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

Independent licensees of the Blue Cross and Blue Shield Association

Provider Administrative Office Manual

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

Revised: March 2022

In the event of any inconsistency between information contained in this handbook and the agreement(s) between you and BlueCross, the terms of such agreement(s) shall govern. The information included is general information and in no event should be deemed to be 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.

Introduction

Established in 1946 in Greenville, SC, BlueCross BlueShield of South Carolina is a mutual insurance company now headquartered in Columbia, S.C. We have major offices in Columbia, Florence, Surfside Beach, Greenville, Charleston and Camden, S.C.; Dallas, Texas; Augusta, G.A.; and Nashville, Tenn. – all serving multiple lines of business.

The BlueCross BlueShield division of the company offers health insurance to individuals and small groups in South Carolina. It also provides administrative services for larger, self-funded group health plans in South Carolina.

Subsidiary companies offer products related to other types of insurance, such as life, mental health, and substance abuse benefits. The largest subsidiaries administer federal Medicare and TRICARE contracts. Some subsidiaries are technology-focused, offering back-office claims processing, cloud hosting and other services to outside companies in our data centers.

The only South Carolina-owned and operated health insurance carrier, BlueCross is a major supporter of community and charitable causes in all its locations. It also supports health care-related research, education, and service in South Carolina through the BlueCross BlueShield of South Carolina Foundation.

A.M. Best (www.ambest.com), the world's oldest and most authoritative insurance rating and information source, has rated our group of companies at A+ (Superior*). This high rating is held by only a few health insurance companies in the nation.

BlueCross is committed to providing quality service, education and problem resolution to the health care community. This Administrative Office Manual for Providers is part of that commitment. We developed this manual to guide you through claim filing and to help you deal more effectively with our company.

We have put great effort into making sure the information in these pages is accurate. If there is any conflict between the contents of this manual and a contract or member's certificate, the contract or certificate will prevail. Likewise, if a conflict exists between the contents of this manual and a provider's contract with BlueCross, the contract will prevail.

We will make annual revisions and updates to this manual. We will update provider information in the Education Center of our website at www.SouthCarolinaBlues.com as needed.

In the event of any inconsistency between information contained in this manual and the agreement(s) between you and BlueCross BlueShield of South Carolina (BlueCross) the terms of such agreement(s) shall govern. Also, please note that BlueCross, and other Blue Cross and/or Blue Shield Plans, may provide available information concerning an individual's status, eligibility for benefits and/or level of benefits. The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits. Further, presentation of BlueCross identification cards in no way creates, nor serves to verify an individual's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits.

BlueCross BlueShield of South Carolina and BlueCross Blue Shield of South Carolina Foundation are independent licensees of the Blue Cross and Blue Shield Association.

** For the latest rating, access www.ambest.com.*

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Section 1
General Information

1.1. Contacts

We direct all phone calls and emails to a central distribution center and assign them to the provider advocate who can most efficiently handle the request. The provider advocate who responds to your inquiry may not be the one dedicated to your county but is available to respond to your inquiry.

1.1.1 Provider Advocates

Our Provider Relations and Education staff focuses on providing training and support to health care professionals. It serves as liaisons between BlueCross and the health care community to promote positive relationships through continued education and problem resolution. The staff is available for on-site office training and participation in regional practice manager meetings.

If you have a training request or question about a topic – such as compliance requirements, electronic claim filing updates and changes or problem identification/resolution – please contact the Provider Education department by calling 803-264-4730, emailing your provider advocate or using the Provider Advocate Contact Form available on www.SouthCarolinaBlues.com.

Our provider advocates cover the state of South Carolina and contiguous counties in Georgia and North Carolina. We will route your inquiry to the appropriate staff member for resolution.

1.1.2 Lines of Business

Use this list of contact information for Preferred Blue, Health Insurance Marketplace, FEP, SHP and BlueCard.

Lines of Business Contacts			
Name	**Contact Description**	**Telephone/Fax**	**Email/Web**
Preferred Blue and BlueEssentials℠	For claim status, benefits and eligibility	800-868-2510 (outside of Columbia) 800-334-2583 (Columbia area only) 803-264-4172 (Fax)	www.SouthCarolinaBlues.com (My Insurance Manager)
Federal Employee Program	For claim status and inquiries	888-930-2345 (Toll free) 803-788-0222, ext. 48800 803-264-8104 (Fax)	www.FEPBlue.org
	For benefits and eligibility		
State Health Plan	For claim status, benefits and eligibility	800-444-4311 (Toll free) 803-264-4204 (Fax)	www.SouthCarolinaBlues.com (My Insurance Manager)
BlueCard	For claim status and inquiries	800-868-2510 (outside of Columbia) 800-334-2583 (Columbia area only) 803-264-4172 (Fax)	www.SouthCarolinaBlues.com (My Insurance Manager)
	For benefits and eligibility	800-676-BLUE (2583)	

1.1.3 Other Service Areas

Use this list of contact information for Companion Benefit Alternatives (CBA), National Imaging Associates (NIA) Magellan, prior authorizations and other helpful resources.

Other Service Area Contacts			
Name	**Contact Description**	**Telephone/**	**Email/Web**
Avalon Healthcare Solutions (Avalon) Avalon is an independent company that provides laboratory benefit management services on behalf of BlueCross.	Administers laboratory medical management and precertification	844-227-5769	www.AvalonHCS.com
CBA CBA is a separate company that manages behavioral health and substance abuse benefits on behalf of BlueCross.	Credentialing for mental health physicians or practices; get mental health benefits	800-868-1032	www.CompanionBenefitAlternatives.com
OptumRx Optum is an independent company that provides pharmacy services on behalf of BlueCross.	Pharmacy benefit management and specialty pharmacy services	OptumRx 877-440-0089 (Medical specialty drugs)	Access MBMNow through My Insurance Manager
Find Care Tool	To verify provider network participation with Blue Plans nationwide	N/A	www.SouthCarolinaBlues.com or www.bcbs.com
Electronic Data Interchange (EDI)	Problems submitting claims electronically	N/A	edi.services@bcbssc.com
Electronic Data Interchange Gateway (EDIG)	Enroll your practice or billing service as a recipient of electronic data	N/A	edig.services@bcbssc.com
NIA Magellan NIA Magellan is an independent company that handles prior authorization for certain imaging services on behalf of BlueCross.	Get prior authorization for certain advanced radiology, interventional pain management, lumbar surgery and radiation oncology procedures	866-500-7664	www.radmd.com
Provider Enrollment	Credentialing, provider updates, network status	803-870-8919 (Fax)	Provider.Blue.Enroll@bcbssc.com
Technology Support Center	Technical problems with My Insurance Manager	855-229-5720	N/A

Utilization Management	Prior authorization	800-334-7287 (Preferred Blue and BlueEssentials) 800-327-3238 (Federal Employee Program) 800-925-9724 (State Health Plan)	www.SouthCarolinaBlues.com (My Insurance Manager)

1.2. News and Updates

1.2.1 Frequently Asked Questions (FAQs)

FAQs can be viewed online. FAQs are created from inquiries received from the provider community or are developed by the plan(s) in anticipation of provider questions.

1.2.2 Bulletins

View the latest BlueCross news announcements for providers online. Bulletins cover a range of important topics from all areas of our business. We alert you of a recent news bulletin via email notification, through faxed responses and by call campaigns.

1.2.3 Newsletters

BlueNews[SM] for Providers is a publication available online and emailed by request. It is for educational and research purposes only. While the articles in the newsletter are derived from sources believed reliable, BlueNews is not intended to be professional health care advice.

1.3. Health Insurance Portability and Accountability Act (HIPAA) and Electronic Data Interchange (EDI) Services

HIPAA became law in 1996. HIPAA portability provisions ensure that insurance companies do not deny individuals health insurance coverage under pre-existing conditions when the individual moves from one employer group health plan to another. HIPAA includes provisions for administrative simplification. The purpose of these provisions is to improve the efficiency and effectiveness of health care transactions by standardizing the electronic exchange of administrative and financial data, as well as protecting the privacy and security of individual health information that insurance companies maintain or transmit electronically.

HIPAA administrative simplification imposes stringent privacy and security requirements on health plans, health care providers and health care clearinghouses that maintain and/or transmit individual health information in electronic form. In addition, HIPAA mandates that EDI complies with the adoption of national uniform transaction standards and code sets, and requires new, unique provider identifiers.

1.3.1 HIPAA Transactions

The BlueCross gateway processes these ASC X12N Version 4010A1 transactions as required by HIPAA:

- 270 (Health Care Eligibility/Benefit Inquiry)
- 271 (Health Care Eligibility/Benefit Response)
- 276 (Health Care Claim Status Request)
- 277 (Health Care Claim Status Response)
- 278 (Health Care Services Review)
- 834 (Benefit Enrollment and Maintenance)
- 835 (Health Care Payment/Advice)
- 837 (Health Care Claim-Professional)
- 837 I (Health Care Claim-Institutional)

1.3.2 Transaction Code Sets

The HIPAA Transactions and Code Sets regulation (45 CFR Parts 160 and 162) required the implementation of specific standards for transactions and code sets by Oct. 16, 2003. We met this deadline and are fully HIPAA compliant.

Applicability. The regulation pertains to:

- All health plans (Medicare, Medicaid, BlueCross plans, employer-sponsored group health plans and other insurers).
- All vendors and clearinghouses (e.g., billing services, re-pricing companies and value-added networks that perform conversions between standard and non-standard transactions).
- All providers (physicians, hospitals and others) who conduct any of the HIPAA transactions electronically.

Purpose. The intent of HIPAA's Administrative Simplification regulation is to achieve a single standard for claims, eligibility verification, referral authorization, claims status, remittance advice (e.g., Explanation of Benefits) and other transactions. Adoption of standard transactions should streamline billing, enhance eligibility inquiries and referral authorizations, permit receipt of standard payment formats that can post automatically to your accounts receivable system and automate claims status inquiries.

Your Responsibility. HIPAA requirements impact the majority of physicians and other providers, but not all. You should assign responsibility for ensuring compliance with the transactions and code sets to a specific person within your office who can work with the information systems vendors, payers and clearinghouses, as applicable. Also, you should establish a process to monitor the status of new regulations and changes to comply with them as they become effective.

1.3.3 Trading Partner Agreements

Trading Partner Agreements. In general, a trading partner is any organization that enters into a business arrangement with another organization and agrees to exchange information electronically. Typically, the two organizations develop a contract or agreement to describe this arrangement. BlueCross requires providers or their vendors to complete a Trading Partner Agreement (TPA). You can find the TPA application at www.HIPAACriticalCenter.com under Enrollments and Agreements.

Companion Guide. A companion guide clarifies the specifics about the data content a provider transmits electronically to a specified health plan. For example, it may clarify what identification number is needed for the Payer Identifier data element. We call our companion guides "Supplemental Implementation Guides" (SIGs), since they supplement the HIPAA Implementation Guides. These guides address the situational fields that HIPAA allows for and explain how we use these fields. You can find all our guides at www.HIPAACriticalCenter.com.

Supplemental Implementation Guide (SIG). There are data elements that we require in all cases (these are called "required"), and there are data elements we require only when the situation calls for them (these are called "situational"). Many situational data elements are related to the specialty of the physician. While you may choose to rely on your vendor to provide you with the necessary upgrade to capture the applicable data, it may be prudent to validate that the vendor has supplied all the necessary data for two reasons:

i. It is the provider's responsibility to be compliant. If you are not compliant, you risk having us return claims or even fine you for non-compliance.

ii. Vendors are not covered entities under HIPAA. Most vendors will do the best they can to assist their clients in becoming HIPAA compliant, but it is critical for you to ensure that your software upgrade meets the HIPAA requirements.

iii. The capture of additional data usually means changes in business processes. You may need to change procedures or alter workflow. By understanding the new data, you need to capture, you can plan where to make any necessary changes in your office.

Understanding the data requirements, however, is not easy. You may want to consider getting expert assistance, especially if you are a multi-specialty practice. If you decide to begin the task of validating your data requirements yourself, you should get a copy of the SIGs.

1.3.4 Electronic Funds Transfer (EFT)

Complete the Electronic Funds Transfer and Electronic Remittance Advice (ERA) form to participate in the EFT program and if your practice does not currently receive an ERA. The authorized person who signs this form must also sign the EFT Terms and Conditions. You can fax completed forms to 803-870-8065, Attn: EFT Coordinator; or email to provider.eft@bcbssc.com. The EFT and ERA form is available on www.SouthCarolinaBlues.com.

