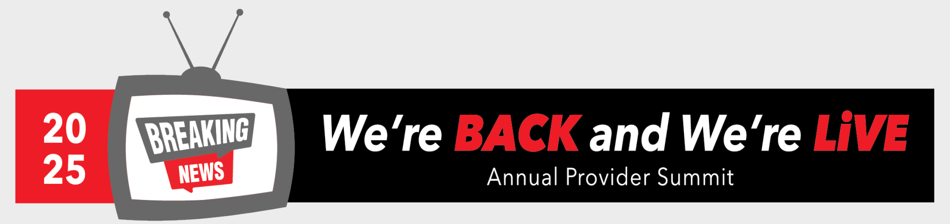
Welcome to the

2025 Annual Provider Summit



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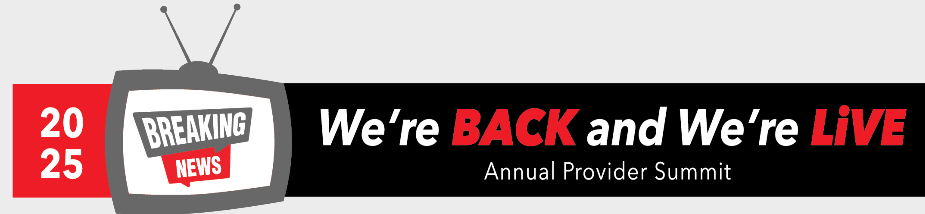
Important Disclaimer

The information included in this presentation 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.

Topics

- ❑ Authorizations
- ❑ Benefits
- ❑ Claims
- ❑ Dental Networks
- ❑ Pharmacy
- ❑ Provider Enrollment
- ❑ Quality
- ❑ Self-serving Tools

Authorizations



Topics to Discuss

- ❑ Overview of Authorizations
- ❑ Process for Authorizations
- ❑ Authorization Vendors
- ❑ Available Resources

Authorizations Overview

What You Need to Know About Authorizations

Authorizations are used to determine whether a service is medically necessary.

Authorization requirements can vary per plan and network.

Authorizations do not guarantee payment.

Common Services That Require Authorization

- Elective inpatient services (including maternity)
- Skilled nursing facility admission
- Home health and hospice
- Durable medical equipment (DME)*
- Mental health and substance abuse
- High tech imaging**
- Certain medications under the medical benefit

*DME dollar thresholds vary per plan but are typically $500 or $1,000. Please note threshold amounts can be lower than $500.
**These services are typically handled by Evolent.

General Guidelines for Authorizations

Submit elective requests prior to rendering services.

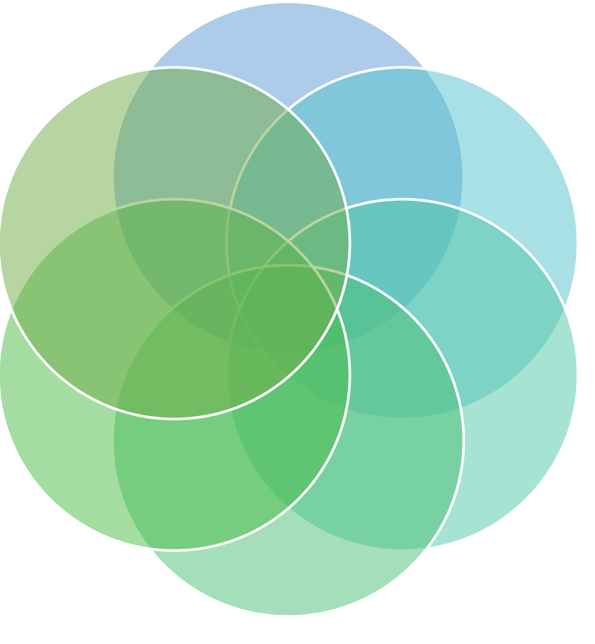
Submit requests once.

Services must be covered under the member's plan.

Members must have active coverage at the time of request.

Submit a notification of emergency admission within 24-48 hours of admission.

Mark requests as urgent **only** when they are urgent.



Main Steps in the Authorization Process

Verify the member's benefits and provider network.

If authorization is required, initiate the request.

Receive a decision (Approval or denial).

Required Information for Authorizations

Patient Details	Service Details	Location Details	Contact Information	Clinicals
❑Name ❑ID number ❑Date of birth	❑CPT or HCPCS codes ❑Diagnosis codes ❑Date of service	❑Facility – Name – Address – Tax ID or NPI ❑Rendering – Name – Address – Tax ID or NPI	❑Phone number ❑Fax number ❑Email	❑Length of issue ❑Attempted treatment ❑Conservative medications ❑Studies (i.e., labs, imaging)

Process for Authorizations

New Process to Get an Authorization

- Coming soon, we will implement a new process for requesting an authorization.
- My Insurance Manager will route you to a new web-based application, powered by Cohere Health, to enhance the efficiency of prior authorization decisions.
- Benefits of the new process include:
  - Accelerates and expands real-time approvals.
  - More seamless provider experience.
  - Decreases administrative efforts.
- The authorizations process for our third-party vendors will remain the same. This includes:
  - HealthHelp
  - Evolent
  - Avalon Healthcare Solutions
  - MBMNow
- **All clinical decisions are made by BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan.**

Cohere Health is an independent company offering utilization management service on behalf of BlueCross and BlueChoice®.

How to Get an Authorization

- There is a single sign-on through My Insurance Manager℠.
- Under ***Patient Care***, select ***Pre-certification/Referral***.

How to Get an Authorization (Continued)

- When you reach the landing page of the new platform, you will see a full listing of authorizations under your tax identification number (TIN).
- The authorizations can be filtered by:
  - All
  - Upcoming
  - Pending review
  - Approved
  - Denied
  - Draft
  - Withdrawn
  - Completed
- You can also search for a specific patient or authorization.
- To start a new request, select ***Start auth request***.

How to Get an Authorization (Continued)

- ❑ Select whether the service is outpatient or inpatient.
- ❑ Include the diagnosis and procedure code(s).
- ❑ Select ***Continue***.

Doe, John
DOB: 09/16/1986
South Carolina
powered by Cohere Health
Support
My account

Tell us about your request

Request details
Outpatient
Inpatient
Start date
06/01/2024

Diagnosis codes
Primary diagnosis code
M48.06
Search for secondary diagnosis codes (optional)

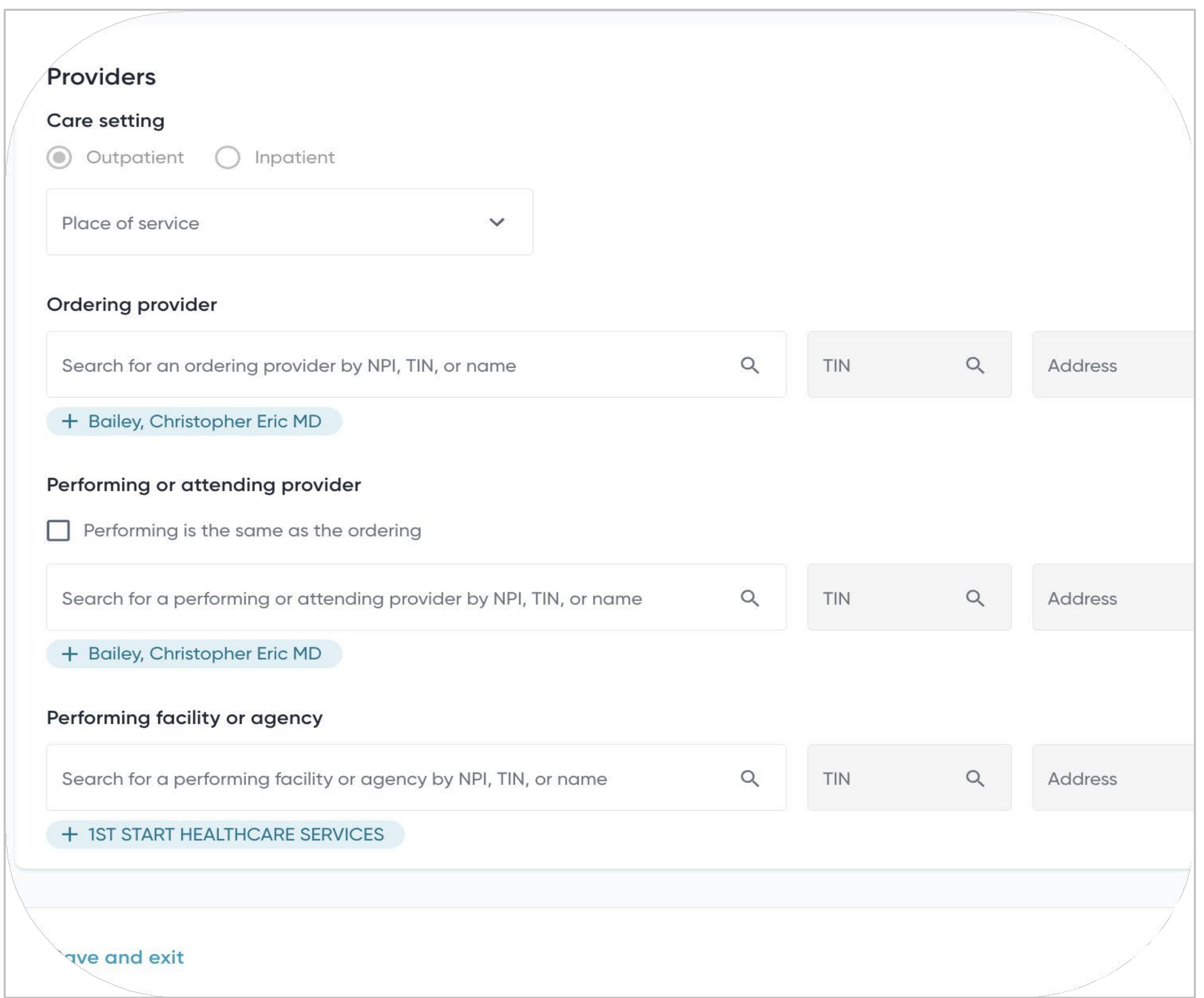
Procedure codes
CPT/HCPCS codes
63047

Save and exit
Cancel
Continue

Note: You have the option to save and exit the request at any time. You can also cancel the request if it's no longer needed.

How to Get an Authorization (Continued)

- ❑ Enter the provider details to include:
  - Ordering provider.
  - Performing or attending provider.
  - Performing facility or agency.
- ❑ There is a TIN search feature to make the process easier.
- ❑ Select ***Continue***.



How to Get an Authorization (Continued)

- On this screen, the top portion will tell you which codes you requested require authorization.
- The bottom portion will tell you which codes do not require authorization.
- There's an option to expedite the request if it's an ***urgent matter***.
- Select ***Continue***.

Requires authorization

Start date 04/30/2024 - End date mm/dd/yyyy

Physical Therapy (PT)

Number of visits
1

97110 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

Add a procedure code

Total Knee Arthroplasty (TKA)

27447 Units 1 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) Remove

Add a procedure code

Expedite

Doesn't require authorization in most cases Download PDF

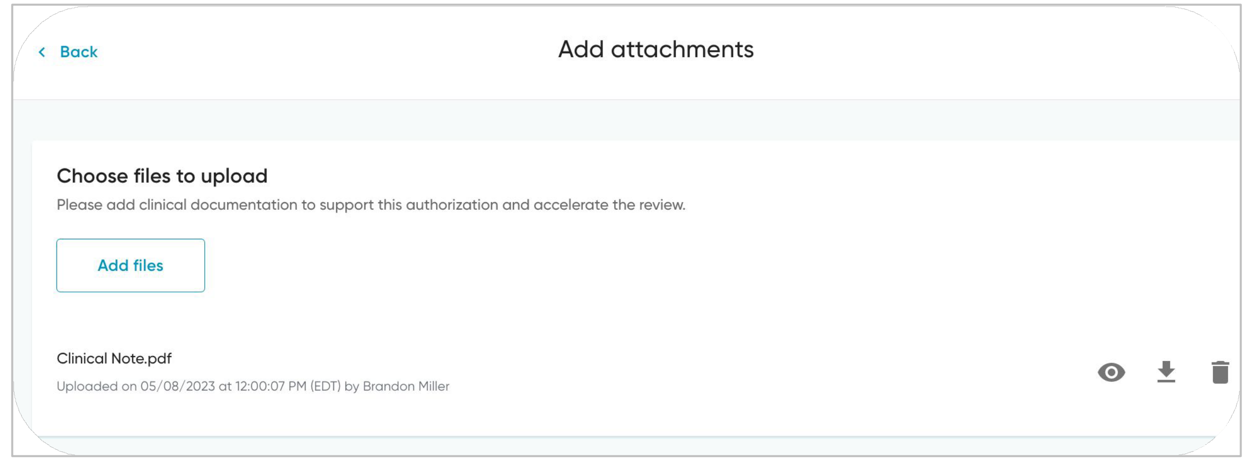
93798

Save and exit Continue with 2 codes

Note: The continue option will indicate the number of codes being requested for review.

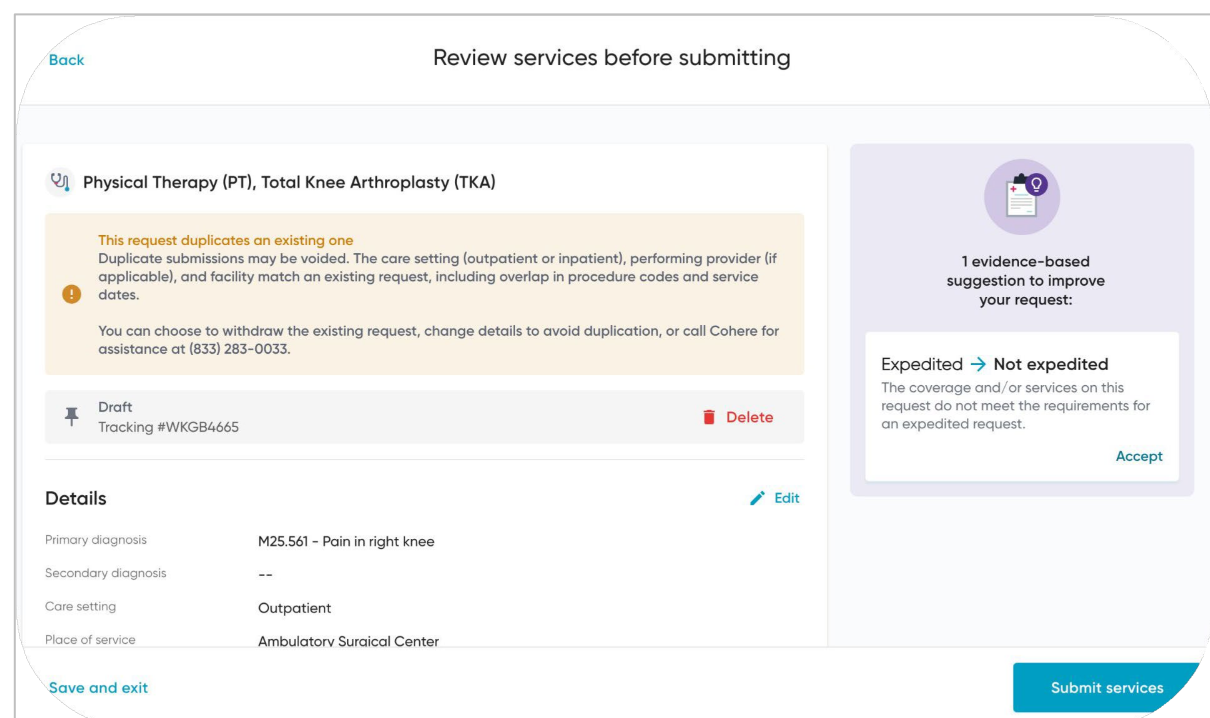
How to Get an Authorization (Continued)

- ❑ Upload all relevant clinical documentation for review.
- ❑ You will have the option to review the uploaded items or remove them.
- ❑ Select ***Continue***.



How to Get an Authorization (Continued)

- ❑ Review all the relevant information.
- ❑ Select ***Submit services***.



How to Get an Authorization (Continued)

- ❑ After submitting the request, you will receive a faxed notification confirming the receipt of your service request.

From: **Cohere Health** Date requested: **05/01/2024**

Response

We are confirming the receipt of your service request

To review the status of your request please go online to **next.coherehealth.com/check_status**

Still faxing? If so, you're missing out on timesaving benefits, including immediate auth decisions and transparent in-app clinical guidelines only available when using the Cohere*Next*:® web portal to manage preauthorizations.
Registration only takes a few minutes, and unlocks access for all users at your practice organization. Visit **www.coherehealth.com/register** to begin.

Tracking #: **NPOA6057**

Patient: **John Doe** Patient DOB: **01/26/1965**

CPT/HCPCS code: **63047**

Units (If applicable): **1**

Dates of service: **06/01/2024 – 09/30/2024**

Please note: Physical therapy, occupational therapy, and speech therapy are not considered "urgent" services as defined in the Medicare Managed Care Manual. Therefore, Cohere Health will process all such requests according to standard timeframes.

For answers to questions regarding the Cohere systems and available resources please go online to **https://coherehealth.zendesk.com** or **https://coherehealth.com/resources**

How to Get an Authorization (Continued)

- You will be notified once the authorization is approved.
  - Portal notification
  - Faxed notification
- To view additional details, select ***View service summary*** inside the portal.

South Carolina | powered by Cohere Health

Your request has been approved

Tracking #: **NPOA6057**
Dates of service: **06/01/2024 – 09/30/2**

Hello <user's name>,

Thank you for submitting a service reque
reviewed your request and it has been a
decision (including the authorization nur

View servic

South Carolina
powered by Cohere Health

From: **Cohere Health** Date requested: **05/01/2024**

Response

We have finished processing your service request

To review the status of your request please go online to **next.coherehealth.com/check_status**

Still faxing? If so, you're missing out on timesaving benefits, including immediate auth decisions and transparent in-app clinical guidelines only available when using the CohereNext:® web portal to manage preauthorizations.
Registration only takes a few minutes, and unlocks access for all users at your practice organization. Visit **www.coherehealth.com/register** to begin.

Final Determination: **Approved** Auth #: **NPOA6057** Tracking #: **NPOA6057**

Patient: **John Doe** Patient DOB: **01/26/1965**

CPT/HCPCS code: **63047**
Units (If applicable): **1**
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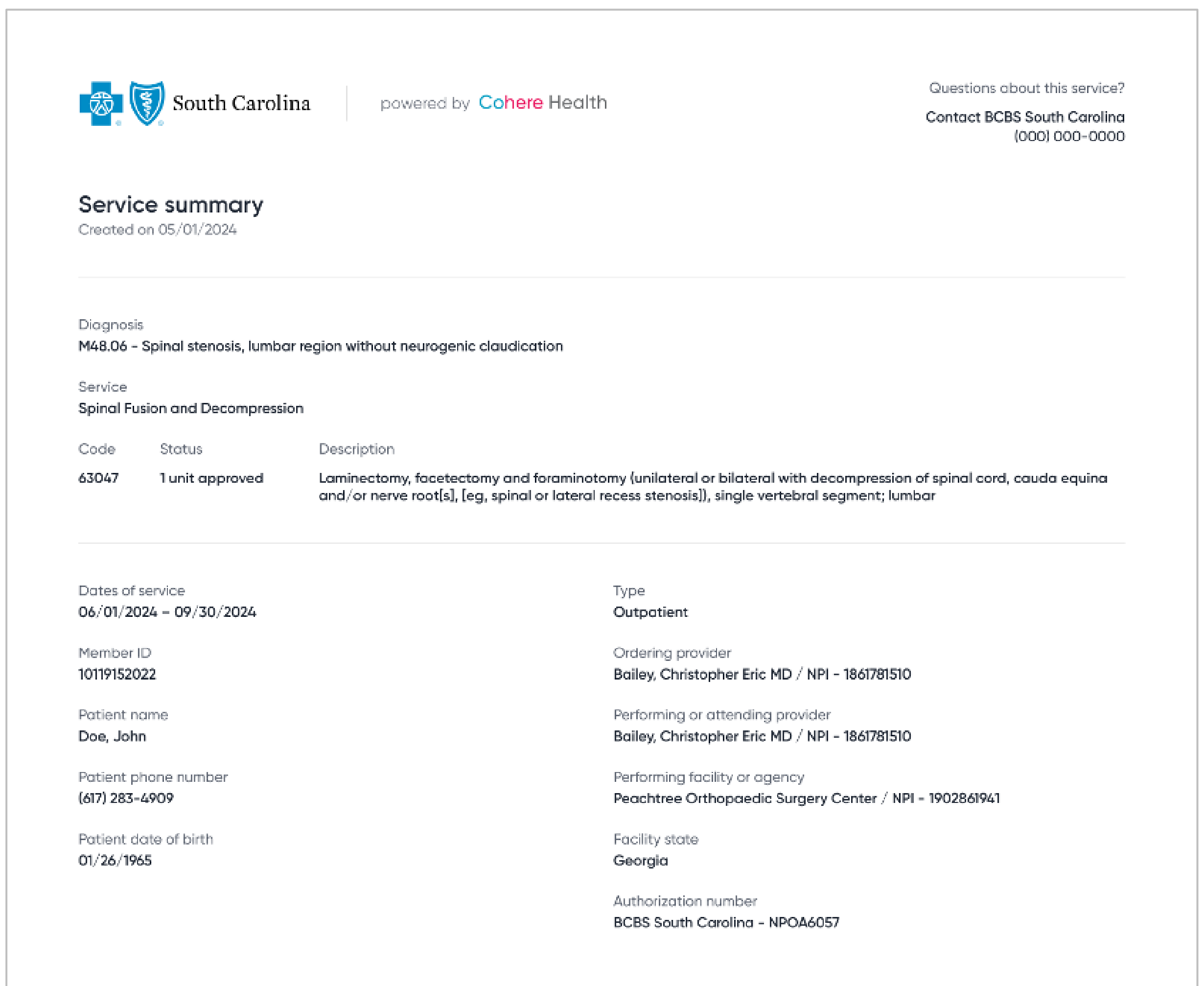
https://coherehealth.zendesk.com or **https://coherehealth.com/resources**

Note: You will also receive a notice if the request is denied.

How to Get an Authorization (Continued)

- The ***service summary*** will outline the requested authorization to include:
  - Diagnosis and procedure code(s).
  - Place of service.
  - Ordering provider.
  - Performing or attending provider.
  - Performing facility or agency.
  - Dates of service.



South Carolina | powered by Cohere Health

Questions about this service?
Contact BCBS South Carolina
(000) 000-0000

Service summary
Created on 05/01/2024

Diagnosis
M48.06 - Spinal stenosis, lumbar region without neurogenic claudication

Service
Spinal Fusion and Decompression

Code	Status	Description
63047	1 unit approved	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

Dates of service
06/01/2024 - 09/30/2024

Member ID
10119152022

Patient name
Doe, John

Patient phone number
(617) 283-4909

Patient date of birth
01/26/1965

Type
Outpatient

Ordering provider
Bailey, Christopher Eric MD / NPI - 1861781510

Performing or attending provider
Bailey, Christopher Eric MD / NPI - 1861781510

Performing facility or agency
Peachtree Orthopaedic Surgery Center / NPI - 1902861941

Facility state
Georgia

Authorization number
BCBS South Carolina - NPOA6057

How to Get an Authorization (Continued)

- The ***patient summary*** will outline the same details as the service summary but will give you the option to view the clinical documentation that was provided.

South Carolina | powered by Cohere Health | Support | My account

Back

Patient summary

Start auth request

Doe, John
Member ID 10119152022

Sex
Male

DOB
01/26/1965

Age
59

Address
420 Harvard St. #301 Brookline, MA

Phone
(617) 283-4909

Preferred written langauge
English

PCP grouper ID
918401720

Plan
BCBS South Carolina

Membership type
Commercial

Plan type
HMO

Plan year
04/24/2024 - 04/24/2025

Spinal Fusion and Decompression

Approved
Authorization #NPOA6057 • Tracking #NPOA6057

Details Edit

Primary diagnosis	M48.06 - Spinal stenosis, lumbar region without neurogenic claudication
Secondary diagnosis	--
Care setting	Outpatient
Place of service	Ambulatory Surgical Center
Ordering provider	Bailey, Christopher Eric MD / NPI - 1861781510 View info
Performing or attending provider	Bailey, Christopher Eric MD / NPI - 1861781510 View info
Performing facility or agency	Peachtree Orthopaedic Surgery Center / NPI - 1902861941 View info
Dates of service	06/01/2024 – 09/30/2024
Expedited	No

Spinal Fusion and Decompression

Code	Status	Description
63047	1 unit approved	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

Attachments (1) Edit

DoeJohn_ClinicalNote.pdf
Uploaded on 05/01/2024 02:39:51 PM (EST) by Connor Feick

Show clinical assessment

Requested by Connor Feick - Portal View info   Withdraw

Authorization Vendors

Third-Party Vendors That Manage Select Authorizations

- HealthHelp
- Evolent
- Avalon Healthcare Solutions
- Companion Benefit Alternatives (CBA)
- Specialty Pharmacy Manager (MBMNow)

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

HealthHelp

- Manages authorizations for select procedures related to:
  - Musculoskeletal (MSK)
    - Procedures not currently reviewed by Evolent.
  - Cardiology
  - Surgical
  - Sleep studies
- Only applies to our Exchange plans with group numbers starting with 61, 62 and 65
- To request an authorization:
  - Use: My Insurance Manager℠
  - Call: 833-715-2255
  - Fax: 844-470-2666

Evolent

- ❑ Manages the following types of authorization for most plans:
  - Radiation oncology
  - Advanced radiology
  - Musculoskeletal care (MSK)
- ❑ To request an authorization:
  - Use: My Insurance Manager or visit www.RadMD.com
  - Call: 866-500-7664 for BlueCross members
  - Call: 888-642-9181 for BlueChoice® members

Avalon Healthcare Solutions

- Manages authorizations for lab services in the following settings:
  - Office
  - Outpatient facility
  - Independent laboratory
- To request an authorization:
  - My Insurance Manager
    - Use the Prior Authorization System (PAS)
  - Call: 844-227-5769
  - Fax: 813-751-3760
    - Fax form located on www.SouthCarolinaBlues.com:
      - Providers>Policies and Authorizations>Prior Authorization>Laboratory Medical Benefits

Note: Avalon does not review requests in an emergency room, ambulatory surgery center or inpatient hospital setting.

MBMNow (Specialty Pharmacy)

BlueCross BlueShield of South Carolina

- Manages authorizations for certain specialty medications.
  - View the available lists on www.SouthCarolinaBlues.com.
    - Providers>Specialty and Pharmacy Drugs>Specialty Medical Medications
- To request an authorization:
  - Access MBMNow through My Insurance Manager
  - Call: 877-440-0089
  - Fax: 612-367-0742

Companion Benefit Alternatives

- Manages authorizations for behavioral health services.
  - Examples of services include:
    - Psychological testing
    - Behavioral health program admissions
    - Repetitive transcranial magnetic stimulation (rTMS)
- To request an authorization:
  - Visit www.CompanionBenefitAlternatives.com.
  - Call: 800-868-1032

Available Resources

Standard Prior Authorization List

- BlueCross developed a standard prior authorization list.
  - www.SouthCarolinaBlues.com
    - Providers>Policies and Authorizations>Prior Authorization
- The list only applies to the following lines of business:
  - National Alliance
  - Major Group
  - Small Group and Individual
  - Planned Administrators Inc.
  - State Health Plan
- **The list is not all inclusive and is subject to change. It's a guide that includes the most requested services that require medical review for prior authorizations.**

SERVICES THAT REQUIRE PRIOR AUTHORIZATION STANDARD LIST EFFECTIVE OCTOBER 2024

Many of our plans require prior authorization for certain procedures and services. This process allows us to check ahead of time whether services meet criteria for coverage by a member's health plan. Some services on this list may not be covered by the benefit plan. **Always verify benefits prior to services being rendered.**

Prior authorization is not a guarantee of payment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied.

This list is not all inclusive and is subject to change. It is a guide that includes the most commonly requested services requiring a medical review. Other services may require review based on our medical policies, guidelines or the employer group's plan of benefits. **Please review specific contract verbiage for exclusions, limitations and/or maximums.**

List does not apply to medical specialty drugs. To find out which medical specialty drugs require prior authorization under the medical plan or the Specialty Medical Benefit Management (SMBM) program, refer to **www.SouthCarolinaBlues.com** or My Insurance Manager℠.

Some plans may require prior authorization for mental health services. Contact Companion Benefit Alternatives (CBA) to verify by calling 800-868-1032. CBA is a wholly owned subsidiary of Blue Cross Blue Shield.

Online Resources and Tools

www.SouthCarolinaBlues.com **www.CompanionBenefitAlternatives.com** **https://www.bcbs.com/blue-distinction-center/facility**

- Medical Policies
- Prior Authorization Forms and Information
- Clinical Form Resource Center
- Blue Distinction Center Facility Finder

Prior Authorization List Applies to the Following BlueCross Lines of Business:

- National Alliance
- Major Group Fully Insured and ASO
- Small Group and Individual
- Planned Administrators Inc (PAI)
- State Health Plan

Contact Information

Benefit Program	Authorization Service	Web-based Requests	Telephone Requests	Fax Requests
BlueCross	[various]	My Insurance Manager	800-334-7287	
BlueChoice	[various]	My Insurance Manager	800-950-5387	
FEP	[various]	My Insurance Manager	800-327-3238	
State Health Plan	[various]	My Insurance Manager	800-925-9724	
Avalon	Laboratory	Avalon PAS (inside My Insurance Manager)	844-227-5769	813-751-3760
CBA	Behavioral/Substance Abuse	www.CompanionBenefitAlternatives.com	800-868-1032	
Evolent	• Advanced Radiology • Musculoskeletal Care • Radiation Oncology	www.RadMD.com	BlueCross: 866-500-7664 BlueChoice: 888-642-9181	888-656-1321
MBMNow	Specialty Medical Drug	My Insurance Manager	877-440-0089	612-367-0742

BlueCard Out-of-State Member Authorizations

Use the BlueCard Authorization/Medical Policy tool to verify authorization requirements for out-of-state members.

Providers | Providers | Search...

/ Providers / Policies and Authorizations / Prior Authorization / BlueCard Prior Authorization/Medical Policies

BlueCard Prior Authorization/Medical Policies

Need prior authorization for a patient who is a member of another Blue plan? If prior authorization is required, you can initiate the process through My Insurance Manager[SM]. Once you've logged in, go to Patient Care. Then select "Pre-Service Review for Out-of-Area Members" from the menu.

To view an out-of-area Blue Plan's medical policy or general prior authorization information, please select the type of information you need, enter the first three letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit.

Type of Information

Please select only one.

- Medical Policy
- General Precertification/Preauthorization Information

This field is required.

Alpha Prefix

This field is required.

Submit

Routes you to the member's Home plan.

If you experience difficulties or need additional information, please contact 800-676-BLUE.

BlueCard Out-of-State Member Authorizations (Continued)

Example

BlueCard Prior Authorization/Medical Policies

Need prior authorization for a patient who is a member of another Blue plan? If prior authorization is requi
ManagerSM. Once you've logged in, go to Patient Care. Then select "Pre-Service Review for Out-of-Area M

To view an out-of-area Blue Plan's medical policy or general prior authorization information, please select
letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit.

Type of Information

Please select only one.

- Medical Policy
- General Precertification/Preauthorization Information

Alpha Prefix

YPP

Submit

If you experience difficulties or need additional information, please contact 800-676-BLUE.

NC | Shop Plans | Members | Providers | Employers | Agents | Contact Us | Log In

Home > Providers > Prior authorization > Prior plan approval

PROVIDERS

Prior plan approval

Prior review (prior plan approval, prior authorization, prospective review or certification) is the process Blue Cross NC uses to review the provision of certain behavioral health, medical services and medications against health care management guidelines prior to the services being provided. Inpatient admissions, services and procedures received on an outpatient basis, such as in a doctor's office, and prescription medications may be subject to prior review.

You can search for services and durable medical equipment, or medications that require authorization for all places of service, including when performed during any inpatient admission, including both planned inpatient admissions and emergent inpatient admissions.[1]

Reviews may confirm:

- Member eligibility
- Benefit coverage
- Compliance with Blue Cross NC corporate and Blue Medicare medical policies regarding medical necessity
- Appropriateness of setting
- Requirements for use of in-network and out-of-network facilities and professionals
- Identification of comorbidities and other problems requiring specific discharge needs

Peer-to-Peer Requests

- ❑ Process to review and discuss denied prior authorizations.
  - Must be requested before submitting claims.
- ❑ 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 authorization
- ❑ Clinical discussion:
  - Facilitated within one business day of receipt of request
  - Our medical doctor makes two attempt to contact the rendering provider
  - A decision is rendered at the end of the call

How to Request a Peer-to-Peer

Initiating Requests and Checking Statuses

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

Utilization Management Courtesy Re-evaluations

- Utilization management courtesy re-evaluations are permitted for denials that are due to the following:
  - No clinical information submitted
  - Insufficient clinical information submitted
- To request a courtesy review, you must:
  - Specify the request is for a re-evaluation upon submission (via fax)
  - Submit clinical documentation within five business days of the denial notice

Benefits

Topics to Discuss

- ❑ 2025 Benefit Updates
- ❑ Benefit Reminders
- ❑ Available Resources

2025 Benefit Updates

Preferred Blue

Preferred Blue – New Groups

Group Name	Prefix	Vision	Dental	Rx
Resolute	SJX	Not covered	Metlife Dental	Express Scripts
Eau Claire Cooperative Health	EEA	Not covered	Not covered	Optum Rx

Note: Be sure to verify eligibility and benefits for these new groups beginning Jan. 1, 2025.

State Health Plan

State Health Plan – Standard Plan

Standard Plan	2024	2025
Deductibles		
Individual	$515	No change
Family	$1,030	No change
Coinsurance Maximum		
Individual (INN)	$3,000	No change
Family (INN)	$6,000	No change
Individual (OON)	$6,000	No change
Family (OON)	$12,000	No change
Services		
Office visits	$15 copay	No change
Outpatient facility	$115 copay	No change
Emergency room	$193 copay	No change
Cardiac and pulmonary rehabilitation	$15 copay	No change

State Health Plan – Savings Plan

Savings Plan	2024	2025
Deductibles		
Individual	$4,000	No change
Family	$8,000	No change
Coinsurance Maximum		
Individual (INN)	$3,000	No change
Family (INN)	$6,000	No change
Individual (OON)	$6,000	No change
Family (OON)	$12,000	No change
Services		
Office visits	Full allowance until the deductible is met. Then, the coinsurance.	No change
Outpatient facility	Full allowance until the deductible is met. Then, the coinsurance.	No change
Emergency room	Full allowance until the deductible is met. Then, the coinsurance.	No change

State Health Plan – MUSC Plan

MUSC Plan	2024	2025
Deductibles		
Individual	$385	No change
Family	$770	No change
Coinsurance Maximum		
Individual (INN)	$2,200	No change
Family (INN)	$4,400	No change
Services		
Office visits	PCP: $25 copay Specialist: $45 copay	No change
Outpatient facility surgery	$290 copay	No change
Outpatient facility radiology (regular and advanced)	$85 copay	No change
Inpatient facility	$0	No change
Emergency room	$193 copay	No change
Urgent care	$85 copay	No change
Cardiac and pulmonary rehabilitation	$15 copay	No change

State Health Plan Authorizations

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

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

State Health Plan – Additional Information

2025 Changes

- State Health Plan is discontinuing the patient incentive for members receiving care at a BlueCross credentialed Patient Centered Medical Home (PCMH).
  - Normal plan provisions (copays and coinsurance) will apply to members who receive care at a PCMH.
- Members 18 years of age and under will have coverage for bone-anchored hearing aids (BAHA).

Federal Employee Program

Federal Employee Program – Blue Focus Plan

Blue Focus – No out-of-network benefits available.	2024	2025
Deductibles		
Individual	$500	No change
Self – Plus One	$1,000	No change
Family	$1,000	No change
Out-of-Pocket Maximum		
Individual	$9,000	No change
Self – Plus One	$18,000	No change
Family	$18,000	No change
Services		
Office visits (Includes primary and/or specialty care combined)	$10 copay (first 10 visits)	No change
Telehealth	$0 copay (first two visits) $10 copay (all additional visits)	No change
Chiropractic care	$25 copay up to 10 visits	No change

Federal Employee Program – Blue Focus Plan (Continued)

Blue Focus – No out-of-network benefits available.	**2024**	**2025**
Services (Continued)		
Urgent care	$25 copay	No change
Hospital care – Inpatient (prior authorization required)	30% COIN + BYD	No change
Hospital care – Outpatient	30% COIN + BYD	No change
ER – Accidental injury (within 72-hours)	$0 copay	No change
ER – Medical emergency	30% COIN + BYD	No change

Note: For a full list of benefits and updates, please visit www.fepblue.org.

Federal Employee Program – Standard Plan

Standard	2024	2025
Deductibles		
Individual	$350	No change
Family	$700	No change
Out-of-Pocket Maximum		
Individual (INN)	$6,000	No change
Family (INN)	$12,000	No change
Services		
Physician care (INN)	$30 copay (PCP) $40 copay (Specialist)	No change
Telehealth (INN)	$0 copay (first two visits) $10 copay (additional visits)	No change
Urgent care – Accidental injury	$0 copay	No change
Urgent care – Medical emergency	$30 copay	No change

Federal Employee Program – Standard Plan (Continued)

Standard	2024	2025
Services (Continued)		
Preventive care (INN)	$0 copay	No change
Chiropractic care (INN)	$30 copay up to 12 visits	No change
Hospital care – Inpatient (prior authorization required) (INN)	$350 copay Per admission	No change
Hospital care – Outpatient (INN)	15% COINS + BYD	No change
ER – Accidental injury (within 72-hours) (INN)	$0 copay	No change
ER – Medical emergency (INN)	15% COINS + BYD	No change

Note: For a full list of benefits and updates, please visit www.fepblue.org.

Federal Employee Program – Basic Plan

Basic	2024	2025
Deductibles		
Individual	$0	No change
Family	$0	No change
Out-of-Pocket Maximum		
Individual (INN)	$6,500	**$7,500**
Family (INN)	$13,000	**$15,000**
Services		
Physician care	$35 copay (PCP) $45 copay (Specialist)	$35 copay (PCP) **$50 copay (Specialist)**
Telehealth	$0 copay (first two visits) $15 copay (additional visits)	No change
Chiropractic care	$35 copay up to 20 visits	No change
Urgent care	$35 copay	No change

Federal Employee Program – Basic Plan (Continued)

Basic	2024	2025
Services (Continued)		
Preventive care	$0 copay	No change
Hospital care – Inpatient (prior authorization required)	$250 copay, per day Up to $1,500 per admission	**$350 copay, per day** **Up to $1,750 per admission**
Hospital care – Outpatient	$150 copay Per day, per facility	**$350 copay** **Per day, per facility**
ER – Accidental injury	$250 copay Per day, per facility	**$350 copay** **Per day, per facility**
ER – Medical emergency	$250 copay Per day, per facility	**$350 copay** **Per day, per facility**

Note: For a full list of benefits and updates, please visit www.fepblue.org.

Federal Employee Program – Preventive Care

Blue Focus, Standard, and Basic	2024	2025
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

BlueChoice® HealthPlan

BlueChoice® – Upcoming Changes

New 2025 Implementations

- ❑ Vision vendor is changing to Pen Vision effective Jan. 1, 2025.
- ❑ Doctor's Care claims will no longer be processed as a primary care provider.
  - Will be considered urgent care.

BlueChoice – Reminders

- **Verify eligibility and benefits before rendering services**
  - Use My Insurance Manager
  - Call Provider Services: 800-868-2528
- **Verify prior authorization requirements**
  - Check the physician office manual.
  - Call Health Care Services: 800-950-5387
- **Continuous glucose monitors**
  - This benefit may fall under pharmacy or medical, depending on the member's plan.
- **Check drug lists to ensure medications are covered**
  - Submit clinical information (including any similar medications tried and the member's reaction) along with the authorization request.
- **Obesity related services**
  - These are not covered and are deemed a contract exclusion.

BlueChoice – Reminders (Continued)

- **Referral forms (located on www.BlueChoiceSC.com)**
  - Referrals must be completed for patients and can be submitted by:
    - Fax: 800-610-5685 or 803-714-6463
    - My Insurance Manager
- **Submit claims within a timely manner**
  - Timely filing limit for original claims is 180 days from the date of service.
  - Timely filing limit for corrected claims is one year from the date of service.
- **Balance billing**
  - Network participating providers should not bill patients more than their liability.
  - Remittances can be found on My Insurance Manager.

Medicare Advantage

Medicare Advantage – Plan Overview

2024 Plans

- ❑ Blue Basic PPO
- ❑ Total PPO (Lowcountry, Midlands, Upstate)
- ❑ Total Value PPO (Lowcountry, Midlands, Upstate)
- ❑ Secure HMO (Greenville, Richland)

2025 Plans

- ❑ Blue Basic PPO
- ❑ Total PPO (Lowcountry, Midlands, Upstate)
- ❑ Total Value PPO (Lowcountry, Midlands, Upstate)
- ❑ **No Secure HMO plans for 2025**

Medicare Advantage – BlueCross Total Plan

BlueCross Total	2024	2025
Deductibles		
In-network & Out-of-network	$0	No change
Out-of-Pocket Maximum		
From in-network providers:	$6,900	**$8,900**
From in-network & out-of-network providers combined	$10,000	**$13,500**
Services		
Outpatient office visits	INN - $0 copay (PCP) INN - $25 copay (Specialist) OON - $30 copay (PCP) OON - $55 copay (Specialist)	INN - $0 copay (PCP) **INN - $17 - $47 copay (Specialist)** OON - $30 copay (PCP) **OON - $50 copay (Specialist)**
Inpatient hospital – Acute	INN - $300 copay, per day (1-4) INN - $0 copay, per day (5-90) OON - 40% COINS for total stay	**INN - $450 copay, per day (1-2)** INN - $0 copay, per day (**3-90**) OON - 40% COINS for total stay
Inpatient hospital – Psychiatric	INN - $645 copay, per day (1-4) INN - $0 copay, per day (5-90) OON - 40% COINS for total stay	**INN - $675 copay, per day (1-3)** INN - $0 copay, per day (**4-90**) OON - 40% COINS for total stay

Medicare Advantage – BlueCross Total Plan (Continued)

BlueCross Total	2024	2025
Services (Continued)		
Skilled nursing facility (SNF)	INN - $0 (days 1-20) INN - $203 copay (days 21-100) OON - 40% COINS for total stay	INN - $0 (days 1-20) **INN - $214 copay (days 21-100)** OON - 40% COINS for total stay
Urgently needed services	INN & OON - $55 copay, per visit	**INN & OON - $10 copay, per visit** **Outside of USA - $45 copay, per visit**
Worldwide Emergency/Urgent Coverage	$250 service specific deductible, then 20% COINS for emergency care outside the United States	No change
Ambulance services (Ground or air)	INN & OON - $295 copay, per trip	No change
Hearing aids	$699-$999 using TruHearing Two per year (one per ear)	No change
Preventive dental (Fluoride treatment not covered)	INN - $0 copay (two, per year) OON - 50% COINS $3,500 maximum (combined)	INN - $0 copay (two, per year) OON - 50% COINS **$4,500 maximum (combined)**
Comprehensive dental (Medicare covered services)	INN - $50 copay OON - 40% COINS $3,500 maximum (combined)	INN - $50 copay **OON - $50 copay** **$4,500 maximum (combined)**
Comprehensive dental (non-covered Medicare services)	INN & OON - 50% COINS $1,000 benefit maximum $3,500 maximum (combined)	INN & OON - 50% COINS $1,000 benefit maximum **$4,500 maximum (combined)**

Note: The combined maximum is for preventive and comprehensive dental services.

Medicare Advantage – BlueCross Total Value Plan

BlueCross Total Value	2024	2025
Deductibles		
In-network & Out-of-network	$0	No change
Out-of-Pocket Maximum		
In-network	$7,900	**$9,350**
Out-of-network	$11,300	**$14,000**
Services		
Outpatient office visits	INN - $0 copay (PCP) INN - $30 copay (Specialist) OON - $40 copay (PCP) OON - $55 copay (Specialist)	INN - $0 copay (PCP) **INN - $17 - $47 copay (Specialist)** OON - $40 copay (PCP) OON - $55 copay (Specialist)
Inpatient hospital – Acute	INN - $350 copay per day (1-4) ***Midlands/Coastal/Upstate*** OON – 20% COINS of total cost ***Lowcountry*** OON – 50% COINS of total cost	**INN - $465 copay per day (1-2)** **INN - $0 copay, per day (3-90)** **OON - 40% COINS for total stay**
Inpatient hospital – Psychiatric	INN - $645 copay per day (1-3) ***Midlands/Coastal*** OON – 20% COINS of total cost ***Upstate/Lowcountry*** OON – 50% COINS of total cost	**INN - $675 copay, per day (1-3)** **INN - $0 copay, per day (4-90)** **OON – 50% COINS for total stay**

Medicare Advantage – BlueCross Total Value Plan (Continued)

BlueCross Total Value	2024	2025
Services (Continued)		
Skilled nursing facility (SNF) (100 benefit day max, per year)	INN - $0 (days 1-20) INN - $203 copay (days 21-100) OON - 50% COINS for total stay	INN - $0 (days 1-20) **INN - $214 copay (days 21-100)** OON - 50% COINS for total stay
Emergency care	INN & OON - $100 copay, per visit	**INN & OON - $110 copay, per visit**
Worldwide emergency	$250 service specific deductible, then 20% COINS for emergency care outside the United States	No change
Urgent care	$55 copay	**INN & OON - $10 copay, per visit** **Outside of USA - $45 copay, per visit**
Ambulance services (Ground or air)	INN & OON - $295 per one way trip	**INN - $310 copay, per one-way trip** **OON - $325 copay, per one-way trip**
Hearing aids	$699-$999 using TruHearing Two per year (one per ear)	No change
Preventive dental	INN - $0 copay (two visits per year) OON - 50% COINS $2,000 maximum (combined)	INN - $0 copay (two, per year) OON - 50% COINS **$3,000 maximum (combined)**
Comprehensive dental (Medicare covered services)	INN & OON - $50 copay $2,000 maximum (combined)	INN - $50 copay OON – 50% COINS **$3,000 maximum (combined)**
Comprehensive dental (non-covered Medicare services)	INN & OON - 50% COINS $500 benefit maximum $2,000 maximum (combined)	INN & OON - 50% COINS **$3,000 maximum (combined)**

Note: The combined maximum is for preventive and comprehensive dental services.

Medicare Advantage – BlueCross Blue Basic Plan

BlueCross Blue Basic	2024	2025
Deductibles		
In-network & Out-of-network	$0	No change
Out-of-Pocket Maximum		
In-network	$5,900	No change
Out-of-network	$9,550	No change
Services		
Outpatient office visits	INN - $0 copay (PCP) INN - $35 copay (Specialist) OON - $30 copay (PCP) OON - $45 copay (Specialist)	INN - $0 copay (PCP) **INN - $30 copay (Specialist)** OON - $30 copay (PCP) OON - $45 copay (Specialist)
Inpatient hospital – Acute	INN - $325 copay, per day (1-6) INN - $0 copay, per day (7-90) OON - 20% COINS for total stay	No change
Inpatient hospital – Psychiatric	INN - $645 copay, per day (1-3) OON - 20% COINS for total stay	No change

Medicare Advantage – BlueCross Blue Basic Plan (Continued)

BlueCross Blue Basic	2024	2025
Services (Continued)		
Skilled nursing facility (SNF)	INN - $0 copay (days 1-20) INN - $196 copay (days 21-100) OON - 20% COINS for total stay	INN - $0 copay (days 1-20) **INN - $214 copay (days 21-100)** OON - 20% COINS for total stay
Urgently needed services	INN & OON - $40 copay	**INN & OON - $10 copay** **Outside of USA - $45 copay, per visit**
Emergency care	$90 copay, per visit (Waived if admitted within 24 hours)	**$110 copay, per visit** (Waived if admitted within 24 hours)
Worldwide Emergency/Urgent Coverage	$250 service specific deductible, then 20% COINS for emergency care outside the United States.	No change
Ambulance services (Ground or air)	INN & OON - $275 per trip	No change

Medicare Advantage – BlueCross Blue Basic Plan (Continued)

BlueCross Blue Basic	2024	2025
Services (Continued)		
Hearing Aids	$699-$999 using TruHearing 2 per year (one per ear)	No change
Preventive Dental (Fluoride treatment not covered)	INN & OON - $0 copay (Two per year) $2,000 maximum (combined)	INN - $0 copay (Two per year) **OON – 50% COINS** **$3,500 maximum (combined)**
Comprehensive Dental (Medicare covered services)	INN - $50 copay OON - 30% COINS $2,000 maximum (combined)	INN - $50 copay OON - 50% COINS **$3,500 maximum (combined)**
Comprehensive dental (non-covered Medicare services)	INN & OON - 50% COINS $2,000 benefit maximum	INN & OON - 50% COINS **$3,500 benefit maximum**

Note: The combined maximum is for preventive and comprehensive dental services.

Medicare Advantage – Preventive Care

All Plans (Total, Total Value, & Blue Basic)	**2024**	**2025**
Services		
Annual wellness visit/Annual physical	$0 Copay	No change
Lab work	$0 Copay	No change
Preventive screenings: • Colorectal cancer screening • Breast cancer screening • Bone mineral density tests • Diabetic eye exam • Eyeglasses and frames • Glaucoma screening	$0 Copay	No change

Medicare Advantage Plan Authorizations

- **Medical Services**
  - My Insurance Manager
  - 855-843-2325
- **Behavioral Health**
  - www.CompanionBenefitAlternatives.com
  - 833-971-4075
- **Laboratory Services**
  - My Insurance Manager
    - Prior Authorization System (PAS)
  - 844-227-5769
- **DME (in the home setting), Home Health and Home Infusion Services**
  - Integrated Home Care Services
  - 844-215-4264

Always verify benefits and eligibility prior to rendering services.
Use My Insurance Manager or call 855-843-2325.

Note: Throughout the year there may be changes to the services that require prior authorization. Periodically check, for any code changes, additions, or deletions.

Medicare Advantage Plan – Value Added Benefits

- **FitOn Health**
  - A flexible health and fitness benefit with 22 monthly credits to use on a nationwide network of gyms, local fitness studios, or community centers.
  - Credits can be used to cover a variety of options – monthly gym membership with unlimited visits, fitness studio classes, and at-home fitness accessories and equipment.
- **Transportation (Note: Benefit only applies to Total and Blue Basic plans)**
  - 24 one-way non-emergency rides to health-related locations such as in-patient facilities, health plan sponsored health events and other approved medical centers
  - Members must schedule rides at least 48 hours before pick-up time
  - *Transportation benefit does not apply to the Total Value PPO plans*
- **Over the counter**
  - $55 - $100 credit per quarter (credit dependent on plan – Total, Total Value or Blue Basic)
  - Orders can be placed by phone, online, or catalog
  - Members receive a Flex card for local pharmacies to purchase select items

Medicare Advantage Plan – Value Added Benefits

- **Post discharge meals**
  - 10 free frozen meals after each inpatient or rehab discharge
  - Orders must be placed through the care management team
- **Annual wellness incentive**
  - All members receive a $40 annual incentive after completing a wellness exam or physical
    - Received as additional money on the over-the-counter Flex card
- **In-home health assessment award (New for 2025)**
  - All members receive a $50 health assessment award after completing an in-home health assessment through Signify
- **Routine eye exams and eyewear**
  - One routine eye exam every year and one pair of lenses or contact lenses every year
  - Frames are covered every two years
  - This benefit is only covered through a BlueCross authorized vendor, (EyeMed)

Medicare Advantage Plan – Value Added Benefits

- **Concierge pharmacy services**
  - For members that received a denial due to step therapy or prior authorization, or those who have difficulty obtaining medications
- **Member health events**
  - Members can attend local health events sponsored by BlueCross BlueShield of South Carolina
    - Includes free services
    - Allows members to speak with a BlueCross representative for assistance
    - Has games for social interactions

Medicare Advantage Plan – Inflation Reduction Act

For plans with Part D coverage:

- ❑ $35 limit for monthly insulin copay.
  - Shown as Tier 3 in formulary but special pricing.
- ❑ Part D vaccines (such as shingles) covered at $0 (pharmacy).
- ❑ $35 copay INN and OON for a 1-month supply of Medicare Part B insulins for use in home infusion pumps.
- ❑ Members stay in the Initial Coverage stage until their total out-of-pocket costs reach $2,000. They then move to the Catastrophic Coverage stage. **(New for 2025)**
- ❑ Members will pay 0% cost share in Catastrophic Coverage stage.

Medicare Advantage Plan – CMS Stars Ratings

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

**Centers for Medicaid and Medicare Services*

Medicare Advantage Plan – CMS Stars Ratings (Continued)

- BlueCross BlueShield of South Carolina is pleased to announce we have **successfully repeated** our 4 Star Rating with our PPO Plans. This includes our Total, Total Value and Blue Basic plans.
- In addition to this 4 Star Rating, we have multiple individual star measures that reached 5 Stars:
  - Excellent customer service – based on member survey
  - Reliable call center accuracy and availability – based on CMS secret shopper calls
  - Low rate of member complaints – based on CMS reporting
  - Low rate of member disenrollment – based on CMS reporting
  - Timeliness processing of member appeals – based on CMS reporting
  - Personalized medication review – based on membership participation
  - Quality improvement in clinical measures – based on clinical outcomes

Medicare Advantage Plan – Network Sharing

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

Tips for accuracy:

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

Medicare Advantage Plan – General Reminders

- Check the member's ID card to determine their plan type
- Follow Medicare guidelines at www.cms.gov for covered services
- Verify eligibility and benefits at each visit prior to rendering services
- Prior authorization requirements may differ from other plans
  - View the requirements and methods for obtaining authorization at www.SouthCarolinaBlues.com
    - Providers>Medicare Advantage>Prior Authorization
- When possible, always refer members to network participating providers
- Review the Medicare Advantage provider manuals for more information
  - Update: Section 3:8: Confidentiality and Data Use
    - Visit www.SouthCarolinaBlues.com

Group and Individual

Individual and Family Plans – Chiropractic Coverage

- Beginning Jan. 1, 2025, all individual and family plans will have benefits for chiropractic services.
- High deductible plans will be subject to the applicable deductible and coinsurance.
- All other plans will have a $25 copay.
- **All plans will have $500 benefit period maximum, per member.**

Note: Use My Insurance Manager or call Provider Services to verify member specific benefits.

Individual and Family Plans – Adult Vision Coverage

- Beginning Jan. 1, 2025, the following plans will include benefits for adult vision through VSP:
  - BlueEssentials EPO Silver 14 + Vision
  - Blue Direction POS Silver 1 + Vision
  - Regional HMO Silver 2 + Vision
- $25 copay for exam
- $50 copay for lenses and frames
  - Frames covered up to retail allowance of $100.
    - 20% off any amount over the retail allowance.

Note: Use My Insurance Manager or call Provider Services to verify member specific benefits.

New Regional HMO Plan – Blue Beaufort

- Blue Beaufort will be a new plan available to members in 2025.
  - Members must live in Beaufort county.
- The plan does not have out-of-network benefits except for urgent or emergent services.
- Plan includes Beaufort Memorial providers.

Existing Regional HMO Plans

- Other existing regional HMO plans include:
  - **Blue Reedy**
    - Members must live in Greenville, Laurens, Oconee and Pickens counties.
    - Includes Prisma Health Upstate providers.
  - **Blue Pee Dee**
    - Members must live in Florence, Georgetown, Horry and Marion counties.
    - Includes MUSC, Tidelands and Conway Medical Center providers.
  - **Blue Congaree**
    - Members must live in Kershaw, Lexington and Richland counties.
    - Includes MUSC and Lexington Medical Center providers.
  - **Blue Cooper**
    - Members must live in Berkeley, Charleston, Dorchester, Orangeburg and Williamsburg counties.
    - Includes MUSC providers.
- These plans do not have out-of-network benefits except for urgent or emergent services.

Regional HMO – Plans with Cost Share Reductions (CSR)

Plan	CSR 3	CSR 2	CSR 1	Silver 2*
Deductibles				
Individual	$0	$1,700	$5,900	$7,900
Family	$0	$3,400	$11,800	$15,800
Coinsurances				
	50%	50%	50%	50%
Out-of-Pocket Maximum				
Individual (INN)	$850	$2,250	$7,050	$8,800
Family (INN)	$1,700	$4,500	$14,100	$17,600
Services				
Physician care (PCP and Specialist)	PCP - $10 copay Specialist - $40 copay	PCP - $20 copay Specialist - $40 copay	PCP - $20 copay Specialist - $40 copay	PCP - $20 copay Specialist - $40 copay
Telehealth (Blue CareOnDemand)	$0 copay (up to 4 visits) $15 copay (after 4th visit)	$0 copay (up to 4 visits) $15 copay (after 4th visit)	$0 copay (up to 4 visits) $15 copay (after 4th visit)	$0 copay (up to 4 visits) $15 copay (after 4th visit)

**Benefits are the same for Silver 2 + Vision.*

Note: There are no out-of-network benefits except for urgent or emergent services.

Regional HMO – Bronze Plans

Plan	Bronze 1	Bronze 2
Deductibles		
Individual	$7,900	$9,200
Family	$15,800	$18,400
Coinsurances		
	45%	0%
Out-of-Pocket Maximum		
Individual (INN)	$8,850	$9,200
Family (INN)	$17,700	$18,400
Services		
Physician care (PCP and Specialist)	PCP - $48 copay Specialist - $65 copay	0% coinsurance
Telehealth (Blue CareOnDemand)	$0 copay (up to 4 visits) $20 copay (after 4th visit)	0% coinsurance

Note: There are no out-of-network benefits except for urgent or emergent services.

BlueExtend℠ PPO

- BlueExtend PPO will be a new plan available to members in 2025.
- The plan will have in and out-of-network benefits.
  - Using an in-network provider is preferred as there will be lower cost shares for the member.
- Plan prefix is ***BXZ***.

BlueExtend℠ PPO – Gold Plans

Plan	HD Gold 1	HD Gold 2
Deductibles		
Individual	$3,400	$3,850
Family	$6,800	$7,700
Out-of-Pocket Maximum		
Individual (INN)	$3,400	$3,850
Family (INN)	$6,800	$7,700
Services		
Physician care (PCP and Specialist)	0% Coinsurance	0% Coinsurance
Telehealth (Blue CareOnDemand)	0% Coinsurance	0% Coinsurance

Note: For out-of-network services, the member is responsible for 75% of the service cost with no out-of-pocket maximum.

