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

Independent licensees of the Blue Cross and Blue Shield Association

2023 Annual Provider Summit

Frequently Asked Questions

Authorizations

Why do specialty drugs require an authorization through medical and pharmacy?

Specialty drugs are either covered under the medical benefit or the pharmacy benefit. The authorization requirements will depend on how the claim is submitted. If filed under the medical benefit, the authorization would go through medical. If filed under the pharmacy benefit, the authorization would go through pharmacy.

Can Availity be used to obtain authorizations?

Authorizations for Healthy Blue℠ members can be obtained through Availity. For our commercial lines of business (i.e., State Health Plan, BlueEssentials, etc.), please use My Insurance Manager℠ or contact the phone number on the back of the member's ID card.

Are authorizations required for emergency services like consultations?

As part of the No Surprises Act that went into effect on Jan. 1, 2022, authorization is not required for emergency admissions. However, a notification of emergency admission must be submitted within 24 to 48 hours of admission.

How can the status of an out-of-state member's authorization be verified?

To verify the status of an out-of-state member's authorization, providers would need to contact the member's Home Plan directly or by calling the BlueCard® Eligibility Line at 800-676-BLUE (2583).

Benefits

For State Health plans, can members receive both the Cologuard test and a colonoscopy?

No, members can receive either a Cologuard test OR a colonoscopy, not both. Coverage for both begins at age 45 and will be covered at no cost-share to the member.

Is there a list of prefixes associated with the new Blue Exclusive plans?

Yes, the list of prefixes related to the new Blue Exclusive plans can be found in the 2023 Member Identification Card guide, located on www.SouthCarolinaBlues.com.

Will ID cards be available in My Insurance Manager℠?

Currently, ID cards are not available in My Insurance Manager. However, members have access to their updated ID cards through their My Health Toolkit app.

What place of service should be used for telehealth?

The place of service (POS) does not impact telehealth claims. These types of claims are identified by the modifier 95. However, you would bill the claim using the appropriate POS based on the location in which services were rendered (e.g., if performed in an office, use POS 11).

Claims

Can medical records be submitted with claims?

Medical records cannot be submitted with claims. Medical records should only be submitted when requested.

Who should be contacted for refund questions?

If you have the refund letter (also accessible through My Insurance Manager), please contact the phone number listed at the bottom of the letter.

If you do not have the refund letter, you can contact Provider Services at 800-868-2510, option 4. This line should be used for the following lines of business:

- BlueCard
- BlueChoice® HealthPlan
- BlueEssentials℠
- Major Group
- National Alliance
- Small Group & Individual

How can providers speak with someone if they have questions on claims?

Providers can use STATchat or Ask Provider Services, both of which are available through My Insurance Manager. STATchat allows providers to speak with a live representative and Ask Provider Services allows providers to submit secured web inquiries.

If a mistake is made on a claim, can a correction be submitted through My Insurance Manager?

Yes, corrected claims can be submitted through My Insurance Manager℠ (MIM), do the following:

1. Under the Patient Care menu, select Professional Claim Entry.
2. Select a plan and indicate whether the plan is the primary payer.
3. Select the billing location, rendering provider and/or referring provider when prompted. You can opt to choose a patient or manually enter the patient's information on the Patient Information page.
4. On the Claim Information page, select Replacement of Prior Claim from the Claim Type menu. Enter the prior claim number in the required filed.
5. Enter the new information from the line of your claim.
6. Include ALL lines that need to be processed, including existing lines, corrected lines, or additional lines.
7. Once completed, select Continue.
8. Confirm the claim information is accurate, then click Submit.

If a patient has an out-of-state Blue Plan, where should the claim reconsideration be sent?

As a South Carolina provider, all provider reconsiderations should be sent to BlueCross BlueShield of South Carolina using one of the avenues listed on the bottom of the Provider Reconsideration Form. Once received, it will be submitted to the member's Home Plan for review.

Can providers submit the Accident/Subrogation Questionnaire or Other Health Insurance (OHI) Questionnaire on behalf of the member?

Yes, providers can submit the Accident/Subrogation Questionnaire or the OHI Questionnaire on behalf of the member. However, please be sure the questionnaires have been completed and signed by the member. Also, only submit these questionnaires when requested.

Note: Some lines of business only accept the OHI Questionnaire from the member. The member can also contact customer service or use My Health Toolkit to update their OHI as well.

Who should providers submit reconsideration requests to when a claim denies for non-covered services or ineligible services?

Provider reconsiderations should be submitted for medical necessity reasons. If claims reject due to non-covered services or other non-medical necessity reasons, please contact the Provider Services number on the back of the member's ID card to have the claim reviewed.

Can medical records be submitted instead of the Accident/Subrogation Questionnaire?

Yes, providers can submit medical records in lieu of the Accident/Subrogation Questionnaire. However, please allow the member at least 60 days to return the questionnaire. Also, only submit medical records if the claim rejects for questionnaire.

If the member does not update their Other Health Insurance (OHI), can the provider send them the bill?

If the member does not update their OHI and the claim is showing to be their responsibility, then yes, the provider can bill the member. If there is no member liability on the claim, providers should not bill the member.

Dental

What is the prefix associated with the Blue Cross Blue Shield FEP Dental plans?

