



**2014**

**BlueCross BlueShield of South Carolina  
PROVIDER OFFICE  
ADMINISTRATIVE MANUAL**

## ***Introduction***

BlueCross BlueShield of South Carolina 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 also update provider information in the Education Center of our website [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) as needed.

Please send all suggestions for enhancements to this manual to:

**Provider Relations and Education Department  
BlueCross BlueShield of South Carolina, AX-624  
I-20 at Alpine Road  
Columbia, SC 29219**

[Provider.Education@bcbsc.com](mailto:Provider.Education@bcbsc.com)

*The information in this manual is only general benefit information and does not guarantee payment. Benefits are always subject to the terms and limitations of the plan. No employee of BlueCross BlueShield of South Carolina has authority to enlarge or expand the terms of the plan. The availability of benefits depends on the patient's coverage and the existence of a contract for plan benefits as of the date of service. A loss of coverage, as well as contract termination, can occur automatically under certain circumstances. There will be no benefits available if such circumstances occur.*

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## Section 1: General Information

### Provider Services

Our website, [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com), offers quick access to member eligibility and benefits, claim entry, claim status, remittance advice and other important information by logging into My Insurance Manager<sup>SM</sup>. You can save time by submitting your questions through “Ask Provider Services.”

### Provider News and Updates

We have many informational publications for providers, including this manual. These publications are available on our website. Here’s how you can find these publications:

- Go to [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).
- Click Providers.
- Click Education Center.

By placing our publications on the website, we can provide you with important information quickly and accurately.

### Provider Advocates

Our Provider Relations and Education staff focuses on providing training and support to health care professionals. They serve 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. They can help you with:

- Education and training on all BlueCross programs
- Requirements for compliance with rules and regulations of the plan
- The BlueCard program
- Medicare Advantage
- Electronic claim filing updates and changes
- HIPAA issues
- Problem identification and resolution
- General service information and implementation of changes

Our provider advocates cover the state of South Carolina and contiguous counties in Georgia and North Carolina. You can contact the Provider Education department by emailing [Provider.Education@bcbssc.com](mailto:Provider.Education@bcbssc.com) or by calling 803-264-4730. We will route your inquiry to the appropriate staff member for resolution.

## Section 2: Provider Information Management

### File Application

To file claims to BlueCross BlueShield of South Carolina, you must complete a provider file application. For your convenience, you can download the Health Professional Application to file claims and update from our Forms page on our website.

### File Application Updates

- If your information is not currently in our provider management data system, or if you are joining a new group or practice, please complete and return the entire application.
- If you have changed your Tax ID number, 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 Tax ID number, you can visit the IRS website at [www.irs.gov](http://www.irs.gov).
- For all physical address changes, complete the Change of Address form from the Credentialing/Provider Updates page.

To access these forms, go to [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) and click on Providers. Then click Forms. Choose the appropriate form from the list.

Email completed forms to [provider.cert@cbssc.com](mailto:provider.cert@cbssc.com) or you can mail or fax to:

**BlueCross BlueShield of South Carolina  
Provider Certification, AX-B20  
I-20 at Alpine Road  
Columbia, SC 29219-0001**

**Fax 803-264-4795**

These forms are not applications to join any of the health care networks. They allow you to file claims and enable BlueCross to process the claims, as appropriate.

This is not a guarantee of payment.

## Credentialing

### Credentialing for Network Participation

BlueCross supports several provider networks, including:

- Preferred Blue<sup>®</sup> [the Federal Employee Program (FEP) also uses this network]
- State Health Plan
- Medicare Blue<sup>SM</sup> and Medicare Blue<sup>SM</sup> Saver

BlueCross gives potential network applicants the South Carolina Uniform Credentialing Application (SCUCA), specific network contracts and professional agreements for network participation. The South Carolina Uniform Credentialing Application is available in the Providers' area of the website. Click on Forms, Credentialing/Provider Updates and Credentialing. For contract or professional agreements, email [cred.fax@bcbsc.com](mailto:cred.fax@bcbsc.com) with your name, mailing address and the specific network contracts you need.

To apply for network participation, you must complete the application, attach the required documentation and submit the entire package to BlueCross. We will notify you of any missing or incomplete information. The average processing time for credentialing is 90 business days from when we receive a completed package. Any missing or incomplete information will delay the credentialing process.

You must submit this required documentation with your application:

- State license(s)
- Current DEA certificate
- Proof of malpractice coverage, including supplemental coverage
- Board specialists certificate, if applicable
- Electronic Claims Filing Requirement form (page 10 of the SCUCA application)
- Authorization to Bill form (page 11 of the SCUCA application)
- NPI NPPES confirmation letter or email
- A signed contract signature page for each network to which you wish to apply

**Note:** You only need to submit one SCUCA application, regardless of the number of networks for which you are applying.

Please email your completed application and documentation to [provider.cert@bcbsc.com](mailto:provider.cert@bcbsc.com) or fax to 803-264-4795.



## Credentialing Guidelines for Physician Assistants and Nurse Practitioners

### Physician Assistants (PA)

BlueCross credentials physician assistants (PAs). PAs can choose to file claims for medical and laboratory services they provide in the office under their legacy identifiers or rendering NPIs. They can also bill under the supervising doctor's legacy identification number or NPI. Our policies do not cover a PA as an assistant at surgery. Only MDs are covered as assistant surgeons, if medically necessary. If a PA is assisting during surgery, the PA must bill as the rendering provider using an AS modifier.

### Nurse Practitioners (NP)

BlueCross must credential nurse practitioners (NPs) who are not under direct supervision of a doctor. NPs must submit claims under their NPI numbers. They can also bill under the supervising doctor's NPI number.

### BlueCross does *not* credential these specialties:

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

### Re-credentialing

BlueCross requires all health care providers to go through re-credentialing every three years. We email or fax credentialing packages to health care practices. You must return the packages to us within the allotted time or you could lose your network participation. The re-credentialing package includes:

- BlueCross Credentialing Update forms for each practitioner in the practice. When submitting, include these for each practitioner:
  - State license(s)
  - Current DEA certificate, if applicable
  - Proof of malpractice coverage, including supplemental coverage
  - Board specialist certificate, if applicable
- One practice information update form

Please email Credentialing Update forms and requested documentation to [provider.cert@bcbsc.com](mailto:provider.cert@bcbsc.com) or fax to 803-264-4795.

**Mental Health Network Participation**

Companion Benefit Alternatives (CBA) is a separate company that manages a mental health network on behalf of BlueCross. To participate, please complete the Companion Benefit Alternatives credentialing application found on our website.

Mail or fax completed forms to:

Companion Benefit Alternatives, Inc.  
ATTN: Network Representative  
P.O. Box 100185  
Columbia, SC 29202

Fax 803-714-6456

## Section 3: Provider Obligations

Preferred Blue is a line of preferred provider organization (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. Each preferred provider's professional agreement lists the contractual responsibilities of both BlueCross and that preferred provider. Here is a general summary of the Professional Agreement:

- The preferred provider will file all claims for Preferred Blue members, as well as Exchange Plan 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' 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 Preferred Blue Professional Agreement.
- 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 (EMC) in the 837I or 837P HIPAA-compliant format is the preferred method of filing.

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

### Provider 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 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.


If you have any questions about your fee schedule, please contact your contracting specialist.

## Section 4: Member Identification Cards

When members arrive at your office or facility, remember to ask to see their current member identification cards (ID cards) at each visit. This will help you identify the product the member has and get health plan contact information. It will also help you with claims processing. 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.

Please refer to our 2014 Member Identification Card Reference Guide on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) if you have questions about BlueCross identification cards.

### Sample PPO ID Card

South Carolina				
Member's Name	Member Name <b>Jane Q Doe</b>			
Member's ID Number	Member ID <b>ABC123456789012</b>			
Managed Pharmacy Program	RxBIN	<b>004336</b>	Office Visit	<b>\$00</b>
	RxGRP	<b>SCB15</b>	Specialist Visit	<b>\$00</b>
	Plan Code	<b>380</b>	Routine Visit	<b>\$00</b>
Mammography (M) Network Coverage	<b>Mammography Network</b>			
	<a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a>			

Office Visit Copayment Amount (may or may not be listed on the card)

### Important Facts About the ID Card Prefix

- Using the correct ID card prefix is critical for electronic routing of specific HIPAA transactions to the appropriate BlueCross and/or BlueShield Plan.
- 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 Social Security Number.
- Be sure all of your system upgrades accommodate the ID card alpha 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.

## Section 5: Benefit Information

### Benefit Structure

Each BlueCross BlueShield of South Carolina 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.

#### Grandfathered versus Non-Grandfathered

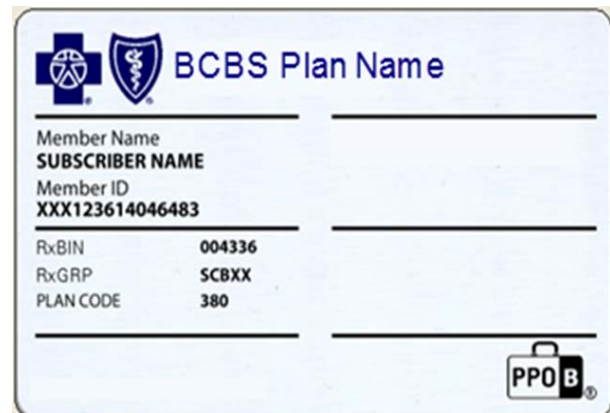
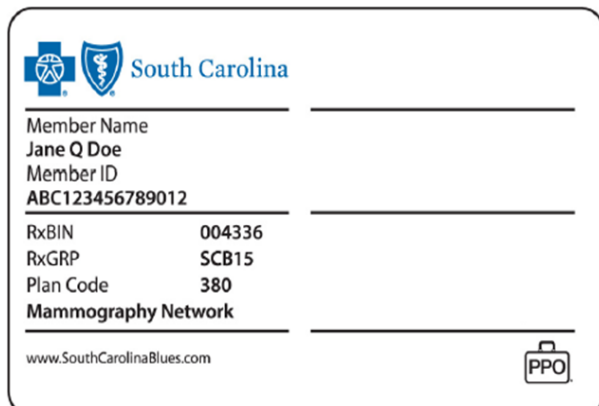
A grandfathered health plan is a plan or policy that had individuals enrolled in it on or before March 23, 2010, the day the Affordable Care Act (ACA) or health care reform law was established. A non-grandfathered plan is a plan that did not take effect until after March 23, 2010, or has not had certain plan changes made to it. You can review all of the health care reform plan requirements by visiting our website, then selecting Insurance Basics.

### Preferred Blue

The PPO product's benefit structure gives members financial incentives for seeking medical care from a network of preferred providers in South Carolina. Some Preferred Blue products are considered grandfathered while others are considered non-grandfathered.

You can access benefits and eligibility for Preferred Blue members by logging into My Insurance Manager or using the Voice Response Unit (VRU).

#### Sample Preferred Blue ID Cards



## Preferred Blue Mental Health Benefits

Contact information for precertification and claim status for mental health services is available on the back of all ID cards. Some Preferred Blue policies have mental health benefits through alternative arrangements. Therefore, it is important that you review members' ID cards to determine whom to contact for precertification. Most PPO plans have coverage through CBA.

You can contact CBA through its website at [www.CompanionBenefitAlternatives.com](http://www.CompanionBenefitAlternatives.com) or by calling one of these numbers:

Companion Benefit Alternatives	803-699-7308
P.O. Box 100185	800-868-1032
Columbia, SC 29202-3185	(Outside Columbia)

## Preferred Blue Prescription Drug Plan

Caremark is an independent company that provides pharmacy benefits management on behalf of BlueCross. Many Preferred Blue members with benefits through our contract with Caremark have a three-tier plan with drug card and/or mail-service benefits. Benefits for some Preferred Blue members, however, are provided under their medical plans, with optional mail-service benefits. You can learn more about our prescription drug benefits, including precertification and other utilization management requirements, on the Prescription Drug Information area of our website.

## Preferred Blue Precertification Requirements

### Inpatient Services

Most inpatient procedures and admissions require precertification (also known as prior authorization, preauthorization, pre-service review or pre-admission review) but are contract-specific. The preferred method for submitting precertification requests for Preferred Blue members is through My Insurance Manager on our website, [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).

### Outpatient Services

These outpatient procedures 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.)]

\*BlueCross has added special programs for patients undergoing chemotherapy and radiation therapy. You need to notify BlueCross about any patients receiving these services.

Some PPO groups may have precertification requirements that differ from the previous list (i.e. some groups require prior notification for physical, speech and occupational therapies). Check for group-specific precertification requirements before providing services and request a precertification via My Insurance Manager. The system will let you know if a precertification is not required. The precertification requirements are on our website in the Education Center.

## Preferred Blue Claims

You can submit Preferred Blue claims electronically using carrier (payer) code 401. The mailing address for Preferred Blue claims is:

BlueCross BlueShield of South Carolina  
Columbia Service Center  
P.O. Box 100300  
Columbia, SC 29202

For prompt payment, we encourage electronic claims submission. You should transmit claims in the HIPAA 837 format under the appropriate payer codes.

### Claim Status

You can submit claim status inquiries by visiting [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) and logging into My Insurance Manager. You can also access claim status through the VRU by calling 800-868-2510.

### Claim Payment

If you do not receive payment for a claim, it is not necessary to resubmit the claim. This confuses members because they receive multiple Explanations of Benefits (EOBs).

You should check claim status by either calling our VRU at 800-868-2510 or using My Insurance Manager at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).

In some cases, a claim may pend because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, we will notify you in writing (via your remittance or a letter) requesting the additional information.

### Corrected Claims

If an adjustment for charges is required, resubmit a corrected claim with the correct charges. Please do your best to bill correctly the first time and limit the number of corrected claims that you file to us. Corrected claims require manual intervention and may decrease your claim adjudication times.

### Appeals

If you are dissatisfied with an initial claim determination, you can appeal a claim disposition by using the Medical Review Form on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). Be sure to include all supporting medical documentation and fax to the appropriate fax number on the bottom of the Medical Review Form.



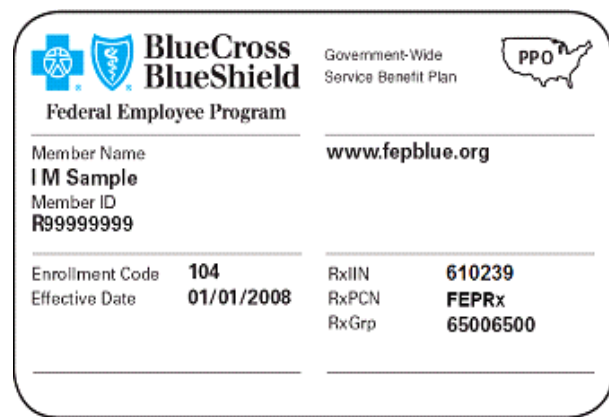
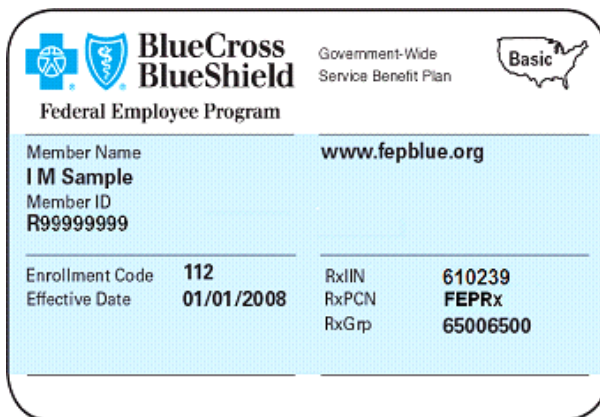
## Federal Employee Program (FEP)

FEP is a non-grandfathered plan BlueCross administers for Federal employees and their families. FEP uses the Preferred Blue provider network. Therefore, providers participating in the Preferred Blue network automatically participate with FEP.

Members can choose from two plan types — Basic and Standard. Under the Basic option, members must use preferred providers in order to receive benefits, while with the Standard option, members can use both preferred and non-preferred providers.

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

### Sample FEP ID Cards



You can access member benefit booklets on the FEP website at [www.FEPBlue.org](http://www.FEPBlue.org).

## Other FEP Information

### FEP Mental Health Benefits

Precertification is not required for outpatient mental health services.

### FEP Prescription Drug Plan

FEP members have drug coverage through Caremark. They have a five-tier plan with either a drug card and/or mail-service benefits. You can download the preferred drug list through the FEP website at [www.FEPBlue.org](http://www.FEPBlue.org).

### Federal Employee Program Fee Allowances

FEP uses the preferred provider network of health care providers, along with the Preferred Blue PPO fee allowance schedule. If you are credentialed and participating in the PPO program, you are automatically an FEP network provider. This means that the member is not financially responsible for payment other than applicable copayments, coinsurance and deductibles. You agree to file all FEP claims electronically to BlueCross and should not bill the member for more than the fee allowance.



## FEP Prior Authorization

### FEP Inpatient

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 a FEP precertification:

- Patient's name
- Identification number
- Call-back 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.

### FEP Outpatient

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 surgeries for 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 BRCA (breast cancer and ovarian cancer) gene test also require prior authorization.

### FEP Hospice

Hospice services do require prior authorization.

FEP Precertification	Fax 803-264-0258
	Voice 800-327-3238

### 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.

## FEP Claims

You can submit FEP claims electronically using carrier (payer) code 402. The mailing address for FEP claims is:

Federal Employee Program  
P.O. Box 600601  
Columbia, SC 29260

For prompt payment, we encourage electronic claims submission. You should transmit claims in the HIPAA 837 format under the appropriate payer codes.

