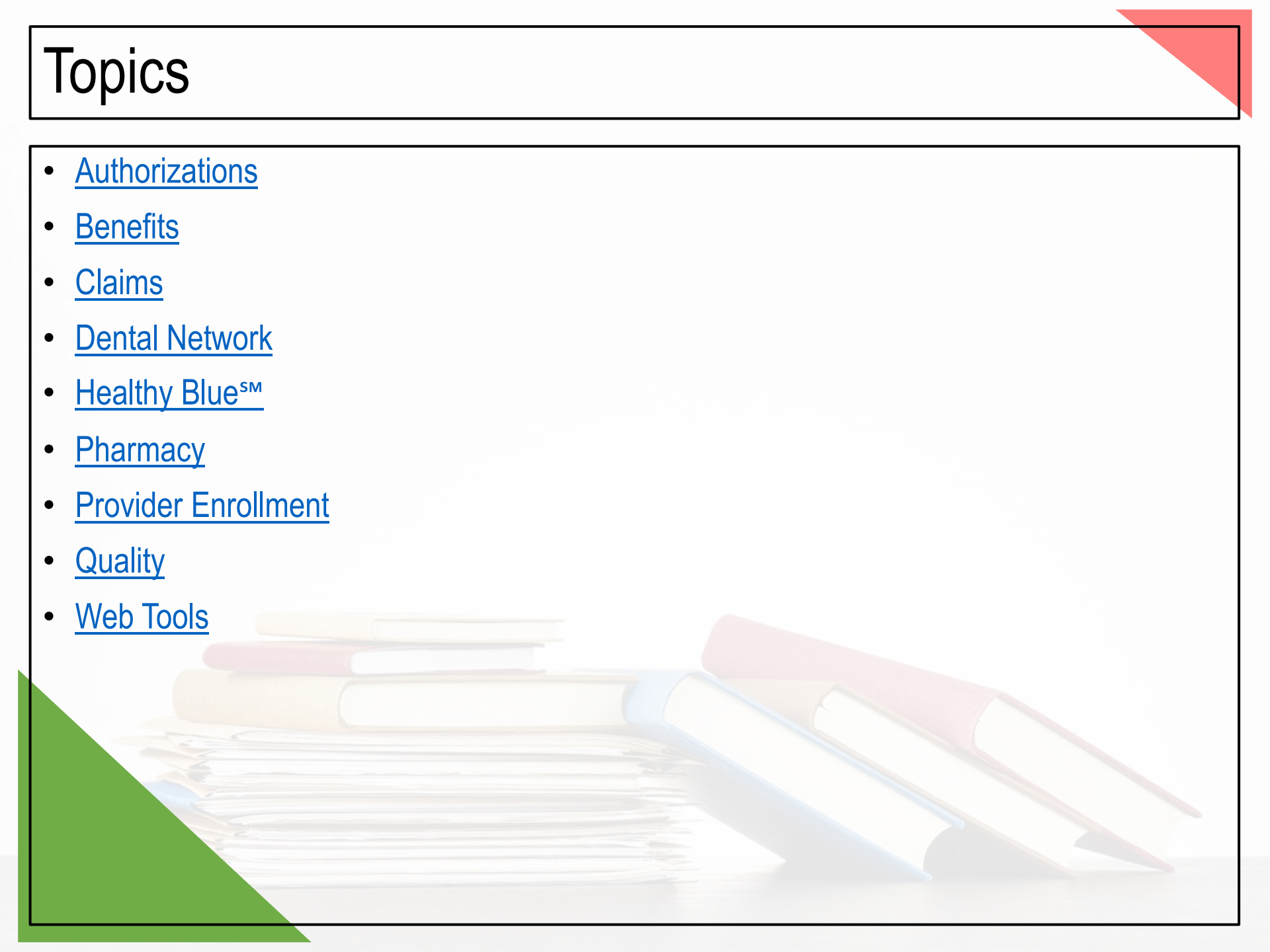
South Carolina

Provider Relations — 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.

Topics

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



Authorizations

Agenda

- Authorizations 101
- Authorization Tools
- Special Programs
- Resources

Authorizations 101

Authorizations 101

Overview

- Authorizations are needed when the health plan needs to determine whether a service is medically necessary.

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)

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, which is an independent organization that offers management utilization services on behalf of BlueCross and BlueChoice®.

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.

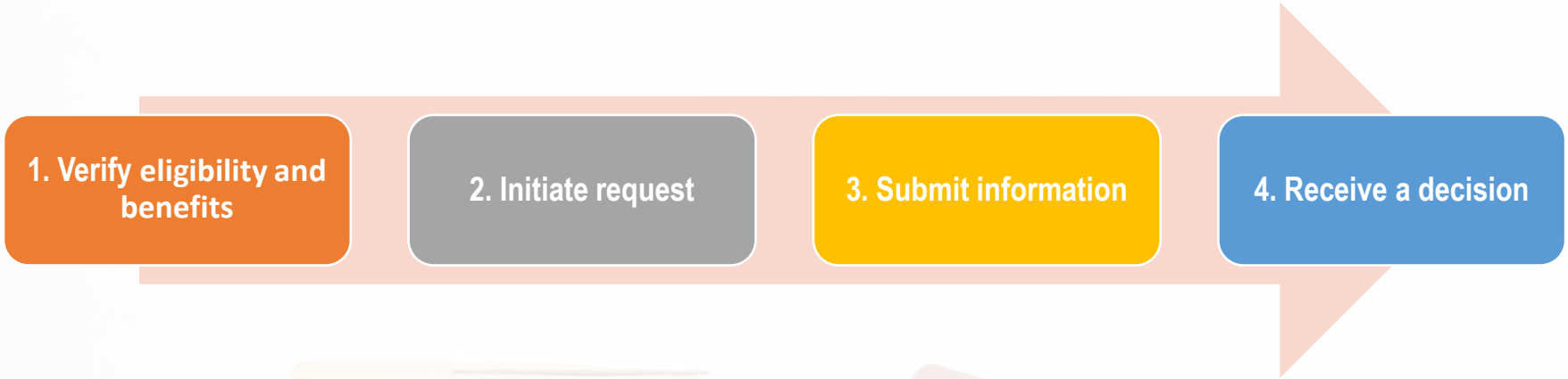
Authorizations 101

General Guidelines for Authorizations (Continued)

- Submit a notification of emergency admission within 24 to 48 hours of admission.
- Forms have been updated to include the date of service.
- 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
  - Check the member's ID card.
- Phone
  - Check the member's ID card.

Authorizations 101

Required Information for Authorizations

Patient Details	• Name, ID number and date of birth
Service Details	• CPT and HCPCS codes with correct units, diagnosis codes and MD orders
Location Details	• Name of facility, address and tax ID or national provider identifier (NPI) • Name of rendering physician or office, address and tax ID or 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, body mass index (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:
    - M.D. or therapist name.
    - Treatment location.
    - Home health visit notes and homebound status.

Authorizations 101

Commonly Requested Authorizations (Continued)

- Phone requests should include:
  - M.D. and nurse name.
  - Therapist name, if the member is only receiving therapy within 15 days of start of care and after evaluations are complete.
- BlueCross requires a signed Plan of Care (POC/485) within 30 days of the start of care per policy CAM 222.

Authorization Tools

Authorizations 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.

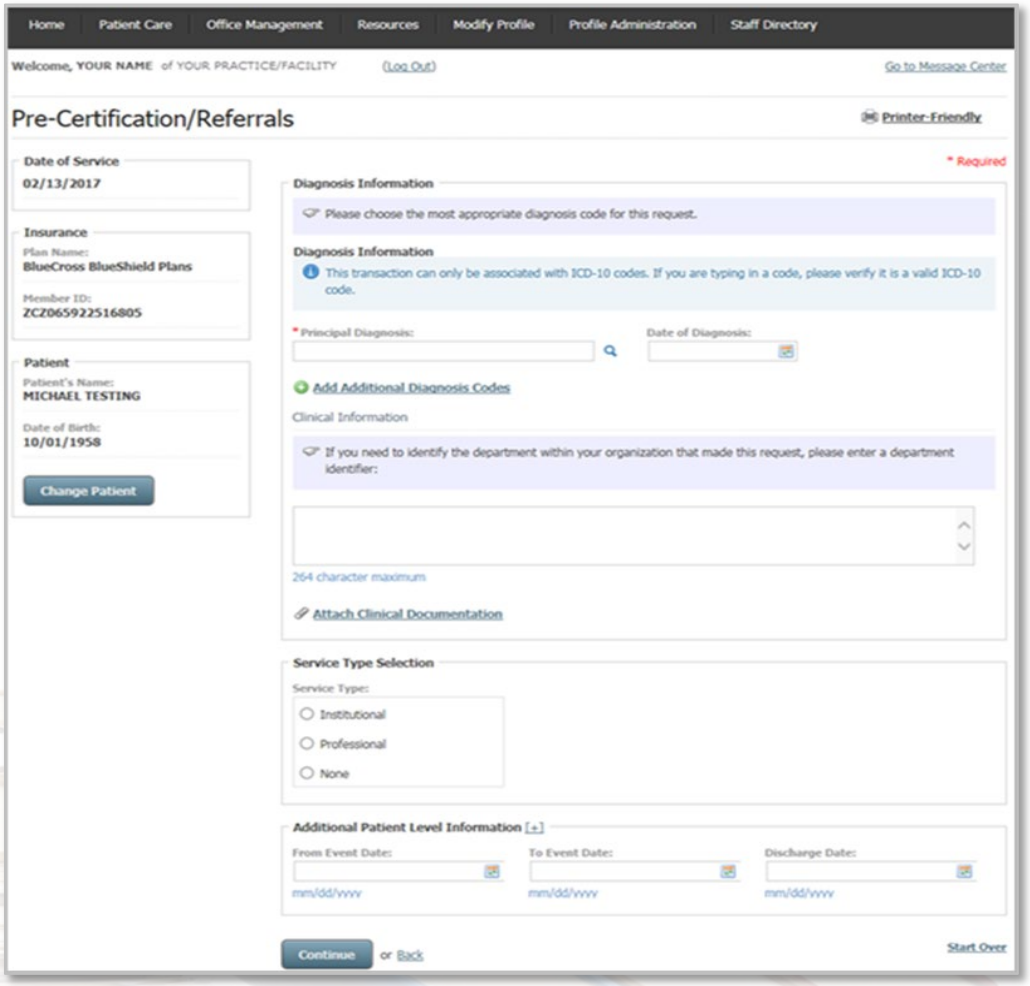
Authorizations Tools

My Insurance Manager (MIM)

Clinical Attachments

- Select Attach Clinical Documentation and upload file(s). (PDF)
- Enter all required contact details, then proceed with completing the request.

Note: If you are unable to attach a file, be sure to add a note in the box provided indicating the CPT codes (along with the units), diagnoses and all pertinent clinical details.



Authorizations Tools

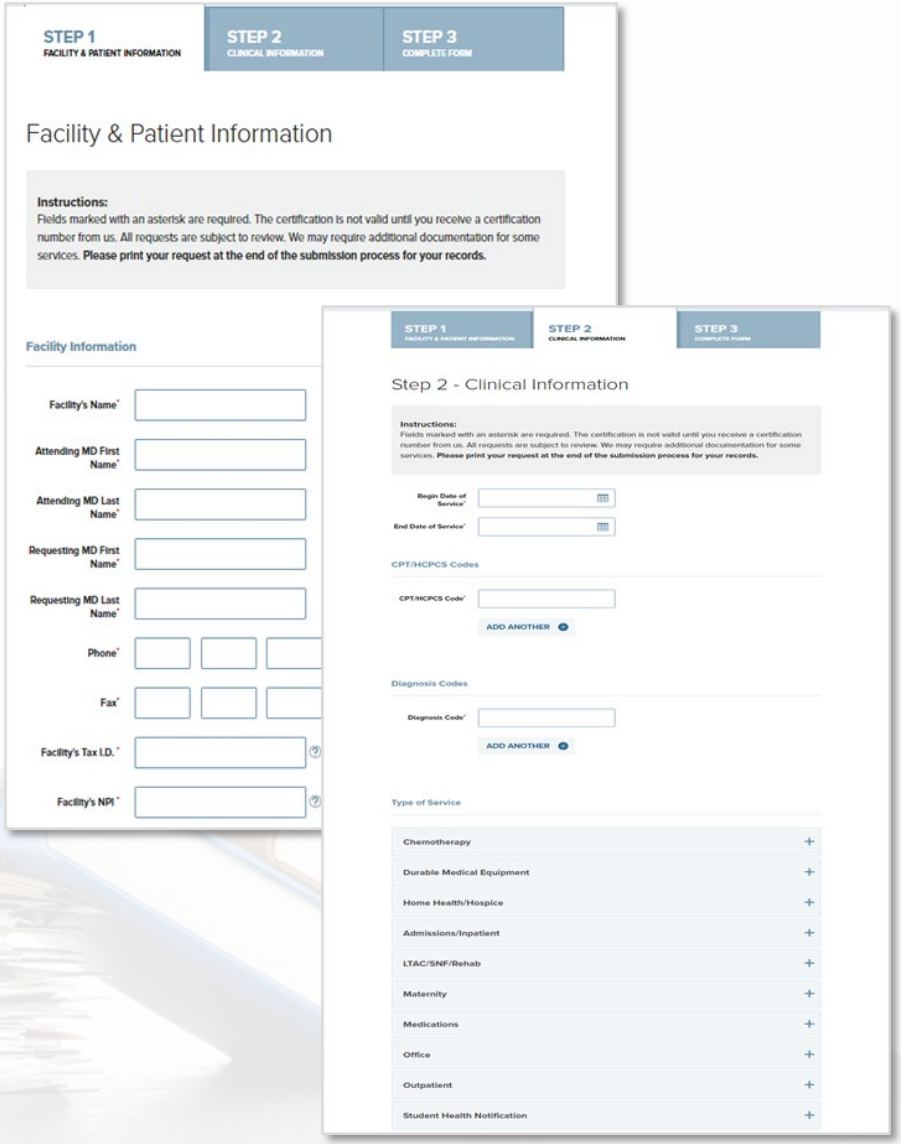
Medical Forms Resource Center (MFRC)

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



Authorizations Tools

Medical Forms Resource Center (MFRC)

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:

Authorizations 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:

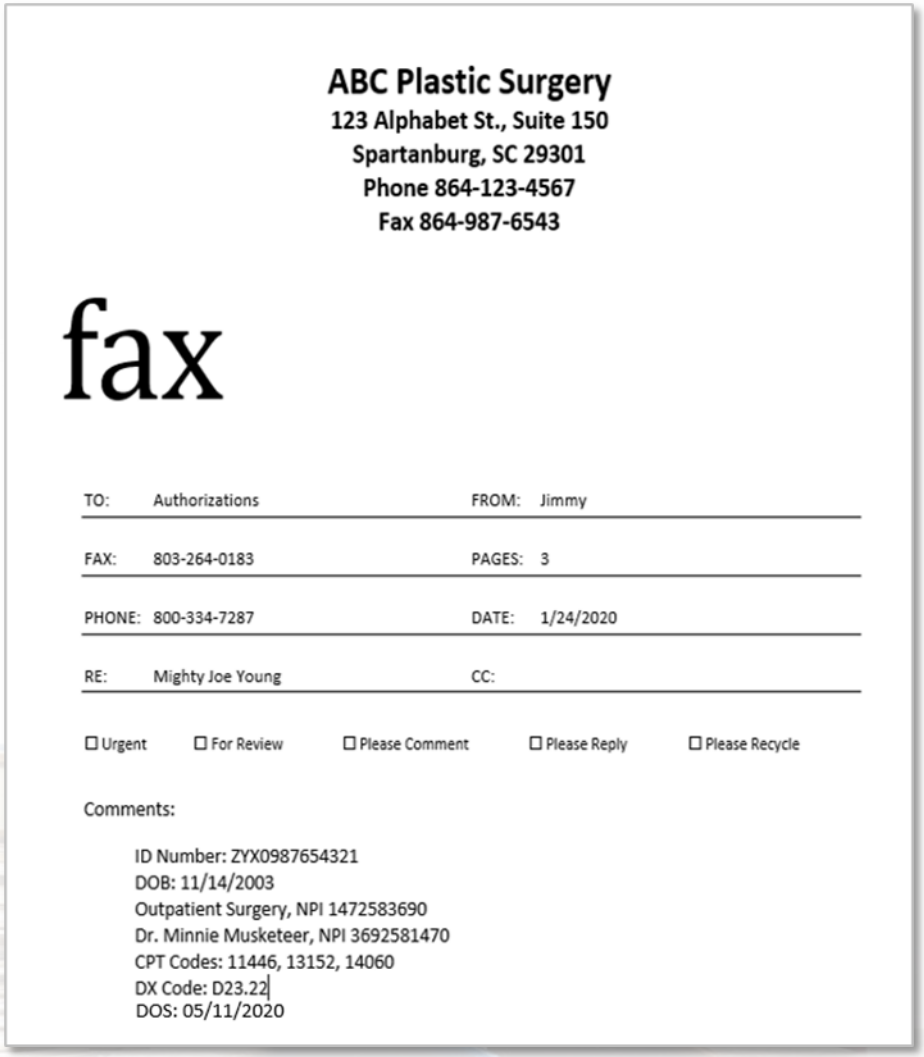
Focus Review/Health Care Services
I-20 @ Alpine Rd., AX-630
Columbia, SC 29219-0001

Authorizations Tools

Fax Requests

Appropriate Fax Request Coversheet

Required Information	Included?
Patient (name, DOB and ID number)	Yes
Service (CPT and diagnosis codes)	Yes
Location (name, address, tax ID/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:

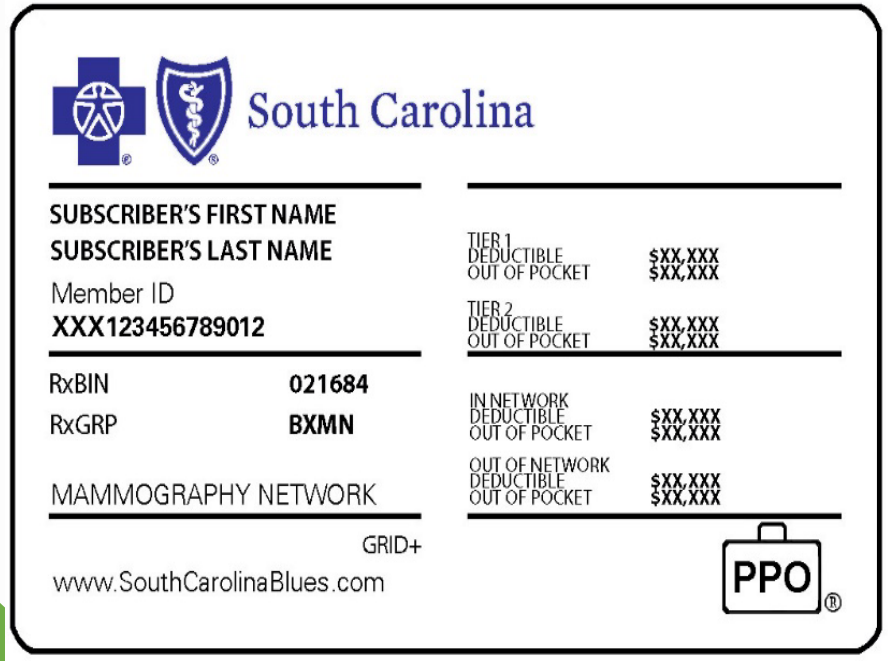
ID Number: ZYX0987654321
DOB: 11/14/2003
Outpatient Surgery, NPI 1472583690
Dr. Minnie Musketeer, NPI 3692581470
CPT Codes: 11446, 13152, 14060
DX Code: D23.22
DOS: 05/11/2020

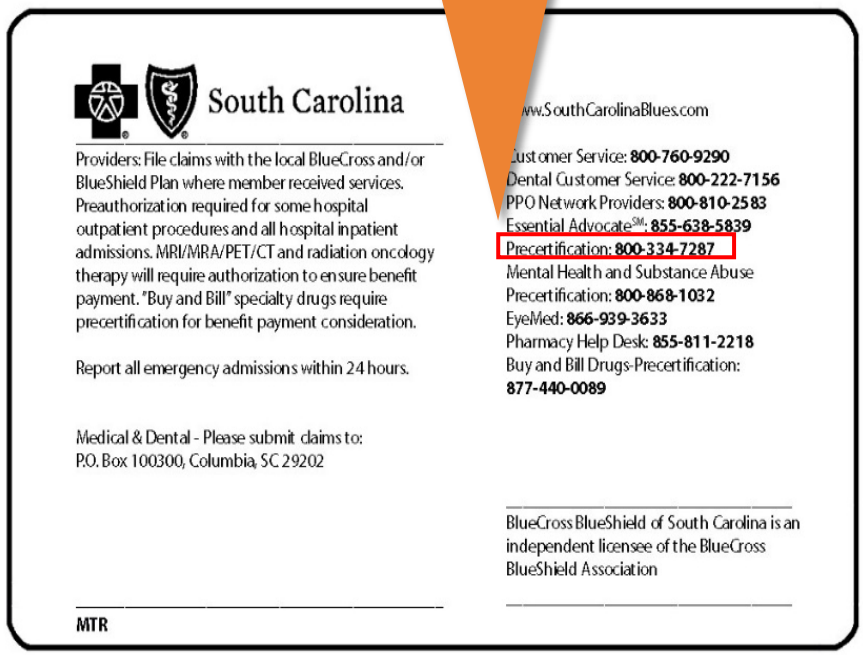
Authorizations Tools

Phone Requests

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

Number will vary per plan.



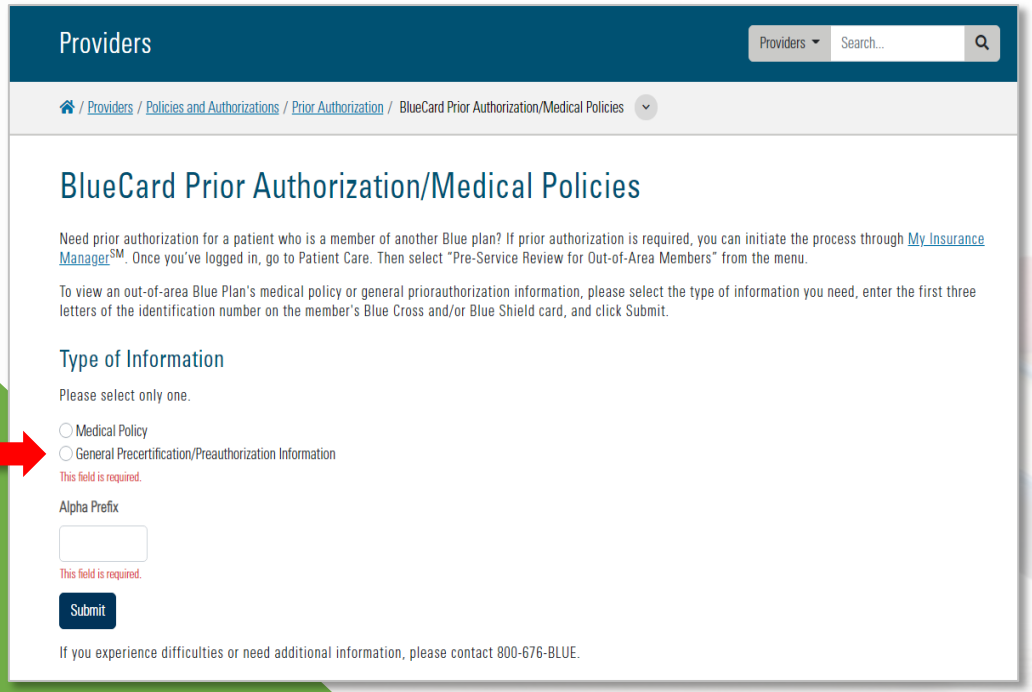


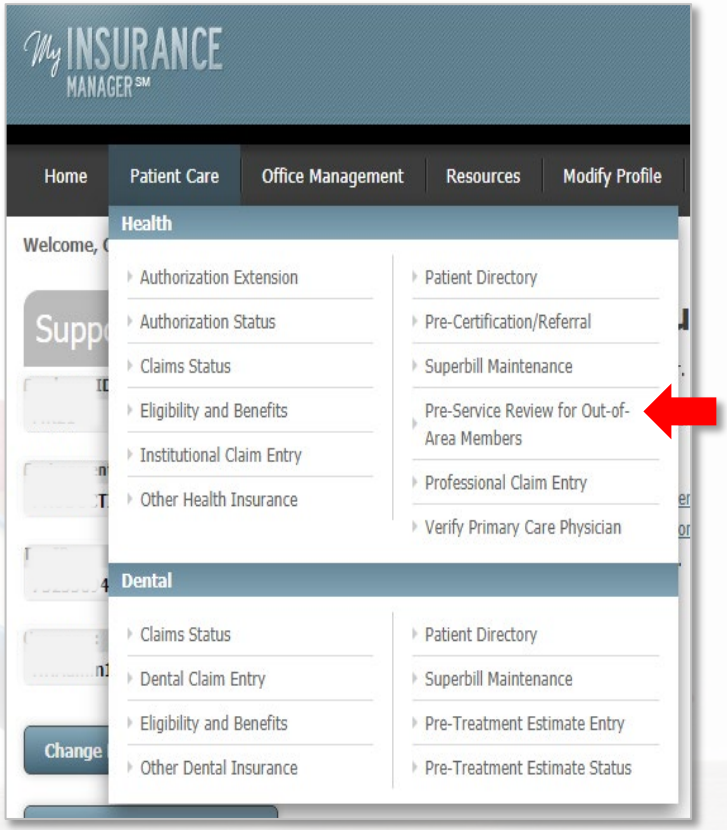
Authorizations Tools

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 authorizations for certain benefits 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

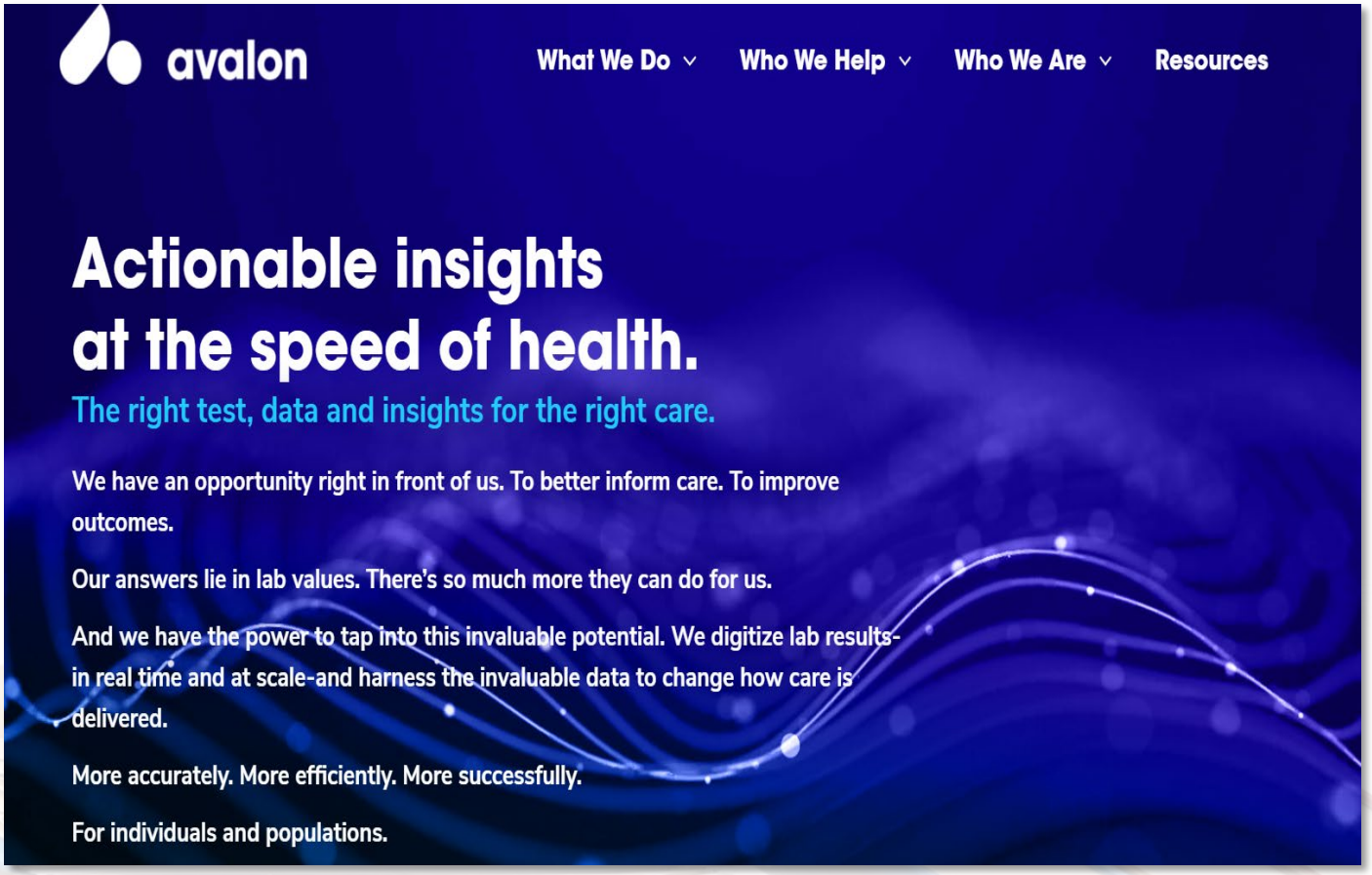
To request an authorization:

- 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 — The Evolution of Lab Oversight



www.avalonhcs.com

Avalon's Lab Insights System

Critical INSIGHTS **at Each Step To Deliver Value-Driven Care**

RIGHT TEST

- Evidence-based lab policies
- Policy enforcement
- Prior authorization
- Lab network

RIGHT DATA

- Lab results capture
- Digitized lab results, across network in real time
- Prior authorization and payment decisions

RIGHT INTEL

- Lab Insights Engine
- Early detection of disease
- Performance reporting
- Clinical decision support

RIGHT CARE

- Lab-informed treatment
- Clinical pathway adherence
- Optimized outcomes
- Lower health care costs

Special Programs

Avalon — Growth with Lab Values Management with First Focus on chronic kidney disease (CKD)

Lab Benefit Management
Ends with adjudication of the lab claim and delivery of results to physician

Lab Insights
Expands value by applying analytics to lab results for informed treatment and improved outcomes

Special Programs

Avalon — In the News

Featuring Dr. Jason Bush

Avalon's 2022 Lab Trend Report, the only one of its kind in the industry, examines how market forces and legislation are shaping the ecosystem.

This year's report features:

- Market Forces Affecting Laboratory Diagnostics and Health Plans
- Legislative and Regulatory Requirements Addressing Healthcare Affordability
- Leveraging Digitized Lab Values to Improve Health Outcomes
- COVID-19 Changed the Laboratory Market Landscape

[2022 Lab Trend Report | Avalon Healthcare Solutions (avalonhcs.com)]

Special Programs

MBMNow

BlueCross BlueShield of South Carolina

- 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

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

Authorization Resources

Authorization 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
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

Authorization 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 to Friday 8:30 a.m. to 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

Authorization 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

Benefits

Agenda

- 2023 Benefits
- What's New?
- Benefit Reminders
- Resources

2023 Benefits

Preferred Blue

2023 Benefits

Preferred Blue

New Groups — Effective Jan. 1, 2023

Group Name	Prefixes
Vallen (split from Sonepar)	• SJX • SGA • SJJ • SJW
Domtar	• SJX • SZT
MacLean Power Systems	• SJS

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

State Health Plan

2023 Benefits

State Health Plan

Standard Plan	2022	2023
Deductibles		
Individual	$490	**$515**
Family	$980	**$1,030**
Coinsurance Maximum		
Individual (INN)	$2,800	**$3,000**
Family (INN)	$5,600	**$6,000**
Individual (OON)	$5,600	**$6,000**
Family (OON)	$11,200	**$12,000**
Services		
Office visits	$14 copay	**$15 copay**
Outpatient facility	$105 copay	**$115 copay**
Emergency room	$175 copay	**$193 copay**
Cardiac and pulmonary rehabilitation	$14 copay	**$15 copay**

2023 Benefits

State Health Plan

Savings Plan	2022	2023
Deductibles		
Individual	$3,600	**$4,000**
Family	$7,200	**$8,000**
Coinsurance Maximum		
Individual (INN)	$2,400	**$3,000**
Family (INN)	$4,800	**$6,000**
Individual (OON)	$4,800	**$6,000**
Family (OON)	$9,600	**$12,000**
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

2023 Benefits

State Health Plan

MUSC Plan	2022	2023
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	Primary care provider (PCP): $25 copay Specialist: $45 copay	No change
Outpatient facility surgery	$265 copay	**$290 copay**
Outpatient facility radiology (regular and advanced)	$75 copay	**$85 copay**
Inpatient facility	$0	No change
Emergency room	$159/$175 copay	**$193 copay**
Urgent care	$75 copay	**$85 copay**
Cardiac and pulmonary rehabilitation	$14 copay	**$15 copay**

2023 Benefits

State Health Plan

Adult well-visits

- Effective Jan. 1, 2023: Standard, Savings and MUSC Plans
  - Covered once per year at no cost-share to the member (non-Medicare primary adults ages 19 and older)
  - Includes evidence-supported services based on United States Preventive Services Task Force (USPSTF) A and B recommendations
  - Available at a network provider specializing in:
    - General practice
    - Family practice
    - Pediatrics
    - Internal medicine
    - Gerontology
    - Obstetrics and gynecology

Note: Eligible female members may use their well-visit at their gynecologist or primary care physician, but not both. If a woman visits both doctors in the same year, only the first routine office visit received will be covered.

2023 Benefits

State Health Plan

Reminders

- Routine and Diagnostic Colonoscopies
  - Covered at 100 percent for State Health Plan primary members, once every 10 years for ages 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 3 years when rendered by an eligible in-network provider for ages 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 Care Medical Home (PCMH) for Standard and 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

2023 Benefits

State Health Plan

Prior Authorizations

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

- 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

Federal Employee Program

2023 Benefits

Federal Employee Program

Blue Focus — No out of network benefits available	2022	2023
Deductibles		
Individual	$500	No change
Self — Plus One	$1,000	No change
Family	$1,000	No change
Out-of-Pocket Maximum		
Individual	$8,500	No change
Self — Plus One	$17,000	No change
Family	$17,000	No change
Services		
Office visits (Includes primary and 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

2023 Benefits

Federal Employee Program

Blue Focus — No out of network benefits available	2022	2023
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-2023.

2023 Benefits

Federal Employee Program

Standard	2022	2023
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)	No change
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

2023 Benefits

Federal Employee Program

Standard	2022	2023
Services (Continued)		
Preventive care (INN)	$0 copay	No change
Chiropractic care (INN)	$25 copay up to 12 visits	No change
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-2023.

2023 Benefits

Federal Employee Program

Basic	2022	2023
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)	No change
Telehealth	$0 copay (first two visits) $15 copay (additional visits)	No change
Chiropractic care	$30 copay up to 20 visits	No change
Urgent care	$35 copay	No change

2023 Benefits

Federal Employee Program

Basic	2022	2023
Services (Continued)		
Preventive care	$0 copay	No change
Hospital care — Inpatient (prior authorization required)	$175 copay, per day Up to $875 per admission	**$250 copay, per day** **Up to $1,500 per admission**
Hospital care — Outpatient	$100 copay Per day, per facility	**$150 copay** **Per day, per facility**
ER — Accidental injury	$175 copay Per day, per facility	**$250 copay** **Per day, per facility**
ER — Medical emergency	$175 copay Per day, per facility	**$250 copay** **Per day, per facility**

Note: For a full list of benefits and updates, please visit: https://www.fepblue.org/open-season/whats-new-2023.

2023 Benefits

Federal Employee Program

Blue Focus, Standard, and Basic	2022	2023
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® HealthPlan

2023 Benefits

BlueChoice HealthPlan

What's new?

- Effective Jan. 1, 2023, Blue Option℠ members will have access to the BlueCard Program.

Reminders

- Verify eligibility and benefits
  - Verify eligibility and benefits via My Insurance Manager 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

2023 Benefits

BlueChoice HealthPlan

Reminders (continued)

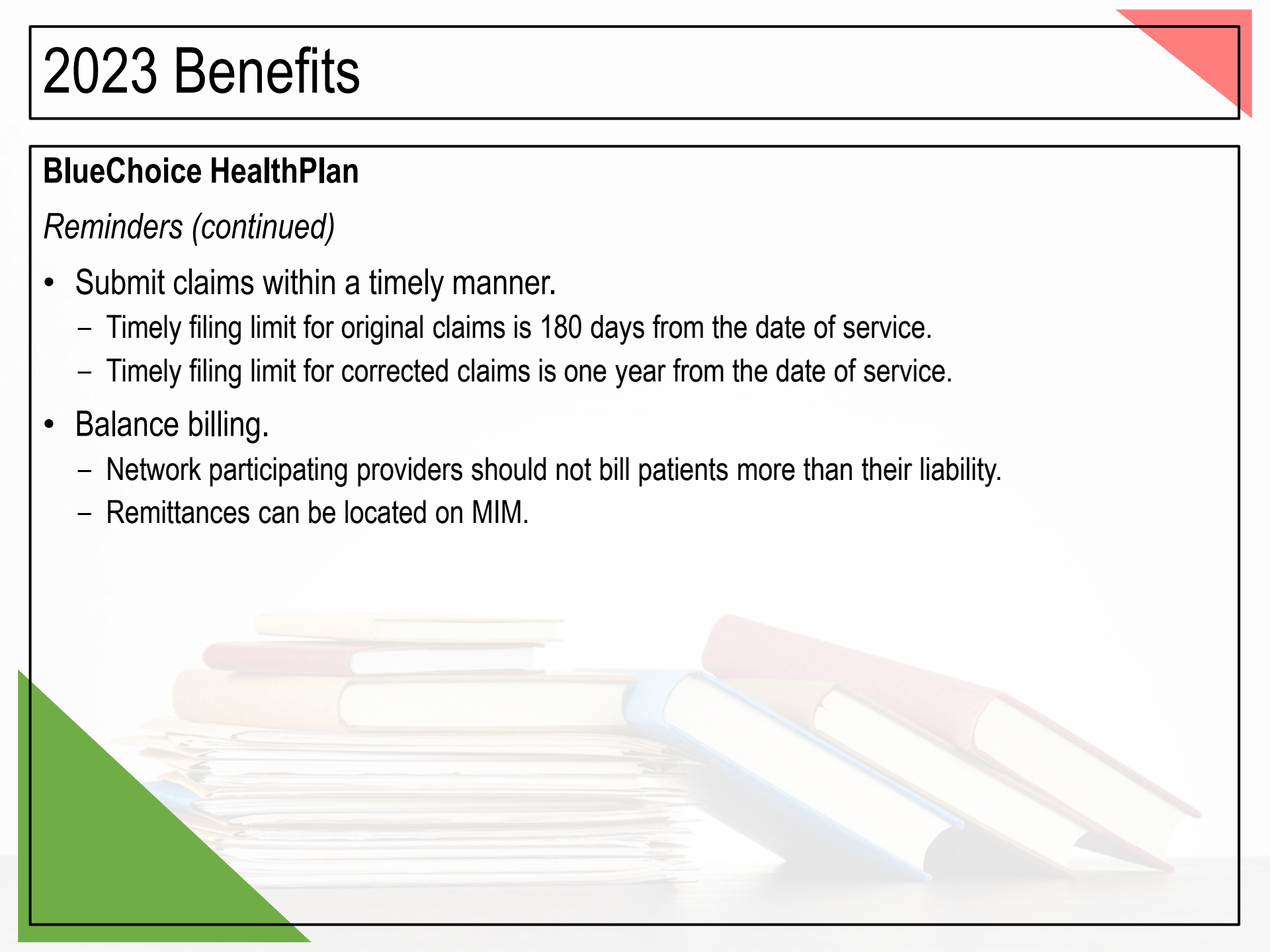
- Check drug lists to ensure medications are covered.
  - Submit clinical information (including any similar medications tried and the member's reaction) along with the authorization request to avoid processing delays.
- Obesity related services are not covered.
  - Considered a contract exclusion
- 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 My Insurance Manager (MIM).