Members that have the Blue Cross Blue Shield FEP Dental plan will have the prefix 'F'.

For dental code D9944, is it required to be upper or lower arch?

Although this is not standardly a covered code, the arch is not required.

Healthy Blue℠

What is the Customer Care Center phone number?

The Customer Care Center phone number is 866-757-8286.

Is there a copay for ambulatory surgical centers (ASCs)?

Yes. For Healthy Blue, the copay for ASCs is $3.30.

Pharmacy

Can a physician request a specific formulary if a drug is not covered?

Under the pharmacy benefit, the member or physician can request a medical necessity exception to have a non-formulary drug covered. Under the medical benefit, the member or physician may file an appeal to have a non-formulary drug covered.

Can PreCheck MyScript (PCMS) be accessed via the web and not embedded in the electronic health record (EHR)?

As a workaround from going through the EHR, PCMS can be accessed through My Insurance Manager. This will ensure the appropriate member's benefits are linked to the request.

Provider Enrollment

Does BlueCross BlueShield of South Carolina accept electronic signatures?

Electronic signatures are accepted on applications, but all contract pages must be signed in ink.

Do behavioral health providers use My Provider Enrollment Portal?

Yes, they do.

If providers do not validate their information in M.D. Checkup every 90 days, will they be removed as an in-network provider?

Currently, a provider will not be removed as an in-network provider. However, as of Jan. 1, 2022, if providers do not validate their information every 90 days, we are required to suppress them from our Provider Directory per the Consolidated Appropriations Act (CAA).

Will providers be notified when it is time to recredential?

Yes, providers will be notified when it is time to recredential.

Will Healthy Blue accept the Medicaid provider enrollment reference number, or will providers have to wait for the Provider Medicaid ID?

Providers will have to have their Medicaid ID number for the Healthy Blue enrollment process to be completed.

How long does the enrollment process take once all required documentation has been submitted?

BlueCross BlueShield of South Carolina's provider enrollment process is going through a transformation. As with any change, there are going to be challenges along the way. My Provider Enrollment Portal (MyPEP) has streamlined the process of enrolling providers by offering the exact requirements needed to file a complete application the first time. Because it has taken longer than expected to get this up and running, we have kept the historical process of faxing and emailing applications open. Unfortunately, we have received applications from providers through both processes, duplicating efforts on providers as well as Blue Cross.

As a result, we have received concerns from providers related to timely processing of their enrollment applications. Please know the concerns have been heard. We are diligently working the submitted applications. If you submitted an application, we will get to it. If you check the status in MyPEP and it has not changed, there is no need to submit multiple applications, support cases, case comments or emails. We have your submission and will get it reviewed as quickly as possible.

We ask that you do not submit or resubmit applications through multiple avenues. We strongly encourage you to review the MyPEP user guide and frequently asked questions for guidance.

While we understand the need to express your concerns, we ask that you please allow us time to work through all the applications.

Will My Provider Enrollment Portal (MyPEP) be the only way to submit enrollment applications?

Soon, applications will no longer be accepted through fax or email. We kept this process open to ensure providers had an avenue for submitting documentation while we worked through the issues with MyPEP. Now that complete applications can be submitted through the portal, all provider enrollment processes and communications will be conducted through the My Provider Enrollment Portal.

What is the difference between the effective date and the affiliation date?

The effective date is the date that the provider is approved by the Credentialing Committee and this date cannot be changed.

The affiliation date is the date in which a provider can render services with an established group. This date can be backdated 45 days from the day we receive all required documentation. Any date past 45 days will require a claim to be submitted with the requested backdate as the

date of service to show the provider was rendering services with the group at the time of approval. **Note: This does not apply to Healthy Blue.**

Quality

If providers have questions for Quality or need assistance with outreach and scheduling trainings, who should they contact?

Providers can reach out to the Quality team at NAVIGATOR@bcbssc.com.

Web Tools

Does My Remit Manager provide the same information included on a remittance?

Yes, the information provided on a remittance can be found in My Remit Manager as well.

How does a provider add a practitioner affiliation through M.D. Checkup?

To add a practitioner affiliation through M.D. Checkup, the practitioner must be enrolled and associated with the base tax identification number (TIN). If you are trying to add a practitioner to a location under a different TIN, you must submit the Add/Terminate Practitioner Affiliation form.

Example:

- TIN A – 123456789
    - Location 1
    - Location 2
- TIN B – 987654321

Dr. Tommy Pickles **is associated** with TIN A and works at Location 1. If he also needs to be added to Location 2, this can be done through M.D. Checkup.

Dr. Pickles **is not associated** with TIN B. For him to be added to this location, the Add/Terminate Practitioner Affiliation form must be completed.

How is prior authorization information obtained in My Insurance Manager?

Prior authorization can be initiated through My Insurance Manager (MIM), along with obtaining the status of a previously submitted authorization. After logging into MIM, hover over Patient Care and select 'Pre-Certification/Referral' to start an authorization or 'Authorization Status' to check the status of one.

Can Tax IDs be combined into one account on My Insurance Manger?

At this time, no. Tax IDs cannot be combined into one account due to HIPAA and security reasons. A profile will need to be created under each individual Tax ID.

For technical issues with My Insurance Manager, who should providers contact?

Providers can contact the Technical Support Center at 855-229-5720.