2021 ANNUAL PROVIDER SUMMIT

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

Independent licensees of the Blue Cross and Blue Shield Association

Welcome and Introductions

Provider Relations' mission is to serve as liaisons between BlueCross BlueShield of South Carolina, BlueChoice HealthPlan and the health care community to promote positive relationships through continued education and problem resolution.

Topics

- Quality
- Dental
- Pharmacy
- COVID-19
- Provider Enrollment
- Claims
- Authorizations
- Healthy Blue℠
- Benefits

Quality

Agenda

- The National Committee for Quality Assurance (NCQA®)
- HealthCare Effectiveness Data and Information Set (HEDIS®)
- Requests for Information and Compliance
- 2020 Measurement Year/HEDIS 2021 Changes
- Quality Navigator Program
- Key Takeaways

The National Committee for Quality Assurance (NCQA)

National Committee for Quality Assurance (NCQA)

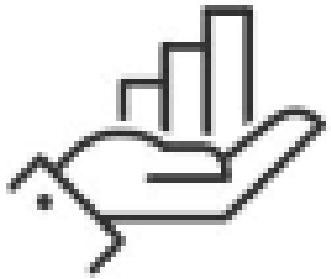
What is the National Committee for Quality Assurance (NCQA)?

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

National Committee for Quality Assurance (NCQA)

What does the NCQA mean to You?

Contracts
Bonuses
Incentives



Reporting data back to the plan

Patient Safety

HealthCare Effectiveness Data and Information Set (HEDIS)

Healthcare Effectiveness Data and Information Set

What is Healthcare Effectiveness Data and Information Set (HEDIS)

- Used to track trends in population health

What entities use HEDIS data?

- NCQA
- Centers for Medicare and Medicaid Services (CMS®)
- Federal Employee Program (FEP)

Healthcare Effectiveness Data and Information Set

HEDIS "Season"

- Sometimes referred to as "Retrospective Season" or "Hybrid Season"
- A look back at the care given or due in the year prior
- January to May of the year AFTER
  - 2020 is the measurement year being reviewed during HEDIS 2021
- Members from your practice will be chosen by NCQA
- All member documentation that is requested is required based on the selected HEDIS measure

Healthcare Effectiveness Data and Information Set

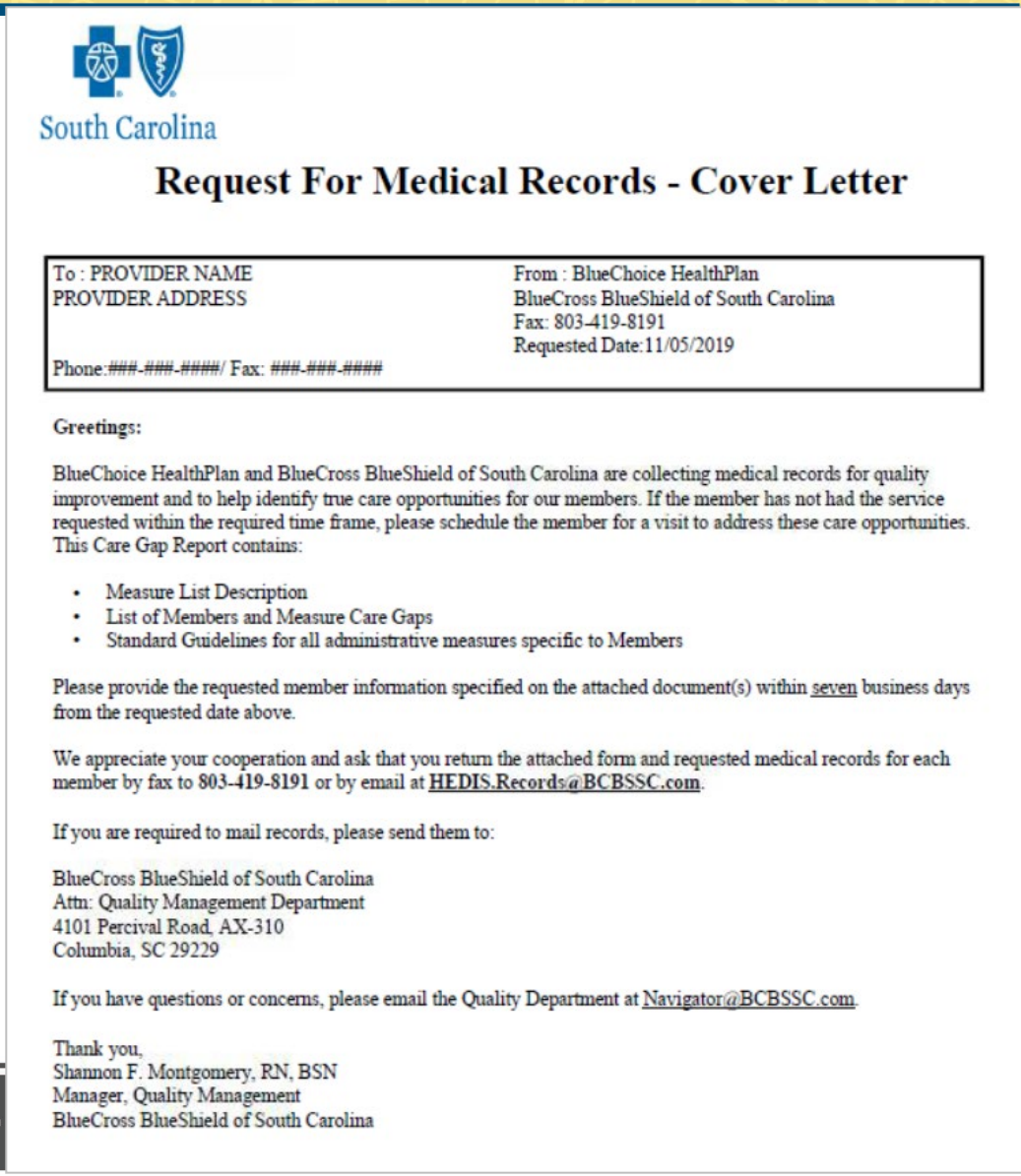
HEDIS "Year-round"

- Sometimes referred to as "Prospective Season"
- Continuously monitoring rates in real-time
- Jan. 1- Dec. 31 of the year being measured
- Total membership rates
- More compliance options
  - Claims
  - Data Transfer
  - Medical Records
  - Compliance Forms

Requests for Information

Requests for Information

- Sent via email, fax, or mail by practice preference
  - We can negate all medical record requests if given remote access to your EMR
    - NAVIGATOR@bcbssc.com
  - You will not receive medical record requests for compliance that was already received during Year Round HEDIS
- Requests are based on claims



South Carolina

Request For Medical Records - Cover Letter

To : PROVIDER NAME PROVIDER ADDRESS Phone:###-###-####/ Fax: ###-###-####	From : BlueChoice HealthPlan BlueCross BlueShield of South Carolina Fax: 803-419-8191 Requested Date:11/05/2019

Greetings:

BlueChoice HealthPlan and BlueCross BlueShield of South Carolina are collecting medical records for quality improvement and to help identify true care opportunities for our members. 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. This Care Gap Report contains:

- Measure List Description
- List of Members and Measure Care Gaps
- Standard Guidelines for all administrative measures specific to Members

Please provide the requested member information specified on the attached document(s) within seven business days from the requested date above.

We appreciate your cooperation and ask that you return the attached form and requested medical records for each member by fax to **803-419-8191** or by email at HEDIS.Records@BCBSSC.com.

If you are required to mail records, please send them to:

BlueCross BlueShield of South Carolina
Attn: Quality Management Department
4101 Percival Road, AX-310
Columbia, SC 29229

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

Thank you,
Shannon F. Montgomery, RN, BSN
Manager, Quality Management
BlueCross BlueShield of South Carolina

Requests for Information

- Most recent HbA1C monitoring test documented in lab or progress note including a date and result, performed any time during 1/1/2020 through 12/31/2020.
- Evidence of nephropathy/ nephropathy screening/ monitoring test performed any time during 1/1/2020 through 12/31/2020 as documented by one of the following:
  - A urine test for protein or albumin from lab results or progress notes.
  - Documentation of a visit to a nephrologist — must provide nephrologist's information
  - Documentation of renal transplant.
  - Documentation of nephrectomy.
  - Prescription of an ACE inhibitor/ ARB therapy (from medication list).

  Note: Medical Attention for nephropathy is only applicable for members belonging to Exchange and Medicare product line
- **Eye exam — including type of examination (dilated/ retinal/ funduscopic/ bilateral eye nucleation) and results, performed any time during 1/1/2020 through 12/31/2020.**
  Note: Can accept a note with a date of service any time from 1/1/2019 through 12/31/2019 if result is negative for diabetic retinopathy and there is documentation of the provider type (ophthalmologist or optometrist)

Providers only need to send back the requested documentation in **BOLD**!

Requests for Information

Please check the appropriate box:

[ ] Documentation of requested information. *** Medical Record attached***

[ ] The member was in hospice or received palliative care any time during 1/1/2020 through 12/31/2020. ***Medical Record Attached***

[ ] This member has a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes any time during 1/1/2019 through 12/31/2020 ***Medical Record Attached***

[ ] No medical records with requested information during the time frame specified.

[ ] This is not my patient.

Measure Changes

2020 Measurement Year/HEDIS 2021 Changes

Measure Changes: 2020 Measurement Year/HEDIS 2021 Changes

Timelines

- 2020 measurement year final specs were released in October 2020 and impact from Jan. 1, 2020 to Dec. 31, 2020
- 2021 measurement year final specs scheduled release March 2021 and impact from Jan. 1, 2021 to Dec. 31, 2021

Palliative Care Exclusions

- Added to 15 measures

Telehealth

- NCQA expanded telehealth options and reduced restrictions for 2020MY and have proposed the same expansions for 2021 measurement year
- www.ncqa.org/COVID

Measure Changes: 2020 Measurement Year/HEDIS 2021 Changes

Measure Updates continued

- **CBP: Controlling High Blood Pressure**
  - Changed denominator inclusion to stop in June of the measurement year
  - Blood pressures taken with any digital device are acceptable
  - Telehealth allowed
- **CDC: Comprehensive Diabetes Care**
  - Addition of Polycystic Ovarian Syndrome optional exclusion
  - Addition of AI (Artificial Intelligence) interpreted retinal eye exams
- **WCC: Weight Assessment, Counseling for Nutrition, Counseling for Physical Activity**
  - Allow member reported biometric data
  - Telehealth allowed

Measure Changes: 2020 Measurement Year/HEDIS 2021 Changes

Measure Updates Continued

- **W30: Well-Child Visits in the First 30 Months of Life**
  - Used to be W15 (Well-Child Visits in the first 15 months of life)
  - 6 well-child visits in the first 15 months
  - 2 well-child visits in the 15-30 months of life
  - Retrospective sample not allowed- entire population rate only
  - Telehealth allowed
- **WCV: Child and Adolescent Well-Care Visits**
  - Combined W34 (Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life) and AWC (Adolescent Well Care) and added in ages 7- 11
  - 1 well-child visit during the measurement year for ages 3-21 years
  - Retrospective sample not allowed- entire population rate only
  - Telehealth allowed

Quality Navigator Program

Quality Navigator Program

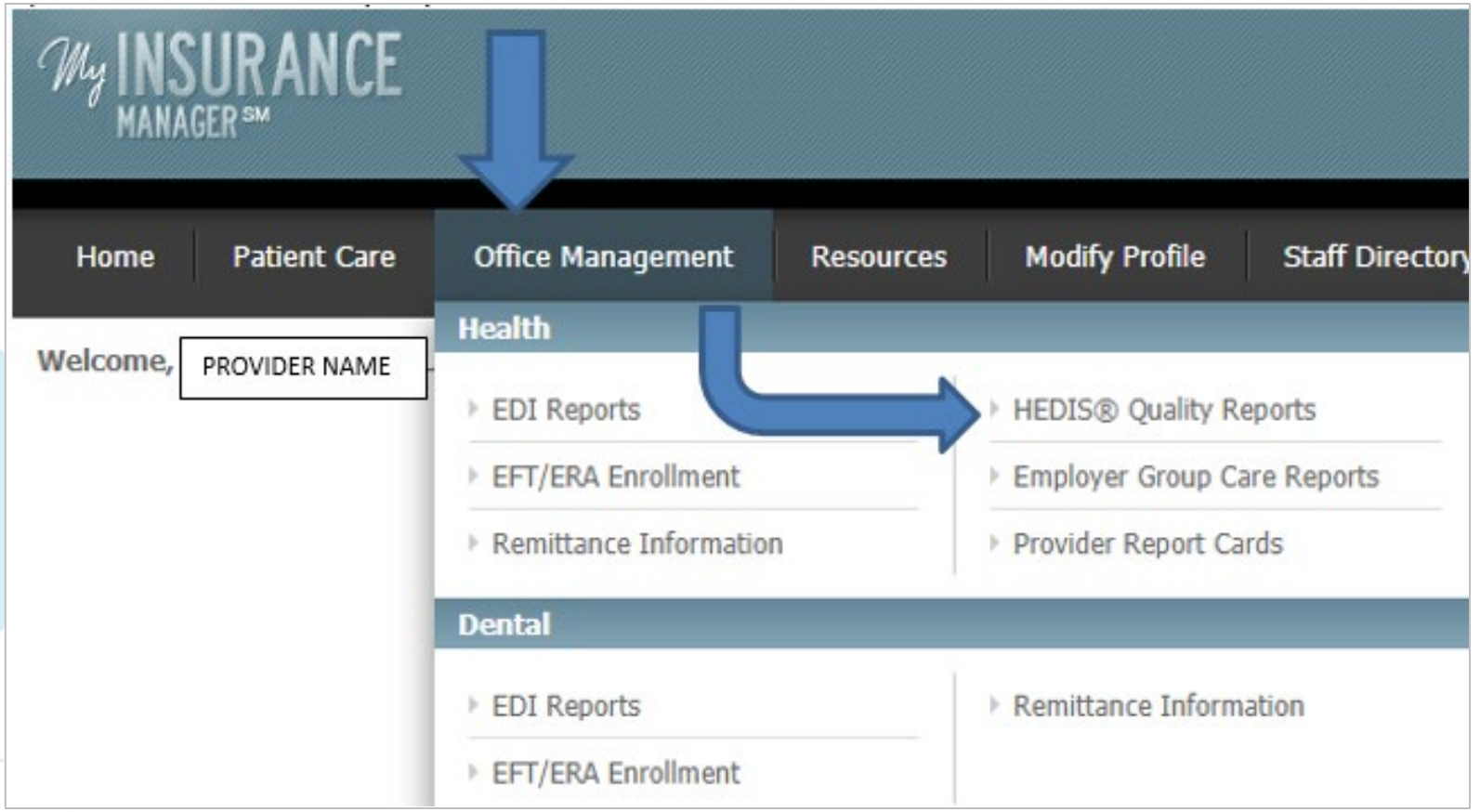
What is the Quality Navigator Program?

- Participation is based on provider attribution within primary care specialties
- Auto-Enroll
- No cost to providers
- Multiple tools and offerings to support providers

Quality Navigator Program

Accessing Your Care Opportunity Reports

- Reports will no longer be emailed
- All quality reporting will be located within My Insurance Manager℠ (MIM) Portal
- Monthly reminders for reports
  - NAVIGATOR@bcbssc.com



Quality Navigator Program

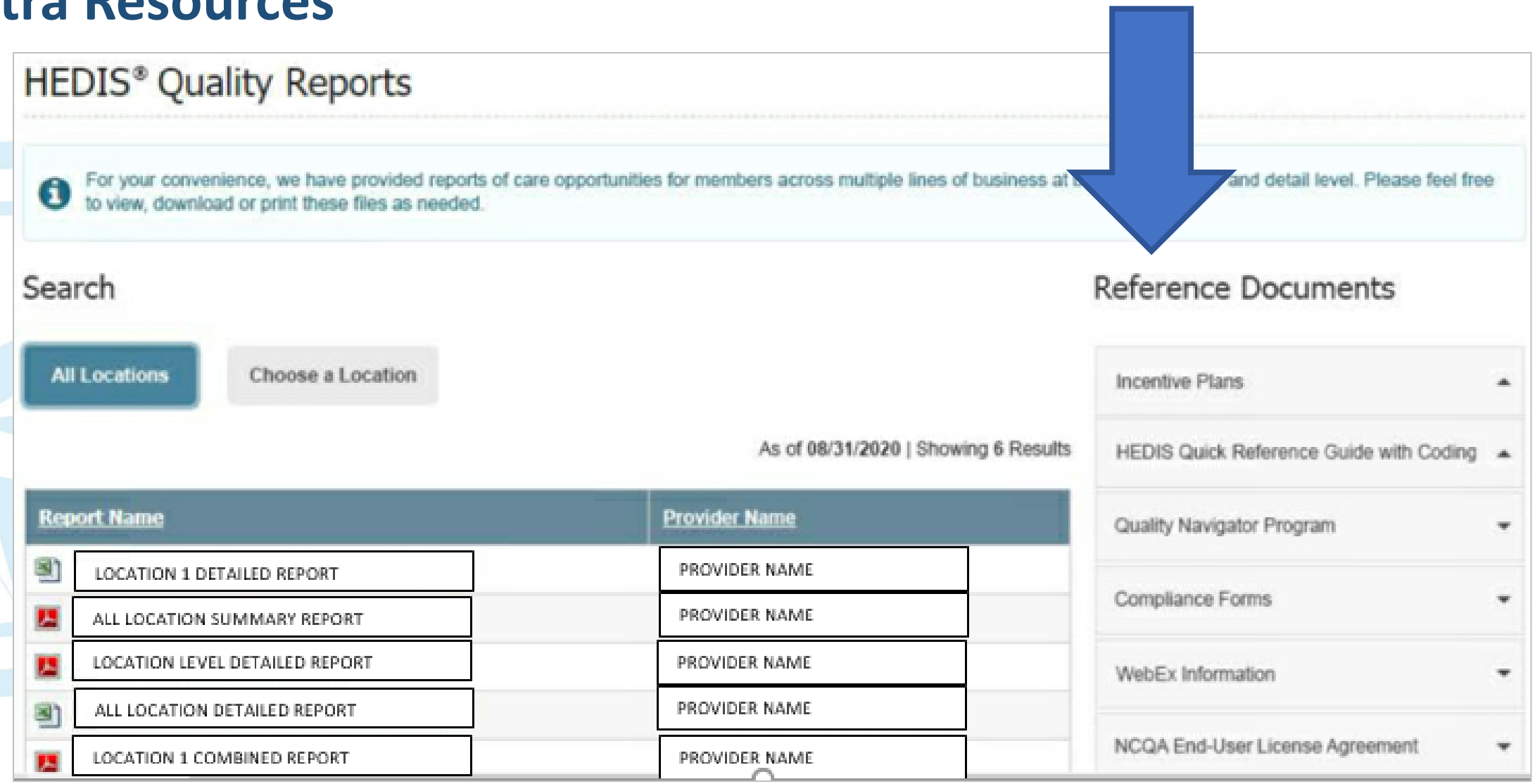
Understanding your Care Opportunity Reports

- Past Medical History has been added for members
- Non-Compliance can be either a true “gap” in care or a “gap” in data

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

Quality Navigator Program

Extra Resources



Key Takeaways

High Impact HEDIS and Quality Ratings

Submit quality codes via claims whenever appropriate.

Schedule patients for annual exams

- Include periodic screenings and preventive services
- Follow up on missed appointments

Promote medication adherence

- Recommend formulary alternatives

Questions? Contact Us!

Navigator@bcbssc.com

Dental

Agenda

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

Dental Plans

Dental Plans

Commercial Plans

- Commercial plans can be identified by noting the following elements located on the ID card:
  - Member ID number (xxx123456789012)
  - Plan code (380)
- There are some dental plans that use a network of participating providers, while other plans do not.
  - Members are encourage to select in-network providers.
- Coverage level includes:
  - Preventive care
  - Restorative care
  - Major restorative care
  - Implant coverage (some plans may not offer this benefit)
  - Orthodontic care (some plans may not offer this benefit)

Dental Plans

State Plans: Basic Dental

- The Public Employee Benefit Association (PEBA) uses BlueCross BlueShield of South Carolina as an administrator for their dental plans.
- Benefits are dividing into four classes:
    1. Diagnostic and preventive services
    2. Basic dental services
    3. Prosthodontics
    4. Orthodontics
- A $1,000 benefit period maximum applies to classes 1 – 3.
- Covered services are paid based on its schedule of dental procedures are allowable charges.

Dental Plans

State Plans: Dental Plus

- Members with the Dental Plus plan will 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 Dental Network for in-network benefits.

Dental Plans

Federal Employee Program (FEP): Basic Option

- Members pay $30 copay for evaluations; FEP pays any balances up to the BlueCross Preferred Blue Participating Dental allowance.
- Basic members must use preferred dentists to receive benefits.
- In accordance to Federal law, always file medical first.
- If a service is not covered by FEP standard, in-network providers can charge their usual and customary charge.

Dental Plans

Federal Employee Program (FEP): Standard Option

- No deductibles, copays or coinsurance apply.
- Members pay the difference between the fee schedule amount and the BlueCross Participating Dental allowance while using a preferred dentist.
- Members pay all charges in excess of the listed fee schedule amounts while using a non-preferred dentist.
- In accordance to Federal law, always file medical first.
- If a service is not covered by FEP standard, in-network providers can charge their usual and customary charge.

Dental Plans

Federal Employee Program (FEP): BCBS FEP Dental

- Members that are covered by FEP Basic Option medical plan and BCBS FEP Dental (High and Standard options), will not be responsible for the annual deductible when using an in-network provider.
- Providers should not collect copays or deductibles from these members.

Dental Plans

BlueCross Total℠ Medicare Advantage

- This plan has no deductible or annual maximum.
- Covered services rendered by an in-network dental provider are covered at 100 % except for the crown and crown buildup (which are covered at 50 %).
- There are no limited codes (no downgrading) for Medicare Advantage.

Dental Plans

BlueCross Total℠ Medicare Advantage: Covered Services

Services covered for the member	Frequency
Periodic Oral Exam	Two per calendar year, includes D0150
Comprehensive Oral Exam	Two per calendar year, includes D0150
Bitewing X-rays	One set per calendar year
Prophylaxis (Cleaning)	Two per calendar year
Amalgam Restoration (Fillings)	One per calendar year
Composite Restorations (Fillings)	Two per calendar year
Crown and Crown Core Build Up	One crown and crown build up per calendar year at 50%
Extraction, erupted tooth or exposed root	One procedure per calendar year, maximum of five teeth per procedure
Reline complete denture, upper and lower	One per calendar year, each
Anesthesia-analgesia, anxiolysis	As needed

Dental GRID

Dental GRID

- Dental GRID allows dentists to see members from other participating BlueCross BlueShield plans at the local plan reimbursement levels.
- Our participating providers' reimbursement levels or provider agreements will not change when treating a GRID member.
- Members in this program can be recognized by noting the word 'GRID' or 'GRID+' on their ID card.

Dental GRID

Participating Plans

- Anthem BlueCross BlueShield Colorado
- Anthem BlueCross BlueShield Connecticut
- Anthem BlueCross BlueShield Indiana
- Anthem BlueCross BlueShield Kentucky
- Anthem BlueCross BlueShield Maine
- Anthem BlueCross BlueShield Missouri
- Anthem BlueCross BlueShield Nevada
- Anthem BlueCross BlueShield New Hampshire
- CareFirst BlueCross BlueShield (Maryland/District of Columbia)
- Anthem BlueCross BlueShield Virginia
- Anthem BlueCross California
- BlueCross BlueShield Kansas
- BlueCross BlueShield Kansas City
- BlueCross BlueShield North Carolina
- BlueCross BlueShield Vermont
- BlueCross BlueShield Arizona
- BlueCross BlueShield Georgia
- BlueCross BlueShield Massachusetts
- BlueCross BlueShield North Dakota
- BlueCross BlueShield South Carolina
- BlueCross BlueShield Wyoming
- BlueCross BlueShield Tennessee
- BlueCross Idaho
- BlueCross & BlueShield Western/BlueShield Northeastern New York
- BlueCross BlueShield Nebraska
- Capital BlueCross
- Anthem BlueCross BlueShield Ohio
- Empire BlueCross BlueShield New York
- Excellus BlueCross BlueShield
- Horizon BlueCross BlueShield New Jersey
- Wellmark BlueCross BlueShield Iowa

Eligibility, Benefits and Claims

Eligibility, Benefits and Claims

Verifying Eligibility and Benefits

- Use My Insurance Manager℠ (MIM) to verify eligibility and benefits or contact Customer Service.
    - MIM does not apply to out-of-state or BCBS FEP Dental members.

Plan	Provider Services Voice Response Unit (VRU)	Fax
Commercial Dental Plans	800-222-7156(Columbia center) 800-922-1185 (Greenville center)	803-264-7629
State Basic Dental and Dental Plus	888-214-6230 803-264-3702 (Columbia area)	803-264-7739
BCBS FEP Dental	855-504-2583	843-763-0631
FEP Dental (Medical)	800-444-4325	
BlueCross Total℠ (MA Dental)	800-222-7156	803-264-7629

Eligibility, Benefits and Claims

Filing Dental Claims

Filing dental under medical benefits

- Use an 837P format with the accurate diagnosis code when rendering oral surgical services under State Dental and health plans.
- For BCBS FEP Dental, always file claims to the medical plan first.

Filing orthodontic clams 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 treatments and the total charge.
    - **For a transfer care**, submit one line with the monthly adjustment code, total months of remaining treatment and the total remaining charge.

Eligibility, Benefits and Claims

Filing Dental Claims: General Guidelines

Dental Plan	Claims Filing Procedures
Commercial and BlueCross Total℠ (MA Dental)	Submit claims electronically using HIPAA 837D format. Use carrier (payer) code 38520. If applicable, mail paper claims to the mailing address on the back of the member's ID card. Timely filing varies. Verify when checking eligibility and benefits.
Dental GRID	Send claims to the mailing address on the member's ID card.
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.
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.

Credentialing

Credentialing

BlueCross BlueShield of South Carolina uses Dentistat Inc. (an independent credentialing verification organization) to credential and recredential the Dental Provider network.

- Dentistat performs all verifications according to the accepted industry standards, as well as NCQA standards.
- Occasionally, the provider's office may be contacted by Dentistat Inc.

Credentialing

- Plans that use the Participating Dental network include:
  - Commercial
  - State Dental Plus
  - Companion Life Dental
  - FEP Basic, Standard and BCBS FEP Dental
  - GRID members
- For initial and recredentialing, providers should use the South Carolina Dental Credentialing application.
  - Fax completed applications, documentation and contract signature page(s) to 803-870-8919.

Coding

Coding

Deleted CDT Codes for 2021

Code	Description
D3427	Periradicular surgery without apicoectomy
D5994	Periodontal medicament carrier with peripheral seal – laboratory processed A custom fabricated, laboratory processed carrier that covers the teeth and alveolar mucosa. Used as a vehicle to deliver prescribed medicaments for sustained contact with the gingiva, alveolar mucosa, and into the periodontal sulcus or pocket.
D6052	Semi-precision attachment abutment Includes placement of keeper assembly.
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure Removal or release of mucosal and muscle elements of a buccal, labial or lingual frenum that is associated with a pathological condition, or interferes with proper oral development or treatment.

Coding

New 2021 CDT Codes

Code	Description	* Coverage
D0604	Antigen testing for a public health related pathogen including coronavirus	Non-covered
D0605	Antibody testing for a public health related pathogen including coronavirus	Non-covered
D0701	Panoramic radiographic image – image capture only	Non-covered
D0702	2-D cephalometric radiographic image – image capture only	Non-covered
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	Non-covered
D0704	3-D photographic image – image capture only	Non-covered
D0705	Extra-oral posterior dental radiographic image – image capture only Image limited to exposure of complete posterior teeth in both dental arches. This is a unique image that is not derived from another image.	Non-covered
D0706	Intraoral – occlusal radiographic image – image capture only	Non-covered
D0707	Intraoral – periapical radiographic image – image capture only	Non-covered
D0708	Intraoral – bitewing radiographic image – image capture only Image axis may be horizonal or vertical	Non-covered

*** Coverage for State Dental/Dental Plus and BlueCross BlueShield of South Carolina Fully Insured Groups**

Coding

New 2021 CDT Codes

Code	Description	* Coverage
D0709	Intraoral – complete series of radiographic images – image capture only A radiographic survey of the whole mouth, usually consisting of 14-22 images (periapical and posterior bitewing as indicated) intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.	**Non-covered**
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use Counseling services may include patient education about adverse oral, behavioral, and systemic effects associated with high-risk substance use and administration routes. This includes ingesting, injecting, inhaling and vaping. Substances used in a high-risk manner may include but are not limited to alcohol, opioids, nicotine, cannabis, methamphetamine and other pharmaceuticals or chemicals.	**Non-covered**
D1355	Caries preventive medicament application – per tooth For primary prevention or remineralization. Medicaments applied do not include topical fluorides.	**Non-covered**
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	**Covered**
D3471	Surgical repair of root resorption – anterior For surgery on root of anterior teeth. Does not include placement of restoration.	**Covered**
D3472	Surgical repair of root resorption – premolar For surgery on root of premolar tooth. Does not include placement of restoration.	**Covered**
D3473	Surgical repair of root resorption – molar For surgery on root of molar tooth. Does not include placement of restoration.	**Covered**

*** Coverage for State Dental/Dental Plus and BlueCross BlueShield of South Carolina Fully Insured Groups**

Coding

New 2021 CDT Codes

Code	Description	* Coverage
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior Exposure of root surface followed by observation and surgical closure of the exposed area. Not to be used for or in conjunction with apicoectomy or repair of root resorption.	**Covered**
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar Exposure of root surface followed by observation and surgical closure of the exposed area. Not to be used for or in conjunction with apicoectomy or repair of root resorption.	**Covered**
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar Exposure of root surface followed by observation and surgical closure of the exposed area. Not to be used for or in conjunction with apicoectomy or repair of root resorption.	**Covered**
D5995	Periodontal medicament carrier with peripheral seal – laboratory processed - maxillary A custom fabricated, laboratory processed carrier for the maxillary arch that covers the teeth and alveolar mucosa. Used as a vehicle to deliver prescribed medicaments for sustained contact with the gingiva, alveolar mucosa, and into the periodontal sulcus or pocket.	**Non-covered**
D5996	Periodontal medicament carrier with peripheral seal – laboratory processed - mandibular A custom fabricated, laboratory processes carrier for the mandibular arch that covers the teeth and alveolar mucosa. Used as a vehicle to deliver prescribed medicaments for sustained contact with the gingiva, alveolar mucosa, and into the periodontal sulcus or pocket.	**Non-covered**
D6191	Semi-precision abutment - placement This procedure is the initial placement, or replacement, of a semi-precision abutment on the implant body.	**Non-covered**
D6192	Semi-precision attachment - placement This procedure involves the luting of the initial, or replacement, semi-precision attachment to the removable prosthesis.	**Non-covered**

*** Coverage for State Dental/Dental Plus and BlueCross BlueShield of South Carolina Fully Insured Groups**

Coding

New 2021 CDT Codes

Code	Description	* Coverage
D7961	Buccal / labial frenectomy (frenulectomy)	**Covered**
D7962	Lingual frenectomy (frenulectomy)	**Covered**
D7993	Surgical placement of craniofacial implant – extra oral Surgical placement of a craniofacial implant to aid in retention of an auricular, nasal, or orbital prosthesis.	**Non-covered**
D7994	Surgical placement: zygomatic implant An implant placed in the zygomatic bone and exiting through the maxillary mucosal tissue providing support and attachment of a maxillary dental prosthesis.	**Covered**

*** Coverage for State Dental/Dental Plus and BlueCross BlueShield of South Carolina Fully Insured Groups**

Pharmacy Benefit Manager

Pharmacy Benefit Management

What's New for 2021

- Formulary Updates by Line of Business
  - Commercial
  - Exchange
  - Medicare
- Specialty Medical Benefit Management Updates
  - New Preferred Drug Strategy for Hyaluronic Acid
- Other
  - HIV PrEP
- Resources

This information does not impact State Health Plan and FEP members.