2023 Benefits

BlueChoice HealthPlan

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

2023 Benefits

Medicare Advantage

BlueCross Total	2022	2023
Deductibles		
In-network and out-of-network	$0	No change
Out-of-Pocket Maximum		
From in-network providers	$6,500	No change
From in-network and out-of-network providers combined	$10,000	No change
Services		
Outpatient office visits	INN — $5 copay (PCP) INN — $45 copay (Specialist) OON — $30 copay (PCP) OON — $55 copay (Specialist)	**INN — $0 copay (PCP)** **INN — $30-40 copay (Specialist)** OON — $30 copay (PCP) OON — $55 copay (Specialist)
Inpatient hospital — acute	INN — $420 copay, per day (1-4) INN — $0 copay, per day (5-90) OON — 30% COINS for total stay	**INN — $350 copay, per day (1-4)** INN — $0 copay, per day (5-90) OON — 30% COINS for total stay
Inpatient hospital — psychiatric	INN — $465 copay, per day (1-4) INN — $0 copay, per day (5-90) OON — 30% COINS for total stay	**INN — $624 copay, per day (1-4)** INN — $0 copay, per day (5-90) OON — 30% COINS for total stay

2023 Benefits

Medicare Advantage

BlueCross Total	2022	2023
Services (Continued)		
Skilled nursing facility (SNF)	INN — $0 (days 1-20) INN — $184 copay (days 21-100) OON — 30% COINS for total stay	INN — $0 (days 1-20) **INN — $196 copay (days 21-100)** OON — 30% COINS for total stay
Urgently needed services	INN & OON - $50 copay, per visit	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 — $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	No change **$3,000 maximum (combined)**
Comprehensive dental (Medicare covered services)	N/A	**INN — $50 copay** **OON — 40% COINS** **$3,000 maximum (combined)**
Comprehensive dental (non-covered Medicare services)	INN and OON — 50% COINS $1,000 benefit maximum	No change **$3,000 maximum (combined)**

2023 Benefits

Medicare Advantage

BlueCross Total Value	2022	2023
Deductibles		
In-network and out-of-network	$0	No change
Out-of-Pocket Maximum		
In-network	$6,900	No change
Out-of-network	$11,300	$11,000 (Midlands/Coastal) $11,300 (Upstate/Lowcountry)
Services		
Outpatient office visits	INN — $0 copay (PCP) INN — $40 copay (Specialist) OON — $40 copay (PCP) OON — $55 copay (Specialist)	INN — $0 copay (PCP) **INN — $30 copay (Specialist)** OON — $40 copay (PCP) OON — $55 copay (Specialist)
Inpatient hospital — acute	INN — $450 copay, per day (1-4) INN — $0 copay (5-90) OON — 40% COINS for total stay	*Midlands/Coastal* **INN $350 copay per days 1-5** *Upstate/Lowcountry* **INN $375 copay per days 1-5** **OON — 50% of total cost**
Inpatient hospital — psychiatric	INN — $620 copay, per day (1-4) OON — 50% COINS for total stay	**INN — $624 copay, per day (1-4)** OON — 50% COINS for total stay

2023 Benefits

Medicare Advantage

BlueCross Total Value	2022	2023
Services (Continued)		
Skilled nursing facility (SNF) (100 benefit day max, per year)	INN — $0 (days 1-20) INN — $188 copay (days 21-100) OON — 40% COINS for total stay	INN — $0 (days 1-20) **INN — $196 copay (days 21-100)** **OON — 50% COINS for total stay**
Emergency care	INN and OON — $95 copay, per visit	No change
Worldwide emergency	$250 service specific deductible, then 20% COINS for emergency care outside the United States	No change
Urgent care	$50 copay	No change
Ambulance services (ground or air)	INN and OON — $275 per trip	**INN — $285 per one way trip** **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	No change **$2,000 maximum (combined)**
Comprehensive dental (Medicare covered services)	N/A	**INN and OON — $50 copay** **$2,000 maximum (combined)**
Comprehensive dental (non-covered Medicare services)	INN and OON — 50% COINS $500 benefit maximum	No change **$2,000 maximum (combined)**

2023 Benefits

Medicare Advantage

BlueCross Secure — No out-of-network benefits	2022	2023
Deductibles		
In-network	$0	No change
Out-of-Pocket Maximum		
In-network	$6,500	No change
Services		
Office visits	INN — $5 copay (PCP) INN — $40 copay (Specialist)	**INN — $0 copay (PCP)** **INN — $30 copay (Specialist)**
Inpatient hospital — acute	INN — $425 copay, per day (1-4) INN — $0 copay (5-90)	**INN — $325 copay, per day (1-6)** **INN — $0 copay (7-90)**
Inpatient hospital — psychiatric	INN — $415 copay, per day (1-4) INN — $0 copay (5-90)	**INN — $624 copay, per day (1-3)** **INN — $0 copay (4-90)**
Skilled nursing facility (SNF)	INN — $0 copay (days 1-20) INN — $188 copay (days 21-100)	INN — $0 copay (days 1-20) **INN — $196 copay (days 21-100)**
Urgently needed services	INN — $40 copay, per visit	No change
Emergency care	$95 copay, per visit (Waived if admitted within 24 hours)	No change

2023 Benefits

Medicare Advantage

BlueCross Secure — No out-of-network benefits	2022	2023
Services (Continued)		
Worldwide emergency/urgent coverage	$250 service specific deductible, then 20% COINS for emergency care outside the United States	$250 service specific deductible, **then 35% COINS** for emergency care outside the United States
Ambulance services (ground or air)	INN — $275 per trip	**INN — $285 per trip**
Hearing aids	$699-$999 using TruHearing Two per year (one per ear)	No change
Preventive dental	Not covered	No change
Comprehensive dental (Medicare covered services)	INN — $50 copay	No change

2023 Benefits

Medicare Advantage

BlueCross Blue Basic	2022	2023
Deductibles		
In-network and out-of-network	$0	No change
Out-of-Pocket Maximum		
From in-network providers	$4,900	**$6,000**
From in-network and out-of-network providers combined	$10,000	No change
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	No change
Inpatient hospital — psychiatric	INN — $620 copay, per day (1-3) OON — 30% COINS for total stay	**INN — $624 copay, per day (1-3)** OON — 30% COINS for total stay

2023 Benefits

Medicare Advantage

BlueCross Blue Basic	2022	2023
Services (Continued)		
Skilled nursing facility (SNF)	INN — $0 copay (days 1-20) INN — $188 copay (days 21-100) OON — 30% COINS for total stay	INN — $0 copay (days 1-20) **INN — $196 copay (days 21-100)** OON — 30% COINS for total stay
Urgently needed services	INN and OON — $0-$40 copay	**INN and OON — $40 copay**
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

2023 Benefits

Medicare Advantage

BlueCross Blue Basic	2022	2023
Services (Continued)		
Hearing aids	$699-$999 using TruHearing 2 per year (one per ear)	No change
Preventive dental (fluoride treatment not covered)	INN — $0 Copay (Two preventive visits) OON — 50% COINS	**INN and OON — $0 copay (Two per year)** **$1,000 maximum (combined)**
Comprehensive dental (Medicare covered services)	N/A	**INN — $50 copay** **OON — 30% COINS** **$1,000 maximum (combined)**
Comprehensive dental (non-covered Medicare services)	INN and OON — 50% COINS $750 benefit maximum	No change **$1,000 maximum (combined)**

2023 Benefits

Medicare Advantage

All Plans (Total, Total Value, Secure and Blue Basic)	2022	2023
Services		
Annual wellness visit/annual physical	$0 Copay	No change
Lab work	$10 copay, per lab	**$0 copay**
Preventive screenings: • Colorectal cancer screening • Breast cancer screening • Bone mineral density tests • Diabetic eye exam • Eyeglasses and frames • Glaucoma screening	$0 Copay	No change
Part D specialty medication (Tier 6) (Total, Total Value and Secure plans)	N/A	**$0 copay for generic medications for diabetes, hypertension, cholesterol, and osteoporosis for 30- or 90-day supply at preferred or mail order pharmacy. Can refill medications earlier than other tiers.**
Insulin savings program	$35 copay	**$30 copay, 30-day supply (Total, Secure)** **$35 copay, 30-day supply (Total Value)**

2023 Benefits

Medicare Advantage

Value-added benefits

- Silver and Fit
  - Free basic membership to participating fitness centers or home fitness programs with fitness tracker (Fitbit)
- Transportation
  - 24-hour, one-way rides to physician offices, pharmacies or grocery stores
  - Members can schedule rides through customer service, case management or smartphone application.
- Over-the-counter
  - $35-55 copay per quarter
  - 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.

2023 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.
    - Includes free services
    - Allows members to speak with a BlueCross representative for assistance
    - Has games for social interactions

2023 Benefits

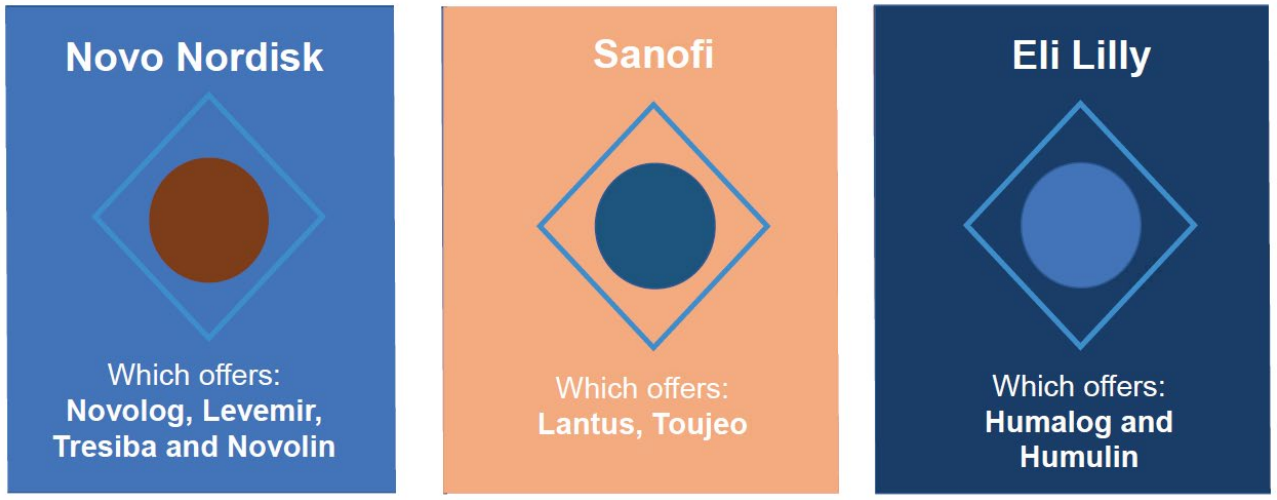
Medicare Advantage

Medicare Part D Insulins

As part of the Inflation Reduction Act, **effective July 1, 2023**, members will pay up to a $35 copay for a one-month supply of Part D insulins used in home infusion pumps.

- Applies to members with the Total, Total Value, Secure and Blue Basic plans
- Benefit will be available for in and out-of-network

Currently, the following insulins are covered for all members (except Blue Basic plan) up to a $35 copay:



2023 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.
    - *The Centers for Medicare and Medicaid Services (CMS) is an independent organization that offers health information you may find helpful.*

2023 Benefits

Medicare Advantage

Prior Authorization

- Medical prior authorizations can be requested through My Insurance Manager, phone or fax.
- Faxed requests should be faxed to 803-264-6552 and include:
  - Member's name
  - Date of birth
  - ID card number including the prefix (ZHP or ZOH)
  - CPT/HCPCS code(s)
  - Diagnosis code(s)
  - Provider's NPI
  - Return fax number
  - Date(s) of service
  - Units, if applicable
  - Supporting clinical documentation

2023 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 My Insurance Manager.
- Submit claims for all Blue Cross Blue Shield 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.

2023 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).

Companion Benefit Alternatives

Companion Benefit Alternatives

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.
- Be sure to 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

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

Provider Credentialing
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

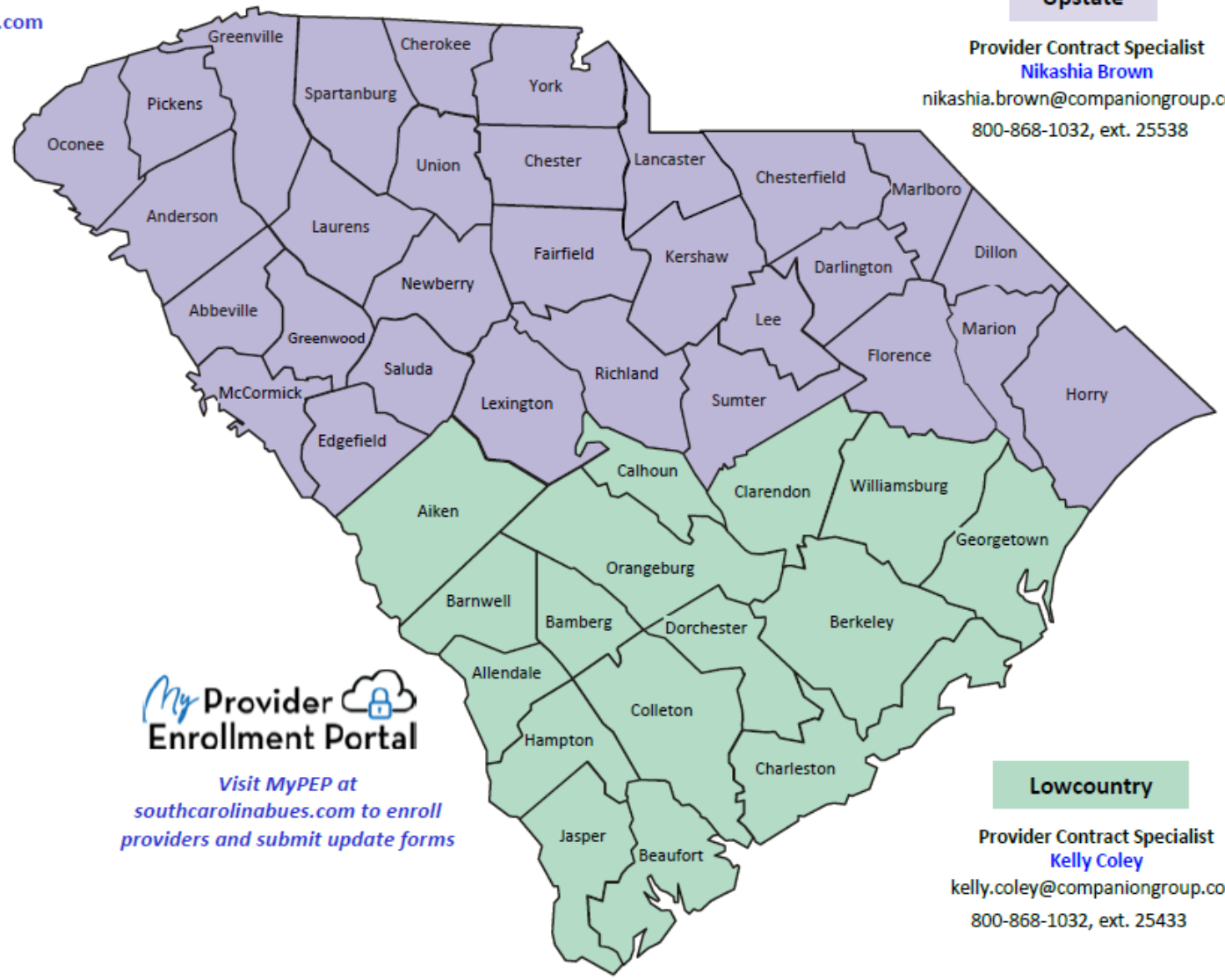
Provider Update/Change Requests
Shamara Evans
shamara.evans@companiongroup.com
800-868-1032, ext.25304

Provider Enrollment
Marisa Geiger
marisa.geiger@companiongroup.com
800-868-1032, ext.25626

Provider Network Supervisor
Robin Wilson
robin.wilson@companiongroup.com
800-868-1032, ext. 25246

Value-Based Program Administrator
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

Upstate

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

Lowcountry

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

Companion Benefit Alternatives

Companion Benefit Alternatives (CBA)

Reminders

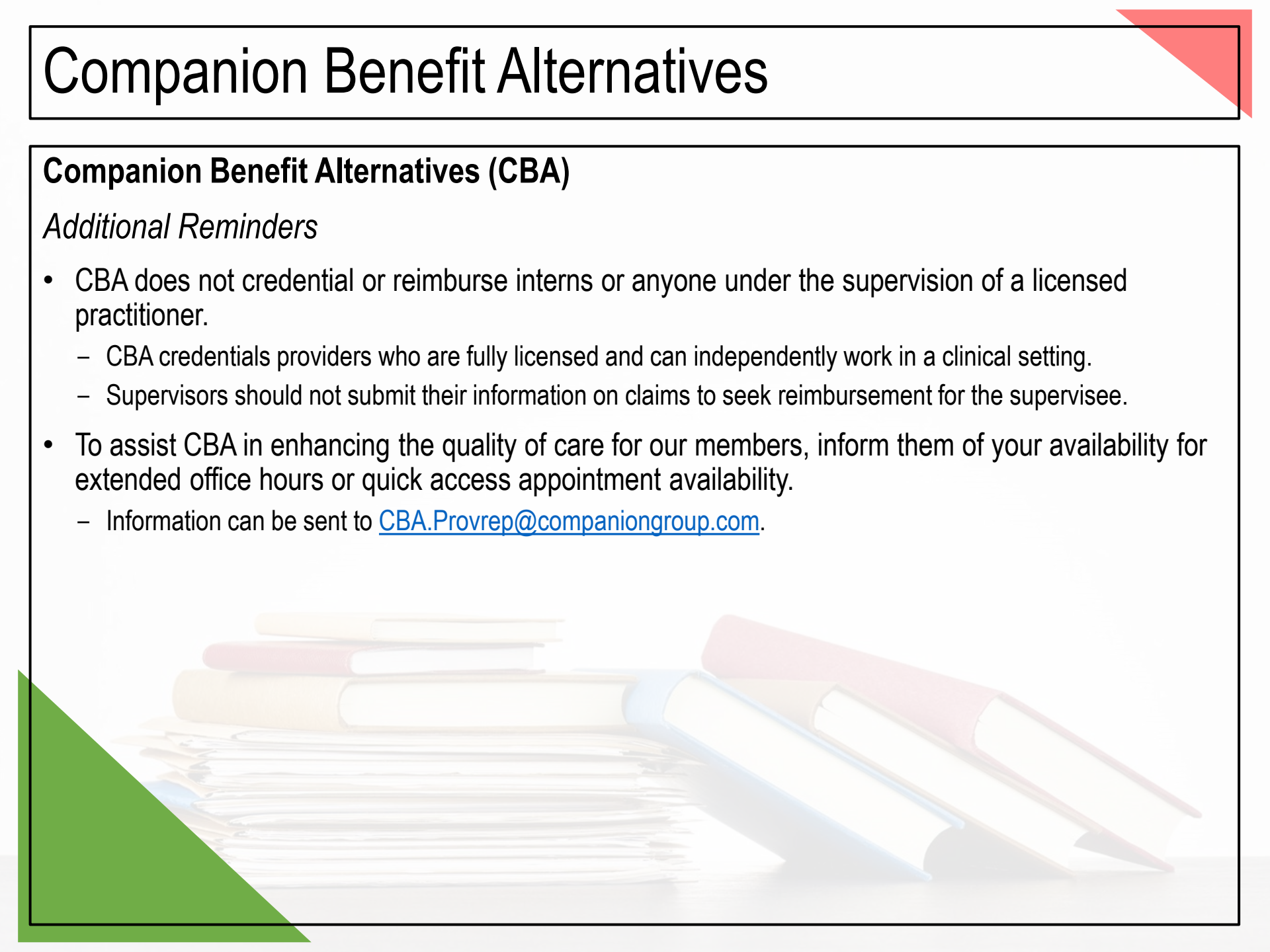
- Providers requesting to change their contracting status with the Behavioral Health (BH) network must contact CBA directly.
  - Termination of a provider's affiliation to a location will not terminate their agreement with CBA.
- CBA network providers who change their practices must notify CBA of the 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.

Companion Benefit Alternatives

Companion Benefit Alternatives (CBA)

Additional Reminders

- 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@companiongroup.com.



Companion Benefit Alternatives

Companion Benefit Alternatives (CBA)

Telehealth Reminders

- 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.

What's New?

What's New?

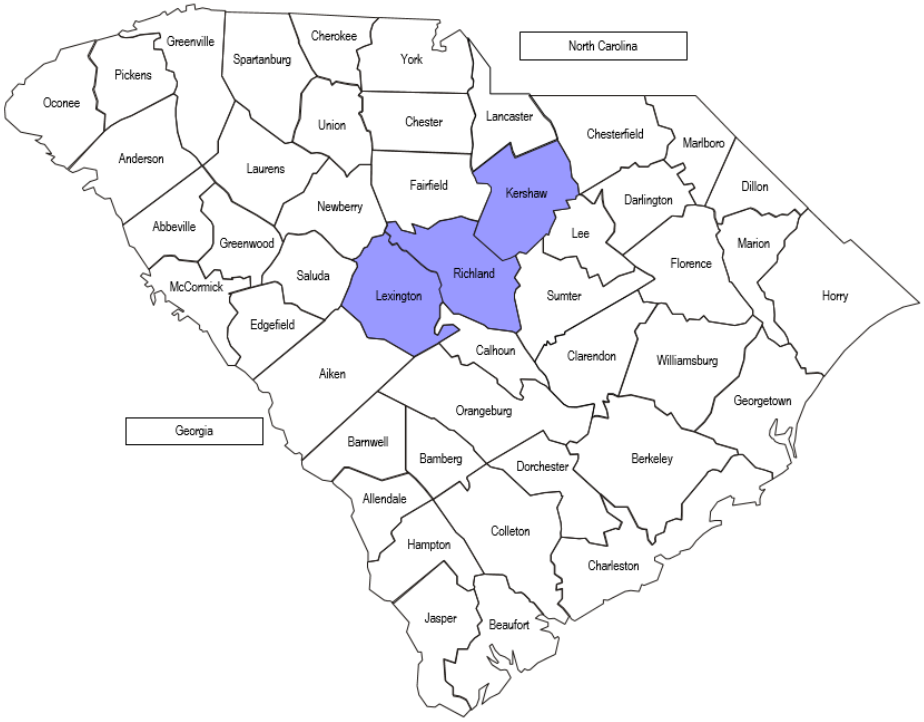
BlueExclusive℠ Congaree Network

- Effective Jan. 1, 2023
- Must reside in: Kershaw, Lexington or Richland counties
- Prefixes: **CNN** and **CNS**

Congaree Network Hospitals:

- Lexington Medical Center
- MUSC Health

Out-of-network benefits are not available, unless for urgent or emergent services.



This is a separate network from our historical and broader Individual Health Exchange Network.

Visit www.SouthCarolinaBlues.com to view the 2023 ID Card Guide to see a sample of the card.

Providers>Tools and Resources>Guides

What's New?

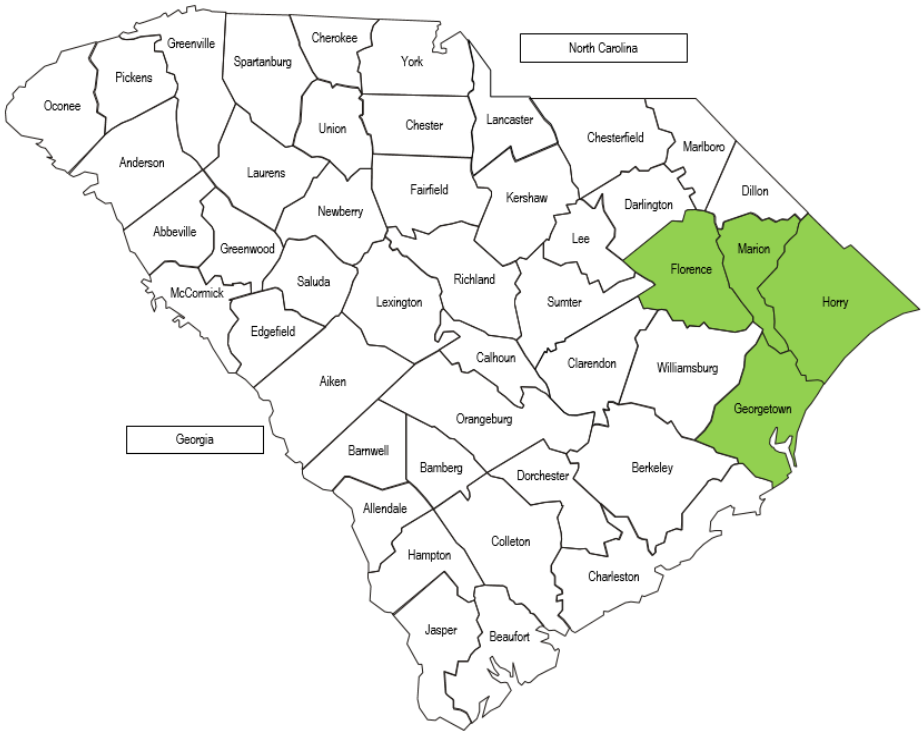
BlueExclusive℠ Pee Dee Network

- Effective Jan. 1, 2023
- Must reside in: Florence, Georgetown, Horry or Marion counties
- Prefixes: **PEQ** and **PEZ**

Pee Dee Network Hospitals:

- Conway Medical Center
- MUSC Health
- Tidelands Health

Out-of-network benefits are not available, unless for urgent or emergent services.



This is a separate network from our historical and broader Individual Health Exchange Network.

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Providers>Tools and Resources>Guides

What's New?

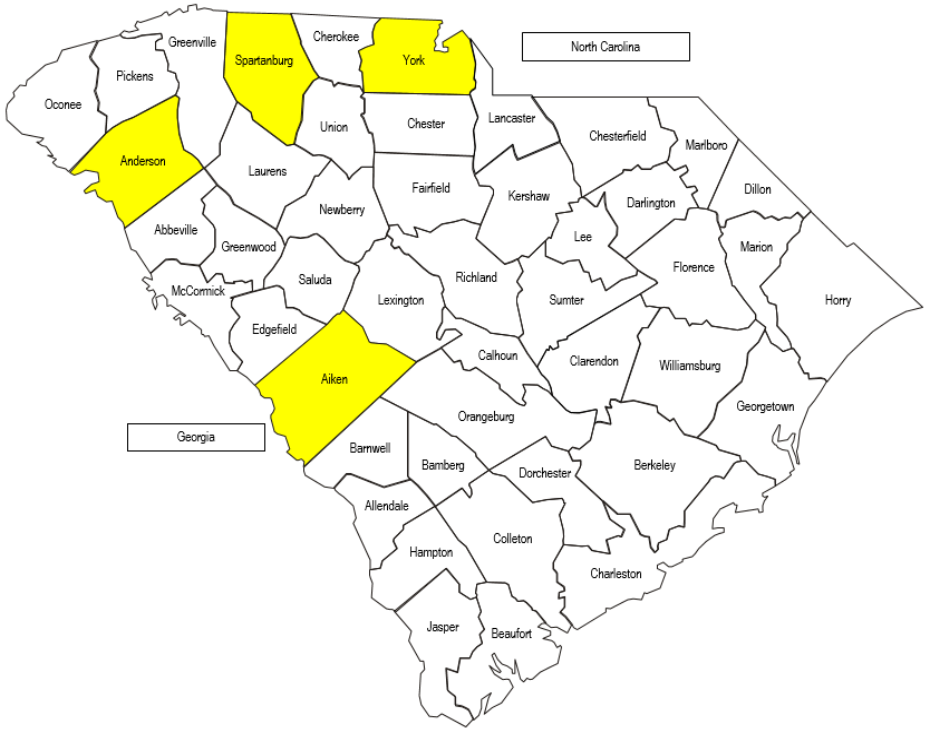
Blue VirtuConnect

- Effective Jan. 1, 2023
- Must reside in: Aiken, Anderson, Spartanburg or York counties
- Prefixes: **ZCF** and **ZCU**

For the BlueEssentials Network:

- Members must visit any hospital or physician in the BlueEssentials network.

Out-of-network benefits are not available, unless for urgent or emergent services.



This is a virtual first product.

Visit www.SouthCarolinaBlues.com to view the 2023 ID Card Guide to see a sample of the card.

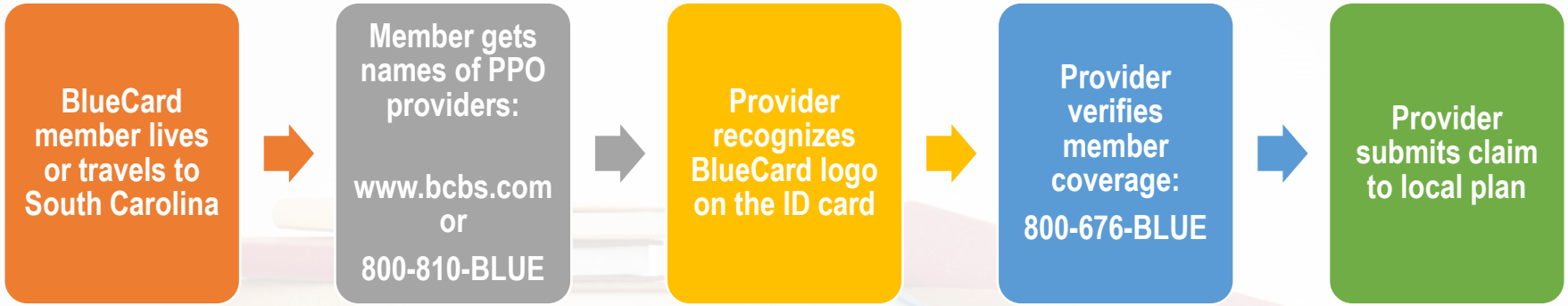
Providers>Tools and Resources>Guides

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

Home Plan vs. Host Plan

Home Plan (for the member)

- Adjudicate claims based on member eligibility and contractual benefits
- Utilization review (prior authorization)
- Member inquiries and education
- Sends member the Explanation of Benefits (EOB)

Host Plan (for the provider)

- Point of contact for claims inquiries and education
- Forwards clean claims to the Home Plan for processing
- Applies pricing and reimbursement to claims
- Sends provider remittances

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.

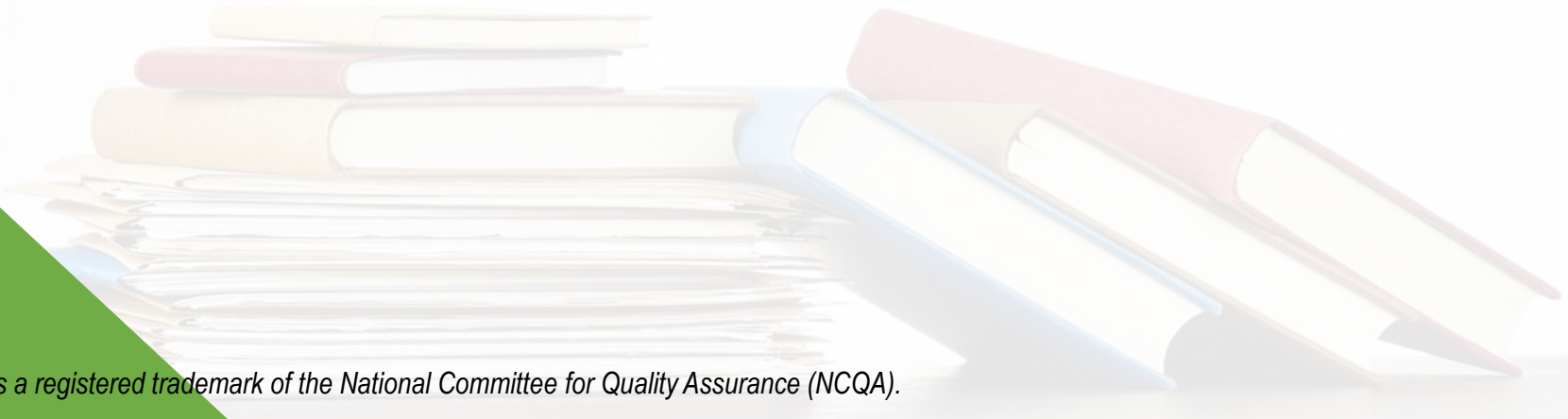
Specialty Pharmacy

- 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

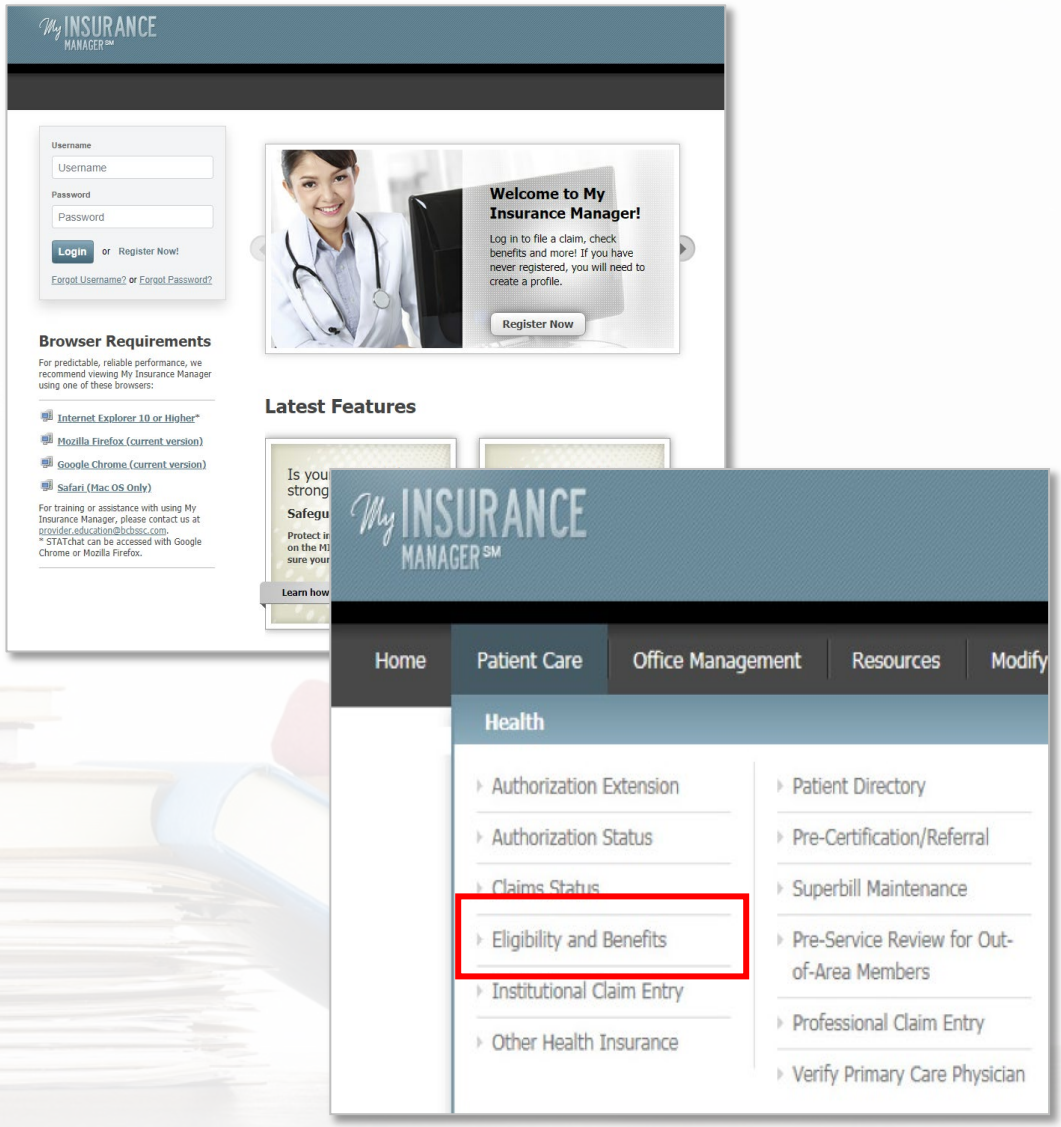
Benefit Resources

Benefit Resources

My Insurance Manager℠

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

- General
- Service type
- Procedure code (recommended)



Benefit 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.

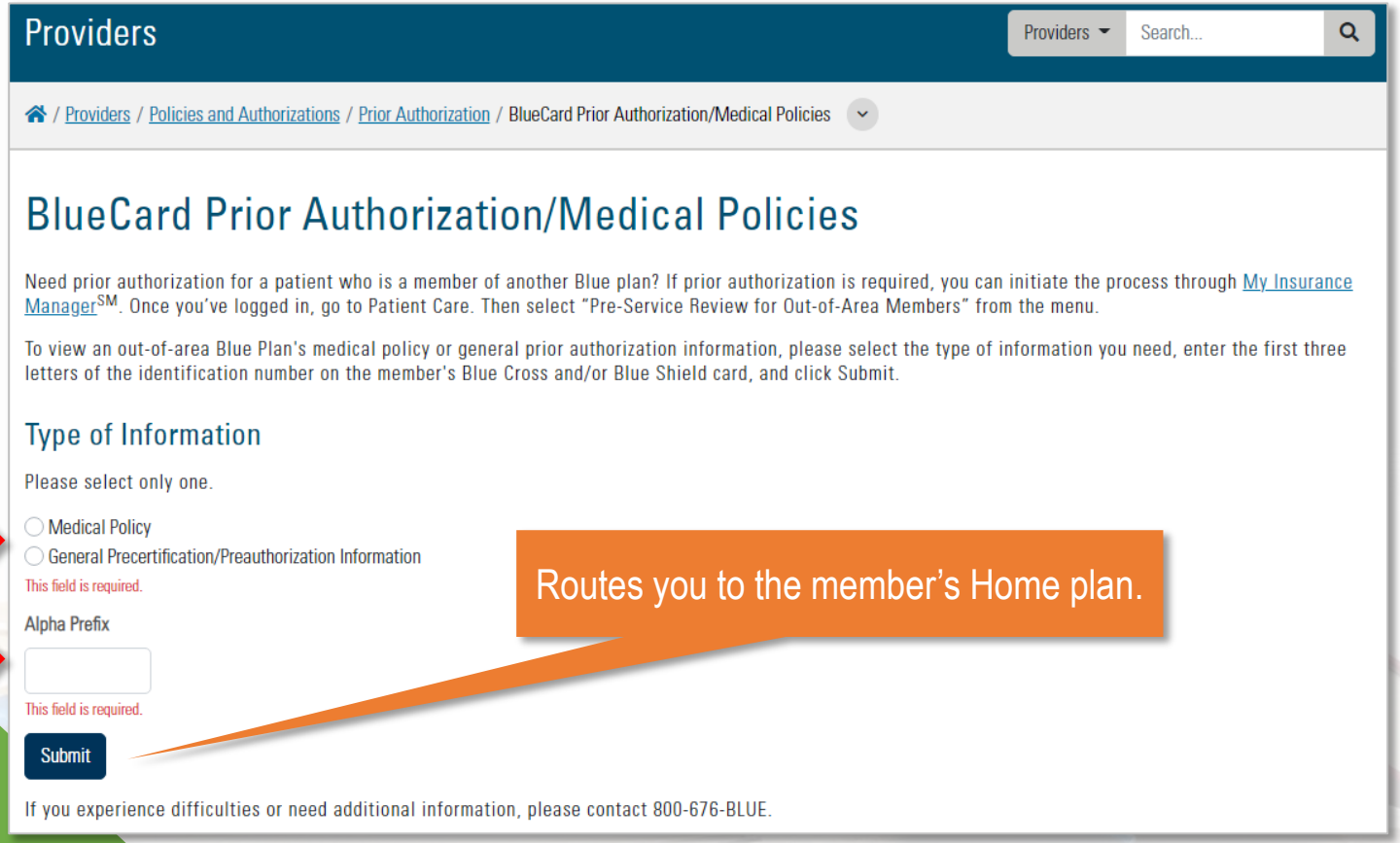
How to Access the VRU

- For BlueCross BlueShield of South Carolina members:
  - In South Carolina, call 800-868-2510.
  - In Columbia or 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.

Benefit 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.



Claims

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

- Claims Reminders
- Claims Tips
- Resources

Claims Reminders

Claims Reminders

Medicare Advantage Partners with Cotiviti

On Sept. 1, 2022, our Medicare Advantage plans partnered with Cotiviti, a market leader in payment accuracy, for periodic reviews of paid claims. Post-payment reviews include payment data validation (PDV) mining and clinical chart validation (CCV) diagnosis-related group review.

What you see:

- PDV reviews are conducted to ensure correct reimbursement and rely on paid claim data to determine accuracy.
- CCV reviews are conducted to ensure proper billing and require medical records.

If a claim is identified for either review, you will receive a letter identifying the claim(s) selected. Details related to the guidelines and time frames will follow.

Cotiviti is an independent company that conducts audits on behalf of BlueCross BlueShield of South Carolina in accordance with current industry standards and practices.

Claims Reminders

High Dollar Pre-payment Reviews

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

- A mandate implemented by the Blue Cross Blue Shield Association (BCBSA) to review high dollar inpatient hospital claims to ensure providers are billing in accordance with services rendered.
  - Effective Oct. 1, 2018, with BlueCross BlueShield of South Carolina

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

Claims 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.**

Claims 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

Claims 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

Claims Reminders

Laboratory Services — Medical Policies

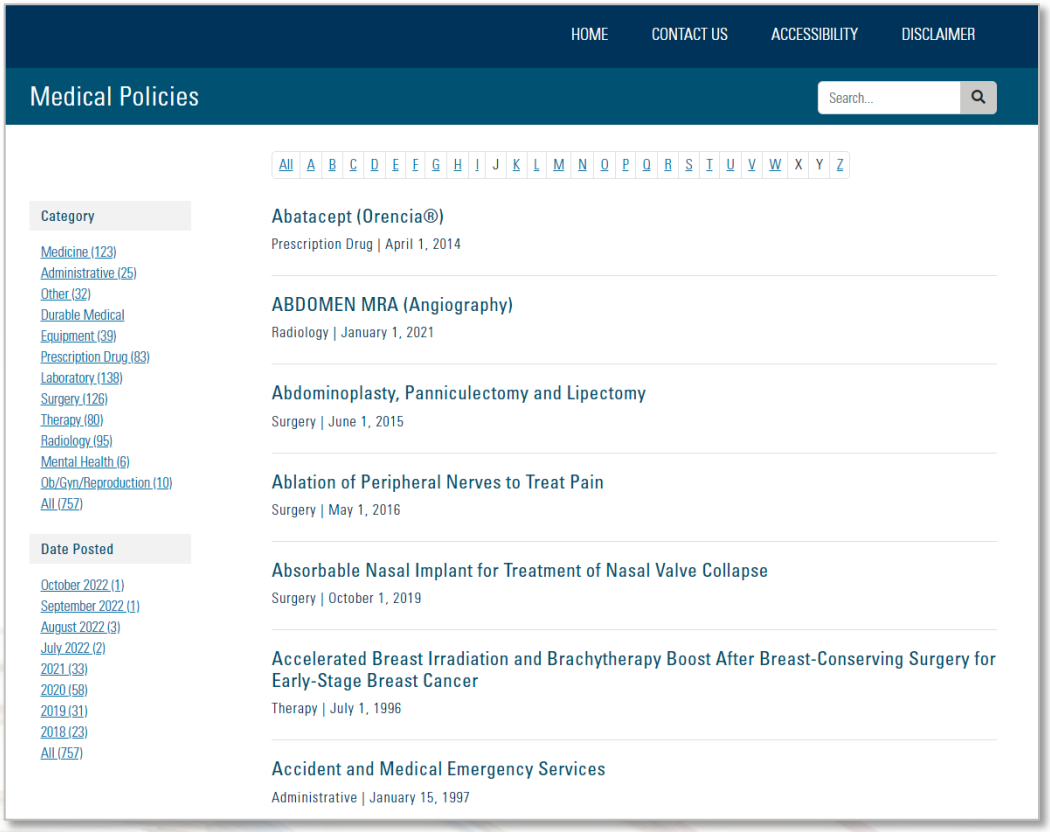
The Medical Policies pages can be accessed through one of the following:

- 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.

Claims Reminders

Laboratory Services — 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 and 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 and 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

Claims 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 member	Lack of authorization for non-emergent services when the member presents themselves as a BlueCross 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.

Claims Reminders

Provider Reconsiderations — Requirements

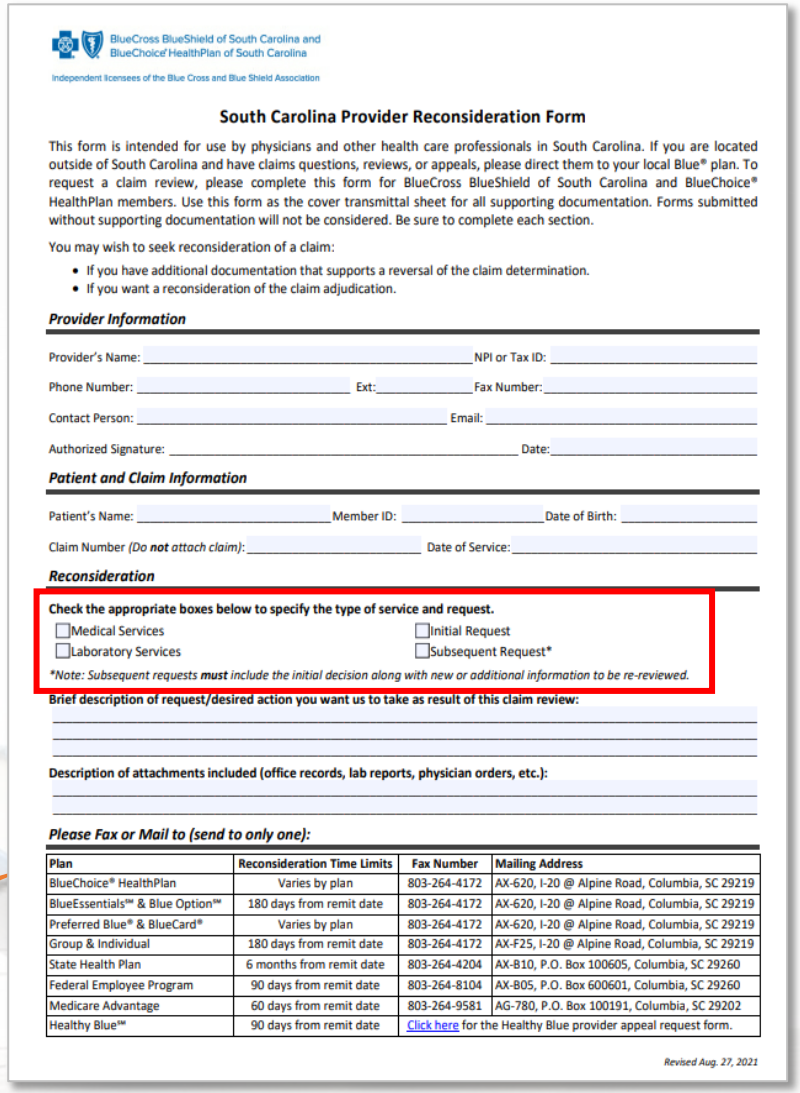
Provider Reconsideration Form

- 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

Claims Reminders

Provider Reconsideration vs. Corrected Claim

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

Claims Reminders

Pricing Inquiries

What is a pricing inquiry?

