MAINTAINING THE CONNECTION

2022 Annual Provider Summit

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

Independent licensees of the Blue Cross and Blue Shield Association

Welcome and Introductions

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.

Welcome and Introductions

Provider Education & Relations — Management Team

Brian Butler, AVP

Shay Looker, Director

Tammy Betts, Manager

Welcome and Introductions

Provider Education & Relations — External Team

Annette Scott

Antoinette Jenkins

Donna Thompson

Fancy Crayton

Jasmin Lee

Ke-Onna Davis

Rikkia Kohn

Tammy Jones

Tracy Brown

Thomas Ingram

Welcome and Introductions

Provider Education & Relations — Internal Team

Cynthia Brown

Donese Pinckney

Michaelia Johnson

Terrence Archie

Provider Education Territory Map

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Tom Ingram
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Jasmin Lee
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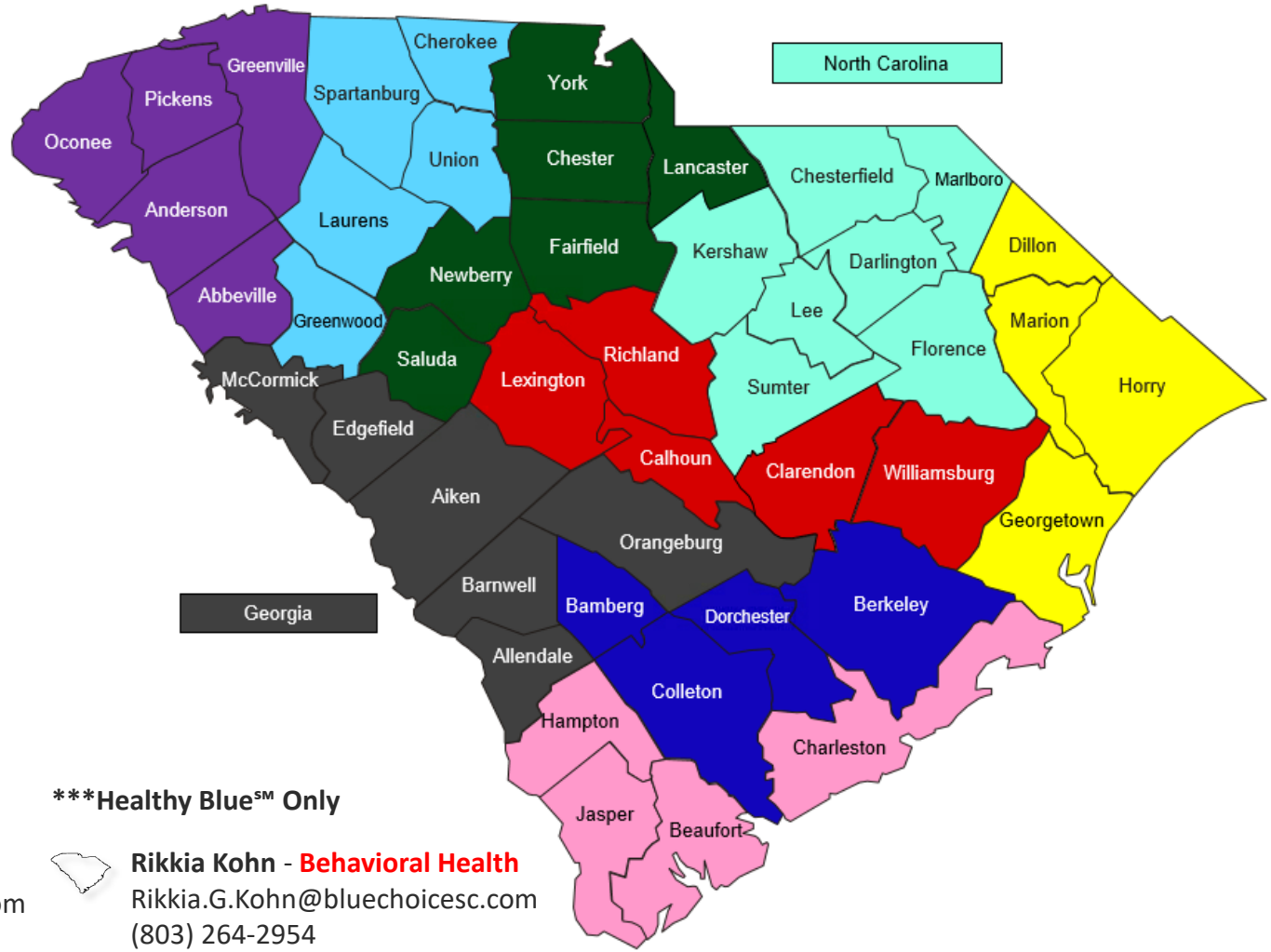
(803) 264-3941



***Healthy Blue℠ Only

Rikkia Kohn - **Behavioral Health**
Rikkia.G.Kohn@bluechoicesc.com
(803) 264-2954

Fancy Crayton - **CIMS/FQHCs**
Fancy.Crayton@bluechoicesc.com
(803) 264-3196

Topics

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

AUTHORIZATIONS

Agenda

- Authorizations 101
- Authorization Tools
- Special Programs
- What's New?
- Resources

Authorizations 101

Authorization 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:

- 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.*

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

Authorizations 101

General Guidelines for Authorizations

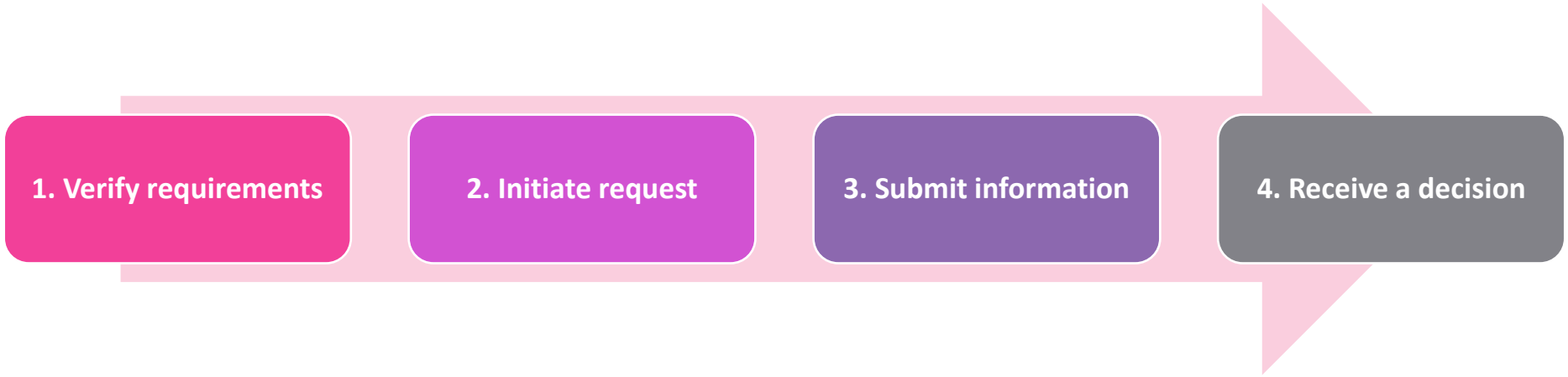
- Submit non-emergent requests prior to rendering services
- Submit emergency requests within 24 hours or the next business day
- Mark requests as urgent **ONLY** when it is urgent

Things to Keep in Mind

- 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

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

Note: All methods listed are for South Carolina members.

Authorizations 101

Required Information for Authorizations

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

Authorizations 101

Commonly Requested Authorizations

- Breast reductions
  - Clinicals should include height, weight, BMI and the number of grams to be removed
- Hysterectomies
  - Clinicals should include recent imaging and conservative measures (or why they were not done)
- Home health
  - Clinicals should include home health visit notes and homebound status
- Surgeries
  - Clinicals should include attempted conservative therapies

Authorization Tools

Authorization Tools

My Insurance Manager℠ (MIM)

There are two options for obtaining authorizations through MIM:

Fast-Track	• Hundreds of available options • Automated authorization number
Custom Request	• Allows specific details to be entered • Authorization will pend for review; if approved, authorization number is provided

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

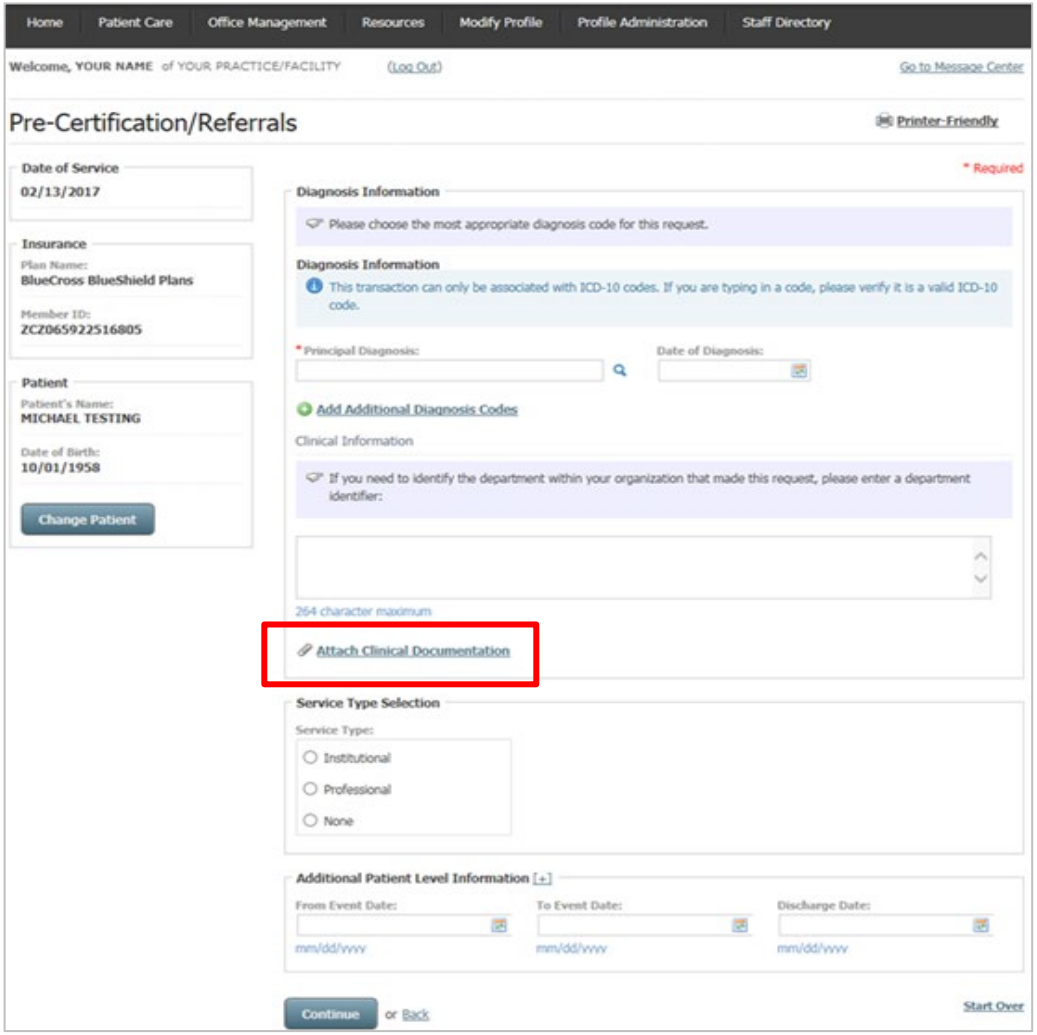
Authorization Tools

My Insurance Manager℠ (MIM)

Clinical Attachments

- Click 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.



Authorization Tools

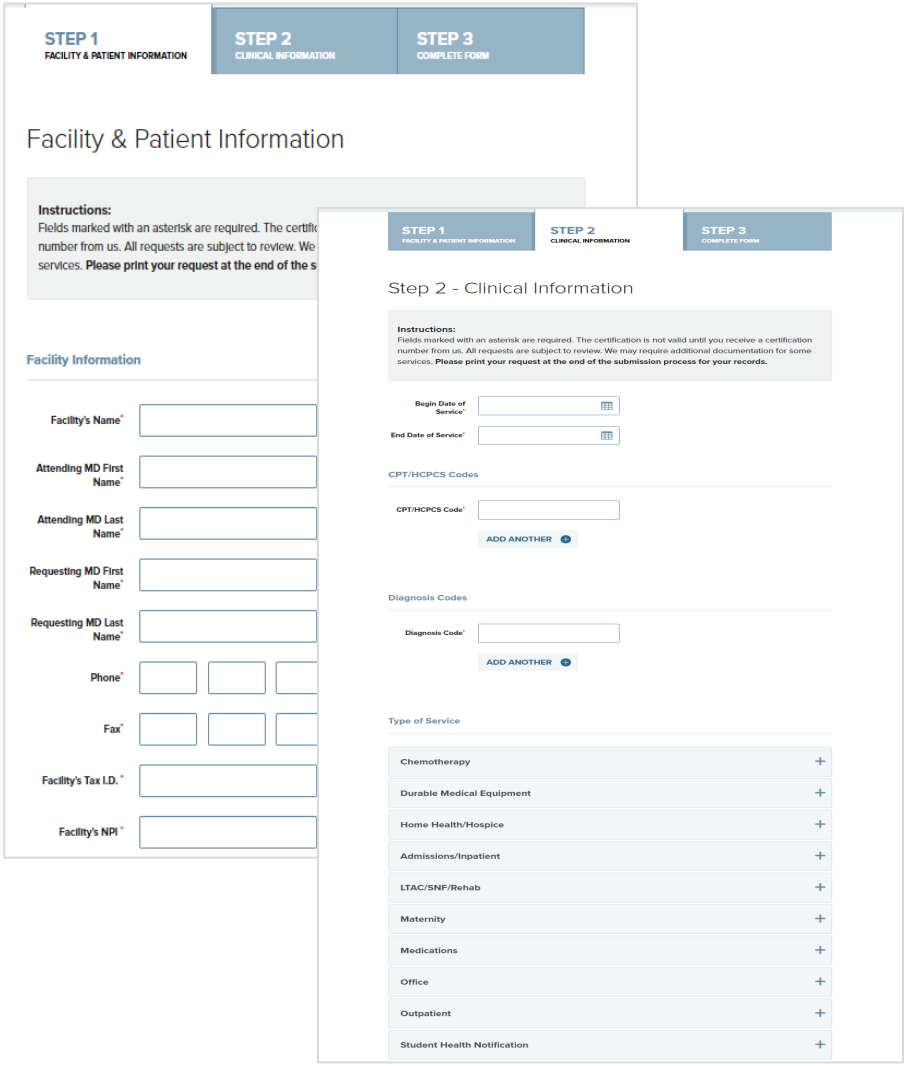
Medical Forms Resource Center

Complete requests in three easy steps:

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

Benefits of Using the MFRC

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



Authorization 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:

Authorization Tools

Fax Requests

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

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

To access this information:

Visit www.SouthCarolinaBlues.com and follow the path:

Providers>Prior Authorization>Precertification Request Form

For Mailing Images:

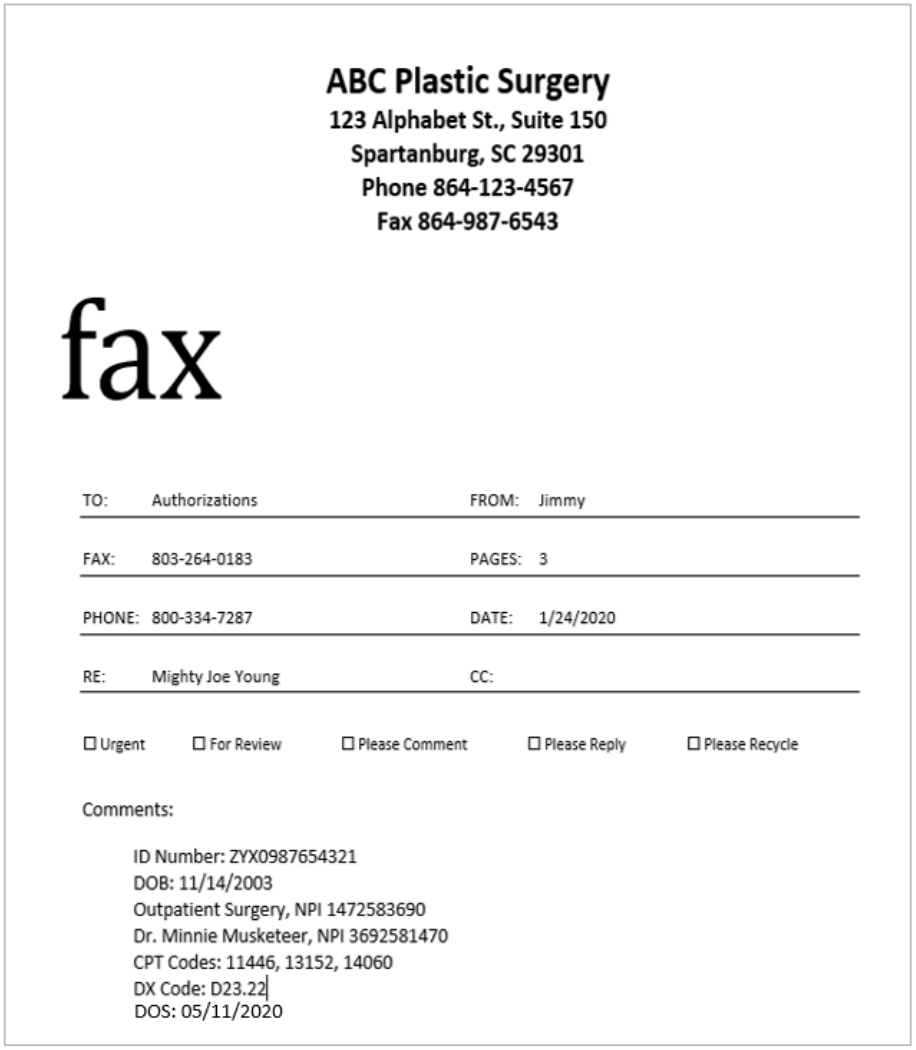
Focus Review/Health Care Services
I-20 @ Alpine Rd., AX-630
Columbia, SC 29219-0001

Authorization Tools

Fax Requests

Appropriate Fax Request Coversheet

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



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

fax

TO:	Authorizations	FROM:	Jimmy
FAX:	803-264-0183	PAGES:	3
PHONE:	800-334-7287	DATE:	1/24/2020
RE:	Mighty Joe Young	CC:	

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

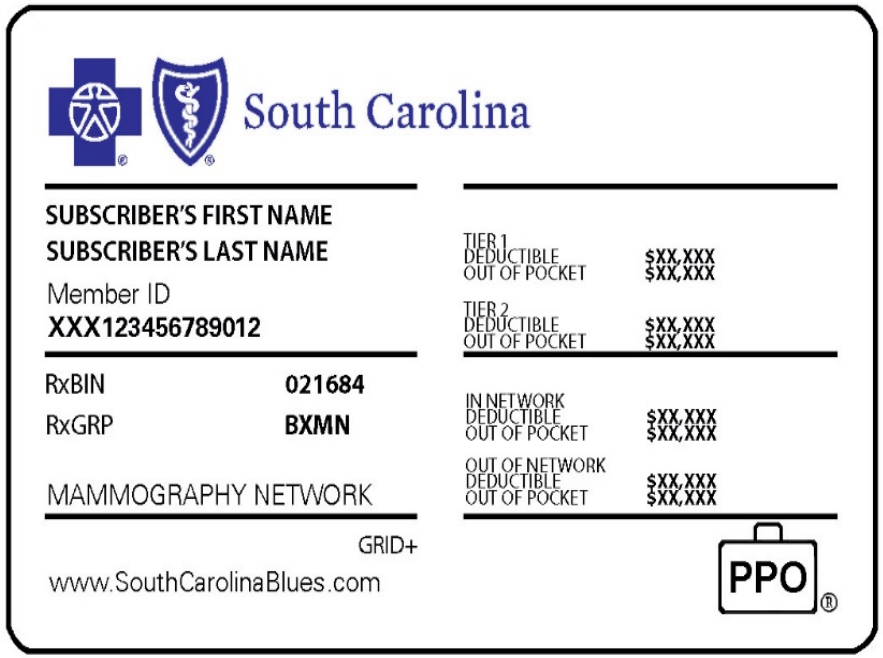
Comments:

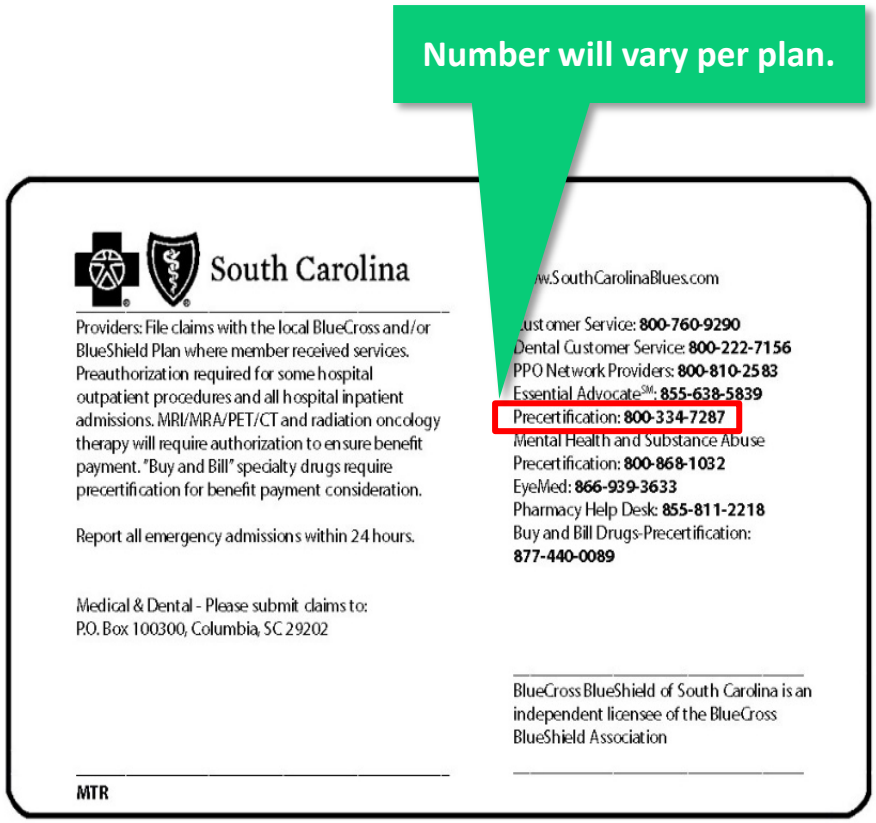
ID Number: ZYX0987654321
DOB: 11/14/2003
Outpatient Surgery, NPI 1472583690
Dr. Minnie Musketeer, NPI 3692581470
CPT Codes: 11446, 13152, 14060
DX Code: D23.22
DOS: 05/11/2020

Authorization Tools

Phone Requests

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



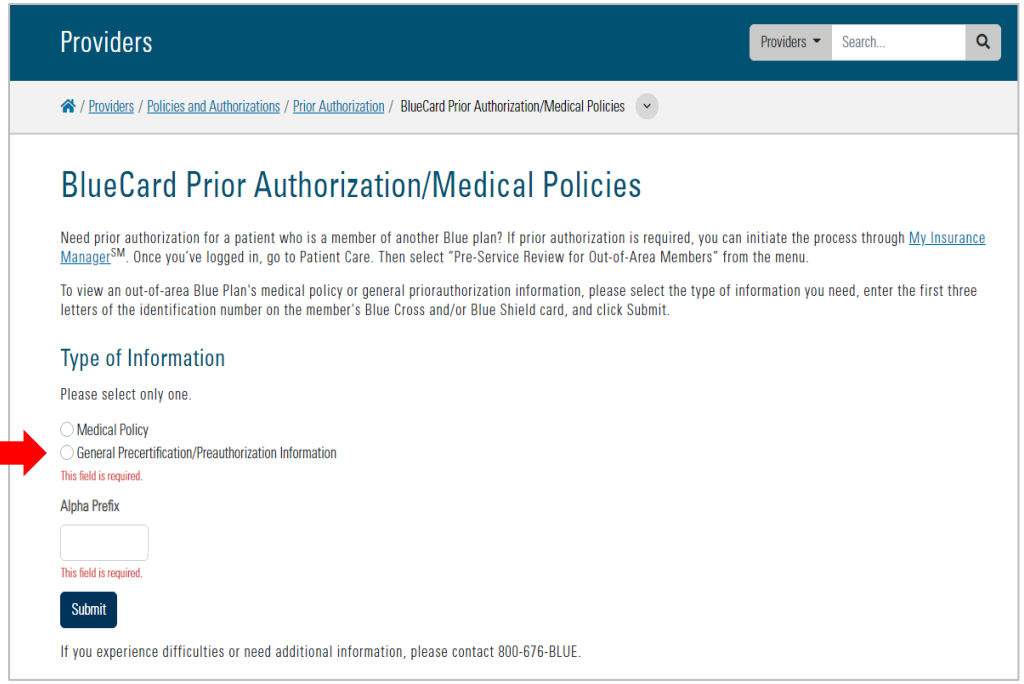


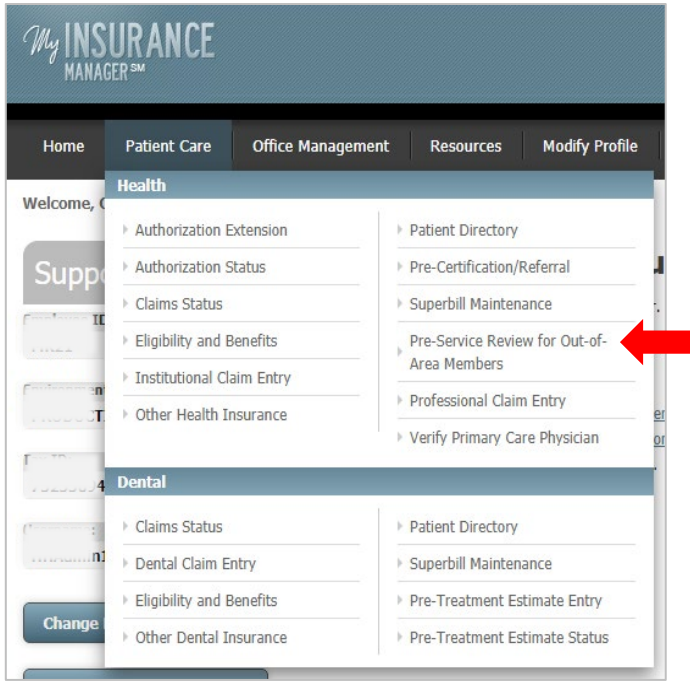
Authorization Tools

BlueCard® Prior Authorization Lookup

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

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





Special Programs

Special Programs

Third-party vendors that manage authorizations for certain benefits include:

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

Note: These are independent organizations that provide prior authorization administration on behalf of BlueCross and BlueChoice.

Special Programs

NIA Magellan

Types of authorization for most plans:

- Nuclear cardiology
- 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:

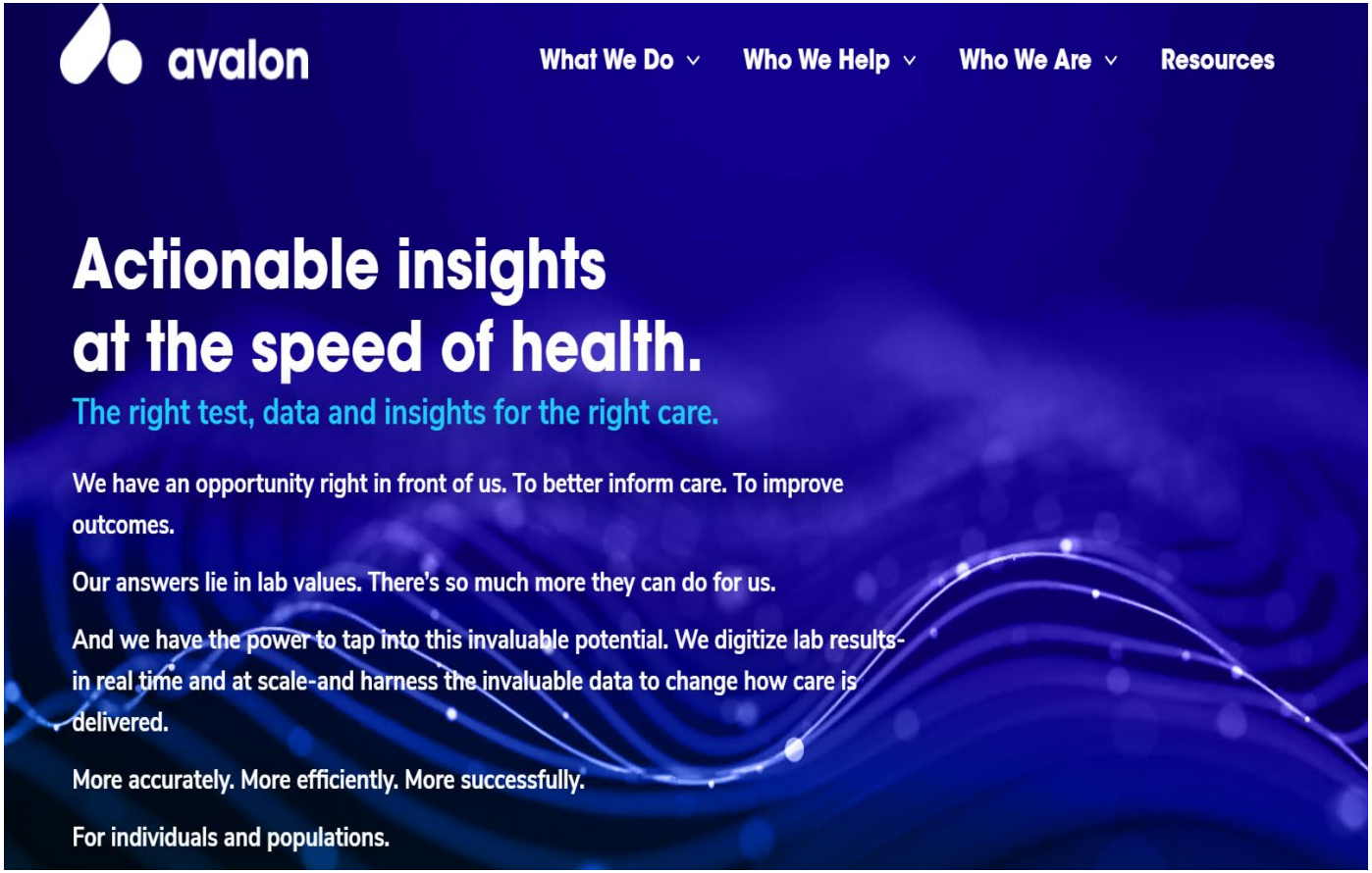
- Office
- Outpatient facility
- Independent laboratory

To request an authorization:

- Prior Authorization System (PAS) through My Insurance Manager℠
- Phone: 844-227-5769
- Fax: 888-791-2181

Special Programs

Avalon – The Evolution of Lab Oversight



www.avalonhcs.com

Special Programs

Avalon — In the News

Featuring Dr. Jason Bush

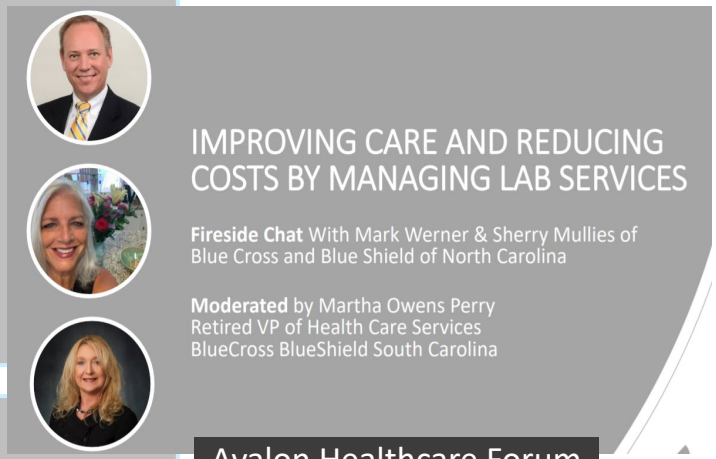
Media Coverage

Interviews with Dr. Rahul Singal:

- 360Dx
- Laboratory Economics

Other Coverage:

- Modern Healthcare
- Kaiser Health News
- Benefits Pro



Press Release Pickup

- AHIP
- Citi Group Research
- Fierce Health

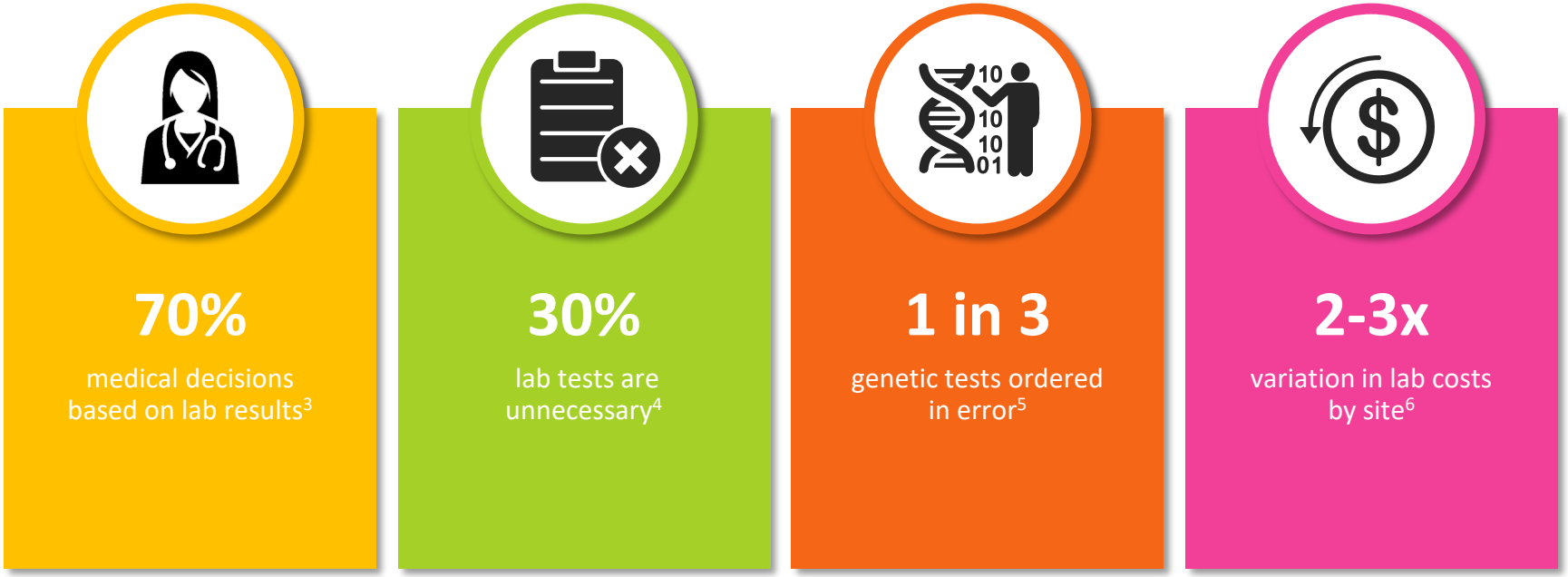
Avalon Healthcare Forum

Click Resources
www.avalonhcs.com

Follow us https://www.linkedin.com/company/avalon-healthcare-solutions/mycompany/

Special Programs

Avalon — Unrecognized Power and Exposure of Lab Testing

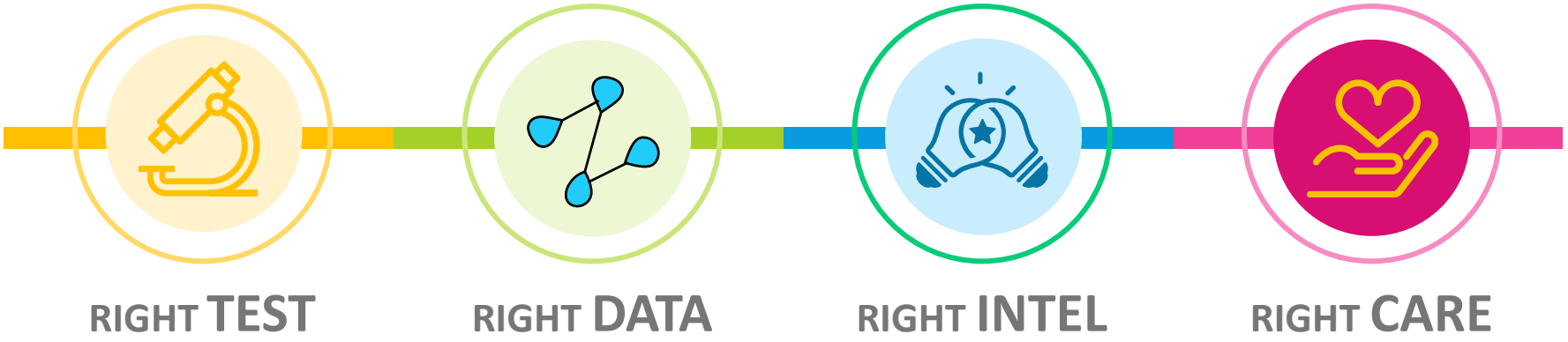


1. https://www.aacc.org/health-and-science-policy/aacc-policy-reports/2015/laboratory-medicine-advancing-quality-in-patient-care
2. U.S. Clinical Laboratory Industry Forecast & Trends 2018-2020, www.laboratoryeconomics.com
3. Forsman, RW. Why is the laboratory an afterthought for managed care organizations? Clin Chem 1996;42:813–6
4. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0078962
5. The Landscape of Inappropriate Laboratory Testing: A 15-Year Meta-Analysis
   Zhi M, Ding EL, Theisen-Toupal J, Whelan J, Arnaout R (2013) The Landscape of Inappropriate Laboratory Testing: A 15-Year Meta-Analysis. PLOS ONE 8(11): e78962. https://doi.org/10.1371/journal.pone.0078962
6. Shrank WH, Rogstad TL, Parekh N. Waste in the US Health Care System: Estimated Costs and Potential for Savings. JAMA. 2019

Special Programs

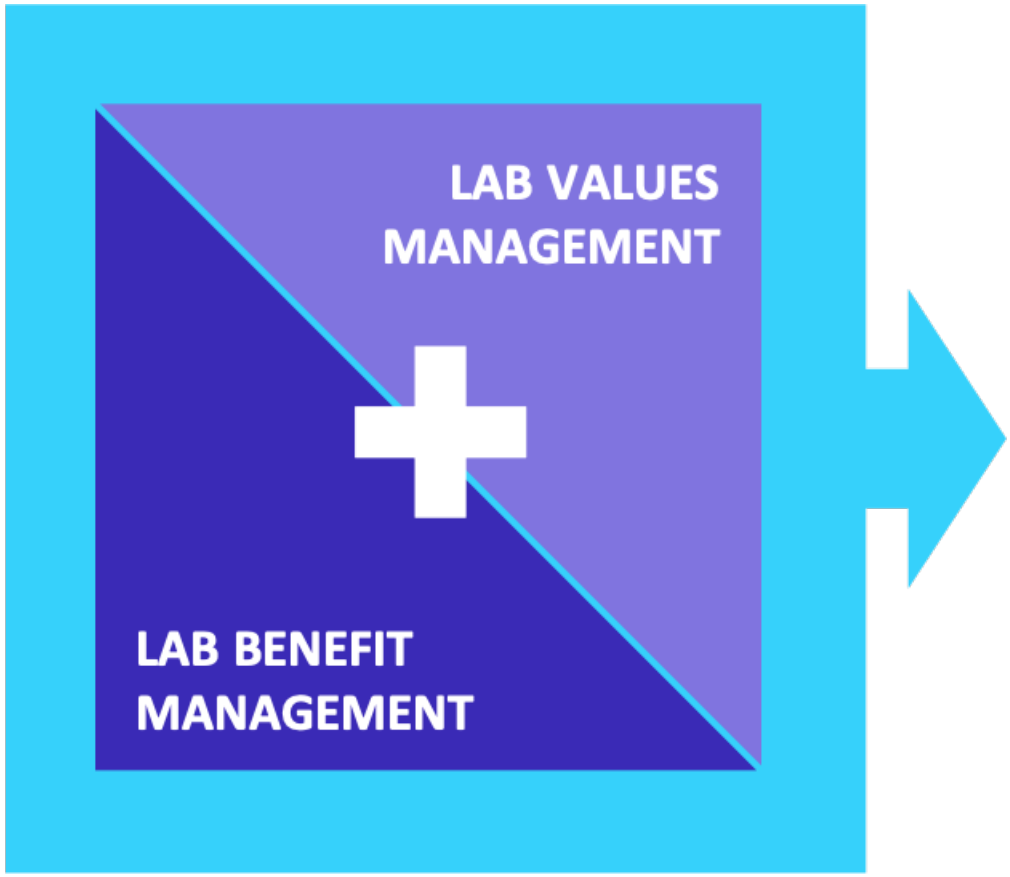
Avalon — Lab Insights System

Critical Insights at Each Step to Deliver Value-Driven Care



Special Programs

Avalon — Expansion into Lab Values Management



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

MBMNow

- Authorizations for specialty medications
- Medication lists are available online

To request an authorization:

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

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	844-227-5769	888-791-2181
CBA	Behavioral/Substance Abuse	www.CompanionBenefitAlternatives.com	800-868-1032	803-714-6456
NIA Magellan	• Advanced Radiology • Musculoskeletal Care • Nuclear Cardiology • 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)**
• Visit www.FormsResource.Center • Select Request a Peer-to-Peer Discussion • Enter all pertinent details • Submit	• Visit www.SouthCarolinaBlues.com Providers>Forms>Other Forms>Peer-to-Peer Request • Enter all pertinent details (and save the document) • Email the form to Peer.Medical@bcbssc.com or fax to 803-264-9175	• Call 803-264-8114 Available Monday – Friday 8:30 a.m. – 5 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 (cont'd)

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

What’s New?