BlueExtend℠ PPO – Silver Plans

Plan	CSR 3 Not HSA Qualified	CSR 2 Not HSA Qualified	CSR 1 HSA Qualified	HD Silver 1 HSA Qualified
Deductibles				
Individual	$575	$1,600	$4,300	$4,950
Family	$1,150	$3,200	$8,600	$9,900
Out-of-Pocket Maximum				
Individual (INN)	$575	$1,600	$4,300	$4,950
Family (INN)	$1,150	$3,200	$8,600	$9,900
Services				
Physician care (PCP and Specialist)	0% Coinsurance	0% Coinsurance	0% Coinsurance	0% Coinsurance
Telehealth (Blue CareOnDemand)	0% Coinsurance	0% Coinsurance	0% Coinsurance	0% Coinsurance

Note: For out-of-network services, the member is responsible for 75% of the service cost with no out-of-pocket maximum.

BlueExtend℠ PPO – Silver Plans

Plan	CSR 3 Not HSA Qualified	CSR 2 Not HSA Qualified	CSR 1 HSA Qualified	HD Silver 2 HSA Qualified
Deductibles				
Individual	$700	$1,750	$4,550	$5,550
Family	$1,400	$3,500	$9,100	$11,100
Out-of-Pocket Maximum				
Individual (INN)	$700	$1,750	$4,550	$5,550
Family (INN)	$1,400	$3,500	$9,100	$11,100
Services				
Physician care (PCP and Specialist)	0% Coinsurance	0% Coinsurance	0% Coinsurance	0% Coinsurance
Telehealth (Blue CareOnDemand)	0% Coinsurance	0% Coinsurance	0% Coinsurance	0% Coinsurance

Note: For out-of-network services, the member is responsible for 75% of the service cost with no out-of-pocket maximum.

BlueExtend℠ PPO – Bronze Plans

Plan	HD Bronze 1 HSA Qualified	HD Bronze 2 HSA Qualified
Deductibles		
Individual	$6,600	$8,000
Family	$13,200	$16,000
Out-of-Pocket Maximum		
Individual (INN)	$6,600	$8,000
Family (INN)	$13,200	$16,000
Services		
Physician care (PCP and Specialist)	0% Coinsurance	0% Coinsurance
Telehealth (Blue CareOnDemand)	0% Coinsurance	0% Coinsurance

Note: For out-of-network services, the member is responsible for 75% of the service cost with no out-of-pocket maximum.

BlueExtend℠ PPO – Standard Plans

Plan	Standard Gold	Standard Silver	Standard Bronze
Deductibles			
Individual	$1,500	$5,000	$7,500
Family	$3,000	$10,000	$15,000
Coinsurances			
	25%	40%	50%
Out-of-Pocket Maximum			
Individual (INN)	$7,800	$8,000	$9,200
Family (INN)	$15,600	$16,000	$18,400
Services			
Physician care (PCP and Specialist)	PCP - $30 copay Specialist - $60 copay	PCP - $40 copay Specialist - $80 copay	PCP - $50 copay Specialist - $100 copay
Telehealth (Blue CareOnDemand)	$30 copay	$40 copay	$50 copay

Note: For out-of-network services, the member is responsible for 75% of the service cost with no out-of-pocket maximum.

BlueExtend℠ PPO – Standard Plans with CSR

Plan	CSR 3	CSR 2	CSR 1	Standard
Deductibles				
Individual	$0	$500	$3,000	$5,000
Family	$0	$1,000	$6,000	$10,000
Coinsurances				
	25%	30%	40%	40%
Out-of-Pocket Maximum				
Individual (INN)	$2,000	$3,000	$6,400	$8,000
Family (INN)	$4,000	$6,000	$12,800	$16,000
Services				
Physician care (PCP and Specialist)	PCP - $0 copay Specialist - $10 copay	PCP - $20 copay Specialist - $40 copay	PCP - $40 copay Specialist - $80 copay	PCP - $40 copay Specialist - $80 copay
Telehealth (Blue CareOnDemand)	$0 copay	$20 copay	$40 copay	$40 copay

Note: For out-of-network services, the member is responsible for 75% of the service cost with no out-of-pocket maximum.

BlueExtend℠ (Private Marketplace)

- The current BlueExtend private marketplace plans will still be available to members in 2025.
- The plan will have in and out-of-network benefits.
  - Members must see providers in the BlueEssentials network while in South Carolina.
  - When traveling outside of South Carolina, they can see providers who participate in the BlueCard Program.
- Plan prefix is ***XBE***.

BlueExtend℠ (Private Marketplace) – Gold Plans

Plan	Gold 1	HD Gold 2
Deductibles		
Individual	$1,800	$3,500
Family	$3,600	$7,000
Coinsurances		
	25%	0%
Out-of-Pocket Maximum		
Individual (INN)	$4,500	$3,500
Family (INN)	$9,000	$7,000
Services		
Physician care (PCP and Specialist)	PCP - $10 copay Specialist - $50 copay	0% coinsurance
Telehealth (Blue CareOnDemand)	$10 copay	0% coinsurance

BlueExtend℠ (Private Marketplace) – Silver Plans

Plan	Silver 1	HD Silver 2
Deductibles		
Individual	$4,400	$5,400
Family	$8,800	$10,800
Coinsurances		
	35%	0%
Out-of-Pocket Maximum		
Individual (INN)	$8,800	$5,400
Family (INN)	$17,600	$10,800
Services		
Physician care (PCP and Specialist)	PCP - $30 copay Specialist - $65 copay	0% coinsurance
Telehealth (Blue CareOnDemand)	$20 copay	0% coinsurance

BlueExtend℠ (Private Marketplace) – Bronze Plans

Plan	Bronze 1	HD Bronze 2
Deductibles		
Individual	$4,500	$7,050
Family	$9,000	$14,100
Coinsurances		
	50%	0%
Out-of-Pocket Maximum		
Individual (INN)	$8,900	$7,050
Family (INN)	$17,800	$14,100
Services		
Physician care (PCP and Specialist)	PCP - $60 copay Specialist - $90 copay	0% coinsurance
Telehealth (Blue CareOnDemand)	$20 copay	0% coinsurance

Blue Direction Point of Service (POS)

- Blue Direction will be a new plan available to members in 2025.
  - Members must live in Hampton, Jasper and Sumter counties.
- The plan does not have out-of-network benefits except for urgent or emergent services.
- Members are assigned a primary care provider.
  - Referrals are required for specialists and other providers.
    - Referrals are not required for emergent services.

Blue Direction – Plans with CSR

Plan	CSR 3	CSR 2	CSR 1	Silver 1*
Deductibles				
Individual	$0	$400	$4,900	$6,500
Family	$0	$800	$9,800	$13,500
Coinsurances				
	20%	40%	50%	50%
Out-of-Pocket Maximum				
Individual (INN)	$1,500	$3,050	$7,350	$9,200
Family (INN)	$3,000	$6,100	$14,700	$18,400
Services				
Physician care (PCP and Specialist)	PCP - $0 copay Specialist - $8 copay	PCP - $12 copay Specialist - $35 copay	PCP - $25 copay Specialist - $60 copay	PCP - $25 copay Specialist - $60 copay
Telehealth (Blue CareOnDemand)	$0 copay	$12 copay	$20 copay	$20 copay

**Benefits are the same for Silver 1 + Vision.*

Note: There are no out-of-network benefits except for urgent or emergent services.

Blue Direction – Plans with CSR (Continued)

Plan	CSR 3	CSR 2	CSR 1	Silver 2
Deductibles				
Individual	$0	$500	$3,000	$5,000
Family	$0	$1,000	$6,000	$10,000
Coinsurances				
	25%	30%	40%	40%
Out-of-Pocket Maximum				
Individual (INN)	$2,000	$3,000	$8,000	$8,000
Family (INN)	$4,000	$6,000	$16,000	$16,000
Services				
Physician care (PCP and Specialist)	PCP - $0 copay Specialist - $10 copay	PCP - $20 copay Specialist - $40 copay	PCP - $40 copay Specialist - $80 copay	PCP - $40 copay Specialist - $80 copay
Telehealth (Blue CareOnDemand)	$0 copay	$20 copay	$40 copay	$40 copay

Note: There are no out-of-network benefits except for urgent or emergent services.

Blue Direction – Standard Plans

Plan	Standard Gold	Standard Silver
Deductibles		
Individual	$1,500	$5,000
Family	$3,000	$10,000
Coinsurances		
	25%	40%
Out-of-Pocket Maximum		
Individual (INN)	$7,800	$8,000
Family (INN)	$15,600	$16,000
Services		
Physician care (PCP and Specialist)	PCP - $30 copay Specialist - $60 copay	PCP - $40 copay Specialist - $80 copay
Telehealth (Blue CareOnDemand)	$30 copay	$40 copay

Note: There are no out-of-network benefits except for urgent or emergent services.

BlueEssentials℠

- BlueEssentials will continue to be available to members in 2025.
- These plans do not have out-of-network benefits except for urgent or emergent services.
- Plan prefixes are ***ZCF*** and ***ZCU***.

BlueEssentials℠ – Gold Plans

Plan	Gold 1	Gold 5
Deductibles		
Individual	$2,500	$250
Family	$5,000	$500
Coinsurances		
	25%	50%
Out-of-Pocket Maximum		
Individual (INN)	$4,900	$9,200
Family (INN)	$9,800	$18,400
Services		
Physician care (PCP and Specialist)	PCP - $20 copay Specialist - $60 copay	PCP - $20 copay Specialist - $40 copay
Telehealth (Blue CareOnDemand)	$10 copay	$20 copay

Note: There are no out-of-network benefits except for urgent or emergent services.

BlueEssentials℠ – Plans with CSR

Plan	CSR 3	CSR 2	CSR 1	Silver 14*
Deductibles				
Individual	$0	$1,100	$4,200	$6,900
Family	$0	$2,200	$8,400	$13,800
Coinsurances				
	15%	15%	20%	50%
Out-of-Pocket Maximum				
Individual (INN)	$1,500	$2,800	$7,350	$8,700
Family (INN)	$3,000	$5,600	$14,700	$17,400
Services				
Physician care (PCP and Specialist)	PCP - $10 copay Specialist - $45 copay	PCP - $10 copay Specialist - $50 copay	PCP - $15 copay Specialist - $50 copay	PCP - $25 copay Specialist - $50 copay
Telehealth (Blue CareOnDemand)	$5 copay	$5 copay	$15 copay	$20 copay

**Benefits are the same for Silver 14 + Vision.*

Note: There are no out-of-network benefits except for urgent or emergent services.

BlueEssentials℠ – Plans with CSR

Plan	CSR 3	CSR 2	CSR 1	Silver 39
Deductibles				
Individual	$0	$0	$0	$0
Family	$0	$0	$0	$0
Coinsurances				
	20%	20%	20%	20%
Out-of-Pocket Maximum				
Individual (INN)	$2,850	$2,850	$5,600	$8,100
Family (INN)	$5,700	$5,700	$11,200	$16,200
Services				
Physician care (PCP and Specialist)	PCP - $5 copay Specialist - $10 copay	PCP - $15 copay Specialist - $45 copay	PCP - $40 copay Specialist - $80 copay	PCP - $40 copay Specialist - $80 copay
Telehealth (Blue CareOnDemand)	$4 copay	$15 copay	$40 copay	$40 copay

Note: There are no out-of-network benefits except for urgent or emergent services.

BlueEssentials℠ – Silver Plans

Plan	Silver 15	Silver 16	HD Silver 20	Silver 21	Silver 28
Deductibles					
Individual	$2,300	$3,900	$5,100	$7,000	$6,900
Family	$4,600	$7,800	$10,200	$14,000	$13,800
Coinsurances					
	50%	50%	0%	25%	50%
Out-of-Pocket Maximum					
Individual (INN)	$8,950	$8,400	$5,100	$8,500	$8,400
Family (INN)	$17,900	$16,800	$10,200	$17,000	$16,800
Services					
Physician care (PCP and Specialist)	PCP - $30 copay Specialist - $60 copay	PCP - $25 copay Specialist - $50 copay	0% coinsurance	PCP - $25 copay Specialist - $60 copay	PCP - $30 copay Specialist - $60 copay
Telehealth (Blue CareOnDemand)	$20 copay	$15 copay	0% coinsurance	$20 copay	$20 copay

Note: There are no out-of-network benefits except for urgent or emergent services.

BlueEssentials℠ – Bronze Plans

Plan	Bronze 4	Bronze 6
Deductibles		
Individual	$7,200	$0
Family	$14,400	$0
Coinsurances		
	50%	0%
Out-of-Pocket Maximum		
Individual (INN)	$9,200	$9,200
Family (INN)	$18,400	$18,400
Services		
Physician care (PCP and Specialist)	PCP - $43 copay Specialist - $65 copay	PCP - $45 copay Specialist - $100 copay
Telehealth (Blue CareOnDemand)	$20 copay	$25 copay

Note: There are no out-of-network benefits except for urgent or emergent services.

Blue VirtuConnect – Standard Plans

Plan	Gold 1	Silver 1	Bronze 1
Deductibles			
Individual	$1,500	$5,000	$7,500
Family	$3,000	$10,000	$15,000
Coinsurances			
	25%	40%	50%
Out-of-Pocket Maximum			
Individual (INN)	$7,800	$8,000	$9,200
Family (INN)	$15,600	$16,000	$18,400
Services			
Physician care (PCP and Specialist)	PCP - $30 copay Specialist - $60 copay	PCP - $40 copay Specialist - $80 copay	PCP - $50 copay Specialist - $100 copay
Telehealth (Blue CareOnDemand)	$0 copay (up to 12 visits) $10 copay (after 12th visit)	$0 copay (up to 8 visits) $10 copay (after 8th visit)	$0 copay (up to 4 visits) $10 copay (after 4th visit)

Note: There are no out-of-network or out-of-state benefits except for urgent or emergent services.

Blue VirtuConnect – Plans with CSR

Plan	CSR 3	CSR 2	CSR 1	Silver 1
Deductibles				
Individual	$0	$500	$3,000	$5,000
Family	$0	$1,000	$6,000	$10,000
Coinsurances				
	25%	30%	40%	40%
Out-of-Pocket Maximum				
Individual (INN)	$2,000	$3,000	$6,400	$8,000
Family (INN)	$4,000	$6,000	$12,800	$16,000
Services				
Physician care (PCP and Specialist)	PCP - $0 copay Specialist - $10 copay	PCP - $20 copay Specialist - $40 copay	PCP - $40 copay Specialist - $80 copay	PCP - $40 copay Specialist - $80 copay
Telehealth (Blue CareOnDemand)	$0 copay	$0 copay (up to 8 visits) $10 copay (after 8th visit)	$0 copay (up to 8 visits) $10 copay (after 8th visit)	$0 copay (up to 8 visits) $10 copay (after 8th visit)

Note: There are no out-of-network or out-of-state benefits except for urgent or emergent services.

Benefit Reminders

Network Participating Providers

- Network participating providers should always use or refer members to other network participating providers, when necessary.
  - This includes laboratories.
- By using other network participating providers:
  - Members will have lower cost-shares.
  - Members will not be subject to balance billing.

Appointment Availability

- **Primary Care Physicians**
  - New and established patient visits
    - Scheduled within 15 days
  - Urgent appointments
    - Scheduled within 48 hours
- **Specialists**
  - New and established patient visits
    - Scheduled within 30 days
  - Urgent appointments
    - Scheduled within 48 hours

Available Resources

Getting Benefits Through the Voice Response Unit

- **Call one of the following numbers to use the voice response unit:**
  - Columbia or Lexington: 803-788-8562
  - Other locations in South Carolina: 800-868-2510
  - Outside of South Carolina: 800-334-2583
  - BlueChoice®: 800-868-2528
  - State Health Plan: 800-444-4311
  - Federal Employee Program: 888-930-2345
  - BlueCard Eligibility: 800-676-BLUE (2583)
- **Be sure to have the following information ready:**
  - Your Tax ID or NPI
  - Patient identification number (including the prefix)
  - Patient's date of birth

Getting Benefits Through the Voice Response Unit (Continued)

- **You will hear the following information:**
  - Type of coverage
  - Effective date
  - Benefit period
  - Group number
- **Available benefit options:**
  - Hospital
    - Inpatient and outpatient
  - Behavioral health
  - Rehabilitation
  - Home health
  - And much more!

Independent licensees of the Blue Cross Blue Shield Association.

Voice Response Unit (VRU)

Manual

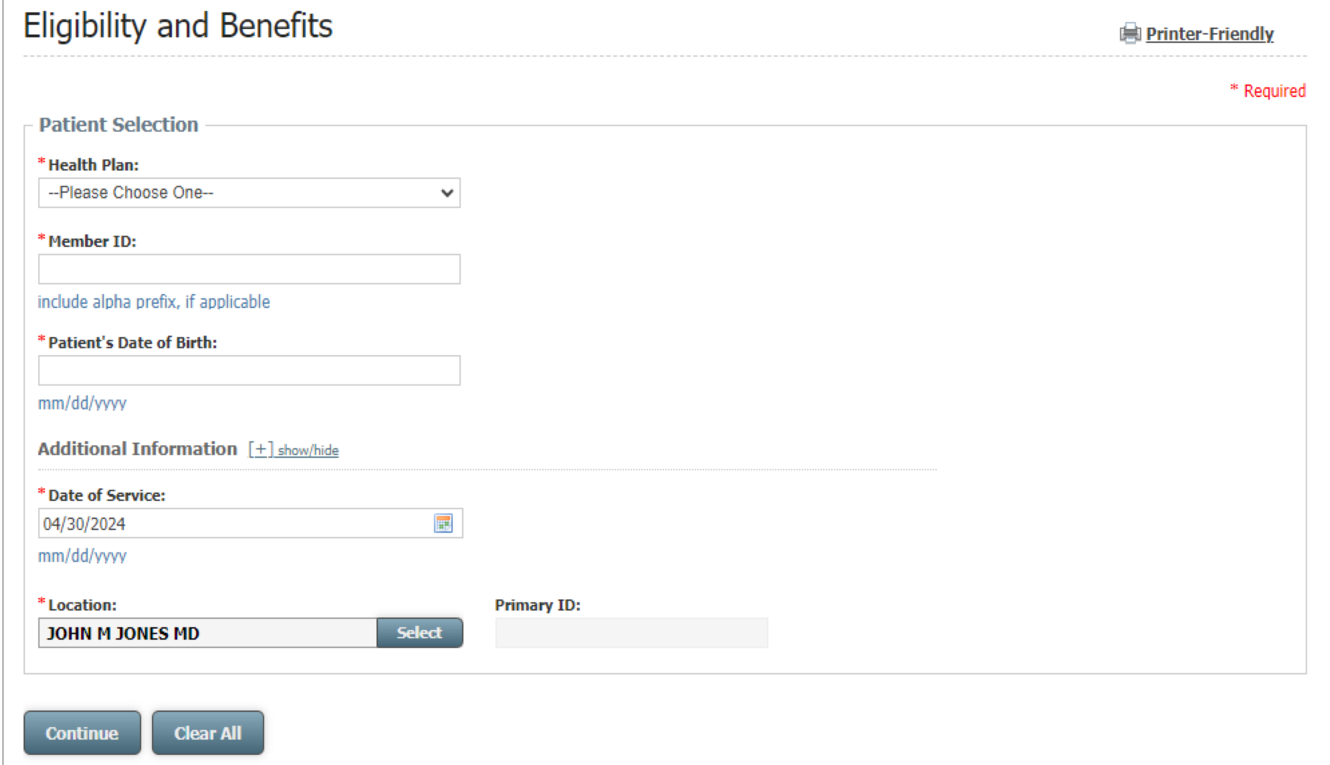
Published by Provider Relations and Education
Your Partners in Outstanding Quality, Satisfaction and Service

Revised: June 2023

Getting Benefits in My Insurance Manager

Step 1

Step 2



Getting Benefits in My Insurance Manager – General Benefits

Step 3 (*When pulling general benefits.*)

Eligibility Request

* Required

Choose Eligibility View

Please note: Unless otherwise required by state law, this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductibles, may change as additional claims are processed.

Deductible and coinsurance amounts are calculated from the member's health or dental plan allowances for the procedures performed.

- (●) General Eligibility and Benefits
- ( ) Eligibility and Benefits by Service Type
- ( ) Eligibility and Benefits by Procedure Code

Submit

Getting Benefits in My Insurance Manager – General Benefits

Date of Service

04/30/2024

Insurance

Plan Name:
BLUECROSS AND BLUESHIELD OF SC

Plan ID:
38520

Member ID:
ZCZ065922516805

Group Number:
036011101

Member's Name:
MICHAEL TESTING

Patient

Patient's Name:
MICHAEL TESTING

Relationship to Member:
SUBSCRIBER

Gender:
MALE

Date of Birth:
10/01/1958

Address:
P O BOX 24015
COLUMBIA, SC 292244015

Change Patient

Printer-Friendly

Response Details

Eligibility Response [+]

Policy Effective Date:
06/01/2002

Benefit Period:
04/01/2024 - 04/01/2025

View Benefit Booklet for this patient

IN AND OUT OF NETWORK

Global Benefits

This patient has active coverage.

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLES MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

INDIVIDUAL DEDUCTIBLE: **$250.00** PER SERVICE YEAR - **$250.00** REMAINING

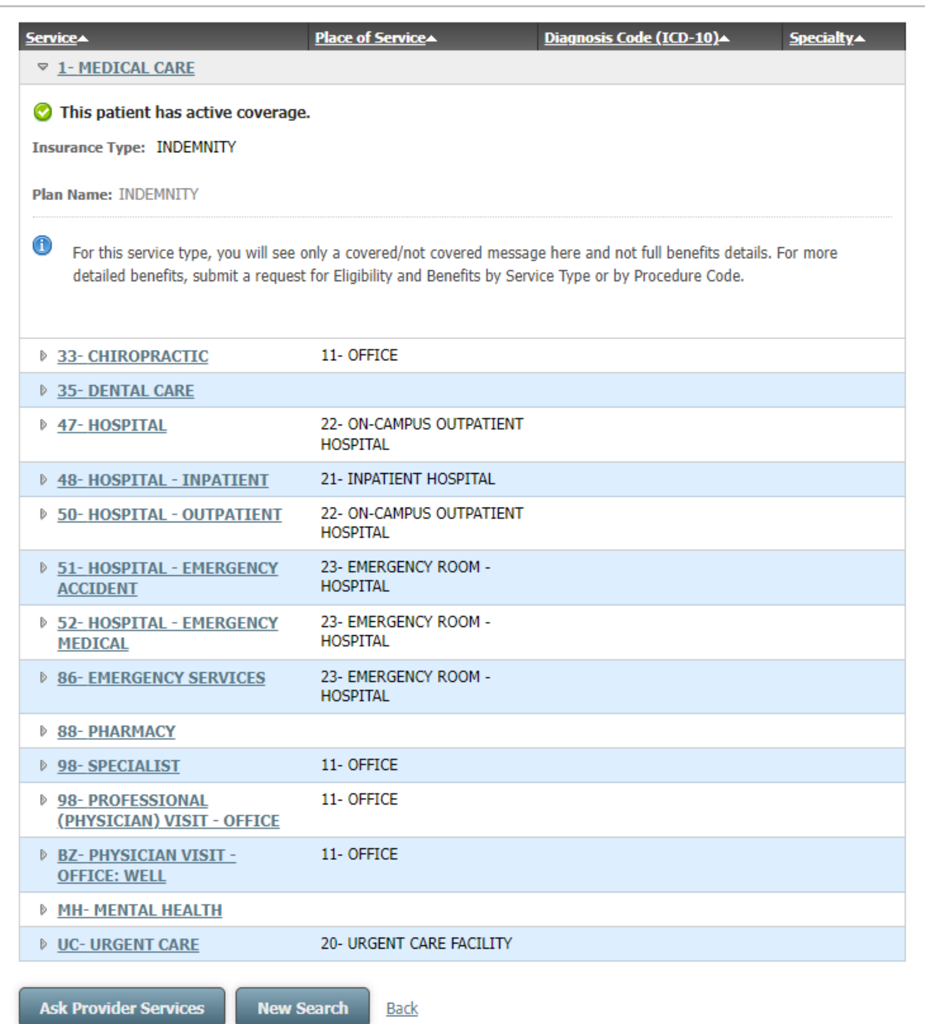
INDIVIDUAL OUT OF POCKET: **$750.00** PER SERVICE YEAR - **$750.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

FAMILY DEDUCTIBLE: **$500.00** PER SERVICE YEAR - **$500.00** REMAINING

FAMILY OUT OF POCKET: **$1,500.00** PER SERVICE YEAR - **$1,500.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE



Service	Place of Service	Diagnosis Code (ICD-10)	Specialty
1- MEDICAL CARE			

This patient has active coverage.

Insurance Type: INDEMNITY

Plan Name: INDEMNITY

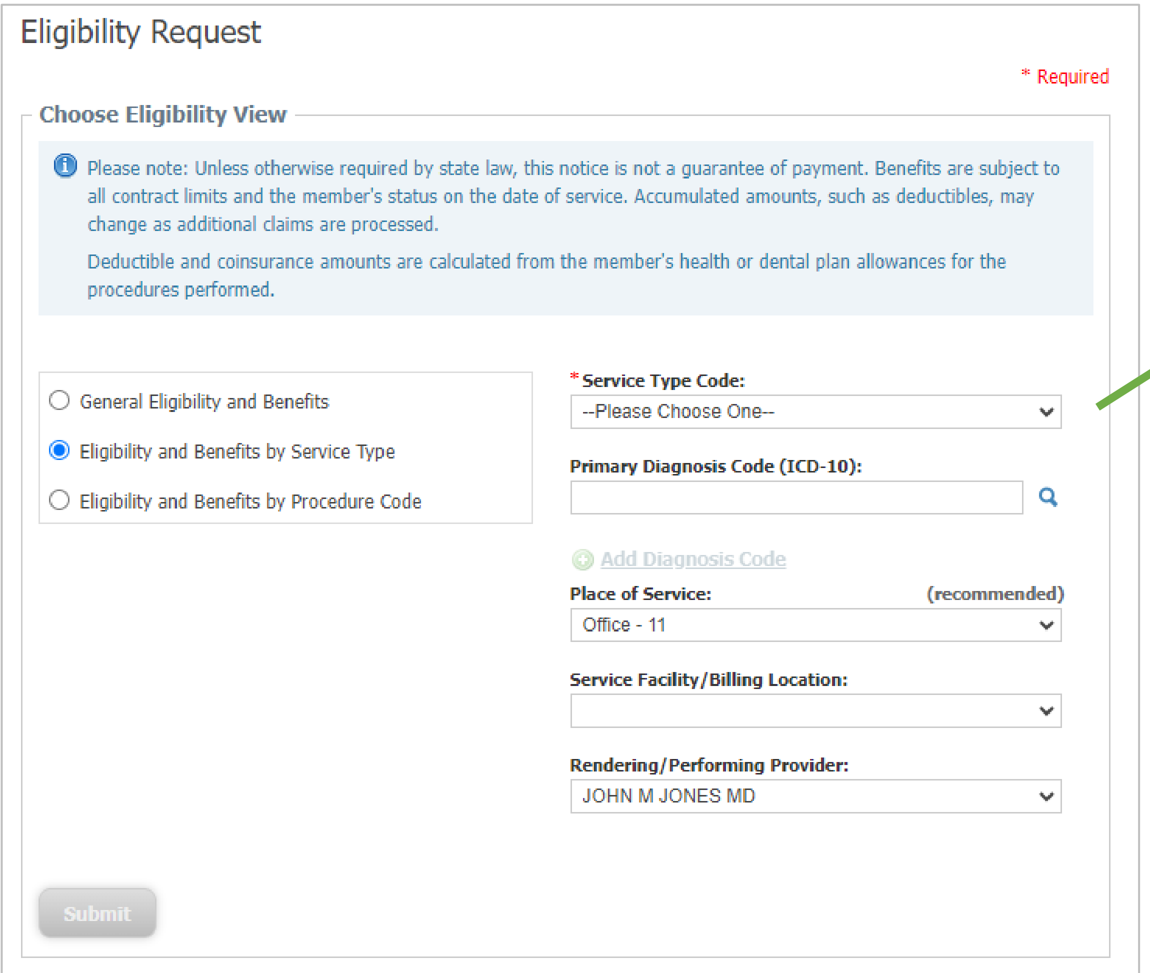
For this service type, you will see only a covered/not covered message here and not full benefits details. For more detailed benefits, submit a request for Eligibility and Benefits by Service Type or by Procedure Code.

Service	Place of Service	Diagnosis Code (ICD-10)	Specialty
33- CHIROPRACTIC	11- OFFICE		
35- DENTAL CARE			
47- HOSPITAL	22- ON-CAMPUS OUTPATIENT HOSPITAL		
48- HOSPITAL - INPATIENT	21- INPATIENT HOSPITAL		
50- HOSPITAL - OUTPATIENT	22- ON-CAMPUS OUTPATIENT HOSPITAL		
51- HOSPITAL - EMERGENCY ACCIDENT	23- EMERGENCY ROOM - HOSPITAL		
52- HOSPITAL - EMERGENCY MEDICAL	23- EMERGENCY ROOM - HOSPITAL		
86- EMERGENCY SERVICES	23- EMERGENCY ROOM - HOSPITAL		
88- PHARMACY			
98- SPECIALIST	11- OFFICE		
98- PROFESSIONAL (PHYSICIAN) VISIT - OFFICE	11- OFFICE		
BZ- PHYSICIAN VISIT - OFFICE: WELL	11- OFFICE		
MH- MENTAL HEALTH			
UC- URGENT CARE	20- URGENT CARE FACILITY		

Ask Provider Services | New Search | Back

Getting Benefits in My Insurance Manager – Service Type

Step 3 (*When pulling benefits by service type.)*


Eligibility Request

* Required

Choose Eligibility View

Please note: Unless otherwise required by state law, this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductibles, may change as additional claims are processed.

Deductible and coinsurance amounts are calculated from the member's health or dental plan allowances for the procedures performed.

- General Eligibility and Benefits
- Eligibility and Benefits by Service Type
- Eligibility and Benefits by Procedure Code

*Service Type Code: --Please Choose One--

Primary Diagnosis Code (ICD-10):

Add Diagnosis Code

Place of Service: (recommended) Office - 11

Service Facility/Billing Location:

Rendering/Performing Provider: JOHN M JONES MD

Submit

Other Service Types

ABORTION - 84
ACUPUNCTURE - 64
AIDS - 85
AIR TRANSPORTATION - 57
ALCOHOLISM - AJ
ALLERGY - GY
ALLERGY TESTING - 79
ALTERNATE METHOD DIALYSIS - 15
AMBULATORY SERVICE CENTER FACILITY - 13
ANESTHESIA - 07
ANESTHESIOLOGIST - 97
AUDIOLOGY EXAM - 71
BLOOD CHARGES - 10
BRAND NAME PRESCRIPTION DRUG - 91
BRAND NAME PRESCRIPTION DRUG - NON-FORMULARY - B3
BURN CARE - B1
Brand Name Prescription Drug - Formulary - B2
CABULANCE - 58
CANCER - 87

Getting Benefits in My Insurance Manager – Service Type

Printer-Friendly

Date of Service
04/30/2024

Insurance
Plan Name: BLUECROSS AND BLUESHIELD OF SC
Plan ID: 38520
Member ID: ZCZ065922516805
Group Number: 036011101
Member's Name: MICHAEL TESTING

Patient
Patient's Name: MICHAEL TESTING
Relationship to Member: SUBSCRIBER
Gender: MALE
Date of Birth: 10/01/1958
Address: P O BOX 24015
COLUMBIA, SC 292244015

Change Patient

Response Details

Eligibility Response [+]

Policy Effective Date: 06/01/2002

Benefit Period: 04/01/2024 - 04/01/2025

View Benefit Booklet for this patient

IN AND OUT OF NETWORK

Global Benefits

This patient has active coverage.

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLES MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

INDIVIDUAL DEDUCTIBLE: **$250.00** PER SERVICE YEAR - **$250.00** REMAINING

INDIVIDUAL OUT OF POCKET: **$750.00** PER SERVICE YEAR - **$750.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

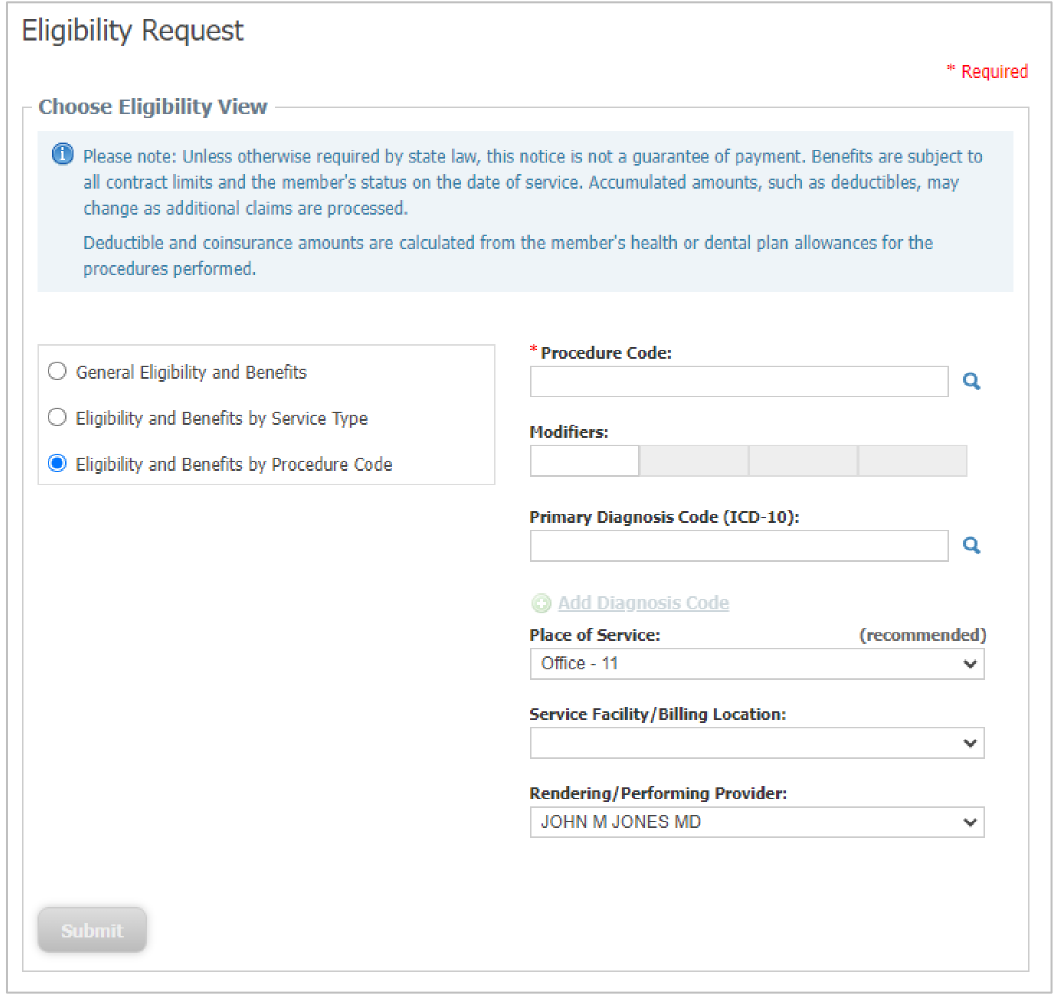
FAMILY DEDUCTIBLE: **$500.00** PER SERVICE YEAR - **$500.00** REMAINING

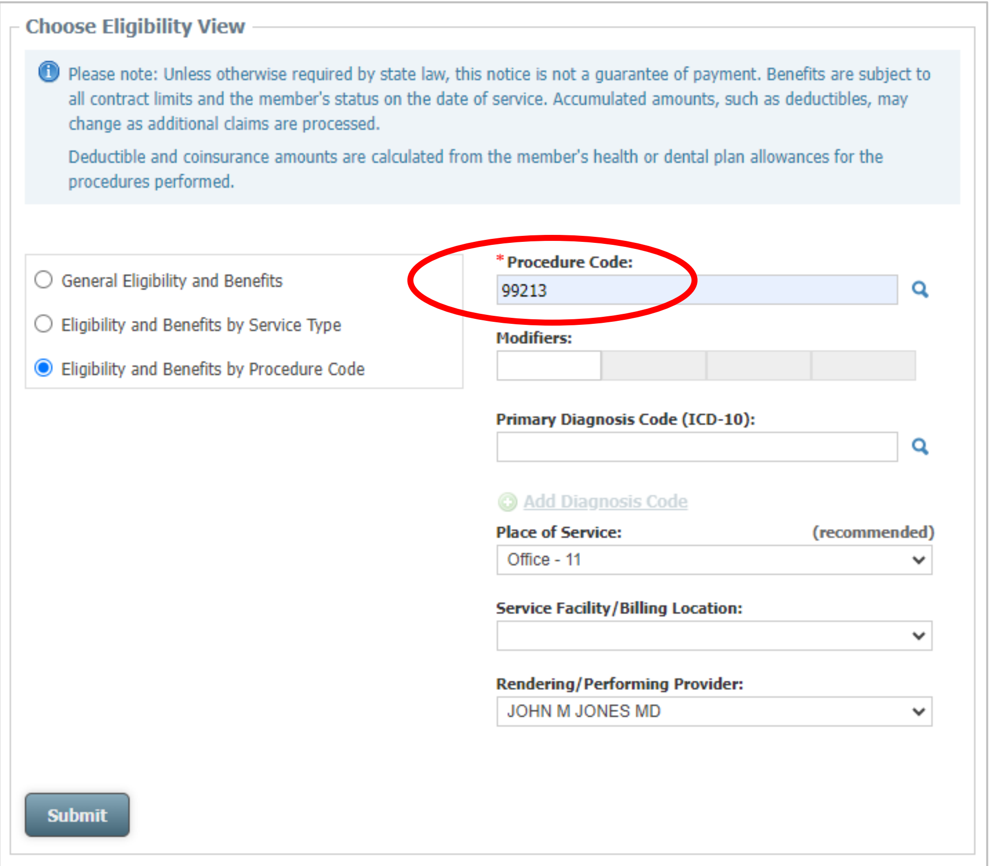
FAMILY OUT OF POCKET: **$1,500.00** PER SERVICE YEAR - **$1,500.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

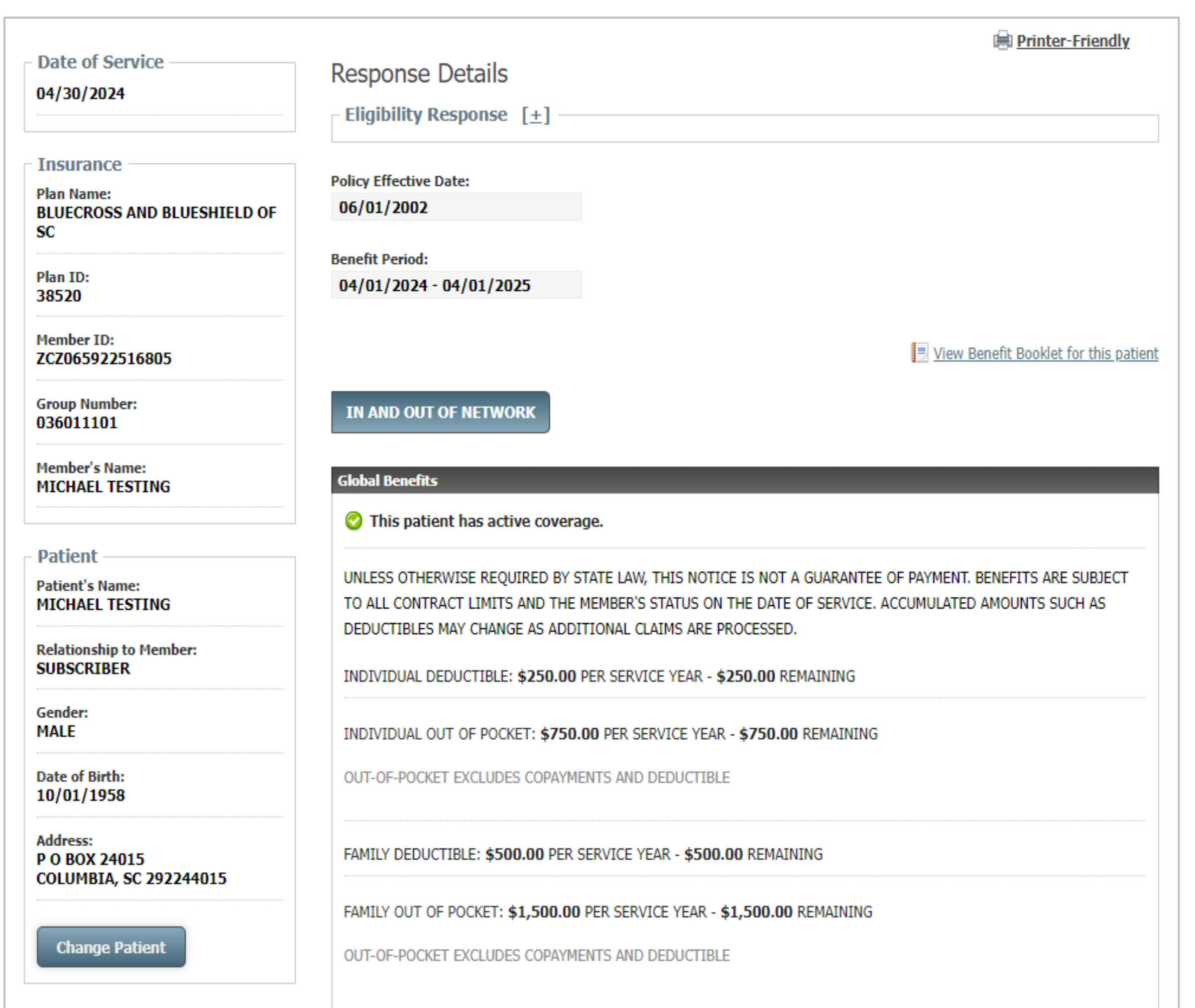
Getting Benefits in My Insurance Manager – Procedure Code

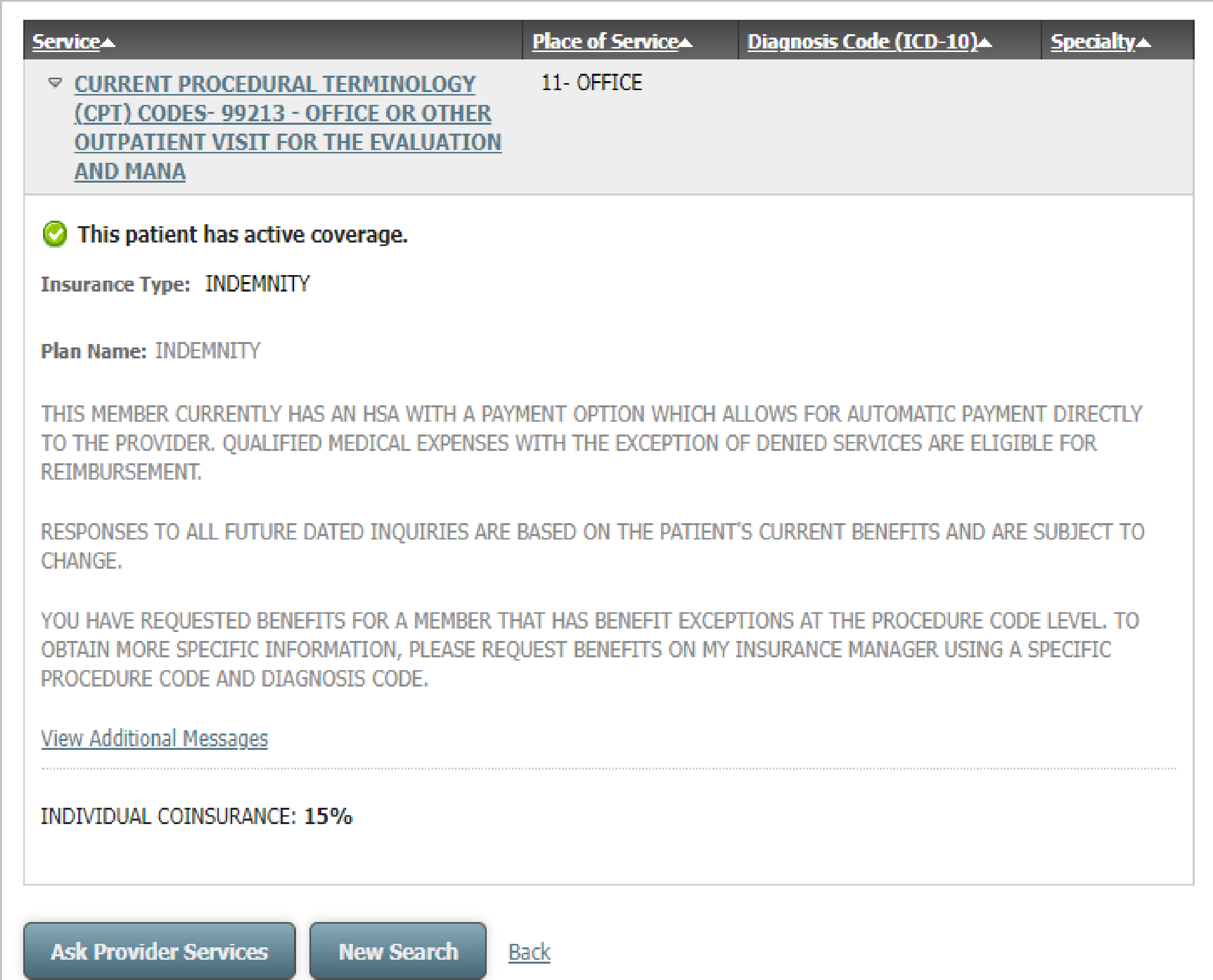
Step 3 (*When pulling benefits by procedure code.)*





Getting Benefits in My Insurance Manager – Procedure Code



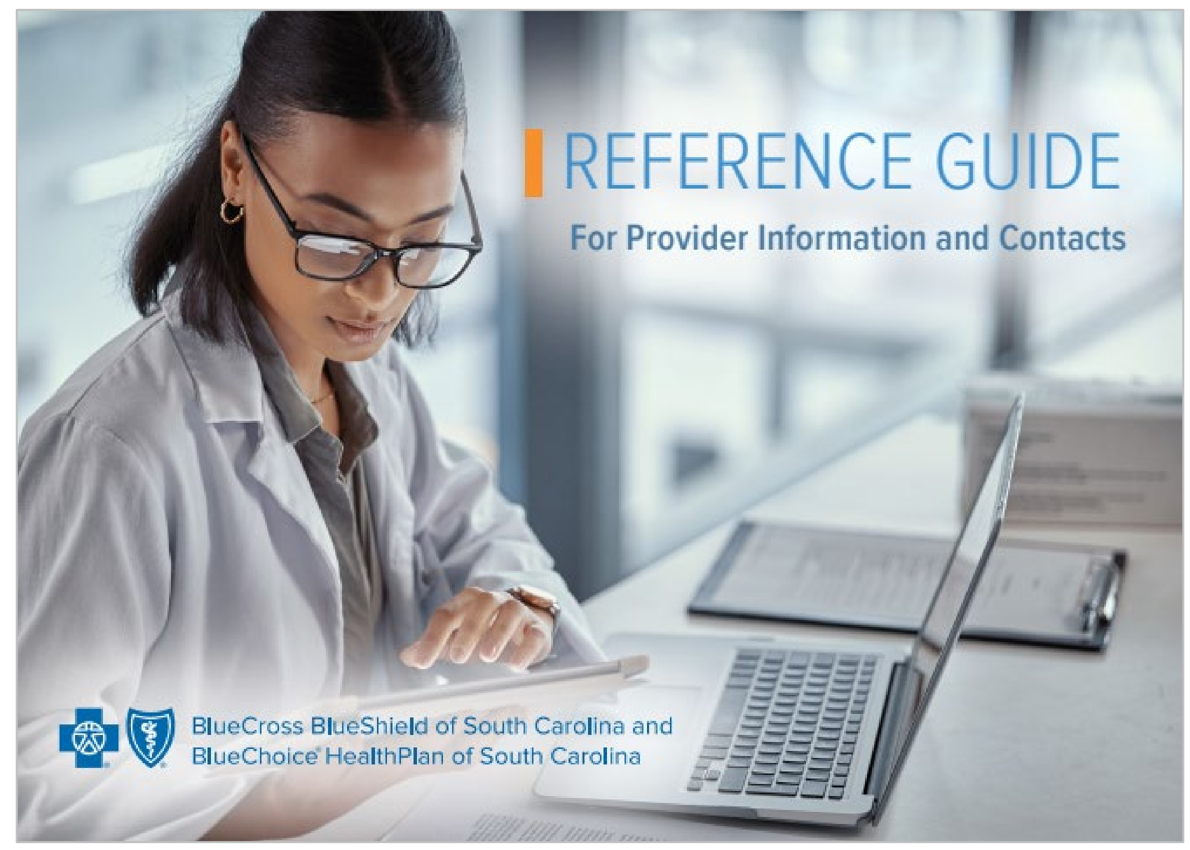


Member ID Card Guide

- Get an overview of various plans, associated networks and example of the ID card you may see.
  - Visit www.SouthCarolinaBlues.com:
    - Providers>Tools and Resources>Guides

Quick Reference Guide

- Identify the most efficient ways to get the benefit information, prior authorizations and much more.
  - Visit www.SouthCarolinaBlues.com:
    - Providers>Tools and Resources>Guides



Claims

Topics to Discuss

- ❑ Submission of Claims
- ❑ Self-serving Claim Tools
- ❑ Claim Reminders
- ❑ Helpful Tips

Submission of Claims

Ways to Submit Claims

- Claims can be submitted:
  - **Electronically (through your clearinghouse)**
    - Use the appropriate payor ID.
  - **Using My Insurance Manager**
    - Select Original Claim on the Claim Information page.
  - **By mail**
    - Use the appropriate address on the back of the member's ID card.

Note: Refer to the Claims section of our website for additional details.
Providers>Claims and Payments

Submitting Claims Electronically

Submitting claims electronically through your clearinghouse is the preferred method.

Benefits of electronic submissions include:

- Quicker turnaround time.
- Shorter reimbursement cycles.
- Ability to catch errors that may delay processing.

Medical Plan Payor IDs	
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 Plan Payor ID	
BlueCross BlueShield of South Carolina	38520

Note: Refer to the Claims section of our website for additional details.
Providers>Claims and Payments>Claims Submission

Submitting Claims through My Insurance Manager

- Submitting claims through My Insurance Manager is quick and easy.
- When you hover over Patient Care, you will see the option to enter institutional or professional claims for health services, as well as claim entry for dental services.

Submitting Claims by Mail

While electronic submission is the preferred method for submitting claims, we do allow providers to submit their claims by mail. The addresses include:

BlueCross BlueShield of South Carolina
(Columbia Service Center)
P.O. Box 100300
Columbia, SC 29202

BlueCross BlueShield of South Carolina
(Greenville Service Center)
P.O. Box 6000
Greenville, SC 29606

State Health Plan
P.O. Box 100605
Columbia, SC 29260

Federal Employee Program
P.O. Box 600601
Columbia, SC 29260

BlueChoice HealthPlan
P.O. Box 6170
Columbia, SC 29260

Healthy Blue℠
P.O. Box 100317
Columbia, SC 29202

Note: If you are unsure of which address to use, you can always refer to the back of the member's identification card.

Important Information on Submitting Corrected Claims

- Corrected claims can be submitted:
  - **Electronically (through your clearinghouse)**
    - 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.
  - **Using My Insurance Manager**
    - Select Replacement of Prior Claim on the Claim Information page.
  - **By mail**
    - Use the appropriate address on the back of the member's ID card.
    - Be sure to label the claim as a corrected claim.
- For all avenues, include all lines from the original claim, along with the correction(s) needed.

Self-serving Claim Tools

Claims Information Through the Voice Response Unit

- **Call one of the following numbers to use the voice response unit:**
  - Columbia or Lexington: 803-788-8562
  - Other locations in South Carolina: 800-868-2510
  - Outside of South Carolina: 800-334-2583
  - BlueChoice®:800-868-2528
  - State Health Plan: 800-444-4311
  - Federal Employee Program: 888-930-2345
- **Be sure to have the following information ready:**
  - Your Tax ID or NPI
  - Patient identification number (including the prefix)
  - Patient's date of birth
  - Date of service of the claim

Independent licensees of the Blue Cross Blue Shield Association.

Voice Response Unit (VRU)

Manual

Published by Provider Relations and Education

Your Partners in Outstanding Quality, Satisfaction and Service

Revised: June 2023

Claims Information Through the Voice Response Unit (Continued)

- **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.

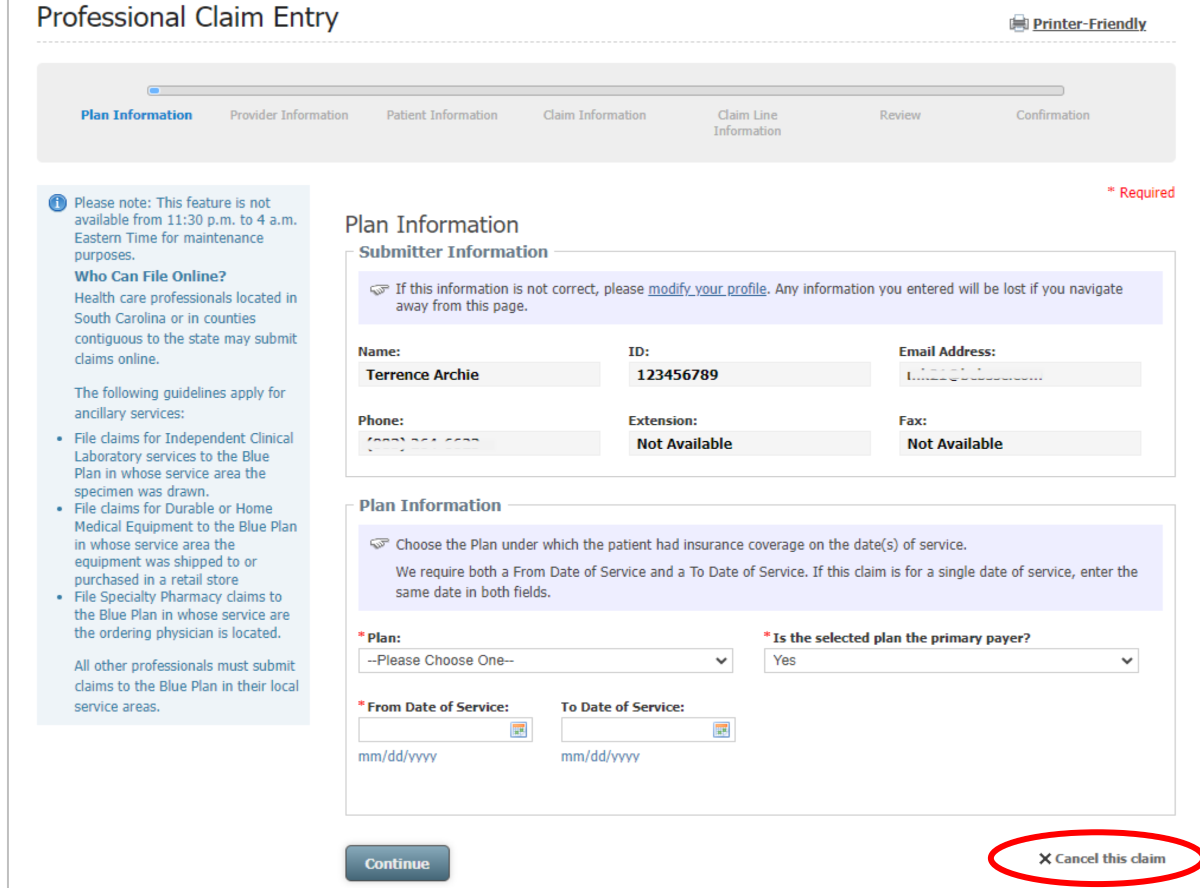
Note: Review the available My Insurance Manager guides on www.SouthCarolinaBlues.com.

My Insurance Manager: Submitting Claims

Submitting Claims Through My Insurance Manager

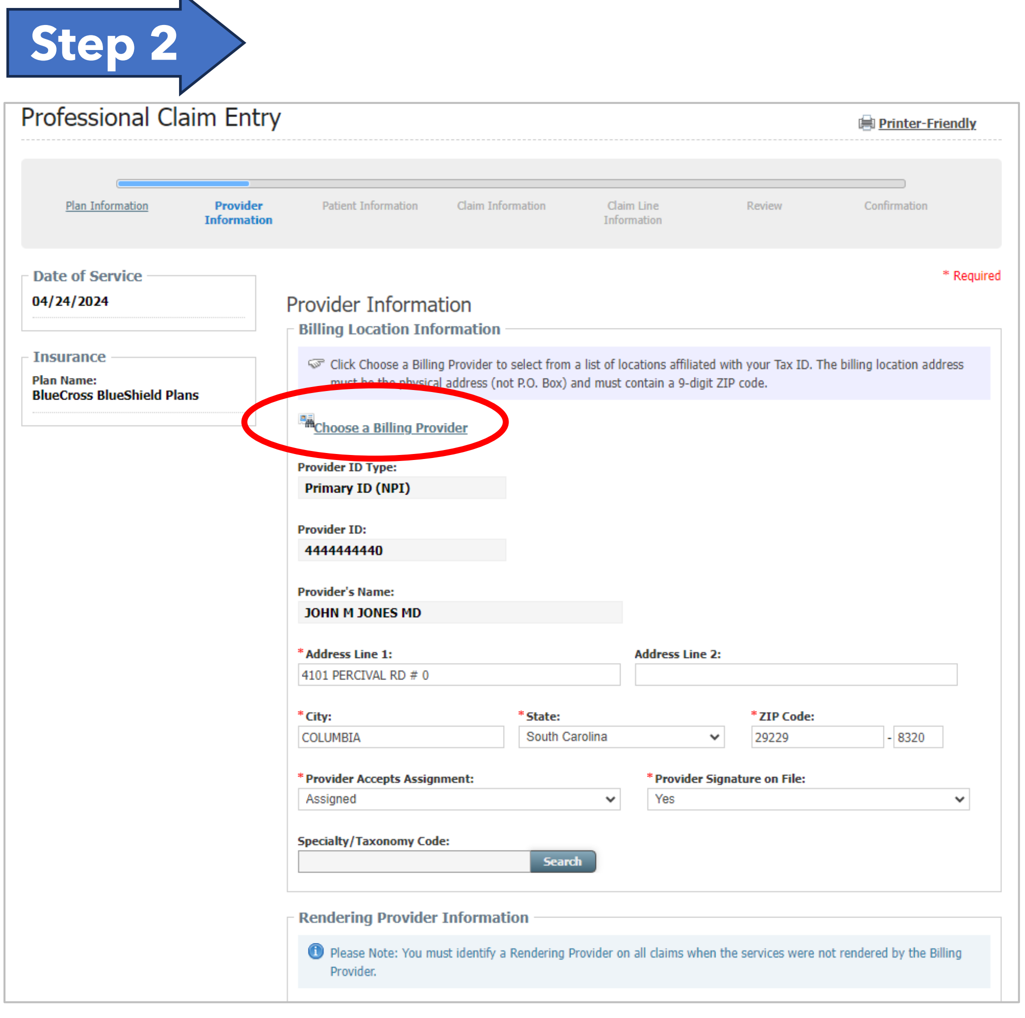
There are seven screens that you will progress through when using My Insurance Manager to submit claims.