- An investigation of the reimbursement applied to a claim.

Before submitting pricing inquiries, verify the following:

- Member's plan (i.e., Commercial or Exchange)
- Non-covered charges or denied lines
- Applied cutbacks
- Date of service
- Medically unlikely edits (MUEs)

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

Claims Reminders

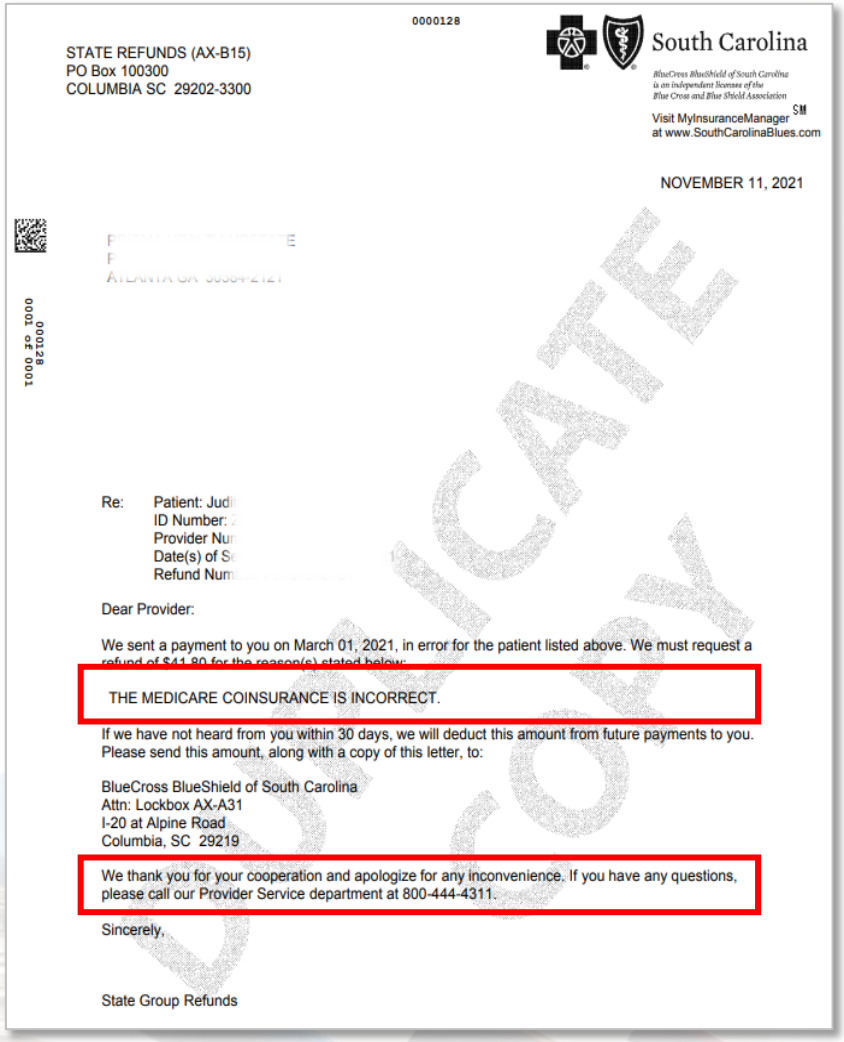
Refunds

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

0000128 2F 0001 0001

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

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

Claims 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.

Claims Reminders

Claims Submission

Claims can be submitted using the following:

- Electronically
  - 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

Claims Reminders

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

Claims Tips

Claims Tips

Claims Requiring Questionnaire Responses

- Accident or subrogation
  - Generated based on trauma related diagnoses on a claim
  - Must be completed by the member or the member can contact customer service to verify or update
    - Claim will remain patient liability until the questionnaire is received
- 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.

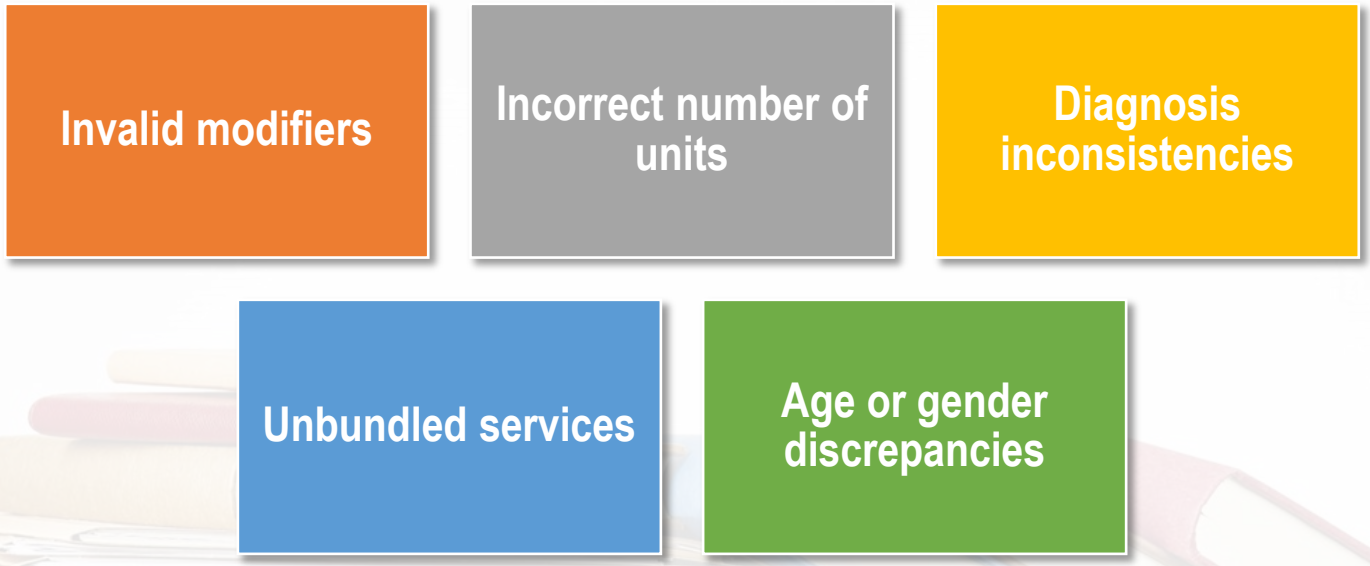
Note: Both forms are on www.SouthCarolinaBlues.com.

Providers>Forms>Other Forms

Claims Tips

Correct Coding

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



Claims Resources

Claims 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.

Claims Resources

My Insurance Manager℠

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

Claims Resources

Ask Provider Services (Web inquiries)

- Ask Provider Services is a feature inside My Insurance Manager that allows providers to submit secured web inquiries for assistance with claims.
- To receive 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?

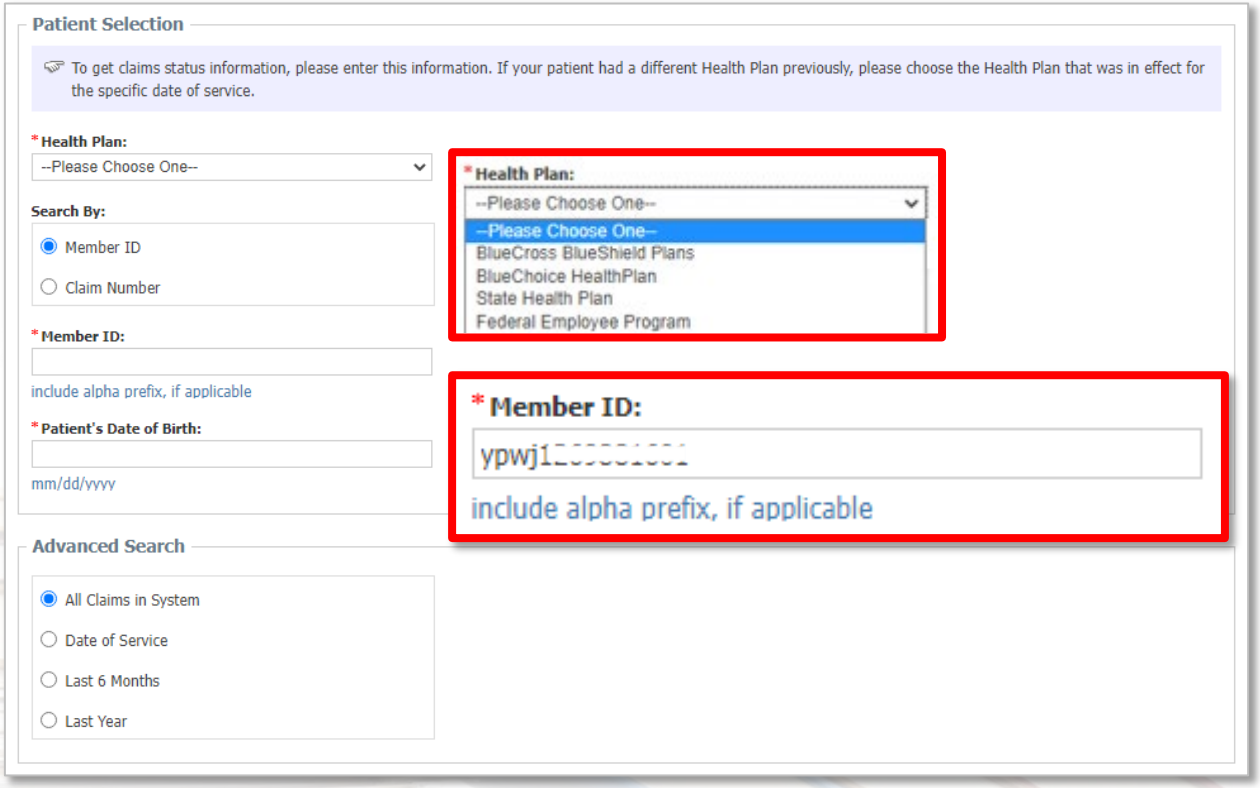
Claims Resources

Ask Provider Services — Submitting Web Inquiries

Searching by Member ID

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.



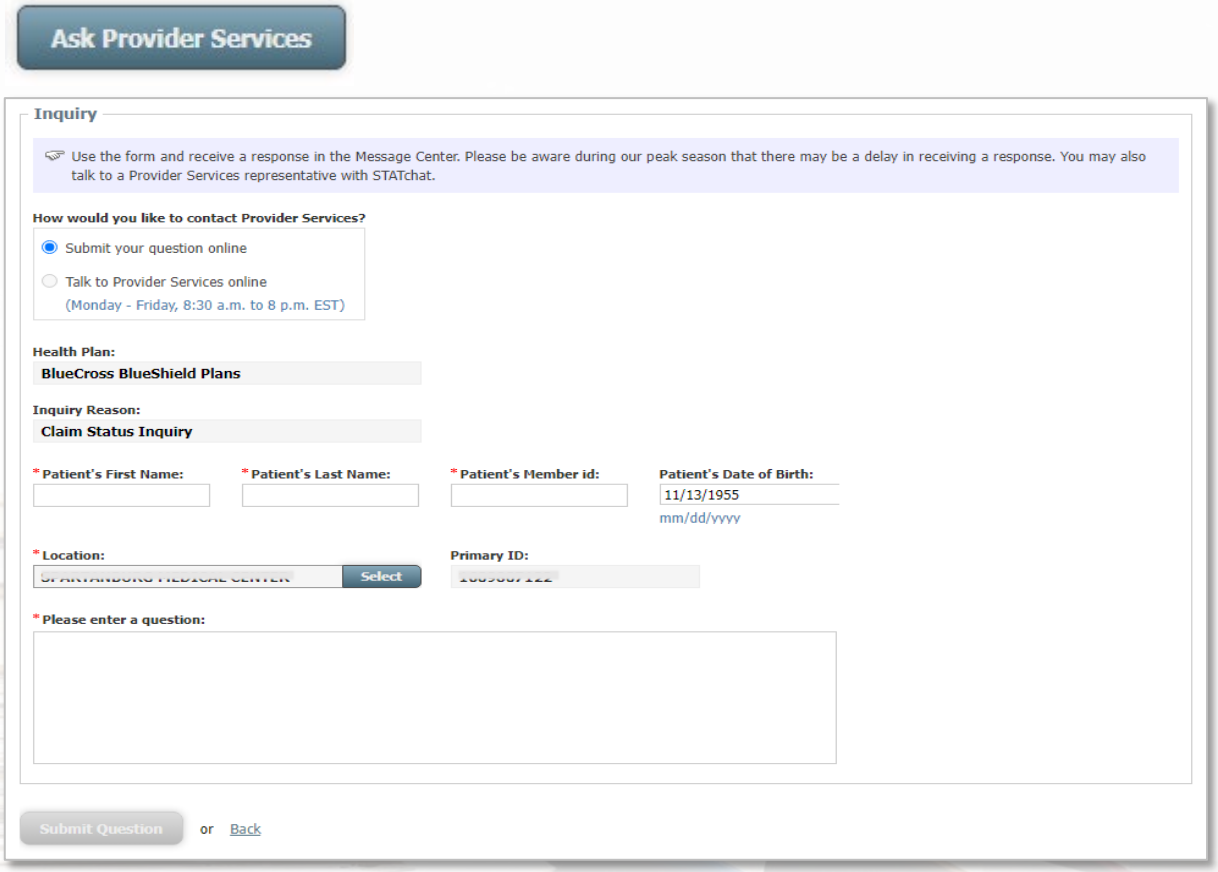
Claims Resources

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).



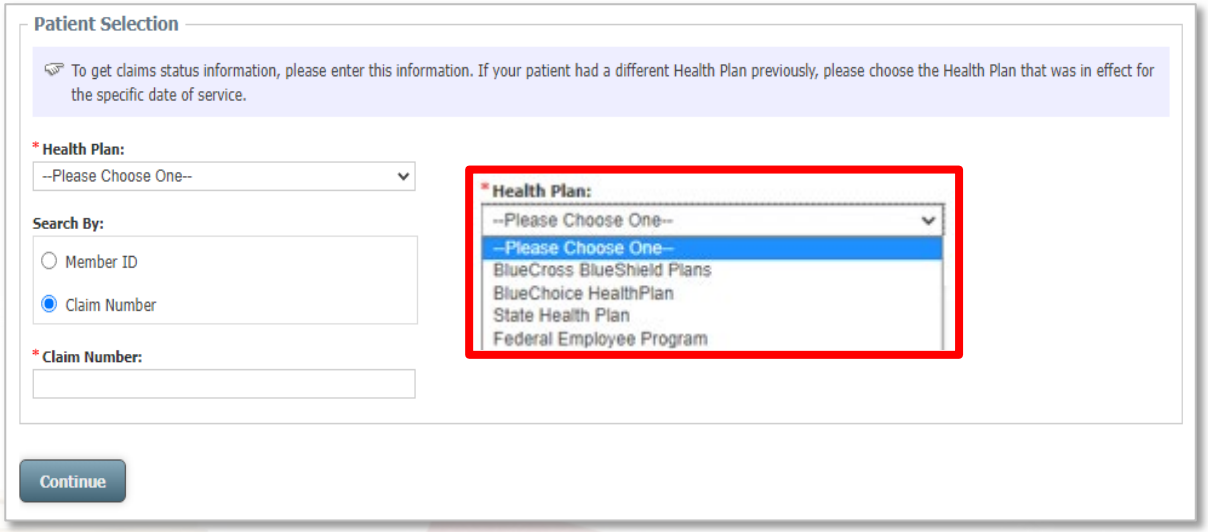
Claims Resources

Ask Provider Services — Submitting Web Inquiries

Searching by Claim Number

Be sure to:

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



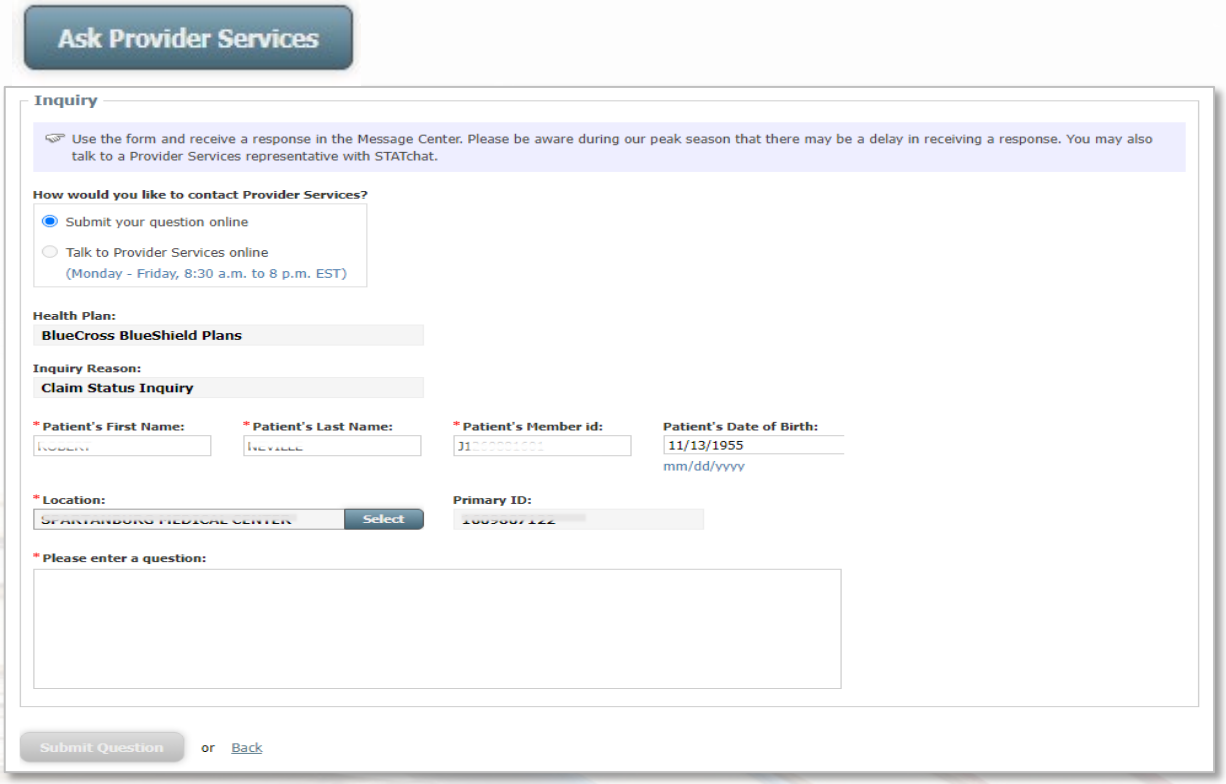
Claims Resources

Ask Provider Services — Submitting Web Inquiries

Searching by Claim Number (Continued)

Be sure to:

- 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).

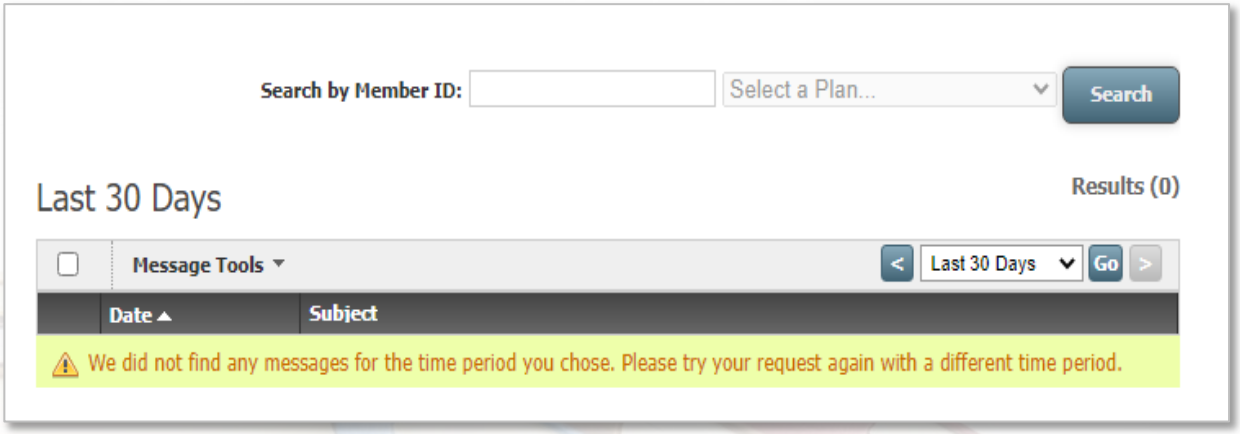


Claims Resources

Ask Provider Services — Submitting Web Inquiries

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.

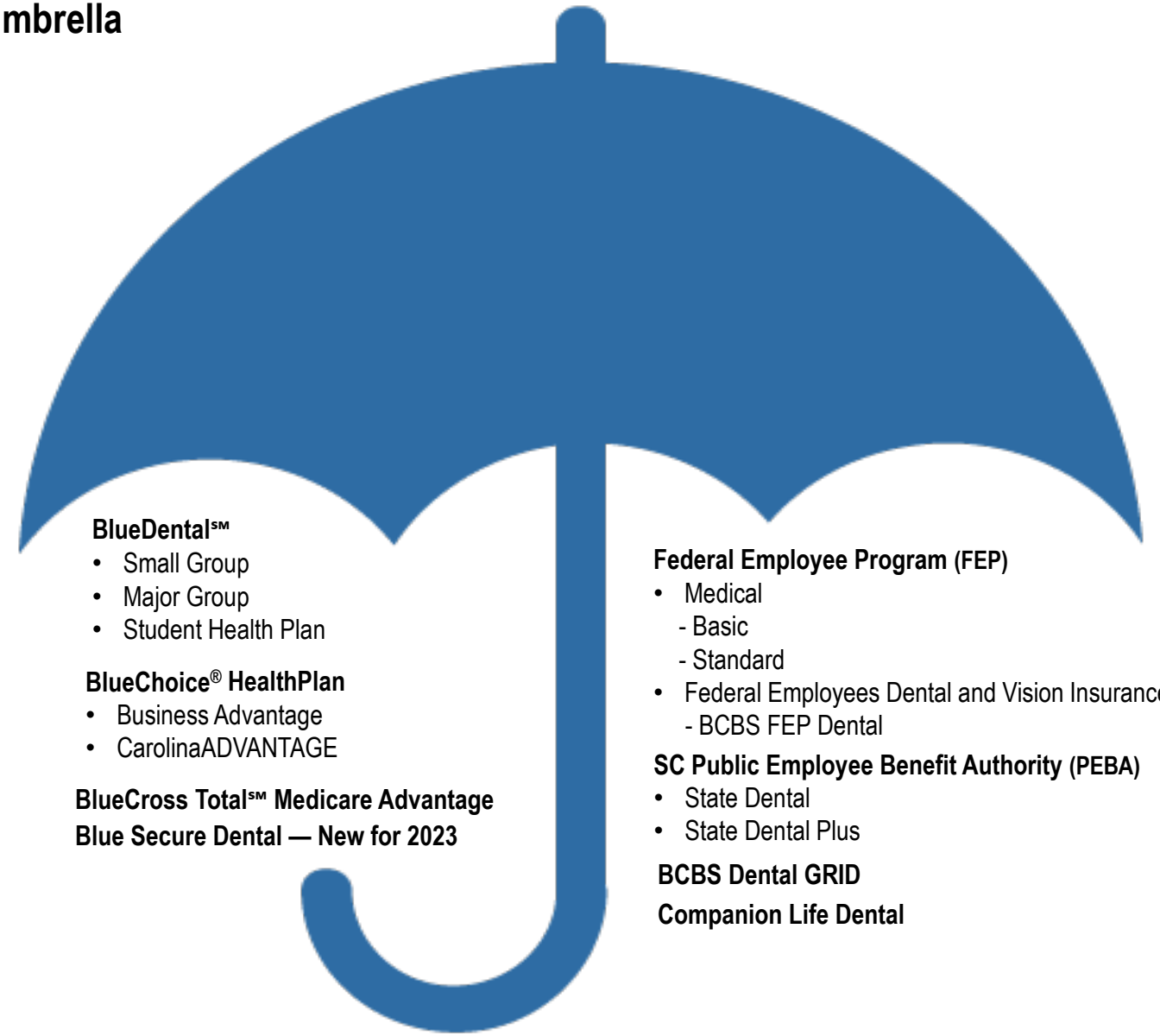
Dental Network

Agenda

- Dental Plans
- Dental GRID
- Eligibility, Benefits and Claims
- Credentialing
- 2023 Coding Updates

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

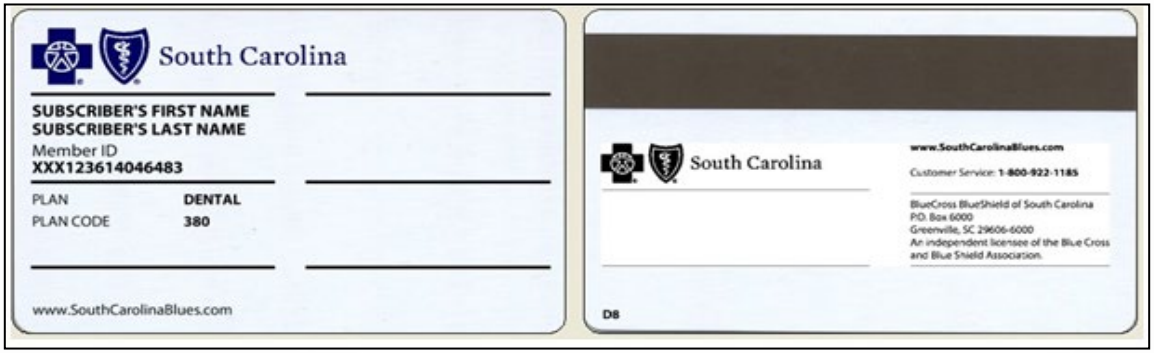
SC Public Employee Benefit Authority (PEBA)
- State Dental
- State Dental Plus

BCBS Dental GRID

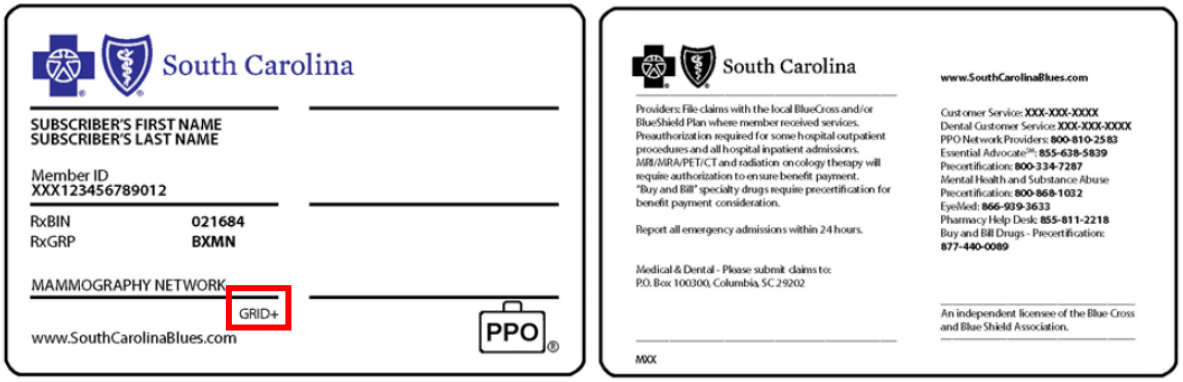
Companion Life Dental

Dental Plans

Commercial Plans



Sample Commercial - Dental Only ID Card



Sample Commercial - Medical and Dental ID Card

Dental Plans

Commercial Plans

- 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)

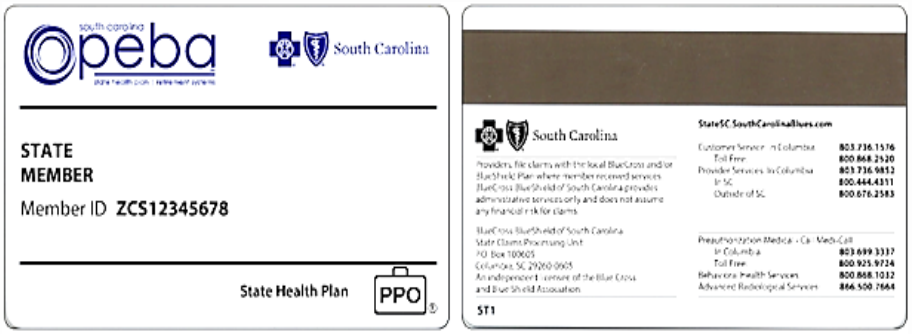
Dental Plans

State Plans: Basic Dental

- SC Public Employee Benefit Association (PEBA) uses BlueCross 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.

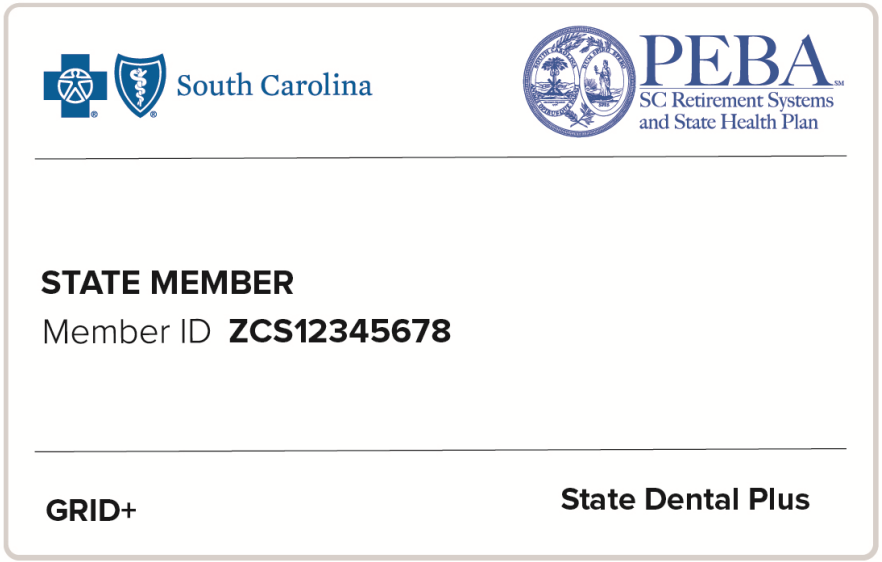
- Covered services are paid based on its schedule of dental procedures and allowable charges.



Dental Plans

State Plans: Dental Plus

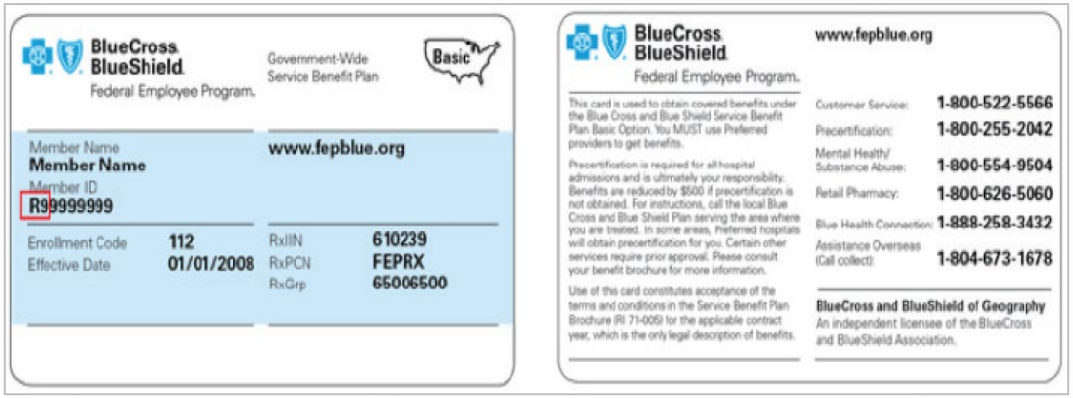
- Members with the Dental Plus plan with have **State Dental Plus** on their ID card
- Dental Plus is a supplement to the Basic Dental plan and provides an additional $1,000 benefit period maximum for classes 1-3.
- Dental Plus provides a higher level of reimbursement for services that the Basic Dental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



Dental Plans

Federal Employee Program (FEP): Basic Option

- Members have a $30 copay for evaluations. If members have Medicare Part B or a FEDVIP plan, the copay is waived and the FEDVIP plan covers it.
- 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 $30 copayment Participating or non-participating: nothing	Preferred: $30 copayment per evaluation Participating or 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 two per person per calendar year)	---	$16	
Prophylaxis — child (up to two 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

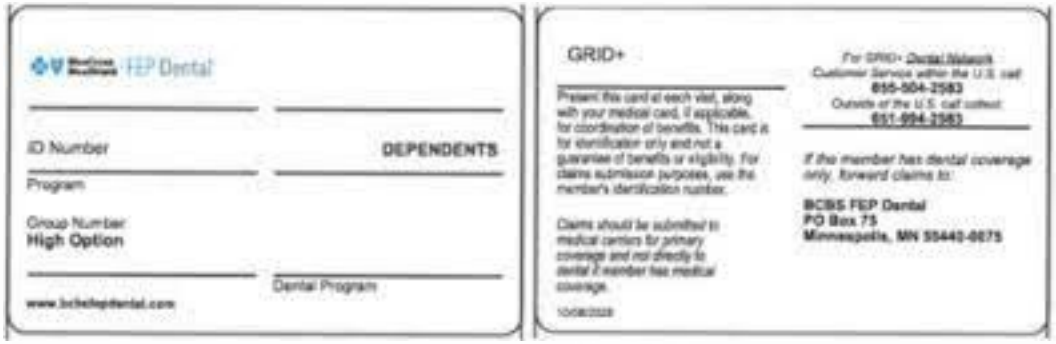
Federal Employee Program (FEP): Blue Focus

- Members with a Blue Focus plan do not have dental benefits directly with their plan.
- Members would need BCBS FEP Dental or another FEDVIP for dental benefits.
- Claims would need to be filed directly to the FEDVIP plan.

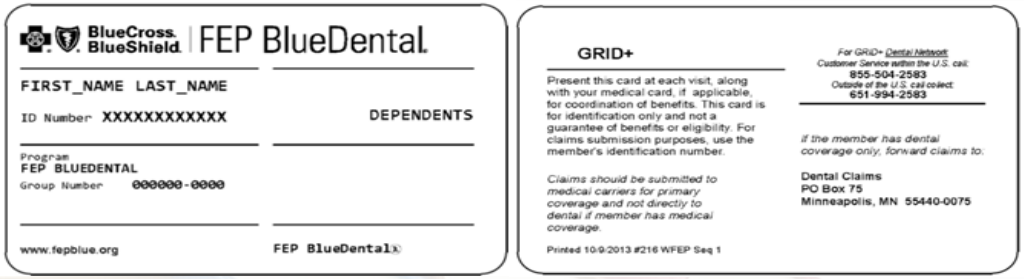
Dental Plans

Federal Employee Program (FEP): BCBS FEP Dental

- On Jan. 1, 2021, FEP BlueDental became Blue Cross Blue Shield (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.



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℠ and Total Value℠

	BlueCross PPO Dental Benefit Highlights			
	Service	**In-Network**	**Visits (Per Year)**	**Out-of-Network**
Preventive dental	**Oral exams Cleanings**	$0	2	50% COINS
	Dental x-rays	$0	1	50% COINS
Comprehensive dental* **(non-Medicare covered services)**	Restorative Endodontics Extractions Prosthodontics	Anesthesia Other oral or maxillofacial surgery Other services (e.g., deep cleanings, fillings, crowns, root canal, dentures, bridges)		50% COINS (INN and OON)
Annual maximum **(per member, per year)**	**BlueCross Total: $3,000** **(comprehensive and preventive combined)** **Total Value: $2,000** **(comprehensive and preventive combined)** **Blue Basic: $1,000** **(comprehensive and preventive combined)**			

***SC Blue Dental Network**

Dental Plans

Blue Secure

The Blue Secure dental plan will begin on Jan. 1, 2023.

	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

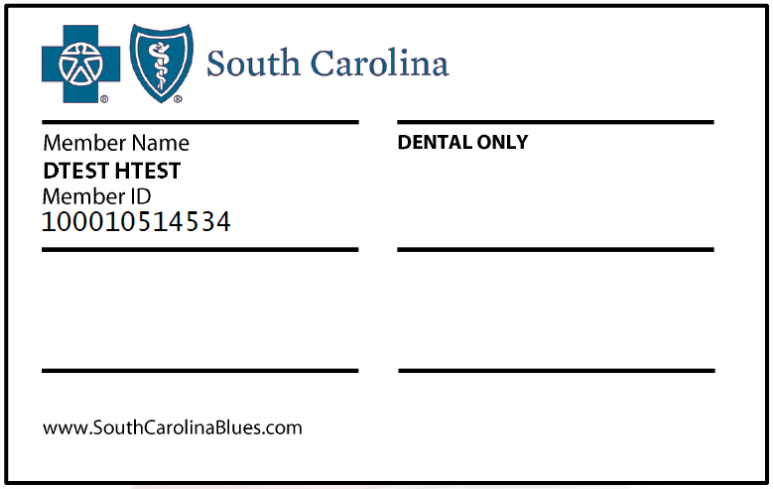
Blue Secure (Continued)

	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	$375	$750	$375	$750
Maximum Out-of-Pocket Total (All Children)	$750	$1,500	$750	$1,500

Dental Plans

Blue Secure (Continued)

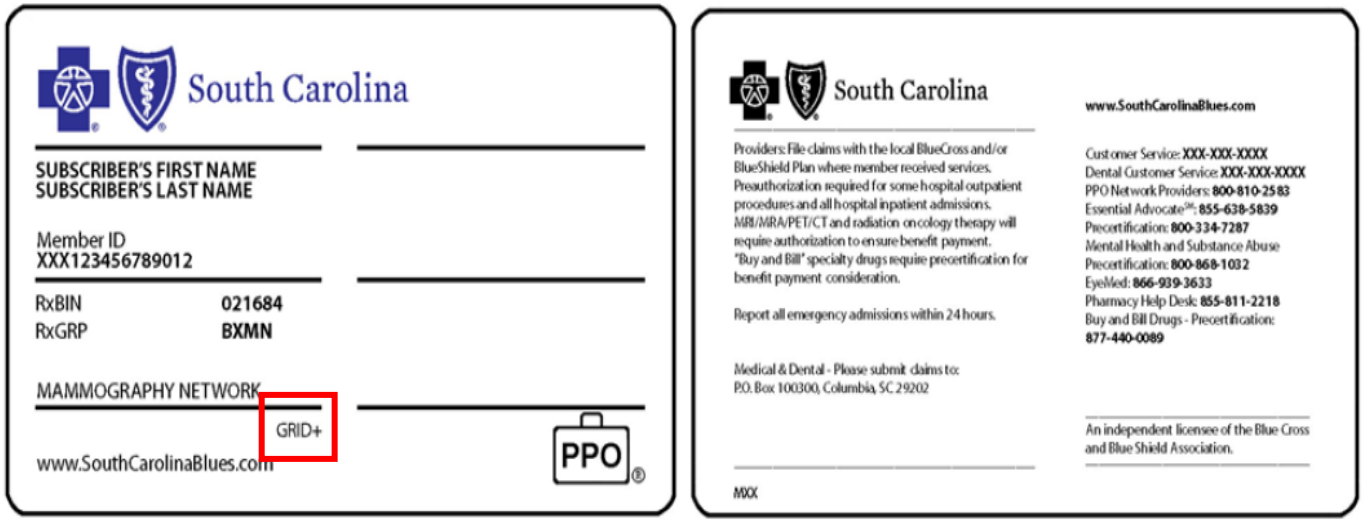
Sample ID card for the plan



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 (MIM) 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	803-264-6763
FEP Dental (Medical)	800-444-4325	
BlueCross Total℠, Total Value℠ and Blue Basic℠ (MA Dental)	800-222-7156	803-264-7629

Eligibility, Benefits and Claims

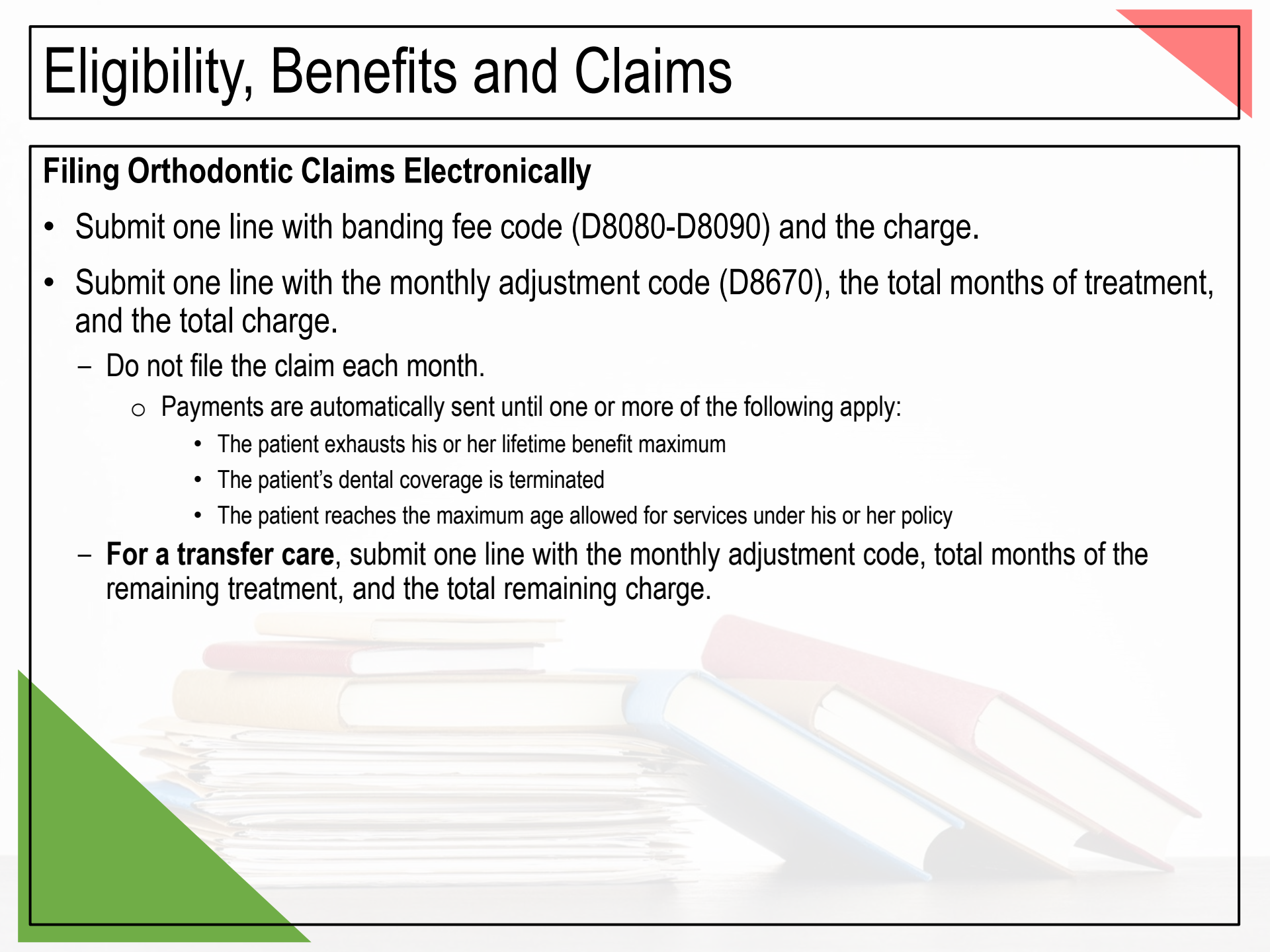
Filing Dental Claims Under Medical Benefits

- 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 Dec. 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.