What's New?

Utilization Management (UM) Courtesy Reevaluations

UM courtesy reevaluations are permitted for denials that were denied due to the following:

- No clinical information was submitted
- Insufficient clinical information was submitted

To request a UM courtesy review, you must:

- Submit the request via phone or fax (use the number on the member's ID card)
  - Specify the request is for a reevaluation upon submission
  - Submit clinical documentation within five business days of denial notice

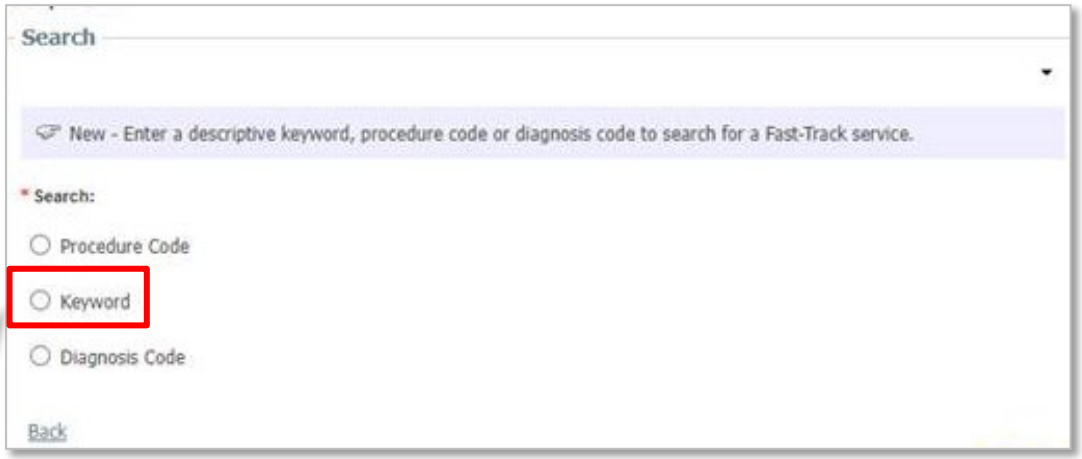
What's New?

Fast-Track Search Function

On Aug. 13, 2021, enhancements were made to the Fast-Track option in My Insurance Manager℠.

Benefits of Enhancements

- Eliminates multiple clicks
- Allows searches by:
  - Keywords
  - CPT/HCPCS codes
  - Diagnosis codes



Latest enhancement.

BENEFITS

Agenda

- 2022 Benefits
- What's New?
- Benefit Reminders
- Resources

2022 Benefits

Preferred Blue®

2022 Benefits

Preferred Blue

New Groups — Effective Jan. 1, 2022

Group Name	Prefixes
JTEKT	• **SJX** – Providers that participate with their local Blue plan • **SGA** – Alternate network for Georgia providers • **STK** – Alternate network for Tennessee providers
Michelin	• **MNV** – Providers that participate with the Southeastern Health Partners (SEHP) network • **MLH** – Providers that participate with the Blue High-Performance network • **MPJ** – Providers that participate with their local Blue plan • **MGN** – Alternate network for Georgia providers • **MDB** – Alternate network for Oklahoma providers

State Health Plan

2022 Benefits

State Health Plan

Standard Plan	2021	2022
Deductibles		
Individual	$490	No change
Family	$980	No change
Coinsurance Maximum		
Individual (INN)	$2,800	No change
Family (INN)	$5,600	No change
Individual (OON)	$5,600	No change
Family (OON)	$11,200	
Services		
Office Visits	$14 Copay	No change
Outpatient Facility	$105 Copay	No change
Emergency Room	$175 Copay	No change
Cardiac and Pulmonary Rehabilitation	$105 Copay	**$14 Copay**

2022 Benefits

State Health Plan

Savings Plan	2021	2022
Deductibles		
Individual	$3,600	No change
Family	$7,200	No change
Coinsurance Maximum		
Individual (INN)	$2,400	No change
Family (INN)	$4,800	No change
Individual (OON)	$4,800	No change
Family (OON)	$9,600	
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

2022 Benefits

State Health Plan

Reminders

- Routine and Diagnostic Colonoscopies
  - Covered at 100% 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%, 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
- PCMH for Standard and HDHP
  - Office visit copay is waived for PCMH in-person visits and subject to a 10% COINS after the deductible is met.
    - PCMH incentives do not apply to telehealth services

2022 Benefits

State Health Plan

Reminders (cont'd)

- Cardiac and Pulmonary Rehabilitation
  - Outpatient copay being reduced from $105 to $14
  - Current CPT/HCPCS codes used for these services include:
    - Cardiac: 93797, 93798
    - Pulmonary: G0237, G0239 and G0424
- Pap Test Office Visit

Effective Jan. 1, 2022, the way liability is calculated on the office visits related to pap tests is changing.

- Member liability will be capped at the allowance of the office visit code filed by the provider when an alternate code allowance is used. This applies to the routine pap office visit only (not well exam).

2022 Benefits

State Health Plan

Always verify benefits and eligibility prior to rendering services.

Use My Insurance Manager℠ (MIM) or call 800-444-4311.

Prior Authorizations

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

Federal Employee Program

2022 Benefits

Federal Employee Program

Blue Focus — No out of network benefits available.	2021	2022
Deductibles		
Individual	$500	No change
Self – Plus One	$1,000	No change
Family	$1,000	No change
Out-of-Pocket Maximum		
Individual	$7,500	**$8,500**
Self – Plus One	$15,000	**$17,000**
Family	$15,000	**$17,000**
Services		
Office Visits (Includes physical, speech and occupational therapy, cognitive therapy, vision services and foot care)	$10 Copay Visits 1-10 (PCP or Specialist)	No change
Telemedicine	$10 Copay per visit	No change
Mental Health and Substance Abuse (Professional Services)	30% COIN + BYD Visits 11+ (PCP or Specialist)	No change

2022 Benefits

Federal Employee Program

Blue Focus — No out of network benefits available.	2021	2022
Services Cont'd		
Urgent Care – Accidental (First 72-hours)	$0 Copay	No change
Urgent Care – Medical	$25 Copay	No change
ER – Accidental (First 72-hours)	$0 Copay	No change
ER – Medical	30% COIN + BYD	No change
Physical, Speech and Occupational Therapy	$25 Copay, 25 visit limit 30% COIN + BYD for drugs/supplies	No change
Cognitive Rehabilitation Therapy	$25 Copay, 25 visit limit	No change
ABA Therapy Disorder/Autism Spectrum	30% COIN + BYD Limited to 200 hours	No change
Continuous Home Hospice Care	No member cost-share	No change
Chiropractic/Osteopathic Care	$25 Copay	No change

Other Changes for 2022:

- Only medical benefits will be allowed for EKGs; they will not be covered under preventive care.

2022 Benefits

Federal Employee Program

Standard	2021	2022
Deductibles		
Individual	$350	No change
Family	$700	No change
Out-of-Pocket Maximum		
Individual (INN)	$5,000	**$6,000**
Family (INN)	$10,000	**$12,000**
Services		
Primary Care	$25 Copay	No change
Telehealth	$0 Copay (Visits 1-2) $10 Copay (Visits 3+)	No change
Telemedicine	$25 Copay (PCP) $35 Copay (Specialist)	No change
Specialist Visit	$35 Copay	No change
Urgent Care	$30 Copay	No change

2022 Benefits

Federal Employee Program

Standard	2021	2022
Services (cont'd)		
Preventive Care	$0 Copay	No change
Accidental Injury (First 72-hours)	$350 Copay Per Admission	No change
Medical Emergency	$350 Copay Per Admission	No change

Other Changes for 2022:

- Only medical benefits will be allowed for EKGs; they will not be covered under preventive care.

2022 Benefits

Federal Employee Program

Basic	2021	2022
Deductibles		
Individual	$0	No change
Family	$0	No change
Out-of-Pocket Maximum		
Individual (INN)	$5,500	**$6,500**
Family (INN)	$11,000	**$13,000**
Services		
Primary Care	$30 Copay	No change
Telehealth	$0 Copay (Visits 1-2) $15 Copay (Visits 3+)	No change
Telemedicine	$30 Copay (PCP) $40 Copay (Specialist)	No change
Specialist Visit	$40 Copay	No change
Urgent Care	$35 Copay	No change

2022 Benefits

Federal Employee Program

Basic	2021	2022
Services (cont'd)		
Preventive Care	$0 Copay	No change
Accidental Injury (First 72-hours)	$175 Copay Per Day, Per Facility	No change
Medical Emergency	$175 Copay Per Day, Per Facility	No change

Other Changes for 2022:

- Only medical benefits will be allowed for EKGs; they will not be covered under preventive care.

2022 Benefits

Federal Employee Program

Blue Focus, Standard and Basic	2021	2022
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% under preventive benefits.
		No change

2022 Benefits

Federal Employee Program

Reminders

Filing Electronic Dental Claims

- Electronic submission effective June 19, 2020
  - Payer ID 00402
  - Sign up through clearinghouse or contact EDI.Services@bcbssc.com

Telehealth Services

- Preventive benefits for telehealth no longer covered
  - Dates of service Oct. 1, 2020 and forward
  - If primary or only diagnosis on the claim is preventive, the claim will deny

BlueChoice® HealthPlan

2022 Benefits

BlueChoice® HealthPlan

Reminders

Frequency Limits

- Please be sure to verify the medical policies pages regarding frequency limits that may apply to certain services (e.g., Thyroid testing, H1c testing, etc.).

Dexcom G6

- The Dexcom G6 glucose monitor may be filed under the member's pharmacy or DME benefit.
  - Authorization is required.
    - For Pharmacy, please contact OptumRx at 855-811-2218.
    - For DME, please contact the number on the back of the member's ID card.

COVID-19

- Claims for the treatment of COVID-19 will be subject to the member's benefit plan.
- Claims for diagnostic testing of COVID-19 will process with no member cost share.

Medicare Advantage

2022 Benefits

Medicare Advantage

BlueCross Total[SM]	2021	2022
Deductibles		
In-network & Out-of-network	$0	No change
Out-of-Pocket Maximum		
From in-network providers:	$6,900	**$6,500**
From in-network & out-of-network providers combined	$10,000	No change
Services		
Outpatient office visits	INN - $10 Copay (PCP) INN - $45 Copay (Specialist) OON - $30 Copay (PCP) OON - $55 Copay (Specialist)	**INN - $5 Copay (PCP)** INN - No Change (Specialist) OON - No change (PCP) OON - No change (Specialist)
Inpatient Hospital — Acute	INN - $450 Copay, per day (1-4) INN - $0 Copay (5-90) OON - 30% COINS for total stay	**INN - $420 Copay, per day (1-4)** OON - No change
Inpatient Hospital — Psychiatric	INN - $465 Copay, per day (1-4) INN - $0 Copay (5-90) OON - 30% COINS for total stay	No change

2022 Benefits

Medicare Advantage

BlueCross Total	2021	2022
Services (cont'd)		
Skilled Nursing Facility (SNF)	INN - $0 (Days 1-20) INN - $184 Copay (Days 21-100) OON - 30% COINS for total stay	No change
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 $25,000 benefit period maximum
Ambulance Services	INN & OON - $295 per trip (Ground) INN & OON - 20% COINS (Air)	**INN & OON - $295 per trip (Ground or Air)**
Hearing Aids	$699-$999 using TruHearing 2 per year (one per ear)	No change
Preventive Dental	Fluoride treatment not covered	**INN - $0 Copay (2, per year)** **OON - 50% COINS** Fluoride treatment not covered
Comprehensive Dental	N/A	**INN & OON - 50% COINS** **$1,000 benefit maximum**

2022 Benefits

Medicare Advantage

BlueCross Total Value℠	2021	2022
Deductibles		
In-network & Out-of-network	$0	No change
Out-of-Pocket Maximum		
In-network	$7,500	**$6,900**
Out-of-network	$11,300	No change
Services		
Outpatient Office Visits	INN - $15 Copay (PCP) INN - $50 Copay (Specialist) OON - $40 Copay (PCP) OON - $55 Copay (Specialist)	**INN - $0 Copay (PCP)** **INN - $40 Copay (Specialist)** OON - No change (PCP) OON - No change (Specialist)
Inpatient Hospital — Acute	INN - $495 Copay, per day (1-4) INN - $0 Copay (5-90) OON - 40% COINS for total stay	**INN - $450 Copay, per day (1-4)** OON - No change
Inpatient Hospital — Psychiatric	INN - $620 Copay, per day (1-4) INN - $0 Copay (5-90) OON - 50% COINS for total stay	No change

2022 Benefits

Medicare Advantage

BlueCross Total	2021	2022
Services (cont'd)		
Skilled Nursing Facility (SNF)	INN - $0 (Days 1-20) INN - $184 Copay (Days 21-100) OON - 40% COINS for total stay	INN - No change (Days 1-20) **INN - $188 Copay (Days 21-100)** OON - No change
Urgently Needed Services	INN & OON - $65 Copay, per visit	**INN & OON - $0-$50 Copay**
Worldwide Emergency/Urgent Coverage	$250 service specific deductible, then 20% COINS for emergency care outside the United States	No change for emergency services **$0 Copay for urgent care services** $25,000 benefit period maximum
Ambulance Services	INN & OON - $310 per trip (Ground) INN & OON - 20% COINS (Air)	**INN & OON - $275 per trip (Ground or Air)**
Hearing Aids	$699-$999 using TruHearing 2 per year (one per ear)	No change
Preventive Dental	INN - $0 Copay OON - 50% COINS	No change
Comprehensive Dental	N/A	**INN & OON - 50% COINS** **$500 benefit maximum**

2022 Benefits

Medicare Advantage

BlueCross Secure℠ — No out of network benefits.	2021	2022
Deductibles		
In-network	$0	No change
Out-of-Pocket Maximum		
In-network	$6,700	**$6,500**
Services		
Outpatient Office Visits	INN - $15 Copay (PCP) INN - $40 Copay (Specialist)	**INN - $5 Copay (PCP)** INN - No change (Specialist)
Inpatient Hospital — Acute	INN - $425 Copay, per day (1-4) INN - $0 Copay (5-90)	No change
Inpatient Hospital — Psychiatric	INN - $425 Copay, per day (1-4) INN - $0 Copay (5-90)	**INN - $415 Copay, per day (1-4)**
Skilled Nursing Facility (SNF)	INN - $0 Copay (Days 1-20) INN - $172 Copay (Days 21-100)	INN - No change (Days 1-20) **INN - $188 Copay (Days 21-100)**
Urgently Needed Services	INN - $40 Copay, per visit	No change

2022 Benefits

Medicare Advantage

BlueCross Secure – No out of network benefits.	2021	2022
Services (cont'd)		
Worldwide Emergency/Urgent Coverage	$250 service specific deductible, then 20% COINS for emergency care outside the United States	No change $25,000 benefit period maximum
Ambulance Services	INN - $265 per trip (Ground) INN - 20% COINS (Air)	**INN - $275 per trip (Ground or Air)**
Hearing Aids	$699-$999 using TruHearing 2 per year (one per ear)	No change
Preventive Dental	INN - $50 Copay (For Medicare-covered services)	No change

2022 Benefits

Medicare Advantage

BlueCross Blue Basic℠	2022
Deductibles	
In-network & Out-of-network	**$0**
Out-of-Pocket Maximum	
From in-network providers	**$4,900**
From in-network & out-of-network providers combined	**$10,000**
Services	
Outpatient Office Visits	**INN - $0 Copay (PCP)** **INN - $35 Copay (Specialist)** **OON - $30 Copay (PCP)** **OON - $45 Copay (Specialist)**
Inpatient Hospital — Acute	**INN - $325 Copay, per day (1-6); $0 Copay (7-90)** **OON - 30% COINS for total stay**
Inpatient Hospital — Psychiatric	**INN - $620 Copay, per day (1-3)** **OON - 30% COINS for total stay**

2022 Benefits

Medicare Advantage

BlueCross Blue Basic	2022
Services (cont'd)	
Skilled Nursing Facility (SNF)	**INN - $0 Copay (Days 1-20)** **INN - $188 Copay (Days 21-100)** **OON - 30% COINS for total stay**
Urgently Needed Services	**INN & OON - $0-$40 Copay**
Worldwide Emergency/Urgent Coverage	• **$250 service specific deductible, then 20% COINS for emergency care outside the United States.** • **$0 Copay for urgent care outside the United States** • **$25,000 benefit period maximum**
Ambulance Services	**INN & OON - $275 per trip (Ground or Air)**
Hearing Aids	**The copay range ($699-$999) is based on different types and styles of hearing aids. The lower range is for the Advanced hearing aid type and the higher range is for the Premium hearing aid type.** ***Premium hearing aids are available in rechargeable style options (for an additional $50 per aid). Member must use TruHearing provider for this benefit.***

2022 Benefits

Medicare Advantage

BlueCross Blue Basic	2022
Services (cont'd)	
Preventive Dental	**INN - $0 Copay (2 preventive visits)** **OON - 50% COINS** **Fluoride treatment not covered.**
Comprehensive Dental	**INN & OON - 50% COINS** **$750 benefit maximum**

2022 Benefits

Medicare Advantage

All Plans (Total, Total Value, Secure & Blue Basic)	**2022**
Services	
Annual wellness visit	**$0 Copay**
Annual physical	**$0 Copay**
Preventive screenings: • Colorectal cancer screening • Breast cancer screening • Bone mineral density tests	**$0 Copay**
Silver&Fit® physical fitness programs and home workout DVDs	**$0 Copay**
Other • Medline OTC (excludes Total Value PPO plan) • Meal Program post hospital discharge (excludes Total Value PPO and Blue Basic PPO plans)	**$40 per quarter, $160 maximum per year** **$0 Copay for 10 meals**

2022 Benefits

Medicare Advantage

Authorization Updates

Effective **Jan. 1, 2022**, the following services require prior authorization:

- Medications covered under Medicare Part B — including, but not limited to visco-supplementation for knee osteoarthritis (hyaluronan), monoclonal antibody treatments and other biologicals for multiple sclerosis, rheumatoid arthritis, psoriasis, inflammatory bowel disease or chronic migraines.
- Continuous glucose monitors — including, but not limited to the Dexcom and Freestyle Libre systems.
- Powered mobility — including, but not limited to electric wheelchairs and scooters.
- Durable medical dquipment (DME) — including, but not limited to prosthetics, orthotics, braces and walkers in the amount of $250 or more

2022 Benefits

Medicare Advantage

Authorization Updates (cont'd)

- Facility-based polysomnography — unsupervised home studies are preferred unless there are specific complicating factors requiring sleep lab monitoring.
- Bariatric surgery
- Inpatient level of care for non-emergency surgery
- Life Vest — external cardiac defibrillators

Visit the Medicare Advantage section of www.SouthCarolinaBlues.com for a listing of the medication and CPT/HCPCs codes.

2022 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
- 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
- Know whether you're in the BlueCross Total PPO network or the BlueCross Secure HMO network

2022 Benefits

Medicare Advantage

Network Sharing

- Allows Medicare Advantage (MA) PPO members from other Blue Plans to get in-network benefits
- Available in 39 states 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 BlueCross BlueShield members, regardless of state, to BlueCross Blue Shield 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.

2022 Benefits

Medicare Advantage

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)

National Alliance Group

2022 Benefits

Publix

Prefixes — PBB, PWA and PXN	2021	2022
Deductibles		
In-network	Individual - $450 Family - $1,350	**Individual - $500** **Family - $1,500**
Out-of-network	Individual - $900 Family - $2,700	**Individual - $1,000** **Family - $3,000**
Out-of-Pocket Maximum		
In-network	Individual - $3,500 Family - $7,000	No change
Out-of-network	Individual - $7,000 Family - $14,000	No change
Services		
Office visits	INN - $25 Copay (PCP) INN - $50 Copay (Specialist) OON - 40% COINS	No change
Breast Pumps	INN & OON - Covered at 100% Lifetime maximum of $200	No change

2022 Benefits

Publix

Prefixes — PBB, PWA and PXN	2021	2022
Services cont'd		
Inpatient Hospital	INN - $50 Copay, per day (1-5) and 20% COINS OON - $100 Copay, per day (1-5) and 40% COINS	No change
Outpatient Hospital	INN - 20% COINS OON - 40% COINS	No change

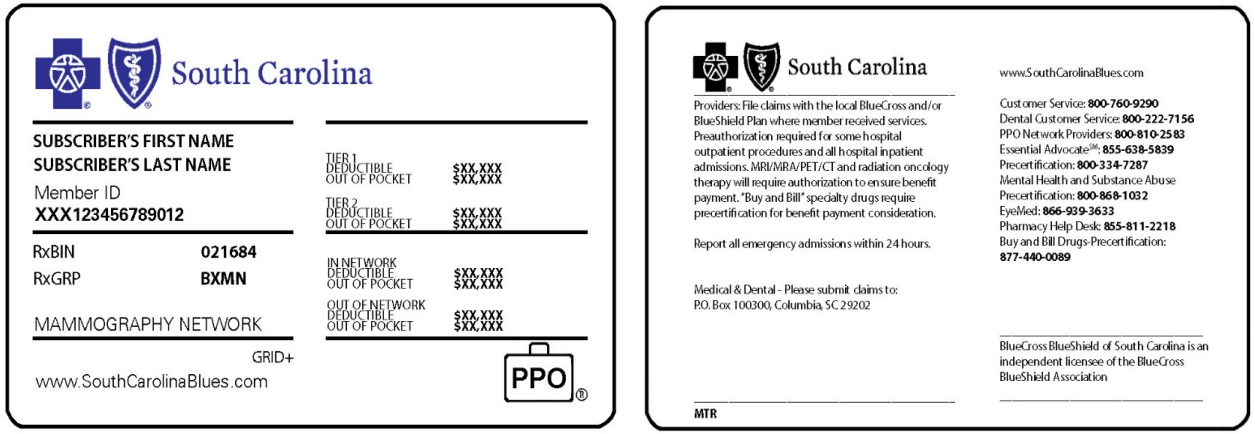
What’s New?

New Implementations

Updated Insurance Cards

- Effective Jan. 1, 2022, BlueCross will issue updated ID cards to members
  - Existing members will not receive a new card.
- New cards will include in and out-of-network deductibles and out-of-pocket maximums
- All members can access their updated cards via My Health Toolkit®

Sample



Note: Refer to the 2022 Member ID Card Guide for more details.

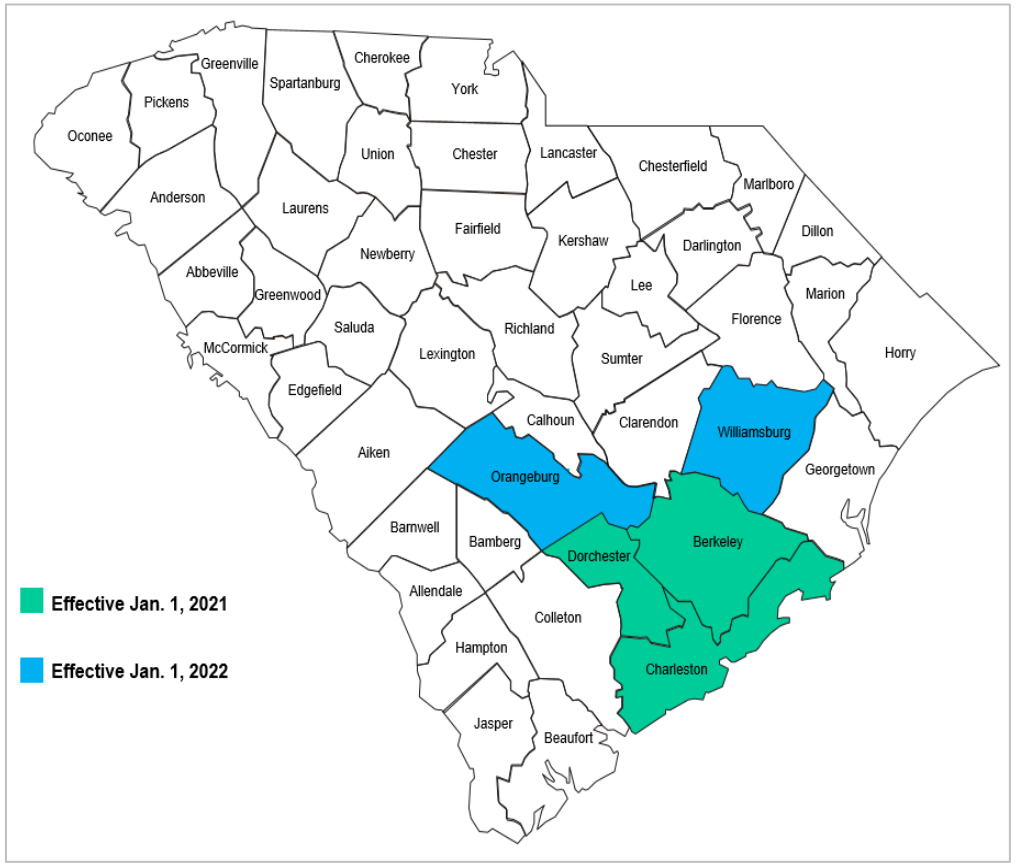
New Implementations

BlueExclusive Cooper[SM] Network

Effective Jan. 1, 2022, Orangeburg and Williamsburg will be added to the BlueExclusive Cooper network.

For the Cooper Network:

- Only MUSC Health Alliance providers are in the Cooper Lowcountry Network
- Members must visit any hospital or doctor in the MUSC Health Alliance Network



Note: 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.

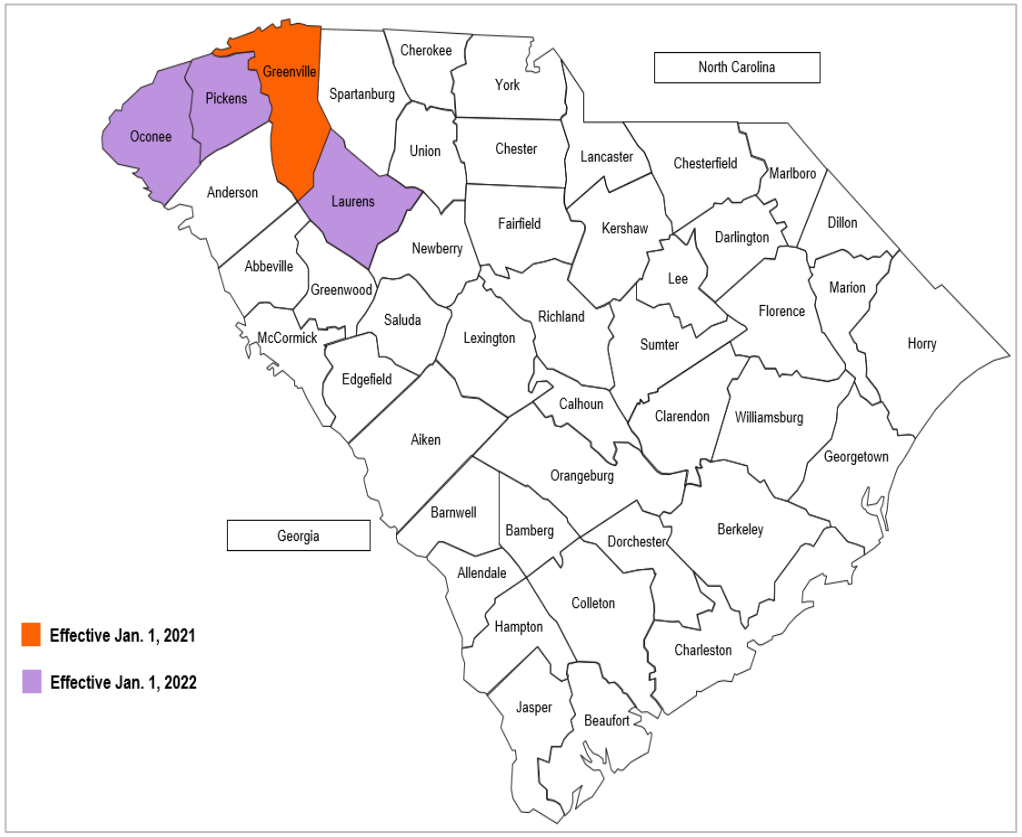
New Implementations

BlueExclusive Reedy℠ Network

Effective Jan. 1, 2022, Laurens, Oconee and Pickens will be added to the BlueExclusive Reedy network.

For the Reedy Network:

- Only Prisma Health Upstate providers are in the Reedy Upstate Network
- Members must visit any hospital or doctor in the Reedy Upstate Network



Note: 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.

New Implementations

Southeastern Health Partners (SEHP) Network

Effective Jan. 1, 2022, Michelin will be joining BlueCross BlueShield of South Carolina with the option of selecting the Southeastern Health Partners (SEHP) plan. This network will consist of the following large hospital systems and their owned/affiliated participating practices:

- Bon Secours St. Francis
- AnMed Health/AnMed Cannon
- Spartanburg Regional
- Self Regional
- Lexington Medical Center

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

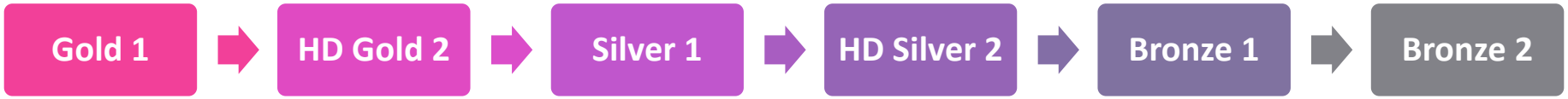
New Implementations

BlueExtend℠ Health Plans

BlueCross BlueShield of South Carolina now offers a new set of health plans called BlueExtend℠.

- Extension of the BlueEssentials℠ plans
  - Members have access to the BlueCard® Program
    - Traditional BlueEssentials plans do not offer out-of-state benefits.
- Alpha prefix for these members will be **BXZ**

Available Plans



To locate providers, members can visit: www.SouthCarolinaBlues.com/links/providers/BlueExtend.

Note: Out-of-network benefits are not available, unless for emergent or urgent care.

New Implementations

BlueExtend℠ Plans	Gold 1	HD Gold 2*	Silver 1
Deductibles			
Individual	$0	$2,600	$4,000
Family	$0	$5,200	$8,000
Coinsurance			
	50%	0%	35%
Out-of-Pocket Maximum			
Individual	$5,000	$2,600	$8,000
Family	$10,000	$5,200	$16,000
Services			
Primary Care	50% COINS + BYD	0% COINS + BYD	$30 Copay
Blue CareOnDemand℠	50% COINS + BYD	0% COINS + BYD	$20 Copay
Specialist Visit	50% COINS + BYD	0% COINS + BYD	$65 Copay
Urgent Care	50% COINS + BYD	0% COINS + BYD	$65 Copay
Emergency Room	50% COINS + BYD	0% COINS + BYD	$500 Copay 35% COINS + BYD
Inpatient Hospital	50% COINS + BYD	0% COINS + BYD	35% COINS + BYD
Ambulatory Surgery Center	50% COINS + BYD	0% COINS + BYD	$525 Copay

New Implementations

BlueExtend℠ Plans	HD Silver 2	Bronze 1	Bronze 2
Deductibles			
Individual	$6,100	$4,500	$8,700
Family	$12,200	$9,000	$17,400
Coinsurance			
	0%	50%	0%
Out-of-Pocket Maximum			
Individual	$6,100	$8,700	$8,700
Family	$12,200	$17,400	$17,400
Services			
Primary Care	0% COINS + BYD	$60 Copay	0% COINS + BYD
Blue CareOnDemand	0% COINS + BYD	$20 Copay	0% COINS + BYD
Specialist Visit	0% COINS + BYD	$90 Copay	0% COINS + BYD
Urgent Care	0% COINS + BYD	$90 Copay	0% COINS + BYD
Emergency Room	0% COINS + BYD	$800 Copay 50% COINS + BYD	0% COINS + BYD
Inpatient Hospital	0% COINS + BYD	$1,500 up to 4 days (max $6,000 per stay)	0% COINS + BYD
Ambulatory Surgery Center	0% COINS + BYD	$525 Copay	0% COINS + BYD

New Implementations

BlueExtend℠ Health Plans

All BlueExtend℠ plans provide the following preventive services at **no cost** for members:

- Mammograms
- Prostate screenings (PSA) and lab work (in accordance with the American Cancer Society)
- Contraceptive devices
- Wellness exams
- Immunizations
- Flu shots

All BlueExtend℠ plans also include vision benefits for members ages 18 or younger, with low copays on exams, discount on lenses, frames and contacts.

- $25 Copay — Exams (one per benefit period)
- $50 Copay — Lenses and frames (once per benefit period)

New Implementations

BlueExtend℠ Health Plans

Benefits not covered include:

- Nonemergency services received from an out-of-network provider or hospital.
- Hospital or skilled nursing facility charges when authorization is not obtained.
- Services and supplies not medically necessary, investigational or experimental in nature, not needed for the diagnosis or treatment or not specifically listed in covered services.
- Any service or supply provided by a member of the patient's family or by the patient, including drugs.
- Charges for a missed appointment of for filling out claim forms.
- Services or supplies related to chewing or biting problems, pain in the face, jaw or neck resulting from problems of the jaw, also known as temporomandibular joint disorders (TMJ)
- Any services or benefits not specifically covered under the terms of the policy.

New Implementations

BlueExtend℠ Health Plans

Benefits not covered include (cont'd):

- Cosmetic surgery, surgery or treatment for the purpose of weight reduction, including any complications from or reversal of these procedures, or reconstructive procedures made necessary by weight loss.
- Services or charges for which the member is entitled to payment of benefits from other sources (i.e., worker's compensation), for which the provider does not charge or for which the member is not legally obliged to pay, including treatment provided in a government hospital or benefits provided under Medicare or other government programs (except Medicaid)
- Illness contacted or injury sustained as the result of ware or act of way (declared or undeclared), or participation in a felony, riot or insurrection.
- Refractive care, such as radial keratotomy, laser eye surgery or LASIK.

Note: This is a partial list of exclusions. The member would need to refer to their policy for the full list.

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)

- Submitted NDCs must have **11 digits following the 5-4-2 format**.
  - 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 table below:

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

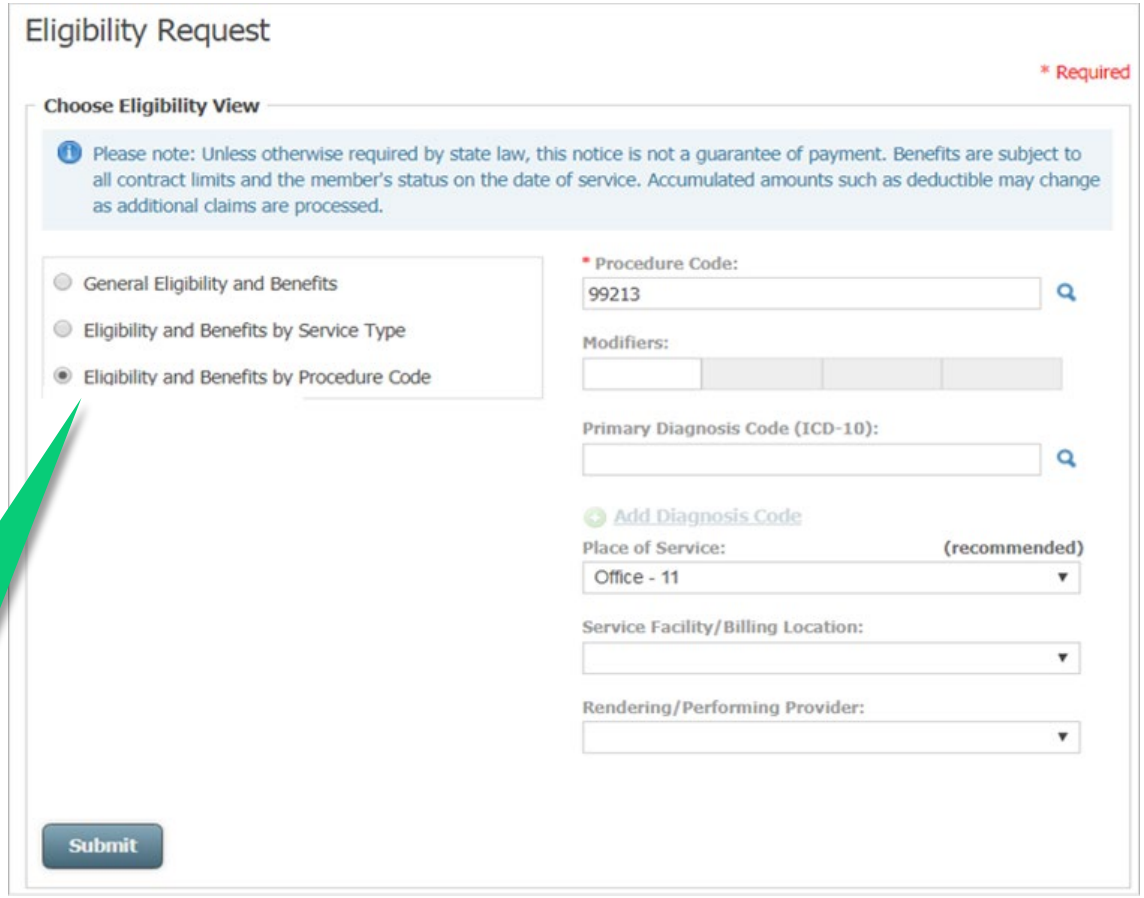
- Be sure all lab tests are supported by the available medical policies

Benefit Resources

Benefit Resources

My Insurance Manager℠

- Online portal giving access to check eligibility and benefits
  - Check general benefits
  - Obtain benefits based on service type
  - Use CPT/HCPCS and diagnosis codes for specific benefits



Recommended option.

