South Carolina

Welcome to the

2026 Annual Provider Summit

Your Complete Solution

2026 Annual Provider Summit

Disclaimer

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

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Topics Included

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

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Authorizations

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Topics to Discuss

- ❑ Overview of Authorizations
- ❑ Authorization Partners
- ❑ Reminders
- ❑ Cohere Health

Overview of Authorizations

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What You Need to Know About Authorizations

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

Authorization requirements can vary per plan and network.

Authorizations do not guarantee payment.

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Common Services That Require Authorization

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

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

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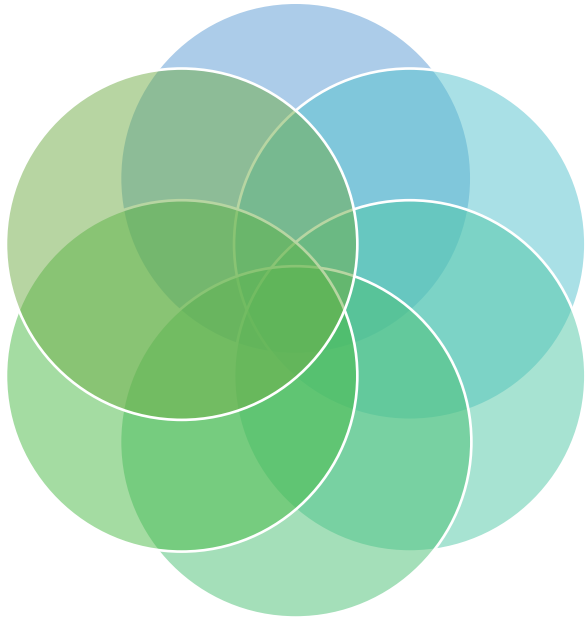
General Guidelines for Authorizations

Submit elective requests prior to rendering services.

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



Submit requests once.

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

Services must be covered under the member's plan.

Members must have active coverage at the time of request.

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Main Steps in the Authorization Process

Verify the member's benefits and provider network.

If authorization is required, initiate the request.

Receive a decision (Approval or denial).

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Required Information for Authorizations

Patient Details

- ❑Name
- ❑ID number
- ❑Date of birth

Service Details

- ❑CPT or HCPCS codes
- ❑Diagnosis codes
- ❑Date of service

Location Details

- ❑Facility
  - –Name
  - –Address
  - –Tax ID or NPI
- ❑Rendering
  - –Name
  - –Address
  - –Tax ID or NPI

Contact Information

- ❑Phone number
- ❑Fax number
- ❑Email

Clinicals

- ❑Length of issue
- ❑Attempted treatment
- ❑Conservative medications
- ❑Studies (i.e., labs, imaging)

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Authorization Partners

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Organizations That Manage Select Authorizations

- Avalon Healthcare Solutions
- Companion Benefit Alternatives (CBA)
- Evolent
- HealthHelp
- Integrated Home Care Services (IHCS)
- OptumRx (MBMNow)

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

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Avalon Healthcare Solutions

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

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

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Companion Benefit Alternatives

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

Companion BENEFIT ALTERNATIVES

Note: This does not apply to commercial autism (ABA therapy) services.
For these services, submit your request to austimsupport@companiongroup.com.

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Evolent

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

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HealthHelp

- Manages authorizations for select procedures related to:
  - Cardiology
  - Musculoskeletal (MSK) care
    - Procedures not currently reviewed by Evolent.
- Only applies to our Exchange plans with group numbers starting with 61, 62 and 65 except for the Blue Direction plan (indicated by a 'B' in the fifth space of the group number).
- To request an authorization:
  - Use: My Insurance Manager℠
  - Call: 833-715-2255
  - Fax: 844-470-2666

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Integrated Home Care Services

- Manages certain authorizations for Medicare Advantage and Group and Individual plana:
- For Medicare Advantage:
  - Durable medical equipment (DME) in the home setting
  - Home health
  - Home infusion services
- For Group and Individual:
  - DME
  - Home health
- To request an authorization:
  - Call: 844-215-4264
  - Fax: 844-215-4265

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OptumRx (MBMNow)

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

OPTUM

BlueCross BlueShield of South Carolina

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Reminders

Standard Prior Authorization List

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

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SERVICES THAT REQUIRE PRIOR AUTHORIZATION
STANDARD LIST EFFECTIVE OCTOBER 2024

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

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

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

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

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

Online Resources and Tools

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

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

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

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

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Contact Information

Plan or Vendor	Authorization Service	Web-based Requests	Telephone Requests	Fax Requests
BlueCross	[various]	My Insurance Manager	800-334-7287	
BlueChoice	[various]	My Insurance Manager	800-950-5387	
FEP	[various]	My Insurance Manager	800-327-3238	
State Health Plan	[various]	My Insurance Manager	800-925-9724	
Avalon	Laboratory	My Insurance Manager	844-227-5769	813-751-3760
CBA	• Behavioral health • Substance abuse	My Insurance Manager or www.CompanionBenefitAlternatives.com	800-868-1032	
Evolent	• Advanced Radiology • Musculoskeletal Care • Radiation Oncology	My Insurance Manager or www.RadMD.com	BlueCross: 866-500-7664 BlueChoice: 888-642-9181	888-656-1321
MBMNow	Specialty Medical Drug	My Insurance Manager	877-440-0089	612-367-0742
IHCS	• DME, home health and home infusion		844-215-4264	844-215-4265
Cohere Health	*Platform for medical authorization requests.	My Insurance Manager	888-787-0309	

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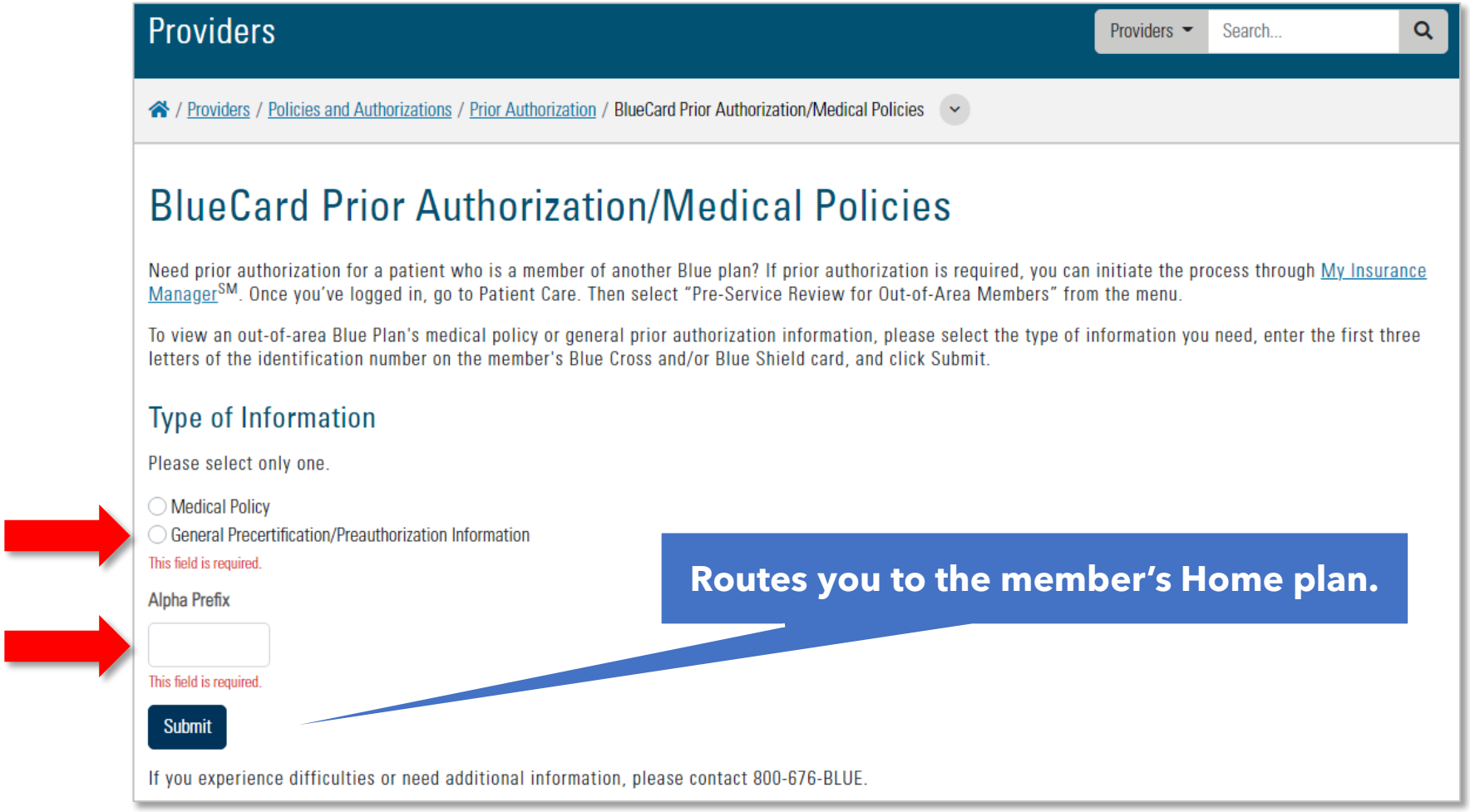
BlueCard Out-of-State Member Authorizations

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



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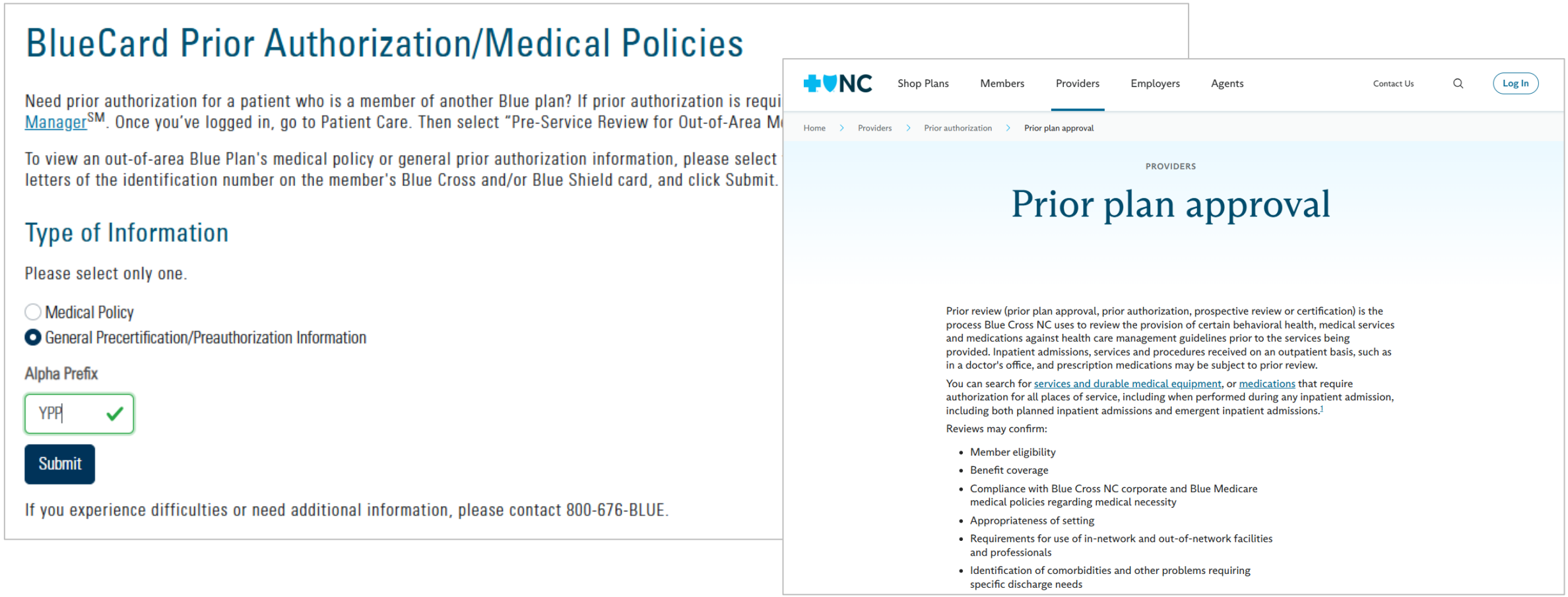
BlueCard Out-of-State Member Authorizations (Continued)

Example



Note: If you run into any issues with the other Blue plan's website, you must contact that Blue plan for assistance.

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Peer-to-Peer Requests

- Process to review and discuss denied prior authorizations.
  - Must be requested before submitting claims.
- Required criteria:
  - Medical necessity adverse decision was received, along with health plan denial
  - Requested within two business days of the denial for inpatient or continued stay requests OR five business days for all other denials
- Clinical discussion:
  - Facilitated within one business day of receipt of request
  - Our medical doctor makes two attempt to contact the rendering provider
  - A decision is rendered at the end of the call

How to Request a Peer-to-Peer

- Visit SouthCarolinaBlues.com and complete the Peer-to-Peer Request form.
  - Providers>Forms>Other Forms
    - Email: Peer.Medical@bcbssc.com
    - Fax: 803-264-9175
- For status or questions, call 803-264-8114.
  - Available Monday – Friday, 8:30 a.m. to 5 p.m., EST

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Utilization Management Courtesy Re-evaluations

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

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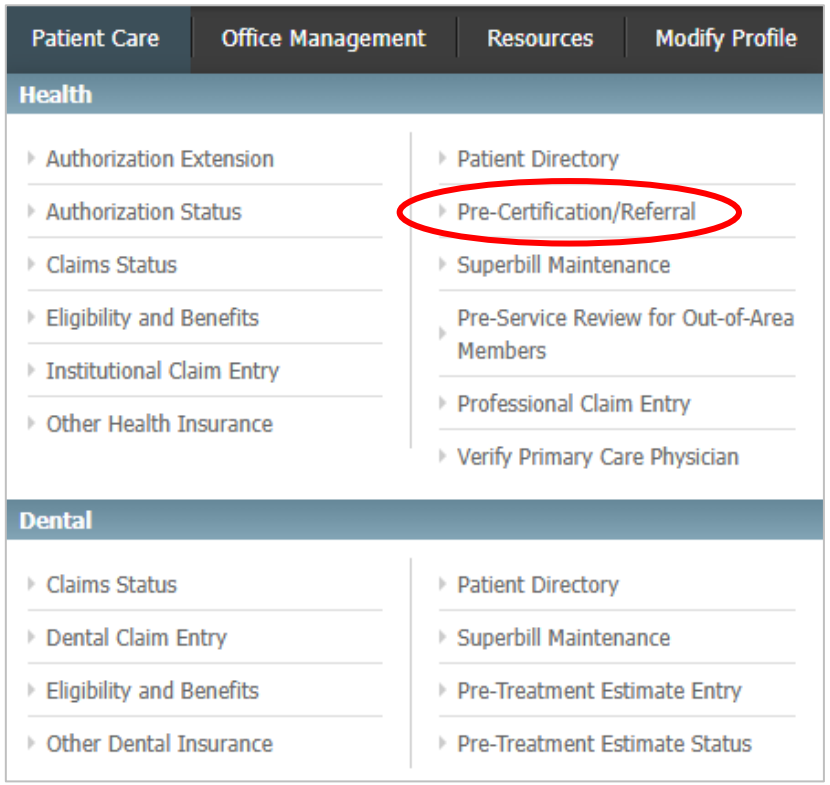
How to Get an Authorization

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



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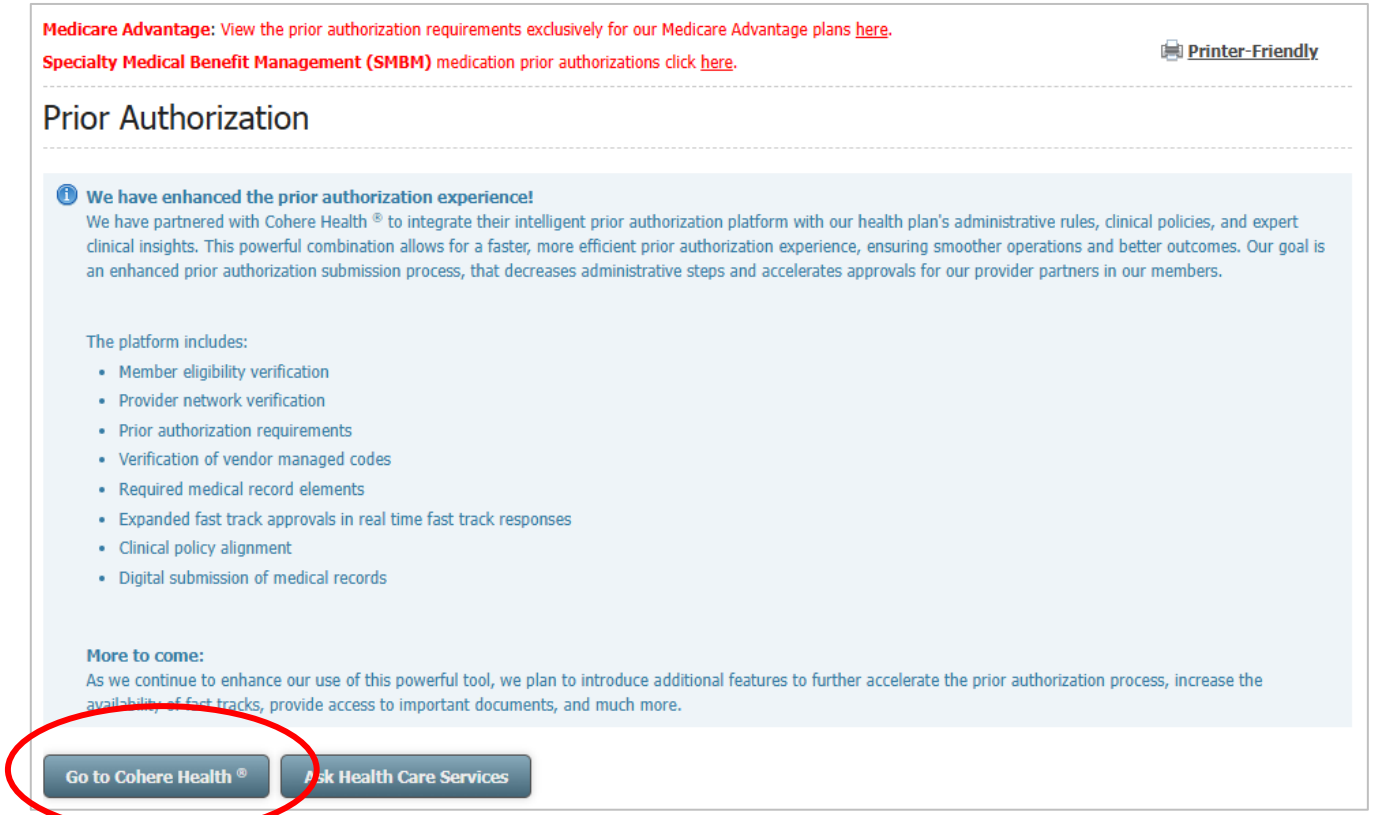
Proceed to the Cohere Health

- You will be prompted to go to the Cohere Health platform to submit the prior authorization request.
- Medicare Advantage will begin going through the Cohere Health platform **Dec. 19, 2025**.
  - DME, home health and home infusion services will still be managed by IHCS.



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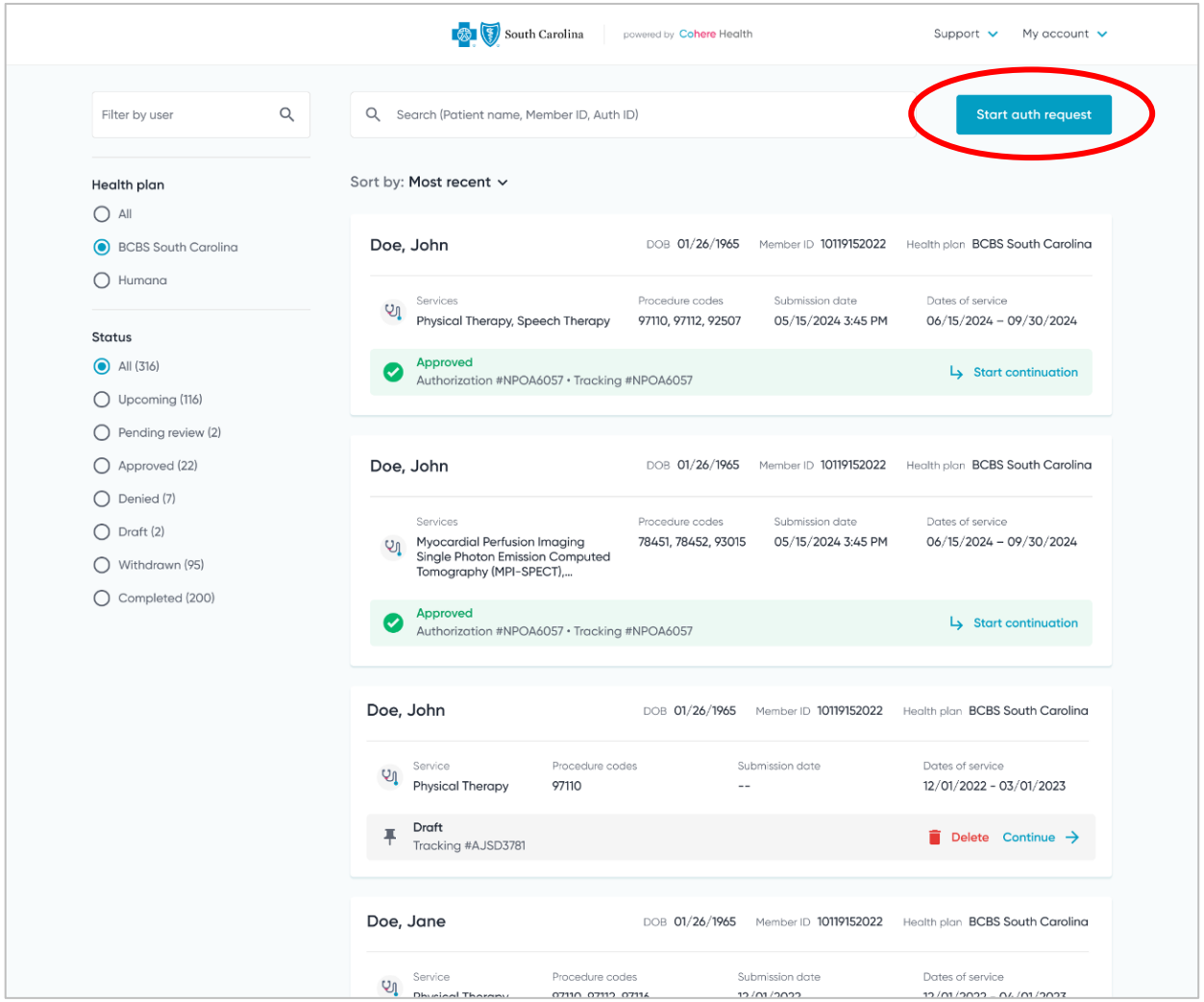
Cohere Health Landing Page

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



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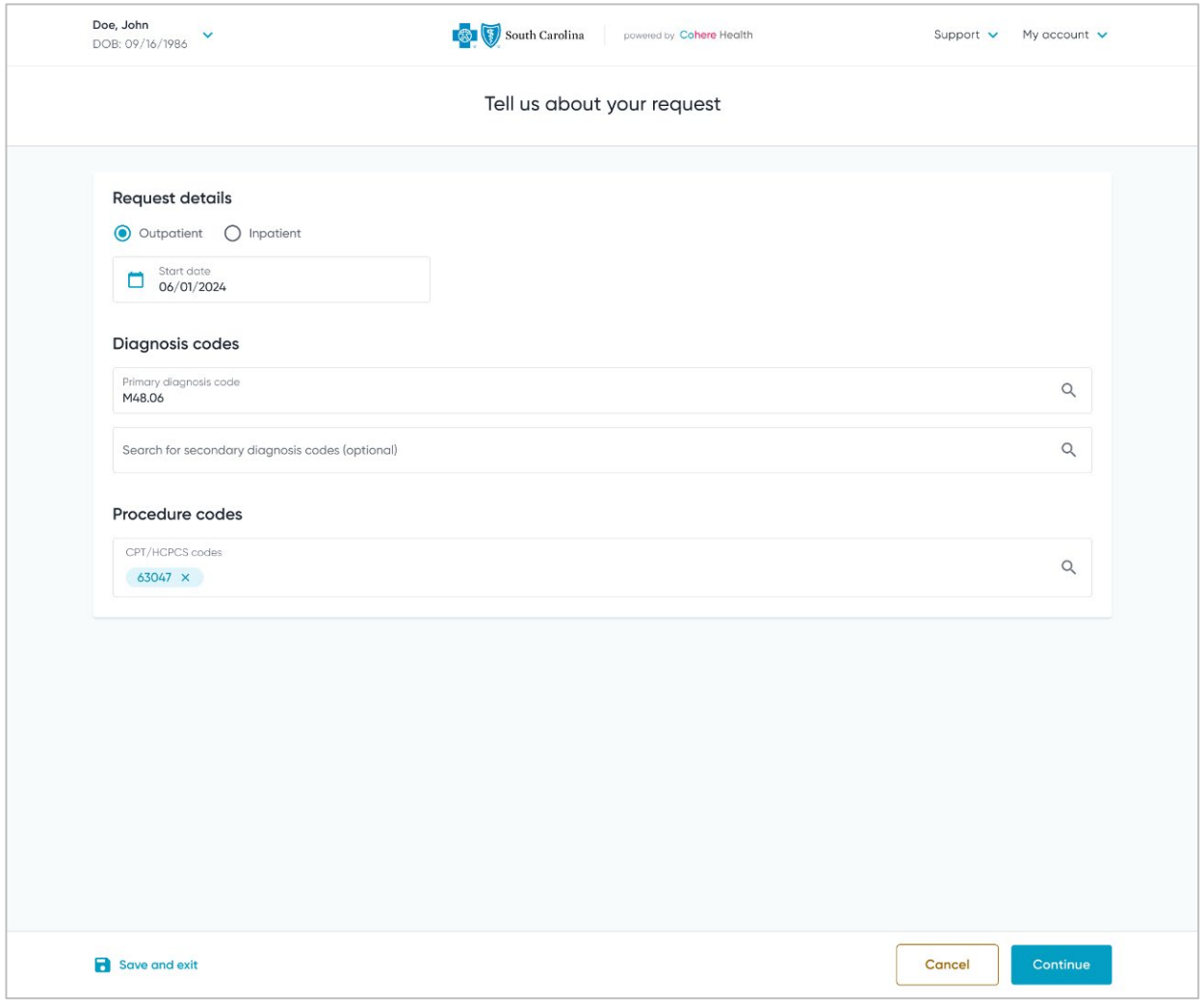
Cohere – Information About the Request

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



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

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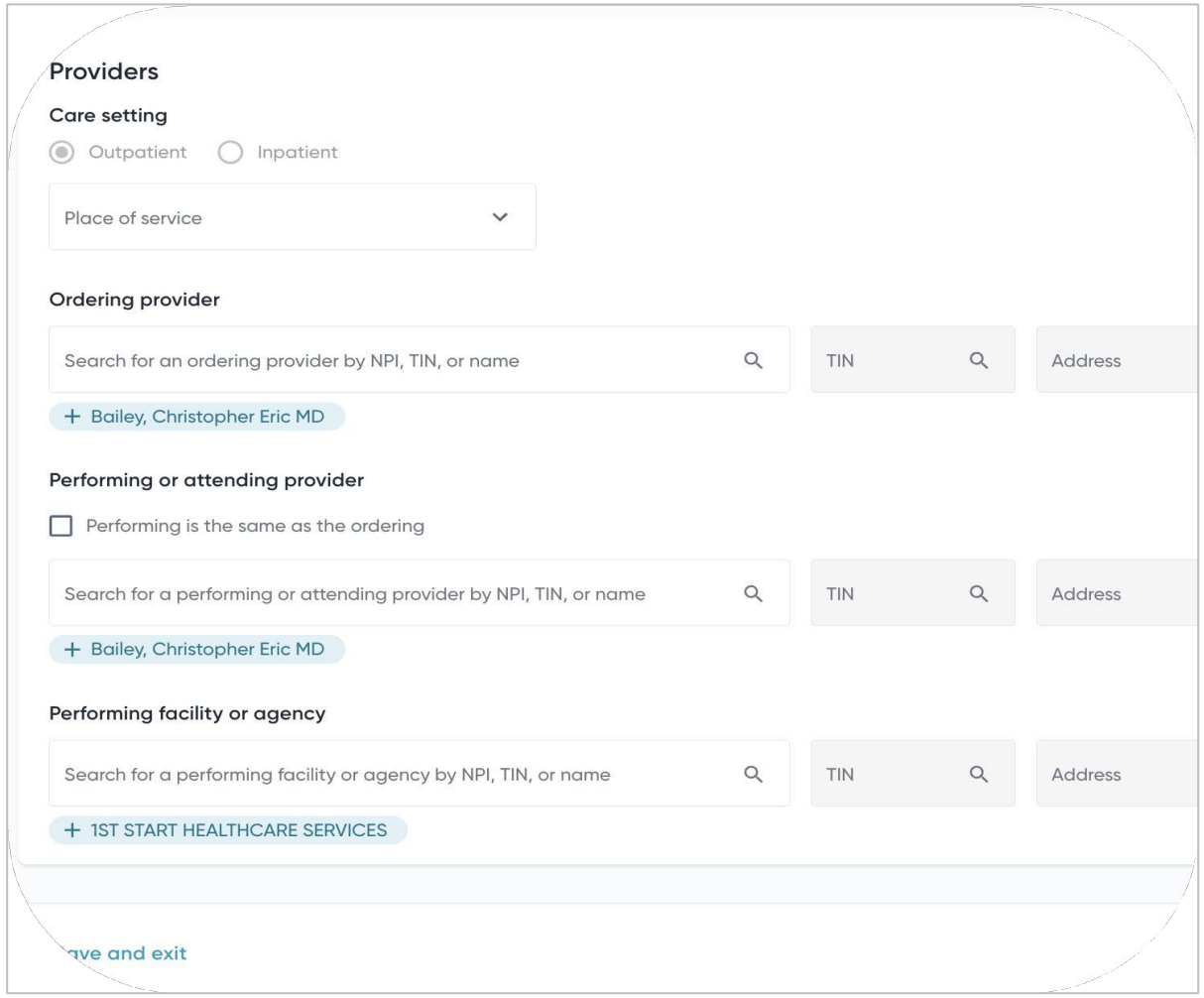
Cohere – Provider Details

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



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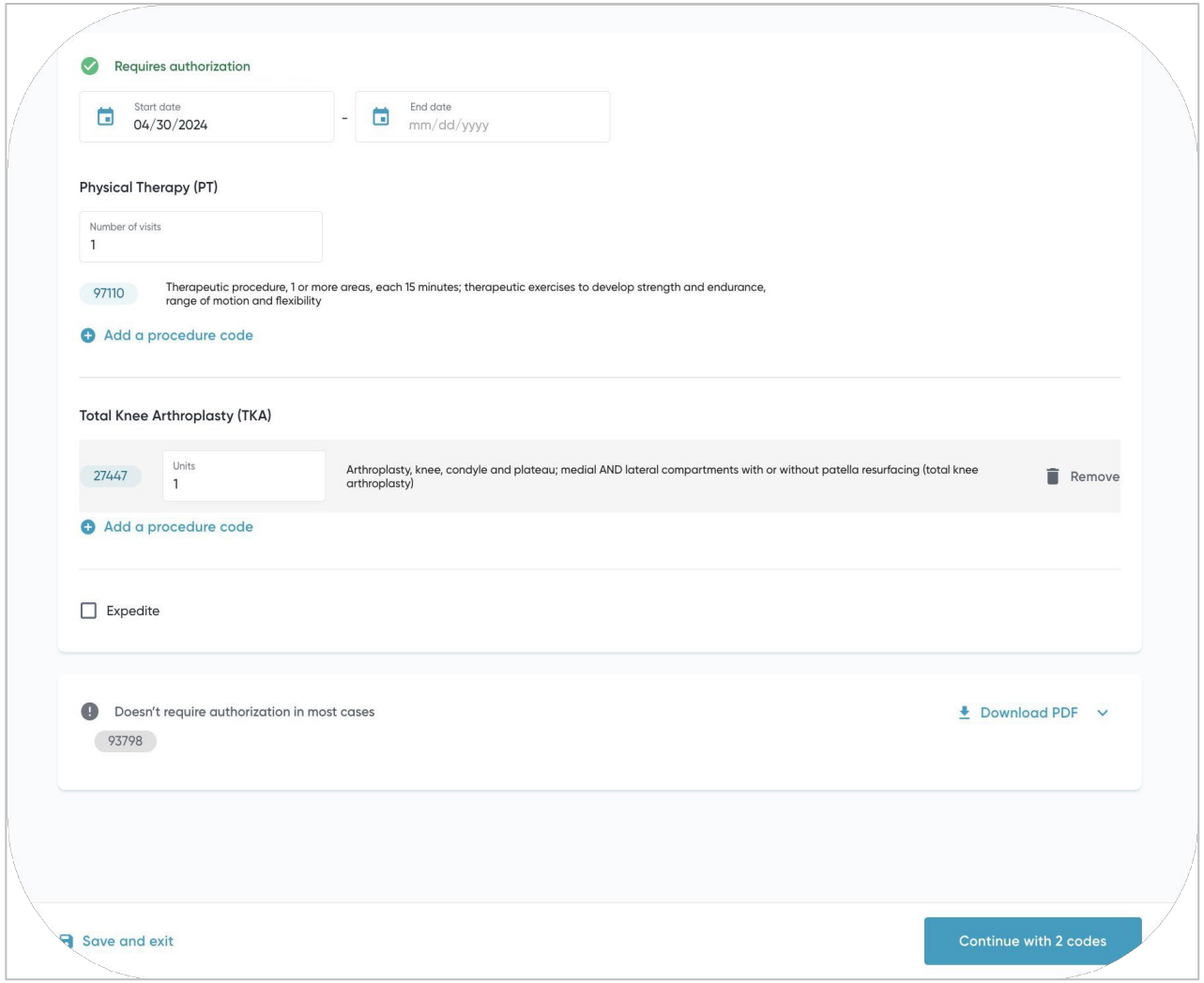
Cohere – Determination of Authorization Requirements

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



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

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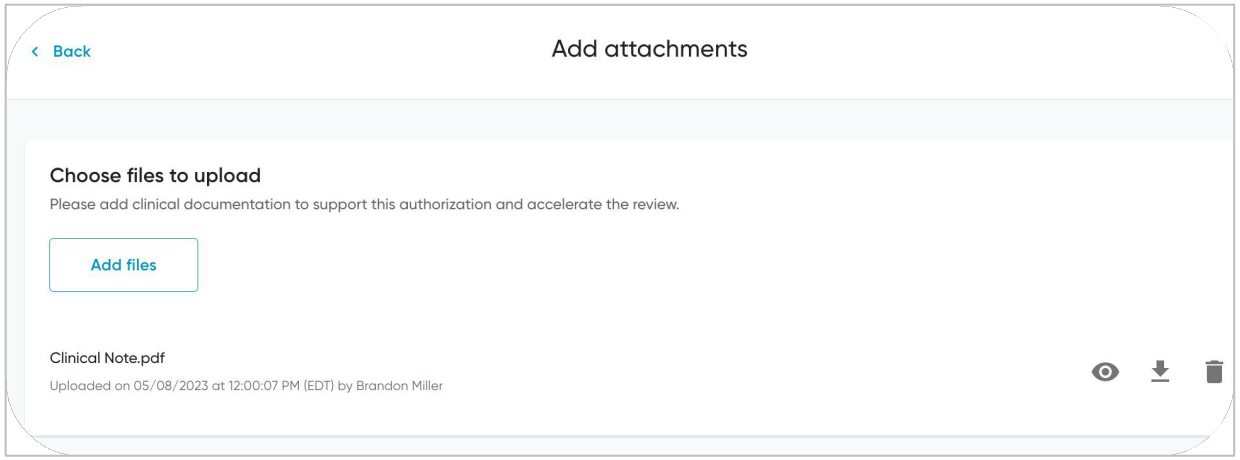
Cohere – Clinical Documentation

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



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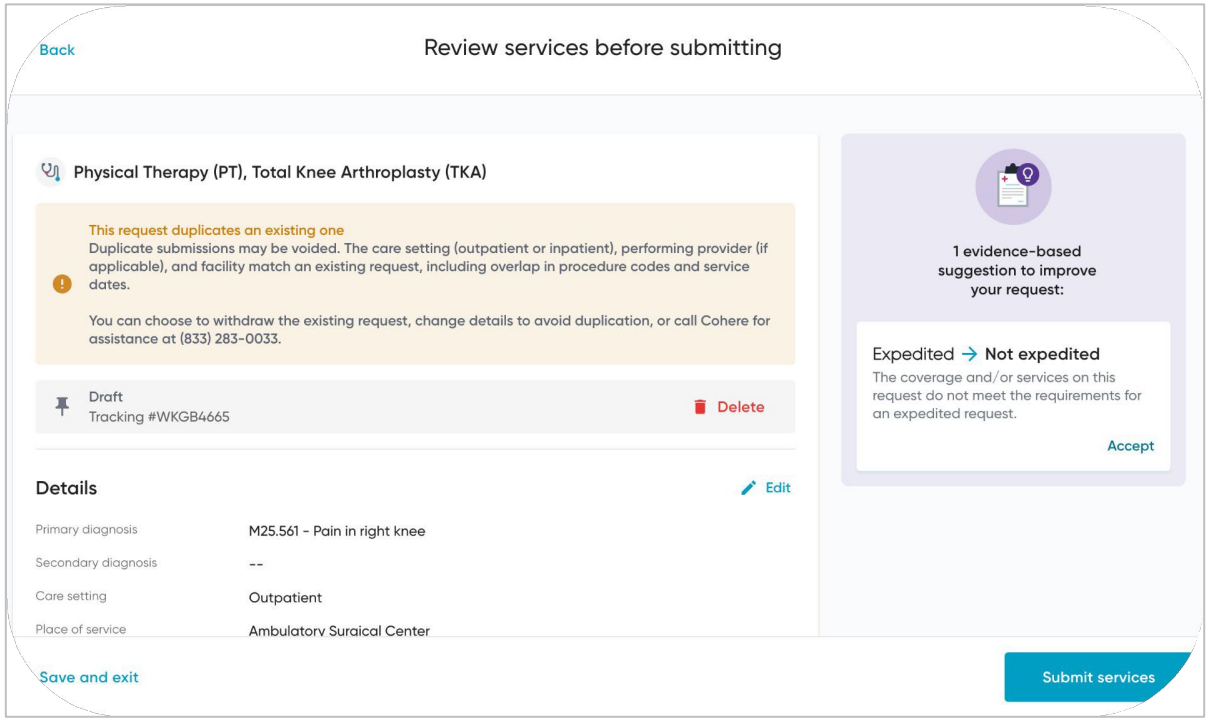
Cohere – Submitting Request

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



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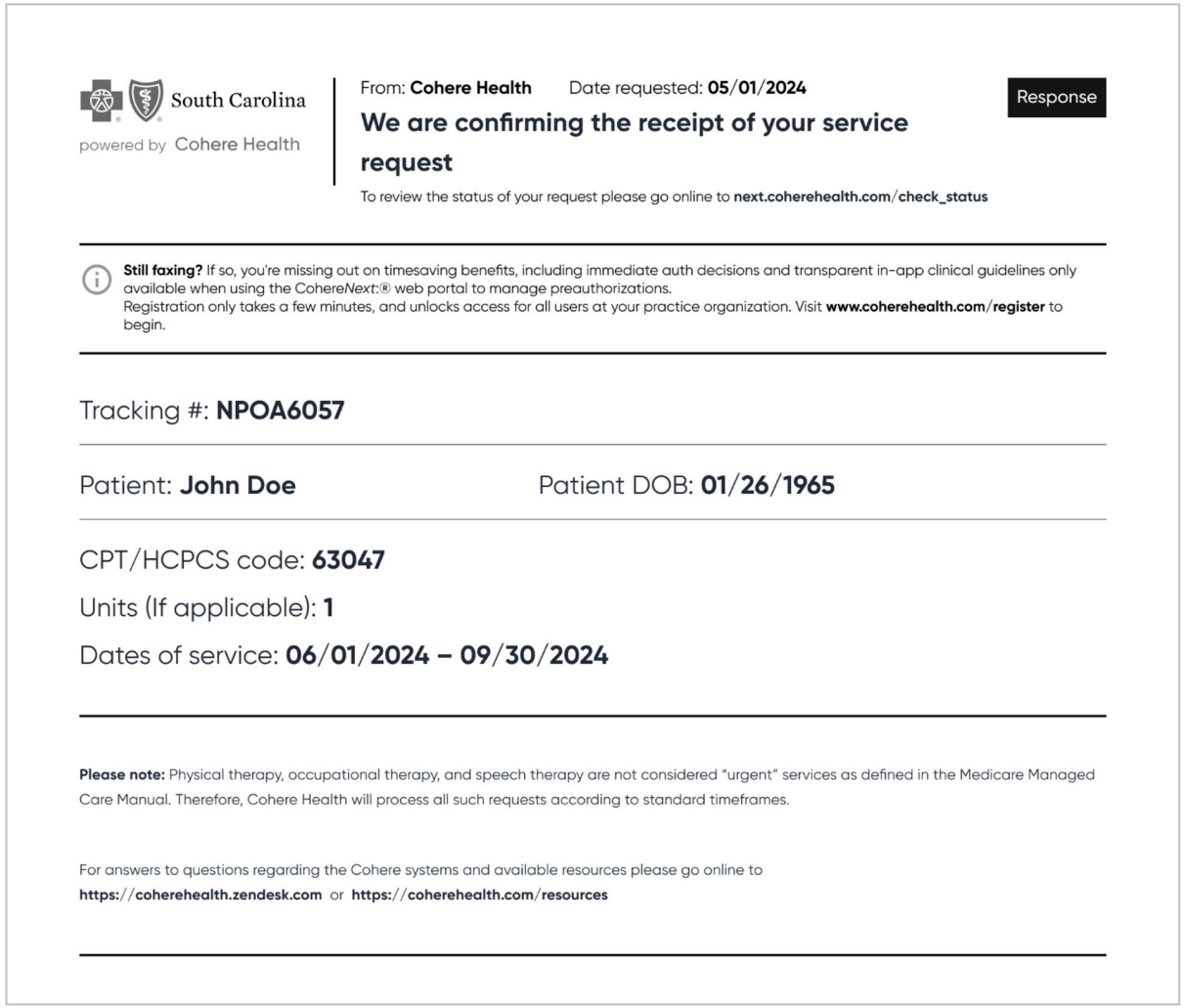
Cohere – Confirmation

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



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

Response

We are confirming the receipt of your service request

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

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

Tracking #: **NPOA6057**

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

CPT/HCPCS code: **63047**

Units (If applicable): **1**

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

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

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

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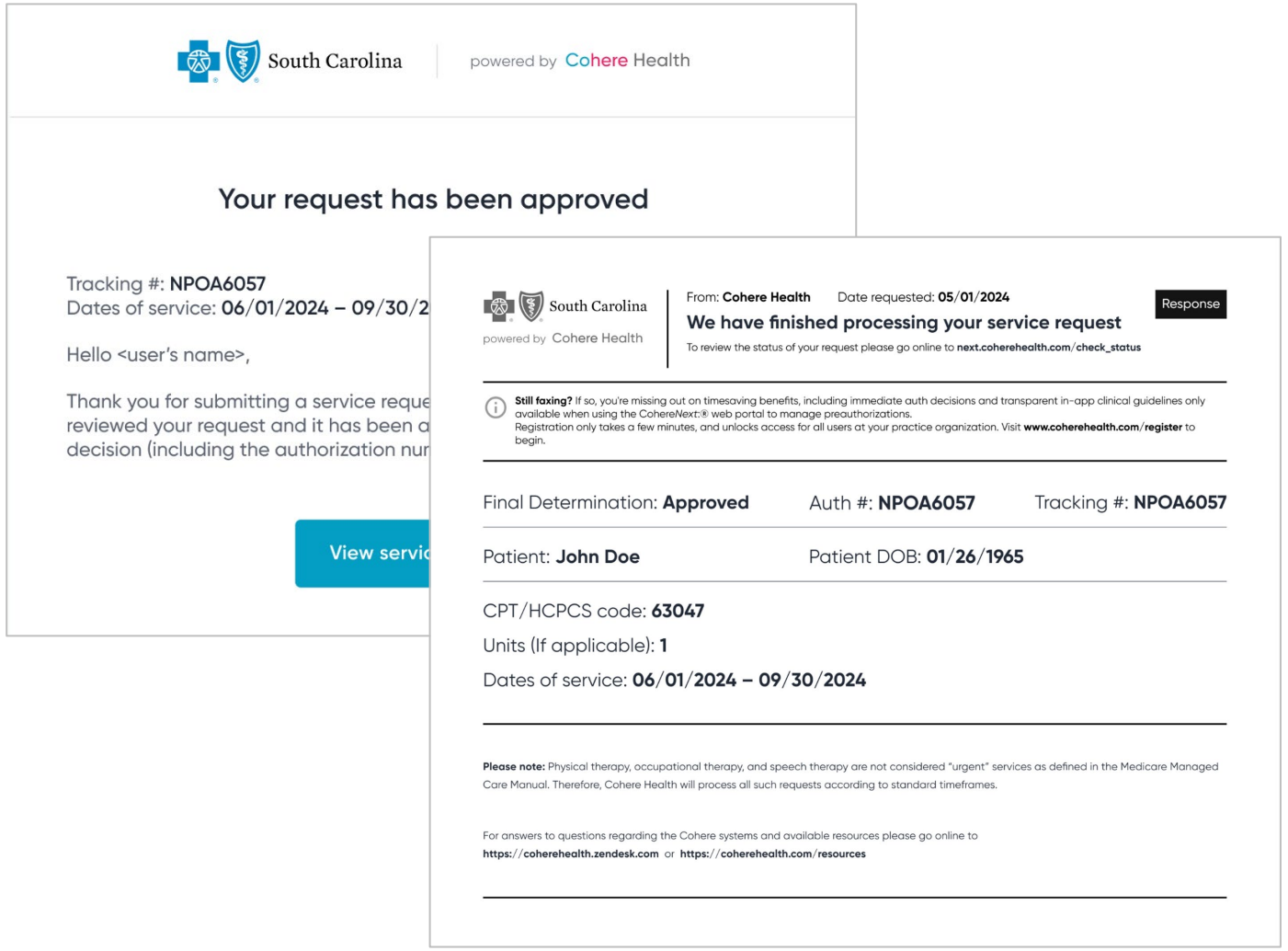
Cohere – Notification

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



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

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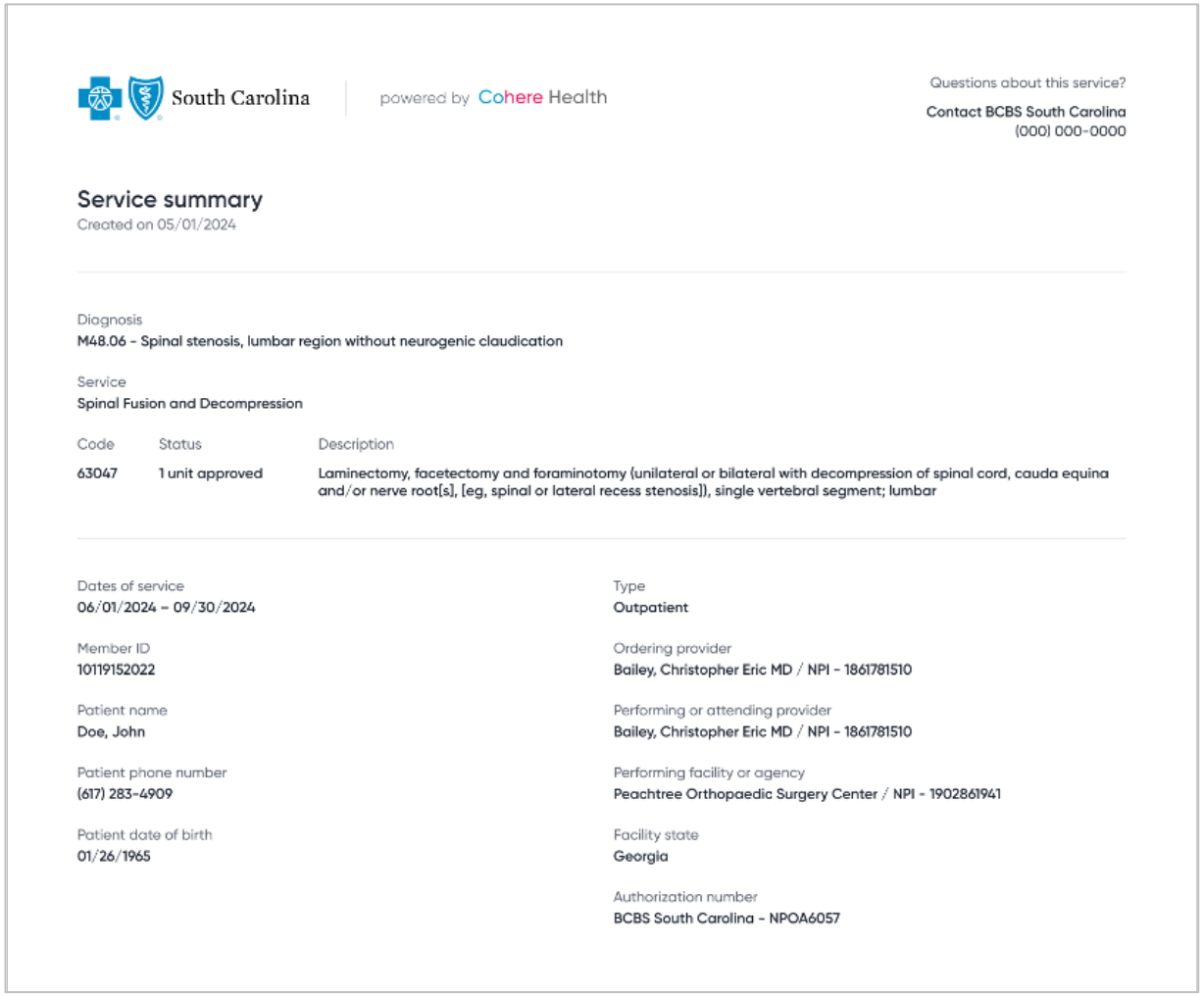
Cohere – Service Summary

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



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

Service summary

Created on 05/01/2024

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

Service
Spinal Fusion and Decompression

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

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

Member ID
10119152022

Patient name
Doe, John

Patient phone number
(617) 283-4909

Patient date of birth
01/26/1965

Type
Outpatient

Ordering provider
Bailey, Christopher Eric MD / NPI - 1861781510

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

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

Facility state
Georgia

Authorization number
BCBS South Carolina - NPOA6057

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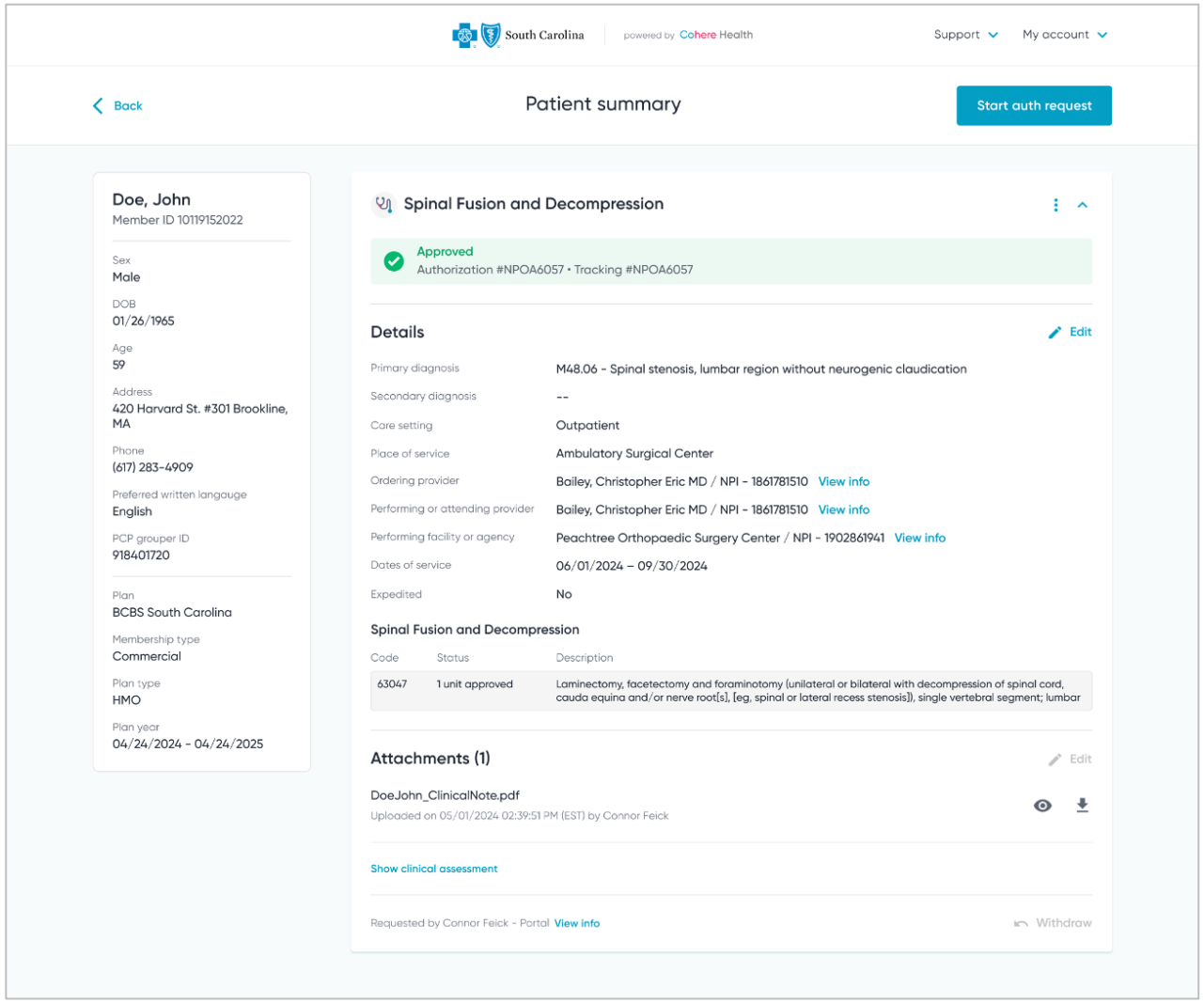
Cohere – Patient Summary

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



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Benefits

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Topics to Discuss

- 2026 Benefit Updates
  - State Health Plan
  - Federal Employee Program
  - BlueChoice® HealthPlan
  - Medicare Advantage
  - Group and Individual
- Benefit Reminders
- Available Resources
- My Insurance Manager℠
  - Benefits and Eligibility

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2026 Benefit Updates

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State Health Plan

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State Health Plan – Standard Plan

Standard Plan	2025	2026
Deductibles		
Individual	$515	No change
Family	$1,030	No change
Coinsurance Maximum		
Individual (INN)	$3,000	No change
Family (INN)	$6,000	No change
Individual (OON)	$6,000	No change
Family (OON)	$12,000	No change
Services		
Office visits	$15 copay	No change
Outpatient facility	$115 copay	No change
Inpatient hospitalization	Full allowance until the deductible is met. Then, the coinsurance.	No change
Emergency room	$193 copay	No change

INN: In network; OON: Out-of-network

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State Health Plan – Savings Plan

Savings Plan	2025	2026
Deductibles		
Individual	$4,000	No change
Family	$8,000	No change
Coinsurance Maximum		
Individual (INN)	$3,000	No change
Family (INN)	$6,000	No change
Individual (OON)	$6,000	No change
Family (OON)	$12,000	No change
Services		
Office visits	Full allowance until the deductible is met. Then, the coinsurance.	No change
Outpatient facility	Full allowance until the deductible is met. Then, the coinsurance.	No change
Inpatient hospitalization	Full allowance until the deductible is met. Then, the coinsurance.	No change
Emergency room	Full allowance until the deductible is met. Then, the coinsurance.	No change

State Health Plan Authorizations

- **Medical Services**
  - Medi-Call: 800-925-9724
- **Advanced Radiology**
  - Evolent: 866-500-7664
- **Behavioral Health**
  - Companion Benefit Alternatives: 800-868-1032
- **Pharmacy Specialty Drug**
  - Caremark: 833-291-3646
- **Medical Specialty Drug**
  - MBMNow: 877-440-0089
- **Laboratory Services**
  - Avalon Healthcare Solutions: 844-227-5769

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

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State Health Plan – Additional Information

2026 Changes

- Effective Jan. 1, 2026, Caremark will be the pharmacy benefit manager for State Health plans.
  - Members will receive a new pharmacy card by Dec. 31, 2025.

Sample ID Card

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Federal Employee Program

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Federal Employee Program – Blue Focus Plan

Blue Focus – No out-of-network benefits available.	**2025**	**2026**
Deductibles		
Individual	$500	**$750**
Self – Plus One	$1,000	**$1,500**
Family	$1,000	**$1,500**
Out-of-Pocket Maximum		
Individual	$9,000	**$10,000**
Self – Plus One	$18,000	**$20,000**
Family	$18,000	**$20,000**
Services		
Office visits (Includes primary and/or specialty care combined)	$10 copay (first 10 visits)	No change
Telehealth	$0 copay (first two visits) $10 copay (all additional visits)	No change
Chiropractic care	$25 copay up to 10 visits	No change

Note: For 2026, FEP separated Federal employees and Postal Service employees for all plans.
Visit www.fepblue.org for a full list of benefits.

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Federal Employee Program – Blue Focus Plan (Continued)

Blue Focus – No out-of-network benefits available.	**2025**	**2026**
Services (Continued)		
Urgent care	$25 copay	No change
Hospital care – Inpatient (prior authorization required)	30% COIN + BYD	No change
Hospital care – Outpatient	30% COIN + BYD	No change
ER – Accidental injury (within 72-hours)	$0 copay	No change
ER – Medical emergency	30% COIN + BYD	No change

BYD: Benefit year deductible

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Federal Employee Program – Standard Plan

Standard	2025	2026
Deductibles		
Individual	$350	No change
Family	$700	No change
Out-of-Pocket Maximum		
Individual (INN)	$6,000	No change
Family (INN)	$12,000	No change
Services		
Physician care (INN)	$30 copay (PCP) $40 copay (Specialist)	No change
Telehealth (INN)	$0 copay (first two visits) $10 copay (additional visits)	No change
Urgent care – Accidental injury	$0 copay	No change
Urgent care – Medical emergency	$30 copay	No change

South Carolina

Federal Employee Program – Standard Plan (Continued)

Standard	2025	2026
Services (Continued)		
Preventive care (INN)	$0 copay	No change
Chiropractic care (INN)	$30 copay up to 12 visits	No change
Hospital care – Inpatient (prior authorization required) (INN)	$350 copay Per admission	No change
Hospital care – Outpatient (INN)	15% COINS + BYD	No change
ER – Accidental injury (within 72-hours) (INN)	$0 copay	No change
ER – Medical emergency (INN)	15% COINS + BYD	No change

Federal Employee Program – Basic Plan

Basic	2025	2026
Deductibles		
Individual	$0	No change
Family	$0	No change
Out-of-Pocket Maximum		
Individual (INN)	$7,500	No change
Family (INN)	$15,000	No change
Services		
Physician care	$35 copay (PCP) $50 copay (Specialist)	No change
Telehealth	$0 copay (first two visits) $15 copay (additional visits)	No change
Chiropractic care	$35 copay up to 20 visits	No change
Urgent care	$35 copay	No change

Federal Employee Program – Basic Plan (Continued)

Basic	2025	2026
Services (Continued)		
Preventive care	$0 copay	No change
Hospital care – Inpatient (prior authorization required)	$350 copay, per day Up to $1,750 per admission	**$425 copay, per day** **Up to $2,975 per admission**
Hospital care – Outpatient	$350 copay Per day, per facility	**$425 copay, per day** **Up to $2,975 per admission**
ER – Accidental injury	$350 copay Per day, per facility	**$425 copay** **Per day, per facility**
ER – Medical emergency	$350 copay Per day, per facility	**$425 copay** **Per day, per facility**

South Carolina

Federal Employee Program – Preventive Care

Blue Focus, Standard, and Basic	2025	2026
Adult Preventive Care		
• Colorectal cancer tests, including: – Fecal occult blood test – Colonoscopy, with or without biopsy Sigmoidoscopy – Double contrast barium enema – DNA analysis of stool samples • Prostate cancer tests – Prostate Specific Antigen (PSA) test • Cervical cancer tests (including pap tests) • Screening mammograms (including mammography using digital technology)	Preventive care benefits for each of the following services listed are limited to one per calendar year. Pathology for Sigmoidoscopy and colonoscopy covered at 100% under preventive benefits.	No change

South Carolina

BlueChoice HealthPlan

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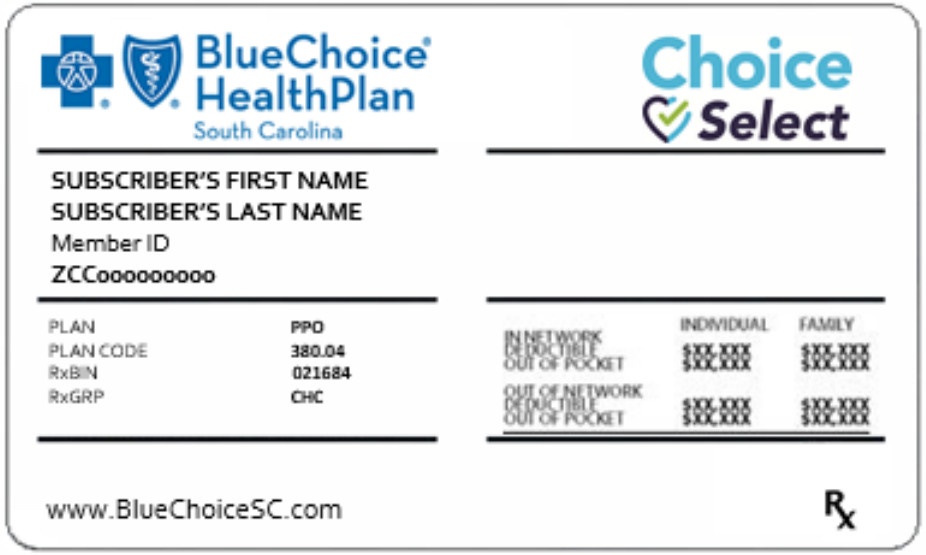
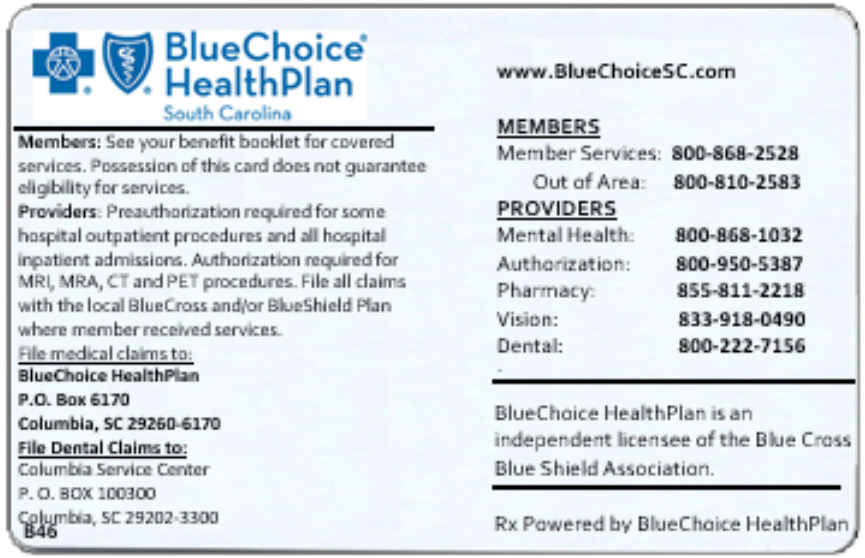
South Carolina

BlueChoice – New HMO Plan

- **Choice Select**
  - New small group for BlueChoice effective Jan. 1, 2026.
  - Members must select a ProActive MD physician within the appropriate network.
  - Referrals are required for specialist visits.
  - The prefix for this plan will be ZCC.

Sample ID Card



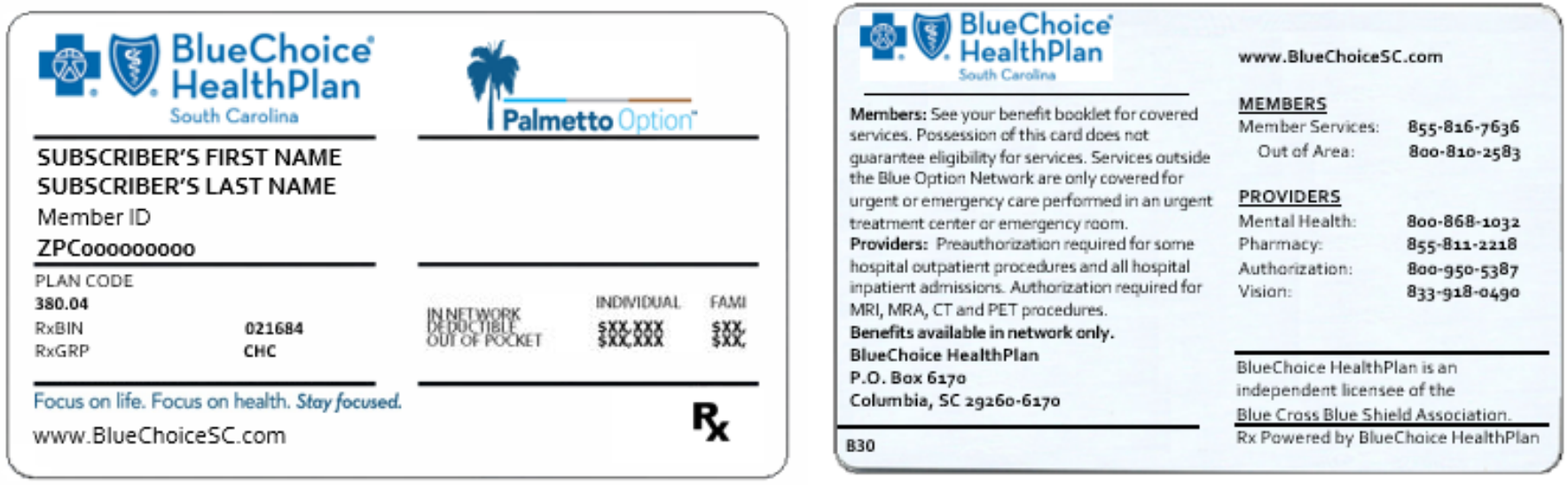


South Carolina

BlueChoice – New EPO Plan

- **Palmetto Option**
  - New Affordable Care Act plan for BlueChoice effective Jan. 1, 2026.
  - Members will not have OON benefits, except for emergent services.
  - Referrals and prior authorization required for specialist visits.
  - The prefix for this plan will be ZPC.

Sample ID Card



South Carolina

BlueChoice – Reminders

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

BlueChoice – Reminders (Continued)

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

South Carolina

Medicare Advantage

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Medicare Advantage – Plan Overview

2026 Plans

- ❑ Blue Basic PPO
- ❑ Total PPO (Lowcountry, Midlands, Upstate)
- ❑ Total Value PPO (Lowcountry, Midlands, Upstate)

South Carolina

Medicare Advantage – BlueCross Total Plan

BlueCross Total	2025	2026
Deductibles		
In-network & Out-of-network	$0	No change
Out-of-Pocket Maximum		
From in-network providers:	$8,900	No change
From in-network & out-of-network providers combined	$13,500	No change
Services		
Physician office visits	INN - $0 copay (PCP) INN - $17 - $47 copay (Specialist) OON - $30 copay (PCP) OON - $50 copay (Specialist)	INN - $0 copay (PCP) **INN - $35 copay (Specialist)** OON - $30 copay (PCP) **OON - $55 copay (Specialist)**
Inpatient hospital – Acute	INN - $450 copay, per day (1-2) INN - $0 copay, per day (3-90) OON - 40% COINS for total stay	**INN - $425 copay, per day (1-3)** **INN - $0 copay, per day (4-90)** OON - 40% COINS for total stay
Inpatient hospital – Psychiatric	INN - $675 copay, per day (1-3) INN - $0 copay, per day (4-90) OON - 40% COINS for total stay	**INN - $690 copay, per day (1-3)** INN - $0 copay, per day (4-90) OON - 40% COINS for total stay

South Carolina

Medicare Advantage – BlueCross Total Plan (Continued)

BlueCross Total	2025	2026
Services (Continued)		
Skilled nursing facility (SNF) (100 benefit day max, per year)	INN - $0 (days 1-20) INN - $214 copay (days 21-100) OON - 40% COINS for total stay	INN - $0 (days 1-20) **INN - $218 copay (days 21-100)** OON - 40% COINS for total stay
Urgently needed services	INN & OON - $10 copay, per visit Outside of USA - $45 copay, per visit	No change
Worldwide Emergency/Urgent Coverage	$250 service specific deductible, then 20% COINS for emergency care outside the United States	No change
Ambulance services (Ground or air)	INN & OON - $295 copay, per trip	**INN & OON - $350 copay, per trip**
Hearing aids	$699-$999 using TruHearing Two per year (one per ear)	No change
Preventive dental (Fluoride treatment not covered)	INN - $0 copay (two visits, per year) OON - 50% COINS $4,500 maximum (combined)	INN - $0 copay (two visits, per year) OON - 50% COINS **$2,500 maximum (combined)**
Comprehensive dental (Medicare covered services)	INN - $50 copay OON - $50 copay $4,500 maximum (combined)	INN - $50 copay OON - $50 copay **$2,500 maximum (combined)**
Comprehensive dental (non-covered Medicare services)	INN & OON - 50% COINS $4,500 maximum (combined)	INN & OON - 50% COINS **$2,500 maximum (combined)**

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

South Carolina

Medicare Advantage – BlueCross Total Value Plan

BlueCross Total Value	2025	2026
Deductibles		
In-network & Out-of-network	$0	No change
Out-of-Pocket Maximum		
In-network	$9,350	**$9,250**
Out-of-network	$14,000	**$13,900**
Services		
Physician office visits	INN - $0 copay (PCP) INN - $17 - $47 copay (Specialist) OON - $40 copay (PCP) OON - $55 copay (Specialist)	INN - $0 copay (PCP) **INN - $45 copay (Specialist)** OON - $40 copay (PCP) OON - $55 copay (Specialist)
Inpatient hospital – Acute	INN - $465 copay per day (1-2) INN - $0 copay, per day (3-90) OON - 40% COINS for total stay	**INN - $425 copay per day (1-4)** **INN - $0 copay, per day (5-90)** OON - 40% COINS for total stay
Inpatient hospital – Psychiatric	INN - $675 copay, per day (1-3) INN - $0 copay, per day (4-90) OON – 50% COINS for total stay	**INN - $690 copay, per day (1-3)** INN - $0 copay, per day (4-90) OON – 50% COINS for total stay

South Carolina

Medicare Advantage – BlueCross Total Value Plan (Continued)

BlueCross Total Value	2025	2026
Services (Continued)		
Skilled nursing facility (SNF) (100 benefit day max, per year)	INN - $0 (days 1-20) INN - $214 copay (days 21-100) OON - 50% COINS for total stay	INN - $0 (days 1-20) **INN - $218 copay (days 21-100)** OON - 50% COINS for total stay
Emergency care	INN & OON - $110 copay, per visit	**INN & OON - $115 copay, per visit**
Worldwide emergency	$250 service specific deductible, then 20% COINS for emergency care outside the United States	No change
Urgent care	INN & OON - $10 copay, per visit Outside of USA - $45 copay, per visit	No change
Ambulance services (Ground or air)	INN - $310 copay, per one-way trip OON - $325 copay, per one-way trip	**INN - $350 copay, per one-way trip** **OON - $365 copay, per one-way trip**
Hearing aids	$699-$999 using TruHearing Two per year (one per ear)	$699-$999 using TruHearing Two per year (one per ear)
Preventive dental	INN - $0 copay (two visits, per year) OON - 50% COINS $3,000 maximum (combined)	INN - $0 copay (two visits, per year) OON - 50% COINS **$1,500 maximum (combined)**
Comprehensive dental (Medicare covered services)	INN - $50 copay OON – 50% COINS $3,000 maximum (combined)	INN - $50 copay OON – 50% COINS **$1,500 maximum (combined)**
Comprehensive dental (non-covered Medicare services)	INN & OON - 50% COINS $3,000 maximum (combined)	INN & OON - 50% COINS **$1,500 maximum (combined)**

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

South Carolina

Medicare Advantage – BlueCross Blue Basic Plan

BlueCross Blue Basic	2025	2026
Deductibles		
In-network & Out-of-network	$0	No change
Out-of-Pocket Maximum		
In-network	$5,900	No change
Out-of-network	$9,550	No change
Services		
Physician office visits	INN - $0 copay (PCP) INN - $30 copay (Specialist) OON - $30 copay (PCP) OON - $45 copay (Specialist)	INN - $0 copay (PCP) **INN - $35 copay (Specialist)** OON - $30 copay (PCP) OON - $45 copay (Specialist)
Inpatient hospital – Acute	INN - $325 copay, per day (1-6) INN - $0 copay, per day (7-90) OON - 20% COINS for total stay	**INN - $325 copay, per day (1-5)** **INN - $0 copay, per day (6-90)** OON - 20% COINS for total stay
Inpatient hospital – Psychiatric	INN - $645 copay, per day (1-3) OON - 20% COINS for total stay	**INN - $690 copay, per day (1-3)** OON - 20% COINS for total stay

South Carolina

Medicare Advantage – BlueCross Blue Basic Plan (Continued)

BlueCross Blue Basic	2025	2026
Services (Continued)		
Skilled nursing facility (SNF)	INN - $0 copay (days 1-20) INN - $214 copay (days 21-100) OON - 20% COINS for total stay	INN - $0 copay (days 1-20) **INN - $218 copay (days 21-100)** OON - 20% COINS for total stay
Urgently needed services	INN & OON - $10 copay Outside of USA - $45 copay, per visit	No change
Emergency care	$110 copay, per visit (Waived if admitted within 24 hours)	**$115 copay, per visit** (Waived if admitted within 24 hours)
Worldwide Emergency/Urgent Coverage	$250 service specific deductible, then 20% COINS for emergency care outside the United States.	No change
Ambulance services (Ground or air)	INN & OON - $275 per trip	No change

South Carolina

Medicare Advantage – BlueCross Blue Basic Plan (Continued)

BlueCross Blue Basic	2025	2026
Services (Continued)		
Hearing Aids	$699-$999 using TruHearing Two per year (one per ear)	No change
Preventive Dental (Fluoride treatment not covered)	INN - $0 copay (Two per year) OON – 50% COINS $3,500 maximum (combined)	INN - $0 copay (Two per year) OON – 50% COINS **$3,000 maximum (combined)**
Comprehensive Dental (Medicare covered services)	INN - $50 copay OON - 50% COINS $3,500 maximum (combined)	INN - $50 copay OON - 50% COINS **$3,000 maximum (combined)**
Comprehensive dental (non-covered Medicare services)	INN & OON - 50% COINS $3,500 benefit maximum (combined)	INN & OON - 50% COINS **$3,000 benefit maximum (combined)**

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

South Carolina

Medicare Advantage – Preventive Care

All Plans (Total, Total Value, & Blue Basic)	**2025**	**2026**
Services		
Annual wellness visit/Annual physical	$0 Copay	No change
Lab work	$0 Copay	No change
Preventive screenings: • Colorectal cancer screening • Breast cancer screening • Bone mineral density tests • Diabetic eye exam • Eyeglasses and frames • Glaucoma screening	$0 Copay	No change

South Carolina

Medicare Advantage Plan Authorizations

- **Medical Services**
  - Use: My Insurance Manager
  - Call: 855-843-2325
- **Behavioral Health**
  - Visit: www.CompanionBenefitAlternatives.com
  - Call: 833-971-4075
- **Laboratory Services**
  - Use: My Insurance Manager
  - Call: 844-227-5769
- **DME (in the home setting), Home Health and Home Infusion Services**
  - Integrated Home Care Services
    - Call: 844-215-4264
    - Fax: 844-215-4265
      - Use one of the appropriate coversheets on the website.

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

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

South Carolina

Medicare Advantage Plan – Value Added Benefits

FitOn Health	Transportation	Over the counter
Post discharge meals	Annual wellness incentive	In-home health assessment award
Routine eye exams and eyewear	Concierge pharmacy services	Member health events

South Carolina

Medicare Advantage Plan – Inflation Reduction Act

For plans with Part D coverage:

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

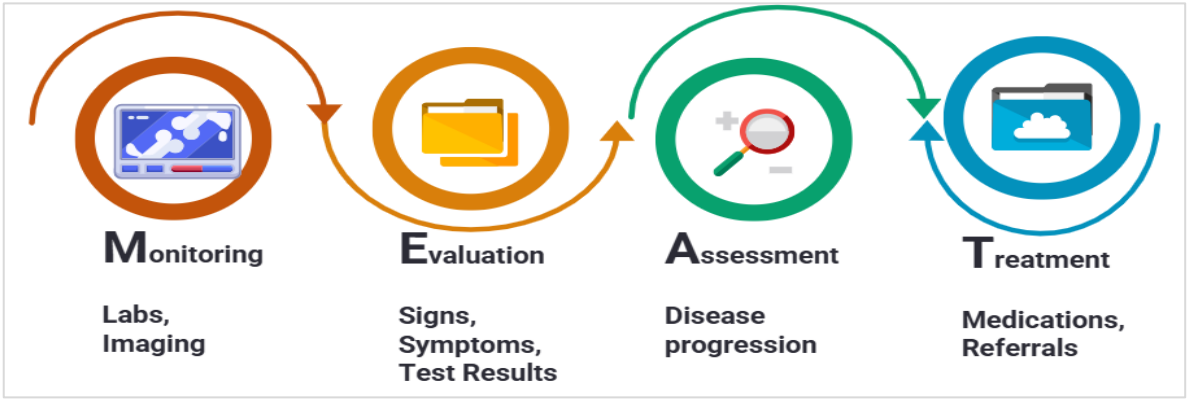
Medicare Advantage Plan – CMS Star Ratings

- Providers are eligible to earn financial incentives for Star rating performance by submitting CPT II codes or by joining a value-based program.
- To best impact Star ratings, providers should:
  - **Schedule** patients for Medicare Annual Wellness Exams annually
  - **Document** all care in the patient's medical records
  - **Code and bill** appropriately for services rendered and conditions addressed
  - **Promote** medication adherence
  - **Recommend** formulary alternatives, when necessary
  - **Recommend** participation in disease management programs
  - **Respond** to medical record requests (within five business days)

CMS: Centers for Medicaid and Medicare Services

Medicare Advantage Plan – Chronic Conditions

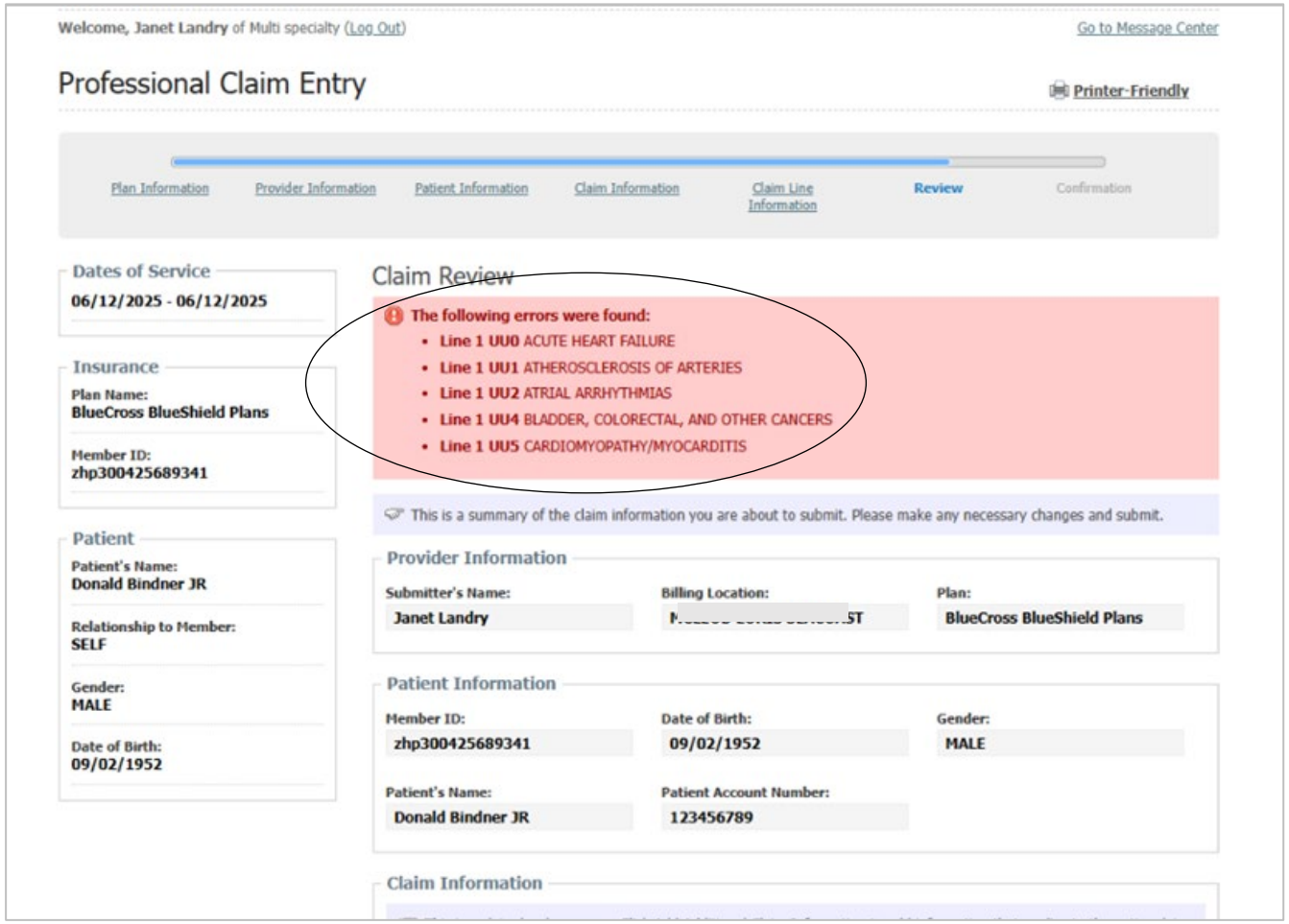
- To ensure the full health status of the member is captured correctly, BlueCross will soon implement a new alert in the claim system to notify providers when chronic conditions are missing for a patient.
- **Key action**: Providers should review the patient record and resubmit the claim appropriate documentation.
- More information will be shared with providers when the alerts are live in the system.



South Carolina

Medicare Advantage Plan – Upcoming HCC Changes

- Once the alerts go live, the claims system will compare claims submissions to the patient's historical profile to determine whether a hierarchical category condition (HCC) code is missing.
- Error codes will start with a "UU".
- In the example, it shows heart failure, bladder, colorectal and other conditions are missing.