### Claim Status

You can submit claim status inquiries by visiting [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) and logging into My Insurance Manager. You can also access claim status through the VRU by calling 888-930-2345.

**Claim Payment**

If you do not receive payment for a claim, it is not necessary to resubmit the claim. This confuses members because they receive multiple EOBs.

You should check claim status by either calling our VRU at 888-930-2345, or in My Insurance Manager at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).

In some cases, a claim may pend because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, BlueCross will notify you in writing (via your remittance or a letter) requesting the additional information.

**Corrected Claims**

If an adjustment for charges is required, resubmit a corrected claim with the correct charges. Please do your best to bill correctly the first time and limit the number of corrected claims that you file to us. Corrected claims require manual intervention and may decrease your claim adjudication times.

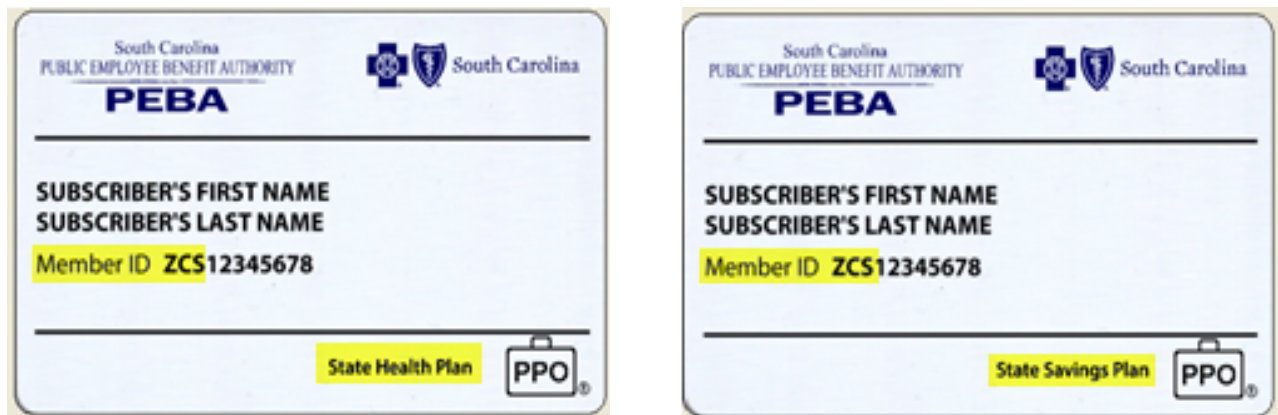
**Appeals**

If you are dissatisfied with an initial claim determination, you can appeal a claim disposition by using the Medical Review Form on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). Be sure to include all supporting medical documentation and fax to the appropriate fax number on the bottom of the Medical Review Form.

## State Health Plan (SHP)

SHP is a self-insured grandfathered medical plan available for the 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.

### Sample State Health Plan ID Cards



You can access current eligibility and benefit information, deductible amounts, coinsurance percentages and claim status by logging into My Insurance Manager at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). You can also access member benefit booklets on the SHP employee website at <https://StateSC.SouthCarolinaBlues.com/web/public/statesc/>.

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 into My Insurance Manager on our website.

## Other SHP Information

### SHP Retiree Coverage

State retirees can elect two types of coverage, the Standard Plan and the Medicare Supplement Plan. The ID cards for both of these plans read as "State Health Plan."

Retirees covered under the Standard Plan use the carve-out method to coordinate benefits when Medicare is primary over the State Plan. With carve-out, BlueCross uses different procedures for calculating secondary benefits on assigned and non-assigned Medicare claims. A detailed explanation of the two procedures is in the Coordination of Benefits (COB) section. The SHP Medicare Supplement Plan will never pay for charges that are more than the SHP's allowed amount.

For the Medicare Supplement Plan, we pay the coinsurance and deductible amounts for Medicare-covered services. Dependents on this plan without Medicare are covered using the Standard Plan's provisions. The Medicare Supplement Plan does cover a limited number of benefits not covered by Medicare, which you can identify by accessing benefit information in My Insurance Manager at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). You can also access the member's benefit booklet on the State employee website at <https://StateSC.SouthCarolinaBlues.com/web/public/statesc/>.

The State Health Plan participates in Coordination of Benefits Agreement (COBA) so we automatically receive cross-over claims for Medicare primary members. If you receive notification that a claim has crossed-over, you should not file separate claims directly to BlueCross.

### **SHP Mental Health Benefits**

CBA is the behavioral health manager that handles mental health and substance abuse treatment precertification, case management and provider networks for the SHP.

Providers can contact CBA by calling one of these numbers:

Companion Benefit Alternatives	803-699-7308
P.O. Box 100185	800-868-1032
Columbia, SC 29202-3185	(Outside Columbia)

### **SHP Prescription Drugs**

The SHP has a three-tier prescription drug program with either a drug card and/or mail-service benefits. Catamaran is an independent prescription drug company that contracts directly with the SHP. For more information about prescription drugs, including a list of in-network providers, visit [www.MyCatamaranRX.com](http://www.MyCatamaranRX.com) or call 855-901-7322.

### **SHP Fee Allowances**

You can access the SHP's fee schedule at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) by logging into My Insurance Manager.

## **SHP Precertification**

You can request precertification at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) by logging into My Insurance Manager or by calling Medi-Call at 800-925-9724. Medi-Call is a division of BlueCross BlueShield of South Carolina 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.

## **SHP Outpatient**

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

- MRI
- MRA
- Septoplasty
- Sclerotherapy in an outpatient or office setting
- CT scan
- Chemotherapy/radiation therapy (one-time notification)\*
- Hysterectomy
- Synagis
- Any procedure that may potentially be cosmetic in nature [Submit them for review in writing five to seven days before the scheduled procedure. Include pictures if appropriate (blepharoplasty, reduction mammoplasty, TMJ surgery, etc.).]

\*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.

The copayment is waived for:

- Emergency room services
- Physical therapy
- Speech therapy
- Occupational therapy
- Oncology
- Dialysis
- Routine mammograms
- Routine Pap tests
- Clinic visits (an office visit at an outpatient facility)
- Electric-convulsive therapy
- Psychiatric medication management

## **SHP Home Health**

All home health services require precertification.

## **SHP Durable Medical Equipment**

Precertification is required for:

- Any purchase or rental of durable medical equipment
- Any purchase or rental of durable medical equipment that has a nontherapeutic use or a potentially non-therapeutic use
- C-Pap or Bi-Pap machines
- Oxygen and equipment for oxygen use outside a hospital setting, whether purchased or rented
- Any prosthetic appliance or orthopedic brace, crutch or lift, attached to the brace, crutch or lift, whether initial or replacement

You can also check the status of precertification requests at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) by logging into My Insurance Manager.

**A precertification is not a guarantee payment of benefits.  
Claim payments are subject to the rules of the plan.**

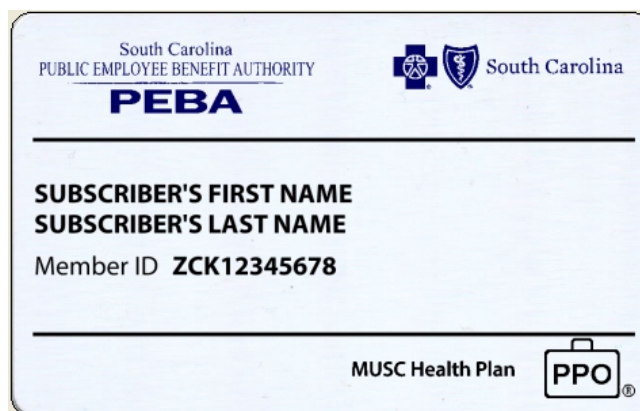
### **SHP Vision**

The SHP offers vision care benefits through the State Vision Plan, which is provided through EyeMed Vision Care®. EyeMed is an independent company that provides vision benefits on behalf of BlueCross BlueShield of South Carolina. Providers can contact EyeMed by visiting its website at [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com) or by calling 877-735-9314.

## **Medical University of South Carolina (MUSC) State Health Plan**

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

### **Sample MUSC State Health Plan ID Card**



## SHP Claims

You can submit SHP claims electronically using carrier (payer) code 400. The mailing address for SHP claims is:

State Health Plan  
State Claims  
P.O. Box 100605  
Columbia, SC 29260

For prompt payment, we encourage electronic claims submission. You should transmit claims in the HIPAA 837 format under the appropriate payer codes.

### Claim Status

You can submit claim status inquiries by visiting [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) and logging into My Insurance Manager. You can also access claim status through the VRU by calling 800-444-4311.

### Claim Payment

If you do not receive payment for a claim, it is not necessary to resubmit the claim. This confuses members because they receive multiple EOBs.

You should check claim status by either calling our VRU at 800-444-4311 or using My Insurance Manager at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).

In some cases, a claim may pend because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, we will notify you in writing (via your remittance or a letter) requesting the additional information.

### Corrected Claims

If an adjustment for charges is required, resubmit a corrected claim with the correct charges. Please do your best to bill correctly the first time and limit the number of corrected claims that you file to us. Corrected claims require manual intervention and may decrease your claim adjudication times.

### Appeals

If you are dissatisfied with an initial claim determination, you can appeal a claim disposition by using the Medical Review Form on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). Be sure to include all supporting medical documentation and fax to the appropriate fax number on the bottom of the Medical Review Form.

## Third Party Administrators (TPAs)

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

- Planned Administrators, Inc. (PAI)
- Thomas H. Cooper & Company, Inc. (TCC)
- Companion Property & Casualty (P&C)
- Key Benefit Administrators

PAI, TCC and Companion P&C are separate companies, and Key Benefit Administrators is an independent company, that provides 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, with the exception of Companion P&C, electronically to BlueCross using the appropriate carrier codes. BlueCross will forward the claim electronically to the individual TPA. File claims for Companion P&C directly to:

Companion P&C  
Attention Bill Review Unit  
Post Office Box 100165  
Columbia, SC 29202-3165

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.



# Section 6: BlueCross Medicare Advantage Plans

We offer two Medicare Advantage plans to Medicare-eligible recipients in South Carolina. These plans are Medicare Blue and Medicare Blue Saver. You should confirm the level of coverage for all Medicare Advantage members before providing services because level of benefits and coverage rules may vary.

## Medicare Advantage PPO

- Medicare Blue
- Medicare Blue Saver

## Medicare Blue

Medicare Blue is a Medicare Advantage PPO product that combines the benefits of traditional Medicare with Medicare Part D prescription drug coverage. Members can go to any doctors, specialists or hospitals in the network. A member can choose an out-of-network provider, but he or she may have to pay more for services.

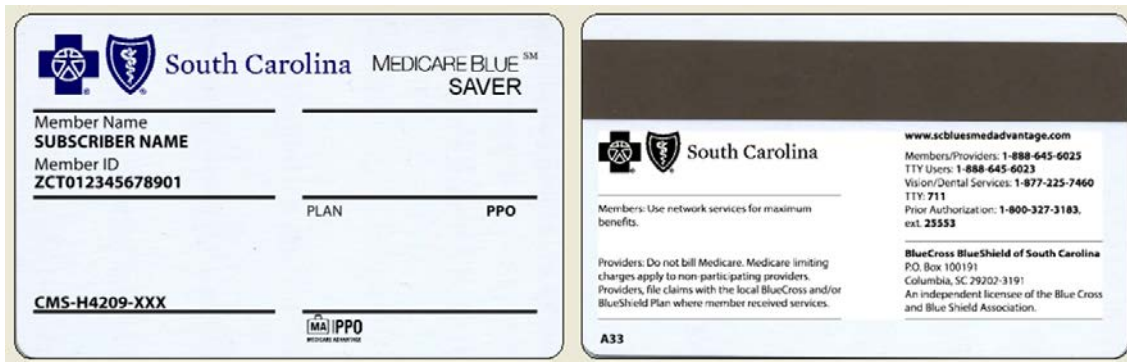
### Sample Medicare Blue ID Card



## Medicare Blue Saver

Medicare Blue Saver is a Medicare Advantage PPO plan that provides benefits for traditional Medicare-covered services without Medicare Part D prescription drug coverage.

### Sample Medicare Blue Saver ID Card



## How to Identify Medicare Advantage Plan Members

Medicare Advantage members have three-character alpha prefixes at the beginning of the ID numbers on their insurance cards. Their ID numbers begin with ZCT.

## Medicare Blue and Medicare Blue Saver Service Areas

The service area for Medicare Blue and Medicare Blue Saver includes these South Carolina counties: Abbeville, Aiken, Anderson, Calhoun, Cherokee, Chester, Clarendon, Edgefield, Fairfield, Greenville, Greenwood, McCormick, Laurens, Lexington, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, York, Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Charleston, Chesterfield, Colleton, Darlington, Dillon, Dorchester, Florence, Georgetown, Hampton, Horry, Jasper, Kershaw, Lancaster, Lee, Marion, Marlboro, Williamsburg.

Members must be residents of one of these counties to purchase and keep these plans.

## Benefits and Eligibility

Providers and enrollees can quickly get the most current member eligibility and benefit information by using My Insurance Manager on our website at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). You can also call the Medicare Advantage Provider Services VRU at 888-645-6025, option 3.

## Balance Billing

Providers can collect only applicable copayments or coinsurance amounts from Medicare Advantage members and cannot otherwise charge or bill the members for covered services. BlueCross prohibits balance billing by network and deemed providers who provide covered services to Medicare Advantage members. You should collect copayments or coinsurance for covered services from the member at the time of service. If a provider (either deemed or not deemed) incorrectly collects more from a member than the designated copayment or coinsurance amount, the provider must refund the difference to the member.

## Advanced Beneficiary Notice (ABN)

You should issue an Advanced Beneficiary Notice of Noncoverage to Medicare members when you expect that Medicare will deny the payment. Do not use it for supplemental items or services provided under the Medicare Advantage program as outlined by Medicare. BlueCross will accept a valid ABN or written agreement on provider letterhead that confirms the agreement between you and the member.

You should notify the member at the time of service if Medicare statutorily excludes that service, and have the member complete a valid ABN or written agreement on provider letterhead. Collect payment up front from the member for statutorily excluded services or items and then electronically file the claim with a GY modifier to the Medicare Advantage plan. BlueCross will conduct post-adjudication review to ensure you used the GY modifier appropriately and it's supported by a valid executed ABN or written agreement on provider letterhead. If an ABN or written agreement is deemed invalid and not acceptable, the member is not liable for the charges. You must refund the payment to the member.

## How to File Claims

- Use carrier (payer) code C63.
- Timely filing is 12 months from date of service.
- Submit claims electronically to BlueCross using Medicare billing guidelines. BlueCross will pay all claims for Medicare Advantage plans. Payments will not come from a fiscal intermediary or Part B carrier.

The mailing address for Medicare Advantage products is:

Medicare Advantage  
P.O. Box 100191  
Columbia, SC 29202-3191

For prompt payment, we encourage electronic claims submission. You should transmit claims in the HIPAA 837 format under the appropriate payer codes. **How to File Claims for Supplemental Dental and Vision Benefits**

Avesis is an independent company that administers routine dental and routine vision benefits on behalf of BlueCross to our Medicare Advantage members.

Use Avesis carrier (payer) identification code 86098 for dental claims. For routine vision claims, use Avesis carrier (payer) identification code 87098.

The mailing address for Avesis is:

Avesis Claims Center  
Attn: (Dental or Vision)  
P.O. Box 7777  
Phoenix, AZ 85011

For prompt payment, we encourage electronic claims submission. You should transmit claims in the HIPAA 837 format under the appropriate payer codes.

### Claim Status

You can submit claim status inquiries by visiting [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) and logging into My Insurance Manager. You can also access claim status through the VRU by calling 800-868-2510.

### Claim Payment

If you do not receive payment for a claim, it is not necessary to resubmit the claim. This confuses members because they receive multiple EOBs.

You should check claim status by either calling our VRU at 800-868-2510 or using My Insurance Manager at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).

In some cases, a claim may pend because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, BlueCross will notify you in writing (via your remittance or a letter) requesting the additional information.

## Corrected Claims

If an adjustment for charges is required, resubmit a corrected claim with the correct charges. Please do your best to bill correctly the first time and limit the number of corrected claims that you file to us. Corrected claims require manual intervention and may decrease your claim adjudication times.

## Appeals

If you are dissatisfied with an initial claim determination, you can appeal a claim disposition by using the Medical Review Form on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). Be sure to include all supporting medical documentation and fax to the appropriate fax number on the bottom of the Medical Review Form.

### Levels of Appeals

- **Level 1: Redetermination – Appealing the initial decision by BlueCross**

If you disagree with the plan's decision of how a claim was processed, you can request a redetermination. The time limit for filing the appeal request is 120 days from the date of receipt of the initial determination. After reviewing, BlueCross will decide whether the initial decision should be affirmed, dismissed or reversed.

- **Level 2: Reconsideration – Request for a review by an independent review organization**

If the claim has gone through the first level appeal process and you are still dissatisfied, you can request an independent review organization review the claim. The time limit for filing the appeal request at this level is 180 days from the date of receipt of the redetermination. The organization will review the request and decide to affirm, dismiss or reverse the original decision.

- **Level 3: Administrative Law Judge (ALJ) Hearing**

At this level of appeal request, you can ask for an administrative law judge to consider the case and make a decision. The time limit for filing the appeal request is 60 days from the date of receipt of the reconsideration. The monetary threshold to be met is at least \$130 that remains in controversy.

- **Level 4: Departmental Appeals Board (DAB) Review**

At this level of appeal request the Departmental Appeals Board can review the case. The time limit for filing the appeal request is 60 days from the date of receipt of the ALJ hearing decision.

