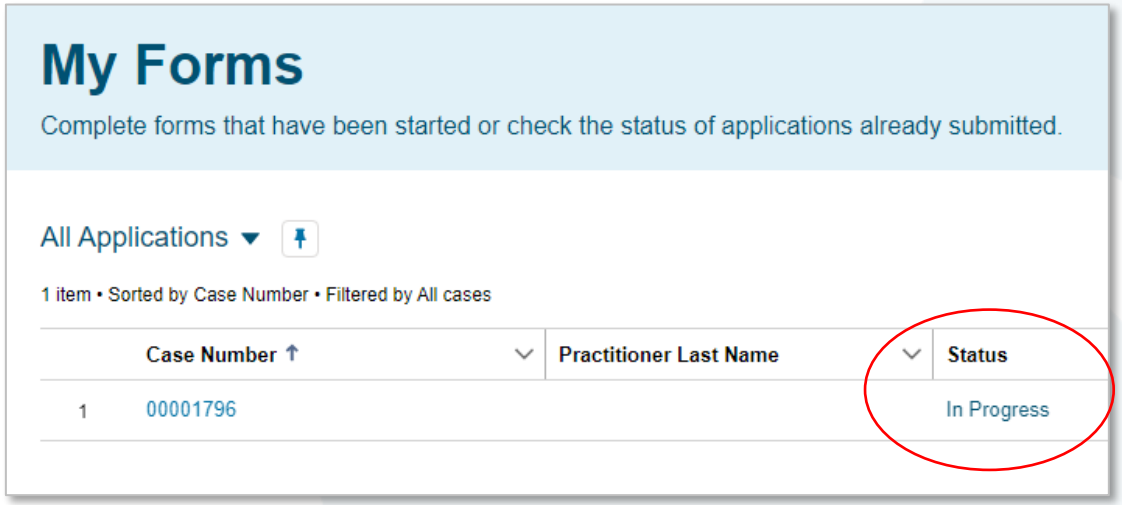


Case numbers are used for:

- Checking statuses.
- Submitting case comments.
- Uploading provider contracts.

My Provider Enrollment Portal Overview

Statuses — Changes as the application or form progresses, or if additional information is needed.



Statuses include:

- In Progress/Not Submitted.
- Submitted.
- Awaiting Signature.
- Awaiting Provider Response/Not Submitted.
- Under Review.
- Congratulations! Complete.
- Denied.
- Canceled.

Note: Providers should not manually change their statuses.

My Provider Enrollment Portal Overview

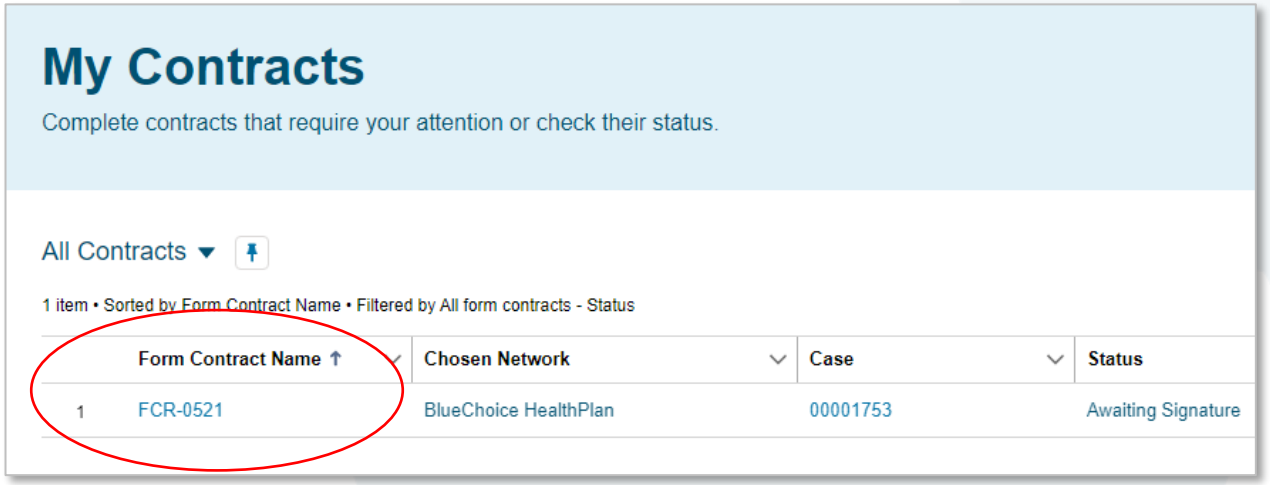
In progress/Not submitted	The application or form is being worked by the provider or their practice. It has not been completed for submission.
Submitted	The application and **all required documentation with applicable signatures, initials and dates** have been uploaded.
Awaiting signature/Not Submitted	The application or form has been completed and submitted, **but signatures are missing**.
Awaiting provider response	Missing items are needed to continue the credentialing process.

My Provider Enrollment Portal Overview

Under review	The application or form has been assigned and has progressed through the credentialing process.
Congratulations! Complete	The application or form has been approved.
Denied	The application or form was not approved. ***Note: Explanation for the denial is sent through email or case comment.***
Canceled	The application or form is no longer being worked and has been closed.

My Provider Enrollment Portal Overview

Contracts — Provided during the application review process and must be included with the application.



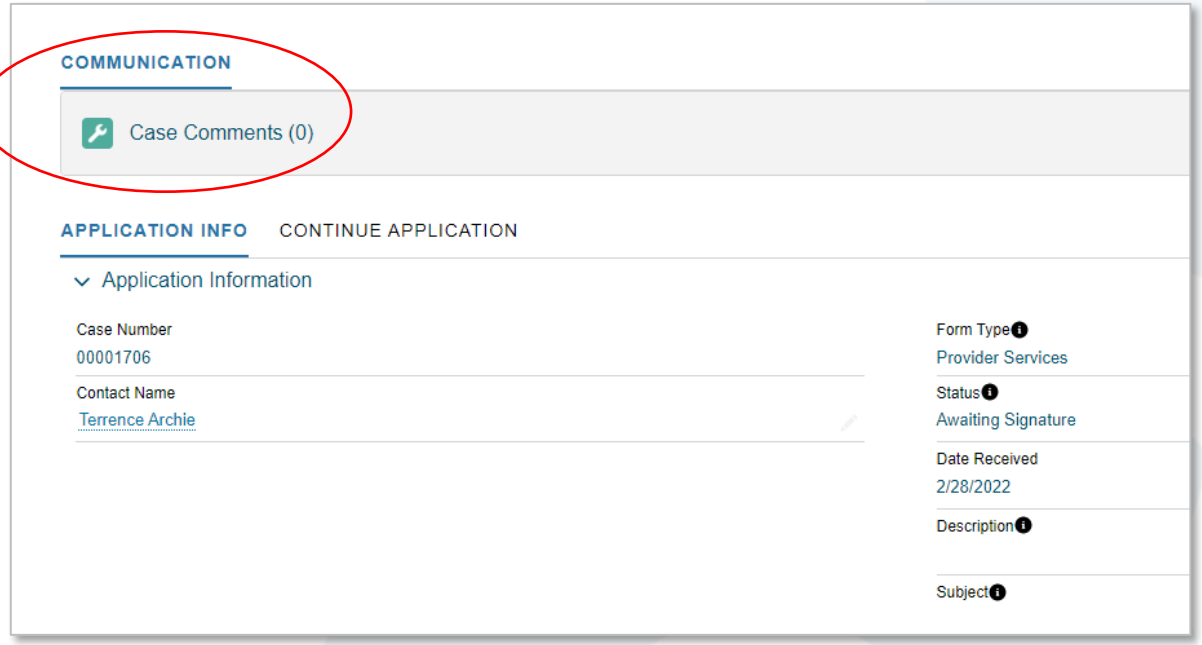
Steps for contracts:

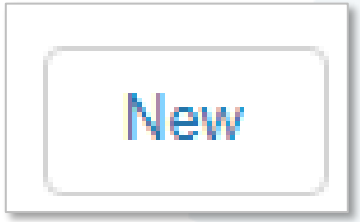
1. Download the contract(s).
2. Print the contract(s).
3. Have the practitioner sign the contract(s) in ink.
4. Upload the signed contract(s) to the appropriate case.

Note: Behavioral health contracts can be signed electronically.

My Provider Enrollment Portal Overview

Case Comments — Use for case-specific questions on applications and forms.





Steps for case comments:

1. Select Case Comments
2. Select New
3. Enter your comment or question in the body
4. Select Save

Completing Clean Applications

Completing Clean Applications

Steps to Submitting Clean Applications

1. Complete the enrollment application inside My Provider Enrollment Portal.
2. Download, print and sign (include signatures, initials and dates) the application and other applicable documents.
   - Documents will be listed under Form Information.
3. Scan and upload the signed documents back to the case.
   - Select My Forms.
   - Select the case number.
   - Select Form Information.
   - Select Upload Files.
4. Download, print and sign (include signatures and dates) all applicable contracts.
5. Scan and upload the signed contracts to the case.

Completing Clean Applications

Checklist Items	Mid-Level	Physician	DDS*
Provider Enrollment Application			
Copy of SC Medical/Practice License			
DEA Certification			Note 1
Current Copy of Malpractice (Min. $1M/$3M)			
Authorization to Bill for Services			
Clinical Lab Improvement Amendments			
Nurse Practitioner Preceptor Form			
Signed Contracts			
Hold Harmless – BlueChoice HealthPlan			
Appendix D – BlueChoice HealthPlan			
Professional Training		Note 2	
Additional Items for Medicaid			
Medicaid ID Number			
Protocols (Written Agreement)	Note 3		

**Doctor of Dental Surgery*

1. **Only needed if applicable.**
2. **DOs, DPMs and MDs require at minimum residency.**
3. **Only needed for NPs and PAs.**

Start Here!

Provider Enrollment Application

Provide the following information and then click Next to continue.

* **Networks (Select all that apply)**

Available

- Blue Essentials
- Blue Option℠
- BlueChoice HealthPlan
- Healthy Blue℠
- Medicare Advantage
- Preferred Blue® (PPC and FEP)

Selected

* Your Role: --None--

* Provider's License Type: --None--

* Credentialing Contact First Name

* Credentialing Contact Last Name

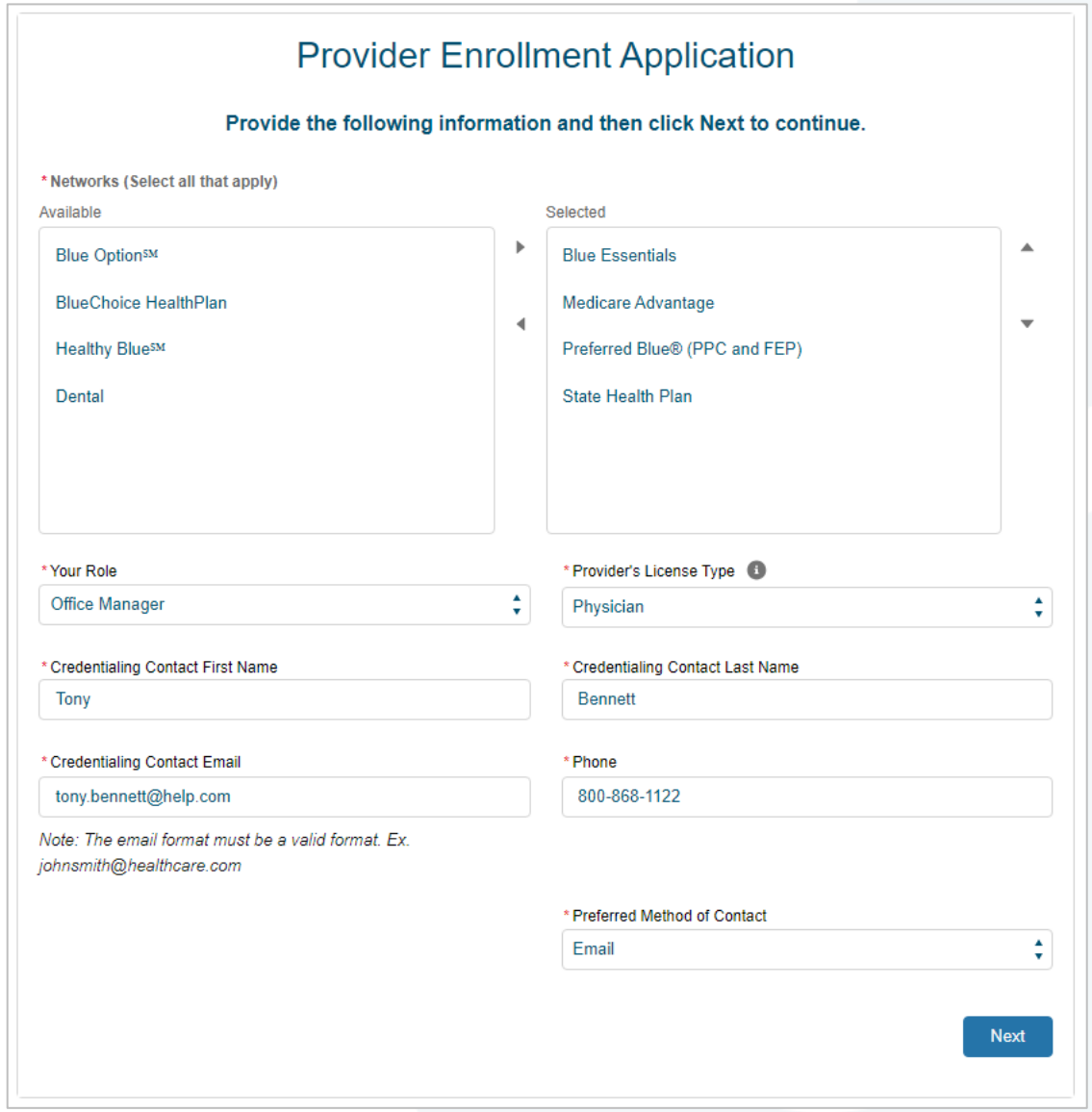
* Credentialing Contact Email: you@example.com

Note: The email format must be a valid format. Ex. johnsmith@healthcare.com

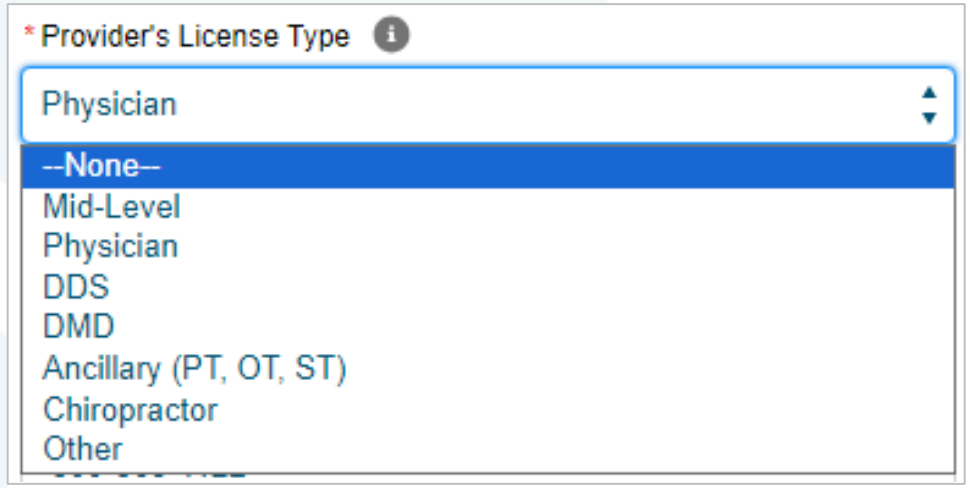
* Phone

* Preferred Method of Contact: --None--

Completing Clean Applications



Available license types.



Note: Only select "other" if the provider's type is not listed. Also, you MUST have your Medicaid ID number to enroll in the Healthy Blue℠ network.

Completing Clean Applications

Provider Enrollment Application

Applicant Information | Medical/Professional Education | Professional Training | L >

Applicant Information

First Name*
Angelica

Last Name*
Pickles

Middle Initial

Suffix

Maiden Name

Gender(optional): M/F
--select an item--

Race*
White

Ethnicity*
Not Hispanic or Latino

Title (if applicable)

Professional Designation*
MD

Social Security #*
001122334

National Provider ID#*
9632587410

Birth Date (MM/DD/YYYY)*
02/01/1987

Provider Email Address*
angelica.pickles@abctesting.com

ECFMG # (if applicable)

What date will this provider start working for your practice (MM/DD/YYYY)*
11/13/2023

Must match Authorization to Bill.

Language(s) Spoken (other than English)*
× English

What language services are offered through your practice?*
× Telephone

Area(s) of Specialty

Primary*
DERMATOLOGY

Include in Directory
☑

Sub-Specialty
--select an item--

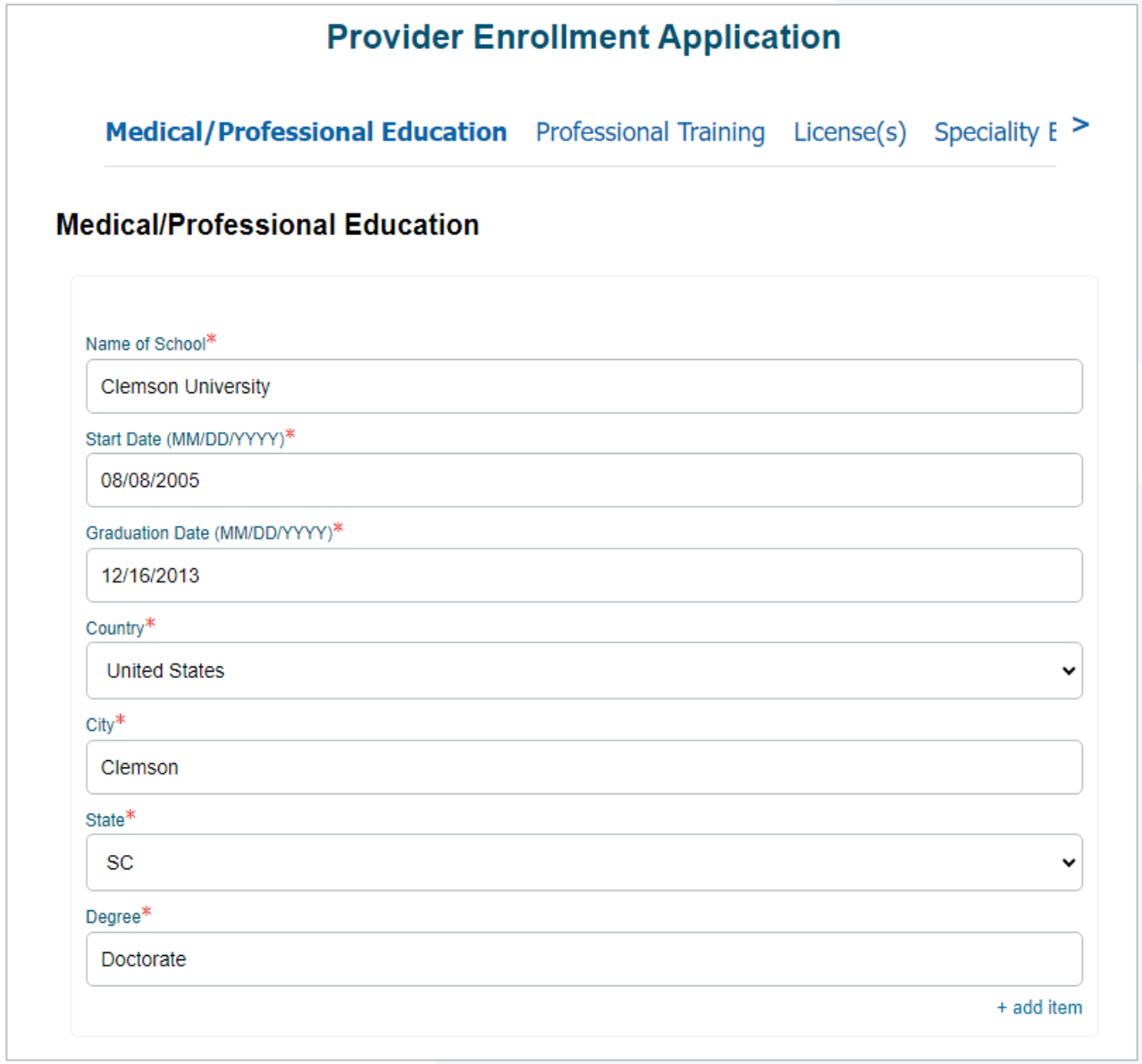
Include in Directory
☐

Primary Taxonomy*
229N00000X

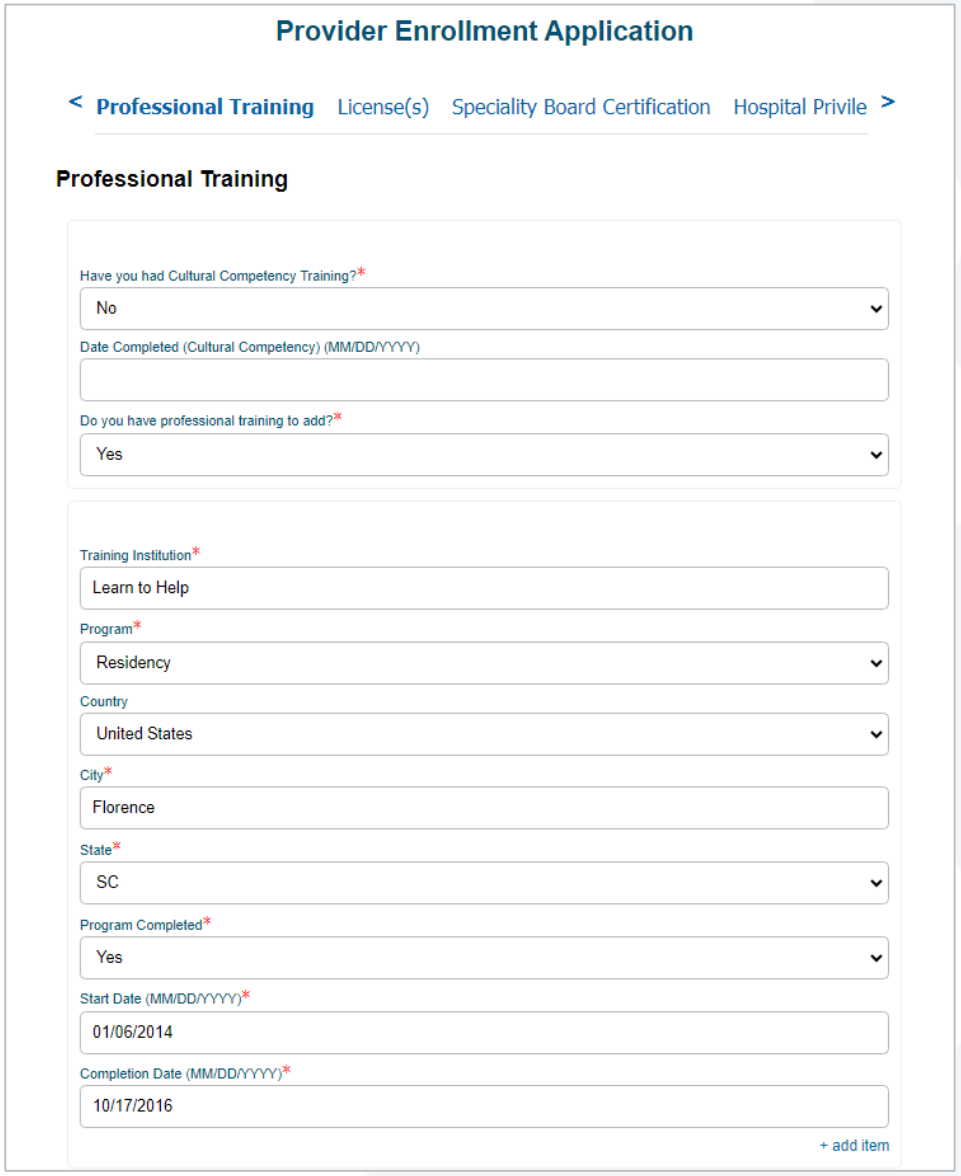
Provider Type*
Specialist

Save & Exit | Next

Completing Clean Applications

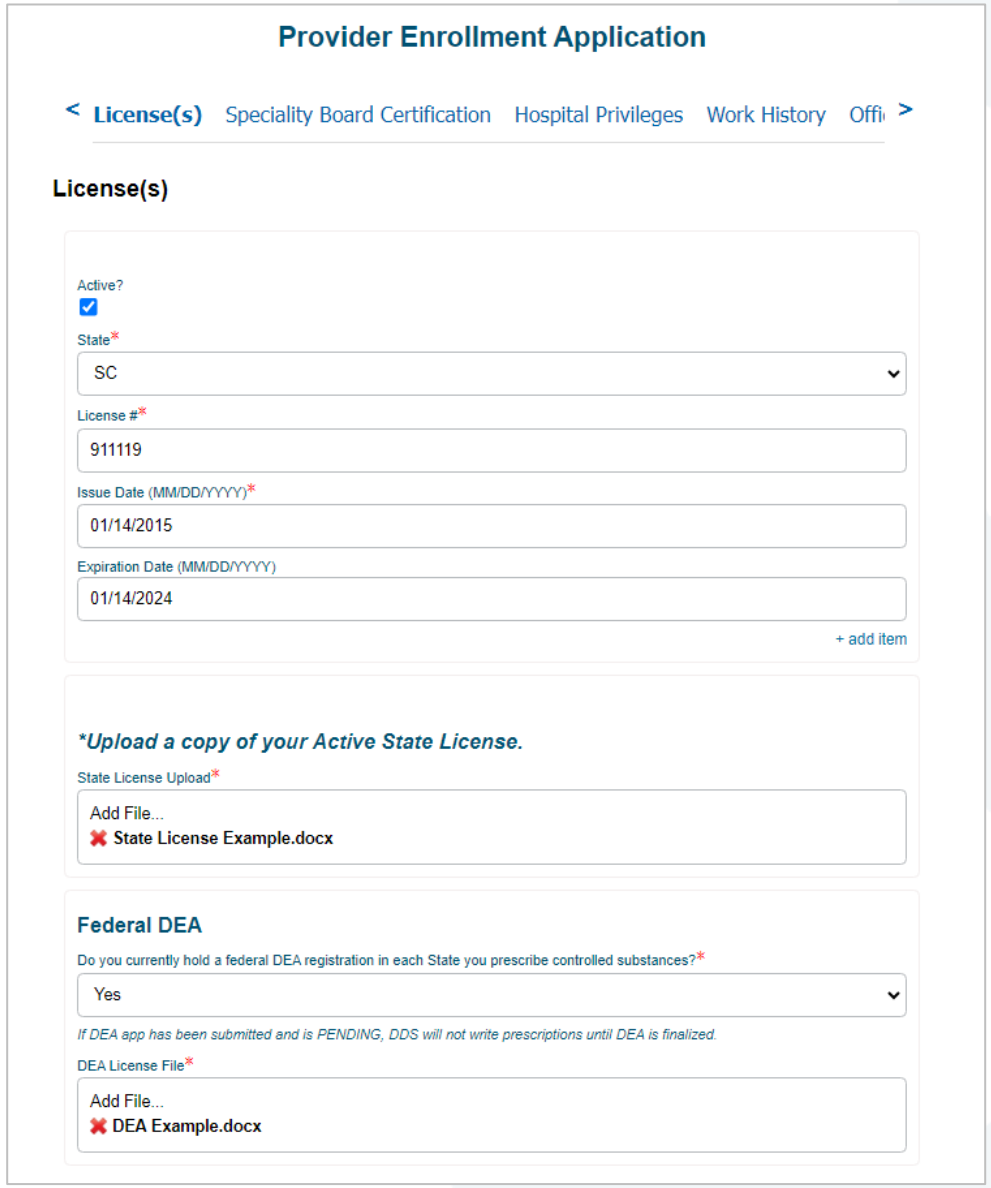


Completing Clean Applications



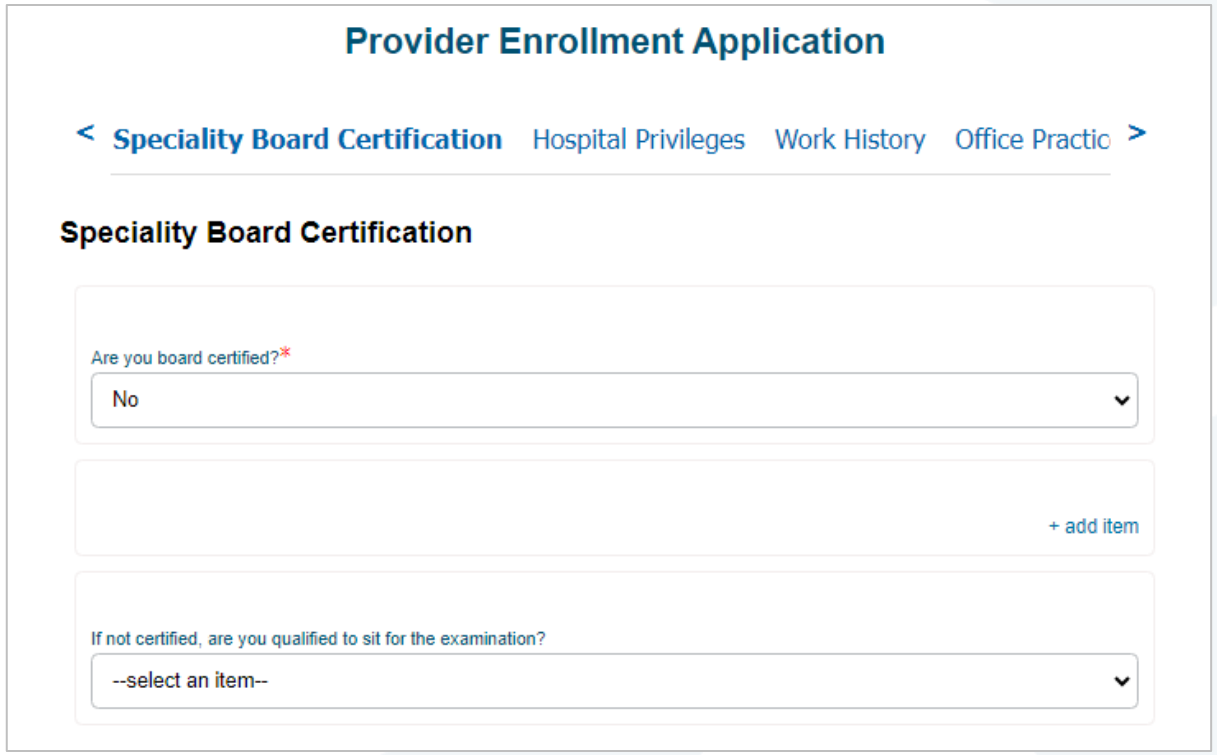
DOs, DPMs and MDs must have a minimum of residency training for credentialing.

Completing Clean Applications



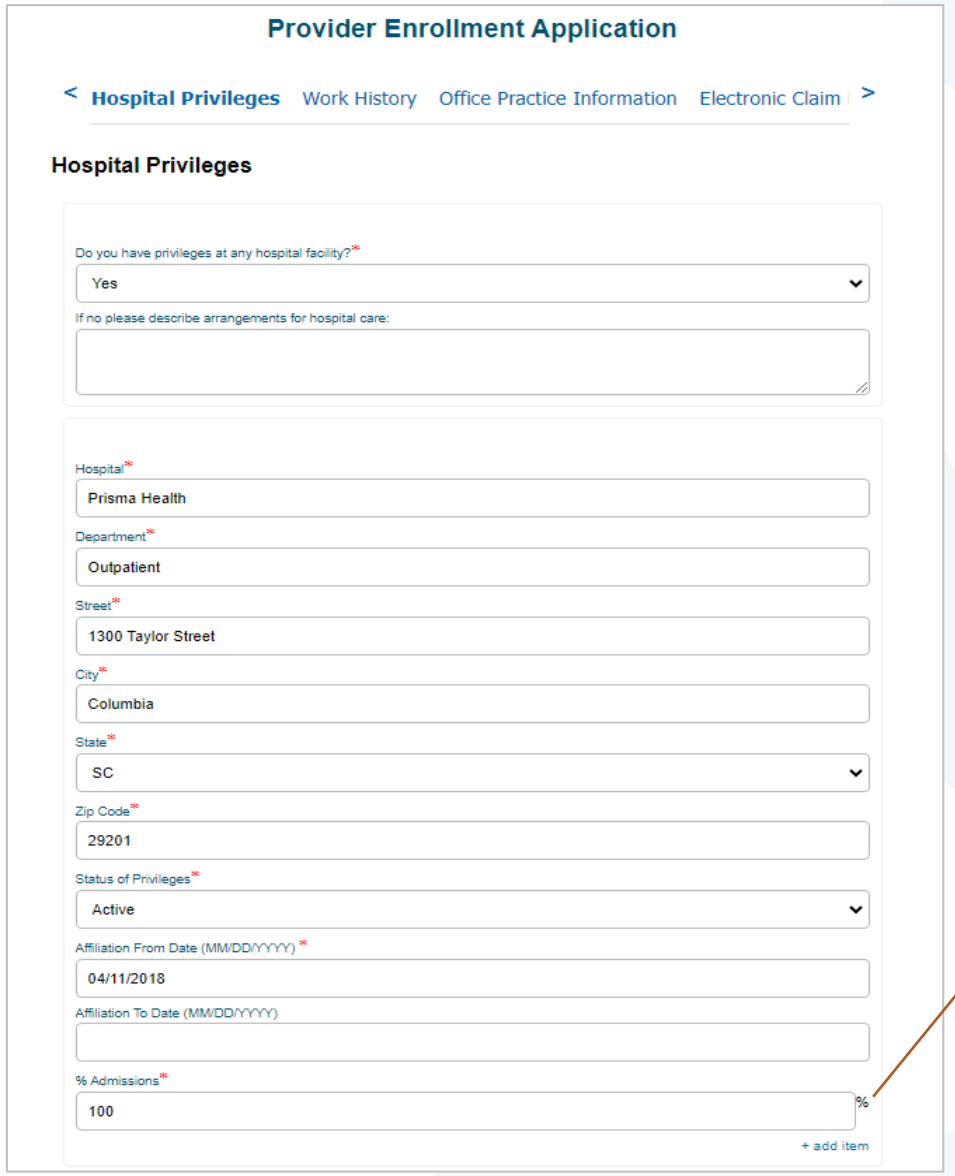
Licenses must be active on or before the requested start date for the practice.

Completing Clean Applications



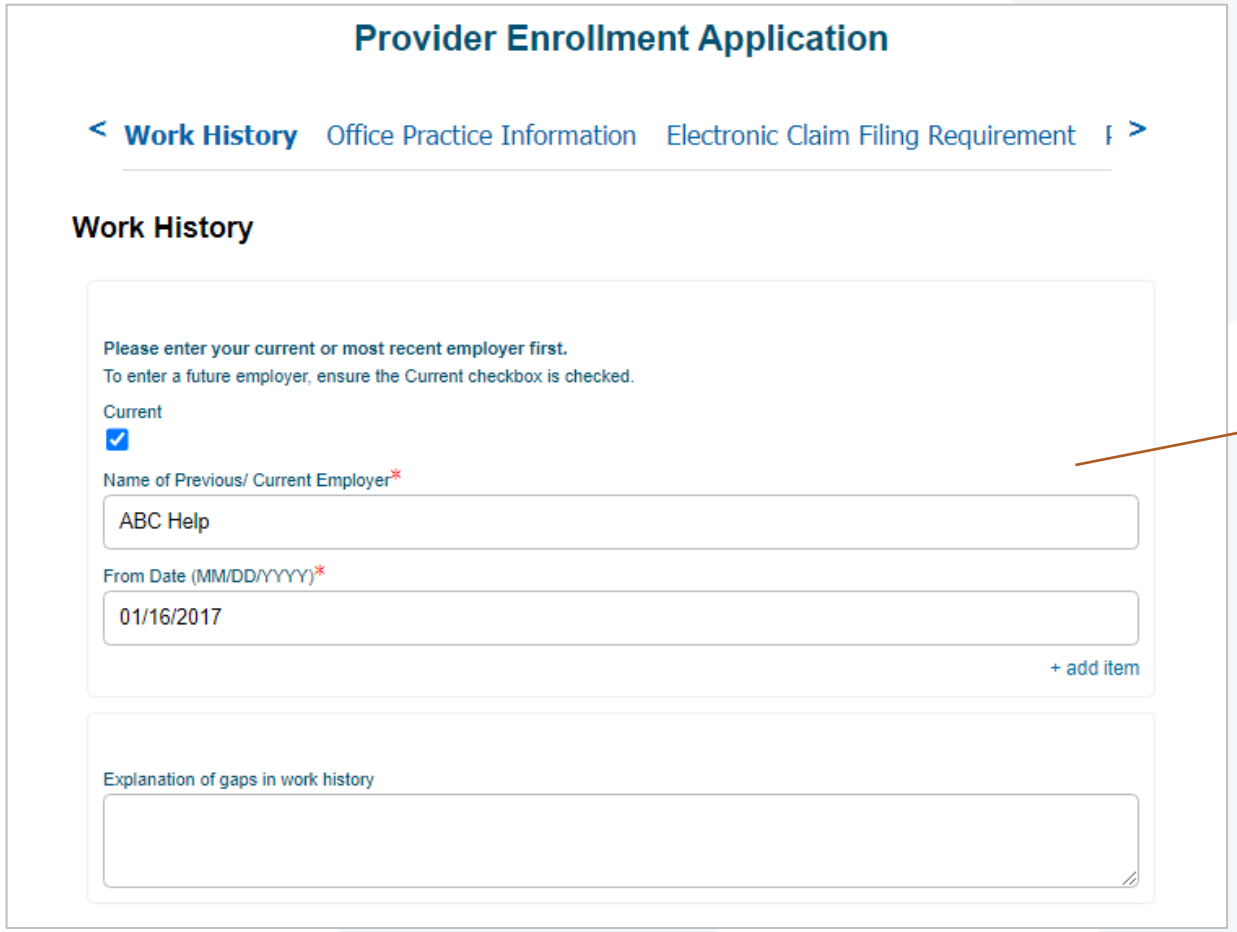
If you select Yes, additional details are required.