South Carolina

Medicare Advantage Plan – Network Sharing

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

Tips for accuracy:

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

South Carolina

Medicare Advantage Plan – General Reminders

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

South Carolina

Benefit Reminders

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Network Participating Providers

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

Appointment Availability Standards

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

Available Resources

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2026 Annual Provider Summit

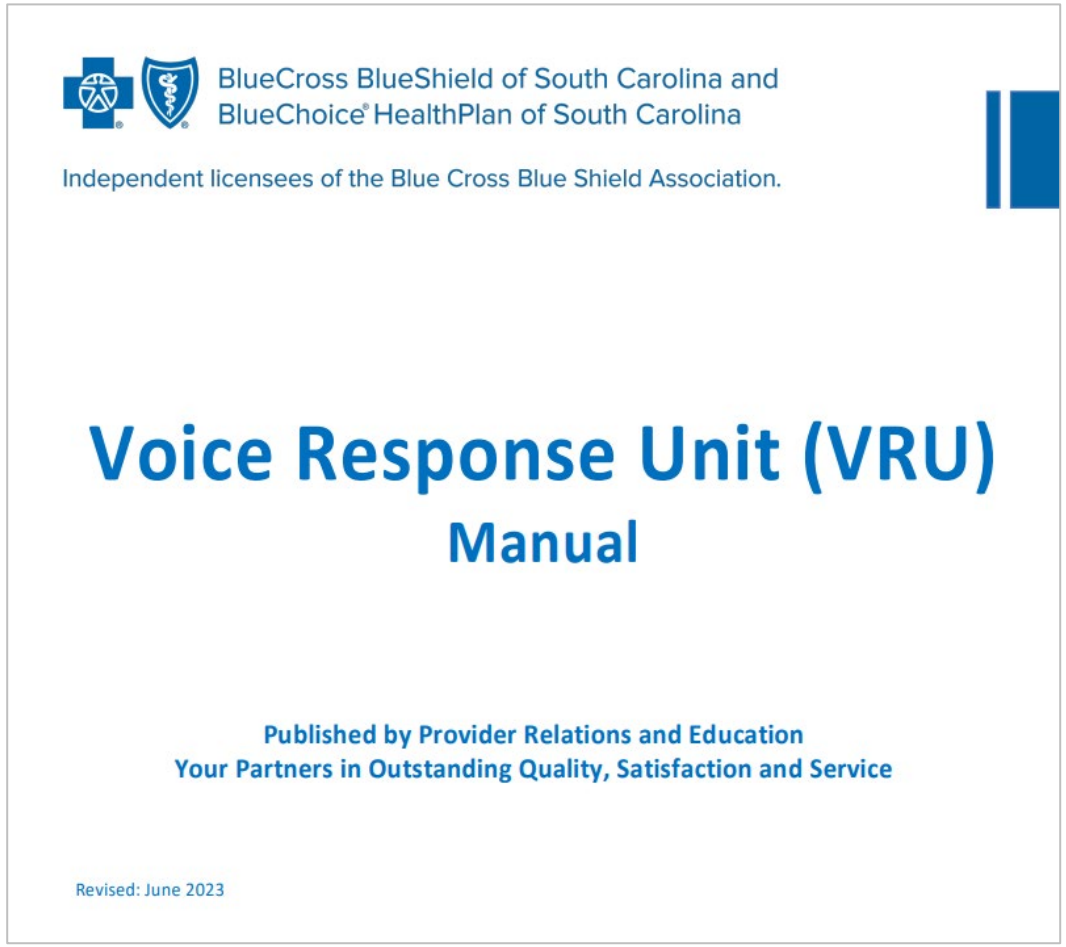
South Carolina

Getting Benefits Through the Voice Response Unit

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

Getting Benefits Through the Voice Response Unit (Continued)

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



South Carolina

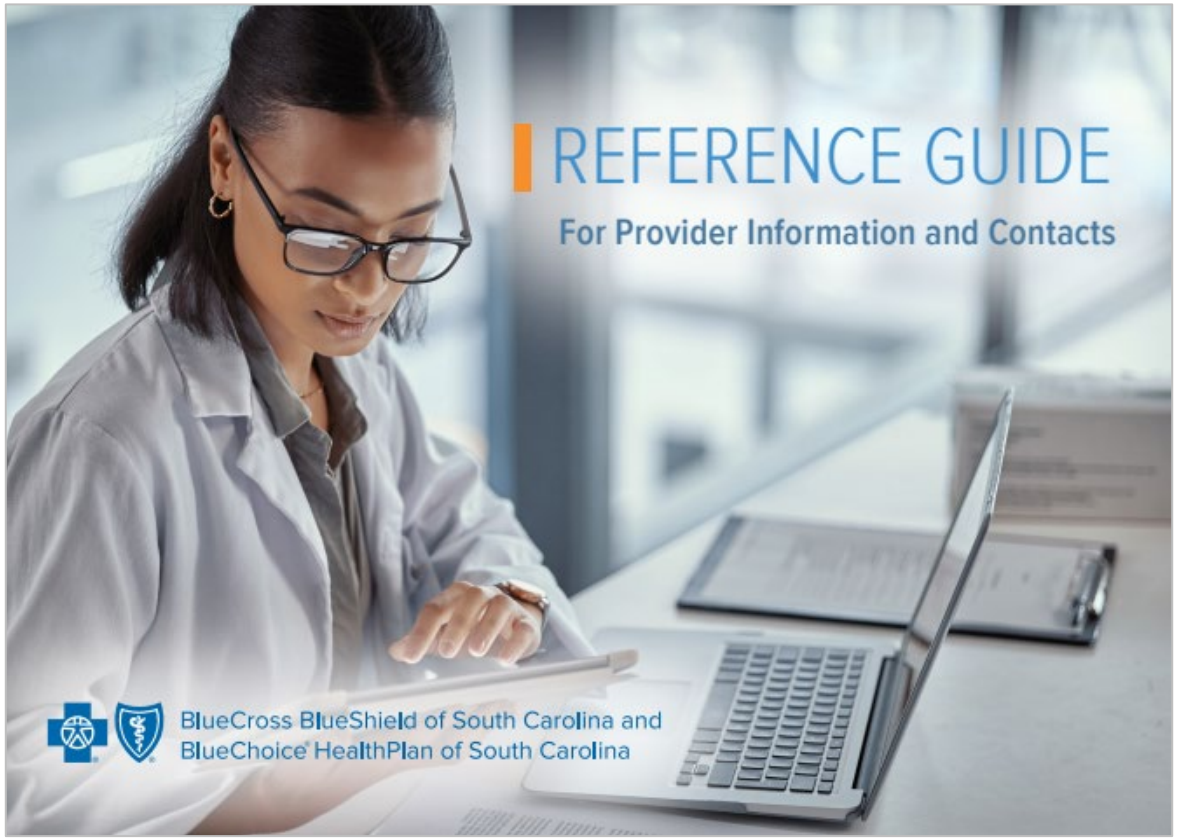
Member ID Card Guide

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

South Carolina

Quick Reference Guide

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



South Carolina

My Insurance Manager

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Benefits and Eligibility

Your Complete Solution

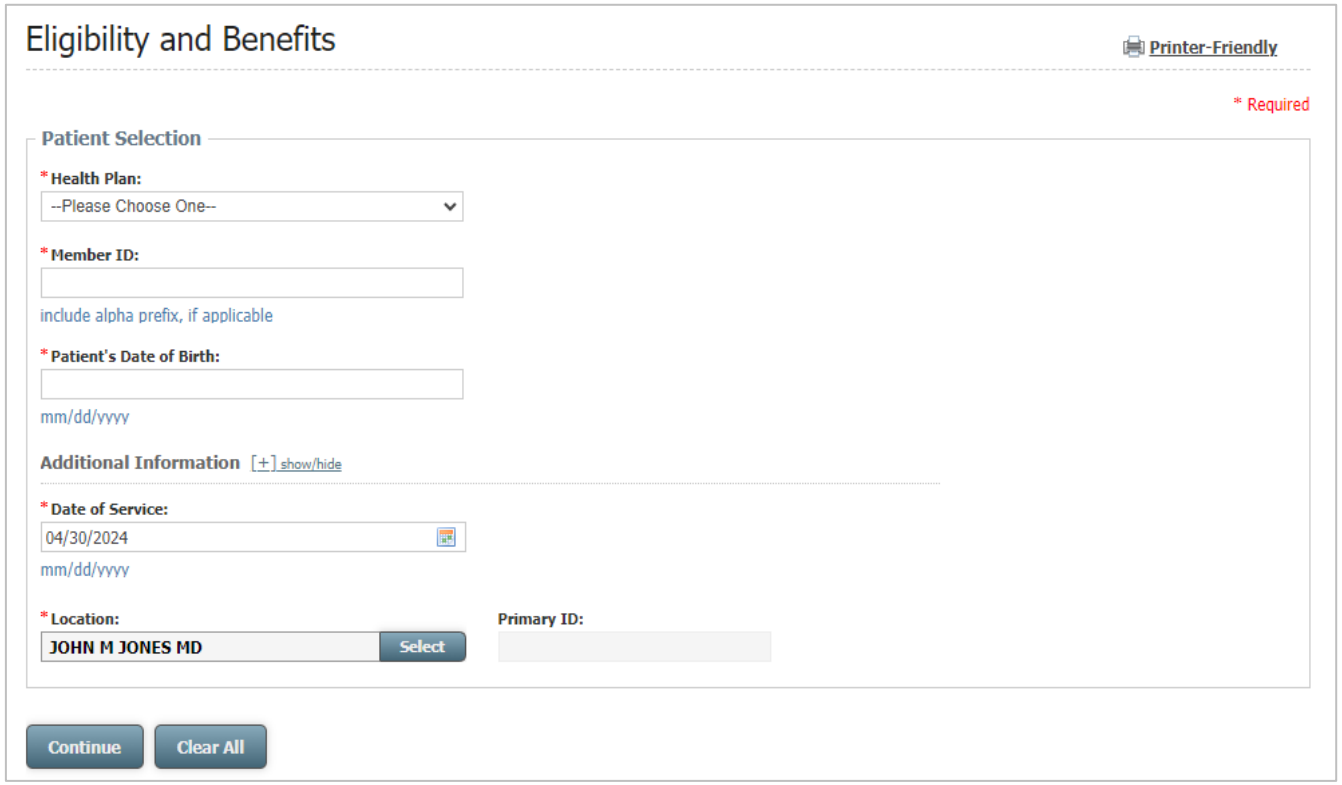
2026 Annual Provider Summit

South Carolina

Getting Benefits in My Insurance Manager

Step 1

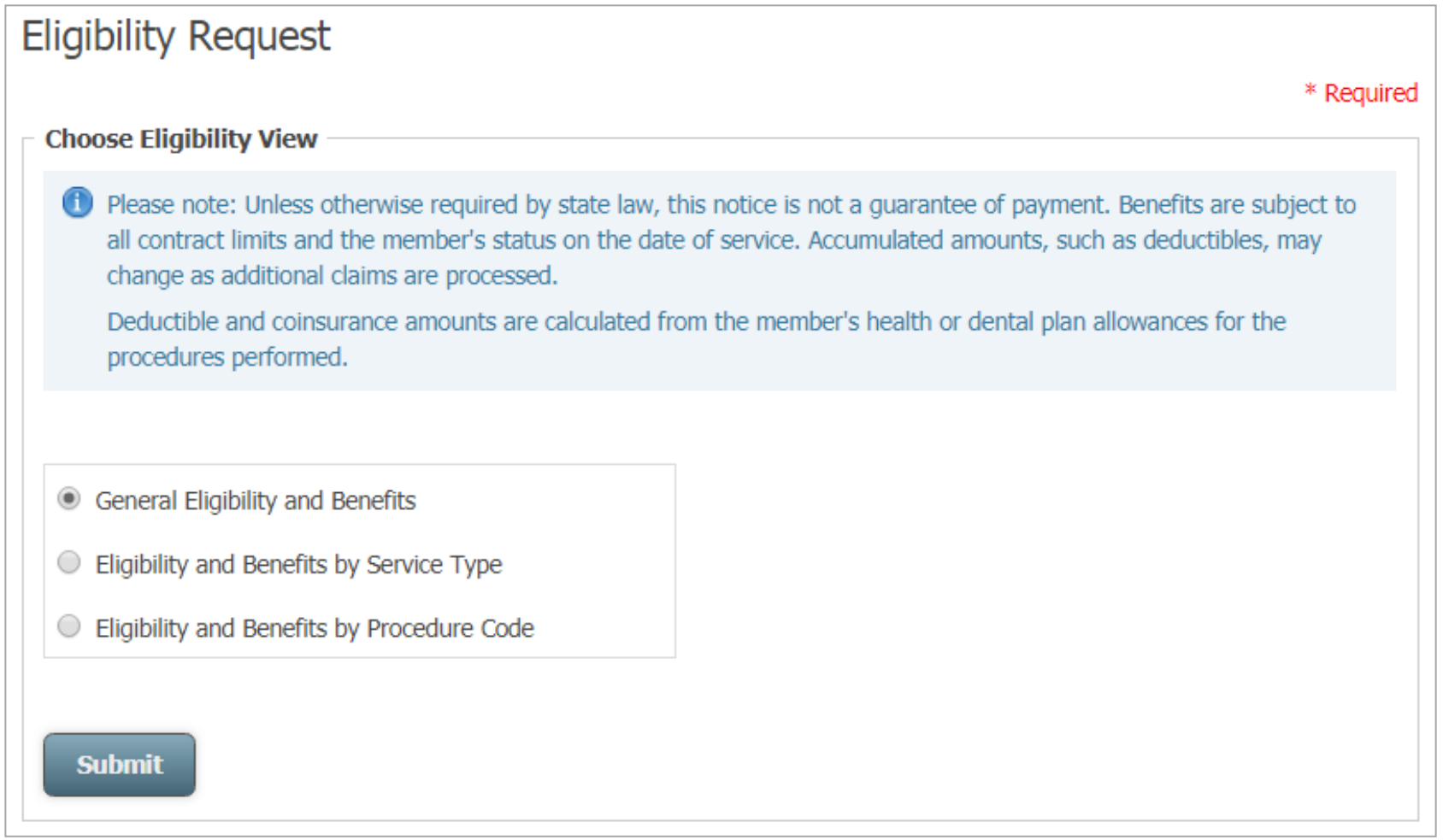
Step 2



South Carolina

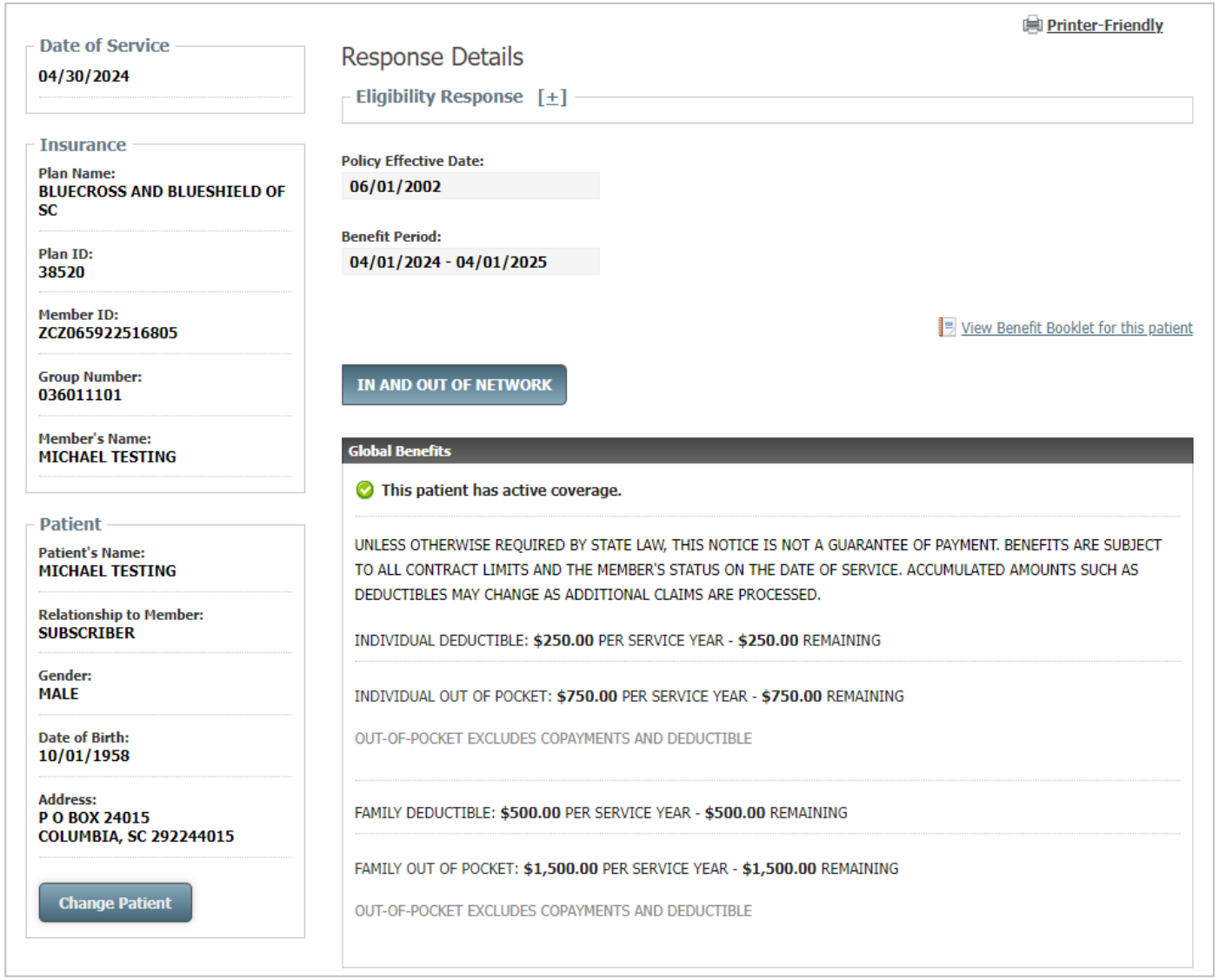
Getting Benefits in My Insurance Manager – General Benefits

Step 3 (*When pulling general benefits.*)



South Carolina

Getting Benefits in My Insurance Manager – General Benefits



Printer-Friendly

Date of Service
04/30/2024

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

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

Change Patient

Response Details

Eligibility Response [+]

Policy Effective Date: 06/01/2002

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

View Benefit Booklet for this patient

IN AND OUT OF NETWORK

Global Benefits

This patient has active coverage.

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

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

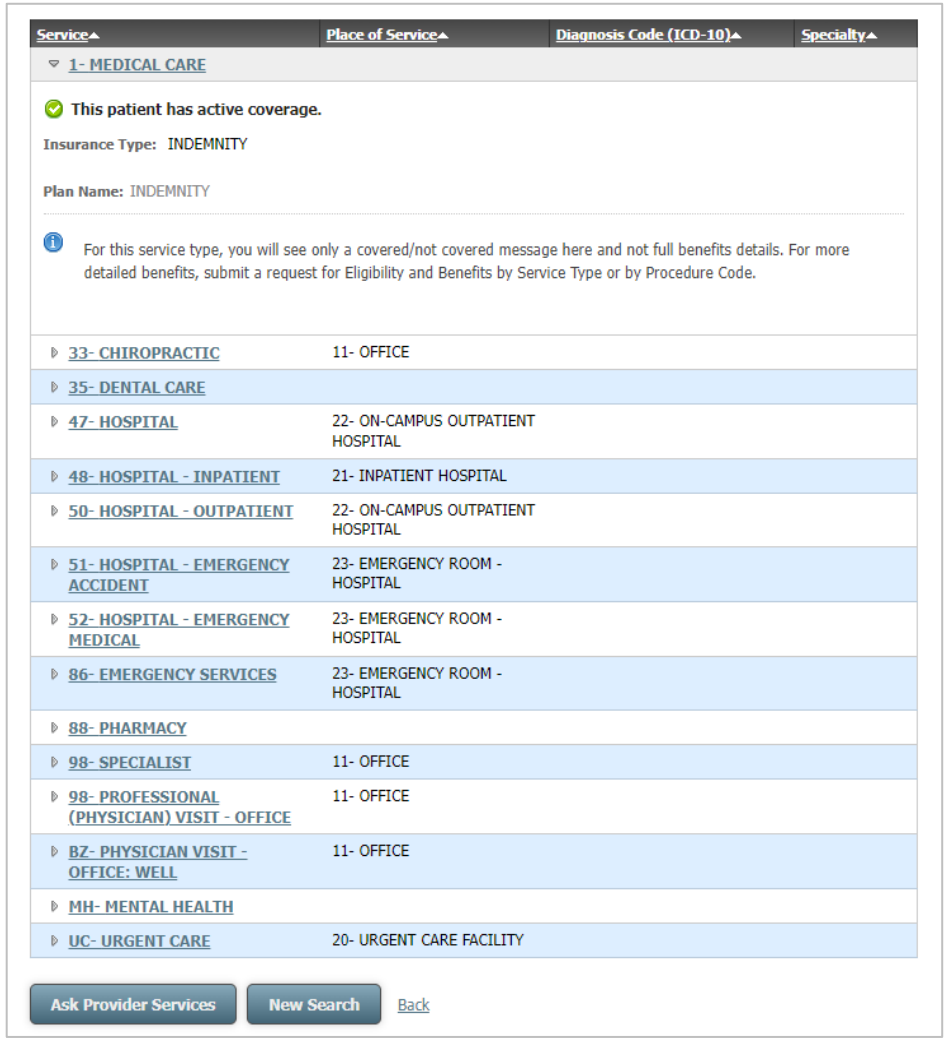
INDIVIDUAL OUT OF POCKET: **$750.00** PER SERVICE YEAR - **$750.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

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

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

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE



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

This patient has active coverage.

Insurance Type: INDEMNITY

Plan Name: INDEMNITY

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

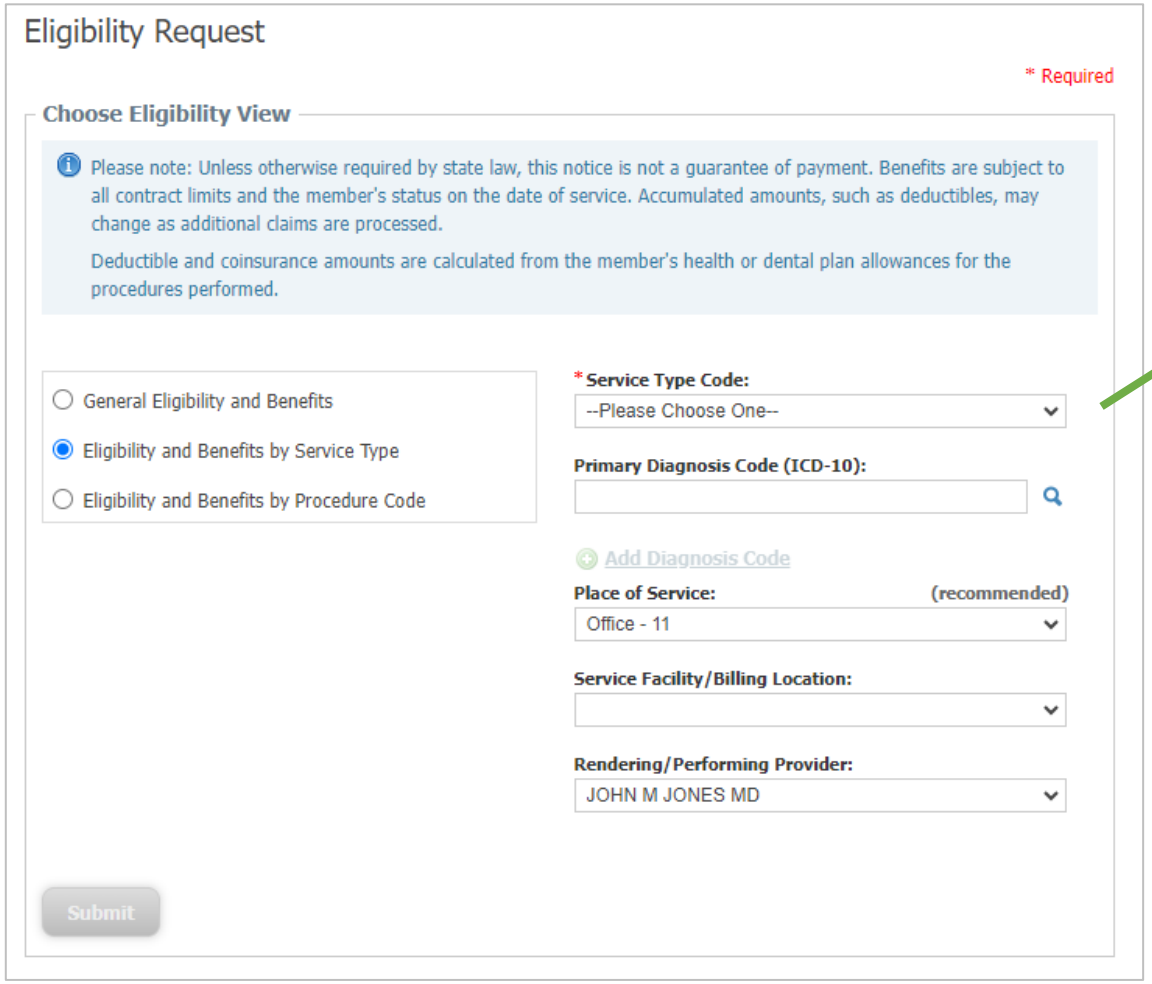
33- CHIROPRACTIC	11- OFFICE
35- DENTAL CARE	
47- HOSPITAL	22- ON-CAMPUS OUTPATIENT HOSPITAL
48- HOSPITAL - INPATIENT	21- INPATIENT HOSPITAL
50- HOSPITAL - OUTPATIENT	22- ON-CAMPUS OUTPATIENT HOSPITAL
51- HOSPITAL - EMERGENCY ACCIDENT	23- EMERGENCY ROOM - HOSPITAL
52- HOSPITAL - EMERGENCY MEDICAL	23-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

Ask Provider Services | New Search | Back

South Carolina

Getting Benefits in My Insurance Manager – Service Type

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



Other Service Types

ABORTION - 84
ACUPUNCTURE - 64
AIDS - 85
AIR TRANSPORTATION - 57
ALCOHOLISM - AJ
ALLERGY - GY
ALLERGY TESTING - 79
ALTERNATE METHOD DIALYSIS - 15
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BRAND NAME PRESCRIPTION DRUG - NON-FORMULARY - B3
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Brand Name Prescription Drug - Formulary - B2
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South Carolina

Getting Benefits in My Insurance Manager – Service Type

Printer-Friendly

Date of Service
04/30/2024

Insurance
Plan Name:
BLUECROSS AND BLUESHIELD OF SC

Plan ID:
38520

Member ID:
ZCZ065922516805

Group Number:
036011101

Member's Name:
MICHAEL TESTING

Patient
Patient's Name:
MICHAEL TESTING

Relationship to Member:
SUBSCRIBER

Gender:
MALE

Date of Birth:
10/01/1958

Address:
P O BOX 24015
COLUMBIA, SC 292244015

Change Patient

Response Details

Eligibility Response [+]

Policy Effective Date:
06/01/2002

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

View Benefit Booklet for this patient

IN AND OUT OF NETWORK

Global Benefits

This patient has active coverage.

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

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

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

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

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

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

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

Service	Place of Service	Diagnosis Code (ICD-10)	Specialty
50- HOSPITAL - OUTPATIENT	22- ON-CAMPUS OUTPATIENT HOSPITAL		

This patient has active coverage.

Insurance Type: INDEMNITY

Plan Name: INDEMNITY

THIS MEMBER CURRENTLY HAS AN HSA WITH A PAYMENT OPTION WHICH ALLOWS FOR AUTOMATIC PAYMENT DIRECTLY TO THE PROVIDER. QUALIFIED MEDICAL EXPENSES WITH THE EXCEPTION OF DENIED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT.

RESPONSES TO ALL FUTURE DATED INQUIRIES ARE BASED ON THE PATIENT'S CURRENT BENEFITS AND ARE SUBJECT TO CHANGE.

YOU HAVE REQUESTED BENEFITS FOR A MEMBER THAT HAS BENEFIT EXCEPTIONS AT THE PROCEDURE CODE LEVEL. TO OBTAIN MORE SPECIFIC INFORMATION, PLEASE REQUEST BENEFITS ON MY INSURANCE MANAGER USING A SPECIFIC PROCEDURE CODE AND DIAGNOSIS CODE.

View Additional Messages

INDIVIDUAL COINSURANCE: **15%**

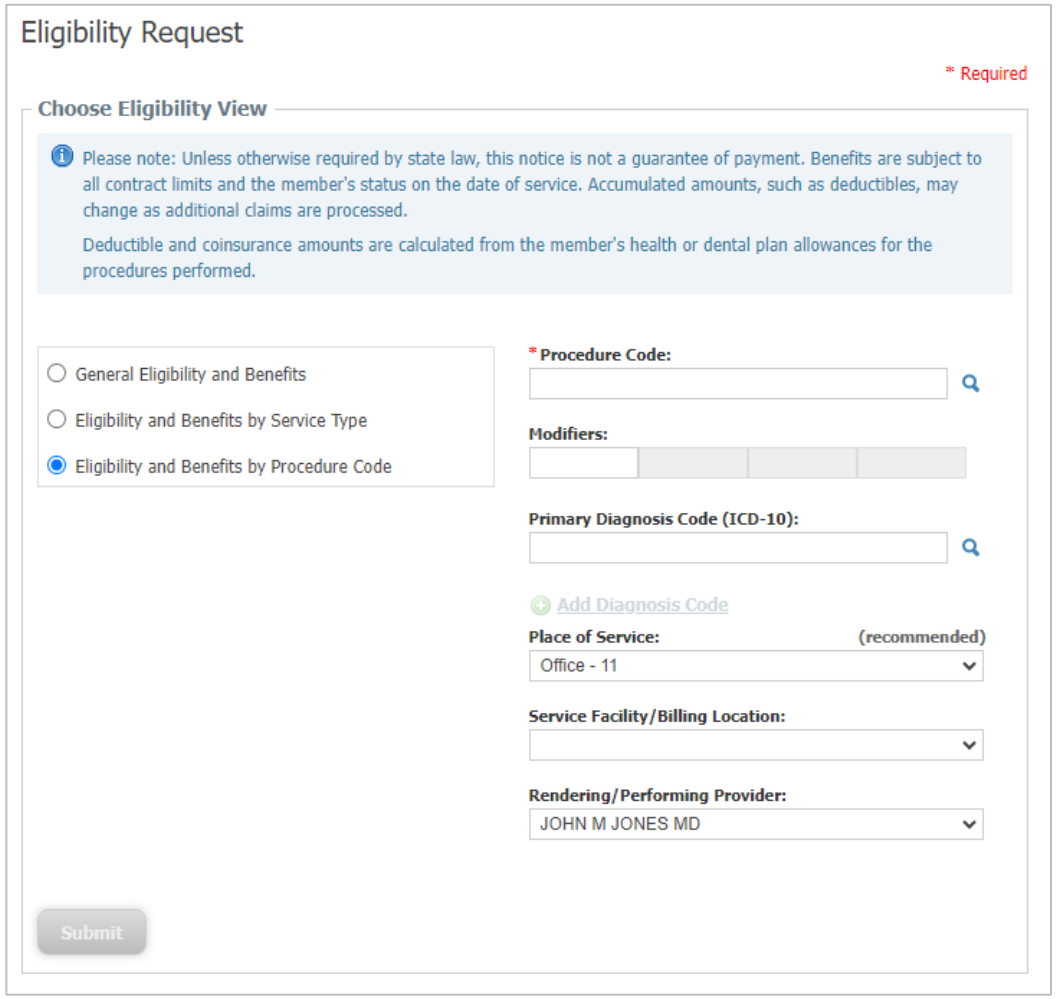
51- HOSPITAL - EMERGENCY ACCIDENT	23- EMERGENCY ROOM - HOSPITAL		
52- HOSPITAL - EMERGENCY MEDICAL	23- EMERGENCY ROOM - HOSPITAL		
A0- PROFESSIONAL (PHYSICIAN) VISIT - OUTPATIENT	22- ON-CAMPUS OUTPATIENT HOSPITAL		

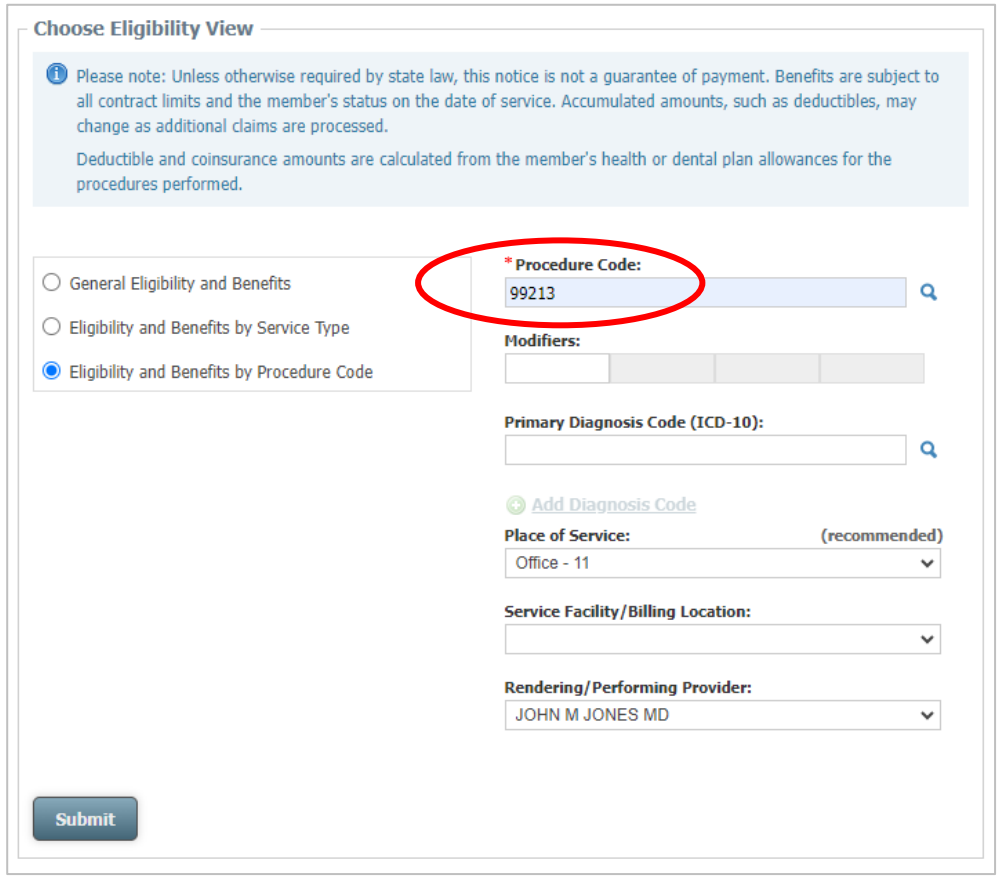
Ask Provider Services | New Search | Back

South Carolina

Getting Benefits in My Insurance Manager – Procedure Code

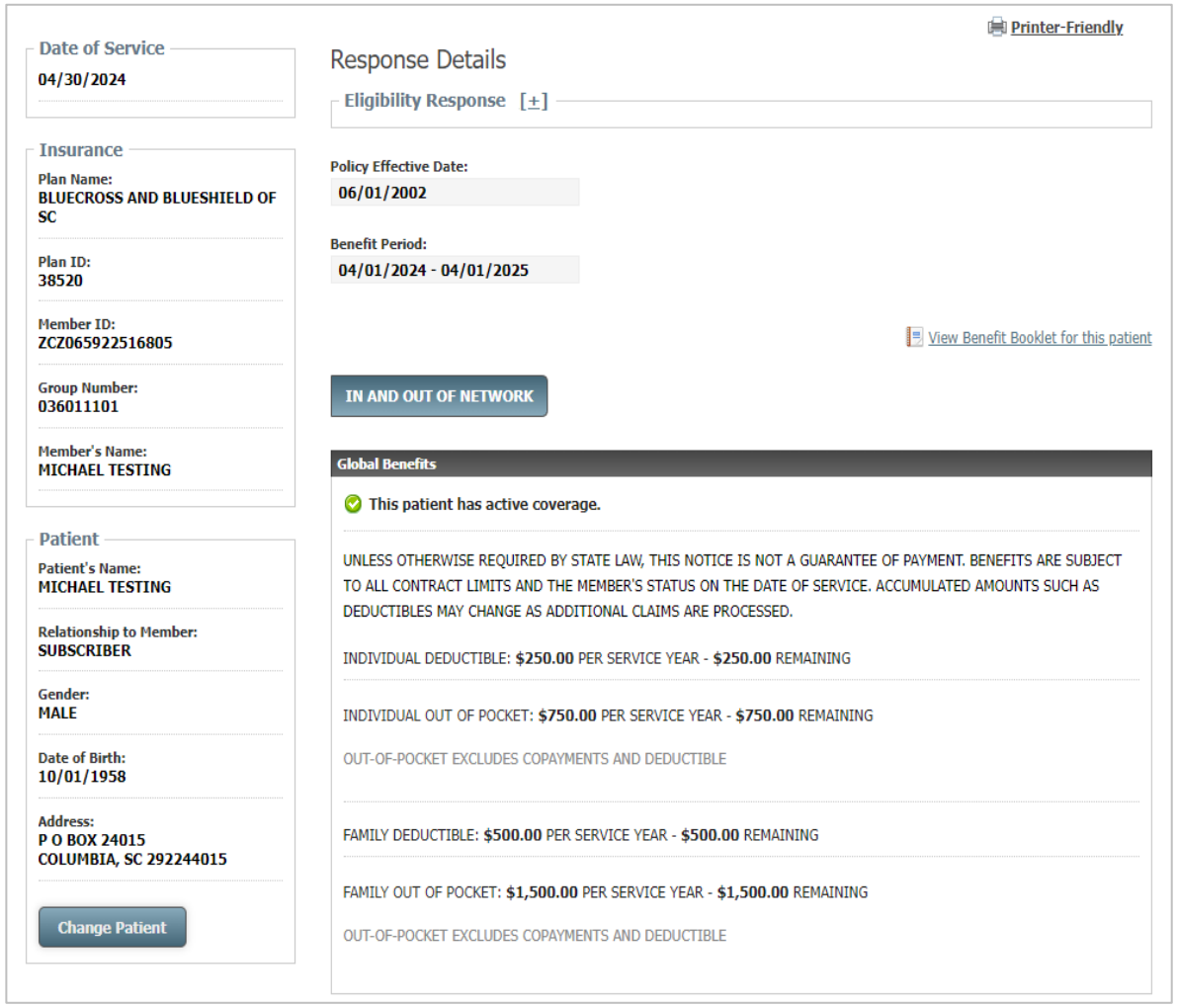
Step 3 (*When pulling benefits by procedure code.*)





South Carolina

Getting Benefits in My Insurance Manager – Procedure Code



Printer-Friendly

Date of Service
04/30/2024

Insurance
Plan Name:
BLUECROSS AND BLUESHIELD OF SC

Plan ID:
38520

Member ID:
ZCZ065922516805

Group Number:
036011101

Member's Name:
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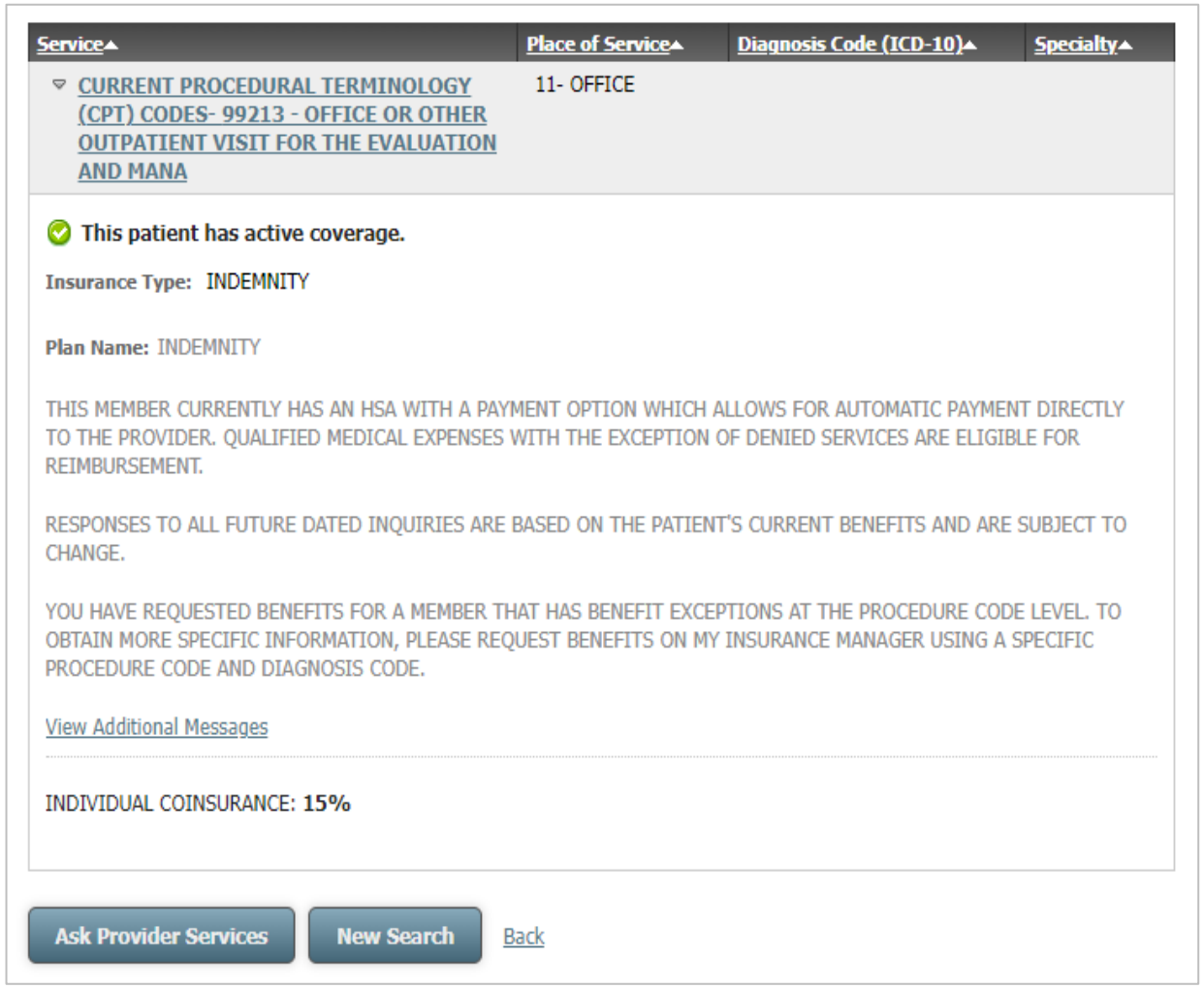


Service	Place of Service	Diagnosis Code (ICD-10)	Specialty
CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES- 99213 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANA	11- OFFICE		

This patient has active coverage.

Insurance Type: INDEMNITY

Plan Name: INDEMNITY

THIS MEMBER CURRENTLY HAS AN HSA WITH A PAYMENT OPTION WHICH ALLOWS FOR AUTOMATIC PAYMENT DIRECTLY TO THE PROVIDER. QUALIFIED MEDICAL EXPENSES WITH THE EXCEPTION OF DENIED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT.

RESPONSES TO ALL FUTURE DATED INQUIRIES ARE BASED ON THE PATIENT'S CURRENT BENEFITS AND ARE SUBJECT TO CHANGE.

YOU HAVE REQUESTED BENEFITS FOR A MEMBER THAT HAS BENEFIT EXCEPTIONS AT THE PROCEDURE CODE LEVEL. TO OBTAIN MORE SPECIFIC INFORMATION, PLEASE REQUEST BENEFITS ON MY INSURANCE MANAGER USING A SPECIFIC PROCEDURE CODE AND DIAGNOSIS CODE.

View Additional Messages

INDIVIDUAL COINSURANCE: **15%**

Ask Provider Services | New Search | Back

South Carolina

South Carolina

Claims

Your Complete Solution

2026 Annual Provider Summit

Topics to Discuss

- Submission of Claims
- Claim Reminders
- Helpful Tips
- My Insurance Manager℠
  - Claims Submission
  - Claims Status
  - Ask Provider Services
  - STATchat℠
- My Remit Manager

South Carolina

Submission of Claims

Your Complete Solution

2026 Annual Provider Summit

South Carolina

Ways to Submit Claims

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

**** Preferred method***

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

South Carolina

Submitting Claims Electronically

Submitting claims electronically through your clearinghouse is the preferred method.

Benefits of electronic submissions include:

- ❑ Quicker turnaround time
- ❑ Shorter reimbursement cycles
- ❑ Improved cash flow
- ❑ Reduced administrative burden
- ❑ Payer compliance and data security
- ❑ Ability to catch errors that may delay processing

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

Dental Plan Payor ID	
BlueCross BlueShield of South Carolina	38520

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

South Carolina

Submitting Claims through My Insurance Manager

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

Note: This option should be used for claims that you may not get to go through your clearinghouse.

South Carolina

Submitting Claims by Mail

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

BlueCross BlueShield of South Carolina
(Columbia Service Center)

P.O. Box 100300
Columbia, SC 29202

BlueCross BlueShield of South Carolina
(Greenville Service Center)

P.O. Box 6000
Greenville, SC 29606

State Health Plan

P.O. Box 100605
Columbia, SC 29260

Federal Employee Program

P.O. Box 600601
Columbia, SC 29260

BlueChoice HealthPlan

P.O. Box 6170
Columbia, SC 29260

Medicare Advantage

P.O. Box 100191
Columbia, SC 29260

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

South Carolina

Important Information on Submitting Corrected Claims

- Corrected claims can be submitted:
  - **Electronically (through your clearinghouse)**
    - Use the appropriate payor ID.
    - For institutional claims, use frequency code 7 (which indicates an adjustment).
    - For professional claims, enter the original claim number in Box 22 of the CMS-1500.
      - Include a description for the reason of the adjustment in Box 19.
  - **Using My Insurance Manager**
    - Select Replacement of Prior Claim on the Claim Information page.
  - **By mail**
    - Use the appropriate address on the back of the member's ID card.
    - Be sure to label the claim as a corrected claim.
- For all avenues, include all lines from the original claim, along with the correction(s) needed.

South Carolina

Claim Reminders

Your Complete Solution

2026 Annual Provider Summit

South Carolina

Laboratory Services

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

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

avalon

South Carolina

Medical Policy Criteria for Laboratory Services

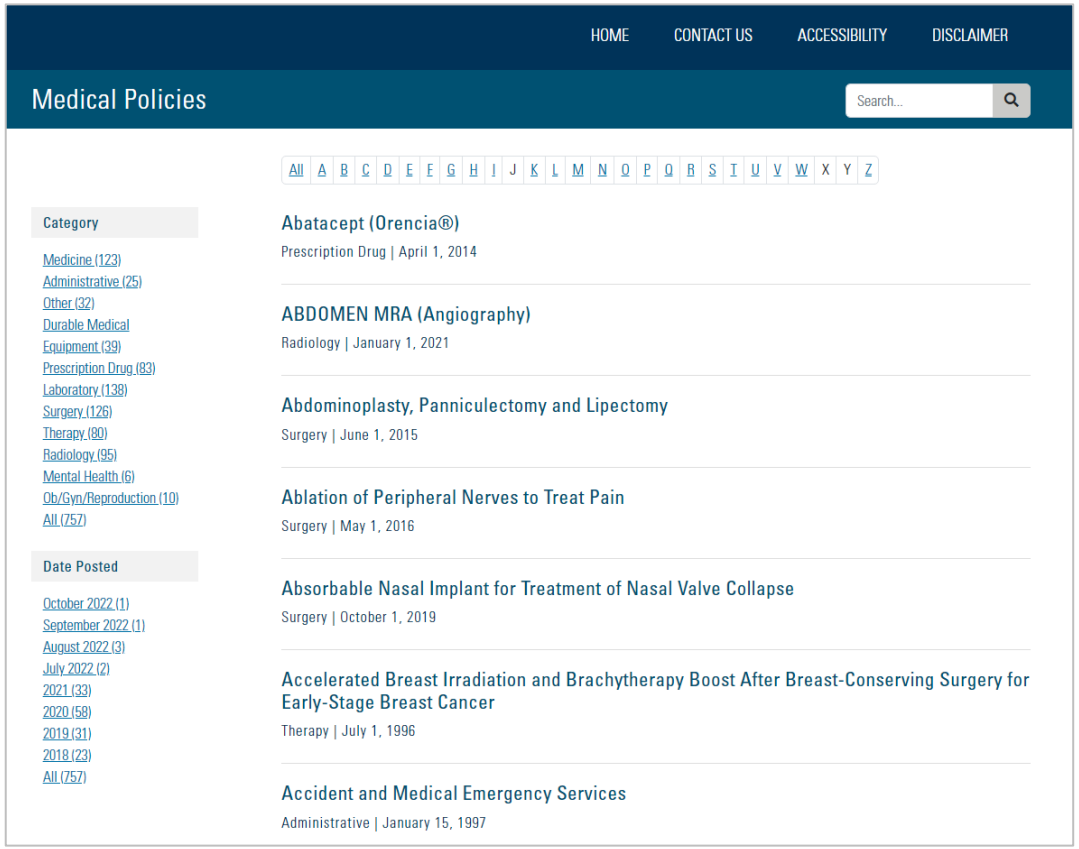
Policy Rule	Definition
Experimental and investigational	Procedure is not covered under the member's benefit due to exclusion
Demographic limitations	Limitations based on the member's age/sex
Excessive procedure units	Total units within and across claims for a single date of service more than necessary
Excessive units per period of time	Maximum allowable units within a defined period of time has been exceeded
Insufficient time between procedures	Minimum time required before a second procedure is warranted
Rendering provider limitations	Providers/procedures not permitted in combination
Diagnosis does not support test requested	Procedure was not appropriate for the clinical situation
Mutually exclusive codes	The procedure is not valid with other procedures on the same date of service

Examples of claims that rejected due to policy criteria not being met:

Laboratory Test	Issue With the Claim	Rejection Applied
Vitamin D	Testing rendered two weeks after initiation of Vitamin D therapy	Insufficient time between procedures
Thyroid Disease	Testing of reverse T3, T3 uptake	Experimental and investigational
Testosterone	Testing saliva for testosterone	Experimental and investigational

Locating Medical Policies

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



South Carolina

Example of Medical Policy

Vitamin D Testing - CAM 126

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

Description

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

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

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

Regulatory Status

Food and Drug Administration (FDA)

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

Policy

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

1. For individuals with an underlying disease or condition which is specifically a
   suspected of hypervitaminosis of Vitamin D, 25-hydroxyvitamin D serum testi
2. As part of the total 25-hydroxyvitamin D analysis, testing for D2 and D3 fracti
3. For individuals who have documented vitamin D deficiency, repeat testing for
   supplementation therapy is considered **MEDICALLY NECESSARY** with the fo
   a. Repeat testing for the monitoring of supplementation therapy should nc
   b. Once therapeutic range has been reached, annual testing meets cover
4. For the evaluation or treatment of conditions that are associated with defects
   MEDICALLY NECESSARY.
5. The following testing is considered **NOT MEDICALLY NECESSARY**:
   a. Measurement of serum 1,25-dihydroxyvitamin D to screen for vitamin D
   b. Routine screening for vitamin D deficiency with serum testing in asymp

Coding Section

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

History From 2016 Forward

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

South Carolina

High Dollar Pre-payment Review (HDPR)

The process of reviewing high dollar ***inpatient*** hospital claims.

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

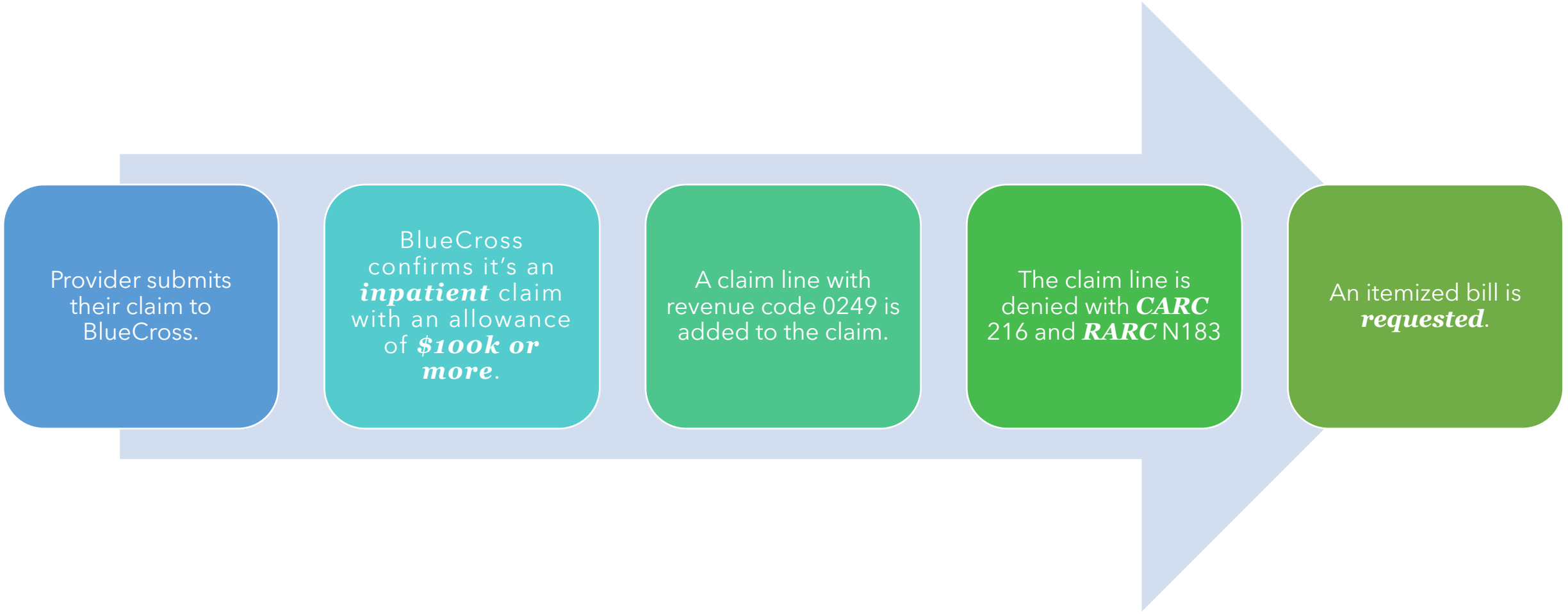
South Carolina

Criteria Used for HDPR

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

- Inpatient institutional (acute care) claim
- Claim has an allowed amount of $100k or more
- Any pricing methodologies except for per diem, flat-fee case rate and DRG

General Process of an HDPR



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

South Carolina

Examples of Itemized Bills

- ***Acceptable*** itemized bill:

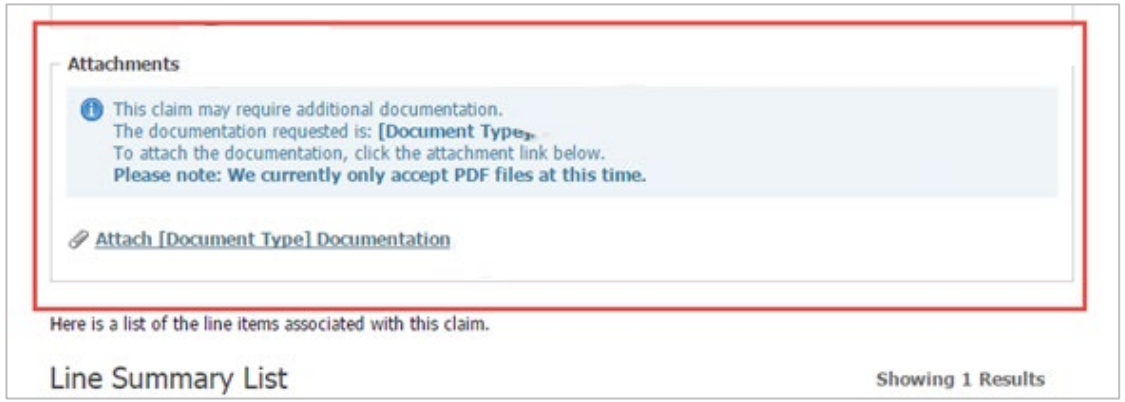
42 Rev. Co.	43 Description	44 HCPCS/Rate/HPPS Code	45 Serv. Date	46 Serv. Units	47 Total Charges
0250	Dicyclomine 10 MG		010322	1	27.00
0250	Nitroglycerin 0.4 MG		010322	1	28.73
0250	Midazolam 10 MG	J2250	010322	2	29.09
0250	Atorvastatin 40 MG		010322	2	76.93
0272	Catheter Angiographic		010322	1	226.00

- ***Unacceptable*** itemized bill:

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

Claim Attachments in My Insurance Manager

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

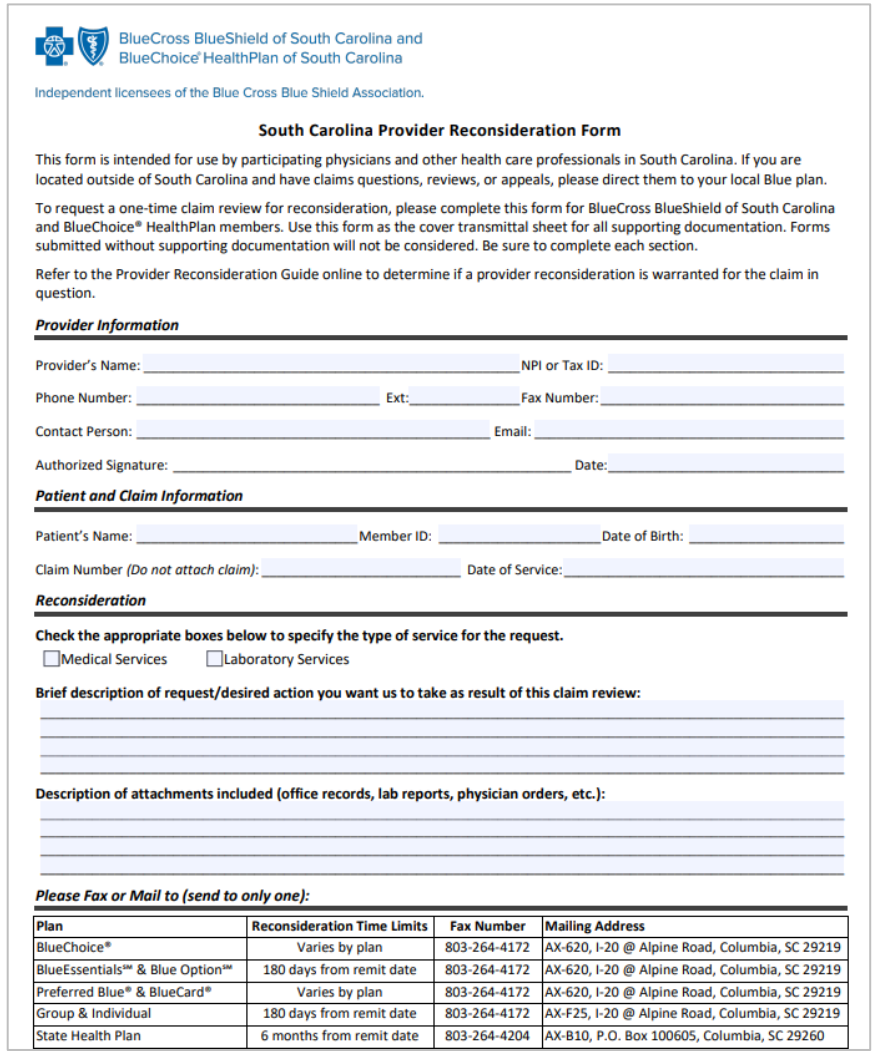


Note: Review the "What You Need to Know About Claim Attachments" guide on www.SouthCarolinaBlues.com for more information.

South Carolina

Provider Reconsiderations

- A provider reconsideration is a ***one-time courtesy review*** offered to participating providers used to investigate the outcome of a processed claim.
  - Typically related to medical necessity, lack of authorization for emergent services, etc.
- Use the South Carolina Provider Reconsideration Form.
  - www.SouthCarolinaBlues.com
  - www.BlueChoiceSC.com
- Include supporting documentation.
  - History and physical records
  - Operative notes
  - Office notes
  - Progressive notes
- Be mindful of the timely filing limits.



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

Independent licensees of the Blue Cross Blue Shield Association.

South Carolina Provider Reconsideration Form

This form is intended for use by participating physicians and other health care professionals in South Carolina. If you are located outside of South Carolina and have claims questions, reviews, or appeals, please direct them to your local Blue plan.

To request a one-time claim review for reconsideration, please complete this form for BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan members. Use this form as the cover transmittal sheet for all supporting documentation. Forms submitted without supporting documentation will not be considered. Be sure to complete each section.

Refer to the Provider Reconsideration Guide online to determine if a provider reconsideration is warranted for the claim in question.

Provider Information

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

Phone Number: _____ Ext: _____ Fax Number: _____

Contact Person: _____ Email: _____

Authorized Signature: _____ Date: _____

Patient and Claim Information

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

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

Reconsideration

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

☐ Medical Services ☐ Laboratory Services

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

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

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

Plan	Reconsideration Time Limits	Fax Number	Mailing Address
BlueChoice®	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
BlueEssentials℠ & Blue Option℠	180 days from remit date	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Preferred Blue® & BlueCard®	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Group & Individual	180 days from remit date	803-264-4172	AX-F25, I-20 @ Alpine Road, Columbia, SC 29219
State Health Plan	6 months from remit date	803-264-4204	AX-B10, P.O. Box 100605, Columbia, SC 29260

South Carolina

Reconsideration, Corrected Claim, or Provider Services

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

Examples of when to submit a provider reconsideration:

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

Examples of when to submit a corrected claim:

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

Examples of when to contact Provider Services:

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

South Carolina

Pricing Inquiries

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

Member's plan
(i.e., Commercial, Exchange or Medicare Advantage)

Non-covered charges or denied lines

Applied cutbacks

Date of service
(Fee schedule year)

MUEs

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

South Carolina

Ancillary Claim Filing Guidelines

Durable Medical Equipment

- ❑File to the Plan whose state the equipment was purchased at a retail store; or
- ❑File to the Plan whose state the equipment was shipped

Independent Clinical Laboratory

- ❑File to the Plan where the specimen was drawn.

Note: The location of where the specimen was drawn is determined by the physical location of the referring provider.

Specialty Pharmacy

- ❑File to the Plan whose state the ordering physician is located.

Submission of Requested Medical Records

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

HEDIS: Healthcare Effectiveness Data and Information Set

South Carolina

National Drug Codes

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

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

South Carolina

The BlueCard Program

Overview

- The BlueCard program allows Blue plan members to get health care services while traveling or living in another Blue plan's service area.
- The program links participating health care providers across the country and internationally through a single, electronic network for claims processing and reimbursement.

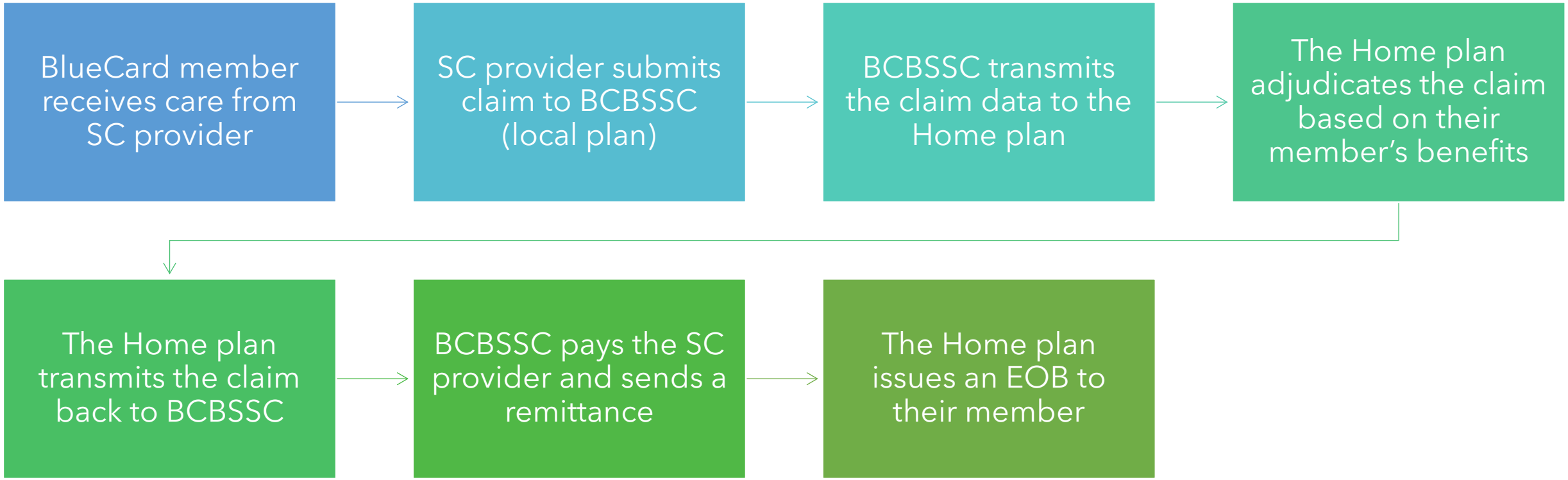
Benefits to Providers

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

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

South Carolina

The BlueCard Program – Process Flow for Claims



South Carolina

Helpful Tips

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Claims That Require a Questionnaire Response

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

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

Incorporate the forms in the onboarding paperwork
Only submit the documentation if requested.

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

South Carolina

Importance of Using Correct Coding

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

Invalid modifiers

Incorrect number of units

Diagnosis inconsistencies

Unbundled services

Age discrepancies

Unspecified codes

Note: This list may not be all-inclusive.

South Carolina

My Insurance Manager

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Claims Submission

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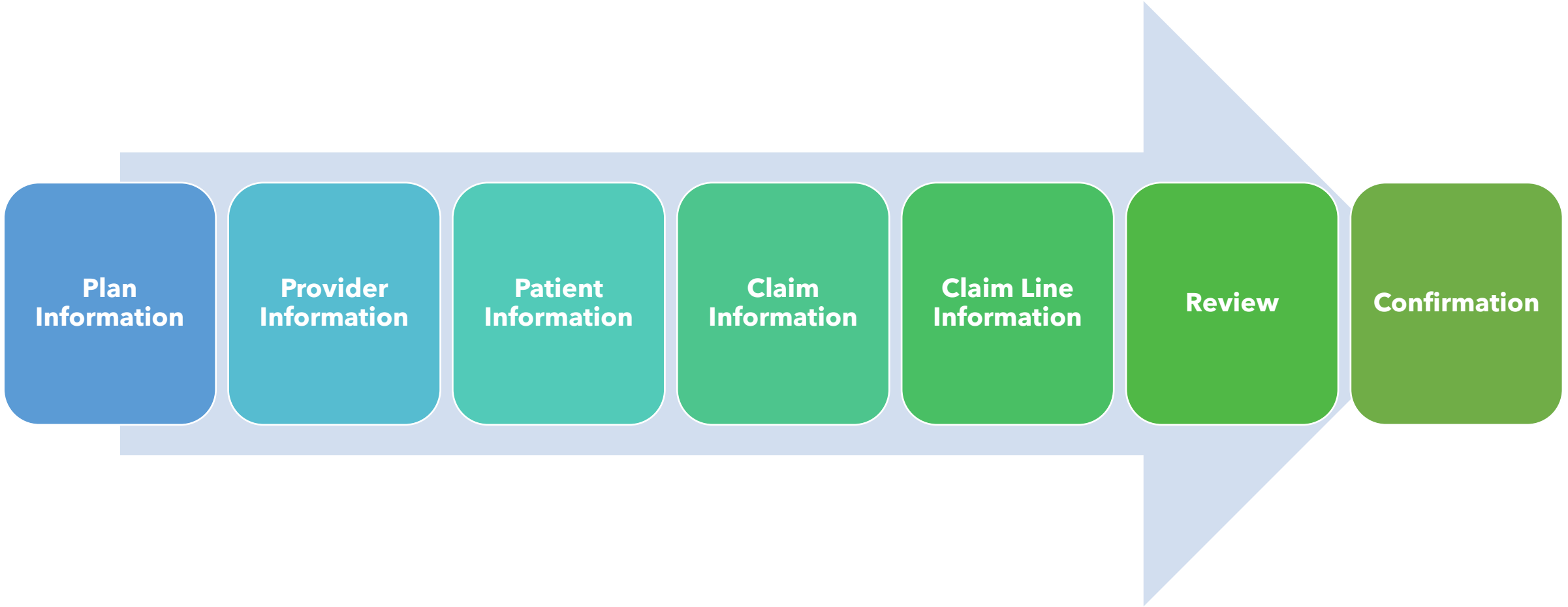
Submitting Claims Through My Insurance Manager

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

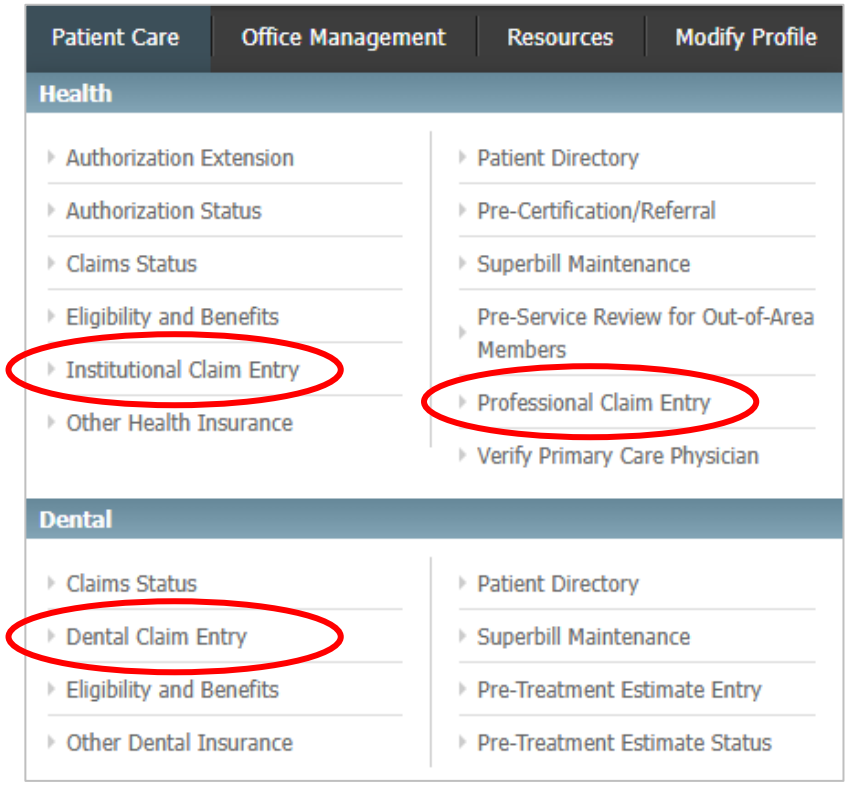


Note: The screens for institutional and dental claim entry may include an additional screen.

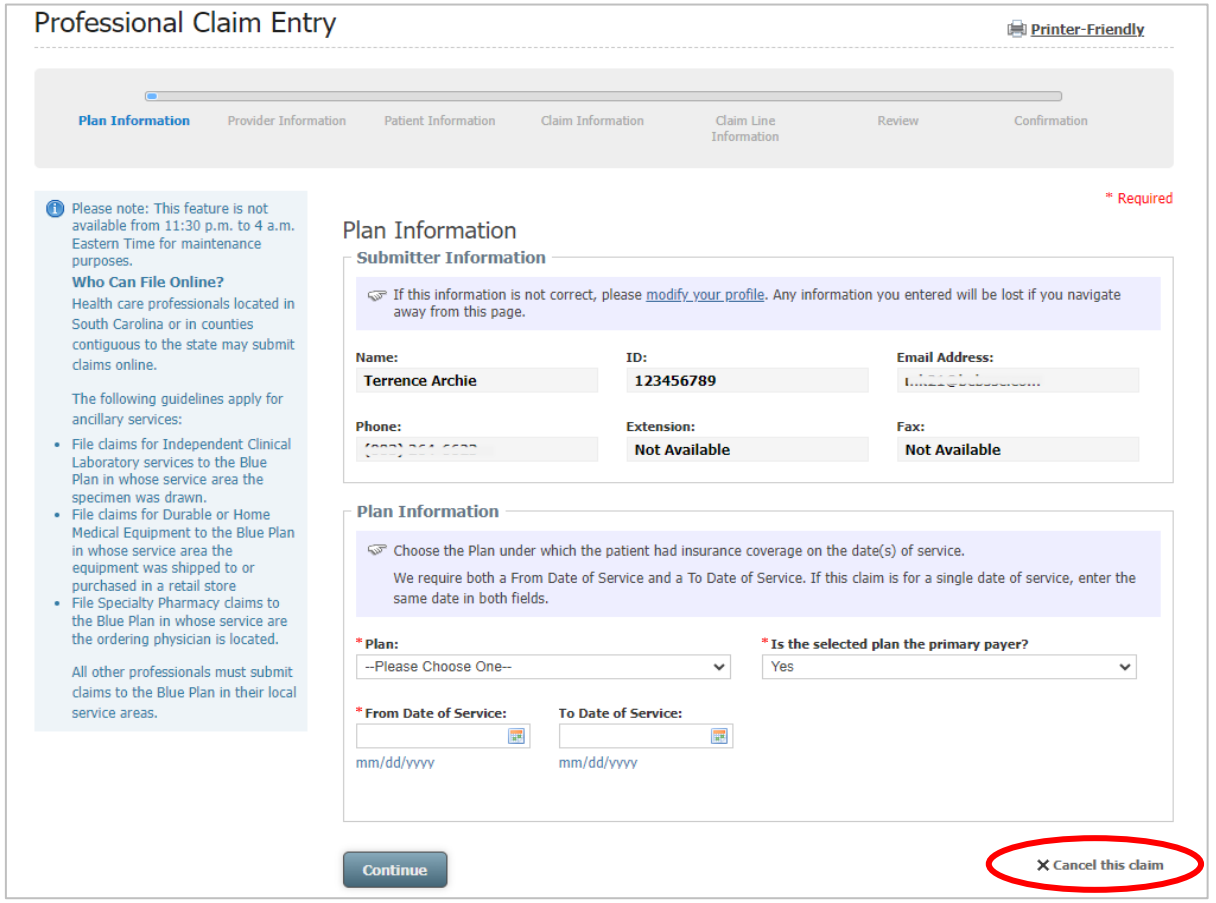
South Carolina

Steps to Submit Claims Through My Insurance Manager

Start Here



Step 1

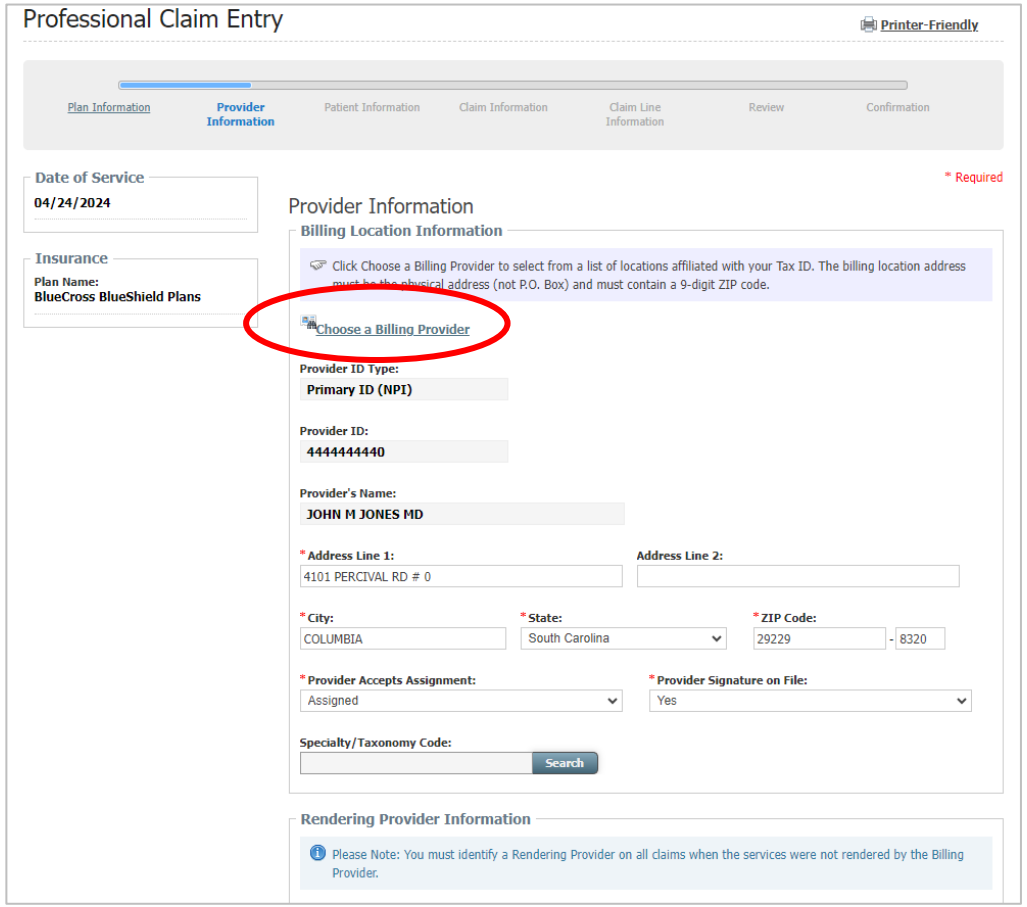


Note: At any time, you can select "Cancel this claim" to end the process.

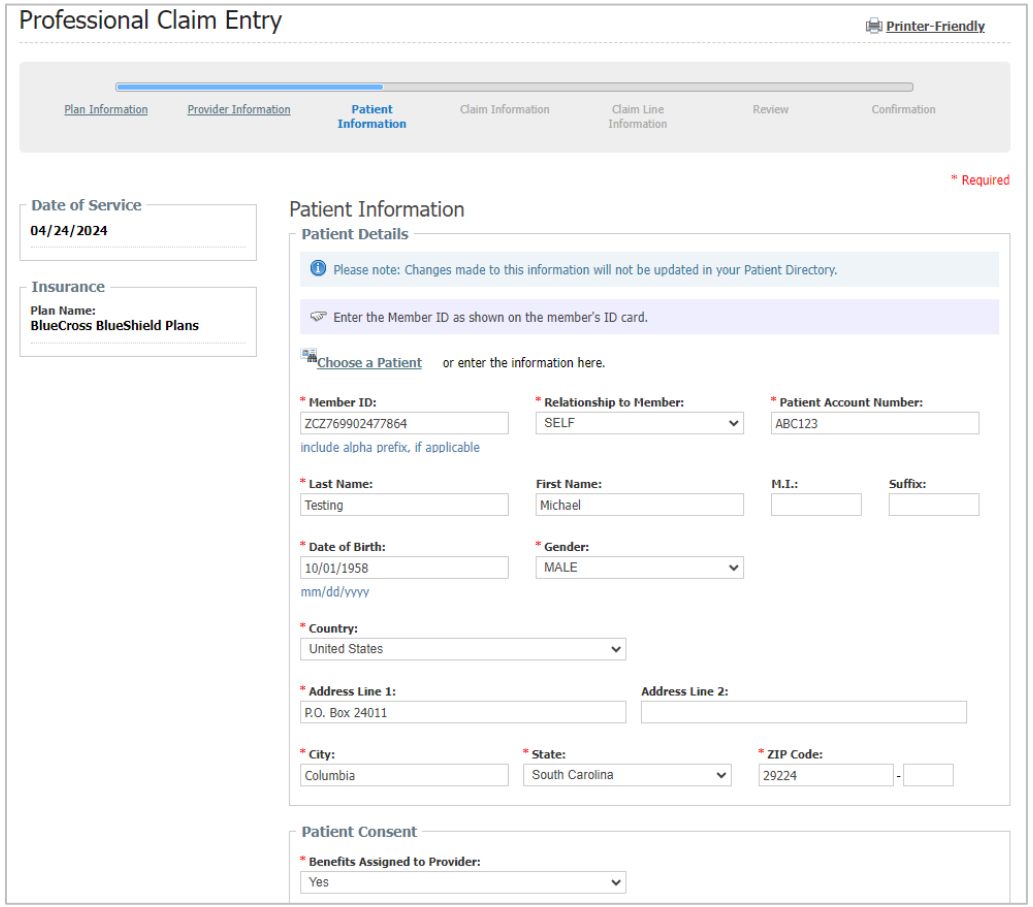
South Carolina

Steps to Submit Claims Through My Insurance Manager (Continued)

Step 2



Step 3

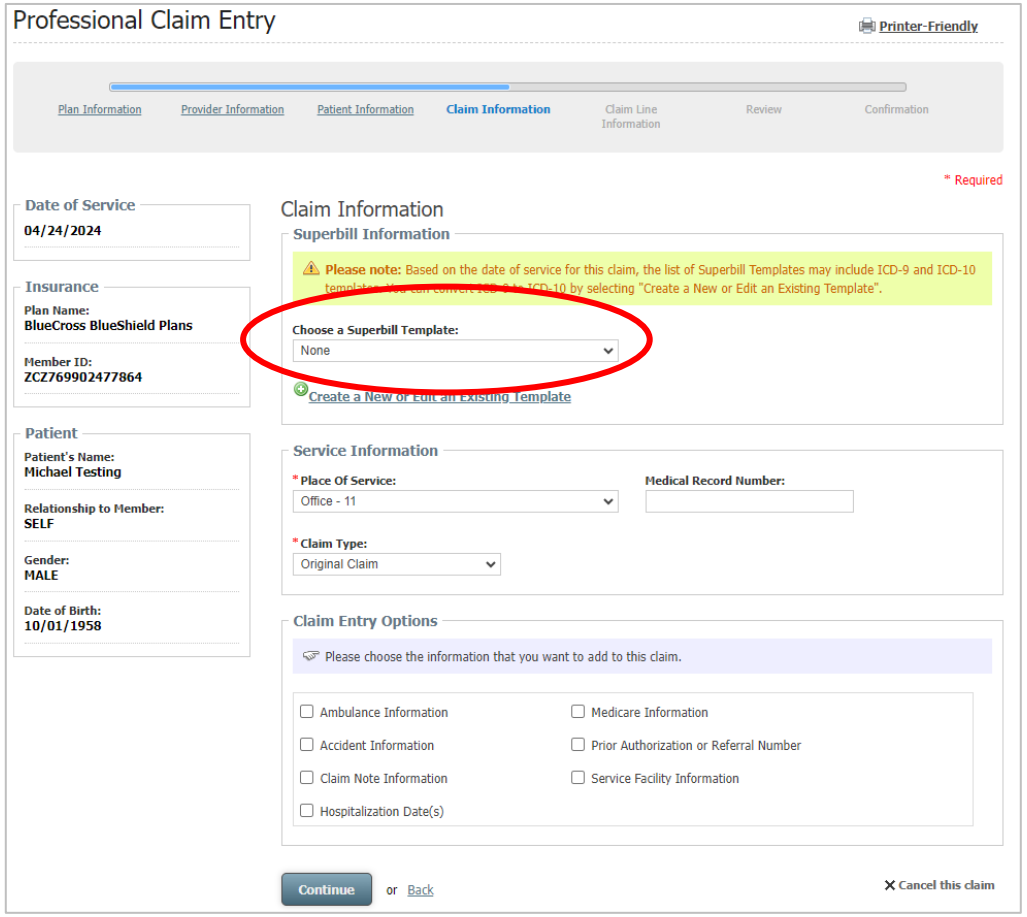


Note: You must select "Choose a Billing Provider" if more than one location is on file.

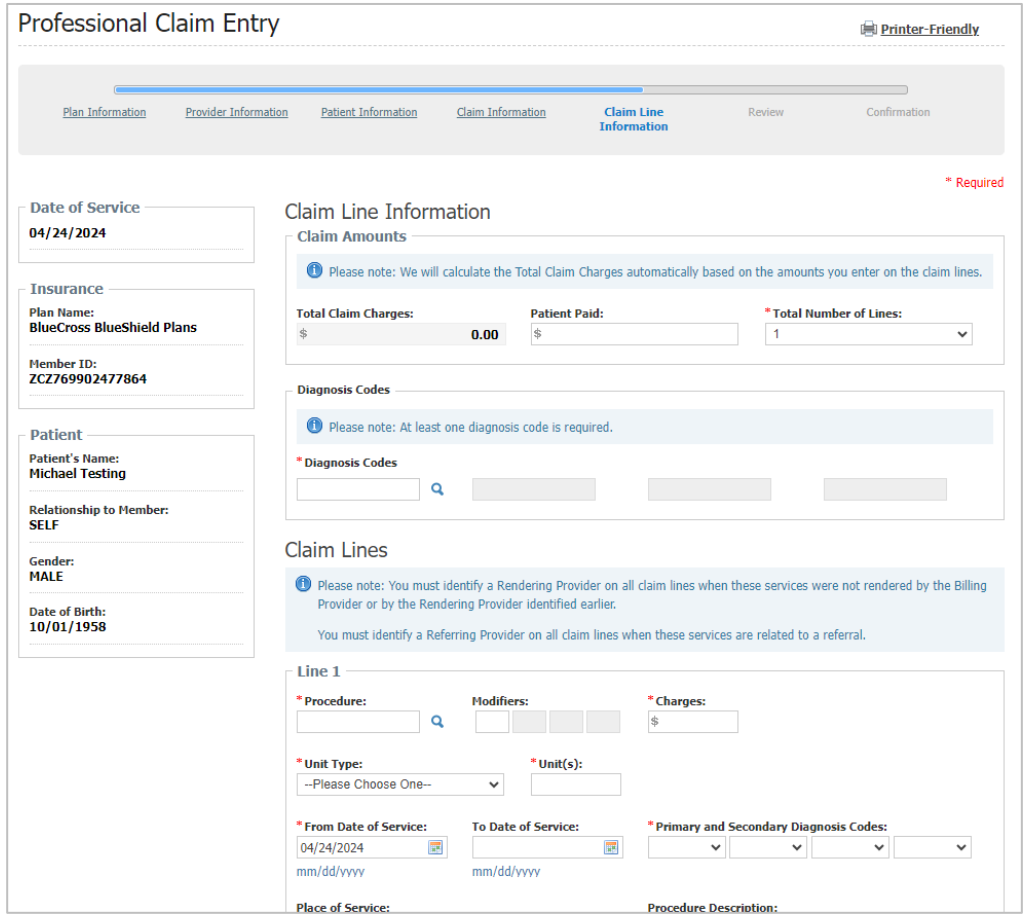
South Carolina

Steps to Submit Claims Through My Insurance Manager (Continued)

Step 4



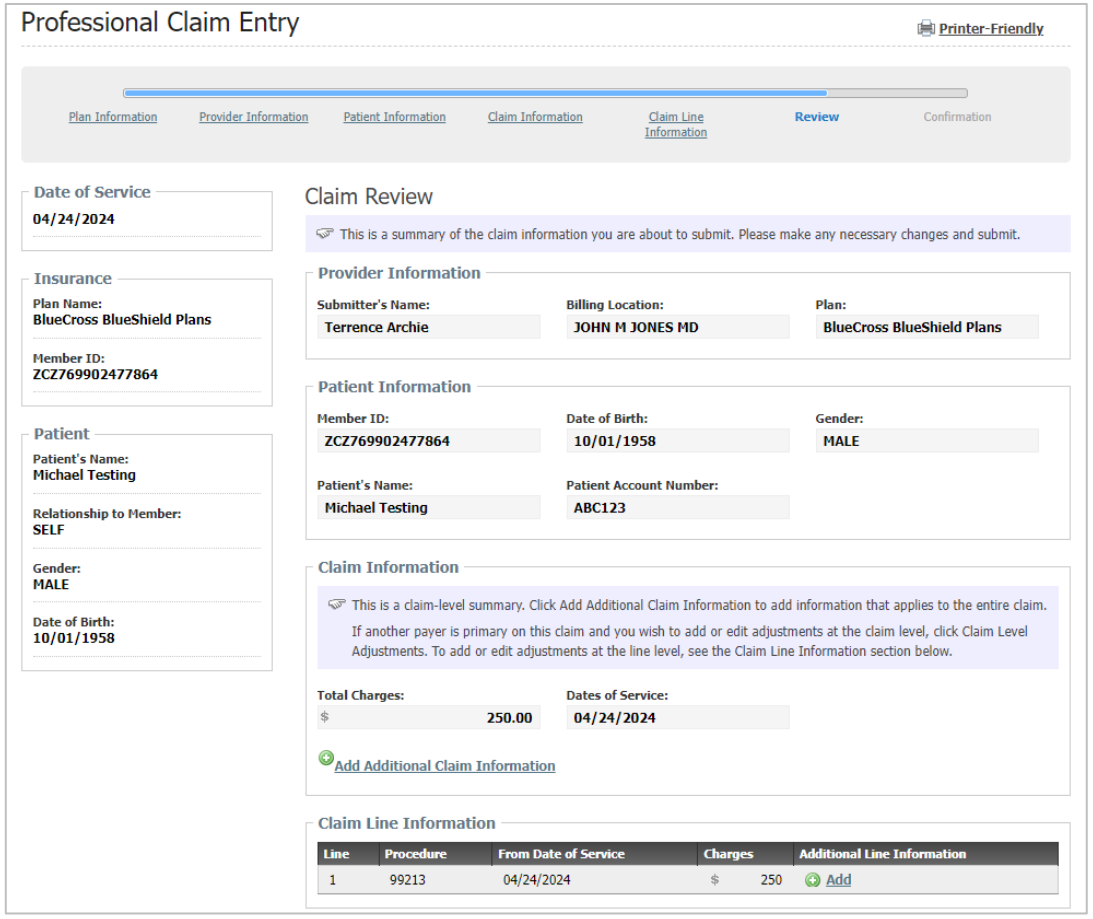
Step 5



South Carolina

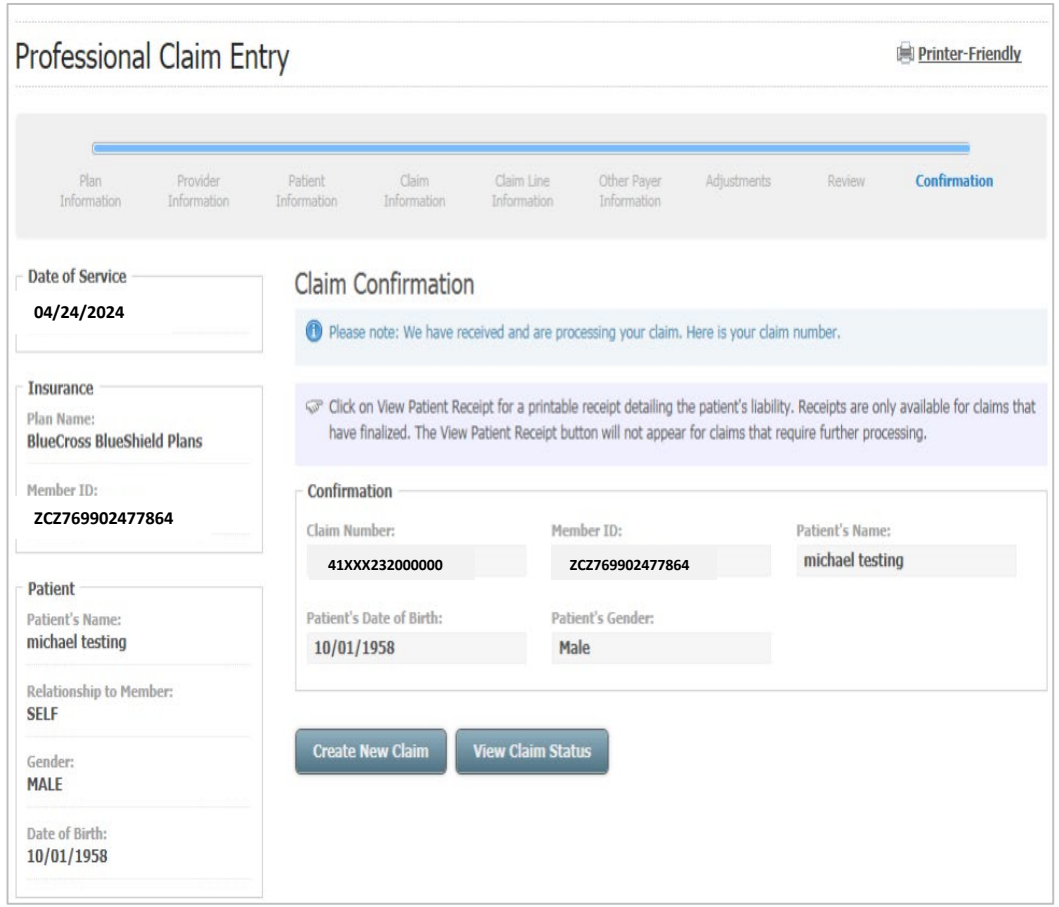
Steps to Submit Claims Through My Insurance Manager (Continued)

Step 6



Select Submit from this screen.

End Here



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Claims Status

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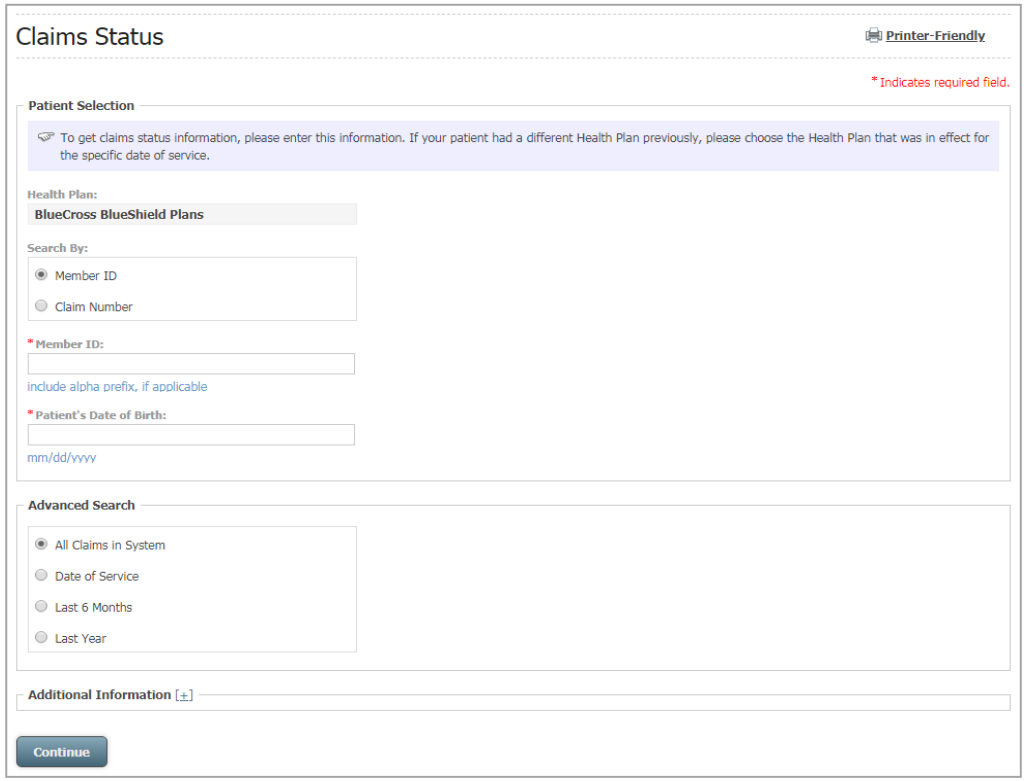
Checking the Status of a Claim

Start Here

Step 1

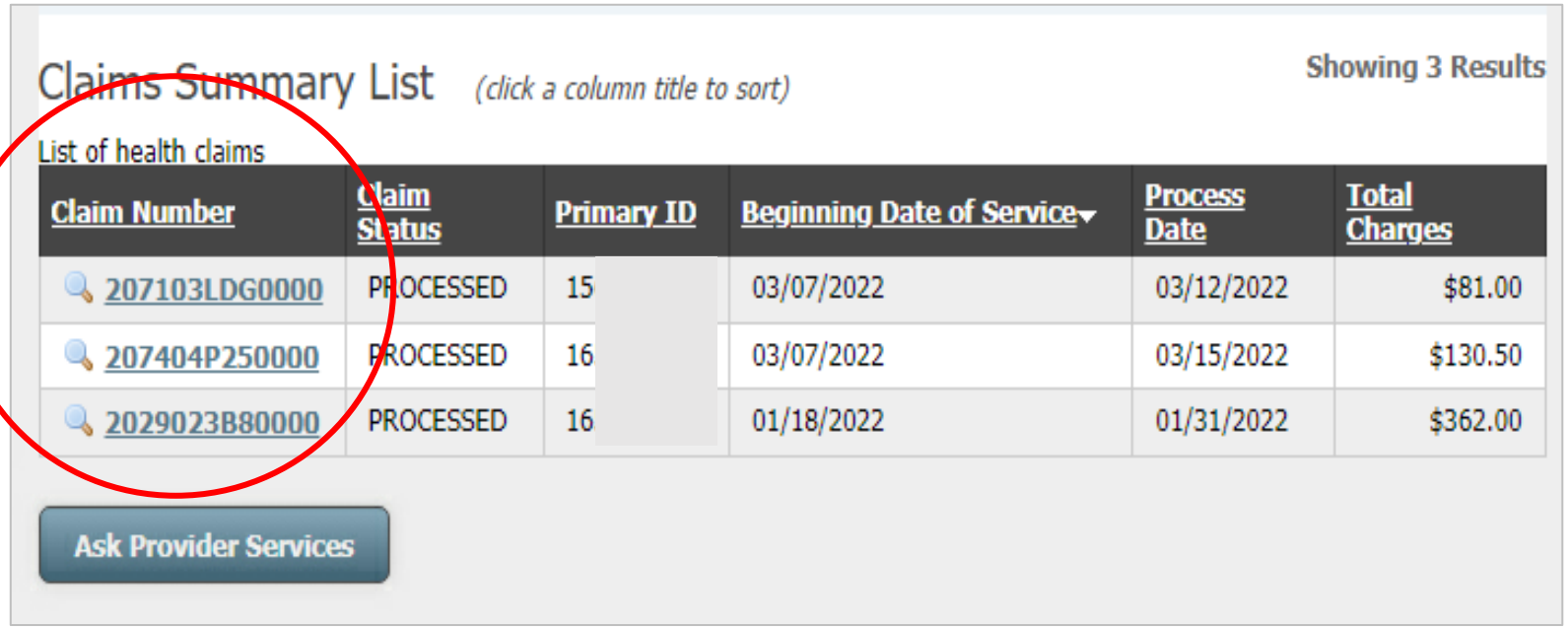


Note: Searching for claims using the member's identification number is the recommended option.