- **Level 5: Federal Court Review**

If the provider disagrees with the decision the Departmental Appeals Board made in appeal level 4, the federal court can review the case. The time limit for filing the appeal request is 60 days from date of receipt of DAB decision or declination of review by DAB. The dollar value of the contested benefit must be at least \$1,350 in controversy.

For additional information about Medicare Advantage coverage, please refer to the Medicare Advantage Office Administrative Manual available on our website.

## Section 7: Health Insurance Marketplace (Exchange) Plans

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 that may be uninsured, underinsured or otherwise eligible for federal subsidies and small businesses.

Non-grandfathered health plans within the Health Insurance Marketplace (exchanges) must offer a core package of items and services called “essential health benefits.”

- Ambulatory patient services
- Prescription drugs
- Emergency services
- Habilitative and rehabilitative services and devices
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Preventive and wellness services and chronic disease management
- Mental health and substance use disorder services, including behavioral health treatment
- Pediatric services, including oral and vision care

### Benefit Overview

All preventive benefits such as prostate screenings, pediatric oral and vision care are covered at 100 percent. Women’s designated preventive services include, but are not limited to, mammography screenings and Pap smears at 100 percent. The U.S. Preventive Service Task Force (USPSTF) defines preventive services. Benefits are provided for in-network providers only for individual plan members. There are no benefits for out-of-network providers unless it is a true emergency.

Members may be eligible to receive a federal subsidy. This subsidy can be administered as a tax credit, in which the member pays the entire premium for the year and then receives the credit when he or she files income taxes. It can also be applied as a credit towards the member’s monthly premium. The member would pay a portion of the monthly premium and the federal government would contribute on a monthly basis.

### BlueEssentials<sup>SM</sup> Individual Plans

The individual exchange products offered by BlueCross are called BlueEssentials and are non-grandfathered products. BlueEssentials plans operate under an Exclusive Provider Organization (EPO), which means they use a network of participating doctors, hospitals and other health care providers.

If a provider is not in the BlueEssentials EPO network, we will not cover services unless in the event of an emergency. While the range of benefits is the same among plans, the value of benefits will vary. Always verify coverage for members, as eligibility may change based on premium status.



## Transition of Care



If a BlueEssentials member is under the care of a physician who is not in the BlueEssentials network, they can request special consideration to have benefits applied 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. You can find the Transition of Care form on our website.



## How to Identify BlueEssentials Plan Members

- Only **NEW individual** product lines access the **new** BlueEssentials network.
- Alpha prefixes are ZCU, ZCF and ZCQ.
- These ID cards also distinguish the new networks by having “BlueEssentials Network” and “Exclusive Provider Organization” on the cards.
- Benefits are only available in network! See the back of the ID card.
- The suitcase in the lower right indicates the network that members access when out of state.
- Individual policies only provide coverage to the subscriber. A parent’s plan does not cover dependents. Covered individuals each have their own ID cards.

## Sample BlueEssentials ID Cards

 <span>South Carolina</span>		
Member Name <b>(NAME)</b>		Blue Essentials Network
Member ID		Exclusive Provider Organization
ZCF12345678999		
RxBIN	004336	
RxGRP	SCB15	
Plan Code	380	
www.SouthCarolinaBlues.com		

 <span>South Carolina</span>		
Member Name <b>(NAME)</b>		Blue Essentials Network
Member ID		Exclusive Provider Organization
ZCU12345678999		
RxBIN	004336	
RxGRP	SCB15	
Plan Code	380	
www.SouthCarolinaBlues.com		

 <span>South Carolina</span>		
Member Name <b>(NAME)</b>		Blue Essentials Network
Member ID		Exclusive Provider Organization
ZCQ12345678999		
RxBIN	004336	
RxGRP	SCB15	
Plan Code	380	
www.SouthCarolinaBlues.com		

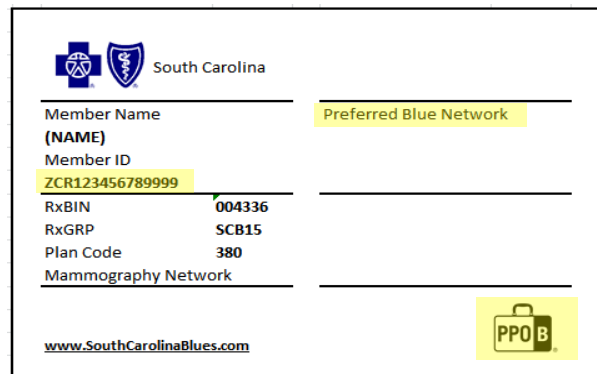
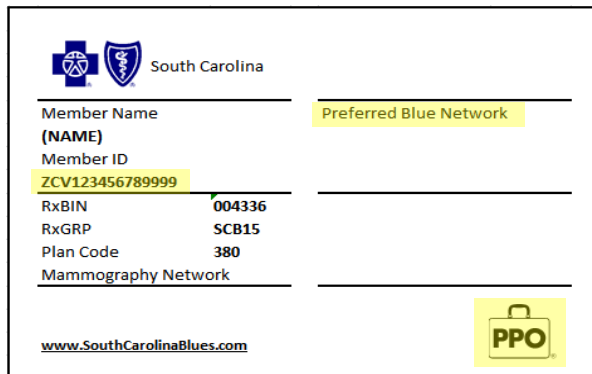
### Small Group Exchange Plans

The small group exchange products BlueCross offers are non-grandfathered products. The small group private exchange products use the BlueCross Preferred Blue network.

### How to Identify Small Group Exchange Plan Members

- Group product lines access the broad commercial BlueCross Network (Preferred Blue).
- New alpha prefixes are ZCV and ZCR.
- These ID cards also have “Preferred Blue Network” on the cards.
- The suitcase in the lower right indicates the network that members access when out of state.

### Sample Small Group Exchange Cards





## Other Information

### Mental Health

You should get treatment plans through CBA. You can visit [www.CompanionBenefitAlternatives.com](http://www.CompanionBenefitAlternatives.com) or call one of these numbers:

Companion Benefit Alternatives	803-699-7308
P.O. Box 100185	800-868-1032
Columbia, SC 29202-3185	(Outside Columbia)

### Prescription Drug Plan

Members have drug coverage through Caremark. They have a four-tier plan with either a drug card and/or mail-service benefits. You can download the Preferred Drug List through our website, [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).

### Benefits and Eligibility

Always verify coverage for members, as eligibility may change based on the premium status. You can quickly get the most current member eligibility and benefit information by using My Insurance Manager on our website. You can also call the Provider Services VRU at 800-868-2510.

### Precertification

Certain categories of benefits require precertification. Failure to get preauthorization may result in us denying benefits. Precertification is not a guarantee that we will cover the service.

For precertification requirements, verify benefits and eligibility through My Insurance Manager. Once you have verified precertification requirements you can initiate the precertification request in My Insurance Manager.

### Premium Delinquencies

Members who do not have a federal subsidy do not have a delinquency grace period. We will deny claims immediately upon delinquency.

Members who have an FFM policy and receive a federal subsidy have a three-month grace period. During the first month of delinquency, we will process all claims and apply benefits accordingly. During the second and third month of delinquency, claims will pend until the member pays the premiums. If the premium is not current at the end of the third month (90 days), we will deny claims. We will notify you of a member's premium delinquency:

1. When verifying eligibility and benefits through My Insurance Manager and the VRU.
2. When verifying claim status through My Insurance Manager and the VRU.
3. When reviewing your remittance advice.



## Section 8: BlueCard Program

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

You can get eligibility and benefits information by calling 800-676-BLUE (2583). Use this number for all members with out-of-state BlueCross and/or BlueShield Plans.

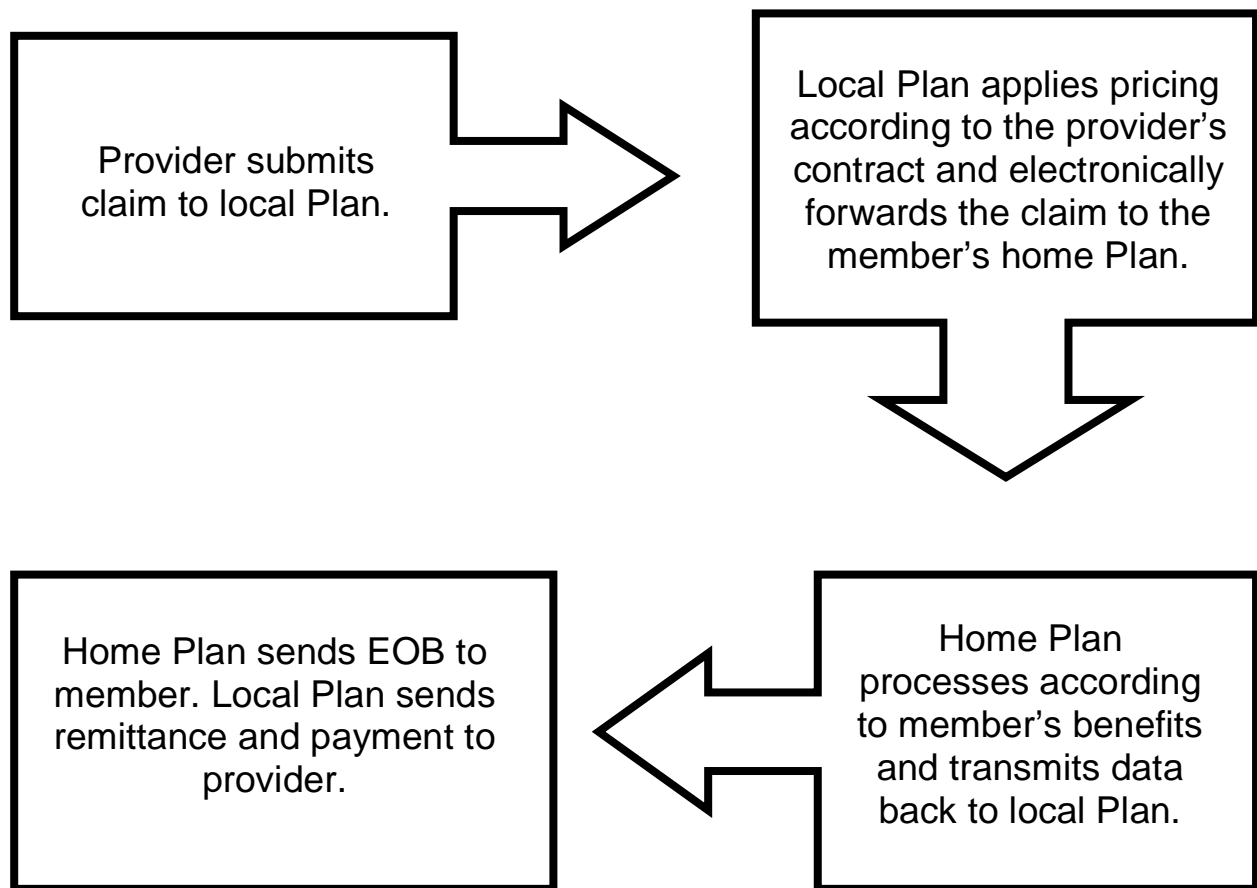
The BlueCard program applies to all inpatient, outpatient and professional claims.

The BlueCard program includes traditional, PPO, POS and HMO products. These products are **optional** under the BlueCard program:

Stand-alone dental and prescription drugs  
Stand-alone vision and hearing

Claims for FEP are exempt from the BlueCard program. You should submit FEP claims to the administering Plan in the state where you provide services.


## The BlueCard Process Illustration



## How to Identify BlueCard Members

When members from other BlueCross and/or BlueShield Plans arrive at your office or facility, be sure to ask for their current membership ID cards. You can identify BlueCard members by the alpha prefix, a blank suitcase logo or a PPO in the suitcase logo on their cards.

### Sample ID Cards

BlueCross BlueShield of Geography		Blue Product <b>ALPHA</b> Employer Group	
Member Name	Dependents		
<b>Member Name</b>	<b>Dependent One</b>		
Member ID	<b>Dependent Two</b>		
<b>XYZ123456789</b>	<b>Dependent Three</b>		
Group No.	<b>023457</b>	Plan	<b>PPO</b>
BIN	<b>987654</b>	Office Visit	<b>\$15</b>
Benefit Plan	<b>HIOPT</b>	Specialist Copay	<b>\$15</b>
Effective Date	<b>00/00/00</b>	Emergency	<b>\$75</b>
Plan Code	<b>123</b>	Deductible	<b>\$50</b>
			

The three-character alpha prefix

The “PPO in a suitcase” logo may appear in the lower right corner of the ID card.

South Carolina			
Member Name	_____		
<b>Jane Q Doe</b>	_____		
Member ID	_____		
<b>ABC123456789012</b>	_____		
R/BIN	<b>004336</b>		
R/GRP	<b>SCB15</b>		
Plan Code	<b>380</b>	Specialist Visit	<b>\$00</b>
<b>Mammography Network</b>		Routine Visit	<b>\$00</b>
www.SouthCarolinaBlues.com			
			

The three-character alpha prefix

The “blank (empty) suitcase” logo may appear in the lower right corner of the ID card.

BlueCard ID cards have a suitcase logo, either as an empty suitcase or as a PPO in a suitcase.

The PPO in a suitcase logo indicates that the member is enrolled in a PPO product. You will be reimbursed according to the BlueCross PPO provider contract.

The blank (empty) suitcase logo indicates that the member has out-of-area coverage that is not a PPO product. Benefit products that display a blank (empty) suitcase logo on ID cards include:

- Traditional
- HMO (Health Maintenance Organization)
- POS
- Limited benefits products

## Alpha Prefix

BlueCross uses a three-character alpha prefix at the beginning of members' ID numbers to identify and correctly route out-of-area claims. The alpha prefix identifies the BlueCross and/or BlueShield Plan to which the member belongs. It is critical for confirming a patient's membership and coverage. Changes to alpha prefixes may appear on your remittance advice. Please review this information carefully to make sure claims are routed correctly.

Examples of ID numbers:

ABC1234567

Alpha  
Prefix

ABC1234H567

Alpha  
Prefix

ABC12345678901234

Alpha  
Prefix

Some ID cards may not have an alpha prefix. This indicates that the claims are handled outside the BlueCard program. Please look on the back of members' ID cards for instructions or telephone numbers on how to file these claims.

As a provider servicing out-of-area members, you may find these tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in your patient's file.
- Verify with the member that the ID number on the card is not his or her Social Security Number. If it is, call the BlueCard Eligibility line at 800-676-BLUE (2583) to verify the ID number.
- Make copies of the front and back of the member's ID card and pass this key information on to your billing staff.
- Remember: Member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID numbers or alpha prefix.

## Eligibility and Benefits

Once you've identified the alpha prefix, call BlueCard Eligibility at 800-676-BLUE (2583) to verify a patient's eligibility and benefit coverage. You can also call the number on the back of the member's ID card.

## Precertification

Each Blue Plan establishes its own precertification requirements. It is important to complete this process before treating a member. After verifying eligibility and benefits, ask to be transferred to the precertification or utilization review area or ask for the direct precertification number. Generally, the precertification number is on the member's ID card.

Blue Cross and Blue Shield Plans launched a new tool on January 1, 2014, that will let you access out-of-area members' Blue Plan (Home Plan) provider portals to conduct electronic pre-service review. The term "pre-service review" refers to pre-notification, pre-certification, pre-authorization and prior approval, among other pre-claim processes. You will be able to access our version of this tool through My Insurance Manager.

Electronic Provider Access (EPA) will let you use My Insurance Manager to gain access to a BlueCard member's Home Plan provider portal through a secure routing mechanism. Once in the portal, you will have the same access to electronic pre-service review capabilities as you would with My Insurance Manager. You will not need a separate login once you get to the Home Plan landing page.

The availability of EPA on January 1 will vary depending on the capabilities of each Home Plan. Some Home Plans will be fully implemented and have electronic pre-service review for many services. Others will not yet have implemented electronic pre-service review capabilities.

## Claim Submission

Always submit BlueCard primary and secondary claims to your local Plan, BlueCross BlueShield of South Carolina. You should transmit BlueCard claims electronically using the 401 carrier or payer code for BlueCross. Be sure to include the member's complete ID number when you submit the claim. The ID number includes the three-character alpha prefix. Incorrect or missing alpha prefixes and member ID numbers will delay claims processing. For secondary BlueCard claims, include the primary payer payment information in the X12N electronic data fields. You can file primary and secondary BlueCard claims electronically by logging into My Insurance Manager.

Once we receive the claim, we electronically route it to the member's Home Plan with pricing based on your contractual agreement with us. The Home Plan verifies eligibility and determines benefits, processes the claim, approves payment and sends instructions back to us to pay you on your BlueCross remittance advice.

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

## Exceptions to BlueCard Claim Submissions

Exceptions may occasionally arise when you must file the claim directly to the member's Plan. Here are some of those exceptions:

- You contract with the member's Blue Plan (for example, in a contiguous county)
- The member ID card does not include an alpha prefix
- A separate vendor processes services which requires direct filing (e.g., APS Healthcare or the State Health Plan)

## Claim Status

Always check the status of your claims through your local BlueCross Plan. Visit [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) and log into My Insurance Manager to check the status of your claim. We send claim status inquiries you submit via the Web directly to the member's Home Plan so we can send you a response immediately.

## Ancillary Claims

Generally, you should file claims directly to BlueCross. There are circumstances, however, when claims filing directions will differ based on the type of provider and service.

Ancillary providers are independent clinical laboratory, durable/home medical equipment and supplies and specialty pharmacy providers. The local Blue Plan as defined for ancillary services is:

- Independent Clinical Laboratory (Lab)
  - The Plan in whose state the specimen was drawn based on the location of the referring provider.
- Durable/Home Medical Equipment and Supplies (DME)
  - The Plan in whose state the equipment was shipped to or purchased at a retail store.
- Specialty Pharmacy
  - 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.**

This claim table demonstrates how to identify the local Plan, as defined for ancillary services.

