

# BlueNews<sup>SM</sup> for Providers

## NPI-Related Changes to My Insurance Manager<sup>SM†</sup>

Since May 11, 2007, you have seen the following changes to My Insurance Manager related to the National Provider Identifier (NPI):

- On many screens, your NPI appears where you are accustomed to seeing your Tax ID or 12-digit provider number.
- In some fields, you now have the option to enter an NPI.
- Location selection lists indicate which locations have not registered NPIs with us.
- When creating new profiles, you only need to use your nine-digit Tax ID.
- How you view remits depends on whether or not you have registered an NPI with us.

For specific information and an overview of the new screens, see our [guide](#).

For more information about NPI, go to the HIPAA Critical Center's [NPI Overview](#).

## Rendering Information Needed

We recently discovered we are receiving claims that do not contain the rendering provider information. Submitting the rendering provider information is a **critical requirement** to ensure the accuracy of claims processing. Failure to submit the rendering information may result in payment errors.

Please take a moment to review your claims submission data and/or contact your trading partner, if appropriate, to ensure the rendering information appears on your claims. We are currently in a contingency period that allows providers and trading partners to continue to submit transactions that contain Legacy Identifiers. During this contingency period, providers can submit claims with either Legacy Identifiers only, or both the Legacy Identifiers **and** an NPI.



**Please remember, it is critical that you provide the rendering provider information on your claims submissions for accurate claims processing.**

If you have questions regarding this information, please contact the Provider Education department at [Provider.Education@bcbsc.com](mailto:Provider.Education@bcbsc.com).

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## Claim Filing Tip

We no longer accept faxed copies of claims. Please file your claims to us electronically through your vendor/clearinghouse or via My Insurance Manager at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).

## Balance Billing

Please do not balance bill patients at the time of service or after we process the claim. Only collect the appropriate copayment, deductible and coinsurance amounts. If, after reviewing your remittance advice, you need assistance with determining the correct patient liability, contact Provider Services at 1-800-868-2510, or via My Insurance Manager at [SouthCarolinaBlues.com](http://SouthCarolinaBlues.com).

## Need Technical Assistance? Contact our TSC!

Have you ever experienced technical difficulties while using My Insurance Manager, or navigating SouthCarolinaBlues.com? If so, our Technology Support Center (TSC) is here to help you!



You can contact the TSC at 1-800-868-2505.

## How to Recognize an International Blue Plan Member

Occasionally, you may see identification (ID) cards from Blue members from a foreign country. These ID cards will also contain three-character alpha prefixes. Please treat Blue international members the same as domestic Blue Plan members. The steps you follow for domestic Blue Plan members are the same steps you should follow for foreign Blue Plan members:

1. Verify eligibility and benefits by sending an electronic eligibility transaction to us, or call the BlueCard Eligibility<sup>®</sup> line at 1.800.676.BLUE (2573) and provide the three-character alpha prefix.
2. File claims to us directly. We will be your focal point for claims collection, payment and problem resolution for health care claims incurred by international Blue Plan members.
3. Please follow the same payment collection practice as you do for domestic members. Be sure to only collect payment up front for amounts that are considered patient liability (copayment, deductible and coinsurance). These members may not have coverage for non-emergency outpatient or physician services. In these instances, you should collect payment for **non-covered services only** from the members.

## Get Instant Claim Processing with Superbill!

Superbill in My Insurance Manager is ideal for providers who want to submit primary claims at the time of service. Create and store your Superbill online, then use it to submit a professional Web claim with minimal keystrokes. Just check the procedure codes and diagnosis codes on your Superbill and hit "Submit!" Use the Superbill with Your Patient Directory for the fastest possible Web claim submission. The majority of your claims will instantly adjudicate and you will receive immediate claim disposition!

Learn how to create and submit a [Superbill](#).