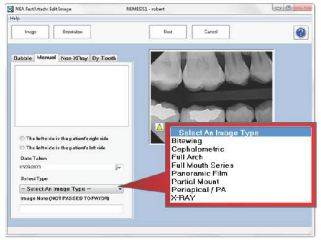
Improve claim adjudication times by electronically transmitting:

- 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.

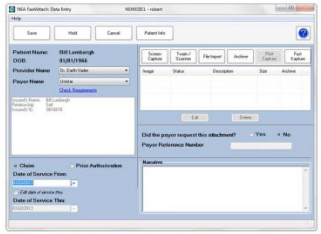
Easy to Use & Access

- 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).

Credentialing

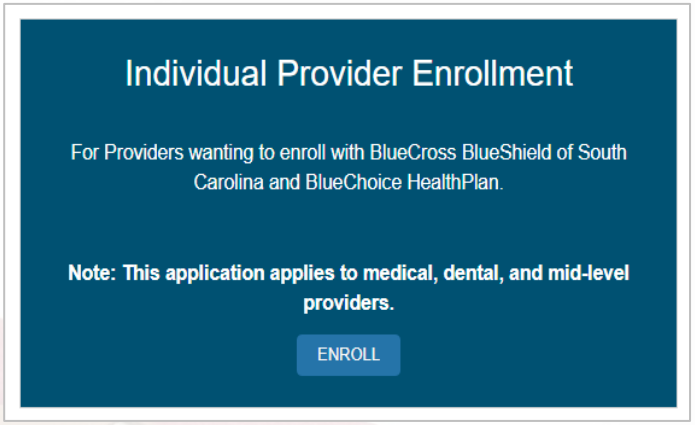
Credentialing

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



2023 Coding Updates

2023 Dental Coding Updates

Deleted CDT Codes for 2023

Code	Description
D0351	3D photographic image
D0704	3D photographic image — image capture only

2023 Dental Coding Updates

New CDT Codes for 2023

Code	Description
D0372	Intraoral tomosynthesis — comprehensive series of radiographic images
D0373	Intraoral tomosynthesis — bitewing radiographic image
D0374	Intraoral tomosynthesis — periapical radiographic image
D0387	Intraoral tomosynthesis — comprehensive series of radiographic images, image capture only
D0388	Intraoral tomosynthesis — bitewing radiographic image, image capture only
D0389	Intraoral tomosynthesis — periapical radiographic image, image capture only
D0801	3D dental surface scan — direct
D0802	3D dental surface scan — indirect
D0803	3D facial surface scan — direct
D0804	3D facial surface scan — indirect
D1781	Vaccine administration — human papillomavirus, dose 1

Note: The new American Dental Association (ADA) CDT codes may or may not be covered as plan coverage varies by product or group benefits. To determine benefit coverage, please submit a preauthorization or call the number on the back of the member's ID card.

2023 Dental Coding Updates

New CDT Codes for 2023

Code	Description
D1782	Vaccine administration — human papillomavirus, dose 2
D1783	Vaccine administration — human papillomavirus, dose 3
D4286	Removal of non-resorbable barrier
D6105	Removal of implant body not requiring bone removal or flap elevation
D6106	Guided tissue regeneration — resorbable barrier, per implant
D6107	Guided tissue regeneration — non-resorbable barrier, per implant
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant
D7509	Marsupialization of odontogenic cyst
D7956	Guided tissue regeneration, edentulous area — resorbable barrier, per site
D7957	Guided tissue regeneration, edentulous area — non-resorbable barrier, per site
D9953	Reline custom sleep apnea appliance (indirect)

Note: The new ADA CDT codes may or may not be covered as plan coverage varies by product or group benefits. To determine benefit coverage, please submit a preauthorization or call the number on the back of the member's ID card.

Healthy Blue

Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

Agenda

- Contacts and Resources
- Benefits
- Claims
- Reminders
- Quality
- Marketing

Contacts and Resources

Contacts and Resources

Website:
www.HealthyBlueSC.com

Provider Customer Care Center:
Phone: 866-757-8286 or TTY: 866-773-9634
Fax: 912-233-4010 or 912-235-3246
Hours: Monday to Friday, 8 a.m. to 6 p.m. EST

Disease Management (DM) Department:
Phone: 888-830-4300 TTY: 800-855-2880
Hours: Monday to Friday, 8 a.m. to 5 p.m. EST

Utilization Management (UM) Department for Physical & Behavioral Health:
Phone: 866-902-1689
Fax: 800-823-5520
Hours: Monday to Friday, 8 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 prior authorization for certain services.

Vision Service Plan (VSP)*:
Phone: 800-615-1883
Hours: Monday to 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: 866-577-9710 TTY: 800-368-4424

Case Management (CM) Department:
Phone: 866-757-8286
Hours: Monday to Friday, 8 a.m. to 5 p.m. EST

AIM Specialty Health®**
Phone: 800-252-2021
Hours: Monday to Friday, 8 a.m. to 5 p.m. CST

IngenioRx™***
Prior authorizations: 844-410-6890
Hours: Monday to Friday, 8 a.m. to 8 p.m. EST

**VSP is an independent company that provides vision services on behalf of BlueChoice HealthPlan.*
***AIM Specialty Health is a separate company providing some utilization review services on behalf of BlueChoice HealthPlan.*
****IngenioRx is an independent company that provides pharmacy benefit management services on behalf of BlueChoice HealthPlan.*

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.
    - Manuals include general information, billing details, claims guidelines and more.

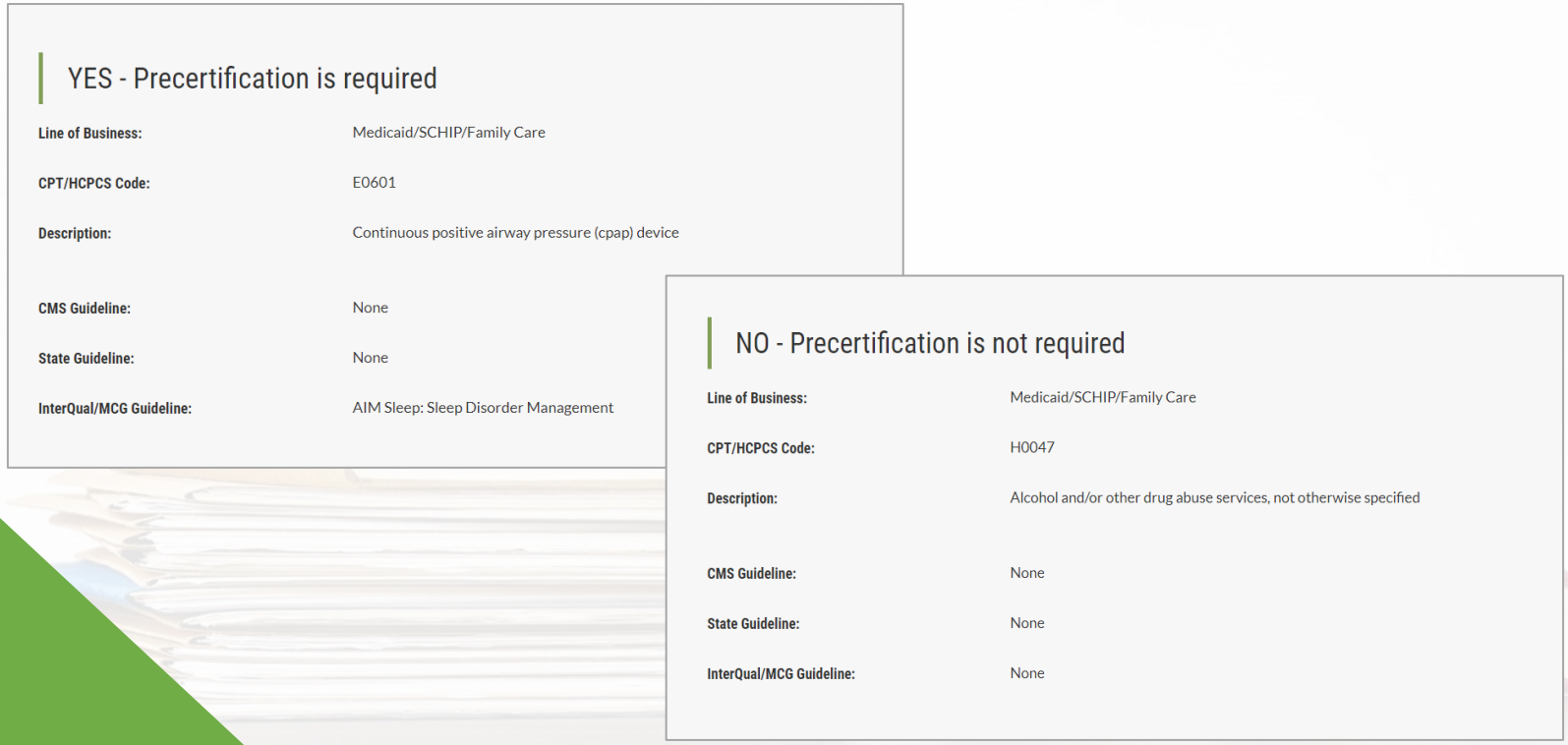
**The South Carolina Department of Health and Human Services (SCDHHS) is an independent organization that provides health information you may find helpful.*

Benefits

Prior Authorization Lookup Tool

Visit www.HealthyBlueSC.com: *Providers>Resources>Prior Authorization Lookup Tool.*

- Use the tool for outpatient services only.
- Always verify eligibility and benefit coverage prior to rendering services.



YES - Precertification is required

Line of Business:	Medicaid/SCHIP/Family Care
CPT/HCPCS Code:	E0601
Description:	Continuous positive airway pressure (cpap) device
CMS Guideline:	None
State Guideline:	None
InterQual/MCG Guideline:	AIM Sleep: Sleep Disorder Management

NO - Precertification is not required

Line of Business:	Medicaid/SCHIP/Family Care
CPT/HCPCS Code:	H0047
Description:	Alcohol and/or other drug abuse services, not otherwise specified
CMS Guideline:	None
State Guideline:	None
InterQual/MCG Guideline:	None

Benefits

Requesting Prior Authorizations

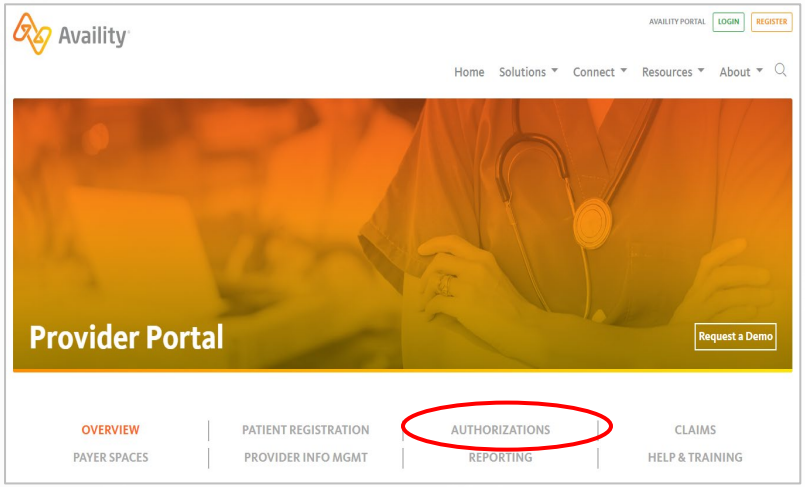
Prior authorizations can be requested through these avenues:

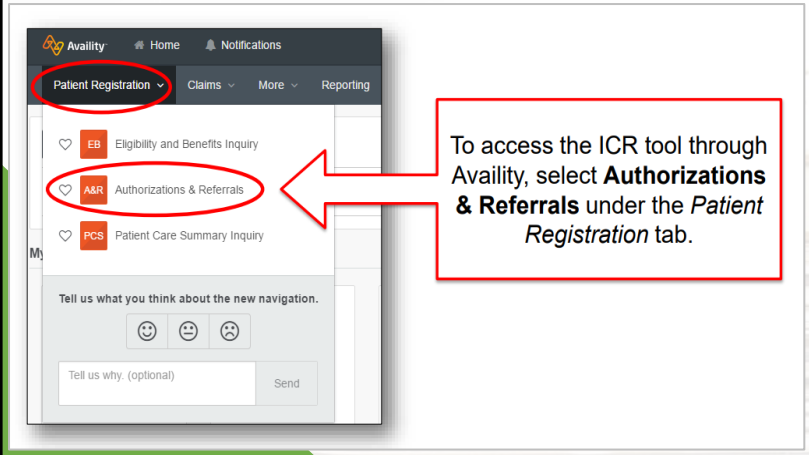
- Availity* (preferred)
  - www.Availity.com
- Phone (utilization management)
  - 866-902-1689
- Fax (utilization management)
  - 800-823-5520 (general requests)

**Availity LLC is an independent company that provides administrative support services on behalf of BlueChoice HealthPlan.*

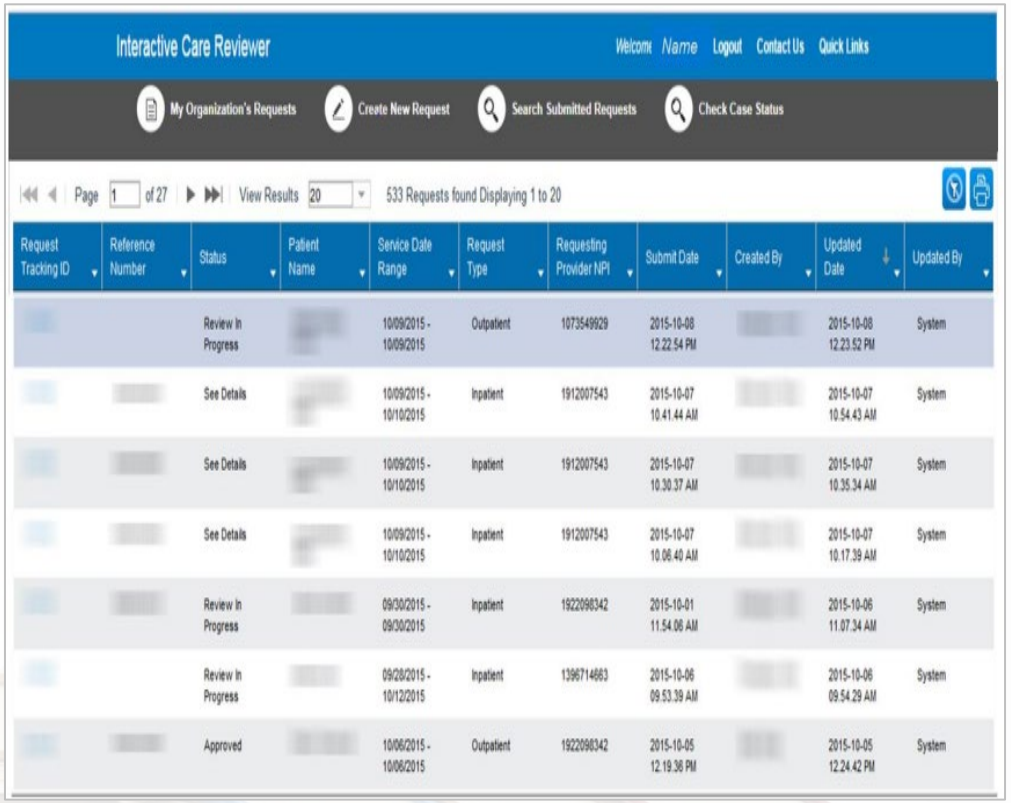
Benefits

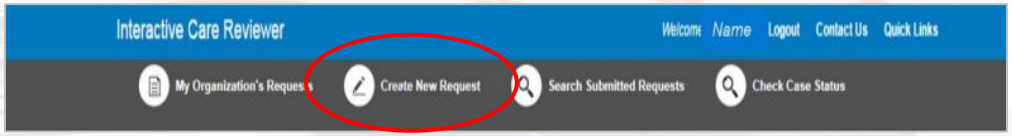
Requesting Prior Authorizations — Availity





To access the ICR tool through Availity, select **Authorizations & Referrals** under the *Patient Registration* tab.





Benefits

Requesting Prior Authorizations — Phone

Contact the utilization management (UM) team at 866-902-1689. The following information is required:

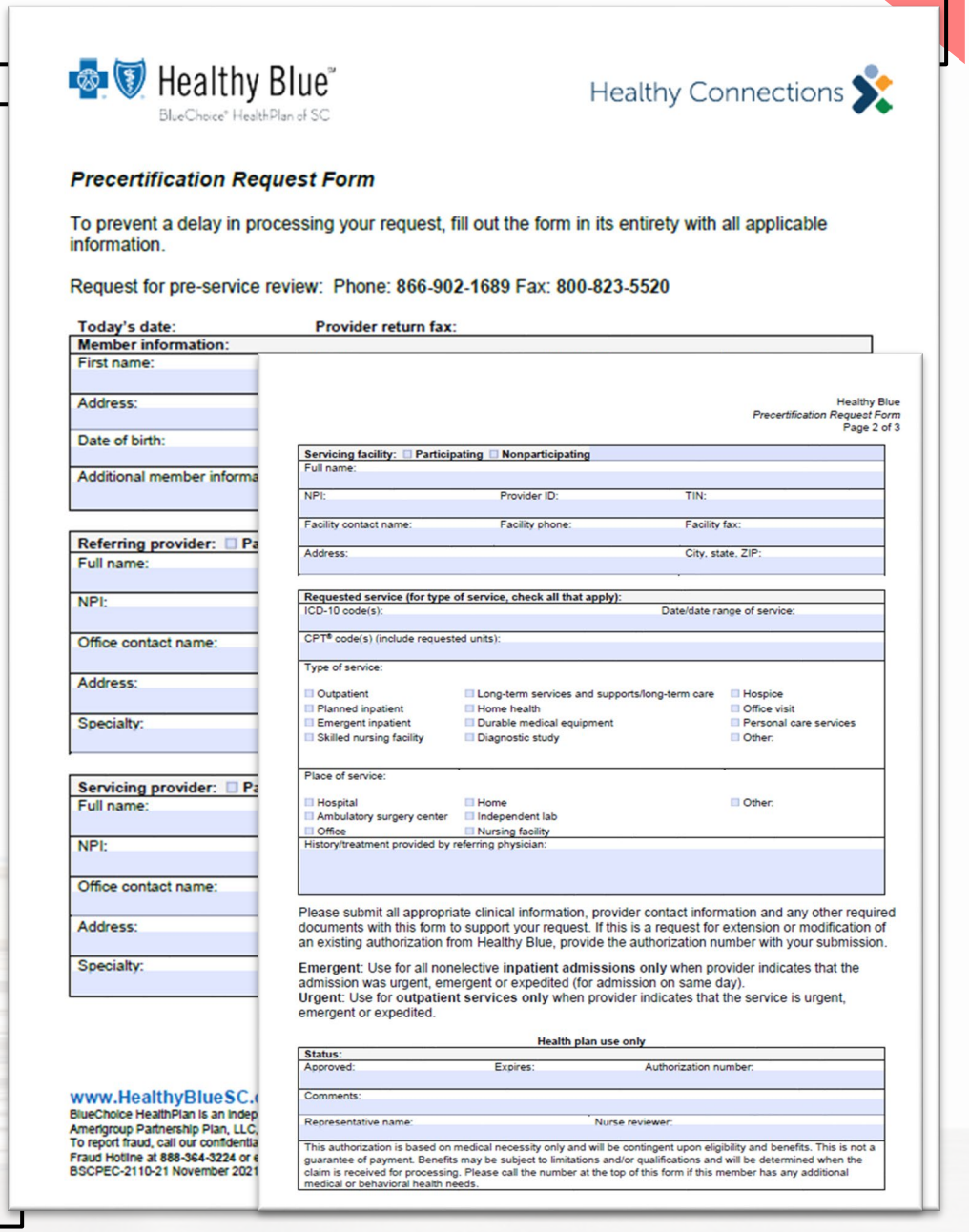
- Member's name, date of birth, Medicaid number and address
- ICD-10 codes
- CPT or HCPCS codes and units or visit amounts where appropriate
- Date(s) of service
- Level of care as appropriate
- Requesting or servicing provider's tax ID or NPI, address, phone, and fax number
- Servicing facility's tax ID or 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

Benefits

Requesting Prior Authorizations — Fax

Types of fax request forms include:

- Inpatient
- Psychological testing
- Managed care organization (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 applicable information.

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

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

Member information:
First name:
Address:
Date of birth:
Additional member informa

Referring provider: ☐ Pa
Full name:
NPI:
Office contact name:
Address:
Specialty:

Servicing provider: ☐ Pa
Full name:
NPI:
Office contact name:
Address:
Specialty:

www.HealthyBlueSC.
BlueChoice HealthPlan is an indep
Amerigroup Partnership Plan, LLC,
To report fraud, call our confidentia
Fraud Hotline at 888-364-3224 or e
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.

Benefits

Copays

Service	Copay Amount
Primary care visits, rural health clinics (RHC) and federally qualified health centers (FQHC)	$3.30
Specialist visits (including optometrists)	$3.30
Durable medical equipment (DME)	$3.40
Chiropractic care	$1.15
Home health (limited to 50 visits)	$3.30
Prescription drugs (brand and generic)	$3.40
Outpatient hospital	$3.40
Inpatient hospital	$25.00

Benefits

Copays — Exemptions

Members

- Those under 19 years of age
- Those who are pregnant
- Those who are institutionalized
- Those receiving emergency services in the emergency room (ER)
- Those receiving hospice care
- Those of a federally recognized Native American tribe

Services

- Medical equipment and supplies provided by the Department of Health and Environmental Control (DHEC)
- Family planning
- End-stage renal disease care
- Services provided at an infusion center
- Services provided in urgent or minor care clinics

Benefits

AIM Specialty Health

- AIM Specialty Health®* manages authorization requests for these services.
- Call: 800-252-2021

Advanced Imaging	Cardiology Services	Radiation Oncology Services
Computed tomography scans (including cardiac)	Resting transthoracic tachocardiography	Brachytherapy
Magnetic resonance imaging (including cardiac)	Transesophageal echocardiography	Intensity modulated radiation therapy
Positron emission tomography scans (including cardiac)	Arterial ultrasound	Proton beam radiation therapy
Nuclear cardiology	Cardiac catheterization	Stereotactic radiosurgery or stereotactic body radiotherapy
Stress echocardiography	Percutaneous coronary intervention (PCI)	3D conformal therapy[1] (EBRT) for bone metastases and breast cancer
		Hypofractionation for bone metastases and breast cancer when requesting EBRT and intensity modulated radiation therapy (IMRT)
		Special procedures and consultations associated with a treatment plan (CPT codes 77370 and 77470)
		Image guided radiation therapy

[1]Radiation oncology performed as part of an inpatient admission is not part of the AIM program. Radiation oncology providers are strongly encouraged to verify that authorization has been obtained before initiating scheduling and performing services.

**AIM Specialty Health is a separate company providing some utilization review services on behalf of BlueChoice HealthPlan.*

Claims

Claims

Filing Claims

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

- Electronically (preferred)
  - Payer ID: 00403
  - For set up and information, contact E-Solutions at 800-470-9630.
- Availity
- Mail (hard copy)

  Healthy Blue
  Attn: Medicaid Claims
  P.O. Box 100124
  Columbia, SC 29202

E-Solutions is an independent company that helps administer electronic claim filing on behalf of BlueChoice HealthPlan.

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
- 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 or 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:

- **Verbally**
  - Customer Care Center: 866-757-8286
- **Availity**
  - www.Availity.com
- **Mail (written)**
  - Healthy Blue, Payment Dispute Unit
    P.O. Box 100124
    Columbia, SC 29202-3124

Claims

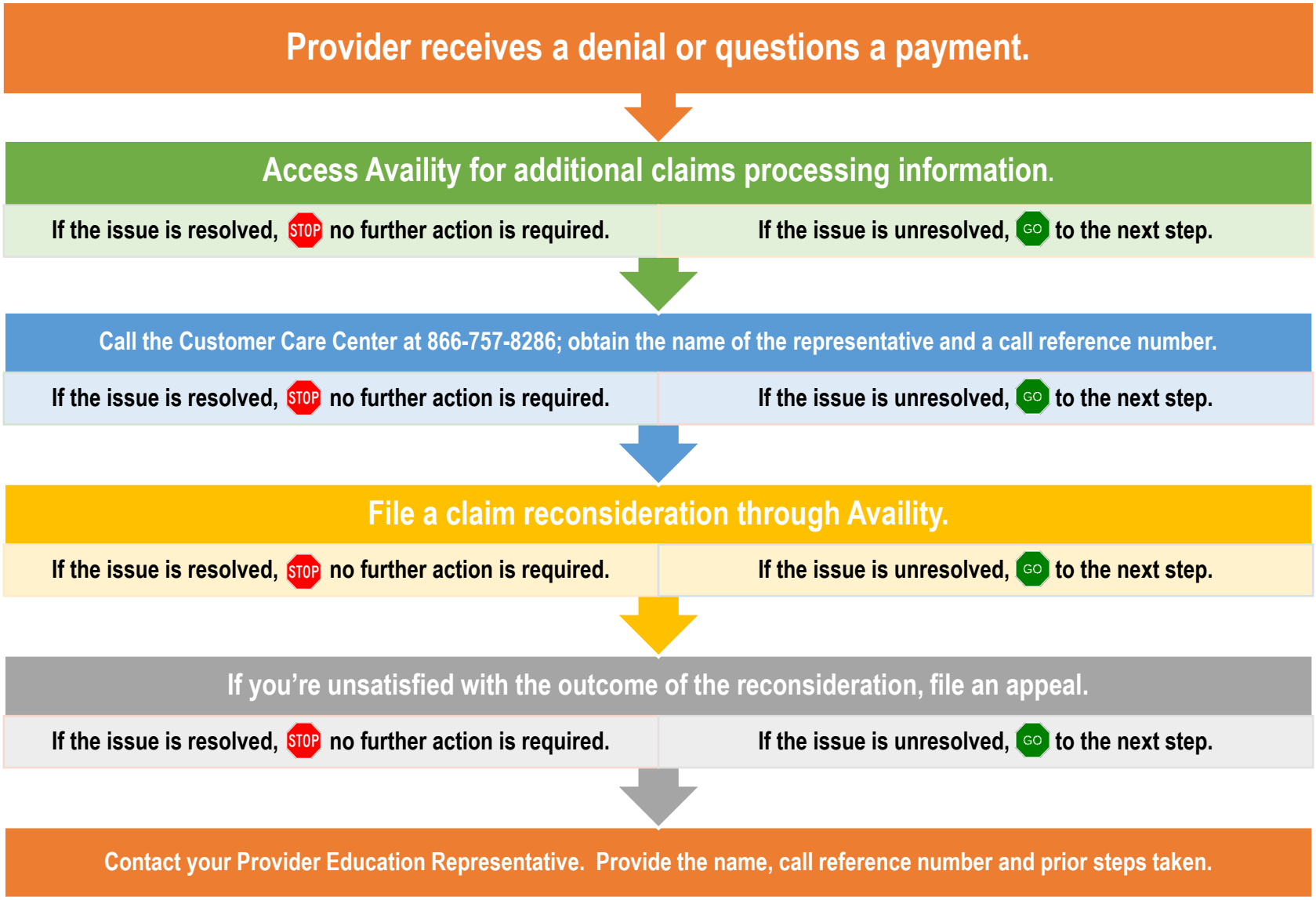
Claim Payment Disputes – Claim Payment Appeals

- 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:

- **Availity**
  - www.Availity.com
- **Mail (hard copy)**
  - Healthy Blue, Payment Dispute Unit
    P.O. Box 100124
    Columbia, SC 29202-3124

Claims Assistance Workflow



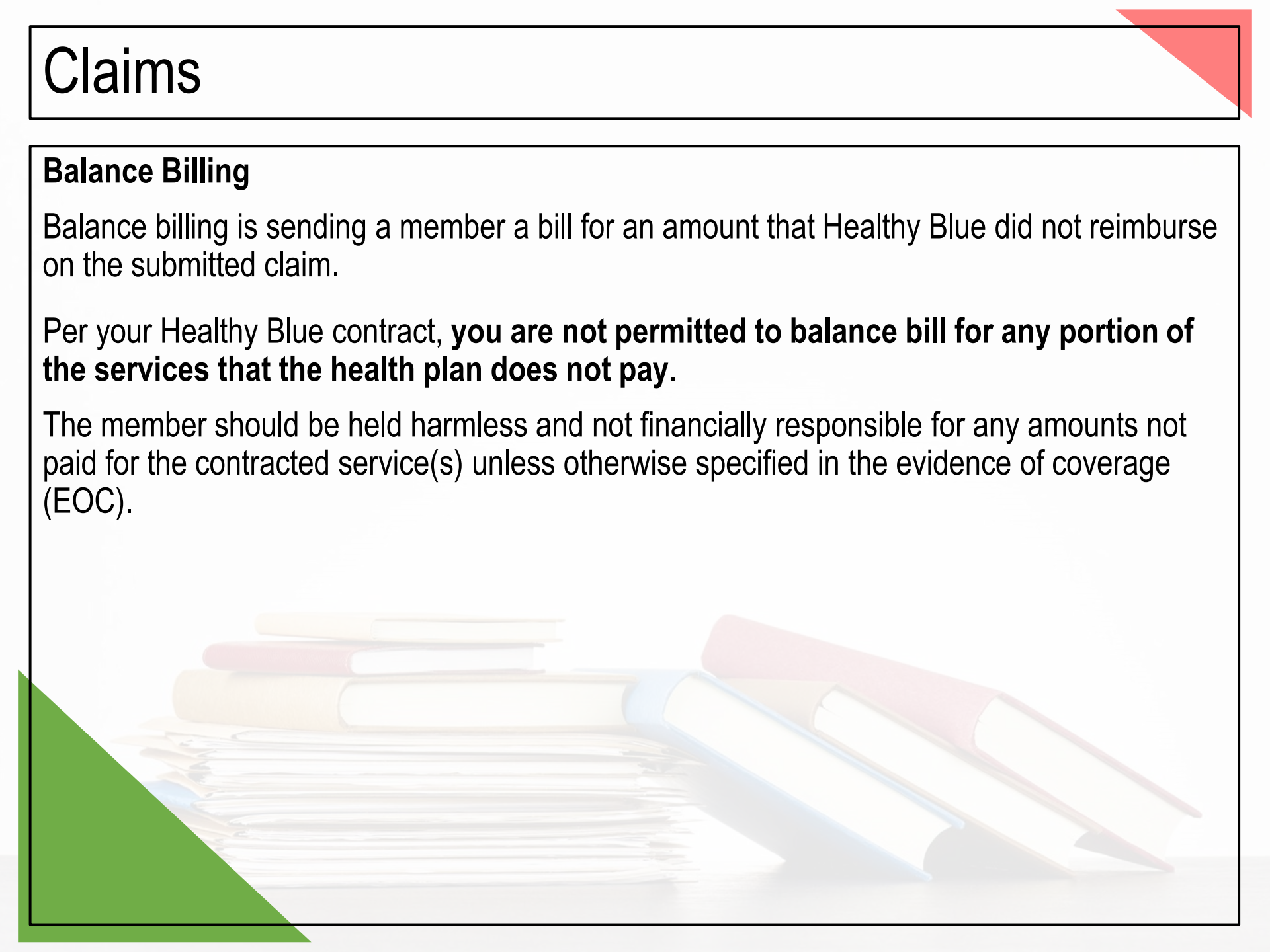
Claims

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).



Healthy Blue Reminders

Healthy Blue 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*
- www.HealthyBlueSC.com: Select Providers

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

Healthy Blue 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 the Healthy Blue confidential fraud hotline at 877-725-2702 or email MedicaidFraudInvestigations@Amerigroup.com.
- Call the South Carolina Department of Health and Human Services (SCDHHS) at 888-364-3224 or email fraudres@scdhhs.gov.

Healthy Blue 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

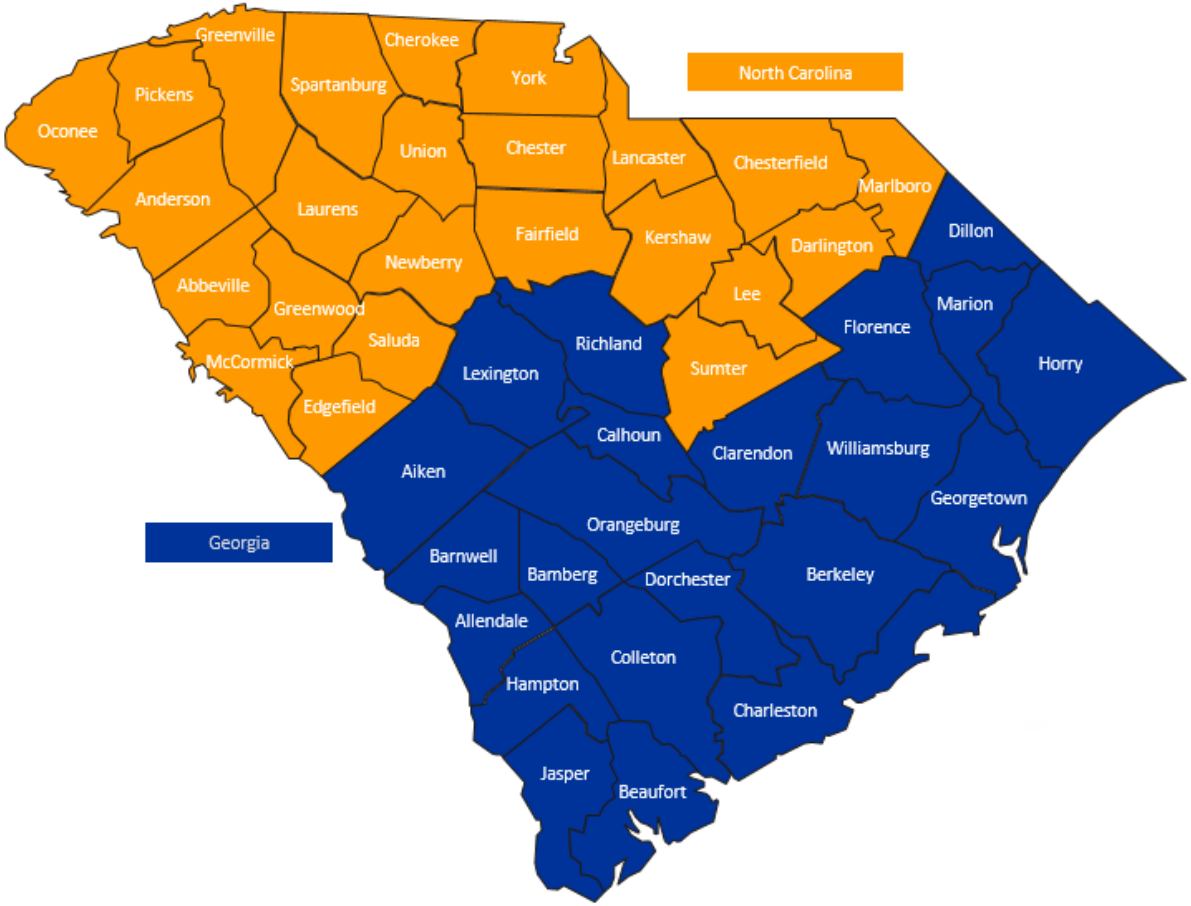
Note: Wait times should not exceed 45 minutes for a scheduled appointment of a routine nature.

Quality

Territory Map

Bunny Temple
Bunny.Jackson-Temple@Amerigroup.com

Vicki Johnson
Vickie.Johnson@Amerigroup.com



Other Contacts:

- **Shana Hunter, Quality Director**
  Shana.Hunter@Amerigroup.com
- **Physical Address:**
  Healthy Blue
  Attn: Quality Department
  4101 Percival Road, AX-E13
  Columbia, SC 29229
- **Quality Fax:**
  855-238-2257

www.HealthyBlueSC.com

Healthy Blue is the trade name of BlueChoice HealthPlan. BlueChoice HealthPlan is an independent licensee of the Blue Cross Blue Shield Association. BlueChoice HealthPlan has contracted with 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 and Human Services Fraud Hotline at 888-364-3224 or email fraudres@scdhhs.gov.

Quality

Department Contacts

- HEDIS and Care Opportunity
  - Trish Whitehead: Trish.Whitehead@Amerigroup.com
- Clinic Days
  - Devon Murphy: Devon.Murphy@Amerigroup.com
- Medical Records (Care Opportunities During HEDIS Offseason)
  - Email: HEDIS_SC@Amerigroup.com
  - Fax: 855-238-2257

Marketing

Marketing

Marketing and Community Outreach

Our community partnerships are just a few examples of the way we go above and beyond the provision of basic health coverage.

Marketing

Provider Outreach Contacts

Midlands Region

- Melody Clark, Marketing Coordinator
- Melody.Clark@Amerigroup.com
- 803-683-1896

Lowcountry and Pee Dee Region

- Erica Gattison, Community Outreach Manager
- Erica.Gattison@Amerigroup.com
- 803-638-1948

Upstate Region

- Denisse Martinez, Community Relations Representative
- Denisse.Martinez@Amerigroup.com
- 803-354-3304

Marketing

Social Media Platforms

@HealthyBlueSC

@HealthyBlueSC

@HealthyBlueSC

#HealthyBlueSC

Marketing

Extra Benefits

Free one-time paid membership to Sam's Club

- For pregnant moms
- Eligibility requirements apply

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

- Eligibility requirements apply

Free adult vision

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

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

Free General Education Development (GED) Ready Assessment

- Ages 17 and up

Free tutoring services for grades K – 8th grade

Free Sports Physicals

- Ages 6 – 18

and MUCH, MUCH MORE!

Pharmacy

Agenda

- Formulary Updates
  - Commercial (BlueCross and BlueChoice)
    - Lowest Net Cost (LNC) Formulary
    - Premium Formulary
  - Exchange
  - Medicare
- Specialty Medical Benefit Management (SMBM) and MBMNow Enhancements
- Academic Detailing
- Pharmacy Resources

Formulary Updates

Commercial, Exchange and Medicare

Commercial

BlueCross and BlueChoice

Lowest Net Cost Formulary Updates

Formulary Updates — Lowest Net Cost

Additions

- Effective Jan. 1, 2023, the following drugs will added.

Product	Formulary Status
Afstyla	Non-preferred specialty
Briviact^	Non-preferred
Hemlibra	Non-preferred specialty
Hyftor*	Non-preferred
Igalmi#	Non-preferred
Jivi	Non-preferred specialty
Nuwiq	Non-preferred specialty
Sunosi*	Preferred
Trokendi XR^	Non-preferred
Wakix*	Non-preferred
Xywav*	Non-preferred specialty

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

Formulary Updates — Lowest Net Cost

Exclusions

- Effective Jan. 1, 2023, the following drugs will move to non-formulary status.
  - The **InPen Smart Insulin Pen** will also not be covered.
- The products listed have many alternatives on the formulary at a lower cost to the member.
  - *Some covered alternatives may require prior authorization (PA).*

Afinitor Tab	Akynzeo Cap 300-0.5	Ampyra Tab 10mg	Baraclude Tab
Combigan Sol 0.2/0.5%	Condylox Gel 0.5%	Esbriet Cap 267mg	Esbriet Tab
Exjade Tab	Gelnique Gel 10%	Nexavar Tab 200mg	Tecfidera
Triamterene Cap	Vascepa Cap	Velcade Inj 3.5mg	Veletri
Verapamil Cap	Viibryd Tab	Vimpat	Xifaxan 200mg

Formulary Updates — Lowest Net Cost

Preventive Drug Lists

ACA $0 Preventive Drug List

- The Affordable Care Act (ACA) requires health plans to cover several drugs that are considered preventive at no cost to the member.
- Effective Jan. 1, 2023, **Aspirin 325mg** (all manufacturers and brands) will be removed from the list of no-cost preventive drugs in accordance with United States Preventive Services Task Force (USPSTF) recommendations.

HDHP Preventive Drug List

- Effective Jan. 1, 2023, **Xolair and Korlym** will be removed from the list of preventive drugs for high deductible health plans (HDHP).
- This change only affects groups with HDHPs that have elected a preventive drug benefit.

Commercial

Premium Formulary Updates

Formulary Updates — Premium

Premium Formulary vs. Lowest Net Cost (LNC) BlueChoice Formulary

Premium Formulary	Lowest Net Cost (LNC) BlueChoice Formulary
• National Pharmacy & Therapeutics Committee • Six tier plan design – Tier 4: specialty generic – Tier 5: preferred brand specialty – Tier 6: nonpreferred brand specialty	• The Pharmacy & Therapeutics Committee is made up of South Carolina physicians (varying specialties) and pharmacists • BlueCross LNC – Tier 3, tier 4, and tier 6 plan designs • BlueChoice: six tier plan design

Formulary Updates — Premium

Exclusions

Effective Jan. 1, 2023, the following drugs will move to non-formulary status.