EFT deposits payments directly into your bank accounts, allowing you to receive funds before BlueCross mails checks.

1.3.5 Electronic Remittance Advice (ERA)

Providers with electronic file transfer capabilities can choose to receive the 835 ERA containing their

Provider Payment Registers. Once you download the remittance files at your office, you can upload the files into an automated posting system. This eliminates a number of manual procedures.

If you are adding or changing billing services or clearinghouses, please complete the ERA Addendum-Billing Services and Clearinghouse or ERA Addendum-Corporate Headquarters found on www.HIPAACriticalCenter.com. You will not need the BlueCross EDIG Trading Partner Enrollment form when only requesting 835 transactions for existing trading partners.

Remittance advices are available in My Insurance Manager and My Remit Manager.

1.4. Website

Visit the Provider page of www.SouthCarolinaBlues.com for educational information, news, updates, resources and forms.

To protect privacy and comply with HIPAA standards, we use the latest encryption technology to ensure that no unauthorized person can access protected health information (PHI).

1.4.1 News and Updates

We have many informational publications for providers, including this manual. These publications are available on our website. By placing our publications on the website, we can provide you with important information quickly and accurately.

1.4.2 Resources

We've developed several resources to make your interactions with BlueCross easy and efficient. Document types include instructional manuals, user guides, managed care magazines, quick reference guides and educational handouts. Resources are available to view online or to print. You can find these documents:

- Provider Office Administrative Manual
- BlueNews for Providers newsletter
- Provider News Bulletins
- My Insurance Manager User Guides
- Identification (ID) Card Guide
- FAQs

1.4.3 Forms

All forms are available to download and print on the Forms page of www.SouthCarolinaBlues.com. Many are also available in a Spanish version. Some of the forms you may find most useful are explained below.

a. *Other Health/Dental Insurance Questionnaire* – Ask your patients to update this information annually or when a change occurs in other health and/or dental coverage, including Medicare, that the subscriber or any covered dependent may have.

b. *Electronic Funds Transfer and Electronic Remit Advice Enrollment form* – Complete these forms if you want to participate in the EFT program and/or do not currently receive an ERA. The authorized person who signs this form must sign the EFT Terms and Conditions. You can fax completed forms to 803-870-8065, Attn: EFT Coordinator, or email to provider.eft@bcbssc.com. An authorized person at

your company must sign the required EFT Terms and Conditions Form and submit it along with the EFT and ERA Enrollment Form. The authorized person who signs this form must also sign the EFT and ERA Enrollment Form.

c. *Overpayment Refund Form* – Complete this form when sending BlueCross unsolicited (voluntary) refund checks.

d. *Provider Reconsideration (Appeal) Form* – Use this form to request review of a claim that has processed with an adverse determination. It ensures the medical information and supporting documentation you fax, or mail gets to the right area at BlueCross.

1.4.4 Registering for Trainings

As part of our service efforts, we have created Palmetto Provider University. This curriculum educates new and experienced providers, along with their staff, on our business objectives and processes.

From the Provider page of www.SouthCarolinaBlues.com, select the Provider Training link from the Education Center drop-down menu. View a complete list of current course offerings and descriptions from the Palmetto Provider University page. Choose the link to complete the registration form. Submit the registration.

You will receive a confirmation email that includes instructions for logging on for the selected webinar.

1.4.5 Provider Advocate Map and Contact Form

You can view the provider advocates according to county by using the Provider Advocate State Map. It is located on our website on the Contact Us page. To access the map, choose the statement "Educational support for BlueCross and BlueChoice HealthPlan of South Carolina plans that is not related to claims status," then follow the hyperlinks to the Provider Advocate Map.

If you have a training request or question that is not related to specific claims or patients, please contact your county's designated provider advocate by using the Provider Advocate Contact Form. It is located on our website on the Contact Us page. To access the contact form, choose the statement "Educational support for BlueCross and BlueChoice HealthPlan of South Carolina plans that is not related to claims status," then follow the hyperlinks to the Provider Advocate Contact Form.

1.4.6 Locating Patients' Schedule of Benefits

You can access a patient's benefit booklet when viewing eligibility and benefits in My Insurance Manager. From the Patient Care tab, select Eligibility and Benefits for Health from the drop-down menu. Enter the required data, then select Continue. Choose eligibility view according to general, service type or procedure code, then select Submit. Select See Member Benefit Booklet.

1.5. Electronic Solutions and Provider Self-Help

1.5.1 My Insurance Manager

My Insurance Manager is an online tool providers can use to access these options:

- Benefits and Eligibility
- Claims Entry

- Prior Authorization Request and Status
- Claims Status
- Remittance Information
- Your Mailbox
- EDI Reports

It is a valuable provider tool that can be freely accessed after you have registered with a valid Tax ID number on our system. Secure encryption technology ensures any information you send or receive is completely confidential. My Insurance Manager can provide you with eligibility information and general benefits for members in Preferred Blue, Federal Employee Program, State Health Plan and Health Insurance Marketplaces. It can also give eligibility information and general benefits at the service-type level for BlueCard members.

My Insurance Manager is not available during weekly maintenance on Sunday evenings from 5 p.m. until midnight.

How to Register. Select the My Insurance Manager tab on www.SouthCarolinaBlues.com. Choose Create a Profile, and then enter your Tax ID number for BlueCross. Create a username and password. Your profile administrator and each authorized user must have a unique username and password registered in My Insurance Manager. Submit the information. You are now ready to access My Insurance Manager.

1.5.2 My Remit Manager

My Remit Manager is an online tool provider can use to search remittances by patient, account number and check number. It is free to all providers who receive EFT payments and ERAs. It accepts 835s from all commercial BlueCross lines of business, and it works independently of your practice management system or clearinghouse.

Use My Remit Manager to:

- View ERA information by file and see all details. You have the option of viewing the specific American National Standard Institute (ANSI) details the payer sends or the standardized information in a conventional format.
- Instantly see patient errors and denials. The system highlights any claims that have errors or that BlueCross has denied.
- View information categorized by check numbers or by patient. It clearly lists the name of each patient whose EOB is associated with an individual check or EFT.
- Print individual remits for a single patient. Eliminate the need to remove or black out other patient information on the remit.
- Print remits for selected patients. Print individual or group remits.
- Generate and analyze reports. Analyze claim, payment, subscriber, CPT code, etc., and specific data over a specific time period.

How to Register. You can register to use My Remit Manager by completing our Provider Advocate Contact Form or by emailing Provider.Education@bcbssc.com.

1.5.3 Electronic Data Interchange (EDI)

The BlueCross EDI department facilitates electronic transfer of data services to health care providers and serves as a communication link between your office and BlueCross.

There are three primary methods available for electronically submitting your claims:

1. Direct submission
2. Clearinghouse submission
3. Data entry via the web using My Insurance Manager

Some of the features and benefits of the electronic claim submission are:

- Shortened reimbursement cycle
- Reduced office administrative costs
- Decreased claim preparation costs
- Verification of receipt of claim
- Error identification for immediate correction

For assistance or information about submitting electronic claims, please contact the EDI Help Desk at 800-868-2505. We require all professional providers to submit electronic claims in the HIPAA X12 format. You can also view a list of vendors who are currently submitting HIPAA-compliant claims to us as certified vendors at www.HIPAACriticalCenter.com.

1.5.4 Voice Response Unit (VRU)

The VRU is available 24 hours a day, seven days a week. The VRU is a fully automated tool that provides quick and easy information to providers seeking benefits and eligibility, routine claim status and refund statuses. If the requested information is available in the VRU, you will not have the option to speak to a provider services representative.

- For BlueCross member information, call:
- South Carolina – 800-868-2510
- Columbia/Lexington area – 788-8562
- Out of state – 800-334-2583
- For BlueCard member information (members who have coverage with another BlueCross plan outside of South Carolina): 800-676-BLUE (2583).
- For SHP member information, call 800-444-4311.
- For FEP member information, call 888-930-2345.

See our VRU Guide in the Education Center of our website for information you'll need and tips on navigating menu options. If you still have questions about eligibility, benefits or claims, My Insurance Manager has the answers! If you have not visited the website recently, please go to www.SouthCarolinaBlues.com and sign in to My Insurance Manager for the most efficient and user-friendly experience.

1.5.5 VRU Fax Back

Our Fax Back option is also available through the VRU. Simply enter your fax number, and we will fax the member's benefits or claim status directly to you. You will usually receive the fax in less than five minutes, and you can keep it in the patient's file for future reference.

For BlueCard members, the VRU is only available for claim status inquiries. To check eligibility and benefits, please call
800-676-BLUE (2583).

1.5.6 STATchat

STATchat is a fast, free and simple way to talk with a provider services representative after you've searched online for the answer to a claim status or eligibility question. To use STATchat, log in to My Insurance

Manager. When you view member claims status or eligibility and benefits, select the "Connect" button at the top of the page to speak to a provider services representative online. You will receive priority service and be connected to the next available agent. To ensure quick service for all customers, please limit use to only one issue per call.

System Requirements:

- Adobe Flash Player*
- A compatible web browser: EDGE*, Mozilla Firefox* or Google Chrome*.
- A headset (recommended) or stand-alone microphone and speakers connected to your computer.

*Must be a version currently supported by the manufacturer.

Firewall Configuration:
Your firewall should allow outgoing UDP to the public internet from the browsers that will be using STATchat and allow return traffic in response. If your router includes SIP Application Level Gateway (ALG) function or Stateful Packet Inspection (SPI), disable both these functions for the *.twilio.com domain.

Bandwidth Requirements:
For each concurrent call, allow WebRTC: 8 kB/s. This does not scale based on bandwidth. On browsers using Flash, fallback bandwidth requirement is 6 kB/s.

Port Requirements:

Component	Address	Client-side Port Used	Server-side Port Used	Protocol
Signaling	*.twilio.com	Any (1,024 to 65,535)	443	TCP
RTP	54.172.60.0/23, 34.203.250.0/23	Any (1,024 to 65,535)	10,000–20,000	UDP

If you experience problems, please call for technical help at 855-229-5720.

1.6. Enrollment and Contracting

BlueCross gives potential network applicants the Provider Enrollment Application, specific network contracts and professional agreements for network participation. In the second quarter of 2022, all enrollment applications and communications will go through My Provider Enrollment Portal, our new enrollment tool which will give providers who credential with BlueCross BlueShield of South Carolina a new way of completing their enrollment processes, one that is quick and easy to navigate.

1.6.1 Certifying Physicians

To apply for network participation, you must complete the application, include the required documentation, and submit it to BlueCross through My Provider Enrollment Portal. We will notify you of any missing or incomplete information. The average processing time for enrollment is 90 business days from when we receive a completed application. Any missing or incomplete information will delay the enrollment process.

Once our Enrollment department receives a fully completed application, it will take approximately 30 to 60 days to complete the process.

Until a physician has successfully completed the enrollment process, we cannot publish his or her name in the BlueCross Network Directory, nor will members be able to select him or her as their physician. The

effective date will be the date of approval by the Credentialing committee. Effective dates are not retroactive.

Note: You only need to submit one Provider Enrollment Application, regardless of the number of networks for which you are applying.

1.6.2 Certifying Mid-Level Practitioners

Physician Assistants (PAs). BlueCross credentials PAs. PAs can choose to file claims for services they provide in the office under their NPI once they have credentialed with the plan; **OR** they can bill under the supervising doctor's NPI.

Nurse Practitioners (NPs). BlueCross cannot credential NPs who are not under direct supervision of a doctor. If an NP has not been credentialed by BlueCross, they must bill under the supervising doctor's NPI. If an NP has been credentialed with BlueCross, they can bill for services under their NPI; **OR** under the supervising doctor's NPI.

BlueCross does **not** credential these specialties:

Associate Counselor	Diabetes Educator	Sports Trainer
Massage Therapist	Education Specialist	Technician
Dietitian	Homeopath	Christian Science Practitioner
Physical Therapy Assistant	Lay Midwife	Occupational Therapy Assistant
School Psychologist	Naturopath	Recreational Therapist
Acupuncturist	Psychology Assistant	

1.6.3 Provider File Updates

For us to maintain accurate participating provider directories and also for reimbursement purposes, providers are contractually required to report all changes of address or other practice information electronically. Changes may include:

- Provider name
- Federal tax ID number
- NPI
- Physical and billing addresses
- Telephone number, including daytime and 24-hour numbers
- Fax number
- Email address
- Hours of operation
- Practice URL (website)
- Name changes, mergers or consolidations
- Languages spoken
- Accepting new patients
- Age range and gender of patients accepted
- Group affiliations
- Practice management system

As part of the Consolidated Appropriations Act (CAA), effective Jan. 1, 2022, providers must verify and/or

update their demographic data at least every 90 days. Validations can be made within My Insurance Manager using M.D. Checkup and are determined based on the number of days since the last validation was made. If more than 90 days has passed since the provider's last validation, we are required to remove them from our directories.

