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 the following 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 — as needed.

Please send all suggestions for enhancements to this manual to:

Provider Relations and Education Department
BlueCross BlueShield of South Carolina, AX-620
I-20 at Alpine Road
Columbia, SC 29219

Provider.Education@bcbssc.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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Provider Services

Our website, 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℠. 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 www.SouthCarolinaBlues.com. Here’s how you can find these publications:

- 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 focus 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

Currently, there are three provider advocates covering the state of South Carolina and contiguous counties in Georgia and North Carolina. We also have internal provider advocates who can assist you with your “everyday” questions. You can contact the Provider Education department by emailing 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 application and update forms from our website at www.SouthCarolinaBlues.com.

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.
- For all physical address changes, complete the Change of Address form.

To access these forms, go to www.SouthCarolinaBlues.com and click on Providers. Then click Forms. Choose the appropriate form from the list.

Fax or mail completed application forms 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 three provider networks:

- Preferred Blue® (the Federal Employee Program also uses this network)
- State Health Plan
- Medicare BlueSM and Medicare BlueSM 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@bcbssc.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 three 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)
- NPI NPPES confirmation letter or email
- Appropriate IRS documentation (Letter 147C, CP 575 E or tax coupon 8109-C)
- 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 fax your completed application and documentation to:

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

Re-credentialing

BlueCross requires all health care providers to go through re-credentialing every three years. We mail credentialing packages to health care practices. They must return the packages to us within the allotted time or they could lose their 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

Fax Credentialing Update forms and requested documentation to 803-264-4795.
Section 3: Benefit Plans and Information

Preferred Blue

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.

The network consists of physicians, hospitals and other health care professionals who contract with us to offer medical care to Preferred Blue members for set fees.

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

The Preferred Blue Professional Agreement lists the contractual responsibilities of both BlueCross and a preferred provider. Here is a general summary of the Professional Agreement:

- The preferred provider will file all claims for Preferred Blue members.

- BlueCross will reimburse the preferred provider for covered services based on the fee allowance in 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.
Other Preferred Blue Products

Point-of-Service

Point-of-Service (POS) is a product that uses the Preferred Blue network. POS members choose primary care physicians who refer them to other providers when necessary. If a primary care physician refers a member to a provider who does not participate in Preferred Blue, the primary care physician must contact BlueCross for authorization. A primary care physician is a preferred provider whose specialty is general practice, family practice, internal medicine, pediatrics, or obstetrics and gynecology.

POS offers maximum benefits for primary care physician services as well as for other preferred or BlueCross-approved providers when primary care physicians refer members to them. There are usually copayments for office visits to primary care physicians. When a primary care physician refers a member to a Preferred Blue specialist, BlueCross pays benefits at a higher level than if the member “self-refers” to a specialist. Covered expenses and exclusions do not change, only the level of reimbursement.
PPO Mental Health Benefits

Contact information for preauthorization and claim status for mental health services is available on the back of all identification (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 preauthorization. Most PPO plans have coverage through Companion Benefit Alternatives (CBA). CBA is a separate company that administers mental health and substance abuse benefits for most members on behalf of BlueCross. Members can contact CBA by calling one of these numbers:

<table>
<thead>
<tr>
<th>Companion Benefit Alternatives</th>
<th>803-699-7308</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 100185</td>
<td>800-868-1032</td>
</tr>
<tr>
<td>Columbia, SC 29202-3185</td>
<td>(Outside Columbia)</td>
</tr>
</tbody>
</table>

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 preauthorization and other utilization management requirements, on the Prescription Drug Information area of our website.

Benefits for State Health Plan members are administered by Medco. Medco is an independent company that contracts directly with the State of South Carolina.

Preferred Blue 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. The member is not financially responsible for anything other than applicable copayments, coinsurance and deductibles and should not be billed for any amount that exceeds the fee allowance.
Preferred Blue Preauthorization Requirements

Inpatient Services
Most inpatient procedures and admissions require preauthorization but are contract-specific.

Outpatient Services
These outpatient procedures may require preauthorization:

- Septoplasty
- Sclerotherapy performed in an outpatient or office setting
- Chemotherapy/radiation therapy (one-time notification)*
- Hysterectomy
- Procedures that may potentially be cosmetic in nature (You must submit these for review in writing five to seven days before the scheduled procedure. Include pictures if appropriate [blephero-plasty, reduction mammoplasty, TMJ surgery, etc.].)

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

Some PPO groups may have preauthorization requirements that differ from the previous list (i.e., some groups require prior notification for physical, speech and occupational therapies). Check for group-specific preauthorization requirements with members before providing services. Or request a preauthorization via My Insurance Manager and the system will let you know if a preauthorization is not required. You can also get preauthorization requirements by visiting the website.

PPO Home Health

Most contracts require prior authorization for home health services.

PPO Durable Medical Equipment (DME)

Verify patient benefits and preauthorization requirements using the Voice Response Unit (VRU) or the Web. Preauthorizations are contract-specific. We base the threshold on the total price for the item, not on the monthly rental fee.
Federal Employee Program (FEP)

FEP is a plan of health care benefits BlueCross BlueShield of South Carolina administers. FEP uses the Preferred Blue provider network. Therefore, providers participating in the Preferred Blue network automatically participate with the Federal Employee Program.