Aczone	Adzenys XR-ODT	Auryxia	But/Apap/Caf capsule	Carospir
Clonidine dis	Combigan	Cotempla XR-ODT	Daytrana	Diclofenac/Misoprostol tablet
Diltiazem ER tablet or capsule (non-formulary generic manufacturer)	Droxidopa capsule	Dyanavel XR	Esbriet	Levocetirizi misoprostol
Methylphenid tablet 72 mg ER	Mydayis	Nebivolol	Nicardipine capsule	Nisoldipine tablet ER
Paroxetine capsule 7.5 mg	Pentasa 500 mg	Pregabalin ER tablet	Quillichew ER/XR	Quillivant XR
Ravicti	Rubraca	Talzenna	Toviaz	Vimpat
Xifaxan 200 mg	Zenzedi	Zolmitriptan spray 2.5mg	Zomig spray 2.5mg	

Formulary Updates — Premium

Prior Authorization

Effective Jan. 1, 2023, the following drugs will require prior authorization:

Bydureon/Bcise	Byetta	Mounjaro	Ozempic
Prevymis	Rybelsus	Trulicity	Victoza

Quantity limits

Effective Jan. 1, 2023, the following products will have new quantity limits:

Drug	Quantity Limit
Arixtra	35 days supply per 180 days
Baraclude Sol	630 mL per 30 days
Bydureon/Bcise	Four pen-inj per 28 days
Byetta	One syringe per 30 days
Fragmin/Lovenox	35 days supply per 180 days
Glycopyrrolate 1 mg/2 mg	Four tablets per day
Jakafi 5 mg	Two tablets per day
Mounjaro	Four pens per 28 days
Ozempic	One or two pens per 28 days, depending on strength
Pimecrolimus	60 gm per 30 days
Protopic	60 gm per 30 days
Rybelsus 7 mg/14 mg	One per day
Trulicity	Four pen-inj per 28 days
Victoza	Three pen-inj per 30 days

Formulary Updates — Premium

Step Therapy

Effective Jan. 1, 2023, the following products will have a step therapy requirement:

STEP 1 DRUG You must try these drugs first, or your doctor must request an override for you …	STEP 2 DRUG … before you can get coverage for these drugs.
Any three of the following generics or preferred brands: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER, Vyvanse	Adzenys ER
Generic pemetrexed	Alimta
Any three of the following generics or preferred brands: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER, Vyvanse	Aptensio XR
Any one of the following generics or preferred brands: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER, Vyvanse	Azstarys
Any two of the following generics or preferred brands: calcium acetate, lanthanum carbonate, sevelamer carbonate, sevelamer HCl	Fosrenol
Any one of the following generics or preferred brands: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER, Vyvanse	Jornay PM
Any three of the following generics or preferred brands: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER, Vyvanse	Methylin Soln
Generic pemetrexed	Pemfexy
Any two of the following generics or preferred brands: calcium acetate, lanthanum carbonate, sevelamer carbonate, sevelamer HCl	Phoslyra
Any three of the following generics or preferred brands: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER, Vyvanse	Procentra
Any three of the following generics or preferred brands: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER, Vyvanse	Relexxii
One of the following generics: metronidazole 0.75% vaginal gel, clindamycin 2% vaginal cream, metronidazole tablet, tinidazole tablet	Solosec
Any one of the following generics: metronidazole 0.75% vaginal gel, clindamycin 2% vaginal cream	Vandazole
Generic vilazodone	Viibryd; Viibrid Kit

Exchange

Formulary Updates — Exchange

Exchange plan changes in tier structure from 2022 (four tier) to 2023 (six tier)

- 2023 six tier:
  - Tier 1: Low-cost generic
  - Tier 2: Generic
  - Tier 3: Preferred brand
  - Tier 4: Non-preferred brand
  - Tier 5: Generic specialty or preferred brand specialty
  - Tier 6: Non-preferred brand specialty

118+ custom utilization management (UM) criteria updates

- 14 new custom UM criteria guidelines
- New customer intravenous (IV) to subcutaneous (SC) criteria added for the following therapies:
  - Actemra, Cimzia, Fasenra, Nucala, Orencia, Simponi and Xolair
- New customer criteria added for the following therapies:
  - Oxervate, Omnipod, Vyndgel, Vyndamax, Empaveli, Sunosi, oral and injectable oncology, and Restasis

Medicare

Formulary Updates — Medicare

Removal of high-risk medication (HRM) prior authorization criteria, effective Sept. 1, 2022

- HRM — Antipsychotics
- HRM — Butalbital
- HRM — Phenobarbital, Pentobarbital
- HRM — Skeletal muscle relaxants
- HRM — Tricyclic antidepressants (TCA)
- HRM — Barbiturates

Medicare Advantage prescription drug Total PPO and Total Value plans change in tier structure: 2022 (five tier) to 2023 (six tier)

- Tier 6 has the same cost-share as Tier 1 but contains mostly maintenance medications.

Senior savings insulin continues for Medicare Advantage prescription drug Total PPO and Total Value plans

- All claims for insulins and vaccines will process according to the Inflation Reduction Act (IRA).

Standard formulary insulin change

- Authorized generic (AG) insulins and ReliOn Novolin or Novolog labeled insulins will be non-formulary for 2023.
- A place of service rejection messaging will be returned directing the pharmacy to consider substituting the covered originator brand insulins in place of the non-formulary AG or ReliOn labeled insulins.

Part B strategy blood glucose options

- Preferred diabetic supplies strategy with Lifescan preferred products (OneTouch) with QL 100/30ds.

MBMNow Enhancements

MBMNow Enhancements

Improved Physician Experience

- When the physician contacts MBMNow to request a prior authorization, they will be asked if they want to authorize the drug under medical **or** pharmacy.
- Prior to enhancement (Phase I), if a member called MBMNow, they could only authorize drugs under medical.

Additional Updates

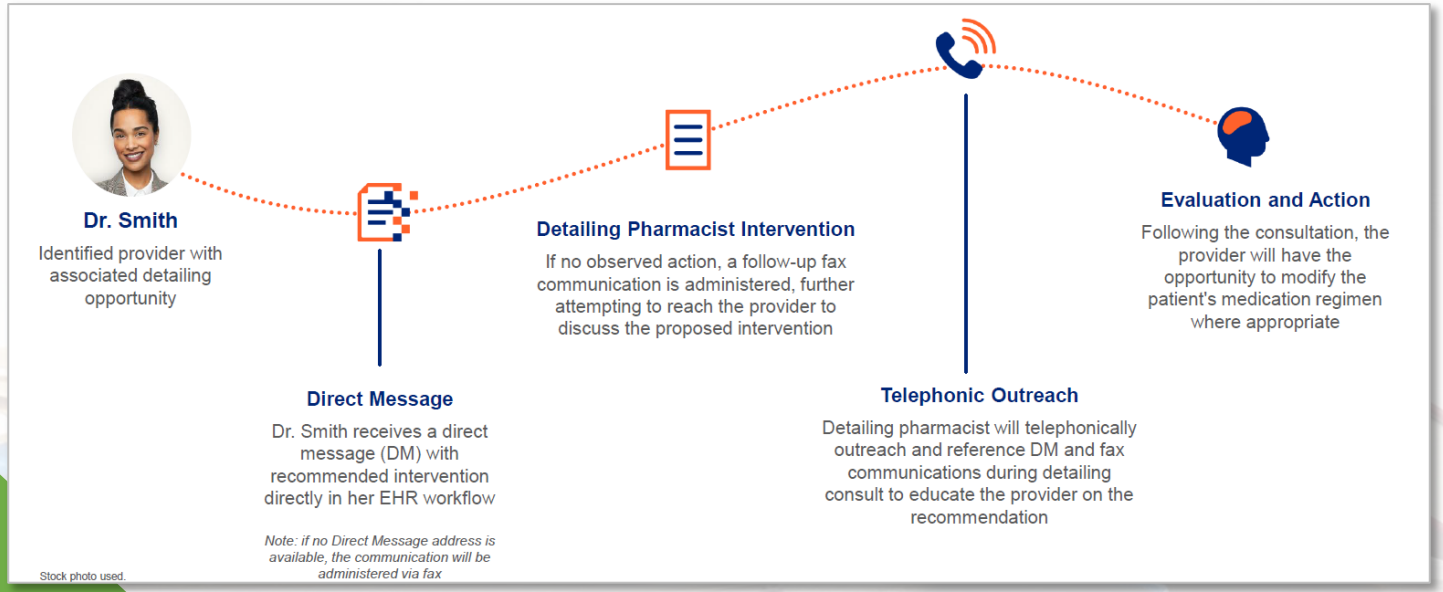
- Authorization capabilities around **antiemetics drugs** (nausea)
- **Rounding up** for certain dosage-based products
- **Cancer pathways**
  - When the physician contacts MBMNow to authorize medications for a cancer treatment, they will present the physician with recommended treatment pathways.
    - The physician will not be required to follow the pathway.

Academic Detailing

Academic Detailing

Overview

- A solution that can educate providers when claims data reveals the opportunity to decrease spending or waste
- Provides clinicians with a nonbiased, accurate source of information about the effectiveness, safety and cost of pharmaceuticals
- Beneficial way to communicate evidence-based comparative effectiveness research



Pharmacy Resources

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 a 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.
- savings opportunities at Optum Home Delivery and Optum Specialty Pharmacy.
- members access to the same information via the Optum Rx 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

*Optum Rx is an independent company that handles pharmacy benefit management on behalf of BlueCross BlueShield of South Carolina.

Pharmacy Resources

Commercial and Affordable Care Act (ACA) Plans

- Optum Home Delivery Mail Service
  - E-scribe National Council for Prescription Drug Programs (NCPDP)
    - Mail NCPDP ID: 0556540
    - Specialty NCPDP ID: 5732676
- Optum Home Delivery
  - Call: 855-811-2218
  - Fax: 800-491-7997
- Optum Rx 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

- Optum Home Delivery Mail Service
  - E-scribe National Council for Prescription Drug Programs (NCPDP)
    - Mail NCPDP ID: 0556540
    - Specialty NCPDP ID: 5732676
- Optum Rx Home Delivery
  - Call: 855-540-5951
- Optum Rx 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

Agenda

- Provider Enrollment Requirements
- My Provider Enrollment Portal
- Enrollment Process Overview
- Provider Enrollment Reminders

Enrollment Requirements

Provider Enrollment Requirements

Enrollment Applications and Forms

Enrollment applications and forms for BlueCross BlueShield of South Carolina include:

Application or form	Used for …
Individual Enrollment	New practitioners that want to enroll with BlueCross (**not Behavioral Health**)
Group Practice Enrollment	New groups that want to enroll with BlueCross
Facility Information Request	Medical facilities that want to credential with BlueCross
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 BlueCross
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 BlueCross
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 or Practice License			
Drug Enforcement Administration (DEA) Certificate			**Note 1**
Current Copy of Malpractice (Minimum $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			
Additional Items for Medicaid			
Medicaid ID Number			
Nurse Protocols			
Physician Assistant Protocols	**Note 2**		

*Doctor of Dental Surgery (DDS)

1. **Only needed if applicable.**
2. **Only needed for PAs.**

Provider Enrollment Requirements

What To Include — Individual Enrollment (Continued)

Checklist Items	DMD*	Ancillary	Chiro
Provider Enrollment Application			
Copy of SC Medical or Practice License			
Drug Enforcement Administration (DEA) Certificate			
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 HealthPlan			
Appendix D — BlueChoice HealthPlan			
Additional Items for Medicaid			
Medicaid ID Number	**Note 1**		
Nurse Protocols			
Physician Assistant Protocols			

*Doctor of Medicine in Dentistry (DMD)

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

Provider Enrollment Requirements

What To Include — Group Practice Enrollment

Checklist Items	Physician's Office	Ambulance	DME	Home Health, Hospice, Dialysis, Hospitals, Skilled Nursing, Ambulatory Surgery Centers	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						

Provider Enrollment Requirements

What To Include — In-State, Out-of-Network Enrollment

Checklist Items	Individual Enrollment	Group Practice Enrollment
Health Professional Application	**Note 1**	
Authorization To Bill for Services		
Group Practice Application		
IRS Verification of Tax ID (No W-9s)		
Electronic Funds Transfer Enrollment		

1. Needed for each individual being linked to the practice

Provider Enrollment Requirements

What to Include — Behavioral Health Enrollment

Checklist Items	
Behavioral Health Application	X
IRS Verification of Tax ID (or W-9)	X
CBA* Professional Agreements (Signed Contracts)	X
Hold Harmless Agreement	X
Appendix C	X
Copy of SC State License	X
Copy of DEA License, if Applicable	X
Copy of Board Certification, if Applicable	X
Nurse Protocols (Nurse Practitioners Only)	X
Current Copy of Malpractice (Min. $1M/$3M)	X

*Companion Benefit Alternatives (CBA)

Provider Enrollment Requirements

E-Signatures vs. Wet (Ink) Signatures

Medical	Allowed Signature	Behavioral Health	Allowed Signature
Provider Enrollment	**Electronic or wet**	Behavioral Health	**Electronic or wet**
Recredentialing	**Electronic or wet**	Autism Panel	**Electronic or wet**
Facility Information Request	**Electronic or wet**	Facility Information Request	**Electronic or wet**
Health Professional	**Electronic or wet**	Authorization To Bill	**Electronic or wet**
Doing Business As (DBA)	**Electronic or wet**	All Contracts	**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**		

My Provider Enrollment Portal

Note: For case specific questions, please be sure to submit a case comment within the case or submit a support case.

My Provider Enrollment Portal

What is My Provider Enrollment Portal?

Use the portal to:

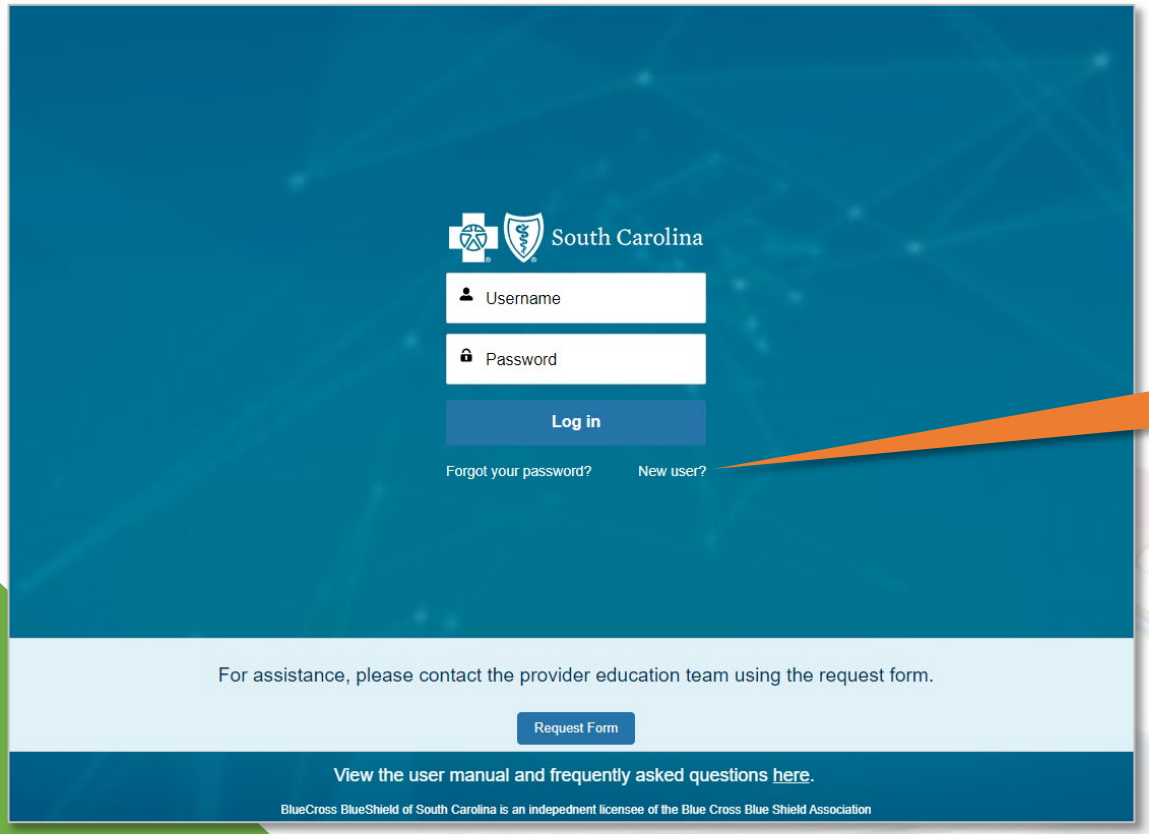
- Become a network provider.
- Receive automated status updates.
- Make certain updates for the physician or practice.
- Receive notifications when additional information is needed.

My Provider Enrollment Portal

Signing Up for 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

Available Resources

Visit www.SouthCarolinaBlues.com:

My Provider Enrollment Portal Manual

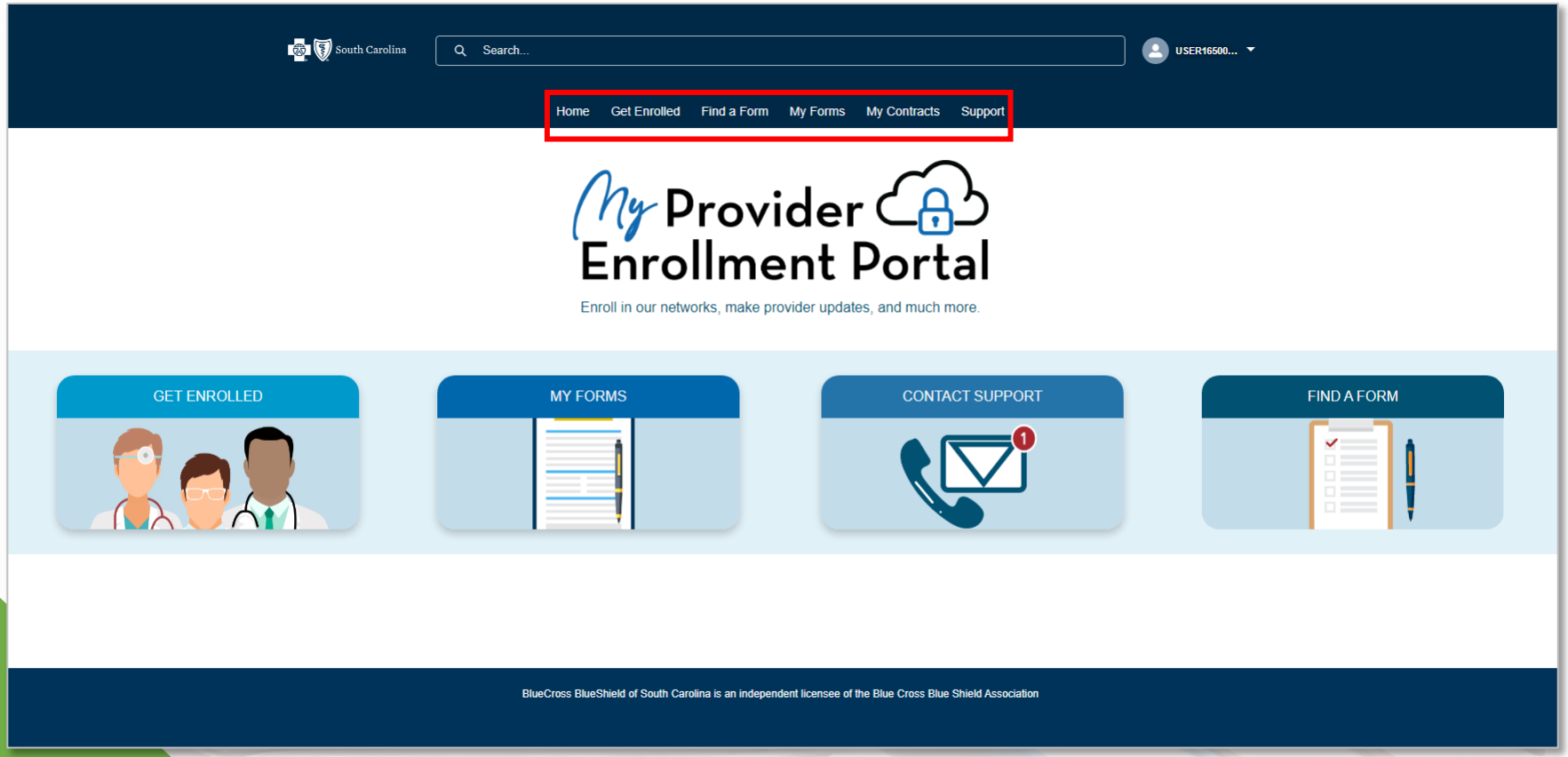
Providers>Tools and Resources>Guides>My Provider Enrollment Portal

My Provider Enrollment Portal Frequently Asked Questions (FAQs)

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

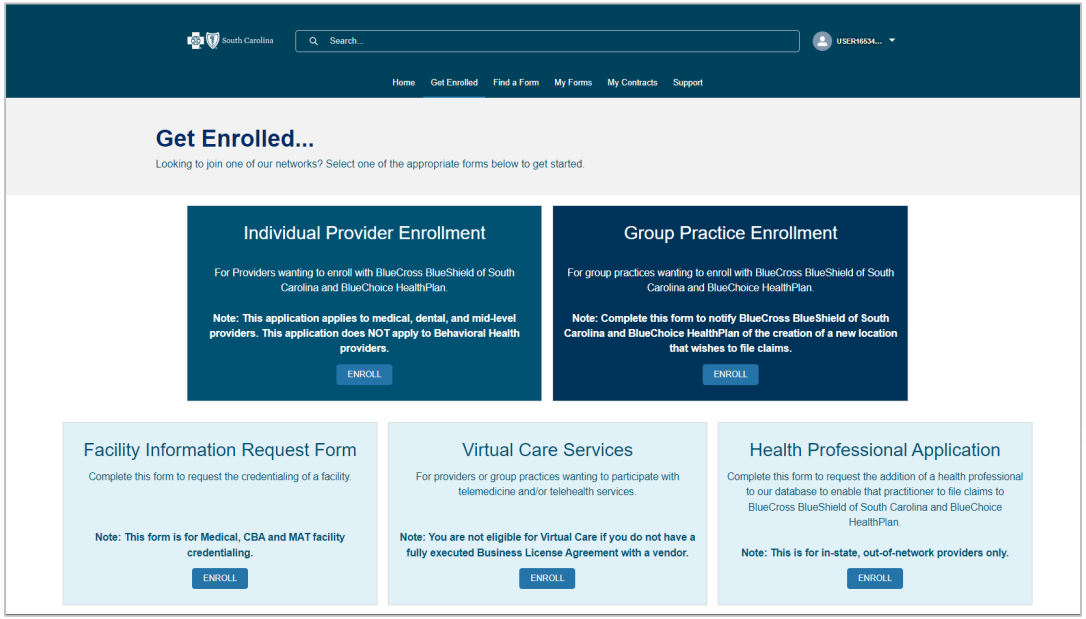
My Provider Enrollment Portal

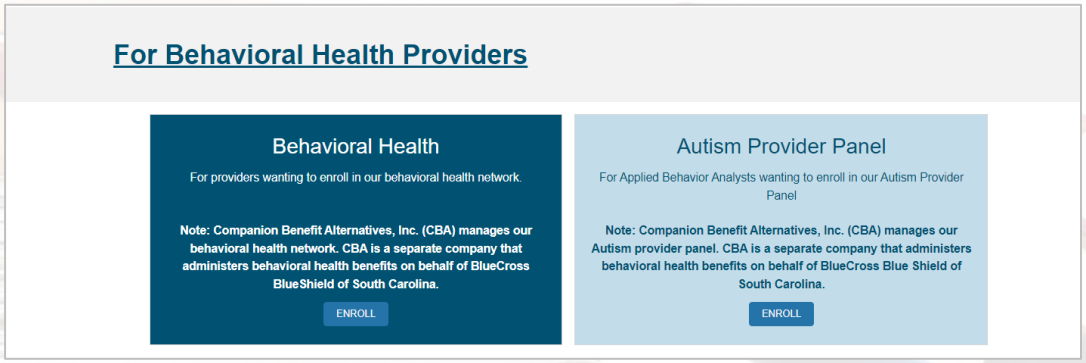
Homepage



My Provider Enrollment Portal

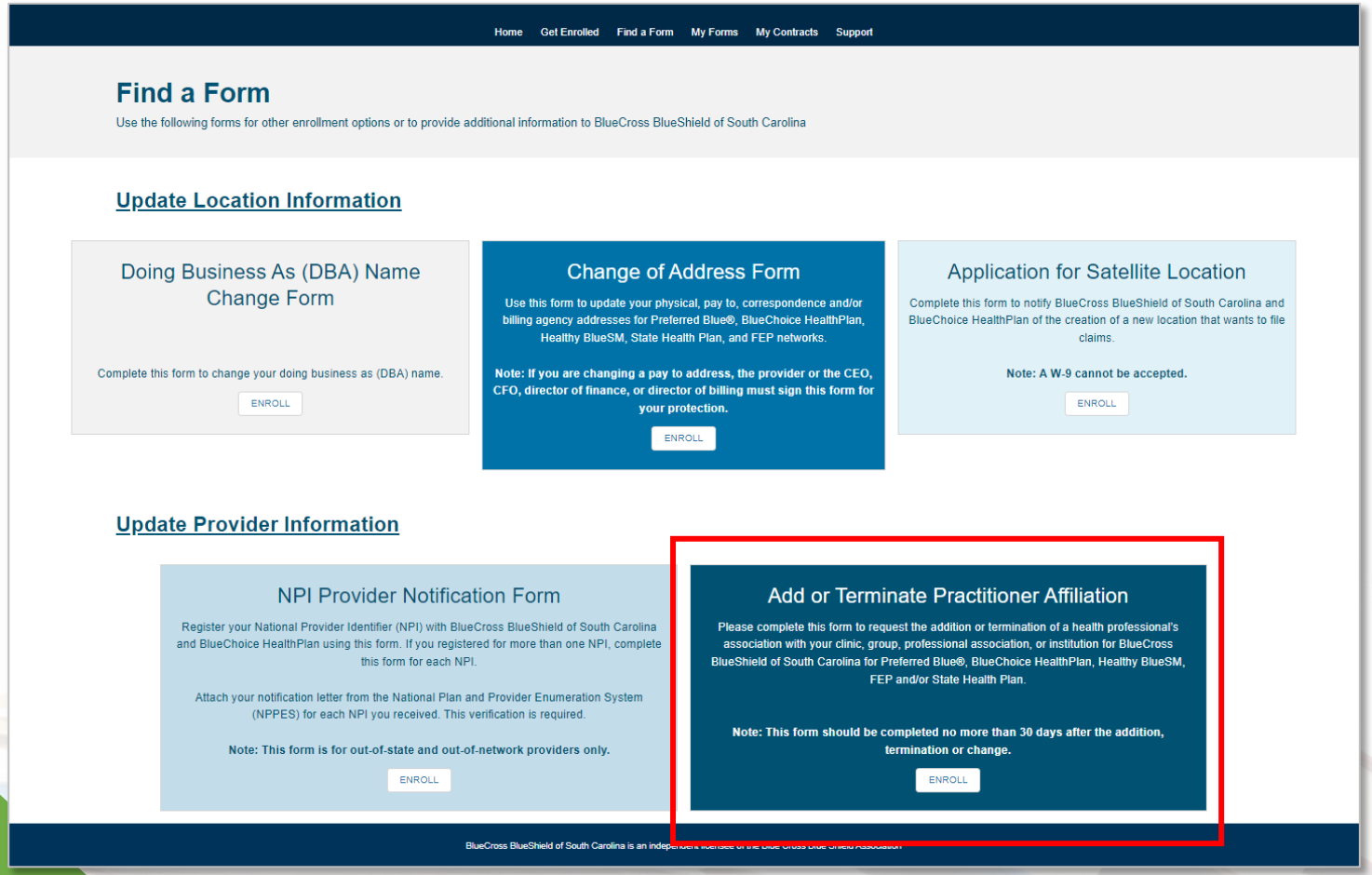
Get Enrolled





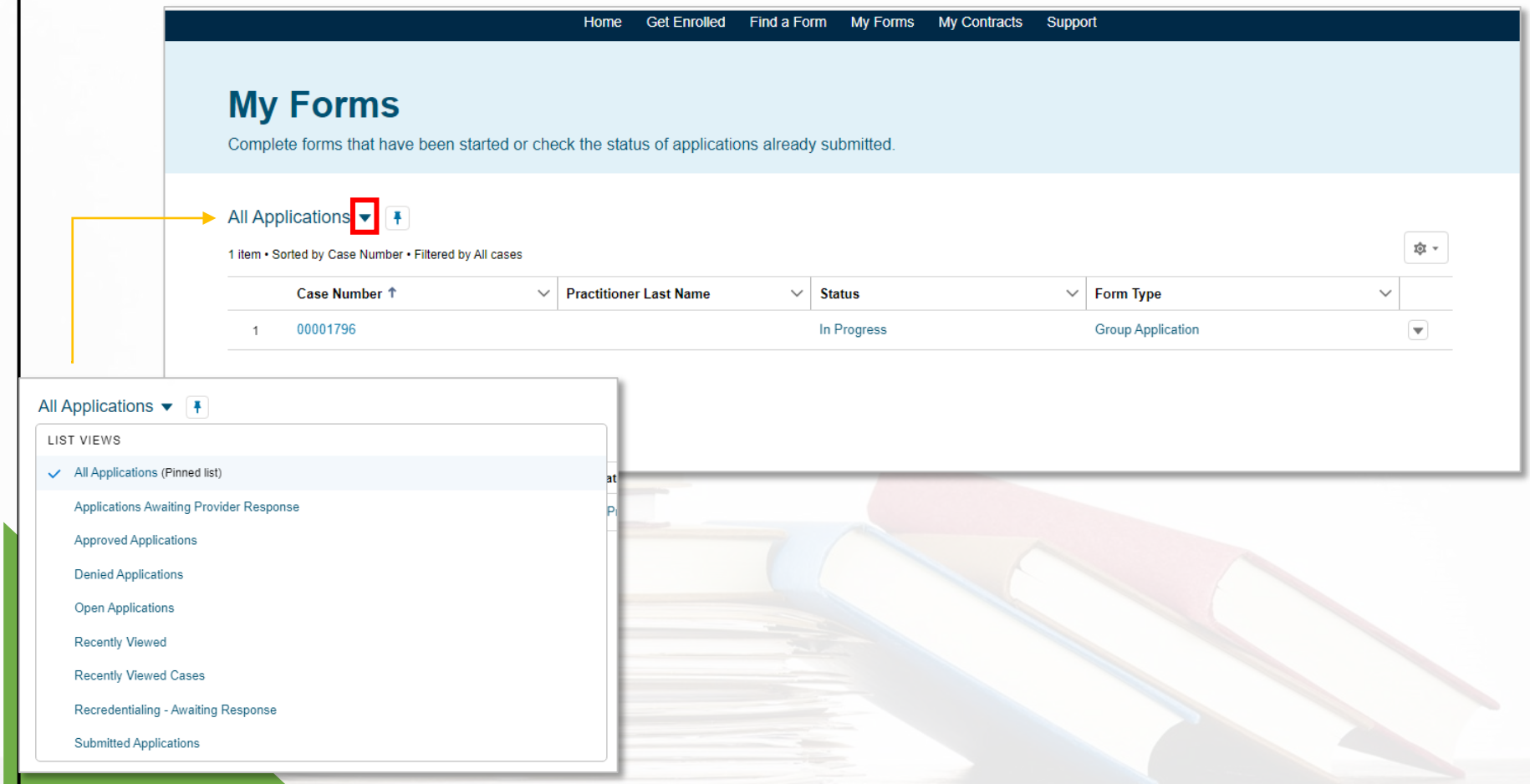
My Provider Enrollment Portal

Find a Form



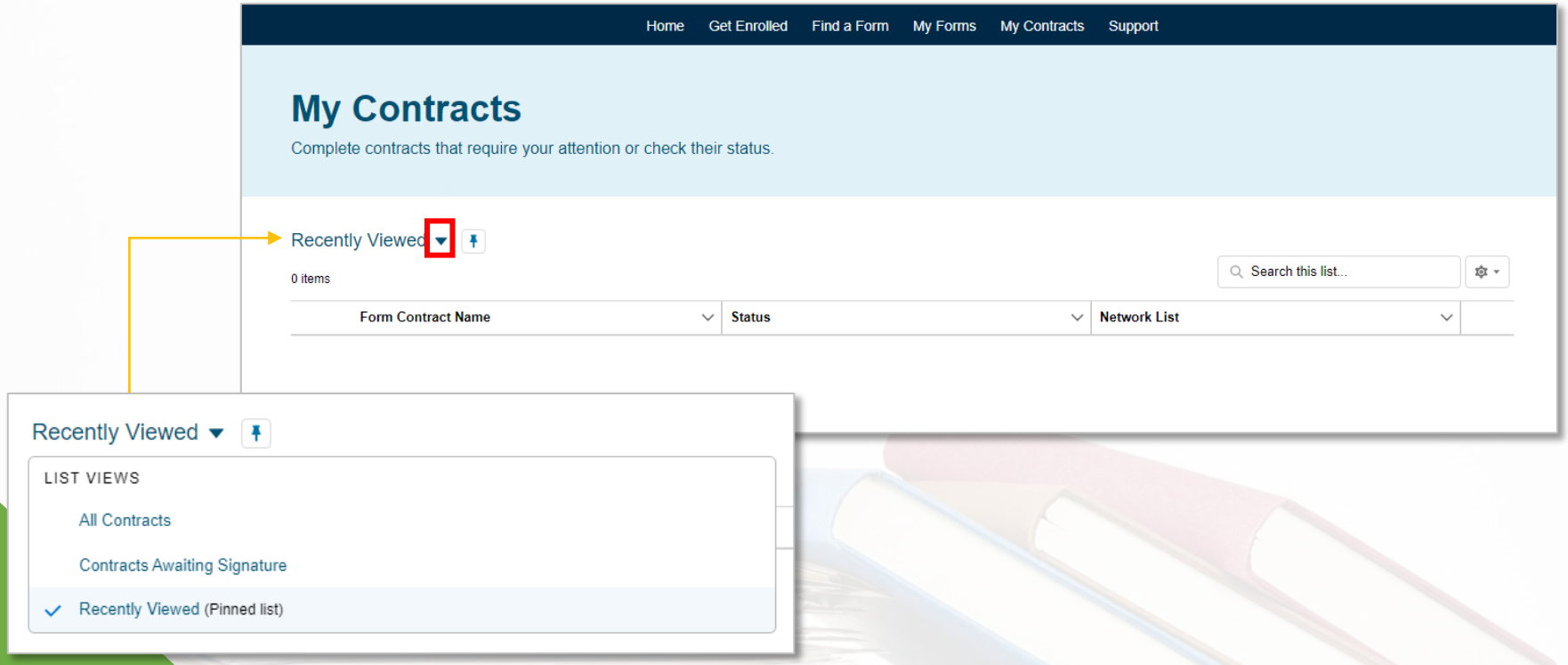
My Provider Enrollment Portal

My Forms



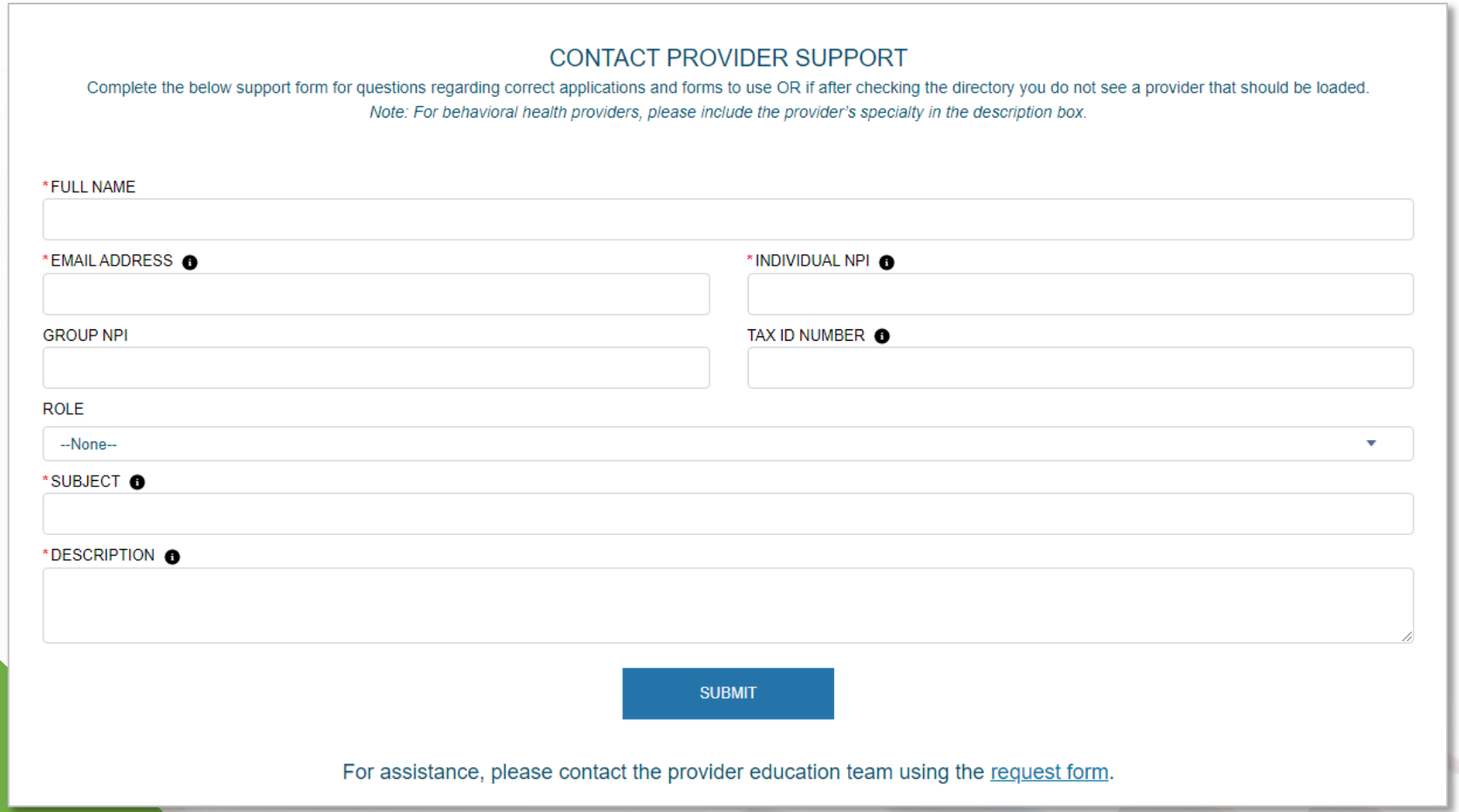
My Provider Enrollment Portal

My Contracts



My Provider Enrollment Portal

Support



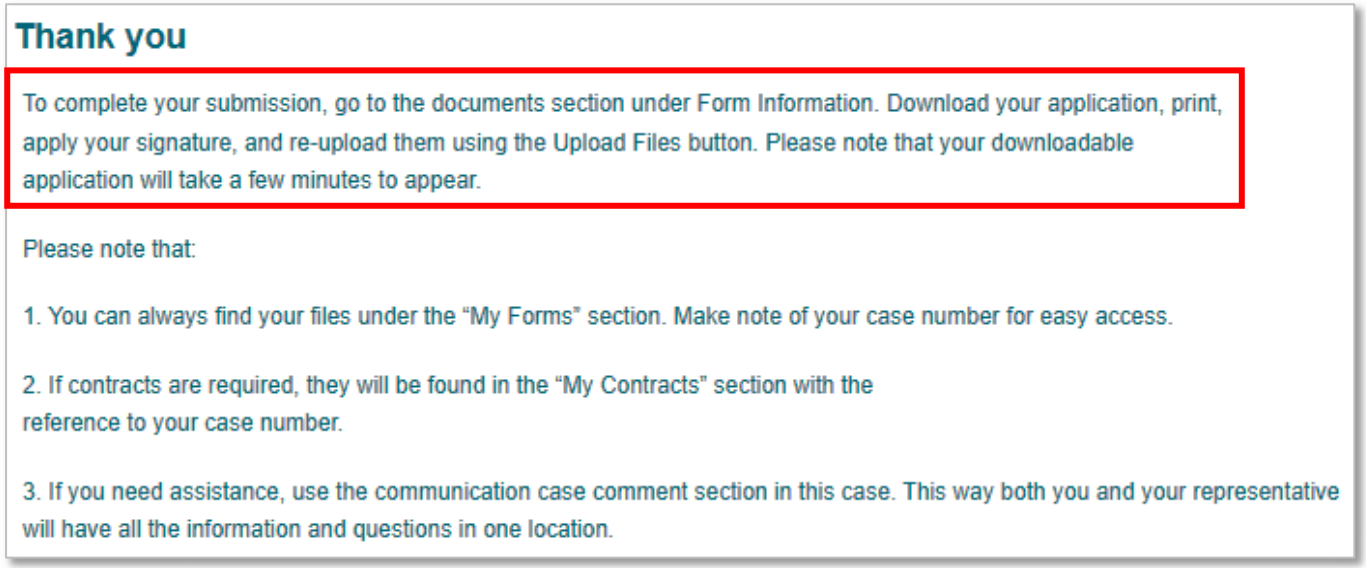
My Provider Enrollment Portal

Navigating through the Portal

Navigational Buttons

My Provider Enrollment Portal

Next steps for medical documents that must be signed.



Thank you

To complete your submission, go to the documents section under Form Information. Download your application, print, apply your signature, and re-upload them using the Upload Files button. Please note that your downloadable application will take a few minutes to appear.

Please note that:

1. You can always find your files under the "My Forms" section. Make note of your case number for easy access.

2. If contracts are required, they will be found in the "My Contracts" section with the reference to your case number.

3. If you need assistance, use the communication case comment section in this case. This way both you and your representative will have all the information and questions in one location.

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. Follow steps 1 – 4 and select Upload Files

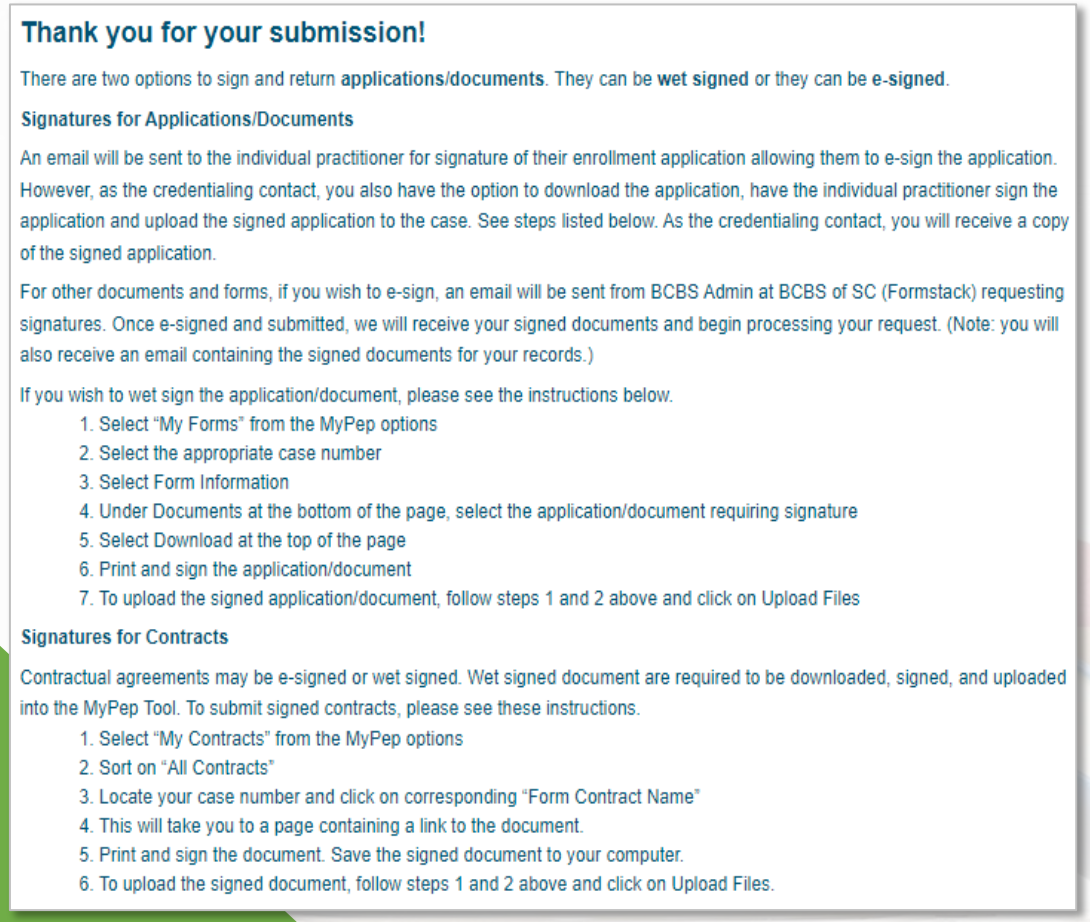
For contracts (Wet signature)

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

Next steps for behavioral health documents that must be signed.