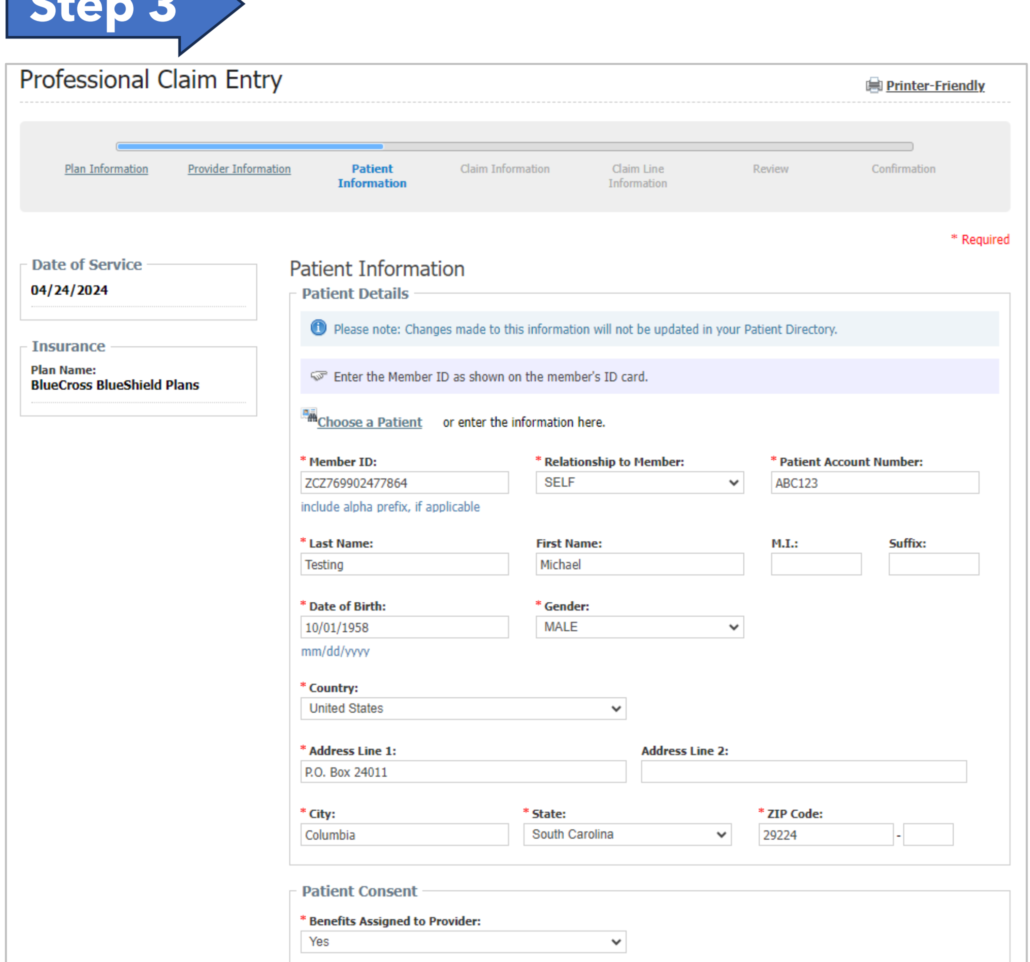
Steps to Submit Claims Through My Insurance Manager



Note: At any time, you can select "Cancel this claim" to abort the process.

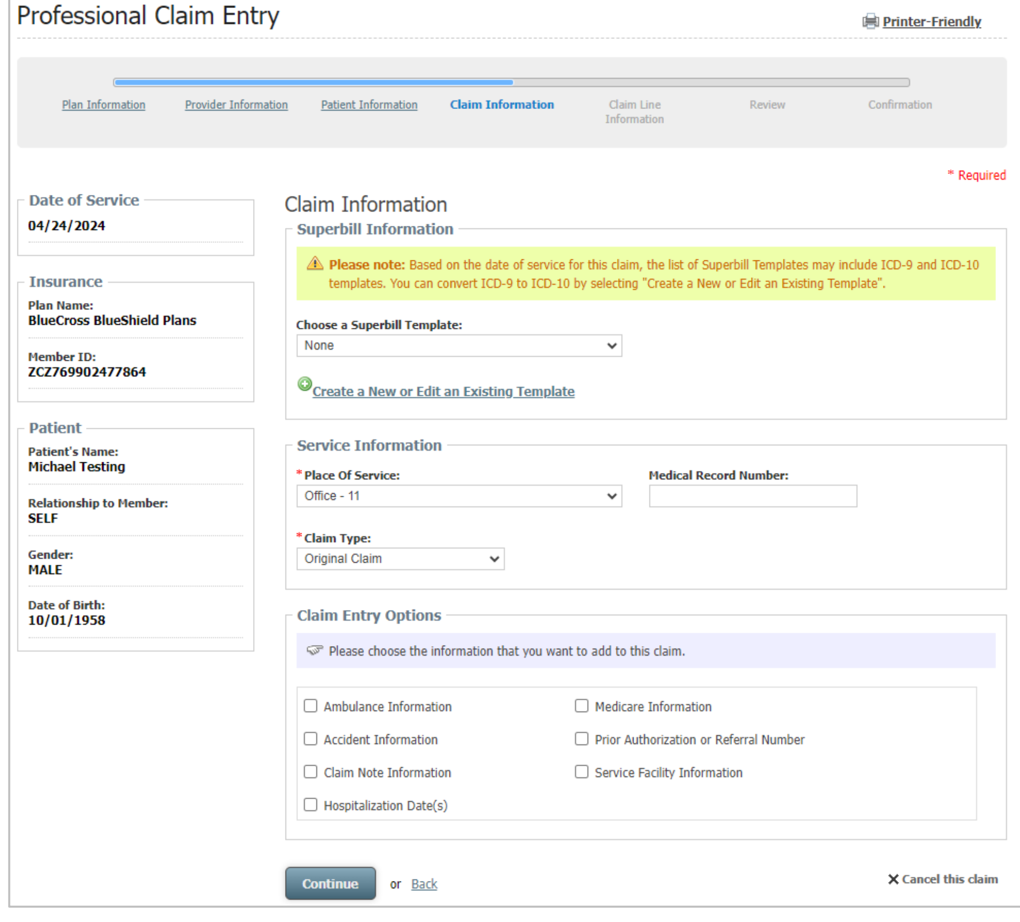
Steps to Submit Claims Through My Insurance Manager (Continued)

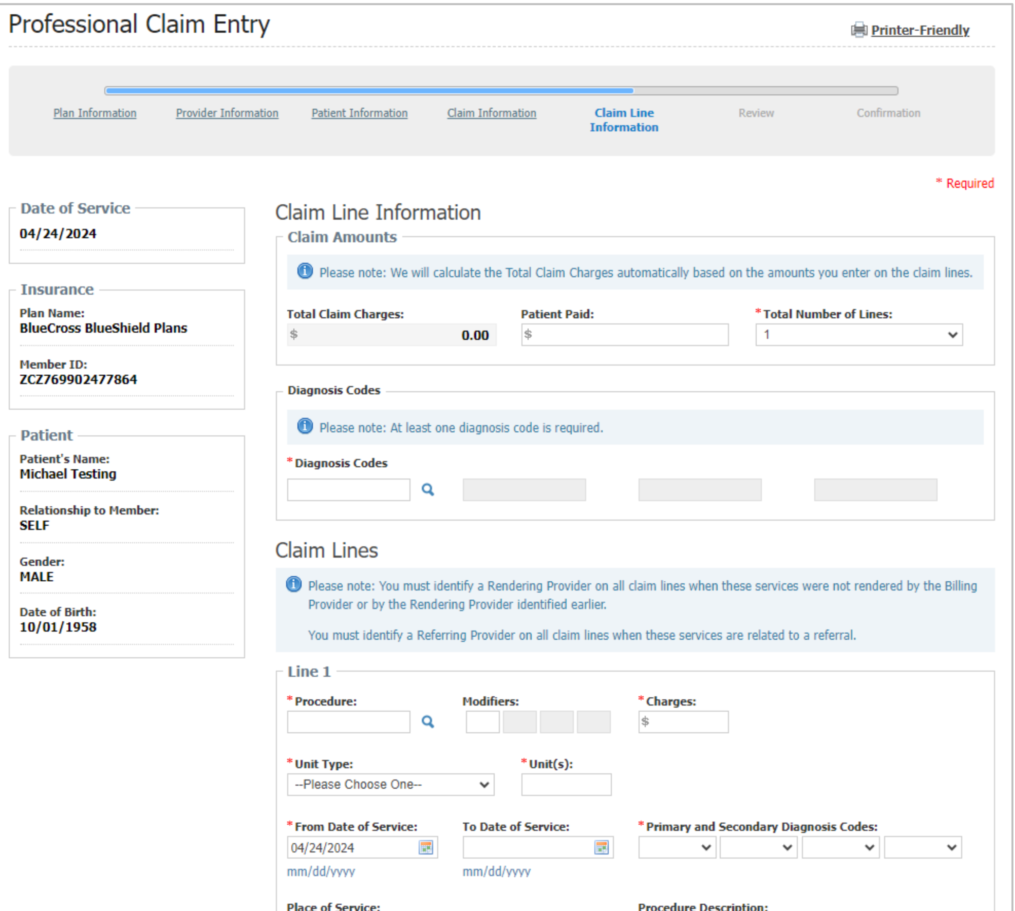




Note: You must select "Choose a Billing Provider" if more than one location is on file.

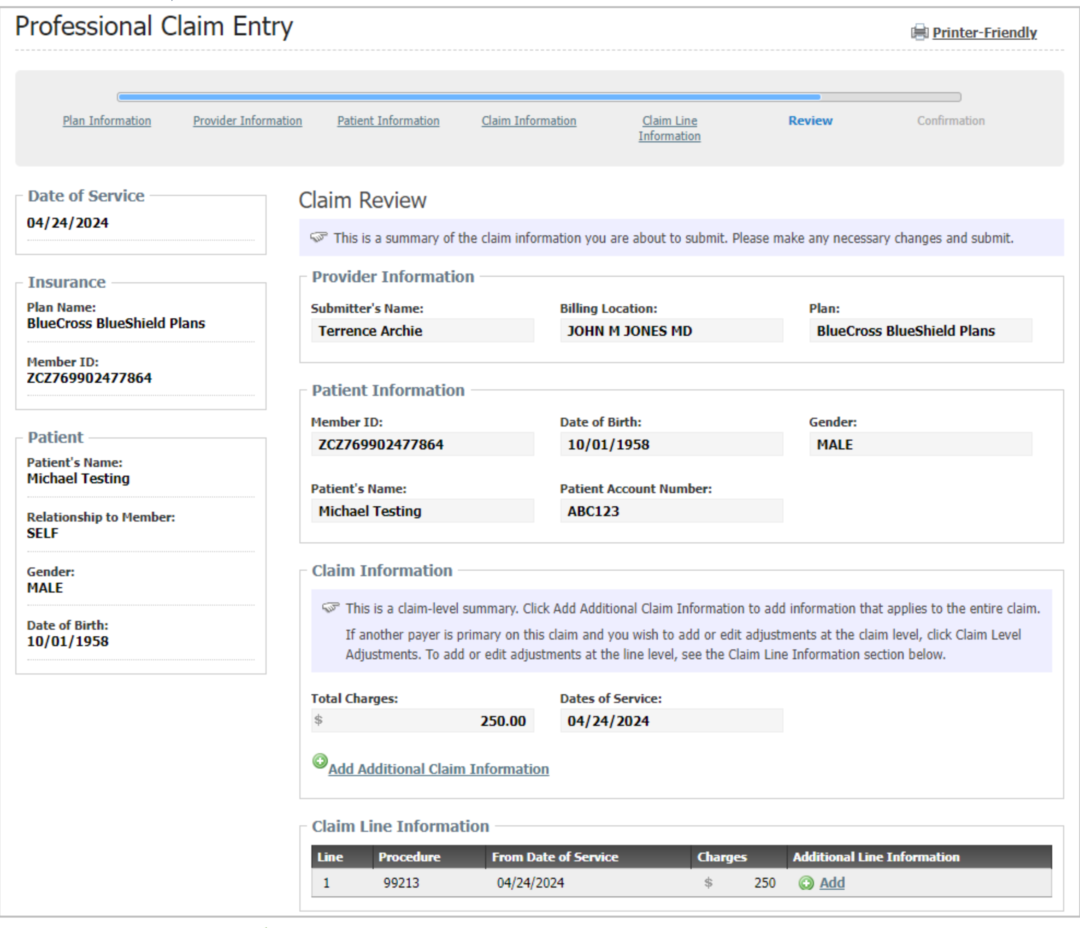
Steps to Submit Claims Through My Insurance Manager (Continued)





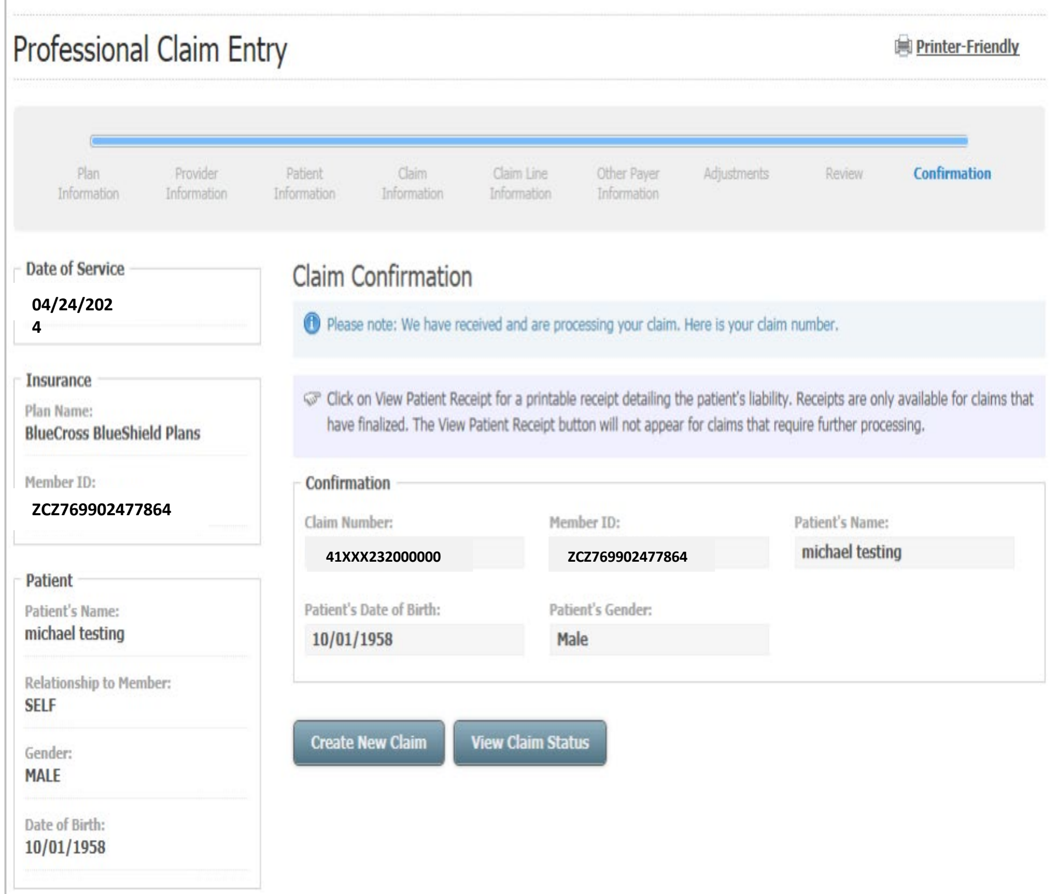
Steps to Submit Claims Through My Insurance Manager (Continued)

Step 6



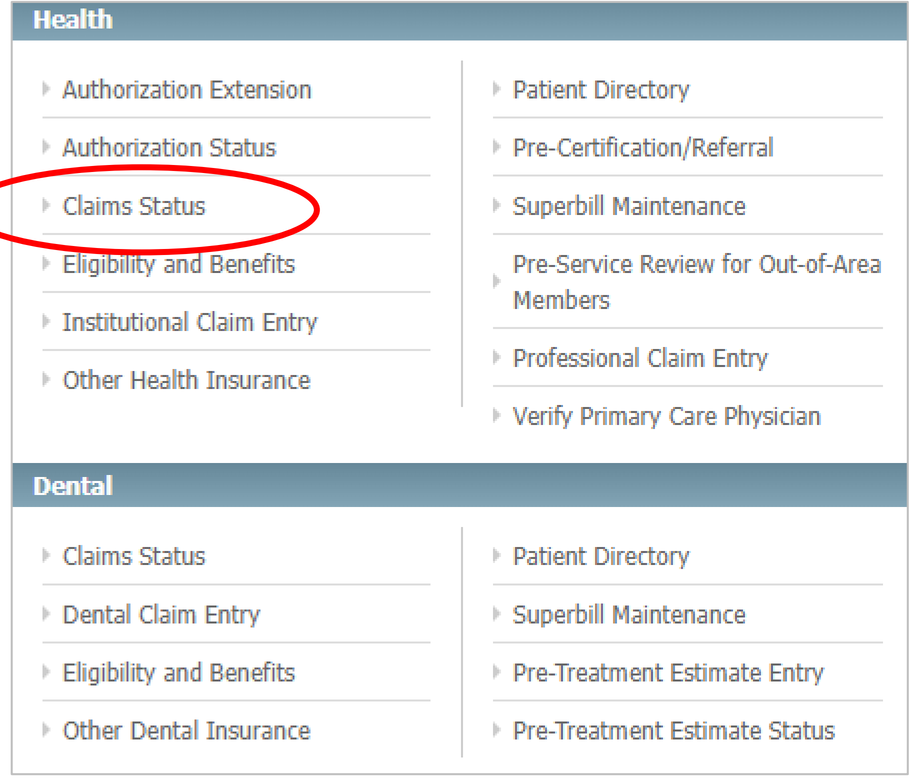
Select Submit from this screen.

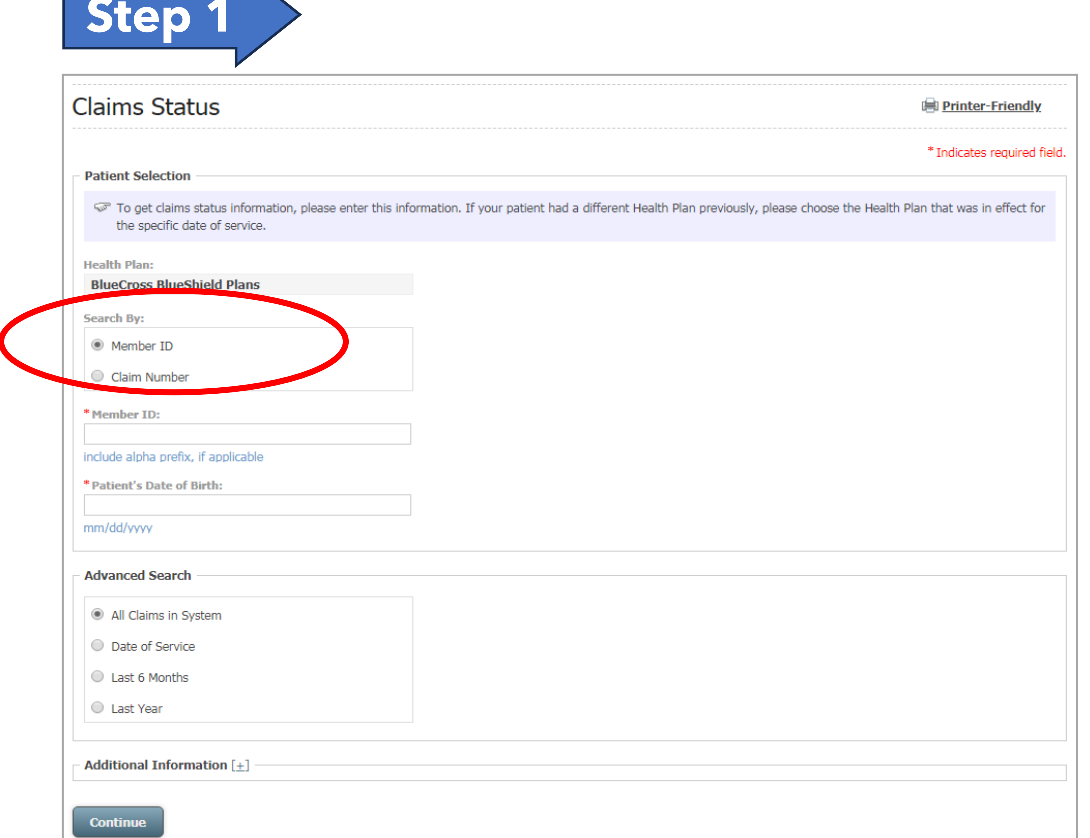
End Here



My Insurance Manager: General Claims Status

Checking the Status of a Claim

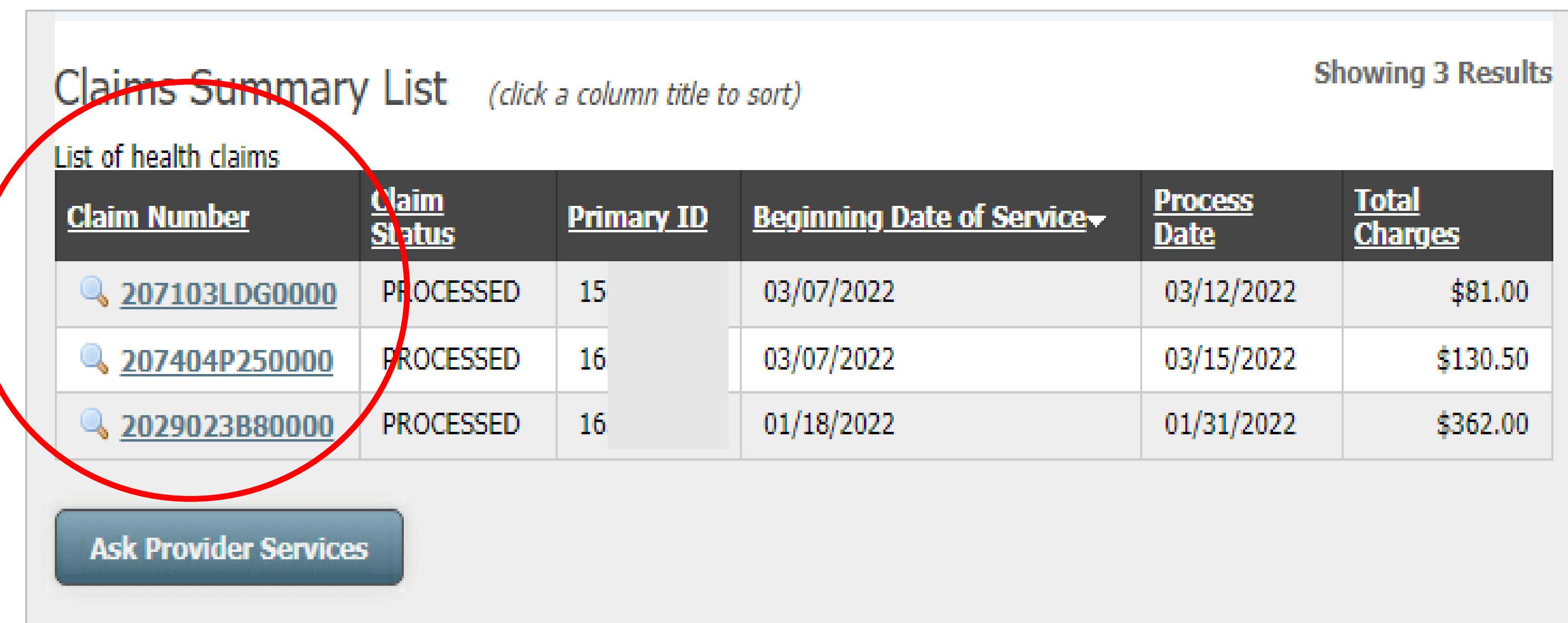




Note: Searching for claims using the member's identification number is the recommended option.

Checking the Status of a Claim (Continued)

Step 3



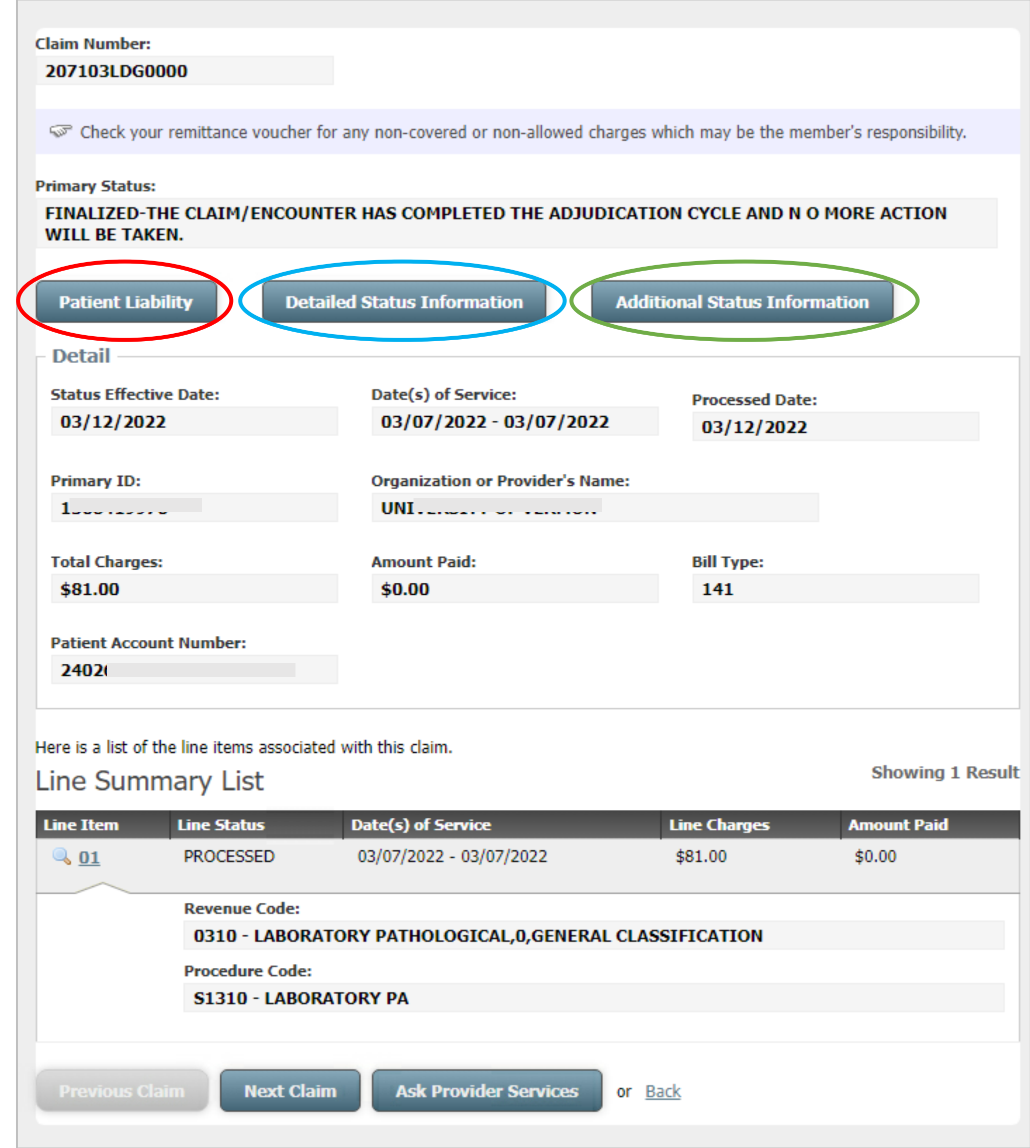
Claims Summary List *(click a column title to sort)* Showing 3 Results

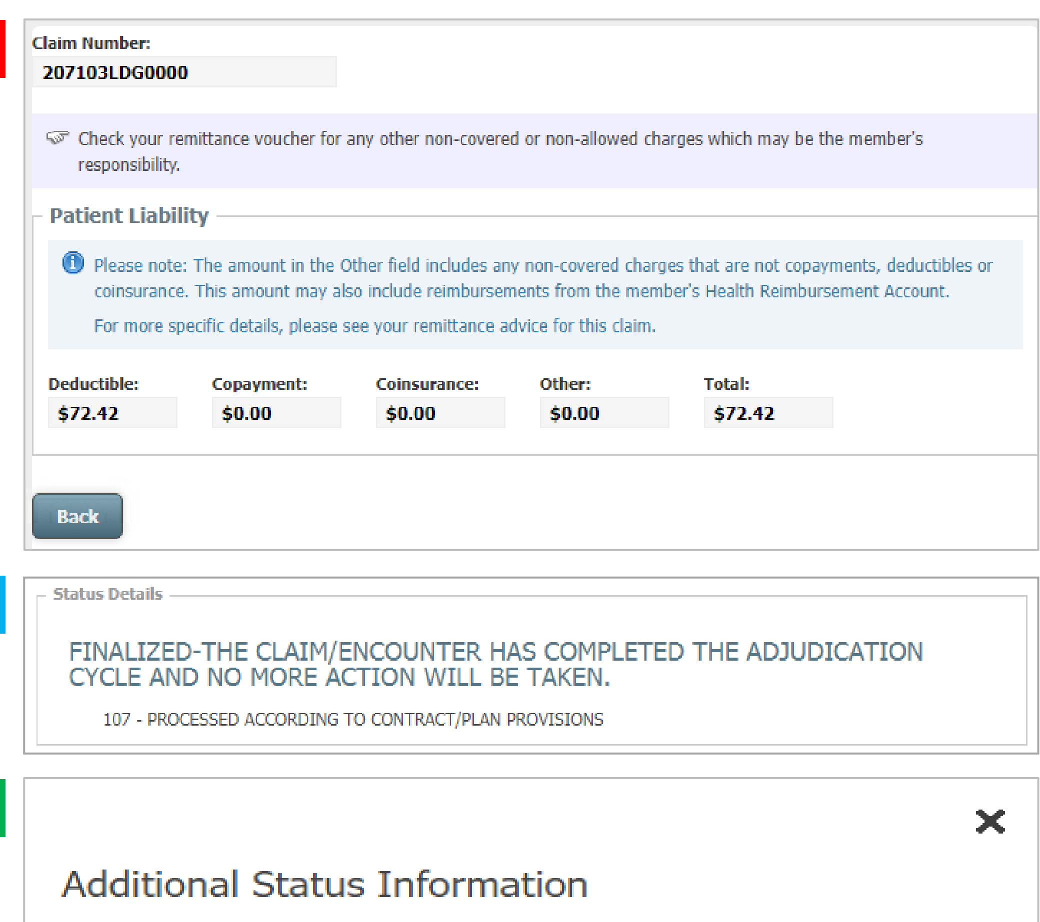
List of health claims

Claim Number	Claim Status	Primary ID	Beginning Date of Service	Process Date	Total Charges
207103LDG0000	PROCESSED	15	03/07/2022	03/12/2022	$81.00
207404P250000	PROCESSED	16	03/07/2022	03/15/2022	$130.50
2029023B80000	PROCESSED	16	01/18/2022	01/31/2022	$362.00

Ask Provider Services

Checking the Status of a Claim (Continued)





My Insurance Manager: Refunds

Getting Assistance with Refunds

- Refund letters are in My Insurance Manager.
  - Search by the refund control number (RCN) or posting date.
  - Includes the patient details and reason for the refund request.
- Call Provider Services at 800-868-2510 and select option 4 if you need additional information on a refund.
  - Certain lines of business have a separate phone number (i.e., State Health Plan).

Refund Letters

Plans included: BlueCross BlueShield of South Carolina, State Health Plan, BlueChoice HealthPlan, HealthyBlue and FEP. Refund Letters are stored by the dates we create them.

Refund Control Number — Or — Posting Date: --Please Choose One--

All Locations | Choos

Search

0000128

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

South Carolina

Visit MyInsuranceManager℠ at www.SouthCarolinaBlues.com

NOVEMBER 11, 2021

Re: Patient:
ID Numb
Provider
Date(s)
Refund

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 $11.00 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:

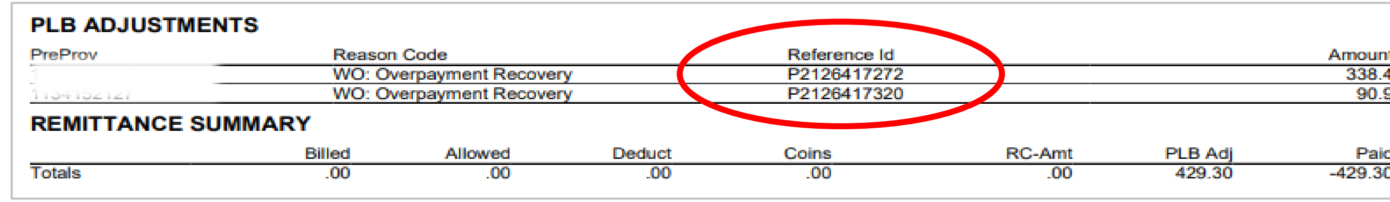
BlueCross BlueShield of South Carolina
Attn: Lockbox AX-A31
I-20 at Alpine Road
Columbia, SC 29219

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



PLB ADJUSTMENTS

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

REMITTANCE SUMMARY

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

My Insurance Manager: Ask Provider Services

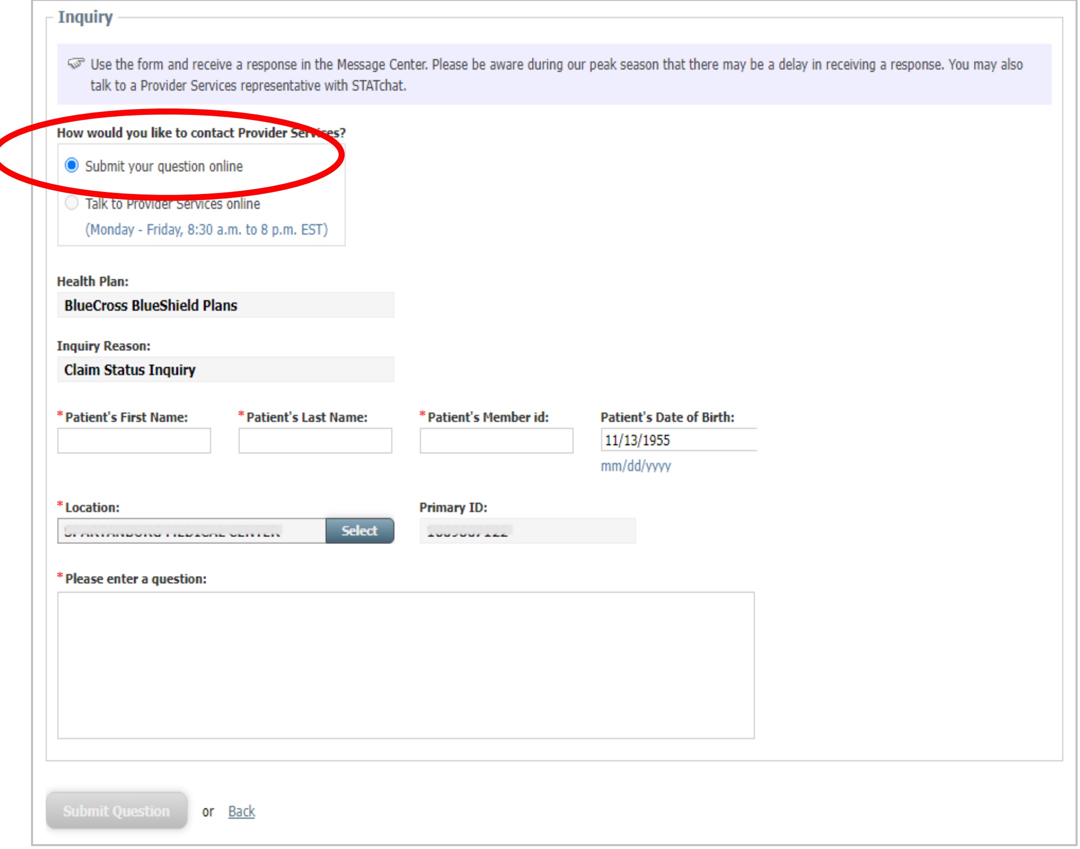
Overview of Ask Provider Services

- 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?
Has the member returned the coordination of benefits questionnaire?	Has the claim been processed?

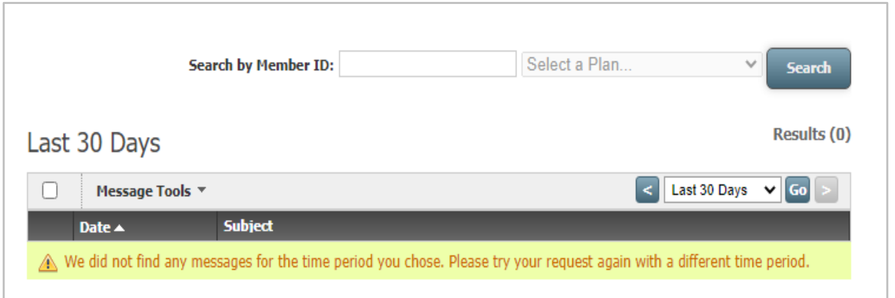
Submitting Web Inquiries

- 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.

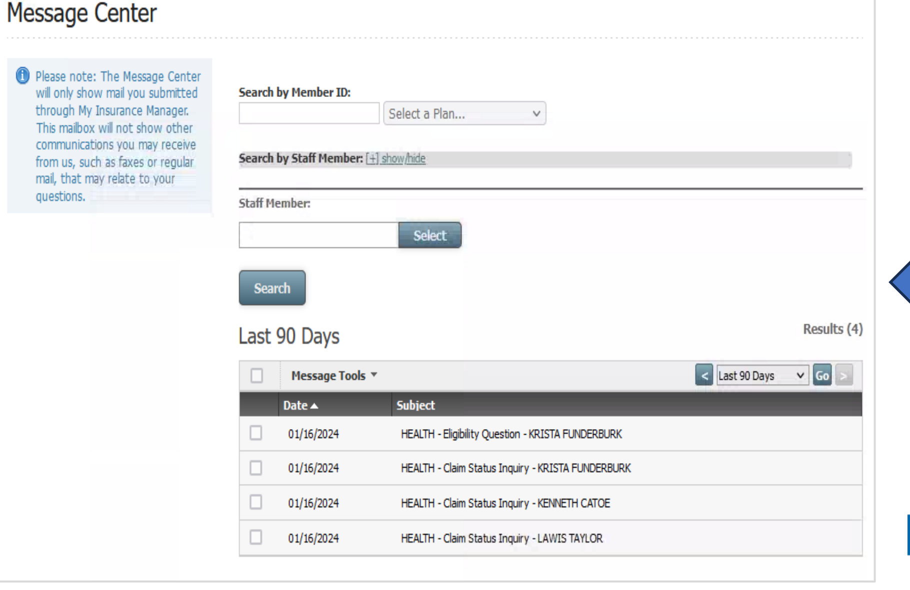


Viewing Web Inquiry Responses

- 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

My Insurance Manager: STATchat

Overview of 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.

Ask Provider Services

* Required

STATchat

Use the form and receive a response in the Message Center. Please be aware during our peak season that there may be a delay in receiving a response. You may also talk to a Provider Services representative with STATchat.

How would you like to contact Provider Services?

Submit your question online

Talk to Provider Services online
(Monday - Friday, 8:30 a.m. to 8 p.m. EST)

Inquiry Name:
BlueCross BlueShield Plans

Inquiry Reason:
Claim Status Inquiry

*Patient's First Name: *Patient's Last Name: *Patient's Member id:

*Location: Select Primary ID: 1

Need help using STATchat?

Launch STATchat or Back

STATchat - Internet Explorer

STATchat

Hang Up

Wearing a headset?

Status: Connected

Call Id: 8141917300

1 2 ABC 3 DEF 4 GHI 5 JKL 6 MNO 7 PQRS 8 GHI 9 WXYZ * 0 + #

MUTE KEYPAD

Having trouble with the audio?

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

Claim Reminders

Laboratory Services

- Avalon Healthcare Solutions manages the laboratory benefits on behalf of BlueCross and BlueChoice®.
- Access the current list of participating laboratories at www.SouthCarolinaBlues.com.
- Review the medical policies before rendering services to ensure criteria is followed for coverage.
  - Benefits of reviewing the medical policies:

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

Medical Policy Criteria for Laboratory Services

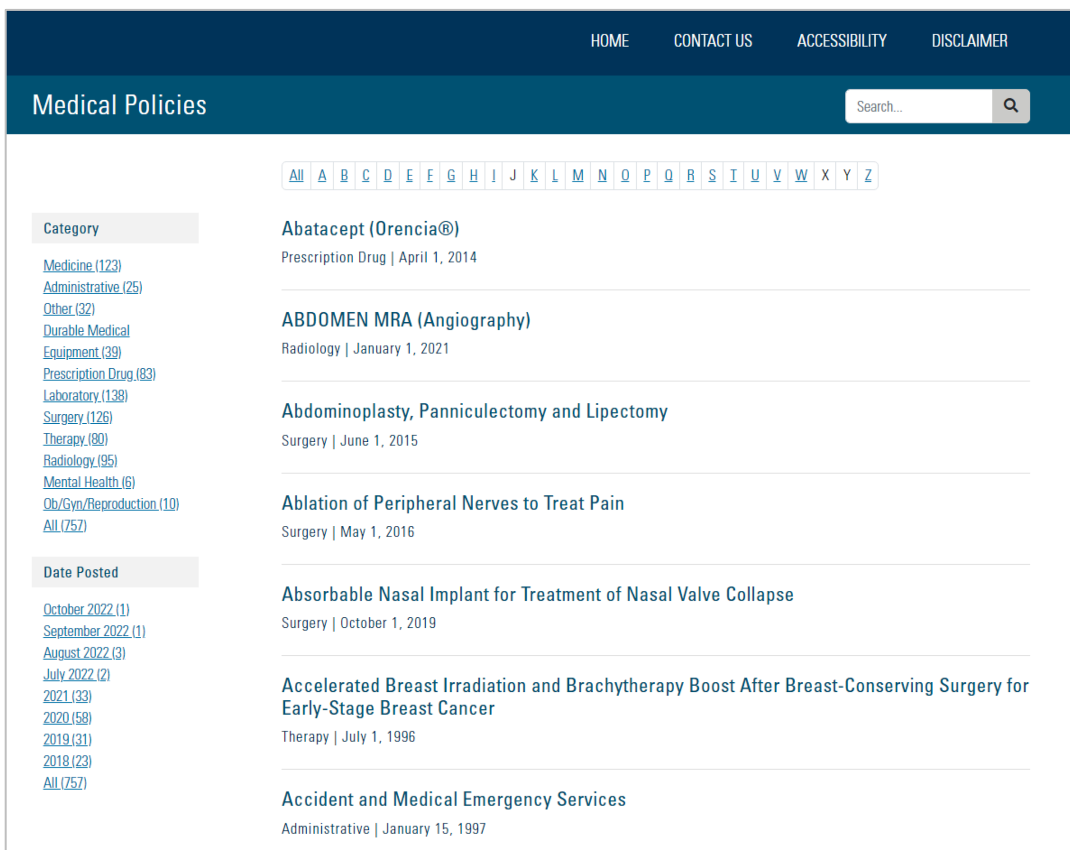
Policy Rule	Definition
Experimental and investigational	Procedure is not covered under the member's benefit due to exclusion
Demographic limitations	Limitations based on the member's age/sex
Excessive procedure units	Total units within and across claims for a single date of service more than necessary
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 due to policy criteria not being met:

Laboratory Test	Issue With the Claim	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

- Medical policies can be found on:
  - www.SouthCarolinaBlues.com
    - Providers>Policies and Authorizations>Medical Policies
  - www.BlueChoiceSC.com
    - Providers>Medical Policies
- CPT and diagnosis codes listed on each policy are not a guarantee of payment.
  - Included for general reference.
  - Lists may not be all-inclusive.



Example of Medical Policy

Vitamin D Testing - CAM 126

Category: Laboratory
Department: Medical Affairs
Original Date: January 2016
Last Reviewed: January 2024
Next Review:

Description
Vitamin D is a precursor to steroid hormones and plays a key role in calcium absorp
intestinal absorption of calcium. Other effects include a lesser stimulation of intesti
osteoblast function, osteoclast activation, and bone resorption (Pazirandeh & Burns

Vitamin D is present in nature in two major forms. Ergocalciferol, or vitamin D2, is f
contain significant amounts of vitamin D. Cholecalciferol, or vitamin D3, is synthesi
fortified with vitamin D, most notably milk and cereals (Sahota, 2014).

Though "The risk of vitamin D deficiency differ[s] by age, sex, and race and ethnicit
inadequate dietary intake of vitamin D-containing foods, and malabsorption syndron

Regulatory Status
Food and Drug Administration (FDA)
A search of the FDA Device database on May 26, 2022, for "vitamin D" yielded 42 re
perform in house. These laboratory-developed tests (LDTs) are regulated by the Ce
Laboratory Improvement Amendments of 1988 (CLIA '88). As an LDT, the U.S. Food
approval is not currently required for clinical use.

Policy
Application of coverage criteria is dependent upon an individual's benefit coverage

1. For individuals with an underlying disease or condition which is specifically a
   suspected of hypervitaminosis of Vitamin D, 25-hydroxyvitamin D serum testi
2. As part of the total 25-hydroxyvitamin D analysis, testing for D2 and D3 fracti
3. For individuals who have documented vitamin D deficiency, repeat testing for
   supplementation therapy is considered **MEDICALLY NECESSARY** with the fol
   a. Repeat testing for the monitoring of supplementation therapy should no
   b. Once therapeutic range has been reached, annual testing meets cover
4. For the evaluation or treatment of conditions that are associated with defects
   MEDICALLY NECESSARY.
5. The following testing is considered **NOT MEDICALLY NECESSARY**:
   a. Measurement of serum 1,25-dihydroxyvitamin D to screen for vitamin D
   b. Routine screening for vitamin D deficiency with serum testing in asymp

Coding Section

Code	Number	Description
CPT	82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed
	82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed
	0038U	Vitamin D, 25 hydroxy D2 and D3, by LC-MS/MS, serum microsample, quantitative Proprietary test: Sensieva™ Droplet 25OH Vitamin D2/D3 Microvolume LC/MS Assay Lab/Manufacturer: InSource Diagnostics
ICD-10-CM	A15.0 – A15.9	Tuberculosis
	A19.0 – A19.9	Military Tuberculosis
	A15.7, A19.0 – A19.9	Primary or military tuberculosis
	C81.00 – C84.99	Other Lymphoma
	C81.00 – C96.9	Lymphoma
	C85.10 – C85.99	Unspecified B-cell lymphoma
	C85.20 – C85.29	Unspecified B-cell lymp
	C85.80 – C85.89	Other specified types of
	C85.90 – C85.99	Non-Hodgkin lymphoma
	D61.09	Fanconi's anemia
	E66.01 – E66.09	Obesity
	D86.0 – D86.85	Sarcoidosis
	D86.86	Sarcoid arthropathy
	D86.87	Sarcoid myositis
	D86.89	Sarcoidosis of other site
	D86.9	Sarcoidosis, unspecified
	E20.0	Idiopathic hypoparathyr
	E20.1	Pseudohypoparathyroid
	E20.8	Other hypoparathyroidis
	E20.9	Hypoparathyroidism, un
	E21.0	Primary hyperparathyro
	E21.1	Secondary hyperparathy
	E21.2	Other hyperparathyroidi
	E21.3	Hyperparathyroidism, ur

History From 2016 Forward

Date	Action
01/25/2024	Annual review, no change to policy intent. Updating description, table of terminology, rationale and references.
01/26/2023	Annual review, updating policy for clarity and consistency. Adding verbiage to guidelines regarding bariatric procedures. Also updating description, rationale and reference.
08/08/2022	Interim review, updating policy for clarity. Also updating description, rationale, and references.
01/11/2022	Annual review, no change to policy intent. Updating rationale and references.
01/05/2021	Annual review, no change to policy intent. Updating description, rationale and references.
04/08/2020	Interim review to add Z79.2 to the policy. No change to policy intent.
01/06/2020	Annual review, updating guidelines and coding. No change to policy intent.
05/23/2019	Corrected typo to coding
01/08/2019	Annual review, no change to policy intent. Updating ICD coding.
01/22/2018	Annual review, no change to policy intent.
08/21/2017	Updated coding. No other changes.
08/09/2017	Updated coding. No other changes.
06/19/2017	Updated coding section. No other changes.
04/26/2017	Updated category to Laboratory. No other changes made.
01/04/2017	Annual review, no change to policy intent.
01/05/2016	NEW POLICY

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

The following criteria must be met for an HDPR to occur:

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

1. Provider submits their claim to BlueCross.
2. BlueCross confirms it's an ***inpatient*** claim with an allowance of ***$100k or more***.
3. A claim line with revenue code 0249 is added to the claim.
4. The claim line is denied with ***CARC*** 216 and ***RARC*** N183
5. An itemized bill is ***requested***.

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

Examples of Itemized Bills

- ***Acceptable*** itemized bill:

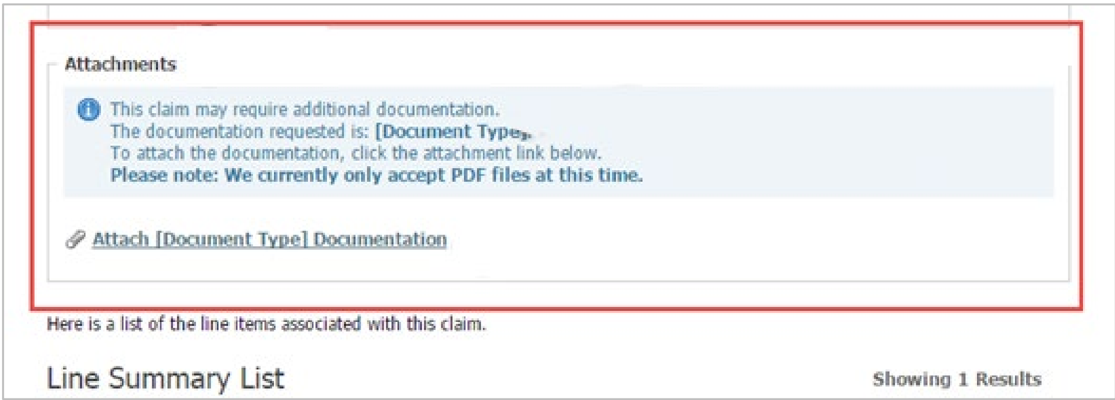
42 Rev. Co.	43 Description	44 HCPCS/Rate/HPPS Code	45 Serv. Date	46 Serv. Units	47 Total Charges
0250	Dicyclomine 10 MG		010322	1	27.00
0250	Nitroglycerin 0.4 MG		010322	1	28.73
0250	Midazolam 10 MG	J2250	010322	2	29.09
0250	Atorvastatin 40 MG		010322	2	76.93
0272	Catheter Angiographic		010322	1	226.00

- ***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.

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 identification card.*

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:

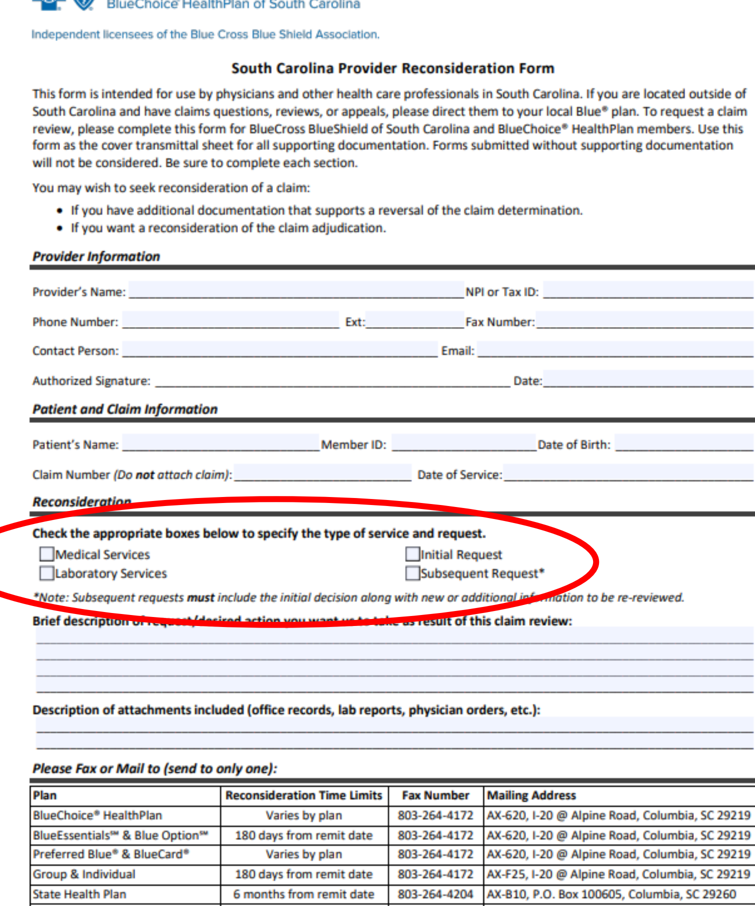
Corrected claim
An anesthesia claim is submitted with the incorrect modifier and rejects as a duplicate.
A provider only performs the Cesarean delivery but submits their claim with the procedure 59515 (which includes postpartum care), causing the claim to process globally.

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.

Submitting a Provider Reconsideration

- ❑ Use the South Carolina Provider Reconsideration Form.
  - www.SouthCarolinaBlues.com
  - www.BlueChoiceSC.com
- ❑ Include supporting documentation.
  - History and physical records
  - Operative notes
  - Office notes
  - Progressive notes
- ❑ Be mindful of the timely filing limits.



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

Independent licensees of the Blue Cross 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

Revised: February 2023

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.

Ancillary Claim Filing Guidelines

Durable Medical Equipment	Independent Clinical Laboratory	Specialty Pharmacy
❑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	❑File to the Plan where the specimen was drawn. ❑The location of where the specimen was drawn is determined by the physical location of the referring provider.	❑File to the Plan whose state the ordering physician is located.

Submission of Requested Medical Records

- If medical records are requested, be sure to submit them as soon as possible.
- Medical records could be requested to:
  - Adjudicate claims.
  - Support medical necessity for a denied claim.
  - Close gaps in care for quality measures (HEDIS®) based on claim history.
- The submission of medical records is a ***non-billable*** event.
  - Share this information with any third-party vendors that submit medical records on your behalf (i.e., Ciox, ScanSTAT).

HEDIS: Healthcare Effectiveness Data and Information Set
HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

National Drug Codes

- National drug codes (NDCs) are used when submitting claims for drugs.
- NDCs must have 11 digits and follow the 5-4-2 format.
- If the drug package lists an NDC with 10 digits, it must be converted into an 11-digit NDC using the following table:

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

The BlueCard Program

Overview

- The BlueCard program allows Blue plan members to get health care services 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.

Benefits to Providers

- Let's you conveniently submit claims for members from other Blue plans directly to BlueCross BlueShield of South Carolina.
- Gives you one point of contact for all your claims-related questions.

Note: For more information, review the BlueCard Program manual on www.SouthCarolinaBlues.com.

The BlueCard Program (Continued)

Products Included

- ❑ Preferred Provider Organization (PPO)
- ❑ Exclusive Provider Organization (EPO)
- ❑ Health Maintenance Organization (HMO)
- ❑ Point of Service (POS)

Products Excluded

- ❑ Stand-alone dental
- ❑ Vision products delivered through a vendor
- ❑ Self-administered prescription drugs products delivered through a vendor
- ❑ Medicaid and SCHIP plans
- ❑ Medicare Advantage
- ❑ Federal Employee Program (FEP)

The BlueCard Program (Continued)

Process Flow

BlueCard member receives care from SC provider → SC provider submits claim to BCBSSC (local plan) → BCBSSC transmits the claim data to the Home plan → The Home plan adjudicates the claim based on their member's benefits → The Home plan transmits the claim back to BCBSSC → BCBSSC pays the SC provider and sends a remittance → The Home plan issues an EOB to their member

Helpful Tips

Claims That Require a Questionnaire Response

- Accident or subrogation
  - Generated based on trauma related diagnoses on a claim
  - Allow members at least ***60 days*** to respond and for the review to be completed
- Other health insurance (OHI)
  - Generated based on the member's age, if they have more than only policy on file, etc.
  - Must be completed by the member.
    - Members can mail or fax the questionnaire, call Member Services or update their information using My Health Toolkit.

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 available on www.SouthCarolinaBlues.com.

Importance of Using Correct Coding

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

Invalid modifiers	**Incorrect number of units**	**Diagnosis inconsistencies**
Unbundled services	**Age discrepancies**	**Unspecified codes**

Note: This list may not be all-inclusive.

Dental Networks

Topics to Discuss

- ❑ Dental Enrollment
- ❑ Dental Plans
- ❑ Dental GRID
- ❑ Dental Benefits and Claims
- ❑ 2025 Coding Updates

Dental Enrollment

Participating in the Dental Network

- Plans that use the Participating Dental Network include:
  - Commercial plans
  - Medicare Advantage plans
  - State Dental Plus
  - Companion Life Dental
  - FEP Basic, Standard, and BCBS FEP Dental
  - GRID members
- Visit www.SouthCarolinaBlues.com.
  - Providers>Provider Enrollment>**Join Our Networks**

Individual Dental Enrollment

Checklist Items	Oral Surgery	Routine
Provider Enrollment Application		
Copy of SC Medical or Practice License		
Drug Enforcement Administration (DEA) Certification*		
Current Copy of Malpractice (Min. $1M/$3M)		
Authorization to Bill for Services		
Signed Contracts	Footnote 1	Footnote 2
Professional Training		
Hold Harmless**		
Appendix D**		
Medicaid ID Number***		

***Only if applicable.**

****Only if applying for BlueChoice® HealthPlan.**

*****Only if applying for Healthy Blue.**

1 Medical contract, dental contract or both.

2 Dental contract only.

Group Practice Dental Enrollment

Checklist Items
Group Practice Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer
Signed Contracts*
Medicaid ID Number**
Add Practitioner Form***

***For oral surgeons applying for BlueChoice® and Healthy Blue. All other contracts are based on the individual practitioner's credentialing status.**

****Only for oral surgeons applying for Healthy Blue.**

*****For each physician being added to the group. This is under the Maintain section of the portal.**

Note: If the provider is not credentialed, you must complete the Provider Enrollment application.