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/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

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

- Reminders
- Claims Tips
- What's New?
- Resources

Claims Reminders

Claims Reminders

ClaimsXten™

- **Review your current coding practices**
- **Consult with all business partners who code and bill on your behalf**
- **Ensure all appropriate staff are refreshed on correct coding guidelines**
- **Review our training materials and share it with your staff members**
- **Identify potential impacts and make changes**

Claims Reminders

Modifiers

Modifiers play an integral role in the processing of claims. Common modifiers used when coding for clinical situations include:

- Modifier 25
- Modifier 50
- Modifier 57
- Modifier 59
- Modifier 76
- Modifier 77

Claims Reminders

Modifier 25

Description	Example	Coding
Used to report an evaluation and management (E/M) service on a day when another procedure or service is rendered to a patient by the same physician or other qualified health care professional.	A patient visits the cardiologist due to discomfort in his chest while exercising. He has a history of high blood pressure. Once the physician completes the office visit, it's determined that the patient needs a stress test, which is performed the same day by the same provider.	Line 1 – 99213, 25 Line 2 – 93015

Claims Reminders

Modifier 50

Description	Example	Coding
Used to report bilateral surgical procedures as a single unit of service, but is dependent upon: • The CPT/HCPCS Level II code descriptor • The bilateral indicator assigned to the code • Nature of the service	A patient has breast cancer that has spread and as a result, must have a double mastectomy performed.	Line 1 – 19303, 50

Claims Reminders

Modifier 57

Description	Example	Coding
Used to report an evaluation and management (E/M) service when the E/M results in the decision to go to surgery the same day or the day before the surgery takes place.	A patient visits the emergency room with abdominal pain and fever. After consulting with the patient, the physician determines that an emergency appendectomy is need and performs the procedure that day.	Line 1 – 99243, 57 Line 2 – 44950

Claims Reminders

Modifier 59

Description	Example	Coding
Used to report services not normally reported together but are appropriate under the circumstances. If a more appropriately established modifier is available, it should be used instead of the modifier 59.	A patient visits the neurologist to have a nerve conduction study performed on separate nerves.	Line 1 – 95907, 59 Line 2 – 95908

Claims Reminders

Modifier 76

Description	Example	Coding
Used to report services that were repeated subsequent to the original procedure/service by the same physician or qualified health care professional.	A patient visits the hospital with pain in their lower abdomen that radiates to their back. The physician decides to perform an ultrasound for flank pain and sends the patient home with medicine. The patient returns the same day and sees the same physician who performs another ultrasound for possible renal issues.	Line 1 – 76700 Line 2 – 76700, 76

Claims Reminders

Modifier 77

Description	Example	Coding
Used to report services that were repeated subsequent to the original procedure/service by another physician or qualified health care professional.	A patient is involved in a car accident and visits the hospital because of chest pain that spreads to her jaw and arm. The physician performs an EKG and an arrythmia is noted. Due to other injuries that cannot be treated at the current hospital, the patient is transferred to another facility. Now that the patient has increased pain, the physician at the new hospital performs another EKG to rule out cardiac arrest.	Line 1 – 93000, 77

Claims Reminders

High Dollar Pre-payment Review

Hospitals are required to submit itemized bills to process claims 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 (those in which a portion of the claim is charge-sensitive)

Itemized bills can be submitted using the claims attachment feature in My Insurance Manager℠ (MIM).

Note: Refer to the "High Dollar Pre-payment Review: CARC 216, RARC N183" bulletin located on www.SouthCarolinaBlues.com for more information.

Claims Reminders

Laboratory Services

Before rendering lab services, be sure to view the Medical Policies pages on www.SouthCarolinaBlues.com or www.BlueChoiceSC.com to view the complete medical policy for specific labs to ensure the criteria is followed for coverage.

Benefits if reviewing medical policies:

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

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 (cont'd)

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

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

Examples

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

Claims Reminders

Provider Reconsiderations

Provider reconsideration requests should include an explanation of the issue(s) to be reconsidered along with supporting documentation. Supporting documentation could include, but is not limited to:

- History and physical records
- Operative reports
- Office notes
- Pathology and/or laboratory reports
- Progressive notes
- Radiology reports

We are unable to review requests without support.

Claims Reminders

Provider Reconsiderations (cont'd)

Provider reconsideration requests should include an explanation of the issue(s) to be reconsidered along with supporting documentation. We are unable to review requests without support. Keep in mind that:

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

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

Provider Reconsiderations (cont'd)

Provider Reconsideration Form

Visit www.SouthCarolinaBlues.com and follow the path:

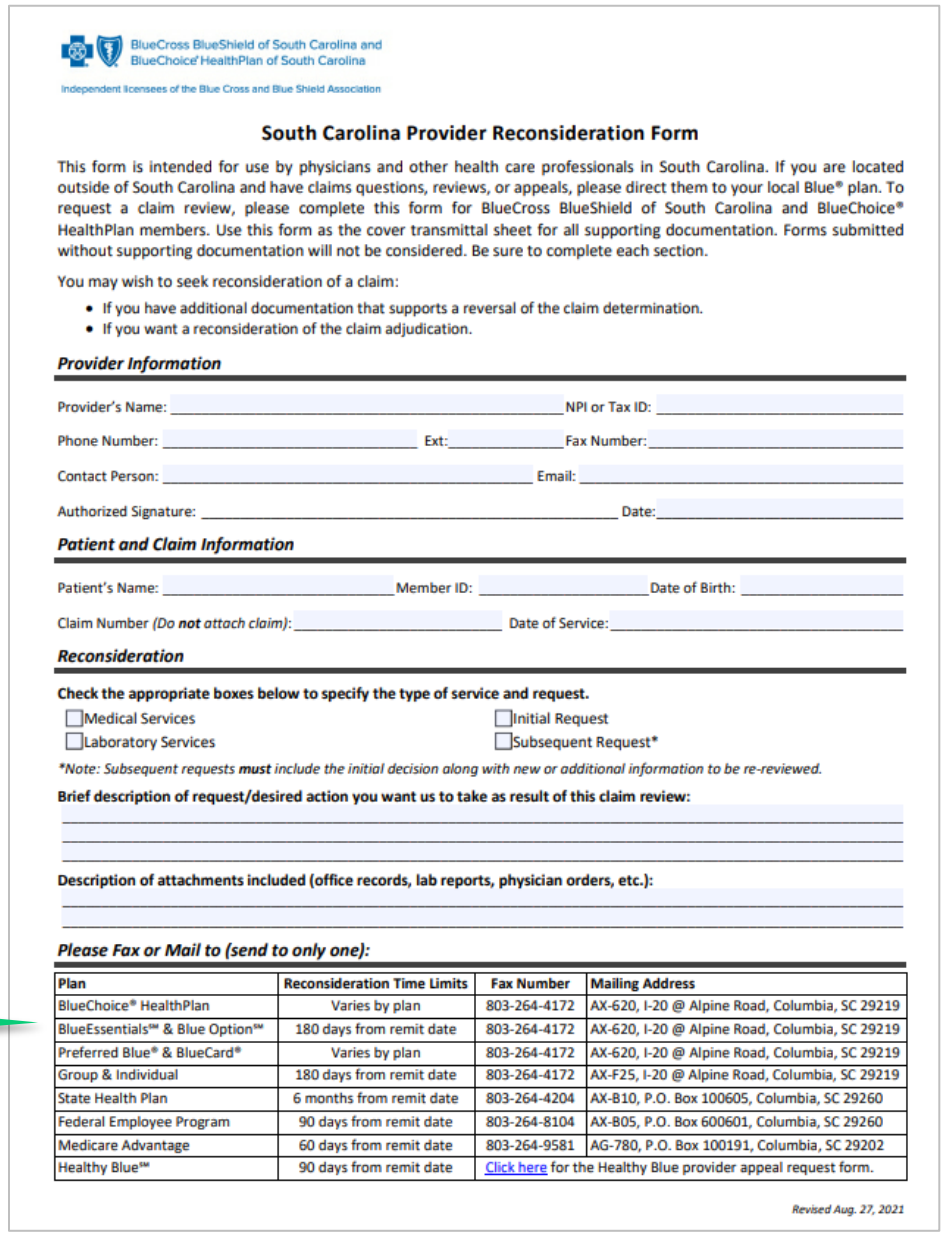
Providers>Claims & Payment>Appeals & Reconsiderations

OR

Visit www.BlueChoiceSC.com and follow the path:

Providers>Find a Form>Provider Reconsideration Form

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):

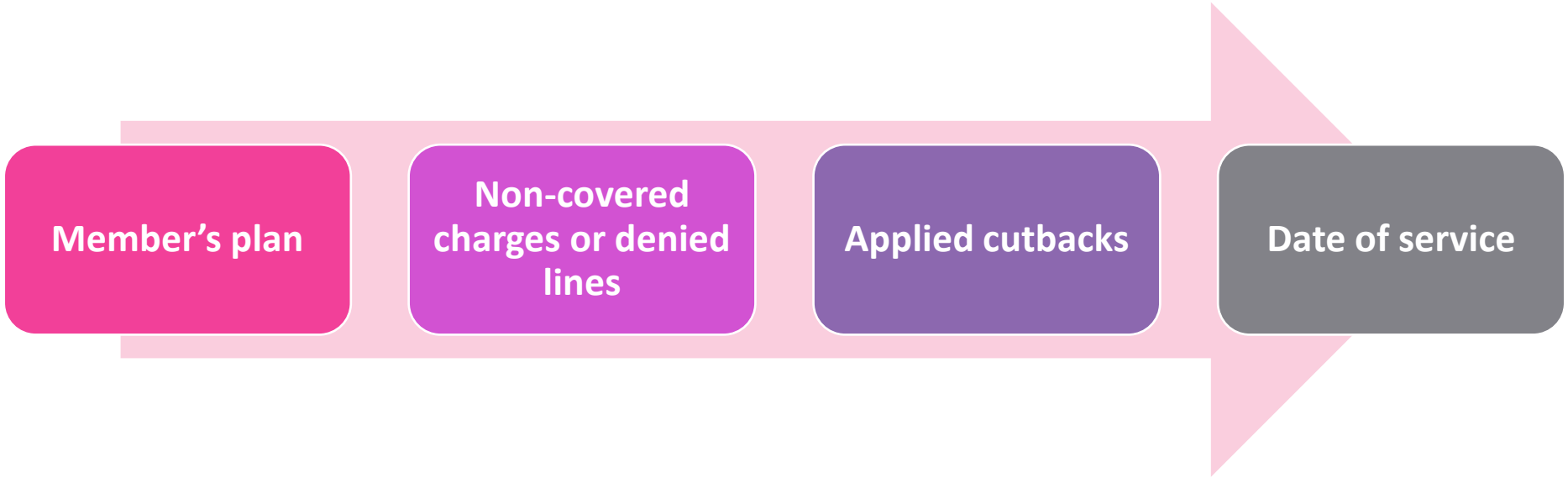
Plan	Reconsideration Time Limits	Fax Number	Mailing Address
BlueChoice® HealthPlan	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
BlueEssentials℠ & Blue Option℠	180 days from remit date	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Preferred Blue® & BlueCard®	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

Pricing Inquiries

Before submitting pricing inquiries, be sure to verify the following:



Note: If you utilize third-party vendors, be sure to relay this information to them.

Claims Reminders

Refund Inquiries

For assistance with refunds, contact Provider Services at 800-868-2510, Option 4. This line is used for the following lines of business:

- BlueCard®
- BlueEssentials℠
- Major Group
- National Alliance
- Small Group & Individual

Note: This line is for refunds only. All other inquiries will be routed back through the VRU.

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

Note: Refer to the 2021 Provider Administrative Office Manual for additional guidance and details.

Claims Reminders

Claims Submission

Claims can be submitted using the following avenues:

- My Insurance Manager℠ (MIM)
- Electronically
  - **Preferred method**
  - See the Payer IDs.
- Hard copy (via mail)
  - The address is located on the back of the ID card.

For more information, visit www.SouthCarolinaBlues.com and follow the path:

Providers>Claims & Payments>Claims Submission

Medical Plans	
PAI (formerly Thomas Cooper as of **10/01/2021**)	00315
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:

- My Insurance Manager℠ (MIM)
  - If using MIM, be sure to select Replacement of Prior Claim.
- Electronically (the preferred method)
  - If filing electronically, use the correct frequency code (7).
- Hard copy (via mail)
  - If filing via mail, use the correct frequency code (7) and ensure “Corrected Claim” is 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.

Note: Refer to the Corrected Claims bulletin located on www.SouthCarolinaBlues.com for additional details.

Claims Tips

Claims Tips

Accident/Subrogation Questionnaire

- CARC: 252, RARC: N686

Possible Solutions:

Encourage members to submit the requested questionnaire

Incorporate the form in the onboarding paperwork

Note: Only submit the documentation if requested.

Note: The form can be located on www.SouthCarolinaBlues.com.

Claims Tips

Other Health Insurance (OHI) Questionnaire

- CARC: 252, RARC: N686/MA92

Possible Solutions:

Encourage members to submit the requested questionnaire

Incorporate the form in the onboarding paperwork
Note: Only submit the documentation if requested.

Note: The form can be located on www.SouthCarolinaBlues.com.

Claims Tips

Duplicate Claim Submission

- CARC: 18, RARC: N522

Possible Solutions:

Claims Tips

Inconsistent Diagnosis

- CARC: 11, RARC: N657

Possible Solutions:

Claims Tips

Patient Ineligible for Services

- CARC: 27, RARC: N30

Possible Solutions:

What’s New?

What's New?

Specialty Rx Medical Policy & Prior Authorization Match Enhancement

Avalon Healthcare Solutions

Effective Jan. 1, 2022, Avalon will be making enhancements to the specialty Rx medical policies and prior authorization matches to:

- Ensure our medical policies are enforced based on the best medical evidence
- Use automated technology enforcement to evaluate medical policies and historical claims reporting medical policies and guidelines
- Evaluate medical specialty drug code procedures on the claim for appropriateness

CAM 50115 – Infilximab/Remicade

Infilximab/Remicade will be the first specialty drug released during the initial phase.

J1745	Q5103	Q5104	Q5109

Note: Additional medical specialty drug policies will be added in the future.

What's New?

Specialty Rx Medical Policy & Prior Authorization Match Enhancement

Avalon Healthcare Solutions (cont'd)

Decision Code Description	
Not valid with other procedures on the date of service	Experimental and investigational testing
Procedure/diagnosis code mismatch	Procedure is inappropriate for patient's age
Historical unit threshold	Frequency — once per lifetime
Experimental and investigational (situational)	Historical frequency threshold
Procedure is inappropriate for patient's gender	DOS unit/frequency threshold met
Procedure code is not valid for reimbursement	Incorrect place of service

Note: Additional medical specialty drug policies will be added in the future.

What's New?

Advance Cost Estimates and Explanation of Benefits (EOB)

- Effective in 2023, as part of the Consolidated Appropriations Act (CAA), we will provide an advance Explanation of Benefits (EOB) for scheduled services at least three days in advance.
- Gives patients transparency to:
  - Which providers are expected to provide treatment and their network status
  - Estimates of cost, cost-sharing and progress towards meeting deductibles and out-of-pocket maximums
  - Whether a service is subject to medical management and relevant disclaimers of estimates

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 the claim was processed to the member, please contact them for the details.

Claims Resources

My Insurance Manager℠ (MIM)

- MIM is the quickest way to obtain the status of claims.
- Use the Ask Provider Services option to submit a secured web inquiry. To get the most effective and accurate response, be sure to ask specific, probing questions such as:
  - Why was line one of the claim denied as non-covered?
  - Why were services applied towards the member's deductible?
  - Has the member returned the Coordination of Benefits questionnaire?

Note: Ask Provider Services should not be used for general claims status.

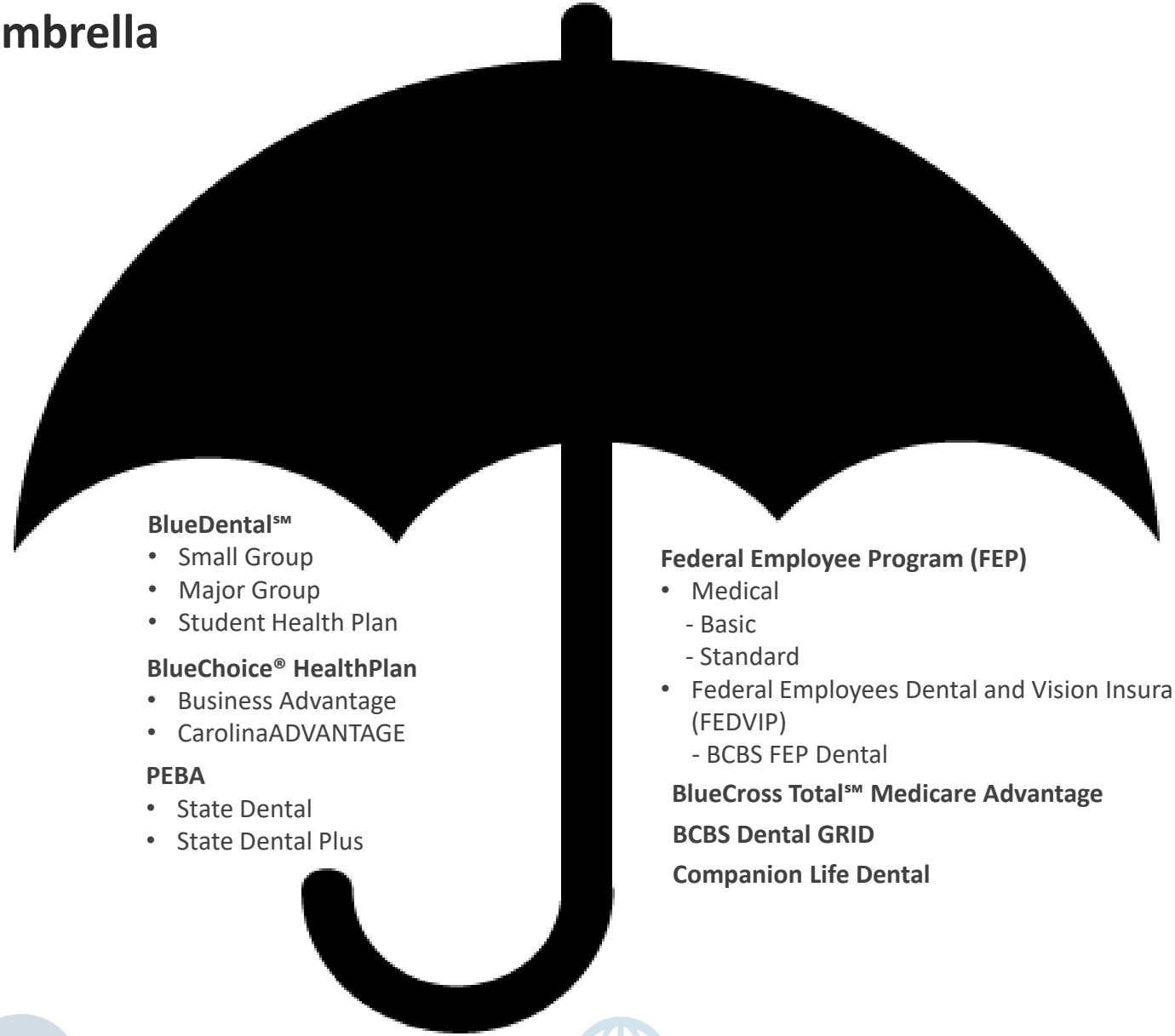
DENTAL NETWORK

Agenda

- Dental Plans
- Dental GRID
- Eligibility, Benefits and Claims
- Credentialing
- 2022 Coding Updates

Dental Plans

BlueCross BlueShield of South Carolina
Dental Umbrella



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

BlueChoice® HealthPlan
- Business Advantage
- CarolinaADVANTAGE

PEBA
- State Dental
- State Dental Plus

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

BlueCross Total℠ Medicare Advantage

BCBS Dental GRID

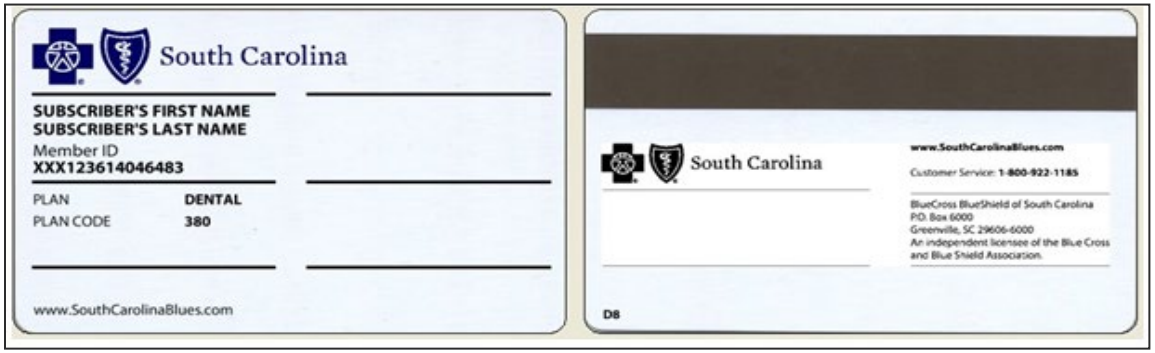
Companion Life Dental

Dental Plans

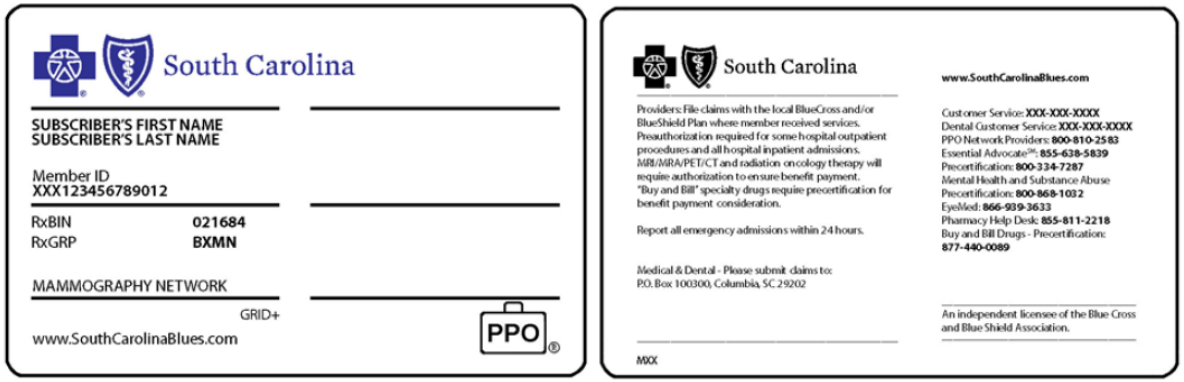
Commercial Plans

Commercial plans can be identified by noting the following elements on the ID card:

1. Member ID number
2. Plan code



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.
- Coverage levels include:
  - Preventive care
  - Restorative care
  - Major restorative care
  - Implant services (coverage varies per plan)
  - Orthodontic care (coverage varies per plan)

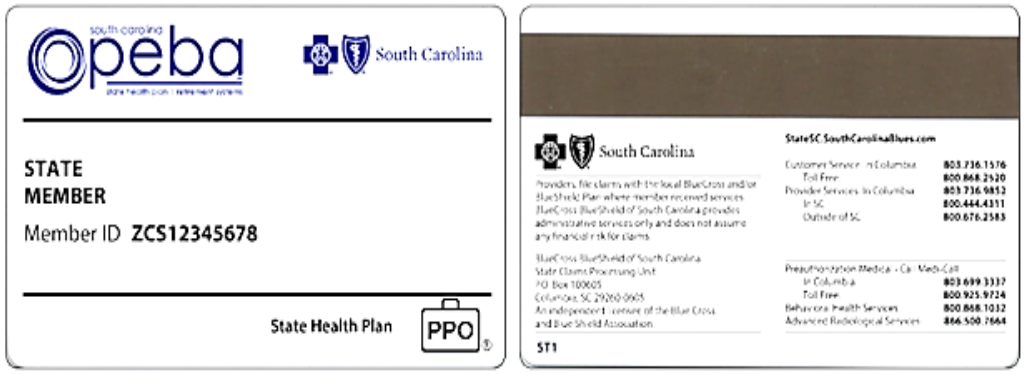
Dental Plans

State Plans: Basic Dental

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

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

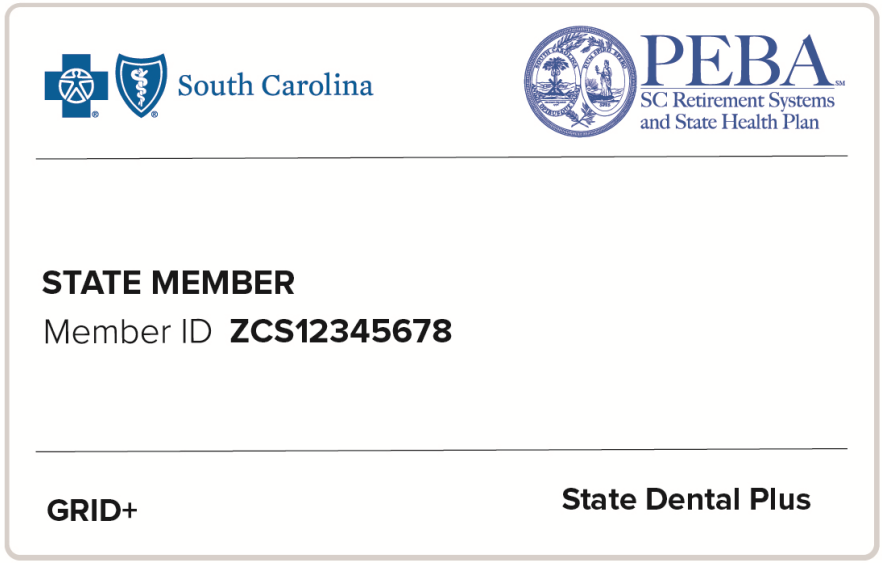
- Covered services are paid based on its schedule of dental procedures and allowable charges.



Dental Plans

State Plans: Dental Plus

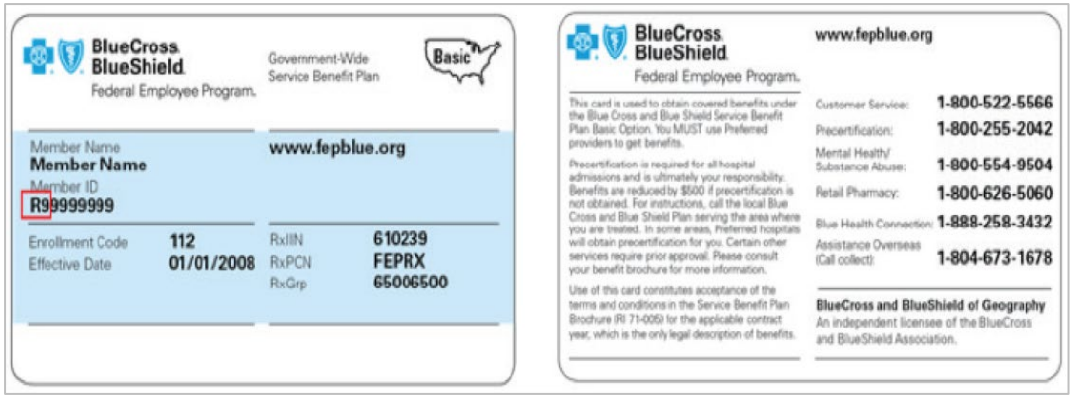
- Members with the Dental Plus plan with have **State Dental Plus** on their ID card.
- Dental Plus is a supplement to the Basic Dental plan and provides an additional $1,000 benefit period maximum for classes 1-3.
- Dental Plus provides a higher level of reimbursement for services that the Basic Dental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



Dental Plans

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

FEP: Basic Option

Covered Service	FEP Pays	Member Pays
Clinical Oral Evaluations	Preferred: All charges in excess of member's $30 copayment Participating/Non-participating: Nothing	Preferred: $30 copayment per evaluation Participating/Non-participating: Member pays all charges
Periodic oral evaluation*		
Limited oral evaluation		
Comprehensive oral evaluation*		
*Benefits are limited to a combined total of two evaluations per person per calendar year		
Diagnostic Imaging		
Intraoral — complete series including bitewings (limited to one complete series every three years)		
Preventive		
Prophylaxis — adult (up to two per calendar year)		
Prophylaxis — child (up to two per calendar year)		
Topical application of fluoride or fluoride varnish — for children only (up to two per calendar year)		
Sealant — per tooth, first and second molars only (once per tooth for children up to age 16 only)		
Not covered: Any service not specifically listed above	Nothing	All charges

Dental Plans

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

FEP: Standard Option

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

Dental Plans

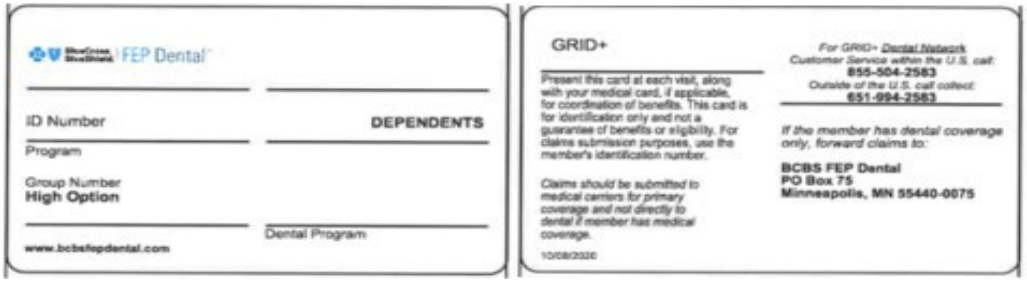
FEP: Blue Focus

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

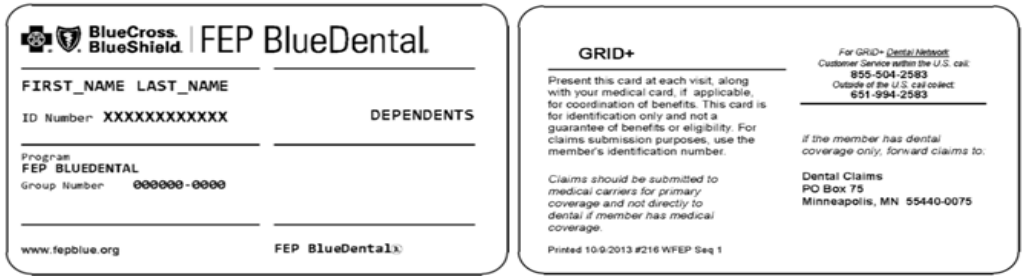
Dental Plans

FEP: BlueCross BlueShield FEP Dental

- On Jan. 1, 2021, FEP BlueDental became BlueCross BlueShield FEP Dental.
- Members covered by FEP Basic Option medical plan and BlueCross BlueShield 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

FEP: BlueCross BlueShield FEP Dental

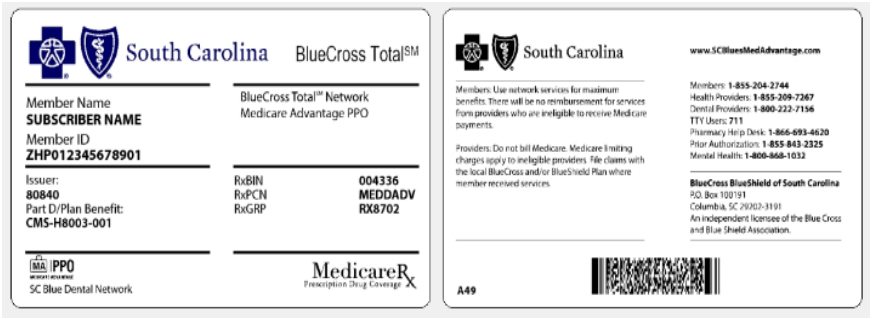
- Effective Jan. 1, 2022, the **Standard Option** covers benefits for Class A, B and C services at 100% for children ages 13 and under.

Benefits	High Option		Standard Option	
	IN-NETWORK Member Responsibility	OUT-OF NETWORK Member Responsibility	IN-NETWORK Member Responsibility	OUT-OF-NETWORK Member Responsibility
Class A (Basic) Services e.g., exams, cleanings, X-rays, sealants[1]	0%	10%	0%	40%
	THREE CLEANINGS A YEAR COVERED		THREE CLEANINGS A YEAR COVERED	
Class B (Intermediate) Services e.g., oral surgery, fillings, gum scaling	30%	40%	45%	60%
Class C (Major) Services e.g., crowns, bridges, implants, root canals, dentures	50%	60%	65%	80%
Annual Deductible for Class A, B and C Services	No deductible	$50 per person	No deductible	$75 per person
Annual Maximum Benefits for Class A, B and C Services	UNLIMITED MAXIMUM PER PERSON	$3,000 per person	$1,500 per person	$750 per person
Class D (Orthodontic) Services Adults & Children	50% up to $3,500 lifetime maximum	50% up to allowed amount	50% up to $2,500 lifetime maximum	50% up to $1,250 lifetime maximum
	NO WAITING PERIOD		NO WAITING PERIOD	

Dental Plans

Medicare Advantage: BlueCross Total℠, Blue Basic℠ and Total Value℠

Benefit Highlights		
	In-Network*	**Out-of-Network**
Deductible	**$0**	**$0**
Class I (Preventive)	**$0 Copay**	**50% Coinsurance**
Class III (Major)	**50% Coinsurance**	**50% Coinsurance**
Annual Maximum (Per member, per year)	**BlueCross Total: $1,000** **Blue Basic: $750** **Total Value: $500**	



Example of BlueCross Total℠ ID card.

***SC Blue Dental Network**

Dental Plans

Medicare Advantage: BlueCross Total℠, Blue Basic℠ and Total Value℠

Services Covered	
Class I – Preventive Services (No Waiting Period)	
• Exams and Cleanings (2/benefit year) • Full Mouth X-Ray (1/every 3 benefit years) • Bitewing X-Rays (1/benefit year)	• Emergency Treatment for Pain (1/benefit year) • Pulp Vitality Test and Diagnostic Casts • General Anesthesia
Preventive Services do not apply to the Annual Maximum	
Class III – All Other Services	
• Fillings • Periodontal Cleanings (3/benefit year) • Pulp Capping • Root Canal Therapy (1/5 years / tooth) • Simple Extractions • Oral Surgery • Inlays (1/3 years) • Crowns (1/1 years) • Onlays (1/3 years) • Removable Dentures - complete and partial • Complete Dentures - relining or rebasing of removable dentures (1/2 years)	• Partial Dentures - relining or rebasing of removable dentures (1/2 years) • Bridges – fixed and removable (1/2 years) • Hemisection • Apicoectomy • Gingival Curettage • Gingivectomy and Gingivoplasty • Osseous Surgery • Biopsies of Oral Tissue • Repair of Removable Dentures • Implants (1/lifetime) • Occlusal Guard (1/3 years)

Dental GRID

Dental GRID

- Dental GRID allows dentists to see members from other participating BlueCross BlueShield 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 word **GRID** or **GRID+** on their 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
BlueCross BlueShield FEP Dental	855-504-2583	803-264-6763
FEP Dental (Medical)	800-444-4325	
BlueCross Total℠ (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 BlueCross BlueShield 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.
  - **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 BlueCross Total℠ (MA Dental)	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.
BlueCross BlueShield FEP Dental	Submit all claims to the member's primary medical plan first. See the member's medical ID card for submission. Timely filing is December 31 of the year following the year of service.
State Basic Dental and State Dental Plus	Submit claims electronically using HIPAA 837D format. Use carrier (payer) code 38520. Timely filing is 24 months from date of service. Do not file a separate claim for Dental Plus members.
FEP Dental	Submit all claims to the member's primary medical plan first. See the member's medical ID card for submission. Timely filing is December 31 of the year, following the year of service.

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.

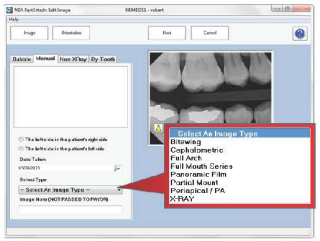
Improve claim adjudication times by electronically transmitting:

- 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.

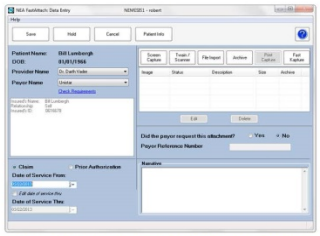
Easy to Use & Access

- 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 $278 savings.*
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-EA-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

Dentistat, Inc.

BlueCross BlueShield of South Carolina uses Dentistat, Inc. (a credentialing verification organization) to credential and recredential the Dental Provider Network. Dentistat performs all verifications according to the accepted industry standards, as well as NCQA standards. Occasionally, Dentistat may contact your office.

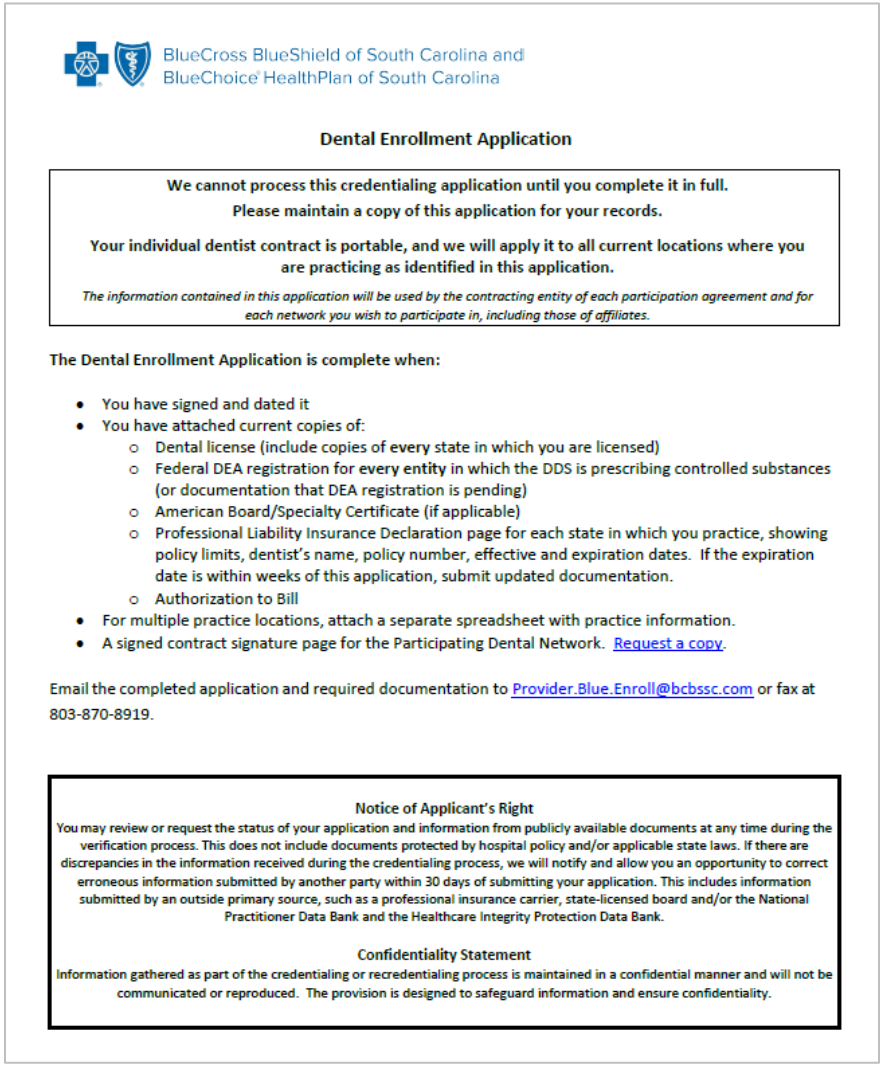
Credentialing

Participating Dental Network

Plans that use the Participating Dental Network include:

- Commercial plans
- State Basic and Dental Plus
- Companion Life Dental
- FEP Basic, Standard, and BlueCross BlueShield FEP Dental
- GRID members

For initial credentialing, use the Dental Enrollment Application, which can be located under the Forms section of Provider Enrollment.



BlueCross BlueShield of South Carolina and
BlueChoice HealthPlan of South Carolina

Dental Enrollment Application

We cannot process this credentialing application until you complete it in full.
Please maintain a copy of this application for your records.

Your individual dentist contract is portable, and we will apply it to all current locations where you are practicing as identified in this application.

The information contained in this application will be used by the contracting entity of each participation agreement and for each network you wish to participate in, including those of affiliates.

