South Carolina

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

CLAIMS

DISCLAIMER

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

AGENDA

- Claim Reminders
- Claim Tips
- Resources

CLAIM REMINDERS

HIGH DOLLAR PRE-PAYMENT REVIEW (HDPR)

The process of reviewing high dollar inpatient hospital claims.

Used to validate the services billed align with what was rendered.

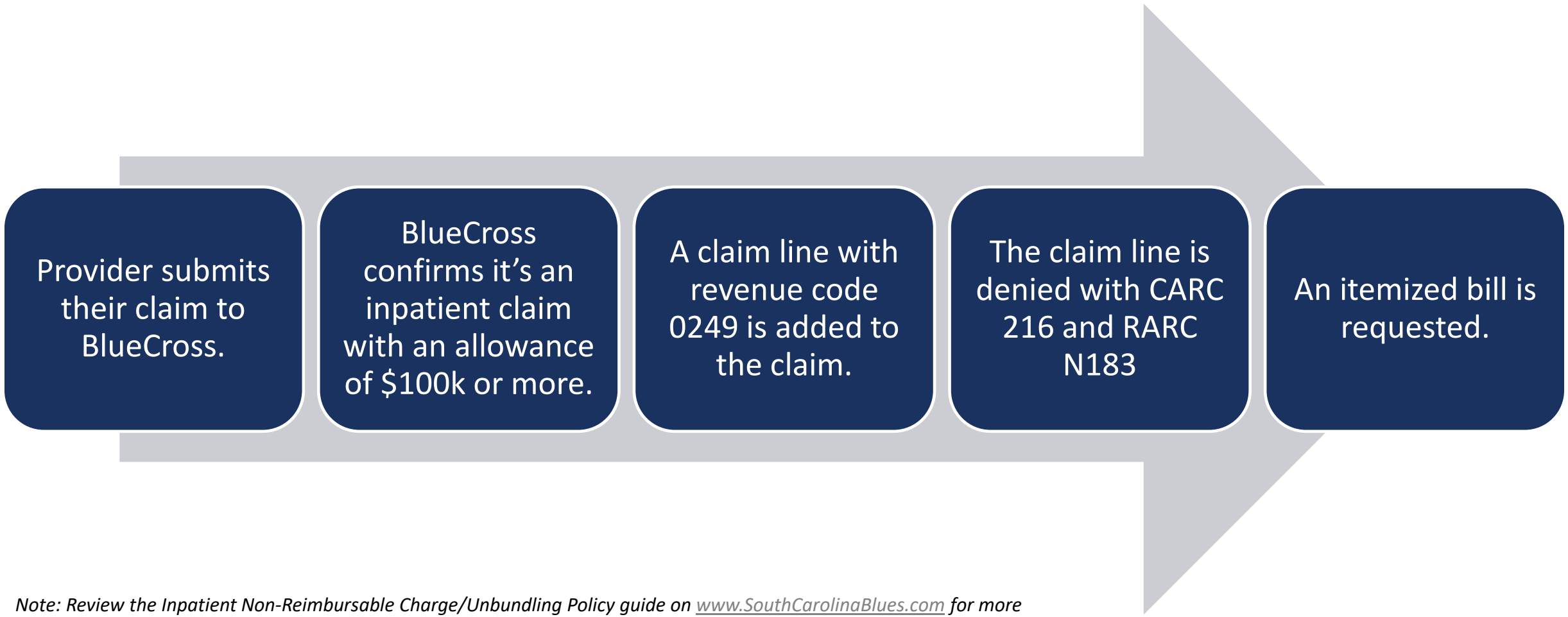
CRITERIA USED FOR HDPR

Inpatient institutional (acute care) claim

Claim has an allowed amount of $100k or more

Any pricing methodologies except for per diem, flat-fee case rate and DRG

GENERAL PROCESS OF AN HDPR



Note: Review the Inpatient Non-Reimbursable Charge/Unbundling Policy guide on www.SouthCarolinaBlues.com for more information.