Electronic or wet signature available



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)

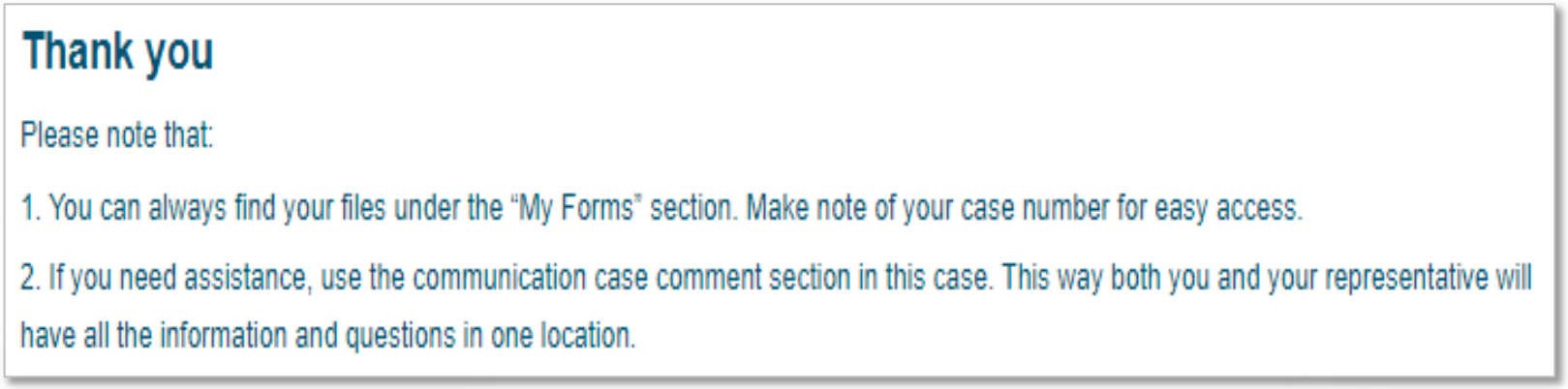
1. Select My Forms
2. Select the appropriate case number
3. Select Form Information
4. Under Documents, select the document(s) that require signature
5. Download the document(s) and have the signature(s) appended
6. Follow steps 1 – 4 and select Upload Files

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

My Provider Enrollment Portal

Next steps for documents that do not have to be signed.



Includes:

- NPI Provider Notification form
- Satellite Location application
- Virtual Care application

My Provider Enrollment Portal

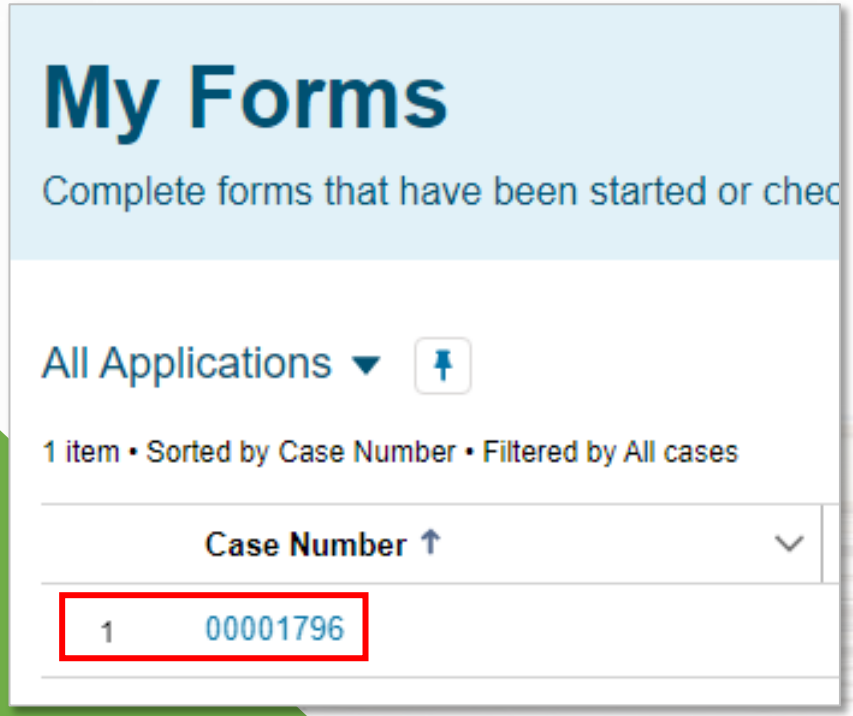
Important Items in the Portal

- Case numbers
- Statuses
- Contracts
- Case Comments

My Provider Enrollment Portal

Case numbers

Generated with each application, form and support case



Case numbers are used for:

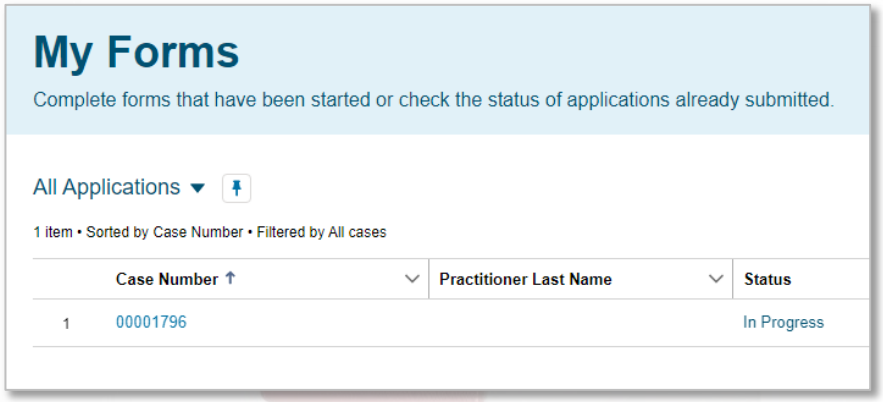
- Checking statuses.
- Submitting case comments.
- Uploading provider contracts.

My Provider Enrollment Portal

Statuses

Changes as the application or form progresses

Note: Providers should not manually change the status of their cases.



Statuses include:

- In Progress
- Awaiting Signature
- Awaiting Provider Response
- Under Review
- Congratulations! Complete
- Denied
- Canceled

My Provider Enrollment Portal

Status Explanations

In progress	The application or form is being worked on by the provider or their practice. It has not been completed for submission.
Awaiting signature	The application or form has been completed and submitted. Ensure **ALL signed and required** documents have been included.
Awaiting provider response	Missing items are needed to continue the enrollment process.

My Provider Enrollment Portal

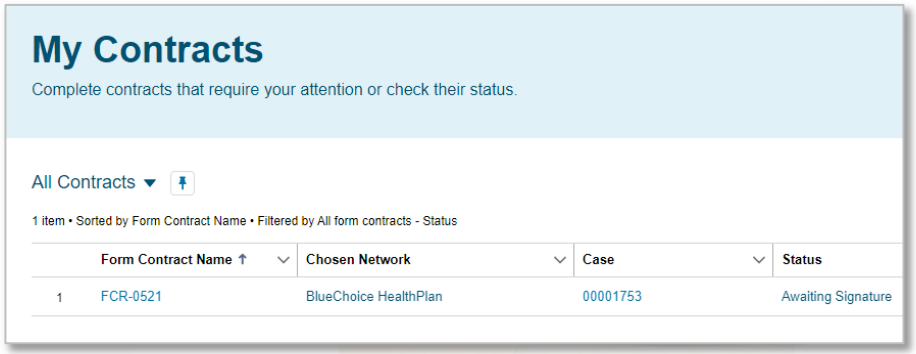
Status Explanations

Under review	The application or form has been assigned and has progressed through the enrollment 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 on and has been closed.

My Provider Enrollment Portal

Contracts

Provided during the application review process



Steps for contracts:

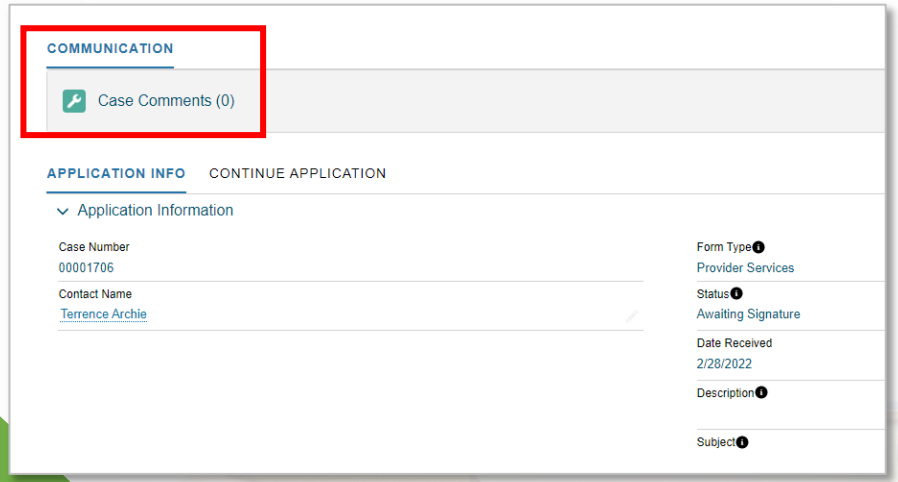
1. Download the contract(s).
2. Print the contract(s).
3. Have the practitioner sign the contract(s) in ink.
4. Upload the signed contract(s) to the appropriate case.

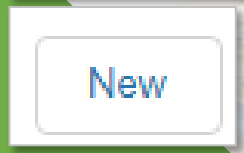
Note: Behavioral health contracts can be signed electronically.

My Provider Enrollment Portal

Case comments

Use for case specific questions (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.

Enrollment Process Overview

Enrollment Process Overview

Clean Application Process

Four main steps in the clean application enrollment process include:

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 or incomplete documentation, providers have **30 days** to submit the requested items.
3. Providers are notified if the application is approved
   - Non-approved applications go to the Disciplinary Committee for approval or denial, and the verdict is sent to the provider.
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, but no more than 45 days from the date the completed information is received from the provider.
    - For requested dates greater than 45 days, a hard copy claim must be submitted for review.
      - If the application is pending, email the claim to Provider.Requested.Info@bcbssc.com.
      - If the application is completed, fax the claim to 803-264-4795.

Provider Enrollment Reminders

Provider Enrollment 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 requires a signature(s).
5. Download the document(s) and have the signature(s) appended.
6. Follow steps 1 – 4 and select Upload Files.

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. Follow steps 1 – 2 and select Upload Files.

Invalid dates

- Malpractice dates must be valid within **90 days** of submission.
- Signature dates must be valid within **45 days** of submission.
- Application dates must be within **150 days** from the date signed when the file is determined complete

Incomplete applications

- Malpractice missing the provider's name or roster not submitted
- Authorization to bill missing effective date and/or representative information

Note: An automated notification for missing items is sent every seven days until the information is received and reviewed.

Provider Enrollment Reminders

Recredentialing

- Recredentialing occurs every three years.
- Our credentialing team reaches out when the provider's recredentialing date is approaching.
- If the provider misses their recredentialing date, initial enrollment will be required.

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

Provider Enrollment Reminders

Non-Credentialed Providers

Providers not credentialed by BlueCross BlueShield of South Carolina:

Provider Enrollment Reminders

Provider Directory Validation

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

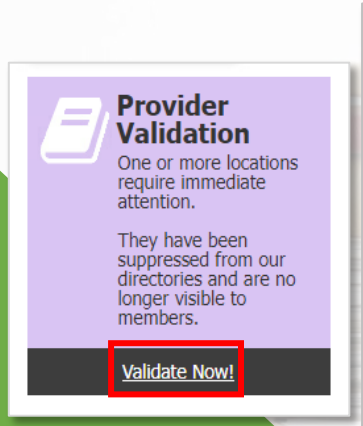
- M.D. Checkup

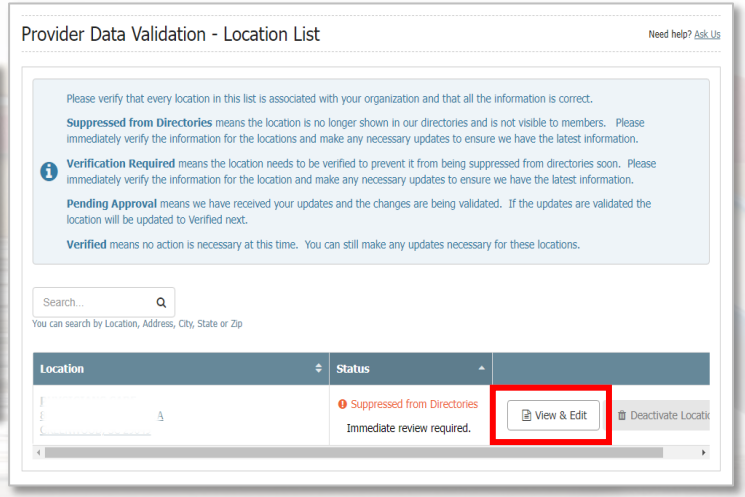
Provider Enrollment Reminders

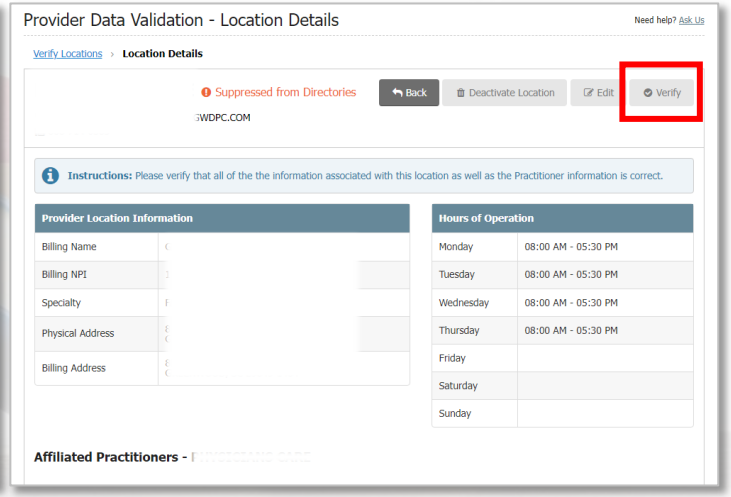
Provider Directory Validation (Continued)

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 (CAA) guidelines.
- To have the suppressed status updated, the group administrator should:
  - Log in to 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.







Provider Enrollment Reminders

Provider Updates — My Provider Enrollment Portal (Preferred Method)

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

Provider Enrollment Reminders

Provider Updates — M.D. Checkup

What is M.D. Checkup?

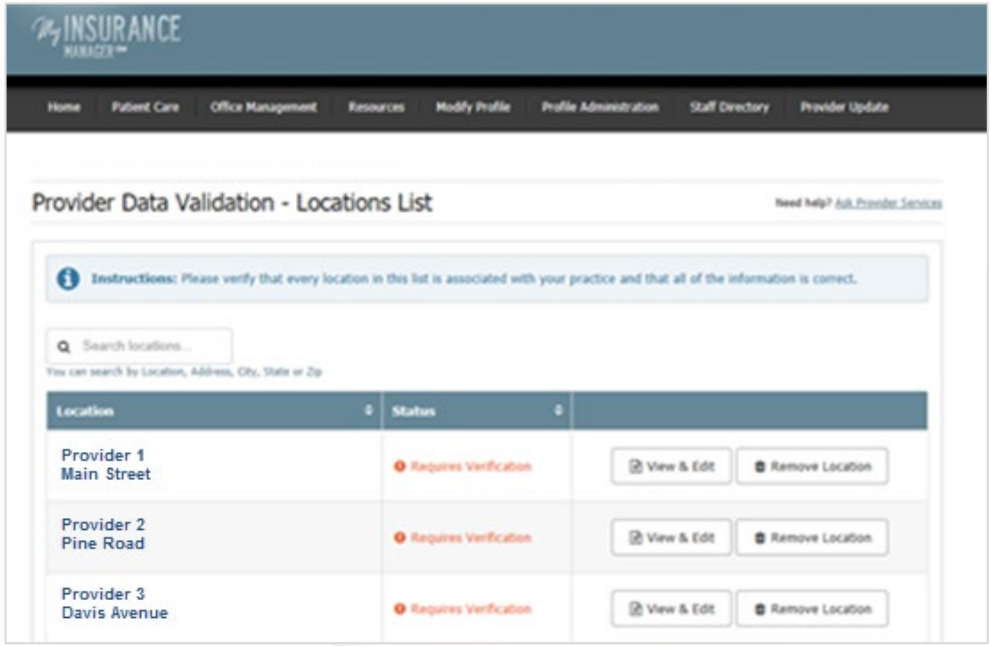
- A web-based tool used for provider demographic updates
- M.D. Checkup is accessible through My Insurance Manager.

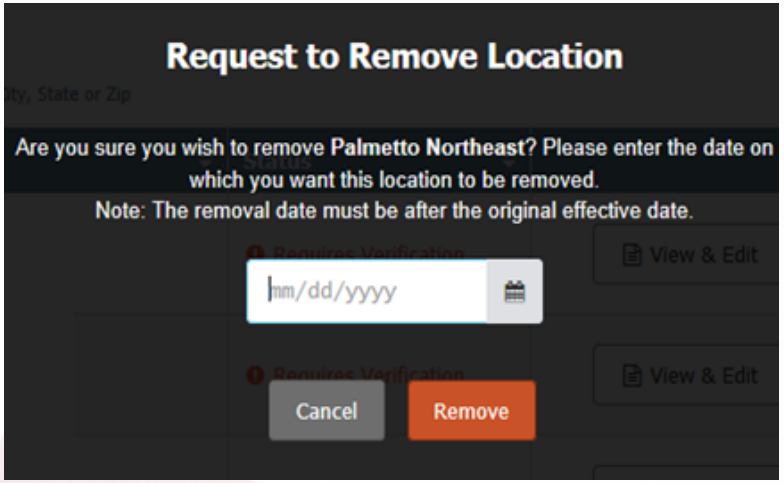
The following updates can be made through M.D. Checkup:

- Business name change
- Address change
- Adding or terminating a location
- Adding or terminating a practitioner affiliation

Provider Enrollment Reminders

M.D. Checkup — Removing Locations





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

Provider Enrollment 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 base 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

Introductions

Patricia Carter
Manager, Corporate
Quality Management

Adianez Gomez-Espada
Manager, Quality Improvement
Federal Employee Program

Christal McCall
Manager, Quality Improvement

Brittany Schoen
Manager, Quality Improvement
Exchange

Agenda

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

National Committee for Quality Assurance (NCQA®)

National Committee for Quality Assurance

What is the National Committee for Quality Assurance (NCQA)?

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

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

What Does NCQA Mean to You?

Contracts
Bonuses
Incentives

Reporting
data back to
the plan

Patient
Safety

Healthcare Effectiveness Data and Information Set (HEDIS®)

Healthcare Effectiveness Data and Information Set

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

- HEDIS is used to track trends in population health.

What entities utilize HEDIS data?

- NCQA®
- Members
- Centers for Medicare and Medicaid Services (CMS)
  - Quality Rating System for the ACA and Exchange products
  - Medicare Advantage
- Federal Employee Program (FEP)

Healthcare Effectiveness Data and Information Set

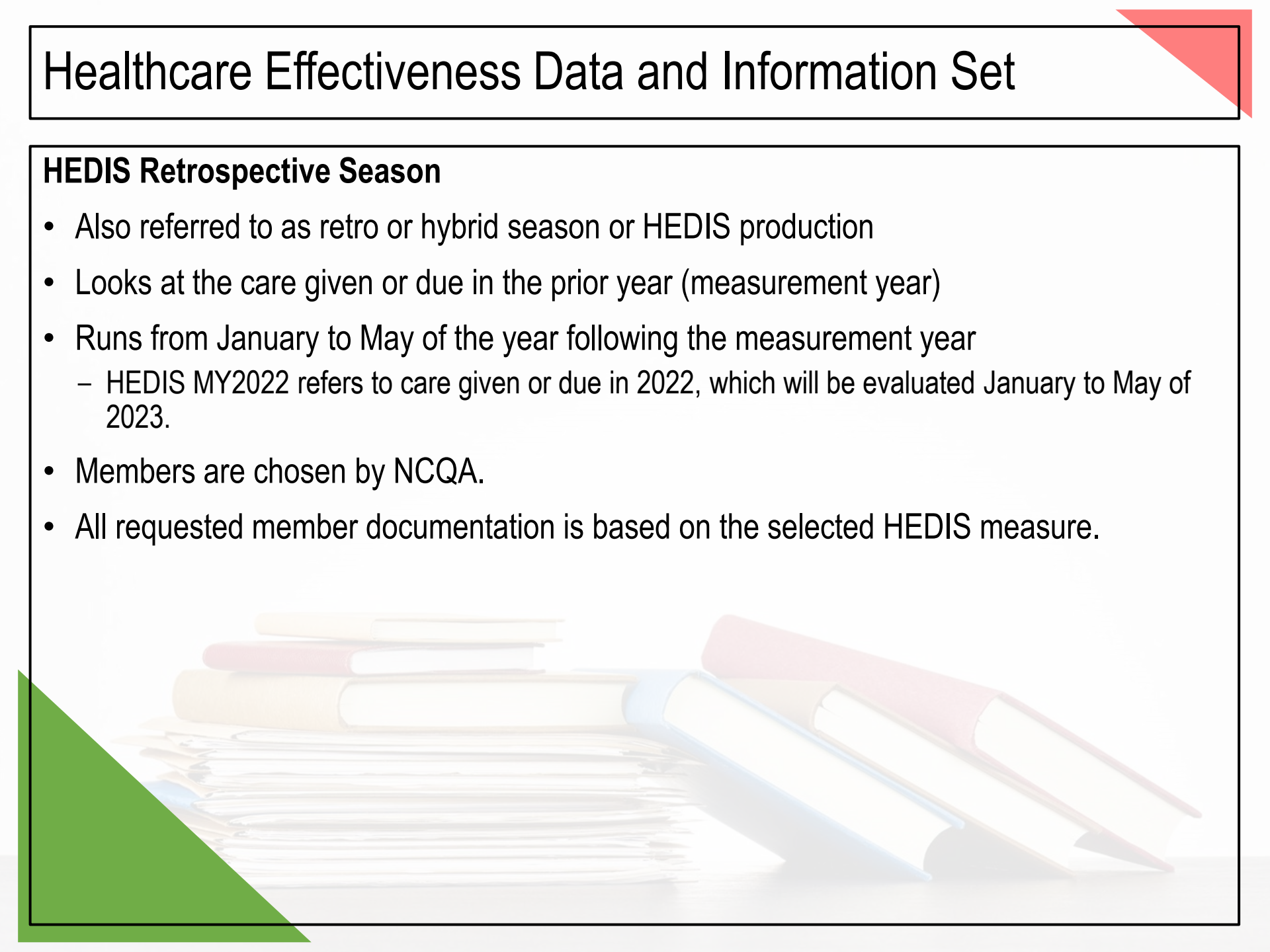
HEDIS Seasons

- Types of HEDIS seasons include:
  - Retrospective (also referred to as retro or hybrid)
  - Prospective (also referred to as year-round)
- Each season is based on when the data is being gathered related to the measurement year.

Healthcare Effectiveness Data and Information Set

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 MY2022 refers to care given or due in 2022, which will be evaluated January to May of 2023.
- Members are chosen by NCQA.
- All requested member documentation is based on the selected HEDIS measure.



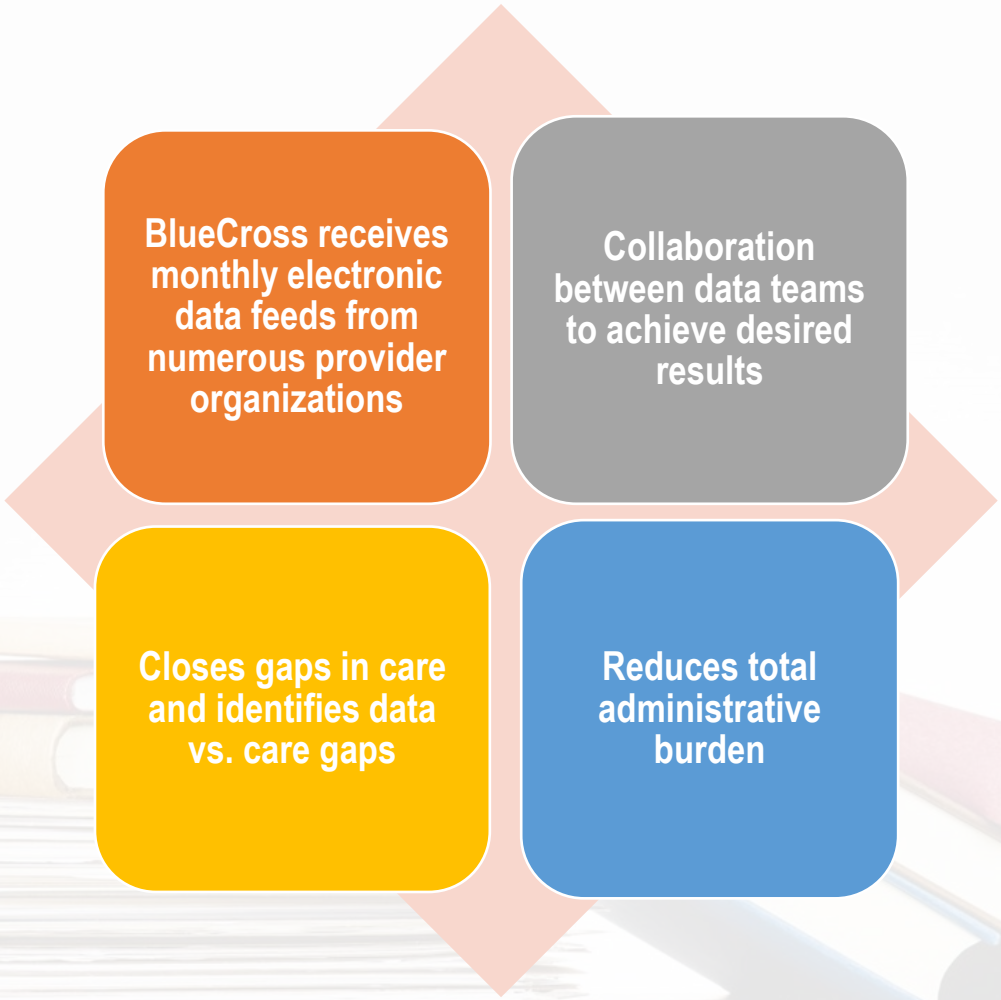
Healthcare Effectiveness Data and Information Set

HEDIS Prospective Season

- Also referred to as the year-round season
- Continuously monitors rates in real-time
- Runs from January 1 to December 31 of the current or measurement year
- Total membership rates
- Additional options for compliance
  - Claims
  - Data transfer
  - Medical records
  - Compliance forms

Healthcare Effectiveness Data and Information Set

Electronic Data Transfer



Healthcare Effectiveness Data and Information Set (HEDIS®)

Remote Access

BlueCross currently has many providers that allow remote access to their electronic medical records (EMR).

Assigned navigator can locate and retrieve records from the EMR remotely.

Remote access helps to reduces provider burden.

Requests for Information

Medical Records Request — Cover Letter

Medical Records Request

Prospective/ Year-Round Season

Medical Records Request

Retrospective Review/HEDIS Hybrid Season

Requests for Information

How are requests sent?

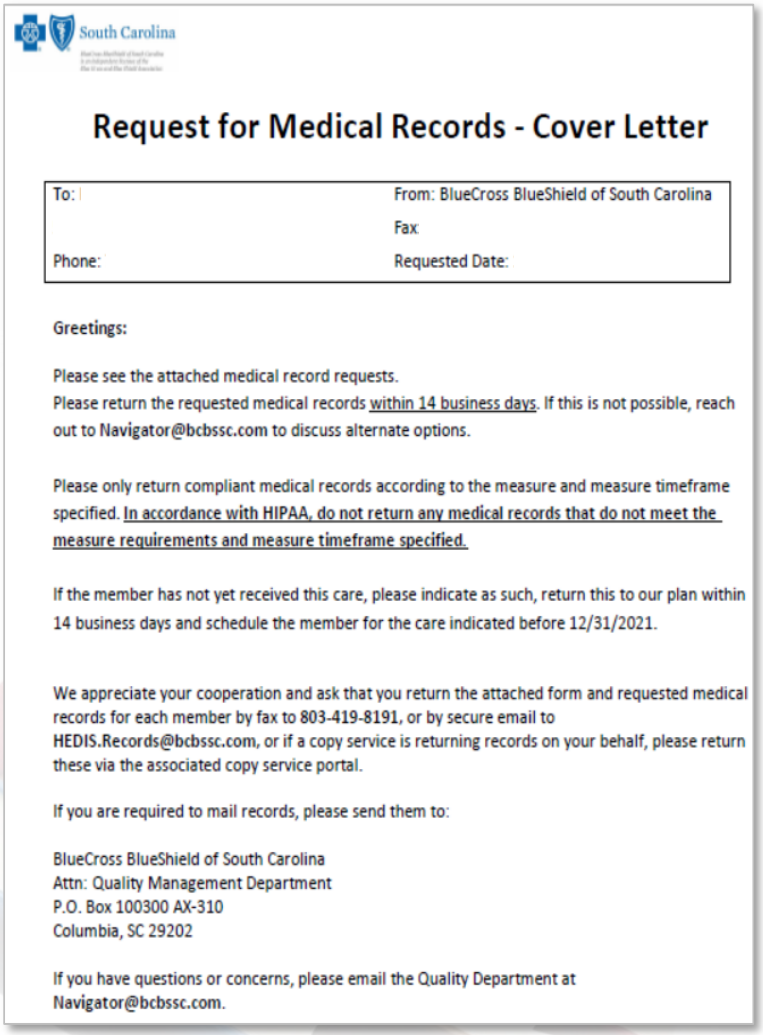
- Sent via email, fax or mail
- Can be avoided by giving remote access to EMR
  - Email NAVIGATOR@bcbssc.com

How are requests created?

- Claims

How are members attributed?

- Claims data



South Carolina

Request for Medical Records - Cover Letter

To:	From: BlueCross BlueShield of South Carolina
	Fax:
Phone:	Requested Date:

Greetings:

Please see the attached medical record requests.
Please return the requested medical records within 14 business days. If this is not possible, reach out to Navigator@bcbssc.com to discuss alternate options.

Please only return compliant medical records according to the measure and measure timeframe specified. In accordance with HIPAA, do not return any medical records that do not meet the measure requirements and measure timeframe specified.

If the member has not yet received this care, please indicate as such, return this to our plan within 14 business days and schedule the member for the care indicated before 12/31/2021.

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 the Quality Department at Navigator@bcbssc.com.

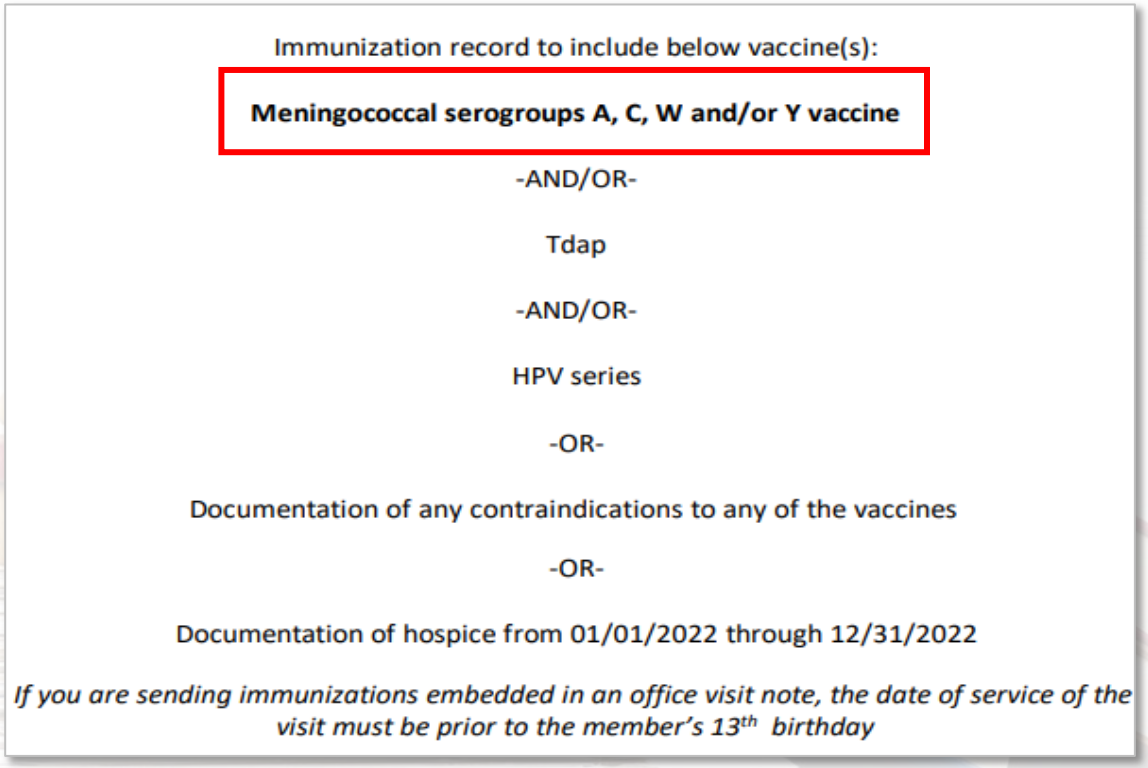
Note: You will not receive medical records requests for compliance that was already received during prospective HEDIS.

Requests for Information

What Information Should Be Returned?

- Providers are required to return the requested information in **BOLD** if there are multiple sub-measures on a page.

Example



Immunization record to include below vaccine(s):

Meningococcal serogroups A, C, W and/or Y vaccine

-AND/OR-

Tdap

-AND/OR-

HPV series

-OR-

Documentation of any contraindications to any of the vaccines

-OR-

Documentation of hospice from 01/01/2022 through 12/31/2022

If you are sending immunizations embedded in an office visit note, the date of service of the visit must be prior to the member's 13th birthday

Requests for Information

What Should I do if I Can't Locate the Patient?

- Check the appropriate box and return the letter via fax, email or mail.

Please check the appropriate box:

☐ Unable to locate patient in medical records

☐ 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

☐ No medical records with requested information during the time frame specified

Lines of Business

Lines of Business

Which Lines of Business are Included?

- Health Insurance Exchange (HIX) or Affordable Care Act (ACA)

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

Independent licensees of the Blue Cross Blue Shield Association.

- Federal Employee Program (FEP)

BlueCross
BlueShield
Federal Employee Program.

Lines of Business

Health Insurance Exchange

Rating System

- Quality Ratings System (QRS)

CMS.gov
Centers for Medicare & Medicaid Services

Technical Specifications

- Used by more than 90 percent of the nation's health plans, employers and regulators
- Clinical, customer satisfaction and patient quality measurement
- Many plans collect HEDIS data and the measures are specific
- Outcome is a star rating

Lines of Business

Health Insurance Exchange (Continued)

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

Independent licensees of the Blue Cross Blue Shield Association.

Lines of Business

Federal Employee Program (FEP)

Rating System

- 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

High Performing and Improving Plan Status

- QCR HEDIS score
- Second year in a row

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 helpful tools and resources to support patient care efforts.
- Benefits include:
  - Promoting accurate coding guidance
  - Facilitating referrals to disease and case management programs to support treatment plans
  - Assisting 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

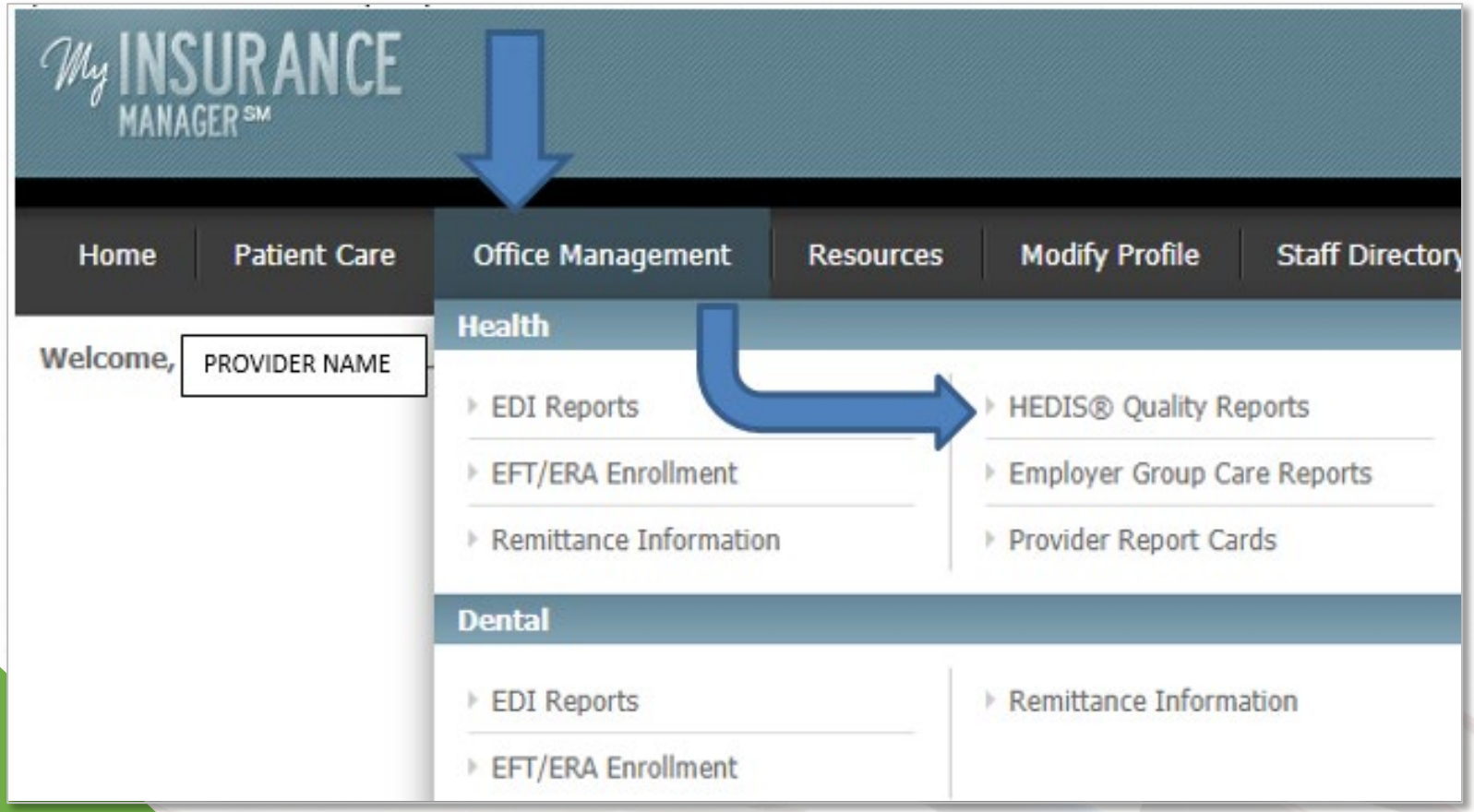
What is a Quality Navigator?

- A 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

Accessing Care Opportunity Reports — Prospective Season

Reports are located in My Insurance Manager.



Quality Navigator Program

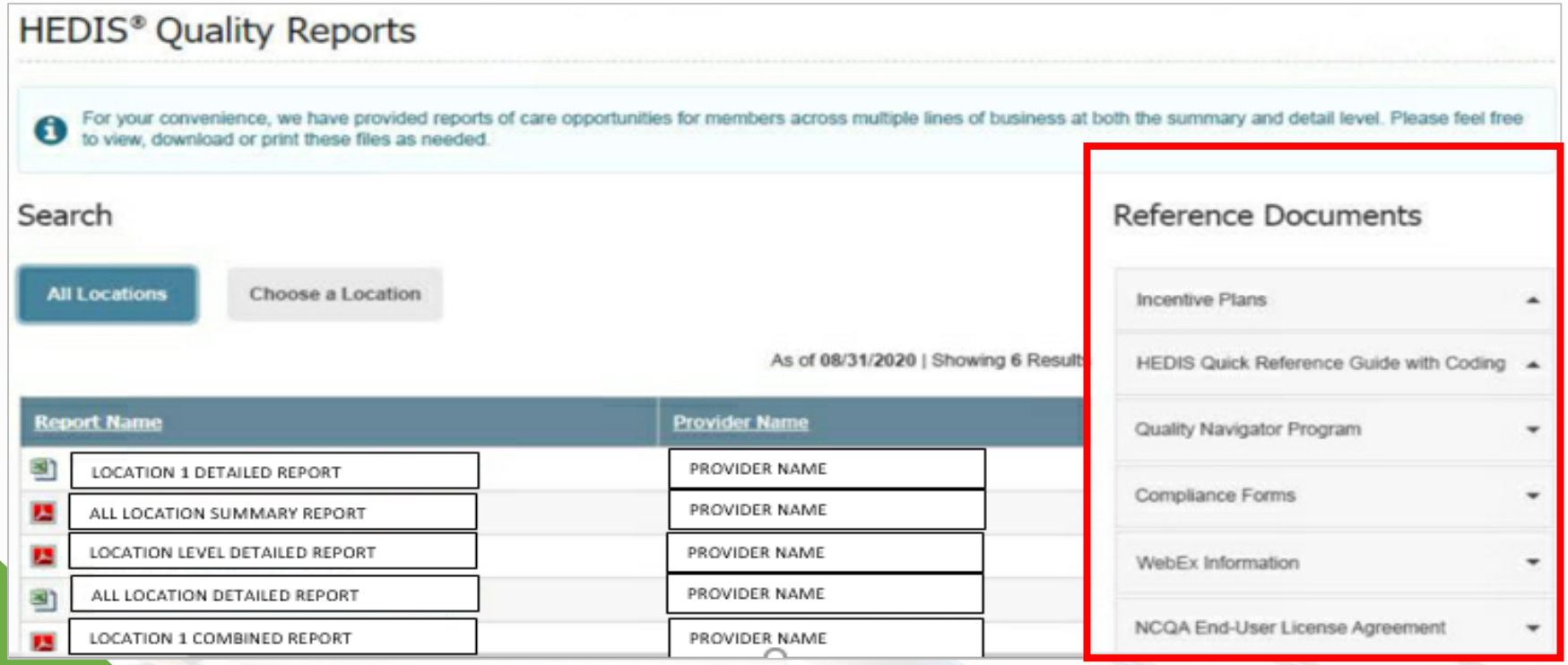
Understanding Care Opportunity Reports — Prospective Season

- 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

Quality Navigator Program

Additional Resources — Prospective Season



Key Takeaways

Key Takeaways

How Can You Assist With Quality?