Completing Clean Applications



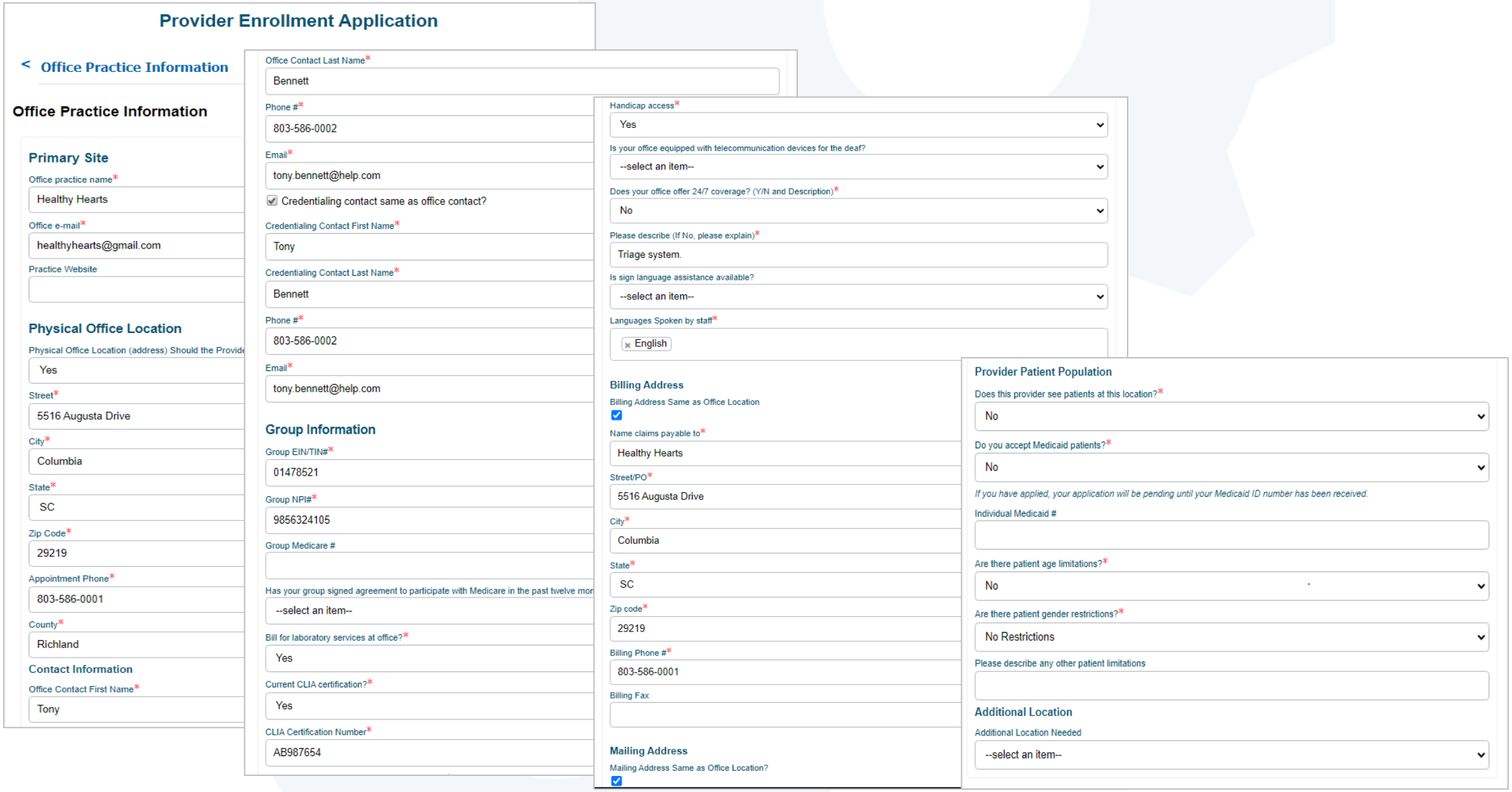
Admissions must total 100 percent. If there are multiple privileges, the TOTAL should be 100 combined, not separately.

Completing Clean Applications



Be sure to select the 'Current' box if the provider is currently working for the practice. Additionally, if their work history does not cover five years, please include an explanation.

Completing Clean Applications



Completing Clean Applications

Provider Enrollment Application

< **Provider Disclosure Information** Malpractice Insurance Auth to Bill You are >

Provider Disclosure Information

If you are filling out this application on behalf of a provider, please skip this section. This section must be completed by the provider.

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

1. Do you have any pending misdemeanor or felony charges?*
No

2. Have you ever been convicted of a felony?*
No

3. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited?*
No

4. In the past five years and up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?*
No

5. Considering the essential functions of a practitioner in your area of practice is the past five years and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients?*
No

6. Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board?*
No

7. Has your DEA certification or state-controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?*
No

8. Have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, not renewed or otherwise limited?*
No

9. Has your participation in Medicare, Medicaid, or any other government program ever been limited, curtailed or have you voluntarily excluded yourself from any of these programs?*
No

10. Has your participation in an Insurance Company network ever been limited or terminated?*
No

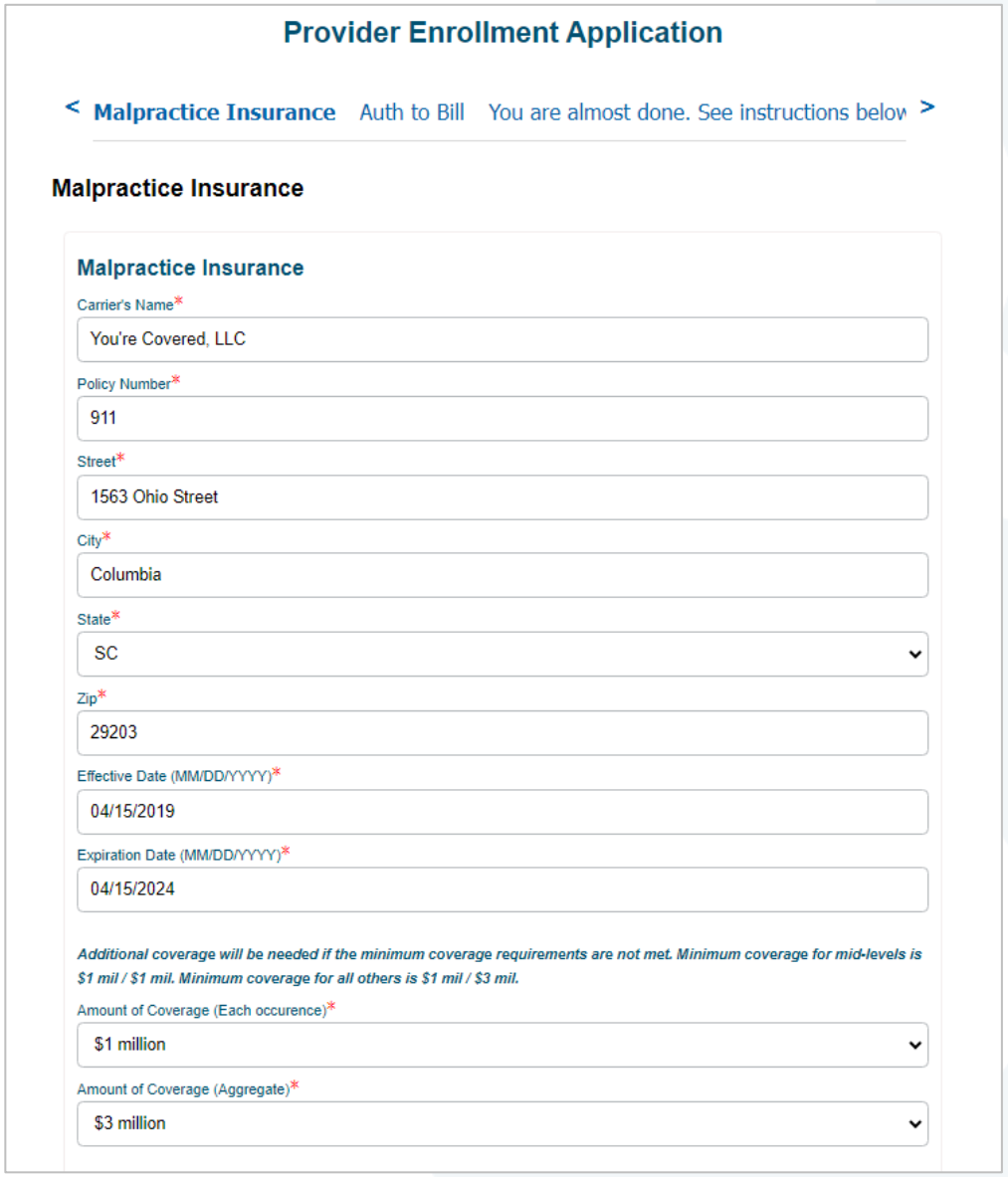
11. In the past five year and up to the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?*
No

12. In the past five years and up to and including the present, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?*
No

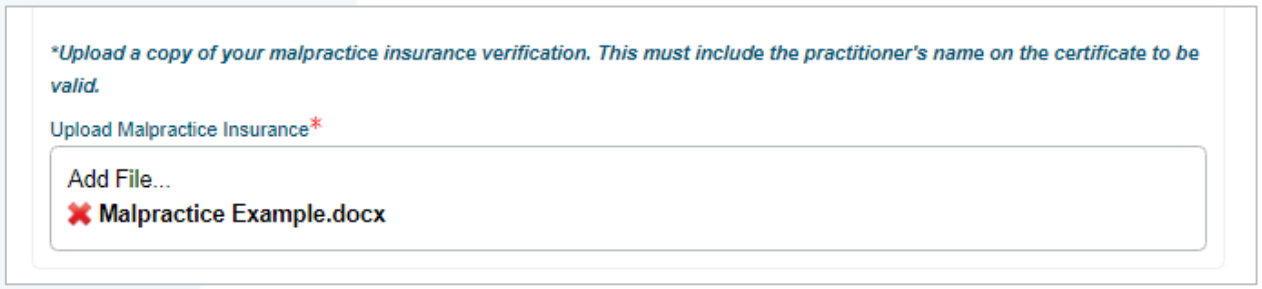
13. Has any malpractice carrier ever made an out-of-court settlement or paid a judgement of a medical malpractice claim on your behalf or are any medical malpractice suits pending against you?*
No

14. Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to obtain coverage?*
No

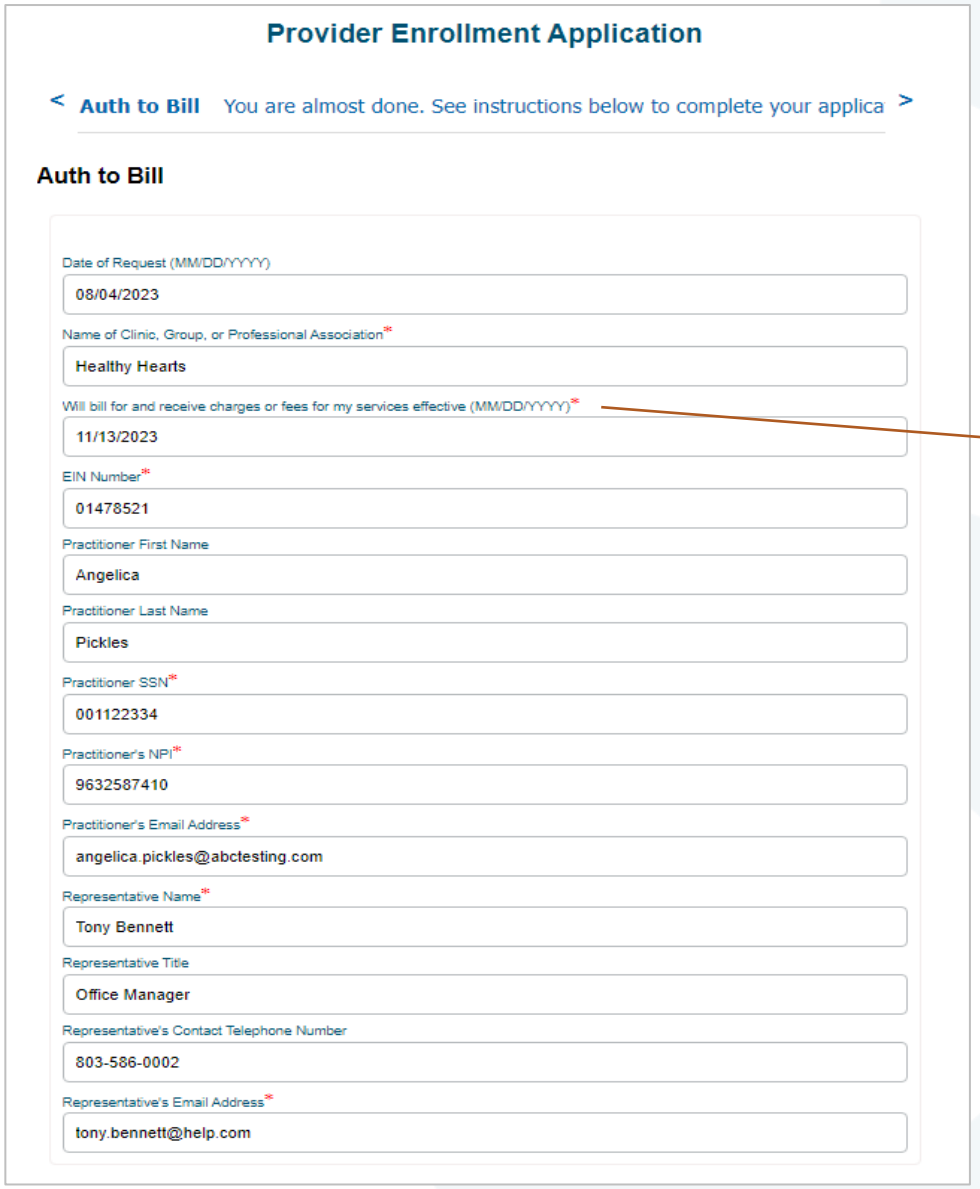
Completing Clean Applications



Malpractice must be current and active on or before the requested start date for the practice.



Completing Clean Applications



Provider Enrollment Application

< Auth to Bill You are almost done. See instructions below to complete your applica >

Auth to Bill

Date of Request (MM/DD/YYYY)
08/04/2023

Name of Clinic, Group, or Professional Association*
Healthy Hearts

Will bill for and receive charges or fees for my services effective (MM/DD/YYYY)*
11/13/2023

EIN Number*
01478521

Practitioner First Name
Angelica

Practitioner Last Name
Pickles

Practitioner SSN*
001122334

Practitioner's NPI*
9632587410

Practitioner's Email Address*
angelica.pickles@abctesting.com

Representative Name*
Tony Bennett

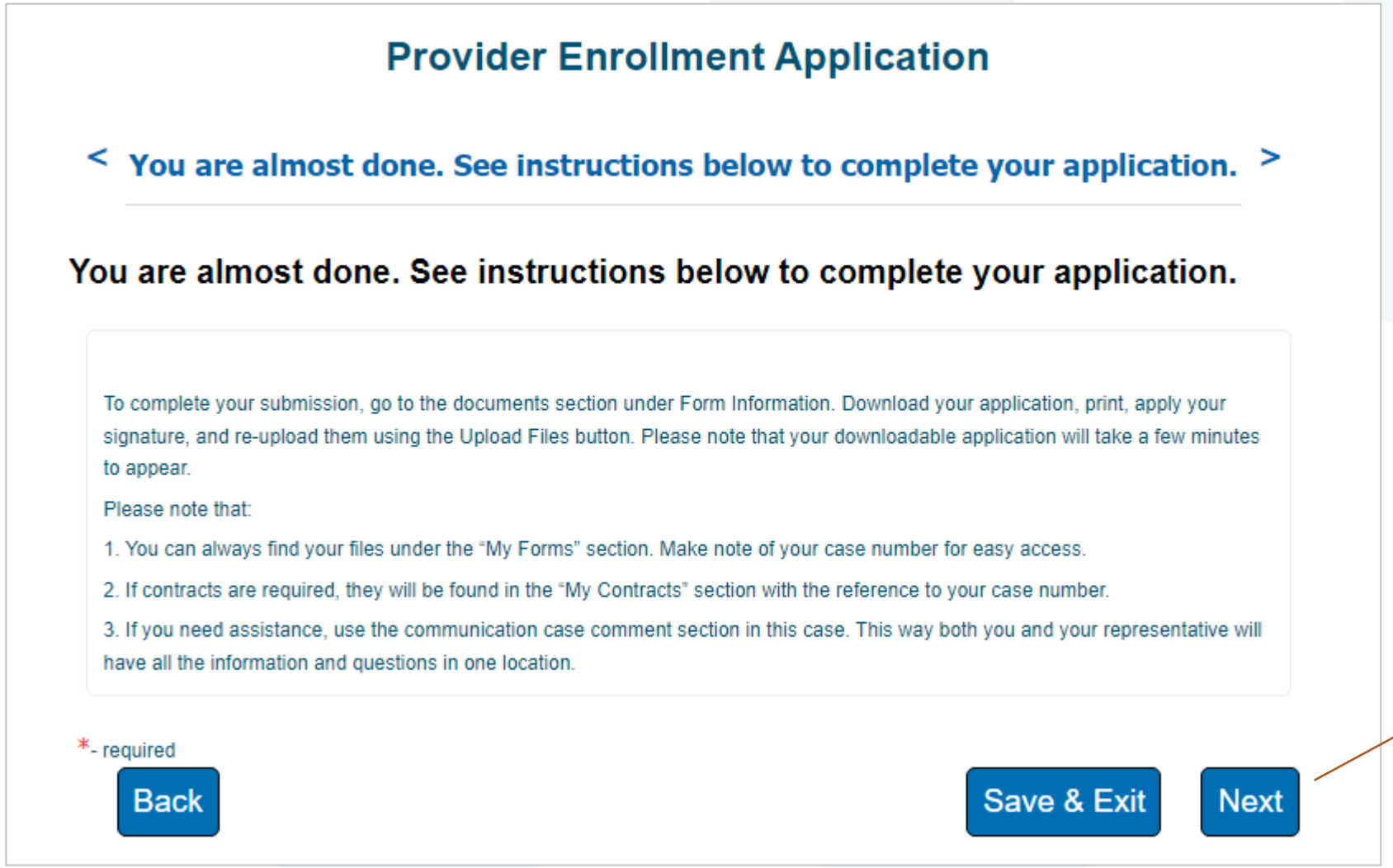
Representative Title
Office Manager

Representative's Contact Telephone Number
803-586-0002

Representative's Email Address*
tony.bennett@help.com

Must match the requested start date with the practice on page one of the application.

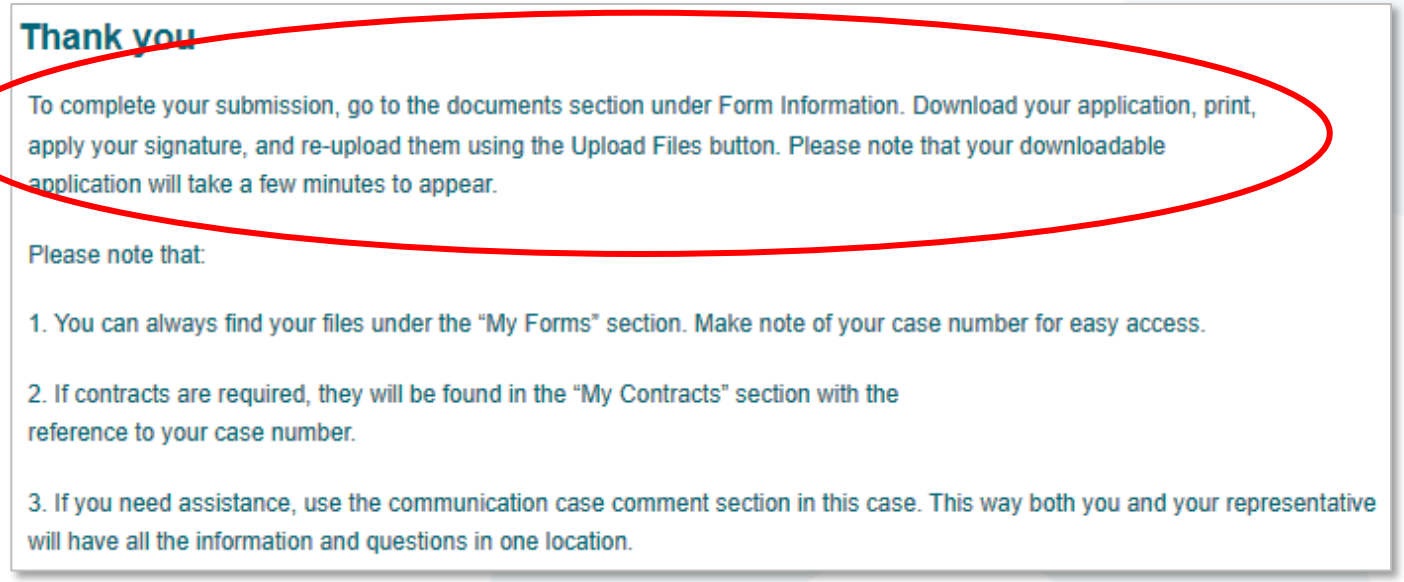
Completing Clean Applications



Select Next.

My Provider Enrollment Portal Overview

Next Steps for Medical Documents That Must Be Signed



For applications and forms (electronic or wet signature)

1. Select My Forms.
2. Select the appropriate case number.
3. Select Form Information.
4. Under Documents, select the document(s) that require signature.
5. Download the document(s) and have the signature(s) appended.
6. Scan the signed documents and follow steps 1 – 4 and select Upload Files.
7. Select the Confirm button to attest that **all required documentation with applicable signatures, initials and dates** have been uploaded.

For contracts (wet signature)

1. Select My Contracts.
2. Select the appropriate form contract name that corresponds with your case number.
3. Under Download Contract, select the link to download and sign the contract.
4. Follow steps 1 – 2 and select Upload Files.

My Provider Enrollment Portal Overview

Next Steps for Behavioral Health Documents That Must Be Signed

Thank you for your submission!

There are two options to sign and return **applications/documents**. They can be **wet signed** or they can be **e-signed**.

Signatures for Applications/Documents

An email will be sent to the individual practitioner for signature of their enrollment application allowing them to e-sign the application. However, as the credentialing contact, you also have the option to download the application, have the individual practitioner sign the application and upload the signed application to the case. See steps listed below. As the credentialing contact, you will receive a copy of the signed application.

For other documents and forms, if you wish to e-sign, an email will be sent from BCBS Admin at BCBS of SC (Formstack) requesting signatures. Once e-signed and submitted, we will receive your signed documents and begin processing your request. (Note: you will also receive an email containing the signed documents for your records.)

If you wish to wet sign the application/document, please see the instructions below.

1. Select "My Forms" from the MyPep options
2. Select the appropriate case number
3. Select Form Information
4. Under Documents at the bottom of the page, select the application/document requiring signature
5. Select Download at the top of the page
6. Print and sign the application/document
7. To upload the signed application/document, follow steps 1 and 2 above and click on Upload Files

Signatures for Contracts

Contractual agreements may be e-signed or wet signed. Wet signed document are required to be downloaded, signed, and uploaded into the MyPep Tool. To submit signed contracts, please see these instructions.

1. Select "My Contracts" from the MyPep options
2. Sort on "All Contracts"
3. Locate your case number and click on corresponding "Form Contract Name"
4. This will take you to a page containing a link to the document.
5. Print and sign the document. Save the signed document to your computer.
6. To upload the signed document, follow steps 1 and 2 above and click on Upload Files.

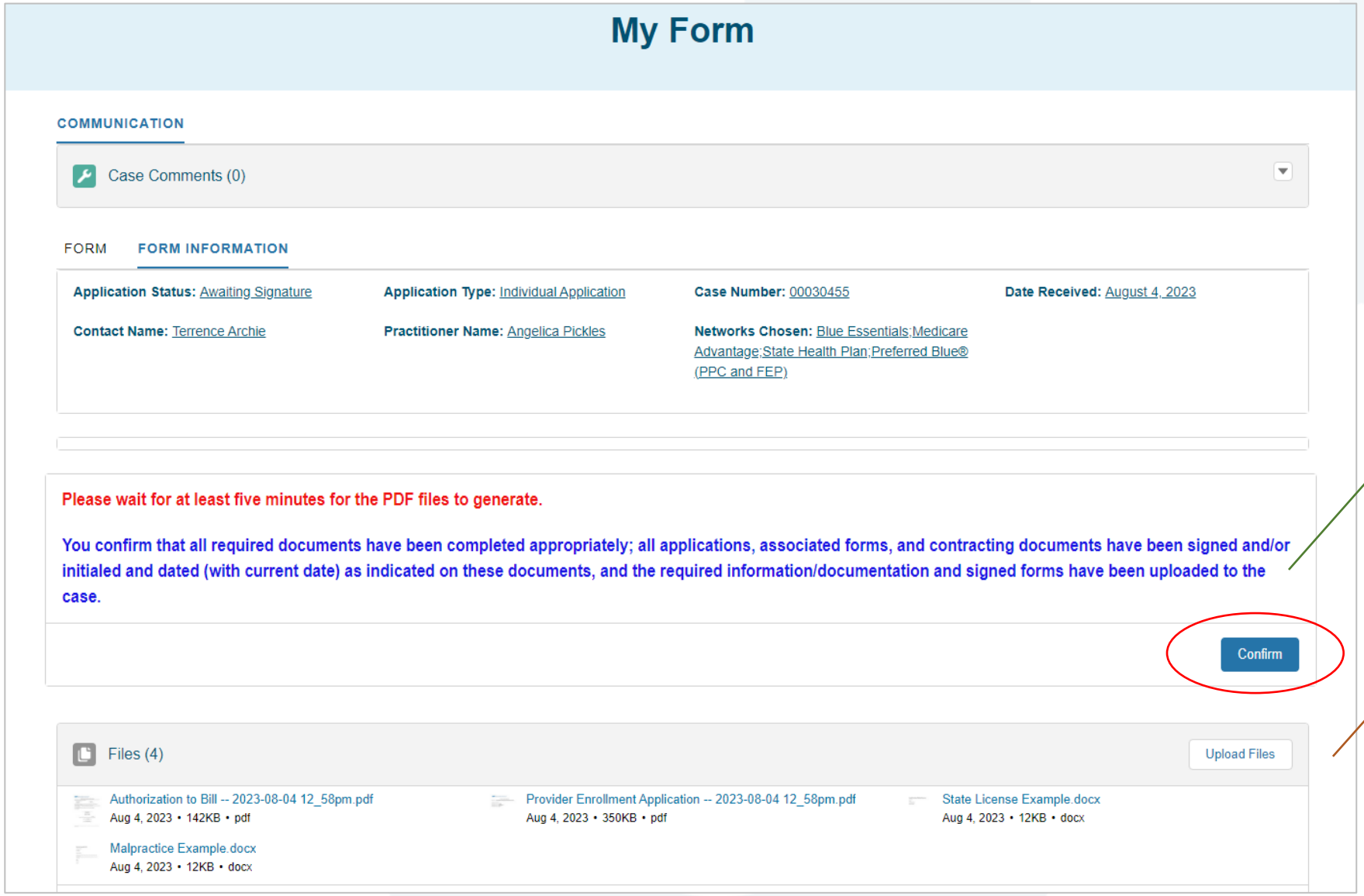
For applications (if wet signing)

1. Select My Forms.
2. Select the appropriate case number.
3. Select Form Information.
4. Under Documents, select the document(s) that require signature.
5. Download the document(s) and have the signature(s) appended.
6. Scan the signed documents and follow steps 1 – 4 and select Upload Files.
7. Select the Confirm button to attest that **all required documentation with applicable signatures, initials and dates** have been uploaded.

For contracts (if wet signing)

1. Select My Contracts.
2. Select the appropriate form contract name that corresponds with your case number.
3. Under Download Contract, select the link to download and sign the contract.
4. Follow steps 1 – 2 and select Upload Files.

Completing Clean Applications



Only select this button AFTER the documents have generated and all required items have been uploaded.

If some of your files do not generate, Select Upload Files to add any missing documents.

Completing Clean Applications

FORM **FORM INFORMATION**

Application Status: Submitted

Application Type: Individual Application

Case Number: 00030455

Date Received: August 4, 2023

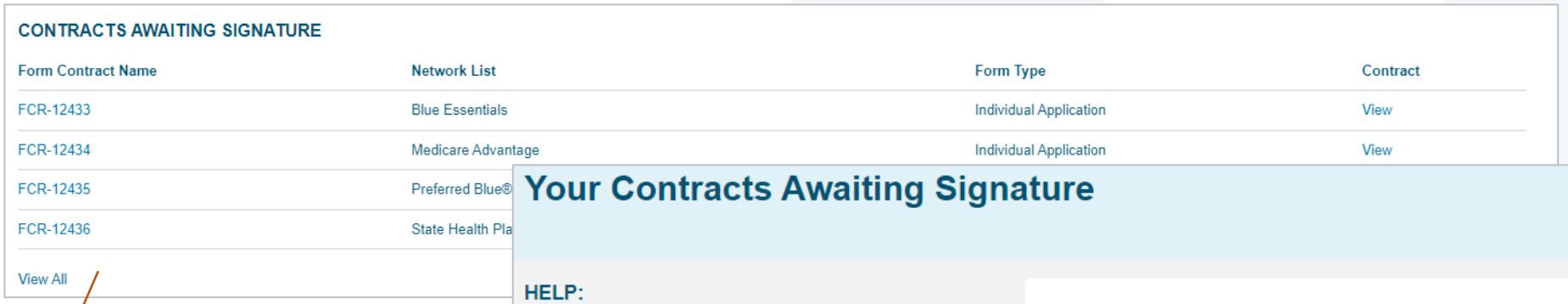
Contact Name: Terrence Archie

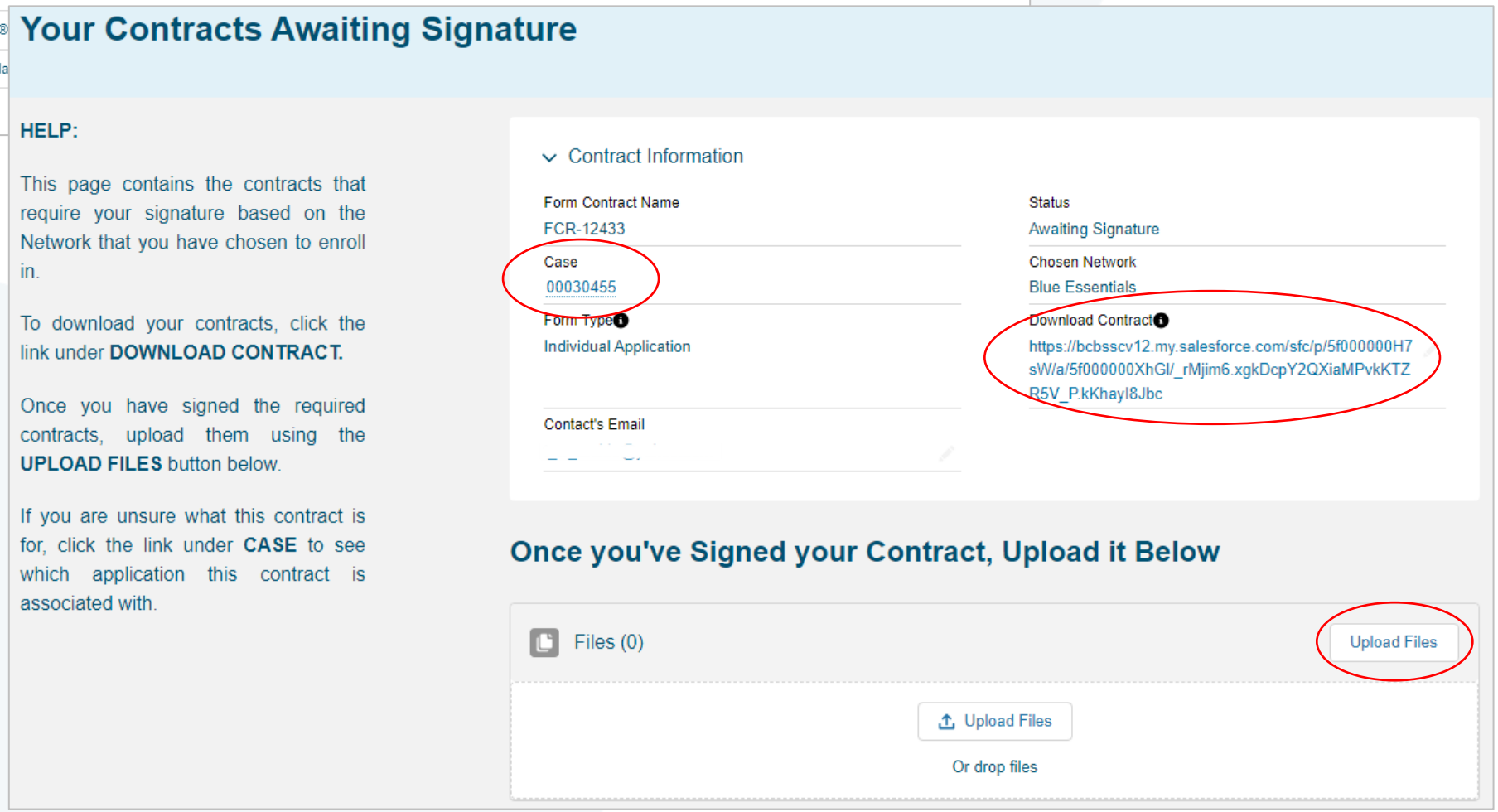
Practitioner Name: Angelica Pickles

Networks Chosen: Blue Essentials;Medicare Advantage;State Health Plan;Preferred Blue® (PPC and FEP)

Thank you for uploading your documents.

Completing Clean Applications





Remember to download, sign and upload the contracts to your case.

Making Corrections to Applications

Making Corrections to Applications

Correcting Applications

- All corrections must be made in the portal.
  - Allows the system to track the corrections and applies them to the appropriate fields
  - The newly generated documented will have the corrections and should be printed, signed, dated and initialed.
- Handwritten corrections will not be accepted and will be returned.

Making Corrections to Applications

Below is the information we are missing:

Here are your next steps:

1. If you are **ONLY** correcting information in the application:

- **CLICK** the Form tab to make your corrections in the application.
- **CLICK** the **NEXT** button at the bottom of each section.
- **AFTER** clicking the last **NEXT** button, **WAIT** until the new forms generate
- **DOWNLOAD** the updated PDFs to have them signed.