Commercial Plans

Commercial Plans

BlueCross and BlueChoice HealthPlan Formularies

- Additions

Darzalex Faspro (SP)	Nexlizet (P)	Retevmo (SP)	Trodelvy (SP)
Koselugo (SP)	Pemazyre (SP)	Sarclisa (SP)	Tukysa (SP)
Nexletol (P)	Qinlock (SP)	Tabrecta (SP)	Xcopri (NP)

SP = Specialty, P = Preferred non-specialty, NP = Non-preferred non-specialty

- Exclusions

Excluded Product	Covered Alternatives
Asmanex	Arnuity Ellipta, Flovent Diskus/HFA, Pulmicort Flexhaler, QVAR Redihaler
Dayvigo	Eszopiclone, Temazepam, Zaleplon, Zolpidem/ER
Licart	Diclofenac
Naprosyn susp. 125 mg/5 mL (BRAND)	Naproxen Suspension 125mg/5mL
Treximet (BRAND)	Sumatriptan-Naproxen Sodium Tab
Zerviate	Azelastine, Olopatadine

Commercial Plans

BlueCross and BlueChoice® Formularies

- Clinical Program Updates: Prior Authorization
  - Rybelsus will be added as a preferred option in this class

Condition/Drug Class	Before member has coverage for one of these drugs…	…they must have tried one (or more) of these alternative drugs first.
Diabetes (GLP-1)	Bydureon/BCISE, Byetta	Ozempic, Rybelsus, Trulicity, Victoza*

*These drugs require prior use of metformin, metformin ER (generic Glucophage XR) or Prior Authorization.

Commercial Plans

BlueCross and BlueChoice Formularies

- Clinical Program Updates: Prior Authorization
  - Durolane, Eufexxa and Gelsyn-3 will be the new preferred hyaluronic acid products

Condition/Drug Class	Before member has coverage for one of these drugs…	…they must have tried TWO of these alternative drugs first.
Osteoarthritis of the Knee (Hyaluronic Acid)	Gel-One, GenVisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz/FX, Synvisc/One, SynoJoynt, Triluron, Visco-3	Durolane, Euflexxa, Gelsyn-3

Commercial Plans

BlueCross and BlueChoice Formularies

- Clinical Program Updates: Prior Authorization
  - Two preferred Growth Hormone products will be required before coverage is approved for non-preferred products

Condition/Drug Class	Before member has coverage for one of these drugs…	…they must have tried TWO of these alternative drugs first.
Growth Deficiency	Genotropin, Nutropin/AQ, Omnitrope, Saizen, Zomacton	Humatrope, Norditropin

Commercial Plans

BlueCross and BlueChoice Formularies

- Clinical Program Updates: Step Therapy
  - Seizure Treatments will be added to the Step Therapy List.

Condition	Member must try one or more *Step 1 drugs* first, or doctor must request an override…	… before member can get coverage for this *Step 2 drug.*
Seizures	Lamotrigine Immediate-Release (IR), Levetiracetam IR, Levetiracetam Extended-Release (ER), Oxcarbazepine IR, Topiramate IR	Xcopri

Affordable Care Act Plans

Affordable Care Act Plans

Formulary Definition

Tier	BlueCross – 4 Tier	BlueChoice – 6 Tiers
1	Generic	Low Cost Generics
2	Preferred Brands	Remaining Generics
3	Non Preferred Brands	Preferred Brands
4	Specialty	Non Preferred Brands
5	N/A	Generic & Preferred Brand Specialty
6	N/A	Non Preferred Brand Specialty

Affordable Care Act Plans

Affordable Care Act: 2021 Formulary Additions

Drug Name	2021 Formulary Tier
Aimovig	Preferred Brand
Corlanor	Non-Preferred Brand
Diacomit	Non-Preferred Brand Specialty
Emgality	Preferred Brand
Epidiolex	Non-Preferred Brand Specialty
Farxiga	Preferred Brand
Fluocinonide Cre 0.1%	Generic
Ilevro	Non-Preferred Brand
Kovaltry	Non-Preferred Brand Specialty
Mayzent	Non-Preferred Brand Specialty
Nucynta ER	Non-Preferred Brand

Drug Name	2021 Formulary Tier
Nuwiq	Preferred Brand
Oxiconazole Cream Nitrate	Non-Preferred Brand
Rocklatan	Non-Preferred Brand
Skyrizi	Preferred Brand Specialty
Sumatripan/Naproxen Sodium	Non-Preferred Brand
Sunosi	Preferred Brand
Taltz	Non-Preferred Brand Specialty
Trelegy Ellipta	Preferred Brand
Xigduo XR	Preferred Brand
Zerviate	Non-Preferred Brand
Zioptan	Non-Preferred Brand

Affordable Care Act Plans

2021 Formulary Exclusions

Drug Name	2021 Formulary Alternatives
Albuterol Sulfate HFA (Made by PRASCO) and Tab	Generic Albuterol Inhaler
Amitiza	Linzess, Symproic
Armour Thyroid	Levothyroxine, Levoxyl, Unithroid
Atripla	Efavirenz-Emtricitabine –Tenofovir (generic Atripla)
Clonazepam ODT	Clonazepam Tablet
Colcrys	Colchicine Tab 0.6mg
Cosentyx	Taltz
Cyclobenzaprine HCL 7.5mg and ER Tab	Cyclobenzaprine 5mg and 10mg Tab
Doxycycline (Rosacea) Cap Delayed Release 40mg	Metronidazole Cream/Gel /Lotion, Azelaic Acid Gel
Doxycycline Monohydrate	Doxycycline Tab
Frovatriptan Succinate	Almotriptan, Eletriptan, Rizatriptan, Sumatriptan, Zolmitriptan
Invokamet and Invokamet XR	Synjardy, Synjardy XR, Xigduo XR
Invokana	Farxiga, Jardiance
Levalbuterol Tartrate HFA	Generic Albuterol HFA Inhaler
Lotemax SM	Loteprednol
Minocycline Hydrochloride ER	Minocycline Immediate Release
Oxycodone ER	Hydromorphone ER, Oxymorphone ER, Morphine ER, Oxycontin, Embeda, Hysingla ER, Hydrocodone ER, Xtampza ER

Affordable Care Act Plans

2021 Formulary Exclusions (cont'd.)

Drug Name	2021 Formulary Alternatives
Pataday and Pazeo	Azelastine Ophthalmic Solution, Olopatadine Ophthalmic Solution, Epinastine Ophthalmic Solution
ProAir Digihaler and ProAir HFA	Generic Albuterol HFA Inhaler
Proventil HFA	Generic Albuterol HFA Inhaler
SF Gel 1.1%	Cavarest Gel 1.1%; Sodium Fluoride Cream 1.1%
SF 5000 Plus Cream 1.1%	Sodium Fluor Cream 5000 ppm; Sodium Fluor Cream 1.1%
Tretinoin Microsphere Gel 0.04% and Pump	Tretinoin Gel 0.025% and 0.01% or Tretinoin Cream 0.025%, 0.05% or 0.1%
Tretinoin Gel 0.05%	Tretinoin Gel 0.025% and 0.01% or Tretinoin Cream 0.025%, 0.05% or 0.1%
Tretinoin Microsphere Gel 0.1% and Pump	Tretinoin Gel 0.025% and 0.01% or Tretinoin Cream 0.025%, 0.05% or 0.1%
Xopenex	Levalbuterol Nebulizer; Albuterol Nebulizer
Xopenex HFA	Generic Albuterol HFA Inhaler
Zolpidem Tartrate Sublingual Tab	Zolpidem Tablet

Affordable Care Act Plans

2021 Utilization Management (UM) Changes

UM Change	Specialty	Drug
Add PA, QL	No	Aimovig
Add PA	No	Descovy
Add QL	No	Econazole Cream 1%
Add PA, QL	No	Emgality
Add PA	Yes	Epidiolex
Add QL	No	Erythromycin SOL 2%
Revise ST	No	Fanapt and Fanapt Pack
Revise ST	No	Farxiga
Add QL	No	Gentamicin SOL 0.3% OP
Add QL	No	Ilevro 0.3%
Add QL	No	Ketoconazole Cream 2%
Revise QL	No	Levorphanol 2mg
Add PA, QL	Yes	Mayzent
Add PA	No	Migranal 4mg/ml

UM Change	Specialty	Drug
Add QL	No	Mupirocin Ointment 2%
Add QL	No	Naproxen Sus 125/5ml
Add PA, QL	No	Nucynta ER
Add PA	No	Omega-3-Acid Cap
Add QL	No	Rocklatan 0.02-0.005%
Add PA	Yes	Skyrizi
Add QL	Yes	Stelara
Add PA, QL	No	Sunosi
Add PA	Yes	Taltz
Add QL	No	Trelegy Aer Ellipta
Add ST	No	Uloric
Revise ST	No	Xigduo XR
Add QL	No	Zioptan 0.0015%
Revise ST	No	Zomig Nasal

PA – Prior Authorizations **QL – Quantity Limit** **ST – Step Therapy**

Medicare Advantage Plans

Medicare Advantage Plans

The Medicare Advantage and the Medicare PDP Formularies will remain the same for 2021!

Medicare Advantage Plans

MAPD Formulary

- 5-Tier Formulary
- Standard Utilization Management
- Adherence Drugs on Lowest Tiers
- Dual Insulin Strategy
- Part D Formulary Designed Specifically for MAPD Part D

Tier Composition (Drug Type Labels)

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

Star Adherence Strategy

Generic STAR Adherence Drugs: Tier 1 low to moderate cost, Tier 2 if high cost generics <$670/month

Formulary Rules

Tier 1: Very Low-cost generics
Tier 2: Low to moderate cost generics
Tier 3: Preferred Brand Tier
Tier 4: Non-Preferred Brand Tier and high cost generics
Tier 5: Specialty >$670/month (Brands, Generics)

Tier Assignment may also be impacted by:

- P&T Compliance review (Risk to Benefit, Essential Drug)
- CMS Category/class review concerns (representation, preferred product)
- Actuarial considerations

High-Risk Medication Strategy

HRM's: Tier 4 with PA or QL, or Tier 2 with PA or QL if the drug is both a STARS and an HRM. Exception for digoxin: Tier 2 with PA/QL

Medicare Advantage Plans

PDP Formulary

- 5-Tier Formulary
- Standard Utilization Management
- Adherence Drugs on Lowest Tiers
- Solo Insulin Strategy
- Part D Formulary Designed Specifically for PDP

Tier Composition (Drug Type Labels)

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

Star Adherence Strategy

Generic STAR Adherence Drugs: Tier 1 if low cost; Tier 2 if moderate, Tier 4 high cost generics <$670/month

Formulary Rules

Tier 1: Low cost maintenance generics (including most STAR adherence drugs)

Tier 2: Low to moderate cost generics including acute use products

Tier 3: Preferred Brand and moderate cost generics

Tier 4: Non-Preferred Brand Tier and higher cost generics

Tier 5: Specialty >$670/month (Brands, Generics)

Tier Assignment may also be impacted by:

- P&T Compliance review (Risk to Benefit, Essential Drug)
- CMS Category/class review concerns (representation, preferred product)
- Actuarial considerations

High-Risk Medication Strategy

Generally Tier 4 with PA and/or QL or Tier 2 with PA or QL if the drug is both a STAR adherence drug and an HRM. Some HRM's will be NF based on clinical review and volume of utilizations.

Specialty Drug Medical Benefit Management

Specialty Drug Medical Benefit Management

Drug lists can be found on the Precertification and Pharmacy pages of the websites:

- www.SouthCarolinaBlues.com
- www.BlueChoiceSC.com

Access MBMNow via My Insurance Manager℠ when you check member benefits

- Contact info for medical specialty drug authorizations
  - Call 877-440-0089, Fax 612-367-0742

Specialty Drug Medical Benefit Management

What's New for 2021

- **Durolane, Euflexxa, Gelsyn-3** will be the new preferred hyaluronic acid products.

Condition/Drug Class	Before member has coverage for one of these drugs…	…they must have tried TWO of these alternative drugs first.
Osteoarthritis of the Knee (Hyaluronic Acid)	Gel-One, GenVisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz/FX, Synvisc/One, SynoJoynt, Triluron, Visco-3	Durolane, Euflexxa, Gelsyn-3

What's New in 2021?

HIV PrEP Update

For members who have a higher chance to become infected with human immunodeficiency virus (HIV) but are not yet infected, these preventive medications are available at $0 cost-share. To qualify, a member must:

- Be taking an antiretroviral therapy for pre-exposure prophylaxis (PrEP)
- Be a part of a comprehensive prevention strategy including other prevention measures
- Obtain copay waiver: Provider must submit 'Health Care Reform - $0 HIV PrEP Preventive copay waiver review form to request $0 cost-share for primary prevention

HIV Pre-exposure Prophylaxis Medications

- Tenofovir Tab 300mg (generic Viread)
- Emtricitabine/Tenofovir (Generic Truvada)
- Truvada
  - Member must be unable to take generic Truvada before coverage would be allowed for brand Truvada.
- Descovy
  - Member must be unable to take Truvada and/or its generic before Descovy is covered.

Resources: Commercial and ACA Plans

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

Resources: Provider Plan Contact Information

Affordable Care Act Plans

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

  www.SouthCarolinaBlues.com

Commercial Plans

- View list of covered drugs, excluded drugs and drug management programs
  www.SouthCarolinaBlues.com www.BlueChoiceSC.com
- Use the number on the back of the member's ID card.
- Prior Authorization, Formulary Exceptions and General Inquiries
  - Call 855-811-2218

Resources: Medicare Advantage

- E-scribe National Council for Prescription Drug Programs (NCPDP) Mail and Specialty
  - Mail NCPDP ID = 0556540
  - Specialty NCPDP ID = 5732676
- OptumRx Home Delivery Phone
  - Call 855-540-5951
- OptumRx Mail Address
  - P.O. Box 2975
    Shawnee Mission, KS 66201-1375
- Coverage Determinations and General Inquiries
  - Call 888-645-6025
  - Fax 844-403-1028
- Websites
  - www.optumrx.com
  - www.SCBluesMedadvantage.com

COVID-19

Agenda

- COVID Coverage, Coding and Billing
- Telehealth Services
- High Dollar Pre-payment Reviews
- Resources

COVID Coverage, Coding & Billing

COVID Coverage, Coding & Billing

BlueCross BlueShield of South Carolina and its subsidiary BlueChoice® HealthPlan **cover the diagnosis and treatment of COVID-19 at 100% of the allowed amount** for members when medically necessary and prescribed by health providers. Both plans have been working diligently and actively to ensure the provider community is abreast of pertinent information that will allow for seamless services.

Note: Refer to CAM 244 for further guidance on COVID-19 coverage.

COVID Coverage, Coding & Billing

At the start of the COVID-19 pandemic, there was limited coding that directly identified COVID-19 services. As a result, coding guidance was provided to help with claims submission.

Since that time, coding (CPT and ICD-10) which specifically identifies COVID-19 services has been developed and is now in use.

CPT Codes

U0001	U0002	U0003	U0004	86408
86409	87426	87428	87631	87632
87633	87635	0098U	0099U	0100U

Diagnosis Codes

U07.1	B97.29	J12.82	M35.81	M35.89
Z03.818	Z11.52	Z20.822	Z20.828	Z86.16

COVID Coverage, Coding & Billing

Serology (antibody) testing **will only be covered when medically appropriate** for an individual, as determined and ordered by their physician, after an evaluation is completed and in accordance with accepted standards of current medical practice. Serology testing **should not be used as the only means to diagnose the COVID-19 infection**.

Note: Refer to CAM 244 for further guidance on COVID-19 coverage.

COVID Coverage, Coding & Billing

Testing for COVID-19 includes Polymerase Chain Reaction (PCR) testing. **Only one COVID-19 PCR/DIAG test, per day, is considered medically appropriate and will be covered** based on our medical policy (CAM 244) and best clinical evidence.

At this time, testing for back to school and work **will not be included in coverage**, which is in alignment with the Centers for Disease Control and Prevention (CDC).

Note: Refer to CAM 244 for further guidance on COVID-19 coverage.

COVID Coverage, Coding & Billing

For testing, use one of the following in-network laboratories.

Aegis	BAKO	BioReference	Eurofins-Diatherix	LabCorp
LabTech	Luxor	Mako Medical Lab	Medical Disgnostic Lab (MDL)	Neogenomics
Precision Genetics	Premier Medical Lab	Quest	Radeas	Sonic-CPL

COVID Coverage, Coding & Billing

COVID-19 vaccines have been developed to help fight the virus, but there are terms and conditions that must be followed prior to rendering services.

- **Enroll**
  - To receive and administer the COVID-19 vaccine, you must enroll in the federal COVID-19 Vaccination Program.
  - You must be credentialed with BlueCross BlueShield of South Carolina, and sign and agree to the conditions outlined in the *CDC COVID-19 Vaccination Program Provider Agreement.*
  - To view the conditions and sign the agreement, visit the following website: https://scdhec.gov/covid19providerenrollment?page=24

COVID Coverage, Coding & Billing

- **Report**
  - Within 24-hours of administering the COVID-19 vaccine, record it in the recipient's medical records and report all required information to the relevant state, local or territorial public health authorities within 72-hours.
  - Maintain the vaccines administration records for at least three years following vaccination, or longer if required by state, local or territorial law.
- **Communicate**
  - For most COVID-19 vaccines, two doses, separated by 21 or 28 days, is needed. As the different vaccines are not interchangeable, the recipient's second dose must be from the same manufacturer as the first dose.
  - Be sure to make every attempt to schedule the patient's second dose appointment when they receive their first dose.

COVID Coverage, Coding & Billing

The following CPT codes have been implemented for the administration of the COVID-19 vaccine.

- **Pfizer**
  - Administration codes:
    - 0001A, first dose
    - 0002A, second dose
- **Moderna**
  - Administration codes:
    - 0011A, first dose
    - 0012A, second dose

Note: The vaccine itself is funded by the government and should not be billed for payment.

Telehealth Services

Telehealth Services

BlueCross and BlueChoice have extended the temporary expansion for telehealth services **until further notice**. This expansion will be continually assessed during the pandemic and continues to help minimize unnecessary exposure to individuals needing medical care.

Providers are required to enroll in the telehealth program prior to rendering services. To enroll, do the following:

- Complete the Virtual Care Services Application.
- Email the completed application to VirtualCare@bcbssc.com.

Note: Refer to CAM 176 for further guidance on telehealth coverage.

Telehealth Services

As of **Oct. 5, 2020**, both BlueCross and BlueChoice have modified the review process for enrolling into telehealth. In the past, approval of telehealth vendors was part of the review process, however, this has changed.

Although a formal approval of the telehealth vendor being utilized by the provider is no longer required for reimbursement, they will be asked to confirm if they have a business associate agreement (BAA) in place with their telehealth vendor. This confirmation, along with other criteria, will be reviewed to determine if the provider will be approved to render telehealth services.

Note: This modification does not affect those already approved to render telehealth services.

High Dollar Pre-payment Reviews

High Dollar Pre-payment Reviews

- Beginning April 10, 2020, BlueCross and BlueChoice altered the audit process on high dollar claims by completing them on a post payment basis instead of pre-payment, which was extended to Oct. 31, 2020.
- Claims over $200,000.00 were processed with a post-payment review and required itemized bills.
- **On Nov. 1, 2020**, both plans reverted to processing high dollar claims in the amount of $200,000.00 or more on a pre-payment review basis.
- Be mindful that beginning Jan. 1, 2021, the dollar amount will be reduced to $100,000.00*.

** This dollar amount is based on the allowed amount of the claim.*

Resources

Resources

Medical Policies –

- CAM 244: COVID-19 Testing
- CAM 176: Telehealth

Bulletins –

- COVID-19 Coverage
- COVID-19 Testing: Billing Updates
- Serology Testing
- PCR & Back to School/Work Testing
- COVID-19 Testing: Laboratories
- Telehealth Services Expansion
- Telehealth Approval Updates
- HDPR Updates
- HDPR Reverts to Normal
- HDPR New Threshold

Note: Be sure to visit www.SouthCarolinaBlues.com and www.BlueChoiceSC.com to view the latest bulletins.

Provider Enrollment

Agenda

- Missing Documentation
- The Provider Enrollment Process
- Demographic Updates
- Recredentialing
- Contact Us

Missing Documentation

Missing Documentation

- The provider enrollment and recredentialing processes will only begin once **all** required documentation has been received.
- We contact the office and/or credentialing contact listed on the Provider Enrollment Application if we receive an application that is incomplete or missing documentation via email and phone.
- Outreach will be made to the provider for 60 days in an attempt to collect the missing items. If missing items are not received within that 60 days, the application will be returned, the enrollment process will be closed for that provider and a new COMPLETE enrollment form will be required to re-start the enrollment process.

Missing Documentation

- 54 percent of enrollment applications are received incomplete!
- The enrollment process will **NOT** begin until all enrollment items have been received.
    - Even if **one** item is missing, incomplete or contains inaccurate information, the process will not begin until that **one** item is received or corrected.
- Signature pages as well as effective dates for certain documents can expire while the application is waiting on missing items.

Missing Documentation

Five Common Missing or Incorrect Items

1. Current application
    I. Previous versions of the Credentialing application are not accepted; visit www.SouthCarolinaBlues.com for current forms
2. Five-year work history, including current employer
    I. Gaps longer than six months need to be explained
    II. Include schooling if work history is less than six months
3. Malpractice roster and/or coversheet with provider's name included
4. CLIA Form with ALL applications, except non-medical dental
    I. Form must be filled out even if the provider does not have a CLIA certificate.
5. Unaltered contract pages with wet signatures

Provider Enrollment Process

Provider Enrollment Process

The enrollment process is performed to:

- Confirm accurate directories so members can find you.
- Ensure we have accurate and complete information on providers as well as the practice they are joining.
- Verify providers are in good standing.
- Confirm providers meet requirements.
- Validate practitioners' qualifications.

To begin the provider enrollment process, each provider must complete the Provider Enrollment Application and submit required documentation.

Provider Enrollment Process

- To ensure that you are submitting a complete provider enrollment packet, please visit the Provider Enrollment section of www.SouthCarolinaBlues.com.
- Here you will find instructions on how to enroll a new medical or dental provider, a behavioral health provider, laboratory or patient-centered medical home (PCMH).
- You will also find instructions on updating demographic information, how to recredential an existing provider along with the forms required for these updates.

Provider Enrollment Process

Clean Application Enrollment Process

1. We receive a complete enrollment packet via Provider.Blue.Enroll@bcbssc.com.
2. We review the packet and confirm it is complete and send it to the Credentialing Committee for review. (Only complete and accurate enrollment packets will be sent to the Credentialing Committee.)
3. If the Credentialing Committee approves the applications, we inform the provider's enrollment contact via email. If the provider is not approved, the enrollment packet goes to a Disciplinary Committee to approve or deny, and a notification of the verdict is sent to the provider.
4. When the additional steps in the Enrollment process are completed, a welcome email will be sent, along with a welcome packet. The welcome email will include the provider's effective dates in our system. Once the welcome email is received with effective dates, the provider can accept patients and file claims.

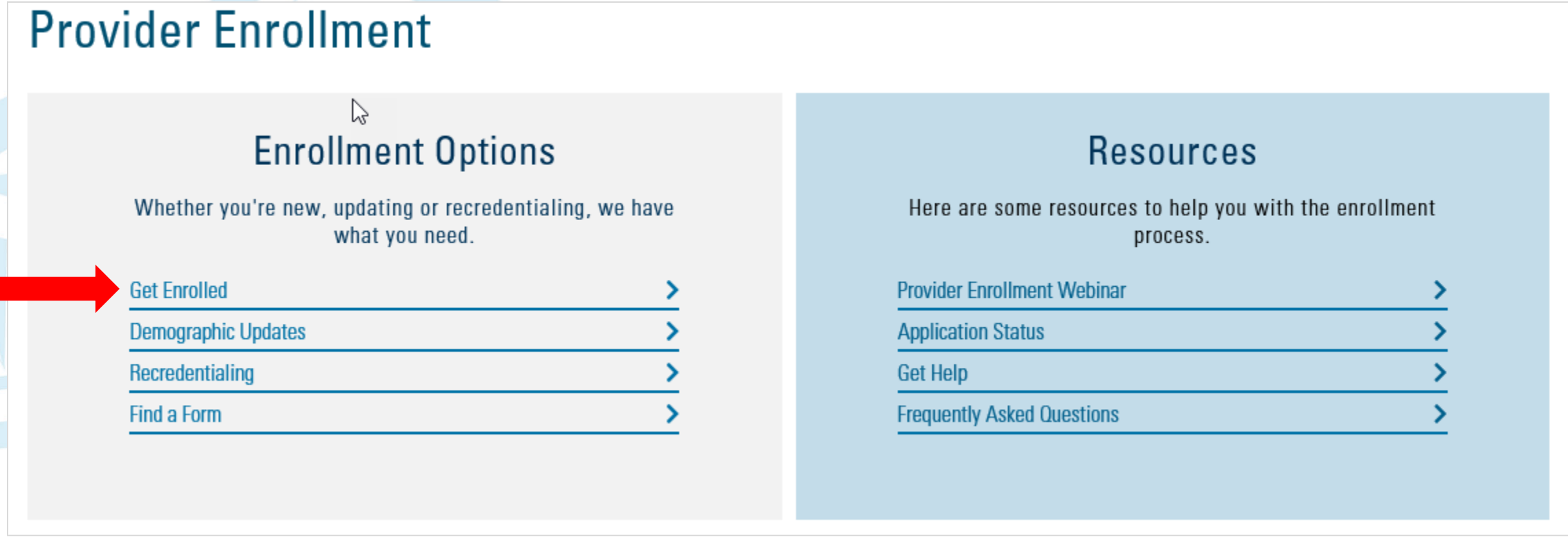
Provider Enrollment Process

- The effective date is the date the credentialing committee approves the application per Utilization Review Accreditation Commission (URAC) requirements.
- Back dating of network dates set by committee are not allowed.
- You receive a notification email from our Credentialing Department within a few days of the Credentialing Committee's approval. Once the entire Enrollment process is complete, including the provider record update to our system, the provider will receive a welcome email with their effective dates, along with a welcome packet.
- The credentialing committee reviews all enrollment packets to ensure providers meet credentialing criteria, including URAC, the National Committee for Quality Assurance (NCQA) or South Carolina's Department of Health and Human Services (SCDHHS)-required items.

Provider Enrollment Process

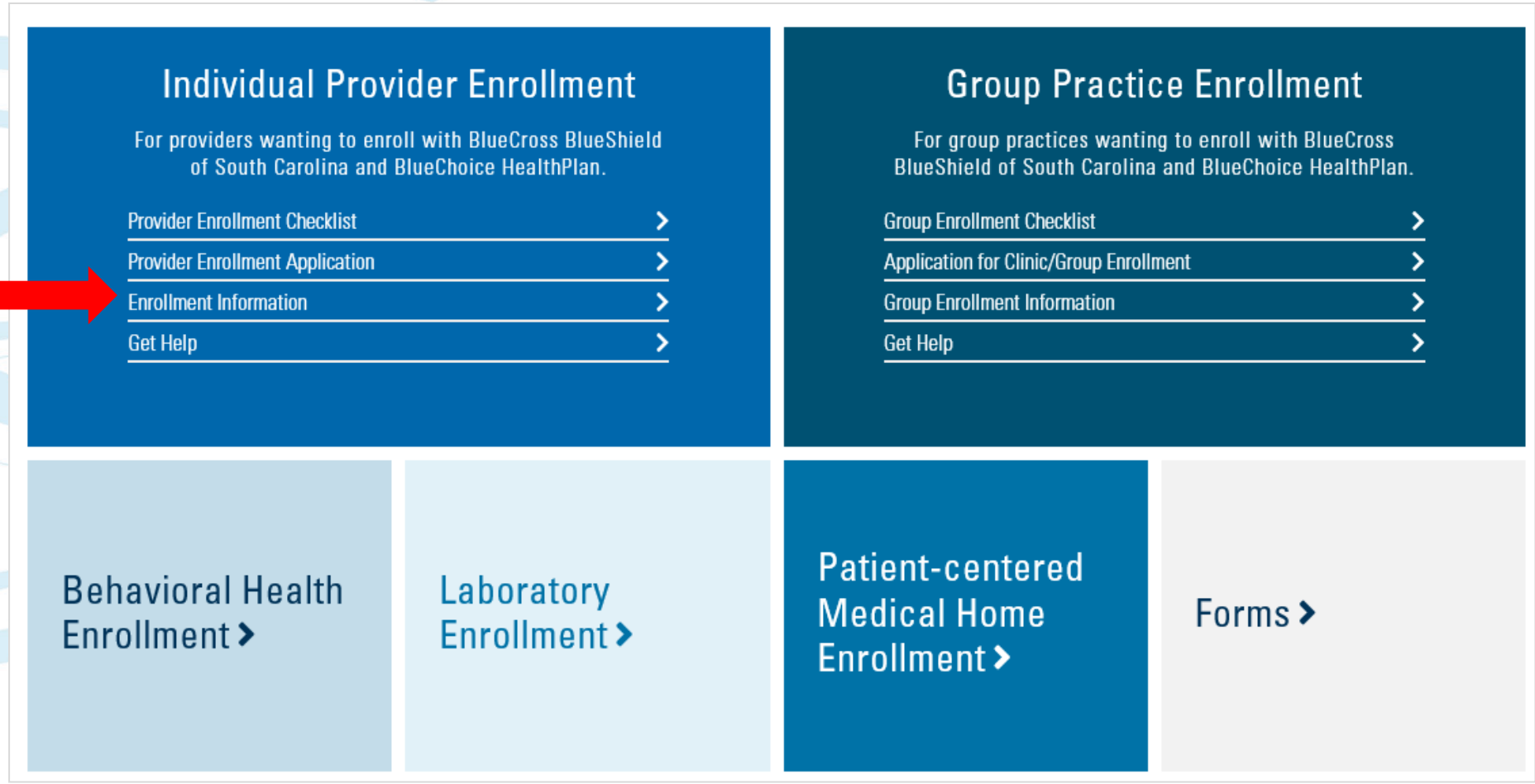
The Provider Enrollment page gives you options to enroll in our networks, update your information or recredential. You also have access to valuable resources.

Click **Get Enrolled** to start a new enrollment.



Provider Enrollment Process

Select **Enrollment Information** to learn how to add a new provider to your practice.