The Dental Enrollment Application is complete when:

- You have signed and dated it
- You have attached current copies of:
  - Dental license (include copies of **every** state in which you are licensed)
  - Federal DEA registration for **every entity** in which the DDS is prescribing controlled substances (or documentation that DEA registration is pending)
  - American Board/Specialty Certificate (if applicable)
  - Professional Liability Insurance Declaration page for each state in which you practice, showing policy limits, dentist's name, policy number, effective and expiration dates. If the expiration date is within weeks of this application, submit updated documentation.
  - Authorization to Bill
- For multiple practice locations, attach a separate spreadsheet with practice information.
- A signed contract signature page for the Participating Dental Network. Request a copy.

Email the completed application and required documentation to Provider.Blue.Enroll@bcbssc.com or fax at 803-870-8919.

Notice of Applicant's Right

You may review or request the status of your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable state laws. If there are discrepancies in the information received during the credentialing process, we will notify and allow you an opportunity to correct erroneous information submitted by another party within 30 days of submitting your application. This includes information submitted by an outside primary source, such as a professional insurance carrier, state-licensed board and/or the National Practitioner Data Bank and the Healthcare Integrity Protection Data Bank.

Confidentiality Statement

Information gathered as part of the credentialing or recredentialing process is maintained in a confidential manner and will not be communicated or reproduced. The provision is designed to safeguard information and ensure confidentiality.

2022 Coding Updates

2022 Coding Updates

Deleted CDT Codes for 2022

Code	Description
D4320	Provisional splinting — intracoronal
D4321	Provisional splinting — extracoronal
D8050	Interceptive orthodontic treatment of the primary dentition
D8060	Interceptive orthodontic treatment of the transitional dentition

2022 Coding Updates

New CDT Codes for 2022

Code	Description
D3911	Intraorifice barrier
D3921	Decoronation or submergence of an erupted tooth
D4322	Splint — intra-coronal; natural teeth or prosthetic crowns
D4323	Splint — extra-coronal; natural teeth or prosthetic crowns
D5227	Immediate maxillary partial denture — flexible base (including any clasps, rests and teeth)
D5228	Immediate mandibular partial denture — flexible base (including any clasps, rests and teeth)
D5725	Rebase hybrid prosthesis
D5765	Soft liner for complete or partial removable denture — 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.

2022 Coding Updates

New CDT Codes for 2022

Code	Description
D6198	Remove interim implant component
D7298	Removal of temporary anchorage device [screw retained plate], requiring flap
D7299	Removal of temporary anchorage device, requiring flap
D7300	Removal of temporary anchorage device without flap
D9912	Pre-visit patient screening
D9947	Custom sleep apnea appliance fabrication and placement
D9948	Adjustment of custom sleep apnea appliance
D9949	Repair of custom sleep apnea appliance

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
- Healthy Blue℠ Reminders
- Quality
- Marketing
- What's New?

Contacts & Resources

Contacts & 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 – Friday, 8 a.m. to 6 p.m. ET

Utilization Management (UM) Department for Physical & Behavioral Health:
Phone: 866-902-1689
Fax: 800-823-5520
Hours: Monday – Friday, 8 a.m. to 5 p.m. ET

IngenioRx
Prior authorizations: 844-410-6890

24/7 Nurse line:
Phone: 866-577-9710 TTY: 800-368-4424

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

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

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

Contacts & Resources

BlueBlast℠

Monthly provider focused newsletter

Topics include:

- Important health plan updates
- Healthy Connections
- Announcements
- Billing and claims information
- Frequently asked provider questions
- Community outreach efforts and upcoming events

Be sure to 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

Visit www.scdhhs.gov/resource/fee-schedules *

- Information is listed by provider specialty type
- If the code appears on the SCDHHS 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)

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

Benefits

Checking Covered Services

Manuals

Visit www.scdhhs.gov/provider-manual-list *

- Manuals are listed by service type
- Includes general information, billing details, claims filing information and much more

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

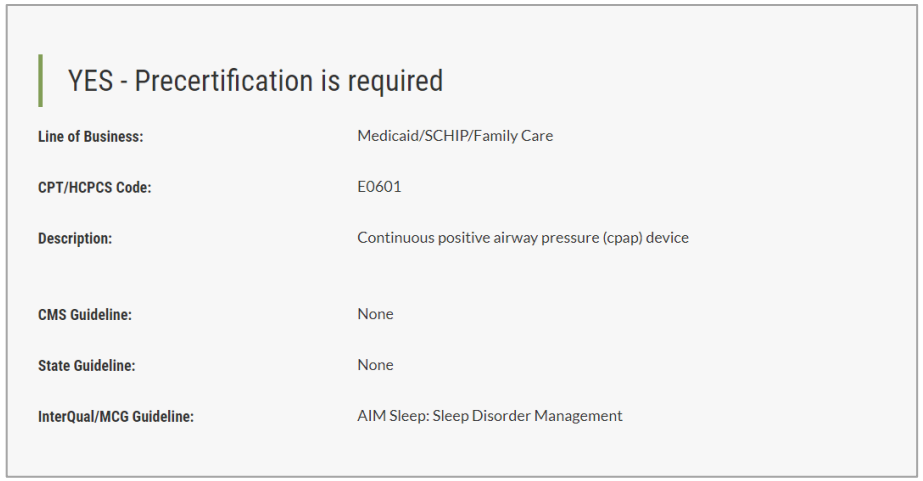
Benefits

Prior Authorization Lookup Tool

Visit www.HealthyBlueSC.com and follow the path below:

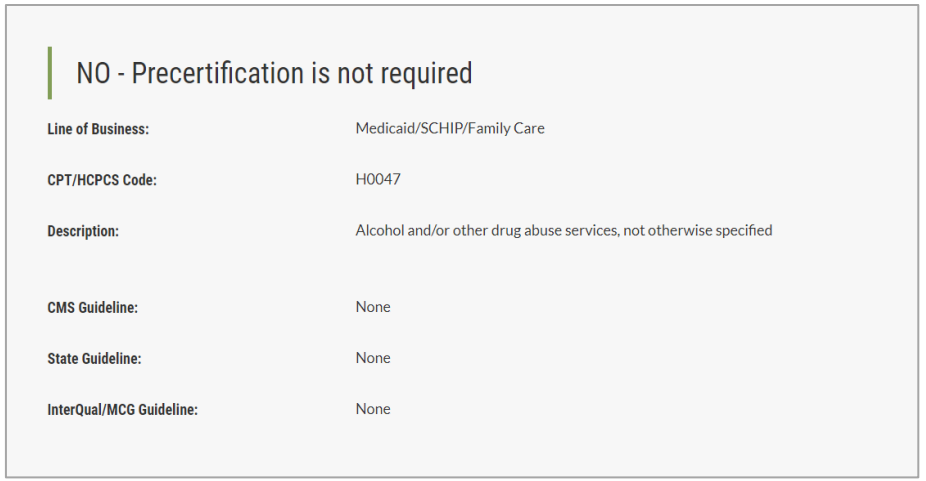
Providers>Resources>Prior Authorization Lookup Tool

- Use the tool for outpatient services only
- Always verify eligibility and benefits 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



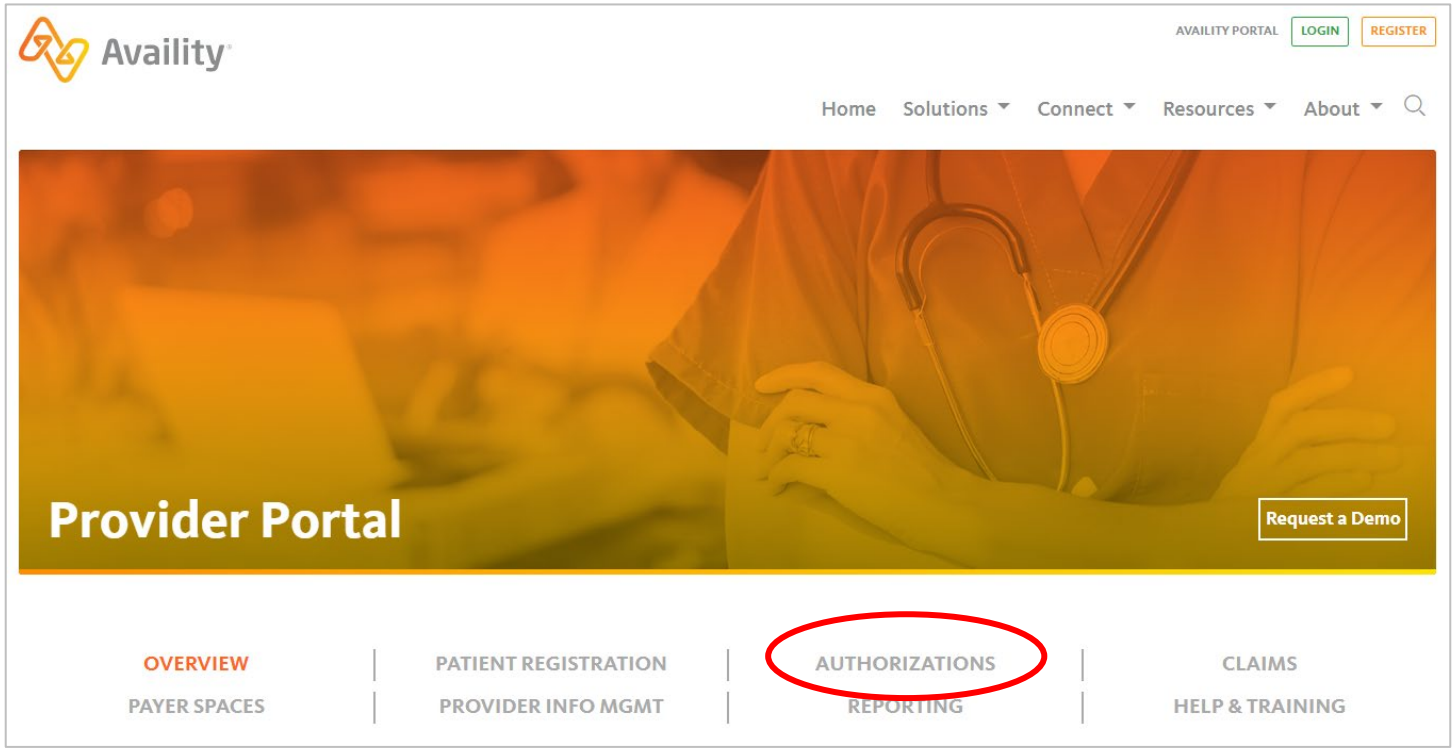
NO - Precertification is not required

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 Authorizations

Availity



Availity, LLC is an independent company providing administrative support services on behalf of BlueChoice® HealthPlan.

Benefits

Copays

Type of Service	Copay
Primary care visits, RHCs and FQHCs	$3.30
Specialist visits (including optometrists)	$3.30
Durable medical equipment	$3.40
Chiropractic care	$1.15
Home health (limited to 50 visits)	$3.40
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 that are pregnant
- Those who are institutionalized
- Those receiving emergency services in the ER
- Those receiving hospice care
- Those of a federally recognized Native American tribe

Services

- Medical equipment and supplies provided by DHEC
- Family planning
- End-stage renal disease care
- Services provided at an infusion center
- Services provided in urgent/minor care clinics

Benefits

American Imaging Management (AIM)

AIM Specialty Health® handles authorization requests on behalf of Healthy Blue for the following advanced imaging/cardiology services and outpatient rehabilitative services.

Advanced Imaging and Cardiology Services	
Computed Tomography Scans (including cardiac)	Resting Transthoracic Tachocardiography
Magnetic Resonance Imaging (including cardiac)	Transesophageal Echocardiography
Positron Emission Tomography Scans (including cardiac)	Arterial Ultrasound
Nuclear Cardiology	Cardiac Catheterization
Stress Echocardiography	Percutaneous Coronary Intervention (PCI)

Outpatient Rehabilitative Services		
Physical Therapy (CG-REHAB-04)	Occupational Therapy (CG-REHAB-05)	Speech Language Pathology (CG-REHAB-06)

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

Benefits

American Imaging Management (AIM) (cont'd)

AIM Specialty Health® handles authorization requests on behalf of Healthy Blue for the following radiation oncology services.

Radiation Oncology Services	
Brachytherapy	3D conformal therapy[1] (EBRT) for bone metastases and breast cancer
Intensity Modulated Radiation Therapy	Hypofractionation for bone metastases and breast cancer when requesting EBRT and intensity modulated radiation therapy (IMRT)
Proton Beam Radiation Therapy	Special procedures and consultations associated with a treatment plan (CPT codes 77370 and 77470)
Stereotactic Radiosurgery/Stereotactic Body Radiotherapy	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 rendering 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.

Use one of the following avenues:

- Electronically (preferred method)
  - Payer ID: 00403
  - For set-up and information, call 800-470-9630
- Availity
- Hard Copy
  - Healthy Blue

  Attn: Medicaid Claims

  P.O. Box 100124

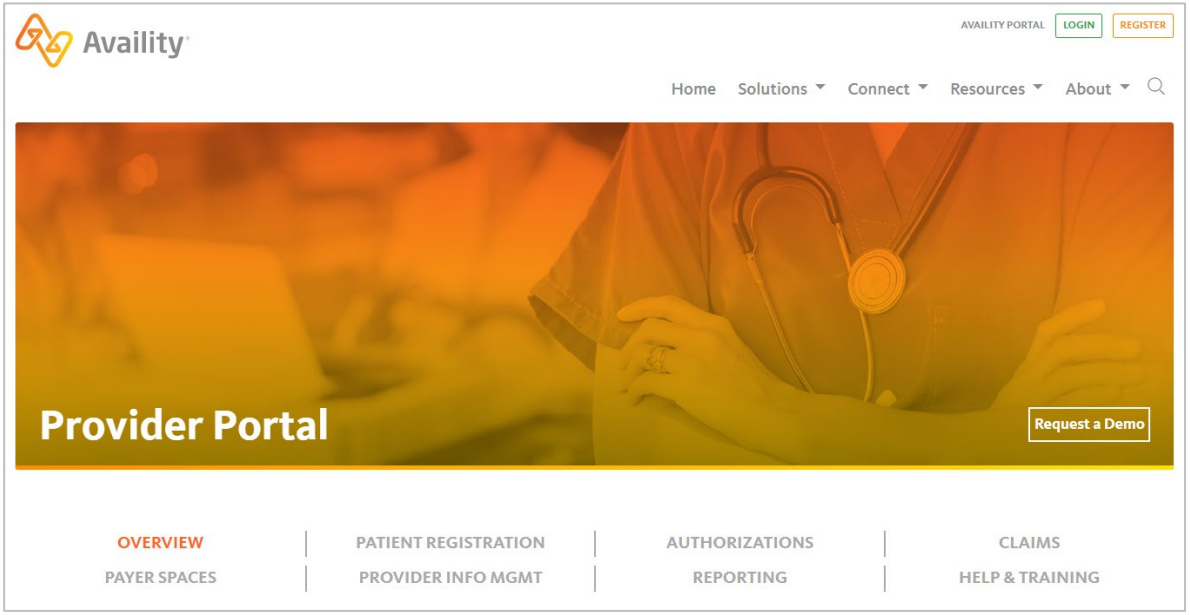
  Columbia, SC 29202-3124

Claims

Availity

Availity allows you to:

- Check claims status
- Check member eligibility
- View remittances
- File claims (at no cost)
  - Primary
  - Secondary
  - Corrected
- Submit claims disputes/appeals
- Request authorizations



Availity, LLC is an independent company providing administrative support services on behalf of BlueChoice® HealthPlan.

Claims

Claim Payment Disputes

Claim disputes are broken down into two steps:

1. *Claim payment reconsiderations*
   - Initial request to investigate the outcome of a finalized claims and should include as much information as you can provide to explain why you feel the claim was processed incorrectly.
   - Must be submitted within **90 calendar days** from the date of the Explanation of Payment.
2. *Claim payment appeals*
   - Request submitted when you disagree with the outcome of the claim payment reconsideration. Again, include as much information as you can to explain why you feel the claim was processed incorrectly.
   - Must be submitted within **30 calendar days** from the date of the Explanation of Payment or the claim payment reconsideration determination letter.

Claims Workflow

Provider receives a denial or questions a payment.

Access Availity for additional claims processing information.

If the issue is resolved, STOP no further action is required.

If the issue is unresolved, GO to the next step.

Call the Customer Care Center at 866-757-8286; obtain the name of the representative and a call reference number.

If the issue is resolved, STOP no further action is required.

If the issue is unresolved, GO to the next step.

File a claim reconsideration through Availity.

If the issue is resolved, STOP no further action is required.

If the issue is unresolved, GO to the next step.

If you're unsatisfied with the outcome of the reconsideration, file an appeal.

If the issue is resolved, STOP no further action is required.

If the issue is unresolved, GO to the next step.

Contact your Provider Education Representative. Provide the name, call reference number and prior steps taken.

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 Explanation 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:

- Cultural factors
- Norms
- Values
- Communication patterns
- and more

Healthy Blue℠ Reminders

Cultural Competency Skills

- Listen to others in an unbiased manner; respect other points of view; promote the expression of diverse opinions and perspectives
- Use appropriate methods of interacting sensitively, effectively and professionally with persons of all ages and lifestyle preferences from diverse cultural, socioeconomic, educational, racial, ethnic and professional backgrounds
- Recognize the importance of the role cultural, social and behavioral factors play in determining delivery methods for public health services
- Consider cultural differences when developing and adapting approaches to problems
- Understand the dynamic forces contributing to cultural diversity and the importance of a diverse public health workforce

Learn more by visiting

- 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 play a vital role in the effort to prevent, detect and report Medicaid noncompliance as well as possible fraud, waste and abuse. As a Healthy Blue provider, you:

- Are required to comply with all applicable statutory, regulatory and other Medicaid managed care requirements in South Carolina
- Have a duty to Medicaid to report any law violations and follow your organization's code of conduct that expresses your 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 fraud hotline at 888-364-3224 or email fraudres@scdhhs.gov

Healthy Blue℠ Reminders

Access and Availability

Primary Care

Visit Type	Availability Standard
Routine Visit	Within 4 weeks to 6 weeks
Urgent, Non-emergent Visit	Within 48 hours
Emergent Visit	Immediately upon presentation at a service delivery site

Specialist Care

Visit Type	Availability Standard
Routine Visit	Within 4 weeks; maximum of 12 weeks for unique specialists
Urgent Medical Condition Care Appointment	Within 48 hours of referral or notification from PCP
Emergent Visit	Immediately upon referral

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

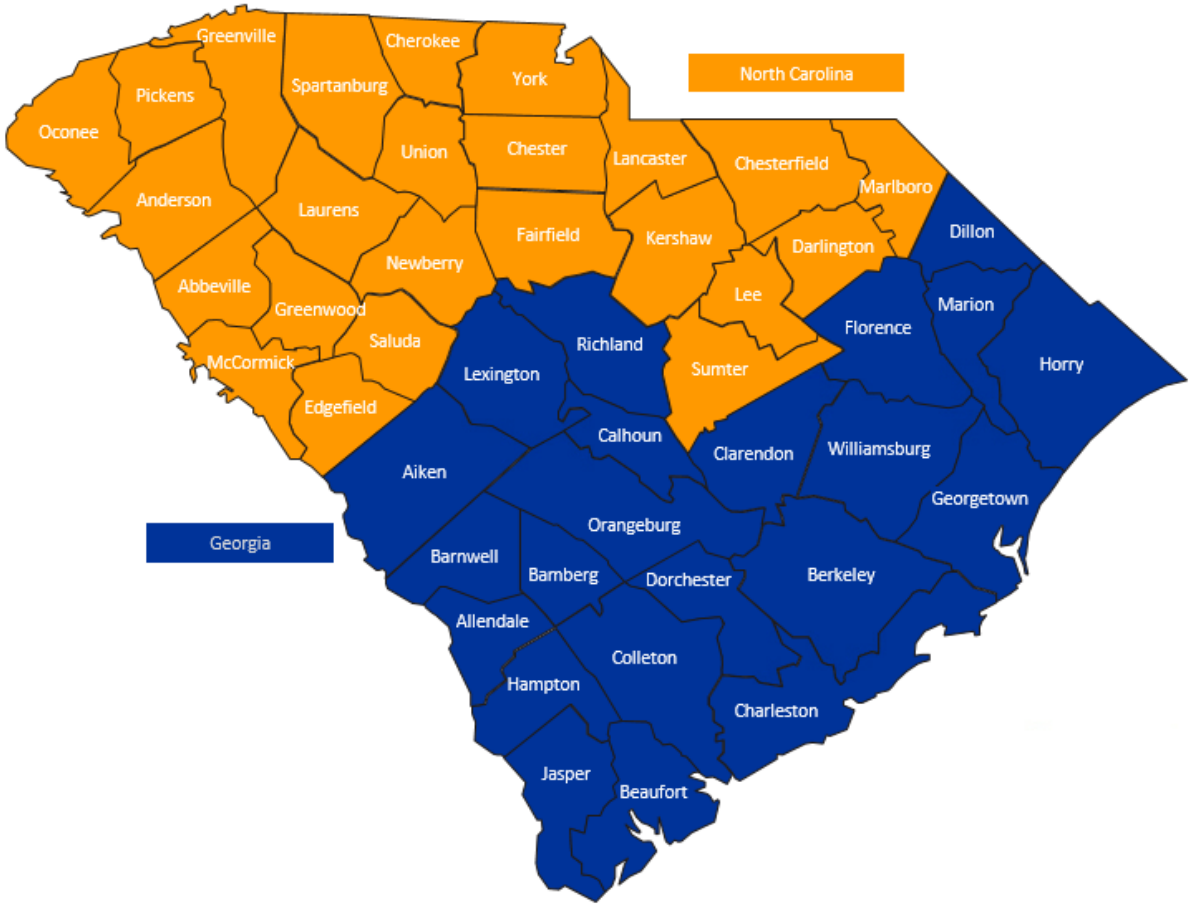
Quality

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 Rd., AX-E13
  Columbia, SC 29229
- **Quality Fax:**
  855-238-2257

Quality

Department Contacts

- HEDIS & 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

Pee Dee Region

- Darrian Brown, Community Relations Rep.
- Darrian.Brown@Amerigroup.com
- 803-394-1588

Lowcountry Region

- Erica Gattison, Community Relations Rep.
- Erica.Gattison@Amerigroup.com
- 803-638-1948

Upstate Region

- Letitia Lindsay, Manager
- Letitia.Lindsay@Amerigroup.com
- 803-231-9138

Coastal Region

- Tanya Ramos, Community Relations Rep.
- Tanya.Ramos@Amerigroup.com
- 803-260-6863

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 & 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 GED Ready Assessment

- Ages 17 & up

Free tutoring services for grades K – 8th

Free Sports Physicals

- Ages 6 – 18

and MUCH, MUCH MORE!

What’s New?

What's New?

Updates for Healthy Blue℠

Behavioral Health

- On July 1, 2021, Licensed Addiction Counselors (LACs) were added as approved providers to render rehabilitative behavioral health services (RBHS).

Quality

- On Oct. 1, 2021, the well-child incentive was increased to $60, and diabetes and hypertension was increased to $40.

Non-payment Remittance Advice Enhancements

- In the coming months, you will be able to search, review and download remittances through Availity when there is no associated payment.
  - Non-payment remittances will be assigned a unique number, which can be used to search for the corresponding remittance

Claim Payments

- Effective Jan. 3, 2022, claim payments will be made on Mondays to all South Carolina providers unless:
  - The Monday payment date is an Anthem or Federal holiday, and then the payment would be made on Tuesday

PHARMACY

Agenda

- New Implementations
- Reminders
- Resources

New Implementations

New Implementations

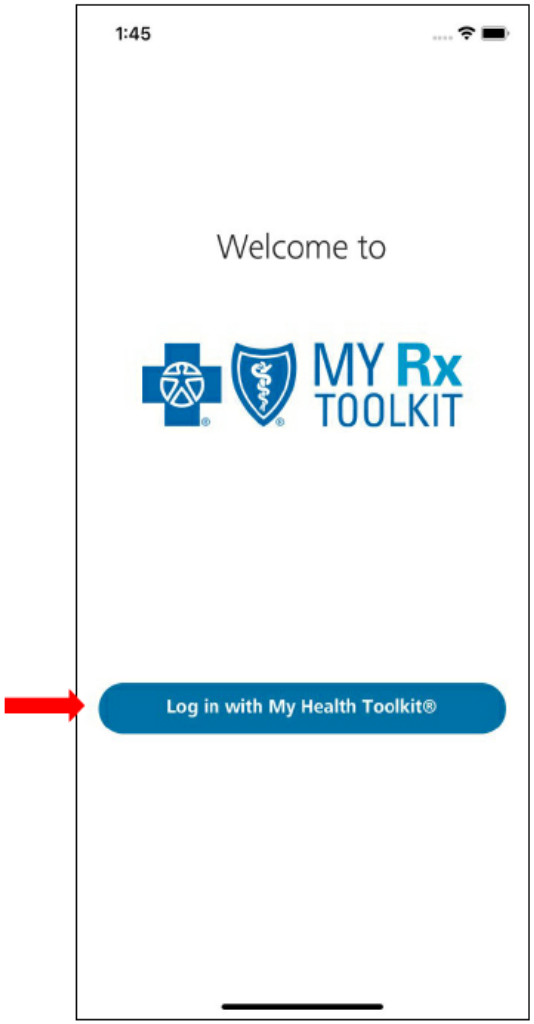
My Rx Toolkit

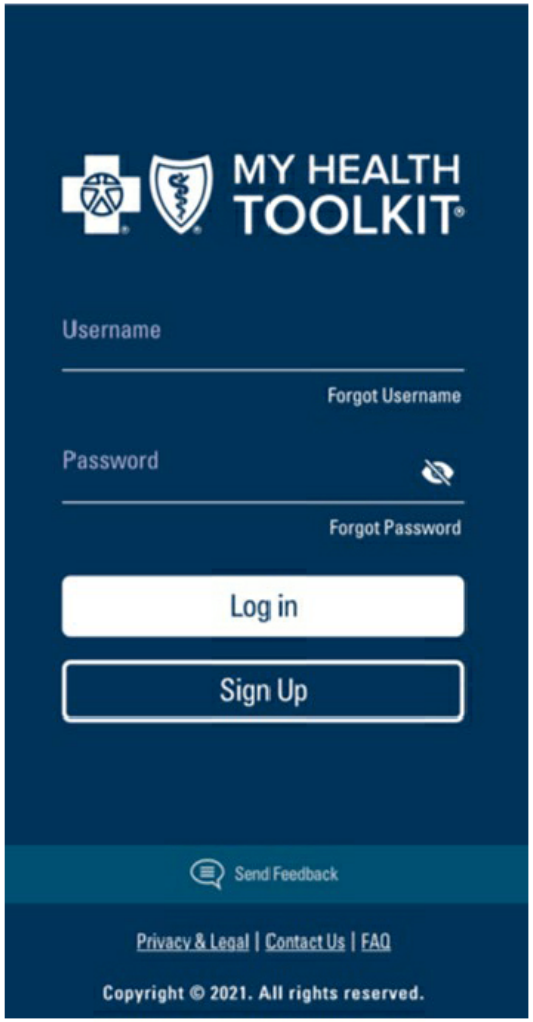
Mobile App

- Launched June 7, 2021

Benefits of My Rx Toolkit:

- Members can take the app wherever they go and perform tasks such as:
  - Set up and manage home deliveries
  - Locate nearby in-network pharmacies
  - Look up medication costs





New Implementations

Commercial and Affordable Care Act (ACA) Plans

Biosimilars

- Effective July 1, 2021
  - Expanded coverage of select biosimilars

- Biosimilar First
  - Impacts new prescriptions and when existing PAs for non-preferred drugs expire, biosimilars are required unless medical necessity documentation is submitted and approved.

Drug Class	Current, Non-preferred Drug	New, Preferred Drugs
Autoimmune	Remicade (infliximab)	Inflectra, Renflexis
Granulocyte Colony Stimulating Factors, Long Acting	Neulasta (pegfilgrastim)	Neulasta, Ziextenzo
Granulocyte Colony Stimulating Factors, Short Acting	Neupogen (filgrastim)	Zarxio, Nivestym
Oncology/B-cell Malignancies	Rituxan (rituximab)	Truxima, Ruxience
Oncology/First or Second Line Multiple Cancer Indications	Avastin (bevacizumab)	Mvasi, Zirabev
Oncology/HER2 positive Breast Cancer	Herceptin (trustuzumab)	Kanjinti, Trazimera

New Implementations

Commercial and Affordable Care Act (ACA) Plans

Enhancements to Specialty Medical Benefit Management Programs

- Site of Care Steerage — **Oct. 2021**
  - Question about requested site of care has been moved to an earlier screen so providers know sooner that their request will be pended if they continue with a non-preferred provider.

- Additional Drugs Added — **Q1 2022**
  - 45 additional drugs added to the Self-Administration Block list.
    - This change particularly targets drugs that have both a self-administered and IV formulation. Beginning sometime in Q1 2022, we will no longer cover the IV formulations, other than IV induction doses, when required per the drug label. Impacted drugs are:

Stelara	**Actemra**	**Orencia**	**Simponi**
Cimzia	**Xolair**	**Nucala**	**Fasenra**

  - 11 additional drugs added to the Site of Care steerage list

New Implementations

Commercial Plans

BlueCross and BlueChoice HealthPlan Formularies — Additions

Product	BlueCross Tier	BlueChoice Tier
Amondys 45 *	4	6
Artesunate	3	4
Cosela *	4	6
Fotivda *	4	6
Glyxambi	2	3
Jemperli *	4	6
Margenza *	4	6
Nayxilam #	3	4
Nulibry *	4	6

Product	BlueCross Tier	BlueChoice Tier
Nurtec	2	3
Pepaxto *	4	6
Ponvory *#	4	6
Trijardy XR	2	3
Ubrelvy *	2	3
Valtoco #	3	4
Verquvo *	3	4
Xofluza # (Effective 10/1/21)	3	4
Zynlonta *	4	6

* Requires Prior Authorization | # Quantity Limit | **Specialty drugs in bold**

New Implementations

Commercial Plans

BlueCross and BlueChoice HealthPlan Formularies — Exclusions

Excluded Drug	Formulary Alternatives
Acuvail Solution	Ketorolac Solution
Bepreve Drops	Cromolyn Sodium Solution
But/Apap/Caf Capsules	But/Apap/Caf Tablets
Colchicine Capsules	Colchicine Tablets
Diclofenac/Misoprostil Tablets 75-0.2mg	Diclofenac + Misoprostil, other Diclofenac tablet formulations
Doxycycline Hyclate Tabs	Doxycycline Capsules
Equetro Capsules	Carbamazepine ER
Fenofibric Capsules 135 mg DR (Brand Trilipix)	Fenofibrate Capsules 134mg

Excluded Drug	Formulary Alternatives
Butalbital-acetaminophen-caffeine 50-300-40 mg	Multiple pain medications
Ilevro Drops	Ketorolac Solution
Invokana	Farxiga, Jardiance, Synjardy/XR, Xigduo XR
Invokamet/XR	Farxiga, Jardiance, Synjardy/XR, Xigduo XR
Lastacaft Solution	Cromolyn Sodium Solution
Nevanac Suspension	Ketorolac Solution
Pazeo Drops	Cromolyn Sodium Solution
Venlafaxine Tablets 150mg	Venlafaxine Capsules 150mg

New Implementations

Commercial Plans

- Tier Changes
  - Pancreaze is moving to Tier 3 on the BlueCross formulary, Tier 4 on the BlueChoice formulary
- Prior Authorization Additions
  - Pancreaze, Pertzye, Restasis, Viokace
- Step Therapy Additions

Condition/Drug Class	Step 1 Drug At least one drug must be tried first (or requires an override)	Step 2 Drug …before this drug will be covered
ADHD	amphetamine-dextroamphetamine IR/ER, dextroamphetamine IR/SR, methylphenidate IR/ER, dexmethylphenidate IR/ER, Vyvanse	Daytrana

Affordable Care Act — *2022 Formulary Additions* *(Lists are not exhaustive.)*

2022 Formulary Additions	2022 Formulary Tier
ALECENSA CAP 150MG	SPECIALITY
AMELUZ GEL 10%	NON-PREFERRED
ASMANEX, ASMANEX HFA	PREFERRED
BREZTRI AEROAERSPHERE	PREFERRED
BYDUREON	PREFERRED
BYETTA	PREFERRED
CARISOPRODOL TAB ASA/COD	NON-PREFERRED
DIFLORASONE CRE 0.05%	NON-PREFERRED
ERTACZO CRE 2%	NON-PREFERRED
FLUOCINONIDE CRE 0.1%	GENERIC
FLURANDRENOL CRE 0.05%	NON-PREFERRED
GALAFOLD CAP 123MG	SPECIALTY
KENALOG-80 INJ	NON-PREFERRED
LULICONAZOLE CRE 1%	NON-PREFERRED
MANNITOL INJ 20%	NON-PREFERRED
MEFENAMACID CAP 250MG	NON-PREFERRED
MENTAX CRE 1%	NON-PREFERRED
MEPROBAMATE TAB 200MG, 400MG	NON-PREFERRED
MOTEGRITY TAB 1MG, 2MG	NON-PREFERRED

2022 Formulary Additions	2022 Formulary Tier
NUCYNTA TAB 75MG, 50MG, 100MG	NON-PREFERRED
ORPH CIT/ASP TAB CAFFEINE	NON-PREFERRED
ORPH/ASA/CAF TAB	NON-PREFERRED
PEGINTRON KIT 50MCG	SPECIALTY
PRED-G S.O.P OIN OP	NON-PREFERRED
PREMARIN VAG CRE 0.625MG	PREFERRED
QVAR REDIHA AER 40MCG, 80MCG	PREFERRED
RYBELSUS TAB 3MG, 7MG, 14MG	PREFERRED
SODCITRATE SOL CITRACD	GENERIC
SOLIQUA INJ 100/33	PREFERRED
STRIVERDI AER 2.5MCG	PREFERRED
SULCONAZOLE CRE 1%	NON-PREFERRED
VABOMERE INJ 2GM(1-1)	NON-PREFERRED
VANDAZOLE GEL 0.75%	GENERIC
VASOSTRICT INJ 20UNT/ML	NON-PREFERRED
VELPHORO CHW 500MG	NON-PREFERRED
XEPI CRE 1%	NON-PREFERRED
XULTOPHY INJ 100/3.6	PREFERRED
ZYLET SUS 0.5-0.3%	NON-PREFERRED

Affordable Care Act — *2022 Formulary Uptier to Non-Preferred* *(Lists are not exhaustive.)*

2022 Tier Changes Drug Name — Uptier to Non-Preferred		
ACETAZOLMIDE TAB 250MG, CAP 500MG ER	DESONIDE	OLOPATADINE SPR 0.6%
AMITRIPTYLINE TAB	DESVENLAFAXINE ER	OMEGA-3-ACID CAP 1GM
AMLOD/OLMESA TAB	DEXMETHYLPHENIDATE ER	OSELTAMIVIR CAP
AMLOD/VALSAR TAB	DOXEPIN HCL CAP	PRASUGREL TAB
AMPHET/DEXTR TAB 5MG	ELETRIPTAN TAB	PROMETHAZINE SUP
ARMODAFINIL TAB	EMTR/TENOFOV TAB	PROPRANOLOL CAP ER
ATOMOXETINE CAP	ENOXAPARIN INJ	RAMELTEON TAB 8MG
BUDESONIDE	ESTRADIOL TAB 10MCG	RANOLAZINE TAB
CHOLESTYRAM POW 4GM	FENOFIBRATE CAP	RITONAVIR TAB 100MG
CIPRO/DEXA SUS 0.3-0.1%	FENOFIBRIC CAP	TAZAROTENE CRE 0.1%
CLINDAMYCIN GEL 1%, LOT 1%	FLUVOXAMINE TAB	TESTOSTERONE GEL
CLOBETASOL	GUANFACINE TAB ER	TRAZODONE TAB 300MG
COLESEVELAM TAB 625MG	METAXALONE TAB 800MG	VANCOMYCIN CAP
COLESTIPOL TAB 1GM	METHYLPHENID TAB ER	YUVAFEM TAB 10MCG
DESLORATADINE TAB 5MG	NIFEDIPINE TAB 90MG ER	

Affordable Care Act — *2022 Formulary Exclusions*

2022 Non-Formulary Drug Name	Formulary Alternatives
ACYCLOVIR CRE 5%	acyclovir oint, valacyclovir, famciclovir
AZEL/FLUTIC SPR 137-50	azelastine spray 0.1%, fluticasone spray 50mcg
AZELASTINE SPR 0.15%	azelastine spray 0.1%, flunisolide spray 0.025%, fluticasone spray 50mcg; mometasone spray 50mcg
BACLOFEN TAB 5MG	baclofen tab 10mg
BUSPIRONE TAB 7.5MG	buspirone tab 5mg
BYSTOLIC TAB	nebivolol tab
CEPHALEXIN TAB	cephalexin cap 500mg, cephalexin cap 250mg
CLOBETASOL AER 0.05%	fluocinonide sol 0.05%, amcinonide lotion 0.1%, betamethasone dip lotion 0.05%, desoximetasone gel 0.05%
DAPSONE GEL 5%	adapalene cr, adapalene gel, adapalene/benzoyl peroxide, clindamycin gel/lotion/solution, clindamycin/benzoyl peroxide, erythromycin/benzoyl peroxide, tretinoin cream
DENTA 5000 CRE PLUS	sodium fluoride cream, sodium fluoride gel
FLUOXETINE TAB	fluoxetine capsule
GENVOYA TAB	Biktarvy, Symtuza
HUMALOG, HUMULIN	Novolog, Novolin
LIVALO TAB	atorvastatin tablet, pravastatin tablet, simvastatin tablet, lovastatin tablet, rosuvastatin tablet

Affordable Care Act — *2022 Formulary Exclusions (cont'd)*

2022 Non-Formulary Drug Name	Formulary Alternatives
LO LOESTRIN TAB 1-10-10	Several contraceptive alternatives available
MIRTAZAPINE TAB 7.5MG, ODT TABS	mirtazapine tablet
OLM MED/AMLO TAB/HCTZ	amlodipine tab, valsartan/hctz tab, irbesartan/hctz tab, losartan/hctz tab, olmesartan/hctz tab, valsartan/hctz tab
PROAIR HFA AER	albuterol HFA inhaler (EXCEPTION: albuterol HFA made by Prasco)
TELMISARTAN/HCTZA TAB	irbesartan/hctz tab, losartan/hctz tab, olmesartan/hctz tab, valsartan/hctz tab
TIZANIDINE CAP	tizanidine tab
TRUVADA TAB 200-300	emtricitabine/tenofovir disoproxil fumarate
VENLAFAXINE TAB 225MG ER	venlafaxine capsule
VENTOLIN HFA AER	albuterol HFA inhaler (EXCEPTION: albuterol HFA made by Prasco)

Affordable Care Act — *2022 Utilization Management (UM) Changes*

2022 UM Changes	UM Changes
ABACA/LAMIVU TAB 600-300	QL Addition
ANNOVERA MIS	QL Addition
BIKTARYVY TAB	QL Addition
BREZTRI AERO AER SPHERE	QL Addition
COMPLERA TAB	QL Addition
DUREZOL EMU 0.05%	PA Addition
ELMIRON CAP 100MG	PA Addition
EMTR/TENOFOV TAB 200-300	QL Addition
EVOTAZ TAB 300-150	QL Addition
INTRAROSA SUP 6.5MG	PA Addition, ST Addition
JULUCA TAB 50-25MG	QL Addition
LATUDA TAB	PA Addition
MOTEGRITY TAB 2MG	QL Addition, PA Addition, ST Addition

2022 UM Changes	UM Changes
NUCYNTA TAB 100 MG	QL Addition, PA Addition
ODEFSEY TAB	QL Addition
PIMECROLIMUS CRE 1%	PA Addition, ST Addition
POSACONAZOLE TAB 100MG DR	PA Addition
PREZCOBIX TAB 800-150	QL Addition
RYBELSUS TAB	QL Addition, PA Addition, ST Addition
SOLIQUA INJ 100/33	QL Addition, PA Addition, ST Addition
TAZAROTENE CRE 0.1%	PA Addition
TRAMADOL HCL TAB ER	PA Addition
TRIUMEQ TAB	QL Addition
VANCOMYCIN CAP 125MG	QL Addition
VIIBRYD TAB	PA Addition

PA – Prior Authorization | QL – Quantity Limit | ST – Step Therapy

New Implementations

Medicare Plans

- New Essential PDP Plan with narrow formulary
- Preferred Pharmacy Network
  - Copay differential for prescriptions filled at preferred pharmacies, lower tiers
- MAPD Plans ONLY:
  - New insulin savings coverage with $35 30-day member cost share
    - Lilly (Humalog products), Novo-Nordisk (Novolog products, Levemir), Sanofi (Lantus) + Tresiba, Toujeo, etc.