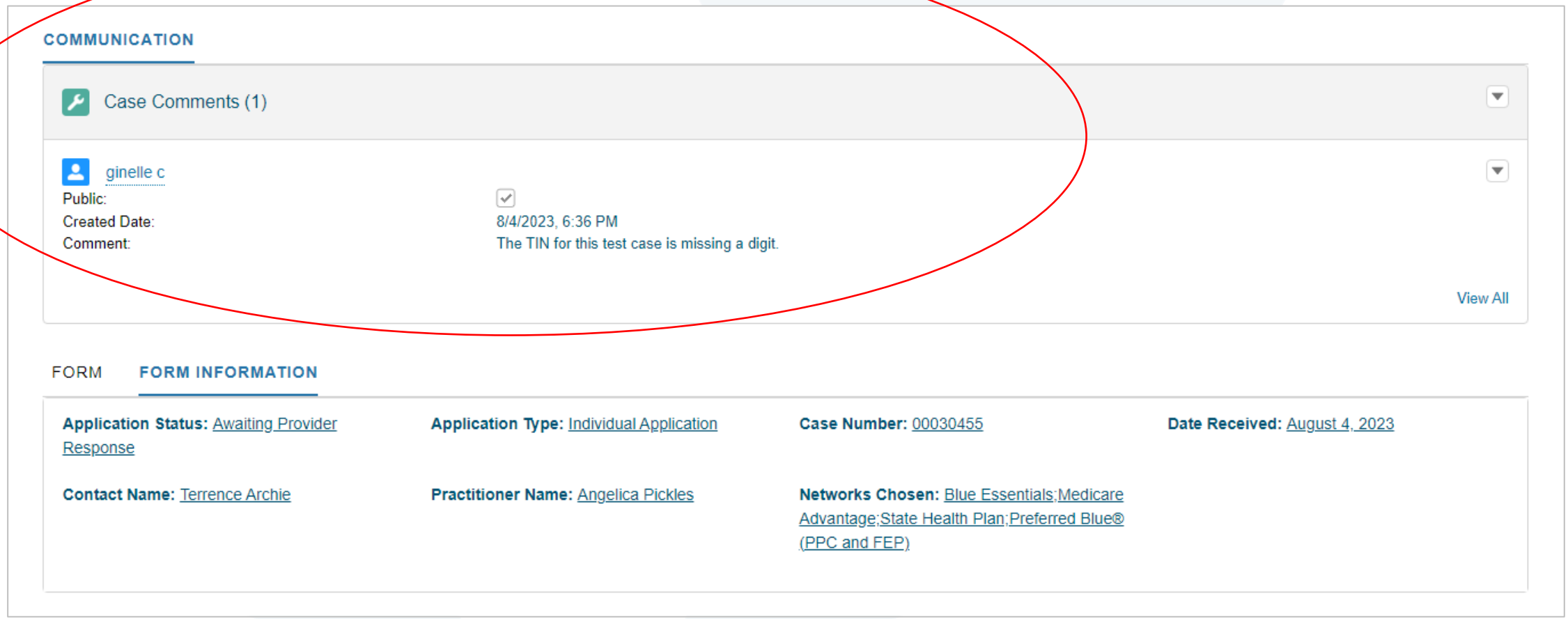
2. If you are **ONLY** uploading files and **DID NOT** correct any information in the application:

- **UPLOAD** your files **FIRST.**
- **CLICK** the **CONFIRM** button below the Documents section.

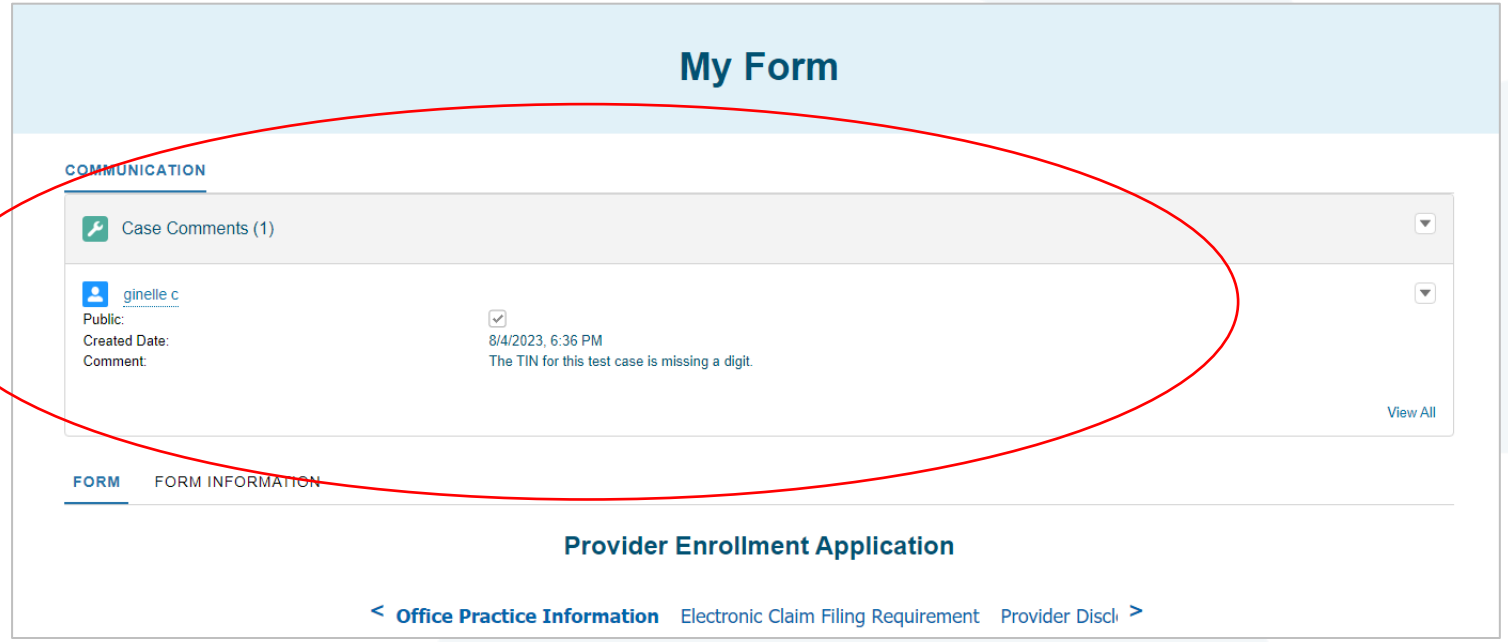
3. If you are correcting information in the application **AND** uploading files:

- **CORRECT** the information in the form like in Step 1 **FIRST.**
- **UPLOAD** the applicable files after the new PDFs are generated like in Step 2.
- **AFTER** your signed documents have been uploaded, click the **CONFIRM** button below the Documents section.

Making Corrections to Applications



Making Corrections to Applications



Resources and Helpful Tips

Resources and Helpful Tips

Available Resources

Visit www.SouthCarolinaBlues.com.

My Provider Enrollment Portal Manual

Providers>Tools and Resources>Guides>My Provider Enrollment Portal

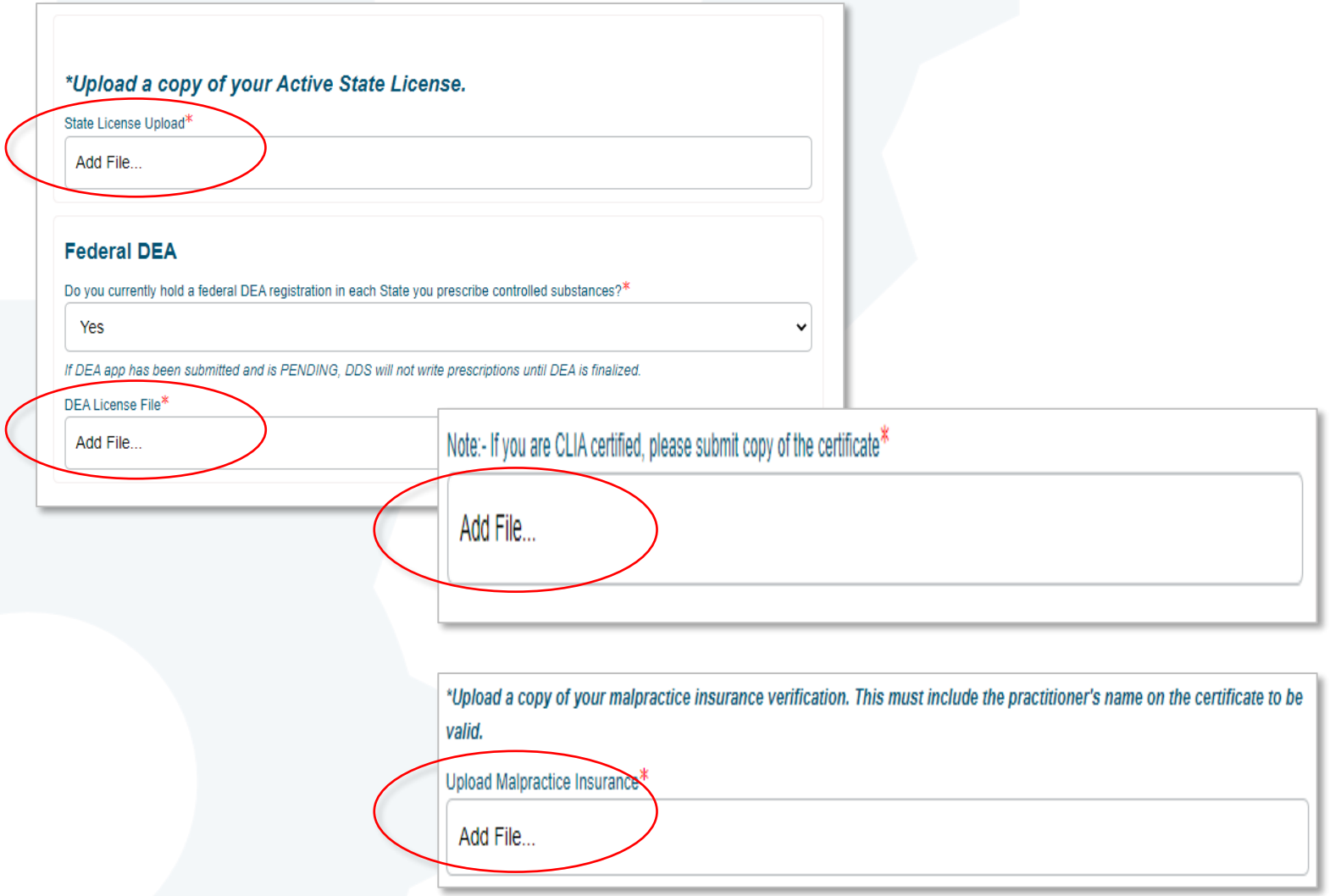
My Provider Enrollment Portal FAQs

Providers>Tools and Resources>Frequent Questions>My Provider Enrollment Portal

Resources and Helpful Tips

Helpful Tips — File Uploads

- When you have a prompt to “Add file,” be sure to upload the corresponding item.
  - Applies to licenses and certificates.
- This helps ensure the document is included with the application and promotes a clean application.



Resources and Helpful Tips

Missing items — submit missing items as soon as possible.

- If items are missing, the application will be placed in the “Awaiting Signature” or “Awaiting Provider Response” status.
- An automated notification for missing items is sent every seven days until the missing information is received.
  - Outreach is made on:
    - Day 7 – First request
    - Day 14 – Second request
    - Day 21 – Third (final) request
- If the missing items are not received, the case will be placed in the “Canceled — Incomplete Submission” status.
  - Once in this status, it cannot be reopened, and a new application must be completed.

Pharmacy

Back To Basics

Agenda

- Formulary Updates
  - Commerical (BlueCross and BlueChoice)
    - Lowest Net Cost (LNC) Formulary
    - Premium Formulary
  - Exchange
  - Medicare
  - Healthy Blue Medicaid

Formulary Updates

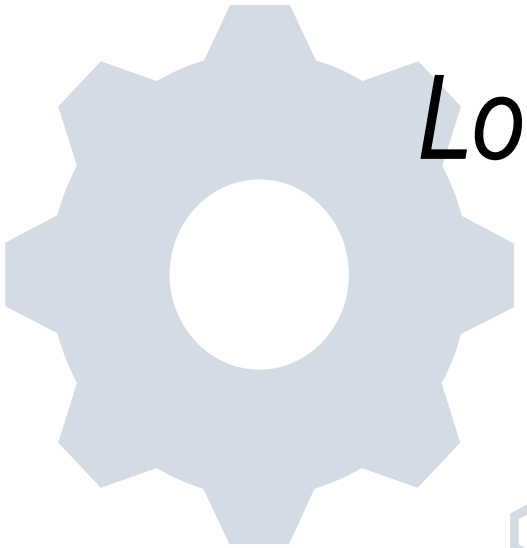
Commercial, Exchange, Medicare and Medicaid

Back To Basics

Commercial

BlueCross and BlueChoice

Lowest Net Cost Formulary Updates



Back To Basics

Lowest Net Cost Formulary Updates

- Additions
  - Effective Jan. 1, 2024, the following drugs will be added:

Product	Formulary Status
Uzedy^	Non-Preferred
Veozah*#	Non-Preferred
Vowst*#	Non-Preferred

*** Requires Prior Authorization | # Quantity Limit | ^ Step Therapy**

Lowest Net Cost Formulary Updates

Exclusions

- Effective Jan. 1, 2024, the following drugs will move to non-formulary status.
- The products listed have alternatives on the formulary, many times, at a lower cost to the member.

Non-Formulary Exclusion

- *Some covered alternatives may require prior authorization (PA).*
  - ✓ Advair Diskus
  - ✓ Airsupra
  - ✓ Flovent Diskus/HFA
  - ✓ Trokendi XR
  - ✓ Zavzpret

Excluded

- ✓ Qalsody

Lowest Net Cost Formulary Updates

Prior Authorization

Effective Jan. 1, 2024, the following drug will require prior authorization:

- ✓ Saxenda

Quantity Limits

Effective Jan. 1, 2024, the following drug will have quantity limits:

- ✓ Wegovy — 4 pens per 28 days

Lowest Net Cost Formulary Updates

Influenza and RSV Vaccines

- Members of non-grandfathered groups have flu vaccine coverage for a $0 member copay.
- Grandfathered groups can elect seasonal vaccine coverage at either a $0 or associated plan copay.

Covered RSV Vaccines	
Abrysvo*	Beyfortus ^
Arexvy**	

** Only approved for those ≥ 60 years old and in pregnancy at 32-36 weeks*
*** Only approved for those ≥ 60 years old*
^ Only approved for neonates and up to 24 months old

Covered Flu Vaccines	
Afluria Quadrivalent	Fluad Quadrivalent*
Fluarix Quadrivalent	Flublok Quadrivalent
Flucelvax Quadrivalent	Flulaval Quadrivalent
Flumist Quadrivalent Intranasal**	Fluzone High-Dose PF*
Fluzone Quadrivalent	

** Only approved for those aged 65 years and older*
*** Only approved for those aged 2-49 years.*

Lowest Net Cost Formulary Updates

Continuous Glucose Monitors (CGM) Dexcom and Freestyle Libre Meters

Updated PA Criteria

- The prior authorization (PA) criteria for Dexcom and Freestyle CGMs will be updated to allow coverage for all members currently utilizing insulin. This is based on recommendations in the 2023 American Diabetes Association guidelines that CGMs be offered to individuals using intensive insulin therapy as well as basal insulin users that are capable of using the devices safely.
- “Smart PA” technology will be utilized to allow coverage for members with an insulin claim in the preceding 180 days without a formal PA request needing to be submitted.
- The PA criteria will also allow coverage for members using non-insulin anti-diabetic medication that have frequent recurring episodes of hypoglycemia (less than 70 mg/dL) despite appropriate modifications to medication, hypoglycemia unawareness, episodes of ketoacidosis, or hospitalization for uncontrolled glucose levels.
- The PA requirement will be moved to the **sensor** component of the CGM system. This change is being made as the sensor is the one component of every CGM system needed by all utilizers.

Commercial

Premium Formulary Updates

Back To Basics

Premium Formulary Updates

- Additions
  - Effective Jan. 1, 2024, the following drugs will be added:

Product	Formulary Status
QVAR	PREFERRED
Udencya	NON-PREFFERED BRAND
Insulins by Lilly: Insulin lispro, Basaglar, and Rezvoglar	PREFERRED
Insulins by Novo: Novolog, Novolin, and Fiasp	PREFERRED
Insulins by Sanofi: Admelog and Apidra	PREFERRED
Humira Biosimilars: Adalimumab-adaz, Cyltezo, Hyrimoz	PREFFERED BRAND SPECIALTY

*** Requires Prior Authorization | # Quantity Limit | ^ Step Therapy**

Premium Formulary Updates

Exclusions

- Effective Jan. 1, 2024, the following drugs will move to non-formulary status.
- The products listed have alternatives on the formulary, many times, at a lower cost to the member.
  - *Some covered alternatives may require PA.*

- ✓ ADVAIR DISKUS
- ✓ AMPYRA
- ✓ AUBAGIO
- ✓ COPAXONE INJ
- ✓ ESBRIET
- ✓ FLOVENT HFA/DISKUS
- ✓ IMBRUVICA TABLETS
- ✓ LATUDA
- ✓ PULMICORT FLEXHALER
- ✓ REVATIO
- ✓ TROKENDI XR
- ✓ VYVANSE
- ✓ XALKORI
- ✓ XYOSTED
- ✓ XYREM
- ✓ HUMIRA BIOSIMILARS: ADALIMUMAB-FKIP, HADLIMA, HULIO, IDACIO, YUFLYMAN, YUSIMRY

Premium Formulary Updates

Prior Authorization

Effective Jan. 1, 2024, the following drug will require prior authorization:

- ✓ Nocdurna

Premium Formulary Updates

Step Therapy

Effective Jan. 1, 2024, the following products will have a step therapy requirement added or updated:

Added	Step 1	Updated	Step 1
Pylera	Generic bismuth subcitrate-metronidazole-tetracyline	Azstarys	Any one of the following generics: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER
Symbicort	Any two of the following generic or preferred brands: budesonide/formoterol, Advair HFA, Breo Ellipta	Adderall XR	Any three of the following generics: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER
Wixela and formoterol/salmeterol	Any one of the following generic or preferred brands: budesonide/formoterol, Advair HFA, Breo Ellipta	Aptensio XR, Concerta, Jornay PM, Methylin, Relexxi	Any three of the following generics: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER
Evekeo	Any three of the following generics: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER	Desoxyn	Any three of the following generics: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER
Dexedrine, Procentra	Any three of the following generics: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER		

Exchange

Back To Basics

Exchange Formulary Updates

Key Formulary Additions

Product	Formulary Status
Dexcom and Freestyle Libre Continuous Glucose Monitors	Preferred Brand Tier with PA
Mounjaro	Preferred Brand Tier with PA
Vraylar	Non-Preferred Drug Tier with PA
Ubrelvy	Preferred Brand Tier with PA
Humira Biosimilars (Hadlima & adalumamab- adaz)	Preferred Brand Tier with PA
Viracept	Non-Preferred Specialty Tier
Xofluza	Non-Preferred Drug Tier with Quantity Limit

Exchange Formulary Updates

Quantity limits

Effective Jan. 1, 2024, the following products will have changes to quantity limits:

- Actemra
- Cibinqo
- Cimzia
- Dilaudid
- Enbrel
- Humira,
- hydromorphone
- Orencia
- Otezla
- Rinvoq
- Simponi
- Skyrizi
- Taltz
- tramadol
- tramadol/acetaminophen
- Tremfya
- venlafaxine
- Xeljanz/Xeljanz XR

Prior Authorization

Effective Jan. 1, 2024, the following products will require prior authorization:

- Byetta
- Mounjaro
- Ozempic
- Rybelsus
- Trulicity
- Victoza

Exchange Formulary Updates

Step Therapy

- Effective Jan. 1, 2024, the following product will have a step therapy requirement added:

Product	Step 1
Pradaxa	Generic dabigatran

Uptiers

- Effective Jan. 1, 2024, the following products will be covered at a higher tier:

Product	2023 Tier	2024 Tier
Pradaxa	Preferred Brand Tier	Non-Preferred Drug Tier
Dotti/Lyllana/Estradiol Biweekly Patch	Generic Tier	Non-Preferred Drug Tier
fluorouracil cream	Generic Tier	Non-Preferred Drug Tier
Fesoterodine ER	Generic Tier	Non-Preferred Drug Tier
hydrocortisone valerate cream	Generic Tier	Non-Preferred Drug Tier

Exchange Formulary Updates

Key Formulary Removals:

- Effective Jan. 1, 2024, the following products will be moving to Non-Formulary status:

Products Removed	Formulary Alternative (s)
Mavyret	Epclusa, Harvoni, Zepatier, ribavirin
Viibryd	Generic vilazodone
Veltassa	Sodium polystyrene sulfonate, SPS
Zioptan and Rocklatan	Latanoprost, Lumigan, tafluprost, travoprost
Xiidra and Restasis	Generic cyclosporine ophthalmic
Latuda	Generic lurasidone
IVIG Products: Bivigam, Cuvitru, Flebogamma, Gammaplex, Hyqvia, Octagam, Privigen	Gammagard, Gammaked, Gamunex-C, Gamastan, Hizentra

Some covered alternatives may require prior authorization (PA).

Pharmacy Benefit to Medical Benefit

- Effective Jan. 1, 2024, the following products will be covered under the Medical benefit only:
  - All hemophilia factor products
  - Strensiq

Healthy Blue Medicaid

Back To Basics

Healthy Blue Medicaid Formulary Updates

Key Formulary Updates:

- Effective Jan. 1, 2024, the following products will be moving to Preferred status:

Therapeutic class	Medication	Formulary status change	Potential alternatives (preferred products)
Colony-Stimulating Factors (G-CSF)	Fulphila	Non-Preferred to Preferred	N/A
Colony-Stimulating Factors (G-CSF)	Ziextenzo	Non-Preferred to Preferred	N/A
Colony-Stimulating Factors (G-CSF)	Nyvepria	Non-Preferred to Preferred	N/A
Nonsteroidal Anti-inflammatory Agents (NSAIDs)	celecoxib (all strengths)	Non-Preferred to Preferred; Remove PA	N/A
Antifungals - Topical	nystatin/triamcinolone ointment	Non-Preferred to Preferred; Remove PA	N/A
Human Insulin	Lantus	Non-Preferred to Preferred; Remove PA	N/A
Human Insulin	Basaglar Kwikpen	Preferred to Non-Preferred; Add PA	Lantus; insulin glargine-yfgn

Medicare

Back To Basics

Medicare Formulary Updates

2024 Key Formulary Changes:

Products Added	Products Removed
Gemtesa	Flovent HFA
Nurtec	Invokana
Orencia	Suprep Bowel Kit
Otezla	Symbicort
Sutab	Victoza

2024 Part D Humira and Biosimilars Coverage:

Covered Products	Formulary Status
Humira	Tier 5 requiring PA with Quantity Limits
Cyltezo	Tier 5 requiring PA with Quantity Limits
Yuflyma	Tier 5 requiring PA with Quantity Limits

Medicare Formulary Updates

Covered Injectable Diabetes Treatment:

GLP-1 Receptor Agonists	Branded Insulins covered
Mounjaro	Humulin/Humalog
Ozempic	Novolin/Novolog
Trulicity	Lantus
	Levemir
	Toujeo
	Tresiba

Key UM Change

- GLP-1s will require Prior Authorization effective 1/1/2024

Pharmacy Resources

Back To Basics

Pharmacy Resources

Specialty Drug Medical Benefit Management

Drug lists can be found on the Precertification and Pharmacy pages of the websites:

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

Access MBMNow via My Insurance Manager when you check the member's benefits.

- Contact information for medical specialty drug authorizations:
  - Phone: 877-440-0089
  - Fax: 612-367-0742

Pharmacy Resources

PreCheck MyScript (PCMS)

PreCheck MyScript (PCMS) is a great tool that functions in real-time to provide:

- Benefit-specific, clinically appropriate, alternative medications.
- Displays savings opportunities at Optum Home Delivery and Optum Specialty Pharmacy.
- Provides members access to the same information via the OptumRx digital tools.

The benefits of using PCMS include:

- $225 average member savings per prescription switch.
- More time with patients with fewer administrative tasks.
- Patient medication adherence and clinical outcomes due to lower costs.

Pharmacy Resources

Commercial and Affordable Care Act (ACA) Plans

- OptumRx Home Delivery Mail Service
  - E-scribe National Council for Prescription Drug Programs (NCPDP)
    - Mail NCPDP ID: 0556540
    - Specialty NCPDP ID: 5732676
- OptumRx Home Delivery
  - Call: 855-811-2218
  - Fax: 800-491-7997
- OptumRx Specialty Pharmacy
  - Call: 877-259-9428
  - Fax: 800-218-3221
- Specialty Medical Benefit Management
  - Call: 877-440-0089
  - Fax: 612-367-0742

Pharmacy Resources

Provider Plan Contact Information

Affordable Care Act (ACA) Plans

- BlueCross
  - ACA Individual Plan Members
    - Call: 855-823-0387
  - ACA Small Group Plan Members
    - Call: 855-819-0955

www.SouthCarolinaBlues.com

Commercial Plans

- View lists of covered drugs, excluded drugs and drug management programs at www.SouthCarolinaBlues.com or www.BlueChoiceSC.com.
- The contact number is listed on the back of the member's ID card.
- For prior authorization, formulary exceptions and general inquiries, call 855-811-2218.

Pharmacy Resources

Medicare Advantage

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

Provider Enrollment

Back To Basics

Agenda

- Provider Enrollment Requirements
- Enrollment Process Overview
- Reminders

Provider Enrollment Requirements

Provider Enrollment Requirements

Enrollment Applications and Forms

Application or form	Used for…
Individual Enrollment	New practitioners that want to enroll with BCBSSC (**not Behavioral Health**)
Group Practice Enrollment	New groups that want to enroll with BCBSSC
Facility Information Request	Medical facilities that want to credential with BCBSSC
Virtual Care Services	Practitioners or groups that want to render telemedicine and telehealth services
Health Professional	In-state, out-of-network practitioners that want to file claims to BCBSSC
Behavioral Health	New practitioners or groups that want to enroll in our behavioral health network
Autism Provider Panel	Applied behavior analysts that want to enroll in our autism provider panel
DBA Name Change	Changing the doing business as (DBA) name of a practice
Change of Address	Updating the physical, pay to, correspondence and billing agency address
Satellite Location	Enrolled groups that have new locations that want to file claims
NPI Provider Notification	Registering an NPI with BCBSSC
Add or Terminate Practitioner	Adding or terminating a practitioner's affiliation with a clinic, group or institution

Provider Enrollment Requirements

What to Include — Individual Enrollment

Checklist Items	Mid-Level	Physician	DDS*
Provider Enrollment Application			
Copy of SC Medical/Practice License			
DEA Certification			Note 1
Current Copy of Malpractice (Min. $1M/$3M)			
Authorization to Bill for Services			
Clinical Lab Improvement Amendments			
Nurse Practitioner Preceptor Form			
Signed Contracts			
Hold Harmless — BlueChoice			
Appendix D — BlueChoice			
Professional Training		Note 2	
Additional Items for Medicaid			
Medicaid ID Number			
Protocols (Written Agreement)	Note 3		

Locate the checklists by visiting www.SouthCarolinaBlues.com.

Providers>Provider Enrollment>Checklists and Signature Requirements

Doctor of Dental Surgery

1. **Only needed if applicable.**
2. **DOs, DPMs and MDs require at minimum residency.**
3. **Only needed for NPs and PAs.**

Note: Shaded fields are required.

Provider Enrollment Requirements

What to Include — Individual Enrollment (Continued)

Checklist Items	DMD*	Ancillary	Chiro
Provider Enrollment Application			
Copy of SC Medical/Practice License			
DEA Certification			
Current Copy of Malpractice (Min. $1M/$3M)			
Authorization to Bill for Services			
Clinical Lab Improvement Amendments	**Note 1**		
Nurse Practitioner Preceptor Form			
Signed Contracts			
Hold Harmless — BlueChoice			
Appendix D — BlueChoice			
Additional Items for Medicaid			
Medicaid ID Number	**Note 1**		
Protocols (Written Agreement)			

Doctor of Dental Medicine

1. Only needed if the DMD is applying for medical networks.

Note: Shaded fields are required.

Provider Enrollment Requirements

What to Include — Group Practice Enrollment

Checklist Items	Physician's Office	Ambulance	DME	Home Health, Hospice, Dialysis, Hospitals, Skilled Nursing, ASCs*	Pharmacy	Dental
Group Practice Application						
IRS Verification of Tax ID (No W-9s)						
Electronic Funds Transfer Enrollment						
Application for Satellite Location						
Clinical Lab Improvement Amendments						
Signed Contracts						
Copy of CMS Letter						
Copy of Medicare PTAN Letter						
Copy of Business License						
Copy of DHEC License						
Additional Items for Medicaid						
Medicaid ID Number						

Ambulatory Surgery Centers

Note: Shaded fields are required.

Provider Enrollment Requirements

What to Include — In-State, Out-of-Network

Checklist Items
[1]Health Professional Application
[1]Authorization to Bill for Services
[2]Group Practice Application
[2]IRS Verification of Tax ID (No W-9s)
[2]Electronic Funds Transfer Enrollment

Note: This checklist applies to individual practitioners. Group practices that wish to remain out-of-network would complete the Group Enrollment application and select No for the network participation question.

1. **Needed for each individual being linked to the practice.**
2. **Needed if the group is not on file.**

Provider Enrollment Requirements

What to Include — Behavioral Health

Checklist items — all items are needed
Behavioral Health or Autism Panel Application
IRS Verification of Tax ID (or W-9)
CBA* Professional Agreements (Signed Contracts)
Hold Harmless Agreement
Appendix C
Copy of SC State License
Copy of DEA License, if applicable
Copy of Board Certification, if applicable
Nurse Protocols (NPs only)
Current Copy of Malpractice (Min. $1M/$3M)

Companion Benefit Alternatives

Provider Enrollment Requirements

E-signatures vs. Wet Signatures (Ink)

Medical	Allowed Signature
Provider Enrollment	**Electronic or wet**
Recredentialing	**Electronic or wet**
Facility Information Request	**Electronic or wet**
Health Professional	**Electronic or wet**
Doing Business As (DBA)	**Electronic or wet**
Change of Address (COA)	**Electronic or wet**
Add/Term Practitioner	**Electronic or wet**
Authorization to Bill	**Electronic or wet**
Electronic Funds Transfer (EFT)	**Wet**
Appendix D (BlueChoice only)	**Wet**
Hold Harmless (BlueChoice only)	**Wet**
All Contracts	**Wet**

Behavioral Health	Allowed Signature
Behavioral Health	**Electronic or wet**
Autism Panel	**Electronic or wet**
Facility Information Request	**Electronic or wet**
Authorization to Bill	**Electronic or wet**
All Contracts	**Electronic or wet**

Enrollment Process Overview

Enrollment Process Overview

Clean Application Process

1. Enrollment team receives complete enrollment application
2. Application is reviewed for completion and sent to the Credentialing Committee
   - Only complete and accurate applications are sent to the committee.
     - For applications with missing/incomplete documentation, providers are notified for **21 days** to submit the requested items.
     - If the missing items are not received within **28 days**, the application is canceled.
   - Non-approved applications go to the Disciplinary Committee for approval or denial
     - The verdict is sent to the provider.
3. Approved applications are sent to contracting for review
   - Approved contracts are executed
4. Welcome email and packet (with effective dates) is sent to the provider

Enrollment Process Overview

Clean Application Process — Things to Keep in Mind

- The credentialing committee reviews all enrollment applications to ensure all required credentialing criteria are met:
  - Utilization Review Accreditation Commission (URAC).
  - National Committee for Quality Assurance (NCQA).
  - South Carolina Department of Health & Human Services (SCDHHS), when applicable.
- Effective dates are based on the credentialing committee's approval date, per URAC requirements.
- Backdating **network dates** is not allowed.
  - Affiliation dates can be backdated.
    - Up to Jan. 1st of the previous year (e.g., affiliations for 2023 can go back to Jan. 1, 2022)
      - If the application is pending, email the claim showing the earliest date of service to Provider.Requested.Info@bcbssc.com.
      - If the application is completed, fax the claim to 803-264-4795.

Reminders

Reminders

Missing Items — Common Missing Items that Cause Delays in the Processing of Applications

Unsigned applications and contracts

For applications

1. Select My Forms.
2. Select the appropriate case number.
3. Select Form Information.
4. Under Documents, select the document(s) that require signature.
5. Download the document(s) and have the signature(s) appended.
6. Scan the documents and follow steps 1 – 4 and select Upload Files.
7. Select the Confirm button to attest that **all required documentation with applicable signatures, initials and dates** have been uploaded.

For contracts

1. Select My Contracts.
2. Select the appropriate form contract name that corresponds with your case number.
3. Under Download Contract, select the link to download and sign the contract.
4. Scan the documents and follow steps 1 – 2 and select Upload Files.

Invalid dates

- Malpractice dates must be current, valid and active on or before the requested start date.
- Signature dates on contracts and applications must be current.

IMPORTANT NOTE:

An automated notification for missing items is sent every seven days until the information is received. Outreach is made on:

- ***Day 7 – First request***
- ***Day 14 – Second request***
- ***Day 21 – Third (final) request***

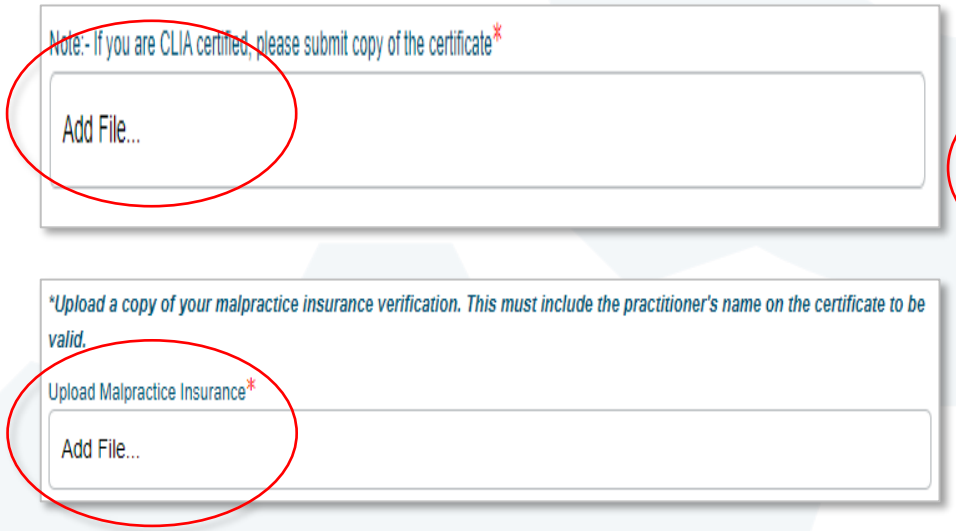
If the missing items are not received, the case will be placed in the "Canceled – Incomplete Submission" status. Once in this status, it cannot be reopened, and a new application must be completed.