In State, Out-of-Network Dental Enrollment

❑ Individual Physician

Checklist Items
Health Professional Application*
Authorization to Bill for Services*

***Needed for each individual being linked to the practice.**

❑ Group Practice

Checklist Items
Group Practice Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer Enrollment

Dental Plans

BlueCross BlueShield of South Carolina Dental Umbrella

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

BlueChoice®
- Business Advantage
- CarolinaADVANTAGE

BlueCross Total℠ Medicare Advantage

Blue Secure Dental

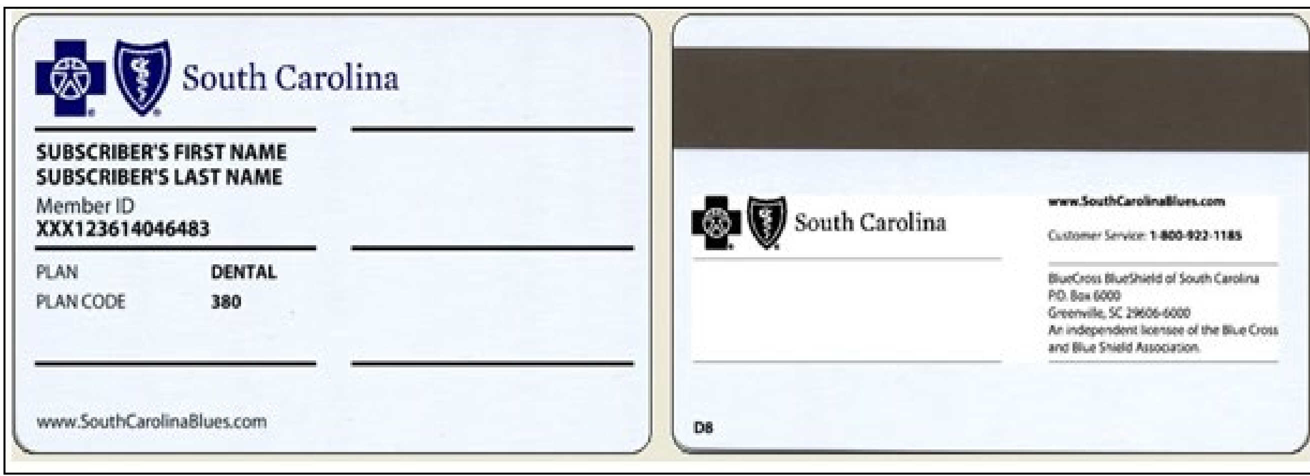
Federal Employee Program (FEP)
- Medical
  - Basic
  - Standard
- Federal Employees Dental and Vision Insurance Program (FEDVIP)
  - BCBS FEP Dental

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

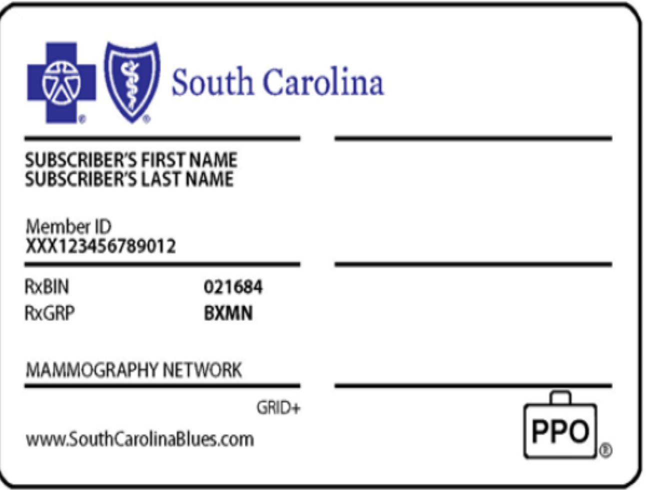
BCBS Dental GRID/GRID+

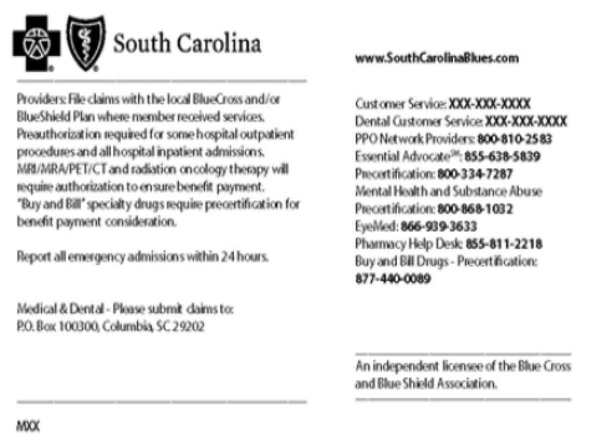
Companion Life Dental

Commercial Plans – Examples of ID Cards



Dental only.





Medical and dental.

Commercial Plans – Overview of Coverage

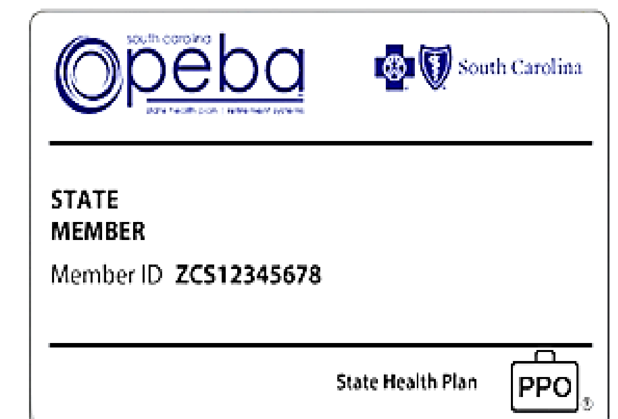
- There are some dental plans that use a network of participating providers, while other plans do not.
  - Members are always encouraged to select in-network providers.
    - Members that use out-of-network providers will be responsible for all charges exceeding the schedule of dental allowances
- Coverage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

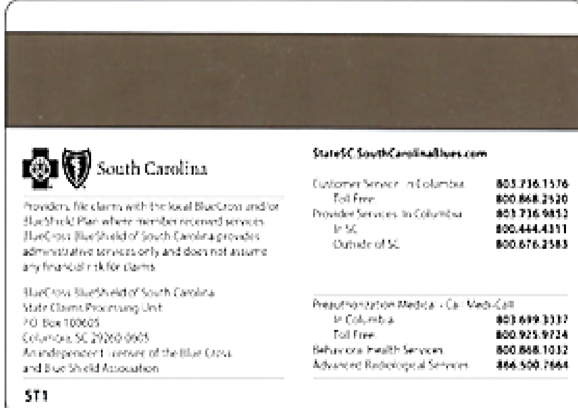
State Basic Dental Plan

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

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

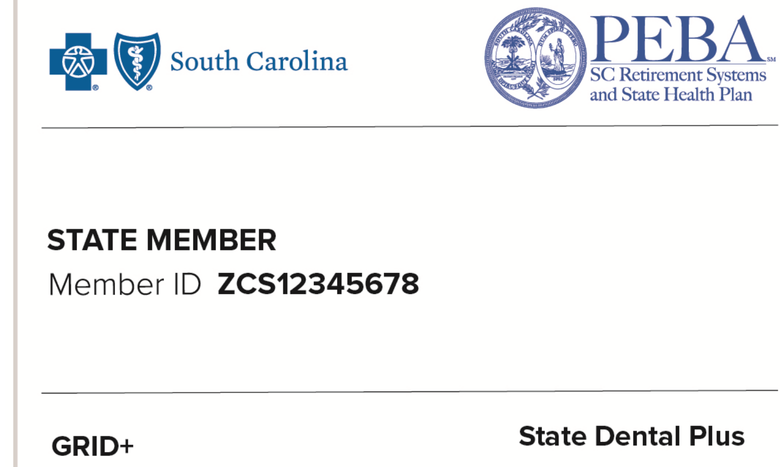
- Covered services are paid based on its schedule of dental procedures and allowable charges.
- As of Jan. 1, 2024, State Dental and Dental Plus no longer apply the alternate benefit for codes D2391 – D2394.





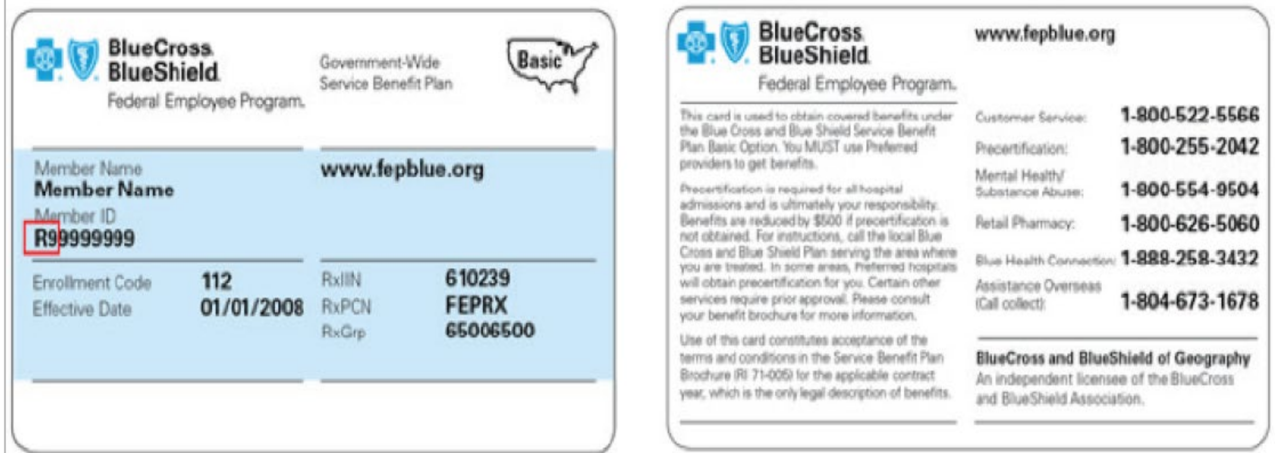
State Dental Plus Plan

- 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.



Federal Employee Program – Basic Option Plan

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



Federal Employee Program – Basic Option Plan (Continued)

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

Federal Employee Program – Standard Option Plan

- ❑ 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.

Federal Employee Program – Standard Option Plan (Continued)

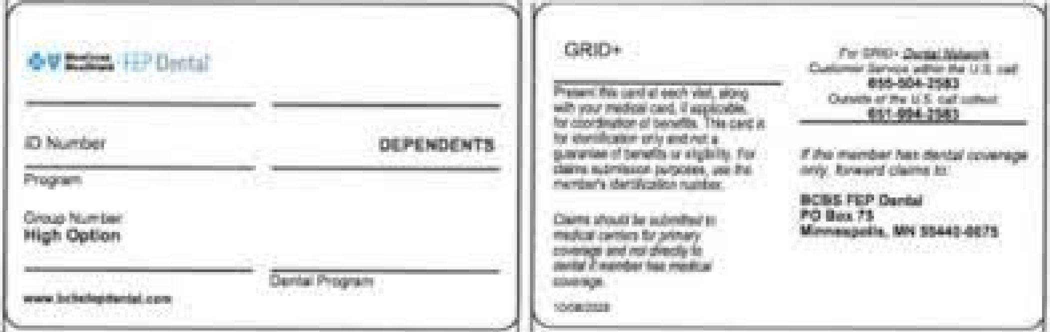
Covered Service	FEP Pays		Member Pays
Clinical Oral Evaluations	**To Age 13**	**Age 13 and Over**	In Network The difference between the amounts listed to the left and the BlueCross Participating Dental Allowance Out of Network All charges in excess of the scheduled amounts listed to the left.
Periodic 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

Federal Employee Program – Blue Focus Plan

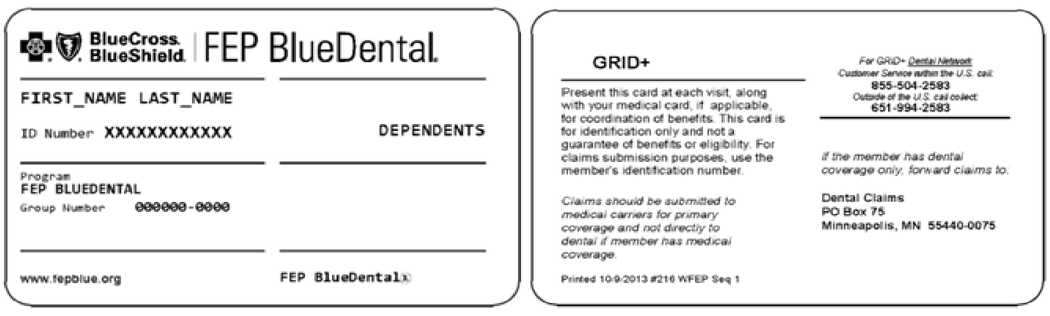
- Members with a Blue Focus plan do not have dental benefits directly with their plan.
- Members would need BCBS FEP Dental or another Federal Employees Dental and Vision Insurance Program (FEDVIP) for dental benefits.
- Claims would need to be filed directly to the FEDVIP plan.

Federal Employee Program – Blue Cross Blue Shield FEP Plan

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



Sample of new BCBS FEP Dental ID Card



Sample of old FEP BlueDental ID Card

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

Federal Employee Program – Blue Cross Blue Shield FEP Plan (Continued)

	High Option		Standard Option	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Class A (Basic) services (e.g., exams, cleanings, x-rays, sealants)	**$0**	**10% COINS**	**$0**	**40% COINS**
Class B (Intermediate) services (e.g., oral surgery, fillings, gum scaling)	**30% COINS**	**40% COINS**	**45% COINS**	**60% COINS**
Class C (Major) services (e.g., crowns, bridges, root canals, dentures)	**50% COINS**	**60% COINS**	**65% COINS**	**80% COINS**
Class D (Orthodontics) services (Adults and children)	**50% COINS up to $3,500** lifetime maximum per person	**50% COINS up to $3,500** lifetime maximum per person	**50% COINS up to $2,500** lifetime maximum per person	**50% COINS up to $1,250** lifetime maximum per person

Annual Deductible **Class A, B and C services** (Does not include Class D services)	**$0**	**$50 per person**	**$0**	**$75 per person**
Annual Maximum **Class A, B and C services** (Does not include Class D services)	**Unlimited**	**$3,000 per person**	**$1,500 per person**	**$750 per person**

Medicare Advantage: BlueCross Total, Blue Basic and Total Value

	BlueCross PPO Dental Benefit Highlights			
	Service	**In-Network**	**Visits (per year)**	**Out-of-Network**
Preventive Dental	**Oral exams** **Cleanings**	$0	2	50% COINS
	Dental x-rays	$0	1	50% COINS
Comprehensive Dental* **(Non-Medicare covered services)**	Restorative Endodontics Extractions Prosthodontics	Anesthesia Other oral/maxillofacial surgery Other services (e.g., deep cleanings, fillings, Crowns, root canal, dentures, bridges) ***Note: Implants are not covered.***		50% COINS (INN and OON)
Annual Maximum **(Per member, per year)**	BlueCross Total℠: **$4,500** (Comprehensive and preventive combined) Total Value℠: **$3,500** (Comprehensive and preventive combined) Blue Basic℠: **$3,000** (Comprehensive and preventive combined)			

***SC Blue Dental Network**

Blue Secure – Members 19 and Older

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

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

South Carolina

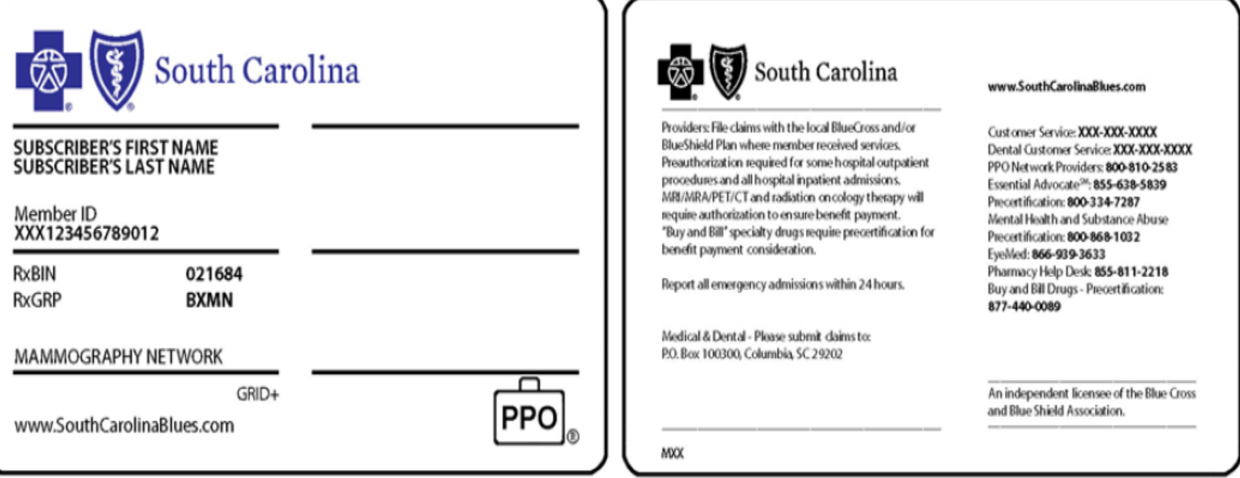
Blue Secure – Members Under 19

	Blue Secure Dental Gold 1		Blue Secure Dental Silver 1	
Member Age	**Under 19 years old**			
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	$50 per child	$100 per child	$50 per child	$100 per child
Annual Maximum (Coverage limit)	**No limit**			
Class I – Preventive Procedures and Exams	0% COINS	20% COINS	0% COINS	30% COINS
Class II – Basic and Restorative	30% COINS	50% COINS	40% COINS	60% COINS
Class III – Major Procedures	50% COINS	60% COINS	50% COINS	60% COINS
Class IV – Orthodontia Services (Prior authorization required)	50% COINS		50% COINS	
Maximum Out-of-Pocket per child	**$425**	**$850**	**$425**	**$850**
Maximum Out-of-Pocket total (All children)	**$850**	**$1,700**	**$850**	**$1,700**

Dental GRID

Overview of 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 work **GRID** or **GRID+** on their ID card.



Sample Commercial - Medical and Dental ID Card

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

Dental Benefits and Claims

Verifying Eligibility and Benefits

Plan	My Insurance Manager℠	Provider Services
Commercial Dental Plans	Yes	800-222-7156 (Columbia center) 800-922-1185 (Greenville center)
State Basic Dental and Dental Plus	Yes	888-214-6230 803-264-3702 (Columbia area)
BCBS FEP Dental	Yes	855-504-2583
FEP Dental (Medical)	No	800-444-4325
BlueCross Total, Total Value and Blue Basic (Medicare Advantage Dental)	Yes	800-222-7156
Companion Life Dental	No	800-765-9603 or 800-753-0404, ext. 45921

Filing Dental Claims Under the Medical Benefit

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

Filing Orthodontic Claims Electronically

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

General Guidelines for Filing Dental Claims

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

National Electronic Attachment

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.

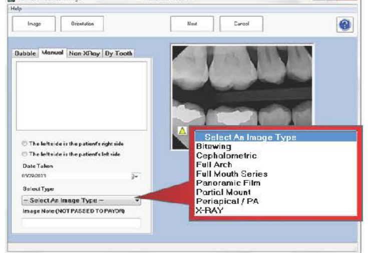
Improve claim adjudication times by electronically transmitting:

- 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.

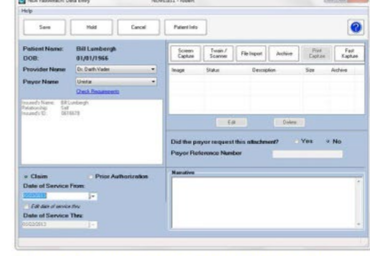
Easy to Use & Access

HITRUST CSF Certified

- 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

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

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



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

Unparalleled Customer Service

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

Get Started Fast

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

Easily view payer requirements

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

Communicate with Confidence Using Vyne Connect Encrypted Email

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

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

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

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

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Connecting Disconnected Data™

NEA-VYNE-FA-OVERVIEW-PROMOS-021919

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Note: All dental plans use the NEA except FEP.

2025 Coding Updates

New Dental Codes

Code	Description
D2956	Removal of an indirect restoration on a natural tooth
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments
D6193	Replacement of an implant screw
D8091	Comprehensive orthodontic treatment with orthognathic surgery
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery
D9913	Administration of neuromodulators
D9914	Administration of dermal fillers
D9959	Unspecified sleep apnea services procedure, by report

Note: Verify eligibility and benefits prior to rendering services.

Deleted Dental Codes

Code	Description
D2941	Interim therapeutic restoration
D6180	Repair implant abutment, by report

Pharmacy

Agenda

- Formulary Updates
  - Commercial (BlueCross and BlueChoice® HealthPlan)
    - Lowest Net Cost (LNC) Formulary
    - Premium Formulary
  - Exchange
  - Medicare
  - Healthy Blue℠

Formulary Updates

Commercial Plans

Commercial

Lowest Net Cost Formulary Updates

Lowest Net Cost Formulary Updates

Additions

- ❑ Beginning Jan. 1, 2025, the following drugs will be added.

Product	Formulary Status
EOHILLIA *#	Non-preferred Brand
REZDIFFRA *	Non-preferred Specialty
WINREVAIR *#	Non-preferred Specialty
ALYGLO *	Non-preferred Specialty
VOYDEYA *#	Non-preferred Specialty
MEIBO *	Preferred Brand
CEQUA *	Non-preferred Brand
TYRVAYA *	Non-preferred Brand

**Requires Prior Authorization*

 # Quantity limit applies

Lowest Net Cost Formulary Updates (Continued)

Exclusions

- Beginning Jan. 1, 2025, the following drugs will be moved to non-formulary status.
- The products listed have alternatives on the formulary, many times, at a lower cost to the member.
  - Some covered alternatives may require prior authorization.

Product	Formulary Status
RIVFLOZA INJ	Non-formulary
ZYMFENTRA	Non-formulary
DUVYZAT	Non-formulary
OPSYNVI	Non-formulary

Lowest Net Cost Formulary Updates (Continued)

Prior Authorization

- Beginning Jan. 1, 2025, ***XIIDRA OPTHALMIC DROPS*** will require prior authorization.

Quantity Limits

- Beginning Jan. 1, 2025, the following drugs will be moved to non-formulary status.

Product	Quantity Limit
ZYMFENTRA*	2 Syringe per 28
DUVYZAT *	420ml/30 days
FILSUVEZ *	19 tubes/30 days
OPSYNVI *	1 tab/day

**Non-formulary*

Tier Changes

- Beginning Jan. 1, 2025, ***WAKIX*** will have an updated tier placement and will move from non-preferred brand to non-preferred specialty.
- Prior authorization will still be required.

Lowest Net Cost Formulary Updates (Continued)

Humira Biosimilar Update

- Beginning Jan. 1, 2025, Humira (brand) will be removed from the Lowest Net Cost Formulary. Adalimumab biosimilars will replace Humira as preferred products.
- This new biosimilar strategy provides continued quality of care for patients, guaranteed supply, availability of high-concentration doses, and affordability for patients, including manufacturer copay assistance programs and significant cost reduction.

High Concentration	Low Concentration
Amjevita by Nuvaila (Low WAC) 20mg/0.2mL 40mg/0.4mL 80mg/0.8mL	**Hadlima** 40mb/0.8mL

- Providers should send new prescriptions for one of the preferred biosimilar products to a network Specialty Pharmacy.
- Existing utilizers will have active prior authorizations pre-loaded for biosimilars.

Commercial

Premium Formulary Updates

Premium Formulary Updates

Additions

- Beginning Jan. 1, 2025, the following drugs will be added.

Product	Formulary Status
CUTAQUIG	Non-preferred
PANZYGA	Non-preferred

Exclusions

- Beginning Jan. 1, 2025, the following drugs will be moved to non-formulary status.
- The products listed have alternatives on the formulary, many times, at a lower cost to the member.
  - Some covered alternatives may require prior authorization.

Product	Formulary Status	Product	Formulary Status
VELPHORO	Non-formulary	HYRIMOZ	Non-formulary
VICTOZA	Non-formulary	ADALIM-ADBM	Non-formulary
HUMIRA	Non-formulary	CYLTEZO	Non-formulary
ADALIM-ADAZ	Non-formulary	AMJEVITA (specific NDCs)	Non-formulary

Premium Formulary Updates (Continued)

Prior Authorization

- Beginning Jan. 1, 2025, the following drugs will require prior authorization and are excluded on the premium formulary.

Product	Formulary Status
WINREVAIR	Excluded
IQIRVO	Excluded
KISUNLA	Excluded

Step Therapy

- Beginning Jan. 1, 2025, the following drugs will require a step therapy added or updated.

Therapeutic Class	Step 2 Drugs (Requires trial)	Step 1 Drugs
ANTI-INFECTIVES	MONDOXYNE NL AVIDOXY	Anyone one of the following generics: doxycycline and minocycline.
OPHTHALMOLOGY	BROMFENAC	Any of the following generic ophthalmic solutions: diclofenac, flurbiprofen and ketorolac.

Premium Formulary Updates (Continued)

Quantity Limits

- Beginning Jan. 1, 2025, the following drugs will require prior authorization and are excluded on the premium formulary.

Product	Quantity Limit
NUZYRA	1 course per fill, 2 fills per year
FASENRA	1 syringe per 56 days
XOLAIR 75 MG	2 syringes per 28 days
XOLAIR 300 MG	4 syringes per 28 days
AUBAGIO*	1 tablet per day
AUSTEDO XR	1 tablet per day
CABOMETYX	1 tablet per day
OJJAARA*	1 tablet per day
RUBRACA*	4 tablets per day
VIZIMPRO	1 tablet per day
POMALYST	1 capsule per day
KALYDECO	2 packets per day
EVERYSDI	8mL per day
NUZYRA	1 course per fill, 2 fills per year

**Excluded from Premium Formulary.*

Premium Formulary Updates (Continued)

Tier Changes

- ❑ Beginning Jan. 1, 2025, the following drugs will have an updated tier placement.

Downtiers	Uptiers
OMVOH	MULPLETA
SOTYKTU	NUTROPIN AQ
TALZ	CIMERLI

Premium Formulary Updates (Continued)

Humira Biosimilar Update

- Beginning Jan. 1, 2025, Humira (brand) will be removed from the Premium Formulary. Adalimumab biosimilars will replace Humira as preferred products.
- This new biosimilar strategy provides continued quality of care for patients, guaranteed supply, availability of high-concentration doses, and affordability for patients, including manufacturer copay assistance programs and significant cost reduction.

High Concentration	Low Concentration
Amjevita by Nuvaila (Low WAC) 20mg/0.2mL 40mg/0.4mL 80mg/0.8mL	**Amjevita by Amgen** 10mg/0.2mL 20mg/0.4mL 40mg/0.8mL

- Providers should send new prescriptions for one of the preferred biosimilar products to a network Specialty Pharmacy.
- Existing utilizers will have active prior authorizations pre-loaded for biosimilars.

Overview of Vaccines: LNC, Premium and ACA Updates

Influenza and RSV Vaccines

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

Covered RSV Vaccines	
Abrysvo*	Beyfortus^
Arexvy**	mRESVIA+

* *Approved for those ≥ 60 years old and in pregnancy at 32-36 weeks*
** *Approved for those ≥ 50 years old*
^ *Approved for neonates and up to 24 months old*
+ *Approved for those ≥ 60 years old*

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

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

Exchange Plans

Exchange Formulary Updates

	Current Formulary	2025 Broad Formulary	2025 Narrow Formulary (Blue Direction Plan)
Tier Design	Tier 1: Low-Cost Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-Preferred Drug Tier 5: Generic/Preferred Brand Specialty Tier 6: Non-Preferred Brand Specialty	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Drug Tier 4: Specialty	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Drug Tier 4: Specialty
Formulary Design	Average Coverage	Broad Coverage	Narrow Coverage
Amount of Formulary Drugs	3700+	6500+	2500+
HCR $0 Copay List (Health Care Reform)	Yes	Yes	Yes

*Note: Tiers 1, 2 are being combined to **Tier 1: Generic** and Tiers 5, 6 are being combined to **Tier 4: Specialty** for 2025.*

Exchange Formulary Updates (Continued)

Top Disrupted Products

Product	Disease Category	Type of Disruption	Formulary Alternative
Vyvanse	ADHD/Narcolepsy	Up Tier	lisdexamphetamine
Symbicort	Asthma/COPD	Up Tier	Breyna, budesonide-formoterol fumarate
Humira	Inflammatory Conditions	Removal	Amjevita
Tresiba FlexTouch	Diabetes	Removal	Toujeo Solostar
Freestyle 3 Sensor GMS	Diabetic Supplies	Removal	Dexcom
Levemir FlexPen	Diabetes	Removal	Lantus Solostar
Tivicay	HIV	Up Tier	N/A
Pulmicort Flexhaler	Asthma/COPD	Removal	Qvar
One Touch Ultra 2 Device	Diabetic Supplies	Removal	N/A
fluticasone HFA	Asthma/COPD	Removal	Qvar
Victoza	Diabetes	Removal	Liraglutide, Trulicity

Exchange Formulary Updates (Continued)

Humira Biosimilar Update

- Beginning Jan. 1, 2025, Humira (brand) will be removed from the ACA formularies. Adalimumab biosimilars will replace Humira as preferred products.

Humira Biosimilar Coverage
Humira EXCLUDED **No continuation of therapy**
Amjevita by Nuvaila 20mg/0.2mL 40mg/0.4mL 80mg/0.8mL
Hadlima 40mg/0.8mL

- Providers should send new prescriptions for one of the preferred biosimilar products to a network Specialty Pharmacy.
- Existing utilizers will have active prior authorizations pre-loaded for biosimilars.

Exchange Formulary Updates (Continued)

Prior Authorizations

- Remain active through authorization term date.
  - Members who remain on an existing plan.
- Prior authorization terms Dec. 31, 2024
  - Members who move to a new plan.
    - Individual ACA > Small Group ACA
    - Individual ACA or Small Group ACA > Blue Direction
    - Individual ACA or Small Group ACA > BlueChoice HealthPlan
  - Drugs that are excluded on the new formulary.
  - Drugs that do not require a prior authorization under new formulary.

Exchange Formulary Updates (Continued)

Member and Provider Communications

- Member formulary change notification letters
  - Inform members of disruption in coverage assuming they will remain on their existing plan.
  - Letters mailed:
    - Nov. 1, 2024
    - Dec. 15, 2024
    - Feb. 1, 2025
  - Letters recommend consultation with provider and formulary alternatives when appropriate.
- Member prior authorization termination notification letters
  - Mailed to the member and provider.
  - Letters began mailing Nov. 1, 2024.

Medicare

2025 IRA Changes

2025 IRA Changes

In August 2022, the Inflation Reduction Act (IRA) was signed into law.

2025 IRA directed changes for Medicare Part D:

1. Part D Benefit structure changes from a 4-phase to 3-phase
   - Elimination of Coverage Gap Phase (often called the "Donut Hole")
   - 3-phases: (1) Deductible, (2) Initial Coverage Limit (ICL), and (3) Catastrophic

2. **Maximum $2,000 out-of-pocket** for Part D covered drugs

3. Implementation of Medicare Prescription Payment Plan (M3P) (i.e. Copay Smoothing)
   - Allows members the option to spread their prescription costs over monthly installments paid directly to the plan versus at the pharmacy counter

Medicare Prescription Payment Plan

Medicare Prescription Payment Plan (M3P)

The **Medicare Prescription Payment Plan**, originally called "copay smoothing," is part of the Inflation Reduction Act (IRA) that was signed into law in August of 2022. The IRA includes a wide range of provisions for clean energy, tax revenues, and healthcare costs.

Nicknamed the M3P, the Medicare Prescription Payment Plan requires Medicare Part D plans to provide their members the **option** to pay for Part D prescriptions through monthly payments to their plan instead of paying at the pharmacy starting January 1, 2025.

While the IRA contains other provisions aimed at lowering prescription drug costs, the M3P **does not change** the amount that members pay for their prescriptions.

M3P – Likely to Benefit

Members are likely to benefit from M3P if:

✓ ≥ **$2,000** in out-of-pocket drug costs from January – September prior to the plan year

✓ **$600** out-of-pocket costs for a single prescription claim during the plan year

✓ Identified through additional plan-defined strategies during the plan year

M3P – Likely to NOT Benefit

Members are NOT likely to benefit from M3P if:

- ☒ Yearly drug costs are low.
- ☒ Drug costs are the same each month.
- ☒ Members who sign up late in the calendar year (after September).
- ☒ Don't want to change how you pay for your drugs.
- ☒ Get or are eligible for Extra Help from Medicare.
- ☒ Get or are eligible for a Medicare Savings Program.
- ☒ Get help paying for your drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP), a coupon program, or other health coverage.

2025 Medicare Advantage Plan and Formulary Changes

2025 Medicare Advantage Plan and Formulary Changes

Important Reminders:

- All members should review their Annual Notice of Change (ANOC) that were mailed.
- Members experiencing disruption from the 2025 changes may receive additional communication via:
  - Letters
  - Call campaigns
  - Text messages
- Humira remains on formulary for 2025

Drug Name	Formulary Information
Humira	Tier 5, PA, QL
Adalimumab-ADBM	Tier 5, PA, QL
Adalimumab-AATY	Tier 5, PA, QL

PA: Prior Authorization | QL: Quantity Limit

Medicare Advantage Medication Adherence

- Prioritize 90-day supply prescriptions
- Some 90-day supply generic medications at **$0 member cost** available for MAPD members
- Remember:
  - Insulin products have a **maximum $35 copay**
  - GLP-1 products are not insulin
  - CMS still **excludes treatment for weight loss** from Part D coverage

Sample list 90-day supply products at **$0 cost** for MAPD members:

- Alendronate
- Atorvastatin
- Glipizide
- Lisinopril
- Losartan
- Metformin / Metformin ER
- Pioglitazone
- Pravastatin
- Rosuvastatin
- Simvastatin
- Valsartan

Medicare Pharmacy Resources

- MA (MAPD) Customer Service: **1-855-204-2744**
  - Now through March 31, we are available from 8 a.m. to 8 p.m. seven days a week.
- PDP Customer Service: **1-888-645-6025**
  - Now through March 31, we are available from 8 a.m. to 8 p.m. seven days a week.
- Online Resources: **www.scbluesmedadvantage.com**

Healthy Blue

Healthy Blue Formulary Updates

- Effective Jan. 1, 2025, the following products will be changing status:

	Previous Status	New Status	Effective Date
Rho Kinase Inhibitors			
Rhopressa® (netarsudil)	Non-PDL	PDL preferred	Effective 1/1/2025
Rocklatan® (netarsudil/latanoprost)	Non-PDL	PDL preferred	Effective 1/1/2025
Rectal Anticonvulsants			
Diastat Acudial® (diazepam)	Non-PDL	PDL preferred	Effective 1/1/2025
Diastat Pedi System® (diazepam)	Non-PDL	PDL preferred	Effective 1/1/2025
Diazepam rectal gel system	Non-PDL	PDL preferred	Effective 1/1/2025
Multiple Sclerosis - Oral			
Dalfampridine (generic for Ampyra®)	PDL non-preferred	PDL preferred	Effective 1/1/2025
Fingolimod (generic for Gilenya®)	PDL non-preferred	PDL preferred	Effective 1/1/2025
Teriflunomide (generic for Aubagio®)	PDL non-preferred	PDL preferred	Effective 1/1/2025
Multiple Sclerosis - Injectable			
Kesimpta® (ofatumumab)	PDL non-preferred	PDL preferred with criteria	Effective 1/1/2025

Healthy Blue Formulary Updates (Continued)

	Previous Status	New Status	Effective Date
Hypoglycemia Agents			
Baqsimi® (glucagon) nasal powder	Non-PDL	PDL preferred	Effective 1/1/2025
Glucagon 1mg injection	Non-PDL	PDL preferred	Effective 1/1/2025
Glucagon 1mg emergency kit	Non-PDL	PDL preferred	Effective 1/1/2025
Gvoke Hypopen® (glucagon)	Non-PDL	PDL preferred	Effective 1/1/2025
Proglycem® (diazoxide) oral suspension	Non-PDL	PDL preferred	Effective 1/1/2025
Zegalogue® (dasiglucagon) autoinjector/syringe	Non-PDL	PDL preferred	Effective 1/1/2025
Glucagon emergency kit (Fresenius Kabi)	Non-PDL	PDL non-preferred	Effective 1/1/2025
Diazoxide suspension	Non-PDL	PDL non-preferred	Effective 1/1/2025
Gvoke® (glucagon) vial/syringe	Non-PDL	PDL non-preferred	Effective 1/1/2025
Bladder Antispasmodic			
Fesoterodine ER (generic for Toviaz®)	PDL non-preferred	PDL preferred	Effective 1/1/2025
Myrbetriq® tablet	PDL non-preferred	PDL preferred	Effective 1/1/2025
Toviaz® tablet	PDL preferred	PDL non-preferred	Effective 1/1/2025

Healthy Blue Pharmacy Resources

Pharmacy Benefit

- Medications at retail, specialty and mail order pharmacies.
- Drug is self-administered.
- Use the Comprehensive Drug Lookup Tool: https://client.formularynavigator.com/Search.aspx?siteCode=1404420163

Prior Authorization Information – CarelonRx

- Phone: 844-410-6890
- Fax: 844-512-9005
- ePA Portal: Covermymeds
- Review time: 24 hours

Medical Benefit

- Drug is provider-administered in the office, infusion center, etc.
- Use the Medical Specialty Drug List: https://www.healthybluesc.com/providers/pharmacy

Prior Authorization Information – CVS/Novologix

- Phone: 844-345-2803
- Fax: 866-494-9927
- Online Portal: My Insurance Manager℠
- Review time: Urgent, 72 hours; Standard, 14 days

Healthy Blue Pharmacy Resources (Continued)

Mail Order and Home Delivery

- ❑ Extra benefit available on most medications.
- ❑ Controlled substances are excluded.
- ❑ Up to 31-day supply or 90-day supply for certain medications.
- ❑ Phone: 833-396-0309
- ❑ Fax: 833-389-4172

Provider Enrollment

Topics to Discuss

- ❑ Provider Enrollment Requirements
- ❑ Overview of the Enrollment Process
- ❑ My Provider Enrollment Portal
- ❑ Completing Clean Applications
- ❑ Making Corrections to Applications
- ❑ Important Reminders
- ❑ Available Resources

Provider Enrollment Requirements

Provider Enrollment Applications

Application	Description
Enroll a Practitioner	New practitioners that want to enroll with BlueCross BlueShield of South Carolina.
Enroll a Group	New groups that want to enroll with BlueCross BlueShield of South Carolina.
Facility Information Request	Medical facilities that want to credential with BlueCross BlueShield of South Carolina.
Add Virtual Care	Practitioners or groups that want to render telemedicine and telehealth services.
Health Professional**	**In-state, out-of-network** practitioners that want to file claims to BlueCross BlueShield of South Carolina.
Behavioral Health**	New practitioners or groups that want to enroll in our behavioral health network.
Autism Provider Panel**	Applied behavior analysts that want to enroll in our autism provider panel.
Add a Satellite Location	**Enrolled groups** that have **new locations** that want to file claims to BlueCross BlueShield of South Carolina.
Submit a Name Change	Request to change the doing business as (DBA) name of a practice.
Change of Address	Request to update the physical, pay to, correspondence or billing agency address.
NPI Provider Notification**	**Out-of-state and out-of-network** practitioners or groups that want to register their NPI with BlueCross BlueShield of South Carolina.
Request to Add a Practitioner	Adding a practitioner's affiliation with a clinic, group or institution.
Remove a Practitioner	Terming a practitioner's affiliation with a clinic, group or institution.

***These are included with either the Enroll a Practitioner or Enroll a Group application. The responses to the questions will trigger the path the application takes.*

Provider Enrollment Checklists

Individual Provider Enrollment

- Ancillary Providers
- Dental Providers
- Advanced Practice Providers
- Pharmacists
- Physicians and Chiropractors

Group Practice Enrollment

- Ambulance
- Dental
- Durable Medical Equipment
- Home Health, Hospice, etc.
- Pharmacy
- Physician Office

Other

- Behavioral Health
- In State, Out-of-Network
- Out-of-State, Out-of-Network
- Satellite Locations

Note: Visit www.SouthCarolinaBlues.com to review the available checklists.

Example of an Individual Enrollment Checklist

Physicians and Chiropractors

Checklist Items
Provider Enrollment Application
Copy of SC Medical or Practice License
Drug Enforcement Administration (DEA) Certification*
Current Copy of Malpractice (Min. $1M/$3M)
Authorization to Bill for Services
Signed Contracts
Professional Training**
Hold Harmless***
Appendix D***
Medicaid ID Number****

*Only if applicable.

**Required for MDs, DOs and DPMs.

***Only if applying for BlueChoice HealthPlan.

****Only if applying for Healthy Blue.

Example of a Group Practice Enrollment Checklist

Physician Office

Checklist Items
Group Practice Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer
Signed Contracts**
Medicaid ID Number*
Add Practitioner Form***

*Only if applying for Healthy Blue.

**Only for BlueChoice and Healthy Blue. All other commercial contracts are based on the individual practitioner's credentialing status.

***For each physician being added to the group. This is under the Maintain section of the portal.

Note: If the provider is not credentialed, you must complete a full enrollment application.

Overview of the Enrollment Process

What Happens When an Application is Received

- **The provider enrollment team reviews applications to determine if they are clean and completed.**
  - Only clean applications can be sent to the Credentialing Committee for review.
    - Applications that are incomplete or missing items are sent back to the provider, and they have ***21 days*** to return the necessary documentation.
    - If the missing items are not received, the application will be canceled on the 28th day.
- **Applications approved by the Credentialing Committee progress through the process and are sent to contracting for review.**
  - Applications that are not approved by the Credentialing Committee are sent to the Disciplinary Committee.
    - The outcome of the review is sent to the provider.
- **Once contracting reviews and executes the contracts, the application is sent to the enrollment team to load the provider into the system.**
  - If contracts are not executed, an explanation is sent to the provider.
- **After the provider is loaded into the system, a welcome email is sent to the provider and includes the network and affiliation dates.**

Things to Keep in Mind

- **The Credentialing Committee reviews enrollment applications to ensure all required credentialing criteria is met.**
- **Network effective dates are determined by the Credentialing Committee's approval date per the following entity requirements:**
  - Utilization Review Accreditation Commission (URAC)
  - National Committee for Quality Assurance (NCQA)
  - South Carolina Department of Health and Human Services (SCHDDS), when applicable
- **Network effective dates cannot be backdated.**
- **Affiliation dates can be backdated.**
  - Affiliation dates are used to process commercial claims.
  - Can be backdated to the earliest start date for the practitioner, but no more than Jan. 1st of the previous year.

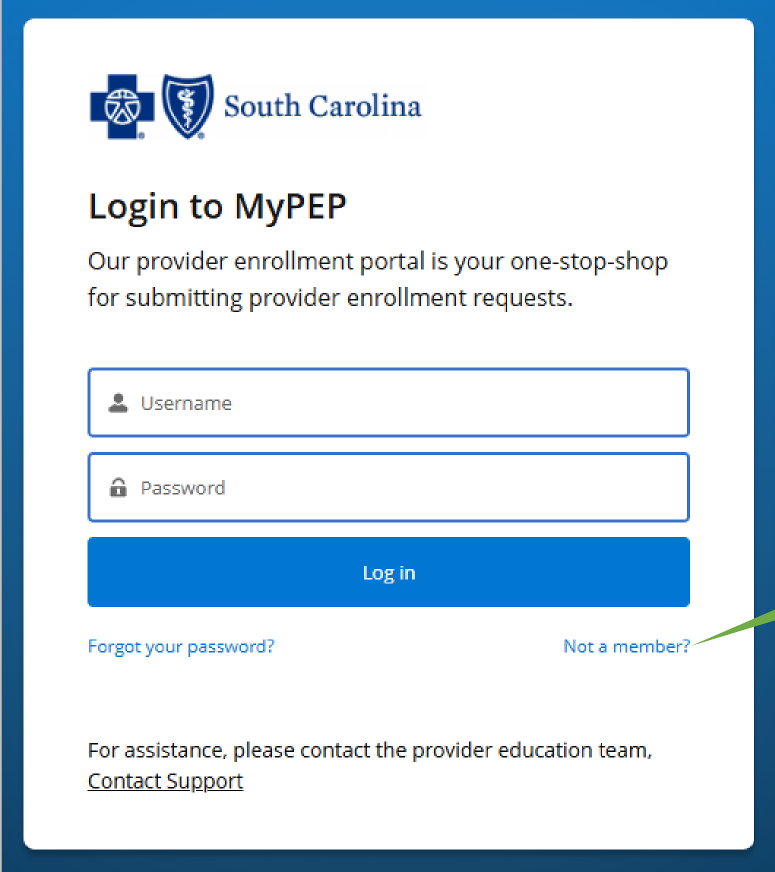
My Provider Enrollment Portal

New and Improved My Provider Enrollment Portal

- Coming soon, we will release our new and improved portal.
- The enhanced portal will make your interactions with enrollment smoother, more efficient and easier to manage.
- Key features and benefits:
  - Multiple user accounts linked to one Tax ID.
  - Simplified navigation.
  - Streamlined signing process with one event.
  - Clearer “action required” notifications.
  - Better application management.
  - Enhanced application tracking.
  - Personalized role selection for a customized experience.

Getting Started with My Provider Enrollment Portal

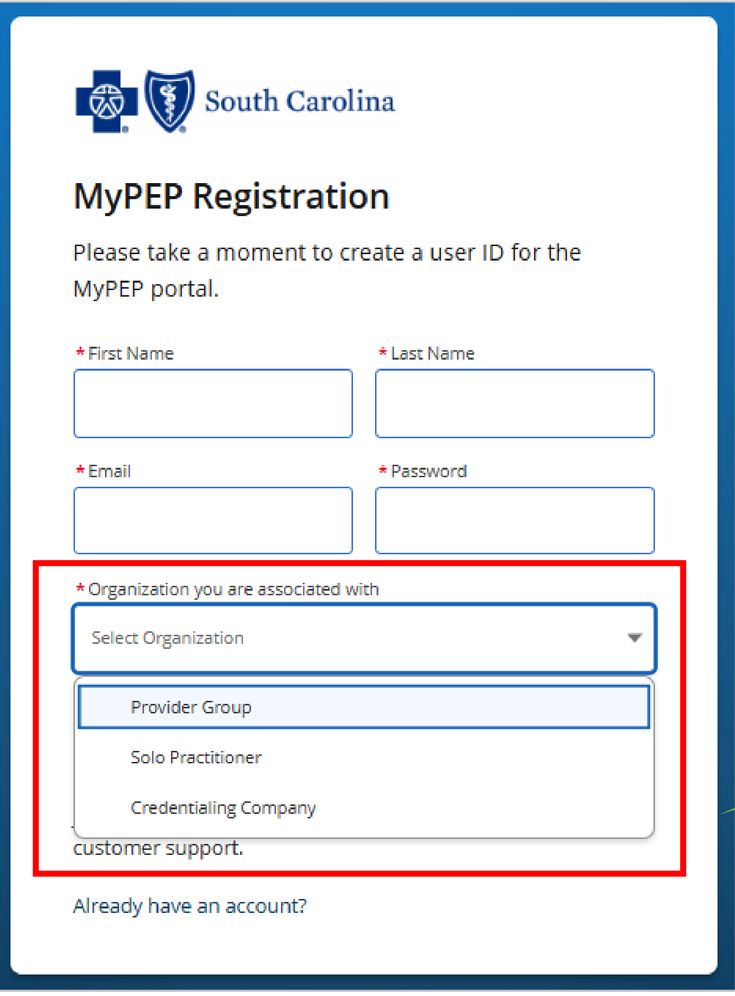
- Visit www.SouthCarolinaBlues.com.
  - Providers>Provider Enrollment>**Join Our Networks**
- New users should select New User from the landing page of the portal.



Select "Not a member?" if you've never signed up!

Registering

- ❑ Options include: solo practitioner, provider group and credentialing company.



The required details will vary based on the selection made.

My Provider Enrollment Portal – Home Page

Search...

Archie

Home | Applications | Enroll | Maintain | Support

My Provider Enrollment Portal

Enroll with BlueCross BlueShield of South Carolina

Enroll to BlueCross BlueShield of South Carolina and BlueChoice Health Plan

Enrollment Options

Already enrolled, but want to make changes?

#1 Join the largest health insurer in South Carolina

11,000+ Physicians and nearly every hospital in South Carolina

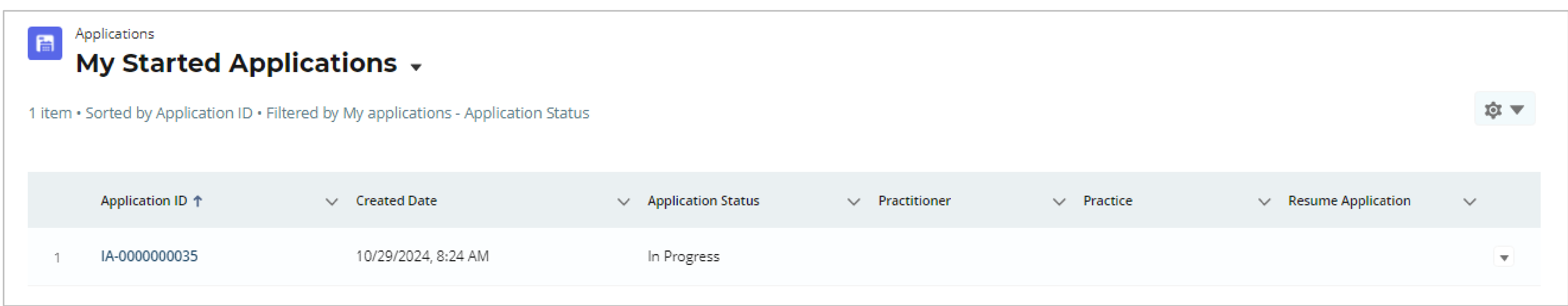
Thank you for your interest in joining our network

My Provider Enrollment Portal (MyPEP) is our new provider enrollment tool. It offers a web-based solution for providers who are credentialed or interested in credentialing with BlueCross BlueShield of South Carolina to complete the enrollment process.

What you'll see under Applications.

- My Started Applications
- My In-Progress Applications
- My Applications Action Required
- My Closed Applications

My Provider Enrollment Portal – Applications Page


Applications

My Started Applications

1 item • Sorted by Application ID • Filtered by My applications - Application Status

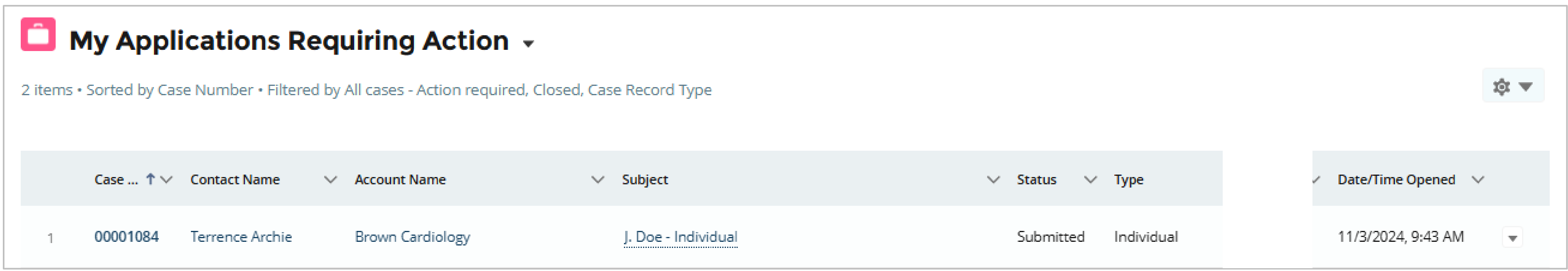
	Application ID	Created Date	Application Status	Practitioner	Practice	Resume Application
1	IA-0000000035	10/29/2024, 8:24 AM	In Progress			

My In-Progress Applications

4 items • Sorted by Case Number • Filtered by All cases - Status, Closed, Case Record Type

	Case Number	Contact Name	Account Name	Subject	Status	Type	Date/Time Opened
1	00001038	Terrence Archie	Brown Cardiology	Back to Mobility - Group	Submitted	Group	10/29/2024, 9:07 AM
2	00001039	Terrence Archie	Brown Cardiology	J. Doe - Individual	Signed	Individual	10/29/2024, 9:07 AM
3	00001041	Terrence Archie	Brown Cardiology	. - Satellite Location	Submitted	Satellite Location	10/29/2024, 11:07 AM
4	00001042	Terrence Archie	Brown Cardiology	. - Business Name Change	Submitted	Business Name Change	10/29/2024, 11:10 AM

My Provider Enrollment Portal – Applications Page



My Applications Requiring Action

2 items • Sorted by Case Number • Filtered by All cases - Action required, Closed, Case Record Type

	Case ...	Contact Name	Account Name	Subject	Status	Type	Date/Time Opened
1	00001084	Terrence Archie	Brown Cardiology	J. Doe - Individual	Submitted	Individual	11/3/2024, 9:43 AM

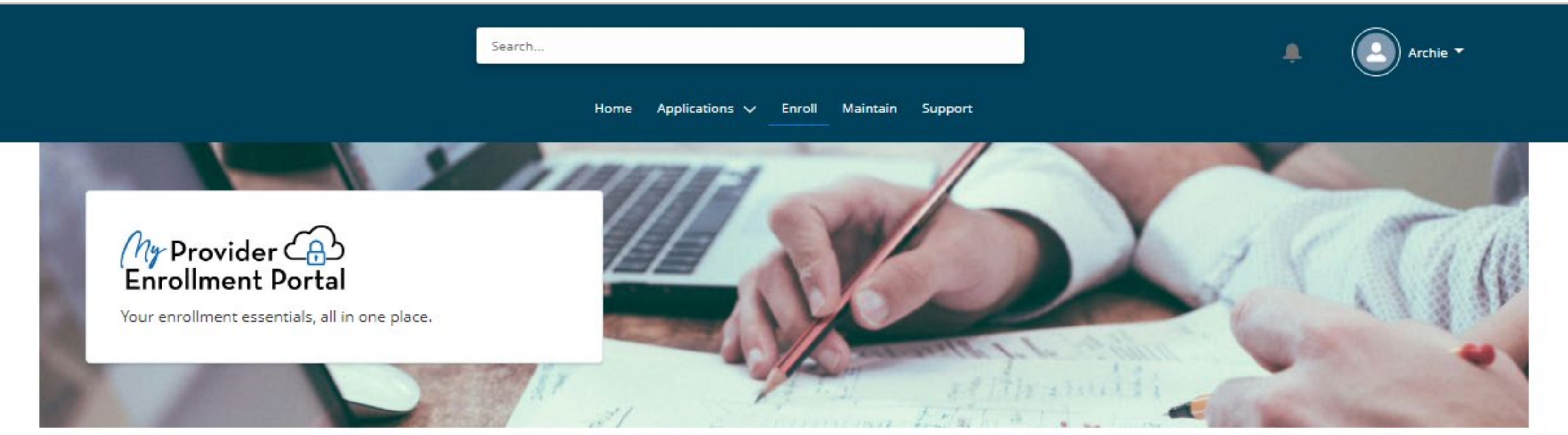
My Closed Applications

6 items • Sorted by Case Number • Filtered by All cases - Closed, Case Record Type • Updated a minute ago

Search this list...

	Case Number	Subject	Status	Provider_Contact_Name
1	00001091	D. Doe - Individual	Approved	Daisy Doe
2	00027892	Health Core Medical & Aesthetics Inc - Satellite Location	Approved	
3	00027909	Health Core Medical & Aesthetics Inc - Virtual Care	Approved	
4	00027936	Health Core Medical & Aesthetics Inc - Business Name Change	Approved	
5	00027937	Health Core Medical & Aesthetics Inc - Business Name Change	Approved	
6	00027939	Health Core Medical & Aesthetics Inc - Business Name Change	Approved	

My Provider Enrollment Portal – Enroll Page



Enroll

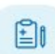
Enrolling with BCBS-SC is easy. First, tell us what you are trying to do. Are you enrolling a group practice? Are you enrolling a practitioner? Would you like to submit a facility information request? Make your selection and we will get some additional information to determine which of our networks apply (or to proceed and register out-of-network).

Enroll a Group

A group practice consists of more than one healthcare practitioner working together under a single organization & has an NPI (type II organization). Start here to submit a group practice enrollment application.

Enroll a Practitioner

A healthcare practitioner is any individual offering healthcare services & with an NPI (type I individual). Every practitioner offers their services through their individual practice or within a group practice. Start here to submit an enrollment application for a practitioner.



Facility Information Request

An organization that offers healthcare services, is not classified as a practitioner or group of practitioners, & has an NPI (type II organization), can submit a facility information request.

My Provider Enrollment Portal – Maintain Page

Search...

Archie

Home | Applications | Enroll | Maintain | Support

My Provider Enrollment Portal

Your enrollment essentials, all in one place.

Maintain

Here you can submit updates and requests to manage your practice and / or providers. Select from the menu below to get started.

Add a satellite location

Add a new satellite location to your profile to expand your services.

Request to add a practitioner to practice

Request to add a practitioner's association with your clinic, group, professional association, or institution.

Remove a practitioner from practice

Remove a practitioner's association with your clinic, group, professional association or institution.

Change of address

Update your location, billing, pay to or mailing/correspondence address to ensure you receive all correspondence and notifications.

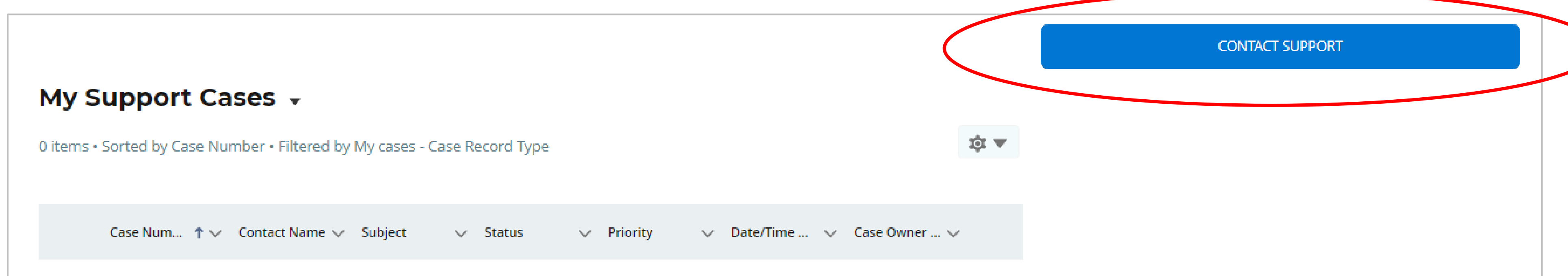
Add virtual care

Add telehealth / telemedicine services to your profile to offer remote consultations and care. You must already be enrolled in BCBS networks to add this option.