Members can choose from two plan types — Basic and Standard. View copies of ID cards for both plans below. FEP ID numbers begin with the letter “R” and the card reads, “BlueCross BlueShield Federal Employee Program.”

Effective October 1, 2010, the front of the Basic Option ID card was changed to reflect:
• New Processing Control Number (PCN) FEPRX
• New Issuer Identification Number (IIN) 610239

Effective October 1, 2010, the front of the Standard Option ID card was changed to reflect:
• New Processing Control Number (PCN) FEPRX
• New Issuer Identification Number (IIN) 610239

You can access member benefit booklets on the FEP website at www.FEPBlue.org.
Other FEP Products

FEP Mental Health Benefits

Prior authorization is not required for outpatient mental health services.

Providers should get treatment plans through Companion Benefit Alternatives (CBA) for Federal Employee Program members. Contact information for preauthorization and claim status for mental health services is available on the back of all ID cards.

FEP Prescription Drug Plan

Federal Employee Program 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 from www.SouthCarolinaBlues.com. It includes 375 preferred brand-name drugs and more than 300 generic drugs.

Federal Employee Program Fee Allowances

The Federal Employee Program uses the preferred provider network of health care providers, along with the Preferred Blue PPO fee allowance schedule. If the provider is credentialed and participating in the PPO program, he or she is automatically an FEP network provider. This means that the member is not financially responsible for payment other than applicable copayments, coinsurance and deductibles. The provider agrees 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 preauthorization if FEP is primary. BlueCross must receive inpatient admission authorizations 24 to 48 hours before services. Please include this information when getting FEP preauthorizations:

- Patient’s name
- Identification number
- Call-back number

Failure to get prior authorization 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 Home Health

All home health services require prior authorization if services are rendered by in-network providers, per the PPO contract.

<table>
<thead>
<tr>
<th>FEP Preauthorization</th>
<th>Fax</th>
<th>803-264-0258</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Voice</td>
<td>800-327-3238</td>
</tr>
</tbody>
</table>

FEP Outpatient

Outpatient procedures for FEP members do not require prior authorization. Most outpatient procedures do not require prior authorization. You must get prior authorization for all surgeries related to morbid obesity and congenital anomalies. Surgeries for oral maxillofacial surgical procedures to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth also require prior approval.

FEP Durable Medical Equipment

FEP does not require preauthorization for any DME products. We do, however, require a Certificate of Medical Necessity (CMN). The preferred method of submission is electronic for all DME claims.

Note: FEP DME supplies do not require preauthorization, but are subject to medical necessity and individual contract benefit limitations. Also, supplies are not reimbursable when the member is renting the equipment.
State Health Plan

The State Health Plan is a self-insured medical plan. It offers participating members, spouses and dependent children valuable medical coverage if they become sick or injured. It also offers limited coverage for routine care. State and county boards write and govern the State Health Plan. These government agencies develop all benefits and reimbursements. BlueCross BlueShield of South Carolina administers the State Health Plan, providing claims management; customer and provider services; and medical management.

The State Health Plan ID card is easy to identify. It has the South Carolina seal and logo in the upper left-hand corner, “State Agencies, Public School Districts and Other Participating Groups” in the title header, and the member’s ID number will always begin with the “ZCS” prefix. Here are some examples of State Health Plan 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.

The State Health Plan consists of two separate plans, the Savings Plan and the Standard Plan. You can view a member’s State Health Plan benefit booklet by logging into My Insurance Manager at www.SouthCarolinaBlues.com.
Other State Health Plan (SHP) Products

SHP Standard Policies

The South Carolina State employees’ plan uses the carve-out method to coordinate benefits. “Carve-out” is a method of calculating benefits when group contracts are secondary to Medicare.

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 supplemental plan will never pay for charges that are more than the SHP’s allowed amount. Total benefits (Medicare plus the SHP) will be equivalent to those of active employees and retirees not entitled to Medicare.

When members receive services in South Carolina, Medicare automatically sends the claims to the SHP. You should not file separate claims. You must send claims for mental health or substance abuse services, whether you provide them inside or outside of South Carolina, and the Medicare Summary Notice (MSN) to American Psychiatric Services (APS) Healthcare, Inc. The State Health Plan contracts directly with APS, an independent company.

State Health Plan Mental Health Benefits

APS Healthcare is an independent company that administers mental health benefits. Contact APS Healthcare at 800-221-8699. BlueCross is not affiliated with APS Healthcare, so you must contact APS Healthcare for network participation. You should direct any prior authorizations for services, claim submissions and claim status to APS Healthcare.

State Health Plan Prescription Drugs

State Health Plan members have prescription drug coverage through Medco with either a drug card and/or mail-service benefits. The State Health Plan contracts directly with Medco, an independent company. You can download the Preferred Drug List at www.MedcoHealth.com. Or, you can call 800-711-3450.

State Health Plan Fee Allowances

You can access the State Health Plan’s fee schedule at www.SouthCarolinaBlues.com by logging into My Insurance Manager.
State Health Plan Prior Authorization

You can apply for prior authorization at www.SouthCarolinaBlues.com by logging into My Insurance Manager.

SHP Inpatient
All State Health Plan inpatient procedures and admissions require prior authorization. The SHP has a special deductible for each emergency room visit. The plan waives this special deductible if the hospital admits the patient.