Provider Enrollment Process

1. Open the Checklist.
2. Complete and collect all necessary forms.
3. You will need network contract pages. Click here to request the contract pages.
4. Submit **completed** enrollment applications to Provider.Blue.Enroll@bcbssc.com

The enrollment process will begin when all items are received and complete.

New Provider Enrollment

To enroll in our health or dental network, use the Checklist for Initial Provider Enrollment.

Follow these steps:

1. Use the checklist to find what forms you need.
2. Complete the forms and collect any required documentation.
3. Use this online form to request network contract pages.
4. Submit your completed application, including all required signatures and documentation to Provider.Blue.Enroll@bcbssc.com.

When you'll hear from us:

- When we receive your entire application
- If we need any additional materials
- When your application moves to the onboarding phase
- When your enrollment is complete

Have Questions? Contact us.

Checklist

- We have included an interactive Provider Enrollment Checklist in the application.
- Each requirement is linked with a form or example.
- This checklist outlines each form that is required for each provider type.
- Mid-levels are required to complete the full application for Healthy Blue (Medicaid). An abbreviated two-page application is required for commercial networks.

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

CHECKLIST FOR INITIAL PROVIDER ENROLLMENT

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

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

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

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

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

[4]Required for M.D.s, DOs, ODs, NPs and PAs.
[5]A copy is included in the Provider Enrollment Application.
[6]On the Provider Enrollment Application.π
[7]Required when DMD is applying for medical networks.

Healthy Blue® BlueChoice® HealthPlan of SC

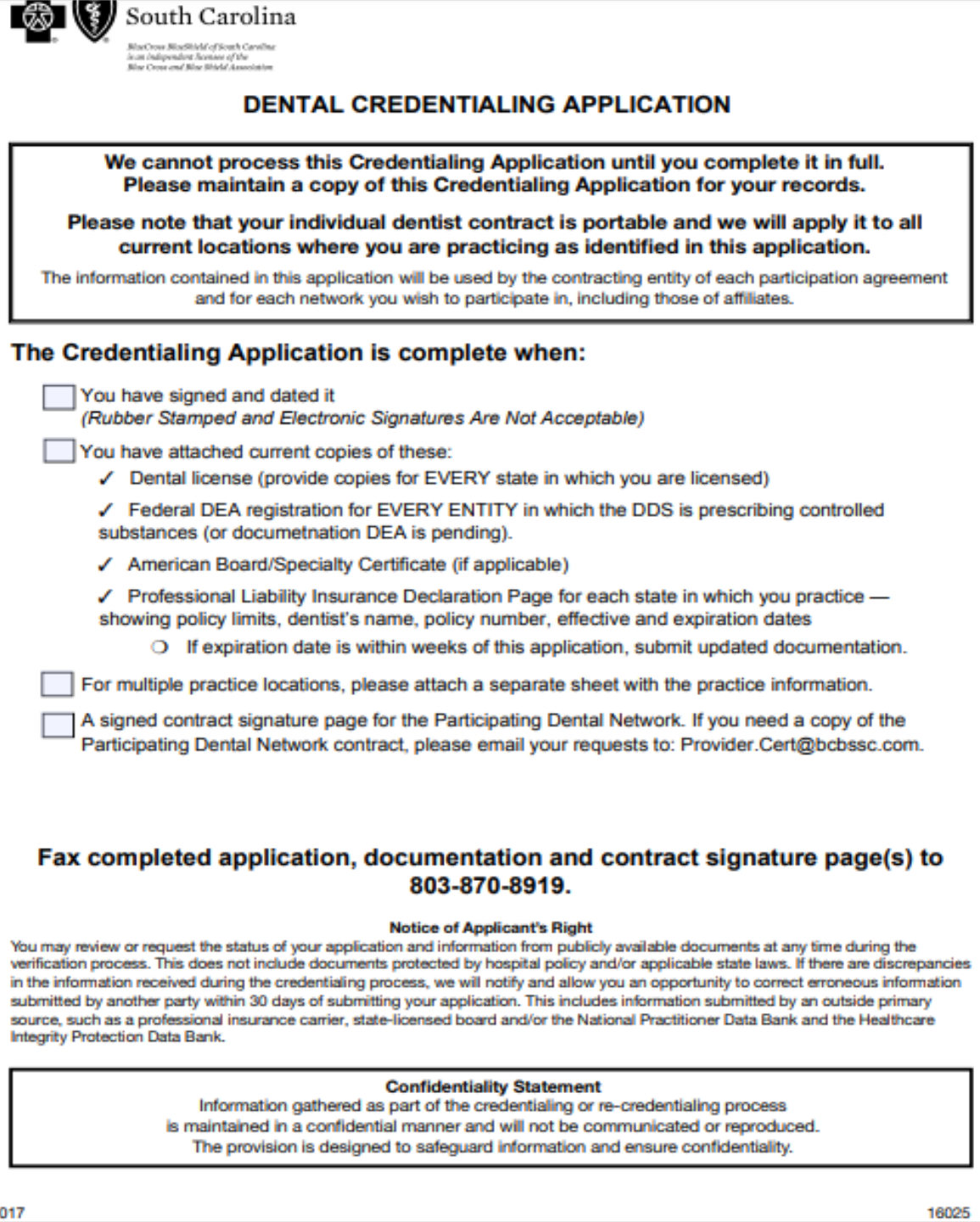
Healthy Connections

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the Blue Cross and Blue Shield Association.
BlueChoice HealthPlan has contracted with Amerigroup Partnership Plan, LLC, an independent company, for services to support administration of Healthy Connections.

211885-7-2020

Dental Credentialing

- Dental credentialing is for the Participating Dental and State Dental Plus networks.
- Other plans that use the Participating Dental Network include:
  - BlueCross Federal Employee Program (FEP) BlueDental℠
  - FEP Basic and Standard
  - GRID members
- For **Initial Credentialing** use the South Carolina Dental Credentialing Application.



South Carolina

DENTAL CREDENTIALING APPLICATION

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

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

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

The Credentialing Application is complete when:

☐ You have signed and dated it
(Rubber Stamped and Electronic Signatures Are Not Acceptable)

☐ You have attached current copies of these:

✓ Dental license (provide copies for EVERY state in which you are licensed)

✓ Federal DEA registration for EVERY ENTITY in which the DDS is prescribing controlled substances (or documetnation DEA is pending).

✓ American Board/Specialty Certificate (if applicable)

✓ Professional Liability Insurance Declaration Page for each state in which you practice — showing policy limits, dentist's name, policy number, effective and expiration dates

❍ If expiration date is within weeks of this application, submit updated documentation.

☐ For multiple practice locations, please attach a separate sheet with the practice information.

☐ A signed contract signature page for the Participating Dental Network. If you need a copy of the Participating Dental Network contract, please email your requests to: Provider.Cert@bcbssc.com.

Fax completed application, documentation and contract signature page(s) to 803-870-8919.

Notice of Applicant's Right

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

Confidentiality Statement

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

7/2017 16025

Behavioral Health Credentialing

- Companion Benefit Alternatives (CBA) coordinates credentialing for mental health practitioners.
- Complete these steps to enroll with CBA.

Behavioral Health

Companion Benefit Alternatives, Inc. (CBA) manages our behavioral health network. CBA is a separate company that administers behavioral health benefits on behalf of BlueCross BlueShield of South Carolina.

Want to join this network? You'll need to do the following:

1. Complete and sign the CBA Practitioner Credentialing Application.
2. Complete and sign the CBA Professional Agreement. Please email CBA.ProvRep@companiongroup.com to request this document.
3. Sign the Hold Harmless Agreement (HMA) (Appendix C of the CBA Professional Agreement).
4. Include:
    1. A copy of your South Carolina state license
    2. A copy of your DEA license, if applicable
    3. A copy of the protocol (nurse practitioners only)
    4. Proof of current malpractice coverage

You can submit these items via mail or fax to:

- Companion Benefit Alternatives, Inc.
  ATTN: Network Coordinator AX-315
  P.O. Box 100185
  Columbia, SC 29202
- Fax: 803-714-6456

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

Behavioral Health Credentialing

Now Available

Behavioral health providers can now apply for network enrollment via an online application at www.CompanionBenefitAlternatives.com.

- Send general inquiries to cba.provrep@companiongroup.com
- If you have enrollment questions, please contact CBA at 800-868-1032, ext. 25744.

Companion
BENEFIT ALTERNATIVES

BEHAVIORAL HEALTH
PROVIDER CREDENTIALING APPLICATION

APPLICATION CHECKLIST:

[ ] Completed application.
[ ] Completed W9 form or appropriate IRS documentation *(Letter 147C, CP 575 E or tax coupon 8109-C) if this is a new office location.*
[ ] A signed network agreement for each network you wish to apply.
- Companion Benefit Alternative (CBA) Professional Agreement
- CBA Health Insurance Exchange Addendum
- BlueChoice® HealthPlan Healthy Blue(sm) Medicaid MCO Agreement

[ ] Copy of state license.
[ ] Copy of Drug Enforcement Administration (DEA) license (if applicable).
[ ] Copy of board certification (if applicable).
[ ] Copy of protocol (advanced practice registered nurses).
[ ] Proof of current malpractice coverage.*
[ ] Completed disclosure of ownership and control interest statement (required for Medicaid MCO network).

*Coverage limits vary: Medical Doctors = JUA/PCF[1] or $1,000,000/$3,000,000
All others = $1,000,000/$1,000,000

Our health plan partners no longer use paper remittances. This includes paper remittance advices and paper checks. You will receive payments and remittance advices electronically. If your group or practice is not currently enrolled in the Electronic Funds Transfer (EFT) program, be sure to complete both the Terms and Conditions for Electronic Payment and the Electronic Funds Transfer Enrollment Form and return them with your application.

CBA is a separate company that provides behavioral health benefits on behalf of BlueChoice® HealthPlan and BlueCross® BlueShield® of South Carolina. BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina are independent licensees of the Blue Cross and Blue Shield Association.

Please enclose all information and allow at least 30 days for processing before checking on the application status. We cannot process applications until we receive all information. Retain a copy of all application materials for your records.

RETURN APPLICATION TO:
Companion Benefit Alternatives, Inc.
ATTN: Provider Network Coordinator AX-315
P.O. Box 100185
Columbia, SC 29202
Fax Number: 803-714-6456

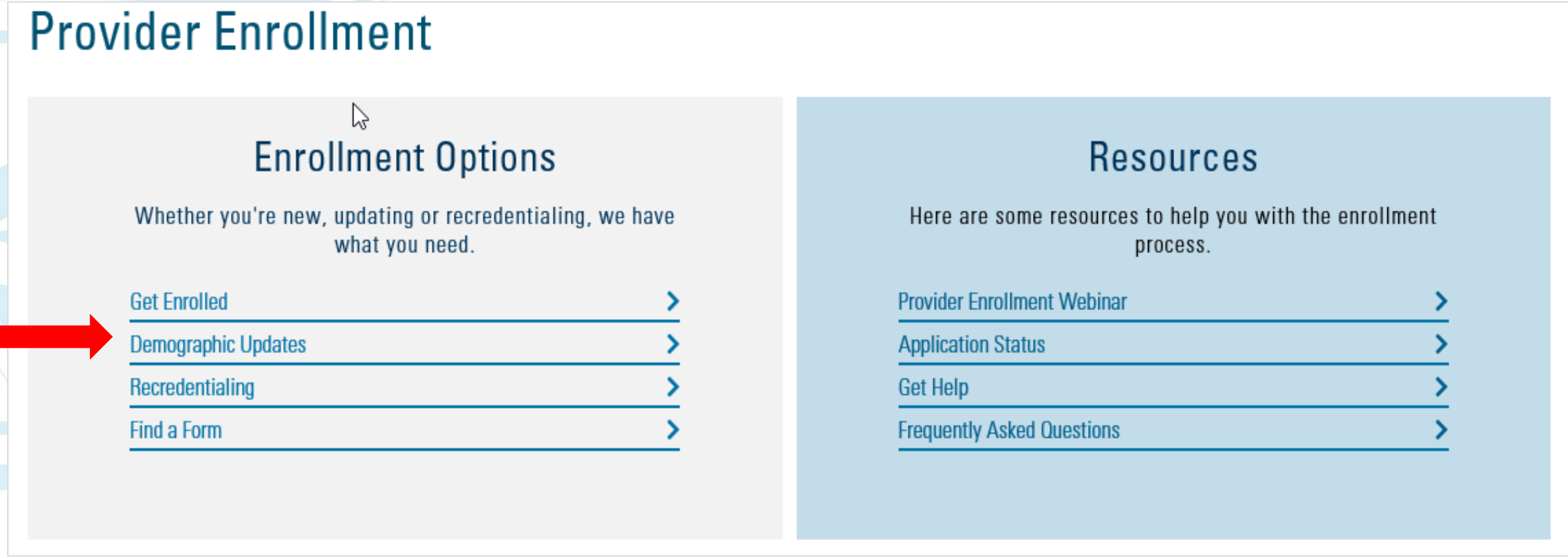
[1] JUA = Joint Underwriting Association; PCF = Patient Compensation Fund

Demographic Updates

Demographic Updates

You can make updates easily through Medical Directory Check Up (M.D. CheckUp).

Click on **Demographic Updates** to update your information.



Demographic Updates

- M.D. Checkup allows you to view information for all associated locations and affiliated practitioners for each location.
- You can update information at any time.
- We require verification for each location on a quarterly basis.
  - Jan. 1 – March 31
  - April 1 – June 30
  - July 1 – Sept. 30
  - Oct. 1 – Dec. 31

Demographic Updates

Has your information changed? It's important for us to know. You can easily make updates with MD Checkup. Access MD Checkup through My Insurance Manager℠ to:

- Update your practice address.
- Change or add where an already-enrolled physician practices within your group. The tax ID number must be the same.
- Terminate a provider.
- Update your office/directory information.

To learn more, access the MD Checkup User Guide.

Other Provider Updates

- Authorization to Bill - Affiliate a practitioner to a new group
- Change of Address Form - Update billing address(es)
- Doing Business As (DBA) Name Change Form - (In order to update the Legal Business Name for a provider group, we require a copy of the most current official IRS letter for the entity. Examples include an IRS LTR 147C, CP267, CP 575 A, CP 575 E, CP-224 or tax coupon 8109-C. Send to Provider.Blue.Updates@bcbssc.com) W-9s are not accepted.
- Electronic Funds Transfer (EFT) and Electronic Remittance Advise (ERA) Enrollment Form/EFT Terms and Conditions
- Request to Add or Terminate Practitioner Affiliation - Add, terminate or change practitioner affiliation
- Satellite Location Application - Add a new location to file claims to an existing group or change your tax identification number.

Demographic Updates

M.D. CHECKUP
MEDICAL DIRECTORY CHECKUP

M.D. Checkup is available within My Insurance Manager℠. With it, you can:

- **Verify** – Confirm information shown is current and accurate.
- **Update** – Once a change has been made, Update must be selected to confirm and accept the change.
- **View & Edit** – Access and edit location information (addresses, telephone number, fax number, hours of operation, etc.).
- **Remove Location** – Enter or select a date to indicate that a location shown in the Location list is no longer active or part of the organization. (Note: This action inactivates/closes the location in our claims system. DO NOT use this action to remove a location from your VIEW in M.D. Checkup!)

Demographic Updates

M.D. Checkup continued.

- **Remove Practitioner** – Enter or select a date to indicate that a practitioner is no longer participating with the specific location. (Note; If you need to remove a practitioner from one of your locations and add them to another location, your MUST complete the ADD function first; otherwise, you may remove the practitioner from your view.)
- **Add Practitioner** – Add a practitioner to the specific location by using the Add Practitioner's search function. You will only find practitioners that are already affiliated to your Tax ID. If you need to add a new practitioner, please complete the appropriate forms located on www.SouthCarolinaBlues.com.

Demographic Updates

M.D. CHECKUP
MEDICAL DIRECTORY CHECKUP

Why are these updates so critical? You could be losing patients!

- Keeping the provider directory accurate and up to date is essential to the health plan and to the providers.
- If you receive the notice to update your demographic information, please do not just click accept without fully reviewing the information.
- If you are not the correct person that should be reviewing this data, please send this to the appropriate person who can accurately validate.

Demographic Updates

M.D. CHECKUP
MEDICAL DIRECTORY CHECKUP

Common Errors Found During Secret Shopper

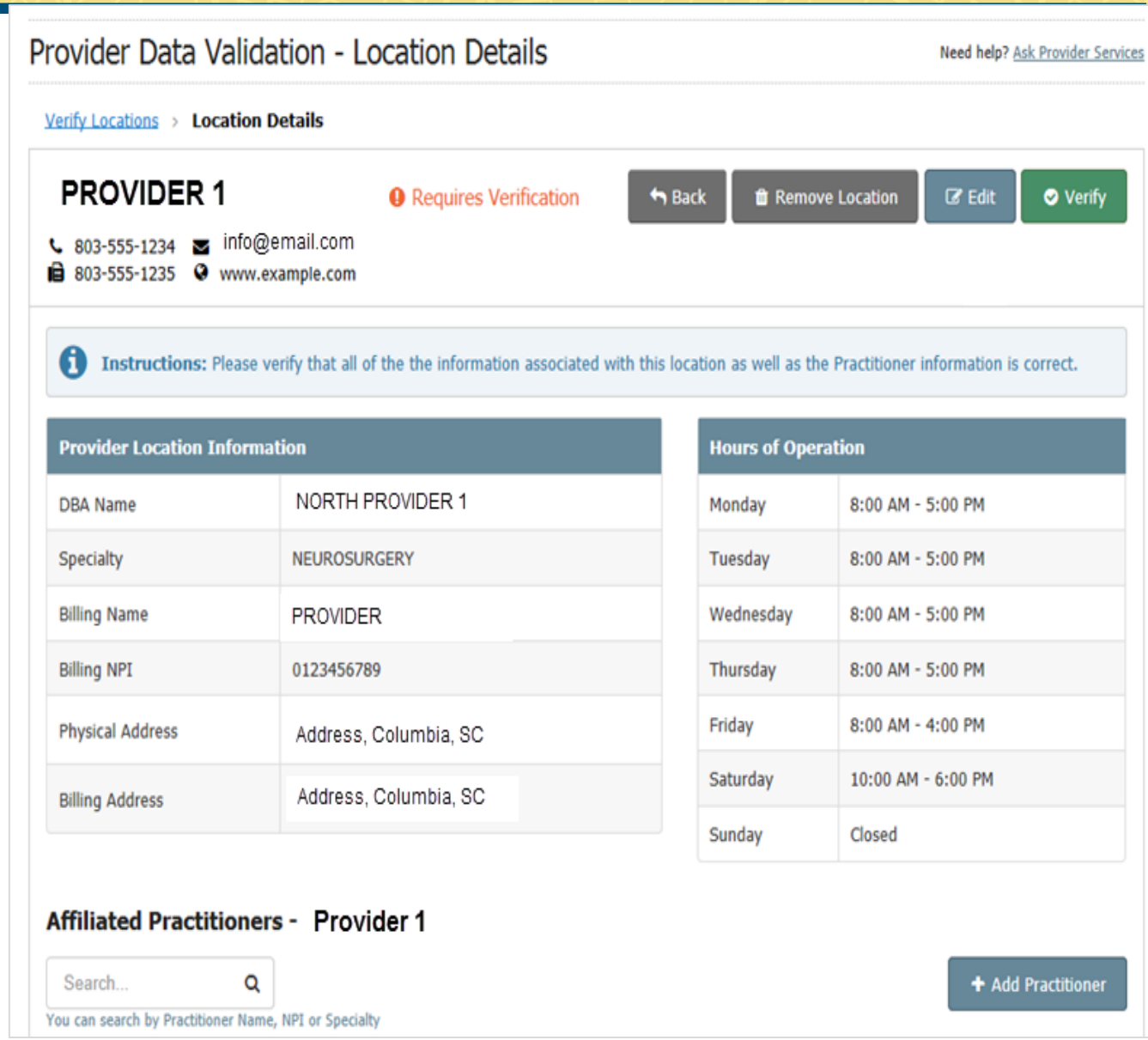
- **Appointment phone numbers are incorrect** – A patient calls and cannot reach the office to make an appointment. Patients will choose to call another practice.
- **Practitioners are listed at locations where they do not practice** – A patient calls to schedule an appointment with a certain practitioner. They are told he is not at this location. Patients get frustrated and may choose another practice.
- **Practitioners listed as accepting new patients** – Patients call to make a new patient appointment and are told that physician's panel is closed. Patients get frustrated and may choose a another practice.
- **Staff unaware of updates** – Sometimes updates are made but the staff is not aware. Be sure staff knows about all demographic updates.

Demographic Updates

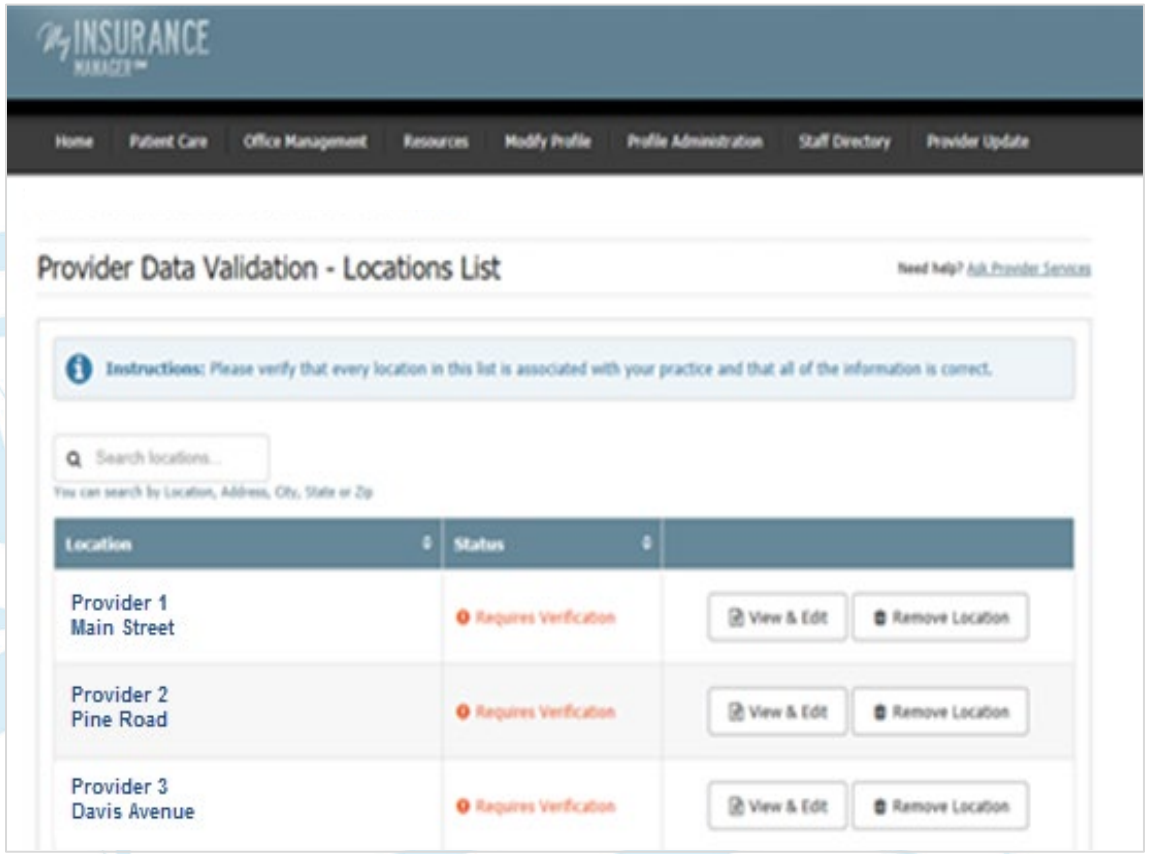
The Location Details screen shows the practice details:

- Address
- Telephone
- Fax
- Email
- Website
- Hours of operation
- Affiliated practitioners

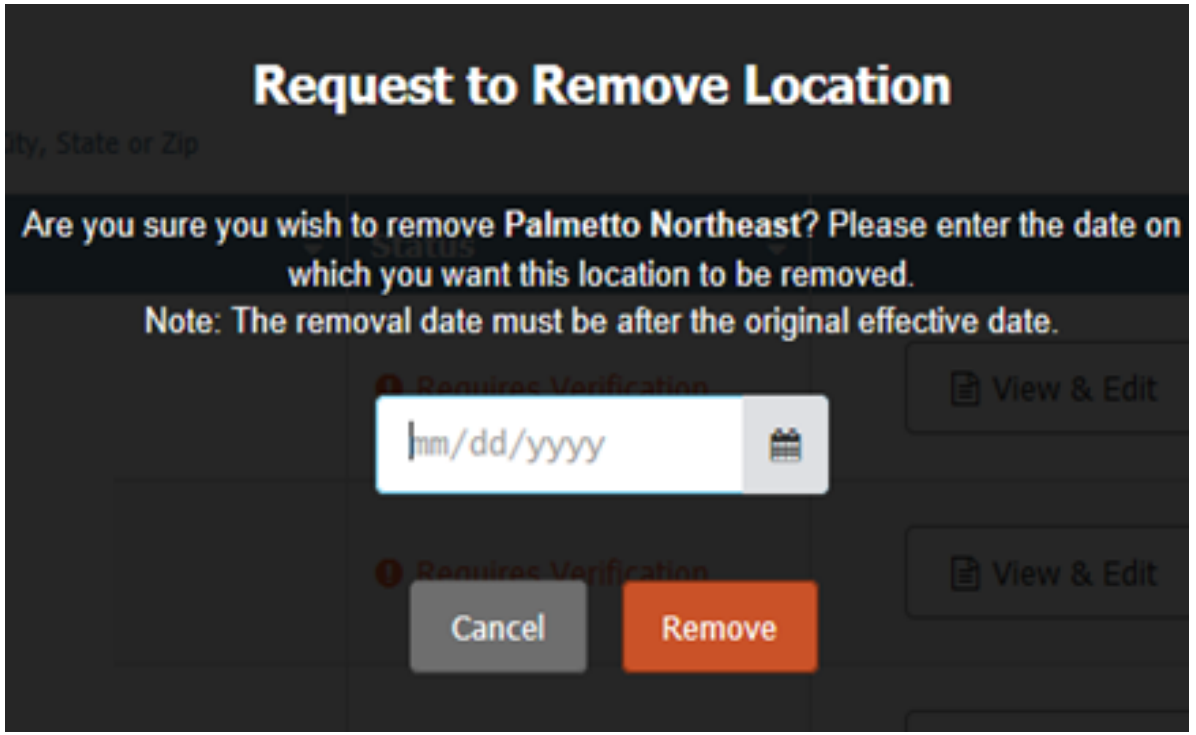
The Edit function allows users to modify the information shown.



Demographic Updates



If you click on Remove Location, you are closing out that location in our system as well as removing it from the directory. **DO NOT use this function to remove a location from your VIEW**.



Recredentialing

Recredentialing

- Established providers are required to recredential every three years.
- You can access the forms necessary to recredential by clicking on **Recredentialing**.
- If the provider is 30 days past the recredentialing date, the provider must re-enroll by submitting the initial provider enrollment information.

Recredentialing

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

Additional Documentation

We'll also need the following:

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

Submitting Your Recredentialing Materials

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

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

Recredentialing

Our credentialing staff will notify you when it is time for you to complete this update.

The recredentialing process consists of a **5 page South Carolina Uniform Managed Care Practitioner Credentials Update Form**. This is an abbreviated version of the Provider Enrollment Application, so the same guidelines apply:

- Office/credentialing contact , phone number and email address is needed.
- Hospital Admitting information is required. If the provider does not admit, an admitting plan must be submitted.
- Providers will need to submit a copy of their malpractice coverage that will not expire within 30 days.
- If the provider answers **Yes** to any question on **page 2,** a detailed explanation is required.
- **Signature dates on page 2, 3 and 5 must be less than 150 days old.**

Contact Us

Contact Us

BlueCross, BlueChoice, and Healthy Blue℠ have streamlined the Provider Enrollment Process to improve the enrollment experience.

- Initial Enrollment Applications – Provider.Blue.Enroll@bcbssc.com
- Returning Documentation – Provider.Requested.Info@bcbssc.com
- Provider Demographic Updates – Provider.Blue.Updates@bcbssc.com
- Recredentialing – Recred.App@bcbssc.com

Do not email Provider.Cert@bcbssc.com – This email address is no longer valid.

Note: Do not send your email to multiple addresses.

Contact Us

- BlueCross, BlueChoice, and Healthy Blue[SM] streamlined the Provider Enrollment Process to improve the enrollment experience.
- Fill out the online form to ask questions via email. Do not email directly.
- This form contains all the information needed to respond to inquiries quickly and accurately.

Get Help

If you need help with the provider enrollment process, please fill out this form. Someone will contact you within two business days.

To see which forms are needed for provider enrollment, please see the individual checklist and group checklist.

If you're checking on the status of an application, please note we will contact you at these points in the application process:

1. When we receive your entire application
2. If we need any additional documentation
3. When your application is moving to the onboarding phase
4. When your enrollment is complete and you are enrolled with BlueCross BlueShield of South Carolina and/or BlueChoice HealthPlan

Your First Name

Your Last Name

Your Email

Your Phone Number

Provider's First Name

Provider's Last Name

Provider's Specialty

Provider's Individual NPI

Contact Us

- Use the VRU to check status of a submitted application or ask questions.
- Call Provider Services at 1-800-868-2510 and select option 5.
    - Press 1 to check the status of an application.
- The phone lines are available Monday through Friday from 8 a.m. to 5 p.m.
- There is no voicemail option.
- **This line is for credentialing questions only.**

Claims

Disclaimer

In the event of any inconsistency between information contained in this presentation and the agreement(s) between you and BlueCross, the terms of such agreement(s) shall govern. The information included is general information and in no event should be deemed as a promise or guarantee of payment. We do not assume and hereby disclaim any liability for loss caused by errors or omissions in preparation and editing of this publication.

Agenda

- New Implementations
- Common Trends
- Tools and Resources
- Informational Reminders

New Implementations

New Implementations

ClaimsXten: Phase II

To ensure benefits and reimbursement are applied correctly to claims, it is imperative that claims are coded completely and accurately.

In the first quarter of 2021, we will implement Phase II of ClaimsXten™, which will continue to better align our claims adjudication with:

- Benefit plans
- Medical policies
- National Correct Coding Initiatives (NCCI)
- Centers for Medicare & Medicaid Services (CMS)

Rule	Description	Example
Duplicate Line Items	Recommends the denial of a claim line that matches a previously submitted claim line on a different claim or the current claim. Fields that must match are the member, provider, procedure code, modifier, date of service, quantity and billed amount.	**Claim 1** Claim | Line | Mem | Prov | CPT | Mod | Qty | DOS | Total AB12 | 1 | 001 | 123 | 74150 | 26 | 1 | 8/1/19 | $350 **Claim 2** Claim | Line | Mem | Prov | CPT | Mod | Qty | DOS | Total AB34 | 1 | 001 | 123 | 74150 | 26 | 1 | 8/1/19 | $350 Claim 2 will be denied, as is matches Claim 1. *OR* **Claim 1** Claim | Line | Mem | Prov | CPT | Mod | Qty | DOS | Total AB12 | 1 | 001 | 123 | 74150 | 26 | 1 | 8/1/19 | $350 AB12 | 2 | 001 | 123 | 99213 | N/A | 1 | 8/1/19 | $80 AB12 | 3 | 001 | 123 | 74150 | 26 | 1 | 8/1/19 | $350 Line 3 of the claim will be denied, as it matches Line 1 of the same claim.