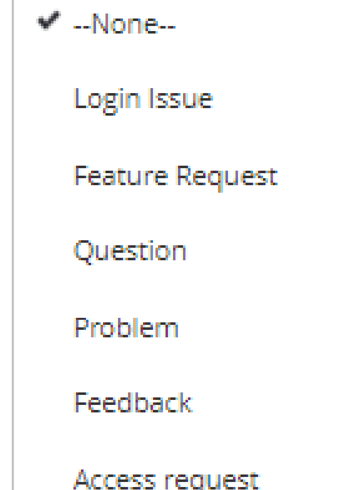
Submit a name change

Submit a request to change your Doing Business As (DBA) name for accurate business representation.

My Provider Enrollment Portal – Support Page



Available types.



Search...

Archie

Home Applications Enroll Maintain Support

CONTACT MYPEP SUPPORT

TELL US HOW WE CAN HELP.

TYPE

--None--

SUBJECT

DESCRIPTION

Upload File

SUBMIT

Got a technical problem? A suggestion? You've come to the right place.

We want to hear from you.

- Question: We moved some things around - let us know if you have a question. We'll get it answered, and you'll help us improve others' experience in the process.
- Feature request: Got a provider enrollment wish list? (we do, too!) Tell us what would make things easier for you - we'd love to relay the message to our tech teams.
- Login issue: Tell us if you, or anyone on your account, is having an issue logging in and we'll get to the bottom of it.
- Problem: Any other issue related to myPEP's site and navigating, this is the spot for it.
- Feedback: The good, the great, the fantastic! And anything not-so-great - we want to hear that, too, because we are always looking to improve.

Got an application question? Need help or an update?

Leave us a comment!

We see your comments - and leaving them where we know exactly which application, practitioner, or practice you are working on makes it so that we can get you answers even faster.

Leave us a comment on your open cases and we'll get back to you as soon as possible.

My Provider Enrollment Portal – Status Details

Status	Details
Submitted	The application and ***all required documents*** have been sent to BlueCross BlueShield of South Carolina for review. Note: Submitted does not mean completed.
Preliminary Review	The application is in the first review stage to ensure it's clean.
Awaiting Signature	The application and applicable contracts have been sent to the provider (and other designated signers) for signatures.
Signed	The application and applicable contracts have been signed.
Secondary Review	The application has progressed to the next review stage.

My Provider Enrollment Portal – Status Details (Continued)

Status	Description
Final Review	The application has reached the final review stage.
Approved	The application has been approved.
Denied	The application has been denied.
Cancelled	The application has been cancelled.
Withdrawn	The application has been withdrawn per the provider's request.

Completing Clean Applications

Steps to Submitting a Clean Application

1. Complete the enrollment application inside the portal.
2. Sign the application and contracts ***electronically***.
    - These items will be available once the enrollment team sends the documents to you and the case is in the awaiting signature status.
3. If additional items are requested, submit those as soon as possible.

Example of an Individual Enrollment Application

Clear navigation.

Steps

1. Let's Get Started
   - Provider Identifiers
   - Network pre-qualifications
   - Network selection
2. Practitioner Information
3. Upload Documents
4. Review
5. Submit

Let's Get Started

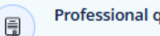
Practitioner - What to have ready

We'll walk you through setting up a new practitioner, and ensuring they are aligned with the correct group practice or established as an individual practice.

Provider identifiers for the practitioner
You'll need the practitioner's NPI Number (type I individual). You will also need the Social Security Number (SSN).

Contact Information
The full name, former surname(s), phone & preferred email are all important information we collect for each practitioner.

Demographic Information
In addition to capturing gender, race and ethnicity, we'll also capture the practitioner's language(s).



Professional qualifications
The practitioner's care specialty, state medical license, and board certification are all required.

Education & professional training
The practitioner's relevant degrees and training (including the highest degree) are required. We also require residency for MDs, DOs, & DPMs.

Employment
Aside from establishing current employment for the practitioner, we collect employment history up to 5 years (which can also span to include education and professional training).

Authorization to Bill
For practitioners that are part of a group practice, they will sign off for the group on their authorization to bill.

Next

Pay close attention to what's needed.

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
   - Provider Identifiers
   - Network selection
2. Practitioner Information
3. Upload Documents
4. Review & Sign
5. Submit

Provider Identifiers

To get started, we need to run a search to see if you are already in our system. For practitioners, a Social Security Number and / or NPI Number (type I individual) will help us locate the correct practitioner.

Every practitioner is associated with a practice, be it a Group Practice or Individual Practice. The practice's Tax Id Number (TIN) and / or NPI Number (type II organization) will help us locate the correct practice.

Practitioner information

Enter the practitioner's Social Security Number (SSN) and the unique NPI Number (type I individual) to jump start this enrollment application.

* NPI Number (type I individual)

0011223344

Practice information

Enter the practice's Tax Id Number (TIN) and NPI Number (type II organization) to identify the practice to which this practitioner is associated. Individual practices do not provide an NPI Number (type II organization); the practitioner's NPI Number (type I individual) is sufficient. If the practitioner has acquired a unique Tax Id Number (TIN), such as an EIN, it can be entered here. If the practitioner uses their SSN as the TIN for the individual practice, do not enter it here.

Practice Type

Individual Practice | Group Practice

* Tax Id Number (TIN)

00-5555555

NPI Number (type II group)

How we protect your information ?

We use state of the art 256-bit encryption to protect your data from prying eyes. Your personal information is safe with us.

Save for later

Previous

Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
   - Provider Identifiers
   - Provider search results
   - Network pre-qualifications
   - Network selection
2. Practitioner Information
3. Upload Documents
4. Review & Sign
5. Submit

Provider search results

No Group Found

We didn't find a group practice based on the lookup criteria you entered.

We didn't find a group practice based on the lookup criteria you entered. Here are some things you'll need to have ready:

1. Location information
2. Office contacts
3. Office hours
4. EFT information
5. Accreditations
6. and more

Click *Previous* to revisit your entry information; click *Next* to start fresh and we will walk you through our enrollment application.

How we protect your information ?

We use state of the art 256-bit encryption to protect your data from prying eyes. Your personal information is safe with us.

Previous   Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
   - Provider Identifiers
   - Provider search results
   - Network pre-qualifications
   - Network selection
2. Practitioner Information
3. Upload Documents
4. Review & Sign
5. Submit

Network pre-qualifications

Before we dig in, let's be sure we get aligned to the right provider networks.

Are all of your locations in South Carolina?

- (●) Yes ( ) No

Does the practice offer telehealth visits or participate in telemedicine consults?

- ( ) Yes (●) No

Are you a Behavioral Health or Autism Provider?

Behavioral Health Provider | Autism Provider

* Speciality Code

207Q00000X - Family Medicine Physician

How we protect your information ?

We use state of the art 256-bit encryption to protect your data from prying eyes. Your personal information is safe with us.

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Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
   - Provider Identifiers
   - Provider search results
   - Network pre-qualifications
   - Network selection
2. Practitioner Information
3. Upload Documents
4. Review & Sign
5. Submit

Network selection

Here are the available networks that align based on what we know. Select the networks for this enrollment application.

* Available Networks

CBA Behavioral Health	Preferred Blue	Blue Essentials
Healthy Blue	Medicare Advantage	CBA Autism Panel
Blue Options	Blue Participating Dental	State Health Plan
BlueChoice HealthPlan		

Out of Network

How we protect your information?
We use state of the art 256-bit encryption to protect your data from prying eyes. Your personal information is safe with us.

Note that selecting a network does not guarantee approval; your application will be reviewed to determine eligibility.

Previous | Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
   - Provider Identifiers
   - Provider search results
   - Network pre-qualifications
   - Network selection
   - Practice Information
   - Business Information
2. Practitioner Information
3. Upload Documents
4. Review & Sign
5. Submit

Practice Information

Please provide information about your primary practice. Your primary practice is the main location where you provide healthcare services.

Primary Practice

Your primary practice is the main location where you provide healthcare services.

* Practice Name: ABC Family

* Tax Id Number (TIN): 00-5555555

* NPI (type II organization): 0099999999

* Medicaid Id: 01234567890

Medicare Number:

Medicare Certificate Date:

* Website: https://www.abcfamily.com

* Office Email: abcfamily@yahoo.com

Is this practice to be included in the directory?

Yes No

How we protect your information?
We use state of the art 256-bit encryption to protect your data from prying eyes. Your personal information is safe with us.

Save for later | Previous | Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
   - Provider Identifiers
   - Provider search results
   - Network pre-qualifications
   - Network selection
   - Practice Information
   - Business Information
2. Practitioner Information
3. Upload Documents
4. Review & Sign
5. Submit

Business Information

Please provide your business name, owner details,

Business Names

* Legal Business Name: ABC Family
* Doing Business As (DBA): ABC Family
* Date Established: 10-01-2024

☑ I own the business / am a business owner.

☐ I have additional business owners to add.

Business Tax Identification

* Type: CP 575 E

Tax Id Number (TIN): 005555555

Required Document

Please upload a copy of your CP575E

Upload Document

Please upload a copy of the required file(s) below.

Drag and drop here, or choose a file

Note: You may proceed with the form and upload this document at a later time.

Uploaded Files

Business Example.docx
Successfully uploaded

Note: You may proceed with the form and upload this document at a later time.

Business License

All hospitals, institutions and other facilities must complete this section.

Business License #

Certification Date

Indicate the number of beds, excluding exempt units

Required Document

Please upload a copy of your Business License.

Upload Document

Please upload a copy of the required file(s) below.

Drag and drop here, or choose a file

Note: You may proceed with the form and upload this document at a later time.

Note: You may proceed with the form and upload this document at a later time.

Save for later | Previous | Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Group Information
2. Location Details
   - Location information
   - Hours of operation
   - Electronic funds transfer (EFT)
   - Accreditations
3. Practitioner Information
4. Upload Documents
5. Review
6. Submit

Location Details

Will we require a list of all satellite locations (that are possibly already in PIMS) or just the new satellite locations? If we are asking for the NEW satellite locations, then the verbiage needs to be updated to state NEW.

Location - What to Have Ready

Once we've established your primary location (either existing or new), you'll have an opportunity to add new satellite locations.

Location addresses

The physical address, as well as the billing & correspondance addresses, are necessary to complete this section.

Location contacts

Identify the office contacts for this location for credentialing, claims, billing, and others.

EFT information

Enter your financial institution's information so that we can quickly, efficiently process your claims. Note that you'll need a designated fiduciary contact as a signer

Accreditations

You'll need your accreditations as applicable, including the accrediting body, accreditation number, and the most recent assessment date.

> What is a primary location?

> What is a satellite location?

> Why do I need to provide information about my primary location?

What you'll see...

As you move through the next pages, you'll find a side navigation menu that will guide you smoothly through each step of the process.

Primary Practice Location

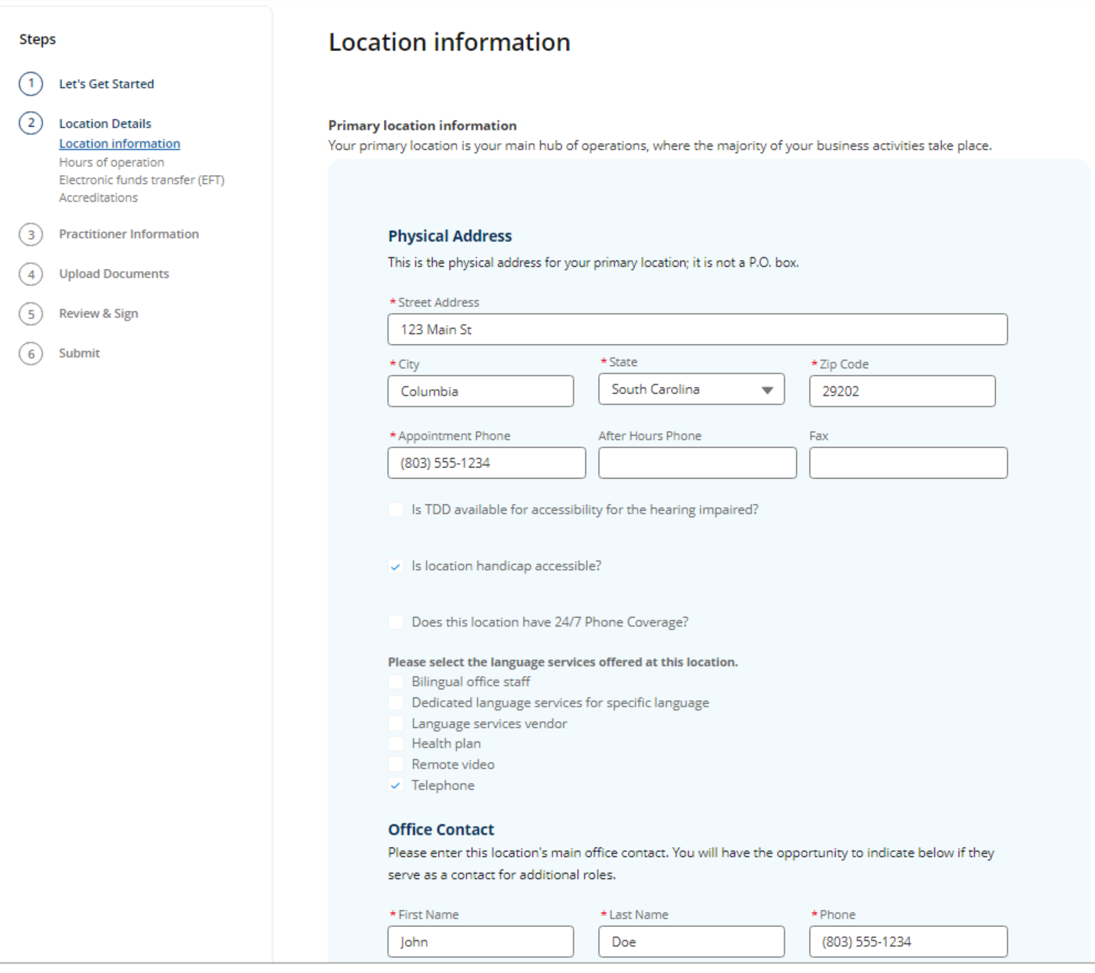
Your main hub of operations, where the majority of your business activities take place.

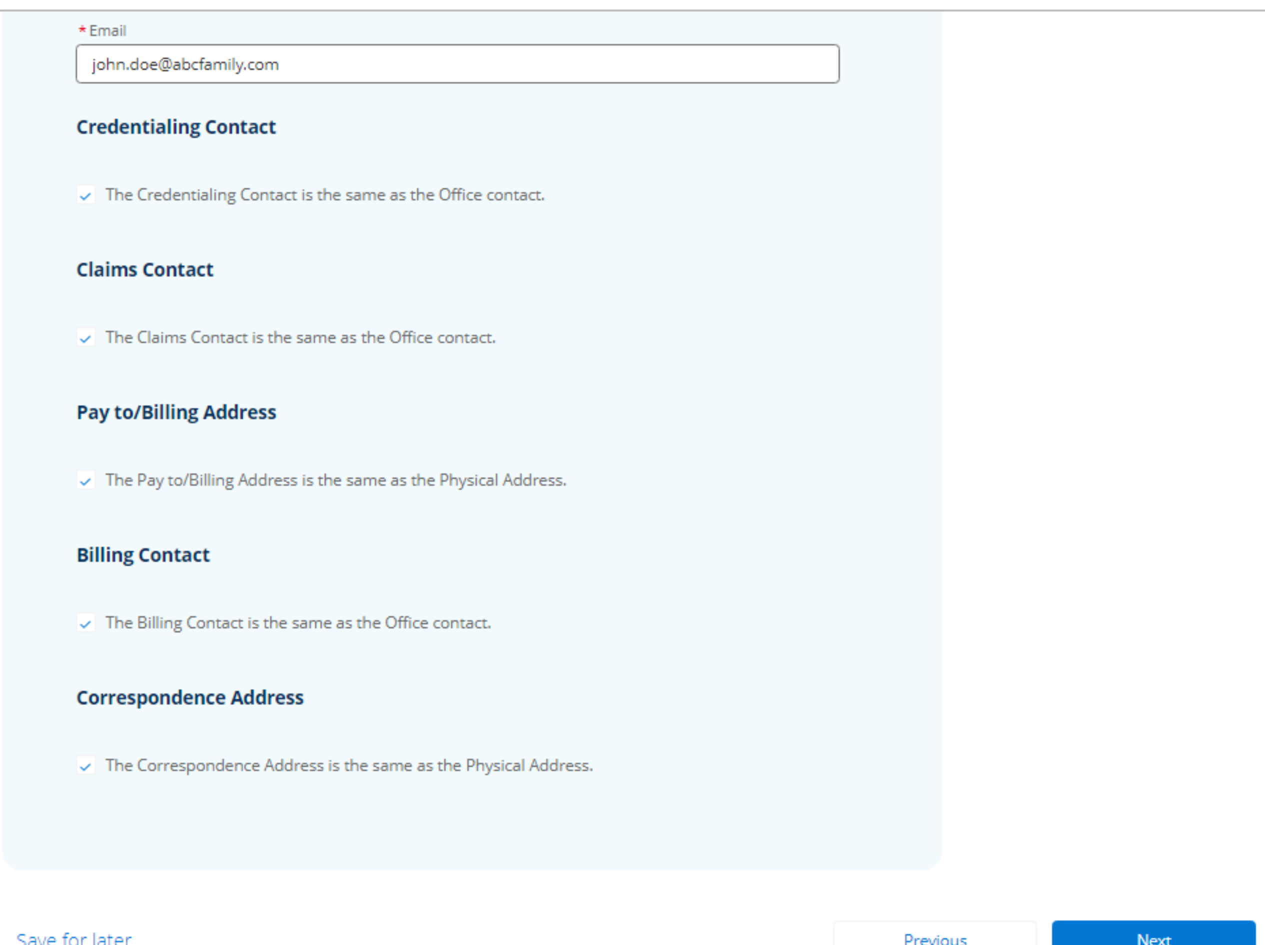
Satellite Locations

Additional locations that help in supporting and expanding your business operations.

Pay close attention to what's needed.

Example of an Individual Enrollment Application (Continued)





Example of an Individual Enrollment Application (Continued)

Steps

1. Group Information
2. Location Details
   - Location information
   - Hours of operation
   - Electronic funds transfer (EFT)
   - Accreditations
3. Practitioner Information
4. Upload Documents
5. Review
6. Submit

Hours of operation

Please enter the hours of operation for the location, including the days and times your office is open to patients.

Applying Times to Open Days

Note that you can enter a single day's start time and end time. When you click the button *Copy Times*, we'll apply the entered times to each day of the week that the office is open.

Copy times to all open days

Day of the Week	*Start Time	To	*End Time	
Monday	08:30 am	To	05:00 pm	Open
Tuesday	08:30 am	To	05:00 pm	Open
Wednesday	08:30 am	To	05:00 pm	Open
Thursday	08:30 am	To	05:00 pm	Open
Friday	08:30 am	To	05:00 pm	Open
Saturday		To		Closed
Sunday		To		Closed

Save for later

Previous Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Location Details
   - Location information
   - Hours of operation
   - Electronic funds transfer (EFT)
   - Accreditations
3. Practitioner Information
4. Upload Documents
5. Review & Sign
6. Submit

Electronic funds transfer (EFT)

Please provide your banking details to set up Electronic Funds Transfer (EFT) for payments. EFT allows for secure and efficient direct deposit of payments into your bank account, ensuring timely and accurate reimbursement for services rendered.

Financial Institution Information

Provide the details of your bank, including the bank name, account number, and routing number, to set up or update your EFT.

*Financial Institution Name: Bank of America

*Street Address: 1000 Sumter St

*City: Columbia | *State: South Carolina | *Zip Code: 29201

*Routing Number: 999999999 | *Account Number: 111222333444

Requested EFT Start/Change Date

*Start Date: 10-01-2024

Fiduciary Contact

Please enter a fiduciary contact who can confirm your banking information. This is typically a CFO, CEO, business owner or other individual with financial signing authority.

***Are you authorized to sign?**

- (●) Yes
- ( ) No

Save for later | Previous | Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Location Details
   - Location information
   - Hours of operation
   - Electronic funds transfer (EFT)
   - Accreditations
3. Practitioner Information
4. Upload Documents
5. Review & Sign
6. Submit

Accreditations

Please select *Yes* on the accreditations and certifications that pertain to your location and upload the corresponding document.

CLIA Certification

Enter your Clinical Laboratory Improvement Amendments (CLIA) certification details. All hospitals, institutions and other facilities must complete this section.

***Does this location bill for lab services?**

Yes No

***Do you have a CLIA certificate?**

Yes No

*Certification Number

AB987654

*Test Numbers

15

*Effective Date

09-01-2024

*Expiration Date

12-31-2026

Upload CLIA Certificate Document

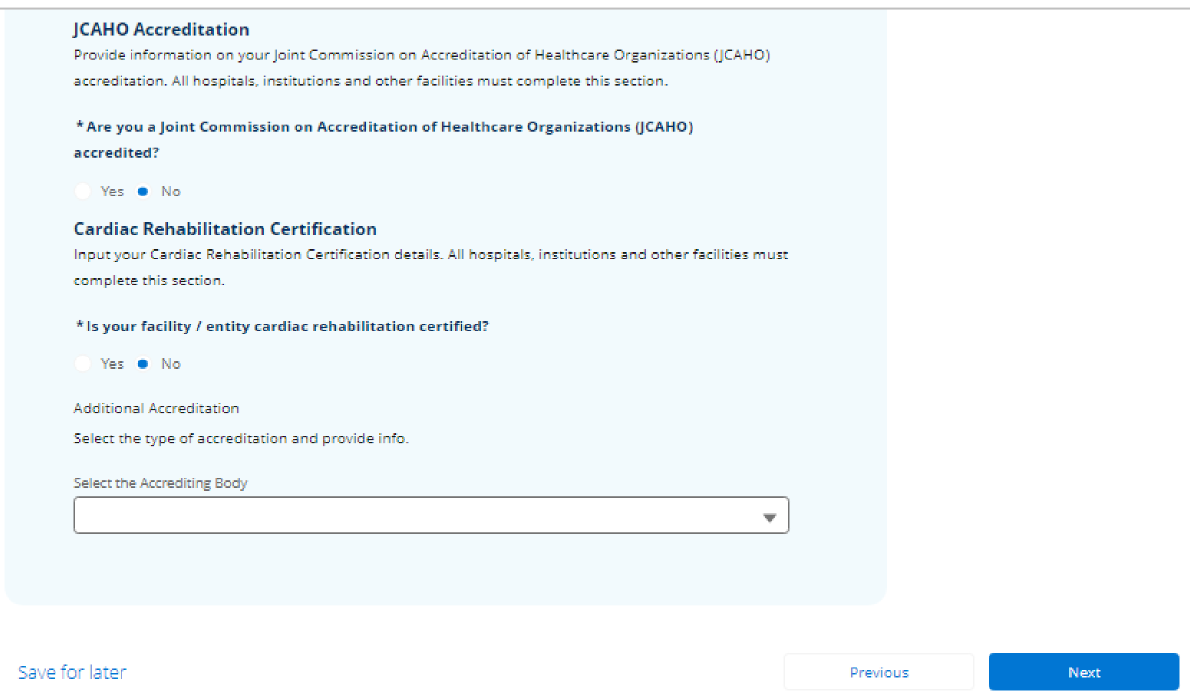
Please upload a copy of the required file(s) below.

Drag and drop here, or choose a file

Note: You may proceed with the form and upload this document at a later time.

Uploaded Files

CLIA Example.docx
Successfully uploaded



Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Practitioner Information
   - Practitioner information
   - Professional qualifications
   - Educational History & Training
   - Employment history
   - Hospital privileges
   - Patient Population
3. Upload Documents
4. Review
5. Submit

Practitioner Information

Practitioner - What to have ready

We'll walk you through setting up a new practitioner, and ensuring they are aligned with the correct group practice or established as an individual practice.

Contact Information
The full name, former surname(s), phone & preferred email are all important information we collect for each practitioner.

Demographic Information
In addition to capturing gender, race and ethnicity, we'll also capture the practitioner's language(s).

Professional qualifications
The practitioner's care specialty, state medical license, and board certification are all required.

Employment
Aside from establishing current employment for the practitioner, we collect employment history up to 5 years (which can also span to include education and professional training).

Education & professional training
The practitioner's relevant degrees and training (including the highest degree) are required. We also require residency for MDs, DOs, & DPMs.

Authorization to Bill
For practitioners that are part of a group practice, they will sign off for the group on their authorization to bill.

Previous | Next

Pay close attention to what's needed.

Example of an Individual Enrollment Application (Continued)

This script has been automatically saved, in order to resume in the future: Copy the link or Email me the link

Steps

1. Let's Get Started
2. Practitioner Information
   - Practitioner information
   - Professional qualifications
   - Educational History & Training
   - Employment history
   - Hospital privileges
   - Patient Population
3. Upload Documents
4. Review
5. Submit

Practitioner information

Contact information

Please enter the practitioner's name and identifying information as accurately as possible to ensure smooth processing.

Field	Value
* First Name	Jason
Middle Name	
* Last Name	Doe
Title	
Suffix	
Former surnames/Maiden Names	
* Social Security Number	444-11-4444
* Date of Birth	07-13-1970
Tax Id	
NPI Group	
* NPI Number (type I individual)	1444444444
Medicaid ID	
Medicare Number	

Preferred Email

Please provide the practitioner's preferred email so that they will be able to sign their application package.

* Practitioner's preferred email: jason.doe@twoonone.com

Demographic information

Providing language information is important and will be displayed in the directory

Field	Value
* Gender	Male
* Race	Black or African American
* Ethnicity	Not Hispanic or Latino

Languages

Field	Value
* Primary Spoken Language	English
* Secondary Language	French
* Do you provide a translation service?	No

*** Do you offer Sign Language?**

Yes ● No

Authorization to bill

The practitioner will sign off an authorization to bill alongside the practice. Please verify the date this authorization to bill is to take effect. This is the date from which the practitioner is allowed to submit claims for services rendered. This date should align with the practitioner's start date with the group practice.

Auth to Bill Effective Date: 10-01-2024

✓ I authorize to bill on my behalf

Save for later | Previous | Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Location Details
3. Practitioner Information
   - Practitioner information
   - Professional qualifications
   - Educational history
   - Professional training
   - Employment history
   - Hospital privileges
   - Patient Population
4. Upload Documents
5. Review & Sign
6. Submit

Professional qualifications

As we review your application, we will look to ensure that the care taxonomy specialty code(s) you enter align to the credentials you provide. Please take a moment to select the correct specialty and provide the pertinent license(s) and certification(s) so that the credentialing process is a smooth one.

Care Taxonomy Lookup

The practitioner's care taxonomy & specialty help ensure we get the right credentials for verification. Please enter the 10-character code, or use a keyword search, to find your specialty. We can take up to two specialties.

*Primary Speciality
207Q00000X - Family Medicine Physician

Secondary Speciality

State Medical License

Enter all state medical license detail, including the issue date and expiration date.

*Professional Designation	*Provider's License Type	*License Number
MD - Medical Doctor	State Medical License	ABC9999
***State**	***Issue Date**	***Expiration Date**
South Carolina	01-13-2015	12-31-2025

Upload State Medical License Document

Please upload a copy of the required file(s) below.

Please upload a copy of the required file(s) below.

Drag and drop here, or choose a file

Note: You may proceed with the form and upload this document at a later time.

Uploaded Files

State Example.docx
Successfully uploaded

Save for later | Previous | Next

Example of an Individual Enrollment Application (Continued)

Educational History & Training

Educational History

Please provide detailed information about your educational history, including degrees earned, institutions attended, and date of completion, to help us verify your academic qualifications.

What determines a full educatio
Please be sure to include the institution
you have less than 5 years of employme
picture of the practitioner's professional

* Educational Level: Medical School
* Program Name: MD
* Start Month: August
* Year: 2005
* End Month: December
* Year: 2014
* City: Greenville
State: South Carolina

Degree Conferred

☑ Individual asserts they have completed their education and holds the qualifications associate

Delete | Add Degree

* Educational Level: Masters Program
* Program Name: Biology
* Start Month: August
* Year: 2001
* End Month: March
* City: Rock Hill
State: South Carolin

Degree Conferred

☑ Individual asserts they have completed their education and holds th

Professional Training

If the practitioner has completed an internship, fellowship or reside professional training. You may add additional entries / remove entr

☑ Add Trainings

Training

* Training Type: Professional Training
* Institution Name: USC Greenville
* Program Name: Residency
City: Greenville
Country: United States
State: South Carolina

☐ I am actively taking this training/program

* Start Date: 02-03-2015
* End Date: 12-31-2017

Cultural Competency Training

We verify that our practitioners have completed a cultural compentency training as part of our enrollment process. Have you completed a cultural competency training?

○ Yes ● No

Complete your training at MyDiversePatients.com

Save for later | Previous | Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Location Details
3. Practitioner Information
   - Practitioner information
   - Professional qualifications
   - Educational history
   - Professional training
   - Employment history
   - Hospital privileges
   - Patient Population
4. Upload Documents
5. Review & Sign
6. Submit

Employment history

Employment History

Please provide detailed information about the past five years of your employment history. Be sure to provide an explanation for work history gaps; any gap greater than 6 months requires an explanation.

Delete   Add Additional Employment

Employment Entry

Provide the timeframe and detail for the employment entry.

Employer Name	* Start Month	* Year
ABC Family	October	2024

Are you currently employed at this organization?

(●) Yes ( ) No

Employment Gap

For any employment gap greater than 6 months, please provide additional information for this timefra

☐ Practitioner had gap of employment.

Delete   Add Additional Employment

Employment Entry

Provide the timeframe and detail for the employment entry.

Employer Name	* Start Month	* Year	* End Month	* End Year
Spring Valley Family	August	2013	October	2024

Are you currently employed at this organization?

( ) Yes (●) No

Employment Gap

For any employment gap greater than 6 months, please provide additional information for this timeframe.

☐ Practitioner had gap of employment.

Save for later   Previous   Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Location Details
3. Practitioner Information
   - Practitioner information
   - Professional qualifications
   - Educational history
   - Professional training
   - Employment history
   - Hospital privileges
   - Patient Population
4. Upload Documents
5. Review & Sign
6. Submit

Hospital privileges

Hospital Privilege Information

Do you have privileges at any hospital facility?

*** Do you have privileges at any hospital facility?**

Yes No

Describe arrangements for hospital care:

Send the patient to the emergency room.

Save for later | Previous | Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Location Details
3. Practitioner Information
   - Practitioner information
   - Professional qualifications
   - Educational history
   - Professional training
   - Employment history
   - Hospital privileges
   - Patient Population
4. Upload Documents
5. Review & Sign
6. Submit

Patient Population

Population Details

Please answer the following questions regarding the practitioner's patient population.

*Are there patient gender restrictions?

Yes No

*Are there patient age limitations?

Yes No

*Minimum Patient... 0

*Maximum Patien... 75

*Do you have any other patient limitations?

Yes No

Save for later

Previous Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Location Details
3. Practitioner Information
4. Upload Documents
   - Speciality Board Certification
   - Malpractice Insurance
   - Federal DEA license
5. Review & Sign
6. Submit

Upload Documents

Upload your licenses

Save for later

Previous

Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Practitioner Information
3. Upload Documents
   - Speciality Board Certification
   - Malpractice Insurance
   - Federal DEA license
4. Review
5. Submit

Speciality Board Certification

Please take a moment to review your information for accuracy before we begin your application

*** Are you board certified?**

○ Yes ● No

Are you qualified to sit for the examination?

○ Yes ● No

Save for later

Previous | Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Practitioner Information
3. Upload Documents
   - Speciality Board Certification
   - Malpractice Insurance
   - Federal DEA license
4. Review
5. Submit

Malpractice Insurance

Add Additonal Insurance

Select if more than one is needed due to malpractice crossover dates.

Field	Value	Field	Value
*Carrier's Name	Cover Me	*Policy Number	911
*Street	1500 Hampton St.	*City	Columbia
*State	South Carolina	*Zip Code	29201
*Effective Date	09-01-2024	*Expiration Date	09-01-2025
*Coverage Amount (Each Occurrence)	$1 million	*Coverage Amount (Aggregate)	$3 million

Upload Malpractice Insurance Document

Please upload a copy of the required file(s) below.

Drag and drop here, or choose a file

Note: You may proceed with the form and upload this document at a later time.

Uploaded Files

Malpractice Example.docx
Successfully uploaded

Save for later | Previous | Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Location Details
3. Practitioner Information
4. Upload Documents
   - Speciality Board Certification
   - Malpractice Insurance
   - Federal DEA license
5. Review & Sign
6. Submit

Federal DEA license

Is the practitioner eligible to hold a DEA license?

*** Are you eligible to hold a DEA license?**

Yes No

*** Is the practitioner DEA certified?**

Yes No

* License #: AB1234567

* Issue Date: 01-01-2015

Upload DEA Registration Document

Please upload a copy of the required file(s) below.

Drag and drop here, or choose a file

Note: You may proceed with the form and upload this document at a later time.

Uploaded Files

DEA Example.docx
Successfully uploaded

Save for later

Previous Next

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Practitioner Information
3. Upload Documents
4. Review
5. Submit

Review

Save for later

Previous | Next

Note: Review your application before selecting Next. Also, if any additional uploads are needed, they will be requested here.

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Location Details
3. Practitioner Information
4. Upload Documents
5. Review & Sign
6. Submit

Submit

Save for later

Previous

Submit Application

Example of an Individual Enrollment Application (Continued)

Search...

Archie

Home | Applications | Enroll | Maintain | Support

Submitted | Awaiting signatu... | Signed | Preliminary review | Secondary review | Final review | Approved | Denied | Cancelled | Withdrawn

Case #00001084 - Individual Application

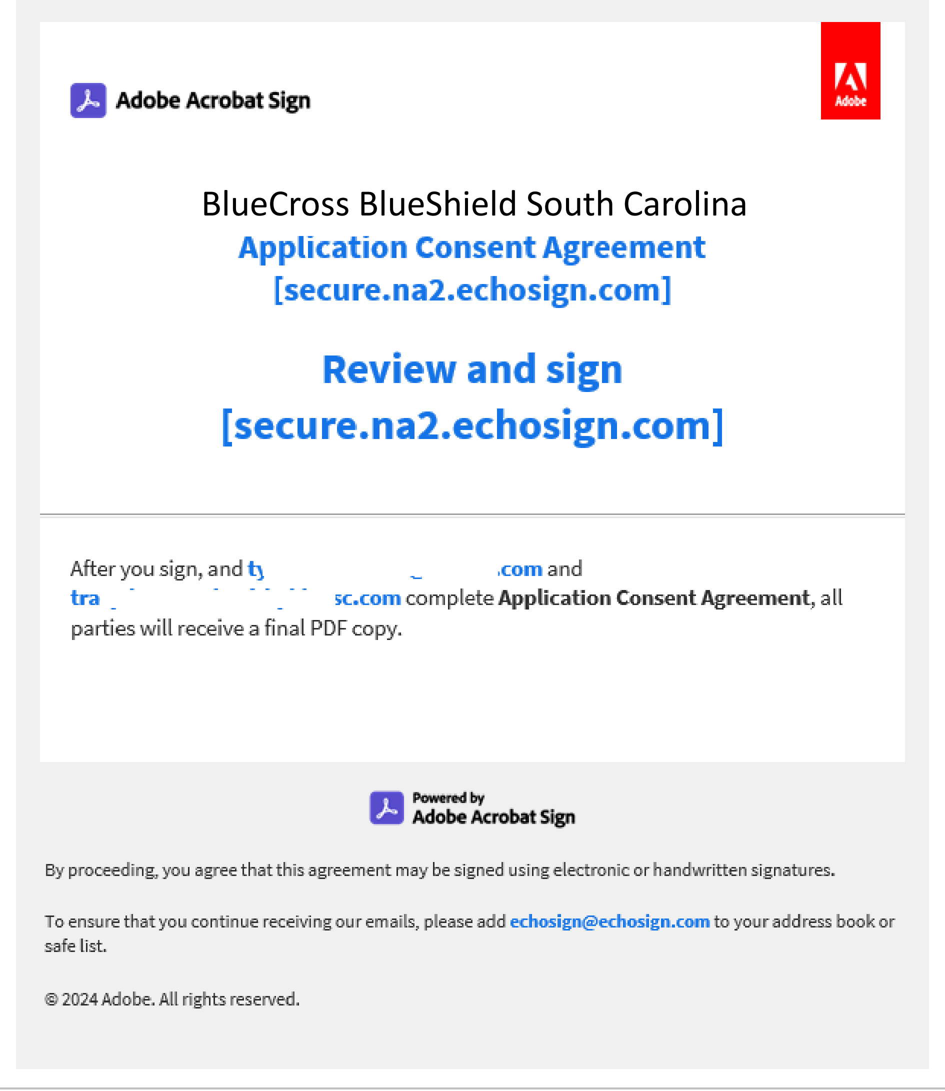
Provider Name James Doe	Status Submitted
Provider Practice ABC Family	Case Reference Number Case #00001084
Requested Networks *Blue Essentials;BlueChoice HealthPlan;Healthy Blue;Preferred Blue;State Health Plan*	Contact Name Terrence Archie
	Contact Practice / Company Brown Cardiology
Application Type Individual	

No Action required at this time.

Case Comments (0) New

Open Agreements

Example of an Individual Enrollment Application (Continued)



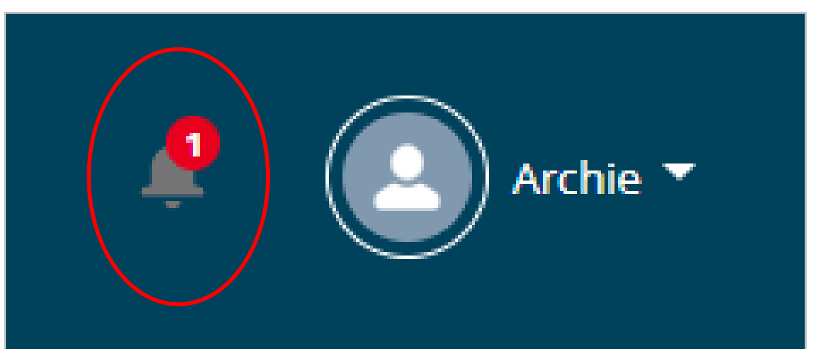
All appropriate parties will receive the appropriate document to sign.

All appropriate parties will receive confirmation once completed.

Making Corrections to Applications

Missing Items?

- If items are missing, you will see a notification once you log in.
- After selecting the notification bell, you will see details on the notice.

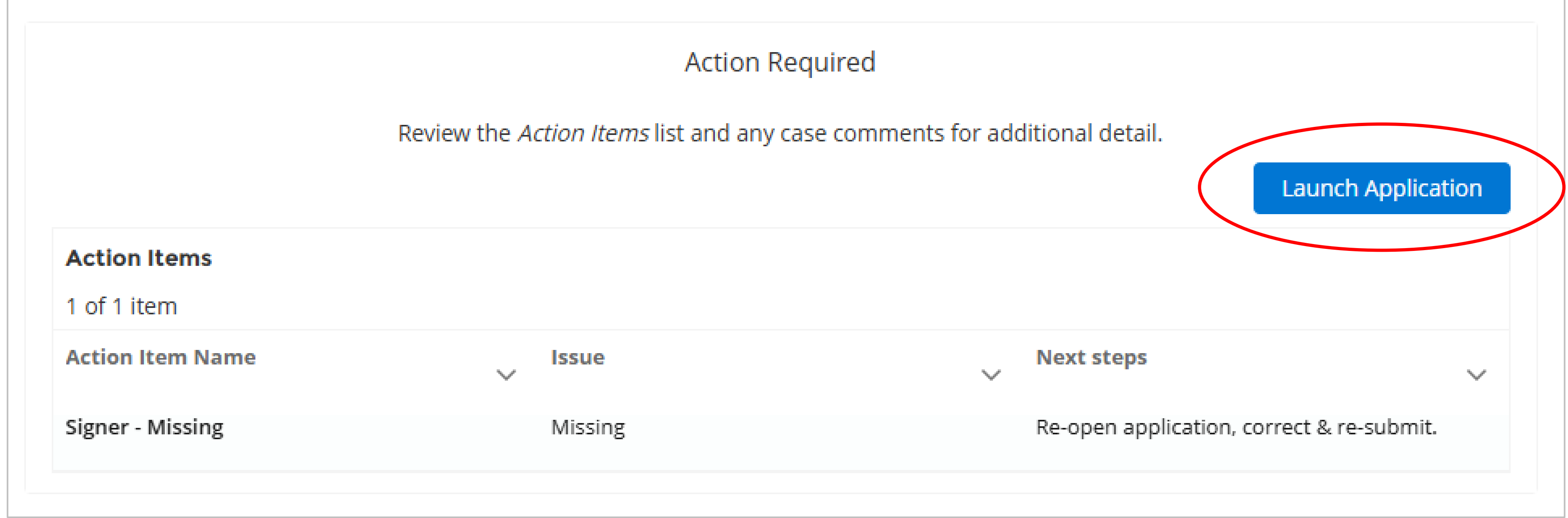


Correcting Applications

- ❑ All corrections must be made in the portal.
  - Allows the system to track the corrections and applies them to the appropriate fields
  - The newly system generated document will include the corrections and should be resigned.
- ❑ Handwritten or other altered corrections are not accepted and will be returned.

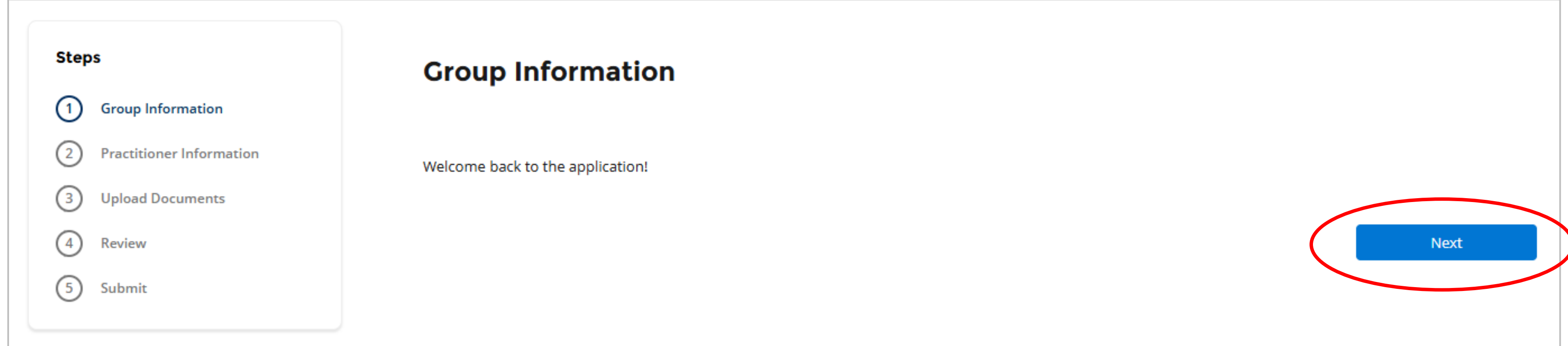
Steps for Making Corrections

- ❑ Review the action required.
- ❑ Select ***Launch Application*** to make the necessary corrections or to supply the requested items.

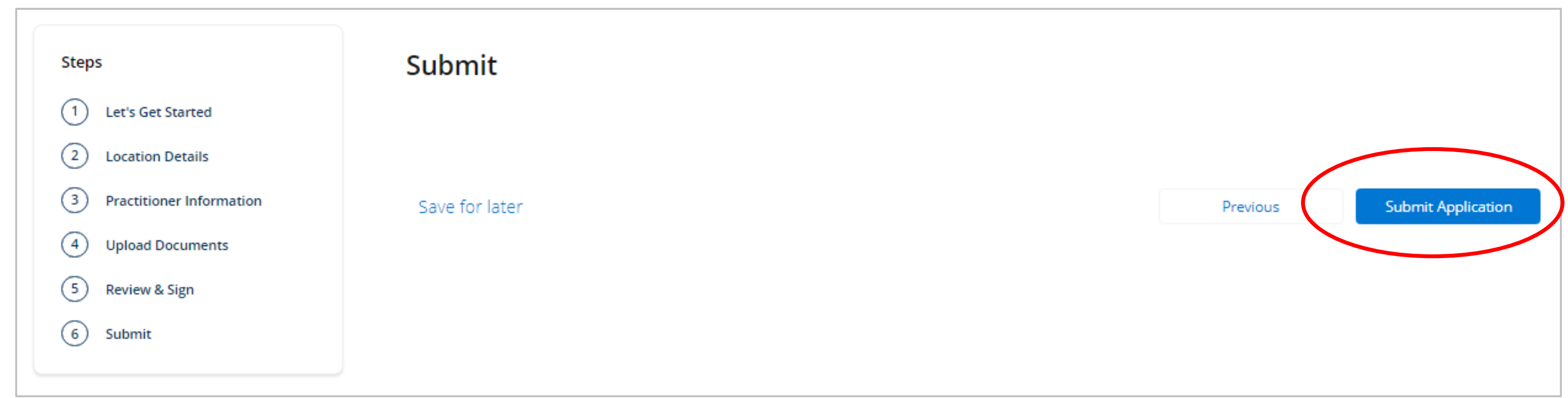


Steps for Making Corrections (Continued)

- ❑ You'll see the "Welcome back" message.
- ❑ Select ***Next*** to begin the process.



- ❑ Once all the necessary corrections are made, resubmit the case.



Important Reminders

Missing Items That Could Delay the Enrollment Process

Incorrectly signed applications or contracts

- ❑All applications and contracts must be signed by the appropriate parties (i.e., provider, fiduciary contact, etc.)

Invalid dates

- ❑Malpractice dates must be valid and active on or before the requested start date.
- ❑State licenses must be active with current dates.

Incomplete submissions or documentation

- ❑Licenses, certificates (CLIA, when applicable) and malpractice verification must be included with the application.

IMPORTANT NOTE:

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

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

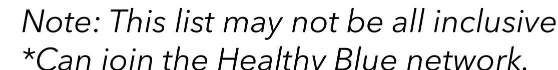
If the missing items are not received, the case will be placed in the "Cancelled" status.

Recredentialing Process

- **Recredentialing for established providers occurs every three years.**
  - If you need to know the upcoming recredentialing dates for a provider, email Recred.App@bcbssc.com.
    - Include the provider's name and NPI.
- **The credentialing team reaches out when the provider's recredentialing dates is approaching.**
  - First, the team calls to see if the provider is actively working at the location we have on file. If they are, the recredentialing application is sent by email or fax.
    - If a response is not received after the first outreach, a second attempt is made in 14 days.
    - If a response is not received after the second outreach, a third attempt is made in seven days.
    - If a response is not received after the third and final outreach, the process to terminate the provider is initiated.
- **If the recredentialing date is missed, the provider is termed, and new enrollment is required.**

Non-credentialed Providers

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



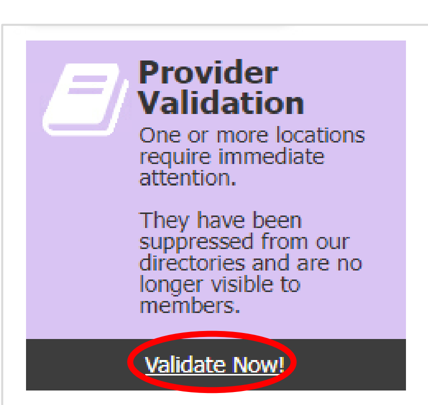
Note: This list may not be all inclusive.
**Can join the Healthy Blue network.*

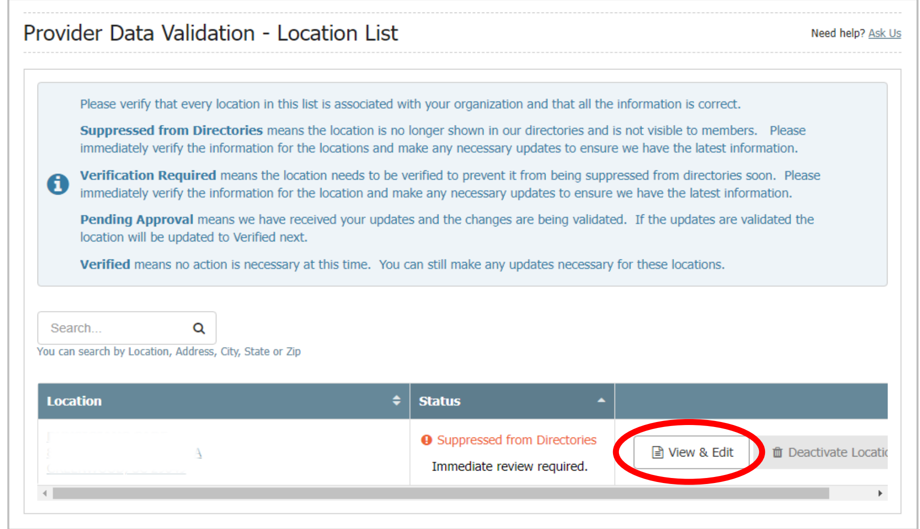
Provider Directory Validation

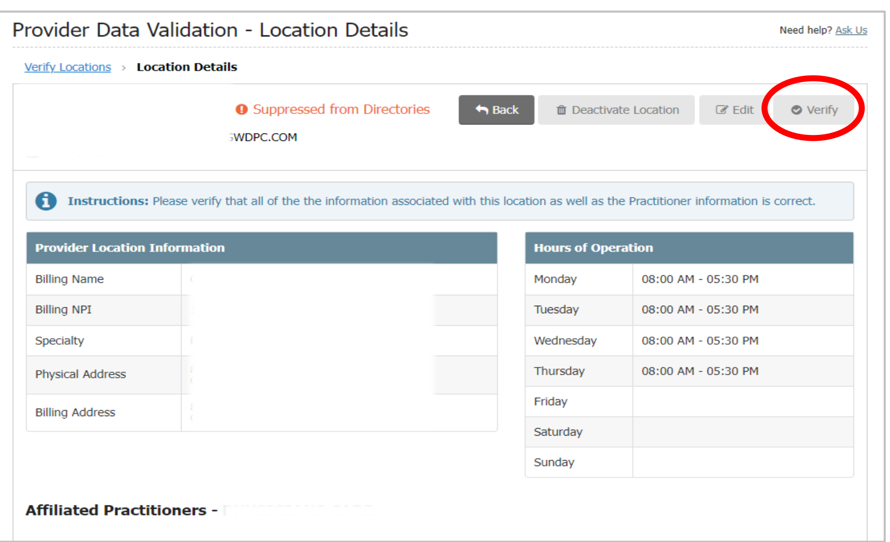
- Providers have been required to verify their demographic data at least ***every 90 days*** since Jan. 1, 2022.
  - This implementation was part of the No Surprises Act.
- Validation allows us to maintain accurate directories.
- Verification can be completed in M.D. Checkup (accessible through My Insurance Manager℠).
  - You can also respond to the email received from Provider.Directory@bcbssc.com.

Location Suppressions Due to Missing Validation

- Locations are suppressed in the provider directory if more than 90 days has passed since the last validation was made.
- To have the suppressed status updated, the profile administrator should:
  - Log into My Insurance Manager.
  - Select Validate Now in the Provider Validation box.
  - Select View an Edit from the location list.
  - Review the information, make any necessary updates and select Verify.







Making Demographic Updates

My Provider Enrollment Portal

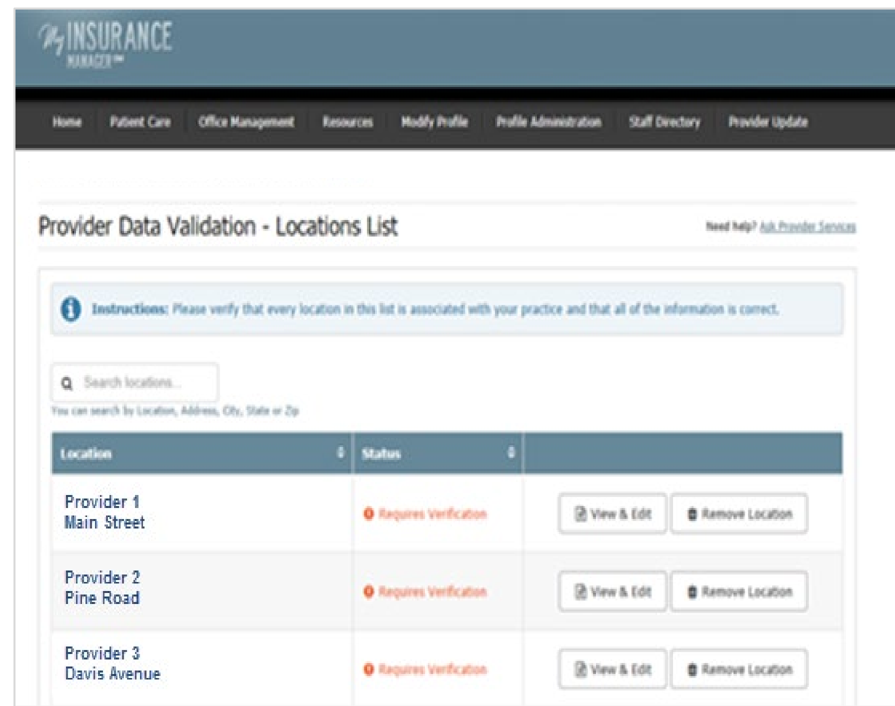
- ❑Doing Business As Name Change
- ❑Change of Address
- ❑Satellite Location
- ❑Add or Terminate Practitioner Affiliation

M.D. Checkup

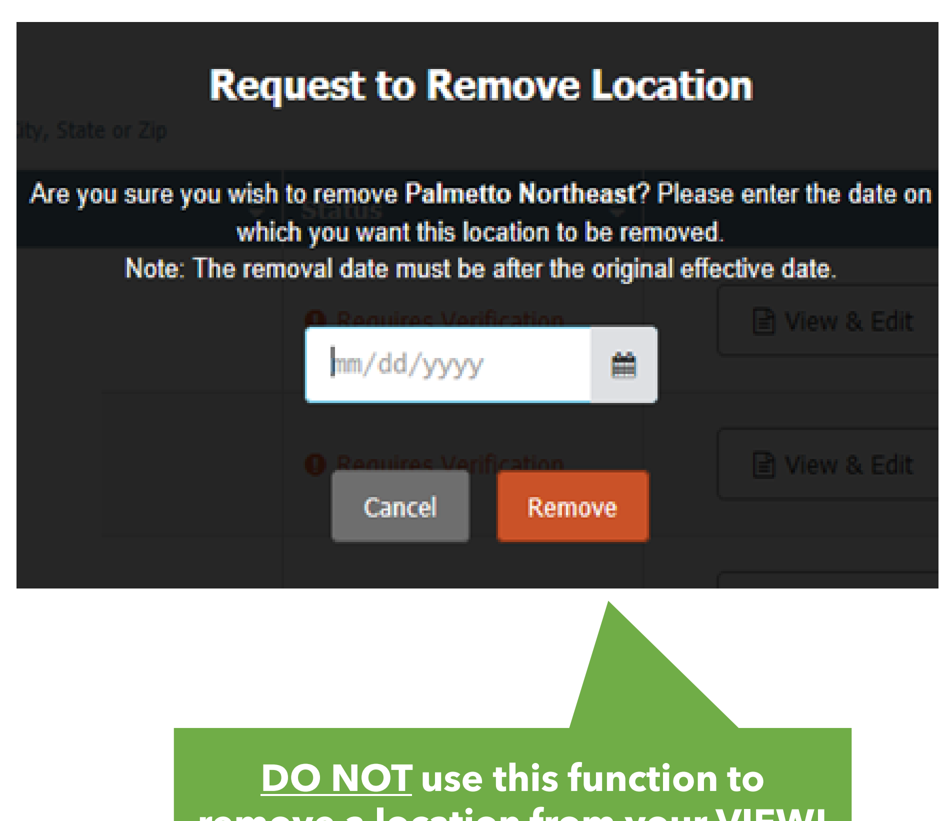
- ❑Terminate (close) Location
- ❑Add or Terminate Practitioner Affiliation

Note: You can only add a practitioner in M.D. Checkup if they are ***enrolled and associated*** *with the tax identification number (TIN).*

Terminating (Closing) Locations in M.D. Checkup



View & Edit | Remove Location



<u>DO NOT</u> use this function to remove a location from your VIEW!

Adding Practitioner Affiliations in M.D. Checkup

- The practitioner must be ***enrolled and associated*** with the Tax ID.
  - If you are trying to add a practitioner to a different Tax ID, you must complete and submit the ***Add Practitioner Form*** in My Provider Enrollment Portal.
- Example:
  - TIN A – 123456789
    - Location 1: 123 Omega St., Columbia, SC 29203
    - Location 2: 456 Alpha Rd., Hopkins, SC 29061
  - TIN B – 987654321

Dr. Jane Doe is enrolled and associated with TIN A. She works at location 1 but is scheduled to see patients at location 2. She will be submitting claims for location 2 and needs to be added. Because Dr. Doe is already associated with TIN A, she can be added to location 2 through M.D. Checkup.

Dr. Jane Doe is enrolled but not associated with TIN B. She is scheduled to see patients at this new location. Because Dr. Doe is not associated with TIN B, the Add Practitioner Form must be completed and submitted through My Provider Enrollment Portal.

Available Resources

What Resources Are Available

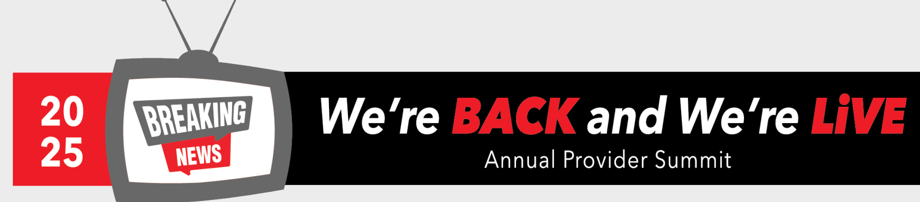
- Visit www.SouthCarolinaBlues.com and use the following path to access great resources for the portal and provider enrollment.
  - Providers>Provider Enrollment>***Join Our Networks***

My Provider Enrollment Portal Manual

Provider Enrollment Presentation

Provider Enrollment FAQs

Quality



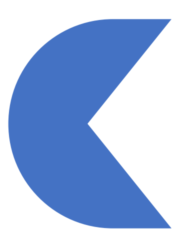
Topics to Discuss

- ❑ About Us
- ❑ National Committee for Quality Assurance (NCQA®)
- ❑ Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- ❑ Healthcare Effectiveness Date and Information Set (HEDIS®)
- ❑ Request for Information
- ❑ Lines of Business
- ❑ Quality Navigator Program
- ❑ Risk Adjustment Data Validation (RADV)
- ❑ Key Takeaways

About Us

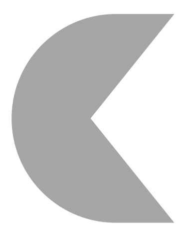
About Us

Healthcare Innovation and Improvement (HII) Quality Department



Vision: To ensure a Quality experience with every interaction.