1.6.4 Change of Ownership

You must promptly notify BlueCross if your organization changes ownership. Complete the Application for Clinic/Group/Institution/Location to File Claims or to Change Employer Identification Number (EIN) which is located inside My Provider Enrollment Portal.

1.6.5 Recredentialing

BlueCross requires all health care providers to go through recredentialing every three years. We will notify provider when it is time to begin the recredentialing process. Recredentialing is also performed through My Provider Enrollment Portal.

1.6.6 Networks and Participation

BlueCross supports several provider networks, including: Preferred Blue (FEP also uses this network), State Health Plan, and BlueEssentials Exclusive Provider Organization (EPO).

1.6.7 Fee Allowances

The Preferred Blue Professional Agreement states that a preferred provider will accept the fee allowance for covered services — (defined as the provider's normal charge or the Preferred Provider Organization PPO allowance, whichever is lower) — as payment in full. Do not bill the member for any amount that exceeds the fee allowance. The member is not financially responsible for anything other than applicable copayments, coinsurance and deductibles.

1.6.8 Language and Provisions

Each preferred provider's agreement lists the contractual responsibilities of both BlueCross and that preferred provider. Here is a general summary of the agreements:

- The preferred provider will file all claims for all applicable members.
- BlueCross will reimburse the preferred provider for covered services based on the member's contract. Fee allowances are the lower of the preferred provider's charge for a procedure or the Preferred Blue fee schedule of maximum allowances.
- The preferred provider will accept BlueCross' or Associate Plan's payment plus any patient copayments, coinsurance and deductibles as full reimbursement. The preferred provider will not bill the patient for more than his or her applicable patient liability amount, not to exceed the fee allowance.
- The preferred provider agrees to cooperate fully with the utilization review procedures in the agreements.
- The preferred provider will use other preferred providers for a member's care unless medically necessary services, supplies or equipment are not available from a preferred provider, or in cases of medical emergencies or urgently needed services.
- The preferred provider agrees to bill promptly and, in a manner, approved by BlueCross for all services. Electronic claims submission (ECS) in the 837I or 837P HIPAA-compliant format is the preferred method of filing.
- To the extent that a written agreement allows for sub-contracting with participating providers, the

written agreement specifies that all sub-contracts will be subject to the terms of the written agreement.

If you have any questions about contracting, please submit a request by going to the Contact Us page on our website.

Section 2
Product (Plan) Information

2.1. Product (Plan) Overview

2.1.1 Benefit Structure

Each BlueCross insurance plan, whether group or individual, offers a variety of coverage. In addition, plans may also have different precertification and mental health requirements. Plans may also have separate insurance vendors for certain benefits, such as vision or dental.

2.1.2 How Members Access Physicians and Health Care Professionals

Members are encouraged to access care from an in-network doctor or other health care provider for Blue Cross and Blue Shield Plans nationwide. To determine whether you are in network for a particular member's plan, use the Find Care Tool at www.SouthCarolinaBlues.com or the Doctor and Hospital Finder at www.bcbs.com. Providers participating in the network are displayed based on the member's prefix.

2.2. Member Identification (ID) Cards Overview

2.2.1 How to Identify Members

When members arrive at your office, remember to ask to see their current member ID cards at each visit. This will help you identify the product the member has and get dental plan contact information. It will also help you with filing claims. Please note that all ID cards do not look the same and are for identification purposes only. They do not guarantee eligibility or payment of your claim.

Important Facts About the ID Card Prefix

- Using the correct ID card prefix is critical for electronic routing of specific HIPAA transactions.
- It is important to capture all ID card data at the time of service.
- Do not assume that a member's ID card number is his or her Benefits Identification Number.
- Be sure all of your system upgrades accommodate the ID card prefix and all characters that follow it.
- Do not add, delete or change the sequence of characters or numbers in a member's ID card number.
- Make copies of the front and back of the ID card. Share this information with your billing staff.

Please refer to our Member Identification Card Reference Guide on www.SouthCarolinaBlues.com if you have questions about BlueCross ID cards.

2.2.2 Verifying Eligibility and Benefits

Use My Insurance Manager to verify eligibility and benefits. Select the plan for which you want to review eligibility and benefits. Choose your eligibility view according to general benefits, service type or procedure code. Unless otherwise required by state law, the 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 a deductible, may change as additional claims are processed.

- For Preferred Blue and BlueEssentials Plan members, you can call the Provider Services VRU at 800-334-2583 (Columbia area only) or 800-868-2510 (outside of Columbia). The fax number is 803-264-4172.
- For FEP plan members, you can call Provider Services at 888-930-2345 or 803-788-0222, ext. 48800. The fax number is 803-264-8104.

- For SHP members, you can call Provider Services at 800-444-4311. The fax number is 803-264-4204.
- For out-of-state (BlueCard) members, you can call 800-676-BLUE (2583).

2.2.3 Sample ID Card

Sample ID Card

2.3. Preferred Blue

2.3.1 Product Name(s)

There are multiple group product lines that access the broad commercial Preferred Blue network. Plan benefits vary. Some Preferred Blue products are grandfathered, while others are non-grandfathered.

2.3.2 Network

Preferred Blue is a line of PPO health insurance plans we offer. The product's benefit structure gives members financial incentives for seeking medical care from a network of preferred providers in South Carolina.

2.3.3 Requirement for Referral to Specialist

Generally, members can see a specialist of choice without permission from this plan. Providers should always refer members to other in-network providers when necessary.

2.3.4 When the Treating Physician and/or Facility is Required to Give Notice for Certain Services

Inpatient Services. BlueCross requests notification for any admission to a hospital or SNF. This notification enables the member to access optional benefits, such as case management and disease management programs, along with discharge planning. The preferred method for submitting precertification requests for Preferred Blue members is through My Insurance Manager on our website, www.SouthCarolinaBlues.com.

Outpatient Services. Other services may also require prior authorization. These outpatient providers may require precertification.

- Septoplasty
- Sclerotherapy performed in an outpatient or office setting

- Chemotherapy/radiation therapy (one-time notification) *
- Hysterectomy
- Procedures that may be cosmetic in nature [You must submit these for review in writing five to seven days before the scheduled procedure. Include pictures if appropriate (blepharoplasty, reduction mammoplasty, TMJ surgery, etc.)]

You can get prior authorization using the Authorization/Precertification/Referral link in My Insurance Manager. This feature also includes the Referral and Authorization Status functions.

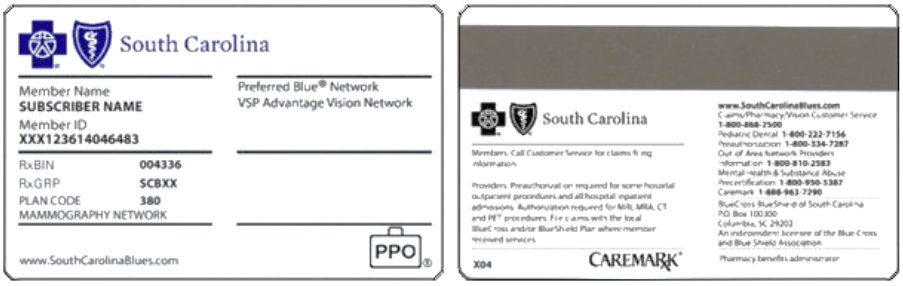
*BlueCross has added special programs for patients undergoing chemotherapy and radiation therapy. Please notify us of any patients receiving these treatments. You will only need to notify us once for a patient's course of treatment.

Some PPO plans may have precertification requirements that differ from the previous list (i.e., some plans require prior notification for physical, speech and occupational therapies). Check for plan-specific precertification requirements before providing services and request a precertification via My Insurance Manager.

Note: Prior authorizations do not guarantee payment of benefits. Claim payments are subject to the rules of the plan. Members are not responsible for denied charges if authorization is not received.

2.3.5 Sample ID Card

Sample BlueCross (Large Group) ID Card



2.4. Federal Employee Program (FEP)

The Federal Employee Program (FEP) offers benefits for our FEP members, retirees and their families. It is a non- grandfathered plan.

2.4.1 Product Name(s)

There are two plan options, Basic and Standard. Basic plan members do not have out-of-network benefits. The Standard plan operates as a traditional PPO, allowing members to see both in-network and out-of-network providers.

2.4.2 Network

FEP uses the broad commercial Preferred Blue provider network. Providers participating in the Preferred Blue network automatically participate with FEP.

2.4.3 Requirement for Referral to Specialist

FEP members do not need a referral to see a specialist.

2.4.4 When the Treating Physician and/or Facility is Required to Give Notice for Certain Services

FEP Inpatient Services. All inpatient hospitalizations for FEP members require precertification if FEP is primary. We must receive inpatient admission authorizations 24 to 48 hours before services. Please include this information when requesting an FEP precertification:

- Patient's name
- ID number
- Callback number

Failure to get precertification within two business days following the day of an emergency admission, or getting authorization after admission on an elective admission, will result in a $500 provider penalty. Members are not responsible for this penalty if authorization is not received.

FEP Hospice Services. Hospice services do require prior authorization. Providers can call 800-327-3238 or fax
803-264-0258 for FEP precertification.

FEP Outpatient Services. In general, most outpatient procedures for FEP members do not require prior authorization. You must get prior authorization for all surgeries related to morbid obesity and congenital anomalies, as well as oral maxillofacial surgical procedures to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth. Intensity-modulated radiation therapy (IMRT), as well as the breast cancer and ovarian cancer (BRCA) gene test, also require prior authorization.

We require genetic counseling and evaluation in addition to prior authorization for preventive BRCA testing.

FEP Durable Medical Equipment (DME). FEP does not require precertification for any DME products, but they are subject to medical necessity and individual contract benefit limitations. We do require a Certificate of Medical Necessity (CMN). Supplies are not reimbursable when the member is renting the equipment. The preferred method of submission is electronic for all DME claims.

2.4.5 Sample ID Card

FEP ID numbers begin with the letter "R," and the card reads, "BlueCross BlueShield Federal Employee Program."

Sample FEP Basic Plan ID Card

2.5. State Health Plan (SHP)

2.5.1 Product Name(s)

The SHP consists of two separate plans, the Savings Plan, and the Standard Plan. You can view a member's SHP benefit booklet by logging in to My Insurance Manager on our website. You can also access member benefit booklets on the SHP employee website at https://StateSC.SouthCarolinaBlues.com/web/public/statesc/.

2.5.2 Network

SHP is a self-insured grandfathered medical plan available for state of South Carolina employees and their families. It offers valuable medical coverage if a member becomes sick or injured. It also offers some limited services for routine care.

The South Carolina Public Employee Benefit Authority (PEBA) determines the benefits, develops reimbursements and governs the SHP. BlueCross administers the SHP, providing claims management; customer and provider services; and medical management.

2.5.3 Requirement for Referral to Specialist

SHP members do not need a referral to see a specialist.

2.5.4 When the Treating Physician and/or Facility is Required to Give Notice for Certain Services

You can request precertification at www.SouthCarolinaBlues.com by logging in to My Insurance Manager or by calling Medi-Call at 800-925-9724. Medi-Call is a division of BlueCross that handles the medical precertification and case management services for the SHP.

SHP Inpatient. All SHP inpatient procedures and admissions require precertification. The SHP has a special deductible for each emergency room visit. The plan waives this special copayment if the hospital admits the patient.

- All admissions for obstetrical and sick newborn services
- Hospitalizations that are longer than the length of stay that Medi-Call previously authorized

SHP Outpatient. There is a special copayment for each outpatient visit. These outpatient procedures require precertification for SHP members:

- Pregnancy
- Any non-emergency surgery (e.g., septoplasty, hysterectomy or sclerotherapy)
- Chemotherapy or radiation therapy
- In vitro fertilization for the member or spouse
- Extended care services, such as hospice, home health care, SNF or DME
- Any medical treatment involving inpatient rehabilitative services and extended care
- Organ transplant, bone marrow transplant or other stem cell rescue or tissue transplant
- Any procedure that may potentially be considered cosmetic in nature (e.g., blepharoplasty, reduction mammoplasty, TMJ or other jaw surgery, etc.), requires written precertification to Medi-Call seven days before the scheduled procedure
- MRI
- MRA
- CT scan
- Chemotherapy/radiation therapy (one-time notification) *
- Synagis

*BlueCross has added special programs for patients undergoing chemotherapy and radiation therapy. Please notify us of any patients receiving these treatments. You will only need to notify us once for a patient's course of treatment.