Rule	Description	Example
Missing Professional Component Modifier	Recommends the denial of a claims lines containing a procedure code submitted without a professional component modifier -26 in a facility setting (POS 02, 19, 21, 22, 23, 24, 26, 31, 34, 51, 52, 53, 56 or 61). The rule will replace the line with a new line with the same procedure code and the professional component modifier -26.	Laboratory procedure 88106 is submitted without modifier -26 with a POS of 21, 22 or 24 and this claim line is denied. The same procedure (88106) is then added to the claim with the modifier -26 appended for payment.
Obstetrics Package Rule	Audits potential overpayments for obstetric care. It evaluates claim lines to determine if any global obstetric (OB) care codes (defined as containing antepartum, delivery and postpartum services, i.e. 59400, 59510, 59610 and 59618) were submitted with another global OB care code or a component code such as the antepartum care, postpartum care, or delivery only services, during the average length of time of the typical pregnancy (and postpartum period as applicable) 280 and 322 days respectively.	A claim line is submitted with global obstetrical procedure code 59400 (routine obstetric care including antepartum care, vaginal delivery and postpartum care) on 03/01/2018. In history, global obstetrical procedure code 59400 was previously submitted on 2/1/2018 for the same member, and was paid. The claim line would be denied with a Certainty of Apply. Global obstetrical code 59400 was submitted within 322 days of this current submission of global code 59400.

<table>
<tr><th>Rule</th><th>Description</th><th>Example</th></tr>
<tr><td>Inpatient Consultations</td><td>Recommends the denial of claim lines containing an inpatient consultation when another inpatient consultation was billed by the same provider for the same member with at least one matching diagnosis within a specified interval of time.</td><td>Inpatient consultation code 99252 was previously submitted on another claim for the same member and provider, with a claim line date of service within five days of the date for the current claim line submitted with inpatient consultation code 99253. Both claims have 250.82 as the diagnosis reported. Inpatient consultation code 99253 is denied and replaced with Evaluation and Management services code 99499 (or by the crosswalk value designated in the Consultation Recoding Guide).</td></tr>
<tr><td>Ambulance Bundled Services</td><td>Recommends the denial of any claim lines with a procedure code other than a valid ambulance HCPCS service or mileage code reported along with a valid ambulance HCPCS procedure code for the same beneficiary, same date of service, by the same provider and on Same Claim Only.</td><td>A claim has a HCPCS code for ground transport and a non-ambulance CPT code for the same member, same date of service, and by the same provider.
<table>
<tr><th>Claim</th><th>Line</th><th>Mem</th><th>Prov</th><th>CPT</th><th>DOS</th><th>Total</th></tr>
<tr><td>AB123</td><td>1</td><td>001</td><td>12345</td><td>AD428</td><td>8/1/19</td><td>$100</td></tr>
<tr><td>AB123</td><td>2</td><td>001</td><td>12345</td><td>A4931</td><td>8/1/19</td><td>$50</td></tr>
</table>
Line 2 (A4931) will deny using Line 1 (AD428) as support.</td></tr>
</table>

<table>
<tr><th>Rule</th><th>Description</th><th>Example</th></tr>
<tr><td>Ambulance Modifier Procedure Validation</td><td>Recommends the denial of ambulance services for the following reasons:
Claim lacks an appropriate origin-destination modifier or modifier QL.
Institutional (facility-based) claim lacks an appropriate arrangement modifier (QM or QN).
Two claim lines for the same date of service lack identical origin-destination and arrangement modifiers.</td><td>There are two lines of coding for a supplier (professional) claim.<table><tr><th>Claim</th><th>Line</th><th>Mem</th><th>Prov</th><th>CPT</th><th>Mod</th><th>DOS</th><th>Total</th></tr><tr><td>AB123</td><td>1</td><td>001</td><td>12345</td><td>AD430</td><td>DG</td><td>8/1/19</td><td>$100</td></tr><tr><td>AB123</td><td>2</td><td>001</td><td>12345</td><td>AD435</td><td>DG</td><td>8/1/19</td><td>$50</td></tr></table>Both lines will deny, as the modifier is not appropriate for the air ambulance codes submitted.</td></tr>
<tr><td>Valid Ambulance Services</td><td>Recommends the denial of inappropriate ambulance services for supplier and provider claims, as defined by CMS. Generally, two lines of coding (i.e. mileage code and transport/service code) are required in most ambulance billing scenarios. This rule also recommends the denial of claim lines, which lack the presence of an ambulance origin-destination modifier and institutional claim lines which lack appropriate arrangement modifiers as required.</td><td>There are two lines of coding a mileage code and a transport/service code on the same claim ID.<table><tr><th>Claim</th><th>Line</th><th>Mem</th><th>Prov</th><th>CPT</th><th>Mod</th><th>Rev</th><th>DOS</th><th>Total</th></tr><tr><td>AB12</td><td>1</td><td>001</td><td>123</td><td>A0425</td><td>RH,QN</td><td>540</td><td>8/1/19</td><td>$100</td></tr><tr><td>AB12</td><td>2</td><td>001</td><td>123</td><td>A0428</td><td>RH,QN</td><td>000</td><td>8/1/19</td><td>$50</td></tr></table>Both lines will deny, as Line 1 has a valid mileage code, but an unsupported transport/service code and Line 2 has an invalid transport/service code due to the revenue code.</td></tr>
</table>

<table>
<tr><th>Rule</th><th>Description</th><th>Example</th></tr>
<tr><td>Ambulance Frequency</td><td>Recommends the denial of an ambulance claim line when the frequency exceeds than allowed limits for a valid ambulance HCPCS service code reported for the same member on the same date of service from.</td><td>There is a single line of coding reported for the supplier (professional) claim.

<table><tr><th>Claim</th><th>Line</th><th>Mem</th><th>CPT</th><th>Mod</th><th>Qty</th><th>DOS</th><th>Total</th></tr><tr><td>AB123</td><td>1</td><td>001</td><td>A0428</td><td>DG</td><td>2</td><td>8/1/19</td><td>$100</td></tr></table>
The claim will deny, as the frequency (quantity) is exceeded for the A0428.</td></tr>
<tr><td>Local Coverage Determinations Procedure to Diagnosis Coverage

Note: Only applies to Medicare Advantage claims.</td><td>Identifies claim lines for certain procedure codes associated with a single diagnosis code/multiple diagnosis codes or no diagnosis code, modifier, age and frequency requirement where the procedure is not considered medically necessary, payable, or has payment constraints according to Local Coverage Determinations (LCDs).</td><td>Place of Service (POS) Check

A Medicare Part B claim (POS 22) is submitted for procedure code 11055.

The claim line will exit the rule since POS 22 with procedure code 11055 does not qualify for the LCD policy.</td></tr>
</table>

Rule	Description	Example
National Coverage Determination Procedure to Diagnosis Coverage **Note: Only applies to Medicare Advantage claims.**	Identifies claim lines for certain procedure codes associated with a single diagnosis code/multiple diagnosis codes or no diagnosis code, modifier, age and frequency requirement where the procedure is not considered medically necessary, payable, or has payment constraints according to National Coverage Determinations (NCDs).	*Multiple Explicit Diagnoses Covered and Non-covered* An inpatient facility claim (Bill Type 111) is submitted with procedure code 43645 and several claim diagnosis codes. Per NCD policy, diagnosis code G83.9 is covered, Z00.00 requires additional review and F01.50 is not covered with procedure code 43645. The default rule will evaluate claim level diagnosis fields only for facility claims. The claim line will exit the rule since the diagnosis code G83.9 is identified as covered when submitted with procedure code 43645 according to the applicable NCD policy. This example illustrates how a single covered diagnosis code will satisfy the coverage criteria and outweigh the documentation review and non-covered recommendations.

Rule	Description	Example
National Coverage Determination Procedure to Diagnosis: Exclusionary Lab Policy **Note: Only applies to Medicare Advantage claims.**	Recommends the denial of procedure code claim lines if any of the claim header or line diagnoses are defined by CMS to meet one of following two conditions: According to this Exclusionary policy, CMS has a defined list of "ICD-10-CM Codes That Do Not Support Medical Necessity." Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the non-payable conditions list. **OR** Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the CMS defined list of "Non-covered ICD-10-CM Codes for All NCD Edits" in the Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report.	An outpatient facility claim (Bill Type 131) is submitted with a procedure code 85049 and claim diagnosis code of D23.9: The default rule will evaluate claim level diagnosis fields only for facility claims. 85049 is denied (with Certainty of APPLY) because diagnosis code D23.9 is in the CMS defined list of "ICD-10-CM Codes That Do Not Support Medical Necessity." Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the non-payable conditions list.

Rule	Description	Example
National Coverage Determination Procedure to Diagnosis: Inclusionary Lab Policy **Note: Only applies to Medicare Advantage claims.**	Recommends the denial of procedure code claim lines if any of the claim header or line diagnoses are defined by CMS to meet one of following two conditions: According to this Inclusionary policy, CMS has a defined list of "ICD-10-CM Codes Covered by Medicare Program." Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is not part of the payable list. **OR** Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is part of the CMS defined list of "Non-covered ICD-10-CM Codes for All NCD Edits" in the Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report.	An outpatient facility claim (Bill Type 131) is submitted a procedure code 80074 and claim diagnosis code of K76.1: The default rule will evaluate claim level diagnosis fields only for facility claims. 80074 is denied (with Certainty of APPLY) because diagnosis code K76.1 is not in the CMS defined list of "ICD-10-CM Codes Covered by Medicare Program" or in the CMS defined list of "Non-covered ICD-10-CM Codes for All NCD Edits." Denial of the procedure code occurs because of its submission with an ICD-10 diagnosis code that is not part of the payable list.

New Implementations

ClaimsXten: How to stay in the know…

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

New Implementations

High Dollar Pre-payment Review (HDPR): New Dollar Threshold

- Reduced to $100,000.00*, effective Jan. 1, 2021
- Applies to non DRG, inpatient claims
- Itemized bills are required

Note: If needed, medical records will be requested.

** This dollar amount is based on the allowed amount of the claim.*

Common Trends

Common Trends

Over the past couple of years, the same top front-end edits have surfaced:

- **Subscriber is not on file as entered**
  - EDI Reject Code: 251
- **Billing provider number is not on file**
  - EDI Reject Code: 560
- **Invalid rendering physician ID number**
  - EDI Reject Code: HA9
- **Invalid prefix on the subscriber's ID number**
  - EDI Reject Code: P57

Going forward, we want to help avoid these edits and allow for more clean claims processing.

Common Trends

- Subscriber is not on file as entered
- Invalid prefix on the subscriber's ID number

How to avoid:

Common Trends

- **Billing provider number is not on file**
- **Invalid rendering physician ID number**

How to avoid:

Common Trends

This year we had some new top claim edits emerge and they include:

- **Bundled services**
  - CARC: 234, RARC: M15
- **Inclusive/exclusive services**
  - CARC: P14, RARC: M15
- **Inconsistent diagnosis**
  - CARC: 11, RARC: N657
- **Patient ineligible for services**
  - CARC: 27, RARC: N30

Like the front-end edits, we want to avoid these going forward and promote more clean claims processing.

Common Trends

- **Bundled services**
- **Inclusive/exclusive services**

How to avoid:

Verify billing and coding

Verify NCCI guidelines

Verify claim submission

Common Trends

- **Inconsistent diagnosis**

How to avoid:

Verify billing and coding

Verify medical policies

Verify claim submission

Common Trends

- **Patient ineligible for services**

How to avoid:

Ask for the most current ID card

Verify eligibility at each visit

Confirm the payer ID and plan code

Tools & Resources

Tools & Resources

Voice Response Unit (VRU)

If we paid a claim or applied it to the patient's liability, the VRU will provide:

- Processed date
- Remittance date
- Check number
- Amount paid
- Amount applied to patient's liability (deductible, copay or coinsurance)

If we denied a claim, the VRU will provide:

- Denial reason
- Remittance date

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

Tools & Resources

My Insurance Manager℠ (MIM): Claims Status

MIM is the quickest way to obtain the status of claims, as there are no hold times or delays involved. It allows you to see whether claims have been approved, rejected or in pending status. For your convenience, this information is broken down by line, CPT code and charges.

Tools & Resources

My Insurance Manager℠ (MIM): Ask Provider Services

If you need assistance with claims or are unclear of the processing of claims, you can use the Ask Provider Services option in MIM. To provide you with the most effective and accurate response, it is important to ask specific, probing questions in your inquiry. A few examples include:

- Why was line to denied as non-covered?
- Why were services applied towards the member's deductible?
- Has the member returned the Coordination of Benefits questionnaire?

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

Tools & Resources

Electronic Payer IDs

Medical Plans	Payer ID
Thomas Cooper	00315
State Health Plan	00400
BlueCross BlueShield of South Carolina	00401
Federal Employee Plan (FEP)	00402
Healthy Blue℠	00403
Planned Administrators, Inc. (PAI)	00886
BlueChoice® HealthPlan	00922
Medicare Advantage	00C63
Dental Plans	**Payer ID**
BlueCross BlueShield of South Carolina	38520
Companion Life	77828

Thomas Cooper and PAI are separate companies that provide third party administration services on behalf of BlueCross.

BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association.

Companion Life is a separate insurance company from BlueCross. Companion Life is responsible for all services related to its dental insurance product.

Informational Reminders

Informational Reminders

Filing Corrected Claims

Corrected claims can be submitted using one of the following avenues:

- My Insurance Manager℠ (MIM)
- Electronically*
- Hard copy (mail)

When submitting corrected claims, be sure to:

- Select “Replacement of Prior Claim” when submitting via MIM
- Use the correct frequency code (7) when submitting electronically or by mail
- Include all lines from the original claim, along with the correction(s) to be made

** This is the preferred and quickest method for submitting claims.*

Informational Reminders

Provider Reconsiderations

Provider reconsideration requests should include an explanation of the issue(s) to be reconsidered, such as seeking additional benefits, or why we should reconsider the service.

We require you to include any supporting documentation, such as member's history and physical, any operative reports, office notes, pathology reports, hospital progress notes, radiology reports and/or laboratory reports. We are unable to review requests that are submitted without supporting documentation.

Informational Reminders

Provider Reconsiderations

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

* For the reasons listed in this column, contact the Provider Services phone number on the back of the member's ID card.

Informational Reminders

Provider Reconsiderations

Plan	Timely Filing Limit	Fax Number	Mailing Address
BlueChoice® HealthPlan	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Rd., Columbia, SC 29219
BlueEssentials℠ & BlueOption℠	60 day from the processed date	803-264-4172	AX-620, I-20 @ Alpine Rd., Columbia, SC 29219
Preferred Blue® & BlueCard®	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Rd., Columbia, SC 29219
Group & Individual	180 days from the processed date	803-264-4172	AX-F25, I-20 @ Alpine Rd., Columbia, SC 29219
State Health Plan	180 days from the processed date	803-264-4204	AX-B10, P.O. Box 100605, Columbia, SC 29260
Federal Employee Program	90 days from the processed date	803-264-8104	AX-B05, P.O. Box 600601, Columbia, SC 29260
Medicare Advantage	60 days from the processed date	803-264-9581	AG-780, P.O. Box 100191, Columbia, SC 29202

Note: This information is also located on the Provider Reconsideration form.

Informational Reminders

Pricing Inquiries

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

- Member's plan
- Non-covered charges or denied lines
- Applied cutbacks
- Date of service

Informational Reminders

Refund Inquiries

For assistance with refunds, contact Provider Services:

- 800-868-2510, Option 4

This line is used for the following lines of business:

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

Informational Reminders

Network Participating Providers

As a network participating provider with BlueCross BlueShield of South Carolina, part of your responsibility is to use or refer members to other network participating providers when needed.

By using or referring other network participating providers, members will not have to bear the burden of higher out of pocket cost or be subject to balance billing usually seen with out-of-network providers.

Note: Refer to the 2020 Provider Administrative Office Manual for more details.

Authorizations

Agenda

- Authorizations 101
- Authorization Tools
- Peer-to-Peer Requests
- Special Programs

Authorizations 101

Authorizations 101

Authorizations are necessary for certain services where a member's plan needs notification before treatment is administered. In these cases, the plan and providers work together to ensure the best care is offered to the member.

You may also see these terms used when referring to authorizations:

- Prior Authorization
- Prior Approval
- Precertification

Note: An authorization is not a guarantee of payment and authorization requirements may vary per plan.

Authorization Requirements

Services requiring authorization for most plans:

- Inpatient services
- Maternity
- Skilled nursing facility admission
- Home health and hospice
- DME when the purchase price or rental is $XXX* or more
- Transplants
- Mental health and substance abuse services
- MRIs, MRAs, and CT Scans (required through NIA Magellan)

Always check benefits and eligibility for authorization requirements!

Some plans do have exceptions to authorization requests.

- *DME purchase maximums vary by plan.
- Check eligibility and benefits for the purchase or rental price that requires authorization.

Request Authorizations

When do you need to request an authorization?

- Prior to qualified services being rendered
- Within 24 hours of qualified emergent services

Authorization Submission Tips

- Submit a request once and allow time to process
- Submit all requests with specific and complete information

Note: Request training through your provider advocate if needed.

Authorization Process

1. Verify requirements

2. Initiate request

3. Submit all relevant information to include:

- Patient's name, ID number and date of birth
- Date of service
- Service details (CPT/HCPCS, diagnoses, clinical data, etc.)
- Provider name and Tax ID or NPI

4. Receive a decision

- Approval – proceed with service
- Denial – review the information provided to ensure it was submitted correctly
  - ➢ You can request a Peer-to-Peer review or appeal, when appropriate.

Authorization Methods

Preferred Method: My Insurance Manager℠ (MIM)

- From www.SouthCarolinaBlues.com and www.BlueChoiceSC.com

Preferred Method: Medical Form Resource Center (MFRC)

- From www.SouthCarolinaBlues.com and www.BlueChoiceSC.com

Fax

- Check the member's ID card

Phone

- Check the member's ID card

Guidelines

Submit authorization in advance of the service with complete information.

Submit emergency authorizations within 24 hours or the next business day.

Mark URGENT what is truly urgent.

- 80 percent of our workload is marked urgent
- Decreases likelihood of truly urgent being handled

Durable Medical Equipment (DME) Tips

- Build requests as DME, instead of HOME in MIM even when being used at home. (Authorization is for the DME, not the place of service.)
- Include the estimated cost of the item – some plans have a threshold. Below the ceiling? No preauthorization required.
- Include an UPDATED Letter of Medical Necessity with the UPDATED clinical notes to include diagnosis codes that support the member's diagnosis.
- Use MFRC for pre-formatted DME requests.
- Refer to CAM 115.

Home Health Service Tips

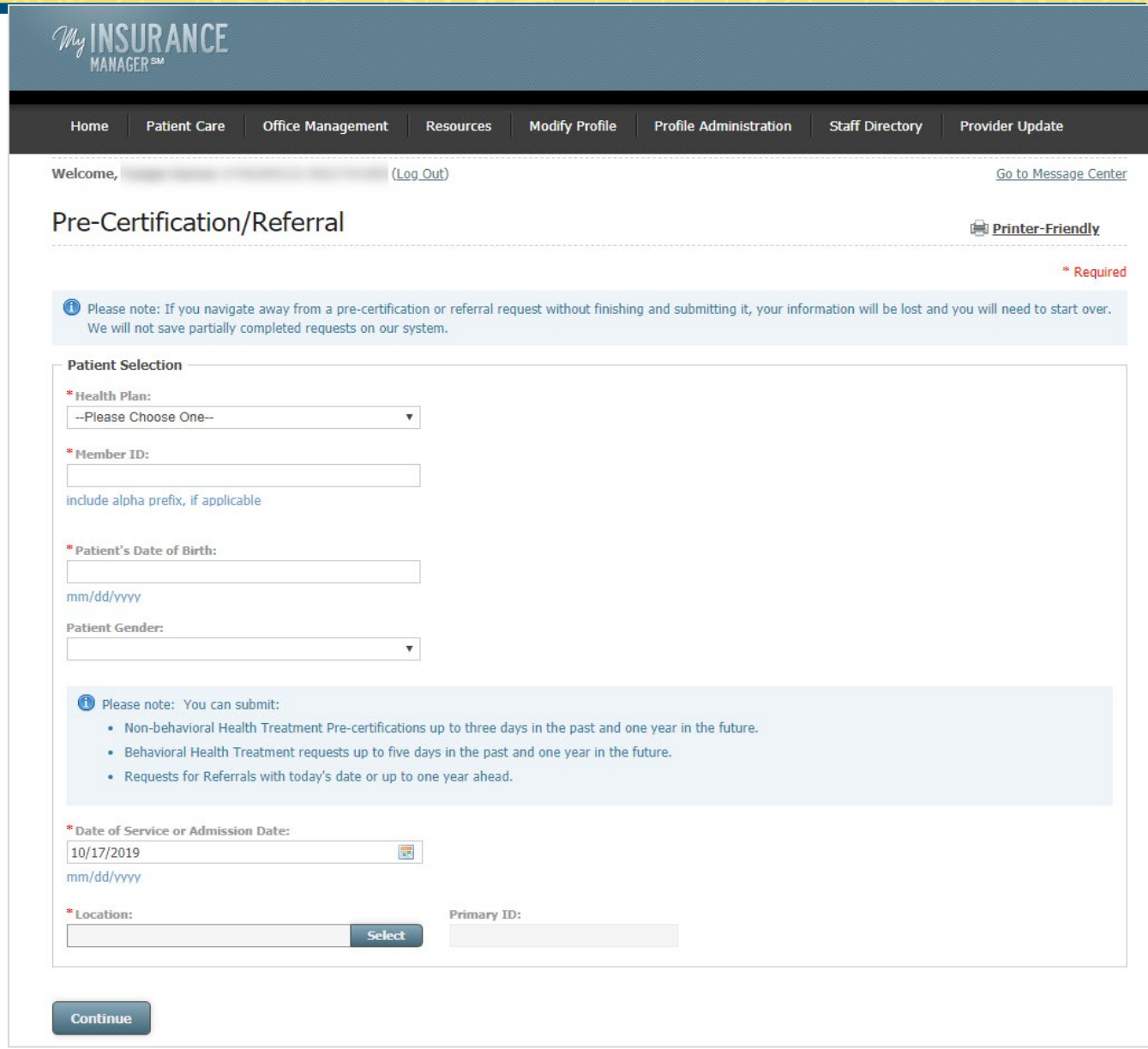
- Approvals are for one month at a time.
- Request specific services and be sure to include the rendering physician to avoid conflicting authorizations.
- Notify us when a patient has not used the requested date range of services.
- Respond to requests for additional information with the specifically requested information.
- When requesting additional days, give clinical update since last request, entire history is not required.
- You can also use MFRC for forms dedicated to home health services.

Authorization Tools

My Insurance Manager

My Insurance Manager

- MIM is always the best option.
- Fast Track Requests in MIM typically do not require additional information and will give you an authorization number upon completion.
- There are hundreds of Fast Track Requests available.

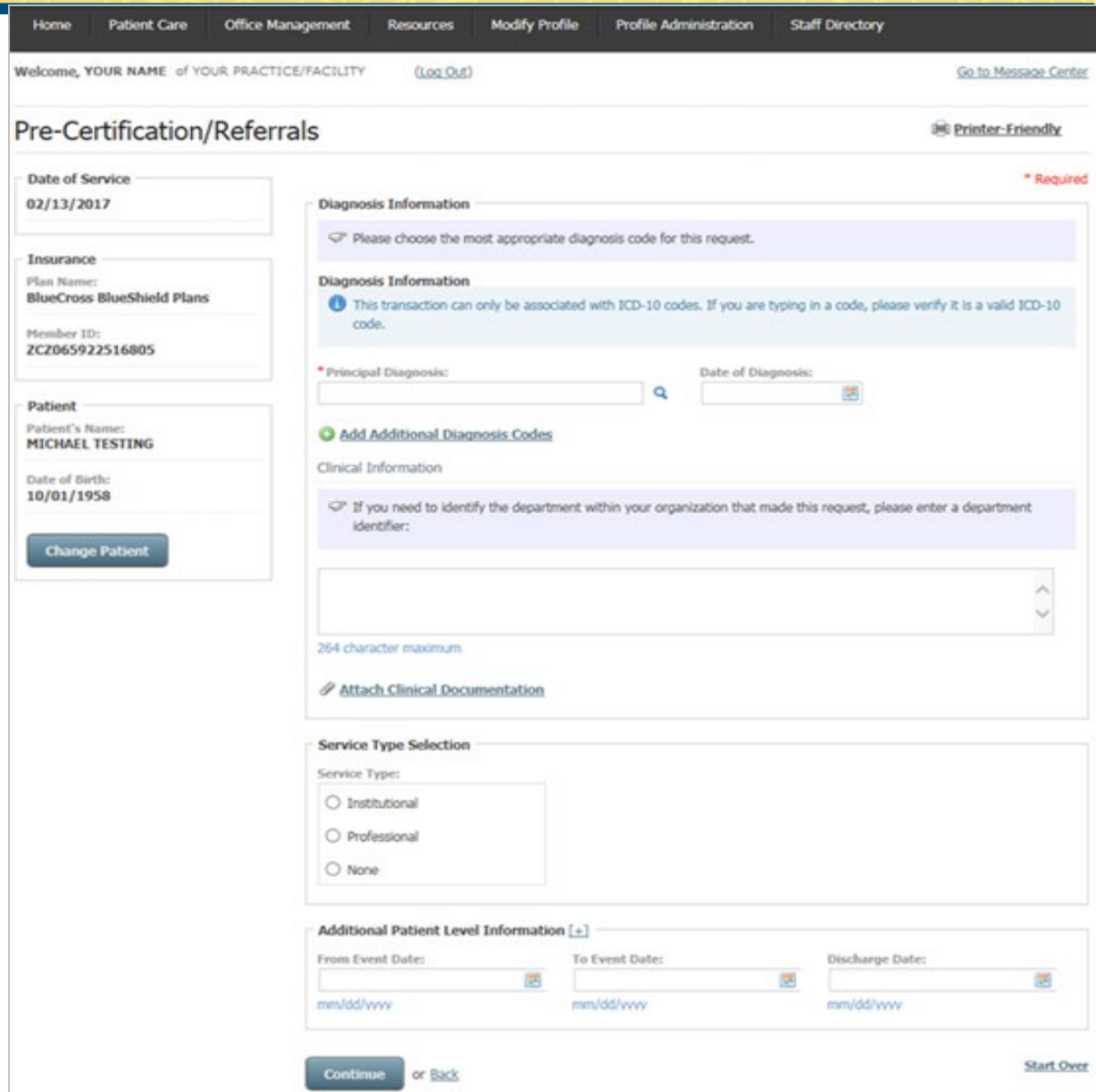


My Insurance Manager

Clinical Attachments

To attach clinical information for authorization requests that pend, follow these steps:

- Choose Attach Clinical Documentation from the Diagnosis Information page within the Precertification/Referral progression.
- Attach a File when prompted. Follow guidelines for acceptable file type and size.
- Confirm the attached document.
- Complete required fields for Contact Name, Phone Number and Fax Number, then Continue.



Medical Forms Resource Center

Medical Forms Resource Center

- Approvals are for one month at a time.
- Medical Forms Resource Center (MFRC) authorizations jump ahead of faxes.
- Form fields ask for all information needed to complete the authorization.
- Select SEE A FULL LIST OF FORMS on the home screen.
- Use MIM to check the status of your request.
- Receive approval or denial using existing methods.

Chemotherapy
- Chemotherapy Notification

Durable Medical Equipment
- Continuous Glucose Monitoring
- Insulin Pump
- Lymphedema Pump
- Neuromuscular Stimulator
- Orthotics
- Prosthetics
- Wound Vac
- Miscellaneous

Home Health/Hospice
- Home Health
- Hospice

Admissions/Inpatient
- Breast Reduction
- Chemotherapy
- Excision of Lesion Tumor Mass
- General Precertification
- Hysterectomy
- Spinal Fusion Diskectomy Laminectomy

LTAC/SNF/Rehab
- LTAC
- SNF/IP Rehab

Maternity
- Maternity Notification

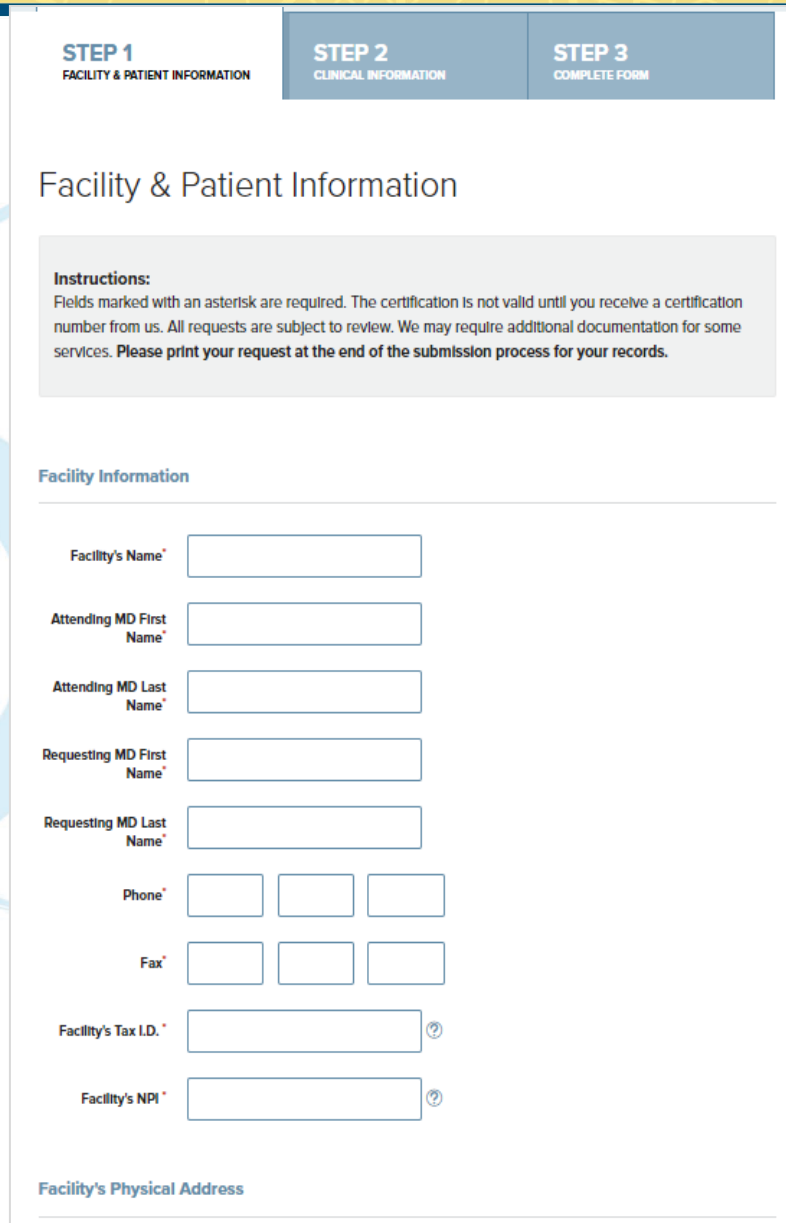
Medications
- General Medication Request

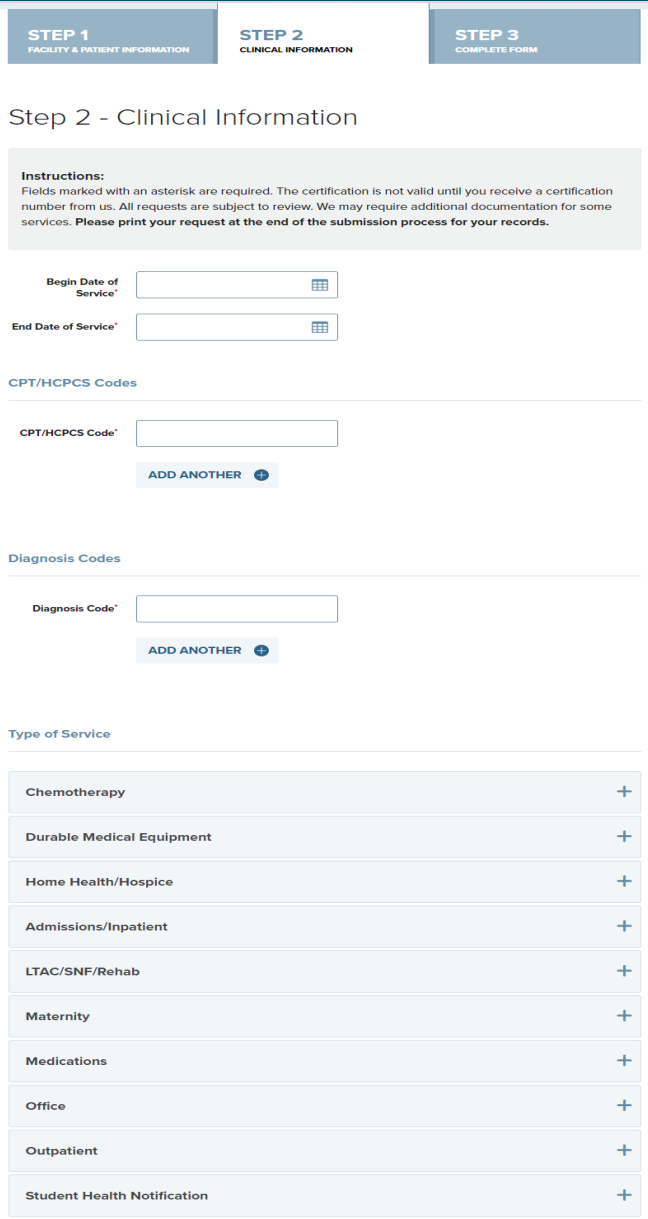
Office
- Breast Reduction
- Chemotherapy
- Excision of Lesion Tumor Mass
- General Precertification
- Radiofrequency Facet Ablation
- Septoplasty

Outpatient
- Breast Reduction
- Chemotherapy
- Excision of Lesion Tumor Mass
- General Precertification
- Hysterectomy
- Radiofrequency Facet Ablation
- Septoplasty
- Spinal Fusion Diskectomy Laminectomy

Medical Forms Resource Center

1. Complete facility and patient information
2. Add clinical information in step 2
3. Complete request





Fax Requests

When submitting fax requests, please include the Authorization Request Form or a coversheet or fax form which includes the following:

- Patient name
- Date of birth
- CPT code/DX code
- Fax number
- Contact number (with extension)

Providing this information allows us to process your request quickly and reduces delays.