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



Committed to working with YOU to better serve our members.

NCQA

National Committee for Quality Assurance

NCQA

NCQA is a private organization dedicated to improving healthcare quality by developing quality standards and performance measures.

Is a nonprofit organization that measures provider and health plan care quality and offers accreditation to high performing organizations.

Healthcare Effectiveness Data and Information Set (HEDIS) coordination

Provider involvement

NCQA (Continued)

What does NCQA mean to Providers?

Contract

Bonuses Incentives

Provider performance in HEDIS measures often impacts the level of bonus and incentive payouts. Providers have the potential to earn through Value-Based Care, PCMH+ program, the PCMH+ Kids program, as well as through the Accountable Care Organizations offerings that have the upside and downside risk.

Reporting

Data to the plan

When you report services rendered to our members back to us, it is a Win-Win for both of us. It helps us report HEDIS rates accurately & It helps you with your Quality Payment Program through CMS by impacting the Merit-Based Incentive Payment System (MIPS) and/or Alternative Payment Model (APM).

Safety

Patient

Through NCQA, we are able to maintain a high-level of patient safety by providing you with accurate and up-to-date information via quality-based reporting which can help you in making decisions on your patients care. This can help to reduce unwarranted procedures and duplicative care, should a member transitions between providers.

CAHPS

Consumer Assessment of Healthcare Providers and Systems

CAHPS

- It's a survey used to report on and evaluate patient experiences with healthcare.
- A random sample of members are offered a survey from February to May.

Consumer Satisfaction	Prevention	Treatment
Assesses patient's feedback ranking the health plan	Gauges patient's ranking of annual visits, vaccines, etc.	Measures the plan's consistency in providing recommended care

- The CAHPS survey represents the member or the patient experience portion of the HEDIS measure set. Once the survey is completed, plans submit CAHPS results to NCQA annually.

CAHPS (Continued)

- The survey asks specific questions about member experience with the providers.
- Here's an example of the CAHPS questions and some possible solutions if they arise:

Opportunities	Possible Solutions
Q22 – Rating of Specialist seen most often	❑ Listen to patient concerns and spend adequate time with them ❑ Engage the patient in discussions about medications ❑ Avoid using medical jargon and technical language
Q18 – Rating of personal doctor	❑ Ensure that providers are informed about the patient's relevant medical and person background ❑ Remain up-to-date on medical advancements ❑ Connect with the patient on a personal level ❑ Reduce wait times in the office
Q9 – Ease of getting care, tests, or treatment	❑ Conduct a thorough assessment of the patient's needs ❑ Treat patients with urgent issues promptly ❑ Provider care and service quickly ❑ Minimize wait times and communicate reasons for delays

HEDIS

Healthcare Effectiveness Date and Information Set

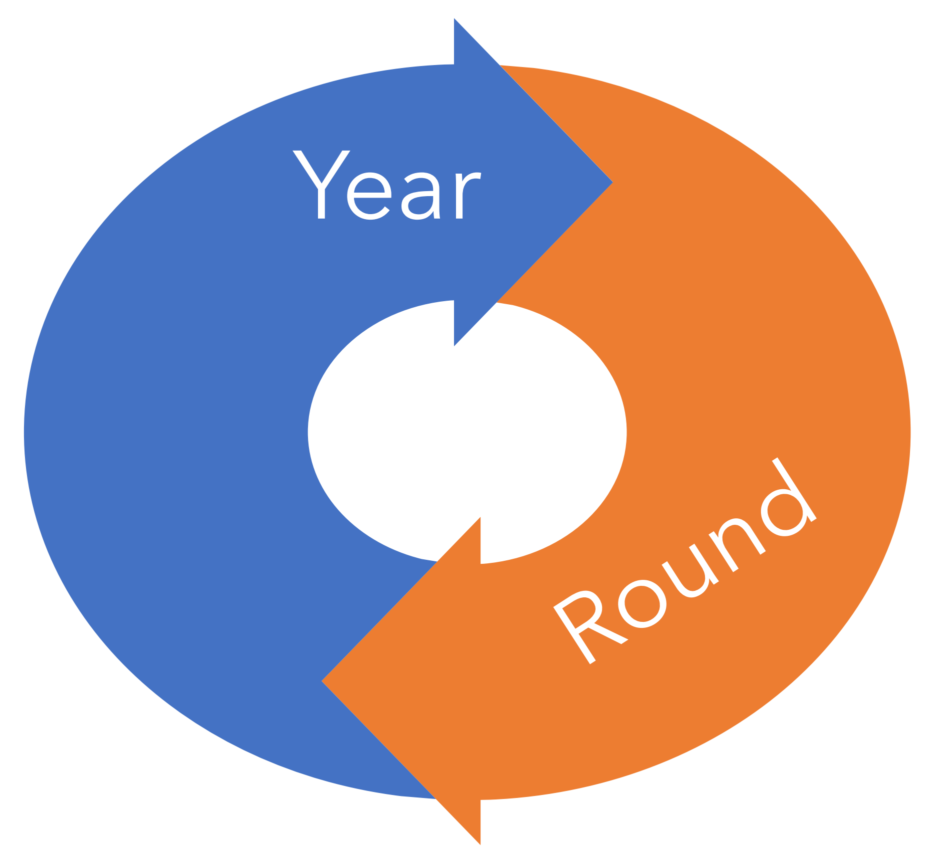
What is HEDIS?

- HEDIS is a tool that America's health plans use to measure performance on important dimensions of care and service.
- Its rates are designed to evaluate the effectiveness of a health plan's ability to demonstrate an improvement in its preventive care and quality measures to its members.

Entities Using HEDIS

HEDIS: Prospective Season

- Continuously monitors rates in real-time.
- Runs from Jan. 1 to Dec. 31 of the current or measurement year.
- All quality data collected throughout the year will reduce the burden on your practice during HEDIS Production season, increase accuracy of the monthly quality repots we share and may impact those incentives and contractual bonuses.



HEDIS: Prospective Season (Continued)

- Options for compliance include:
  - **Claims**: NCQA approved quality codes are going to be your fastest and easiest way to share this information. There is no manipulation of data or changes to normal business processes on your end or ours.
  - **Data transfer**: Electronic medical records (EMR) data transfer is how BlueCross BlueShield of South Carolina receives EMR data from providers. Please contact us at Navigator@bcbssc.com.
  - **Medical records**: Can also be accepted in Prospective season, but this a very labor-intensive option for both parties.
  - **Compliance forms**: The least preferred option, as these are just an attestation of care. If you submit a compliance form for a member, the form must be filled out in its entirety and submitted to BlueCross by Dec. 31 of the measurement year, and we may require a copy of the official medical record to prove the care for our auditor.
- **THE BIG TAKEAWAY**: By submitting appropriate quality codes via claims or submitting data transfers we will not need to request the actual medical record to verify services were completed during the measurement year.

HEDIS: Retrospective Season

- Also referred to as Retro or Hybrid season or HEDIS Production.
- Looks at the care given or due in the prior measurement year.
- Runs from January to May of the year following the measurement year.
- HEDIS MY2024 refers to care given or due in 2024, which will be evaluated from January to May 2025.
- All requested member documentation is based on the selected HEDIS measure by NCQA.
- **BIG REMINDER**: As a contracted provider, you are contractually obligated to respond to the HEDIS medical record requests.

On the Horizon

Method of collecting healthcare data through electronic systems, such as electronic health records (EHR), to improve the tracking, reporting, and analysis of clinical performance.

Providers use ECDS to ensure accurate and real-time data sharing across different healthcare settings, which is essential for maintaining quality care, patient safety, and meeting regulatory requirements.

For providers, both ECDS and HEDIS measures are crucial for:

1. Ensuring high-quality care delivery.
2. Meeting accreditation and regulatory requirements.

Hybrid measures are phasing out by MY 2030.

This represents a major impact on the way information is collected and reported, so we must all transition.

Request for Information

Request for Information

- Medical record requests are sent by email, fax or mail.
- Medical record requests are created based on the claims we receive from providers.
- Members are attributed to the primary care provider where the most claims have been received from over the last 18 months.
- Giving the Quality team remote access to your electronic health record (EHR) system allows them us to pull the medical records. This reduces the burden on the providers.
- Each medical record requests will be specific to the member and will include what information is needed to close the gap for a specific HEDIS measure.
- Providers must return the information listed in the box on the form.

Request for Information (Continued)

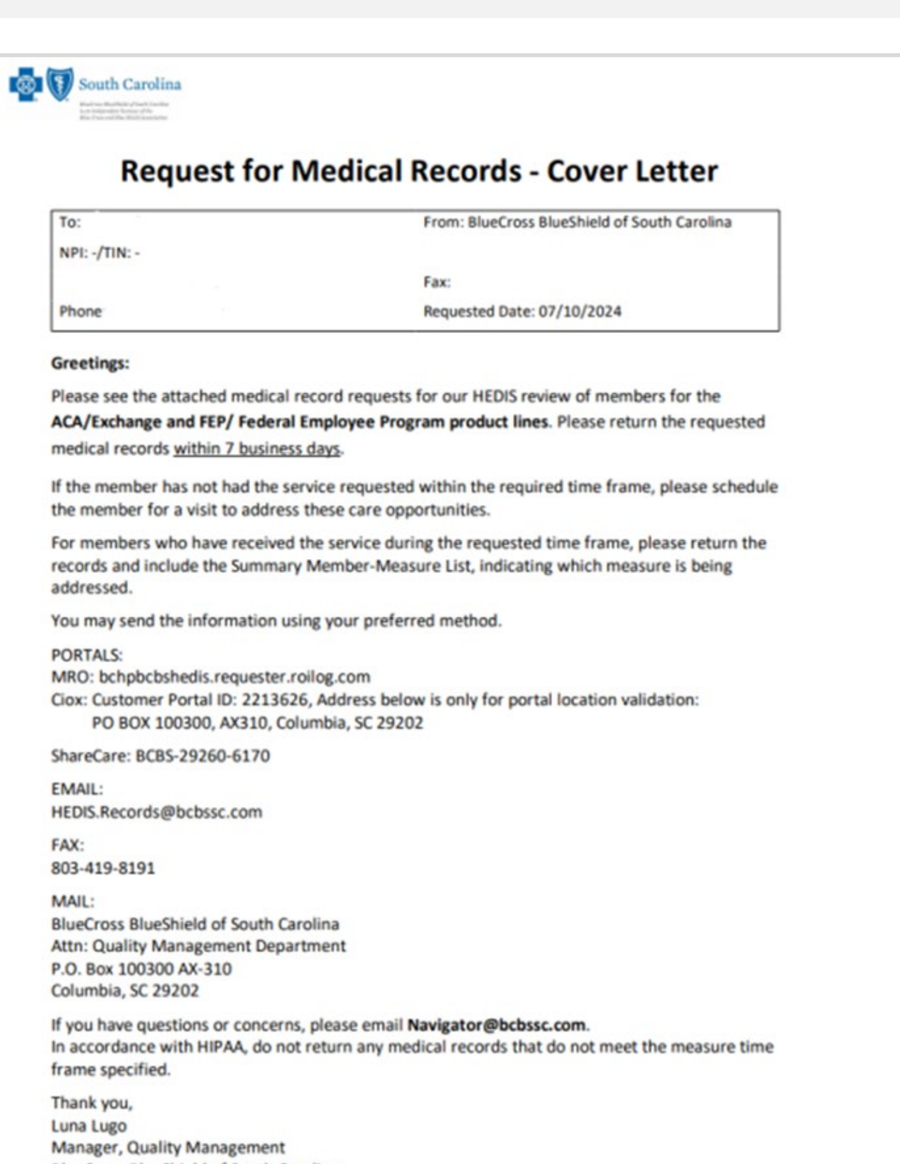
- Providers must return the information listed in the box on the form.
- Medical record requests will include the list of items needed along with the time frame to close the gap.

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

Demographics page -AND- All office visit/encounter notes from 01/01/2024 to 12/31/2024 -AND- Past Medical/Surgical history 2023 to 12/31/2024 -AND- All lab tests from 01/01/2024 to 12/31/2024 -AND- All consultation notes especially Urologist/Endocrinologists from to 12/31/2024

Request for Information (Continued)

- Example of a Request for Information cover letter for our Exchange and FEP plans.
- Request will be sent via email, fax or mail.
- Email the Quality Navigator of your preferred method of contact at Navigator@bcbssc.com.



South Carolina

Request for Medical Records - Cover Letter

To:	From: BlueCross BlueShield of South Carolina
NPI: -/TIN: -	
	Fax:
Phone	Requested Date: 07/10/2024

Greetings:

Please see the attached medical record requests for our HEDIS review of members for the **ACA/Exchange and FEP/ Federal Employee Program product lines**. Please return the requested medical records within 7 business days.

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

For members who have received the service during the requested time frame, please return the records and include the Summary Member-Measure List, indicating which measure is being addressed.

You may send the information using your preferred method.

PORTALS:
MRO: bchpbcbshedis.requester.roilog.com
Ciox: Customer Portal ID: 2213626, Address below is only for portal location validation:
PO BOX 100300, AX310, Columbia, SC 29202

ShareCare: BCBS-29260-6170

EMAIL:
HEDIS.Records@bcbssc.com

FAX:
803-419-8191

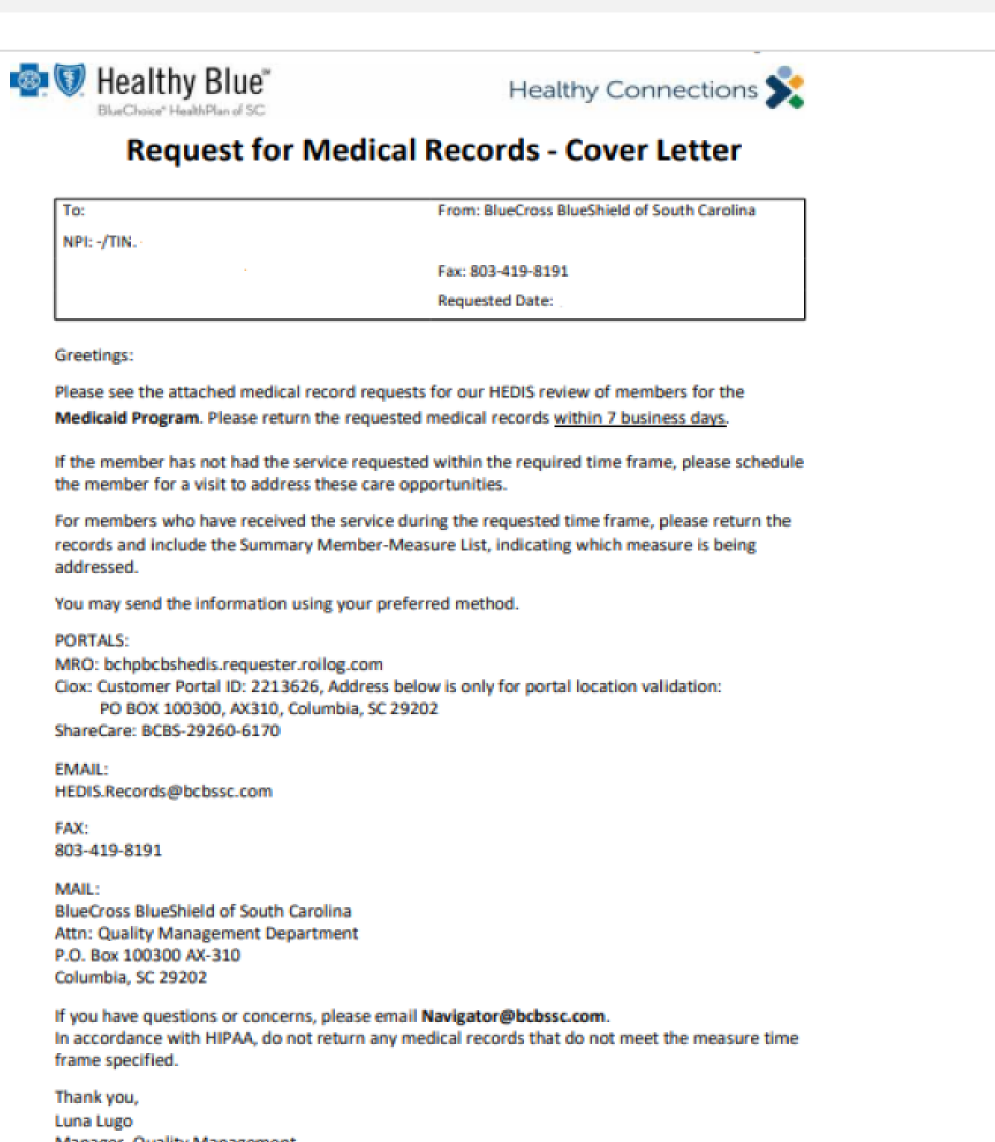
MAIL:
BlueCross BlueShield of South Carolina
Attn: Quality Management Department
P.O. Box 100300 AX-310
Columbia, SC 29202

If you have questions or concerns, please email **Navigator@bcbssc.com**.
In accordance with HIPAA, do not return any medical records that do not meet the measure time frame specified.

Thank you,
Luna Lugo
Manager, Quality Management
BlueCross BlueShield of South Carolina

Request for Information (Continued)

- Example of a Request for Information cover letter for our Healthy Blue (Medicaid) plan.
- Request will be sent via email, fax or mail.
- Email the Quality Navigator of your preferred method of contact at Navigator@bcbssc.com.



Healthy Blue
BlueChoice HealthPlan of SC
Healthy Connections

Request for Medical Records - Cover Letter

To:	From: BlueCross BlueShield of South Carolina
NPI: -/TIN.	Fax: 803-419-8191
	Requested Date:

Greetings:

Please see the attached medical record requests for our HEDIS review of members for the **Medicaid Program**. Please return the requested medical records within 7 business days.

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

For members who have received the service during the requested time frame, please return the records and include the Summary Member-Measure List, indicating which measure is being addressed.

You may send the information using your preferred method.

PORTALS:
MRO: bchpbcbshedis.requester.roilog.com
Ciox: Customer Portal ID: 2213626, Address below is only for portal location validation:
PO BOX 100300, AX310, Columbia, SC 29202
ShareCare: BCBS-29260-6170

EMAIL:
HEDIS.Records@bcbssc.com

FAX:
803-419-8191

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

If you have questions or concerns, please email **Navigator@bcbssc.com**.
In accordance with HIPAA, do not return any medical records that do not meet the measure time frame specified.

Thank you,
Luna Lugo
Manager, Quality Management
BlueCross BlueShield of South Carolina

Request for Information (Continued)

- ❑ Check the appropriate box and return the letter if you cannot find the patient, nor have medical records.
- ❑ Use My Insurance Manager (Office Management) to see Gaps in Care reports.
  - Gaps in Care reports are available monthly along with helpful documents for providers to access during the year.
  - Medicaid reports are sent separately by your Quality Navigator.

Please check the appropriate box:

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

Portal Locations:

MRO: bchpbcbshedis.requester.roilog.com
Ciox: Customer Portal ID: 2213626, Address below is only for portal location validation:
PO BOX 100300, AX310, Columbia, SC 29202
ShareCare: BCBS-29260-6170

EMAIL: HEDIS.Records@bcbssc.com

FAX: 803-419-8191

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

☐ No medical records found for the time frame requested
☐ Unable to locate patient in our system

Lines of Business

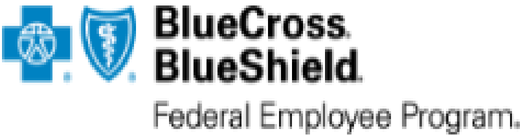
Lines of Business

- ❑ **Healthy Blue (Medicaid)**

- ❑ **Health Insurance Exchange (HIX or ACA)**

Independent licensees of the Blue Cross Blue Shield Association.

- ❑ **Federal Employee Program (FEP)**



Health Insurance Exchange (Marketplace)

- The Exchange Line of Business (LOB) covers health plans on the insurance marketplace.
- Used by more than 90 percent of the nation's health plans, employers and regulators.
- The current population has over 276,000 members.
- Measures Clinical, customer satisfaction and patient quality.
- CMS provides guidance to health plans for the Exchange LOB via the Quality Ratings System (QRS) and Quality Health Plan (QHP) Technical Specifications and call letter.
  - The Annual Call letter communicates updates/changes during the Measurement Year, as well as discusses future planning for the LOB.
- For the Exchange line of business, QRS are produced in a star-based rating. The overall rating includes member experience, medical care and health plan administration.

Federal Employee Program (FEP)

- Clinical quality, customer service and resource use (QCR).
- FEP program works based on priority measures that are weighted.
- This system is administered by the Federal Employee Plan Directors
- FEP is known to members as the Service Benefit Plan.
- Current State Population for FEP: Around 89,000.
- In January 2025, FEP will launch the Postal Service Health Benefit (PSHB) program. This program designation is for members within USPS. For 2025, we do not anticipate any impacts to our current quality structure.

Healthy Blue℠

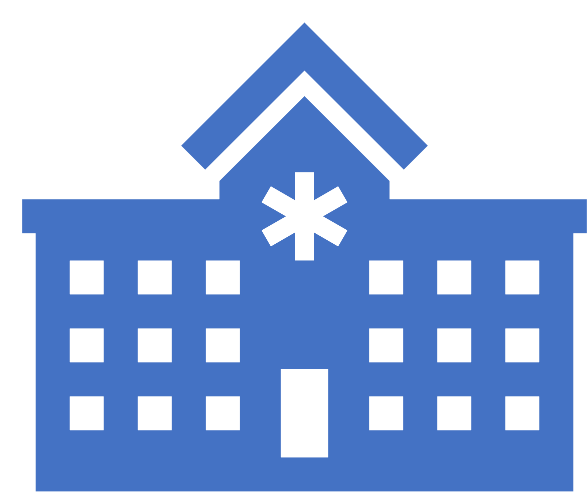
- Rating System
  - Reporting of all health plan rating measures is required.
  - Adult and child health care quality measures.
  - Core set of children's health care quality measures.
  - Audit will be completed by an outside vendor, then submitted to NCQA.
  - Additional information can be found on www.HealthyBlueSC.com.

Quality Navigator Program

Quality Navigator Program

Quality Navigator Model

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



Quality Navigator Program (Continued)

What is the Quality Navigator Program?

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

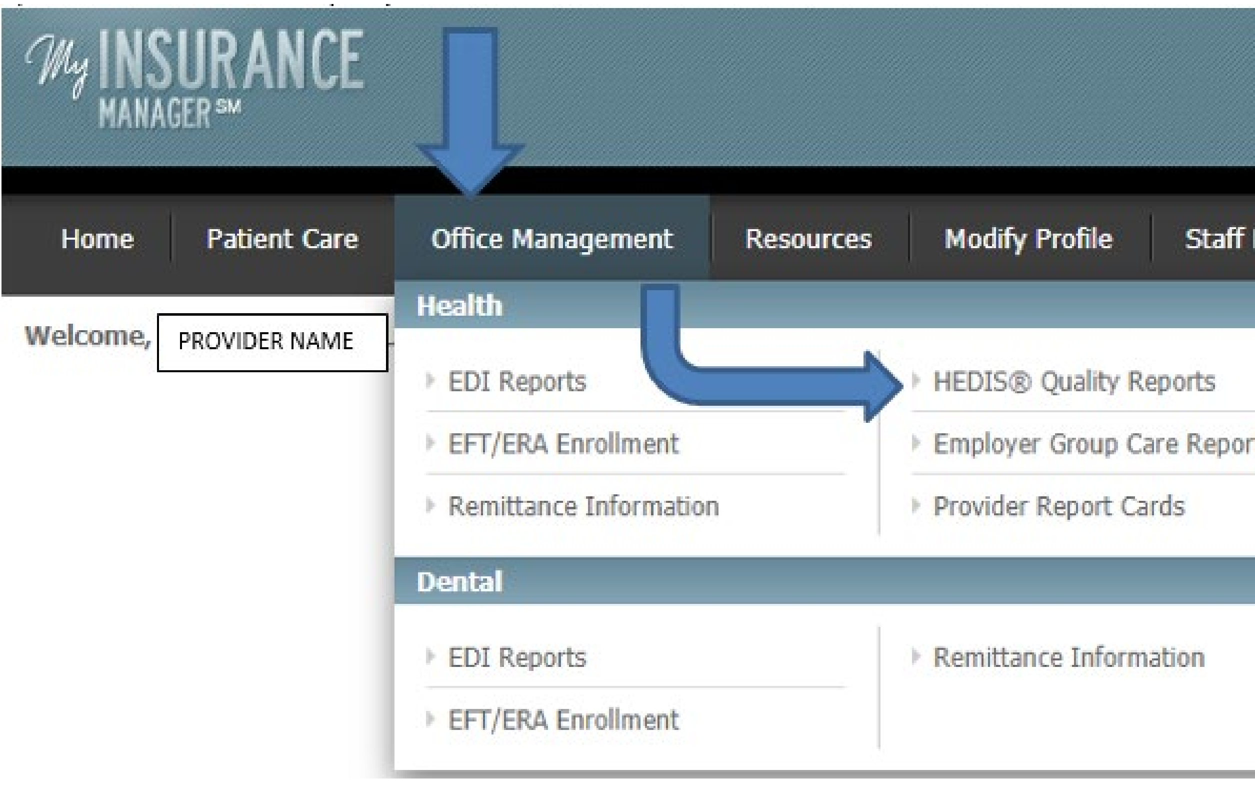
What is a Quality Navigator?

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

Quality Navigator Program (Continued)

My Insurance Manager

Use My Insurance Manager to access Care Opportunity Reports or Gap in Care (GIC) Report for Prospective Season.



Quality Navigator Program (Continued)

Understanding Care Opportunity Reports or Gap in Care (GIC) Report

- ❑ Past medical history has been added for members (▭)
- ❑ Non-compliance can be a true "gap" in care or a "gap" in data (▭)
  - A true gap in care or non-compliance is when the member has not received the care.
  - A data gap is when the member has received the care, but this information was not shared with the plan.
  - Either way, the member will remain listed as "non-compliant" until the care is given AND that information is shared with us.
- ❑ Gap in Care report are available to access for providers **monthly** on My insurance manager portal.

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

Incentives

Bump up to qualify for incentives by end of year to get bonuses or incentives.

HEDIS® Measures Coding Reference Sheet for Practitioners and Coders

Glycemic Status Assessment for Patients With Diabetes (GSD)

This measures the percentage of members 18-75 years of age with diabetes (types 1 and type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status <8.0%.
- Glycemic Status >9.0%.

To improve your score:

- CPT CAT II codes are available for coding HbA1C levels (see table below). Coding in a claim is equivalent to results from a lab for HEDIS.
- Order labs prior to patient appointments so they are available to code at the visit. Bill HbA1c testing if completed in office and ensure HbA1c result, and date are documented in the chart and the correct CPT II code is on the claim.
- Adjust therapy to improve HbA1c and BP levels and schedule follow-ups with patients to monitor changes.

Glycemic Status Billing Codes - Visit Date Must Be Specified

Code System	Codes	Definition	Charge $ (24F)
CPT-CAT-II	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%	$5.00
	3046F	Most recent hemoglobin A1c (HbA1c) level greater than 9.0%	$5.00
	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%	$5.00
	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%	$5.00

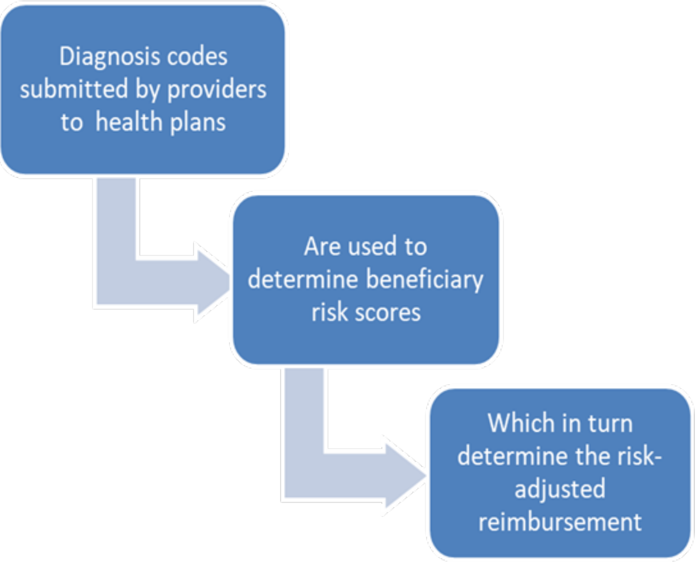
FEP Provider CPT II Incentive

Healthy Blue Provider Incentive Program

RADV and RISK

RISK Adjustment

- Risk Adjustment (RA) is a Payment methodology used by Medicare Advantage health plan and ACA (Affordable Care Act) plans to adjust health plan payments based on the enrollee health status and demographic characteristics.
- Risk adjustment methodology relies on enrollee diagnosis as specified by the ICD-10CM guidelines to prospectively adjust payments for a given enrollee based on the health status of the enrollee.
- This process allows for the estimated cost to treat a patient in a given year and make sure health providers are paid fairly for the patients they treat.
- Records are requested the 3rd quarter of the year. We request records and review charts for chronic conditions that were not submitted via claims but affect patient care and can be captured for patient status.



RADV – RISK Adjustment Data Validation

- Center for Medicare & Medicaid Services (CMS) has a formal audit program to monitor health plan compliance with HCC (Hierarchical Condition Category) reporting regulations. HCCs are sets of medical codes (ICD-10CM) that are grouped into related categories.
- The goal of RADV audits is to ensure that the health status submitted by the plan is supported by health record documentation and meets reporting guidelines.
- RADV is CMS primary way to address improper overpayments. Accuracy is confirmed from reviewing charts from providers and sending them to CMS for secondary review after an initial review by our selected auditor.
- CMS requires all HCC diagnoses be submitted each year the condition is present. It is of critical importance that plans ensure that members with HCC diagnoses be seen by a qualified provider and all current HCC diagnoses be evaluated and reported each year.
- Audit reviews the prior benefit year for our selected Cross and Choice members.
- HHS - RADV is conducted every year for all issuers and the project runs form June- December.

How RISK Adjustment Helps Providers

- ❑ Allows sicker members to receive fairly priced coverage since healthy members offset the difference.
- ❑ Identifies potentially new problems early.
- ❑ Reinforces self-care and prevention strategies.
- ❑ Coordinates care collaboratively.
- ❑ Avoids potential drug-drug/disease interactions.
- ❑ Improves the overall patient health care evaluations process.
- ❑ Improved office practice patterns and communication among the patient's health care team.

RISK Cover Letter for Release of Information

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina

Request for Medical Records (RISK) - Cover Letter

10/01/2024

Dear Provider,

We are contacting you because we are collecting medical records for our ACA Risk Adjustment process. We want to assure you that there are no financial consequences to you because of this request. Please note this is not related to previous medical record requests you may have received from us or any other vendor acting on our behalf.

To comply with this request, we have identified member medical records needed for 2024 dates of service. Enclosed, you will find the list of members seen by your practice in 2024. ***Please provide the entire 2024 medical chart for review, if unable to send whole year we have included the must have dates of services.***

*Required medical record documentation: progress notes and/or a standard template that includes a subjective, objective assessment plan (SOAP) for face-to-face office visit. Notes should include member name, date of visit and provider signature with credentials.
Medical record documentation IF available: history and physical, consult/specialist notes or letters. Demographics sheet, operative and pathology notes, procedure notes, physical, speech, and/or occupational therapist reports, emergency department records, discharge summary, signature logs.

We appreciate your cooperation and ask that you return the attached form and requested medical records via one of the following methods:

a) Please fax to 803-419-5715
b) Please email to ACARISK.RECORDS@BCBSSC.COM
c) Please mail using the address with P.O. Box number indicated below:
Blue Cross Blue Shield of South Carolina and Blue Choice Health Plan
Attn: ACARISK.RECORDS
Quality Improvement AX-310
P.O Box 6170, Columbia, SC 29260

Please understand it is very important that we receive the requested information in a timely manner and ask that you respond as quickly as possible. Please provide the requested member information specified on the attached documents within ***10 business days*** of this request. Failure to respond to this request will result in an increase in medical record requests.

If you have any questions regarding this request, please contact *Nicole Hurd @ 803-264-3374 or Tara Dunn @ 803-382-5531* or send an email to ACARISK.RECORDS@bcbssc.com.

Thank you in advance for your cooperation.

Sincerely,

Nive Raman, PMP, CPC, CRC

Manager, Program Change Quality Improvement

Member Details for RISK

Provider: <<Name>>| <<TIN>> | <<Address>> : <<MemberCount>> Member(s)

Member Name | Registration No. | ID Card No.	Date of Birth | Gender	Chase ID	DOS From - DOS To	Measurement Year
<<Name>> | <<RegNo>><<CellMerge>>	<<Dob>> | <<Gender>><<CellMerge>>	<<ChaseId>>	<<DOS>>	<<MeasurementYear>>

- Letter includes:
  - Members information and dates of services we must have if they cannot provide the whole year.
  - The types of records we are looking for (i.e., office notes, consults, etc.).
  - How to return the records (i.e., fax, mail or email.).
  - How you can reach use if you have any questions.

RADV Cover Letter for Release of Information

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight

Date: May 28, 2024

To: Hospitals, Physicians, and Practitioner Health Care Providers

From: Elizabeth Parish
Director, Payment Policy & Financial Management Group
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services (HHS)

Re: Medical Record Requests for the HHS-operated Risk Adjustment Data Validation (HHS-RADV) Audit

SPECIAL NOTE: In accordance with CMS policies, DO NOT FORWARD ANY MEDICAL RECORDS TO CMS OR ITS CONTRACTORS. Medical records received by CMS will be destroyed. Please follow the instructions provided by the requestor.

The current HHS-RADV audit pertains to services provided during the 2023 calendar year.[1] The requesting entity has determined that one or more of your patients are included in the HHS-RADV audit sample for services rendered during 2023. Because 2023 HHS-RADV medical record review is time sensitive, **your immediate attention to this request is appreciated.**

Please find attached a medical record request from a health insurance company or its delegated entity. It is important to respond to this request by the date in the medical record request letter. These requests are applicable to all providers, whether or not the provider has a contractual agreement with the health insurance company.

Thank you in advance for your prompt cooperation.

Date:__________,

2024 Dear Provider,

Why we are writing:
We are contacting you because we have been notified by the Centers for Medicare & Medicaid Services (CMS) that we have been selected for Risk Adjustment Data Validation (RADV). This audit requires that we submit medical records validating diagnostic information that was previously submitted to CMS through claims.

We want to assure you that there are no financial consequences to you because of this audit. Please note this request is not related to previous medical record requests you may have received from us or any other vendor acting on our behalf.

What you need to do:
To comply with this audit request, CMS has identified member medical records needed for 2023 dates of service. Enclosed, you will find the list of members seen by your practice in 2023. ***Please provide the entire 2023 medical chart for review, if unable to send whole year we have included the must have dates of services.***

Please bear in mind that medical records requested for audit purposes should be provided at no cost as a part of your contractual agreement with us.

How to submit the requested records:
To meet the CMS deadline, please submit the required medical records for 2023 to us by ___________. You can submit the records via fax to 803-419-5715 or via email to RADV.RECORDS@bcbssc.com. If you prefer, you can mail the medical records to:

BlueCross BlueShield of South Carolina
Attn: ACA RADV Records
Quality Improvement, AX-310
P.O. Box 6170, Columbia, SC 29260

Please understand it is very important that we receive the requested information in a timely manner and ask that you respond as quickly as possible. *Also, please send the requested medical records to us and don't send it to CMS or its contractors.* Thank you in advance for your cooperation.

Sincerely,
Nive Raman, PMP, CPC, CRC
Manager, Program Change
Quality Improvement
BlueCross BlueShield of South Carolina/BlueChoice HealthPlan

RADV Cover Letter for Release of Information (Continued)

Please return by: **Process within 10 business days**

Please return to: Send the medical records to us along with a copy of the face sheet via fax to 803-419-5715; or via email to RADV.RECORDS@bcbssc.com. If you prefer, you can mail the medical records to:

BlueCross BlueShield of South Carolina
Attn: ACA RADV Records
Quality Improvement, AX-310
P.O. Box 6170, Columbia, SC 29260

If any additional questions regarding this request, please contact ***Nicole Hurd @ 803-264-3374 or Savannah Miano @ 803-382-4519***

Provider Info-

TAX ID	NPI	GROUP NAME

Provider

TAX ID	NPI	GROUP NAME

Member Details-

MEMBER NAME	MEMBER ID Card	DOB	Chase ID	From DOS	To DOS

- Letter includes:
  - Members information and dates of services we must have if they cannot provide the whole year.
  - The types of records we are looking for (i.e., office notes, consults, etc.).
  - How to return the records (i.e., fax, mail or email.).
  - How you can reach use if you have any questions.

RADV Invoice Response Letter

Date: 09/09/2024

FAX Coversheet

To: Medical Records Dept.
Fax No: XXX-XXX-XXXX
Pages: 1
From: Provider Education
Contact No: 803-264-4730

Re:

Your medical records vendor is billing BCBSSC for medical records that were previously received or requested.

The submission of medical records is a non-billable event. Network providers should submit medical records requested at no cost to BCBSSC when requested.

Please inform your medical records vendor and share this information with the appropriate staff.

09/9/2024

Re: Record invoice response

Hello,

As a company BCBSSC does not make payments for any medical records. Providers have a contractual obligation to send us the charts free of charge-please refer to your contract with us or call providers office if this is a third party vendor. It is addressed under IV.A(10) last sentence, "BCBSSC or the Associate Plan will have the right to inspect, review and obtain copies of such records upon request at no charge." All providers signed an individual HIX Agreement with this language in it. If you have any questions about the contract you may contact provider education 800-288-2227

Kindly let us know if you need any other details regarding the requests.

Thanks for your prompt attention to this time sensitive request.

Thank you,

Nive Raman, PMP,CPC,CRC
Risk Manager- Quality Improvement
BlueCross BlueShield of South Carolina
Phone: 803-264-4224
Nivedhitha.Raman@bcbssc.com
http://www.bcbssc.com/confidentiality.htm

The document being transmitted contains private, privileged and confidential information belonging to the sender and is intended for the use of the addressee only. If this transmission is received by anyone other than the addressee, please advise the sender immediately at 1-803-419-8191 (fax) so that we can arrange for the return of the documents. In such circumstances, you are advised that you may not review, disclose, copy, distribute or take any other action in connection with the documents transmitted.

P.O Box 6170 Columbia, SC 29260-6170

www.southcarolinablues.com, www. BlueChoiceSC.com
An Independent licensee of BlueCross and BlueShield Association.

IV. PREFERRED PROVIDER'S RESPONSIBILITIES.

A. Preferred Provider shall:

(1) Accept payment of the Fee Allowance amount as payment in full for Covered Services rendered to Members. All payments are subject to the terms of the Member's Benefits Contract. Member shall be solely responsible for any required Patient Pay Amounts and Preferred Provider shall not bill the Member any amount in excess of such Patient Pay Amounts for Covered Services. Payment will be adjusted for payments made to Preferred Provider pursuant to any coordination of benefits provisions in any health plan other than the Benefits Contract.

(2) While performing services, maintain a physician-patient relationship with enrolled Members. Any and all medical service decisions, treatment decisions or exercises of medical judgment are Preferred Provider's responsibility.

(3) Not discriminate against any Member on the basis of race, color, sex, age, religion, national origin, handicap or insurance plan in providing services under this Agreement. Preferred Provider may choose to be closed to new Members as a group but only if Preferred Provider is closed to new patients from all payor sources.

(4) Cooperate and comply with the Provider Office Administrative Manual (located at www.southcarolinablues.com at the time of this writing).

(5) Use only HIX Network Providers in the delivery of Covered Services unless Covered Services, supplies or equipment are not available from any HIX Network Provider, or in the case of an Emergency.

(6) Provide Covered Services in an appropriate outpatient setting whenever safe, quality care can be provided in such a setting.

(7) Cooperate fully with the Utilization Management Program.

(8) Agree to provide a second opinion to Members who have already consulted with another HIX Network Provider.

(9) Cooperate and participate with BCBSSC and any Associate Plan in any utilization control procedures, quality assurance activities, analysis of Member's risk status, external audit systems and grievance procedures, as may be established pursuant to the terms of the Benefits Contract, and comply with all final determinations rendered through the grievance process.

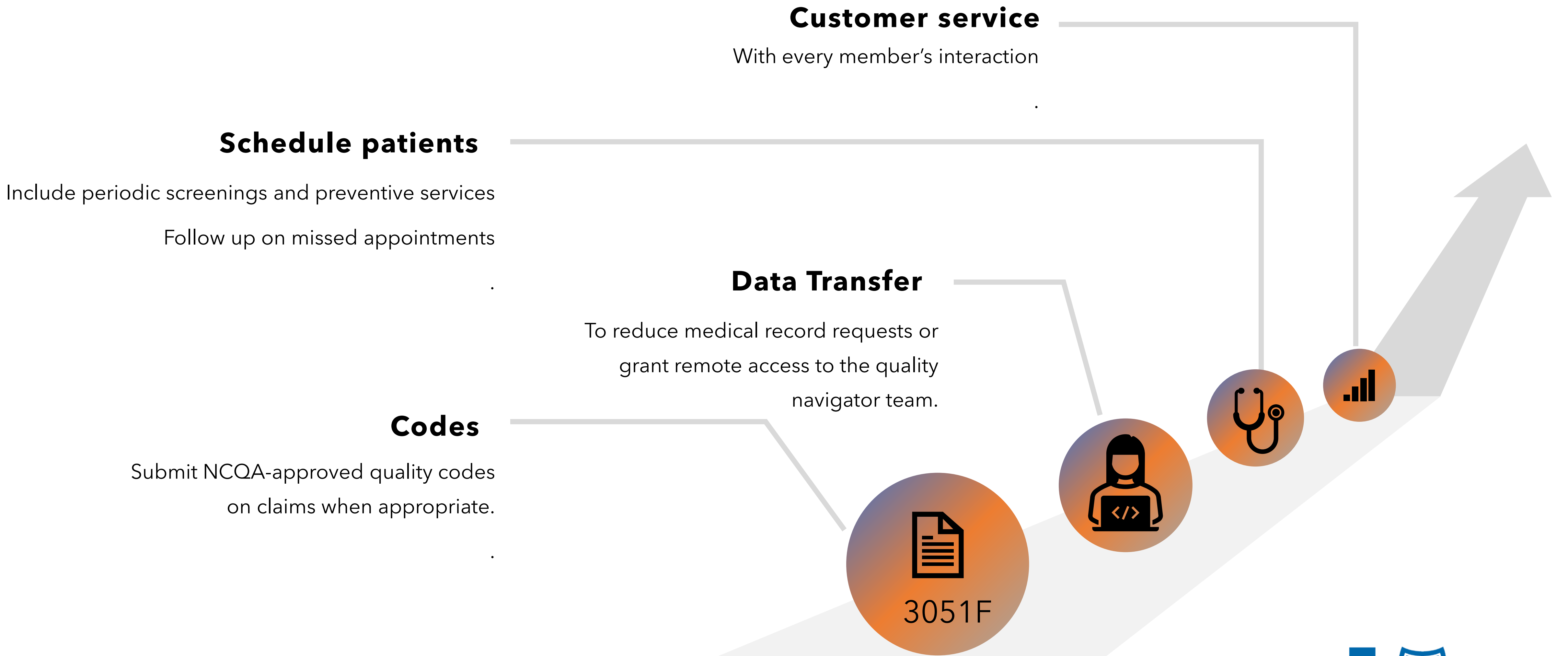
(10) Maintain, with respect to each Member for whom Covered Services are provided under this Agreement, standard medical records in such form, containing such information, and meeting such record keeping requirements as might be required by applicable federal and state law. Preferred Provider will keep confidential, and take all reasonable precautions to prevent the unauthorized disclosure of any and all records prepared and/or maintained by this Agreement. BCBSSC or the Associate Plan will have the right to inspect, review and obtain copies of such records upon request at no charge.

How Providers Can Help the Program

- The best thing you can do for your patients to keep this program going is have clear and thorough documentation in your notes.
- Another help is sending medical records as soon as request are received from insurer. Please call if you need help with pulling records. Help receive records from a third-party vendor in a timely manner.
- Only use the term "history of" if the patient no longer has this condition. Try using patient current medical conditions are… instead of patient with a history of.
- Address any chronic issue that may affect your decision making- coders are not doctors and can not make the connection if not clearly stated.
- Document all cause and effect relationships-document conditions which coexist at the time of the visit that require or affect patient care or treatment.
- More details on the condition are better for coding accuracy.

Key Takeaways

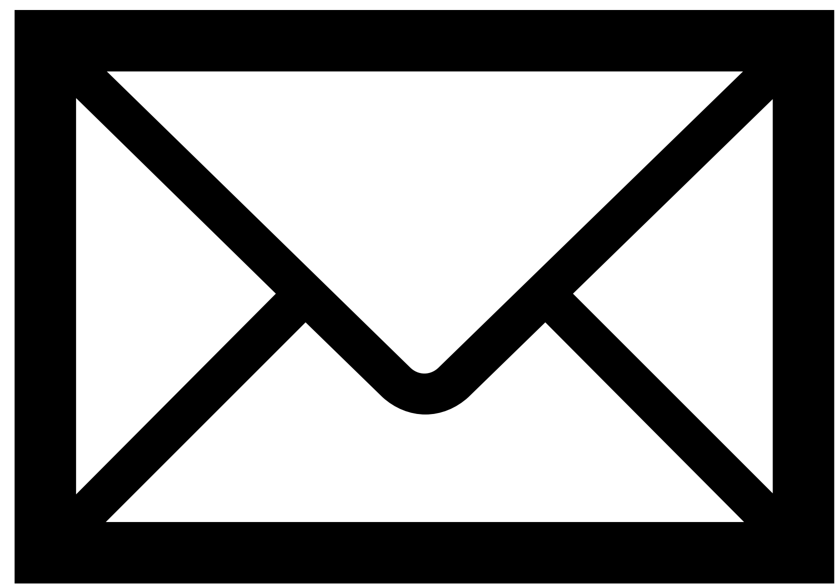
Positive Impacts on Quality Scores



South Carolina

Contact Information

- ❑ For general assistance or information about the Quality Navigator Program, email Navigator@bcbssc.com.



Self-serving Tools

Topics to Discuss

- ❑ Website Overview
- ❑ Voice Response Unit
- ❑ My Insurance Manager℠
  - Getting Benefits
  - Submitting Claims
  - Claims Status
  - Ask Provider Services
  - STATchat℠
- ❑ My Remit Manager

Website Overview

SouthCarolinaBlues.com

South Carolina

SHOP PLANS MEMBERS PROVIDERS EMPLOYERS AGENTS

Providers

Providers Search...

My Insurance Manager

File claims, get prior authorizations, check eligibility and benefits, and more.

Log In

Feedback

Policies and

Claims and Payments

Provider Enrollment

BlueChoiceSC.com

BlueChoice® HealthPlan South Carolina

Focus on life. Focus on health. *Stay focused.*

EMPLOYERS AGENTS PROVIDERS CONTACT MEDICAID

COVID-19 MEMBER CENTER FIND CARE FIND A FORM

My Insurance Manager

File claims, get preauthorizations, check eligibility and benefits and more.

Log In

Education Center

Tools and Resources

Manuals & User Guides

Prior Authorization

Laboratory Benefits

HealthyBlueSC.com

Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

A A A Español Members

Authorization and Eligibility ⌄ Claims ⌄ Patient Care ⌄ Pharmacy Resources ⌄

JOIN OUR NETWORK

Providers

Interested in joining our provider network? We look forward to working with you to provide quality services to our members.

JOIN OUR NETWORK

My Insurance Manager

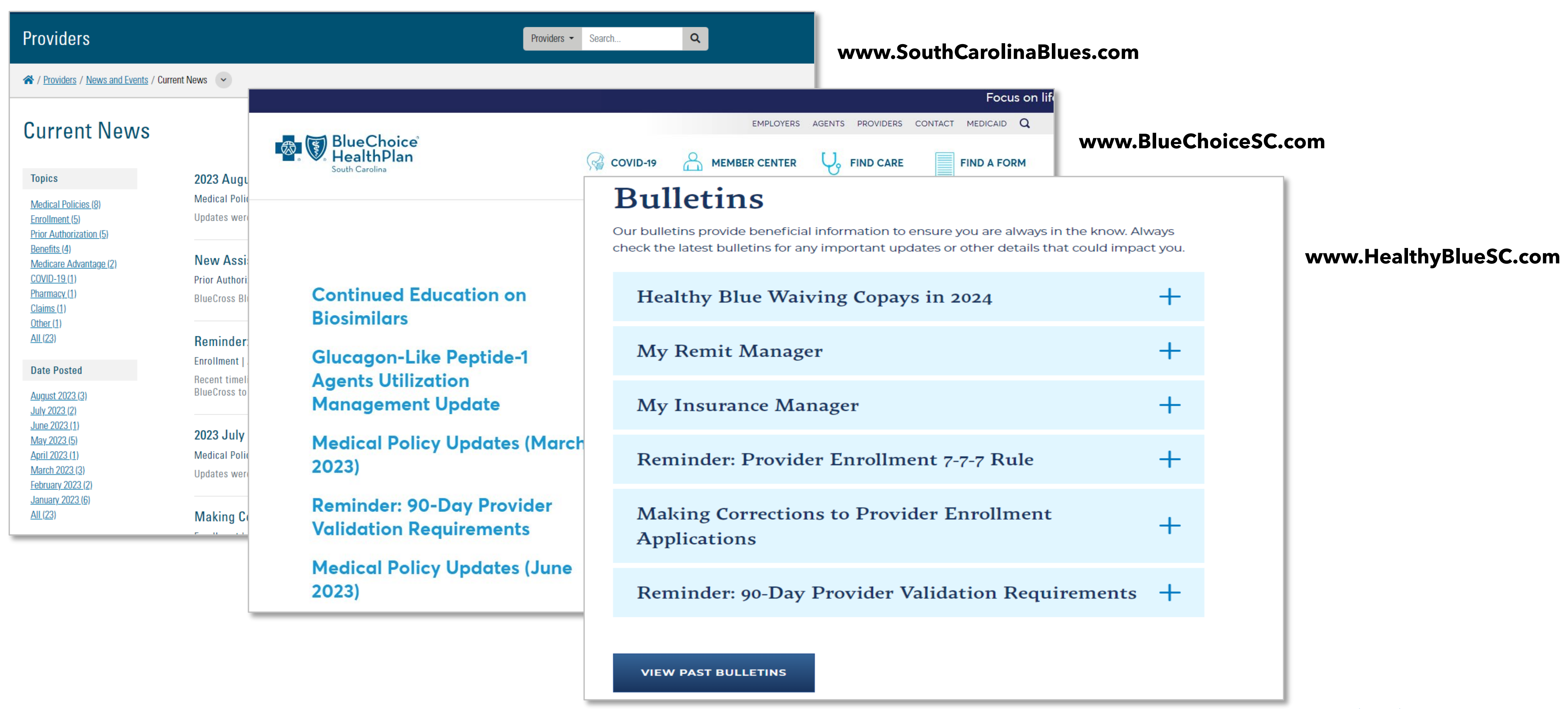
File claims, get prior authorizations, check eligibility and benefits and more.

LOG IN REGISTER

2023 Date of Service Login

Forgot Username or password?

News Bulletins



South Carolina

Manuals and Guides

South Carolina

SHOP PLANS | MEMBERS | PROVIDERS | EMPLOYERS | AGENTS

Providers

Providers ▾ Search...

/ Providers / Tools and Resources / Guides

Guides

We want to make your interactions with BlueC
need quickly:

- Ancillary Claims Filing Reminders - This guide
- Anesthesia Guidelines - This guide provides an
- ClaimsXten™: Correct Coding Initiative Refere
  coded properly. Get details about the claim cod
- Cultural Competency - Learn about the importa
- Inpatient Non-Reimbursable Charge/Unbundlin
  considered to be non-reimbursable, unbundled
  decisions.
- Medical Forms Resource Center User Guide - G
  precertification requests quickly.
- Member ID Card Guide - This guide provides yo
- My Provider Enrollment Portal Guide - Get instr
- Patient-Centered Medical Home Practice Locat
  - Patient-Centered Primary Care Collabora
  - National Committee for Quality Assuran
- Provider Reconsideration Guide - Use this form
- Provider Validation: MD Checkup User Guide -
  information you provide is used to maintain ou
- Preventive Care Guide - This guide provides an
- Preventive Care Guidelines - This guide include
- Quick Reference Guide - Use this guide to iden
- What You Need to Know About Claim Attachm
  attach records or documents to claims that req

www.SouthCarolinaBlues.com

Focus on life. Focus on health. *Stay focused.*

EMPLOYERS | AGENTS | PROVIDERS | CONTACT | MEDICAID

BlueChoice HealthPlan South Carolina

COVID-19 | MEMBER CENTER | FIND CARE | FIND A FORM

Please re

- BlueCard Program Manual — This m
  program. It will also help you guide t
  out-of-area members.
- ClaimsXten: Correct Coding Initiativ
  auditing software designed to ensur
  coding rules and the benefits of this
  company that offers assistance in co
- Cultural Competency — Learn abou
- Medical Forms Resource Center (MF
  you to submit your precertification r
  ensures accuracy. It also cuts down
- Member ID Card Guide — This guide
  the identification cards you may see
- Precertification and Referral Guide –
  Insurance Manager℠ and determin
- Preventive Care Guide — This guide
  preventive for non-grandfathered pl

www.BlueChoiceSC.com

Home / Providers / Resources / Forms, Policies & Guidelines

Healthy Blue is committed to supporting you in providing quality care and services to the members in our network. On this page you will find frequently used forms, provider manuals and guides, information for assessing coverage options, guidelines for clinical utilization management (UM), practice policies and support for delivering benefits to our members.

Provider Manual

The Healthy Blue provider manual provides key administrative information, including the quality improvement program, the UM program, quality standards for participation, claims appeals, and reimbursement and administration policies.

View Provider Guides

Provider Manual

Quick Reference Guide

www.HealthyBlueSC.com

Available Forms

www.SouthCarolinaBlues.com

South Carolina

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Providers

/ Providers / Forms

Forms

Provider Enrollme

Financial and App

www.BlueChoiceSC.com

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EMPLOYERS AGENTS PROVIDERS CONTACT MEDICAID

BlueChoice HealthPlan South Carolina

Search for forms.

Enter Search Terms

Categories:

Members Employers Agents Prov

www.HealthyBlueSC.com

VIEW THE ONLINE LIBRARY FOR THE APPROPRIATE FORM.

Provider Forms

- Prior Authorizations +
- Claims & Billing +
- Clinical +
- Behavioral Health +
- Pharmacy +
- Maternal Child Services +
- Other Forms +

How to Contact Provider Education

South Carolina

SHOP PLANS MEMBERS PROVIDERS EMPLOYERS AGENTS

Providers

/ Providers / Contact Us

Contact Us

Online Res

You can send a secure messa
Services in MIM or

My Insurance Manager

Voice Response Unit

www.SouthCarolinaBlues.com

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BlueChoice HealthPlan South Carolina

Pro

For questions on eligibility, benefits, deductibles
Insurance Manager℠. You'll be able to get infor
information secure.

If you have a question that is not related to spec
department by calling 803-264-4730 or using the
emails to a central distribution center and assign
request. The person who responds to your inquiry
since he or she may be unavailable to reply as q

Request training for your practice or organizatio
join our email registry for the latest news, online

www.BlueChoiceSC.com

Contact Us

Home / Providers / Resources / Contact Us

Do you have questions beyond what you can find through our website or My Insurance Manager℠? Do you want to learn more about our programs? Our provider education consultants serve as liaisons between Healthy Blue and the health care community.

You can easily contact our Provider Education team to connect with a consultant or to request training. The quickest way is by emailing Provider.Education@bcbssc.com or calling 803-264-4730. We will assign your inquiry to the consultant who can most efficiently handle your request.

You can also reach out to your consultant directly. To see who handles your region, view the latest territory map.

www.HealthyBlueSC.com

Voice Response Unit

Getting Benefits Through the Voice Response Unit

- **Call one of the following numbers to use the voice response unit:**
  - Columbia or Lexington: 803-788-8562
  - Other locations in South Carolina: 800-868-2510
  - Outside of South Carolina: 800-334-2583
  - BlueChoice® HealthPlan:800-868-2528
  - State Health Plan: 800-444-4311
  - Federal Employee Program: 888-930-2345
  - BlueCard Eligibility: 800-676-BLUE (2583)
- **Be sure to have the following information ready:**
  - Your Tax ID or NPI
  - Patient identification number (including the prefix)
  - Patient's date of birth

Independent licensees of the Blue Cross Blue Shield Association.

Voice Response Unit (VRU)

Manual

Published by Provider Relations and Education
Your Partners in Outstanding Quality, Satisfaction and Service

Revised: June 2023

Providers>Contact Us>Voice Response Unit

Getting Benefits Through the Voice Response Unit (Continued)

- **You will hear the following information:**
  - Type of coverage
  - Effective date
  - Benefit period
  - Group number
- **Available benefit options:**
  - Hospital
    - Inpatient and outpatient
  - Behavioral health
  - Rehabilitation
  - Home health
  - And much more!