Provider Type	How to File (required fields)	Where to File	Example
<p><b>Independent Clinical Laboratory</b> (any type of non-hospital-based laboratory)</p> <p>Types of service include, but are not limited to: Blood and urine samples and analysis, etc.</p>	<p><b>Referring Provider:</b></p> <ul style="list-style-type: none"> <li>Field 17 on CMS 1500 Health Insurance Claim Form or</li> <li>Loop 2310A (claim level) on the 837 Professional Electronic</li> </ul>	<p>File the claim to the Plan in which state the <b>specimen was drawn</b>. *</p> <p>*Where the <b>specimen was drawn</b> will be determined by which state the referring provider is located.</p>	<p>Blood is drawn* in lab located in <b>Alabama</b>. Blood analysis is done in <b>South Carolina</b>.</p> <p><b>File to:</b> BlueCross BlueShield of Alabama.</p> <p>*Claims for the analysis of a lab must be filed to the Plan in which state the <b>specimen was drawn</b>.</p>
<p><b>Durable/Home Medical Equipment and Supplies (DME)</b></p> <p>Types of service include, but are not limited to: Hospital beds, oxygen tanks, crutches, etc.</p>	<p><b>Patient's Address:</b></p> <ul style="list-style-type: none"> <li>Field 5 on CMS 1500 Health Insurance Claim Form or</li> <li>Loop 2010CA on the 837 Professional Electronic Submission</li> </ul> <p><b>Ordering Provider:</b></p> <ul style="list-style-type: none"> <li>Field 17 on CMS 1500 Health Insurance Claim Form or</li> <li>Loop 2420E (line level) on the 837 Professional Electronic Submission</li> </ul> <p><b>Place of Service:</b></p> <ul style="list-style-type: none"> <li>Field 24B on CMS 1500 Health Insurance Claim Form or</li> <li>Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions</li> </ul> <p><b>Service Facility Location Information:</b></p> <ul style="list-style-type: none"> <li>Field 32 on CMS 1500 Health Insurance Form or</li> <li>Loop 2310C (claim level) on the 837 Professional Electronic Submission</li> </ul>	<p>File the claim to the Plan in which state the equipment was <b>shipped to or purchased in a retail store</b>.</p>	<p>Wheelchair is purchased at a retail store in <b>South Carolina</b>.</p> <p><b>File to:</b> BlueCross BlueShield of South Carolina.</p> <p><b>HIPAA Place of Service:</b> 99</p> <p>Wheelchair is purchased on the Internet from an online retail supplier in <b>Ohio</b> and shipped to <b>South Carolina</b>.</p> <p><b>File to:</b> BlueCross BlueShield of South Carolina.</p> <p><b>HIPAA Place of Service:</b> 12</p>
<p><b>Specialty Pharmacy</b></p> <p>Types of Service: Non-routine, biological therapeutics ordered by a healthcare professional as a covered medical benefit as defined by the member's Plan's Specialty Pharmacy formulary. Include, but are not limited to: injectable, infusion therapies, etc.</p>	<p><b>Referring Provider:</b></p> <ul style="list-style-type: none"> <li>Field 17B on CMS 1500 Health Insurance Claim Form or</li> <li>Loop 2310A (claim level) on the 837 Professional Electronic Submission.</li> </ul>	<p>File the claim to the Plan whose state the <b>Ordering Physician is located</b>.</p>	<p>Patient is seen by a physician in <b>Ohio</b> who orders a specialty pharmacy injectable for the patient. Patient will receive the injections in <b>South Carolina</b> where the member lives for 6 months of the year.</p> <p><b>File to: Blue Cross Blue Shield of Ohio</b></p>

These rules apply regardless of your contracting status with the Blue Plan where you file the claim.

- Before providing any ancillary service, please verify a member's eligibility and benefits by calling the number on the back of the member's ID card. Or you can call 800-676-BLUE (2583).
- If you use an outside vendor to provide services (e.g., you send a blood specimen for special analysis that the lab where the specimen was drawn cannot do), please use an in-network ancillary provider. This will reduce the possibility that the member will be liable for more costs.
- Members are financially liable for ancillary services not covered under their benefit plans. It is your responsibility to request payment directly from the member for non-covered services.

### **Contiguous Counties**

A contiguous area is generally a border county in another Plan's service area one county over from the Plan's own service area.

File ancillary claims incurred in a contiguous county directly to the member's Plan, but solely for its members who live or work in its service area. File claims for all other members to the local Plan, as defined for ancillary services.

Claims filing rules for contiguous area providers are based on the permitted terms of the provider contact, which may include:

- Provider location (i.e., in which Plan service area the provider's office is located).
- Provider contract status with the two contiguous counties (i.e., is the provider contracted with only one or both service areas).
- The member's Home Plan and where the member works and resides (i.e., is the member's Home Plan with one of the contiguous counties' Plans).

The location of where the services were received (i.e., does the member work and reside in one contiguous county and see a provider in another contiguous county).



## Traditional Medicare-Related Claims

When Medicare is the primary payer, submit claims to your local Medicare carrier. Most Blue claims are set up to automatically cross over to the member's Blue Plan after being adjudicated by the Medicare carrier.

These guidelines will help you handle claims for Medicare beneficiaries who also have BlueCross coverage:

- Enter the correct Blue Plan name as the secondary carrier. Check the member's ID card for the correct Blue Plan name.
- Include the alpha prefix as part of the member identification number. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.
- When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan.
  - If the Medicare claim has crossed over to the appropriate Blue Plan, DO NOT resubmit the claim to BlueCross. Wait 30 days to receive the payment from the Blue Plan before sending another claim. Sending another claim slows down the claim payment process and creates confusion for the member.
  - If the Medicare claim was not crossed over, submit the claim along with the Medicare remittance advice to BlueCross.

**Note:** Processed claims submitted to the Medicare intermediary will be crossed over to the Blue Plan within 14 business days. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for cross-over processing about the same time you receive the Medicare remittance advice. As a result, it may take an additional 14-30 business days for you to receive payment from the Blue Plan.

## BlueCard Contacts and Resources

BlueCard Contacts and Resources	
BlueCard Eligibility	800-676-BLUE (2583)
BlueCard Access Line (Provider Search)	800-810-BLUE (2583) <a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a> Select <i>Find a Provider</i>
BlueCard Authorization	<a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a> Select <i>My Insurance Manager</i>
BlueCard Claim Status	<a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a> Select <i>My Insurance Manager</i>
BlueCard Program Provider Manual	<a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a>
Provider Education	Email: <a href="mailto:Provider.Education@bcbsc.com">Provider.Education@bcbsc.com</a> 800-288-2227, ext. 44730

## Section 9: BlueCross Dental Plans

### Commercial Dental Plans

There are commercial dental plans that use a network of participating providers and other plans that do not have a network. Members may visit any provider, however, an out-of-network provider may 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)

### How to Identify Commercial Dental Plan Members

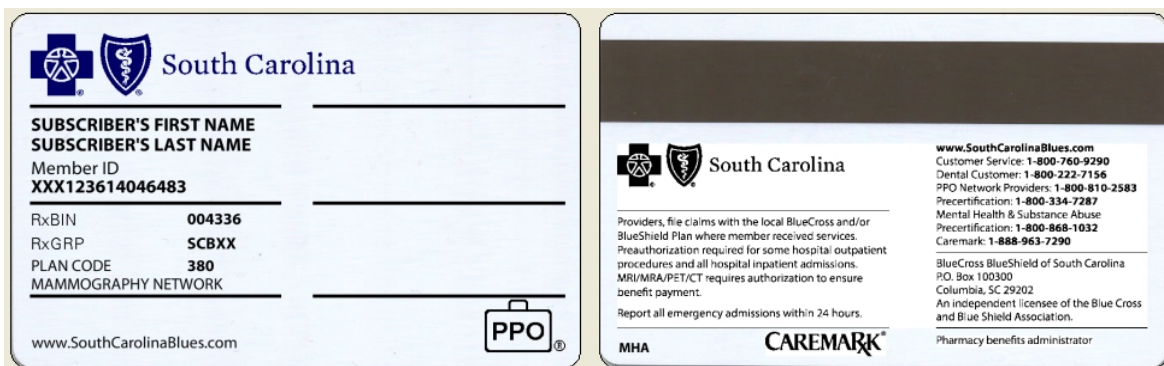
The ID card shows the plan, member's identification number and plan code number. On the reverse side is the customer service telephone number. Depending on the plan, coverage may be for dental only or offered in conjunction with a member's health benefits.

Here are examples of member identification cards from our commercial group plans that offer dental benefits.

### Sample Commercial — Dental Only ID Card



### Sample Commercial — Medical and Dental ID Card



## Benefits and Eligibility

You can access benefits – in network and out of network – and eligibility for commercial dental plan members by logging into My Insurance Manager or by calling the Provider Services VRU at 800-222-7156 (Columbia Service Center) or 800-922-1185 (Greenville Service Center).

## How to File Claims for Commercial Dental Plans

The mailing address for Commercial dental claim forms is on the back of the member's ID card. When submitting a hard copy claim, use the standard 2012 American Dental Association (ADA) Claim form.

- Use carrier (payer) code 38520.
- Timely filing is 12 months from the date of service.
- Submit claims electronically to BlueCross BlueShield of South Carolina in the HIPAA 837D format.  
**This is our preferred method of claim submission for all providers.**

## Dental GRID

Several BlueCross and BlueShield Plans around the nation have developed a program that enables dentists to see patients from other participating BlueCross and BlueShield Plans at their local Plan reimbursement levels. We call this program the national Dental GRID.

### What This Means for You

More patients will likely turn to your dental office for their dental care. This is because you will be “in network” for patients who are members of BlueCross and BlueShield groups based in other states.

It will not change your reimbursement levels or participating provider agreement in any way. We will continue to reimburse you based on your current participating provider agreement.

### How to Recognize a GRID Program Member

On either the front or back of the member's dental-only ID card or his or her combined medical-dental ID card, you should see the word “GRID.” There will also be a customer service number to contact with your benefit or eligibility questions.

A small number of participating BlueCross and/or BlueShield Plans may not immediately update their member ID cards to add the word “GRID.” If a member states he or she has the GRID network, but you don't see “GRID” on his or her card, please verify participation. Please call the provider service or customer service phone number on the ID card that is listed for dental questions.

### Where to Send Claims for GRID

Send claims to the address on the member's ID card. Please check the front or back of the card for address information. The BlueCross and/or BlueShield Plan where the member's group is located pays the claims. Reimbursement is at your negotiated Participating Dental Agreement fees.

## When Did GRID Begin?

The GRID program became effective January 1, 2012.

## Participating Plans as of 01/01/14

- Anthem Blue Cross
- Anthem Blue Cross and Blue Shield
- Arkansas BlueCross BlueShield
- Blue Cross and Blue Shield of Nebraska
- Blue Cross Blue Shield of Wyoming
- BlueCross BlueShield of Arizona
- BlueCross BlueShield of Florida
- BlueCross BlueShield of Georgia
- BlueCross BlueShield of Kansas
- BlueCross BlueShield of North Carolina
- BlueCross BlueShield of North Dakota
- BlueCross BlueShield of South Carolina
- BlueCross BlueShield of Tennessee
- BlueCross BlueShield of Vermont
- BlueCross of Idaho
- Capital BlueCross- Dominion Dental
- CareFirst BlueCross BlueShield
- DeCare Dental
- Empire BlueCross BlueShield
- Excellus BlueCross BlueShield
- Horizon Blue Cross Blue Shield of New Jersey
- Wellmark
- Wellpoint

*These Plans are independent licensees of the Blue Cross and Blue Shield Association.*

## FEP BlueDental<sup>SM</sup>


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.

### How to Identify FEP BlueDental Plan Members

The ID card will indicate the provider network (GRID+), member's identification number, group number, program name, and on the reverse side, the address to send the claims and the customer service telephone number. The lower left corner of the member's ID card will display GRID+ indicating the use of the GRID+ network.

The ID card is for identification ONLY. The ID card is not a guarantee of eligibility or benefits. When a member provides your office with his or her FEP BlueDental ID Card, it is important to also ask for his or her medical ID card. The medical ID card is important because by law, the member's medical plan is the primary carrier.

### Sample FEP BlueDental ID Card

 <b>BlueCross. BlueShield.</b>		<b>FEP BlueDental.</b>	
FIRST_NAME LAST_NAME		_____	
ID Number	XXXXXXXXXXXX	DEPENDENTS	_____
Program <b>FEP BLUEDENTAL</b>			
Group Number	000000-0000	_____	
www.fepblue.org		FEP BlueDental	

<p><b>GRID+</b></p> <p>Present this card at each visit, along with your medical card, if applicable, for coordination of benefits. This card is for identification only and not a guarantee of benefits or eligibility. For claims submission purposes, use the member's identification number.</p> <p><i>Claims should be submitted to medical carriers for primary coverage and not directly to dental if member has medical coverage.</i></p> <p>Printed 10/9/2013 #216 WFEP Seq 1</p>	<p><i>For GRID+ Dental Network: Customer Service within the U.S. call: 855-504-2583 Outside of the U.S. call collect: 651-994-2583</i></p> <hr/> <p><i>If the member has dental coverage only, forward claims to:</i></p> <p><b>Dental Claims PO Box 75 Minneapolis, MN 55440-0075</b></p>
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### Benefits and Eligibility

FEP BlueDental recommends that you verify coverage for the date of service. Call the FEP BlueDental Customer Service department at 855-504-2583.

### How to File FEP BlueDental Claims

The mailing address for FEP BlueDental claim forms is:

FEP BlueDental Claims  
 P.O. Box 75  
 Minneapolis, MN 55440-0075

**COB**

The member's medical coverage is always primary, while FEP BlueDental is secondary. Submit all claims to the primary medical plan first. Refer to the back of the member's medical ID card for submission. Submit pre-estimates of benefits directly to FEP BlueDental. Upon completion of the dental care, submit the claim to the primary medical plan.

**Service Benefit Plan (FEP) Medical Member**

Submit claims to the local BlueCross BlueShield Plan. Primary payment will be sent to you and then FEP Medical will forward the claim, along with the primary payment amount, to FEP BlueDental. The primary benefit will be coordinated on the claim received from the medical carrier and upon completion of COB, FEP BlueDental will send the secondary payment to you.

**Reconsiderations/Claim Dispute**

If you and your FEP BlueDental patient disagree with the initial decision of how dental services were processed, please encourage your FEP BlueDental patient to refer to his or her FEP BlueDental Brochure on how to submit a reconsideration.

Send reconsiderations or claim disputes to:

FEP BlueDental Claims Appeals  
P.O. Box 551  
Minneapolis, MN 55440-0551

## State Dental and Dental Plus Plans

BlueCross administers the State Dental and Dental Plus Plans. The dental benefits are divided into 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 covered under the State Dental Plan. 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 pay what the State Dental Plan does not. Instead, it covers the same procedures and services (except orthodontics) at the same percentage of coverage as the State Dental Plan. The difference is the payment is based on a higher allowance for the covered services.

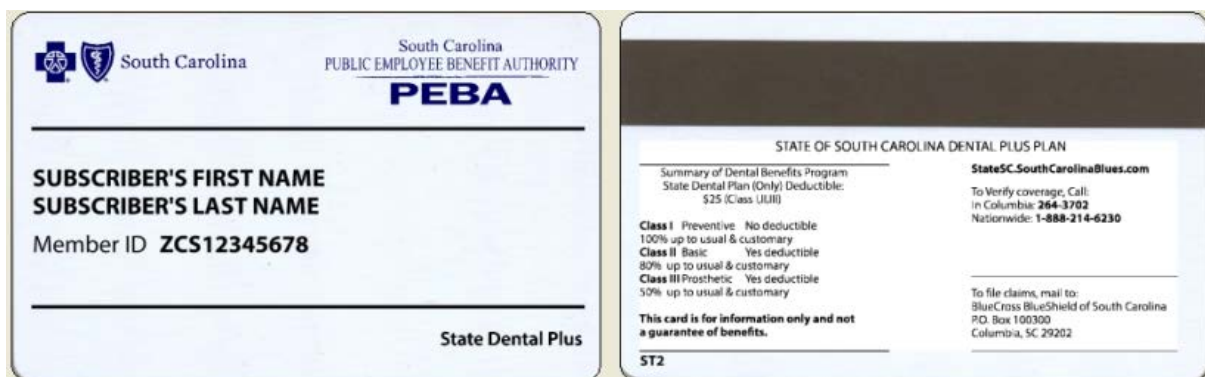
### How to Identify Dental Plus Plan Members

The ID card displays the subscriber's first and last name, the identification number, including the three-digit alpha prefix, and the plan name. The reverse side of the ID gives a brief summary of benefits, the claims mailing address and the customer service telephone number.

Important facts about the alpha prefix that you should know are:

- Use of the correct alpha prefix is critical for electronic routing of specific HIPAA transactions to the appropriate BlueCross and/or BlueShield Plan.
- Capture all ID card data at the time of service.
- The member's ID card number is his or her Social Security Number.
- Be sure all of your system upgrades accommodate the alpha 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.

### Sample State Dental Plus ID Card





## Benefits and Eligibility

You can access benefits and eligibility for State Dental and Dental Plus members by logging into My Insurance Manager or by calling State Dental Customer Services at 888-214-6230 (toll free) or 803-264-3702 (in Columbia).

## How to File State Dental and Dental Plus Claims

- Use carrier (payer) code 38520.
- Timely filing is 24 months from the date of service.
- Submit claims electronically to BlueCross in the HIPAA 837 format under the appropriate carrier code. This is our preferred method of claim submission for all providers.