ITEMIZED BILLS

Example of an acceptable itemized bill:

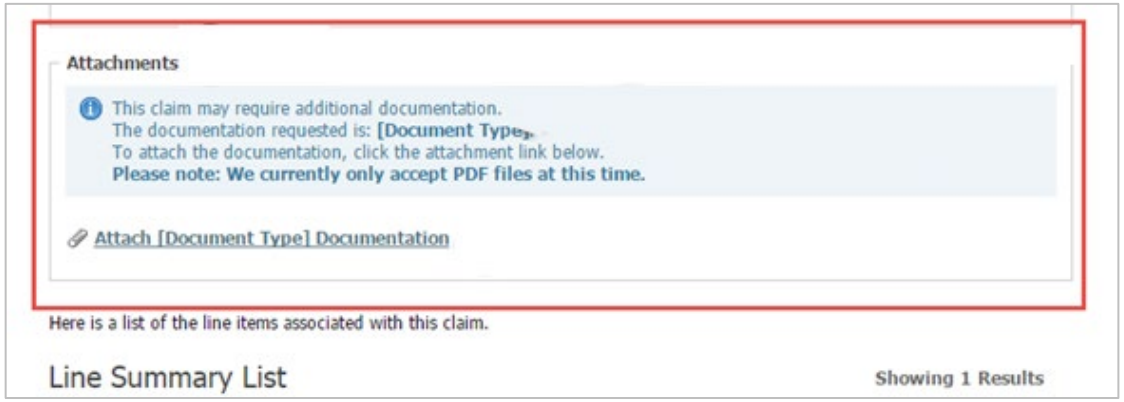
42 Rev. Co.	43 Description	44 HCPCS/Rate/HPPS Code	45 Serv. Date	46 Serv. Units	47 Total Charges
0250	Dicyclomine 10 MG		010322	1	27.00
0250	Nitroglycerin 0.4 MG		010322	1	28.73
0250	Midazolam 10 MG	J2250	010322	2	29.09
0250	Atorvastatin 40 MG		010322	2	76.93
0272	Catheter Angiographic		010322	1	226.00

Example of an unacceptable itemized bill:

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

CLAIM ATTACHMENTS IN MY INSURANCE MANAGER℠

- Claim Attachments is a feature in My Insurance Manager that allows you to upload requested documentation directly into the portal for a claim.
  - 30 MB limit for each document.
- Documentation that can be uploaded includes:
  - Accident questionnaires
  - Certificate of medical necessity (for DME)
  - Medical records
  - Other health insurance
  - Primary explanation of benefits
  - Itemized bills



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

LABORATORY SERVICES

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

  Providers>Policies and Authorizations>Prior Authorization>Laboratory Medical Benefits
- Before rendering lab services, review the Medical Policies pages to view the complete medical policy for specific labs to ensure the criteria is followed for coverage.

Benefits of reviewing medical policies:

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

avalon

MEDICAL POLICY CRITERIA 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 of claims that rejected.