SHP Outpatient
There is a special deductible for each outpatient visit. SHP waives this special deductible for oncology and physical therapy visits. These outpatient procedures require prior authorization for State Health Plan members:

- MRI
- MRA
- Septoplasty
- Sclerotherapy in an outpatient or office setting
- CT scan
- Chemotherapy/Radiation therapy (one-time notification)*
- Hysterectomy
- 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 [blepheroctomy, reduction mammaplasty, 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.

SHP Home Health
All home health services require prior authorization.
SHP Durable Medical Equipment
Prior authorization is required for:

- All DME charges greater than $500
- Rental up to the purchase price on items if the purchase price is $500 or more
- BIPAP, CPAP, oxygen, lymphedema pumps, neuromuscular stimulators, orthoprone beds, portable nebulizers, involved/expensive leg braces, CPMs and phototherapy lights/blankets

Prior authorization is not necessary for:

- Items under $500
- Rental if charges are under $500 per month
- Short-term rental (less than six months)
- Apnea monitors less than six months’ rental
- Insulin pump supplies, oxygen refills, CPAP, BIPAP or other supplies used with DME
- Regular nebulizers, code E0570

Note: Urinary, trach, ostomy and glucometer do not fall under the DME guidelines and therefore do not require preauthorization.

You can also check the status of prior authorizations at www.SouthCarolinaBlues.com by logging into My Insurance Manager.

Prior authorizations do not guarantee payment of benefits. Claim payments are subject to the rules of the plan.
BlueCard Program

The BlueCard program enables a member getting health care services while traveling or living in another Plan’s service area to receive the benefits of his or her BlueCross Plan while accessing the local BlueCross Plan’s provider networks and savings. Through a single electronic network for claims processing and reimbursement, a member’s BlueCross Plan handles eligibility and benefit determination and gains access to health care providers participating in the local BlueCross network.

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

The BlueCard program lets you submit claims for members from other BlueCross Plans, including international Blue Plans, directly to BlueCross BlueShield of South Carolina. BlueCross BlueShield of South Carolina will be your point of contact for all of your claims-related questions as a participating network provider.

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 the Federal Employee Program (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

Provider submits claim to local Plan.

Local Plan applies pricing according to the provider’s contract and electronically forwards the claim to the member’s home Plan.

Home Plan processes according to member’s benefits and transmits data back to local Plan.

Home Plan sends EOB to member. Local Plan sends remittance and payment to provider.
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

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 BlueShield of South Carolina PPO provider contract.
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  ABC1234H567  ABC12345678901234
Alpha     Alpha     Alpha
Prefix    Prefix    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 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 to verify a patient’s eligibility and benefit coverage.

| BlueCard Eligibility | 800-676-BLUE (2583) or STATchat via My Insurance Manager |

BlueCard Preauthorization

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

BlueCard 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 carrier or 401 payer code for BlueCross BlueShield of South Carolina. 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, and approves payment and sends instructions back to us to pay you on your BlueCross BlueShield of South Carolina remittance advice.

In some instances, medical records may be required to process a claim. Please note: BlueCross BlueShield of South Carolina does NOT pay for fees for supplying medical records. Please send the requested records so we may expedite the processing of your claim(s). You can call the Provider Services Education line at 803-264-4730 if you require additional information.
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 contiguous county or overlapping service area situations)
- The member ID card does not include an alpha prefix
- Services are processed by a separate vendor which requires direct filing (e.g., APS Healthcare or the State Health Plan)

BlueCard Claim Status

If you haven’t received payment, visit www.SouthCarolinaBlues.com and log into My Insurance Manager to check the status of your claim. BlueCross BlueShield of South Carolina sends 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

Ancillary providers are:
- Independent clinical laboratory
- Durable/home medical equipment and supplies
- Specialty pharmacy

The local Blue plan as defined for ancillary services is:
- Independent clinical laboratory (Lab)
  - The Plan in which state the specimen was drawn
- Durable/Home medical equipment and supplies (DME)
  - The Plan in which state the equipment was shipped to or purchased at a retail store
- Specialty pharmacy
  - The Plan in which state the Ordering Physician is located

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<th>Provider Type</th>
<th>How to File (required fields)</th>
<th>Where to File</th>
<th>Example</th>
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| **Independent Clinical Laboratory** (any type of non-hospital-based laboratory) | Referring Provider:  
  - Field 17 on CMS 1500 Health Insurance Claim Form or  
  - Loop 2310A (claim level) on the 837 Professional Electronic | File the claim to the Plan in which state the specimen was drawn.*  
  *Where the *specimen was drawn* will be determined by which state the referring provider is located. | Blood is drawn* in lab located in Alabama. Blood analysis is done in South Carolina.  
  *File to: BlueCross BlueShield of Alabama.  
  *Claims for the analysis of a lab must be filed to the Plan in which state the specimen was drawn.* |
| **Durable/Home Medical Equipment and Supplies (D/HME)** | Patient’s Address:  
  - Field 5 on CMS 1500 Health Insurance Claim Form or  
  - Loop 2010CA on the 837 Professional Electronic  
  Ordering Provider:  
  - Field 17 on CMS 1500 Health Insurance Claim Form or  
  - Loop 2420E (line level) on the 837 Professional Electronic  
  Place of Service:  
  - Field 24B on CMS 1500 Health Insurance Claim Form or  
  - Loop 2300, CLM05-1 on the 837 Professional Electronic | File the claim to the Plan in which state the equipment was shipped to or purchased in a retail store. | A. Wheelchair is purchased at a retail store in South Carolina.  
  *File to: BlueCross BlueShield of South Carolina.  
  B. Wheelchair is purchased on the Internet from an online retail supplier in Ohio and shipped to South Carolina.  
  *File to: BlueCross BlueShield of South Carolina. |
BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

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<td>- Loop 2310C (claim level) on the 837 Professional Electronic Submission</td>
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1. These rules apply regardless of your contracting status with the Blue Plan where you file the claim.