South Carolina

Checking the Status of a Claim (Continued)

Step 2



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

Showing 3 Results

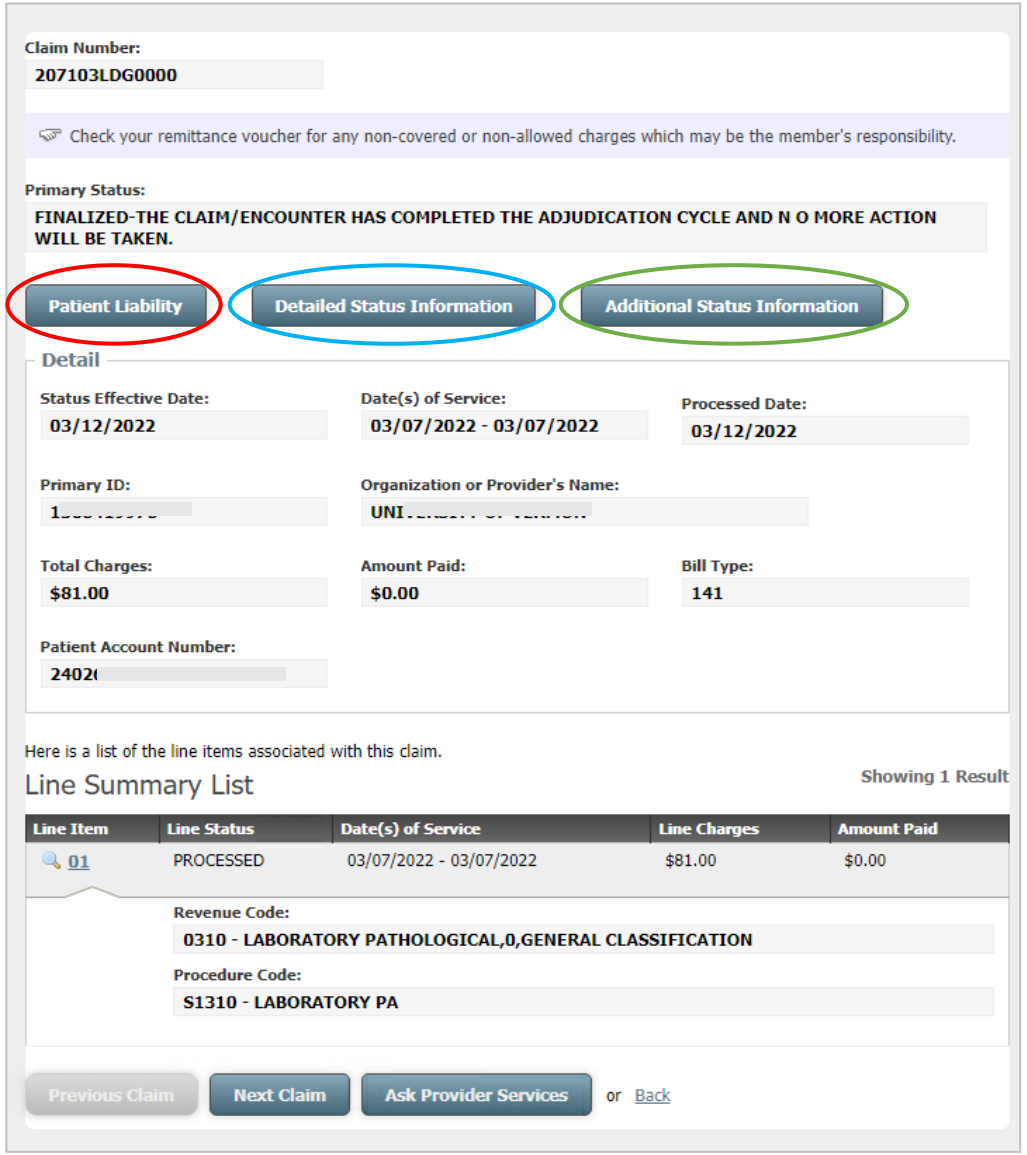
List of health claims

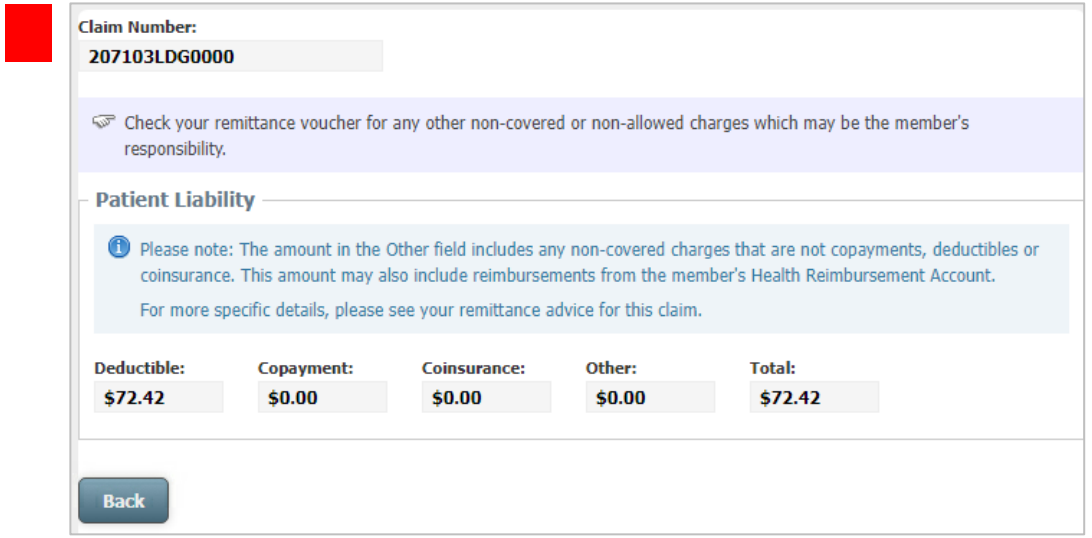
Claim Number	Claim Status	Primary ID	Beginning Date of Service	Process Date	Total Charges
207103LDG0000	PROCESSED	15	03/07/2022	03/12/2022	$81.00
207404P250000	PROCESSED	16	03/07/2022	03/15/2022	$130.50
2029023B80000	PROCESSED	16	01/18/2022	01/31/2022	$362.00

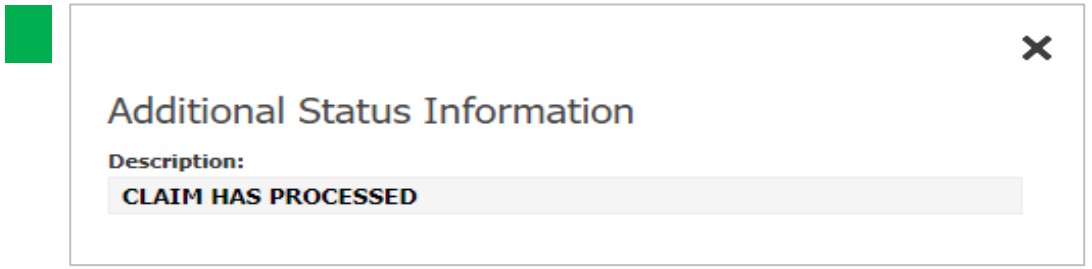
Ask Provider Services

South Carolina

Checking the Status of a Claim (Continued)







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Ask Provider Services

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Overview of Ask Provider Services

- Ask Provider Services is a feature in My Insurance Manager that lets you submit secured web inquiries for help with claims.
- This feature is intended to assist with ***complex issues*** and not general claim questions where the answers can be found in the portal or the VRU.

Examples of ***appropriate*** requests	Examples of ***inappropriate*** requests
Why was line one of the claim denied as noncovered?	What is the status of the claim?
Has the member returned the coordination of benefits questionnaire?	Has the claim been processed?
I need clarification regarding a recent recoupment made on the claim for date of service 01/30/2025.	Did you receive the medical records for this claim?
Claim denied for no authorization, but the authorization number is on file under 123456789.	Is there a claim on file for date of service 07/10/2025?

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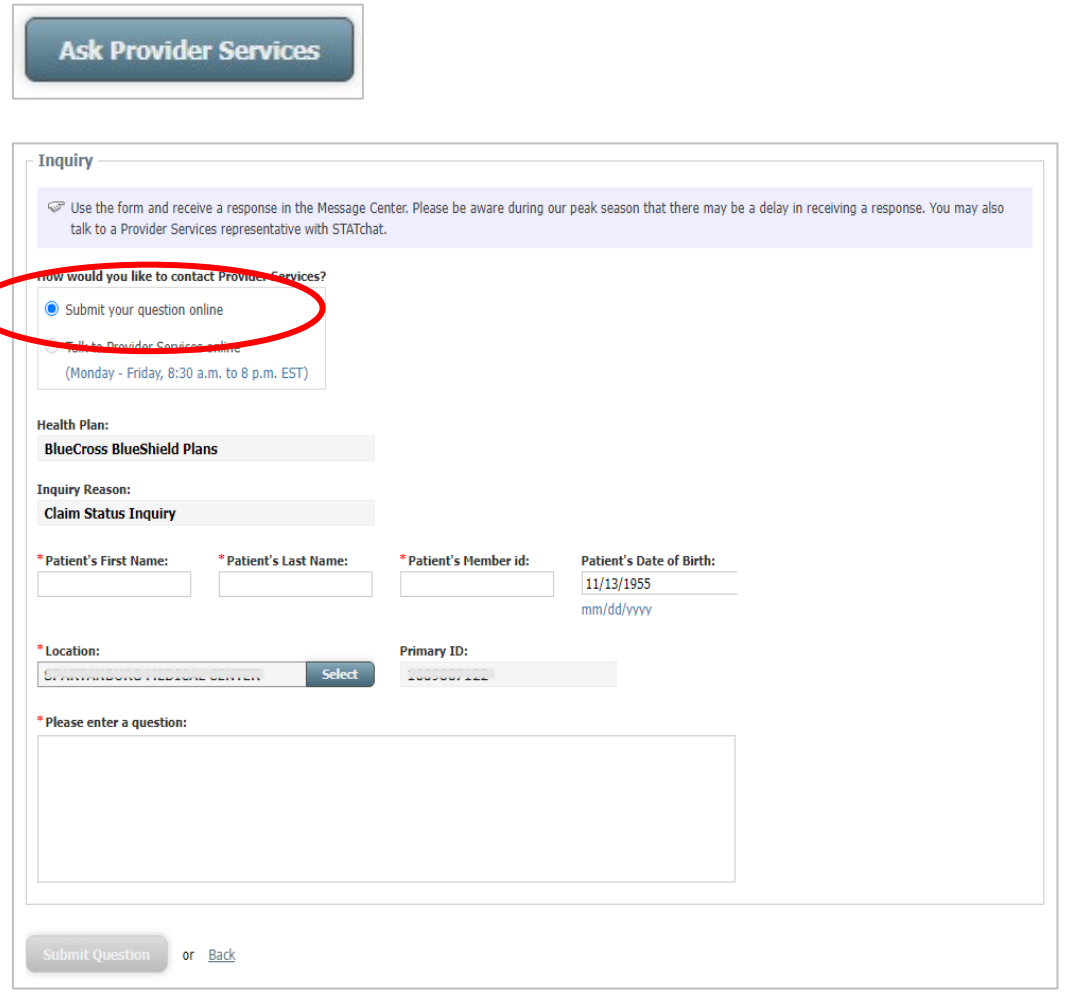
Submitting Web Inquiries

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



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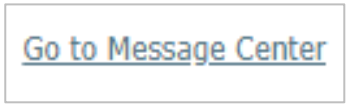
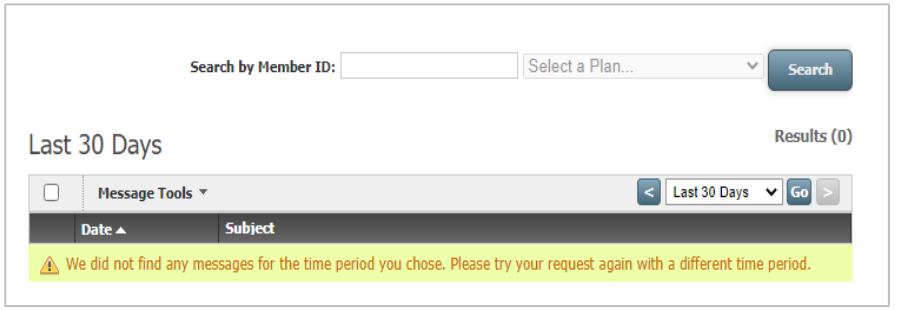
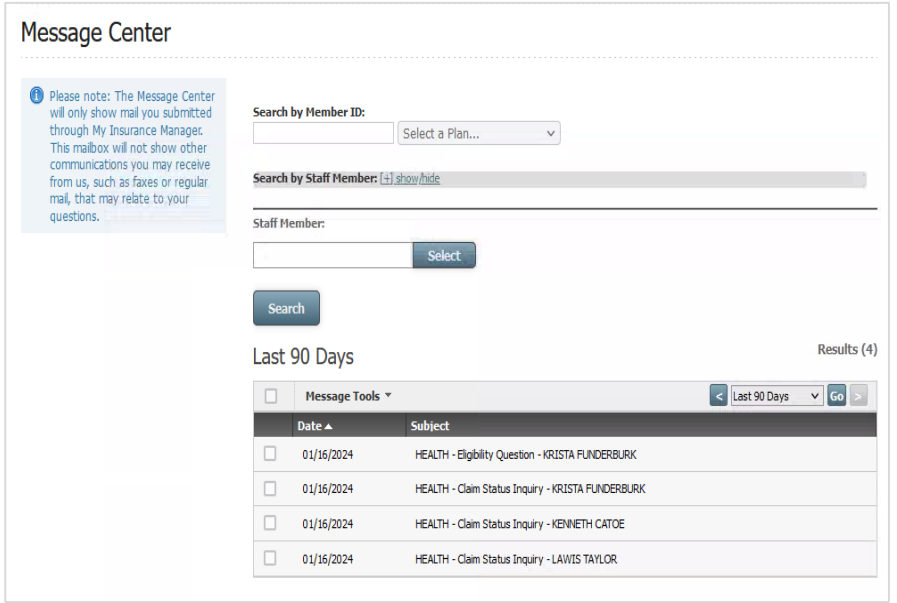
Viewing Web Inquiry Responses

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





Office Staff View



Administrator View

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STATchat

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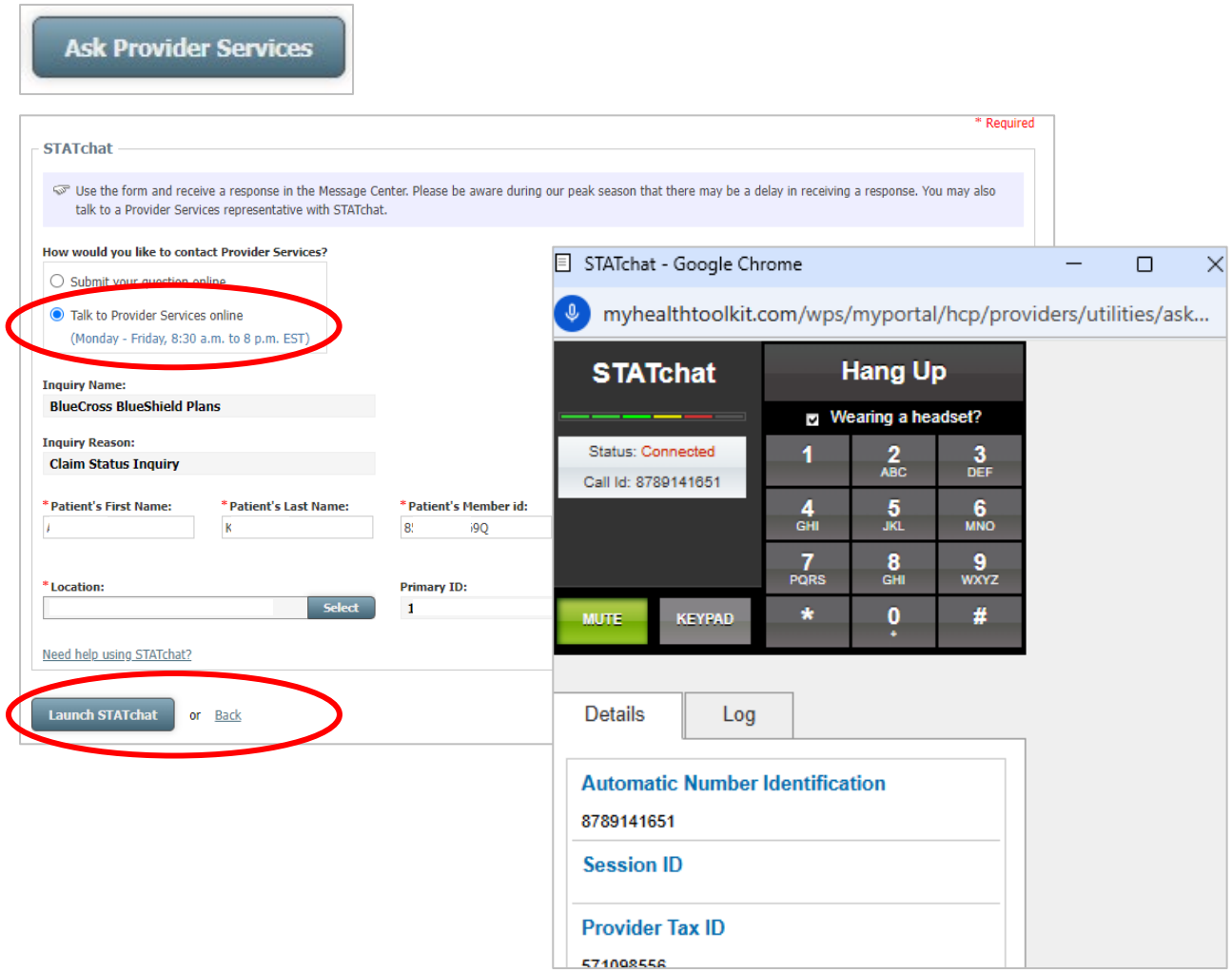
Overview of STATchat

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



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

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My Remit Manager

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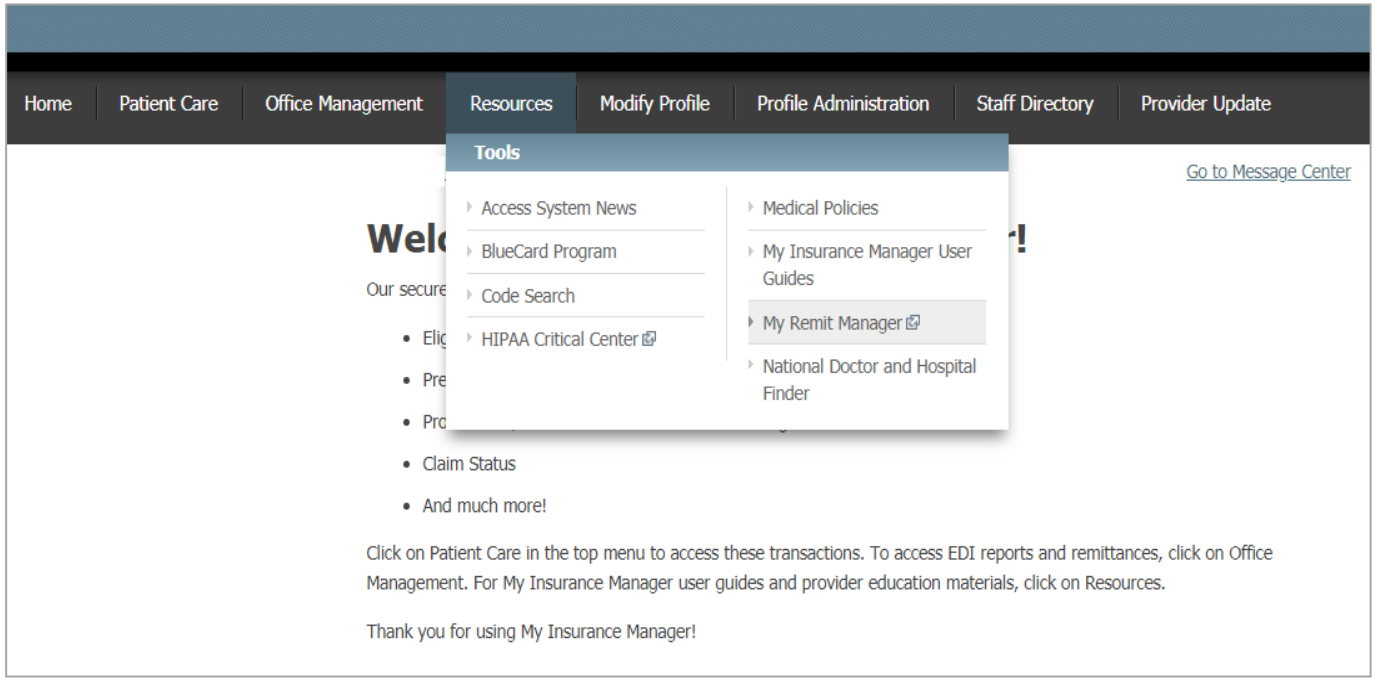
Accessing My Remit Manager

- While in My Insurance Manager, hover over Resources and select My Remit Manager.



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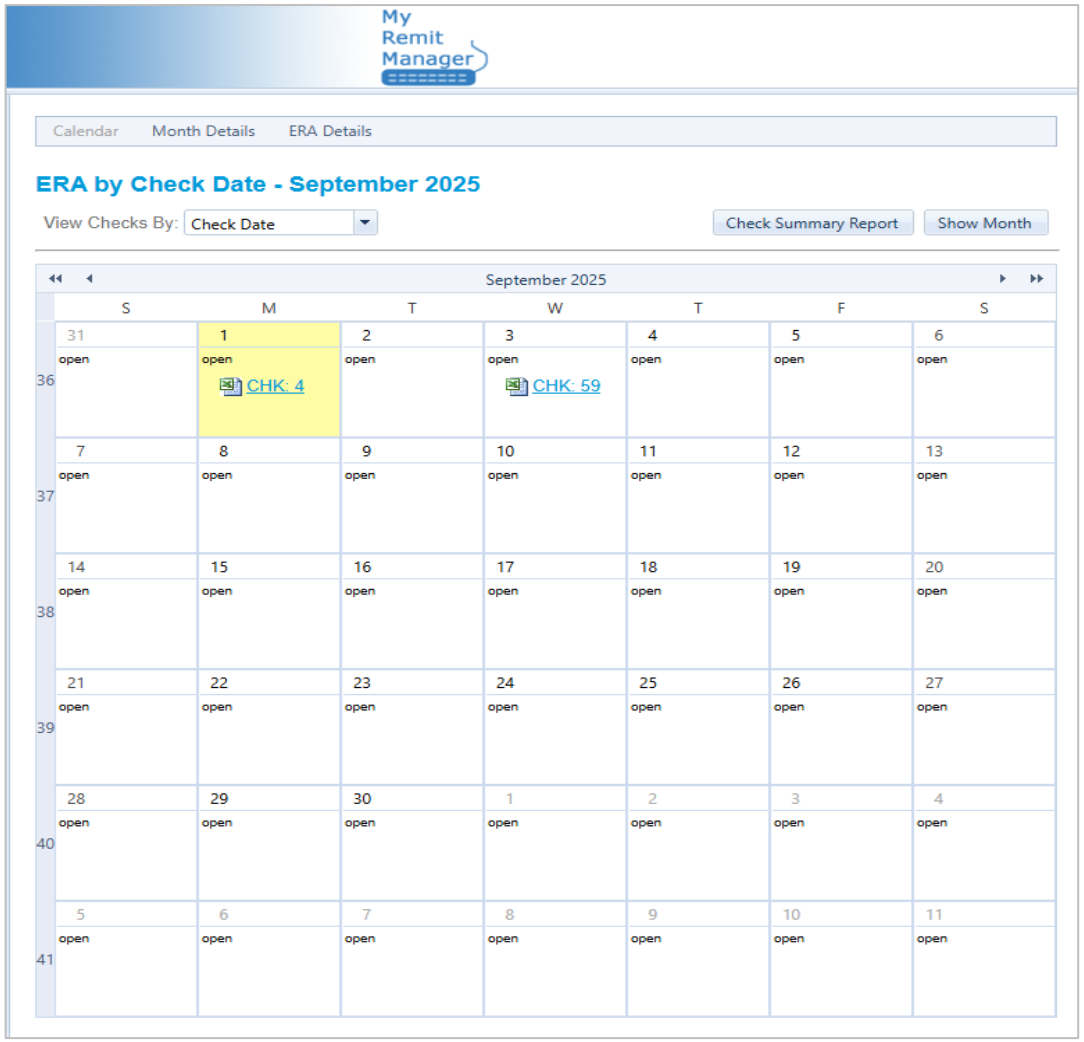
Available Remittances – Calendar View

- If remittances are available, there will be check links on the calendar.
- Providers can view previous months by selecting the appropriate arrows on the calendar.



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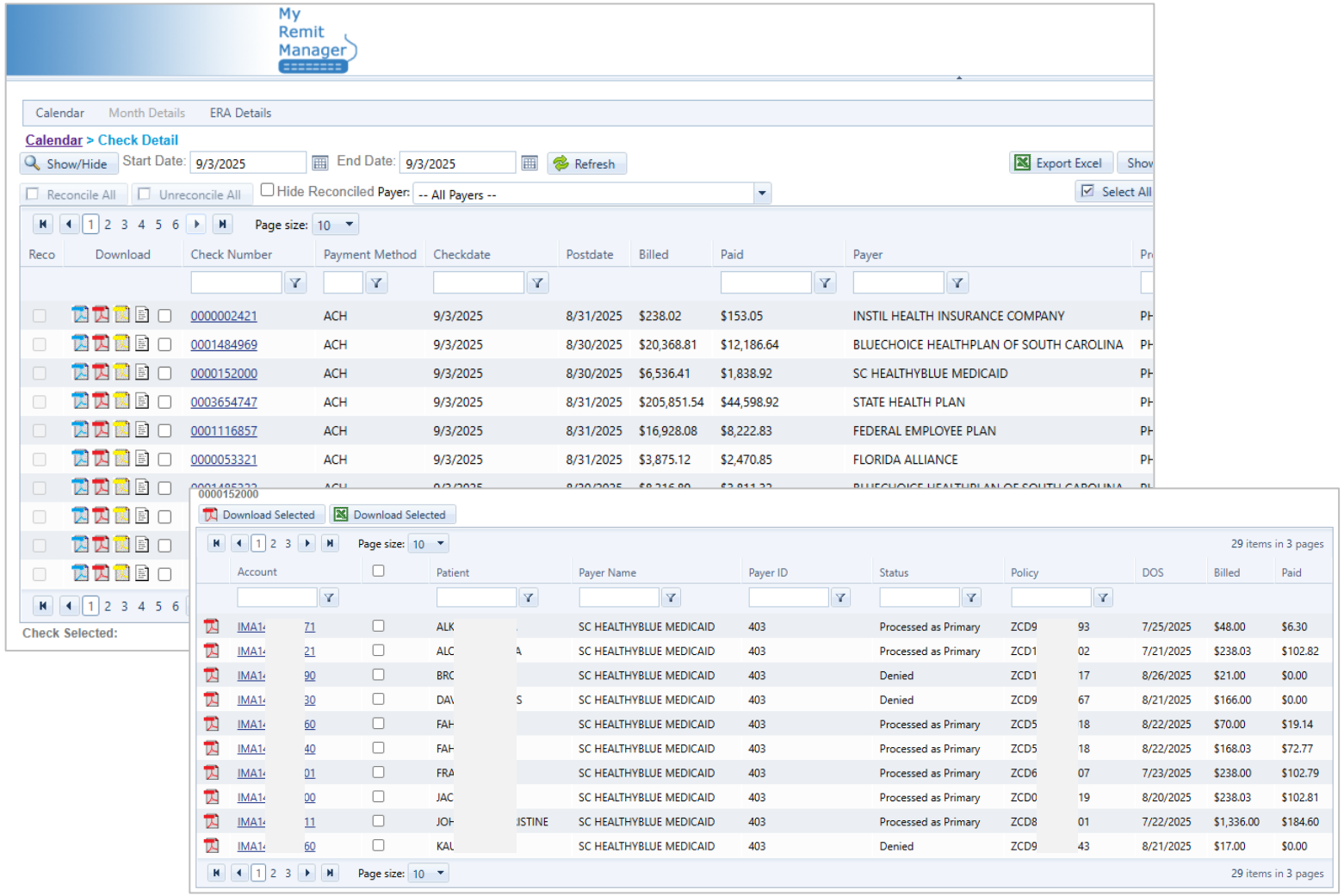
Viewing Available Remittances

- Providers can view remittances based on the check number, payment amount, or payer.
- If they select a specific check number, the applicable remittances will populate.
- Select the Adobe icon next to the appropriate patient for the remittance to display.



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Example of Remittance

ERA Patient Listing

Electronic Reproduction ASC 005010X221A1

PH UNI AL GRP

A 74

AL FA **CHECK/EFT: 00 000** **CHECK DATE: 09/03/2025**
SC HEALTHYBLUE MEDICAID

Account: IMA1445923771 POS: 11 HIC: ZCD978 3 ICN: 5240097MD0000 Provider: 108 571004 8295641
Status: Processed as Primary

PreProv	ServDate	NOS	REV	Proc/Mods	Billed	Allowed	Deduct	Coins	RC-Amt	Paid	CAS Summary
571004971	07/25/2025	1		HC:36415	17.00				17.00	0.00	CO 45 17.00 HE N174
571004971	07/25/2025	1		HC:85025:QW	31.00	6.30			24.70	6.30	CO 45 24.70 HE N45
REMITTANCE SUMMARY					48.00	6.30	.00	.00	41.70	6.30	

TOTALS

Denied/Non-Covered: 0.00

CO	45	41.70	[Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).]
HE	N45		[Payment based on authorized amount.]
HE	N174		[This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group "PR".]

* Denotes Denied Or Non-covered Charges

REMITTANCE SUMMARY

	Billed	Allowed	Deduct	Coins	RC-Amt	PLB Adj	Paid
Totals	48.00	6.30	.00	.00	41.70	.00	6.30

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Dental Networks

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Topics to Discuss

- Dental Enrollment
- Dental Plans
- Dental GRID
- Dental Benefits and Claims
- 2026 Coding Updates

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Dental Enrollment

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Participating in the Dental Network

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

South Carolina

Individual Dental Enrollment

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

*Must include past five years (active and inactive).

**Only if applicable.

***Only if applying for BlueChoice® HealthPlan.

****Only if applying for Healthy Blue.

*****If board certified.

1 Medical contract, dental contract or both.

2 Dental contract only.

South Carolina

Group Practice Dental Enrollment

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

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

**Only for oral surgeons applying for Healthy Blue.

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

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

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Dental Plans

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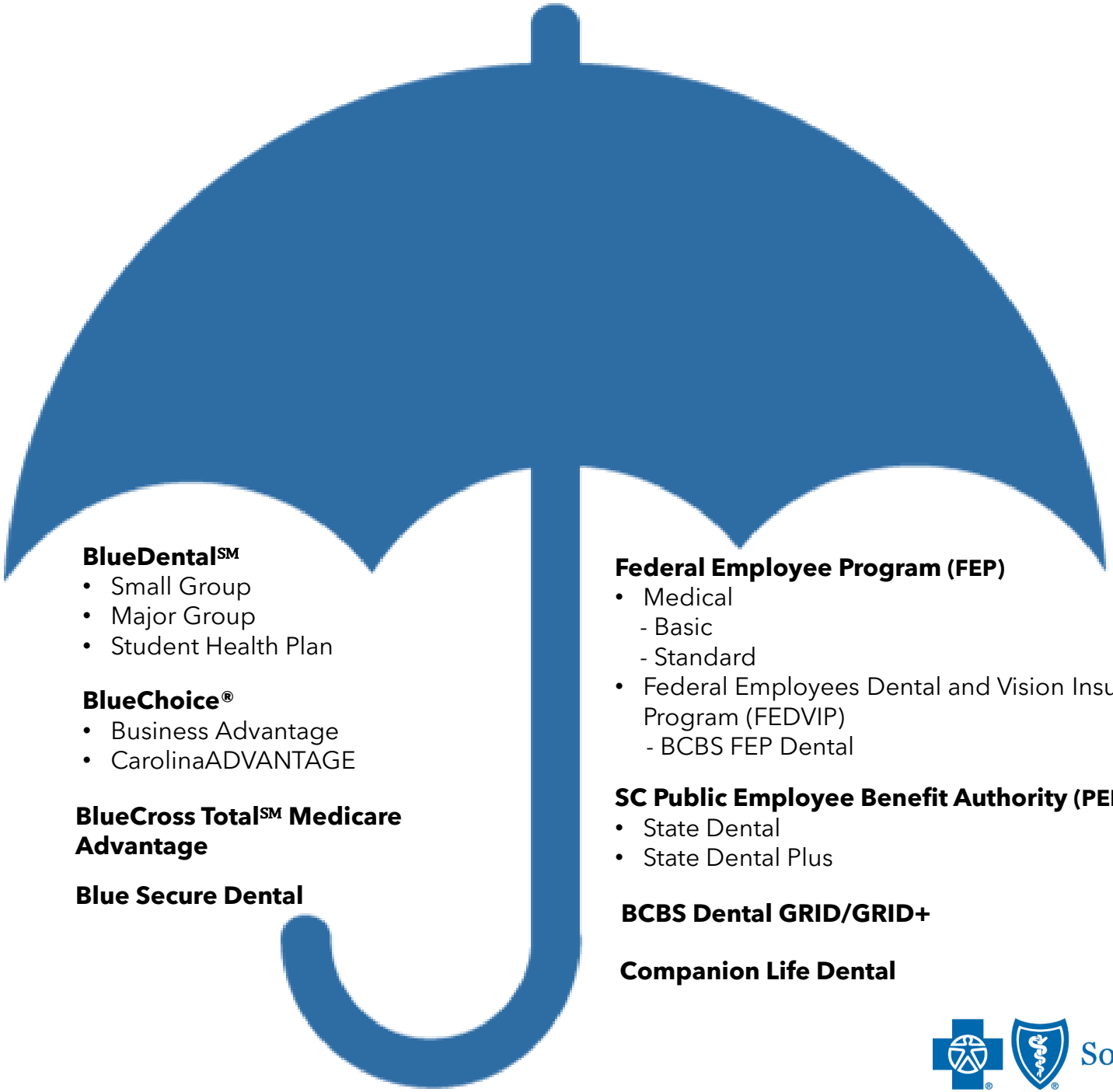
BlueCross BlueShield of South Carolina Dental Umbrella



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

BlueChoice®
- Business Advantage
- CarolinaADVANTAGE

BlueCross Total℠ Medicare Advantage

Blue Secure Dental

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

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

BCBS Dental GRID/GRID+

Companion Life Dental

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Commercial Plans

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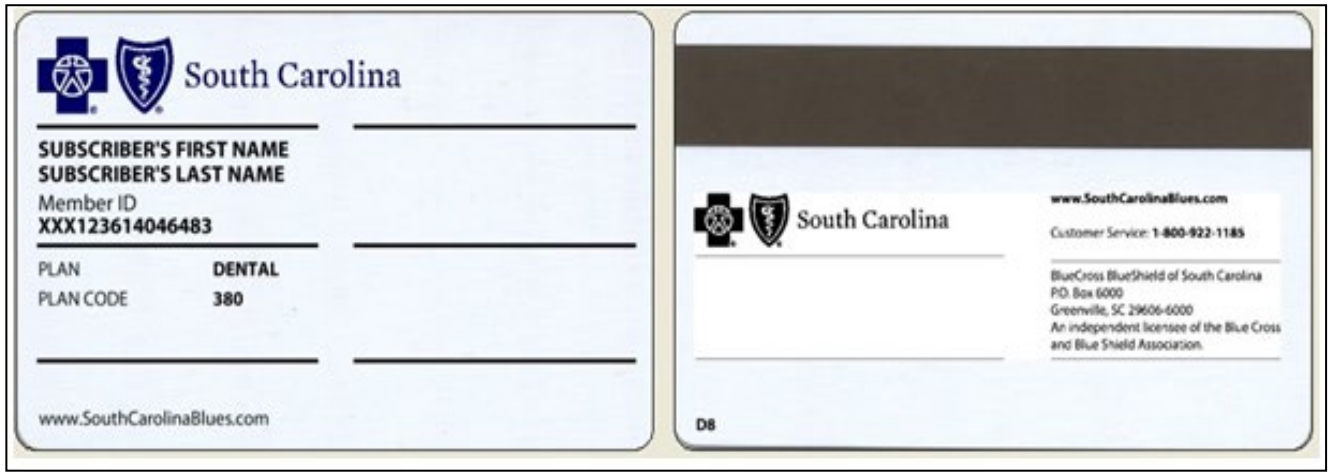
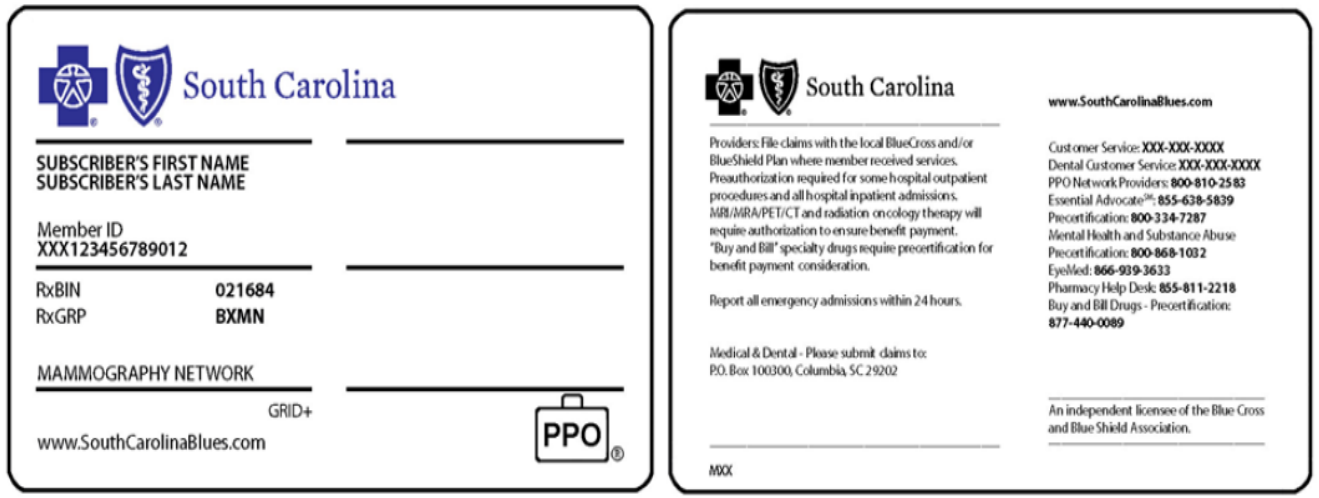
Commercial Plans – Examples of ID Cards



Dental only.



Medical and dental.

South Carolina

Commercial Plans – Overview of Coverage

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

State Health Plan

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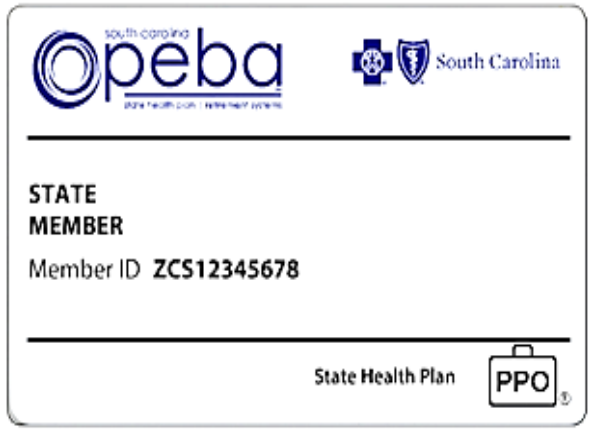
State Basic Dental Plan

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

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

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



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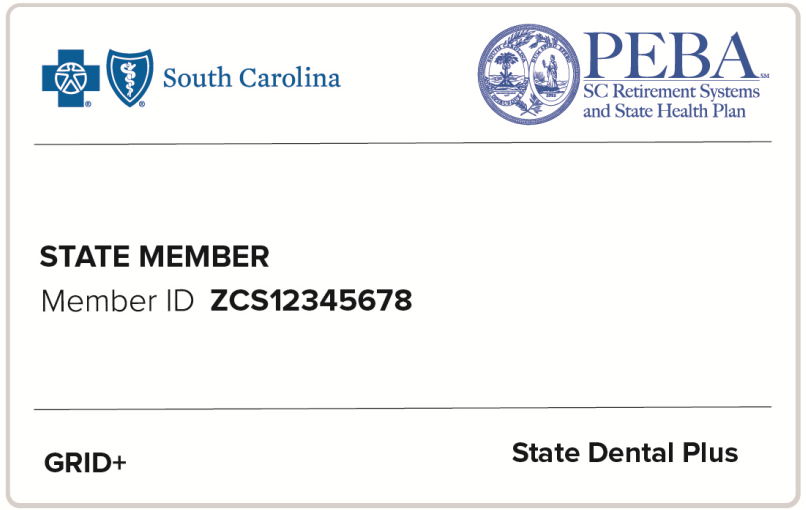
State Dental Plus Plan

- Members with the Dental Plus plan with have ***State Dental Plus*** on their ID card.
- Dental Plus is a supplement to the Basic Dental plan and provides an additional $1,000 benefit period maximum for classes 1-3.
- Dental Plus provides a higher level of reimbursement for services that the Basic Dental plan covers.
  - Reimbursement is based on the commercial negotiated rate with BlueCross BlueShield of South Carolina.
- Dental Plus members utilize the BlueCross BlueShield of South Carolina Network for in-network benefits.



South Carolina

Federal Employee Program

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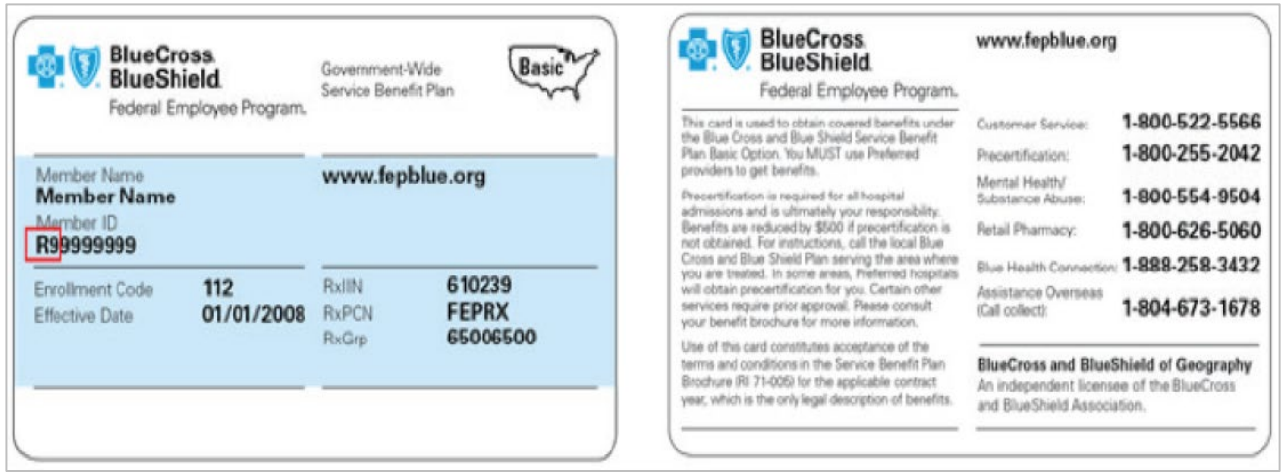
Federal Employee Program – Basic Option Plan

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



South Carolina

Federal Employee Program – Basic Option Plan (Continued)

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

Federal Employee Program – Standard Option Plan

- Members have no deductibles, copays or coinsurance.
- Members pay the difference between the fee schedule amount and the BlueCross Participating Dental allowance while using preferred dentists.
  - When using non-preferred dentists, members pay all charges in excess of the listed fee schedule.
- If a service is not covered by FEP Standard, both in and out-of-network providers can charge their usual and customary charge.

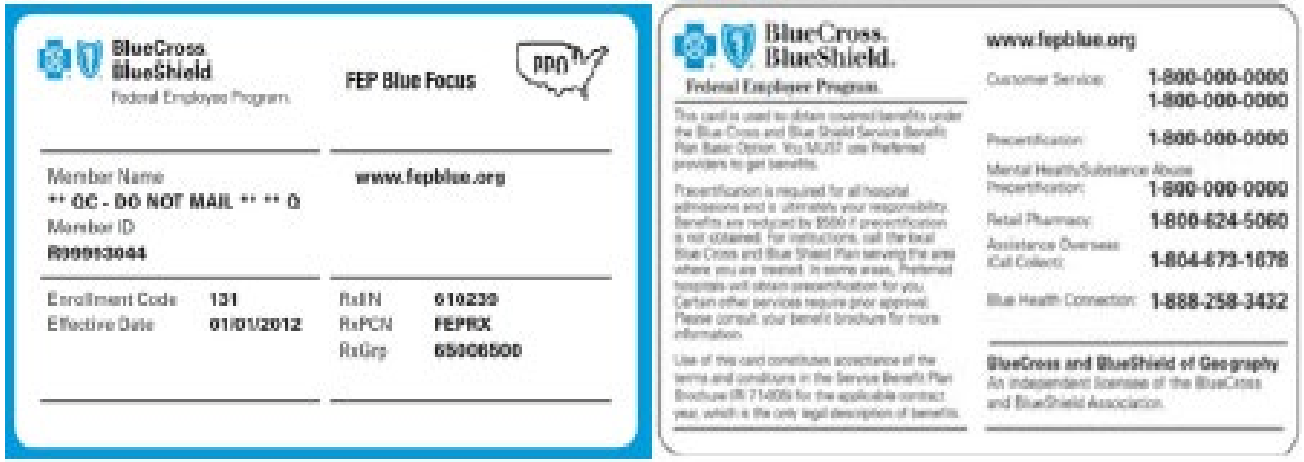
South Carolina

Federal Employee Program – Standard Option Plan (Continued)

Covered Service	FEP Pays		Member Pays
Clinical Oral Evaluations	**To Age 13**	**Age 13 and Over**	**In Network** The difference between the amounts listed to the left and the BlueCross Participating Dental Allowance **Out-of-Network** All charges in excess of the scheduled amounts listed to the left.
Periodic oral evaluation (up to two per person per calendar year)	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
Diagnostic Imaging			
Intraoral complete series	$36	$22	
Palliative Treatment			
Palliative treatment of dental pain – minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive			
Prophylaxis – adult (up to 2 per person per calendar year)	---	$16	
Prophylaxis – child (up to 2 per person per calendar year)	$22	$14	
Topical application of fluoride or fluoride varnish (up to two per person per calendar year)	$13	$8	
Not covered: Any service not specifically listed above	Nothing	Nothing	All charges

Federal Employee Program – Blue Focus Plan

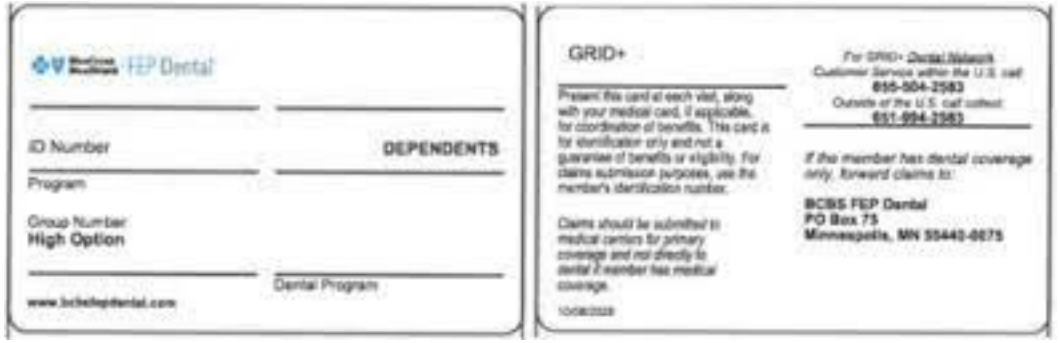
- Members with a Blue Focus plan do not have dental benefits directly with their plan.
- Members would need BCBS FEP Dental or a FEDVIP plan for dental benefits.
- Claims would need to be filed directly to the FEDVIP plan.



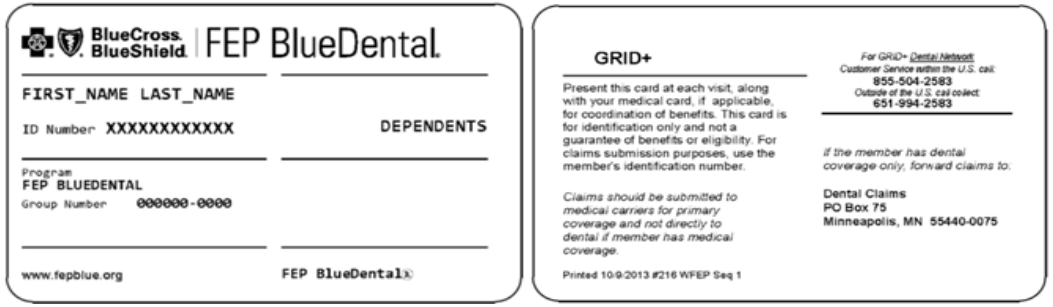
South Carolina

Federal Employee Program – Blue Cross Blue Shield FEP Plan

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



Sample of new BCBS FEP Dental ID Card



Sample of old FEP BlueDental ID Card

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

South Carolina

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

	High Option		Standard Option	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Class A (Basic) services (e.g., exams, cleanings, x-rays, sealants)	**$0**	**10% COINS**	**$0**	**40% COINS**
Class B (Intermediate) services (e.g., oral surgery, fillings, gum scaling)	**30% COINS**	**40% COINS**	**45% COINS**	**60% COINS**
Class C (Major) services (e.g., crowns, bridges, root canals, dentures)	**50% COINS**	**60% COINS**	**65% COINS**	**80% COINS**
Class D (Orthodontics) services (Adults and children)	**50% COINS up to $3,500** lifetime maximum per person	**50% COINS up to $3,500** lifetime maximum per person	**50% COINS up to $2,500** lifetime maximum per person	**50% COINS up to $1,250** lifetime maximum per person
Annual Deductible **Class A, B and C services** (Does not include Class D services)	**$0**	**$50 per person**	**$0**	**$75 per person**
Annual Maximum **Class A, B and C services** (Does not include Class D services)	**Unlimited**	**$3,000 per person**	**$1,500 per person**	**$750 per person**

South Carolina

Medicare Advantage

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Medicare Advantage: BlueCross Total, Blue Basic and Total Value

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

***SC Blue Dental Network**

South Carolina

Blue Secure

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Blue Secure – Members 19 and Older

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

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

South Carolina

Blue Secure – Members Under 19

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

South Carolina

Dental GRID

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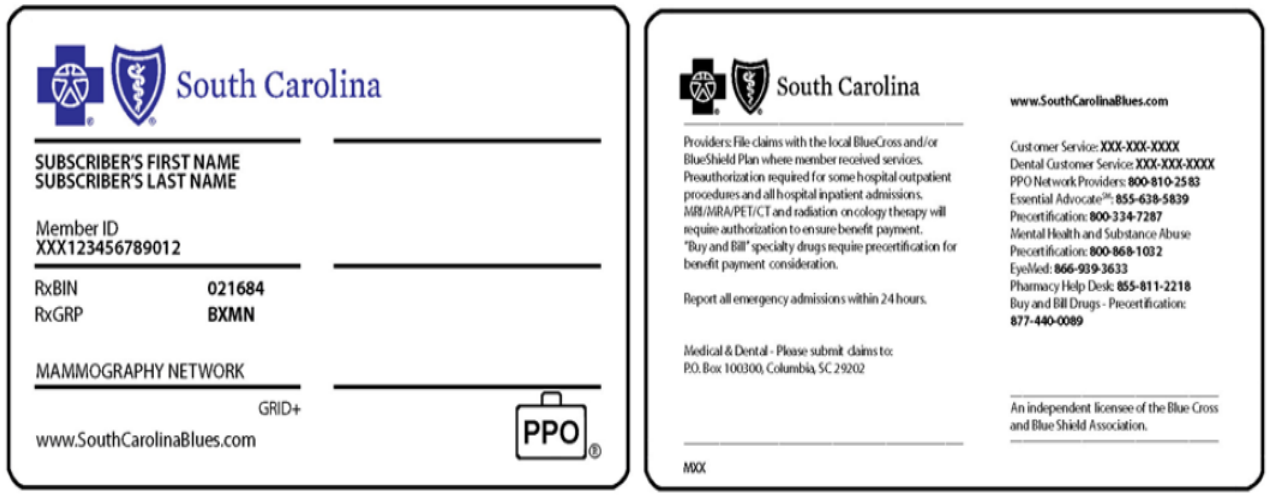
Overview of Dental GRID

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



Sample Commercial - Medical and Dental ID Card

South Carolina

GRID Participating Plans

Anthem Insurance Companies, Inc.		
Anthem Blue Cross of California	Anthem Blue Cross and Blue Shield of Colorado	Anthem Blue Cross and Blue Shield of Connecticut
Blue Cross and Blue Shield of Georgia	Anthem Blue Cross and Blue Shield of Indiana	Anthem Blue Cross and Blue Shield of Kentucky
Anthem Blue Cross and Blue Shield of Maine	Anthem Blue Cross and Blue Shield of Missouri	Anthem Blue Cross and Blue Shield of Nevada
Anthem Blue Cross and Blue Shield of New Hampshire	Empire Blue Cross and Blue Shield of New York	Anthem Blue Cross and Blue Shield of Ohio
Anthem Blue Cross and Blue Shield of Virginia	Anthem Blue Cross and Blue Shield of Wisconsin	
Health Care Service Corporation (HCSC)		
Blue Cross and Blue Shield Illinois	Blue Cross and Blue Shield Montana	Blue Cross and Blue Shield New Mexico
Blue Cross and Blue Shield Oklahoma	Blue Cross and Blue Shield Texas	
Other		
Blue Cross and Blue Shield of Arizona	Blue Cross and Blue Shield of Kansas	Blue Cross and Blue Shield of Kansas City
Blue Cross and Blue Shield of Massachusetts	Blue Cross and Blue Shield of Nebraska	Blue Cross and Blue Shield of Vermont (CBA Blue)
BlueCross BlueShield of North Carolina	BlueCross BlueShield of Tennessee	BlueCross of Idaho
BlueCross & BlueShield of Western/ BlueShield of Northeastern New York	Capital Blue Cross (Central PA)	CareFirst Blue Cross and Blue Shield (Maryland/District of Columbia)
Excellus BlueCross BlueShield (Rochester NY)	Horizon Blue Cross and Blue Shield of New Jersey	Wellmark Blue Cross and Blue Shield of Iowa

South Carolina

Dental Benefits and Claims

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Verifying Eligibility and Benefits

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

South Carolina

Filing Dental Claims Under the Medical Benefit

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

South Carolina

Filing Orthodontic Claims Electronically

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

General Guidelines for Filing Dental Claims

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

2026 Coding Updates

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New Dental Codes

Code	Description
D0426	Point of care saliva sample collection, preparation, and analysis
D0461	Cracked tooth testing
D1720	Administration of influenza vaccine
D5877	Duplication of maxillary denture
D5878	Duplication of mandibular denture
D5909	Maxillary guidance device using a flange
D5930	Maxillary guidance device without using a flange
D5938	Complete maxillary removable resection prosthesis
D5939	Complete mandibular removable resection prosthesis
D5940	Partial maxillary removable resection prosthesis
D5941	Partial mandibular removable resection prosthesis
D5942	Maxillary implant removable prosthesis for edentulous arch
D5943	Mandibular implant removable prosthesis for edentulous arch
D5944	Maxillary implant removable prosthesis for edentulous arch partial
D5945	Mandibular implant removable prosthesis for edentulous arch partial
D5946	Maxillary implant fixed prosthesis for edentulous arch

Note: Verify eligibility and benefits prior to rendering services.

South Carolina

New Dental Codes

Code	Description
D5947	Mandibular implant fixed prosthesis for edentulous arch
D5948	Maxillary implant fixed prosthesis for edentulous arch partial
D5949	Mandibular implant fixed prosthesis for edentulous arch partial
D6280	Implant maintenance procedures
D6049	Scaling and debridement of a single implant with bleeding, inflammation and increased pocket depth
D6196	Restoration removal on an implant retained abutment
D9128	Photo biomodulation therapy; 15 minutes
D9129	Photobiomodulation therapy; subsequent 15 minutes
D9244	Enteral minimal sedation in office administration
D9245	Enteral moderate sedation administration
D9246	Non-IV parenteral moderate sedation administration 15 minutes
D9247	Non-IV parenteral moderate sedation administration subsequent 15 minutes
D9224	General anesthesia 15 minutes
D9225	General anesthesia subsequent 15 minutes
D9936	Occlusal guard cleaning

Note: Verify eligibility and benefits prior to rendering services.

South Carolina

Deleted Dental Codes

Code	Description
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth
D1705	AstraZeneca Covid-19 vaccine administration – first dose
D1706	AstraZeneca Covid-19 vaccine administration – second dose
D1707	Janssen Covid-19 vaccine administration
D1712	Janssen Covid-19 vaccine administration - booster dose
D9248	Non-intravenous conscious sedation

South Carolina

Pharmacy

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Agenda

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

Formulary Updates

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Commercial Plans

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Commercial

Lowest Net Cost Formulary Updates

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Lowest Net Cost Formulary Updates

Additions

- Beginning Jan. 1, 2026, the following drugs will be added.

Therapeutic Class	Product	Formulary Status
ONCOLOGY	ENSACOVE CAP *	NON-PREFERRED BRAND SPECIALTY
ONCOLOGY	GOMEKLI CAP/TAB*	NON-PREFERRED BRAND SPECIALTY
ONCOLOGY	GRAFAPEX INJ *	NON-PREFERRED BRAND SPECIALTY
ANTI-PARKINSONS	ONAPGO INJ *#	NON-PREFERRED BRAND SPECIALTY
HEMOPHILIA	QFITLIA INJ #	NON-PREFERRED BRAND SPECIALTY
ONCOLOGY	ROMVIMZA CAP *	NON-PREFERRED BRAND SPECIALTY

**Requires Prior Authorization*

 # Quantity limit applies

South Carolina

Lowest Net Cost Formulary Updates (Continued)

Exclusions

- Beginning Jan. 1, 2026, the following drugs will be moved to non-formulary status.
- The products listed have alternatives on the formulary, many times, at a lower cost to the member.
  - Some covered alternatives may require prior authorization.

Therapeutic Class	Product	Formulary Status
ANTIBIOTIC	BLUJEPA TAB	NON-FORMULARY
OPTHALMIC GENE THERAPY	ENCELTO OPTHALMIC	NON-FORMULARY
ANALGESIC	JOURNAVX TAB	NON-FORMULARY
ANTIBIOTIC	ORLYNVAH TAB	NON-FORMULARY
NEPHROPATHY	VANRAFIA TAB	NON-FORMULARY
PRADER-WILLI SYNDROME	VYKAT XR TAB	NON-FORMULARY

Lowest Net Cost Formulary Updates (Continued)

Quantity Limits

- Beginning Jan. 1, 2026, the following drugs will be moved to non-formulary status.

Product	Quantity Limit
ORLYNVAH*	10 TABS/28 DAYS
VANRAFIA*	1 TAB/DAY

**Non-formulary*

Lowest Net Cost Formulary Updates (Continued)

Preferred Glucometer Test Strips Current and After Jan. 1, 2026

Product	Current Formulary Status (as of 09/15/25)	After 01/01/2026
ONETOUCH STRIPS	PREFERRED	NON-PREFERRED with prior authorization
CONTOUR STRIPS	PREFFERED	PREFERRED
ACCU-CHECK STRIPS	PREFFERED	PREFERRED

- Vouchers for Contour and Accu-Check Glucometers will be available as well as messaging at the pharmacy point of sale for $0 coverage.

Stelara Biosimilar Update

- As of July 1, 2025, Stelara (brand) was removed from the Lowest Net Cost Formulary. The biosimilars below replaced Stelara as preferred products. Prior authorization still applies.

Product	Formulary Status
YESINTEK SC INJ	PREFERRED
SELARSDI SC INJ	PREFERRED

South Carolina

Commercial

Premium Formulary Updates

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Premium Formulary Updates

Downtiers/Additions

- Beginning Jan. 1, 2026, the following drugs will change tiering status.

Product	Formulary Status
EMGALITY	EXCLUDED to Tier 2
SUPPRELIN LA KIT	Tier 2 to Tier 3
OMECLAMOX-MIS Pak	Tier 2 to Tier 3
DEPEN Titratab	Tier 2 to Tier 3

Exclusions

- Beginning Jan. 1, 2026, the following drugs will be moved to non-formulary status.
- The products listed have alternatives on the formulary, many times, at a lower cost to the member.
  - Some covered alternatives may require prior authorization.

Product	Formulary Status	Product	Formulary Status
AJOY	Non-formulary	DAYVIGO	Non-formulary
APTIOM	Non-formulary	DYMISTA	Non-formulary
BRILINTA	Non-formulary	ESTRO GEL	Non-formulary
COPAXONE	Non-formulary	NAMZARIC	Non-formulary

South Carolina

Premium Formulary Updates (Continued)

New Generic Availability

❑ Beginning Jan. 1, 2026, the following drugs will have a generic alternative available at Tier 1.

Therapeutic Class	Brand Drug	Formulary status	Alternative
ANTICONVULSANT AGENT	APTION TAB	EXCLUDED	ESLICARBAZEPINE TAB
CARDIOVASCULAR AGENT	ENTRESTO	EXCLUDED	SACUBITRIL-VALSARTAN TAB
HEMATOLOGICAL AGENT	BRILINTA	EXCLUDED	TICAGRELOR TAB
HORMONAL AGNET	ESTROGEL GEL 0.06%	EXCLUDED	ESTRASIOL GEL PUMP 0.06%
MUTIPLE SCLEROSIS AGENT	COPAXONE 40mg SC INJ	EXCLUDED	GLATIRAMER SC INJ
NASAL AGENT	DYMISTA NASAL SPRAY	EXCLUDED	AZELASTINE-FLUTICASONE

ADHD Shortage Resolution

❑ Beginning Jan. 1, 2026, Adderall XR will have a generic alternative available at Tier 1.

Brand	Formulary Status	Alternative
ADDERALL XR	EXCLUDED	AMPHETAMINE-DEXTROAMPHETAMINE ER CAP

Premium Formulary Updates (Continued)

Updates to Vigilant Drug List

- Beginning Jan. 1, 2026, except for Stelara, which started July 1, 2025.

Clinical Duplicate Drugs	High-Cost Brands with Generics				High-Cost Generics	NEDL Non-FDA/Creams and Patches
Adderall XR	Activella	Cortef	Lipofen	Sinemet	But/APAP/CAF Codeine	Sodium Sulf Sus
Ajovy	Acular	Cosopt	Lomotil	Tamiflu	Candesartan tab	Diclofenac Gel
Auryxia	Adderall XR	Cosopt PF	Macrobid	Tenoretic	Bromfenac Drop 0.075%	
Dayvigo	Adipex-P	Daraprim	Maxitrol	Tiazac	Loteprednol Sus 0.2%	
Ferric Citra	Aldactone	Detrol LA	Mozobil	Venxxiva	Octreotide Kit	
Hercessi	Alrex	Dymista	Nardil	Vigamox	Clindamycin Gel 1%	
Herzuma	Analpram-HC	Edecrin	Neruontin	Zenzedi		
Inzirqo	Azopt	Emend Bipack	Ocuflox	Zyprexa Zydis		
Nypozi	Azulfidine	Emend Tripack	Pred Forte			
Ogivri	Bromsite	Estrace	Reglan			
Omeclamox	Carbaglu	Fasodex	Remeron			
Ontruzant	Carnitor	Hydrea	Teyataz			
Stelara	Cipro	Invega	Salafen			
Vyepti	Copaxone	Kaletra	Sandostatin			

Premium Formulary Updates (Continued)

Biosimilar Strategy Update

- As the **biosimilar market** continues to expand, we support strategies that align with our patient-first guiding principles of clinical quality, accessibility, and affordability.

Therapeutic Class	Originator	Current Tier	New Strategy
Osteoporosis	Prolia	Tier 2 PA/QL	Tier 2 PA/QL Stoboclo Tier 2 PA/QL Jubbonti TBD Conexxence TBD
Cancer	Xgeva	Tier 2 PA	Tier 2 PA Osenvelt Tier 2 PA Wyost TBD Bomyntra TBD
Autoimmune	Stelara	Non-Formulary	Tier 2 PA Wezlana Yesintek

Premium Formulary Updates (Continued)

Diabetes Test Strip Coverage Update

- Beginning Jan. 1, 2026, due to availability and accessibility concerns with OneTouch manufacturer LifeScan, BlueCross will be moving to Contour and Accu-check.
- New preferred brand **Contour** by Ascensia and **Accu-Check** by Roche will be preferred on Sep. 15, 2025.
- **OneTouch** by LifeScan will be moved to excluded on Jan. 1, 2026.

Product	Current Formulary Status 9/15/2025	Formulary Status After 1/1/2026
Onetouch Strips	Preferred	Excluded
Countour	Preferred	Preferred
Accu-check	Preferred	Preferred

Note: Vouchers for Contour and Accu-Check Glucometers will be available as well as messaging at Pharmacy Point of Sale.

South Carolina

Overview of Vaccines: LNC, Premium and ACA Updates

Influenza and RSV Vaccines

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

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

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

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

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

South Carolina

Pharmacy Resources

Pharmacy Benefit

- Medications at retail, specialty and mail order pharmacies.
- Drug is self-administered.
- Use the Comprehensive Drug Lookup Tool: https://www.southcarolinablues.com/web/public/brands/sc/members/prescription-drugs/other-group-plans/pharmacy-benefits/

Medical Benefit

- Drug is provider-administered in the office, infusion center, etc.
- Use the Medical Specialty Drug List:
  - *Specialty Medical Drug List, effective July 1, 2025*

Prior Authorization Information – Optum

- Phone: 855-811-2218
- Online Portal: CoverMyMeds
- Review time: Standard, 72 hours; Appeals, 14 days

South Carolina

Exchange Plans

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General Pharmacy Updates for Exchange Plans

GLP-1 Provider Taxonomy Edit

Goal: Align use of GLP-1 medications with clinical expertise.

- As of Oct. 1, 2025, prescriptions for GLP-1 agents used to treat type 2 diabetes must be issued by an authorized provider whose scope of practice includes the diagnosis, monitoring, and management of diabetes.
- The edit reviews all diabetes GLP-1 medications at the point of sale or pharmacy counter.
- A reject occurs for diabetes GLP-1 medication claims if the provider does not have an eligible practice taxonomy code.
- The edit applies to all GLP-1 medications indicated for diabetes including:
  - dulaglutide (Trulicity)
  - exenatide (Byetta)
  - liraglutide (Victoza)
  - semaglutide (Ozempic, Rybelsus)
  - tirzepatide (Mounjaro)

Exchange Formulary Updates

	2026 Core (Broad) Formulary	2026 Select (Narrow) Formulary Narrow Network/HMO Plans
Tier Design	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Drug Tier 4: Specialty	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Drug Tier 4: Specialty
Formulary Design	Broad Coverage	Narrow Coverage
Amount of Formulary Drugs	4500+	2500+
HCR $0 Copay List (Health Care Reform)	Yes	Yes

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Exchange Formulary Updates (Continued)

Core Formulary (Broad)

- Reduced the amount of covered drug products
- Stratified generic tiering
  - Current formulary has most generic products on Tier 1
  - Placing higher cost generics on higher tiers
- HCR $0 copay list still in place

Select Formulary (Narrow)

- Minimal removals
- Addition of general maintenance products to reduce member disruption
- Addition of quantity limit edits
- HCR $0 copay list still in place

Note: Confirm formulary drug coverage status using the drug look-up tool on www.SouthCarolinaBlues.com.

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Exchange Formulary Updates (Continued)

Diabetes Test Strip Coverage Update

- Due to availability and accessibility concerns with OneTouch manufacturer LifeScan BCBSSC will be moving Contour and Accu-check to formulary.
- **Contour** by Ascensia and **Accu-Check** by Roche will be preferred beginning 9/15/2025.
- **OneTouch** by LifeScan will be moved to excluded on 1/1/2026.

Product	Current Formulary Status (as of 9/15/2025)	After 1/1/2026
ONETOUCH STRIPS	PREFERRED	EXCLUDED
CONTOUR STRIPS	PREFFERED	PREFERRED
ACCU-CHECK STRIPS	PREFFERED	PREFERRED

- Vouchers for Contour and Accu-Check Glucometers will be available at the pharmacy for $0.
- Members, providers and pharmacies are being notified of preferred product changes.

Exchange Formulary Updates (Continued)

Biosimilar Reminder

- Humira (brand) and Stelara (brand) products have been removed from Exchange formularies. The biosimilars below replaced Humira and Stelara as preferred products. Prior Authorization will still apply.

Formulary	Reference Product	Preferred Biosimilars
Core (Broad)	Stelara	Yesintek, Wezlana
	Humira	Amjevita, Hadlima
Select (Narrow)	Stelara	Yesintek, Selarsdi
	Humira	Amjevita, Hadlima

Exchange Formulary Updates (Continued)

Narrow Networks (Blue Cooper, Reedy, Pee Dee, Congaree and Beaufort)

- Narrow network plans are transitioning from the Core formulary to the Select formulary.
- Key areas of member impact:
  - Specialty anti-inflammatory products
  - GLP-1 products
  - Migraine products
  - Brand products with available generic alternatives

Note: Confirm formulary drug coverage status using the drug look-up tool on www.SouthCarolinaBlues.com.

Exchange Pharmacy Resources

Pharmacy Benefit

- Medications at retail, specialty and mail order pharmacies.
- Drug is self-administered.
- Use the Comprehensive Drug Lookup Tool: https://www.southcarolinablues.com/web/public/brands/sc/members/prescription-drugs/other-group-plans/pharmacy-benefits/

Medical Benefit

- Drug is provider-administered in the office, infusion center, etc.
- Use the Medical Specialty Drug List:
  - *Specialty Medical Drug List, effective July 1, 2025*

Prior Authorization Information – Optum

- Phone: 855-811-2218
- Online Portal: CoverMyMeds
- Review time: Urgent, 24 hours; Standard, 72 hours.

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Medicare

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2026 IRA Changes

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Maximum Fair Price

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2026 IRA Changes – Maximum Fair Price

- In August 2022, the Inflation Reduction Act (IRA) was signed into law.
- The law established the Medication Negotiation Program to negotiate maximum fair prices (MFPs) for certain high expenditure, single source and biological products.
- MFPs will be effective Jan. 1, 2026.
- The drug company with a selected drug is required to ensure the negotiated price is made available to eligible individuals and to the pharmacies, mail-order services, and other entities that dispense the selected drug to such individuals.
- All selected drugs must be included on Medicare formularies.

2026 IRA Changes – Maximum Fair Price (Continued)

2026 Selected Drugs

Drug Name	Commonly Treated Condition
Eliquis	Prevention & treatment of blood clots
Enbrel	Rheumatoid arthritis; Psoriasis; Psoriatic arthritis
Entresto	Heart failure
Farxiga	Diabetes; Heart failure; Chronic kidney disease
Fiasp, Novolog	Diabetes
Imbruvica	Blood cancers
Januvia	Diabetes
Jardiance	Diabetes; Heart failure
Stelara	Psoriasis; Psoriatic arthritis' Crohn's disease; Ulcerative colitis
Xarelto	Prevention & treatment of blood clots; Reduction of risk for patients with coronary or periphery artery disease

Looking ahead to 2027:

Austedo, Austedo XR
Breo Ellipta
Calquence
Ibrance
Janumet, Janumet XR
Linzess
Ofev
Otezla
Ozempic, Rybelsus, Wegovy
Pomalyst
Tradjenta
Trelegy Ellipta
Vraylar
Xifaxan
Xtandi

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Medicare Prescription Payment Plan

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Medicare Prescription Payment Plan (M3P)

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

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

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

M3P – 2026 Opt-in Requirements

- Effective in 2026, Part D plans will be required to automatically renew members who opted-in to the Medicare Prescription Payment Plan in 2025.
- If members change plans, they will need to opt-in to the payment option with their new plan.
- Members can sign up for this payment option anytime throughout the year.
  - Note: Opting-in prior to or at the beginning of the plan year will give the member more months to spread out their costs.

M3P – Likely to Benefit

Members are likely to benefit from M3P if:

- ≥ **$2,100** in out-of-pocket drug costs from January – September prior to the plan year
- **$600** out-of-pocket costs for a single prescription claim during the plan year
- Identified through additional plan-defined strategies during the plan year

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M3P – Likely to NOT Benefit

Members are NOT likely to benefit from M3P if:

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

2026 Medicare Advantage Plan and Formulary Changes

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2026 Medicare Advantage Plan and Formulary Changes

Important Reminders:

- ❑ All members should review their Annual Notice of Change (ANOC) that were mailed.
- ❑ Members experiencing disruption from the 2026 changes may receive additional communication via:
  - Letters
  - Call campaigns
  - Text messages
- ❑ **New Preferred Diabetic Testing Products**
  - ✓ **Accu-Chek** and **Contour** diabetic testing supplies are preferred
    - ✓ **New meters available to members at $0**
  - × OneTouch diabetic testing supplies will become Non-formulary effective Jan. 1, 2026

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Medicare Advantage Medication Adherence

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

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

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

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Medicare Pharmacy Resources

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

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Healthy Blue

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Healthy Blue℠

BlueChoice® HealthPlan of SC

Healthy Connections

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Healthy Blue Formulary Updates

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

	Previous Status	New Status
Immunomodulators, Topical Atopic Dermatitis		
pimecrolimus cream (generic for Elidel®)	PDL Non-Preferred	PDL Preferred
tacrolimus ointment (generic for Protopic®)	PDL Non-Preferred	PDL Preferred
Steroids, Medium Potency		
fluocinolone cream / ointment / solution (generic for Synalar®)	PDL Non-Preferred	PDL Preferred
fluticasone cream / ointment (generic for Cutivate®) NOTE: Lotion will remain Non-Preferred	PDL Non-Preferred	PDL Preferred
Corticosteroids, Inhaler Devices		
Pulmicort® Flexhaler	PDL Non-Preferred	PDL Preferred
Anti-Migraine, CGRP Modulators, Preventive		
Ajovy® Injection	PDL Non-Preferred	PDL Preferred
Qulipta® Tablet	PDL Non-Preferred	PDL Preferred
ACE Inhibitors and Combinations		
ramipril (generic for Altace) capsule	PDL Non-Preferred	PDL Preferred
Beta Adrenergic Devices, Short Acting Inhalers		
albuterol HFA inhaler (generic for Proair® HFA)	PDL Non-Preferred	PDL Preferred
albuterol HFA inhaler (generic for Ventolin® HFA)	PDL Non-Preferred	PDL Preferred

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Brand Over Generic

- Medicaid does not routinely cover brand-name products for which there are therapeutically equivalent generic products available.
- However, SCDHHS does mandate coverage of certain BRAND name products. See below and the list can be found here: https://southcarolina.fhsc.com/

Brand Name Preferred over Generic List Updated 10/1/2025						
Advair Diskus®	Carbatrol®	Epipen®*	Natroba®	Sabril® Powder Pack	~~Ventolin® HFA~~	
Advair HFA®	Celontin®	Epipen Jr®*	Oxycontin®	Spiriva® Handihaler®	Victoza®	
Alphagan P® 0.1%, 0.15%	Combigan®	Exelon® Patch	Pentasa®	Suboxone® Film	Vyvanse® Capsule	
Anoro® Ellipta®	Copaxone® 20mg/ml dose	Farxiga®	Pradaxa®	Symbicort®	Vyvanse® Chewable	
~~Apriso®~~	Daytrana®	Fycompa®	Proglycem®	Tegretol® XR	Xarelto® Tablet	
Arnuity® Ellipta®	Dexilant®	Lantus® Solostar®	Protonix® Suspension	Tekturna®	Xarelto® Suspension	
Azopt®	Dificid® Tablet	Lantus® Vial	Relpax®	Testim® Gel 1% Packet	Xigduo® XR	
Banzel® Tab	Durezol®	Lumigan®	Restasis®	Travatan-Z®		
Brilinta®	Elidel®	Myrbetriq® Tablet	~~Retin-A® Cream~~	Tresiba®		
Butrans®	Entresto® Tablet	Narcan® Nasal	~~Retin-A® Gel~~	Trileptal® Suspension		

- * = Brand and AUTHORIZED GENERIC (only) are BOTH Preferred
- Products listed in RED are new to the list since the last posted update

This list is current as of 10/01/2025, is subject to change at any time, should not be considered all-inclusive, and cannot be used for claims payment. **FOR INFORMATIONAL PURPOSES ONLY**.

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Healthy Blue Pharmacy Resources

Pharmacy Benefit

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

Prior Authorization Information – CarelonRx

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

Medical Benefit

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

Prior Authorization Information – CVS/Novologix

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

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Healthy Blue Pharmacy Resources (Continued)

Mail Order and Home Delivery

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

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Provider Enrollment

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Topics to Discuss

- Provider Enrollment Requirements
- Overview of the Enrollment Process
- Important Reminders
- My Provider Enrollment Portal
- Available Resources

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Provider Enrollment Requirements

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Provider Enrollment Application Types

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

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

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Provider Enrollment Checklists

Individual Provider Enrollment

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

Group Practice Enrollment

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

Other

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

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

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Example of an Individual Enrollment Checklist

Physicians and Chiropractors

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

*Must include past five years (active and inactive).

**Only if applicable.

***Required for MDs, DOs and DPMs.

****Only if applying for BlueChoice HealthPlan.

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

******If board certified.

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Example of a Group Practice Enrollment Checklist

Physician Office

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

*Only if applying for Healthy Blue.

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

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

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

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Overview of the Enrollment Process

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Understanding the General Process of an Application

- After you complete and submit your application in My Provider Enrollment Portal, the application will be in the submitted status pending review.
- During the preliminary review, the application is assigned to an enrollment analyst for a high-level review to determine whether the application is clean (all the required information and items are included).*
- If the application is deemed clean, the analyst will send the application and agreements to the appropriate parties for electronic signatures.
- Once all appropriate parties have signed their applicable sections of the documents, the application will move to the next stage of the process.
- During the secondary review, the credentialing team takes a deeper look at the application, to include background checks for the practitioners, and sends the application to committee.*
- If everything is clear and approved by the committee, the application progresses to contracting.*
- During the final review, the enrollment team loads the provider into the system and sends a welcome notification to the credentialing contact that includes the network and affiliation dates.

**During these stages, any missing items or corrections needed will cause the application to be sent back to the provider.*
To prevent delays, be sure to review the checklists, include appropriate emails for signatures and answer disclosure questions correctly.

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7-7-7 Rule for Missing Items

- Once an application is reviewed and an analyst determines something is needed, they will add a case comment explaining the issue.
- When you receive a notice for missing items or corrections that are needed to an application, we encourage you to return the requested information or make the necessary corrections as soon as possible.
- An automated notification is sent every seven days (**up to 21 days**).
  - Day seven: You will receive the first notification.
  - Day 14: You will receive the second notification.
  - Day 21: You will receive the final notification.
- If the requested items or corrections are not received by day 21, the application will be up for cancellation.

Note: The automated notifications will stop once the case is reviewed by the assigned analyst.

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E-signing Process

- As of June 9, 2025, applications, contracts and other enrollment related documents can be signed electronically.
- For each application type—whether for initial enrollment or maintenance—you will be prompted to provide specific email addresses for various roles, such as:
  - Practitioner
  - Credentialing contact
  - Fiduciary contact
- When documents are ready for signature:
  - An email will be sent to the first required signer (for example, the practitioner for an individual application).
  - Once they sign, the next designated contact (such as the credentialing contact) will receive their e-sign email.
  - When all applicable parties have signed their portion of the documents, they will receive confirmation via email.

Note: When applicable, you must enter the practitioner's email address. It cannot be the email address for the practice.

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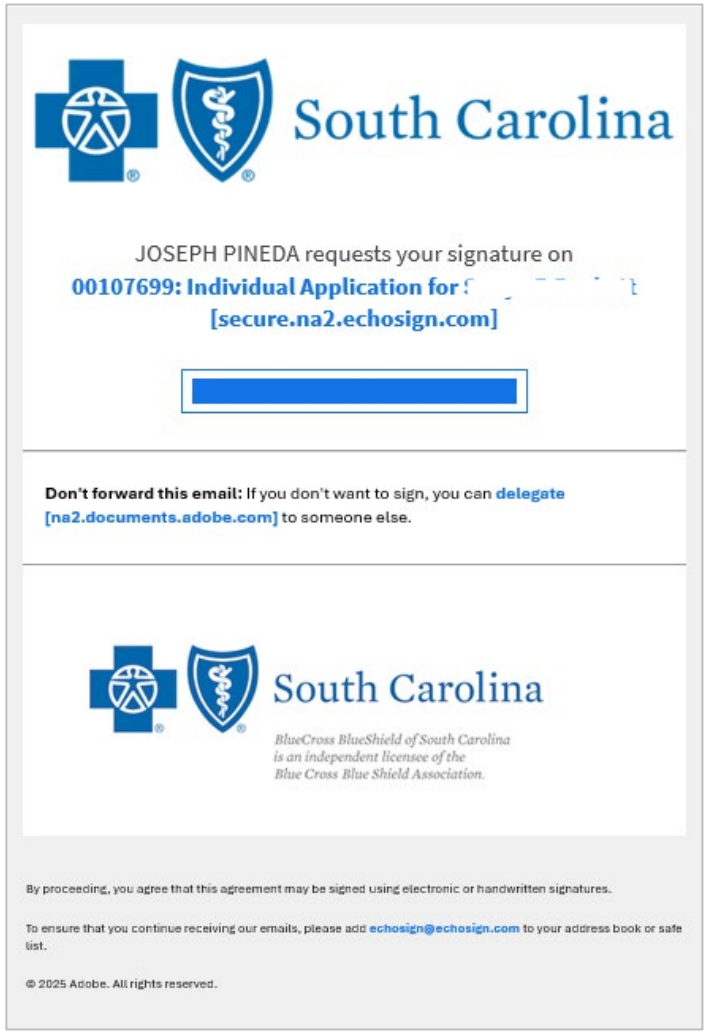
Example of E-sign Emails



All appropriate parties will receive the appropriate document to sign.

All appropriate parties will receive confirmation once completed.

Note: Do not delete or ignore these emails—they are not spam or phishing attempts. Also, please do not respond to these emails.

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Network and Affiliation Dates

- Network effective dates are based on the credentialing committee's approval date.
  - Network effective dates **cannot** be backdated.
- Affiliation dates are based on the practitioner's start date with the practice they are joining.
  - Affiliation dates can be backdated to the earliest start date for the practitioner, but no more than Jan. 1st of the previous year.
  - **This does not apply to the Healthy Blue network.**
    - This ensures we comply with South Carolina Department of Health and Human Services (SCDHHS) and National Committee for Quality Assurance (NCQA) standards and guidelines.

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Important Reminders

Medicaid ID Requirements

- The Medicaid ID is needed for any practitioner or group that wishes to participate in the Healthy Blue network.
  - We encourage you to wait until you have the Medicaid ID number before beginning an application for the practitioner or group.
- The Medicaid ID must be registered with SCDHHS and **must be assigned to the practitioner or group NPI**, not the TIN.
- During the review process of an application, if the practitioner or group's Medicaid ID number is not validated or active with SCDHHS, they will not be considered for participation in the Healthy Blue network.

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Important Information for the Healthy Blue Network

- When it comes to the credentialing process for the Healthy Blue network, providers have the right to:
  - Review information obtained from outside sources (i.e., state licensing boards) used to evaluate their credentialing application.
    - This does not include references, recommendations, or other peer-review protected information.
  - Correct any erroneous information submitted by outside sources.
    - If the credentialing staff identifies a discrepancy, they will notify the provider in writing (case comment).
  - Question the status of their credentialing application and receive a response by phone or email within seven calendar days to include:
    - The date their completed application was received.
    - Any outstanding items needed for completion.
    - The expected date of the credentialing decision.
- To exercise the above rights:
  - Submit a support case or a case comment if the application is still open and being worked.
  - Submit a faxed inquiry to 803-870-9997 if the application has been canceled.
    - Faxed inquiries can be submitted using a free formed letter.

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Provider Medical Licenses and Work History

- For both the provider's medical licenses and work history, we need five years (60 consecutive months) of data.
- For medical licenses, you would include any applicable active and inactive licenses.
- For the work history, if there is a gap of six months or more, a detailed explanation is required for review.
  - When adding the work history in My Provider Enrollment Portal, we encourage you to list them in chronological order, starting with the current job.

Expiring Documents

- All documents being uploaded with the application must be current and should not expire within 30 days. This includes:
  - Medical licenses
  - Malpractice (COI)
    - Be sure the copy uploaded covers the requested start date for the practitioner.
  - DEA license
  - CLIA certificates
- If the document is going to expire within 30 days of submission, be sure to include a copy of the current document and the new or updated document.

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Taxonomy and Languages

- The taxonomy selected during the application process must coincide with the practitioner's medical license.
  - For example, a nurse practitioner may specialize in family medicine; however, they should not select family medicine as their taxonomy. Instead, they should select nurse practitioner based on their license.
- When completing the enrollment application, be sure to select all the applicable languages the practitioner speaks.
  - This information is included in our directories and allows patients to select provider's that meet their language needs.

Misrouted Inquiries

- There are times when the provider enrollment team receives inappropriate requests related to:
  - Prior authorizations
  - Claims
  - Benefits
- For these types of inquiries, be sure to contact the appropriate Provider Services area based on the member's plan or use My Insurance Manager℠.

Recredentialing Process

- **Recredentialing for network participating practitioners occurs every three years.**
  - If you need to know the upcoming recredentialing dates for a provider, email Recred.App@bcbssc.com.
    - Include the provider's name and NPI.
- **The credentialing team reaches out when the provider's recredentialing dates is approaching.**
  - The team reaches out to the practice on file that the provider is affiliated with to see if they are actively working at the location. It is important that we have the most accurate and up-to-date contact information on file.
    - If a response is not received after the first outreach, a second attempt is made in 14 days.
    - If a response is not received after the second outreach, a third attempt is made in seven days.
    - If a response is not received after the third and final outreach, the process to terminate the provider is initiated.
- **If a provider is past due for their recredentialing or if the recredentialing is due within 60 days, a new enrollment application must be submitted.**

Note: Outreach begins two to three months in advance.

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Non-credentialed Providers

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

**Can join the Healthy Blue network.*

Note: This list may not be all inclusive.

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Provider Directory Validation

- Providers have been required to verify their demographic data at least ***every 90 days*** since Jan. 1, 2022.
  - This implementation was part of the No Surprises Act.
- Validation allows us to maintain accurate directories.
- Verification can be completed in M.D. Checkup (accessible through My Insurance Manager).
  - You can also respond to the email received from Provider.Directory@bcbssc.com.
- For outreach purposes, it is important to have the correct contact information on file.
  - If contact information needs to be updated for your practice, you can submit a support case in My Provider Enrollment Portal.
    - If contacts are different based on the location, be sure to include the specific details.

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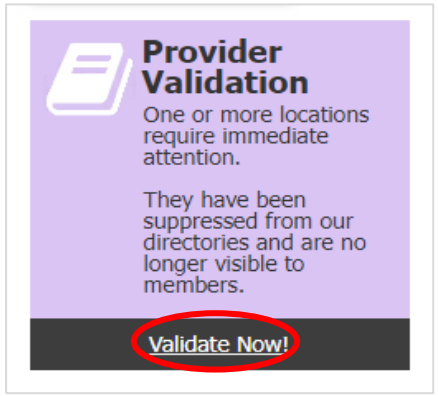
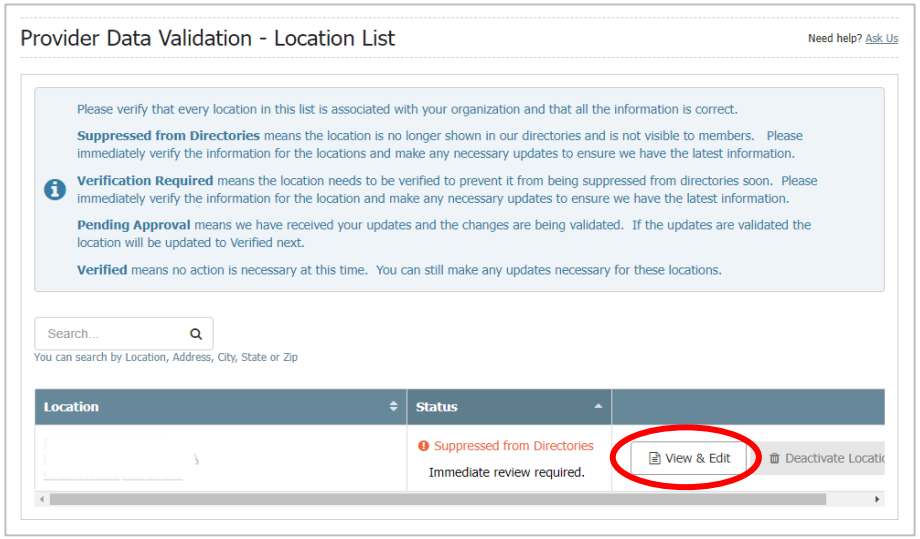
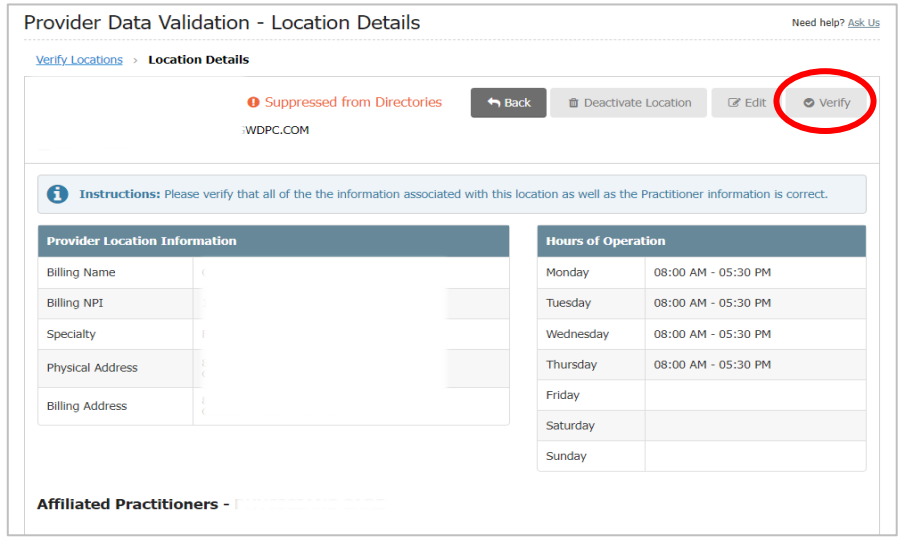
Location Suppressions Due to Missing Validation

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







South Carolina

Making Demographic Updates

- There are times in which you must make demographic updates to your practice or practitioner.
- Some updates can be made in My Provider Enrollment Portal, and some can be made using M.D. Checkup.