Members are not responsible for denied charges if authorization is not received.

Members who fill prescriptions for specialty medication must use the Plan's custom credentialed specialty network. The network will include Accredo, Express Scripts' specialty pharmacy and accredited locally-owned pharmacies. Patients seeking specialty medication should contact Express Scripts at 855-612-3128 for more information.

State Health Plan requires authorization for medical specialty drugs through MBMNow. MBMNow is an online prior authorization tool accessible through My Insurance Manager with single sign-on.

2.5.5 Sample ID Card

The SHP and State Savings Plan prefix is ZCS. Newer cards reflect the PEBA logo.

Sample SHP Standard Plan ID Card

2.6. Health Insurance Marketplaces (Exchanges)

Health plans in the individual and small group markets are offered through the Federally Facilitated Marketplace (FFM) and private marketplaces. The federal government manages the FFM, and insurance companies manage private marketplaces. Plans are available to both individuals who may be uninsured, underinsured or otherwise eligible for federal subsidies and small businesses.

2.6.1 Product Name(s)

The individual ACA products BlueCross offers are called BlueEssentials℠ and are non-grandfathered products. Non-grandfathered health plans must offer a core package of items and services (essential health benefits).

BlueCross also offers small group ACA plans to businesses with two to 50 employees. These plans are called Business BlueEssentials.

2.6.2 Network

BlueEssentials is a line of individual EPO health insurance plans we offer that use the BlueEssentials Network. BlueEssentials members do not have out-of-network benefits or benefits when services are provided outside of South Carolina. However, services from providers in contiguous counties (bordering counties outside of South Carolina) that are currently contracted and participate in the BlueEssentials networks are considered in-network.

BlueCross small group ACA plans (Business BlueEssentials) use the Preferred Blue (PPO) network.

2.6.3 Requirement for Referral to Specialist

Exchange plan members do not need a referral to see a specialist.

Transition of Care. If a BlueEssentials member is under the care of a physician who is not in the BlueEssentials network, he or she can request special consideration to have us apply benefits at in-network levels. Members can submit a Transition of Care form for consideration. Upon review by our Utilization Management area, we may approve a member to continue care with the out-of-network provider for a specified time. Members will be responsible for the difference between the amount the health plan pays for those services and what the provider charges. Please note, requests should only be made when there is not an in-network provider that can perform the services the patient requires.

2.6.4 When the Treating Physician and/or Facility is Required to Give Notice for Certain Services

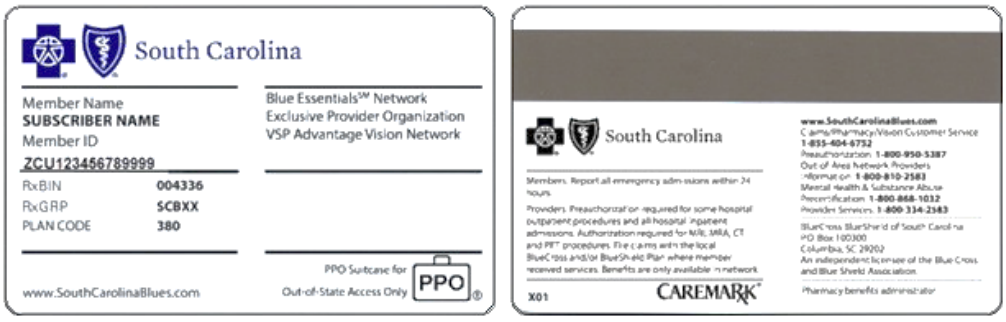
These services or treatments require authorization:

- Hospital admission, including maternity notifications
- SNF admission
- Continuation of a hospital stay for a medical condition
- Outpatient hysterectomy or septoplasty
- Home health care or hospice services
- DME, when the purchase price or rental is $500 or more
- Admissions for habilitation, rehabilitation and/or human organ and/or tissue transplants
- Treatment for hemophilia
- Mental health and substance use disorders
- Cosmetic procedures
- Advanced radiology (required through NIA Magellan)
- Musculoskeletal care, such as interventional spine management services and lumbar and cervical spine surgeries (required through NIA Magellan)
- Radiation oncology (required through NIA Magellan)
- Nuclear cardiology (required through NIA Magellan)
- Certain labs (through Avalon)
- Certain prescription drugs, all compound drugs and all specialty pharmacy drugs (through OptumRx)
- All specialty medical drugs (through MBMNow, OptumRx's online prior authorization tool)
- Dialysis treatment

2.6.5 Sample ID Card

Prefixes for the individual ACA products are ZCF, ZCU and ZCQ. Prefixes for the small group ACA products are ZCR and ZCV. The suitcase on the front of the card, lower right, indicates the network member's access when out of state.

Sample BlueEssentials Individual Private Plan ID Card



2.7. BlueCard Program

As a participating provider of BlueCross, you may render services to patients who are National Account members of other Blue Plans, and who travel or live in South Carolina.
The BlueCard program lets you submit claims for Blue Plan members directly to your local BlueCross. We will be your point of contact for education, contracting, claims payment/adjustments and problem resolution. Refer to the 2018 BlueCard Program Provider Manual for complete out-of-area Plan information.

2.7.1 Product Name(s)

A variety of products and claim types are eligible for delivery via BlueCard; however, not all Blue Plans offer all of these products to their members. Currently, BlueCross BlueShield of South Carolina offers products in these categories:

- Traditional (indemnity insurance)
- PPO
- Health maintenance organization (HMO)
- Medicare Advantage (MA)*

*MA is a separate program from BlueCard. You may see members of other Blue Plans who have MA coverage.

Product Exclusions. We exclude these claims from the BlueCard Program:

- Stand-alone dental
- FEP

Please follow the BlueCross BlueShield of South Carolina billing guidelines.

2.7.2 Network

The BlueCard program links participating health care providers across the country and internationally through a single electronic network for claims processing and reimbursement.

2.7.3 Requirement for Referral to Specialist

BlueCard Program members may need a referral to see a specialist. Contact their home plan.

2.7.4 When the Treating Physician and/or Facility is Required to Give Notice for Certain Services

As a BlueCross provider, you are responsible for getting precertification/preauthorization for inpatient and/or outpatient services from a member's Blue Plan. Participating providers are responsible for getting preservice review for inpatient facility services when the account or member contract (provider financial responsibility) requires it.

BlueCross BlueShield of South Carolina and other Blue Plans launched a tool called Electronic Provider Access (EPA). This tool gives you the ability to access out-of-area members' Blue Plans' (home Plan) provider portals to conduct electronic preservice review through a secure routing mechanism. The term "preservice review" refers to prenotification, precertification, preauthorization and prior approval, among other pre-claim processes.

2 .7 .5 Confidentiality and Data Use

Your use of Confidential Information and/or Inter-Plan Data shall be strictly for the purpose for which it was disclosed. This use must be consistent with our data use and display requirements.

You are not permitted to re-sell Confidential Information and/or Inter-Plan Data.

You are not permitted to de-aggregate Inter-Plan Data to identify a Licensee, National Account and/or Member information.

You shall limit the use of Confidential Information and/or Inter-Plan Data to the minimum amount necessary to fulfill the purpose for which it was disclosed.

You may not Comingle Inter-Plan Data without our prior written consent.

You agree that we shall be able to audit your compliance with this Section relative to the use and disclosure of Confidential Information and/or Inter-Plan Data, provided that we will give you reasonable notice of the audit and shall make reasonable efforts to perform the audit in a way that minimizes disruption to your business.

You agree to return or destroy all copies of Confidential Information and/or Inter-Plan Data, upon conclusion of the purpose(s) for which it was disclosed. Should you be unable to completely return or destroy the Confidential Information and/or Inter-Plan Data because of legal or licensure requirements, you must maintain the confidentiality of the Confidential Information and/or Inter-Plan Data pursuant to the terms of this Section until the expiration of the applicable legal or licensure requirement. Upon expiration of that requirement, the Confidential Information and/or Inter-Plan Data must be returned or destroyed.

You agree that you shall notify us within thirty (30) days of any change in your ownership interests.

2.7.6 Sample ID Card

The ID cards may have: PPO in a suitcase logo, PPOB in a suitcase logo or a blank suitcase logo. The PPO in a suitcase logo indicates that the member is enrolled in either a PPO or EPO product. The PPOB in a suitcase logo indicates the member has selected a PPO or EPO exchange product from a Blue Plan. The empty suitcase logo indicates the member is enrolled in either a traditional or an HMO product. Some Blue ID cards do not have a suitcase logo.

The prefixes will vary. They are critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.

Sample Blue Plan ID Card

2.8. Other Products

2.8.1 Medical University of South Carolina (MUSC)

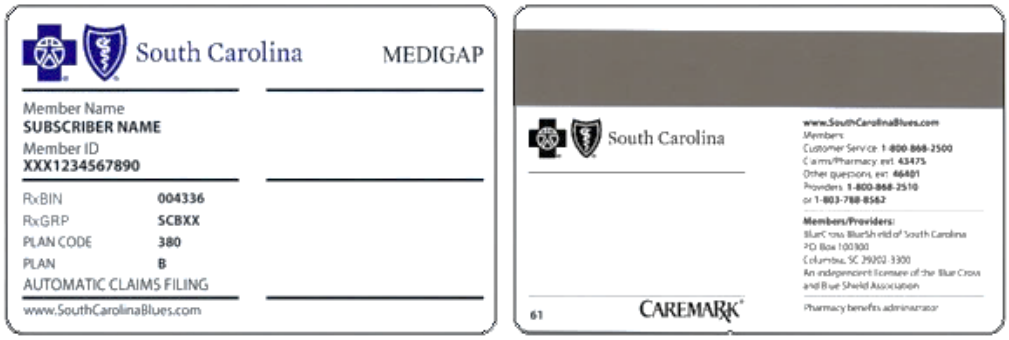
The MUSC Plan is a State Plan specific to MUSC employees and dependents. If a covered member presents an MUSC Plan ID card and the provider is not in the MUSC network, then the Standard Plan benefits would apply for the member. The MUSC Health Plan prefix is ZCK.

Sample SHP MUSC Health Plan ID Card

2.8.2 Medicare Supplemental Products

BlueCross offers Medicare supplement plans to help fill the gaps in Medicare coverage. BlueCare® Standard Plans and Blue Select® Plans are the available products. Plans typically pay the Medicare deductible or the coinsurance, or sometimes both. Medicare supplemental plans do not cover services that Medicare denies.

Sample BlueCross Medigap ID Card



2.8.3 Third Party Administrators (TPAs)

Several health insurance administrators use the BlueCross Preferred Blue network of health care providers. Here are active TPAs that access the network:

- Planned Administrators, Inc. (PAI)
- Thomas H. Cooper & Company, Inc. (TCC)
- Key Benefit Administrators

PAI and TCC are separate companies, and Key Benefit Administrators is an independent company, that provide third party administration services on behalf of BlueCross.

Precertification for services follows the rules of each plan. Please review the member's ID card to determine the appropriate contact numbers for precertification. File all TPA claims electronically to BlueCross using the appropriate carrier codes. BlueCross will forward the claim electronically to the individual TPA.

The TPA will apply benefits, adjudicate the claim and make payment on its remittance advice. Contact the individual carriers for claim status.

Place your provider number in the appropriate form indicator for the 837 (I and P) when filing claims. Follow these same instructions for entering the rendering provider's NPI number.

2.9. Other Benefits

2.9.1 Dental

Each BlueCross plan offers a variety of coverage and differs by employer. Please verify eligibility and benefits before providing services.

BlueEssentials plans no longer use the Participating Dental Network nor include pediatric dental benefits. Individuals can purchase a separate dental plan if their Exchange plans do not offer dental benefits.

Refer to the Administrative Office Manual for Dental Providers – 2018 edition for complete BlueCross dental information.

Commercial. Some commercial dental plans use a network of participating providers, and other plans do not. Members can visit any dental provider; however, an out-of-network provider can balance bill for the difference in BlueCross' allowable and actual charges.

Levels of dental coverage for these plans include:

- Preventive care
- Restorative care
- Major restorative care
- Orthodontic care (optional)

Dental GRID. Dental GRID allows dentists to see members from other participating Blue Cross and Blue Shield Plans at local Plan reimbursement levels. We consider you as an in-network dental provider to more patients who may be members of out-of-state plans. Your reimbursement levels or provider agreements will not change. GRID is a separate company that offers a dental network on behalf of BlueCross.