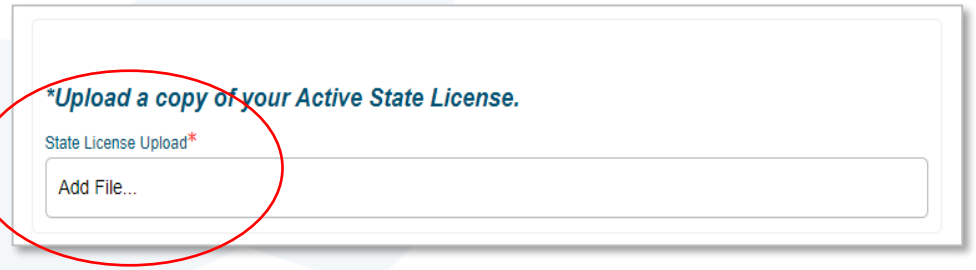
Reminders

Missing Items — Common Missing Items that Cause Delays in the Processing of Applications (Continued)

Incomplete submissions

- Missing a copy of the following:
  - State or medical license
  - CLIA certificate
  - Malpractice verification





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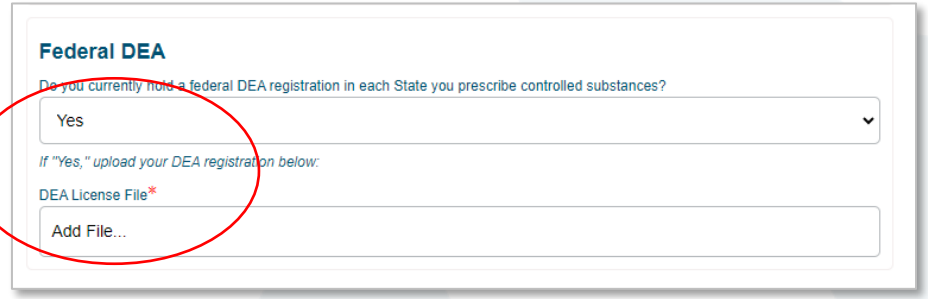
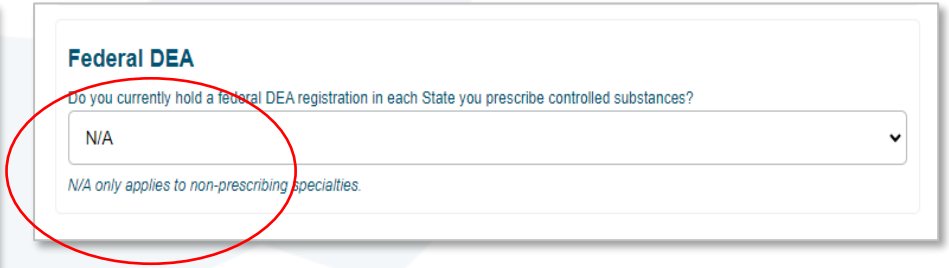
Reminders

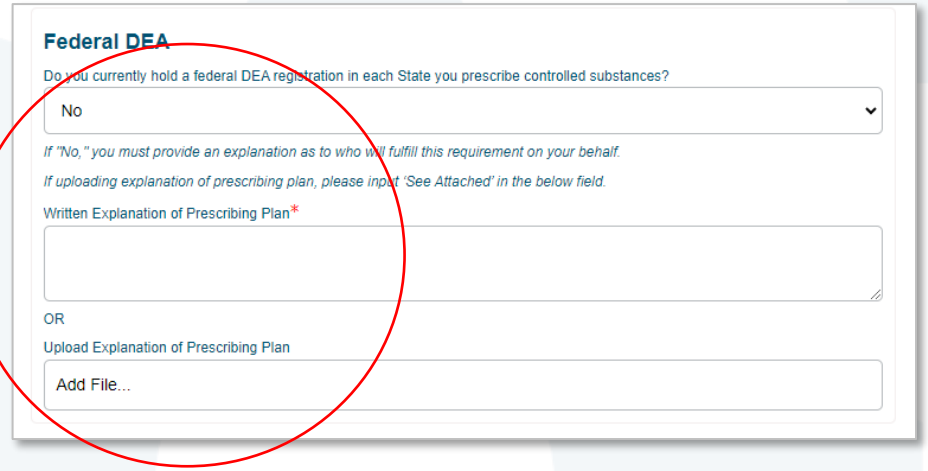
Missing Items — Common Missing Items that Cause Delays in the Processing of Applications (Continued)

Incomplete submissions

- Missing DEA details







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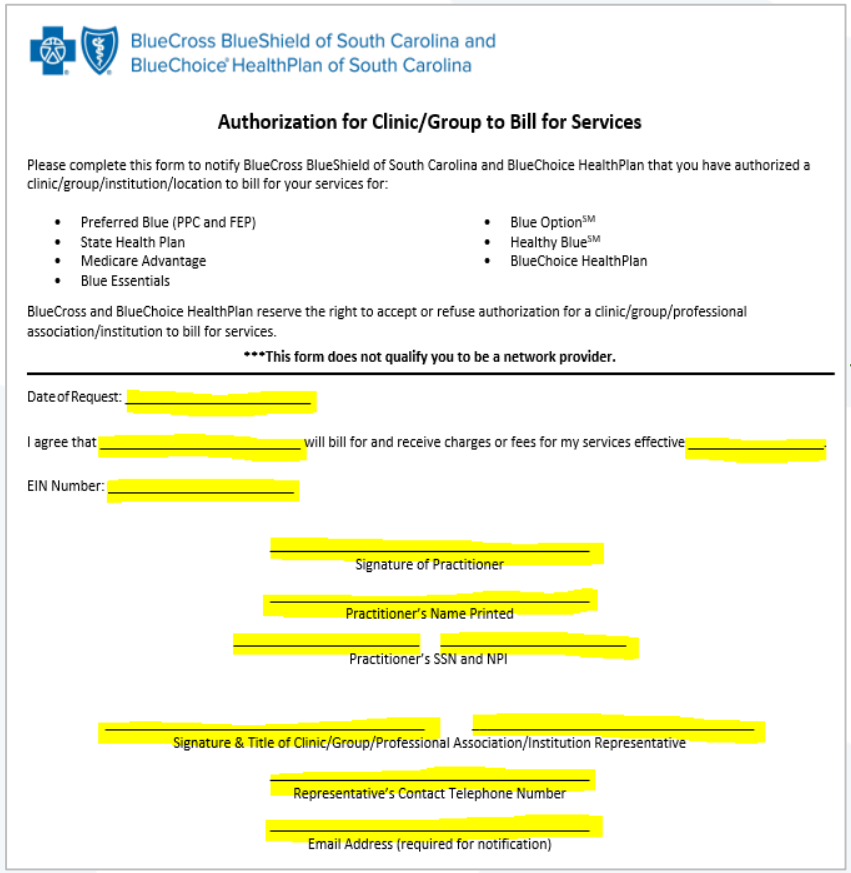
Reminders

Missing Items — Common Missing Items that Cause Delays in the Processing of Applications (Continued)

Incomplete documentation

- Authorization to Bill missing effective dates and representative details



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

Authorization for Clinic/Group to Bill for Services

Please complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan that you have authorized a clinic/group/institution/location to bill for your services for:

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

BlueCross and BlueChoice HealthPlan reserve the right to accept or refuse authorization for a clinic/group/professional association/institution to bill for services.

***This form does not qualify you to be a network provider.

Date of Request: _____

I agree that _____ will bill for and receive charges or fees for my services effective _____

EIN Number: _____

_____
Signature of Practitioner

_____
Practitioner's Name Printed

_____ _____
Practitioner's SSN and NPI

_____ _____
Signature & Title of Clinic/Group/Professional Association/Institution Representative

_____
Representative's Contact Telephone Number

_____
Email Address (required for notification)

All highlighted fields MUST be completed.

IMPORTANT NOTE:

An automated notification for missing items is sent every seven days until the information is received. Outreach is made on:

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- ***Day 21 – Third (final) request***

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Reminders

Recredentialing

- Recredentialing occurs every three years.
- Our credentialing team makes outreach when the provider's recredentialing date is approaching.
  - First, they call to see if the provider is actively working at the location on file.
    - If no response is received after the first attempt, a second attempt is made in **14 days**.
    - If no response is received after the second attempt, a third attempt is made in **seven days**.
    - If no response is received after the third and final attempt, the status change process begins.
- If the recredentialing date is missed, the provider is termed, and a new enrollment is required.

Note: Be sure the credentialing contact email address is current for outreach.

Reminders

Non-credentialed Providers

- Acupuncturists
- Associate Counselors
- Christian Science Practitioners
- Diabetes Education
- Dieticians
- Education Specialists
- Homeopaths
- Lay Midwives
- Massage Therapists
- Naturopaths
- Occupational Therapy Assistants
- Physical Therapy Assistants
- Psychology Assistants
- Recreational Therapists
- School Psychologists
- Sports Trainers
- Technicians

Note: This list may not be all inclusive.

Reminders

Provider Validation

As of **Jan. 1, 2022**, providers are required to verify their demographic data at least **every 90 days**. Our provider directory team also makes outreach every 90 days to ensure validation.

Note: Be sure the credentialing contact email address is current as this is what's used for outreach.

Importance of Validation

- Allows us to maintain accurate directories
- Ensures members know where to find you

How to Validate Information

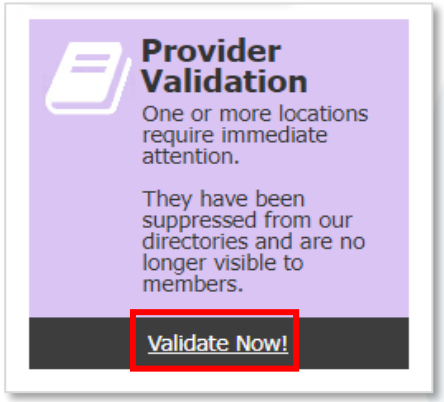
- M.D. Checkup

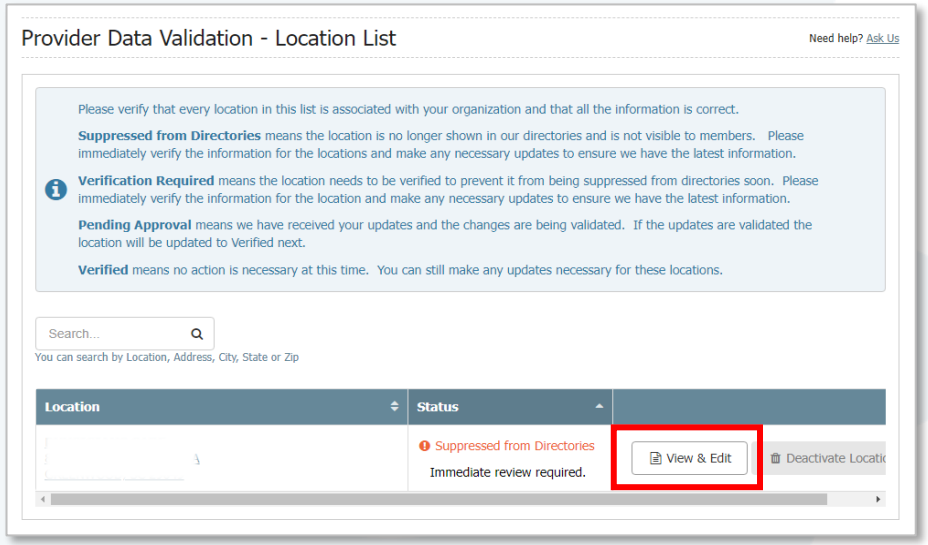
Reminders

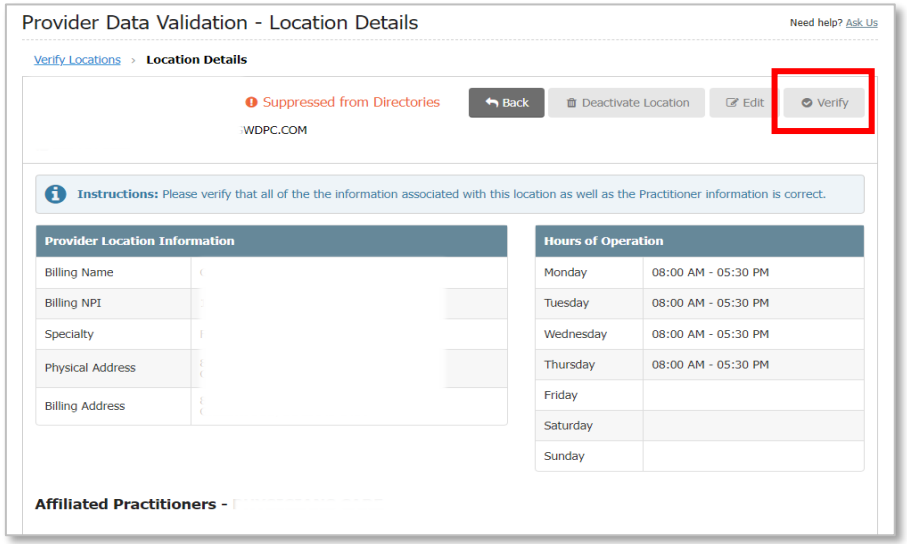
Provider Validation (Continued)

Has your location been suppressed?

- Locations are suppressed in the provider directory if more than 90 days has passed since the last validation was made, per the Consolidated Appropriations Act guidelines.
- To have the suppressed status updated, the group administrator should:
  - Log into My Insurance Manager.
  - Select Validate Now in the Provider Validation box.
  - Select View and Edit from the location(s) listed.
  - Review the information, make the necessary updates, if needed, and select Verify.







Reminders

Provider Updates — My Provider Enrollment Portal

The following updates can be made using My Provider Enrollment Portal:

- Business name change
  - Using the Doing Business As (DBA) Name Change form
- Address change
  - Using the Change of Address form
- NPI update
  - Using the NPI Provider Notification form
- Adding a location
  - Using the Application for Satellite Location form
- Adding or terminating practitioner affiliation
  - Using the Add or Terminate Practitioner Affiliation form

Reminders

Provider Updates — M.D. Checkup

What is M.D. Checkup?

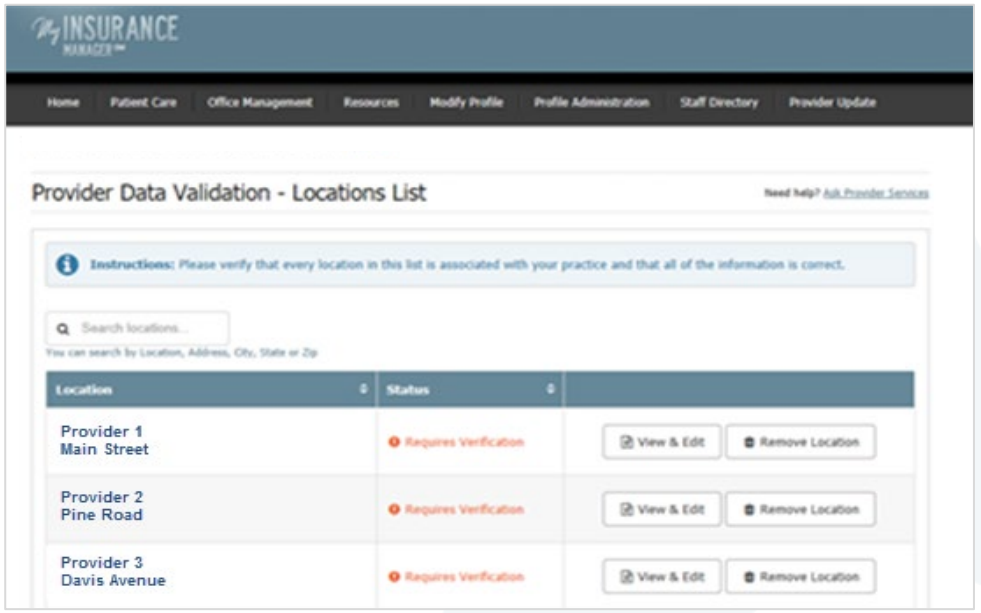
- Web-based tool used for provider demographic updates
- M.D. Checkup is accessible through My Insurance Manager

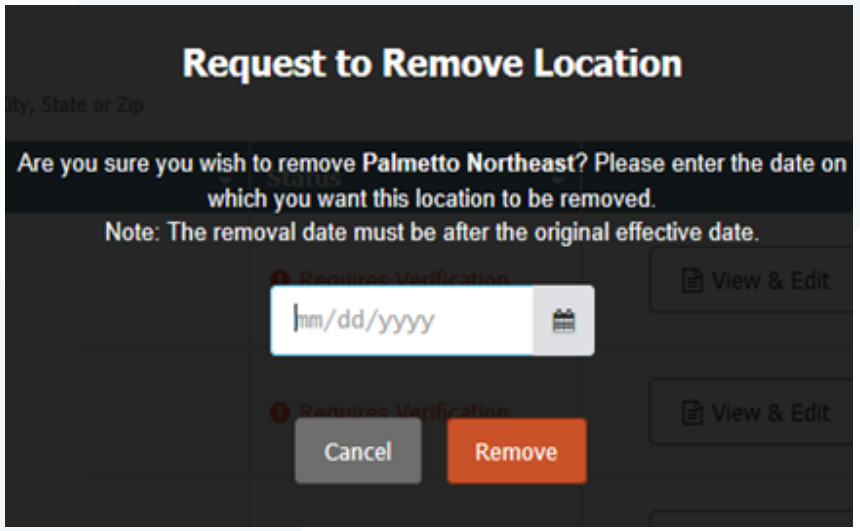
The following updates can be made through M.D. Checkup:

- Business name change
- Address change
- Adding or terminating a location
- Adding or terminating a practitioner affiliation
  - You can only add a practitioner through M.D. Checkup if they are enrolled and associated with the tax identification number.

Reminders

M.D. Checkup — Removing Locations





DO NOT use this function to remove a location from your VIEW!

Reminders

M.D. Checkup — Adding Practitioner Affiliations

To add a practitioner affiliation through M.D. Checkup:

- The practitioner must be enrolled and associated with the tax identification number (TIN).
  - Submit the Add/Terminate Practitioner Affiliation form to add a practitioner to a location under a different TIN.

Example:

- *TIN A — 123456789*
  - Location 1
  - Location 2
- *TIN B — 987654321*

Dr. Tommy Pickles **is associated** with TIN A and works at Location 1. He can be added to Location 2 through M.D. Checkup.

Dr. Tommy Pickles **is not associated** with TIN B. To be added to this location, the Add/Terminate Practitioner Affiliation form must be submitted.

Quality Improvement Strategy

Back To Basics

Introductions

Hollie Strange
Director, Quality Improvement Strategy

Luna Lugo Latorre
Manager, Quality Management

Agenda

- About Us
- National Committee for Quality Assurance (NCQA®)
- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Request for Information
- Lines of Business
- Quality Navigator Program
- Key Takeaways

About Us

About Us

Health Care Innovation and Improvement

Vision: To ensure a quality health care experience with every interaction

Mission: Improve the health and experience of our members through innovative programs and collaborative partnerships that help make health care more affordable.

Committed to working with you to better serve our members

National Committee for Quality Assurance (NCQA®)

National Committee for Quality Assurance (NCQA®)

- NCQA is a private organization dedicated to improving healthcare quality by developing quality standards and performance measures.
- Healthcare Effectiveness Data and Information Set (HEDIS) coordination
- Provider involvement

National Committee for Quality Assurance (NCQA®)

What does NCQA mean to you?

Contract	Reporting	Safety
Bonuses Incentives	Data to the plan	Patient

Health Care Effectiveness Data and Information Set (HEDIS®)

Health Care Effectiveness Data and Information Set (HEDIS®)

Health Care

Effectiveness

Data and

Information

Set

It is a tool that America's health plans use to measure performance on important dimensions of care and service.

HEDIS rates are designed to evaluate the effectiveness of a health plan's ability to demonstrate an improvement in its preventive care and quality measures to its members.

Health Care Effectiveness Data and Information Set (HEDIS®)

Which entities use HEDIS data?

South Carolina

NCQA®

Exist to improve the quality of health care.

CMS

*Centers for Medicare and Medicaid Services (CMS)

*Quality Rating System for the ACA/Exchange products

*Medicare Advantage

.

FEP

Federal Employee Program (FEP)

Health Care Effectiveness Data and Information Set (HEDIS®)

HEDIS Prospective Season

- Also referred to as year-round.
- Continuously monitors rates in real-time.
- Runs from Jan. 1 to Dec. 31 of the current or measurement year.
- Additional options for compliance include:
  - Claims.
  - Data transfer.
  - Medical records.
  - Compliance forms.

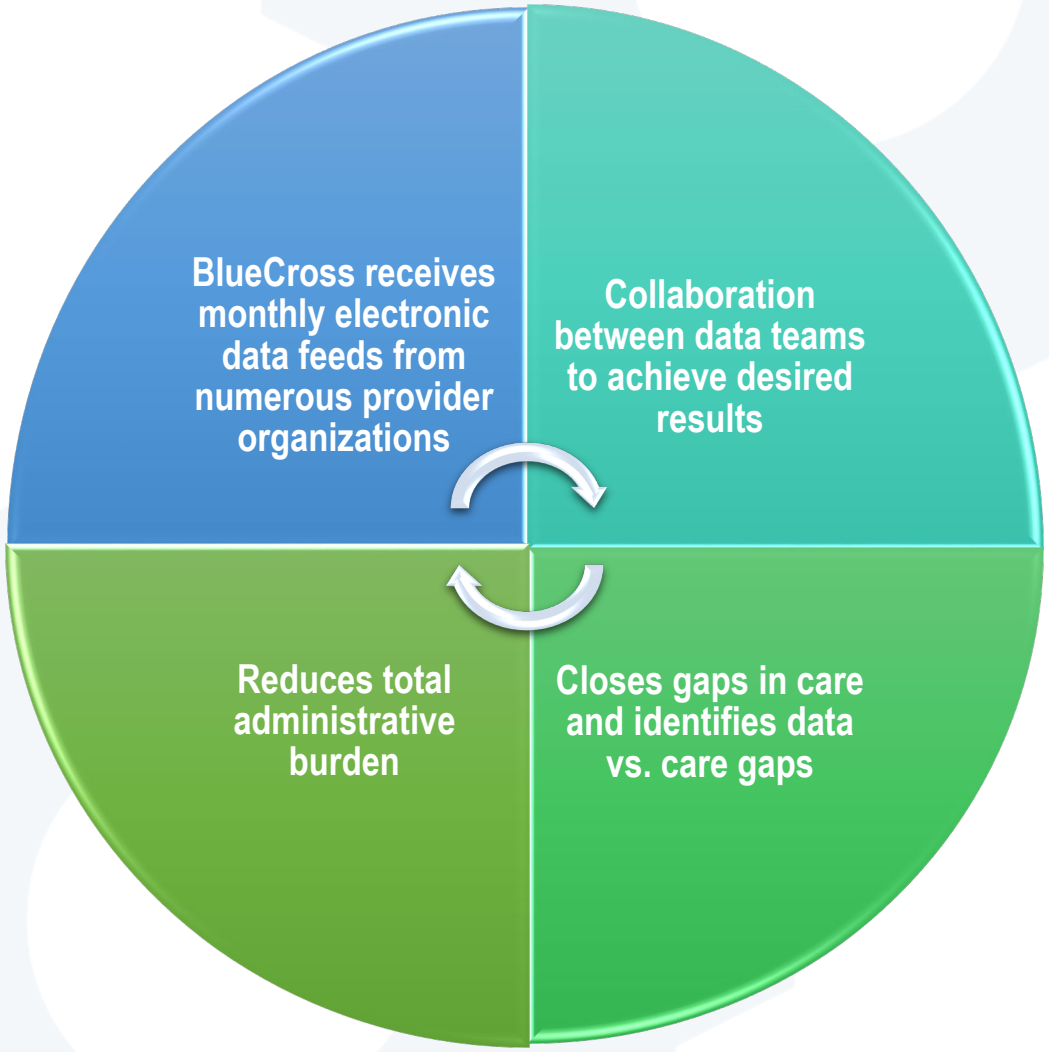
Health Care Effectiveness Data and Information Set (HEDIS®)

HEDIS Retrospective Season

- Also referred to as retro or hybrid season or HEDIS production
- Looks at the care given or due in the prior year (measurement year)
- Runs from January to May of the year following the measurement year
- HEDIS My2023 refers to care given or due in 2023, which will be evaluated from January to May 2024
- All requested member documentation is based on the selected HEDIS measure by NCQA

Health Care Effectiveness Data and Information Set (HEDIS®)

Electronic Data Transfer



Healthcare Effectiveness Data and Information Set (HEDIS®)

Electronic Data Transfer (Continued)

BlueCross currently has many providers that allow remote access to their EMR

Assigned navigator can locate and retrieve records from the EMR remotely

Helps to reduce provider burden

Request for Information

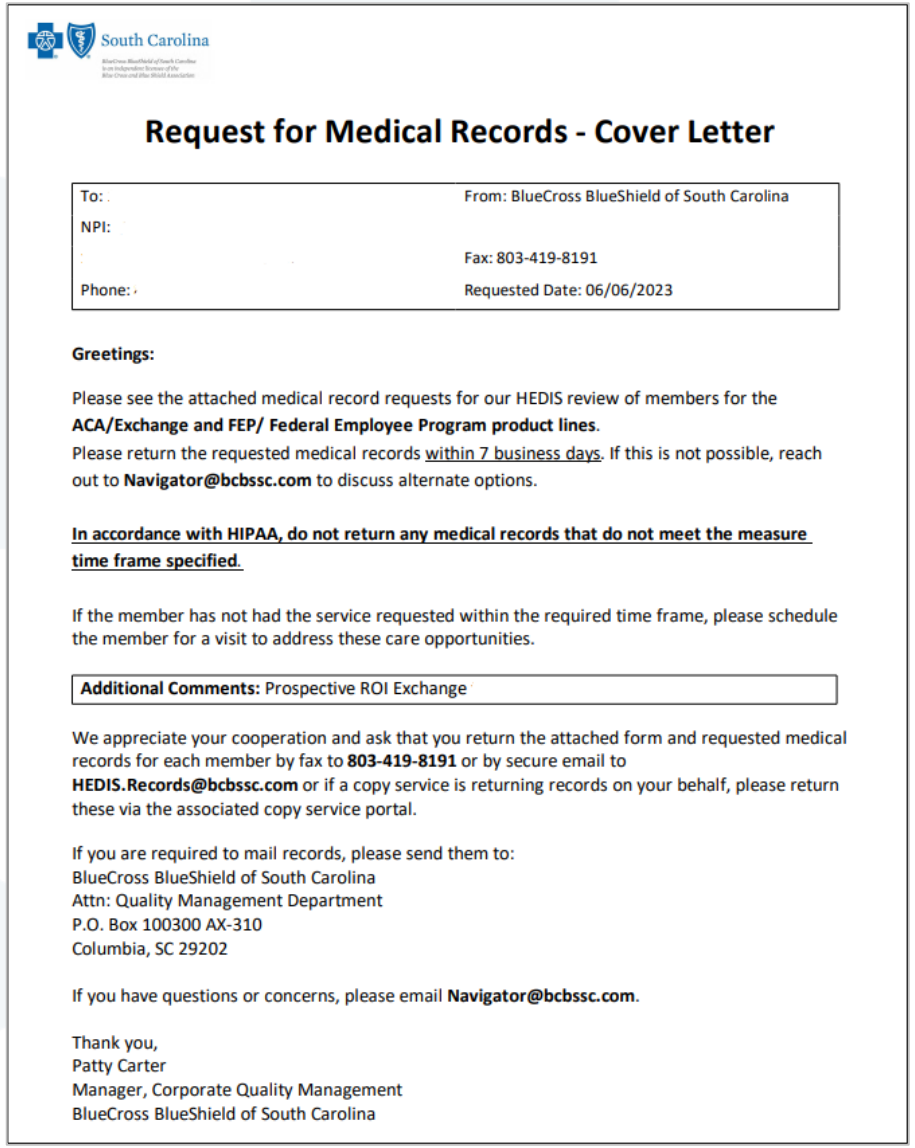
Request for Information

- How are requests sent?
  - Email
  - Fax
  - Mail

Note: Can be avoided by giving remote access to EMR. Email NAVIGATOR@bcbssc.com.

- How are requests created?
  - Claims
- How are members attributed?
  - Claims data

Note: You will only receive a request for medical records if the member has an open care gap.



South Carolina

Request for Medical Records - Cover Letter

To:	From: BlueCross BlueShield of South Carolina
NPI:	
	Fax: 803-419-8191
Phone:	Requested Date: 06/06/2023

Greetings:

Please see the attached medical record requests for our HEDIS review of members for the **ACA/Exchange and FEP/ Federal Employee Program product lines**.
Please return the requested medical records within 7 business days. If this is not possible, reach out to **Navigator@bcbssc.com** to discuss alternate options.

In accordance with HIPAA, do not return any medical records that do not meet the measure time frame specified.

If the member has not had the service requested within the required time frame, please schedule the member for a visit to address these care opportunities.

Additional Comments: Prospective ROI Exchange

We appreciate your cooperation and ask that you return the attached form and requested medical records for each member by fax to **803-419-8191** or by secure email to **HEDIS.Records@bcbssc.com** or if a copy service is returning records on your behalf, please return these via the associated copy service portal.

If you are required to mail records, please send them to:
BlueCross BlueShield of South Carolina
Attn: Quality Management Department
P.O. Box 100300 AX-310
Columbia, SC 29202

If you have questions or concerns, please email **Navigator@bcbssc.com**.

Thank you,
Patty Carter
Manager, Corporate Quality Management
BlueCross BlueShield of South Carolina

Request for Information

- What information should be returned?
  - Providers must return the information listed in the requested box on the form.

Example of Request

Please send a copy of the following medical record(s) requested below:

Demographics page

-AND-

All office visit/encounter notes from 01/01/2023 to 12/31/2023

-AND-

Past Medical/Surgical history 2022 to 12/31/2023

-AND-

Vital sign flow sheets from 01/01/2023 to 12/31/2023

-AND-

All consultation notes from 01/01/2023 to 12/31/2023

Request for Information

- What should I do if I cannot locate the patient, nor have medical records for the timeframe requested?
  - Check the appropriate box and return the letter via fax, email or mail.

Please check the appropriate box:

☐ Medical record attached; please return via one of the following methods:

FAX: 803-419-8191

EMAIL: HEDIS.Records@bcbssc.com

MAIL: BlueCross BlueShield of South Carolina, Attn: Quality Management Department, P.O. Box 100300 AX-310, Columbia, SC 29202

Portal Locations:

MRO: bchpbcbshedis.requester.roilog.com

Ciox: PO BOX 6170, AX310, Columbia, SC 29260, Customer ID: 1080191

ShareCare: BCBS-29260-6170

☐ No medical records found for the time frame requested

☐ Unable to locate patient in our system

Lines of Business

Lines of Business

Which lines of business are included?

- Health Insurance Exchange (HIX or ACA)
- Federal Employee Program (FEP)
- Healthy Blue℠ (BlueChoice Medicaid)

Lines of Business

Health Insurance Exchange

- Quality Rating System (QRS)
- Technical specifications
  - Clinical, customer satisfaction, and patient quality measurement
  - Many plans collect HEDIS data, and the measures are specific
  - Outcome is a Start rating

Lines of Business

Federal Employee Program

- Clinical quality, customer service and resource use (QCR)
- Technical specifications
  - NCQA technical specifications are the same as HIX
  - Audit is completed by an outside vendor, then submitted to NCQA
  - Clinical, customer satisfaction and patient experience
  - Outcome is Performance Improvement Plan (PIP) rating

Lines of Business

Healthy Blue

- Rating System
  - Voluntary reporting is changing to required
  - Adult and child health care quality measures
  - Core set of children's health care quality measures
  - Audit will be completed by an outside vendor, then submitted to NCQA

Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

Quality Navigator Program

Quality Navigator Program

Quality Navigator Model

- The quality navigator model is a population health and quality improvement program designed to assist primary care physicians (PCPs) in meeting quality metrics.
- The goal of the program is to assist PCPs by:
  - Streamlining care coordination
  - Providing help tools and resources to support patient care efforts
- Benefits include:
  - Promotes accurate coding guidance
  - Facilitates referrals to disease and case management programs to support treatment plans
  - Assists with care coordination

Quality Navigator Program

What is the Quality Navigator Program?

- Participation is based on primary care specialties
- Providers are automatically enrolled
- There is no cost to providers
- Multiple tools and offerings available to support providers

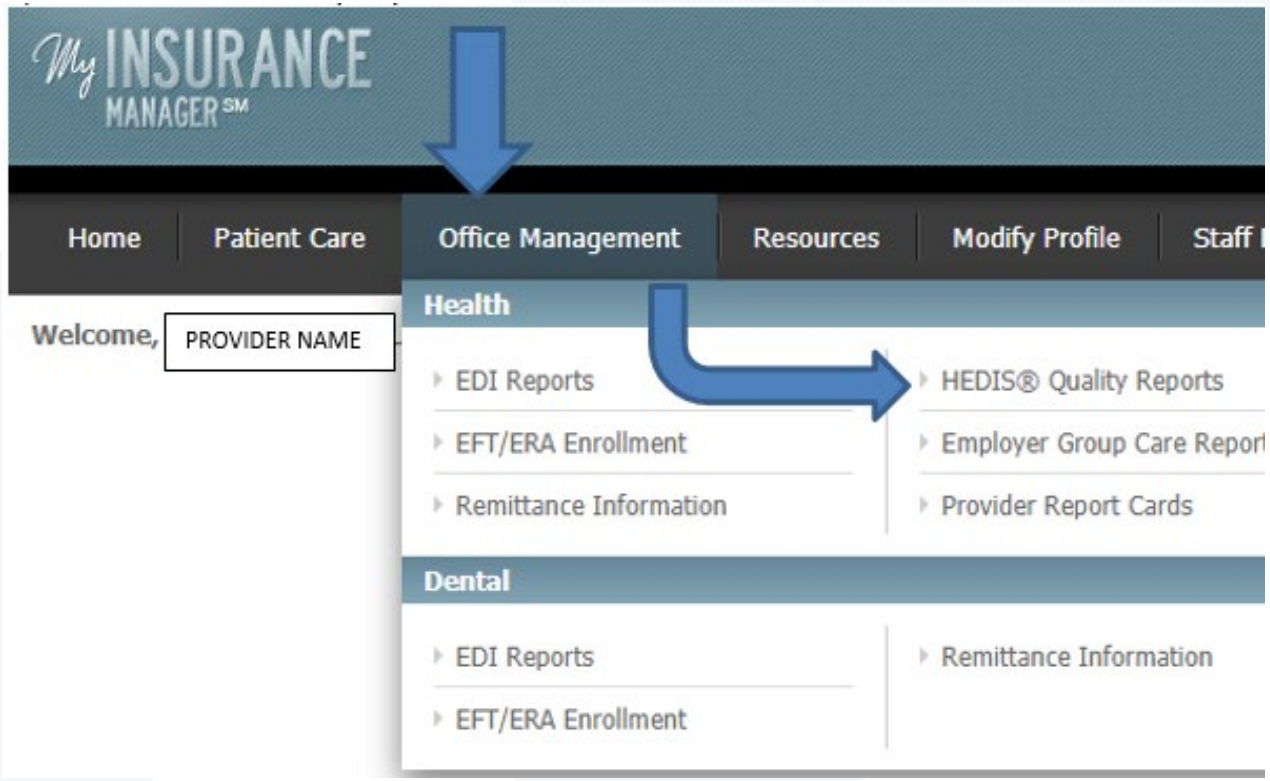
What is a Quality Navigator?

- Dedicated team member with a registered nursing license or related health care bachelor's degree
- Point of contact for care coordination and patient engagement
- Education representative that can schedule sessions to assist with understanding NCQA measures, review open quality care opportunities, and collaborate with providers to improve quality scores

Quality Navigator Program

My Insurance Manager

Use My Insurance Manager to access care opportunity reports for prospective season.



Quality Navigator Program

Understanding Care Opportunity Reports

- Past medical history has been added for members (▭)
- Non-compliance can be a true “gap” in care or a “gap” in data (▭)
  - A true gap in care or non-compliance is when the member has not received the care.
  - A data gap is when the member has received the care, but this information was not shared with the plan.
  - Either way, the member will remain listed as “non-compliant” until the care is given AND that information is shared with us.

First Name	Last Name	Date of Birth	Gender	Member ID_Card	LOB	Servicing Provider	Compliant Measures	Non-Compliant Measures	Past Medical History
John	Doe	1/1/1953	M	R12345566	Cross Exchange	My Provider	Acute Hospital Utilization, Acute Emergency Department Utilization	Colorectal Cancer Screening	Asthma COPD
Jane	Doe	1/1/1970	F	R12345566	Cross Exchange	My Provider	Controlling High Blood Pressure Breast Cancer Screening	Cervical Cancer Screening	Hypertension

Risk Adjustment Data Validation (RADV)

- **HHS-RADV** — CMS has a formal audit program to monitor health plan compliance with HCC (Hierarchical Condition Category) reporting regulations. Occurs each year auditing the previous benefit year. The goal of RADV audits is to ensure that the health status submitted by the plan is supported by health record documentation and meets reporting guidelines.

- **HHS-Risk Adjustment** — medical charts are retrieved and coded for missed opportunities each year to generate a more complete picture of member health status.

- **Documentation and Coding Practices**
  - Improve health record documentation
  - Code chronic conditions every year and document all cause-and-effect relationships
  - Clearly link complications or manifestations of a disease process
  - Include all diagnoses and only document diagnoses as “history of” or “past medical history (PMH)” when they no longer exist and are resolved.
  - ICD-10-CM codes for the encounter must be captured in the electronic health record (EHR), correctly passed to the practice management platform, and submitted on a claim

Key Takeaways

Key Takeaways

What will positively impact your quality score?

Customer service 4

With every member's interaction

.

Schedule patients 3

Include periodic screenings and preventive services.

Follow up on missed appointments.

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Data Transfer 2

To reduce medical record requests or grant remote access to the quality navigator team

Codes 1

Submit NCQA-approved quality codes on claims when appropriate.