Peer-to-Peer Requests

Peer-to-Peer Requests

Peer-to-Peer Discussions must meet the following criteria:

- Received a medical necessity adverse decision
    - Vendor/Partner denials are afforded a P2P with a vendor/partner Physician. These must be completed with the vendor.
- Received a health plan authorization denial
- Requested within five business days of initial denial notification
- Requested prior to an appeal

Peer-to-Peer Requests

Requesting a Peer-to-Peer Discussion

Form and Resources

Medical Forms Resource Center	SouthCarolinaBlues.com	Phone
• Access www.FormsResource.Center • Select “Request a Peer-to-Peer Discussion” • Type all pertinent information • Submit	• Access www.SouthCarolinaBlues.com Providers > Forms > Specialties/Other > Peer-to-Peer Request Form • Type & save all pertinent information • Send via E-mail: Peer.Medical@bcbssc.com or Fax: 803-264-9175	• Complete status checks and receive Peer-to-Peer education by calling: 803-264-8114 • Monday – Friday • 8:30 a.m. – 5 p.m. EST

Peer-to-Peer Requests

Clinical Discussion

Peer-to-peer discussions are typically facilitated within one business day of receipt of the completed Peer-to-Peer Request Form.

Our MD will make two attempts to call the rendering provider at the provided number within the scheduled three-hour window to complete the peer-to-peer request.

A decision is rendered at the end of the call and the health care provider is made aware of the rationale.

- If approved the authorization will be updated and a formal notification will be faxed and mailed.
- If the authorization is still denied there is still an option to utilize remaining appeal rights.

Special Programs

Authorization and Benefit Management Partners

Third-party vendors manage authorizations for certain benefits.

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

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

Magellan Healthcare

Check the member's ID card and eligibility and benefits to determine if authorization through NIA Magellan is required.

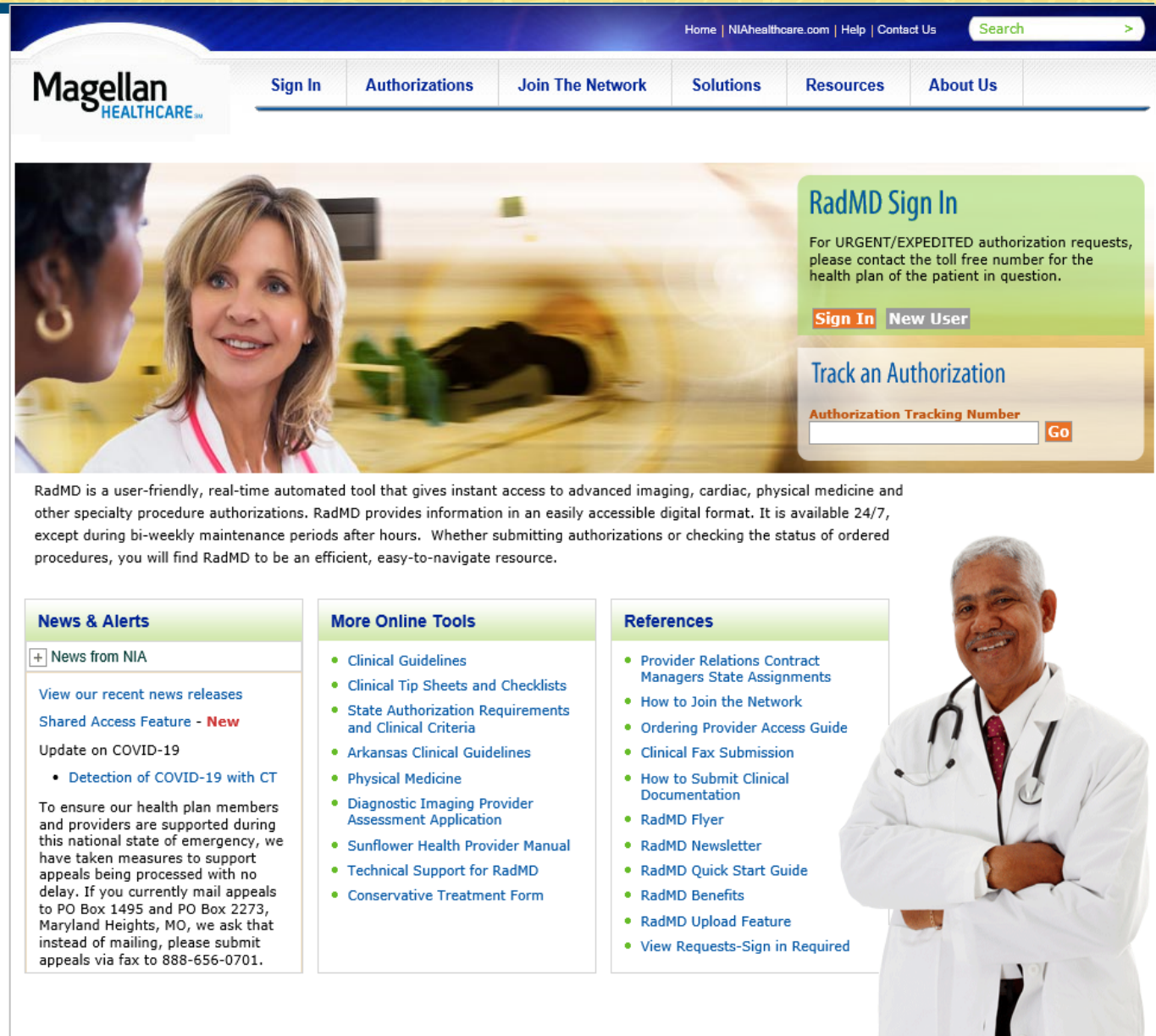
- Advanced radiology
- Radiation oncology
- Musculoskeletal care
- Nuclear cardiology

Magellan HEALTH SM

Magellan Healthcare

To request an authorization or review the status of an authorization:

- Visit RadMD.com
- Call 866-500-7664 for BlueCross members
- Call 888-642-9181 for BlueChoice members



Magellan Healthcare

Advanced Radiology

- On Jan. 1, 2020, NIA began managing the following CPT codes for all groups that currently have the Radiology program.

Authorized CPT Codes	Description	Allowable Billed Groupings
78472	MUGA Scan	78472, 78473, 78494, 78496
78451	Myocardial Perfusion Imaging Nuclear Cardiology Study	78451, 78452, 78454, 78466, 78468 78469, 78481, 78483, 78499

Magellan Healthcare

Radiation Oncology

- Submit all required patient clinical information to Magellan for review. You will get a medical necessity determination within two to three business days. For the fastest turnaround time, use RadMD.com to submit requests.
- Supply all requested information at the time of the request to ensure medical necessity can be confirmed quickly for your physicians and patients.

Magellan Healthcare

Musculoskeletal Program (MSK)

- Components of non-emergent MSK care:
  - Outpatient, interventional spine pain management services
  - Inpatient and outpatient lumbar and cervical spine surgeries.
- BlueCross and BlueChoice plans not participating in the program include:
  - FEP
  - State Health Plan
  - Some self-funded plans

Note: Check benefits via MIM or the VRU to determine where to get an authorization if needed.

Magellan Healthcare

Musculoskeletal Program (MSK)

- Ordering physician must get authorization for all interventional spine pain management procedures and spine surgeries.
- Rendering physicians should verify they have the necessary authorization.

Note: You must request authorization for emergency spine surgery cases admitted through the emergency room (ER) or spine surgery procedures outside the procedures listed on our websites through our plans.

Specialty Drug Authorizations

We require authorization for some specialty drugs through our Specialty Pharmacy Manager.

Three ways to get prior authorizations:

- Online through My Insurance Manager (fastest option)
- Fax Specialty Pharmacy Manager at 612-367-0742
- Call Specialty Pharmacy Manager at 877-440-0089

Specialty Drug Authorizations

- Non-Authorization Remittance Remark Codes
- You will receive an adverse determination if you file self-administered drugs under the medical benefit that should be filed under the pharmacy benefits.

Remittance Type	Code	Description
Electronic	197	Precertification/Authorization/Notification absent
Hardcopy	9331	This service requires prior authorization: Please contact Specialty Pharmacy Manager at 877-440-0089

Companion Benefits Alternative (CBA)

Some groups require authorization for mental health, behavioral health and substance abuse services through CBA.

Determine authorization requirements when verifying eligibility and benefits for each member.

Examples of services requiring authorization:

- Psychological testing
- Repetitive transcranial magnetic stimulation (rTMS)
- Behavioral health program admissions

Get authorization through the Forms Resource Center on www.CompanionBenefitAlternatives.com

Laboratory Benefit Management

We require some groups to get authorization for specific laboratory services through Avalon, our laboratory benefit manager.

Integrated Network

Lab Management

- Merges **>50** individual vendor relationships into a **single standard reimbursement** mechanism
- Manages **new** and **emerging** lab **technologies**
- Aligns test utility to policy, coding and **appropriate reimbursement**

Lab Policy Development & Enforcement

Policy Development

Clinical Advisory Board

- Independent Clinical Advisory Board **(CAB)**
- CAB evaluates new laboratory science
- **~140** evidence-based lab policies, reviewed annually
- Policy portal & quarterly client updates on policy changes

Genetic Testing Management

Review of PA Codes

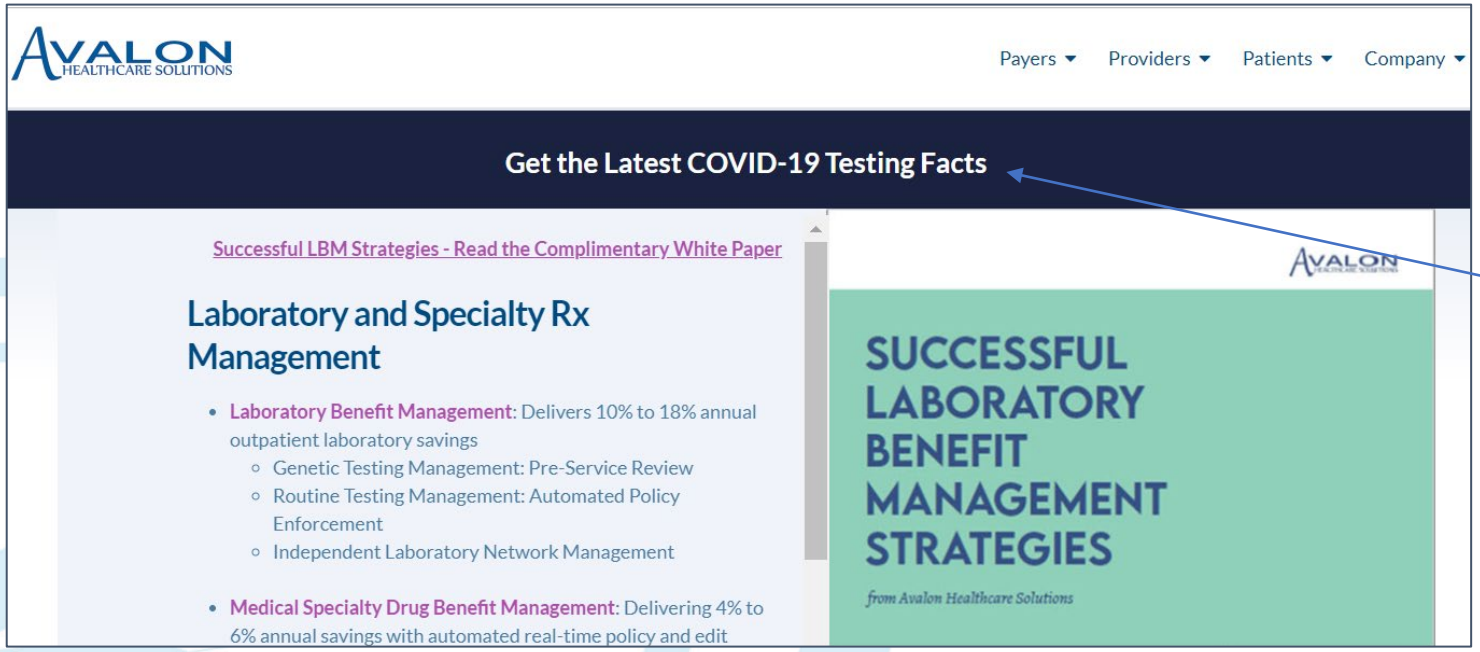
- **>200 PA codes**
- **~100 codes automatically approved** using self-service tool when patient meets necessary coverage criteria
- Very low appeal rate
- Excellent clinical alignment

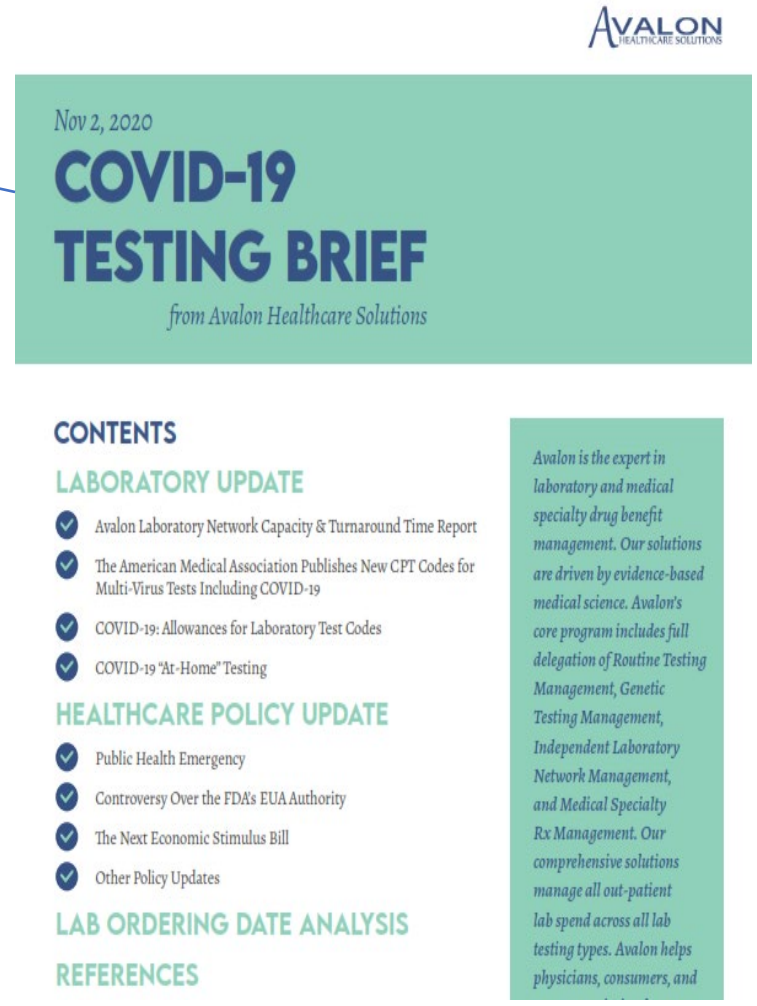
Routine Testing Management

Avalon Software Solution

- Provide **real-time** clinical lab claim editing
- Cloud-based running on Amazon Web Services
- **<1 second** provides advice to deny, reduce, or approve claims

Avalon's COVID-19 is on our website: www.avalonhcs.com





Saliva Testing
Antigen Testing
Respiratory Pathogen Panel Testing

Lab Capacities
Under Capacities and Current Deficiencies
Specimen/Test Pooling

Resources and Other Information

Benefit Program	Authorization Service	Web-based Requests	Telephone Requests	Fax Requests
BlueCross	[various]	My Insurance Manager and MFRC	800-334-7287	803-264-0258 (utilization management) 803-264-0259 (case management)
BlueChoice	[various]	My Insurance Manager and MFRC	800-950-5387	800-610-5685
Federal Employee Program	[various]	My Insurance Manager and MFRC	800-327-3238	N/A
State Health Plan (Medi-Call)	[various]	My Insurance Manager and MFRC	800-925-9724	803-264-0183
Avalon	Laboratory	Avalon PAS	844-227-5769	888-791-2181
CBA	Behavioral and Substance Abuse	www.CompanionBenefitAlternatives.com	800-868-1032	803-714-6456
NIA Magellan	Advanced Radiology	www.RadMD.com	BlueCross: 866-500-7664 BlueChoice: 888-642-9181	888-656-1321
NIA Magellan	Musculoskeletal Care	www.RadMD.com		888-656-1321
NIA Magellan	Nuclear Cardiology	www.RadMD.com		888-656-1321
NIA Magellan	Radiation Oncology	www.RadMD.com		888-656-1321
Specialty Pharmacy Manager	Specialty Medical Drug	My Insurance Manager	877-440-0089	612-367-0742

Healthy Blue℠

Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

Agenda

- Contacts and Resources
- Covered Benefits
- Claims Submission Tools
- New Information
- Reminders
- Quality
- Marketing

Contacts & Resources

Contacts & Resources

Catawba
Bunny Temple
Bunny.Temple@bluechoicesc.com
803-264-2361

Lowcountry
Tom Ingram
Thomas.Ingram@bluechoicesc.com
803-382-5778

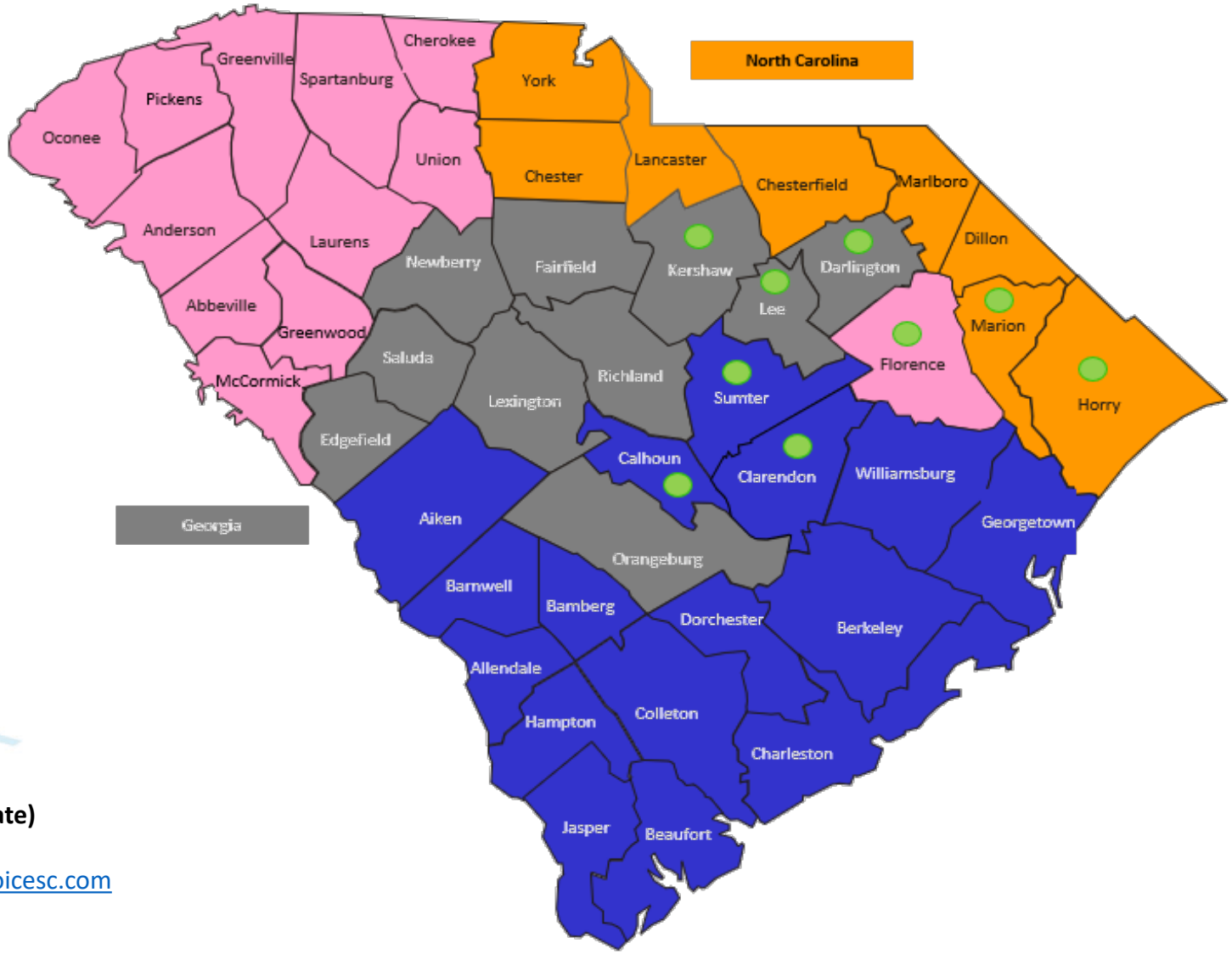
Upstate
Donese Pinckney
Donese.Pinckney@bluechoicesc.com
803-382-5125

Midlands
Jon Keith
Jon.Keith@bluechoicesc.com
803-382-5085

Pee Dee
TBD
TBD@bluchoicesc.com
803-264-1414

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

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



Contacts & Resources

Website:
www.HealthyBlueSC.com

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

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

IngenioRx
Prior authorizations: 844-410-6890

*VSP is an independent company that offers a vision network on behalf of BlueChoice® HealthPlan.

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

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

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

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

Contacts & Resources

BlueBlast

Monthly provider focused newsletter.

Topics include:

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

Contact your Healthy Blue Representative to sign-up.

Covered Benefits

Covered Benefits

Checking Covered Benefits

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

- Information is listed by provider specialty type.
- If the code appears on the SCDHHS fee schedule, it is covered.
- Medicaid Managed Care Organization (MCO) plans are required to offer at a minimum the same benefits as Healthy Connections Fee for Service (FFS).

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

Covered Benefits

Checking Covered Benefits: Provider Manuals

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

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

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

Covered Benefits

Prior Authorization Lookup Tool

- Use for outpatient services only
- Non-covered services may be listed as requiring prior authorization
- ALWAYS verify eligibility/benefit coverage prior to rendering services

Accessing the Authorization Lookup Tool

- Visit www.HealthyBlueSC.com
- Click the ‘Provider’ link, followed by ‘Prior Authorizations’
- Under Related Information, click ‘Prior Authorization Lookup Tool’
- Enter the CPT/HCPCS code and click ‘Search’

Covered Benefits

Prior Authorization Lookup Tool

YES - Precertification is required

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

NO - Precertification is not required

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

Covered Benefits

Copays

Service	Copay
Primary care visits, RHCS and FQHCS	$3.30
Specialists visits (including optometrists)	$3.30
Durable medical equipment	$3.40
Chiropractic care	$1.15
Home health (limited to 50 visits)	$3.30
Prescription drugs (brand and generic)	$3.40
Outpatient hospital	$3.40
Inpatient hospital	$25.00

Covered Benefits

Copay Exemptions

Members

- Those under 19 years of age
- Those that are pregnant
- Those who are institutionalized
- Those receiving emergency services in the ER
- Those receiving hospice care
- Those of a federally recognized Indian tribe

Services

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

Claims Submission Tools

Claims Submission Tools

Filing Limit

The timely filing limit is 365 days for original claims.

Electronically

- Payer ID 00403
- Preferred and fastest way to submit your claims:
  - For set-up and information, call 800-470-9630.

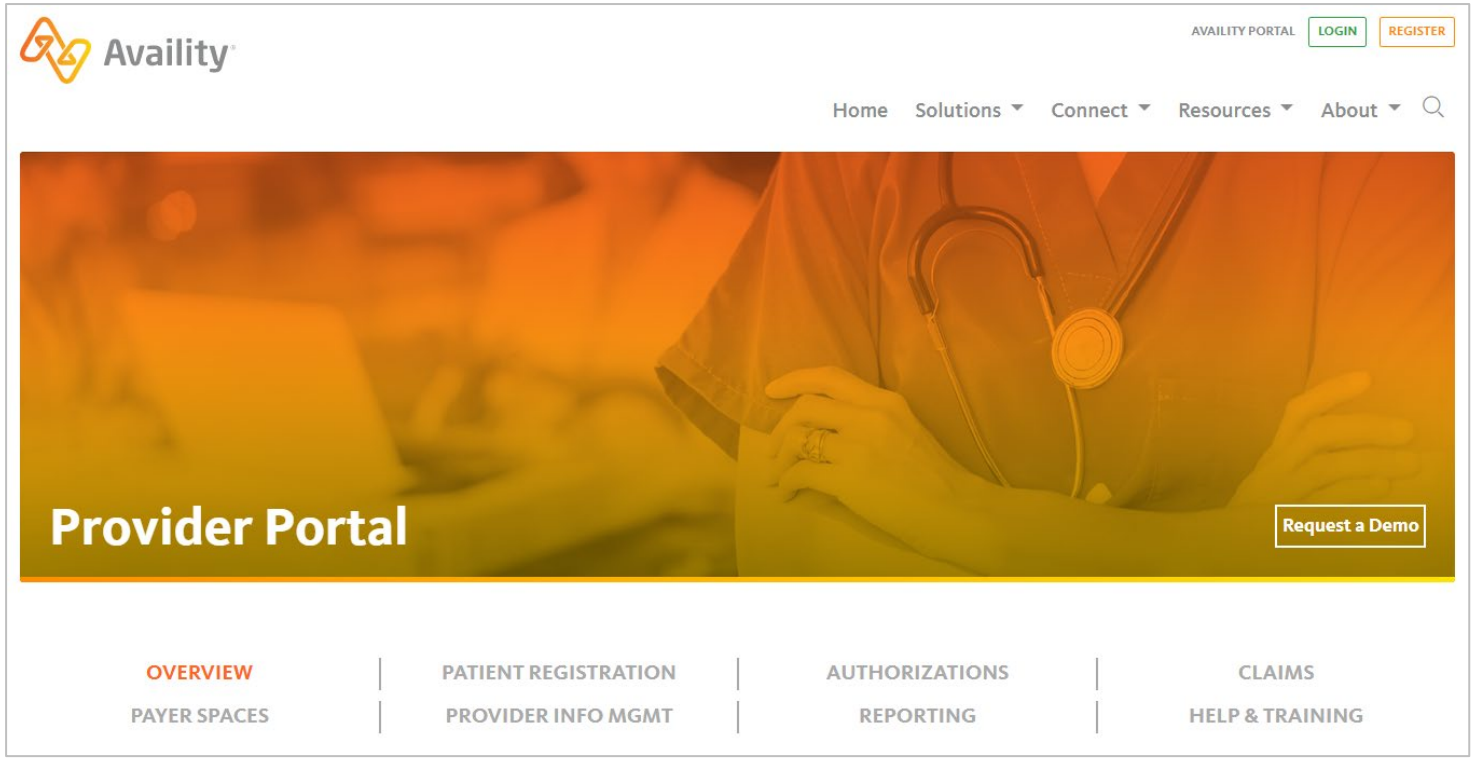
Hard Copy

- To file a hard copy claim or submit a corrected claim, please mail to:
  - Healthy Blue
    ATTN: Medicaid Claims
    P.O. Box 100124
    Columbia, SC 29202-3124

Claims Submission Tools

Availity

- Check Claim Status
- Check Member Eligibility
- View Remittances
- File Claims – At No Cost
  - Secondary
  - Corrected
- Claims Disputes and Appeals
- Request PA via Availity
- Access Availity via Healthy Blue website



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

New Information

New Information

Behavioral Health: Opioid Treatment Program (OTP)

New procedure codes, effective July 1, 2020:

Current Code	New Code	Service Description	Billing Frequency
H0016	G2068	Medication assisted treatment, buprenorphine (oral)	Bi-weekly
H0020	G2067	Medication assisted treatment, methadone	Bi-weekly
H0047	G2077	Periodic assessment for medication assisted treatment	No limitations
H0047	G2076	Medication Assisted Treatment (MAT) assessment	Once, per year
N/A	G2069	Medication assisted treatment, buprenorphine (injectable)	Once every 4 weeks
N/A	G2073	Medication assisted treatment, naltrexone	Once every 4 weeks
N/A	G2074	Medication assisted treatment; no medication administered	No limitations

New Information

Social Determinants of Health (SDOH)

According to World Health Organization (WHO), social determinants of health refer to “Conditions in which people are born, grow, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequalities.”