2. 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).

3. 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 possibly that the member will be liable for more costs.

4. 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.

Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.
BlueCross BlueShield of South Carolina offers two Medicare Advantage plans to Medicare-eligible recipients in South Carolina. These plans are Medicare BlueSM and Medicare BlueSM Saver. Providers should confirm the level of coverage for all Medicare Advantage members before providing services because level of benefits and coverage rules may vary.

**Preferred Provider Organization (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.

**Medicare Blue Saver ID Card**

![Medicare Blue Saver ID Card Image]

**How to Identify Medicare Advantage Plan Members**

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

### Benefits and Eligibility

Providers and enrollees can quickly get the most current member eligibility and benefit information by calling 800-334-2583.

### How to File Claims

Use carrier (payer) code C63.

Submit claims electronically to BlueCross BlueShield of South Carolina 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.
**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.

**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 800-288-2227, ext. 43664.

**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 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**

Providers can appeal a claim disposition by using the [Medical Review Form](http://www.SouthCarolinaBlues.com) 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

Step 1: The initial decision by BlueCross
When BlueCross BlueShield of South Carolina makes its initial decision, it is giving its interpretation of how the Medicare Advantage member’s covered benefits and services apply to the specific situation.

Step 2: Appealing the initial decision by BlueCross
If a member disagrees with the decision made in Step 1, the member can ask for reconsideration. 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 member is still dissatisfied, he or she can then request an independent review organization review the claim. The organization will review the request and decide to affirm, dismiss or reverse the original decision.

Step 4: Administrative law judge
If the member is still unhappy with the decision, he or she can ask for an administrative law judge to consider the case and make a decision. The dollar value of the contested benefit must be at least $110.

Step 5: Review by a Medical Appeals Council
If the member is not happy with the decision made in Step 4, the Medicare Appeals Council can review the case. This Council is part of the federal department that runs the Medicare program.

Step 6: Federal court
If the member is not happy with the decision the Medicare Appeals Council made in Step 5, the federal court can review the case. The dollar value of the contested benefit must be at least $1,090.
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 provide third party administration services on behalf of BlueCross.

Prior authorization for services follows the rules of each plan. Please review the member’s ID card to determine the appropriate contact numbers for prior authorization. File all TPA claims, with the exception of Companion P&C, electronically to BlueCross BlueShield of South Carolina 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 then 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 4: Other Carrier Liability

One method of controlling health insurance costs is called Other Carrier Liability, or 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 below.

Coordination of Benefits

Calculating payments between the primary and secondary plans is called Coordination of Benefits (COB). Coordination of Benefits (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.
COB Rules

1. Two policies involved and only one has a COB provision:
   - **Primary:** Contract without the COB provision
   - **Secondary:** Contract with the COB provision

2. Two policies involved. Both have a COB provision and the patient is the member:
   - **Primary:** The policy that covers the patient as an active employee
   - **Secondary:** The policy that covers the patient as a retired or laid-off employee (includes COBRA extension)

3. Patient covered under two policies, one as a member and the other as a dependent:
   - **Primary:** Patient’s own policy
   - **Secondary:** Policy under which the patient is a dependent

4. Patient is a child (natural or legally adopted) covered under both the father and mother’s policy:
   - **Primary:** The policy of the parent whose birth month (regardless of birth year) falls earlier in the year
   - **Secondary:** The policy of the parent whose birth month (regardless of birth year) falls later in the year

5. Dependent children of divorced or separated parents:
   - **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 the Gender or the Birthday Rule will be used. 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 BlueShield of South Carolina 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

1. 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 prior authorization rules, such as preadmission, emergency admission, continued stay reviews and second surgical opinions.

2. 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.

3. 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.

4. Medicare Carve-out
Carve-out is a method of calculating benefits when group contracts are secondary to Medicare. The South Carolina State employees’ 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.

*For assistance with filing a secondary claim via the Web, visit the Education Center at www.SouthCarolinaBlues.com for claim filing tutorials.

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 BlueShield of South Carolina, 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 BlueCross to receive and process your cross-over claims before submitting a claim to BlueCross. On average, allow at least 21 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
- Federal Employee Program

**Automated Cross-Over Policy Option**

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

**Sample ID Card**

![Sample ID Card Image]
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 – injury 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 BlueCross receives a claim for services with a diagnosis code of 800 or greater, it will send a workers’ compensation/subrogation questionnaire to the member. Providers can bill the member for these services until the member returns the questionnaire and BlueCross has updated the file.
Section 5: Claim Submission

Filing Claims

As a participating network provider, you agree to submit claims for BlueCross, the Federal Employee Program, 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 BlueShield of South Carolina Supplemental Implementation Guides (SIGs) are available in the HIPAA Critical Center at www.HIPAACriticalCenter.com. These will help you with the electronic claim filing process. You can also file both professional and institutional claims (primary, secondary and corrected claims) by using My Insurance Manager.