State Dental and Dental Plus Plans. BlueCross administers the State Dental and Dental Plus Plans. The dental benefits have four classes: diagnostic and preventive services; basic dental services; prosthodontics; and

orthodontics. We pay covered services under the State Dental Plan based on its Schedule of Dental Procedures and Allowable Charges.

Dental Plus is a supplement to the State Dental Plan that provides a higher level of reimbursement for dental services the State Dental Plan covers. Members pay the entire premium with no contribution from the state. Dental Plus pays up to
$1,000 for covered services in each benefit period for each covered member in addition to the $1,000 maximum payment under the State Dental Plan.

Dental Plus does not cover services that are not covered under the State Dental Plan. Instead, it covers the same procedures and services (except orthodontics) at the same percentage of coverage as the State Dental Plan. The allowances are based on whether the provider participates in the BlueCross dental provider network.

FEP BlueDental®. GRID® Dental Corporation (GDC) is a separate company that administers FEP BlueDental on behalf of BlueCross. FEP BlueDental members use the GRID+ network as an in-network provider source. Participating providers now have access to FEP BlueDental members.

2.9.2 Mental Health

Companion Benefits Alternative (CBA) is a separate company that manages behavioral health and substance abuse benefits on behalf of BlueCross. Mental health benefits vary between plans. Verify eligibility and benefits for each member.

2.9.3 Pharmacy

Many BlueCross plans use OptumRx for prescription drug benefits. OptumRx is an independent company that provides pharmacy benefit management services on behalf of BlueCross. Pharmacy benefits vary between plans. Verify eligibility and benefits for each member.

2.9.4 Vision

Many BlueCross plans offer vision benefits. Vision benefits vary between plans. Some of our vision benefit business partners include EyeMed and Vision Service Provider (VSP). Verify eligibility and benefits for each member. These are independent organizations that provide vision benefits on behalf of BlueCross.

Section 3
Claims and Billing Guidelines

3.1. Claims Filing

For prompt payment, we encourage electronic claims submission. Transmit claims in the HIPAA 837 format under the appropriate carrier codes. You should complete all applicable claim information in full to ensure you receive accurate payment without delay. You can also file both professional and institutional claims (primary, secondary and corrected claims) in My Insurance Manager.

3.1.1 Using the Correct Provider Identifier

Tax Identification Number (TIN). Each participating provider should use his or her nine-digit TIN or NPI when filing claims. This will ensure accurate and timely payment. An exception to this occurs if you do not have a TIN and use your Social Security number to report income.

Place your provider number in the appropriate form indicator for the 837 (I and P) when filing claims. Follow these same instructions for entering the rendering provider's NPI number.

If you have changed your TIN, complete only the Request to Change Tax ID form. You will need to submit a copy of your TIN confirmation before we will update your profile. The IRS will send this confirmation to you. If you have any questions about your TIN, you can visit the IRS website at www.irs.gov.

NPI. The NPI is a 10-digit, all-numeric identifier. NPIs are only issued to providers of health services and supplies. As a provision of HIPAA, the NPI is intended to improve efficiency and reduce fraud and abuse.

There are several advantages to using the Provider NPI for claims and billing:

- It allows providers to bill with only one number.
- It simplifies the billing process since it is no longer necessary to maintain and use legacy identifiers for each health care plan.
- It simplifies making changes to addresses or locations. NPIs are divided into two types:
- Type 1: Individual providers, which includes, but is not limited to, physicians, dentists, and chiropractors
- Type 2: Hospitals and medical groups, which includes, but is not limited to, hospitals, residential treatment centers, laboratories, and group practices

For billing purposes, claims must be filed with the appropriate NPI for billing, rendering, and referring providers. Providers can apply for an NPI online at the NPPES website https://nppes.cms.hhs.gov or can get a paper application by calling NPPES at 800-465-3203. These websites offer additional NPI information:

- Centers for Medicare & Medicaid Services (CMS)
- National Uniform Claims Committee

Rendering Provider Number. We require you to report the rendering provider NPI on all claims. Any claim we receive that is missing the required rendering provider's information will result in a claim denial. We will accept corrected claims if your office inadvertently omits the rendering provider information.

3.1.2 Diagnosis Codes, Procedure Codes, Modifiers

Claims filed with BlueCross are subject to these procedures: 1) Verification that all required fields are completed on the claim and 2) Verification that all diagnosis codes, modifiers, and procedure codes are valid for the date of service.

Diagnosis Codes. All claims must include the proper ICD-10-CM diagnostic code. Using deleted or incorrect codes will result in inability to process your claim or payment delays. These are guidelines CMS established about use of diagnosis codes:

- Code the primary diagnosis first, followed by the secondary, tertiary, and so on.
- Code any coexisting conditions that affect the treatment of the patient for that visit or procedure as supplementary information.
- Do not code a diagnosis that is no longer applicable.
- Code to the highest degree of specificity.
- Code a chronic diagnosis, when it is applicable to the patient's treatment or when follow-up on the condition is requested during the visit.

Procedure Codes. Common Procedure Technology (CPT) is a standardized system of five-digit codes and descriptive terms used to report the medical services and procedures performed by physicians or health care professionals. Accurate CPT coding is crucial for proper reimbursement and compliance with government regulations.

All physicians and health care professionals must use the appropriate procedure codes from the most recent Healthcare Common Procedure Coding System (HCPCS) and CPT coding manuals or quarterly updates. Claim processing cannot be completed without accurate procedure codes, which reflect the services provided to members.

Consult the American Medical Association's (AMA) website for annual revisions and publications to the CPT Book. The AMA is an independent organization that provides health information on behalf of BlueCross.

Modifiers. Use modifiers to report that the procedure has been altered by a specific circumstance. Modifiers provide valuable information about the actual services rendered, reimbursement and payment data. Modifiers also provide for coding consistency and editing for Level I (CPT Codes) and Level II (HCPCS). Because the use of modifiers is frequently the only way to alter the meaning of a CPT code, it is very important to know how to use modifiers correctly.

3.1.3 Carrier Codes

BlueCross uses carrier codes (payer ID) to route electronic transactions to the appropriate line of business once the Gateway accepts the claim. Failure to use the correct electronic carrier code will result in misrouted claims or delayed payments. If you transmit through a clearinghouse, check with the clearinghouse to see if it requires a different carrier code for claim submission.

Use these carrier codes for direct electronic claim submission to BlueCross.

400	State Health Plan
401	Preferred Blue and BlueEssentials (also includes all out-of-state BlueCard claims)
402	FEP
403	Healthy Blue℠ Medicaid
922	Healthy Blue and Blue Option℠
C63	Medicare Advantage

Use these carrier codes for TPAs that use the Preferred Blue network and are accepted electronically.

315	TCC
886	PAI

Use these carrier codes for dental claim submission.

38520	BlueCross BlueShield of South Carolina

3.1.4 Electronic Loops and Data Segments

Each individual loop on an electronic claim has a segment component where the data is entered. The loops and segments contain the readable information that provides the clearinghouse the identifying information for the claim that was filed. The loops on an electronic claim are organized by categories of information that match data elements on the CMS-1500 claim form.

Here are examples and solutions of common edits that apply to loops and segments for professional claims, institutional claims, and dental claims.

- 837 Professional Edit HA9 – Invalid Rendering Physician ID Number Loop(s) and Segment(s) Impacted: 2310B | NM109

  Corrective action: Validate the rendering physician provider identification number is sent. Call the appropriate provider service area for BlueCross BlueShield of South Carolina to validate the rendering provider identification number needs any additional paperwork to update the provider database.

- 837 Institutional Edit QAC – Medicare COB amounts from Medicare remit were entered incorrectly Loop(s) and Segment(s) Impacted:
  2320 | AMT
  2320 | CAS
  2430 | SVD
  2430 | CAS
  Corrective action: Sum of CAS Segments and Medicare payment must equal Total Charges.

- 837 Dental Edit L25 – Missing or invalid tooth number submitted on claim Loop(s) and Segment(s) Impacted:
  2400 | TOO
  Corrective action: Submit a valid tooth number for the service given on the claim. Visit the www.HIPAACriticalCenter.com for more information.

3.2. Claims Management

As a participating network provider, you agree to submit claims for BlueCross, FEP, BlueCard (out of area) and SHP members electronically. You should complete all applicable claim information in full to ensure you receive accurate payment without delay. BlueCross Supplemental Implementation Guides (SIGs) are available in the HIPAA Critical Center at www.HIPAACriticalCenter.com. These will help you with the electronic claim-filing process. You can also file both professional and institutional claims (primary, secondary, and corrected claims) by using My Insurance Manager.

We currently accept these claim submission formats:

- CMS-1500 claims (filed via the web or paper)
- CMS-1500 claims filed via the Superbill tool in My Insurance Manager
- CMS UB-04 claims (filed via the web or paper)
- HIPAA 4010A1 electronic format claims (professional and institutional)

3.2.1 Electronic Medical Claim (EMC)

Submit claims electronically to BlueCross using the HIPAA-compliant 837 (I or P), X12 format. This is more efficient because it allows hospitals and physicians to receive payment five to seven days faster than for claims they file via hard copy. EMC filing also ensures claims accuracy through system edits.

You can file both CMS-1500 and CMS UB-04 claims to BlueCross via the web using My Insurance Manager. You can also submit CMS-1500 claims to BlueCross using the Superbill tool within My Insurance Manager. This tool is ideal for providers who want to submit primary claims for one date of service only. Submit claims for all BlueCross plans (including dental), State Health Plan, FEP, PAI, Employee Benefit Services and TCC.

You can submit primary, secondary, and corrected claims for both professional and institutional providers. File online, and most claims with amounts due will process in three to five days.

3.2.2 National Drug Code (NDC) Requirements

BlueCross requires the reporting of the NDC, NDC unit of measure and NDC quantity for all outpatient-administered drug claims. When submitting NDCs on professional electronic and paper (CMS-1500) claims, you must include this related information:

- 11-digit NDC
- NDC qualifier (N4)
- NDC quantity
- NDC unit of measure [Unit (UN), Milliliter (ML), Gram (GR) and International Unit (F2)]

You can find additional information about the NDC requirements and the Drug Rebate Program in the Provider News section of our website at www.SouthCarolinaBlues.com. You can also find additional NDC information, as well as an NDC to HCPCS crosswalk, on the CMS website.

3.2.3 Timely Filing

Generally, providers must file claims within 180 days from the date of service. Some policies, however, require you to file claims within 90 days. Since timely filing limits vary, we encourage you to file your claims as soon as possible. BlueCross will deny claims it receives after the timely filing period. The member and

BlueCross should be held harmless for these amounts.

3.2.4 Claim Status

You can submit claim status inquiries by visiting www.SouthCarolinaBlues.com and logging in to My Insurance Manager. You can also access claim status through the voice response unit by calling the appropriate plan.

3.2.5 Corrected Claims

File corrected claims electronically via the HIPAA X12N format or via My Insurance Manager at no charge. You can submit hard copy corrected claims that include the rendering provider NPI as well by filing to the address on the back of the member's ID card. Corrected claims require manual intervention and may increase your claim adjudication times.

Using My Insurance Manager. You can log in to My Insurance Manager to submit a corrected claim. From the Patient Care menu, choose Professional Claim Entry. The Plan Information page will list your profile information first. Select a plan and indicate whether the plan is the primary payer. Select the billing location, rendering provider and/or referring provider when prompted. You can opt to choose a patient or manually enter the patient's information on the Patient Information page.

On the Claim Information page, select Replacement of Prior Claim from the Claim Type menu. Enter the prior claim number in the required field. Enter the information from the line of your claim. When you are done, select Continue. Confirm the claim information you entered. After reviewing your claim, select Submit.

Using a Clearinghouse. If you file through a clearinghouse, please contact your vendor for additional information about submitting corrected claims.

If you don't know where the 2300 loop or 2300 NTE ADD fields are in the form you use, contact your software vendor. If your software vendor has additional questions, direct it to call the EDI Helpline.

a. Enter Claim Frequency Type code (billing code) 7 for a replacement/correction, or 8 to void a prior claim, in the 2300 loop in the CLM*05 03.
b. To ensure we process the claim accurately, add a note explaining the reason for the resubmission in loop 2300 NTE (segment) ADD (Qualifier). For example: NTE*ADD* (changed CPT).
c. Enter the original claim number in the 2300 loop in the REF*F8*.
d. 7 - Replace (replacement/correction of prior claim).
e. 8 - Void (void/cancel of prior claim).