When submitting a hard copy claim, use the 2012 ADA State Claim form, which can be found at <https://StateSC.SouthCarolinaBlues.com> in the Publications and Forms section.

The mailing address for State Dental claim forms is:

BlueCross BlueShield of South Carolina  
State Dental Claims  
P.O. Box 100300  
Columbia, SC 29202-3300

## Claim Status

You can submit claim status inquiries by visiting [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) and logging into My Insurance Manager. You can also access claim status through the State Dental VRU by calling 888-214-6320 (toll-free) or 803-264-3702 (in Columbia).

## Other Health/Dental Insurance Questionnaire

Dental providers can assist members who need to update their Other Health/Dental Insurance (OHI) information. We require our members to update this information yearly.

You can make it easy by giving members computer access right in your office. Ask them to log into My Health Toolkit<sup>®</sup> and update their information. Have the member follow a link to the Other Health/Dental Insurance Questionnaire. Or, you can print the Other Insurance form from [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) and give it to your patient if he or she does not have access to our website.



## Section 10: Other Carrier Liability

One method of controlling health insurance costs is called Other Carrier Liability (OCL). We use OCL when the payment for a member's medical expenses is the responsibility of more than one third-party payer. Examples of third-party payers include group health insurance plans, Medicare, workers' compensation and subrogation. We define and explain the four rules of OCL here.

### COB

Calculating payments between the primary and secondary plans is called of COB. COB is a contractual provision of our group contracts. The COB rules determine which insurance carrier will be primary and pay regular benefits. They also determine which insurance carrier will be secondary and pay the remaining balance, not to exceed the policy limit.

When filing for patients covered by two or more health plans, bill the primary carrier first. When you receive payment, file the claim with the secondary information electronically to the secondary carrier, and then to the tertiary (third) carrier, if applicable.

The Other Health and Dental Coverage Questionnaire form is available on our website. Members can also update this information when they log into My Health Toolkit.

If you require members to update this information regularly, please keep a copy of the form on file. Sending in these forms unsolicited may cause a delay in processing or updating information. If you receive a claim denial requesting the member submit this questionnaire, you can then take the completed form and fax or mail to the appropriate location indicated on the form. Sending in completed forms to the incorrect area may also cause a delay in processing.

## COB Rules

- Two policies involved and only one has a COB provision:
  1. Primary: Contract without the COB provision
  2. Secondary: Contract with the COB provision
- Two policies involved. Both have a COB provision and the patient is the member:
  1. Primary: The policy that covers the patient as an active employee
  2. Secondary: The policy that covers the patient as a retired or laid-off employee (includes COBRA extension)
- Patient covered under two policies, one as a member and the other as a dependent:
  1. Primary: Patient's own policy
  2. Secondary: Policy under which the patient is a dependent
- Patient is a child (natural or legally adopted) covered under both the father and mother's policy:
  1. Primary: The policy of the parent whose birth month (regardless of birth year) falls earlier in the year
  2. Secondary: The policy of the parent whose birth month (regardless of birth year) falls later in the year
- Dependent children of divorced or separated parents:

If there is a court decree establishing financial responsibility for a child's health care, the plan of the parent assigned that responsibility is primary. If the parents have joint custody, either the Birthday or Gender Rule will apply, depending on which rule governs the contracts.

**Gender Rule:** The father's insurance plan is primary for dependent children.

**Birthday Rule:** The plan of the parent born earlier in the year is primary for dependent children. For example, if the father's birth date is March 1, 1950, and the mother's birth date is February 1, 1952, the mother's plan will be primary for the children because her birthday occurs earlier in the year than the father's.

Each state decides whether to use the Gender or the Birthday Rule. In South Carolina, the Birthday Rule is used for fully insured group plans with effective or anniversary dates on or after June 1, 1990. If BlueCross must coordinate with an insurance plan that uses the Gender Rule, and this results in a conflict, the Gender Rule will be followed.

## Other Factors Under COB Regulations

### Preservation of the Primary Plan's Cost Containment Features

The secondary plan can exclude from consideration any benefits the primary plan reduces when the patient doesn't follow precertification rules, such as preadmission, emergency admission, continued stay reviews and second surgical opinions.

### Personal Injury Protection

The secondary plan can reduce its benefits by the amount paid under the personal injury protection (PIP) portion of a person's automobile insurance policy.

### Medicare Part B

Since Medicare Part B is voluntary, the secondary plan can reduce its benefits by the amount that Medicare Part B would have paid if the patient had chosen Part B coverage (called "Phantom B"). This only applies when the group plan is secondary to Medicare.

### Medicare Carve-Out

Carve-out is a method of calculating benefits when group contracts are secondary to Medicare. The State Health Plan uses the carve-out method to coordinate benefits.

The State Health Plan carve-out method uses different procedures for calculating secondary benefits on assigned and non-assigned Medicare claims. Here are the steps for each of the two procedures in detail:

#### Medicare Carve-Out for Non-Assigned Claims

We use these steps to determine secondary benefits when providers do not accept Medicare assignment:

1. Calculate what the benefits would be in the absence of Medicare. Apply deductibles and coinsurance to this calculation.
2. Subtract Medicare's payment from normal benefits. This gives the dollar amount. If the remaining dollar amount is positive, then BlueCross will pay that amount. If the remaining dollar amount is zero or a negative amount, then we will not pay any benefits.

#### Medicare Carve-Out for Assigned Claims

Carve-out COB requires additional calculations when providers accept assignment of Medicare benefits. BlueCross uses these steps to calculate secondary benefits on assigned claims:

1. Subtract the Medicare payment from the Medicare-approved amount. Refer to this as calculation "A."
2. Calculate normal benefits, including appropriate deductibles and coinsurance.
3. Subtract Medicare's payment from normal benefits. Refer to this as calculation "B." If this results in a negative amount, consider calculation "B" to be equal to zero.
4. Compare calculations "A" and "B." Payment will be the lesser of the two amounts.

## Medicare Secondary and Supplemental Policies

These guidelines will help you handle claims for Medicare beneficiaries who also have BlueCross coverage:

When Medicare is primary and assignment is **accepted**:

- Do not charge the patient.
- File the claim to Medicare.
- Receive the Medicare Summary Notice (MSN).
- Most claims automatically cross over from Medicare to BlueCross. Verify this automatic claims feature before filing a claim to BlueCross. If the claim does not automatically cross over from Medicare, file the claim electronically to BlueCross.
- If the beneficiary does not have this “piggy-back” option, file the claim to BlueCross and include a copy of the MSN. You can file these electronically by using My Insurance Manager. Indicate in the “other coverage” field that Medicare is primary.
- BlueCross pays the balance up to, but not exceeding, the Medicare-allowable amount shown on the MSN.

When Medicare is primary and assignment is **not accepted**:

- Charge the member in full, but within Medicare’s guidelines.
- File the claim to Medicare.
- File the claim to BlueCross indicating in the “other coverage” field that the member has Medicare and has “paid in full.”
- After Medicare processes the claim, the member can file a copy of the MSN to BlueCross for the balance.

The majority of Medicare supplemental claims will automatically cross over to BlueCross, and you do not have to file secondary claims. After Medicare processes benefits, the claim and payment information are electronically transmitted to BlueCross. BlueCross will then process the claim for supplemental benefits according to the subscriber contract.

Please allow sufficient time for us to receive and process your cross-over claims before submitting a claim to BlueCross. On average, allow at least 30 days for the primary Medicare claim to cross over and for BlueCross to process the supplemental payment. Do not submit a secondary claim to BlueCross until you have verified that the claim did not cross over automatically from the Medicare payer. You can verify claim status through My Insurance Manager.

## Medicare Provider Number

When BlueCross has a Medicare location number, Tax ID number or Unique Physician Identification Number (UPIN) that is different from the information that Medicare has, it delays claims processing.

If your Medicare provider number changes, or if you have not previously given BlueCross your Medicare provider number, please submit your current Medicare provider number to your contracting specialist.

## Medicare Non-Automated Cross-Over System

You can submit these claims electronically through the X12N HIPAA-compliant format or by using My Insurance Manager.

## Medicare Automated Cross-Over System

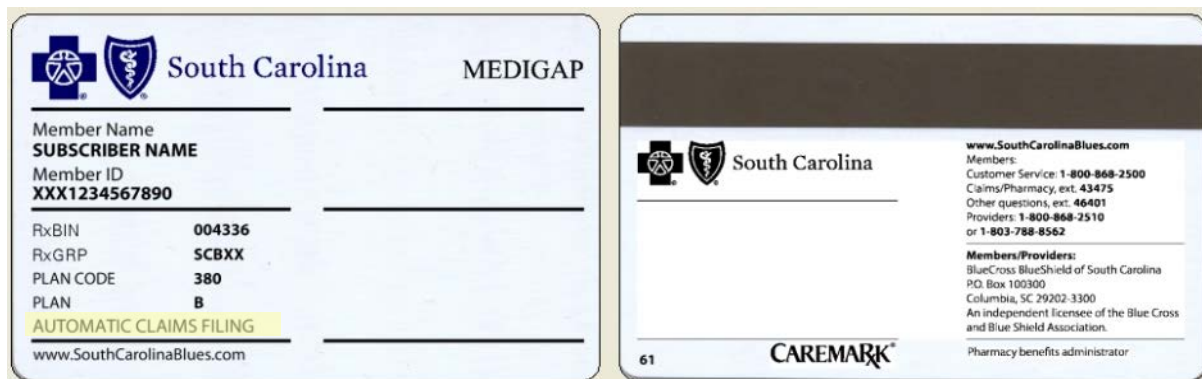
### Automated Cross-Over Policy Benefit

- State Health Plan
- FEP

### Automated Cross-Over Policy Option

- BlueCross Medicare Supplements
- Indicated by “automated claim filing” on the member’s ID card

### Sample ID Card



## Subrogation

All BlueCross contracts contain a subrogation clause. This clause provides for situations in which a third party is responsible for a patient's medical expenses. This provision prevents duplicating payments to the patient and, in turn, allows BlueCross to keep premiums at a more competitive rate.

BlueCross will pay the claim and issue a notice of lien. This lien will guarantee the recovery of any benefits the member received for medical expenses as a result of the accident.

Examples of potential subrogation cases include:

- Automobile accidents – a person is injured because of another person's fault.
- Medical malpractice – the doctor or hospital is responsible for injury or illness.
- Homeowner's – the injury is caused by a homeowner's negligence, such as steps in need of repair.
- Slip and fall cases – a store fails to clean up liquid on the floor, causing someone to slip, fall or sustain injury.
- Product liability case – a defective product causes injury.

## Workers' Compensation

BlueCross considers treatment of an occupational illness or injury a workers' compensation service. When we receive a claim for services with potential accidental diagnosis, we will send an Accident Questionnaire to the member. The Accident Questionnaire form is available on our website. You can bill the member for these services until the member returns the questionnaire and we have updated the file.

# Section 11: Claim Submission

## Procedure Codes and Guidelines

BlueCross uses physicians' Current Procedural Terminology (CPT), a systematic listing and coding of procedures and services performed by providers, for processing claims. A five-digit code identifies each procedure or service.

Because medical nomenclature and procedural coding are rapidly changing fields, certain codes may be added, modified or deleted each year. Please make sure your office uses the current edition of the codebook when filing claims. BlueCross will reject claims containing invalid codes at the EDI Gateway and will return paper claims to the providers.

## Diagnosis and Procedure Coding

The International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM) is the basis of diagnosis and procedure coding at BlueCross. This system is composed of three volumes:

- Volume 1 Diseases: Tabular List
- Volume 2 Diseases: Alphabetic Index
- Volume 3 Procedures: Tabular List and Alphabetic Index

This system classifies diagnoses by three-digit categories with the addition of a fourth or fifth digit to provide specificity, or additional information, regarding etiology, site or manifestations.

It is necessary to use the current edition of the codebook when filing claims. The applicable codebooks include, but are not limited to, ICD-9-CM Volumes 1, 2 and 3, CPT and the Healthcare Common Procedure Coding System (HCPCS).

## Modifiers

A modifier lets the reporting provider indicate that a specific circumstance has altered a service or procedure, but not changed its definition or code. You should use modifiers appropriately.

Visit [www.CMS.gov](http://www.CMS.gov) for the most up-to-date information on valid and invalid modifiers.

## Filing Claims

As a participating network provider, you agree to submit claims for BlueCross, FEP, BlueCard (out of area) and State Health Plan members electronically using the HIPAA-compliant 837 (I or P), X12 format. 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](http://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.

## Superbill

The Superbill tool within My Insurance Manager is ideal for professional providers who want to submit primary claims for a single date of service. You can create and store your Superbill online, then use it to submit a professional Web claim with minimal keystrokes. It takes only seconds to submit a claim to BlueCross, and you will receive instant claim disposition!

## Timely Filing

All plans have time limitations for claim submission. 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, you are encouraged 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.

Note: Timely filing limits are subject to change. You can verify timely filing limits by checking eligibility and benefits in My Insurance Manager.

## Provider Number

Each participating provider should use his or her Tax Identification Number (TIN) or National Provider Identifier (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.

## Refunds

There may be times when we must request refunds of payments we 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.



## Section 12: Remittance Advice

### Remittance Types

Institutional and professional health care providers receive 835 remittance advices and Electronic Funds Transfers (EFTs). The Electronic Remittance Advice (ERA), or 835, is the electronic transaction which provides claim payment information in the HIPAA-mandated (ACSX12 005010X221A1) format. Practices, facilities and billing companies use these files to automatically post claim payments into their systems.

The State Health Plan issues remittances and EFTs twice a week. All other plans issue payments once per week. Patients are responsible for any amounts shown in the Patient Liability “Deductible” column and the “Other” column. You can view or print remittance advices by logging into My Insurance Manager.

You can determine a claim’s submission channel by reviewing the BlueCross claim number. Electronic claims through the HIPAA X12N or Web formats will result in faster reimbursement, reduced administrative costs and the elimination of keying errors.

- Electronic claim (claim submitted through clearinghouse)  
Example – 1C0000111000
- Web claim (claim submitted through our website, [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com))  
Example – 33000000W0000
- Superbill claim (claim submitted for professional providers who want to file multiple charges for one date of service)  
Example – 33000000P0000
- Hardcopy claim (claim mailed hardcopy)  
Example – 1600011110000

## My Remit Manager

My Remit Manager ([www.MyRemitManager.com](http://www.MyRemitManager.com)) is an online tool you can use to search remits by patient, account number and check number.

We offer My Remit Manager **free** to all providers who receive Electronic Funds Transfer (EFT) payments and electronic remittance advices. My Remit Manager:

- Accepts 835s from all commercial BlueCross lines of business.
- Works independently of your practice management system or clearinghouse.

With My Remit Manager, you can:

- **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.** My Remit Manager highlights any claims that have errors or that BlueCross has denied.
- **View information categorized by check numbers or by patient.** My Remit Manager 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 blackout 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., specific data over a specific time period.

In order to access My Remit Manager, please contact Provider Education at 803-264-4730 to request us to set up a profile for you. You can submit your request via email to [Provider.Education@bcssc.com](mailto:Provider.Education@bcssc.com).

## Section 13: Medical Management

Most BlueCross members have managed care requirements in their contracts. These requirements make sure inpatient stays are medically necessary and the members are spending their health care dollars wisely. All members have ID cards showing the preadmission review requirements and the telephone numbers for reporting admissions. Precertification is also known as prior authorization, preauthorization, pre-service review or pre-admission review.

### Online Precertification Requests

You can request a precertification via My Insurance Manager at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). With the “Pre-Certification/Referral” feature under Patient Care, you can submit precertification requests to BlueCross, the State Health Plan, BlueEssentials and BlueChoice® HealthPlan, and some other Blue Plans. Precertification requests are not available online for FEP members.

Visit the Education Center at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) to learn more about online precertification requests.

**A precertification is a not guarantee payment of benefits. Claim payments are subject to the rules of the plan and eligibility at the time the service is rendered.**

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

## National Imaging Associates (NIA)

Some fully insured groups require certain advanced imaging services be precertified by National Imaging Associates (NIA) when performed and billed in an outpatient or office location. NIA is an independent company that manages outpatient imaging and radiology services on behalf of BlueCross.

BlueCross will retain control over claims adjudication and all medical policies and procedures. NIA manages certain outpatient imaging and radiology services. We will continue to pay claims for imaging services based upon the terms of your BlueCross agreement.

Non-emergent procedures requiring prior authorization are:

- Computerized Axial Tomography (CAT) scan
- Positron Emission Tomography (PET) scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)

You can view the NIA Reference Guide, Claim Resolution Matrix, a list of group prefixes that require precertification for these services and other radiology information in the Radiology Precertification section of the Education Center at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). Please note, some of the groups include ASO plans, as well.

Each Blue Plan establishes its own prior authorization requirements. It is important to complete this process before treating the member. Be sure to verify precertification requirements when verifying eligibility and benefits. Generally, the prior authorization number is on the member's ID card.

### Note:

- The ordering physician should get the prior authorization. The provider rendering the service should verify that he or she has received the precertification. **Failure to do so may result in non-payment of the claim.**
- We do not require precertification for emergency room, observation and inpatient imaging procedures.
- We exclude members with Medicare primary coverage from this NIA agreement.

Visit [www.RadMD.com](http://www.RadMD.com) or call 866-500-7664 to request a precertification or check the status of a request. You can also access the NIA website by visiting the Precertification section of [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).

## Preadmission Authorization Program

The Preadmission Authorization Program reviews and authorizes hospital admission before hospitalization to make sure the service is medically necessary, appropriate and in accordance with the member's group contract.