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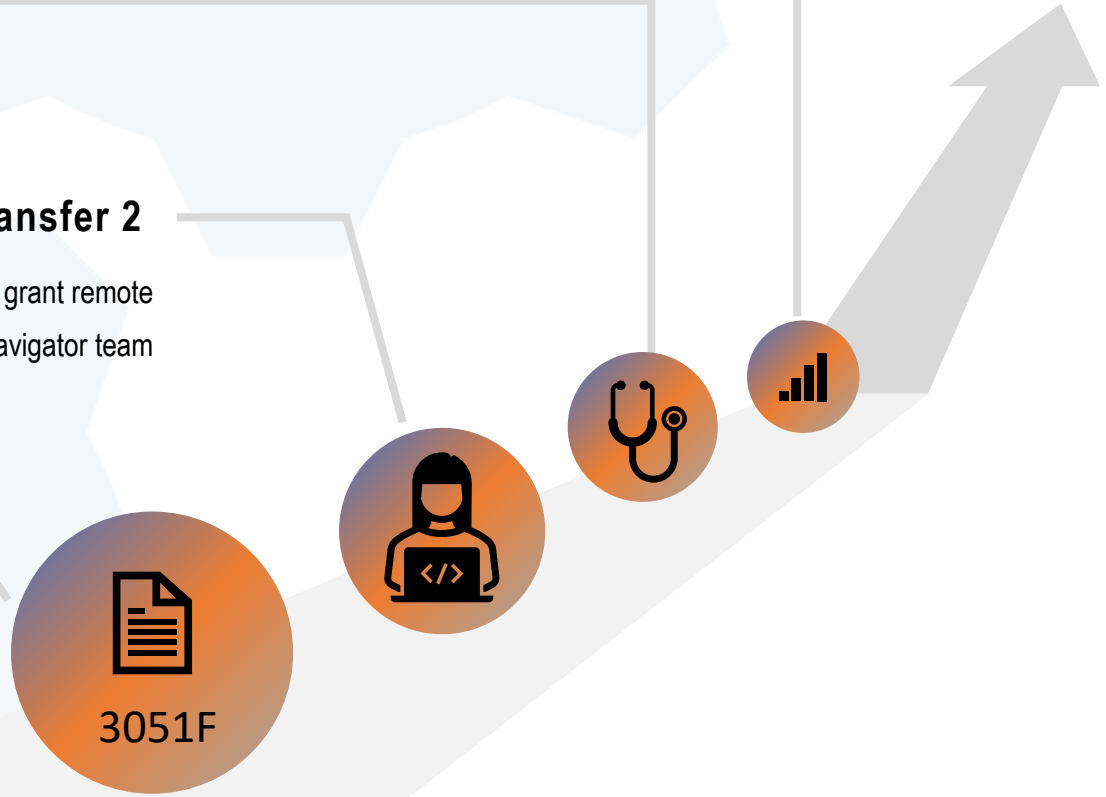


Key Takeaways

Contact Us

- Hollie Strange — Director, Quality Improvement Strategy
  - Hollie.Strange@bcbssc.com
- Luna S. Lugo RN, MSC — Manager, Quality Management
  - Luna.Lugo@bcbssc.com
- General assistance or information
  - NAVIGATOR@bcbssc.com

Web Tools

Back To Basics

Agenda

- Website Overview
- My Insurance Manager
  - Ask Provider Services
  - STATchat℠
- My Remit Manager
- My Provider Enrollment Portal

Website Overview

Website Overview

We have three main websites:

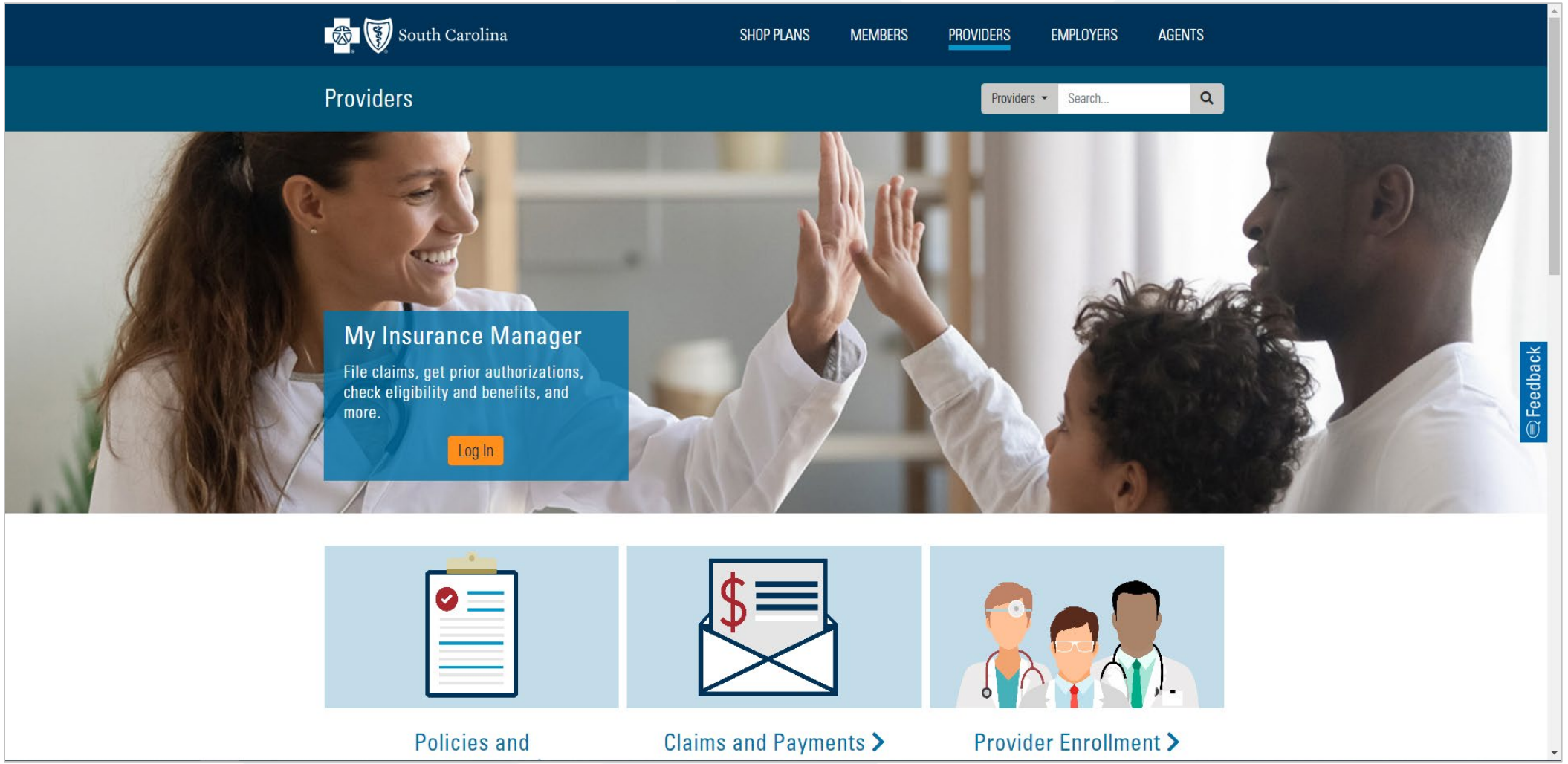
- www.SouthCarolinaBlues.com
- www.BlueChoiceSC.com
- www.HealthyBlueSC.com

Provider pages of our websites include:

- Educational materials
- Access to various secure web tools
  - My Insurance Manager
  - My Remit Manager
  - My Provider Enrollment Portal

Website Overview

www.SouthCarolinaBlues.com

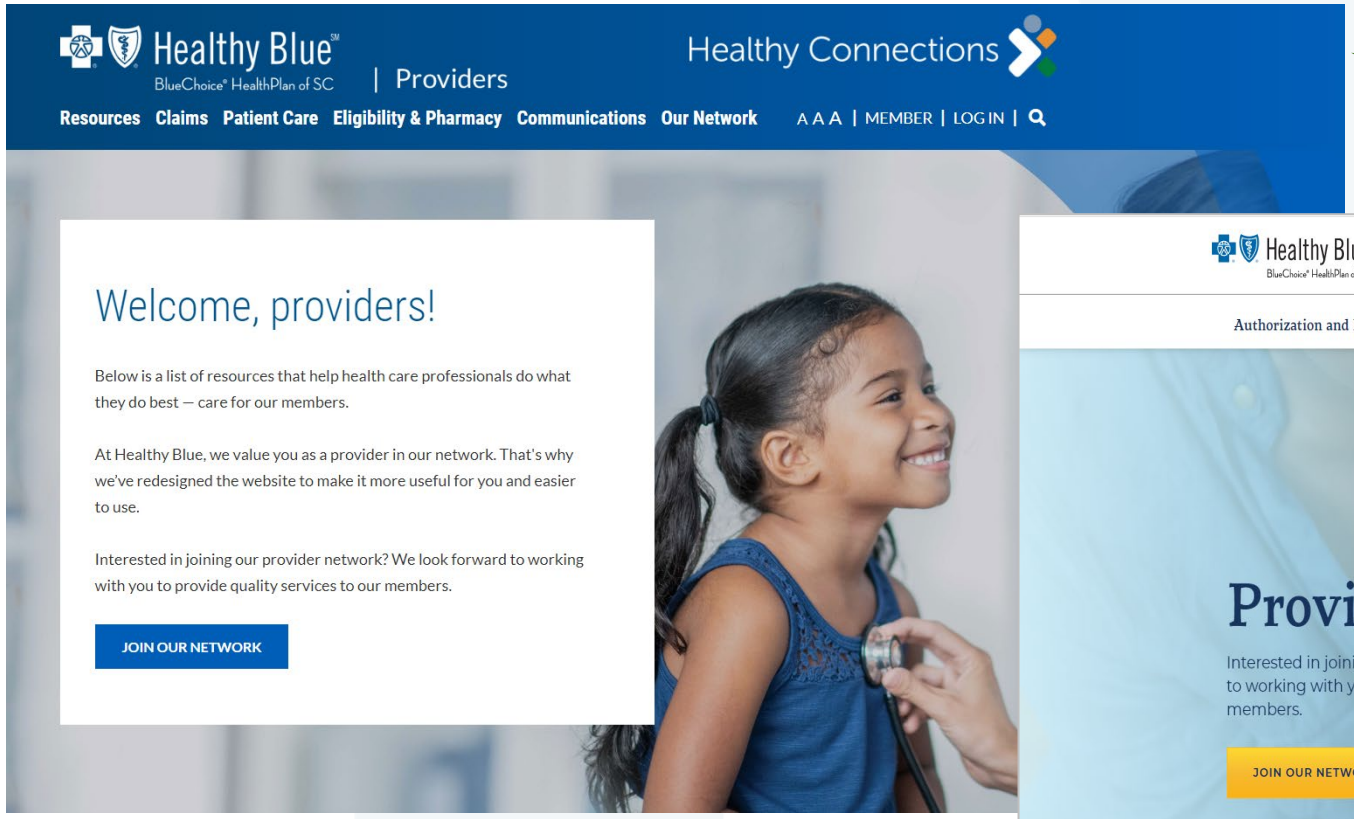


Website Overview

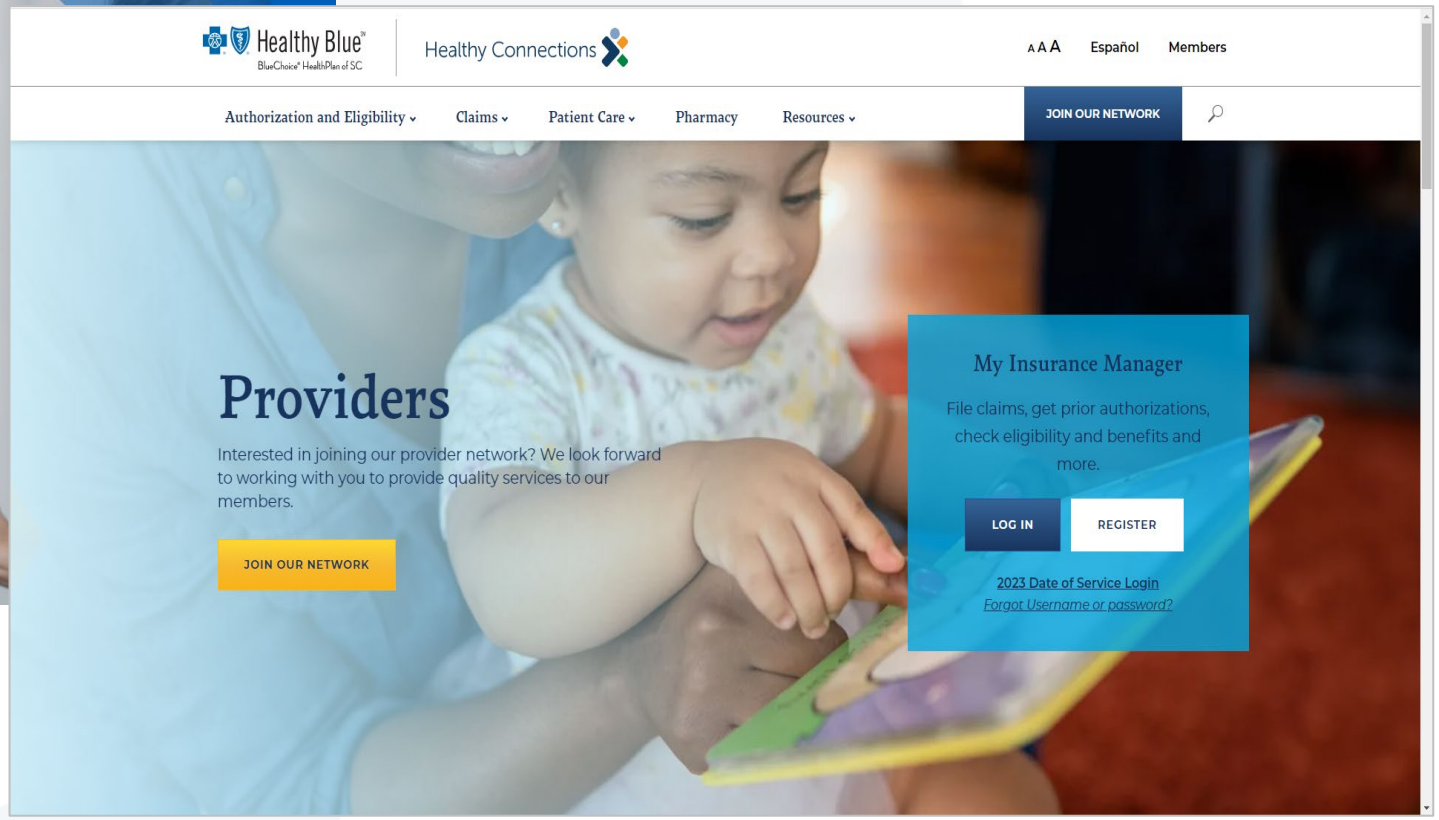
www.BlueChoiceSC.com

Website Overview

www.HealthyBlueSC.com



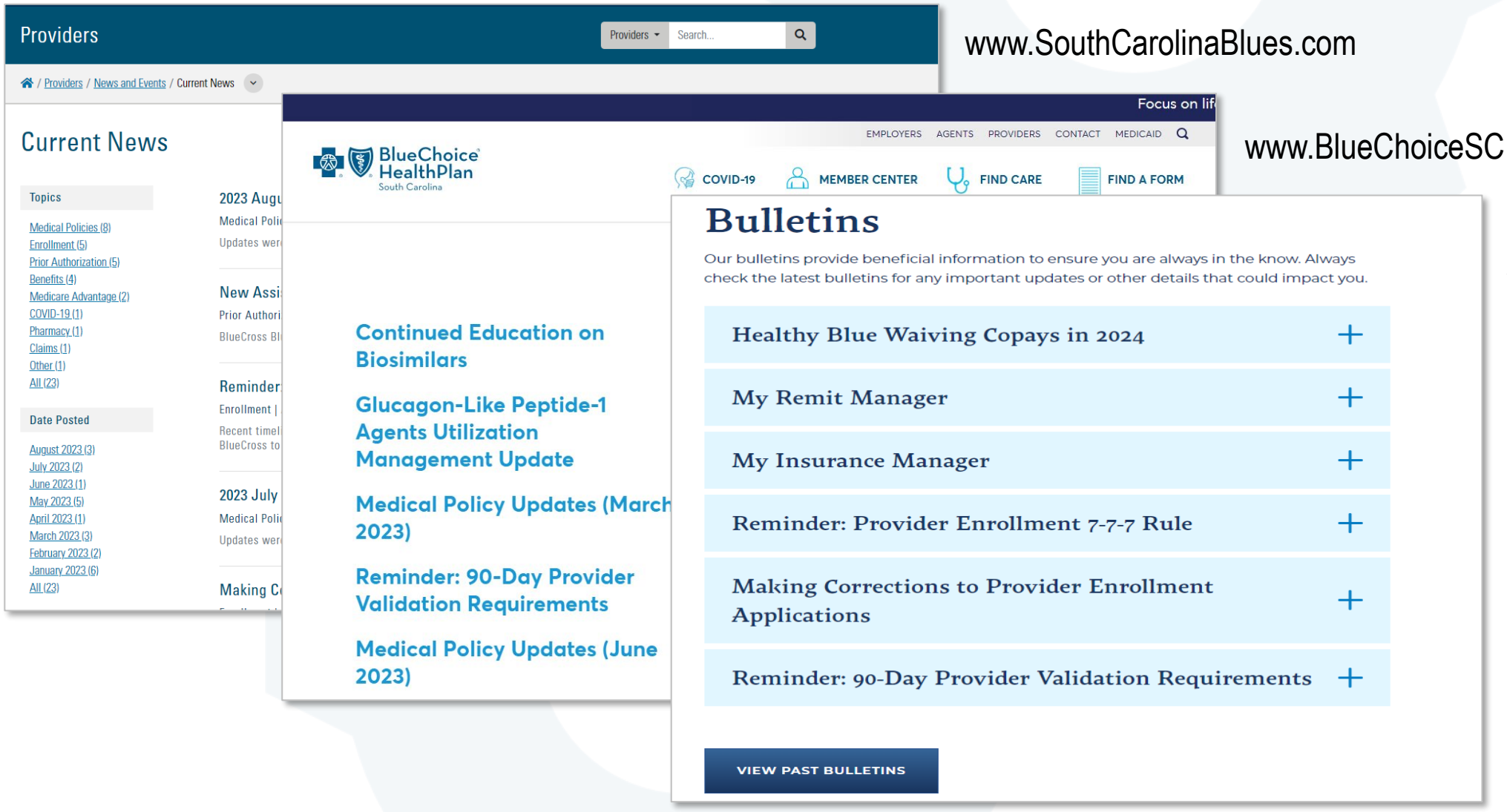
2023



2024

Website Overview

Provider Bulletins



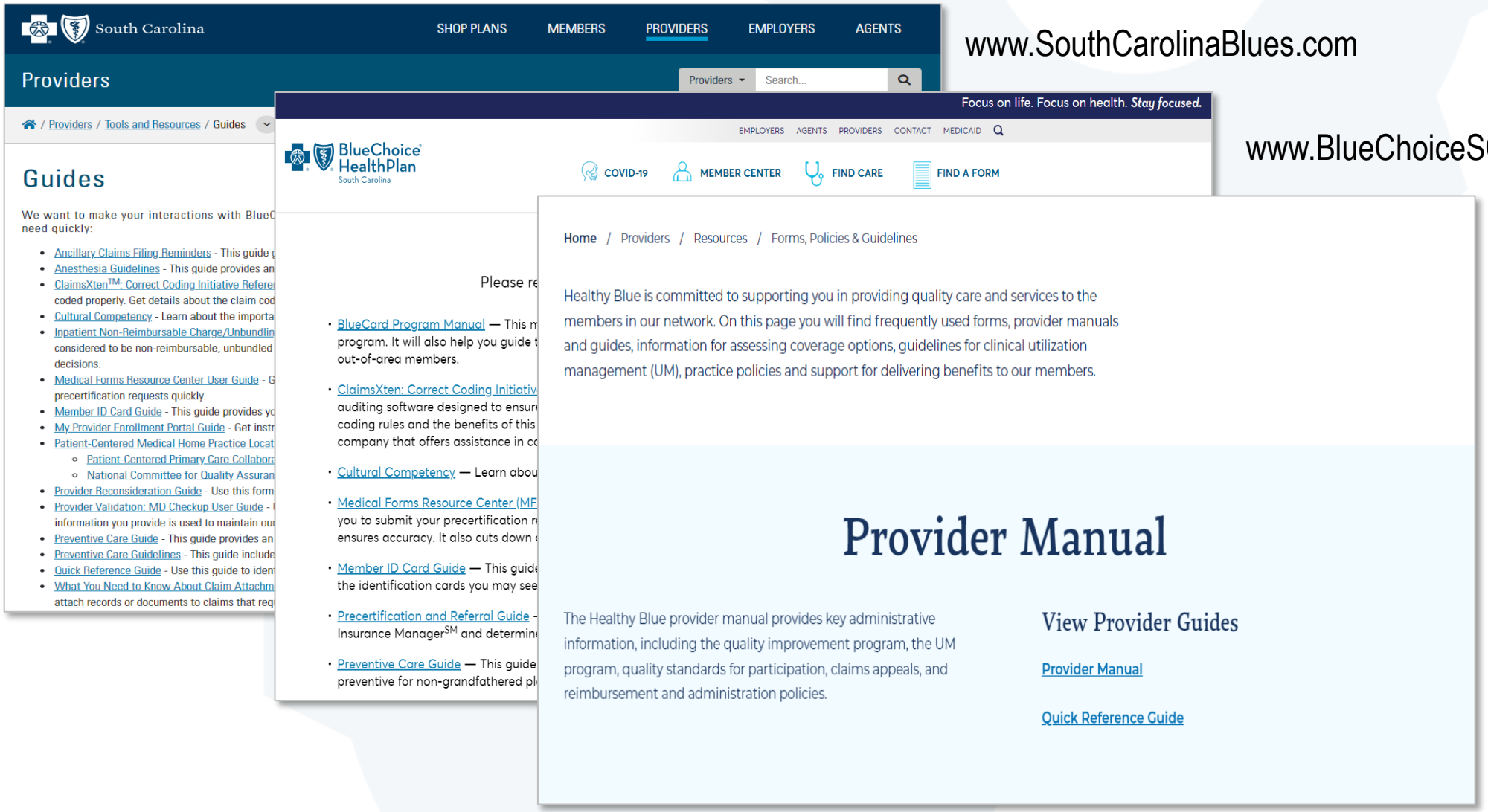
www.SouthCarolinaBlues.com

www.BlueChoiceSC.com

www.HealthyBlueSC.com

Website Overview

Manuals and Guides



www.SouthCarolinaBlues.com

www.BlueChoiceSC.com

www.HealthyBlueSC.com

Website Overview

Forms

www.SouthCarolinaBlues.com

www.BlueChoiceSC.com

www.HealthyBlueSC.com

Website Overview

Contact us

My Insurance Manager

My Insurance Manager

Overview

Tool used to check eligibility and benefits, claims status, request prior authorizations and much more

Available Guides:

- Getting Started
- Eligibility & Benefits
- Claims Entry
- Claims Status, Patient Directory, Superbill Maintenance & Coordination of Benefits
- Precertification, Pre-Treatment Estimate for Authorization Status
- Office Administration
- Provider Validation: M.D. Checkup

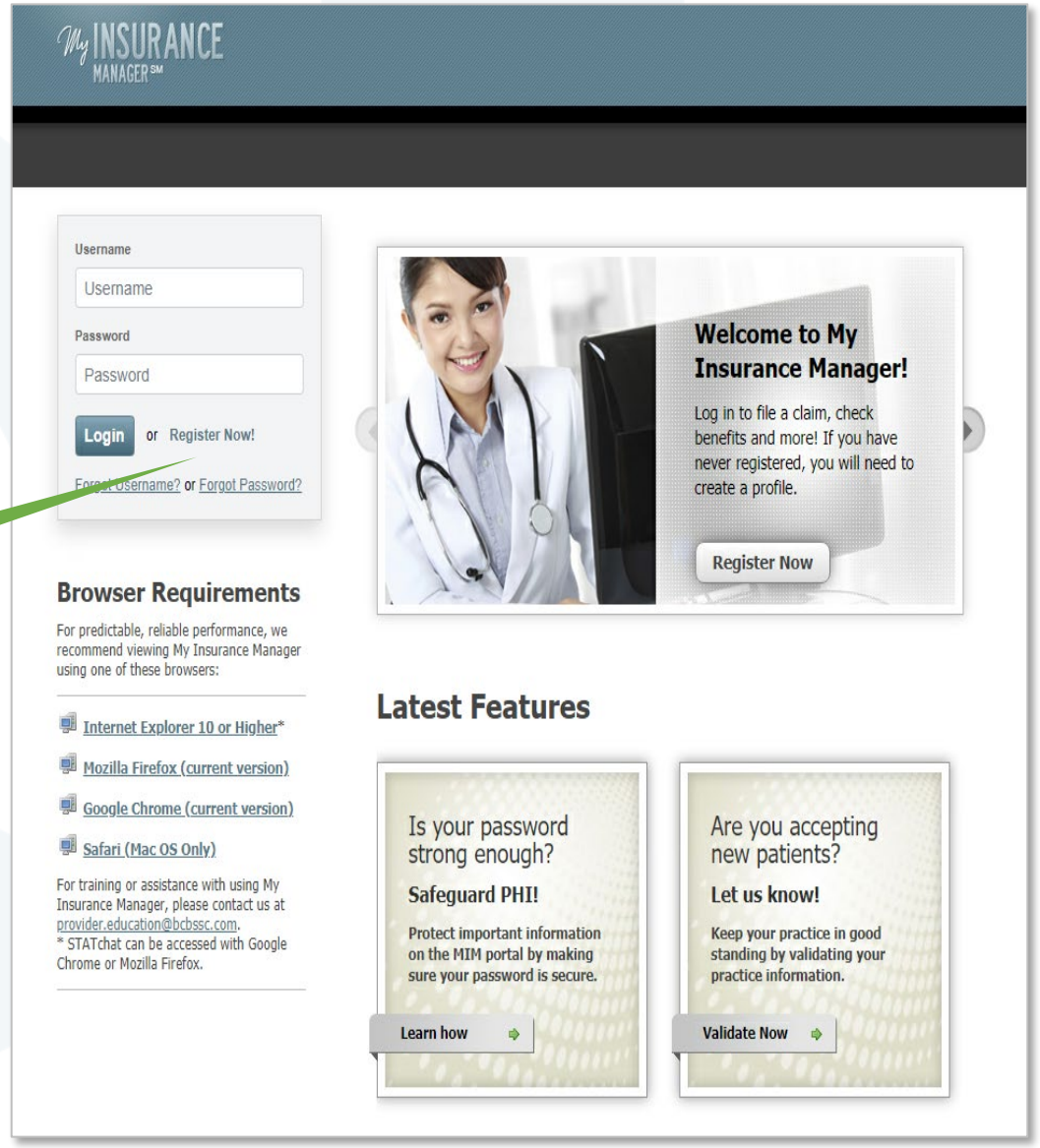
My Insurance Manager

Getting Started

- Select **Register Now** to get started.

Southcarolinablues.com>Providers>My Insurance Manager>Register Now

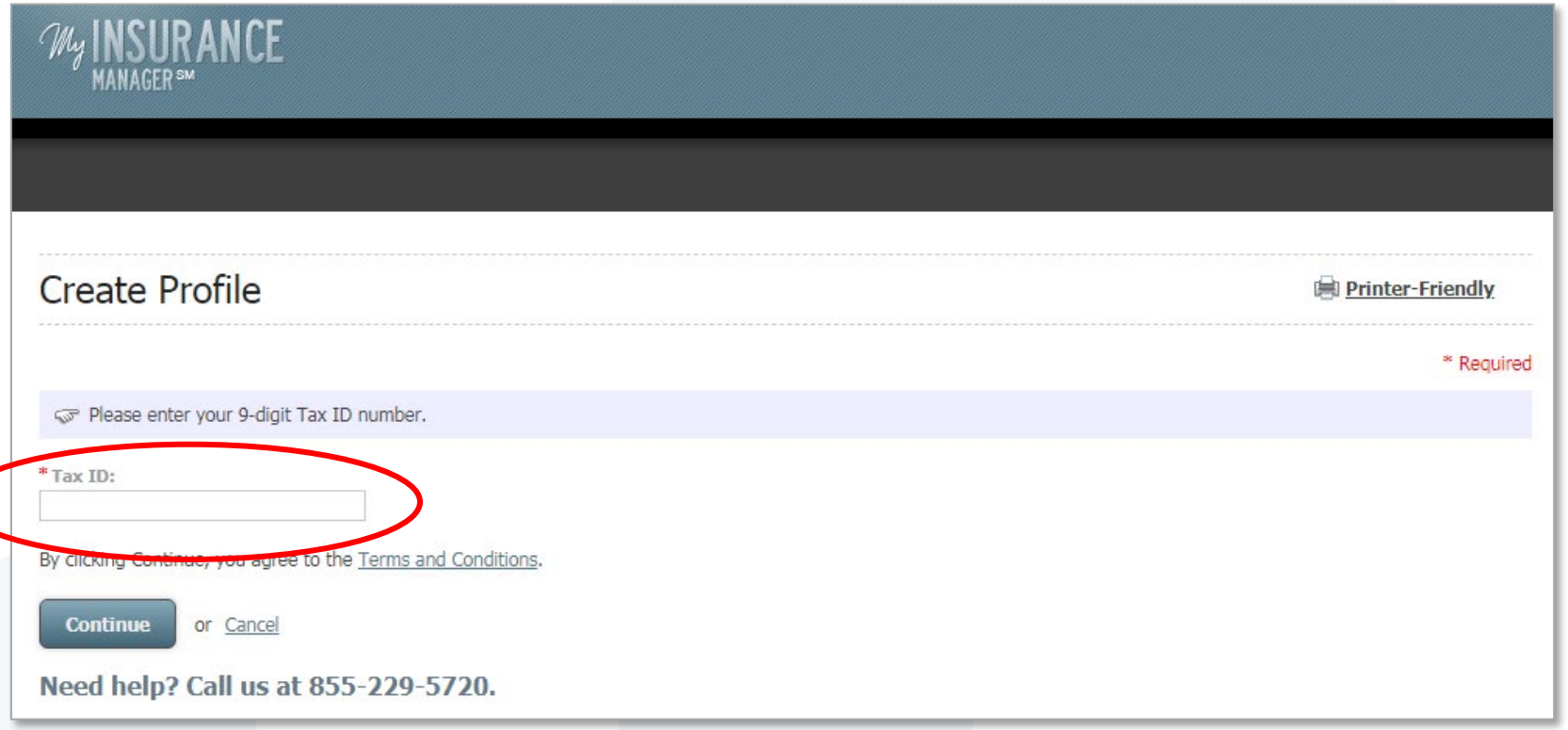
Start here.



My Insurance Manager

Getting Started (Continued)

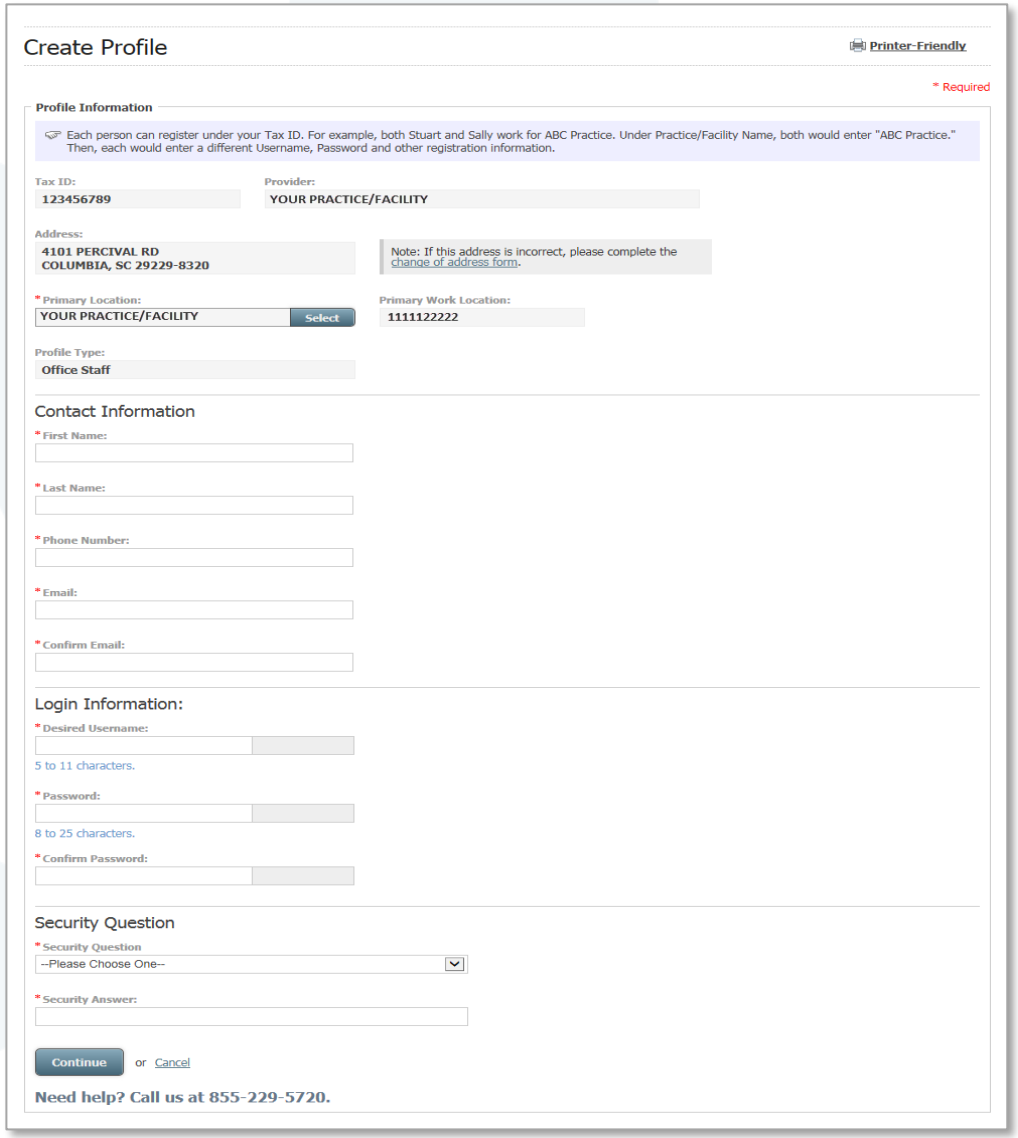
When creating a profile, the 9-digit Tax ID must be entered. Select **Continue**.



My Insurance Manager

Getting Started (Continued)

- The information associated with the Tax ID entered will auto-populate.
  - If there are multiple locations associated with the provider's practice, they will be given the option to select the primary location.
- Enter the remaining contact and login information, along with selecting a security question.
- Select **Continue**.

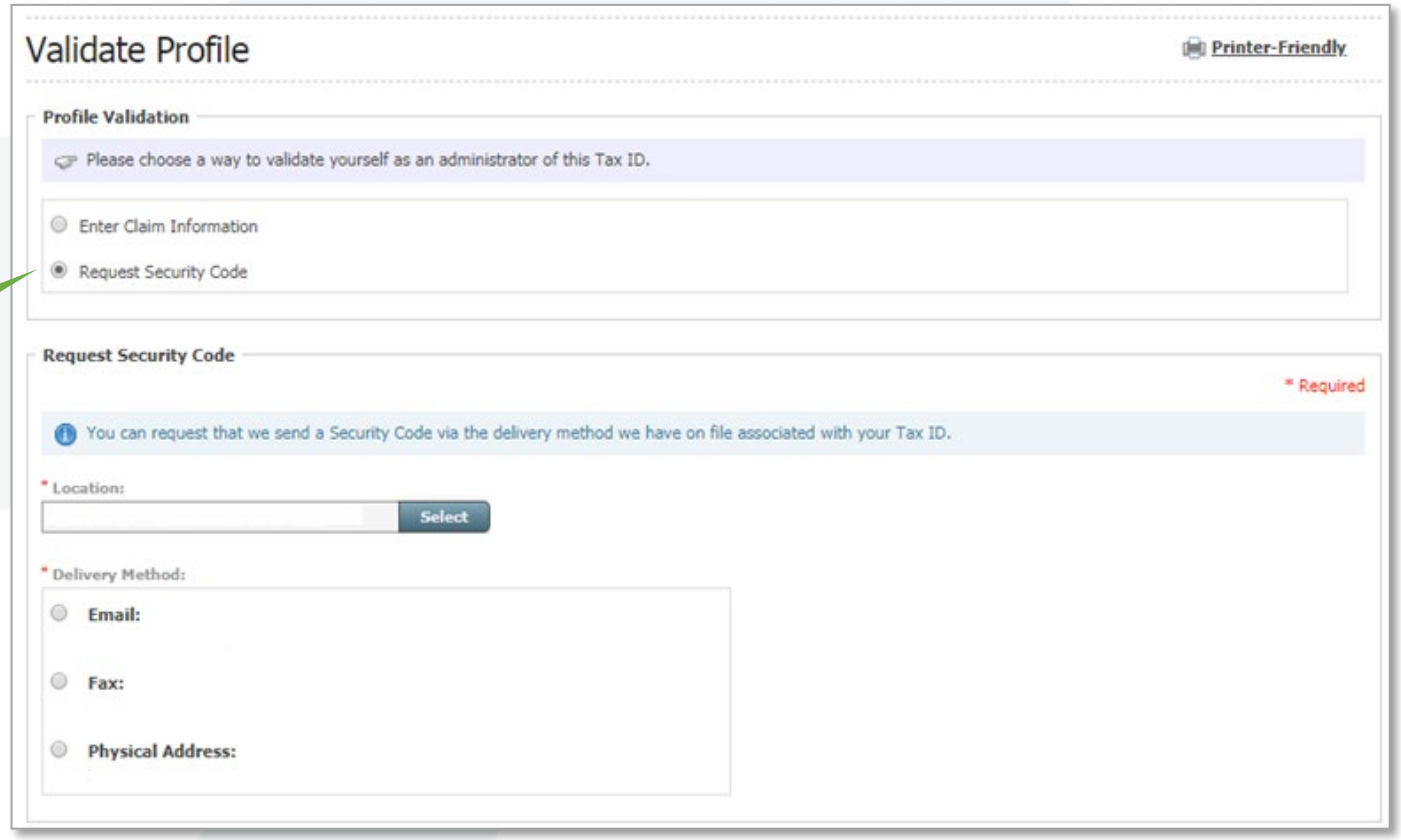


My Insurance Manager

Getting Started (Continued)

If registering as the administrator, validation must be made by selecting: **Enter Claim Information** or **Request Security Code**. Also, select the delivery method to receive the code.