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

LOCATING MEDICAL POLICIES

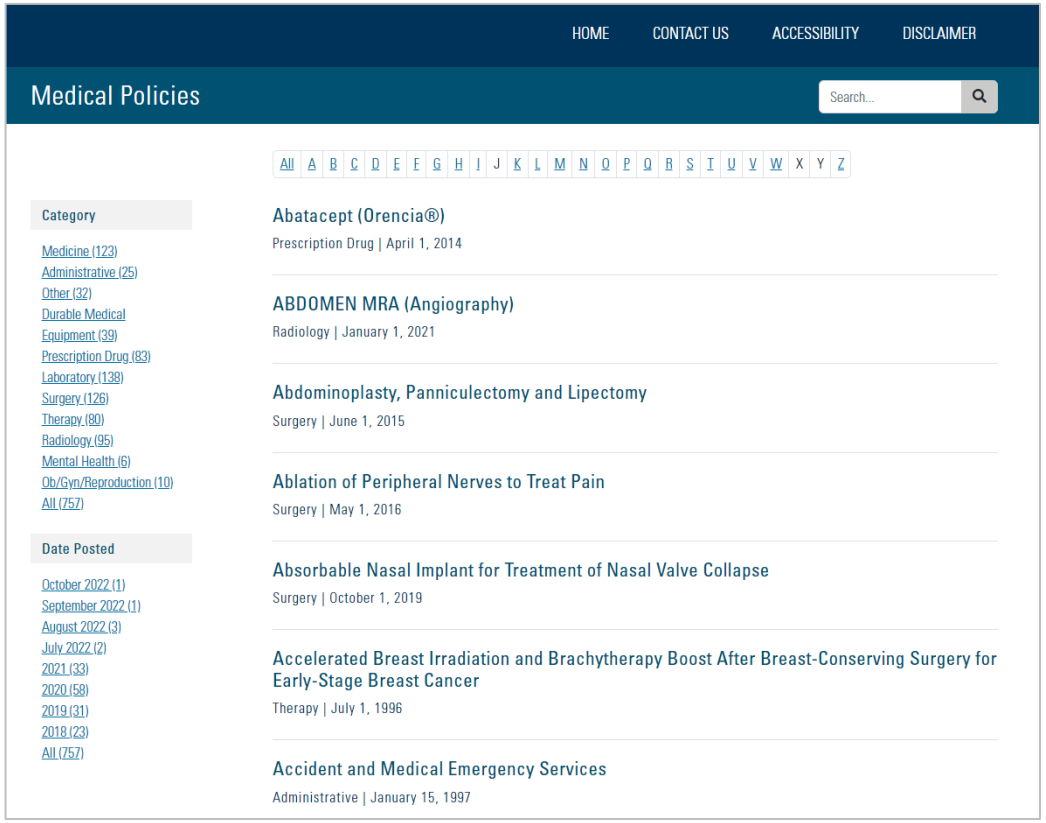
The Medical Policies pages can be accessed through one of the following:

- www.SouthCarolinaBlues.com

Providers>Medical Policies>Commercial and Contracted Plan Policies

- www.BlueChoiceSC.com

Providers>Medical Policies



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.

PROVIDER RECONSIDERATIONS AND GUIDELINES

- Provider reconsiderations are used to investigate the outcome of a finalized claim.
- General guidelines for provider reconsiderations:

Reasons for a reconsideration	*Reasons that do not require a reconsideration
• Medical necessity determination • Lack of authorization for emergent services when the member cannot present themselves as a BlueCross member	• Membership issues • Eligibility or benefit denials • Lack of authorization for non-emergent services when you know the member is a BlueCross member