Superbill

The Superbill tool within My Insurance Manager is ideal for providers who want to submit primary claims for one date of service only. You can create and store your Superbill online, then use it to submit a professional Web claim with a minimum of 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. Except in the absence of legal capacity, claims must be filed no later than 15 months following the date services were received. Generally, providers must file claims within 180 days from the date of service. Some policies, however, require providers to file claims within 90 days. BlueCross will deny claims it receives after the timely filing period, as defined in your agreement with us. The member and BlueCross should be held harmless for these amounts.

**Note:** Timely filing limits are subject to change. If you are not sure of a time limit, you can review members’ benefit books in My Insurance Manager.
Refunds

There may be times when BlueCross must request refunds of payments it previously made to providers. When refunds are necessary, we notify the provider 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 the provider contacts us within 21 days.

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 the above occurs if a provider does not have a TIN and uses his or her 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.

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 is a rapidly changing field, 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 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. Providers should use modifiers appropriately.

Visit www.CMS.gov for the most up-to-date information on valid and invalid modifiers. If you have questions about how to file a modifier for a procedure, please contact Provider Education at provider.education@bcbssc.com.
Section 6: Remittance Advice

Remittance Types

Institutional and professional health care providers receive 835 remittance advices and Electronic Funds Transfers (EFTs). 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
  Example – 1C0000111000

- Hardcopy claim
  Example – 1600011110000

- Web claim
  Example – 33000000W0000

- Superbill claim
  Example – 33000000P0000

- Swipe card
  Example – 33000000J0000
My Remit Manager

My Remit Manager (www.MyRemitManager.com) is an online tool providers 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 BlueShield of South Carolina 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.
Section 7: Medical Management

Most BlueCross BlueShield of South Carolina 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.

Online Prior Authorization Requests

You can get a prior authorization via My Insurance Manager at www.SouthCarolinaBlues.com. With the “Pre-Certification/Referral” feature under Patient Care, you can submit prior authorization requests to BlueCross, the State Health Plan and BlueChoice® HealthPlan. Authorizations are not available online for Federal Employee Program members.

Visit the Education Center at www.SouthCarolinaBlues.com to learn more about online prior authorization requests.

Prior authorizations do 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. The alpha prefixes for those groups are available below.

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)

Visit [www.RadMD.com](http://www.RadMD.com) or call 866-500-7664 to request prior authorization or check status.

Each Blue Plan establishes its own prior authorization requirements. It is important to complete this process before treating the member. After verifying eligibility and benefits, ask to be transferred to the prior authorization or utilization review area, or ask for the direct prior authorization number. Generally the prior authorization number is on the member’s ID card.
These group prefixes will require precertification for MRIs, MRAs, CT and PET scans:

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<td>GGV</td>
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<td>GJE</td>
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</tbody>
</table>

*These alpha prefixes represent fully insured as well as ASO groups. ASO group members are not required to get prior authorizations through NIA. Check the backs of members’ ID cards to verify prior authorization requirements.
Diagnostic Imaging Prior Authorization

BlueCross has entered into an agreement with NIA for outpatient imaging management services.

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

We require prior authorization for these outpatient radiology procedures:

- CAT scans
- MRIs and MRAs
- PET scans

Note:

- The ordering physician should get the prior authorization. The providers who are rendering the above services, however, should verify that the patient has the necessary authorization. **Failure to do so may result in non-payment of the claim.**
- We do not require prior authorizations for emergency room, observation and inpatient imaging procedures.
- We exclude members with Medicare primary coverage from this NIA agreement.

There are two ways to get authorizations — either through NIA’s website at [www.RadMD.com](http://www.RadMD.com) (preferred method), or through NIA’s toll-free number 866-500-7664.
**Preadmission Authorization Program**

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

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

We resolve a high percentage of Web requests immediately and provide prior authorization 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. BlueCross 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 the provider plans 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, BlueCross will need pertinent medical information to complete the authorization. If BlueCross approves the request, it notifies the contact person by telephone or fax within one working day of making the decision. BlueCross provides the authorization number and approved length of stay at this time. A confirmation letter is sent to the physician, hospital and member within 24 hours of the reported admission. If BlueCross denies the authorization, the contact person is notified by telephone within one working day of making the decision. BlueCross provides the reason for denial at this time.

The prior authorization 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. Pertinent medical information will be requested to document the medical necessity of all emergency admissions.

Newborn Hospitalizations

BlueCross requires prior authorization 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, the provider 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 BlueCross identifies 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. BlueCross will provide benefits for the level of care carrying the highest allowable charge.
Section 8: 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. BlueCross covers 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. BlueCross recognizes 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. BlueCross will not reimburse modifiers QK, QX, QY and QZ for supervision of monitored anesthesia care (MAC). BlueCross 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**

<table>
<thead>
<tr>
<th>Risk Modifier</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>P-3</strong></td>
<td>Add one time unit when a patient has a severe systemic disease, such as uncontrolled diabetes or hypertension requiring medication.</td>
</tr>
<tr>
<td><strong>P-4</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>P-5</strong></td>
<td>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.</td>
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</table>
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. BlueCross 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:

49 minutes/15 increment = 3.266 units
3.266 would round to 3.3 time units
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

**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. BlueCross 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, the Federal Employee Program, the State Health Plan and all BlueCard members.
Benefits Outside of Global Care

1. Lab work

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 one ultrasound medically necessary for any pregnancy from 10–18 weeks of gestation.
   - Repeat ultrasounds during pregnancy must meet medically necessary criteria.