SDOH include the following:

- Neighborhood and environment
- Health care
- Education
- Economic stability
- Social and community context

New Information

Social Determinants of Health (SDOH)

SDOH codes are represented in ICD-10-CM code categories Z55-Z65. See the table below for a sample of the codes.

Code Grouping	Examples
Z55; Problems related to education and literacy	Illiteracy/low level of literacy, schooling unavailable
Z56; Problems related to employment and unemployment	Unemployment, change of job, threat of job loss, military deployment status sexual harassment on the job
Z57; Occupational exposure to risk factors	Occupational exposure to noise, radiation, dust, tobacco, toxic agents in agriculture, extreme temperature
Z59; Problems related to housing and economic circumstances	Homelessness, inadequate housing, discord with neighbors, extreme poverty, low income
Z60; Problems related to social environment	Adjustment to lifestyle transition, problems living alone, acculturation difficulties, social exclusion and rejection

For a full list of SDOH diagnosis codes, click here.

New Information

Newborn Authorizations

Authorization is no longer required for normal (non-complicated) newborn deliveries:

- 48-hour stay for vaginal deliveries
- 96-hour stay for Cesarean section (C-section) deliveries

The Newborn Notification Form is still required. The form can be located by doing the following:

- Visit www.HealthyBlueSC.com
- From the home page, click “Providers”
- Scroll down and click “Forms”
- Click the ‘+’ next to “Prior Authorizations”
- Click “Universal Newborn Prior Authorization Form”

New Information

COVID-19 and Telehealth

- Waived Cost Shares — Copays, coinsurance and deductibles
  - Includes visits to determine if testing is needed.
  - Tests samples may be obtained in various settings to include doctor's office, urgent care, ER or drive-thru testing.
- Reporting, Coding, Billing and Claims
  - Follow the CDC updates for reporting, testing and specimen collection
    - https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html
  - Follow the CDC coding guidelines for diagnoses related to COVID-19
    - https://www.cdc.gov/nchs/data/icd/ICD-10- CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf
    - https://www.cdc.gov/nchs/data/icd/COVID19-guidelines-final.pdf

New Information

COVID-19 and Telehealth

- Telehealth (video + audio):
  - Waived member cost shares for telehealth visits, including visits for mental health or substance use disorders.
  - Telehealth providers can help get members to a provider for testing.
  - Facility Providers - Report the CPT/HCPCS code with the applicable revenue code as an in-person visit and also append either modifier GT.
- Telephonic-Only Care
  - Covered for in-network providers.
    - Cost shares will be waived for in-network providers only
  - Out-of-network coverage will be provided where required.
  - Includes covered visits for mental health or substance use disorders and medical services.
    - Exceptions include chiropractic services and physical, occupational, and speech therapies.
- Resources
  - Visit www.HealthyBlueSC.com and view the May 2020 BlueBlast for more FAQ

New Information

Corrected Claims

Effective Aug. 1, 2020, providers have 365 days to submit corrected claims.

Filing Corrected Claims

- Availity
  - There is a field titled Billing Frequencies. Select Replacement of prior claim.
  - For set-up and information, call 800-470-9630.
- Electronically
  - Use loop 2300 & segment REF02 to indicate the original claim number
  - Use loop 2300 & segment CLM05-3 to indicate the claim frequency code.
  - 7 = replacement of a prior claim.
- Hard Copy
  - Healthy Blue
    ATTN: Medicaid Claims
    P.O. Box 100124
    Columbia, SC 29202-3124

Reminders

Reminders

Cultural Competency

- Cultural competency is a set of congruent behaviors, attitudes and policies that enable effective work in cross-cultural situations.
- Cultural awareness is the ability to recognize the cultural factors, norms, values, communication patterns/types, socioeconomic status and world views that shape personal and professional behavior.

Reminders

Cultural Competency Skills

- Listens to others in an unbiased manner; respects other points of view; promotes the expression of diverse opinions and perspectives
- Uses appropriate methods of interacting sensitively, effectively and professionally with persons of all ages and lifestyle preferences from diverse cultural, socioeconomic, educational, racial, ethnic and professional backgrounds
- Recognizes the importance of the role cultural, social and behavioral factors play in determining delivery methods for public health services

Reminders

Cultural Competency Skills

- Takes into account cultural differences when developing and adapting approaches to problems
- Understands the dynamic forces contributing to cultural diversity
- Understands the importance of a diverse public health workforce
- Obtain *no-cost* continuing medical education credits through further study of cultural competency topics. Go to:
  - https://www.thinkculturalhealth.hhs.gov/education *
    or
  - www.HealthyBlueSC.com to review Cultural Competency Training
    - select Providers

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

Reminders

Fraud, Waste and Abuse

Providers are a vital part of the effort to prevent, detect and report Medicaid noncompliance as well as possible fraud, waste and abuse.

- You are required to comply with all applicable statutory, regulatory and other Medicaid managed care requirements in South Carolina, including adopting and implementing an effective compliance program.
- You have a duty to Medicaid to report any violations of laws that you may be aware of.
- You have a duty to follow your organization's code of conduct that articulates your commitment to standards of conduct and ethical rules of behavior.
- Visit www.HealthyBlueSC.com and select **Providers** to view more information about fraud, waste and abuse.

Reminders

Reporting Fraud, Waste and Abuse

If you suspect it, report it to your Compliance department or your sponsor's Compliance Department.

- Compliance Department will investigate and make the proper determination.

To report fraud:

- Call Healthy Blue confidential fraud hotline at 877-725-2702 or email medicaidfraudinvestigations@amerigroup.com
- Contact the South Carolina Department of Health and Human Services fraud hotline at 888-364-3224 or email fraudres@scdhhs.gov.

Reminders

Primary Access and Availability

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

Wait times must not exceed 45 minutes for a routine, scheduled appointment.

Walk-in patients with non-urgent needs should be seen or scheduled for an appointment.

24-hour coverage by direct access or through arrangements with a triage system should be provided.

Reminders

Specialist Access and Availability

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

Wait times must not exceed 45 minutes for a routine, scheduled appointment.

Walk-in patients with non-urgent needs should be seen or scheduled for an appointment.

24-hour coverage by direct access or through arrangements with a triage system should be provided.

Quality

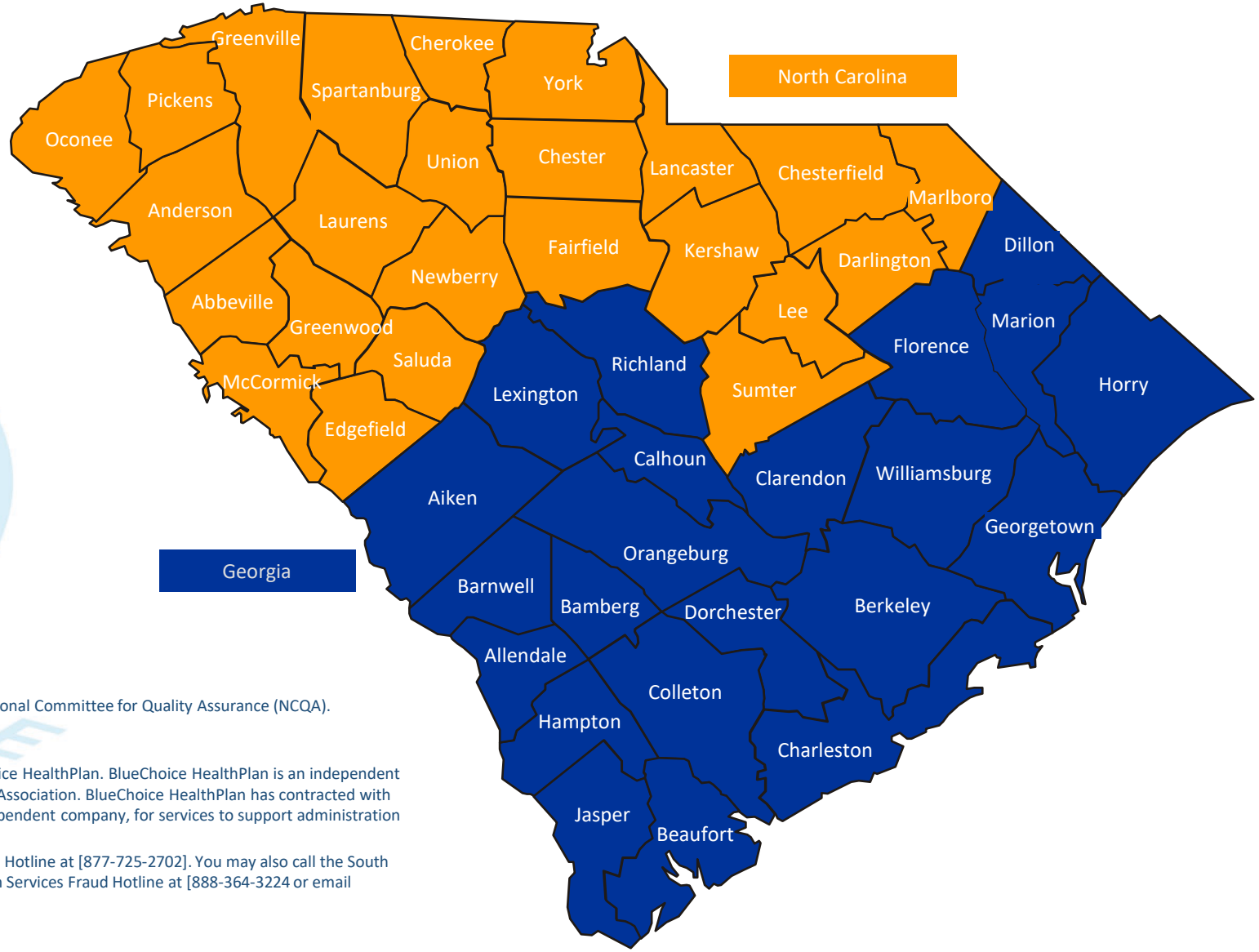
Quality

Terry Pennington
terry.pennington@amerigroup.com
803-834-0168

Alfred Thomas, Jr.
alfred.thomasjr@amerigroup.com
803-391-2452

Other Contacts:

- **HEDIS Questions:**
  HEDIS_SC@amerigroup.com
- **Physical Address:**
  Healthy Blue
  Attn: Quality Department
  4101 Percival Rd., AX-E13
  Columbia, SC 29229
- **Quality Fax:**
  855-238-2257



HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

www.HealthyBlueSC.com

Healthy Blue is the trade name of BlueChoice HealthPlan. BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association. BlueChoice HealthPlan has contracted with Amerigroup Partnership Plan, LLC, an independent company, for services to support administration of Healthy Connections.

To report fraud, call our confidential Fraud Hotline at [877-725-2702]. You may also call the South Carolina Department of Health and Human Services Fraud Hotline at [888-364-3224 or email fraudres@scdhhs.gov].

Quality

Quality Department Contacts

- HEDIS
  - Kim Chmiel at Kimberly.Chmiel@amerigroup.com
  - Trish Whitehead at Trish.Whitehead@amerigroup.com
- Care Opportunity
  - Devon Murphy at Devon.Murphy@amerigroup.com
- Clinic Days
  - Danetta Gibbs at Danetta.Gibbs@amerigroup.com
- Medical records for Care Opportunities during HEDIS off Season, send records:
  - Email to HEDIS_SC@amerigroup.com
  - Fax to 855-238-2257

Marketing

Marketing

Marketing and Community Outreach

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

Marketing

Provider Outreach Contacts

Midlands Region

- Melody Clark, Outreach Specialist Sr.
- Melody.Clark@Amerigroup.com
- 803-683-1896

Pee Dee Region

- Jermaine Tart, Outreach Specialist Sr.
- Jermaine.Tart@Amerigroup.com
- 803-683-0634

Lowcountry Region

- Erica Gattison, Outreach Specialist Sr.
- Erica.Gattison@Amerigroup.com
- 803-638-1948

Upstate Region

- David Rojas, Outreach Specialist Sr.
- David.Rojas@Amerigroup.com
- 803-391-1299

Modified Region

- David Liethen, Community Relations Rep.
- David.Liethen@Amerigroup.com
- 704-607-6769

BlueChoice HealthPlan is an independent licensees of the Blue Cross and Blue Shield Association. BlueChoice HealthPlan has contracted with Amerigroup Partnership Plan, LLC, an independent company, for services to support administration of Heathy Connections

Marketing

Social Media

fb.me/HealthyBlueSC*

@CoachBlueSC

@HealthyBlueSC

#HealthyBlueSC

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

Marketing

Extra Benefits

Free one-time paid membership to Sam's Club

- For pregnant moms
- Eligibility requirements apply

Fruit and vegetable delivery

- For diabetic members, up to two months
- Eligibility requirements apply

Free adult vision

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

Free diapers and car seats

- Up to 15 months of age
- Case of diapers (200 count)
- Limited to no more than six, after well-child visits
- Car seat – eligibility requirements apply

Free GED Ready Assessment

- Ages 17 and up

Free Sports Physicals

- Ages 6 - 18

and MUCH, MUCH MORE!

Benefits

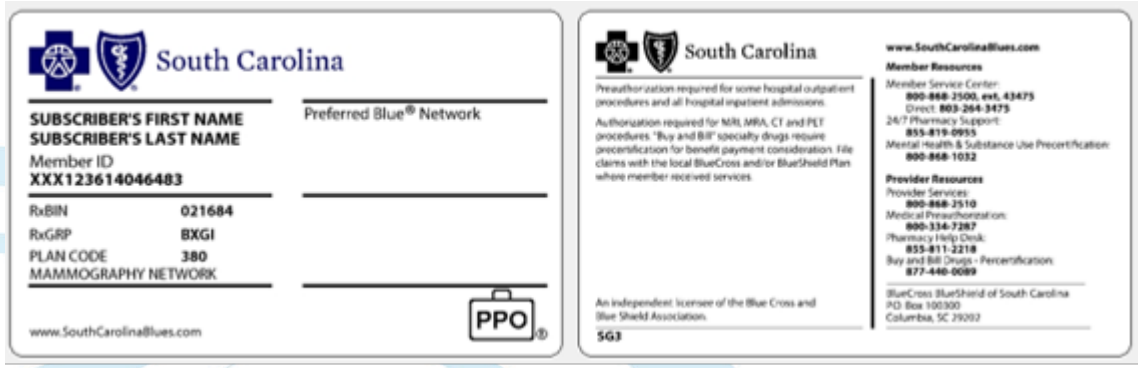
Agenda

- Preferred Blue
- BlueChoice HealthPlan
- Medicare Advantage
- State Health Plan
- Federal Employee Plan
- Affordable Care Act Plan
- BlueCard® Program
- South Carolina Plan Reminders
- Other Groups

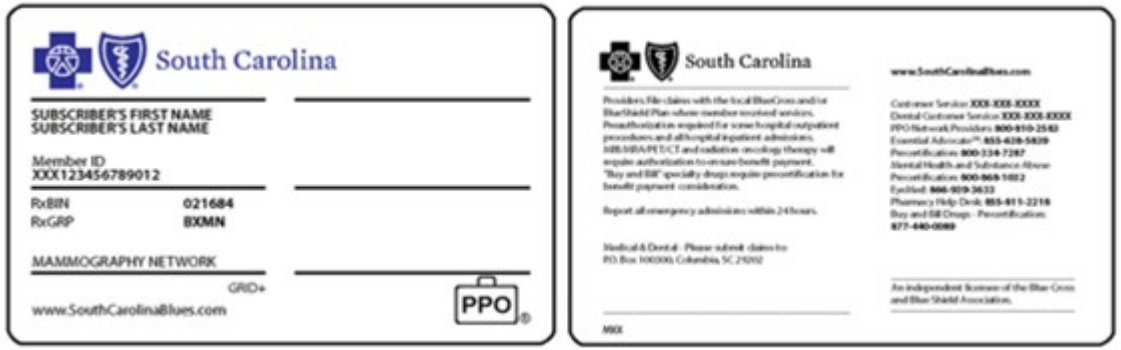
Preferred Blue

Preferred Blue

Small Group



Large Group



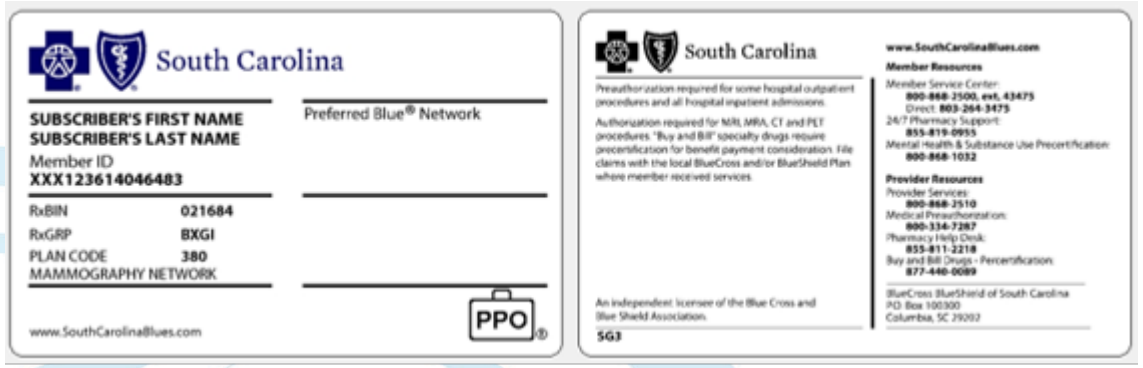
New Groups Effective Jan. 1, 2021

Group Name	Prefix
AVX	AVC
Pure Power / Stanadyne	SJS
Pure Fishing	

Group Name	Prefix
Vitesco Technologies	SJX
Marsh & McLennan Agency;	ZCZ
HMR Veteran Services	

Preferred Blue

Short Term Health Care – Prefix ZCX



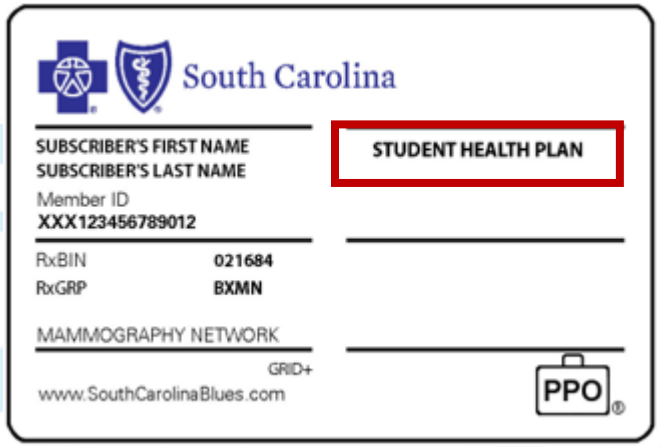
Members are subject to a five-year pre-existing review. Medical records will be requested as needed.

Short Term Health Care

- Pre-existing Condition
  - A condition which:
    a) symptoms existed that would cause a reasonable person to seek diagnosis, care, or treatment within a one-year period preceding the effective date of the policy; or
    b) medical advice or treatment was recommended or received from a physician or other Clinician within a five-year period preceding the effective date of the policy, regardless of whether the condition was diagnosed or not diagnosed.

Preferred Blue

Student Health Plan



Participating Colleges and Universities		
Clemson University	Coastal Carolina	University of South Carolina
The Citadel	MUSC	Winthrop University

BlueChoice HealthPlan

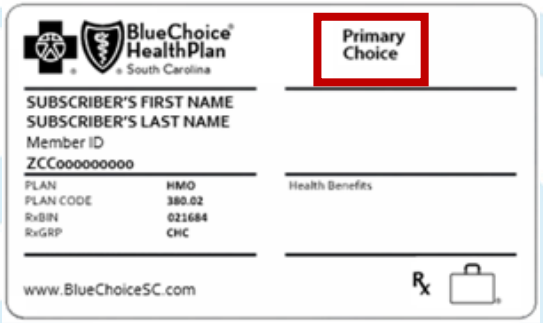
BlueChoice HealthPlan

Primary Choice

Prefix ZCC

BlueChoice HMO Network

Large Group

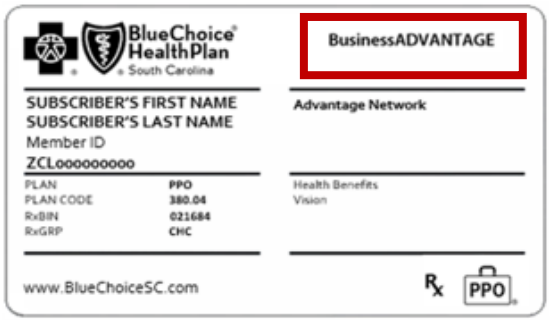


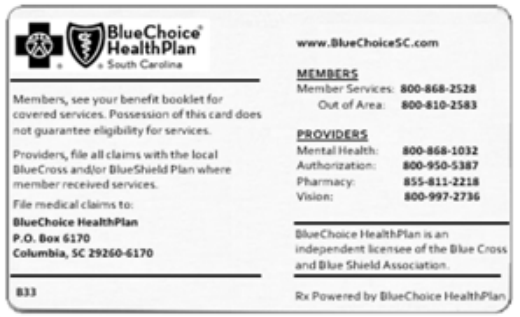
Business ADVANTAGE

Prefix ZCL

Advantage Network

Small Group





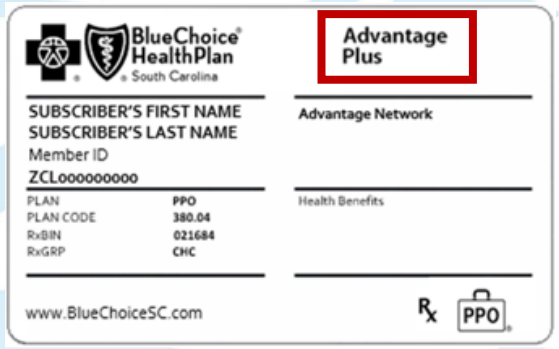
BlueChoice HealthPlan

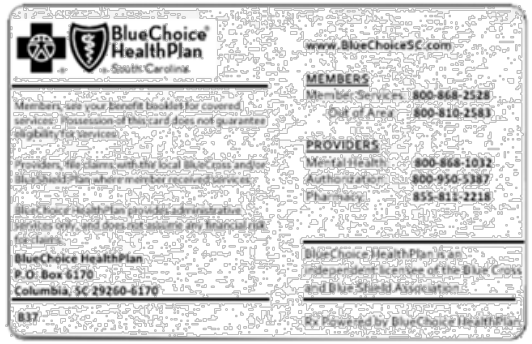
Advantage Plus

Prefix ZCL

Advantage Network

Large Group

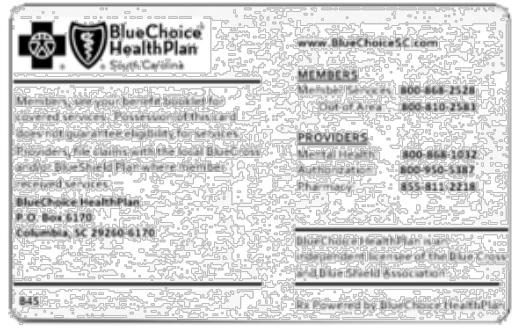


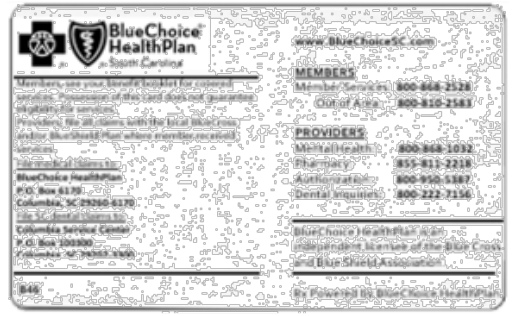


CarolinaADVANTAGE

Prefix ZCL

BlueChoice Network





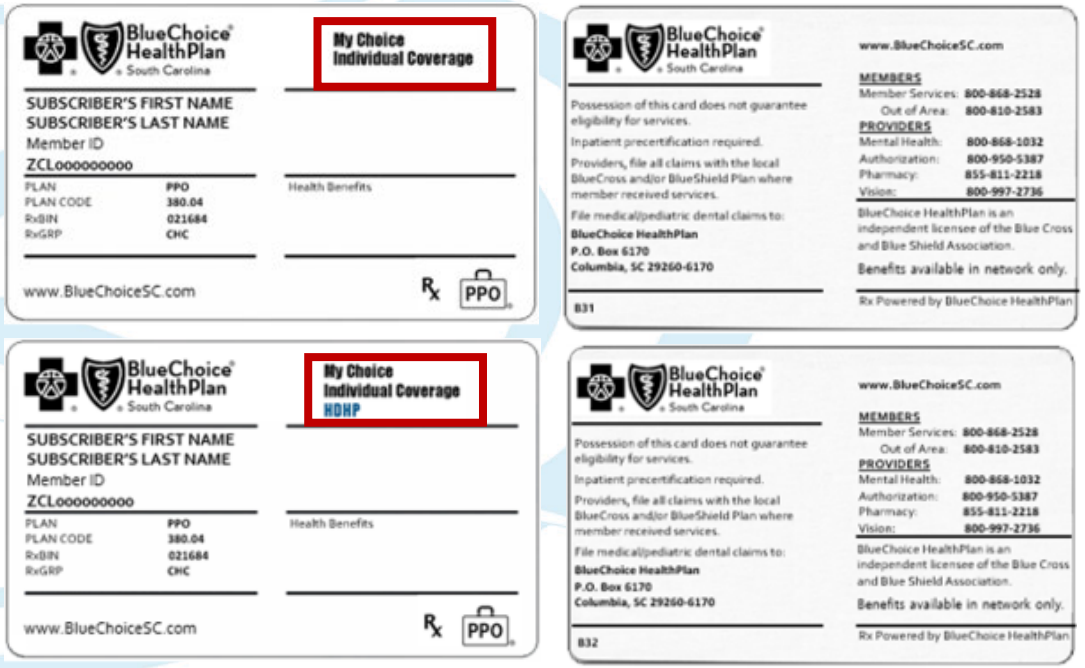
BlueChoice HealthPlan

My Choice Individual/HDHP

Prefix ZCL

Advantage Network

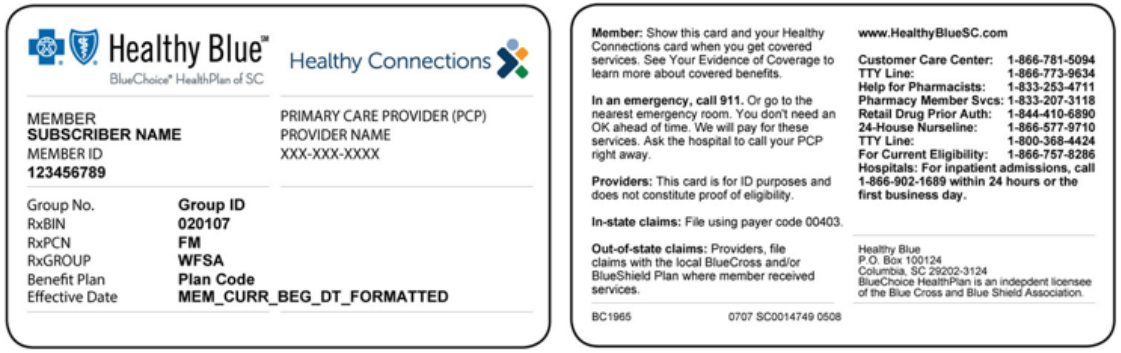
Small Group



HealthyBlue℠

Prefix ZCD

Medicaid Network



Visit www.HealthyBlueSC.com

BlueChoice HealthPlan

Reminders:

- Use the Ask Provider Services option in MIM for assistance with claims or if you are unclear of the processing of claims.
  - Ask specific, probing questions in your inquiry.
    - Why was line two denied as non-covered?
    - Why were services applied towards the member's deductible?
    - Has the member returned the Coordination of Benefits questionnaire?
- Must be telehealth credentialed for rendered services to be covered.
- Verify eligibility at each visit.
- Submit claims with the correct alpha prefix to expedite claim processing at the appropriate Plan and prevent member billing issues.

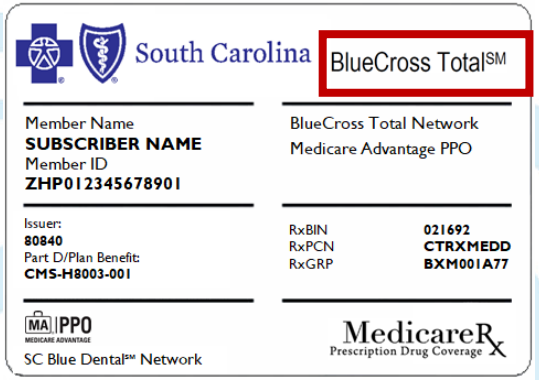
Medicare Advantage

Medicare Advantage

BlueCross Total

Prefix ZHP

Medicare Advantage PPO



If a BlueCross Total member chooses to seek out-of-network services when in-network services are available, higher out-of-network cost sharing will apply.

Medicare Advantage

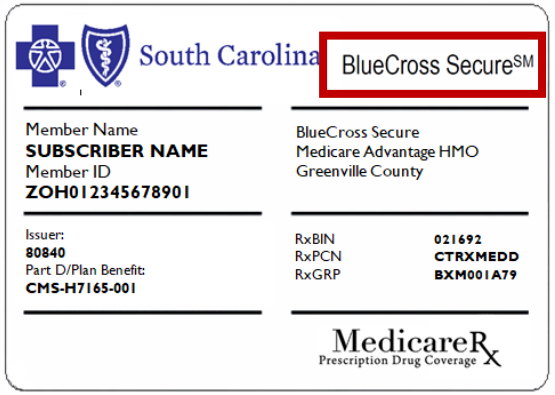
BlueCross Total	2020	2021
Deductible	In-network providers: $0 Out-of-network providers: $0	No Change
Maximum Out-of-Pocket Amount	From in-network providers: $6,700	$6,900
	From in-network and out-of-network providers combined: $10,000	No Change
In-Patient Hospital Acute	In-network: $400 copay per day for days 1-4; $0 for days 5-90	$450 per day for days 1-4; $0 for days for 5-90
Inpatient Hospital-Psychiatric	$440 per day for days 1-4 $0 for days 5-90	$465 per day for days 1-4 $0 for days 5-90
Skilled nursing facility (SNF) care	$0 per day for days 1-20; $178 per day for days 21-100	$0 per day for days 1-20; $184 per day for days 21-100
Urgently Needed Services	$45 copay per visit	In and out-of-network $50 copay per visit

Medicare Advantage

BlueCross Total	2020	2021
Worldwide Emergency/Urgent Coverage	$250 copay once per calendar year, then 20% coinsurance	$250 service specific deductible, then a 20% coinsurance for emergency care outside of the United States
Ambulance Services	Not covered	In-network and out-of-network $295 per one-way trip for ground ambulance
Hearing Aids	The copay range is based on different types and styles of hearing aids. The lower range is for the Advanced hearing aid type and the higher range is for the Premium hearing aid type	The copay range is based on different types and styles of hearing aids. The lower range is for the Advanced hearing aid type and the higher range is for the Premium hearing aid type. *Premium hearing aids are available in rechargeable style options (for and additional $50 per aid). Member must use TruHearing provider for this benefit.*
Preventive Dental	Fluoride Treatment is covered	Fluoride Treatment not covered

Medicare Advantage

BlueCross Secure[SM]
Prefix ZOH
HMO Greenville County


South Carolina BlueCross Secure[SM]

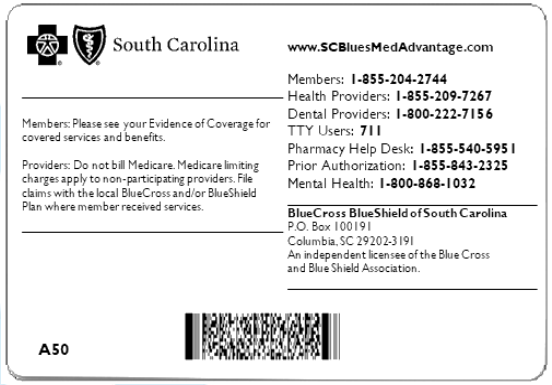
Member Name
SUBSCRIBER NAME
Member ID
ZOH012345678901

BlueCross Secure
Medicare Advantage HMO
Greenville County

Issuer:
80840
Part D/Plan Benefit:
CMS-H7165-001

RxBIN **021692**
RxPCN **CTRXMEDD**
RxGRP **BXM001A79**

MedicareRx Prescription Drug Coverage


South Carolina

www.SCBluesMedAdvantage.com

Members: Please see your Evidence of Coverage for covered services and benefits.