My Provider Enrollment Portal

- Submit a Name Change
- Change of Address
- Add a Satellite Location
- Request to Add a Practitioner
- Remove a Practitioner

M.D. Checkup

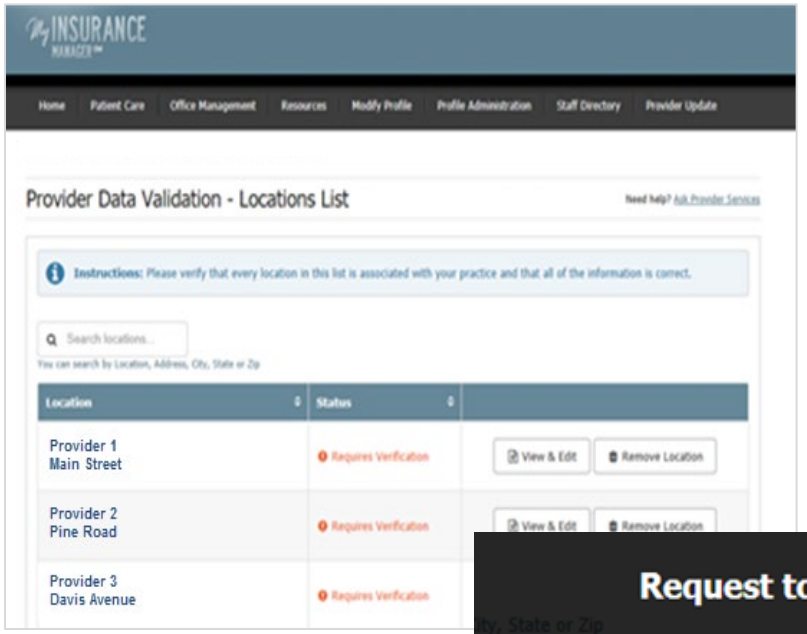
- Terminate (close) Location
- Change of Address
- Hours of Operations
- Add a Practitioner Affiliation
- Terminate Practitioner Affiliation

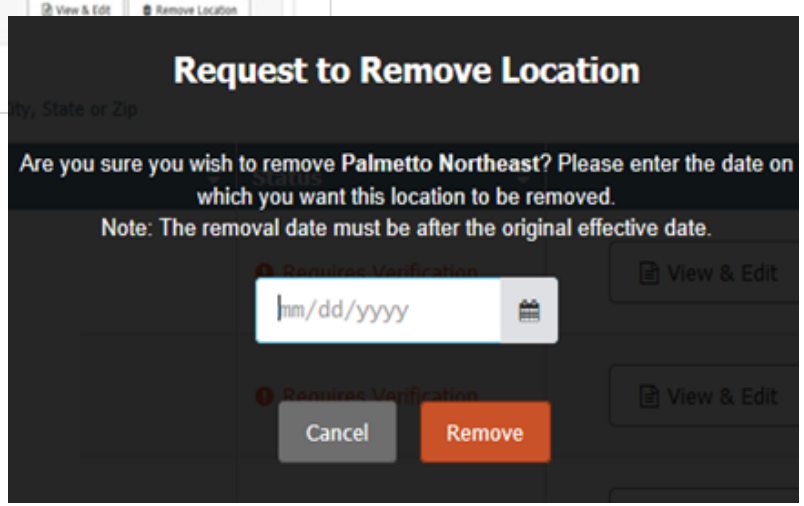
Note: You can only add a practitioner in M.D. Checkup if they are ***enrolled and associated*** *with the TIN.*

South Carolina

Terminating (Closing) Locations Using M.D. Checkup

- To close a location for your practice using M.D. Checkup:
  - Log into My Insurance Manager.
  - Select Provider Update.
  - Select Remove Location next to the location you wish to close.
  - Enter the effective date of change.
  - Select Remove.





Note: This function closes the location in our claims system.

South Carolina

Adding Practitioner Affiliations Using M.D. Checkup

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

My Provider Enrollment Portal	M.D. Checkup
Dr. Jane Doe is enrolled but not associated with TIN B. She is scheduled to see patients at this new location. Because Dr. Doe is not associated with TIN B, the Add Practitioner Form must be completed and submitted through My Provider Enrollment Portal.	Dr. Jane Doe is enrolled and associated with TIN A. She works at location 1 but is scheduled to see patients at location 2. She will be submitting claims for location 2 and needs to be added. Because Dr. Doe is already associated with TIN A, she can be added to location 2 through M.D. Checkup.

South Carolina

My Provider Enrollment Portal

Your Complete Solution

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Overview of Portal

Your Complete Solution

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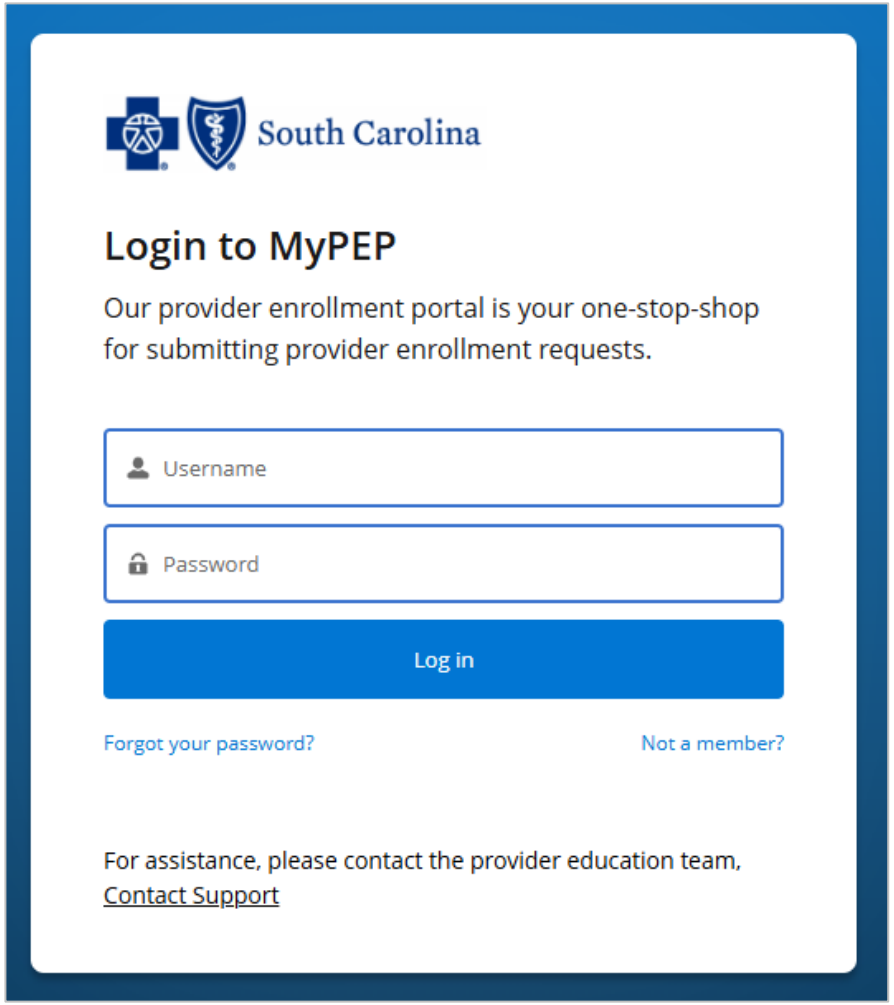
Getting Started with My Provider Enrollment Portal

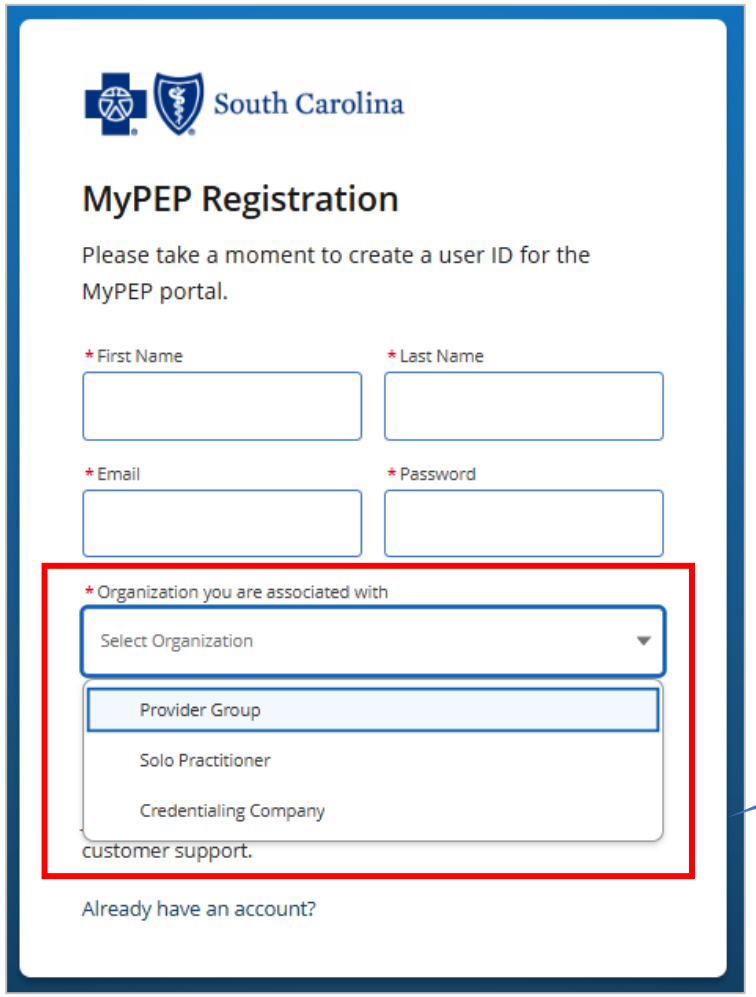
- Visit www.SouthCarolinaBlues.com.
  - Providers>Provider Enrollment>**Join Our Networks**
- Username format: **email.firstname.lastname**
- New users should select Not a member from the landing page of the portal.



South Carolina

Registering

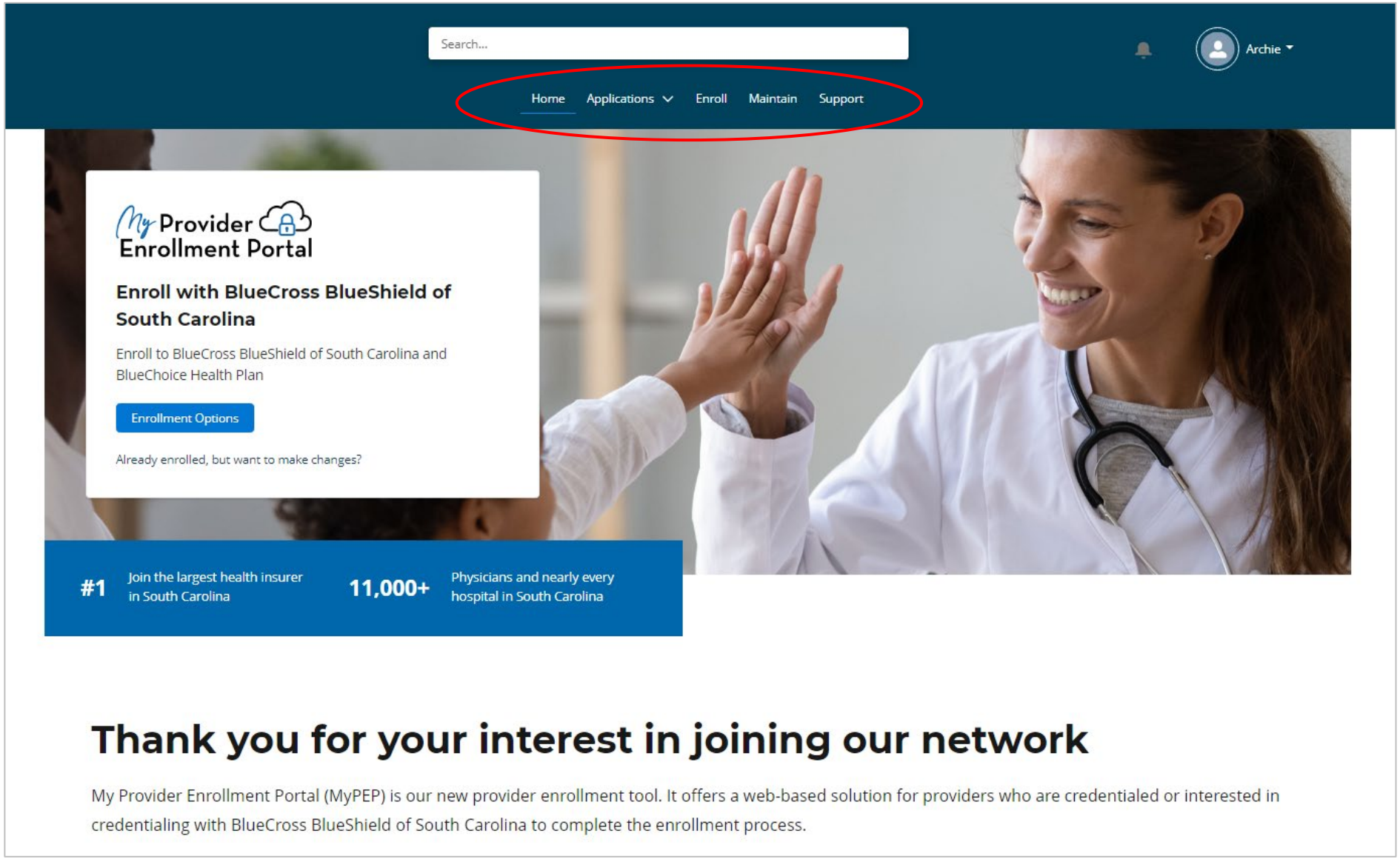
- Options include: solo practitioner, provider group and credentialing company.



The required details will vary based on the selection made.

South Carolina

My Provider Enrollment Portal – Home Page



What you'll see under Applications.

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

South Carolina

My Provider Enrollment Portal – Started Applications

Applications

My Started Applications

13 items • Sorted by Application Type • Filtered by My applications - Application Status

	Application Type	Application Status	NPI Type I	NPI Type II	Resume Application	Created Date
1		In Progress				3/31/2025, 7:28 AM
2		In Progress				4/2/2025, 10:13 AM
3		In Progress				4/29/2025, 8:45 AM
4	Individual	In Progress				3/26/2025, 7:56 AM
5	Individual	In Progress			Resume	4/2/2025, 10:30 AM
6	Individual	In Progress			Resume	4/29/2025, 8:35 AM
7	Individual	In Progress			Resume	5/9/2025, 9:19 AM
8	Individual	In Progress	1555555555		Resume	6/23/2025, 7:42 AM
9	Individual	In Progress	1777777777		Resume	7/1/2025, 7:06 AM
10	Satellite Location	In Progress		1444444444	Resume	6/19/2025, 5:23 AM

South Carolina

My Provider Enrollment Portal – In-Progress Applications

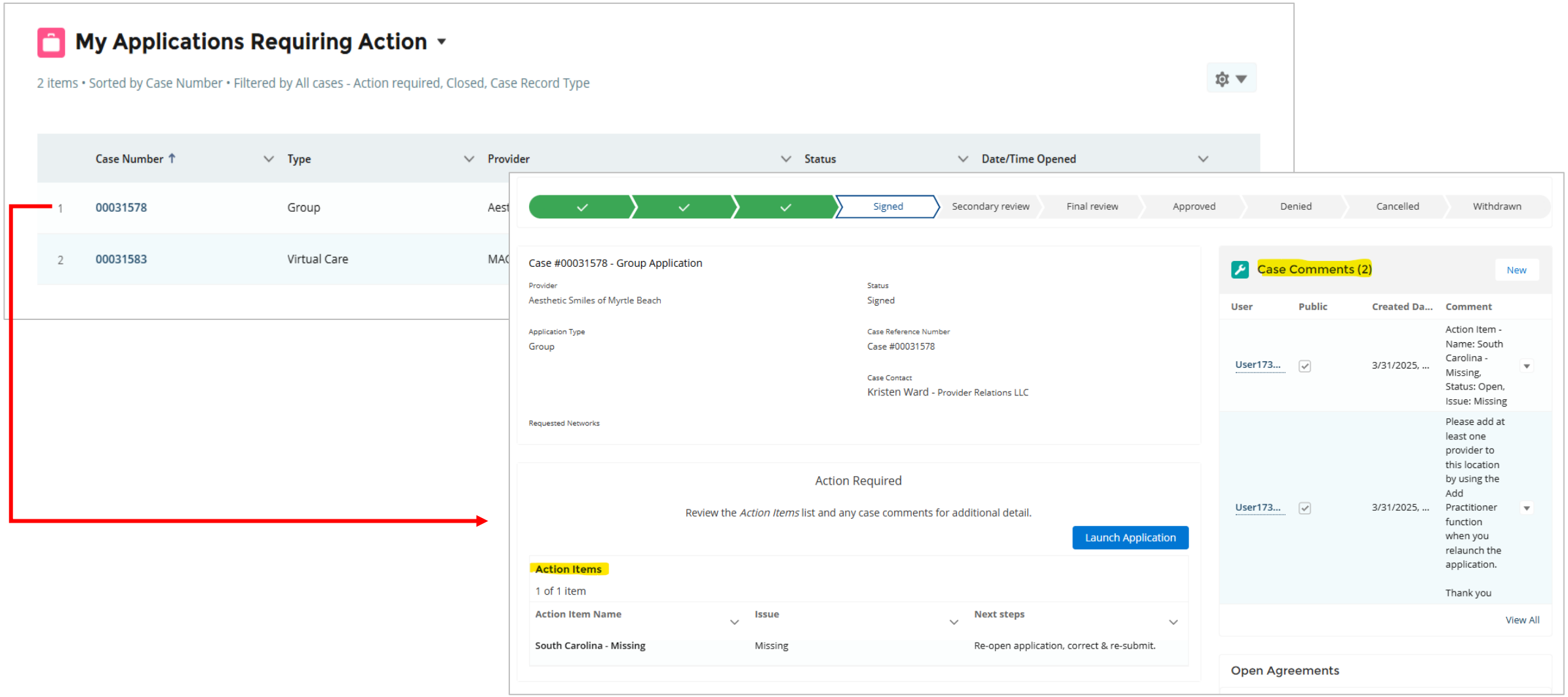
My In-Progress Applications

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

	Case Number	Type	Provider	Status	Date/Time Opened
1	00031578	Group	Aesthetic Smiles of Myrtle Beach	Signed	3/31/2025, 7:37 AM
2	00031581	Individual	Terrence Archie - MAGNOLIA ENDOCRINOLOGY LLC	Submitted	3/31/2025, 8:02 AM
3	00031583	Virtual Care	MAGNOLIA ENDOCRINOLOGY LLC	Signed	3/31/2025, 8:29 AM
4	00031584	Change of Address		Signed	3/31/2025, 8:36 AM
5	00031585	Request to Add Practitioner	DAVID YOUNIE - FLOSSY PEDIATRIC DENTISTRY	Submitted	3/31/2025, 8:52 AM
6	00031590	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	3/31/2025, 10:40 AM
7	00031612	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	4/1/2025, 8:05 AM
8	00031614	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	4/1/2025, 8:12 AM
9	00031664	Request to Term Practitioner	TIMOTHY KAYLOR - ZONE PHYSICAL THERAPY	Submitted	4/2/2025, 5:18 AM
10	00031668	Business Name Change	Provider Relations LLC	Submitted	4/2/2025, 5:53 AM

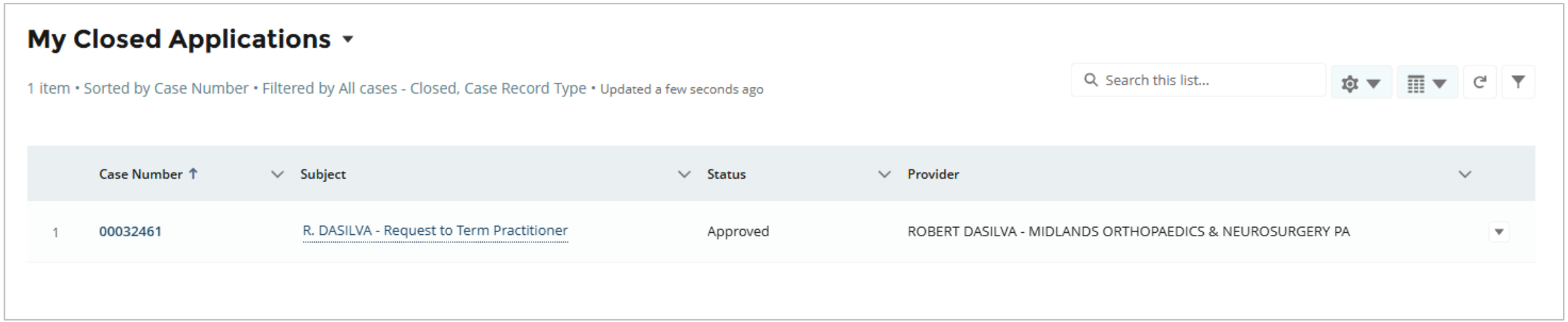
South Carolina

My Provider Enrollment Portal – Applications Needing Action



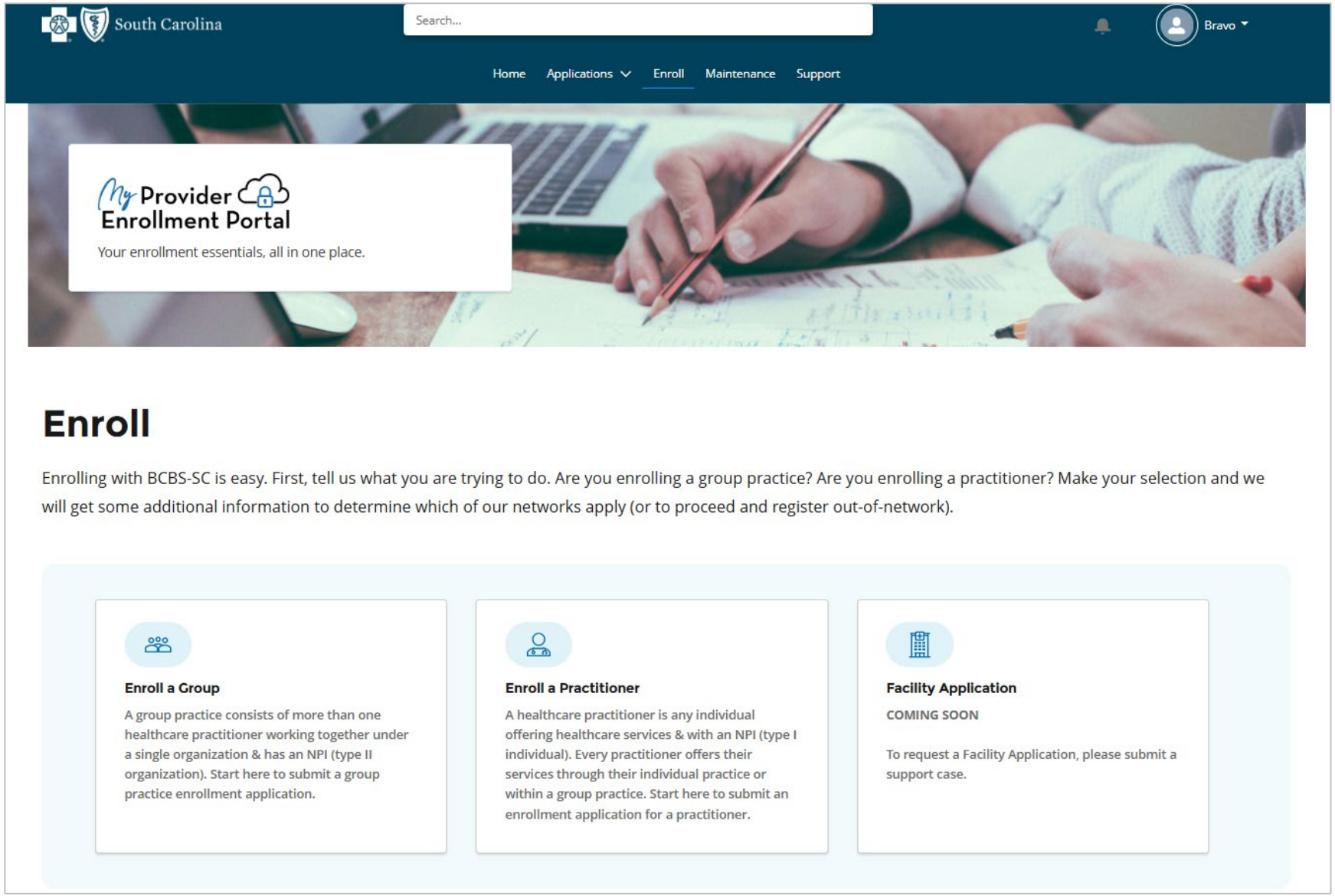
South Carolina

My Provider Enrollment Portal – Closed Applications



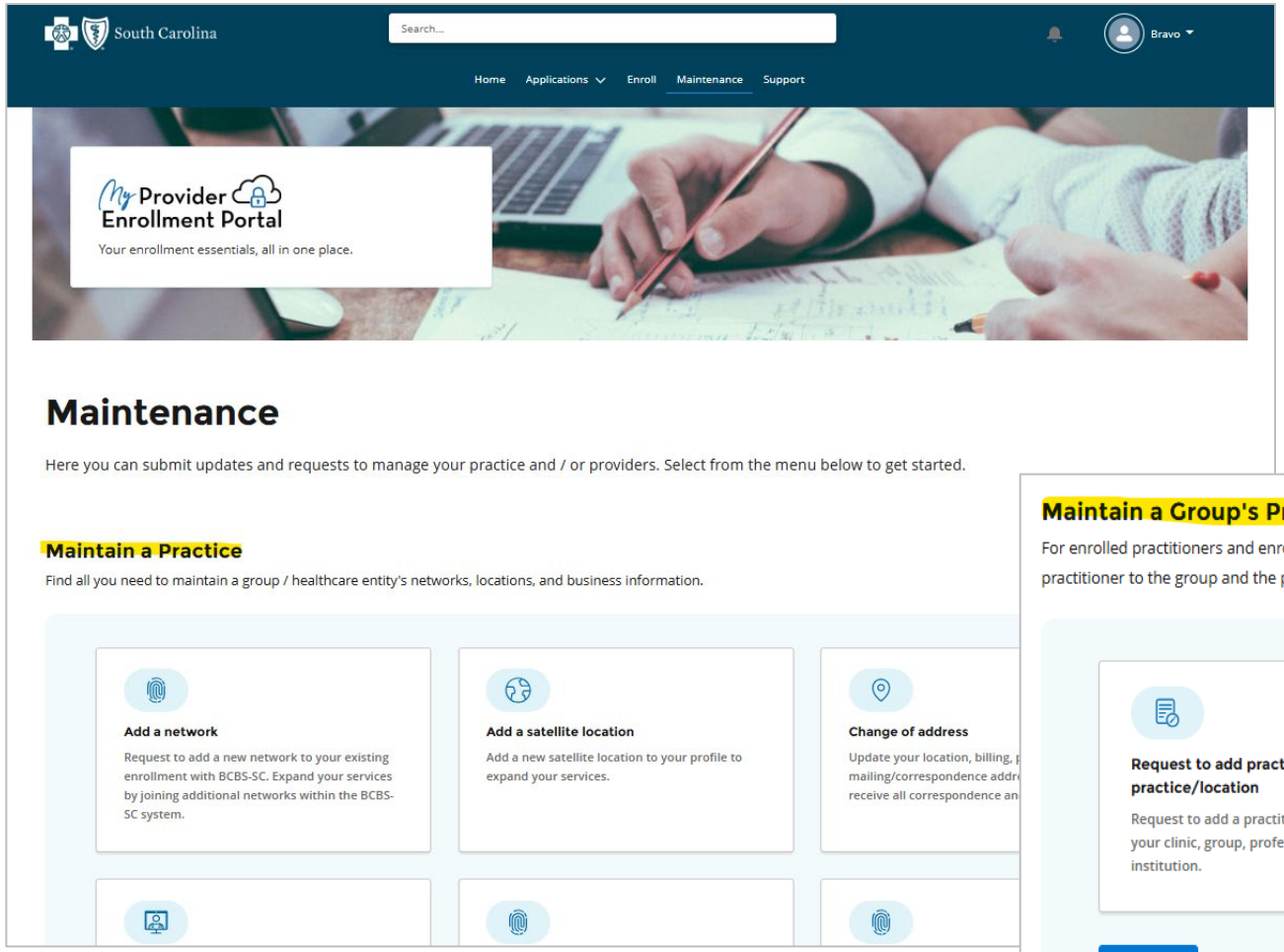
South Carolina

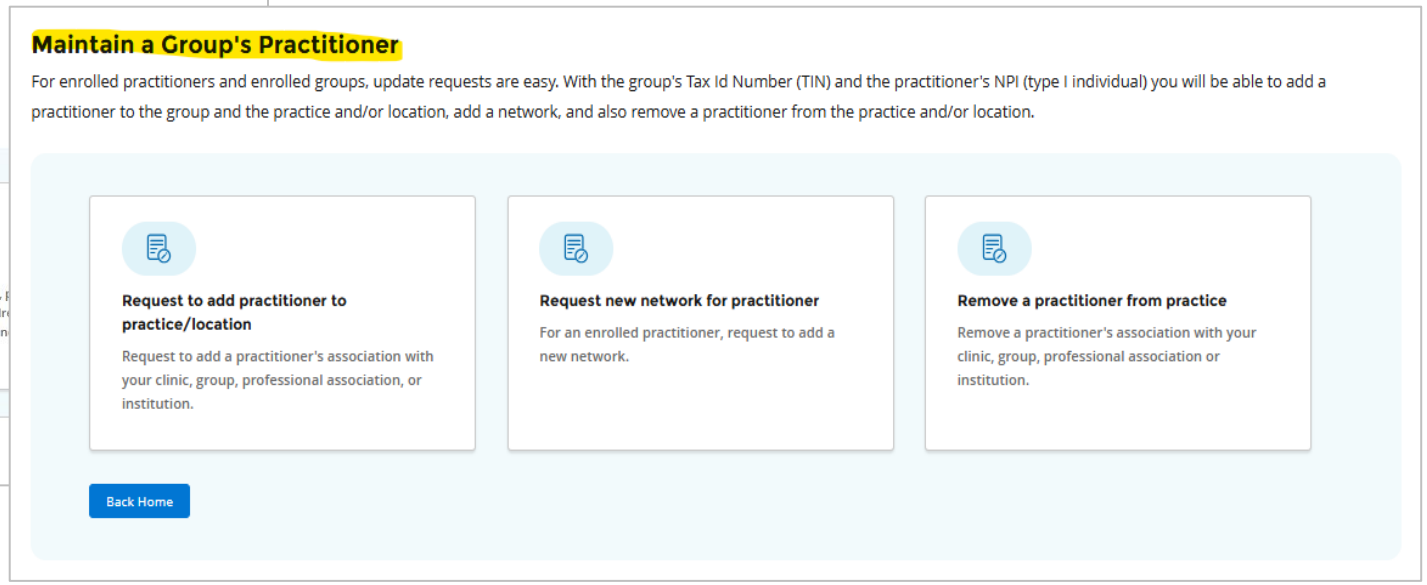
My Provider Enrollment Portal – Enroll Page



South Carolina

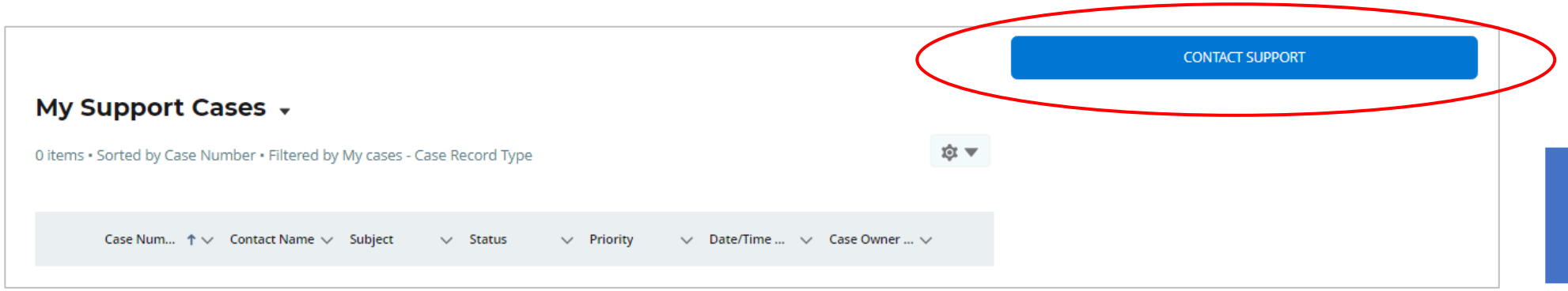
My Provider Enrollment Portal – Maintenance Page

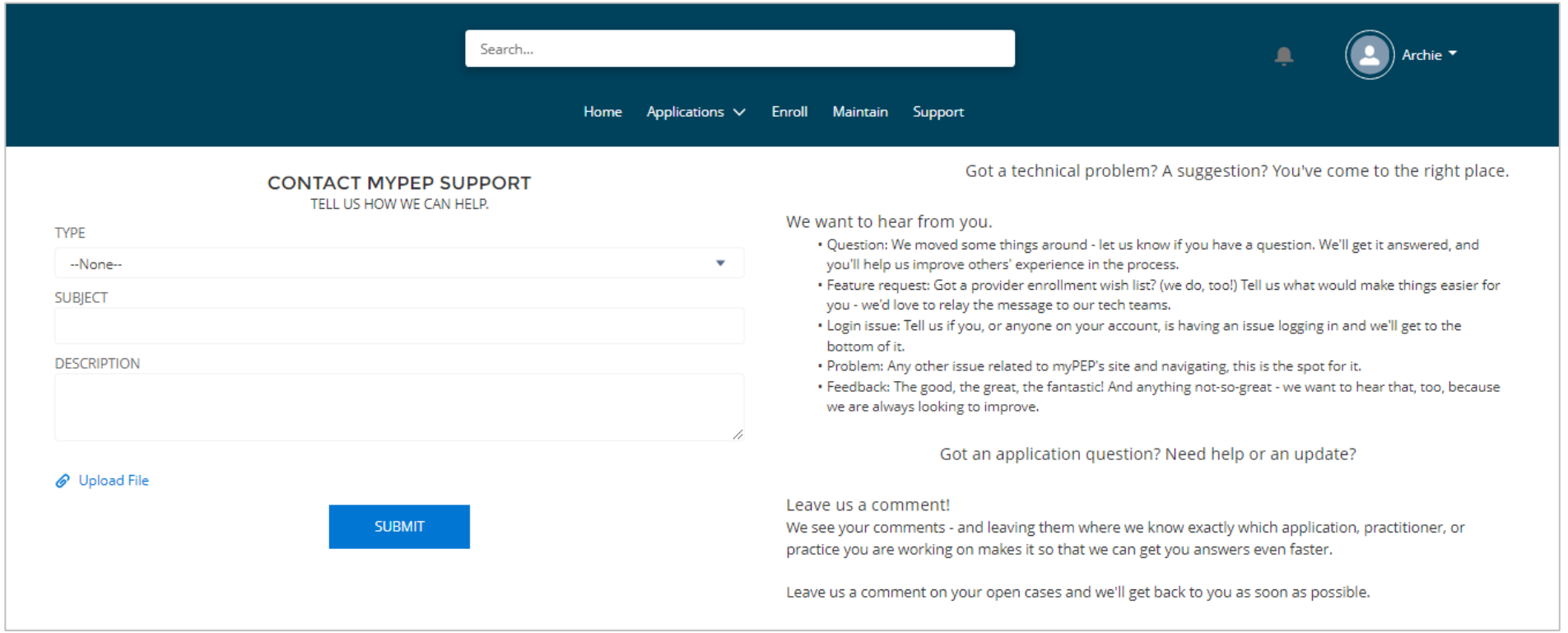




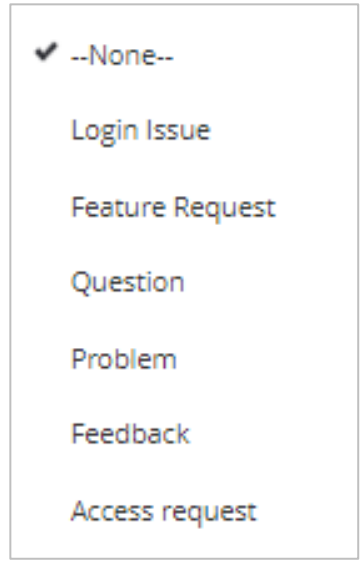
South Carolina

My Provider Enrollment Portal – Support Page





Available types.



South Carolina

Completing Clean Applications

Your Complete Solution

2026 Annual Provider Summit

South Carolina

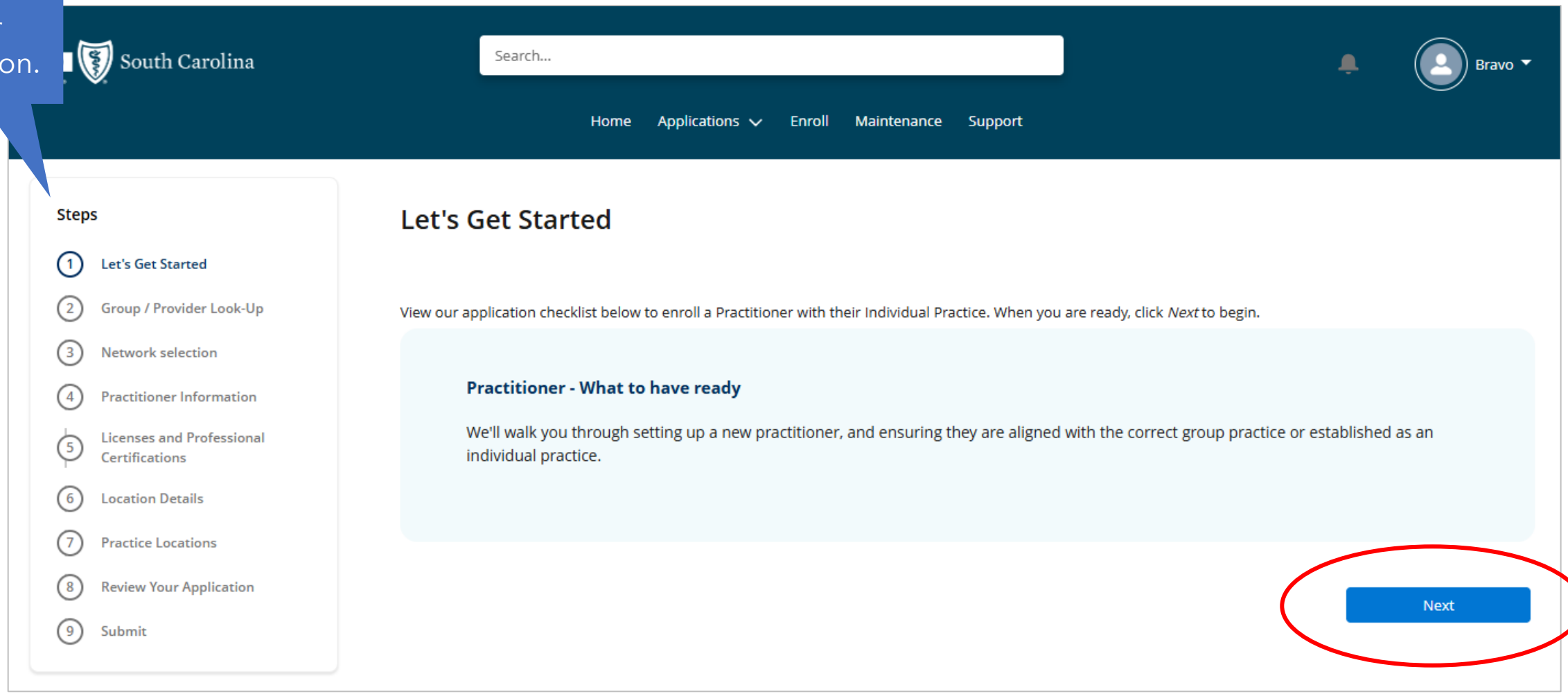
Steps to Submitting a Clean Application

1. Complete the enrollment application inside the portal.
2. Sign the application and agreements ***electronically***.
   - The documents that must be signed will be sent to the appropriate parties included on the application.
     - **It is important to include the correct email addresses for each individual (i.e., provider, fiduciary contact, etc.)**
   - These items will be available once the enrollment team sends the documents to you, and the case is in the awaiting signature status.
3. If additional items are requested, submit those as soon as possible.

South Carolina

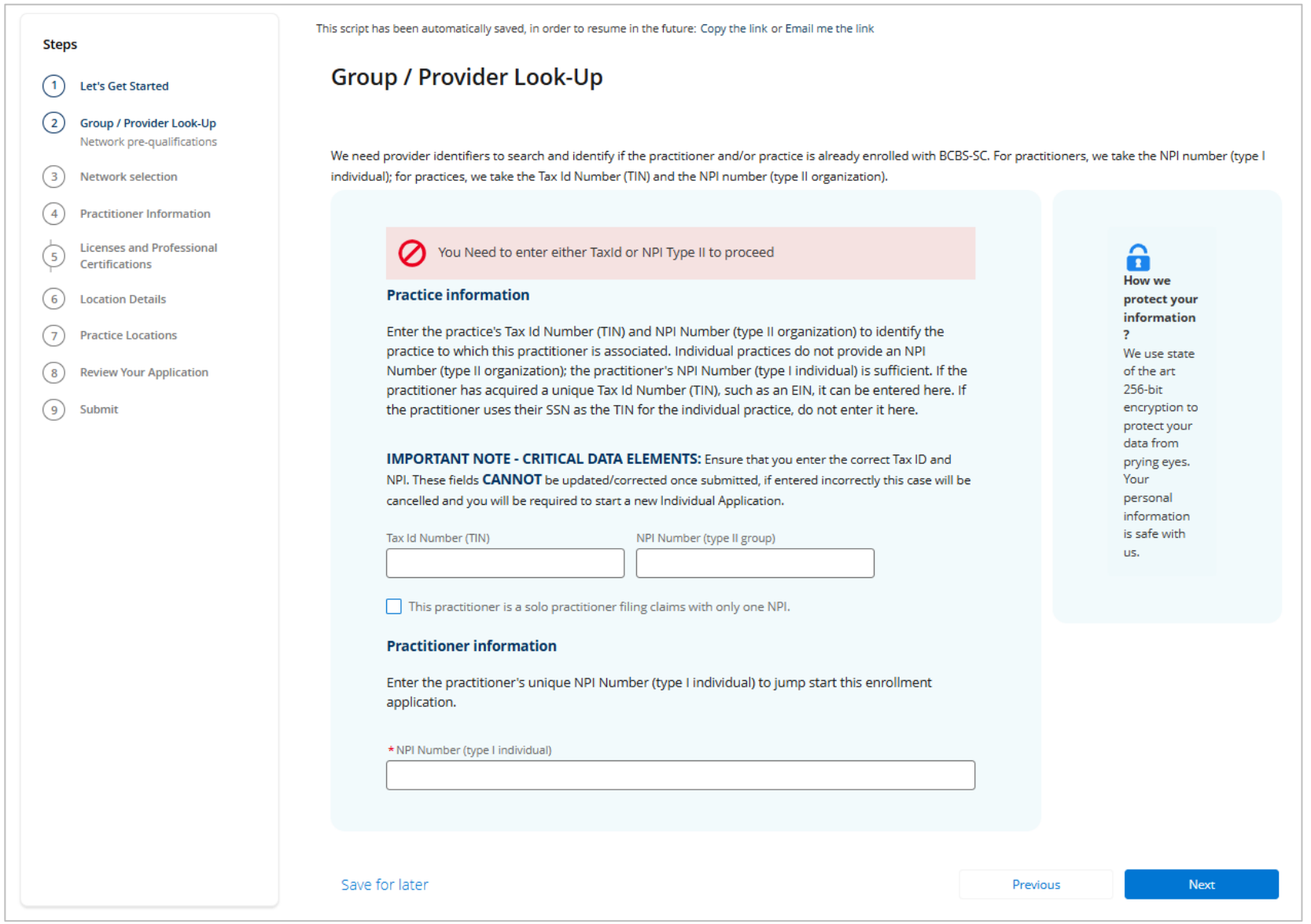
Example of an Individual Enrollment Application

Clear navigation.



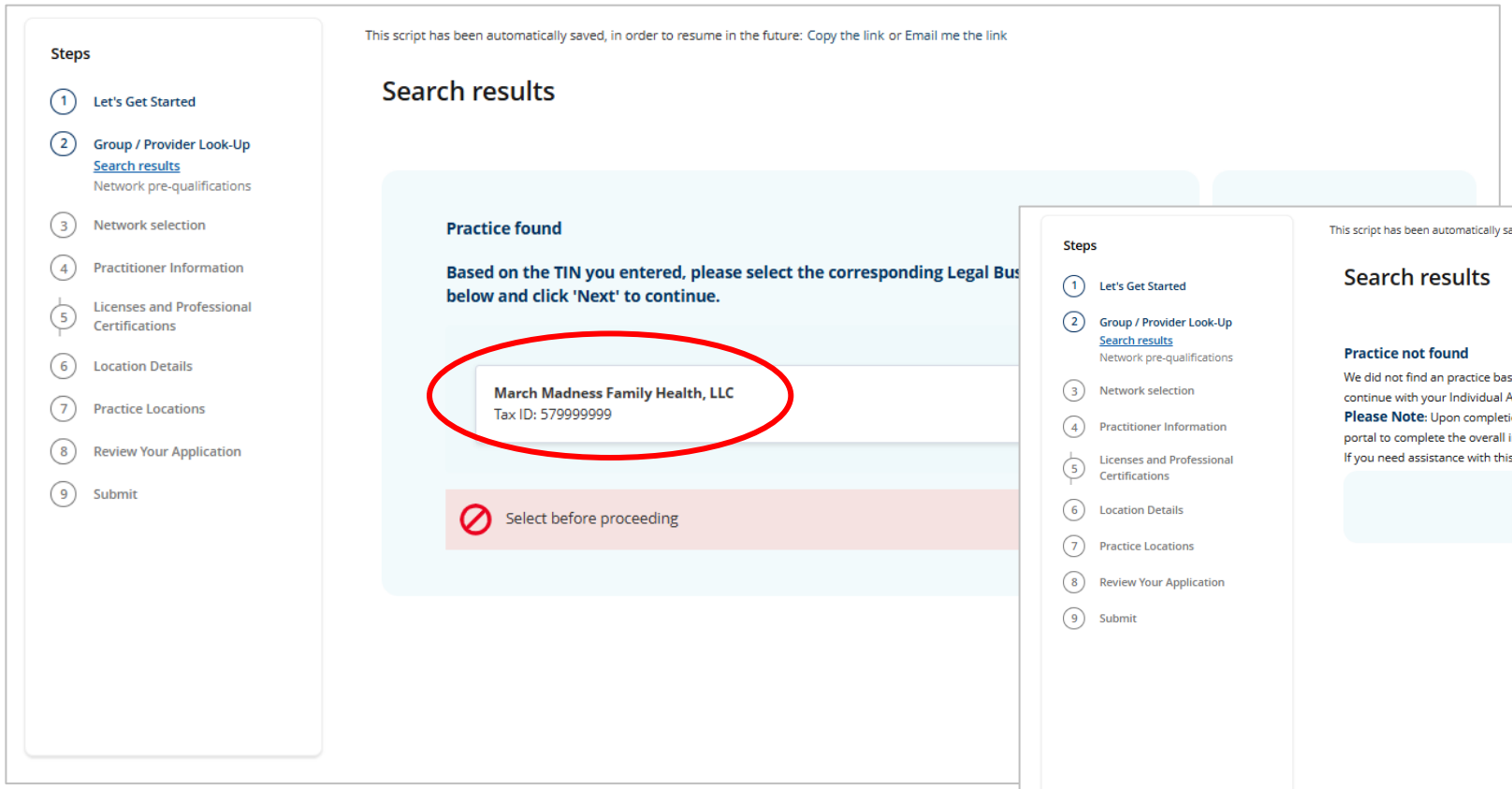
South Carolina

Example of an Individual Enrollment Application (Continued)

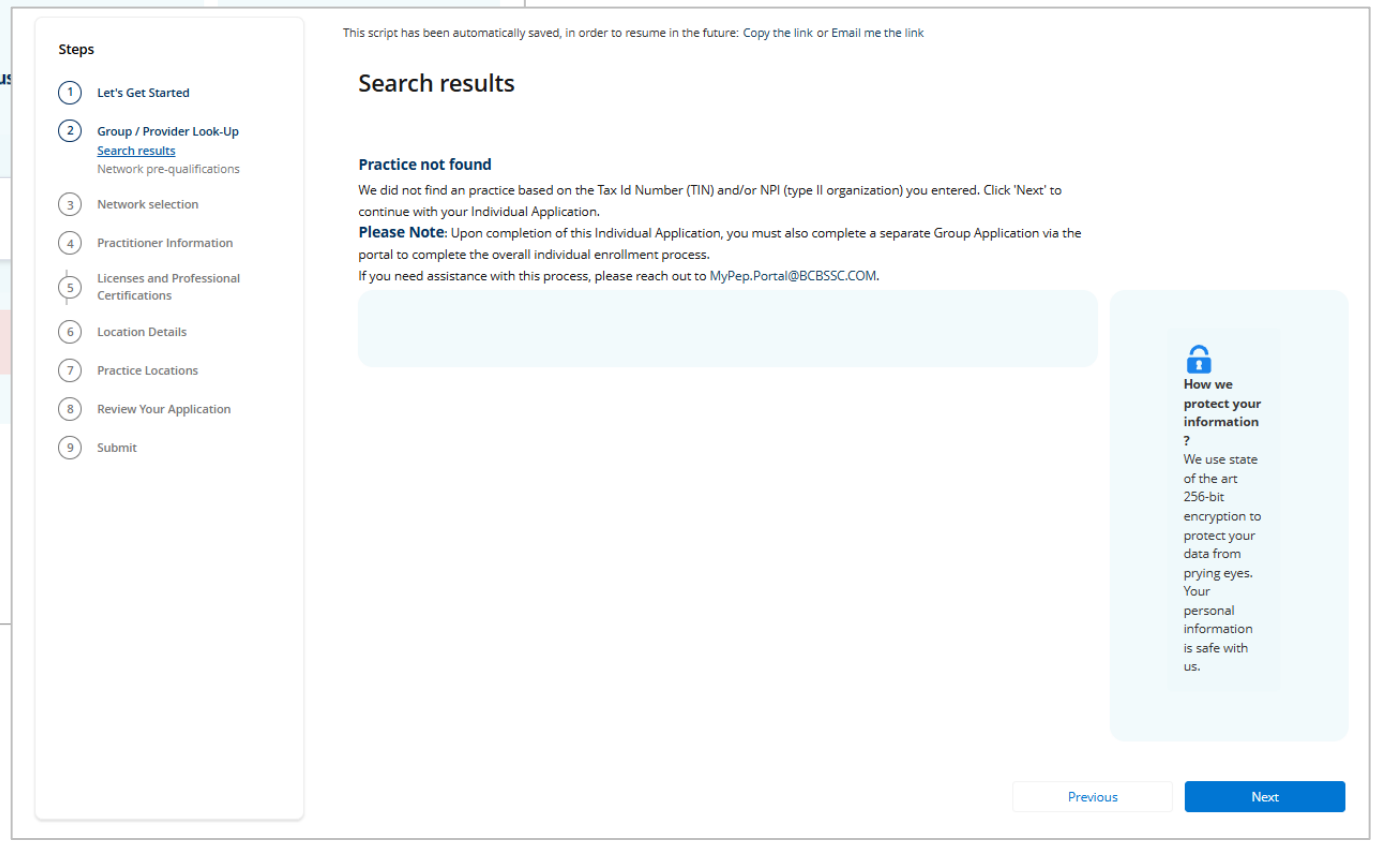


South Carolina

Example of an Individual Enrollment Application (Continued)



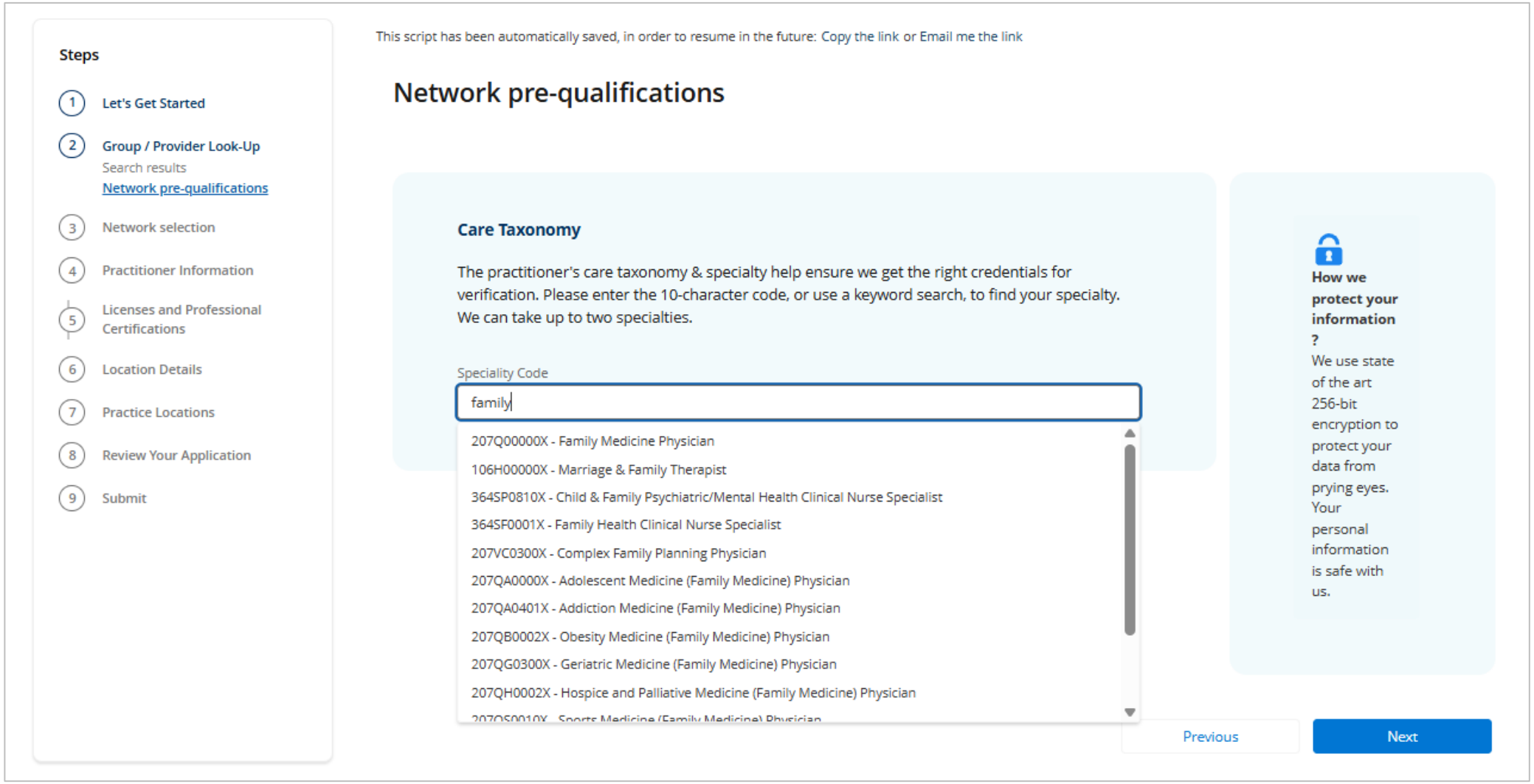
View when practice is found.



View when practice is not found.

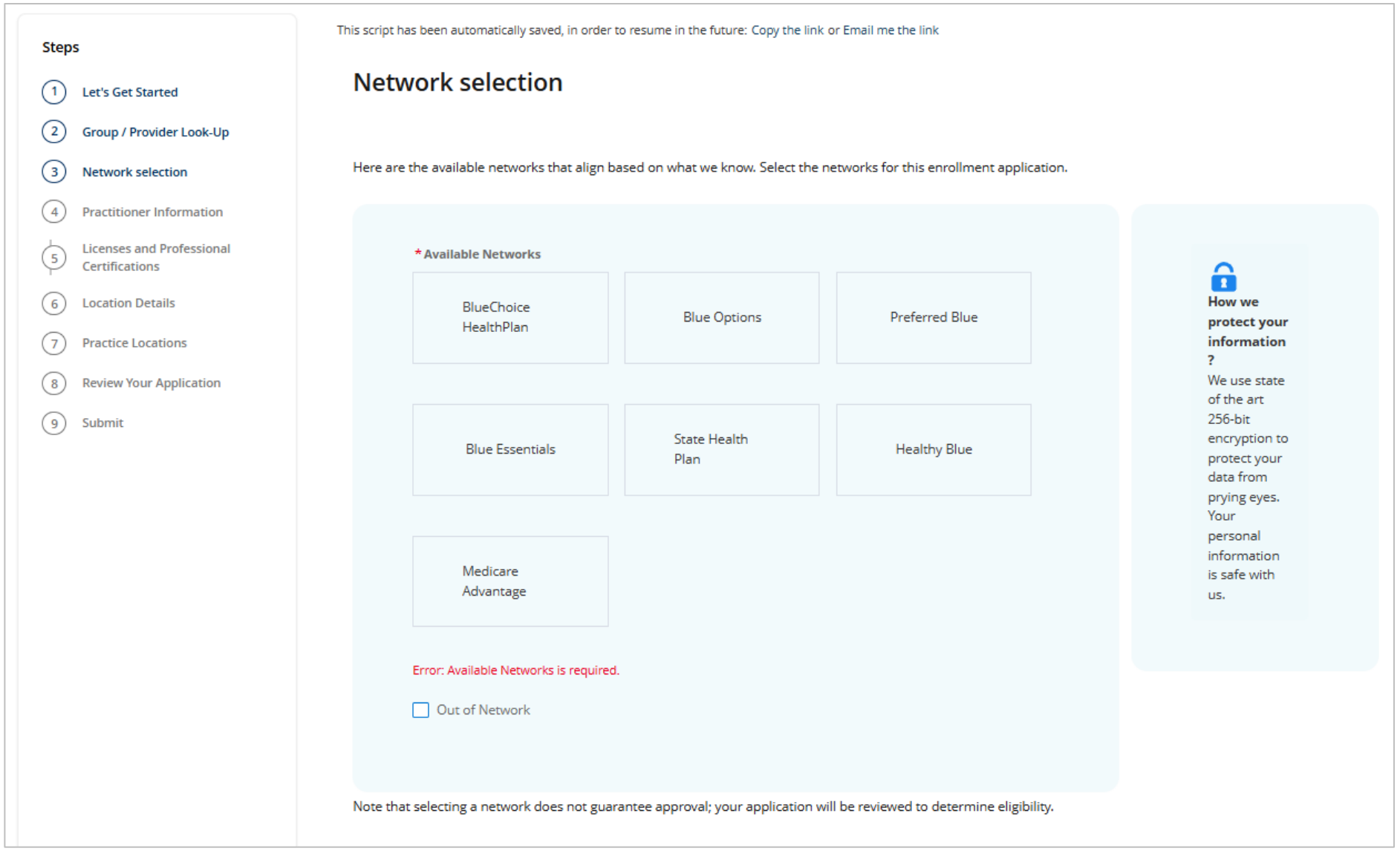
South Carolina

Example of an Individual Enrollment Application (Continued)



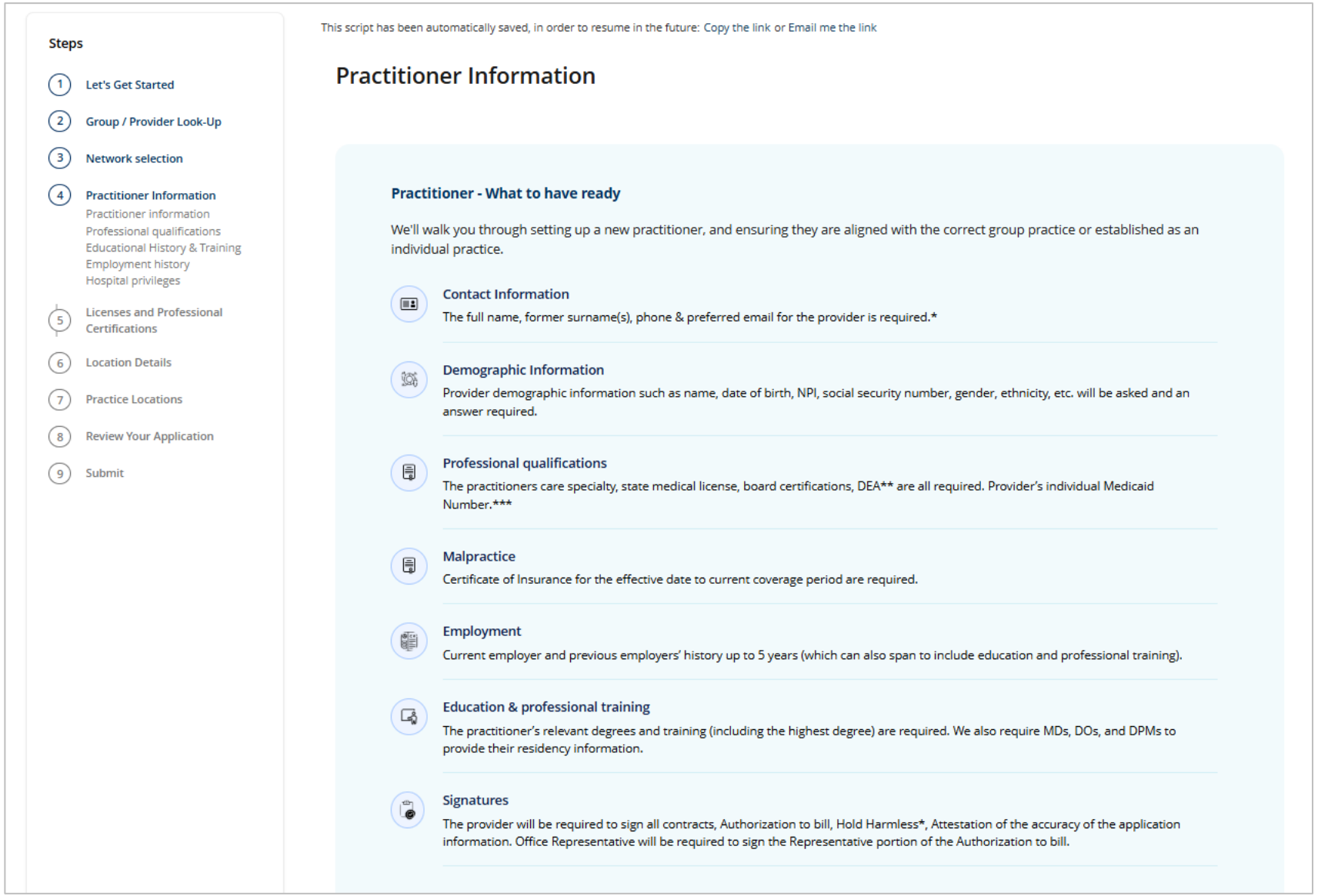
South Carolina

Example of an Individual Enrollment Application (Continued)



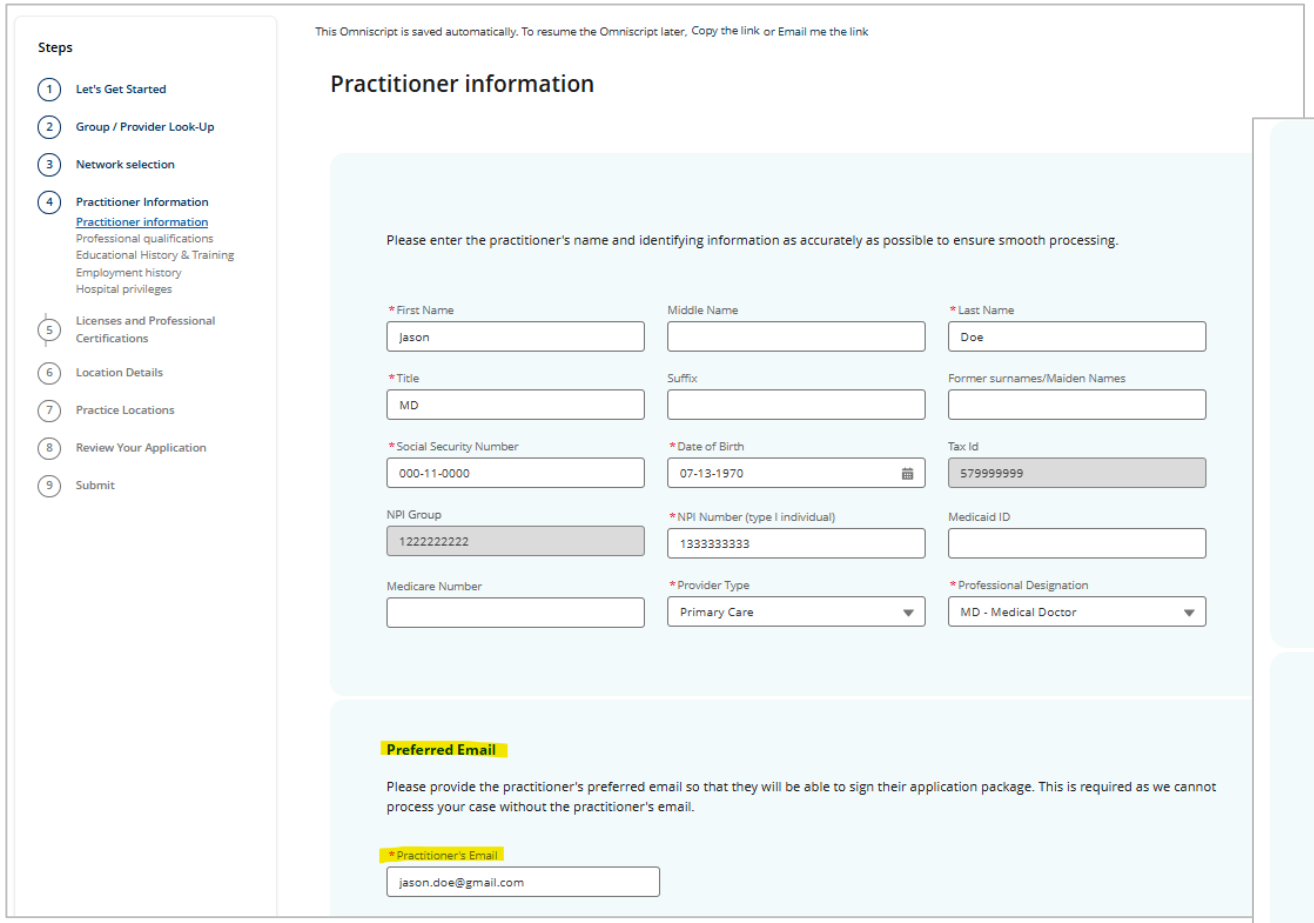
South Carolina

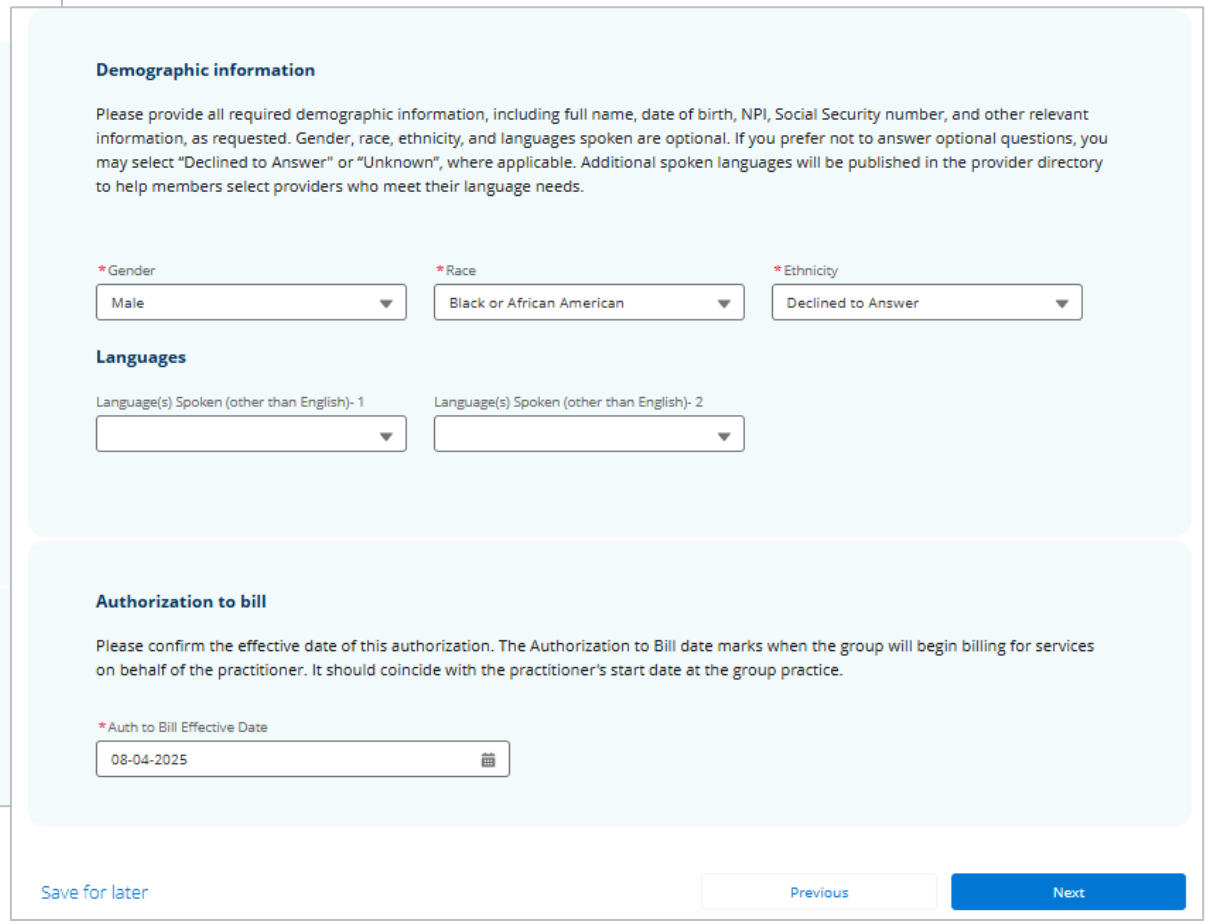
Example of an Individual Enrollment Application (Continued)



South Carolina

Example of an Individual Enrollment Application (Continued)

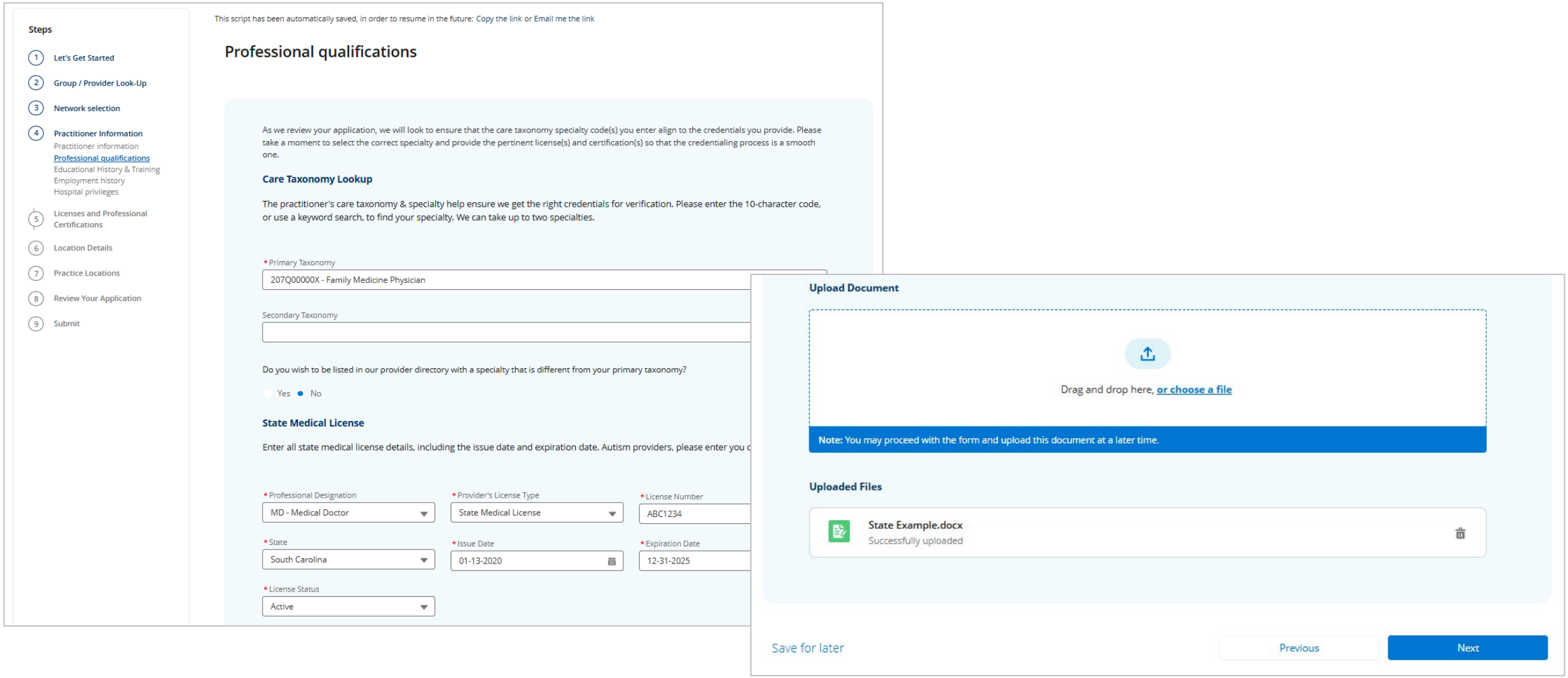




Note: You must enter the practitioner's email address. It cannot be the email address for the practice or anyone else.

South Carolina

Example of an Individual Enrollment Application (Continued)



South Carolina

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Group / Provider Look-Up
3. Network selection
4. Practitioner Information
   - Practitioner information
   - Professional qualifications
   - Educational History & Training
   - Employment history
   - Hospital privileges
5. Licenses and Professional Certifications
6. Location Details
7. Practice Locations
8. Review Your Application
9. Submit

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

Educational History & Training

Educational History

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

What determines a full educational history?

Please be sure to include the institution where the practitioner received their most advanced me
you have less than 5 years of employment history, include additional educational history to prov
picture of the practitioner's professional timeline.

* Educational Level	* Institution Name	* Please Specify Institution Name.
Medical School	OTHER	USC
* Degree Type	* Start Month	* Year
MD - DOCTOR OF MEDICINE	January	2010
* End Month	* Year	* Country
November	2016	United States
* City	State	
Columbia	South Carolina	

Degree Conferred

☑ Individual asserts they have completed their education and holds the qualifications associated with that degree

Professional Training

If the practitioner has completed an internship, fellowship or residency, please update the selection from the dropdown provided and enter detail for this professional training. You may add additional entries / remove entries.

☑ Add Trainings

Add Additional Training

Training

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

☐ I am actively taking this training/program

* Start Date	* End Date
02-01-2016	12-31-2018

Cultural Competency Training

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

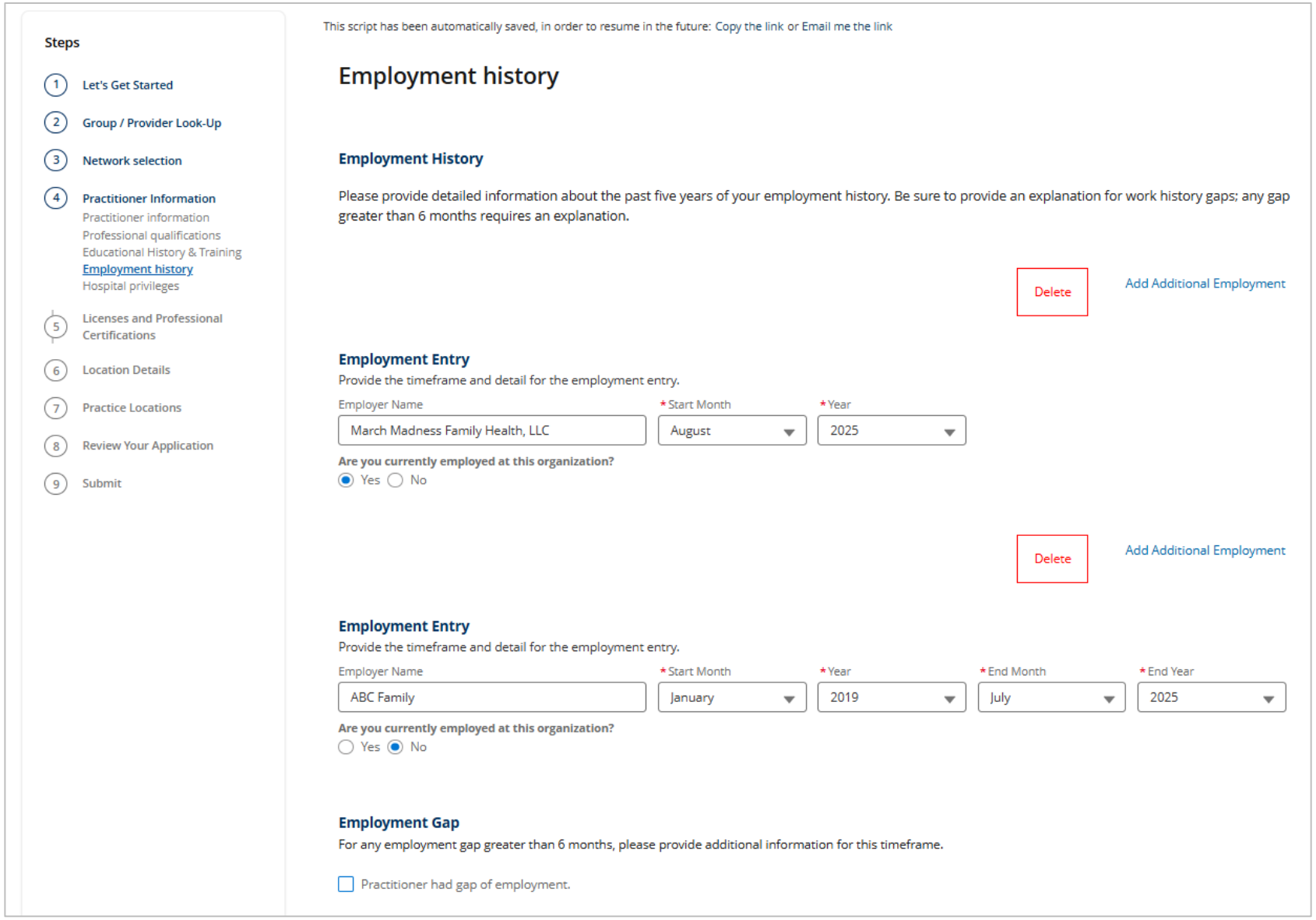
○ Yes ● No

Complete your training at https://thinkculturalhealth.hhs.gov/

Save for later | Previous | Next

South Carolina

Example of an Individual Enrollment Application (Continued)



Steps

1. Let's Get Started
2. Group / Provider Look-Up
3. Network selection
4. Practitioner Information
   - Practitioner information
   - Professional qualifications
   - Educational History & Training
   - Employment history
   - Hospital privileges
5. Licenses and Professional Certifications
6. Location Details
7. Practice Locations
8. Review Your Application
9. Submit

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

Employment history

Employment History

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

Delete | Add Additional Employment

Employment Entry

Provide the timeframe and detail for the employment entry.

Employer Name: March Madness Family Health, LLC
*Start Month: August
*Year: 2025

Are you currently employed at this organization?
(•) Yes ( ) No

Delete | Add Additional Employment

Employment Entry

Provide the timeframe and detail for the employment entry.

Employer Name: ABC Family
*Start Month: January
*Year: 2019
*End Month: July
*End Year: 2025

Are you currently employed at this organization?
( ) Yes (•) No

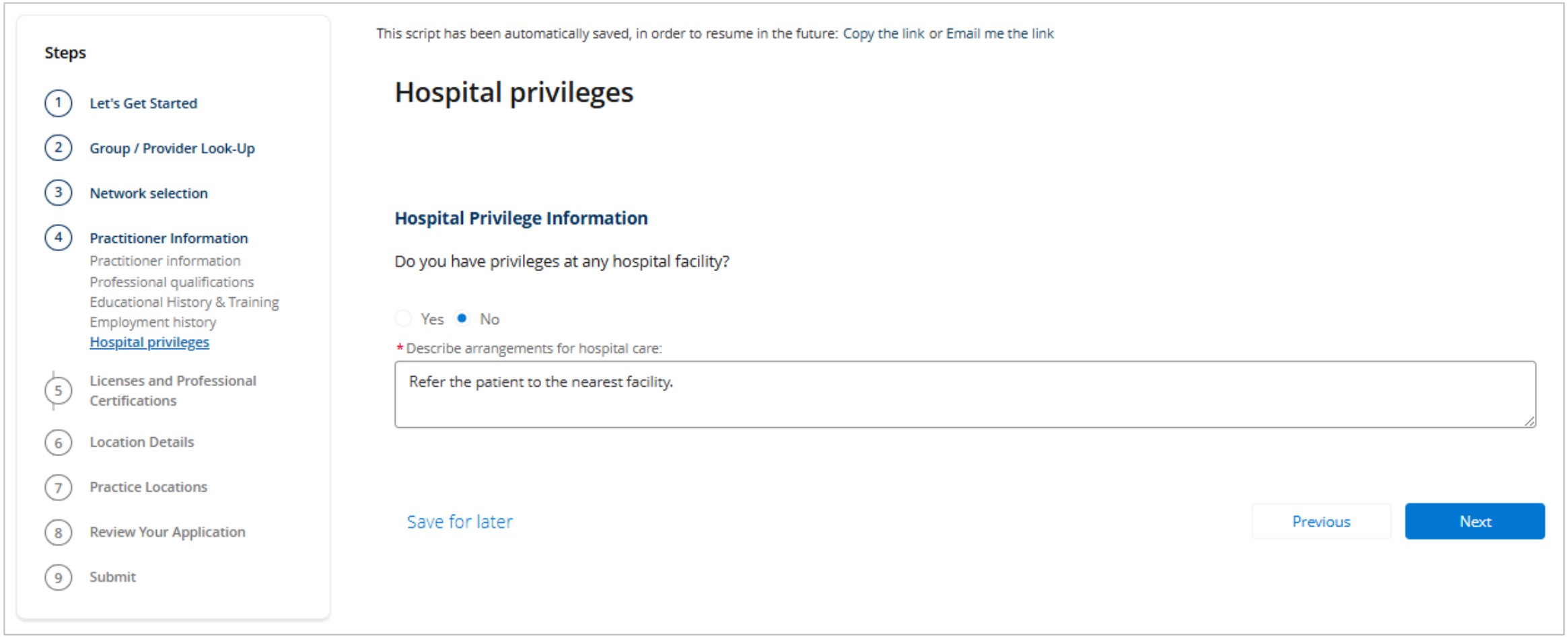
Employment Gap

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

☐ Practitioner had gap of employment.

South Carolina

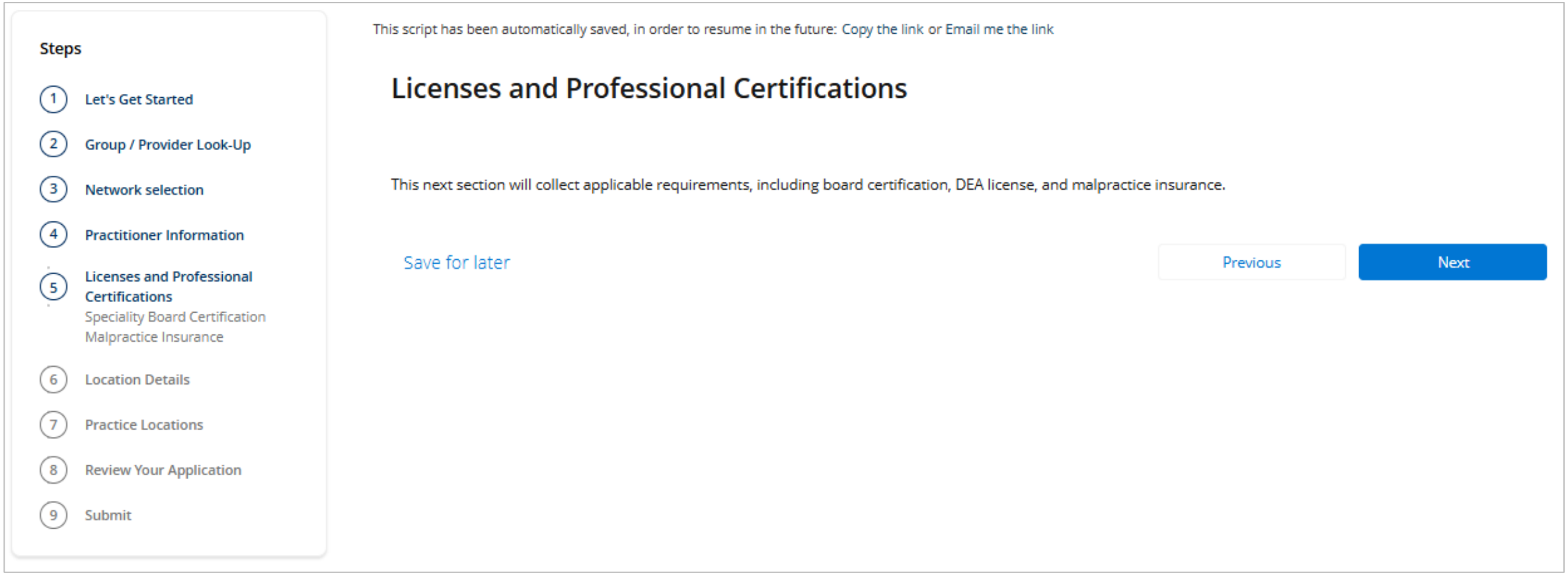
Example of an Individual Enrollment Application (Continued)



Note: Hospital privileges are based on admitting privileges.