4. Amniocentesis

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.
Anesthesia 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 and 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.
Section 9: 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:

- Pre-existing, cosmetic and not medically necessary procedures
- Multiple surgery or medical care a patient receives on the same day
- Extenuating medical circumstances supporting additional reimbursement

Complete a Request for Medical Review form. 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 (if for a pre-existing denial)
- Operative notes
- Office notes
- Discharge notes

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

Appeal

An appeal is a second-line review that you can request after BlueCross has reviewed a claim and upheld its original decision. Complete a Request for Medical Review form and indicate that this 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 Voice Response Unit (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 BlueShield of South Carolina 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 claim review, please complete this information for Blue Cross Blue Shield of South Carolina members (including Preferred Blue® 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.

**Patient Information**

- Patient’s Name: ____________________________
- Identification Number: _______________________

**Type of Plan:**
- [ ] State Health
- [ ] Federal Employee
- [ ] Group & Individual
- [ ] Preferred Blue
- [ ] BlueCard®

**Provider Information**

- Provider’s Name: ____________________________
- Provider Number: ____________________________
- Provider’s Address: ____________________________
- Contact Person: ____________________________
- Signature of Person Requesting Review/Appeal: ____________________________

**Claim Number:** ____________________________

**Date of Service:** ____________________________

**Description of Request:**

**Attachments**

- [ ] 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**
  - 2G® (Alpha Prefix)
  - STATE HEALTH PLAN, AX-816
  - ATTN: MEDICAL APPEALS
  - P.O. BOX 300053, COLUMBIA, SC 29007-5051
  - FAX 803-264-4104

- **FEDERAL EMPLOYER PLAN/FC**
  - 11® (Alpha Prefix)
  - FEDERAL EMPLOYER PLAN, AX-805
  - ATTN: MEDICAL APPEALS
  - P.O. BOX 300051, COLUMBIA, SC 29007-5051
  - FAX 803-264-4104

- **GROUP & INDIVIDUAL**
  - 12® (Alpha Prefix)
  - GROUP & INDIVIDUAL, AX-725
  - ATTN: MEDICAL APPEALS
  - 125 ALPINE ROAD, COLUMBIA, SC 29219
  - FAX 803-264-4172

- **PREFERRED BLUE AND ALL OTHER BlueCross (BlueCard):**
  - PRO PROVIDER SERVICES, AX-820
  - ATTN: MEDICAL APPEALS
  - 125 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 claim questions, reviews or appeals, please direct them to your local Blue Plan.
Section 10: 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 BlueShield of South Carolina recognizes.

Please note: This section of the manual outlines information specific to ancillary health providers.

Ambulatory Surgery Centers

Ambulatory surgery centers should file claims electronically to BlueCross in the HIPAA-compliant 837I (UB-92) 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 (formerly UB-92).
- File dialysis claims under the appropriate revenue code for the type of treatment as a single line item.

<table>
<thead>
<tr>
<th>Revenue Codes</th>
<th>HCPCS/CPT4</th>
<th>Type of Dialysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>821</td>
<td>N/A</td>
<td>Hemodialysis</td>
</tr>
<tr>
<td>831</td>
<td>Yes</td>
<td>Intermittent Peritoneal Dialysis</td>
</tr>
<tr>
<td>841</td>
<td>Yes</td>
<td>Continuous Ambulatory Peritoneal Dialysis</td>
</tr>
<tr>
<td>851</td>
<td>Yes</td>
<td>Continuous Cycling Peritoneal Dialysis</td>
</tr>
</tbody>
</table>

- 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-92) 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.

<table>
<thead>
<tr>
<th>Revenue Codes</th>
<th>Type of Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>551</td>
<td>Skilled Nursing</td>
</tr>
<tr>
<td>421</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>441</td>
<td>Speech Therapy</td>
</tr>
<tr>
<td>561</td>
<td>Medical Social Worker</td>
</tr>
<tr>
<td>571</td>
<td>Home Health Aide</td>
</tr>
<tr>
<td>431</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>279</td>
<td>Wound Care</td>
</tr>
</tbody>
</table>

Hospice

Bill hospice care electronically to BlueCross in the HIPAA-compliant 837I (UB-92) 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-92) 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-92) 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. You must get prior authorization for all infusion therapy services.
Durable Medical Equipment (DME)

Durable Medical Equipment (DME) items serve a specific therapeutic purpose in the treatment of an illness or injury, can withstand repeated use, are generally not useful to a person in the absence of illness, injury or disease and are appropriate for use in a patient’s home.

BlueCross offers benefits for durable medical equipment when it meets all these criteria:

1. A physician has ordered the device or equipment.
2. The device or equipment is medically necessary to meet a specific need.
3. The device or equipment is of a medical nature (e.g., a wheelchair or splint). Air conditioners, whirlpools, treadmills, spas and vacuum cleaners are not covered items.
4. Only the patient a physician orders the device for will use it.

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 and 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 Benefits**

BlueCross provides DME benefits as stated in a member’s contract. If a member’s contract covers DME and the prescribed equipment meets the plan’s DME and medical necessity requirements, BlueCross will provide coverage for the equipment. Most contracts allow members to rent DME if the total rental cost does not exceed the purchase allowance.

**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. BlueCross will reimburse DME purchases when the patient receives the equipment, not at the time of order.