New Implementations

Medicare Plans

MAPD Formularies

- 3 Plans: Total, Total Value, Secure (HMO)
- 5-Tier Formularies Designed Specifically for MAPD
- Adherence Drugs on Lowest Tiers
- Dual Insulin Strategy with $35 cost share
- Standard Utilization Management (PA, QL, ST)

PDP Formularies

- 3 Plans: Rx Value℠, Rx Plus℠, Rx Essential℠
- 5-Tier Formularies Designed for PDP
- Adherence Drugs on Lowest Tiers
- Standard Utilization Management (PA, QL, ST)

PA – Prior Authorization | QL – Quantity Limit | ST – Step Therapy

New Implementations

Medicare Plans

Tier Composition (Drug Type Labels)

Tier 1: Preferred Generic
Tier 2: Generic
Tier 3: Preferred Brand
Tier 4: Non-Preferred Drug
Tier 5: Specialty Tier

Star Adherence Strategy

Generic STAR Adherence Drugs:

- Tier 1 if low cost
- Tier 2 if moderate, Tier 4 high-cost generics <$830/month

Formulary Rules

Tier 1: Preferred generics (including most STAR adherence drugs)
Tier 2: Low-cost generics
Tier 3: Preferred brands and moderate cost generics
Tier 4: Non-preferred brands and higher cost generics
Tier 5: Specialty >$830/month (brands, generics)

Tier assignment may also be impacted by:

- P&T compliance review (Risk to Benefit, Essential Drug)
- CMS category/class review concerns (representation, preferred product)

High-Risk Medication Strategy

- Manage many HRMs with PAs/QLs that trigger for members 65 years and older
- Generally, Tier 4 with PA and/or QL or Tier 2 with PA or QL if the drug is both a STAR adherence drug and an HRM.
- HRMs based on Beer's List

Pharmacy Reminders

Pharmacy Reminders

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℠ (MIM) when you check the member's benefits.

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

Pharmacy Reminders

PreCheck MyScript® (PCMS)

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

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

The benefits of using PCMS include:

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

Pharmacy Resources

Pharmacy Resources

Commercial and Affordable Care Act Plans

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

Pharmacy Resources

Provider Plan Contact Information

Affordable Care Act (ACA) Plans

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

www.SouthCarolinaBlues.com

Commercial Plans

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

Pharmacy Resources

Medicare Advantage

- OptumRx Home Delivery Mail Service
  - E-scribe National Council for Prescription Drug Programs (NCPDP)
    - Mail NCPDP ID: 0556540
    - Specialty NCPDP ID: 5732676
- OptumRx Home Delivery
  - Call: 855-540-5951
- OptumRx Mailing Address
  - P.O. Box 2975

  Shawnee Mission, KS 66201-1375
- Coverage Determinations and General Inquiries
  - Call: 888-645-6025
  - Fax: 844-403-1028
- Websites
  - www.optumrx.com
  - www.SCBluesMedadvantage.com

PROVIDER ENROLLMENT

Agenda

- My Provider Enrollment Portal
- Current Enrollment Processes
- Resources

My Provider Enrollment Portal

My Provider Enrollment Portal

New Enrollment Tool

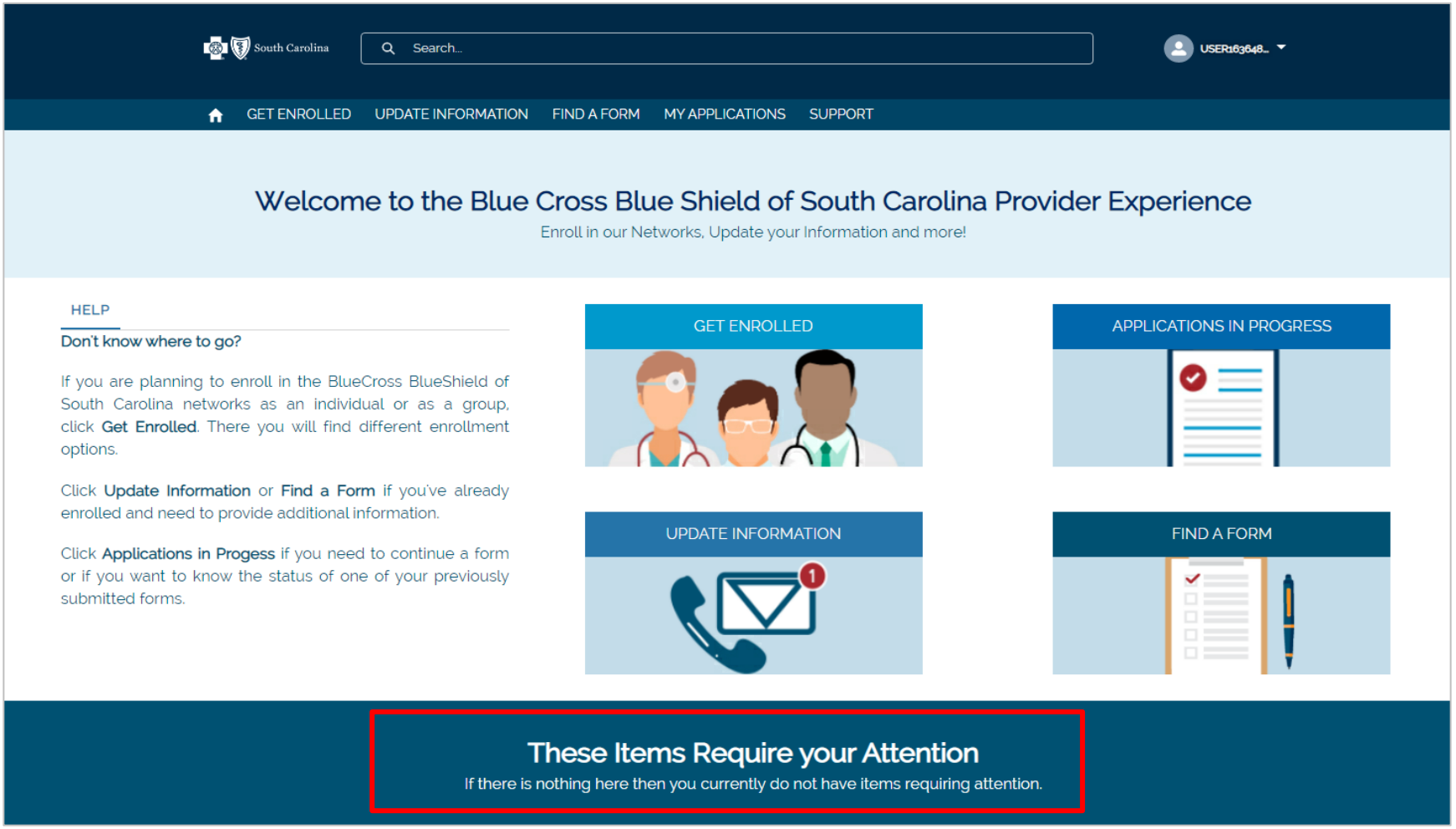
My Provider Enrollment Portal

Details of the portal include:

- Launches in Q1 of 2022
- Has quick and easy navigation
- Allows documents to be uploaded and stored until ready for submission
- Offers automated statuses and notifications when additional information is needed

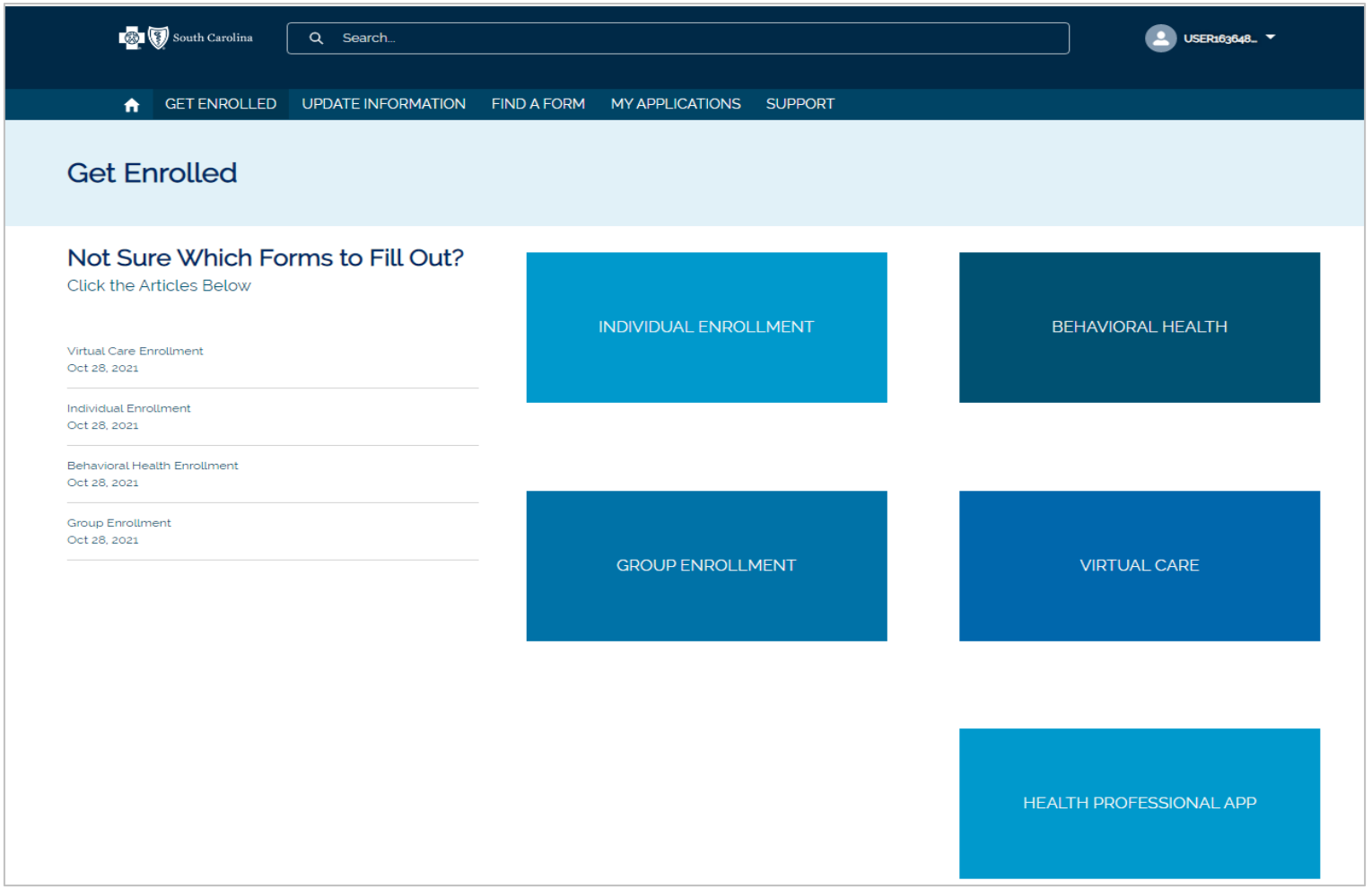
My Provider Enrollment Portal

Home Page



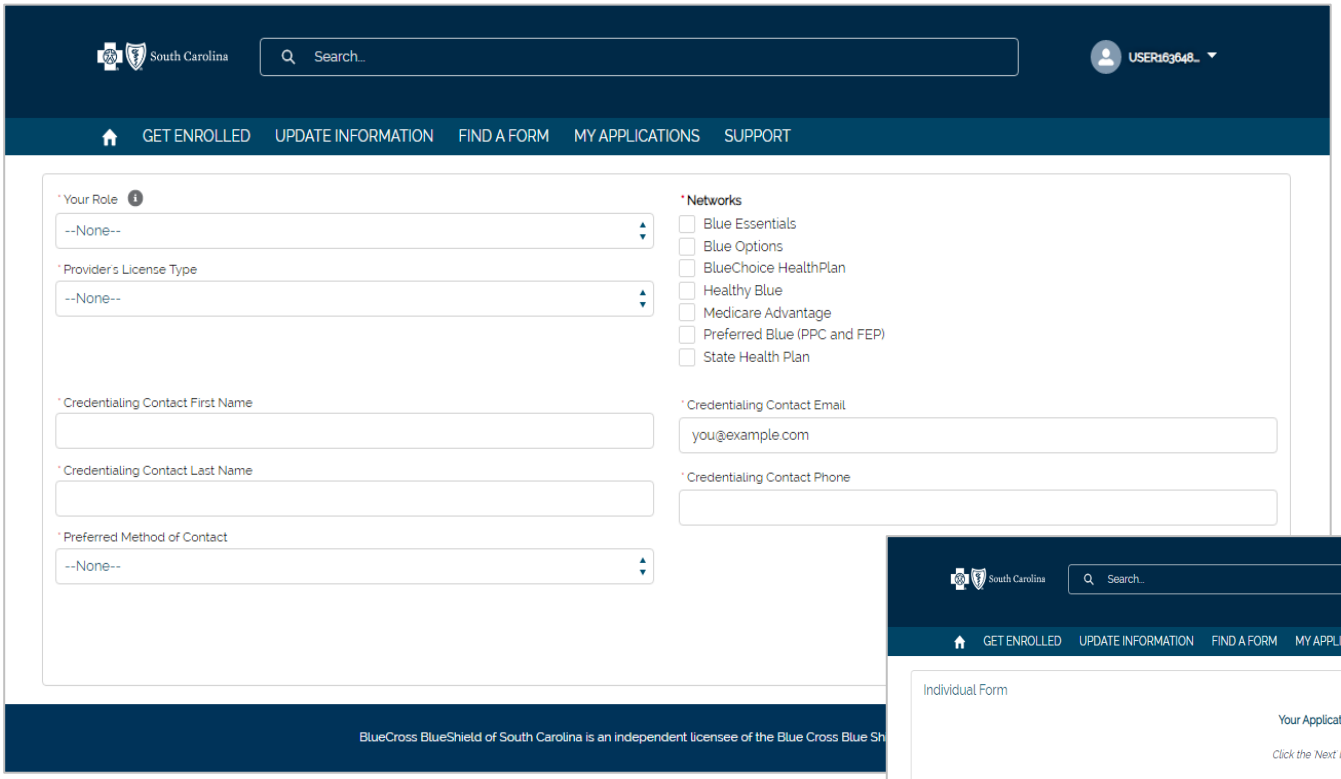
My Provider Enrollment Portal

Get Enrolled



My Provider Enrollment Portal

Get Enrolled — Individual Enrollment



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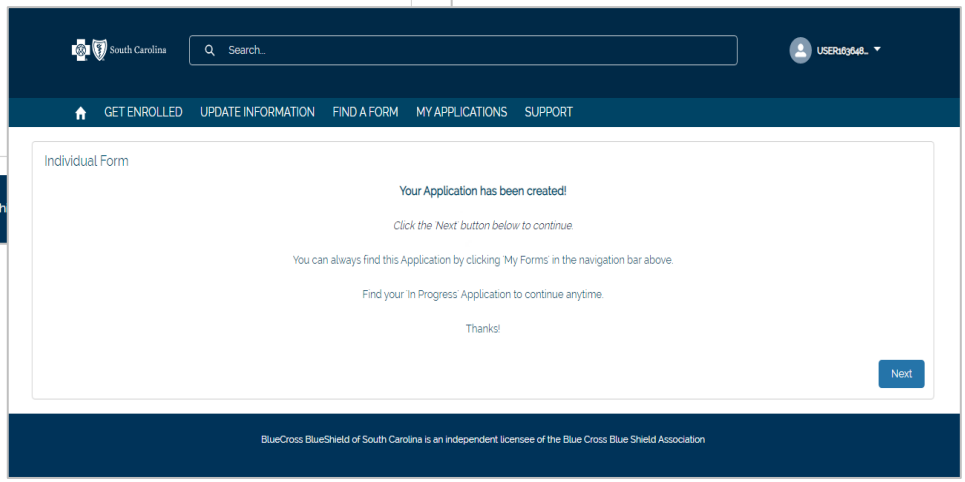
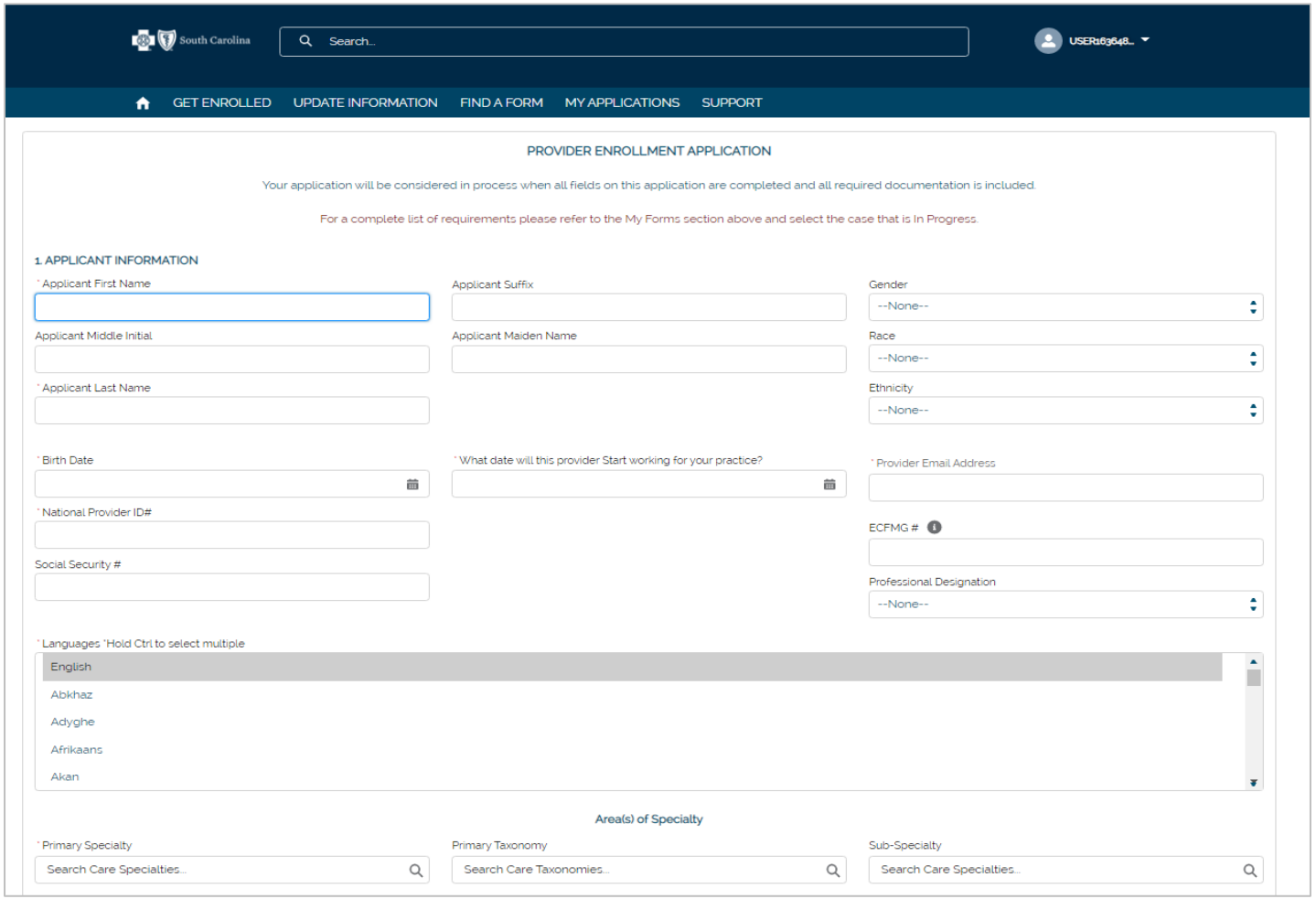


Notification advising the application has been created.

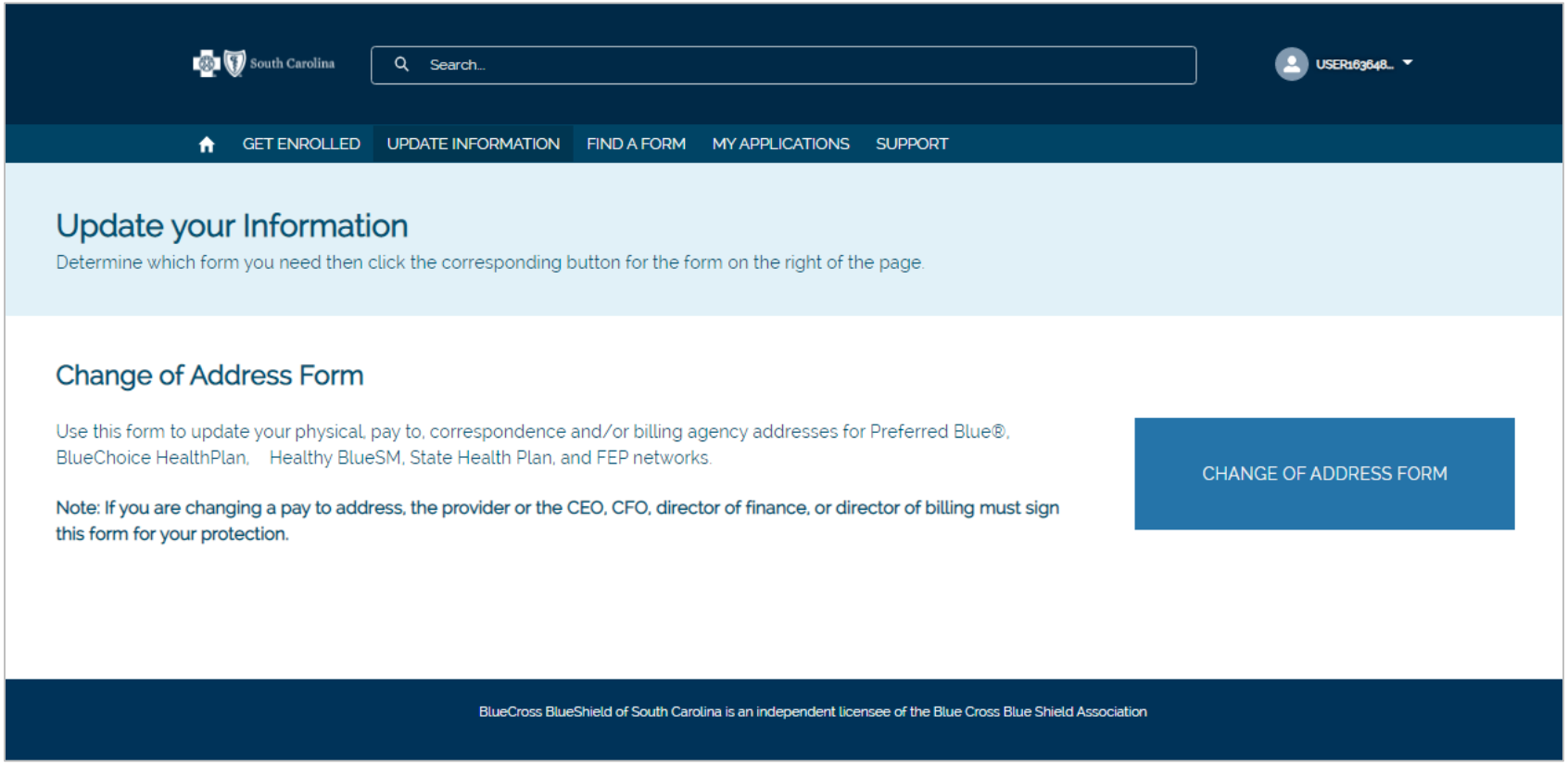
My Provider Enrollment Portal

Get Enrolled — Individual Enrollment



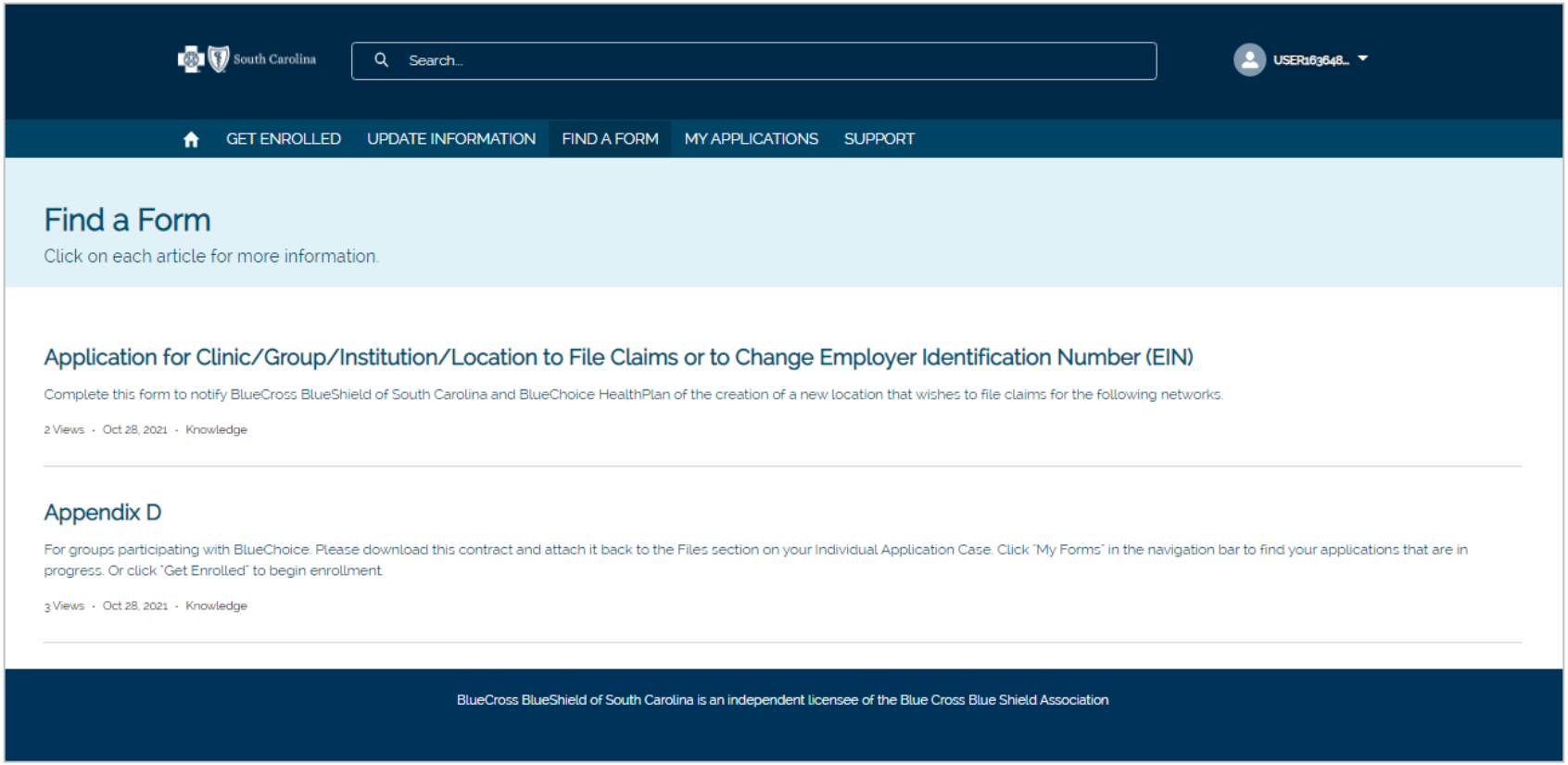
My Provider Enrollment Portal

Update Information



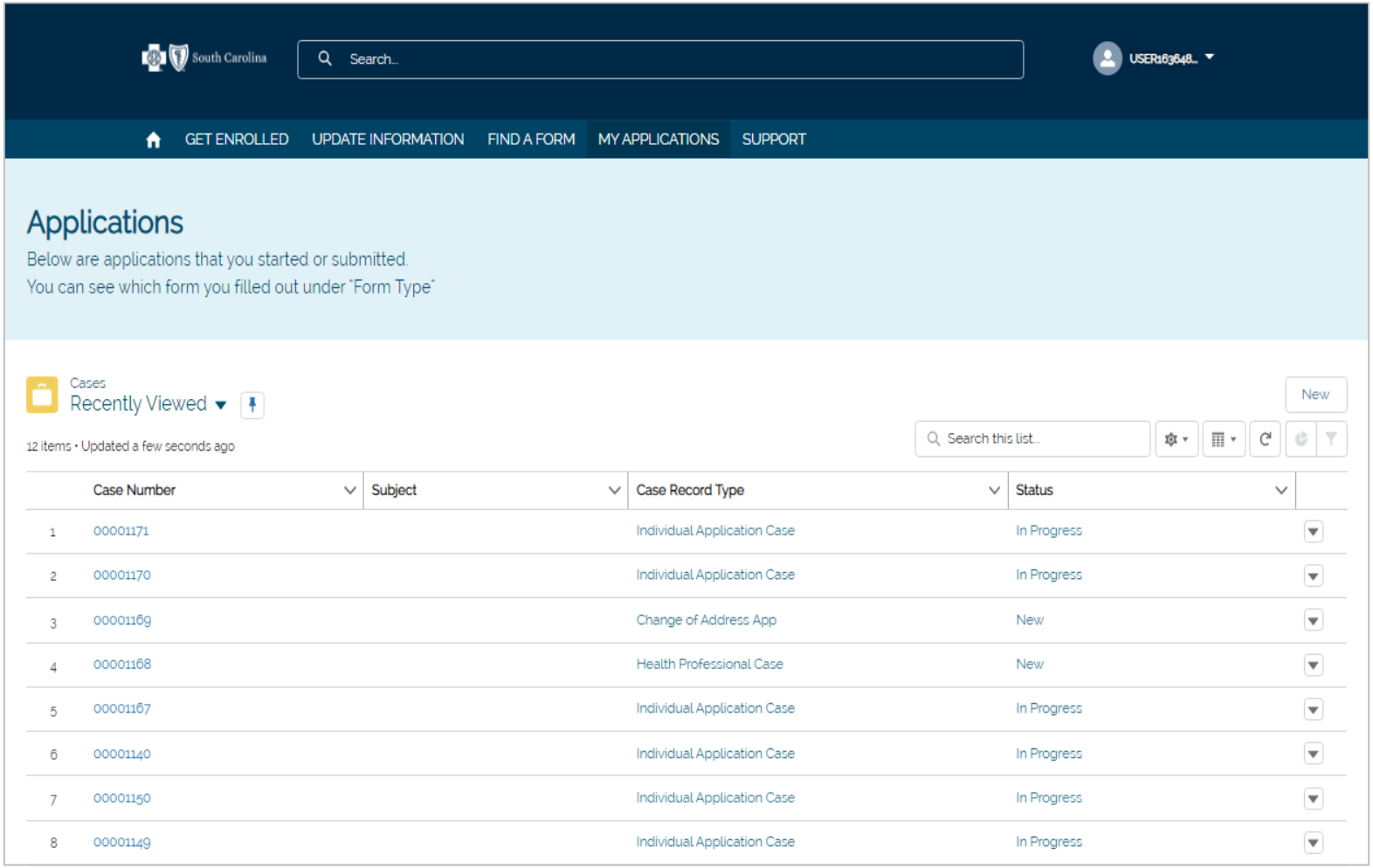
My Provider Enrollment Portal

Find a Form



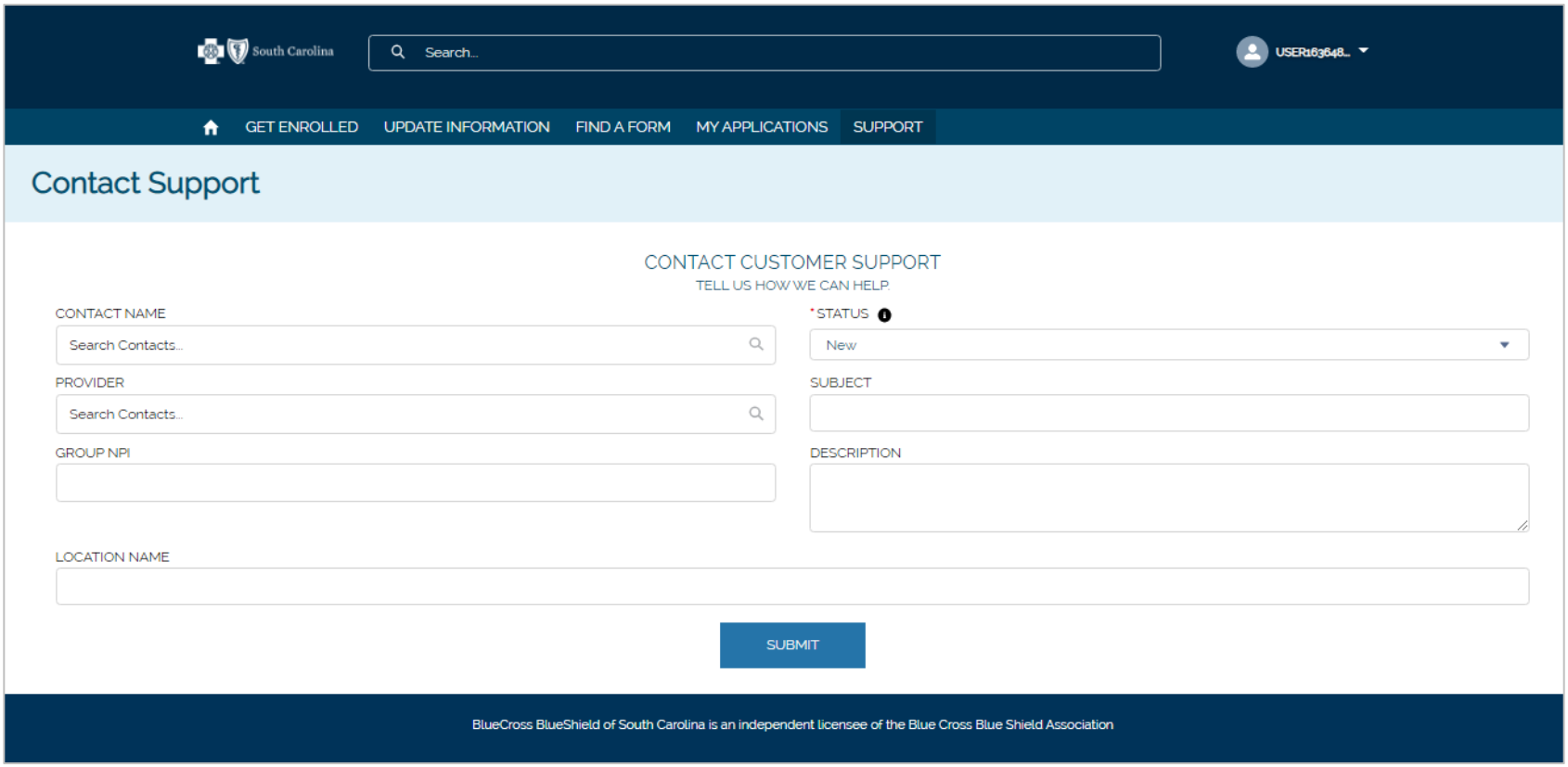
My Provider Enrollment Portal

My Applications



My Provider Enrollment Portal

Support

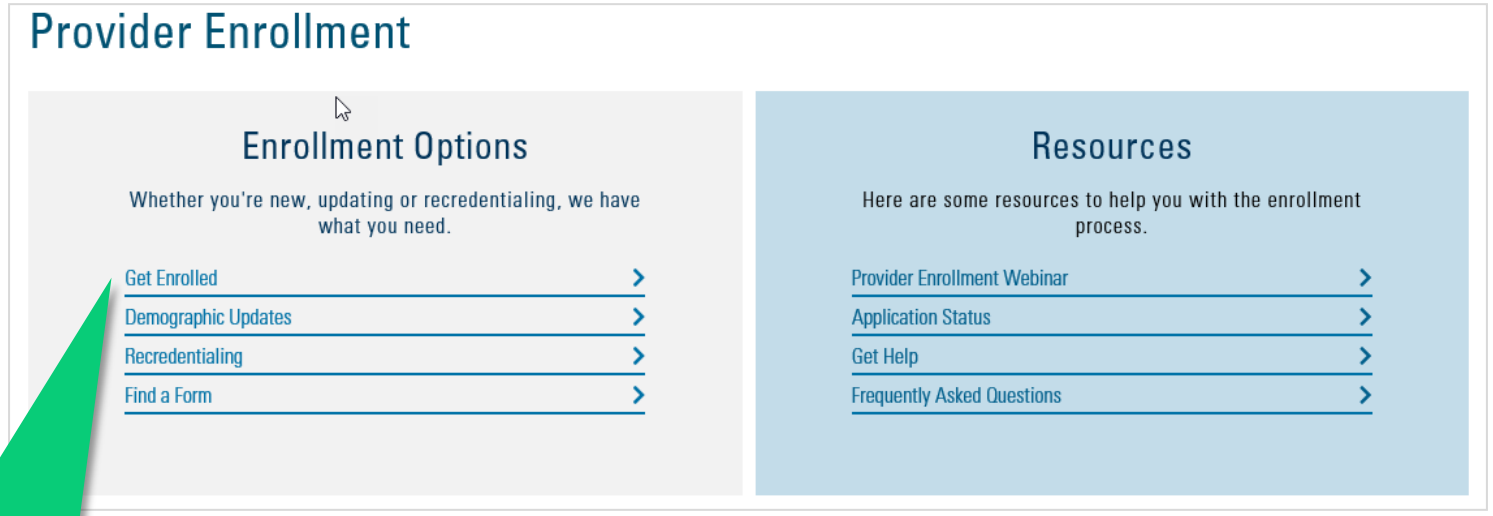


Current Enrollment Processes

Current Enrollment Processes

Getting Started

The Provider Enrollment page provides options to join a network, make updates for your practice and more.



Click Get Enrolled to join one of our many networks.

Current Enrollment Processes

Getting Started (cont'd)

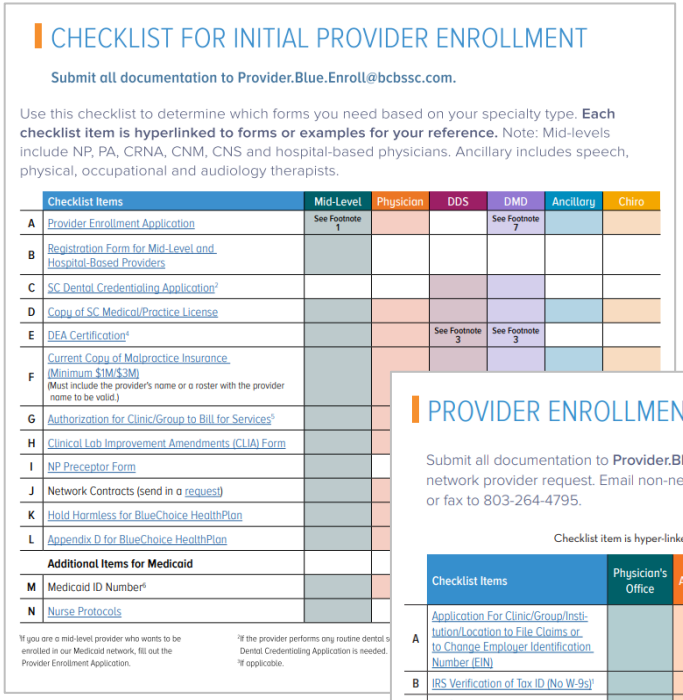
Only for primary care practices.

Current Enrollment Processes

Enrollment Checklists

Available checklists

- Individual enrollment
- Group/practice enrollment



CHECKLIST FOR INITIAL PROVIDER ENROLLMENT

Submit all documentation to Provider.Blue.Enroll@bcbssc.com.