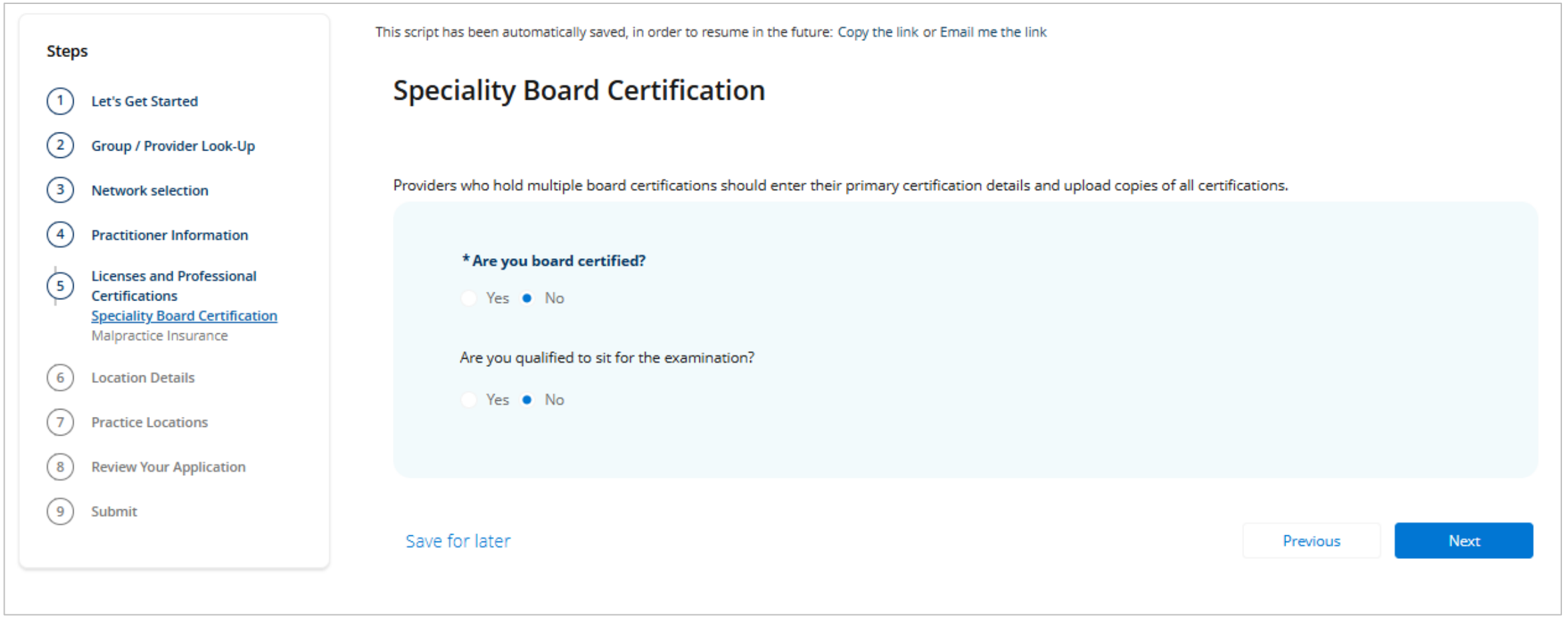
South Carolina

Example of an Individual Enrollment Application (Continued)



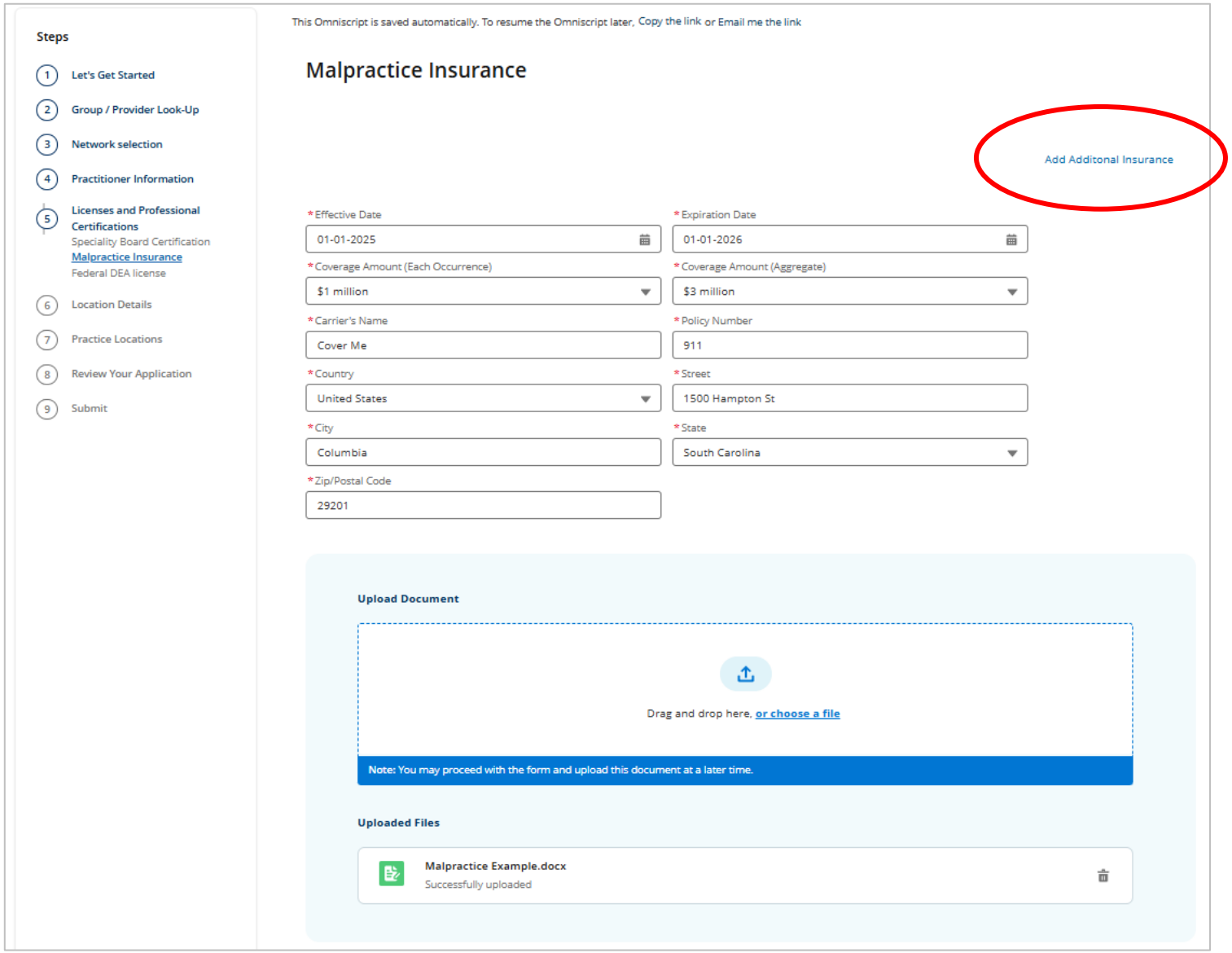
South Carolina

Example of an Individual Enrollment Application (Continued)



South Carolina

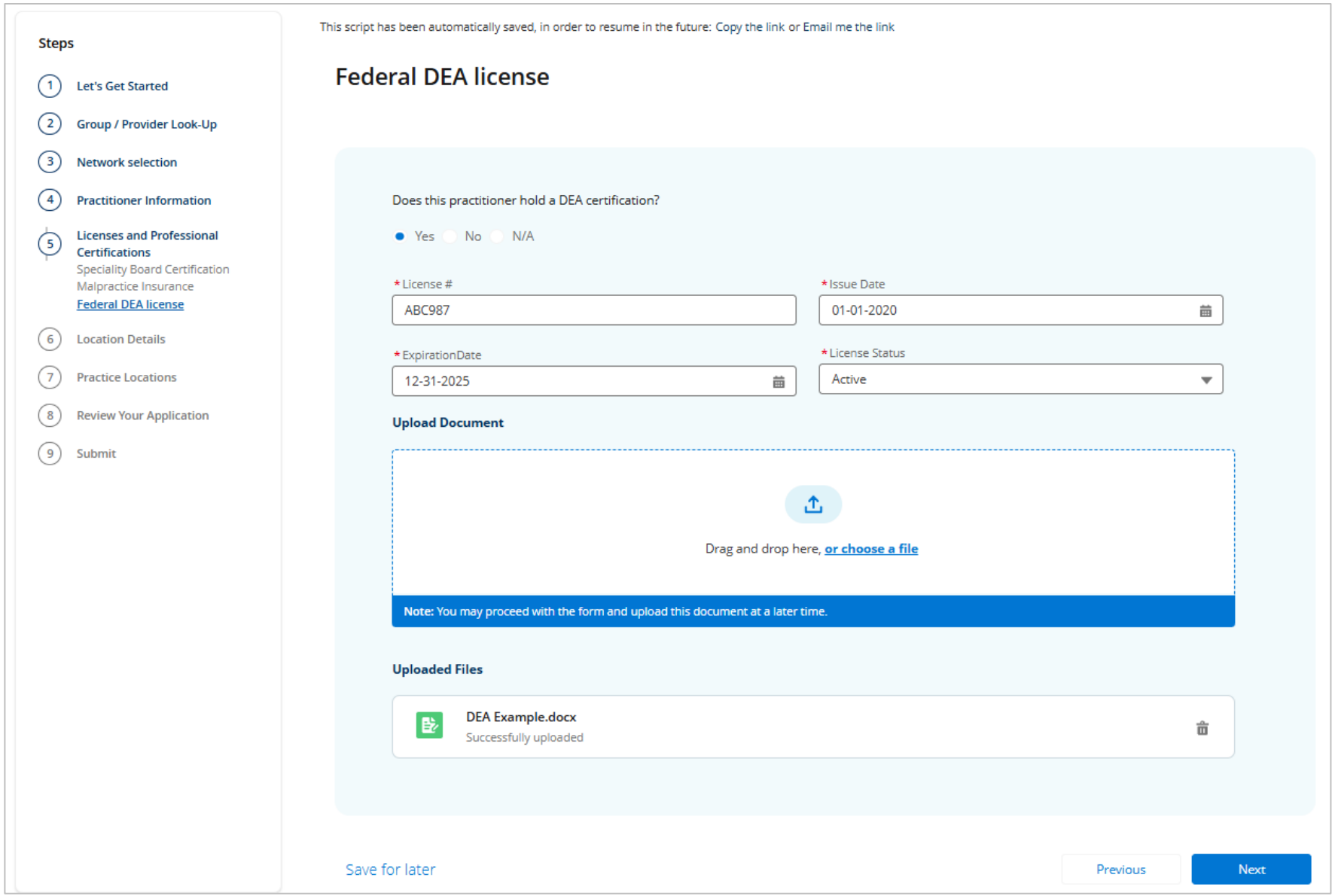
Example of an Individual Enrollment Application (Continued)



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

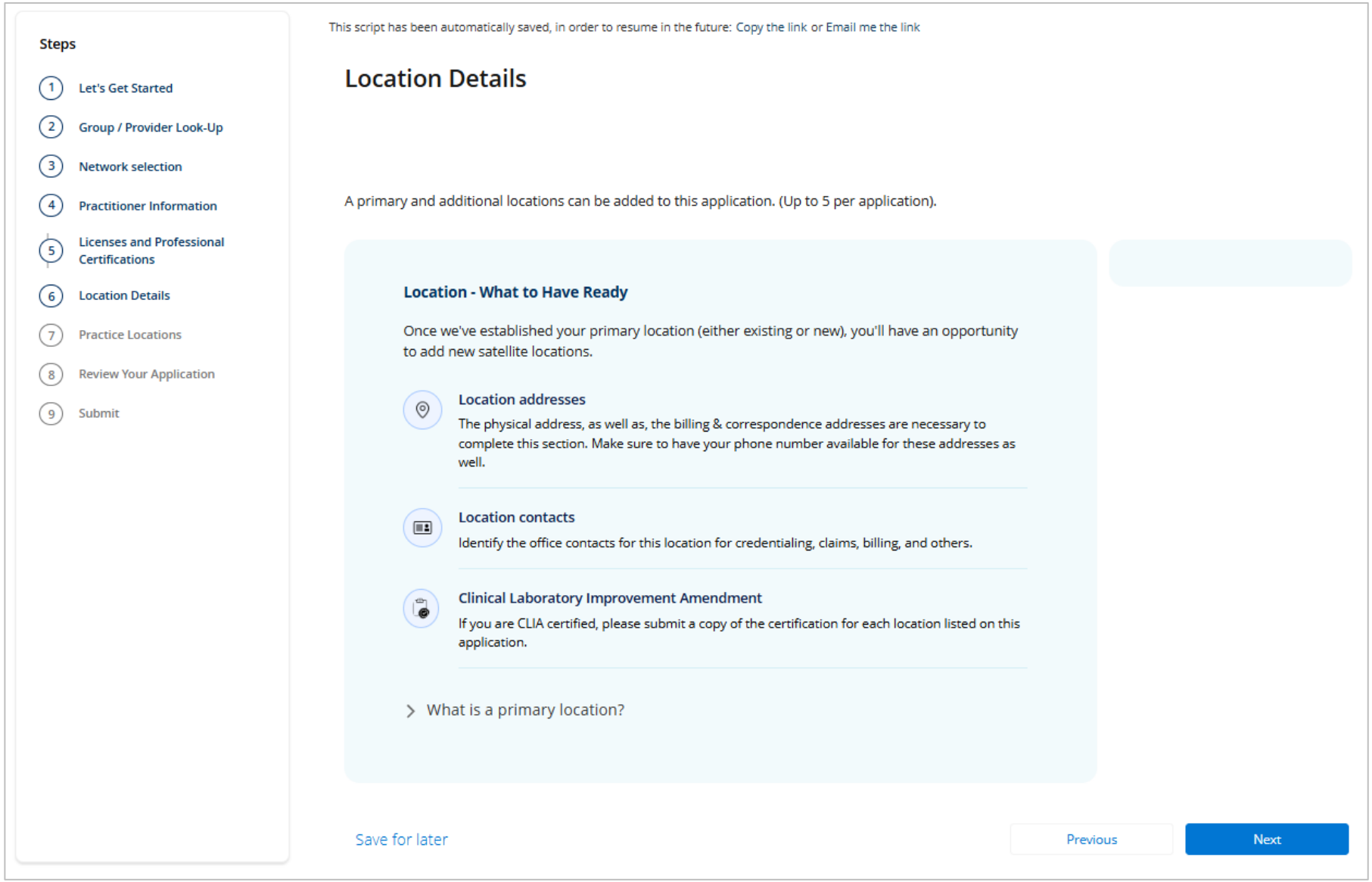
South Carolina

Example of an Individual Enrollment Application (Continued)



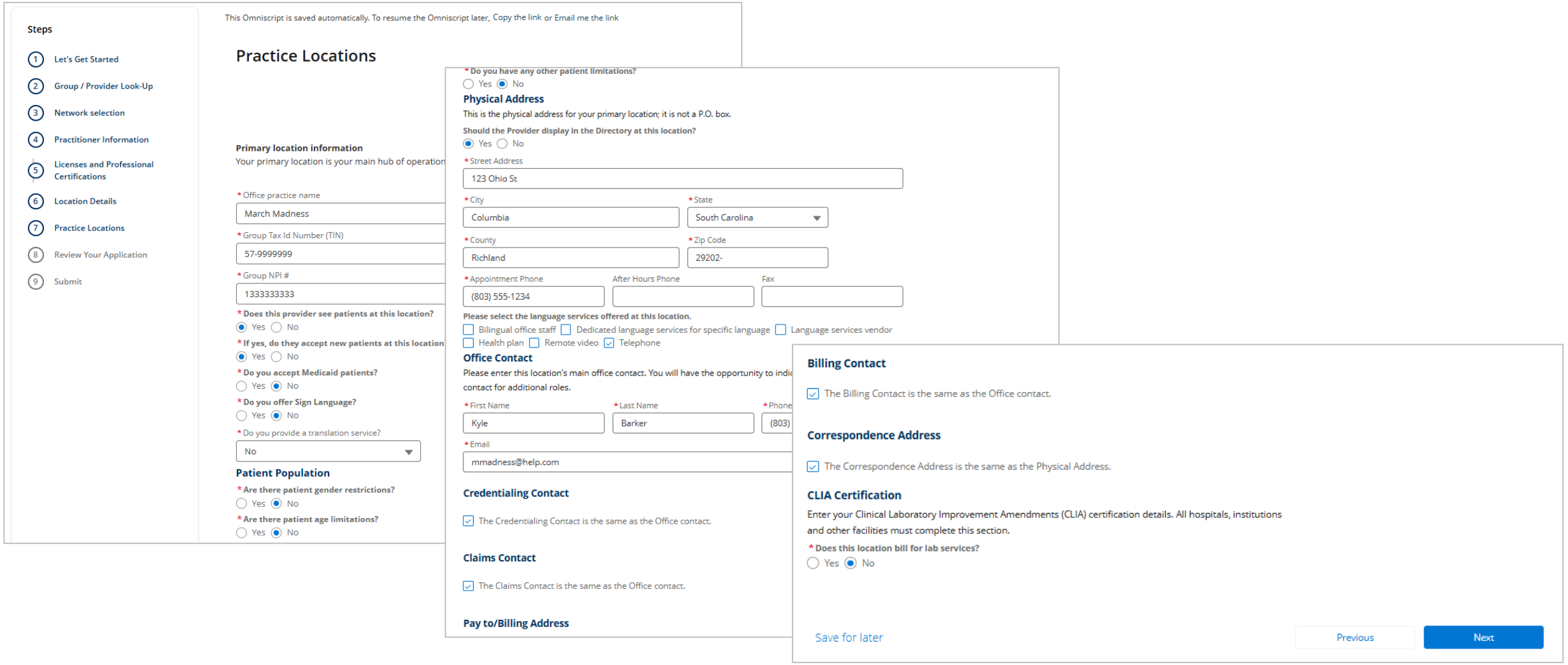
South Carolina

Example of an Individual Enrollment Application (Continued)



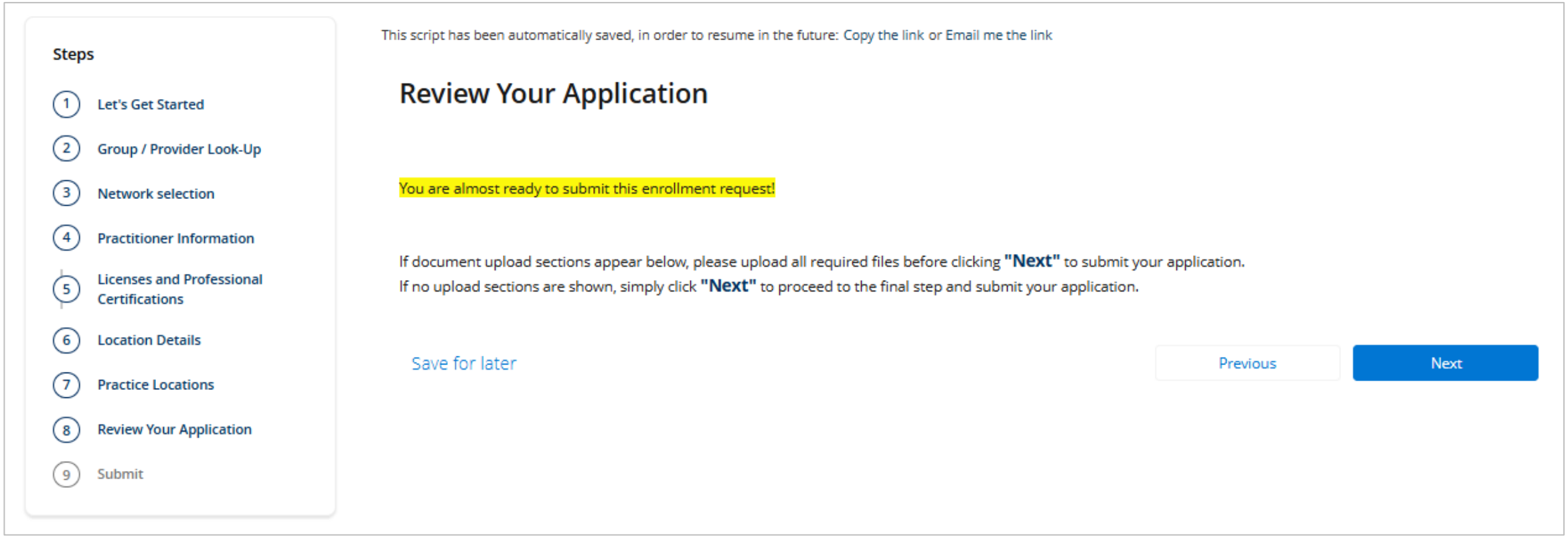
South Carolina

Example of an Individual Enrollment Application (Continued)



South Carolina

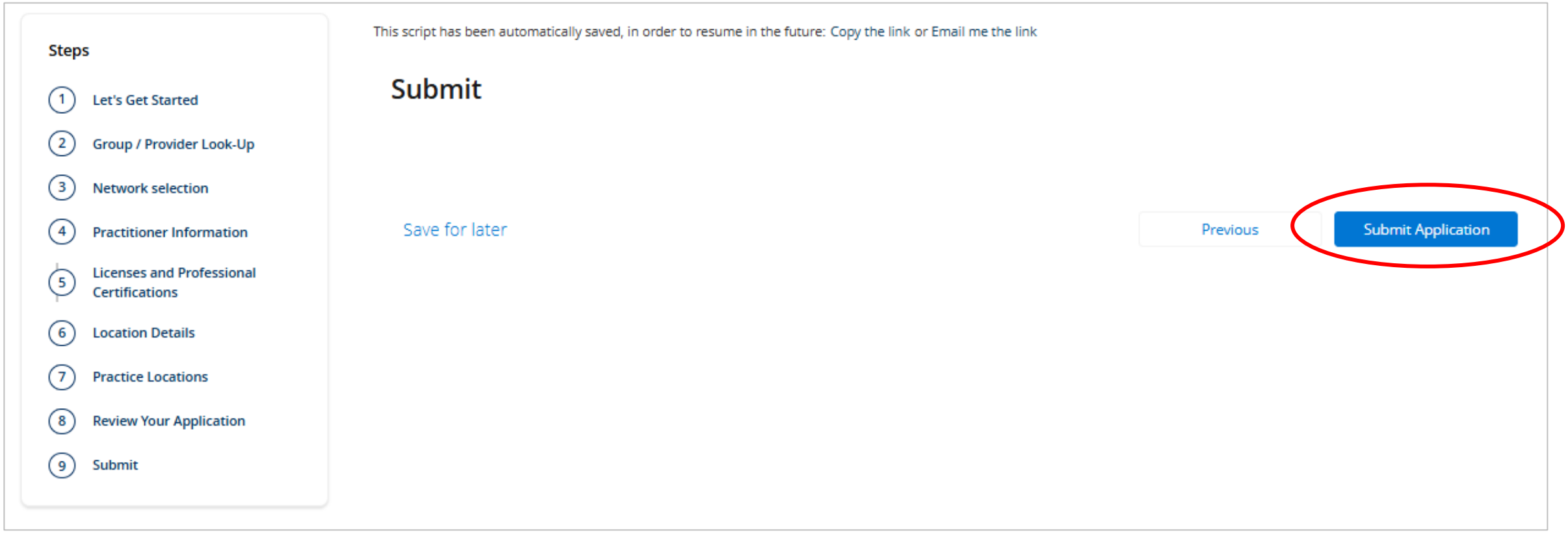
Example of an Individual Enrollment Application (Continued)



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

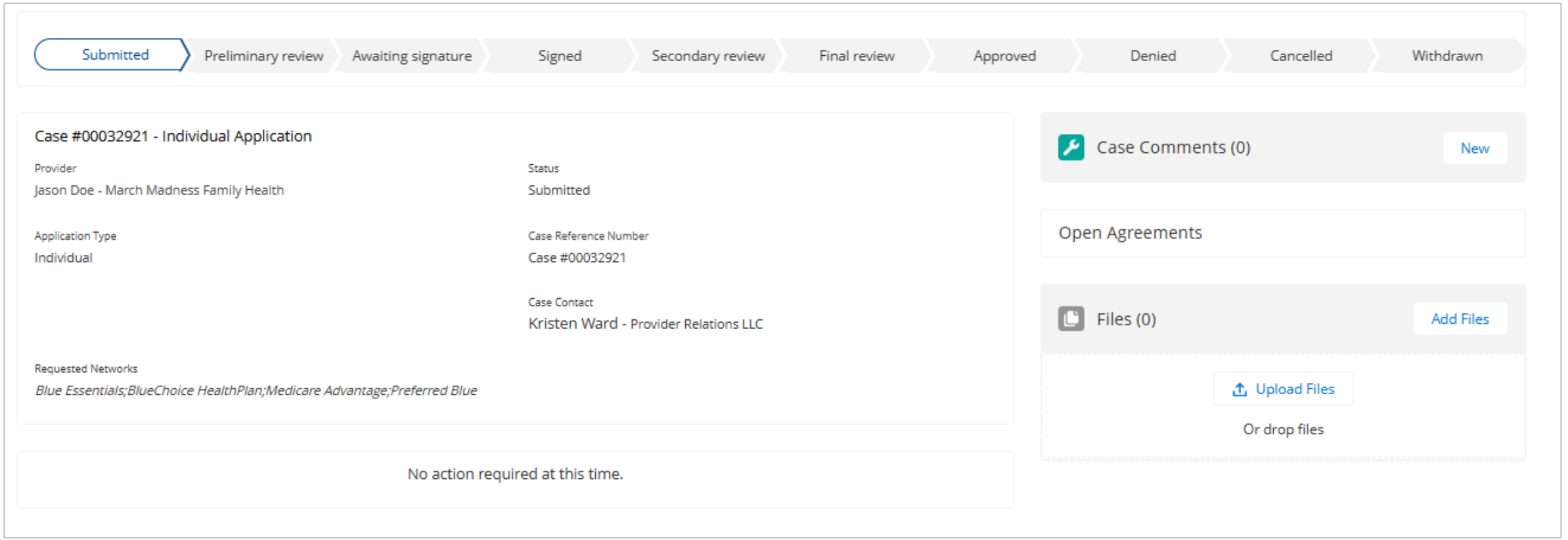
South Carolina

Example of an Individual Enrollment Application (Continued)



South Carolina

Example of an Individual Enrollment Application (Continued)



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Making Corrections to Applications

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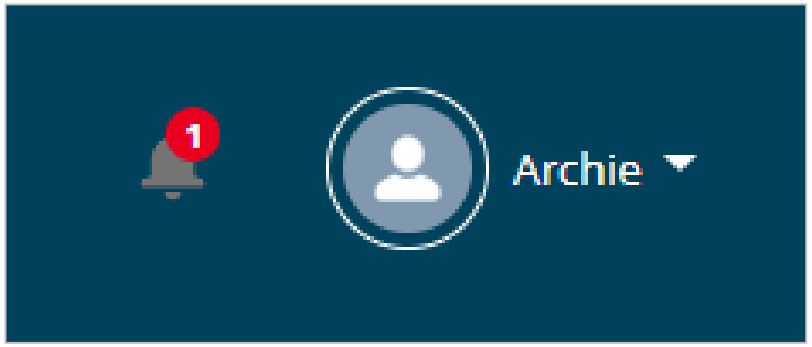
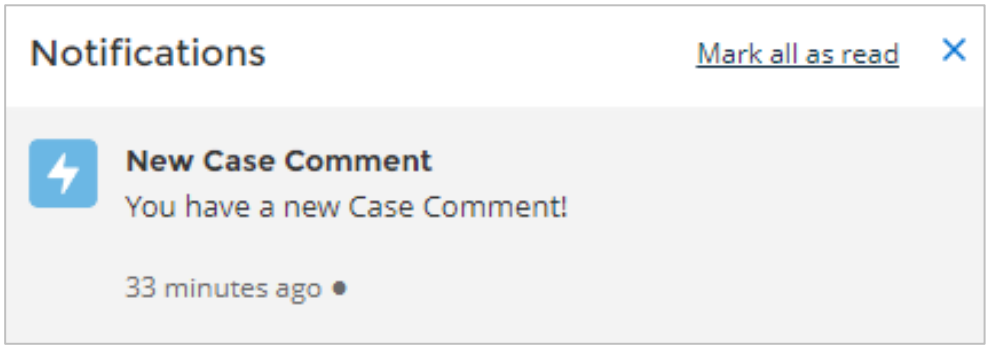
Correcting Applications

- Currently, corrections can only be made to group or individual enrollment applications.
  - Corrections cannot be made to maintenance applications.
    - If an error or mistake is made after submission, a case comment must be made on the current case requesting to have it canceled, and a new maintenance application must be submitted.
- If items are missing or corrections are needed for an application, you will see a notification once you log into the portal.
- After selecting the notification bell, you will see that there is a new case comment for you to review.
- All corrections must be made in the portal.
  - Handwritten or other altered corrections are not accepted and will be returned.

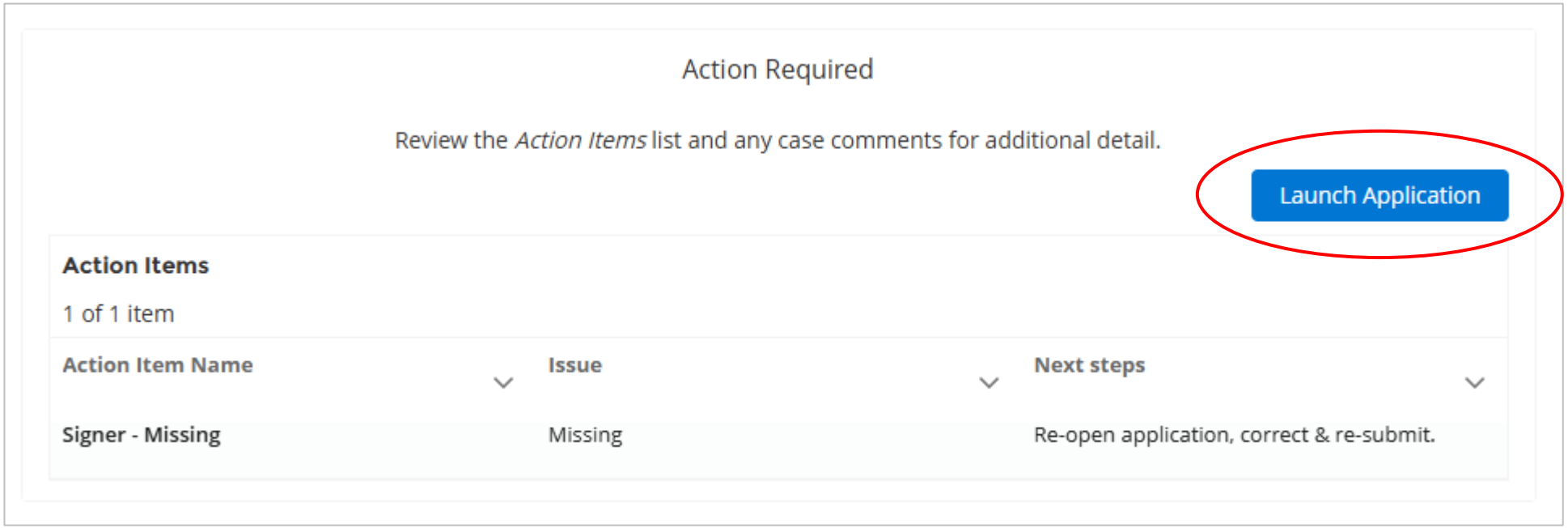




South Carolina

Steps for Making Corrections

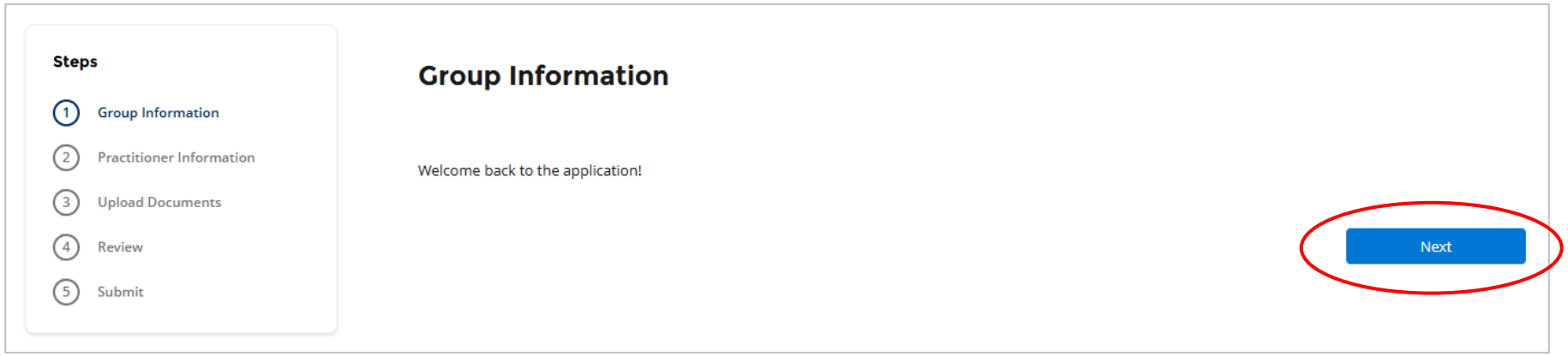
- Review the action required.
- Select ***Launch Application*** to make the necessary corrections or to supply the requested items.



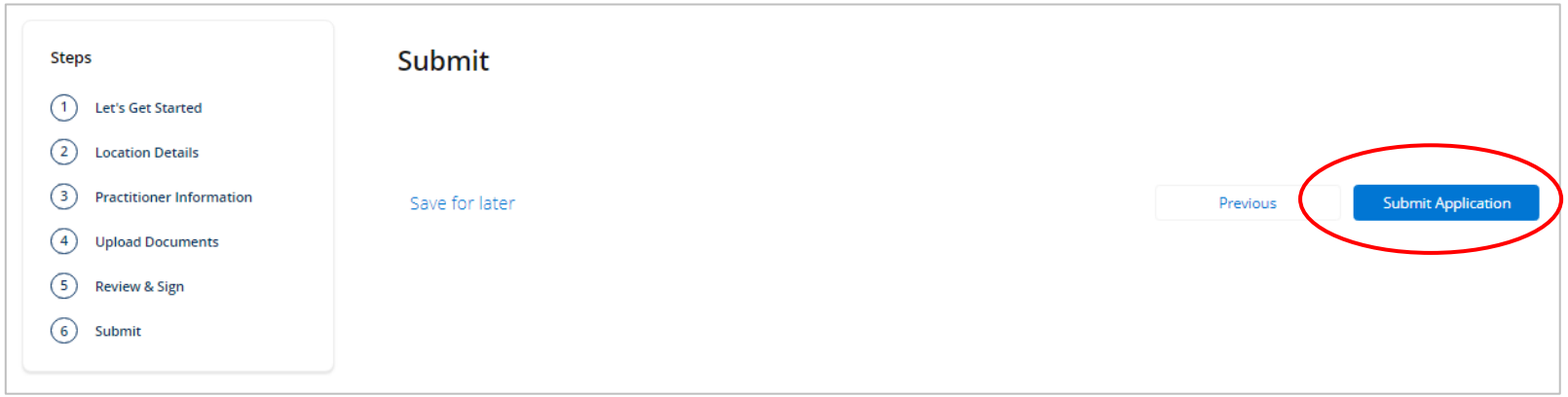
South Carolina

Steps for Making Corrections (Continued)

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



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



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Available Resources

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Useful Resources

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

My Provider Enrollment Portal Manual

Provider Enrollment Presentation

Provider Enrollment FAQs

Checklists

"How to" Videos

South Carolina

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Quality Improvement Strategy

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Topics to Discuss

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

About Us

About Us

Healthcare Innovation and Improvement (HII)
Quality Department

Vision: To ensure a Quality experience with every interaction.

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

Committed to working with YOU to better serve our members.

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NCQA

National Committee for Quality Assurance

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NCQA – Overview

- NCQA is a private organization dedicated to improving healthcare quality by developing quality standards and performance measures.
- Is a nonprofit organization that measures provider and health plan care quality and offers accreditation to high performing organizations.
- Healthcare Effectiveness Data and Information Set (HEDIS) coordination
- Provider involvement

South Carolina

NCQA – What It Means to Providers

Contract

Bonuses Incentives

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

Reporting

Data to the plan

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

Safety

Patient

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

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CAHPS

Consumer Assessment of Healthcare Providers and Systems

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CAHPS – Overview

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

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

*Consumer Assessment of Healthcare Providers and Systems (CAHPS)

South Carolina

CAHPS – Sample of Survey Questions

Opportunities	Possible Solutions
Q22 – Rating of Specialist seen most often	❑ Listen to patient concerns and spend adequate time with them ❑ Engage the patient in discussions about medications ❑ Avoid using medical jargon and technical language
Q24 – Customer Service provided need information or help	❑ Ensure that representative are friendly and polite ❑ Resolve issues completely and follow up with members ❑ Ensure that representatives listen carefully and avoid interrupting
Q18 – Rating of personal doctor	❑ Ensure that providers are informed about the patient's relevant medical and person background ❑ Remain up-to-date on medical advancements ❑ Connect with the patient on a personal level ❑ Reduce wait times in the office
Q9 – Ease of getting care, tests, or treatment	❑ Conduct a thorough assessment of the patient's needs ❑ Treat patients with urgent issues promptly ❑ Provider care and service quickly ❑ Minimize wait times and communicate reasons for delays
Q5 – Made appointments for routine care at office or clinic	❑ Schedule appointments within sufficient time frame ❑ Treat patients with great urgent issues promptly
Q4 – Got an appointment for urgent care as soon as needed	❑ Schedule appointments within sufficient time frame ❑ Treat patients with great urgent issues promptly

HEDIS

Healthcare Effectiveness Data and Information Set

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What is HEDIS?

HEDIS

- Evaluates performance in terms of clinical quality
- Administered by NCQA and used by Centers for Medicare & Medicaid Services for monitoring
- HEDIS Retrospective Review –
  - HEDIS MY2025 refers to care given or due in 2025, which will be evaluated from January to May 2026
- HEDIS Prospective Review –
  - Runs from Jan. 1 to Dec. 31 of the current measurement year

South Carolina

Healthcare Effectiveness Data and Information (HEDIS)

Exist to improve the quality of health care

*Centers for Medicare and Medicaid Services

*Quality Rating System for the ACA/Exchange

*Medicare Advantage

*Medicaid

Federal Employee Program (FEP)

South Carolina

HEDIS: Prospective Season

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

South Carolina

HEDIS: Retrospective Season

- Also referred to as Retro or Hybrid season or HEDIS Production.
- Looks at the care given or due in the prior measurement year.
- Runs from January to May of the year following the measurement year.
- HEDIS MY2025 refers to care given or due in 2025, which will be evaluated from January to May 2026.
- All requested member documentation is based on the selected HEDIS measure by NCQA.
- **BIG REMINDER**: As a contracted provider, you are contractually obligated to respond to the HEDIS medical record requests.

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On the Horizon

- Method of collecting healthcare data through electronic systems, such as electronic health records (EHR), to improve the tracking, reporting, and analysis of clinical performance.
- Providers use electronic clinical data systems (ECDS) to ensure accurate and real-time data sharing across different healthcare settings, which is essential for maintaining quality care, patient safety, and meeting regulatory requirements.
- For providers, both ECDS and HEDIS measures are crucial for:
  1. Ensuring high-quality care delivery.
  2. Meeting accreditation and regulatory requirements.
- Hybrid measures are phasing out by MY 2030.
  - This represents a major impact on the way information is collected and reported, so we must all transition.

Request for Information

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Request for Information

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

Request for Information (Continued)

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

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

Demographics page

-AND-

All office visit/encounter notes from 10/1/2023 to 12/31/2025

-AND-

Past Medical/Surgical history 2024 to 12/31/2025

-AND-

All radiology reports specifically mammograms from 10/1/2023 to 12/31/2025

-AND-

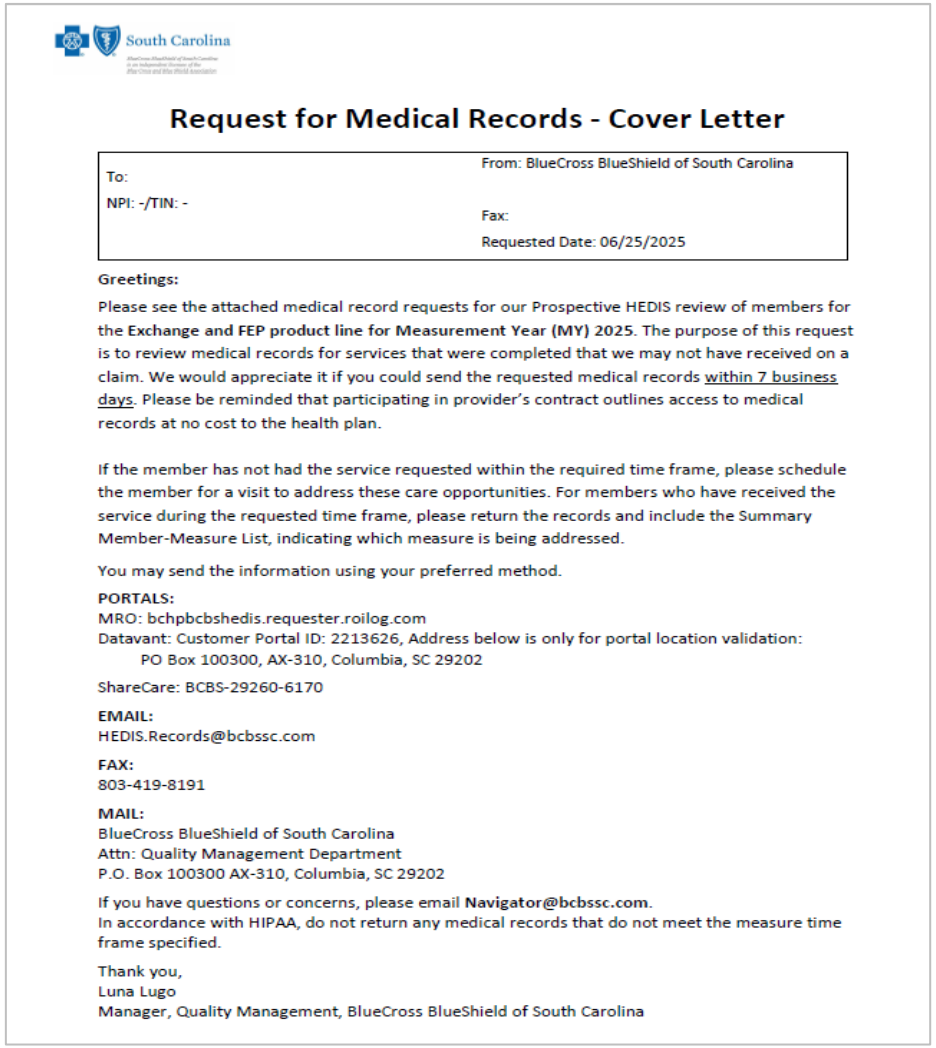
All consultation especially OB/GYN notes from 2023 to 12/31/2025

Quick Tip: Look for documentation of the most recent mammogram completed between Oct. 1, 2023-December 31, 2025.

South Carolina

Request for Information (Continued)

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



South Carolina

Request for Medical Records - Cover Letter

To:
NPI: -/TIN: -

From: BlueCross BlueShield of South Carolina
Fax:
Requested Date: 06/25/2025

Greetings:

Please see the attached medical record requests for our Prospective HEDIS review of members for the **Exchange and FEP product line for Measurement Year (MY) 2025**. The purpose of this request is to review medical records for services that were completed that we may not have received on a claim. We would appreciate it if you could send the requested medical records within 7 business days. Please be reminded that participating in provider's contract outlines access to medical records at no cost to the health plan.

If the member has not had the service requested within the required time frame, please schedule the member for a visit to address these care opportunities. For members who have received the service during the requested time frame, please return the records and include the Summary Member-Measure List, indicating which measure is being addressed.

You may send the information using your preferred method.

PORTALS:
MRO: bchpbcbshedis.requester.roilog.com
Datavant: Customer Portal ID: 2213626, Address below is only for portal location validation:
PO Box 100300, AX-310, Columbia, SC 29202

ShareCare: BCBS-29260-6170

EMAIL:
HEDIS.Records@bcbssc.com

FAX:
803-419-8191

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

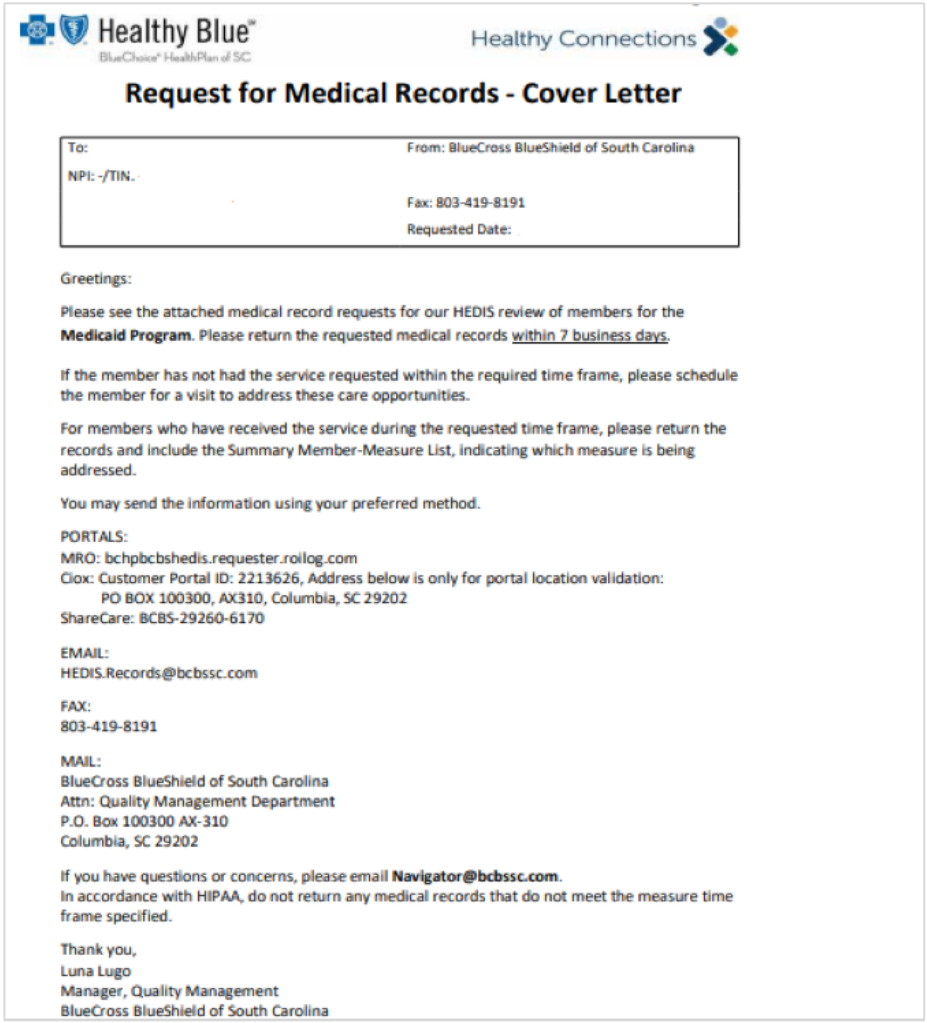
If you have questions or concerns, please email **Navigator@bcbssc.com**.
In accordance with HIPAA, do not return any medical records that do not meet the measure time frame specified.

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

South Carolina

Request for Information (Continued)

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



Healthy Blue
BlueChoice® HealthPlan of SC

Healthy Connections

Request for Medical Records - Cover Letter

To:

From: BlueCross BlueShield of South Carolina

NPI: -/TIN.

Fax: 803-419-8191

Requested Date:

Greetings:

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

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

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

You may send the information using your preferred method.

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

EMAIL:
HEDIS.Records@bcbssc.com

FAX:
803-419-8191

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

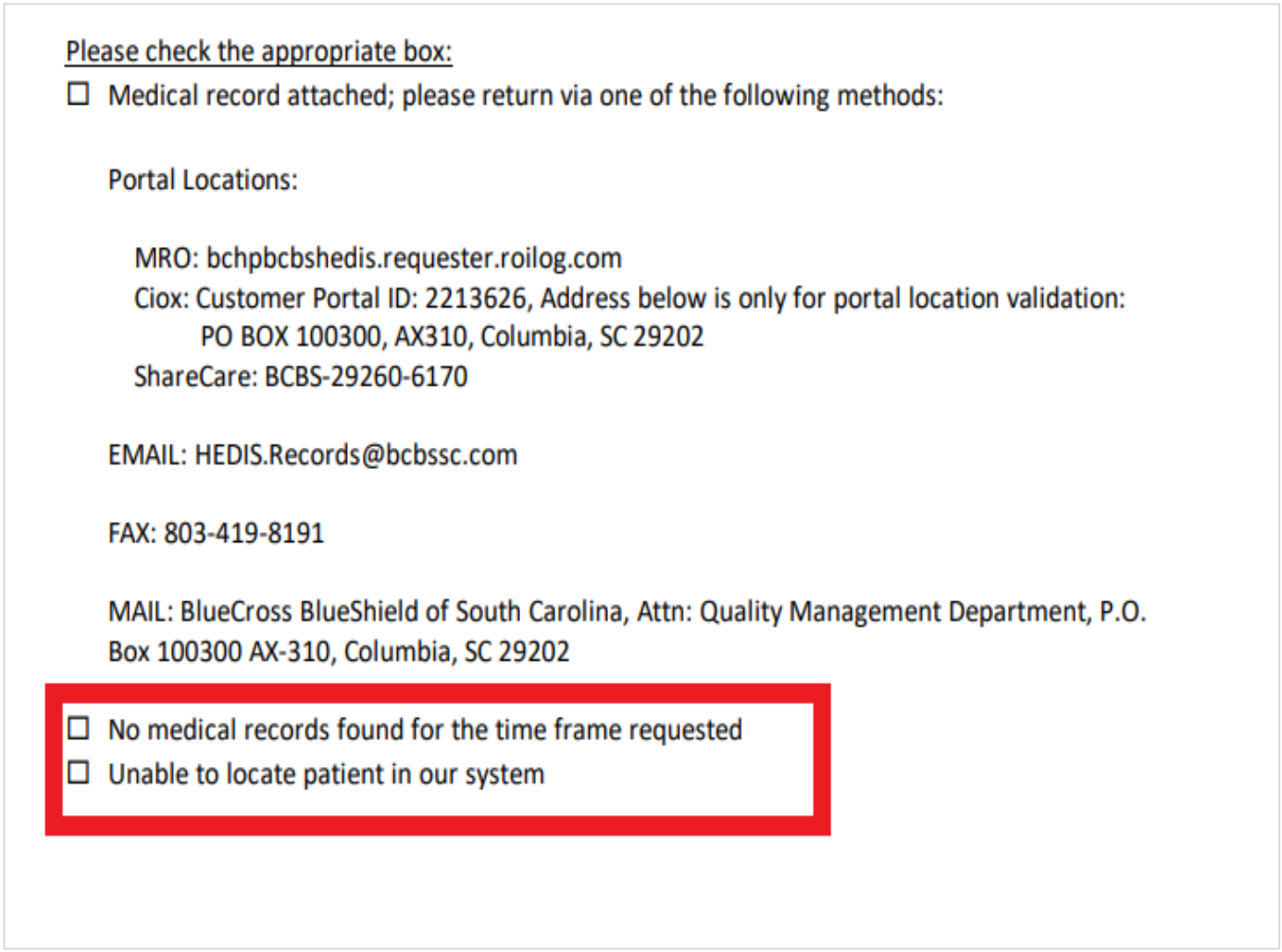
If you have questions or concerns, please email **Navigator@bcbssc.com**.
In accordance with HIPAA, do not return any medical records that do not meet the measure time frame specified.

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

South Carolina

Request for Information (Continued)

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



Please check the appropriate box:

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

Portal Locations:

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

EMAIL: HEDIS.Records@bcbssc.com

FAX: 803-419-8191

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

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

South Carolina

Lines of Business

Lines of Business

- **Healthy Blue (Medicaid)**

Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

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

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

Independent licensees of the Blue Cross Blue Shield Association.

- **Federal Employee Program (FEP)**

BlueCross BlueShield
Federal Employee Program.

South Carolina

Health Insurance Exchange (Marketplace)

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

South Carolina

Federal Employee Program (FEP)

- Clinical quality, customer service and resource use (QCR).
- FEP program works based on priority measures that are weighted.
- This system is administered by the Federal Employee Plan Directors
- FEP is known to members as the Service Benefit Plan.
- Current State Population for FEP: Around 89,000.
- This year FEP launched the Postal Service Health Benefit (PSHB) program. This program designation is for members within USPS.

Healthy Blue℠

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

Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

South Carolina

Quality Navigator Program

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Quality Navigator Program

Quality Navigator Model

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

South Carolina

Quality Navigator Program (Continued)

What is the Quality Navigator Program?

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

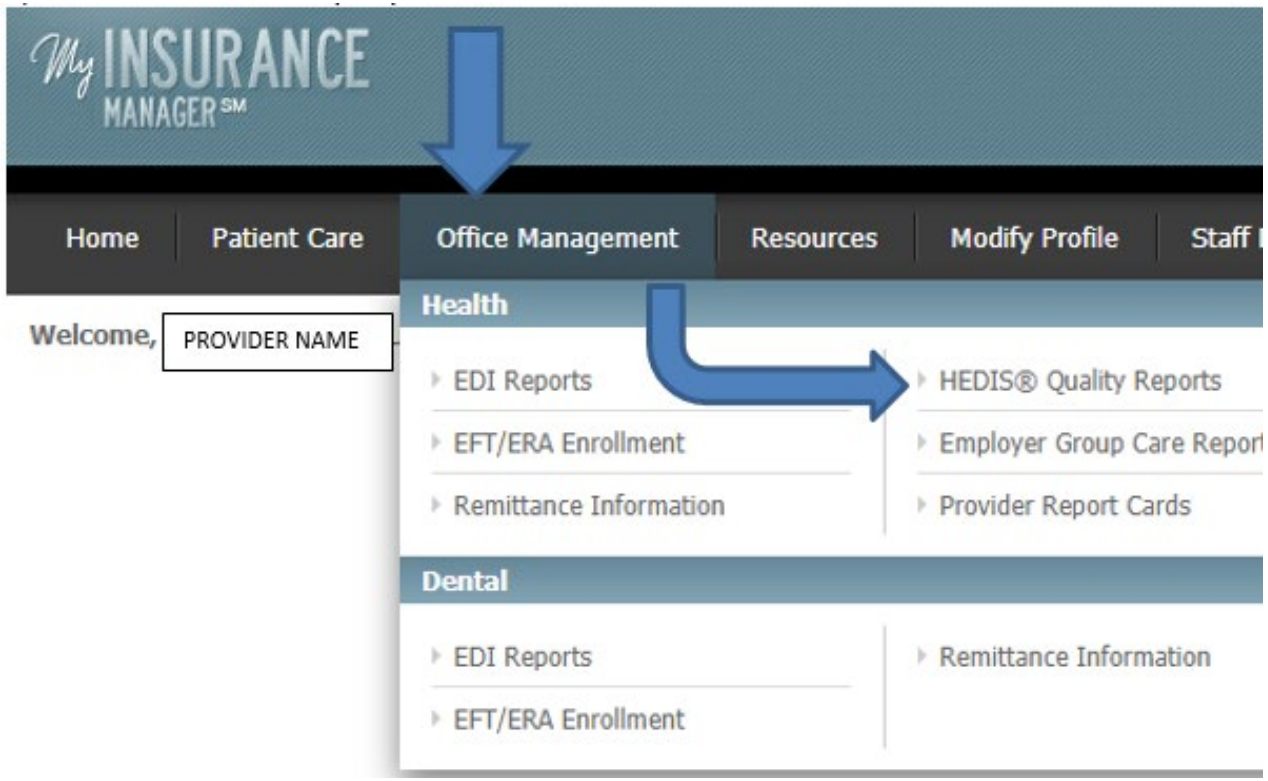
What is a Quality Navigator?

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

Quality Navigator Program (Continued)

My Insurance Manager

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

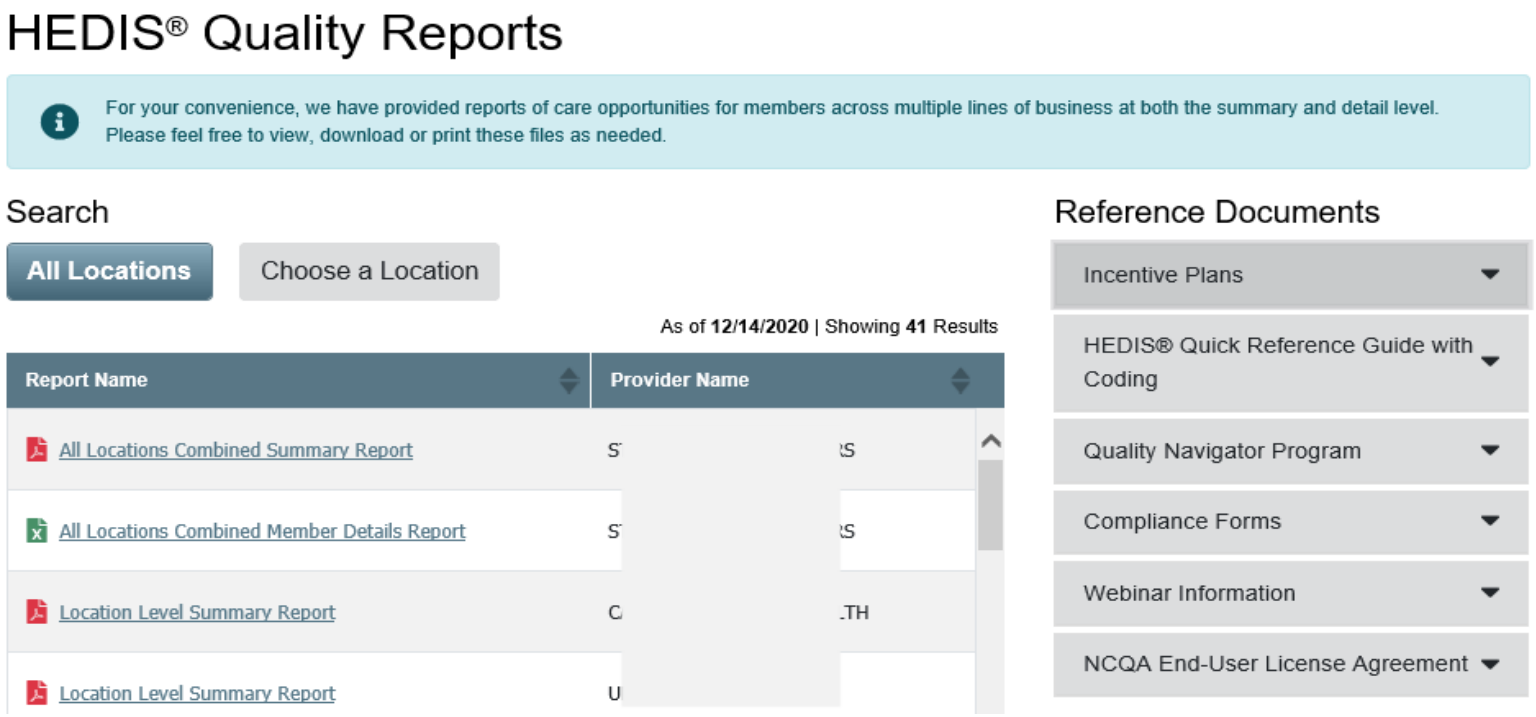


South Carolina

Quality Navigator Program (Continued)

My Insurance Manager

- Convenient Solution for Providers
- Group and Location Level Reporting
- Additional Resources and Education Material



Note: Healthy Blue Gaps in Care reports are coming soon. Other lines of business are currently available.

South Carolina

Quality Navigator Program (Continued)

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

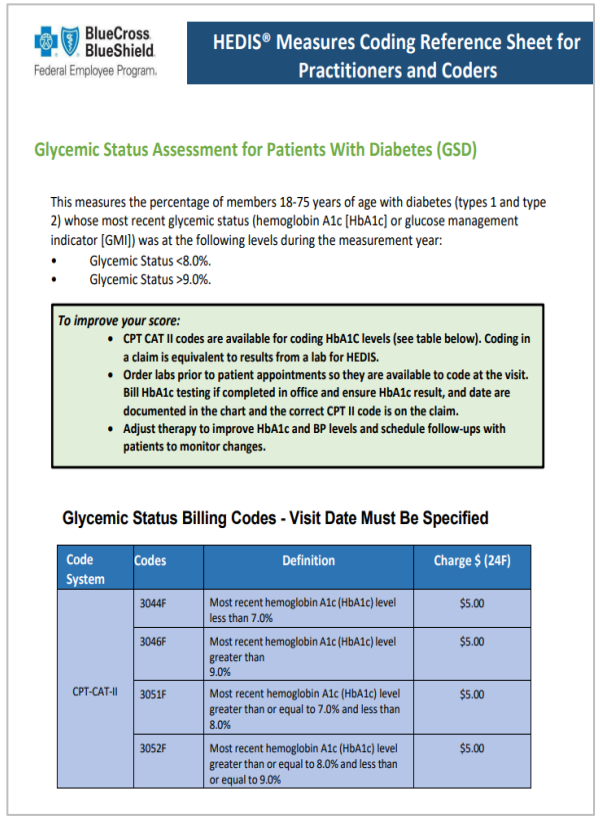
- Past medical history has been added for members ( )
- Non-compliance can be a true "gap" in care or a "gap" in data ( )
  - A true gap in care or non-compliance is when the member has not received the care.
  - A data gap is when the member has received the care, but this information was not shared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

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

South Carolina

Incentives

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



BlueCross BlueShield
Federal Employee Program

HEDIS® Measures Coding Reference Sheet for Practitioners and Coders

Glycemic Status Assessment for Patients With Diabetes (GSD)

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

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

To improve your score:

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

Glycemic Status Billing Codes - Visit Date Must Be Specified

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

FEP Provider CPT II Incentive

Healthy Blue Provider Incentive Program

South Carolina

RADV and RISK

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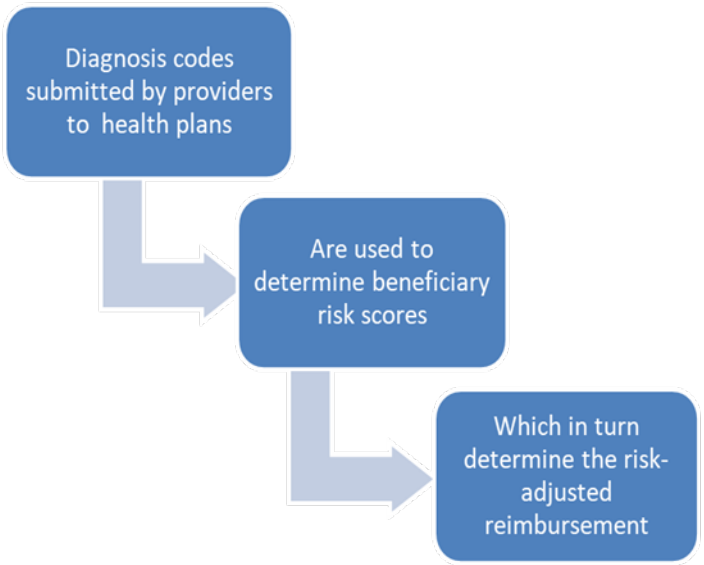
RISK Adjustment

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



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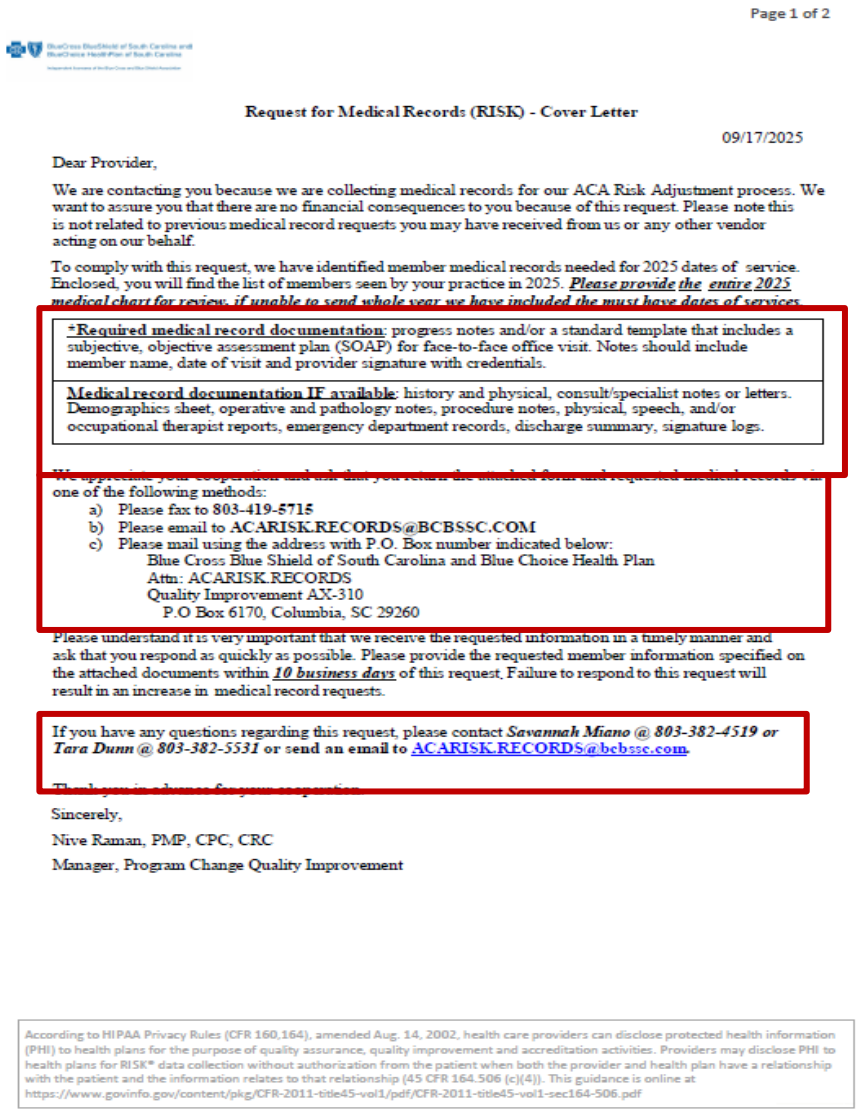
RADV – RISK Adjustment Data Validation

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

How RISK Adjustment Helps Providers

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

RISK Cover Letter for Release of Information



Page 1 of 2

Request for Medical Records (RISK) - Cover Letter

09/17/2025

Dear Provider,

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

To comply with this request, we have identified member medical records needed for 2025 dates of service. Enclosed, you will find the list of members seen by your practice in 2025. ***Please provide the entire 2025 medical chart for review, if unable to send whole year we have included the must have dates of services***

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

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

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

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

If you have any questions regarding this request, please contact ***Savannah Miano @ 803-382-4519 or Tara Dunn @ 803-382-5531*** or send an email to ACARISK.RECORDS@bcbssc.com.

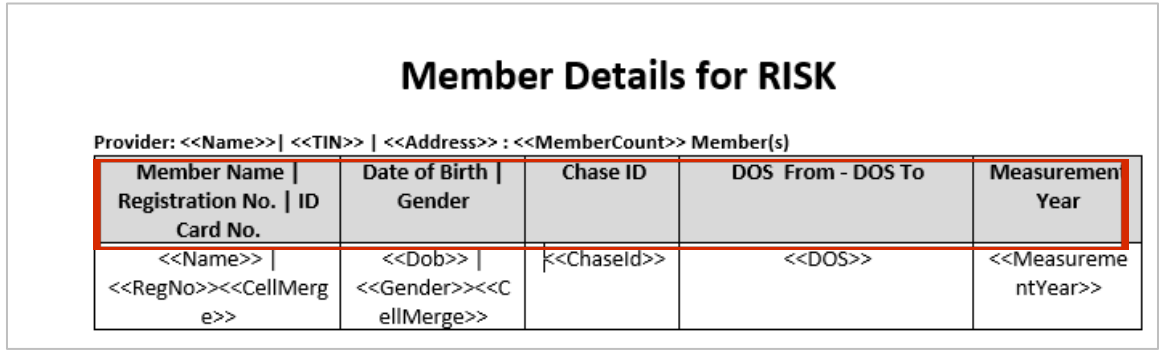
Thank you in advance for your cooperation.

Sincerely,

Nive Raman, PMP, CPC, CRC

Manager, Program Change Quality Improvement

According to HIPAA Privacy Rules (CFR 160,164), amended Aug. 14, 2002, health care providers can disclose protected health information (PHI) to health plans for the purpose of quality assurance, quality improvement and accreditation activities. Providers may disclose PHI to health plans for RISK* data collection without authorization from the patient when both the provider and health plan have a relationship with the patient and the information relates to that relationship (45 CFR 164.506 (c)(4)). This guidance is online at https://www.govinfo.gov/content/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-sec164-506.pdf



Member Details for RISK

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

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

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

South Carolina

RADV Cover Letter for Release of Information

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: May 20, 2025

To: Hospitals, Physicians, and Practitioner Health Care Providers

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

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

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

The current HHS-RADV audit pertains to services provided during the 2024 calendar year.[1] The requesting entity has determined that one or more of your patients are included in the HHS-RADV audit sample for services rendered during 2024. Because 2024 HHS-RADV medical record review is time sensitive, **your immediate attention to this request is appreciated.**

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

Thank you in advance for your prompt cooperation.

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina

Date:_____,2025

IMPORTANT CMS AUDIT REQUEST

Dear Provider,

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

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

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

Please bear in mind that medical records requested for audit purposes should be provided at no cost as a part of your contractual agreement with us. *In addition, we do not have any affiliation nor contractual agreement with third-party record retrieval vendors and as such, are not permitted to contact them on your behalf.*

How to submit the requested records:
To meet the CMS deadline, please submit the required medical records for 2024 to us by _____. You can submit the records via fax to 803-419-5715 or via email to RADV.RECORDS@bcbssc.com. If you prefer, you can mail the medical records to:

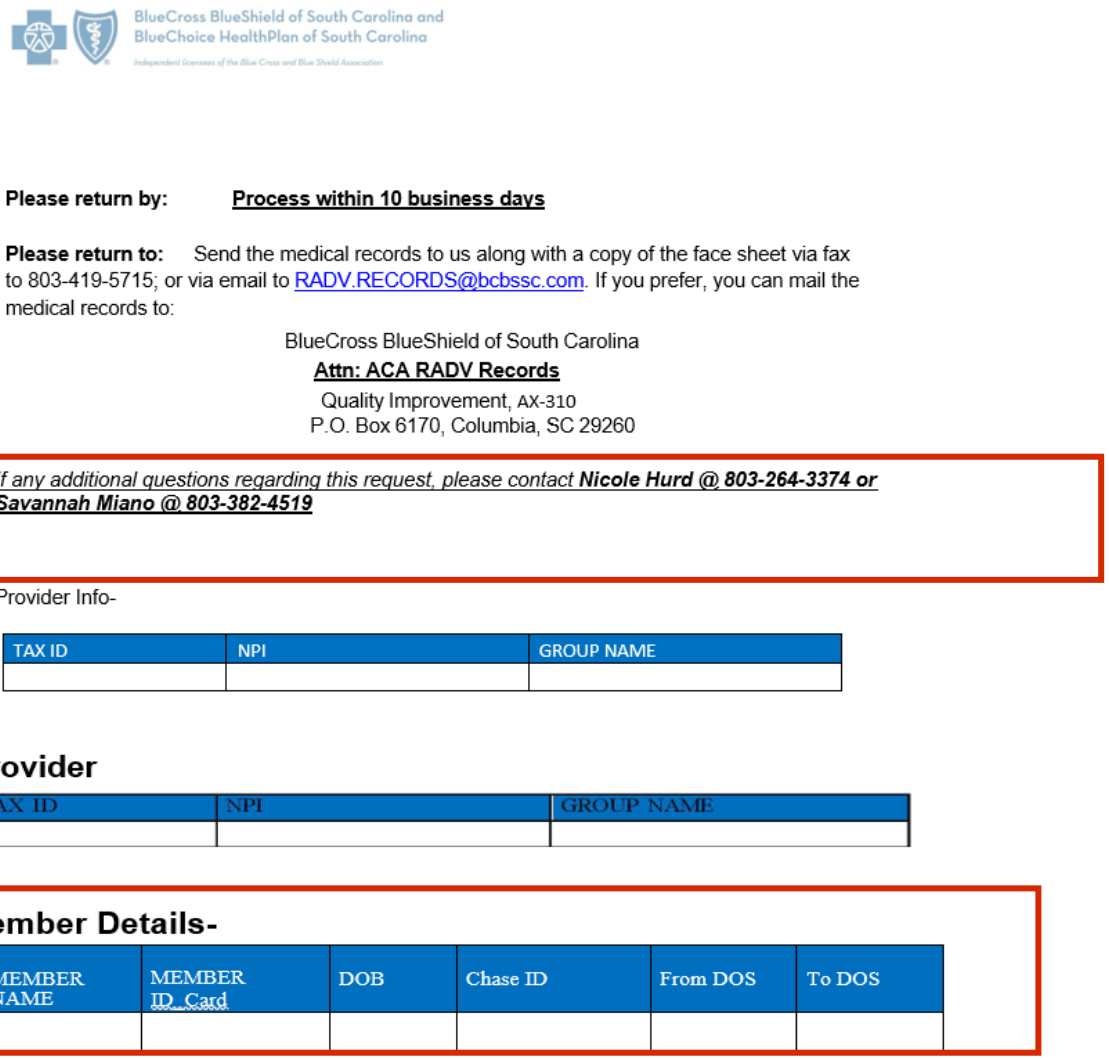
BlueCross BlueShield of South Carolina
Attn: ACA RADV Records
Quality Improvement, AX-310
P.O. Box 6170, Columbia, SC 29260

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

Sincerely,
Nive Raman, P.MP, CPC, CRC
Manager, Program Change
Quality Improvement

South Carolina

RADV Cover Letter for Release of Information (Continued)



BlueCross BlueShield of South Carolina and
BlueChoice HealthPlan of South Carolina

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

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

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

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

Provider Info-

TAX ID	NPI	GROUP NAME

Provider

TAX ID	NPI	GROUP NAME

Member Details-

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

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

South Carolina

RADV Invoice Response Letter

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Date: 09/11/2025

FAX Coversheet

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

Re:

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

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

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

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

09/9/2025

Re: Record invoice response

Hello,

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

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

Thanks for your prompt attention to this time sensitive request.

Thank you,

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

Healthcare Innovation and Improvement | South Carolina

P.O Box 6170 Columbia, SC 29260-6170

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

IV. PREFERRED PROVIDER'S RESPONSIBILITIES.

Preferred Provider shall:

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

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

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

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

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

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

(7) Cooperate fully with the Utilization Management Program.

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

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

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

South Carolina

How Providers Can Help the Program

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

South Carolina

Key Takeaways

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Key Takeaways – Providers

What will positively impact your quality score?

Customer service

Deliver care in a kind and courteous manner

Patient Care Coordination

Include periodic screenings and preventive services

Follow up on missed appointments

Data Transfer

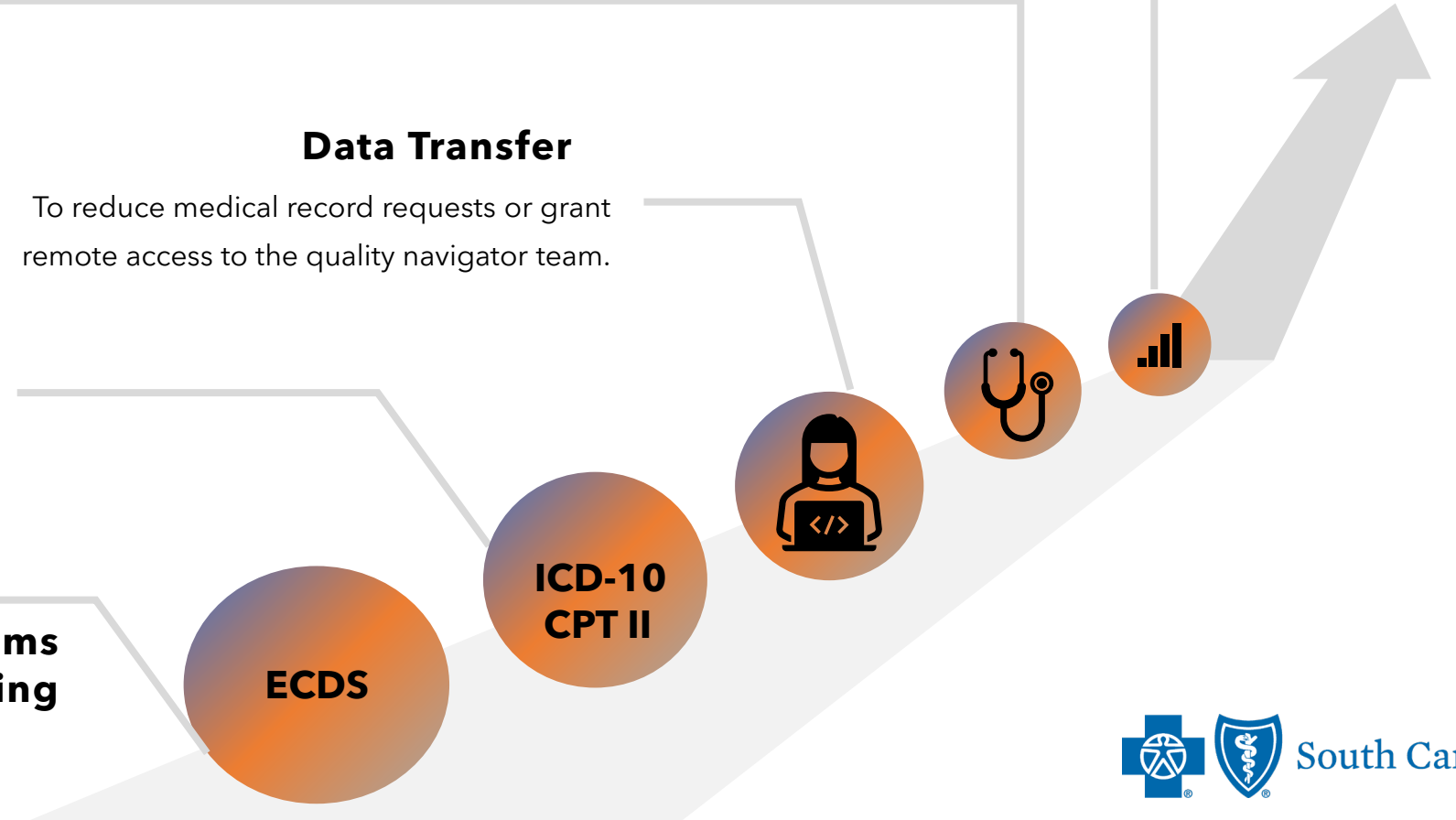
To reduce medical record requests or grant remote access to the quality navigator team.

Codes

Submit NCQA-approved quality codes on claims when appropriate.

Take advantage of available coding incentives

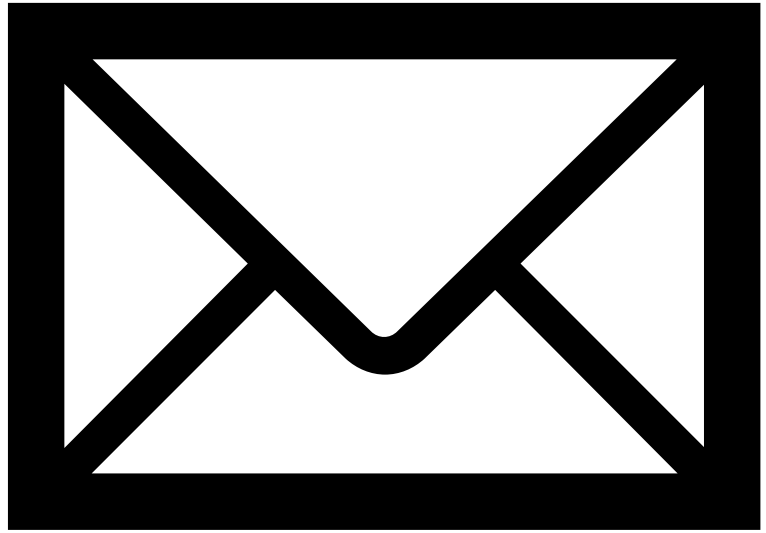
HEDIS Electronic Clinical Data Systems Reporting



South Carolina

Contact Information

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



South Carolina

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Self-service Tools

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Topics to Discuss

- Website Overview
- My Insurance Manager℠
  - Registration and Overview
  - Benefits and Eligibility
  - Claims Submission
  - Claims Status
  - Ask Provider Services
  - STATchat℠
- My Remit Manager
- Cohere Health®
- My Provider Enrollment Portal
  - Overview of Portal
  - Completing Clean Applications
  - Making Corrections

Website Overview

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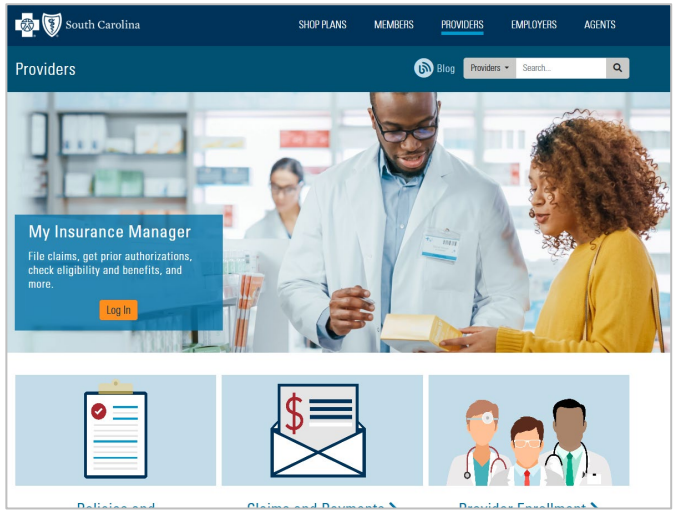
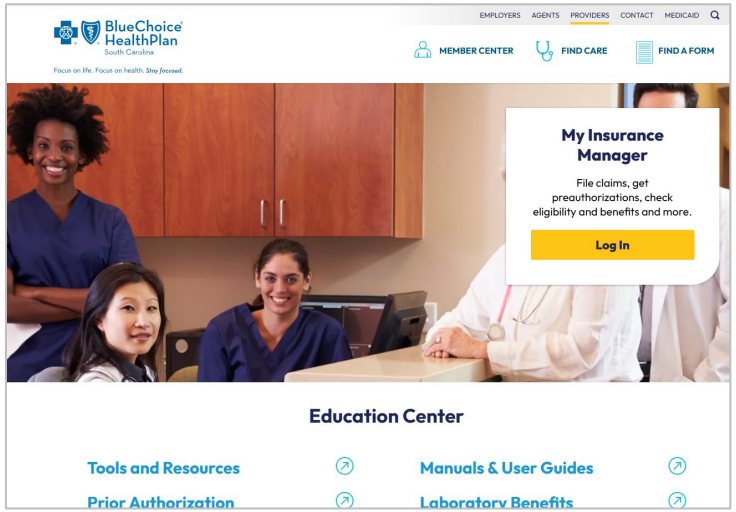
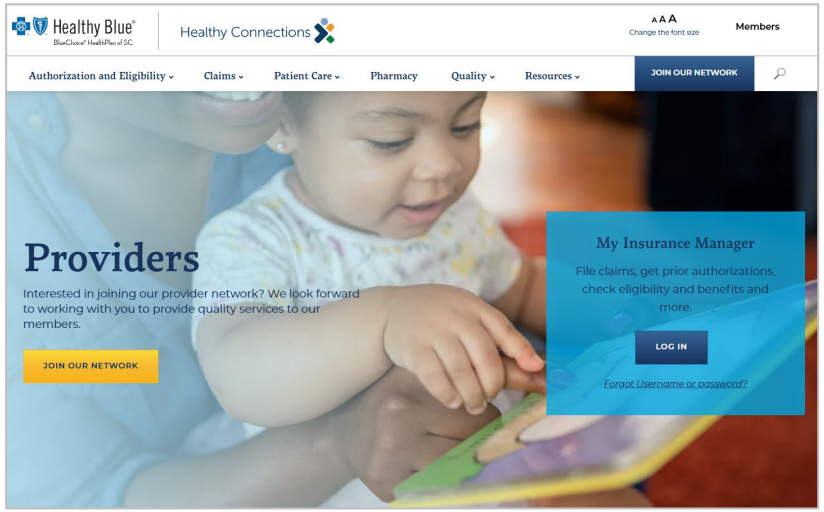
Available Websites

- Our websites include:
  - www.SouthCarolinaBlues.com
  - www.BlueChoiceSC.com
  - www.HealthyBlueSC.com







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My Insurance Manager

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Registration and Overview

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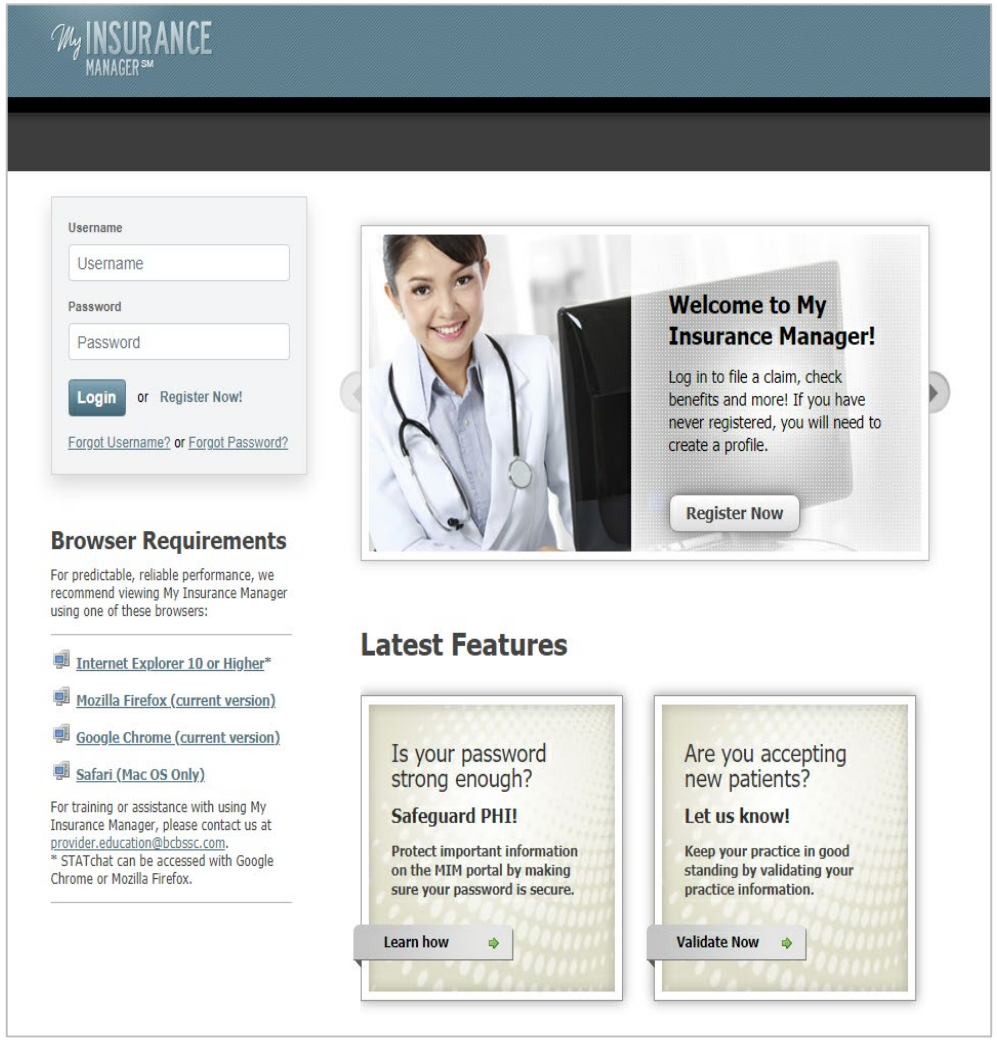
Getting Started with My Insurance Manager

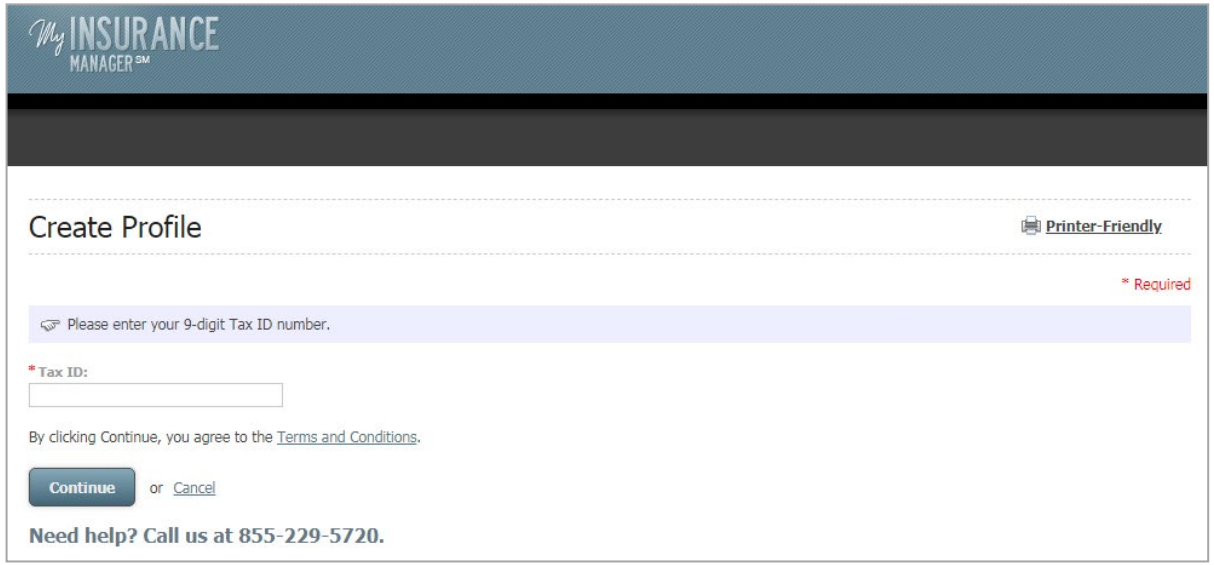
- Visit one of our websites and select Providers.
- You will have the option to access My Insurance Manager from several pages under the Provider section.
- If you do not already have an account for My Insurance Manager, from the home page of the portal, select Register Now.



South Carolina

Creating a Profile in My Insurance Manager

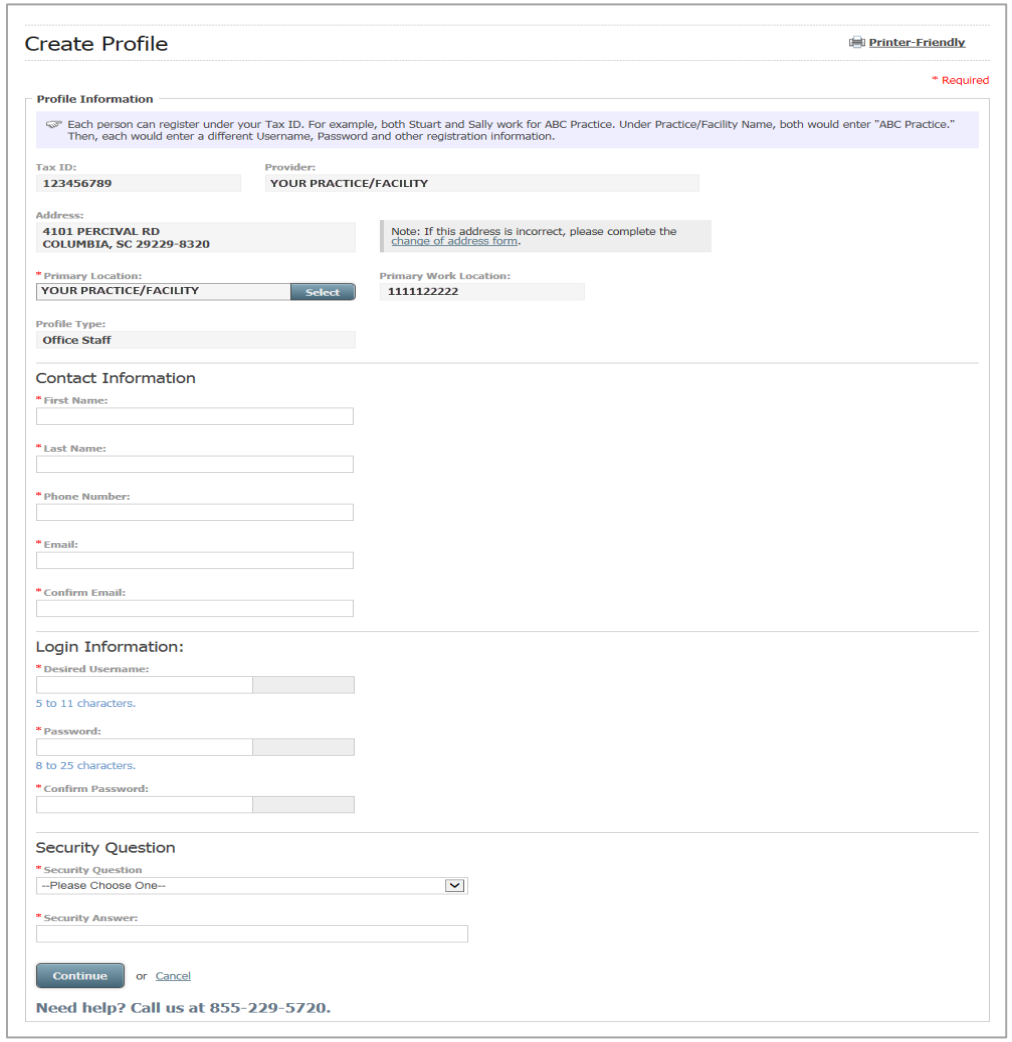
- To create a profile in My Insurance Manager, you must have a 9-digit tax identification number (TIN).
- Enter the TIN in the appropriate field and select Continue.
- If you run into any technical issues, contact our technical support team at 855-229-5720.



