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

Independent licensees of the Blue Cross Blue Shield Association.

2022 Annual Provider Summit

Frequently Asked Questions

Authorizations

1. **Why do specialty drugs require an authorization through medical and pharmacy?**
   The authorization requirements for specialty drugs will depend on how the claim is going to be submitted. If being filed under the medical benefit, the authorization would go through medical; if filed under the pharmacy benefit, the authorization would go through pharmacy.
2. **Can Availity be used to obtain authorizations?**
   Availity can be used for Healthy Blue℠ members. For our commercial lines of business, please use My Insurance Manager℠ or contact the phone number on the back of the member's ID card.
3. **Can maternity notifications be submitted through My Insurance Manager℠?**
   Yes, maternity notifications can be submitted through My Insurance Manager℠.
4. **How can the status of an out-of-state member's authorization be verified?**
   To verify the status of an out-of-state member's authorization, providers would need to contact the member's Home Plan directly or by calling the BlueCard® Eligibility Line at 800-676-BLUE (2583).

Benefits

5. **Is there a limit for COVID-19 testing?**
   No, there is no limit for COVID-19 testing. It is based on medical necessity.
6. **Are nurse practitioners (NPs) considered primary care physicians (PCPs)?**
   This would vary per plan. Under some members' benefits, NPs are considered PCPs, while others consider them to be specialist. For this reason, it is important to always verify eligibility and benefits prior to rendering services. This can be done through My Insurance Manager℠ or by calling the Provider Services number on the back of the member's ID card.
7. **Is there a list of prefixes associated with the Medicare Advantage plans?**
   Yes, the list of prefixes related to Medicare Advantage plans can be found in the 2022 Member Identification Card Guide, located on www.SouthCarolinaBlues.com.
8. **For the BlueExtend℠ Plans, is vision services through the medical plan or an outside vendor (e.g., EyeMed, VSP)?**
   Vision benefits are through the medical benefit.
9. **What providers are included in the Southeastern Health Partners (SEHP) network?**
   The following hospital groups and their owned/affiliated participating practices are included in the SEHP network:

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

10. **Will ID cards be available in My Insurance Manager℠?**
    Currently, ID cards are not available in My Insurance Manager℠. However, members have access to their updated ID cards through their My Health Toolkit app.

Claims

11. **Can medical records be submitted with claims?**
    Medical records cannot be submitted with claims. Medical records should only be submitted when requested.
12. **How should be contacted for refund questions?**
    For questions related to refunds, please contact Provider Services at 800-868-2510, Opt. 4. This line should be used for the following lines of business:
    - BlueCard®
    - BlueChoice®
    - BlueEssentials℠
    - Major Group
    - National Alliance
    - Small Group & Individual

    For Federal Employee Program (FEP) and State Health Plan, please contact the Provider Services number on the back of the member's ID card.

    Also, please note that refund letters are now available in My Insurance Manager℠.
13. **How can providers speak with someone if they have questions on claims?**
    Providers can use STATchat or Ask Provider Services, both of which are available through My Insurance Manager℠. STATchat allows providers to speak with a live representative and Ask Provider Services allows providers to submit secured web inquiries.
14. **If a mistake is made on a claim, can a correction be submitted through My Insurance Manager℠?**
    Yes, corrected claims can be submitted through My Insurance Manager℠. When filing a corrected claim through My Insurance Manager℠ (MIM), do the following:
    - Under the Patient Care menu, select Professional Claim Entry.
    - Select a plan and indicate whether the plan is the primary payer.
    - Select the billing location, rendering provider and/or referring provider when prompted. You can opt to choose a patient or manually enter the patient's information on the Patient Information page.
    - On the Claim Information page, select Replacement of Prior Claim from the Claim Type menu. Enter the prior claim number in the required filed.

- Enter the new information from the line of your claim.
- Include ALL lines that need to be processed, including existing lines, corrected lines, or additional lines.
- Once completed, select Continue.
- Confirm the claim information is accurate, then click Submit.

15. **When billing items such as mastectomy bras or breast prosthetics, should modifier 50 be used?**
    Modifier 50 is typically used for surgical procedures and not durable medical equipment (DME).
16. **If a patient has an out-of-state Blue Plan, where should the claim reconsideration be sent?**
    As a South Carolina provider, all provider reconsiderations should be sent to BlueCross BlueShield of South Carolina using one of the avenues listed on the bottom of the Provider Reconsideration Form. Once received, it will be submitted to the member's Home Plan for review.
17. **Can providers submit the Accident/Subrogation Questionnaire or Other Health Insurance (OHI) Questionnaire on behalf of the member?**
    Yes, providers can submit the Accident/Subrogation Questionnaire or the OHI Questionnaire on behalf of the member. However, please be sure the questionnaires have been completed and signed by the member. Also, only submit these questionnaires when requested.

    Note: State Health Plan only accepts the OHI Questionnaire from the member.
18. **Who should providers submit reconsideration requests to when a claim denies for non-covered services or ineligible services?**
    Provider reconsiderations should be submitted for medical necessity reasons. If claims reject due to non-covered services or other non-medical necessity reasons, please contact the Provider Services number on the back of the member's ID card to have the claim reviewed.
19. **If the member does not update their Other Health Insurance (OHI), can the provider send them the bill?**
    If the member does not update their OHI and the claim is showing to be their responsibility, then yes, the provider can bill the member. If there is no member liability on the claim, providers should not bill the member.