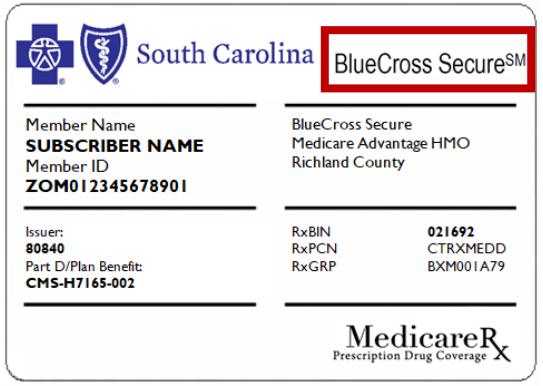
Providers: Do not bill Medicare. Medicare limiting charges apply to non-participating providers. File claims with the local BlueCross and/or BlueShield Plan where member received services.

Members: **1-855-204-2744**
Health Providers: **1-855-209-7267**
Dental Providers: **1-800-222-7156**
TTY Users: **711**
Pharmacy Help Desk: **1-855-540-5951**
Prior Authorization: **1-855-843-2325**
Mental Health: **1-800-868-1032**

BlueCross BlueShield of South Carolina
P.O. Box 100191
Columbia, SC 29202-3191
An independent licensee of the Blue Cross and Blue Shield Association.

A50

BlueCross Secure[SM]
Prefix ZOM
HMO Richland County


South Carolina BlueCross Secure[SM]

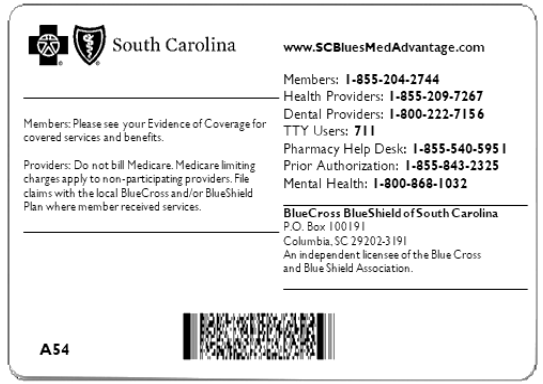
Member Name
SUBSCRIBER NAME
Member ID
ZOM012345678901

BlueCross Secure
Medicare Advantage HMO
Richland County

Issuer:
80840
Part D/Plan Benefit:
CMS-H7165-002

RxBIN **021692**
RxPCN CTRXMEDD
RxGRP BXM001A79

MedicareRx Prescription Drug Coverage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Mental Health: **1-800-868-1032**

BlueCross BlueShield of South Carolina
P.O. Box 100191
Columbia, SC 29202-3191
An independent licensee of the Blue Cross and Blue Shield Association.

A54

Beginning on January 1, 2020, BlueCross Secure Greenville and BlueCross Secure Richland began using **the same** provider network as our PPO plan. This large provider network includes every hospital in SC except for MUSC.

Out-of-network services are not covered.

Medicare Advantage

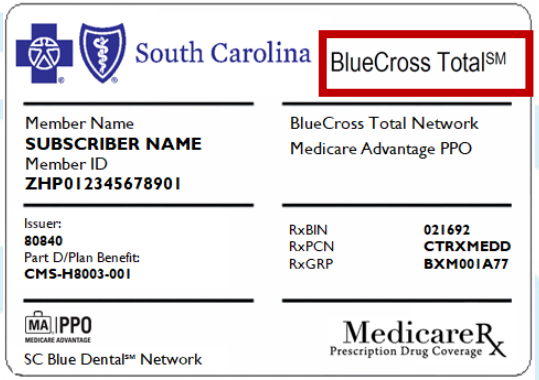
BlueCross Secure	2020	2021
Deductible	$0	No Change
Maximum Out-of-Pocket Amount	$6,700	No Change
Primary Care	$15 copay per visit	No Change
Specialist (Excludes Mental Health Services)	$40 copay per visit	No Change
Telehealth Services	$5 copay each visit	$5 copay for each primary care or urgent care visit
In-Patient Hospital Stays	$400 copay per day, days 1-4; $0 for days 5-90	$425 copay per day, days 1-4; $0 for days 5-90
Worldwide Emergency/Urgent Coverage	$250 copay once per calendar year, then 20% coinsurance	There is a $250 service specific deductible and then 20% coinsurance for emergency care outside of the United States

Medicare Advantage

BlueCross Total Value

Prefix ZHP

Medicare Advantage PPO



If a BlueCross Total member chooses to seek out-of-network services when in-network services are available, higher out-of-network cost sharing will apply.

Medicare Advantage

BlueCross Total Value	2021
Deductible	$0
Maximum Out-of-Pocket Amount	$7,550
Combined Maximum Out-of-Pocket *(Costs for covered medical services from INN and OON count towards combined maximum OOP. Plan premium does not count toward Maximum OOP.)*	$11,300
Inpatient Hospital-Acute	$495 per day for days 1-4; $0 for days 5-90
Inpatient Hospital-Psychiatric	$620 per day for days 1-3; $0 for days 4-90
Outpatient Hospital	$0-395 copay per visit
Emergency Care	$90 copay per visit
Urgent Care	$65 copay per visit
Diagnostic Tests and Procedures	$0-275 copay per visit
Lab Services	$10 copay

Medicare Advantage

BlueCross Total Value	2021
Mental Health Services	Inpatient Hospital-Psychiatric: $620 per day for days 1-3; $0 per day for days 4-90 Outpatient visit with a psychiatrist (Group and Individual Therapy): $40 copay Outpatient visit (Group and Individual Therapy): $40 copay
Skilled Nursing Facility	$0 per day for days 1 through 20; $184 per day for days 21 through 100
Rehabilitation Services	Occupational therapy visit: $40 copay Physical therapy visit: $40 copay Speech and language therapy visit: $40 copay
Ground Ambulance	$310 copay
Podiatry Services	Foot exams and treatment: $50 copay
Medical Equipment/Supplies	Durable Medical Equipment: 20% coinsurance per item Prosthetics: 20% coinsurance per item Diabetes supplies: 0-20% coinsurance per item

Medicare Advantage

BlueCross Total Value	2021 *There may be limits on how much the plan will provide
Diagnostic radiology services (e.g., MRI)	$0-150 copay per visit
Outpatient x-rays	$10-20 copay
Annual Physical Exam	$0 copay for one physical exam per year. *In addition to the Medicare-covered annual wellness visit and the "Welcome to Medicare" Preventive Visit.*
Hearing	Hearing Exam: $45 copay Hearing Aids: $699-999 copay*
Preventive Dental	Oral Exam: $0 copay* Cleaning: $0 copay* Dental X-rays: $0 copay*
Vision	Routine Eye Exam: $0 copay* Contact Lenses: $0 copay* Eyeglasses (Frames and Lenses): $0 copay* Eyeglass Frames: $0 copay* Eyeglass Lenses: $0 copay*

Medicare Advantage

Methods for Requesting Prior Authorization

- My Insurance Manager – A secure online provider portal available at www.SouthCarolinaBlues.com
- Medical Forms Resource Center (MFRC) – A secure online tool available at www.FormsResource.Center
- Telephone – 855-843-2325
- Fax – 803-264-6552

- **Companion Benefit Alternatives (CBA)**
  - Online – www.CompanionBenefitAlternatives.com
  - Telephone – 800-868-1032

Medicare Advantage

Reminders

- Check the member's ID card to determine his/her plan.
- Know whether you are in the BlueCross Total PPO network or the BlueCross Secure HMO network.
- Refer members to in-network providers.
- Verify eligibility and benefits at each visit prior to rendering services.
- Follow Medicare guidelines at www.cms.gov for covered services.
- Review the Medicare Advantage provider manuals for more information.
  - UPDATE: Section 3.8: Confidentiality and Data Use
    - Visit www.SouthCarolinaBlues.com

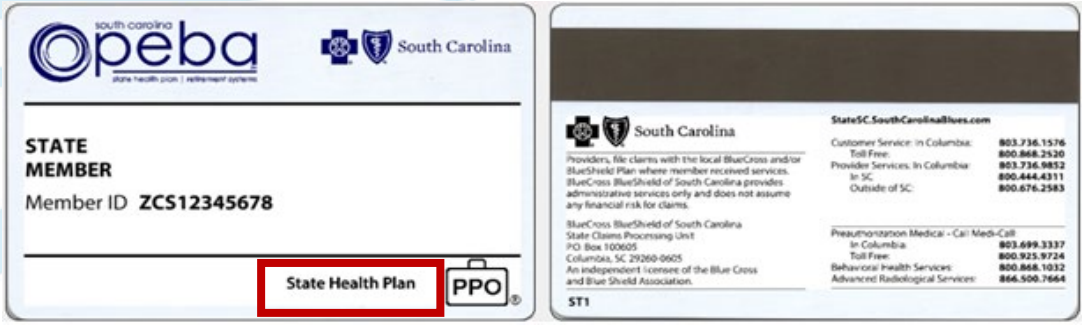
State Health Plan

State Health Plan

Standard Plan

Prefix ZCS

State Health Plan Network



Savings Plan

Prefix ZCS

State Health Plan Network

State Health Plan

Standard Plan	2020	2021
Deductibles		
Individual	$490	No Change
Family	$980	No Change
Copays		
Office Visits	$14	No Change
Outpatient Facility Services	$105	No Change
Emergency Room	$175	No Change
Coinsurance Maximums		
Individual (Network)	$2800	No Change
Family (Network)	$5600	No Change
Individual (OON)	$5600	No Change
Family (OON)	$11,200	No Change
Dollar Maximums		
Hospice	$7500 lifetime maximum	80 days

State Health Plan

Savings Plan	2020	2021
Deductibles		
Individual	$3600	No Change
Family	$7200	No Change
Copays		
Office Visits	$0	No Change
Outpatient Facility Services	$0	No Change
Emergency Room	$0	No Change
Coinsurance Maximums		
Individual (Network)	$2400	No Change
Family (Network)	$4800	No Change
Individual (OON)	$4800	No Change
Family (OON)	$9600	No Change
Dollar Maximums		
Hospice	$7500 lifetime maximum	80 days

State Health Plan

Reminder: Adult Well Visits for Members

- The Standard and Savings Plans include evidence-based services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF) as part of an adult well visit under the State Health Plan.
- The benefit is available to all non-Medicare primary adults aged 19 and older.
- Members can take advantage of this benefit at a network provider specializing in:

Family Practice	Gerontology	Obstetrics and Gynecology
General Practice	Internal Medicine	Pediatrics

State Health Plan

Reminder: Adult Well Visits Process – Standard Plan

- Allows one visit in covered years based on the following schedule:

Age	Timeframe
19-39	one visit every three years
40-49	one visit every two years
50 and up	one visit per year

- Considerations
  - Eligible female members may use their well visit at their gynecologist or their primary care physician
    - If both doctors are seen in the same covered year, only the first routine office visit received will be allowed.
    - In a non-covered year, members will pay the full allowed amount for the visit.
      - The full allowed amount will not apply to a member's deductible and coinsurance maximum.
    - Plan covers 100 percent of the cost of the lab work and office visit associated with a pap test for eligible female members in a non-covered well visit year.

State Health Plan

Reminder: Adult Well Visits Process – Savings Plan

- Allows one visit per year at no member cost share
- Considerations
  - Eligible female members may use their well visit at their gynecologist or their primary care physician
    - If both doctors are seen in the same covered year, only the first routine office visit received will be allowed.

State Health Plan

Other Reminders:

Always verify benefits and eligibility using My Insurance Manager (MIM) or by call 800-444-4311

- Prior Authorizations
  - Medical Services and Certain Drugs
    - Call Medicall at 800-925-9724
  - Medical Specialty Drugs (Buy and Bill)
    - See Drug Lists on the Pharmacy Page of www.SouthCarolinaBlues.com
    - Submit online via MBMNow via the MIM portal
    - Call Optum at 877-440-0089
  - Pharmacy Benefit Manager
    - Express Scripts at 855-621-3128
  - Laboratory Services
    - Submit online via Avalon Healthcare's Prior Authorization System (PAS)
    - Send email to Avalon-PAS-Help@avalonhcs.com for access.

State Health Plan

Other Reminders:

- Colonoscopy Benefits
  - Diagnostic and routine colorectal cancer screenings are covered at no cost to SHP primary members when rendered by network providers.
  - Covered screenings include colonoscopies and fecal occult blood test.
  - Some early detection take-at-home tests for routine and diagnostic colonoscopies are covered at no cost for eligible members.
    - Coverage includes the consultation, generic prep kit, procedure and associated anesthesia.
      - If a non-generic prep kit is used, additional charge will apply.
  - Cologuard test is covered once every 3 years for members 50 and over
    - Payable at 100% of the allowance at an in-network provider only (Exact Sciences).

Always verify benefits and eligibility using My Insurance Manager (MIM) or by call 800-444-4311

State Health Plan

Other Reminders:

- Standard Plan member claims are subject to the deductible, copay and coinsurance.
  - Members can have all three apply for one service.
- Diabetes Education
  - Covered at no cost to primary members when rendered from in network certified diabetes educators
  - Covered Codes – G0108 and G0109 only
- Submitting Medical Dental Services
  - Dental services filed to medical are subject to the deductible, coinsurance and copay.
  - Dental surgery for bony, impacted teeth is covered when supported by X-rays.
  - Dental treatments or surgery to repair damage from an accident, caused by cancer treatment or due to a congenital birth…
    - Covered for up to one year from the date of the accident.
    - File with appropriate diagnosis code.

State Health Plan

Other Reminders:

- Birth Control
  - No member cost sharing applies to covered contraceptives.
  - Contraceptives are only covered with no member cost share amounts for the subscriber and spouse on the policy.
  - Contraceptives are not covered with member cost share amounts for dependents unless deemed medically necessary and prior authorization obtained by Medi-Call.
  - Covered codes are:

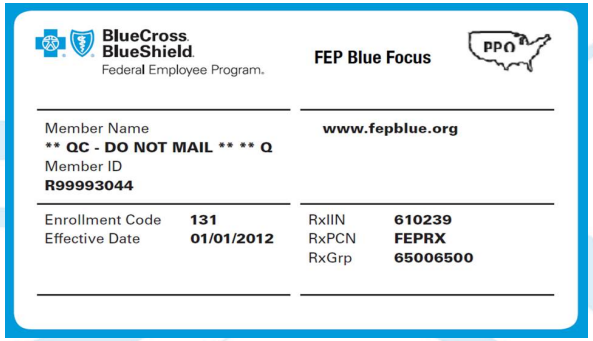
11983	58301	J7297	J7302
57170	A4627	J7298	J7303
58300	J1050	J7300	J7307

- State Health Plan Resources
  - Website
    - www.statesc.southcarolinablues.com
  - Medical Policies
    - http://www.cam-policies.com/internet/cmpd/cmp/mdclplcy.nsf/dispDisclaimer?openform

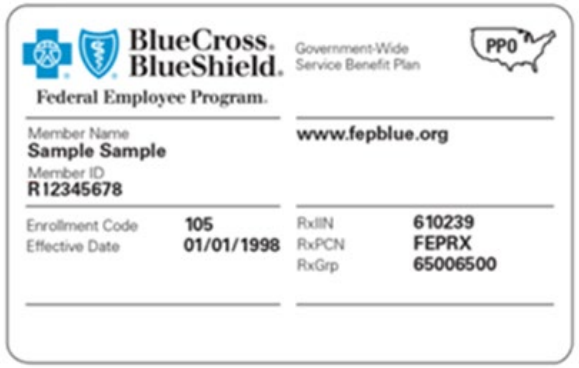
Federal Employee Plan

Federal Employee Program

Blue Focus Plan


BlueCross BlueShield
Federal Employee Program.
FEP Blue Focus
PPO
Member Name
** QC - DO NOT MAIL ** ** Q
Member ID
R99993044
www.fepblue.org
Enrollment Code 131
Effective Date 01/01/2012
RxIIN 610239
RxPCN FEPRX
RxGrp 65006500

Blue Standard Plan


BlueCross BlueShield
Federal Employee Program.
Government-Wide Service Benefit Plan
PPO
Member Name
Sample Sample
Member ID
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www.fepblue.org
Enrollment Code 105
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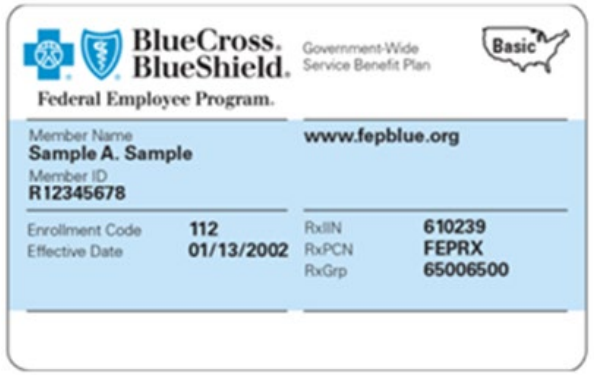
RxPCN FEPRX
RxGrp 65006500

Blue Basic Plan


BlueCross BlueShield
Federal Employee Program.
Government-Wide Service Benefit Plan
Basic
Member Name
Sample A. Sample
Member ID
R12345678
www.fepblue.org
Enrollment Code 112
Effective Date 01/13/2002
RxIIN 610239
RxPCN FEPRX
RxGrp 65006500

FEP Blue Focus and Blue Basic Plan members must use preferred network providers.

Federal Employee Plan

Blue Focus	2020	2021
Deductibles		
Individual	$500	No Change
Self-Plus One	$1,000	No Change
Family	$1,000	No Change
Catastrophic Out-of-Pocket Maximums		
Individual (Network)	$6,500	$7,500
Self-Plus One (Network)	$13,000	$15,000
Family (Network)	$13,000	$15,000
Individual (OON)	No OON Benefits	No Change
Self-Plus One (OON)	No OON Benefits	No Change
Family (OON)	No OON Benefits	No Change
Services		
Office Visits (Network) (including physical therapy, speech therapy, occupational therapy, cognitive therapy, vision services and foot care)	Visits 1-10, PCP or Specialist, $10 copay	No Change

Federal Employee Plan

Blue Focus (cont'd)	2020	2021
Telemedicine	Not Covered	$10 copay per visit, per calendar year
Mental Health and Substance Abuse (Professional Services)	Visits 11+, PCP or specialist, 30% coinsurance after deductible	No Change
Urgent Care- Accidental (1st 72 hours)	$0 copay	No Change
Urgent Care- Medical	$25 copay	No Change
ER- Accidental (1st 72 hours)	$0 copay	No Change
ER (Network)- Medical	30% coinsurance after deductible	No Change
Physical, Occupational and Speech Therapy	$25 copay per visit with 25 visit limit combined; 30% coinsurance for agents drugs and supplies after deductible	No Change

Federal Employee Plan

Blue Focus (cont'd)	2020	2021
Cognitive Rehabilitation Therapy	$25 copay per visit; Limited to 25 visits	No Change
ABA Therapy Disorder/Autism Spectrum	30% coinsurance after deductible Limited to 200 hours	No Change
Continuous Home Hospice Care (Network)	30% coinsurance after deductible	No member cost-share
Chiropractic/Osteopathic Care (Network)	$25 copay per visit	No Change
Acupuncture by a healthcare provider who is licensed or certified to perform acupuncture by the state where service are provided	$25 copay 30% coinsurance for agents, drugs and supplies after deductible Limit of 10 manipulative/acupuncture benefits combined	No Change

Federal Employee Program

Blue Focus

- **Other Benefit Coverage for 2021**
  - All chest X-rays
  - Hepatitis C screening beginning at age 18
  - No member cost-share for screening pregnant members for HIV.

Federal Employee Plan

Blue Standard Option	2020	2021
Deductibles		
Individual	$350	No Change
Family	$700	No Change
Primary Care	$25	No Change
Telehealth	$0 copay visits 1-2; $10 copay visits 3+	No Change
Telemedicine	Not Covered	$25 copay for PCP; $35 for Specialist
Specialist	$35	No Change
Urgent Care	$30	No Change
Individual (Network)	$5,000	No Change
Family (Network)	$10,000	No Change
Preventive Care	$0	No Change
Accidental Injury	$0 copay within 72 hours of the injury	No Change
Medical Emergency	Subject to deductible and coinsurance	No Change

Federal Employee Program

Blue Standard Option

- **Other Coverage for 2021**
  - Preventive Care Benefits for:
    - Bowel preparation medications associated with colon cancer screenings
    - Certain HIV medications (known as antiretroviral therapy)
    - All chest X-rays
    - Hepatitis C screening beginning at age 18
    - Hearing aids for adults age 22 and over, limited to $2,500 every 5 calendar years. Previously, the limit was every 3 calendar years.

Federal Employee Plan

Blue Basic Option	2020	2021
Deductibles		
Individual	$0	No Change
Family	$0	No Change
Copays		
Primary Care	$30	No Change
Telehealth	$0 copay visits 1-2; $15 copay visits 3+	No Change
Telemedicine	Not Covered	$30 copay for PCP; $40 for Specialist
Specialist	$40	No Change
Urgent Care	$35	No Change
Coinsurance Maximums		
Individual (Network)	$5,500	No Change
Family (Network)	$11,000	No Change
Preventive Care	$0	No Change
Emergency Care		
Accidental Injury & Medical Emergency	$125 copay per day per facility	$175 copay per day per facility

Federal Employee Program

Blue Basic Option

- **Other Coverage for 2021**
  - Preventive Care Benefits for:
    - Bowel preparation medications associated with colon cancer screenings
    - Certain HIV medications (known as antiretroviral therapy)
    - All chest X-rays
    - Hepatitis C screening beginning at age 18
    - Hearing aids for adults age 22 and over, limited to $2,500 every 5 calendar years. Previously, the limit was every 3 calendar years.

Federal Employee Plan

Adult Preventive Care: Blue Focus, Blue Standard and Blue Basic

	2020	2021
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 services listed are limited to one per calendar year. Pathology for Sigmoidoscopy and Colonoscopy covered 100% under preventive benefits.	No Change

Federal Employee Program

Other Information

- FEP Website – www.FEPBlue.org
- FEP Provider Service Number – 888-930-2345
- Eligibility and benefits for FEP members is also available on My Insurance Manager℠
- FEP considers one month as 30 days
  - Benefits with requirements or limits expressed in months must be multiplied by 30.
  - **Example:** Gastric bypass surgery requires nutritional counseling for at least three months prior to surgery. Three months is equal to 90 days.

Affordable Care Act

Affordable Care Act

BlueCross Individual Plans

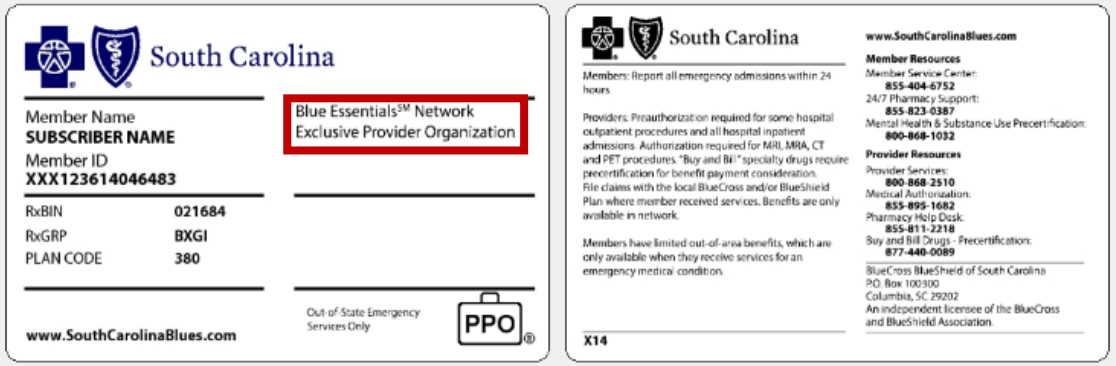
BlueEssentials℠

Blue Essentials Network

Prefixes:

ZCF

ZCU



BlueCross Small Group Plans

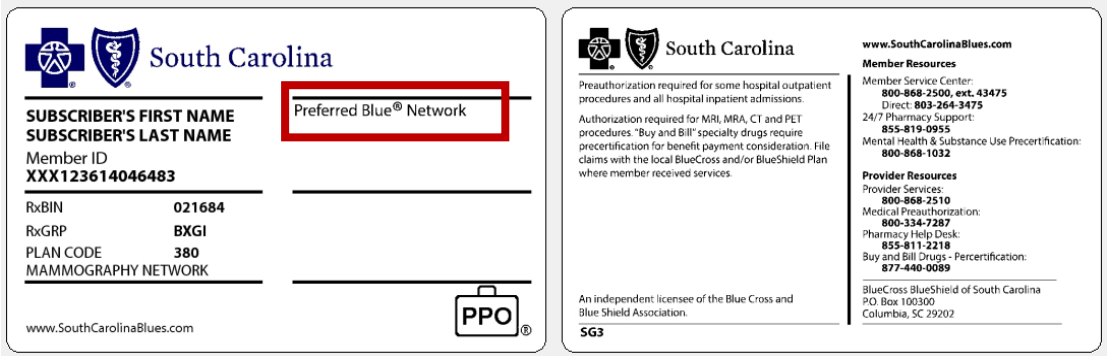
Preferred Blue Network

Prefixes:

ZCV – Small Group Private

ZCR – Small Group FFM

(Federally Facilitated Marketplace)



Always use in-network providers. Go to the Find Care link on www.SouthCarolinaBlues.com or www.BlueChoiceSC.com.
Members do not have out of network benefits, except in true emergencies.

Affordable Care Act

BlueChoice Small Group Plans

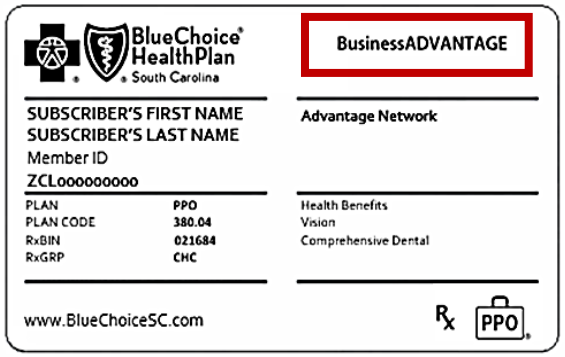
Business Advantage

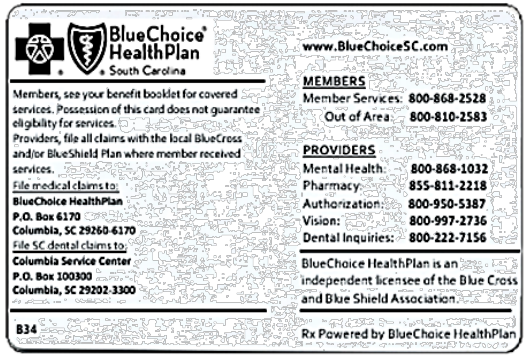
BlueChoice Advantage Network

Prefixes:

ZCG

ZCL





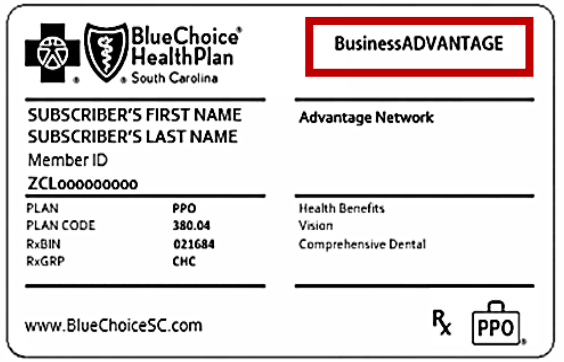
BlueChoice Individual Plans

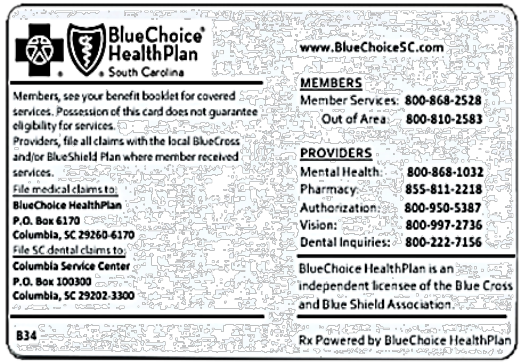
Blue Option℠

Blue Option Network

Prefixes:

ZCJ





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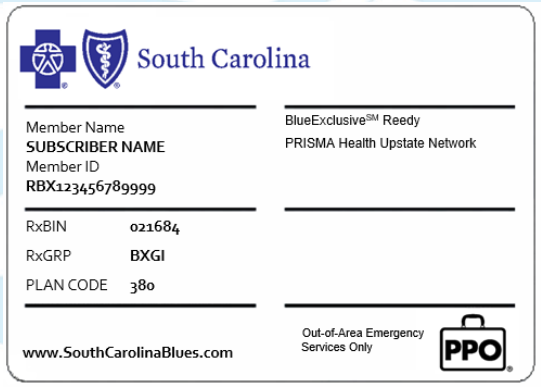
Affordable Care Act

Blue Exclusive℠ Reedy
PRISMA Health Upstate Network
Prefix:
RBX


South Carolina

Member Name
SUBSCRIBER NAME
Member ID
RBX123456789999

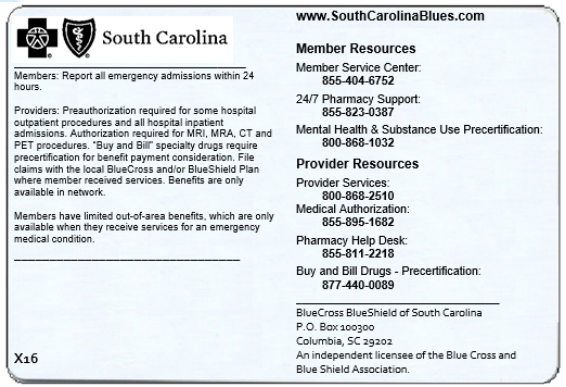
RxBIN 021684
RxGRP BXGI
PLAN CODE 380

BlueExclusive℠ Reedy
PRISMA Health Upstate Network

www.SouthCarolinaBlues.com

Out-of-Area Emergency Services Only

PPO


South Carolina

Members: Report all emergency admissions within 24 hours.