High Impact to HEDIS and Quality Ratings

- Submit NCQA approved quality codes on claims when appropriate.
- Consider data transfer to reduce medical record requests.
- Grant remote access to the quality navigator team.
- Schedule patients for exams.
  - Include periodic screenings and preventive services.
  - Follow up on missed appointments.
- Promote medication adherence.
  - Recommend formulary alternatives.
- Remember customer service happens with every member interaction.
  - Lab and test results should be returned in a timely manner and explained.
  - Telehealth is a wonderful option for practices that are overwhelmed at the bedside or office.
- Remember, increasing ratings is a win-win for everyone.

Quality Navigator Program

Team Members

- Christine Wlodarczyk, RN, MSN, CCRK-K
- Connie Groomes, RN, CPN
- Dawn Saxman, RN, BSN
- Jermika Kennedy, RN, MSN
- Tanya Loyd, RN
- Twilah Nunn-Diamond, MBA, CPC

Key Takeaways

How To Contact the Quality Team

For questions or additional assistance, send an email to:

NAVIGATOR@bcbssc.com

Web Tools

Agenda

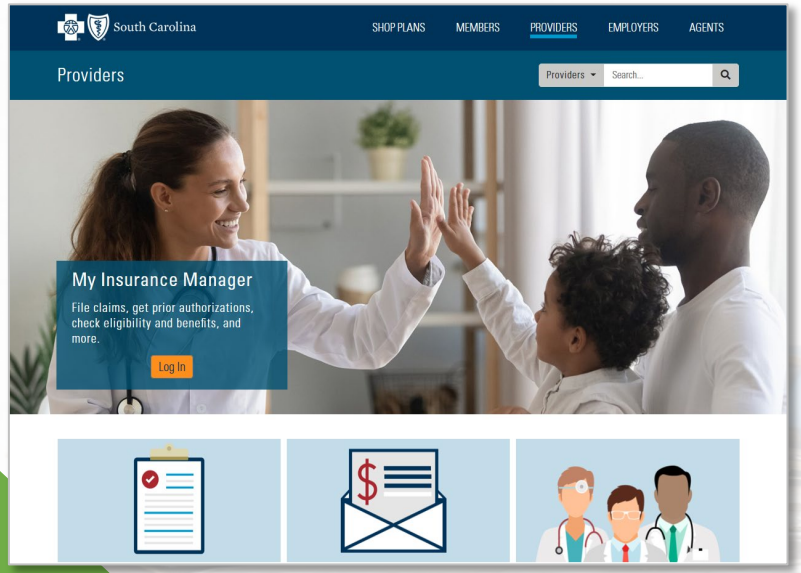
- Website Review
- My Insurance Manager (MIM)
- My Remit Manager (MRM)

Website Review

Website Review

Provider Pages of Our Websites Include:

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

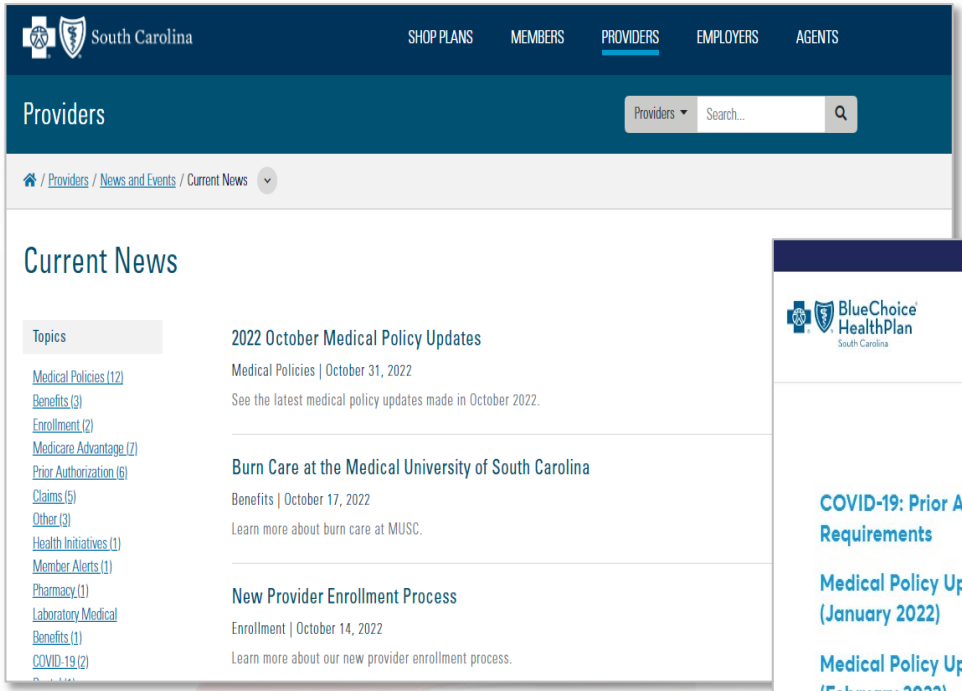


www.SouthCarolinaBlues.com

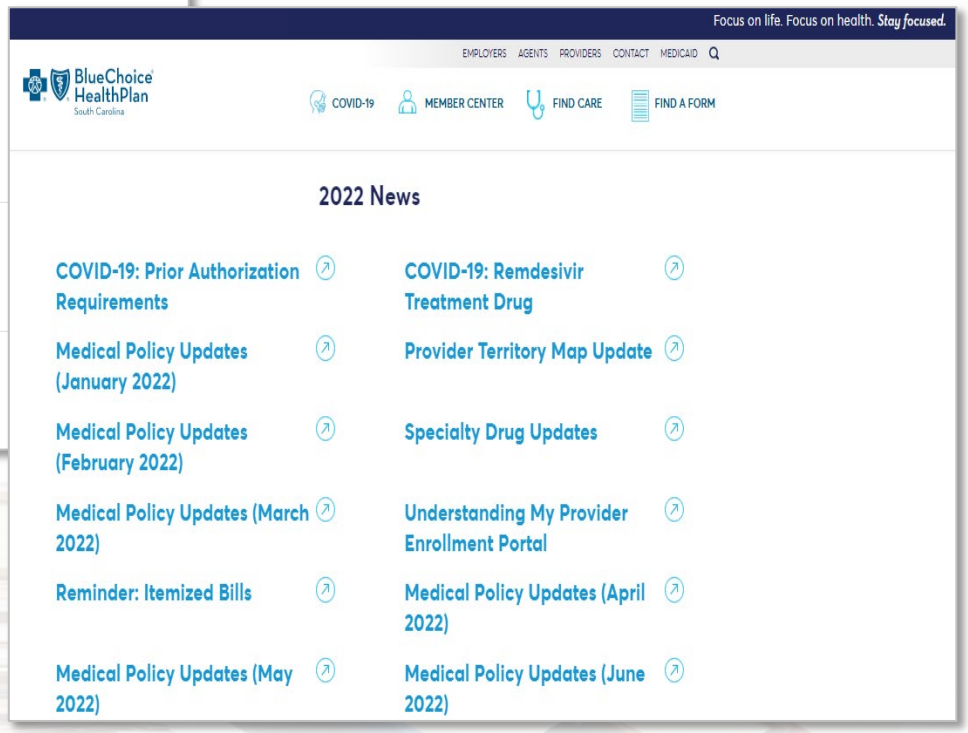
www.BlueChoiceSC.com

Website Review

Provider Bulletins



SouthCarolinaBlues.com

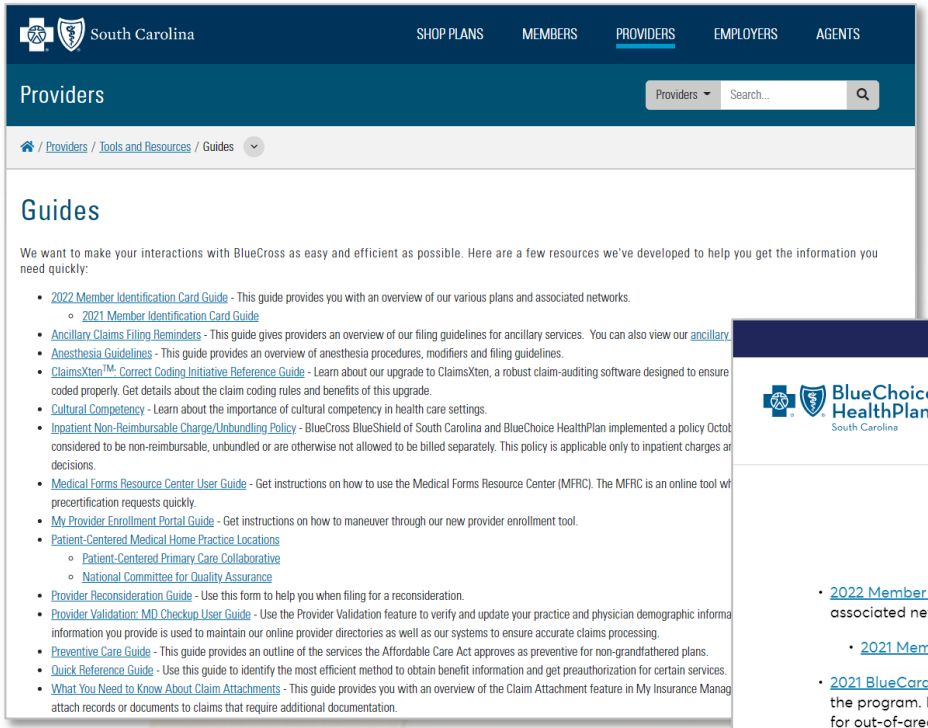


BlueChoiceSC.com

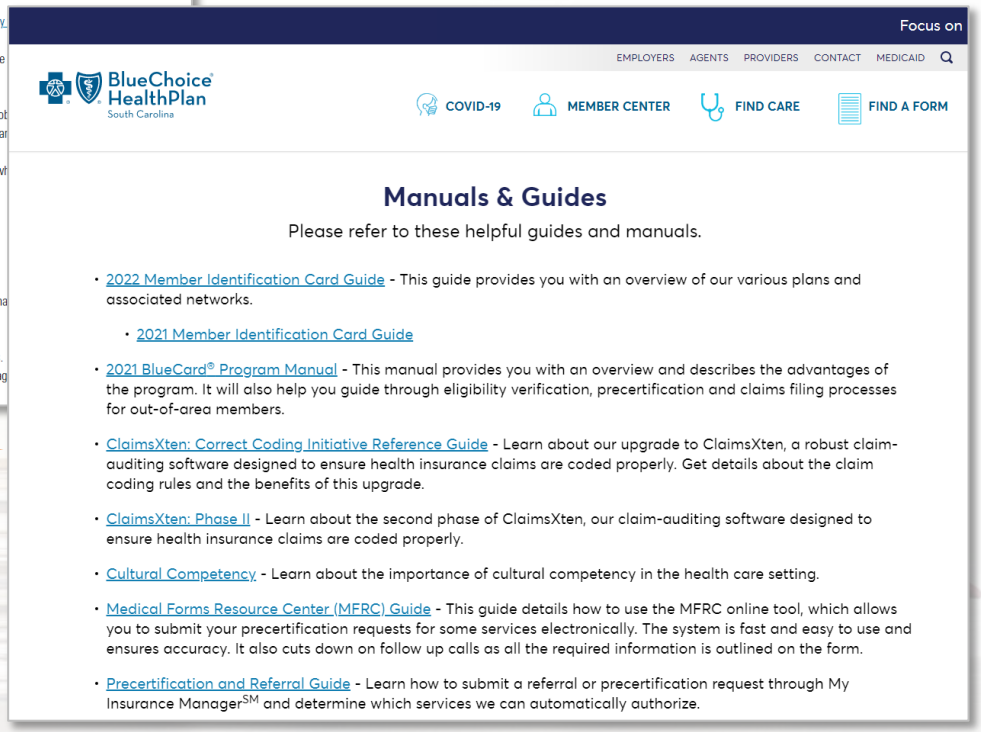
Website Review

Manuals and Guides

SouthCarolinaBlues.com

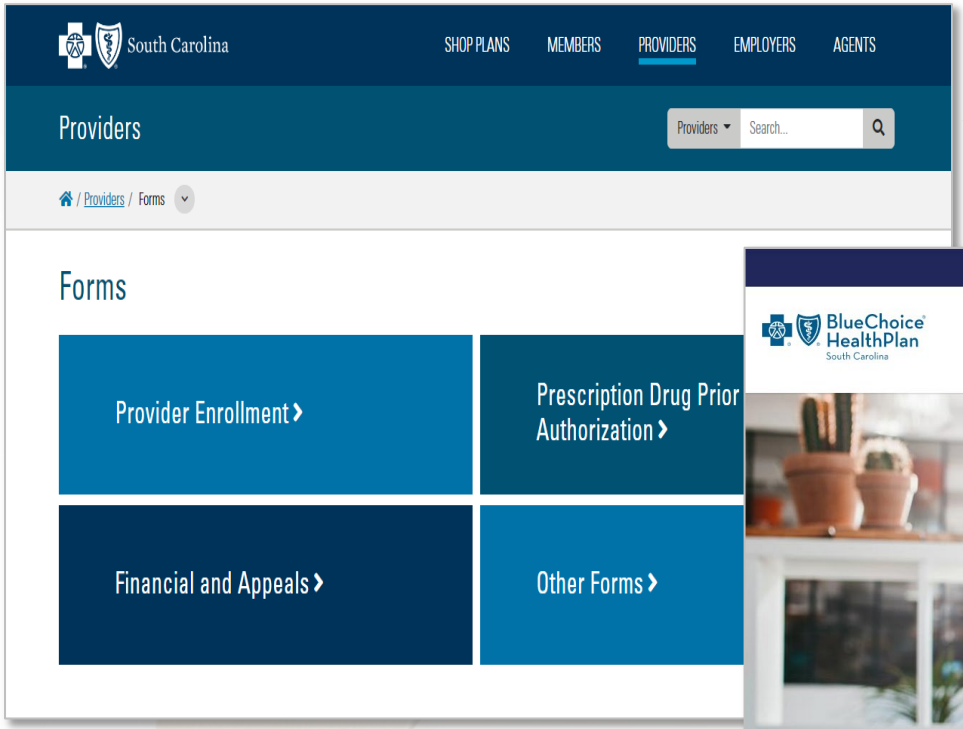


BlueChoiceSC.com

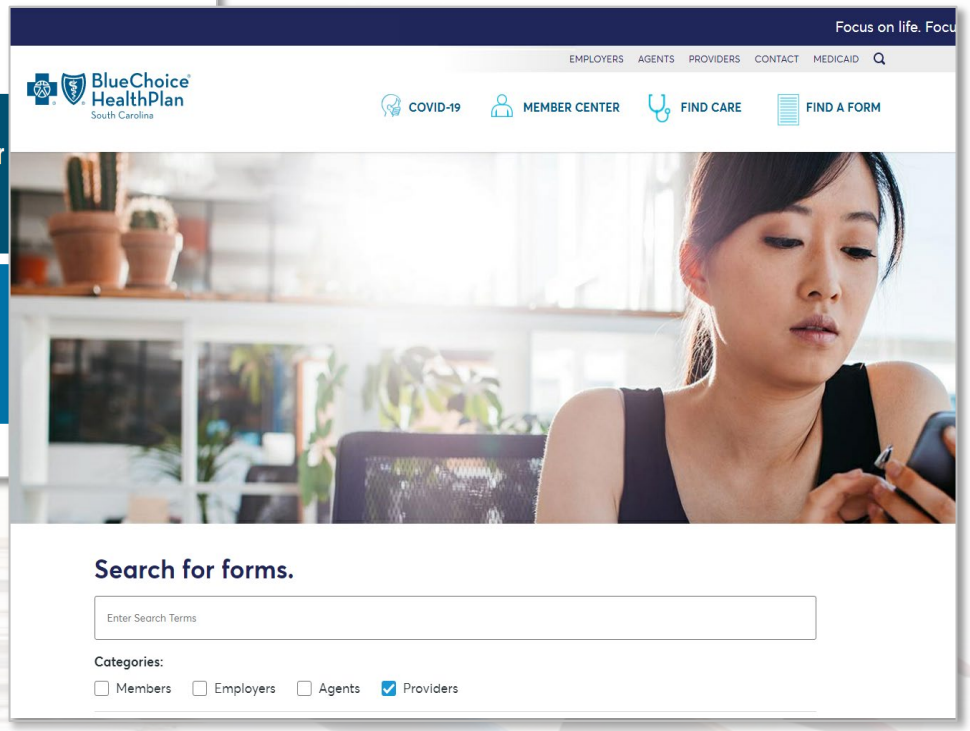


Website Review

Forms



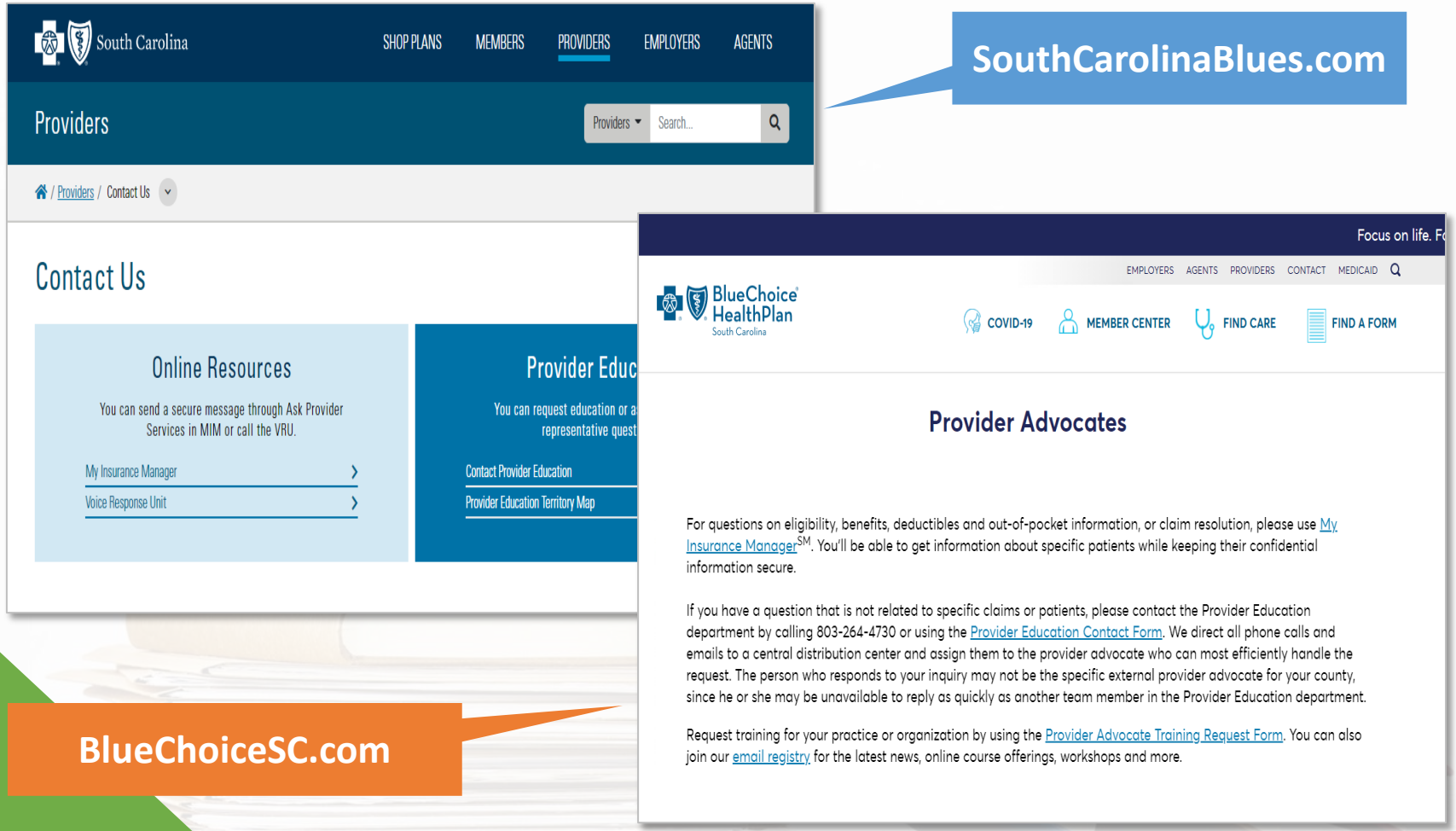
SouthCarolinaBlues.com



BlueChoiceSC.com

Website Review

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

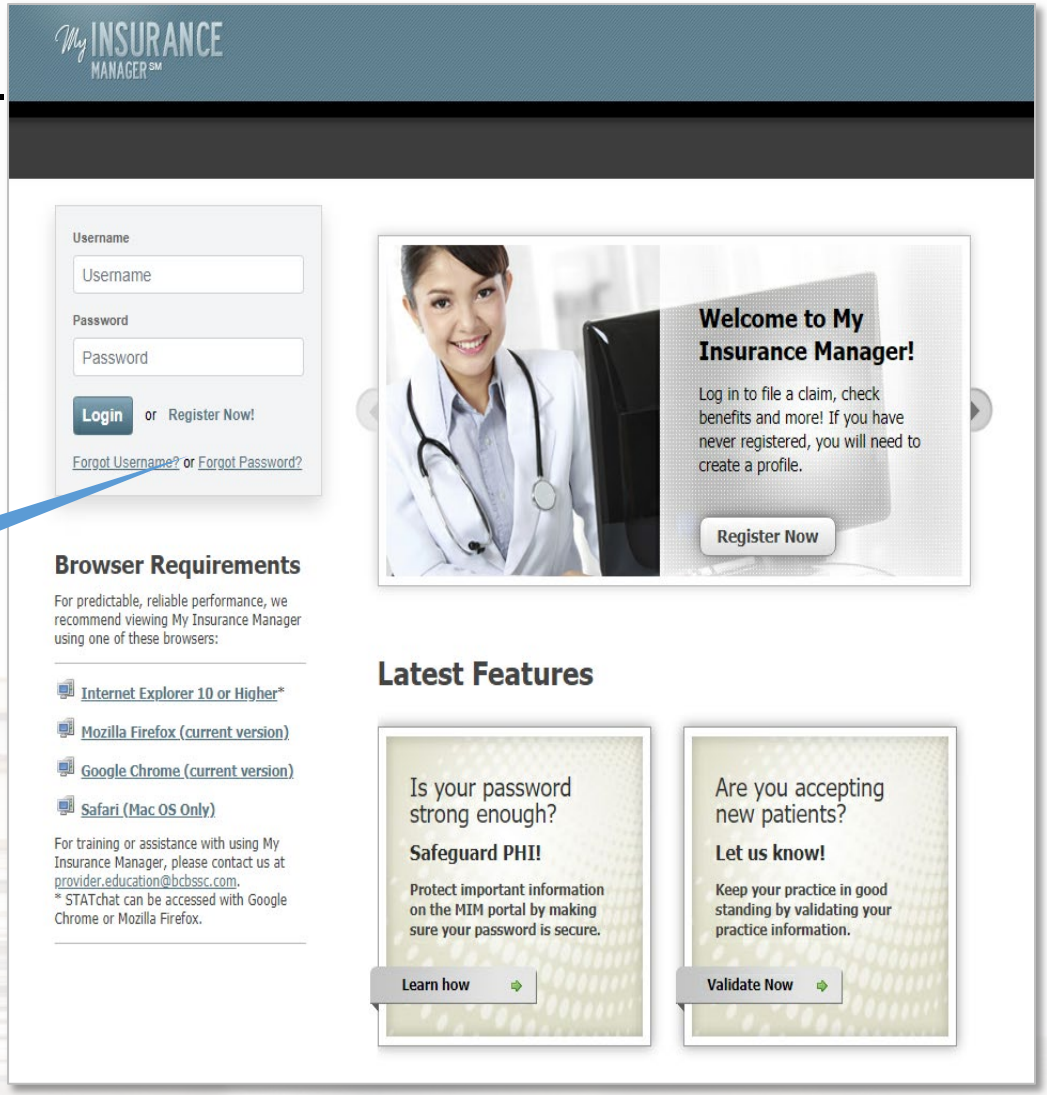
My Insurance Manager

Getting Started

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

Southcarolinablues.com>Providers>
My Insurance Manager>Getting Started

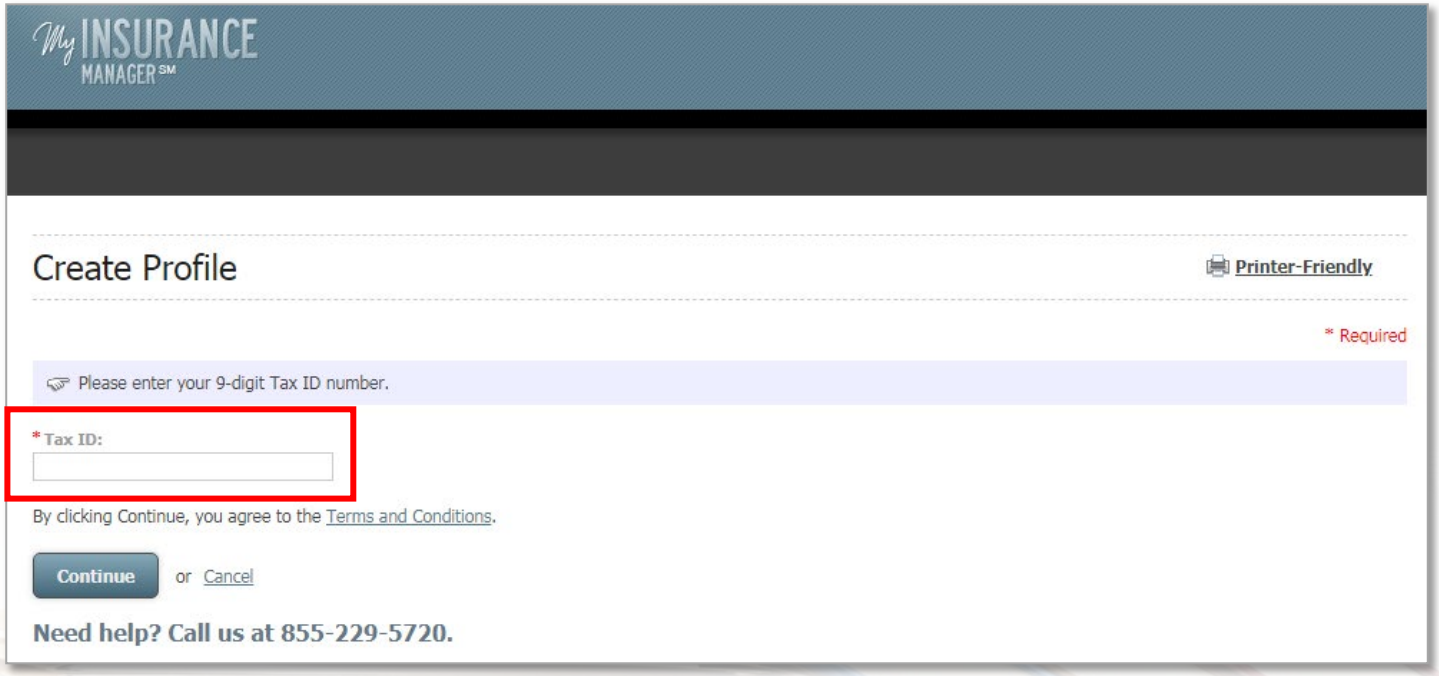
Start here.



My Insurance Manager

Getting Started (Continued)

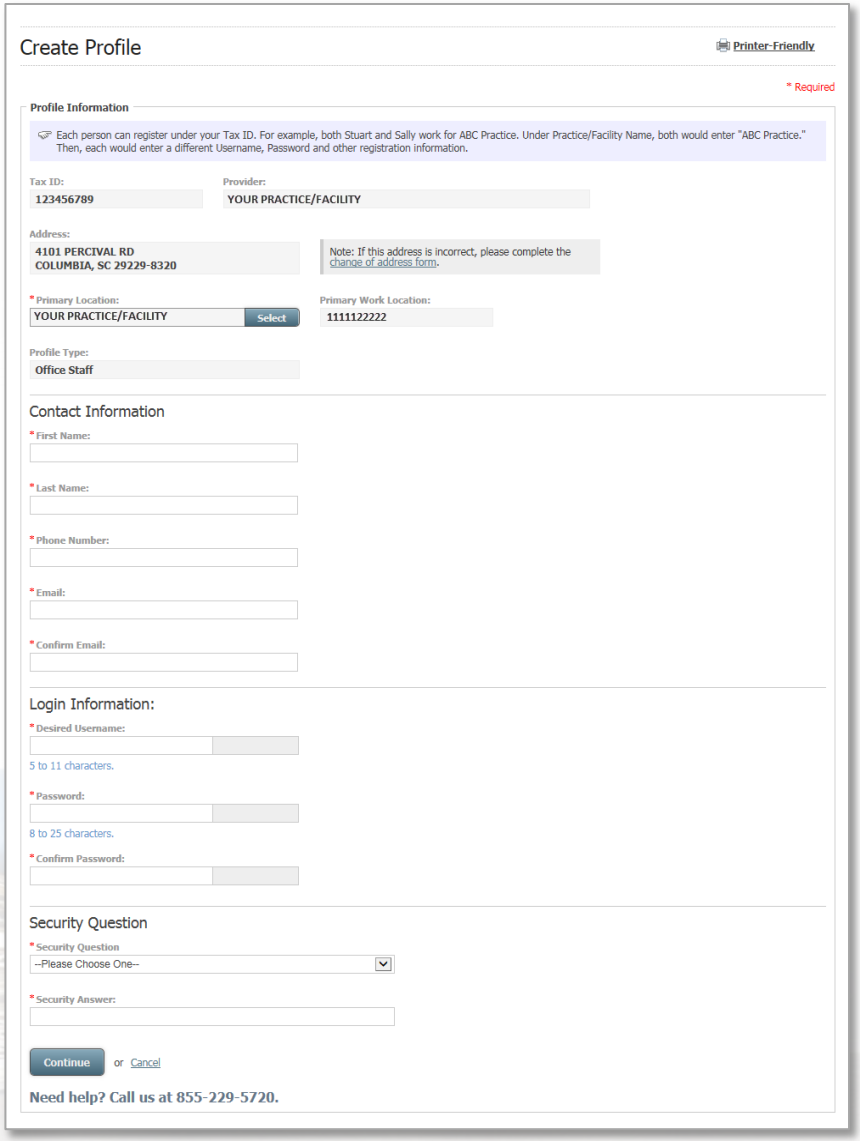
When creating a profile, the nine-digit tax ID must be entered. Select **Continue**.



My Insurance Manager

Getting Started (Continued)

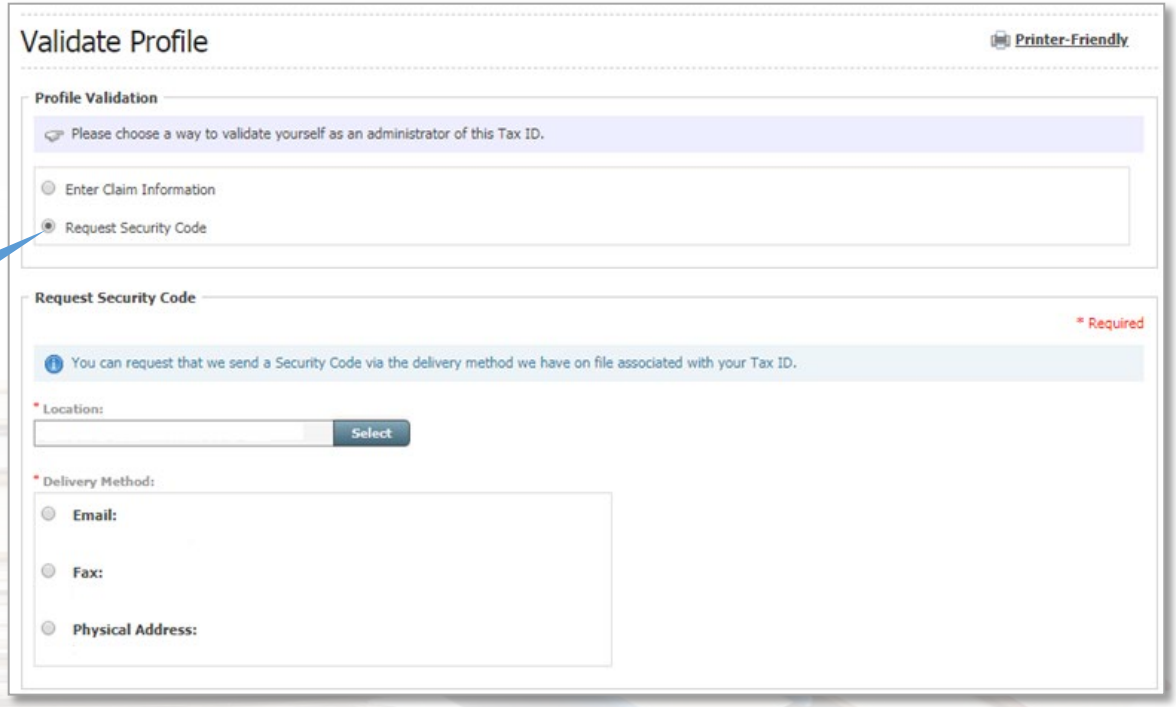
- The information associated with the tax ID entered will auto-populate.
  - If there are multiple locations associated with the provider's practice, they will be given the option to select the primary location.
- Enter the remaining contact and login information, along with selecting a security question.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

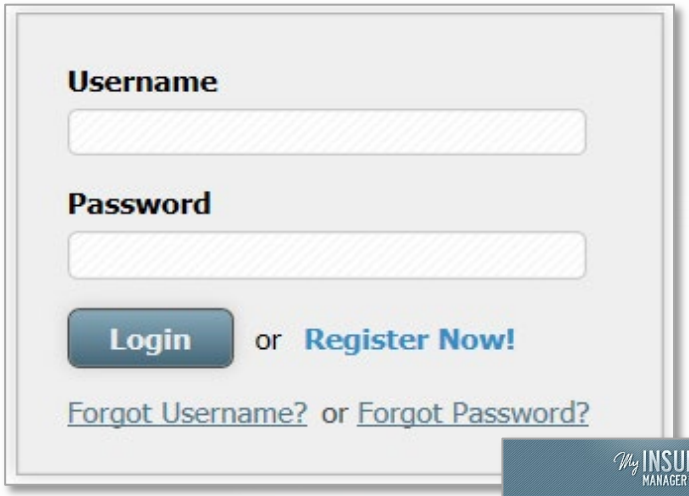


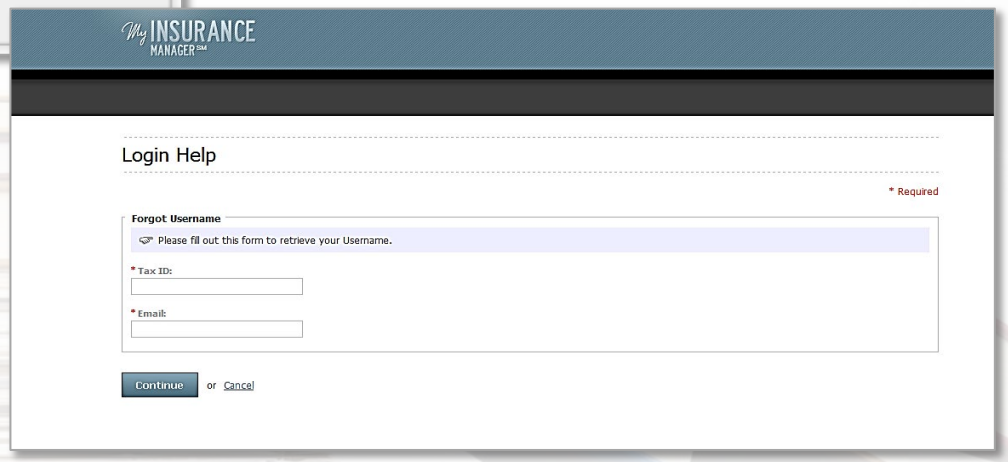
Recommended option.

My Insurance Manager

Logging In

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



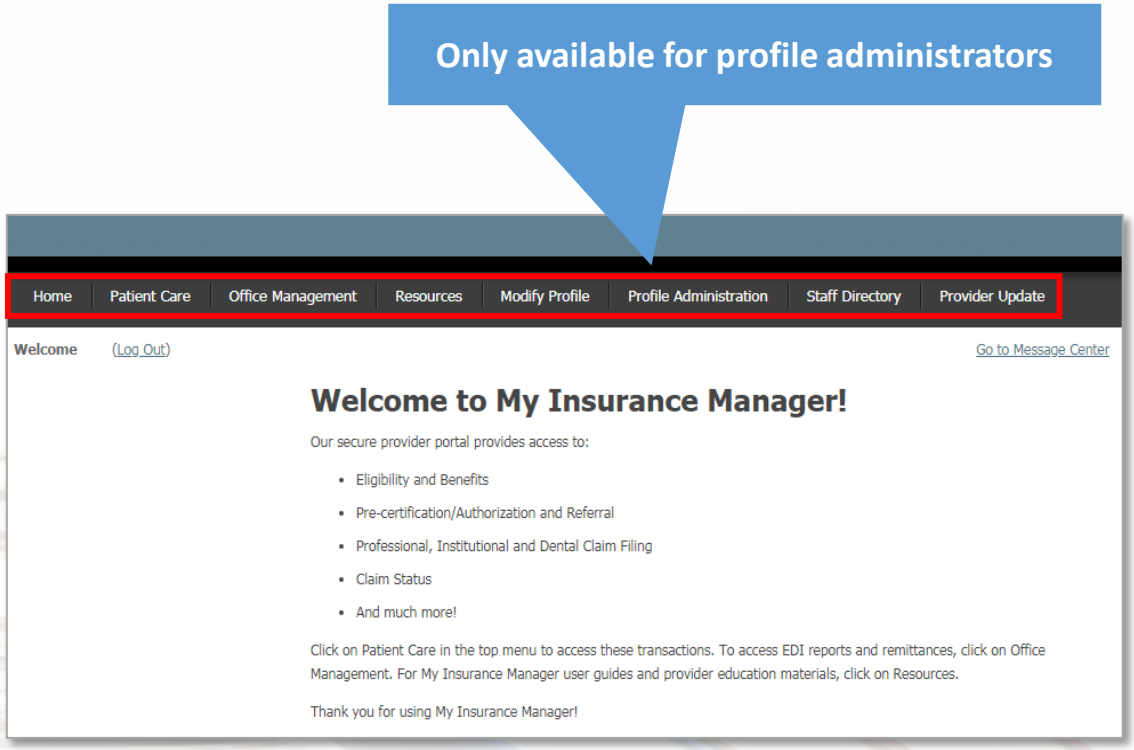


My Insurance Manager

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 are included:

- 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, EFT/ERA enrollment and 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

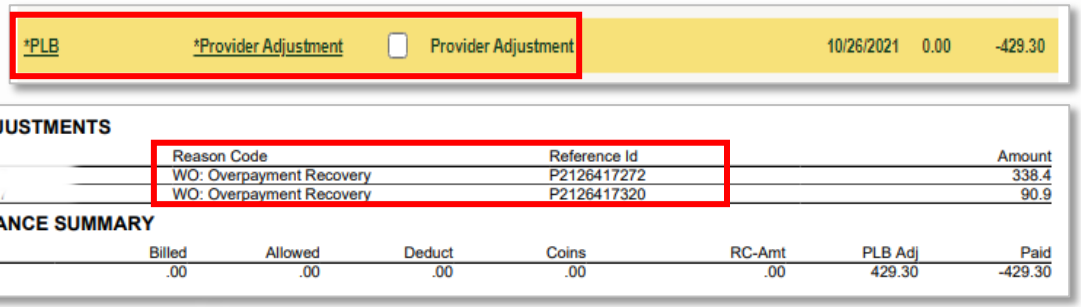
Refund Letters

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



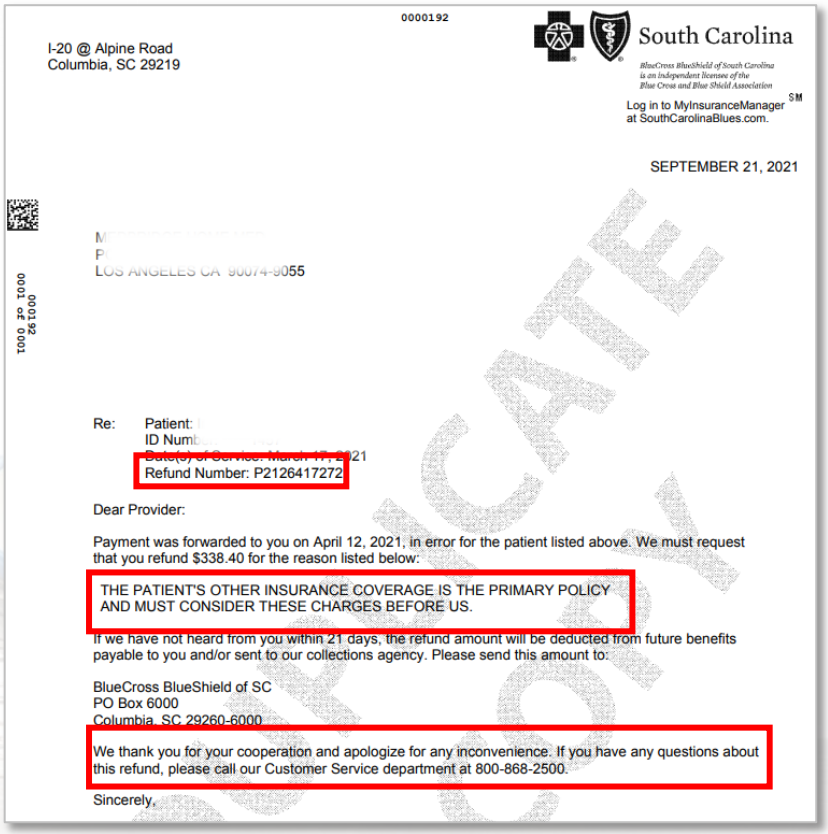
*PLB	*Provider Adjustment	☐ Provider Adjustment		10/26/2021	0.00	-429.30

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

0001 OF 0001 0000192

Re: Patient:
ID Numb
Date(s) of Service: March 17, 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.