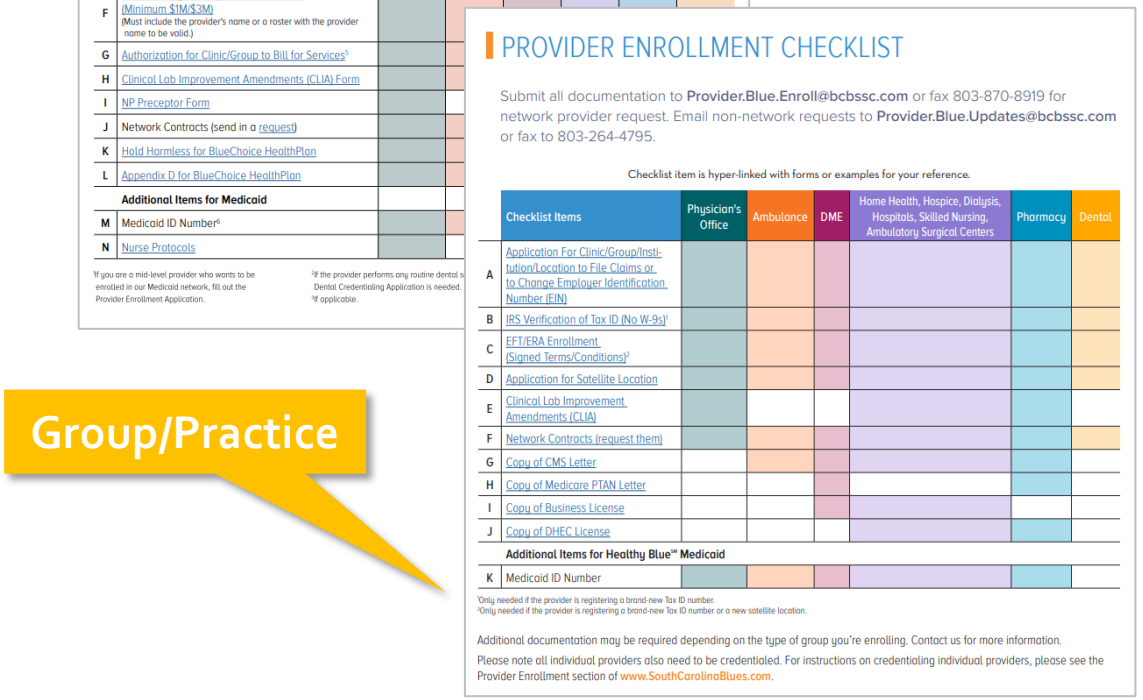
Use this checklist to determine which forms you need based on your specialty type. **Each checklist item is hyperlinked to forms or examples for your reference.** Note: Mid-levels include NP, PA, CRNA, CNM, CNS and hospital-based physicians. Ancillary includes speech, physical, occupational and audiology therapists.

	Checklist Items	Mid-Level	Physician	DDS	DMD	Ancillary	Chiro
A	Provider Enrollment Application	See Footnote 1			See Footnote 7		
B	Registration Form for Mid-Level and Hospital-Based Providers						
C	SC Dental Credentialing Application[2]						
D	Copy of SC Medical/Practice License						
E	DEA Certification[4]			See Footnote 3	See Footnote 3		
F	Current Copy of Malpractice Insurance (Minimum $1M/$3M) (Must include the provider's name or a roster with the provider name to be valid.)						
G	Authorization for Clinic/Group to Bill for Services[5]						
H	Clinical Lab Improvement Amendments (CLIA) Form						
I	NP Preceptor Form						
J	Network Contracts (send in a request)						
K	Hold Harmless for BlueChoice HealthPlan						
L	Appendix D for BlueChoice HealthPlan						
	Additional Items for Medicaid						
M	Medicaid ID Number[6]						
N	Nurse Protocols						

[1]If you are a mid-level provider who wants to be enrolled in our Medicaid network, fill out the Provider Enrollment Application.

[2]If the provider performs any routine dental s... Dental Credentialing Application is needed.
[3]If applicable.

Individual



PROVIDER ENROLLMENT CHECKLIST

Submit all documentation to **Provider.Blue.Enroll@bcbssc.com** or fax 803-870-8919 for network provider request. Email non-network requests to **Provider.Blue.Updates@bcbssc.com** or fax to 803-264-4795.

Checklist item is hyper-linked with forms or examples for your reference.

	Checklist Items	Physician's Office	Ambulance	DME	Home Health, Hospice, Dialysis, Hospitals, Skilled Nursing, Ambulatory Surgical Centers	Pharmacy	Dental
A	Application For Clinic/Group/Institution/Location to File Claims or to Change Employer Identification Number (EIN)						
B	IRS Verification of Tax ID (No W-9s)[1]						
C	EFT/ERA Enrollment (Signed Terms/Conditions)[2]						
D	Application for Satellite Location						
E	Clinical Lab Improvement Amendments (CLIA)						
F	Network Contracts (request them)						
G	Copy of CMS Letter						
H	Copy of Medicare PTAN Letter						
I	Copy of Business License						
J	Copy of DHEC License						
	Additional Items for Healthy Blue℠ Medicaid						
K	Medicaid ID Number						

[1]Only needed if the provider is registering a brand-new Tax ID number.
[2]Only needed if the provider is registering a brand-new Tax ID number or a new satellite location.

Additional documentation may be required depending on the type of group you're enrolling. Contact us for more information.

Please note all individual providers also need to be credentialed. For instructions on credentialing individual providers, please see the Provider Enrollment section of www.SouthCarolinaBlues.com.

Group/Practice

Current Enrollment Processes

Clean Application Process

Four main steps in the clean application enrollment process include:

1. Credentialing team receives complete enrollment application
2. Application is reviewed for completion and sent to the Credentialing Committee
   - Only complete and accurate packets are sent to the committee.
     - For applications with missing/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

Current Enrollment Processes

Clean Application Process (cont'd)

Keep in mind that:

- Effective dates are based on the Credentialing Committee's approval date, per Utilization Review Accreditation Commission (URAC) requirements
- The Credentialing Committee reviews all enrollment applications to ensure all required credentialing criteria are met
  - URAC
  - National Committee for Quality Assurance (NCQA)
  - South Carolina Department of Health & Human Services (SCDHHS), when applicable
- Back dating network dates are not allowed

Current Enrollment Processes

Missing/Incorrect Documentation

Five common missing or incorrect items that cause delays in the processing of applications:

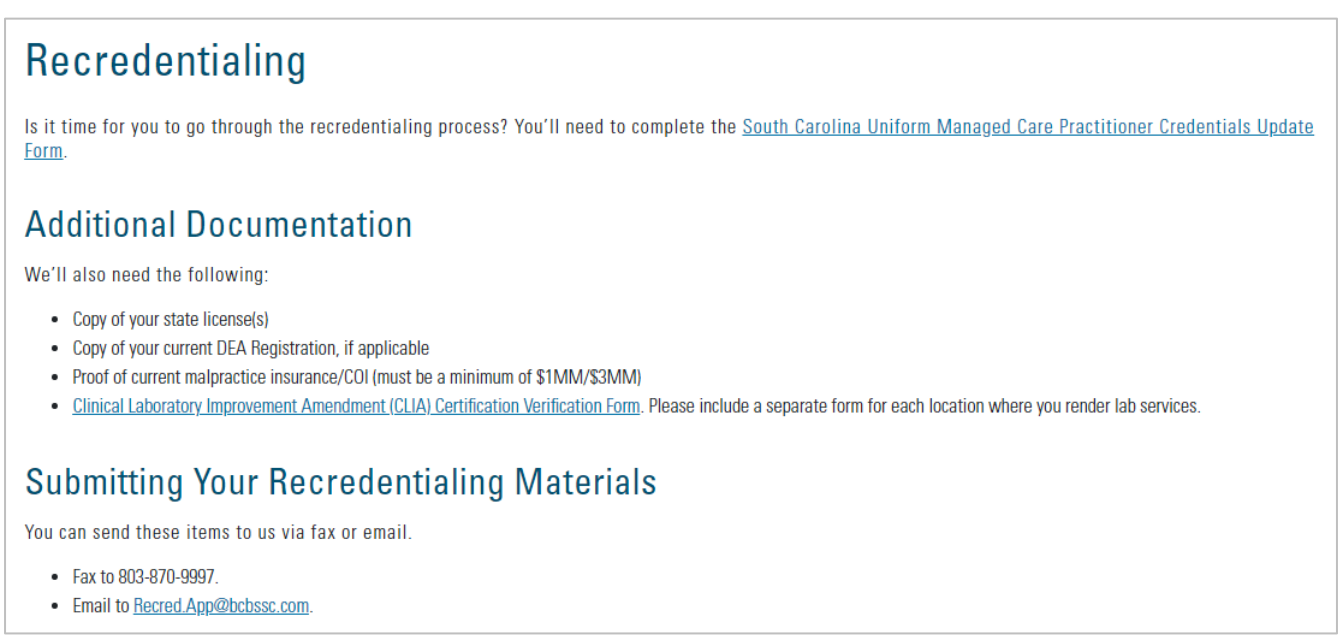
1. Outdated applications
2. Five-year work history, including current employers
   - Gaps longer than six months must include an explanation.
   - If work history is less than six months, include schooling.
3. Malpractice roster and/or coversheet with provider's name included
4. Clinical Laboratory Improvement Amendment (CLIA) form with ALL applications, except non-medical dental
   - Form must be completed even if the provider does not have a CLIA certificate.
5. Unaltered contract pages with wet signatures and current dates

Current Enrollment Processes

Recredentialing

When is recredentialing required?

- Every three years
- Initial enrollment required if recredentialing timeframe is missed



Recredentialing

Is it time for you to go through the recredentialing process? You'll need to complete the South Carolina Uniform Managed Care Practitioner Credentials Update Form.

Additional Documentation

We'll also need the following:

- Copy of your state license(s)
- Copy of your current DEA Registration, if applicable
- Proof of current malpractice insurance/COI (must be a minimum of $1MM/$3MM)
- Clinical Laboratory Improvement Amendment (CLIA) Certification Verification Form. Please include a separate form for each location where you render lab services.

Submitting Your Recredentialing Materials

You can send these items to us via fax or email.

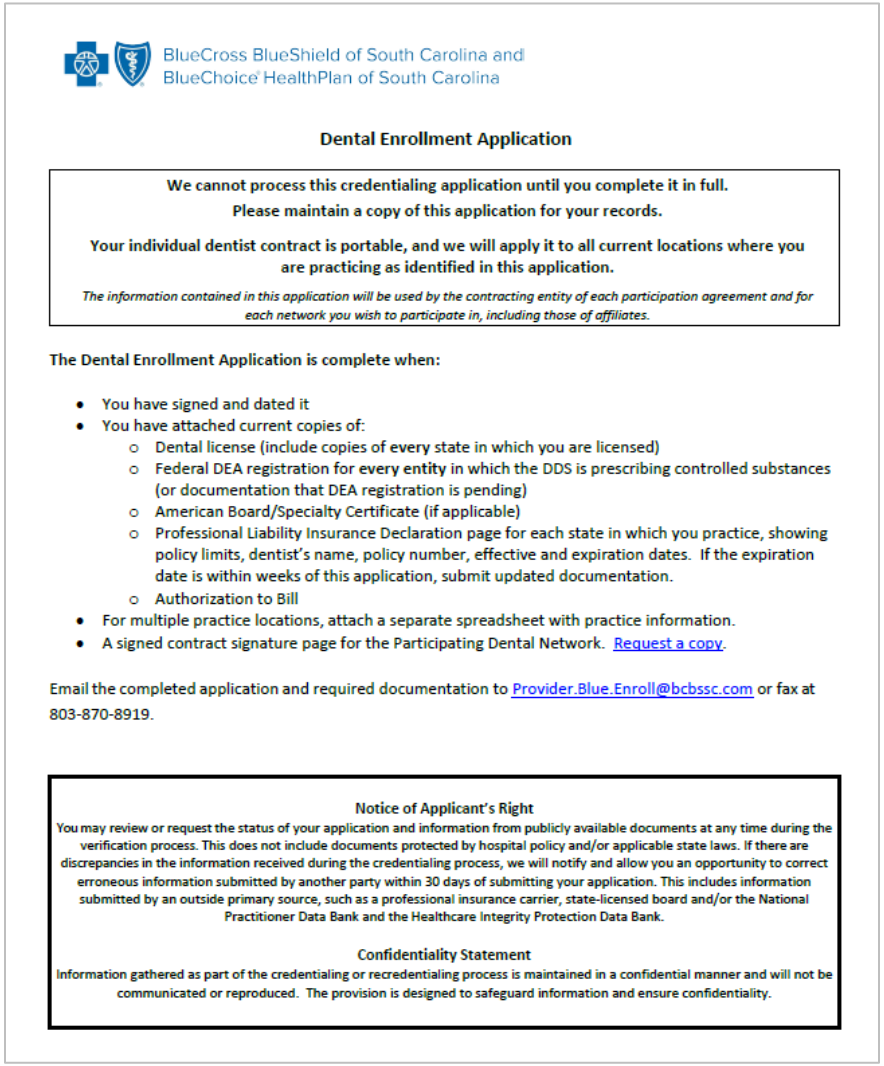
- Fax to 803-870-9997.
- Email to Recred.App@bcbssc.com.

Current Enrollment Processes

Dental Credentialing

Included Plans:

- GRID members
- State Health Plan members
- Medicare Advantage members
- Federal Employee Program (FEP)



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

Dental Enrollment Application

We cannot process this credentialing application until you complete it in full.
Please maintain a copy of this application for your records.

Your individual dentist contract is portable, and we will apply it to all current locations where you are practicing as identified in this application.

The information contained in this application will be used by the contracting entity of each participation agreement and for each network you wish to participate in, including those of affiliates.

The Dental Enrollment Application is complete when:

- You have signed and dated it
- You have attached current copies of:
  - Dental license (include copies of **every** state in which you are licensed)
  - Federal DEA registration for **every entity** in which the DDS is prescribing controlled substances (or documentation that DEA registration is pending)
  - American Board/Specialty Certificate (if applicable)
  - Professional Liability Insurance Declaration page for each state in which you practice, showing policy limits, dentist's name, policy number, effective and expiration dates. If the expiration date is within weeks of this application, submit updated documentation.
  - Authorization to Bill
- For multiple practice locations, attach a separate spreadsheet with practice information.
- A signed contract signature page for the Participating Dental Network. Request a copy.

Email the completed application and required documentation to Provider.Blue.Enroll@bcbssc.com or fax at 803-870-8919.

Notice of Applicant's Right

You may review or request the status of your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable state laws. If there are discrepancies in the information received during the credentialing process, we will notify and allow you an opportunity to correct erroneous information submitted by another party within 30 days of submitting your application. This includes information submitted by an outside primary source, such as a professional insurance carrier, state-licensed board and/or the National Practitioner Data Bank and the Healthcare Integrity Protection Data Bank.

Confidentiality Statement

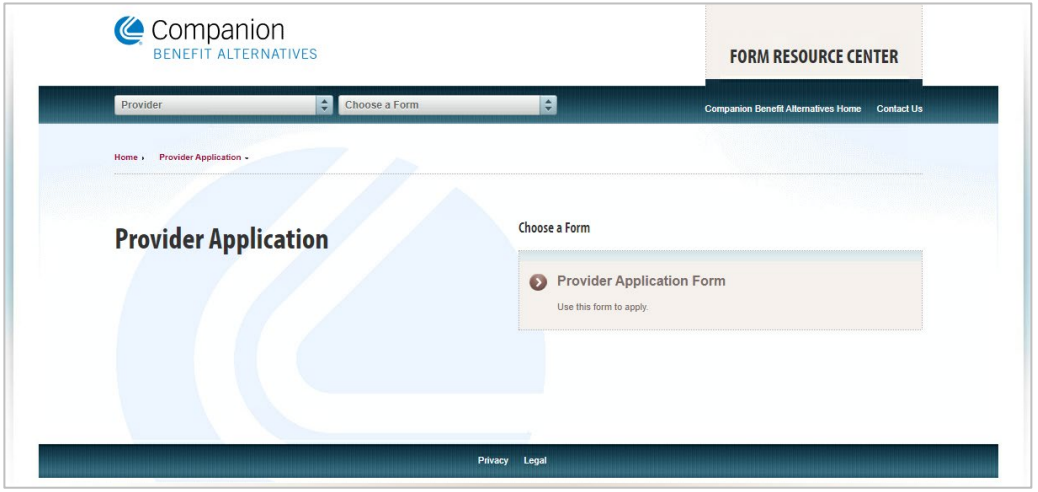
Information gathered as part of the credentialing or recredentialing process is maintained in a confidential manner and will not be communicated or reproduced. The provision is designed to safeguard information and ensure confidentiality.

Current Enrollment Processes

Behavioral Health Credentialing

Included providers:

- Psychiatrists
- Psychologists
- Addictionologists
- Clinical social workers
- Licensed professional counselors
- Licensed marriage and family therapists



For Questions:

Call: 800-868-1032, ext. 25744
or
Email: CBA.ProvRep@companiongroup.com

CBA is a separate company that administers mental health and substance abuse benefits on behalf of BlueCross and BlueChoice® HealthPlan.

Current Enrollment Processes

Non-credentialed Providers

Providers not credentialed by BlueCross BlueShield of South Carolina:

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

Current Enrollment Processes

Provider Directory Validation

Effective Jan. 1, 2022, providers must verify their demographic data at least every 90 days. This applies to both individual physicians and facilities.

Importance of Validation

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

How to Validate Information

- M.D. Checkup

Current Enrollment Processes

M.D. Checkup

What is M.D. Checkup?

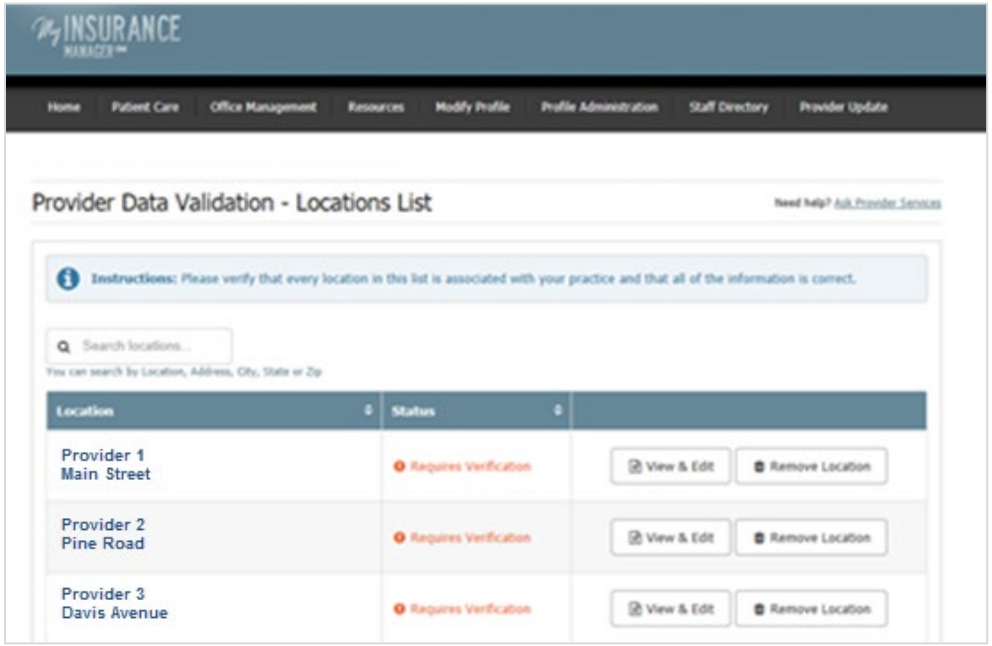
- Web-based tool used for provider demographic updates
- Updates can be made at any time

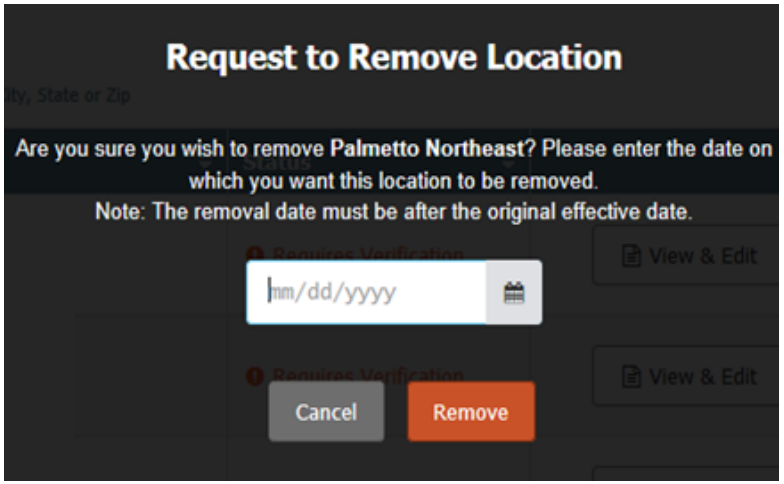
What can be done in M.D. Checkup?

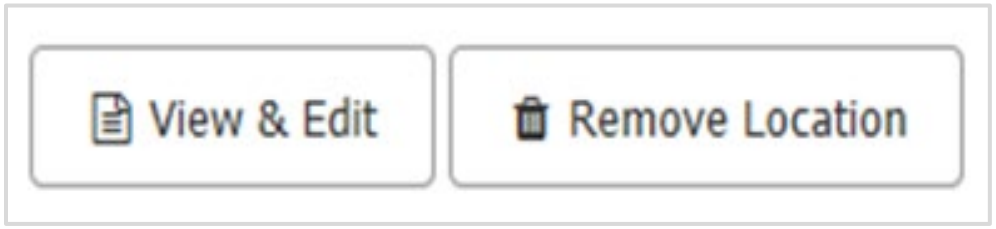
- **Verify** current data
- **Update** data for your office or practice
- **View & Edit** office or practice details
- **Terminate or Inactivate** locations and/or practitioners
- **Add** practitioners

Current Enrollment Processes

M. D. Checkup (cont'd)







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

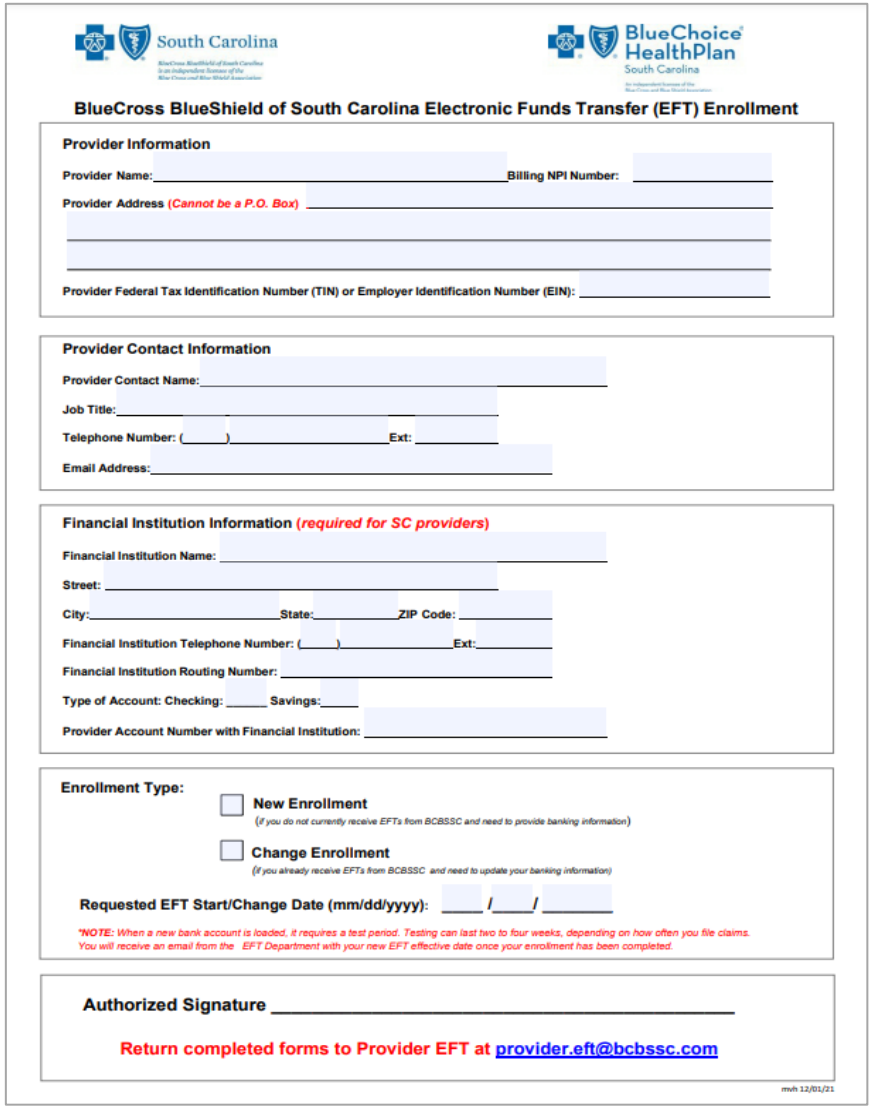
Current Enrollment Processes

Electronic Funds Transfer (EFT)

Benefits of EFT:

- Eliminates paper checks
- Quicker payment turnaround

Form available on www.SouthCarolinaBlues.com



South Carolina

BlueChoice HealthPlan South Carolina

BlueCross BlueShield of South Carolina Electronic Funds Transfer (EFT) Enrollment

Provider Information

Provider Name:_____ Billing NPI Number: _____

Provider Address (*Cannot be a P.O. Box*) _____

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): _____

Provider Contact Information

Provider Contact Name:_____

Job Title:_____

Telephone Number: (_____)_____ Ext: _____

Email Address:_____

Financial Institution Information (*required for SC providers*)

Financial Institution Name: _____

Street: _____

City:_____ State:_____ ZIP Code: _____

Financial Institution Telephone Number: (_____)_____ Ext:_____

Financial Institution Routing Number: _____

Type of Account: Checking: _____ Savings:_____

Provider Account Number with Financial Institution: _____

Enrollment Type:

☐ **New Enrollment**
(*if you do not currently receive EFTs from BCBSSC and need to provide banking information*)

☐ **Change Enrollment**
(*if you already receive EFTs from BCBSSC and need to update your banking information*)

Requested EFT Start/Change Date (mm/dd/yyyy): ____ /____/ _____

**NOTE: When a new bank account is loaded, it requires a test period. Testing can last two to four weeks, depending on how often you file claims. You will receive an email from the EFT Department with your new EFT effective date once your enrollment has been completed.*

Authorized Signature _____

Return completed forms to Provider EFT at provider.eft@bcbssc.com

mvh 12/01/21

Provider Enrollment Resources

Provider Enrollment Resources

Contact Us

For Questions

- Provider Services: 800-868-2510, Option 5

Note: This option will be available until Q2 of 2022.

Once My Provider Enrollment Portal is implemented, all business will be conducted through the new tool.

QUALITY

Introductions

Alicia Buffum
Manager
Provider Quality Improvement

Stacey Penning
Manager
Provider Quality Improvement

Shannon Montgomery
Manager
Corporate Quality Management

Agenda

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

National Committee for Quality Assurance (NCQA®)

National Committee for Quality Assurance (NCQA®)

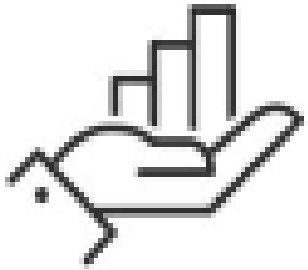
What is the National Committee for Quality Assurance (NCQA)?

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

National Committee for Quality Assurance (NCQA®)

What does the 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 (HEDIS)

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/ Exchange products
  - Medicare Advantage
- Federal Employee Program (FEP)

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS "Season"

- Also referred to as **Retro Season** or **Retrospective Season** or **Hybrid Season**
- Looks at the care given or due in the prior year
- Runs from January through May of the following year
  - 2021 will be the measurement year reviewed during HEDIS 2022
- Members are chosen by NCQA
- All requested member documentation is based on the selected HEDIS measure

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS "Year-Round"

- Also referred to as **Prospective Season**
- Continuously monitors rates in real-time
- Runs from Jan. 1 through Dec. 31 of the current year
- Total membership rates
- Additional options for compliance:
  - Claims
  - Data transfer
  - Medical records
  - Compliance forms

Things to do!

Requests for Information

Requests for Information

South Carolina

Medical Records Request

Prospective/ Year-Round HEDIS

vs.

South Carolina

Medical Records Request

Retrospective Review/ HEDIS Hybrid Season

Requests for Information

How are requests sent?

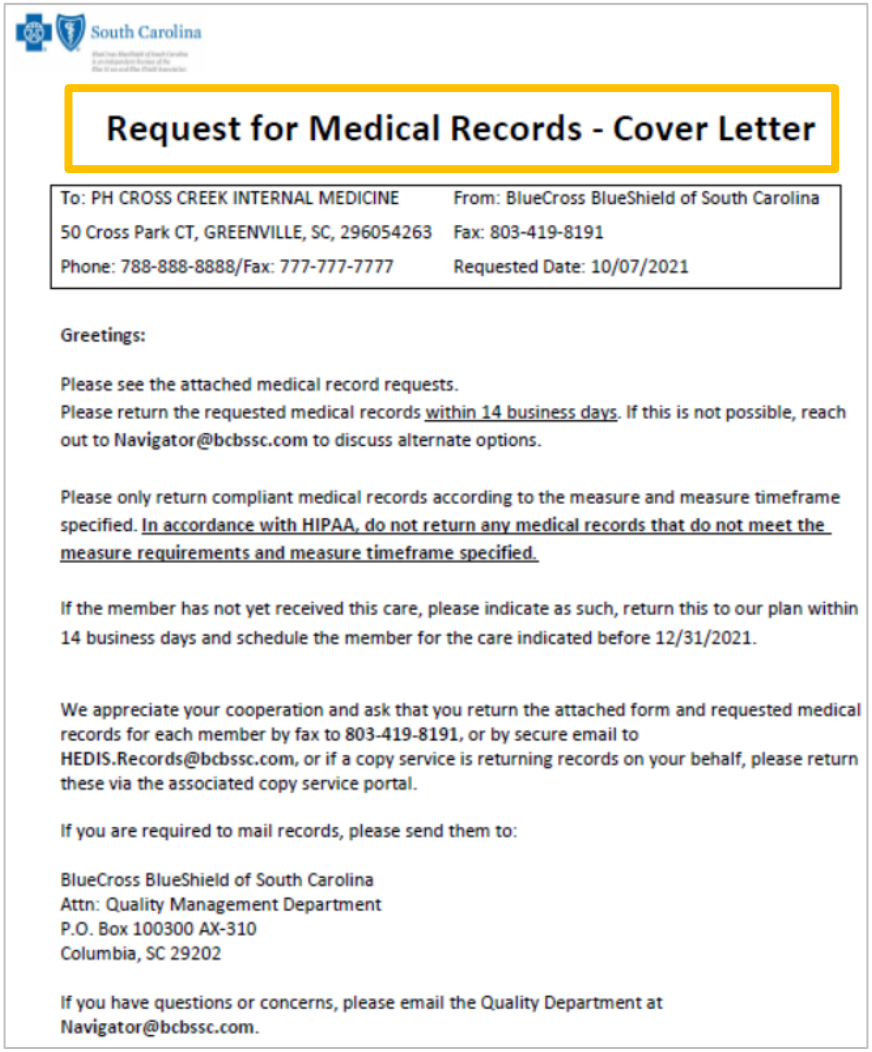
Requests are based on claims and are sent via email, fax or mail.

We can negate all medical records requests if given remote access to your EMR. This can be done by emailing NAVIGATOR@bcbssc.com.

How are requests created?

Claims!

Note: You will not receive medical record requests for compliance that was already received during Prospective/Year-round HEDIS.



South Carolina

Request for Medical Records - Cover Letter

To: PH CROSS CREEK INTERNAL MEDICINE	From: BlueCross BlueShield of South Carolina
50 Cross Park CT, GREENVILLE, SC, 296054263	Fax: 803-419-8191
Phone: 788-888-8888/Fax: 777-777-7777	Requested Date: 10/07/2021

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

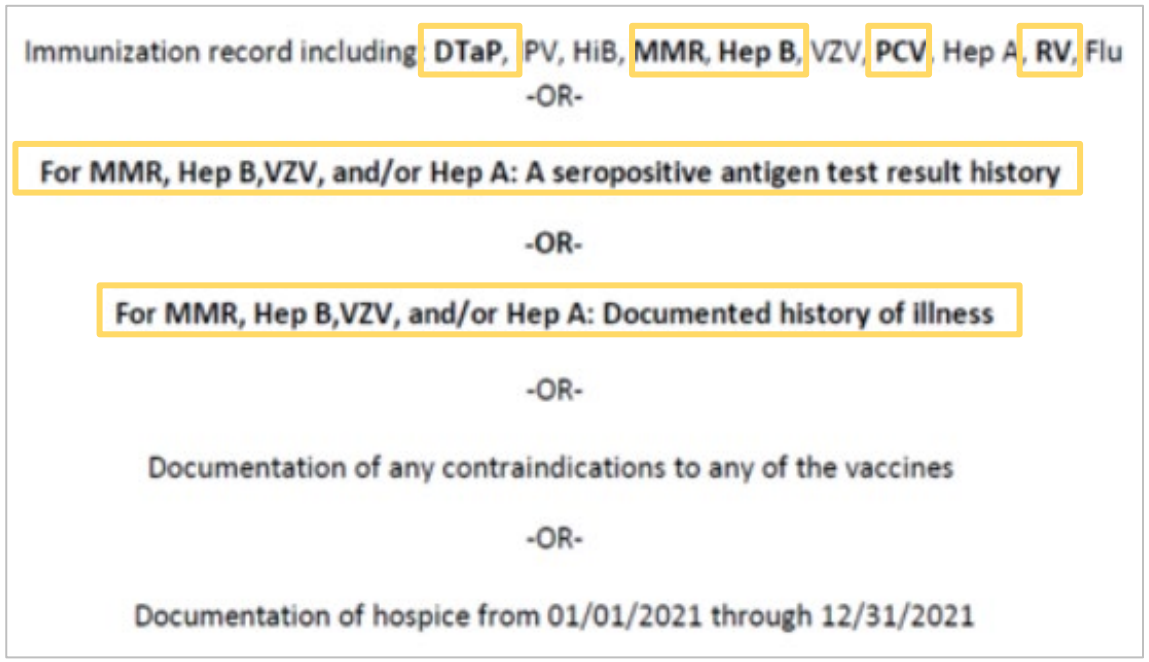
If you have questions or concerns, please email the Quality Department at Navigator@bcbssc.com.

Requests for Information

What information should be returned?

Providers are required to return the requested documentation in **bold**.

Example



Providers only need to send back the requested documentation in bold if there are multiple sub-measures on one page.

Requests for Information

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

Health Insurance Exchange BCBSSC

CMS.gov
Centers for Medicare & Medicaid Services

Rating System

- Quality Ratings System (QRS)

Technical Specifications

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

Health Insurance Exchange BCBSSC

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

Independent licensees of the Blue Cross and Blue Shield Association

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

Federal Employee Program (FEP) — 2020MY

Quality Navigator Program

Quality Navigator Program

What is the Quality Navigator Program?

- Participation is based on the provider attribution within primary care specialties.
- Providers are automatically enrolled.
- There is no cost to providers.
- There are multiple tools and offerings to support providers.

What is a Quality Navigator?

- A dedicated team member in the quality department with either a registered nursing license or related healthcare bachelor's degree
- Your point of contact for care coordination and patient engagement
- Available to schedule in-office or conference call education sessions to assist with understanding the NCQA measures, review your open quality care opportunities, and collaborate with you to improve your overall quality scores

Quality Navigator Program

What can the Quality Navigator do for you during the Retrospective/HEDIS Season?

- Answer questions about the specific records that are being requested for the sample members
- Pull records via remote access for the sample members
- Come on-site to pull records for the sample members

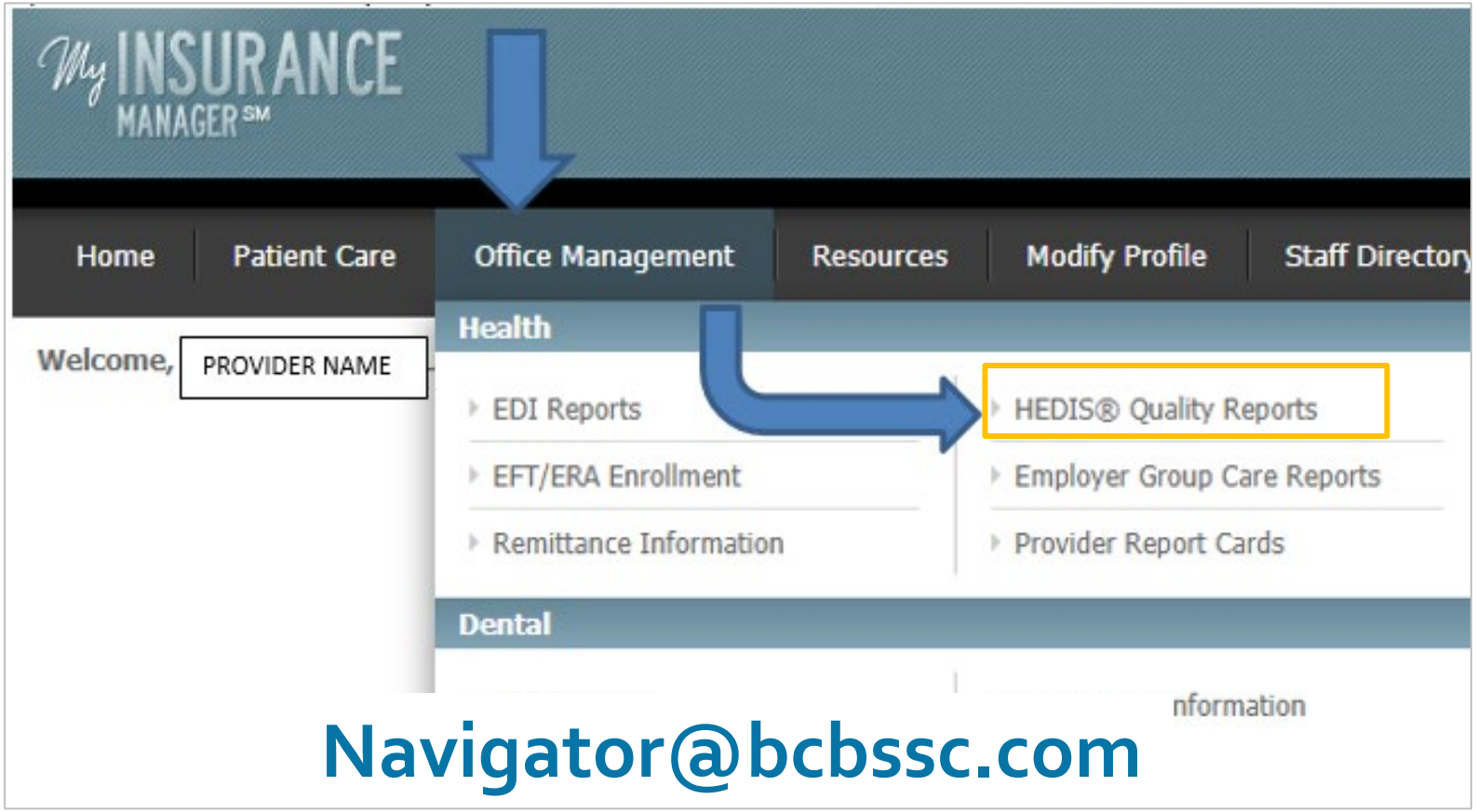
What can the Quality Navigator do for you during the Prospective/Year-round Season?

- Assist in analyzing GIC reports
- Collaborate on targeting specific measures
- Link you with our Data department for scheduling educational sessions on quality EHR transfers
- Assist in closing your assigned gaps in care
- Link you with the Value Based Care programs

Quality Navigator Program — Prospective/Year-Round Season

Accessing Care Opportunity Reports

Reports are no longer emailed and are in My Insurance Manager℠ (MIM).