**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.*

SUBMITTING A PROVIDER RECONSIDERATION

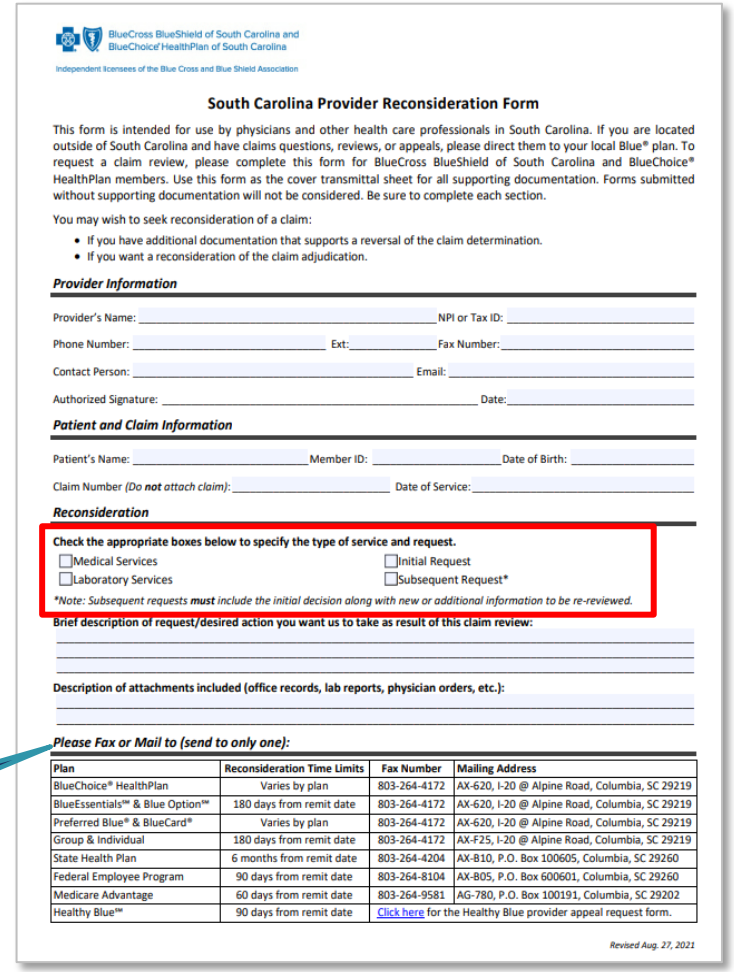
Provider Reconsideration Form

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

Supporting Documentation

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

Be mindful of the filing guidelines.



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

Independent licensees of the Blue Cross and Blue Shield Association

South Carolina Provider Reconsideration Form

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

You may wish to seek reconsideration of a claim:

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

Provider Information

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

Phone Number: _____ Ext: _____ Fax Number: _____

Contact Person: _____ Email: _____

Authorized Signature: _____ Date: _____

Patient and Claim Information

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

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

Reconsideration

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

☐ Medical Services ☐ Initial Request

☐ Laboratory Services ☐ Subsequent Request*

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

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

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

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

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

Revised Aug. 27, 2021

RECONSIDERATION, CORRECTED CLAIM OR PROVIDER SERVICES

- Knowing when to submit a provider reconsideration versus a corrected claim or contacting Provider Services is important.

Examples of when to submit a provider reconsideration:

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

Examples of when to submit a corrected claim:

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

Examples of when to contact Provider Services:

Provider Services
A corrected claim was submitted but rejected as a duplicate.
A claim is rejected for no prior authorization, but you have the authorization number.

PRICING INQUIRIES

- A pricing inquiry is an investigation of the reimbursement applied to a claim.
- Before submitting pricing inquiries, verify the following:

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

Note: If you use third-party vendors to submit inquiries on your behalf, be sure they are aware of this information.