3.2.6 Duplicate Claims

BlueCross will deny any claims you submit after the originals as duplicates. If you have not received payment for a claim, do not resubmit the claim. You should check claim status through My Insurance Manager or VRU.

Our EDI department can work with your clearinghouse if there is a problem with us not getting your claims submissions. Contact EDI by email at EDI.Services@bcbssc.com or by phone at 800-868-2505.

3.2.7 Medicare Crossover Claims

The claims you submit to the Medicare intermediary will cross over to the Blue Plan only after the Medicare intermediary processes them. This process may take about 14 business days. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up

to 30 additional calendar days for you to receive payment or instructions from the Blue Plan.

You should continue to submit services that Medicare covers directly to Medicare. This allows the crossover process to occur and the member's benefit policy to be applied.

We will reject Medicare primary claims, including those with Medicare-exhausted services, which have crossed over and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date.

3.2.8 Facts About Resubmitting Claims

Before you resubmit a claim because you have not received your payment or a response regarding your payment, stop and think. By sending another claim, you are adversely affecting the claims payment process and potentially creating confusion for the member.

a. By resubmitting your service(s), we must conduct an additional investigative step that lengthens the claim processing time.
b. If you resubmit a claim, we will ultimately deny the claim as a duplicate.
c. The member will receive multiple EOBs for the same service, often resulting in a call to your office and/or ours.
d. Most claims submitted to BlueCross are processed before 30 days.
e. In fact, most electronically submitted claims are processed within 14 days.

3.2.9 Balance Billing

Participating hospitals, physicians or health care professionals may not bill BlueCross members for deductible and coinsurance or balances above our allowable fees. In your contract with us, it states that you shall not look to BlueCross members for payment for covered services:

"[Provider] agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, or have any recourse against a Member or persons acting on behalf of a Member, except to the extent that the applicable Plan specifies a copayment, coinsurance or deductible."

If the service is not covered, there must be prior written agreement to bill the member for these non-covered services.

You may collect only the applicable cost sharing (i.e., copayment) amounts from the member at the time of service and may not otherwise charge or balance bill the member. Reimbursement is made directly to the Blue Plan.

Providers are responsible for getting prior authorization for inpatient facility services for out-of-area members. The member will not be responsible when prior authorization is required but not received for inpatient services. Failure to get necessary prior authorizations will result in claim penalties or denials. Here's what you should know:

- We base the amount of the penalty on your contract and applicable pricing methods.
- The member's plan will continue to determine which services require prior authorization.
- The member will not be responsible and cannot be balance billed, unless the member has signed a written consent to be billed prior to the service being rendered. Members are liable for services denied as not medically necessary.

Out-of-network providers may balance bill for the difference in BlueCross' allowable and actual charges.

3.2.10 Overpayment and Refunds

There may be times when we must request refunds of payments previously made to you. When refunds are necessary, we notify you of the claim in question 30 days before any adjustment. The notification letter explains that we will deduct the amount owed from future payments unless you contact us within 21 days.

If you identify we made an overpayment and have not received a notice from us, you can return the overpayment with the Overpayment Refund Form found on our website. Provide documentation supporting the refund and include a check for the appropriate amount.

Solicited Refunds. We request solicited refunds when we determine there is a claims overpayment, or we made a payment in error.

Please send the refund to us within the requested 30 days from the date of the letter. You must include a copy of the refund request letter for accurate and timely processing. Send your refund to:

BlueCross BlueShield of South Carolina
Attn: Lockbox, AX-A31
I-20 E at Alpine Road
Columbia, SC 29219-0001

It is critical that you return the refund within the specified time frame. If we do not receive the refund within 30 days of the date of the refund request letter, we will systematically offset the amount on a future remittance. The systematic offset is the preferred method for many providers to reconcile refunds. This approach reduces the administrative costs associated with paper processing and minimizes the potential for duplicate refunds.

If you still need more information about a refund, please log in to My Insurance Manager and submit your question using “Ask Provider Services.”

Unsolicited Refunds. Unsolicited refunds are those you voluntarily submit as the result of a possible claims overpayment or a payment made due to a billing and/or processing error.

Please complete all the information on the Overpayment Refund Form.

We will review the information to determine the validity of the unsolicited refund request. We’ll then determine if we will either adjust the claim to process the unsolicited request or return the request and check with a written explanation of our findings.

3.2.11 Split Billing Pre-op Charges

If lab work is performed within 72-hours of an inpatient surgery, the charges can be billed on the inpatient claim. They do not have to be split unless the 72-hour timeframe has passed.

3.3. Release of Medical Records

In some instances, we may require medical records to process a claim. Please note: We do NOT pay for fees for supplying medical records. Please send the requested information, so we can expedite the processing of your claim(s).

We may also need medical records when an admission review is performed or for appeals.

3.3.1 When Medical Records are Required

If we need records from your office for a member with BlueCross insurance through another BlueCross and/or BlueShield Plan, you will receive a letter from Inovalon ordering the records. Inovalon is an independent company that coordinates medical records retrieval on behalf of BlueCross. Having a single records vendor among all BlueCross Plans streamlines the records request process. It helps eliminate multiple requests from various Plans.

We also collect medical records to gather data to measure our performance, develop quality initiatives — such as member outreach programs – and enhance educational programs for providers and members.

You should only receive requests for records from BlueCross or Inovalon.

- Records requests will only come from Inovalon for non-claim-related requests for out-of-state BlueCross members.
- You will continue to receive requests from your local BlueCross for claims-related issues.
- You may receive requests from us or one of our business partners to review medical charts for one or several of your patients in support of HEDIS activities.
- Forward all requested medical records within 10 calendar days.

3.3.2 Non-Payment for Medical Record Requests

You or any entity designated for such responsibilities should not charge BlueCross for the creation or submission of medical records. As a participating provider, your contract states you agree to permit BlueCross or one of our business partners to inspect, review and acquire copies of records upon request at no charge. We appreciate you working with your vendors to ensure they understand this contractual arrangement to submit the requested records (on your behalf) without delay or request for payment.

3.4. Guidance for Physician Office

Physicians should file claims electronically to BlueCross in the HIPAA-compliant 837P (CMS HCFA 1500) format. File with the appropriate place of service codes, procedure codes, modifiers, NDCs, diagnoses and referring physician. Prior authorization follows each specific group requirement.

3.5. Guidance for Hospitals and Facilities

3.5.1 Ambulatory Surgery Center (ASC)

ASCs should file claims electronically to BlueCross in the HIPAA-compliant 8371 UB-04 format. File with the appropriate bill type, revenue code and the CPT codes. You will not need the SG modifier on these institutional forms. Prior authorization follows each specific group requirement.

3.5.2 Home Health

Home health providers should file claims electronically to BlueCross in the HIPAA-compliant 837I (UB-04) format. File with the appropriate bill type and revenue code for the type of treatment as a single line item. You must get prior authorization for all home health services.

Revenue Codes	Type of Home Health
551	Skilled Nursing
421	Physical Therapy
441	Speech Therapy
561	Medical Social Worker
571	Home Health Aide
431	Occupational Therapy
279	Wound Care

3.5.3 Hospice

Bill hospice care electronically to BlueCross in the HIPAA-compliant 837I (UB-04) format using revenue code 651, 655 or 656. You must get prior authorization and re-authorization for all hospice services.

Revenue Codes	Type of Home Health
651	Home Hospice Care
655	Respite Care
656	General Inpatient Care

3.5.4 Long-Term Acute Care (LTAC)

LTAC facilities should submit claims electronically to BlueCross in the HIPAA-compliant 837I (UB-04) format using the appropriate revenue codes. You must get prior authorization for all LTAC services.

3.5.5 Skilled Nursing Facility (SNF)

Skilled nursing providers should file claims electronically to BlueCross in the HIPAA-compliant 837I (UB-04) format. File with the appropriate bill type and revenue code for the type of treatment as a single line item. You must get prior authorization for all skilled nursing services.

We may consider skilled nursing coverage medically necessary when all these criteria are met:

- Services require an SNF level of care (LOC) and cannot be provided in a less intensive setting.
- Services require the skills of qualified technical or professional health personnel, such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, speech language pathologists or audiologists.
- These skilled nursing or skilled rehabilitation personnel directly provide or generally supervise services to ensure the safety of the patient and to achieve the medically desired result.
- You provide services under a plan of care a physician establishes and periodically reviews.

3.5.6 Dialysis

Dialysis providers should file claims electronically to BlueChoice® in the HIPAA-compliant 837I (UB04) format.

When filing secondary to Medicare, please be sure to use the appropriate revenue code to ensure secondary processing. Please refer to Exhibit A of your contract for additional billing guidelines.

3.5.7 Inpatient Non-Reimbursable Charge/Unbundling Policy

BlueCross implemented a policy Oct. 1, 2018 to address charges considered to be non-reimbursable, unbundled or are otherwise not allowed to be billed separately. This policy is applicable only to inpatient charges and is not intended to impact care decisions. You can view this policy at https://www.southcarolinablues.com/web/public/brands/sc/providers/tools-and-resources/guides/.

3.6. Guidance for Ancillary Providers

Ancillary providers are independent clinical laboratory, durable/home medical equipment and supplies and specialty pharmacy providers. You should file claims for your Blue Plan patients to BlueCross BlueShield of South Carolina as your local Plan. There are unique circumstances, however, when claims-filing directions will differ based on the type of provider and service.

Durable Medical Equipment (DME). File to the Plan in whose state the equipment was shipped to or purchased at a retail store. You must file all DME claims with the referring provider NPI number. If you do not include this information, it will delay the accurate processing of your claim.

Independent Clinical Laboratory (Lab). File to the Plan where the ordering or referring physician is located.

Specialty Pharmacy. File to the Plan in whose state the ordering physician is located.

If you contract with more than one Plan in a state for the same product type (i.e., PPO or traditional), you can file the claim with either Plan.

3.7. Most Common Denials

- Authorization or referral number invalid or missing
- Confirm authorization requirements prior to rendering services
- Contact the appropriate benefits manager to complete prior authorization requests
- Billed charges missing or incomplete
- Rendering NPI not listed on claim
- Include the rendering physician NPI for all claims
- NDC/NDC unit of measure not listed on claim
- Include the NDC, unit of measure and quantity
- Diagnosis, procedure, or modifier codes invalid or missing
- DRG codes missing or invalid
- Duplicate claims
- Submit modifiers as appropriate
- Verify claim status prior to submitting claims a second time
- Coordination of benefits (COB) information missing or incomplete
- Verify if the member has other insurance that may be primary
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) information missing or incomplete
- Eligibility/enrollment is not valid on date of service (DOS)
- EOB missing or incomplete
- Submit the primary payment information as necessary
- Spanning dates of service do not match the listed days/units

Section 4
Provider Administration

4.1. Medical Policies

Medical policies consist of medical guidelines that are used when making clinical determinations in connection with a member's coverage under a health plan. The medical policies and associated medical guidelines are interpreted and applied at the sole discretion of the health plan fiduciary and may be subject to state or federal laws.

These guidelines are accessible to you on our provider websites. You can also contact our Medical Affairs department if you have questions about our medical policies.

Medical guidelines are based on medical research that provides evidence of scientific merit (or the lack of scientific merit) for medical services as related to medical conditions. Medical guidelines are based on appropriate and available medical research available at the time they are written. Because of the changing nature of medical science, medical guidelines are reviewed and updated periodically. Accordingly, the information on the web is provided for information only and may not reflect a recent policy change or all the applicable medical guidelines.

The inclusion of a medical guideline on the website does not indicate that the referenced service (or supply) is necessarily available to a member. For a determination of the benefits that a particular member is entitled to receive under his or her health plan, such member's health plan must be reviewed. In the event of a conflict between the medical policy and any health plan, the express terms of the health plan will govern. The existence of a medical guideline is not an authorization, certification, Explanation of Benefits, or a contract for the service (or supply) that is referenced in the medical guideline.

Medical guidelines are written to address frequently occurring clinical situations. Because of the variety of clinical circumstances, however, some services (or supplies) or conditions addressed in the medical guidelines may be appropriate for additional, individualized review.

Medical policies ARE NOT medical advice and DO NOT guarantee any results or outcomes.

4.2. Utilization Management (UM)

UM is the evaluation of the appropriateness and medical need of health care services, procedures, and facilities according to evidence-based criteria or guidelines, and under the provisions of an applicable health benefits plan. Typically, UM addresses new clinical activities or inpatient admissions based on the analysis of a case, but may relate to ongoing provision of care, especially in an inpatient setting.