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## Prior Authorization Drug List Additions



We are making a change to our prescription drug prior authorization program that affects the following prescription drugs:

- Amevive
- Enbrel
- Humira
- Kineret
- Orencia
- Raptiva
- Remicade
- Rituxan

Any of your patients who are currently getting one of these drugs from a pharmacy **will not** need to get prior authorizations to continue using them. We will require prior authorization, however, for new prescriptions for any of your patients who begin using these drugs on or after July 1.

You can request prior authorizations for any newly diagnosed or prescribed patients by contacting our Prior Authorization department at 1-866-513-5214. Physicians can also fax prior authorization requests to 1-888-836-0730.

You can always find the most up-to-date information about our prescription drug program on our Web site at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). From our home page, click on "I am a Provider." Then, click on "Prescription Drug Information" on the left side of the page. On the Prescription Drug Information page, you can search our Preferred Drug List (PDL), view a comprehensive list of drugs on our PDL and review the PDL brochure that we provide to our members. You can also view the most current list of drugs that require prior authorization and review instructions for requesting a prior authorization. Be sure to check out the "News" section for important updates.

Another way you can stay informed about changes to our prescription drug program is by using iScribe's<sup>®†</sup> Prescription Management tools – now available free of charge to Preferred Blue<sup>®</sup> physicians! iScribe is a product of Caremark. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of the program. Caremark is an independent company that provides pharmacy benefits management. From the convenience of your personal computer and Internet connection, you can use the iScribe tools to easily check PDL and formulary status and alternatives for drugs for all the patients in your practice – not just those covered by our plan. You can also download PDL and formulary information for all your patients to your Palm OS-based Personal Digital Assistant (PDA). To learn more about iScribe Prescription Management tools, click "iScribe" on the right side of the Provider's Prescription Drug Information page.

**Note:** These changes do not apply to State Health Plan members. Medco administers their pharmacy coverage. On behalf of BlueCross, Medco assists in the administration of the program. Medco is an independent company that provides pharmacy benefits management.

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## STATchat<sup>SM†</sup> Headsets

Unfortunately, we will no longer be able to provide headsets free of charge for use with our STATchat feature in My Insurance Manager. STATchat is a Web-based tool that allows you to speak with a live provider service representative over the Internet. This tool also drastically reduces the hold times that you may experience if you call Provider Services via a regular land line. All you need is a headset with an attached microphone in order to use this amazing tool. If you do not have a headset, you can purchase one for only \$9.95 via the Web at [www.alpineroad.biz](http://www.alpineroad.biz). If you need help using STATchat, please send us an e-mail at [Provider.Education@bcbsc.com](mailto:Provider.Education@bcbsc.com).

**\*\*\*While visiting the product store, be sure to check out our new apparel and add some blue to your wardrobe!\*\*\***

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## **Are You Doing All You Can to Ensure You Are Submitting Your Medical Records Accurately?**

Our Medical Review and Appeals departments have noticed the way providers submit records can sometimes result in non-receipt of records or delays in processing. Please review the accuracy of the records before submitting them for review. This will ensure we are able to process all requests timely and accurately.

### **How to Avoid Delays in Processing Your Medical Review Requests:**

1. Please use the Medical Review Request form. It should be the first page of the fax.
2. Attach *one* copy of the records to *one* Medical Review Request form.
3. Send the correspondence to the fax number listed on the Medical Review Request form. Only mail them to us when they are greater than 50 pages.
4. Use the entire date for the billed service. We need this to make sure we are using the correct claim when reviewing the medical record.
5. Make sure you attach the correct member's records to the request.
6. Only send documentation that we request. We don't always require the entire record.

### **Common Submission Errors:**

- Submitting multiple Medical Review Request forms with only one set of medical records.  
**Result:** Causes delays in reviewing the information. We will only review the request that pertains to the medical records. We will deny all other requests.
- Attaching multiple records to one Medical Review Request form.  
**Result:** Causes delays with reviewing the information.
- Submitting records for a specific member, but attaching another member's records (or a few pages of another member's records).  
**Result:** Full denial of requests.
- Sending records with the Medical Review Request form in the middle of the record.  
**Result:** Causes delays with reviewing the information.

Get a copy of the [Medical Review form](#).

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