Providers: Preauthorization required for some hospital outpatient procedures and all hospital inpatient admissions. Authorization required for MRI, MRA, CT and PET procedures. "Buy and Bill" specialty drugs require precertification for benefit payment consideration. File claims with the local BlueCross and/or BlueShield Plan where member received services. Benefits are only available in network.

Members have limited out-of-area benefits, which are only available when they receive services for an emergency medical condition.

X16

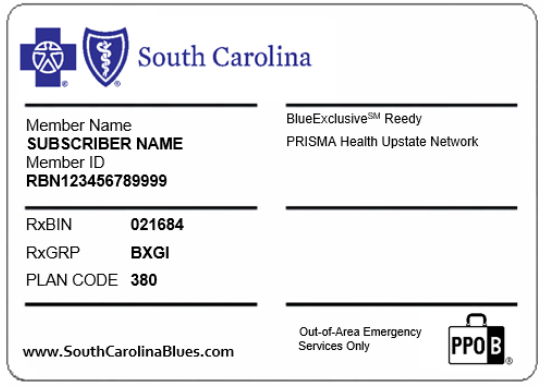
www.SouthCarolinaBlues.com

Member Resources
Member Service Center: 855-404-6752
24/7 Pharmacy Support: 855-823-0387
Mental Health & Substance Use Precertification: 800-868-1032

Provider Resources
Provider Services: 800-868-2510
Medical Authorization: 855-895-1682
Pharmacy Help Desk: 855-811-2218
Buy and Bill Drugs - Precertification: 877-440-0089

BlueCross BlueShield of South Carolina
P.O. Box 100300
Columbia, SC 29202
An independent licensee of the Blue Cross and Blue Shield Association.

Blue Exclusive℠ Reedy
PRISMA Health Upstate Network
Prefix:
RBN


South Carolina

Member Name
SUBSCRIBER NAME
Member ID
RBN123456789999

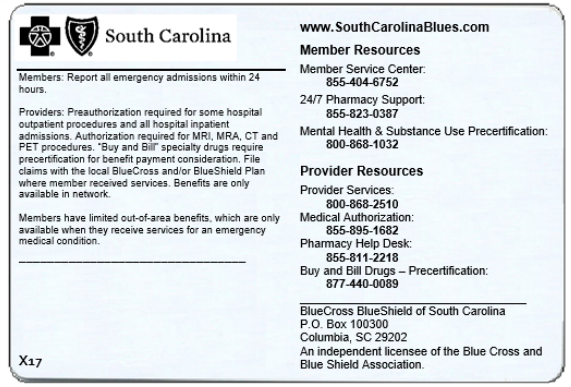
RxBIN 021684
RxGRP BXGI
PLAN CODE 380

BlueExclusive℠ Reedy
PRISMA Health Upstate Network

www.SouthCarolinaBlues.com

Out-of-Area Emergency Services Only

PPO B


South Carolina

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X17

www.SouthCarolinaBlues.com

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Provider Resources
Provider Services: 800-868-2510
Medical Authorization: 855-895-1682
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Buy and Bill Drugs – Precertification: 877-440-0089

BlueCross BlueShield of South Carolina
P.O. Box 100300
Columbia, SC 29202
An independent licensee of the Blue Cross and Blue Shield Association.

IMPORTANT: A BlueCross Upstate Blue Network Provider Agreement is required to service these members. These members are not part of the historical and broader BlueCross Individual Health Insurance Exchange Preferred Provider Network. This product is separate from the other Affordable Care Act network products. Members do not have out of network benefits, except in true emergencies.

Affordable Care Act

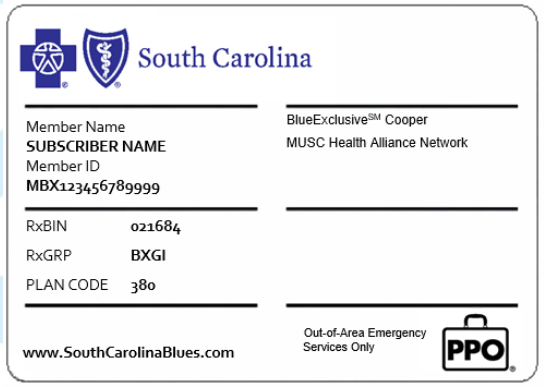
Blue Exclusive℠ Reedy
PRISMA Health Upstate Network

- To enroll in a Blue Exclusive Reedy plan, the member must live in Greenville County.
- Members must visit any hospital and doctor in the Prisma Health Upstate network:
    - Greenville
    - Anderson
    - Spartanburg

  Note: This is a separate network from historical and broader BCBSSC Individual Health Exchange Network.
- Visiting medical providers outside of the network for non-emergency services will not be covered.
- Plans will be offered on the FFM for members who qualify for financial assistance.
- Look up providers at www.SouthCarolinaBlues.com/links/providers/PRISMA

Affordable Care Act

Blue Exclusive[SM] Cooper
MUSC Alliance Health Network
Prefix:
MBX


South Carolina

Member Name
SUBSCRIBER NAME
Member ID
MBX123456789999

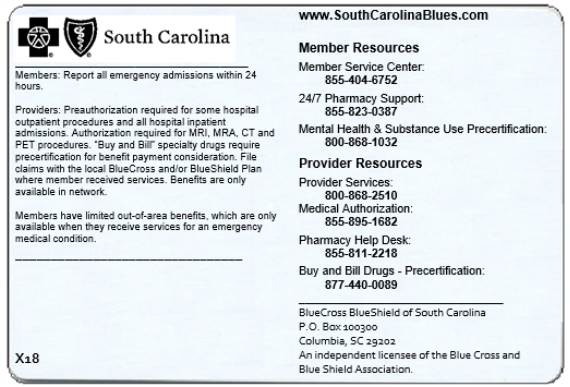
RxBIN **021684**
RxGRP **BXGI**
PLAN CODE **380**

BlueExclusive[SM] Cooper
MUSC Health Alliance Network

www.SouthCarolinaBlues.com

Out-of-Area Emergency Services Only

PPO


South Carolina

Members: Report all emergency admissions within 24 hours.

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Members have limited out-of-area benefits, which are only available when they receive services for an emergency medical condition.

X18

www.SouthCarolinaBlues.com

Member Resources
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24/7 Pharmacy Support:
855-823-0387
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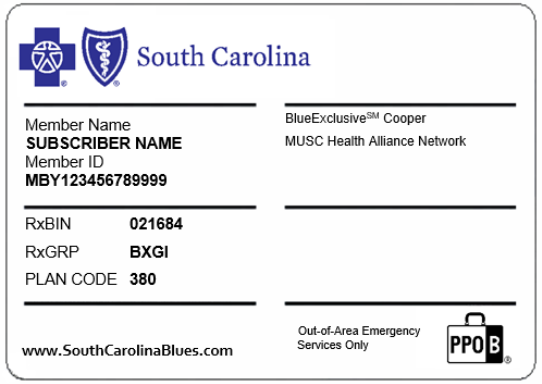
855-811-2218
Buy and Bill Drugs - Precertification:
877-440-0089

BlueCross BlueShield of South Carolina
P.O. Box 100300
Columbia, SC 29202
An independent licensee of the Blue Cross and Blue Shield Association.

Blue Exclusive[SM] Cooper
MUSC Alliance Health Network
Prefix:
MBY


South Carolina

Member Name
SUBSCRIBER NAME
Member ID
MBY123456789999

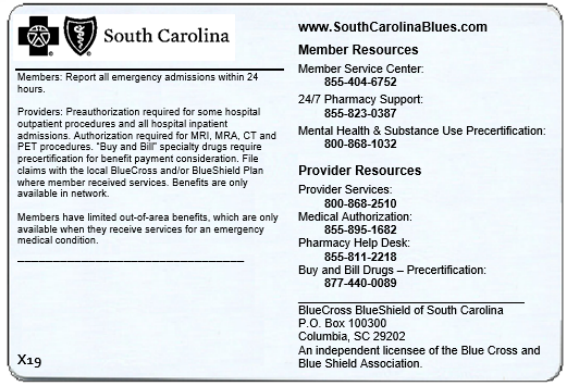
RxBIN **021684**
RxGRP **BXGI**
PLAN CODE **380**

BlueExclusive[SM] Cooper
MUSC Health Alliance Network

www.SouthCarolinaBlues.com

Out-of-Area Emergency Services Only

PPO B


South Carolina

Members: Report all emergency admissions within 24 hours.

Providers: Preauthorization required for some hospital outpatient procedures and all hospital inpatient admissions. Authorization required for MRI, MRA, CT and PET procedures. "Buy and Bill" specialty drugs require precertification for benefit payment consideration. File claims with the local BlueCross and/or BlueShield Plan where member received services. Benefits are only available in network.

Members have limited out-of-area benefits, which are only available when they receive services for an emergency medical condition.

X19

www.SouthCarolinaBlues.com

Member Resources
Member Service Center:
855-404-6752
24/7 Pharmacy Support:
855-823-0387
Mental Health & Substance Use Precertification:
800-868-1032

Provider Resources
Provider Services:
800-868-2510
Medical Authorization:
855-895-1682
Pharmacy Help Desk:
855-811-2218
Buy and Bill Drugs – Precertification:
877-440-0089

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IMPORTANT: A BlueCross Lowcountry Blue Network Provider Agreement is required to service these members. These members are not part of the historical and broader BlueCross Individual Health Insurance Exchange Preferred Provider Network. This product is separate from the other Affordable Care Act network products. Members do not have out of network benefits, except in true emergencies.

Affordable Care Act

Blue Exclusive℠ Cooper
MUSC Health Alliance Network

- To enroll in a Blue Exclusive Cooper plan, the member must live:
  - Charleston County
  - Dorchester County
  - Berkley County
- Members must visit any hospital and doctor in the MUSC Health Alliance network.

  Note: This is a separate network from historical and broader BCBSSC Individual Health Exchange Network.
- Visiting medical providers outside of the network for non-emergency services will not be covered.
- Plans will be offered on the FFM for members who qualify for financial assistance.
- Look up providers at www.SouthCarolinaBlues.com/links/providers/MUSC

Affordable Care Act

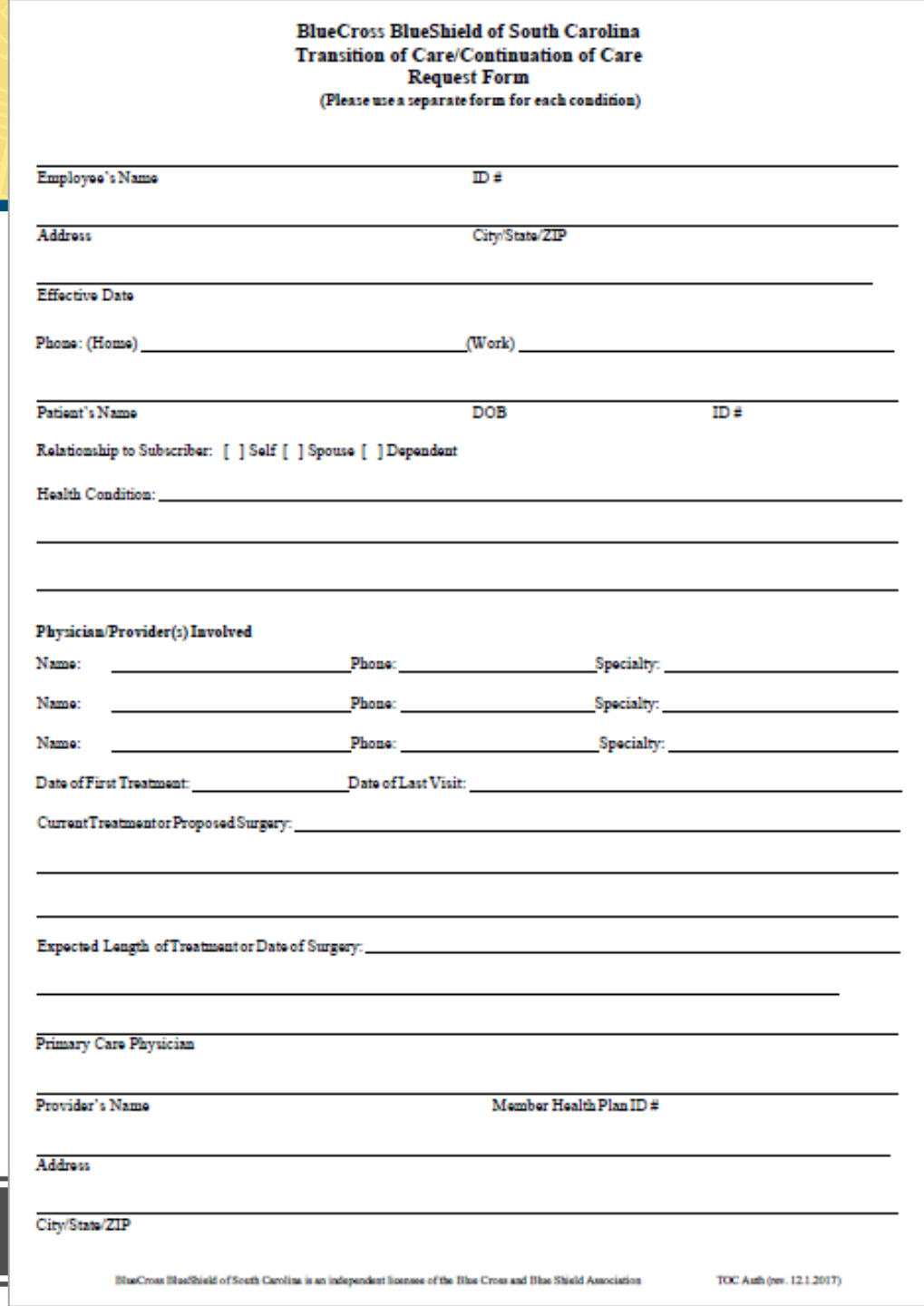
Premium Delinquencies

- Members who do not have a federal subsidy do not have a delinquency grace period. Delinquent payments may result in unpaid claims.
- Three-month grace period for individual policies with subsidies:
  - First month of delinquency – BlueCross pays claims/notifies provider
  - Second/third month of delinquency – BlueCross will hold claims until premiums paid
  - Provider will receive message when verifying benefits via My Insurance Manager or voice response unit (VRU)

Affordable Care Act

Transition of Care Form

- Members must complete the Transition of Care form to receive ongoing treatment from an out-of-network provider:
  - Form must be submitted for approval prior to services being rendered
  - Payment will be submitted to the patient
  - Form is available on both websites:
    - www.SouthCarolinaBlues.com
    - www.BlueChoiceSC.com



BlueCross BlueShield of South Carolina
Transition of Care/Continuation of Care Request Form
(Please use a separate form for each condition)

Employee's Name _____ ID # _____

Address _____ City/State/ZIP _____

Effective Date _____

Phone: (Home) _____ (Work) _____

Patient's Name _____ DOB _____ ID # _____

Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Dependent

Health Condition: _____

Physician/Provider(s) Involved

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

Date of First Treatment: _____ Date of Last Visit: _____

Current Treatment or Proposed Surgery: _____

Expected Length of Treatment or Date of Surgery: _____

Primary Care Physician

Provider's Name _____ Member Health Plan ID # _____

Address _____

City/State/ZIP _____

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TOC Auth (rev. 12.1.2017)

BlueCard Program

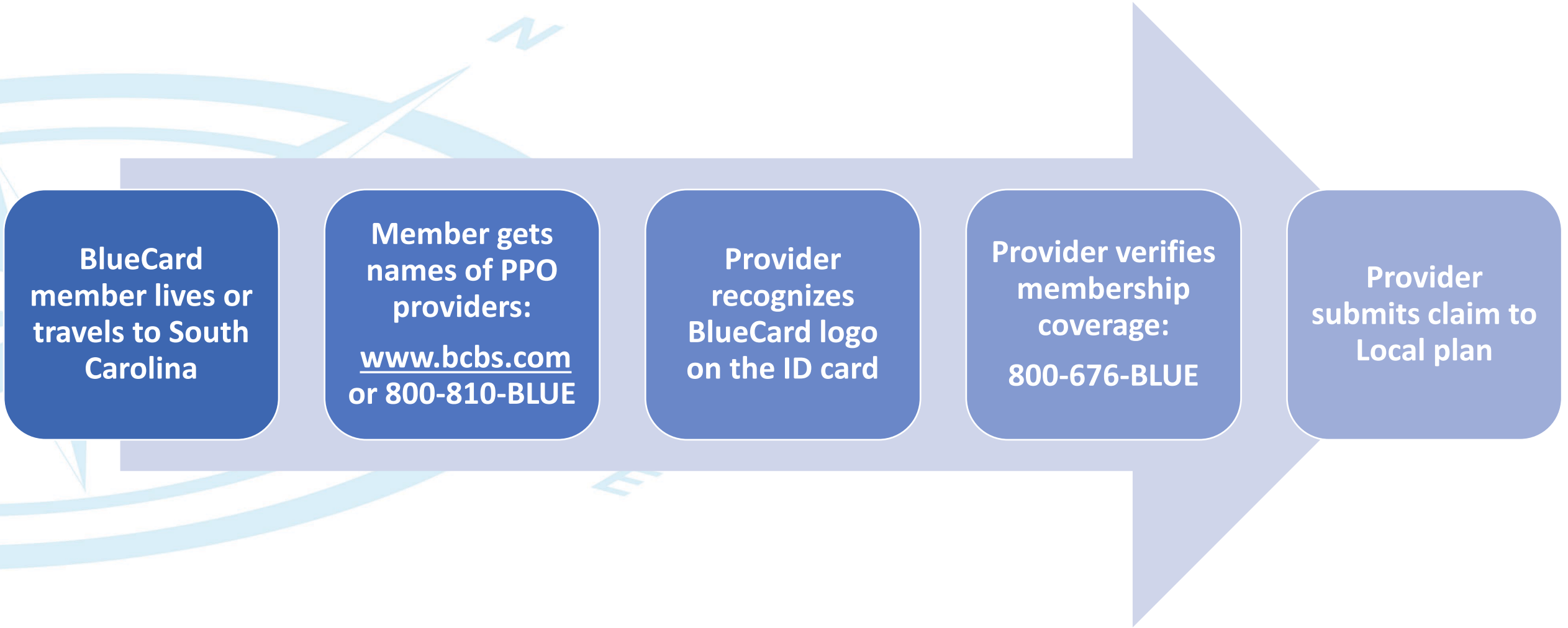
BlueCard Program

Overview

- The BlueCard Program enables Blue Plan members to get health care service benefits and savings while traveling or living in another Blue Plan's service area. The program links participating health care providers across the country and internationally through a single electronic network for claims processing and reimbursement.
- The BlueCard Program lets providers submit claims for other Blue Plan members directly to BlueCross BlueShield of South Carolina Plan for processing.
- BlueCross is your point of contact for education, contracting, claims payment/adjustments and problem resolution.

BlueCard Program

BlueCard Process for Providers



BlueCard Program

Home Plan

- Responsibilities to member:
  - Adjudicate claims based on member eligibility and contractual benefits
  - Utilization Review
  - Member inquiries and education
  - Send member explanation of benefits

Host Plan

- Responsibilities to provider:
  - Point of contact for claims inquiries and education
  - Forward clean claims to the Home Plan for processing
  - Apply pricing and reimbursement to claims
  - Send provider remittances

BlueCard Program

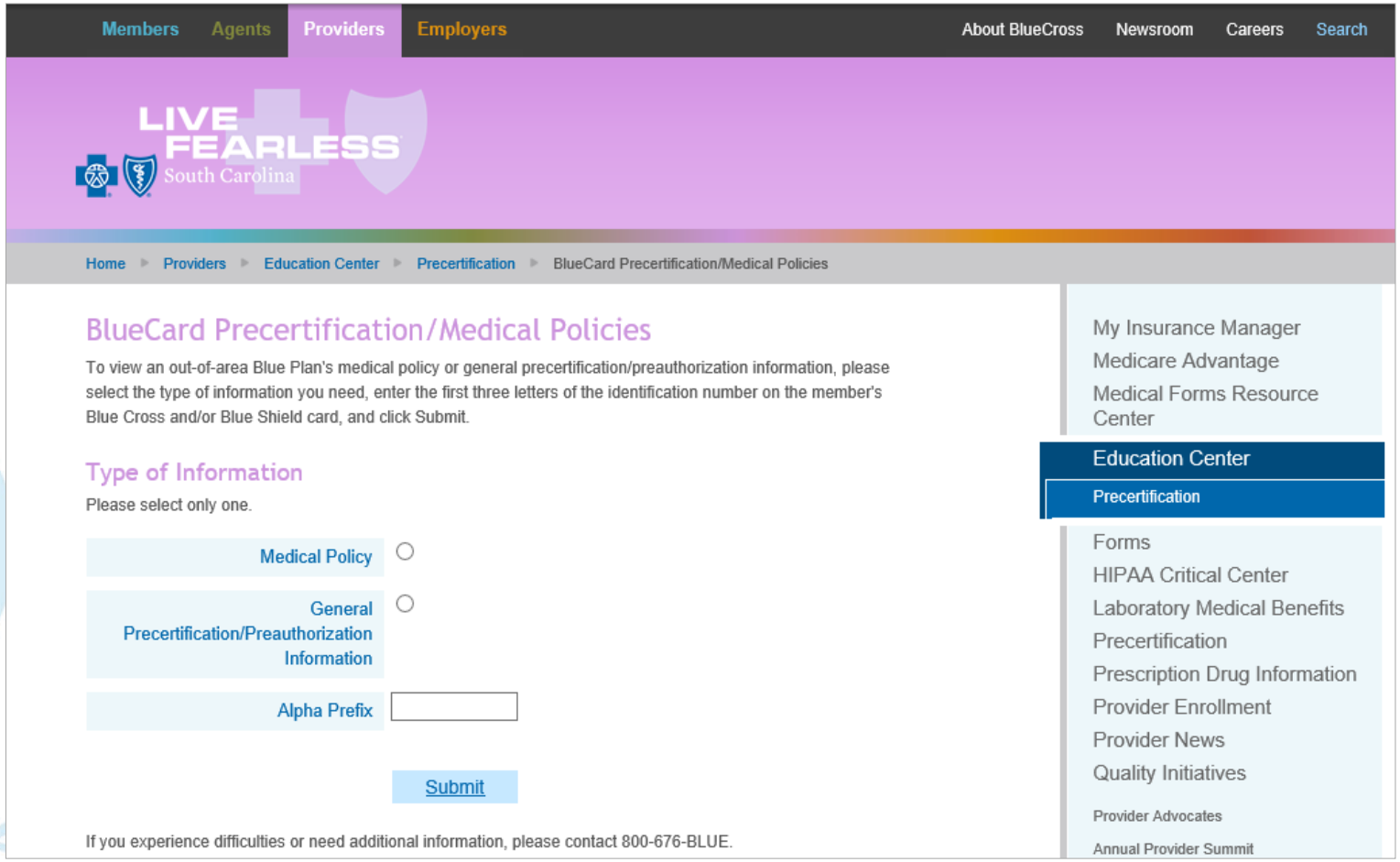
Ancillary Filing Guidelines

- **Durable Medical Equipment (DME)**
  - File to the Plan whose state the equipment was purchased at a retail store.
  - File to the Plan whose state the equipment was shipped.
- **Independent Clinical Laboratory (Lab)**
  - File to the Plan where the specimen was drawn.
  - File to the Plan where the referring is located.
- **Specialty Pharmacy**
  - File to the plan whose state the ordering physician is located.

BlueCard Program

Electronic Provider Access

- Access out-of-area Blue Plan's provider portals to view:
  - Prior authorization information
  - Medical policies
- Enter the member's prefix from the member ID card



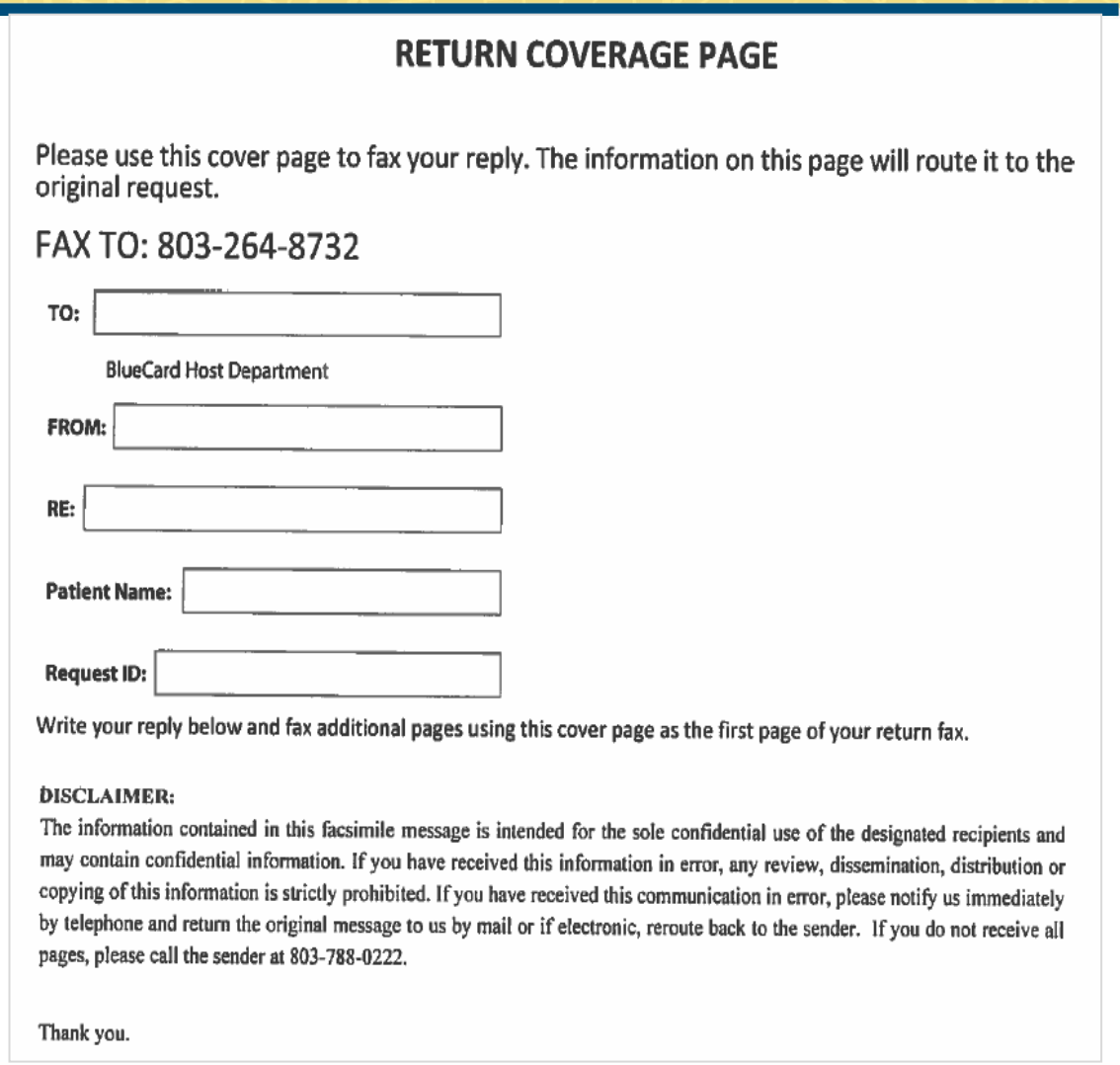
www.SouthCarolinaBlues.com and www.BlueChoiceSC.com

BlueCard Program

Medical Record Requests

- Submit the Return Coverage page with the medical records.
- Forward all medical records within 20 days from the receipt date of the request.
- Send the specified requested records or the name of the provider that may have the records.

Important: Submission of medical records is a non-billable event.



RETURN COVERAGE PAGE

Please use this cover page to fax your reply. The information on this page will route it to the original request.

FAX TO: 803-264-8732

TO: _____

BlueCard Host Department

FROM: _____

RE: _____

Patient Name: _____

Request ID: _____

Write your reply below and fax additional pages using this cover page as the first page of your return fax.

DISCLAIMER:

The information contained in this facsimile message is intended for the sole confidential use of the designated recipients and may contain confidential information. If you have received this information in error, any review, dissemination, distribution or copying of this information is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us by mail or if electronic, reroute back to the sender. If you do not receive all pages, please call the sender at 803-788-0222.

Thank you.

SC Plan Reminders and Updates

SC Plan Reminders and Updates

New Office or Outpatient E/M Visit – Effective Jan. 1, 2021

Code		
99202	99205	99213
99203	99211	99214
99204	99212	99215

- 99201 is deleted.
- Listed codes must be billed with either a time component or with complexity.
  - Both (component/complexity) cannot be used.
  - Documentation must support the choice made.
- The use of the codes for expanded visits may only be used in conjunction with 99205 or 99215 when filed with the time component.

SC Plan Reminders and Updates

Accident Date and Illness Date

- Be sure to use the below fields only when indicating accident dates:

Claim Type	Field
UB04	OCCURRENCE CODE 05
HCFA 1500	Field # 14

Medical Records

- Submission of medical records is a non-billable event.

National Drug Code (NDC)

- Use the appropriate NDC for all administered drug claims with the corresponding J-codes on institutional outpatient and professional claim.
- When submitting NDCs on professional electronic and paper (CMS-1500) claims include:

11-digit NDC	NDC Qualifier (N4)	NDC Quantity	NDC Unit of Measure

Other Groups

Publix

Benefit Updates - PBB PWA PXN	2020	2021
Hospice	No Annual Maximums	No Change
Breast Pumps	Subject to deductible INN DME Provider - 20% coinsurance ONN - 40% coinsurance	INN and OON – covered at 100%; no deductible or coinsurance
	$200 Lifetime Max	Up to Lifetime Max of $200 (Updated mid-year 2020)
Cardiac Rehabilitation	INN Specialist - No copay INN OP visit - No deductible or coinsurance	No Change
Diabetes Self- Management Education Service	INN Specialist - No copay INN OP visit - No deductible or coinsurance	No Change
Gender Reassignment Services	Services covered in accordance with BCBS Medical Policy and subject to the Publix Schedule of Benefits	No Change
NPP Copays (Non-Physician Practitioners – NPs and PAs)	$50 Specialist copay for NPs and PAs	$25 PCP copay for NPs and PAs (Updated mid-year 2020)

Cracker Barrel

Behavioral Health Benefits – Effective Jan. 1, 2021

Prefixes: ODJ, ODL and ODN

- Behavioral health benefits will become part of the BlueCross BlueShield of Tennessee benefit plan.
  - File behavioral health claims to BCBSSC
- ComPsych will continue to handle run-out for any date of service prior to Jan. 1, 2021.

THANK YOU!