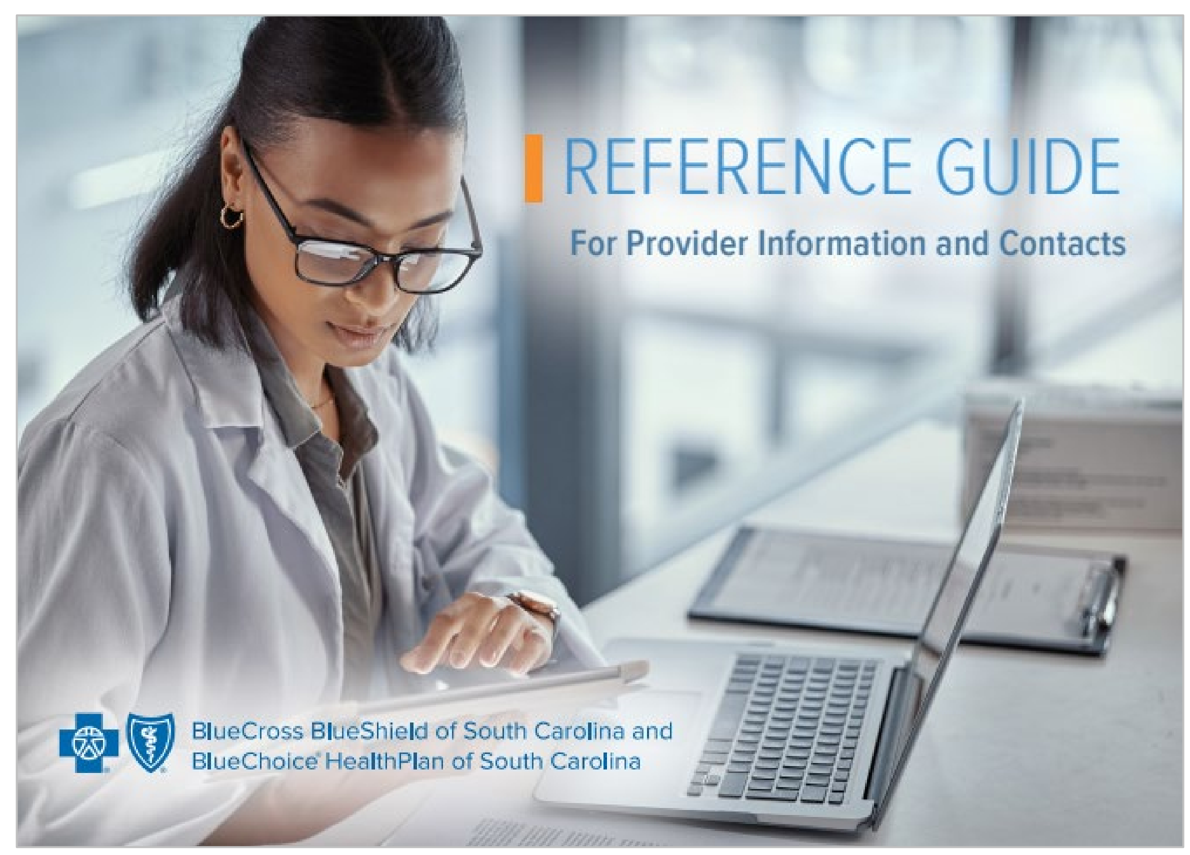
Getting Claim Details Through the Voice Response Unit

- **Call one of the telephone numbers from the previous slide.**
- **Be sure to have the following information ready:**
  - Your Tax ID or NPI
  - Patient identification number (including the prefix)
  - Patient's date of birth
  - Date of service
- **If a claim was paid or applied patient liability, you will receive:**
  - Processed date
  - Remittance date
  - Check number
  - Amount paid or applied to 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.

Quick Reference Guide

- ❑ Identify the most efficient ways to the benefit information, prior authorizations and much more.
  - Visit www.SouthCarolinaBlues.com:
    - Providers>Tools and Resources>Guides



My Insurance Manager

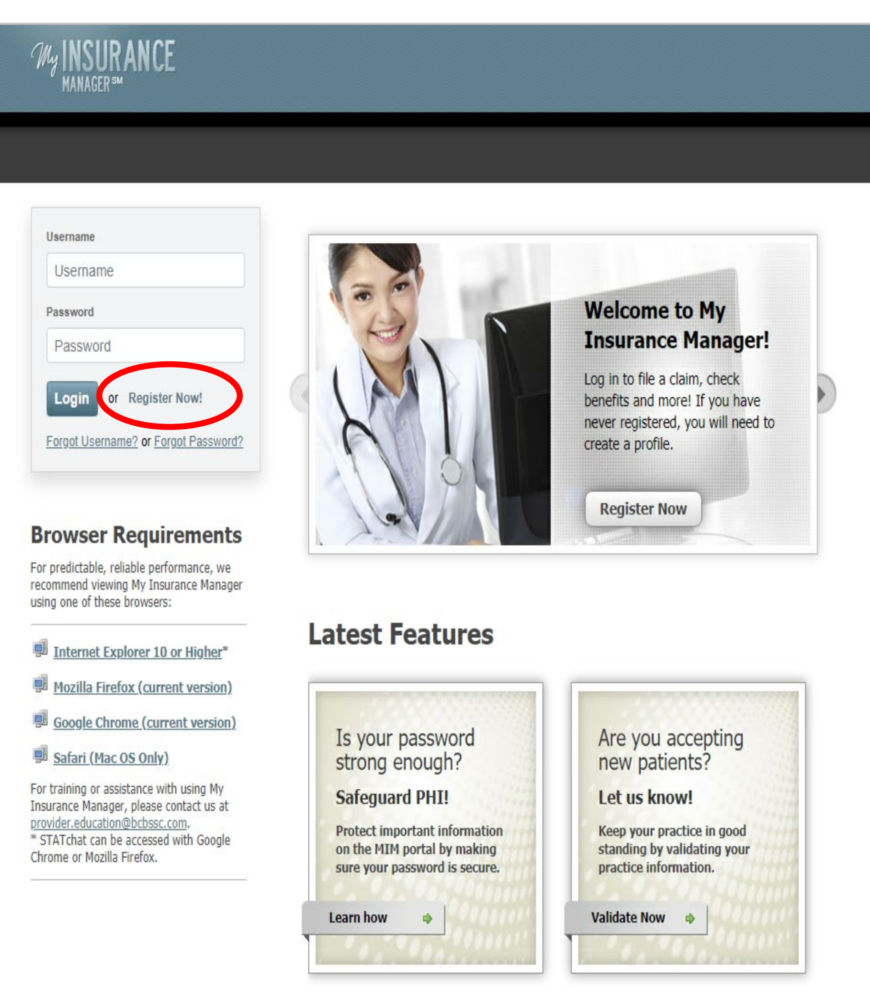
Overview of My Insurance Manager

- My Insurance Manager is a web-based tool used to check eligibility, benefits, claim status, get prior authorizations and much more.
- Available reference guides include:
  - Getting Started
  - Eligibility and Benefits
  - Claims Entry
  - Claims Status, Patient Directory, Superbill Maintenance and Coordination of Benefits
  - Precertification, Pre-Treatment Estimate for Authorization Status
  - Office Administration
  - Provider Validation: M.D. Checkup

Note: Visit www.SouthCarolinaBlues.com to review the available guides.

Getting Started with My Insurance Manager

- Visit one of the websites:
  - www.SouthCarolinaBlues.com
  - www.BlueChoiceSC.com
  - www.HealthyBlueSC.com
- Select the available link to My Insurance Manager.
- From the home page, select ***Register Now*** if you're a first-time user.



Creating a Profile in My Insurance Manager

- When creating a profile, your ***9-digit Tax ID number*** must be entered.

My INSURANCE MANAGER℠

Create Profile

Printer-Friendly

* Required

Please enter your 9-digit Tax ID number.

* Tax ID:

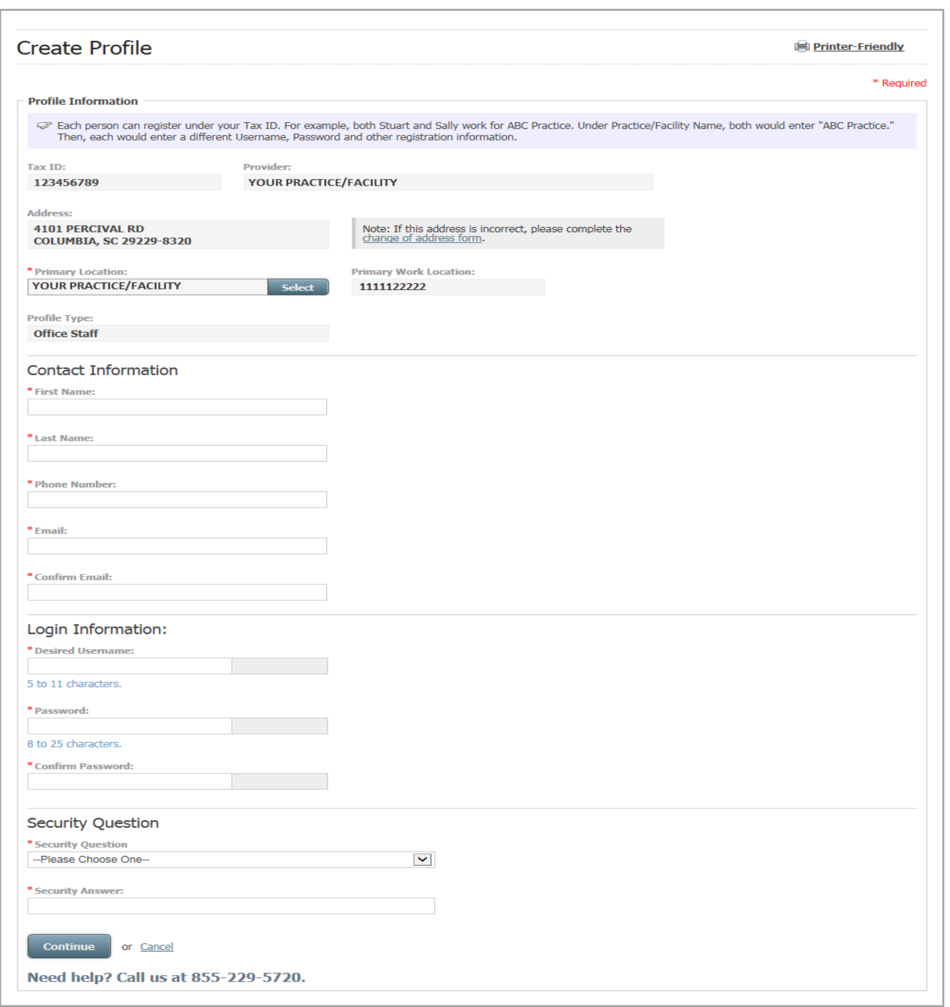
By clicking Continue, you agree to the Terms and Conditions.

Continue or Cancel

Need help? Call us at 855-229-5720.

Creating a Profile in My Insurance Manager (Continued)

- The information associated with the Tax ID will pre-populate.
  - If there are multiple locations for the practice, you will be given the option to select the primary location.
- Enter the remaining contact and login information.
- Select a security question.



Create Profile

Printer-Friendly

* Required

Profile Information

Each person can register under your Tax ID. For example, both Stuart and Sally work for ABC Practice. Under Practice/Facility Name, both would enter "ABC Practice." Then, each would enter a different Username, Password and other registration information.

Tax ID: 123456789

Provider: YOUR PRACTICE/FACILITY

Address: 4101 PERCIVAL RD COLUMBIA, SC 29229-8320

Note: If this address is incorrect, please complete the change of address form.

*Primary Location: YOUR PRACTICE/FACILITY Select

Primary Work Location: 1111122222

Profile Type: Office Staff

Contact Information

*First Name:

*Last Name:

*Phone Number:

*Email:

*Confirm Email:

Login Information:

*Desired Username:

5 to 11 characters.

*Password:

8 to 25 characters.

*Confirm Password:

Security Question

*Security Question

--Please Choose One--

*Security Answer:

Continue or Cancel

Need help? Call us at 855-229-5720.

Creating a Profile in My Insurance Manager (Continued)

- If registering as the ***profile administrator***, you must validate your profile by entering claim information or requesting a security code (recommended). Also, choose the delivery method for the code.

Validate Profile

Printer-Friendly

Profile Validation

Please choose a way to validate yourself as an administrator of this Tax ID.

- Enter Claim Information
- Request Security Code

Request Security Code

* Required

You can request that we send a Security Code via the delivery method we have on file associated with your Tax ID.

* Location:

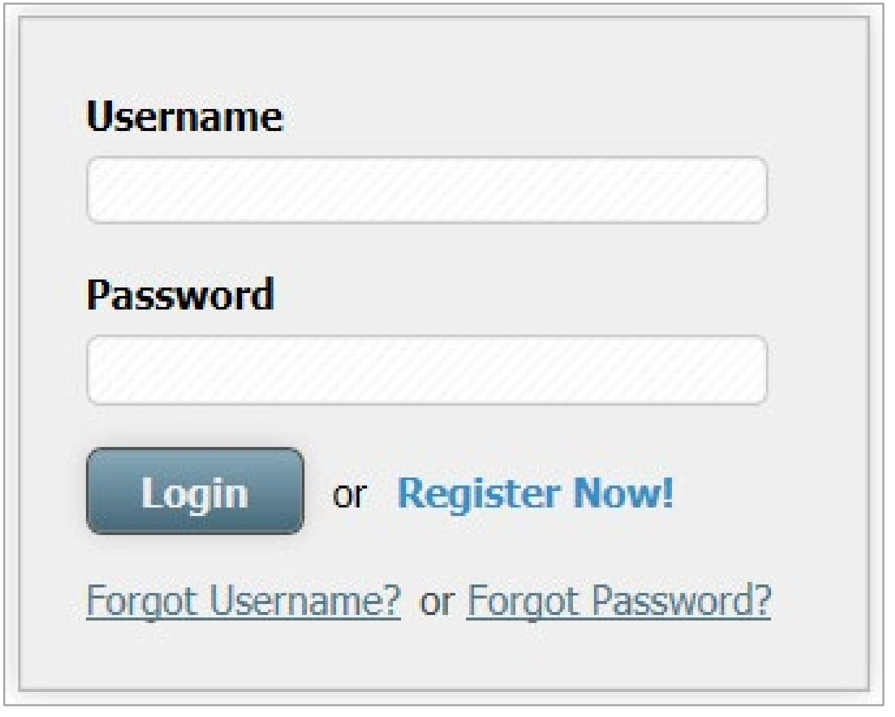
Select

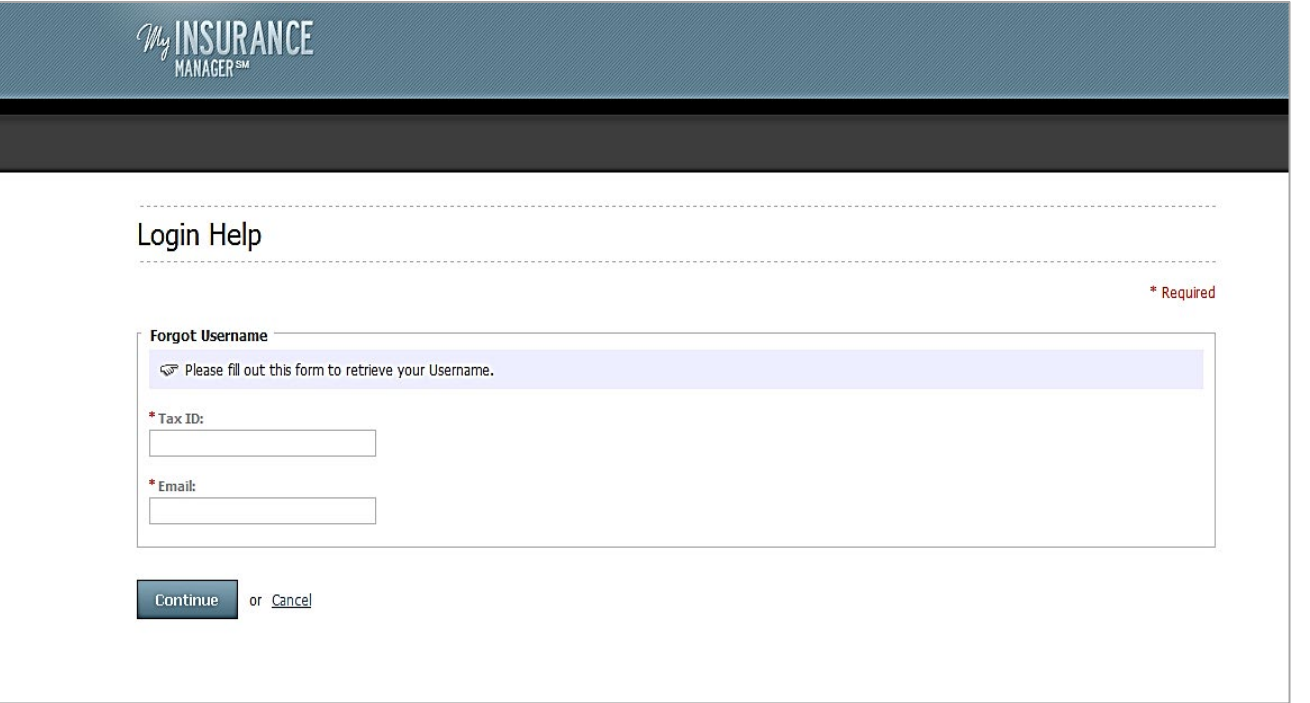
* Delivery Method:

- **Email:**
- **Fax:**
- **Physical Address:**

Log Into My Insurance Manager

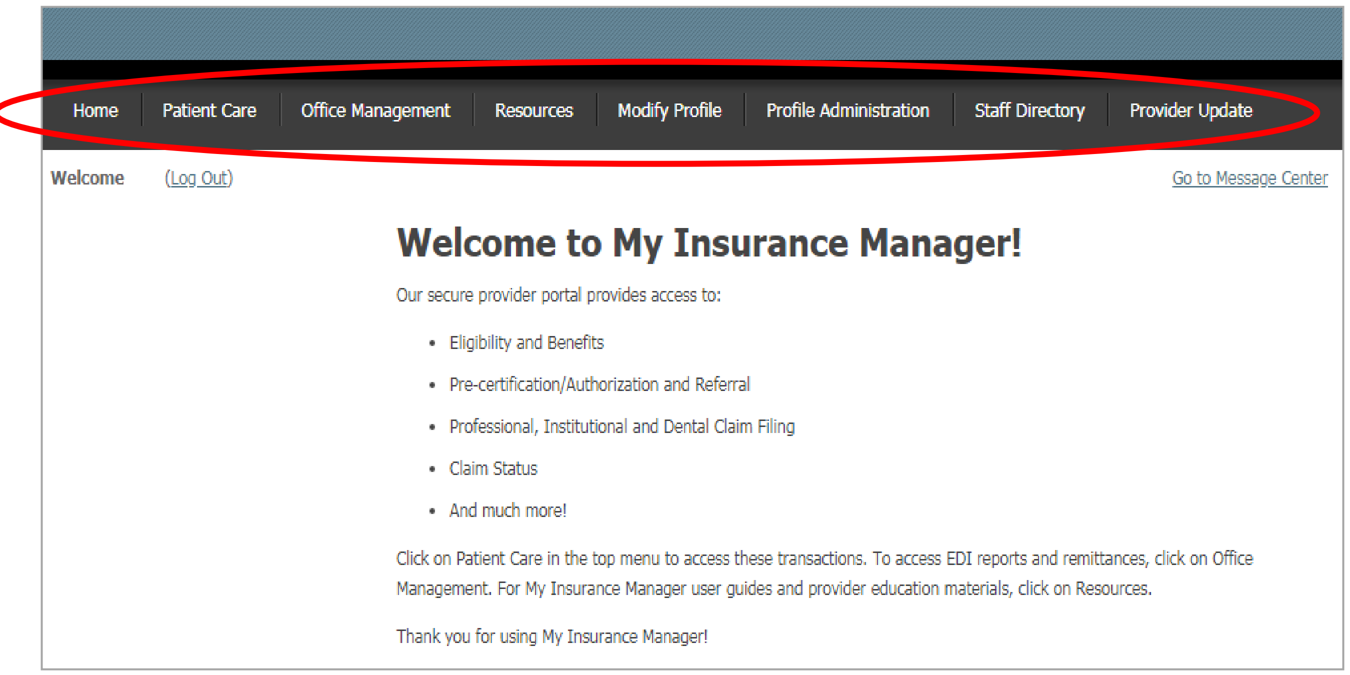
- ❑ After completing registration, it can take up to two business days for the profile to be approved.
  - If the practice already has an established Profile Administrator, they can approve profiles immediately.
- ❑ When the profile is approved, use your username and password to log in.





Navigational Options

- The following administrative tabs are located at the top of the home page:
  - Patient Care
  - Office Management
  - Resources
  - Modify Profile
  - Profile Administration
    - Only available for administrators
  - Staff Directory
  - Provider Update (M.D. Checkup)



Patient Care

Patient Care | Office Management | Resources | Modify Profile

Health

- Authorization Extension
- Authorization Status
- Claims Status
- Eligibility and Benefits
- Institutional Claim Entry
- Other Health Insurance
- Patient Directory
- Pre-Certification/Referral
- Superbill Maintenance
- Pre-Service Review for Out-of-Area Members
- Professional Claim Entry
- Verify Primary Care Physician

Dental

- Claims Status
- Dental Claim Entry
- Eligibility and Benefits
- Other Dental Insurance
- Patient Directory
- Superbill Maintenance
- Pre-Treatment Estimate Entry
- Pre-Treatment Estimate Status

Office Management

Note: PCMH reports are only available for PCMH providers.

Office Management – Refund Letters

- ❑ Refund letters are in My Insurance Manager.
  - Search by the refund control number (RCN) or posting date.
  - Includes the patient details and reason for the refund request.
- ❑ Call Provider Services at 800-868-2510 and select option 4 if you need additional information on a refund.
  - Certain lines of business have a separate phone number (i.e., State Health Plan).

Refund Letters

Plans included: BlueCross BlueShield of South Carolina, State Health Plan, BlueChoice HealthPlan, HealthyBlue and FEP. Refund Letters are stored by the dates we create them.

Refund Control Number | Or | Posting Date --Please Ch | All Locatio

Search

0000128

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

South Carolina

Visit MyInsuranceManager SM at www.SouthCarolinaBlues.com

NOVEMBER 11, 2021

Re: Patient:
ID Numb
Provider
Date(s)
Refund

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 $11.00 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:

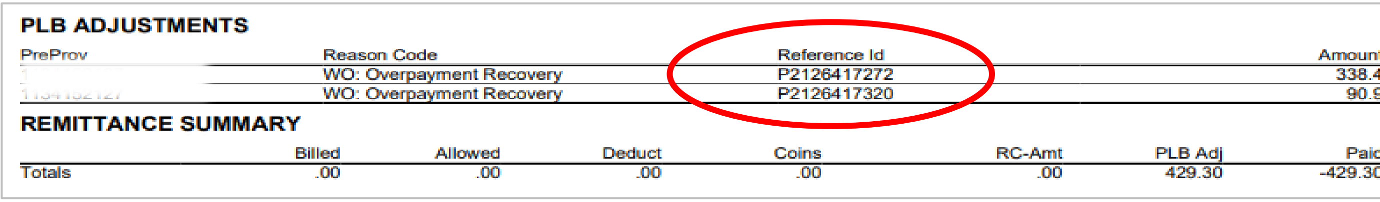
BlueCross BlueShield of South Carolina
Attn: Lockbox AX-A31
I-20 at Alpine Road
Columbia, SC 29219

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



PLB ADJUSTMENTS

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

REMITTANCE SUMMARY

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

Office Management – Provider Report Card

Provider Report Card

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

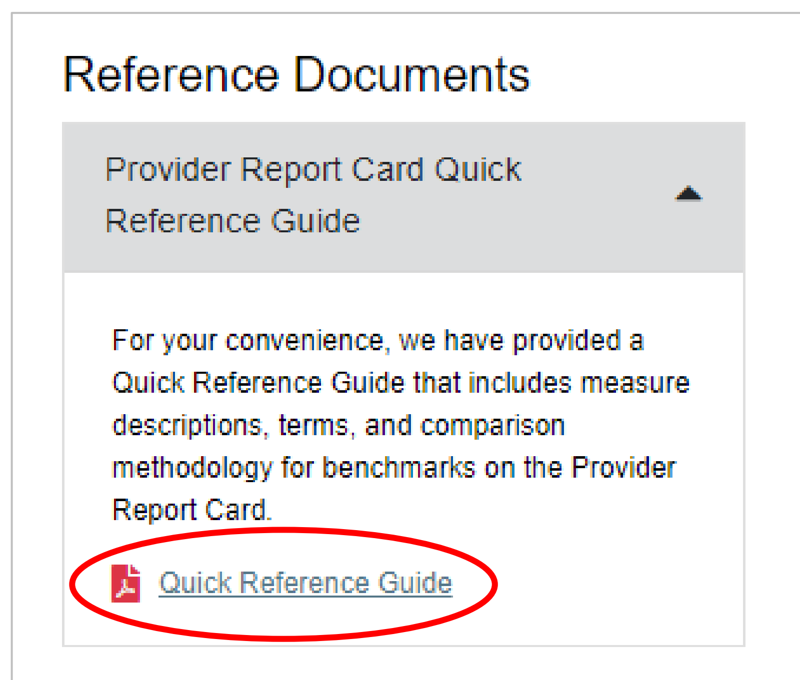
Provider Name: ABC Hospital

Provider Number: 147258369

Last Roster Update Not Current

Report Month: 8/1/2022

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



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

Resources

Resources | Modify Profile | Profile Administration | Staff Directo

Tools

- Access System News
- Avalon Lab Benefit Manager Provider Portal
- BlueChoice Find Care
- Blue Cross Find Care
- Code Search
- EDI Resources
- FEP Website
- Forms
- Lab/Biometric Data Upload
- Medical Policies
- My Remit Manager
- Provider News and Events
- State Dental Plan Fee Schedule
- State Health Plan Fee Schedule
- Tools and Resources
- Washington Publishing Company Claim Adjustment Reason Codes

Modify Profile

Modify Profile | Profile Administration | Staff Directory | Provider

Profile Settings

- Change Contact Information
- Change Password
- Change Security Question

Profile Administration

Profile Administration | Staff Directory | Provider Update

Manage Profiles

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

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

Staff Directory

Staff Directory | Provider Update

All Profiles for Tax ID: 123456789

Results (5)

Name ▲	Phone Number	Email	Location	Type
			JOHN M JONES MD	Profile Administrator
			JOHN M JONES MD	Profile Administrator
			JOHN M JONES MD	Office Staff
			JOHN M JONES MD	Profile Administrator
			JOHN M JONES MD	Office Staff

Provider Update (M.D. Checkup)

- Providers have been required to verify their demographic data at least ***every 90 days*** since Jan. 1, 2022.
  - This implementation was part of the No Surprises Act.
- Validation allows us to maintain accurate directories.
- Verification can be completed in M.D. Checkup (accessible through My Insurance Manager).
  - You can also respond to the email received from Provider.Directory@bcbssc.com.

Provider Update

Troubleshooting Tips for My Insurance Manager

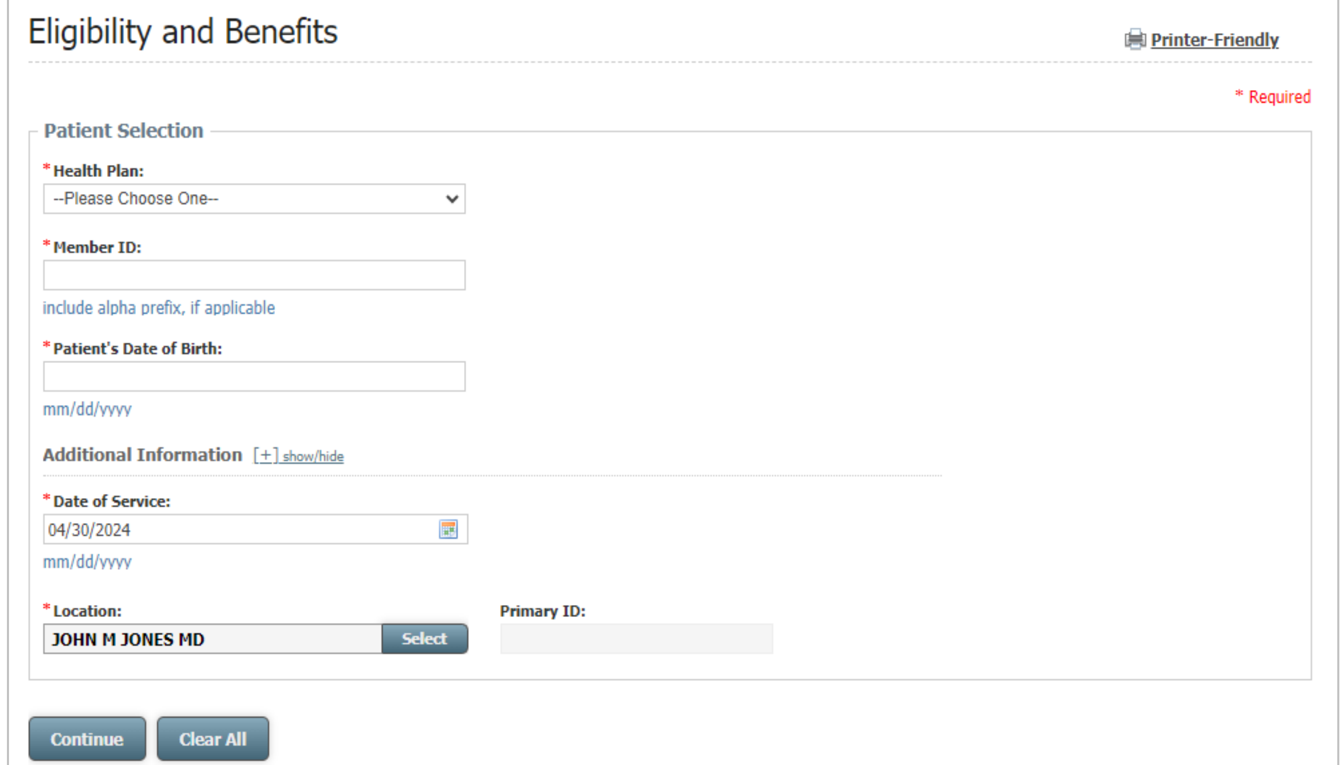
- Complete the registration process to avoid limited access.
  - If credentialing is pending, be sure to wait until you receive confirmation that it is completed.
- Use one of the recommended browsers:
  - Internet Explorer 10 or higher
  - Mozilla Firefox
  - Google Chrome
  - Safari
- On Sundays, the portal is unavailable for maintenance from 5 p.m. to midnight.
- For any technical issues, call Technical Support at 855-229-5720.

Getting Benefits

Getting Benefits in My Insurance Manager

Step 1

Step 2



Getting Benefits in My Insurance Manager – General Benefits

Step 3 (*When pulling general benefits.*)

Eligibility Request

* Required

Choose Eligibility View

Please note: Unless otherwise required by state law, this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductibles, may change as additional claims are processed.

Deductible and coinsurance amounts are calculated from the member's health or dental plan allowances for the procedures performed.

- (selected) General Eligibility and Benefits
- Eligibility and Benefits by Service Type
- Eligibility and Benefits by Procedure Code

Submit

Getting Benefits in My Insurance Manager – General Benefits

Printer-Friendly

Date of Service
04/30/2024

Insurance
Plan Name:
BLUECROSS AND BLUESHIELD OF SC

Plan ID:
38520

Member ID:
ZCZ065922516805

Group Number:
036011101

Member's Name:
MICHAEL TESTING

Patient
Patient's Name:
MICHAEL TESTING

Relationship to Member:
SUBSCRIBER

Gender:
MALE

Date of Birth:
10/01/1958

Address:
P O BOX 24015
COLUMBIA, SC 292244015

Change Patient

Response Details

Eligibility Response [+]

Policy Effective Date:
06/01/2002

Benefit Period:
04/01/2024 - 04/01/2025

View Benefit Booklet for this patient

IN AND OUT OF NETWORK

Global Benefits

This patient has active coverage.

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLES MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

INDIVIDUAL DEDUCTIBLE: **$250.00** PER SERVICE YEAR - **$250.00** REMAINING

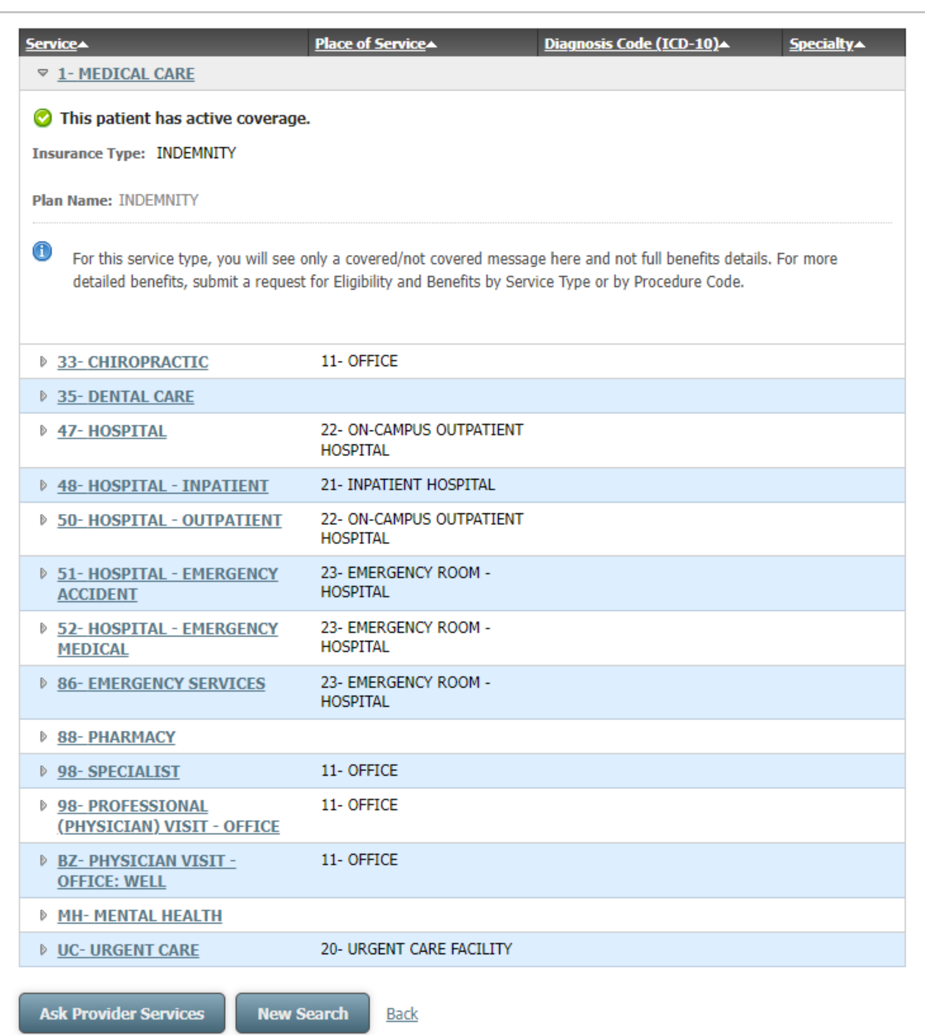
INDIVIDUAL OUT OF POCKET: **$750.00** PER SERVICE YEAR - **$750.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

FAMILY DEDUCTIBLE: **$500.00** PER SERVICE YEAR - **$500.00** REMAINING

FAMILY OUT OF POCKET: **$1,500.00** PER SERVICE YEAR - **$1,500.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE



Service	Place of Service	Diagnosis Code (ICD-10)	Specialty
1- MEDICAL CARE			

This patient has active coverage.

Insurance Type: INDEMNITY

Plan Name: INDEMNITY

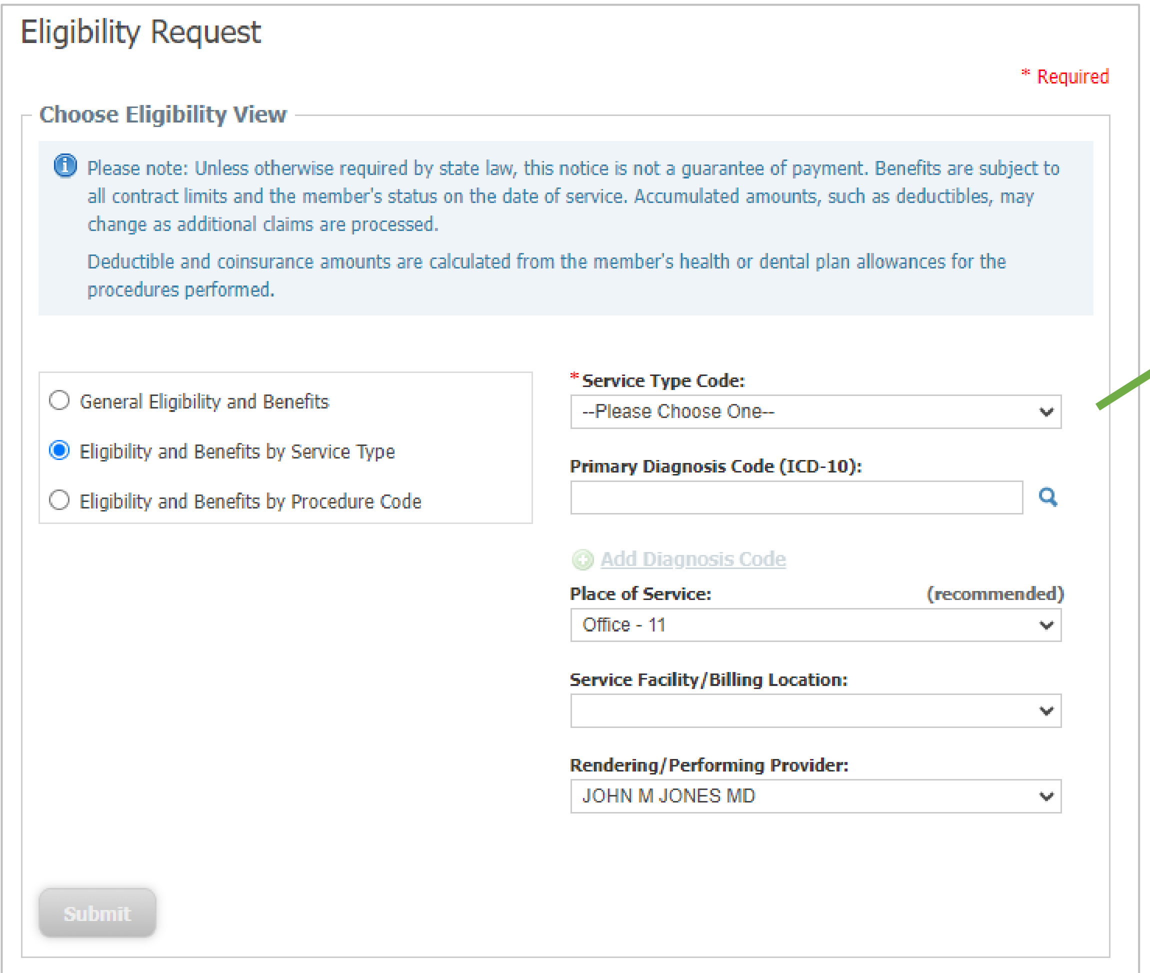
For this service type, you will see only a covered/not covered message here and not full benefits details. For more detailed benefits, submit a request for Eligibility and Benefits by Service Type or by Procedure Code.

Service	Place of Service	Diagnosis Code (ICD-10)	Specialty
33- CHIROPRACTIC	11- OFFICE		
35- DENTAL CARE			
47- HOSPITAL	22- ON-CAMPUS OUTPATIENT HOSPITAL		
48- HOSPITAL - INPATIENT	21- INPATIENT HOSPITAL		
50- HOSPITAL - OUTPATIENT	22- ON-CAMPUS OUTPATIENT HOSPITAL		
51- HOSPITAL - EMERGENCY ACCIDENT	23- EMERGENCY ROOM - HOSPITAL		
52- HOSPITAL - EMERGENCY MEDICAL	23- EMERGENCY ROOM - HOSPITAL		
86- EMERGENCY SERVICES	23- EMERGENCY ROOM - HOSPITAL		
88- PHARMACY			
98- SPECIALIST	11- OFFICE		
98- PROFESSIONAL (PHYSICIAN) VISIT - OFFICE	11- OFFICE		
BZ- PHYSICIAN VISIT - OFFICE: WELL	11- OFFICE		
MH- MENTAL HEALTH			
UC- URGENT CARE	20- URGENT CARE FACILITY		

Ask Provider Services | New Search | Back

Getting Benefits in My Insurance Manager – Service Type

Step 3 (***When pulling benefits by service type.***)



Other Service Types

ABORTION - 84
ACUPUNCTURE - 64
AIDS - 85
AIR TRANSPORTATION - 57
ALCOHOLISM - AJ
ALLERGY - GY
ALLERGY TESTING - 79
ALTERNATE METHOD DIALYSIS - 15
AMBULATORY SERVICE CENTER FACILITY - 13
ANESTHESIA - 07
ANESTHESIOLOGIST - 97
AUDIOLOGY EXAM - 71
BLOOD CHARGES - 10
BRAND NAME PRESCRIPTION DRUG - 91
BRAND NAME PRESCRIPTION DRUG - NON-FORMULARY - B3
BURN CARE - B1
Brand Name Prescription Drug - Formulary - B2
CABULANCE - 58
CANCER - 87

Getting Benefits in My Insurance Manager – Service Type

Printer-Friendly

Date of Service
04/30/2024

Insurance
Plan Name:
BLUECROSS AND BLUESHIELD OF SC
Plan ID:
38520
Member ID:
ZCZ065922516805
Group Number:
036011101
Member's Name:
MICHAEL TESTING

Patient
Patient's Name:
MICHAEL TESTING
Relationship to Member:
SUBSCRIBER
Gender:
MALE
Date of Birth:
10/01/1958
Address:
P O BOX 24015
COLUMBIA, SC 292244015

Change Patient

Response Details

Eligibility Response [+]

Policy Effective Date:
06/01/2002

Benefit Period:
04/01/2024 - 04/01/2025

View Benefit Booklet for this patient

IN AND OUT OF NETWORK

Global Benefits

This patient has active coverage.

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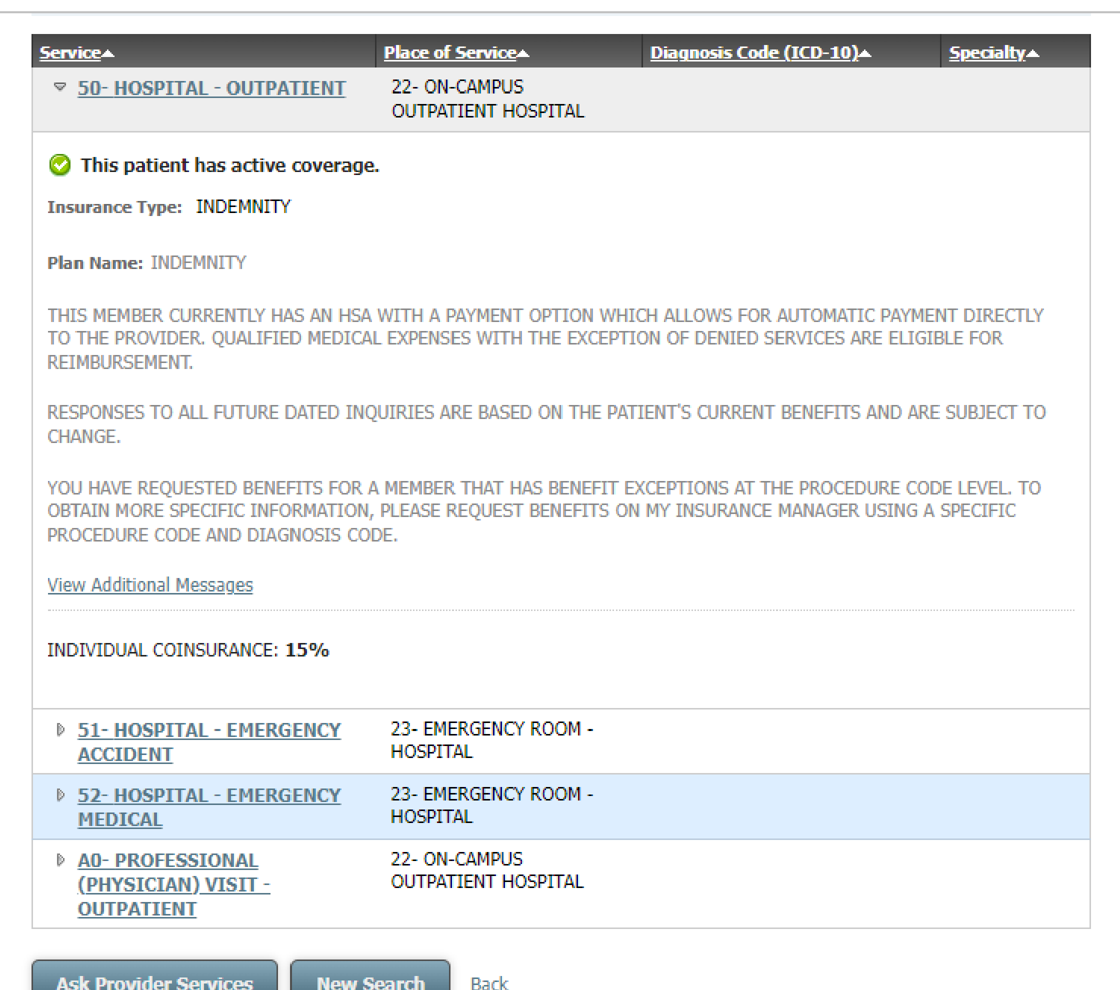
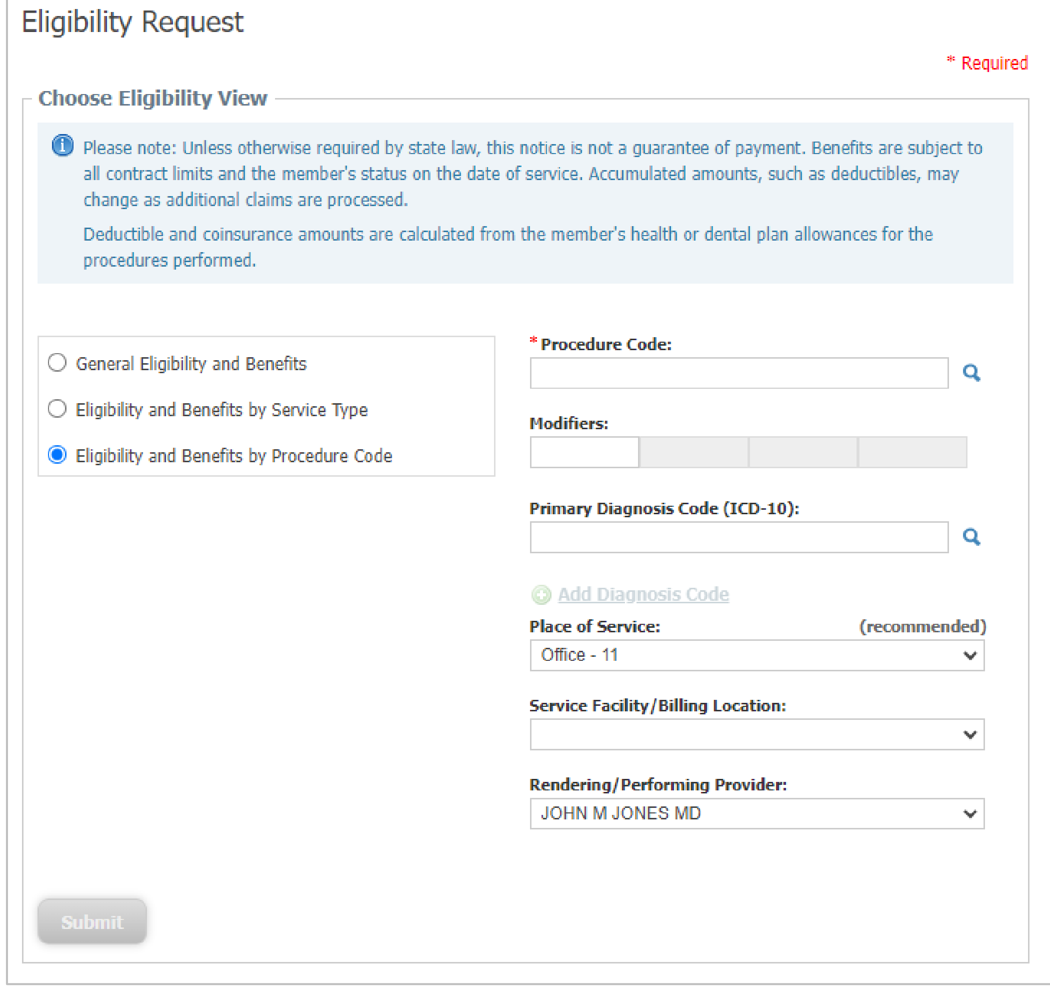
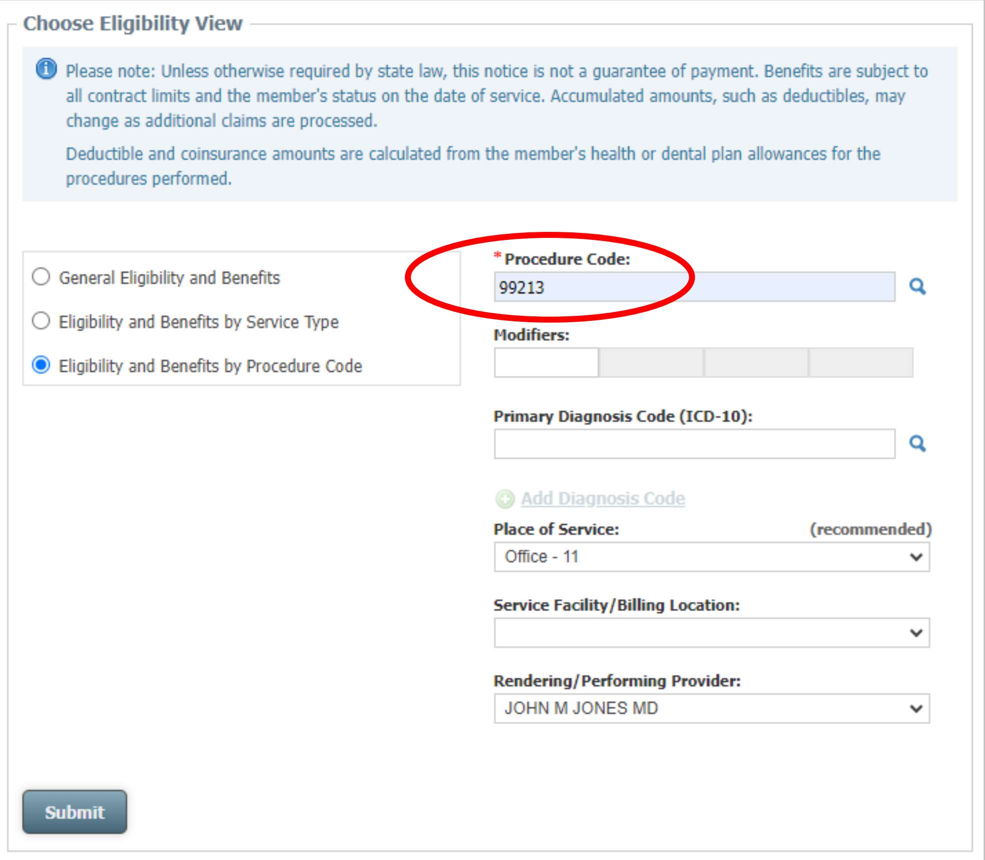


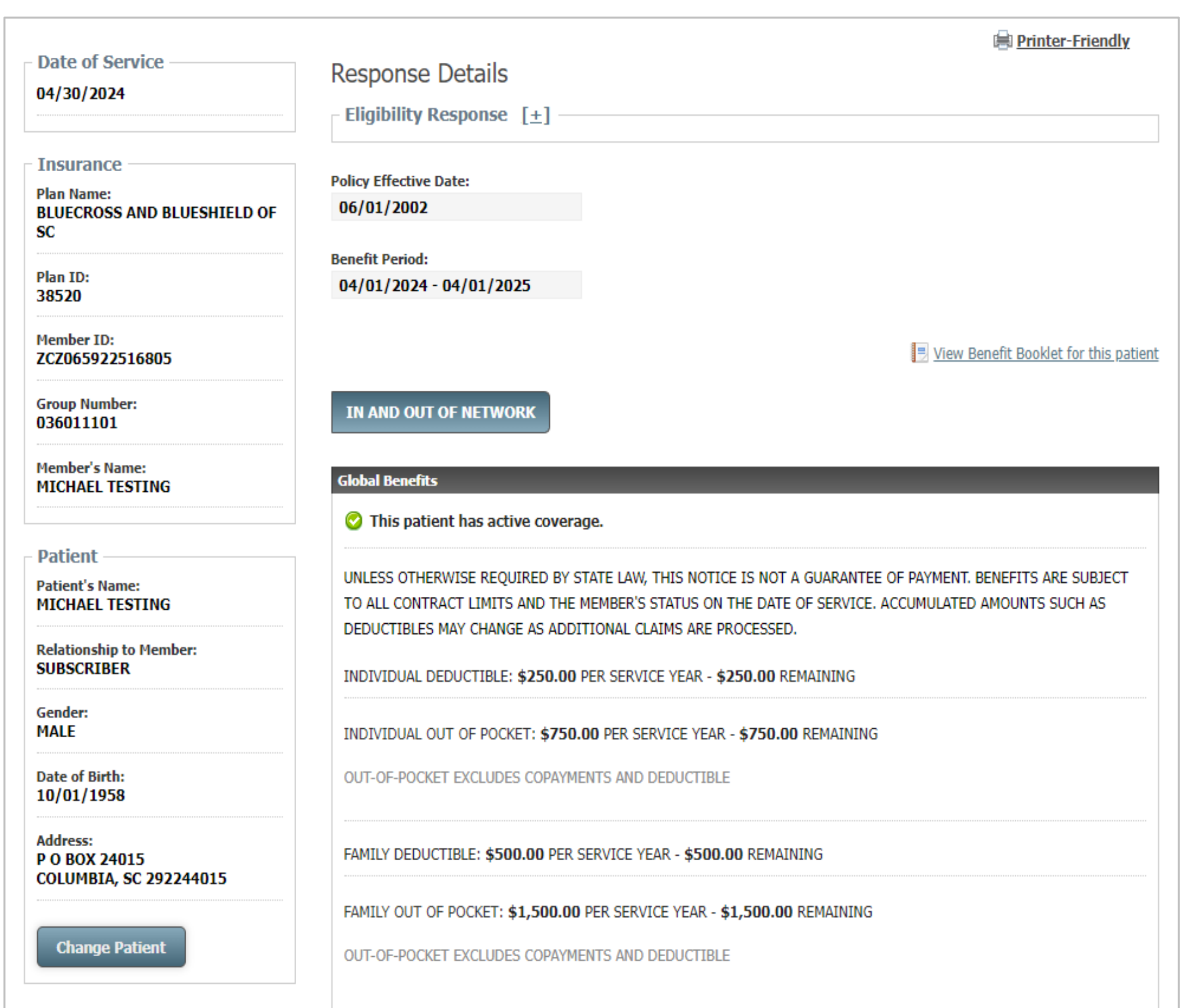
Getting Benefits in My Insurance Manager – Procedure Code

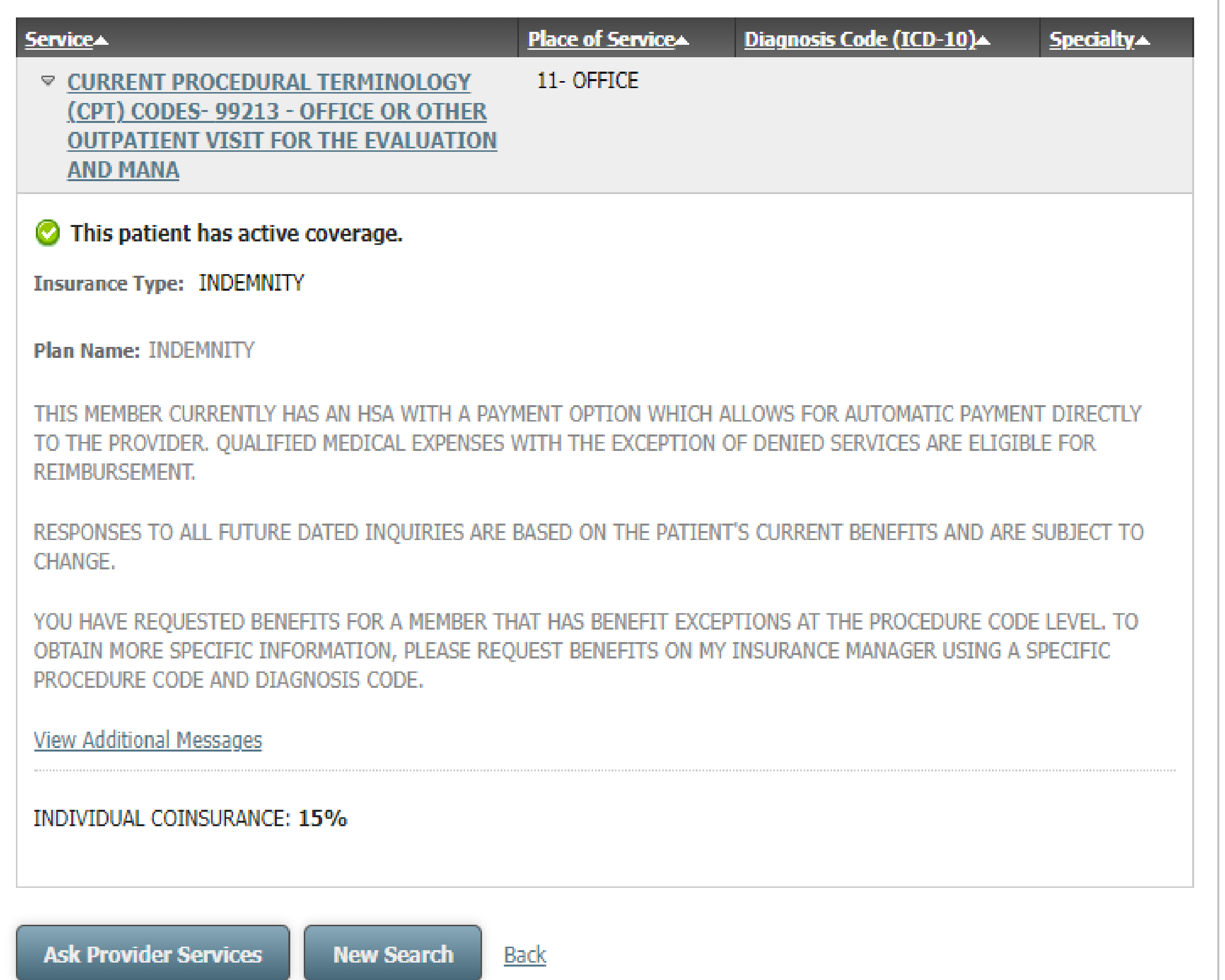
Step 3 (*When pulling benefits by procedure code.*)





Getting Benefits in My Insurance Manager – Procedure Code





Submitting Claims

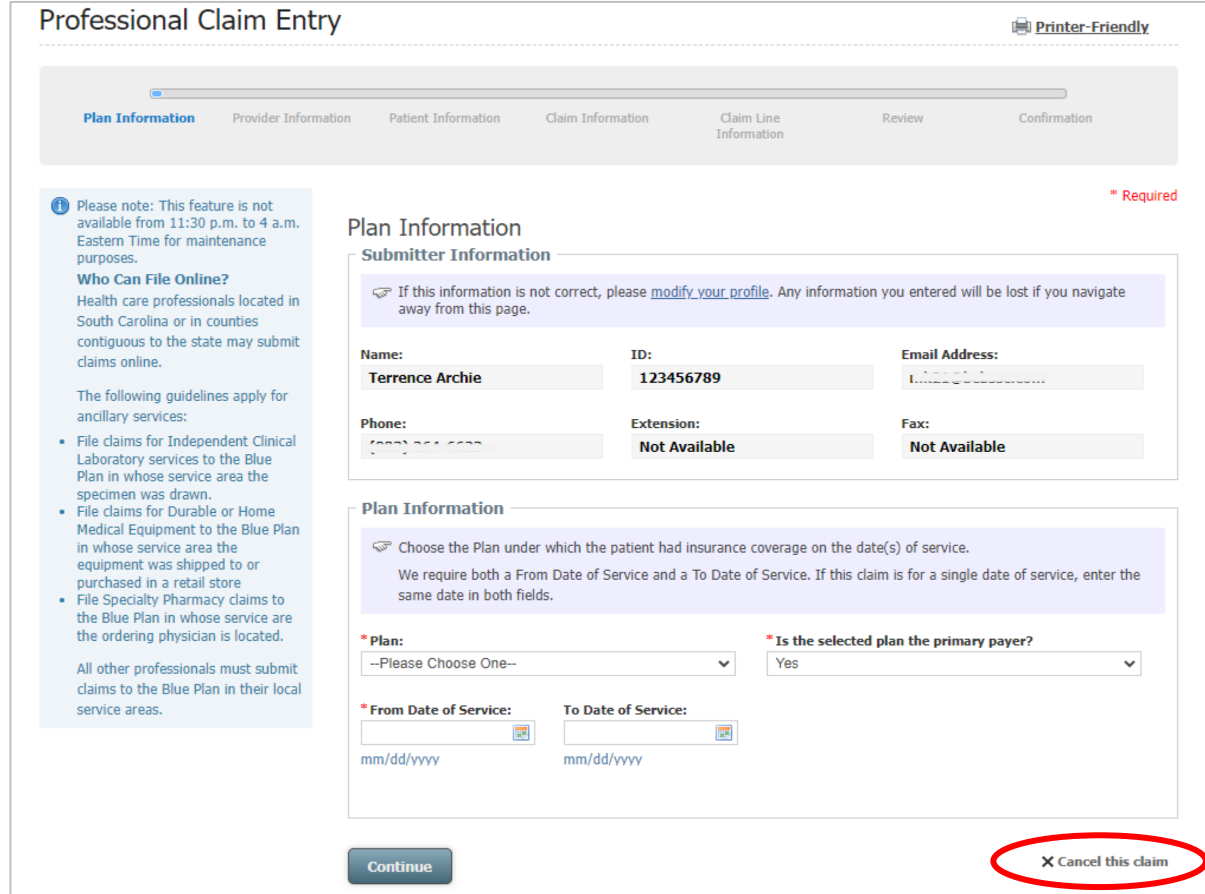
Submitting Claims Through My Insurance Manager

There are seven screens that you will progress through when using My Insurance Manager to submit claims.