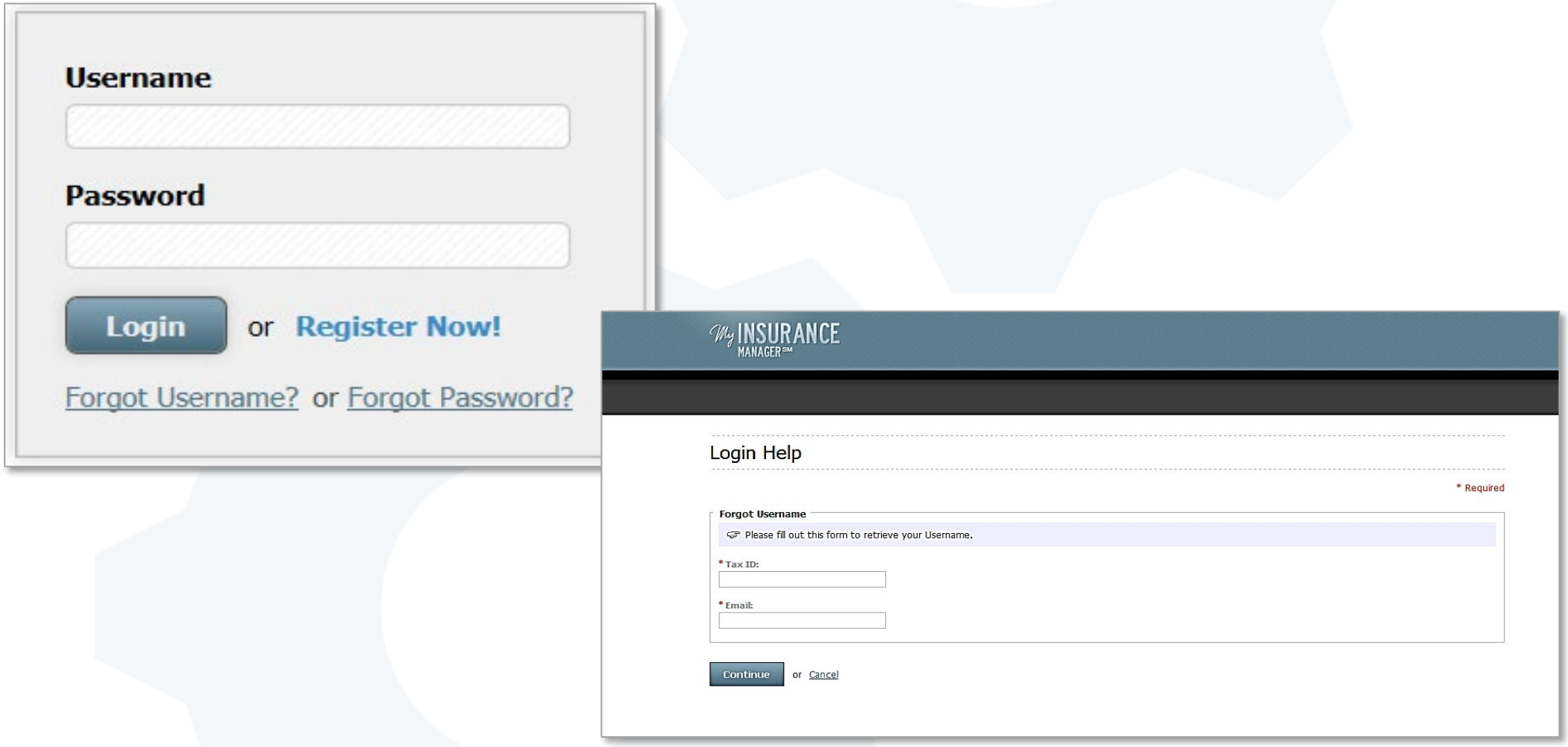
Recommended option



My Insurance Manager

Logging In

From the MIM homepage, enter the username and password. Select **Login**.

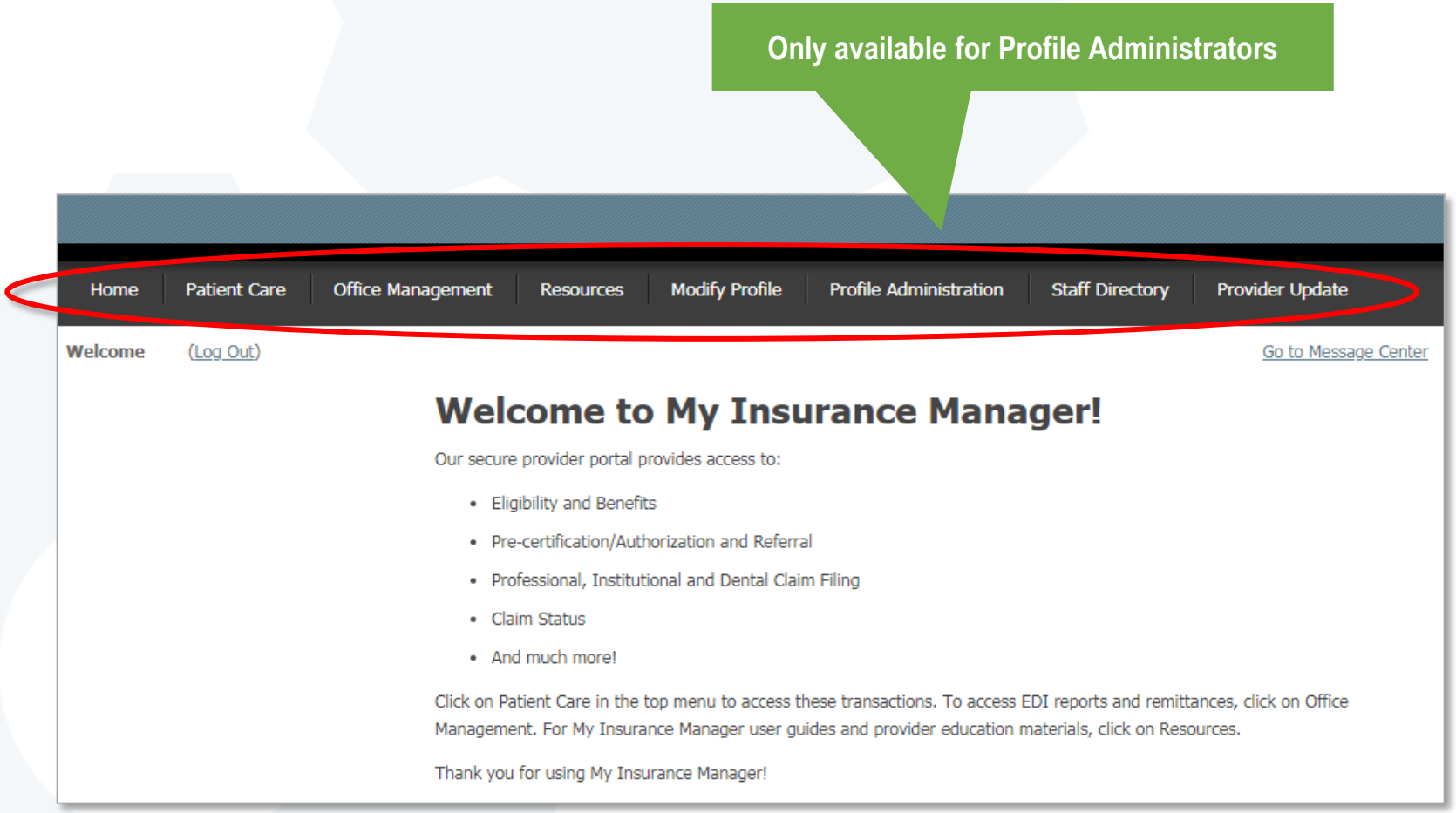


My Insurance Manager

Administrative Tabs

The following administrative tabs will be located at the top of the homepage:

- Patient Care
- Office Management
- Resources
- Modify Profile
- Profile Administration
- Staff Directory
- Provider Update (M.D. Checkup)



My Insurance Manager

Patient Care

- Patient Care is categorized by Health and Dental.
- For both Health and Dental services, the following options include:
  - View claims status.
  - Check eligibility and benefits.
  - Request prior authorizations.
  - and much more.

My Insurance Manager

Office Management

- For both Health and Dental services, available options include EDI reports, enroll for EFT/ERA and view remittance information.
- Additional options for Health services include:
  - PCMH Reports and Patient Validation *
  - Refund Letters
  - HEDIS Reports
  - Employer Group Care Reports
  - Provider Report Cards

***This report only applies and shows up for PCMH providers.**

My Insurance Manager

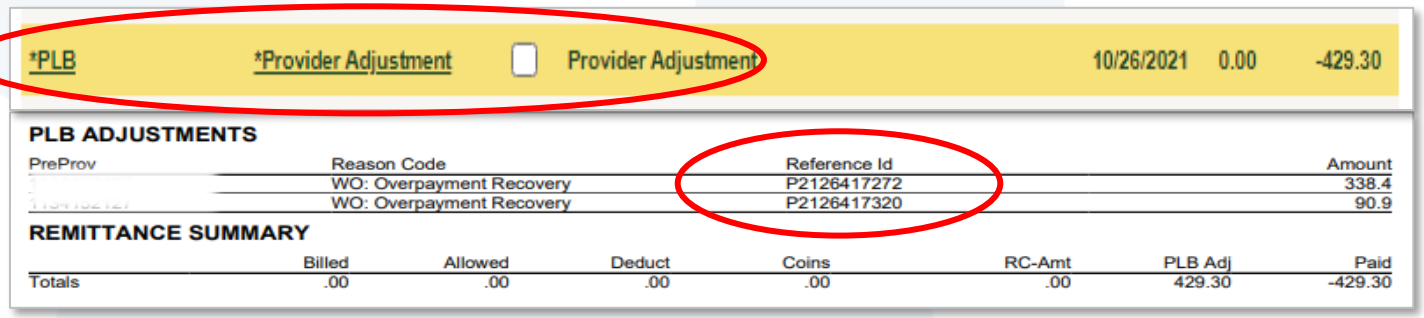
Office Management — Refund Letters

Refund letters include:

- Reason for the refund
- Refund control number (RCN)
- Claim details
- Patient details

If you do not have the refund letter:

- Call Provider Services: 800-868-2510, opt. 4.
  - Used for the following lines of business:
    - BlueCard
    - BlueEssentials℠
    - Major Group
    - National Alliance
    - Small Group & Individual



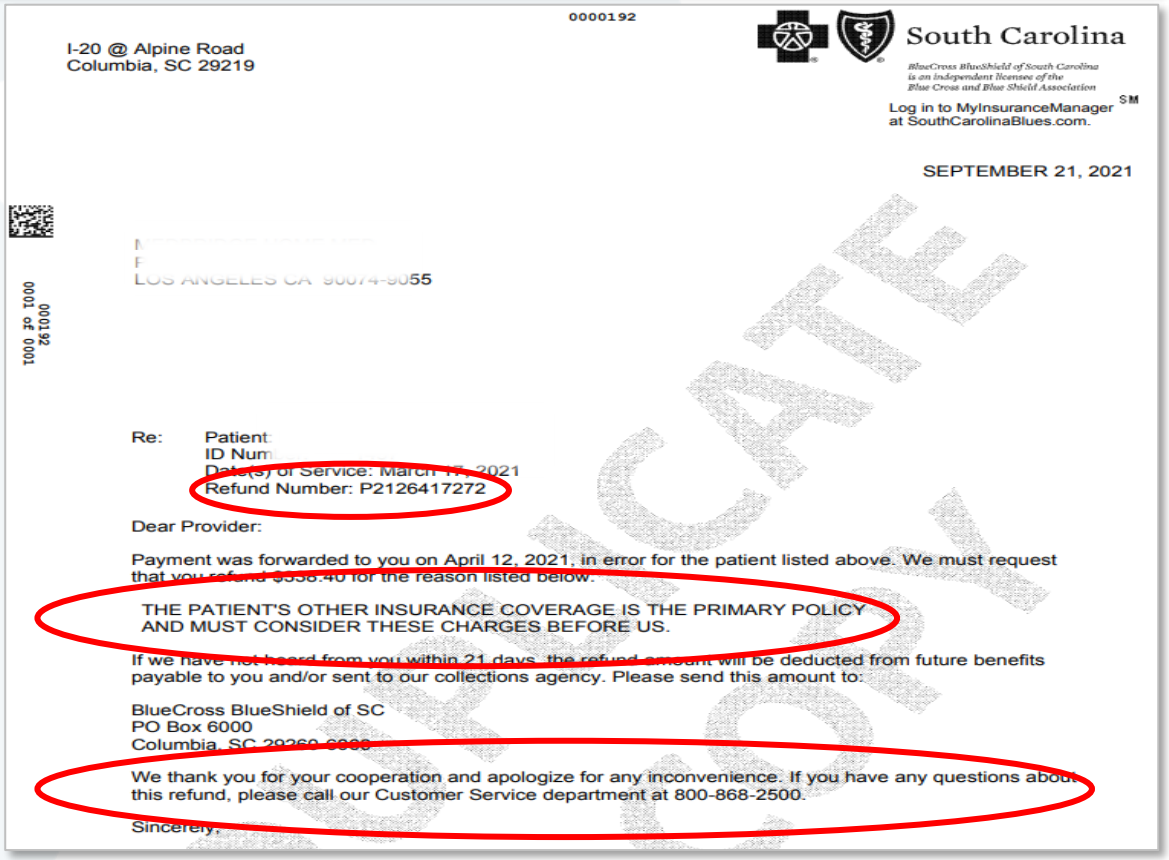
*PLB *Provider Adjustment ☐ Provider Adjustment 10/26/2021 0.00 -429.30

PLB ADJUSTMENTS

PreProv	Reason Code	Reference Id	Amount
	WO: Overpayment Recovery	P2126417272	338.4
	WO: Overpayment Recovery	P2126417320	90.9

REMITTANCE SUMMARY

	Billed	Allowed	Deduct	Coins	RC-Amt	PLB Adj	Paid
Totals	.00	.00	.00	.00	.00	429.30	-429.30



0000192

I-20 @ Alpine Road
Columbia, SC 29219

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

Log in to MyInsuranceManager℠ at SouthCarolinaBlues.com.

SEPTEMBER 21, 2021

LOS ANGELES CA 90074-9055

0000192 1000 2F 0001

Re: Patient
ID Num
Date(s) of Service: March 19, 2021
Refund Number: P2126417272

Dear Provider:

Payment was forwarded to you on April 12, 2021, in error for the patient listed above. We must request that you refund $338.40 for the reason listed below:

THE PATIENT'S OTHER INSURANCE COVERAGE IS THE PRIMARY POLICY AND MUST CONSIDER THESE CHARGES BEFORE US.

If we have not heard from you within 21 days, the refund amount will be deducted from future benefits payable to you and/or sent to our collections agency. Please send this amount to:

BlueCross BlueShield of SC
PO Box 6000
Columbia, SC 29260-6000

We thank you for your cooperation and apologize for any inconvenience. If you have any questions about this refund, please call our Customer Service department at 800-868-2500.

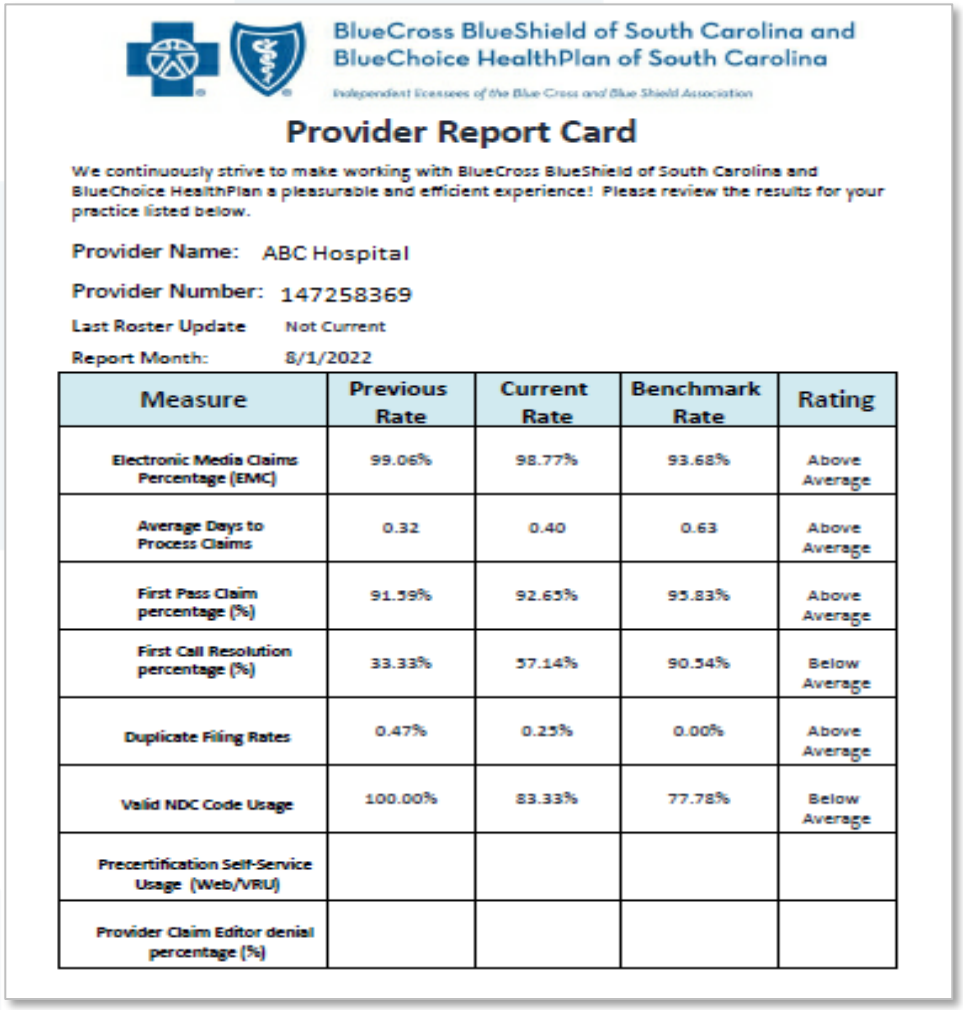
Sincerely,

My Insurance Manager

Office Management — Provider Report Cards

Provider Report Cards provide:

- Electronic Media Claims Percentages.
- Average Days to Process Claims.
- First Pass Claim Percentages.
- First Call Resolution Percentages.
- Duplicate Filing Rates.
- Valid NDC Code Usage.
- Precertification Self-Service Usage.
- Provider Claim Editor Denial Percentage.



BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Provider Report Card

We continuously strive to make working with BlueCross BlueShield of South Carolina and BlueChoice HealthPlan a pleasurable and efficient experience! Please review the results for your practice listed below.

Provider Name: ABC Hospital

Provider Number: 147258369

Last Roster Update: Not Current

Report Month: 8/1/2022

Measure	Previous Rate	Current Rate	Benchmark Rate	Rating
Electronic Media Claims Percentage (EMC)	99.06%	98.77%	93.68%	Above Average
Average Days to Process Claims	0.32	0.40	0.63	Above Average
First Pass Claim percentage (%)	91.59%	92.65%	95.83%	Above Average
First Call Resolution percentage (%)	33.33%	57.14%	90.54%	Below Average
Duplicate Filing Rates	0.47%	0.25%	0.00%	Above Average
Valid NDC Code Usage	100.00%	83.33%	77.78%	Below Average
Precertification Self-Service Usage (Web/VRU)				
Provider Claim Editor denial percentage (%)				

Note: Empty fields indicate there was no data available for the measure during that period.

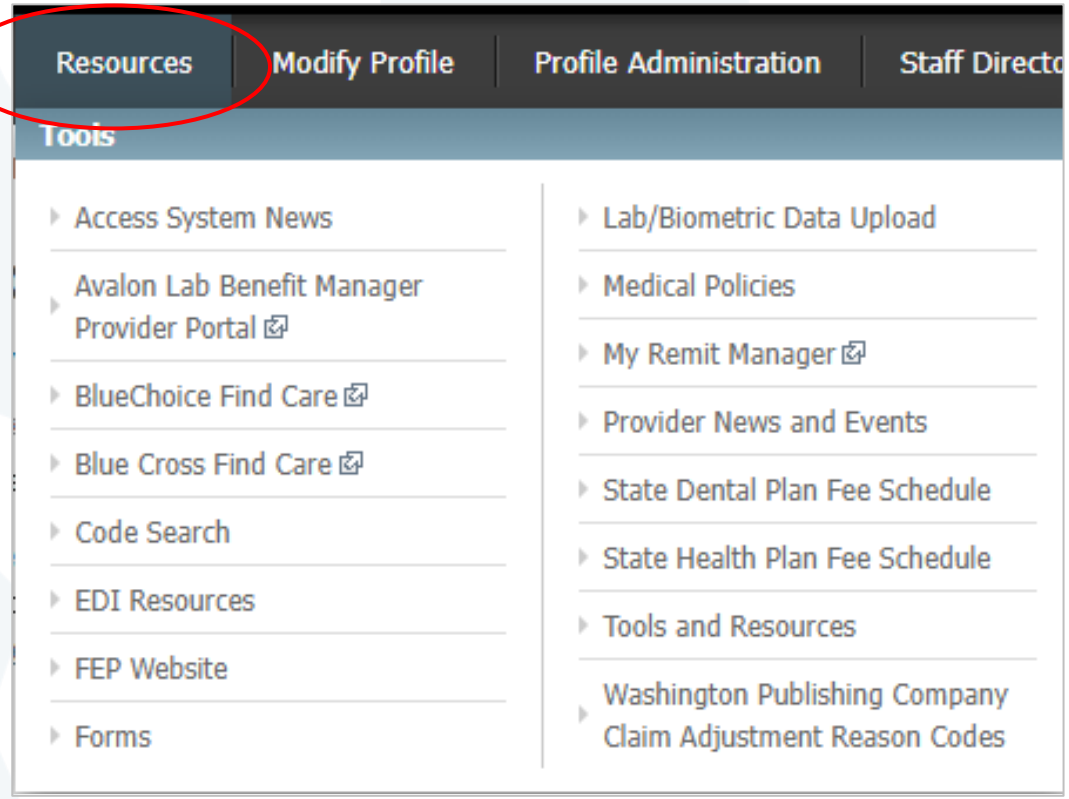
My Insurance Manager

Resources

Resources provide beneficial information, some of which may route to a separate website.

Most used resources are:

- Avalon Lab Benefit Manager Provider Portal
- Medical Policies
- My Remit Manager

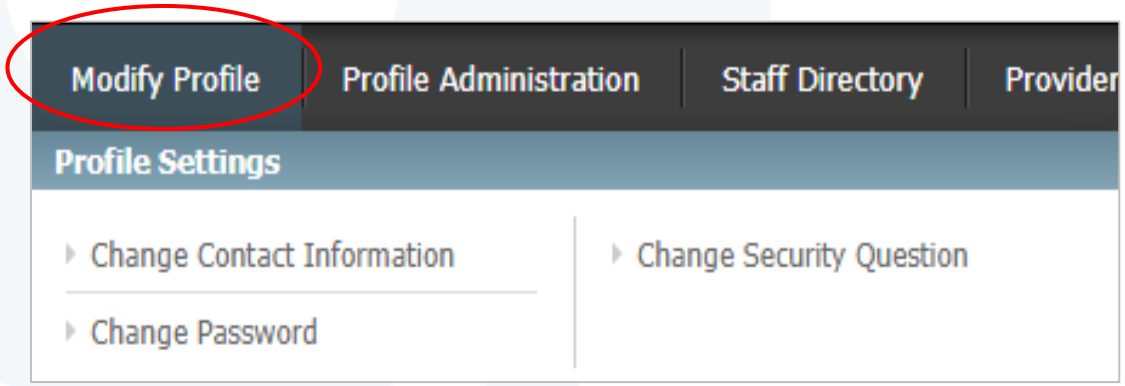


My Insurance Manager

Modify Profile

If changes are needed to your profile, look under Modify Profile. Options include:

- Change Contact Information.
- Change Password.
- Change Security Question.



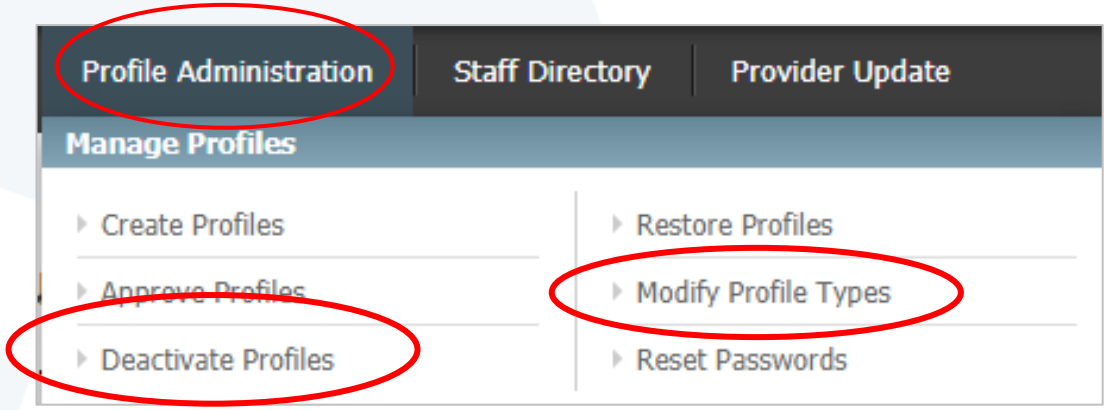
My Insurance Manager

Profile Administration

Profile Administration is available for the administrator(s) for the practice to:

- Create profiles.
- Approve profiles.
- Deactivate profiles.
- Restore profiles.
- Modify profile types.
- Reset passwords.

Only available for Profile Administrators.



Note: If someone no longer works at your practice, deactivate their profile. Also, if you are the profile administrator and plan to leave, please make someone else the profile administrator.

My Insurance Manager

Staff Directory and Provider Update

- Staff Directory provides a list of profiles associated with the Tax ID in MIM.
- Provider Update (M.D. Checkup) allows updates and validations to be made to the demographic information we have in the Provider Directory.
  - As of Jan. 1, 2022, a provider update is required at least **every 90 days**, as part of the Consolidated Appropriations Act (CAA).
    - Locations are suppressed if validations are not made.

My Insurance Manager

Troubleshooting Tips

- Complete the MIM registration process to avoid limited access features.
- Be sure to use one of the recommended browsers:
  - Internet Explorer (IE) 10 or higher.
  - Mozilla Firefox.
  - Google Chrome.
  - Safari.
- On Sundays from 5 p.m. to midnight EST, MIM is unavailable for maintenance.
- For technical issues, call Technical Support at 855-229-5720.

Ask Provider Services

Ask Provider Services

Ask Provider Services (Web inquiries)

- Ask Provider Services is a feature inside My Insurance Manager that allows you to submit secured web inquiries for help with claims.
- To get the most effective and accurate responses, ask specific, probing questions.
  - This feature should not be used for general claim status.

These answers are in MIM.

Examples of appropriate questions to ask…	Examples of inappropriate questions to ask…
Why was line one of the claim denied as noncovered?	What is the status of the claim?
Why were services applied to the member's deductible?	Have medical records been received?
Has the member returned the coordination of benefits questionnaire?	Has the claim been processed?

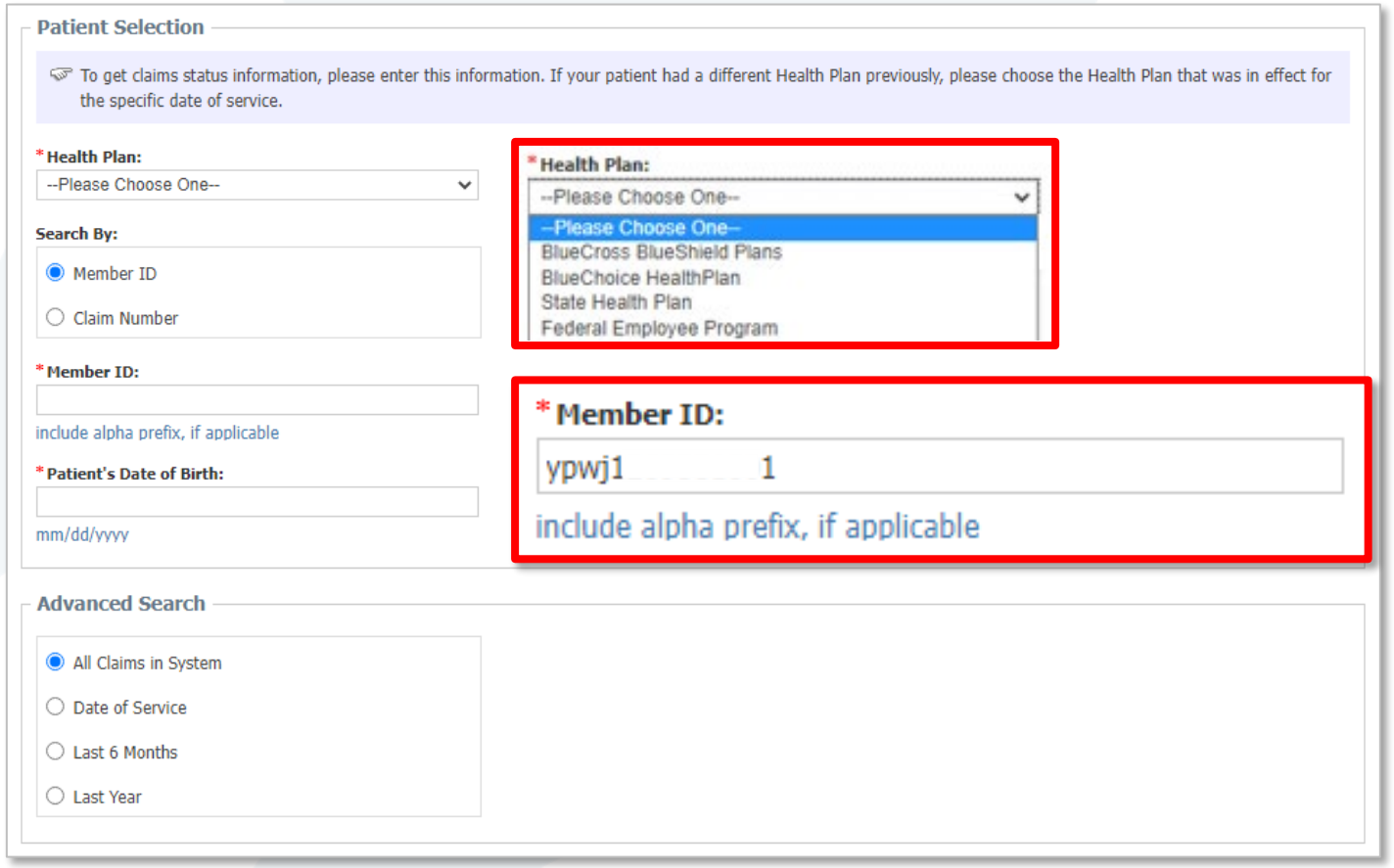
Ask Provider Services

Ask Provider Services — Submitting Web Inquiries

Searching by Member ID (recommended option)

Be sure to:

- Select the appropriate Health Plan.
- Enter the **FULL** Member ID, including the prefix and any additional letters.
- Enter the date of birth.
- Select one of the advanced options.



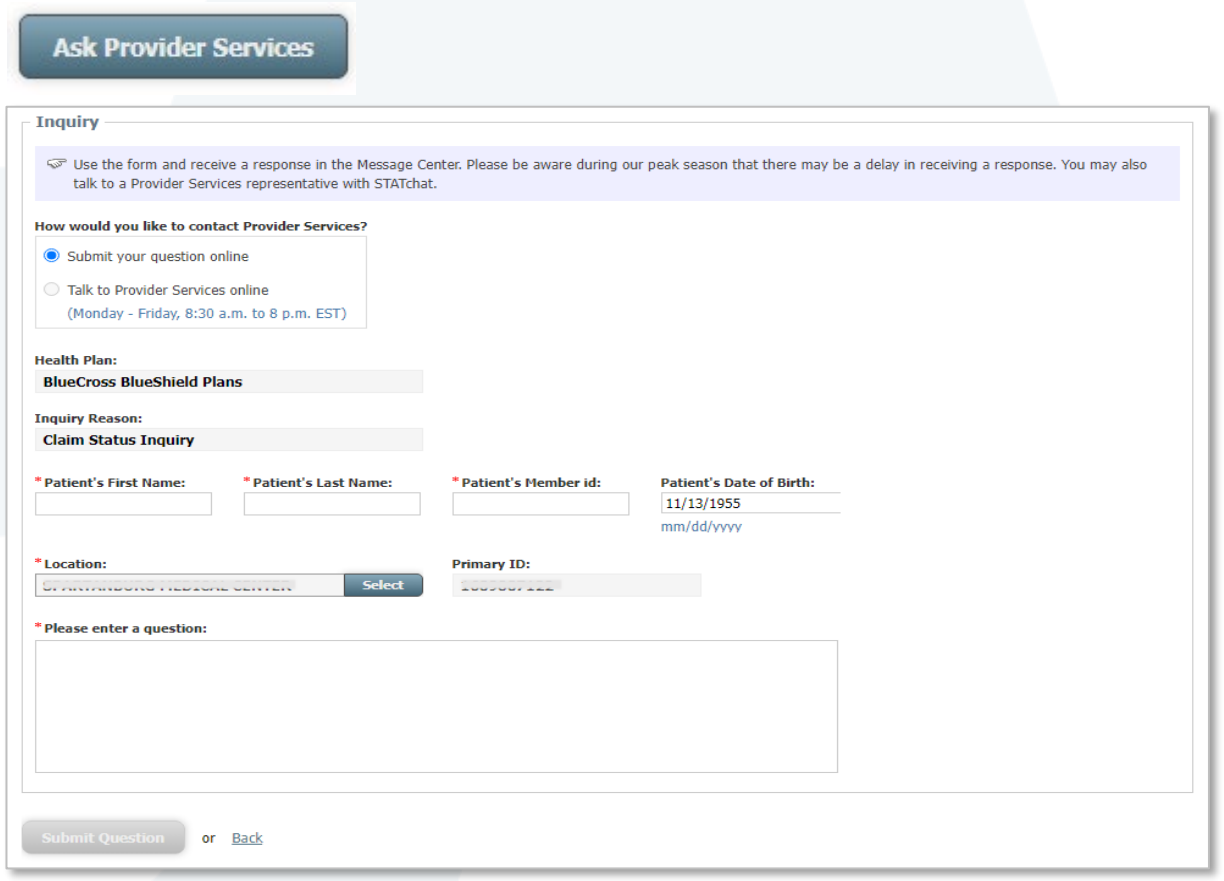
Ask Provider Services

Ask Provider Services — Submitting Web Inquiries

Searching by Member ID (Continued)

Be sure to:

- Enter the patient's first and last name.
- Enter the **FULL** Member ID, including the prefix and any additional letters.
- The date of birth and location will auto-populate from the selected claim.
- Enter your question (be specific as possible).



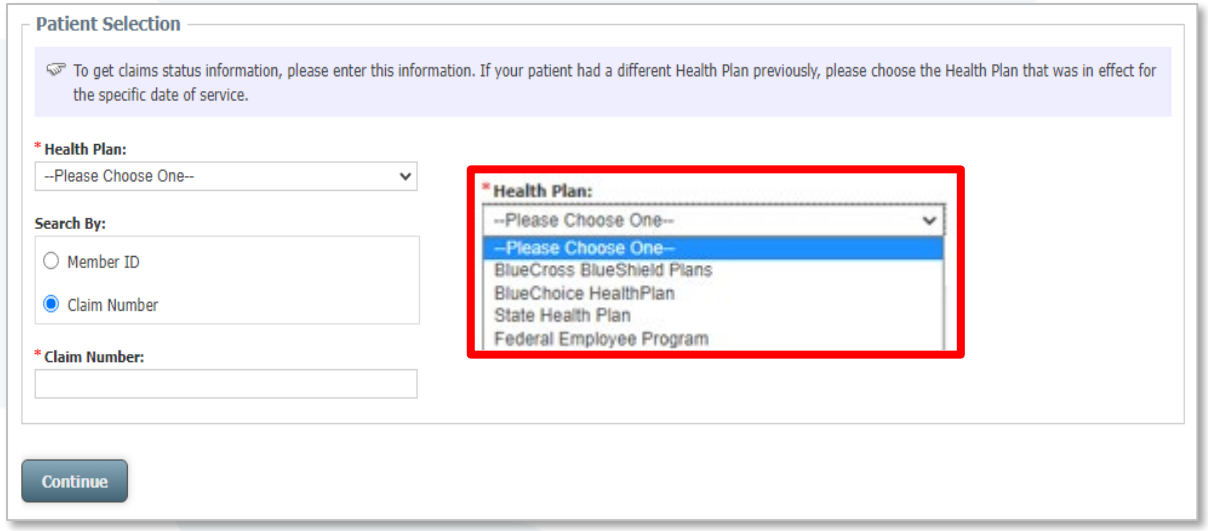
Ask Provider Services

Ask Provider Services — Submitting Web Inquiries

Searching by Claim Number

Be sure to:

- Select the appropriate Health Plan.
- Enter the claim number.