UM describes proactive procedures, including discharge planning, concurrent planning, precertification, and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the provider, payer, or patient. A UM program comprises roles, policies, processes, and criteria.

UM roles may include: UM reviewers (often an RN with UM training), a UM program manager and a physician adviser. UM policies may include: the frequency of reviews, priorities, and balance of internal and external responsibilities.

UM processes may include: escalation processes when a clinician and the UM reviewer are unable to resolve a case, dispute processes to allow patients, caregivers or patient advocates to challenge a point of care decision and processes for evaluating inter-rater reliability among UM reviewers.

4.2.1 Prior Authorizations

There are some services that routinely require precertification or admission certification for BlueCross. Other services require precertification due to the member's contract benefits, type of service or other criteria.

We require you to submit initial precertification requests for certain services.

To improve the efficiency and quality of processing initial precertification requests, we must have you submit, at minimum, this information with your request:

a. Member's Name
b. Database Number/Subscriber ID
c. Date of Birth
d. ICD-9 and/or ICD-10 Diagnosis
e. Service: CPT, HCPCS and/or Notification of Emergent Admission
f. Provider's Name and TIN or NPI number

Incomplete or missing patient information can prolong the response time to your precertification request. The health plan will send a response to the requestor that notifies you of the missing data.

In the table are the business partners that provide care management services on behalf of BlueCross.

Business Partner	Description	Contact Information
CBA	Precertification for mental health services	Call 800-868-1032 or visit www.companionbenefitalternatives.com.
Avalon	Precertification for certain lab procedures	Send precertification requests to Avalon by calling 844-227-5769 or by faxing 888-791-2181.
NIA Magellan	Precertification for certain advanced radiological procedures Precertification for radiation oncology procedures Precertification for musculoskeletal interventional pain management/spine surgery	Send precertification requests to NIA Magellan by calling 866-500-7664 or via www.RadMD.com.
OptumRx	Precertification for certain medical (injectable/infusible) specialty drugs through MBMNow. *MBMNow is an online prior authorization tool*	Access through My Insurance Manager.

Verify prior authorization requirements before providing services. Please note: Some services require prior authorization directly through BlueCross.

Use My Insurance Manager to request prior authorization. My Insurance Manager features an automated authorization, precertification and referrals tool that allows you to request authorizations for many patient services online. You can also check the status of an existing request. Select Precertification/Referral from the drop-down menu under the Patient Care tab in My Insurance Manager. Choose the appropriate member health plan, enter member information in all required data fields and then select the type of service. For certain services, the authorization request may automatically approve or be placed in a pending status for further review. A pended authorization is review of information from the precertification request, along with any supporting documentation to determine medical necessity of the treatment.

Use Clinical Attachments for uploading information. Use the clinical attachments feature in My Insurance Manager to upload supporting documentation for services that do not automatically approve. Records must be in a portable data file (PDF) format with a maximum size of 30MB for a single attachment. You may attach up to 10 documents at a time.

There are several online resources you can reference for additional guidance on using My Insurance Manager: My Insurance Manager User Guides, What You Need to Know About Precertification and What You Need to Know About Clinical Attachments.

Use Electronic Provider Access (EPA) to request precertification for out-of-area (BlueCard) members.

Go to www.SouthCarolinaBlues.com. Select the menu options Education Center, Precertification and then the BlueCard precertification tool.

Next, enter the prefix from the member's ID card. The prefix is the first three characters that precede the member ID. You can first check whether the Home Plan requires precertification by either:

- Sending a service-specific request through BlueExchange®.
- Accessing the Home Plan's precertification requirements pages by using the medical policy router. Go to www.SouthCarolinaBlues.com. You will then select Providers, Education Center, Precertification and then BlueCard Precertification Medical Policies Tool.

Once in the Home Plan's provider portal, you will have the same access to electronic preservice review capabilities as the Home Plan's local providers. The Home Plan landing page will look similar across Home Plans but will be customized to the Home Plan based on the electronic preservice review services it offers.

The availability of EPA will vary depending on the capabilities of each Home Plan. Some Home Plans will be fully implemented and have electronic preservice review for many services. Others will not yet have implemented electronic preservice review capabilities. This section describes how to use EPA and what to expect when attempting to contact Home Plans at different stages of implementation.

4.2.2 Case Management

Case Management bridges the gap between standard utilization management processes and the need for innovative approaches for persons afflicted with chronic conditions that may require high levels of benefit usage. It is a voluntary service offered to members to help guide them through difficult conditions.

This is a collaborative process involving the identified patient, service providers and the case manager that includes assessing, care planning, coordinating, monitoring, and evaluating options and services to meet a patient's needs. Through increased communication with and involvement of the patient in a mutually agreed upon care plan and use of available resources to promote quality, cost-effective outcomes, the primary goal of case management is to facilitate continuity of care and support of chronic conditions while effectively managing the available health insurance benefits.

A physician can contact Health Care Services to request evaluation for case management services or to discuss a member's treatment. A registered nurse case manager will then review information from the physician, member, and other appropriate sources to determine if the member is a candidate for case management. Once we have reviewed a referral, we either accept or decline the case. If we accept the case, the case manager will contact the member, identify problems, develop a care plan, develop primary goals, and establish interventions, all in coordination with the physician's treatment plan for the member.

You may be provided with resources to integrate your patient care with our services.

4.2.3 Prescription Monitoring Program

The South Carolina Reporting & Identification Prescription Tracking System (SCRIPTS) is required for use by all providers that prescribe opioids to State Health Plan members from category II-IV controlled substances. It is recommended that use of this program should be a part of every patient's care. It is intended to improve the state's ability to identify and stop diversion of prescription drugs in an efficient and cost-effective manner that will not impede the appropriate medical use of licit controlled substances where there is a valid prescriber-patient or pharmacist-patient relationship.

If you receive a letter from us that indicates your patient has been identified as overusing/abusing a prescription drug, you can review SCRIPTS to gauge prescribing patterns for that patient. Talk with your patients about any adverse findings found on their SCRIPTS report. Let the patient know that you can lawfully monitor his or her prescriptions in accordance with SC Code Ann. Section 44-53-1610 et. seq. (Prescription Monitoring Act).

SCRIPTS is a free service designed to help physicians monitor patient behavior. Create an account to use SCRIPTS at https://southcarolina.pmpaware.net.

4.2.4 Peer-to-Peer (P2P) Review

Clinical reviews are offered for cases when an adverse decision for medical necessity is reached. When we receive the completed P2P request form, one of our physicians will call the treating provider on the next business day to discuss the medical necessity non-certification decision. A BlueCross physician will make two attempts to contact the treating physician between 8:30 a.m. and 5:30 p.m. It is critical that you provide a direct phone number to ensure we are successful in contacting you for the review. If you have questions, please contact us at 800-334-7287.

Requests for P2P reviews received through our call center will be transferred to the appropriate reviewer for disposition. Expedited appeal time frames will not be impacted, as the P2P process is not part of the appeals process.

4.3. Medical Review

If a provider submits an appeal without written consent from the member, this is referred to as provider reconsideration. Physicians and physician groups may file provider reconsideration if they disagree with the adjudication of a claim.

Provider reconsiderations are forwarded to and handled by the Provider Services team. Member appeals are forwarded to and handled by the Appeals team.

4.3.1 Member Appeals

BlueCross members have the right to submit an appeal if a claim has processed with an adverse determination. An adverse determination is a denial or penalty that unfavorably affects the member (such as increased liability). Members can give written authorization for a physician or physician group to appeal on their behalf. The Designation of Authorized Representative to Appeal Form is optional for use by any individual or physician to appeal on behalf of a member. This form is located in the Forms section on the Provider page of www.SouthCarolinaBlues.com.

4.3.2 Provider Reconsiderations

Provider reconsideration is a provider's written request for review of a prior benefit decision. This is a voluntary process we offer to ensure the benefit decision was correct.

A provider can pursue provider reconsideration by using the Provider Reconsideration Form. This form is intended for use by physicians and other health care professionals in South Carolina only. It is located in the Forms section on the Provider page of www.SouthCarolinaBlues.com. Complete the form in its entirety and use it as a cover for all supporting documentation. Send the Provider Reconsideration Form to the appropriate Plan fax number or address as provided on the form.

If a provider is found to consistently file provider reconsideration requests for inappropriate reviews, an education specialist may initiate a training session to discuss proper procedure.

4.3.3 Determinations

It generally takes BlueCross 30 days to complete provider reconsideration reviews. After the review is complete, the appropriate service area will initiate claim adjustments or generate letters of denial to providers.

4.4. Subrogation and Coordination of Benefits

4.4.1 Subrogation

A BlueCross member's health contract contains an important clause called "subrogation" or "reimbursement." This means when BlueCross pays medical bills for an injury or illness that has been caused by a third party, we have a right to seek reimbursement of those medical bills from the third party, their insurance company and/or the member's insurance company.

BlueCross' staff of physicians has established a list of diagnosis codes that indicate an injury or illness

may be accident-related or work-related. When claims are processed through our system, a questionnaire is generated if the patient has received treatment for an injury or illness that has one of these "accident-type" diagnosis codes.

You should have members complete our Subrogation (Accident) Questionnaire available on the Forms page of the Provider section at www.SouthCarolinaBlues.com. A Spanish version of this form is also available. The answers will help us properly administer claims and determine if we need to seek reimbursement from a third party or an insurance company for these claims. If the questionnaire is not returned, we may withhold payment on medical claims.

4.4.2 Coordination of Benefits (COB)

Member contracts contain a COB provision to ensure we provide correct benefits on claims for members with more than one health/dental coverage plan.

Have your patient complete the Other Health/Dental Insurance Questionnaire form to give BlueCross information about possible other health/dental coverage, including Medicare, to process your claims correctly. A Spanish version of this form is also available. Download a form by going to the Forms page of the Provider section at www.SouthCarolinaBlues.com.

4.5. Quality Initiatives

4.5.1 Practitioner/Provider Performance Data

Practitioner/provider performance data refers to compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual health care practitioner, such as a physician, or a health care organization, such as a hospital. Common examples of performance data would include the HEDIS quality of care measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF). We can use practitioner/provider performance data for multiple plan programs and initiatives, including, but not limited, to:

- Reward programs – Pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie provider or facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include, but are not limited to, shared savings programs, enhanced fee schedules and bundled payment arrangements.
- Recognition Programs – Programs designed to transparently identify high-value providers and facilities and make that information available to consumers, employers, peer practitioners and other health care stakeholders.

4.5.2 Maternity

BlueCross has partnered with the South Carolina Department of Health and Human Services (SCDHHS) and implemented programs to improve birth outcomes. These programs include:

- Birth Outcomes Initiative (BOI)
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Centering Pregnancy

Within the BOI program, BlueCross uses specific filing requirements to identify at what point during gestation deliveries are occurring and why. Append these modifiers to the CPT C-section or delivery

procedure code for claims. If the appropriate modifier is not filed with the CPT, we may deny the services.

Modifiers	Uses
GB - 39 weeks gestation or more	For all deliveries at 39 weeks gestation or more, regardless of method (induction, C-section, or spontaneous labor).
CG - Less than 39 weeks gestation	• For deliveries resulting from patients presenting in labor or at risk of labor, and subsequently delivering before 39 weeks. • For inductions of C-sections that meet The American College of Obstetricians and Gynecologists (ACOG) or approved BOI medically necessary guidelines, please complete the appropriate ACOG Patient Safety Checklist. Keep the documents in the patient's file. • For inductions of C-sections that do not meet the ACOG or approved BOI guidelines, please complete the appropriate ACOG Patient Safety Checklist. Also, you must get approval from the regional perinatal center's maternal fetal medicine physician. Then, keep these
No Modifier - Elective non-medically necessary deliveries	For deliveries less than 39 weeks gestation that do not meet ACOG or approved BOI guidelines or are not approved by the designated regional perinatal center's fetal medicine physician.
UA - Prolonged labor when a vaginal delivery fails to progress and converts to a C-section	• Document the time of admission to the hospital and the start time of the C-section in the patient's record. • Prolonged labor is defined as at least six hours of documented labor.

The SBIRT program allows physicians to identify, intervene and refer at-risk patients to treatment by using the universal SBIRT Integrated Screening Tool (the SBIRT referral). Providers that screen patients using this form can also receive additional reimbursement by using specific coding.

The primary diagnosis should be pregnancy-related or postpartum-related (based upon when the screening or intervention takes place). The secondary diagnosis should be V82.9 (ICD-9) or Z139 (ICD-10).

