



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

Independent licensees of the Blue Cross Blue Shield Association.

Prior Authorization

Frequently Asked Questions

1. What is a dollar threshold for durable medical equipment (DME)?

Prior authorization requirements for DME can vary per plan. For this reason, it is important to verify eligibility and benefits.

2. How can I check authorization requirements for out-of-state members?

To check authorization requirements for out-of-state members, you can use the BlueCard® Prior Authorization Lookup Tool located on www.SouthCarolinaBlues.com or by calling the BlueCard® eligibility line at 800-676-BLUE (2583).

3. What methods can be used to obtain prior authorization?

Authorization requests can be submitted through My Insurance Manager. After selecting the appropriate option, you will be routed to the Cohere Health platform to initiate the request. Note: Cohere Health is just the platform used for requesting authorization. All clinical decisions are made by the health plan.

4. What information is required when requesting prior authorization?

When requesting prior authorization, the following information should be included:

- Patient details – Name, ID Number, and Date of Birth
- Service details – CPT/HCPCs codes with correct units, diagnosis codes, and MD orders
- Location details – Name of facility and rendering physician, address, and Tax ID/NPI
- Contact details – Call back number and fax number
- Date of service
- Clinical documentation – Including how long the problem has been occurring, attempted treatments, conservative medications, studies (e.g., labs, imaging, assessments, etc.

5. What are the guidelines for authorizations?

The general guidelines for authorizations include:

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

6. What can I do if an authorization request is denied?

If an authorization is denied, you can request an appeal or a peer-to-peer review. Peer-to-peer reviews are available if:

- A 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 days for all other denials
- Requested prior to an appeal

7. What partners or organizations are used for authorizations?

Partners or organizations that manage authorization for certain benefits and plans include:

- Evolent
- Avalon Healthcare Solutions
- OptumRx (MBMNow)
- HealthHelp
- Companion Benefit Alternatives (CBA)