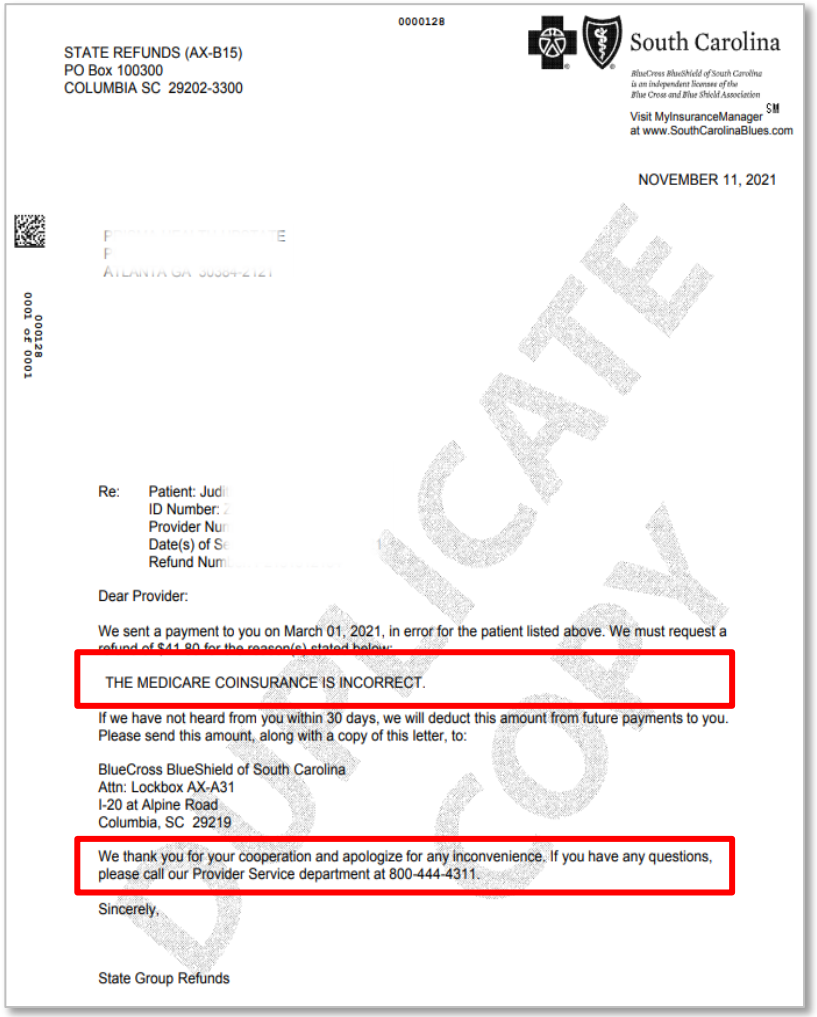
REFUND LETTERS

For assistance with refunds:

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

If you do not have the refund letter:

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



0000128

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

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

Visit MyInsuranceManager℠ at www.SouthCarolinaBlues.com

NOVEMBER 11, 2021

0000128 0001 of 0001

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

Dear Provider:

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

THE MEDICARE COINSURANCE IS INCORRECT.

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

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

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

Sincerely,

State Group Refunds

DUPLICATE COPY

SUBMISSION OF CLAIMS

Claims can be submitted using the following:

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

For more information, visit www.SouthCarolinaBlues.com:

Providers>Claims & Payments>Claims Submission

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

Dental Plans	
BlueCross BlueShield of South Carolina	38520

CORRECTED CLAIMS

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

CLAIM TIPS

SUBROGATION AND OHI QUESTIONNAIRES

- Accident or subrogation
  - Generated based on trauma related diagnoses on a claim
  - Must be completed by the member or the member can contact customer service to verify/update
    - Claim will remain patient liability until the questionnaire is received
- Other health insurance (OHI)
  - Generated based on the member's age, if they have more that one policy on file, etc.
  - Must be completed by the member or the member can contact customer service to verify/update

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

Incorporate the forms in the onboarding paperwork

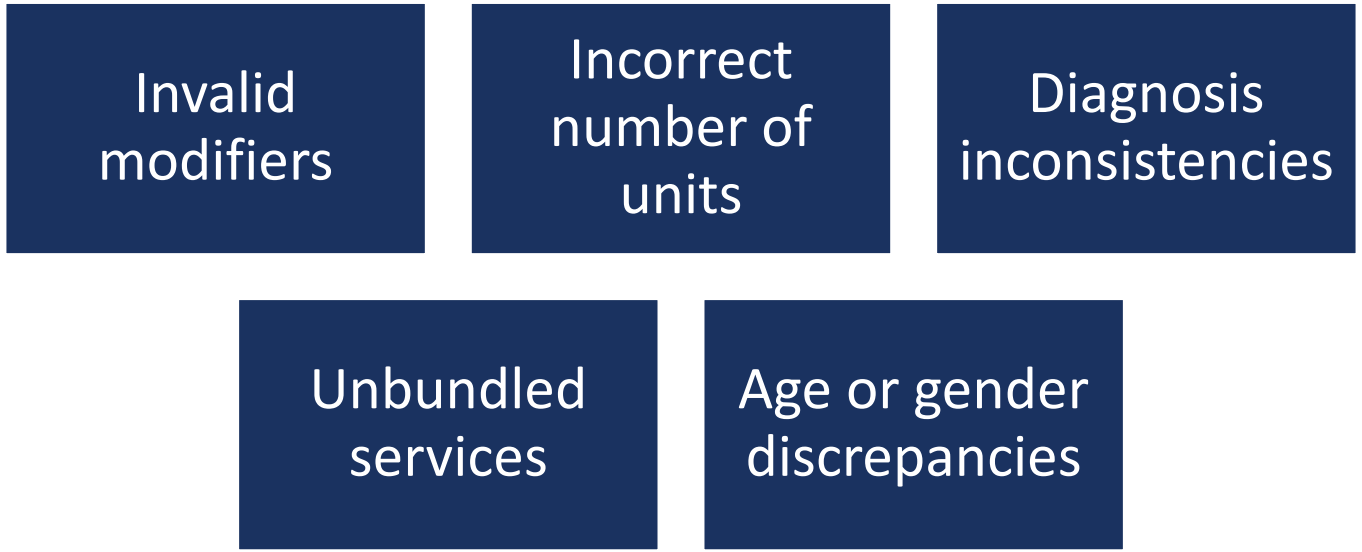
Only submit the documentation if requested.