- H0002: Behavioral health screening – $24 reimbursement Completion of the SBIRT referral for the screening. Screening can be billed once per 12-month period Append the HD modifier for positive screenings only
- H0004: Behavioral health intervention - $48 reimbursement Intervention and referral to treatment, documented within the SBIRT referral Brief intervention, can be billed twice per 12-month period. Defined as a brief intervention or session in which a referral is made or attempted.

The SBIRT initiative applies to all BlueCross plans except FEP, out-of-state (BlueCard) members, State Children's Health Insurance Program (SCHIP) and plans that do not have maternity benefits. Program participation is open to network participating obstetricians and gynecologists and midwives.

The Centering Pregnancy program model gathers eight to 12 women with similar due dates to meet as a group with their physician for a total of 10 sessions. The sessions occur throughout their pregnancies and early postpartum care. Approved practices receive additional reimbursement for conducting centering sessions.

Participating providers will receive reimbursement for providing these services:

- 98078 with TH modifier – reimbursement is $30 per visit, up to 10 visits total
- 0502F – reimbursement is $175 as a one-time retention incentive on or after the fifth visit

You should bill for centering pregnancy visits separately from global maternity benefits and file the

appropriate pregnancy diagnosis code.

To participate as a centering pregnancy provider, practices must have Centering® Healthcare Institute membership and be in the process of achieving (or have already achieved) site approval status. The Centering Healthcare Institute is a separate company that provides wellness education on behalf of BlueCross. Providers must maintain accreditation/ licensure with Centering Healthcare Institute to maintain participation in our centering pregnancy program.
Complete the Centering Pregnancy Application Form located at www.SouthCarolinaBlues.com to seek approval to receive reimbursement for centering pregnancy services.

For additional information about these programs, please visit the Provider section of www.SouthCarolinaBlues.com.

4.5.3 Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a tool developed by the NCQA that measures performance in the delivery of medical care and preventive health services. It provides a consistent way to evaluate the quality of care you provide to our members. BlueCross uses HEDIS to identify and acknowledge areas of excellence and opportunities for improvement. We also use HEDIS to develop quality initiatives and educational programs for members and providers.

You can use our provider reference matrix guides to get an overview of HEDIS measures that BlueCross focuses on. These matrices provide measure-specific information on what services are needed and how you can help prevent or close our members' gaps in care. If you have relevant information indicating the member has already received the service or has a condition that excludes him or her from the measure, you can close the gap by:

- Submitting a claim for the service.
- Submitting the medical record.
- Submitting the appropriate Compliance Companion Form.

Use of a Compliance Companion Form helps to improve our awareness of the preventive services you provide. It also reduces the number of record requests you receive during annual audits our quality improvement nurses perform.

You can submit up to 25 procedure codes with any claim to help transmit this information to us.

BCBSSC may provide certain documents that contain Healthcare Effectiveness Data and Information Set (HEDIS®) measures and specifications and survey specifications for the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) (the "**Data**"). The Data is owned and copyrighted by the National Committee for Quality Assurance ("**NCQA**"). The HEDIS measures and specifications expressly exclude third-party intellectual property rights in the HEDIS Value Set Directory ("**HEDIS VSD**"), including without limitation code values owned, licensed, or otherwise provided by third parties ("**Third-Party Codes**"). Please access and read the NCQA End-User License Agreement ("**EULA**") (https://www.ncqa.org/wp-content/uploads/2019/11/20191119_AU_and_LU_End_User_License_Agreement.pdf), which is a binding agreement between you and NCQA, carefully before accessing and using the Data. BY ACCESSING AND USING THE DATA, YOU AGREE TO BE BOUND BY THE TERMS AND CONDITIONS OF THE NCQA EULA. IF YOU DO NOT AGREE TO THE TERMS OF THIS EULA, YOU MAY NOT ACCESS AND USE THE DATA. Please contact NCQA at my.ncqa.org with any questions.

4.5.4 Release of Medical Records

There are times when BlueCross may request medical records from you for a patient. We may request records to determine medical necessity or apply benefits to a claim, or we may request records for risk adjustment or HEDIS review. When you receive a request for records, please respond to the appropriate mailing address or fax number provided with the request.

You or any entity designated for such responsibilities should not charge BlueCross for the creation or submission of medical records. As a participating provider, you agree to permit BlueCross or one of our business partners to inspect, review and acquire copies of records upon request at no charge. We appreciate you working with your vendors to ensure they understand this contractual arrangement to submit the requested records (on your behalf) without delay or request for payment.

4.5.5 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

BlueCross conducts surveys to assess members' satisfaction with the care and services they receive. CAHPS is a standardized national survey that measures members' experiences with health plan services and the care and services that network professionals offer. Each year, we send the CAHPS to a random sample of members. We ask for feedback on issues related to getting the care they need, getting timely care, the quality of care received, customer service and claims processing.

We share the results of these surveys with physicians annually. For information on the results of the most recent survey, please contact Provider Education at 803-264-4730 or Provider.Education@bcbssc.com.

4.5.6 Quality Health Plan Enrollee Experience Survey (QHPEES)

QHPEES is a consumer survey that assesses enrollee experience with the Qualified Health Plans (QHPs) offered through the Health Insurance Marketplace (Exchanges). This survey was designed to capture accurate and reliable information from consumers about their experiences with health care services during the previous six months.

CMS-approved survey vendors administer the distribution and evaluation of the survey.

For information about this survey, please contact Provider Education at 803-264-4730 or Provider.Education@bcbssc.com.

4.5.7 Patient-Centered Medical Home (PCMH)

PCMHs are primary care practices that use a team-based approach to health care. Its compensation model is a blended payment methodology that recognizes infrastructure changes and enhanced patient services:

1. Fee-for-service payment, including payments for some non-traditional services (e.g., electronic visits and pharmacist consultations).
2. Per-member, per-month care coordination fee.
3. Bonus adjustments to care coordination fee for quality outcomes.

If you would like more information about becoming a PCMH, please visit the Provider section of www.SouthCarolinaBlues.com.

4.6. Provider Reviews and Audits

4.6.1 Fraud, Waste and Abuse (FWA)

Providers participating in BlueCross BlueShield Medicare Advantage medical or prescription drug plans (PDP) plans must complete CMS annual compliance training for "Medicare Parts C and D Fraud, Waste, and Abuse" and "Medicare Parts C and D General Compliance." Go to www.CMS.gov/Medicare Learning Network to access training and receive Certificates of Completion after you are finished. BlueCross requires attestations and/or copy of the Certificate of Completion for our MA and PDP plans from contracted network providers. You must complete FWA compliance training and submission of the attestation by April 1 annually.

How to Report Suspected Fraud. If you suspect fraud, we encourage you to let us know anonymously. Include as many details as possible. To report fraud, call the BlueCross Fraud Hotline at 800-763-0703 or fax to 803-264-4050. You can also complete an online form available on the Contact Us page at www.SouthCarolinaBlues.com.

4.6.2 Provider Report Cards

Many provider report cards are made available to you during site visits from your designated provider education representative and upon request. Use these reports to gauge and improve performance in your practice.

- Gaps in Care Provider Report (Detail and/or Summary) Card – lists patient data and practice information in relation to quality measurements; also displays provider rating for Rewarding Excellence Program
- OB/GYN Report Card – shows how your patient care impacts our maternity quality initiatives
- Provider Report Card – encompasses an overview of the provider's EMC percentage, duplicate filing provider on claim

4.6.3 Responding to Patient Reviews

Patient reviews provide insight into their experiences with your medical office and their interaction with your practitioners. These reviews – submitted by our members via My Health Toolkit® – can also attract new patients to your practice. My Health Toolkit is an online resource for your patients to manage their benefits, locate an in-network doctor and many other tools to take charge of their health care.

You should log in to My Insurance Manager to respond to each patient review. By making it a priority to respond to online reviews in a way that reflects a high level of personal care, you can build rapport with current patients. This increases your practice's appeal and credibility with potential patients.

Section 5
Appendix

5.1 Glossary

Adjustment – The reprocessing of a claim to make changes to information submitted on the original claim

Affordable Care Act – Legislation passed on March 23, 2010, that requires quality and affordable health care and/or health insurance; plans are required to cover certain preventive services termed as essential health benefits

Ancillary – Professional diagnostic or therapeutic services – such as DME, laboratory and specialty pharmacy – provided on an outpatient basis as part of basic medical or surgical services

Appeal – A member's request to reconsider a decision about a disallowed claim for payment

Balance Bill – The practice of billing a patient for the difference between what the Plan pays and what the provider charges

Benefit – Services and supplies the Plan pays for; it also refers to the amount a health plan will pay

Clearinghouse – Companies that function as intermediaries who forward claims information from the provider to the Plan

Comingling – The combination of data sets from multiple sources, including, but not limited to, the combination of Inter-Plan Data and/or Blue Cross Blue Shield Association data with non-Inter-Plan Data and/or non-Blue Cross Blue Shield Association data

Commercial – Plans that are offered individually or collectively as a group

Compliance – An understanding and willingness to meet the terms of all applicable federal and state regulations as pertaining to health care

Confidential Information – Non-public information that includes strategic and/or competitively sensitive information including, but not limited to, the Blue Cross Blue Shield Association or Licensee trade secrets, policies, procedures, data and processes

Contiguous county – Sharing a common border with the state of South Carolina

Data segment - An intermediate unit of information in a transaction. The data segment comprises a number of data elements.

Date of service – The day in which a patient was seen or given treatment by a health care provider

DME – Durable Medical Equipment; any equipment that provides therapeutic benefits to a patient in need because of certain medical conditions and/or illnesses

EDI – Electronic Data Interchange; standardized format that allows providers to send information to the Plan electronically rather than with paper

EFT – Electronic Funds Transfer; any transfer of funds, other than a transaction originated by cash, check or similar paper instruments, that is initiated through an electronic terminal, telephone, computer or magnetic tape, for the purpose of ordering, instructing or authorizing a financial institution to debit or credit an account

Electronic Loop - A group of related data segments; all data segments related to claim information may be one loop; this loop may be repeated several times to provide several sets of claim information

Eligibility – Able to receive services based on enrollment in a Plan

EMC – Electronic Media Claims; the process of transmitting medical claims electronically to a Plan

ERA (remit) – Electronic Remittance Advice; a statement to the provider that explains how and why benefit calculations were determined

Federally Facilitated Marketplace – An organized marketplace for health insurance plans that operate under the ACA

Fraud – The act of deliberate deception performed to gain an unlawful benefit, such as improper coding of health services on a claim for payment

Grandfathered - A plan or policy in place before March 23, 2010, when the ACA became effective; these plans are allowed to offer the coverage they did before the ACA

In-network – Providers or health care facilities that are part of a Plan's network of contracted providers

Inter-Plan Data – Information that relates to 1) another Licensee, 2) another Licensee's Member(s), or 3) activity of a Licensee's Member(s) in another Licensee's Service Area

Licensee – A Blue Cross and/or Blue Shield Plan or other entity that holds a license to use the brands owned by the Blue Cross Blue Shield Association

Member – Any person entitled to receive benefits under a product issued or administered by a Licensee

Network – Group of physician, hospitals and other clinical providers that a specific Plan has contracted to deliver services to its members

National Account – An entity with employee and/or retiree locations in more than one Licensee's Service Area

Non-grandfathered - A plan that did not take effect until after the ACA took effect on March 23, 2010, or has had certain plan changes made to it

NPI – National Provider Identifier; a unique 10-digit identification number issued to providers in the United States by the Centers for Medicare & Medicaid Services (CMS)

Opioids – Any synthetic narcotic that has opiate-like activities but is not derived from opium

Out-of-Network – Providers or health care facilities that are not part of a Plan's network

Participating provider – A contracted health care professional who accepts assignment and is paid directly by the Plan

Prior authorization (preauthorization, precertification) – A process used to determine if services will be covered by the Plan

PHI – Protected health information; any information about health status, provision of health care or payment for health care that is collected by a Plan

Provider reconsideration – A provider's written request for review of a prior benefit **Referring provider** - The physician who directs a patient for care to a specialist for service **Rendering provider** – The individual who provided the care to the patient

Service Area – The geographic area in which a Licensee is authorized to use the BCBSA-owned brands

Specialist – A health care professional whose practice is limited to a particular area, such as a branch of medicine, surgery or nursing

TIN – Tax Identification Number; a unique provider identifier conferred by the Social Security Administration or the IRS; referred to interchangeably as provider number

UB-04 – The standard paper claim form to bill hospital claims

Vendor (business partner) – A company or individual that has some involvement with the Plan's management and/or administration of a service