You can request precertification for BlueCross, BlueChoice HealthPlan and State Health Plan members by logging into My Insurance Manager. Contact FEP to get precertification for FEP members at 803-264-0258 (fax) or 800-327-3238.

We resolve a high percentage of Web requests immediately and provide precertification numbers instantly. If you do not have access to the Web, refer to the member's ID card to get the phone number for preadmission authorization. We will request this information:

- Patient's/member's name, current address, date of birth, BlueCross ID number and relationship of the patient to the member
- Provider's name, address and telephone number
- Name of the hospital to which you plan to admit the patient
- Anticipated admission date
- Requested length of stay
- Admitting diagnosis, major procedures, plan of treatment, medical justification for inpatient admission and complications or other factors requiring the inpatient setting
- Caller's name, phone number, fax number and email address

BlueCross classifies the initial telephone call received before a scheduled inpatient admission or outpatient procedure as a non-urgent authorization. At the time of the initial call, we will need pertinent medical information to complete the authorization. If we approve the request, we notify the contact person by telephone or fax within one working day of making the decision. We provide the authorization number and approved length of stay at this time. We send a confirmation letter to the physician, hospital and member within 24 hours of the reported admission. If we deny the authorization, we notify the contact person by telephone within one working day of making the decision. We provide the reason for denial at this time.

The precertification process only evaluates the medical necessity of the inpatient setting for treatment. Payment of benefits remains subject to all other member contract or certificate terms, conditions, exclusions and the patient's eligibility for benefits at the time he or she incurred the expenses.

## Emergency Admission

BlueCross requires notification for emergency admissions within 24 hours or the next business day. We will request pertinent medical information to document the medical necessity of all emergency admissions.

## Newborn Hospitalizations

BlueCross requires precertification for a sick baby or a newborn that the hospital does not discharge with the mother.

## Notification of Admission/Status Change

Occasionally, it may be necessary to change or cancel an admission, or adjust the anticipated length of stay. When a change in the nature, duration or reason(s) for an authorized admission occurs, you should notify the authorization unit of the change.

### What Happens When an Admission Review Isn't Done?

- Your patient or facility may receive a penalty, such as denial of room and board charges.
- BlueCross may reduce the member's benefits (additional copayment/deductible).
- BlueCross may delay payment for the claim to determine medical necessity.
- BlueCross may need medical records to review the claim.

## Case Management

Case management is a free service BlueCross offers to all Preferred Blue and State Health Plan members on a voluntary basis to help them and their families plan, coordinate and evaluate the options and services necessary to help deal with the complex health care delivery system. BlueCross case managers are registered nurses who are knowledgeable in the care of patients and work in cooperation with all the health care providers involved in a patient's care. When we identify a member as someone who may benefit from case management services, a case manager will call the patient, explain the benefits of the program and ask if he or she is interested in participating. Or, if you feel that a patient needs case management, you can call the number on the back of his or her ID card to ask how to take advantage of this service.

Case managers work with the patient, his or her family, and providers to maximize the use of available health care resources. They are knowledgeable about the member's health care benefits and community resources available for patients.

## Retrospective Review

BlueCross' Retrospective Review Unit reviews claims to make sure the services received by the patient were medically appropriate and met the definition of covered services under the members' contracts/certificates. BlueCross may perform a retrospective review to assess the medical need and correct billing levels for services that providers have already performed. Registered nurses handle retrospective reviews, but the medical director makes the final determination.

The nurses claim diagnoses, treatments or procedures including, but not limited to, cosmetic, experimental or investigational services, that the member's contract/certificate may limit or exclude. The nurses also conduct medical reviews for possible pre-existing conditions.

## Concurrent Care

Concurrent Care consists of the treatment of one or more diseases or areas of the body when those services are more extensive than consultative services and more than one physician provides the services during the same period of time or the same hospital admission. It also may refer to medical and surgical care one physician provides during the same admission.

### Medical-to-Medical Concurrent Care

When two physicians provide care for unrelated conditions at the same time, BlueCross pays benefits to each physician if:

- The physicians are not of the same or similar specialty (e.g., endocrinologist and cardiologist).
- Each physician is treating the patient for a condition unique to his or her specialty.
- The admitting physician releases care of the patient to a consulting physician and provides supporting documentation.

### Medical-to-Surgical Concurrent Care by Different Physicians

BlueCross pays benefits for inpatient medical services physicians other than the admitting surgeon perform in addition to benefits for inpatient surgical services under these circumstances:

- The medical care was not related to the condition causing the surgery and is not part of routine preoperative or postoperative care.
- The medical care required skills that the admitting or assisting physicians do not possess.
- A physician other than a surgeon admits the patient for medical treatment and surgery becomes necessary.

### Medical Care Benefits (more than one visit per day)

BlueCross reimburses only one level of care when a physician files for more than one service he or she provided to a patient on the same date of service. We will provide benefits for the level of care carrying the highest allowable charge.

## Section 14: Medical Guidelines

### Multiple Surgeries

Multiple surgical procedures are operations physicians perform during the same session. When physicians perform multiple procedures at the same time through the same surgical opening or by the same surgical approach, the total amount BlueCross covers for such operations or procedures will be the allowable charge for the major covered procedure only.

If physicians perform two or more operations or procedures at the same time, through different surgical openings or by different surgical approaches, the total amount BlueCross covers will be the allowable charge for the covered operation or procedure bearing the highest allowance, plus one-half of the allowable charge for all other covered operations. If a service includes a combination of procedures, you should use one code rather than reporting each procedure separately.

If an operation consists of the excision of multiple benign skin lesions, BlueCross will pay the total amount it covers according to the allowable charge for the covered procedure bearing the highest allowance, 50 percent for the covered procedures bearing the second and third highest allowances, 25 percent for the covered procedures bearing the fourth through the eighth highest allowances and 10 percent for all other covered procedures.

If a physician performs an operation or procedure in two or more steps or stages, BlueCross will limit coverage for the entire operation or procedure to the allowable charge set forth for that operation or procedure.

### Assistant Surgeon

There are medical policies that will reimburse for services a physician assistant performs. Our current contracts, however, do not cover services a physician assistant performs and only reimburse for those a licensed MD performs.

We do have certain instances in which we will reimburse for a physician assistant. Use of an assistant surgeon must meet medical necessity for BlueCross to consider reimbursement. This results in one physician acting as the primary surgeon and the other acting as an assistant. BlueCross provides benefits for an assistant surgeon under these conditions:

- The assistant is a licensed, practicing physician.
- There is sufficient complexity to the procedure or the patient's condition warrants an assistant.
- An intern, resident or house physician is not available to assist.



## Bilateral Procedures

File all bilateral procedures to BlueCross on one line with the CPT code and modifier “-50 Document one unit (DUT).” The modifier indicates the physician performed the procedure on two sides, and BlueCross will reimburse 150 percent of the allowable for covered procedures.

### Anesthesia

BlueCross requires anesthesiologists and CRNAs to file claims using CPT anesthesia codes. We cover general anesthesia services when the operating physician requests them and a nurse anesthetist or physician, other than the operating physician, performs them for covered surgical services. We cover anesthetic or sedation procedures the operating physician or an advanced practice registered nurse performs as a part of the surgical or diagnostic procedure. We consider local anesthesia to be an integral part of the surgical procedure and do not provide additional benefits. We recognize these modifiers:

### Anesthesiologist Modifiers

- AA – Anesthesia services an anesthesiologist personally performs
- AD – Medical supervision by a physician (more than four concurrent anesthesia procedures)
- QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
- QY – Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist

### CRNA Modifiers

- QX – CRNA service with medical direction by a physician
- QZ – CRNA service without medical direction by a physician

### Monitored Anesthesia Care Modifiers

BlueCross may reimburse for modifiers QS, G8 and G9 if a physician personally performs the procedure (modifier AA) and if the procedure meets medical necessity criteria. We will not reimburse modifiers QK, QX, QY and QZ for supervision of monitored anesthesia care (MAC). We will not reimburse CRNAs for MAC.

- QS – Monitored anesthesia care service (must appear in the second modifier field)
- G8 – Monitored anesthesia care for a deep complex, complicated or markedly invasive surgical procedure (must appear in the second modifier field)
- G9 – Monitored anesthesia care for a patient who has a history of severe cardiopulmonary condition (must appear in the second modifier field)

## Anesthesia Risk Factors

There are three modifiers anesthesiologists or nurse anesthetists can file indicating they have added time limits when the physical status of the patient presented a serious health risk. They must place these modifiers in the second modifier field of the claim form.

BlueCross will only pay risk factors if the physician (modifier AA on the primary anesthesia code) administers the anesthesia personally. There will be no separate reimbursement for risk factors for CRNAs or anesthesiologist supervision of CRNAs, even if they report it separately.

### Risk Modifiers

<b>P-3</b>	Add one time unit when a patient has a severe systemic disease, such as uncontrolled diabetes or hypertension requiring medication.
<b>P-4</b>	Add two time units when a patient has a severe systemic disease that is a constant threat to life, such as severe respiratory or cardiac disease.
<b>P-5</b>	Add three time units when the patient is not expected to survive for 24 hours with or without the operation, such as multiple severe trauma or severe head injury.

## Other Anesthesia

### Maternity Epidural Anesthesia

- Global allowance with no consideration of time units
  - Limited to practitioner who personally inserts the epidural needle
  - File AA or QZ modifiers
- No separate reimbursement for monitoring or supervising

### Stand-By Anesthesia

BlueCross provides benefits if the anesthesiologist offers the personal patient care normally provided when administering anesthesia (e.g., examines patient, connects monitoring lines, personally monitors patient during operative procedure), but does not actually administer the anesthesia unless required. We may reimburse the anesthesiologist for both the procedure and time. File claims for stand-by anesthesia using the appropriate anesthesia code, anesthesia modifier and time units.

### Qualifying Circumstances

Physicians provide many anesthesia services under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions and unusual risk factors. These circumstances significantly impact the character of the anesthesia service the physician provides.

BlueCross may only reimburse qualifying codes if the physician administers the anesthesia personally. There will be no separate reimbursement for risk factors for CRNAs or anesthesiologist supervision of CRNAs, even if providers report these separately.

If a CRNA inserts the needle under the direct supervision of an anesthesiologist, the anesthesiologist may bill a QK modifier.

## Conscious Sedation

Physicians use sedation with or without analgesia to achieve a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and ability to respond to stimulation or verbal commands. Benefits for this service are included in the benefits BlueCross provides for medical care consultations or surgical care, including the pre- and postoperative care.

Monitoring of IV sedation by an anesthesiologist for gastrointestinal endoscopy, arteriograms, CT scans, MRIs, cardiac catheterizations and PTCA may be medically necessary for children, acutely agitated patients, or, in some cases, acutely ill patients who cannot have the procedure without sedation. Exceptions may be made for CT scans and MRIs for agitated patients. Examples include, but are not limited to, patients:

- With organic brain disease
- With senile dementia
- With delirium
- With claustrophobia
- Who are uncooperative mentally retarded

In the case of cardiac catheterization and PTCA, the catheterization lab setting provides monitoring availability. Any monitoring not done by the attending cardiologist is done by hospital personnel, and we do not provide separate benefits.

## Nerve Blocks

BlueCross includes administration of a nerve block in the allowance for total anesthesia time. It is not eligible for separate reimbursement.

When the nerve block is a separate procedure and is for the treatment of a non-surgical condition or for non-postoperative pain management, providers should bill it using the appropriate surgical procedure.

## Anesthesia Units

### Base Units

BlueCross uses the Medicare base units for procedures.

### Time Units

Providers should report anesthesia time units in minutes. BlueCross calculates the number of units for claims adjudication based on 15-minute increments, rounded to the nearest tenth (1/10). For example, we would calculate 49 minutes as follows:

$$\begin{aligned} 49 \text{ minutes}/15 \text{ increment} &= 3.266 \text{ units} \\ 3.266 &\text{ would round to } 3.3 \text{ time units} \end{aligned}$$

### We do not provide anesthesia benefits for:

- The administration of anesthesia for non-covered services, such as cosmetic surgery.

**We do not provide separate benefits for these if in conjunction with other surgical or medical services:**

- Preoperative anesthesia consultation
- Transesophageal cardiography
- Emergency intubation
- The administration of anesthesia by the attending surgeon or surgical assistant, except as outlined above
- Local anesthesia

## **Anesthesia Frequently Asked Questions (FAQ)**

**Question:** Will BlueCross cover anesthesia when a physician provides it with a non-covered service?

**Answer:** No. When a physician provides anesthesia services with a non-covered service, BlueCross does not cover the physician's charge for the anesthesia, with the exception of general anesthesia for dental surgical procedures that are covered under a separate dental contract.

**Question:** When does anesthesia time begin and end?

**Answer:** Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area. It ends when the patient may be safely placed under postoperative supervision.

**Question:** Does BlueCross cover anesthesia when an attending or assisting physician administers it?

**Answer:** BlueCross does not provide benefits when an attending or assisting physician administers anesthesia, with the exception of regional anesthesia administered during delivery.

## Maternity Care

Most BlueCross plans offer maternity benefits that require a member to notify the plan within the first trimester of a pregnancy. A member who does not notify the plan may receive a penalty. Maternity benefits for covered members are subject to reimbursement under these conditions:

### Global Care Maternity Benefits

BlueCross reimburses for global maternity benefits. These benefits include:

- Antepartum care
- Delivery
- Postpartum care

If a patient leaves her physician's care before delivery, the physician should file either office visits or the appropriate antepartum CPT codes as we outline here. We may require a statement supporting the reason for the non-global charges before reimbursing the provider. Some reasons a patient may terminate care are:

- Patient establishes care with a new practice.
- Patient moved to another geographic location.
- Patient has a high-risk pregnancy and her physician transfers her to another practitioner.

If the patient has less than or equal to three visits, file single office visits for each date of service. For four or more visits, file the appropriate antepartum, delivery or postpartum CPT code. File one DUT for all antepartum codes, regardless of the number of visits. This is applicable for Preferred Blue, FEP, the State Health Plan and all BlueCard members.

## Benefits Outside of Global Care

### 1. Lab work

- An obstetrical lab panel is reimbursable outside of the global care benefits.  
(Please see our medical policy for additional information.)

### 2. Fetal non-stress test

- Eligible for reimbursement in addition to global payment when a provider performs the test not more than once every seven days or with supporting medical records of an “at-risk” pregnancy.

### 3. Ultrasounds

- BlueCross considers the use of an ultrasound to be a medically necessary tool in pregnancies from 10-18 weeks gestation.
- More than **two** or repeat ultrasounds during the course of a pregnancy require medical justification.

### 4. Amniocentesis

- BlueCross considers this procedure to be performed between the 16<sup>th</sup> and 20<sup>th</sup> weeks of gestation to aid in the diagnosis of fetal abnormalities.
- An infrequent indication for an amniocentesis is for fetal sex determination for pregnancies, which are at risk for x-linked heredity disorders

### 5. Multiple births

- BlueCross does **not** consider multiple births a complication of pregnancy when no other complications or risk factors exist. If there is a complication during the pregnancy or delivery, the provider should file for additional reimbursement consideration using the appropriate modifier indicating complications.

### 6. Tubal ligation during or after delivery.

- Vaginal delivery – BlueCross reimburses at 100 percent of allowed amount.
- Caesarean delivery – BlueCross reimburses at 50 percent of the allowed amount.

### 7. Anesthesia that the attending obstetrician or delivering physician gives.

- BlueCross will reimburse the attending obstetrician or delivering physician at 50 percent of the allowed amount if he or she performs the insertion and maintenance of epidural anesthesia.

BlueCross typically reimburses hospital admissions due to pregnancy complications or other non-pregnancy related conditions outside of global care.

## Accessing Medical Policies

BlueCross BlueShield of South Carolina uses medical policies and guidelines to make clinical determinations for members' coverage. These guidelines are accessible to you on our website, [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). You can also contact our Medical Affairs department if you have questions about our medical policies.

To access medical policies from the BlueCross homepage:

- Select "Provider" at the top of the page.
- Select "Education Center" on the right side of the page.
- Under "Medical Policies and Clinical Guidelines" in the center of the page, select "Medical Policies."
- You will be taken to the Medical Policies disclaimer page. Once you have read and accepted the disclaimer, you will be taken to the listing of Medical Policies.
- You can then search topics by alphabet or category as well as searching by keywords.
- If you have questions about medical policies, you can contact Medical Affairs by choosing "Contact Us" at the top of the screen. Our clinical staff will review your question and contact you.

Please note, you should submit specific eligibility, coverage and claims questions through My Insurance Manager.

## Section 15: Medical Review

### Review

A review is a request for reconsideration, based on extenuating medical circumstances, when BlueCross denies a claim or there is a discrepancy in the denial or payment amount.

Examples include:

- Cosmetic and procedures that are not medically necessary
- Multiple surgery or medical care a patient receives on the same day
- Extenuating medical circumstances supporting additional reimbursement

Complete a Medical Review Form, found on our website in the Forms section. Attach the applicable medical records and supporting information to the form. Fax or mail the form and supporting documents to the appropriate service area. This information may include, but is not limited to:

- Records from the primary or referring physician
- Operative notes
- Office notes
- Discharge notes

Do not submit a review for claim status or for a service that is not a covered benefit. It generally takes BlueCross 30 days to complete reviews and initiate claim adjustments or generate letters of denial to providers.

### Appeals

An appeal is a second-line review you can request after BlueCross has reviewed a claim and upheld its original decision. Complete a Medical Review Form and indicate it is an appeal by checking the appropriate box. Attach additional medical records, supporting information and the review denial letter to the form. Fax or mail this information to the appropriate service area.