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

Providers>Forms>Other Forms

CORRECT CODING

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



RESOURCES

VOICE RESPONSE UNIT

- **If a claim was paid or applied patient liability, you will receive the following:**
  - Processed date
  - Remittance date
  - Check number
  - Amount paid
  - Amount applied to the patient liability
- **If a claim is denied, you will receive the following:**
  - Denial reason
  - Remittance date

Note: If a claim is processed to the member, please contact them for the details. Submitting a HIPAA transaction (267/277) will let you know if the claim processed to the member.

MY INSURANCE MANAGER

- My Insurance Manager is the quickest way to get claims information. You can use the portal to:
  - Submit claims.
  - Check the status of claims.
  - View refund letters.
  - Get help with claims using:
    - Ask Provider Services.
    - STATchat℠.

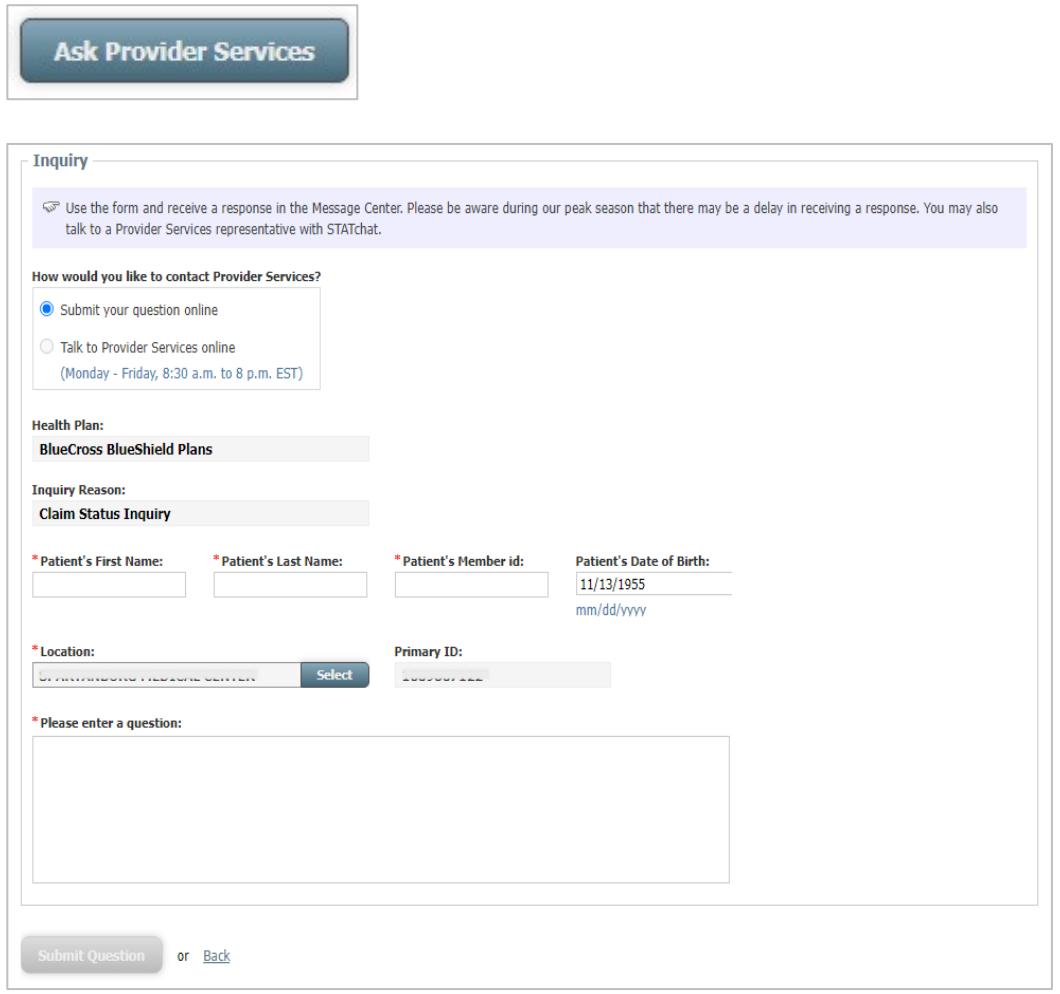
ASK PROVIDER SERVICES