Quality Navigator Program — Prospective/Year-Round Season

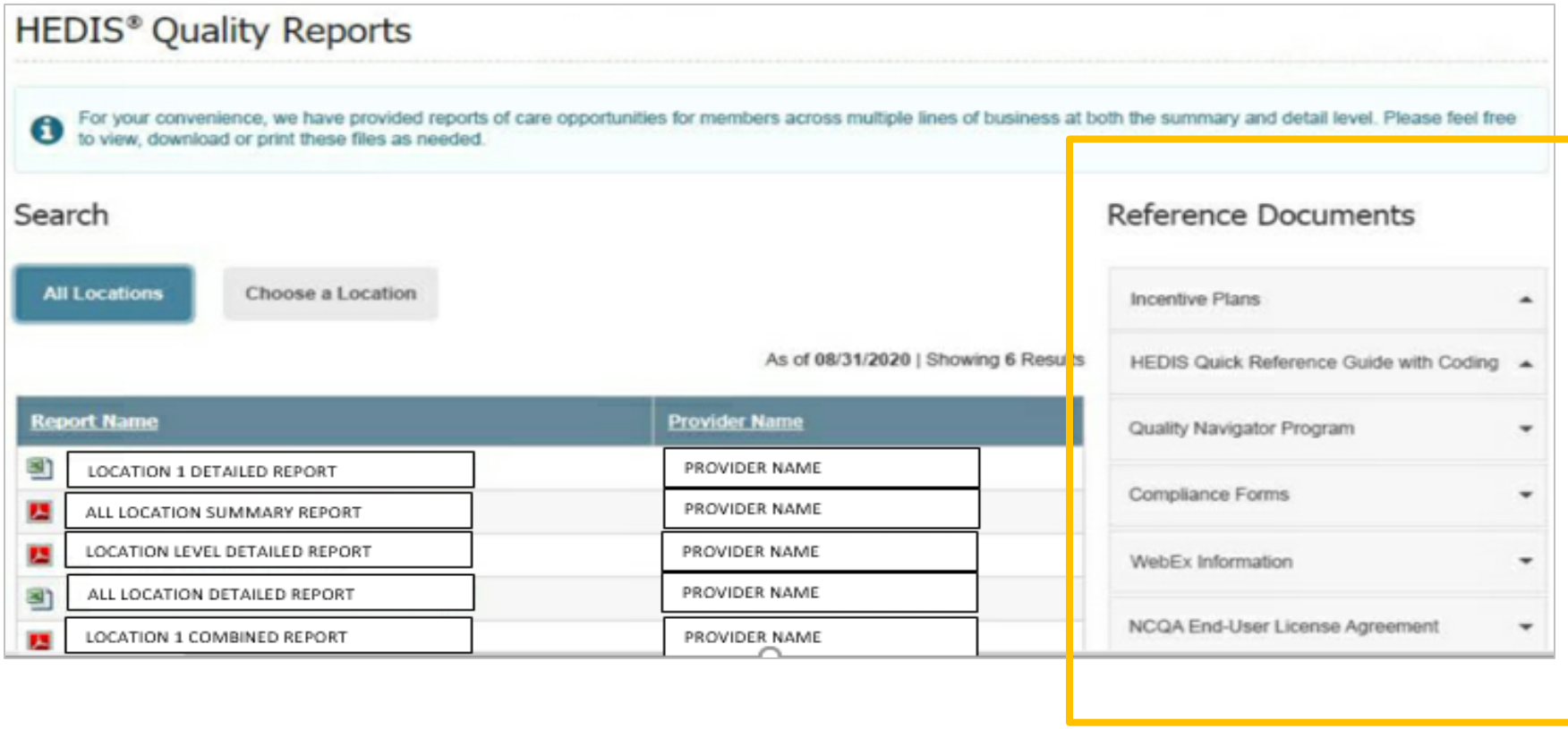
Understanding Care Opportunity Reports

- Past medical history has been added for members ( ).
- Non-compliance can be a true “gap” in care or a “gap” in data ( ).

PATIENT FIRSTNAME	PATIENT LASTNAME	DATEOF BIRTH	GENDER	MEMBER ID_CARD	LOB	SERVICING PROVIDER SSUI	SERVICING PROVIDER FIRST NAME	COMPLIANT MEASURES	NON-COMPLIANT MEASURES	PAST MEDICAL HISTORY
JOHN	DOE	10/22/1936	M	R12345566	CROSS EXCH	134290167012	CAROLINA INTERNAL MEDICINE	ACUTE HOSPITAL UTILIZATION, ACUTE EMERGENCY DEPARTMENT UTILIZATION	DISEASE MODIFYING ANTI-RHEUMATIC DRUG THERAPY FOR RHEUMATOID ARTHRITIS	RHEUMATOID ARTHRITIS ASTHMA COPD
JANE	DOE	12/23/1940	F	R12345566	CROSS EXCH	134290167012	CAROLINA INTERNAL MEDICINE	CONTROLLING HIGH BLOOD PRESSURE BREAST CANCER SCREENING	COLORECTAL CANCER SCREENING CERVICAL CANCER SCREENING	STAGE 3A BREAST CANCER, RIGHT BILATERAL MASTECTOMY HYPERTENSION

Quality Navigator Program - Prospective/Year-Round Season

Additional Resources



Key Takeaways

Key Takeaways

High Impact to HEDIS® and Quality Ratings

- Submit NCQA approved quality codes on claims whenever appropriate.
- Schedule patients for exams.
  - Include periodic screenings and preventive services.
  - Follow up on missed appointments.
- Promote medication adherence.
  - Recommend formulary alternatives.
- Remember that customer service happens with every member interaction.
  - A smile goes a long way when a patient is nervous or stressed out.
  - 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/office.

Contact Us!

Questions or Assistance

- For any questions that you may have or if additional assistance is needed, be sure to contact the Quality team at:

NAVIGATOR@bcbssc.com

WEB TOOLS

Agenda

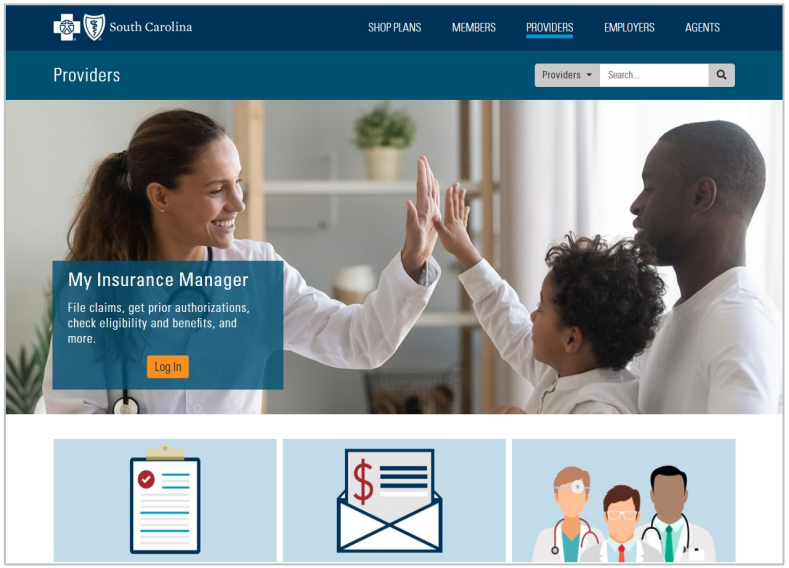
- Website Review
- My Insurance Manager℠ (MIM)
- My Remit Manager (MRM)

Website Review

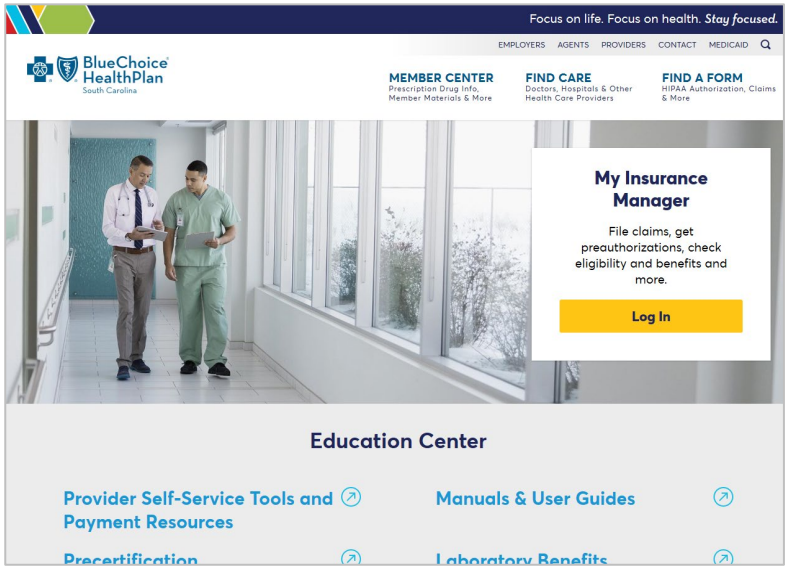
Website Review

Provider pages of our websites include:

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



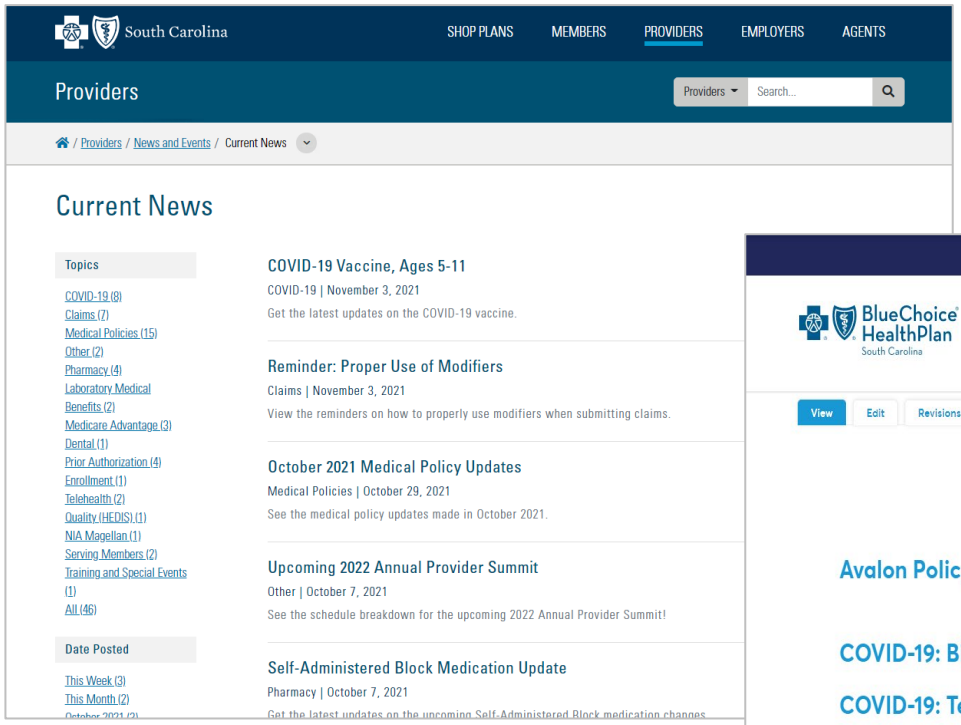
www.SouthCarolinaBlues.com



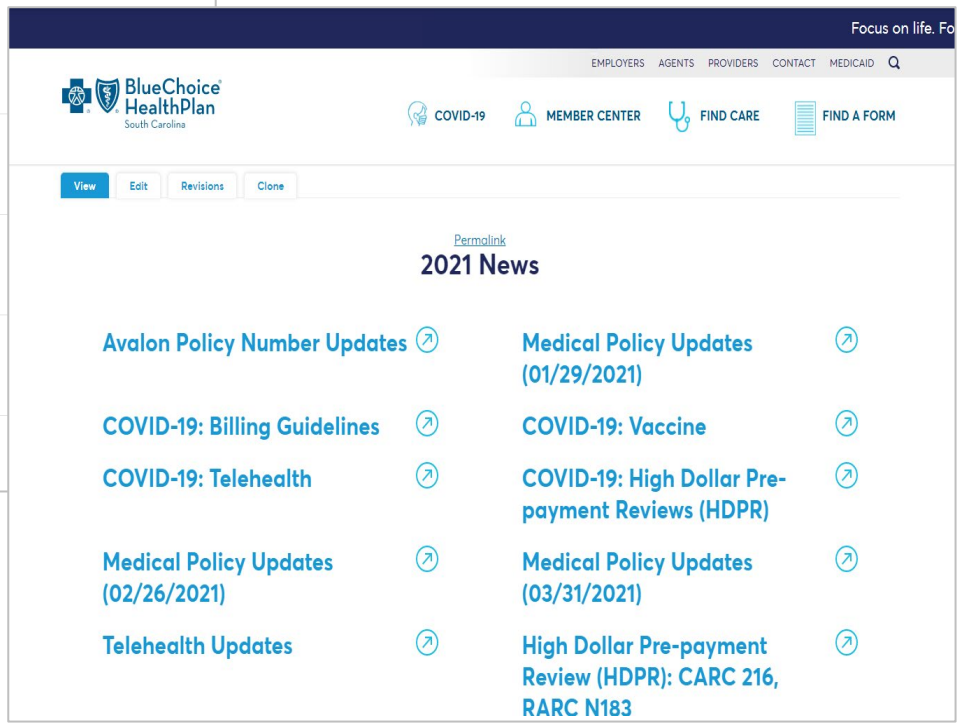
www.BlueChoiceSC.com

Website Review

Provider Bulletins



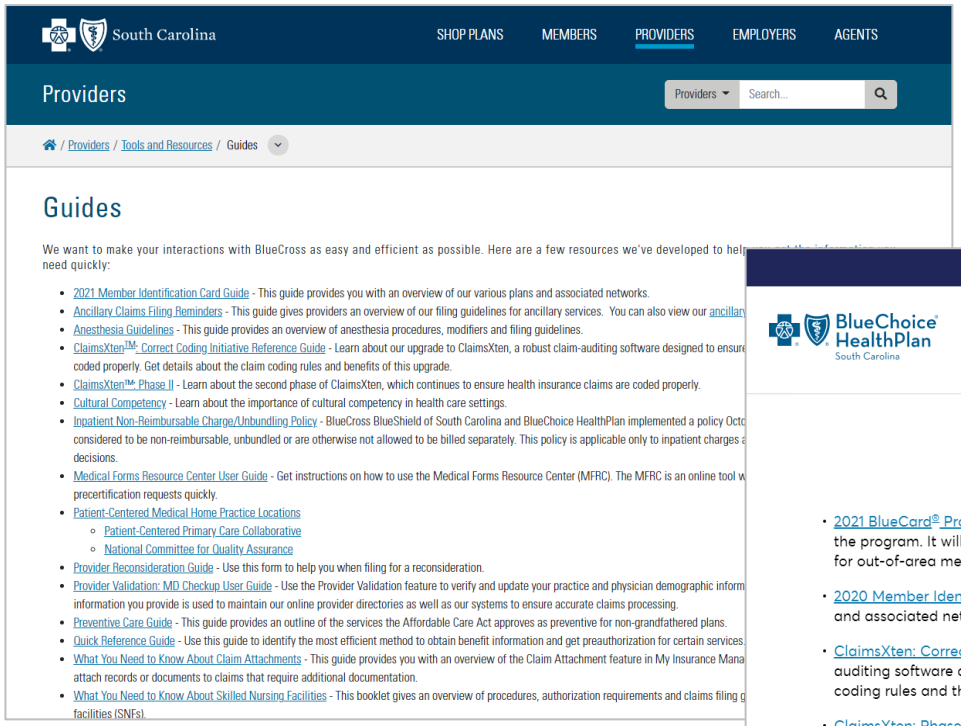
SouthCarolinaBlues.com



BlueChoiceSC.com

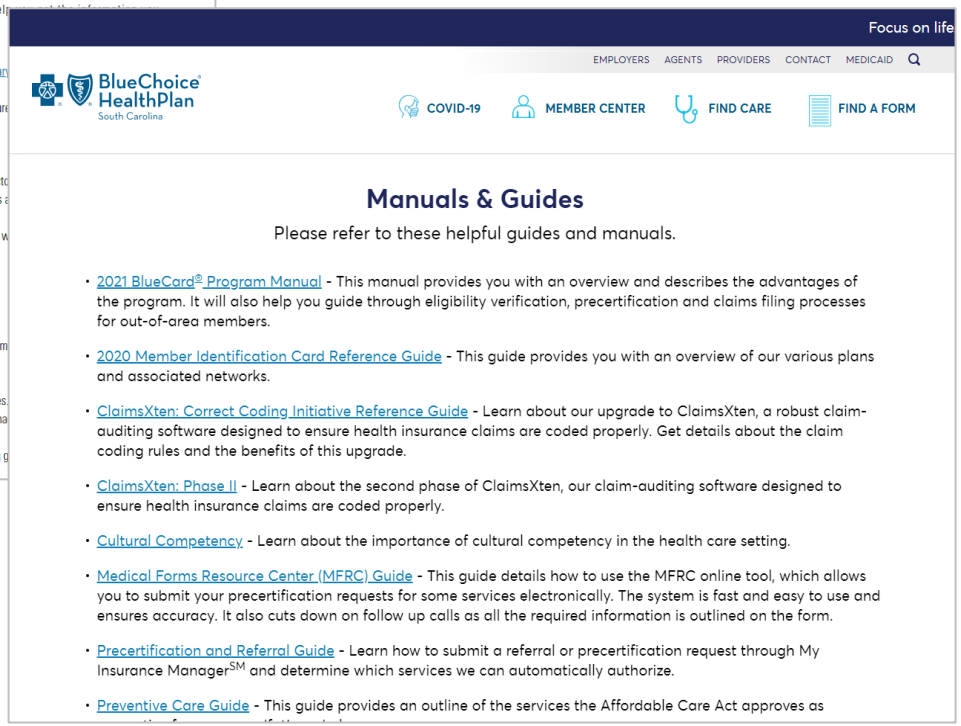
Website Review

Manuals & Guides



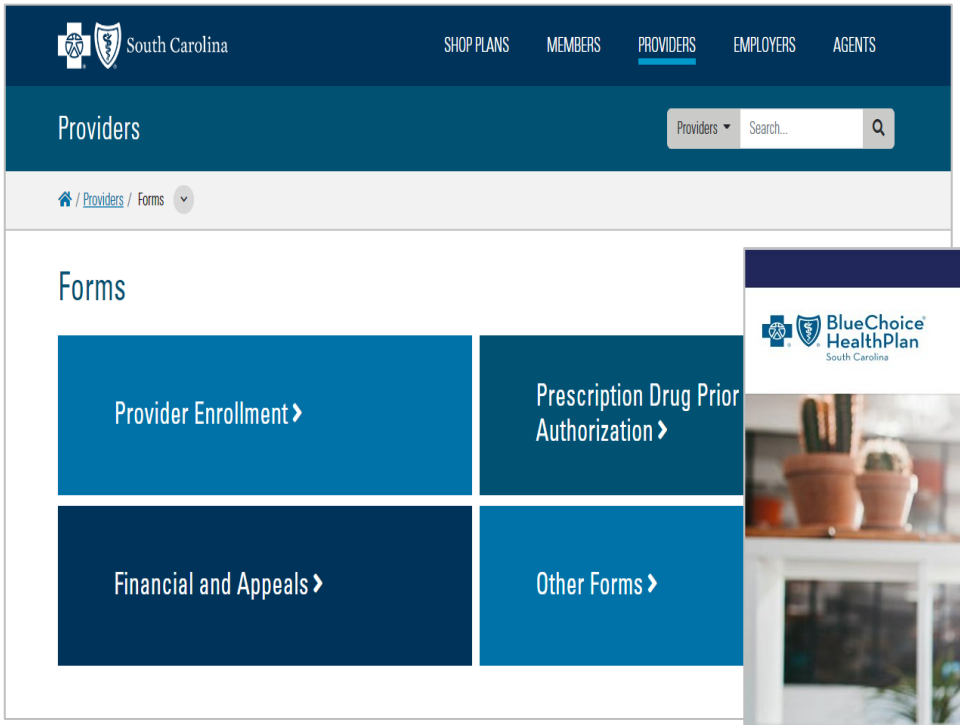
SouthCarolinaBlues.com

BlueChoiceSC.com

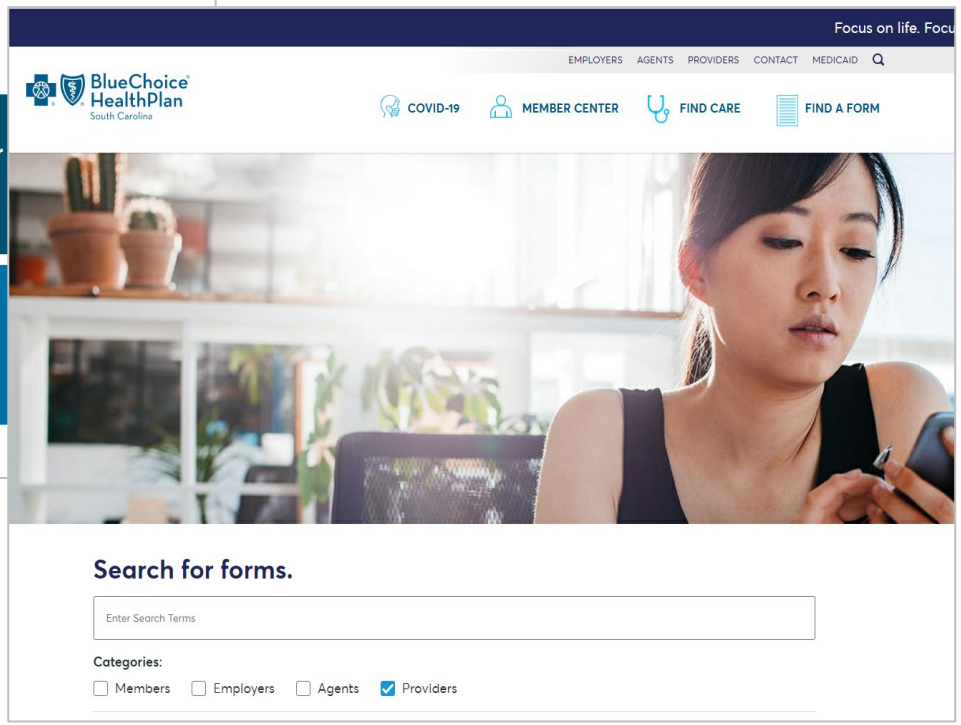


Website Review

Forms



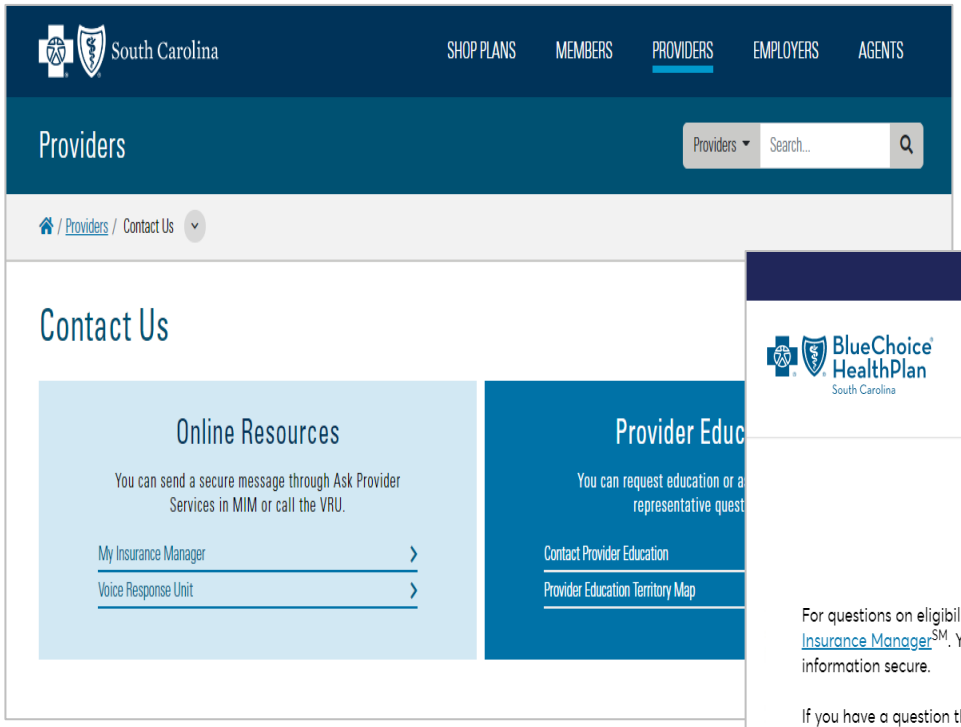
SouthCarolinaBlues.com



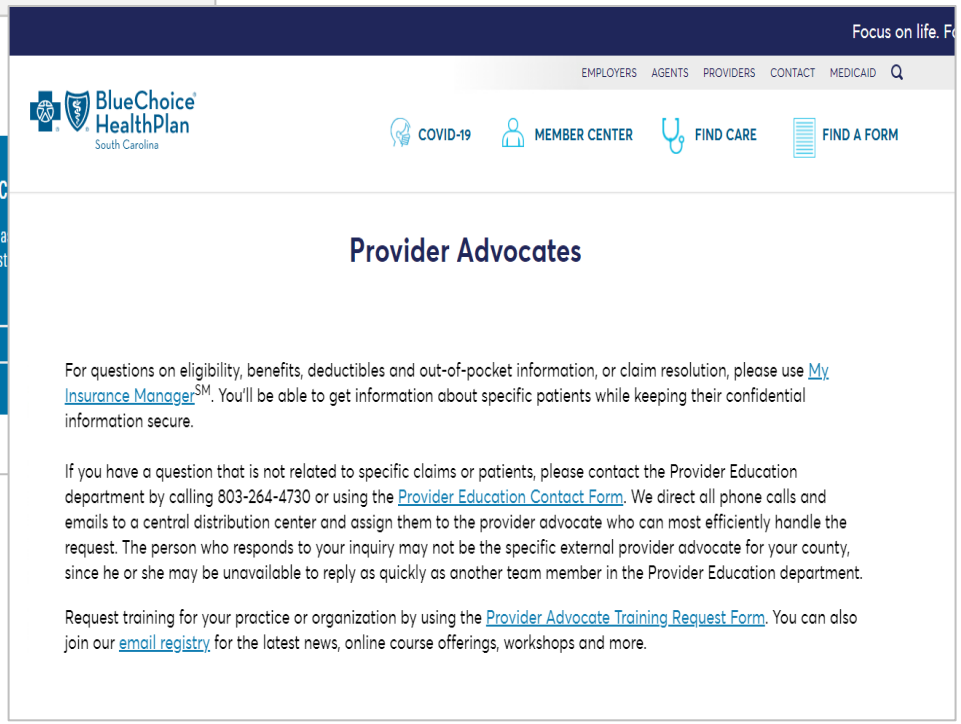
BlueChoiceSC.com

Website Review

Contact Us



SouthCarolinaBlues.com



BlueChoiceSC.com

My Insurance Manager℠

My Insurance Manager℠

Overview

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

Available Guides:

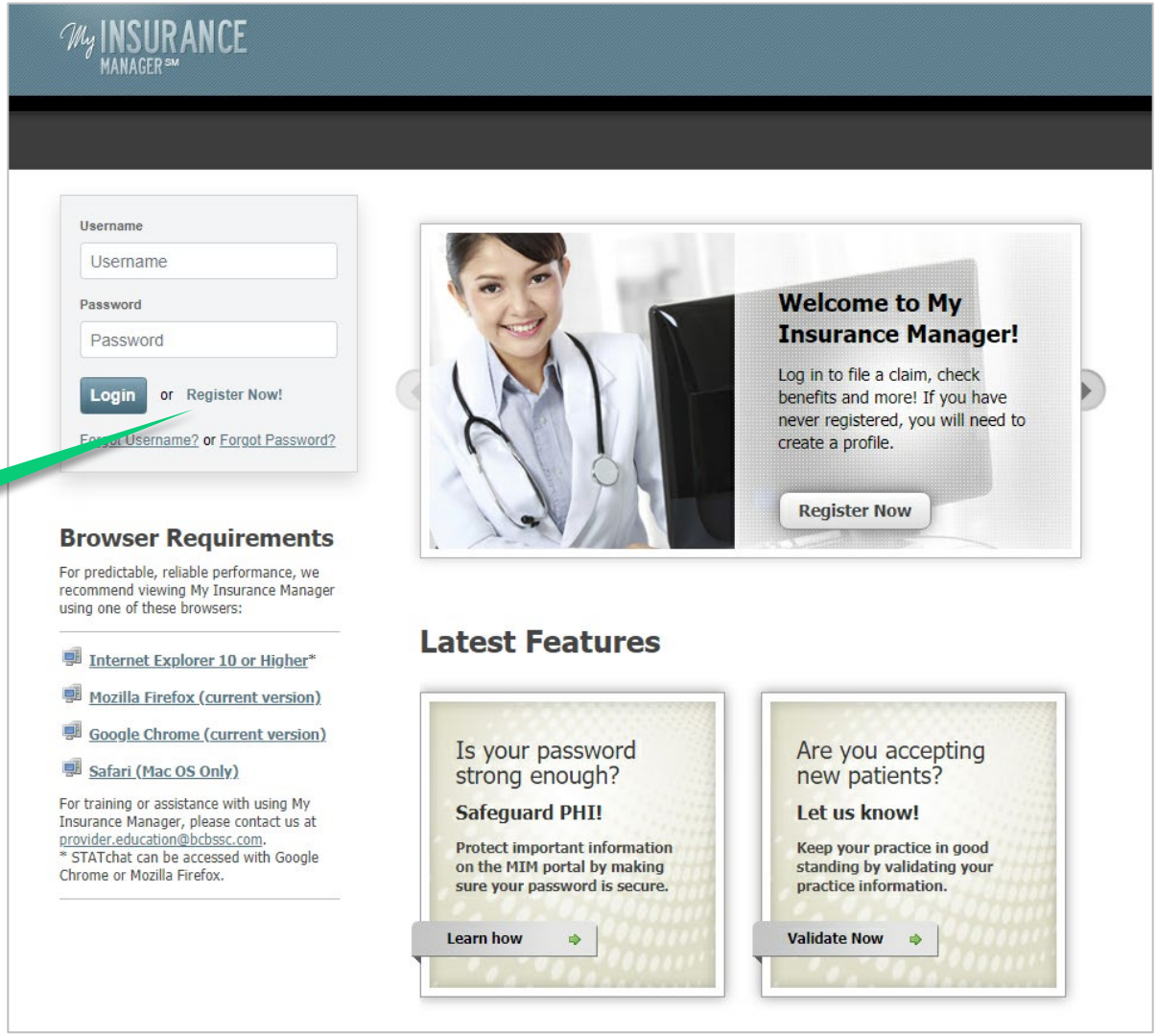
- Getting Started
- Eligibility & Benefits
- Claims Entry
- Claims Status, Patient Directory, Superbill Maintenance & Coordination of Benefits
- Precertification, Pre-Treatment Estimate for Authorization Status
- Office Administration
- Provider Validation: M.D. Checkup

My Insurance Manager℠

Getting Started

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

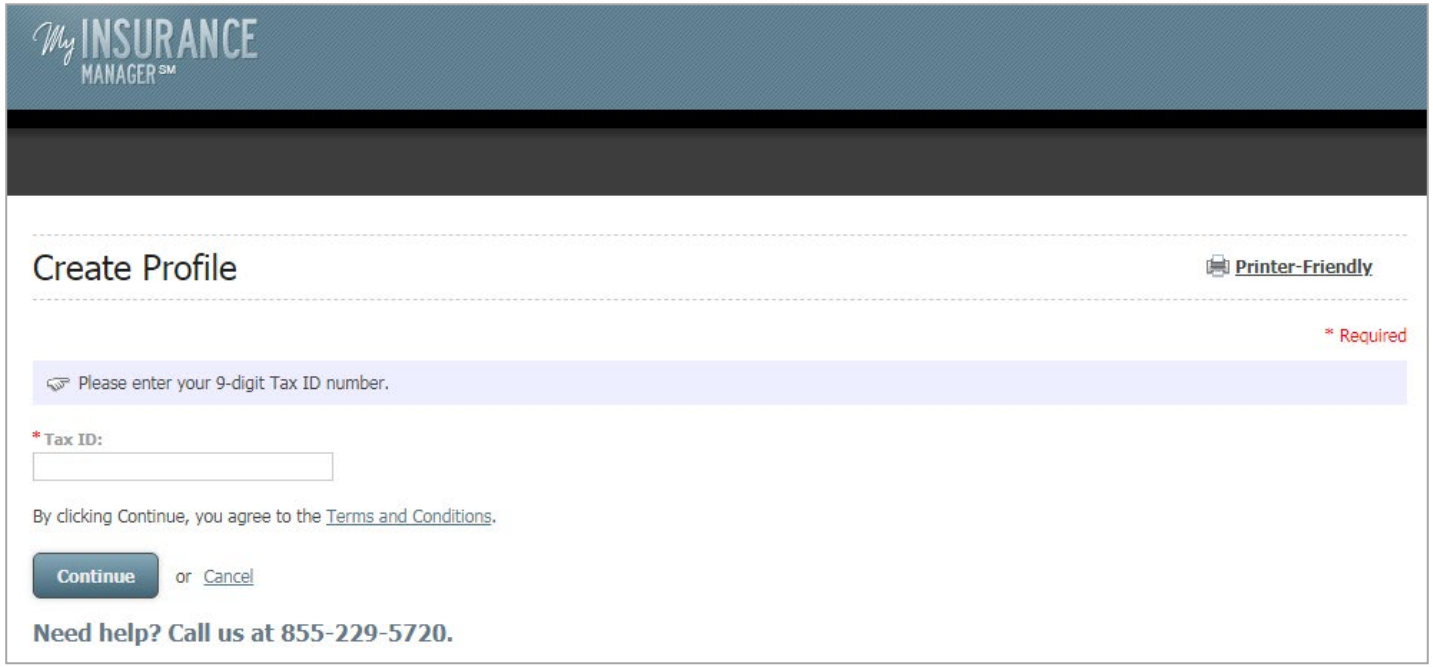
Start here.



My Insurance Manager℠

Getting Started (cont'd)

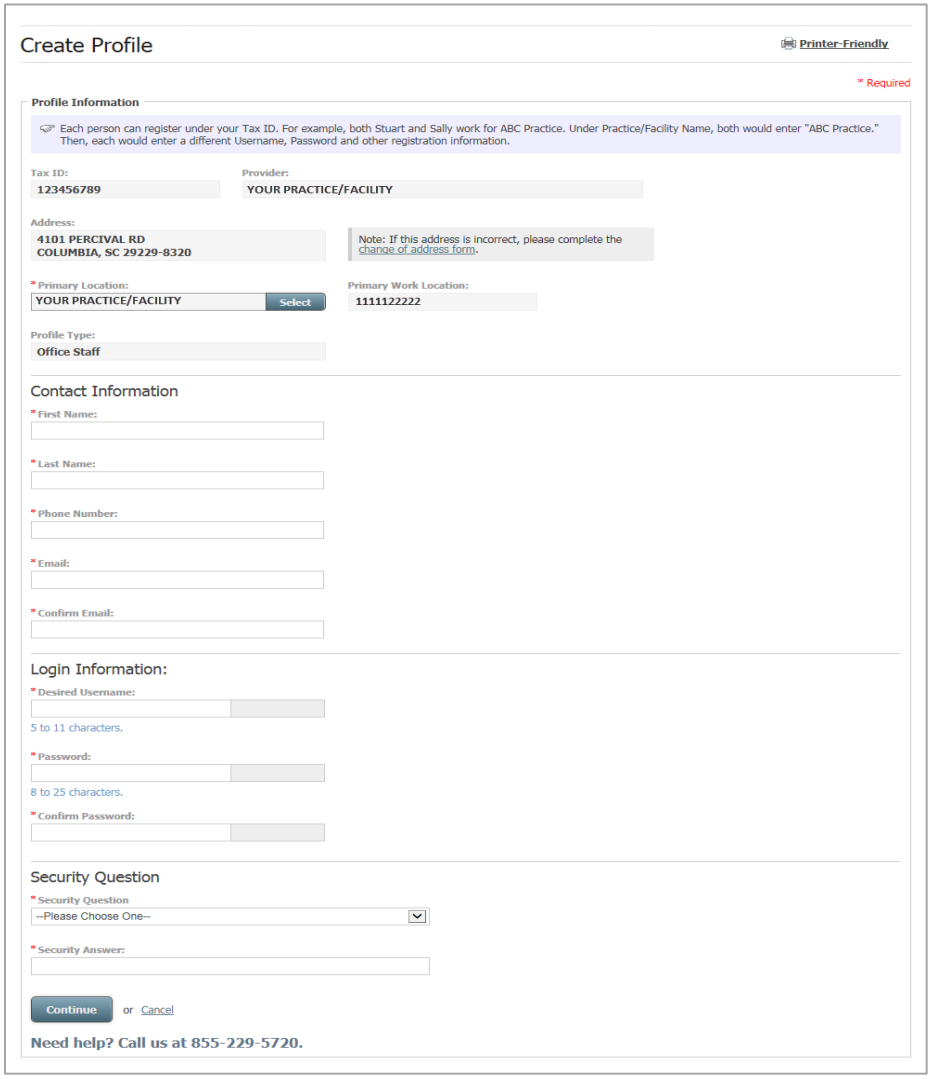
When creating a profile, the 9-digit Tax ID must be entered; click **Continue**.



My Insurance Manager℠

Getting Started (cont'd)

- 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.
- Click **Next**.

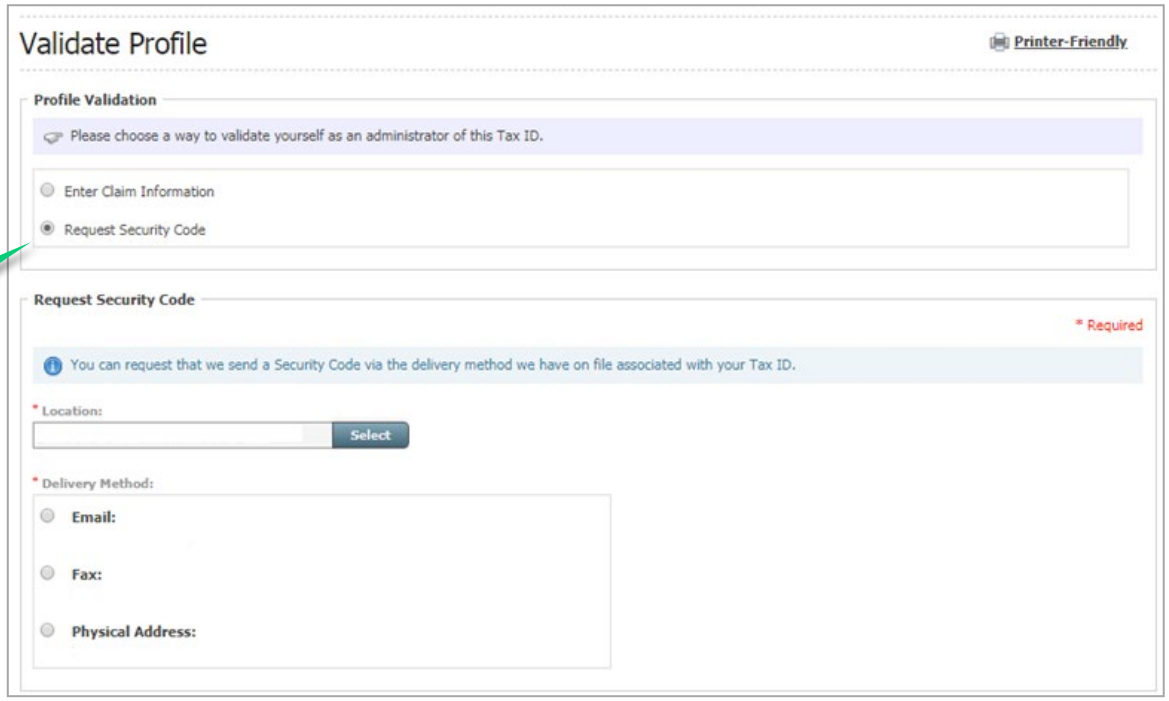


My Insurance Manager℠

Getting Started (cont'd)

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.