It generally takes BlueCross 30 days to complete appeals and initiate claim adjustments or generate letters of second denial to providers.



## Inappropriate Reviews

There are some instances when providers file reviews or appeals for reasons other than claim denials. We call these “inappropriate reviews.” Here are some examples of inappropriate use of the review and appeal processes:

- Checking claim status.
  - Get claim status by using My Insurance Manager or the VRU.
- Sending a claim follow-up letter, “tracer” claim, patient account report or corrected claim.
  - BlueCross will deny any claims you submit after the originals as duplicates.
  - File corrected claims electronically through the HIPAA X12N format or via My Insurance Manager.
- The procedure or service is not a covered benefit for the patient under his or her contract.
  - A request for medical review will not alter the coverage.

If your office consistently files medical reviews for items that are not appropriate for review, an education specialist may initiate a training session to discuss proper procedures.

## Levels of Appeals

### **Step 1: The initial decision by BlueCross**

When BlueCross makes its initial decision, it is giving its interpretation of how the member’s covered benefits and services apply to the specific situation.

### **Step 2: Appealing the initial decision by BlueCross**

If a physician or physician group disagrees with the decision made in Step 1, it can appeal a claim disposition by using the Medical Review Form. Be sure to include all supporting medical documentation and fax to the appropriate fax number on the bottom of the Medical Review Form. After reviewing the reconsideration, BlueCross will decide whether the initial decision should be affirmed, dismissed or reversed.

### **Step 3: Request for a review by an independent review organization**

If the claim has gone through the reconsideration process and the physician or physician group is still dissatisfied, it can request an independent review organization to review the claim. The organization will review the request and decide to affirm, dismiss or reverse the original decision.

You can find the Medical Review form in the Providers section of our website. Just click Forms, then Provider Appeals and Medical Review.

**SAMPLE**



To request claims review, please complete this information for BlueCross BlueShield of South Carolina members (including Preferred Blue<sup>®</sup> members, state of South Carolina employees, and federal employees). When submitting review requests, please use this form as a cover to all attachments. Be sure to complete or check each section, as appropriate. When you submit a second level appeal, we require *additional* information. If you do not submit new or additional documentation, we will uphold the denial.

**Patient Information**

Patient's Name: \_\_\_\_\_ Identification Number: \_\_\_\_\_

Type of Plan (Check only one):  State Health  Federal Employee  Group & Individual  Preferred Blue  BlueCard<sup>®</sup>

**Provider Information**

Email Address: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Signature of Person Requesting Review/Appeal: \_\_\_\_\_

1<sup>st</sup> level Review  2<sup>nd</sup> level  Appeal (check one) Attach copy of 1<sup>st</sup> review denial for Appeal

Claim Number: \_\_\_\_\_ Date of Service: \_\_\_\_\_

Description of Request:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Attachments** – Please attach all documentation you would like us to consider in the review/appeal.

Remittance Advice  History and Physical  Operative Report  Office Notes  Pathology Report  
 Hospital Progress Notes  Radiology Report  Laboratory Report  Other \_\_\_\_\_

\*\*\*\*Do not attach claim\*\*\*\*

Fax or mail to the appropriate address:

STATE HEALTH PLAN:  
("ZCS" ALPHA PREFIX)

STATE HEALTH PLAN: AX-B10  
ATTN: MEDICAL APPEALS  
P.O. BOX 100605, COLUMBIA, SC 29260  
FAX 803-264-4204

FEDERAL EMPLOYEE PROGRAM/FEP:  
("R" ALPHA PREFIX)

FEDERAL EMPLOYEE PROGRAM: AX-B05  
ATTN: MEDICAL APPEALS  
P.O. BOX 600601, COLUMBIA SC 29260  
FAX 803-264-8104

GROUP & INDIVIDUAL:  
("ZCY" ALPHA PREFIX)

GROUP & INDIVIDUAL: AX-F25  
ATTN: MEDICAL APPEALS  
I-20 at ALPINE ROAD, COLUMBIA, SC 29219  
FAX 803-264-4172

PREFERRED BLUE AND ALL OTHER  
BlueCross (BlueCard):

PPO PROVIDER SERVICES: AX-620  
ATTN: MEDICAL APPEALS  
I-20 at ALPINE ROAD, COLUMBIA, SC 29219  
FAX 803-264-4172

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

## Solicited Records Requests

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

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 Verisk ordering the records. Having a single records vendor among all BlueCross plans streamlines the records request process. It helps to eliminate multiple requests from various plans. You should only receive requests for records from BlueCross, Inovalon or Verisk.

- Records requests will only come from Verisk for non-claim related requests for out-of-state BlueCross members. Verisk is an independent company that coordinates medical records retrieval on behalf of BlueCross.
- You will continue to receive requests from Inovalon for Medicare Advantage members. Inovalon is an independent company that handles clinical documentation services on behalf of BlueCross.
- You will continue to receive requests from your local BlueCross for claims-related issues.

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, BlueChoice® 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.

## Section 16: Ancillary Health Services

Ancillary health providers are licensed and/or certified health care professionals other than physicians or hospitals. These can include dialysis centers, durable medical equipment suppliers, ambulatory surgical centers, diagnostic centers and any other health care provider, organization or institution BlueCross recognizes.

### Ambulatory Surgery Centers

Ambulatory surgery centers should file claims electronically to BlueCross in the HIPAA-compliant 837I (UB-04) format. File with the appropriate bill type, revenue code and CPT codes. You will not need the SG modifier on these institutional forms. Prior authorization follows each specific group requirement.

### Dialysis

- File electronically using the HIPAA-compliant 837I (UB-04).
- File dialysis claims using the appropriate CPT-4 codes.
- Use the service unit's field to indicate the number of treatments within the dates of service that appear on the claim.
- Itemize all other billed charges for services or products and include the appropriate HCPCS code on the claim.

### Home Health Services

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
651	Home Hospice Care
655	Respite Care
656	General Inpatient Care
431	Occupational Therapy
279	Wound Care

## Hospice

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

## Skilled Nursing Facility

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.

## 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.

## IV Infusion Therapy

Infusion therapy providers should file claims electronically to BlueCross in the HIPAA-compliant 837P (HCFA 1500) format using the appropriate CPT or HCPCS codes. We encourage you to check a member's benefits and eligibility to determine if prior authorization is required.

## Durable Medical Equipment (DME)

DME is any equipment that provides therapeutic benefits to a patient in need due to certain medical conditions and/or illnesses. DME includes, but is not limited to, wheelchairs (manual/electric), hospital beds, traction equipment, crutches, walkers, kidney machines, ventilators, oxygen, monitors, pressure mattresses, prostheses, etc. DME is any equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose. DME is used to treat any illness or injury and is appropriate for home use.

BlueCross offers benefits for DME when it meets all these criteria:

- The equipment provides therapeutic benefit to a patient in need due to certain medical conditions and/or illnesses.
- A physician prescribes the equipment.
- The equipment does not serve primarily as a comfort, convenience or hygienic item or safety item.
- The equipment does not have significant non-medical uses (environmental control equipment).

As a general rule, the patient must be capable of operating the equipment unassisted. Equipment that is for the convenience of a caregiver is not eligible for coverage. BlueCross will, however, cover a hospital bed for a quadriplegic patient requiring body positioning. This exception meets the medical necessity requirement, but not the criteria for operating the equipment unassisted.

We do not offer DME benefits for repair or maintenance of rented equipment. The repair or maintenance of rented DME is the responsibility of the participating DME supplier at no additional charge to the member. The member is responsible for DME repair and maintenance of purchased equipment (subject to warranty provisions or medical necessity).

For purchased DME, the participating DME supplier must provide a two-year warranty agreement to the member even for used equipment that the member purchases following rental.

The participating DME supplier must always inform the member about any DME warranty the manufacturer provides. The DME supplier agrees to provide all DME services, supplies and orthotic and prosthetic devices, if applicable, according to these standards:

- Free delivery
- Free installation
- 24-hour emergency services seven days a week by both technicians and professionals
- Rental equipment repair and maintenance service (same day service, if necessary)
- Clinical professionals for patient education and home management
- Where necessary, graphically illustrated patient education and instruction manuals
- Availability of standard/economical models that meet a patient's needs and quality standards

### **DME Rental vs. Purchase**

BlueCross has the option of approving either the rental or purchase of DME. Based on medical necessity, we may approve rental for a specified number of months or up to the purchase allowance. We may also approve a member to purchase DME. We will reimburse DME purchases when the patient receives the equipment, not at the time of order.

We consider rented DME purchased once the monthly rental allowance equals the purchase allowance. The patient then owns the DME and the DME supplier cannot bill the member or BlueCross for additional rental or purchase of the equipment. After the rent-up-to-purchase has been met, you can bill for supplies and medically necessary repairs.

### **Deluxe and Special Features**

BlueCross considers certain DME "deluxe" equipment due to its mechanical or electrical features (e.g., electric hospital beds). A deluxe item is any equipment with operating expenses, including supplies that are in excess of the cost of the standard equipment meeting the medical necessity requirements of the plan. The preferred DME provider will make physicians aware of the availability of more economical versions of DME and/or orthotics and prosthetics that will meet the member's needs and quality standards.

We cover deluxe equipment only if it is both medically necessary and therapeutic in nature. We will not pay for deluxe equipment a physician orders primarily for a member's comfort or convenience that is not medically necessary and therapeutic.

When the member requests deluxe equipment and his or her physician does not document medical necessity for the deluxe features of covered DME, we will base benefits on the rental or purchase allowance for standard/economical equipment. Due to certain conditions, illnesses or injuries, we may consider DME with special or customized features medically necessary. All equipment of this type is subject to individual payment consideration before we approve.

DME suppliers should include charges for rental equipment accessories in the rental price of the equipment when billing BlueCross. You should submit all DME requests for special or customized features to us for precertification.

### **Certificate of Medical Necessity (CMN) Form**

For FEP only, DME suppliers must file all initial claims for the rental or purchase of DME with a completed CMN. You can submit the CMN Form found on Medicare's website at [www.CMS.gov](http://www.CMS.gov).

When prescribing DME, the patient's physician should complete the CMN form. BlueCross may, in some cases, request additional medical records and documentation from the prescribing physician. This additional documentation includes, but is not limited to:

- A clinical assessment, in narrative form, including past and present history and signs and symptoms expected to improve with the use of the equipment.
- Reports of any clinical/diagnostic tests [e.g., pulmonary function, complete blood count (CBC), oxygen and saturation, etc.] that show evidence of the diagnosis and need for the equipment.
- Written verification that the physician has tried other methods of treatment, such as drug therapy, gravity feeding and supplemental oxygen, etc., and has proven them unsuccessful or noted these methods were not clinically indicated.
- A report of polysomnography studies documenting a diagnosis of obstructive sleep apnea. The report should indicate at least one four-hour sleep session as well as a session using the monitor that shows a significant improvement.

A member should give the DME certification form to the participating DME supplier, along with his or her ID card. DME suppliers should file all claims electronically to BlueCross. If we need additional information, we will request it.

For certain DME, we may require a precertification to determine medical necessity of continued use after the member has rented the equipment for a specified number of months (e.g., SIDS apnea monitor). We will notify the member and the participating DME supplier of the recertification requirements when we approve the initial length of rental. We will not pay any claims we receive beyond this approved period without a recertification of medical necessity.



## Section 17: Electronic Data Interchange

The BlueCross Electronic Data Interchange (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.

### Carrier Codes

BlueCross uses carrier codes (payer codes) 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. Here are the carrier codes:

- 400 – State Health Plan (SHP)
- 401 – BlueCross BlueShield of South Carolina  
(including all out-of-state BlueCard claims)
- 402 – Federal Employee Program (FEP)
- 922 – BlueChoice HealthPlan
- 886 – Planned Administrators Incorporated (PAI)
- 315 – Thomas Cooper & Company
- 446 – Key Benefit Administrators (KBA)
- C63 – Medicare Advantage Preferred Provider Organization (PPO)

Planned Administrators, Inc. and Thomas Cooper & Company are separate companies that offer third party administration services on behalf of BlueCross. Key Benefit Administrators is an independent company that offers third party administration services on behalf of BlueCross.



## Electronic Remittance Advice (ERA - 835) and Electronic Funds Transfer (EFT)

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.

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

You can request ERA and EFT together or separately. They are independent of each other. Complete the ERA Addendum found on [www.HIPAACriticalCenter.com](http://www.HIPAACriticalCenter.com). The EFT form is available on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).

Remittance advices are also available in My Insurance Manager.

### EDI Help

For all questions concerning the electronic interchange of health care data, contact the EDI Help Desk at **800-868-2505**.

You can submit professional and institutional claims, including corrected and secondary claims, through My Insurance Manager at no charge. View the tutorials on filing claims on our website. If you would like a live demonstration or training on e-claims, contact your provider advocate to schedule an appointment. You can also email [Provider.Education@bcbsc.com](mailto:Provider.Education@bcbsc.com) to request this education.

## EDI FAQ

**Question: How much does it cost to establish an electronic connection with BlueCross?**

**Answer:** It depends on the features and functionality you want.

Internet – There is no charge to access the features and services on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). The only cost will be that of a computer and an Internet connection.

Validated Vendor – The charge for an electronic connection through a validated vendor is usually included in the practice management software package. A communication service charge may apply. Contact the vendor of your choice for pricing details.

Clearinghouse – A clearinghouse can either be its own validated vendor that only handles claim submission, audit trail and remittance retrieval. Or, it can be incorporated as part of another validated vendor practice management software system that handles the claims system within that product.

File Transfer Protocol (FTP) – Some validated vendors offer FTP as a connection option. The use of a vendor product or “script” would cost more than programming directly from your office. It would, however, most likely offer user-friendly functionality and support. Although FTP is one of the options some of our validated vendors have programmed, you can use it without a vendor product to connect directly to BlueCross.

**Question: How long does it take to get set up for electronic filing?**

**Answer:** It depends on which method of electronic communication you choose. Internet setup is instant. All other methods depend on the vendor involved.

**Question: Do I need to go through a vendor or can I use the Web applications?**

**Answer:** Either is acceptable. The volume of claims that your office files will determine which is most practical and cost effective for you.

**Question: What is the cost for filing claims on the BlueCross website?**

**Answer:** There is no cost, other than for the computer and Internet connection. The website is totally free.

**Question: How do I get a list of certified vendors?**

**Answer:** We publish a list of certified vendors in the HIPAA Critical Center at [www.HIPAACriticalCenter.com](http://www.HIPAACriticalCenter.com).

**Question: Who is the best vendor, or whom do you recommend?**

**Answer:** We do not make specific recommendations, but offer the list of certified vendors who currently transmit to us electronically.

**Question: What types of claims can be sent electronically?**

**Answer:** All claims. We accept institutional (facility) and professional (medical and dental) claims, including corrected and secondary claims. This also includes e-claims in My Insurance Manager.

**Question: Can I send attachments electronically?**

**Answer:** Currently, there are no claim attachments that we require you to submit electronically.

## Section 18: HIPAA

The Health Insurance Portability and Accountability Act (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.

The BlueCross Gateway processes these ASC X12N Version 4010A1 transactions 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)

## Transactions and 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 October 16, 2003. We met this deadline and are fully HIPAA-compliant.

### Applicability

The regulation pertains to:

- All health plans (including 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 (including 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., EOBs) 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.

## HIPAA Transactions

- 270/271 - Benefits and Eligibility
- 276/277 - Claim Status
- 278 - Review
- 834 - Membership
- 835 - Remittance
- 837 I/P/D - Claim submission

**270** – Health Care Eligibility Benefit Inquiry  
**271** – Health Care Eligibility Benefit Response

**276** – Health Care Claims Status Request  
**277** – Health Care Claims Status Response

**278** – Health Care Services Review-Request for Review and Response – for prior authorizations and referral authorizations

**835** – Health Care Claim Payment/Advice – Commonly called Electronic Remittance Advice (ERA)

**837** - Health Care Claim – The **837 Professional** version replaces the HCFA-1500 or NSF electronic format, the **837 Institutional** version replaces the UB-92 and the **837 Dental** version is for dental claims.

## Trading Partner Agreements and Supplemental Implementation Guides

### Trading Partner Agreement

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](http://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](http://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:

- 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.

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.

- 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.

## EDIG Trading Partner Enrollment Form Instructions

Enrollment with the EDI Gateway requires prospective trading partners to complete and submit:

- The BlueCross EDIG Trading Partner Enrollment Form (an example is on the next page).
- The Trading Partner Agreement.

The purpose of the EDIG Trading Partner Enrollment Form is to enroll providers, software vendors, clearinghouses and billing services as trading partners and recipients of electronic data. It is important you follow the instructions and complete all the required information. We will return incomplete forms to the applicant, which could delay the enrollment process.

You can find the enrollment form at the HIPAA Critical Center or in the Appendix of the EDI Gateway Technical Communications User's Manual.

If you are a prospective BlueCross or BlueChoice HealthPlan trading partner, print and mail a hard copy of the completed Trading Partner Agreement to:

BlueCross BlueShield of South Carolina  
Technology Support Center: EDI Enrollment  
I-20 at Alpine Road, AA-E05  
Columbia, SC 29219

We will acknowledge our EDI Gateway's receipt of your completed enrollment form via email within three business days and will include your Trading Partner ID.