- Ask Provider Services is a feature in My Insurance Manager that lets you submit secured web inquiries for help with claims.
- This feature is intended to assist with ***complex issues*** and not general claim status.

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

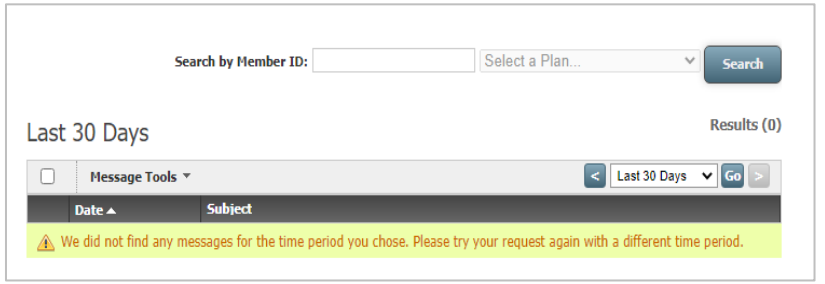
SUBMITTING WEB INQUIRIES

- From the claim screen, select ***Ask Provider Services***.
- Enter all the necessary information in the available fields.
- Be sure to ask clear, probing questions.
- Select Submit Question.

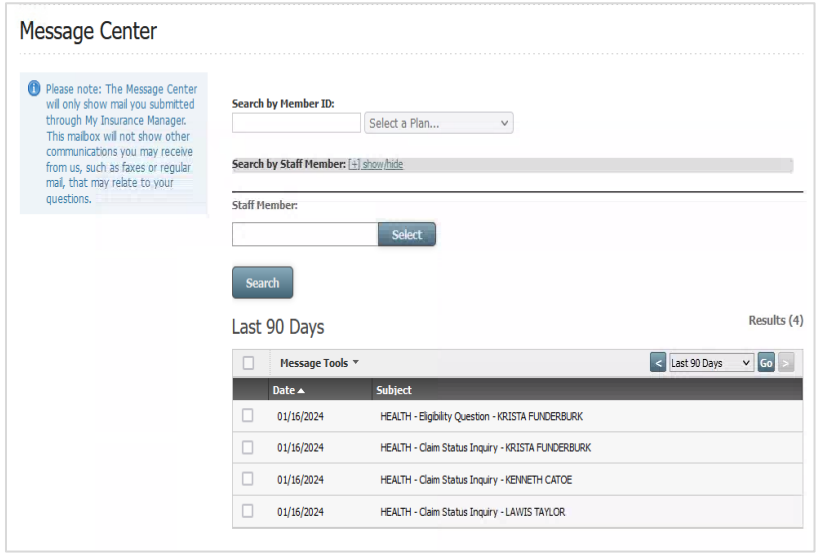


VIEWING WEB INQUIRY RESPONSES

- To view responses to your inquiries:
  - Select Go to Message Center.
  - You can narrow the results by entering the ID number and selecting specific months.
- Enhancements made:
  - You now have the option to see up to ***90 days*** of inquiries.
  - Provider Administrators can view all the web inquiries submitted and responses received under the Tax ID.
    - Enter the member's ID number and select the staff member from the drop-down menu.