South Carolina

Profile Information

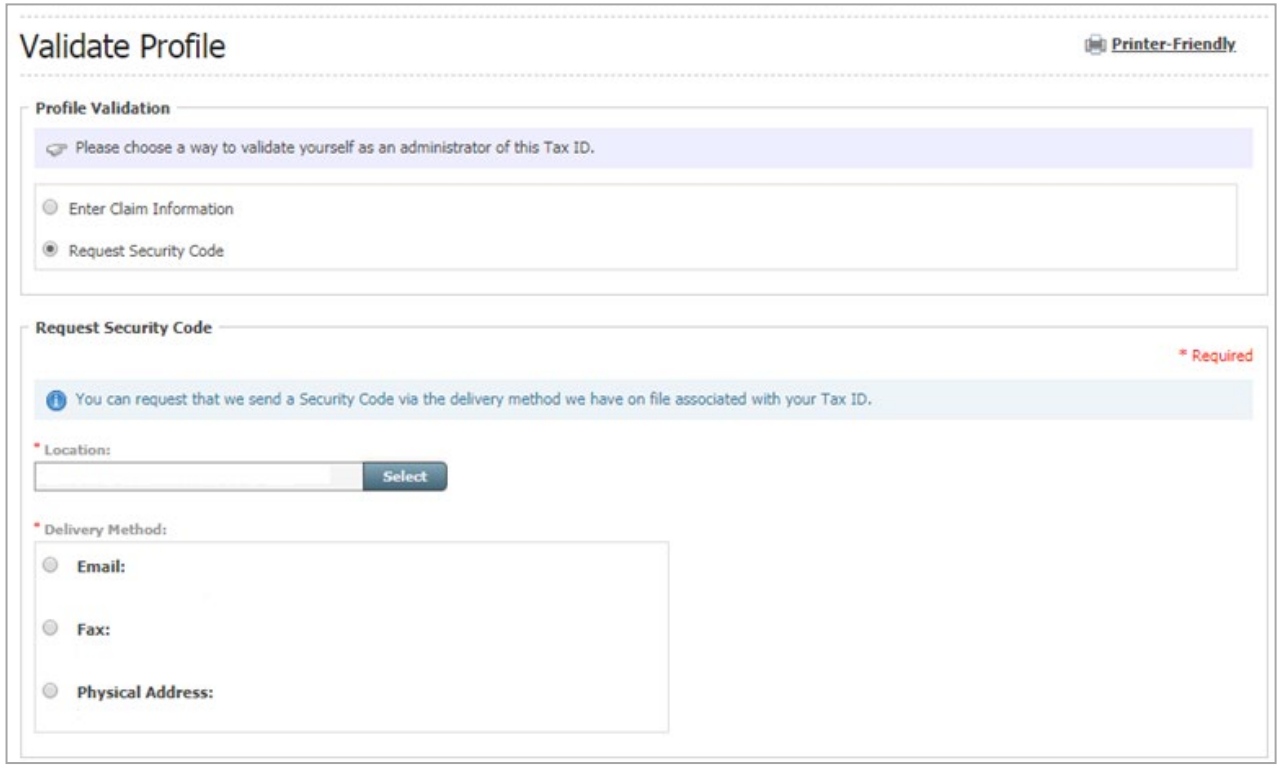
- The information associated with the Tax ID will pre-populate.
  - If there are multiple locations for the practice, you will be given the option to select the primary location.
- Enter the remaining contact and login information.
- Select a security question and include the answer.
- Select ***Continue***.



South Carolina

Validating Profile

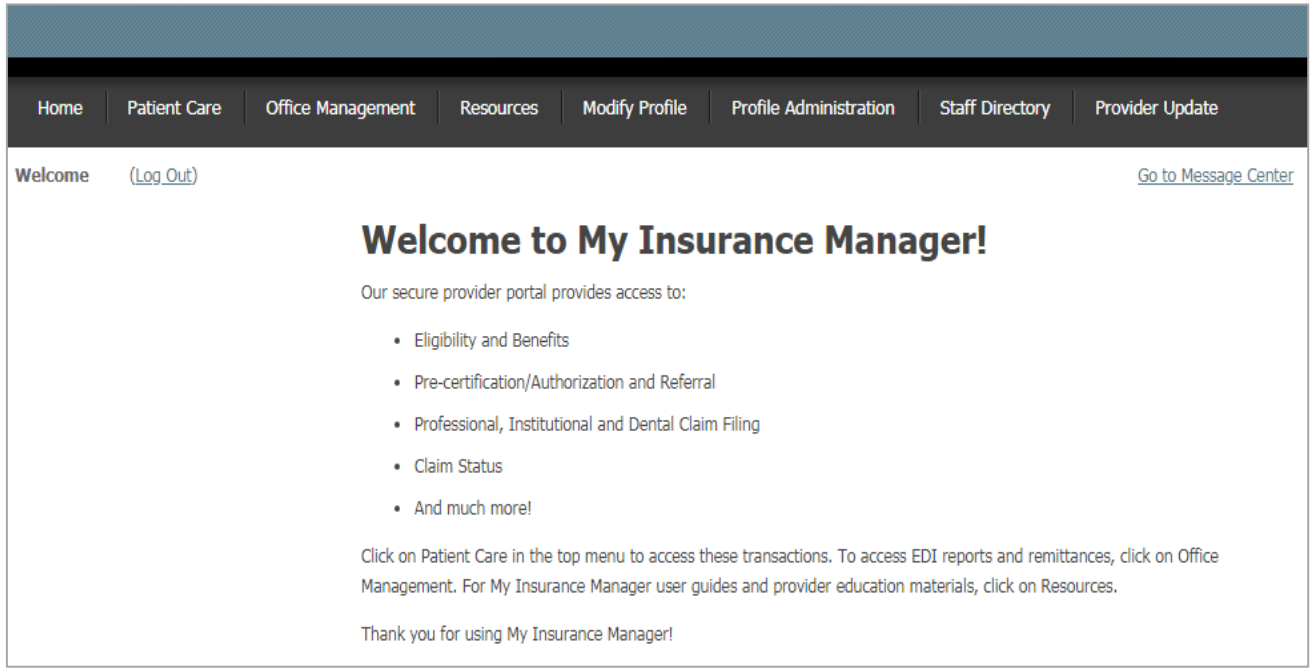
- If registering as the profile administrator, you must validate your profile by entering claim information or requesting a security code (recommended). Also, choose the delivery method for the code.
- After completing registration, it can take up to two business days for the profile to be approved.
  - If the practice already has a profile administrator, they must review and approve profile requests.
- When the profile is approved, use your username and password to log in.



South Carolina

Navigational Options

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



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Patient Care

- There are several options available under Patient Care. Some of the most common requests include:
  - Claims Status
  - Eligibility and Benefits
  - Institutional or Professional Claim Entry
  - Pre-certification/Referral

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Office Management

- There are several options available under Office Management. Some of the most common requests include:
  - EDI Reports
  - Remittance Information
  - Refund Letters
  - HEDIS® Quality Reports

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Resources

- There are several options available under Resources. Some of the most common requests include:
  - Find Care
  - Medical Policies
  - My Remit Manager

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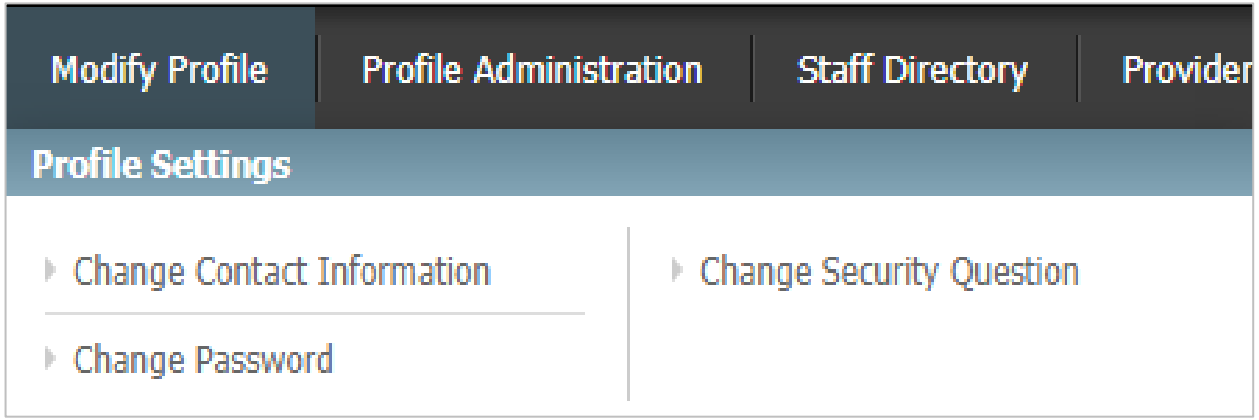
Modify Profile

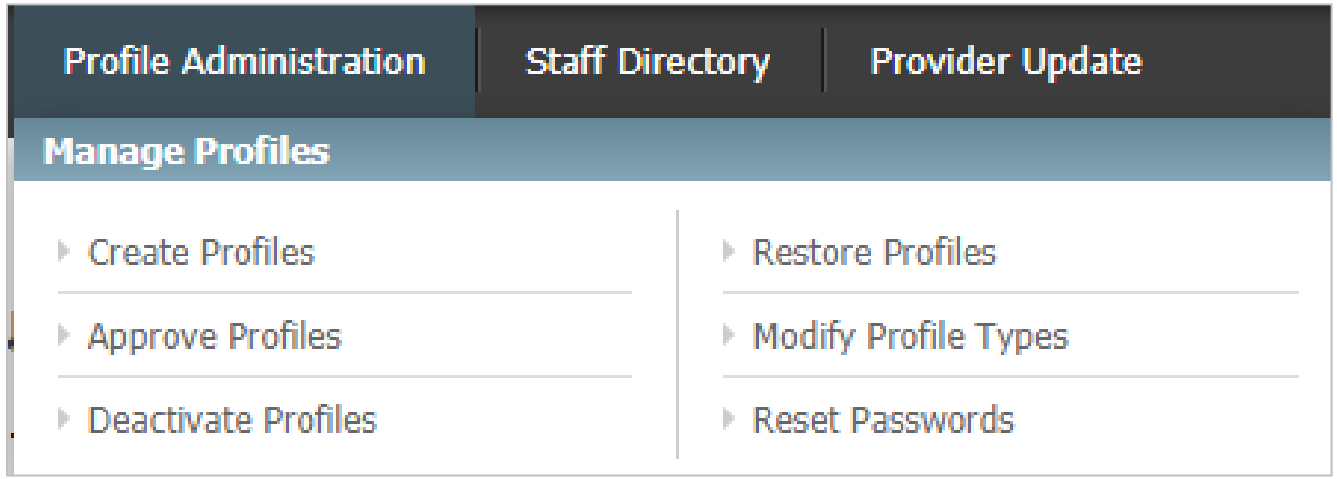
- Modify Profile gives the user three options related to their profile settings:
  - Change Contact Information
  - Change Password
  - Change Security Question



South Carolina

Profile Administration

- Only the profile administrator for the practice will have this tab. The administrator can manage the following options for profiles:
  - Create Profiles
    - Create individual profiles for staff members.
  - Approve Profiles
    - Approve profiles that were created by staff members.
  - Deactivate Profiles
    - Close profiles for staff members that no longer work for the practice.
  - Restore Profiles
    - Restore profiles that were deactivated.
  - Modify Profile Types
    - Change a profile type from staff member to profile administrator and vice versa.
  - Reset Passwords
    - Reset password for staff members.

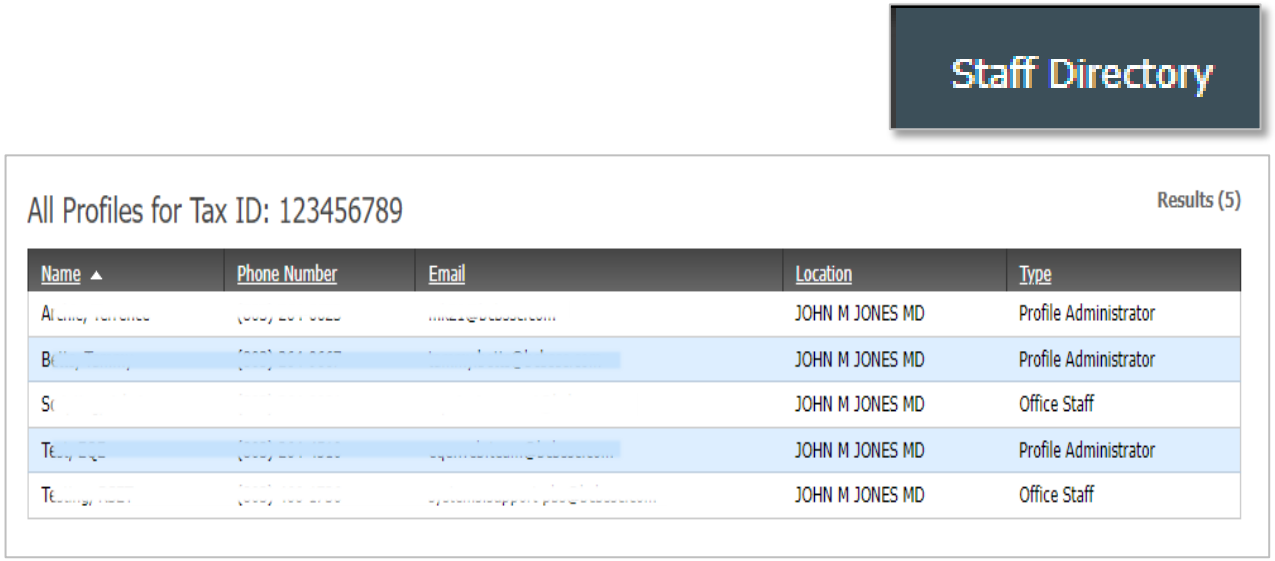


Note: If someone no longer works at your practice, deactivate their profile. Also, if you are the profile administrator and plan to leave, make someone else the profile administrator.

South Carolina

Staff Directory

- The staff directory simply shows a list of profiles associated with the TIN.



South Carolina

Provider Update

- Providers are required to verify their demographic data at least every 90 days as part of the No Surprises Act implemented on Jan. 1, 2022.
- Validation allows us to maintain accurate provider directories.
- Verification can be completed using Provider Update (M.D. Checkup).
  - You can also respond to the email received from Provider.Directory@bcbssc.com.

South Carolina

Troubleshooting Tips

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

Benefits and Eligibility

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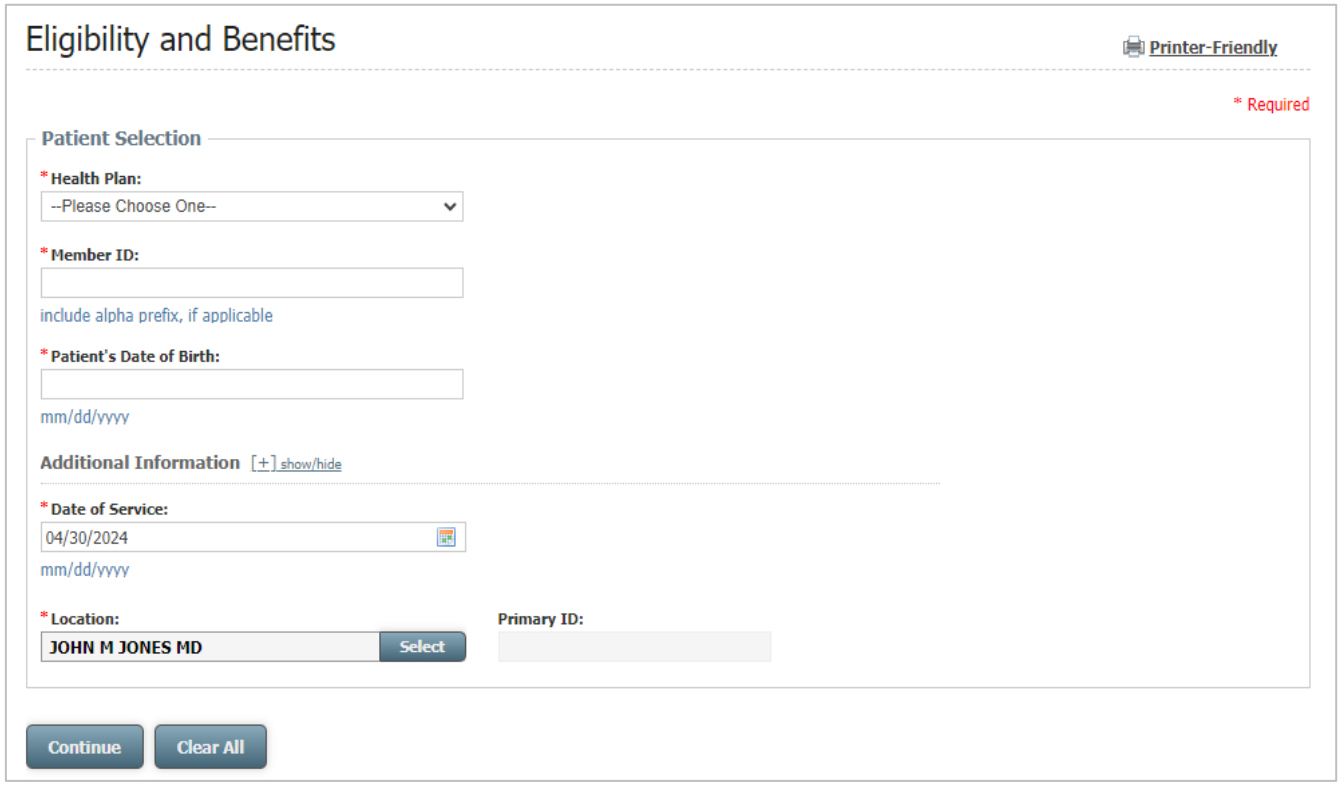
South Carolina

Getting Benefits in My Insurance Manager

Step 1

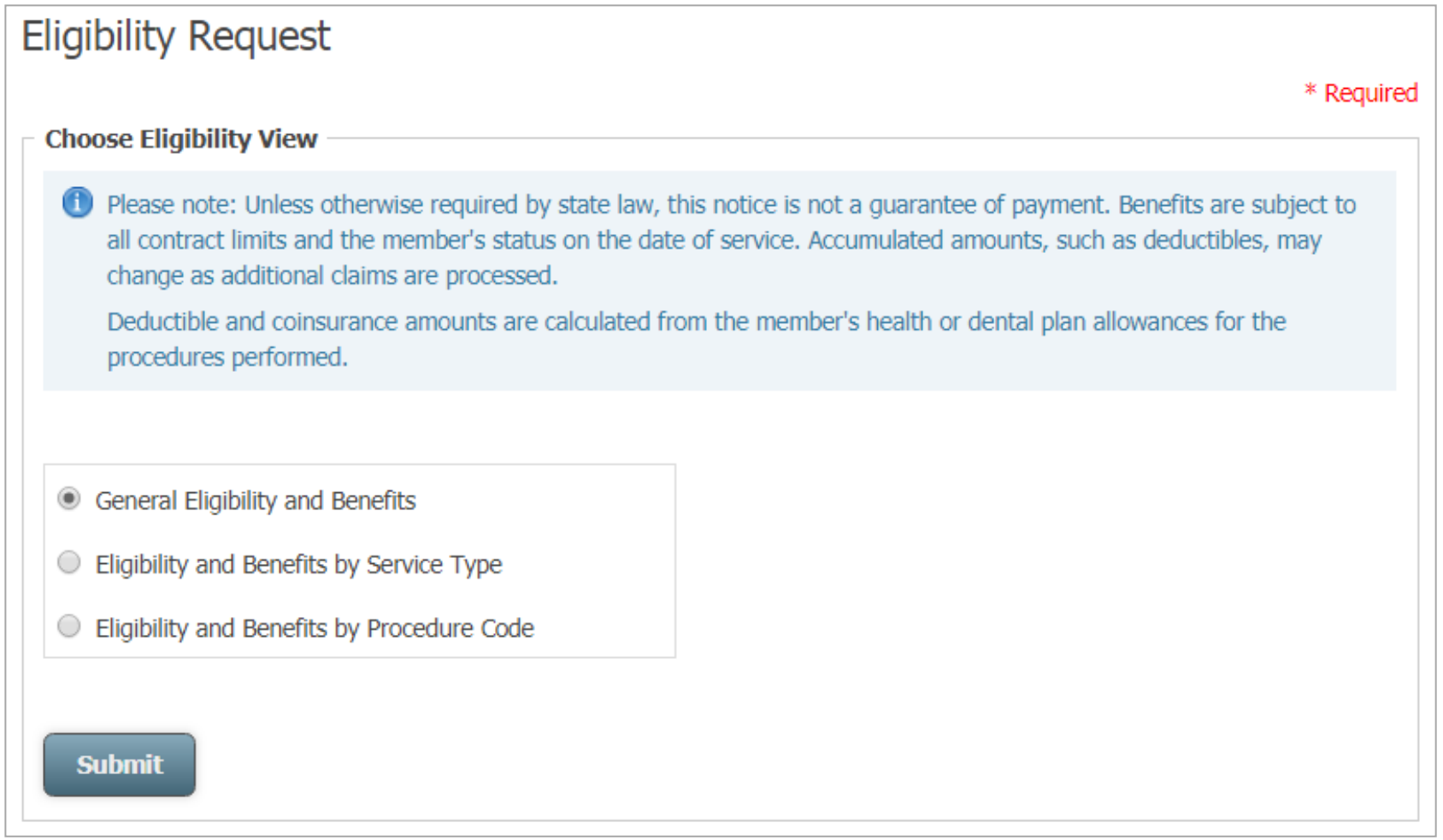
Step 2



South Carolina

Getting Benefits in My Insurance Manager – General Benefits

Step 3 (*When pulling general benefits.*)



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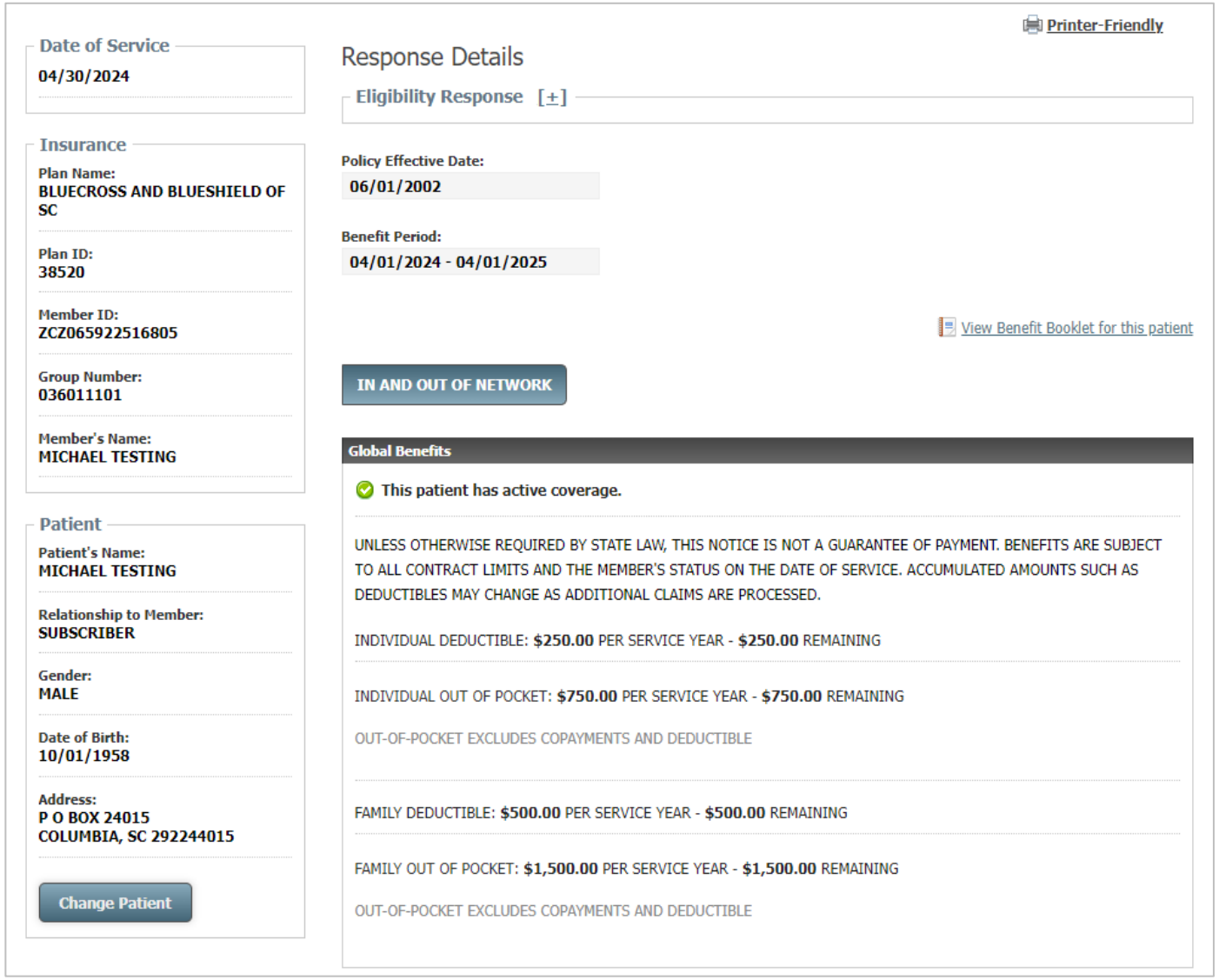
Getting Benefits in My Insurance Manager – General Benefits



Printer-Friendly

Date of Service
04/30/2024

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

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

Change Patient

Response Details

Eligibility Response [+]

Policy Effective Date: 06/01/2002

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

View Benefit Booklet for this patient

IN AND OUT OF NETWORK

Global Benefits

This patient has active coverage.

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

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

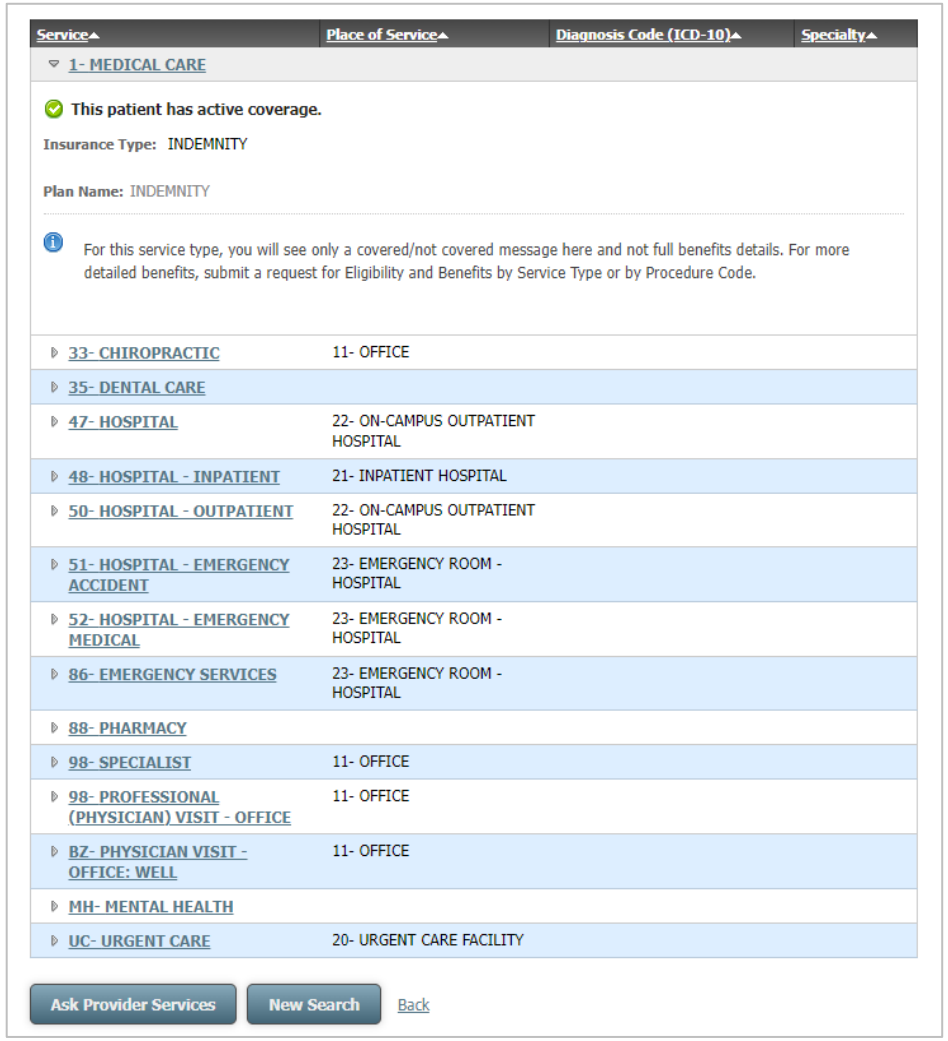
INDIVIDUAL OUT OF POCKET: **$750.00** PER SERVICE YEAR - **$750.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

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

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

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE



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

This patient has active coverage.

Insurance Type: INDEMNITY

Plan Name: INDEMNITY

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

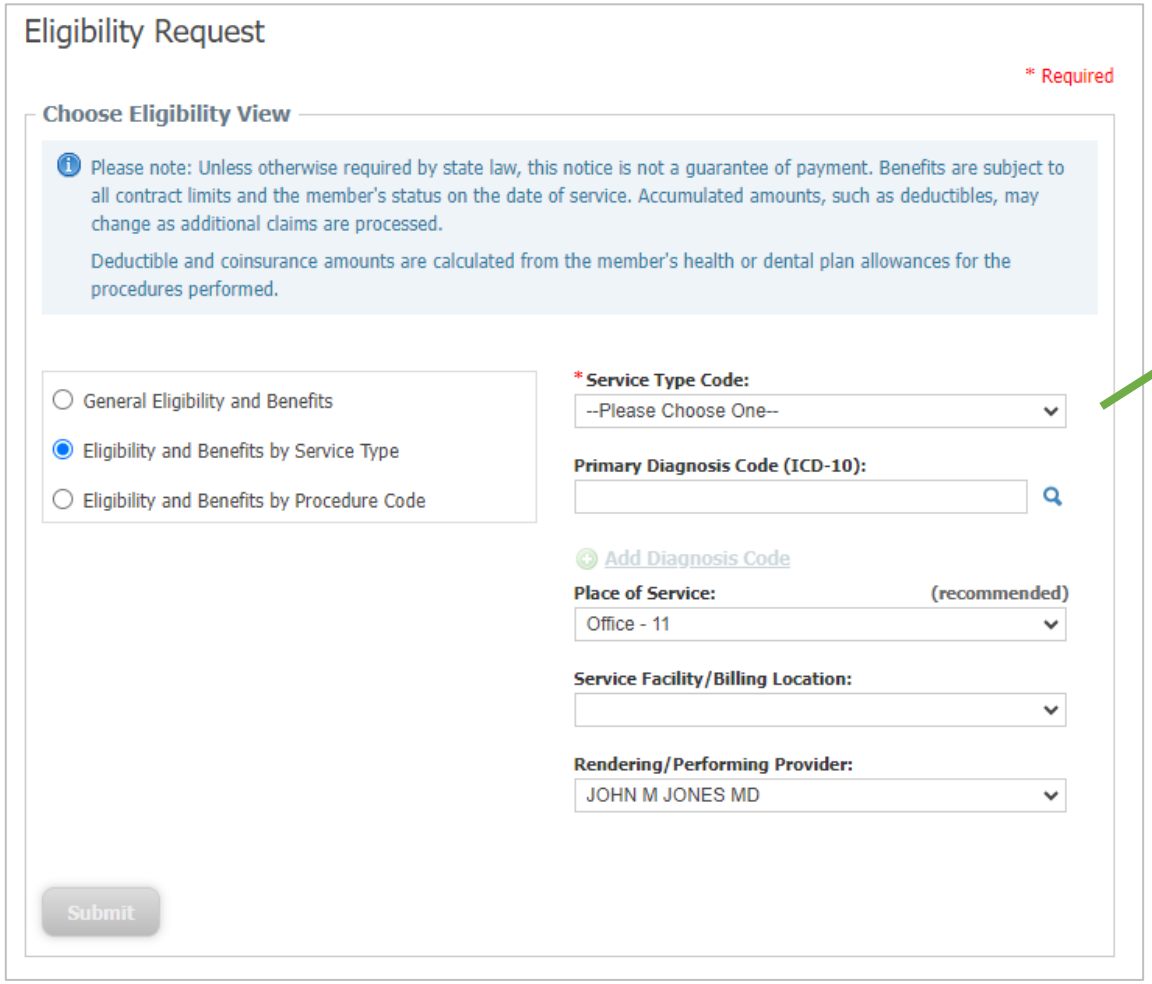
33- CHIROPRACTIC	11- OFFICE
35- DENTAL CARE	
47- HOSPITAL	22- ON-CAMPUS OUTPATIENT HOSPITAL
48- HOSPITAL - INPATIENT	21- INPATIENT HOSPITAL
50- HOSPITAL - OUTPATIENT	22- ON-CAMPUS OUTPATIENT HOSPITAL
51- HOSPITAL - EMERGENCY ACCIDENT	23- EMERGENCY ROOM - HOSPITAL
52- HOSPITAL - EMERGENCY MEDICAL	23-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

Ask Provider Services | New Search | Back

South Carolina

Getting Benefits in My Insurance Manager – Service Type

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



Other Service Types

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

South Carolina

Getting Benefits in My Insurance Manager – Service Type

Printer-Friendly

Date of Service
04/30/2024

Insurance
Plan Name:
BLUECROSS AND BLUESHIELD OF SC

Plan ID:
38520

Member ID:
ZCZ065922516805

Group Number:
036011101

Member's Name:
MICHAEL TESTING

Patient
Patient's Name:
MICHAEL TESTING

Relationship to Member:
SUBSCRIBER

Gender:
MALE

Date of Birth:
10/01/1958

Address:
P O BOX 24015
COLUMBIA, SC 292244015

Change Patient

Response Details

Eligibility Response [+]

Policy Effective Date:
06/01/2002

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

View Benefit Booklet for this patient

IN AND OUT OF NETWORK

Global Benefits

This patient has active coverage.

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

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

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

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

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

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

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

Service	Place of Service	Diagnosis Code (ICD-10)	Specialty
50- HOSPITAL - OUTPATIENT	22- ON-CAMPUS OUTPATIENT HOSPITAL		

This patient has active coverage.

Insurance Type: INDEMNITY

Plan Name: INDEMNITY

THIS MEMBER CURRENTLY HAS AN HSA WITH A PAYMENT OPTION WHICH ALLOWS FOR AUTOMATIC PAYMENT DIRECTLY TO THE PROVIDER. QUALIFIED MEDICAL EXPENSES WITH THE EXCEPTION OF DENIED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT.

RESPONSES TO ALL FUTURE DATED INQUIRIES ARE BASED ON THE PATIENT'S CURRENT BENEFITS AND ARE SUBJECT TO CHANGE.

YOU HAVE REQUESTED BENEFITS FOR A MEMBER THAT HAS BENEFIT EXCEPTIONS AT THE PROCEDURE CODE LEVEL. TO OBTAIN MORE SPECIFIC INFORMATION, PLEASE REQUEST BENEFITS ON MY INSURANCE MANAGER USING A SPECIFIC PROCEDURE CODE AND DIAGNOSIS CODE.

View Additional Messages

INDIVIDUAL COINSURANCE: **15%**

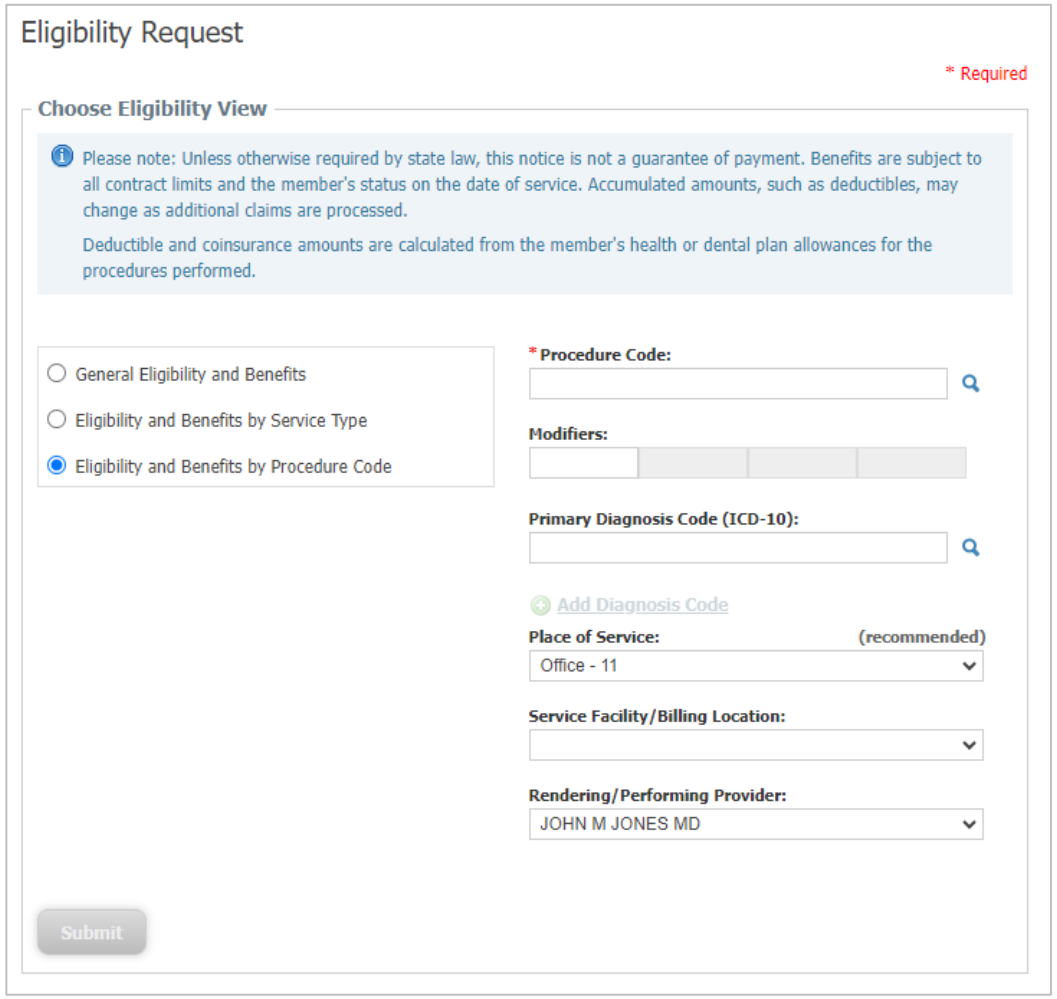
51- HOSPITAL - EMERGENCY ACCIDENT	23- EMERGENCY ROOM - HOSPITAL		
52- HOSPITAL - EMERGENCY MEDICAL	23- EMERGENCY ROOM - HOSPITAL		
A0- PROFESSIONAL (PHYSICIAN) VISIT - OUTPATIENT	22- ON-CAMPUS OUTPATIENT HOSPITAL		

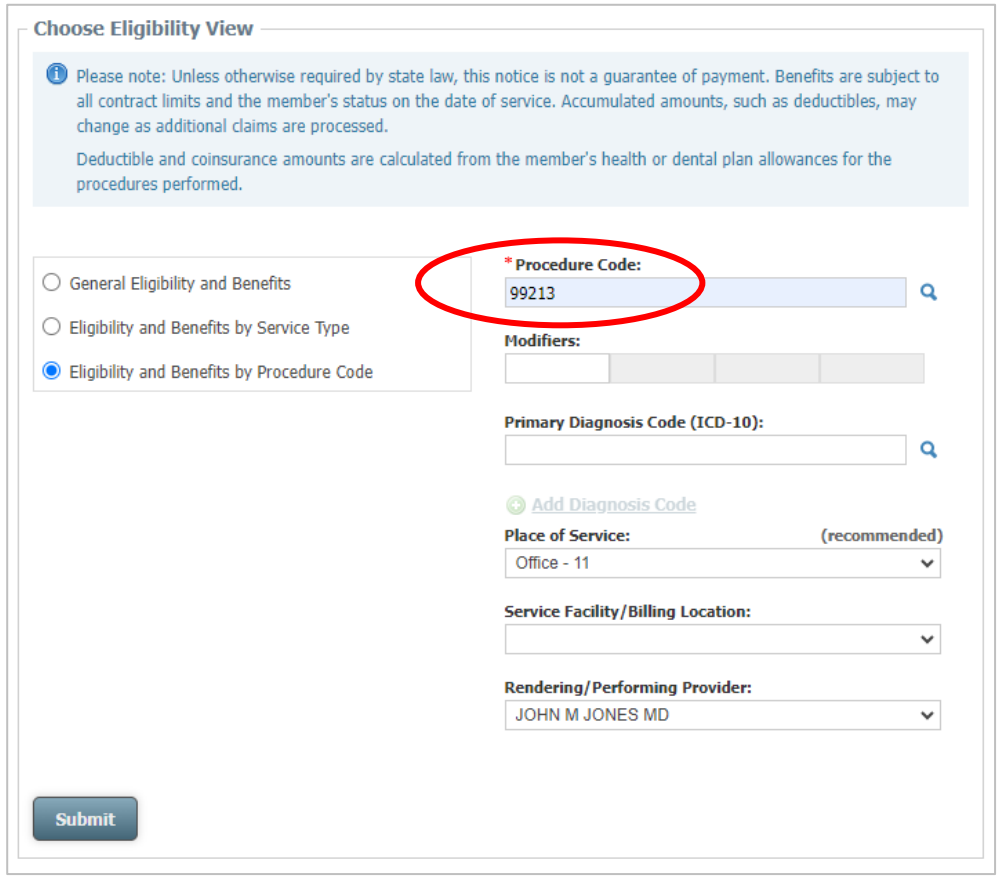
Ask Provider Services | New Search | Back

South Carolina

Getting Benefits in My Insurance Manager – Procedure Code

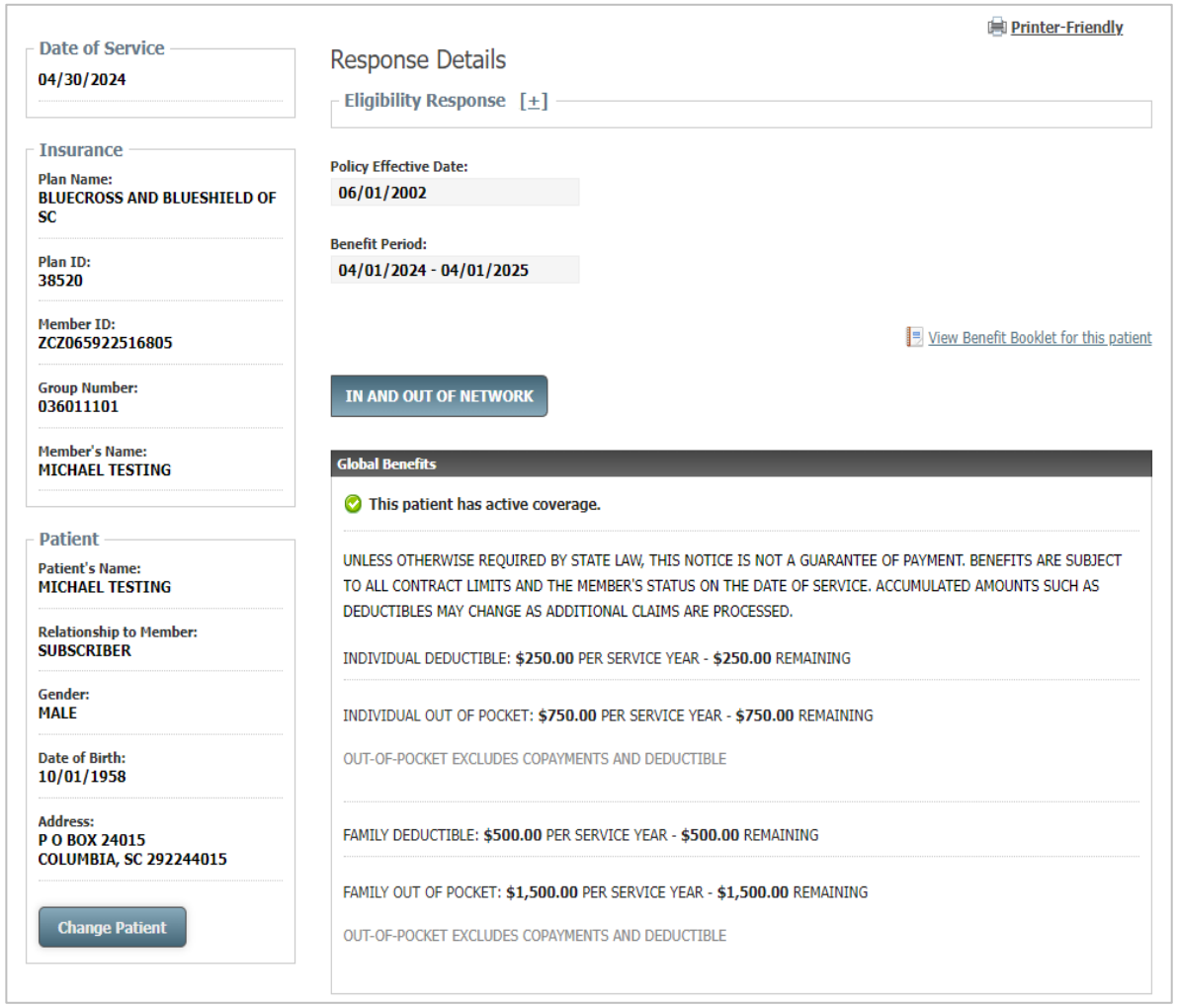
Step 3 (*When pulling benefits by procedure code.*)





South Carolina

Getting Benefits in My Insurance Manager – Procedure Code



Printer-Friendly

Date of Service
04/30/2024

Insurance
Plan Name:
BLUECROSS AND BLUESHIELD OF SC

Plan ID:
38520

Member ID:
ZCZ065922516805

Group Number:
036011101

Member's Name:
MICHAEL TESTING

Patient
Patient's Name:
MICHAEL TESTING

Relationship to Member:
SUBSCRIBER

Gender:
MALE

Date of Birth:
10/01/1958

Address:
P O BOX 24015
COLUMBIA, SC 292244015

Change Patient

Response Details

Eligibility Response [+]

Policy Effective Date:
06/01/2002

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

View Benefit Booklet for this patient

IN AND OUT OF NETWORK

Global Benefits

This patient has active coverage.

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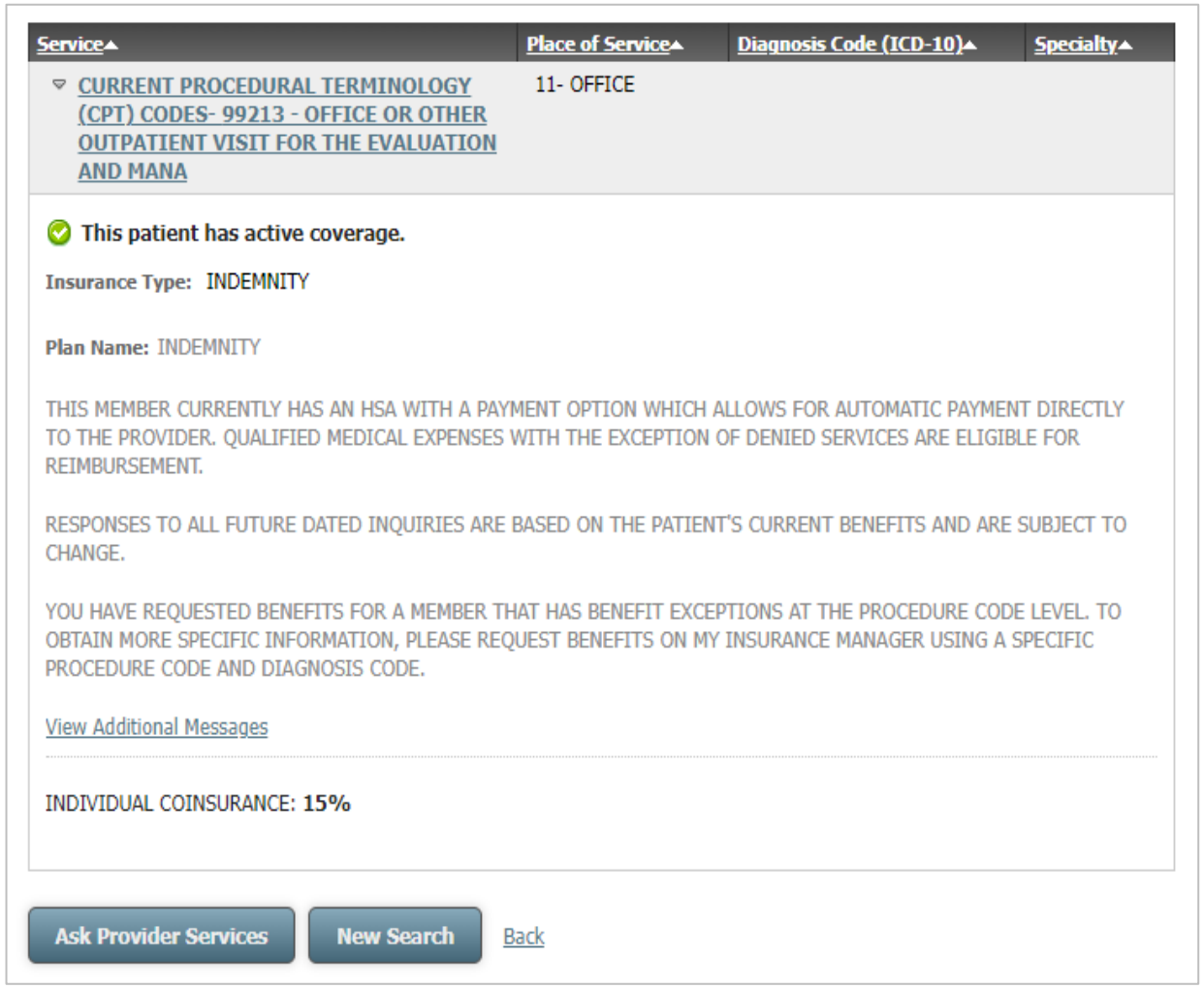
INDIVIDUAL OUT OF POCKET: **$750.00** PER SERVICE YEAR - **$750.00** REMAINING

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE

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

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

OUT-OF-POCKET EXCLUDES COPAYMENTS AND DEDUCTIBLE



Service	Place of Service	Diagnosis Code (ICD-10)	Specialty
CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES- 99213 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANA	11- OFFICE		

This patient has active coverage.

Insurance Type: INDEMNITY

Plan Name: INDEMNITY

THIS MEMBER CURRENTLY HAS AN HSA WITH A PAYMENT OPTION WHICH ALLOWS FOR AUTOMATIC PAYMENT DIRECTLY TO THE PROVIDER. QUALIFIED MEDICAL EXPENSES WITH THE EXCEPTION OF DENIED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT.

RESPONSES TO ALL FUTURE DATED INQUIRIES ARE BASED ON THE PATIENT'S CURRENT BENEFITS AND ARE SUBJECT TO CHANGE.

YOU HAVE REQUESTED BENEFITS FOR A MEMBER THAT HAS BENEFIT EXCEPTIONS AT THE PROCEDURE CODE LEVEL. TO OBTAIN MORE SPECIFIC INFORMATION, PLEASE REQUEST BENEFITS ON MY INSURANCE MANAGER USING A SPECIFIC PROCEDURE CODE AND DIAGNOSIS CODE.

View Additional Messages

INDIVIDUAL COINSURANCE: **15%**

Ask Provider Services | New Search | Back

South Carolina

Claims Submission

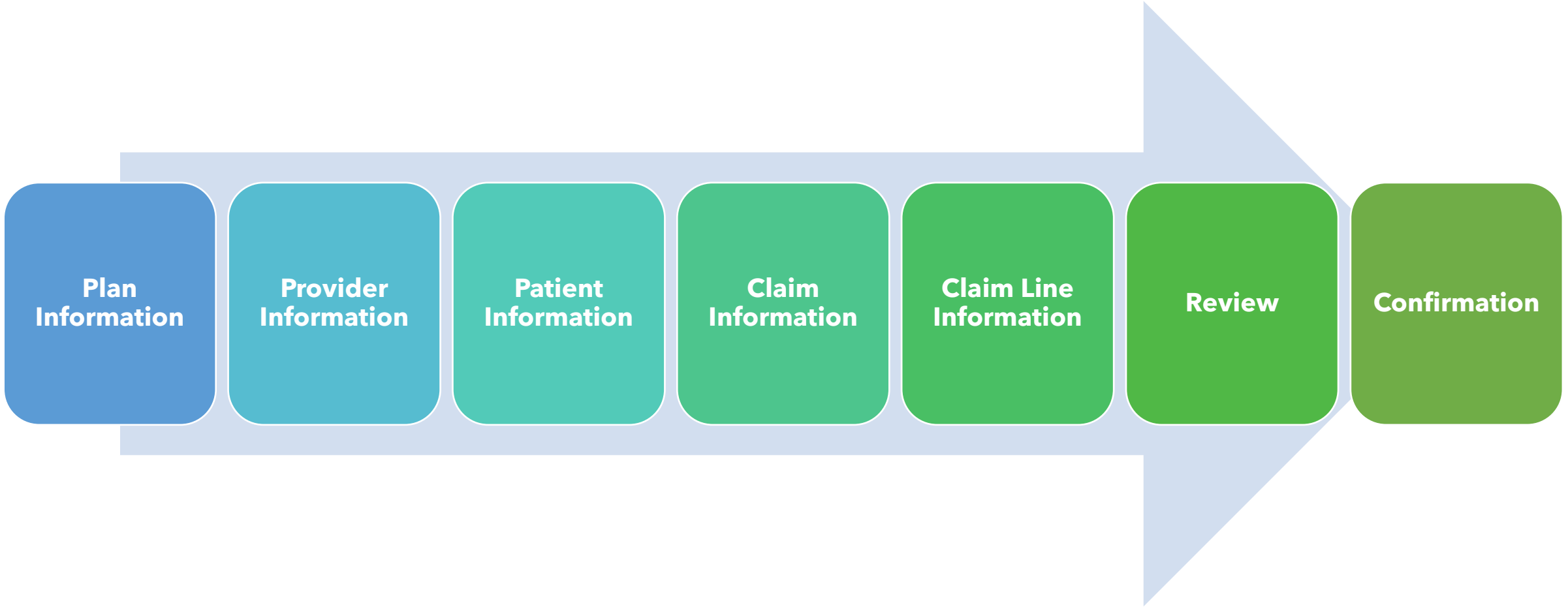
Your Complete Solution

2026 Annual Provider Summit

South Carolina

Submitting Claims Through My Insurance Manager

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

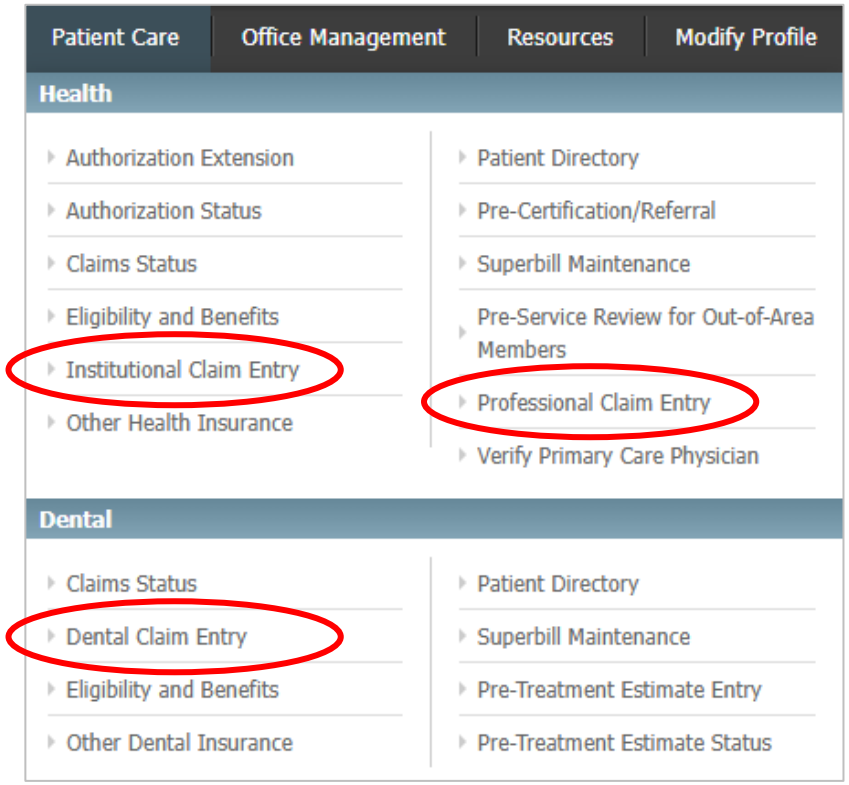


Note: The screens for institutional and dental claim entry may include an additional screen.

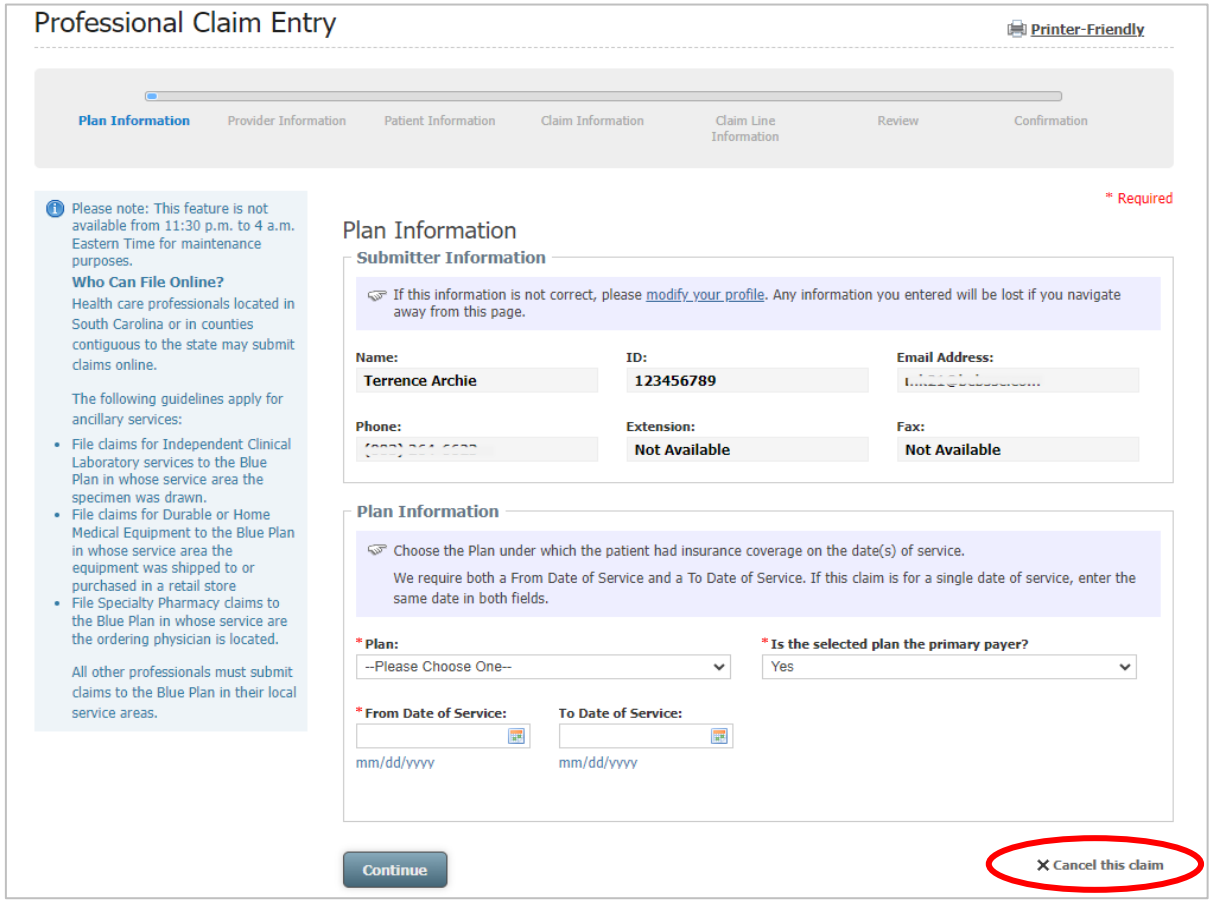
South Carolina

Steps to Submit Claims Through My Insurance Manager

Start Here



Step 1

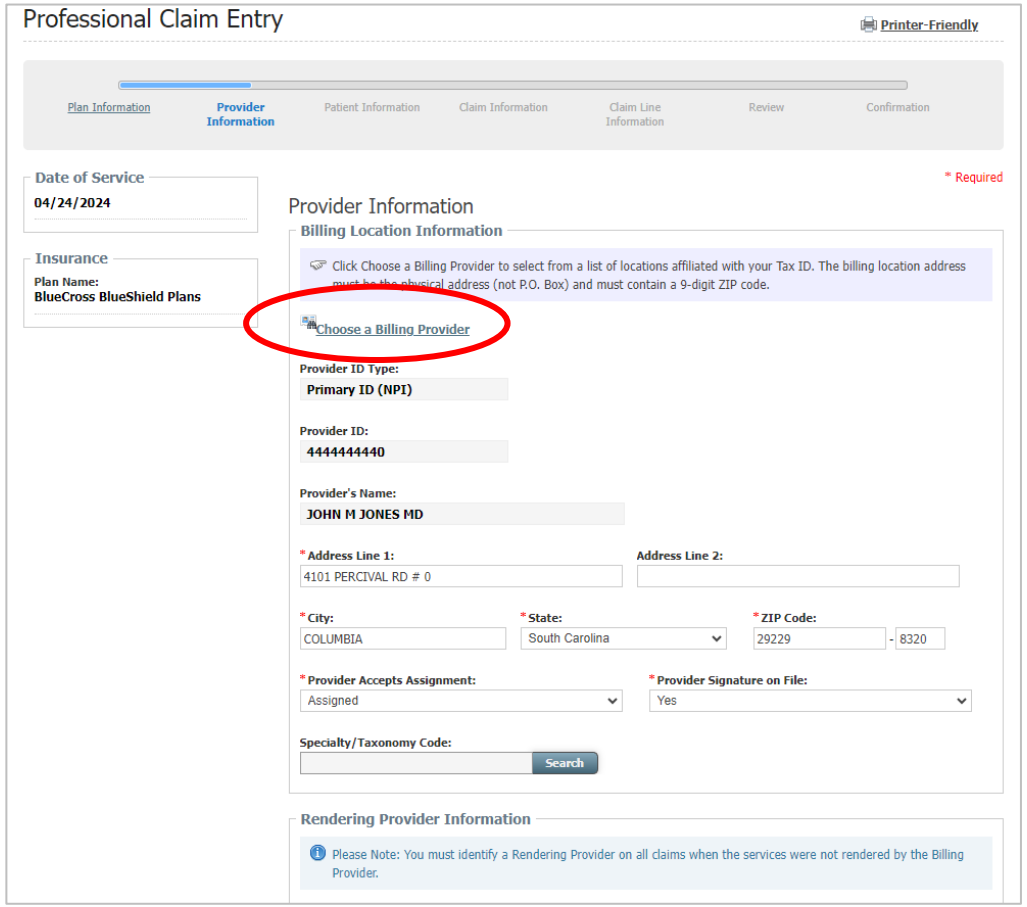


Note: At any time, you can select "Cancel this claim" to end the process.

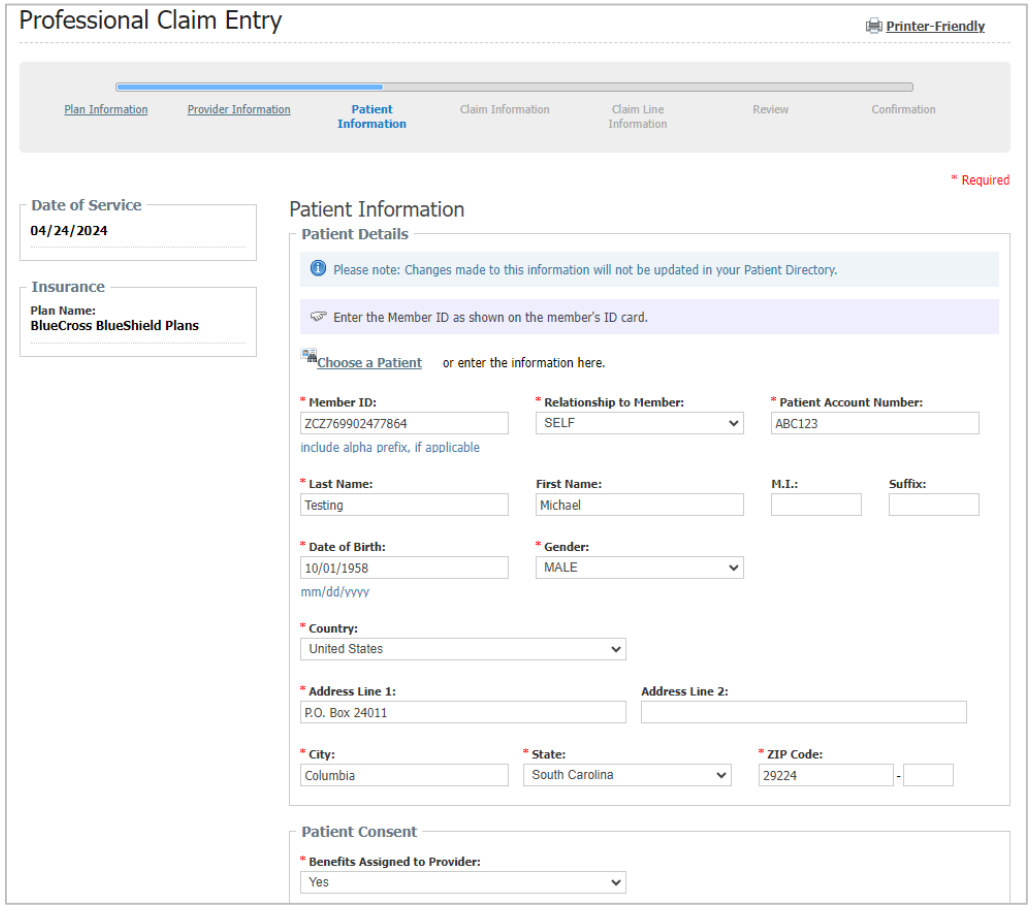
South Carolina

Steps to Submit Claims Through My Insurance Manager (Continued)

Step 2



Step 3

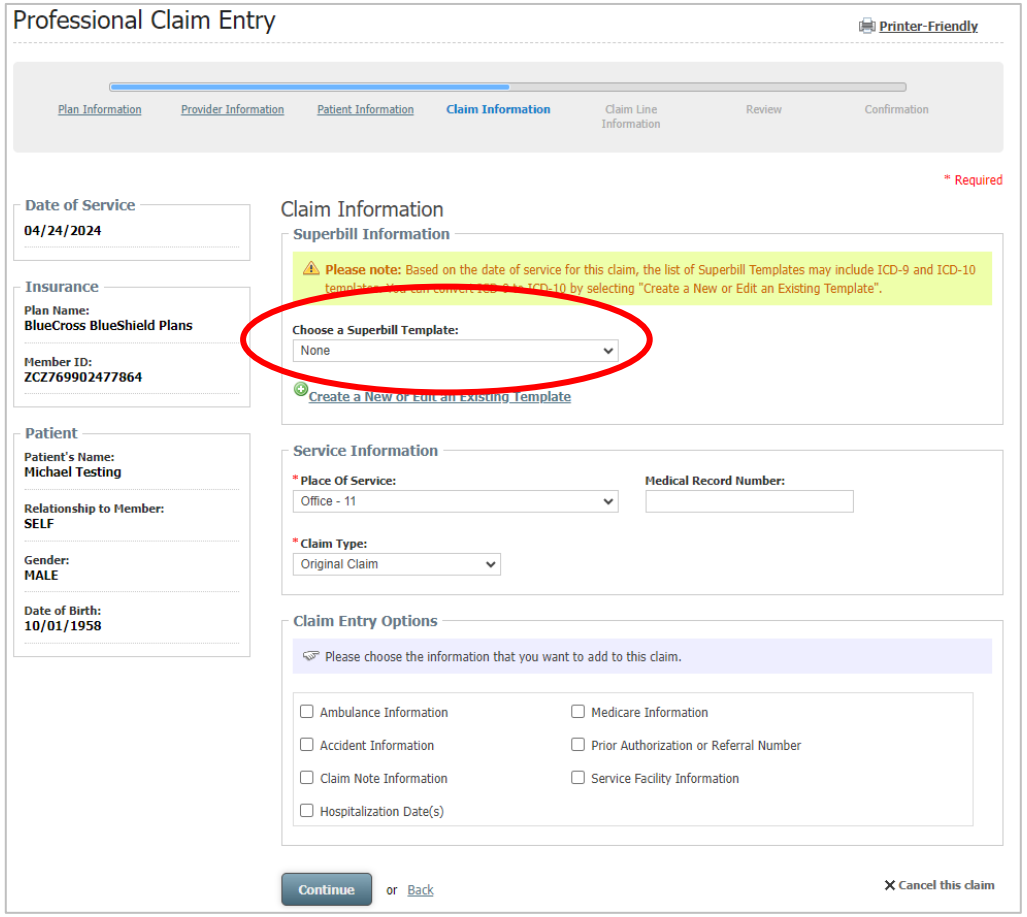


Note: You must select "Choose a Billing Provider" if more than one location is on file.

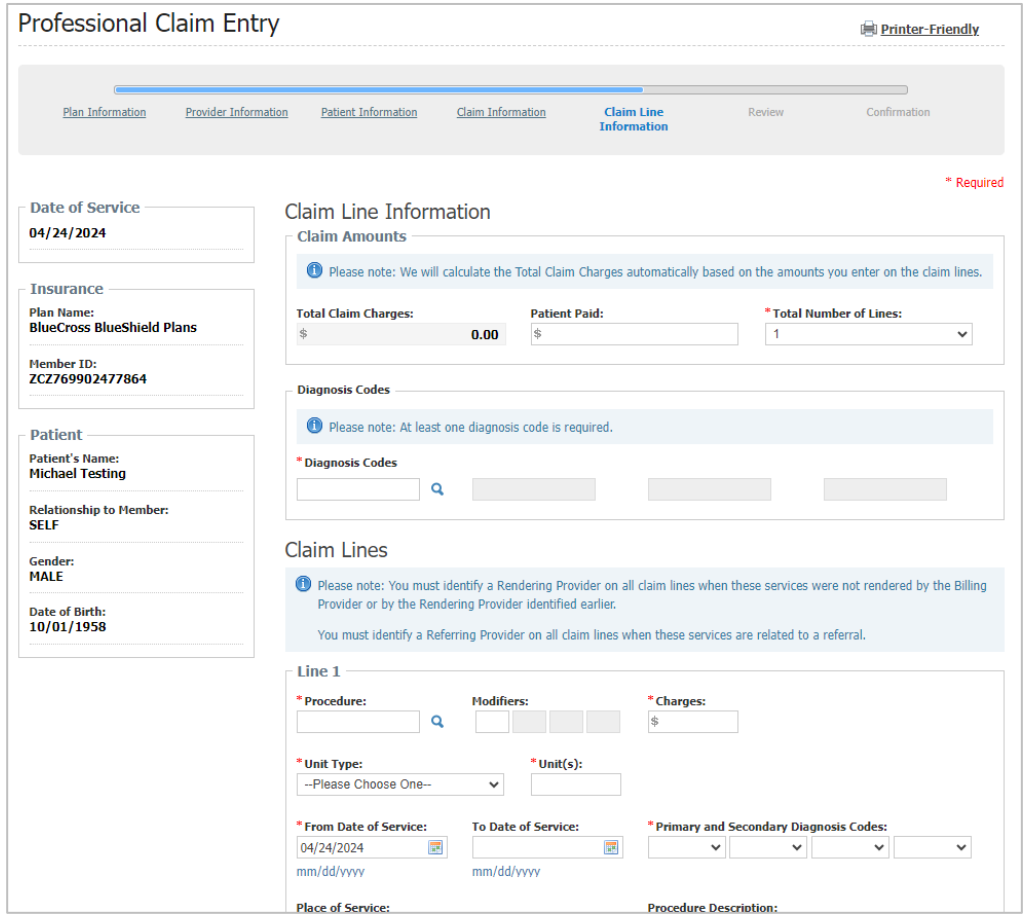
South Carolina

Steps to Submit Claims Through My Insurance Manager (Continued)

Step 4



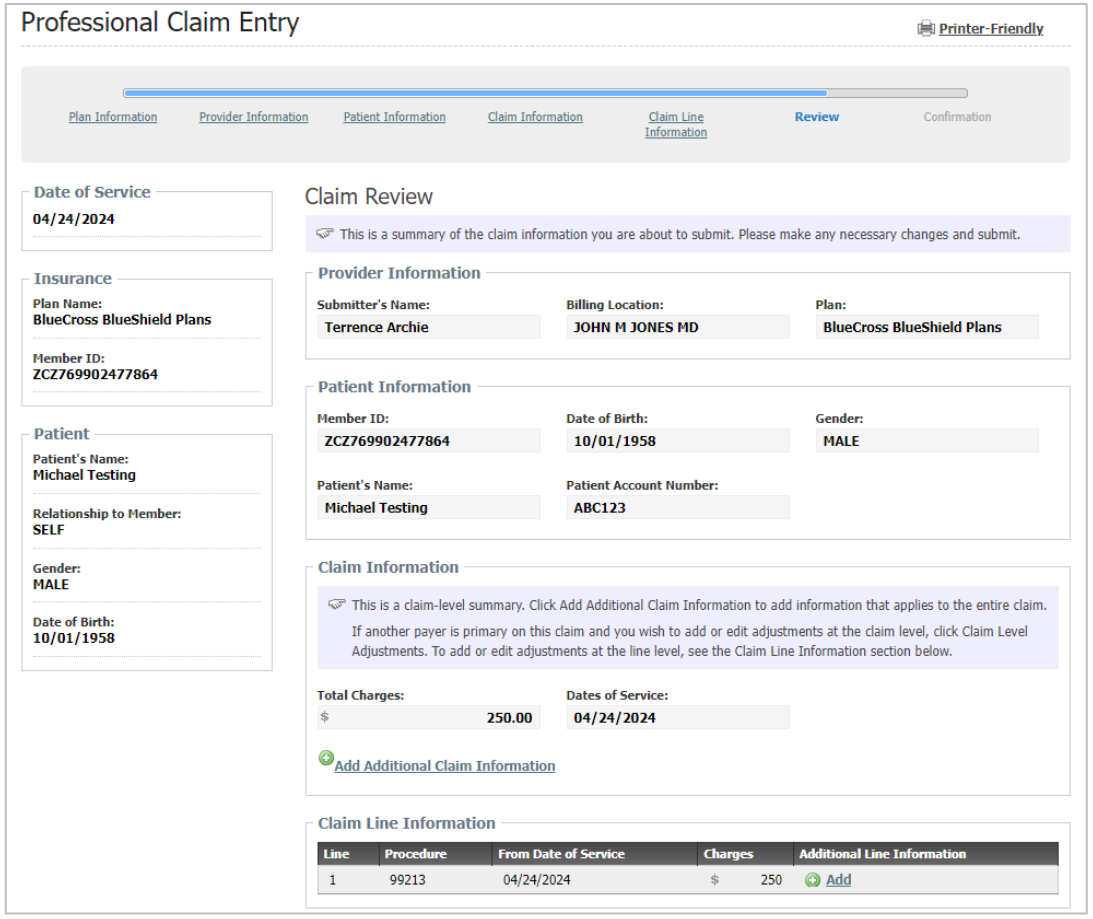
Step 5



South Carolina

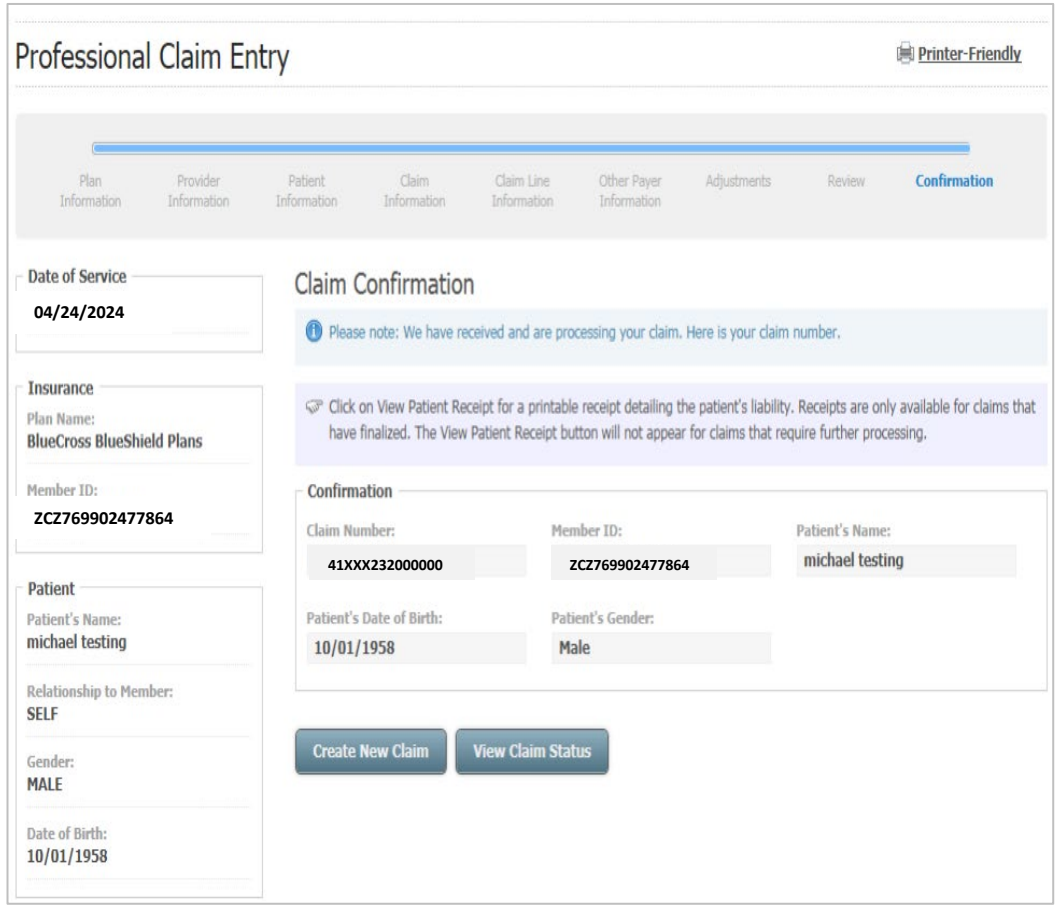
Steps to Submit Claims Through My Insurance Manager (Continued)

Step 6



Select Submit from this screen.

End Here



South Carolina

Claims Status

Your Complete Solution

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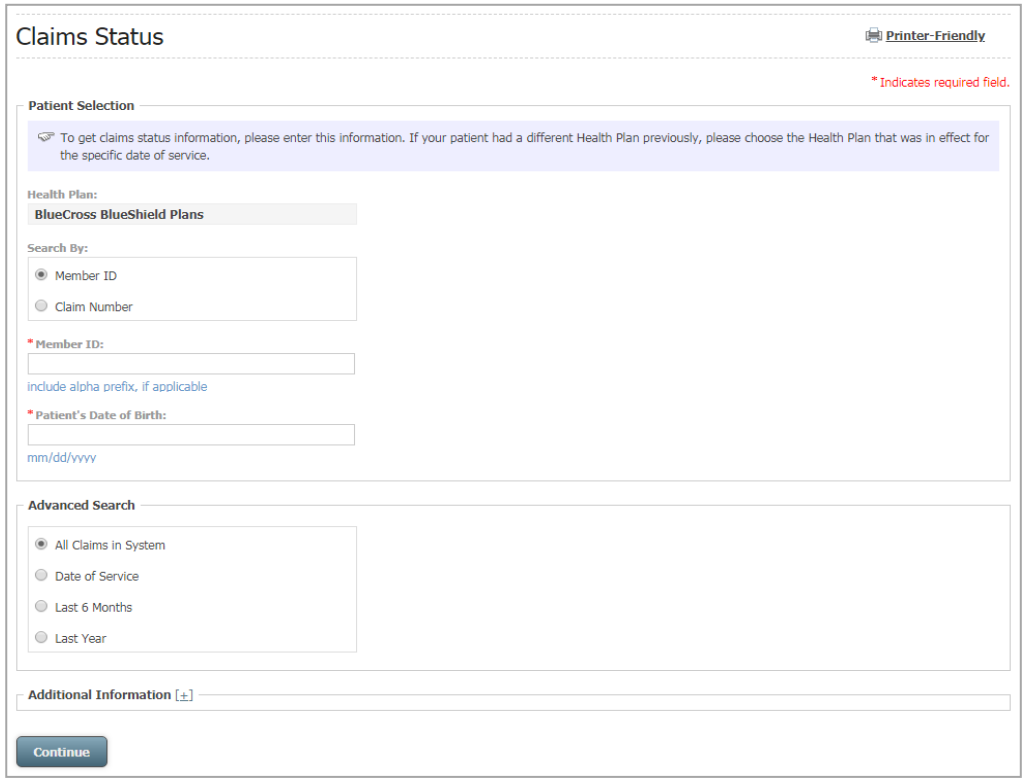
South Carolina

Checking the Status of a Claim

Start Here

Step 1

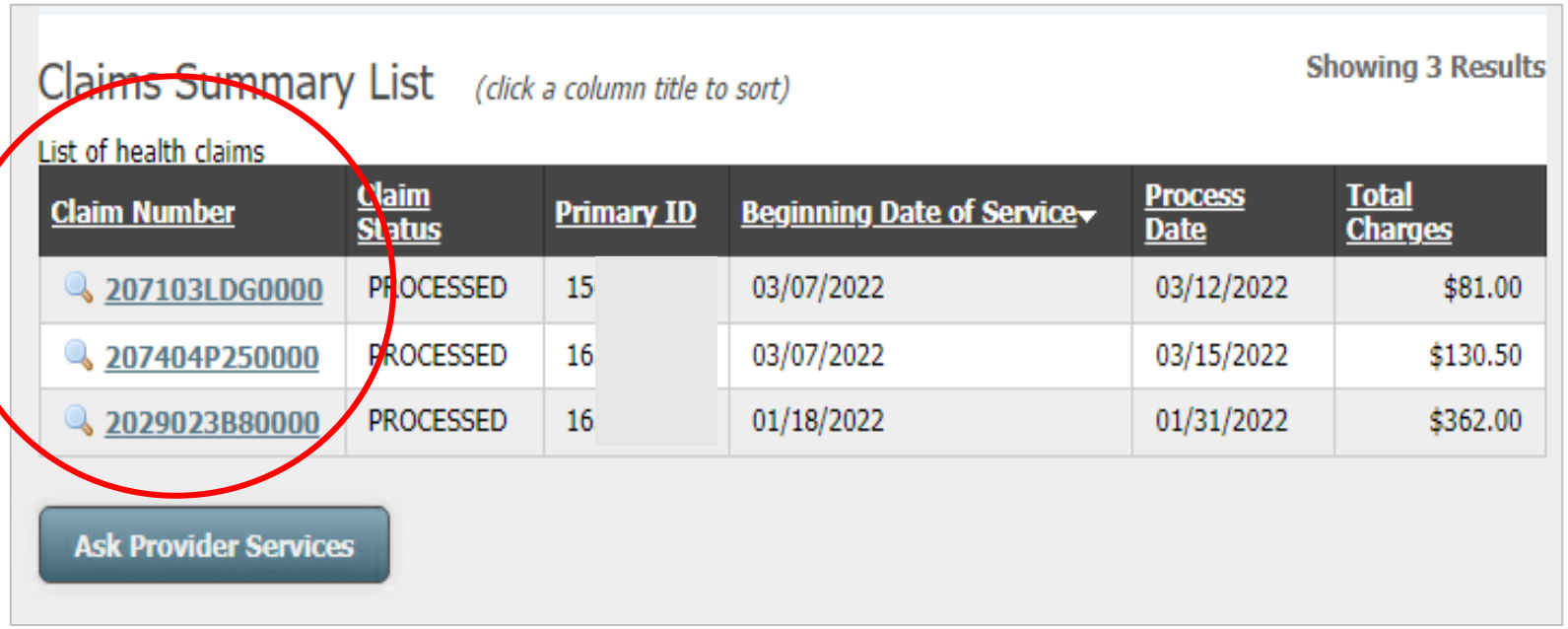


Note: Searching for claims using the member's identification number is the recommended option.

South Carolina

Checking the Status of a Claim (Continued)

Step 2



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

Showing 3 Results

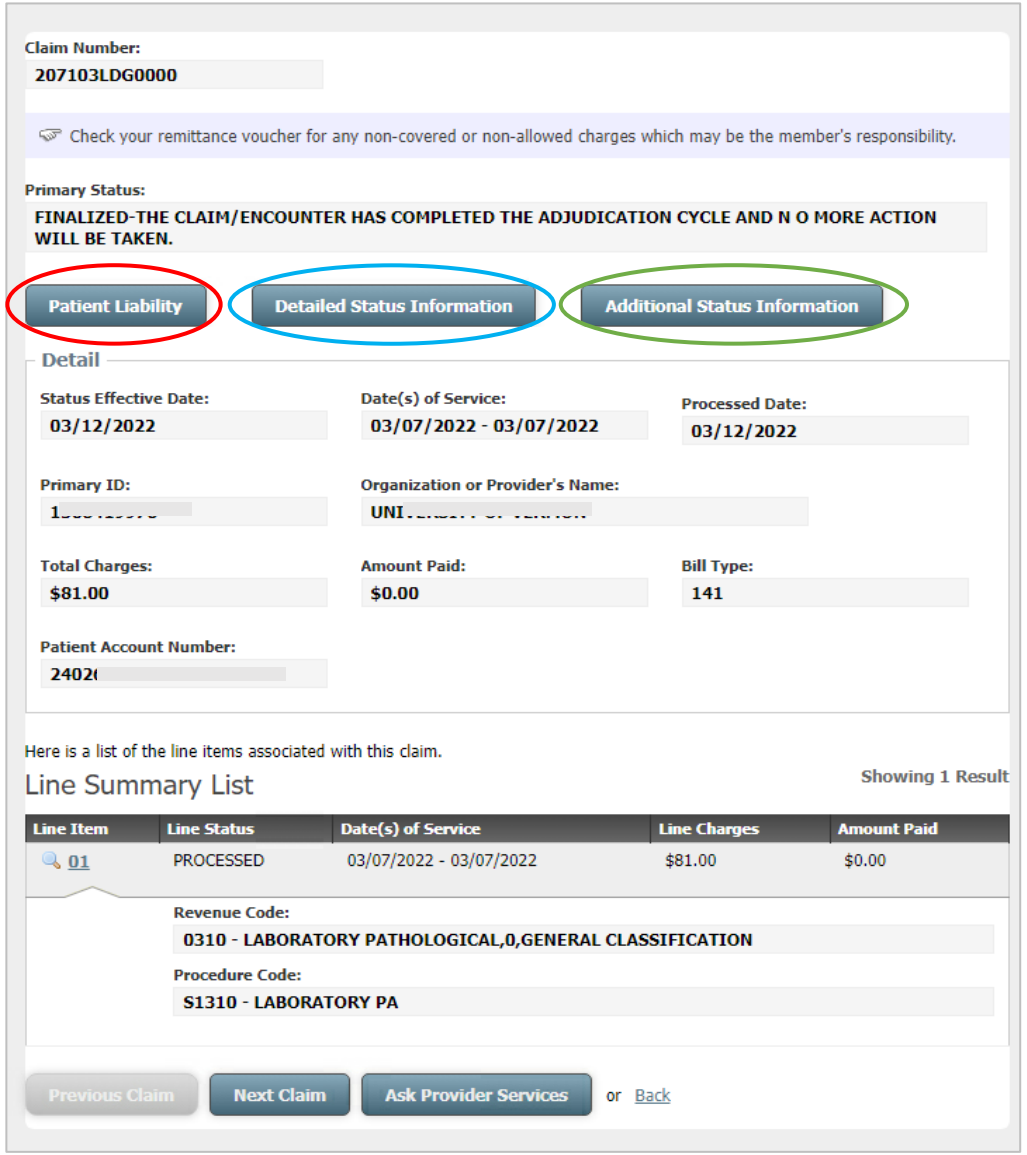
List of health claims

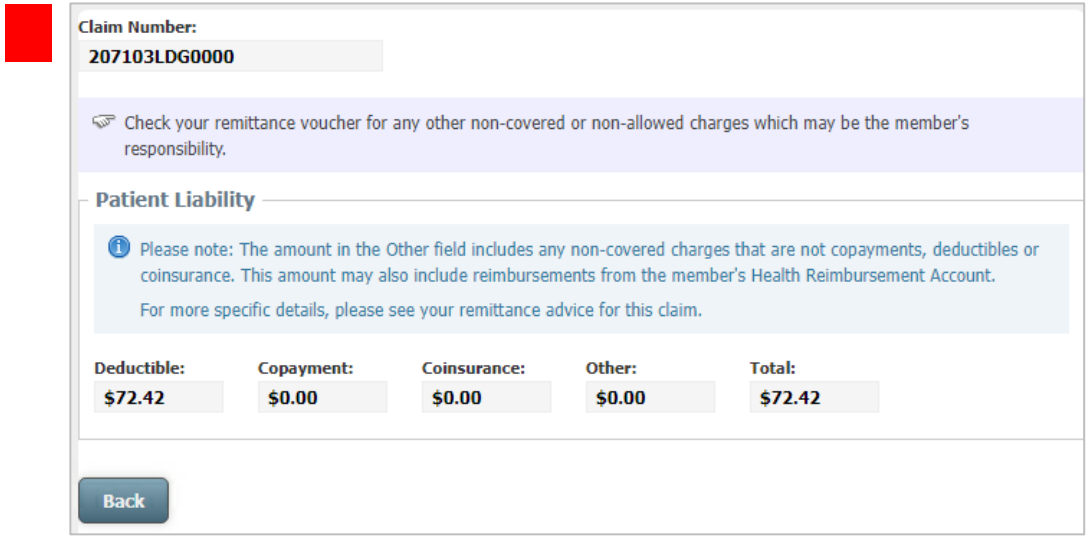
Claim Number	Claim Status	Primary ID	Beginning Date of Service	Process Date	Total Charges
207103LDG0000	PROCESSED	15	03/07/2022	03/12/2022	$81.00
207404P250000	PROCESSED	16	03/07/2022	03/15/2022	$130.50
2029023B80000	PROCESSED	16	01/18/2022	01/31/2022	$362.00

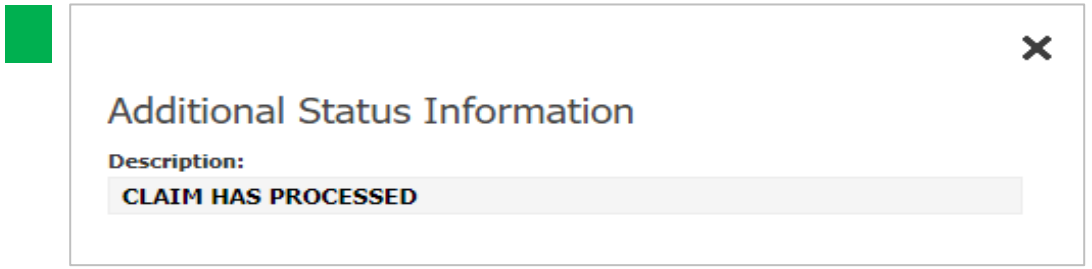
Ask Provider Services

South Carolina

Checking the Status of a Claim (Continued)







South Carolina

Ask Provider Services

Your Complete Solution

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Overview of Ask Provider Services

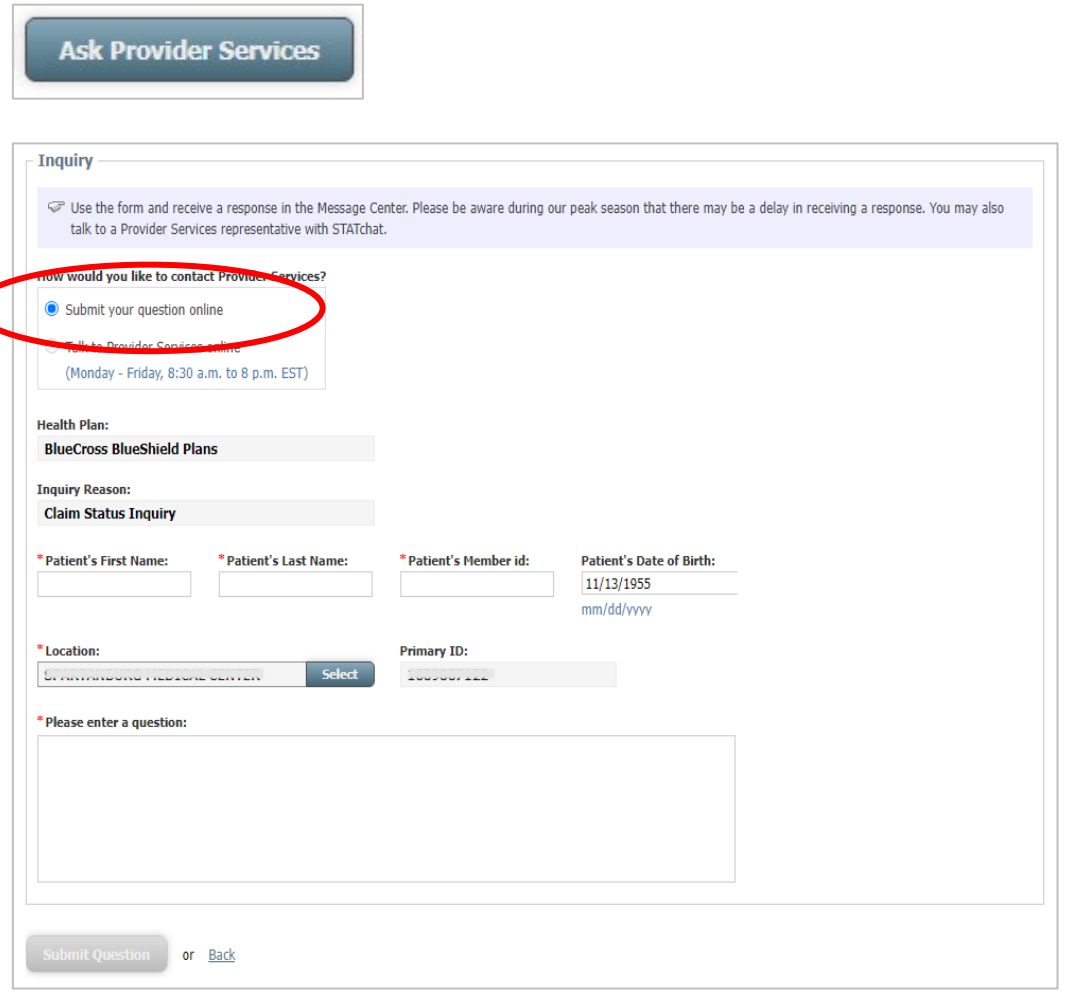
- Ask Provider Services is a feature in My Insurance Manager that lets you submit secured web inquiries for help with claims.
- This feature is intended to assist with ***complex issues*** and not general claim questions where the answers can be found in the portal or the VRU.