Dental

20. **What is the prefix associated with the Blue Cross Blue Shield FEP Dental plans?**
    Members that have the Blue Cross Blue Shield FEP Dental plan will have the prefix 'F'.

Healthy Blue℠

21. **What is the Customer Care Center phone number?**
    The Customer Care Center phone number is 866-757-8286.
22. **How much is the well-child incentive?**
    As of Oct. 1, 2021, the well-child incentive was increased from $30 to $60.

    For the well-child incentive, be sure to file code G9153 and the billed charges of $60 along with the appropriate well-child visit CPT and diagnosis code.

Pharmacy

23. **Can a physician request a specific formulary if a drug is not covered?**
    Under the pharmacy benefit, the member or physician can request a medical necessity exception to have a non-formulary drug covered. Under the medical benefit, the member or physician may file an appeal to have a non-formulary drug covered.
24. **Will there be a change to the preferred medication for Visco supplementation injections?**
    No, the preferred medications are remaining the same for 2022.
25. **How will providers know when to request a medical necessity exception?**
    Providers may file an exception when a drug is denied due to it being a non-formulary drug or through the prior authorization process (e.g., not meeting clinical criteria per policy).
26. **With only one of the Rituxan biosimilars being FDA approved for RA, should providers use a non-formulary drug?**
    This should not be an issue as Truxima, which is the Rituxan biosimilar that has an RA indication, is preferred. However, for any issues regarding the Rituxan biosimilars, the appeal process can be completed, and clinical documentation will be reviewed.

Provider Enrollment

27. **Does BlueCross BlueShield of South Carolina accept electronic signatures?**
    Electronic signatures are accepted on applications, but all contract pages must be signed in ink (except for Behavioral Health).
28. **With the My Provider Enrollment Portal, will BlueCross BlueShield of South Carolina use DocuSign for electronic signatures?**
    No, DocuSign will not be used. As of now, Adobe Sign will be used for electronic signatures.
29. **If providers do not validate their information in M.D. Checkup every 90 days, will they be removed as an in-network provider?**
    Currently, a provider will not be removed as an in-network provider. However, as of Jan. 1, 2022, if providers do not validate their information every 90 days, we are required to remove them from our Provider Directory per the Consolidated Appropriations Act (CAA).
30. **Will providers be notified when it is time to recredential?**
    Yes, providers will be notified when it is time to recredential.
31. **Will Healthy Blue℠ accept the Medicaid provider enrollment reference number, or will providers have to wait for the Provider Medicaid ID?**
    Providers will have to have their Medicaid ID number for the Healthy Blue℠ enrollment process to be completed.
32. **Will My Provider Enrollment Portal replace M.D. Checkup?**
    No, My Provider Enrollment Portal will not replace M.D. Checkup. Certain updates can be made in the portal, but all provider validations must be made through M.D. Checkup.
33. **How long will the current methods for the enrollment process remain in place?**
    The current enrollment process will be in effect until the My Provider Enrollment Portal is fully implemented (late quarter one).
34. **Will provider fee schedules be available in My Provider Enrollment Portal?**

No, provider fee schedules will not be available in My Provider Enrollment Portal. Providers will still need to contact their contracting specialist to obtain this information.

35. **If a provider is inactivated through M.D. Checkup, can they be reactivated?**
    Providers cannot be reactivated through M.D. Checkup. They will need to complete the required documentation to re-enroll.
36. **Should behavioral health providers submit enrollment applications through BlueCross?**
    Enrollment for behavioral health providers is coordinated through Companion Benefit Alternatives, Inc. (CBA).
37. **What is the difference between the effective date and the affiliation date?**
    The effective date is the date that the provider is approved by the Credentialing Committee and this date cannot be changed.

    The affiliation date is the date in which a provider can render services with an established group. This date can be backdated 45 days from the day we receive all required documentation. Any date past 45 days will require a claim to be submitted with the requested backdate as the date of service to show the provider was rendering services with the group at the time of approval.
38. **How long does the enrollment process take once all required documentation has been submitted?**
    The initial review can take between 30-45 days for a clean application (meaning all required documentation has been received). If there are any missing items, outreach is completed, which could extend the period as the review process cannot move forward without the requested information.

Quality

39. **If providers have questions for Quality or need assistance with outreach and scheduling trainings, who should they contact?**
    Providers can reach out to the Quality team at NAVIGATOR@bcbssc.com.

Web Tools

40. **Does My Remit Manager provide the same information included on a remittance?**
    Yes, the information provided on a remittance can be found in My Remit Manager as well.
41. **How does a provider add a facility in My Insurance Manager℠?**
    If the facility already has an active account in My Insurance Manager℠, the profile administrator would be able to add a new location for the facility. If the facility does not have an active account, they would need to register.
42. **How is prior authorization information obtained in My Insurance Manager℠?**
    Prior authorization can be initiated through My Insurance Manager, along with obtaining the status of a previously submitted authorization. After logging into MIM, hover over Patient Care and select 'Pre-Certification/Referral' to start an authorization or 'Authorization Status' to check the status of one.
43. **Can Tax IDs be combined into one account on My Insurance Manger℠?**
    At this time, no, Tax IDs cannot be combined into one account due to HIPAA and security reasons. A profile will need to be created under each individual Tax ID.
44. **For technical issues with My Insurance Manager℠, who should providers contact?**
    Providers can contact the Technical Support Center at 855-229-5720.