## BlueCross BlueShield of South Carolina EDIG Trading Partner Enrollment Form ASC X12N Transactions

Date: \_\_\_\_\_

**Action Requested:**  New Trading Partner ID  
 (Check One)  Change  Cancel

**Trading Partner's Name:** \_\_\_\_\_

**Trading Partner ID:** \_\_\_\_\_

**Federal Tax ID #:** \_\_\_\_\_

**Type of Business:**  Institutional Health Care Provider  Clearinghouse  Billing Service  
 (Check One)  Professional Health Care Provider  Health Care Plan  
 Retail Pharmacy  Pharmacy Benefit Manager  
 Software Vendor  Other (*indicate*): \_\_\_\_\_

**Line of Business:**  BlueCross BlueShield of South Carolina Commercial  
 (Check One)  PGBA TRICARE

**Start Date:** \_\_\_\_\_ (mm/dd/ccyy)

**End Date:** \_\_\_\_\_ (mm/dd/ccyy)  
*(Required when canceling an account)*

**Compression:**  No Compression  PKZIP  UNIX  
 (Check One)

**Protocol:**  NDM  FTP DIALUP  ASYNC DIALUP (product) \_\_\_\_\_  
 (Check One)  Secure FTP  VPN  TCPIP via VPN  
 TCPIP via AGNS

### Service Address

**Address 1:** \_\_\_\_\_

**Address 2:** \_\_\_\_\_

**City/State/ZIP:** \_\_\_\_\_

### Billing Address (If different from the Service Address)

**Address 1:** \_\_\_\_\_

**Address 2:** \_\_\_\_\_

**City/State/ZIP:** \_\_\_\_\_

### Primary Contact's Information

**First/Last Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Telephone:** ( ) \_\_\_ - \_\_\_ ext. \_\_\_\_\_ **Fax:** ( ) \_\_\_ - \_\_\_

### Primary Technical Contact's Information

**First/Last Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Telephone:** ( ) \_\_\_ - \_\_\_ ext. \_\_\_\_\_ **Fax:** ( ) \_\_\_ - \_\_\_

### After Hours Technical Contact's Information

**First/Last Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Telephone:** ( ) \_\_\_ - \_\_\_ ext. \_\_\_\_\_ **Fax:** ( ) \_\_\_ - \_\_\_

### On-Call Technical Contact's Information

**First/Last Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Telephone:** ( ) \_\_\_ - \_\_\_ ext. \_\_\_\_\_ **Fax:** ( ) \_\_\_ - \_\_\_



If you are a clearinghouse or software vendor and would like to be added to the Certified Vendor list on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com), please provide this information:

Website Address/URL: \_\_\_\_\_

Salesperson's Name and Telephone #: \_\_\_\_\_

If you would like to provide additional contact information, please do so here. On the description line give a brief explanation or purpose for the additional contact.

### Additional Contact Information

<b>1<sup>st</sup> Additional Contact Information</b>	
First/Last Name: _____	Email: _____
Telephone: ( ) ____ - ____ ext. ____	Fax: ( ) ____ - ____

<b>2<sup>nd</sup> Additional Contact Information</b>	
First/Last Name: _____	Email: _____
Telephone: ( ) ____ - ____ ext. ____	Fax: ( ) ____ - ____

<b>3<sup>rd</sup> Additional Contact Information</b>	
First/Last Name: _____	Email: _____
Telephone: ( ) ____ - ____ ext. ____	Fax: ( ) ____ - ____

*BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.*

# Section 19: www.SouthCarolinaBlues.com

In keeping with the latest technology, BlueCross BlueShield of South Carolina provides health care information available at your fingertips at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).



The screenshot shows the homepage of www.SouthCarolinaBlues.com. At the top left is the BlueCross BlueShield of South Carolina logo. To the right, there is a navigation menu with options: "I am a ...", "Provider", "Agent", and "Employer". Below the logo is a main navigation bar with links for "Home", "Insurance Basics", "Shop", "Member Perks", and "Live Healthy". A search bar is located on the right side of this bar.

The main content area features a large banner with a smiling woman in a blue top. The text reads: "Because it matters how you're treated." Below this, a call to action says "Avoid the Penalty! Enroll by March 31." with a "Shop Now" button. A secondary message states: "We'll help you find a health insurance plan that's right for you. You may be eligible for lower monthly costs. If you are, we'll help you apply. Even if you're not eligible, we have lots of easy ways to shop for coverage." Below the banner are three smaller images: "2014 HEALTH PLANS", "NEW MEMBERS", and "COLON CANCER".

On the right side, there are three utility boxes:
 

- Member Login**: Includes a "My Health Toolkit" link, fields for "Username" and "Password", and buttons for "Login" and "Register Now!". Links for "Forgot Username?" and "Forgot Password?" are also present.
- Shop for Insurance**: Includes links for "See Our Plans", "South Carolina BLUE Retail Center", "Get a Quote", "Find an Agent", and "Individual & Family".
- Find a Doctor or Hospital**: Includes links for "Find a Provider", "Print a Directory", and "Worldwide Directory".

The footer contains three URAC accreditation logos (Case Management, Disease Management, Health Plan), "About Us" links (About BlueCross, Careers, Newsroom, Privacy & Legal), "Need Assistance?" links (Contact Us, Feedback, Report Fraud, Technical Support), and social media icons for Facebook, Twitter, LinkedIn, and YouTube.

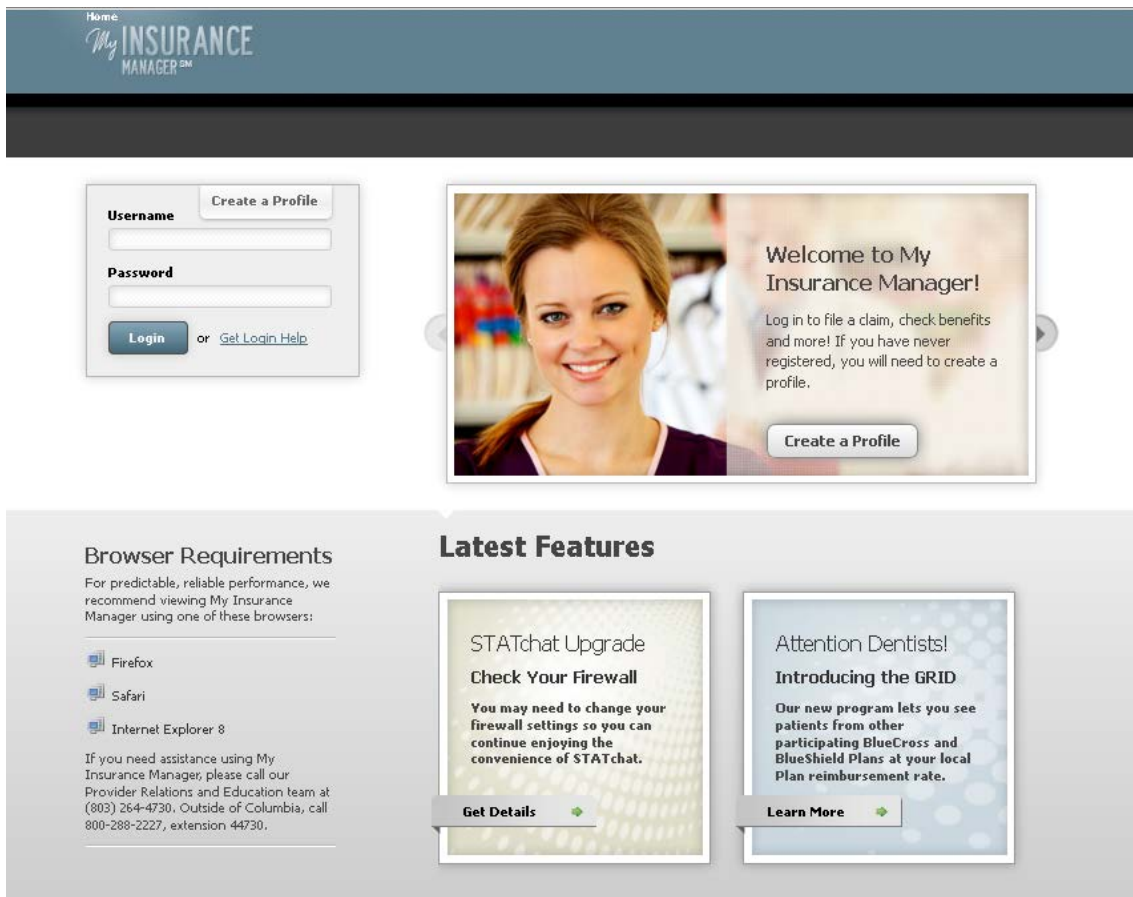
All information is real-time and confidential. To protect privacy and comply with HIPAA standards, we use the latest encryption technology to ensure that no unauthorized person can access protected health information (PHI).

## 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

My Insurance Manager is safe, secure, simple and most of all, it's free! For weekly maintenance, My Insurance Manager is not available on Sunday evenings from 5 p.m. until midnight.



The screenshot shows the My Insurance Manager website interface. At the top, there is a navigation bar with a "Home" link and the "My INSURANCE MANAGER" logo. Below the navigation bar, there is a login section on the left with fields for "Username" and "Password", a "Login" button, and a "Create a Profile" link. To the right of the login section is a large banner featuring a smiling woman and the text "Welcome to My Insurance Manager!". The banner includes a "Create a Profile" button and a message: "Log in to file a claim, check benefits and more! If you have never registered, you will need to create a profile." Below the banner, there are two main sections: "Browser Requirements" and "Latest Features". The "Browser Requirements" section lists Firefox, Safari, and Internet Explorer 8, and provides contact information for assistance. The "Latest Features" section contains two cards: "STATchat Upgrade" with a "Check Your Firewall" button and "Attention Dentists!" with an "Introducing the GRID" button.

## Here's how to get started:

**It's easy.** Just follow the steps as you move through the screens.

**It's secure.** Secure encryption technology ensures any information you send or receive is completely confidential.

1. Go to [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).
2. Click on Providers, and then log in under **My Insurance Manager**. The first time you use My Insurance Manager you will have to register.
3. Register by choosing Create a Profile.
4. Read and accept our terms and conditions.
5. Enter your nine-digit Tax ID. If you use multiple Tax ID numbers, you should register under each one. My Insurance Manager uses your Tax ID for BlueCross or BlueChoice HealthPlan for registration. **Note:** You must fill in the Tax ID in both spaces. The system will verify these numbers and when they match, you can register yourself or your practice.
6. Create your profile. Choose a Username and Password. Then, fill out the information about your practice. Have more than one staff person who could use My Insurance Manager? No problem. Several people from your practice can create profiles under your Tax ID number. All locations need at least one profile administrator. The profile administrator will be responsible for approving other staff members pending My Insurance Manager profiles. The profile administrator will use his or her Profile Management tab to view, approve and/or deny a staff member access to My Insurance Manager.
7. Submit the information.

## You are now ready to access My Insurance Manager.

Simply choose the task you want from the menu. When you are finished using My Insurance Manager, select Exit.

It is a fast and easy way to find information on your patients with BlueCross and BlueChoice HealthPlan coverage.

## My Insurance Manager FAQ

**Question** I registered to use My Insurance Manager. Why can't I find the claims (or other) information I want on a patient?

**Answer** There are several possible reasons:

- You can only view patient information you submitted under the Tax ID and suffix you used to register. For example, if you belong to a group practice and filed claims under the group Tax ID, you must be registered on My Insurance Manager using that number, rather than your individual provider Tax ID.
- Check your profile to make sure you have entered the appropriate Tax ID — one for BlueCross and one for BlueChoice HealthPlan. These numbers may or may not be the same.
- You can only view claims information for the services your practice offers, not for the services of another provider or practice.

**Question** How can we use My Insurance Manager for my entire group practice?

**Answer** You can create multiple usernames and passwords for the same Tax ID number. The profile administrator will manage these usernames.

**Question** Is My Insurance Manager secure?

**Answer** Yes. You can only register if you have a valid Tax ID number on our systems. We verify this number against our internal systems. With our profile administrator process, the office administrator will have the ability to add and remove access to all user accounts, thus keeping your information secure.

## Section 20: PPO Voice Response Unit and STATchat<sup>SM</sup>

### VRU

Need to know the status of a claim? Looking for eligibility or benefits for a patient? Call our VRU line! The VRU is available 24 hours a day, seven days a week using a touchtone phone. 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. We recently updated our system and if the requested information is available in the VRU, you will no longer receive 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 **State Health Plan** 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](http://www.SouthCarolinaBlues.com) and sign into My Insurance Manager for the most efficient and user-friendly experience.

### 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) or use STATchat in My Insurance Manager.



### **STATchat: Call a Provider Services Rep Online!**

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 claims status or eligibility question. To use STATchat, simply log into My Insurance Manager (users logging in for the first time will need to create a profile). If you still have a question after viewing claims status or eligibility and benefits, just click the "Ask Provider Services" button at the bottom of the page. You can submit your inquiry online and receive a response within 24 hours.

Click the "Connect" button at the top of the page, and you'll soon be speaking to a provider services representative online. In fact, you will receive priority service and be connected to the next available agent! To ensure quick service for all customers, please limit yourself to only one issue per call.

### **STATchat Available for Precertification**

When a precertification pends in My Insurance Manager, you can now talk to a health care services representative immediately using STATchat through your computer. There are also four options in My Insurance Manager for updating your existing authorizations: Provide Clinical Information, Request Appeal, Request Extension and Update Authorization Information. After choosing an authorization from any of these options, you can use STATchat to speak with a health care services representative immediately.

To get started, you'll need a headset with a microphone, or a speaker and microphone. Use STATchat now! Please visit My Insurance Manager.

### **STATchat Firewall Settings**

If you have a problem connecting to STATchat, check the STATchat firewall settings. If you see a message about a missing Flash plugin, please make sure you have Adobe Flash Player 8.0 or higher installed on your computer.

Recently, STATchat upgraded to User Datagram Protocol (UDP) from Transmission Control Protocol (TCP). This upgrade may mean you or your IT administrator will need to make some adjustments. If you don't have firewalls within your organization, you won't have to do anything. Our system will automatically convert your protocol when you connect to STATchat. If your organization has firewalls, your IT administrator will need to configure your network and make it compatible with the new protocol.

STATchat uses port numbers 1935, 8080, 8443 and port ranges 19350-65535. Please ensure your firewall allows access to these ports. Also make sure these source IP address ranges are opened for the appropriate port:

<b>Protocol</b>	<b>Port</b>	<b>Source IP Address Ranges</b>
UDP	1935, 19350-65535	54.244.93.164
UDP	1935, 19350-65535	107.20.176.54
TCP	1935, 8080, 8443	54.208.165.112
TCP	1935, 8080, 8443	54.213.218.20
TCP	1935, 8080, 8443	54.213.218.21
TCP	1935	54.244.93.164
TCP	1935	107.20.176.54
TCP	1935, 8080, 8443	107.21.16.178

If you continue experiencing problems after these changes, please call technical help at 855-229-5720.

## Section 21: Communicating with BlueCross

Department	Local	Toll Free
BlueCross Switchboard	800-788-3860	800-288-2227
EDI Help Desk		800-868-2505
<b>Provider Services</b>		
APS Healthcare		800-221-8699
BlueCard Eligibility		800-676-BLUE (2583)
<b>Preauthorization</b>		
Preferred Blue	803-736-5990	800-327-3238 800-334-7287
Federal Employee Program		800-327-3238
State Health Plan	803-699-3337	800-925-9724
Planned Administrators, Inc.		888-376-6544
National Imaging Associates	<a href="http://www.RadMD.com">www.RadMD.com</a>	866-500-7664
BlueCard Authorization		800-676-BLUE (2583)
Companion Benefit Alternatives		800-868-1032
<b>Education and Credentialing</b>		
Provider Education	<a href="mailto:Provider.Education@bcssc.com">Provider.Education@bcssc.com</a>	800-288-2227, ext. 44730
Provider Certification	<a href="mailto:Provider.Cert@bcssc.com">Provider.Cert@bcssc.com</a>	800-288-2227, ext. 48402

**PPO Provider Services In and Out of State**

Ask Provider Services functionality

Phone 800-868-2510  
Phone 800-334-2583 (Toll Free)  
Fax 803-264-4172  
Brian Butler, Senior Director 803-264-3235  
Brenda Bethel, Director 803-264-8416

[brian.butler@bcbsc.com](mailto:brian.butler@bcbsc.com)  
[brenda.bethel@bcbsc.com](mailto:brenda.bethel@bcbsc.com)

**PPO Dental Provider Services**

Phone 800-222-7156  
Fax 803-264-7629  
Belinda Stokes, Manager 803-264-5460  
David Strobel, Supervisor 803-264-9079

[belinda.stokes@bcbsc.com](mailto:belinda.stokes@bcbsc.com)  
[david.strobel@bcbsc.com](mailto:david.strobel@bcbsc.com)

**State Health Plan Provider Services**

Ask Provider Services functionality

Phone 800-444-4311  
Fax 803-264-4204  
Donna Frishcosy, Manager 803-264-2520

[donna.frishcosy@bcbsc.com](mailto:donna.frishcosy@bcbsc.com)

**State Health Plan Dental Provider Services**

Phone 888-214-6230 (Toll Free)  
Phone 803-264-3702 (Local)  
Fax 803-264-8109  
Bonnie Tucker, Manager 803-264-7284

[bonnie.tucker@bcbsc.com](mailto:bonnie.tucker@bcbsc.com)

**FEP Provider Services**

Phone 888-930-2345 (Toll Free)  
Fax 803-264-8104  
Cynthia Lagatore, Director 803-264-3325  
Pamela Johnson, Supervisor 803-264-3052

[cynthia.lagatore@bcbsc.com](mailto:cynthia.lagatore@bcbsc.com)  
[pamela.johnson@bcbsc.com](mailto:pamela.johnson@bcbsc.com)

**FEP Dental Provider Services**

Phone 800-444-4325 (Toll Free)  
Fax 843-763-0631  
Chris Jones, Supervisor 803-264-8702

[christopher.jones4@bcbsc.com](mailto:christopher.jones4@bcbsc.com)