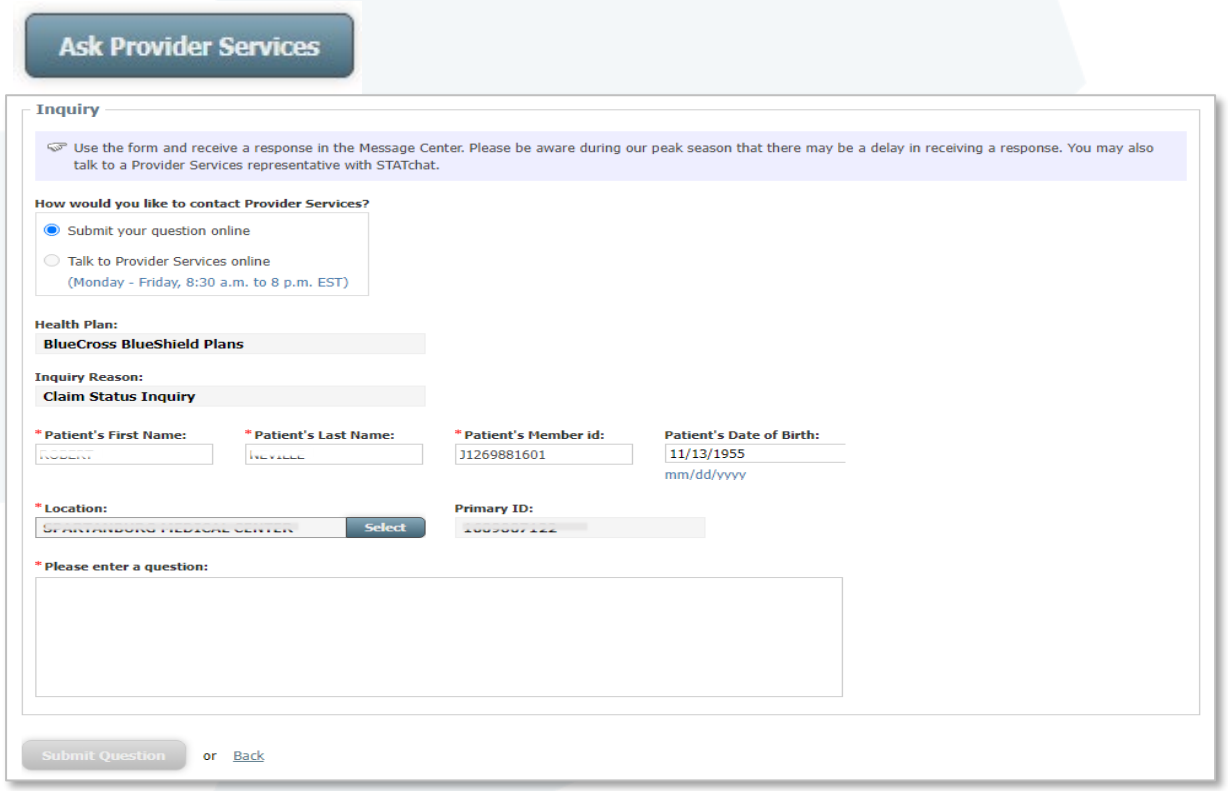
Ask Provider Services

Ask Provider Services — Submitting Web Inquiries

Searching by Claim Number (Continued)

Be sure to:

- Enter the patient's name, ID number, date of birth and location will auto-populate from the entered claim.
- Enter your question (be specific as possible).

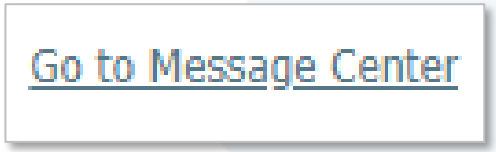


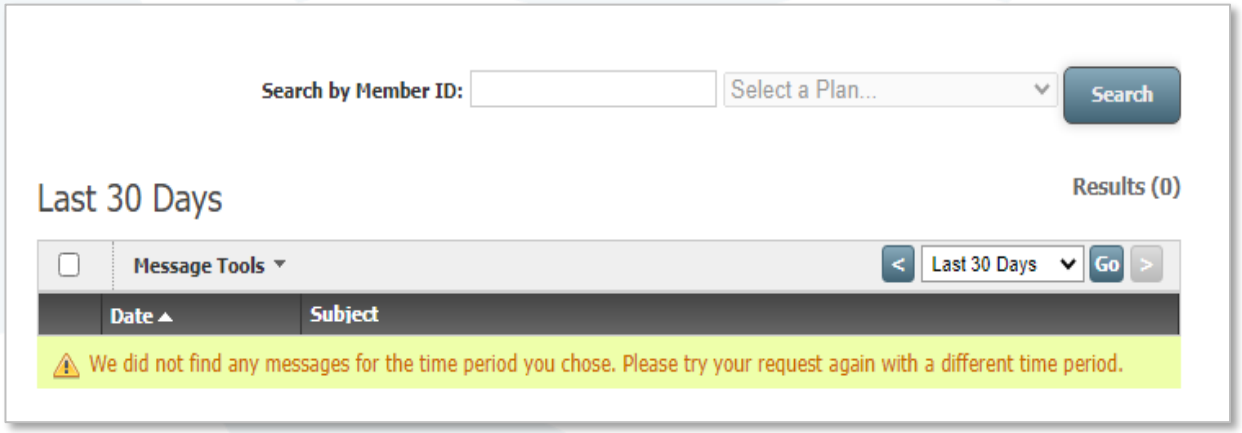
Ask Provider Services

Ask Provider Services — Viewing Web Inquiry Responses

Be sure to:

- Select Go to Message Center.
- To narrow the results, you can:
  - Enter the ID number and select the health plan.
  - Select specific months.





Note: If you submit an inquiry in one month and do not see a response, search by the member's ID number. The response may be listed under a different month.

STATchat

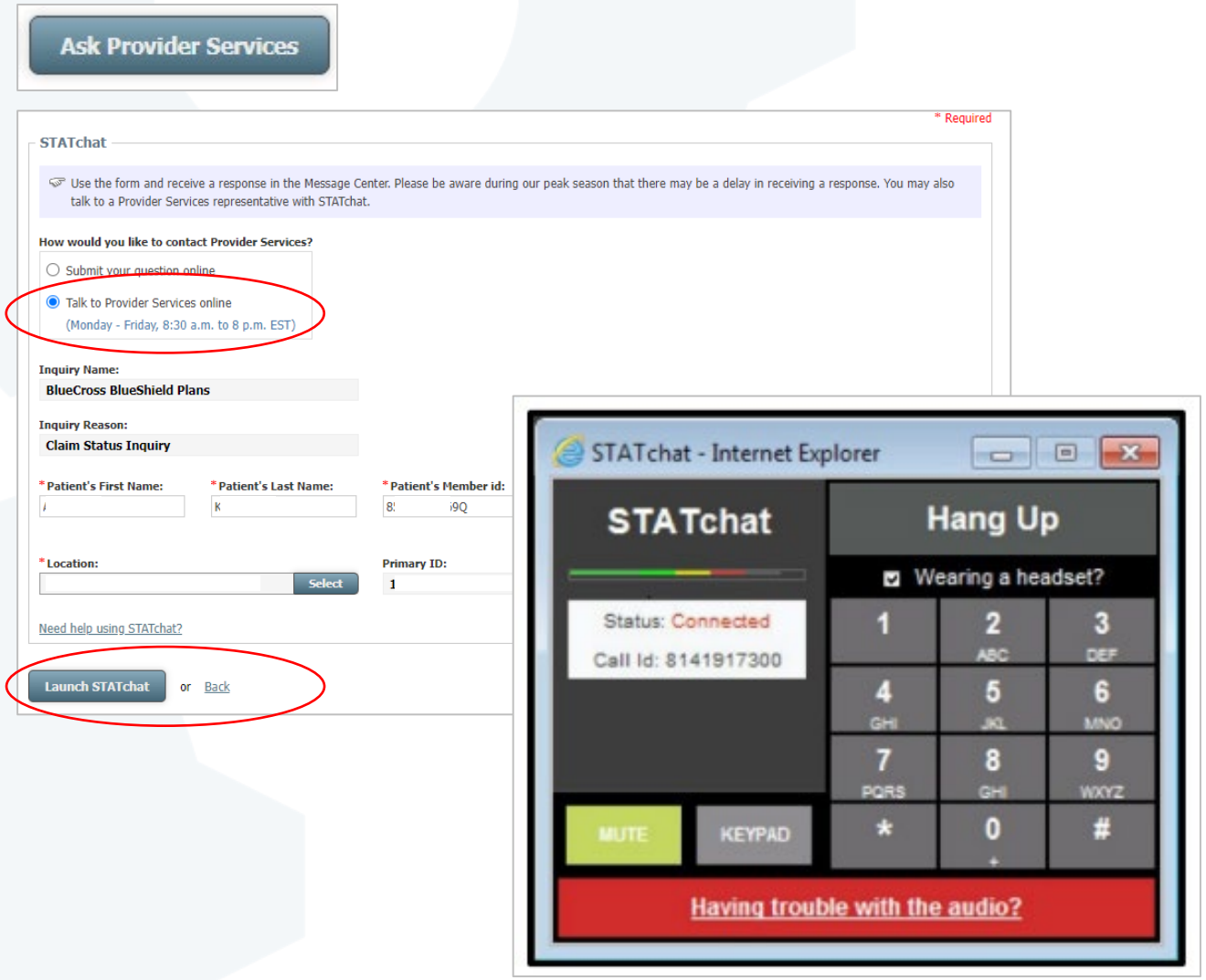
STATchat

STATchat

- STATchat is a fast and simple way to speak with a provider services representative.
- The feature is available through My Insurance Manager.

System Requirements

- A current version of Adobe Flash Player
- A compatible web browser, such as Microsoft Internet Explorer 10 or EDGE® or Google Chrome®
- A headset (recommended) or standalone microphone and speakers connected to your computer

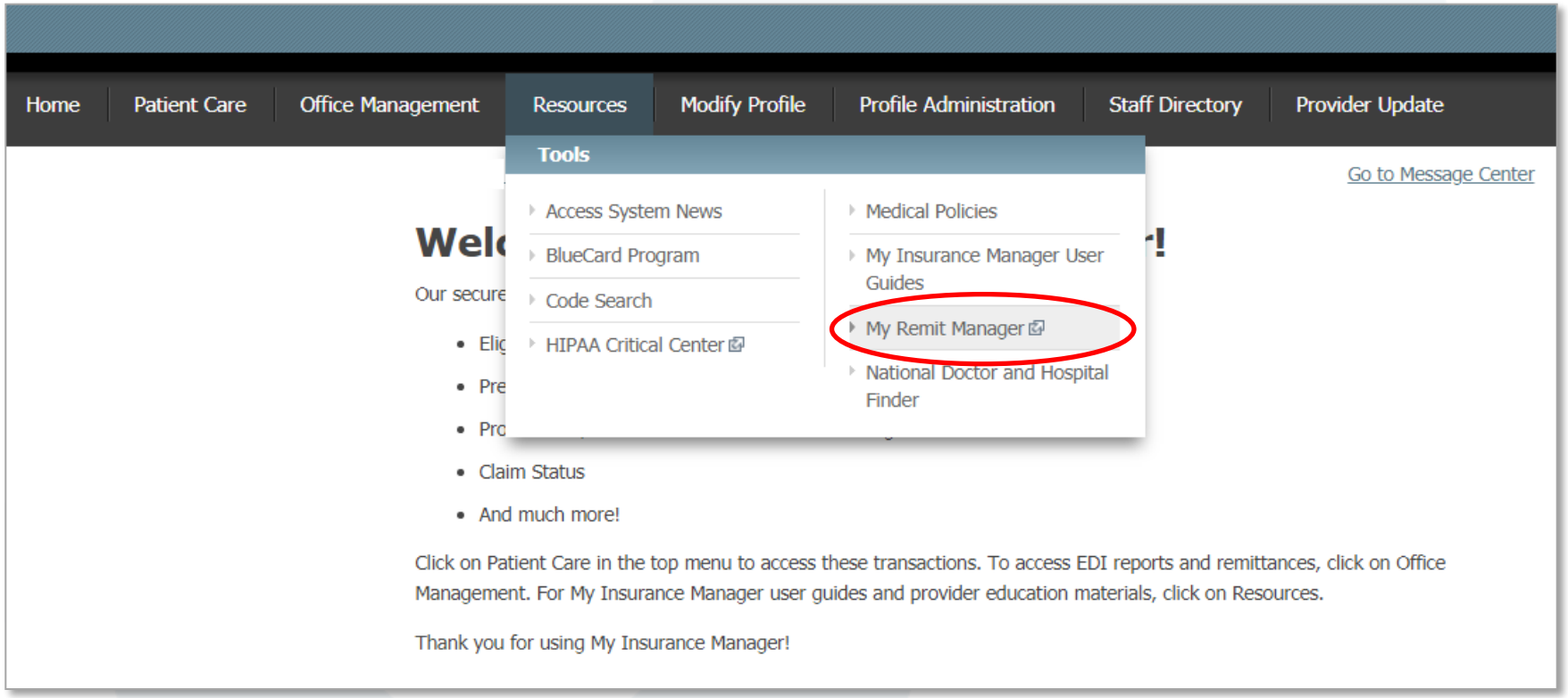


My Remit Manager

My Remit Manager

Access Through My Insurance Manager

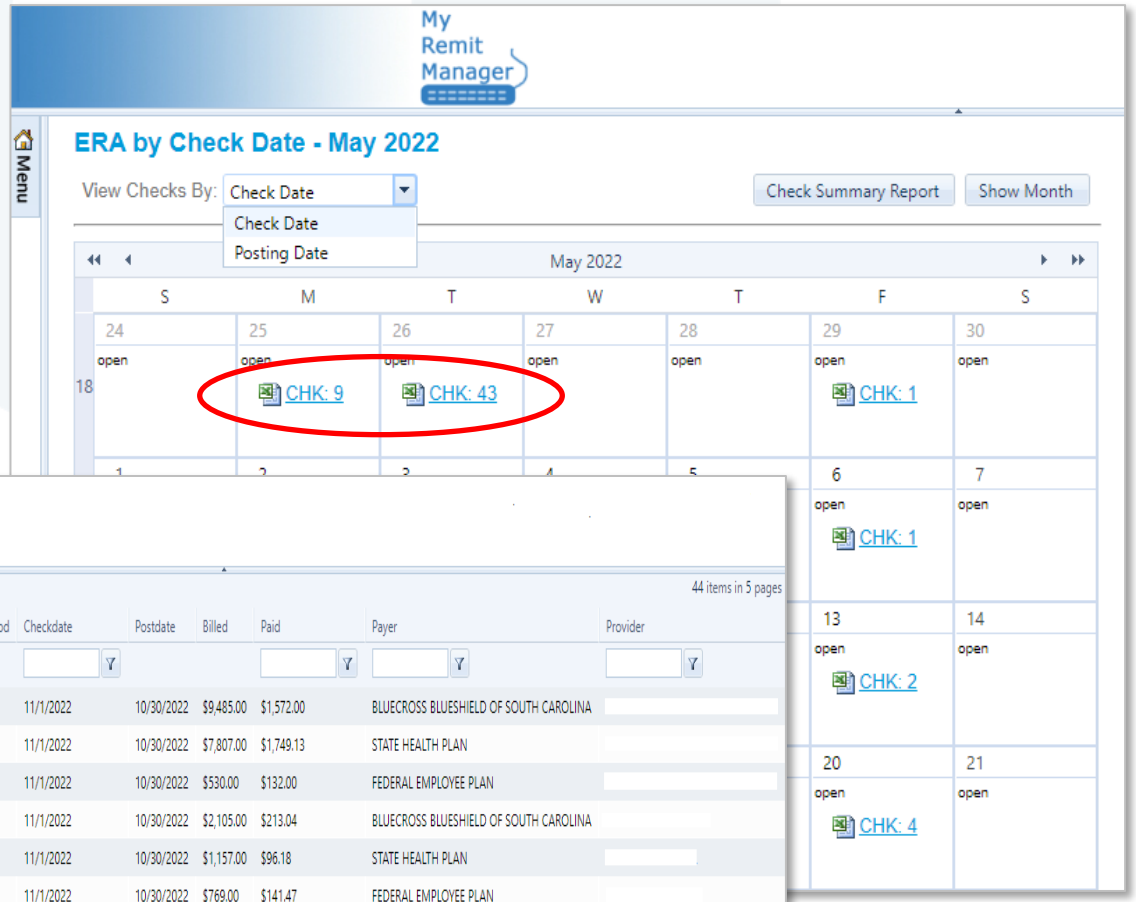
- Tool used to track payments and pull electronic remittance advices
- From My Insurance Manager, hover over Resources, then select My Remit Manager

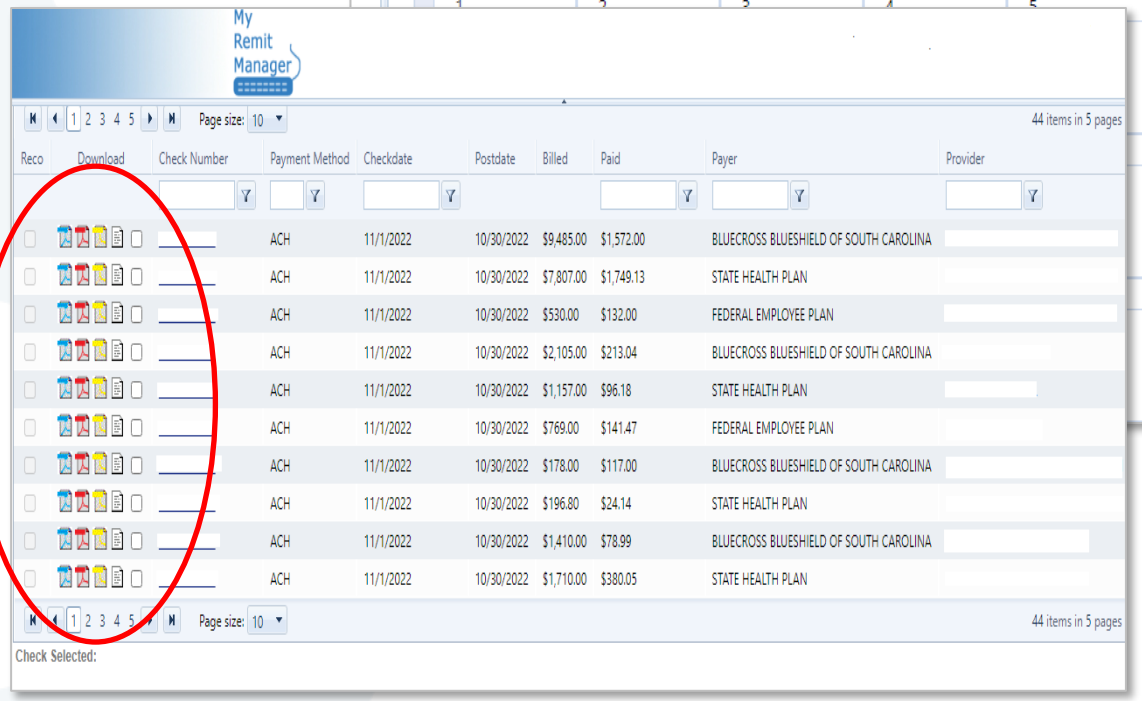


My Remit Manager

My Remit Manager Through My Insurance Manager

- Sort and view checks by the check date or posting date
- Select the Adobe icon to view the Remit
- Select the check number to view:
  - Members associated with the check
  - DOS
  - Processed status (paid or denied)
  - Amount billed and paid



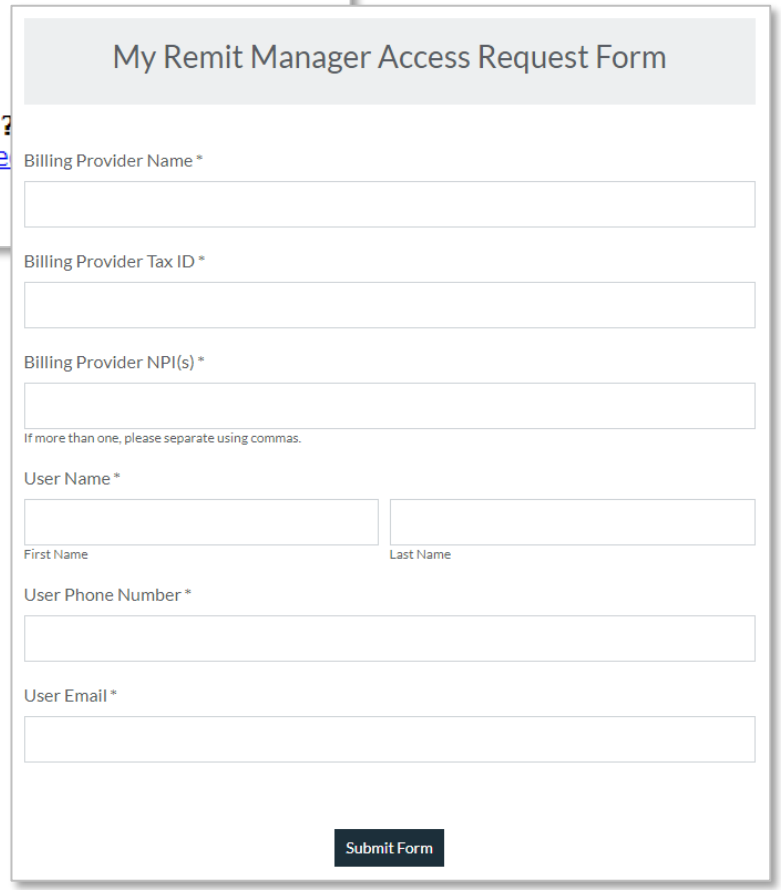


My Remit Manager

External Access to My Remit Manager

- Link: https://client.webclaims.com/v07_03/
- To sign up or for password resets, email EDI.Services@bcbssc.com.
  - The MRM Access Request Form can also be completed, which is located on www.SouthCarolinaBlues.com.

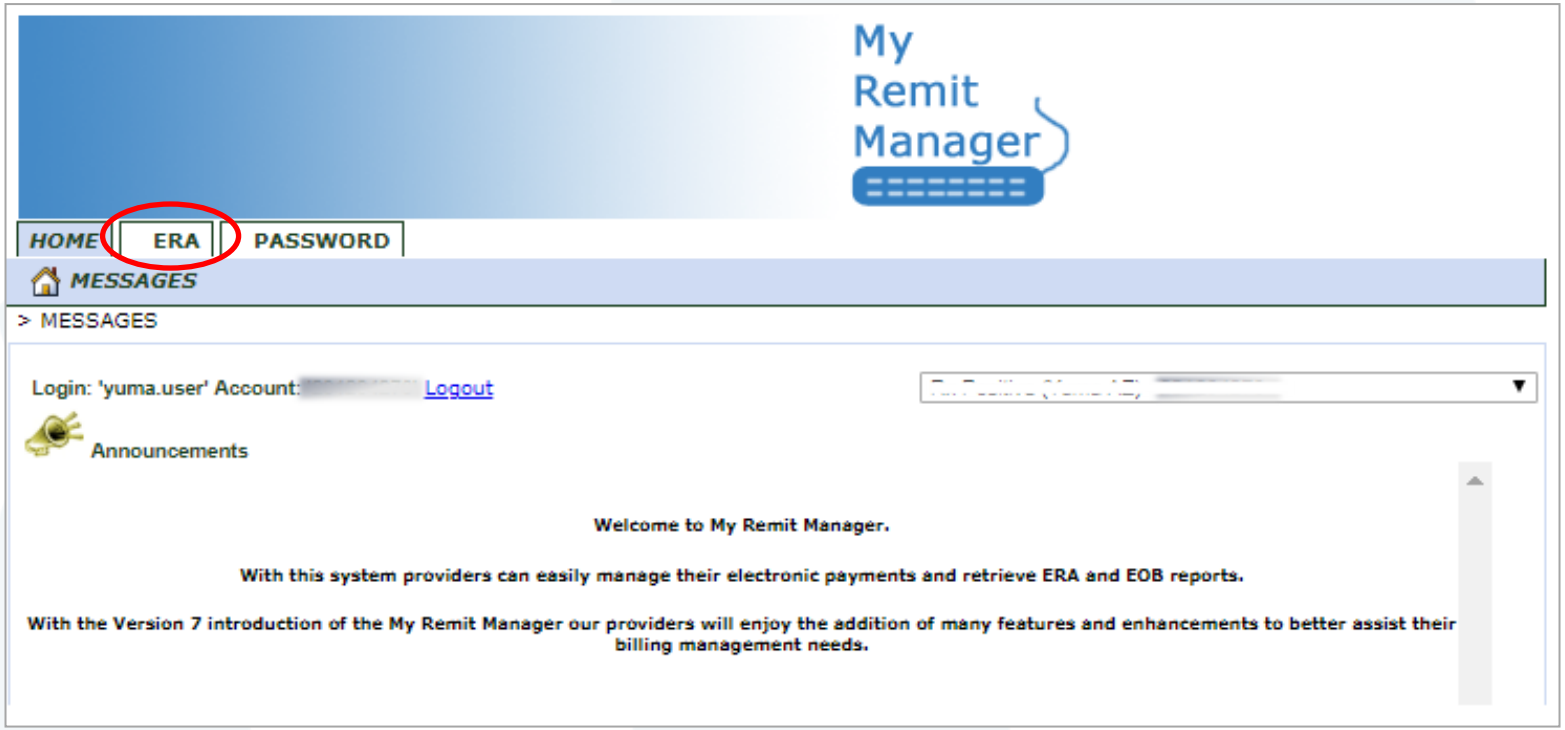
    Providers>Tools and Resources>My Remit Manager
- New registrants will receive their username and password, along with instructions via email.



My Remit Manager

External Access to My Remit Manager (Continued)

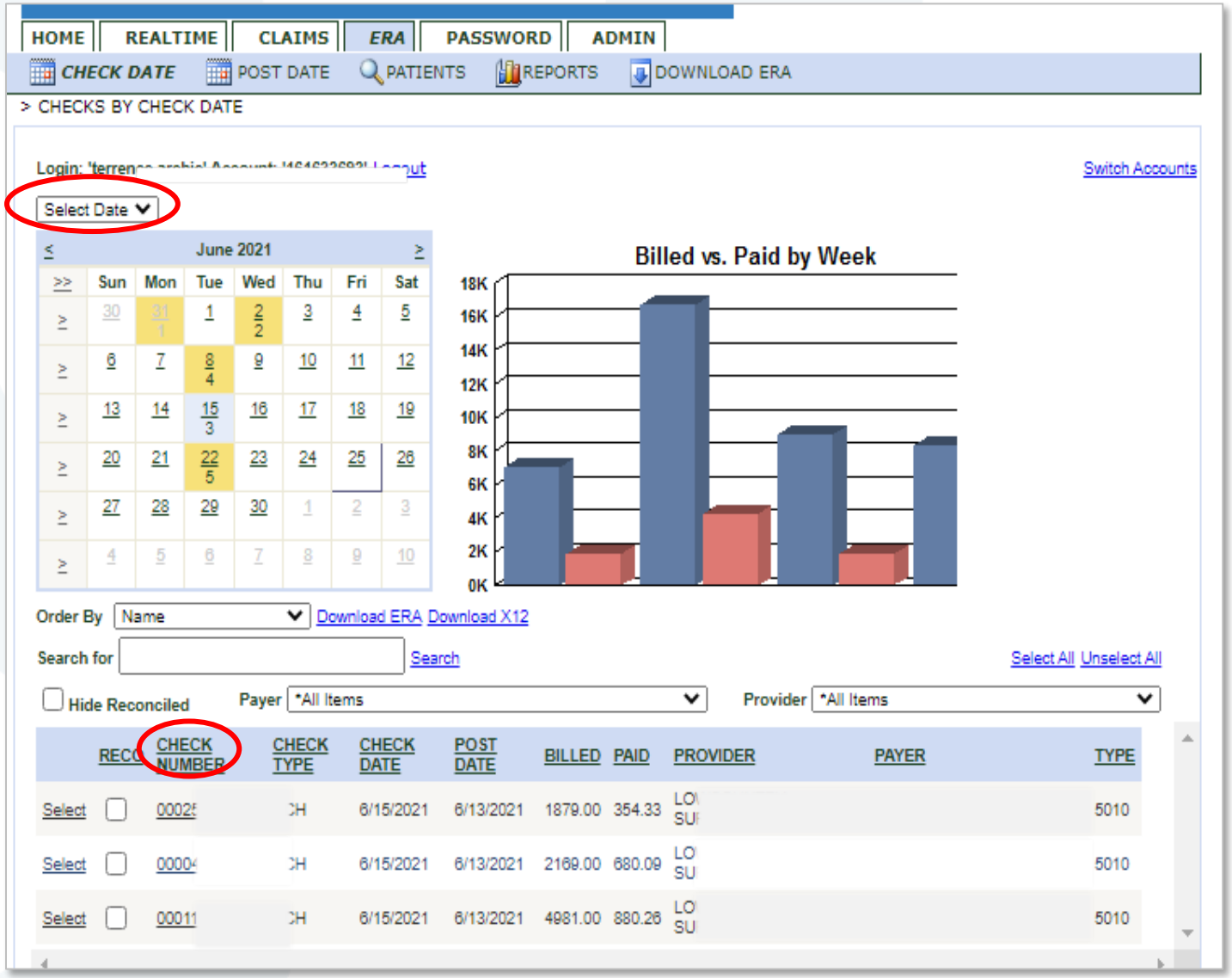
Select the ERA tab to view check and remittance information.



My Remit Manager

ERA Tab — Pulling the Remittance

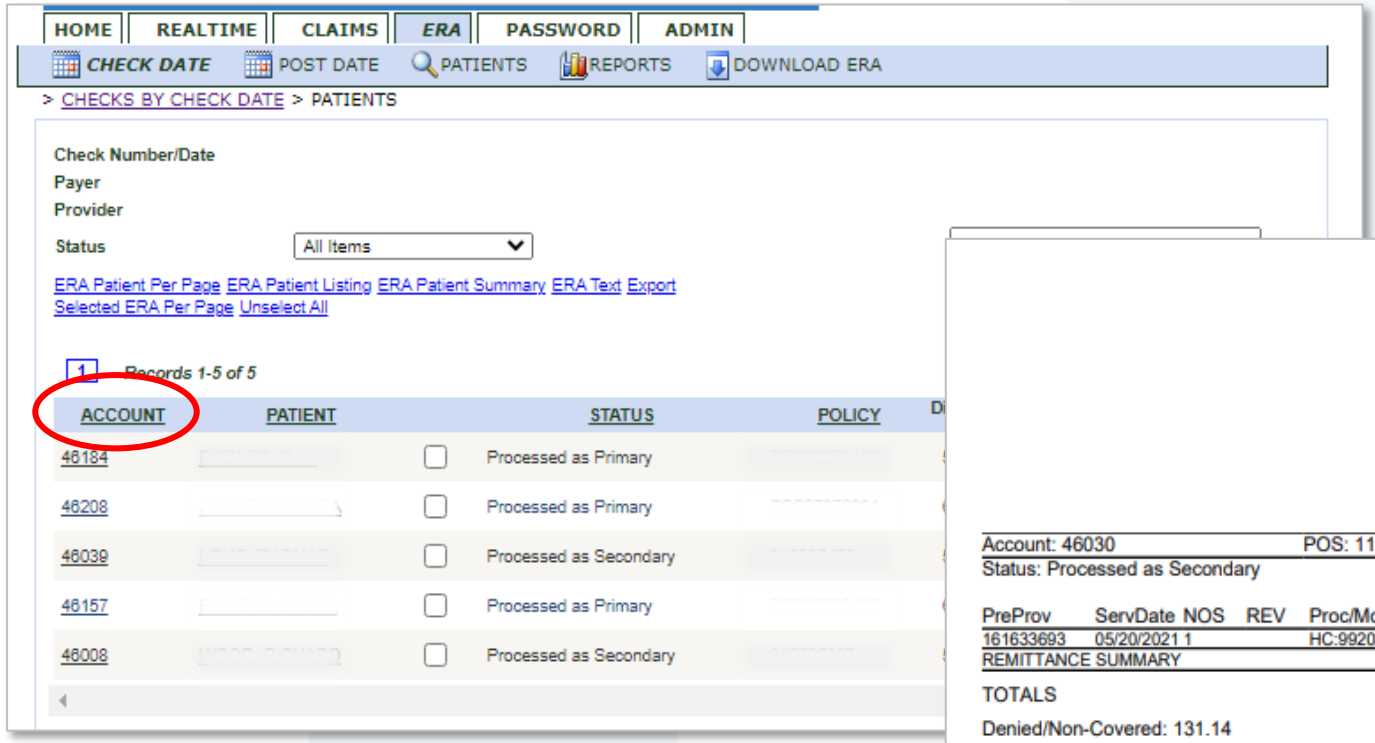
- Select the date of the remittance needed.
- Select the associated check number.

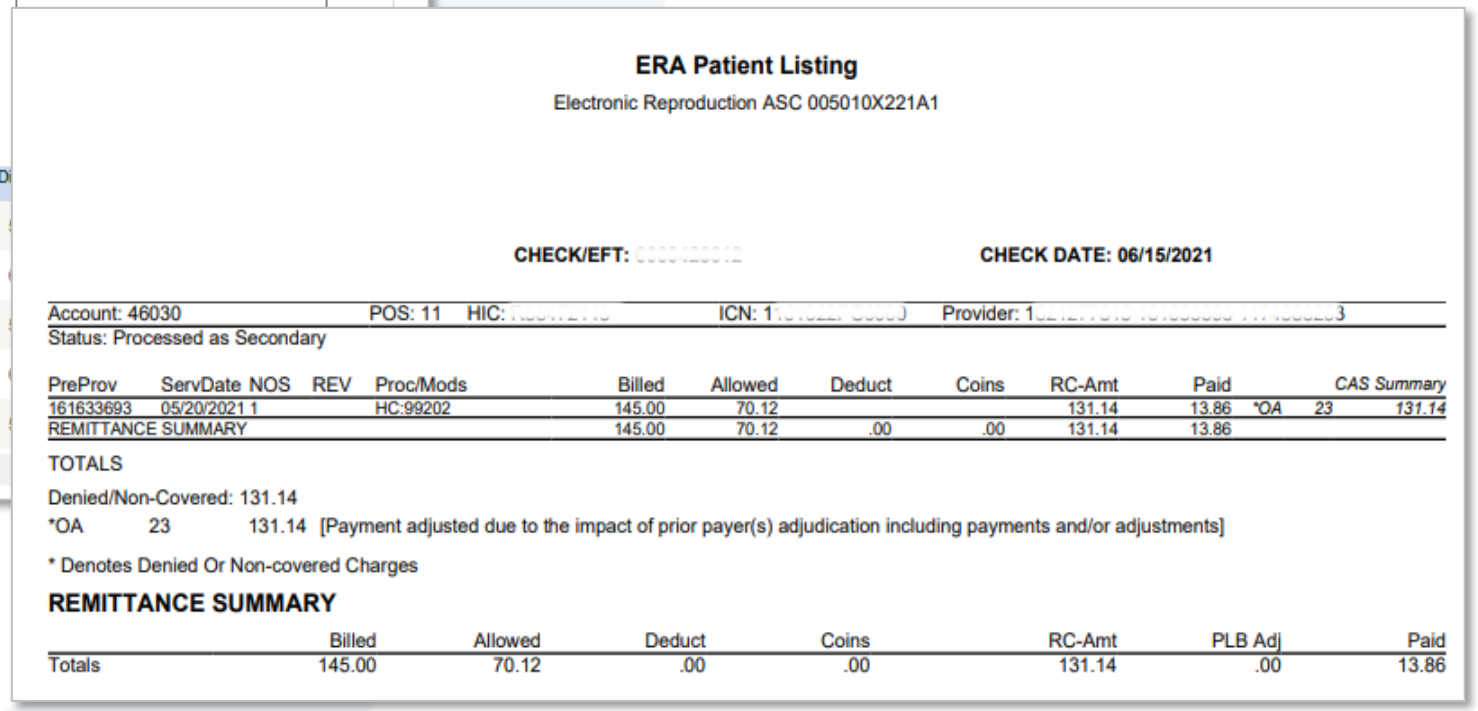


My Remit Manager

ERA Tab — Pulling the Remittance (Continued)

Select the account of the patient.