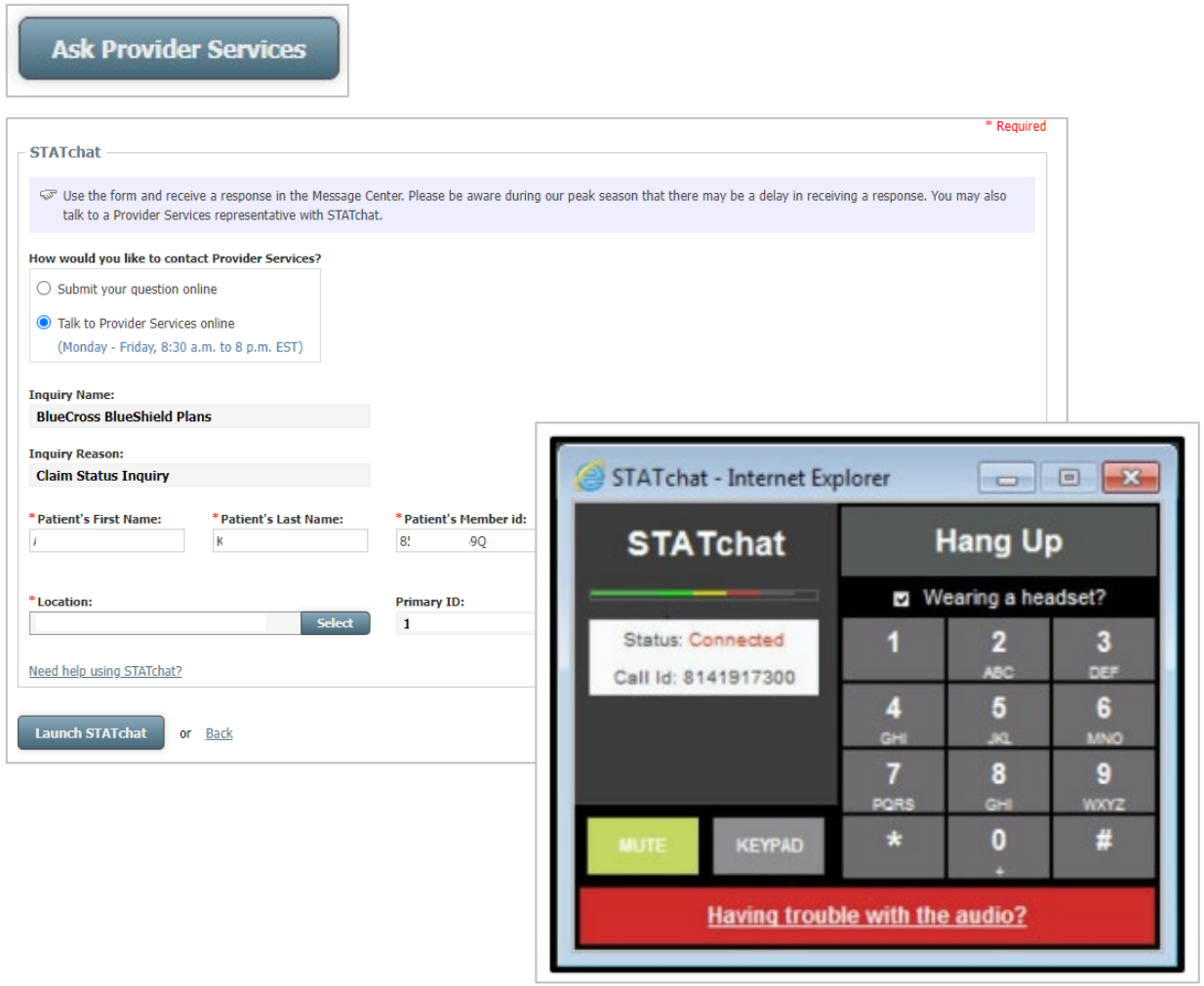
Office Staff View



Administrator View

STATCHAT

- STATchat is a feature that let's you speak with a Provider Services representative.
- The feature is available through My Insurance Manager.
- System requirements include:
  - A current version of Adobe Flash Player
  - A compatible web browser, such as Microsoft Edge or Google Chrome.
  - A headset or standalone microphone with speakers connected to your computer.



Note: The operation hours may vary for certain lines of business.

THANK YOU