**Deductible, Coinsurance and Non-Covered Services**

After a member meets his or her deductible, BlueCross will pay a specified benefit percentage of the remaining rental or purchase allowance for covered DME. The deductible and benefit amounts will vary according to the member’s contract.

A member is responsible for paying any deductible, coinsurance and non-covered services amounts. The DME provider, however, cannot bill a member for any amount that exceeds the BlueCross-allowable charge for rented or purchased DME.
Payment Allowance

BlueCross bases benefit payments for the rental of DME on the plan’s monthly rental allowance (not to exceed the purchase allowance). BlueCross bases benefit payments for the purchase of DME on the plan’s purchase allowance. BlueCross considers 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 rent-up-to-purchase has been met, the provider may 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). BlueCross covers deluxe equipment only if it is both medically necessary and therapeutic in nature. BlueCross 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, BlueCross will base benefits on the rental or purchase allowance for standard/economical equipment. Due to certain conditions, illnesses or injuries, BlueCross may consider DME with special or customized features medically necessary. All equipment of this type is subject to individual payment consideration before BlueCross approves.

DME suppliers should include charges for rental equipment accessories in the rental price of the equipment when billing BlueCross. Providers should submit all DME requests for special or customized features to BlueCross for precertification.
Certificate of Medical Necessity (CMN) Form

For the Federal Employee Program only, DME suppliers must file all initial claims for the rental or purchase of DME with a completed CMN. Providers can submit the CMN form found on Medicare’s website at 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. BlueCross will not pay any claims it receives beyond this approved period without a recertification of medical necessity.
Section 11: Electronic Data Interchange

The BlueCross BlueShield of South Carolina 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. BlueCross requires all professional providers to submit electronic claims in the HIPAA X12 format. The BlueCross Supplemental Implementation Guides (SIGs) for electronic interchange are in the HIPAA Critical Center at www.HIPAACriticalCenter.com. You can also view a list of vendors who are currently submitting HIPAA-compliant claims to BlueCross 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)
Electronic Remittance Advice (ERA - 835) and Electronic Funds Transfer (EFT)

Providers with electronic file transfer capabilities can choose to receive the 835 Electronic Remittance Advice (ERA) containing their Provider Payment Registers. Once providers download the remittance files at their offices, they can upload the files into an automated posting system. This eliminates a number of manual procedures.

Electronic Funds Transfer (EFT) deposits payments directly into providers’ bank accounts, allowing them to receive funds before BlueCross mails checks.

Providers can request ERA and EFT together or separately. They are independent of each other. Complete the ERA Addendum found on www.HIPAACriticalCenter.com. The EFT form is available on 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 Electronic Data Interchange (EDI) Help Desk.

EDI Help Desk 800-868-2505

You can submit professional and institutional claims, including corrected and secondary claims, through My Insurance Manager at no charge. View tutorials on filing claims on the Web at www.SouthCarolinaBlues.com. 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@bcbssc.com to request this education.
EDI Questions and Answers

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. 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: BlueCross publishes a list of certified vendors in the HIPAA Critical Center at www.HIPAACriticalCenter.com.
Question: Who is the best vendor, or whom do you recommend?

Answer: BlueCross does not make specific recommendations, but offers the list of certified vendors who currently transmit to BlueCross electronically.

Question: What types of claims can be sent electronically?

Answer: All claims. BlueCross accepts 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 BlueCross requires you to submit electronically.
Section 12: 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 electronic data interchange (EDI) comply with the adoption of national uniform transaction standards and code sets, and requires new unique provider identifiers.

The BlueCross BlueShield of South Carolina 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. BlueCross met this deadline and is 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., explanation of benefits [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. Providers should assign responsibility for ensuring compliance with the transactions and code sets to a specific person within their offices who can work with the information systems vendors, payers and clearinghouses as applicable. Also, providers 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 under Enrollments and Agreements.

Companion Guide

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

Supplemental Implementation Guide (SIG)

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

- It is the provider’s responsibility to be compliant. If a provider is not compliant, he or she risks having BlueCross return claims or even fine the provider 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 BlueCross 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. Please complete enrollment forms electronically and email them to EDIG.OPS@PalmettoGBA.com. Use your TAB key to move forward through the form fields or click your cursor in a desired field or box. Be sure to save the file after you have completed the form.

The Trading Partner Agreement is a legal document. All trading partners are required to print, complete and return the originally signed hard copy via mail before being moved to production status. You can find the BlueCross Trading Partner Agreements at the HIPAA Critical Center. The PGBA Trading Partner Agreement can be found on www.MyTRICARE.com in the Electronic Claims Filing section under Provider.

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
- [ ] Change
- [ ] Cancel

**Trading Partner’s Name:**

**Trading Partner ID:**

**Federal Tax ID #:**

**Type of Business:**
- [ ] Institutional Health Care Provider
- [ ] Professional Health Care Provider
- [ ] Retail Pharmacy
- [ ] Software Vendor
- [ ] Other (indicate): ____________________________

**Line of Business:**
- [ ] BlueCross BlueShield of South Carolina Commercial PGBA
- [ ] TRICARE

**Start Date:** ____________________ (mm/dd/ccyy)  **End Date:** ____________________ (mm/dd/ccyy)

(Required when canceling an account)

**Compression:**
- [ ] No Compression
- [ ] PKZIP
- [ ] UNIX

**Protocol:**
- [ ] NDM
- [ ] FTP DIALUP
- [ ] ASYNC DIALUP (product)________
- [ ] Secure FTP
- [ ] VPN
- [ ] TCPIP via VPN
- [ ] TCPIP via AGNS

**Service Address**

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**Billing Address** (if different from the Service Address)

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**Primary Contact’s Information**

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**Primary Technical Contact’s Information**

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**After Hours Technical Contact’s Information**

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**On-Call Technical Contact’s Information**

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If you use a vendor’s software to create ASC X12N transactions you submit to the EDI Gateway, please provide the vendor’s name and address below and list the transactions.