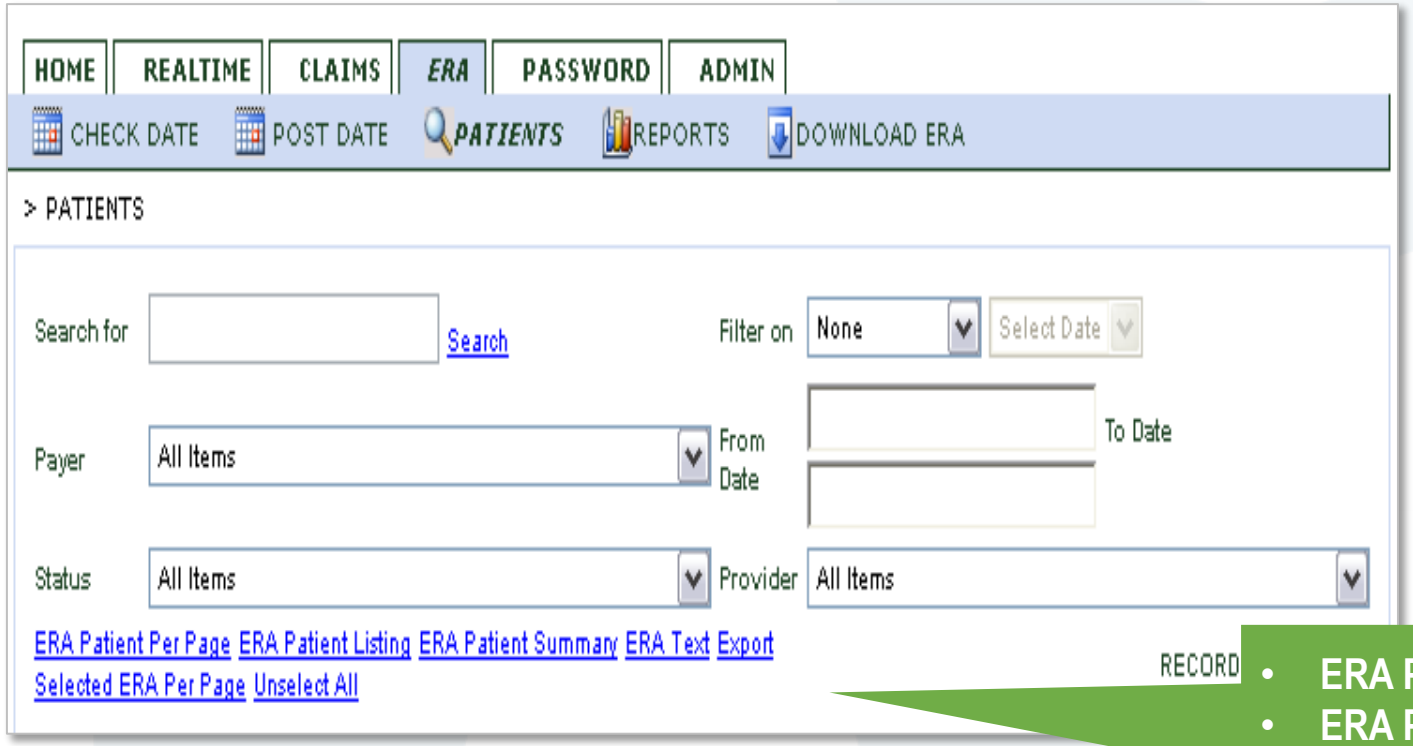




My Remit Manager

ERA Tab — Patient Search

Enter the patient's name in last name, first name format.



- ERA Patient Per Page
- ERA Patient Listing
- ERA Patient Summary
- ERA Text
- Export Selected ERA Per Page
- Unselect All

My Remit Manager

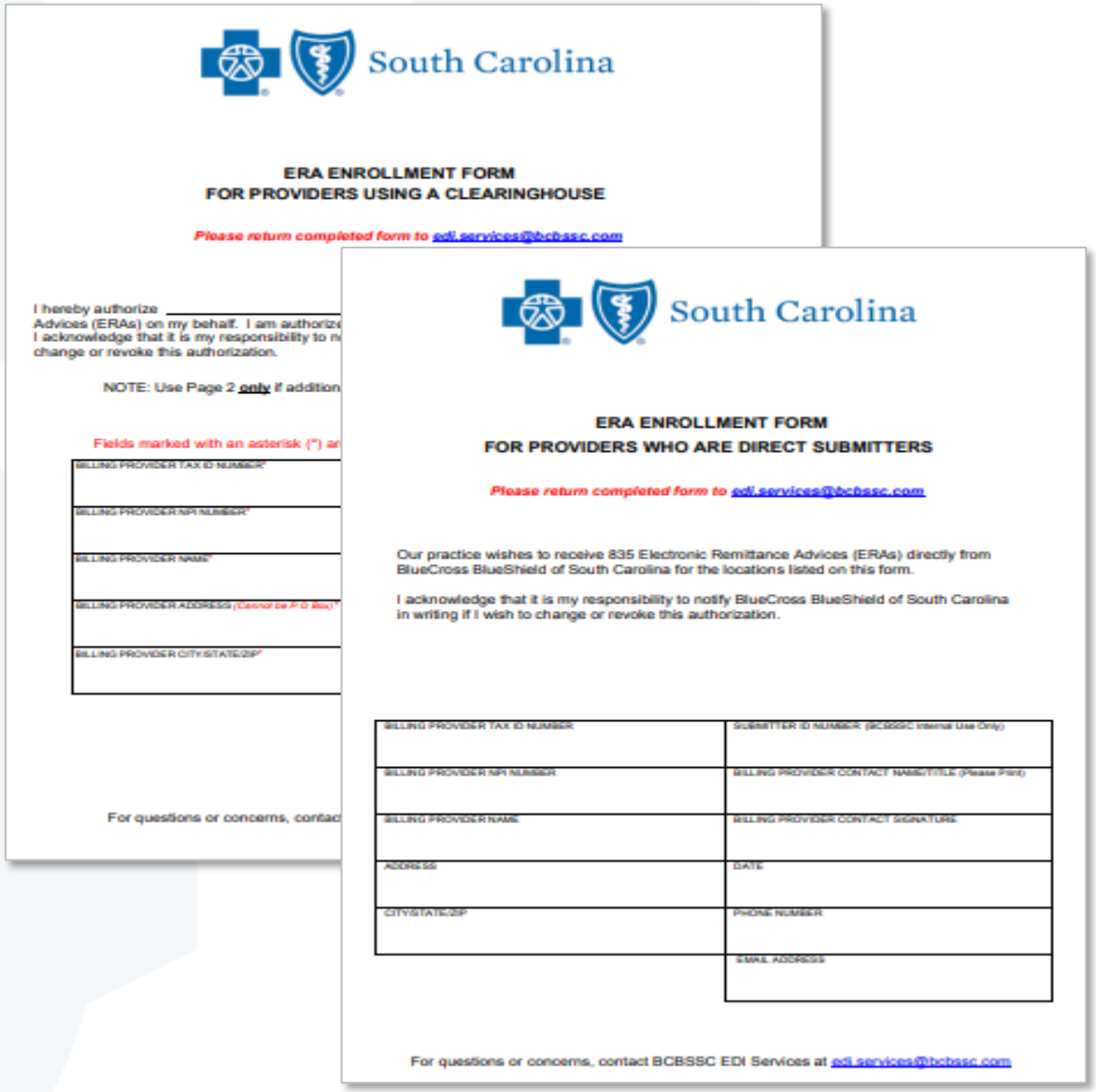
Electronic Remittance Advice (ERA)

How to Receive ERAs

- Complete the ERA Enrollment/Clearinghouse or ERA Enrollment/Direct Submitter Form located on www.SouthCarolinaBlues.com.

  Providers>Claims and Payment>Payment and Remittance Advices

- Submit the completed form to EDI.Services@bcbssc.com.



South Carolina

ERA ENROLLMENT FORM
FOR PROVIDERS USING A CLEARINGHOUSE

Please return completed form to edi.services@bcbssc.com

I hereby authorize
Advices (ERAs) on my behalf. I am authorize
I acknowledge that it is my responsibility to n
change or revoke this authorization.

NOTE: Use Page 2 only if addition

Fields marked with an asterisk (*) ar

BILLING PROVIDER TAX ID NUMBER*
BILLING PROVIDER NPI NUMBER*
BILLING PROVIDER NAME*
BILLING PROVIDER ADDRESS (Cannot be P.O Box)*
BILLING PROVIDER CITY/STATE/ZIP*

For questions or concerns, contac

South Carolina

ERA ENROLLMENT FORM
FOR PROVIDERS WHO ARE DIRECT SUBMITTERS

Please return completed form to edi.services@bcbssc.com

Our practice wishes to receive 835 Electronic Remittance Advices (ERAs) directly from BlueCross BlueShield of South Carolina for the locations listed on this form.

I acknowledge that it is my responsibility to notify BlueCross BlueShield of South Carolina in writing if I wish to change or revoke this authorization.

BILLING PROVIDER TAX ID NUMBER	SUBMITTER ID NUMBER (BCBSSC Internal Use Only)
BILLING PROVIDER NPI NUMBER	BILLING PROVIDER CONTACT NAME/TITLE (Please Print)
BILLING PROVIDER NAME	BILLING PROVIDER CONTACT SIGNATURE
ADDRESS	DATE
CITY/STATE/ZIP	PHONE NUMBER
	EMAIL ADDRESS

For questions or concerns, contact BCBSSC EDI Services at edi.services@bcbssc.com

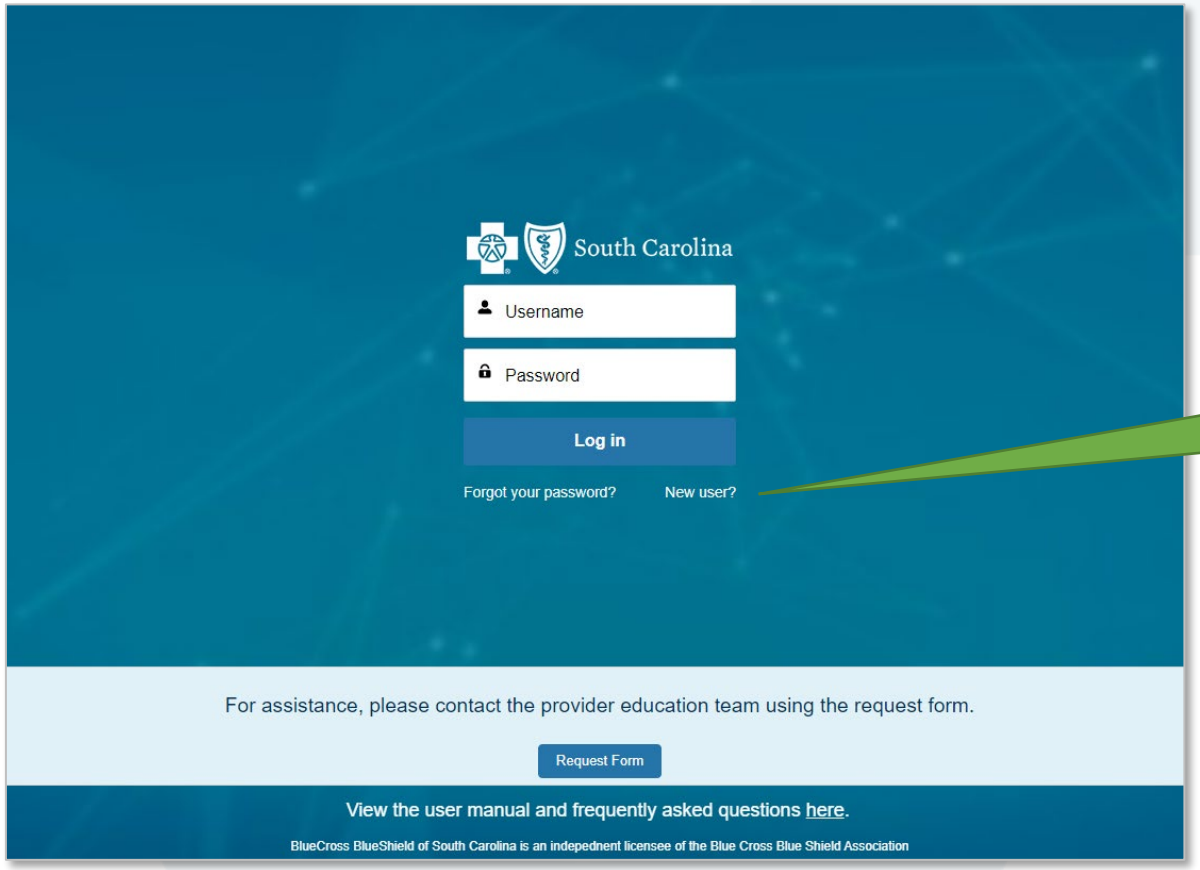
My Provider Enrollment Portal

My Provider Enrollment Portal

Sign Up for Access to the Portal

Visit www.SouthCarolinaBlues.com.

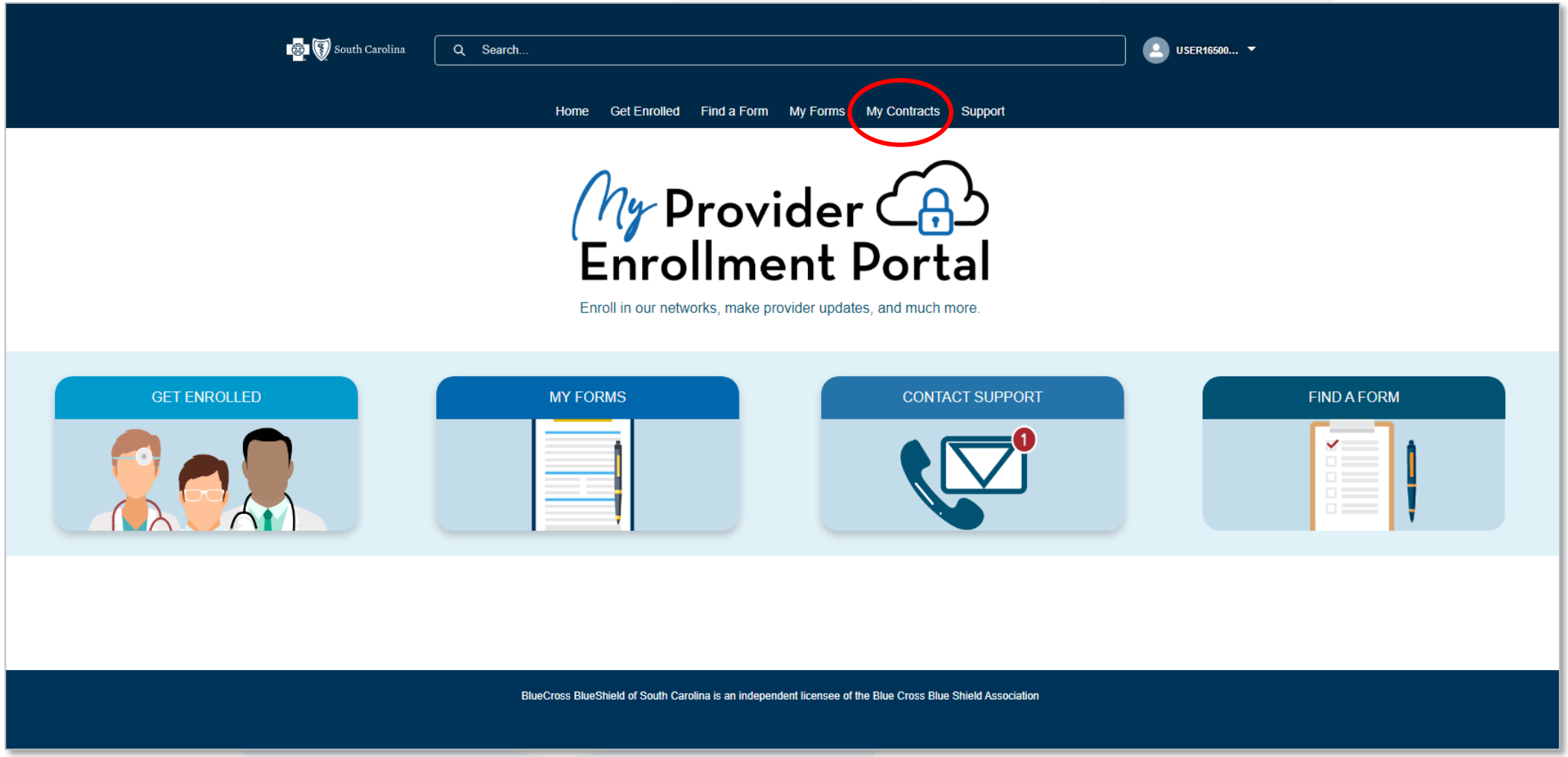
Providers>Provider Enrollment>My Provider Enrollment Portal



Select New user if you've never signed up!

My Provider Enrollment Portal

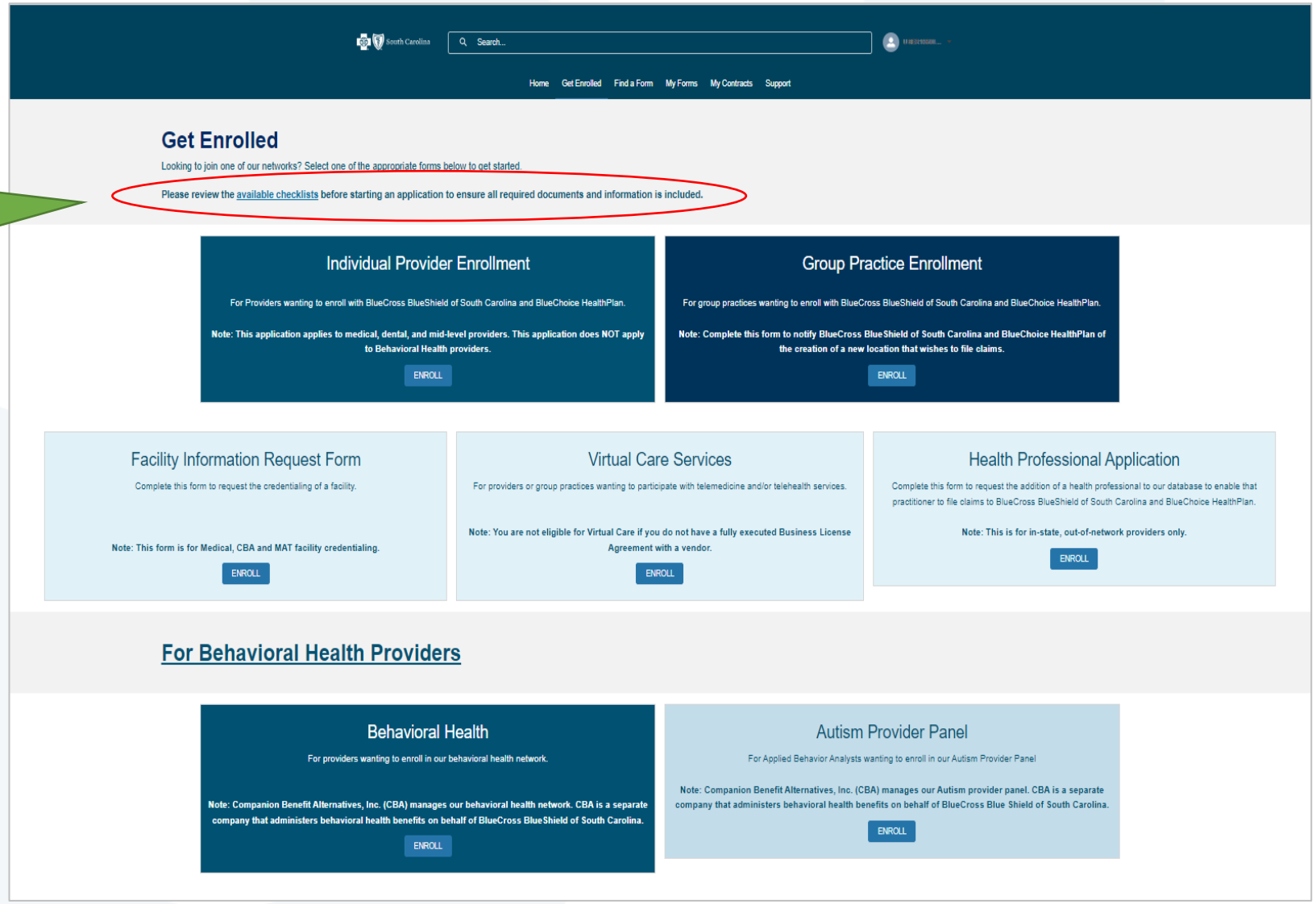
Home Page



My Provider Enrollment Portal

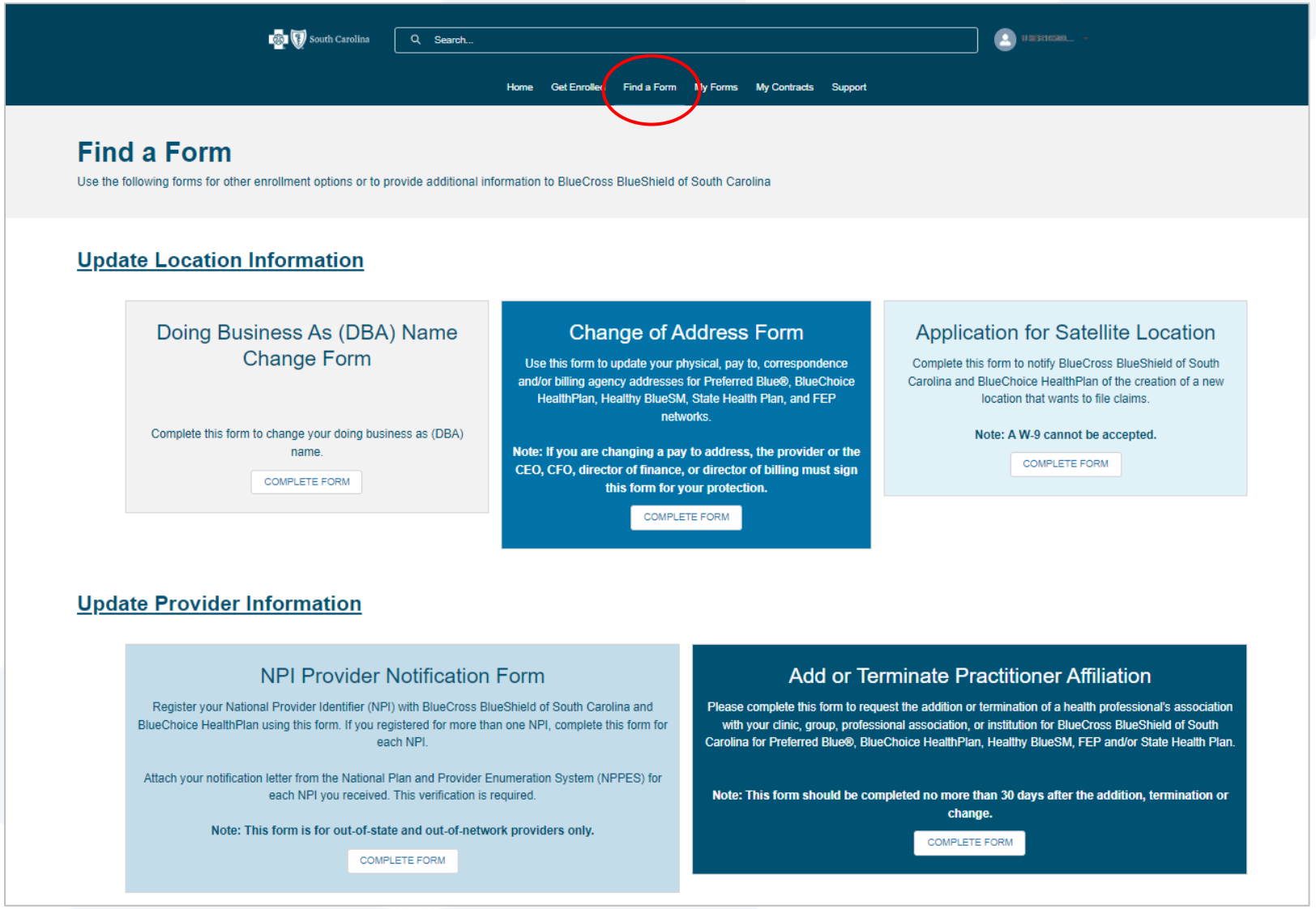
Get Enrolled

Review the available checklists before starting an application.



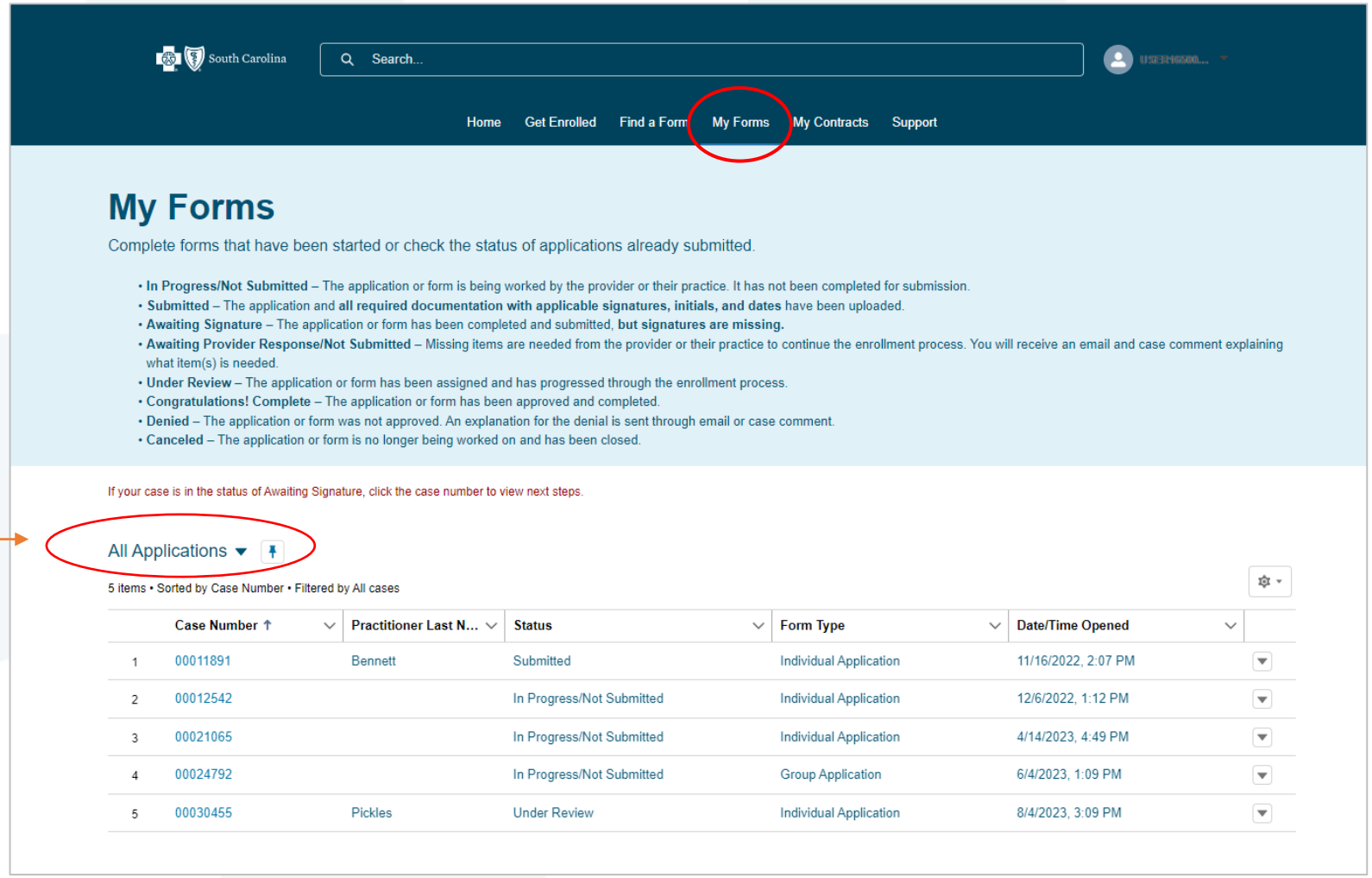
My Provider Enrollment Portal

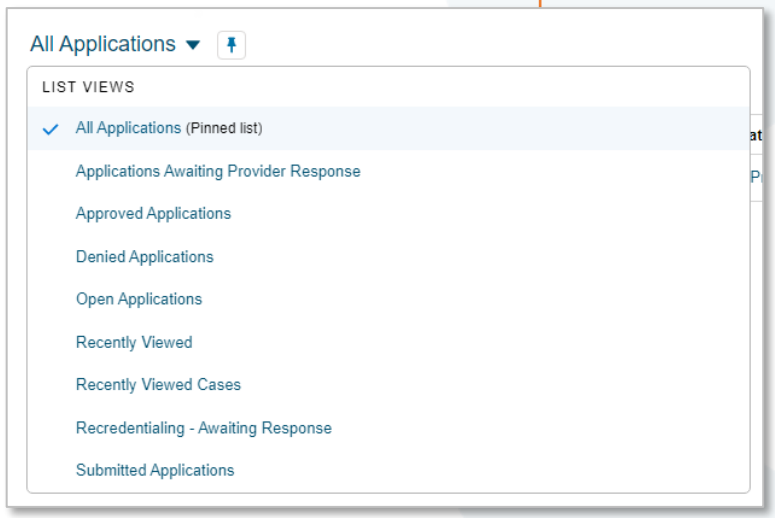
Find a Form



My Provider Enrollment Portal

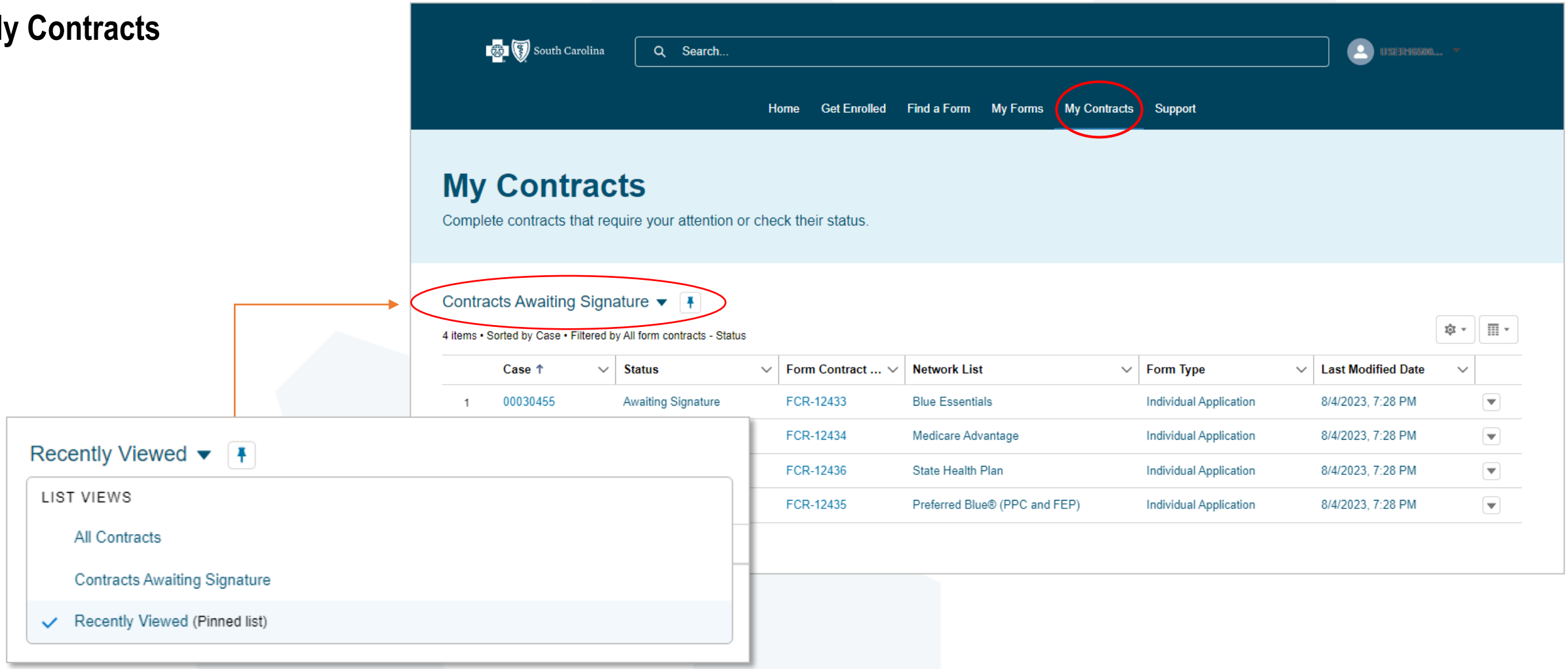
My Forms





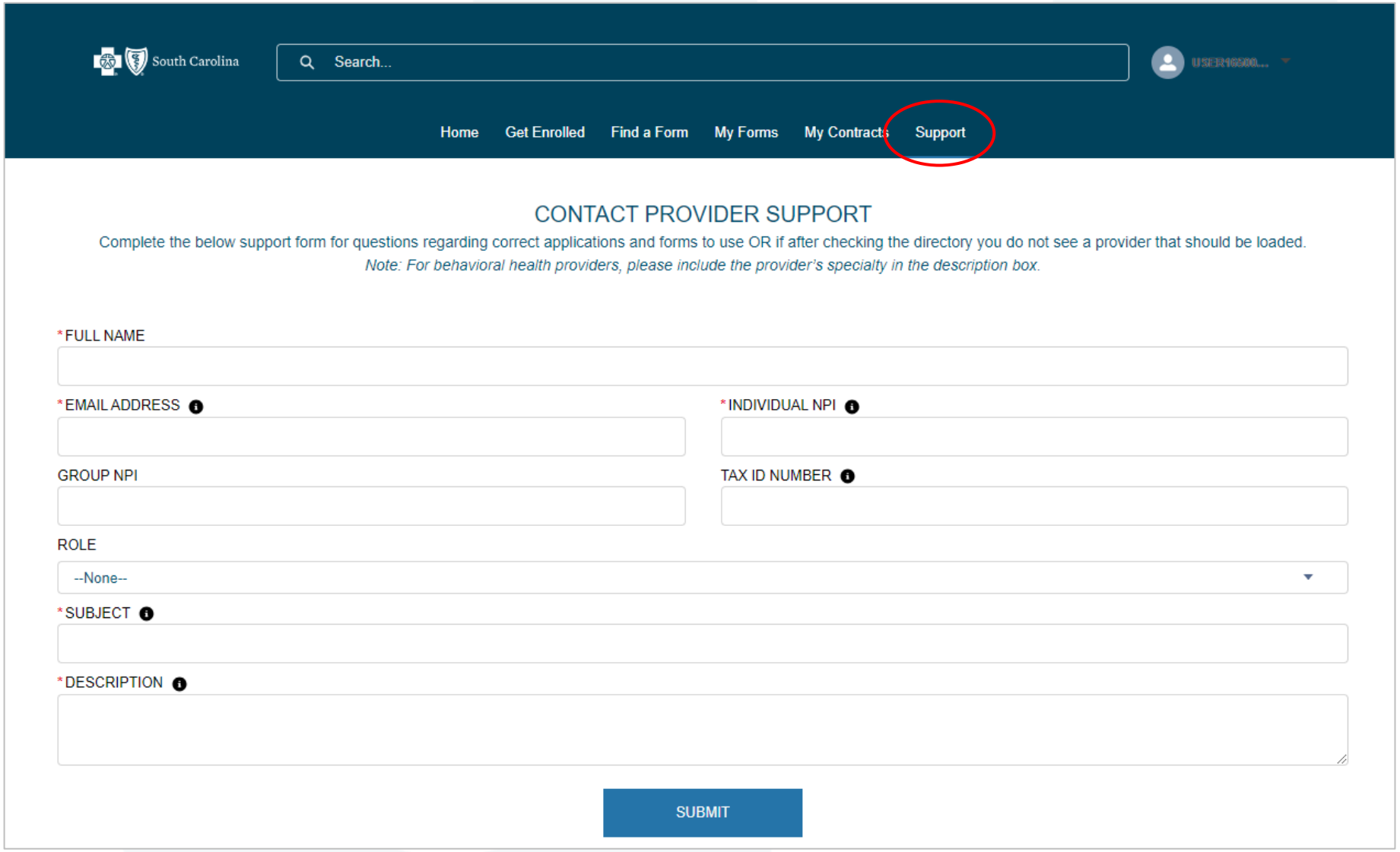
My Provider Enrollment Portal

My Contracts



My Provider Enrollment Portal

Support



Thank you!

Back To Basics