Examples of ***appropriate*** requests	Examples of ***inappropriate*** requests
Why was line one of the claim denied as noncovered?	What is the status of the claim?
Has the member returned the coordination of benefits questionnaire?	Has the claim been processed?
I need clarification regarding a recent recoupment made on the claim for date of service 01/30/2025.	Did you receive the medical records for this claim?
Claim denied for no authorization, but the authorization number is on file under 123456789.	Is there a claim on file for date of service 07/10/2025?

South Carolina

Submitting Web Inquiries

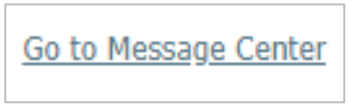
- From the claim screen, select ***Ask Provider Services***.
- Enter all the necessary information in the available fields.
- Be sure to ask clear, probing questions.
- Select Submit Question.

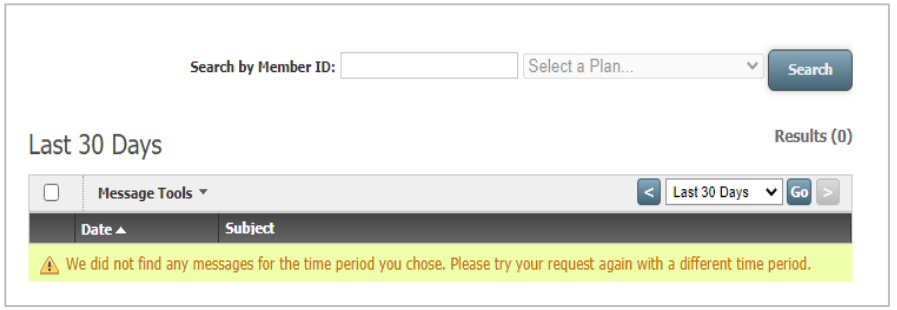


South Carolina

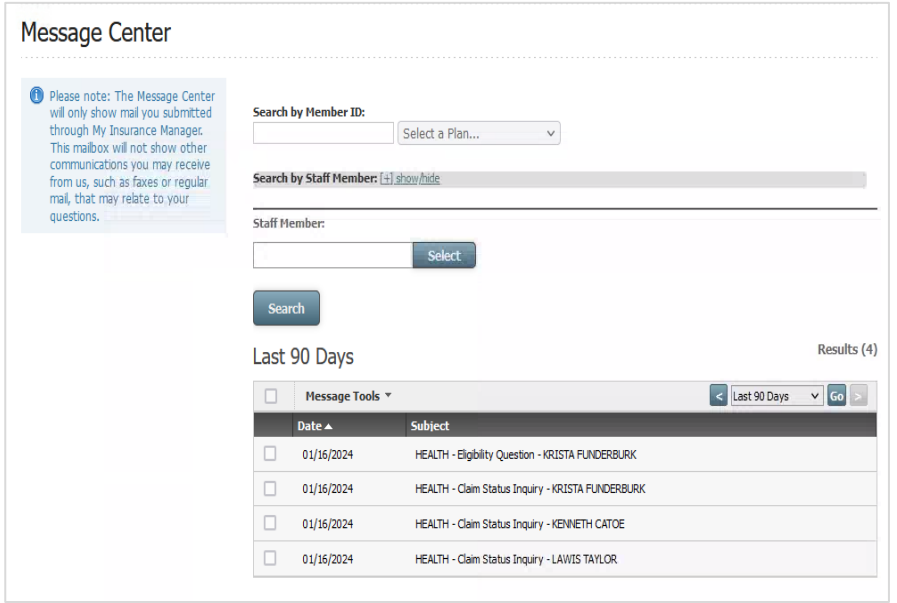
Viewing Web Inquiry Responses

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





Office Staff View



Administrator View

South Carolina

STATchat

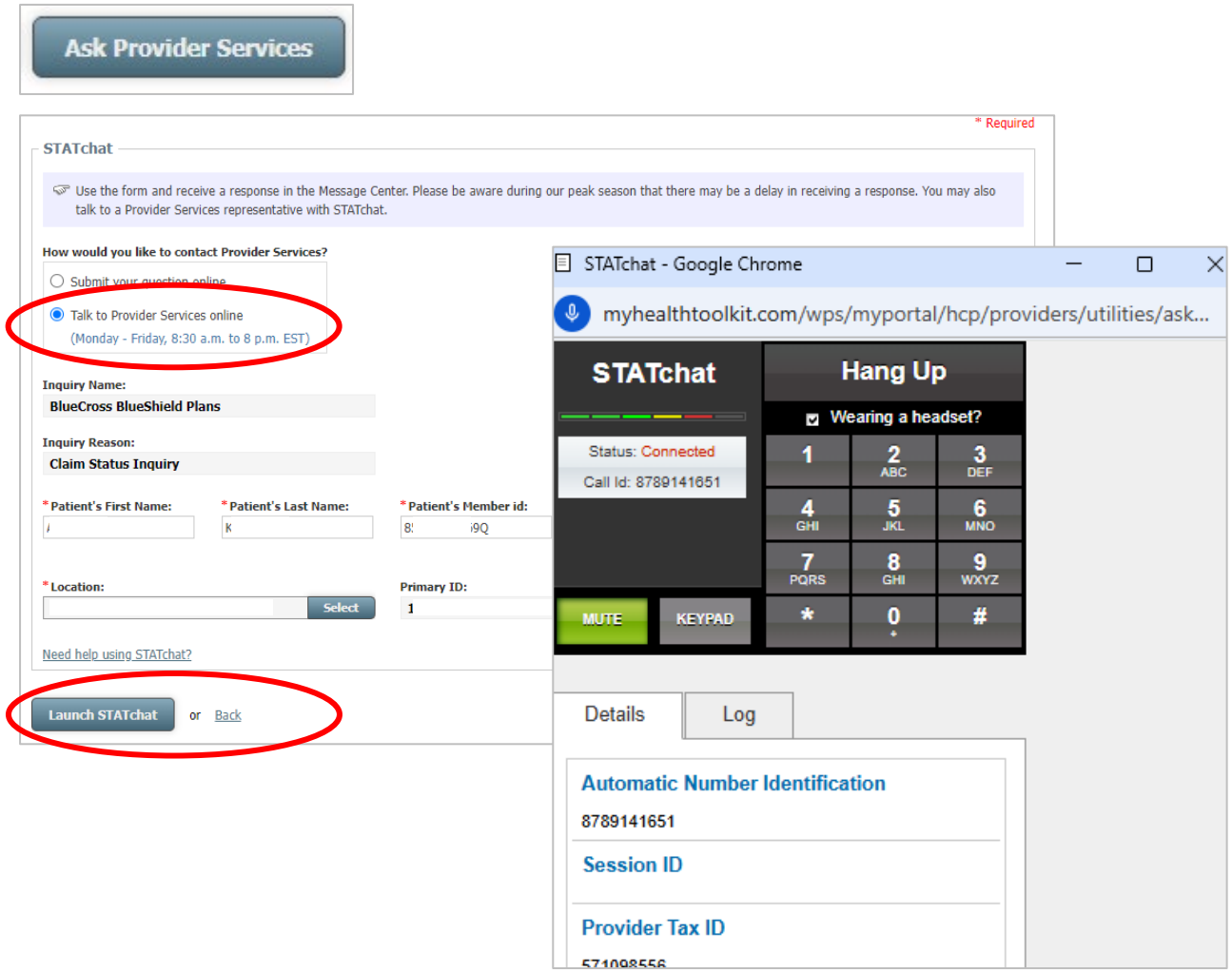
Your Complete Solution

2026 Annual Provider Summit

South Carolina

Overview of STATchat

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



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

South Carolina

My Remit Manager

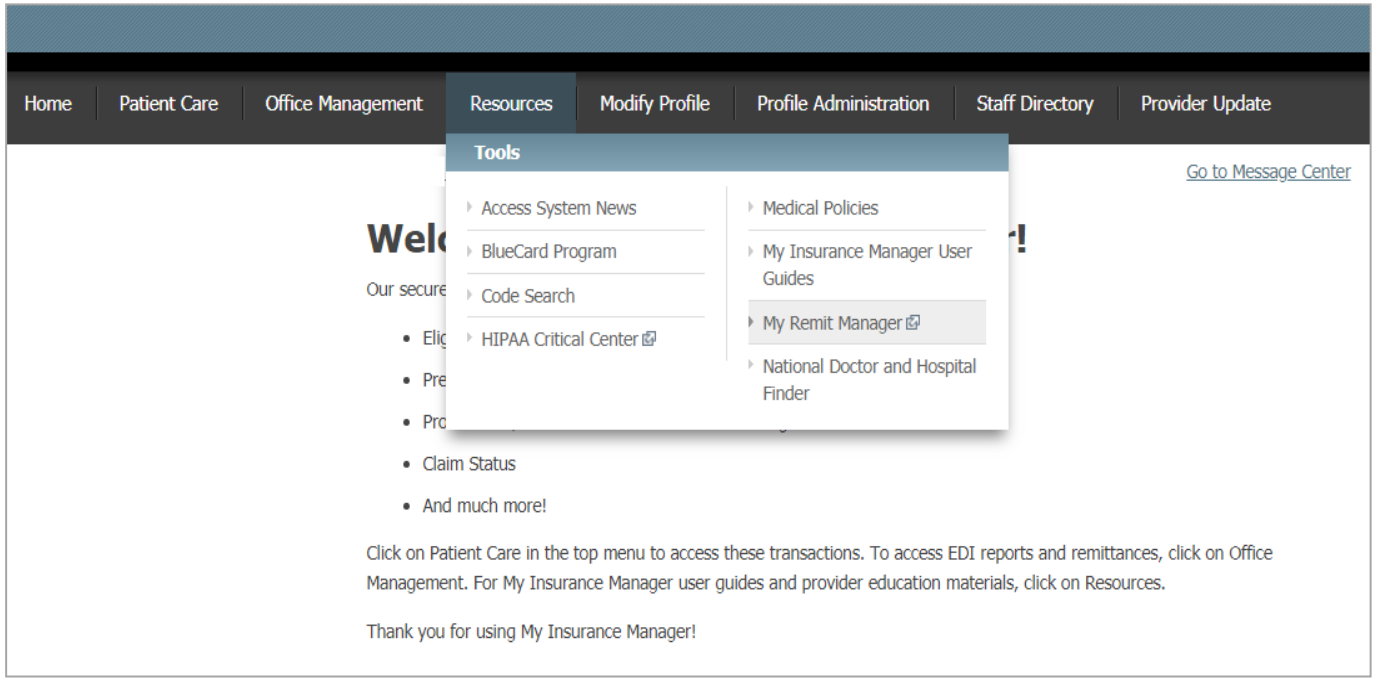
Your Complete Solution

2026 Annual Provider Summit

South Carolina

Accessing My Remit Manager

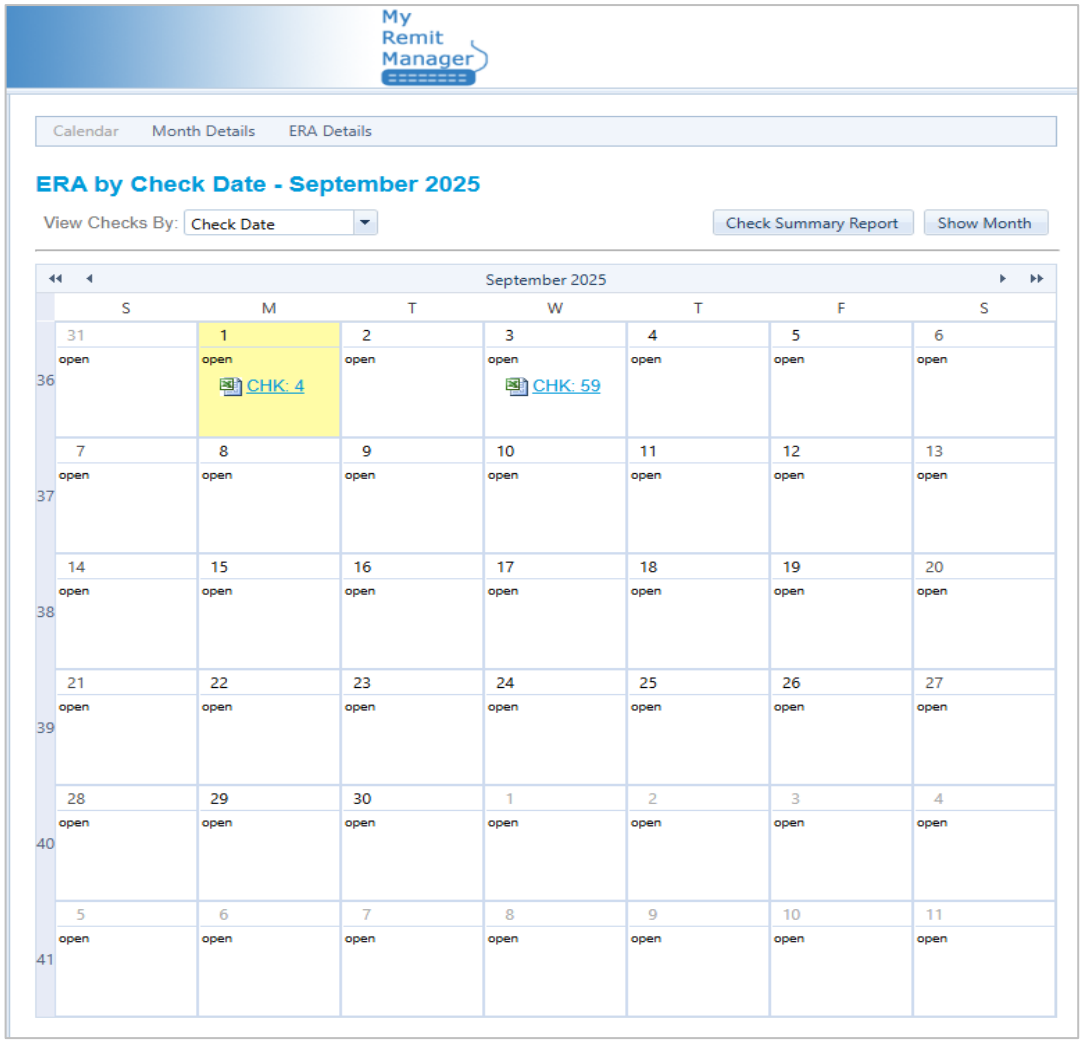
- While in My Insurance Manager, hover over Resources and select My Remit Manager.



South Carolina

Available Remittances – Calendar View

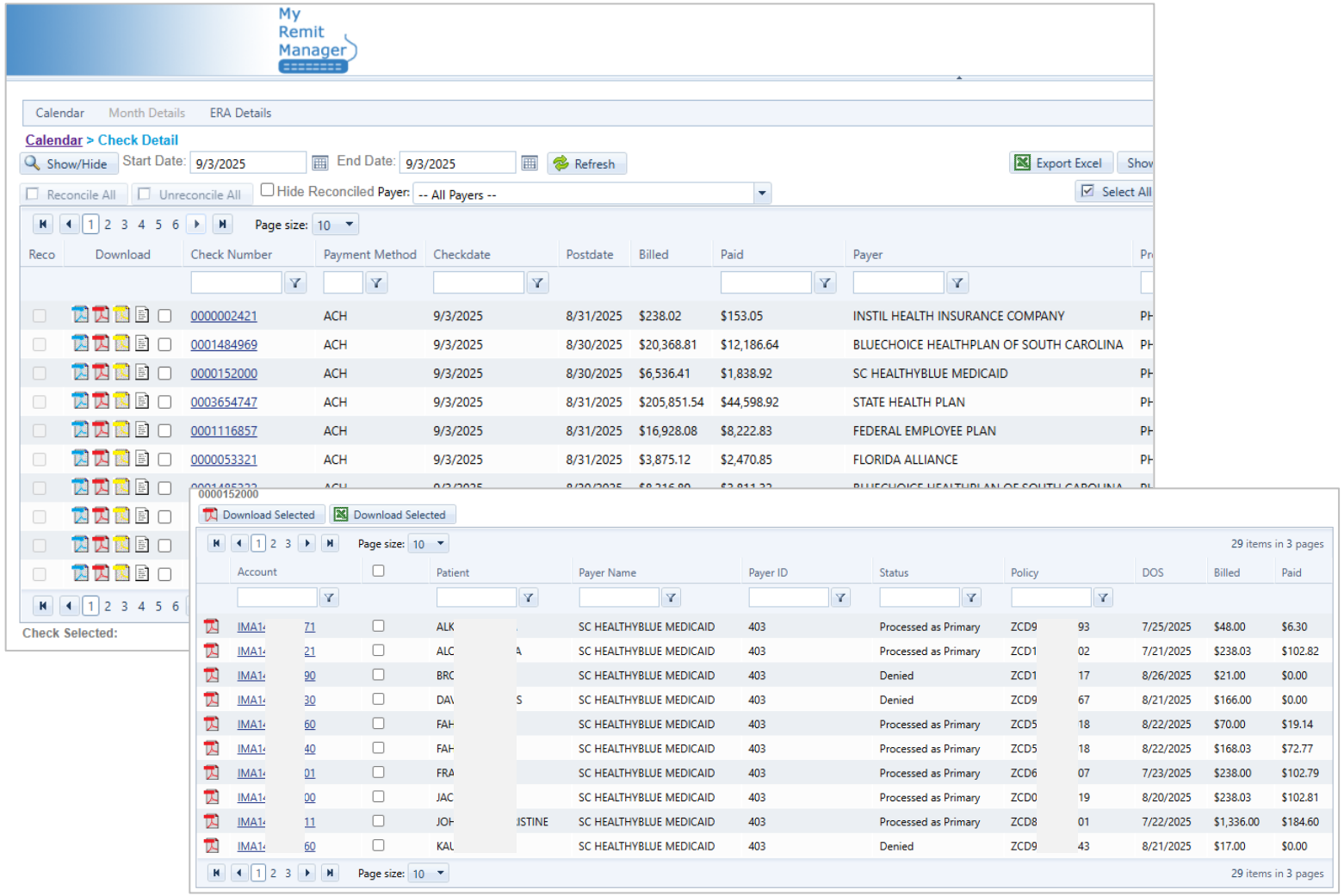
- If remittances are available, there will be check links on the calendar.
- Providers can view previous months by selecting the appropriate arrows on the calendar.



South Carolina

Viewing Available Remittances

- Providers can view remittances based on the check number, payment amount, or payer.
- If they select a specific check number, the applicable remittances will populate.
- Select the Adobe icon next to the appropriate patient for the remittance to display.



South Carolina

Example of Remittance

ERA Patient Listing

Electronic Reproduction ASC 005010X221A1

PH UNI AL GRP

A 74

AL FA **CHECK/EFT: 00 000** **CHECK DATE: 09/03/2025**
SC HEALTHYBLUE MEDICAID

Account: IMA1445923771 POS: 11 HIC: ZCD978 3 ICN: 5240097MD0000 Provider: 108 571004 8295641
Status: Processed as Primary

PreProv	ServDate	NOS	REV	Proc/Mods	Billed	Allowed	Deduct	Coins	RC-Amt	Paid	CAS Summary
571004971	07/25/2025	1		HC:36415	17.00				17.00	0.00	CO 45 17.00 HE N174
571004971	07/25/2025	1		HC:85025:QW	31.00	6.30			24.70	6.30	CO 45 24.70 HE N45
REMITTANCE SUMMARY					48.00	6.30	.00	.00	41.70	6.30	

TOTALS

Denied/Non-Covered: 0.00

CO	45	41.70	[Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).]
HE	N45		[Payment based on authorized amount.]
HE	N174		[This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group "PR".]

* Denotes Denied Or Non-covered Charges

REMITTANCE SUMMARY

	Billed	Allowed	Deduct	Coins	RC-Amt	PLB Adj	Paid
Totals	48.00	6.30	.00	.00	41.70	.00	6.30

South Carolina

Cohere Health

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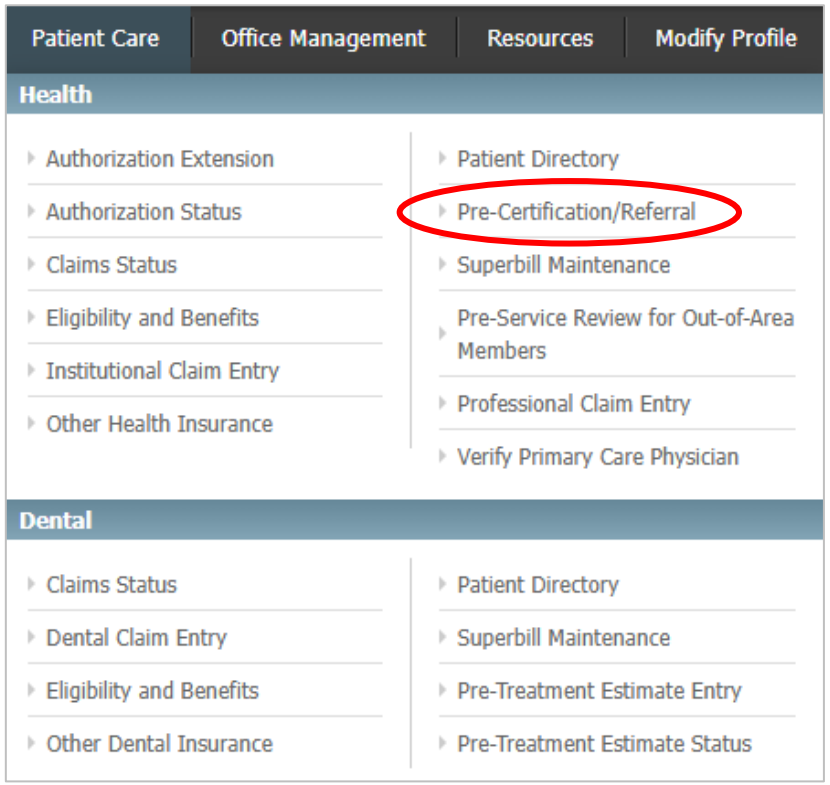
How to Get an Authorization

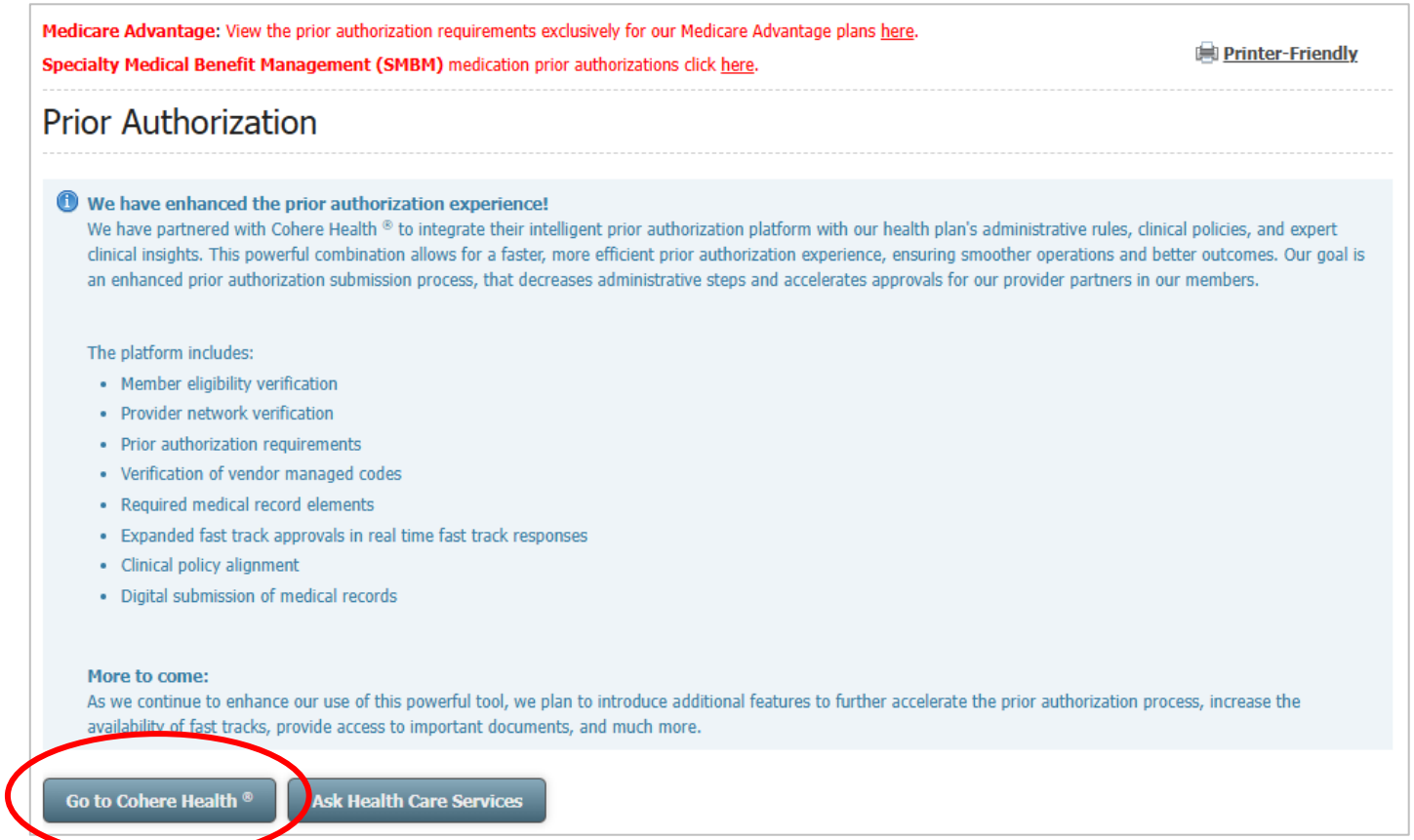
- There is a single sign-on through My Insurance Manager.
- Under ***Patient Care***, select ***Pre-certification/Referral***.



South Carolina

Proceed to the Cohere Health

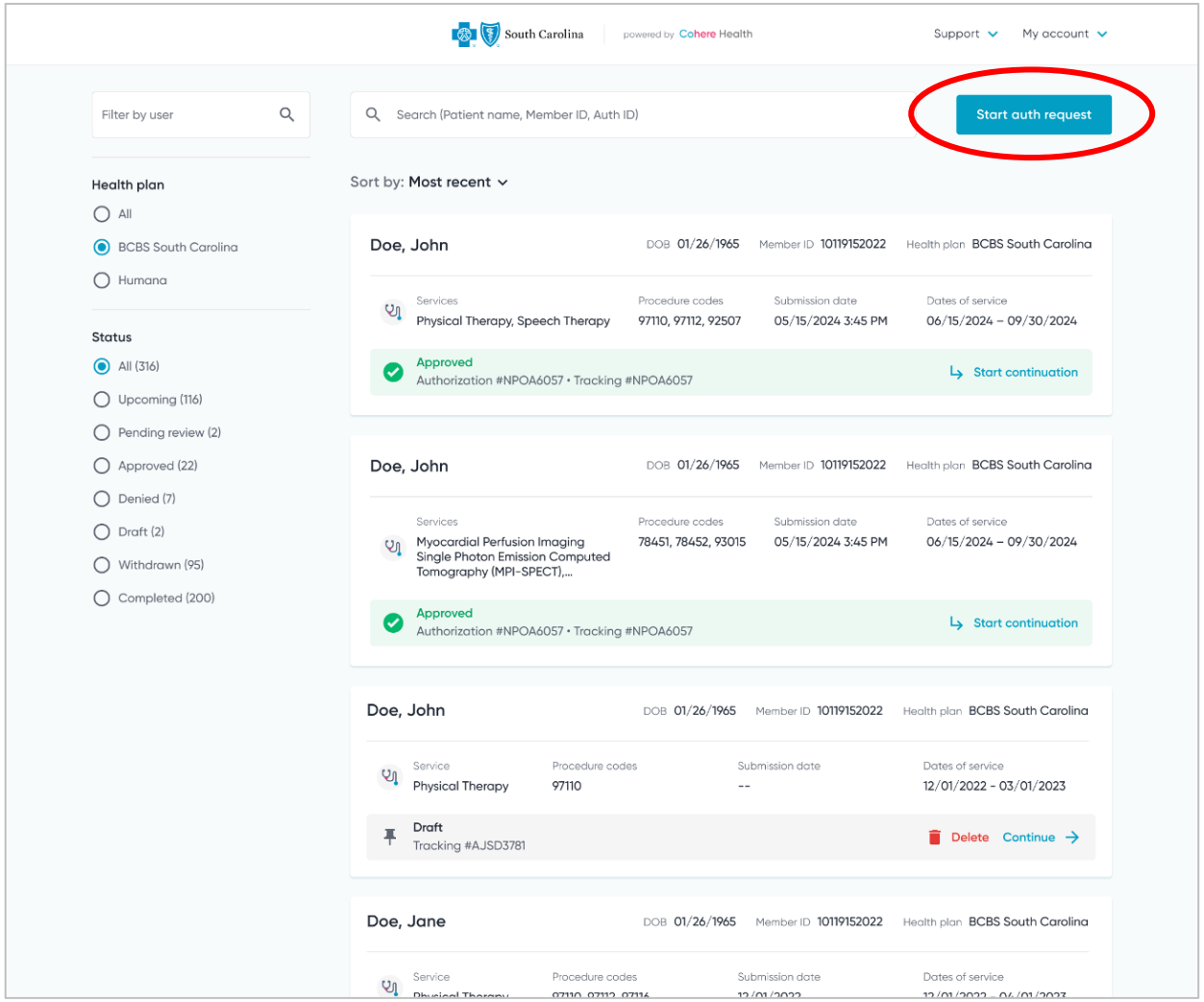
- You will be prompted to go to the Cohere Health platform to submit the prior authorization request.
- Medicare Advantage will begin going through the Cohere Health platform **Dec. 19, 2025**.



South Carolina

Cohere Health Landing Page

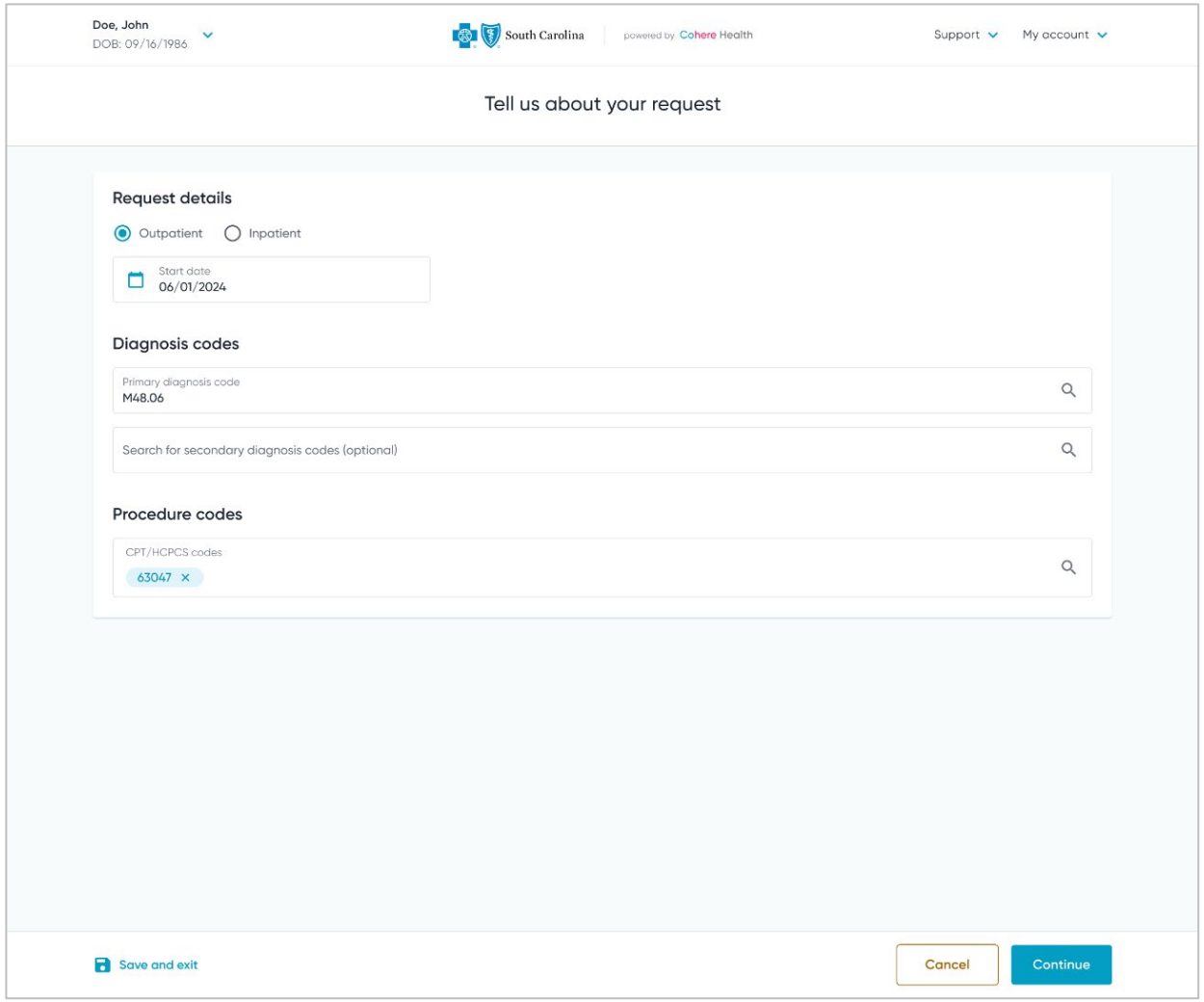
- When you reach the landing page of the new platform, you will see a full listing of authorizations under your tax identification number (TIN).
- The authorizations can be filtered by:
  - All
  - Upcoming
  - Pending review
  - Approved
  - Denied
  - Draft
  - Withdrawn
  - Completed
- You can also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



South Carolina

Cohere – Information About the Request

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

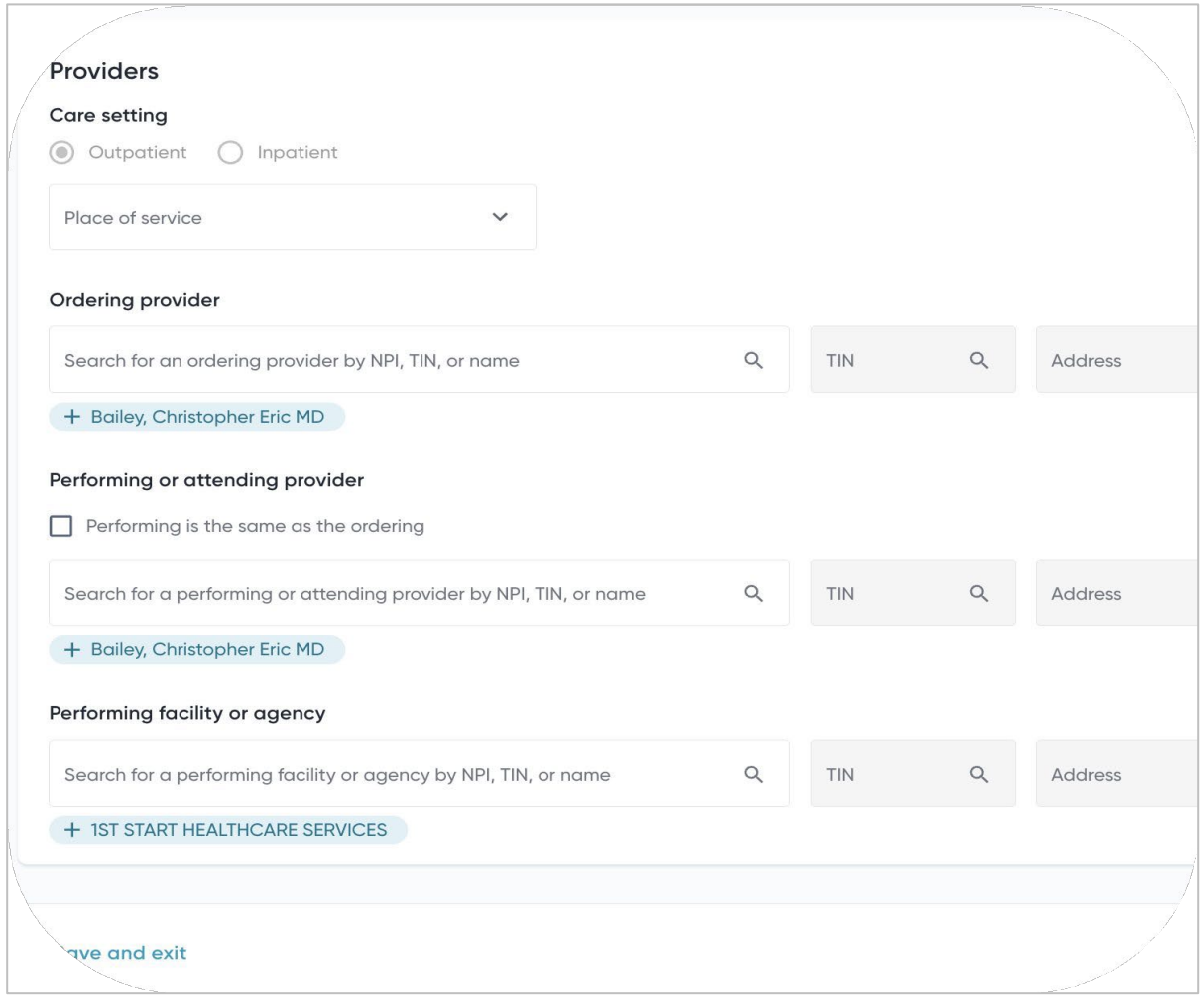


Note: You have the option to save and exit the request at any time. You can also cancel the request if it's no longer needed.

South Carolina

Cohere – Provider Details

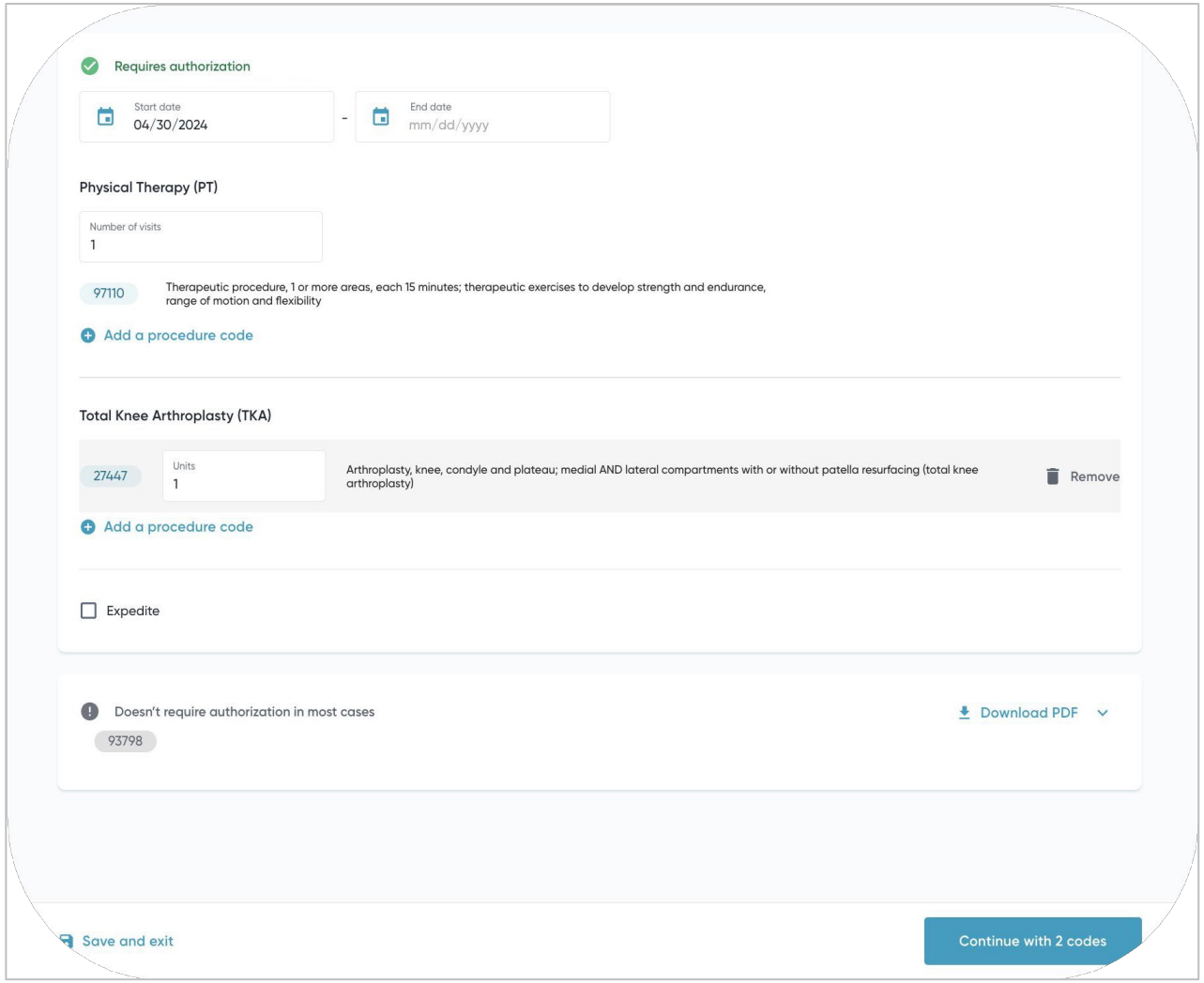
- Enter the provider details to include:
  - Ordering provider.
  - Performing or attending provider.
  - Performing facility or agency.
- There is a TIN search feature to make the process easier.
- Select ***Continue***.



South Carolina

Cohere – Determination of Authorization Requirements

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

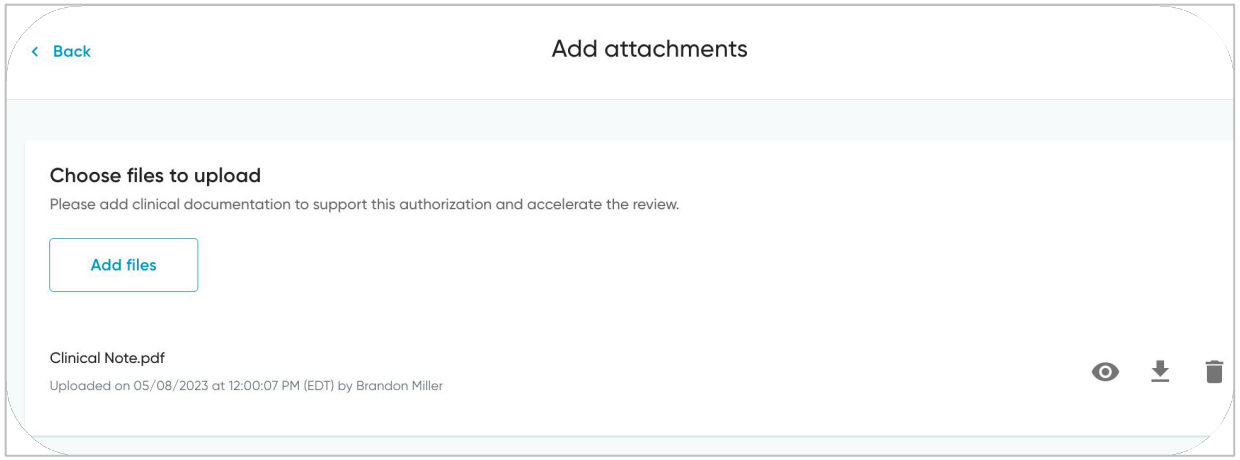


Note: The continue option will indicate the number of codes being requested for review.

South Carolina

Cohere – Clinical Documentation

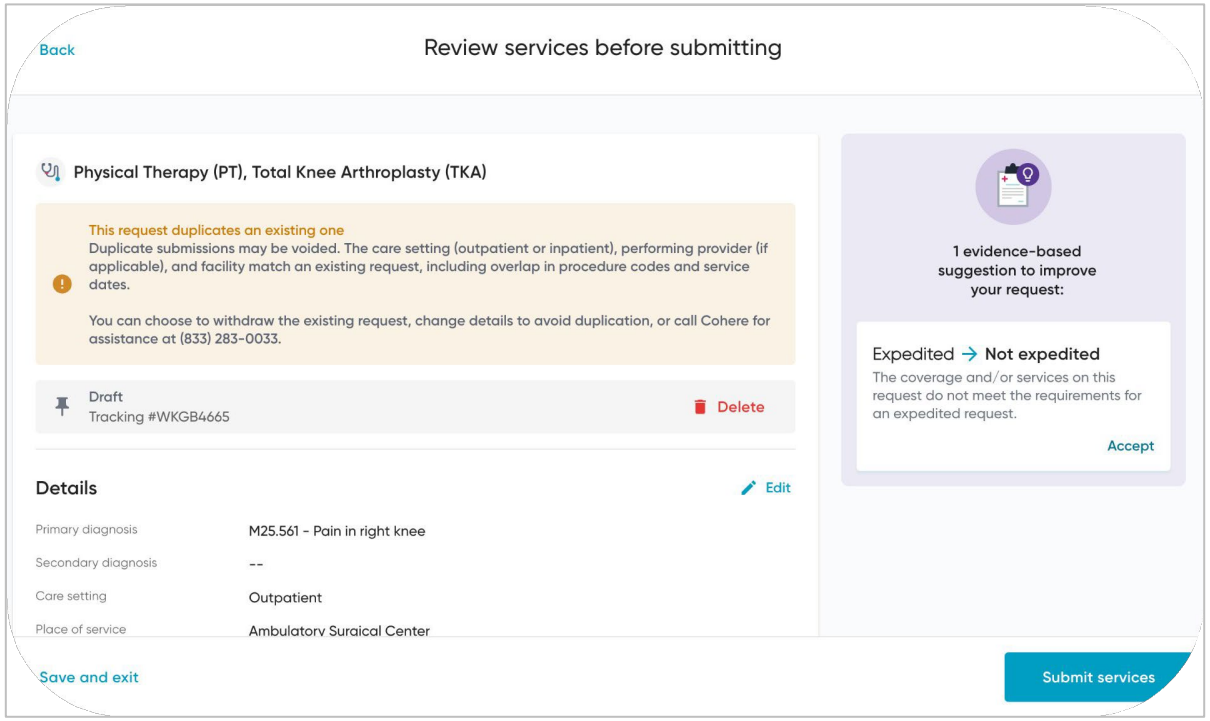
- Upload all relevant clinical documentation for review.
- You will have the option to review the uploaded items or remove them.
- Select ***Continue***.



South Carolina

Cohere – Submitting Request

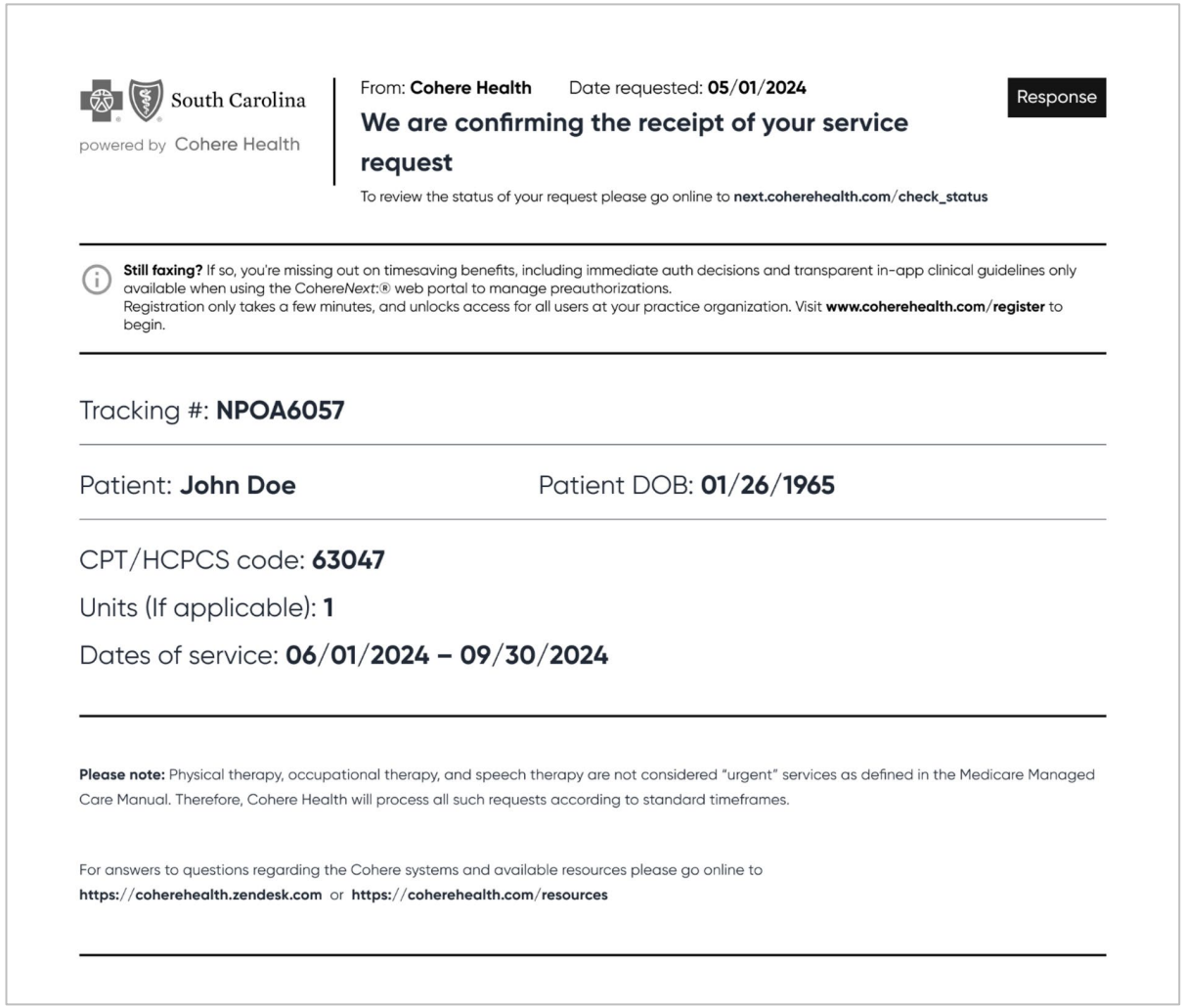
- ❑ Review all the relevant information.
- ❑ Select ***Submit services***.



South Carolina

Cohere – Confirmation

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



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

Response

We are confirming the receipt of your service request

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

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

Tracking #: **NPOA6057**

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

CPT/HCPCS code: **63047**

Units (If applicable): **1**

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

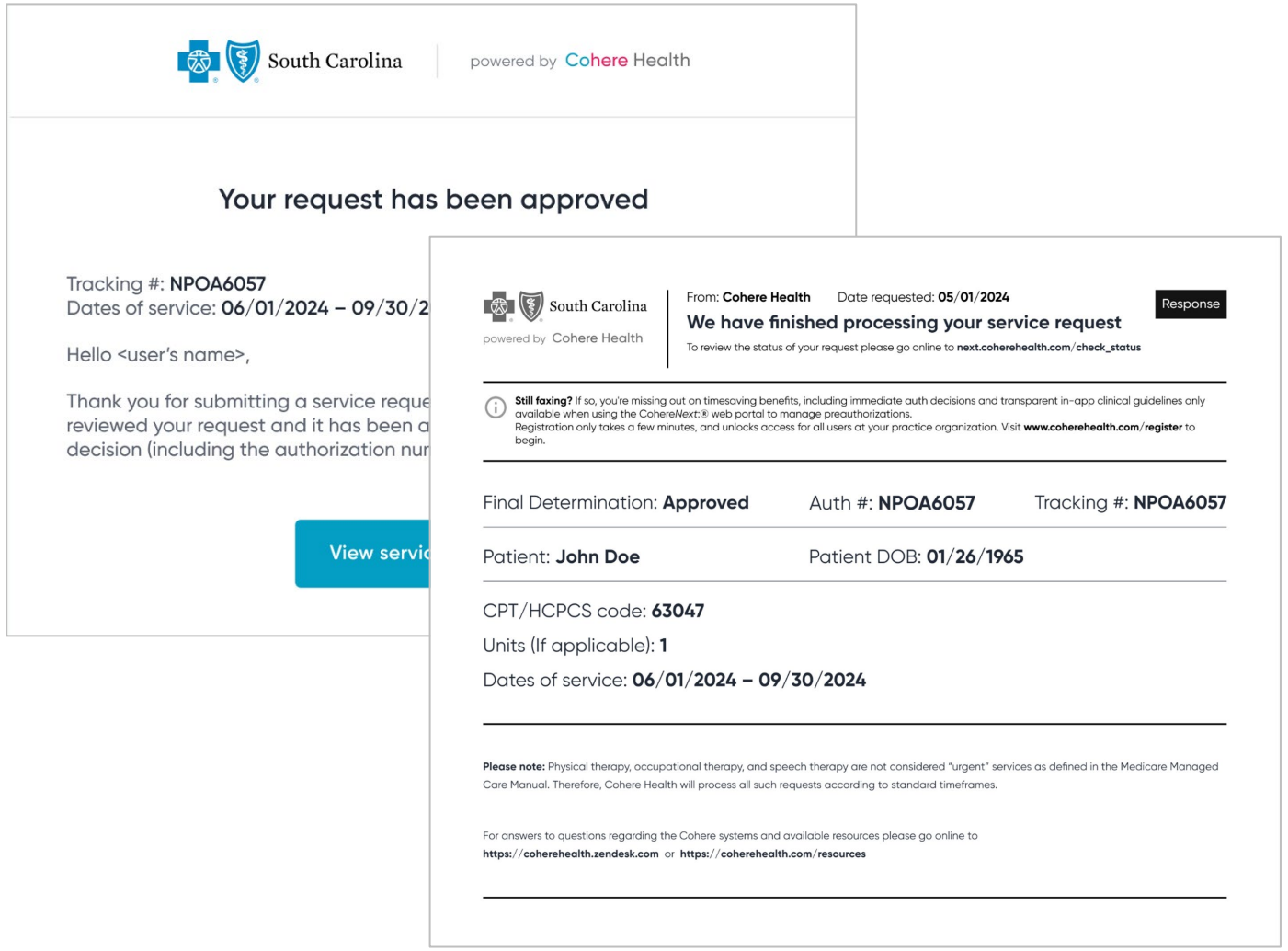
Please note: Physical therapy, occupational therapy, and speech therapy are not considered "urgent" services as defined in the Medicare Managed Care Manual. Therefore, Cohere Health will process all such requests according to standard timeframes.

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

South Carolina

Cohere – Notification

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

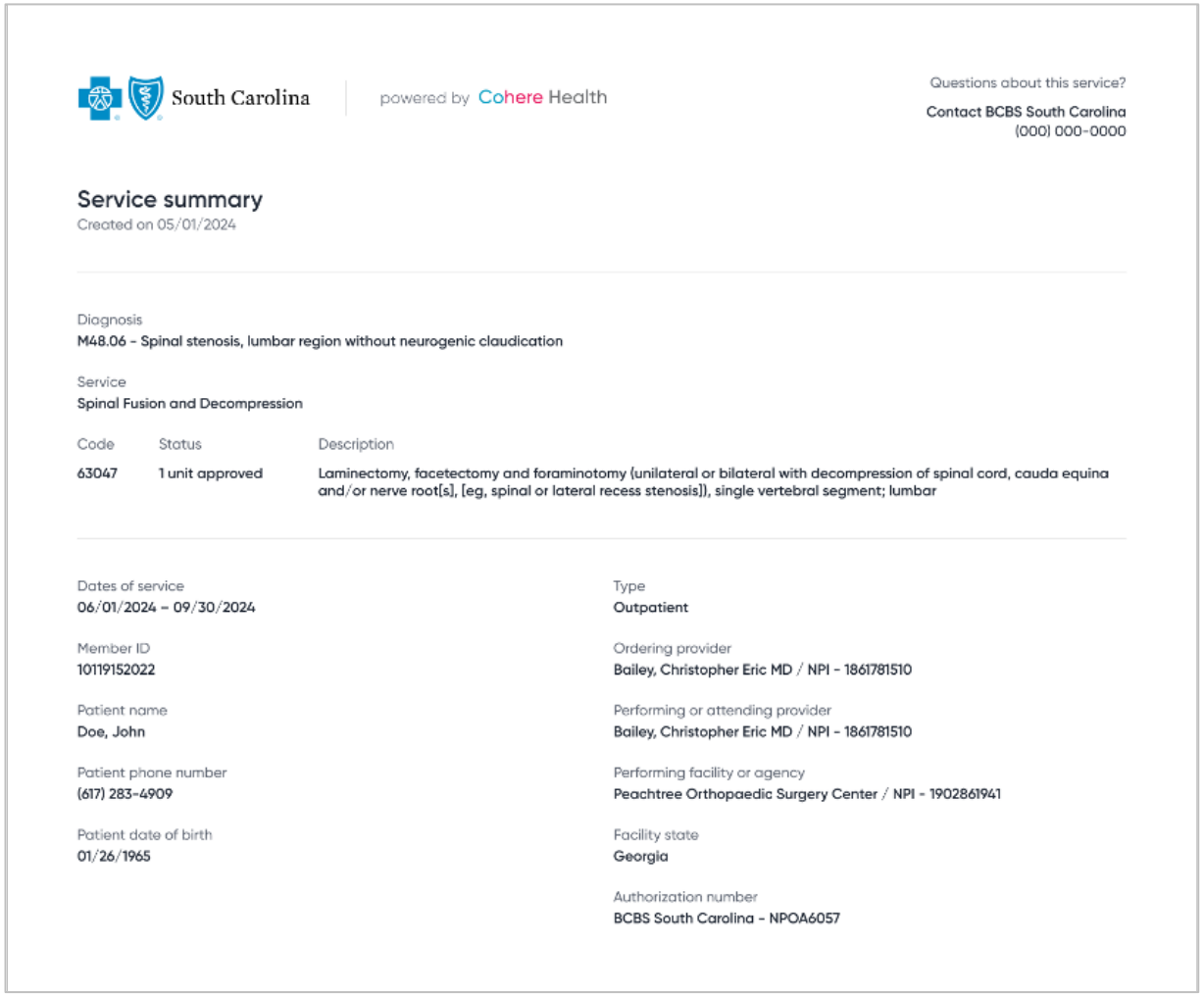


Note: You will also receive a notice if the request is denied.

South Carolina

Cohere – Service Summary

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



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

Service summary

Created on 05/01/2024

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

Service
Spinal Fusion and Decompression

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

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

Member ID
10119152022

Patient name
Doe, John

Patient phone number
(617) 283-4909

Patient date of birth
01/26/1965

Type
Outpatient

Ordering provider
Bailey, Christopher Eric MD / NPI - 1861781510

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

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

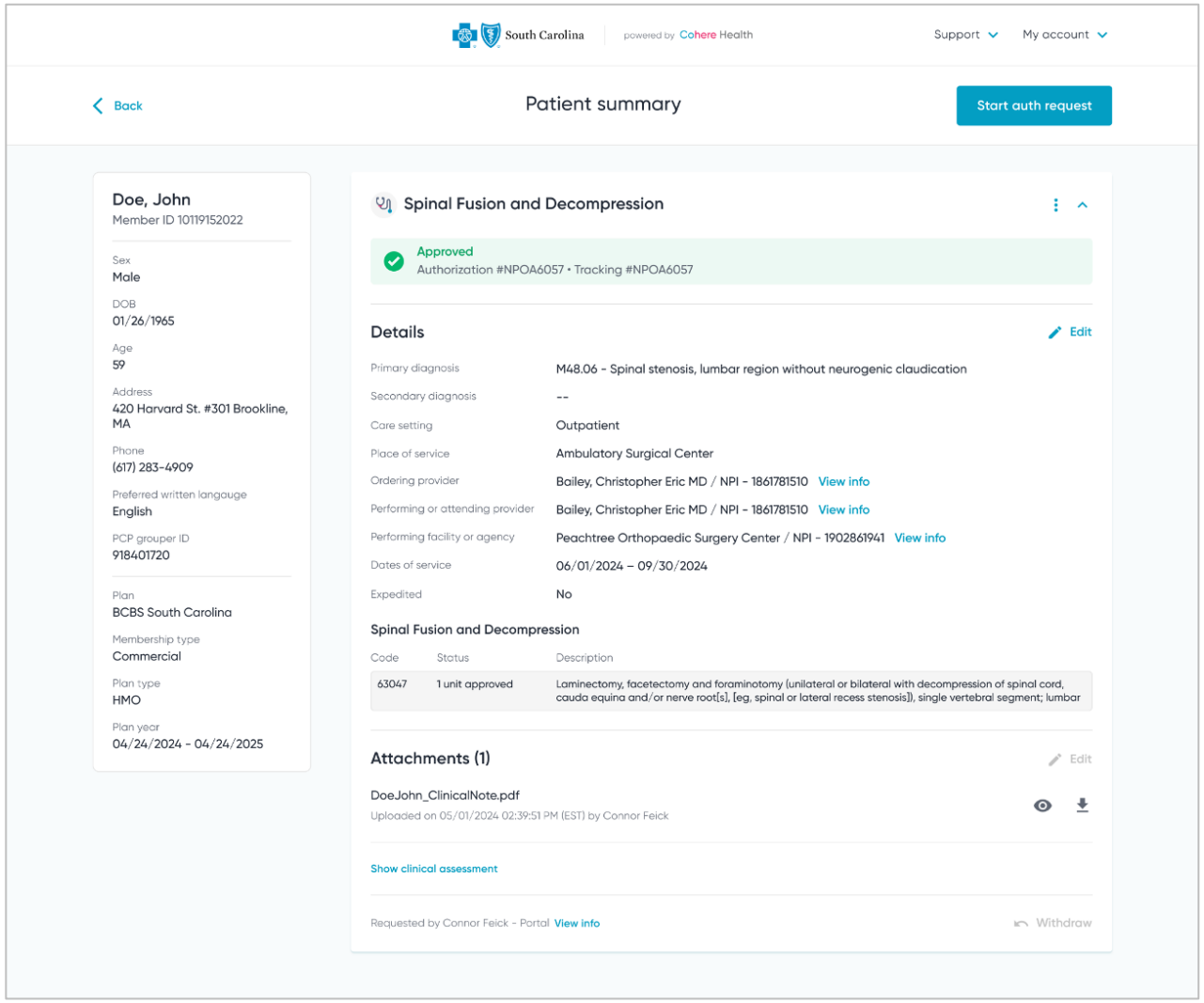
Facility state
Georgia

Authorization number
BCBS South Carolina - NPOA6057

South Carolina

Cohere – Patient Summary

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



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My Provider Enrollment Portal

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Overview of Portal

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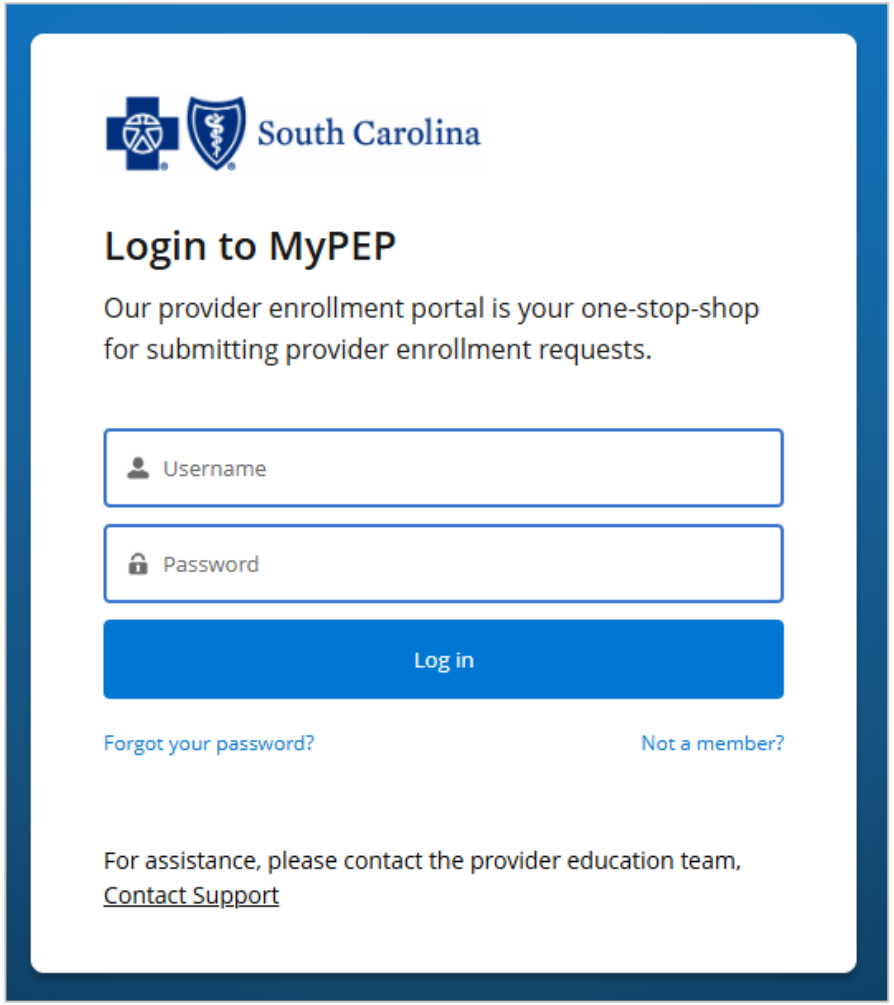
Getting Started with My Provider Enrollment Portal

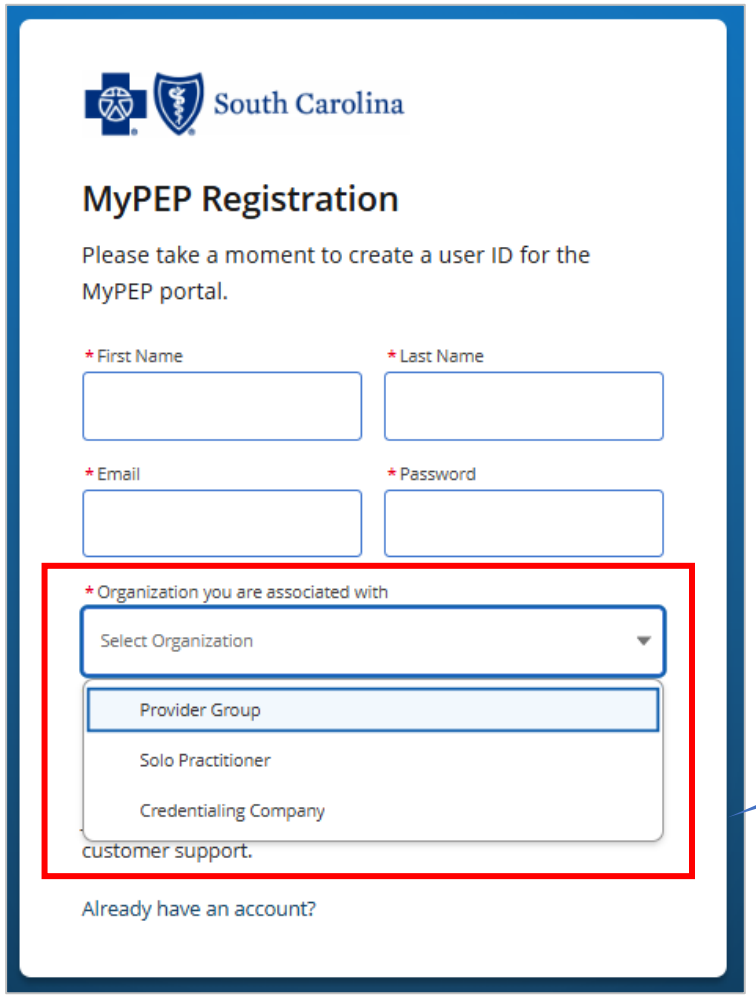
- Visit www.SouthCarolinaBlues.com.
  - Providers>Provider Enrollment>**Join Our Networks**
- Username format: **email.firstname.lastname**
- New users should select Not a member from the landing page of the portal.



South Carolina

Registering

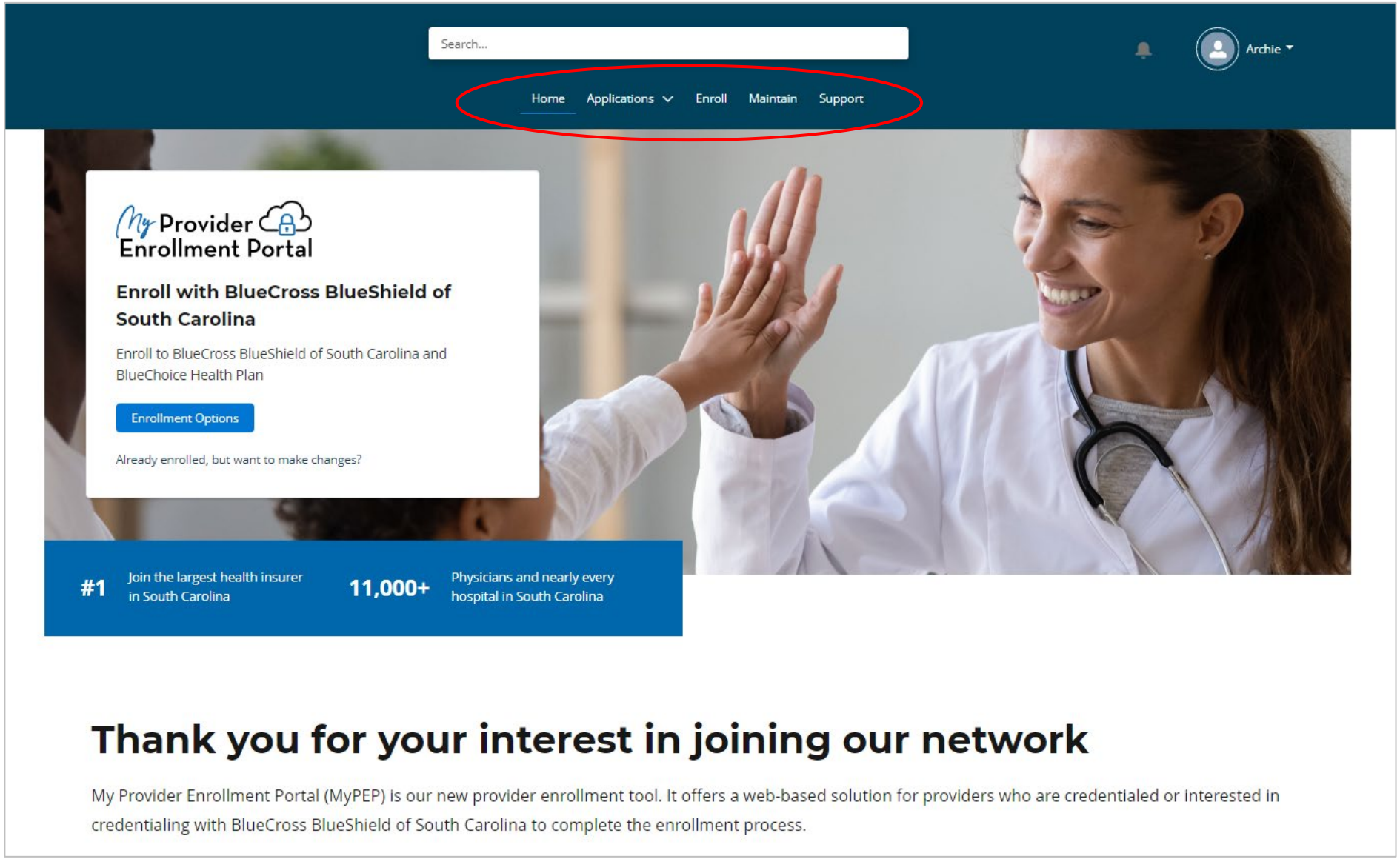
- Options include: solo practitioner, provider group and credentialing company.



The required details will vary based on the selection made.

South Carolina

My Provider Enrollment Portal – Home Page



What you'll see under Applications.

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

South Carolina

My Provider Enrollment Portal – Started Applications

Applications

My Started Applications

13 items • Sorted by Application Type • Filtered by My applications - Application Status

	Application Type	Application Status	NPI Type I	NPI Type II	Resume Application	Created Date
1		In Progress				3/31/2025, 7:28 AM
2		In Progress				4/2/2025, 10:13 AM
3		In Progress				4/29/2025, 8:45 AM
4	Individual	In Progress				3/26/2025, 7:56 AM
5	Individual	In Progress			Resume	4/2/2025, 10:30 AM
6	Individual	In Progress			Resume	4/29/2025, 8:35 AM
7	Individual	In Progress			Resume	5/9/2025, 9:19 AM
8	Individual	In Progress	1555555555		Resume	6/23/2025, 7:42 AM
9	Individual	In Progress	1777777777		Resume	7/1/2025, 7:06 AM
10	Satellite Location	In Progress		1444444444	Resume	6/19/2025, 5:23 AM

South Carolina

My Provider Enrollment Portal – In-Progress Applications

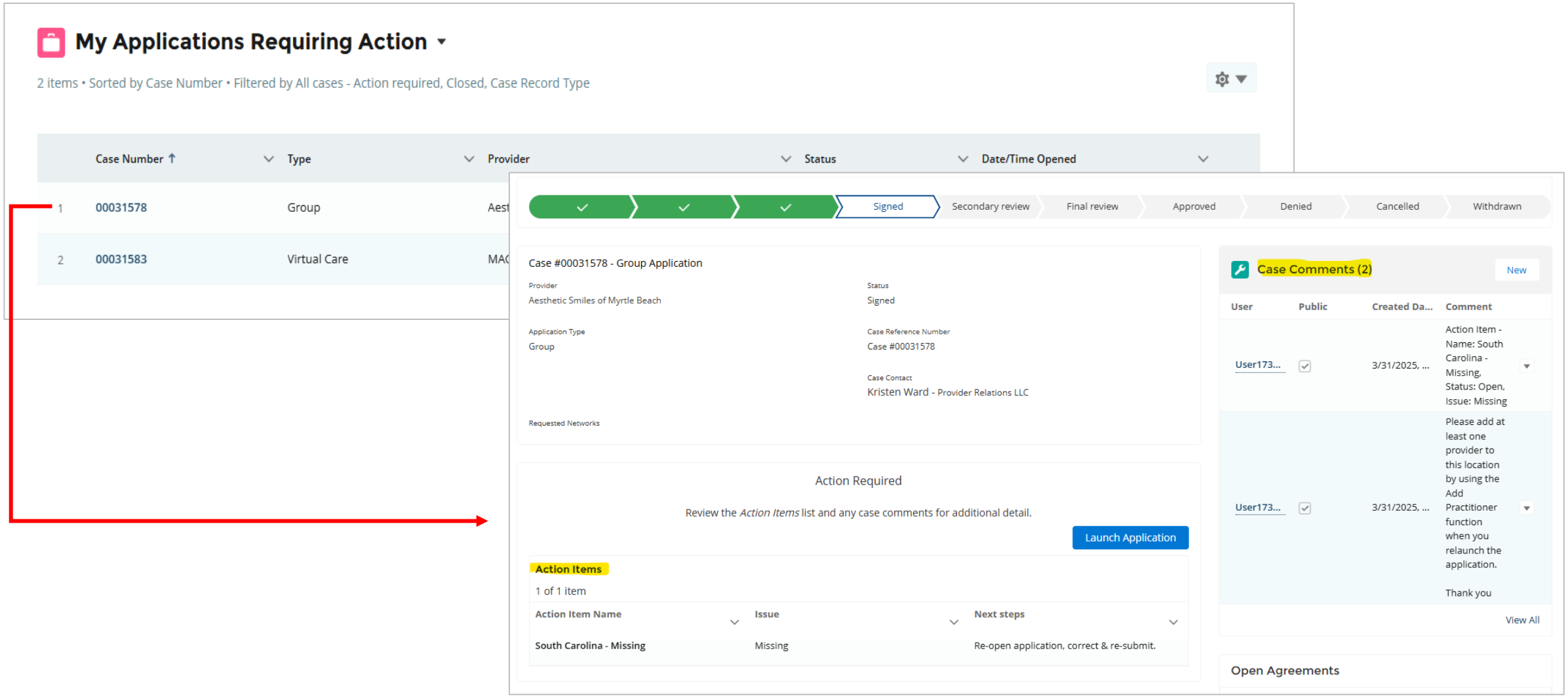
My In-Progress Applications

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

	Case Number	Type	Provider	Status	Date/Time Opened
1	00031578	Group	Aesthetic Smiles of Myrtle Beach	Signed	3/31/2025, 7:37 AM
2	00031581	Individual	Terrence Archie - MAGNOLIA ENDOCRINOLOGY LLC	Submitted	3/31/2025, 8:02 AM
3	00031583	Virtual Care	MAGNOLIA ENDOCRINOLOGY LLC	Signed	3/31/2025, 8:29 AM
4	00031584	Change of Address		Signed	3/31/2025, 8:36 AM
5	00031585	Request to Add Practitioner	DAVID YOUNIE - FLOSSY PEDIATRIC DENTISTRY	Submitted	3/31/2025, 8:52 AM
6	00031590	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	3/31/2025, 10:40 AM
7	00031612	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	4/1/2025, 8:05 AM
8	00031614	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	4/1/2025, 8:12 AM
9	00031664	Request to Term Practitioner	TIMOTHY KAYLOR - ZONE PHYSICAL THERAPY	Submitted	4/2/2025, 5:18 AM
10	00031668	Business Name Change	Provider Relations LLC	Submitted	4/2/2025, 5:53 AM

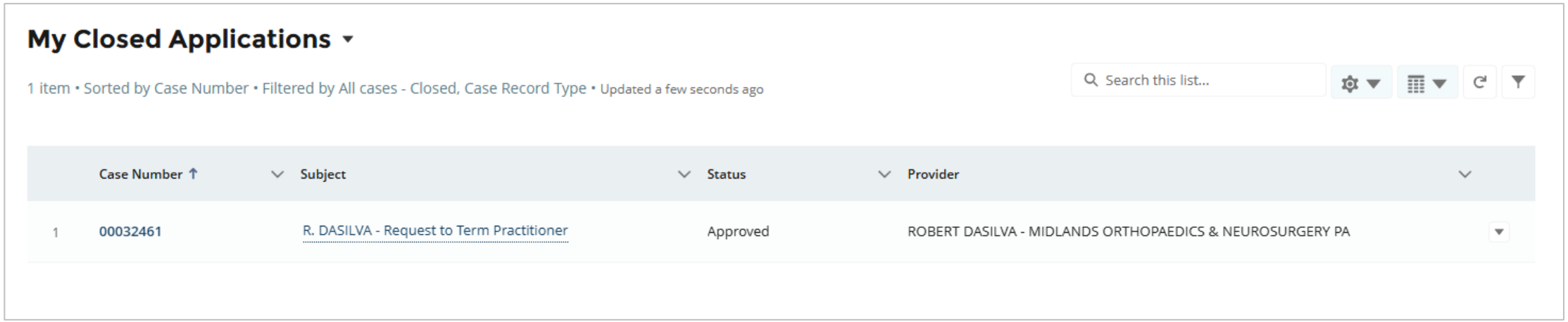
South Carolina

My Provider Enrollment Portal – Applications Needing Action



South Carolina

My Provider Enrollment Portal – Closed Applications



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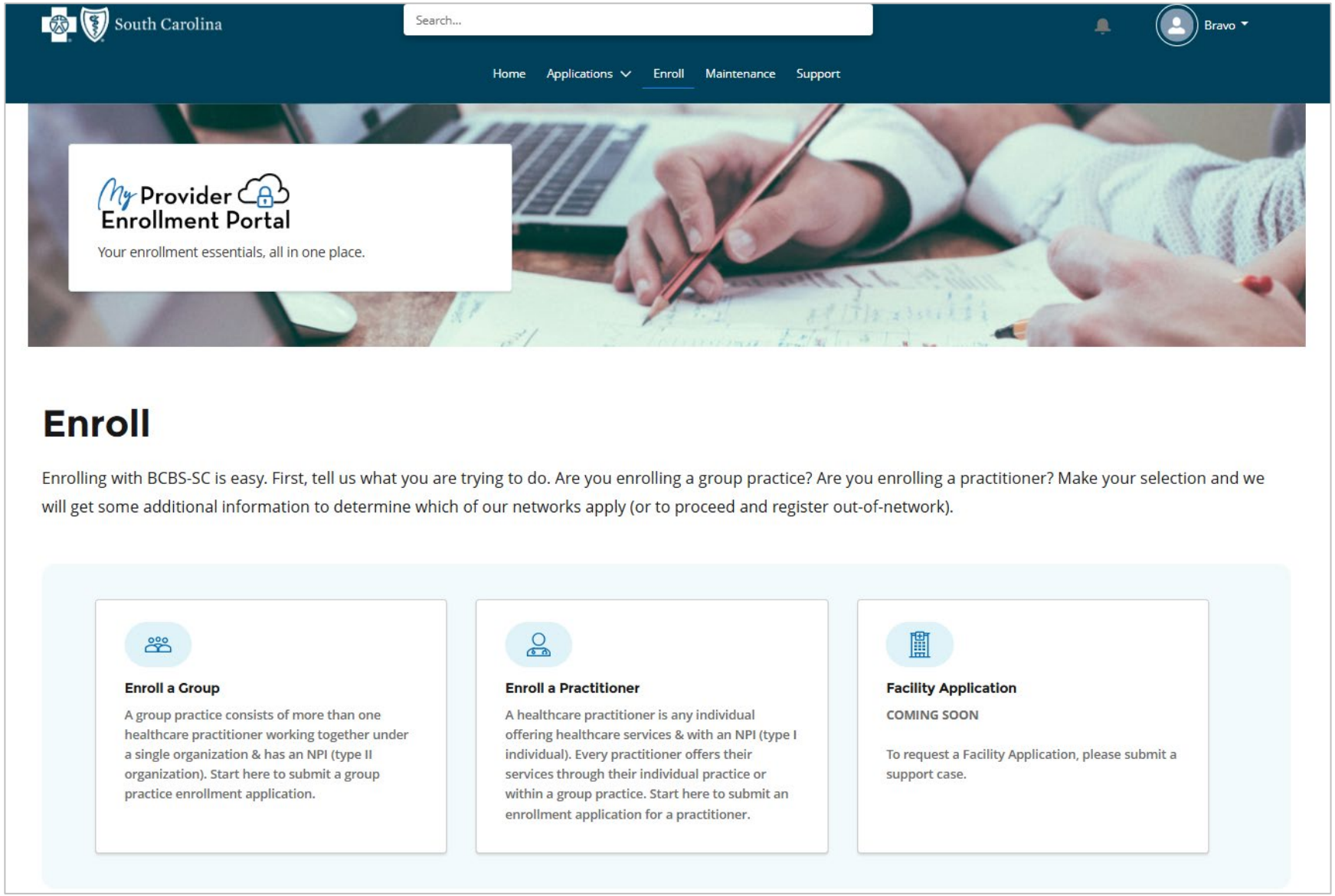
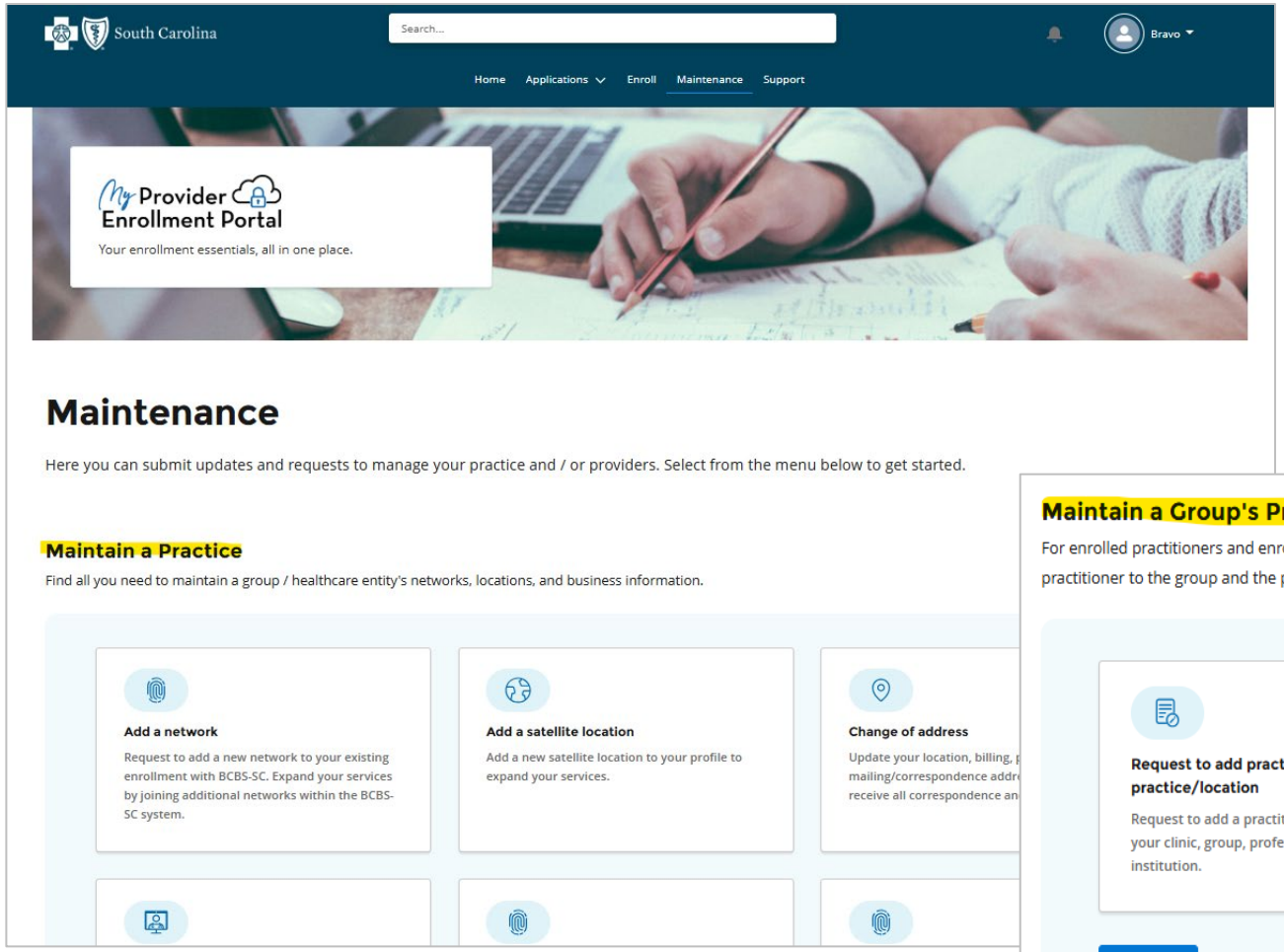
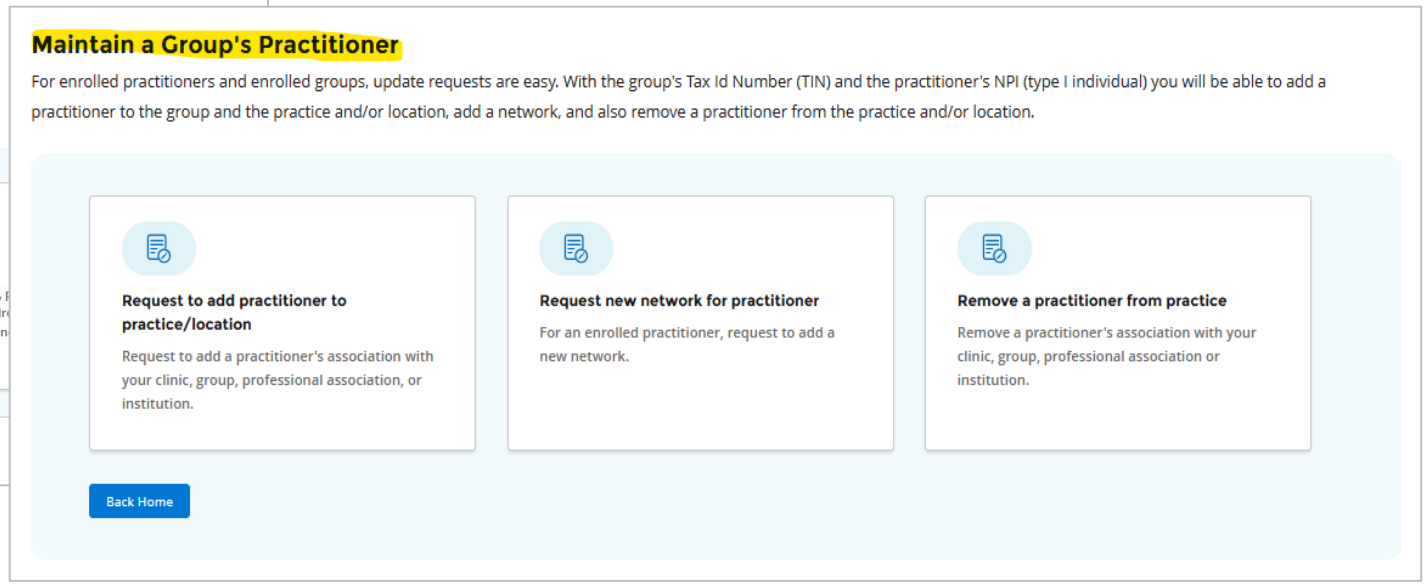
My Provider Enrollment Portal – Enroll Page



South Carolina

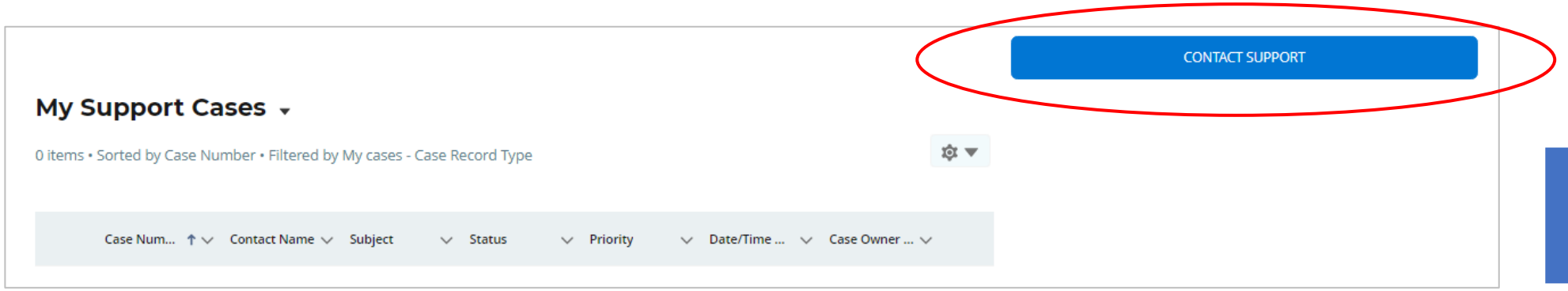
My Provider Enrollment Portal – Maintenance Page

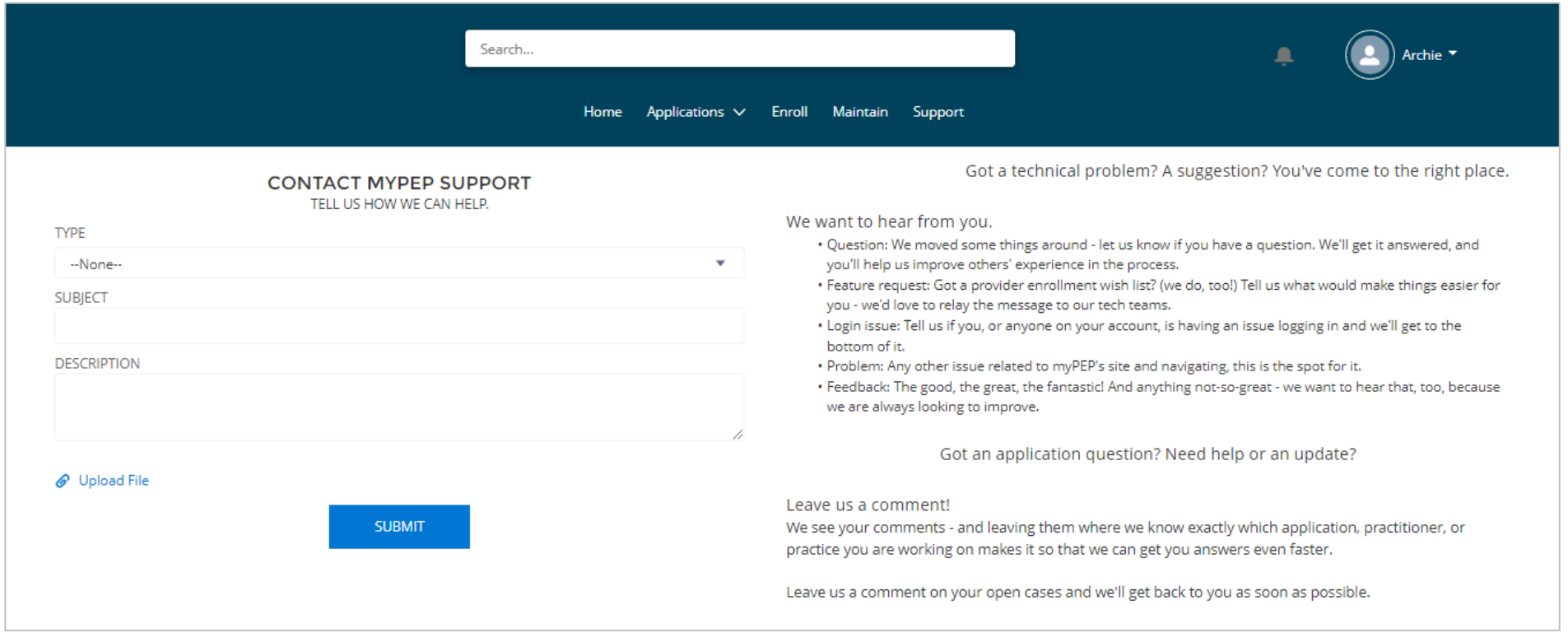




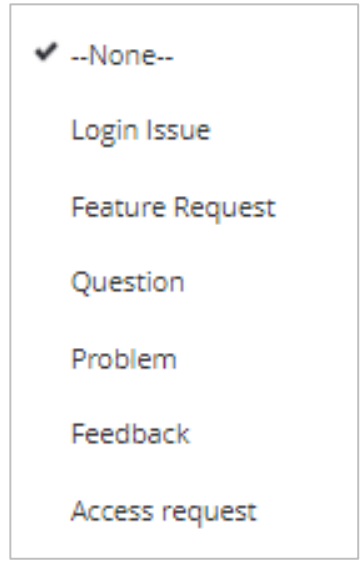
South Carolina

My Provider Enrollment Portal – Support Page





Available types.