### Vendor’s Information

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<td>City/State/ZIP:</td>
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<td>Transactions:</td>
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### Vendor Customer’s Information

If another entity has authorized your business to send or receive transactions on its behalf, please provide the entity’s name, federal Tax Identification Number and service/physical address state. **This is required for all transactions.**

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<tr>
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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**

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<td><strong>2nd Additional Contact Information</strong></td>
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<td><strong>3rd Additional Contact Information</strong></td>
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<td>Fax: ( ) -</td>
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BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association
Section 13: 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.

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.
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.

2. Click on Providers 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.
Frequently Asked Questions

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 new 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 14: PPO Voice Response Unit

Voice Response Unit (VRU)

The Provider Services area and the Voice Response Unit (VRU) are available for eligibility and claim status information.

The VRU provides all routine claim status and eligibility/benefit information. This accessible tool gives quick and easy information 24 hours a day, seven days a week using a touchtone phone. It is available for all BlueCross members and some national accounts. If the VRU cannot handle your inquiry, you can transfer to a phone representative.

We also have a VRU guide with tips on navigating menu options.

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.

Phone Representatives

Phone representatives are available to answer problem calls. You can transfer to a phone representative for any information that is not available through the VRU. You should get routine claims status and eligibility through the VRU before opting out to speak to a representative.

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 on My Insurance Manager.
## Section 15: Communicating with BlueCross

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<th>Department</th>
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<tr>
<td>BlueCross Switchboard</td>
<td>800-788-3860</td>
<td>800-288-2227</td>
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<tr>
<td>EDI Help Desk</td>
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<td>800-868-2505</td>
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**Provider Services**

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<td>APS Healthcare</td>
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<td>800-221-8699</td>
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<tr>
<td>BlueCard Eligibility</td>
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**Preauthorization**

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<td></td>
<td></td>
<td>800-334-7287</td>
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<tr>
<td>Federal Employee Program</td>
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<tr>
<td>State Health Plan</td>
<td>803-699-3337</td>
<td>800-925-9724</td>
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<td>Planned Administrators, Inc.</td>
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<td>888-376-6544</td>
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<td>BlueCard Authorization</td>
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<td>800-676-BLUE (2583)</td>
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<td>Companion Benefit Alternatives</td>
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<td>800-868-1032</td>
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**Education and Credentialing**

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<tr>
<td>Provider Education</td>
<td><a href="mailto:Provider.Education@bcbssc.com">Provider.Education@bcbssc.com</a></td>
<td>800-288-2227, ext. 44730</td>
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<tr>
<td>Provider Certification</td>
<td><a href="mailto:Provider.Cert@bcbssc.com">Provider.Cert@bcbssc.com</a></td>
<td>800-288-2227, ext. 48402</td>
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PPO Provider Services In and Out of State

Ask Provider Services functionality

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<tr>
<th>Phone</th>
<th>800-868-2510</th>
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<tr>
<td>Phone</td>
<td>800-334-2583 (Toll Free)</td>
</tr>
<tr>
<td>Fax</td>
<td>803-264-4172</td>
</tr>
<tr>
<td>Brian Butler, Senior Director</td>
<td>803-264-3235</td>
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<td>Brenda Bethel, Director</td>
<td>803-264-8416</td>
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PPO Dental Provider Services

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<tr>
<th>Phone</th>
<th>800-222-7156</th>
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<tr>
<td>Fax</td>
<td>803-264-7629</td>
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<tr>
<td>Belinda Stokes, Manager</td>
<td>803-264-5460</td>
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<tr>
<td>David Strobel, Supervisor</td>
<td>803-264-9079</td>
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State Health Plan Provider Services

Ask Provider Services functionality

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<th>Phone</th>
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<tr>
<td>Fax</td>
<td>803-264-4204</td>
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<tr>
<td>Donna Frishcosy, Manager</td>
<td>803-264-2520</td>
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State Health Plan Dental Provider Services

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<th>Phone</th>
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<tr>
<td>Phone</td>
<td>803-264-3702 (Local)</td>
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<tr>
<td>Fax</td>
<td>803-264-8109</td>
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<td>Sharon Grier, Supervisor</td>
<td>803-264-2089</td>
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FEP Provider Services

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<tr>
<th>Phone</th>
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<tr>
<td>Fax</td>
<td>803-264-8104</td>
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<tr>
<td>Cynthia Lagatore, Director</td>
<td>803–264-3325</td>
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<td>Pamela Johnson, Supervisor</td>
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FEP Dental Provider Services

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<th>Phone</th>
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<tr>
<td>Fax</td>
<td>843-763-0631</td>
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<tr>
<td>Virgie Reid, Supervisor</td>
<td>843-766-5296, ext. 22131</td>
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