Steps to Submit Claims Through My Insurance Manager

Start Here

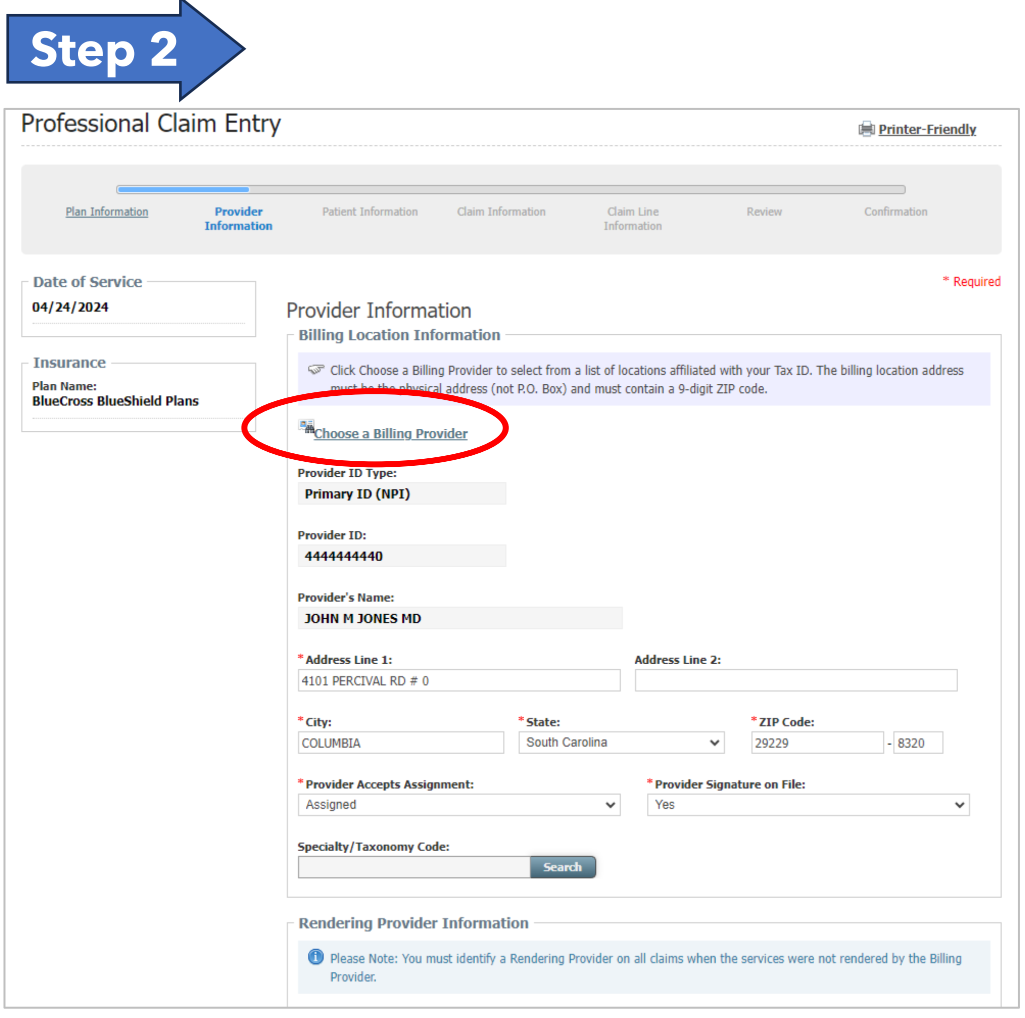
Step 1



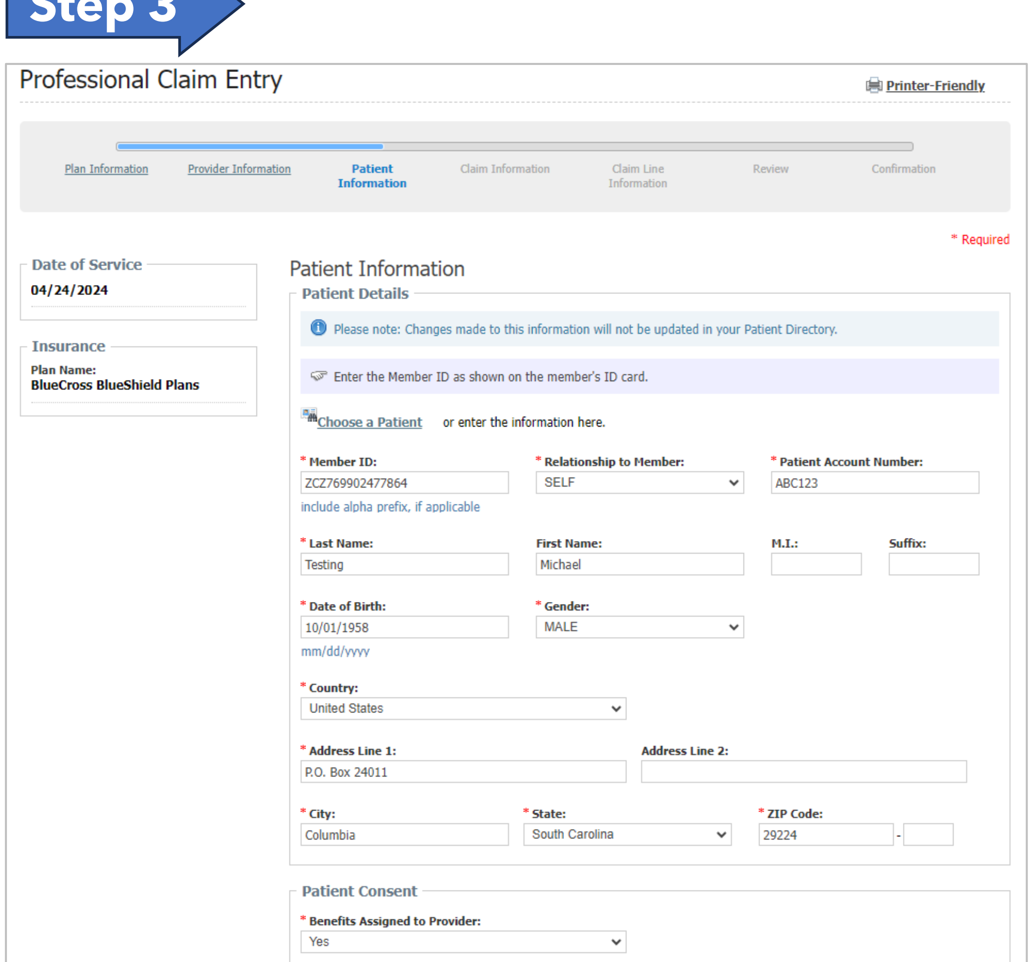
Note: At any time, you can select "Cancel this claim" to abort the process.

Steps to Submit Claims Through My Insurance Manager (Continued)

Step 2

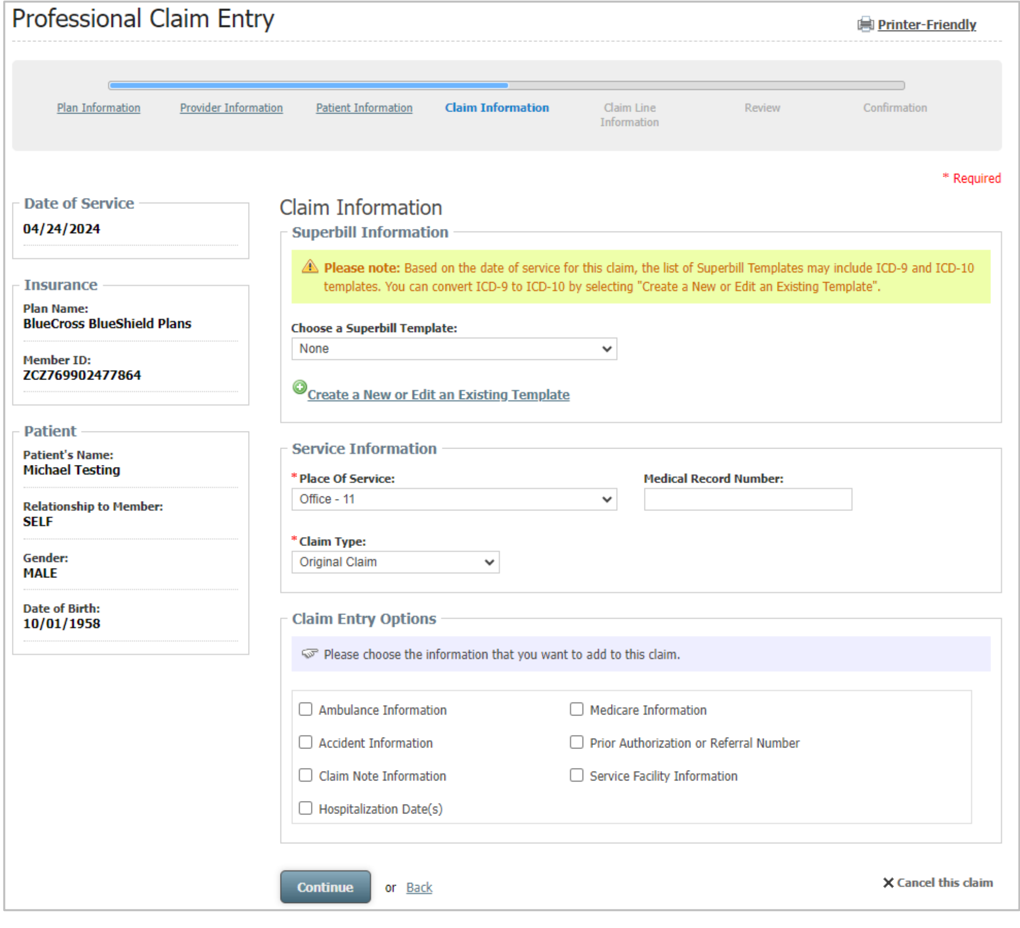


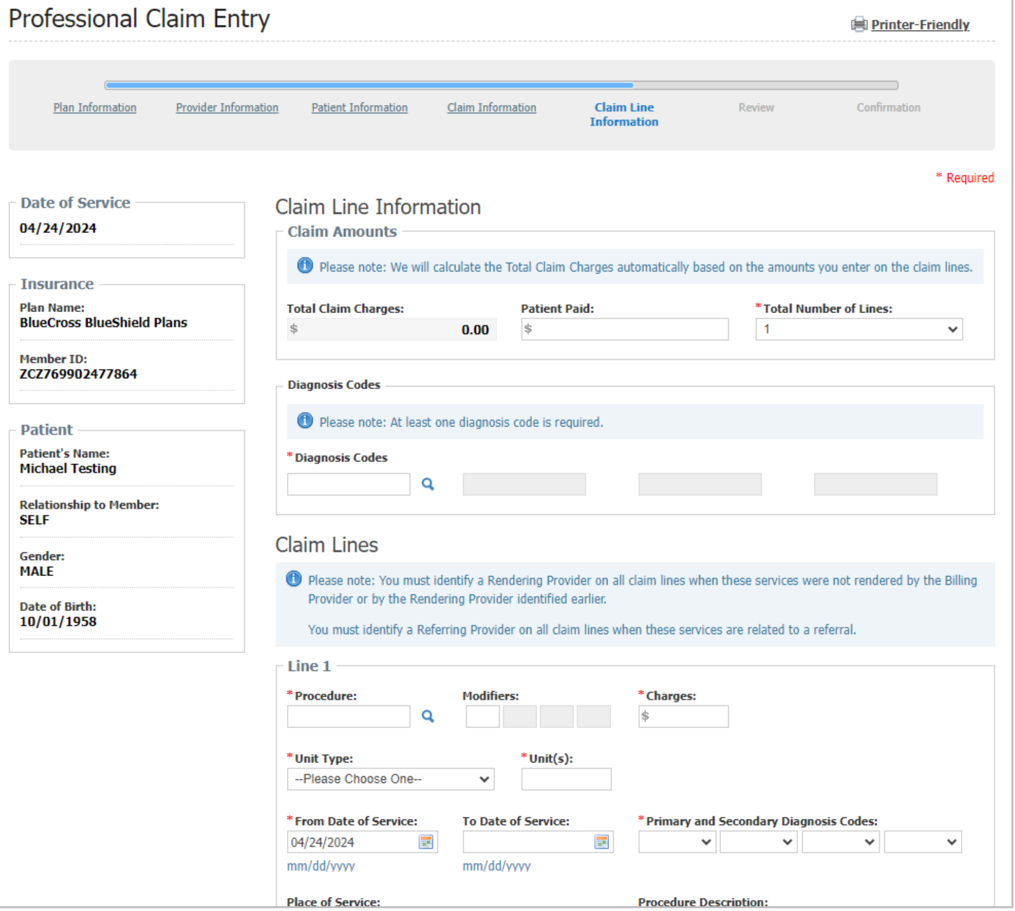
Step 3



Note: You must select "Choose a Billing Provider" if more than one location is on file.

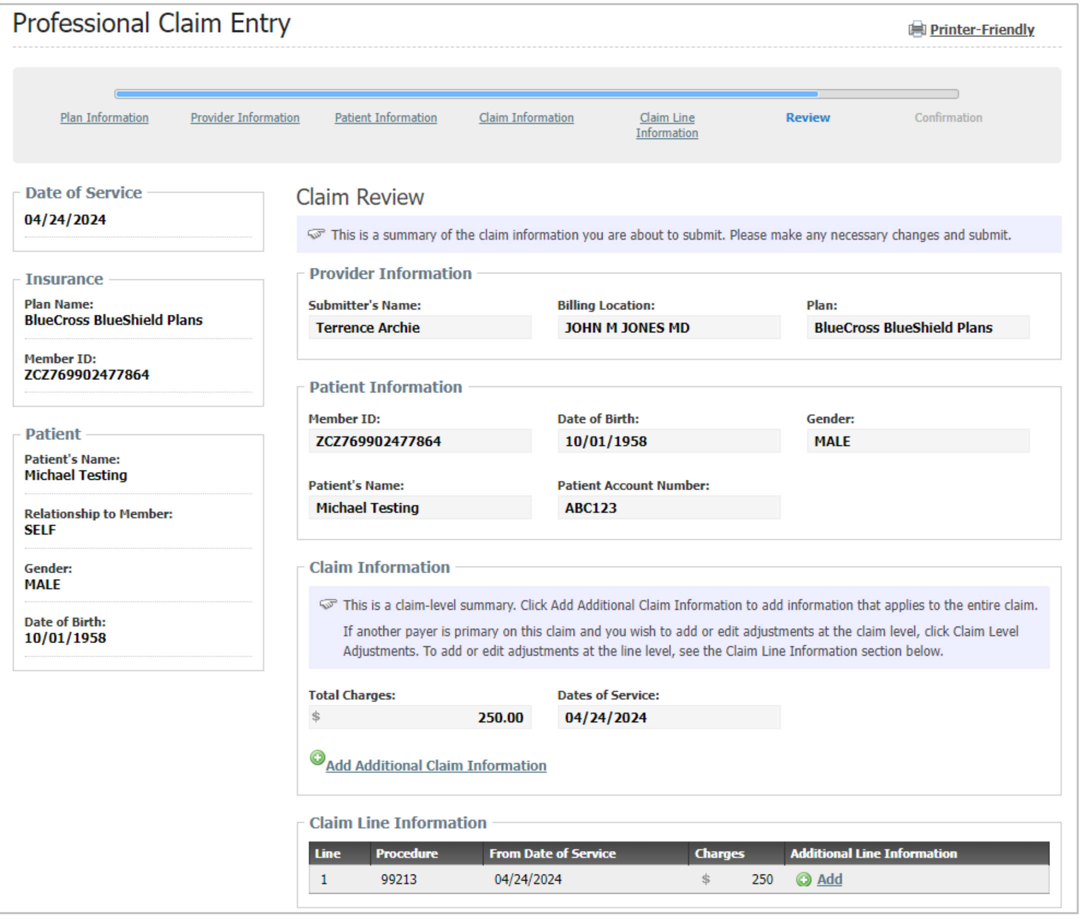
Steps to Submit Claims Through My Insurance Manager (Continued)





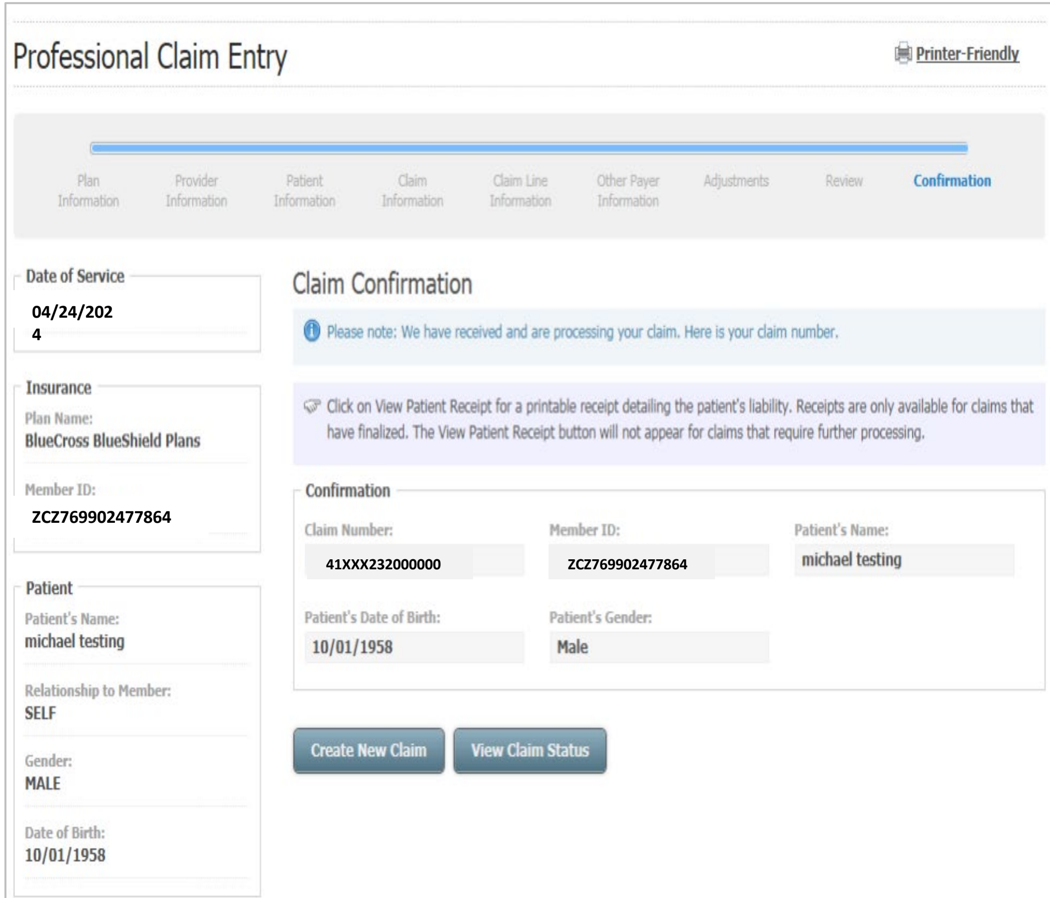
Steps to Submit Claims Through My Insurance Manager (Continued)

Step 6



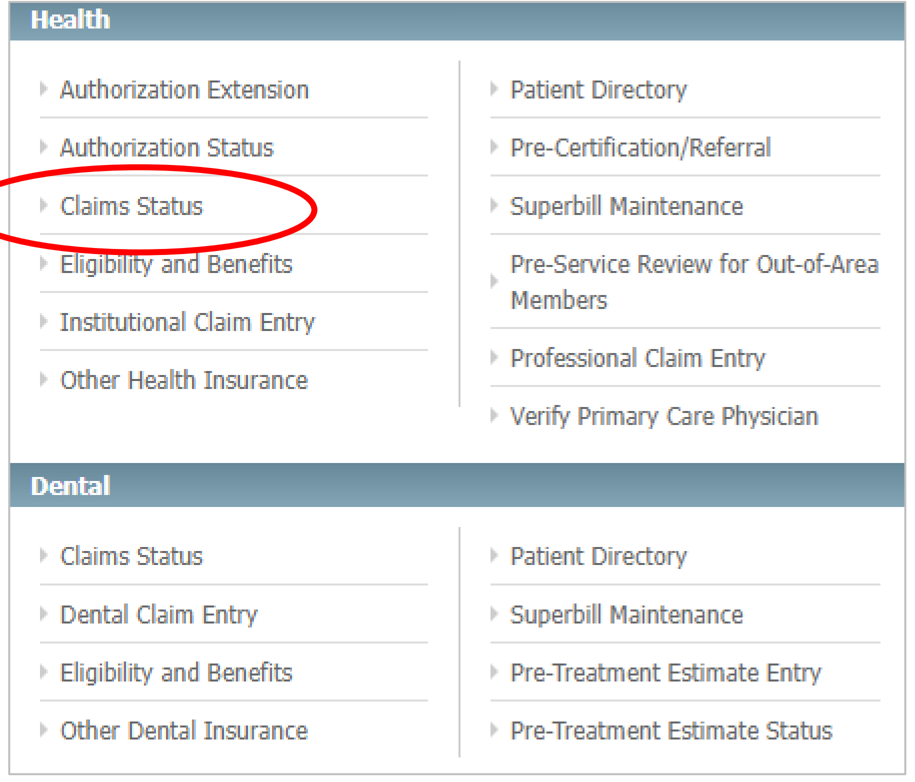
Select Submit from this screen.

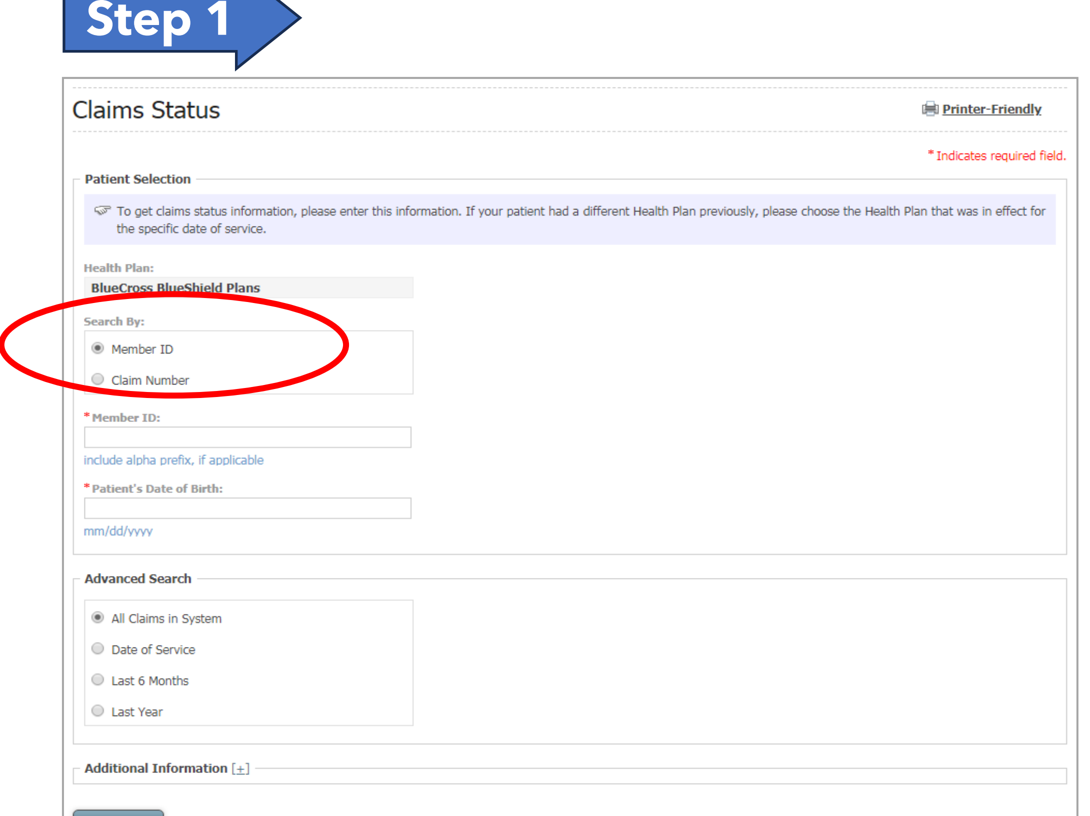
Step 7



Claims Status

Checking the Status of a Claim

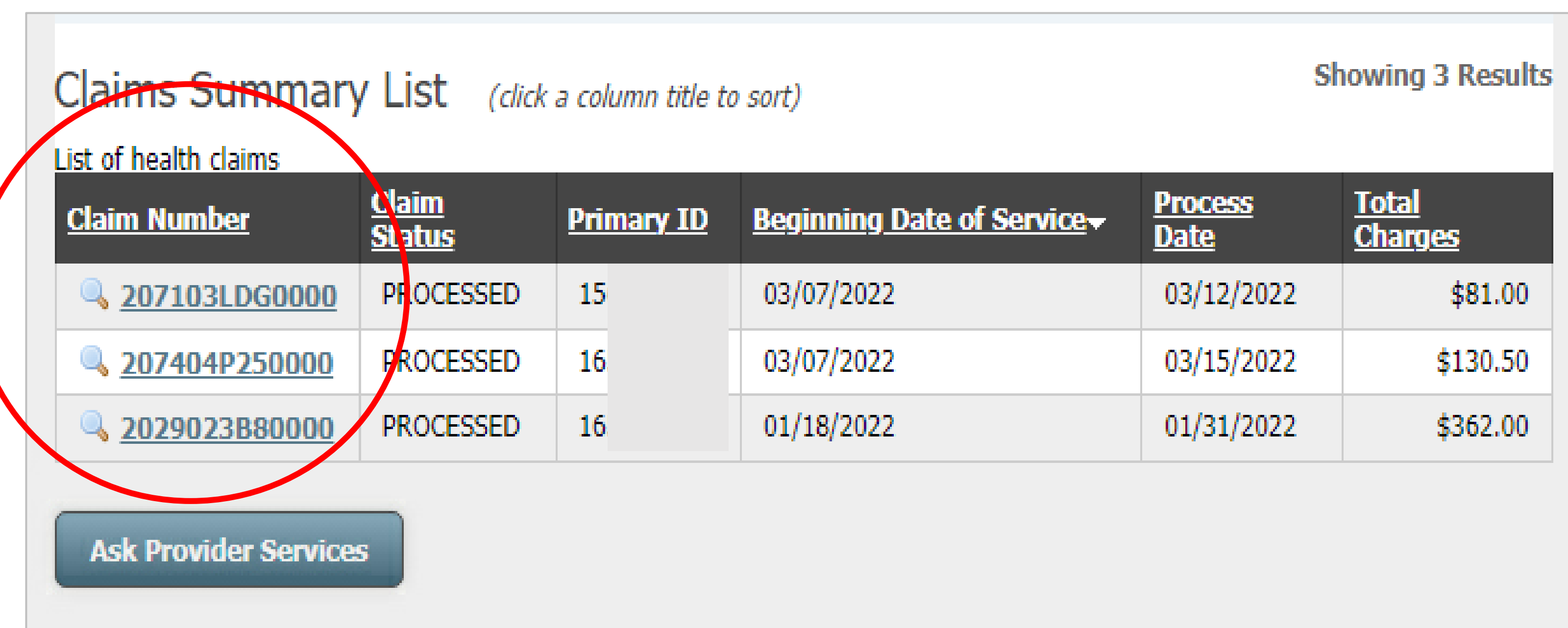




Note: Searching for claims using the member's identification number is the recommended option.

Checking the Status of a Claim (Continued)

Step 3

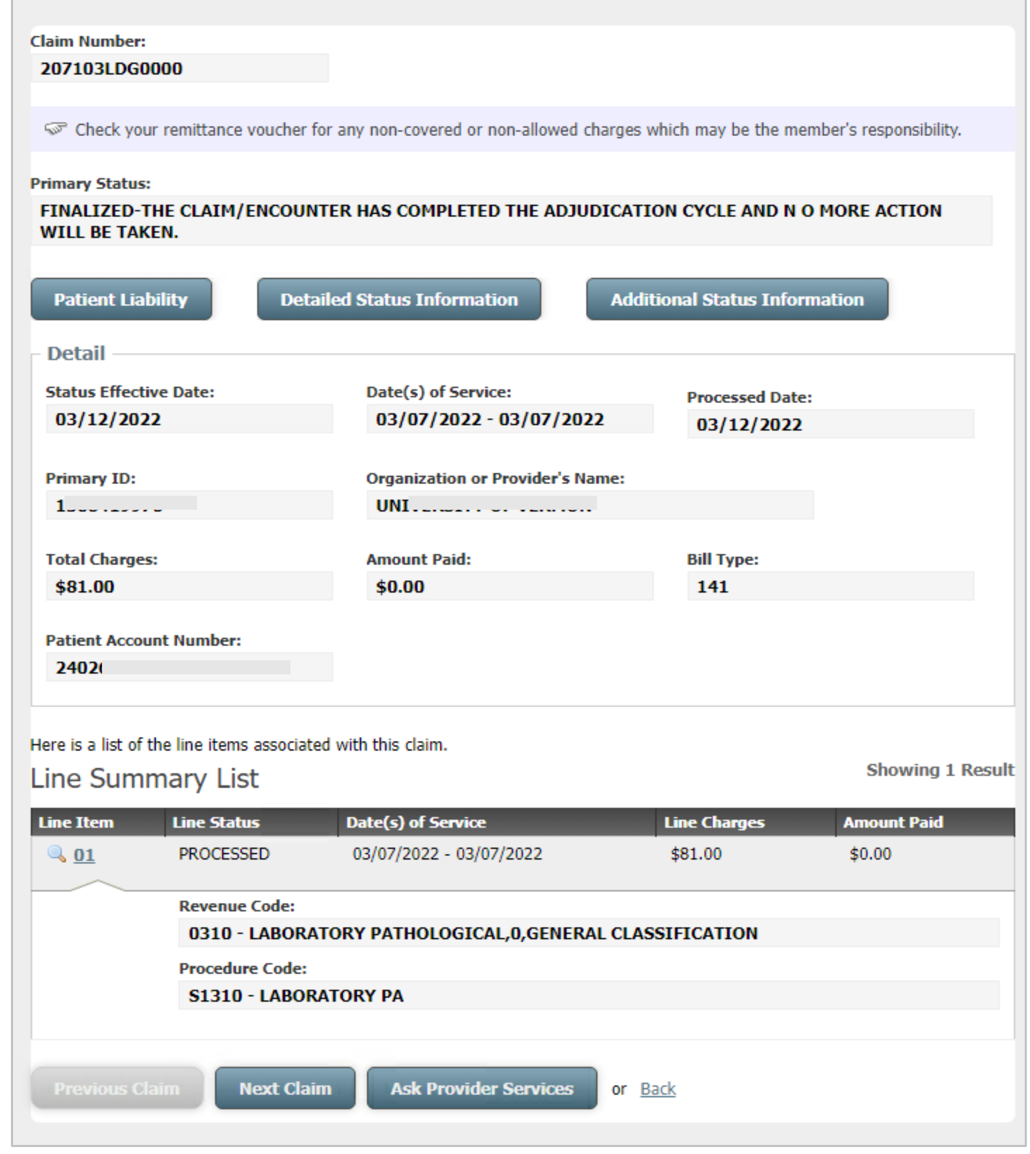

Claims Summary List *(click a column title to sort)*

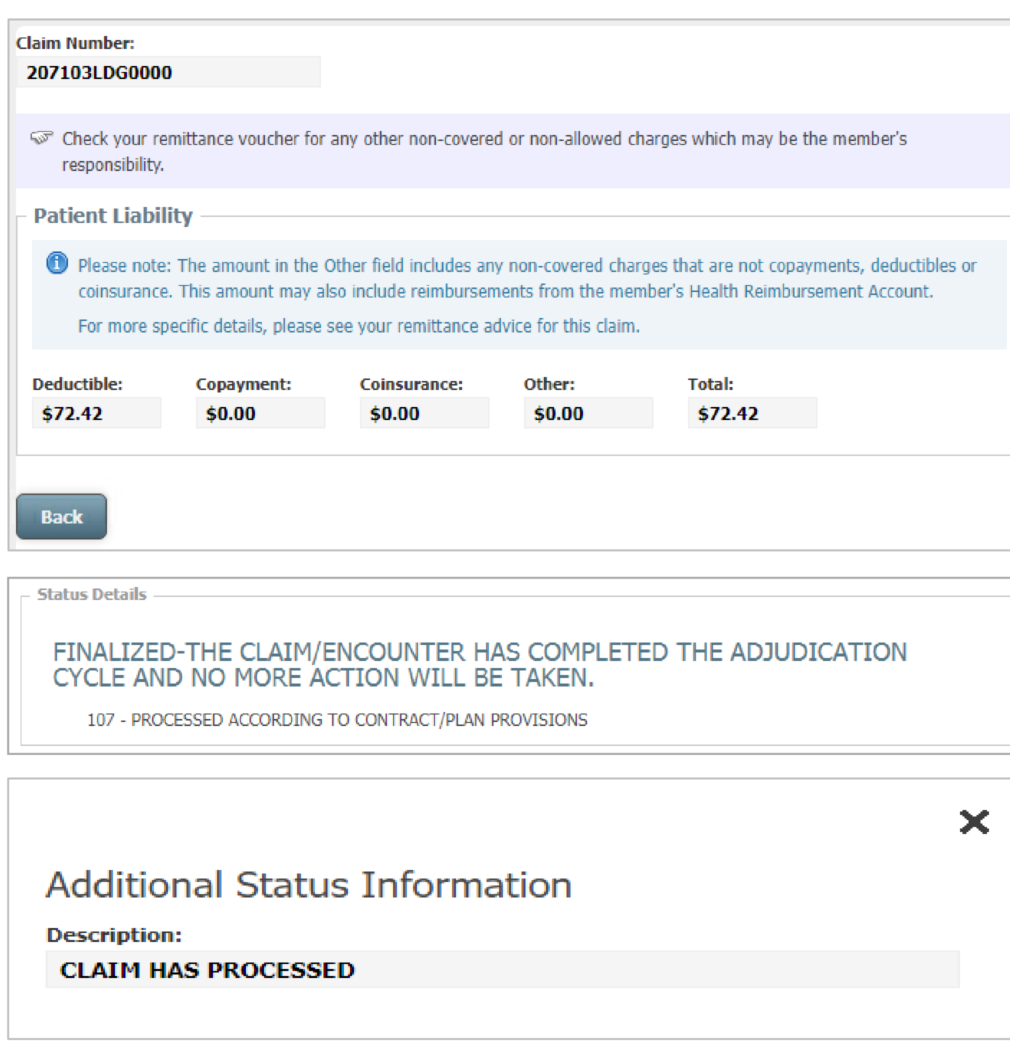
Showing 3 Results

List of health claims

Claim Number	Claim Status	Primary ID	Beginning Date of Service	Process Date	Total Charges
207103LDG0000	PROCESSED	15	03/07/2022	03/12/2022	$81.00
207404P250000	PROCESSED	16	03/07/2022	03/15/2022	$130.50
2029023B80000	PROCESSED	16	01/18/2022	01/31/2022	$362.00

Checking the Status of a Claim (Continued)





Ask Provider Services

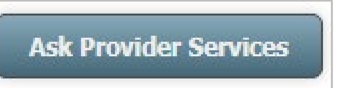
Overview of Ask Provider Services

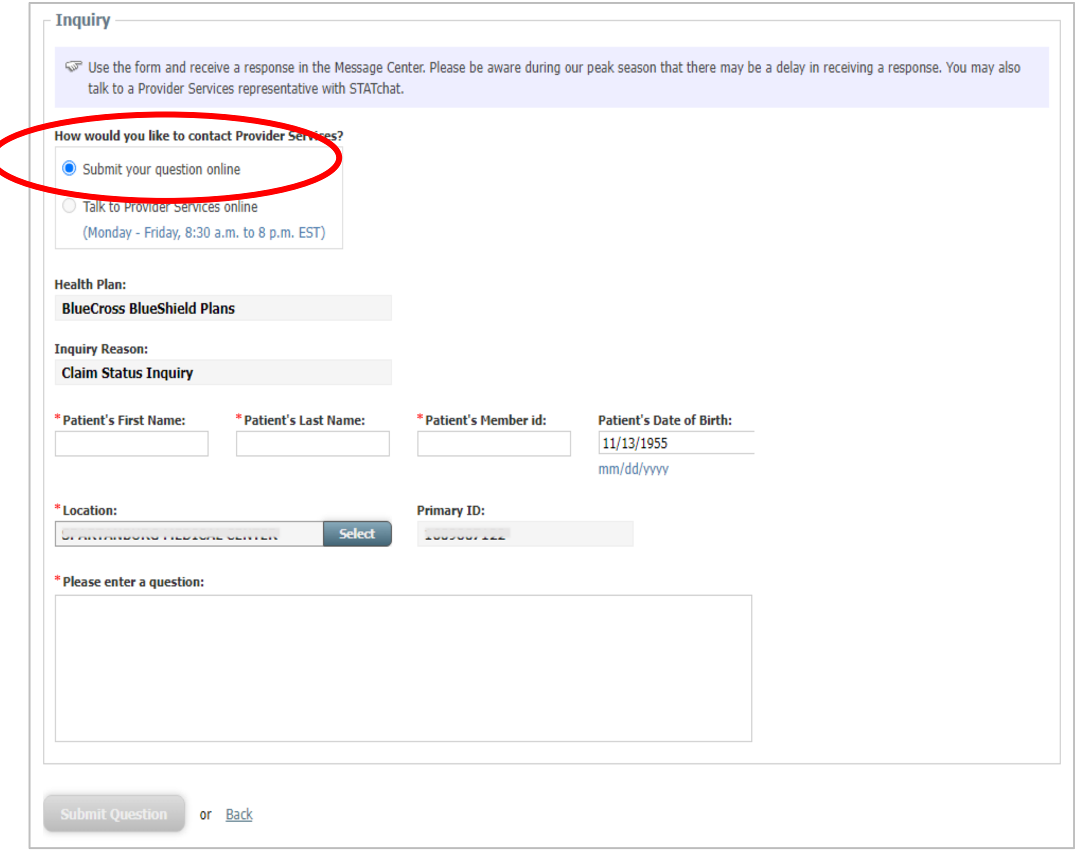
- ❑ Ask Provider Services is a feature in My Insurance Manager that lets you submit secured web inquiries for help with claims.
- ❑ This feature is intended to assist with ***complex issues*** and not general claim status.

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?
Has the member returned the coordination of benefits questionnaire?	Has the claim been processed?

Submitting Web Inquiries

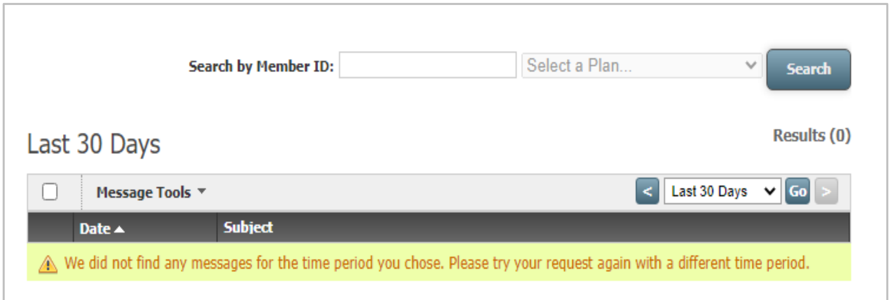
- Enter all the necessary information in the available fields.
- Be sure to ask clear, probing questions.
- Select Submit Question.

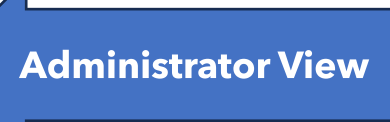


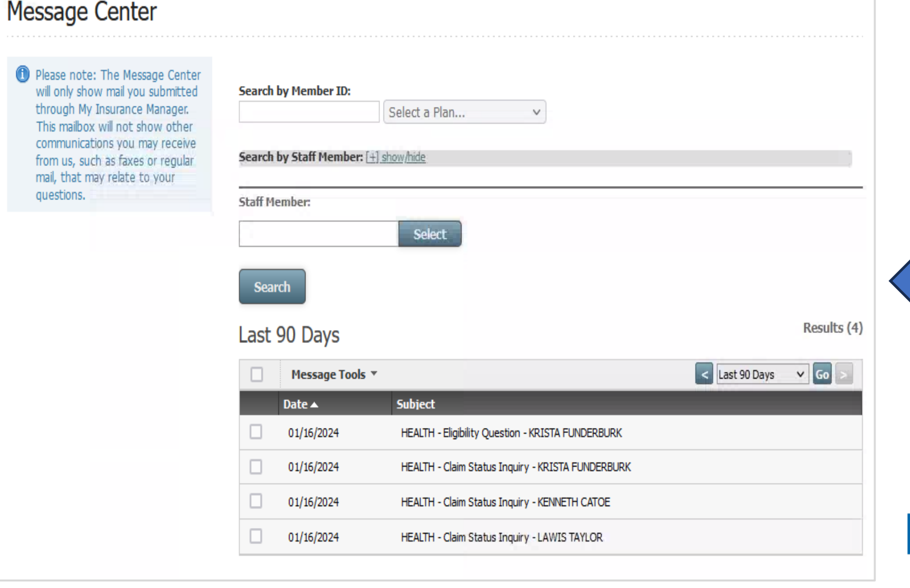


Viewing Web Inquiry Responses

- 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.







Administrator View

STATchat

Overview of STATchat

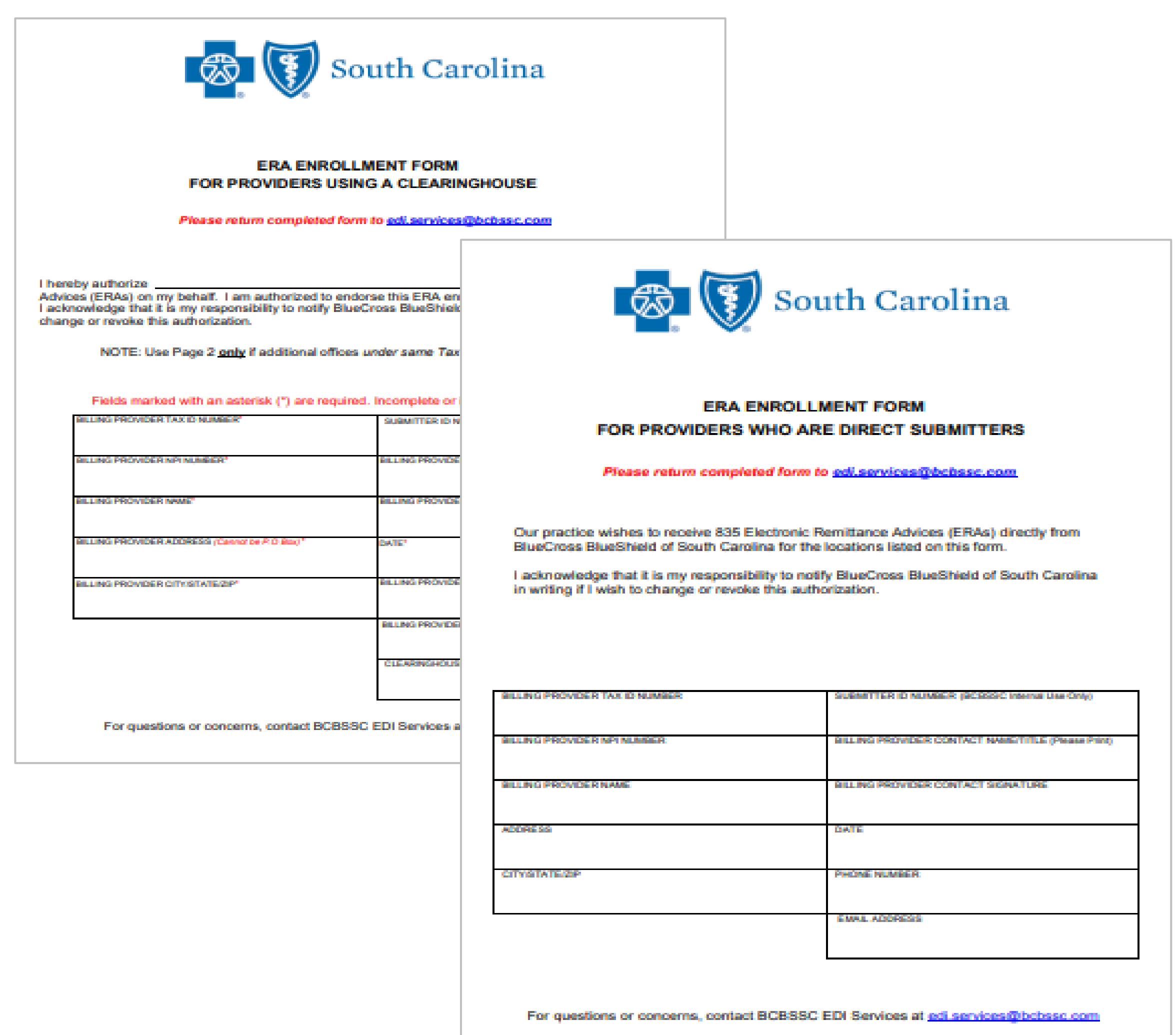
- ❑ STATchat is a fast and simple way to speak with a Provider Services representative.
- ❑ The feature is available through My Insurance Manager.
- ❑ System requirements include:
  - A current version of Adobe Flash Player
  - A compatible web browser, such as Microsoft Edge or Google Chrome.
  - A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

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

My Remit Manager

How to Receive Electronic Remittance Advices

- To pull remittances in My Remit Manager, you must ensure the necessary documents have been completed and submitted.
- Complete the ERA Enrollment Clearinghouse or ERA Enrollment Direct Submitter form located on www.SouthCarolinaBlues.com.
- Email the completed form to EDI.Services@bcbssc.com.


South Carolina

ERA ENROLLMENT FORM
FOR PROVIDERS USING A CLEARINGHOUSE

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

South Carolina

ERA ENROLLMENT FORM
FOR PROVIDERS WHO ARE DIRECT SUBMITTERS

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

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

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

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

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

Accessing My Remit Manager in My Insurance Manager

- ❑ While in My Insurance Manager, hover over Resources and select My Remit Manager.

Home | Patient Care | Office Management | Resources | Modify Profile | Profile Administration | Staff Directory | Provider Update

Tools

- Access System News
- BlueCard Program
- Code Search
- HIPAA Critical Center
- Medical Policies
- My Insurance Manager User Guides
- My Remit Manager
- National Doctor and Hospital Finder

Go to Message Center

Welc… r!

Our secure…

- Elig…
- Pre…
- Pro…
- Claim Status
- And much more!

Click on Patient Care in the top menu to access these transactions. To access EDI reports and remittances, click on Office Management. For My Insurance Manager user guides and provider education materials, click on Resources.

Thank you for using My Insurance Manager!

Viewing the Available Remittances

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

My Remit Manager

ERA by Check Date - May 2022

View Checks By: Check Date (Check Date / Posting Date)

Check Summary Report | Show Month

May 2022

	S	M	T	W	T	F	S
18	24 open	25 open CHK: 9	26 open CHK: 43	27 open	28 open	29 open CHK: 1	30 open
19	1 open	2 open CHK: 12	3 open CHK: 40	4 open CHK			
20	8 open	9 open CHK: 12	10 open CHK: 41	11 open			
21	15 open	16 open CHK: 11	17 open CHK: 57	18 open			

My Remit Manager

1 2 3 4 5 Page size: 10 — 44 items in 5 pages

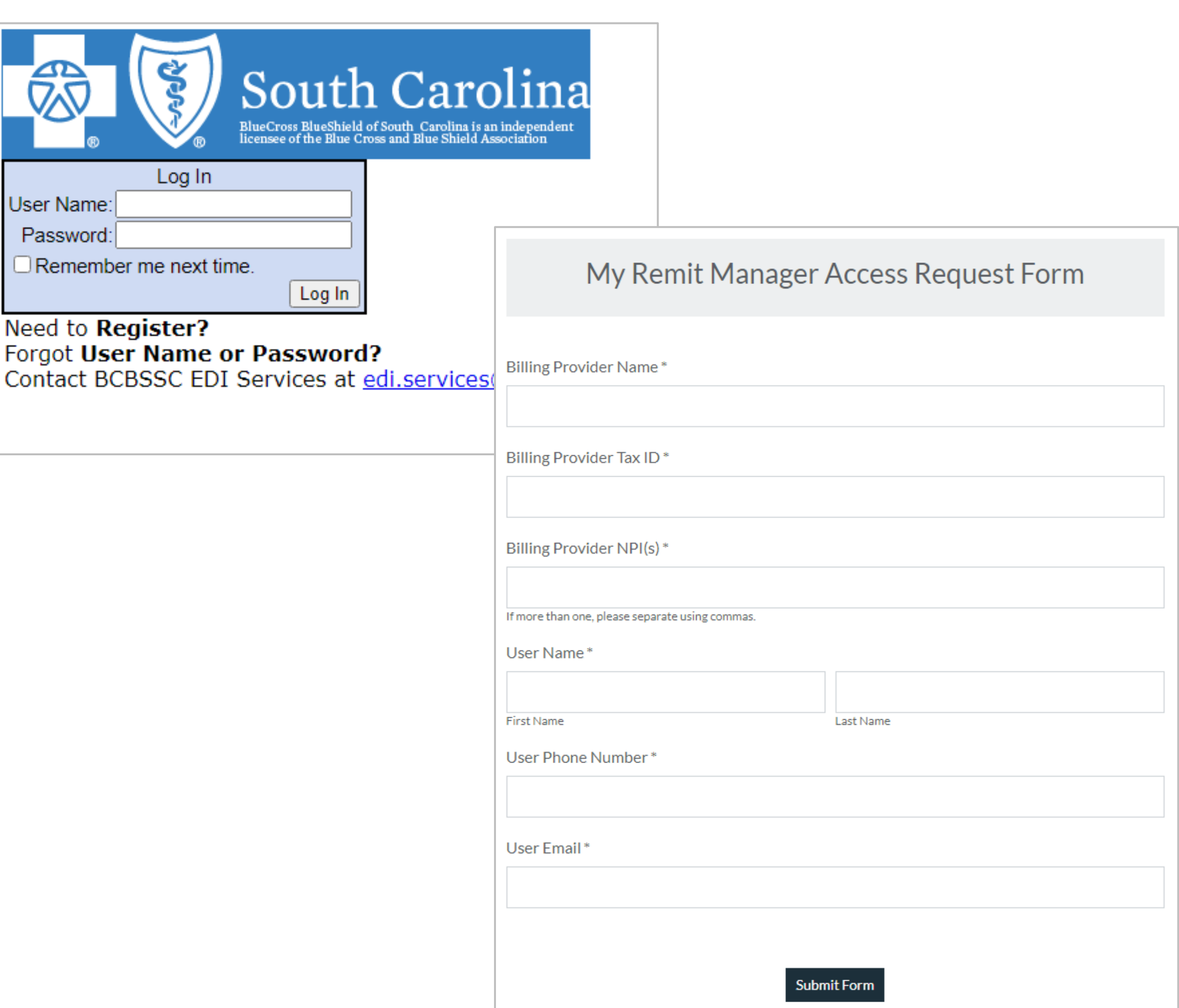
Reco	Download	Check Number	Payment Method	Checkdate	Postdate	Billed	Paid	Payer	Provider
			ACH	11/1/2022	10/30/2022	$9,485.00	$1,572.00	BLUECROSS BLUESHIELD OF SOUTH CAROLINA	
			ACH	11/1/2022	10/30/2022	$7,807.00	$1,749.13	STATE HEALTH PLAN	
			ACH	11/1/2022	10/30/2022	$530.00	$132.00	FEDERAL EMPLOYEE PLAN	
			ACH	11/1/2022	10/30/2022	$2,105.00	$213.04	BLUECROSS BLUESHIELD OF SOUTH CAROLINA	
			ACH	11/1/2022	10/30/2022	$1,157.00	$96.18	STATE HEALTH PLAN	
			ACH	11/1/2022	10/30/2022	$769.00	$141.47	FEDERAL EMPLOYEE PLAN	
			ACH	11/1/2022	10/30/2022	$178.00	$117.00	BLUECROSS BLUESHIELD OF SOUTH CAROLINA	
			ACH	11/1/2022	10/30/2022	$196.80	$24.14	STATE HEALTH PLAN	
			ACH	11/1/2022	10/30/2022	$1,410.00	$78.99	BLUECROSS BLUESHIELD OF SOUTH CAROLINA	
			ACH	11/1/2022	10/30/2022	$1,710.00	$380.05	STATE HEALTH PLAN	

1 2 3 4 5 Page size: 10 — 44 items in 5 pages

Check Selected:

External Access to My Remit Manager

- Link: https://client.webclaims.com/v07_03/
- To sign up, email EDI.Services@bcbssc.com.
- You can also complete the My Remit Manager Access Request Form located on www.SouthCarolinaBlues.com.



Start With the ERA Tab

- ❑ Select the ERA tab to view the check and remittance information.

My Remit Manager

HOME | ERA | PASSWORD

MESSAGES

> MESSAGES

Login: 'yuma.user' Account: Logout

Rx Positive (Yuma AZ) -

Announcements

Welcome to My Remit Manager.

With this system providers can easily manage their electronic payments and retrieve ERA and EOB reports.

With the Version 7 introduction of the My Remit Manager our providers will enjoy the addition of many features and enhancements to better assist their billing management needs.

Pulling the Remittance

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

HOME | REALTIME | CLAIMS | ERA | PASSWORD | ADMIN

CHECK DATE | POST DATE | PATIENTS | REPORTS | DOWNLOAD ERA

> CHECKS BY CHECK DATE

Switch Accounts

Select Date

June 2021

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
>	30	31 1	1	2 2	3	4	5
>	6	7	8 4	9	10	11	12
>	13	14	15 3	16	17	18	19
>	20	21	22 5	23	24	25	26
>	27	28	29	30	1	2	3
>	4	5	6	7	8	9	10

Billed vs. Paid by Week

18K 16K 14K 12K 10K 8K 6K 4K 2K 0K

Order By Name   Download ERA Download X12

Search for   Search   Select All Unselect All

Hide Reconciled   Payer *All Items   Provider *All Items

	RECO	CHECK NUMBER	CHECK TYPE	CHECK DATE	POST DATE	BILLED	PAID	PROVIDER	PAYER	TYPE
Select	☐	00025	CH	6/15/2021	6/13/2021	1879.00	354.33	LO SU		5010
Select	☐	00004	CH	6/15/2021	6/13/2021	2169.00	680.09	LO SU		5010
Select	☐	00011	CH	6/15/2021	6/13/2021	4981.00	880.26	LO SU		5010

Pulling the Remittance (Continued)

❑ Select the account for the patient.

HOME | REALTIME | CLAIMS | ERA | PASSWORD | ADMIN

CHECK DATE | POST DATE | PATIENTS | REPORTS | DOWNLOAD ERA

> CHECKS BY CHECK DATE > PATIENTS

Check Number/Date
Payer
Provider
Status: All Items

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

1 Records 1-5 of 5

ACCOUNT	PATIENT		STATUS	POLICY	Displ
46184		☐	Processed as Primary		5/30
46208		☐	Processed as Primary		6/2/
46039		☐	Processed as Secondary		5/13
46157		☐	Processed as Primary		6/1/
46008		☐	Processed as Secondary		5/17

ERA Patient Listing

Electronic Reproduction ASC 005010X221A1

CHECK/EFT: **CHECK DATE: 06/15/2021**

Account: 46030 POS: 11 HIC: ICN: 1 Provider: 1 3
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

Thank you!