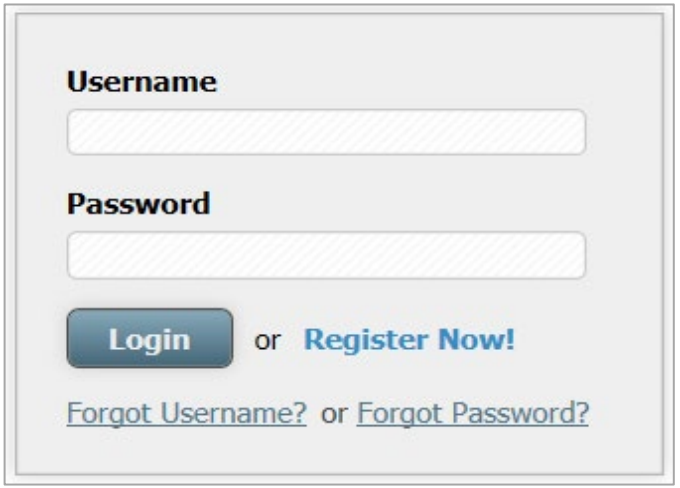
Recommended option.

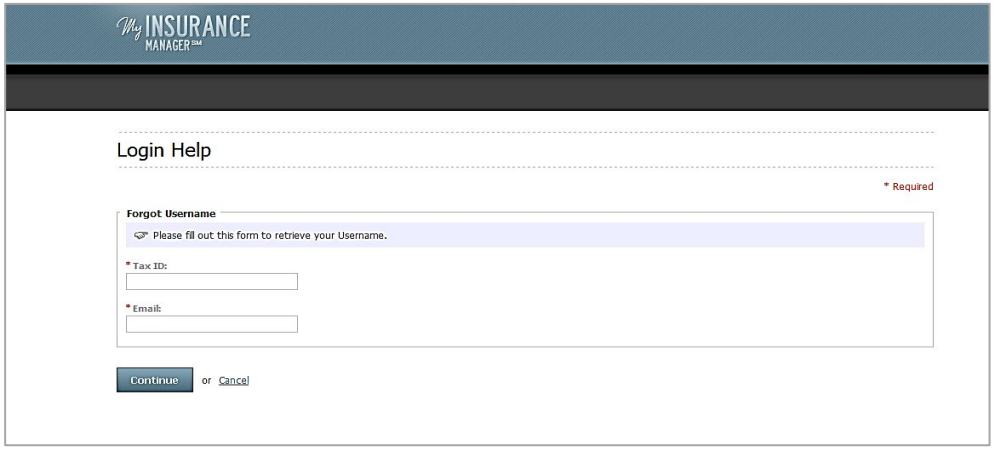


My Insurance Manager℠

Logging In

- From the MIM homepage, enter the username and password; click Login.



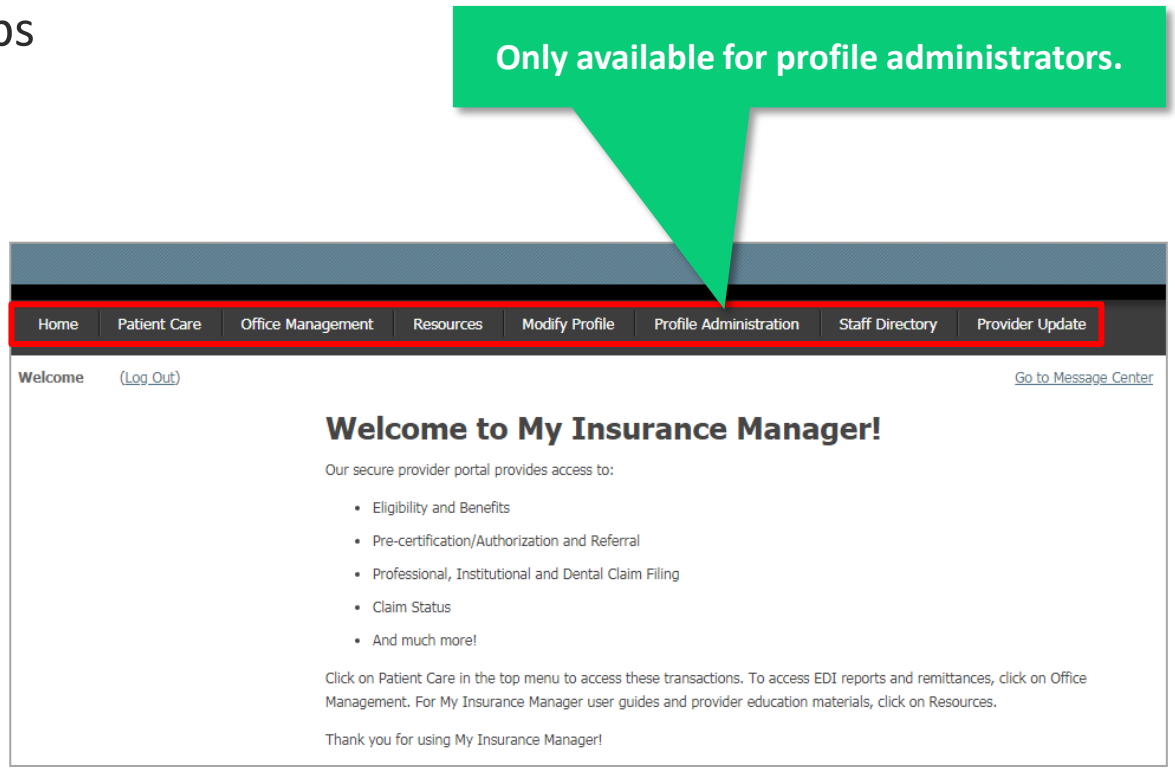


My Insurance Manager℠

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

The Patient Care tab is broken down into Health and Dental.

For both Health and Dental services, the following options include:

- View claims status
- Check eligibility and benefits
- Request prior authorizations
- and much more.

My Insurance Manager℠

Office Management

For both Health and Dental services, available options include EDI reports, enroll for EFT/ERA and view remittance information.

Additional options for Health services include:

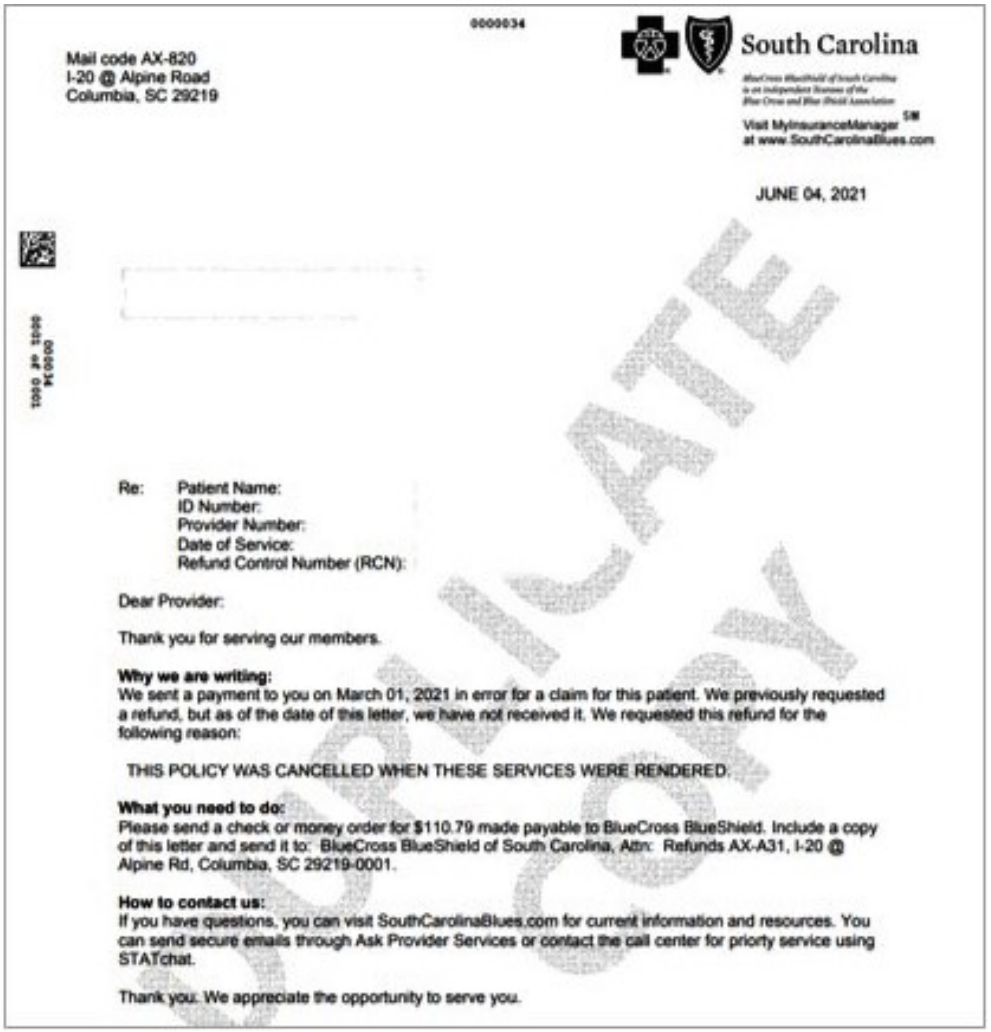
- PCMH Reports/Patient Validation
- Refund Letters
- HEDIS® Reports
- Employer Group Care Reports
- Provider Report Cards

My Insurance Manager℠

Refund Letters

Refund letters include:

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



0000034

Mail code AX-820
I-20 @ Alpine Road
Columbia, SC 29219

South Carolina

Visit MyInsuranceManager℠ at www.SouthCarolinaBlues.com

JUNE 04, 2021

Re: Patient Name:
ID Number:
Provider Number:
Date of Service:
Refund Control Number (RCN):

Dear Provider:

Thank you for serving our members.

Why we are writing:
We sent a payment to you on March 01, 2021 in error for a claim for this patient. We previously requested a refund, but as of the date of this letter, we have not received it. We requested this refund for the following reason:

THIS POLICY WAS CANCELLED WHEN THESE SERVICES WERE RENDERED.

What you need to do:
Please send a check or money order for $110.79 made payable to BlueCross BlueShield. Include a copy of this letter and send it to: BlueCross BlueShield of South Carolina, Attn: Refunds AX-A31, I-20 @ Alpine Rd, Columbia, SC 29219-0001.

How to contact us:
If you have questions, you can visit SouthCarolinaBlues.com for current information and resources. You can send secure emails through Ask Provider Services or contact the call center for priorty service using STATchat.

Thank you. We appreciate the opportunity to serve you.

Note: A refund letter is also mailed to your practice.

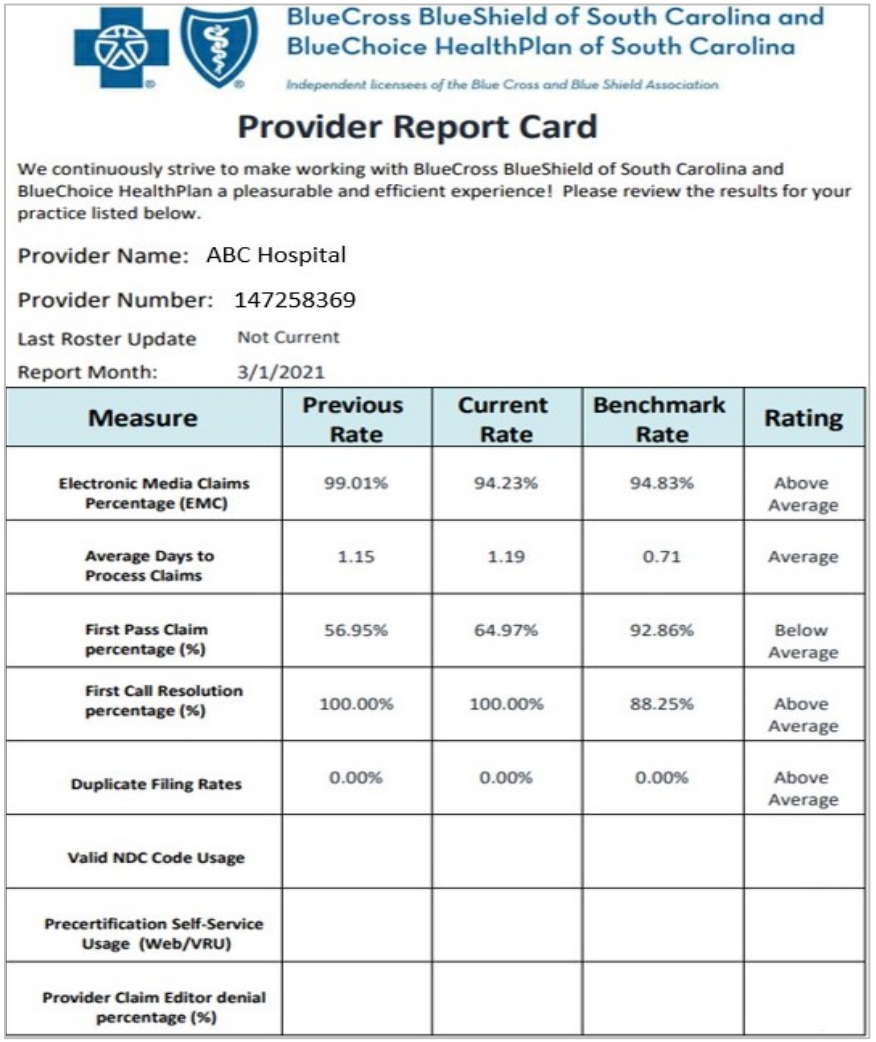
My Insurance Manager℠

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 Code Usage
- Precertification Self-Service Usage
- Provider Claim Editor Denial Percentage

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



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: 3/1/2021

Measure	Previous Rate	Current Rate	Benchmark Rate	Rating
Electronic Media Claims Percentage (EMC)	99.01%	94.23%	94.83%	Above Average
Average Days to Process Claims	1.15	1.19	0.71	Average
First Pass Claim percentage (%)	56.95%	64.97%	92.86%	Below Average
First Call Resolution percentage (%)	100.00%	100.00%	88.25%	Above Average
Duplicate Filing Rates	0.00%	0.00%	0.00%	Above Average
Valid NDC Code Usage				
Precertification Self-Service Usage (Web/VRU)				
Provider Claim Editor denial percentage (%)				

My Insurance Manager℠

Resources

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

Most used resources include:

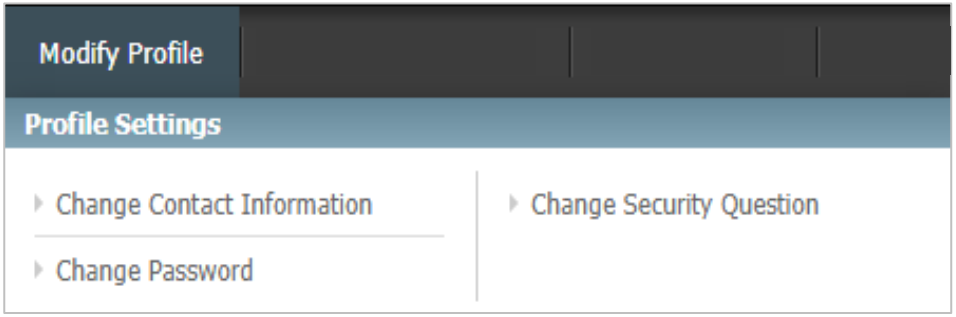
- Avalon Lab Benefit Manager Provider Portal
- Education Center
- Medical Policies
- My Remit Manager

My Insurance Manager℠

Modify Profile

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

- Change Contact Information
- Change Password
- Change Security Question

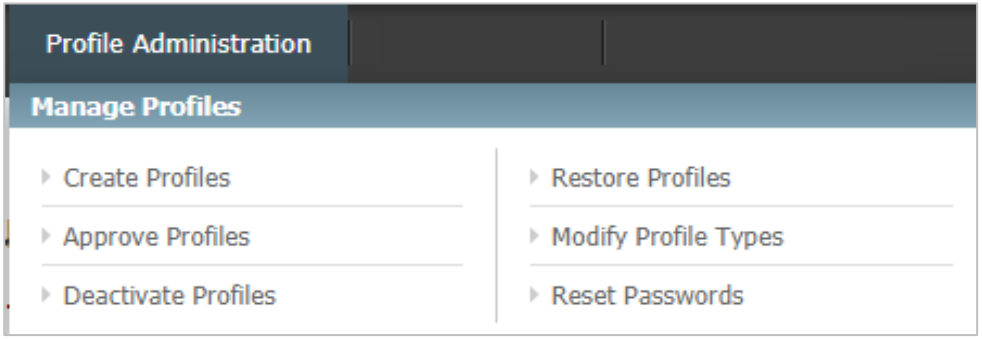


My Insurance Manager℠

Profile Administration

The Profile Administration tab is available for the administrator(s) only. This gives them the option to:

- Create Profiles
- Approve Profiles
- Deactivate Profiles
- Restore Profiles
- Modify Profile Types
- Reset Passwords



Only available for profile administrators.

My Insurance Manager℠

Staff Directory & Provider Update

- The Staff Directory tab provides a list of profiles associated with the Tax ID in MIM.
- The Provider Update (M.D. Checkup) tab allows updates and/or validations to be made to the demographic information we have in the Provider Directory (e.g., address, phone number, etc.).
  - Effective Jan. 1, 2022, this will be required at least **every 90 days**, as part of the Consolidated Appropriations Act (CAA).

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

My Remit Manager

Overview

Tool used to track payments and pull electronic remittance advices.

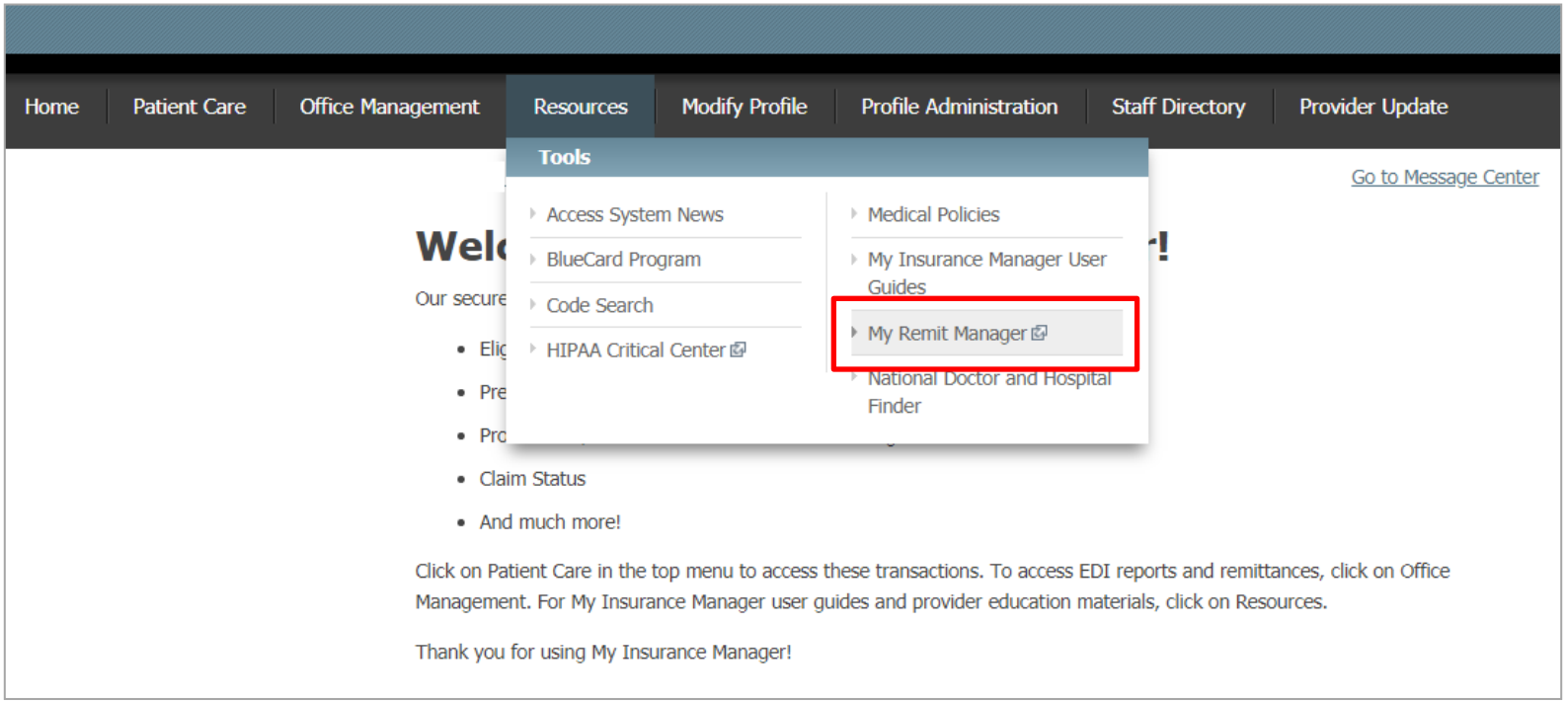
Available Guides:

- My Remit Manager

My Remit Manager

Getting Started

From My Insurance Manager℠, hover over Resources, then click My Remit Manager.



My Remit Manager

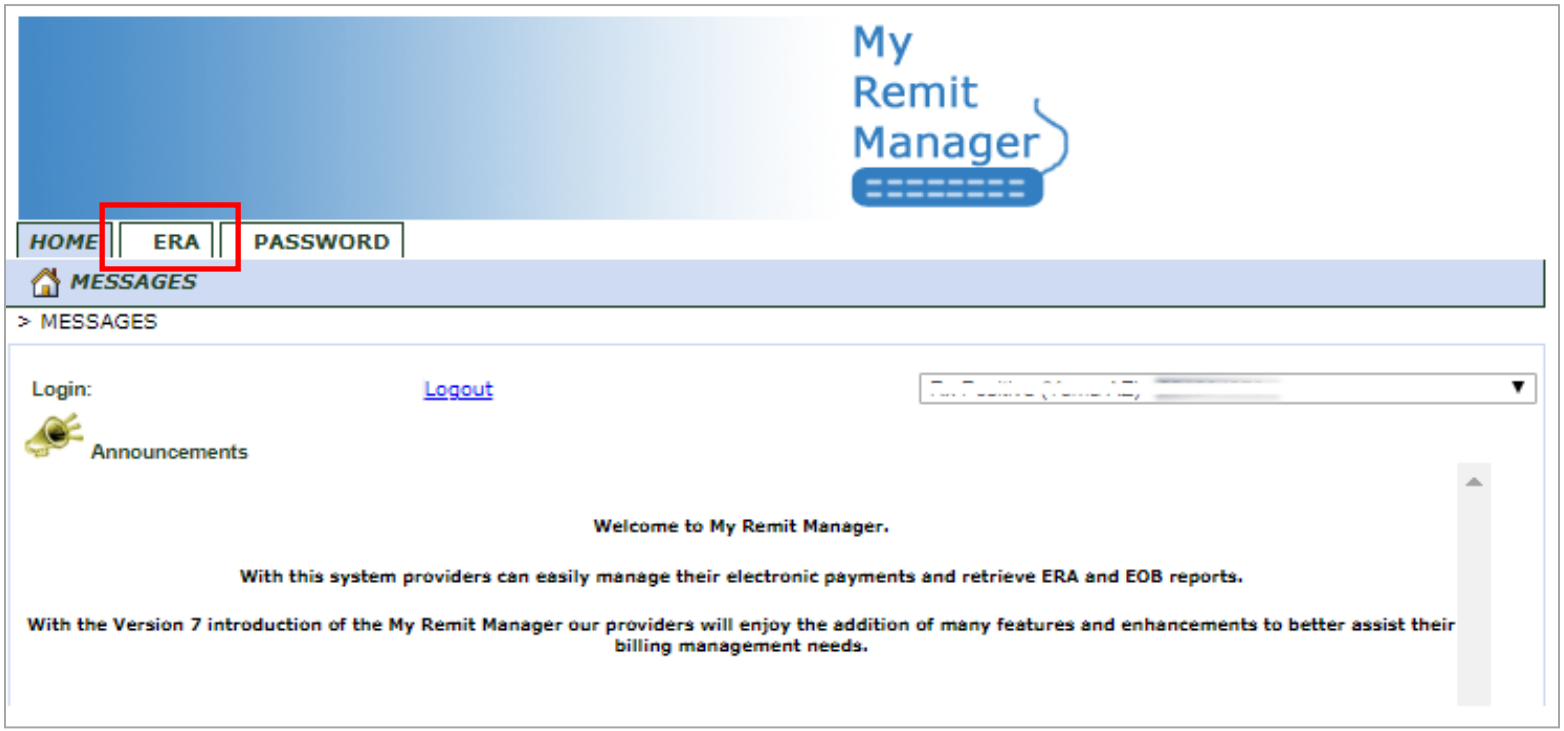
Getting Started (cont'd)

- To sign up or for password resets, click the Provider Education Contact Form link.
- New registrants will receive their username and password, along with instructions via email.

My Remit Manager

Getting Started (cont'd)

Click the ERA tab (Electronic Remittance Advice) to view check and remittance information.

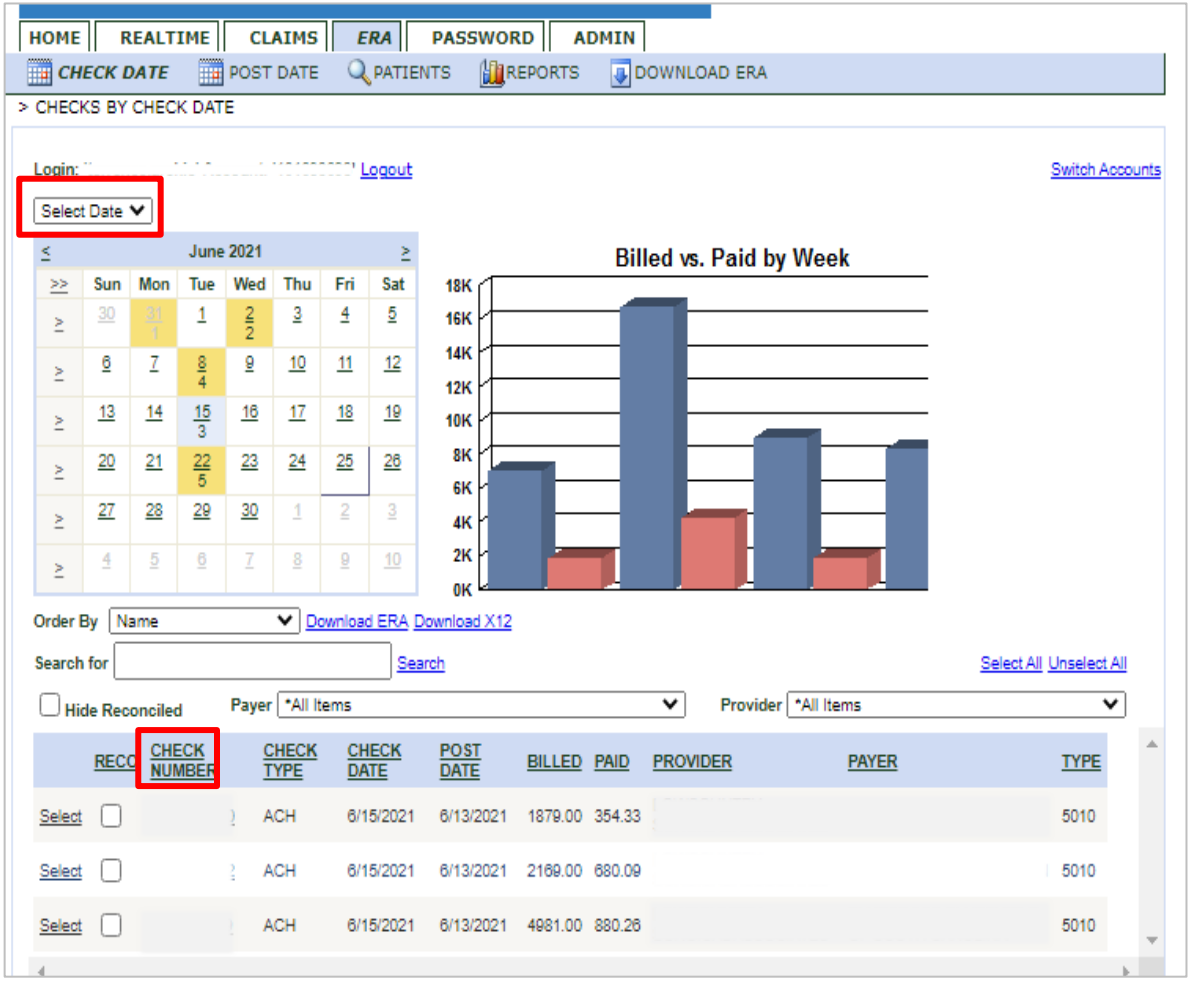


My Remit Manager

ERA Tab

Check Date

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

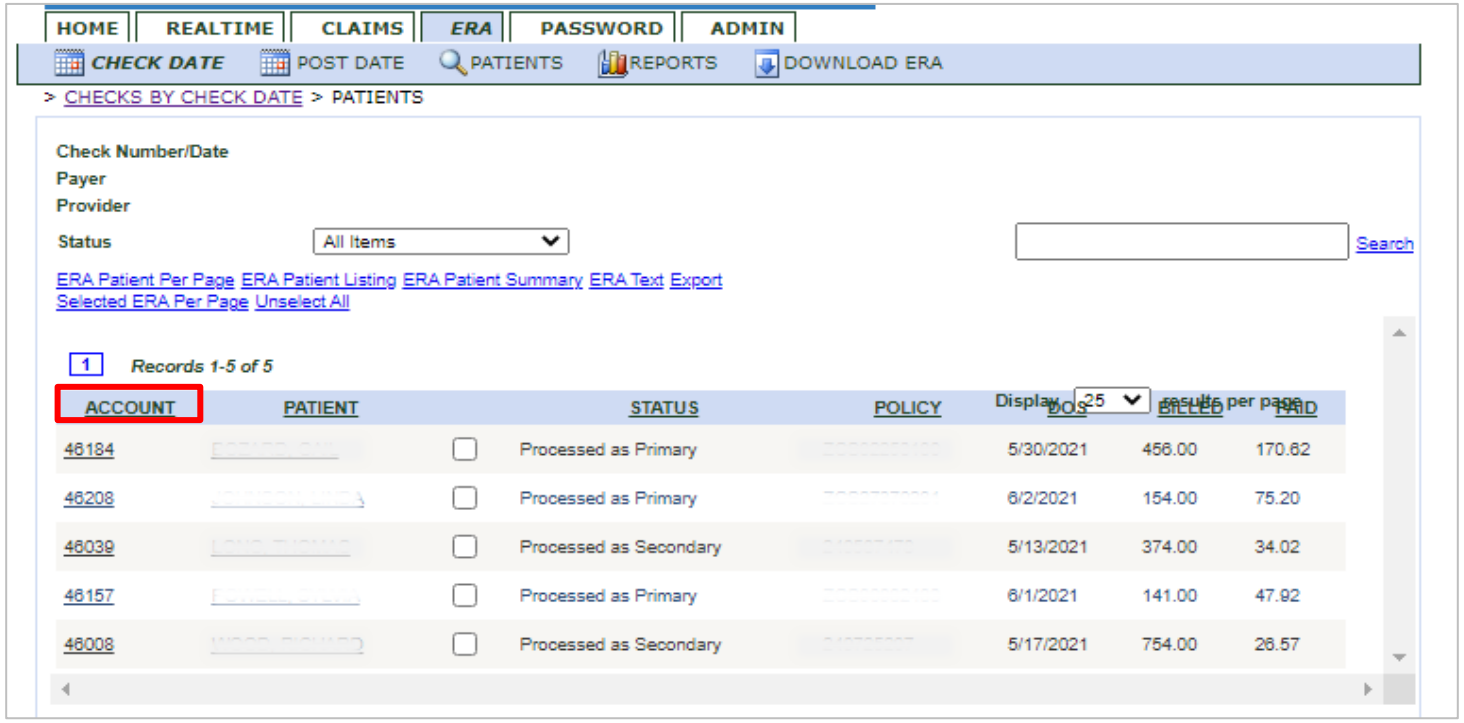


My Remit Manager

ERA Tab (cont'd)

Check Date

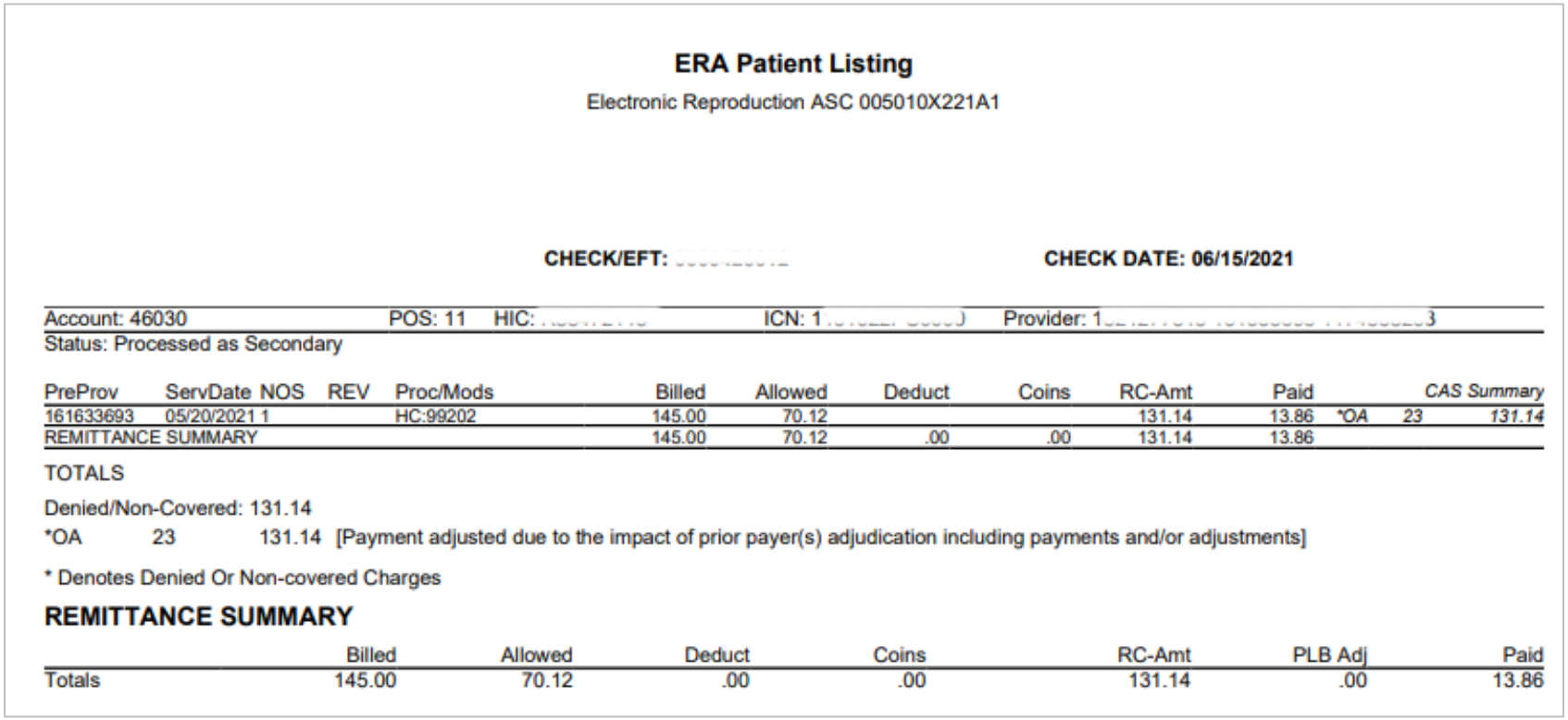
Select the account of the patient.



My Remit Manager

ERA Tab (cont'd)

Below is an example of how the remittance will pull.



ERA Patient Listing

Electronic Reproduction ASC 005010X221A1

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	
161633693	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

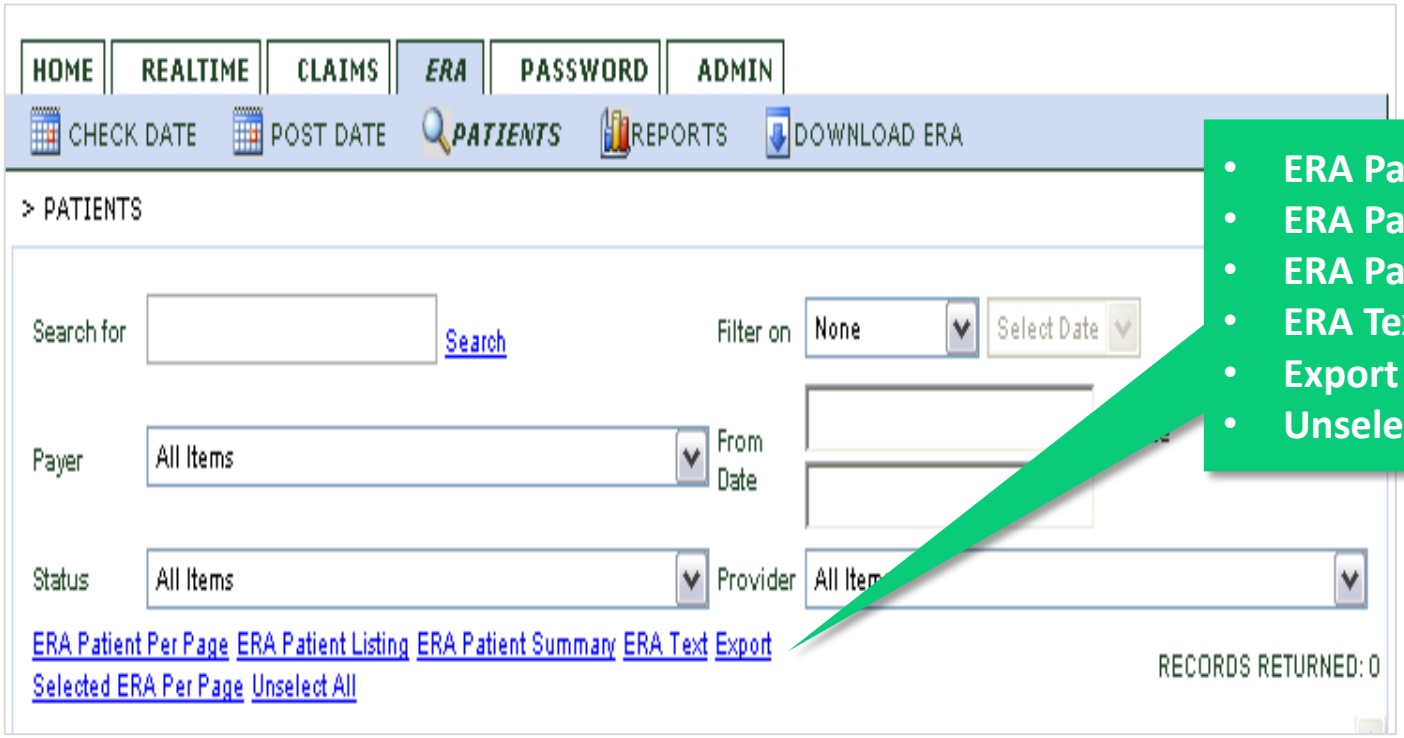
	Billed	Allowed	Deduct	Coins	RC-Amt	PLB Adj	Paid
Totals	145.00	70.12	.00	.00	131.14	.00	13.86

My Remit Manager

ERA Tab (cont'd)

Patients

- Enter the patient's name in Last Name, First Name format.



My Remit Manager

Electronic Remittance Advice (ERA)

ERA Received from BlueCross

- Complete the ERA Enrollment/Clearinghouse or ERA Enrollment/Direct Submitter Forms located on www.SouthCarolinaBlues.com to receive ERAs.
- Complete the Electronic Funds Transfer (EFT) Application located at the above-mentioned website to receive EFTs (direct deposits).
- Submit both forms via email to Provider.EFT@bcbssc.com.

ERA Received from Clearinghouse

- Complete the EDI Gateway ERA Enrollment Form.
- Submit form via email to EDI.Services@bcbssc.com.

Thank You!