South Carolina

Completing Clean Applications

Your Complete Solution

2026 Annual Provider Summit

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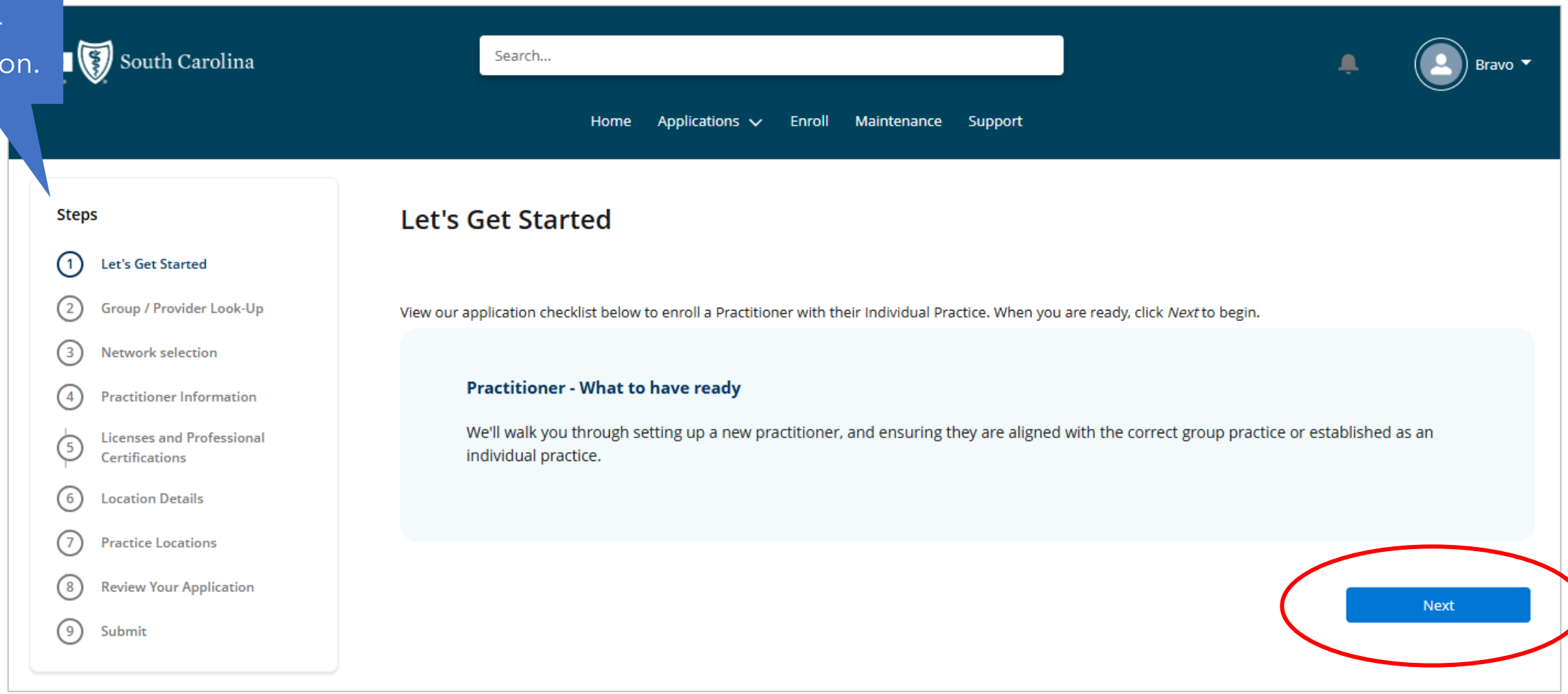
Steps to Submitting a Clean Application

1. Complete the enrollment application inside the portal.
2. Sign the application and agreements ***electronically***.
   - The documents that must be signed will be sent to the appropriate parties included on the application.
     - **It is important to include the correct email addresses for each individual (i.e., provider, fiduciary contact, etc.)**
   - These items will be available once the enrollment team sends the documents to you, and the case is in the awaiting signature status.
3. If additional items are requested, submit those as soon as possible.

South Carolina

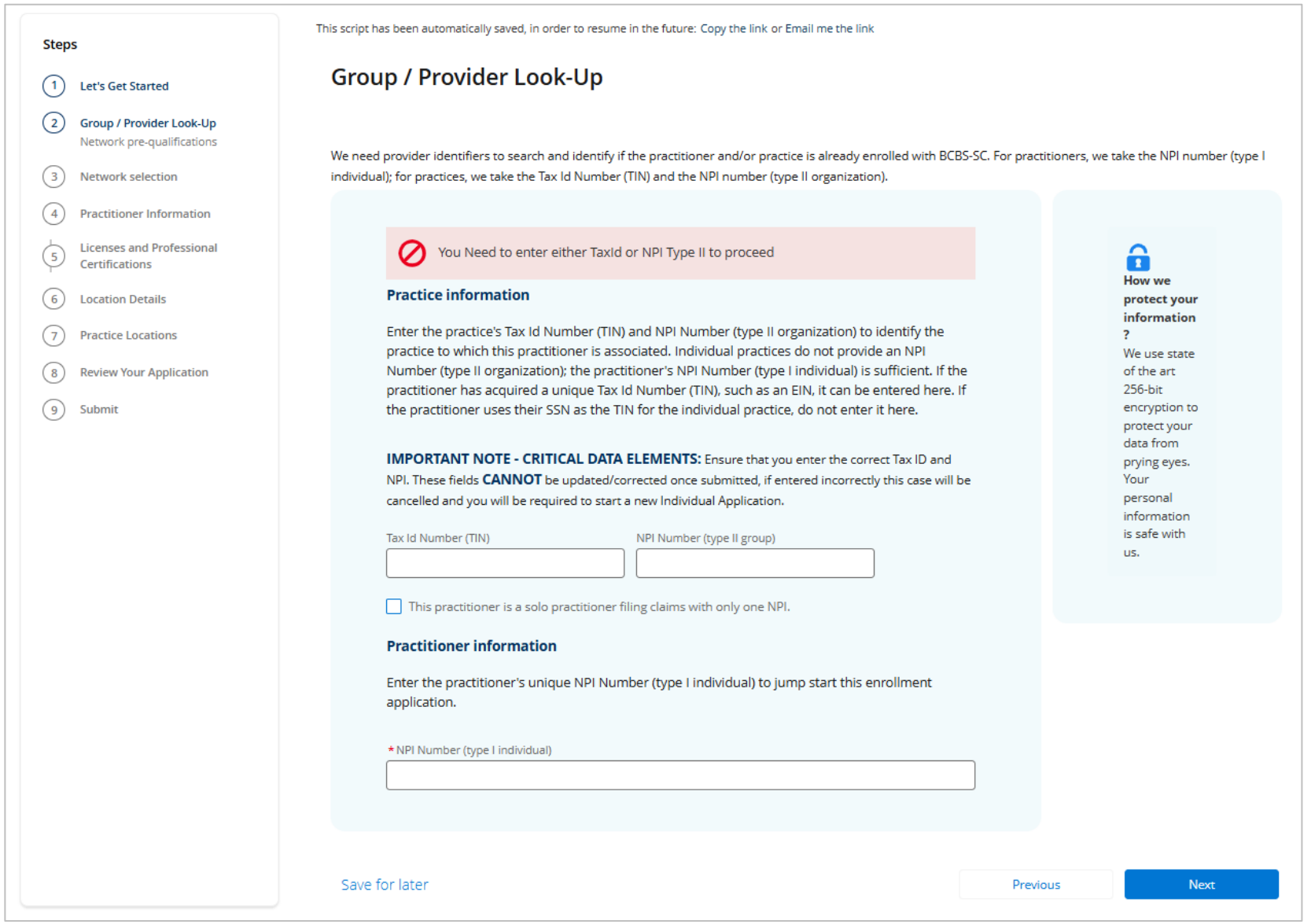
Example of an Individual Enrollment Application

Clear navigation.



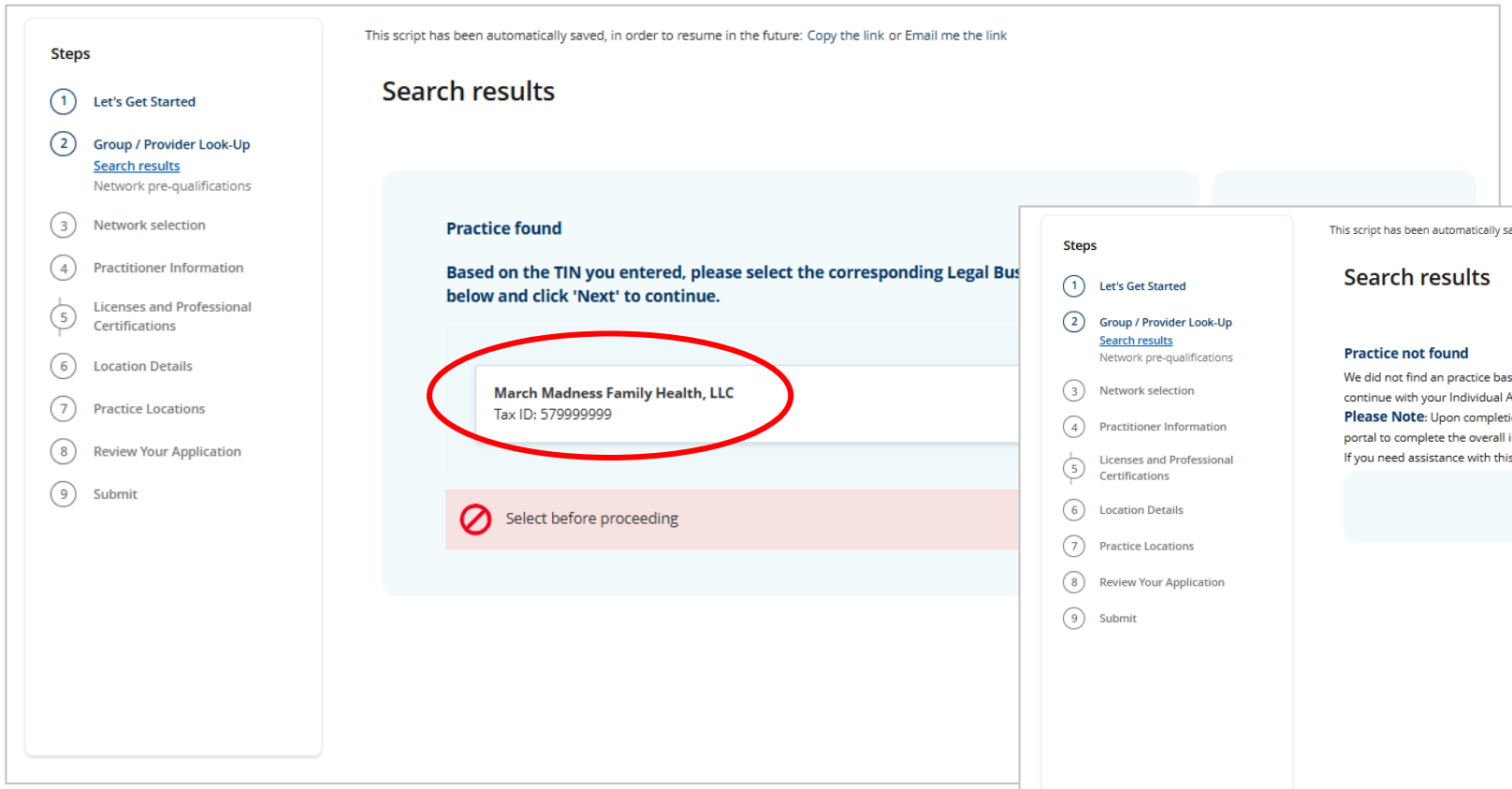
South Carolina

Example of an Individual Enrollment Application (Continued)

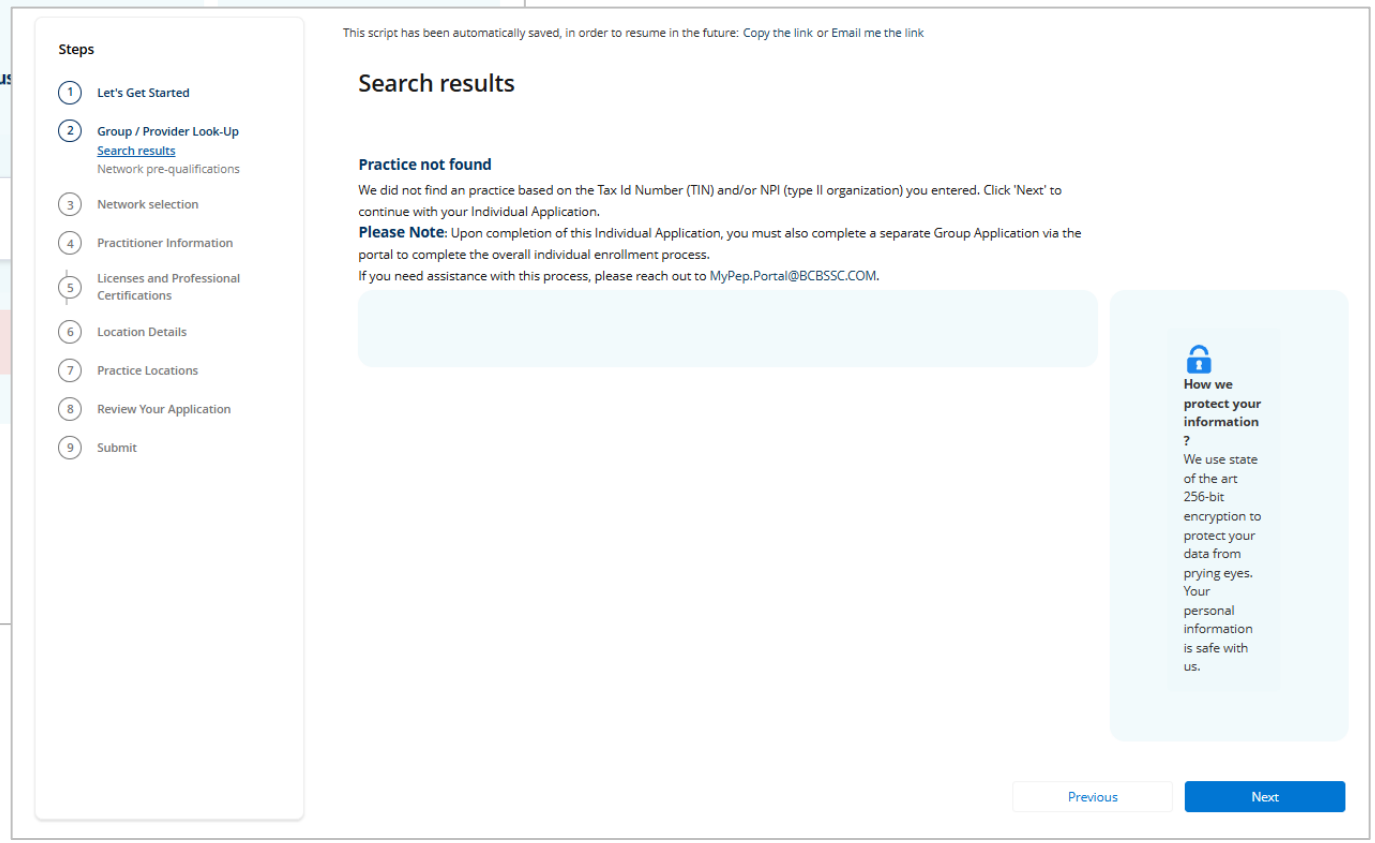


South Carolina

Example of an Individual Enrollment Application (Continued)



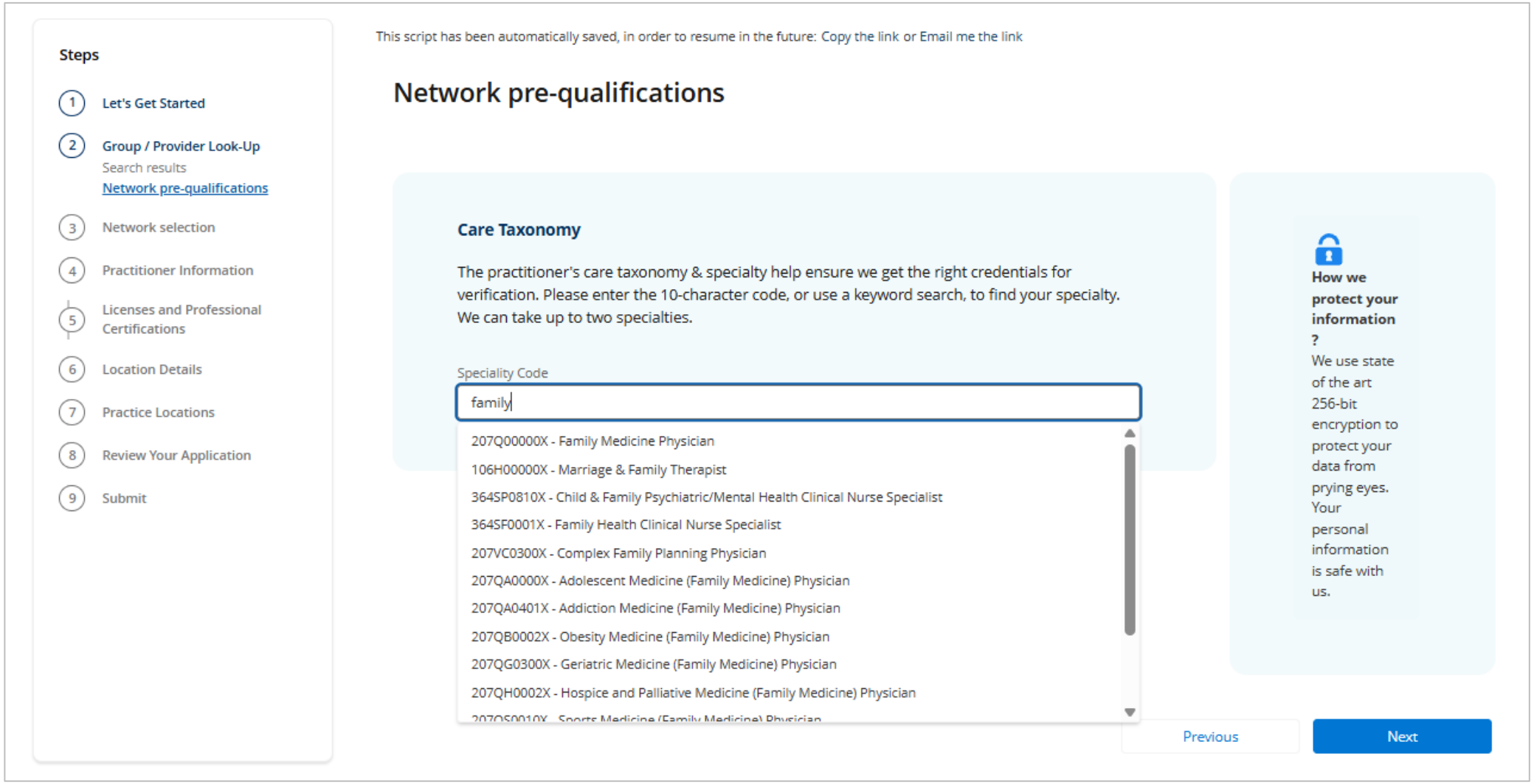
View when practice is found.



View when practice is not found.

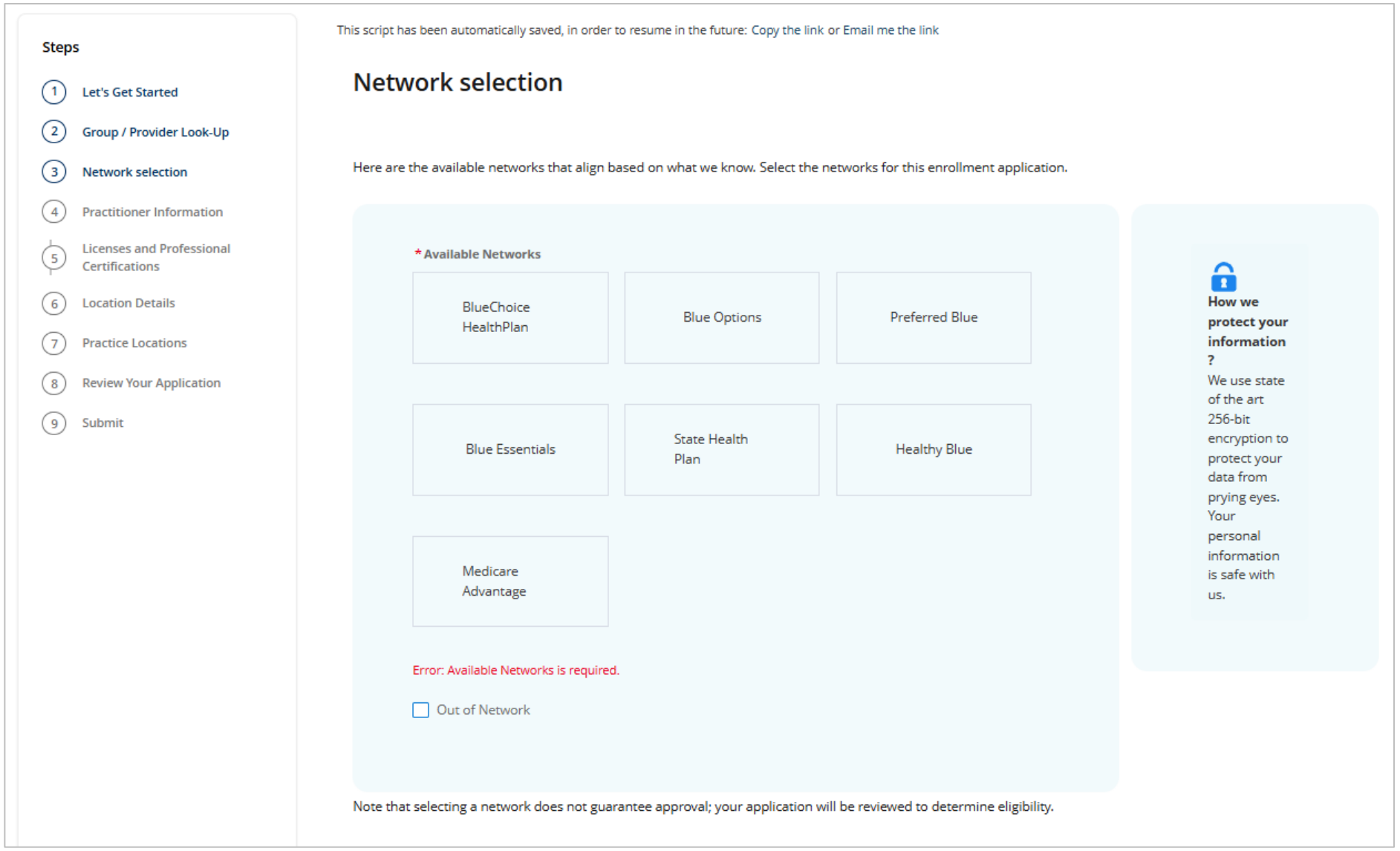
South Carolina

Example of an Individual Enrollment Application (Continued)



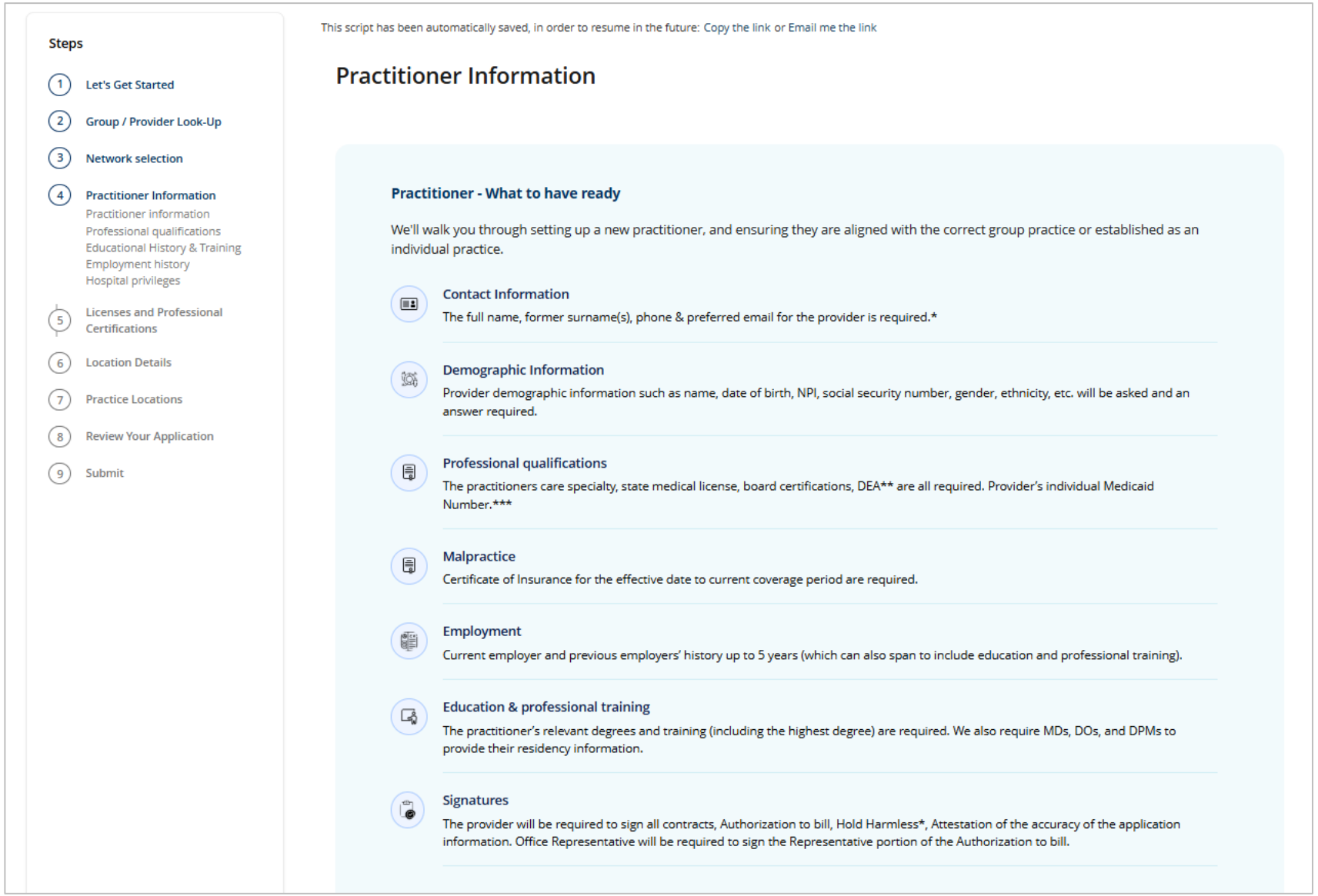
South Carolina

Example of an Individual Enrollment Application (Continued)



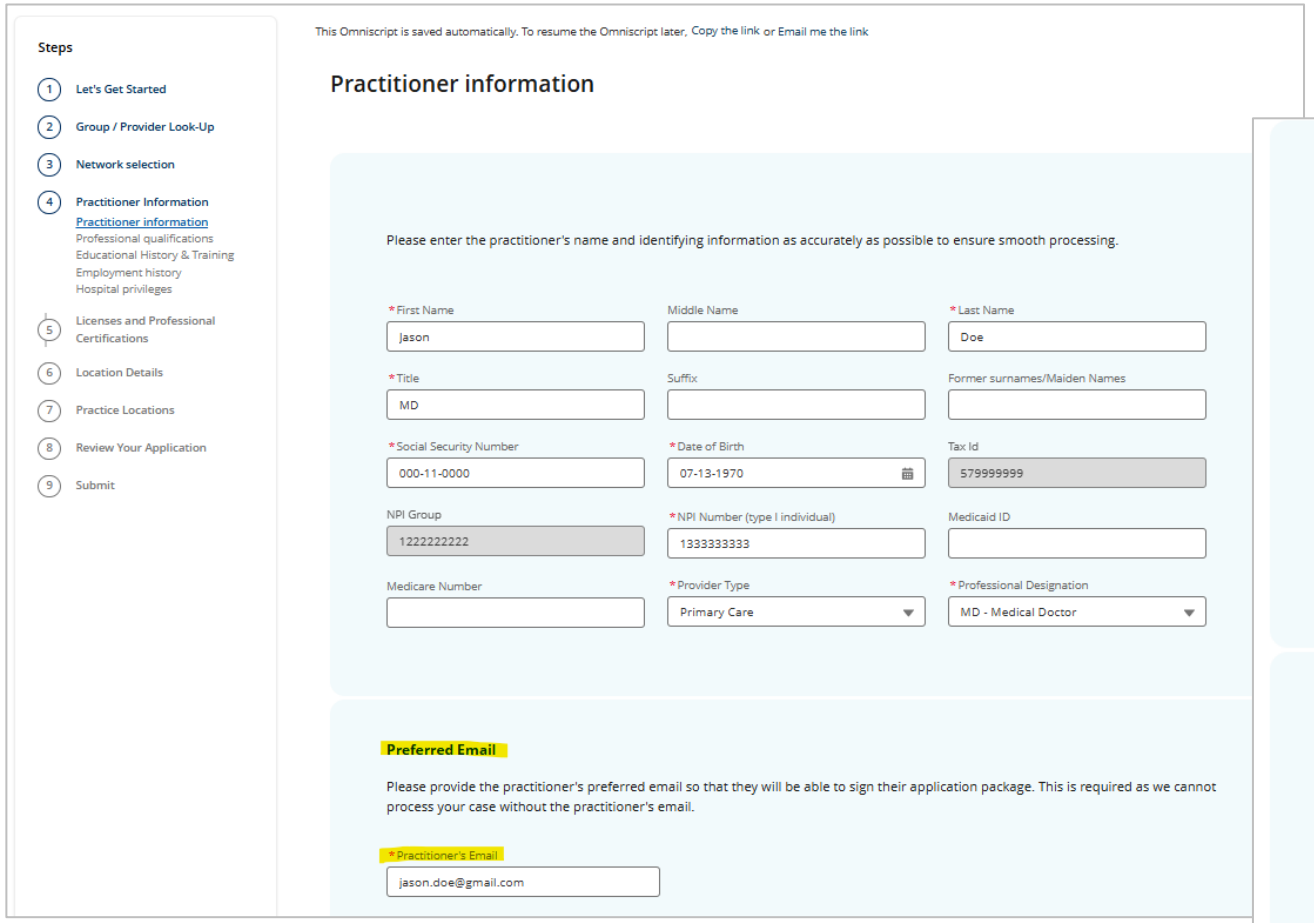
South Carolina

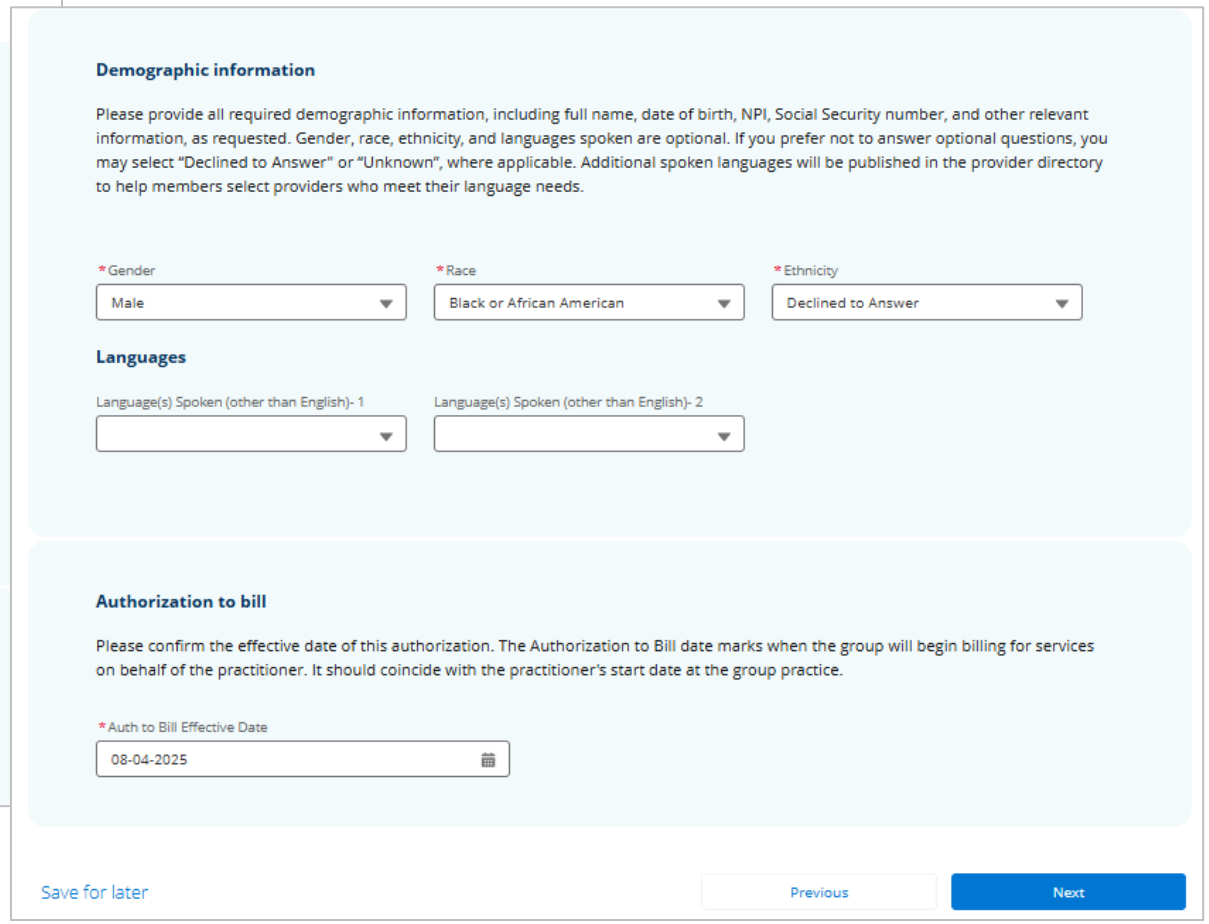
Example of an Individual Enrollment Application (Continued)



South Carolina

Example of an Individual Enrollment Application (Continued)

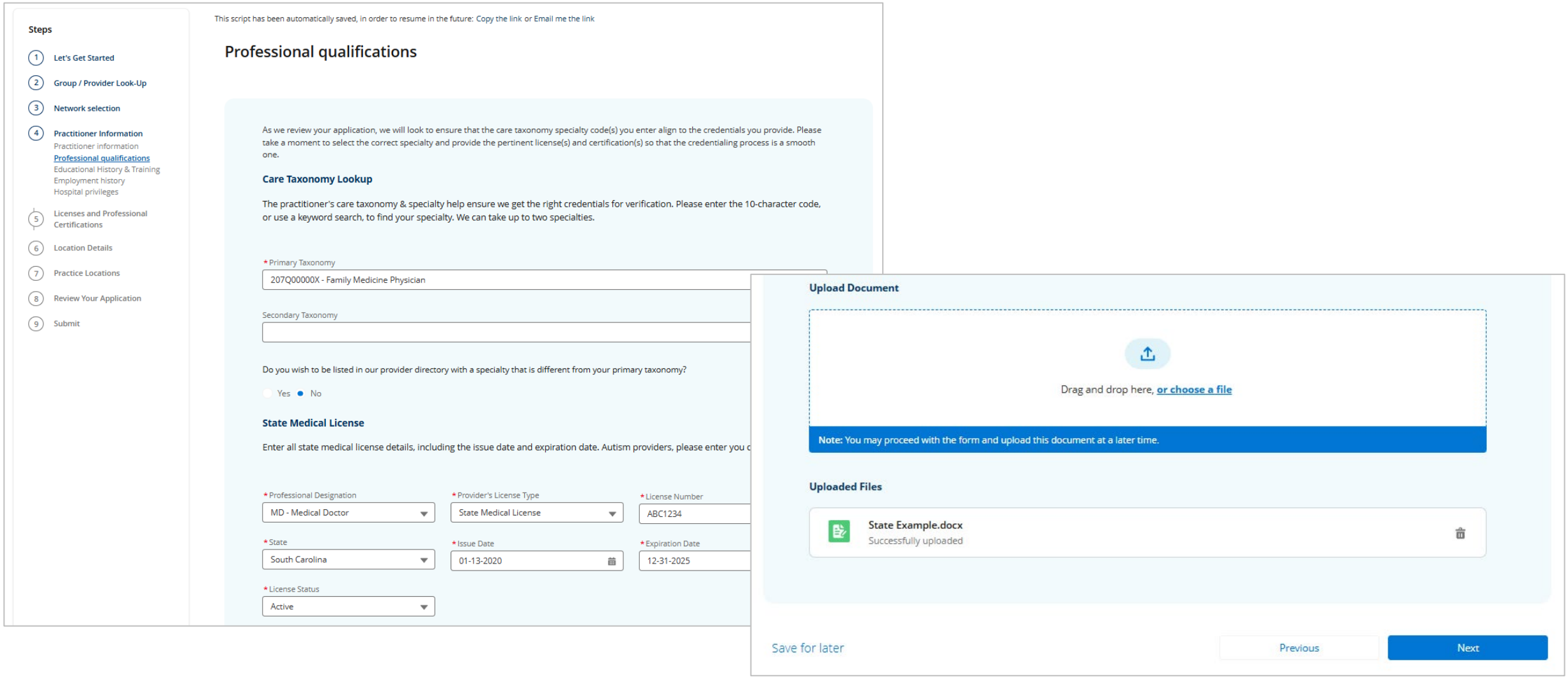




Note: You must enter the practitioner's email address. It cannot be the email address for the practice or anyone else.

South Carolina

Example of an Individual Enrollment Application (Continued)



South Carolina

Example of an Individual Enrollment Application (Continued)

Steps

1. Let's Get Started
2. Group / Provider Look-Up
3. Network selection
4. Practitioner Information
   - Practitioner information
   - Professional qualifications
   - Educational History & Training
   - Employment history
   - Hospital privileges
5. Licenses and Professional Certifications
6. Location Details
7. Practice Locations
8. Review Your Application
9. Submit

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

Educational History & Training

Educational History

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

What determines a full educational history?

Please be sure to include the institution where the practitioner received their most advanced me
you have less than 5 years of employment history, include additional educational history to prov
picture of the practitioner's professional timeline.

* Educational Level	* Institution Name	* Please Specify Institution Name.
Medical School	OTHER	USC
* Degree Type	* Start Month	* Year
MD - DOCTOR OF MEDICINE	January	2010
* End Month	* Year	* Country
November	2016	United States
* City	State	
Columbia	South Carolina	

Degree Conferred

☑ Individual asserts they have completed their education and holds the qualifications associated with that degree

Professional Training

If the practitioner has completed an internship, fellowship or residency, please update the selection from the dropdown provided and enter detail for this professional training. You may add additional entries / remove entries.

☑ Add Trainings

Add Additional Training

Training

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

☐ I am actively taking this training/program

* Start Date	* End Date
02-01-2016	12-31-2018

Cultural Competency Training

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

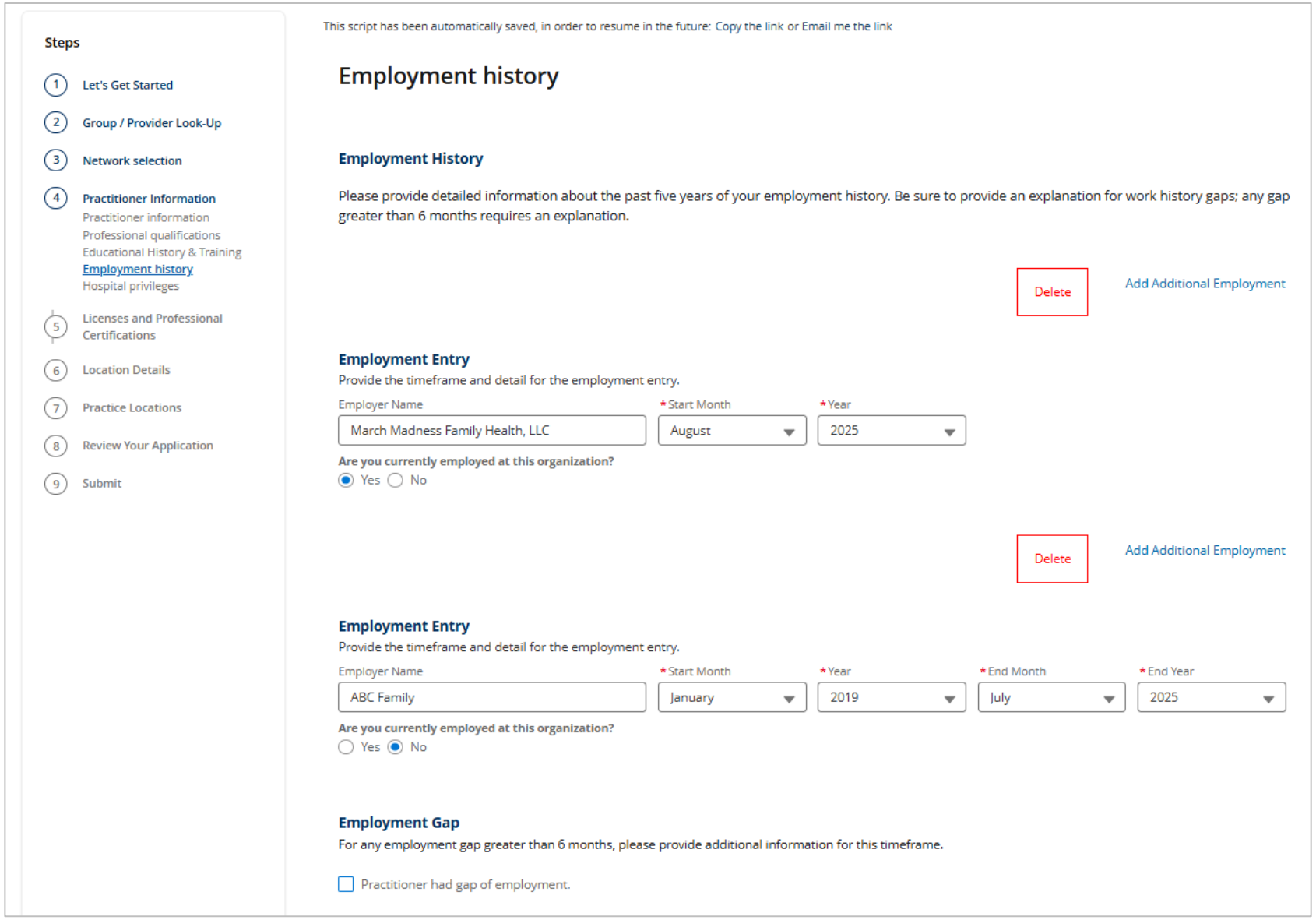
○ Yes ● No

Complete your training at https://thinkculturalhealth.hhs.gov/

Save for later | Previous | Next

South Carolina

Example of an Individual Enrollment Application (Continued)



Steps

1. Let's Get Started
2. Group / Provider Look-Up
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4. Practitioner Information
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5. Licenses and Professional Certifications
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7. Practice Locations
8. Review Your Application
9. Submit

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Employment history

Employment History

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

Delete | Add Additional Employment

Employment Entry

Provide the timeframe and detail for the employment entry.

Employer Name: March Madness Family Health, LLC
*Start Month: August
*Year: 2025

Are you currently employed at this organization?
(•) Yes ( ) No

Delete | Add Additional Employment

Employment Entry

Provide the timeframe and detail for the employment entry.

Employer Name: ABC Family
*Start Month: January
*Year: 2019
*End Month: July
*End Year: 2025

Are you currently employed at this organization?
( ) Yes (•) No

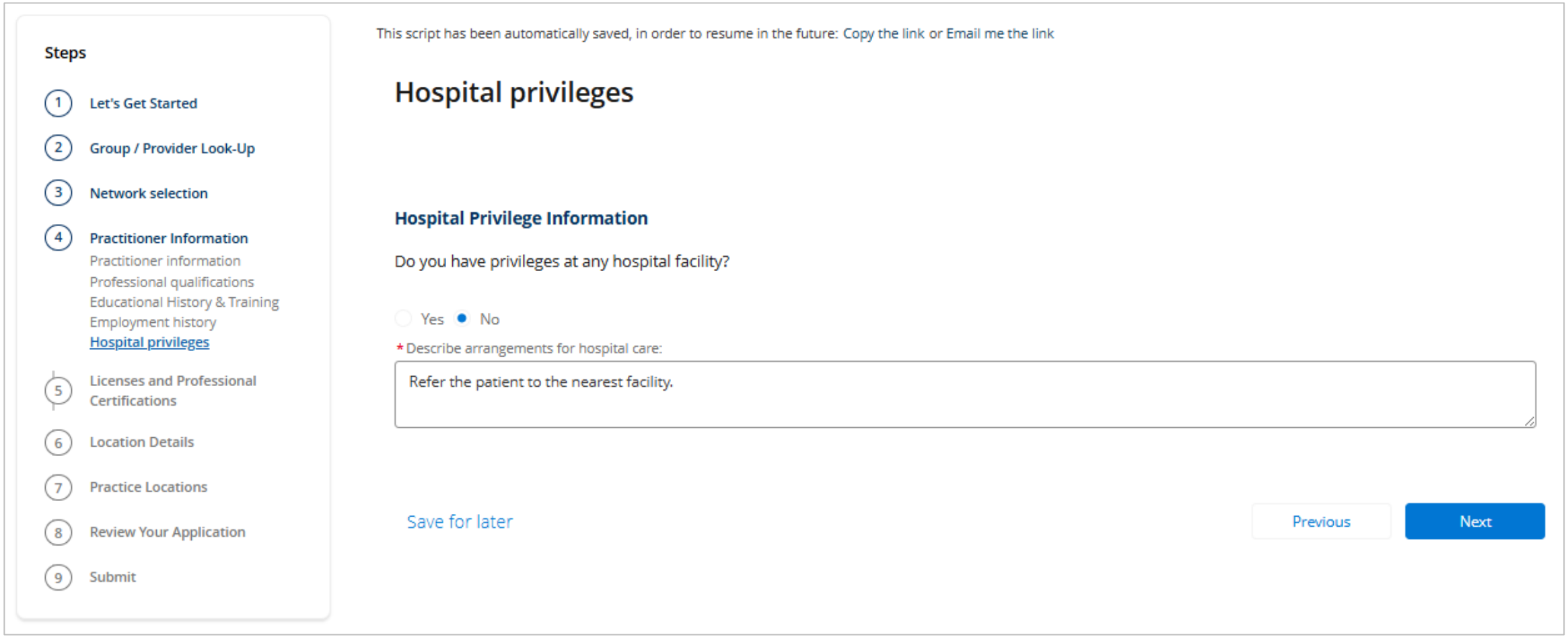
Employment Gap

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

☐ Practitioner had gap of employment.

South Carolina

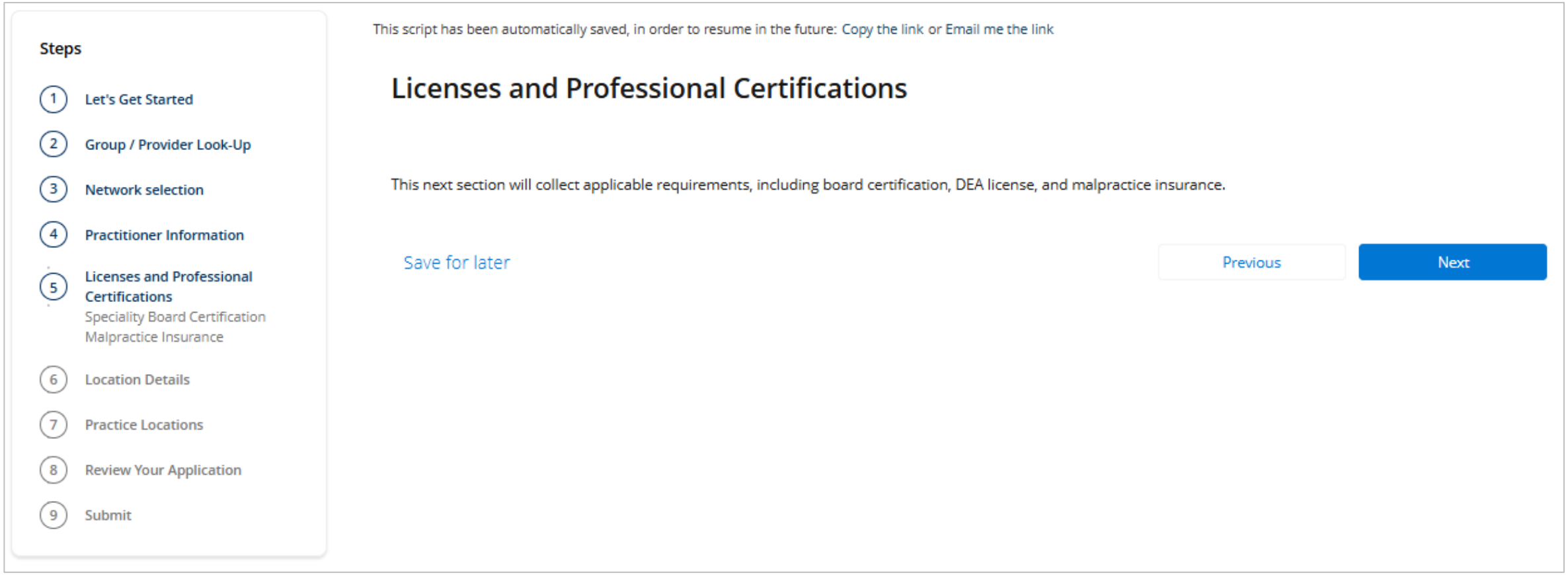
Example of an Individual Enrollment Application (Continued)



Note: Hospital privileges are based on admitting privileges.

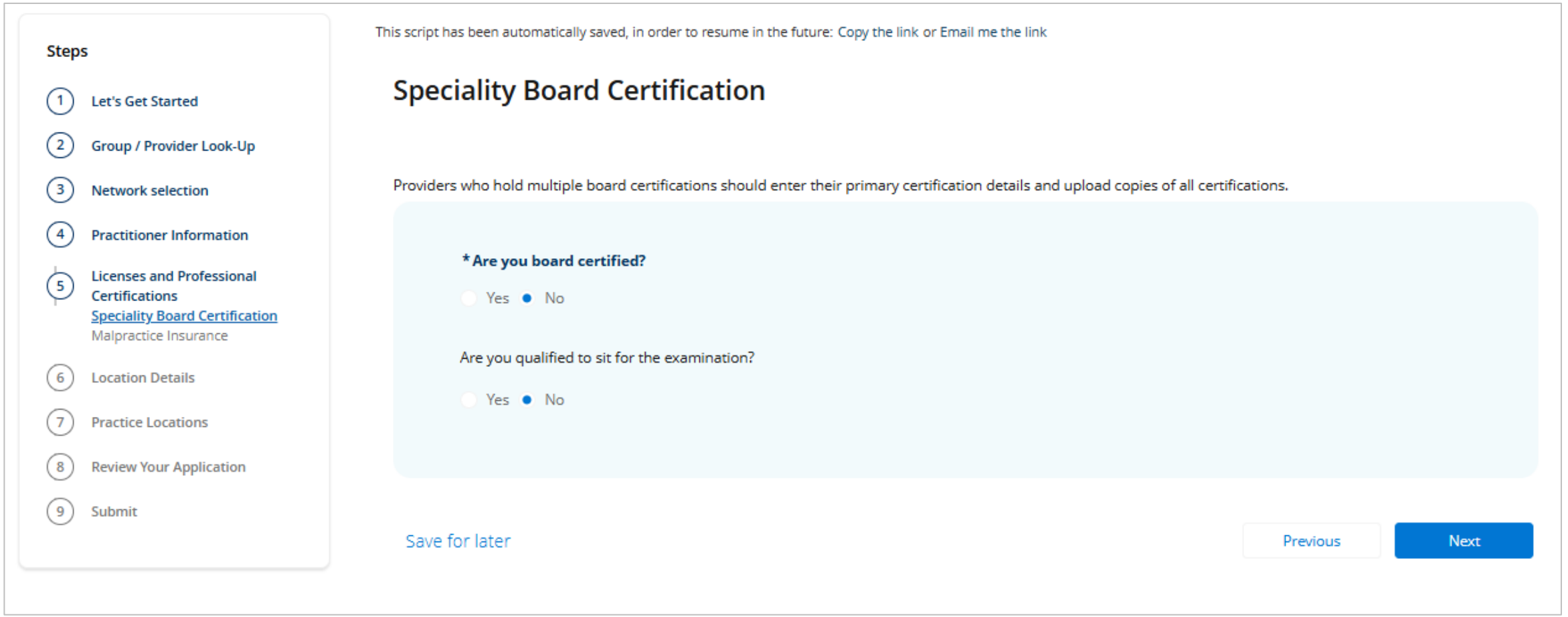
South Carolina

Example of an Individual Enrollment Application (Continued)



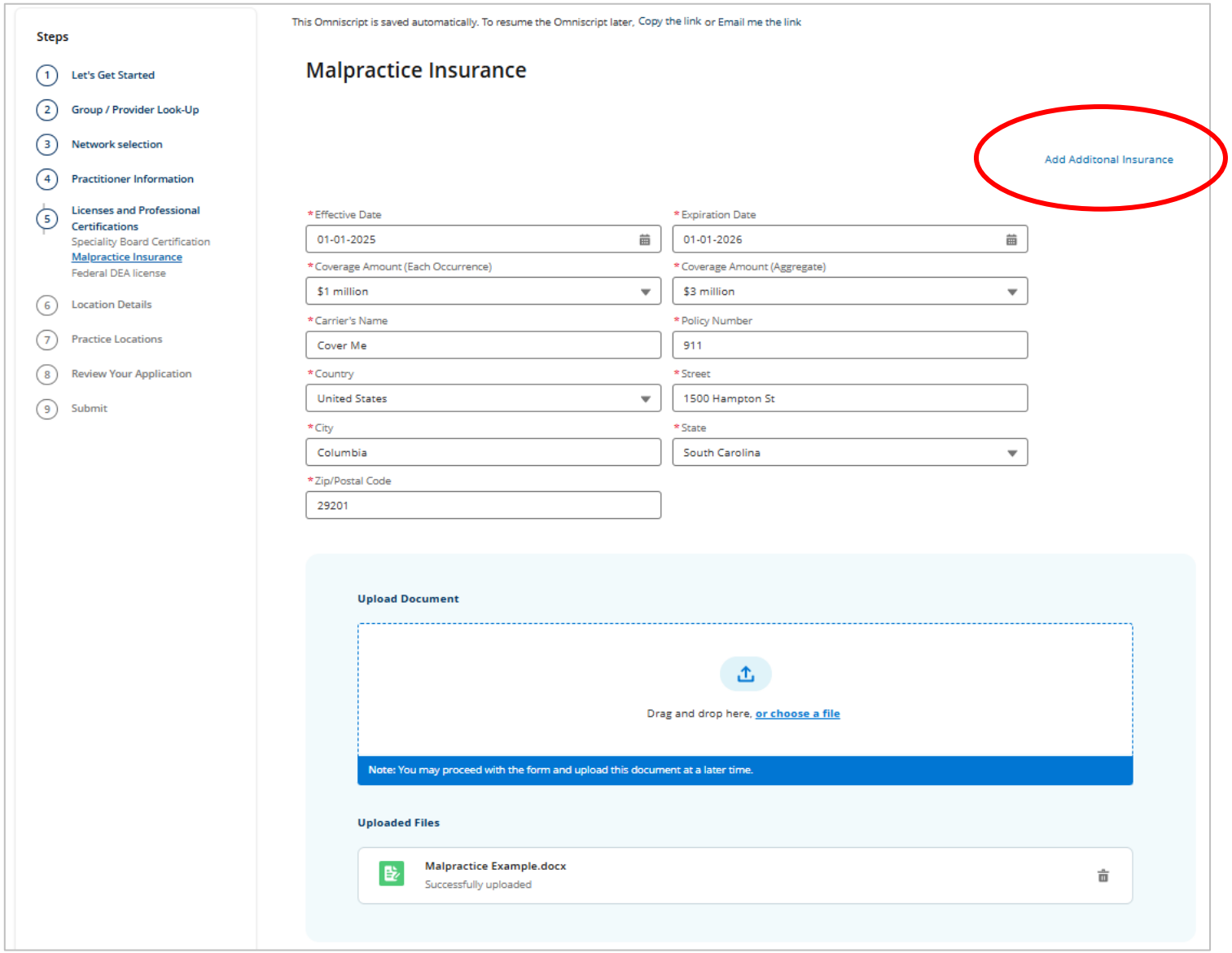
South Carolina

Example of an Individual Enrollment Application (Continued)



South Carolina

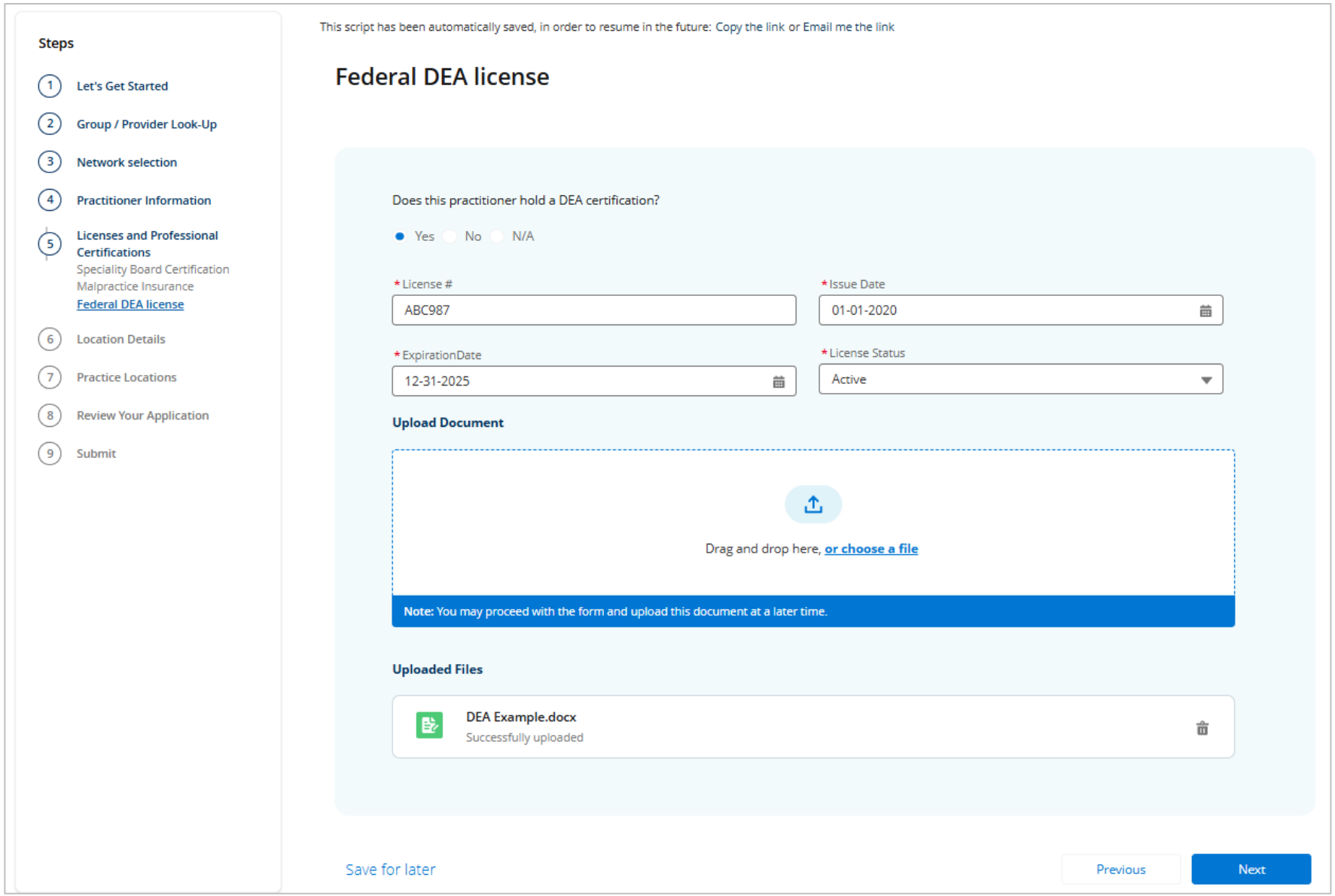
Example of an Individual Enrollment Application (Continued)



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

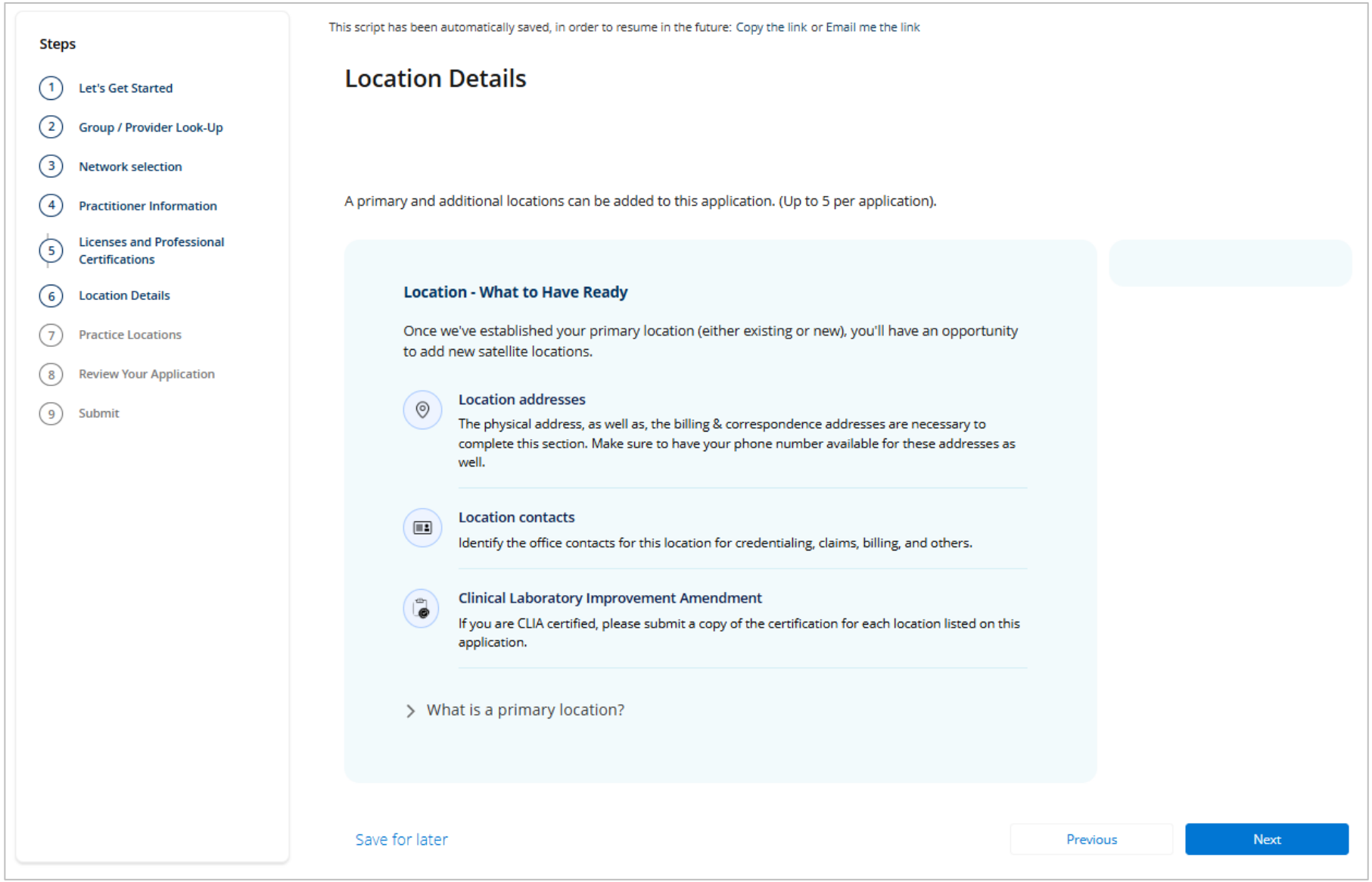
South Carolina

Example of an Individual Enrollment Application (Continued)



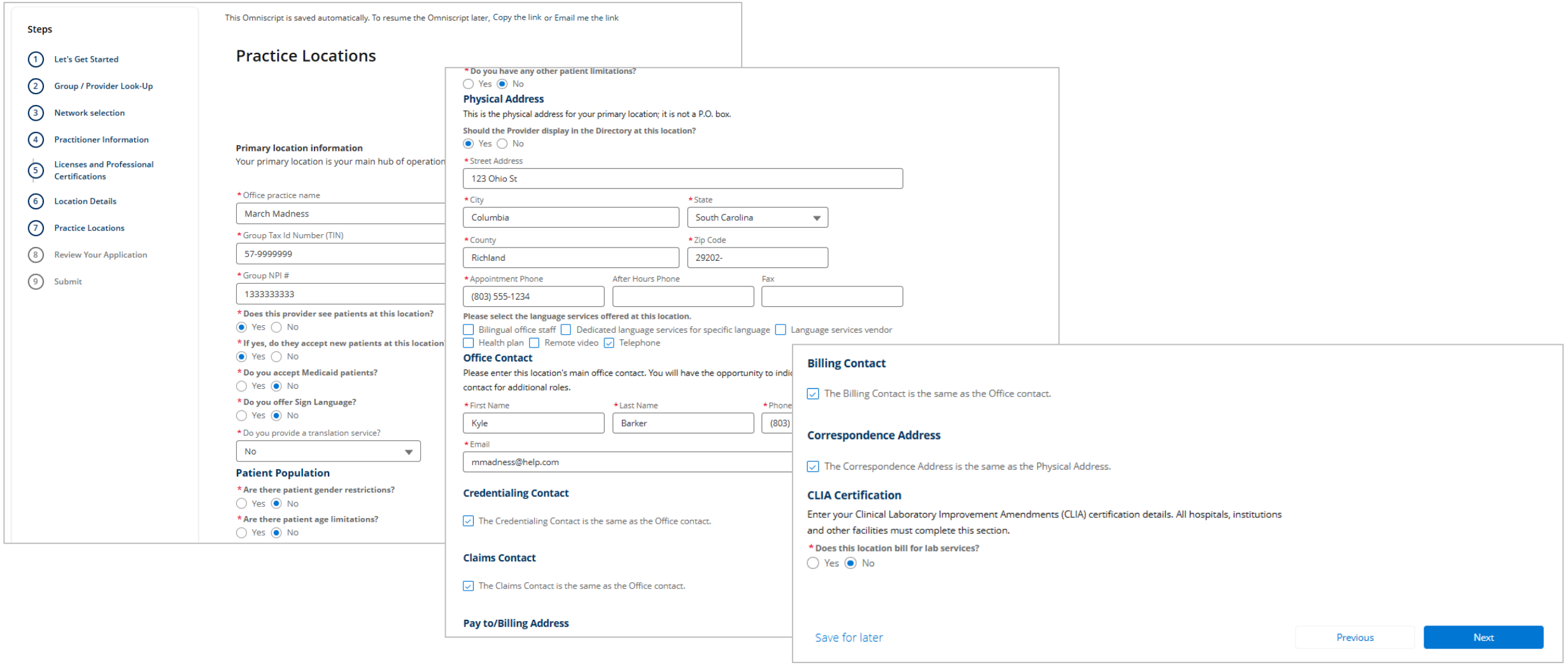
South Carolina

Example of an Individual Enrollment Application (Continued)



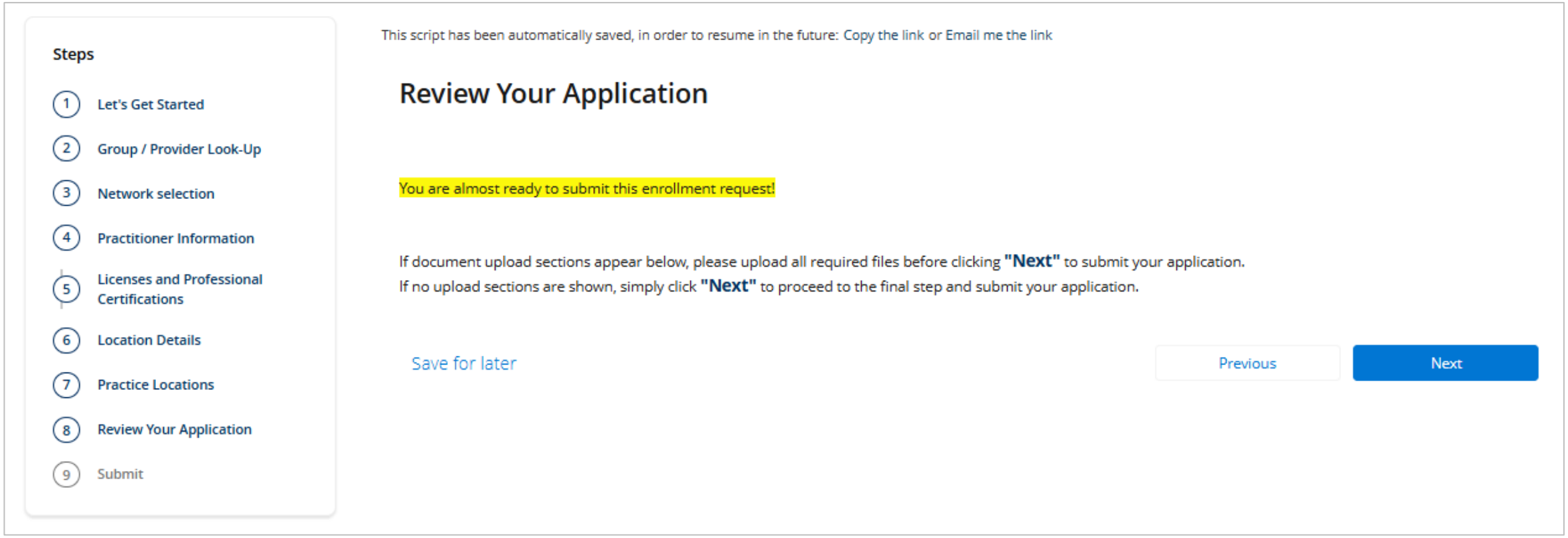
South Carolina

Example of an Individual Enrollment Application (Continued)



South Carolina

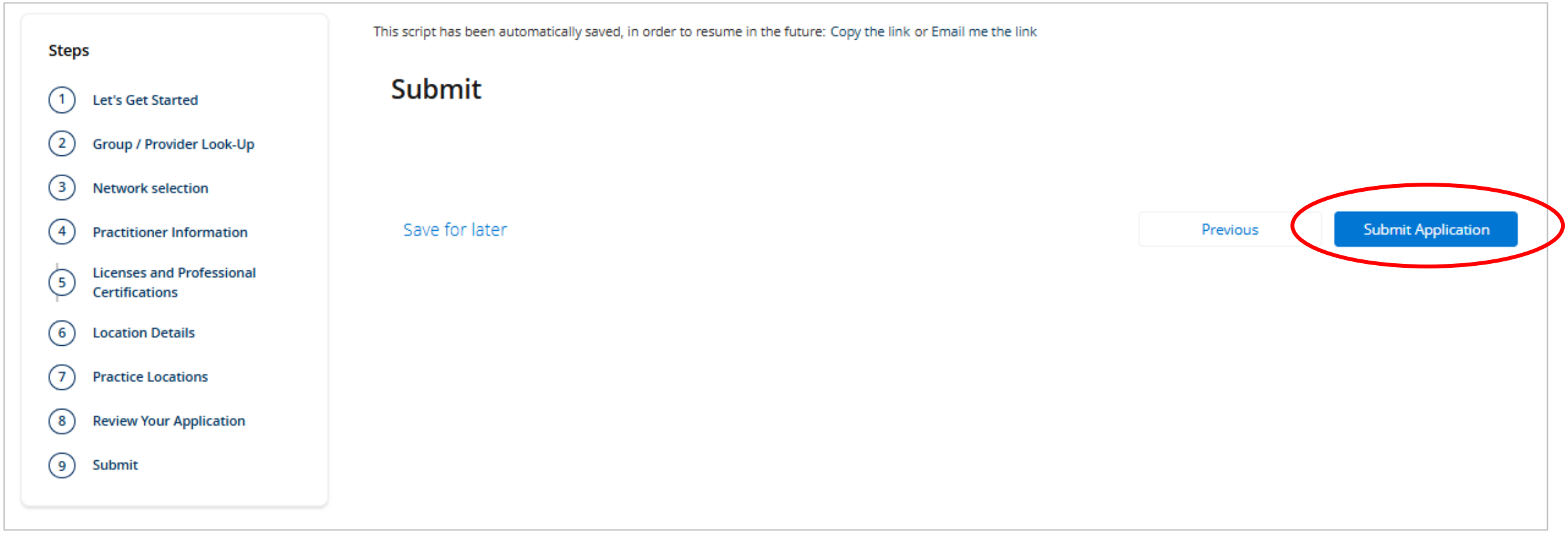
Example of an Individual Enrollment Application (Continued)



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

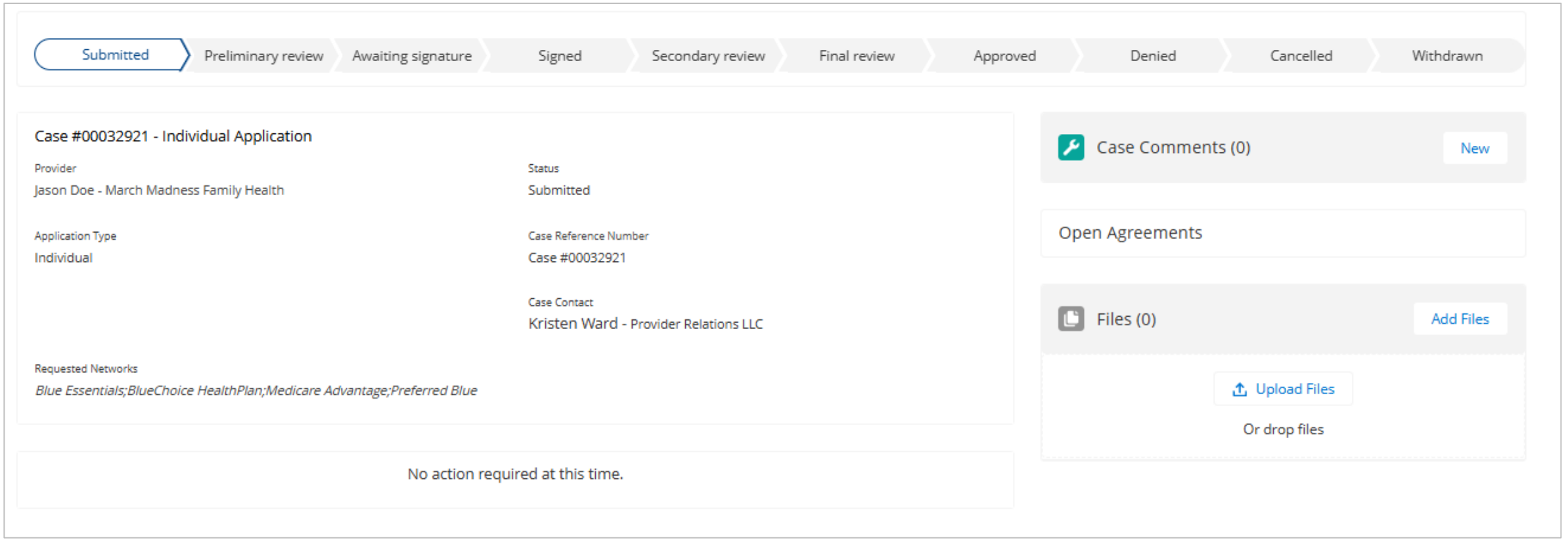
South Carolina

Example of an Individual Enrollment Application (Continued)



South Carolina

Example of an Individual Enrollment Application (Continued)



South Carolina

Making Corrections to Applications

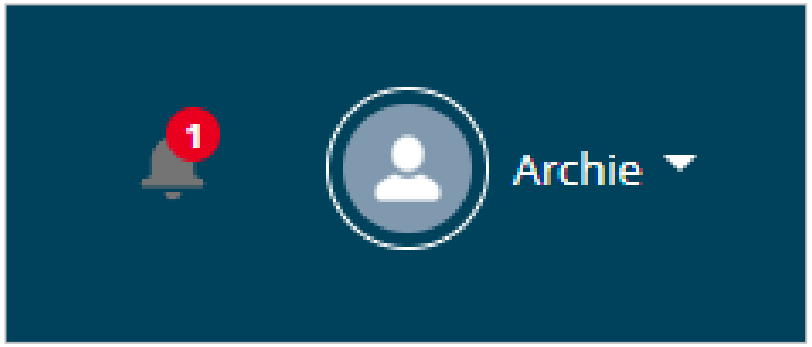
Your Complete Solution

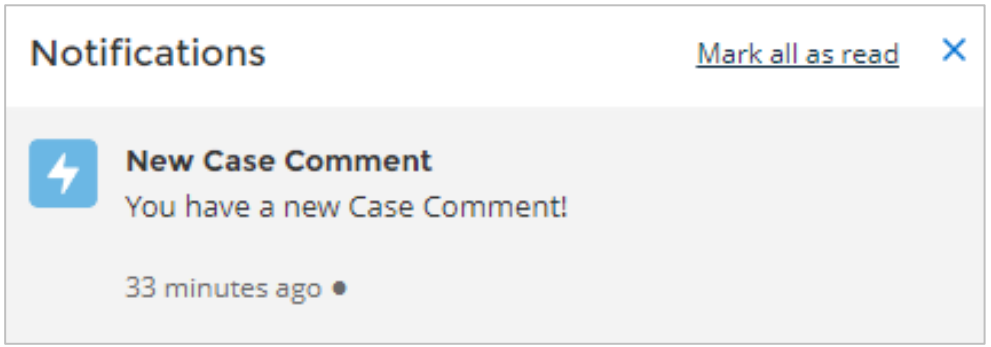
2026 Annual Provider Summit

South Carolina

Correcting Applications

- Currently, corrections can only be made to group or individual enrollment applications.
  - Corrections cannot be made to maintenance applications.
    - If an error or mistake is made after submission, a case comment must be made on the current case requesting to have it canceled, and a new maintenance application must be submitted.
- If items are missing or corrections are needed for an application, you will see a notification once you log into the portal.
- After selecting the notification bell, you will see that there is a new case comment for you to review.
- All corrections must be made in the portal.
  - Handwritten or other altered corrections are not accepted and will be returned.

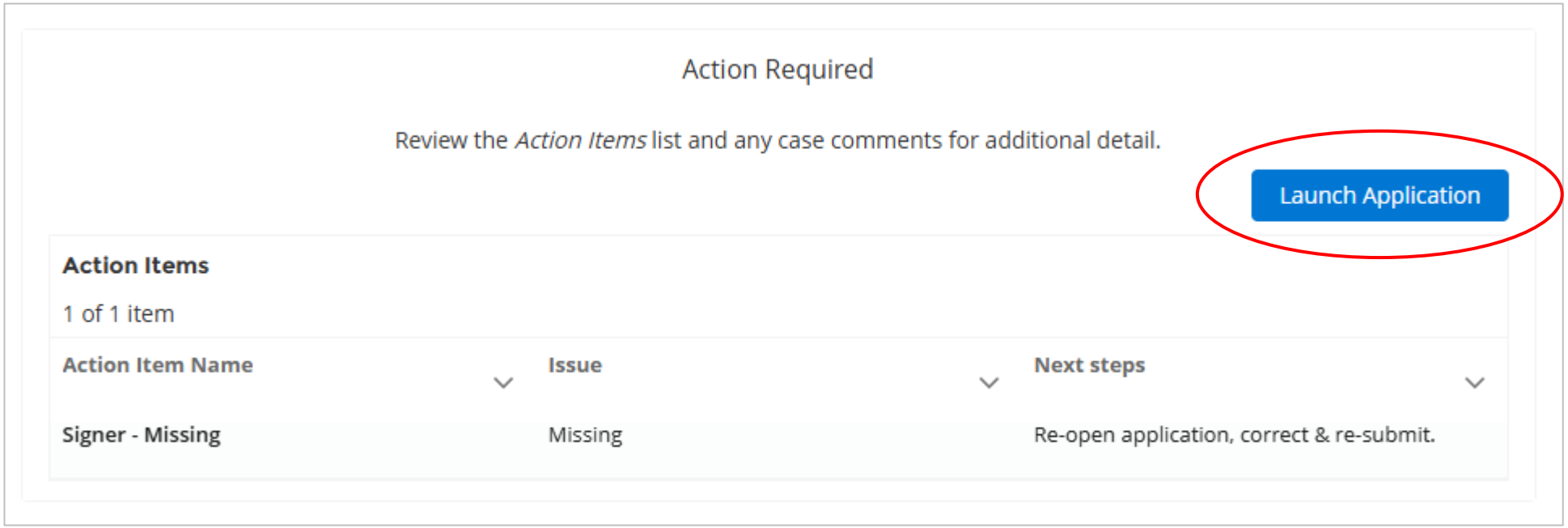




South Carolina

Steps for Making Corrections

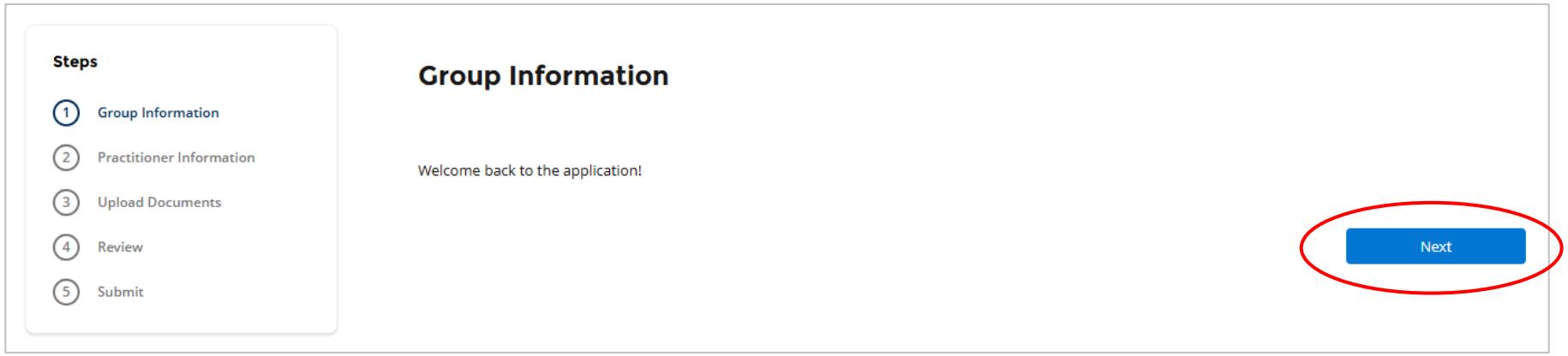
- Review the action required.
- Select ***Launch Application*** to make the necessary corrections or to supply the requested items.



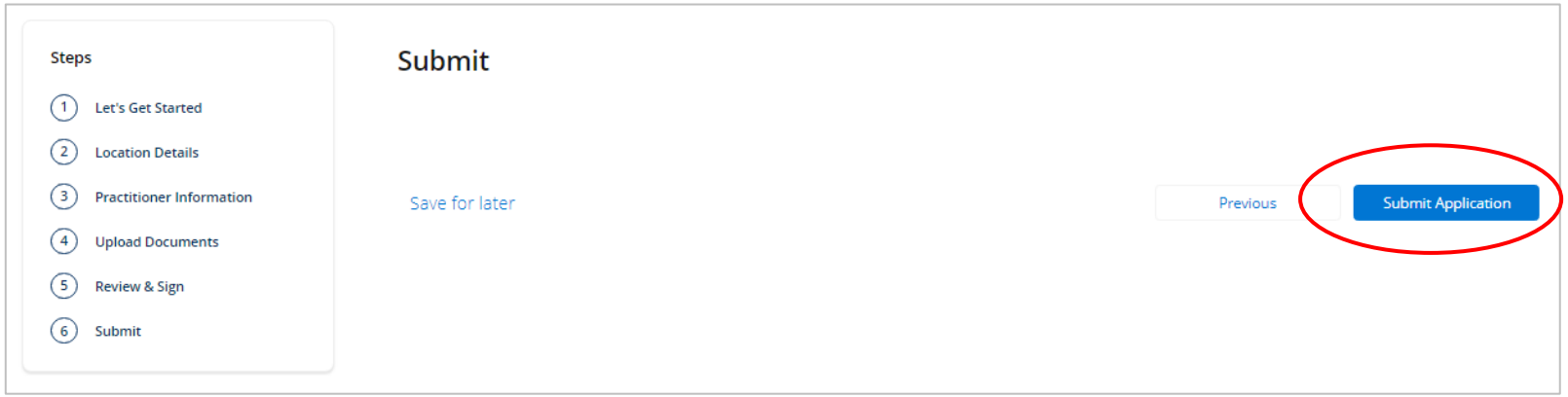
South Carolina

Steps for Making Corrections (Continued)

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



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



South Carolina

Thank you!

Your Complete Solution

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