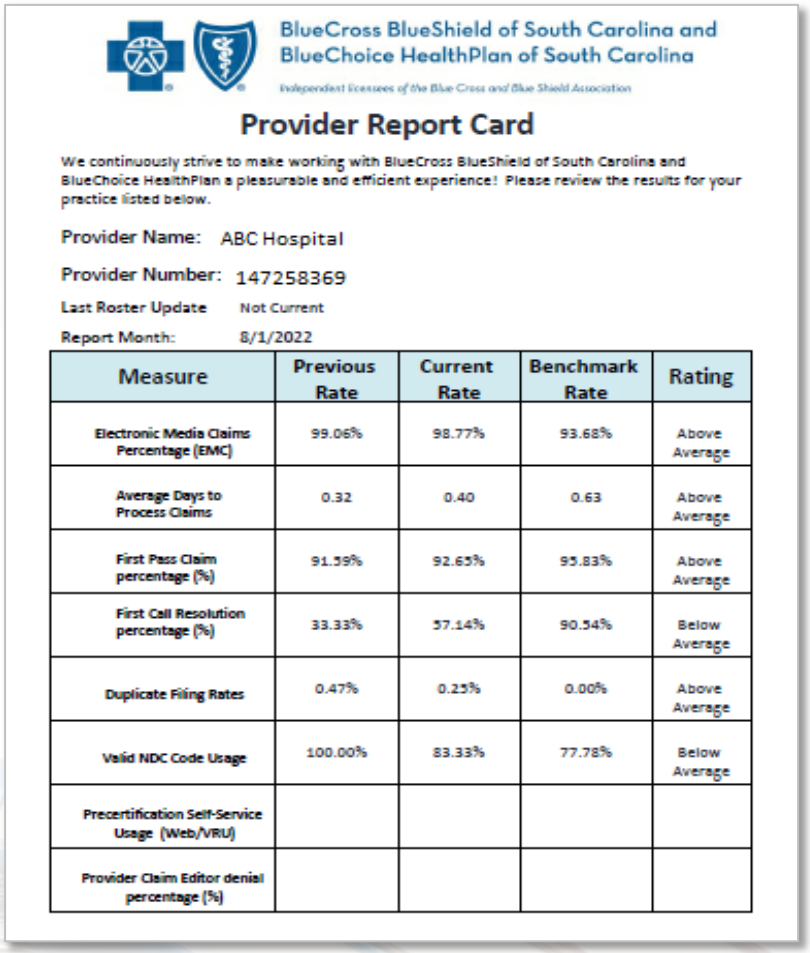
Sincerely,

My Insurance Manager

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 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.

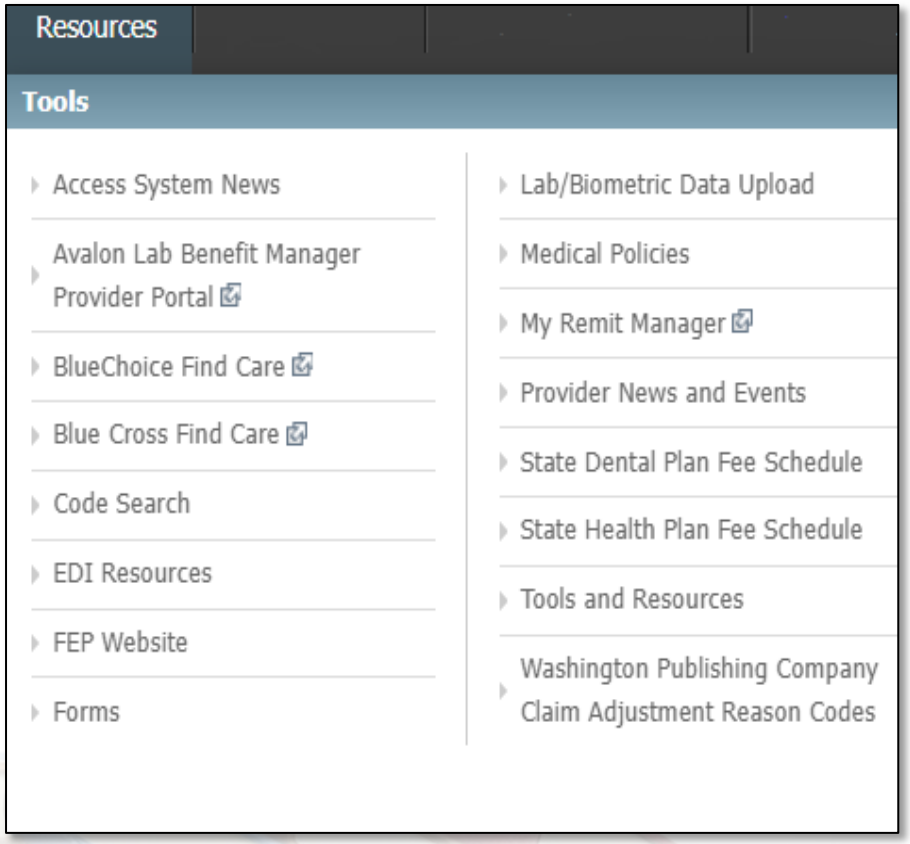
My Insurance Manager

Resources

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

Most used resources include:

- Avalon Lab Benefit Manager Provider Portal
- Education Center
- Medical Policies
- My Remit Manager℠

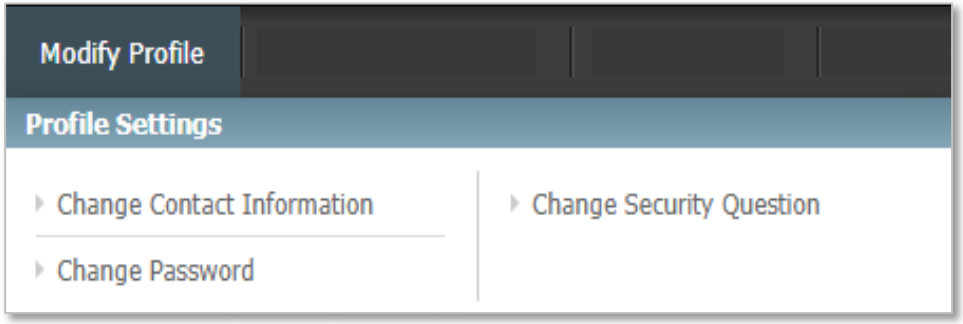


My Insurance Manager

Modify Profile

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

- Change Contact Information
- Change Password
- Change Security Question



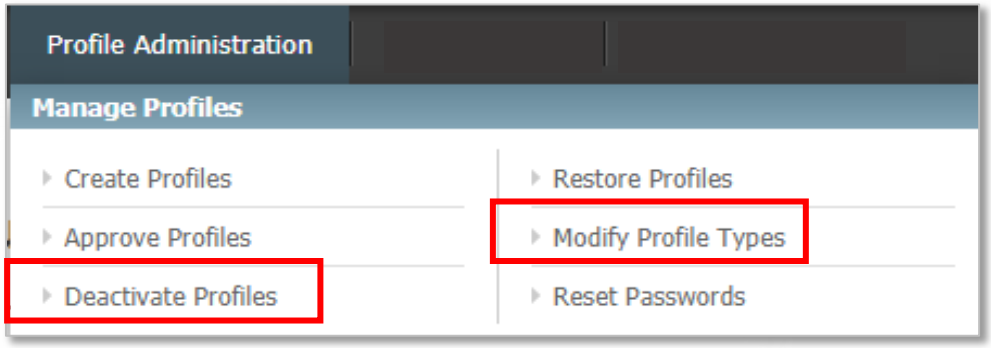
My Insurance Manager

Profile Administration

Profile administration is available for the administrator(s) of 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, this 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

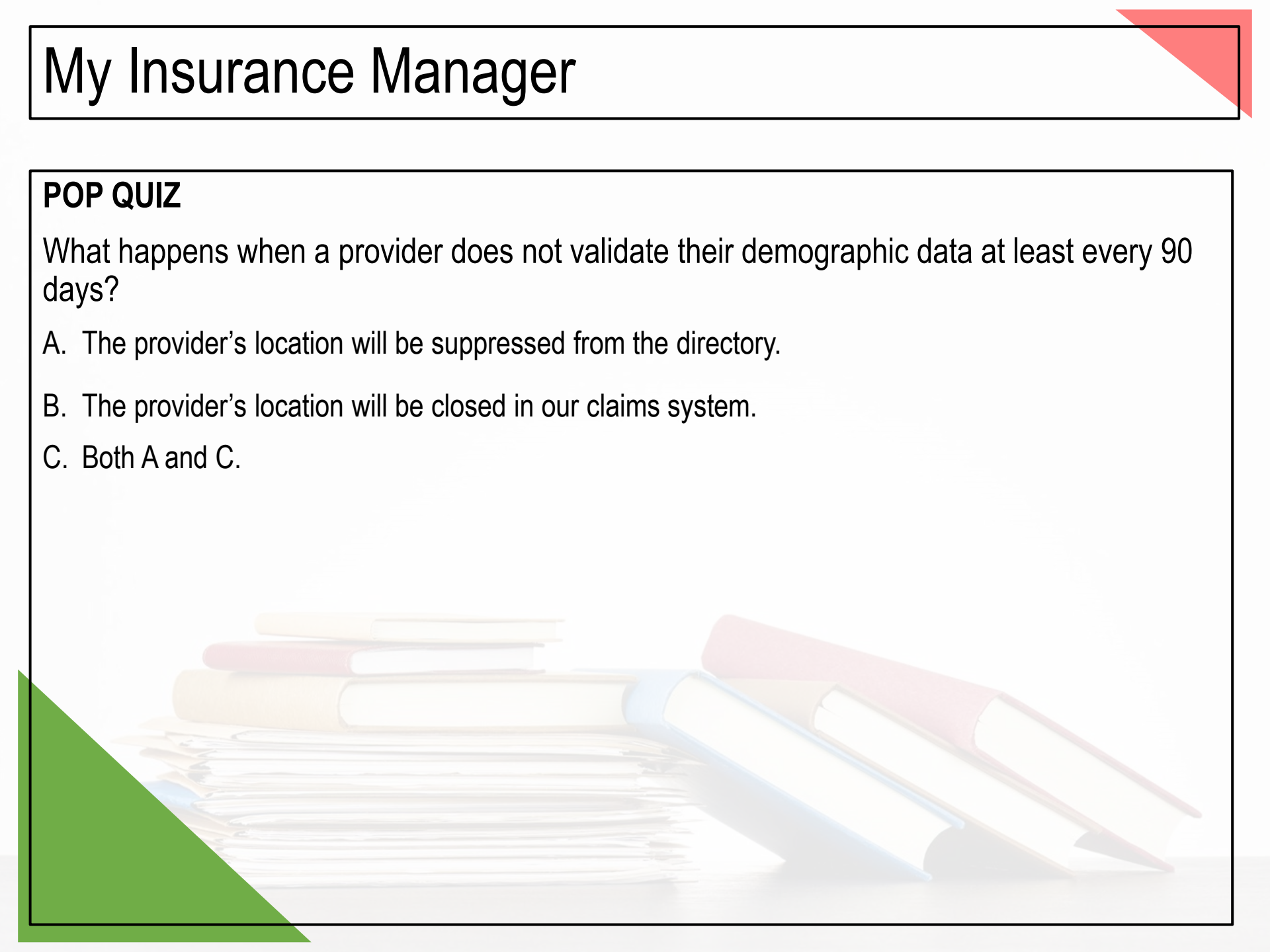
POP QUIZ

What happens when a provider does not validate their demographic data at least every 90 days?

A. The provider's location will be suppressed from the directory.

B. The provider's location will be closed in our claims system.

C. Both A and C.



My Insurance Manager

Troubleshooting Tips

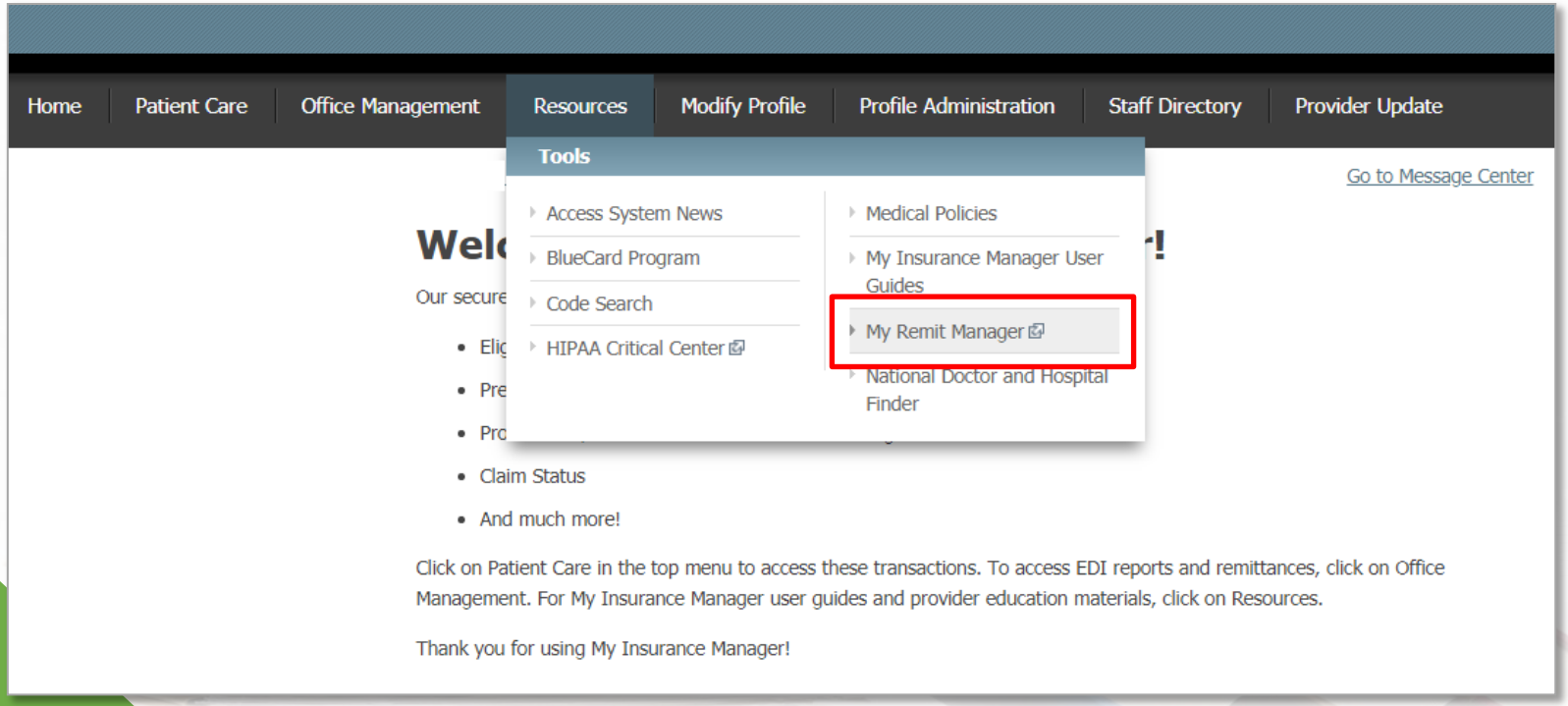
- Complete the MIM registration process to avoid limited access features.
- Be sure to use one of the recommended browsers:
  - Internet Explorer (IE) 10 or higher
  - Mozilla Firefox
  - Google Chrome
  - Safari
- On Sundays from 5 p.m. to midnight EST, MIM is unavailable for maintenance.
- For technical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

My Remit Manager (MRM)

My Remit Manager

Access Through My Insurance Manager

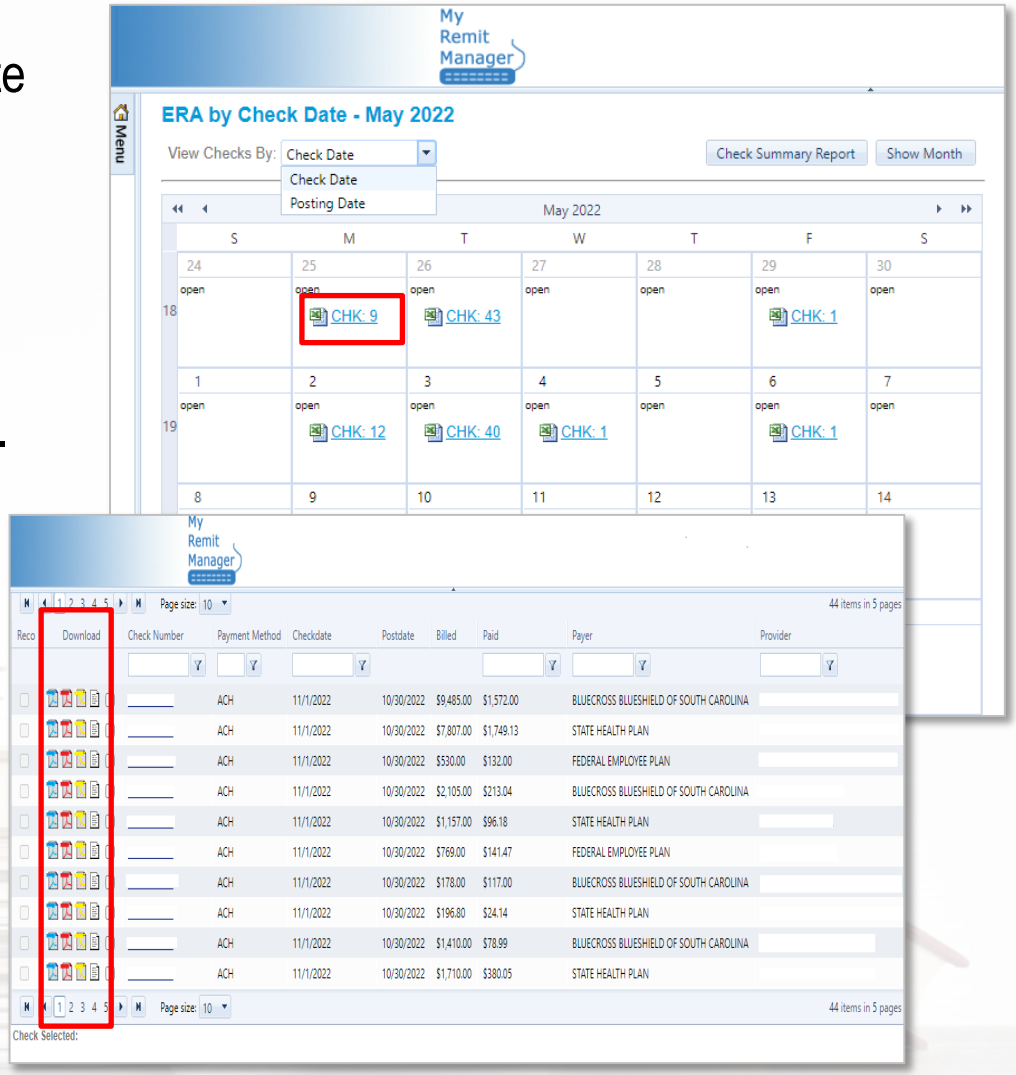
- Tool used to track payments and pull electronic remittance advices
- From My Insurance Manager, hover over Resources, then select My Remit Manager.



My Remit Manager

What You Will See

- Sort and view checks by the check date or posting date.
- Select the Adobe icon to view the remittance.
- Select the check number to view
  - Members associated with the check.
  - Date of service.
  - Processed status (paid or denied).
  - Amount billed and paid.

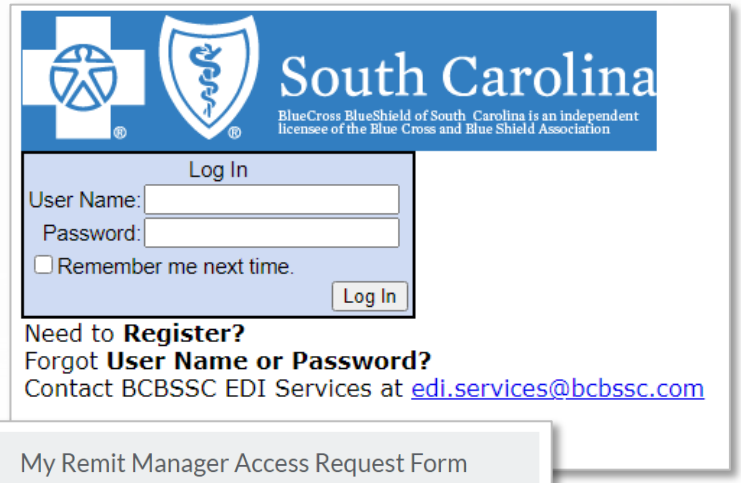


My Remit Manager

Access Outside of My Insurance 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.

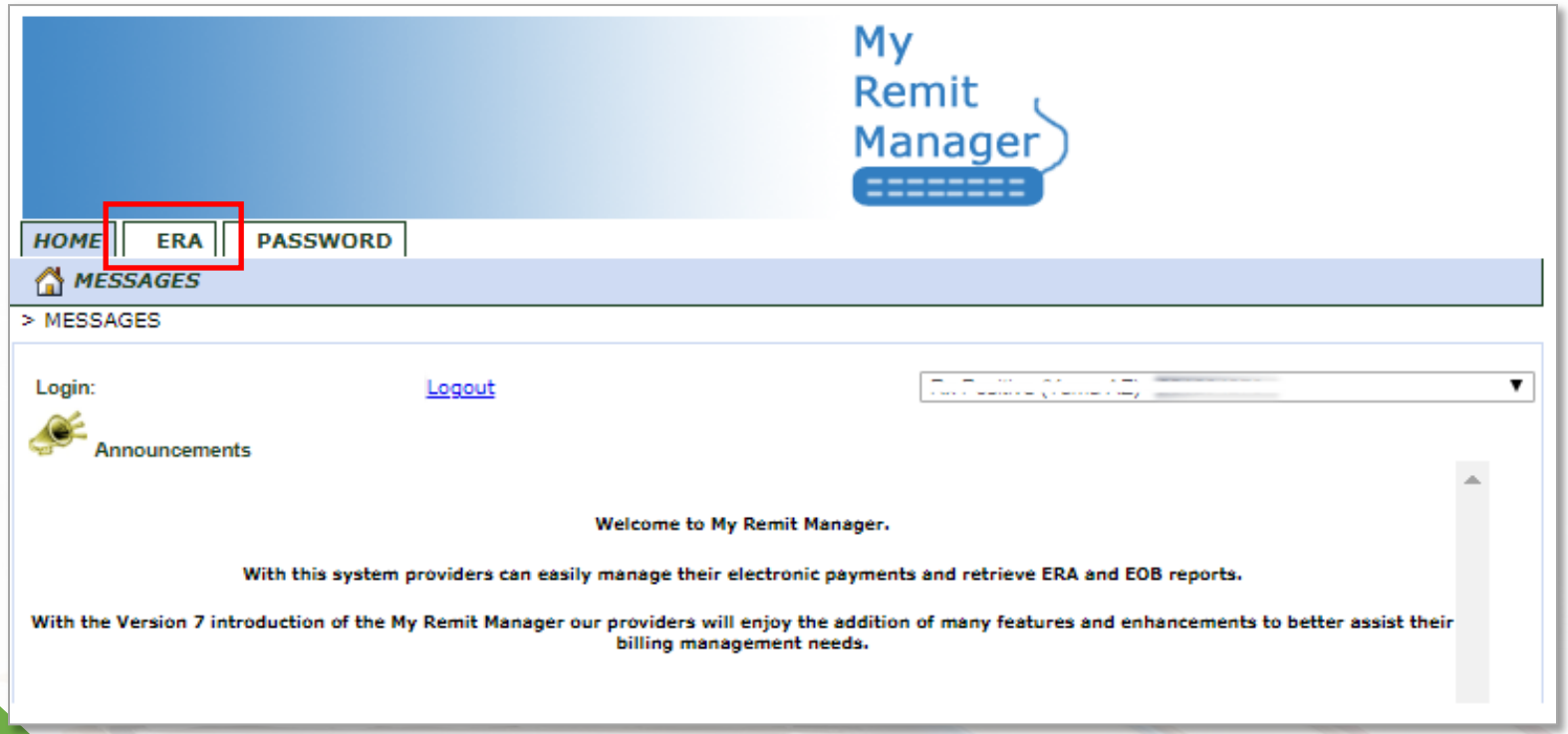
    Providers>Tools and Resources>My Remit Manager
- New registrants will receive their username and password, along with instructions via email.



My Remit Manager

What You Will See

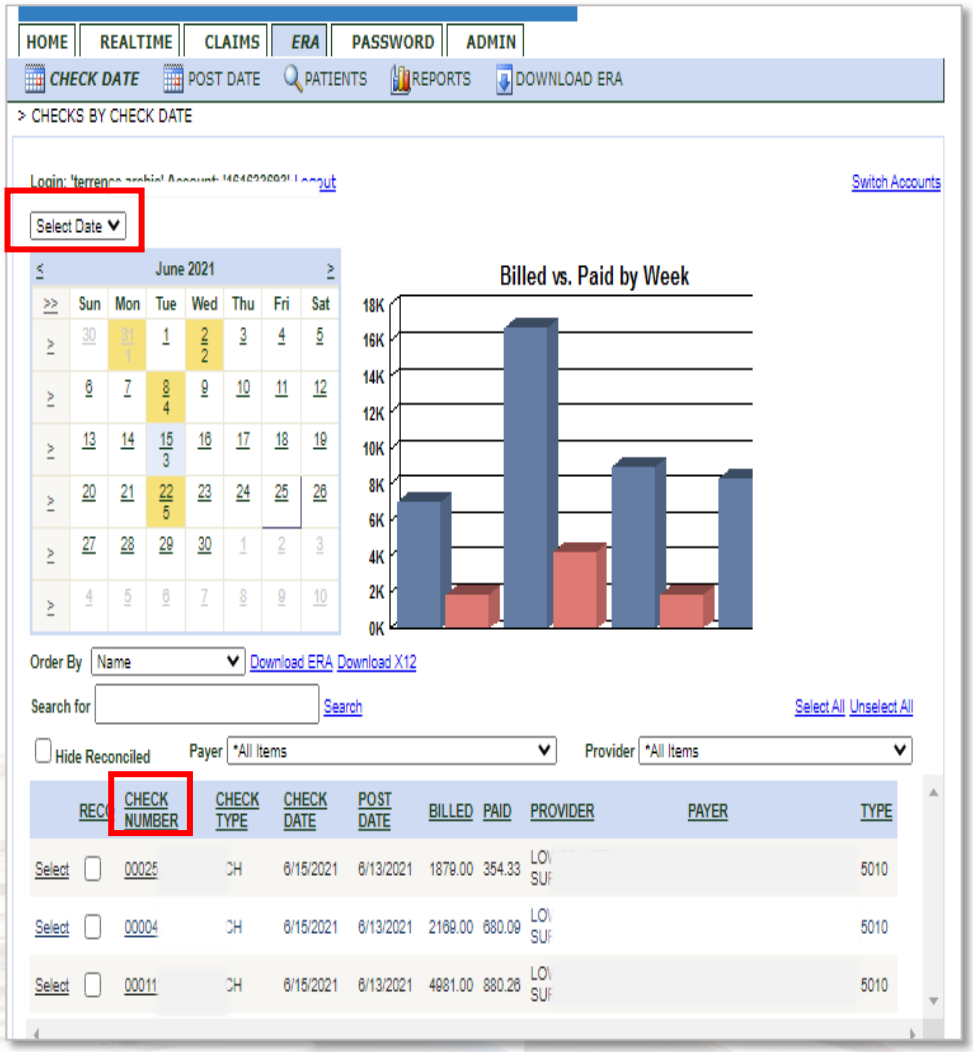
Select the electronic remittance advice (ERA) tab to view check and remittance information.



My Remit Manager

ERA Tab — Check Date

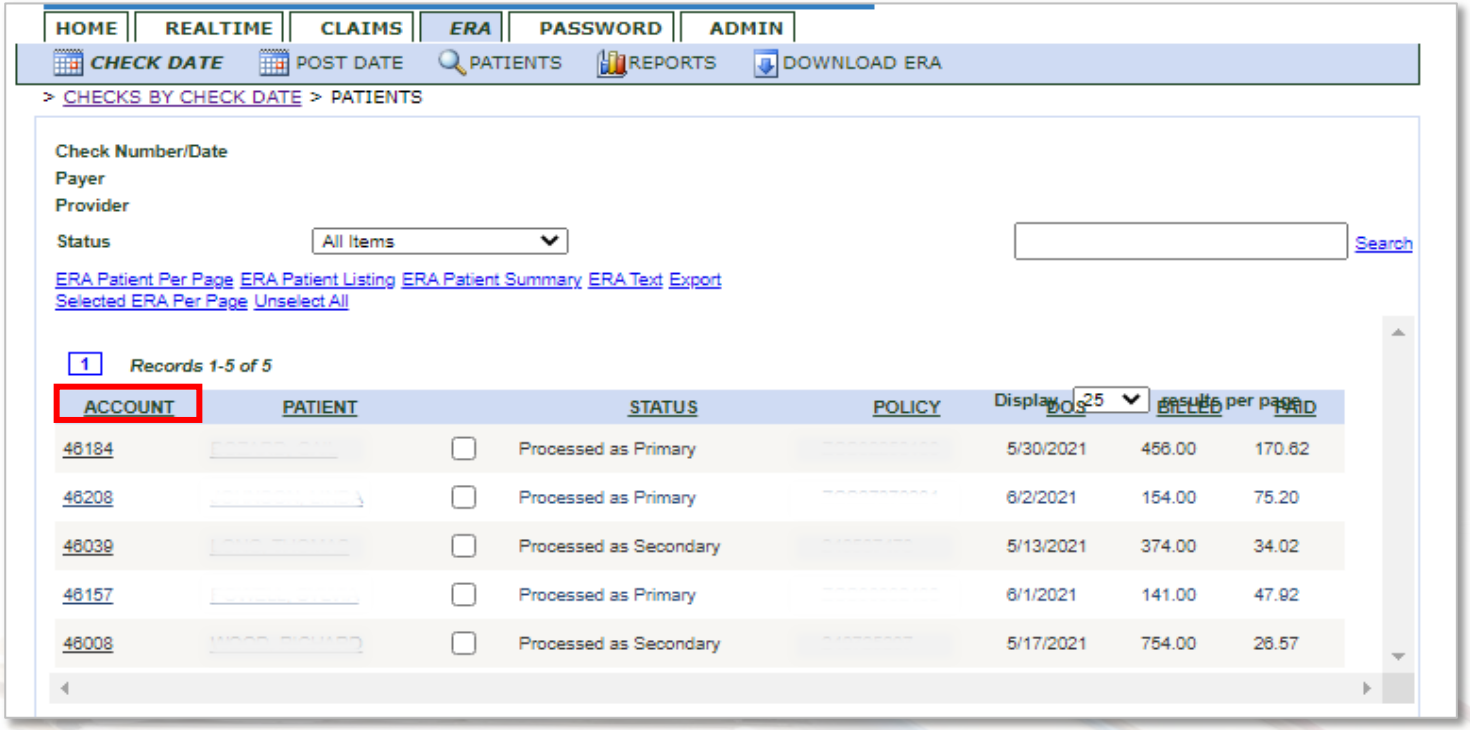
- Select the date of the remittance needed.
- Select the associated check number.



My Remit Manager

ERA Tab — Check Date

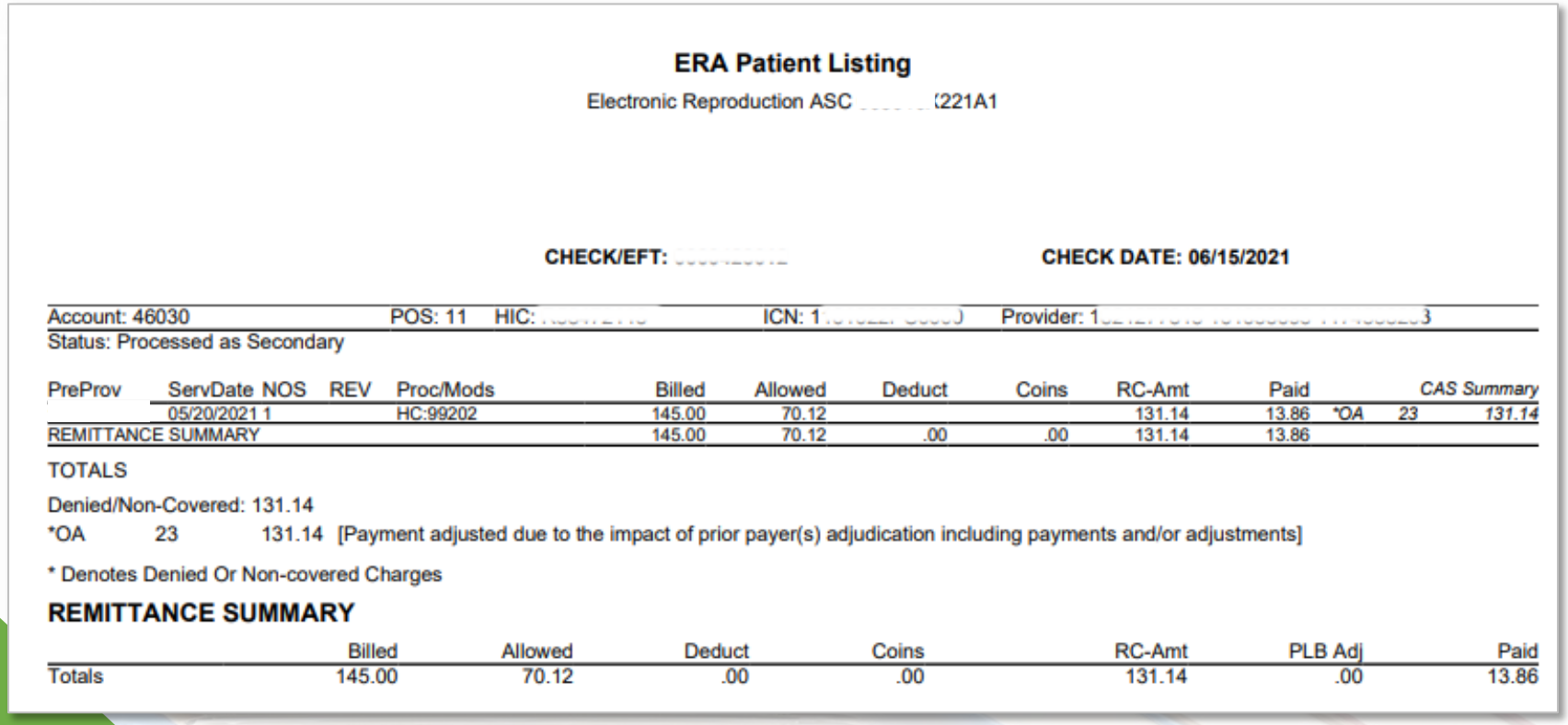
Select the account of the patient.



My Remit Manager

The Remittance

Here is an example of how the remittance will appear.



ERA Patient Listing

Electronic Reproduction ASC [redacted]221A1

CHECK/EFT: [redacted] **CHECK DATE: 06/15/2021**

Account: 46030 POS: 11 HIC: [redacted] ICN: 1[redacted] Provider: 1[redacted]

Status: Processed as Secondary

PreProv	ServDate	NOS	REV	Proc/Mods	Billed	Allowed	Deduct	Coins	RC-Amt	Paid		CAS Summary	
	05/20/2021	1		HC:99202	145.00	70.12			131.14	13.86	*OA	23	131.14
REMITTANCE SUMMARY					145.00	70.12	.00	.00	131.14	13.86			

TOTALS

Denied/Non-Covered: 131.14

*OA 23 131.14 [Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments]

* Denotes Denied Or Non-covered Charges

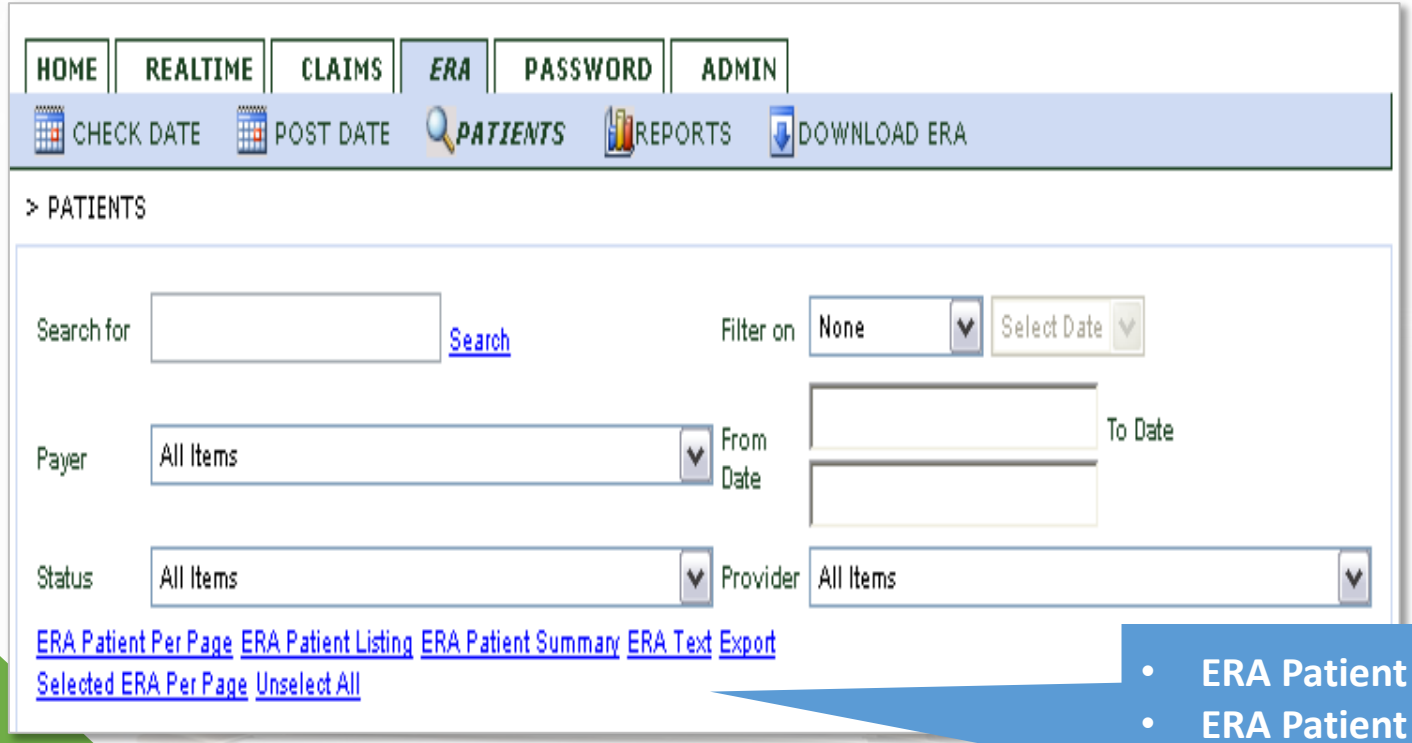
REMITTANCE SUMMARY

	Billed	Allowed	Deduct	Coins	RC-Amt	PLB Adj	Paid
Totals	145.00	70.12	.00	.00	131.14	.00	13.86

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

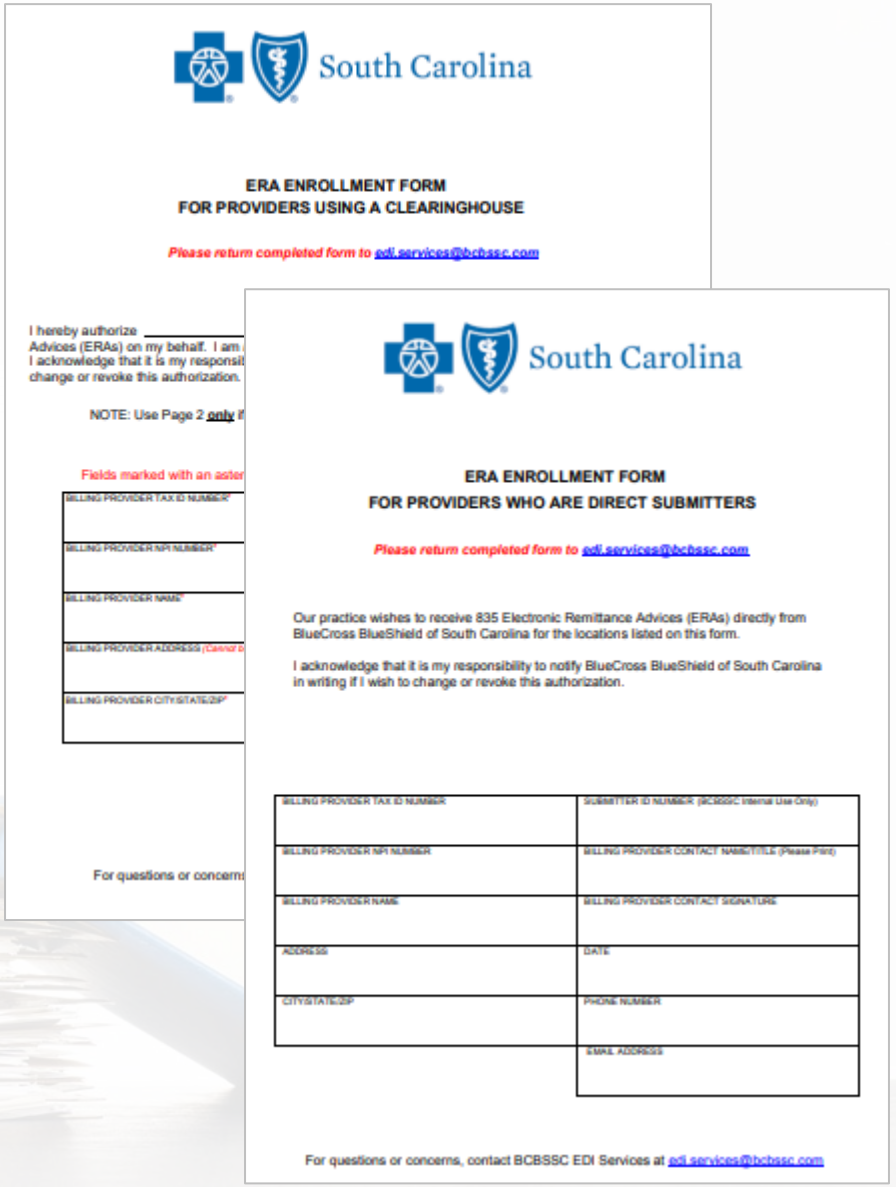
Electronic Remittance Advice (ERA)

How to Receive ERAs

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

  Providers>Provider Enrollment>Electronic Funds Transfer 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
I acknowledge that it is my responsibi
change or revoke this authorization.

NOTE: Use Page 2 only if

Fields marked with an aster

BILLING PROVIDER TAX ID NUMBER*
BILLING PROVIDER NPI NUMBER*
BILLING PROVIDER NAME*
BILLING PROVIDER ADDRESS (Cannot b
BILLING PROVIDER CITY/STATE/ZIP*

For questions or concerns

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

Thank you!